



SAMHSA-HRSA Center for Integrated Health Solutions

Treatment Innovations: Perspectives from Addiction Providers Integrating Primary Care

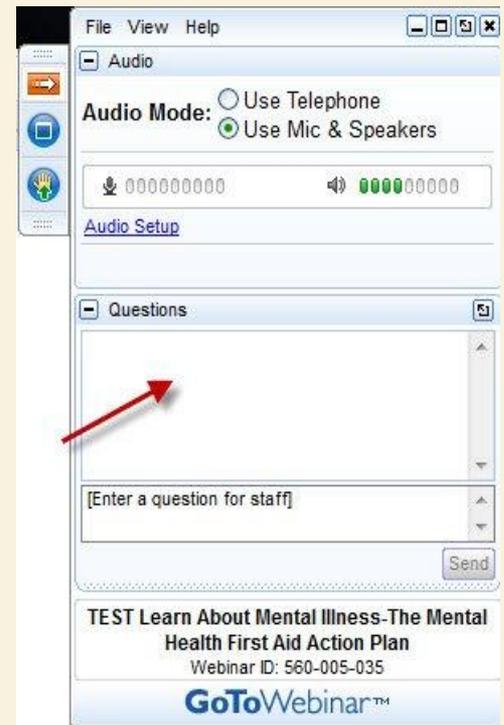
Prospective from Providers

How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**





SAMHSA-HRSA Center for Integrated Health Solutions

Integrated Substance Abuse Treatment in a Federally Qualified Health Center

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Conflict of Interest Disclosures

Name	Commercial Interests	Relevant Financial Relationships: What Was Received	Relevant Financial Relationships: For What Role	No Relevant Financial Relationships with Any Commercial Interests
Titan Pharmaceutical		Travel support		
Braeburn Pharmaceutical				Advisory Committee
BioDelivery Sciences International		Grant support to my institution		Advisory committee
Orexo AB		Grant support to my institution		



Stanley Street Treatment and Resources, Inc. (SSTAR)





Introduction

- Overview of SSTAR
- Overview of SSTAR's Family Health Center
- Overview of SSTAR's Office-Based Buprenorphine Treatment Program
- Description of protocols
- Treatment outcomes
- Financial data

Overview of Stanley Street Treatment and Resources, Inc. (SSTAR)

Founded in 1977 as a private, not-for-profit organization

Original programs included: 20-bed alcohol detox, out patient alcohol treatment program and education program for persons convicted of DUI's

Currently, Fall River site provides:

- Inpatient detox, Dual Diagnosis detox and stabilization
- Open access IOP, MH and SA counseling
- Community support program
- ARISE family interventions
- Buprenorphine
- Primary health care services in TWO clinics
- Methadone maintenance clinic
- Population-specific services such as domestic violence counseling and HIV/HVC/STD counseling & testing

Two additional sites in Rhode Island: one providing inpatient detox and another providing long-term substance abuse treatment for mothers and their children

Overview of Family Healthcare Centers

- Established as leadership realized our patients were not receiving adequate primary medical care for:
 - Diseases related to substance use
 - Mental health issues
 - HIV/AIDS
- Opened primary site in 1996; second site in March 2012
- Currently classified as a 330 Federally Qualified Health Center (FQHC)

Overview of Family HealthCare Centers

- Staffing
 - 3 Family Medicine physicians
 - 3 Family nurse practitioners
 - 2 Psychiatric nurse practitioners
 - 0.2 FTE ID MDs
 - 0.6 FTE Pediatrician
 - 0.2 FTE Psychiatrist
- 118 total employees
- Provides chronic illness case management for diabetes, hypertension, asthma, chronic pain, HIV, and HCV

HealthCare Center Statistics

	2011	2012
Number of unduplicated clients	4773	5152
Medical visits	21,511	21,353
Mental health visits	4281	3769
Unduplicated mental health clients	620	802
Substance abuse visits	4861	17,107 (MMP opened in 3/12)
Case management visits	3631	5462
Relapse prevention groups	1842	2276
Methadone group visits		2061
Total clinic visits	35,611	49,004



Primary Diagnosis: Patients' Presenting Problems

	2011 (Primary)	2012 (Top Three)
Alcohol disorder	1%	2%
Substance abuse disorder	10%	29%
Depressive disorder	5%	15%
Anxiety disorder and PTSD	4%	2%
Other mental disorders	4%	2%
Totals for mental health and substance abuse	24%	60%



Screening in Healthcare Center

- All patients are screened with Cage-aid at initial visit and annual exams
- Nicotine use is monitored as a fifth vital sign and is one of our FQHC quality indicators
- Clinic is initiating carbon monoxide monitoring
- BAL's available on all clients and urine toxicology screens ordered when indicated to monitor prescription compliance as well illicit use

Medication Assisted Therapy (MAT)

- MAT for **Nicotine Dependency** is provided by individual practitioners
- All current, evidence-based smoking cessation aids are paid for by Massachusetts health plans
- Practitioners utilize Chantix, Wellbutrin, as well Nicotine Replacement Therapy (NRT)
- Individuals wishing to stop nicotine use are referred to QUIT WORKS
- Individual smoking cessation counseling is also available

Medication Assisted Therapy

- **QuitWorks is a free, evidence-based stop-smoking service developed by the Massachusetts Department of Public Health in collaboration with all major health plans in Massachusetts.**
- Using a simple form, providers refer patients to the Massachusetts Smokers' Helpline. The form is faxed or electronically transmitted to the Helpline.
- Helpline counselors make up to five attempts to contact patients and offer quit smoking services. Counselors also screen patients for **eligibility for 2 weeks of free nicotine patches.**
- Six months later, the Helpline evaluation team attempts to contact patients who completed an initial screener call. During this call, they assess smoking status and success with quitting.
- Providers receive faxed reports from the Helpline after the initial and 6-month follow-up contacts with referred patients.

[How it Works: QuitWorks at a Glance](#) provides more details.

<http://quitworks.makesmokinghistory.org>

Medication Assisted Therapy

MAT for **Alcohol Dependency** is provided by individual practitioners

Oral naltrexone, Acamprosate, and Antabuse are paid for by Massachusetts health plans

Injectable naltrexone, or Vivitrol, is increasingly available, but often requires prior authorization and may not be covered

Health center nursing staff have been trained on the administration of Vivitrol and it occurs within the routine flow of our clinic

Medication Assisted Therapy

- MAT for **Opiate Dependency** is provided in specific clinics
- SSTAR currently owns and operates a methadone clinic which is now located in our newest Family HealthCare Center site. We provide evening dosing.
- Methadone is paid for by Massachusetts health plans
- Methadone is prescribed by an ASAM-certified physician and NPs who are supervised directly by this physician
- Presently we are serving **603 clients**
- Injectable naltrexone, or Vivitrol, is also an option but patient acceptance and insurance coverage issues are complex

Why Buprenorphine?

How the decision was made

Agency philosophy

- Utilize evidence-based treatments

Community need

- High incidence of opiate addiction

Limited treatment access

- Inpatient detoxification and methadone maintenance only options

Our desire to expand treatment capacity

- Working people were unable to commit to inpatient admissions

Coverage available

- Buprenorphine was paid for by Massachusetts Medicaid

First induction: September 2004

SSTAR's Healthcare Center Model

- **SSTAR is committed** to providing buprenorphine to Healthcare Center patients
- SSTAR requires that **every physician hired** obtain or currently possess a DEA waiver to dispense buprenorphine
- SSTAR has also hired:
 - 3 full time RNs
 - PT program assistant
 - PT medical assistant

SSTAR's HealthCare Center Model

- Suboxone patients **must also receive their primary health care at SSTAR**
- Inductions occur on site, guided by written protocols
- Once inducted patient are seen weekly by buprenorphine provider or nurse for 12 weeks, with a pill count at each visit and UDS as indicated
- Client attends weekly relapse prevention group for 12 weeks and then if **abstinent and adherent** may begin monthly group and clinical visits

SSTAR's HealthCare Center Model

- Once long-term sobriety established, may be given refills and seen in clinic every two months
- Individual counseling is offered and available to all patients.

SSTAR's HealthCare Center Model

- Diversion = Immediate discharge
- Illicit use:
 - Random UDS and pill counts
 - Weekly visits
 - Increased SA treatment (1:1, IOP or detox)
 - Eventual taper or referral to methadone or daily buprenorphine
- Former clients can reapply **at any time**

Notable Features of SSTAR Model

- **Collaborative care model**

Alford DP, LaBelle CT, Kretsch N, et al. "Collaborative Care of Opioid-Addicted Patients in Primary Care using Buprenorphine." Arch Intern Med, Mar 2011; 171(3):425-437.

- **On-site induction, not in-home induction**

- Significant physician involvement

- Regular multi-disciplinary team meetings

- Psychosocial treatment done within SSTAR system

- **Harm reduction philosophy**

- Goal is to keep patients in treatment

Whom Do We Treat?

75% Medicaid, 5.8% private insurance

26% Employed full- or part-time

55% Unemployed

49% Heroin users

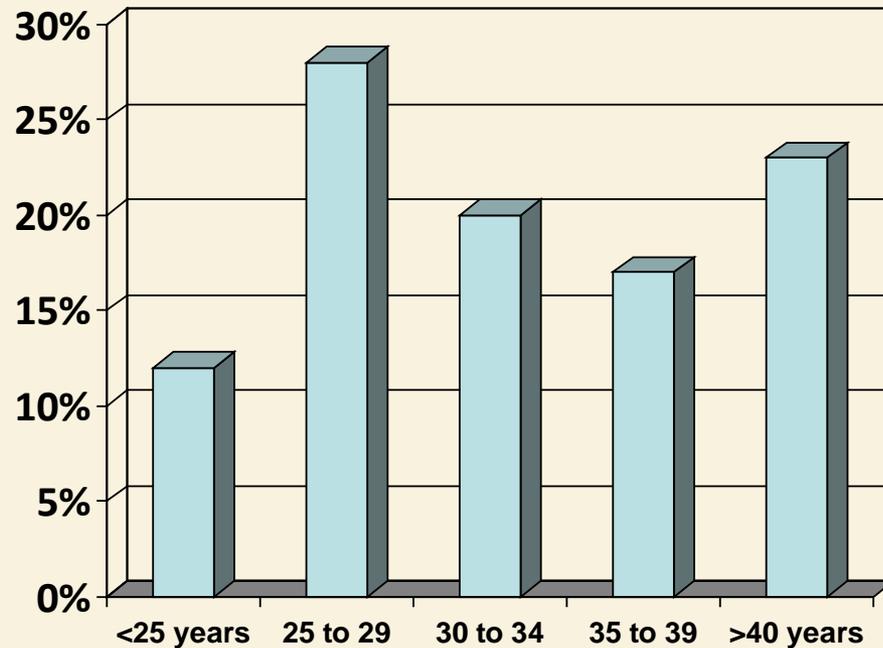
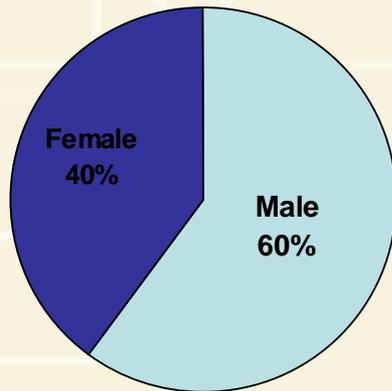
37% Other opiates

47% IV use in last 12 months

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau.
OBOT Admission/Enrollment Profile. July 1, 2011 through June 30, 2012:

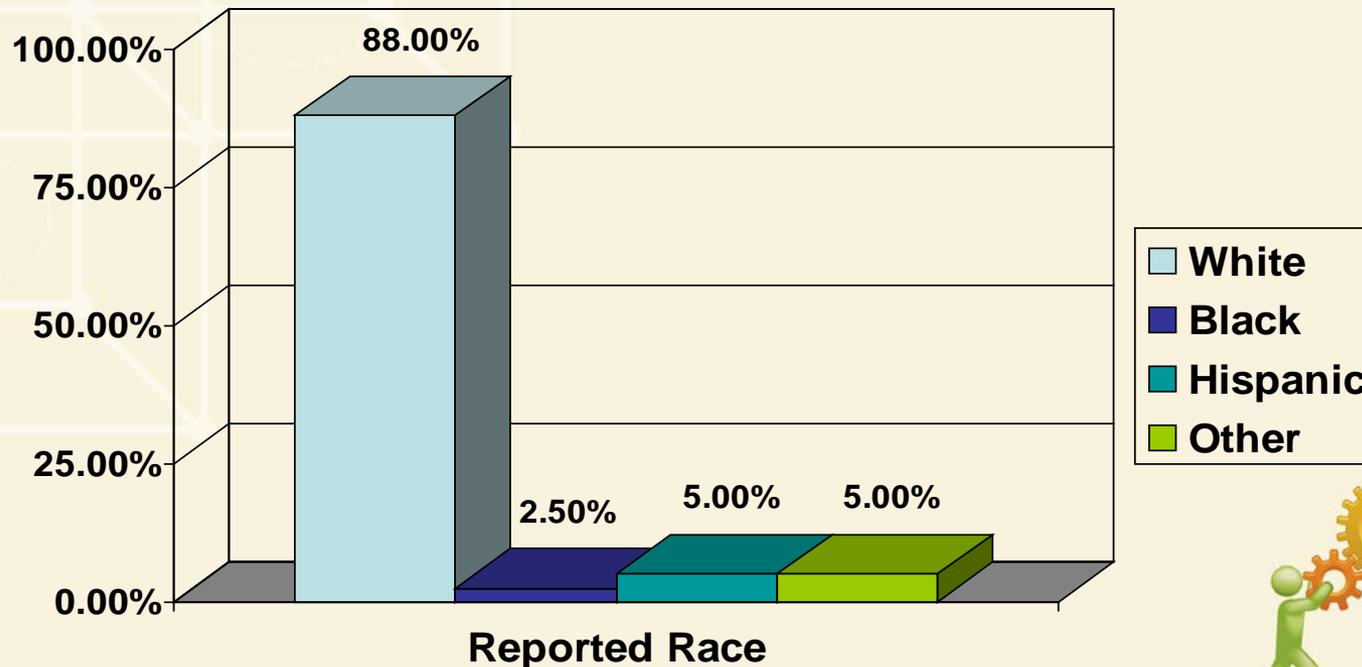
Whom Do We Treat?

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Whom Do We Treat?

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How Are We Doing?

Access

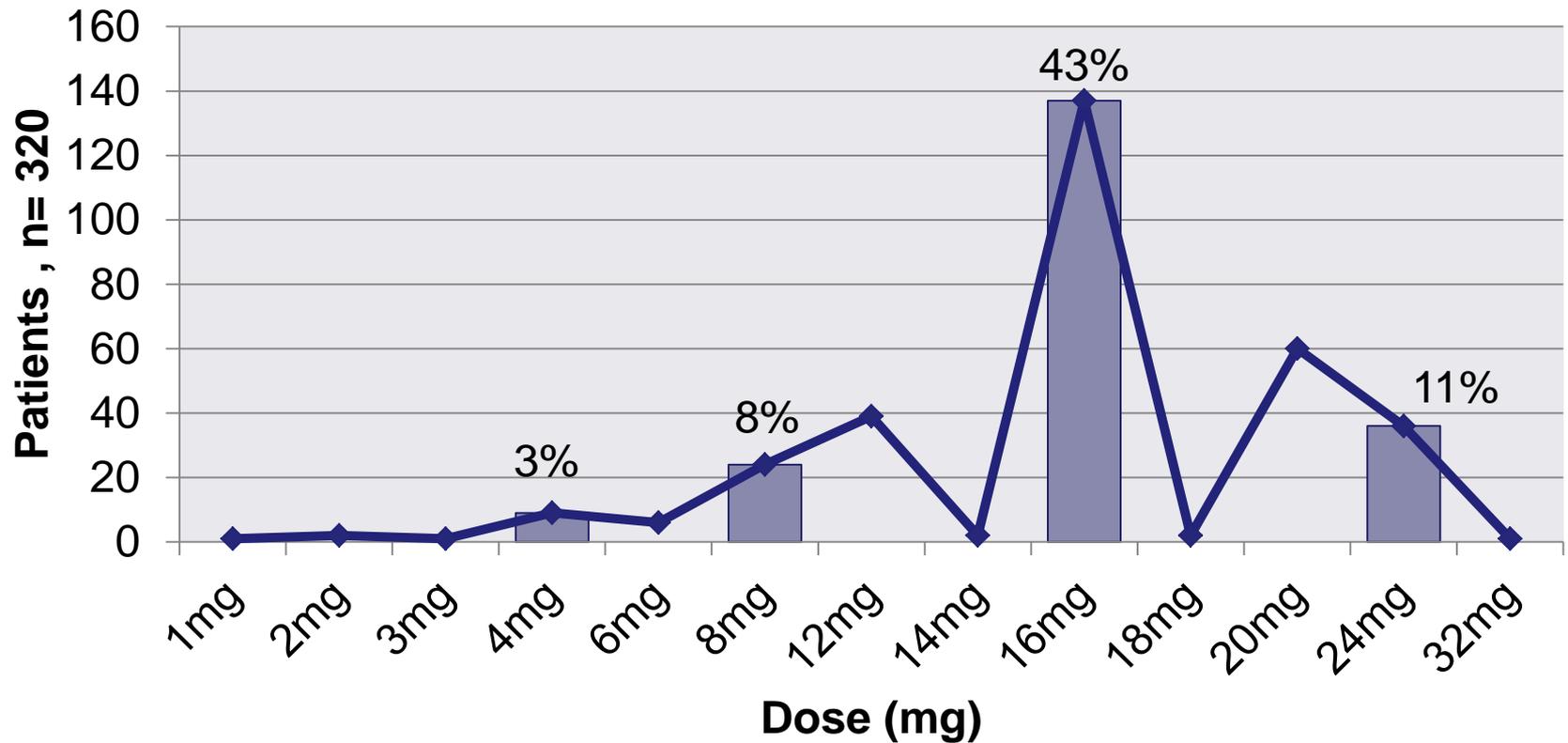
Average wait time between initial contact and enrollment:

State wide : 13.81 days

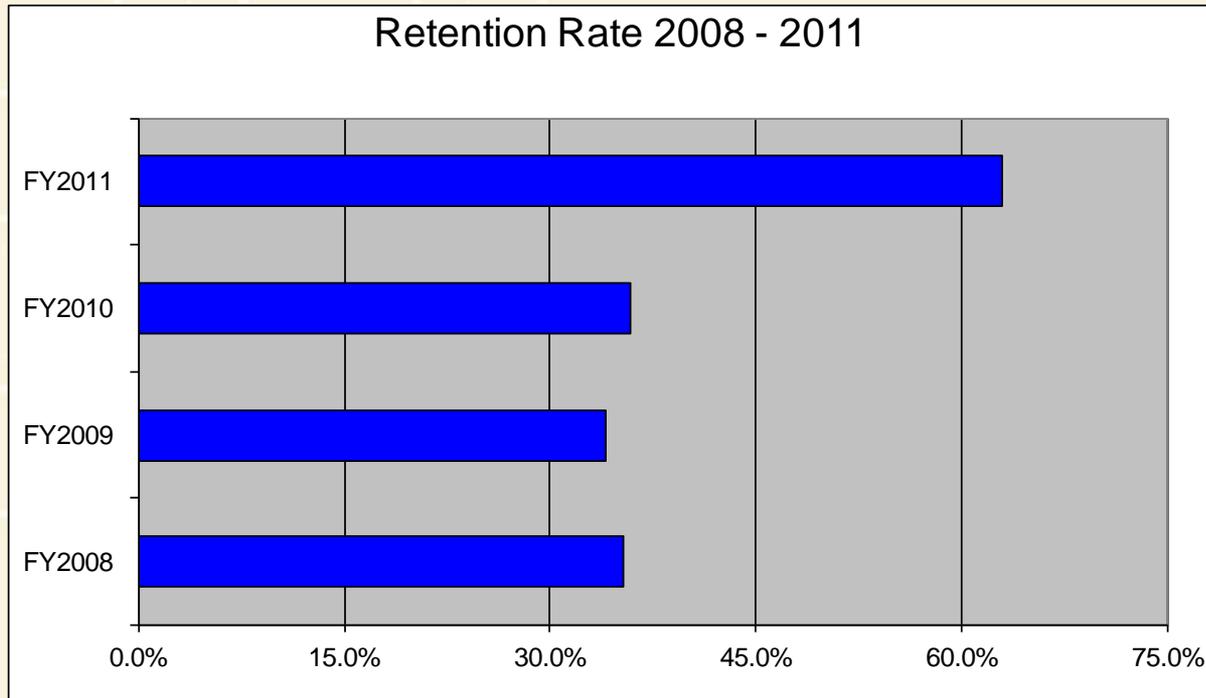
SSTAR : 3.88 days

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau.
OBOT Admission/Enrollment Profile, 7/1/2011-6/30/12, p40.

Dosing practice: # of patients receiving buprenorphine by dose



How are we doing?

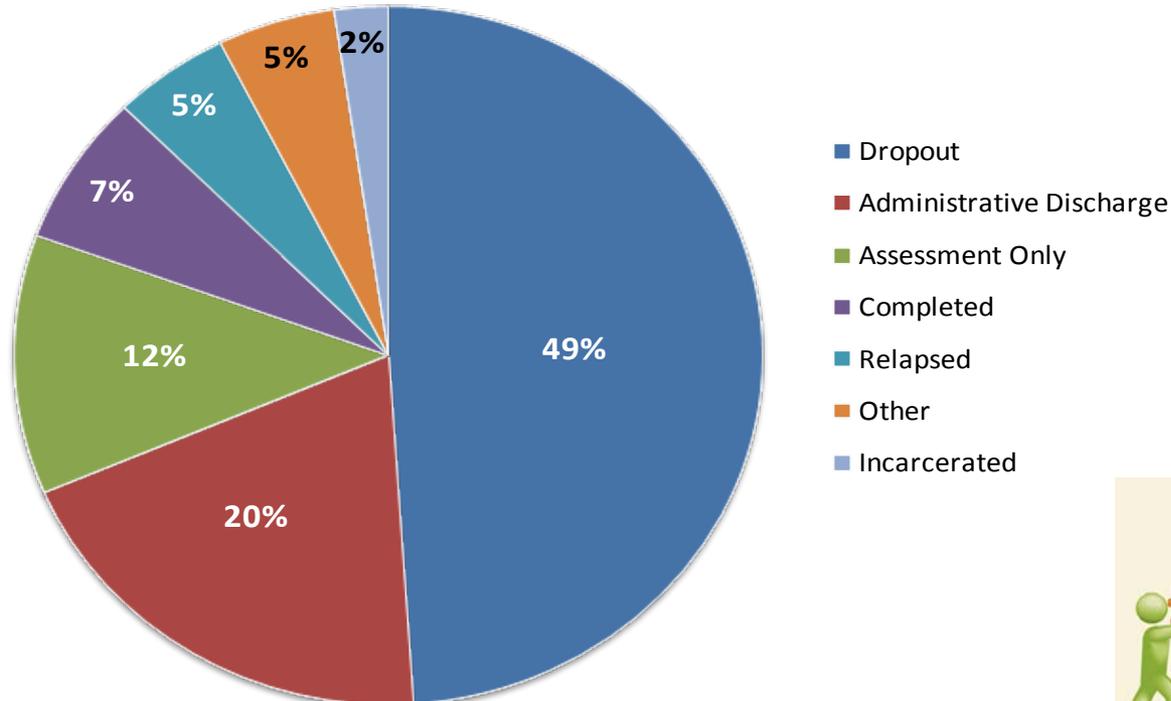


Overall retention rate is the # enrollments reaching engagement (>12 months) / # total enrollments

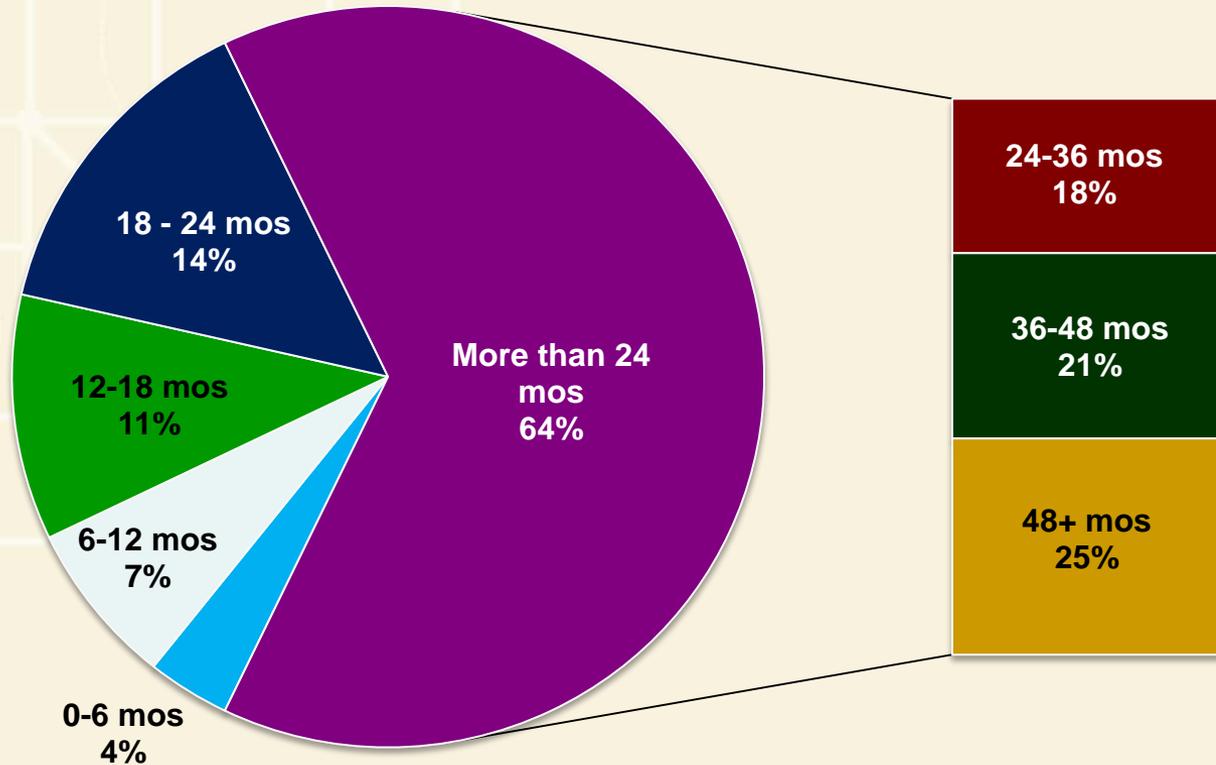


How are we doing?

Disenrollment By Reason, 2008-2011



Time in treatment, in months



How are we doing financially?

2012

Medical revenues:

Billed to third - party insurance	\$1,020,165
Net expected revenues	759,741
Actual payments collected	721,536
Uncollectible/bad debt	38,205
State OBOT grant	82,815

TOTAL REVENUE **\$ 804,351**

Medical expenses:

Nursing, MA and PA salaries	\$255,342
Physician salaries	155,051
Patient supplies	24,000
Occupancy	22,000
Indirect (18%)	82,115

TOTAL EXPENSES **\$ 538,544**

MEDICAL SURPLUS **\$ 265,807**



How are we doing financially?

2012

Behavioral health revenues:

Intakes and individual sessions	\$90,343
Group sessions	48,996

TOTAL REVENUE **\$139,339**

Behavioral health expenses:

Counselor salaries (1 FTE LMHC, 0.8 FTE LICSW, 2 FTE CADACs)	\$ 194,086
Occupancy	7,500
Program support	1,500
Indirect (18%)	36,555

TOTAL EXPENSES: **\$239,641**

TOTAL DEFICIT **\$100,302**



How are we doing financially?

	2012
Medical surplus	\$265,807
Behavioral health deficit	(\$100,302)
SURPLUS/PROFIT	\$165,505



How are we doing financially?

	2012
HC Total Revenues	\$7,179,124
HC Total Cost	\$6,701,204
HC Surplus/Profit	\$477,920
% from Buprenorphine	34.6%



Visit us at SSTAR.org
If questions: Genie_Bailey@brown.edu



MANY THANKS!

Dee Wright, RN HealthCare Center Director
Colleen LaBelle RN, CARN, OBOT Coordinator
Nancy Paull, MA, CEO of SSTAR
Portia Thurmond, MD, Project Coordinator Sstar





SAMHSA-HRSA Center for Integrated Health Solutions

Treatment Innovations: Perspectives from Addiction Providers Integrating Primary Care

Tarzana Treatment Centers
Los Angeles County

Tarzana Treatment Centers

Demographics

- Founded in 1972
- 501 (c) (3) Non-profit Corporation
- 600+ Employees and Contract Staff
- 9 locations in Los Angeles County
- Persons served in FY 2012:
 - Primary care = 10, 507 persons
 - Substance use disorder specialty care = 5,325
 - Mental health specialty care = 1,472
 - HIV/AIDS specialty care = 996

Integrated Healthcare

- Primary Care
- Specialty Care
 - Substance Use Disorder Treatment
 - Mental Health Disorder Treatment
 - HIV / Medical Care and Related Services
 - Housing
 - Assessment & Referral Services in Hospital Emergency Depts
 - In Home Services
 - Telehealth Services

Tarzana Treatment Centers

Revenue Sources

- Federal, State, Foundation Grants
- Los Angeles, Inyo, Ventura County Contracts
- City of Los Angeles Contracts
- Medicare and Medi-Cal fee for service & Managed Care
- Managed Care Contracts with all major private insurance carriers
- Private Pay
- Sliding Fee and Charity Care

Integrated Healthcare

- **Primary Care**

- Licensed as Community Health Centers
- Not FQHCs / Look A Likes
- At 5 of 9 Locations
 - Northridge
 - Lancaster
 - Palmdale
 - Tarzana
 - Reseda
- 34,052 visits in FY 2012
- Payer Mix
 - Low Income Health Plan 78%
 - Managed Medicaid 7%
 - Fee-for-service Medicaid 4%
 - Medicare 3%
 - Other 8%

Integrated Healthcare

Specialty Substance Use / Mental Health Treatment

- Acute Psychiatric Hospital: 60 beds w/ 2300 discharges/Year
- Residential Treatment SU/MH and Co-occurring Disorders: 314 beds w/ 1275 discharges/ Year
- Outpatient SUD/MHD and Co-occurring Disorders: 100,000+ group plus individual sessions / Year
- Medication Assisted SUD Treatment
- Sober Living and Transitional Housing
- Case Management

Integrated Healthcare

Specialty HIV/AIDS Care

- HIV/AIDS Medical Clinics
 - Palmdale
 - Reseda
- Prevention and Testing
- Case Management
- Jail In-Reach
- MH/SU Disorder Treatment
- Transitional Housing
- Home Health Care

Accreditation / Certification

Accredited under Joint Commission:

- Hospital Standards
- Behavioral Health Standards
- Opioid Treatment Standards

Working toward:

- Joint Commission PCMH Accreditation
- NCQA PCMH Certification

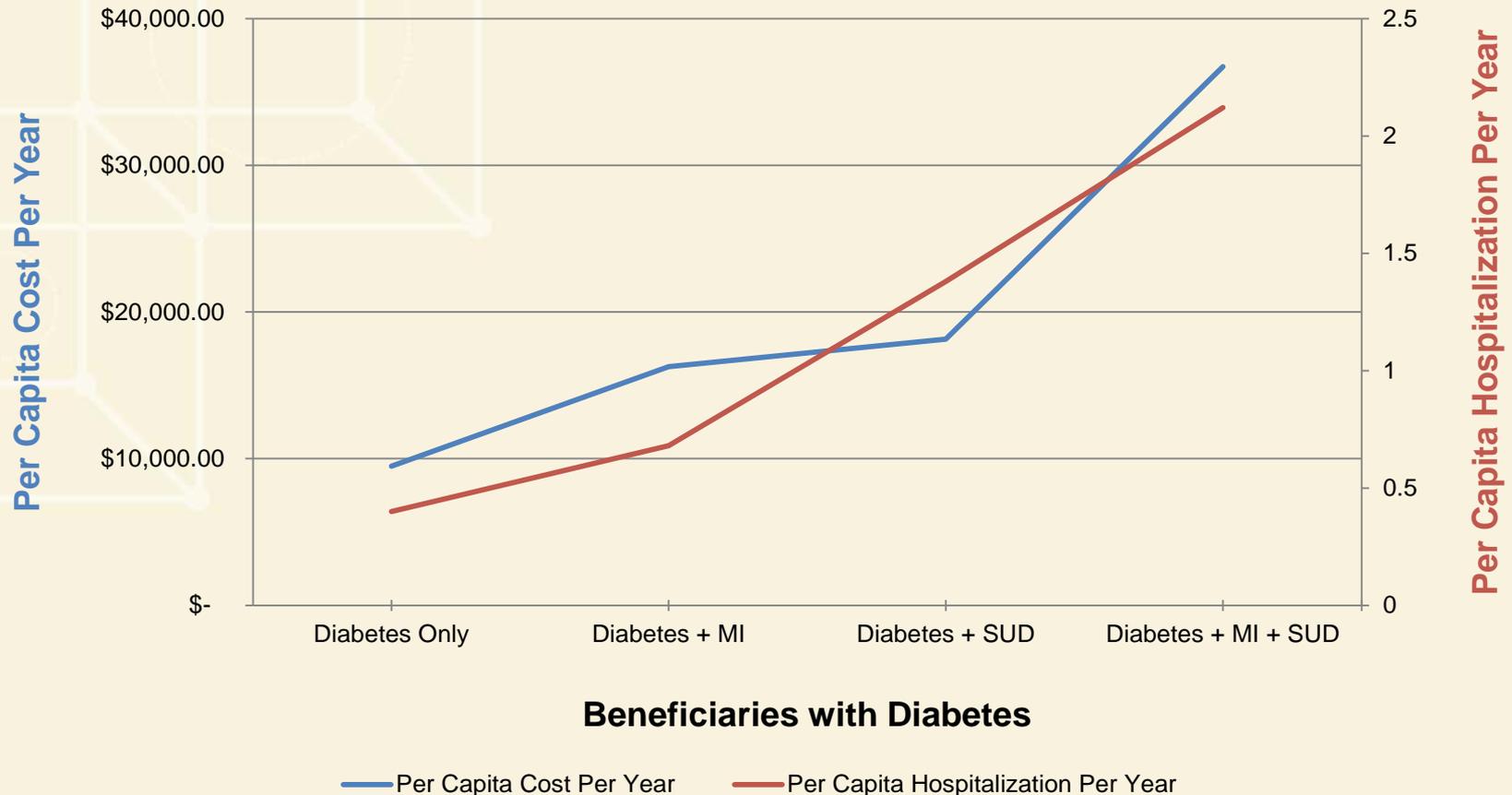
Factors that Maintain Care Disintegration

- External
 - Separate Funding Streams and Regulations
 - Separate State and County Departments Purchasing Care
 - Patient Constituencies / Advocates
 - Behavioral Health Carved-Out
- Internal
 - Separate Funding / Programs
 - Separate Locations
 - Separate Medical Records

Factors That Will Drive Care Integration In 2014

- Funding streams that support integration
- Consolidation of State and County Departments Purchasing Care
- Patient Constituencies / Advocates for Care Integration
- Carved In Behavioral Health
- Partnership with Accountable Care Organizations
- Contracts to Provide Whole Person Care
- Incentives for Lowering the Total Cost of Care

Impact of Mental Illness & Substance Use Disorders on Cost and Hospitalization for People with Diabetes



SOURCE: C. Boyd et al. *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services*. Center for Health Care Strategies, December 2010.

The Opportunity: Capitated and Incentivized Care

- Members of Health Care LA IPA (HCLA IPA)
- Composed of 40+ Safety Net Clinic Organizations in LA
- HCLA IPA Contracts with Safety Net Health Plans in LA County
- 200,000 Lives under capitated Managed Care contracts
- Clinic Compensation
 - Per Member Per Month Capitation
 - Quality of care incentives
 - Share of net revenue

Controlling Total Cost of Care

- Avoidable emergency department visits and hospital admissions largest visible contributor to cost
- Cost contribution of SUD/MI there but not made visible
- IPA notification of hospital admission dependent on claim processing
- Health information exchange solution to notification emerging
- TTC Case managers in emergency departments of 4 San Fernando Valley hospitals

Strategy for Integrated Care

- Communicate the vision
- Build and strengthen component services
- Win the opportunity to provide integrated care
- Reorganize Delivery of Care
- Use technology as a driver of change
- Execute on contracts
- Demonstrate how we contribute to bending the cost curve

Vision - Integrated Healthcare Home (IHH)

- Patient – Centered
- Primary Care and Specialty MHD / SUD treatment in a single organization
- Supplemented by services needed by Safety Net patients with MHD/SUDs
 - Case Management
 - Housing
 - Transportation

Vision: Patient Centered Care Principles in the IHH

- Whole-person care
- Team-based care
- Personal clinician provides first contact, continuous, comprehensive care
- Care is coordinated across the organizations and health care system

Reorganize Delivery of Care: TTC Primary Care Team Composition

Core

- MD / Physician Extender
- Medical Assistant
- Care Coordinator
- RN Care Manager
- Case Manager
- Pharmacist

Supplemented by MH / SU staff as needed

Reorganize Delivery of Care: NCQA PCMH Standards Applied to IHH

PCMH 1: Enhance Access and Continuity

PCMH 2: Identify and Manage Patient Populations

PCMH 3: Plan and Manage Care

PCMH 4: Provide Self-Care and Community Support

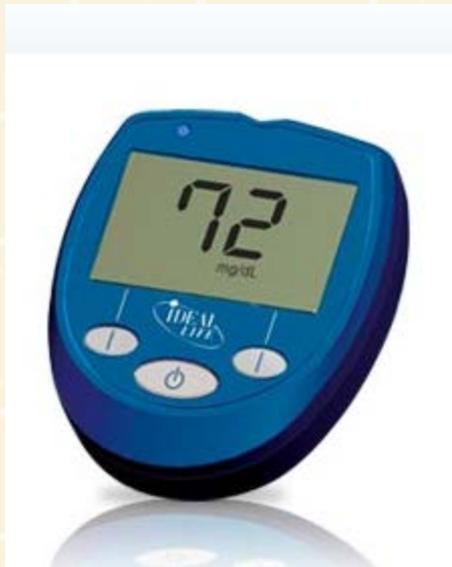
PCMH 5: Track and Coordinate Care

PCMH 6: Measure and Improve Performance

Technology: eConsult

- Links Primary Care Providers to Specialists
- Avoids Costly Visits to Specialists
- Lobbying to add Behavioral Health Specialists

Technology: Diabetes Home Monitoring Pilot



Reading Alert

Ideal Life <noreply@ideallifeonline.com>

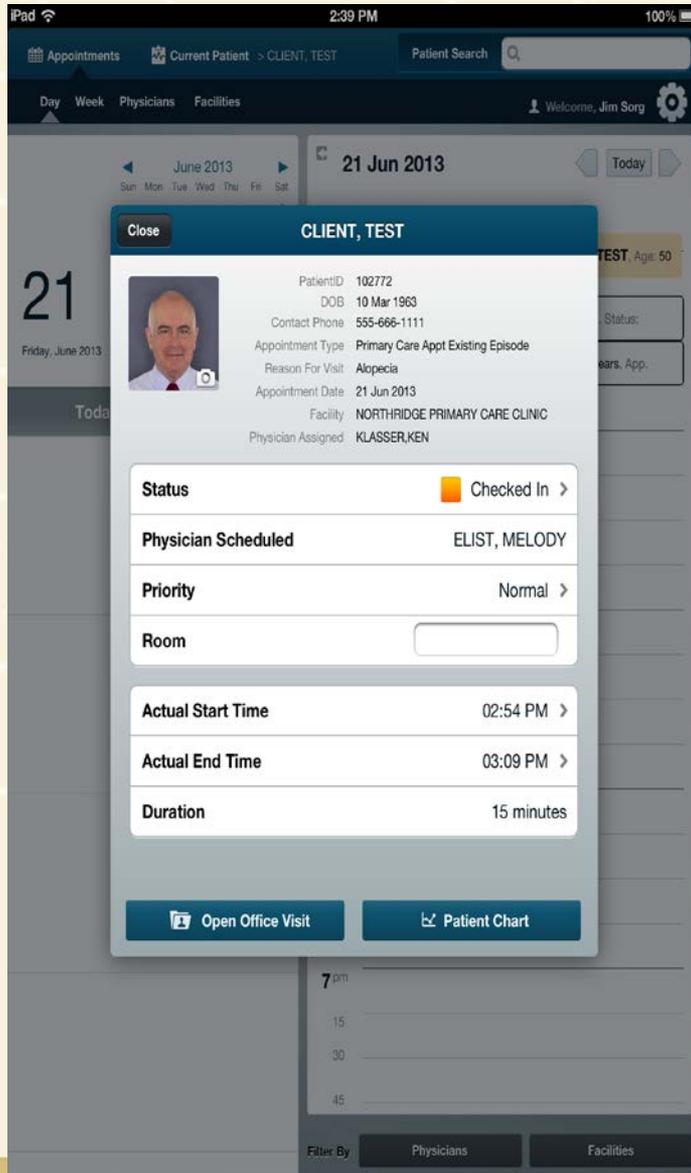
Sent: Sun 6/23/2013 7:14 PM

To: Kattia Chavarria; Leonard Dootson; Bertha Siguenza; Jim Sorg

Reading Alert

Glucose greater than 250 mg/dL - Glucose: 440 mg/dL, Jun 23 2013 7:13PM





Technology: Netsmart Primary Care Module Patient Check In

The screenshot displays a mobile application interface for a patient chart. At the top, there are navigation tabs for 'Appointments', 'Current Patient > CLIENT, TEST', and 'Patient Search'. Below this, there are tabs for 'Office Visit' and 'Patient Chart'. The patient's name 'CLIENT, TEST' is displayed at the top of the main content area. A patient information card shows a profile picture, Patient ID 102772, Date of Birth 10 Mar 1963 (Age 50 years), Gender Male, SSN, Address 55 RODEO ST, Northridge CA 91334, Email, and Phone 555-666-1111. A 'Critical Alerts' section indicates 'No Critical Alerts'. Below the patient information, there are tabs for 'Patient Chart', 'BH/ SA Info', 'Office Visits', 'Diagnosis', 'Vitals', 'Allergies', 'Medication', 'Procedure s/Orders', and 'Lab Order'. The 'BH/ SA Info' tab is selected, showing 'Behavioral Health / Substance Abuse Information' with a 'Notes' filter. A 'Progress Notes' section contains a table with the following data:

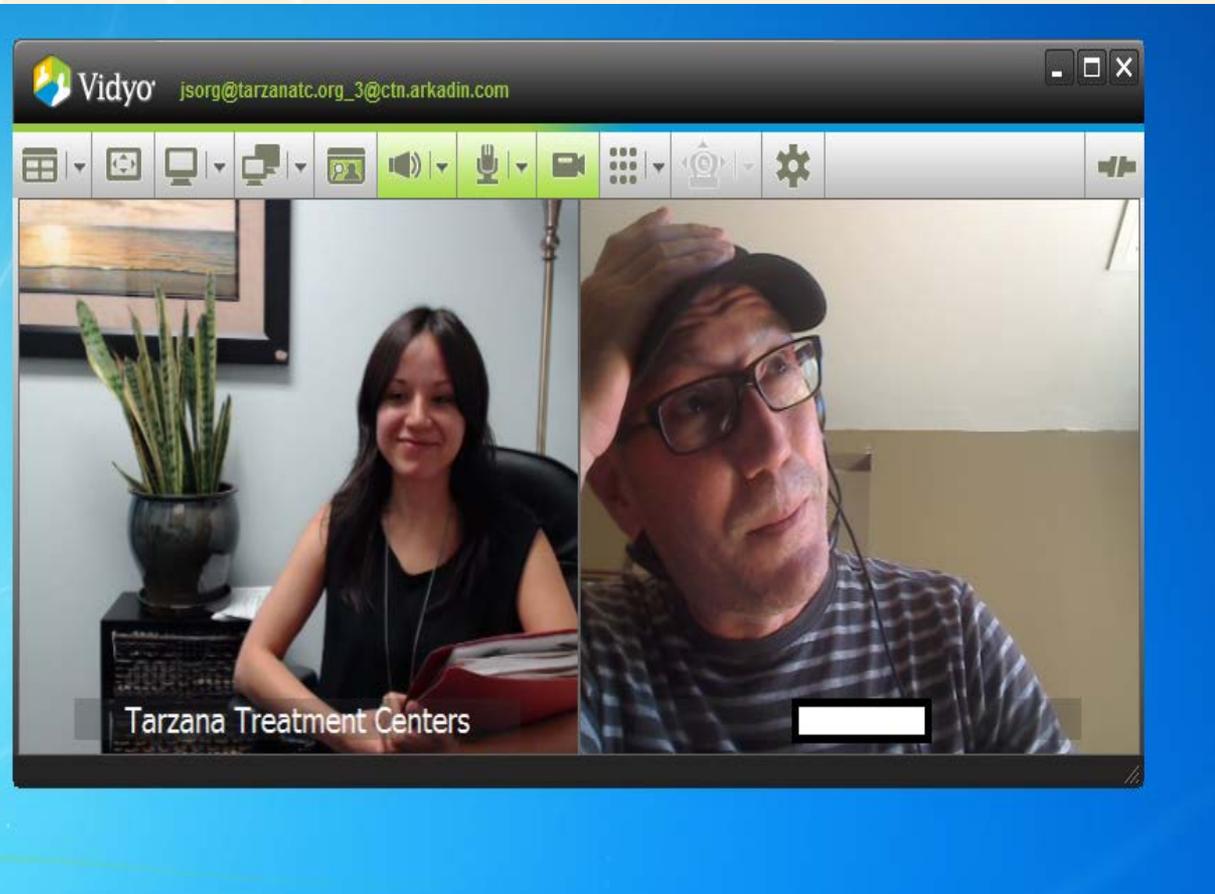
Date/Time	Provider	Program	Note Type	Status
20 Jun 2013, 12:09 PM	KLASSER,KEN	PRIMARY CARE NORTHRIDG...	Primary Care	
12 Jun 2013, 12:27 PM	WIEMANN,PATRICIA	PRIMARY CARE NORTHRIDG...	Primary Care	Final
12 Jun 2013, 11:52 AM	WIEMANN,PATRICIA	PRIMARY CARE NORTHRIDG...	Primary Care	Final
05 Jun 2013, 02:41 PM	WIEMANN,PATRICIA	PRIMARY CARE NORTHRIDG...	Primary Care	Final
15 Mar 2013, 12:14 PM	KLASSER,KEN	Tarzana Detox SAPC(132)	Dietary	
15 Mar 2013, 11:59 AM	KLASSER,KEN	Tarzana OP Mental Health PL...	Dietary	
29 Nov 2012, 09:46 AM	KLASSER,KEN	Tarzana CASC GR SAPC(237)	Case Management	
29 Nov 2012, 09:44 AM	KLASSER,KEN	Tarzana CASC GR SAPC(237)	Case Conference	
29 Nov 2012, 09:43 AM	KLASSER,KEN	Tarzana CASC GR SAPC(237)	Case Conference	
16 Oct 2012, 02:45 PM	KLASSER,KEN	Tarzana CASC GR SAPC(237)	Progress Note	
24 Sep 2012, 03:41 PM	DOOTSON,LEONARD	PRIMARY CARE NORTHRIDG...	Case Management	
22 Aug 2012, 09:55 AM	KLASSER,KEN	LBOP OP Mental Health DMH...	Progress Note	

Technology: Netsmart Primary Care Module Patient Chart



Technology: Netsmart Primary Care Module Patient Chart

Technology: Telehealth



Next Steps

- Train staff about reconfigured EHR
- Collaborate with IPA and Health Plans to demonstrate how we bend the cost curve

Jim Sorg, Ph.D.
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Integration Partnerships

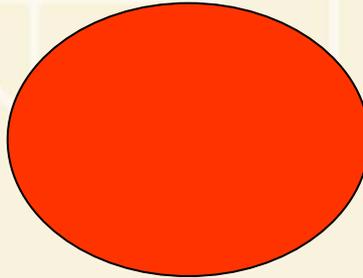
Les Sperling
Central Kansas Foundation
Salina, Kansas

Central Kansas Foundation

CKF is a not-for-profit corporation whose mission, since its inception in 1967, has been to provide both quality and affordable alcohol and other drug education and treatment services.

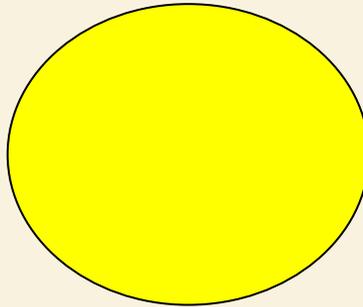
- Community Based
- 65 employees
- 5 locations
- Services include: All levels of Outpatient Therapy, Detox, Medication Assisted Withdrawal, Buprenorphine, (do not use Vivitrol) Residential Treatment, and Prevention/Education Programs

4%



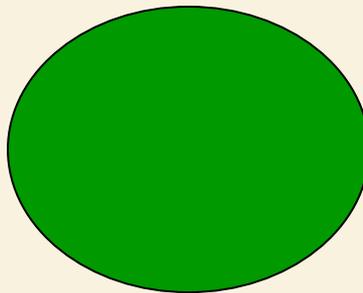
Dependent

25%



Excessive

71%



Low or No Risk

Presented with permission from Steven O'Neill
Georgia SBIRT

Our Three Guiding Principles For Integration

- 1) SUD providers possess expertise that is incredibly valuable to medical professionals.
- 2) When this expertise is available in acute and primary medical care settings, patient health improves and costs associated with chronic illness are reduced.
- 3) SUD services have a significant impact on health care costs and SUD work will be compensated adequately.

CKF STRATEGY

- 1) Become integral part of Health Home
- 2) Implement SBIRT in Primary and Acute Care Settings
- 3) Reduce recidivism to High Cost Care Settings
- 4) Demonstrate impact of SUD on general health
- 5) Increase capacity for SUD patients to access primary health and oral health care
- 6) Full integration of SUD services into Primary and Acute Care Settings

Integration Timeline

2009

- Initial discussions with FQHC leadership related to collaboration, SBIRT, and co-location

2010

- Formal review of patient data, reimbursement analysis, work flow mapping, staffing patterns, and other high level barriers

2011

- Collaboration agreement executed, staff hired, trained in MI, Brief Intervention and SBIRT.
- Co-location and universal screening begins.
- Planning for on-site Level I and II outpatient services begins.
- SUD staff participates in clinical staffings and patient treatment planning.
- Executed contract with acute care hospital to provide 24/7 coverage of ED and full-time staff on medical/surgical floors.

Integration Timeline

2012

- On-site Level I-II outpatient services at FQHC
- SBIRT screening data reviewed and work flows adjusted
- Brief Intervention training provided to faculty and residents
- Strategic discussions related to program expansion and establishment of clinic at SUD locations
- FQHC awarded grant to expand behavioral health services at the FQHC
- SBIRT codes approved in state Medicaid Plan

Integration Timeline

2013

- FQHC receives Person Centered Medical Home accreditation at highest level
- Clinic planning continues
- Integration of patient health information and medical records begins
- Active recruitment by Regional Health Center and FQHC of an Addictionologist begins

Integration Timeline

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Salina Regional Health Center

- 199 Bed Acute Care Regional Health Center-Level III Trauma Center
- 27,000 ED presentations per year
- Alcohol/Drug DRG was 2nd most frequent re-admission
- **Services provided**
 - ✓ 24-7 coverage of ED
 - ✓ Full time SUD staff on medical and surgical floors
 - ✓ Warm hand off provided to all SUD/MH services
 - ✓ Universal Screening and SBI beginning in 2013

Outcomes

- Re-admission DRG moved from 2nd to off the list completely
- 70% of alcohol/drug withdrawal LOS were 3 days or less
- 83% of SUD patients triaged in ED were not admitted
- 58% of patients recommended for further intervention attended first two appointments (warm hand off)
- Adverse patient and staff incidents decreased by 60%.
- CKF detox admissions increased 450% in first year
- 300% increase in commercial insurance reimbursement

Salina Family Healthcare/Smoky Hill Residency Program

Outcomes

10,000 unique patients, 13 Family Medicine Residents, 10 dental chairs
Universal Screening of every patient annually
ASAM Level I and II provided on-site
2 FTE Licensed Addiction Counselors located at FQHC.

- 23% screening positive on Audit-C
- Average daily census in treatment groups is 12.5
- Residents and other practitioners becoming interested in SUD interventions
- Level III Person Centered Medical Home accreditation received
- SUD staff a key component of Medical Home

Personnel

- Licensed Addiction Counselors
- Licensed Clinical Marriage and Family Therapists
- Licensed Specialist Clinical Social Worker
- Person Centered Case Managers
- Recovery Coaches and Peer Mentors (Recovery Health Coaches)

Essential Staff Attributes

- Trained in motivational interviewing and brief intervention. (Stages of change, FRAMES)
- Able to thrive in fast paced medical settings
- Understand medical cultures and can adapt

Post Integration Issues and Concerns

1) Staff retention:

Difficult to compete with salaries offered in medical settings.

2) Change in Reimbursement:

At risk, shared risk, bundled payments, and other emerging systemic changes. How much of the health care dollar will be available for SUD services?

***CKF Lessons
Learned***

- 1) Research and understand the external and internal constraints experienced by safety net clinics and acute care hospitals.
- 2) Understand reimbursement and funding challenges for clinics and hospitals.
- 3) Develop a champion within the clinic staff. Ultimately has to be MD or CEO, but tell your story to nurses and mid-level practitioners.
- 4) Request data and use it.

***CKF Lessons
Learned***

- 5) Be prepared to do the administrative work and be the “go to” person for all problem solving.
- 6) Be persistent, but lean instead of push. Double the time you think it will take to operationalize.
- 7) Don’t waste medical staff’s time. Be prepared for meetings. Keep e-mail and other communications focused and brief. Always respond to their requests immediately.
- 8) Focus on addiction as chronic illness.

***CKF Lessons
Learned***

- 9) Prepare and use cost-benefit data.
- 10) Have a good plan to increase income over the long term with specific billing codes, grants, etc. to shoot for.
- 11) Increase your capacity to effectively treat and manage co-occurring and chronic illness.
- 12) Build mental health services capacity via contract or staff.

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