A System Approach to the Opioid Crisis and the Evolution of Behavioral Health Integration: From I can’t do it, to this is fantastic!

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.
Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.
Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Describe the Hub and Spoke model for Integrated Medication Assisted Treatment.

2. Identify strategies and change processes for supporting the BHI clinicians’ confidence and competence in relation to IMAT spokes.

3. Define an Action Plan for developing or expanding IMAT services in their systems.
Bibliography / Reference

1. Primary Care Buprenorphine Programs: Ten Elements of Success. California Health Care Foundation 2016
2. SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery. SAMHSA PEP12-RECDEF
Learning Assessment

A learning assessment is required for CE credit. A question and answer period will be conducted at the end of this presentation.
Before we begin...

Are you presently doing substance use treatment or MAT in your practice?

1. It’s already up and running
2. We are actively planning to start this
3. It is just an idea now
4. It is not yet an idea for our practice
Who We are….

- A non-profit integrated healthcare system with 8 member and 3 affiliate acute care general hospitals—serving 10 Maine counties and 1 NH county
- Maine’s largest behavioral health provider is an integrated member of the system, including a 100-bed psychiatric hospital and comprehensive array of outpatient services
- Providers of healthcare for over 250,000 individuals
- The largest integrated healthcare system in northern New England
  - Member hospitals operate over 1,400 inpatient acute care beds
  - An ACO with over 1,200 independent and employed physicians and over 300 primary care physicians
  - A network of home health care and rehabilitative service organizations linked tightly with acute care
Where is Maine in the Opioid Crisis?

OD Deaths

2015: 272
2016: 378
2017: 418

OD Deaths

Maine Behavioral Healthcare
MaineHealth
Where is Maine...

- An estimated 28 thousand Mainers 18 years old and older have an illicit drug use disorder and about 25 thousand are in need of treatment for illicit drug use, but are not receiving it (National Survey on Drug Use and Health 2015-2016, SAMHSA, 2018).

- In 2017, there was a 27% increase in deaths related to illegal fentanyl and fentanyl analogs (Maine Attorney General, 2018).
  - 85% involved at least one opioid whether prescribed or illicit, an increase from 70% in 2014

- In 2017, the average age of drug overdose death was 41
  - Males outnumber females 2.5 to 1

- Drug overdoses continue to claim more than twice as many people in Maine as traffic accidents as of February 2018.
MaineHealth Response: System-wide Approach

• As Maine’s largest health care provider system, MaineHealth has an imperative to respond to this public health crisis
  - These are our patients – in our practices, in our EDs, in our beds and in our communities
  - Opioid crisis was only public health topic that was consistently raised as a high priority in every Community Health Needs Assessment
• Need for a comprehensive, evidence-based approach was clear
  - Pockets of activity throughout system were uncoordinated
  - Policy experts turning to MaineHealth for leadership
• **Limited history/experience treating substance use disorders**
MaineHealth Opioid Use Workgroup formed to develop a system-wide response to the opioid epidemic

**Purpose:** To lead the development of a system-wide response to the urgent community need surrounding the opioid epidemic.

**Scope:** To identify those facets of prevention and treatment for which health care providers can be influential and accountable.
Treatment: Integrated Approach

Unanimously approved by the CMO Council and MH Board, this model integrates prevention, education and treatment through a collaboration between providers of different specialties.
MaineHealth Hub and Spoke Treatment Model

**Hubs:** Serving the most complex and acute cases of OUD. Services are delivered in a behavioral health setting.

**Intermediate:**
Services are delivered in a primary care setting (patient-centered medical home). May provide buprenorphine induction and stabilization.

**Spokes:**
Services are delivered throughout the service area in primary care settings (patient-centered medical homes) to treat most stable patients—do not do buprenorphine inductions.

### Intensive Hubs
Co-located with comprehensive behavioral health services designed to screen and meet highest level of treatment need, including co-occurring disorders.

- Medical Evaluation & Screening
- Induction of IMAT
- Intensive Outpatient Treatment
- Specialty Treatment
- Consultative Support for Intermediate & Primary Care Practices
- **Staff:** Addiction medicine specialist or experienced suboxone prescriber
- Psychiatrist on staff
- Behavioral Health Clinicians
- MA/Nurse support

### Intermediate:
- PCMH: Screening
- IMAT Treatment (may induce treatment as well)
- Behavioral Health Counseling & Support for Primary Care Practices
- Staff: Suboxone prescriber
- Behavioral Health Clinicians
- MA/nurse(s)

### Spokes:
Patient Centered Medical Homes will provide MAT and supportive behavioral health services for stable patients and with support from behavioral health.
More Simply…

**HUB**
1. Addiction Psychiatrist
2. Behavioral Clinicians
3. Clinical Staff

**Spoke**
1. Primary Care Providers
2. BHI Clinician
3. Clinical team

**Intermediate Spoke**
IMAT Induction-Stabilization-Maintenance Care
Primary Care

**Spoke IMAT Maintenance Care**
Primary Care
Fundamental question: Is the integrated behavioral health workforce actually ready to provide IMAT services in the primary care environment and in which medication use is going to become a significant component of addiction treatment?

And...what do we do about all the anxiety getting started?
Let’s Hear From Them

https://www.dropbox.com/s/t4me8nikvv0bdn8/IMAT%20PROJECT%20EDIT%2009.26.18.wmv?dl=0
What did you hear? How does this fit your setting?
When you started to hear about IMAT and your role with IMAT in primary care, how confident did you feel about your ability to do this work?

At this time, how confident are you feeling about your ability to do this work?

Confidence in Delivering IMAT Behavioral Health Services
1 - Not Confident, 10 - Very Confident
What has been the most positive surprise about this work?

• How much I enjoy the people.... And combating stigma within my practice and people in my personal life

• Working with clients as they make positive changes in their lives and see the personal growth and successes

• The people are very grateful

• Working with and serving patients in recovery is a satisfying and rewarding aspect of this work

• Growth opportunity is embedded in the work I do regularly in BHI

• Group has been seamless and the patients seem to be getting a lot out of it
What would you recommend this program and other programs like it do to prepare staff for IMAT work?

- Supervision (including in-person supervision), shadowing, and seeing other groups
- Peer support - have a chance to spend time with people doing it
- Get hubs up and running before the spokes (to make the flow work better)
- Have all parties involved in the planning
- Establish timelines
- Support the clinician with training opportunities
- Set up a collaborative and ongoing model of consultation
- Offer resources, including fees paid, to pursue an LADC
- Co-facilitation with someone more experienced
Perceived Helpfulness of Programmatic Support for BHI Clinicians doing IMAT

1 - Not Helpful, 10 - Very Helpful
What the BHI Clinicians need to know

- It takes some time to get a cohort of patients to form a group – In the meantime you can begin individual work
- Maintenance treatment has an end-point
- It is helpful for the patients, you and the team to have a general sense of when the group will begin
- It takes an additional hour of time after the group to do the notes – so put that in your schedule
- And.....
What is your next step in moving forward?
Groups

Stabilization: usually done in the Hubs but could be done in some “Intermediate” spokes. Where there is more intensity needed, specific BHI clinician resource may be needed.

Maintenance groups: Done in the spokes/primary care to further the recovery of IMAT patients who have successfully met their goals in the Acute and Stabilization phases of treatment

Functions of the group:
1. Reinforce regular attendance
2. Help patients increase their functioning in identified areas of impairment/challenge,
3. Nurture and support a collaborative trusting relationship with the providers
4. Use the group process to support each group member’s treatment
Maintenance Group skill building content

- Relapse prevention tools and plans
- Improving coping and stress management skills
- Learning anger management and relaxation techniques
- Enhancing self-efficacy and handling risky situation
- Responding safely to slips
- Developing healthy leisure activities
- Structuring time and avoiding boredom
- Healthy habits
- Handling strong emotions
- Understanding family dynamics
- Building healthy relationships
- Enhancing education and occupational skills
- Daily living skills
- Finding meaning in life
- Parenting skills
- Interpersonal effectiveness and communication skills
- Loss and grief
- Ongoing development of future goals
Contacts

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Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!