Implementing Substance Abuse Services in Health Center Settings - Part 2: Lessons from the Field

August 17, 2017
SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderators:

Aaron Williams, Senior Director, Training and Technical Assistance for Substance Use, CIHS

Roara Michael, Associate, CIHS
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Before We Begin

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Learning Objectives

- Understand appropriate workflows for start-up and integration of substance abuse and Medication-Assisted Treatment (MAT) services
- Learn provider strategies for managing complex patients
- Understand appropriate substance abuse and MAT financing options
- Increase awareness of the impact of stigma
- Understand the proper opioid prescribing protocols
Today’s Speakers

**Brittany Tenbarge, PhD**  
Behavioral Health Consultant,  
Cherokee Health Systems

**Mark McGrail**  
Director, Addiction Medicine Services,  
Cherokee Health Systems
Today’s Speakers

**Rhonda Hauff**
Chief Operating Officer,
Yakima Neighborhood Health Services

**Jocelyn Pedrosa, MD**
Chief Medical Officer,
Yakima Neighborhood Health Services
Welcome from HRSA

Sue Lin, PhD, MS, Division Director
Bureau of Primary Health Care, Health Resources and Services Administration
Poll Question

1. What types of substance abuse treatment services are you delivering in your health center? (Select all that apply)
Establishing MAT Services: The Cherokee Health Services Experience

August 17, 2017

Brittany Tenbarge, PhD
Clinical Psychologist

Mark McGrail, M.D.
Director, Addiction Medicine Services
Our Concept – A Behaviorally Enhanced Healthcare Home

• Behaviorist on Primary Care (PC) team
• Consulting Psychiatrist & Addiction Specialist on PC Team
• Shared patient panel and population health goals
• Shared support staff, physical space, and clinical flow
• BH Access and collaboration at point of PC
• PC Team based co-management and care coordination
• Shared clinical documentation, communication, and treatment planning
Integrated MAT Clinic – Areas to Address

- **Personnel Actions** – hired a primary care/addiction medicine specialist, reallocated psychologist time, initiated hiring actions for additional primary care provider and nursing staff, dedicated a community health coordinator/case manager to team
- **Logistics** – facility renovations to allow for a dedicated space to conduct individual and group encounters, acquire appropriate urine drug screen testing materials
- **Training** – education of organizational clinical staff especially regarding SBIRT and MAT and distribution of referral guidelines; DEA “X” number required training
- **Clinical** – EHR templates, consent forms and treatment agreements, medication protocols, establish clinical competency for nursing/lab staff, IOP curriculum
The Medical Home Approach to Addiction Care

- **Addiction Specialist** – overall responsibility, gives and receives guidance, review consults, chart review for intake patients

- **Primary Care Provider** – screen routine preventive health/primary care needs, care coordination, medication safety

- **Behavioral Health Consultant** – provides IOP review, directs therapy needs, chart review for intake patients

- **Pharmacist** – TN CSMD report, medication safety and review

- **Nursing** – screens routine preventive health/primary care needs, lab test monitoring, clinic management, care coordination

- **Community Health Coordinator** - recovery environment review and action, care coordination/referral assistance

- **Peer Support Specialist** – Coming Soon!!
A Day in The Life of the Addiction Clinic

0800-0830: Arrival, pre-screen the day’s patients

0830-0900: Team Huddle

0930-1200: New Patient Intakes, Follow-up Visits, PC Visits, Group Therapy (Wed and Fri), Case Management

1300-1630: New Patient Intakes, Follow-up Visits, PC Visits, Group Therapy (Mon, Tues, and Fri), Case Management

1630-1700: Wrap-up/Debrief, Prep for the next day

As required: community meetings, internal and external training, continuing education, unscheduled patient care
Lessons Learned

• Complexity is the norm

• Rapid, imperfect implementation is okay

• Patients always point the way

• Early integration of the addiction medicine specialist

• Built upon an established IOP

• Staff, Staff, Staff

• Lack of community awareness, stigma of diagnosis and treatment (MAT)
And, of course - Show Me The Money

• Commercial insurance (few patients)
• Medicare/Medicaid (mostly pregnant on TennCare)
• HRSA Grant, State MAT Grant (homeless and uninsured)
• Personal Pay/Sliding Scale Fee (for additional services)

• Future of Funding
  • ????????????
  • Continuation of grants is critical
  • Unknowns regarding future
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Yakima Neighborhood Health Services

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Opioid related drug deaths 59% of all drug deaths 2004-2014
Yakima County

Publicly funded treatment admission rate, any opiate
2002 - 2004
State-wide rate 59.4 per 100,000

2011 - 2013
State-wide rate 176.3 per 100,000

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Starting With the Blank Slate

- Chief Medical Officer
- Clinical Pharmacist
- Psychiatric Nurse Practitioner
- Chief Operating Officer

- Patient eligibility
- Training needs
- Special situations
- Prescribing protocols
- Establish workflow
Workflow
(tools available if interested)

1) Patient identified for screening
2) Initial screening by Care Coordinator
3) Behavioral Health / CDP Assessment
4) Psychologist & Clinical Pharmacist Visit
5) Prescribing Provider Initial Visit
6) Maintenance Visits

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# Typical Visit Frequency

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Follow-up Interval</th>
<th>Medications Dispensed (Max of 32mg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction</td>
<td>Within 7 days</td>
<td>Maximum 7 days</td>
</tr>
<tr>
<td>Weeks 2 through 4</td>
<td>Weekly visits</td>
<td>Maximum 7 days</td>
</tr>
<tr>
<td>Weeks 5 through 8</td>
<td>Visits every 2-4 weeks</td>
<td>Maximum 14 days</td>
</tr>
<tr>
<td>Week 9 and beyond*</td>
<td>Visits at provider discretion</td>
<td>14-28 day supply</td>
</tr>
</tbody>
</table>

*For the first six months, follow-up can be extended to monthly. After the first six months, follow-up interval can be every 3 months and prescription can have up to a maximum of 28 days with 2 additional refills.*
Lessons Learned

- No ONE stands alone – MDs / ARNPs/ PA’s all trained together.
- Established patients only.
- Be prudent.
- Local methadone program is an option.
- Standing Orders (including Labs )
- Ongoing Behavioral Health support essential.
- Use of “My Phrases” (memorized documentation in E.H.R.) for prompts to assure consistent and complete evaluation.
Lessons Learned / Special Populations

- Care coordinators needed to follow up with missing patients.
- Coordinate with Street Outreach / Housing Case Managers when needed
- Ongoing meetings to refine workflow / what’s not working
- Ask patients if they have a safe place to store medications. Ask about housemate practices (protect against diversion).
## PRAPARE
Protocol for Responding to & Assessing Patients’ Assets, Risks, & Experiences

<table>
<thead>
<tr>
<th>Neighborhood</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>Where do you live at?</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
</tr>
<tr>
<td>Homeless Yakima, WA 98901</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Money and Resources:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>During the past year, what was the total combined income for you and your family members you live with?</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
</tr>
<tr>
<td>$9000.00</td>
</tr>
<tr>
<td>What is the highest level of school that you have finished?</td>
</tr>
<tr>
<td>Less than a high school degree</td>
</tr>
<tr>
<td>What is your current work situation?</td>
</tr>
<tr>
<td>Part time or temporary work</td>
</tr>
<tr>
<td>How many hours a week do you work?</td>
</tr>
<tr>
<td>Work 20-34 hours a week</td>
</tr>
<tr>
<td>How many jobs do you work?</td>
</tr>
<tr>
<td>2 jobs</td>
</tr>
<tr>
<td>What is your main insurance?</td>
</tr>
<tr>
<td>Medicaid</td>
</tr>
<tr>
<td>Do you have insurance through your job?</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Check all that apply.)</td>
</tr>
<tr>
<td>Food, Utilities, Clothing and Other</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Barriers to Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>Has lack of transportation kept you from medical appts., meetings, work or from getting things needed for daily living? (Select All That Apply)</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
</tr>
<tr>
<td>-- Kept from Medical Appt. and/or Medicine</td>
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## Social and Emotional Health:

<table>
<thead>
<tr>
<th>Social Integration and Health</th>
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<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>Who are the people or groups you usually see or talk to at these times?</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
</tr>
<tr>
<td>Friends</td>
</tr>
<tr>
<td>How often do you see or talk to people that you care about and feel close to? (Ex. talking to friends on phone, visiting friends or family, going to church or club meetings)</td>
</tr>
<tr>
<td>Less than once a week</td>
</tr>
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<thead>
<tr>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>Stress is when someone feels tense, nervous, anxious, or can’t sleep at night because their mind is troubled. How stressed are you?</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
</tr>
<tr>
<td>Very much</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Incarceration History:</th>
</tr>
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<tbody>
<tr>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
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Current Challenges

- Marijuana (recreational use legal in Washington State)
- Streamlining the workflow (condensing time from patient identification to first prescription)
- Mentorship for providers
- Keeping track of patients
- Diversion monitoring!
- Ongoing provider education to assure appropriate use of opiates in primary care.
- Naloxone – overdose prevention
- Quality Assurance - reporting
Patients

• As of last week
  33 patients screened
  • 11 found eligible and prescribed
    • 4 of these have been lost to follow-up
    • 2 lost before they got to prescriber visit
  • 2 referred to a higher level of care (inpatient treatment or specialty treatment provider)
Billing

• Medicaid Expansion
  • 94% patients Medicaid, 6% uninsured
  • 340b in-house pharmacy ($52/month average)

• Direct Reimbursement (Medicaid & MCOs):
  • Provider visits (MDs/ DOs, ARNPs, PA’s)
  • Behavioral Health Specialists
  • Psychologist
  • Psychiatric Nurse Practitioner

• Not Reimbursed – supported by SASE grant
  • Care Coordinators
  • Clinical Pharmacist
Questions?

Rhonda Hauff, Chief Operating Officer / Deputy CEO
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Jocelyn Pedrosa, MD
Chief Medical Officer
Jocelyn.pedrosa@ynhs.org
Poll Questions

1. What are your barriers to providing MAT? (Select all that apply)

2. What’s your greatest barrier to Buprenorphine induction? (Select one)
Discussion
Questions ?
CIHS Resources

- **Centers for Disease Control and Prevention**
  - [Overdose Data](#)
  - [Guidelines for Prescribing Opioids for Chronic Pain](#)

- **PCSS MAT Waiver Training**
  - [http://pcssmat.org/education-training/mat-waiver-training/](http://pcssmat.org/education-training/mat-waiver-training/)

- **Available for download under Event Resources:**
  - YNHS Workflow for Medication Assisted Treatment (MAT)
  - Initial Questionnaire for Buprenorphine-naloxone Treatment (MAT)
  - MAT Algorithm for Care Coordinators
  - Implementing Substance Abuse Services in Health Center Settings Part 1 Presentation

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CIHS Tools and Resources
Visit at www.samhsa.gov/integrated-health-solutions
or
e-mail integration@thenationalcouncil.org
Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.