

# Father Joe's Villages

Village Health Center



# Our ATSH Team & Goals for ATSH Participation

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- **Our Core MAT Team:**

- Loretta Contreras, Physician Assistant, MAT Lead & X-Waivered Provider
- Serena Arts, Nurse Practitioner
- Teresa Whitney, Manager of Alcohol and Drug Counselors
- Dana O'Donnell, RADT, Counselor

- **Our Site's MAT Team by Function and FTE (Full time equivalent):**

- MAT Prescribers: 8 total X-waivered prescribers (3.5 FTE's)
- Nursing: 4 RN's (3 FTE's)
- Behavioral Health: 3.5 BH Clinicians
- Behavioral Health: AOD Counselors (4.5 FTE's)

- **Goals for ATSH Participation**

- To learn best practices, strategies for engaging hard to reach patient populations.
- To learn from other programs that use a harm reduction model: What are the limits to this approach?
- To learn how other programs utilize different forms of buprenorphine. For example, when is it appropriate for clients to switch from Suboxone (daily sublingual) to Sublocade (monthly injection)?

# Our Community

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## About Us and Our Community

- We are located in San Diego's East Village neighborhood, a highly populated urban area that is near the center of our city's homeless epidemic.
- Our clinic provides medical, dental, psychiatric, and behavioral health services to our homeless and at-risk neighbors. Our clinic includes a state-certified outpatient treatment program for substance use disorders, with on-site counseling and group therapy.
- Our clinic works with a "hub and spoke" system of MAT programs in the San Diego area to coordinate a variety of services for OUD, including buprenorphine, naltrexone, naloxone trainings, as well as referrals for methadone, detox services, and inpatient treatment.



Our campus includes an emergency shelter and transitional housing programs for the homeless



# Our Current State

- We use a low-barrier, harm reduction model to make our MAT services as accessible as possible. We allow for same-day inductions at our clinic on a walk-in basis. We have a unique model of Street Medicine that allows us to do "Home Inductions" for patients experiencing homelessness, who are unlikely or unable to go to the clinic.
- Patients to whom we prescribe buprenorphine are given 7-day prescriptions and are required to return for group counseling and urinalysis screenings to continue receiving refills.
- We see the vast majority of our MAT patients in two group visits per week. At these visits, called "MAT Groups", patients are seen by a prescribing doctor individually as well as by their AOD counselors in a group therapy setting.
- We have 8 x waived providers. In the past 6 months, we filled 900 prescriptions for 183 unique patients.



We use a combination of education and interpersonal process in MAT group sessions

# Capability Assessment: What We Learned

- In completing the assessment, we were surprised by how far our MAT program has come since we started. The program as it exists in its current form has only been running since March 2019, and already, we are scoring mostly 3s, 4s, and 5s.

## Our areas of strength

- Cohesiveness
- Integrated multidisciplinary approach
- **A host of supportive services available on-site for our clients**
- The way we share ideas and implement strategies to create an efficient workflow.

## Our areas for development

- How do we create a group environment that is conducive to a process group that would be engaging for participants at different stages of change?
- How do we structure group visits with the least amount of interruptions (e.g. interruptions due to doctor interaction, service animals, client's inability to focus)?
- Time management
- Further integration between medical and behavioral health / AOD.



Clients have access to a variety of services at the Village, from basic needs such as showers and food, to critical life resources like computers and printers.



# Current State Assessment

How we assessed our current state:

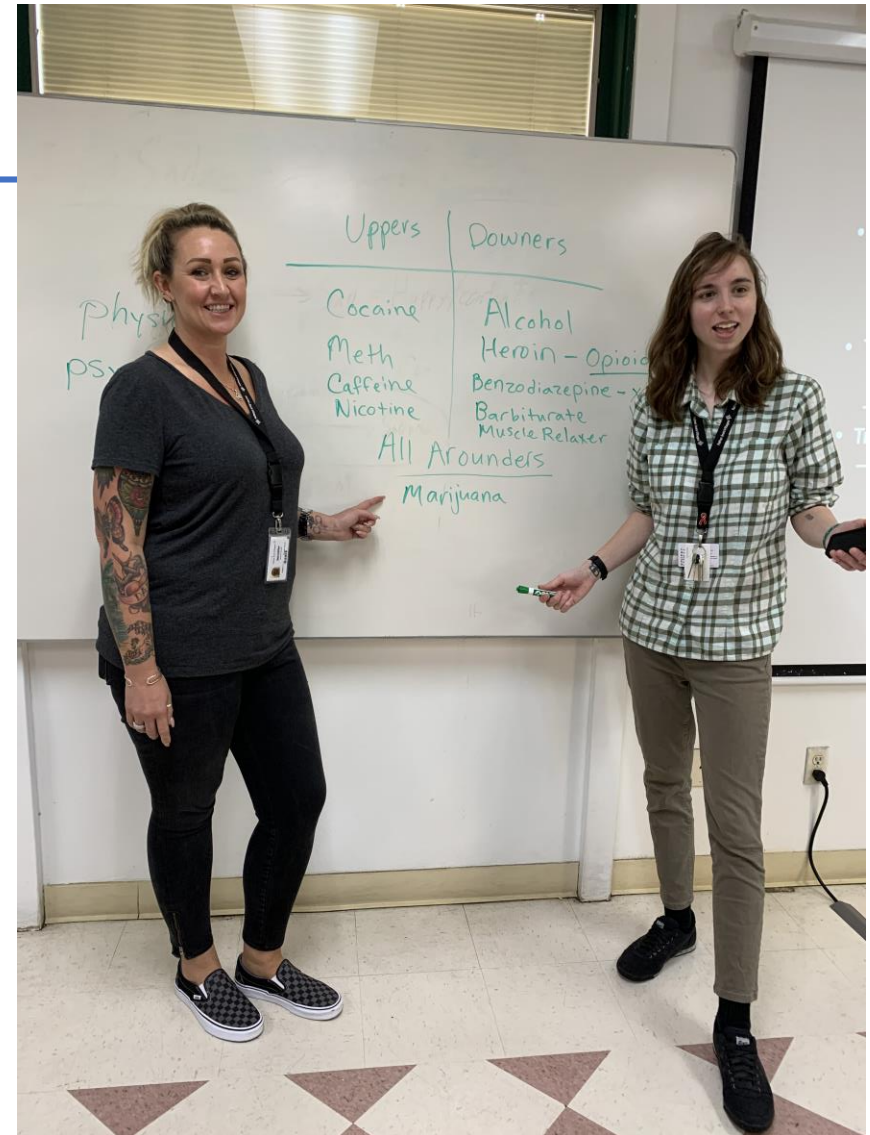
- We used metrics derived from our EHR system to assess the scope and reach of our program.
- We also spoke to staff, patients, and local partners such as those in our "hub and spoke" system of MAT programs.

From providers and staff we learned:

- Our MAT patients are a diverse population that come from many different walks of life, with different motivation levels, and at different stages of change.

From patients we learned:

- Our MAT services are some of the lowest-barrier-to-entry in the entire region.
- Patients appreciate the accessibility of our MAT services and have expressed frustration that MAT is not more accessible in other places, such as jails and prisons.
- One patient even said that if MAT services had been more accessible to him earlier in his life, he would not have continued to relapse as many times as he did.



MAT patients respond well to educational groups with a focus on harm reduction

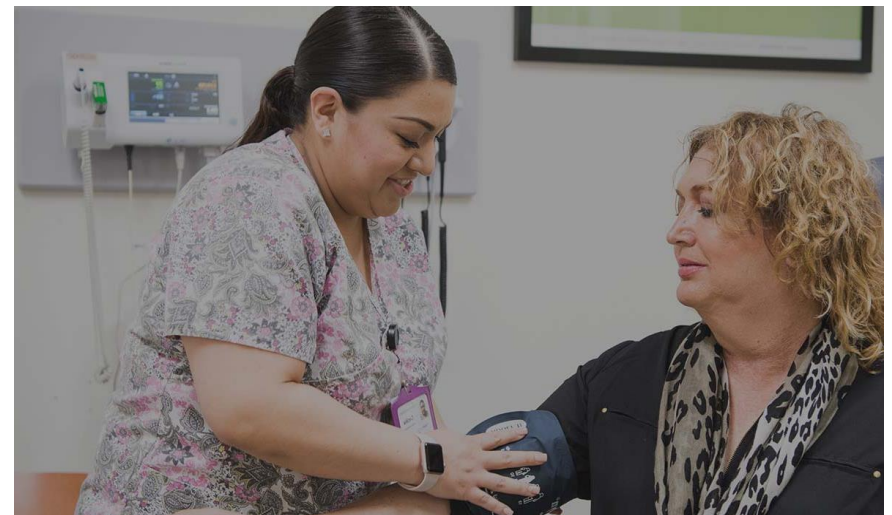
# Current State Assessment, continued

We received the following feedback on the appropriateness and acceptability of using MAT in our clinic:

- While we boast a very comprehensive MAT program, **our clinic is primarily a Family Medicine practice**. There has been some concern with the rapid expansion of MAT that our clinic would become like a methadone clinic, when that is not our intended specialty.
- We have had to "turn off" and "turn on" acceptance of new MAT intakes as we bump up against our clinic's capacity for MAT patients. We put a limit on the number of new MAT intakes per day.



Our clinic's specialty is Family Medicine.



# Our Team Has Been Wondering . . .

Our questions to other teams:

- How to address confidentiality issues when integrating AOD treatment services into a medical setting, when the two disciplines have different confidentiality laws that apply to each (e.g. 42 CFR Part 2, HIPAA)?
- For other teams that also utilize the group visit format, what best practices have you learned for maximizing the efficiency of these visits? We are running into issues with people showing up on time, group interruptions and motivating patients to attend. What kind of contingency management and motivational incentives work?
- Respecting patient autonomy in decisions about when and how fast to taper off the medication, how can we best serve patients who want to taper off more quickly than is recommended, set them up for success as much as possible with less than ideal conditions for tapering, and help prevent relapse/OD after tapering?



Our team of registered and certified AOD counselors



# We're Wondering...

Our questions for faculty:

- What lessons did teams from ATSH Wave 1 learn that could be applicable to us in Wave 2?
- Do any teams from Wave 1 or Wave 2 utilize a **mobile health unit or street medicine team** that can provide MAT services outside of a traditional treatment center or clinic setting? **What is the future of "street health" approaches to MAT?**

We need support to accomplish:

- Integrating MAT patients into a comprehensive recovery program so they have access to individual counseling support and other recovery services.
- Balancing a comprehensive approach to substance use treatment with the time and space limitations of a high-volume, low-threshold MAT program running out of a small health clinic.
- More fruitful outreach to the community. We are running up against limits to our x-waivered capacity when we scout a potential MAT participant and need to "strike while the iron is hot"



Our mobile health unit brings medical services directly to patients living on the street



# Advice/Guidance/Tools For Other Teams

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- We collaborated with another local MAT program to create a comprehensive 12-week curriculum for our MAT group. We would love to share and get input on this.
- We are still fine-tuning a workflow for maximum efficiency of MAT group visits. We would like to compare and contrast with other teams that use the group visit model.
- One of the advantages our program has over other MAT programs in the area is our accessibility. We think one of our strengths is our ability to provide low-threshold MAT services to the underserved homeless population in our community.
- We serve a complex population with a high rate of co-occurring disorders and polysubstance use. We can speak to the difficulties of treating patients whose primary ailment may not be opioid addiction, yet they still need MAT services. Our MAT program is a "jumping off point" for many patients to access sorely needed medical care, dental care, psychiatry, and behavioral health services.

