Engaging Your Team and Your Clinic in MAT

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So, Why Aren't You Already Doing This?

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Common Barriers and Stigma

- I don’t see addiction patients
- I don’t want “those” people in my clinic
- It’s just trading one addiction for another
- Why bother?
- We don’t have the staff
- We don’t have the space
- We don’t have the time

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I don’t see addiction patients

- **Yes, you do!!**
- Approximately 1 in 9 people in the U.S. over the age of 12 years has used an illicit substance in the past 30 days
- Approximately 1 in 13 people in the U.S. over the age of 12 years has a Substance Use Disorder
- Of adults 18 years and older diagnosed with any mental illness, 18.3% had a co-morbid Substance Use Disorder
- So, Yes – you do, you just may not know it!

I don’t want “those” people in my clinic

- **They are already there!!**
- Just over 1 million people with a SUD are OVER 65 years old
- One-third of patients with a SUD are employed
- While lower SES correlates with smoking in young adults, those with HIGHER SES are more likely to use marijuana and have heavy/episodic drinking
- From 2004-2013, heroin use increased 60% in those with an income more than $50k and 63% in those with private insurance
- Addiction affects everyone!

It's just trading one addiction for another

- Buprenorphine and naltrexone are prescribed medications for a chronic disease

DSM5	Addiction	Bup	Naltrexone
Larger amounts/longer time	Y	N	N
Unsuccessful at controlling use	Y	N	N
Time spent around use	Y	N	N
Cravings/strong desire to use	Y	N	N
Fail to fulfill obligations	Y	N	N
Use despite recurrent problems	Y	N	N
Activities given up	Y	N	N
Use when hazardous	Y	N	N
Use despite knowing problems	Y	N	N
Tolerance	Y	N	N
Withdrawal	Y	Y	N

- Patients are not addicted to MAT!

Why Bother?

- Because treatment works!
- Many patients will need multiple attempts at treatment
- Definitions matter!!
- Relapse rates in addiction are similar to other chronic diseases, e.g., hypertension at 50-70% compared to addiction at 40-60%
- Treatment results in cost savings of up to 12:1 compared to healthcare and criminal justice systems costs
- By the way, you're already treating these patients – treating addiction makes treating other chronic diseases more effective

We don’t have blah, blah, blah…

- Build the plane as you fly it!
- Some care is better than no care
- Start slow, be flexible, build your program – patients will show you the way
- Most barriers can be overcome – find an innovative champion
- Remember when you were an intern/resident/post-doc – do your homework, have a good knowledge base, identify a mentor, and jump in
- Healthcare utilization improves with treatment (i.e., you may end up with more time)

Pause and Reflect

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Getting Started

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Integrated Addiction Care Clinical Model

1. Design your workflow; put it on paper.
2. Develop roles and responsibilities for Addiction Specialists, Psychiatry Providers, BHCs, Peer Support, Nursing, Lab, Front Desk, Scheduling, etc.
3. Get the right people on board – Especially focus on hiring and retaining strong and Addiction Specialists and BHCs (often a limiting factor in many parts of the country)
4. Get the schedule “right”

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Integrated Addiction Care Clinical Model

6. Structure your screening process (which screening tools, who does them, quick documentation, communications)
7. Layout your facilities (as you've heard, proximity matters!)
8. Consider a pilot and conduct PDSA improvements *quickly*
9. Start multidisciplinary huddle/treatment team
   - Block out around 15-20 minutes
   - Review schedule for day or shift, patient needs
   - Standing orders, know what's needed for patients and perform tasks

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Schedule

Scheduling

- Orientation of Clinic to Community Needs
  - Homeless Populations
  - Trauma-Informed Care
- Extended Hours (Evenings, Weekends)

Productivity

- Function of demand, work flow, staff mix, funding
- 30-60 minutes for Addiction Specialist intakes; 15-30 minutes for follow-ups
- 15-30 minutes for BHC intakes and follow-ups
- Group medical visits for improved population-based care

Continued Investment in Training & Professional Development

- Clinical Mentorship/Coaching
- Team Meetings/list-servs/conf calls
- Peer Review
- Organizational Cont Ed
- Clinical Leadership Oversight

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Building Key Relationships

- Relationships with staff will be key to clinical effectiveness
- Take time to get to know staff at all levels
  - Consider shadowing others
- Observe, Observe, Observe!
  - Take note of office culture, office alliances, informal leaders, & work flow
- Put your clinical skills to work!
  - Be positive, authentic, warm, personable

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Embrace Change

- Approximately 1 in 14 people 12 years of age and older have a SUD – you are seeing them everyday!
- Like most medical conditions, there is more than one “right” treatment plan
- The evidence is there – MAT works
- If you build it, they will come
- Patients will show you the way

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Strategies for Success

- Open Access
- Group Medical Visit Model
- Workforce Development
- Team Work

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Open Access

- Intake clinic
  - Walk-in
  - Team of Staff—BHCs, Therapists, Community Health Coordinators, and Peer Support Specialist
  - Present continuum of A&D treatment options
- Triage for high priority patients
  - Pregnant women
  - Recent overdose(s)
  - Recent hospitalization for drug-related medical or psychiatric condition
  - Discharging from detox/inpatient A&D facilities
  - Patients' partners/family likely to impact a current patient's recovery

Group Medical Visit Model

- Routine component of care
  - Join group 2-4 weeks after intake
  - Group becomes the medication follow up visit; prescription duration varies based on progress
- 3 hour group weekly
  - 1 hour of “check-in”
    - Progress, recent use, current medical and behavioral health needs
  - 2 hours of curriculum
    - Didactic education, discussion, hands-on activities, goal-setting
- Co-facilitated by Behavioral Provider and Certified Peer Recovery Specialist
  - Both providers present for “check-in” and didactics
  - Pulled out for vitals + brief visit with Addiction Specialist at least monthly
- Group attendance dramatically improved when services performed concurrently

Workforce Development

- Continuing Education events for CHS providers
- Clinic visits for ongoing education and collaboration
- Real-time phone consultation
- APA Accredited Psychology Internship
- APPIC Postdoctoral Fellowship
- Training for Family Medicine residents

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Team Work

- Team work is critical
- Everyone in the practice must be on board
- Be part of a broader community effort
  - Healthcare partners
  - Law enforcement
  - Schools
  - Community organizations
  - Politics ☹

Lessons Learned

- Rapid, imperfect implementation is okay. Patients always point the way.
- Complexity is the norm. All conditions are primary and require concurrent treatment.
- Rapid access, depth and breadth of services, continuity of care, and high level care coordination and communication are essential.
- This is a marathon, not a sprint.
- Practical barriers and resource needs complicate the path to recovery. Enhanced community-based outreach and support are needed.