National Academies of Sciences, Engineering, and Medicine’s Forum on Mental Health and Substance Use Disorders

Medication Assisted Therapy (MAT) and Substance Use Disorder (SUD) Treatment in Primary Care Settings: Focus on Community Health Centers

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Disclosures

I have no disclosures related to this presentation.
CHCI Profile:
- Founding year: 1972
- Locations: 15
- Patients/year: 100,000
Weitzman Institute

The Weitzman Institute works to improve primary care and its delivery to medically underserved and special populations through research, innovation, and the education and training of health professionals.
The Center for Key Populations is the first center of its kind that focuses on key groups who experience health disparities secondary to stigma and discrimination and who belong to communities that have suffered many barriers to healthcare.

The Center brings together healthcare, training, research, and advocacy for: People who use drugs, the LGB and Transgender populations, the homeless and those experiencing housing instability, the recently incarcerated, and sex workers.
Weitzman Institute
National ECHO Learning Network

- 385 practices
- 948 ECHO sessions
- 3,076 case presentations
- Primary care providers from 38 states, PR, and DC
  - 991 Medical Providers
  - 334 Behavioral Health Providers
  - 569 Care Team Members
Weitzman ECHO MAT
Since February 2013

- 126 practice sites
- 72 organizations
- 122 ECHO sessions
- Primary care providers from 21 states and DC
  - 251 Medical Providers
  - 136 Behavioral Health Providers
  - 165 Care Team Members
Weitzman Learning Academy provides evidence-based strategies to support practice transformation and culture change through dynamic coaching & learning opportunities to address needs or goals in specific focus areas.

(Examples of focus areas include; Implementing or expanding a Medication Assisted Treatment program, Integration of Behavioral Health Services, Quality Improvement Training, Practice Transformation Coaching)

Learning Methods:
- Customized coaching and consultation
- Collaborative site visits
- In-person formal training events
- Interactive virtual training sessions
- Dynamic webinars
- Interactive Learning Series (Virtual or In-Person)
Technical Assistance for MAT/SUD

Technical Assistance Contracts
Content: CKP / MAT
(Planning and/or Enhancement/Implementation)

On-Line Registration / Interest
Content: CKP / MAT / Consultation

National Educational Webinars
Content: CKP / MAT Program Implementation

National Educational Webinars
Content: CKP / Addiction 101

Weitzman ECHO Connection
Content: Weitzman ECHO MAT Clinic Contracts
MAT Program Models at Community Health Centers

- **Integrated Primary Care Model (CHCI’s model)**
  - Induction, stabilization and maintenance done onsite.
  - MAT patients booked as any other patient in primary care.

- **Integrated MAT Clinic Model**
  - Induction, stabilization and maintenance done onsite.
  - Prescribers have set times/days only for MAT patients.

- **Co-located MAT Clinic Model**
  - MAT prescribed in clinic separate from primary care.
  - Prescribers in MAT clinic could be primary care providers.

- **Hub and Spoke Model**
  - Induction/stabilization at expert hub; maintenance at health center.
  - If relapse/complications, back to expert hub.

- **Telemedicine Models**
Common Challenges for MAT Programs in Primary Care

- Buy-In
- Financial Cost
- Training and Expertise
- Time and Support
- Information Technology
- Polysubstance Use
- Diversion
Buy-In

- **Administrative**
  - Leadership
    - E.g. CEO, Chief Medical Officer, Chief Behavioral Health Officer, Chief Nursing Officer, Site Directors

- **Clinical**
  - Medical providers, Nursing, Medial Assistants, Behavioral Health providers, Frontline staff
  - Medical or Behavioral health lead

- **Tension (potential) between the two**
Financial Cost

- **Reimbursement structure**
  - Fee for Service
  - Billable Visits
    - Nursing
    - Behavioral health (group, individual)
    - Same day multidisciplinary visits
  - Patient Coverage Breakdown
  - Non clinical staff (e.g. Coordinators, Case managers, CHW)
  - Telemedicine

- **Grants**
  - Limited usually
  - Sustainability issues
Training and Expertise

- Lack of education and training in addiction
- Philosophy and approach to addiction treatment
  - Harm reduction approach
  - Chronic disease model
Time and Support

- Competing priorities
  - Clinical staff stretched

- No extra time provided
  - For patient visits
  - For training of providers and clinical teams

- Ongoing support minimal

- Minimal or no non-clinical staff available for program

- Incomplete or inadequate behavioral health integration
Information Technology

- IT capabilities limited
- No uniform data input and collection
- Population management limited
- Lack of quality measures identified
Polysubstance Use

- Lack of understanding of addiction
- Fear of doing harm
- Fear of getting into trouble
- Discomfort with drug use
- Personal biases
Diversion

- Fear of being duped
- Taking it personally
- Fear of getting into trouble
- Confusion of roles
  - Healthcare vs. Law & Order
Approaches to Challenges

- **Buy-In**
  - Appeal to organizational and personal mission and vision
  - Present statistics
    - National, State, and Local
  - Find and lead with champions (clinical and non-clinical)

- **Financial Cost**
  - Assess patient coverage breakdown
  - Determine whether billing for nursing visits allowed
    - RN vs. LPN
  - Determine whether billing for behavioral health visits allowed
    - Group, individual
    - Qualifications of BH provider
  - Determine what visits can be billed on same day
  - Assess capacity and maximize reimbursement
Approaches to Challenges

- Training and Expertise
  - Support waiver training and costs.
  - Promote ways to continue ongoing training (on-line or in-person).
    - Project ECHO - monthly sessions for 1 ½ hours each
    - eConsultations
    - Mentorships (internal and/or external)
  - Recruit and hire addiction-trained providers and staff.
  - Encourage current providers to manage addiction including MAT.
  - Establish organizational protocol, policies, guidance, resource list.
  - Conduct agency-wide and discipline specific trainings.
Approaches to Challenges

- Time and Support
  - Team-based approach with prescriber at the center
  - Behavioral health/Nursing heavily involved in care
  - Care coordinator (or equivalent)
  - Voucher system for patient contingency management, team empowerment, and cross coverage
  - Home inductions
  - Team meetings to review/revise treatment plans
  - Peer-led BH support meetings
  - ECHO sessions
Interdisciplinary Pods Promote Team-Based Care
Approaches to Challenges

- Information Technology
  - Electronic health records
    - Clinical data input routinized and structured
  - Buprenorphine dashboard
  - Some basic data pulls—visits, buprenorphine prescriptions, ICD10 codes, toxicology screening
Approaches to Challenges

- Polysubstance Use
  - Training around approaches (harm reduction, chronic disease)
    - Include entire clinical team
    - ECHO
  - Behavioral health resistance
    - Increased training and support
- Cocaine, Benzo, and Alcohol
  - Harm in continuing treatment vs. harm in discontinuing
  - Naloxone and overdose prevention
- Higher levels of care
  - Pushing out of care vs. engagement in care
  - Benefit vs. risk
Approaches to Challenges

- **Diversion**
  - Put in place strategies to limit diversion and tampering
    - Medication counts, random/announced.
    - Toxicology screening, random/announced.
      - Urine and/or saliva vs. observed
      - No jacket, bag, children during collection
  - Urine cups with temperature gauges
  - Tox screens include specimen validity
  - Buprenorphine and metabolite levels
  - Designate a pharmacy
In 2007, 4-5 DATA-waivered MDs at CHCI.
In 2019, >50 DATA-waivered MDs/NPs/PAs at CHCI.
Number of CHCI Patients Prescribed Buprenorphine as of 10/1/2019

- Total (since 2007): N=2691
- Since ECHO (2013): N=2284
- Last 6 months: N=1107
Buprenorphine Treatment Retention Rates

Percentage of Patients Retained

- N=1514
- 55% at 6 months
- 46% at 1 year
- 38% at 2 years
- 35% at 3 years
- 33% at 4 years
- 33% at 5 years
- 31% at 6 years
- 33% at 7 years
- 29% at 8 years
- 29% at 9 years

CHCI MAT Program: Preliminary Data Analysis
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Primary Care Screening Rates

<table>
<thead>
<tr>
<th>Screening Test</th>
<th>At First Prescription</th>
<th>At Last Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV Screen/Dx</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td>HIV Screen</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Syphilis Screen</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Depression Screen</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Breast Ca Screen</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Cervical Ca Screen</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Colon Ca Screen</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Larger Structural and Societal Barriers

- Stigma and discrimination and the War on Drugs
- Business of medicine
- Lack of social and political will to effectively address social determinants of health
- Complete absence of addiction training in healthcare
- Requirement of a waiver
  - Differentiation between MD/DO (8hr) and NP/PA (24hr)
- Limits on number of patients on buprenorphine per provider per years of experience
- Strict restrictions around methadone treatment
- Pain Management vs. Opioid Use Disorder
  - Fractured approach to addressing the problem
- Lack of voices of people with lived experience in policy/funding/programs etc.
- Inadequate overdose prevention response—naloxone education and distribution, syringe services programs, safe injection sites
Ideas for Solutions

1. Do away with waivers, limits, restrictions.
2. Make screening, prevention, treatment part of UDS measures for community health centers; tie to funding.
3. Find ways to fully capitalize on allowable reimbursements—nursing, BH, groups.
4. Change reimbursement fee-for-service structure.
5. Allay fears of medical providers, teams, and organizations; not get into trouble if follow standards.
6. Find ways to get to true harm reduction principles.
7. Provide time for training.
8. Educate and expose workforce on addiction early in training.
9. Use team-based care.
10. Be able to hire non clinical staff to support programs.
11. Involve people with lived experience in decision making on all levels.
12. Start campaigns for overdose prevention; make availability easy for SSPs, naloxone.
13. Address social determinants of health (housing, food, employment).
Thank You!

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