Engaging Your Team and Your Clinic in MAT

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So, Why Aren’t You Already Doing This?
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
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

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

- 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
Getting Started
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”
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
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
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
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
Strategies for Success

• Open Access

• Group Medical Visit Model

• Workforce Development

• Team Work
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
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.