NATIONAL ASSOCIATION OF Community Health Centers®

Fostering Effective Mental Health Services in Community Health Centers

Part 2

May 22, 2024

Agenda

Today's objective:

Provide health center models of services implemented to provide substance use disorder and Medications for Opioid Use Disorder (SUD-MOUD) services.

Rachel Solotaroff, MD
Executive Clinical Director of Integrated Behavioral Medicine and Community Wellness

Michelle O'Brien, DO
Associate Behavioral Health Medical Director

Paulina Castillo, LISAC
Behavioral Health Therapist

Understanding Integrating Behavioral Health & Primary Care

May: Mental Health Awareness Month

The Substance Abuse and Mental Health Services Association (SAMHSA) is leading the charge with a focus each week throughout May.
This is a great opportunity to learn more and spread the word!

Include the following #s on your social media posts!

#MHAM24
#ValueCHCs

SAMHSA provides key messages and themes each week. Check out their resources, share the materials, and remember, we all have a role to play in prioritizing mental health!

- **Week 1: May 1-4 (Older Adults)**
- **Week 2: May 5-11 (Children and Teens)**
- **Week 3: May 12-18 (Pregnant and Postpartum People)**
- **Week 4: May 19-25 (Racial and Ethnic Minority Groups)**
- **Week 5: May 26-31 (LGBTQIA+ Communities)**

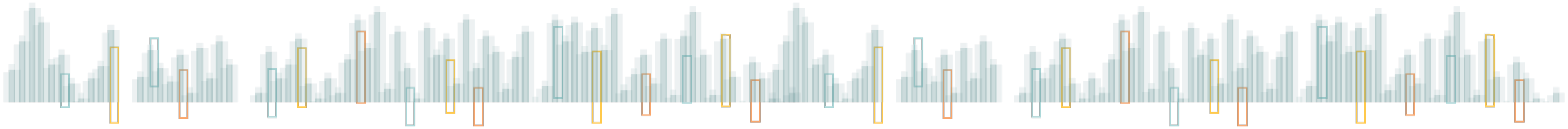
Fostering Effective SUD Services in Community Health Centers – A View from Maine

Rachel Solotaroff, MD, MCR, FACP

Executive Clinical Director, Substance Use Disorder Services

Penobscot Community Health Care

May 22, 2024



Objectives

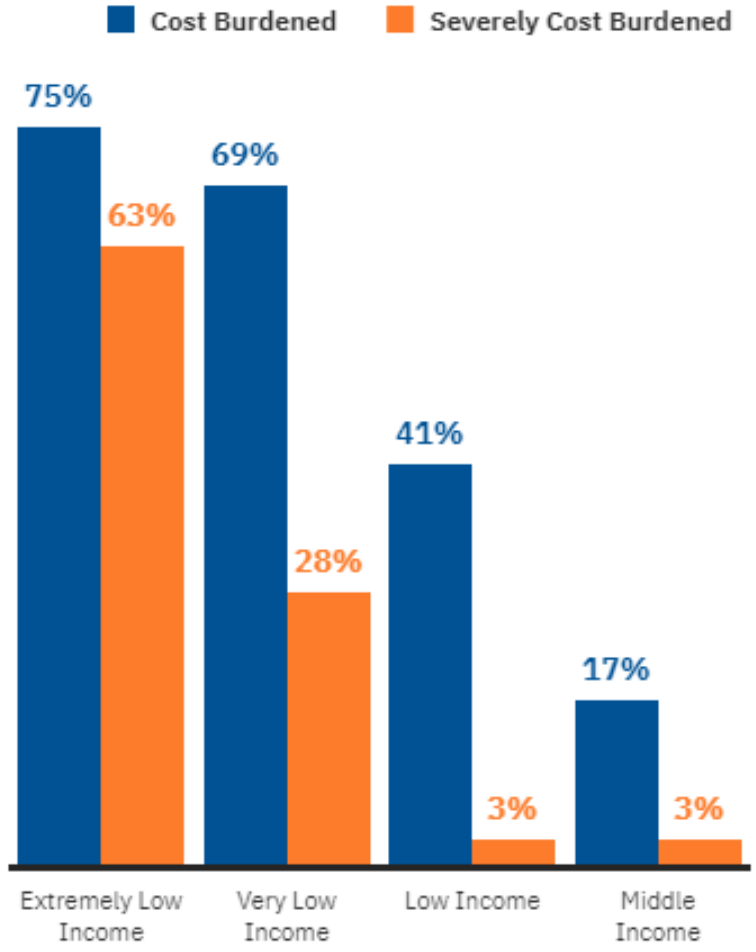
- Setting the context: Rural Maine and Substance Use Disorders
- Establishing an SUD Model of Care within an FQHC – "Focus on the Fundamentals"
- Challenges and Barriers
- Innovations and Optimism

The State of Maine

Maine Quick Facts

- Population 1.4 million
- Most rural state in the nation
- Least populated state east of the Mississippi
- Largest percentage of adults over 65 years old
- Birth rate among lowest in the nation
- Population of non-Hispanic white people is 92%
- Compared to US average:
  - Lower median household income
  - More persons with disability
- 42% of households cannot afford basic costs of living
- 23% of households are extremely low income

HOUSING COST BURDEN BY INCOME GROUP



Note: Renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are severely cost burdened.
Source: 2022 ACS PUMS

Substance Use in Rural Maine

INDICATOR	MAINE POINT 1	MAINE POINT 2	MAINE CHANGE	BENCHMARKS U.S.	BENCHMARKS +/-
SUBSTANCE AND ALCOHOL USE					
Overdose deaths per 100,000 population	2016 28.2	2020 37.3	!	2019 21.5	!
Drug-induced deaths per 100,000 population	2015 21.8	2019 31.3	!	2019 22.8	!
Alcohol-induced deaths per 100,000 popu					
Alcohol-impaired driving deaths per 100,(population					
Drug-affected infant reports per 1,000 bir					
Chronic heavy drinking (adults)					
Binge drinking (adults)					
Past-30-day marijuana use (adults)					
Past-30-day misuse of prescription drugs					
Past-30-day alcohol use (high school stud					
Past-30-day alcohol use (middle school st					
Binge drinking (high school students)					
Binge drinking (middle school students)					
Past-30-day marijuana use (high school students)	2015 19.6%	2019 22.1%	!	–	N/A
Past-30-day marijuana use (middle school students)	2015 3.8%	2019 4.1%	○	–	N/A
Past-30-day misuse of prescription drugs (high school students)	2015 4.8%	2019 5.0%	○	–	N/A
Past-30-day misuse of prescription drugs (middle school students)	2015 2.2%	2019 3.0%	!	–	N/A
Narcotic doses dispensed per capita by retail pharmacies	2018 13.1	2020 12.1	★	–	N/A
Overdose emergency medical service responses per 10,000 population	2018 65.9	2020 76.7	○	–	N/A
Opiate poisoning emergency department rate per 10,000 population	2016 9.6	2018 8.6	★	–	N/A
Opiate poisoning hospitalizations per 10,000 population	2016 1.4	2018 1.2	○	–	N/A

Maine drug overdose deaths

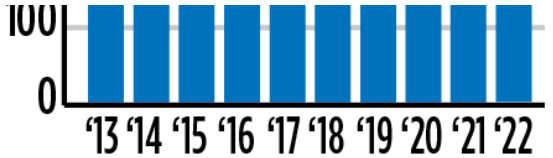
Health Local & State

Maine records one of nation's biggest declines in overdose deaths

Maine, which reported a 16% drop, is one of four states that saw at least a 15% decline in fatal drug overdoses in 2023.

Posted May 15 Updated May 15

Joe Lawlor
Press Herald



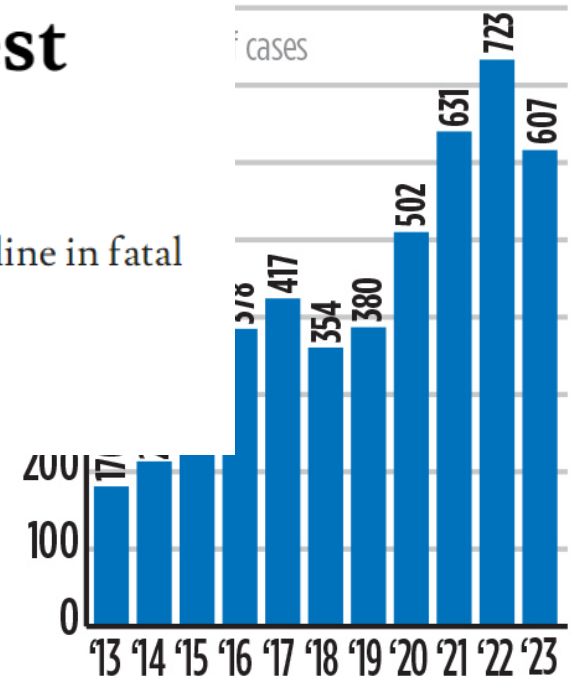
*preliminary estimate

SOURCE: University of Maine and Office of the Chief Medical Examiner

STAFF GRAPHIC | JAKE LAWS

Maine drug overdose deaths

Overdose deaths declined since 2018.



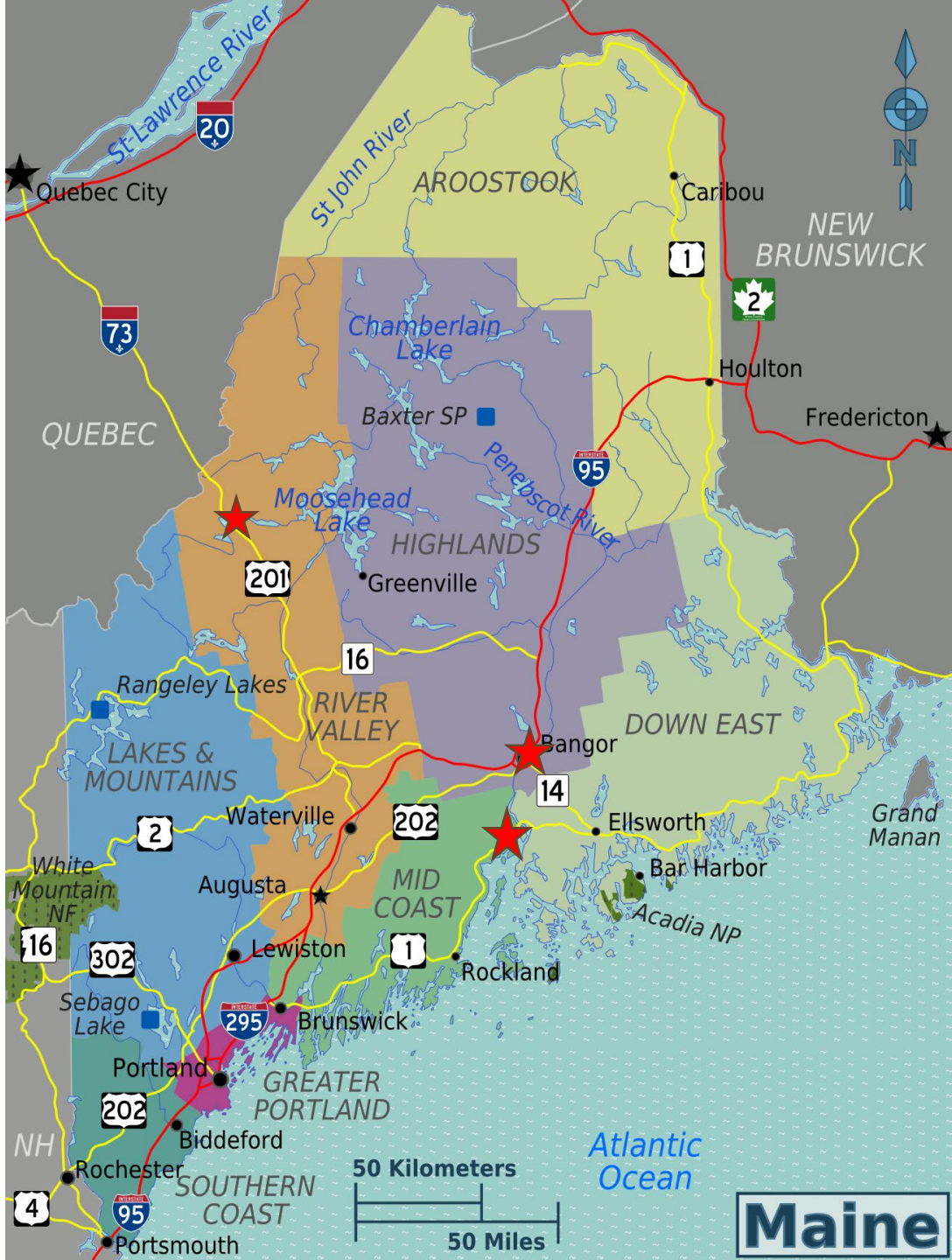
SOURCE: University of Maine and Office of the Chief Medical Examiner

STAFF GRAPHIC | DAVID TRIPP

Penobscot Community Health Care

PCHC Quick Facts

- Largest FQHC in Maine; 58,000 patients
- Provides integrated health services in 3 counties, 22+ clinical service sites
- Integrated Clinical services include medical care, mental health, SUD, Dental, Walk-in Care, Pharmacy
- Numerous specialty services, incl street outreach
- Operate one of 3 low-barrier homeless shelters in Maine
- Own and manage 48 units of transitional housing
- Patients reside in over 174 zip codes
- Nearly 2000 houseless patients
- 60% of patients are at < 200%FPL



Legacy of SUD Care: Multiple Approaches at Multiple Sites

Low-Barrier Bridge

- No group requirements
- Weekly visits
- Low barrier to entry
- Less intensive monitoring
- Co-occurring mental health and medical care
- Attention to Social Determinants of Health
- Support for the whole practice to care for this population

Healthcare for Homeless Site

- Emphasis on safety
- Daily Dosing
- Collateral info from Housing/Shelter
- Integrated medical care
- Group 3x/week

Primary Care Sites

- Must meet with counselor prior to seeing provider
- Groups/individual counseling required
- "If/Then" approach
- Detailed processes of care
- Monitoring
- Standards
- Team Collaboration
- Energy
- Co-occurring MH care

High Variability

- Maximum dose of buprenorphine
- Use of extended release buprenorphine
- Management of other SUDs
- Visit intervals
- UDS monitoring
- Engagement of site leadership
- Eagerness of change among providers

What Do We Have? What Do We Need?

Assets

Strong provider bench

Recovery Coordinators

Program Manager

Exec commitment

SUD presence at all large sites

Strong relationship with Other BH Leadership

Needs/Liabilities

SUD-specific operational infrastructure and leadership

Sufficient Counseling Resources
- *Master's Level Clinicians*
- *LADC's*

Training/Meeting time

Inadequate census at Bridge Clinic

No meaningful outcomes

Potential for culture clash within clinics and SUD programs

Sense that "COVID ruined everything"

Exec Commitment

So where do we start?

"Focus on the Fundamentals"

1. Define our Core Values
2. Model of Care/Org Design Vision
3. Establish sustainable business model
4. Define and train on standard clinical practices, esp for OUD and AUD
5. Streamline Access to SUD Care, make it seamless
6. Create meaningful measures
7. Strengthen BH Component of SUD Care
8. Expand care to include other SUDs
9. Partner to create integrated SUD continuum of care in each community
10. Recruit funding for operational support

Values
Model of Care
Org Design
Sustainable Business Model

Values Clarification Exercise

Trauma-Informed Care

People use drugs when their experience has become intolerable, replacing one coping skill with another
- Nurse Practitioner

Harm reduction = don't ask someone to take off their life jacket before they get in the boat
- Licensed Alcohol and Drug Counselor

It's not the drug, it's the ACES
- SUD Therapist (LCSW)

Stigma and Biases

We all have them. Sometimes it's counter-transference
- PMHNP

Our language has an impact on the options people are offered
- Recovery Coordinator

This is why we have the team
- Medical Assistant

Abstinence vs Harm Reduction

Who decides the goal for you?
- PCP

"Virtual signaling of abstinence"; their quality of recovery is better than others
- Community Outreach Worker

Harm reduction does not have to be a step to something else
- RN Care Manager

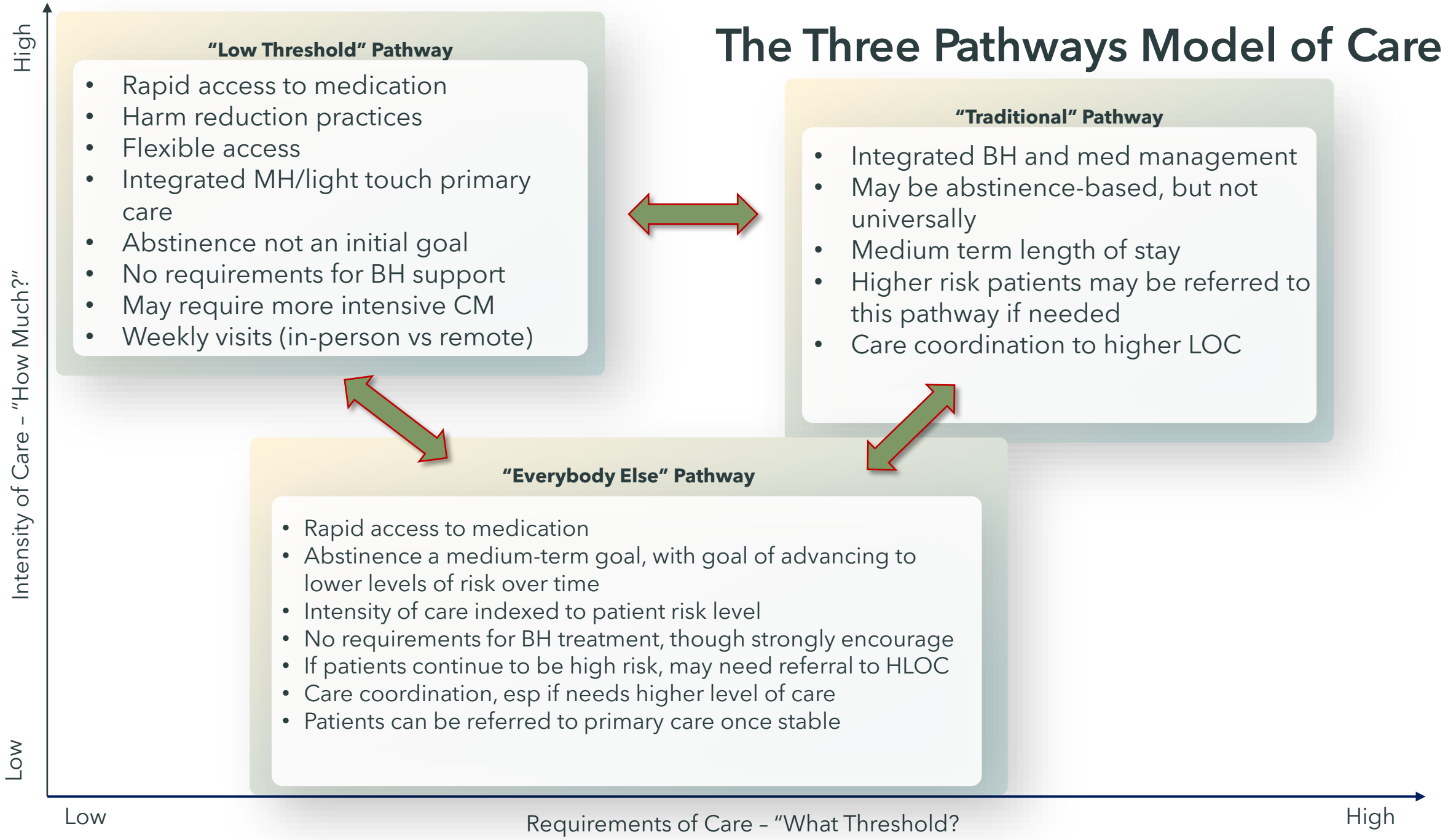
What did we see in our Values?

- *Person-driven*
- *Respectful*
- *Holistic*
- *Collaborative*
- *Integrated with community*

What did we NOT see in our Values?

- *Recovery = Abstinence*
- *Innate hostility to abstinence in harm reduction*
- *Action instead of principles*

The Three Pathways Model of Care



SUD Care Team :
"Hybrid" Model of Specialty + Primary Care Embedded in all Major Sites

SUDS Specialty Provider/MA

High risk/complex patients
New SUDS patient
Co-managed SUD/MH mgmt.
Clinical consults
SUDS Triage

SUDS Generalist Provider/MA

Stable patients
High risk/complex patients (w/consult)
SUDS Triage

Recovery Coordinator

RN Care Manager
PMHNP

SUD Therapist

Clinical Pharmacist
PCP

Scheduling/Access for Specialty SUD Care:

- Separate schedule
- Separate access methodology
- Intensive care coordination for SUD patients
- *Service line financial analysis for specialty*

Scheduling/Access for Generalist SUD Care:

- No separate schedule
- Utilize primary care access guidelines
- No separate financial analysis

Standards of care
Streamline access
Meaningful measures
Strengthen SUD BH

Safety

Choice

Collaboration

Trustworthiness

Empowerment

Definitions

Ensuring physical and emotional safety

Individual has choice and control

Making decisions with the individual and sharing power

Task clarity, consistency, and Interpersonal Boundaries

Prioritizing empowerment and skill building

Principles in Practice

Common areas are welcoming and privacy is respected

Individuals are provided a clear and appropriate message about their rights and responsibilities

Individuals are provided a significant role in planning and evaluating services

Respectful and professional boundaries are maintained

Providing an atmosphere that allows individuals to feel validated and affirmed with each and every contact at the agency

PCHC SUD Medication Management Guidance

MAGENTA 1- BUPE Non-Responding
1 Provider visit/WK
UDS every 1-2 weeks
PMP every 12 weeks
HOT-LIST ROUNDING/Care Coordination
Prep for warm handoff to HLOC/OTP/withdrawal mgmt

Injectable?

MAG 2- BUPE Responding + Impairment/high risk use from other substance
1 Provider visit/WK
UDS every 1-2 weeks
PMP every 12 weeks
HOT-LIST ROUNDING/Care Coordination
Prep for warm handoff to internal or external higher level of care or withdrawal mgmt, as appropriate.

ORANGE: NEW Patient/Rejoin
1 Provider Visit/WK during the first 2-4 weeks
UDS each visit
PMP at first visit

ORANGE: Stabilization
Episodic
Stimulant/Benzo/EtOH Use
1 Provider Visit/2 weeks
UDS every 2-4 weeks
PMP every 12 weeks

Yellow: Maintenance
OHH
MOUD Taper
Co-occurring MH mgmt
1 Provider Visit/4 weeks
UDS every 4-8 weeks
PMP every 12 weeks

Green: Maintenance Patient
Buprenorphine Only
1 Provider Visit/8 weeks
UDS every 8-12 weeks
PMP every 12 weeks

Managing the Cycle of Relapse and Recovery requires:
-Uniform Clinical Interpretation and Response
-Consistent communication with the patient
-Recovery Coordinator Panel Management
-High-Risk Care Coordination Assignment

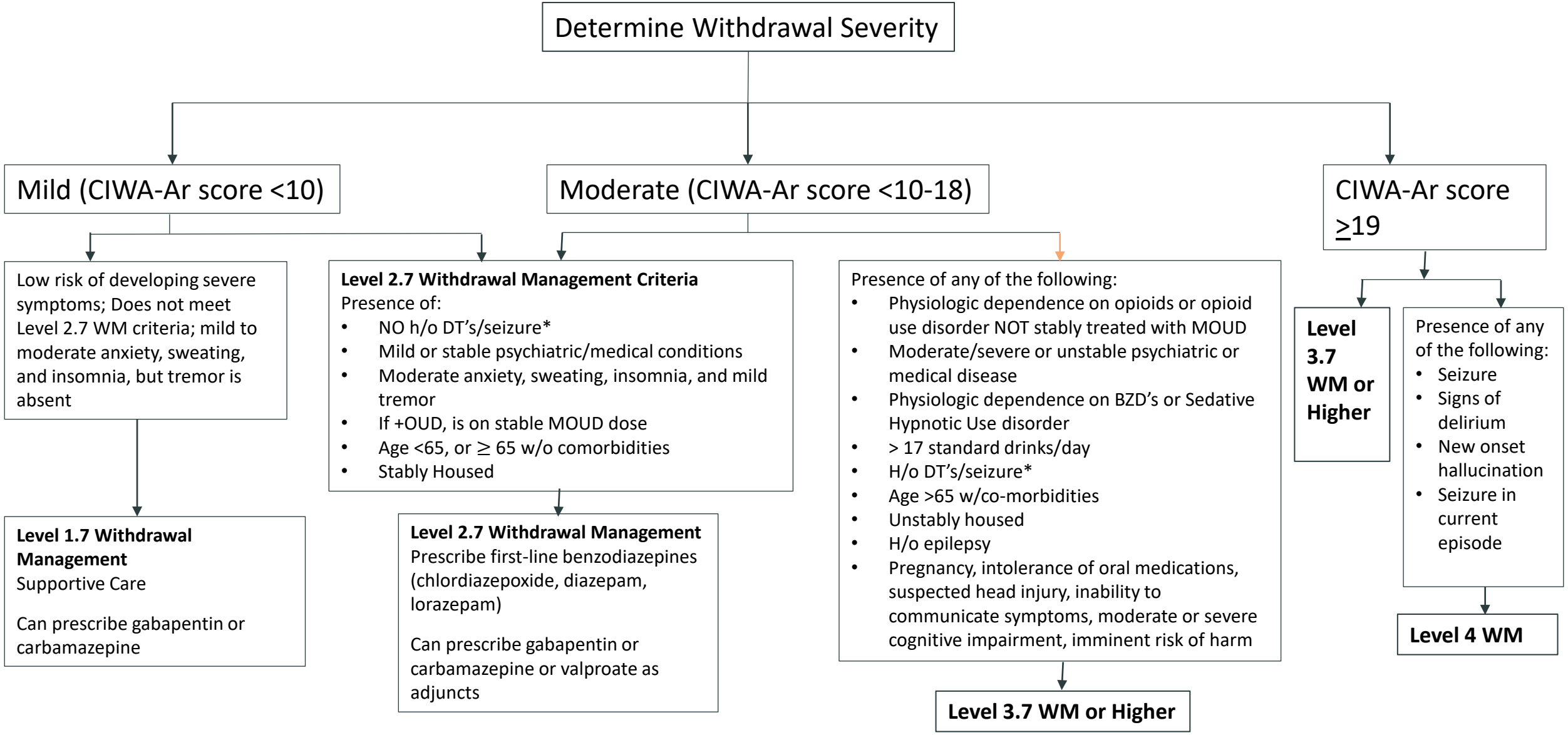
12-week intensive review

60 Day Minimum

6 Month Minimum

12 Months +

Clinical Standards for Alcohol Withdrawal Management



*This criterion will be re-visited in future guidance, as providers become more experienced with ambulatory WM

Minimum Standards of Comprehensive Care

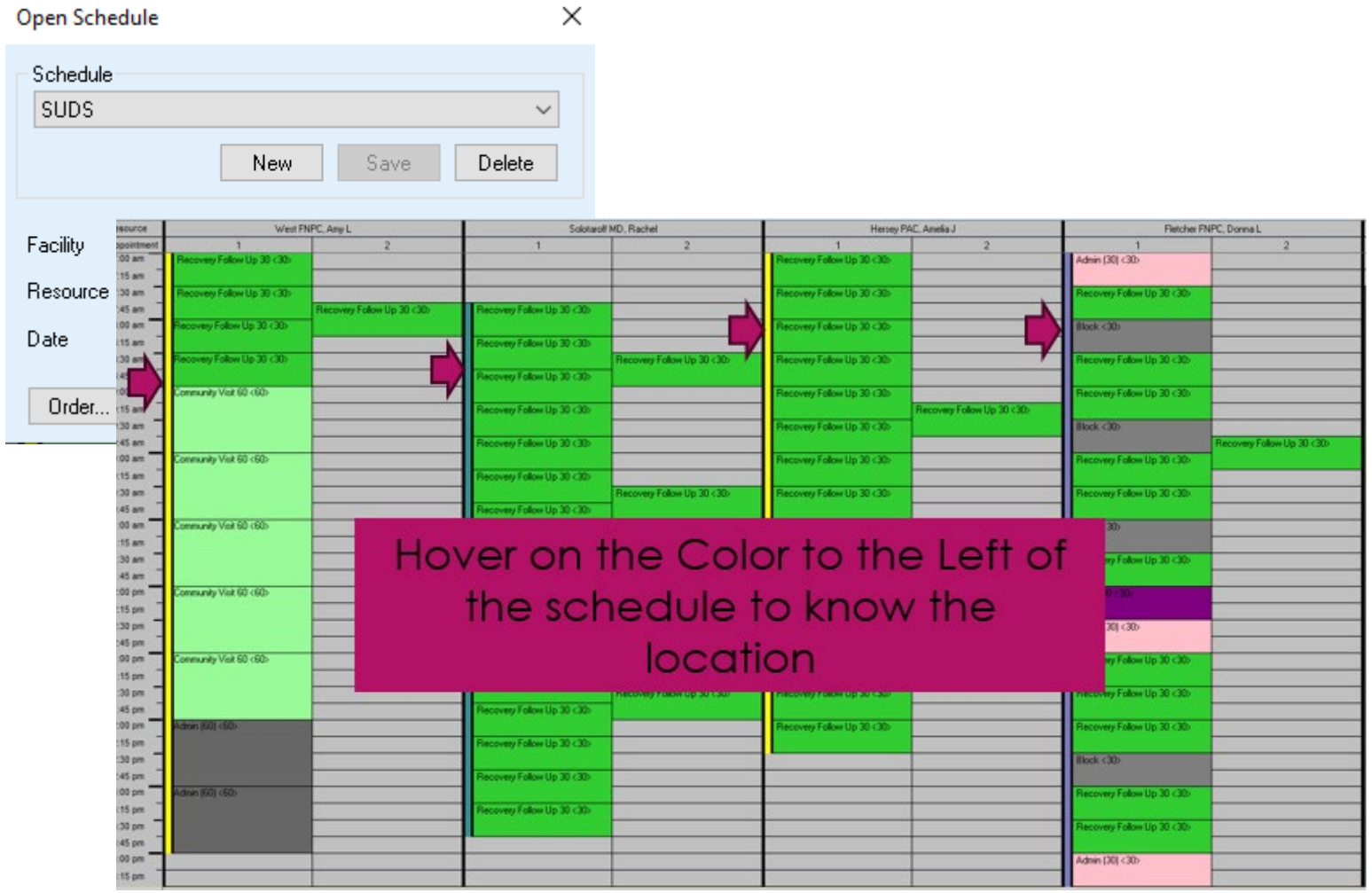
SUD care IS Comprehensive Care

- A full and practical medical, SUD, MH history
- Who is on your team?
  - PCP, MH, Dental Providers
  - Case Manager, Counselor, Probation Officer if appropriate
- Vaccines
- Contraception/sexual health
- Hep C testing and treatment
- Screenings (CRC, Breast CA, Cervical CA)
- Initial screening labs, initiate treatment
- Basic and advanced psychiatric medication management

Example: A practical social history

Housing status	**Housed, couch surfing, homeless**
Transportation Status	In need of bus tickets? Medical Transportation assistance?
Food Status	Food insecure, Electronic Benefits Transfer status (food stamps)
Domestic Violence	Current or at risk
Family status	Other SUD in the home? Children in the home? DHHS involvement? Marital status?
Legal involvement	Probation, drug court, family court, suspended license, bail
Cell Phone	Have one? Doesn't have one? Have one but no minutes? Difficult to keep one and keep one on.

SUDS Access Project: Seamless Same-Day Access to Comprehensive SUD Care Across PCHC



- Walk-in or call SUDS Line
- Org-wide access to SUD HUB
- Any willing provider can join SUD HUB
- Virtual or in-person connection

SUDS Engagement Metric: Opioid Use Disorder

Quality/Performance Indicator	Definition
Initiation/Engagement	
Initiation	Percentage of patients who initiated treatment with medication within 0 days of the diagnosis/request for treatment
Engagement	Percentage of patients who engaged in ongoing treatment including two additional interventions for the treatment of OUD within 34 days of the initiation visit. At least one of the engagement events must be a medication treatment visit
Retention	
3 months	6+ SUD visits within 3 months of the initiation visit. At least one visit per month must be a medication treatment visit
6 months	12+ SUD visits within 6 months of the initiation visit. At least one visit per month must be a medication treatment visit
One Year	24+ SUD visit within 12 months of the initiation visit. At least one visit per month must be a medication treatment visit

Behavioral Health Improvements

Promoted seasoned therapist to “Clinical Supervisor for SUD Behavioral Health”

Streamlined referrals to SUD and SUD/MH therapy

“Road Show Reframe” to all sites about Group offerings and Referrals:

- Consider group as any other prescribed intervention
- Collaboratively decide on the clinical intervention/ group
- **Together** how will you measure if group is helpful?
- Include expectations of goals and participation in the note (increase time between returns to use, attend weekly for 90 days)
- Regular follow-up with patients

Train all therapists and LADC’s in new ASAM Level of Care criteria and assessment

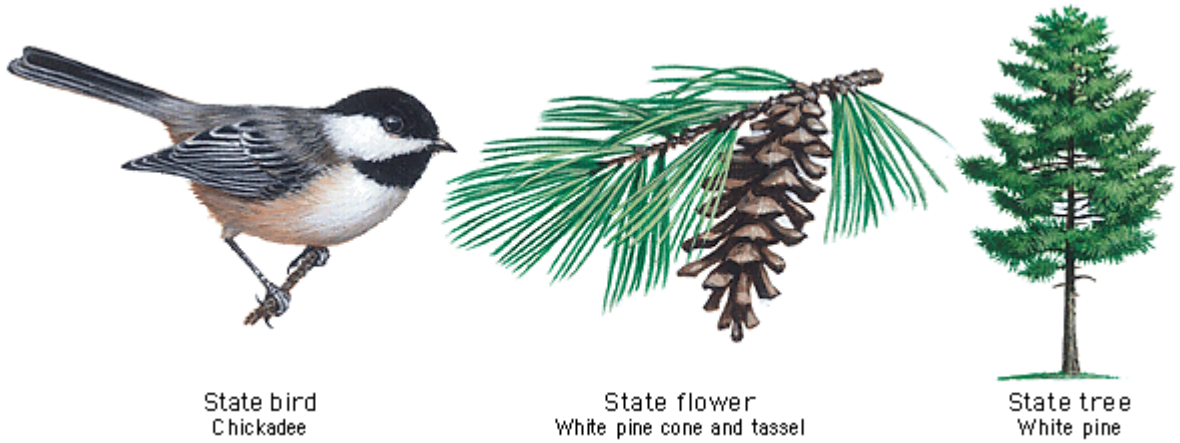
Work with HR and Grants team to institute hiring and retention incentives for therapists

Coming Soon...

Expand Care to Other SUDs
Continuum of SUD Care
Operational Leadership

Key takeaways, ie Things I Wish I Knew Two Years Ago…

- Start from where you are: what are the assets/needs in your community and your organization?
- “Focus on the Fundamentals”: values, model/design, core clinical guidance, easy access
- GO SLOW: Keep showing up and the support will come
- Having a clear vision and path forward helps to mitigate the sense of moral injury in going slow



Thank you!

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Presentation for the National Association of Community Health Centers (NACHC)

Fostering Effective Mental Health Services at El Rio Health SUD/MOUD Services

Presenters:
Michelle O'Brien, DO, Associate Behavioral Health Medical Director
Paulina Castillo, LISAC, Behavioral Health Therapist

EL RIO HEALTH

History of El Rio Health

Michelle O'Brien, DO, Associate Behavioral Health Medical Director

Background, Late 1960's

- Local advocates served as champions for basic services in the underserved south and westside Tucson neighborhoods, where many residents were minorities living at or below federal poverty level
- The most pressing need was accessible and affordable healthcare
- Advocates partnered with The University of Arizona to apply for a federal neighborhood health center grant

1970

- The grant was awarded and a building was donated by Pima County
- El Rio's first health center opened with primary care and dental care
- The University of Arizona College of Medicine, established a residency program at the clinic for medical students

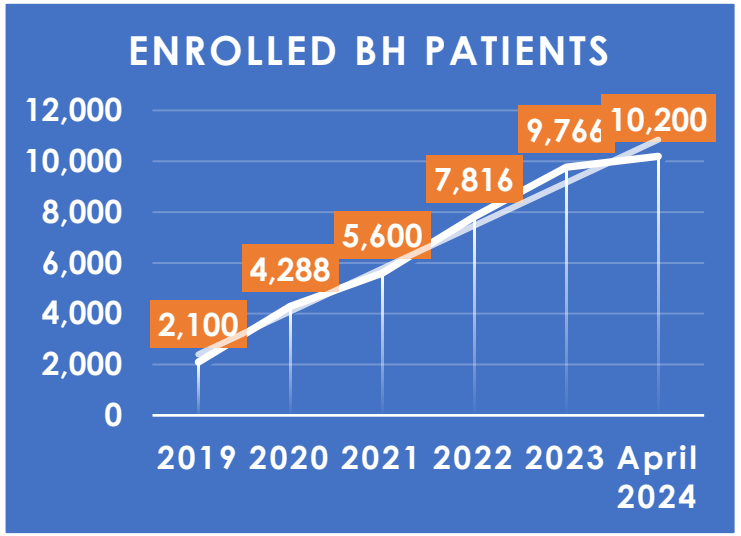
2024

- 14 El Rio health centers
- 1900 staff
- 12%, or 128,000 of Pima County's 1.1M residents are El Rio patients
- 14th largest FQHC in the nation

EL RIO HEALTH

Mental Health Referrals and Patients

- **Exponential Growth Since March 2020/Pandemic**
- **Current Behavioral Health Enrollment**
  - 10,200 behavioral health patients
    - 79% increase from 2020
    - Projected enrollment for 2024 year-end is 11,360
  - Averaging 100+ new weekly referrals
  - 90% internal Primary Care referrals, 10% external referrals
- **Seven Specialty Behavioral Health Locations**
- **140 Staff**



EL RIO HEALTH

The Joint Commission & NCQA

Joint Commission Behavioral Health Care and Human Services Accreditation Program

El Rio has been Joint Commission accredited since 2010. El Rio received the Joint Commission Behavioral Health and Human Services accreditation in November 2022.

NCQA Distinction in Behavioral Health Integration

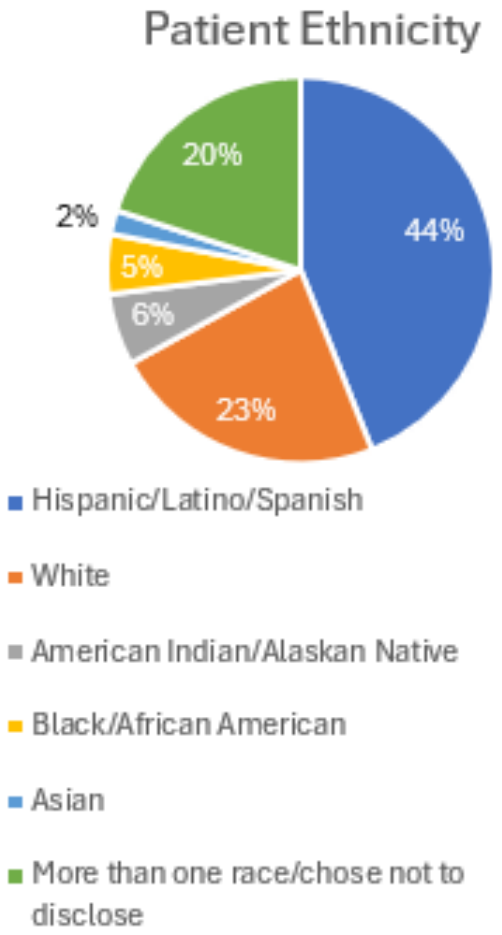
El Rio has had NCQA Primary Care Behavioral Health distinction since 2009. El Rio received NCQA Behavioral Health distinction in March 2023.

EL RIO HEALTH

Patient Demographics

Patient Demographics

- 57% of El Rio patients live at or below federal poverty level
- 50% Medicaid enrolled, 26% commercial, 13% Medicare enrolled, and 10% uninsured
- 28% children, 58% adults, 14% age 65+
- 55% female, 38% male, 1% transgender, 6% chose not to disclose/other
- 44% Hispanic/Latino/Spanish origin, 23% White, 6% American Indian/Alaska Native, 5% Black/African American, 2% Asian, 20% more than one race/chose not to disclose
- 24% are best served in a language other than English



EL RIO HEALTH

El Rio's SUD Program

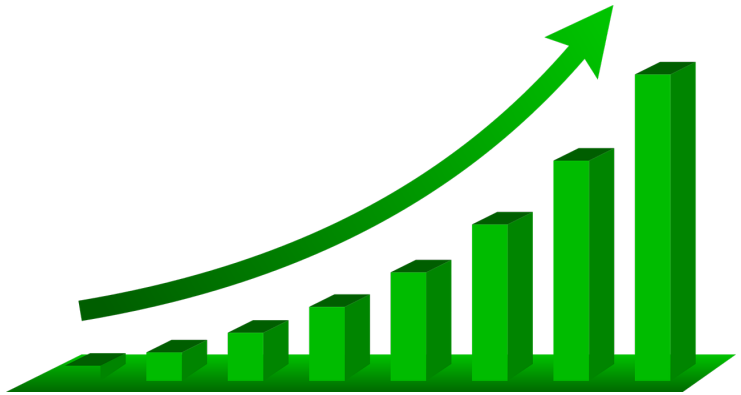
- Began in 2018
- Interdisciplinary Team Across Behavioral Health, Family Medicine, And Pediatrics
- Approx 300 SUD Enrolled Patients
  - Many More Receiving SUD Treatment Through Primary Care/BH
- 11 SUD Providers (4 BH, 6 Family Medicine, 1 Pediatric)
- Designated SUD RN
- SUD Therapists (LISAC, LCSW)
- 2 Case Managers (CM)
- SUD Intensive Outpatient Program (IOP)
- Behavioral Health Consultants (BHCs) Who Assist With Screens In Primary Care Setting

- 24/7 MAT Line Staffed By CM/RN/Providers
- Initial Contact Through Clinics (BH Or PCP) Or External Consults
- Patient Screened And Intake Completed By CM
- Assess Using ASAM Dimensions To Recommend Level Of Care
- Coordination Of Care: Detox, Outpatient Appointment
- Intake Assessment With Provider For Medication Management, Ongoing Treatment Planning
- Wrap Around Services With Therapy, IOP, Groups

EL RIO HEALTH

SUD Program Challenges/Successes

- **Growth**
- **Staffing**
- **Coordination Across Disciplines (Family Medicine, Pediatrics, BH)**
- **Education Of Staff In:**
  - Screening
  - Intervention
  - Referral
  - Treatment
- **Harm Reduction Model**



EL RIO HEALTH

Intensive Outpatient Treatment Program (IOP)

Paulina Castillo, LISAC, Behavioral Health Therapist

- **IOP Established in October 2020**
- **Based on Hazelden Model**
- **Primarily Medicaid Patients**
- **9 Hours Per Week**
  - Tuesday/Wednesday/Thursday, 9am – 12pm
- **12 Active Enrolled Patients**
- **Most Referrals From Case Managers**
- **Average Length of Enrollment: 6 – 12 Months**
- **After IOP Completion, Patients Referred to Seeking Safety Program or Dialectical Behavior (DBT) Therapy**

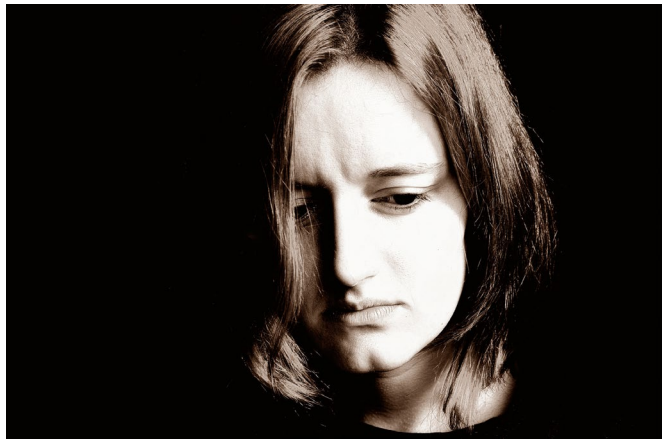
EL RIO HEALTH

Seeking Safety Program

- Focus Is On PTSD And Substance Abuse
- Goal Is To Increase Skills To Cope As Patients Integrate Into Life
- Program Consists Of 24 Weeks, Addressing A Topic Each Week
- Group Is 90 Minutes On Wednesdays, 3:30pm-5:00pm
- Most Referrals Are From Case Managers And Providers
- Participants Are Also Patients Who Completed IOP Groups And Stepped Down To Seeking Safety

EL RIO HEALTH

Case Scenario



- **47 Year-old Female**
- **Diagnoses:**
  - Opioid Use Disorder (OUD)
  - Stimulant Use Disorder (StUD)
  - Alcohol Use Disorder (AUD)
  - Attention Deficit Disorder (ADHD)
  - Major Depressive Disorder (MDD)
  - Intermittent Explosive Disorder (IED)
- **Receiving PCP Services At El Rio Since 2018 And BH Services At Outside Agency**
- **Presented To Covering PCP Provider in June 2022 And Endorsed Relapse On Meth And Fentanyl 6 Months Prior**
  - SUD Referral Placed
  - Started PO Naltrexone →Vivitrol
  - Individual Therapy/IOP Referral
- **Acute Stressors: DCS Removed Children From Home Due To Drug Use, Ongoing Divorce**

EL RIO HEALTH

Case Scenario

- **June 2022: Moved Behavioral Health Services To El Rio**
  - Engaging In IOP
  - Treating Mood Disorder, ADHD And SUD
  - Coordinating With DCS
- **Sober For About 6 Months, Then Relapsed On Meth And Alcohol**
- **Transitioned To Residential Care, Ongoing DCS Case**
- **Transitioned To PHP, Then IOP, Then BH Weekly Group**
- **Ongoing Individual Therapy And Engagement In NA Meetings**
- **SUD And BH Appointments With Adjustment Of Medications To Better Address Symptoms**

EL RIO HEALTH

Case Scenario

- **9/2023: DCS Case Was Resolved And The Children Moved Back Home**
- **Has Support System With Sober Partner**
- **Works Full-time At Local Grocery Store**
- **January 2024: Completed Individual Therapy**
- **Attends Daily Narcotics Anonymous (NA) Meetings**
  - Became Co-chair Of Local Meeting
  - Completes A Weekly Check-in With Sponsor
- **Ongoing Sobriety And Engagement In Treatment**

EL RIO HEALTH

US Incarceration Data: BH and SUD Risk

- **US Prison Statistics 2022:**
  - 1.2 million people incarcerated
  - 2% increase from 2021
  - 6th highest incarceration rate globally
  - Rate of 531 per 100,000 (in AZ 868/100,000)
- **Increased Rates Of Mental Health Issues (SMI), Lifetime Suicide Attempts, SUD, HIV**
- **Post Release Opioid Related Overdose Death Is Leading Cause Of Death**
- **40 Fold Increase Risk Of Death From Opioid Related Death Within First 2 Weeks Of Release**

EL RIO HEALTH

Prerelease/Discharge:

Prerelease Contact/Care Significantly Improves Post Release Engagement In Care

- Reduction in relapse on substances
- Reduction in recidivism
- Improved stability in medical and behavioral health symptoms/treatment
- Reduced use of emergency medical and BH community resources

Coordination of Care/Reentry

- Services prerelease and bridging care to outpatient (some states applying for a waiver to have Medicaid coverage 30-90 prerelease)
- "Warm handoff" coordination of discharge including housing, appointments, connect to medical/BH services
- Pick up patients on release date
- SUD harm reduction: SUD treatment during incarceration, Narcan, Vivitrol prerelease

EL RIO HEALTH

El Rio Collaboration

- **Current HIV Service Line With Local Jail And State Prison System:**
  - Treatment during incarceration
  - Ongoing outpatient care and engagement
- **BH Coordinating With State Prison System With Remote CM Coordination And Treatment Team Pre Release**
- **Goal Of Improved Integrated Pre-Release Coordination For BH And SUD Patients**

EL RIO HEALTH

NATIONAL ASSOCIATION OF Community Health Centers®

Thank You to All Community Health Centers

#ThankYouCHCs

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Thank You for Joining Us!

Let's stay connected!

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ADDITIONAL RESOURCES

EVALUATION FORM

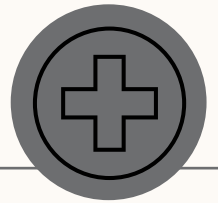
Please complete this evaluation after today's session, Click Here!

To access part 1 of the series please visit NACHC.org

INCREASING HEALTH EQUITY IN PAIN MANAGEMENT, SUBSTANCE USE DISORDER TREATMENT AND LINKAGES TO CARE

A Resource Guide for Health Centers

Rural Health Information Hub – Mental Health in Rural Communities



PATIENT-CENTERED MENTAL HEALTH IN PEDIATRIC PRIMARY CARE PROGRAM

Hosted by The REACH Institute, empowers primary care providers with the skills and confidence needed to deliver effective, evidence-based mental health care.

Scholarship deadline June 3

Questions for our Panelists