SUMMIT

Substance Use, Motivation and Medication Integrated Treatment

Implementing the Continuum of Care for Substance Use Disorders in Primary Care: Findings and Lessons Learned from the SUMMIT Study

Karen Lamp, MD, Venice Family Clinic

Allison Ober, MSW, PhD, RAND Corporation

Tobin Shelton, LCSW, Venice Family Clinic

Statewide Integrated Care Conference

October 25, 2017

RAND CORPORATION

Venice Family Clinic

INTRODUCTION

SUMMIT

Substance Use, Motivation and Medication Integrated Treatment

Today's objectives

- Describe and discuss a model for integrating the continuum of care for substance use disorders (SUDs) into primary care services in a federally qualified health center
- Discuss barriers and solutions to integrating the continuum of care for substance use disorders into primary care services of a federally qualified health center
- Share key elements of sustaining the continuum of care for substance use disorders in primary care

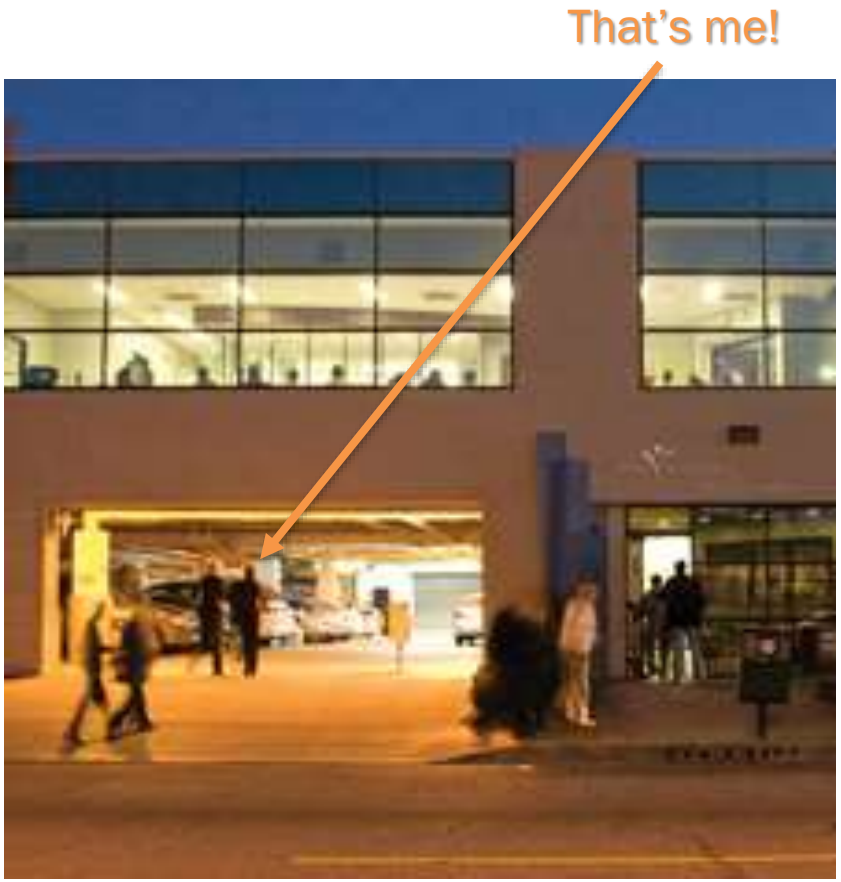
In the beginning….

Partnership between RAND Corporation and Venice Family Clinic began in 2012

- Opportunity to participate in NIH/NIDA funded research
- Chance to add a new service line to our primary care menu
- Participation provided a substantial funding opportunity for VFC

Venice Family Clinic

- Community Health Center located on Westside of Los Angeles
- Venice Family Clinic is the medical home for 25,000 people
- $37M annual budget



RAND Corporation

- Non-profit research institute headquartered in Santa Monica, CA
- RAND Health conducts research and analysis to improve health services and policy

Welcome addition or clinic disruption?

- Opioid epidemic had not yet gained widespread public attention in 2012
- VFC was in midst of implementing EMR
- Primary care overload/burn out was a significant dynamic at the clinic
- Anticipating ACA's impact
  - Expected to be flooded with new patients
  - New and stable funding for the clinic
- Adding SUD services tested the VFC's culture and attitudes

Key perceived barriers

- Identified barriers to integrating SUD treatment prior to the study
- Barriers fell into three areas:
  1. Training
  2. Resources
  3. Culture

Key perceived **training** barriers

- Providers don't feel knowledgeable enough to provide SUD treatment
- Providers worry that they haven't had adequate training to treat SUD patients
- There is too much staff turnover – it's hard to keep everyone trained

Key perceived **resources** barriers

- There isn't enough time to commit to SUD patients
- There is not enough staff to provide SUD treatment

Key perceived **cultural** barriers

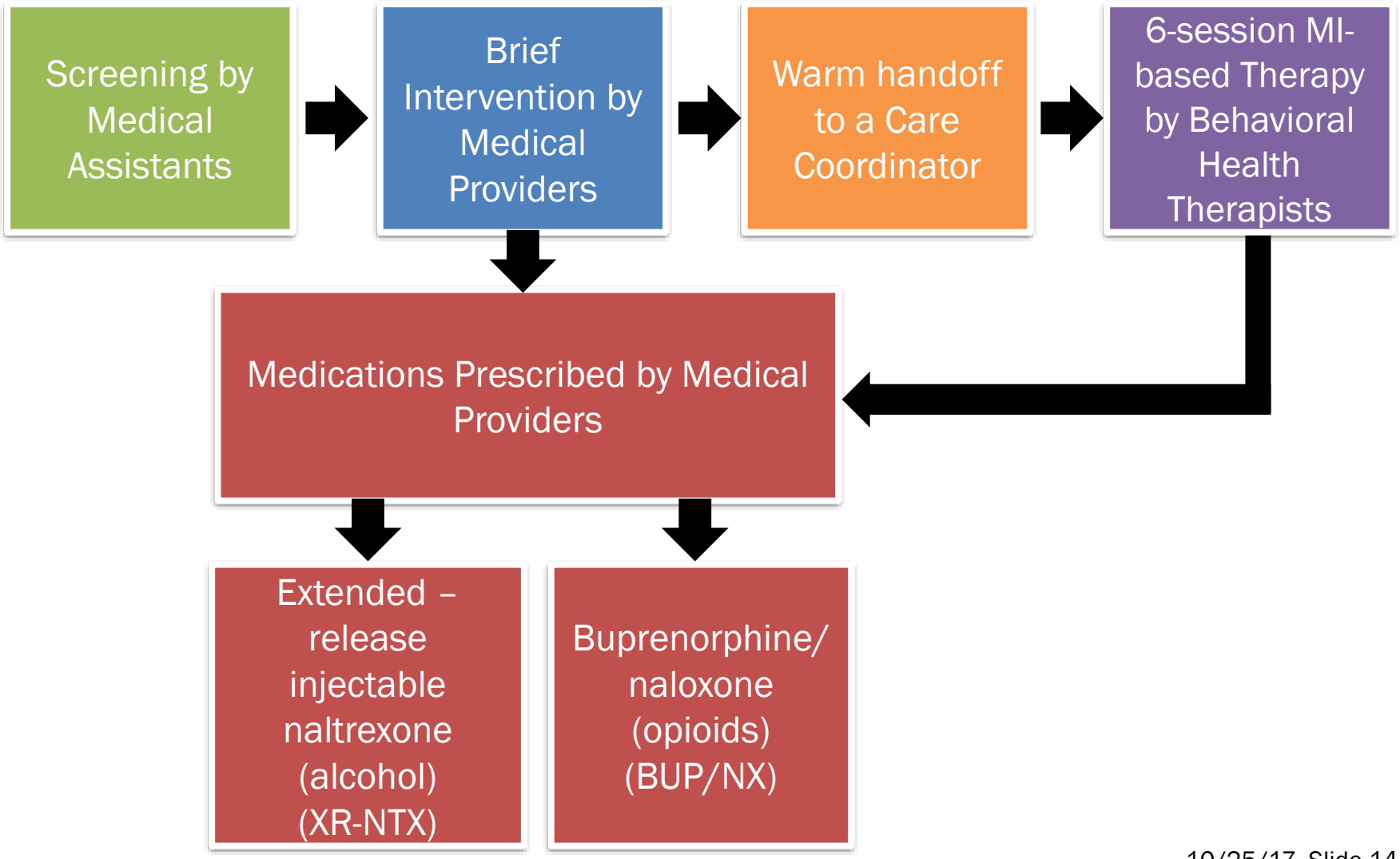
- There is a lack of motivation to provide SUD treatment
- SUD treatment should have a dedicated provider or specialty clinic
- There are barriers to treating the homeless population
- Patients with mental health comorbidities may not be appropriate

Key perceived **cultural** barriers

- The clinic may attract too many SUD patients who would disrupt the clinic (Stigma/bias)
- The clinic has a no-narcotic policy
- Providers fear SUD treatment will not remain a priority among leadership (Sustainability)

SUMMIT Study Overview

We set out to address barriers and implement the continuum of care for substance use disorder (SUD) treatment



We examined the effectiveness of a two-part implementation intervention

Organizational Readiness Intervention

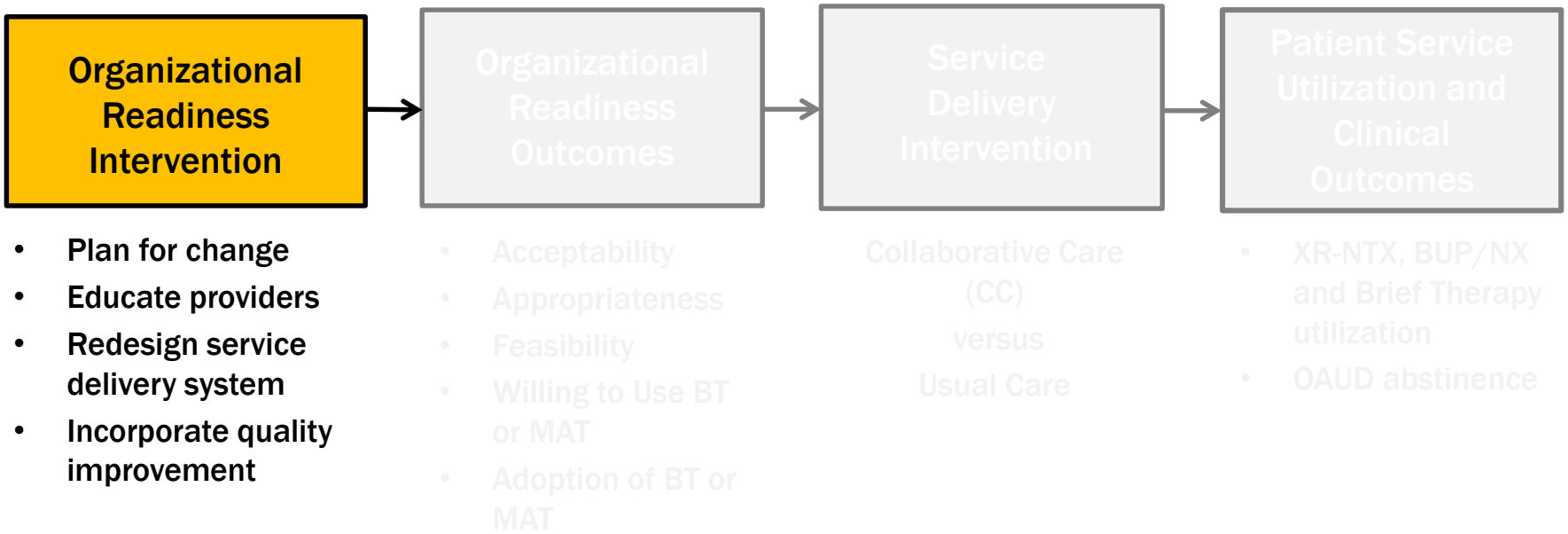
- Goal: To prepare the organization to deliver SUD treatment services using collaborative care (CC)
- Evaluated using a pre-post design

Collaborative Care Intervention

- Goal: To increase patient linkage to and primary care providers' use of medication-assisted treatment (MAT) and brief treatment (BT) for opioid and alcohol use disorders (OAUD)*
- Evaluated using a randomized design

**We focused on OAUD because both have a substantial impact on public health and there are medications considered to be best practices for treating these disorders*

We started with the organizational readiness intervention



The organizational readiness intervention consisted of a cluster of implementation strategies

Plan for Change

- Gathered info about current processes
- Obtained feedback on perceived barriers from all staff and leadership through focus groups and interviews

Educate Providers

- Educated all providers at every level
- Identified MAT and BT champions
- Informed stakeholders (e.g., Boards of Directors)

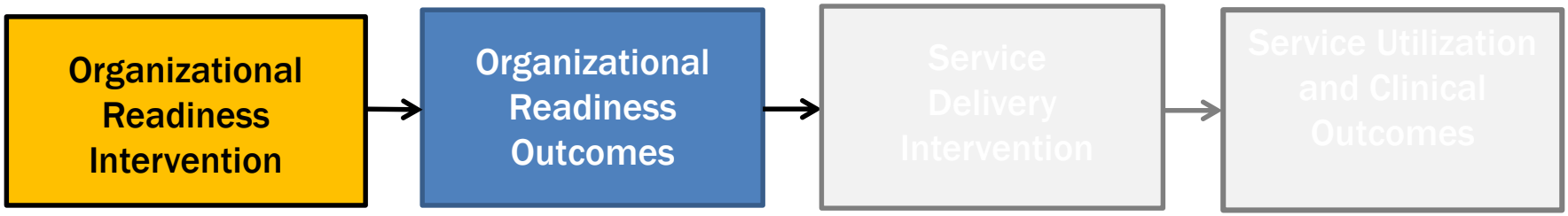
Restructure Delivery Systems

- Created new workflow for patients with OAUDs
- Developed treatment and CC protocols

Incorporate Quality Improvement

- Conducted Plan-Do-Study-Act cycles to introduce new practices
- Pilot tested all practices
- Adapted protocols to address barriers

We measured organizational readiness outcomes at four time points through provider focus groups, interviews and surveys



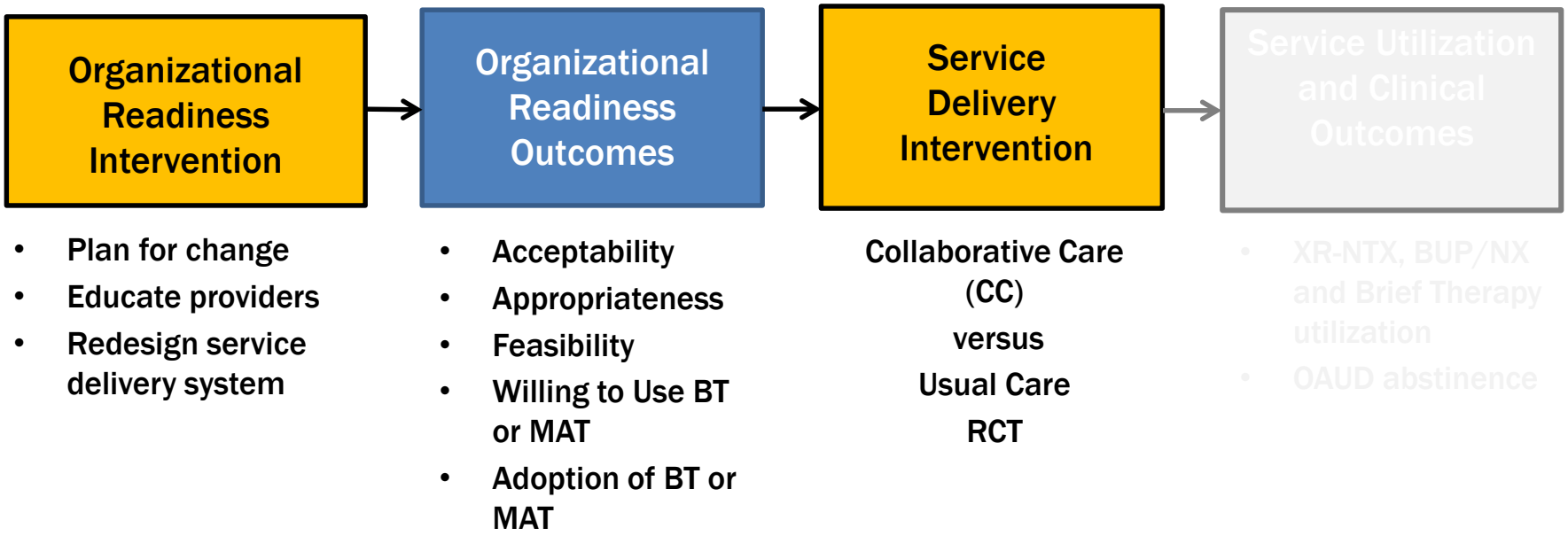
- Plan for change
- Educate providers
- Redesign service delivery system

- Acceptability
- Appropriateness
- Feasibility
- Willing to Use BT or MAT
- Adoption of BT or MAT

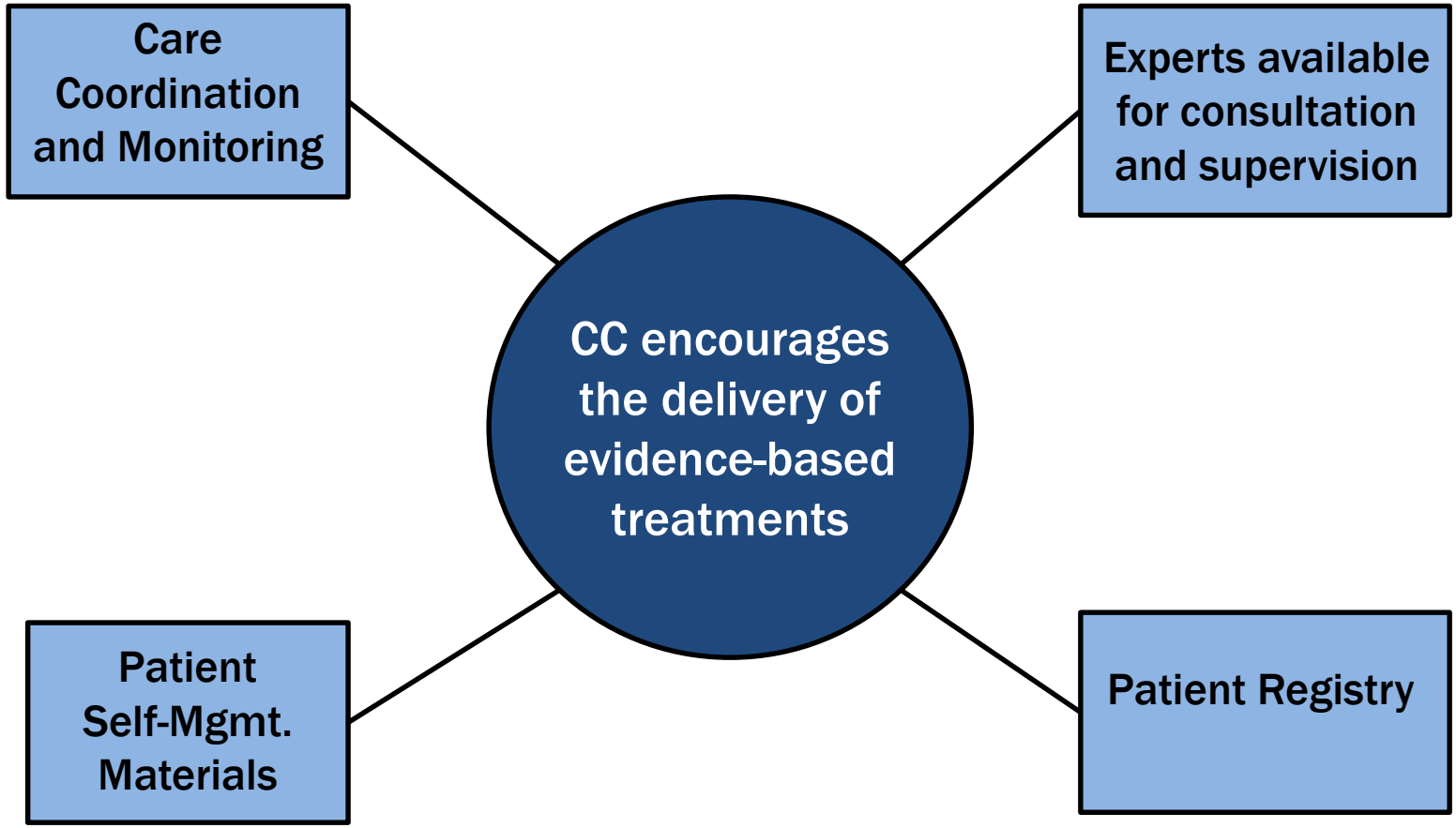
Collaborative Care (CC) versus Usual Care

- XR-NTX, BUP/NX and Brief Therapy utilization
- OAUD abstinence

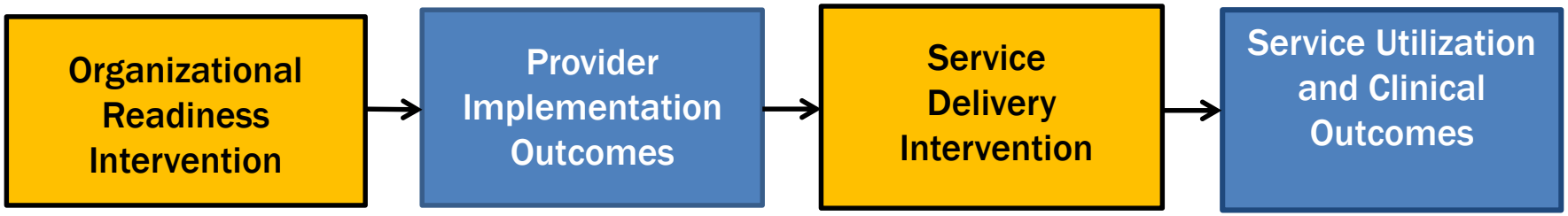
18 months after we started organizational readiness, we implemented and tested the CC service delivery intervention



The CC intervention was designed to facilitate treatment linkage and retention



After the RCT, we measured patient service utilization and clinical outcomes



- Plan for change
- Educate providers
- Redesign service delivery system

- Acceptability
- Appropriateness
- Feasibility
- Willing to Use BT or MAT
- Adoption of BT or MAT

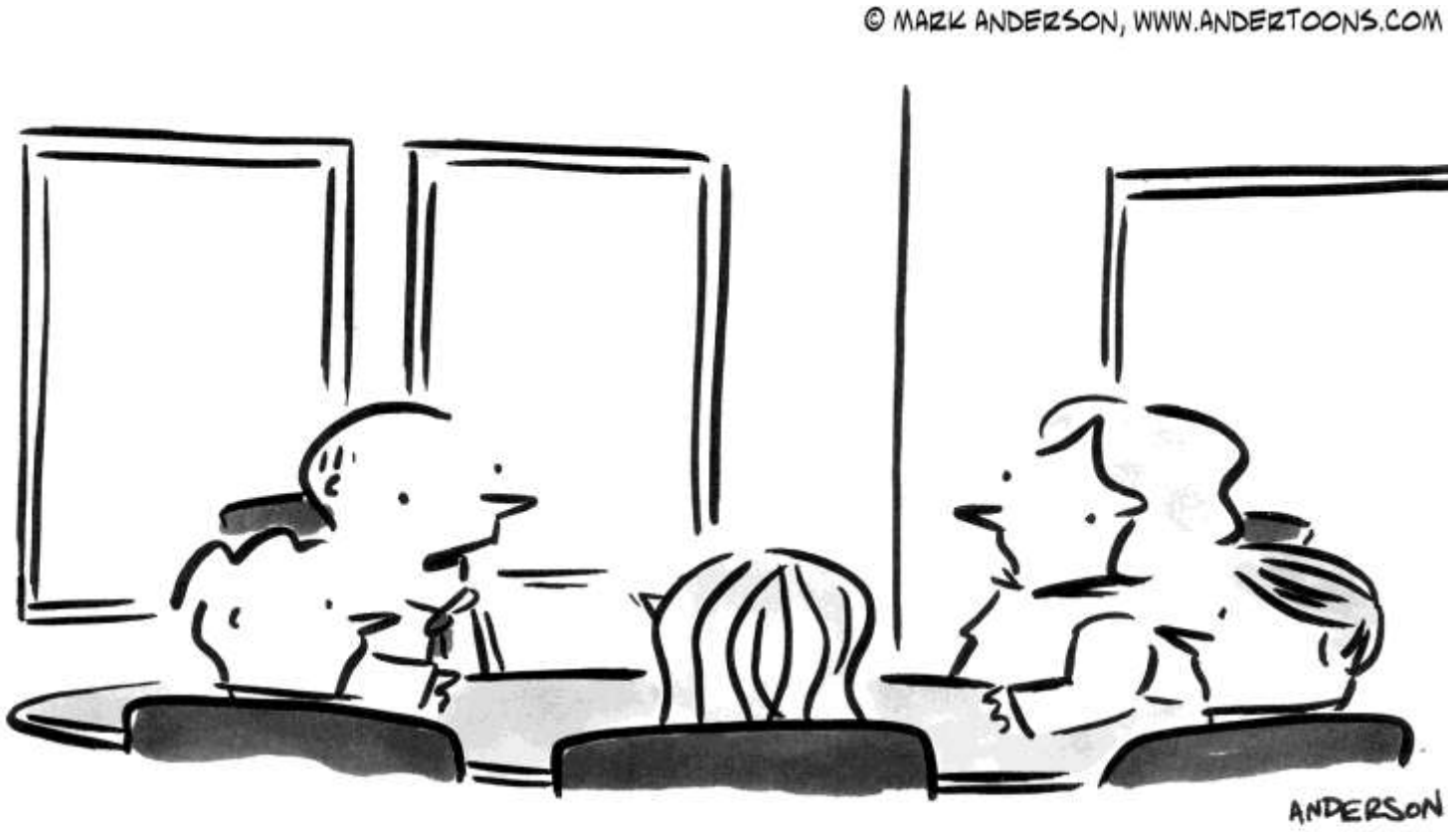
Collaborative Care (CC)

versus

Usual Care

- XR-NTX, BUP/NX and BT utilization
- OAUD abstinence

Needless to say, we had our work cut out for us …



"OK, now that we all agree, let's all go back to our desks and discuss why this won't work."

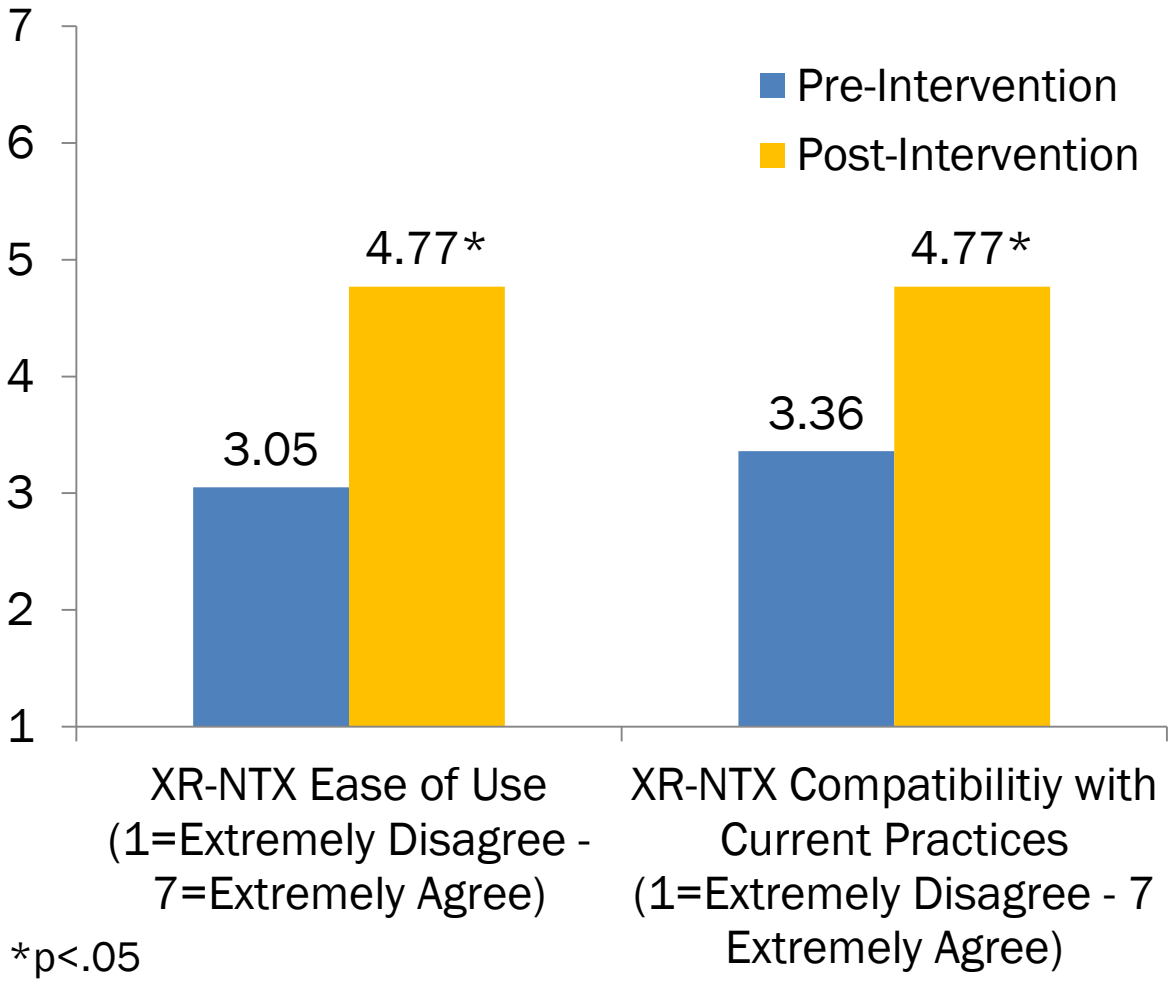
… and things didn't always go exactly as planned, but we did it.

Participant enrollment took place between June 3, 2014 and January 15, 2016

- All clinic patients were screened for risky alcohol or opioid use at every visit (about 15,000 patients of 15,753 visits, about 95% of all visits)
- 4-6% screened positive for risky or worse substance use
- Patients that consented were referred to a survey interviewer for further screening and enrollment
- We enrolled 392 individuals and had a 69% 6-month follow-up rate

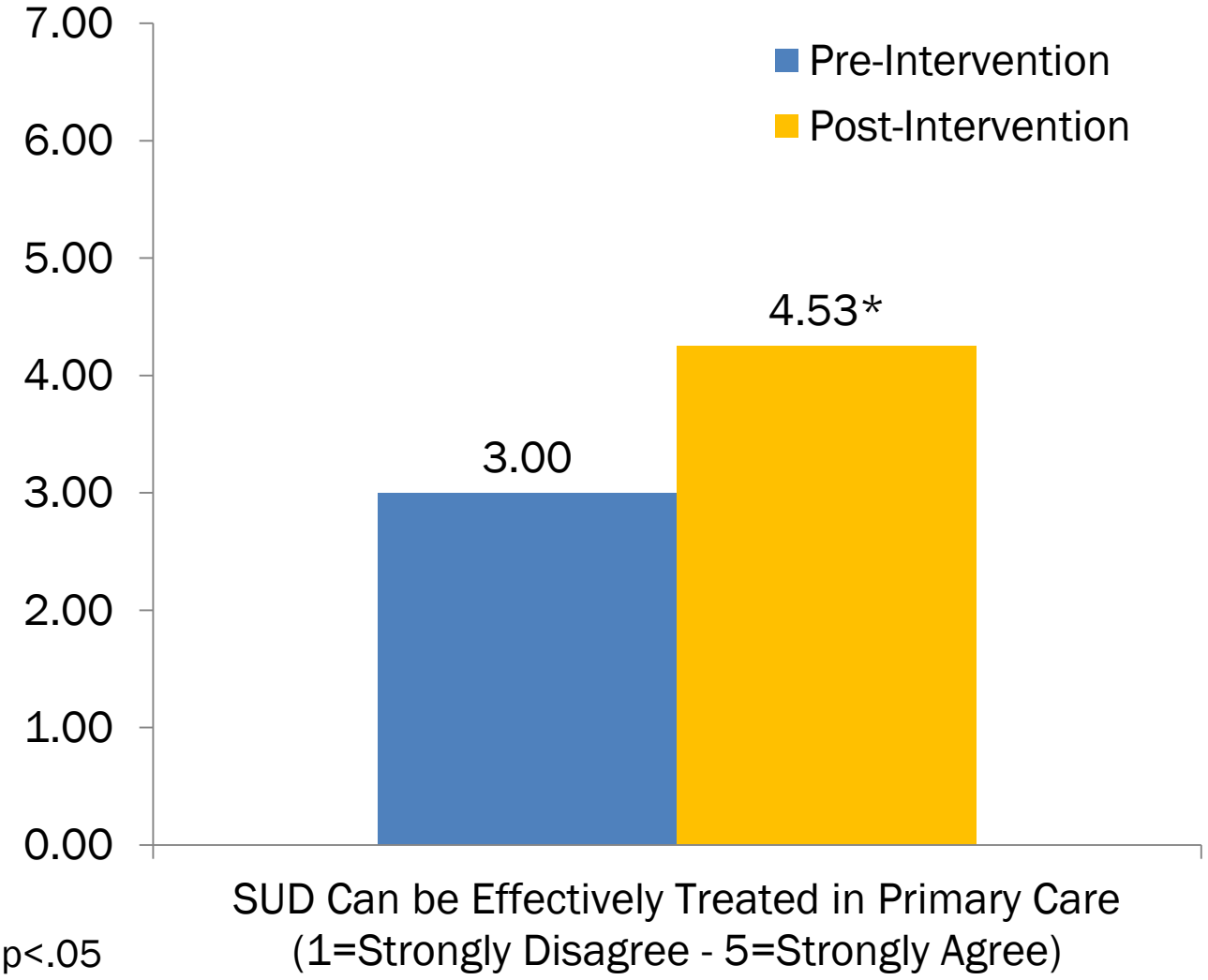
Key Organizational Readiness Findings

Medical providers' perceptions of *ease of use and compatibility of* medical treatment for alcohol use disorders increased one year after organizational readiness intervention



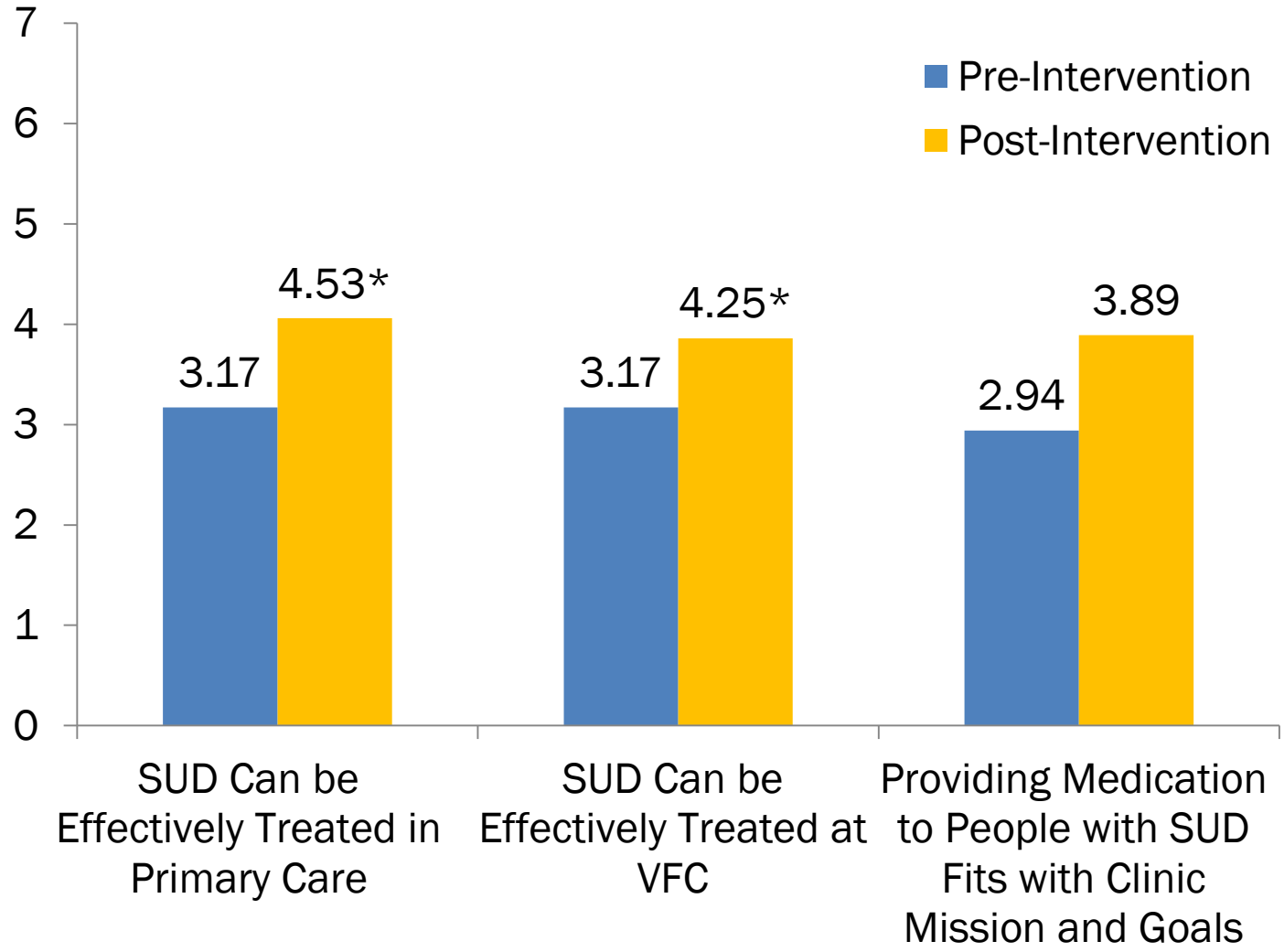
*p<.05

Medical providers' perceptions of *appropriateness in primary care* also improved after one year



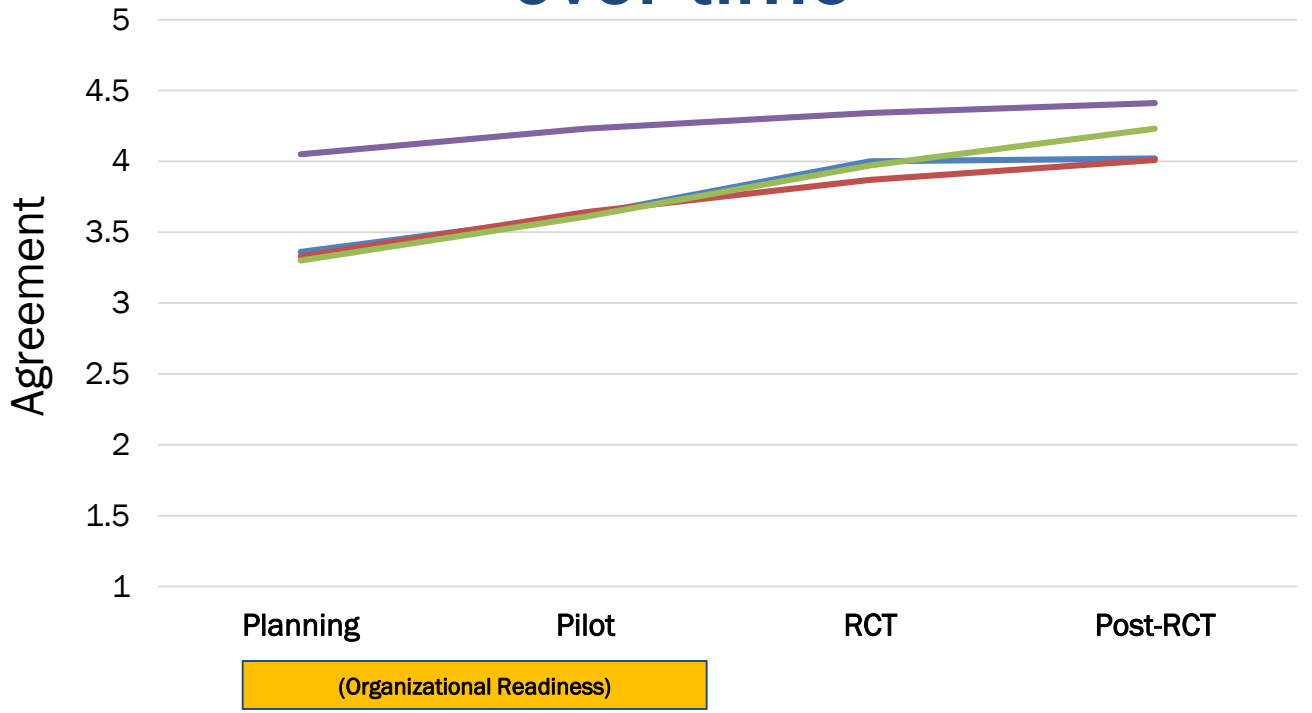
*p<.05

General clinic staff perceptions of *appropriateness* also improved after one year



*p<.01

All staff perceptions of acceptability and appropriateness improved and were sustained over time



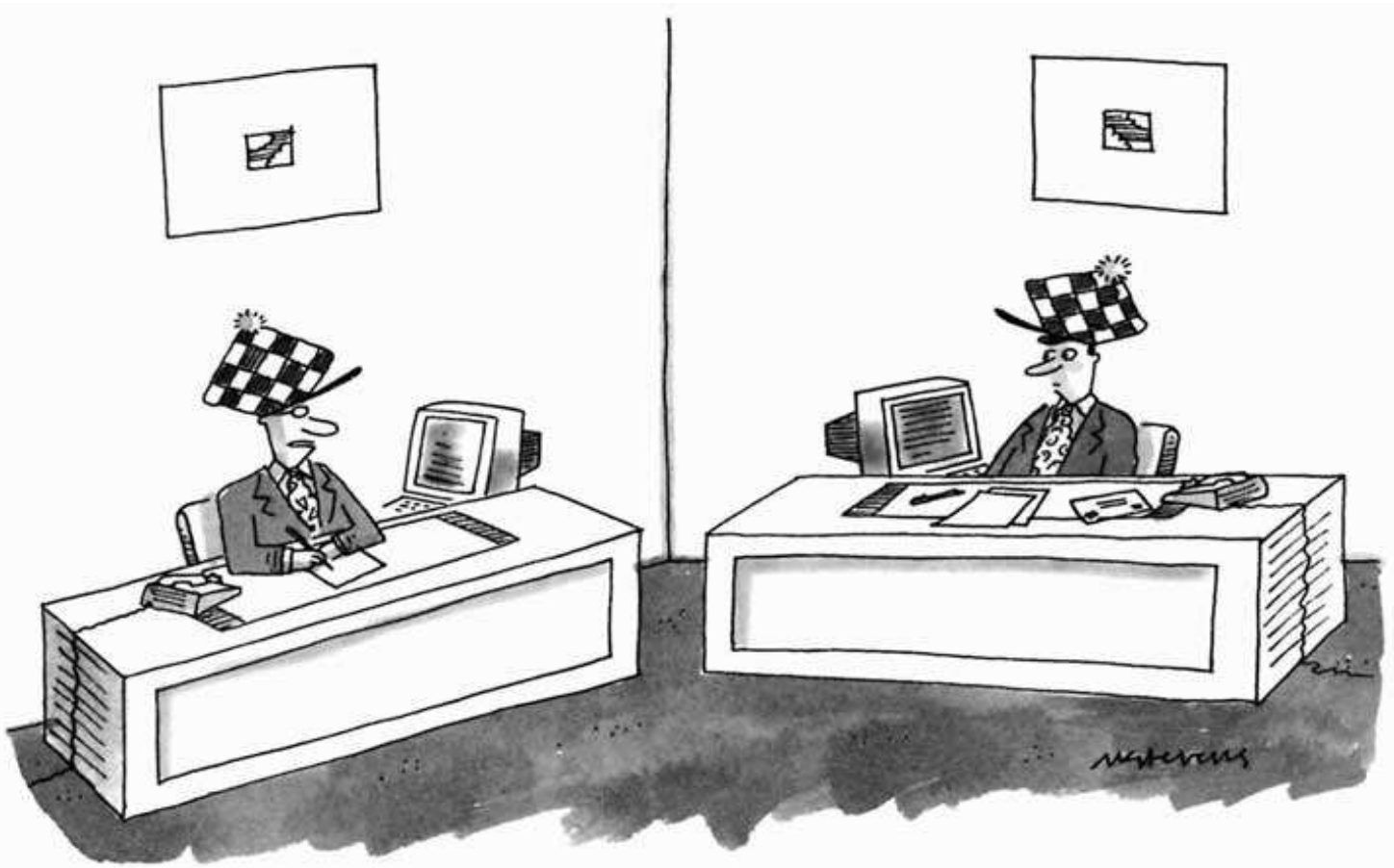
Differences from first to last year, $p < 0.001$;

Fast forward five years …, the majority of medical providers attended training and many are prescribing MAT

- 24/28 providers trained on use of extended-release naltrexone (XR-NTX)
- 16 have prescribed XR-NTX
- 21/28 attended buprenorphine/naloxone training (BUP/NX); 10 have X-waivers
- 10 have prescribed BUP/NX

In the words of one VFC medical provider:

"SUMMIT has completely changed the culture of care at Venice Family Clinic"



"I don't know how it started, either. All I know is that it's part of our clinic *culture."*

Key Findings: CC versus Usual Care

The majority of participants were male; one third were Hispanic, almost half were White; more than one third were homeless

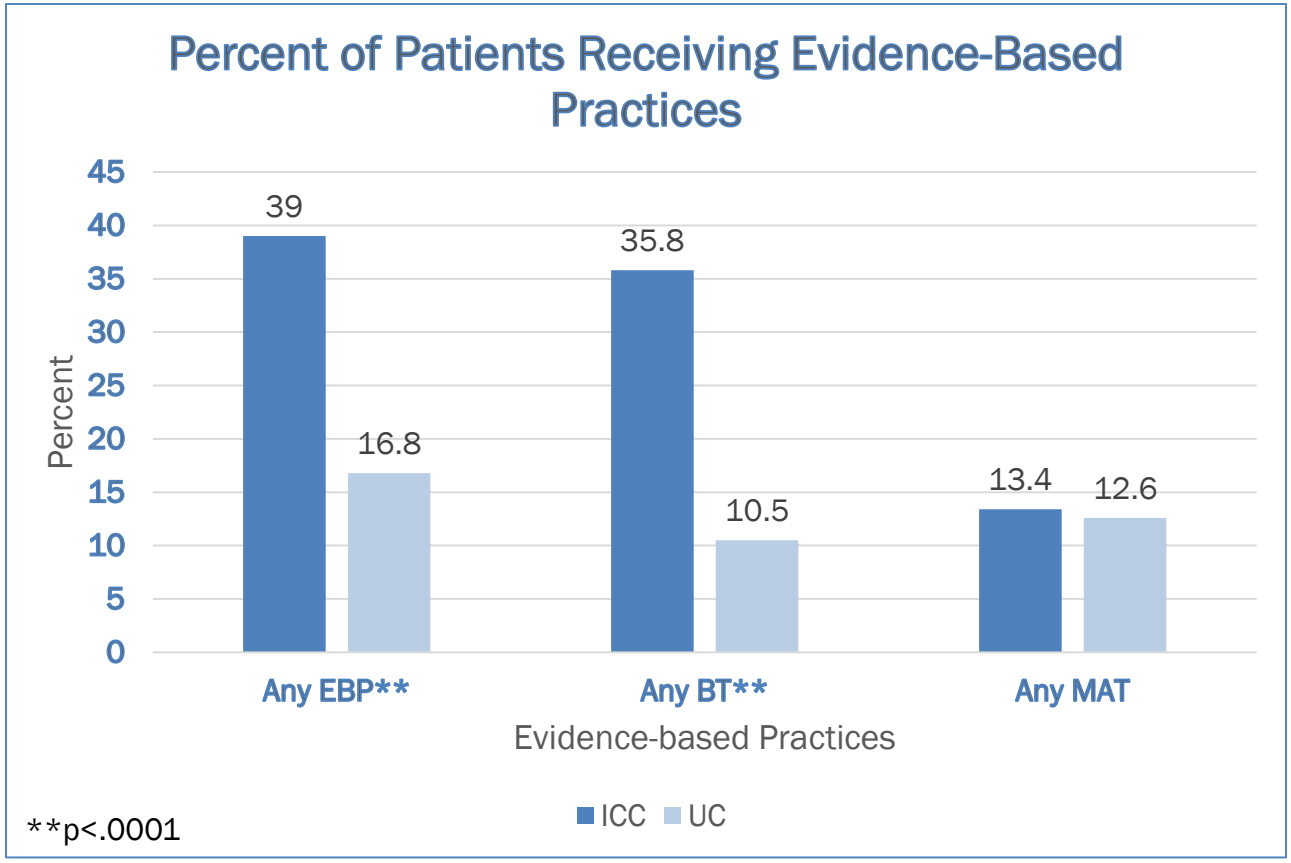
	Overall (n=377*) %	Usual Care (n=187) %	CC (n=190) %
Male	80	80	79
Ethnicity (% Hispanic)	31	32	30
Race			
White	44	45	42
Black	13	14	13
Multi-Racial/Other	41	39	43
Homeless Status			
Homeless	37.1	40.7	33.5

*Analytic sample size

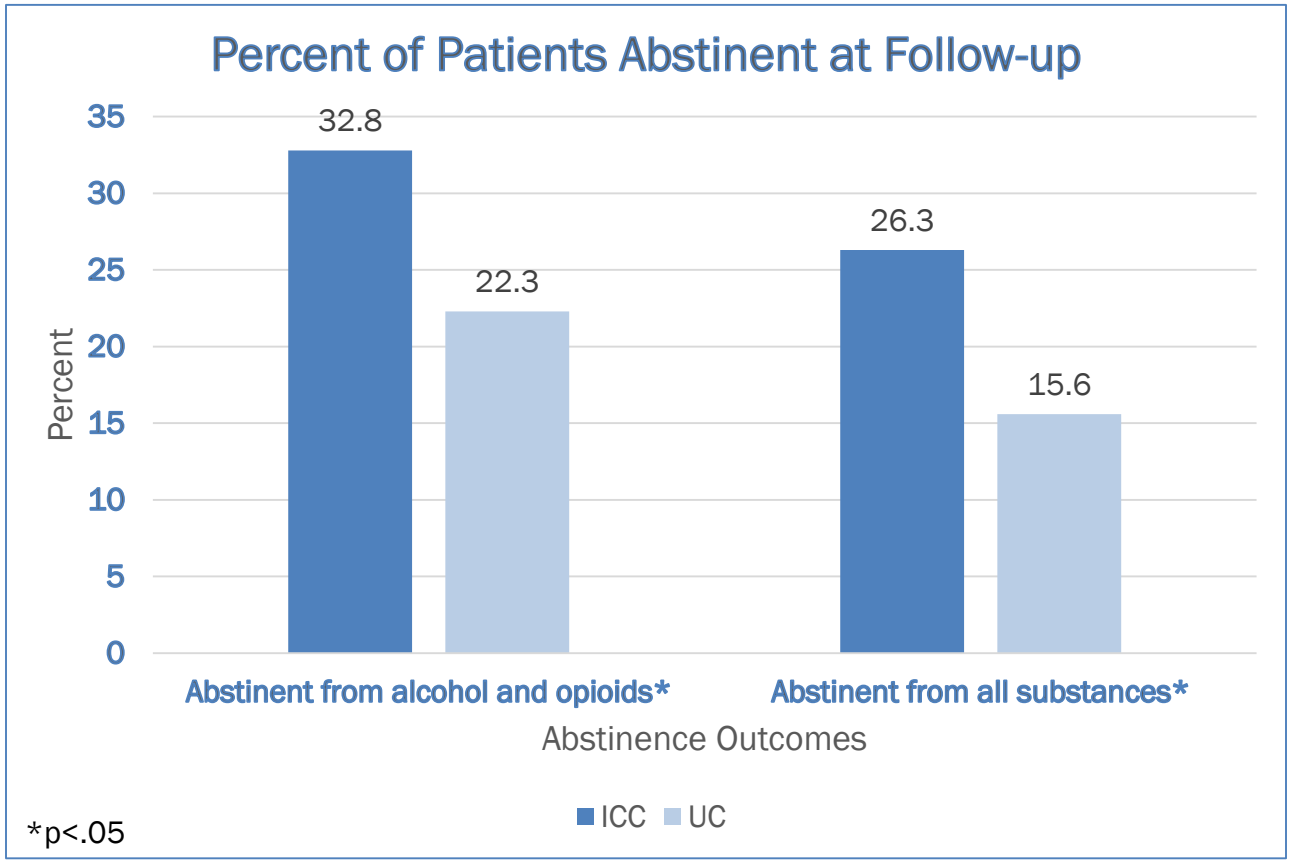
Half of the patients had alcohol use disorders without an opioid use disorder

	Overall (n=377) %	Usual Care (n=187) %	CC (n=190) %
Alcohol Only	54	52	56
Heroin, with or without Alcohol or Prescription Opioids	31	34	27
Prescription Opioid Dependence with our without Alcohol	16	24	27

CC patients were more likely to receive any evidence-based practice, and more likely to receive BT but not more likely to receive MAT than UC patients



CC patients were more likely to be abstinent from all substances 6 months after enrollment than UC patients



SUMMIT Study Take-Aways

Take-away 1: A strategy consisting of BOTH organizational readiness and collaborative care can facilitate implementation of SUD treatment in primary care and lead to improved patient outcomes

Take-away 2: A collaborative care service delivery intervention is critical to helping patients initiate SUD treatment in primary care

Take-away 3: Patients who receive any treatment (with CC) do better than those who do not, regardless of type of treatment

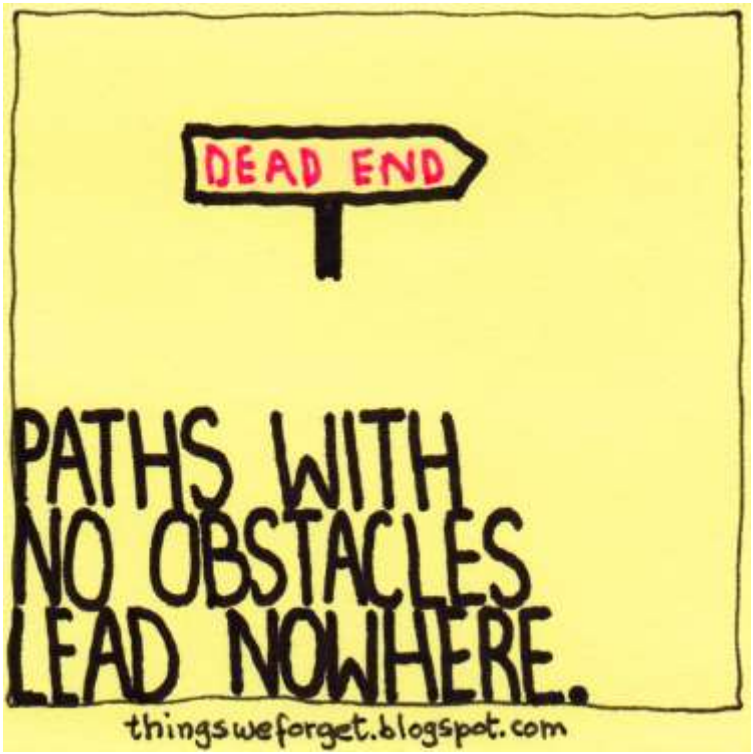
Take-away 4: Despite perceived barriers, treatment can be successfully integrated

Overcoming Barriers to Integrating SUD Treatment in Primary Care

Overcoming barriers

- Understand the perceived barriers in your organization so you can address them effectively

1. Training
2. Resources
3. Culture



Overcoming TRAINING barriers: Lack of expertise and need for technical support

Medical Providers:

- XR-NTX training: 2 ½ hours in person
- BUP/NX training: 4 hours in person, 4 hours on-line module
- Cash incentives for providers to get X-waiver

Behavioral Health Providers:

- 8+ hours of MI-based brief therapy intervention

*Plus: Refresher Trainings and accessible Expert Consultation

Overcoming TRAINING Barriers: Written procedures for referral and treatment

Overcoming RESOURCE barriers

- Develop warm handoff with care manager into behavioral health
- Additional time (30 minutes) for providers for new SUMMIT clients
- Providers given permission to just address patient's addiction at SUMMIT visit

Overcoming CULTURAL barriers

- Identify motivated champions to spread buy-in
  - Clinical leadership champion (CMO)
  - Behavioral health champion (Director of BH)
  - Medical provider champion (AMD)
- Show early successes through small pilots
  - P-D-S-A (Plan-Do-Study-Act)
  - Use your champions for the pilots
- Train all staff in HARM REDUCTION philosophy

Sustainability and New Directions for SUMMIT

Sustain by developing workforce

Staffing:

- HRSA MAT Expansion
- Add expertise and new staff—CADC, CAADE, dedicated case management, prescribers (currently 10)
- Provide clear information about transition
- Expand education and training -- Workshops and trainings on harm reduction, MAT etc…
- Merger with syringe exchange and HIV program (Common Ground)

Sustain by trusting what works

Operations and clinical:

- Screenings and referrals (PHQ-9; NIDA quick screen bi-annual)
- Co-location of BH and medical services already in place
- Care coordination

Sustain by learning from others

- Treating Addiction in Primary Care (TAPC) involvement
- RAND relationships
- Encouraging continuing education webinars
- Expert consultation

Sustain by learning from participants

Suggestions:

- *"I don't like that our sessions are limited to 45 min. And rooms are not always available."*
- *"Healthier snacks…potluck." "Pizza night would be good."*
- *"I think we should go outside and walk and talk to the people outside [these] walls about our program we can be good in a pack."*
- *"Meditation"*
- *"How do we [SUMMIT staff] cope?"*
- *"Will this program change/go away?"*

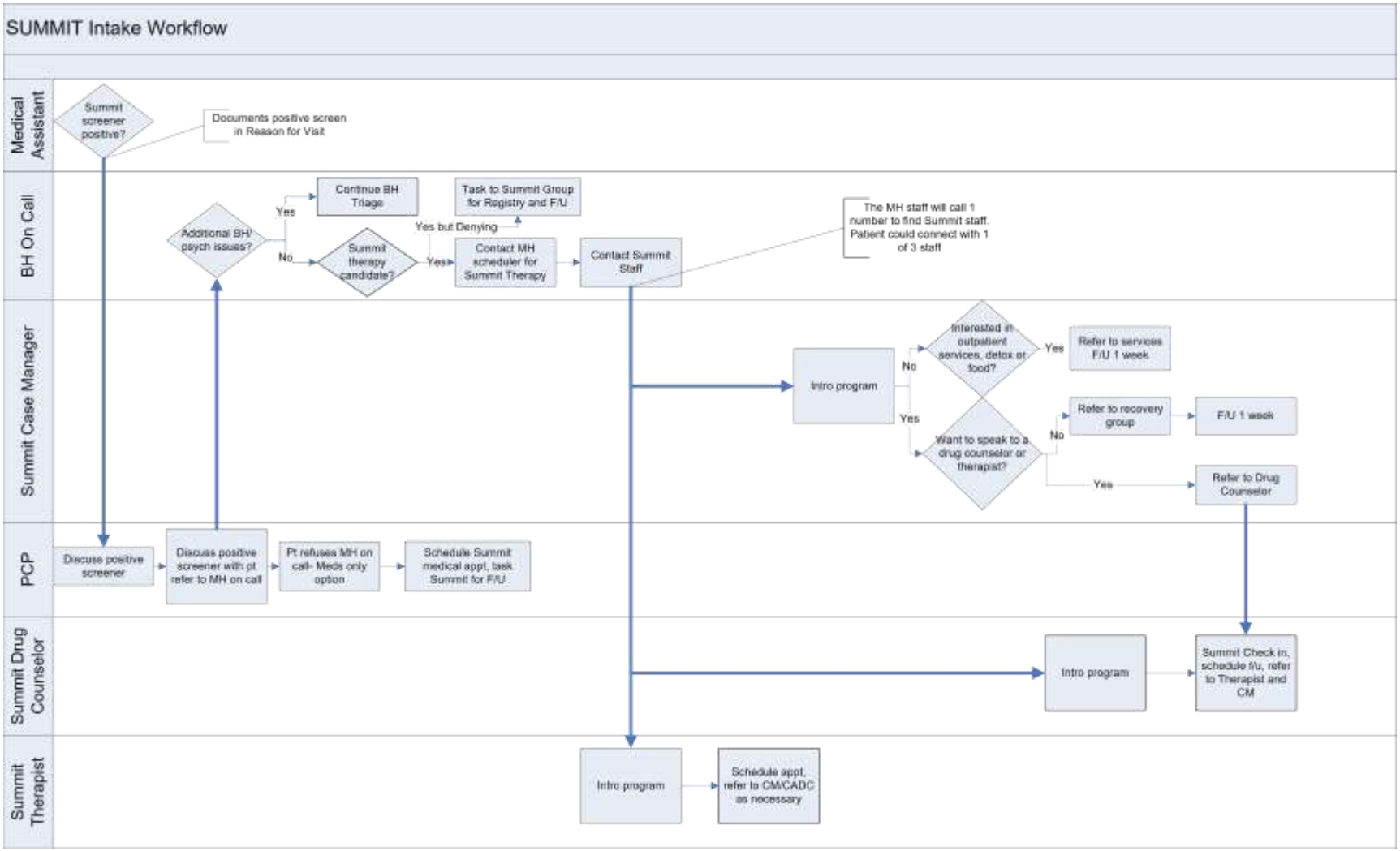
Sustain by learning from participants

Positive feedback: What does SUMMIT mean to you?

- *"SUMMIT gave me a new life I was re-born with happiness by talking about my pain, distress etc. I've been able to see life in a different positive way through the pain of my fellows and love, compassion, understanding of the SUMMIT group of women…"*
- *"Support, family."*
- *"This is the place where I learned I actually had options for my life and things could get better."*
- *"Community, safety, support, love, hope, encouragement, laughter, purpose."*
- *"People to love and care about me in this sometimes cold world."*

Working with clinic staff and providers

Sustain by helping staff visualize workflow



NEW! – Team of BH professionals!

- Case management to support transportation, linkage to care, and personal and professional goals
- Individual and/or group therapy with addiction counselor or LCSW to support emotional and community health
- Support groups focused on individualized treatment plan—bio-psycho-social-spiritual

IMPORTANT! Ongoing care coordination sustained from SUMMIT has been critical to supporting relationships with medical providers and staff

Harm reduction on the continuum of care

Accepting use as fact:

- We are inviting people who use alcohol or other drugs inside

Being honest about what is available:

- The range of care from coffee and fliers to MAT; counseling; support through in-home induction; referral to sober living….

Setting short-term and achievable goals WITH participants:

- The person can only benefit from care if we view them as self-governing

Near future goals for SUMMIT at VFC

- Group refill clinic
- Evaluate and implement SBIRT for teens
- Start group for people affected by AOD (CRAFT)
- Build more effective working relationships with other agencies
- Hub and spoke model

Ongoing challenges

- Expanding SUMMIT program across sites
- Time and capacity for ongoing education around issues of SUD
- Maintaining clinic workflow while upholding values of harm reduction
- How to capture data outside of medical infrastructure
  - E.g.: “touches” with case manager; participant-specific goals.
- Same-day billing
- Referrals to inpatient, detox and residential.

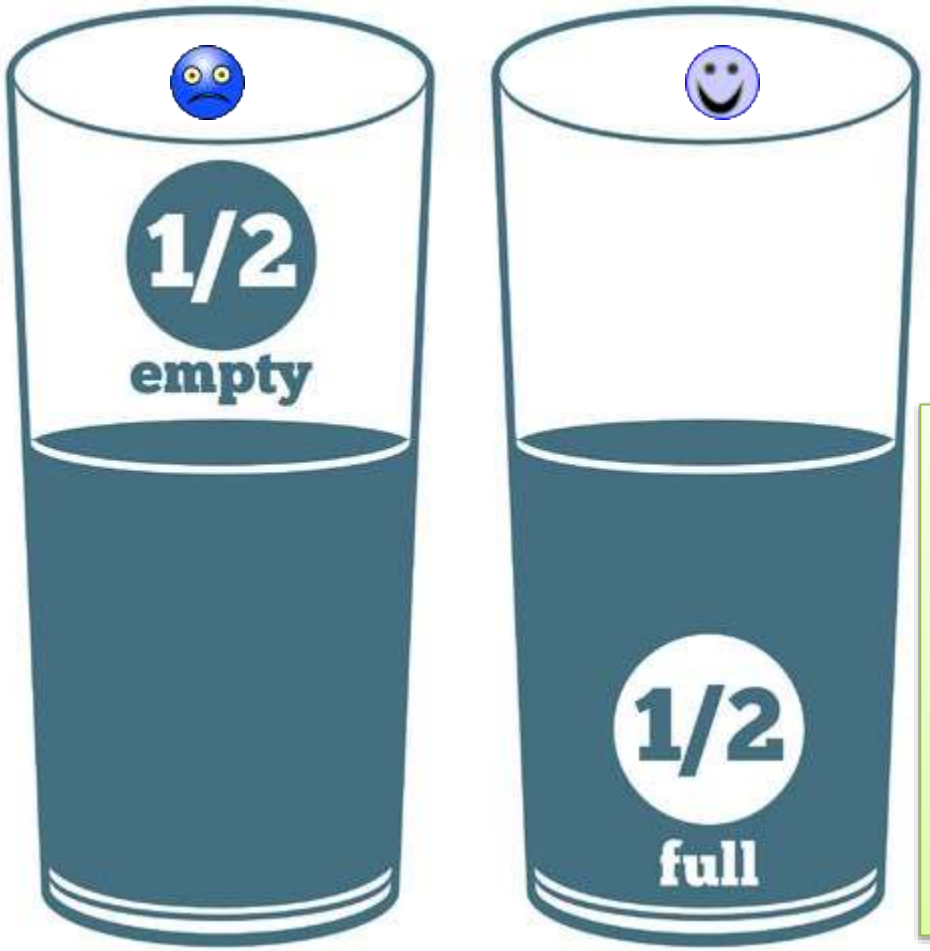
Conclusions and Next Steps

Despite perceptions of multiple barriers, SUD treatment can be successfully implemented in primary care

- An organizational readiness intervention can help overcome barriers and change the culture of care to include SUD treatment
- A CC service delivery intervention can improve linkage to care and outcomes
- A specialized workforce, funding support and listening to patients and providers can help sustain a newly integrated SUD program

However, the glass is only half full

72% of patients who needed SUD treatment did not get it



28% of patients going to primary care for something other than an SUD got SUD treatment!

Next steps

- Learn more about what patients need to respond to screening and initiate SUD treatment in primary care
- Continue to study SUMMIT data to
  - Better understand patient factors that predict use of medication and brief treatment
  - Better understand provider barriers and facilitators to prescribing medication
  - Learn about sustainability
- Continue to share our findings

Study publications to date

1. Watkins, K.E., Ober, A.J., Lamp, K., Lind, M., Setodji, C.M., Osilla, K.C., Hunter, S.B., McCullough, C.M., Becker, K., Iyiewuare, P.O., Diamant, A., Heinzerling, K., & Pincus, H.A. (2017). Collaborative Care for Opioid and Alcohol Use Disorders in Community Health Clinics. *JAMA Internal Medicine, 8(4*).
2. Watkins, K.E., Ober, A.J., Lamp, K., Lind, M., Diamant, A., Osilla, K.C., Heinzerling, K., Hunter, S.B., & Pincus, H.A. Implementing the chronic care model for opioid and alcohol use disorders in primary care. *Progress in Community Health Partnerships: Research, Education, and Action.* In press.
3. Storholm, E.D, Ober, A.J., Hunter, S.B., Becker, K, & Watkins, K.E. Barriers to integrating the continuum of care for opioid and alcohol use disorders in primary care: A qualitative longitudinal study. *Journal of Substance Abuse Treatment.* In press.
4. Iyiewuare, P.O., McCullough, C., Ober, A., Becker, K., Osilla, K., & Watkins, K.E. Demographic and mental health characteristics of individuals who present to community health clinics with substance misuse. *Journal of Primary Care and Community Health.* In press.
5. Kulesza, M., Watkins, K.E., Ober, A., Osilla, K., & Ewing, B. Internalized stigma as an independent risk factor for substance use problems among primary care patients: Rationale and preliminary support. *Drug and Alcohol Dependence.* In press.

Study publications to date (continued)

6. Ober, A.J., Watkins, K.E., Hunter, S.B., Ewing, B., Lamp, K., Lind, M., Becker, K., Heinzerling, K., Osilla, K.C., Diamant, A., & Setodji, C.M. Assessing and improving organizational readiness to implement substance use disorder treatment in primary care: Findings from the SUMMIT study. *BMC Family Practice.* Under review.
7. Ober, A.J., Watkins, K.E., Lamp, K., Lind, M., Osilla, K.C., Heinzerling, K.G., De Vries, D., Iyiewuare, P.O., & Diamant, A. (2017). *SUMMIT Study Protocol: Step-by-Step Procedures for Providing Screening, Brief Intervention, and Treatment Services to Primary Care Patients with Opioid or Alcohol Use Disorders.* Santa Monica, CA: RAND Corporation, TL-219-NIDA. Available at: https://www.rand.org/pubs/tools/TL219.html
8. Heinzerling, K.G., Ober, A.J., Lamp, K., De Vries, D., & Watkins, K.E. *SUMMIT: Procedures for medication-assisted treatment of alcohol or opioid dependence in primary care.* Santa Monica, CA: RAND Corporation, TL-148-NIDA, 2016. Available at: http://www.rand.org/pubs/tools/TL148.html
9. Osilla, K.C., D'Amico, E.J., Lind, M., Ober, A.J., & Watkins, K.E. *Brief treatment for substance use disorders: A guide for behavioral health providers.* Santa Monica, CA: RAND Corporation, TL-147-NIDA, 2016. Available at: http://www.rand.org/pubs/tools/TL147.html
10. Ober A.J., Watkins K.E., Hunter S.B., Lamp K., Lind M., & Setodji C.M. (2015). An organizational readiness intervention and randomized controlled trial to test strategies for implementing substance use disorder treatment into primary care: SUMMIT study protocol. *Implementation Science, 10*(66).

Many people contributed to this project (it takes a village …)

- Kate Watkins (PI)
- All of the staff at Venice Family Clinic
- Kirsten Becker
- Allison Diamant
- Brett Ewing
- Keith Heinzerling
- Sarah Hunter
- Erik Storholm
- Praise Iyiewuare
- Mimi Lind
- Colleen McCullough
- Karen Osilla
- Claude Setodji
- Chau Pham
- Tiffany Hruby

Project funded by NIDA R01DA034266 and Alkermes for XR-NTX

Questions?

Karen: klamp@mednet.ucla.org

Allison: ober@rand.org

Tobin: tdshelton@mednet.ucla.org

RAND CORPORATION

Venice Family Clinic

Several factors influenced who received any evidence-based practice

- Those more likely to receive any evidence based practice …
  - were older ($p<.0001$)
  - were stably housed (i.e., not homeless ($P<.01$)
  - had more severe SUDs ($p<.05$)
  - had greater perceptions of self-stigma around their SUD ($p<.05$)

Several factors influenced who received MAT

- Those more likely to receive MAT among those with an AUD
  - were older (OR = 1.07, CI = 1.03, 1.11, p<.05)
  - had received BT prior to MAT (OR = 3.34, CI = 1.35, 8.91, p<.01)
- Those more likely to receive MAT among those with an OUD
  - were older (OR = 1.06, CI = 1.03, 1.10, p<.01)
  - male gender (OR = .37, CI = 0.16, 0.85, p<.05)
  - working full-time (OR = 3.26, CI = 1.14, 9.28, p<.05)
  - had more negative consequences from substance use (OR = 1.14, CI = 1.02, 1.28, p<.05)