FINAL REPORT AND RECONCILIATION

PRESENTED TO: CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,
FEDERAL GRANTS DIVISION

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS FOUNDATION AND
CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
Contract Number 22-20410
SOR III

SUBMITTED JUNE 27, 2024

CAFP FOUNDATION

Investing in the future of family medicine

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CAFP
California Academy of Family Physicians

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EXECUTIVE SUMMARY

SAMHSA and DHCS support of our California Residency Program Collaborative (CRPC) and other activities funded through SOR III have made a real impact on patient lives in California and have set in motion cultural and systems changes that will lead to sustainability and improvements far beyond this grant cycle.

This multi-specialty physician residency program collaborative has exceeded our expectations. We see before our eyes a sea change in SUD care where interns and residents who know very little about addiction care and medication for opioid use disorder (MOUD), end up as champions and trainers to their colleagues (and many times re-trainers of attending faculty) that has resulted in a new culture and standard of care in these residency programs. These residents will continue throughout their careers to affect positive change and we are humbled and proud to be a part of this process.

"As the healthcare system begins to realize and fund 'addiction as a treatable chronic condition,' CRPC and DHCS support is critical to demonstrate the moral and financial data to sustain and expand SUD services." ~ CRPC-3 Grantee

We asked our grantees to complete this statement, "Without this Collaborative and CRPC resources, we would not have been able to…" Their responses are in their final reports (see Appendix I). However, we wanted to highlight a few of them to quickly demonstrate the true value of this work:

Without this Collaborative and CRPC resources, we would not have been able to…

- Change a hospital and community culture surrounding substance use disorder and its associated conditions
- Inspire the next generation of family physicians to view substance use disorder as a chronic, treatable disease which they can address
- Initiate adolescent addiction services that provide immediate harm reduction, evidenced based SUD care and longitudinal follow up.
- Transform addiction education and care in our region
- Remove institutional barriers for primary care physicians at Kaiser Permanente San Diego to prescribe Suboxone for OUD or Chronic Pain.
- Design, deliver and sustain a culture of low threshold MAT for AUD
- Seriously affect the policies of the hospital to become MAT friendly and OUD understanding.
- Realize a large [unmet] diagnostic and treatment need for our clinic patients and bring new processes and resources to bear in helping meet and sustain their treatment needs.
- Build an energetic community of health care providers with the expertise to care for marginalized individuals while simultaneously challenging and improving the system of care.

In addition to success, we also identified ongoing barriers to progress and some of these are described in our Quality Improvement section below on page 33. One of the most onerous obstacles to progress includes Pharmacy policies, formularies, and actions thwarting access to buprenorphine. Undue and outright fear of DEA and CDPH audits exists which limits what can be done for patients in need. In the end, these attitudes and fears undoubtedly result in more overdose deaths and injuries. Another barrier was the lack of ability to use grant funds for contingency management. Not all our grantees were in the pilot counties that offered these funds. We hope the restriction can be lifted for future grants.

During this grant cycle, we were fortunate to be able to develop a framework anchored to our three overarching objectives: increase the identification of those in need of treatment, expand treatment, and

expand harm reduction services, that allowed us to demonstrate the collective ability of our collaborative to move the needle on our overarching objectives.

Some high-level data points of our progress over SOR III (14 months, April 2023-May 2024) include:

- *Increased **identification** of SUD: 8,781 screened for mental health.*
- *Expanded **treatment**: 5,253 patients referred to SUD recovery services.*
- *Expanded **harm reduction**: 6,100 xylazine test strips distributed, 13,442 units of naloxone distributed.*

This grant has contributed to California being on the leading edge of efforts to increase the number of primary care providers offering MOUD. Not only through our Residency Collaborative, but also through two important initiatives: the MOUD champions program and the Treating Addiction in Primary Care Podcast Series. Both efforts have been recognized by the National Institute on Drug Abuse (NIDA). Our data has indicated that ***333 more providers began prescribing MAT/MOUD*** through our collective efforts.

We are thankful for the team we worked with, Anita Charles, CAFP Education Program Manager, Laurie Isenberg, MILS, CHCP, CAFP Director of Education and Professional Development, Pam Kittleson, RPh, IPMA Director of Quality, and Sheila Robertson, Data Consultant. We also wish to thank Christina Flores, Stephanie Williams, Vicki Watkins and other team members at the Department of Health Care Services, who have supported our work throughout the project.

Carol Havens, MD, FAAFP
CRPC-3 Chair, Executive Advisory Panel

Jerri L. Davis, CHCP
CAFP Vice President, Education and Professional Development

Pamela Mann, MPH
CAFP Foundation Executive Director

Project Goals and Objectives

As stated in the approved Request for Applications (RFA), the overall goal of this initiative was to reduce opioid overdose-related deaths, particularly in the most vulnerable populations, while encouraging creative and innovative approaches to meeting program and community needs.

With these goals in mind, we selected three objectives for the RFA:

- **Identify those in need of treatment**
- **Initiate/engage/sustain individuals in treatment**
- **Expand harm reduction**

We encouraged applicants to use SMART goals/objectives and include an action plan and measurable outcomes, a methodology to both implement the action plan and measure the project's impact, and a timeline for spread and plan for sustainability. While continuous assessment of the project goals/objectives and participation in the quality improvement module resulted in several of the grantees revising their initial proposals, we believe the ultimate outcomes proved very successful and we are proud of all that was accomplished through this learning collaborative and overall project.

CRPC Expert Advisory Panel (EAP)

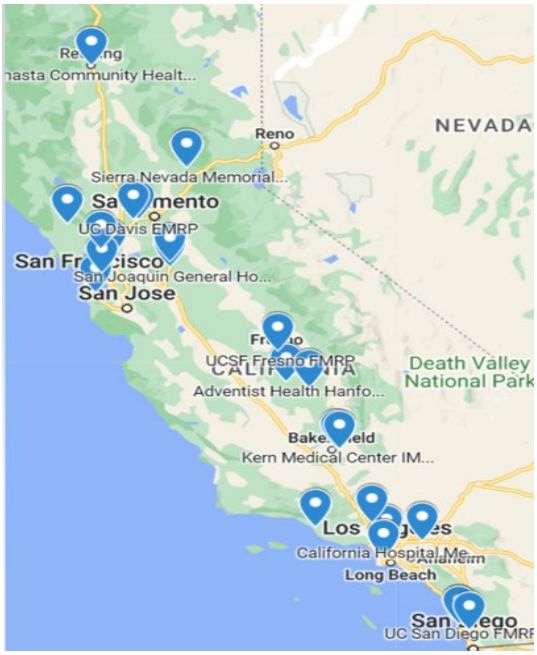
The project's Expert Advisory Panel, chaired by Carol Havens, MD, FAAFP, was identified and invited based on a series of criteria. We sought to have a broad panel, with representatives from a variety of specialties, locations, and practice settings. The panel members participated in a thorough review of the Request for Proposal; grant review, scoring and grantee selection; development of educational content; webinars and meetings. They also served as clinical advisors for staff and grantees throughout the project, attended webinars and meetings and were always willing to help when asked. We are very appreciative of their support.

"These programs have done such amazing and truly inspirational work. They are having such an impact on the lives of their patients and their colleagues and programs." ~ Carol Havens, MD, FAAFP, FASAM

"I knew I was impressed with these grantees before but after seeing them present the highlights of their accomplishments at the convocation, I am absolutely floored!" ~ Jean Marsters, MD

EAP Members	Specialty/Constituency
Carol Havens, MD, FAAFP, FASAM, EAP Chair	Family Medicine and Addiction Medicine, Chair, CAFP's Committee on Continuing Professional Development
Thomas C. Bent, MD, FAAFP	Family Medicine, CAFP Foundation Board of Trustees
Cynthia Chatterjee, MD	Psychiatry, Addiction Medicine
Condessa Curley, MD, MPH, FAAFP	Family Medicine, Public Health
Tipu V. Khan, MD, FAAFP, FASAM	Family Medicine and Addiction Medicine with emphasis in Obstetrics
Jean Marsters, MD	Psychiatry and Addiction Medicine
Heyman Oo, MD	Pediatrics
David Pating, MD	Psychiatry and Addiction Medicine
Michael Potter, MD, FAAFP	Family Medicine, Practice based research
Elisa Pujals, MD	Family Medicine, MAT/MOUD Champion
Siddarth Puri, MD	Psychiatry, Addiction Medicine (former grantee)
Jesse Ristau, MD	Internal Medicine, Addiction Medicine

CRPC Grantees



• Adventist Health Hanford Family Medicine Residency Program • Adventist Health Tulare Family Medicine Residency Program • California Hospital Medical Center Family Medicine Residency Program • Contra Costa Regional Medical Center Family Medicine Residency Program • Harbor-UCLA Pediatric Medicine - Family Medicine Residency Program • Harbor-UCLA Internal Medicine - Family Medicine Residency Programs • Highland Hospital / Alameda Health System Emergency Medicine Residency Program • Kaiser Permanente Santa Rosa Family Medicine Residency Program • Kaiser Permanente Vallejo Family Medicine Residency Program (Fourth Second: One Love Vallejo Mobile Health) • Kaiser Permanente San Diego Family Medicine Residency Program • Kern Medical Center Internal Medicine Residency Program • Olive View UCLA Medical Center Emergency Medicine Residency Program • Pomona Valley Hospital Medical Center Family Medicine Residency Program • Rio Bravo Family Medicine Residency Program • San Joaquin General Hospital Family Medicine Residency Program • San Mateo County Psychiatry Residency Training Program • Shasta Community Health Center Family Medicine Residency Program • Sierra Nevada Memorial Hospital Family Medicine Residency Program • St. Joseph's Medical Center Stockton Emergency Medicine Residency Program • UC Davis Emergency Medicine Residency Program • UC Davis Family Medicine Residency Program • UC San Diego Family Medicine Residency Program • UC San Diego Internal Medicine Residency Program • UC San Francisco Fresno Family Medicine Residency Program • Ventura County Medical Center Family Medicine Residency Program

We received a total of 36 qualified applications. Ultimately, the 25 programs recommended by the EAP using the approved DHCS scoring rubric, and approved by DHCS, were approved. They represented both community-based and academic medical center-based residency programs. Their specialty and geographic breakdown follows:

Medical Specialty
16 - Family Medicine (FM) proposals
1 - combined Family Medicine-Internal Medicine (IM) proposal
1 - combined Family Medicine -Pediatrics proposal
4 - Emergency Medicine proposals
2 - Internal Medicine proposal
1 - Psychiatry proposal

Geographic Range (counties)
7 - Central Valley: Fresno, Kern (2), Kings, San Joaquin (2), Tulare
9 - Northern CA: Alameda, Contra Costa, Nevada, Shasta, Sacramento (2), San Mateo, Solano, Sonoma
9 - Southern CA: Los Angeles (5), Ventura, San Diego (3)

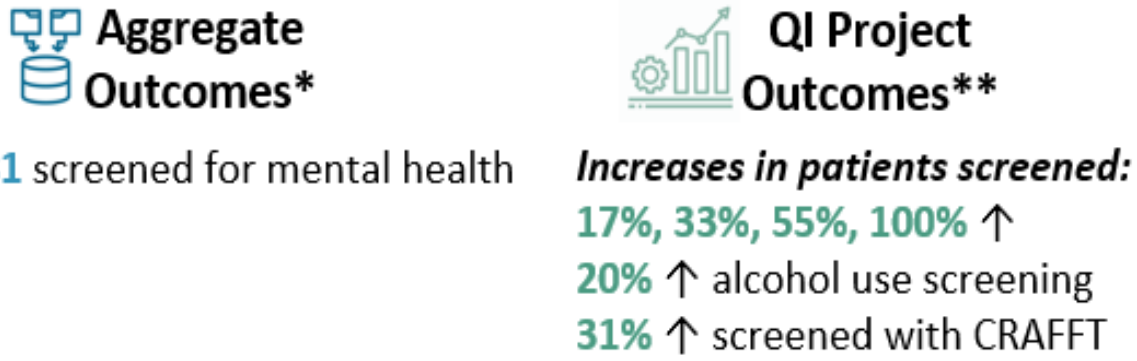
AGGREGATE OUTCOMES/HIGHLIGHTS

A data framework that highlights change
We developed a framework anchored to our three overarching objectives: increase the identification of those in need of treatment, expand treatment, and expand harm reduction services. Aggregate outcomes collected from all grantees (such as the DHCS/UCLA quarterly report data), as well as QI Project and other outcomes data that were more individualized based on grantee projects, were then grouped under respective objectives. This helps demonstrate the collective ability of our collaborative to move the needle on our overarching objectives. Outcomes highlights for each objective are shown below.

Objective 1: Identifying those in need of treatment

Example grantee activities:

- Initiated SUD screening and providing MOUD at multiple clinic sites through increasing provider confidence and establishing screening protocols and standard workflows.



**Per quarterly reports covering 14 months, approx. 4-1-23 through 5-30-24*
***Per QI Online Module, improvement over baseline. Numbers represent the percent of key aim achievement at project conclusion minus the percent of achievement at baseline. Some started at 0%, others started higher. Some reached full potential during the relatively short data collection timeframe (8-10 months), and others are trending positive and expected to reach/sustain potential as the projects' momentum continues into the future.*

Objective 2: Initiate/Engage/Sustain Individuals in Treatment

Example grantee activities:

- Created resident rotations that service incarcerated patients
- Train the trainer/faculty development fellowship (shadowing & education)
    - Connected multispecialty providers in health system; hands-on training and education
- Provided education and training to increase nursing staff knowledge about MOUD and their participation in patient screening
- Initiated teen advisory panels to hear from local teen community about issues that they see within their life and school around SUD
- Developed and shared order sets for micro and macro dosing
- Launched Addiction Medicine Elective for residents
- Increased services to unhoused patients through "backpack medicine program" and expanded number of street medicine teams
- Provided residents (and now nurses who previously were opposed to involvement) with training on long-acting injectables (LAIs)
- Changed hospital policies that are barriers to care or used to target patients with SUD (i.e. ending MAT formulary restrictions)
- Addressed system barriers by providing data to leadership to show benefits to providing prompt services to SUD patients

"We had the pleasure of seeing a gentleman in his mid 60's who suffers from schizoaffective disorder, methamphetamine use disorder and has been living with HIV for >20 yrs. During an outpatient visit for HIV my resident noticed amphetamine use disorder in his chart and that he had been referred to an addiction specialist. Inquiry revealed his intake with the addiction specialist had been rescheduled multiple times and to his knowledge he had never been offered medication for his methamphetamine struggles. After a conversation about his use history and discussion of options, the patient desired to trial Naltrexone. Upon 1 week follow up he had moved from twice daily use routinely to zero use in the first week. Naltrexone gave him the power to quit immediately and now; >4 months out, he has yet to relapse. For me, this reinforces the potential that family medicine doctors have to intervene in the lives of their patients and their communities. ***Educational funding that CRPC provides drives this change, and our patients are forever blessed."***

Aggregate Outcomes*

Attended Training:
3,779 MAT
1,935 Other SUD Tx

***Began* prescribing MAT: 333**

Patients Referred:
2,939 to SUD treatment services
5,253 to SUD recovery services
1,494 to housing services

QI Project Outcomes**

41%, 100% ↑ trained on MAT
67%, 84% ↑ patients received MAT
38% ↑ inmates receive OUD care
15% ↑ ED SUD pts f/u in 30 days
1.44 ↑ MAUD rx/month in PC

Objective 3: Expand Harm Reduction Services

Example grantee activities:

- Deployed cutting edge sophisticated harm reduction vending machines reaching some of our most vulnerable patients with SUD
- Increased distribution of Narcan in many ways
- The "View from the Street" webinar led to many planned changes in practice in this area

Aggregate Outcomes*

Attended Training:
1,707 overdose & naloxone
1,402 harm reduction

Distributions:
13,442 naloxone
6,100+ xylazine test strips
1,750+ fentanyl test strips
933 safer consumption kits

The Highland Emergency Medicine (EM) resident team collaborated with Alameda County Healthcare for the Homeless (ACHCH), Cardea Health, and Bay Area Community Services (BACS) to set up the first iteration of a mobile medication-assisted treatment (MAT) clinic at the Henry Robinson center, a BACS transitional housing center for 137 Oakland residents.

TECHNICAL ASSISTANCE, EDUCATION & SUPPORT

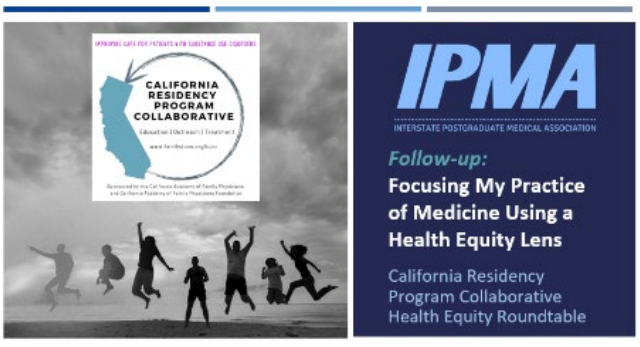
Members of the EAP, the CAFP, and Interstate Postgraduate Medical Association (IPMA) designed, developed, and implemented several activities and educational offerings based on the grant proposal submitted to DHCS and, of course, on grantees' needs. The activities included webinars, regional workshops, a performance improvement project, live and enduring education materials, links to DHCS information and a robust online resource library. We accredited many of the educational sessions, offering learners a total of 12.50 CME/CE credits through this collaborative, excluding the additional credit offered through the Quality Improvement module described below. Our grantees also participated in regular check-in calls, data reporting and email updates with the CAFP and IPMA teams.

Education – Content Development

Designing and delivering educational content on important topics is an important part of this collaborative project. We engaged with addiction medicine experts, state and local community leaders, and even law enforcement to produce timely relevant, and impactful, education for our grantees.

Health Equity Education

A strong focus on health equity was integrated in our collaborative for this 2023-2024 cycle. In line with this focus, IPMA developed educational sessions aimed at improving care for patients with substance use disorders (SUD) to address this focus. These sessions were designed to foster a collaborative approach to addressing health equity challenges in SUD treatment, promoting continuous improvement and innovation.

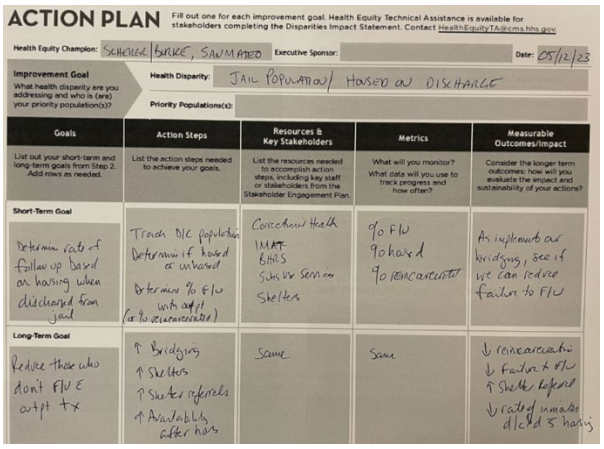


Learning Objectives:

- Recognize the impact of Social Determinants of Health (SDOH) on patient outcomes.
- Apply the CMS Disparities Impact Statement Framework to develop SMART goals for advancing health equity in SUD programs.

The educational components featured two key items:

1. ***In-person Sessions (May 2023)****:*
   - **Locations and Dates**: Held in Sacramento and Los Angeles on May 12-13, 2023.
   - **Faculty**: Dr. Alvia Siddiqi and Dr. Debra Levinthal led the sessions, focusing on integrating health equity goals into SUD programs.
   - **Activities**: These half-day sessions introduced Health Equity (HE), showcased a case study from a large health system, and introduced the CMS Disparities Impact Statement Framework & Action Plan.
   - **Workshops**: 21 Participants engaged in interactive small group sessions where they used the CMS framework to develop short-term health equity goals tailored to their specific projects.
   - **Outcome**: The sessions concluded with group presentations of action plans, followed by discussions and feedback, enhancing participants' skills in addressing health disparities.
   - Participants described their learning experience with words such as "Inspired," "Curious," and "Reinvigorated," highlighting the positive impact of the sessions.
   -
2. ***Wrap-up Webinar (April 2024)****:*
   - **Focus**: This session reviewed the results and learnings from the year's programs, highlighting the successful integration of health equity into SUD treatment.
   - **Discussion**: 26 Participants discussed the successes and challenges of the past year, including cultural and logistical barriers, and shared strategies developed to enhance the integration of health equity into their projects.
   - **Feedback**: The collaborative nature of the webinar facilitated a rich exchange of ideas and experiences, aimed at fostering ongoing improvement and innovation.
   - **Impact on Projects**: 5 of 6 responding participants strongly agreed the sessions made them more effective in integrating Health Equity goals into their SUD programs. The aggregate outcomes data through May 2024 reported 4,139 individuals from underserved and/or diverse communities were reached through community outreach events and activities associated with the 2023-2024 CRPC3 projects.



ACTION PLAN

Fill out one for each improvement goal. Health Equity Technical Assistance is available for stakeholders completing the Disparities Impact Statement. Contact HealthEquityTA@cms.hhs.gov

Health Equity Champion: SCHERER/BURKE, SAMMATEO Executive Sponsor: Date: 05/12/23

Improvement Goal — What health disparity are you addressing and who is (are) your priority population(s)?

Health Disparity: JAIL POPULATION/ HOUSED ON DISCHARGE

Priority Population(s):

Goals	Action Steps	Resources & Key Stakeholders	Metrics	Measurable Outcomes/Impact
List out your short-term and long-term goals from Step 2. Add rows as needed.	List the action steps needed to achieve your goals.	List the resources needed to accomplish action steps, including key staff or stakeholders from the Stakeholder Engagement Plan.	What will you monitor? What data will you use to track progress and how often?	Consider the longer term outcomes: how will you evaluate the impact and sustainability of your actions?
Short-Term Goal: Determin rate of follow up based on housing when discharged from jail	Track DIC population Determin if housed or unhoused Determin % F/U with outpt (or to reincarceration)	Correctional Health IMAT BHRS Substance Services Shelters	% F/U % housed % reincarceration	As implement our bridging, see if we can reduce failure to F/U
Long-Term Goal: Reduce those who don't F/U E outpt tx	↑ Bridging ↑ Shelters ↑ Shelter referrals ↑ Availability after hours	Same	Same	↓ reincarceration ↓ Failure to F/U ↑ Shelter referral ↓ rate of inmates dicharged & housing

Summary

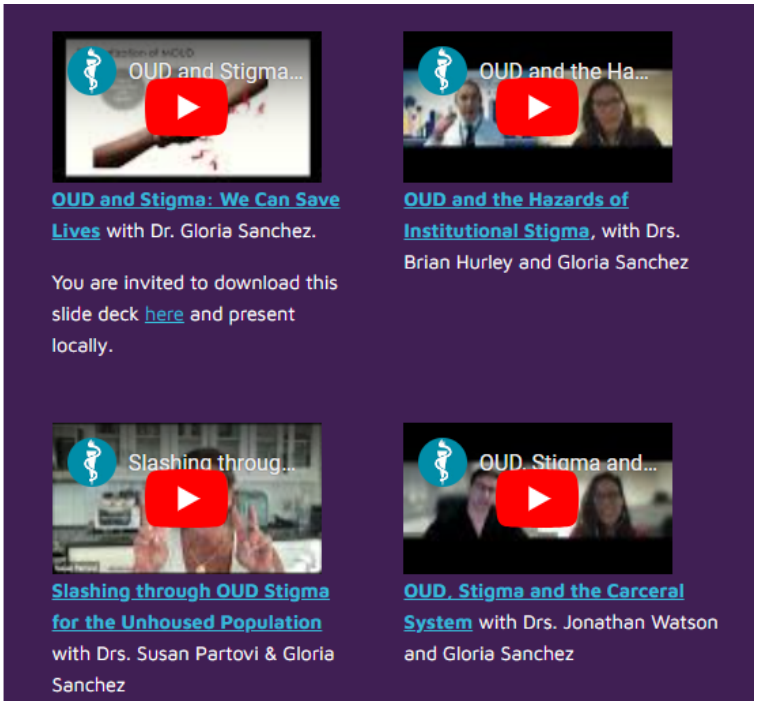
The IPMA Health Equity Roundtable educational sessions provided in CPRC3 grant have helped to effectively equip residency programs with the tools and knowledge needed to advance health equity goals. Participants have reported they are more effective in their ability to integrate these goals into their SUD treatment programs, highlighting the program's value. This training is essential not only for immediate improvements in treating substance use disorders but also crucial for addressing the broader needs of underserved populations.
Furthermore, the skills and knowledge acquired through these sessions are highly transferable and invaluable for future healthcare work. Professionals trained in these programs are better prepared to identify and address health disparities, utilize strategic frameworks like the CMS Disparities Impact Statement, and implement comprehensive action plans. Expanding and delivering more educational programs of this nature will be vital in cultivating a healthcare workforce proficient in advancing health equity, ultimately leading to substantial and sustainable improvements in patient care and health outcomes across the healthcare system.

Educational Resources on Stigma

Working with CRPC grantee Gloria Sanchez, MD, FASAM, we developed a package of resources to address stigma associated with OUD. These resources include four short videos, as well as an annotated slide deck, to empower champions to educate their own colleagues locally. These materials are now available to grantees through our portal and are available to the general public via https://familydocs.org/sud.

Series Title: *Voices of Stigma*

- Dr. Gloria Sanchez, "OUD and Stigma: We Can Save Lives" With assistance from Dr. Clay Thibodeaux, Dr. Marina Costanza, and Dr. Jonathan Vargas. 20 minute video & annotated slide deck
- Dr. Brian Hurley & Dr. Gloria Sanchez, "OUD and the Hazards of Institutional Stigma." 14 minute video
- Dr. Susan Partovi & Dr. Gloria Sanchez, "Slashing through OUD Stigma for the Unhoused Population." 24 minute video
- Dr. Jonathan Watson & Dr. Gloria Sanchez, "OUD, Stigma and the Carceral System." 29 minute video

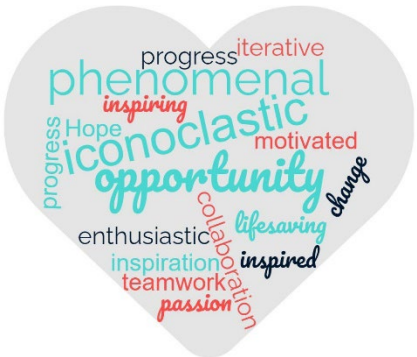


CRPC Meetings & Webinars

Below is a summary of the meetings and webinars, in date order, conducted during this learning collaborative. Each session offered education and opportunities to collaborate with fellow grantees. If requested, we are happy to provide the complete agenda, presentation and resources used for each session.

April 22, 2023 – Full Grantee in person 5-hour Meeting in Sacramento

The first full grantee meeting was held in Sacramento. We had active engagement and participation from the 49 participants - all 25 residency programs were represented - as well as members of the EAP and staff. The agenda included an overview of the California OUD-SUD/Addiction/MAT landscape by Dr. Aimee Moulin, Professor, UC Davis and the UC Davis Emergency Department Behavioral Health Director along with brief presentations by each of the grantees about their projects. We also provided an introduction to Quality Improvement, reviewed the many tools and resources available, heard from prior CRPC-1 & 2 grantees sharing their experience and advice for getting the most out of this collaborative and broke into small groups based on the grantee proposals so that grantees could share information, resources and anticipated barriers and challenges from the very beginning of the collaborative.

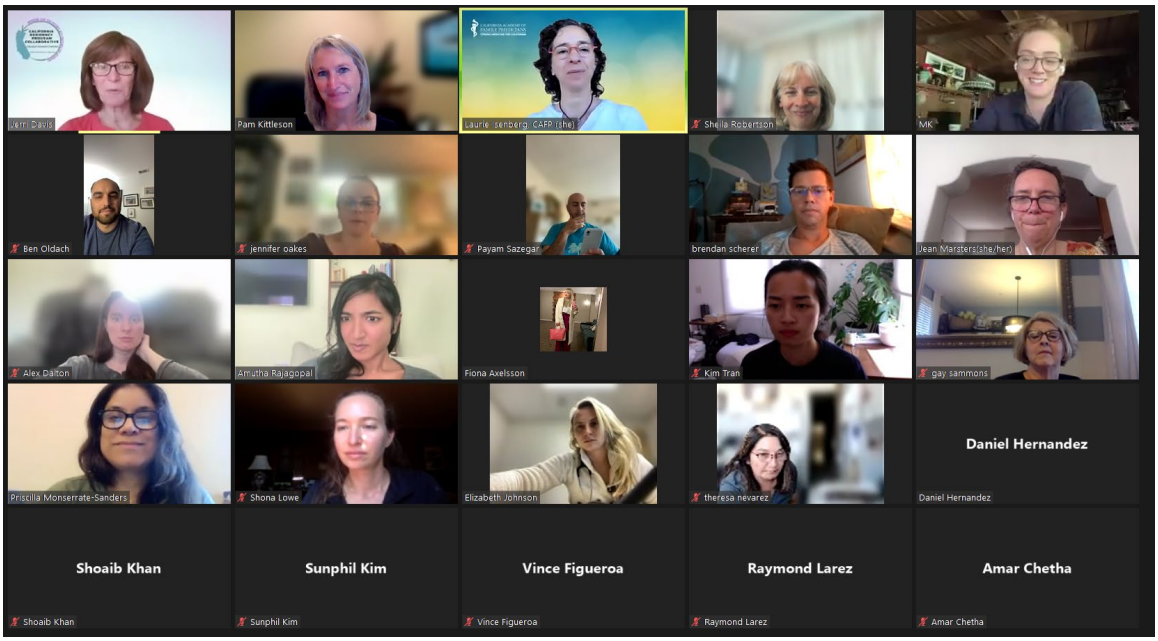


The final "One Word Reflection" where we asked learners to provide us with one word about how they felt after the session is reflected in the wordle image to the right here. We were off to the races!

CRPC-3 Kick Off Meeting

June 14, 2023 – Lunch and Learn 1 hour Virtual Workshop

Our next meeting (after the Health Equity in person meetings described above) was held in June with active engagement and participation from the 50 participants – 23 of the 25 residency programs were represented - as well as members of the EAP and staff. At this session, we discussed the Framework developed to demonstrate more effectively the data we are collecting in this collaboration. Our goal was to ensure all grantees understood what we were collecting and why and also find out if we could help with any barriers to collection. We provided the grantees with useful information and resources from our Quality Improvement Project and then had a long discussion about how to increase provider engagement. We recorded the webinar and made the full meeting available to grantees on the private CRPC website along with meeting and chat notes.



Live virtual Webinar - June 21st, 12 noon - 1 PM - *View From The Street*

A week after our first virtual CRPC Webinar, we presented a public live webinar co-presented by one of our very own CRPC grantees, Rebecca Trotsky-Sirr, MD, and she was joined by Sergeant Brian Gunsolley with the Orange County Sheriff's Department. This session described how patients are obtaining Fentanyl and other synthetic opioids and how clinicians can help their patients recognize and understand the dangers of non-prescribed medication as well as encourage the use of reversal agents. In addition, there was discussion around breaking down barriers to increase use of MAT in primary care. We recorded this session and it is still actively available in Homeroom. To date, we have had 60 enrollments and 51.4 percent plan to make changes based on the education received.

Some of the changes these learners indicated that they planned to make as a result of this webinar include:

- ***Expand treatment through:*** Advocating for broader availability of MAT, use more Suboxone, I will be better able to counsel patients and advocate for earlier treatment, allow appropriate patients to begin Suboxone at home, convince patients to seek treatment for substance use disorder, and provide education regarding treatment options available.

- ***Expand harm reduction through:*** Advocating for broader availability of Narcan and fentanyl test strips, Discuss Narcan more often, I plan to obtain Naloxone ASAP and train my office staff as well as family members on how to administer it.

- ***General:*** Inquire more with my teens, provide education, Make patients aware of presence of fentanyl in most of the street drugs and understand it's potency and ability to cause death, Discuss these drugs better with patients

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Creating a very "alive" collaboration with a pediatric clinic that serves very at-risk children with multiple ACES and unmet needs has been amazing! The teens that we have seen after screening are very engaged and willing to discuss sud and any available mat/sud services.

Regional Webinars

We held our first set of regional meetings virtually one week apart, starting with northern California. At each of the three following meetings, we discussed local resources available to grantees and included a "capsule exercise," which is a means of "crowdsourcing" ideas and potential solutions to a problem, project, or question. We broke into small groups and each grantee was able to introduce their problem/concern and get ideas for solutions and feedback from the others in the group. The grantees were so appreciative of this process and took away a lot of great ideas and possibilities for improving their project efforts. We shared the meeting recordings, and the helpful notes from the meetings on the CRPC Private Webpage for all grantees to benefit from.

"This was a very helpful meeting, you guys have been incredible!"

"This was helpful to walk through the data submission and get us started on the QI portal."

"Thank you for helping us build bridges and connections."

Thirty-three attendees completed our regional webinar evaluation and when asked if they were satisfied with the webinar, 45.5 percent were "Extremely" satisfied and 54.5 percent were "Satisfied." We asked what topics they would like to learn more about from us and they responded with things like: stigma, examples of successes and failures with MOUD, evidence behind MAT screening tools, examples of how to approach the QI project, harm reduction and ideas for following up with patients. When asked what they'd like CRPC's help with, they replied: Ideas for implementing case managers, substance use navigators, how to open/fund a harm reduction clinic, funding sources to hire MAT champions at all levels: MD, PA/NP, SW, SUD Counselors, and create a "Resource Library" for grantees and others to share helpful resources. It was this suggestion that led to our Resource Library on the CRPC Private Page.

July 12, 2023 – 2-hour Northern CA Virtual Webinar

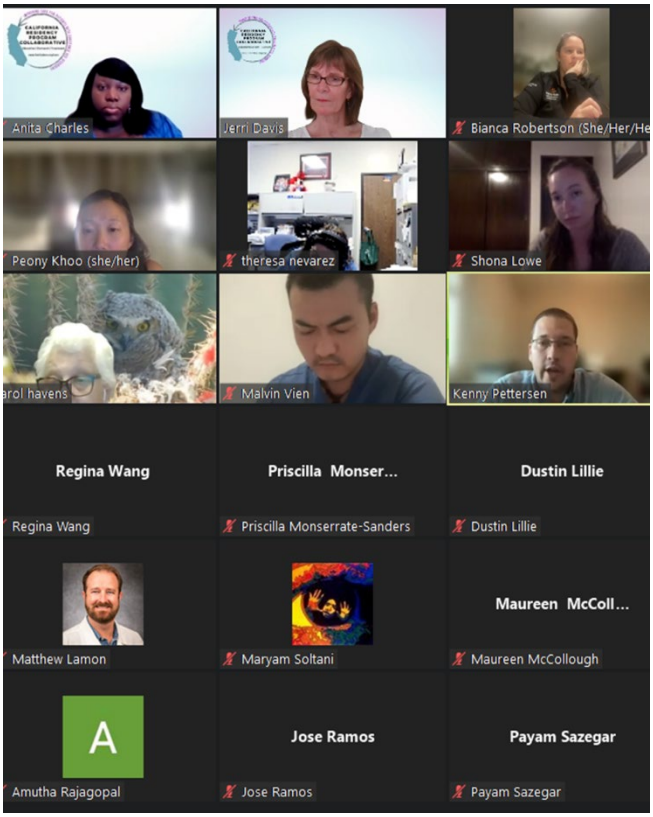
We held our first regional webinar with 10 northern California grantees: Contra Costa Regional Medical Center FMRP, County of San Mateo/San Mateo Psych RP, Fourth Second: One Love Vallejo Mobile Health, Highland Hospital/Alameda Health System EMRP, San Joaquin General Hospital FMRP, Shasta Community Health Center FMRP, Sierra Nevada Memorial Hospital FMRP, St Joseph's Stockton EMRP, UC Davis EMRP, and UC Davis FMRP. There was robust and active engagement from the 16 attendees. We heard from CRPC-1 & 2 grantees that shared advice, and discussed sustainability and also asked grantees to share one success with their project so far.

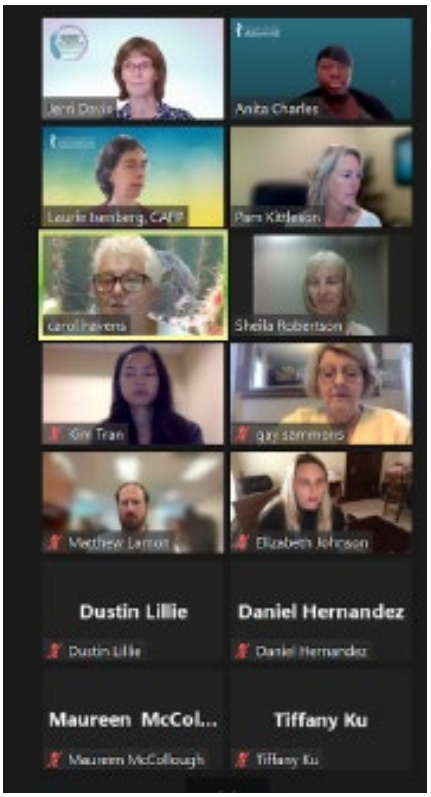
July 19, 2023 – 2-hour Central CA Virtual Regional Webinar

Our next regional meeting included our 5 grantee programs from Central California: Adventist Health Hanford FMRP, Adventist Health Tulare FMRP, Kern Medical Center IMRP, Rio Bravo FMRP, and UCSF Fresno FMRP. There was robust and active engagement from the 14 attendees. They enjoyed sharing their one success and the capsule exercise was very helpful to them. We shared the meeting recording, and the helpful notes from the meeting on the CRPC Private Webpage for all grantees to benefit from.

July 26, 2023 – 2-hour Southern CA Virtual Regional Webinar

Our next regional meeting included our 9 grantee programs from Southern California: California Hospital Medical Center FMRP, Harbor UCLA FMRP + PEDs RP, Harbor UCLA IMRP + FMRP, Kaiser San Diego FMRP, Olive View-UCLA Medical Center EMRP, Pomona Valley Hospital Medical Center FMRP, UC San Diego FMRP, UC San Diego IMRP, and Ventura County Medical Center FMRP. There was robust and active engagement from the 17 attendees. The capsule exercise was very helpful to them, along with a review of all the CRPC resources and this small group could really discuss more local resources available as well. We shared the meeting recording, and the helpful notes from the meeting on the CRPC Private Webpage for all grantees to benefit from.





September 13, 2023 – Lunch and Learn 1 hour virtual Workshop

Our next virtual webinar was attended by 35 grantees. We included time on the agenda for those grantees that attended the CA Society of Addiction Medicine (CSAM) meeting the prior month, as well as the CAFP's Family Medicine POP conference, to share their key "takeaways" from the conferences. We then went into small groups and let grantees choose which groups to join below based on their interest:

- ❖ Education Program development
- ❖ Harm Reduction
- ❖ Street/Unhoused Medicine
- ❖ Recruiting MOUD Champions
- ❖ Addressing Stigma

Some of the resources/information shared included in the small groups included:

- Microsoft Planner (institutional license) project management software for delegating tasks/work items for grant deliverables
- MICaresed.org for educational resources and assistance with practice pathway boarding
- IM Addiction Medicine podcast for trainees and faculty
- Info on syringe Services Programs (SSPs): https://www.cdc.gov/ssp/index.html
- https://erowid.org/ for info on psychoactives
- Addiction Medicine Toolkit for Health Care Providers in Training at NIDA: https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/addiction-medicine-toolkit-health-care-providers-training
- San Francisco Department of Public Health website
- Stigma small group: "higher ups" in hospitals not familiar with non-stigmatizing language, hard to reach certain hospital staff for education sessions, poor survey, response rate, and restricting policies such as not allowing buprenorphine prescriptions in the hospital.
- Education group. Obstacles: have an addiction specialist available to provide guidance, getting over the fear of the initial prescription

There were also questions around the Federal MAT/MATE Act and what counted toward the mandatory 8 hours of education before renewing a DEA license. We provided broad guidance from SAMHSA.

One of our faculty who was inspired by the learning during the fellowship is now leading policy change in the hospital to improve care for patient in perinatal/neonatal period.

Two of our faculty fellows are engaged in revisiting the conversations with local CPS to destigmatize and improve care for patient with SUD in the perinatal period.

October 7, 2023 – 4-hour Full Grantee Virtual Webinar

We held a half-day full grantee virtual meeting with presentations from the CA State Association of Counties (CSAC) and Mario San Bartolomé, MD, MBA, MRO, FASAM, one of our MOUD Champions, an update on QI activities, a summary of data collected to date, presentations from three of our grantees about their projects, a review of our collaborative resource sharing efforts and finally, small group discussion about helping grantees continue to succeed with their projects.

Grantees expressed their appreciation for the very helpful information that "Dr. Mario" shared and the tips and useful resources that the three grantee programs shared and that are included in the CRPC Resource page linked on the private website. We recorded the presentation "MAT and Complex Patients" presented at this webinar and it is still available in Homeroom. To date, eight additional learners have accessed Dr. San Bartolome's presentation. Their evaluations show consensus that the material will help make them more effective in their practice and that they are confident that practice change will result.

December 6, 2023 – Lunch and Learn 1 hour Webinar

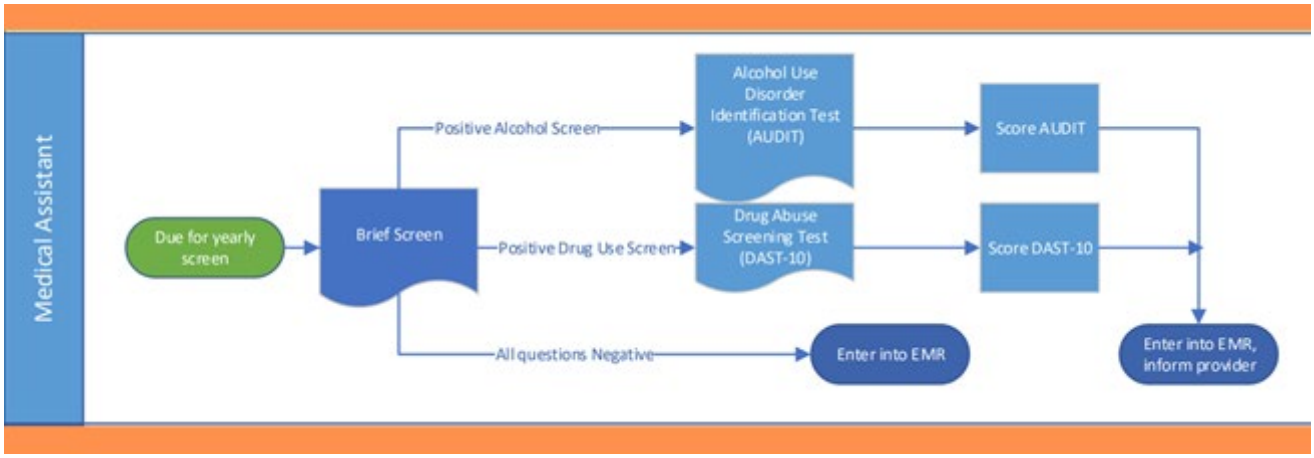
This webinar included presentations by Elissa Feld, MPP, Senior Policy Analyst, County Behavioral Health Directors Association (CBHDA), CA Hospital FMRP and UCSF Fresno FMRP.

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

OVERVIEW OF OPIOID SETTLEMENT FUNDS

December 6, 2023

Grantees appreciated the update regarding CA opioid settlement funding and insights from CBHDA about the importance of connecting with the right people locally to sustain the great work they are doing in the community. The two grantees presented excellent resources that we know will be used by others based on the conversation and appreciation expressed at the meeting. The sample workflow (see image here), specifically, that Dr. Khoo shared from Eisner Health and the CA Hospital FMRP was a highlight for attendees. Evaluations from this meeting were very positive and we gathered specific information from grantees about what topics we should cover at our upcoming regional meetings being held in January.

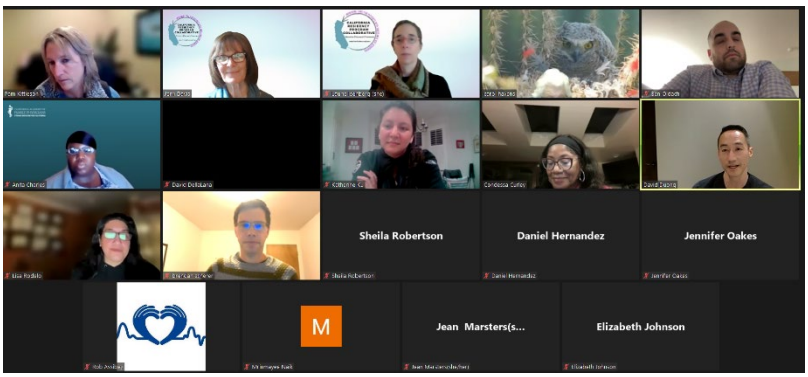


Second Round of Regional Webinars

We held our second set of regional meetings virtually one week apart, starting again with northern California. Since grantees have made it clear that one of the best ways we can help them is by freeing up time for them to collaborate with their fellow grantees, each of the three following regional meetings included "capsule time" again to collaborate and a discussion of resources available and needed.

January 17, 2024 – 2-hour Northern CA Virtual Webinar

We held our second regional webinar with 8 northern California grantees: Contra Costa Regional Medical Center FMRP, County of San Mateo/San Mateo Psych RP, Highland Hospital/Alameda Health System EMRP, San Joaquin General Hospital FMRP, Sierra Nevada Memorial Hospital FMRP, St Joseph's Stockton EMRP, and UC Davis FMRP. There was robust and active engagement from the 19 attendees. We heard from CRPC-1 & 2 grantees that shared advice, and discussed sustainability and also asked grantees to share one success with their project so far.



January 24, 2024 – 2-hour Central CA Virtual Webinar

We held our second regional webinar with 5 southern California grantees: Adventist Health Hanford FMRP, Adventist Health Tulare FMRP, Kern Medical Center IMRP, Rio Bravo FMRP, and UCSF Fresno FMRP as well as 2 northern California grantees that we invited to join: UC Davis EM and Fourth Second: One Love Vallejo Mobile Health. There was robust and active engagement from the 17 attendees.

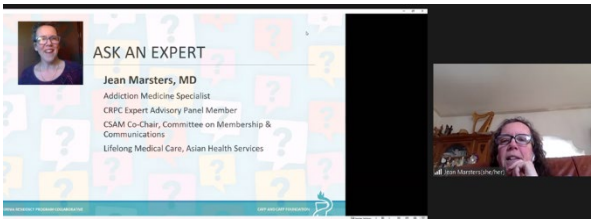
January 31, 2024 – 2-hour Southern CA Virtual Webinar

We held our second and final regional webinar with 9 grantee programs from Southern California: California Hospital Medical Center FMRP, Harbor UCLA FMRP + PEDs RP, Harbor UCLA IMRP + FMRP, Kaiser San Diego FMRP, Olive View-UCLA Medical Center EMRP, Pomona Valley Hospital Medical Center FMRP, UC San Diego FMRP, UC San Diego IMRP, and Ventura County Medical Center FMRP. There was robust and active engagement from the 17 attendees.

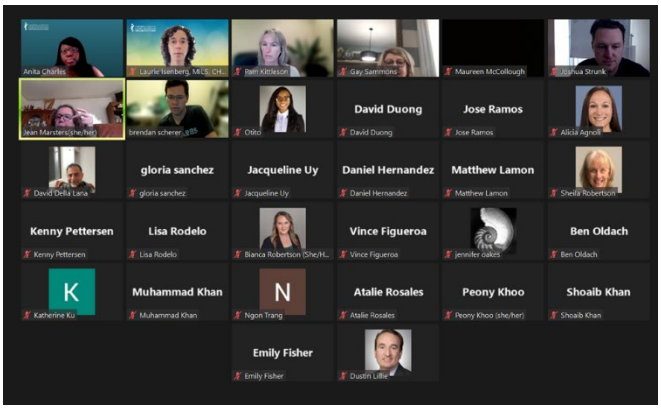
March 13, 2024 – Lunch and Learn 1 hour Workshop

We had 37 attendees at this lunchtime webinar representing nearly all grantee programs. The following topics were addressed in detail:

- Presentation of sustainability resources from DHCS, local governments, and foundations
- *Voices of Stigma* project (see above) from grantee Dr. Gloria Sanchez with suggestions of how this new resource could be leveraged in different grantee environments



· Development/Sharing opportunities at August CSAM conference and scholarships through MERF
· Review of remainder of program events and milestones

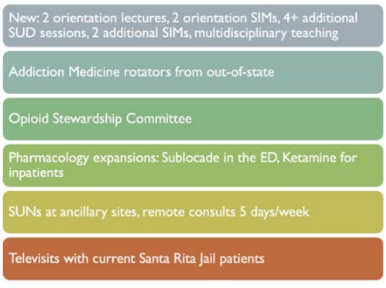


Expert Advisory Panel member Dr. Jean Marsters led a Q&A session with rich discussion on a range of topics, including the implementation of the living library of shared grantee resources on the CRPC private webpage that was suggested at a previous meeting.

The evaluation from this meeting (n=12) showed that 66.7 percent of attendees were "extremely" satisfied with the meeting and 25 percent were satisfied. 100 percent of the attendees indicated that they plan to access and use the resources made available on the private CRPC website.

We asked "Anything else on your mind you'd like to share?," grantees replied:
"Excellent presentation and Q&A session"
"Great program!! Love the ability to collaborate and share resources"
"Thank you for all the resources!"

April 17, 2024 – 1.5 hour Health Equity Webinar



This session is also described above in the "Health Equity Education" section. 37 attendees discussed the successes and challenges of the past year, including cultural and logistical barriers, and shared strategies developed to enhance the integration of health equity into their projects. Several grantees shared their experiences, insights, and successes. Some of these included establishing an opioid stewardship committee, standardized screening of adolescents, increasing the number of residents exposed to working with carceral population (and who now prescribe buprenorphine) from 1 to 6, and removing suboxone restriction in formulary. The collaborative nature of the webinar facilitated a rich exchange of ideas and experiences, aimed at

fostering ongoing improvement and innovation. There was also great interest in publishing a poster or paper describing the success of this collaboration.

May 22, 2024 – 1 hour Optional "Office Hours" Webinar

We held another lunchtime webinar on May 22, giving grantees the option to join and ask questions of the CRPC management team as they conclude their projects and prepare their final reports. We had a few programs join to ask questions around budget reconciliation, data reporting and sustainability.

FINAL CONVOCATION

June 7, 2024 – 5 hour in person meeting (Convocation)
Waterfront Hotel, Oakland, CA

What a fantastic celebration we had with the 36 attendees at our Convocation. It is a very busy time of year for residency programs and four of our grantee programs were unable to attend. The other twenty-one programs, however, spent time sharing the highlights of their projects and what they've accomplished and learned.

CRPC-3 Convocation

HOMEROOM – ENDURING EDUCATION

Homeroom. We are pleased to report that we have fifteen enduring educational activities available in the publicly available CAFP Learning Management System (LMS) "Homeroom" supporting this collaborative at https://education.familydocs.org/.

Twelve of these activities are accredited CME sessions, continuing to offer a total of 12.50 CME Credits to learners, and three are non accredited educational sessions. All are available 24/7 to grantees and others. Here, we are providing a broad range of the educational content.

Educational Offerings in Homeroom:

- Addiction Medicine is Family Medicine (.75 CME)
- Call to Action: The Time for Treating Substance Use Disorder is Now
- Screening and Identifying for Opioid Use and Substance Use Disorders (.5 CME)
- Pain Management and Opioids: Balancing Risks and Benefits (3 CME)
- Pregnancy and Women's SUD (.75 CME)
- Break the Stigma, Save a Life (1 CME)
- Telehealth for Substance Use (.5 CME)
- Medication Assisted Treatments for Opiates, But What About Stimulants: An EBM Literature Review (1 CME)
- OUD and Stigma: We Can Save Lives
- Opioid and Substance Use Disorders in Special Populations: Youth and Young Adult Athletes (1.25 CME)
- Prescribing Medication for Opioid Use Disorder (1 CME)
- Communication Matters: Motivational Interviewing and Substance Use Disorder (.75 CME)
- The Time for Treating Substance Use Disorder is Now (1 CME)
- MAT and Complex Patients: Addressing Provider Concerns
- The View from the Street: What Physicians need to know about Fentanyl and Illicit Drugs (1 CME)

These activities will continue to offer CME credit through August 2024 and be available to learners through the end of the year.

I finally saw our first adolescent patient referred to our addiction medicine clinic after they were seen and screened in the residency clinic! It was expedited and we are starting her on medication, results pending. I think this is the result of the efforts put into training residents to be comfortable screening for adolescent substance use and referring promptly when appropriate.

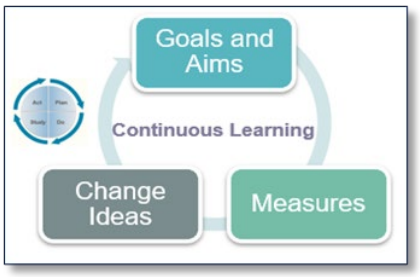
Case Information: Mid 20s patient was connecting to outpatient clinic – she carries a psychiatric history of schizophrenia, depression, and anxiety as well as polysubstance use(methamphetamine, nicotine, opioids). She was currently transitioned to Sublocade while at the local county jail.

MAINTENANCE OF CERTIFICATION (MOC) AND QUALITY IMPROVEMENT (QI)

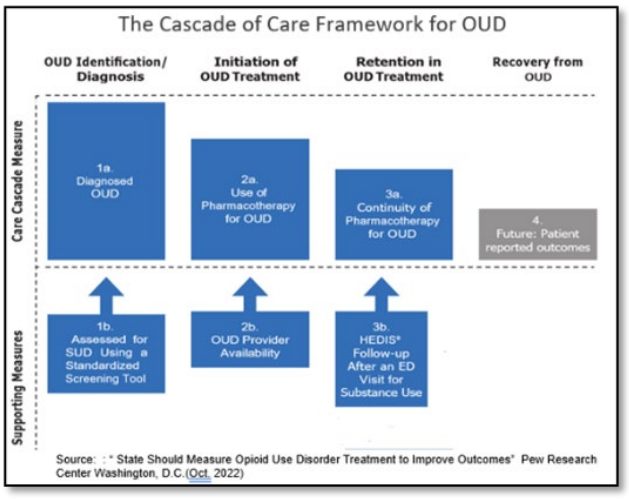
Supporting Practice Transformation through Quality Improvement

Background

IPMA, in collaboration with CAFP, contributed to the *Education, Outreach, and Treatment: Improving Care for Patients with Substance Use Disorder* grant by developing a program to support practice transformation through quality improvement. The program support included quality improvement (QI) education, customized coaching, quality improvement resources, and tools to help plan and implement change. The overall transformation process provided a structure for awardees to work through the implementation of their projects and promote sharing among residencies even as specific implementation and challenges varied. IPMA developed a quality improvement module to support Emergency Medicine, Family Medicine, Internal Medicine, OB/GYN, Pediatrics and Psychiatry residency programs. The project was approved for MOC part IV credit from the American Board of Medical Specialties (ABMS) and provided CME credit.



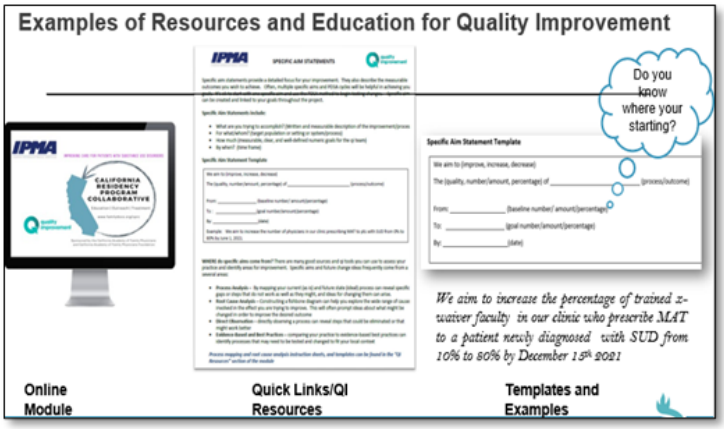
The quality improvement module was designed to assess program readiness for change and provide the framework for linking strategic SMART goals to specific aims (changes in practice) that lead to improvements in their daily work. It is aligned with the Model for Improvement but was not meant to replace change models programs may already be using. Instead, it aims to accelerate improvement and increase the likelihood of making sustainable changes in practice. A literature review was done to assess meaningful measures applicable to primary care and emergency medicine practices. As a result, learners were introduced to the "*Cascade of Care Framework for OUD"* as a model for aligning their Quality Improvement initiatives. Candidate quality measure concepts for various stages at structural, process, and outcome levels were identified. Developing and organizing quality measures under this framework helped practices identify existing quality measures relevant to the context of their programs and identified future measures to work on through the continuum of care for OUD treatment once that goal has been met. Central to the program's support was the availability of a quality improvement coach. The QI coach developed a standardized check-in process and was a resource for the programs to access throughout the grant cycle. The QI coach met individually with residency program contacts to assess practice improvement and provided customized coaching to guide them through the improvement process.



The Improvement Process

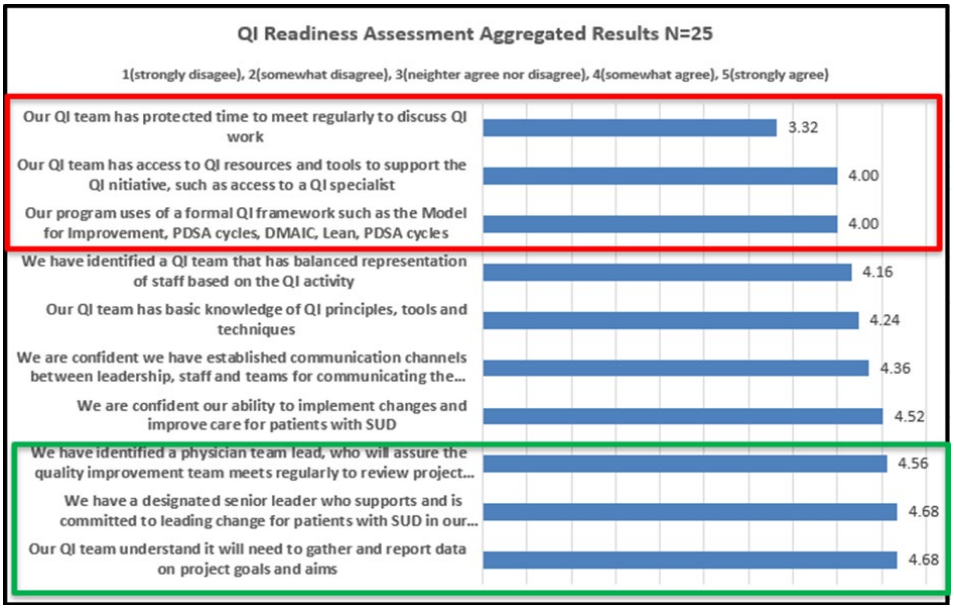
The QI process starts with learning about the principles of quality improvement. An online module was designed to guide teams step by step using the Plan-Do-Study-Act (PDSA) quality improvement framework. Quality improvement education, tools, and templates were embedded.

Team leads from each program began with a QI readiness assessment that identified critical foundational elements for engaging in quality improvement areas. Next, programs created a work plan that identified project goals and aligned them with the creation of specific aims statements to focus their improvement work. The specific aim statements were detailed written statements of how programs intended to meet their goals, including processes, populations, measurements, and time frames. Teams identified and clarified their measures by documenting the measure title, numerator, and denominator used to calculate performance and began collecting baseline data. As part of the QI education, teams were encouraged to assess current practices to help identify changes and areas for improvement. Process mapping and root cause analysis instruction sheets and templates could be found in the "QI resources" section of the module. After baseline data were collected, teams identified actional change ideas. Separate, distinct change ideas rather than adding them as a group helped the team determine each change idea's effectiveness in supporting the quality improvement aim. Teams then planned out their project and conducted small tests of change using the PDSA cycles. Teams completed two PDSA cycles during the course of their project. The PDSA cycles were about learning what works and what does not in their efforts to improve processes. After each cycle, teams studied and analyzed to see if their changes led to improvements and impacted their objective. As part of the process, teams were encouraged to capture and document a patient story to inspire their improvement work and upload documents, photos, and videos of their improvement journey to share with the collaborative during live webinars. The completed module could be used to track and share progress on your quality improvement story with other team members and leadership. At completion, all members of the QI team were eligible to receive CME and Board activity points for participating in the quality improvement project.

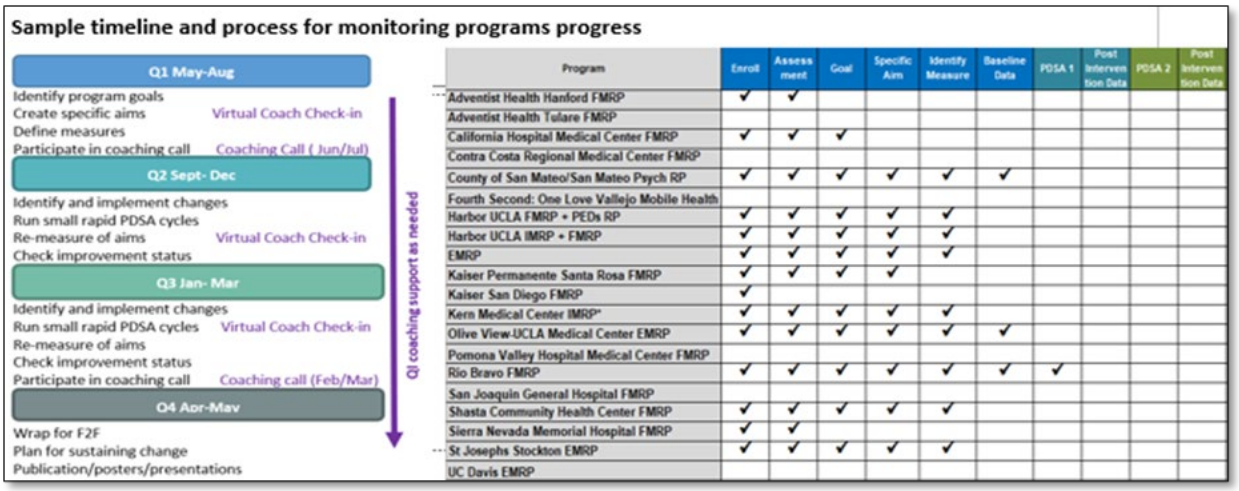


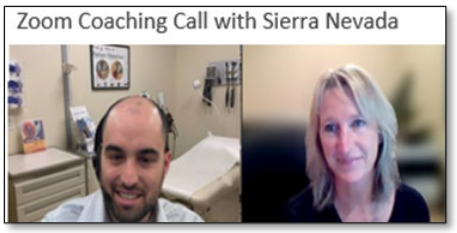
Facilitating Improvement and Guiding Practices through Practice Transformation

Team leads from each program were asked to complete a QI readiness assessment that identified critical foundational elements for engaging in quality improvement areas. The assessment was used to help facilitate improvement and assure successful implementation of quality improvement work. It provided both practices and grant administrators with a scan of available resources, data access, the overall residency function, and QI knowledge and experience. The assessment was administered early in the project and completed by the Team Lead for each program. Results highlighted the variation in the foundational elements across and within the 25 programs. As a collaborative, the programs scored highest in agreement when they identified a team lead, and senior leader who supports the QI work and is committed to leading change. They also understood the need to collect data for improvement. The biggest opportunity was to help teams find time to discuss QI work and provide access to QI resources and support. Findings were used to inform coaching strategies with the individual programs.



The QI coach developed a timeline and standardized check-in process for the residency programs.

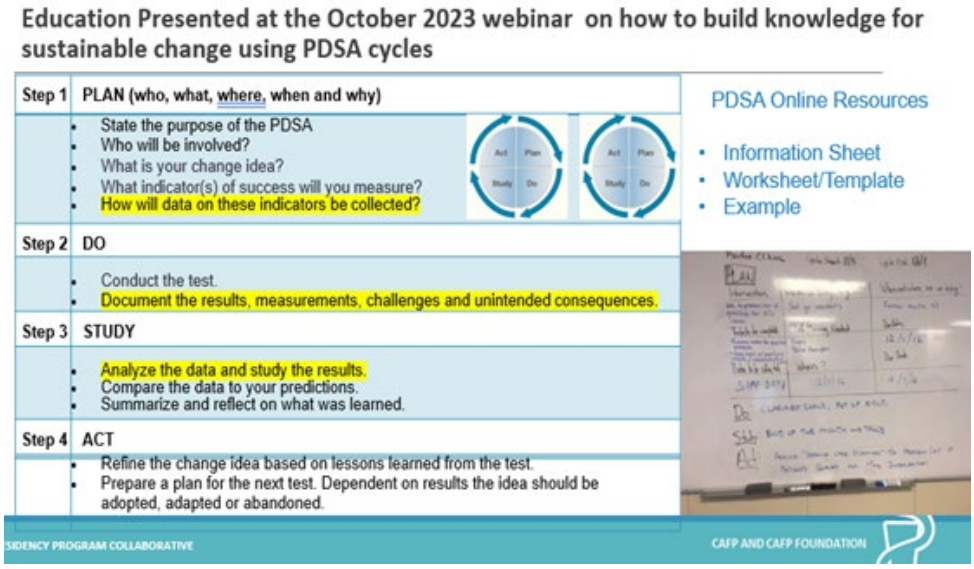




The check-in process included two customized coaching calls and three virtual check-ins to assess practice improvement towards their goal. Programs were invited to participate in customized coaching calls twice throughout the grant period. The calls were scheduled for 30 minutes and lasted anywhere from 20-60 minutes depending on needs. During the call, the QI coach check-in to assist with questions about the QI framework and discuss progress, barriers, and next steps. Common themes from the coaching calls included clarification of specific aims, the importance of gathering baseline data before making changes, clarification on measure definition, and the importance of operational definitions to clarify the data collection process.

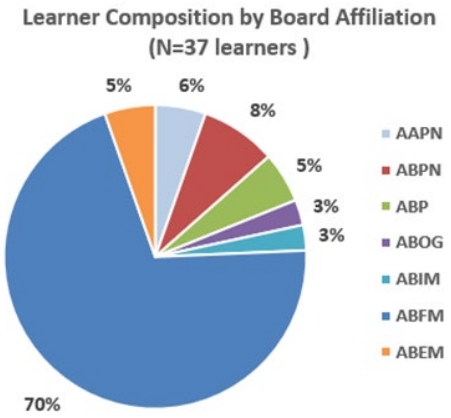
Educating and Supporting the QI Process at Live Meetings and Webinars

Education on quality improvement was reinforced at webinars and live meetings. The quality improvement education was launched through the April 2023 all-team kick-off webinar. The objectives were to illustrate the QI framework adopted for the project, including the timeline, educational module, one-on-one coaching, and reporting process. Review and identification of best practices for relevant measures, steps to meet the MOC Part IV requirements, and QI resources to support the projects were also highlighted. Additional resources and QI education were provided through the remaining webinars and regional meetings throughout 2023 and 2024. Areas of focus included creating SMART goals and specific aim statements, parts of a measure and creating a data collection plan, and an introduction on how to plan and implement PDSA cycles. Collecting patient stories was encouraged throughout the process and shared at the final convocation meeting. Sharing patient stories was a way to put the human face to the data being collected in ways numbers cannot. Team leads were encouraged to discuss at team meetings to help connect to the day-to-day process and with leadership to help focus on why they are doing the work. Patient stories were collected and shared at the final convocation in June 2024.



Results

All 25 teams (100%) enrolled in the quality education module. Twenty programs completed the online module for CME and MOC Part IV credit. One hundred and three learners were identified as being part of their programs quality improvement teams. Quality education and improvement learnings go beyond what was captured in the online module. To date, 75 learners have requested CME and MOC Part IV credit through their member Boards for their participation in the quality improvement initiative. Thirty seven learners representing 7 multi-specialty boards have received CME and MOC Part IV credit.



Teams were coached to break down work processes and outcomes into identifiable and measurable PDSA cycles, with teams recognizing that multiple aims could be needed to reach their intended goal(s). As a result, more than 25 specific aims appropriate for the individual program's context were identified as improvement areas. All the aims contributed to the OUD/SUD landscape and aligned with the collaborative overall objectives to identify those in need of treatment and to initiate/engage and sustain individuals in treatment. Examples of improvement over baseline include:

Increases in patients screened:

17%, 33%, 55%, 100% ↑
20% ↑ alcohol use screening
31% ↑ screened with CRAFFT

Teams with increases in OUD/SUD Management:

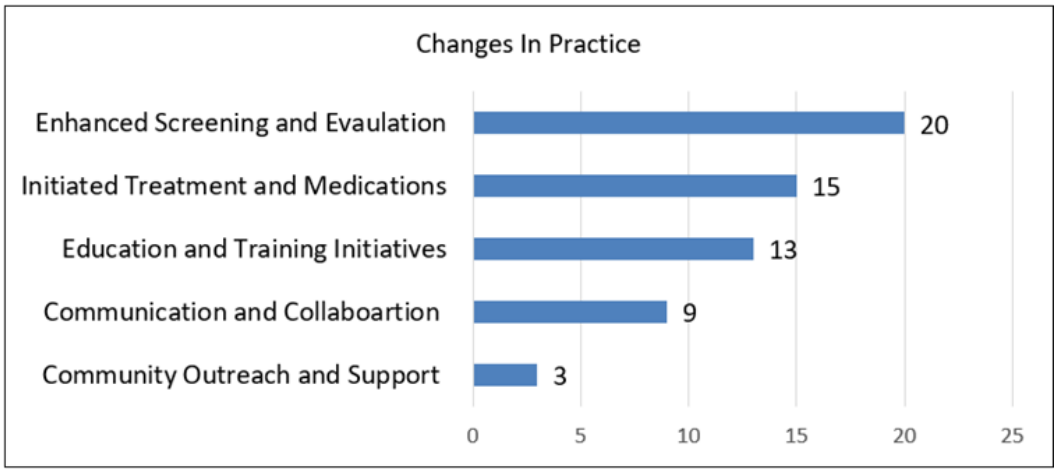
41%, 100% ↑ trained on MAT
67%, 84% ↑ patients received MAT
38% ↑ inmates receive OUD care
15% ↑ ED SUD pts f/u in 30 days
1.44 ↑ MAUD rx/month in PC

Qualitative assessments were analyzed to provide value-added feedback to the program. The following summarizes the findings to date from the 37 respondents.

Changes in Practice

A wide range of initiatives were aimed at improving the screening and treatment of substance use disorder (SUD). These initiatives include expanded coverage for inmates with opioid use disorder in county jails, standardized screening and referral practices, increased access to medication-assisted treatment (MAT) services, and educational efforts for residents and providers on addiction medicine. Other activities involve enhancing communication, improving access to MAT services, and reaching out to SUD patients within the community. Altogether, these efforts signify a dedicated approach to enhancing SUD screening, providing relevant interventions, and advancing patient care.

Summary of responses identifying changes made in practice



Examples that represent the different focus areas and strategies employed to address substance use disorders within the practice:

1. Enhanced Screening and Evaluation:
   - Expansion of coverage in the county jail for inmates with opioid use disorder
   - Implementation of consistent screening practices for substance use disorders
   - Increased screening for drug and alcohol use in various patient groups

2. Treatment and Medication:
   - Increased use of buprenorphine for opioid use disorder and chronic pain management
   - Implementation of medication-assisted treatment (MAT) for alcohol and opioids
   - Improving follow-up and treatment for substance use disorders

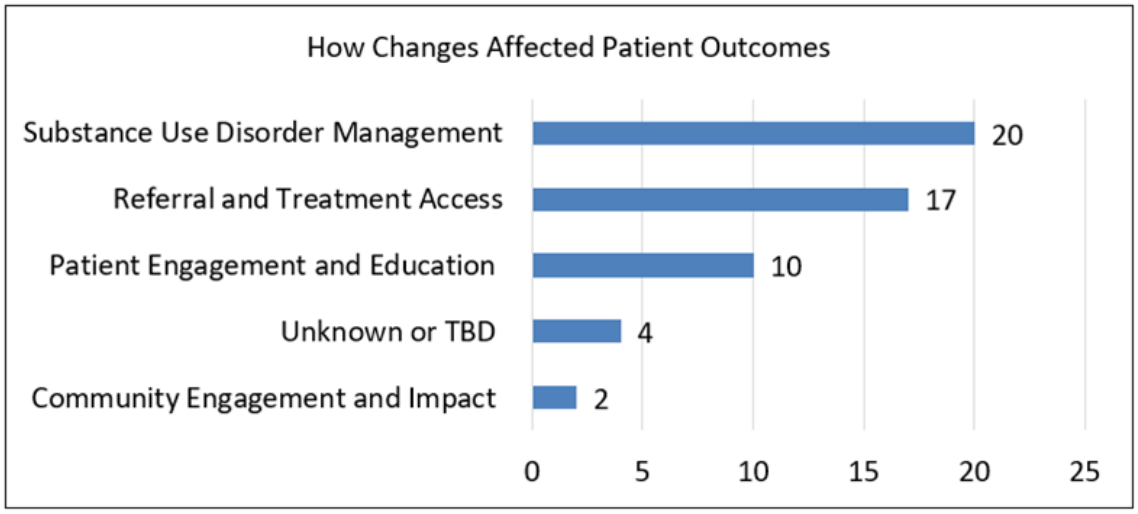
3. Educational Initiatives:
   - Integration of substance use disorder curriculum into medical practice
   - Introduction of addiction medicine curriculum and resources for residents and students

4. Communication and Collaboration:
   - Improved communication between medical assistants and providers for follow-up and referrals
   - Direct communication between different healthcare professionals upon positive substance use screening

Patient Outcomes

Substantial progress has been made in the treatment of patients with substance use disorders. The advancements include enhanced patient engagement, the implementation of more effective screening pathways, improved access to treatment, better diagnosis and referral processes, increased access to Medication Assisted Treatment, and reduced wait times for addiction specialists. These positive changes have resulted in increased referrals for substance abuse treatment, improved patient access to harm reduction services, and higher rates of patients entering recovery. It is apparent that these efforts have had a significant impact on the care and outcomes for patients with substance use disorders.

Summary of responses identifying how changes made in practice affect patient outcomes



Examples of responses that represent the key areas of how changes affected patient outcomes:

1. Substance Use Disorder Management:
   - Improved identification of patients with alcohol overuse issues and improved selection of patients for targeted brief counseling and intervention(s)
   - Patients with substance use disorders treated in a non-judgmental way
   - Increased detection to reduce barriers to effective treatment

2. Referral and Treatment Access:
   - Increased referrals for substance abuse treatment and harm reduction
   - Shorter wait times for addiction specialists and access to resources for recovery
   - Referral to Medication Assisted Treatments (MAT)
   - Increased access to MAT

3. Patient Engagement and Education:
   - More time spent with patients to improve understanding of treatment
   - Use of motivational interviewing and psychoeducation
   - Patients seem engaged and willing to discuss follow-up options

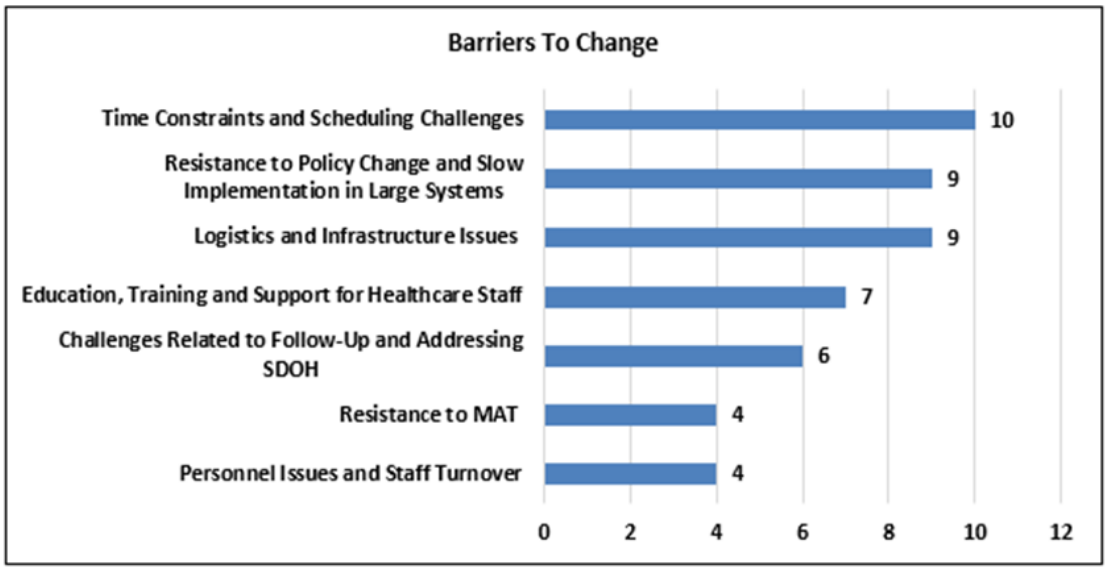
4. Community Engagement and Impact:
   - Engagement of patients from the community who may have never been informed of treatment options
   - Successful transition of patients to Suboxone and local rehabilitation programs

We created a patient centered street medicine outreach clinic with an expanding census and sustained ability for future growth in the form of a permanent longitudinal elective rotation, serving our most vulnerable patient has Alameda county with substance use disorder and despair he has no social determinants of health.

Barriers

The programs encountered several significant challenges, including time constraints, staff turnover, resistance to change, difficulties in accessing resources, EMR system issues, and barriers to patient follow-up. These obstacles have hindered the effective implementation of new interventions and the provision of adequate care for patients with substance use disorders. In addition, logistical concerns, lack of support, and limitations in collaboration with other organizations have presented significant hurdles. Enhanced training, education, and resources are needed to address these challenges and ensure the delivery of equitable care to patients

Summary of responses identifying barriers and challenges



Examples of findings classified into several categories based on the barriers and challenges:

1. Time Constraints and Scheduling Challenges:
   - Difficulty in scheduling patients back in a timely manner due to full schedules
   - Time constraints in office visits, limiting the ability to address certain issues
   - Time constraints in contacting MAT clinics for each patient with a positive CRAFT

2. Resistance to Policy Change and Slow Implementation in Large Systems:
   - Marked resistance to policy change in the hospital, affecting the implementation of the newborn policy
   - Slow to implement changes in large systems due to historic culture and implicit bias
   - Resistance from faculty and residents to incorporating CRAFFT tool into practice and challenges in getting IT support for system-wide integration

3. Logistics and Infrastructure Issues:
   - Challenges in obtaining approval for harm reduction vending machines and navigating MediCal enrollment processes for uninsured patients
   - Infrastructure and burnout impacting the delivery of care and implementation of interventions
     - Logistics issues affecting the conduct of ACEs screening in street medicine clinics

4. Education, Training, and Support for Healthcare Staff:
   - Barriers related to EMR system education and staffing, impacting the adoption of new screening tools and interventions
   - Need for educating faculty and residents on the CRAFFT tool and addressing stigma that prevents equitable care

5. Challenges Related to Patient Follow-Up, Referrals, and Addressing Social Determinants of Health:
   - Patients missing appointments due to transportation or communication issues, leading to challenges in providing care:
   - Numerous competing priorities for clinician time and focus, impacting patient follow-up and referrals for behavioral therapy
   - Poor patient follow-up from the emergency department to the family medicine clinic

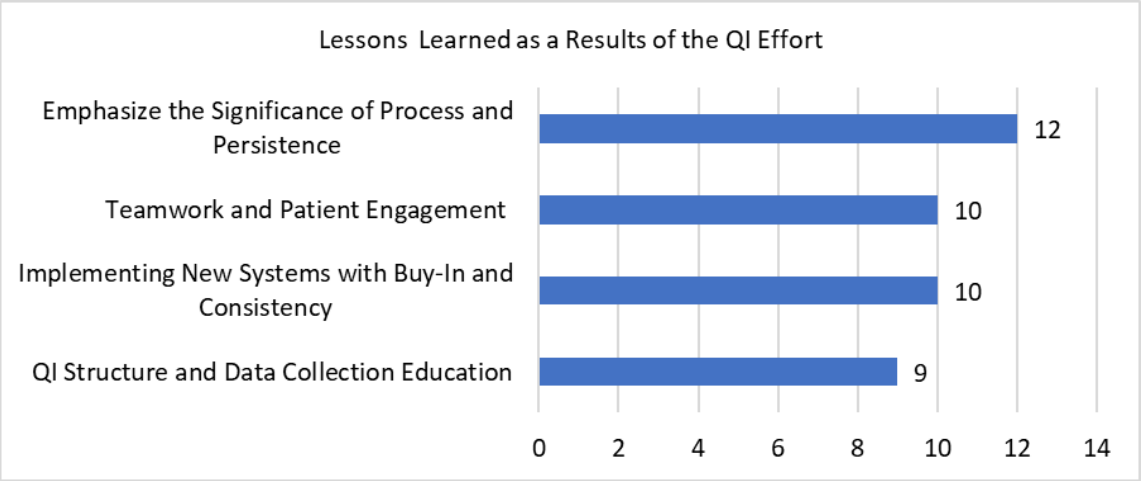
6. Barriers Related to Alcohol Use and Medication-Assisted Treatment (MAT):
   - Challenges in transitioning non-OUD patients from high-risk opioid doses to Suboxone due to suboptimal drug plan coverage
   - Resistance to Suboxone prescribing among core faculty
   - Slow progress toward goals related to addressing alcohol use/initiating MAT for OUD & stimulants

7. Personnel Issues and Staff Turnover:
   - Turnover of healthcare staff impacting training and adaptation of screening and MAT consults
   - Challenges in connecting with planned community partners and personnel issues leading to staff turnover

Lessons Learned

Programs reflected on lessons learned as a result of going through the QI process. Reflecting on the experiences and possibilities help programs to evaluate strengths and weaknesses. It helped programs identify areas for growth and improvement for future work on improving care of patients with OUD. The lessons such as how important communication and collaboration throughout the project and to embed a champion in the clinics can help to speed up future improvements.

Summary of lessons learned as a result of the QI effort include:



Example responses that represent the findings of lessons learned categories:

1. Emphasizing the Significance of Process and Persistence:
   - When physicians start prescribing MAT they are likely to continue prescribing MAT. You just need to get your colleagues to write the 1st prescription in order to move the needle (in a large practice group)
   - Try & Try & Try again. After unsuccessful initial change attempts, our Team re-grouped and brainstormed additional tools and methods to achieve improved outcomes.
   - That change is possible. Sometimes all you need is a nudge to start

2. Teamwork, Patient Engagement:
   - Incorporating community members with lived experience using drugs is an extremely valuable intervention.
   - It takes a whole team to get the job done. Everyone must play their role for everything to be successful.
   - Increasing opportunities to engage patients increased our Tx and or referral success/numbers.

3. Implementing New Systems with Buy-In and Consistency:
   - Implementation of new systems require buy-in and consistency
   - Efficacy of intervention limited by the lack of evidence-based SUD treatment in the community and in the region, making multi-modal (ongoing individual and family interventions) care nearly impossible
   - Negotiation with key stakeholders

4. Quality Improvement (QI) and Data Collection Education :
   - I learned that small wins with actionable interventions can lead to measurable and meaningful change.
   - With a focused QI project we can make a big difference in a relatively short period of time with a collaborative effort
   - Widely accepted data on prevalence rates (or other data for that matter) may not be representative of our own patient population.

Confidence in Making Changes

Additionally, learners were asked on a scale of 1 (not confident) and 5 (very confident) *how confident do you feel in making changes as a result of this quality improvement process*? Thirty-nine learners responded with an **average score of 4.5.** The online module was developed for the multispecialty programs to help assess program readiness for change, introduce and guide them through the Quality Improvement Framework for improvement, and to increase the likelihood of making sustainable changes in practice**.**

Quality Improvement Individualized Coaching Sessions

Learners experience on the Quality Improvement coaching was well received. The participants found the coaching sessions to be exceptionally beneficial in refining SMART goals and objectives for their projects. They emphasized the value of the personalized approach and practical guidance provided, especially in developing metrics for measuring patient outcomes and breaking down targeted projects into achievable steps. The feedback highlighted the role of QI coaching in encouraging critical thinking,

regular tracking of outcomes, and making data-driven decisions. Participants also expressed appreciation for the assistance in adapting to changes, finding practical solutions, and ensuring sustainability of their projects. The coaching was described as invaluable and instrumental in providing a rational framework for leading change, offering insightful feedback, and guiding the participants through project milestones. Overall, the experience with the QI coaching was portrayed as not only positive but also essential for the success and progress of their projects

"The QI coaching was invaluable as it provided us a rational framework for leading change- SMART goals, encouraging critical thinking, regular tracking of outcomes and accountability, making data-driven decisions."

"As a busy primary care clinic with an embedded residency program, it is challenging to find time and personnel who can collect and analyze data from our interventions. The quality improvement coaching helped our team clarify our targeted outcomes and helped us find variables which would be easily captured within our electronic health records without creating a significant documentation burden for the team."

"Coaching was very helpful to encourage breaking our targeted project down to achievable steps to implement. We had a number of steps that we felt would help achieve our goal of increasing first follow up visits. By including periodic check-ins, it helps to keep the physicians in the program who I would imagine are hard-working, way-over-extended to make sure the individual steps of the QI project get completed. I know that was true for me. "

The findings support this approach and indicate a structured quality improvement framework along with individualized QI coaching sessions can be used as a primary approach to make changes to improve the care for patients with substance use disorders.

Next Steps

IPMA continues to support learners in the CRPC3 program and has the online module available through December of 2024. The quality improvement education has given practices the tools and framework to allow them to continue improving the care for patients with substance use disorder beyond the scope of this grant. QI tools and education referenced in this summary can be found in Appendix II.

SUPPLEMENTARY PROGRAMS

Podcasts (https://familydocs.org/podcast)

Podcast Series 1: Treating Addiction in Primary Care

We developed this first podcast series to encourage primary care providers to reach underserved people with Opioid Use Disorder (OUD) through Medication for Opioid Use Disorder (MOUD). The four episodes, launched on March 3, 2023, address the what, the why, and the how of MOUD, helping patient-facing healthcare providers recognize OUD stigma, communicate more effectively, and be more confident in choosing MOUD.

This series was not only supported by the California Department of Health Care Services (DHCS), but also the National Institute on Drug Abuse (NIDA). Below are the titles and participants in the four episodes:

- Episode 1 (186 downloads):
  The Time for Treating Substance Use Disorder Is Now
  Raul Ayala, MD & Arianna Campbell, PA-C
- Episode 2 (197 downloads):
  Break the Stigma, Save a Life
  M. Shoaib Khan, MD, Sky Lee, MD & MK Orsulak, MD
- Episode 3 (161 downloads):
  Prescribing Medication for Opioid Use Disorder
  Tipu Khan, MD & Rebecca Trotzky-Sirr, MD
- Episode 4 (460 downloads):
  Addiction Medicine is Family Medicine!
  Carol Havens, MD & Mario San Bartolome, MD

Podcast Series 2: 1 in 5 series: Stories of doctors and patients reducing harm done by Opioid Use Disorder (OUD)
Released March-April, 2024

In our latest series 1 in 5, released March-April 2024, we published five episodes that bring stories of doctors - and their patients - who have worked together to reduce the harm done by opioid use disorder (OUD). These brief stories take one into the hearts and minds of our guests. Our hope is that this will inspire physicians to do everything in their power to bring medical attention to the OUD patients they serve. The 1 in 5 series interviewer is Dr. Tipu Khan.

- Episode 1 (140 downloads):
  To Help Others Find Doctors Like You: A Patient and Her Doctor Talk MOUD - Gloria Sanchez, MD & Patient Jessica
- Episode 2 (117 downloads):
  The Beauty of the Bus: Meeting Opioid Use Disorder on the Road - Marc Lasher, DO
- Episode 3 (112 downloads):
  From ER to Primary Care: Meeting Patients Where They're At - Karen "Kay" Lind, MD
- Episode 4 (104 downloads):
  I Leaned In: One Family Doc's Story of Treating Opioid Use Disorder - Jay W. Lee, MD
- Episode 5 (84 downloads):
  Addiction Treatment and The Power of Connection - Anusha Chandrakanthan, MD

MOUD Champions

MOUD Champions:
Peer Support for Physicians New to MOUD

New to Medication for Opioid Use Disorder (MOUD)? Do you have questions, or would like a knowledgeable family physician to chat with? Find a MOUD Champion to consult with.

Do you already use Medication for your patients with Opioid Use Disorder? Be a MOUD Champion and share your expertise with peers seeking to build MOUD into their practice.

FIND A MOUD CHAMPION

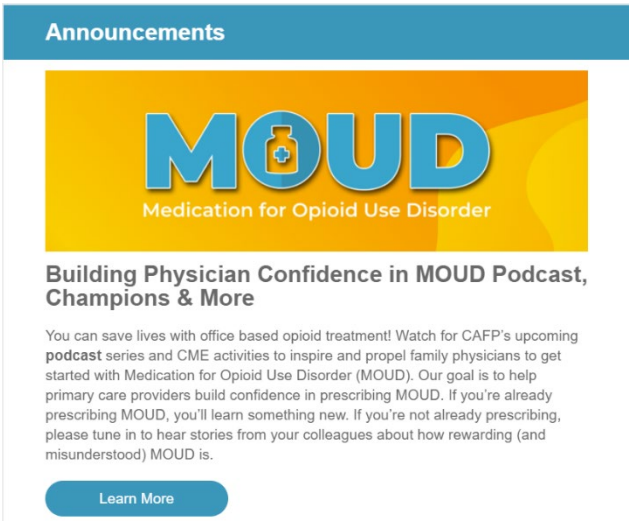
BE A MOUD CHAMPION

This program is sponsored by the California Academy of Family Physicians (CAFP) and supported by the California Department of Health Care Services (DHCS).

In an effort to build Physician confidence in providing MOUD, we developed a MOUD Champions Network. CAFP is partnering with family physicians and key organizations to help primary care providers reach underserved people with Opioid Use Disorder (OUD), paying particular attention to Medication for OUD (MOUD). We assist patient-facing health care providers connect with MOUD Champions through a CAFP-hosted Champions network.

"[My MOUD Champions] were incredible. They both went over educational resources, training materials, and how to bring success to the new SUD program at our FM Residency clinic site. I had a number of questions which they answered, to bring success to our project and practice. They helped me understand legal perspectives regarding SUD management as well. Overall, I found them to be very helpful. I hope to continue the collaboration moving forward."

We reached our goal of recruiting more than 50 Champion family physicians able to counsel peers who are in nascent phases of office-based opioid treatment. Champions are publicized to our membership through our website, enews bulletins and social media, as well as through word of mouth. Several doctors were paired with a MOUD champion over the grant period, with notable success.

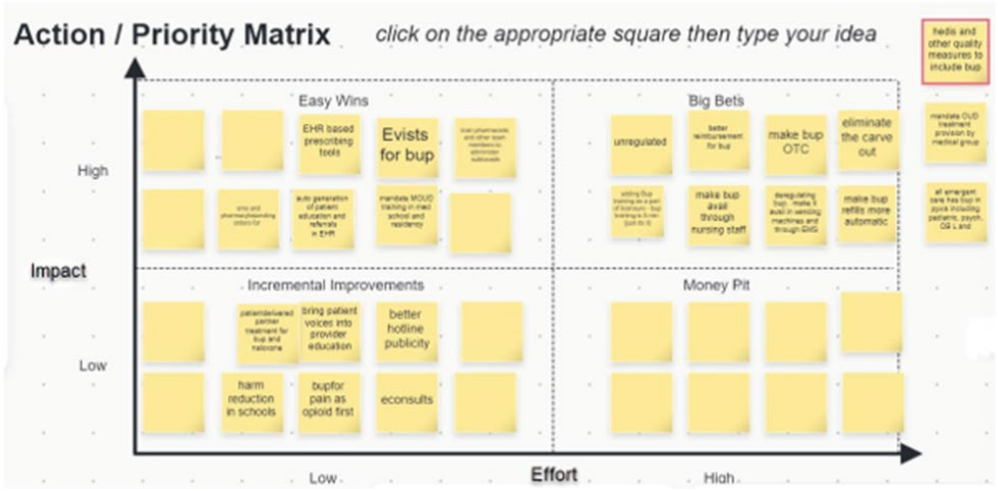


On October 11, 2023, we brought together our Champions for a virtual meeting. Rachel Sussman, MD, a former CRPC grantee, was the moderator for this special gathering. The two goals of this meeting were to:

1. Establish connections with peers in the MAT/MOUD Champion community across California
2. Encourage more physicians to provide life-saving care to their patients with addiction.

Laura Guzman, JD, Executive Director with the National Harm Reduction Coalition presented her organization's efforts to combat stigma and promote harm reduction efforts in California, including a summary of their May 2022 CA Harm reduction Point in Time survey results.

The meeting included small group time for "Blue Sky Thinking" about how to encourage more clinicians to provide life-saving MOUD. Small groups brainstormed, imagining no barriers, then returned to share ideas with the full group.



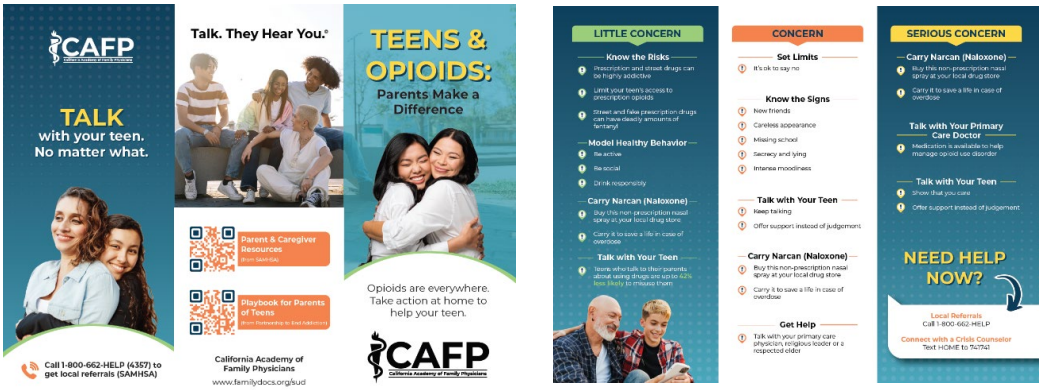
Ideas above & below were generated by small groups during the Blue Sky Thinking exercise. They do not necessarily represent th views of CAFP.

Low Effort, High Impact "Easy Wins": EHR-based prescribing tools E-visits for buprenorphine Train pharmacists and other team members to administer sublocade EMS and pharmacy standing orders for MAT medications Mandate MOUD training in med school and residency	**High Effort, High Impact "Big Bets":** Deregulate buprenorphine Better reimbursement for buprenorphine Make buprenorphine over the counter Eliminate the carve-out Madate OUD treatment provision by medical groups HEDIS and other quality measures to include bup Adding buprenorphine training as part of licensure Make buprenorphine available through nursing staff Buprenorphine in vending machines & through EMS Automate buprenorphine refills Include bup in all emergent care, peds, OB, psych.
Low Effort, Low Impact "Incremental Improvements" Patient delivered partner treatment for buprenorphine and naloxone Bring patient voices into provider education Beter hotline publicity Harm reduction in schools Buprenorphine for pain as opioid first Econsults	

Attendees reported that they connected with new colleagues and that they left the meeting with new ideas about how to encourage more physicians to provide life-saving care to their patients with SUD/OUD. Several of the Champion attendees were tapped for interviews in the new "1 in 5" OUD podcast series. Champions are encouraged to participate in CAFP's ongoing MOUD Discussion Forum in CAFP's new app (https://familydocs.org/app).

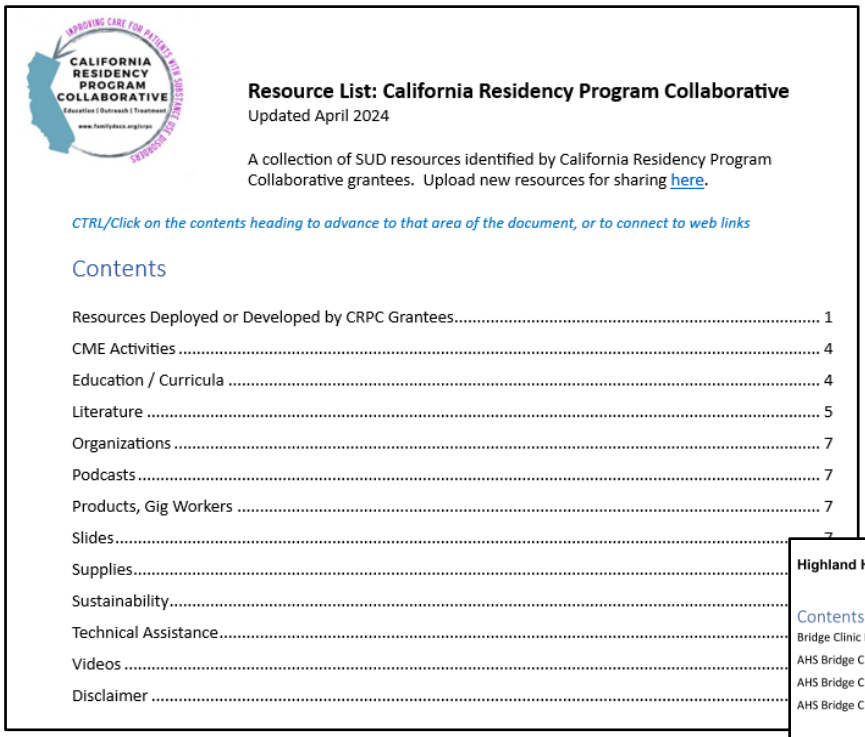
Parents of Youth Awareness Effort

Extensive research and consultation with MOUD Champions with expertise in working with youth and families led to the creation of a parent education brochure. This brochure encourages parents to engage positively with their teenage children regardless of circumstance, while remaining supportive and prepared. Brochures have already been distributed to over 400 family physicians throughout California through chapter meetings and selected PTA organizations, and state and local school board members.

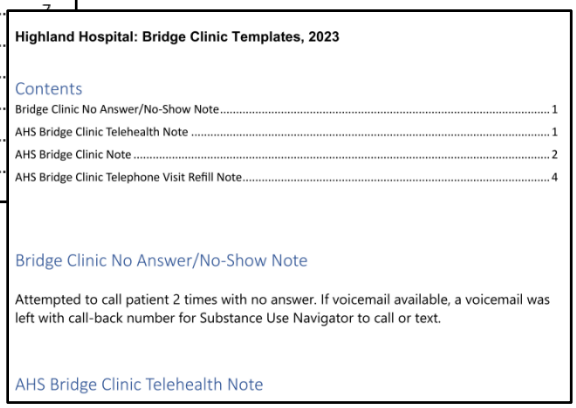


WEBSITE AND ENGAGEMENT

Our CRPC website (https://www.familydocs.org/crpc/) has been a great resource to our grantees and others. It has been accessed 1,965 times during this grant period. We continue to maintain a private site with an access code required that provides grantees with access to their data reporting templates, key initiative dates, the recorded webinars, and contact information of the EAP, all fellow collaborative grantees as well as contact information for our former SOR grantees.

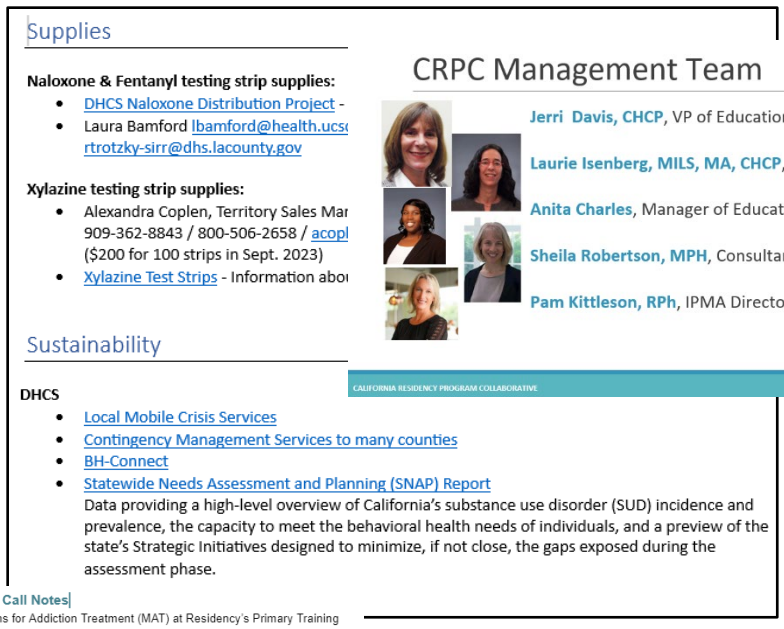


The CRPC private website also gives grantees access to the terrific resources that their colleagues have shared and ones that we've identified throughout the course of this grant. Participants have shared screening tools, workflows, notes templates, order sets, suppliers, patient education, curricula, and more.



CRPC Management Team: Regular Check-ins, Emails and Connection

The CRPC Grant staff management team met throughout the to ensure all grant were



Supplies

Naloxone & Fentanyl testing strip supplies:

- DHCS Naloxone Distribution Project -
- Laura Bamford lbamford@health.ucs
  rtrotzky-sirr@dhs.lacounty.gov

Xylazine testing strip supplies:

- Alexandra Coplen, Territory Sales Mar
  909-362-8843 / 800-506-2658 / acopl
  ($200 for 100 strips in Sept. 2023)
- Xylazine Test Strips - Information abo

Sustainability

DHCS

- Local Mobile Crisis Services
- Contingency Management Services to many counties
- BH-Connect
- Statewide Needs Assessment and Planning (SNAP) Report
  Data providing a high-level overview of California's substance use disorder (SUD) incidence and prevalence, the capacity to meet the behavioral health needs of individuals, and a preview of the state's Strategic Initiatives designed to minimize, if not close, the gaps exposed during the assessment phase.

CRPC Management Team

Jerri Davis, CHCP, VP of Education and Professional Development

Laurie Isenberg, MILS, MA, CHCP, Director of Education and Prof. Devel.

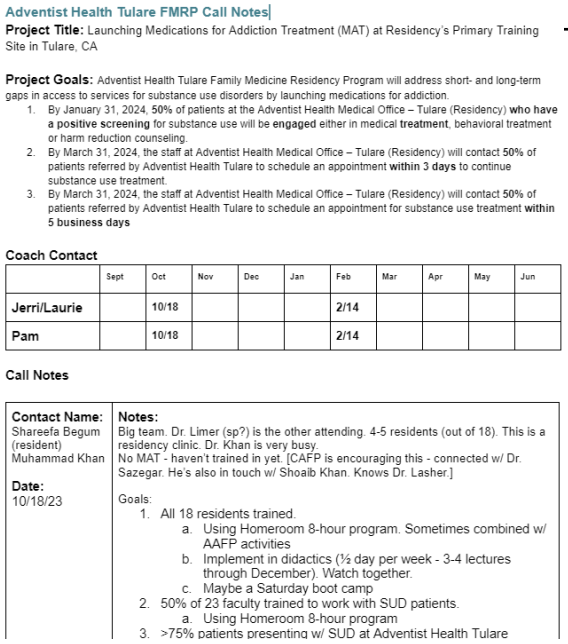
Anita Charles, Manager of Education Programs

Sheila Robertson, MPH, Consultant – Data and Outcomes

Pam Kittleson, RPh, IPMA Director of Quality – QI Coach

CALIFORNIA RESIDENCY PROGRAM COLLABORATIVE — CAFP AND CAFP FOUNDATION

monthly course of the grant components of this coordinated and running smoothly. We kept google planning notes to reflect our progress. CAFP and IPMA arranged check-in calls with all 25 grantees throughout the grant period. To the right is a sample of the notes kept in a google doc so that the CRPC management team members could access them. In addition to the QI specific check-in calls, typically check-ins were meant to get a project status report, ensure that we provided timely assistance to any of the grantees needing it, and to inquire about how we could help ensure their success. We also kept in constant touch with our grantees through email updates and announcements.



Adventist Health Tulare FMRP Call Notes

Project Title: Launching Medications for Addiction Treatment (MAT) at Residency's Primary Training Site in Tulare, CA

Project Goals: Adventist Health Tulare Family Medicine Residency Program will address short- and long-term gaps in access to services for substance use disorders by launching medications for addiction.

1. By January 31, 2024, **50%** of patients at the Adventist Health Medical Office – Tulare (Residency) **who have a positive screening** for substance use will be **engaged** either in medical **treatment**, behavioral treatment or harm reduction counseling.
2. By March 31, 2024, the staff at Adventist Health Medical Office – Tulare (Residency) will contact **50%** of patients referred by Adventist Health Tulare to schedule an appointment **within 3 days** to continue substance use treatment.
3. By March 31, 2024, the staff at Adventist Health Medical Office – Tulare (Residency) will contact **50%** of patients referred by Adventist Health Tulare to schedule an appointment for substance use treatment **within 5 business days**

Coach Contact

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Jerri/Laurie		10/18				2/14				
Pam		10/18				2/14				

Call Notes

Contact Name: Shareefa Begum (resident) Muhammad Khan **Date:** 10/18/23	**Notes:** Big team. Dr. Limer (sp?) is the other attending. 4-5 residents (out of 18). This is a residency clinic. Dr. Khan is very busy. No MAT - haven't trained in yet. [CAFP is encouraging this - connected w/ Dr. Sazegar. He's also in touch w/ Shoaib Khan. Knows Dr. Lasher.] Goals: 1. All 18 residents trained. a. Using Homeroom 8-hour program. Sometimes combined w/ AAFP activities b. Implement in didactics (½ day per week - 3-4 lectures through December). Watch together. c. Maybe a Saturday boot camp 2. 50% of 23 faculty trained to work with SUD patients. a. Using Homeroom 8-hour program 3. >75% patients presenting w/ SUD at Adventist Health Tulare

Conclusion/Photos

As we conclude our 14 months of working together on such a gratifying project, we are humbled by the hard work and dedication of so many individuals and organizations that have gone above and beyond to improve patient care for patients with OUD/SUD now and in the future. As we stated in the opening summary, this experience has truly changed the way that many of these residency programs now

function – with increased systems that streamline everything from x-waiver certification, MAT induction, Narcan distribution, warm handoffs and much more. Many grantees stressed the importance of culture change and credited this change to their program's success.

Following are a few slides showing some of what our grantees have accomplished together throughout the course of their work.

You Focused on the Patient

Conducted a Teenage Advisory Council

Teenage (patient) Advisory Counsil – Kaiser Permanente (Santa Rosa)
Monday, 11/20, 4-5:00p, MOB4, 5
Opioid Use Disorder Grant: Education and Expansion of Services

Dr. David Della Lana (Family Doctor and KP Residency Program Faculty with special interest in substance use issues) asked questions about opioid use among teens. Discussion included "opioids plus" (vaping, drinking, etc.).

Most Relevant Local (Observed) SUD Issues [from teen leader perspectives]:

1. Usage spreads to other friends within a friend group (peer pressure)
2. Also challenging when a friend starts using because, even if you don't also use, you are concerned and don't know how to help
3. Really effected by who your friends are and where you're growing up
4. Parents are not giving the best resources / solutions. Want kids to experiment: more of a "hands-off" – "you need to figure this out yourself" approach
5. Some parents enable/condone ("as long as they do it in my house")
6. Substance use can also be part of a want to fit into certain social groups. Some people pretend to use, some use so they're invited to parties.
7. Rampant on school campuses. Students who don't vape, etc. don't want to use the bathrooms anymore because it's a place people congregate to vape, get high, drink, etc.
8. Schools don't prioritize the prevention of vaping or the education of substance / alcohol abuse. Would like to see schools take it more seriously (patrol the bathrooms, etc.).
9. Most education takes place in middle school or briefly in 9th grade

Seeking Help/Interventions:

1. Challenging because it's so normalized many people don't seek help

Took care to patients in their community

Sought Lived Experience to Inform Improvement

Informational Interview
with a person who has lived experience using drugs

Choose a team leader who will summarize your points at the end of the session

Possible Questions/Talking Points

General

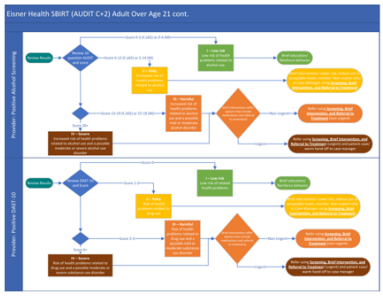
1. What drugs did you use and when did/do you use them? Were they expensive? How did you use them?
2. What did you like about drugs? What didn't you like about drugs?
3. How did drugs positively impact your life? How did they negatively impact your life?
4. Did you meet any nice people while using drugs?
5. Why do you think people use drugs?

CAFP AND CAFP FOUNDATION

You Focused on Teamwork

You Improved Systems and Processes

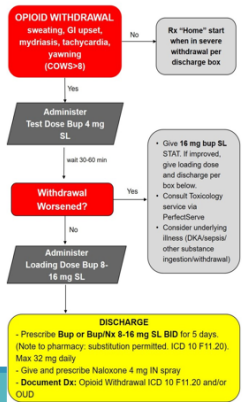
Workflows



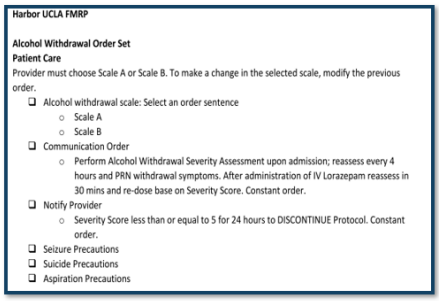
CALIFORNIA RESIDENCY PROGRAM COLLABORATIVE

Protocols

Joe's Buprenorphine (Bup) Quick Start



Order Sets



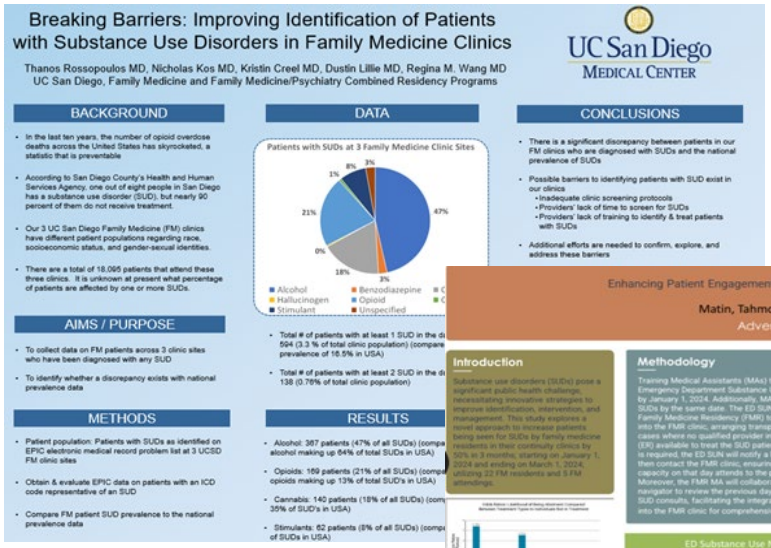
Harbor UCLA FMRP

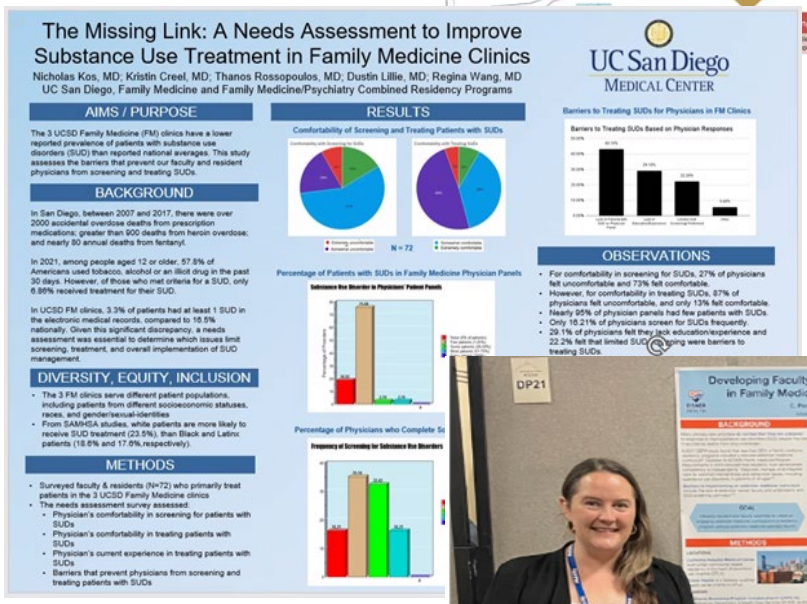
Alcohol Withdrawal Order Set
Patient Care
Provider must choose Scale A or Scale B. To make a change in the selected scale, modify the previous order.

- ❑ Alcohol withdrawal scale: Select an order sentence
  - ○ Scale A
  - ○ Scale B
- ❑ Communication Order
  - ○ Perform Alcohol Withdrawal Severity Assessment upon admission; reassess every 4 hours and PRN withdrawal symptoms. After administration of IV Lorazepam reassess in 30 mins and re-dose base on Severity Score. Constant order.
- ❑ Notify Provider
  - ○ Severity Score less than or equal to 5 for 24 hours to DISCONTINUE Protocol. Constant order.
- ❑ Seizure Precautions
- ❑ Suicide Precautions
- ❑ Aspiration Precautions

CAFP AND CAFP FOUNDATION

One highlight to point out is that many of our residents used their CRPC work to develop and present **posters** at various events. This is an important part of their scholarly work requirements, and we are thrilled they chose to focus their collaborative work in these efforts.





Appendix I includes final reports from each of our 25 California Residency Program Collaborative grantees. All twenty-five residency programs reported their data on a quarterly basis and all twenty five expended their full funding and reconciled their budgets. CAFP-F has also expended all funds and reconciled our overall budget showing a final invoice payment due for Exhibit B, Attachment II deliverables D#38 and D#39, of $22,500.

PHOTOS

Following are selected images from many of our 25 CA Residency Program Grantees.


SJ HEALTH
San Joaquin Health Centers
MOBILE UNIT


SJ HEALTH
San Joaquin Health Centers
(209) 953-6400
www.sjhealth.org


CLINICA SIERRA VISTA
Mobile Clinic


Education Outreach Treatment


Education Outreach Treatment


California Hospital Medical Center
A Dignity Health Member
ADDICTION MEDICINE LECTURE SERIES
The California Hospital Medical Center Family Medicine Residency Program Addiction Medicine Lecture Series provides a lecture series of foundational knowledge in substance use disorders, including screening, evaluation, and treatment.
LEARNING OBJECTIVES
At the completion of each activity, the learner will be able to:
1. implement screening tools for substance use disorder in primary care,
2. accurately diagnose substance use disorders using DSM-5 criteria, and
3. initiate initial intervention/management and/or refer to treatment using appropriate community resources for substance use disorders.
TARGET AUDIENCE
This lecture series is designed for physicians, advance practice providers, residents, students, and other health professionals involved in the management of patient who use substances.
COURSE DIRECTOR
Course Director: C. Peony Khoo, MD
Disclosure: Presenters and all other members of the planning committee have no relevant financial relationships with a commercial interest to disclose
OPIOID USE
DECEMBER 8, 2023
1:00 PM - 2:00 PM
Join via Zoom:
Meeting ID: 836 6062 4371
Password: 564 588 52
Link:
or scan QR code
ACCREDITATION
The California Hospital Medical Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
California Hospital Medical Center designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s). Physicians should claim only the credit commensurate with the extent of their participation in the activity.


OVERDOSE KIT
KIT SOBREDOSIS


St. Joes


AdventistHealth
AdventistHealth


Adventist Health
Physicians Network
Medical Offices

GRANTEE FINAL REPORTS

Grantees submitted final reports to conclude their work in the CRPC learning collaborative. A copy of the final reports, listed alphabetically by program will follow.

Table of Contents

California Residency Program Collaborative

Final Report and Results

Residency Program: Adventist Health Hanford FMRP

Submitted by (name/email): Joshua Strunk/ strunkje@ah.org

Project Title:

Goals of Your Project (as stated in your proposal, or as amended):
Adventist Health Hanford Family Medicine Residency Program will address short- and long-term gaps in access to services for substance use disorders by launching medications for addiction treatment (MAT) at its primary training site, Adventist Health Medical Office – Hanford.

1. By July 1, 2023, 100% of all new residents will become X-waivered.
2. By December 31, 2023, at least 6 out of 9 faculty will become X-waivered. - amended as X-waiver no longer required.
3. By January 31, 2024, 50% of patients at the Adventist Health Medical Office – Hanford (Residency) who have a positive screening for substance use will be engaged either in medical treatment, behavioral treatment or harm reduction counseling.
4. By March 31, 2024, the staff at Adventist Health Medical Office – Hanford (Residency) will contact 50% of patients referred by Adventist Health Hanford to schedule an appointment within 3 days to continue substance use treatment.
5. By March 31, 2024, the staff at Adventist Health Medical Office – Hanford (Residency) will contact 50% of patients referred by Adventist Health Hanford to schedule an appointment for substance use treatment within 5 business days.

High-Level Description/Highlights of the Work Done on the Project:

1. We have been able to successfully launch a MAT program in our family medicine primary training site.
2. 100% of our residents are MAT trained.
3. Set up SBIRT processes / integration into EMR
4. Trained not only residency but faculty and clinical staff, site manager, medical assistants in MAT therapy, chart prep, follow-up, scheduling.

5. 3 of our core faculty besides the grant manager have now sent prescriptions for opioid and methamphetamine use disorder. Previously only the grant manager was sending prescriptions for opioid use disorder.
6. Maintained a full time Substance Use Navigator at the residents primary hospital and emergency department site.
7. Scheduled didactics on Motivational Interviewing by Psych D.

Describe strategies/interventions/approach to reach goals:

1. We standardized MAT training for all incoming residents to take place during orientation (protected time).
2. Provided protected training time to faculty and medical assistants concerning SUD scheduling, clinic flow, follow up.
3. Provided education to faculty concerning SUD treatment
4. Engaged the electronic medical record in SBIRT capabilities.
5. Utilized relationships with SUN and patient liaisons for outreach as far as clinic location and services offered.
6. Frequent feedback from clinic staff (MA's, manager), residents and faculty regarding prescribing and scheduling process for real-time problem solving.
7. Outreach to SUD pt's in the community via community liaisons and residents via door to door and mobile clinic.
8. Direct communication between ED SUN to MA's and Residents.
9. Direct communication between MA and Resident when substance use screening was positive.

Barriers, challenges and solutions:

1. No initial process for scheduling patients from the street to the clinic. Now communicate via direct mobile line to clinic to input patient demographics and schedule f/u and address transportation / insurance concerns.
2. Poor patient f/u from ED SUN to Hanford FM clinic. No solution as of yet. Significant resistance for ED patients for outpatient f/u. Considering call service were inpatient resident or resident on community medicine rotation initiates while patient is still in ED if ED not able.
3. Resistance to Suboxone Rx'ing amongst core faculty. Previously only the program director was Rx'ing Suboxone but now three other core faculty have done so via education provided by CRPC.

How will the progress be sustained?

Funding is now available internally for the following thanks to the example we were able to set with the CRPC's help:

-resident MAT training

-medical assistant MAT training, visit procedures, testing, f/u, workflow, etc.

-core faculty MAT training

-scheduled, core curriculum of motivational interviewing lectures by Psych. D.

-Substance use navigator

Please share your thoughts on your experience on the Quality Improvement coaching:

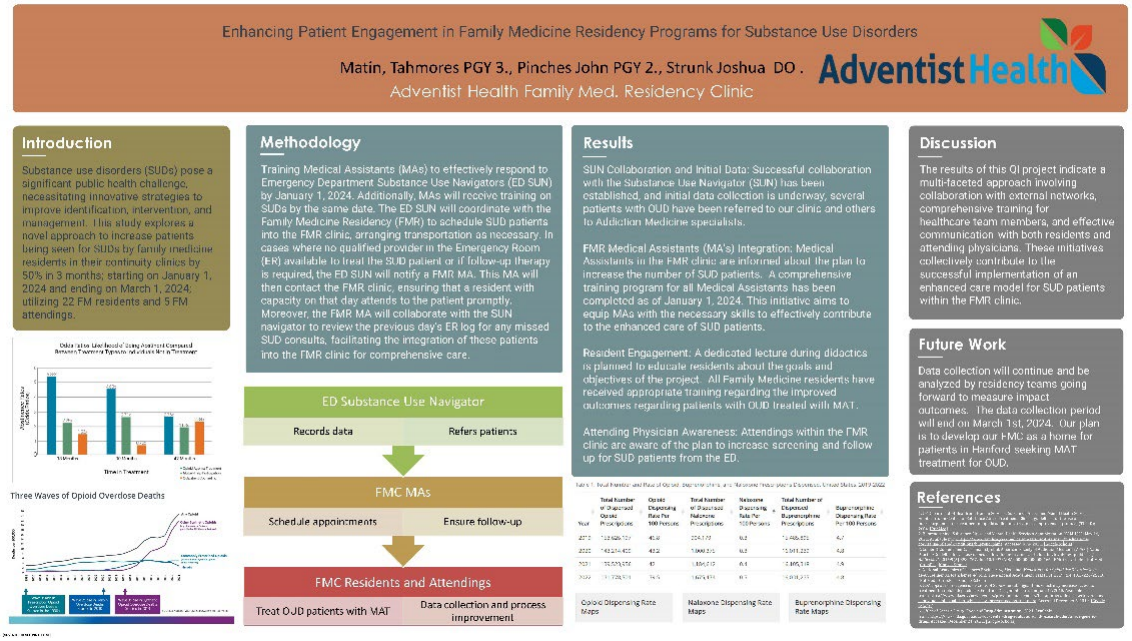
1. Nothing but a benefit.
2. Helps maintain goals and objectives for our projects.
3. Could consider increase in QI coaching visits as optional extra for programs; quarterly etc.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

None, thank you.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:

1. Support for dedicated time for MA's for MAT education, chart prep
2. Set up of SBIRT, alignment with existing forms and processes, the development of a data dashboard and other needed items on the EMR.
3. Development and implementation of educational training sessions for faculty, residents, and clinical staff for implementation and of MAT at the primary training site.
4. Maintain 100% MAT education for all interns and residents (what was previously X-waiver training).
5. Provide our provides at the primary training site and mobile clinic unit with education, harm reduction pamphlets/handouts.
6. Core faculty besides the grant manager have now sent prescriptions for opioid and methamphetamine use disorder. Previously only the grant manager was sending prescriptions for opioid use disorder.
7. Maintained a full time Substance Use Navigator at the residents primary hospital and emergency department site.
8. Scheduled didactics on Motivational Interviewing by Psych D.



California Residency Program Collaborative

Final Report and Results

Residency Program: Adventist Health Tulare Family Medicine Residency Program

Submitted by (name/email): Dr. Muhammad Khan, khanm01@ah.org

Project Title: Integrating Substance Use Disorder curriculum and patient care into the Rural Family Medicine Residency Clinic for Best Practices in the Central Valley of California: A Quality Improvement Project.

Goals of Your Project (as stated in your proposal, or as amended):

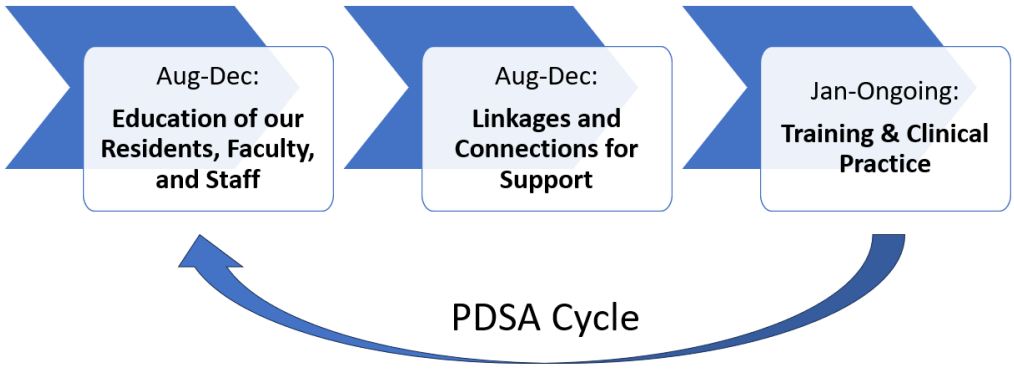
1. By December 31, 2023, 100% of residents will receive education for effective management of Substance Use Disorders in the clinic setting.
2. By December 31, 2023, 100% of faculty will receive education for effective management of substance use disorders in the clinic setting.
3. By January 31, 2024, more than 50% of patients at the Adventist Health Medical Office – Tulare (Residency) who have a positive screening for substance use will be engaged either in onsite medical treatment, behavioral treatment (referral) or harm reduction counseling.
4. By March 31, 2024, the staff at Adventist Health Medical Office – Tulare (Residency) will contact 50% of patients referred by Adventist Health Tulare (Hospital) to schedule an appointment for substance use treatment within 5 business days.

High-Level Description/Highlights of the Work Done on the Project:

Adventist Health Tulare Family Medicine Residency Program utilized project funding to enhance their residency program, focusing on Substance Use Disorder (SUD) management. The funds were allocated to innovate residency training, improve education, and practical skills for SUD management. Additionally, linkages with specialized physicians and community champions were established, providing mentorship and support. This strategic funding has significantly bolstered Adventist Health Tulare Family Medicine Residency Program's ability to educate

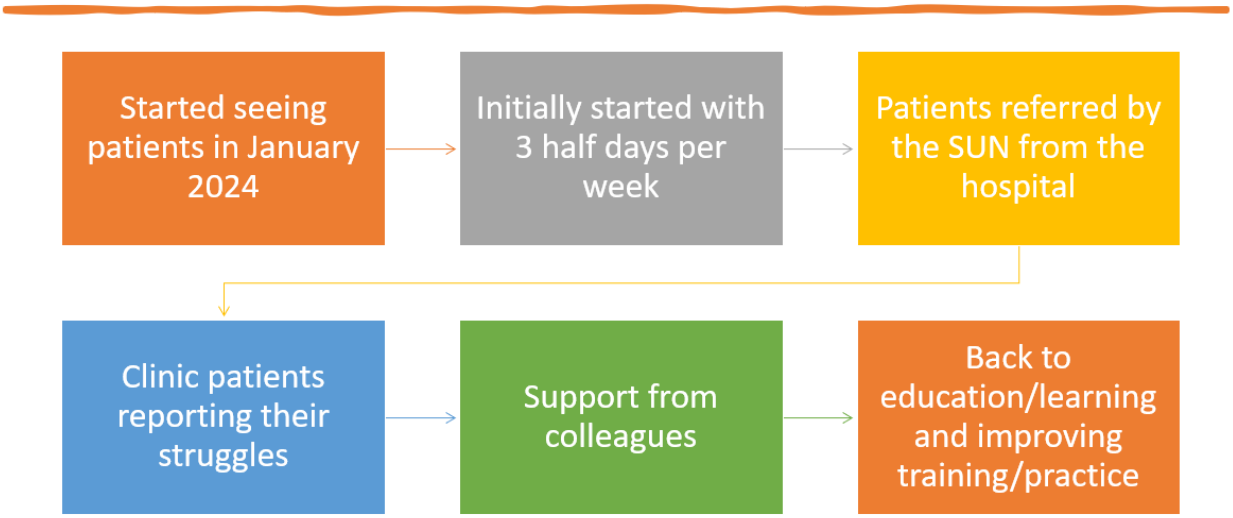
residents, improving their capacity to manage SUD effectively and benefiting the community's overall approach to addressing SUD.

The QI project focused on three key areas: enhancing education for residents, faculty, and staff; providing specialized training; and improving clinical practice. For residents, it included an 8-hour MATE Act training through CAFP Home Room to meet DEA requirements and coursework on Substance Use Disorders via AAFP. The curriculum offered group and directed education sessions through Didactics, self-education opportunities, and constant reminders. Faculty received ongoing reminders on education and support and encouragement to enhance their teaching effectiveness. Staff participated in POC (Point of Care) meetings and morning huddles to ensure consistent communication and coordination. These efforts collectively enhanced the knowledge, skills, and clinical practices of the entire healthcare team.



Support and collaboration for the project were found both within and outside of Adventist Health. Internally, key contributors included Karen Madera, SUN, SUD Champion "Charles" Odeghe Okiemute, the grants team of Atalie Rosales and Elvia Hamner, nursing leaders Greg Cooper (hospital) and Shane Jimenez (clinic), and physician leaders Dr. Lasher and Dr. Ayala. Externally, significant support came from the CAFP CRPC team, including Jerri Davis and Pam Kittleson, as well as addiction specialists Dr. M. Shoaib Khan from UCSF Fresno and Dr. Sazegar from Kaiser Permanente.

SUD Management – PDSA Cycle



Key Achievements:

1. **Increased Access and Timely Appointments:**
   - SUN (Substance Use Navigator - Karen Madera) has enhanced access to care by ensuring appointments are available within 3-5 days post-hospital discharge.
   - The initiative is focused on patients without a Primary Care Physician (PCP) or those wishing to establish/re-establish care with AH PCPs.
2. **Patient Intake and Clinic Integration:**
   - The residency clinic has successfully integrated new patients, averaging 10-12 new patients per month referred from the hospital.
   - This figure excludes patients already part of the clinic or those referred via the call center.
3. **SUD Management Services in FM Clinic:**
   - The Family Medicine (FM) Clinic offers SUD management services under a non-part 2 program (42 CFR Part 2), facilitating streamlined care without stringent confidentiality restrictions.
4. **Optimized Utilization of Addiction Specialists:**
   - Addiction Specialists are reserved for handling very complex cases, allowing them to focus on patients requiring specialized care.
5. **Comprehensive Support Services through SUN:**
   - SUN provides extensive support services, including:
     - Rehabilitation Programs
     - Behavioral Health Services
     - Mental Health Programs
     - Appointments Coordination

- Addressing Social Determinants of Health (SDOH)

Summary: The project effectively increases access to essential health services, optimizes the use of specialized medical professionals, and integrates comprehensive support programs through SUN. The structured approach ensures timely appointments and ongoing support for patients, particularly those without a PCP, enhancing the overall efficiency and effectiveness of SUD management and related health services.

Describe strategies/interventions/approach to reach goals:
Educational resources from CAFP and AAFP were particularly effective in delivering didactic sessions for resident physicians. The same resources were utilized by the faculty members as well To increase knowledge and build confidence for starting substance use disorder management. Establishing linkages with various addiction medicine specialists and building support systems through the CAFP CRPC team bolstered the confidence to begin training efforts and to continue clinical practice effectively. We were able to effectively utilize the substance use navigator to recruit patients from the hospital site. Our health system was particularly supportive of the initiative to take care of patients dealing with substance use disorders.

Barriers, challenges and solutions:
The QI project faced several challenges in addressing substance use disorders. These included frequent no-shows for appointment which resulted in provider confidence shaken by patient relapses, difficulties in conducting urine drug screenings (UDS) in the clinic, and limited availability of Narcan. Below are proposed strategies and solutions to address each obstacle and enhance the effectiveness of the program.

- **No-shows**: Implement reminder systems and analyze reasons for no-shows to tailor interventions. Consider overbooking to fill slots in case of no-shows.
- **Relapses affecting provider confidence**: Offer continuous education on relapse prevention strategies and encourage open communication among providers for support.
- **Screening in the clinic - UDS**: Streamline screening processes, provide clear guidelines, and educate patients on the importance of Urine Drug Screening (UDS).
- **Narcan availability in the clinic**: Ensure Narcan availability, train staff in administration, and educate patients and families on its use.
- **Conferences to learn more and continue practice**: Encourage attendance at conferences, provide financial support, and facilitate knowledge-sharing sessions upon return.
- **Continuing to educate and train residents and faculty**: Develop structured training programs, incorporate addiction topics into curricula, and facilitate mentorship relationships.
- **Involvement of the SUN in the clinic and hospital**: Integrate Substance Use Navigators (SUNs) into the care team, collaborate on care plans, and provide ongoing support.
- **Expanding support and linkages**: Strengthen partnerships with community organizations, establish clear referral pathways, and regularly assess support service effectiveness.

How will the progress be sustained?
Sustaining progress hinges on several key actions. Continuous education through conferences, ongoing training for residents and faculty, integration of Substance Use Navigators (SUNs) into clinic and hospital settings and expanding support linkages within the community will be paramount. These measures collectively fortify the foundation for continued success in the Quality Improvement project.

Please share your thoughts on your experience on the Quality Improvement coaching:
We had an incredible experience while being coached by Pam Kittleson with the CAFP CRPC team. Pam was able to guide the team effectively to refine SMART goals in order to complete the project in a timely manner.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
We hope that the grant funding continues to support education and training of our resident physicians in order to deliver much needed and effective patient care for addressing substance use disorders.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
provide much-needed care to our patients dealing with substance use disorders, and be unable to educate and train our resident physicians effectively regarding substance use disorder management.

California Residency Program Collaborative

Final Report and Results

Residency Program: Highland Hospital Alameda Health System Emergency Medicine Residency Program

Submitted by (name/email): Karen "Kay" Lind, MD kalind@alamedahealthsystem.org

Project Title: Emergency Medicine Residents Creating Mobile Street Medicine Outreach Clinic for Patients with Housing And Security And Substance Use Disorder

Goals of Your Project (as stated in your proposal, or as amended): We will create the opportunity for Oakland residents experiencing housing insecurity to receive in-home care for substance use disorders and other medical issues by Emergency Medicine residents and Addiction Medicine specialists. This opportunity will be created anew and transformed from a volunteer resident initiative into a sustainable, longitudinal care experience during the 2023-2024 academic year.

High-Level Description/Highlights of the Work Done on the Project: American adults experiencing homelessness die at a rate almost 10 times higher than the general population. There are over 150,000 unhoused people in the state of California, and although there are greater than 25 street medicine programs in California, our unhoused population would benefit from ongoing expansion of street medicine services . Previously the Highland Hospital Emergency Medicine residency had no path for participation in pre-existing street medicine services in Oakland, although street medicine is establishing a foothold in emergency medicine practice as a natural extension of our mission-driven care and is now a popular fellowship option . The Highland Emergency Medicine (EM) resident team collaborated with Alameda County Healthcare for the Homeless (ACHCH), Cardea Health, and Bay Area Community Services (BACS) to set up the first iteration of a mobile medication-assisted treatment (MAT) clinic at the Henry Robinson center, a BACS transitional housing center for 137 Oakland residents.

Describe strategies/interventions/approach to reach goals:
The MAT clinic was set up as a resident-staffed extension of the Highland Bridge clinic, which provides substance use disorder care at Highland Hospital. Once a week, EM residents conducted an in-person afternoon drop-in clinic for 4 hours. Patients were referred to the clinic by on-site peer substance use navigators (SUNs) who were hired as part of a grant through the California Health Care Foundation (CHCF), though all work performed by the

Highland EM residents was on a volunteer basis and not grant-funded. EM residents met with patients in a designated private office in the Henry Robinson center and also knocked on patients' doors with a peer SUN to meet with patients in their rooms. EM residents then registered patients with the Highland Bridge Clinic for remote clinic visits and staffed encounters with the on-call Bridge attending via phone call or text. Although focused primarily on MAT services, residents also provided primary care medication refills, initiation of psychiatric medications when appropriate, and helped patients connect to primary care clinics.

Barriers, challenges and solutions:
Over the course of 18 weeks, EM residents held 14 clinic sessions during which they saw 12 patients for a total of 23 encounters including initial evaluations and follow up visits. A total of 6 patients were started on MAT. Residents involved report high satisfaction with their involvement in the project. One resident told us," As residents we were really able to do all the documentation and patient interaction ourselves. It was very high yield learning in my opinion and was also wonderful to follow-up so closely with patients and build a relationship with them. Our interactions were low volume, but I think very high touch." Limitations to the project which may have affected patient census include a broken elevator preventing patient walk-in encounters, lack of clinic visibility within the center, low turnover of residents of the center limiting patient recruitment and relying on EM resident self-reporting of patient numbers rather than Electronic Medical Record data generation.

How will the progress be sustained?
With the support of multiple funding sites including grant funding and funding from Cardea Health/Alameda HCH, 3 days/week SUNs at sites were established. Residents' time and resources on a volunteer basis with reimbursement for supplies and tech support through CPRC grant.

EM residents plan to continue holding the clinic at the Henry Robinson and have expanded the reach of the mobile MAT clinic to other sites such as Eddie's Place, a medical respite center for Alameda Health System. The work of the Highland EM resident team to create a mobile street medicine clinic has laid the foundation for converting this work to a street medicine rotation for a strengthened longitudinal presence, further educational opportunities and increased ability to provide patient-centered care to our most vulnerable population.

Please share your thoughts on your experience on the Quality Improvement coaching:
The quality improvement coaching was timely, very helpful, and easily understandable process to complete. We very much enjoyed collaborating with the grant team to support and refine our quality improvement initiatives.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding: The care linkage tips, ways to focus on equity specifically, and ability to network with other similarly minded programs within the state of California were in valuable and ongoing funding to push through initiatives at hospice but the resources to do so, such as grant funding for our educators and patient-centered grant funding for our medical respite patients at the Cardea sites.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Transform our outreach abilities and creates a patient centered street medicine outreach clinic with an expanding

census and sustained ability for future growth in the form of a permanent longitudinal elective rotation, serving our most vulnerable patient has Alameda County with substance use disorder and despair he has no social determinants of health.

California Residency Program Collaborative

Final Report and Results

Residency Program: California Hospital Medical Center Family Medicine Residency Program

Submitted by (name/email): Peony Khoo, MD / cakhoo@eisnerhealth.org

Project Title: Meeting Community Needs: Implementing Residency Substance Use Disorder Curriculum and Launching Medication for Opioid Use Disorder at Eisner Health Family Medicine Center at California Hospital

Goals of Your Project (as stated in your proposal, or as amended):
1. Implement a structured addiction medicine curriculum and rotation in the residency program
2. Expand harm reduction / safer consumption education and services in the Family Medicine Center
3. Launch medication for opioid use disorder in the Family Medicine Center
4. Increase graduating residents' comfort identifying and managing SUD

High-Level Description/Highlights of the Work Done on the Project:
Our project centered on two main branches: education and clinic services. Education projects centered on creating an addiction medicine curriculum with clinical experiences in a family medicine residency program without an addiction medicine curriculum. Clinic services focused on creating an organized substance use screening workflow to be implemented for all patients starting at a pilot site with plan to disseminate system-wide. Additional clinic efforts focused on enhancing harm reduction services (e.g., applying for Naloxone Distribution Project, assembling harm reduction kits), enhancing care management of patients with substance use disorder, and increasing clinician support to enhance confidence in providing medication for opioid use disorder services in the primary care setting. Further details of components follow:

EDUCATION

- **Resident/faculty champions**
    - Identification of 2 resident and 1 faculty champion in AY 2023-2024
    - 2 additional faculty members started a longitudinal primary care addiction medicine program in

2024

- Foundation-building – support for resident/faculty champions to attend conferences for expanding knowledge base and curriculum development:
    - California Society of Addiction Medicine (CSAM) Conference
    - Medical Education and Research Foundation for the Treatment of Addiction (MERF) Scholars Program
    - University of California, Irvine, Train New Trainers Primary Care – Training and Education in Addiction Medicine (PC-TEAM) Fellowship
    - Boston University Clinical Addiction Research and Education Unit Faculty Scholars Program
    - American Society of Addiction Medicine (ASAM) / California Society of Addiction Medicine (CSAM) membership

- **Addiction Medicine Lecture Series** – series of lectures during residency didactics with CME credit available to encourage additional practicing provider attendance
    - Lecture series
        - Audience: attendees included medical students, resident physicians, faculty physicians, community clinic physicians, clinical pharmacist, case managers, care managers, behavioral health providers
        - 8/18/23: Introduction to Addiction Medicine
        - 8/29/23: Tobacco Use
        - 10/13/23: Alcohol Use
        - 12/8/23: Opioid Use
        - 1/5/24: Marijuana Use
        - 2/2/24: Substance Use in Adolescents
        - 2/16/24: Hot Topics in Addiction Medicine: E-cigarettes and Urine drug screening
        - 2/23/24: Chronic Pain and Safer Opioid Prescribing
        - 3/8/24: Stimulant Use
        - 6/14/24: Substance Use in Pregnancy
    - Additional trainings/sessions
        - 12/5/23: Injectable naltrexone training
        - 1/16/24: Human Behavior Psychosocial Case Conference – Treating Chronic Pain with Buprenorphine
        - 2/16/24: SBIRT Workflow (Residency)
        - 4/5/24: SBIRT Workflow (Clinic Practice Management)
- **Clinical experiences** – to provide practical experiences to residents
    - Integrated experiences in current rotations:
        - Community Medicine – Alcoholics Anonymous meetings added in Community Engagement, adding visit to Tarzana Treatment Center and weekly Street Medicine experience to rotation
        - Emergency Department – Working with Substance Use Navigator
        - Human Behavior – Motivational Interviewing

- Electives:
  - Los Angeles County Department of Public Health Substance Abuse Prevention and Control
  - Street Medicine with Venice Family Clinic
  - Street Medicine with AkidoCare
  - Tarzana Treatment Center

⇒ *Disseminated work via presenting poster at Society of Teachers of Family Medicine Annual Spring Conference in May 2024*

⇒ *Submitted resident poster to American Academy of Family Physicians National Conference (pending)*

⇒ *Resident self-report of ability to initiate buprenorphine increased from 23.5% to 50%*

CLINIC SERVICES

- **Harm reduction**
  - Eisner Health applying for Naloxone Distribution Project
  - Harm reduction kits
- **Addiction medicine services**
  - Standardized substance use screening workflow implemented at pilot site, to be disseminated system-wide
  - Creating clinician support tools including a clinician toolkit and eConsult
- **Care Management**
  - Care Manager dedicated to patients with substance use disorder hired
- **Quality improvement project to improve screening rate**
  - Created workflow with swim lanes for clear delineation of roles
  - Provided two trainings
  - Collaboration with Clinical Informatics to ensure screening tools customized and available to back office staff and providers

⇒ *Substance use screening rate in clinic increased from 0% to 55%*

⇒ *Dissemination of QI project results at hospital quality improvement forum*

Describe strategies/interventions/approach to reach goals:
Our overarching strategy was to develop partnerships to ensure success of our efforts.

Identifying resident and faculty champions for success with educational goals along with program support from behavioralist faculty and program director. For ongoing longevity of educational program, additional faculty were identified to enhance their foundation in addiction medicine through participation in longitudinal educational programming.

For clinic efforts, identifying collaborative partners within the Quality and Population Health Department was key. This allowed for enhanced efforts in launching a screening workflow with QI support to continue to improve

screening rates. Collaboration with clinical informatics, clinic staff, and clinical directors allowed for uptake of new workflow by multiple parties. Hiring a clinic care manager focused on our patients with substance use disorder provided enhanced care for patients to address unstable housing, linkage to care, and behavioral health care.

Barriers, challenges and solutions:

Clinic EMR change: During our grant project period, our clinic electronic medical record (EMR) changed from NextGen to AthenaOne. While a welcome change in EMR, this did create disruption in our ability to collect data. This also slowed our launch of a substance use screening workflow as we had to pivot to utilize tools available within the new EMR which were different from the tools previously used. This also caused delays as staff needed training in the new EMR before introducing a new workflow. We worked closely with our physician clinical informatics specialist with every other week meetings during and after our workflow launch to ensure a smooth launch and troubleshoot EMR challenges early on in the process.

Clinic leadership change: During the grant period, the clinic system also experienced a significant change in clinic leadership. The CEO and CMO changed within a short period of time, so our partners in the clinic leadership transitioned. The team remained supportive throughout, but this did result in some delay with moving forward with our development of policies and procedures, applying for the naloxone distribution project

Lack of addiction medicine faculty: Our program faculty did not have experience with substance use disorder management. As a result, we identified resident and faculty champions to train a smaller team that would then teach the larger residency group. This team was supported in conference attendance, participation in longitudinal programs, and ASAM membership. We also established clinical rotations to incorporate experiences in our local community for residents to apply skills.

How will the progress be sustained?

Our care manager was hired into the Enhanced Care Management team to provide sustainability for this support for our clinic patients with substance use disorder.

Additional faculty have been identified to continue to grow our preceptor pool so that we can integrate more services in the family medicine continuity site. Clinician support tools are also being created such as a clinician toolkit and an eConsult to increase provider comfort at the family medicine continuity site as well as other clinic sites within our system.

With the development of a key stakeholder group that met periodically throughout the grant period, we now have a group to lead our clinic in substance use disorder projects including future projects focused on behavioral health.

Please share your thoughts on your experience on the Quality Improvement coaching:
The Quality Improvement coaching from IPMA was very helpful. The QI coaching was provided in an encouraging manner with an appropriate cadence. Our team appreciated the more practical breakdown of quality improvement that made QI much more approachable.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
Additional priorities for future funding can focus on training site leads to disseminate training at their sites as well as a focus on behavioral health integration. ECHO sessions would be helpful in more local groups as well to continue to foster local collaboration.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Center a health equity lens, collaborate with other programs in our state to share resources, create a team of resident/faculty champions to develop an addiction medicine curriculum in our residency program, organize a group of key stakeholders within the clinic to spearhead SUD projects


Addiction Medicine Review Course
and Board Exam Preparation Track
AUGUST 30 - SEPTEMBER 2, 2023
Welcome
TO
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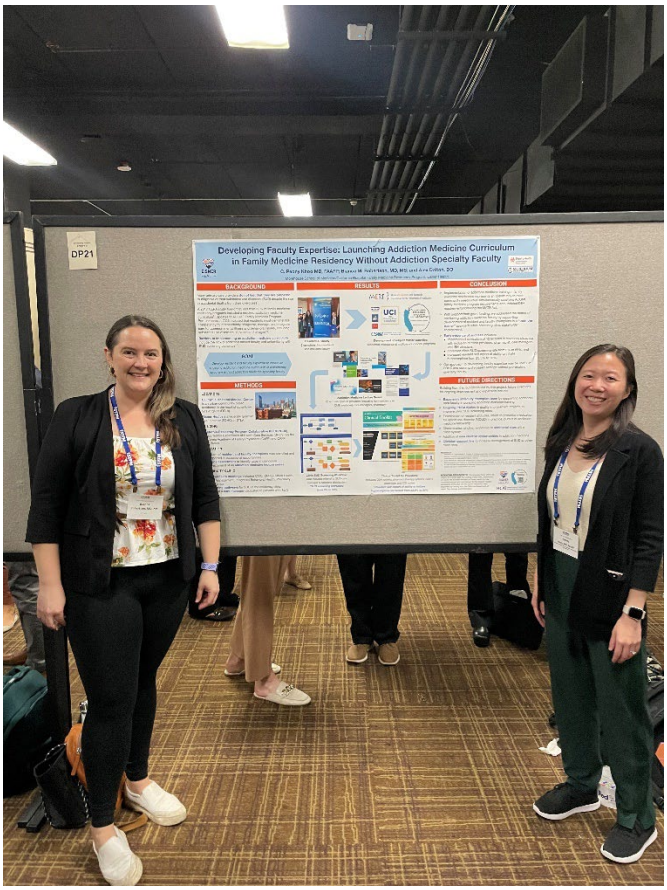

DP21
Developing Faculty Expertise: Launching Addiction Medicine Curriculum
in Family Medicine Residency Without Addiction Specialty Faculty
BACKGROUND
RESULTS
CONCLUSION
METHODS
FUTURE DIRECTIONS

California Residency Program Collaborative

Final Report and Results

Residency Program: Contra Costa Regional Medical Center

Submitted by (name/email): Tiffany Ku (tiffany.ku@cchealth.org); Lisa Rodelo (lisa.rodelo@cchealth.org)

Project Title: Improving Resident Education and Patient Access to MAT for Substance Use Disorders at Contra Costa Health Services

Goals of Your Project (as stated in your proposal, or as amended):

1. Procure and distribute harm reduction kits in the Emergency Department and via street outreach
2. Launch a two-week addiction medicine elective available to all residents
3. Create electronic medical record order sets for buprenorphine induction in the ED, inpatient, and outpatient
4. Host trainings for SUD screenings and buprenorphine inductions in different medical settings made available to all providers

High-Level Description/Highlights of the Work Done on the Project:

Our project had a multi-faceted approach to improve patient care and resident education around MAT and harm reduction practices. Specifically, we created additional curricular activities for residents to learn more about MAT induction and harm reduction, including the creation of an elective and funding residents to attend conferences/away electives. To improve patient care, we launched a buprenorphine induction order set on Epic, and are actively working on a harm reduction kit distribution project with the Public Health Department.

Describe strategies/interventions/approach to reach goals:

In regards to medical education, especially resident education, we focused on creating learning opportunities for addiction medicine topics, specifically around MAT inductions and motivational interviewing. We increased the number of didactic sessions on MAT during mandatory half day conference time. We have also developed a multidisciplinary addiction medicine elective, which included detention health to learn MAT inductions and motivational interviewing training. In addition, we also offered an addiction medicine away elective activity.

To enhance scholarly activity, we funded nine residents to go to CSAM and ASAM this past residency year, including six residents who participated in MERF this past year. Several of our MERF scholars are working to develop an addiction medicine interest group for the coming residency year, and a few of them have shared what they learned at the conferences during noon conference time (noon conferences are available to all providers in our healthcare system).

For patient care, we launched our adult inpatient buprenorphine micro induction and standard induction Epic order set in late summer 2023. This has been widely used by our residents and attendings on inpatient services. Currently, a few of the residents who participated in funded away elective/conference opportunities in addiction medicine are planning on expanding this order set to include OB patients.

Lastly, we are currently laying the groundwork for distributing harm reduction kits in our county hospital. Initially, the plan was to distribute the kits through the Emergency Department; however, after additional discussion with our Public Health Department and a local harm reduction non-profit, we elected for standing vending machines instead. Currently, we are undergoing discussions with other stakeholders to determine where these vending machines will be placed in our county (one will belong in the hospital). Because most of the above interventions do not have a high cost, we plan on spending the rest of the grant funds on harm reduction kits for our high-risk, high-need patient population at Contra Costa County.

Barriers, challenges and solutions:
We encountered various barriers and challenges in terms of the improving patient care portion of our project. Specifically, it took longer than anticipated to implement the harm reduction kit project, as there are many different stakeholders to involve in the steps of the process, such as determining the location of the vending machines and the contents of the harm reduction kit.

In addition, we attempted to work on expanding outpatient availability of MAT inductions (eg: buprenorphine starts in resident primary care clinic and naltrexone injection availability); however, this was limited by several factors. We currently have a robust outpatient multi-disciplinary Choosing Change program, for which patients can be referred to easily. In addition, only some of the outpatient preceptors are comfortable with buprenorphine inductions making it difficult for standard teaching in primary care clinic. We attempted to have a regular supply of naltrexone injections available in clinic sites; however, we did not have enough funds to purchase a regular supply of Vivitrol outpatient (prescribers would have to send for a regular supply for this to be couriered to clinic).

For the buprenorphine micro induction order set, we received primarily positive feedback from inpatient providers about the simplicity of the order set. However, one limitation of the order set is that if a patient was discharged in the middle of the micro induction, we could not continue the micro induction easily outpatient due to CA regulations on full agonist prescribing. Another caveat is that complex patients may have benefited from an inpatient addition medicine consult team, which we one day aspire to have in the future.

How will the progress be sustained?
We hope that with the standing in-house addiction medicine elective, away elective opportunities, and continued mandatory didactics around MAT induction will help to sustain resident education in addiction medicine topics. The high participation in the MERF scholarship program this past year will hopefully be translated to following resident years. The buprenorphine micro induction order set will be continued to be used by inpatient providers, with a referral process for continuation via our Choosing Change clinic. As the harm reduction kits roll out, we hope to involve residents going forward in educating patients on harm reduction principles and directing patients towards the vending machines.

Please share your thoughts on your experience on the Quality Improvement coaching:
We thought that it was helpful as it was a personalized coaching session. Specifically, it was tough for us to develop metrics around measuring patient outcomes when we were early in the planning process, but the coaching sessions were useful in grounding that there can be metrics for planning as well.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
Thank you for this opportunity, our residents have been very eager to learn more about addiction medicine topics but there were not enough structured opportunities prior to this grant. Our patient population have many psychosocial needs, especially related to addiction medicine. We also enjoyed learning from other residency programs during the year about their progress and barriers.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Bolster medical education and improve patient care in addiction medicine for our county.

California Residency Program Collaborative

Final Report and Results

Residency Program: County of San Mateo Psychiatry Residency

Submitted by (name/email): Brendan Scherer MD, bscherer@smcgov.org

Project Title: Increase OUD Evaluations and Treatment in Our County Jail

Goals of Your Project (as stated in your proposal, or as amended):

1) Increase the percentage seen and evaluated of inmates referred for OUD services from 30% to 40% or more
2) Increase the percentage of inmates discharged on OUD treatment who make follow-up visits from 25% to 40% or more
3) Increase the number of residents in the program who are comfortable treating OUD disorder from 1 to many more
4) Increase the number of residents in the program who are comfortable working with carceral populations from 1 to many more

High-Level Description/Highlights of the Work Done on the Project:

The project was remarkably successful in achieving some of its goals. We were able to create an alternative job/moonlighting structure, in accord with available rate limits, that permitted residents to work after hours in our county jail, doing OUD evaluations and treatment.

Residents initially started with exit-strategy patients, whose who planning to be released from jail soon, and had not needed urgent opioid use disorder care while in jail, but could use treatment before discharge with buprenorphine titration and then transition to Sublocade.

As they gained more experience with the jail population and protocol, they were able to take on evaluating inmates with elevated COWS and/or a history of IVDA.

Over time the residents expanded the number of inmates who were evaluated, and improved the assessments, the use of motivational interviewing, and helped facilitate the creation of a team member dedicated to assisting inmates about to be discharged link appropriately to MAT services in the county.

We were able to radically change the residents' experience with OUD treatment/buprenorphine, and their comfort with jail populations.

The residents' good experience and comfort providing this treatment and evaluations has led to notably reduced resistance to providing this care in our behavioral health clinics, and systemic alterations have been made at the main clinic sites to have Sublocade on hand. Rooms were repurposed to have lock/systems to limit access to the medication, and a medical bed was purchased for the one main clinic that was lacking.

Many trainings were done, which engaged with our entire behavioral health staff. These focused on the basics of harm reduction, the basics of OUD treatment and buprenorphine, and on LAI formulations, including specific training in provision of the injectables. Nurses, pharmacists, residents and staff physicians attended.

The residents also presented on this project at a Health Equity conference, engaging with other health care providers and helping other local psychiatry residents learn about the value of this work. There was also a focus on providing this type of evaluation and treatment to the undomiciled, and integration with our street medicine team.

Describe strategies/interventions/approach to reach goals:
Partnership and collaboration and education were critical here. Close partnership and collaboration with our correctional mental health team allowed us to identify areas that required more support and assistance, and then opened up the conversation to how we could achieve that.

Education was critical to building individual confidence around this work, and to reducing systemic resistance to this work. Repeated trainings helped to reduce perceptions of difficulty and de-stigmatize the population.

Barriers, challenges and solutions:

- Onboarding at the county jail took a lot more time than we had hoped. Creating the job in the county system for this moonlighting opportunity took more time than desired.
- The payable rate is lower than other moonlighting opportunities and therefore was not as competitive for residents' time.
- Cell counts and other jail programming restricted hours available to do this work.
- This work had political overtones we would have preferred to avoid, in that the correctional primary care and psychiatry teams did not want to do this work and felt that somebody else should be doing it.
- Harder to track inmates through the system than had been predicted.
- Inmates often discharged unexpectedly.
- Mixed messages to teams about who should be referred.

How will the progress be sustained?
We were able to get $50,000 dollars from the county's opioid settlement funds to continue this project for at least the next year.

Please share your thoughts on your experience on the Quality Improvement coaching:
The QI team was so helpful in directing our goals, in helping us define further steps, and in guiding us when we had some difficulties getting the data we originally anticipated using.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
This was a remarkable opportunity to focus on improving care and saving lives, in a way that will provide dividends for years. I believe our culture of care has been altered for the better in ways that might not have been achieved for years without this kind of attention and support. This programming and funding allowed us to creatively break through systemic barriers and supply much needed care.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Build an energetic community of health care providers with the expertise to care for marginalized individuals while simultaneously challenging and improving the system of care.

California Residency Program Collaborative

Final Report and Results

Residency Program: Kaiser Napa Solano, supporting 4th Second: One Love Vallejo Mobile Health

Submitted by (name/email): Emily Fisher

Project Title: One Love Vallejo Mobile Health: Community-Based Training of Family Medicine Residents in Medication-Assisted Treatment for Substance Use Disorders Among People Experiencing Homelessness

Goals of Your Project (as stated in your proposal, or as amended):
To improve the access to MAT for PEH with OUD, in Vallejo, CA, 4th Second's street outreach team, which is comprised of SUD navigators, care managers and family medicine physicians, , strives to effectively integrate medication-assisted treatment with buprenorphine for opioid use disorder among PEH in the community-based setting. We aim to accomplish this initiative through several overarching goals:

1. We strive to increase resident and faculty knowledge, attitudes and comfort in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders for PEH in the community setting by June 2024.
2. We aim to increase the percentage of residents who completed the 8-hour training course on MAT with buprenorphine by 50% in the KP Vallejo Family Medicine Residency Program by June 2024.
3. We aim to increase the percentage of PEH in Vallejo with OUD to be referred to services and/or receive counsel or treatment for their substance use disorder by 10%.

An added long term goal is the utilization of trained FM residents to provide street-based inductions to people experiencing homelessness.

High-Level Description/Highlights of the Work Done on the Project:

In the course of this year, we were able to provide 8 hours of dedicated training to the Family Medicine Residents on Addiction Medicine, MAT, and managing addiction in underserved (namely people experiencing homelessness) populations. This training will meet the requirements for Residents to proceed with Buprenorphine prescribing and filled a gap of training that had not previously held a formal place in our curriculum.

Additionally, Residents were able to participate in street outreach events where they provided care for people experiencing homelessness while also supporting and collaborating with the 4th Second Care Management and Substance Use Navigation team.

The support provided to the 4th Second team resulted in 60 referrals for substance use treatment. This doubled the referrals noted for the previous year (30) and well outpaced the goals we set.

Describe strategies/interventions/approach to reach goals:
First, we had to assess the current state of the MAT and addiction medicine curriculum in our program as well as the availability of clinical experiences for MAT prescribing.

Next, we locked in times throughout the academic calendar to ensure that the residents would receive a full 8 hours of addiction-focused curriculum over the course of the year. This included the addition of a 2-hour workshop on treating addiction as a chronic disease as well as a 2-hour workshop on treating addiction specifically in the street outreach space. Curriculum was identified primarily through STFM and SAMSHA

In parallel to this, funding support allowed 4th Second to hire a substance use navigator/care manager who worked through street outreach and with the One Love Vallejo Mobile Health medical team to identify clients needing referrals. Family Medicine Residents as well as Touro health professions students provided acute medical care, and sometimes the medical clearance needed to move a patient into detox or rehab.

The 4th Second team identified clients in need of referrals by maintaining a consistent presence at curbside communities through direct outreach and enrolling clients in care management services.

Barriers, challenges and solutions:
The most challenges came in the educational space. When we started the project, we realized that the baseline of MAT prescribing and education in the residency was farther behind than we had thought. The only dedicated time in the curriculum to didactic teaching on MAT or addiction was a 4-hour workshop for incoming interns. We worked closely with an addiction medicine specialist on our team to develop curriculum and get it scheduled into the academic calendar for the residents. What we discovered through this was that our Residents are very eager for this learning and were extremely engaged in the didactics.
Additionally, we discovered that the mechanism by which residents had previously been providing maintenance buprenorphine care to patients had fallen by the wayside, and very few residents (and NO faculty) were actually doing any buprenorphine prescribing. No one was doing any inductions at all.
Our first route to address this challenge was to look into the street medicine space as a place to potentially provide this type of care. We were able to successfully work with one patient to set up an induction schedule.

The greater challenge lies in creating a consistent, longitudinal opportunity for residents to prescribe buprenorphine (induction and maintenance) in their regular clinical work. Until this is set, they will not be comfortable doing this in a street medicine space. Integrating this type of experience will be the next set of goals for this project

How will the progress be sustained?
We intend to maintain the yearly 8 hours of addiction medicine curriculum in didactics. We have already identified a resident who plans to focus his community medicine distinction capstone project on expanding MAT provision within the FM residency, and we plan to create an OUD/MAT specific committee within our clinic/hospital group to identify areas where we may be able to expand MAT provision and integrate this into the fabric of the FM resident experience

Please share your thoughts on your experience on the Quality Improvement coaching:
Overall, this experience was very helpful. We found the team to be patient, understanding, and uplifting throughout the process

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
See the potential for Addiction Medicine and MAT training and expansion of service lines within a Family Medicine Residency program.

California Residency Program Collaborative

Final Report and Results

Residency Program: Harbor UCLA Department of Family Medicine

Submitted by (name/email): Gloria Sanchez, MD, gsanchez@dhs.lacounty.gov and Theresa Nevarez, MD, MBA, tnevarez@dhs.lacounty.gov

Project Title: Harbor UCLA Family Medicine MAT for High-Risk Adolescent Population

Goals of Your Project (as stated in your proposal, or as amended):

- Establish universal SUD screening of youth presenting to the Harbor UCLA Pediatric HUB clinic with the CRAFFT screening.
- For adolescent's screening positive provide SUD harm reduction and low barrier MAT if needed for their use.

High-Level Description/Highlights of the Work Done on the Project:

The Harbor UCLA Pediatric HUB now performs CRAFFT screening of all adolescents. In addition, those youth that screen positive are provided nearly same day consultation with a MAT/Addiction provider to help insure low barrier MAT.

The HUB clinic serves very vulnerable adolescents that are in the Department of Children Families Services and are now able to start evidenced based care for youth struggling with substance use.

Describe strategies/interventions/approach to reach goals:

1. Collaborate with HUCLA Pediatric HUB leadership
2. Work in the HUCLA Pediatric HUB clinic to learn the workflow to better help incorporate CRAFFT screening.
3. Continue to provide coverage for all HUB sessions by on call MAT providers to help with urgent SUD adolescent patients.

Barriers, challenges and solutions:

1. Multiple mandatory screenings that made the addition of CRAFFT screening difficult.
2. Turn over and/or leaves of staff that delayed training.
3. Providing on site training helped staff adopt CRAFFT screening and MAT treatment more feasible.
4. 24/7 MAT Consultation is key to help the most at risk youth

How will the progress be sustained?

1. The CRAFFT screening is now part of the HUB clinic protocol.
2. HUB clinic providers now have an algorithm and on demand MAT provider line to start MAT at the same day visit.
3. HUB clinics now have harm reduction supplies like Narcan, fentanyl test strips and condoms readily available.
4. We are part of the Los Angeles County Department Health Services Behavioral Health Initiative to implement universal SUD screening at all points of contact including ambulatory, urgent care, emergency room visits.

Please share your thoughts on your experience on the Quality Improvement coaching:

Without the QI coaching with Ms. Kittleson this project would not have been feasible. As busy family medicine faculty and "front line" physicians we greatly value and need this type of expertise.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

Without the CRPC Advisory Panel and CA DHCS funding we truly would not have been able to accomplish our current addiction medicine services and education. As the healthcare system begins to realize and fund "addiction is a treatable chronic condition", CRPC and DHCS support is critical to demonstrate the moral and financial data to sustain and expand sud services.

Future funding would be greatly appreciated for initiatives like the following:

a. AAMC and ACGME longitudinal curriculum that teaches premed and residents the fundamentals of evidenced based SUD care that includes destigmatizing patient care with low barrier MAT.
b. Public Policy and legislative changes that eliminate and expand SUD care. Especially for adolescents involved in Department Children Family Services.
c. Create regulatory requirements (i.e. Joint Commission) and financial means to sustain and expand addiction across the healthcare system.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:

Expand evidenced based, low barrier SUD care for vulnerable adolescents that at the national level do not receive MOUD yet have the best outcomes if timely MAT is initiated.

We would not have been able to teach and help pediatricians that have not provided MOUD and/or low barrier MAT and harm reduction in they're very busy high risk clinic.

Initiate adolescent addiction services that provide immediate harm reduction, evidenced based SUD care and longitudinal follow up.

California Residency Program Collaborative

Final Report and Results

Residency Program: Harbor UCLA Medical Center Department of Family Medicine

Submitted by (name/email): Gloria Sanchez, MD and Theresa Nevarez MD, MBA, gsanchez@dhs.lacounty.gov, tnevarez@dhs.lacounty.gov

Project Title: Harbor UCLA Internal Medicine and Family Medicine Addiction Treatment Educational Collaborative

Goals of Your Project (as stated in your proposal, or as amended):

1. Expand educational and clinical experiences for both Internal Medicine and Family Medicine to improve knowledge and confidence for SUD screening and prescribing MAT
   - Expand the FM inpatient consult service to include Internal Medicine residents
   - Increase Family Medicine residents rotating in the Internal Medicine MAT clinic
   - Provide lectures to the Internal Medicine residents and 2-3 Internal Medicine specialties

2.Initiate monthly interdisciplinary rounds with Internal Medicine, Family Medicine, Emergency Medicine, Pediatrics, Surgery, Psychiatry, Social Work to discuss SUD cases that emphasize MAT, and assess how stigma may have effected coordination of care and dual diagnosis.

3. Embed an addiction medicine family medicine fellow in the Harbor UCLA Urgent Care to improve workflows for universal substance use screening using validated assessment tools.

4. Establish a program for distribution of Safe Syringe Supplies including fentanyl test strips and naloxone in the IM MAT and Urgent Care clinics within the first 6 months. Data will be collected to monitor the number of kits dispensed

Brief Description of Key Accomplishments:

- We were able to embed an addiction medicine family medicine fellow in the Harbor UCLA Urgent Care to improve workflows for universal substance use screening using validated assessment tools.
- In addition, we were able to increase easy access of safe syringe supplies at IM MAT and urgent care clinics.

- We have had multiple interdisciplinary rounds but have not been able to establish monthly formal didactics. SUD informal teaching occurs daily with consults.
- There have been many interdisciplinary SUD stigma talks that have increased the number of discussions with physicians, nurses and pharmacists.
- IM residents have been able to rotate on their elective time and the goal is to increase the volume in 2024-2025.

High-Level Description/Highlights of the Work Done on the Project:

By embedding an addiction medicine family medicine fellow in the Harbor UCLA Urgent Care we have been able to improve workflows for universal substance use screening and expedite same day MAT initiation and SUD comprehensive care. The multidisciplinary didactics and "on site" addiction medicine fellow have been fundamental in teaching how SUD stigma can be eliminated so patients struggling with SUD can receive compassionate and evidenced based care.

Barriers, challenges and solutions:

The location of the IM MAT clinic changed during this year which created a small barrier to "in vivo" consults for the Urgent Care team.

In addition, IM Urgent Care nurses were required to do other workflows that delayed the initiation of universal SUD screening.

Outcomes and the impact of the project, in relation to the project goals:

By embedding an addiction medicine fellow in the Harbor UCLA Urgent Care we have created a new universal SUD screening for a very at risk, large volume of patients. We have been able to create "low barrier" MAT that is being facilitated not only by physicians but also associates like nurse practitioners in a busy urgent care.

Most importantly, the Harbor UCLA Urgent care healthcare team is very engaged in how to assess and eliminate stigma that affects patients that use.

Dissemination and Spread Strategies, in place or planned:

1. We are part of the Los Angeles County Department Health Services Behavioral Health Initiative to implement universal SUD screening at all points of contact including ambulatory, urgent care, emergency room visits.
2. We are collaborating with multiple departments like internal medicine, emergency medicine, pediatrics and psychiatry to ensure patients have access to "low barrier" MAT.
3. With the aid of multiple departments and social work we continue to have at least quarterly talks about how to dismantle stigma and SUD care.

Anticipated financial and infrastructural sustainability of progress during the next two years:

We aim to submit a new budget item request that sustains and expand Harbor UCLA's addiction medicine consult service to 24/7 capacity that includes ambulatory and hospital based care.

Have you completed, or do you plan to complete, the PI/MOC module? Please share your thoughts on the experience.

We found the PI/MOC modules integral to be able to make feasible goals and PDSA cycles. We greatly appreciate Ms. Kittleson's amazing assistance and patience as we worked on this project.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

Without the CRPC Advisory Panel and CA DHCS funding we truly would not have been able to… Accomplish our current addiction medicine services and education. As the healthcare system begins to realize and fund "addiction is a treatable chronic condition", CRPC and DHCS support is critical to demonstrate the moral and financial data to sustain and expand SUD services.

Future funding would be greatly appreciated for initiatives like the following:

d. Interdisciplinary SUD healthcare teams that include social work, associate level providers (i.e. PA, NP), pharmacists and healthcare administrators.
e. AAMC and ACGME longitudinal curriculum that teaches premed and residents the fundamentals of evidenced based SUD care that includes destigmatizing patient care with low barrier MAT.
f. Public Policy and legislative changes that eliminate and expand SUD care.

California Residency Program Collaborative

Final Report

Residency Program: Kaiser Permanente Santa Rosa Family Medicine Residency Program

Submitted by (name/email): David F Della Lana (David.F.DellaLana@kp.org)

Project Title: There's no place like Home: Integrating SUD SBIRT into Kaiser Permanente Santa Rosa Family Medicine Residency Clinic

Goals of Your Project (as stated in your proposal, or as amended):

1. Identify the population of patients receiving treatment for Opioid Use Disorder (OUD) who are assigned to primary care physicians, i.e., residents and faculty, in our residency Family Medicine Center Module (FMCM).
2. Pilot buprenorphine prescribing in our FMCM at Kaiser Permanente Santa Rosa (KPSRO): we will pilot new workflows by providing buprenorphine to 10-20 patients and conducting an additional 5-10 inductions in the FMCM, with the intention of expanding this pilot in future.
3. Improve knowledge and comfort with buprenorphine prescribing by integrating the most recent, evidence-based, equity-focused training into the residency curriculum, continuity clinics and additional faculty development for faculty physicians.
4. Improve FP Residency Staff and Provider (Faculty, Residents, Medical Assistants) awareness, screening, and follow-up brief interventions for patients with alcohol overuse – this issue proved to be statistically proved more prevalent in our patient population.

High-Level Description/Highlights of the Work Done on the Project:

1. Initial 1:1 OUD/MAT education occurred with 10 interested FM Residency Faculty.

2. Resident Didactic on SUD/OUD & MAT education/training took place in Dec 2023. Subsequent Resident Didactic on AUD screening, SBIRT occurred in Mar 2024.

3. Fact-finding meeting with KP Santa Rosa Teenage Patient Advisory Council occurred in Nov 2023 to directly converse with 15 teenage leaders in our community regarding their perspectives and experience with various substance use issues amongst the high school teenage population here in Santa Rosa.

4. Formal KP Santa Rosa Grand Rounds presentation on current local public health impacts of Fentanyl (open to all Medical Clinicians) occurred (in collaboration with our KPSRO CDD Director) in Jan 2024 (50 providers attended, 100% positive feedback).

5. Formal Quality Improvement Project was undertaken to improve FP Residency Staff and Provider awareness & screening (and follow-up intervention/treatment) for our patients with unhealthy alcohol use issues. Achieved 20% improvement in overall AUD SBIRT.

Describe strategies/interventions/approach to reach goals:

1. A broad EHR data review was conducted (Q1 2023), 50+ potential patients with (recent) OUD/SUD diagnoses were identified, and their medical charts underwent detailed review -> (only) 12 patients were found that meet Goal A criteria (above).

2. For the 12 patients (identified per inclusion criteria) on [stable] MAT whose clinical needs are being met by our KP Santa Rosa Chemical Dependency Dept. (CDD) – decision was made to keep Rx/Care/Tx in CDD (maintain current provider continuity & Rx stability)

3. New MAT inductions currently take place in our ED or inpatient ward (often after-hours) and patients can quickly and reliably follow-up in our outpatient CDD (*now including KP Medi-Cal patients via state-granted KP waiver*) – many inductions currently done with patient at home via Telephone counseling visits (with CDD provider). Current KPSRO workflow is efficient & reliable.

4. In addition, all 18 of our KPSRO FP Residents currently rotate thru this CDD experience. Therefore, attempting to create or re-create this service in our Residency Module was felt not to be in the best interests of patients, providers, or learners.

Barriers, challenges and solutions:

1. Current KP Chemical Dependency Department (CDD) is well positioned to meet the needs of our OUD/MAT patient population (including MediCal members –> KP medical members have equitable & often enhanced access to necessary KP CD services).

   Therefore, we pivoted to focus our QI Project on Unhealthy Alcohol Use which is highly prevalent (under reported and under treated) in our local FMCM population.

2. Key KP Santa Rosa ED personnel (i.e. our Substance Use Navigator) was on extended leave during this Grant year and thus it proved challenging to facilitate a partnership with our ED colleagues to propose, design, and/or change current (efficient) workflows.

Therefore, we focused on collaboration with our CDD director (for educational guidance) and our Teenage Patient Advisory Council (helping to elicit current "real world" state of SUD behaviors amongst local youth).

3. Numerous competing demands on Resident's educational time made it very challenging to insert new curricular material into current formal didactics schedule.

   Therefore, we partnered with already scheduled lecturers dovetailing time in order to include new AUD/OUD content.

4. Numerous competing demands on Faculty time made it challenging to propose and facilitate a change in current clinical practice for our Family Medicine Clinic Module.

   Therefore, we utilized Faculty Meeting time to emphasize project relevance for our population and envision the potential positive clinic outcomes for our patients & learners.

How will the progress be sustained?
Didactic and other educational sessions will be recurringly (annually) incorporated into our Residency's formal educational curriculum.

In creating our new AUD SBIRT process we deliberately built-in resources and workflows that sustainably incorporate the 'new' processes into our 'normal' daily structure of providing care.

Please share your thoughts on your experience on the Quality Improvement coaching:
Pam Kittleson provided excellent, actionable feedback during the entire QI project.
While we were forced to pivot project focus, additional coaching and feedback helped us realize actionable, measurable, and realistic QI goal(s) given our time & resource limitations.
We are/were very grateful for this additional project resource.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

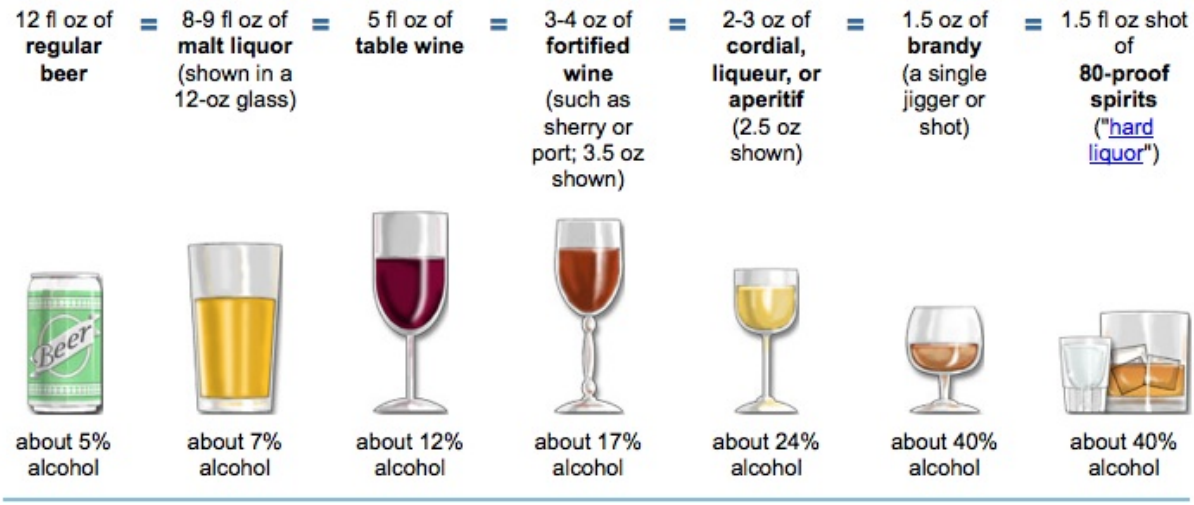
Complete this sentence –

Without this Collaborative and CRPC resources, we would not have been able to...:
Realize a large [unmet] diagnostic and treatment need for our clinic patients and bring new processes and resources to bear in helping meet and sustain their treatment needs.

Adult Screening Laminate

Checking in on your Alcohol use (if any)

(the pictures below show the amount for "one standard drink")



1) How many alcoholic drinks do you consume in one WEEK?

2) How many times in the past 3 months have you had more than 4 alcoholic drinks in one day?

3) In the past year, have you sometimes been under the influence of alcohol in situations where you could have caused an accident or gotten hurt?

4) Have there often been times when you had a lot more to drink than you intended to have?

¿Cuánto alcohol bebes? (si alguna)

(una porción estándar de alcohol)

1) ¿Cuántas bebidas alcohólicas tomas en una SEMANA?

2) ¿Cuántas veces en los últimos 3 meses ha consumido más de 4 bebidas alcohólicas en un día?

3) Durante el año pasado, ¿ha estado alguna vez bajo la influencia del alcohol en situaciones en las que podría haber causado un accidente o haberse lastimado?

4) ¿Ha habido ocasiones en las que ha bebido mucho más alcohol del que pretendía?

Teenage (patient) Advisory Council – Kaiser Permanente (Santa Rosa)
Monday, 11/20, 4-5:00p, MOB4, S
Opioid Use Disorder Grant: Education and Expansion of Services

Dr. David Della Lana (Family Doctor and KP Residency Program Faculty with special interest in substance use issues) asked questions about opioid use among teens. Discussion included “opioids plus” (vaping, drinking, etc.).

Most Relevant Local (Observed) SUD Issues [from teen leader perspectives]:

1. Usage spreads to other friends within a friend group (peer pressure)
2. Also challenging when a friend starts using because, even if you don’t also use, you are concerned and don’t know how to help
3. Really effected by who your friends are and where you’re growing up
4. Parents are not giving the best resources / solutions. Want kids to experiment: more of a “hands-off” – “you need to figure this out yourself” approach
5. Some parents enable/condone (“as long as they do it in my house”)
6. Substance use can also be part of a want to fit into certain social groups. Some people pretend to use, some use so they’re invited to parties.
7. Rampant on school campuses. Students who don’t vape, etc. don’t want to use the bathrooms anymore because it’s a place people congregate to vape, get high, drink, etc.
8. Schools don’t prioritize the prevention of vaping or the education of substance / alcohol abuse. Would like to see schools take it more seriously (patrol the bathrooms, etc.).
9. Most education takes place in middle school or briefly in 9th grade

Seeking Help/Interventions:

1. Challenging because it’s so normalized many people don’t seek help
2. Have a designated , committed, trusted (adult) person at each school
3. One school has a teen clinic that gives out needles (harm reduction)
4. Schools need to prioritize more [resources]. Provide more education. (Understand that staffing is an issue at most schools)

Wellness Centers are becoming more common on campuses. Some believe the people who need them most won’t access them. One person had a friend who received help for substance use through the Wellness Center

California Residency Program Collaborative

Final Report and Results

Residency Program: Kaiser Permanente San Diego Family Medicine Residency Program

Submitted by (name/email): Payam Sazegar (payam.p.sazegar@kp.org)

Project Title: *Increasing Access to Medication Assisted Treatment through a Collaborative Care Model at Kaiser Permanente San Diego*

Goals of Your Project (as stated in your proposal, or as amended):

- Increasing volume of MAT prescriptions for alcohol use disorder (AUD) from all primary care physicians in our medical group to offload at least 30% of the workload of our Addiction Medicine department & improve access for patients with severe substance use disorders (SUDs).
- Providing training, mentorship and clinical experiences for KP San Diego (KPSD) primary care physicians (n=301) who may be interested to prescribe buprenorphine for opioid use disorder (OUD).
- Implement a Transition of Care clinical workflow using a collaborative care model involving addiction medicine, behavioral medicine and primary care to transition 'stable' buprenorphine patients to primary care physician.

-Improving the number of SUD diagnoses made by primary care physicians through site visits by our team to different KP medical office buildings and offering support (for SBIRT and MAT prescribing) and through regular check-ins and educational interventions. Previously there was over-coding of 'unhealthy substance use behavior' which impacts reimbursement and MAT coverage.
-Providing support for residency faculty to precept patients with SUD at our FQHC partners and support residents seeking to do community medicine electives that increase exposure to SUD care.

High-Level Description/Highlights of the Work Done on the Project:

AUD

-We trained 212 primary care physicians about low threshold MAT

-We increased Naltexone prescriptions (related to 43 alcohol related diagnoses) by 56% over 6 months. The medical group currently averaging unique 600-700 Naltrexone prescriptions per month for AUD. Poster from preliminary data is available on the ASAM 2024 conference website.
-Most physicians who prescribed Naltrexone in past year have continued to prescribe
-We enhanced clinical decision support tools to assist with outpatient management of AUD (SmartRx, dotphrases) in primary care, allowing us to sustain practice change and medication offering.
-We improved accurate diagnosis and coding of AUD with support from multiple departments.
-We obtained MOC credit for physicians who wish to continue tracking their AUD diagnoses, MAT prescriptions and other SUD quality measures related to improve care quality.

OUD

-We trained 206 primary care physicians in Suboxone prescribing – 42% desired to prescribe and 75% asked for additional training and coaching
-We removed he formulary restriction so that all KP Southern California (KPSC) physicians can now prescribe buprenorphine (was previously restricted to Pain, Addiction Medicine, Palliative Care). This impacts over 16,000 physicians serving over 4 million patient members.
-We trained 18 family medicine residents to prescribe buprenorphine in their practice
-We developed clinical workflow with Pain Medicine and Addiction Medicine for transfer of stable (remission) patients to primary care for ongoing Suboxone maintenance.
-We change regional clinical practice guidelines regarding chronic pain in KPSC The guidelines now say “Emerging evidence suggests a transition to buprenorphine may be beneficial for patients with risks of continued high-dose opioid use outweigh benefits and are having substantial challenges with tapering, and who do not meet criteria for opioid use disorder. Buprenorphine…has better safety profile including less respiratory depression and overdose risk than other full agonist opioids.”
-There is ongoing development of Clinical Decision Support tools for Suboxone prescribing coming in 2024

Describe strategies/interventions/approach to reach goals:

-collaborative meetings with multiple departments including Pain Medicine, Addiction Medicine, Emergency Medicine, Clinical Pharmacy, Drug Utilization department, CME department. Maximized in-person meetings throughout Southern California to move agenda forward.
-use of IPMA quality improvement framework
-use of Data Services, Quality and Clinical Pharmacy departments for SUD metrics, MAT prescriptions, utilization of EHR tools. Used funding to incentive scholarly work for interested faculty and residents.

Barriers, challenges and solutions:

-the need to work across multiple departments within a large political structure to move agenda forward on everyone else’s time. → maximizing in-person meetings was beneficial
-physician hesitancy to prescribe MAT → partnership across departments and a ‘herd mentality’ approach when moving forward agenda within a large medical group. Increasing the number of presentations, incentivizing physician engagement and accompaniment with colleagues in leading change.

How will the progress be sustained?

We have IRB approval to continue collecting MAT data as part of our quality work at KPSC. We continue to receive monthly reports about MAT utilization (for alcohol and opioids) as well as use of Clinical Decision Support tools in our medical group. Also, OUD metrics have become a heavily weighted metric in 2024 for KPSC. We used Grant funding to incentivize Addiction Medicine training and conferences for interested Residents and encouraged scholarly work in this area (with pre-built research projects).

Please share your thoughts on your experience on the Quality Improvement coaching:
The QI coaching was invaluable as it provided us a rational framework for leading change – SMART goals, encouraging critical thinking, regular tracking of outcomes and accountability, making data-driven decisions.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
There should be discussions with the people who decide the formularies of large HMOs and health systems to see if opioid settlement funds can be used to off-set the cost of Suboxone for off-label prescribing to patients on long-term opioids (without an opioid use disorder diagnosis for various reasons) but who use unhealthy doses of prescription opioids and are at higher risk of unintentional overdose.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Remove institutional barriers for primary care physicians at Kaiser Permanente San Diego to prescribe Suboxone for OUD or Chronic Pain. Design, deliver and sustain a culture of low threshold MAT for AUD.

California Residency Program Collaborative

Final Report and Results

Residency Program: Kern Medical Internal Medicine

Submitted by (name/email): Sarah Gonzalez, MD/sarah.gonzalez@kernmedical.com

Project Title: Increasing Addiction Medicine Education to Internal Medicine Residents

Goals of Your Project (as stated in your proposal, or as amended):

- 2 MAT focused GME sessions each AY, starting 2023-2024
- 2 grand rounds each AY that promote collaboration across sectors with a focus on Behavioral health- including substance use disorder
- IM curriculum:
  - Implementing curricula to include behavioral health didactic training for PGY-3 IM residents
  - Simulation labs with clinical scenarios of alcohol and opioid withdrawal for PGY-1.
  - Addiction Medicine Lecture series for PGY-1,2,3
- 40-hour PGY-3 IM resident addiction medicine rotation, which includes treatment in the inpatient and outpatient settings.
- Use and promote harm reduction by connecting individuals to overdose education, increasing MAT enrollment, referrals for SUD treatment, increasing access to treatment with bus passes.

High-Level Description/Highlights of the Work Done on the Project:

- PGY-3 IM residents completing addiction medicine elective rotation; which includes an inpatient consult service, as well as an ambulatory MAT clinic called MARC (Medication Assistance and Recovery Clinic). Added clinical time for shelter medicine and street medicine.
- Continued utilizing the Naloxone Distribution Project and started a syringe swap program.
- Utilization of our simulation lab for resident education focusing on withdrawal syndromes. Plans to expand topics to include MAT inductions.
- In February, had a grand rounds lecture on Pregnancy and Women's SUD: Focus on OUT Treatment Strategies by Tipu Khan, MD. In March, had a grand rounds lecture on Updates in the Treatment of Stimulant Use Disorder by Sarah Gonzalez, MD.

Describe strategies/interventions/approach to reach goals:
Collaboration with multiple departments-IM resident program director, Graduate Medical Education office and Simulation Center Medical Director.

Barriers, challenges and solutions:
Loss of key personnel involved in the grant application. Additional residents participated to help with the workload.

How will the progress be sustained?
There has been development of an ACGME accredited Primary Care Addiction Medicine Fellowship Program; which will not only help continue the work that has been started, but will give Kern Medical the ability to expand services

Please share your thoughts on your experience on the Quality Improvement coaching:
QI coaching helped us stay focused on the goals, and assisted when we needed to make changes in the project due to limitations with data collection.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
There are lot of requirements for this grant, which make can it burdensome. It would be helpful if the data and reporting requirements could be minimized or more focused on the individual project.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to... to start our Internal Medicine Addiction Medicine Resident rotation.

California Residency Program Collaborative

Final Report and Results

Residency Program: Olive View-UCLA Medical Center

Submitted by (name/email): Maureen McCollough

Project Title:
Substance Use Disorder / MAT - Identification, Retention and Harm Reduction Initiatives

Goals of Your Project (as stated in your proposal, or as amended):

- Increase EMR documentation (coding) of SUD-related ICD-10 codes for ED and inpatient visits.
- Increase contact by an SUD counselor after an ED or inpatient visit for substance use disorders.
  Increase rates of first follow-up appointments in our MAT clinic.
  Increase numbers of patients in sustained remission (>6 months) in our MAT clinic.
- Distribute fentanyl test strips along with patient education handouts on their use.
- Educate critical staff members including providers, nursing, Clinical Social Work and substance use counselor on broader aspects of harm reduction and specifically contingency management and its use for stimulant use disorder.

High-Level Description/Highlights of the Work Done on the Project:

Highlights of our grant include our efforts to increase the number of LA County DHS patients who attended their first follow up appointment within 30 days of their ED visit or inpatient admission. We were able to raise the follow-up rate from 35% to 50%. We continue to offer a MAT provider on-call service with increased consults from our local DHS clinics and several surrounding L.A. hospitals. Our Bridge Clinic has matured this last year adding Addiction Fellows who rotate through our Friday Clinic sessions along with an increased number of Internal Medicine residents, receiving very positive evaluations on the rotation from both groups of learners. Through the CRPC grant, we established a very well attended noontime SUD lecture series for providers and social work staff across DHS. In addition, we sought information through a formal survey from patients who have been in long term recovery and it affirmed our sense that a low-barrier, easily accessible, non-judgmental approach to treatment is key. And finally, as part of our CRPC dive into health disparities and access to treatment, we discovered a large population of LA County DHS patients in a more rural area of Los Angeles seeking SUD care

outside of the DHS system often with troubling interactions with community resources. We are now working to repatriate these patients back to DHS for their ongoing MAT treatment.

Describe strategies/interventions/approach to reach goals:

Identification of patients with substance use disorder in the hospital is the first step to be able to offer treatment. Through frequent messaging, we encouraged ED providers to include an SUD ICD-10 code when appropriate for the ED visit or hospital admission. Faculty were encouraged to also add the diagnosis when residents or NPs had forgotten. We continue to work toward having our clinical social work staff be able to add these diagnoses too in the medical record, but this continues to be stalled at the DHS administrative level.

Retention includes both that initial follow up visit and sustained recovery. We put our biggest effort in this project toward increasing the first follow up visit rate after an ED visit or hospital admission where buprenorphine was started for opioid use disorder. We created several patient handouts - the neurobiology of addiction, an introduction to the Bridge Clinic, an anxiety and insomnia handout and a handout describing how counseling can be obtained - and we now send these handouts to all new patients in the Bridge program. Our Bridge navigator made an increased effort to contact new patients in those first couple of weeks after discharge. We have a continued provider on-call presence to not only help providers who are relatively new to MAT but also available to assist patients who are new to MAT/buprenorphine. We set aside 1-2 MAT clinic appts each week for hospital follow-up cases. This last year we were able to increase the number of patients seen in our weekly clinic because of the additional Addiction Fellows that started rotating with us and because of the increased number of Internal Medicine residents who also rotate with us. We are proud to say that both the fellows and residents rated the Bridge clinic rotation extremely highly. We have capacity for more residents and increased clinic time for the fellows (as requested by the fellows) that will increase the number of patients we can accommodate in clinic. Our Bridge clinic is unique at our hospital in having the ability of our SUD counselor to text via cell phone back and forth directly with patients without using the DHS/hospital patient portal which requires an email to be initiated and requires logging into the portal for both the patient and staff. The phone texts are direct and have a faster response time than messages sent through the traditional patient portal. We find this is an incredible way for patients to be first engaged in treatment and to re-engage when they relapse. Just having access to a phone through our phone distribution program was also a key element to increasing the rate of first follow up visits. Assistance with other social drivers of health such as housing and food assistance also was regarded as key factors for success; all hinging on access to a phone.

We also were able to offer a noon-time lecture series for both primary care providers and social work staff on a variety of topics including opioids, alcohol, SUD in pregnancy, SUD in adolescents, and safer consumption supplies to name a few. We felt that educating the multitude of staff that come in contact with patients just starting their road to recovery would also help to increase our success. We were happy to see our efforts paid off. Our first follow up visit rate went from around 35% to around 50% for patients started on buprenorphine in the hospital.

Retention is also about long term recovery. We felt it was important to learn what we did right and what we did wrong over the last 4 years as we started patients on their road to recovery. We used a survey monkey tool to ask patients who have been in sustained recovery (greater than 6 months, many over 12 months) what aspects of our hospital or program helped them stay in treatment. What could we have done better? We included

additional patients at our sister hospitals – Harbor UCLA and Los Angeles General Hospital. We learned several things. First, having a nonjudgmental attitude and allowing patients to falter (re-use) knowing we wouldn't abandon them was considered the key element to sustained recovery. Ease of access to starting buprenorphine and the ability to get refills without incredible hoop-jumping was also considered vital. Having the support element through clinical social work staff such as help for phone access, housing, ID, access to food, transportation, and applying for health insurance were key elements. Options for ongoing counseling, though not mandatory like many rehab programs, was also considered a great support to our patients.

We had the goal of adding Sublocade (monthly injections of buprenorphine) as an additional option for patients in long term recovery. Our ability to offer in-person visits every week, rather than only once per month, was significantly delayed because of hospital clinic space constraints. We were able to secure clinic space each week only recently but do not yet have the nursing support required to have a significant number of patients receiving injection medications. This continues to be a work in progress and we hope to be able to offer more patients options for monthly injections soon.

Barriers, challenges and solutions:

Although we were successful in increasing our rate of first time follow-up, one key element in that success, keeping 1-2 appts per week open for new patients, we have found challenging to maintain. Even though we have had additional provider staffing through residents and fellows, our MAT follow up clinic is only one day per week. The volume of patients we currently manage plus additional new patients each week is straining our ability to see new patients within 1-2 weeks after ED or inpatient visit. Our solution is to work with our hospital administration to increase the availability of MAT appointments (2nd day, additional providers) to our Olive View patients. Although our own hospital administration is supportive, DHS administration has been less supportive about SUD, not giving it equal resources as other chronic diseases. We are working on creative solutions to satisfy both entities.

Our SUD counselor had great hopes for ongoing group counseling sessions where patients could find support by interacting with others traveling along the same road to recovery. Despite a significant effort (reminder phone calls, Lyft/Uber cards to help with transportation, options for zoom group sessions), we found patients were not interested in group sessions but rather one on one counseling which has been successful. This may be a combination of the general post-pandemic increased use of telehealth in the U.S. and the prior lack of physical clinic space allocated to our MAT program. Patients' clinic appointments were all by phone; many probably didn't feel the need to physically come in for counseling sessions. We continue to emphasize to our administration the importance of these individual sessions with patients ensuring our counselor has adequate time to support these sessions. We have not given up on group sessions and now that we have clinic space for weekly appointments (rather than all visits by phone), we are hoping to offer group sessions again in the future.

One aspect of our goals was related to the distribution of fentanyl test strips. Although intuitively it appears to be a good idea for patients to be able to test their meth or heroin drug supply and decrease their risk of fentanyl exposure, in reality what we found is the vast majority of patients smoking or injecting opioids now actively seek out fentanyl. We do, on occasion, have patients who use meth or heroin and who actively try to avoid fentanyl and those patients are very appropriate for fentanyl test strips. Although we continue to offer fentanyl test strips to all, our opinion is that any future funding should be toward other safer consumption supplies such as continued naloxone (Narcan) distribution, IV or smoking safer consumption supplies, and

prescribing of PrEP (Pre-Exposure Prophylaxis for HIV) for these high-risk patients (a new project we are moving to). Additionally, testing drug supplies for newer additive drugs such as xylazine or medetomidine may be important. We did meet our goal through grand rounds, ED nursing huddles, and our noontime lecture series of educating providers, nurses and social workers on harm reduction efforts we have within DHS including our safer consumption supply cart and local contingency management programs. We still have a goal of placing a safer consumption vending machine in our ED waiting room but that has run into roadblocks at the DHS Administrative level. As we move forward with our new project around PrEP, we will add that to our ongoing education.

How will the progress be sustained?

Progress in the addition of SUD ICD-10 codes is sustainable as our DHS Administration has adopted the Centers for Medicare & Medicaid Services CMMS QIP (Quality Incentive Program) measures of follow up after an ED visit for a substance use and mental health diagnosis. There is a continued push for documentation of SUD diagnoses.

We will continue with our efforts toward increased first follow-up visits. We will continue to push for more clinic providers so we can increase the number of patients seen per clinic and increase the number of clinic days. We are considering a program to link patients in sustained recovery with patients who are just beginning their journey. We need to make sure, however, that we do not put our long-term patients at risk for re-use by exposing them to patients who have recently used or are currently re-using.

We will continue to emphasize safer consumption supplies by adding xylazine test strips and PrEP to our toolbox.

Please share your thoughts on your experience on the Quality Improvement coaching:

Coaching was very helpful to encourage breaking our targeted project down into achievable steps to implement. We had a number of steps that we felt would help achieve our goal of increasing first follow up visits. By ensuring periodic check ins, it helps to keep the physicians in the program who I would imagine are hard-working, way-over-extended to make sure the individual steps of the QI project get completed. I know that was true for me.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

Future funding should include more emphasis on safer consumption such as safer injectable and smoking supplies and prescribing of PrEP for patients with opioid use disorder. A study coming out soon will show that patients with opioid use disorder have a significant increased risk of contracting HIV no matter how they consume opioids, smoking or intravenous. Emergency Medicine programs do not traditionally teach prescribing of PrEP for patients at high risk through sex or drug use. This is an area ripe for education. I would guess that other primary care programs such as Internal Medicine or Pediatrics could also benefit from an education program around PrEP and opioid use disorder.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...
continue to offer an on-call MAT provider, develop creative handouts to educate patients, develop a lecture series to educate DHS staff across L.A. County on SUD issues and ensure patients are able to start their road to recovery with a phone, a critical step in the recovery process.

California Residency Program Collaborative

Final Report and Results

Residency Program: Pomona Valley Hospital Medical Center Family Medicine Residency Program

Submitted by (name/email): José Ramos MD / jose.ramos@pvhmc.org

Project Title: PVHMC Family Medicine Residency Program Street Medicine Harm Reduction Program

Goals of Your Project (as stated in your proposal, or as amended):

1. To provide PVHMC family medicine resident physicians, faculty and support staff with dedicated substance use disorder (SUD) training including obtaining x-waiver certification for all resident physicians prior to graduation.
    a. Objective 1a: Suboxone training
        i. Suboxone training physicians and faculty is an important initial goal because primary care physicians more than ever are expected to address and treat opioid use disorder (OUD) in the clinic setting. This will be one of the first priorities for the residents and faculty and a requirement to work in the street medicine clinic.
        ii. In phase 2, will expand training offerings to other affiliated community clinics and FQHC's
    b. Objective 1b: Interdisciplinary training
        i. Initial training will encompass multiple disciplines with a focus on harm reduction principles, trauma informed care, building empathy and cultural humility. This training will build capacity with our community partners and include providers, case managers, social workers, counselors and support staff, to ensure that resident physicians understand the importance of a collaborative approach to SUD treatment.
2. To expand our SUD treatment: OUD and MUD treatment with Suboxone treatment and harm reduction services to our Street Medicine outreach for the unhoused with opioid use disorder.
    a. Objective 2a: Offer opioid use disorder treatment to unhoused individuals in Pomona, California
        i. This goal addresses identified community needs as indicated by our sponsoring hospital's 2018-2021 CAN's. Pomona, California is home to a significant unhoused population and many of whom suffer from a substance use disorder. These individuals are high utilizers of the PVHMC Emergency services. Offering medical and OUD medication coupled with

behavioral services will lower utilization and decrease overall burden on our hospital medical system.

ii. Residents will become comfortable prescribing suboxone. Gain an understanding of proper protocols for patient selection, induction, maintenance and strategies to mitigate diversion and approach to relapse.

iii. Subsidize funding for suboxone distribution for the uninsured.

iv. Increase hours of operation on street medicine to 2 half days per week

v. Expand current MAT clinic to include Stimulant Use Disorder treatment.

vi. Partner with local pharmacy, Genoa, in Pomona, CA to order and administer long-acting injectable naltrexone with oral Welbutrin as primary treatment modality

vii. Develop and host lecture pertaining to stimulant use disorder treatment and epidemiology in Pomona area.

b. Objective 2b: Exposes resident physicians to vulnerable population and allows them to demonstrate health equity competencies.

i. A key component to health equity training is having exposure and direct contact with our most vulnerable populations. This goal will give residents the opportunity to develop trauma informed care approach and motivational interviewing skills to approach individuals with SUD and who are experiencing homelessness with humility and compassion

ii. Destigmatize treating individuals with SUD and experiencing homelessness.

3. Prevent deaths from Opioid use overdose by expanding naloxone distribution and community education for primary prevention and to identify symptoms of overdose

a. Objective 3a: Increase distribution and education Naloxone administration

i. Education for Naloxone administration to medical providers and ancillary staff

ii. Increase naloxone distribution to all individuals with OUD and increase co-prescribing naloxone in our primary clinic

iii. Outreach to community to provide education for signs and symptoms of opiod overdose

b. Objective 3b: Preventative education through of Community Medicine track residents

i. Create SUD lecture series for our pipeline students at Bright Prospects and high risk youth in restorative justice programs.

1. Lectures to focus on the dangers of opioid, methamphetamine, alcohol, tobacco and marijuana use. Also with an understanding of treatment of SUD and recognition of overdose.

4. Increase population harm reduction by enhancing curriculum and focusing on addressing the social needs that may predispose to relapse by building a sustainable community infrastructure

a. Objective 4a: Expand our longitudinal Harm reduction/SUD curriculum at PVHMC FMRP

i. Expanding our longitudinal addiction/harm reduction curriculum will help build in sustainability for the residency program for yearly QEI projects surrounding this important subject matter. The plan is to continue to grow our quarterly street medicine/SUD combined lectures and computer learning modules. Our new focus will be stimulant use disorder and the various high risk, vulnerable populations that it affects.

ii. This curriculum will also be used as a faculty development tool and hospital wide training to show community need as well as decrease bias and stigma for treating SUD and unhoused, particularly in the ED.

b. Objective 4b: Create community education focusing on harm reduction
    i. Community harm reduction material has several focuses.
        1. SUD individuals: Disseminate information on naloxone use and that we are now treating with suboxone. Also information of harm reduction principles that include HIV and hepatitis.
        2. General public: Shed light on this important Disseminate results and positive personal success stories to show important need that the clinic will serve and to decrease bias and stigma.
c. Objective 4c: Further develop community partners that are working in the areas of housing, restorative justice, food insecurity, stigma reduction and mental health.
    i. Continue to expand our partnership with Tri-City Mental Health to provide longitudinal psychosocial services to support the recovery of patients with SUD in our Street Medicine clinic
        1. Offer structured SUD focused counseling to individuals enrolled in MAT clinic through Tri-City Mental health services
        2. MAT combines medication assistance with behavioral health and SUD treatment and recovery support services. This leads to better outcomes than programs providing little or no counseling
        3. Residents will be integral part of this counseling and teaching under Tri-City supervision
    ii. Purpose Church is a new partner that operates as a community hub for community organizations focused on housing insecurity, restorative justice, food insecurity, stigma reduction. They reach out to high risk populations including sex workers, high risk LGBTQ and formally incarcerated individuals

5. To create opportunities for resident physicians to perform community based participatory scholarly activity and quality equity improvement with the unhoused in Pomona, Ca.
    a. Objective 5a: Continue Quality Equity Improvement Street medicine project
        i. Residents will plan, design and implement QEI project for next academic year focused on new street medicine delivery of MAT and harm reduction techniques focusing of policy, procedures and work flow.
        ii. Residents will also explore scholarly activities that look at the community outcomes, retention of patients and emergency services utilization.
        iii. Residents will be expected to give hospital-wide presentations discussing findings.
        iv. Residents will be encouraged to present findings at regional and national conferences.
        v. Residents will have the opportunity to serve in leadership positions for all scholarly activity and develop a leadership skill set.

High-Level Description/Highlights of the Work Done on the Project:

The Pomona Valley Hospital Medical Center's (PVHMC) Family Medicine Residency Program (FMRP) has been fortunate to be part of 2 CRPC collaboratives. During the first collaborative we focused on laying a foundation of education and training resident physicians and building a community collective. This collaborative we focused on creating new clinical opportunities, expanding our community partnerships, offering more social services, treating public health disease, reducing harm , identify and more effectively track metrics through our EMR and help develop system changes through the hospital.

- We created multiple clinical experiences to help resident physicians and attending physicians feel more comfortable treating SUD.
    - We have now integrated a SUD curriculum into our Emergency Medicine rotation curriculum to have the residents once weekly shadow our CA bridge program substance use navigator. This allows the residents to not only gain more experience with inductions but also to capture the patients into the system.
    - We have also expanded our street medicine clinic from 1 day a week to servicing the community with an "on call" approach. We use both the emergency department and TriCity mental health as our alert messaging system with a new process in place to identify possible new patients in the community that we need to capture.
    - We also started a new weekly specialty clinic within the residency continuity clinic that is a brick and mortar harm reduction clinic. We serve patients experiencing substance use disorder, HIV/Hep C, gender affirming care, pain management. So we will have 2 options for patients coming out of the ED or patients in our practice panel that we can follow more closely and screen for readiness. So increasing options for patients to be seen in our continuity specialty clinic or in our street med clinic.
- We switched to a micro dosing suboxone treatment to capture and retain more individuals
    - During the 2023-2024 academic year, we have been tracking retention rate in our opioid and methamphetamine street medicine treatment program (MAT).
        - We saw 79 patients for opioid and/or methamphetamine use disorder and retention rate is 52% (41/79). This exceeds the national average.
- We also tracked high utilizers of of emergency department
    - In 2022 -23 we tracked several unhoused, high healthcare utilizers.
        - Chart review showed that services provided on street medicine to this cohort likely contributed to a decrease in hospital ED visits by 42% from the previous year.
- Community partners are key to meeting social needs. Positive screen for SDH initiates referral for community partner services. Our community partners offer onsite free showers, free clothing, free food, free vaccinations and grant assisted medications (for individuals with no insurance). They also help plug in to important housing services.
    - From 2022-24 we obtained temporary shelter/housing for 45% of unhoused patients within 1 month of first street medicine clinic contact. (motel vouchers, shelter referrals, domestic violence housing referrals)
    - From 2020-2024, we helped identify, qualify and refer approximately 50 individuals for permanent housing (section 8 housing).

- We serve as an important bridge for mental health treatment especially for uncontrolled bipolar and schizophrenia disease. We continue to strengthen our partnership with TriCity Mental health.
    - We screen every patient for mental health disorders including depression, anxiety, bipolar disease, and schizophrenia.
    - We refer to our onsite mental health partner to schedule an intake appointment.
    - Long waits for community psychiatric treatment average 3 months and we initiate treatment in the interim and monitor closely for appropriate response.
- We are also an important public health bridge to decrease communicable disease in the unhoused and to reduce harm by treating and tracking infectious disease in our street med clinic.
    - We have created a screening and testing protocol to do onsite in street medicine and process to get confirmatory and follow up testing through the PVHMC lab.
    - In 2023, 6 individuals with hepatitis C were treated successfully with confirmed undetectable viral load at SVR12 (sustained virologic response 12 weeks post treatment completion). (Currently treating 2 others)
    - In 2023, we treated at least 17 individuals with Sexually transmitted infections.
    - In 2023, we initiated new HIV treatment on 4 individuals while qualifying them for Medi-Cal and connecting them with an FQHC for further treatment.
    - There are also many individuals who are unhoused with HIV that move to different areas and need refills on their HIV medications. We meet that public health need in our clinic.
- We see a significant population seeking gender affirming hormone therapy.
    - We just entered into new partnerships with community organizations and a pharmacy to provide hormone therapy for transitioning individuals in our street medicine clinic
    - We made offering hormone therapy a priority in our new onsite harm reduction clinic

Describe strategies/interventions/approach to reach goals:

Increased patient engagement and retention:

- Used community partners to identify new patients from emergency department and through our mental health street teams.
- Created a process to notify attending physician on ED discharge or new unhoused in community.
- Strengthened partnership with emergency department leadership and created a new curriculum that included SUD and integrating substance use navigator.
- Created new partnership with local housing shelter to treat and follow patients on their site. Changed to a new suboxone micro dosing approach to enable to start new patients on first day of presentation instead of waiting for them to withdrawal.

Increased clinical experiences for residents and attending physicians for treating patients with SUD:

- Developed strong champions at both the FMRP and hospital that included leadership in multiple departments.
- Developed a sense of urgency by using collected data from our street medicine clinic to prove need.

- Developed new curriculum for ED rotation with the help of resident champion and SUD navigator
- Created new harm reduction clinic on continuity clinic site. Champions at FMRP leadership and resident champion led. Created urgency surrounding physician group concern that community not doing a good job with opioid de-escalation. This opened door to create clinic and build out SUD treatment as well as harm reduction.

Increase harm reduction in Street Medicine Clinic:

- Used ACGME requirements for closing health equity gaps and compiled data of needle borne infectious disease in our street medicine clinic. This led to continue to expand street medicine services that include STI, HIV and Hep C testing and treatment.
- We created protocols for screening every patient, point of care testing and process to follow up confirmatory testing and followup testing at PVHMC.
- Expanded data collection to continue to show value and need to the hospital system

Barriers, challenges and solutions:

- Barriers have overall improved as we continue to change culture surround SUD but buy-in is always important and we continue to strengthen hospital and community relationships to ensure we can continue this important work.
- Also, transition of care and continuity of care from the ED and on the street can sometimes be difficult. Previously, many were lost to follow-up directly after discharge from the ED or they are given instruction to go to American recovery or Aegis but wait times are so long and so they would not get plugged in. This is why we focused on a process as above to strengthen relationship with ED dept and create protocol for handoff.
- We were able to increase follow up by often focusing and addressing their most pressing needs which is often housing. So, we follow higher risk patients by getting them housed that evening if possible and then seeing them for the next few mornings on site at our main shelter for the unhoused. This transition of care has increased the ability to have close followup, increase trust with health care providers because they see how invested we are. And to continue to build an ecosystem of community partners.

How will the progress be sustained?

The hospital and FRMP are committed to continuing the significant advances we have made with regards to treating SUD in the community and harm reduction. The street medicine clinic is largely subsidized by the hospital and we are creating a yearly sustainable budget for MAT/Street medicine. Our community partnerships continue to grow and are all focused on reducing suffering. We have created a community collaborative that meets quarterly to evaluate our work and address any newly identified needs.

Please share your thoughts on your experience on the Quality Improvement coaching:

The Quality Improvement coaching was an invaluable component to our project's success. Moreover, Pam was an excellent coach and provided useful insight and feedback during each session that really helped narrow down each objective into measurable outcomes. Specifically what I found most useful was her advice in developing an internal database to track project metrics and guidance in correctly integrating PDSA cycles to inform our

interventions. Aside from their practical application, these sessions also offered an opportunity for reflection. A moment to step outside of the project with an impartial source to really evaluate (and appreciate) our work and to motivate progress towards our specific aims.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
Just really appreciative for this experience. It has changed the way we practice in Pomona, CA

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
…change a hospital and community culture surrounding substance use disorder and it's associated conditions.

California Residency Program Collaborative

Final Report and Results

Residency Program: Rio Bravo FMRP

Submitted by (name/email): Jacqueline Uy / jacqueline.uy@clinicasierravista.org

Project Title: The Opposite of Addiction is Connection: Implementing an Addiction medicine rotation, Increasing Medication Addiction Treatment (MAT) and Community Outreach in a large Federally qualified health center in the Central Valley.

Goals of Your Project (as stated in your proposal, or as amended):

Goal: Increase understanding of addiction medicine among our resident physicians and attendings to reduce stigma and increase willingness to give medication assisted treatment Specific AIM statement: We will increase the number of patients seen for MAT (Medication Assisted Treatment) at our East Niles residency clinic and by our street medicine team. We will treat 700 patients for MAT in our residency by April 30, 2024.

High-Level Description/Highlights of the Work Done on the Project:

1. Starting an addiction medicine rotation for our PGY-2 residents
2. Bringing in an addiction medicine specialist once a week in our residency clinic.
3. Doing a Monthly Community Outreach with a Community Partner
4. Supporting our Tuesday and Thursday Street Medicine outreach with purchase of supplies, harm reduction kits and medications for MAT
5. Addiction Medicine lectures during didactics sessions
6. Conducting Surveys among Residents and Attendings on Perception of Addiction Medicine Treatment
7. Collection of Adverse Childhood Events Scores during our Street medicine outreaches

Describe strategies/interventions/approach to reach goals:

1. We were able to advocate to make the Addiction Medicine Rotation into a required rotation for the PGY2s. We were able to bring in our addiction medicine specialist into the clinic week with our PGY2s on the addiction medicine rotation and our PGY1s on community medicine rotation. Interested attendings could also shadow.

2. We developed an addiction medicine curriculum. We created an addiction medicine room in the residency. We were able to provide Addiction medicine textbooks and ASAM (American Society of Addiction Medicine) memberships for our rotating residents. Residents were required to complete modules on addiction found on the ASAM website. Addiction medicine lectures were also incorporated into didactics. Attendings and residents attended the CSAM conference in August 2023. Attendings and street medicine staff will also attend the Street Medicine collaborative conference in August 2024.
3. We sought out community partners. Our residents went to the Brundage Lane Navigation Center for naloxone distribution. We partnered with Church without Walls for a monthly second Sunday outreach.
4. We have Tuesday Street Medicine clinic and Thursday Street Medicine clinic. Residents and students join our core faculty on Tuesday Street medicine and our addiction specialist on Thursday Street medicine. During these clinics we do medication assisted treatment, acute and primary care. We also do POCT HIV and Hep C testing as well as lab draws when we have the mobile clinic. We travel with a case manager who can help patients with housing, as well as MAT. We also distribute naloxone, hygiene kits, and harm reduction kits.
5. We created a survey on Perceptions and Knowledge on Addiction Medicine and Medication Assisted Treatment. Residents who rotate with our Addiction medicine specialist were asked to fill this out pre and post rotation.
6. Adverse Childhood Events (ACEs) questionnaires were initially done during our Street medicine clinics.
7. Medications for medication assisted treatment were purchased for patients who had no access to these medications.

Barriers, challenges and solutions:

1. We initially had challenges in connecting with our planned community partner. We were able
2. to find an alternative partner -Church without Walls.
3. One of our initial plans was to conduct ACEs screening in Street medicine clinics. We had to discontinue by October 2023. We had discontinued our partnership with the behavioral health team rotating from a local college. There was poor follow-up and referral to behavioral therapy for the patients screened.
4. We had challenges getting approval for a harm reduction vending machine with our administration.
5. We had personnel issues and staff turnover.
6. We were unable to get our survey data because of staff turnover. We recreated the survey under an easily accessible residency email-rbresidency@clinicasierravista.org. This will be used for the future surveys moving forward.
7. Most our patients had fentanyl use disorder. Most of the guides available were on s acting and long-acting opiates. We created a guide for suboxone treatment for patient fentanyl use disorder.
8. Our addiction medicine specialist has given feedback that there is a high no- show rate to our residency clinic likely due to the distance from his primary clinic and likely from confusion among the patients regarding his location. We will continue to have residents rotate with him in his clinic.

How will the progress be sustained?

1. Our FQHC (Federally qualified health center) has an existing Street Medicine program that

2. has expanded throughout the past year with teams going out throughout the different days of the week in Fresno, Bakersfield and Lake Isabella. We will continue to have our residents and students rotate during the Tuesday and Thursday Street Medicine clinics.
3. We have started an Addiction Medicine Fellowship this July 2024. The FQHC has hired another addiction medicine attending and a fellow. The residents will continue to rotate during the Addiction Medicine rotation and Community Medicine rotation.
4. We will continue to implement the Addiction medicine rotation and the curriculum with pre- and post-surveys to monitor the perception and knowledge on addiction medicine and MAT. We have found that STFM (Society of Teachers in Family Medicine) has free modules on addiction medicine that we will use instead of the ASAM modules. We will continue scheduling Addiction medicine lectures in didactics sessions.

Please share your thoughts on your experience on the Quality Improvement coaching:

The Quality improvement coaching was helpful. We had changes made in our initial specific aim, but we were able to change as we had many planned interventions and strategies.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

1. We feel that we had made significant changes in perceptions to addiction medicine treatment and expanded care for this very much underserved population.
2. I would highly suggest continued funding for education on MAT, to increase comfort in prescribing among primary care providers.
3. I would recommend continued funding for distribution of harm reduction kits and medications for opioid use disorder.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:

Expand our addiction medicine treatment services with our Sunday community outreach, implement our addiction medicine rotation, purchase medications nor bring our addiction medicine specialist into our residency clinic.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Education Outreach Treatment

California Residency Program Collaborative

Final Report and Results

Residency Program: San Joaquin General Hospital Family Residency Program

Submitted by (name/email): Estefania Way /eway@sjgh.org

Project Title: Integrated Wellness

Goals of Your Project (as stated in your proposal, or as amended):

1. To expand the curriculum for opioid use disorder for the residents and faculty, including mandatory MAT training for all Family Medicine Residents.
2. To expand training for Faculty, Substance use disorder Counsellor and residents in emerging evidence-based SUD education as novel opioids are expanding into the community.
3. To develop a comprehensive curriculum for suboxone and harm reduction (e.g. fentanyl awareness) education to the San Joaquin Community, including SJGH patients and Discovery Challenge Academy, a community program for at risk adolescents.
4. To develop promotional materials educating on the risks of fentanyl use and available SUD treatment in the community and begin to disseminate them in the community.
5. Expanding the Integrated Wellness Clinic, due to high demand of patients we want to increase more days a week instead of only 2 half days. We also want to increase access to the clinic by expanding it to our Outreach/Mobile clinic to help our homeless population who has difficulty coming all the way to our clinics in the hospital.
6. -Creation of Addiction Medicine Committee in San Joaquin General Hospital.

High-Level Description/Highlights of the Work Done on the Project:

-Discovery Challenge Academy patients screening
-Discovery Challenge Academy Harm Risk Education and Harm Risk reduction kits distribution
-Starting SUD treatment and MAT in Outreach/Mobile clinic
-Narcan distribution in Outreach/Mobile clinic

-Creation of Order set for MAT in inpatient and training of residents in use of MAT (FM, IM and Surgery).
-Creation of smooth referral process from ED to Integrated Wellness Clinic for SUD treatment
-MERF Scholar and Networking (Dr. Assibey) and now applying Dr Way and PGY3 Dr Chavez
-CSAM conference attendance (Dr. Assibey, Dr. Liu, Substance Abuse Counselor Rosmary Gomez in 2023 and Dr Way, Dr Chavez and Substance Use Counselor Rosemary Gomez in 2024)
-Working in collaboration with San Joaquin Opioid Coalition
-Harm Reduction Introduction Lecture for Residents and Faculty on June 2023
-Implementation of Harm Reduction Kits and distribution on June 2024 at DCA graduation

Describe strategies/interventions/approach to reach goals:
-Education of Residents and Faculty
-Multidisciplinary approach to better serve our community and reach our goals (working and educating other departments, staff in clinic and residents).
-Promoting harm risk reduction and screening in all encounters (outpatient and outpatient)

Barriers, challenges and solutions:
Barriers:
-Staffing, with the loss of a couple faculty members in the Residency Program we have had difficulties with completing all our objectives due to being short staff.
-No Case Manager in clinic to help with our Integrated Wellness Clinic or Outreach
-Change in the CRPC Project Team leadership

Solutions:
-Hiring Case Manager and Dedicated MA for Integrated Wellness Clinic
-New Leadership in CRPC Project (utilizing and merging with existing resources, working close by with dedicated faculty that have same passion and goals towards the development of this important project)

How will progress be sustained?
-Continuation of our hand off referral system, universal screening and harm risk reduction education.
-Continuation in education of SUD, MAT to all residents in training and faculty
-Creation of Addiction Medicine Committee in our hospital
-Case manager and dedicated MA for Integrated Wellness Clinic and Mobile Clinic/Street Medicine.

Please share your thoughts on your experience on the Quality Improvement coaching:
Even though we were running behind with our reports or putting into words and paper our progress we could get the help and motivation to continue working in our goals and succeed.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

-Increasing access to harm reduction supplies and authorization for distribution

-Increasing funds to help hire more personnel (Social workers, Counsellors, Navigators, Case Managers and Medical Assistants).

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:

Successfully completed this project.

California Residency Program Collaborative

Final Report and Results

Residency Program: Shasta Community Health Center

Submitted by (name/email): Douglas McMullin, MD, FASAM
dbmcmullin@shastahealth.org

Project Title: MAT Expansion in the Inpatient Setting at Mercy Medical Center / Redding

Goals of Your Project (as stated in your proposal, or as amended):

1. Improve MAT / OUD-SUD understanding and acceptance among staff and physicians at Mercy – Redding
2. Increase the numbers of MAT consults at Mercy – Redding
3. Educate and involve Family Medicine Residents at Mercy- Redding
    a. Shasta Community Health Center / Family Medicine Program
    b. Common Spirit / Redding Family Medicine Program

High-Level Description/Highlights of the Work Done on the Project:

Prior to commencing this project, there was no inpatient access to Medically Assisted Therapy for Opiate Use Disorder, especially for underserved Medi-Cal patients. Four prongs of education and policy reformation were undertaken:

1. Physician staff education and collaboration – obstetrical, pediatric, general medicine (hospitalist) and surgery departments
2. Nursing staff education regarding OUD/MAT
3. Resident education regarding OUD/MAT and need for clinical awareness
4. Education and policy reformation at the administrative / clinical leadership / pharmacy leadership levels regarding OUD/MAT

Describe strategies/interventions/approach to reach goals:

1. Physician staff.
    a. Regular collaboration and conversations with colleagues in all departments regarding the need to recognize and treat OUD
    b. 24/7 consultation availability regarding treatment of OUD patients

   c. Scheduled OUD/MAT presentations at department provider staff meetings
2. Nursing staff
   a. OUD/MAT presentations at 10 different nursing staff department meetings reaching over 200 nursing staff
   b. 24/7 response to nursing staff concerns for patients with OUD needing MAT services
3. Resident education
   a. Three resident lectures presented on OUD/MAT
      i. Increased resident awareness of patients with OUD
      ii. Facility with buprenorphine induction / outpatient and inpatient
      iii. 24/7 consultation availability for OUD/ MAT
      iv. Primary Care Psychiatry textbooks with excellent OUD/MAT chapters for reference for residents in both teaching programs
      v. Support for MERF scholars at CSAM – 2023 & 2024
4. Administrative
   a. Education for hospital administration as to need for OUD recognition and MAT services during hospitalization; resources for transition of care to outpatient clinic MAT programs. Five consecutive meetings with hospital administration to process:
      i. Policy pathway for hospital admission of perinatal patients with active OUD and need for MAT transition / without other medical need
      ii. Policy pathway for development of inpatient Addiction Consult Service at Mercy-Redding involving both Family Medicine teaching programs
   b. Education of clinical leadership regarding OUD/MAT need withing the hospital / AMA incidents involving OUD and failure to offer MAT. Also present during the five administrative development meetings.
   c. Pharmacy leadership education and collaboration regarding OUD and MAT services. Particularly the need for generous opiate agonist support of withdrawing patients / need for small increment buprenorphine products. Several one-on-one meetings with pharmacy leadership. Leadership was also present during the five admin meetings.

Barriers, challenges and solutions:

Cultural and stigma barriers regarding OUD were pervasively encountered at all levels of interaction with physician colleagues. Educational barriers for nursing staff were easily overcome with presentation of data and concepts of OUD as a disease state. Administrators and clinical leadership were immediately sympathetic with our goals and aims, but found their own policies and directives from the corporation daunting. Outright resistance was fairly uncommon, gratefully.

With persistence, recurrent administrative meetings and investigation of corporate policies more unanimous acceptance of MAT and treatment of OUD were achieved.

Pharmacy policies and formularies remain the most evasive of barriers to tackle at the hospital. Mercy is part of a large chain of Common Spirit Health, and formulary changes are not easily made. There exists pervasive fear of

DEA/CDPH audits and misunderstanding of laws surrounding administration of opiates, methadone and buprenorphine in the inpatient setting.

Overall, the development of policy and structural inpatient services will lead to further attitude and cultural shifts as everyone involved sees the benefits of OUD treatment and MAT firsthand.

How will the progress be sustained?

1. Policy for admission of perinatal patients with OUD to the OB service for transition to buprenorphine via opiate bridge / microdosing without withdrawal is now in the hands of the OB Chair and should shortly be approved.
2. Policy for structural inpatient Addiction Consult Service is being formulated and meetings with shareholders and critical partners are scheduled.
    a. When these are in place, thus giving us bandwidth, more formal physician department presentations and offerings will be arranged (ie, obstetrical department, hospitalist group, surgery and trauma-surgery departments).
3. Ongoing inclusion of OUD/SUD/MAT in Resident curriculae is in place.
4. Ongoing nursing staff meetings to identify OUD/SUD patients are planned.

Please share your thoughts on your experience on the Quality Improvement coaching:
I was very appreciative of the coaching provided by Pam Kittleson. When undertaking an ambitious project, such as this, it is easy to become way to broad and dilute. At her encouragement, the project was reduced to reasonable aims with discreet measurable goals. Thank you Pam!

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

1. Education of pharmacists – inpatient and outpatient about MAT and buprenorphine. Buprenorphine is still lumped in with the monthly “opiate numbers” outpatient pharmacies are held to. As a result, there is broad resistance to providing buprenorphine / methadone for OUD to patients. Walmart and RiteAid have all but refused to provide buprenorphine. The DEA should have a carve-out for buprenorphine / methadone for OUD in these pharmacy surveillance ratios.

2. Hospital pharmacists are often supportive of inpatient MAT, but when they are not it creates a huge barrier for progress in this area. Undue and outright fear of DEA and CDPH audits exists which limits what we can do for these patients. In the end, these attitudes and fears result in more overdose deaths and injuries.

3. Lobbying for law changes surrounding use of methadone for OUD

4. I would love to see CMS come forth with hospital Quality Measures and standards for treatment of OUD and utilization of MAT and MAT specialists. We have seen remarkable inpatient progress in

terms of limiting pressure sores, and utilizing blood transfusions, treatment of sepsis due to CMS Quality Measures. If identification of OUD and utilization of MAT treatment were rewarded financially via Quality I think we would move the bar quickly.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
I would not have been able to devote over 200 hours this past year collaborating with the above noted individuals to increase our MAT treatment at Mercy – Redding. We would not have been able to seriously affect the policies of the hospital to become MAT friendly and OUD understanding. We would not have increased the requests for MAT consultations at Mercy – Redding.

California Residency Program Collaborative

Final Report and Results

Residency Program: Sierra Nevada Memorial Hospital FMRP

Submitted by (name/email): Benjamin Oldach / boldach@chapa-de.org

Project Title: Expanding Access to Medication Assisted Treatment for Opiate Use Disorder In The Primary Care Clinic: A Pathway For Training The Next Generation Of Family Physicians

Goals of Your Project (as stated in your proposal, or as amended):

1. Brief Screening tools including S2BI (Screening to brief intervention) will be incorporated into the outpatient clinic records of adult and adolescent patients at each family medicine residency site by December 2023.
2. A community resource tool for each of the local communities for higher levels of care for SUD will be created and available within the electronic health records of the sponsoring institutions within 6 months of the initiation of S2BI screening tools.
3. By September 2023, the Dignity Health Methodist Hospital of Sacramento Family Medicine Residency Clinic will initiate a weekly medication assisted treatment group for patients with opiate use disorder.
4. A minimum of four family medicine faculty members will be trained in managing group dynamics and the treatment of opiate use disorder prior to the initiation of group MAT visits.
5. All family medicine residents at Methodist Hospital of Sacramento and Sierra Nevada Memorial Hospital will undergo a minimum of 12 hours of co-occurring didactic training in substance use disorders, harm reduction principles, medications for the treatment of opiate, alcohol, and tobacco use disorder and participate in co-leading a MAT group for patients with opiate use disorder during the course of their 3 year residency.

High-Level Description/Highlights of the Work Done on the Project:

This project provided a wonderful opportunity to build on the strengths of the collaborating organizations and search for ways to expand our training for residents and services for our patients. In the early portion of the grant term, all family medicine faculty for the Sierra Nevada Memorial Hospital Family Medicine Residency (SNMH FMR) and all core faculty from Methodist Hospital of Sacramento Family Medicine Residency (MHS FMR) were trained to conduct MAT group visits for opioid use disorder. The core faculty at both programs were trained in SMART

recovery techniques, group dynamic management, buprenorphine inductions using multiple strategies and monitoring and adjustment of buprenorphine and naltrexone. They were also trained in locally available SUD treatment resources for patients who do not stabilize within a primary care setting and peer support resources that are available. Residents from both programs participated in the initial shared didactic session on the treatment of substance use disorder and medication management for opioid use disorder. The didactic curriculum will now include additional yearly training for residents in OUD, AUD, Tobacco use disorder, and harm reduction principles. We have connected with local harm reduction coalition in Nevada County and have begun discussions of having residents learn about harm reduction in the community from their team. A resource for each of our target communities in Sacramento, Placer and Nevada County was also created and protocols for referrals to outside resources are now available for both faculty and residents seeing patients newly diagnosed with substance use disorder. We are screening patients for SUD yearly as a part of annual screening questions.

During the grant term, we expanded SUD services at Chapa-De Indian Health, the outpatient site for SNMH FMR from 4 MAT groups for OUD to 5 groups conducted weekly. We have also initiated 3 Alcohol Recovery groups modeled on the MAT groups for OUD and using SMART recovery principles which will include resident participation beginning in 2024-2025. Two new Nurse Practitioners have started providing MAT for AUD in the group setting and continue to provide consultation and collaboration with all physicians and NPs within our tribal FQHC with multiple providers beginning to offer initiation on MAT within their normal practice. We continue to offer fentanyl testing strips and Narcan for free for patients in our clinic and our oversight board recently approved installing harm reduction vending machines outside our clinic locations to provide those tools to community members. We have commitment from faculty members to attend CSAM yearly and have residents joining us at that conference this coming fall.

Describe strategies/interventions/approach to reach goals:
To achieve the goals of this project, there was a significant need to build connections between local community resources. We collaborated with SUD RN case managers at the Tribal FQHC, our SUD counselor, hospital SUD navigator and County Substance Use Services personnel to create local resource guides for residents and physicians to use to help connect patients to different pieces of SUD treatment which are offered in our community. The locally available resources for intensive outpatient and residential treatment have been over capacity and staffing difficulties for residential treatment in particular has been a challenge. To help address this, we also have begun compiling tele-health options for additional SUD counseling for low income patients seeking MAT through our clinic. We were able to utilize one of the addiction medicine board certified family physicians on faculty to design and conduct didactic material for the residents at our two programs and use the existing MAT groups as a model for initiating new groups and offering training to both faculty and residents through these groups.

Barriers, challenges and solutions:
During the course of the grant term, we had 3 significant staffing changes within the SUD program at Chapa-De Indian Health which presented challenges in accommodating new patients for SUD treatment within our

institution. Those rolls have been filled and have a sustainable funding model, however support staffing remains an area of concern in our communities as we move forward. Healthcare in our region is unfortunately quite fragmented and this trend presents significant challenges for patients seeking addiction treatment and residents who are interested in providing care for patients. During the last year, a local residential treatment center closed, another stopped providing MAT and another stopped providing care for patients with Medi-Cal. Having new connections to our County Substance Use Treatment navigators has been helpful for updating our resource list to help connect patients with additional treatment resources. Inspired by this collaborative, we have begun having a faculty member from SNMH FMR attend community events addressing substance use, meetings with OUD treatment center staff in our community, and meet with County Substance Use Services staff in an attempt to smooth barriers to care for patients when possible, collaborate to offer patients a treatment plan that meets their goals and foster a training environment that can expose residents to the variety of types of addiction treatment services which are available to patients. Recruiting patients into group visits has been a challenge for MHS FMR and we have approached hospital SUD navigators to assist with this. Stigma surrounding addiction treatment and harm reduction remains a challenge. Placer County where one of our clinics is located passed a ban on needle exchange during the course of the last year. The rhetoric surrounding this was concerning however, we hope that creating relationships between our organizations and county decision makers can assist with this issue. Creating shared time between the two residency programs remains a challenge which we work together to prioritize. Finally, the prevalence of high dose fentanyl within our community has presented a challenge in buprenorphine initiation and maintenance. We have developed informal relationships with addiction physicians at Oregon Health Sciences University and UCSF to help bring new treatment strategies to our patients and residents.

How will the progress be sustained?

Through the year, our team has been focused on creating sustainable change, seeking sustainable funding models and attempting to buffer our current programs and personnel to ensure stability over the long term. We have regular feedback from our pharmacy about medication cost, insurance coverage of medications for OUD and provide that feedback to residents and staff. Our tribal FQHC has received a Tribal Opiate response grant and funding from the Tribal Opiate Settlement fund to continue to conduct MAT group visits, provide addiction care for uninsured patients and fund additional support positions (i.e. RN case management, within our clinic, SUD counselor, MA for SUD). We have given administration time for a FM faculty member to assist with program development and implementation within the SUD team at Chapa-De Indian Health and are supporting board certification in addiction medicine through the practice pathway for them. We have two residents who are planning to attend CSAM this year hopefully as MERF scholars and are hopeful that the intergenerational passion treating addiction will remain contagious.

Please share your thoughts on your experience on the Quality Improvement coaching:

As a busy primary care clinic with an embedded residency program, it is challenging to find time and personnel who can collect and analyze data from our interventions. The quality improvement coaching helped our team clarify our targeted outcomes and helped us find variables which would be easily captured within our electronic health records without creating a significant documentation burden for the team.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

Thank you for conducting this collaborative. In addition to funding, this collaborative has provided an impetus to expand substance use services in multiple clinics. The educational resources, connections, reflections, and inspirational stories from other participants was ultimately as valuable as the monetary funding that accompanied this program. As a rural family physician, it has been wonderful to be able to expand my own capacity for providing training for residents and clinical care for my own patients.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:

Without this Collaborative and CRPC resources, we would not have been able to inspire the next generation of family physicians to view substance use disorder as a chronic, treatable disease which they can address.

California Residency Program Collaborative

Final Report and Results

Residency Program: St. Joseph's Medical Center GME – Stockton CA

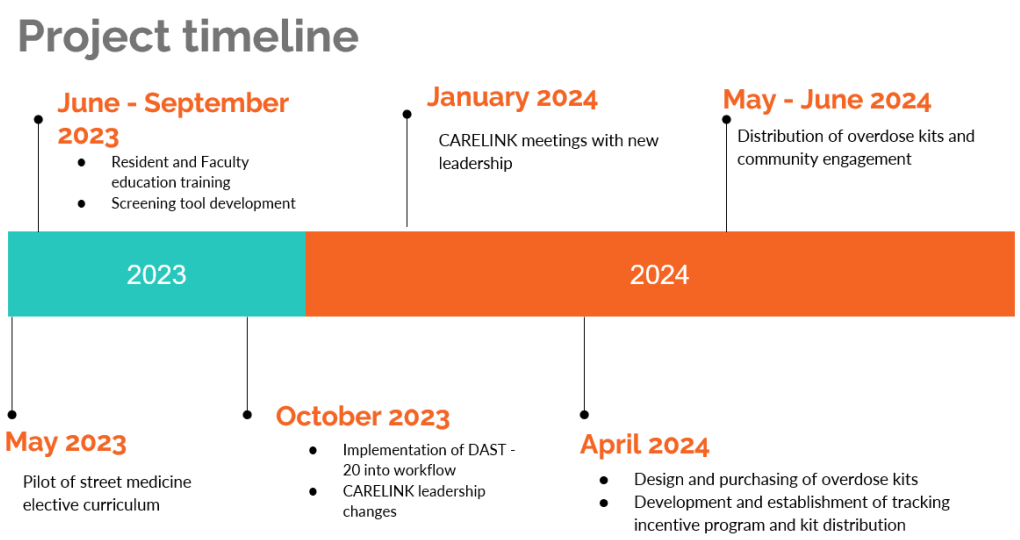
Submitted by (name/email): Katherine Ku/katherine.ku@commonspirit.org

Project Title: A Community Engagement Program and Substance Use Disorder Educa□on for Residents and Faculty in Stockton, CA

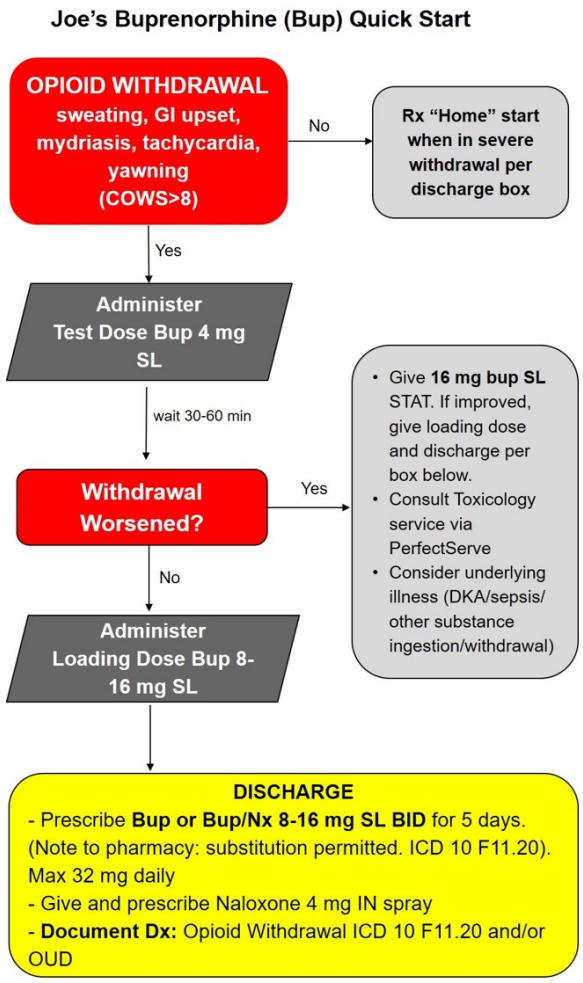
Goals of Your Project (as stated in your proposal, or as amended):
By engaging with local community programs and clinics, creating an incentive program to address structural barriers to care and enhancing provider provider education through MAT training and curriculum development, this proposal aimed to:

- By June 2024, our program will increase SUD screening of vulnerable low SES patient populations through CMC and CARELink by 100%
- By June 2024, there will be 100% increase in EM, FM and IM residents and faculty who are comfortable and trained on screening, identifying and treating SUD
- By June 2024, our program will engage 500 individuals through CMC and CareLink community outreach activities to improve referral follow-up and access to MAT and naloxone.

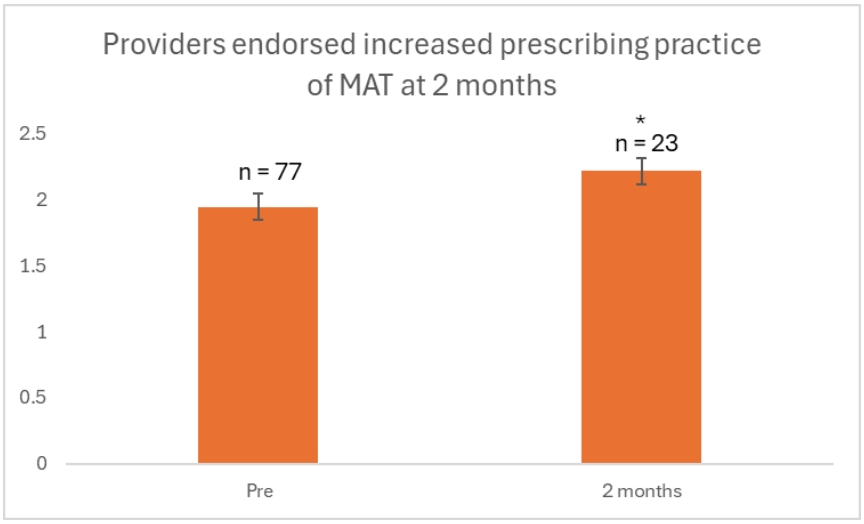
High-Level Description/Highlights of the Work Done on the Project:
We created an innovative academic-community partnership between the Emergency Medicine, Family Medicine, and Internal Medicine GME leadership and community partners at Community Medical Center and CARELINK to create a community engagement program and resident/faculty education program.

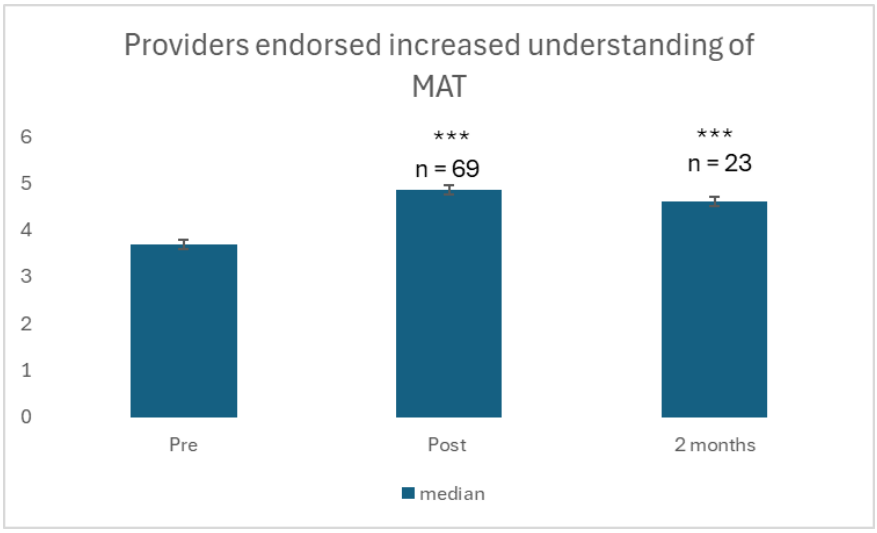


- By June 2024, our program will increase SUD screening of vulnerable low SES patient populations through CMC and CARELink by 100%
    - Since this was a novel intervention, our program increased SUD screening by 100%
    - 1348 patients screened using the DAST 20 screening tool
    - 357 patients referred for MAT
- By June 2024, there will be 100% increase in EM, FM and IM residents and faculty who are comfortable and trained on screening, identifying and treating SUD
    - Created a resident and faculty training session strengthening provider capacity in terms of medical knowledge of MAT, individual MAT prescribing practices, and provider stigma surrounding SUD.
    - Created a MAT quickstart guide for ED providers and distributed as a badge buddy (see below). This was created in collaboration with our Toxicology trained EM faculty who also consulted on this project and provided consult support to inpatient and ED providers who were initiating MAT.

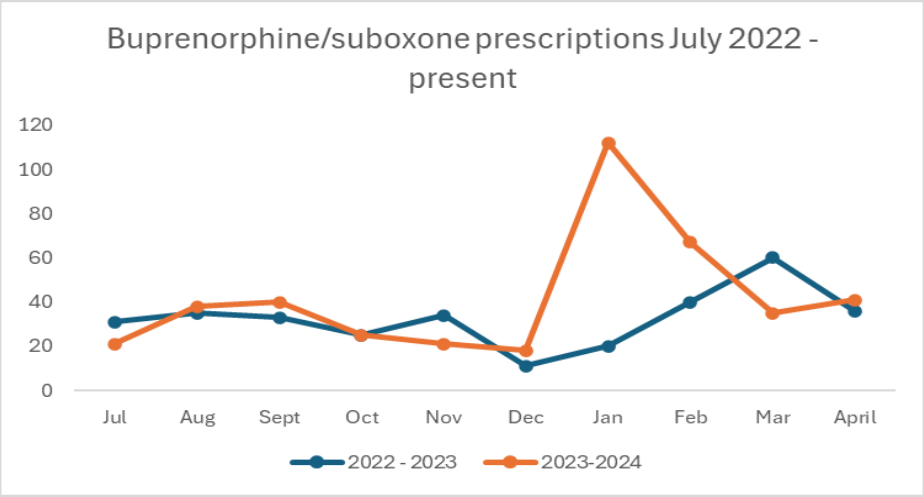


- 78 providers trained on MAT
  - Residents of IM, EM, FM
  - Sound Physician group attendings
  - TeamHealth Physician group attendings
- 70 Badge Buddies distributed
- Statistically significant increase in providers self-endorsing prescribing MAT at the 2 month post training more than before the training ($p = 0.036$)
  - No statistically significant difference between programs



- Statistically significant increase in providers increased understanding about the mechanism of action and indications for MAT the same day after training and 2 month post training more than before the training ($p < 0.0001$)
  - No statistically significant difference between programs
  - 

- No significant overall difference in MAT prescribing practices based on inpatient and ED prescriptions during our grant cycle June 2023 -2024 compared to the year prior.



- By June 2024, our program will engage 500 individuals through CMC and CareLink community outreach activities to improve referral follow-up and access to MAT and naloxone.
    - Created a Street Medicine Curriculum to be offered AY 2024 – 2025 through CareLink community engagement program to residents at PGY2 level in IM, EM, FM programs
    - Created 500 overdose kits that are in the process of being distributed June 2024. Contains Narcan, educational guide, community resources in a durable and waterproof bag

Describe strategies/interventions/approach to reach goals:

As a diverse interprofessional team including program directors from Emergency Medicine, Internal Medicine, Family Medicine GME programs, directors at Community Medical Centers and CARELINK, residents, MAs, family medicine and emergency medicine attendings, substance use navigators, we attempted to make sure everyone had a voice and was given space to express their opinion about how the project was progressing and to give any feedback. We held standing meetings every two weeks to check in on project progress.

The implementation of the DAST-20 tool was a collaborative effort with the CMC team in order to incorporate routine screening for SUD into the workflow. We were able to make it a routine part of MA and resident patient evaluations.

Barriers, challenges and solutions:

Momentum

- Challenges:
    - While we had a large team and held frequent check-in meetings, we lost a bit of momentum in the winter.
- Solutions:
    - Incorporate team building into meetings (i.e. in person gatherings with food, drink, etc)
    - Fewer meetings with more impact
    - Smaller and consistent core team members

Resident faculty education

- Challenges
    - Evaluation survey loss to follow up at two months for residents
    - Survey loss to follow up same day for attendings
- Solutions: increase buy-in by supporting faculty, consistent email messaging, follow up with residents during didactics rather than emailing out a posttest survey.

Street Medicine Elective

- Challenges
    - Leadership changes at CareLink delayed our ability to implement the curriculum
    - Credentialing barriers and EMR overhaul limited the ability for residents to access the EMR and engage with encampment outreach in terms of documentation and orders/prescribing
- Solutions: working closely with CMC and CARELINK to make sure the goals of the street medicine curriculum are still feasible and mutually beneficial to the residents, CARELINK, and individuals in encampments.
    - Creating a curriculum that includes asynchronous learning so that it can easily be implemented and sustained.
    - Plans to implement in the coming AY

How will the progress be sustained?

Because the nature of our project team incorporated leadership from GME programs including our DIO as well as the CMO at Community Medical Centers, there is substantial buy-in to improve and expand upon this project. Resident leaders from the family medicine, internal medicine and emergency medicine programs who helped with the current project are continuing to incorporate resident and faculty MAT training into the standard resident didactics and provider meetings. We are currently discussing expanding our provider training and screening to our OBED and OB/Gyn attendings.

Please share your thoughts on your experience on the Quality Improvement coaching:

Working with Pam was incredibly valuable to our team. It helped keep us on track in terms of thinking through our goals and objectives. It helped frame our project in terms of tangible outcomes that we could measure.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...: engage over 1000 individuals in the Stockton area by implementing standardized screening in our community clinics, refer over 300 individuals to community respite services, distribute Narcan to 500 individuals, connect vulnerable communities with existing resources and services, improve provider capacity in terms of prescribing MAT for patients with SUD in the ED and inpatient settings.

California Residency Program Collaborative

Final Report and Results

Residency Program: UC Davis Emergency Medicine

Submitted by (name/email): Elizabeth Johnson ejjjohnson@ucdavis.edu

Project Title: Promoting Substance Use Disorder Treatments and Measuring Change in Provider Attitudes Through an Education Workshop

Goals of Your Project (as stated in your proposal, or as amended):

1. Implement a 120-minute workshop to educate resident physicians from six residency programs, and nurses, on various aspects of SUD ranging from screening to treatment, led by addiction medicine faculty and community members with lived experience using drugs.

2. Evaluate resident physician and nurses' attitudes towards caring for patients with SUDs by measuring and comparing their DDPPQ scores immediately before and after the workshop, and at 12 weeks after the workshop.

3. Support access to SUD care, as measured by a change in the proportion of ED or hospitalized patients with a SUD diagnosis seen by either SUIT or SUN teams prior to discharge in the 2023-2024 academic year

High-Level Description/Highlights of the Work Done on the Project:

Nationally, over 11% of hospitalized patients have a documented substance use disorder, yet only a fraction are offered treatment in the inpatient setting. We identified two primary factors contributing to this treatment disparity: the lack of provider education on substance use disorders (SUD) and available interventions, and healthcare providers' discomfort in engaging with people who use drugs (PWUD).

To address this treatment gap, we developed a comprehensive workshop targeting these issues. Our approach focused on reducing stigma surrounding SUD by facilitating small group interactions between physicians, nurses, and community members with lived experience in drug use. This oral history-based educational intervention aimed to foster empathy and understanding among medical professionals and PWUD. Following this experience,

participants received a brief presentation outlining the addiction medicine services available at our academic institution.

Throughout the grant period, we conducted nine workshops tailored to medical residents in various specialties including Obstetrics and Gynecology, Emergency Medicine, Internal Medicine, Family Medicine, and Pediatrics. Additionally, we engaged new graduate nurses from the hospital through collaboration with the UC Davis School of Nursing.

Two of our workshops with the UC Davis School of Nursing were postponed to this summer, thus extending the impact of our program beyond the grant period.

Evaluation of workshop participants' attitudes towards SUD and PWUD was conducted using the validated Drug and Drug Problems Perceptions Questionnaire (DDPPQ). Additionally, we analyzed changes in the utilization of our inpatient addiction medicine services before and after the intervention to assess the program's effectiveness in increasing access to care for patients with substance use disorders.

Our initiative represents a proactive approach to addressing the treatment gap for hospitalized patients with substance use disorders, aiming to improve provider education, reduce stigma, and ultimately enhance patient outcomes.

Describe strategies/interventions/approach to reach goals:
Our workshop aimed to reach healthcare providers who have the most direct interactions with patients with lived experience using drugs, which is why we targeted medical residents and nurses. Recognizing the significant presence of nurses within our institution, we strategically included new graduate nurses in our training sessions, as they work across various departments of the hospital.

Through our experience, we discovered that dedicating the majority of the workshop to small group interactions with our volunteer community members yielded better results than solely relying on didactic or educational methods.

Barriers, challenges and solutions:
Initially, we aimed to include the psychiatry residency class in our workshop plans, but due to scheduling constraints, we were unable to integrate our sessions into their didactic schedule. As an alternative, we conducted additional workshops with the school of nursing, expanding our reach to a broader healthcare provider audience.

We encountered challenges in obtaining consistent responses to the DDPPQ survey several months post-intervention. To address this, we shifted our focus to assessing outcome changes. For instance, we analyzed the shift in the proportion of emergency department or hospitalized patients diagnosed with substance use disorder who were subsequently seen by our addiction medicine consult service, providing a more tangible measure of the intervention's impact.

How will the progress be sustained?
We aimed to reach healthcare providers early in their careers through our empathy workshop. This initiative is designed to catalyze a sustained and exponential shift in attitudes toward individuals who use drugs. By targeting this pivotal stage, we seek to foster enduring empathy and understanding within the healthcare community. Our goal is to create a ripple effect, influencing future generations of healthcare professionals. Ultimately, we aspire to transform perceptions and improve the care provided to people who use drugs.

We also plan to give this workshop to four additional nursing groups in the coming years and future Emergency Medicine residency classes.

Please share your thoughts on your experience on the Quality Improvement coaching:
The Quality Improvement coaching provided valuable clarity on the metrics and data necessary to assess the impact of our workshop intervention. It provided us a clearer roadmap for gathering and analyzing data effectively.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
I think funding addressing substance use disorders in pregnant women and adolescents is incredibly important.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to deliver our empathy training and SUD education workshop to five distinct medical residencies and hundreds of nurses. These initiatives are pivotal in advancing our mission to combat stigma associated with patients who use drugs, thereby enhancing outcomes for individuals with substance use disorders within our healthcare system.

California Residency Program Collaborative

Final Report and Results

Residency Program: UC Davis Family Medicine

Submitted by (name/email): Alicia Agnoli

Project Title: Overdose Prevention and Linkage to Care in UC Davis Family Medicine Clinics (OPAL-UCDFM)

Goals of Your Project (as stated in your proposal, or as amended):
Our overall project goal is to improve the health outcomes for patients with SUD while advancing the training of our family medicine residents in the provision of care for patients who use drugs.

1. Increase the number of patients treated in the UC Davis Emergency Department and inpatient service who have a diagnosed SUD and are able to access post-discharge care in one of our FM community health center clinics.
2. Decrease the number of patients referred to our FM clinics who cite transportation barriers as a reason for not attending their primary care/MOUD appointments
3. Increase the number of patients receiving high-quality overdose education and naloxone through distribution of overdose prevention kits.
4. Improve the competency of our FM residents in the management of OUD, other SUD, overdose prevention counseling, and harm reduction principles.

High-Level Description/Highlights of the Work Done on the Project:
We are most proud of our success in launching a Bridge clinic at one of our residency continuity clinic sites, which is a county FQHC where patients with MediCal (or who are previously uninsured) are able to be seen for ongoing SUD treatment after being treated at our main hospital. This improved our ability to have FM residents see patients with SUD in early recovery, continue their MOUD or AUD, and integrate them into their primary care continuity panels. We have also incorporated our addiction medicine fellows into this regular clinic, expanding the patient access and increasing the focused SUD teaching for our residents.

We have also made progress on our transportation voucher project. We have established a contract with a taxi company in Sacramento to allow direct billing for transportation to and from the residency clinics for SUD follow

up appointments, and we are working to pilot a workflow for our frontline substance use navigators to screen for transportation barriers.

Lastly, we have continued our regular trainings for medical students and residents in SUD management and harm reduction.

Describe strategies/interventions/approach to reach goals:
One of our most important strategies was to leverage existing clinical care infrastructure to launch these initiatives. Our hospital's well-established Bridge program and our existing Family Medicine county clinic were already committed to improving these critical care linkages, and Drs. Orsulak and Agnoli have roles in the inpatient addiction consultation service, the health system SUD working group, and the county FM clinic. We were able to achieve the success that we did with this project by aligning our project goals and integrating our proposed interventions with these existing facilitators.

Barriers, challenges and solutions:
Key challenges we faced included 1) difficulty deriving baseline data from the EMR to quantify the problem we were addressing, 2) interpersonal and inter-team tension that made it difficult to impose the responsibility of a novel screening and referral process onto our SUN team, 3) PI (Dr. Agnoli) was unavailable for the duration of her parental leave, 4) logistical challenges in setting up the transportation voucher pilot. We addressed these by 1) foregoing baseline data but working with health system informatic support to ensure we have good data analytic capabilities as we move forward with the program, 2) working to ameliorate tension between our collaborating teams and modify the screening protocol to minimize the burden for the frontline SUN, 3) Dr. Orsulak took over project responsibility and executed the launch of the Bridge clinic, 4) working with our social work collaborators and existing community contacts to establish a straightforward process for providing and billing transportation vouchers.

How will the progress be sustained?
Our Bridge clinic pilot has been formally incorporated into the weekly clinic schedule and will have allocated resident, fellow, and attending involvement to support its continued success. We are working with County partners and our hospital SUN's to continue to improve the transitions of care.

The transportation voucher pilot program will be carefully tracked, and with the help of health system informatics support, we will examine the utilization patterns and leverage this for potentially more permanent funding of the program.

Lastly, we feel that introducing this sort of transportation-barrier screening program at the point of treatment initiation will help to open the door to a more comprehensive approach to addressing the social determinants of health that affect our patient's ability to engage in treatment for their SUD.

Please share your thoughts on your experience on the Quality Improvement coaching:

I found this meeting to be quite useful and appreciated Pam Kittleston's insights for documenting and improving our work. Very helpful to have this time—thank you!

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
We appreciated the increased emphasis on harm reduction in this grant period and would suggest keeping/increasing this at the forefront of future funding.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Finally launch our FM continuity clinic Bridge follow-up program… we had hoped for this for some time, and this grant provided the time, funding, and motivation to finally connect the dots to make this essential pathway come to fruition.

California Residency Program Collaborative

Final Report and Results

Residency Program: UC San Diego FMRP

Submitted by (name/email): Regina Wang/ rmwang@health.ucsd.edu

Project Title: Breaking Barriers: Expanding Substance Use Training and Treatment in Family Medicine Clinics

Goals of Your Project (as stated in your proposal, or as amended):
The goal of this project is to improve upon our existing resident Addiction Medicine curriculum, expand it to the FM faculty, and implement a standardized protocol across all 3clinic sites to better identify, treat and monitor patients with SUDs.

High-Level Description/Highlights of the Work Done on the Project:
1. Obtained EPIC data on the patients with SUDs in our 3 FM clinic sites to compare the prevalence of patients with SUD diagnoses in our clinics to those in the general population nationally.
2. Assessed the barriers that prevent our faculty and residents from screening and treating SUDs.
3. Expanded the existing resident Addiction Medicine curriculum to upskill not only residents, but also the FM faculty.
4. Working to implement a standardized protocol across all 3 FM clinics for identifying, treating, and monitoring patients with SUDs. After the implementation of the clinic SUD protocol, we will assess the efficacy of the plan and impact on patient care.

Describe strategies/interventions/approach to reach goals:
1. Assessed prevalence of patients with SUDs in our 3 FM clinics. Then surveyed faculty and residents to assess barriers to screening and treating patients with SUDs. This data was presented first to the clinic medical directors and then the rest of the department for buy-in to increase SUD education of faculty and residents and incorporate a workflow for identifying and treating patients with SUDs.
2. a) Increased the number of lectures on SUDs during resident didactics.
b) Scheduled several of the lectures during Grand Rounds time slots to ensure more faculty could be present.
c) Currently working on creating educational EPIC smart sets that will facilitate clinic workflow and teach or remind clinicians about evidence-based treatments for patients with specific SUD.

Barriers, challenges and solutions:
1. There may be patients who are undiagnosed with SUDs in our FM clinic and we should evaluate ways to better identify these patients. We have discussed screening options with an addiction psychiatrist and decided on implementing the TAPs tool. We have also increased the number of SUDs lectures for residents and faculty.
2. Our survey showed that many FM faculty lack knowledge in areas of addiction medicine, feel uncomfortable treating patients with SUDs, and/or have biases against patients with SUDs. It is crucial for faculty across the department to have skills and knowledge to teach learners and model care for patients with SUDs. In addition to didactics lectures, we plan to create and implement SUD EPIC smart sets in clinic that not only educate the clinician on a SUD, but also facilitate orders for SUD treatments.

How will the progress be sustained?
We have 3 dedicated combined family/psychiatry residents and 3 faculty members, located at all 3 clinic sites, who are interested in implementing the SUD workflow at the clinics. We also have the support and guidance of an addiction medicine psychiatrist who is willing to help us.

Please share your thoughts on your experience on the Quality Improvement coaching:
Coaching helped us to focus our project. The coaching helped guide what we were measuring for the QI portion of our project. It also helped us to focus on starting small on our clinic workflow implementation, so we can work out any issues before it is implemented across all three clinic sites.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

N/A

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Create a team of faculty & residents from all 3 FM clinic sites to work collaboratively on project to improve care for patients with SUDs in our clinics.

Breaking Barriers: Improving Identification of Patients with Substance Use Disorders in Family Medicine Clinics

Thanos Rossopoulos MD, Nicholas Kos MD, Kristin Creel MD, Dustin Lillie MD, Regina M. Wang MD
UC San Diego, Family Medicine and Family Medicine/Psychiatry Combined Residency Programs

UC San Diego Medical Center

BACKGROUND

- In the last ten years, the number of opioid overdose deaths across the United States has skyrocketed, a statistic that is preventable
- According to San Diego County's Health and Human Services Agency, one out of eight people in San Diego has a substance use disorder (SUD), but nearly 90 percent of them do not receive treatment.
- Our 3 UC San Diego Family Medicine (FM) clinics have different patient populations regarding race, socioeconomic status, and gender-sexual identities.
- There are a total of 18,095 patients that attend these three clinics. It is unknown at present what percentage of patients are affected by one or more SUDs.

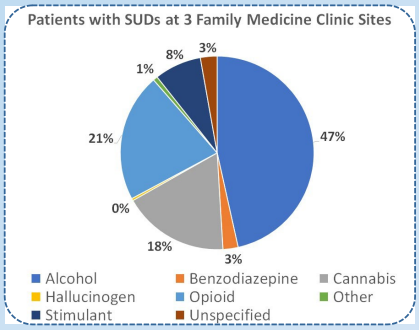
AIMS / PURPOSE

- To collect data on FM patients across 3 clinic sites who have been diagnosed with any SUD
- To identify whether a discrepancy exists with national prevalence data

METHODS

- Patient population: Patients with SUDs as identified on EPIC electronic medical record problem list at 3 UCSD FM clinic sites
- Obtain & evaluate EPIC data on patients with an ICD code representative of an SUD
- Compare FM patient SUD prevalence to the national prevalence data

DATA



- Total # of patients with at least 1 SUD in the dataset: 594 (3.3 % of total clinic population) (compare to SUD prevalence of 16.5% in USA)
- Total # of patients with at least 2 SUD in the dataset: 138 (0.76% of total clinic population)

RESULTS

- Alcohol: 367 patients (47% of all SUDs) (compare to alcohol making up 64% of total SUDs in USA)
- Opioids: 169 patients (21% of all SUDs) (compare to opioids making up 13% of total SUD's in USA)
- Cannabis: 140 patients (18% of all SUDs) (compare to 35% of SUD's in USA)
- Stimulants: 62 patients (8% of all SUDs) (compare to 9.7% of SUDs in USA)

CONCLUSIONS

- There is a significant discrepancy between patients in our FM clinics who are diagnosed with SUDs and the national prevalence of SUDs
- Possible barriers to identifying patients with SUD exist in our clinics
  - Inadequate clinic screening protocols
  - Providers' lack of time to screen for SUDs
  - Providers' lack of training to identify & treat patients with SUDs
- Additional efforts are needed to confirm, explore, and address these barriers

FUTURE DIRECTIONS

- Review additional Epic data focusing on expanded ICD codes, Social History, and previous AUDIT and DAST scores
- Implement new screening instrument and clinic workflow
- Create a Needs Assessment of providers:
  - Assess for barriers to identifying and/or documenting SUDs diagnoses
  - Assess for confidence in treatment of SUDs

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California Residency Program Collaborative

Final Report and Results

Residency Program: UC San Diego IMRP

Submitted by (name/email): Laura Bamford/ lbamford@health.ucsd.edu

Project Title: Development of a Substance Use Disorder Rotation for Internal Medicine Residents at the University of California, San Diego (UCSD) and Veteran's Administration (VA) San Diego Healthcare System

Goals of Your Project (as stated in your proposal, or as amended):

1. Educate IM residents at UCSD on taking a relevant history in patients with substance use disorders as assessed by pre and post substance use disorder rotation surveys of knowledge and competence.
2. Educate IM residents at UCSD on treatment options for substance use disorders assessed pre and post substance use disorder rotation surveys of knowledge and competence.
3. Educate IM residents at UCSD on harm reduction strategies in PWUD as assessed by pre and post substance use disorder rotation surveys of knowledge and competence.
4. Educate IM residents at UCSD on non-stigmatizing and patient-centered language related to substance use disorders as assessed by pre and post substance use disorder rotation surveys of knowledge and competence.
5. Create an inpatient order set to improve the care of PWUD admitted to UCSD Hillcrest Medical Center. Improvement in the care of PWUD will be assessed by the frequency of screening for HIV and hepatitis C, administration of hepatitis A and TDaP vaccinations when appropriate, naloxone prescription upon hospital discharge, MAT initiation in the hospital, MAT prescription upon hospital discharge, STI screening, outpatient referrals for substance use disorder treatment, referrals to syringe service programs, frequency of patient directed discharge (formerly referred to as against medical advice), and 30 day hospital readmission rates before and after implementation of this substance use disorder rotation.

High-Level Description/Highlights of the Work Done on the Project:

1. Internal Medicine residents have uniformly provided feedback on the positive impact on their medical education given the tremendous need to improve access to substance use disorder treatment and harm reduction services in San Diego.
2. We envision that the development of an inpatient order set to improve the care of hospitalized people

who use drugs will improve their overall care and decrease patient directed discharge and 30-day hospital readmission rates. Epic systems is interested in expanding access to this order set across the United Stated so its impact will hopefully extend far beyond San Diego.

Describe strategies/interventions/approach to reach goals:
Our strategies/interventions/approach to reach our goals was to collaborate widely with other substance use disorder treatment providers at UCSD and with the UCSD Opioid Use Disorder Task Force to ensure that we were educating Internal Medicine residents at UCSD on the most up to date standard of care/evidence based, substance use related guidelines, and harm reduction and the management of substance use disorders.

Barriers, challenges and solutions:
We have faced delays in operationalizing the inpatient order set as it has required approval from multiple committees at UCSD. However, this additional scrutiny will ultimately result in every well thought out order set.

How will the progress be sustained?
The project will be sustained as the substance use rotation and curriculum is now a part of the standard curriculum for all Internal Medicine residents at UCSD. Also, the substance use disorder order set that we were able to create with the support of this project will improve the care of inpatients with substance use disorders at UCSD and nationally indefinitely.

Please share your thoughts on your experience on the Quality Improvement coaching:
The Quality Improvement Coaching helped us focus on realistic goals for a one-year project and focus on sustainability of our project.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
The highlight of this project was connecting with other programs and individuals involved with its administration to share best practices to better support individuals with substance use disorders.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
create a comprehensive substance use disorder curriculum and rotation for Internal Medicine residents.

California Residency Program Collaborative

Final Report and Results

Residency Program: UCSF Fresno Family and Community Medicine

Submitted by (name/email): M. Shoaib Khan, MD/Muhammad.khan@ucsf.edu

Project Title: Faculty Development Fellowship for Addiction Care: A Training of Trainer Model

Goals of Your Project (as stated in your proposal, or as amended):
Our goal was to create a local, longitudinal enhanced learning program for faculty and residents to practice harm reduction principles and provide treatment for substance use disorders in primary care clinics. This program will enable physicians to identify those in need of treatment, initiate/engage/sustain individuals in treatment, and expand physician-supported harm reduction strategies.

High-Level Description/Highlights of the Work Done on the Project:

Syllabus: We created a 1-year longitudinal curriculum for the FD fellows and provided them with bimonthly lectures that started in August and ended in May. These include a total of 20 lectures.

Learning Community: We created a learning community of providers across UCSF Fresno by recruiting and working with 9 faculty fellows from 6 departments (FM, IM, Peds, OBGYN, EM, Psychiatry). These fellows shared barriers to care, developed quality improvement projects, worked on curriculum, and enhanced their clinical skills through curbside consults and review of cases with the community.

Online Repository of Resources: We built an online repository of resources on Trello for these fellows to interact with and use in the future that includes accessing all the learning materials that were provided during the year of fellowship.

Faculty Projects: Faculty fellows started creating projects related to substance use disorder in their own departments. These include building curriculum and reviewing resident knowledge around SUD, advocating for policy change related to SUD care that involves maternal-newborn dyad, starting to see patients with SUD in clinic

and developing clinic processes for it, reviewing, and developing opioid-sparing pain management strategies, advocating within their own departments to provide education to residents on SUD, etc.

Describe strategies/interventions/approach to reach goals:
We created the project around the **"Train the trainer"** model. This allowed volunteering faculty champions from different departments, who were internally motivated to learn, teach and promote addiction care amongst their departments to learn from experienced physicians and specialists. This model allows for people who are "driven by a shared purpose" to attain "mastery" in the field of their choosing and "autonomously" develop projects in line with the mission of improving addiction care. This strategy led our grant project to transform into 9 different projects for promoting addiction care.
Another critical element of the project was providing easy access to **"mentoring"** with specialist and experienced physicians. This lack of ready access was found to be a barrier for prescribing medication assisted treatment in a local research project. By removing this barrier through the creation of this project, we found that more physicians were inclined to provide addiction care, which was our stated goal.

Barriers, challenges, and solutions:
Our biggest challenge for the project was the lack administrative support for a major period of the grant. Our project manager who was dedicated to supporting the project quit one month into the project and we were not able to hire a replacement until the new year. A solution to this challenge was met by obtaining support from staff that already had significant existing duties. Therefore, they were able to support the project partially. The faculty and project lead had to step up for the remaining part of providing administrative support to the project.

Some expected challenges were related to the faculty fellow projects being conducted in individual departments. This included lack of flexibility to change curriculum that was addressed through combined advocacy for the need of change. Also, changing policy requires work overtime and approvals through different committees after obtaining consensus. This was met with persistence and developing enhanced support through further education and awareness sessions for local leadership and staff.

How will the progress be sustained?
The local trained faculty champions will continue to have a constant source of learning through the department of family medicine at UCSF Fresno and connection to specialists for further review of cases and consults.

We are also creating a local Addiction Medicine Learning Collaborative that will include primary care residencies in the San Joaquin Valley. As a collaborative, we will be furthering faculty development and involving residents through elective rotations and applying for grant opportunities to fund for their time.

Please share your thoughts on your experience on the Quality Improvement coaching:
It was an excellent way to remain on track and be able to provide updates on the project. Pam was very helpful and supportive.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:

- Consider allowing project lead to be able to dedicate more budget for administrative support.
- Consider allowing certain projects to continue for more than one year if seeing significant progress being made.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
Develop a wide-ranging project that has the ability to transform addiction education and care in our region.

California Residency Program Collaborative

Final Report and Results

Residency Program: Ventura County Medical Center

Submitted by (name/email): Matthew Lamon, DO – Matthew.Lamon@ventura.org

Project Title: VCMC Family Medicine Residency Harm Reduction Initiative

Goals of Your Project (as stated in your proposal, or as amended):
Hypothesis: Providing financial support to bolster numerous aspects of the pre-existing VCMC addiction medicine infrastructure will increase resident education related to the care of patients with substance use disorders. This will augment our capacity as a family medicine residency to provide MAT services to combat various SUDs, including opioid use disorder, in our community.

a. SMART Goals
   i. **HCH Backpack Medicine Program Support** - Distribute 5,000 Xylazine test strips to unhoused individuals through the existing HCH Backpack Medicine program between April 1, 2023 and April 1, 2024. Use three Microsoft surface tablets with mobile hotspot to increase telehealth capacity of the mobile Backpack Medicine team to improve care delivery to a vulnerable patient population. Register 200 patients for mobile visits through our EHR between April 1, 2023 and April 1, 2024.
   ii. **Post-Opioid Overdose Care Kits** - Distribute 50 post-overdose care kits between April 1, 2023 and April 1, 2024 through the Ventura County Emergency Department
   iii. **Resident Education** - Increase resident interest/competency in addiction medicine by sponsoring four VCMC Family Medicine residents to attend the California Society of Addiction Medicine conference in Aug. 2023. Develop curriculum to be delivered to residents & core faculty during the 2023-2024 academic year with the goal of increasing comfort prescribing Buprenorphine (SL & LAI) by 30% assessed with pre/post surveys.
   iv. **Detox Facility Furnishing** - Furnish the inpatient detox facility and waiting room of the VCMC Addiction Medicine & Recovery clinic with massage chairs (3 total) to serve as a patient relaxation space while attending intensive detox management visits. Create 2

slots for outpatient detox management per week through the addiction medicine & recovery clinic.

High-Level Description/Highlights of the Work Done on the Project:
For the 2024 CRPC Grant cycle, we successfully achieved numerous grant goals by distributing 5,000 Xylazine test strips to unhoused individuals and enhancing telehealth capabilities through the HCH Backpack Medicine Program. We created 50 post-overdose care kits for distribution through the VCMC Addiction Medicine Service, and increased resident education in addiction medicine by sponsoring four residents to attend a key conference and developing a curriculum to boost Buprenorphine prescribing competence. Additionally, we furnished the VCMC Addiction Medicine & Recovery clinic's detox facility with furniture/supplies for a private therapy room and created outpatient detox slots, significantly improving care for patients undergoing inpatient detoxification.

Describe strategies/interventions/approach to reach goals:
The Health Care for the Homeless (HCH) Backpack Medicine Program distributed 5,000 Xylazine test strips to unhoused individuals through our existing program. This effort aimed to mitigate the risks associated with Xylazine use among the homeless population and came into effect in a timely manner as Ventura County reported its first two deaths attributed to Xylazine through the Medical Examiner's office in April 2024. Additionally, we enhanced our telehealth capacity by incorporating three Microsoft Surface tablets with mobile hotspots into our Backpack Medicine program. This technological upgrade facilitated better care delivery and allowed us to register 193 patients for mobile visits through our electronic health record (EHR) system over the last year. While this number falls short of our goal of 200 patient encounters, we have added an additional half-day of addiction medicine focused backpack medicine clinic to our schedule and anticipate higher numbers in the year ahead.

In our Post-Opioid Overdose Care Kits initiative, we created 50 post-overdose care kits for distribution through the Ventura County Medical Center Addiction Medicine/Detox Service. While initially intended for distribution through the emergency department, these resources were diverted to the Addiction Medicine Service for more effective allocation to the hospital's most vulnerable patients. The addiction medicine service is regularly staffed by VCMC family medicine residents/fellows and works closely with the emergency department to care for patients who have suffered from opioid overdose. This service has been admitting patients since October 2023. These kits provide immediate care and resources to individuals who have experienced opioid overdoses, ensuring they have the necessary support and information for recovery. The kits include ride-share gift cards, warm blankets, hygiene kits, harm-reduction/safe-injection supplies, and various printed materials for accessing addiction services post-discharge. Plans to publish a journal article with instructions on the contents of the post-overdose care kits are in process.

To increase resident education and interest in addiction medicine, we sponsored four VCMC Family Medicine residents to attend the California Society of Addiction Medicine conference. Two of these residents are now pursuing addiction medicine fellowships. Furthermore, we developed a curriculum on MOUD delivered to residents and core faculty during the 2023-2024 academic year. This curriculum focused on increasing comfort with prescribing Buprenorphine (both sublingual and long-acting injectable) by 30%, which was assessed through pre-and post-surveys. On average, resident and faculty comfort in initiating/prescribing buprenorphine increased

from 4.1 to 7.2 on a 10-point scale post-training. This presentation was adapted and given to the broader community of Ventura County, providing education on MOUD to > 90 community prescribers.

Finally, under the Detox Facility Furnishing initiative, we intended to furnish the inpatient detox facility and waiting room at the VCMC Addiction Medicine & Recovery clinic with three massage chairs. These chairs were intended to create a relaxing space for patients attending intensive inpatient detox management visits. Several unanticipated barriers arose, primarily relating to the safety of the milieu of our facility and space allocation. Through the implementation of our detox facility, we determined that allowing patients access to an unobserved location adjacent to the unit presented a considerable safety risk. As such, massage chairs were abandoned in favor of furniture to support a counseling room where one-on-one counseling is provided by our substance use navigator to patients admitted to the detox service. Additionally, we established two slots per week for outpatient detox management through our clinic, providing much-needed support for patients undergoing detoxification. These have been regularly filled. To date, we have provided voluntary inpatient detox to over 200 patients.

Overall, these initiatives have significantly enhanced our ability to support and treat individuals struggling with addiction, demonstrating the effective use of grant resources to meet our project goals.

Barriers, challenges and solutions:

1) The launch of the Ventura County Medical Center's inpatient detox service was delayed from August to October of 2023 due to issues with construction permits. This was unanticipated but delayed implementation of SMART Goal #4 pertaining to furnishing massage chairs for the detox waiting room.
2) After our first month of service, it became clear that patients leaving the immediate vicinity of our observed unit presented an unacceptable safety risk. Instead, this space will now be used as a counseling space, where VCMC substance use navigators will conduct CBT/Counseling.

How will the progress be sustained?

Progress will be sustained through several key strategies. First, infrastructure improvements such as the integration of telehealth capabilities and the distribution of Xylazine test strips have established a robust foundation for ongoing care delivery. The continued use of Microsoft Surface tablets with mobile hotspots will maintain the enhanced telehealth capacity, ensuring that mobile care can be delivered efficiently to the vulnerable populations we serve. Maintenance and hardware costs will be written into future budget requests as this standard of care has now been established.

The Post-Opioid Overdose Care Kits initiative, although initially intended for the emergency department, has found a sustainable pathway through the Addiction Medicine Service. By reallocating resources to this service, we have ensured that the most vulnerable patients receive the care they need. The planned publication of a journal article detailing the contents and use of these kits will provide a resource for other institutions to replicate this model, promoting broader adoption and sustainability. Our institution will apply for COAST funding to generate funds for ongoing kit supply.

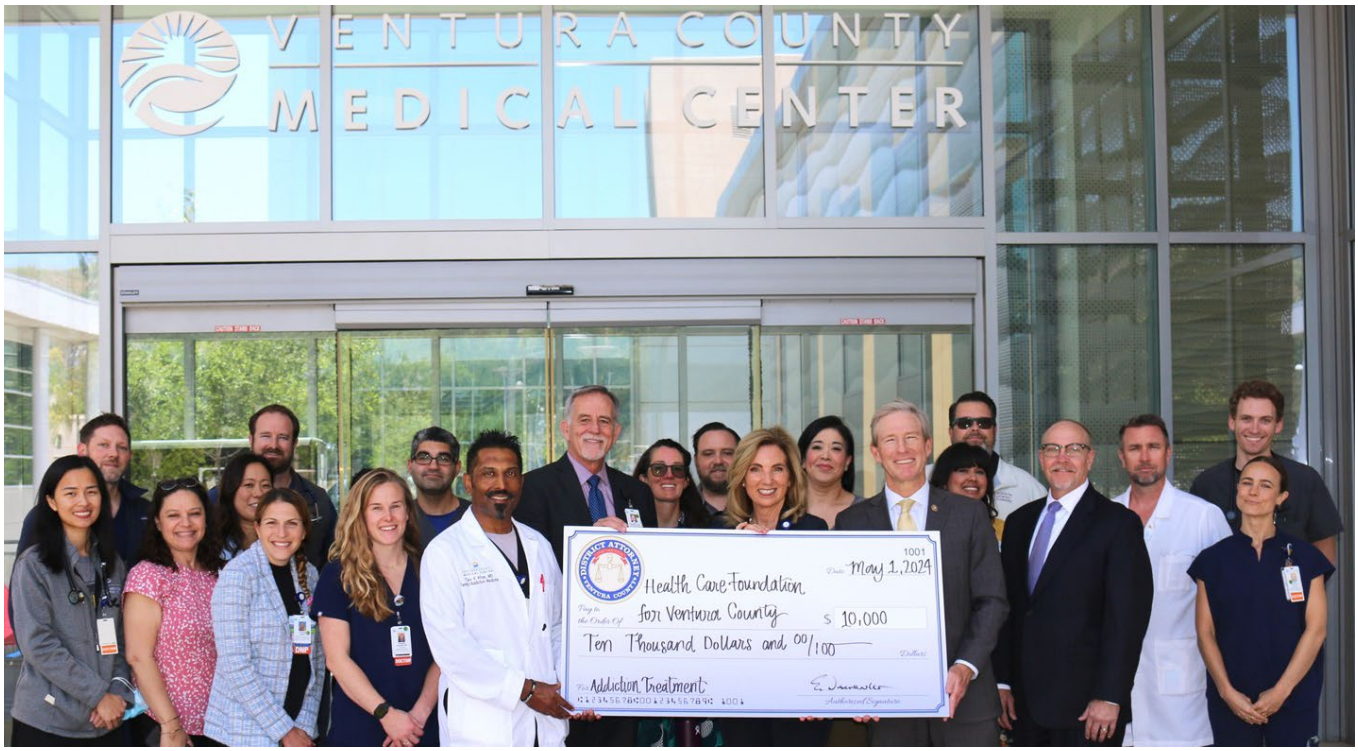
Resident education and training in addiction medicine have seen significant improvements, with the development of a specialized curriculum. This has already resulted in increased competency in prescribing Buprenorphine, with ongoing training and community education sessions ensuring that these skills are maintained and expanded. The increase in resident interest, as evidenced by two residents pursuing addiction medicine fellowships, indicates a growing commitment to this field. This curriculum will be integrated into the core conference schedule for the VCMC family medicine residency, providing ongoing education for future generations of family medicine physicians.

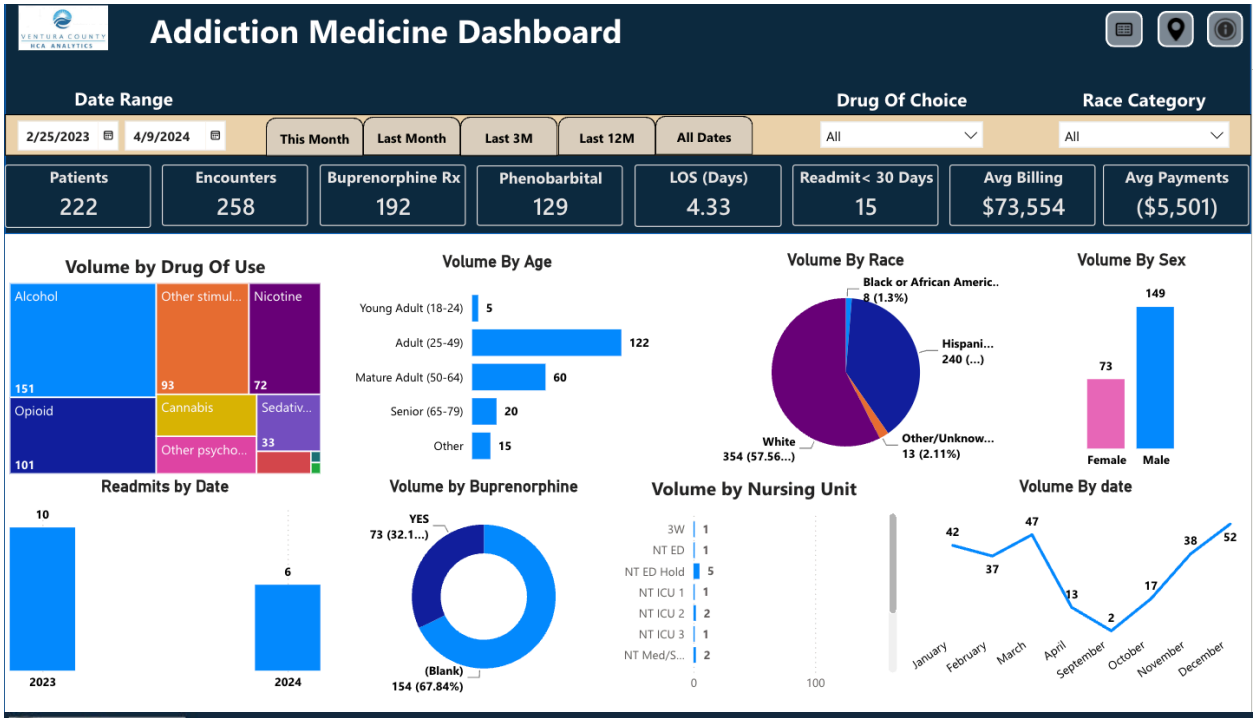
Finally, the adaptations made to the detox facility, including the creation of a counseling room, address both safety and patient care needs. This adjustment ensures that we can continue to provide a safe and supportive environment for detoxification and counseling. The establishment of regular outpatient detox management slots also ensures continuous patient support upon discharge. The consistent filling of these slots and the voluntary inpatient detox provided to over 200 patients demonstrate a strong demand and successful implementation, which will be sustained through ongoing clinic operations. We are working with hospital leadership to demonstrate the fiscal viability of our new service line.

Please share your thoughts on your experience on the Quality Improvement coaching:
Our experience with QI coaching made our project practical, breaking the steps down into manageable pieces. We recruited four family medicine residents to complete a QI project to increase the implementation of the CRAFFT screening questionnaire for adolescents in our clinic.

Other comments to share with the CRPC Advisory Panel and CA Department of Health Care Services, including suggested priorities for future funding:
Fund future projects endeavoring to establish inpatient detox service lines. In the era of Fentanyl, stabilization of severe opioid use disorder is becoming increasingly difficult. Allowing for inpatient monitoring increases the safety and feasibility of this process.

Complete this sentence - Without this Collaborative and CRPC resources, we would not have been able to...:
significantly enhance our telehealth capabilities, distribute critical Xylazine test strips to unhoused individuals, provide comprehensive post-overdose care kits, increase resident education and competency in addiction medicine, or adapt and furnish our detox facility to better serve our patients.

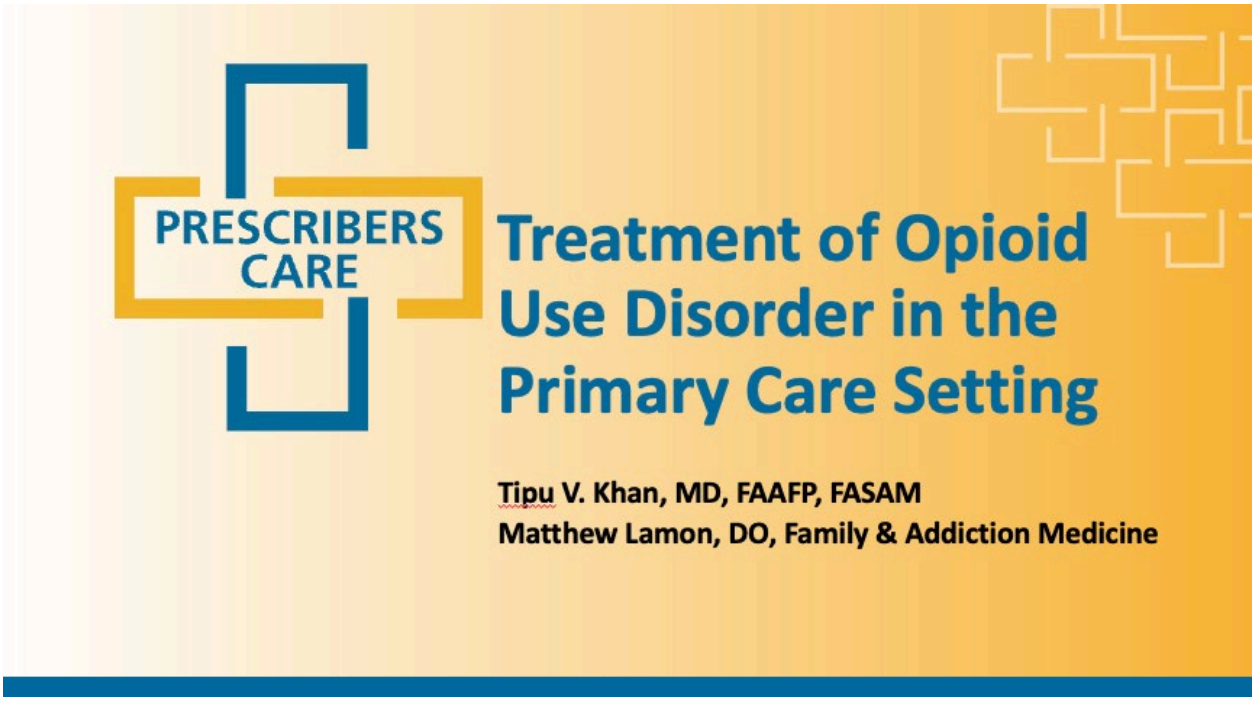

VENTURA COUNTY
MEDICAL CENTER
1001
May 1, 2024
Health Care Foundation
for Ventura County
$ 10,000
Ten Thousand Dollars and 00/100
Addiction Treatment


Addiction Medicine Dashboard
Date Range
2/25/2023
4/9/2024
This Month
Last Month
Last 3M
Last 12M
All Dates
Drug Of Choice
All
Race Category
All
Patients
222
Encounters
258
Buprenorphine Rx
192
Phenobarbital
129
LOS (Days)
4.33
Readmit< 30 Days
15
Avg Billing
$73,554
Avg Payments
($5,501)
Volume by Drug Of Use
Alcohol
151
Other stimul...
93
Nicotine
72
Opioid
101
Cannabis
Sedativ...
33
Other psycho...
Volume By Age
Young Adult (18-24)
5
Adult (25-49)
122
Mature Adult (50-64)
60
Senior (65-79)
20
Other
15
Volume By Race
Black or African Americ..
8 (1.3%)
Hispani...
240 (...)
White
354 (57.56...)
Other/Unknow...
13 (2.11%)
Volume By Sex
149
73
Female
Male
Readmits by Date
10
2023
6
2024
Volume by Buprenorphine
YES
73 (32.1...)
(Blank)
154 (67.84%)
Volume by Nursing Unit
3W
1
NT ED
1
NT ED Hold
5
NT ICU 1
1
NT ICU 2
2
NT ICU 3
1
NT Med/S...
2
0
100
Volume By date
42
37
47
13
2
17
38
52
January
February
March
April
September
October
November
December


Addiction Medicine By Location
VENTURA COUNTY
HCA ANALYTICS
Date Range
2/25/2023
4/9/2024
Sespe Condor Sanctuary
Eastern
Goleta
Valley
Montecito
Santa Barbara
Carpinteria
Mira Monte
Santa Paula
Piru
Moorpark
Simi Valley
Somis
Santa Rosa
Valley
Camarillo
Thousand Oaks
Lake Sherwood
Port Hueneme
Pacific
Missile
Test
Center


Kim
Zachary
SPEAKER
Tipu
Katia
Elizabeth
She/Her
Daniel
SPEAKER


VENTURA COUNTY
MEDICAL CENTER
SANTA PAULA HOSPITAL
A Division of Ventura County Health Care Agency
ADDICTION
IS TREATABLE
You don't have to go far to find support.
At Ventura County Medical Center, we now offer, acute, in-patient
drug & alcohol detoxification services- by referral or appointment.
Our compassionate care team can help you safely detox from
alcohol, opiates (fentanyl & heroin), stimulants (cocaine & meth), &
benzos, as comfortably as possible by offering:
Doctors Specializing in Addiction Medicine
Evidence Based Practices to Help Sustain Remission
Discharge Planning
Drug & Alcohol Counseling
Recovery Begins Now.
To make an appointment to be evaluated for admission (No Walk-Ins):
805-652-3280
We accept most major insurances & Gold Coast Health Plan/Medi-Cal


PRESCRIBERS
CARE
Treatment of Opioid Use Disorder in the Primary Care Setting
Tipu V. Khan, MD, FAAFP, FASAM
Matthew Lamon, DO, Family & Addiction Medicine

VCMC Family Medicine Residency OUD MAT Comfort Post-training Survey

19	00:33	Active
Responses	Average time to complete	Status

1. On a scale of 1 to 10, how comfortable are you diagnosing Opioid Use Disorder?

Promoters	8
Passives	8
Detractors	3

2. On a scale of 1 to 10, how comfortable are you initiating sublingual buprenorphine for treatment of opioid use disorder?

Promoters	2
Passives	11
Detractors	6

3. On a scale of 1 to 10, how comfortable are you initiating long-acting injectable buprenorphine for treatment of opioid use disorder?

Promoters	2
Passives	7
Detractors	10

4. On a scale of 1 to 10, how comfortable are you continuing sublingual buprenorphine for maintenance treatment of opioid use disorder?

Promoters	4
Passives	11
Detractors	4

Item	Description	Ordered	Rate	Amount
1004084-cs	Colgate toothpaste, 1oz tube, regular flavor (24/case)	6	14.44	86.64T
327503-cs	DawnMist shampoo and body wash, 2oz, apricot scent (144/case)	1	60.48	60.48T
447101-cs	Donovan hair conditioner, 2 oz bottle with dispensing cap (144/case)	1	59.28	59.28T
586897-cs	Deodorant stick, clear, 1.6 oz (144/case)	1	136.64	136.64T
911644-bg	McKesson bag, clear, 9"x12", zip closure (100/bag)	2	8.68	17.36T
1113336-cs	SunX SPF30+ sunscreen, 4oz bottle (12/case)	5	35.10	175.50T
877025-cs	McKesson body lotion, 4 oz bottle, cucumber melon scent (48/case)	3	44.62	133.86T
235697-cs	3M Tegaderm, transparent film dressing, 2-3/8"x2-3/4" (400/case)	1	143.28	143.28T
1220888-cs	Bacitracin Zinc, Oint 0.9gm (144/bx 12bx/cs)	1	152.84	152.84T
404119-cs	Soap DawnMist Bar 1 oz. Individually Wrapped Scented case/500..	1	80.64	80.64T
890534-pk	McKesson bag, clear, 3"x5", zip closure (100/bag)	1	1.99	1.99T
	Total sales tax calculated by AvaTax		214.77	214.77
	Select this as a transaction's tax to use AvaTax		0.00%	0.00

Item	Description
191089-cs	McKesson isopropyl alcohol wipe, individual packet, medium (4000/case)
812687-cs	SaniHands wet hand wipe (20/pack, 48 packs/case)
471225-cs	BD 1 quart, red base, flip-top lid (60/case)
2001-bx	Approximately 1,000 Silgan Cookers, w/o handles
3002-pk	Zip Ties, 6" length, black, 1000/pk
1002-bx	0.5 lb cotton, #2 pellet, 7/32", non-sterile, approx 15,500 pieces **On Allocation**
669136-cs	Addipak respiratory therapy solution, sterile water, 5mL vial (1000/case)
1156904-cs	EasyTouch syringe, 28 gauge, 1/2" needle, 1mL barrel, 10/polybag (100/bx, 5bx/case)
1156907-cs	EasyTouch syringe, 29 gauge, 1/2" needle, 1mL barrel, 10/polybag (100/bx, 5bx/case)
1156906-cs	EasyTouch syringe, 30 gauge, 1/2" needle, 1mL barrel, 10/polybag (100/bx, 5bx/case)
464713-cs	McKesson tourniquet strap, 18" length, non-latex, blue (1000/case)
511333-cs	McKesson adhesive plastic patch, 2"x4", sterile (1200/case)
485517-bx	Flexible Drinking Straw McKesson 7-3/4 Inch White Individually Wrapped (500/bx)
1206381-cs	Condom, Lifestyles Ultra Sensitive (1008/cs)
1066699-cs	Lubricating Jelly McKesson 5 Gram Individual Packet Sterile, (864/cs)
1016414-bg	Dr. John's sugar-free hard candy, peppermints, 2.5lbs (1 bag)
4002-cs	Foil Sheets, One-Use, 30pks/case
953736-ct	Carmex lip balm, .35oz tube, original flavor (12/count)
888502-bx	McKesson adult toothbrush, soft bristle (144/case)

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INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION

quality improvement

Tools and Templates

SPECIFIC AIM STATEMENTS

Specific aim statements provide a detailed focus for your improvement. They also describe the measurable outcomes you wish to achieve. Often, multiple specific aims and PDSA cycles will be helpful in achieving your goals. It's ok to start with one specific aim and use the PDSA method to begin testing changes. Specific aims can be created and linked to your goals throughout the project.

Specific Aim Statements include:

- What are you trying to accomplish? (Written and measurable description of the improvement/process)
- For what/whom? (target population or setting or system/process)
- How much (measurable, clear, and well-defined numeric goals for the qi team)
- By when? (time frame)

Specific Aim Statement Template

We aim to (improve, increase, decrease)

The (quality, number/amount, percentage) of _____ (process/outcome)

From: _____ (baseline number/ amount/percentage)

To : _____(goal number/amount/percentage)

By: _____(date)

Example: We aim to increase the number of physicians in our clinic prescribing MAT to pts with SUD from 0% to 80% by June 1, 2021.

WHERE do specific aims come from? There are many good sources and qi tools you can use to assess your practice and identify areas for improvement. Specific aims and future change ideas frequently come from a several areas:

- **Process Analysis** – By mapping your current (as is) and future state (ideal) process can reveal specific gaps or steps that do not work as well as they might, and ideas for changing them can arise.
- **Root Cause Analysis** – Constructing a fishbone diagram can help you explore the wide range of causes involved in the effect you are trying to improve. This will often prompt ideas about what might be changed in order to improve the desired outcome
- **Direct Observation** – directly observing a process can reveal steps that could be eliminated or that might work better
- **Evidence-Based and Best Practices** – comparing your practice to evidence-based best practices can identify processes that may need to be tested and changed to fit your local context

Process mapping and root cause analysis instruction sheets, and templates can be found in the "QI Resources" section of the module

Plan-Do-Study-Act (PDSA) Cycles

The Plan-Do-Study-Act method is a way to test a change that is implemented. By going through the prescribed four steps, it guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it. Having them written down often helps people focus and learn more.

PDSA Cycle(s)

PDSAs are carried out in a step-by-step process to build knowledge and create sustainable change. PDSA allows the team to create new knowledge by conducting small tests of change with a minimum of risk, and builds confidence in the impact of the changes proposed. Ideas with positive impact can be continued on a larger scale

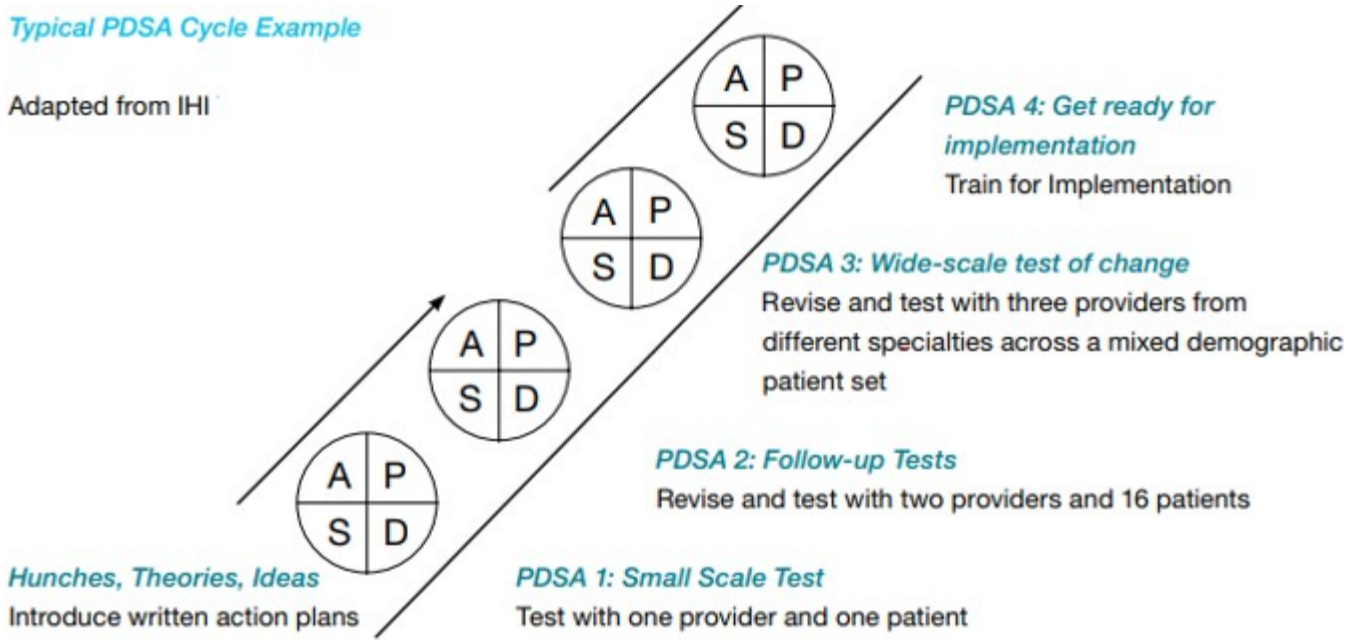
Step 1	**PLAN (who, what, where, when and why)**
	• State the purpose of the PDSA—are you developing a change idea, testing a change, or implementing a change? • What is your change idea? • What indicator(s) of success will you measure? • How will data on these indicators be collected? • Who or what are the subjects of the test? • How many subjects will be included in the test and over what time period? • What are your predictions as to what will happen?
Step 2	**DO**
	• Conduct the test. • Document the results, measurements, challenges and unintended consequences.
Step 3	**STUDY**
	• Analyze the data and study the results. • Compare the data to your predictions. • Summarize and reflect on what was learned.
Step 4	**ACT**
	• Refine the change idea based on lessons learned from the test. • Prepare a plan for the next test. Dependent on results the idea should be adopted, adapted or abandoned.

When to use PDSA?	Don't need to use PDSA:	Some misuses of PDSAs
• For trying changes to existing processes • For trying *new* processes • For trying *new* tools • For trying *new* measures	• For specific project tasks • For gathering data or information (unless you want to learn about the data process) • For general "planning" or setting goals, objectives	• Tendency to do too much in one PDSA, instead of several cycles • Tendency to use PDSAs for information gathering or collecting data on a measure rather than beginning to test an idea for change • Tendency to use PDSAs to complete all 'tasks' on the project

Tips for Testing Changes
• Keep the changes small but continue to test • Involve care teams that have a strong interest in improving care • Study the results after each change. All changes are not improvements, so discontinue testing of anything that does not work. • If help is needed, involve others who do the work—even if they are not on the improvement team • Ensure overall performance is improving; changes in one part of a complex system may adversely affect another

Ramp for testing and modifying change ideas

Initially, these cycles are carried out on a small scale to see if they result in improvement. Teams can then expand the tests and gradually incorporate larger and larger samples until they are confident that the changes will result in sustained improvement.



PDSA Worksheet

Use the Plan-Do-Study-Act (PDSA) worksheet to help your team document a test of change. Fill out one PDSA Worksheet for each test you conduct. Your team will test several different changes, and each change will go through several PDSA cycles.

A PDSA worksheet can be found in the "QI Resources" section of the module

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Plan-Do-Study-Act (PDSA) Worksheet

Name of Practice:_____ **Cycle Start Date:**_____ **Cycle End Date:**_____

Plan

Describe the change you are testing, list the tasks needed to complete the test, and plan for data collection.

List the Test of change/intervention	Who are we testing the change on?	When and where are we testing?

What tasks need to be completed to test the change?	Tools/Training Needed	Due Date	Owner

What data do we need to collect?	When will it be collected?	Due Date	Owner

Do

Carry out the change or test. Collect data and feedback. Describe what happened include reporting of any unexpected events. Begin analysis.

Study

Complete analysis of data. Summarize what was learned. Did you identify any surprises?

Act

Are you ready to implement the change you tested? What modifications or refinements for the next cycle. What will you do next? Plan for next cycle.

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Plan-Do-Study-Act (PDSA) Worksheet

Name of Practice: Clinic A Primary Care **Cycle Start Date:** 3.1.15 **Cycle End Date:** 3.15.15

Plan

Describe the change you are testing, list the tasks needed to complete the test, and plan for data collection.

List the Test of change/intervention	Who are we testing the change on?	When and where are we testing?
Use of a smart phrase to document conversation about NSAIDS	Adult patients with CKD stage II who come into the clinic for ANY visit	The test will take place in clinic A with Dr. Jones care team. Will test Mon, Wed, Frid, when entire care team is in the office

What tasks need to be completed to test the change?	Tools/Training Needed	Due Date	Owner
Develop smart phrase content		2.20.15	Dr. Jones
Create smart phrase for use in system		2.22.15	Mary, Clinic Manager
Train team to use smart phrase	Room with computer	2.25.15	Mary, Clinic Manager

What data do we need to collect?	When will it be collected?	Due Date	Owner
# times smart phrase used. Will us daily tic & tally sheet to track & if smart phrase was used during visit	At the end of the visit	3.15.15	Bill, MA

Do

Carry out the change or test. Collect data and feedback. Describe what happened include reporting of any unexpected events. Begin analysis.

The smart phrase was easy to use and didn't take much time or disrupt visit flow. Once prompted, we realized the patients had many questions about NSAID use and why they shouldn't use them. Tic & Tally was an easy way to track data on a daily basis. We realized in the first few days the smart phrase was not getting used because it was a new step in the process.

Study

Complete analysis of data. Summarize what was learned. Did you identify any surprises?

During the testing period we had 12 eligible patients come in for a visit. The smart phrase was used on 8 patients or 67% of the time. 3 of the patients came in during the first week when the process was new. Utilization improved the second week. The other patient was roomed by another MA who was not aware of the process.

Act

Are you ready to implement the change you tested? What modifications or refinements for the next cycle. What will you do next? Plan for next cycle.

For the next cycle, we are going to highlight eligible patients on the daily schedule as a reminder to use the smart phrase. We are also going to add a comment box to the smart phrase as a way to communicate to the physicians additional questions the patient may have about the use of NSAIDS.

Quality Improvement Measures

Quality improvement measure(s) allow the team to demonstrate current performance (or baseline), set goals for future performance, and monitor the effect of changes as they are made. They consist of a numerator and denominator used to calculate performance and should align with your aim statement.

Parts of the QI Measure
A Quality improvement measure is made up of several parts:

- **Title** – a description of what the measure is and includes target population and measure focus
- **Numerator** - (also called the measure focus) describes the target process, condition, event, or outcome expected for the targeted population. The numerator is the number
- of instances the quality actions of interest was performed in the denominator.
- **Denominator** - defines the population being measured or the #of eligible cases the numerator applies to

Types of Quality Measures
Consider each category of measures listed below. Using a balanced set of measures will ensure that you have an accurate picture of the effects of the changes your quality improvement team will be testing

- **Structural measures** are measure that assesses infrastructure, characteristics, or features of a health care organization or clinician relevant to capacity to provide health care, such as equipment, personnel, or policies

- **Process measures** are the "voice of the workings of the system." In other words, process measurements are those that capture the changes your quality improvement efforts make to the steps that contribute to system outcomes. When working with process measures, it is important to focus on the processes that directly contribute to the desired outcome.

- **Outcome measures** are the "voice of the patient or customer" and capture system performance. They answer the question: "What are the end results of our QI work."

Measurement Plan
Once you have clearly defined your measures work with the QI team to create a measurement plan by agreeing on the following:

- Name of measure
- Type of measure (structure, process, outcome)
- Why the measure is needed for the project
- Operational definition
- Source of the data?
- Who is collecting the data?
- How will data be displayed?
- Is baseline data available?

Review this plan with the team regularly to ensure that it is working and that there is clarity about what the team is trying to achieve by measuring their progress. Also, make sure that the data collected and analyzed is shared with all stakeholders. It is difficult to create momentum among staff without providing them with relevant and timely information.

Data Collection Plan Template

TEAM NAME:

SPECIFIC AIM STATEMENT:

Example Specific Aim Template: We aim to (improve, increase, decrease) the (quality, number/amount, percentage) of _____(process/outcome being improved) from_____(**baseline** number/ amount/percentage) to _____(**goal** number/amount/percentage) by_____(**date**)

	Data Collection Plan							
#	**What is being measured?** ***(define the metric)***	**Operational definition** ***(clear, concise definition of the measure)***	**How will data be collected?** ***(tools or technology needed)***	**Person(s) Responsible**	**Start Date**	**End Date**	**How will the data be presented?** ***(frequency and format)***	**Status/ Comments**
1								
2								
3								

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Process Mapping

Process Mapping, also called flowcharting, is a great method to help teams clarify the current process as well as understand the causes of process breakdowns to help in improving systems. It is an illustration of steps in a process using symbols and arrows.

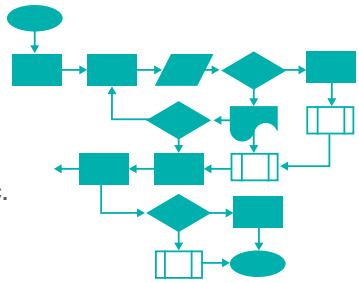
Types of Process Maps:

High Level Process Maps:

- Useful for initiating projects and identifying boundaries of the larger process for improvement.
- Shows only the vital few process steps—typically 5-10 steps with no decision points.

Detailed Process Maps

- Useful for achieving efficiency in improvements and identifying handoffs or gaps in a process.
- More granular level map than the high-level map includes, decision points handoffs, delays, etc.



Instructions and Helpful Tips:

- Use Post-It™ notes first! Post-It™ notes are great to use in case steps need to be added, deleted, or rearranged.
- Select the process start and end steps.
- Identify and define all the steps in the process - from start to finish—by asking what happens first, then what happens, then what happens (keep it simple).
- Number all of the process and decision steps in the process map (1, 2, 3, etc.) for easier comprehension, analysis, and communication.
- Draw arrows to connect the process and decision steps.
- Review the process map for opportunities, such as:
  - — Redundant steps
  - — Hand-offs
  - — Waste – remove steps that do not add value.
  - — Unnecessary variations
- Identify change ideas to address the opportunities.

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Process Map for:_____

How it works:

- Identify the **CURRENT** process/flow by filling in each step of the process in the boxes below. Think about how the process/flow is completed **TODAY.**
- Start by defining where the process **BEGINS** and **END.**
- Next, identify and define all the sequential process steps involved in the process you are trying to improve.

PROCESS BEGINS Step #1	Step #2	Step #3	Step #4	Step #5
Step #6	**Step #7**	**Step #8**	**Step #9**	**PROCESS ENDS Step #10**

Review the process map for opportunities such as waste, redundant steps, documentation and handoffs. Can it be done differently to get a better outcome? Identify change ideas to address opportunities. Remember do not think people, think process. If needed, use the boxes below to input your **NEW** process/flow.

PROCESS BEGINS Step #1	Step #2	Step #3	Step #4	Step #5
Step #6	**Step #7**	**Step #8**	**Step #9**	**PROCESS ENDS Step #10**

quality improvement

Process Map for: Childhood Immunizations

How it works:

- Identify the **CURRENT** process/flow by filling in each step of the process in the boxes below. Think about how the process/flow is completed **TODAY.**
- Start by defining where the process **BEGINS** and **END.**
- Next, identify and define all the sequential process steps involved in the process you are trying to improve.

PROCESS BEGINS Step #1	Step #2	Step #3	Step #4	Step #5
Pt check in for WC visit	MA rooms patient	MD reviews immunization status provides education and orders necessary immunizations: performs WC exam	MA/RN returns to give necessary immunizations	Pt leaves clinic
Step #6	**Step #7**	**Step #8**	**Step #9**	**PROCESS ENDS Step #10**

Review the process map for opportunities such as waste, redundant steps, documentation and handoffs. Can it be done differently to get a better outcome? Identify change ideas to address opportunities. Remember do not think people, think process. If needed, use the boxes below to input your **NEW** process/flow.

PROCESS BEGINS Step #1	Step #2	Step #3	Step #4	Step #5
Huddle to identify those in need of vaccinations/catchup's: Plan for day	Pt check-in for ANY visit	MA rooms patient. Review screening form. If no issues, MA/RN gives immunizations per protocol.	MD addresses patients needs during visit	Pt checks-out and schedules next immunization visits
Step #6	**Step #7**	**Step #8**	**Step #9**	**PROCESS ENDS Step #10**

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Root Cause Analysis

Root cause analysis is a collective term that describes a wide range of approaches, tools, and techniques used to identify and correct a problem's root cause.

Many times, improvement efforts jump to what is thought to be the problem, developing solutions that don't actually fix the real problem. Successful improvements focus on why the problem is occurring to fix the underlying processes that cause the problem.

Two common tools used to help uncover root causes included:

5 Why's

The theory is that asking the question "Why does that happen?" five times will reveal the root cause that contribute to the issue being addressed. The trick is to keep it simple and continue to ask why until the root cause of the problem becomes apparent.

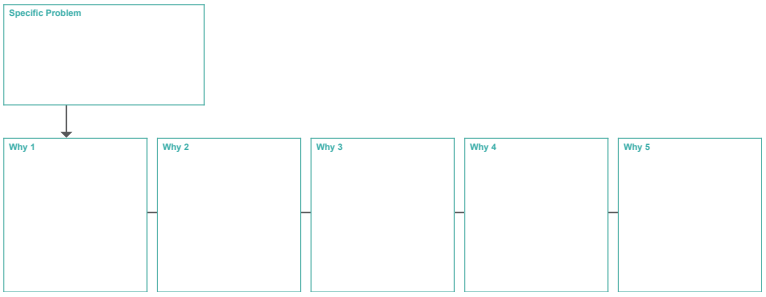
Instructions:

1. Write down the specific problem. Writing the issue helps you formalize the problem and describe it completely. It also helps a team focus on the same problem.

2. Ask Why the problem happens and write the answer down below the problem.

3. If the answer the team just provided doesn't identify the root cause of the problem that you wrote down in Step 1, ask Why again and write that answer down.

4. Loop back to step 3 until the team is in agreement that the problem's root cause is identified. Again, this may take fewer or more times than five Whys.



Fishbone

The Fishbone, also called cause & effect diagram, is a visual diagram that helps teams understand that many causes contribute to an effect. The head indicates the particular problem being analyzed. The bones represent the many potential causes. The Fishbone helps determine which causes are related.

Instructions:

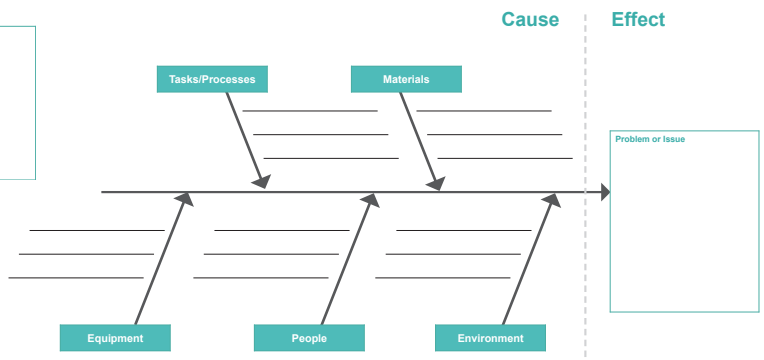
1. Write the effect (problem or issue) in a box on the right-hand side of the page.

2. Decide on the categories of causes for the effect. Useful categories of causes in a classic fishbone diagram include Materials, Tasks/Processes, Equipment, Environment, and People.

3. Generate a list of causes for each category.

4. List the general causes on each fishbone, drawing branch bones to show relationships among the causes.

5. Analyze the causes and determine the top items to work on—eliminate causes that are out of your control.



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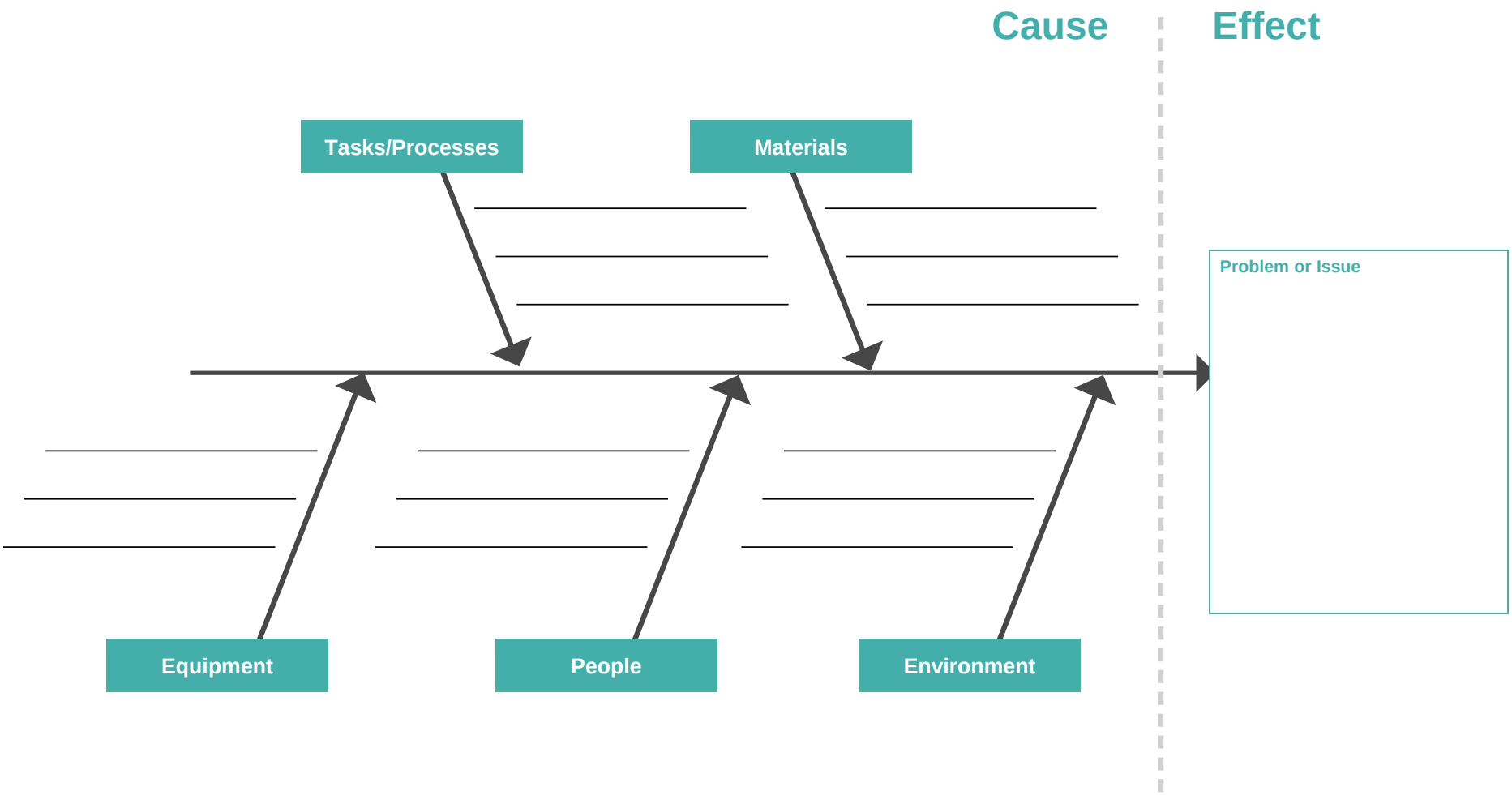
Fishbone Diagram

Project Title: _____



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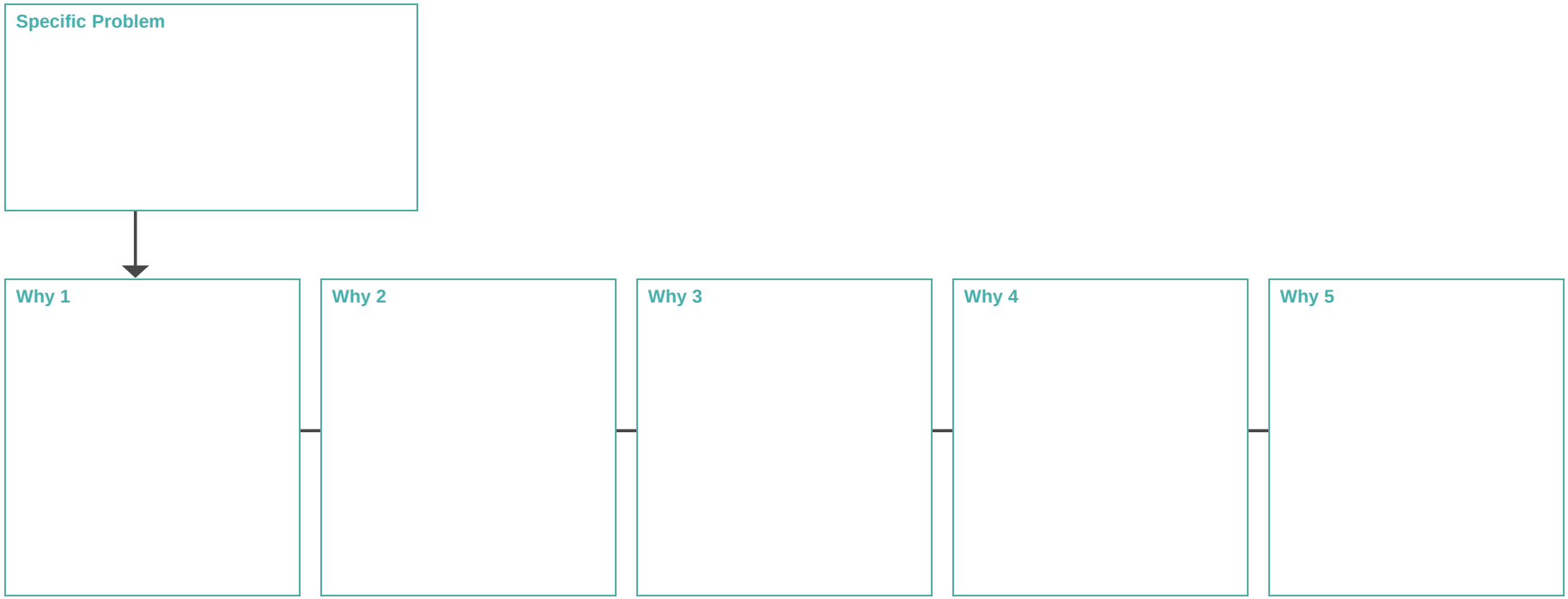
5 Whys

Project Title: _____



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Name of Project
Team Meeting

Date: **Time:** **Location:**

Meeting Roles
Facilitator:
Recorder:
Timekeeper:
Participants

Meeting Goals/Objectives
Goal A
Goal B

Time	Item/Discussion	Person Responsible
	1. Review meeting roles and objectives	
	2. Review agenda and assign times	
	3. Work through agenda items A. B. C.	
	4. Review of New Action Items/Next Steps	
	5. Plan Next Agenda	
	6. Evaluate the Meeting	