Northern Light Health

Integrated Behavioral Health

The Workflow:
Preparing Primary Care Sites to Integrate Medication Assisted Treatment

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Objectives

- I am clear on the tools and resources available to all members of my team to empower my practice to provide care for patients with opioid use disorder.
- I am able to communicate and reinforce with all staff the importance of welcoming, empathetic, trauma-informed care for this patient population.
- I understand the evidence behind the guidelines built into this workflow and can work with my team to adapt it to my practice.

Welcome to Northern Light Health

Northern

1. Home Care & Hospice
2. AR Gould Hospital
3. Continuing Care
4. Home Care & Hospice

Maine Highlands

5. CA Dean Hospital
6. Eastern Maine Medical Center
   Acadia Hospital
   Laboratory
   Pharmacy
   Home Care & Hospice
7. Corporate Office
   Eastern Maine Medical Center
   Laboratory
   Pharmacy

Downeast Acadia

8. Maine Coast Hospital
   Home Care & Hospice
9. Blue Hill Hospital

Kennebec Valley

10. Sebasticook Valley Hospital
11. Inland Hospital
    Continuing Care
    Home Care & Hospice

Southern

12. Mercy Hospital
    Laboratory
    Pharmacy
    Home Care & Hospice

Bangor Area Substance Use Treatment and Recovery Work group

- Mission: Develop a coordinated continuum of care for substance use disorder that expands access and tools for treatment in primary care and integrates recovery and counseling resources.
- Participating members: PCHC, St Joseph Healthcare, Northern Light Eastern Maine Medical Center, Northern Light Acadia Hospital, Wellspring, Community Health & Counseling Services, Bucksport Area Health Center, Mayo Hospital, Health Equity Alliance, Bangor Area Recovery Network and Higher Ground
- Clinical subset of Bangor's Community Health Leadership Board

Downeast Substance Treatment Network

Since 2015, over 30 organizations, joined by community members in recovery, have been working together as a consortium called the Downeast Substance Treatment Network (DSTN) to effect change by:

- Improving access to treatments and services for people struggling with SUD/OUD.
- Supporting better integration and efficacy of treatment teams (with a particular focus on medication assisted treatment.
- Providing increased access to harm reduction tools for people in active use who may one day enter recovery.
- Work at multiple levels to prevent community members from developing SUD/OUD.

Participants: Downeast Treatment Center at AMHC, Bucksport Regional Health Center, Acadia Family Center, Mount Desert Island Hospital, Northern Light Maine Coast Hospital, Northern Light Blue Hill Hospital, Maine Health Equity Alliance, Local Law enforcement, Gordon Smith -Director of Opioid Response, Representatives from Senator Susan Collins' office and Senator Angus King's office, Local Substance Abuse Counsellors

The relationship between trauma and substance use disorders

- Adverse childhood experiences are common – Over 60% of adults have at least one. 25% have three or more.
  - These include abuse, neglect, separation from parents, unstable household, family with substance misuse or mental illness.
- Trauma that impacts health is also evidenced to be cumulative.
  - The more instances and types trauma experienced in childhood and adulthood, the more likely an individual becomes to develop a serious mental illness, substance use disorder, or chronic medical condition.

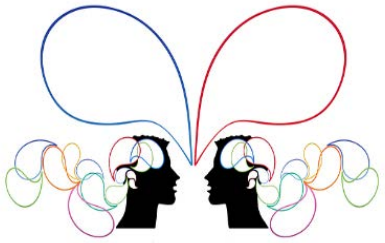
- This results in a **shorter lifespan.**

To Reduce Barriers to Treatment, We Need to Reduce Stigma. The Importance of Language

Some health professionals harbor negative attitudes toward people with substance use disorders, which contributes to poor health outcomes.

The fear of being categorized as “difficult” and using outdated, stigmatizing terms prevent patients from participating more fully in their own health care.

The language we use impacts professional attitudes, relationships with patients, and their access to recovery.



Trauma Informed Care

- **Set the tone**
  - Ask permission before touching/procedures
- **Take the time**
  - Let them know what's happening and why
- **Be sensitive to change**
  - Provide explanation about policy/staffing changes
- **Engage and understand**
  - Ask what questions they have
  - Make eye contact while you're answering

What To Do With a “Difficult Patient”?

- Pay attention and consider an underlying cause
- Know your own strengths and weaknesses
- Remain calm, be genuine and professional
- Connect with the patient as a unique person
- Maintain clear boundaries and seek help if needed

SBIRT for Behavioral Health

- **Screening, Brief Intervention, Referral to Treatment** (SBIRT) is an evidence-based practice that has shown significant success in varied clinic settings, across all age groups, genders, races/ethnicities.
- This is the same workflow for *all* medical concerns presenting in primary care!
- Primary care patients should be screened annually for substance use disorders and mental illness.
- SUD: American Association of Family Physicians (AAFP) recommends a single question: "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons (For instance, because of the experience or feeling it caused)?"
  - For answers > 0, follow with DAST 10, a 10 question tool that asks about past year illegal substance use.
  - Screen patients for intimate partner violence (HITS), Alcohol use disorders (AUDIT), depression (PHQ 9), anxiety (GAD 7), PTSD (PC PTSD), and suicide risk (CSSRS).

Determination of diagnosis

- Diagnosing OUD is a team effort; the workflow depends on the resources available in your clinic. Be certain that everyone is operating within their scope of practice/role.
  - A provider, MA or RN can use the Clinical Opioid Withdrawal Scale (COWS) to determine if patient is currently in withdrawal.
  - If the patient is in withdrawal, PCP will prescribe a symptom-specific “comfort pack” to address withdrawal symptoms and naloxone to prevent accidental overdose.
  - Diagnosis of opioid use disorder can be made by a medical provider or a licensed therapist or psychologist.
- If patient agrees to participate in treatment, review the MAT agreement with patient verbally and in writing and answer any questions the patient might have.
  - Recovery program participation agreement
  - Notice of privacy practices
  - Agreement to sign any recommended releases of information (ROI).

The gateway to treatment: First steps

- All patients new to the MAT recovery program will complete comprehensive screening for co-occurring mental illness, social determinants of health, and safety using SBIRT model.
- Recommend American Society of Addiction Medicine (ASAM) level of care check-list to determine appropriateness for MAT in the ambulatory medical setting.
- MA/RN will room patient, document vital signs and Clinical Opioid Withdrawal Scale (COWS) and complete screening tools.
- Licensed clinician will triage and make same-day recommendations and referrals as needed.

Meeting the MAT prescriber

- When the patient meets with the MAT prescriber:
  - The MAT prescriber will complete a medical exam which may include blood work, urine tests or other tests as medically necessary for the individual patient.
  - MA reviews informed consent for buprenorphine with patient.
  - Follow standard urine drug screen (UDS) procedure/workflow and review Prescription Monitoring Program (PMP).
  - Schedule patient for approved recovery program step-wise individual therapy and/or weekly group therapy.

Counseling and support guidelines for consideration

- **For a minimum of 12 weeks**, patients will see the therapist at least monthly for individual counseling and/or participate in monthly group treatment, if available.
- **Individual counseling** will focus the patients' individual needs and focus on addressing any biopsychosocial issues impacting recovery.
- **Group therapy** will focus on identifying goals and skill development.
- **Group community support** systems are often available online and in small communities.
- After 12 weeks of individual therapy, patients may step down to 3, 2, and then 1 session quarterly as treatment continues and patient exhibits stable engagement in the program.

Access to adequate support is essential to recovery.

We do NOT want lack of access to counseling or support to serve as a barrier to MAT-supported recovery.

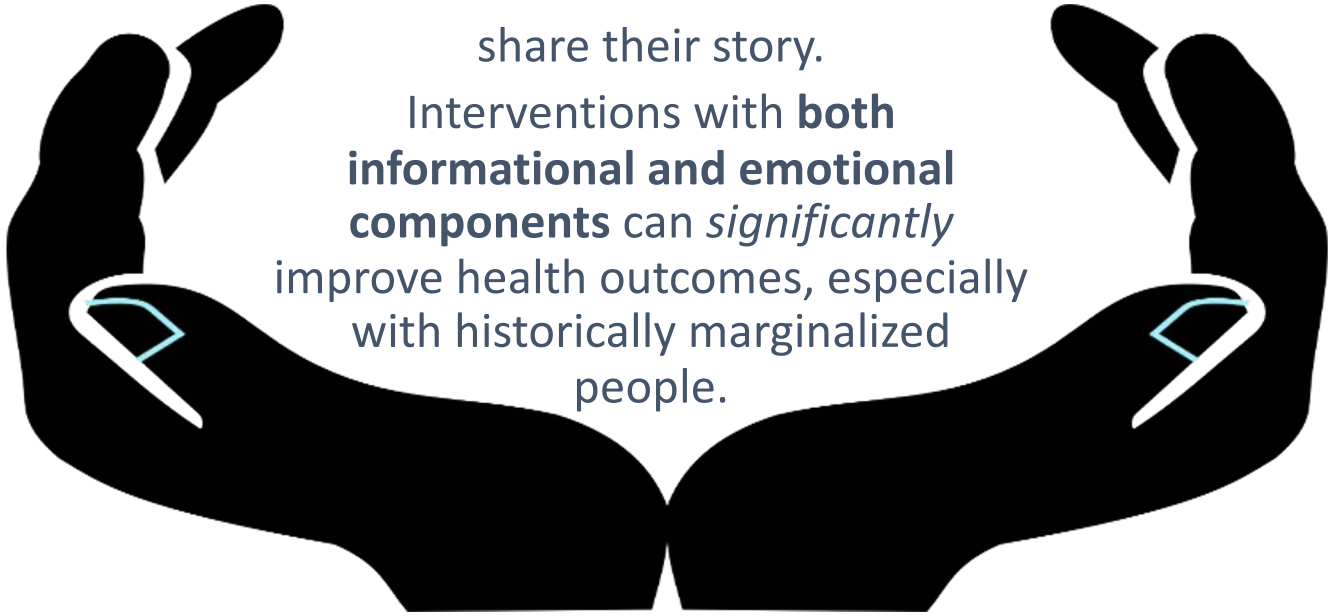
Engaged empathy

Focus on the patient and share an emotional experience.

Allow 5-10 minutes to

share their story.

Interventions with **both informational and emotional components** can *significantly* improve health outcomes, especially with historically marginalized people.



Accountability

- Maintain clear expectations in writing from the patient right at the start of treatment.
- The treatment team must adhere to established boundaries, often repeatedly reinforcing them, for treatment to be successful.
- Patients in long term recovery often recall with gratitude that their the provider holds them to was very valuable for their recovery.

Deceitful behavior and relapse

- Relapse back to drug use and addictive behaviors is *very common* in the first few weeks of treatment, even when patients are motivated and making progress.
- Patients new to treatment are used to lying about their substance use and maladaptive behaviors.
- Patients will challenge the boundaries and sometimes not even engage in the treatment process.

Responding to relapse/concerning behaviors

Having an honest, authentic connection with a health care provider is likely to be a new experience for these patients.

Confrontation is rarely productive.

Avoid a judgmental reaction and stick to known facts.

Allow patients to talk about their use while remaining neutral and present.

Discuss how, given this information, the practice can continue to support the patient's recovery.

"We need to provide treatment in a way that keeps our patients and community safe."

Things to keep in mind…

- Misusing and/or diverting medication can be symptoms of an active substance use disorder.
- We want these patients to come back even if this has been occurring. This is clinically significant information that will help us provide better care.
- Most patients with an opioid use disorder have a co-occurring mental illness and/or a significant trauma history. Agitation is usually masked anxiety.

Scripting for phone support staff

"In order to safely continue your medication, your provider needs you to bring your medication to the office/complete a urine drug screen [within this time frame]."

"What will happen if I don't come in?"	**"I will let you provider know. Please understand that they may talk to you about alternative treatment at your next appointment."**
Patient becomes agitated on the phone	"I understand that you're upset. I will let your provider know. Is there anything you want me to tell them?"
"I'm out of town. I can't come in for my pill count."	"No problem - just give me the name of the closest pharmacy and I will fax them a sheet to fill out once they count your pills."
"I'm out of town, I can't come in for my urine drug screen."	"No problem- just give me the name of the closest hospital and I will call their lab and fax an order."

Scripting for Medical Assistants/RN's

"I just used the bathroom and I cannot urinate."	**"No problem - I can give you as much water as you need to give us a sample. If you leave the clinic without providing a sample, it would be considered the same as a positive test, so we want to be sure that you can leave a sample."**
"I only have a small portion of my (Medication Assisted Treatment or MAT) medications. The others are stored elsewhere." **"I have some of my (MAT) medications with me and the others are at the school, with the other parent, etc."**	"Please bring in what you have for a pill count. You will need to find someone else who can bring your other MAT medications to the nearest pharmacy or bring to this clinic to be counted."
"I lost or flushed some of my pills."	"Please bring in what you have left for medications."
"My pills have been stolen."	"Ok, I will let your provider know."

Reasons to consider higher level of care

- Ongoing opioid use despite adequate buprenorphine dosing
- 2 + unexpected drug screens.
- Non-adherence to UDR and pill counts Ongoing use of high doses of illicit substances or alcohol that pose a health or safety risk.

Tapering/discontinuation

1. Patient interest and motivation
2. Readiness indicators
   - Achievement of key treatment goals.
   - Solid relapse prevention plan
   - Ongoing participation in ongoing community recovery-oriented activities
   - Continued adherence to MAT agreement
3. **Sustained recovery is an active process and a team effort**.

Partnership is key: Look for opportunities

- Model **compassionate, inclusive, coordinated care** for all patients.
- **Provide education and advocate for policies and workflows** that support patients with substance use disorders, trauma and mental illness.
- Help medical providers, patients and families **improve communication** and agree on safe, reasonable plans with **mutual accountability.**
- Provide education and tools to **promote resilience and empathetic engagement** for every health care employee in every role.

NO WRONG DOOR

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