



# Treating Addiction in the Primary Care Safety Net

IMPLEMENTING MEDICATION-ASSISTED TREATMENT AND THE LESSONS LEARNED



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# Executive Summary

In 2016, Substance Abuse Services Expansion grants were provided to federally qualified health centers through the Health Resources and Services Administration. This funding stream offered a valuable opportunity to support clinics in improving the identification and management of substance use disorder (SUD). Thirty-six California health centers were awarded a total of \$12.6 million. These funds were used to increase the number of patients with access to medication-assisted therapy (MAT) for SUD, including SUD related to opioid use.

In 2016, the California Health Care Foundation funded the Center for Care Innovations to augment the grants to California health centers since funding alone is not sufficient to expand MAT. In response, the Center for Care Innovations launched the Treating Addiction in the Primary Care Safety Net (TAPC) program. The 18-month program was designed to augment the grants with tailored technical assistance. Specifically, TAPC helped 25 health centers implement, sustain and/or expand the use of MAT services for opioid use. Program activities included in-person and virtual learning events, individualized team coaching, and site visits to health centers with best practices related to MAT services.

This paper describes the learnings from TAPC, focusing on the experience of the 25 health centers in designing new or enhancing existing MAT programs within their primary care setting. These learnings are organized into the following categories:

- **Attitudes and education.** Shifting perspectives about addiction, the provider's role in treatment, and the use of MAT
- **Reach and adoption.** Increasing the number of prescribers and the number of patients receiving treatment
- **Operational strategies.** Developing new or surfacing existing models for program design and implementation
- **Problem solving and persistent challenges.** Addressing barriers to success
- **Avenues of support.** Facilitating design and implementation of a learning program

Based on both qualitative and quantitative assessments of TAPC, the program was successful in supporting health centers in expanding the delivery of MAT services to patients with SUD. TAPC's technical assistance and peer learning helped participants translate promising practices from the field to operational changes in their care settings. Hands-on support provided through coaches also helped participants address questions and barriers in real-time. As a result, throughout the 18-month program TAPC participants *nearly doubled* the number of providers prescribing MAT and *nearly tripled* the number of patients receiving MAT.





# Overview

## Background

Substance use disorder—related to alcohol, amphetamines, benzodiazepines, cannabis, and opioids—is among the most common and costly health conditions. Contemporary health care has evolved to focus on whole person health, core to models such as the Patient Centered Medical Home. This focus on whole person health includes addressing behavioral health, typically mental health concerns such as depression, anxiety and traumatic stress disorders. Most models of integrated behavioral health, however, do not sufficiently address substance use disorder (SUD) identification, triage, treatment or care coordination. Further, to the extent co-occurring substance use is not addressed, medical and mental health treatments are less effective. Substance use is also a major driver of high-cost utilization in hospital inpatient and emergency department (ED) settings. In fact, California experienced more than 46,000 ED visits for drug overdose in 2017.<sup>1</sup>

Medication-assisted treatment (MAT) is one approach to address SUD generally, and opioid use disorder in particular. The National Institute on Drug Abuse describes MAT as including both medication and behavioral health counseling, resulting in a “whole patient” approach. Persons who receive MAT, including buprenorphine, have significant reductions in opioid use, illegal activities, reduced HIV/HCV and also experience an overall improved quality of life.<sup>2</sup> In addition, data demonstrate a reduction in overdose death as a result of using addiction medication.<sup>3</sup>

Catalyzed by the opioid epidemic, including addiction to prescription narcotics and heroin, there is recognition of the prevalence of substance use and its association with negative outcomes. There is also a burgeoning awareness of substance use and mental health as equivalent components in efforts to integrate behavioral and physical health. Public and private health care systems are scrambling to develop unified models that incorporate mental health and substance use into integrated behavioral health programs.<sup>4</sup>

1. California Opioid Overdose Surveillance Dashboard. (2017). *California ED Visits – Total Population – 2017, All Drug Overdose: Age-Adjusted Rate per 100,000 Residents*. Accessed June 1, 2018 from [discovery.cdph.ca.gov](http://discovery.cdph.ca.gov).
2. Mattick, R.P., Breen, C., Kimber, J. & Davoli, M. “Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence.” *Cochrane Database Syst Rev*. 2014 February 6(2).
3. Schwartz et al. “Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009.” *Am J Public Health*, 2013;103(5): 917–22.
4. McGovern, M, Dent, K, & Kessler, R. “A Unified Model of Behavioral Health Integration in Primary Care.” *Academic Psychiatry*, April 2018(42): 265–268.

Through the Drug Abuse Treatment Act of 2000 (DATA 2000), clinicians can prescribe two (of three) FDA-approved medications for opioid use disorders: buprenorphine and naltrexone. Naltrexone does not require special training or licensure. To prescribe buprenorphine, however, DATA 2000 requires physicians to complete an eight-hour training. A subsequent law extended buprenorphine prescribing to nurse practitioners and physician assistants who complete 24 hours of training. After training, a prescriber's U.S. Drug Enforcement Agency (DEA) license number will include an "x" which signifies the capability to prescribe buprenorphine for addiction. Methadone, also an FDA-approved medication, can only be prescribed and dispensed by licensed opioid treatment programs (OTPs). In California, these are called Narcotic Treatment Programs (NTPs).

In 2016, Substance Abuse Services Expansion (SASE) grants were provided to federally qualified health centers (FQHCs) through the Health Resources and Services Administration (HRSA). The goal of the grants is to increase the number of patients receiving evidence-based FDA-approved addiction medications. The grants include several components, including:

- Establishing or enhancing an integrated primary care/behavioral health model
- Increasing the number of patients with access to MAT for opioid use and SUD
- Coordinating services
- Providing training and educational resources, including updated prescriber guidelines, to support prescribers in making informed decisions and addressing over-prescribing of opioids

In California, 36 FQHCs were awarded a total of \$12.6 million in SASE funding. This funding offered a valuable opportunity to support health centers in improving the identification and management of SUD among their patients.

*“This project has been all about stigma busting and breaking down barriers.”*

— TAPC PARTICIPANT

*“We have to make it harder to prescribe opioids than to treat opioid addiction.”*

— TAPC PARTICIPANT

*“The community is so invested in this topic that getting buy-in and trust was a non-issue.”*

— TAPC PARTICIPANT



## Treating Addiction in the Primary Care Safety Net (TAPC)

HRSA's funding assisted safety net providers that were grappling with implementing care models for patients with behavioral health issues. Establishing MAT programs proved to be sufficiently complex that additional support was needed in order for health centers to be effective in addressing SUD. Recognizing this fact, the California Health Care Foundation funded CCI's development of the TAPC program. Launched in 2016, the 18-month program was designed to help clinics plan for the major shifts in how substance use would be identified, addressed, treated and managed within the context of routine primary care. In addition, it facilitated major changes in attitude, workflow, and practice patterns that are required for MAT to be successful.

Of the 36 SASE awardees in California, 25 elected to participate in TAPC and an additional health center opted to "audit" the program. See the appendix for a list of participating clinics.

### TAPC Components

TAPC included a variety of in-person and virtual activities to support participants in designing strategies to implement or expand MAT in primary care. Activities included:

- **In-person and virtual learning addressing:**
  - Clinical.** Patient selection, buprenorphine 101, safety-driven medication management, induction and management, use of urine drug screens, harm reduction and tapering, clinical case review
  - Operational.** MAT program staffing models (e.g., nurse-managed model), patient confidentiality, building a controlled substance review committee, changing attitudes and behavior
  - Patient activation and adherence.** Compassion with risky or non-adherent patients, contingency management treatment, psychosocial therapies, motivational interviewing
  - Promising practices.** Hub and spoke models, strategies and tactics used by peers in the same region
- **Site visits.** Visits to practice settings further along in MAT implementation; sites included Venice Family Clinic, OBIC San Francisco Department of Health, HealthRIGHT 360, El Dorado Community Health Center, and Contra Costa Health Services
- **Expert coaching.** Hands-on consultation, which ranged from the mechanics of induction, overcoming the fear of prescribing, workflow, team-based care, and managing complex cases
- **Incentives.** One-time \$1,000 incentive to offset the cost of time for the x-waiver training in buprenorphine prescribing

# Impact of TAPC

## Summary of Major Findings

Most TAPC participants made considerable progress in expanding addiction treatment activities. These improvements included increasing the number of patients receiving medication and the number of prescribers. In interviews with TAPC faculty, coaches and participants, an extensive list of strategies to increase capacity to treat opioid addiction in primary care were identified.

Lessons learned from these health centers experiences were organized into five categories:

- **Attitudes and education.** Shifting perspectives about addiction, the provider's role in treatment, and the use of MAT
- **Reach and adoption.** Increasing the number of prescribers and patients receiving treatment
- **Operational strategies.** Developing new or surfacing existing models for program design and implementation
- **Problem solving and persistent challenges.** Addressing barriers to success
- **Avenues of support.** Facilitating design and implementation of a learning program

More information on strategies and tactics used in each of these categories is described below.

## Attitudes Around the Use of MAT

In seeking to change attitudes around the use of MAT, educating providers and staff was a central strategy that proved effective for most clinics. This education went beyond diagnosis and treatment to address a number of important concepts: opioid use disorder and accompanying degradation of wellness that many patients experience, creating a welcoming and non-judgmental environment, establishing a tone of support and accountability, adjusting clinical language to avoid perpetuating stigma, and cross-discipline coordination.

In describing the changes in attitudes among providers and staff, TAPC participants highlighted the following:

- The importance of introducing the concept of harm reduction as opposed to abstinence as the only option.
- How straightforward, effective and transformative addiction treatment can be.
- Moving away from the idea that addiction is a matter of "willpower."

*“To be honest, addiction medicine, really, I ran away from these people. Now I find they are real people, in fact great people. Better people. My attitude totally changed — I am more sympathetic, more compassionate. I don't see addiction as a matter of willpower. I enjoy taking care of these patients.”*

— TAPC PARTICIPANT

*“Providers perceive those with substance use disorders as “difficult patients.” This is what drives the stigma. What’s remarkable is that once providers got their feet wet, they realized they had a total misconception of these patients. They are actually rewarding and not difficult. In fact, this work increases provider job satisfaction. Quite frankly, it is one of the easiest patient populations. It went from a ‘OMG — we’re going to open our doors to heroin addicts’ to being very grateful.”*

— TAPC PARTICIPANT

- Despite the challenges encountered by attitudes around SUD, many clinics reported success in changing perspectives that addiction medicine is hard and unappealing.
- Viewing MAT as easier than managing other chronic diseases (e.g., diabetes) and highly gratifying.
- Appreciating the dramatic outcomes that are achievable and the resulting increase in provider satisfaction.

TAPC participants identified activities that supported this shift, all of which centered around education and awareness. One participant noted that, “Nurses and behavioral health people may have required more training than physicians.” This participant went on to say that, “Physicians are reluctant but once they start, they can do it. Other staff weren’t as reluctant but had a harder time doing it well. Retraining and supervision is essential.” Another participant underscored the need for education, even among staff who were thought to be familiar with addiction and MAT. “I had no idea [our behavioral health staff] were not experienced in substance use,” the participant stated. Another participant agreed, noting that many Certified Alcohol and Drug Counselors (CADCs) have no experience with MAT or may not be supportive of that treatment approach.

## Increases in Reach and Adoption

TAPC activities focused on strategies to improve participant’s ability to get addiction medication to those who need it (i.e., reach) and to increase the number of providers trained to prescribe addiction medication and who actually prescribe it (i.e., adoption). In general, most TAPC participants made considerable progress in expanding addiction treatment in their settings throughout the 18-month program. The result of this progress was a nearly three-fold increase in the number of patients on addiction medicine across the TAPC cohort.

Specifically, estimates of the increase in the number of the patients prescribed buprenorphine range from 2.84 to 2.96 times more patients. This is equivalent to a range of 748 to 1,150 new patients.

TAPC also resulted in the following improvements:

- **Buprenorphine prescribers.** Improved the number of x-waivered prescribers, ranging from a 1.72 to 1.90 times increase (an increase of 75 to 95 x-waivered prescribers). This reflects roughly 3 to 4 newly waived prescribers for each of the 25 TAPC participants.
- **New prescribers.** There were 70 new prescribers writing prescriptions for patients, representing a three-fold increase in the number of prescribers who used addiction medications with patients.
- **X-waivered prescribers.** TAPC participants increased (from 15.9% to 23.5%) the number of prescribers who are x-waivered out of all possible prescribing clinicians at health centers offering MAT services.

TAPC participants were in different stages of MAT adoption. Some were designing MAT programs de novo while others focused on program expansion, either training new providers or providing MAT at additional sites.

Participants in the early stage of implementation needed support to identify a logical starting place and to establish a pathway to implementation. They were often dealing with logistical issues (e.g., locating pharmacies that could dispense needed medications). They also sought to identify clinical champions and buprenorphine prescribers and to establish relationships with non-traditional community partners (e.g., homeless shelters, community police) to connect to patients in need of care.

“It was a very slow start,” stated one TAPC participant. “Everything involved initial buy-in.” This participant went on to describe work marketing the program, including collaboration with nearby addiction treatment programs and the local mission. For this health center, having a case manager conduct the outreach was of significant help.

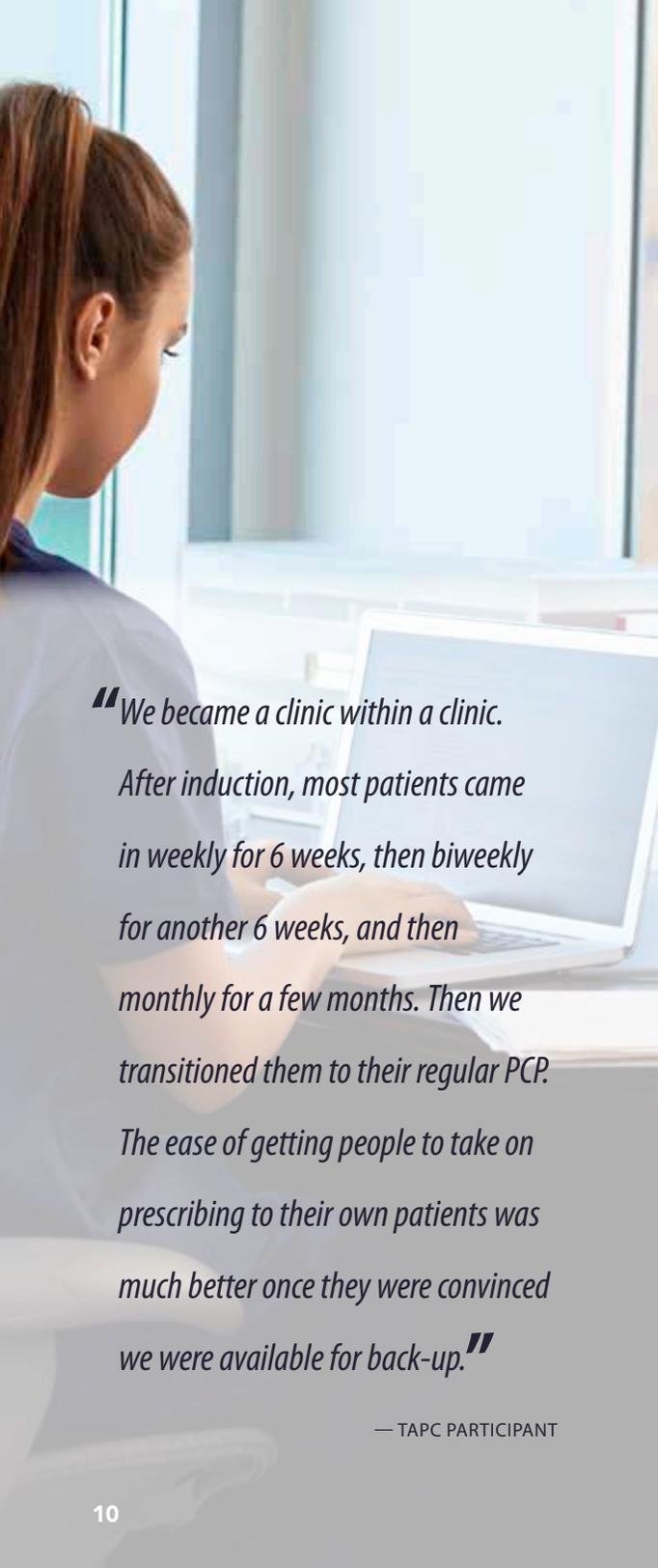
Clinics that were more advanced in implementation had largely solved many of the logistical issues that their counterparts were addressing. Instead, they were focused on scale up and expansion. These clinics were designing strategies to support increased patient loads, developing models that would support this expansion, and addressing issues related to staff turnover. One participant noted that they had begun MAT in one clinic site and managed to expand to three sites. Their eventual goal is to roll out MAT to all eight clinics in their system.

Despite this shift in focus, many expansion clinics were still focusing energy on provider readiness and reducing stigma.



*“It was not as hard to develop a smooth workflow as we thought. We have designated MAT slots, but everyone plays a role as part of the team. These are mostly our patients anyway, so it’s become like any other medical office procedure with certain requirements.”*

— TAPC PARTICIPANT



*“We became a clinic within a clinic. After induction, most patients came in weekly for 6 weeks, then biweekly for another 6 weeks, and then monthly for a few months. Then we transitioned them to their regular PCP. The ease of getting people to take on prescribing to their own patients was much better once they were convinced we were available for back-up.”*

— TAPC PARTICIPANT

## Practical Strategies

In order to increase reach and adoption, programs utilized practical strategies addressing operations, patient identification and tracking, and clinical management. Examples of these approaches included:

### Operations

- Revising scheduling to include protected visits for induction, follow-up, and emergent needs
- Fully integrating MAT into a clinic site, including co-location of addiction medicine clinicians and counselors with primary care providers
- Engaging providers and administrators in advance and ensuring consensus before receiving funding to start MAT
- Preparing training manuals and procedures with a clearly defined chain of command and care team roles
- Establishing a buprenorphine clinic one afternoon a week, using a care team including PCPs, a behavioral health clinician and a community outreach clinician. This care team focused on the induction and stabilization phase. Once those phases were complete, the patient returned to their regular PCP for ongoing care.
- Expanding access through use of home inductions and group visits for medication refills

### Patient Identification and Tracking

- Integrating universal screening into primary care, using either (1) the **National Institute on Drug Abuse** (NIDA) Quick Screen and NIDA-modified ASSIST or (2) Drug Abuse Screening Test (DAST).
- Mining electronic health record data to identify patients. Participants used different criteria, such as medication lists (e.g., patients on high doses of morphine equivalents) or reviewing problem lists for IV drug use.
- Outreaching to community locations where there is likely to be patient need and establishing a pathway to care.
- Using a registry or roster to easily track patients with SUD, their stage of readiness for MAT, medication dose, etc.

## Clinical Management

- Designing a strong stabilization phase to establish a foundation for ongoing management.
- Developing a toxicology plan, including use of urine drug screens to ensure clinicians know what's in the patient's body at the point of prescribing.
- Ensuring capacity for a bio-psychosocial intake within 30 days.
- Establishing refill stabilization groups, including using 7-day prescribing cycles to encourage patients to return to the clinic.

## Problem Solving and Persistent Challenges

In designing, implementing or expanding MAT, participating health centers encountered a range of challenges. Over the course of the project, many of these challenges were addressed, while some challenges endured.

Initial challenges included:

- Designing workflow, documentation requirements and other processes.
- Ensuring the engagement and support of senior leadership.
- Sorting out pain management versus addiction.
- Transitioning from tight protocols to flexibility while maintaining program integrity.
- Identifying qualities that are important in recruiting nursing and behavioral health staff.

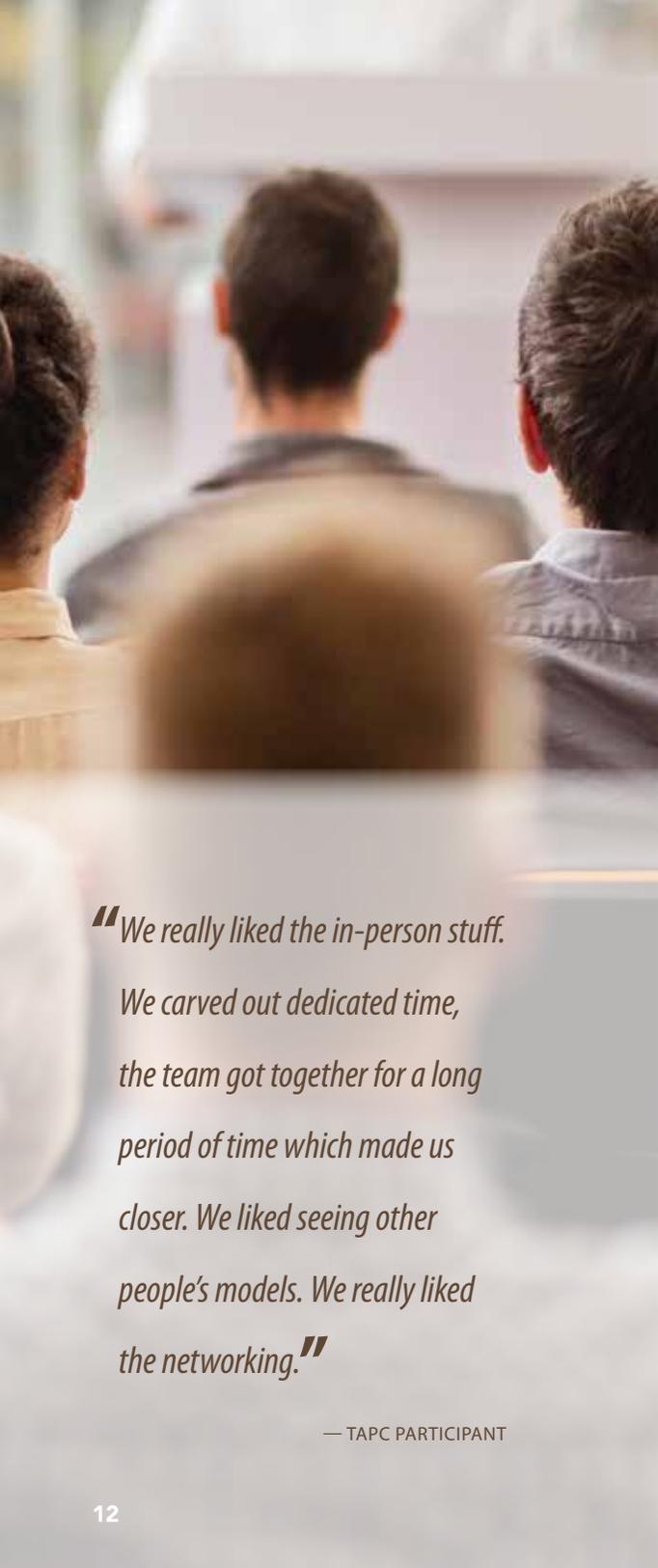
Despite achieving breakthrough improvement, a number of challenges persisted throughout the project.

In interviews with participants and MAT experts, the following themes were identified:

- **Barriers related to staffing**, including prescribers, behavioral health clinicians and staff. Participants identified staff turnover, recruitment, training, and burnout as key concerns. One participant described this issue: "Because these can be high needs patients with lots of social risk factors, we need more care coordination, navigators, and are currently not reimbursed for these services or people. We hire them, pay them poorly, and then wonder why they leave. Grants cover this in the short term."
- **Patient identification** given the fear of being stigmatized as an addict and additional stigma associated with seeking help.

*"We had to build a better selection and training program, and work closely with new nurses and clinicians. You can't assume they can hit the ground running and work independently. It doesn't work that way. We learned the hard way because they either left or just didn't work out."*

— TAPC PARTICIPANT



*“We really liked the in-person stuff. We carved out dedicated time, the team got together for a long period of time which made us closer. We liked seeing other people’s models. We really liked the networking.”*

— TAPC PARTICIPANT

- **Payment issues**, including getting paid for physician services and behavioral health counseling on the same day and identifying payment sources for the uninsured who reside in counties with programs that don’t cover MAT.
- **Developing the business case**, including focusing on sustainability, especially in light of all the care coordination needs. In describing this challenge, one participant said that, “The big question everyone has is what is the cost-benefit to all this. We all need to figure out how to make the ROI business case.” And with regard to sustainability, one participant noted the challenge of working from grant to grant, without a reliable source of funding.

## Avenues of Support

Transforming clinical practice is never easy and support and technical assistance can make a tangible difference to the experience of those implementing change and to effectiveness of the process. Several evaluation components provided insight into the TAPC technical assistance (TA) activities that were most valued by participants. Program participants overwhelmingly appreciated the entire experience of TAPC, though some TA components were more highly rated.

Of all TAPC activities, participants ranked most highly the in-person learning sessions, coaching support, and site visits. With regard to coaching, one participant said it was invaluable, while another described this support as pivotal to their transformation. The participant said the coach, “held our hand, he adapted things to fit our clinic and more important our people. He gave us his cell phone number to call—which we only did once—for the first induction.”

In addition to the narrative feedback, each TAPC activity was assessed either through post-event evaluations or through key informant interviews. These evaluations reinforced the value of TAPC activities. For example, participants ranked the central components of TAPC as follows:

- **In-person learning sessions.** On a 5-point scale, the average rating for each learning session ranged from 4.3 to 4.5. In addition, the overall participation rate for learning sessions was 96%. Teams from 23 (of 25 total) clinics attended all three learning sessions.
- **Coaching.** On a 10-point scale, coaching received a 9.1. More than two-thirds of participants (68%) availed themselves of coaching expertise.
- **Site visits.** On a 10-point scale, the average rating was 8.1 and more than half of TAPC participants either hosted or visited another site.

# Conclusions

Health care organizations are increasingly focused on treating SUD as a part of integrated physical and behavioral health approaches. Designing new care models to reflect this integrated approach requires many adaptive changes to workflow, care team roles, patient identification and clinical care. In addition, it's important to ensure that the culture of each health care setting supports the identification and treatment of SUD. At the same time, care teams need to learn new concepts and skills to engage patients in MAT.

Over the course of TAPC, 25 California FQHCs leveraged program activities to implement or expand MAT programs. Some programs were at the early stage of development and evolving. Others were focused on issues related to expansion, including how to scale services and supports to treat more patients at multiple sites. TAPC offered an opportunity to receive encouragement, advice and support while learning from others with expertise in MAT.

Regardless of the stage of the program implementation, many promising practices and tactical strategies were identified and shared across the TAPC cohort. In addition to the basics around the use of buprenorphine, medication management, and other clinical issues, teams focused on broader organizational concerns that were foundational for change. This included adapting language to eliminate stigma (e.g., avoid calling urine drug screens dirty or clean) and shifting perspectives to embrace harm reduction. Teams also collaborated with non-traditional community partners outside their settings and thought about cross-discipline coordination within their health center. Combined, this work resulted in significant increases in patients receiving MAT.

*“We liked everything.  
Wouldn't change a thing.”*

— TAPC PARTICIPANT

*“Fear and uncertainty as a doctor is  
really uncomfortable. Now I feel a level  
of comfort and confidence treating  
substance use with my patients.  
The way to do this is to start.”*

— TAPC PARTICIPANT

# Appendix

PARTICIPATING HEALTH CENTERS	CITY	COUNTY
Alameda Health System/Healthcare for the Homeless	Oakland	Alameda
Aria/Avenal Community Health Center	Lemoore	Kings
Clinicas De Salud Del Pueblo	Brawley	Imperial
Contra Costa Health Services Department	Martinez	Contra Costa
El Dorado Community Health Center	Placerville	El Dorado
Elica Health Center	Sacramento	Sacramento
Family Health Centers of San Diego	San Diego	San Diego
County of Santa Cruz Health Service Agency	Santa Cruz	Santa Cruz
JWCH Institute	Commerce	Los Angeles
La Maestra Family Clinic	San Diego	San Diego
Lifelong Medical Care	Berkeley	Alameda
Livingston Community Health Center	Livingston	Merced
Los Angeles Christian Health Center	Los Angeles	Los Angeles
Marin City Health and Wellness Center	Marin City	Marin
Neighborhood HealthCare	Escondido	San Diego
Omni Family Health	Bakersfield	Kern
Petaluma Health Center	Petaluma	Sonoma
Santa Barbara Neighborhood Clinic	Santa Barbara	Santa Barbara
Santa Rosa Community Health Centers	Santa Rosa	Sonoma
Serve the People	Santa Ana	Orange
St. John's Well Child and Family Center	Los Angeles	Los Angeles
Venice Family Clinic	Venice	Los Angeles
Vista Community Clinic	Vista	San Diego
West County Health Centers	Guerneville	Sonoma
Western Sierra Medical Clinic	Grass Valley	Nevada

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