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

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INTRODUCTION
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

That's me!
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)
We set out to address barriers and implement the continuum of care for substance use disorder (SUD) treatment.

- Screening by Medical Assistants
- Brief Intervention by Medical Providers
- Warm handoff to a Care Coordinator
- Medications Prescribed by Medical Providers
  - Extended-release injectable naltrexone (alcohol) (XR-NTX)
  - Buprenorphine/naloxone (opioids) (BUP/NX)
- 6-session MI-based Therapy by Behavioral Health Therapists
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

Organizational Readiness Intervention
- Plan for change
- Educate providers
- Redesign service delivery system
- Incorporate quality improvement

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

Service Delivery Intervention
- Collaborative Care (CC) versus Usual Care

Patient Service Utilization and Clinical Outcomes
- XR-NTX, BUP/NX and Brief Therapy utilization
- OAUD abstinence
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.

**Organizational Readiness Intervention**
- Plan for change
- Educate providers
- Redesign service delivery system

**Organizational Readiness Outcomes**
- Acceptability
- Appropriateness
- Feasibility
- Willing to Use BT or MAT
- Adoption of BT or MAT

**Service Delivery Intervention**

**Service Utilization and Clinical Outcomes**
- 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.

Organizational Readiness Intervention:
- Plan for change
- Educate providers
- Redesign service delivery system

Organizational Readiness Outcomes:
- Acceptability
- Appropriateness
- Feasibility
- Willing to Use BT or MAT
- Adoption of BT or MAT

Service Delivery Intervention:
- Collaborative Care (CC) versus Usual Care RCT

Service Utilization and Clinical Outcomes:
- XR-NTX, BUP/NX and Brief Therapy utilization
- OAUD abstinence
The CC intervention was designed to facilitate treatment linkage and retention.

CC encourages the delivery of evidence-based treatments.

- Care Coordination and Monitoring
- Patient Self-Mgmt. Materials
- Patient Registry
- Experts available for consultation and supervision
After the RCT, we measured patient service utilization and clinical outcomes

Organizational Readiness Intervention
- Plan for change
- Educate providers
- Redesign service delivery system

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

Service Delivery Intervention
Collaborative Care (CC) versus Usual Care

Service Utilization and Clinical Outcomes
- 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.
Medical providers’ perceptions of appropriateness in primary care also improved after one year.

SUD Can be Effectively Treated in Primary Care

(1=Strongly Disagree - 5=Strongly Agree)

* p<.05
General clinic staff perceptions of \textit{appropriateness} also improved after one year.

<table>
<thead>
<tr>
<th>Perception</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Can be Effectively Treated in Primary Care</td>
<td>3.17</td>
<td>4.53*</td>
</tr>
<tr>
<td>SUD Can be Effectively Treated at VFC</td>
<td>3.17</td>
<td>4.25*</td>
</tr>
<tr>
<td>Providing Medication to People with SUD Fits with Clinic Mission and Goals</td>
<td>2.94</td>
<td>3.89</td>
</tr>
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</table>

*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”
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.

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

*Analytic sample size
Half of the patients had alcohol use disorders without an opioid use disorder

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=377)</th>
<th>Usual Care (n=187)</th>
<th>CC (n=190)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Only</td>
<td>54%</td>
<td>52%</td>
<td>56%</td>
</tr>
<tr>
<td>Heroin, with or without Alcohol or Prescription Opioids</td>
<td>31%</td>
<td>34%</td>
<td>27%</td>
</tr>
<tr>
<td>Prescription Opioid Dependence with or without Alcohol</td>
<td>16%</td>
<td>24%</td>
<td>27%</td>
</tr>
</tbody>
</table>
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.

**p<.0001
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 online 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
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?”
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

### On-going Walk-In Support Groups

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Day</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (Co-ed)</td>
<td>Mon.</td>
<td>4:30pm—5:45pm</td>
<td>604 Rose Ave.</td>
</tr>
<tr>
<td></td>
<td>Tue.</td>
<td>5:30pm—6:45pm</td>
<td>604 Rose Ave.</td>
</tr>
<tr>
<td></td>
<td>Thur.</td>
<td>3:15pm—4:30pm</td>
<td>503 Olympic Blvd.</td>
</tr>
<tr>
<td>Women’s (Bilingual)</td>
<td>Wed.</td>
<td>10:00am—11:15am</td>
<td>2401 Lincoln Blvd.</td>
</tr>
<tr>
<td>Spanish (Co-ed)</td>
<td>Thur.</td>
<td>9:00am—10:15am</td>
<td>2509 Pico Blvd.</td>
</tr>
</tbody>
</table>

**M—F**
9:00am to 5:00pm

**x7970**

**Services Offered:**
- Medication Assisted Treatment (MAT)
- Psychotherapy
- Counseling
- Support Group
- Case Management
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


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.

Study publications to date (continued)


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

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Questions?

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Allison: ober@rand.org

Tobin: tdshelton@mednet.ucla.org
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)