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Breaking Through Adoption Barriers Of Evidence-Based SUD Treatment Models

How KCS Health Center Expanded From Basic Access To A Fully Integrated SUD 2.0 Model

Why This Matters

- Co-occurring psychiatric conditions, trauma, homelessness, and medical complexity are the norm rather than the exception
- Provider organizations are under pressure— workforce shortages, burnout, turnover, reimbursement challenges, etc
- Despite growing evidence supporting MOUD, long-acting injectable medications, rapid-access treatment models, harm reduction approaches, and integrated care, organizations still struggle with implementation
- Transformation requires leaders who can communicate transparently, build trust, create psychological safety, support workforce readiness, and maintain accountability

Today's Speakers

Stuart Buttlaire, PhD

Vice President, Clinical Excellence
& Leadership at *OPEN MINDS*

Mario San Bartolomé
M.D., M.B.A., M.R.O., FASAM

Medical Director, Substance Use Disorders,
KCS Health Center

KCS Health Center

- FQHC serving complex, high-risk populations across Orange County
- Founded in Los Angeles in 1977, relocated to Orange County in 1992
- 7 full-service Health Clinics, 3 counseling centers, 3 community support centers

KCS Health Center

- Expanded from Korean Community Services into broader community-based behavioral health and SUD care
- Focus on rapid-access treatment, integrated behavioral health, and wraparound support
- Serves patients with significant SDOH, psychiatric, medical, and justice-involved complexity

Why Traditional SUD Models Are No Longer Enough

Traditional models often:

- focus only on medication access
- lack wraparound support
- struggle with retention
- fail during transitions of care
- create provider burnout

Current realities:

- fentanyl complexity
- co-occurring conditions
- justice re-entry
- unstable housing
- workforce shortages
- fragmented care

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KCS Solved The First Challenge: Access

Initial Transformation Goals:

- Same-day/rapid access care
- MAT/MOUD expansion
- Behavioral health integration
- Workforce training
- ASAM competency
- Telehealth access

"We had already exceeded what a typical clinic could imagine doing. But we knew we could do better."

Mario San Bartolomé

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Why KCS Launched "SUD 2.0"

The Question Became:
"What are we still missing?"

Remaining Gaps:

- relapse prevention support
- family engagement
- care coordination
- justice re-entry
- perinatal support
- adolescent pathways
- SDOH stabilization
- reimbursement gaps
- long-term engagement

What SUD 2.0
Actually Added

New Capabilities:

- Psychoeducation groups
- Peer support
- Contingency management
- Employment assistance
- Lead care managers (LCMs)
- Family telehealth integration
- Structured care tracks
- Re-entry support
- Higher-touch engagement models

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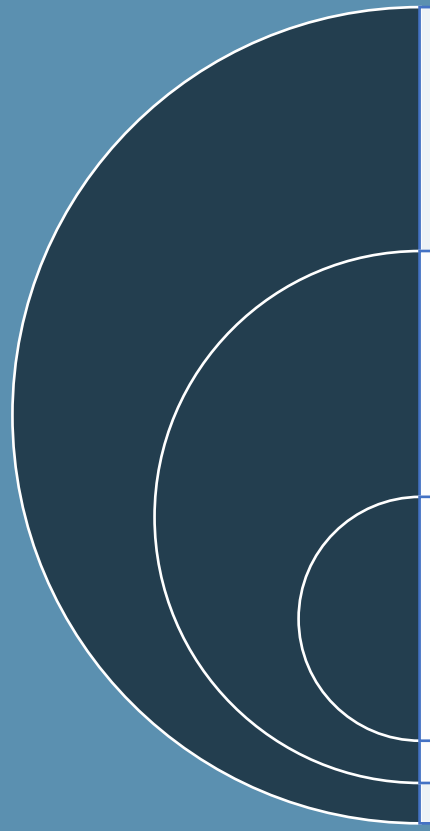
“SUD care became a *system*,
not a service line.”

The Wraparound Care Model



Core Philosophy	• "Every patient receives a wraparound approach — but intensity varies based on need."
Components	• Medical + behavioral integration • Family involvement • Telehealth support • High-touch stabilization • Weekly interdisciplinary review • Dynamic reassessment
Important Concept	• Low barrier to entry + precision support allocation

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Low Barrier Access, High Precision Care

Initial Entry:

- Immediate access
- Minimal barriers
- Telehealth intake
- Rapid assessment

Then:

- Risk stratification
- Interdisciplinary review
- High-priority identification
- Assigned lead care manager
- Escalated touchpoints

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Where Resistance Showed Up

- Mission
  - Staff discomfort with treating SUD populations
- Competence
  - Lack of confidence/training
- Risk
  - Fear of:
    - liability
    - noncompliance
    - diversion
    - burnout
    - legal exposure

What Actually Drove Adoption

- Leadership Strategies
  - Strong clinical champion
  - Mid-level peer champion
  - Ongoing reinforcement
  - Workforce protection
  - Psychological safety
  - Modeling behavior
  - Repetition
  - Accountability
  - Incentivization

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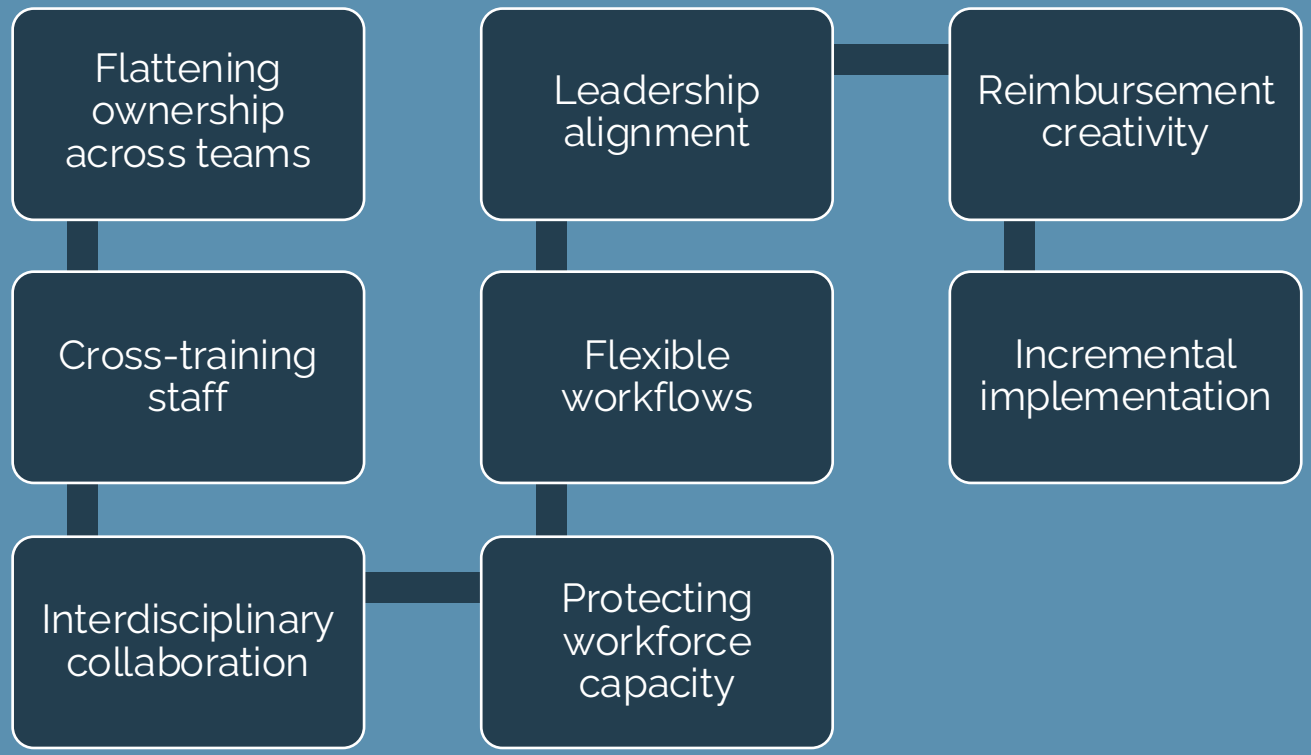
Operational Lessons Learned: What Made The Biggest Difference



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Measurement Strategy

- **Operational Metrics**
  - Patients served
  - MAT/MOUD utilization
  - Screening completion
  - BH referral follow-through
  - Hep C treatment completion
  - Engagement duration

- **Future Focus**
  - Retention measurement
  - Disengagement analysis
  - Longitudinal engagement tracking

Strategic Discussion With Stuart Buttlaire

Many organizations still struggle to move from “basic access” to fully integrated SUD care.

From your perspective, what operational capabilities become most important once access is no longer the primary barrier?

Workforce resistance remains one of the biggest barriers to implementing evidence-based SUD treatment.

What leadership behaviors most strongly influence long-term workforce adoption and engagement?

Many provider organizations worry about sustainability when expanding wraparound services.

How should leaders think about balancing financial realities with long-term patient outcomes and system impact?

Looking ahead, what operational or system-level changes will organizations need to make to remain effective in the evolving SUD treatment environment?

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