AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Treating Substance Use In Collaborative Care

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Advancing Integrated Mental Health Solutions (AIMS) Center Introductions

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AIMS Center Background

The purpose of the AIMS Center is to inspire providers, researchers, and decision-makers to transform healthcare and improve patient outcomes. We accomplish this by translating and researching evidence-based approaches to behavioral health integration.

Zoom Housekeeping

- This webinar is being recorded
  - Link to recording and slide set will be sent out following the presentation
- Using the Q&A function
  - Enter your question at any time
  - We'll answer questions when all presenters are done
  - General questions about Collaborative Care Model (CoCM) Implementation and Financing can be answered at Implementation and Financing Office Hours or the AIMS Center website FAQs

Learning Objectives

By the end of this session, participants should be able to:

- **Identify evidenced based substance use screening tools for primary care**
- **List key research that demonstrates the evidence base for treating substance use disorders in Collaborative Care**
- **Describe important considerations when providing substance use treatment in Collaborative Care**
- **Describe Collaborative Care team skills needed for providing substance use treatment in primary care**

Principles of Collaborative Care

Patient-Centered Team. The patient, primary care and mental health providers collaborate effectively using shared care plans that incorporate patient goals.

Population-Based. A registry is used to facilitate engagement and outcome tracking in a defined group of patients at the caseload and clinic level.

Measurement-based Treatment to Target. Progress is measured regularly, and treatments are actively changed until clinical goals are achieved.

Evidence-Based Treatments. Providers use treatments that have research evidence for effectiveness.

Accountable. The care team is accountable to the patient and other care team members for quality of care and clinical outcomes, not just the volume of care provided.

Today's Presenters

Mark Duncan, MD, Director, University of Washington Psychiatry and Addictions Case Conferences

Elizabeth J. Austin, PhD, MPH, Senior Research Scientist, University of Washington

Paul Barry, LICSW, Clinical Trainer and Practice Coach, AIMS Center

RESEARCH REVIEW

Common Themes of Successful Models of Primary Care OUD Treatment

- Team-based approach
- On-site psychosocial support

Korthuis, P. T., et al. (2017). "Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review." Ann Intern Med 166(4): 268-278.

Why Collaborative Care for SUDs?

1. Most studied and effective evidence-based model of primary care integration for treating mental health disorders
2. Widely disseminated
3. Addresses key barrier for additional support
4. Principles of CoCM lend themselves to the treatment of chronic relapsing conditions
5. Financial support is established and growing
6. Mental health disorders (MHD) are commonly found in patients with SUDs and people do better when their MHD is treated
7. PCPs are reluctant to prescribe without interdisciplinary team
8. Could help with affirming environment?

The SUMMIT Trial

Collaborative Care (CC) for Opioid & Alcohol Use Disorders

Collaborative Care for AUD/OUD vs. Usual Care (facilitated self-referral):

- CA FQHC patients with A/OUDs, 49% unhoused, 6 months

Elements:

- CM
- Therapists
- Clinicians (12/28 waivered)
- Weekly Caseload Reviews
- Registry
- Measurement based care

Main Outcomes:

- Any Evidence-based Treatment
- Self-reported 30 day abstinence

		Treatment Arm	
		Collab. Care (n=187)	Usual Care (n=190)
Intervention Characteristics	Intervention	Enrolled, proactively followed in PC by CC team	Pt given info for in-clinic & external specialty SUDs tx
	Contact Intensity	Goal: 6-sesson psychotherapy +/- MAT	Variable
	Psycho-therapy	MET/CBT	Variable
	MAT	XR-NXT (AUD), bup-nalox. (OUD)	Variable, per clinic or provider

Watkins et al. (2017)

The SUMMIT Trial

Collaborative Care (CC) for Opioid & Alcohol Use Disorders

Engagement:

- Collaborative Care:
  - 93% met Care Coord. ≥ 1 time
  - 45% had ≥ 1 therapy appnt
  - 22% had ≥2 therapy appnts
- Usual Care:
  - Unknown?!

Results:

- Receipt of any EBT CC > Usual Care:
  - Beh Th CC > UC (36% vs 11%)
    P Value < .001
  - MAT CC = UC (13% vs 13%)?
- 30-day Abstinence (self-report)
  - CC > Usual Care (33% vs. 22%)
    [β=0.12, 95 % CI=(0.01, 0.23)]

Conclusions:

- CC-based AOUD treatment can be more effective than usual care…***though a ↑ effect size would be nice, yes?***

OUD Treatment Using CoCM (2022)

- Setting: Existing CoCM program, OUD treatment add-on, Dartmouth
- Goal: Simplify treatment of co-occurring disorders
- Team: Behavioral Health Clinician, Psychiatric Consultant, PCP
- ID'd patients through use of electronic screener completed before the visit and case finding
- Clinic prep: Educational sessions for all staff, 2-3, 1hr clinician meeting
  - Reading for BHCs and Waiver training for PCPs
  - Workflows developed to help with task sharing between PCPs and BHCs
    - BHCs did intake and assessed appropriateness for primary care
- Clinical service: Brief counseling provided at each visit
  - Referred to mutual help groups and outside counseling based on need/preference
  - Weekly to Q4 weeks
  - MOUD mixed into normal PCP schedule
    - MA: collects urine, reviews PMP, ensures completion of BAM
- Implementation supported through regular team meetings, developed organizational wide guideline, access to e-consults with specialists, and offered a learning collaborative

Brackett, C. D., et al. (2022). "Multidisciplinary treatment of opioid use disorder in primary care using the collaborative care model." Subst Abus 43(1): 240-244

OUD Treatment Using CoCM (2022)

- Results
  - Waivered providers increased from 11→35 writing at least 1 prescription
  - Number of PCPs treating 5 + patients increased from 2→18
  - Number of new Bup patients/month
    - 2→18/month (at peak)
  - 180-day treatment retention
    - 53%
  - 81% had negative urine drug screens throughout intervention
- Survey
  - 63 responded to all-staff survey at end of data collection
    - 16 had a waiver
      - Generally positive experience, appreciated ability to share care
    - 47 had no waiver
      - 58% said they were not interested
        - Concerned about additional time demands
        - Lack of interest
        - Belief that MOUD is outside the scope of PC
        - Need more counseling, care management, other resources

Brackett, C. D., et al. (2022). "Multidisciplinary treatment of opioid use disorder in primary care using the collaborative care model." Subst Abus 43(1): 240-244

Research Summary

- Collaborative care can be an effective way to support and deliver SUD treatment
- Building up the workforce to support the treatment of SUDs in primary care is needed
  - Education
  - Address stigma
  - Ongoing support

INTEGRATING ROUTINE SUD SCREENING

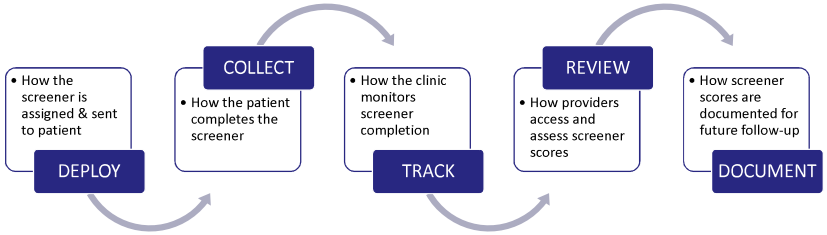
Background

- U.S. Preventive Services Taskforce recommends routine population-based screening for drug use, including in primary care settings
- Routine SUD screening practices are variable and influenced by multilevel factors
- Health systems have limited guidance on best practices for SUD screening implementation

Planning for SUD Screening – Where to Begin?

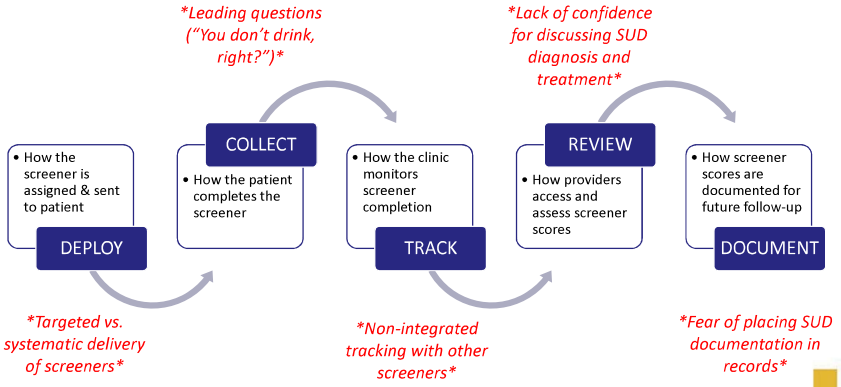
- Take stock of what you already do
  - Where might we already capture SUD screening?
  - What are past experiences with SUD screening and care?
- Get feedback from key stakeholders
  - Providers & frontline staff, administrators, payers, patients
- Thoughtfully select SUD measures
  - Consider measure content (generic vs. condition-specific), length, complexity, specificity
  - Consider provider preferences for diagnostic assessment, HIT capacity, measurement-based care goals
- Design tools & workflows with the end in mind
  - What are the goals for how screening data are used?

What Does it Mean to Screen?



More available at: epros.becertain.org

Why Might SUD Screening be Different?



Case Study: OUD Screening

Routine OUD Screening Practices across 10 Primary Care Clinics		
Geographic setting of clinics		
Urban	2	
Suburban	6	
Rural	2	
Clinic setting characteristics		
FQHC	3	
Trainee site (residents, interns)	3	
Academic medical center affiliated	2	
Existing SUD screening in place?		
Yes	3	
No	7	
Screening frequency		
Universal – every visit	2	★
Universal – annually	8	
Screening visit formats		
In person visits only	8	★
Both in person & telehealth	2	
Primary approach to OUD screening capture		
Patient completes on paper	8	★
Patient completes electronically (e.g., patient portal or third-party app)	2	
Patients completes via verbal administration with clinic staff	0	

Austin EJ, et al. Integrating routine screening for opioid use disorder into primary care settings: experiences from a national cohort of clinics. *J Gen Intern Med*. 2022.

Workflow Considerations

Deciding who and when to screen was challenging → Using a more universal approach (e.g., every patient, every visit)

"[We've had] endless conversations about targeting, **no one is really satisfied with it**, and even if they have tools built into [the patient portal], **the problem still comes down to how do you define, or what do you attach the screener to**, whether it's every patient, every visit, or just attached to all annual visits." [Clinic C]

"[PCPs] have a lot that they need to keep track of with the EMR, documentation, etc., so **they would like the MAs to really bring their attention to the screening tool directly**, like 'you have to talk to this person about this issue.'" [Clinic G]

Missed follow-up of positive screens → Audit & feedback; use of HIT tools (e.g., flags) or visual cues (e.g., colored paper)

Training Considerations

Staff discomfort and uncertainty giving OUD screener → Scripts; repeated training; 1:1 coaching; forums to voice concerns

"As a newly waivered PCP, **it's tough to feel empowered** and educated to say 'well I think you have a problem.'" [Clinic N]

"MAs are just doing a push back… **the MAs feel that they're overworked, you're just adding one more thing to their plate for them to do**, what does a positive screen mean, **what's in it for them**, what does it mean for them?" [Clinic Q]

Discouragement & burden from added work with low yield → Clarifying expected yield and goals for OUD care

Stigma and Community Engagement

Patients may not seek out OUD services in primary care → Aligning services with community needs; advertising OUD services

"Maybe some of our screening could actually come out differently **if people knew as part of our advertisement that we offer buprenorphine**." [Clinic J]

"I think **a lot of people are afraid of being honest** because it's a very hard line they draw at that clinic, if you slip up you're gone, and **in our area there's no where else to go**." [Clinic N]

Stigma may keep patients from disclosing OUD symptoms → Anti-stigma training for staff; reducing stigma in clinic policies

CREATING TEAMS

Patient Identification

- Network with the local "treatment" system
  - Public health, jails, EMS personnel, SUD treatment providers/support services/advocacy groups
- Promote service to your whole organization
  - In-patient units, Emergency Department, outreach team, call center, other BH services
- Outreach to established patients and staff
  - Create a proactive *environment of disclosure*

Organizational Groundwork

- System support
  - Eliminate system disincentives for providers (productivity metrics, bonus structure, etc.)
- Clinic culture
  - Define rationale and goals for the new initiative
  - Encourage feedback/input from clinic staff
- Clinic all-staff preparation
  - Orient to SUD treatment in primary care
  - Manage/address stigma, introduce a *Harm Reduction* perspective

Preparing the Team

- Build support and team unity
  - Manage apprehension: workload, capacity and coverage concerns
  - Facilitate development of policies and procedures, EMR and registry modifications, offer practical support
- Education and training
  - Provide resources for mentoring and support
  - Leverage internal expertise/experience across CoCM team and beyond

Team Skills Building

- Training in SUD Care Management
  - Medication initiation and adherence
  - Collaboration with outside recovery services
  - Strategy for addressing possible intersecting trauma, racism and homelessness
- Harm Reduction Skills
  - Encourage non-punitive attitude to care
    - Urine drug screens, medication contracts etc.
    - Poly substance use, recurrence of symptoms
  - Treating SUD as a chronic medical condition
    - Flexibility in person-centered care management

Patient Engagement

- Provide ready access to care
  - Flexible appointment policies
    - Short wait times to first appointment
    - Managing late arrivals and no shows
    - Specialized clinics/drop in options?
- Outreach
  - Intensive, persistent and welcoming in tone
    - Personalized appt reminders, BHCM encounters in tandem with PCP visits, check ins after PCP visit
    - Varied contact modalities; team is accessible

Additional Clinical Team Members

- Nurse Care Manager (*Office Based Opioid Treatment (OBOT) Model)*
  - Integral part of prescriber's clinical team
  - Provides care coordination and medical care management across multiple physical/BH conditions
  - Manages and monitors medication initiation and treatment
  - Evaluates progress, supports retention in care, manages recurrence of symptoms

Additional Support Staff

- Care Navigator
  - Connects with potential patients in referral settings in the community
  - Facilitates successful linkage to treatment through intensive support and outreach
  - Reconnects and reintroduces to care after recurrence of symptoms
- Peer Counselor or Recovery Coach
  - Provides expertise on lived experience and the patient perspective to clinical team
  - In addition, can offer the same services as above

 https://adai.uw.edu/wordpress/wp-content/uploads/carenavigationmedsfirst2022.pdf

MANY THANKS TO OUR PRESENTERS!

Summary

- Collaborative Care is the most robust evidence-based model for the integration of mental health in primary care and widely disseminated
- Collaborative Care can be used to treat alcohol and opioid use disorders
- Although there are challenges CoCM should be expanded to support co-occurring treatment
- Integration of routine SUD screening requires thoughtful planning and alignment with overall goals for SUD care
- Clinical teams may face multilevel barriers to SUD screening implementation; efforts should ensure clinical teams have the right resources
- Successful integration of SUD in primary care will necessitate attention to patient-centered approaches and efforts to dismantle stigma

Q & A

Additional Resources

AIMS Center Resource

https://aims.uw.edu/sites/default/files/7%20Evidence%20Base%20-%20SUD_082422.pdf

Agency For Healthcare Research and Quality

https://integrationacademy.ahrq.gov/

American Psychiatric Association Resource

https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Treating-SUD-in-the-CoCM.pdf

AIMS Center Implementation and Financial Office Hour Info

https://aims.uw.edu/what-we-do/office-hours

Upcoming Quarterly Webinars

- 3rd Tuesdays 10-11 AM Pacific
  - —October 17, 2023
- Upcoming topics
  - —CoCM Advocacy
  - —SBIRT CoCM
  - —Pediatric CoCM
- Let us know what you'd like to hear about!

WEBINAR FEEDBACK

Thank you for joining us!

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