Addiction Treatment Starts Here: Behavioral Health

Virtual Learning Series
Webinar 3
July 9, 2020
Welcome to our ATSH:BH Virtual Learning Session!

Please rename yourself so we know what organization you’re from. This will help facilitate discussion and follow-up. To rename yourself:

✔ Find the participant list: Go to the bottom of your Zoom window and click on the word Participants

✔ Hover/click: Once the participant list pops up, hover over your name on the participant list; you may be able to click rename or you may have to click the more button and then click rename

✔ Enter your new name: Enter your first name and your clinic’s name (e.g., Briana – CCI, or Shelly – ATSH coach)
Webinar Reminders

1. Everyone is muted.
   - *6 to unmute
   - *6 to re-mute

2. Use the chat box for questions and to share what you’re working on.

3. This webinar is being recorded. The slides and webinar recording will be emailed and posted to the ATSH program page.
Agenda

• Housekeeping + Introductions

• Optimizing Clinical and Non-Clinical Partnerships
  • Framework
  • Perspectives from two clinics

• Discussion

• Closing
Introductions
Clinical + Non-Clinical Partnerships

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• Director of Addiction Medicine, L.A. County Department of Health Services
• Volunteer Assistant Clinical Professor of Addiction Medicine at the UCLA Department of Family Medicine

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• Direction of Addiction and Homeless Services
• Marin City Health and Wellness Center and Bay View Hunters Point Clinic
Disclosures

• Brian Hurley, M.D., M.B.A., DFASAM has no conflicts of interest to report

• Brittany McCafferty, Ph.D. has no conflicts of interest to report

• Dominique McDowell, BA, RLPS, SUDCCII has no conflicts of interest to report
Framework for Partnerships
Treatment Goals

• Range of treatment goals

- Minimization of harms from ongoing use
- Sustained recovery with abstinence from all substances

• Treatment Options; Federations of State Medical Boards 2013
  - Partial Agonist (Buprenorphine) at the mu-receptor – OBOT/OTP
  - Agonist (Methadone) at the mu-receptor - OTP
  - Antagonists (Naltrexone) at the mu-receptor
  - Counseling and/or peer support without MAT
  - Referral to short or long term residential treatment

Source: PCSS Waiver Training Slide Deck
Comprehensive Behavioral Health

Components of Comprehensive Drug Abuse Treatment

- Child Care Services
- Vocational Services
- Family Services
- Mental Health Services
- Housing/Transportation Services
- Medical Services
- Financial Services
- Educational Services
- Legal Services
- HIV/AIDS Services

Intake Processing/Assessment
- Behavioral Therapy and Counseling
- Treatment Plan
- Substance Use Monitoring
- Clinical and Case Management
- Pharmacotherapy
- Self-Help/Peer Support Groups
- Continuing Care

The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

Recovery Oriented System of Care

- Mutual Support Groups (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, LifeRing, etc)
- Therapists (Cognitive Behavioral & Motivational Therapies)
- Residential Support/Sober Living
- Counselors & Aftercare Groups
- Family Support Family Therapy
- Social Support Sober Friends
- Hedonic Rehabilitation
- Workplace
- Addiction Medicine Physicians (Pharmacotherapy)
- Schools and Colleges
- Daily Drug & Alcohol Testing
- Religious Organizations
- Faith-based Organizations
- Relapse Plan
- Cultural Groups Recovery Activism

http://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
CLINICAL-COMMUNITY LINKAGE INITIATIVE
Genesee Community Health Innovation Region

Greater Flint Health Coalition

1. Community member completes social determinants of health screening
2. Community member referred to clinical community linkage hub
3. Community health workers engage with residents in community settings
4. Resources identified and linkages made to address social determinants of health

Social Determinants of Health:
- Food
- Utilities
- Housing
- Child Care
- Medical Care
- Education
- Crime
- Transportation
- Drug Abuse
- Mental Health
- Water
- Social Support

Great Lakes Health Connect Community Referral Platform

http://michirlearning.org/about-chirs/in-your-community/genesee
Example Community-Clinical Linkages Framework

Building Blocks
- Organizations and inter-organizational linkages
  - Health care system
  - Governmental public health
  - Community

Intervention/Innovation
- Practice and/or public health/community interventions in delivery system design, decision support, or information systems, for example:
  - Co-locating services
  - Developing referral mechanism to prevention resources
  - Coordinating services at different sites

Short-term (Process)
- Increased awareness of community resources
- Increased communication across sectors
- Improved referral and tracking mechanisms
- Resource sharing across sectors

Intermediate
- Improved coordination of services for individuals (e.g., changes in practice, greater reach, greater efficiency, new services, sustainability)
- Improved health behaviors (e.g., improved nutrition, increased physical activity, reduced tobacco use)

Long-term
- Improved health outcomes (e.g., obesity, cardiovascular disease, diabetes)

Predisposing, Enabling, and Reinforcing Factors
- Community context (i.e., politics, funding, policies such as reimbursement for services)
- Organizational capacity (prevention delivery system) (i.e., organization features, practices, and processes; staffing and infrastructure; effective leadership and senior management support; policies; shared decision-making)
- Innovation characteristics (i.e., adaptability/flexibility, compatibility/fit with provider, organization, community)
- Provider characteristics (i.e., perceived need for and potential benefits of the innovation, self efficacy, skill proficiency)


Other Community Partners

Core Partners

- Mission/vision alignment
- Strategic planning
- Governance, leadership and resource commitment

- Support and input into mission and key goals
- Specific expertise or areas of focus
- Development and operational support for programs

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<th>Patient Needs</th>
<th>Clinical Partnerships</th>
<th>Non-Clinical Partnerships</th>
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<td>Patient needs that drive our partnership strategy (e.g., higher level of SUD care, other physical health care, housing, etc.)</td>
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<td>What we still need to know about our patient needs</td>
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<td><strong>Partners</strong></td>
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<td>Future Partners</td>
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<td><strong>Next Steps</strong></td>
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<td>Data we collect to understand impact of partnership</td>
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<td>Our communication needs (bi-directional)</td>
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<td>Referral pathway/process</td>
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<td>Use MOU?</td>
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**Rating Scale Key:** 1 = needs development; 3 = developing; 5 = well developed; NA for items that don’t apply
Questions?
Care for Patients with Complex Needs

- Substance use disorder treatment is part a larger framework of complex care
  - Addressing the needs of individuals whose complex physical, behavioral, and social needs resulting in extreme patterns of healthcare utilization
  - Leveraging community supports and institutions
  - Investment in human relationships
- Care delivery – flexible, interdisciplinary, evidence-based, individualized
- Factors that increase success – reducing silos, “skin in the game,” housing

Adapted from: Camden Coalition and The National Center for Complex Health & Social Needs, 2019; Center for Health Care Strategies, 2013
Where to Start: Conduct A Needs Assessment

• Needs assessment should address:
  • Your mission
  • Target population – very complex physical, behavioral, and social needs
  • Where you want to be on the ASAM continuum of care
  • In-house capacity (e.g., staff, facilities, training)
  • Most significant barriers to meeting our patients medical, behavioral and social needs
  • Which of these needs will require coordination with outside entities
Challenges

• Overcoming cognitive bias that more care (expensive, high-tech) is better
  • Invest in relationships between patient and healthcare team
  • Understand and treat root causes concurrently
  • Well coordinated, flexible, easy to access care is better

• Reconceptualizing external care partners (e.g., specialty mental health, behavioral health, primary care) as essential members of care teams
  • Designing workflows, care pathways, communication channels, MOUs, etc., to reflect this new vision

• Leveraging team members’ time to engage patients and partners in a way that not only gets them into care but keeps them in care

Center for Health Care Strategies, 2013
Transitions Between Levels of Care

• Goal = *rapid access* to highest level of care needed/desired and smooth transitions with *minimal gaps between levels of care*

• Significant barriers exist for most

• Advocating and navigating during transitions
  • Workflow
  • Networking/partnering
Marin City: Partners, MOUs
Process to Establish or Refine a Partnership

- **Identify** the clinical or non-clinical need our patient population has that a partner can help address
- **Explore** options in the community to fill this need
- **Contact** organization, introduce Marin City, including goals, philosophy, patient population, etc.
  - Visit site to ensure we understand what a patient may encounter at that site -- helps us establish an authentic understanding of where we’re sending our patients
- **Determine** whether it’s a good fit
- **Determine** whether partnership is informal (e.g., no MOU) or requires an MOU or letter of agreement
- **Discuss** terms for formal agreement
- **Monitor** partnership (e.g., patient satisfaction)
Examples of MOUs used by Marin City

Operational Agreement between
Marin City Health and Wellness Center
And
The Helen Vine Recovery Center

The Marin City Health and Wellness Center (MCHWC) is a Federally Qualified Health Center (FQHC) that provides primary medical, dental, behavioral healthcare, and recovery services for low-income patients.

The Helen Vine Recovery Center is a licensed 26-bed co-ed residential detoxification program that provides welcoming, recovery-oriented services to individuals with alcohol and drug addiction issues, as well as co-occurring psychiatric problems.

The terms of the operational agreement are listed below:

This Operational Agreement will go into effect June 1st, 2019, and will be evaluated and renewed on an annual basis by both organizations.

- MCHWC agrees to see Helen Vine clients for medical clearance for their program (excluding patients in moderate to severe alcohol withdrawal who will go to the hospital for medical clearance).
- MCHWC will keep appointment slots available for Helen Vine clients at 880 Las Gallinas, Suite 2 in San Rafael on Monday mornings and Wednesdays (all day). Number of appointment slots to be determined.
- After Helen Vine clients are established as MCHWC patient, they are candidates for our MAT program.
- If Helen Vine client has met all qualifications for our MAT program (had physical, blood work etc.), Suboxone can be prescribed by MCHWC medical provider and continue treatment at the Helen Vine Center.
- Helen Vine will agree to refer their clients to Marin City Health and Wellness Center for medical, dental and behavioral health care.

Terminating the Agreement. Either party may terminate the Agreement at any time by giving thirty (30) days written notice of termination.

The undersigned affirm that they have read and understood this agreement in its entirety, and hereby agree to the terms and conditions stated therein:

Date: ___________________________  Date: ___________________________

Name: ___________________________  Name: ___________________________

Title: ___________________________  Title: ___________________________

Marin City Health & Wellness Center  The Helen Vine Recovery Center
Peers and People with Lived Experience

• People with lived experience, community health workers (CHWs) and others can help connect patients to services they need
  • They understand the local community and their needs
  • They have unique insight and expertise
• Contributes to effectuating partnerships with clinics/services
• Process for communication/outreach
Discussion
What patient needs are you already addressing well through partnerships you’ve created? What makes this partnership work?
In establishing a partnership, how can you share your culture and learn about a potential partner’s culture to make sure there is alignment?
What steps can you take to effectively prepare your patient for care they get elsewhere?
What is one thing that you can do that would improve your ability to develop new or strengthen existing partnerships?
Upcoming Activities + Poll
Upcoming Activities/Deadlines

- **July 15**: NICHQ data
- **August 19**: Sustaining Improvements to Your MAT Programs webinar *(Save the Date!)*
- **August 31**: Progress report and capability assessment (IMAT). Please finish by this deadline!
- **September 24**: Celebrations webinar *(Save the Date!)*
Poll

1. On a scale of 1-5, please select the number that best represents your overall experience with today's session.
   - 5 - Excellent
   - 4 - Very Good
   - 3 - Good
   - 2 - Fair
   - 1 - Poor

2. Please select the number that best represents your response to the statement: Today's session was a valuable use of my time.
   - 5 - Strongly Agree
   - 4 - Agree
   - 3 - Neutral
   - 2 - Disagree
   - 1 - Strongly Disagree
Questions

• Email: Briana Harris-Mills  
briana@careinnovations.org
Thank you!