Breaking Through Adoption Barriers In Evidence-Based SUD Treatment: How KCS Health Center Expanded From Basic Access To A Fully Integrated "SUD 2.0" Model

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Dr. Buttlaire 0:00
Hello everyone and welcome to today's Recademy webinar. I'm Dr. Stuart Buttlaire and I'm very pleased to have you joining us today. Today's session is titled, Breaking Through Adoption Barriers in Evidence-Based SUD Treatment: How KCS Health Center Transformed Culture, Workforce Readiness, and Clinical Outcomes. Today we're going to focus on something many organizations are struggling with right now. How do you actually move evidence-based addiction treatment from concept to consistent operational practice across an organization. Most organizations are no longer debating whether medications for opioid use disorder work or whether rapid access treatment models improve engagement and outcomes. The evidence is there. The challenge now is how do organizations operationalize these approaches in real-world environments where there may be workforce resistance, competing treatment philosophies, staffing shortages, financial pressure, increasing patient acuity, and growing expectations from payers and regulators. Today, we're going to explore what it actually takes to lead that transformation using a real-world example of an organization that got it right. You know, why does this topic matter? Well, the substance use disorder treatment environment has changed dramatically in recent years. Organizations today are caring for individuals with far greater clinical complexity than many systems were originally designed to manage. Fentanyl and polysubstance use have transformed the overdose landscape. Co-occurring psychiatric conditions, trauma, homelessness, and medical complexity are increasingly the norm rather than the exception. At the same time, provider organizations are operating under enormous pressure, workforce shortages, burnout, turnover, reimbursement challenges and increasing expectations around outcomes, access and implementation of evidence-based care. And yet, despite growing evidence supporting MOUD, long-acting injectable medications, rapid access treatment models, harm reduction approaches, and integrated care, many organizations are still struggling with implementation. In many cases, the issue is no longer whether the evidence

exists, the challenge is whether organizations are truly prepared to operationalize These models consistently for day-to-day clinical practice. Because changing practice is really just about introducing a new policy or workflow, it often requires organizations to confront long-standing treatment philosophies, provider fears, operational habits, and deeply rooted beliefs about recovery and care delivery. Frontline teams are also exhausted. Staff have worked through years of escalating acuity, overdose deaths, staffing instability and emotional fatigue themselves. In that environment, even positive change initiatives can feel overwhelming if they are not implemented thoughtfully. That's why leadership matters so much and why today's discussion centers on what effective leadership looks like when the goal is sustained, culture-level transformation. Successful transformation requires leaders who can communicate transparently, build trust, create psychological safety, support workforce readiness, and maintain accountability around evidence-based care. The model itself is only part of the equation. We've had many of these models conceptually for many years. The real challenge now is whether organizations can operationalize them consistently and sustainably at scale. Joining us today is Dr. Mario San Bartolomé. Dr. San Bartolomé is a nationally recognized addiction medicine physician and healthcare leader with extensive experience advancing evidence-based treatment models and leading organizational transformation efforts in substance use disorder care. He's an addiction medicine specialist who is board certified in both family medicine and addiction medicine. He received his undergraduate degree from UC Davis, his MD from UC Irvine School of Medicine, and received a Master's in Business Administration from the Paul Merage School of Business at UC Irvine. Dr. San Bartolomé has leadership and health delivery experience in multiple levels of care related to substance use disorders, including inpatient medical withdrawal management and residential treatment and outpatient treatment, both in programs and in medical offices. Dr. San Bartolomé has served as director for the Medical Care Addiction Medicine Unit and has held directorships for several residential outpatient treatment organizations. He has been an active and passionate advocate for improving access to care for people with substance use disorders through leadership at the local, state, and national levels. As the Medical Director, Substance Use Disorders at KCS Health Center, he focuses on aligning strategy to improve the organization's ability to address member needs with all things related to substance use while moving forward initiatives to integrate behavioral health and physical medicine across the multiple vulnerable groups that his agency serves. With that, Mario, thank you very much for joining us today and we look forward to your presentation.

Dr. San Bartolomé 6:34
Thank you very much. Well, I am very privileged to have an opportunity to work at a Federally Qualified Health Center. And I think that's important because it very much colors my approach and also the fact that we get to serve a population that has so many facets of barriers. The barriers are financial, there can be transportation. I mean, not unlike other types of community clinics, but the FQHC is a special place. And I've had the opportunity to work with several FQHCs as it relates to integrating addiction medicine services into primary care. And KCS, although it

started off as Korean community services and still holds a very strong capability for meeting the needs of folks that are Korean and across all sorts of different types of services, We've also expanded and expanded KCS now to be a significant player in Orange County as it relates to providing substance use disorders treatment across all sorts of high risk groups.

So at KCS, besides this idea of being a community clinic and providing behavioral health and substance use disorder care, there was a really important need for integration. And the population that we serve really doesn't do well with one-off type of services as a very specific type of thing, really they do better as kind of a wraparound. And I know that wraparound is a term that's used all over the place. And I like to explain it as kind of like a blanket, a very heavy blanket that goes around people. And when we adjust it along the way, depending on what they need, we have patients that have very significant psychiatric needs, that are homeless, they're living in a shelter, they need care from there, they have no transportation, they have significant medical issues, along with sometimes being kind of a back and forth arrangement with the justice system. And so it makes taking care of just general medical things quite difficult, but tack on their substance use disorder and it makes it really, really challenging. The other thing to appreciate is that if you don't, there is some level of a priority. It's very difficult to improve somebody's, say, hemoglobin A1C or their blood pressure mark, you know, their diastolic and systolic blood pressures. If, say, they continue to be on, say, fentanyl. And so you do have to kind of look at, well, where am I going to put this effort to stabilize something so that I can also impact the rest of this individual's health a bit more comprehensively?

And one of the things that we see across most community clinics, and also, you know, we can actually use really just any sort of a health center, an outpatient health center, although I've worked in inpatient centers as well, and many of these things still hold true, that there's a focus on just getting the basics. The basics are, although they are important, like in the case of medication-assisted treatment, getting the medication is probably the number one thing in terms of the outcome, whether somebody has access or not. We also want to say, well, what do we do after we get that part? So traditional models will focus on getting access to the medication, but still, they're not quite sure why somebody shows up, why they don't stay if they did engage with them, or if they show up and then they leave before being evaluated. These are all sometimes failures of engagement that occur and people sometimes need to be transitioning between different lines of services that are important for their overall health. The other thing that I think is also not discussed as much, but I certainly deal with it and get contacted by individuals, is that sometimes people burn out. So if the organization itself does not have the leadership to be able to mitigate this, you know, challenging patient population as it relates to the providers that are giving the care, and this is not just medical, I mean, I'm talking about the clinical staff, the medical staff, as well as even some of the other ancillary services that people will burn out and you will lose really good, really good resources. And every day we know that the goalpost moves a little bit. We have different substances. We have emerging

substances. Right now, we're in our 4th wave of the opioid epidemic. And fentanyl with psycho stimulants are driving a lot of the fatalities. We've had good news pretty recently in terms of some of the drops that we've seen in terms of deaths. However, we still have a lot to do. So fentanyl and Xylazine and Tianeptine and all these other things that keep emerging now, that we keep seeing, they are still impacting our patients. There are many co-occurring conditions that make things quite difficult too. Some people don't even think about, like say somebody with obstructive sleep apnea but might have an opioid or a benzodiazepine use disorder significantly increases the risk, say, of dying. So how do we approach those? Folks that are incarcerated environments, and sometimes that has to do with their preparation before they go into an incarcerated environment, and other times it's on re-entry when they come back. And within the first couple of weeks, we know that they're almost up to 13 times higher likelihood of dying of an overdose in that immediate two-week period. So it's a very special population. And then when they come out, things don't necessarily get better when it comes to housing and dealing with the usual health system. And the usual health system, unfortunately, still has people referred out for everything, you know, seeing the GI person on one side, the cardiovascular guy on the other side, or the endocrinologist versus getting things taken care of in one location. So fragmentation is difficult just from the standpoint of even, say, transportation, where somebody has to take three buses to get to you and if your systems aren't set up to be able to handle somebody that might be late. That third bus may have been late. Maybe they're late. They'd spent half the day to get to your location that your scheduling, for example, needs to be open enough to be able to still serve them and to not be another barrier along the way.

So at KCS, we aggressively attacked the problem of access. That was the first thing. We knew not only from experience in the community, but also from talking to folks that were either coming out of the jail or being seen from shelters, that one of the most common things that people would say is, I just can't get in. You know, I'm withdrawing now and they're telling me I have a three-week wait. And so what am I going to do in the meantime? The likelihood of that person coming back after three weeks of you just telling them to say, yeah, well, I guess you're going to have to keep using your fentanyl and meth and everything else, when they have, you have a special moment when their motivation is ripe. It's the time to engage. So we immediately incorporated telehealth to be able to solve some of that. We changed things like the paperwork that was necessary to make it very basic in order to be able to get the first evaluation and then we would continue to get the rest. We also made a tough decision that I think is also difficult for a lot of folks is sometimes you have to know that even some of the financial information of things is like that might take a back seat before you figure it out and with it, whether it means insurance, somebody's active insurance or not. And what do you do if they are staying unstable at the moment that they present? Many places will just say, well, we just send them away. And so that's a fundamental question of who are you going to be in your community as far as the clinic or whatever the healthcare organization, what are you going to represent? And that's a question every organization has to decide for themselves. But also this idea of expanding the types of

somebody needs to be involved in if they're providers or even if they are front office staff making appointments for people. Everybody needs to be trained and we flatten that knowledge across the whole organization. But even though we did great at some of those, we thought, certainly we thought better than most clinics that are out there, we still have a lot to learn and a lot to do. for our patients, because what remains are these other barriers that show up that might have to do with the type of patient, for example, perinatal substance use. And there's the issues of making sure that they have a family wellness plan filled out, preparing them for neonatal opioid withdrawal, preparing them for parenting. These are things that they're quite important. It's not just pick up your medication. We also had the need for figuring out, well, what about when we want to engage the rest of the family? What if they're not local? How do we do that? And we engaged, we can do that with telehealth right now as well. And there are several things along the world of SDOH, the social determinants of health, and leveraging what is already in the community. All of those things had to live somewhere with somebody that was going to be responsible for those things. And so those were those were the things that we came add to say, this needs to be part of the blanket that wraps around people, all of these things. They're going to decide those things of how successful we are. We got the medicine, we get the diagnosis, now what else? And so these new capabilities really required us to say, well, you know, even even for some of the things that aren't worked out completely, like not everyone's using contingency management, but it is something that's been around for a while. It is evidence-based. And we said, well, let's do that with our support groups. Let's engage folks with our psychoeducation groups. Let it be led in part with peer support as well as with some of our licensed therapists. They can even be integrated with groups where people are getting refills, but it ensures that they have at least a touch point where they're also getting psychoeducation. And they also have an opportunity to engage with one of the medical providers to see if they need a higher level of care or some sort to address something more specific. And that's important because sometimes, even when somebody's in maintenance, it doesn't mean that they stay there. At any given time, somebody can fall off the matrix. They might have a recurrence and they, and they may not know exactly what to do, but hopefully we've done our job to help them feel comfortable enough to say, well, look, you're not going to get kicked out. What happens is we just put our heads together and we come up with better solutions. Sometimes a solution might be, we need to have you go to an IOP in addition to what we're doing, or maybe you need to be in residential treatment, and then we can help the person connect in an appropriate way. And so we included LCMs or lead care managers, trained them to be able to help patients that might be in an unfavorable state to be able to manage making 20 phone calls, seeing who has a spot for a bed open or an intake, or to just engage with the county who has, you know, this funnels that can help the county assist in getting them care for higher levels. But all of these things became important. And then these structured tracks also kind of came out. So when we are providing people with services from the standpoint of substance use, you can begin to see where some of the kind of these areas that are extra challenging. And so sometimes that can be somebody that is a re-entry type of person, or

maybe somebody that has relapsed and, you know, what do you do post-relapse? Do you just have a conversation with them, or can you now have a structured program for them internally to be able to support them in the immediate period after a type of a recurrence to get them back on track and to figure and to also figure out what didn't go so well and how do we refine your new tool, and those are things that we really wanted to focus on in our what we called our SUD 2.0, and so there are many, many, many areas, including employment preparation, that, you know, because a lot of these individuals, they may have felonies, they may not appreciate kind of how to go about things, even things like filling out resumes are potentially a problem. But certainly being independent and self-actualizing from the standpoint of getting employed and moving forward is part of recovery. So these are things that we really should be on the hook for if we can. So what I'm describing to some degree really is, it's across the whole organization. It's a system. It's not just any one thing. Each of these areas has challenges and how do we integrate them to be able to be of use to anybody that might need them? And then how do we make sure that we're constantly reassessing that?

So, what our wrap around care model, which I kind of already told you, is to I envision as a as a heavy blanket because it kind of molds to you and and and so and we need to do that quickly, right? When we start seeing somebody quickly assessing, so that low barrier entry and then figuring out what their particular needs are depending on the individual, and then to create a treatment plan that immediately reflects that. So what we wanted to avoid and what we avoid right now is a one-size-fits-all. That somebody comes in and we say, oh, you're going to be seen once a week. You're going to just receive the medicine, we're going to check in on you, you're going to do a urine drug test X number of times or maybe on a random basis. We really wanted to have a process that might say, well, look, immediately what we need to do right now is, hey, you are in the middle of hepatitis C treatment and you've fallen off and we're at risk that you might not have a successful treatment. Let's immediately get you re-engaged with that. In addition to your to your medication-assisted treatment, or you haven't had your psychotropic meds that have stabilized you and you're hearing voices again. That becomes something immediately we have to take care of. So this philosophy around the wraparound is that it molds to you, it molds to who you are, what you need at the moment. And we know our community and we want them to feel that all treatment is individualized.

So as mentioned before, we really leveraged telehealth in particular, even created space in the clinic for allowing for little pods for people to be able to receive service through telehealth pretty much immediately, many of the times. And the goal was to just minimize all aspects. We put it, we put our intake forms online. They can be filled out online. So you click it and it goes directly and you don't have to fax it to anybody. You don't have to do any of those things. Those are always barriers. If you're at a shelter, where are you going to get your fax machine? Where are you going to get paper? And do you have to take, you know, does transportation become an issue? So immediate access and then immediately figure out, as I kind of described before,

champion and you know that we've recently have now began to appreciate as well having a mid-level peer champion. So having somebody that's an advanced practice nurse or a psych NP, that also has the training in the substance use that has passion. Because I mentioned, as I mentioned, we're a team and in a lot of clinics, the models of care are not heavy on the physician side. They also include the advanced practice nurses and so, and physician assistants. And so we want to be able to also have a champion for them as well. And we believe that that's also very important. And we need to have the staff that provide other services, even the ones that are just at the front office, also feeling safe. If a patient comes in and is unstable and they don't feel safe, then that's going to hurt our ability to take care of people because even they learn that your tone of voice, your words, your posture, all of these things matter too when you engage with our patient, whether they're going to come back or not, whether they feel the blanket wrap around them or not. And so we repeat this with lots and lots of training. In fact, I still hold, initially it was every week, right now it's every other week, that we offer training around this topic of substance use disorders and Matt. We actually hold it open globally, really. I mean, anybody that wants to, because we do it virtually, and we do have lots of physicians, therapists, peer support folks, NPs, PAs that attend them every other Friday. So we also kind of take the approach of being an advocate and teaching the community about these solutions and these things that could come up. So we will go over cases, complex cases and things like that. So lots and lots of importance around the leadership.

And, you know, I would say that all of these components really come together and they resonate well when there's at least capacity for each one of those things. So when people feel trained, well-trained and supported, when people know that there are multiple resources internally, so they don't have to do everything, right? Whether it's a physician or say an NP that says, well, how am I going to also do, I'm going to do motivational interviewing, I'm going to prescribe the medications, I'm going to take care of their hepatitis C, I'm going to take care, it just, you keep, oh, and 15 minutes. And so it can't be just one person. It needs to be flat. And there's needs to be multiple points of ownership, starting with leadership all the way down to, boy, I mean, we even at one point offered training to the folks that were helping us in maintenance, just so that they know they're around. So, you know, when things happen, they need to know. So that's also, there's also a pruning effect that I think was important for us. And by that I mean, no matter what you start with, there will be people that are not focused on your mission. And so sometimes you need to prune like a little bonsai tree who your who your who your who your folks are at your clinic so that they understand that people share the idea of what you stand for in your clinic and in your community, or that you appropriately place people that their gifts and their interests match the patients that they will be most exposed to. And maybe the person that doesn't fit, you know, square peg, round hole type situation, that you have them doing something else, and if they're still good. But that's an important aspect as well. And you cannot be always having to convince somebody that they need to help the patient. And we know that stigma kills, and we know that stigma and bias exists in all of us. And that's why we need to always be aware and

cognizant of how it impacts our ability to take care of people.

In terms of metrics, this is an evolving area for us. We started off on the most basic type of things where we're looking at just, you know, how many patients have we served? How many prescriptions have gone out? And then we start looking at other metrics like our ability to engage. You know, are people still around with us in six months and 12 months? If they're not, do we know why? Why did they leave? Did they move? Did they have a recurrence? Did they have, did they pass away? Right? Our patients pass away. You know, untreated, if they fall off the grid and we don't re-engage them again, substance use disorders can be, you know, high fatality. And so these are all important things that we look at. We prioritize hepatitis C treatment and also look at ways to treat other disorders that maybe we're not as equipped with, but we have partnerships with, like for HIV. And then we maximize as much screening as possible. So all those are good, kind of easy ways, easy things to measure. You can leverage your electronic health record in many ways to be able to do some of those things. And others are more difficult that maybe, hopefully we'll get to one day where we might, you know, brush against the topic of how many people entered a sustained recovery for one year, two years, and what are they doing? You know, how many also we have, we had a need that came about of people wanting to come off of medications like buprenorphine, even though we have a fairly, you know, evidence-based slant for keeping people on the medication, there's patient autonomy and sometimes they want to come off. Well, if they do come off and now their risk of relapse is high and relapse can be associated with overdose and overdose is associated with death, what are we doing to provide a safety net for them? For what we can foreseeably see might be an issue, regardless of, you know, what their wishes are, that we have to still be mindful of what can come before us, you know, or, you know, in the future for us to be able to still secure their safety and risk reduce, mitigate as much as possible.

Dr. Buttlaire 38:31
So thank you so much for describing KCS Health Center. You know, your passion really comes through in your description of the program and how you think about patients and how you think about the organization. I have a few questions that I'd like to have you think through, maybe perhaps discuss a little bit. So let's go to the first question. Many organizations, you know, are really moving beyond getting people through the front door. You know, they have the basic access down and they need to move to a more fully integrated SUD care system. From your perspective, what operational capabilities become most important once access is no longer the primary barrier to people getting served?

Dr. San Bartolomé 39:26
I think you have to start with the end in mind. Where do you, once you see this person that's, say, in recovery and has had their medical needs met, their psychiatric or psychological needs met, that they, what does that person look like? And then you need to work backwards and say,

resources, not even just with medication-assisted treatment, which traditionally has revolved around opioids, alcohol, and I think it's reasonable to say also nicotine use disorder, where we have FDA approved medications. But rarely does somebody come with just one thing. And so what do we do also when they have other needs still even within the scope of substance use disorders, and can you prepare your staff to take care of those things as well? And we also need to know that a large proportion of these patients have co-occurring mental health issues, and those need to be at various levels need to be handled. We need to figure out what maybe is appropriate, maybe at the primary care level, what maybe really necessitates A psychiatrist to be involved. And then also for therapists, the role of therapy and things like cognitive behavioral therapy and then the integration of counselors. So the peer support. So all of these things are important as well as training staff just in general in the organization to understand the ASAM levels of care. And the reason that's important is because it's not really obvious. And unless you really work in the industry, it's one of those things where you go, huh, what's that? And it certainly is not trained in medical schools for the most part. Maybe you're lucky if you did a psychiatry residency, you may have heard about these levels of care. And then oftentimes, even if you know those things, there's the additional complexity of county, how they do things. Every county does things potentially a little different. So those are all important things that you have to keep on top of. And so access, really understanding what those touch points are, understanding what the patient's needs are at the moment and prioritizing them. That's one of the things that helped us really squash the whole access issue. And we now can see folks same day, maybe, you know, oftentimes when they walk in and we can just get them into a special room that's confidential. We do the basic paperwork and we get them connected either in person or at the telehealth appointment. In our clinic, we also actually have a pharmacy in the clinic so people can walk out with their medication because that's an added barrier for anybody that's been involved in medication assisted treatment. One of the main barriers that we also deal with is at the pharmacy level, is the patient not being able to actually access the medication for one reason or another. Sometimes if it's a telehealth appointment, if the person happens to be out of county, the particular pharmacy will reject the prescription because it's not in their local community. So it creates a whole other thing where, well, you have to have staff now to allow the provider to be able to continue to see, do their job seeing the next patient while somebody else is potentially handling that. You have to know that. So the access is not just at the point of when they walk into the facility. It's can they access the medication? Can they have transportation for the next follow-up? Do we have capacity to see them if you did an induction? And I'm speaking now buprenorphine language when we're talking about opioids, you know, after an induction, we want to see somebody soon after. So four weeks out is not appropriate, and that's all that's all infrastructure and work and and and and workflow.

So we really felt comfortable with what we had already accomplished from the standpoint of access and thinking through these more acute circumstances. And we buffed up our policies and procedures and trained everybody. In fact, we have an actual specific training program that

where you're stratifying, you know, where are the big risks and what does this person need right now? And then we need to look at our resources. So our staff, the most important person from our staff standpoint might not be the physician, it might be somebody else, and so that most important person, at least for the immediate taking care of what needs to happen, we need to engage them and in the team. So this is always a team type of approach, and it is not it's not medical centric, so to speak, and I think that's that's an important, but it is still there's a champion behind it, but it's not, you know, left alone.

So I can't emphasize enough, and I really feel privileged that the leadership at KCS, and I'm talking about the CEO, the COO, and the other directors that are there, they get it. And that's who sets the mission. That's who sets the tone. I mean, I'm not talking about rocket science here and we didn't invent anything. OK, this has been this is discussed on many in many industries, but I think in healthcare, one of the things that's also very important is that we model. We've modeled that. So our leaders are part of the meetings that we have as well. And those meetings, and they show that their interest in solving things. When something comes up, they immediately allocate the resources necessary to not become a bottleneck in how, you know, what our internal resources are. So I just can't stress and we're lucky that our leaders, you know, for example, our CEO was once upon a time a social worker, an attorney, and has a great passion for serving not only the Korean population and other Asian populations, but just in general in the community in our county to be significant and to really, sometimes we have to take it on the chin in one place. We know that. But at the same time, still have the smarts to be sustainable. And then the competence came when, I would say as a medical director from the standpoint of substance use, again, leadership was aligned. They said, okay, hey, you know, Dr. San Bartolomé, you think they need to know these things? Go do it. And we will include it as part of their onboarding. And I didn't have to convince anybody. I didn't have to, you know, get shortchanged or say, oh, they can only train for two hours. So that's not enough. And it's significantly more and they have to essentially go through go through a rigorous process to make sure that they feel comfortable. Because if you don't have your medical providers comfortable, what happens is they get distracted with feeling liability. They get distracted with feeling unsupported. They burn out. That's not what we should be thinking about. We should be focusing on what does my patient need and how can we meet that need? And so somebody that understands and is also felt, feels the support, and by that I mean, I'm on call 24-7 at my clinic for a text message, an email, whatever it is, at bedside that somebody can message me to resolve an issue. And sometimes, and it's because you don't have all the answers just because you went through some trainings. And some of them are quite important. Say, hey, somebody says, this person's, you know, looks like they might have cirrhosis, what do I have to take into consideration if we're going to use these medicines? Those are important questions that they need immediate answers for. And if they don't get it, what happens is they fear that whatever choices they make from the standpoint of these substance use disorder medications, they might hurt the patient. Again, a distraction. It shouldn't be there and it just increases human error too. So on our side, having a clinical

where are my gaps in my facility with my resources that will enable us to be able to get that person to that point. So if you have zero access to therapists or to a mental health group or to people that might be peer support in your organization, or just trained individuals. If you just have one provider, let's say, that is the only one that got trained, that is a recipe for burnout. And then you'll lose somebody, and then when you lose them, you'll have no way to fill that gap. So cross-training might be also an important thing. So once you figure out what it is that you want to be able to provide and what you can't, you also have to see, well, what are we not going to be? And then figure out who you're going to collaborate with to be able to do some of those things that you then work backwards to figure out what sort of a hire do you need and what sort of skills do you need to give your current employees to be able to make, you know, the nodes in that matrix that needs to be created for your clinic. You also have to consider that your patient population, where you're at, you know, even in a pretty big county like Orange County, certainly one like Los Angeles County, where depending on where you're at, could also dictate where you use to prioritize. And so if you have a heavy emphasis on folks that are unhoused or a heavy emphasis on re-entry, or maybe you have some sort of agreement with juvenile hall, so you have a lot of adolescent, that you have to then build that out. And so operationally, you have to have those competencies in there to be able to then reach that final point of where you see that person you supported.

Dr. Buttlaire 41:32
What I hear you saying is really first understanding what the person's really needing and then building the program around them to the extent that you can. And if you can't provide it within your services, making sure that that person's getting their needs met through a larger system of care. Do I have that right?

Dr. San Bartolomé 42:03
Yeah, so, you know, a lot of people refer people with substance use disorders for mutual support. But maybe you say, well, we have an opportunity here to provide some sort of a mutual support internally. You have a day of the week that you offer your patients to re-engage with you. And so those are opportunities. That's an opportunity to incorporate contingency management so that they stick, that there's a stickiness to you. And they really, at the end of the day, should be seeing you as a medical home. So you do absolutely need to know what their needs are and then to be able to figure out how to match that.

Dr. Buttlaire 42:41
Thank you. Next question. So workforce resistance remains one of the biggest barriers to implementing evidence-based SUD treatment. What leadership behaviors or actions most strongly do influence long-term workforce adoption and engagement? How do you move the workforce to a place where they really are understanding engagement?

Dr. San Bartolomé 43:09
I really see three prongs to that. The first has to do with just who you selected in the 1st place. Now, obviously, if you already have a workforce, you didn't, it's too late for that. You already have who you have. And so that's a whole separate, maybe involves the second area a little bit more. But as you have opportunities to grow, that needs to be something that you mindfully include in your hiring, that you ask those questions. How do you feel about seeing patients with substance use disorders? And it could be that simple. You'll see, you'll quickly see in body language or maybe interesting curiosity. So you know what, I've never taking care of people with substance use disorder. So I'm not sure what that is, but I'm happy. I'm interested. I have no problem with that. Well, that's wonderful. Somebody's a little bit, you know, open to that versus somebody that says, well, I'd be a little scared and you know, and thank them for their their openness about it as far as being, you know, truthful, because maybe that's not the person that you need because in, especially in like an FQHC, for example, and this maybe could be mirrored in a lot of other types of environments involving substance use, is that you're often left with MacGyver medicine. You have to do whatever it takes and you have to figure out how to be very creative with sometimes less resources than than most. And so, so that's one is the selection part and that needs to be ongoing as not only with the people seeing patients. And the second one is in the training. You have to invest in the training. Most people will not know all of the ins and outs of treating patients with substance use, if you can get at least to the basics of the medication, that's one score for you. But it gets complicated pretty quick with whether somebody's on sublingual or long acting or how do you take care of somebody with co-occurring pain syndromes and so on and so forth. So they're going to need ongoing support from leadership to be able to feel comfortable. And then when they feel comfortable, they can focus on taking care of the patients and not in making a mistake. And then I would say that the third one would be in cultivating a strong sense of support from the organization to those patients who are, excuse me, to those providers who are putting themselves out to be open to seeing highly complex patients and that you match that with how you incentivize them, that you match that with not only monetarily, but also internally with the, you know, the kinds of, there's other non-monetary ways to do that, that are actually quite effective as well to recognize people for that extra mile that they've impacted somebody's life. And you know, by doing that, you also, I would say most of us in any branch of healthcare, however you touch to healthcare, even the accountant that happens to be the CFO for a healthcare organization, but certainly the providers, you probably had some version of a personal statement somewhere in your training where you said, you know, I really want to help people. This is part of this. It matters to me that I'm doing something where I'm helping people. And it's ironic that so many people fear treating folks with substance use disorders because when you do get an opportunity to do that, invariably, you will be brought to your personal statement and feel a level of fulfillment because there's transformation that's happening in front of your eyes versus tracking a number like a hemoglobin A1C or something along that line. And so that reinforcement is part of how you keep the fire going for your organization to be meaningful, to feel meaningful for your community. At the end of the day, we exist for that

purpose.

Dr. Buttlaire 47:14
Thank you for that. And that's a really good description of how you really can, you know, work through some of those issues related to the workforce and so from selection to encouraging people to do their best and to support them in doing that as well. My next question to you is, related to finances and also with in terms of maintaining patients and the realities of the world that we live in now. You know, many provider organizations worry about sustainability when expanding wraparound services. One organization that I work with has told me, you know, they just can't get the support and payment for some of the additional services that are so important in keeping people in RAP and helping benefit them. So what are your thoughts about, you know, the financial, balancing the financial realities with the long-term patient outcomes, and engagement and the system impact?

Dr. San Bartolomé 48:20
Yeah, that's a great question. And there's no simple answer for that because it's ever changing, especially in the world of substance use disorders and mental health, particularly in our country right now where there's, you know, a crisis around overdoses and substances and funding for, you know, public programs. There's an ever-changing type of stressor, I think, for organizations. So that's very legitimate to be. And I think it also has to do with how you identify the wrap-around. So if an organization is stuck with what that specifically that means because of a program or some other, then that's a little bit more difficult. But I think I like to think of the wraparound not so much from the jargon that we tend to use, but to think, well, what's the wraparound necessary in my community for my patients where I'm at? And those can vary. And there's a balancing act where from the standpoint of the organization, certainly in FQHCs, for example, and this would be less applicable for private clinics, you know, private primary care clinics, for example, but targeting the types of grants that support across multiple functions that allow you to or and other sources of funding that allow you to be able to to sometimes take it on the chin and then and then sometimes not. So an example of that would be for, say, peer support, you know, integration. And that may be an area that your clinic doesn't need, you don't feel it needs it, but for those that do, then that could be an area where you intentionally grow those out. And that, again, has to come from leadership that creates those resources intentionally and mindfully that and then you're not distracted by other things if that's a priority. Now, there's lots of different ways that that happens at a clinic, particularly a community clinic, which could be immunizations, it could be cancer surveillance, you know, and screening, it could be all sorts of different things. And so that priority needs to be there. So there's not any one answer except that you have to be nimble. And in general, I think it's very helpful to have, just like there's a champion from the standpoint of the services. My experience is that you also need somebody in the organization that is the champion for finding those opportunities. And that might be in the form of somebody that writes real good grants, or knows how to be able to

collaborate with other organizations for shared goals in terms of, you know, whatever programs that are out there. So not one approach, but certainly being nimble and having that competence on board makes a big difference if somebody's making it their business to just make sure they can do that for you.

Dr. Buttlaire 51:25
We just have a couple of minutes left, and so, you know, looking at this last question, you know, what operational, you know, give us one or two examples of what operational or system level changes will organizations need to make to remain effective in the evolving SUD treatment environment? You know, one or two quick thoughts.

Dr. San Bartolomé 51:52
Well, so, you know, as an extension of that last point, I know for us, we have somebody that we've engaged from the standpoint of quality that helps us meet the metrics that are necessary to succeed at the reporting for those types of grants and programs that we engage in.
but also is involved in figuring out which ones we match the best with. And that's all she does in terms of one of those, and that's a lot already, right, with some of that. But that I think makes a big difference for helping us continue to expand. And sometimes you might find that there are opportunities to expand in an area you didn't think about. Like, maybe there's a, you know, some sort of an opportunity to learn and implement PrEP for HIV, you know, you know, and so you, that might be another way that you can also impact what you do for SUD, right? So maybe, you know, You don't think it's related, but yes, it's actually very related as a high, as a high co-occurring type of thing that's a need.

Dr. Buttlaire 53:01
Thank you. Mario, this has been an extremely thoughtful and a very important discussion. You know, the theme I keep returning to throughout our discussion is that organizational transformation is not simply about adopting a new clinical model or implementing a new workflow. It's about leadership, workforce, engagement, trust, accountability, and really creating the organizational conditions and environment where evidence-based care can actually be delivered consistently and sustainably over time. Mario, again, thank you for joining us and sharing your experience and insights today. And to everyone who joined us today, thank you for the work you do every day to improve care and outcomes for individuals and families impacted by substance use disorders. And we look forward to seeing you at our next Recademy session. Thank you all.

Dr. San Bartolomé 53:59
Thank you.