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>> LAURA MICHAELS: Good afternoon everyone and welcome to the webcast for SAMHSA entitled Incorporated Key Findings to the Surgeon General's Report on Addictions in Your Practice. My Name Is Laura Michaels and I'm the moderator for the webinar today. You may know that SAMHSA HRSA promotes the Center for Integrated Health Solutions in assisting individuals with mental health and substance use conditions. [indiscernible] specialty behavior for primary care provider settings. In addition to national webinars to help provide integrated care, the Center is continually posting practical tools and resources to the website, providing direct phone consultation to providers and working with many primary behavioral healthcare integration grantees and HRSA-funded health centers.

Before we get started a couple of housekeeping items. To download the presentation, please click the dropdown menu and resources on the bottom left of your screen. Slides are also available on the National Council website located on the About us\Webinars tab. During today's presentation your slides will be automatically synchronized with the audio so you will not need to follow any slides to follow along. You will hear audio through your computer speakers so please be sure they are on and the volume is up. You may submit questions to the speaker at anytime during the presentation by typing a question into the Ask a Question box in the lower left portion of your player. Finally if you need technical assistance, please click the ? button in the upper right corner of your player to see a list of frequently asked questions and contact info for tech support if needed. Now I will turn it over to Aaron Williams to discuss today's objective and introduced today's speaker. Aaron?

>> AARON WILLIAMS: My name is Aaron Williams and I'm the senior director for technical at the SAMHSA Center. I will be serving as one of the moderators for today's webinar. In 2016 the US Surgeon General's issued a landmark report entitled Facing Addiction in America: the Surgeon General's Report on Alcohol, Drugs, and Health. One of the amazing takeaways and calls to action from that report was for the increased integration of primary care and addiction services. During today's webinar we'll discuss the findings from that report and what efforts and activities are needed to support integration or integrating screening, assessment, interventions, use of medications, care coordination into routine medical practice. We'll also hear from [indiscernible] Health Center primary care better about the steps that were taken successfully to continually integrate and address some of these issues.

Learning objectives for today's webinar are to understand the key findings related to integrated substance use, primary care findings in the Surgeon General's report, identify concrete ways primary care settings can introduce substance use treatment and early intervention activity into the services. Describe why early intervention activities such as SBIRT are related to overall health. Develop ideas for using the report to educate staff, board, and claims to facilitate a conversation about addictions. Learn about useful resources for setting up and providing substance use services in integrated health settings.

Before we get started, I want to take some time to introduce our speakers for today. Dr. Constance Weisner is a professor in the Department of Psychiatry at [indiscernible] and she is the associate director of Behavioral Health, Aging, and Infectious Diseases for Kaiser Permanente in Northern California. She has a doctorate in public health from the University of California Berkeley and Masters in Social Work from the University of Minnesota. She directs the research program directing access, outcome, and cost-effectiveness of substance use and mental health treatment. She is a member of the international expert advisory group on alcohol and drug dependence for the World Health Organization and the NIAAA Advisory Council. She's also a member of the National Council on the Advisement and the Center of Substance Abuse Treatment to focus on several Institutes of medicine improving the quality of healthcare and mental health and substance use conditions and preventing diagnosis and treating substance use in the US Armed Forces. Her overall work focuses on integrating alcohol, drug, and mental health services within healthcare.

Our second presenter for the day is Dr. Mark Alexakos who's the Chief Health Officer at the Lynn Community Health Center in Massachusetts serving 40,000 patients annually. He studied at the University of Chicago school of medicine and Harrison School of Public Policy. He has a joint degree in medicine and public policy, health disparities, and community health. Dr. Alexakos studied at the Center for Adult Psychiatry at Massachusetts General and Hospital for adolescents. He currently directs multidisciplinary staff that provides a wide range of psychiatric services that are both integrated primary care and community. He has led community health centers major initiatives to integrate services into public schools. Before working at the Lynn Community Health Center he spent seven years developing school-based health services that provides prevention with quick access to behavioral health in public schools.

I want to thank both of our speakers today, and this will be a very helpful and the lending webinar related to the Surgeon General's report. Hopefully we'll take away some practical tools for implementing addiction services into your primary care setting. Without further ado I will turn it over to our first presenter Dr. Constance Weisner.

>> DR. CONSTANCE WEISNER: Good afternoon everyone. Thank you for your interest in the topic of integration. The Surgeon General first commissioned this report on alcohol and drugs because there's a very high prevalence on existing alcohol and drug problems and the new substances continuing to cause huge problems. But at the very same time, the enormous scientific advances in

treatment prevention and the opportunities that are coming from integrating with healthcare. Dr. Murray was highly engaged in the report in his office and the report sponsors and those of us who worked on it are very interested in doing what we can to disseminate and implement the recommendations. This chapter on healthcare integration was intended to address multiple stakeholders and answering questions such as what can patients and family members expect from their healthcare systems and substance use problems. How can clinicians initiate and operationalize clinical services for disorders and what skills do they need to learn, and what should payers and patient relation resources expect in quality and value for patients treated for substance use disorders. While I can only touch these topics lately in this webinar, I encourage you to go to the full report for more details.

I'd like to start by reviewing some of the fundamental changes that impact integration of substance use services in healthcare. I've been involved with substance use, treatment, and research for many years and I have never seen such a time with this many clinical policy breakthroughs for improving treatment. We now have the opportunity and it is clearly happening in many instances to screen and monitor for these things. In the past the focus was only on those individuals who had the most severe problems We are now addressing the full spectrum of problems.

Our field in the past has relied on paper charts with little contact between specialty substance use disorders in healthcare. We now are entering the world of electronic health records for clinical coordination.

Our field has been behind in the use of health information technology and we are now leveraging technologies including patient portals, clinical guidelines, and technology-delivered treatments.

In the past our treatment system has had very little focus on physical health issues. And now medical problems can be addressed with a focus on whole person wellness.

Also in the past medications have been seldom available and we now find them much more readily available, in particular for alcohol and for opioids.

In the past we had several oversight structure for reporting and we now have much more of an integration of performance and outcomes measurement with ongoing quality improvement.

While in the past we relied on twelve-step programs for social support and the important contributions they have made, we now have other innovations to go along with that including other support and recovery support services and other social network innovations.

Why do this through healthcare? First of all healthcare is the one place everyone will go throughout their life while substance use treatment is much more episodic. Also the prevalence of co-occurring health and mental health problems is high even in those whose problems are not severe. Substance abuse disorders are also chronic neurological disorders and need to be treated as other chronic conditions are in healthcare. And integration can help address health disparities, reduce costs for patients and family members and improve health outcomes.

I am emphasizing the full continuum of substance use and problems. This looks at the distribution of drinking—I'm using alcohol as an example—drinking across the general population. As you can see, most people are either abstainers or low risk drinkers and our focus here is on prevention. However, we do have about 7% of our population which falls into the unhealthy drinker category and there they rely on the healthcare system for brief advice in primary care or emergency rooms, whatever department in healthcare they emerge in. And then at the very tip of the pyramid are those who are alcohol dependent really make up only about 1% of the population. This is in the past where we have put our energy and we are now moving to adjust this entire pyramid.

What does innovation look like? Well we borrow from disease management for other health conditions such as diabetes and hypertension. Here we should be screening and treating in primary care if the team order problem and continuing monitoring there. However if the problem is more severe and specialty care is needed, then a referral needs to be made to specialty care. After substance specialty care, back to primary care for monitoring. As the report talks about and we will to some extent, that linkage between primary care and specialty care and the linkage back to primary care is where we need to spend a lot of energy.

Let's first talk about screening. Why should healthcare systems screen for substance abuse? We find that people with substance abuse disorders often access healthcare system for reasons other than their substance use disorder. Also problems are not usually obvious and people do not self disclose. As we have found out about 80% of people who have prescription opioid problems were started on a med by their primary care physician and many times physicians have absolutely no idea that patients have problems. This is an opportunity to catch problems when they are not severe and when they're much more readily treatable and it's also an opportunity to address them there and refer specialty treatment when needed and also refer after specialty treatment.

I want to emphasize that the National Commission on Prevention Priorities and also the US Preventive Services Task Force have recommended screening -- alcohol screening and have found it to be for on the list of 25 most useful prevention services. This is in terms of its effectiveness and cost-effectiveness. Please note that it actually seems to have more benefit than a lot of other health conditions that we screen for automatically such as breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes screening, and so forth.

Now moving towards thinking about the severe group who do need specialty treatment, that group at the top of the pyramid and we saw, why should we integrate specialty treatment with healthcare? Why not just keep it separate alone and free standing institution? These findings come from a study at Kaiser Permanente. We matched people entering treatment who are in the red bar with health plan members in the blue bars were matched on race, ethnicity, gender, age, and census block. And we find that adult patients have more conditions than matched controls. More mental health conditions. I want to take a moment to point out that this higher prevalence of medical conditions among addiction medicine patients is also found among hazardous drinkers and drug users in primary care of all the differences are not as extreme. People who are drinking more than the recommended levels or using drugs also have higher medical conditions. And this is true for the 20 most prevalent and most costly medical conditions. Family members also, the report discusses in the study that shows that family members have higher medical conditions and use of ER and inpatient services than family members of people without alcohol and drug problems. And that these differences however disappear when the family member with alcohol or drug problems receives treatment.

We have the same findings for adolescents. This study again from Kaiser Permanente shows the adolescent addiction treatment patient [indiscernible] so more medical conditions than matched controls and higher costs for all of these listed here. Again 20 of the highest cost and prevalent medical conditions. I want to point out that both for adolescents and adults, when we are looking at our most recent studies, the medical conditions and mental health conditions are even higher than in these earlier studies. I think that's probably because of the epidemic we are all finding that in opioid use.

Just to take a moment to show the huge difference in terms of mental health conditions of adolescent addiction treatment patients. Many of these mental health conditions are tenfold higher than the matched adolescents.

Not only do health problems affect options in use treatment but not addressing them also affects healthcare. So we find in healthcare that substance use is associated with all of these things: misdiagnosis, interference with prescribed medications, one physician time, unnecessary medical testing, poor outcomes, and increased costs.

How do we put this together in an integrated continuing care service model? This would include regular primary care as an anchor, a medical home. Addiction treatment when needed. Psychiatric services when needed. This will have an affect on substance abuse and cost long-term. (Sorry I am having trouble with the slides.)

We interviewed 2000 people in specialty treatment over nine years and examined their health care use and cost in the health plan. We found that patients who received those shown in the previous slide were more than twice as likely to be in remission over nine years and also less likely to have emergency room visits and hospitalizations. Many times this is a proxy for quality. This was true for all demographic characteristics, for alcohol and drugs, mental and psychiatric severity, and whether someone completed treatment.

What are some of the ingredients to do this? There are many new opportunities. These are all illustrated more in the report. We have medical and health homes. We have evidence-based psychosocial treatments and medications which we refer to as Medication Assisted Treatments. Primarily at this point these are for alcohol and opioids. However a great deal of work is happening for medications for other substances as well. We have opportunities for behavioral medicine specialists and primary care to help with screening and monitoring, wellness coaches as well. And importantly I want to spend a few minutes talking about Health IT which can increase the reach and type of services. As of 2014, 80% of primary care physicians—and that is growing—are using electronic health records.

What are some of the opportunities coming from using Health IT? I'm particularly focusing on things such as patient portals and clinical guidelines. This is especially moving forward because of meaningful use which is providing incentives and at some point regulatory sanctions on health systems to put these in place. The Health IT can address access for example of populations that have had trouble with access in the past, people in rural areas, young children who have problems coming into treatment. These include a whole spectrum of interventions such as video visits, online intervention. There's also a huge potential to help address disparities. For example, in our health plan, we have multiple languages and cultures that we need services for. The report details some very exciting work that is happening across the country in terms of developing treatments or services that for example use avatars that are matched to the patient's terms of language, culture, race ethnicity, age, and so forth. Clearly Health IT can easily address language issues.

There can also be anonymous standalone interventions for people who are very concerned about confidentiality. They can also free up time so that service providers can care for more clients. They provide alternative care options for individuals that attempt to seek in-person treatment. The whole focus is wouldn't it be wonderful when a primary care physician finds that someone needs services. They don't want to go to treatment and they can say here is a whole panoply of things you can do. Some of them can be confidential or anonymous.

It also increases the fidelity of interventions. The chances that interventions are delivered as they were designed and intended to be. And very importantly, the electronic health record can make diagnosis and intervention much easier for other clinicians to do in terms of having guidelines easily available.

There are many EHR innovations that can be linked with patients and care. There have been some perceptions that our patients cannot use the electronic health record or they are not interested in doing so. However, in a study that used groups and focused on patient activation and empowerment made great use of Health IT. We found that participants had higher healthcare involvement through the patient portal which included login days, number of times they logged in, and use of each type of activity. For example physician emails, viewing lab tests, looking at medical information, and so forth. And a higher proportions of the LINKAGE participants reported talking to the physician about alcohol and drug problems. This is clearly an important change. And I wanted to note also that results were consistent for those with co-occurring psychiatric conditions. So these patient portal options include all kinds of things like health assessments, apps for sleep, anger management, depression, and can be confidential or can be shared with healthcare professionals.

So there are many types of healthcare systems. Some are community, some are integrated structurally, and some are not. There's a much larger chart than I can show here that shows the continuum of collaboration between healthcare and specialty services. You do not need to be at Level 6 to be fully co-located. I think I would stick my neck out and say anything from Level 2 to Level 6 can really be effective at collaborating between healthcare and substance use treatment. We have so many high-quality both public and private substance use programs that are not at this point embedded within healthcare and probably will not be, do not necessarily need to be. And how to coordinate activities so that our patients get the substance use treatment they need as well as the health and mental health care they need is an important challenge and a doable challenge.

There are innovations having to do with Medicaid. Substance use disorders are the very first focus of the Center for Medicaid and Medicare program, Medicaid Innovation Accelerator Program. States may now offer a wide range of recovery oriented services under Medicaid's rehabilitative services option which are listed here ranging from therapy to many kinds of recovery support and employment skills.

We still have many challenges, we don't want to ignore those. We still have some uninsured. In 17 states for example have not expanded Medicaid and that leaves at least 1 million individuals with substance use disorders who are not going to be eligible for treatment. I think that it's very clear that one of the most important ways of improving or dealing with health disparities is for people to have insurance coverage. We still have huge privacy issues that we have not quite resolved that have to do with 42 CFR Part 2. Much more restrictive than HIPAA for example on providers not knowing whether someone has a diagnosis or has been in substance use treatment or is in substance use treatment. Makes referrals back and forth more difficult. This is being addressed by both healthcare and by substance use and certainly by SAMHSA in terms of electronic health records but we still have a great deal to do in this area and it's very difficult to coordinate care with this.

We also have EHR interoperability problems between systems; health care and specialty treatment, alcohol and drug treatment programs do not usually share EHR and so a great deal of work in interoperability here needs to be done. We still have a gap in implementing medically assisted treatment and that has a lot to do with workforce shortages and training. I want to point out this is in both the healthcare system where we need to provide more training on substance use disorders, on the whole spectrum of screening and monitoring to healthcare providers but also in addiction treatment where we have a large shortage of workers. Many of us feel there needs to be an increase training on medical and health conditions and how to interact with healthcare. Clearly there are still barriers in how to get people from primary care to specialty care and back. And I believe that market is going to be talking for one successful way of doing that.

The report has the following recommendations for health systems. One is to address substance related health issues with the same sensitivity, exactly the same sensitivity and care as any other health condition. Promote use of many evidence-based programs that our field has. Promote effective integration of prevention and treatment services. Develop strong ties with substance use specialty treatment. Work with payers to develop and implement compensability models. And implement health information technology for clinicians and patients to promote efficiency and high-quality care.

In summary I want to say that while we are all aware of the many problems that we have in our society with alcohol and drugs, the huge cost of financial where I believe in 2012 there was an estimated cost of \$420 billion and yet we only spent \$35 billion of that on treatment. Not only cost to the healthcare treatment but they have to do with criminal justice, problems with education, personal violence, and so forth. But the good news in the [indiscernible] way of this report in this chapter in particular is that there are prospective strategies and services ranging from self change to specialty treatment for the whole spectrum of problems. And again to emphasize screening, integrating early before problems are so severe, and when they are much easier to treat, to provide evidence-based treatment, both medications and behavioral services, and an ongoing management. Many of these can be accomplished within healthcare and all can be done when we integrate healthcare and specialty care. Thank you very much for your attention.

>> AARON WILLIAMS: Thank you Constance. Now we will take a few minutes to answer some questions. We had a number of questions that have come in through the system. If you have a question, make sure you type that in. And we will try to answer those as much as possible. So we will take a little bit of time right now as we're more focused on your presentation here Connie. One person was asking you to elaborate a little more on how you see Medical Assistance Treatment fitting into the model and talk more about the need for that.

>> DR. CONSTANCE WEISNER: I would be happy to do that. The idea is that with SBIRT, for individuals whose problems, the clinician can decide if someone's problems are severe enough that they could benefit from medication and they are not ready to go to substance use specialty treatment. We would definitely recommend that medications be provided in primary care. Many times, that



actually helps people become ready to go to treatment but also it may be a very important first line of defense. We have learned that many physicians are reticent to learn about yet another set of treatment for their patients but we are working on a very interesting pilot study right now and I think this is something that can reach across primary care and specialty treatment when it is even in the same system where we have addiction medicine person on call can handle many primary clinics that way so that when someone does have a problem, does not want to go to treatment, the physician can do a video consult with an addiction medicine person with the patient right there in the office to get some help in prescribing medication and also maybe persuasion to come to treatment. But definitely in prescribing medication and this is a way also that physicians can learn to prescribe these medications.

>> AARON WILLIAMS: We have one more and I believe this one is referring to the study on slide 21 looking at integrated outcome care study. You looked at cost and cost effectiveness and cost savings?

>> DR. CONSTANCE WEISNER: Yes we did find a reduction in total cost and it was because of lowered emergency room cost and lowered inpatient cost. These health systems don't necessarily want primary care cost to go down but inappropriate utilization is usually associated with problems and it's generally ER and inpatient. We have found in the study and in others but that is where the costs were reduced. I believe the reference is on that slide right in there.

>> AARON WILLIAMS: One other one before we go to Mark. This one talks about, if the role of other community partners such as law enforcement professionals and work with medical professionals. Also emergency room and others in the first line of substance related problems.

>> DR. CONSTANCE WEISNER: Absolutely. I think that we are nothing about integration, we're thinking about prevention and services but we are really thinking about the good old concept of no wrong door that Center and others have talked about for some time. Wherever you hit a system, that's where it should be addressed. We are also thinking about health systems and especially the new ACOs that are responsible for their patients health at a population level. And then more importantly again coming out of the ACC—I'm having problems with abbreviations right now but the accountable care communities that are now addressing the entire spectrum of multiple kinds of services from criminal justice to health to education and so forth. That is clearly the direction that we need to go. We really need to have no wrong door. And again this has to do with issues we are still dealing with around exchanging information and so forth.

>> AARON WILLIAMS: Okay thank you. Let's stop here for some of the questions. If anyone has questions, please type them into the question box. We will have another question answer period after our next presenter but I want to try and move this forward some. Without further ado, Dr. Mark Alexakos.

>> DR. MARK ALEXAKOS: I'm so excited to be here and share some experience from the Lynn Community Health Center. Constance did a great job of outlining some of that and I will talk more about how we developed our integrated services in particular our addiction services and also talk about how we have implemented SBIRT in our system.

We serve about 45,000 patients in Massachusetts and it's a very diverse population. We are a little bit unique in that we have about a 1:1 ratio of behavior health to medical providers. We have about 100 or so therapists and/or prescribers and about 100 or so nurses and primary care providers. So for us it was not always that way. I've been at the Health Center for about eight years and behavior health has tripled in size. We went from 30,000 visits to about 100,000 visits. That gives you a little bit of a context of the services we provide that it's important as you're thinking about your own health care setting, you know what your services are and where you're at. What people do know about me is I'm a little bit stubborn and what I hope everybody can take away from this is you can do a lot more than you think.

I will talk with a bit more about our current state of substance abuse disorder services. Our strategy is that there is no wrong door. All our teams are integrated and most of them are either Level 5 or Level 6. One is a Level 4 but we have one integrated complex addiction services specialized medical home. I'd like to start with this one when talking about the substance use disorder because it really started out as a OBOT model. There was one nurse and one primary care doctor working together in a prescribed Suboxone zone behavioral care and primary health. Kind of randomly when it got moved around, primary care needed more health it was housed in behavioral health. The nurse care manager just started referring all the patients to behavioral health and we eventually started an integrated service model. It just built over the years obviously with a lot of funding and a lot of hard work. But right now the integrated service model can basically handle complicated patients. It's all outpatient services but it has psychiatry, primary care, nurse care management, Suboxone, Vivitrol, serves around 500 patients, manages co-occurring disorders, and we are working on outpatient detox and potentially a partial program but the key as Constance pointed out is we have a team that can handle all the typical issues that make it hard when it's just primary care or just behavioral health or just substance use disorder. But it started as a small OBOT program that was very silent.

Other services that are available. For us it doesn't matter where you come into the system. We want everybody to be able to be screened and assessed and engaged and then also be treated and we hope for good treatment outcomes. We have four teams that have 6 to 8 primary care doctors, 3 full-time therapists, and a .4 psychopharmacology. (There is a typo on the slide.) Two teams have team-based MAT and we had plans to spread our teams to urgent care. Unfortunately it's a hotspot and even though we've added 100 patients each year in our more specialized primary care home, we cannot keep up with demand. We also have integrated OB and pediatric teams. They have capacity for assessment and some treatment.

We have an integrated specialty mental health care team which is sort of co-located. So just like the substance abuse team, we have highly integrated team with peers support and capacity to manage co-occurring disorders but no MAT's. And we have central behavioral health services but it's also organized into teams that are linked to the primary care teams. They don't have to work with 50 doctors. Each centralized behavior health team works with a smaller cohort. But again our idea is that there is no wrong door and every team has some capacity and that's always how we've built services in the past six years or so.

How did we advance integration this far? It was a combination of events. Some of it was funding and a lot of issues in our community, we knew there was a huge need and a huge demand. At some point there was real emphasis from our board that this was a community need. We knew we had a large behavioral health department and there was a lot of talk about integration so we incorporated into our strategic plan. As a development process, there was discussion about senior management training, we hired consultants. The consultants finally asked us why wouldn't we do it? We spent a lot of time training senior management, studying lots of models like Intermountain Utah, but we really educated ourselves and the more we studied it, the more sense it made for us.

We were fortunate at some point in time that we did actually get seamless money and we were able to build a new building which was the picture you saw of our new building. At that time, that also helped with the co-location and being able to integrate three full-time therapists on each team. What I know about my team is that patients want to get treatment, teachers and others or medical doctors in the community identify people with problems. There's not as much stigma and there's a large large demand that's why our integration model we wanted at least three full-time therapists on our larger teams. Having buy-in at the leadership level is really important because even something like universal screening across the organization, everybody knows about it and there's all kinds of barriers and archives of new services and resources and supports that people need. If you don't have buy-in at the top to help you solve barriers, things are going to go really slow. So that strategic development is really important.

The next up is working at the team level to figure out a team infrastructure to successfully deliver care and successfully support each other. So we have a couple of takeaways and learning we did. If we didn't have champions at the team level to support this work, it wouldn't go very well. Sometimes the hard concept to wrap your head around but it really works. Each team has a behavioral health champion, a nursing champion, and a primary care champion. Me and our CO meet with them once a month for a lunch meeting for support, brainstorming, and as we've added a QA person also have joined that champions team. Our quality improvement efforts were also integrated at the team level. But also more important, there were team-based meeting times. Most teams have a twice a week team meeting. They can do a combination of things, case discussion, problem development, problem-solving case developed. Then there was a broader cross team learning environment where all the

team champions come together and present information and learn and discuss barriers and other issues.

Team-based quality improvement. Three years ago we were able to start to build a small quality improvement and data team so I have a quality improvement coordinator for integration, quality permit manager, and a data analyst. That team of three people, we've been working together and they are integrated into the champions meeting. They work closely with using quality improvement tools with our team leaders to provide quality improvement work.

Here are our integrated team members. I went through that already: primary care providers, nurses, medical assistance, behavioral therapists, psychopharmacologist. All teams have those components.

I will talk little bit about how we implemented SBIRT and MAT. You can do more than you think and it is a journey. You have to prepare yourself and your teams for constant change. Change while anxiety provoking is manageable. We are sort of at a beginning level for quality improvement for starting to use quality improvement tools gives you a roadmap and some ways to manage your change process. We are fortunate enough that GE is local so we've gotten some GE training and we also work with LEI Institute and we got some trainings. Between GE and LEI Institute, we probably have 3 to 4 years of some support and the support has been more intensive. We want to really integrate quality improvement tools to up the organization. It's been a little bit more intensive work send we're still at the beginning stages in our quality improvement journey. But we used some improvement tools and we are getting better using them. We're certainly not perfect. Be PDSA is always a good one to start. Change Management support. We always have issues that come up around change management such as moving too fast, moving too slow, not seeing everything from everybody's perspective. There's lots of resistances that come up especially when you're working with substance use disorders. There's lots of anxiety that comes up and various resistances.

One of our therapists and [indiscernible] were very worried that the medicine prescribing would make them more high risk if the medicine wasn't managed properly with respect to diversion and relapse. There was a lot of work that had to be done. So a lot of what we did with the quality improvement work in our defined stage is understanding our current state. Understanding all the disciplines that may be involved. One of the things we did for SBIRT was trained all disciplines. Medical assistants, nurses, primary care providers -- every health provider that they knew some of the stuff but they were also all trained from a basic level up to a more sophisticated level. We had motivational interviewing, role-playing, case review. We had discipline specific training and also team-based training and question-and-answer. Then we did some phased implementation by team over 3 to 6 months. As we integrated work, we moved over to a standard workflow.

Here's a sample of standard workflow for SBIRT. It has three swim lanes. At the top there is the screening questions that the medical assistant asks. For us, if there is a positive screening on the two

question screen, the medical assistant is the full screen for us, the primary care providers can also do the full screen survey can also engage the patient and assess them. That is the second swim lane. If there is a positive based on the assessment, they can do a warm handoff to a behavioral health therapist after they do their brief intervention. Sometimes the patient doesn't need a warm handoff but if they do, they will receive one. If the warm handoff cannot happen, it can also be scheduled with a team-based therapist or it can be referred to our complex addiction team. That's what's representative in this workflow. For us, with the training, we come back and forth on the team level, we worked out a standardized work for the was pretty comfortable and smooth sailing for most people.

I wanted to show a little bit of our results. Like I said this was over about a six month process screening. Screening can be highly successful. The top part is the total number of patients. Those are all the patients that came in August. In August, either 70% of the patients had already been previously screened or were do so we decided to rescreen them. By November, we're up to screening 90% of our patients for substance use disorders. We noticed there was a point in August looking at our ideas we would take our data and how successful we will screening, our QA manager and data analyst became champion ensuring the data, we noticed there was a cohort that was not being screened. It was almost like there was a subgroup of patients that were being avoided. We had all kinds of ideas but until we started to do a PDSA cycle and engage at the team level, we couldn't figure out why that was. We had a lot of good ideas and they said these are the most competent patients, they are having other issues, were skipped. I thought maybe they were being skipped because the patients were already diagnosed with depression. Other people had other ideas. We created a missed opportunity report and we did a look back of all the patients were due to be screened but were not screened and we interacted so that the nurse managers went back and talked with the medical assistants. What we found out is there were sort of two things. There were two cohorts of patients being skipped: those who had already had mental health or substance use disorder diagnosis, and/or one came in through a walk-in process. For whatever reason in the medical assistants minds, those patients didn't need to be screened. He did PDSA's around that and you can see right away that the patients who were being skipped started to being screened. There's no way we could figure that out without this on the ground working developing relationships and teamwork.

Key steps. We had interbedded champions and champions are really so important to the work we do in a team-based model. Having worked in asylum based [indiscernible] where I sit in my office, I fit in, I've been developed evaluations where people came from all over the state. I give my expert opinion, I read the 10 things and I don't have to do much else. Integrated teamwork, you have to have champions of people dedicated both to the work plan and helping patients to understanding the disease that are working with and substance use disorders.

At the interbedded champions meetings, we do work plans, progress, review data, troubleshoot problems. At each champions meeting, they have direct access to us so we can given support, guide, and also troubleshoot barriers. Team meetings also very important so the champions work with teams

at different phases of the implementation. They were essential in helping to organize the trainings and making sure they went off without a hitch. And like I said just having the team-based conversation around about what the barriers were and analyze the missed opportunity report, case reviews. You always do formal subtle but there's also a lot of teamwork that happens on a day-to-day basis.

We've done different focus groups and from questionnaires for providers about what they like about integrated care and really what comes of the most is the co-consultation. The co-location and the interaction between providers and therapists, that's what they rate the highest. That's what they find the easiest. People can check in with each other and talk to each other.

EHR tools are important. They can both help you become more efficient but sometimes they can also dictate your workflows and create frustrations. We use OCHIN EPIC. Likely they have built in screening for sheets and there's a built-in to alert in schedules and health maintenance models. There are PDSA's around effective use. We noticed in some of the missed opportunity reports, some of the medical assistants don't know how to set the schedule up to see the two alerts so some patients were being missed. Again we need this process of multiple PDSAs to get that high-level screening. We are proud that we got to a 90% level. We have to sustain it now because it's only recently made to the 90% level. We're going to have to move into a sustainability phase but it took us about six months to get there.

OCHIN EPIC is information network so we don't have control of our version of EPIC so other centers can network in. Some of the things we have to create ourselves and create our own missed opportunity reports.

And switching gears a little bit in talking about Suboxone. It's mainly our integrated team that has around 450 patients or so. There are two primary care teams. We serve about 30 patients. One team is a relatively newer team, more of an expansion. The other team has been doing it for about three or four months. We do have guidelines and some quality assurance. As you're looking at medication - assisted treatment on the team, one thing I don't want to make it overly complicated but medication a. Suboxone has a strong effect on preventing relapse. When you look at that relapse, even Suboxone by itself if you cannot do all the other things with respect to behavioral health treatment or you have to refer people out to specialty treatment, those models are helpful in and of themselves. It [indiscernible] so we had to start a OBOT model.

Again we do have guidelines that are complex addiction team created and but what we didn't want was patients to doctor shop between our teams and also from a quality assurance perspective moving from medication assisted treatment to all the primary care teams, want to make sure there is consistency. So there are guidelines around initiation and continuation of Suboxone, urine drugs green monitoring, diversion prevention [indiscernible] involves responding to red flags. There are lots of issues around corporate structure of controlled substances so we do not prescribe

benzodiazepines or but we will start someone on Suboxone if they're already on benzodiazepine. As you know [indiscernible] they're much more likely to develop an addictive disorder and develop trauma. They there can be quite complicated patients. So there are patients who prefer to take stimulants for ADHD but obviously it is controlled substances that can be diverted. We don't have a zero tolerance policy for that. We have a harm reduction model. We will not start that with ADHD unless they are six months into treatment without relapsing. There are other assessment and conditions that we look at. There has to be treatment planning, case review, and role definition is really important in a team-based model. Our nurses are responsible for certain aspects of the treatment. Primary care physician or psychiatrist who is prescribing the Suboxone is responsible for aspects of the medication in case management and the primary care physician, primary care and the psychiatrist if there are co-occurring and all disorders need to be treated. So that's important so people are not stepping on each other's toes.

I wanted to illustrate with a case example the kind of work you can do. Daria had been seen on the team for about 12 years. She had been treated for bipolar. Didn't have a lot of complicated routine primary care, some high cholesterol and she was on meds. She had a history of heroin use but she hadn't used in five years. She had missed a couple psychopharmacological appointments. She had started not coming to her therapy appointment. She was doing all this on an integrated team so the therapy and psychiatry. She was screened at a routine PCP visit just a regular screening questions, she told her physician she was relapsing with heroin. So that primary care doctor got her therapist that was on the team right that day. Turns out she had been using. She had a relapse of her co-occurring disorder and it turned out one of the triggers she had was her bipolar medication had been reduced. She was starting to get a lot of [indiscernible] and she fell back with the wrong crowd but she was able to get immediate access to Suboxone and in with psychopharmacological bipolar medications. This was a patient who was stable for about three years on our team with both her bipolar and her substance use. This is a patient who has probably been picked up 4 or 5 times on the street by police kind of confused. This is the great work you can do. And this for someone who is in their 30s. If we are able to keep her stable as much as possible, she can have another chance of a really positive life ahead of her. She has a son who is seven and she is also working.

That's the end of my presentation. I'm happy to answer questions.

>> AARON WILLIAMS: Thank you Mark for the presentation. Now is the question-and-answer period and it is a general question-and-answer period for both Mark and Connie. If you have questions for both of them, please type them into the question box so we can get those answered. We want to try and answer as many questions as possible here so without further ado, I think the first question is for Mark. There's a question related to the guidelines used for aversion prevention. Do you have specific guidelines you use to prevent aversion to medications? Can you expand about what you do in that area?

>> DR. MARK ALEXAKOS: In particular there is no one answer. There are two things. Basically a random total count and sort of nurses are trained on how to do a random pill count and protocol around that. It's not that complicated. I can get from the team if people are interested in the exact nature of the protocols. I could be off a tiny bit but there is a certain procedure set up and questions that a nurse would ask. They're supposed to do that randomly. They could also request that somebody gets cold and quicker for a pill count. Other things that you look at on the tox, if they're on Suboxone and Suboxone is not in the top screen, why is that? Often that's another way to pick up aversions. But again, red flags.

>> AARON WILLIAMS: Thank you.

>> DR. MARK ALEXAKOS: Red flags are often common and there are inconsistencies and sometimes just using our eyes and ears is the first clue which is something we always encourage.

>> AARON WILLIAMS: The next question here, they're asking have you integrated HIV screening in any way for clients with behavioral health conditions or other risky behaviors?.

>> DR. MARK ALEXAKOS: Yes we have a run-in white program and they're constantly testing and there's counseling and testing available on the team. It is in a different building. I would have to get back to you on that because the primary care theoretically—there are two ways. Counseling and testing but also it's supposed to be part of the primary care team. They should be happening on a routine basis on all our teams. I can double check if there's any follow-up that people are interested in on that. What we're doing around the hepatitis C, there was one vision was more specialized on hepatitis C work and that was happening in a specialty model. So we're also in an integrated complex model team. There was a little bit for us but not much for us to pilot hepatitis C with identification and treatment integrated into our substance use disorder work. We do it some and I highly recommended that is the advantage of doing integrated teams is to be a will to do that.

>> AARON WILLIAMS: Great, thank you. We have a question here for Connie. From your experience, what is a more appropriate entry point to train primary care providers to get more involved with substance abuse screening. I think this question is really speaking to primary care providers and the motivation to engage in this work.

>> DR. CONSTANCE WEISNER: Thank you for whoever asked that question. I really should have addressed this in my talk. It is so important. We found that we are not actually success coming in for visits in the 27 medical centers. This has not been easy. However, what we found made all the difference is really focusing on addressing is screening for alcohol and drug problems is going to help manage their patients. They think that they are going to have 99% of their patients needing a huge amount and trying to get them to treatment as those cases of people they been are very salient to



them. And when we can show them that it's really only about 0.7% of their patients who have a severe problem. This is a general population, not just a specific population. And that the others actually need if a brief intervention and that it will help manage their chronic conditions, it is much easier. We've giving them scripts to use such as "Joe, you're getting older, your hypertension. You really should not be drinking so much. Here are some things you can do about that." What we're really finding is that when people have repeat visits and we look at the screening data, their use is going down.

I think there are studies coming out on this that show physicians that many of their other patient's healthcare conditions are coming under control when they address even the risky use so that basically things like ABS control, adherence to medication, hypertension, and so on. There are really indications that this has positive effects. So it's really making the argument to primary care that this is going to help manage their patient base . And it isn't usually time-consuming. Just like they were going to talk to someone who is obese about getting some exercise, there are really evidence-based quick screening questions that have been put out by [indiscernible] and also brief interventions.

>> DR. MARK ALEXAKOS: In our experience, it is a small percentage of patients that score in the severe range at those are the ones that primary care is most worried about. As you're developing a workflow, it's that we have a plan for dealing with those patients so if you don't have the capacity on site, you do have a plan to refer those patients whether it was a co-manager or some ability to create a follow-up plan. RCM is a champion but having that primary care is champion around outside. But it's important to have primary care physicians who can talk because it really is a public health crisis. Having a primary care champion is important because physicians are already talking about this so intermittently helps buy the conversation a little more and what we found is most of the physicians, this is really intuitive and they found it was really helpful.

>> DR. CONSTANCE WEISNER: Of course performance measurements was already coming in. There are performance measurements on initiation of treatment and engagement but definitely coming in. That's going to make a big difference.

>> AARON WILLIAMS: Thank you for that answer to the question. We have another question here I think it may have to do with the confidentiality around substance use disorder in primary care.

>> DR. MARK ALEXAKOS: There is some break the glass features but it is an integrated problem list and medication list. Patients are aware of that. There are some forms they sign that make them aware of that. It really has not been a huge problem. You have to be careful with the records because also you are printing documents that are going elsewhere so most of the patients who chose to receive team, everybody's working together so they know people are talking and they're not eliciting price. But there are also things that they signed although I don't think many people read those anymore. It is a fully integrated record. When we first committed to EPIC, someone created a

summary. There was a release but there was a summary of some information that went to the hospital. You have to look at all these kinds of summary documents because sometimes there are these templates that put stuff on these documents that can go places. We had a whole review of all of those documents and had to fix one in particular to make sure some of that stuff wasn't going on there. It was a care summary document that went out to a specialty. A specialty visit that had nothing to do with their addiction care but the addiction was listed on the problem list. That kind of stuff but it only happened the one time where the patient was really upset.

>> AARON WILLIAMS: Thank you. We have another question here. I guess this [indiscernible]. Can you speak to this? I know Connie was talking about a change for primary care providers. Any experience or recommendations for potential training or what people need to know in the training program that you are aware of. That would be helpful to get doctors and nurses trained in this integrated care programs.

>> DR. CONSTANCE WEISNER: I think that many of the credentialing programs have classes and courses or even sessions on this. I would definitely look into that and you don't have to do the whole credentialing so you can look at continuing education courses. When you are looking in those courses, be sure to check that this is one of the topics. I think it's definitely one of the places. I know that HRSA is providing some training here. I think it's great when the training can involve both healthcare providers and addiction treatment professionals together in the same training. I think that kind of communication is really what is necessary. I think the ATT sees also have and do work on this and at some point as well as. I think they would be the best source to find out. But I would also look at your local credentialing program for particular courses or classes on that.

>> DR. MARK ALEXAKOS: There can be a [indiscernible] has a specialized SBIRT trainer that we use. We also have some internal expertise so we used a combination of resources. Another MAT leaves have training here in Massachusetts on a variety of substance use disorder issues and SAMHSA is a great resource. There are more resources than you would guess that can actually help you.

>> DR. CONSTANCE WEISNER: In NIAAA has a physician's guidebook that goes integrated to about evidence-based screening questions, brief advice, more detailed motivational training. It's called a physician's guide and it's under the national Institute of [indiscernible] website and I believe SAMHSA has that also. A lot of that can even be online I believe.

>> AARON WILLIAMS: Okay thank you. We have a few more questions here but we have limited time. Maybe one more and then we want to cover a few resources here for the group. There were a couple of questions about this so either of you can speak in general about this. I know that we are beginning to see some of the changing dynamics of the legislative level with the Affordable Care Act and it could be reviewed or replaced. Can you talk about the integration efforts and how there may be

a change in the landscape at the federal level. Can you speak in general how you see this moving forward?

>> DR. CONSTANCE WEISNER: The imperative is where it started all this equal access to treatment for people with or without insurance. The ACA has done amazing things about this. I think the bones of this are there any think many of us feel that the train has left the station anyway in terms of integration. I think our substance-abuse and healthcare providers realize that there is a benefit here. Also we don't know what this is going to look like in terms of what it is replaced with. I think it's going to be important to have a say and to make our field heard in terms of the importance of addressing addiction. We have other fields besides addiction that are really interested in some of the things that the ACA offered in terms of recovery services, recovery, pure health, and so forth. So it useful for other conditions such as diabetes and hypertension. So we are not alone in trying to have our voices heard in terms of what is kept. I think there is a lot to do yet but I do feel optimistic that the basic fundamental skeleton of what has been set in motion will remain. Am I just being overly optimistic, Mark?

>> DR. MARK ALEXAKOS: We've talked about this and it's hard to know until we see what happens but it's really important that your voice is heard. I think the real progress we're making, it's important that there is access to outpatient services. Broad behavioral care, substance use disorder, primary care, we're talking about how important it is to integrate to help instead of waiting for them to go to the hospital. My one worry with the repeal is there will be lots of people losing insurance. We don't want to wait for someone to use catastrophic coverage. We want people to get services as they're healthy to avoid the need for catastrophic services. There may be some stuff that gets decoupled. People will have maybe a savings account—let's hope we can all have a voice in continuing to preserve the access and increase the access. We don't want to spend the money on inappropriate extensive use of care that is not needed. I think that's what the whole ACA model is in the accountable care organizations. That is the goal.

>> DR. CONSTANCE WEISNER: We've always seen that it is the younger people who are healthy that go for the catastrophic incidence, high deductible plan. They are exactly the ones who are at risk for many of the addiction problems and substance abuse problems and including opioids.

>> AARON WILLIAMS: Thank you. We appreciate you sticking around and answering these questions. We have a little bit of time left and want to make sure we made the audience aware of a number of resources. Connie and Mark, some of you have cited these resource. Hopefully you've had a chance to see what these were and what is available related to this topic. SAMHSA in particular has a number of resources available for people now integrated in efforts. There is a mobile app for addiction and other providers. It is a wealth of resources for providers around MAT, use of particles. It's all available in a mobile app where you can use it on your phone or iPad or whatever mobile device you may have.

Additionally on the website, there are items related to substance use training, a lot of the training got cited earlier around integration. There we can learn more about substance use or integrated care. There is a training page related to that.

As well we have a number of different resources related to SBIRT clearinghouse that is on our integrated solutions page. You can check that out if you're looking for things like screening tools or other things that may make some of the screening and interventions more accessible to clients.

SAMHSA also has a number of toolkits related to MAT as well as physician clinical support around MAT and opioid treatment. Those resources are really valuable for clinicians, in particular primary care clinicians who are interested in providing addiction related services.

There are just a few others here. We have the American Society of addiction has practice guidelines around MAT. There are number of different things for clinical quality improvement managers on their website. In particular for some of their substance use and behavioral health expansion grantees. We also have a warm line or providers who are trying to provide substance use resources. We have a link there as part of this resource section.

CDC has also been heavily involved in developing guidelines for prescribing opioids for chronic pain. These are guidelines that were formed earlier last year, national guidelines around prescribing for opioids. That is also available on the CDC website and we have a link to that as well here.

Additionally we wanted to make sure that folks were aware of the Center for Integrated Health, we have something called innovation communities that end out at the [indiscernible] of this month that provide health centers for integrated healthcare providers and the like. The two major innovation communities, one is an implementation of MAT services for tobacco cessation which is a huge public health issue. There are MAT resources that are up. So helping health centers or behavioral health providers implement those MAT services for tobacco use, tobacco cessation. We also have an advanced integration community which is being led by Dr. Joe Parks. We are beginning to develop application for that and also we are thinking about behavioral health integration and chronic disease management. So really looking at it at a population-based which is sort of the next up in integration. That is another integration community where people can participate if you're interested in more information in going further than what we discussed in this webinar.

If you have any other questions or comments, there's a wealth of information on the website related to all things integration. If you need anything or wanted a search for something around integration or

trying to figure something out, the one thing I encourage you to do a search on our website and see if it comes up.

>> LAURA MICHAELS: Thank you for participating in our webinar. You should receive a popup for a survey on our webinar. We hope to see you in our future webinars. Have a great afternoon everybody!

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