Treating Substance Use In Collaborative Care

July 18, 2023

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.

Advancing Integrated Mental Health Solutions (AIMS) Center Introductions

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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

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/ODUs, 49% unhoused, 6 months

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

Main Outcomes:
- Any Evidence-based Treatment
- Self-reported 30 day abstinence

<table>
<thead>
<tr>
<th>Treatment Arm</th>
<th>Collab. Care (n=187)</th>
<th>Usual Care (n=190)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Enrolled, proactively followed in PC by CC team</td>
<td>Pt given info for in-clinic &amp; external specialty SUDs tx</td>
</tr>
<tr>
<td>Contact Intensity</td>
<td>Goal: 6-session psychotherapy +/- MAT</td>
<td>Variable</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>MET/CBT</td>
<td>Variable</td>
</tr>
<tr>
<td>MAT</td>
<td>XR-NXT (AUD), bup-nalox, (OUD)</td>
<td>Variable, per clinic or provider</td>
</tr>
</tbody>
</table>

Engagement:
- Collaborative Care:
  - 93% met Care Coord. ≥ 1 time
  - 45% had ≥ 1 therapy appt
  - 22% had ≥2 therapy appts
- 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 AOD 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 BHs and Waiver training for PCPs
  - Workflows developed to help with task sharing between PCPs and BHs
    - BHs 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

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

OUD Treatment Using CoCM (2022)

- Results
  - Waivered providers increased from 11 to 35 writing at least 1 prescription
  - Number of PCPs treating 5+ patients increased from 2 to 18
  - Number of new Bup patients/month
    - 2 to 18/month (at peak)
  - 180-day treatment retention
    - 33%
  - 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
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?

- How the screener is assigned & sent to patient
- How the patient completes the screener
- How the clinician monitors screener completion
- How providers access and assess screener scores
- How screener scores are documented for future follow-up

Why Might SUD Screening be Different?

- Leading questions ("You don’t drink, right?")*
- Targeted vs. systematic delivery of screeners*
- Non-integrated tracking with other screeners*
- Fear of placing SUD documentation in records*

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More available at: ecorx.becertain.org
Case Study: OUD Screening

<table>
<thead>
<tr>
<th>Routine OUD Screening Practices across 10 Primary Care Clinics</th>
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<tbody>
<tr>
<td>Geographic setting of clinics:</td>
</tr>
<tr>
<td>Urban</td>
</tr>
<tr>
<td>Suburban</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Clinic setting characteristics:</td>
</tr>
<tr>
<td>FQHC</td>
</tr>
<tr>
<td>Trainee site (residents, interns)</td>
</tr>
<tr>
<td>Academic medical center affiliated</td>
</tr>
<tr>
<td>Existing SAD screening in place?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Screening frequency:</td>
</tr>
<tr>
<td>Universal – every visit</td>
</tr>
<tr>
<td>Universal – annually</td>
</tr>
<tr>
<td>Screening visit formats:</td>
</tr>
<tr>
<td>In person visits only</td>
</tr>
<tr>
<td>Phone in person &amp; telehealth</td>
</tr>
<tr>
<td>Primary approach to OUD screening capture:</td>
</tr>
<tr>
<td>Patient completes on paper</td>
</tr>
<tr>
<td>Patient completes electronically (e.g., patient portal or third-party app)</td>
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<tr>
<td>Patient completes via verbal administration with clinic staff</td>
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Workflow Considerations

- Deciding who and when to screen was challenging
  - "[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]

- Using a more universal approach (e.g., every patient, every visit)
- 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
  - "As a newly cafeteria FC, it’s tough to feel empowered and educated to say, ‘Well, I think you have a problem.’" [Clinic N]

- Scripts; repeated training; 1:1 coaching; forums to voice concerns

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

- "MCs are doing a push back... the MCs feel that they’re overwhelmed, you’re just adding one more thing to their plate for them to do, what does a positive screen mean, what’s it for them, what does it mean for them?" [Clinic G]

Stigma and Community Engagement

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

- Anti-stigma training for staff; reducing stigma in clinic policies

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

- "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]
CREATING TEAMS

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

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
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
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.

Additional Resources

AIMS Center Resource
https://aims.uw.edu/sites/default/files/%20Evidence%20Base%20-%20SUD_102422.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!

Thank you for joining us!

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