Addiction Treatment Starts Here: Behavioral Health

Virtual Learning Series

Webinar 3

July 9, 2020

CCI
CENTER FOR CARE INNOVATIONS

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

Brian Hurley, MD, MBA, DFASAM

- Clinical Director of the CCI ATSH Programs
- 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

Brittany (Tenbarge) McCafferty, PhD

- Behavioral Health Consultant, Cherokee Health Systems

Dominique McDowell, BA, RLPS, SUDCCII

- 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

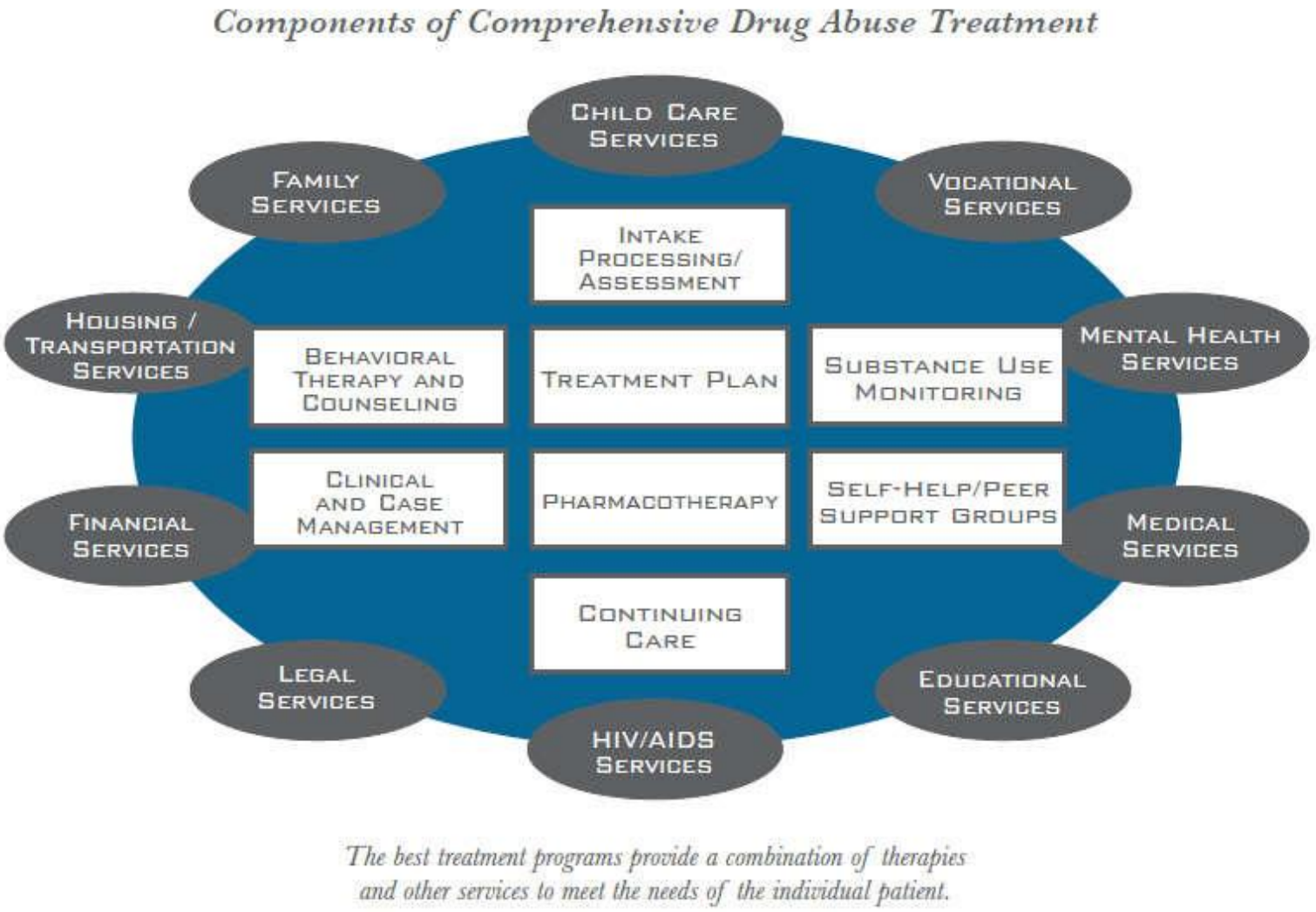
Minimization of harms from ongoing use

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

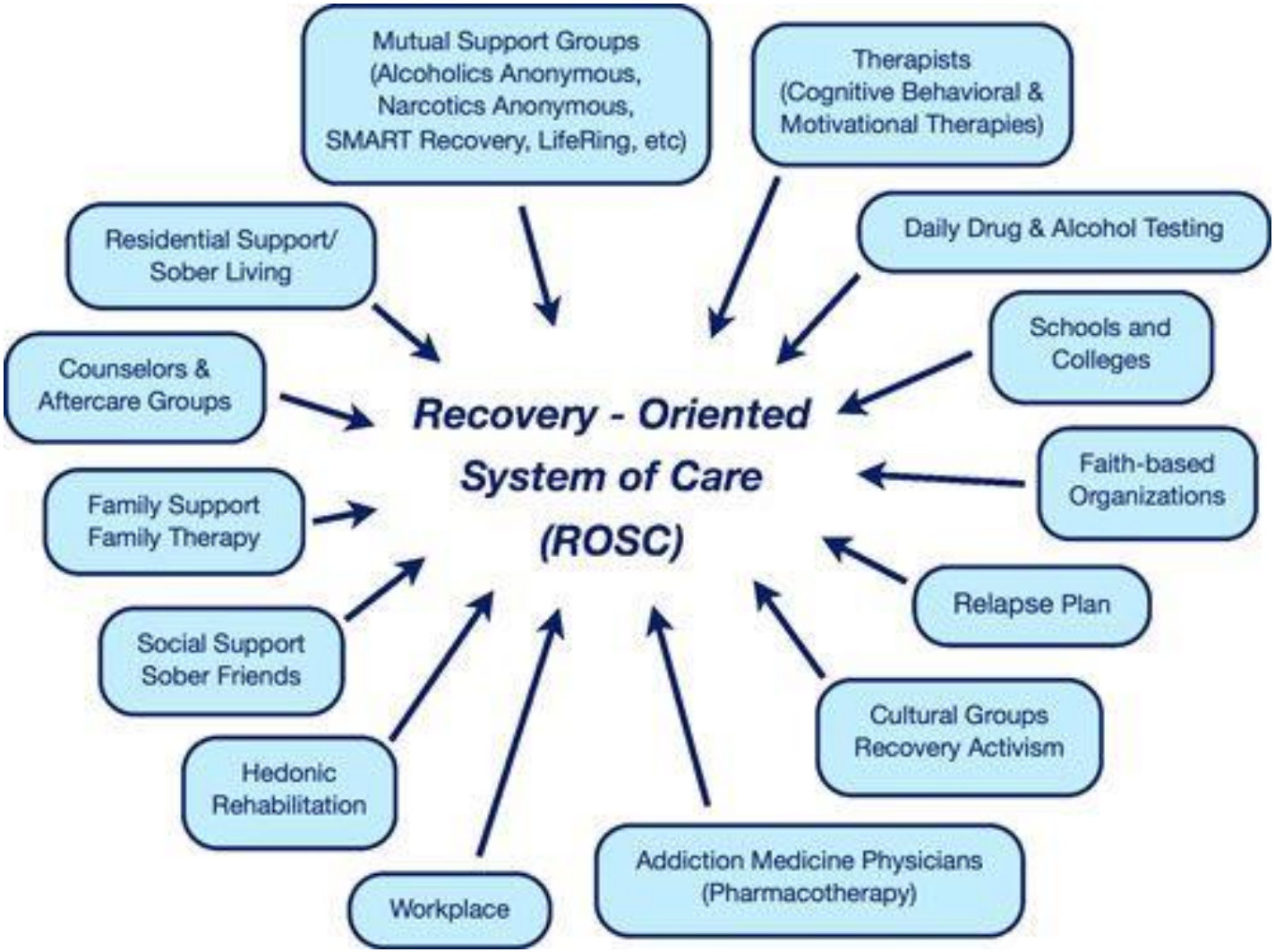
Source: PCSS Waiver Training Slide Deck

Comprehensive Behavioral Health

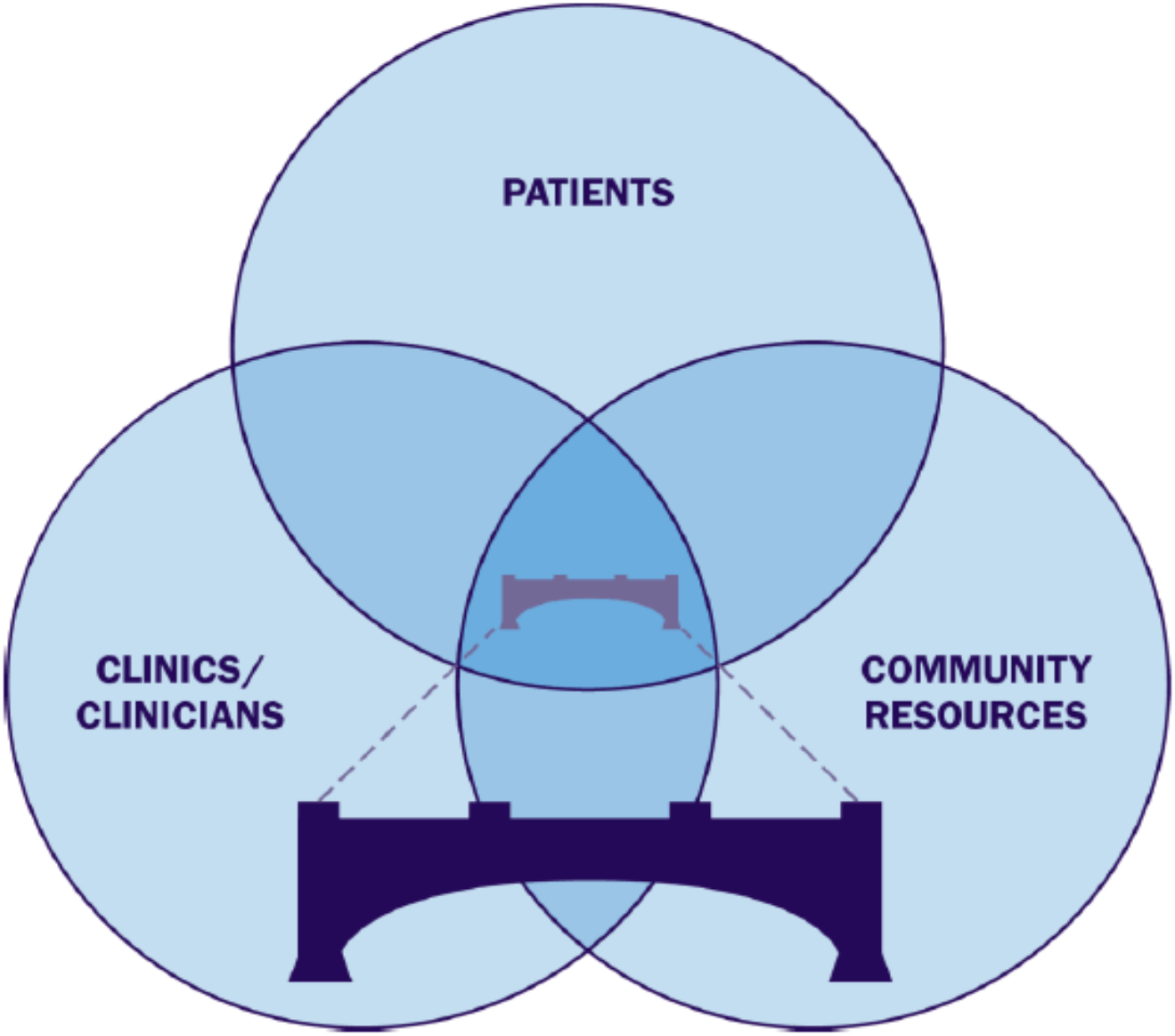


NIDA. (2018, January 17). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). Retrieved from http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition on 2019, April 7

Recovery Oriented System of Care



http://www.samhsa.gov/brss-tacs/recovery-support-tools/peers



Appendix A: Conceptual Framework. Content last reviewed July 2013. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/prevention/resources/chronic-care/clinical-community-relationships-eval-roadmap/ccre-roadmap-apa.html

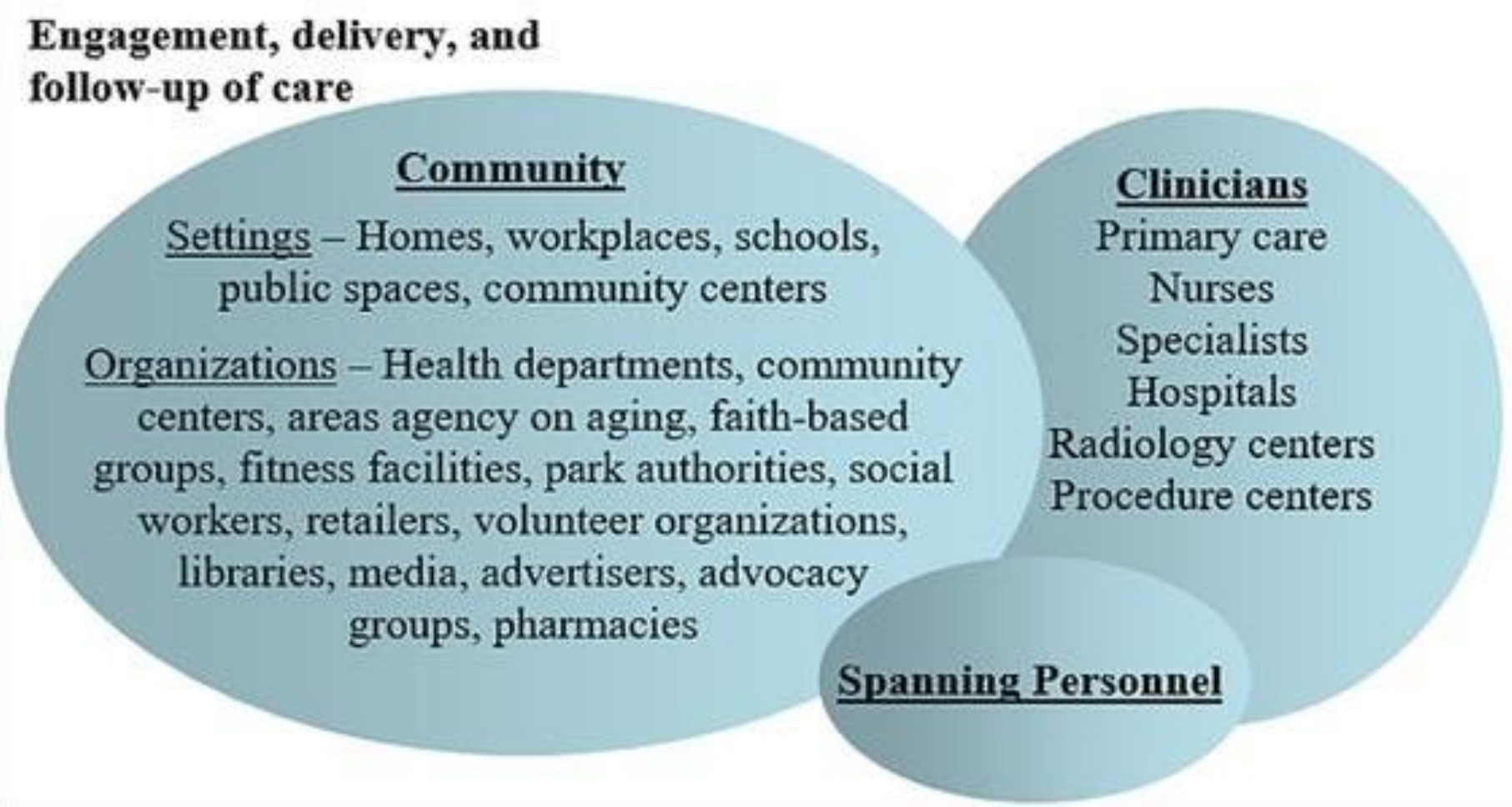
CLINICAL-COMMUNITY LINKAGE INITIATIVE

Genesee Community Health Innovation Region

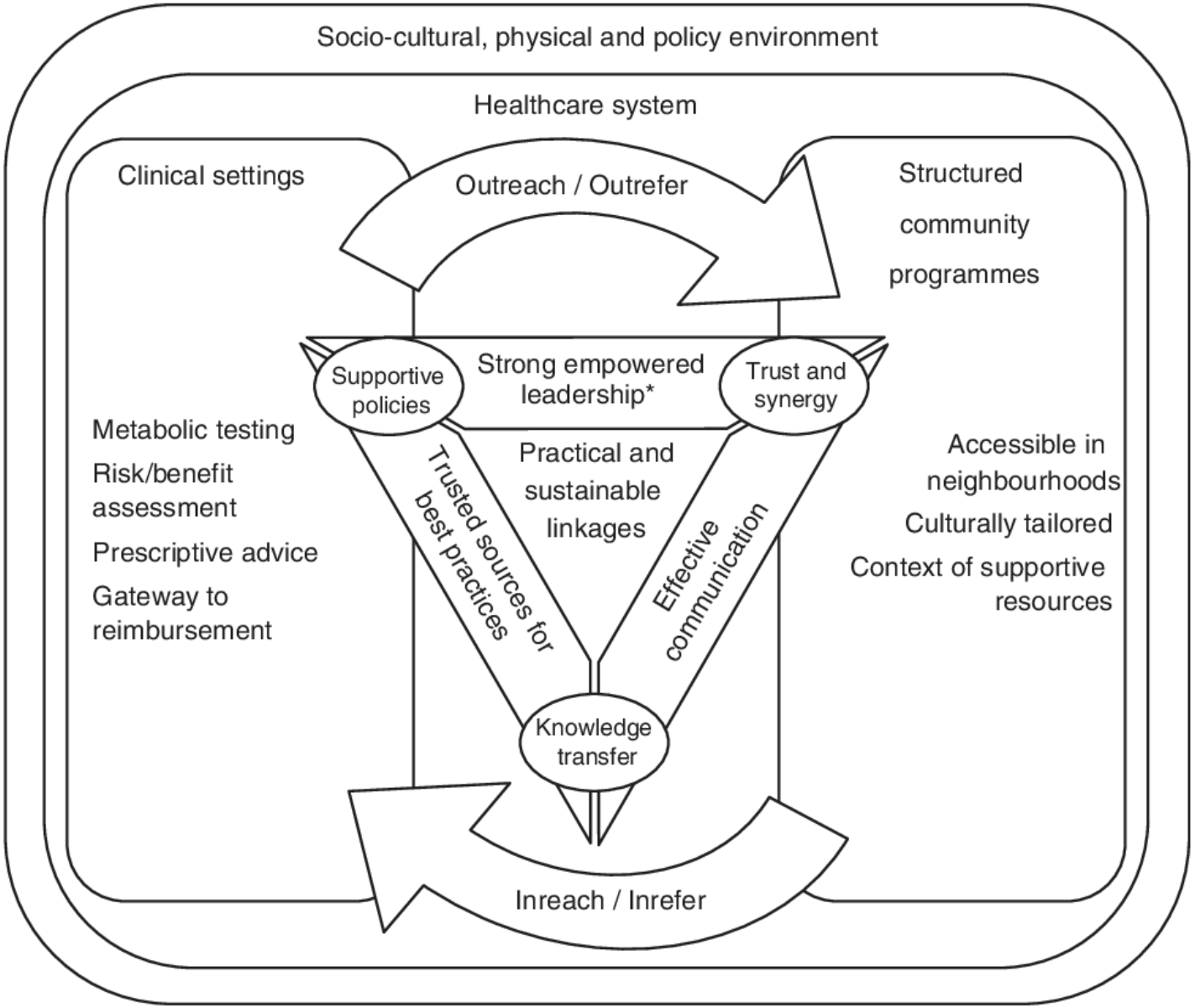
Greater Flint Health Coalition

Great Lakes Health Connect Community Referral Platform

http://michirlearning.org/about-chirs/in-your-community/genesee

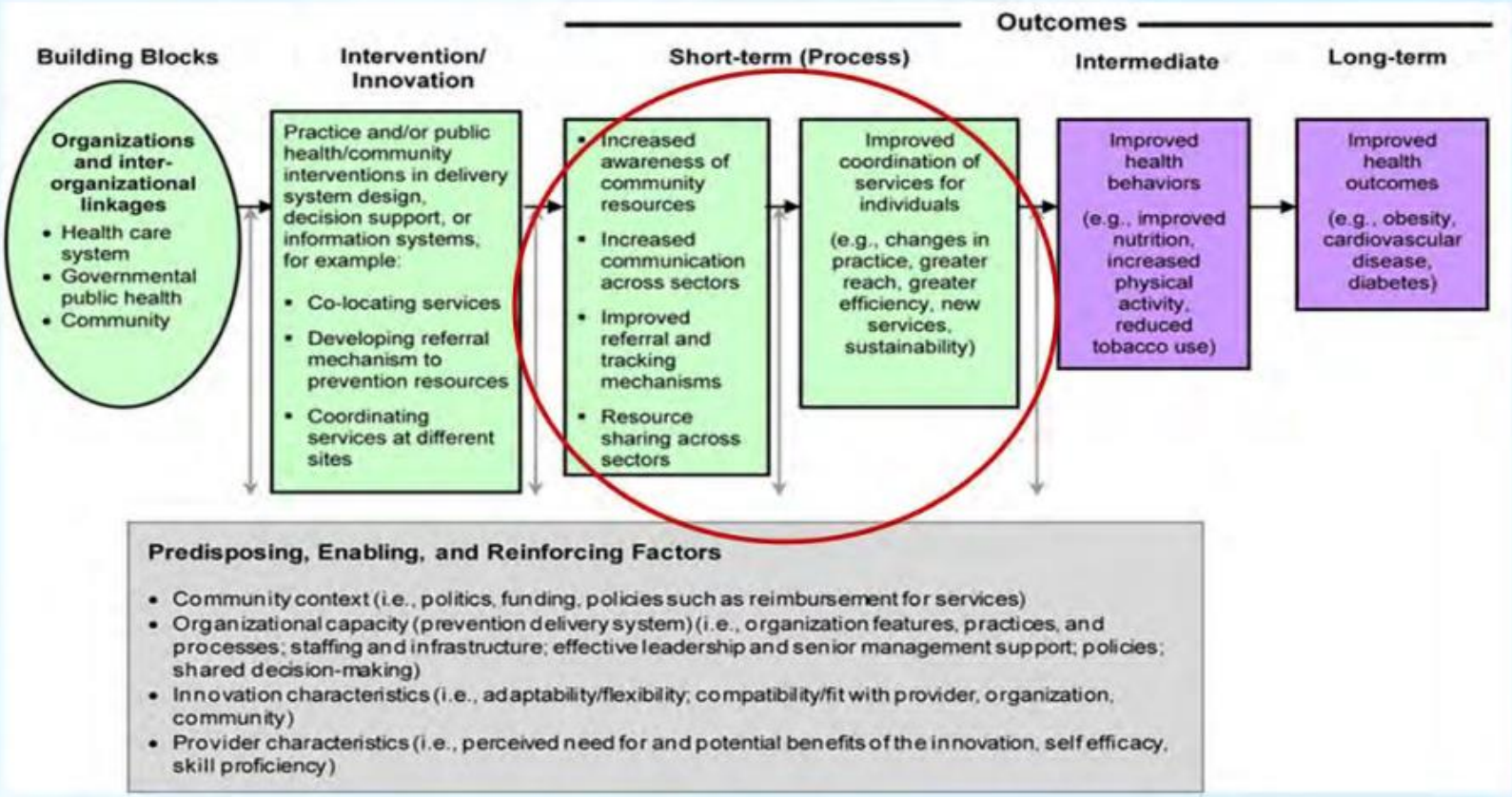


Krist, Alex H., Sebastian T. Tong, Rebecca A. Aycock, and Daniel R. Longo. "Engaging patients in decision-making and behavior change to promote prevention." Information Services & Use 37, no. 2 (2017): 105-122. http://pubmed.ncbi.nlm.nih.gov/28972524



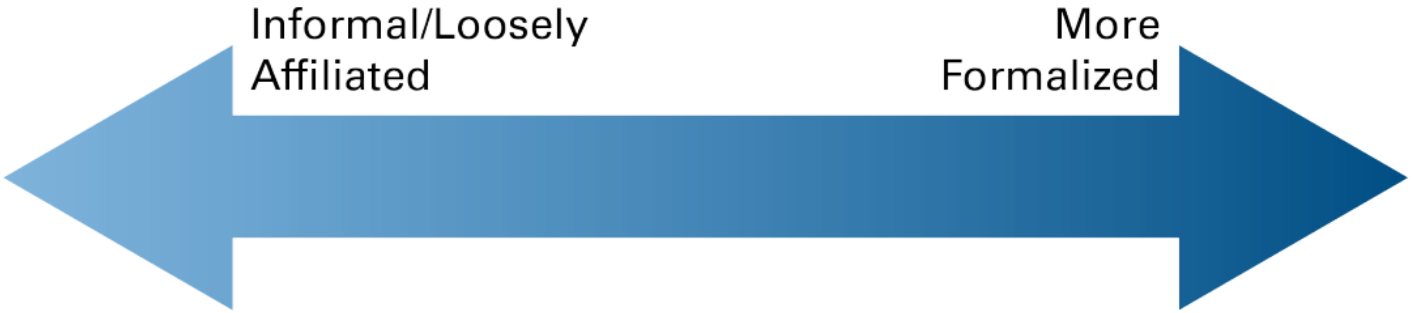
Ackermann, Ronald T. "Description of an integrated framework for building linkages among primary care clinics and community organizations for the prevention of type 2 diabetes: emerging themes from the CC-Link study." *Chronic Illness* 6 (2010): 100 - 89. http://pubmed.ncbi.nlm.nih.gov/20484325

Example Community-Clinical Linkages Framework



Source: Agency for Healthcare Research and Quality (AHRQ). (Prepared by Porterfield D, Hinnant L, Kane H, et al.). Linkages Between Clinical Practices and Community Organizations for Prevention: Final Report. 2010.

https://www.ncbi.nlm.nih.gov/pubmed/22690974



- Preferred referral list
- Nonbinding / verbal agreement for referrals

- Focused on networking, knowledge sharing, targeted resource, or expertise contributions
- Ad hoc committee or task force focused on specific issue or shorter-term solution

- Steering committee or advisory board with shared decision-making, resource contributions, program development and implementation
- Alliance, coalition or consortium focused on common goals

- Strategic alliance with contractual agreement (e.g. memorandums of understanding, binding contracts)

- Joint venture
- New organization such as a 501(c)(3) or separate backbone organization structure
- Dedicated operating division, subsidiary and/or staff

Health Research & Educational Trust. (2016, August). Creating effective hospital-community partnerships to build a Culture of Health. Chicago, IL: Health Research & Educational Trust. Accessed at http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf

Health Research & Educational Trust. (2016, August). Creating effective hospital-community partnerships to build a Culture of Health. Chicago, IL: Health Research & Educational Trust. Accessed at http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf

http://www.conservationgateway.org/ConservationPlanning/partnering/cpc/Pages/step3.aspx

ATSH:BH Virtual Learning Session 3: Team Time Worksheet
Community Partnerships

		Rating Scale (1 – 5)	Clinical Partnerships	Non-Clinical Partnerships
Patient Needs	Patient needs that drive our partnership strategy (e.g., higher level of SUD care, other physical health care, housing, etc.)			
	What we still need to know about our patient needs			
Partners	Current Partners			
	Future Partners			
Next Steps	Data we collect to understand impact of partnership			
	Our communication needs (bi-directional)			
	Referral pathway/ process			
	Use MOU?			

Rating Scale Key: **1** = needs development; **3** = developing; **5** = well developed; **NA** for items that don't apply

Questions?

Cherokee Health

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

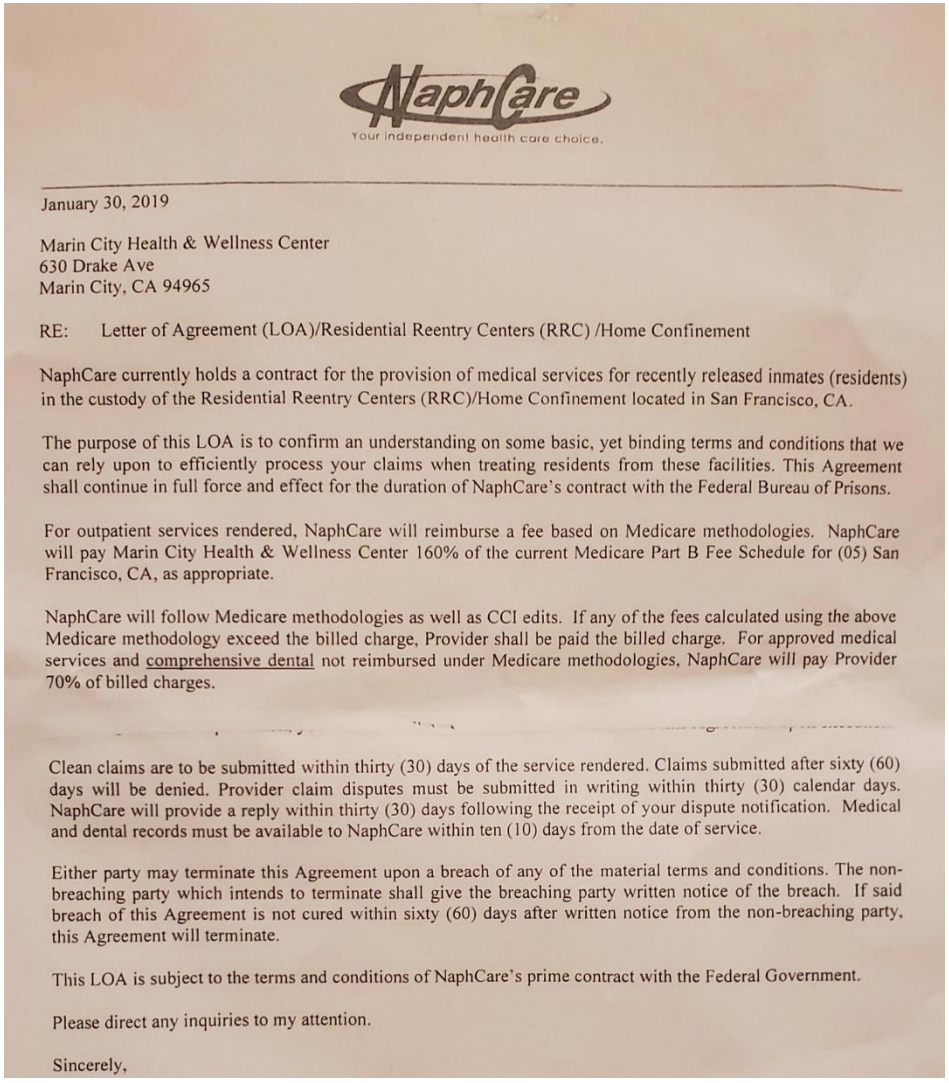
- Goal = *rapid access* to highest level of care needed/desired and smooth transitions with *minimal gaps between levels of care*
- Significant barriers exist for most
- Advocating and navigating during transitions
  - Workflow
  - Networking/partnering

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



NaphCare
Your independent health care choice.

January 30, 2019

Marin City Health & Wellness Center
630 Drake Ave
Marin City, CA 94965

RE: Letter of Agreement (LOA)/Residential Reentry Centers (RRC) /Home Confinement

NaphCare currently holds a contract for the provision of medical services for recently released inmates (residents) in the custody of the Residential Reentry Centers (RRC)/Home Confinement located in San Francisco, CA.

The purpose of this LOA is to confirm an understanding on some basic, yet binding terms and conditions that we can rely upon to efficiently process your claims when treating residents from these facilities. This Agreement shall continue in full force and effect for the duration of NaphCare's contract with the Federal Bureau of Prisons.

For outpatient services rendered, NaphCare will reimburse a fee based on Medicare methodologies. NaphCare will pay Marin City Health & Wellness Center 160% of the current Medicare Part B Fee Schedule for (05) San Francisco, CA, as appropriate.

NaphCare will follow Medicare methodologies as well as CCI edits. If any of the fees calculated using the above Medicare methodology exceed the billed charge, Provider shall be paid the billed charge. For approved medical services and comprehensive dental not reimbursed under Medicare methodologies, NaphCare will pay Provider 70% of billed charges.

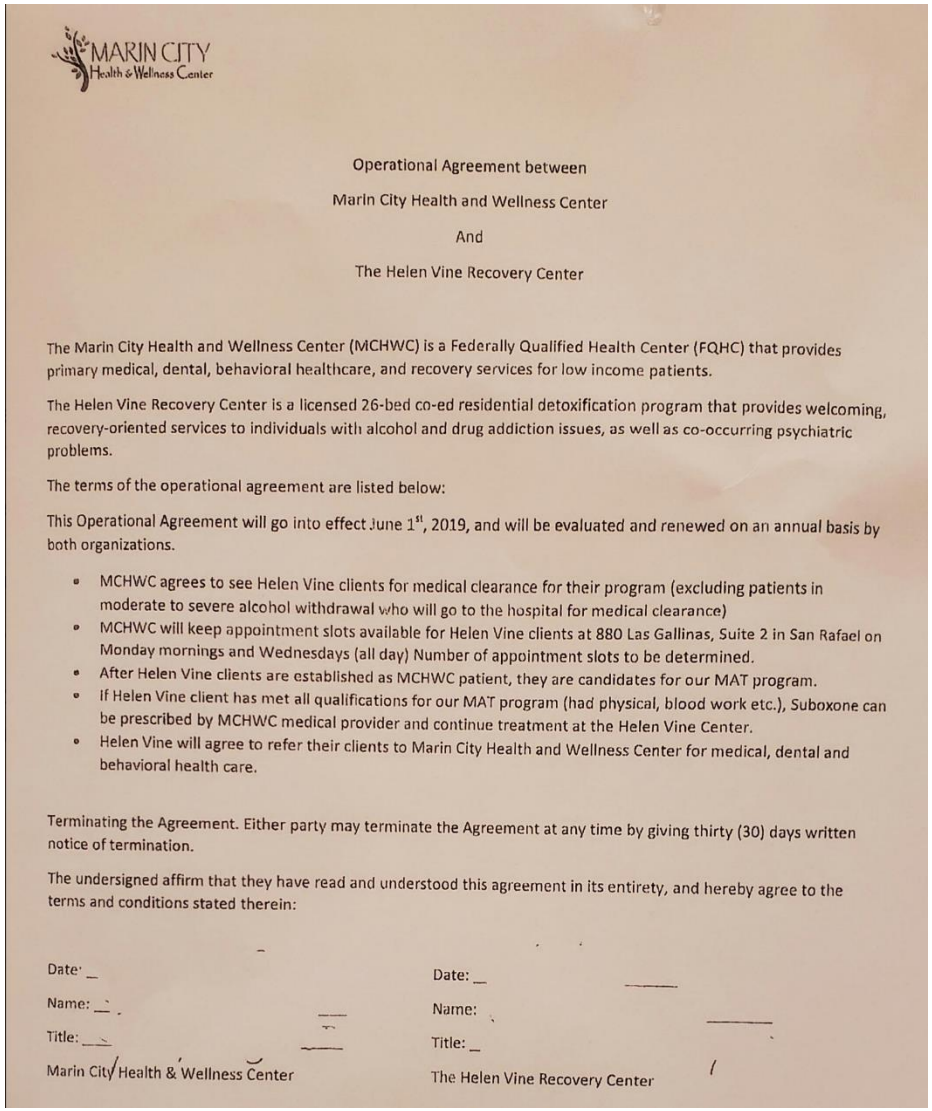
Clean claims are to be submitted within thirty (30) days of the service rendered. Claims submitted after sixty (60) days will be denied. Provider claim disputes must be submitted in writing within thirty (30) calendar days. NaphCare will provide a reply within thirty (30) days following the receipt of your dispute notification. Medical and dental records must be available to NaphCare within ten (10) days from the date of service.

Either party may terminate this Agreement upon a breach of any of the material terms and conditions. The non-breaching party which intends to terminate shall give the breaching party written notice of the breach. If said breach of this Agreement is not cured within sixty (60) days after written notice from the non-breaching party, this Agreement will terminate.

This LOA is subject to the terms and conditions of NaphCare's prime contract with the Federal Government.

Please direct any inquiries to my attention.

Sincerely,



MARIN CITY
Health & Wellness Center

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: _
Name: _
Title: _
Marin City Health & Wellness Center

Date: _
Name: _
Title: _
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 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!