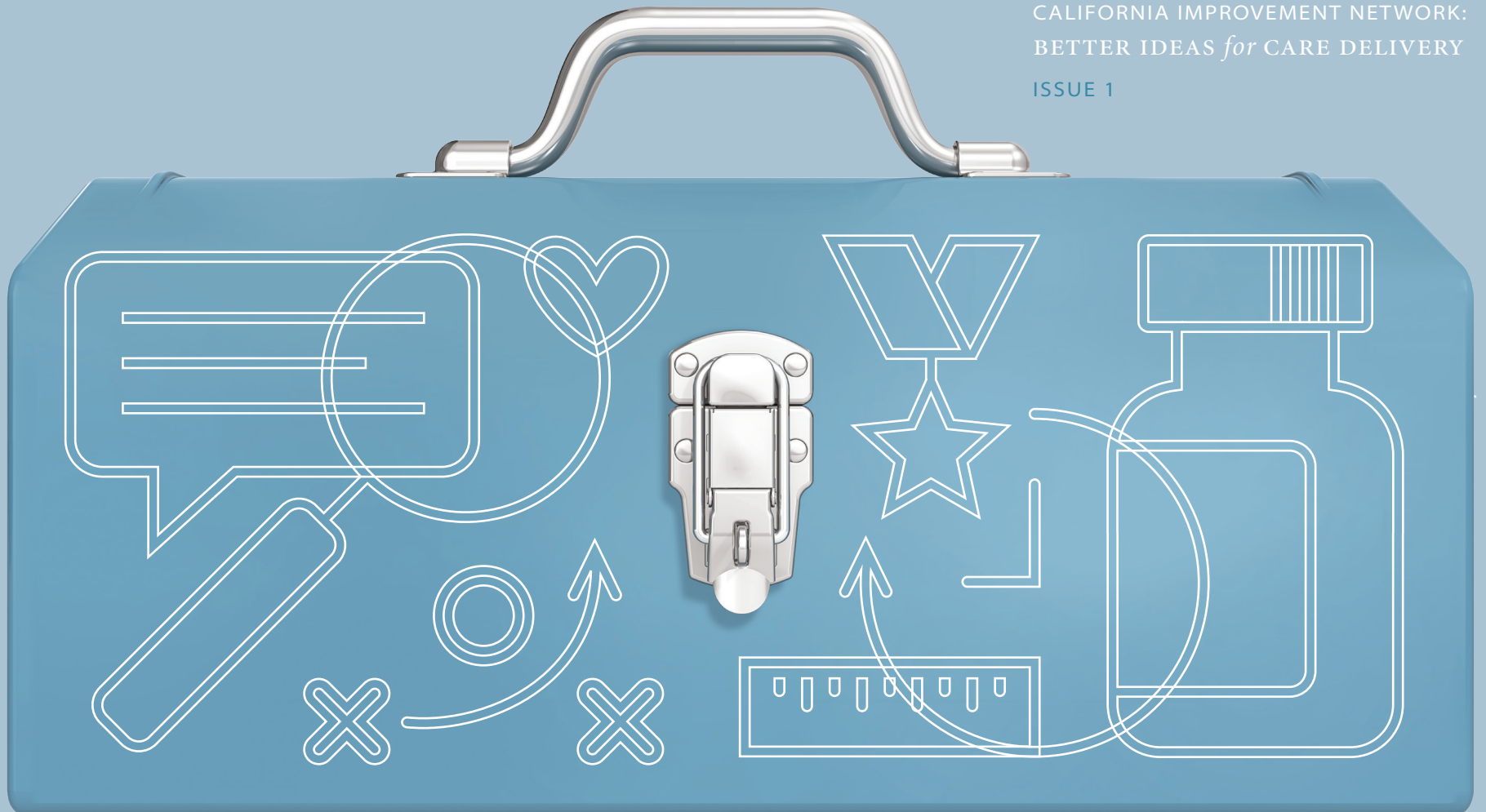


CIN TOOLKIT

Three Strategies to Help Primary Care Teams Treat Substance Use Disorders

CALIFORNIA IMPROVEMENT NETWORK:
BETTER IDEAS *for* CARE DELIVERY

ISSUE 1



This document is a guide for primary care organizations and care teams working to integrate substance use disorder (SUD) treatment services. This toolkit provides proven strategies, best practices, and tools used by organizations within California to expand the capability of primary care teams in commercial and safety-net sectors to confidently and willingly provide SUD services.

The ideas suggested in this toolkit were gleaned from a variety of sources: Evidence-based practices and resources cited in literature, feedback from experts in the field, and interviews with experienced California health care organizations across safety-net and commercial settings (see page 4 for a full list of informant organizations). This toolkit is applicable for all organizations along the journey of integration, from those just starting out to those scaling up to full integration.



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California Improvement Network

CIN is a community of health care professionals committed to identifying and spreading better ideas for care delivery to improve the patient and provider experience and the health of populations while lowering the cost of care. As the only network in California that brings together commercial and safety-net provider organizations, health plans, and quality improvement groups, CIN fosters valuable cross-sector relationships across the state. The California Improvement Network is a California Health Care Foundation project managed by Healthforce Center at UCSF.



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California Quality Collaborative

CQC is a health care improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California. CQC creates scalable, measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans.



We would appreciate hearing from you about your experience using this guide in an effort to improve its use across organizations. Please contact the California Improvement Network with suggestions, comments, or questions: CIN@ucsf.edu

Acknowledgements

ADVISORY GROUP

CIN Behavioral Health Integration Action Group

CIN's behavioral health integration action group convened in May 2018 to identify a common area of improvement across care delivery organizations with diverse geographies and patient populations. After examining challenges across participating organizations, the action group prioritized SUD treatment and primary care integration as a key issue for health care leaders in California. In particular, the group seeks to better understand why primary care teams feel ill-prepared to treat SUD patients and how organizations and leaders can advance integration efforts by expanding the capability of primary care teams to confidently and willingly provide high-quality, evidence-based SUD treatment services.

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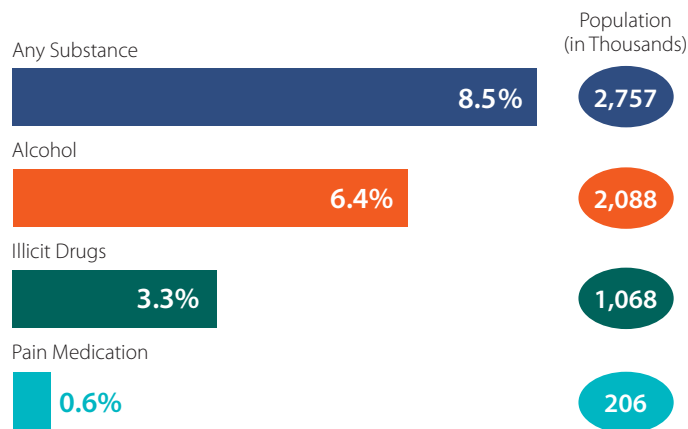
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Introduction

Prevalence of Substance Use Disorder, by Drug Type

California, Annual Average, 2015 to 2016

Percentage of population age 12 and over with this type of substance disorder



Notes: *Illicit drugs* includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, and nonmedical use of prescription drugs. *Pain medication* is referred to as pain reliever in the survey and is defined as use in any way not directed by a doctor.

(Source: California Health Care Foundation's Health Care Almanac, [Substance Use in California: A Look at Addiction and Treatment](#))

The vast majority of Californians with substance use disorders (SUDs) do not receive treatment,ⁱ and there are not enough treatment providers to meet

their needs.ⁱⁱ To expand access to treatment, SUD services must be integrated into primary care organizations and practices, where patients are accessing health care and have developed supportive relationships with care providers. California Improvement Network organizations and key informants report that one of the most challenging barriers to integration is that front-line care team members, both ancillary staff and clinicians, do not feel comfortable with or capable of providing high-quality SUD treatment services in the primary care setting.

The commercial sector in California faces barriers to integrating SUD treatment in primary care. California commercial health plan members are less likely to receive SUD treatment consistent with national standards.ⁱⁱⁱ Due to the managed behavioral health care carve-out in California, it is more financially challenging for commercial primary care providers to integrate SUD services than it is for them to refer to specialists. Subsequently, the commercial sector has been slower than

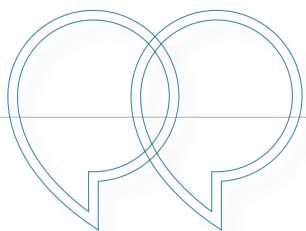
the safety net, which has been supported by government grant funding, to integrate services into primary care and instead focus on expanding access through referrals to addiction specialists in contracted provider networks.

Focus on Care Team Capability

Primary care teams are the foundation of an organization's ability to provide high-quality SUD treatment services because:

- They have established relationships and trust with patients;
- They are familiar with patients' histories and health; and
- They are easier to access than specialists.

Many care teams lack confidence providing SUD treatment services because doing this requires technical solutions such as training and technology, as well as staff behavior change. Care team members face personal and organizational barriers (listed on page 6) to welcoming and caring for patients with addictions, especially those who may be under the influence of a substance when obtaining care. Ill-equipped care teams not only will resist efforts to integrate SUD services but also may further stigmatize patients and inadvertently put patients and staff at greater risk.



What would it be like to create a space where patients do not feel shame saying, “I want to be seen for my addiction”?

Dr. Ako Jacintho, Director of Addiction Medicine, HealthRIGHT 360

Barriers Impacting Care Team Capability to Provide SUD Treatment Services

Ancillary Staff (receptionists, medical assistants, nurses, community health workers)

- Misperception about impact within a clinician's patient population
- Misunderstanding of addiction and risk factors
- Stigma of addiction
- Personal triggers
- Misperception about who is impacted by SUD
- Fear of disruptive behavior by patients using substances
- Feeling unsafe interacting with patients with SUD
- Concern about maintaining patient privacy

Clinicians

- Fear of being overwhelmed with SUD patients and/or the complexity of need
- Fear of identifying a patient's need but not being able to connect the patient to treatment
- Uncertainty about treatment option availability given a patient's insurance coverage
- Insufficient time with patients to effectively address substance use and treatment
- Causing harm from lack of experience
- Misunderstanding of MAT and how it works
- Misperception that patients must have access to counseling services with MAT
- Unprepared for patient interaction beyond prescribing
- Feeling alone

Leaders (executives and managers)

- Misperception that it cannot be reimbursed or be financially sustainable
- Uncertainty about service billing and patient privacy regulations (Title 42 CFR)
- Insufficient resources for care team education and training
- Fear of burdening care teams with more responsibility
- Ambiguous direction and short-term planning

Systems

- Ineffective care coordination due to inability to share or access patient information regarding substance use
- Burden of collecting and documenting patient-reported outcomes
- Customization of health information technology tools for data collection and efficient workflows

Using the Toolkit

For each strategy, this toolkit details actions and resources for key tactics: Connect to the mission, learn from others, give clear direction, provide support, raise awareness, build skills, clarify the process, and measure impact. The actions and resources build care teams' confidence in their organizations and their capability to manage change, remove technical barriers, and support staff to develop the knowledge and skills to become confident in their own abilities. Key informants or experts in the field recommended the resources included in this toolkit, which are intended for those within primary care organizations who are planning or implementing SUD treatment services.

Framework

Key informants identified common elements that contributed to their success in integrating SUD treatment into primary care. These elements have been used to frame this toolkit in three high-level strategies that can be used by all organizations across the integration spectrum:

1. Shift attitudes about SUD, treatment, and patients with addictions
2. Increase awareness of SUD through screening, either sequentially or, ideally, in parallel with the following strategy
3. Accelerate access to SUD treatment in incremental phases scaling towards full integration among all care teams

Learn From Others

All informants underscored the importance of adopting integration approaches that use members of the care team efficiently. They also emphasized the importance of harm reduction as opposed to abstinence as well as the biological, psychological, and social needs of patients with addiction. **Increasing awareness about addiction and the people affected by it reduced push-back and bolstered motivation of care teams. Offering access to experienced local peers, through either on-site mentors or specialists in the community, built the confidence to provide services.**

Using the Toolkit

Toolkit Framework

OBJECTIVE	Expand the capability of primary care teams to confidently and willingly provide SUD services							
STRATEGIES	Shift attitudes		Increase awareness			Accelerate access		
TACTICS	Connect to the mission	Learn from others	Give clear direction	Provide support	Raise awareness	Build skills	Clarify the process	Measure impact

Metrics used by organizations to monitor and improve their services and progress are listed under the tactic measure impact. The metrics reflect adoption of processes and patient outcomes specific to the strategy. SUD treatment measurement is a new and growing body of work; links to standardized metrics and specifications for external reporting are provided at the end of the toolkit, and organizations should adapt metrics for internal tracking based on their own needs and specifications. Most informant organizations

acknowledged that at the outset of their integration efforts, measurement had not received the resources it should have; in hindsight, they wished they had created a measurement plan at the beginning and allocated resources for data collection, as the data could have been used to generate staff buy-in and more easily secure resources for subsequent integration efforts.

Medication-Assisted Treatment

In this toolkit, the use of the acronym “MAT” for “medication-assisted treatment” reflects the general inclusive definition of medications used to treat multiple substance use disorders and does not include counseling or programs that comprise multiple services in conjunction with MAT. MAT is the use of medications to treat SUDs. This toolkit highlights MAT among other substance use treatment services because it is the most common and easily implemented SUD treatment within primary care settings.

Background: MAT is commonly associated with treatment for opioid use, but it is inclusive of all SUDs with available medications for treatment: alcohol, opioids, and tobacco. Primary care clinicians can prescribe all MAT except methadone, which can only be prescribed within licensed opioid treatment programs; buprenorphine requires an X-waiver, available after 8 hours of training (for MDs) and 24 hours (for nurse practitioners and physicians assistants). Many clinicians get waivers but do not prescribe; it is important to use resources to shift attitudes and increase general awareness about MAT.

Misperceptions: There is a misperception that MAT requires the use of behavioral health therapy. Counseling is recommended with MAT, but studies show mixed results on patient outcomes when MAT and counseling are used together. The Prescription Opioid Addiction Treatment Study in 2017 demonstrated that “adding counseling to buprenorphine plus medical management did not improve outcomes.”^{iv} To address other common myths

about MAT, start with [Challenging the Myths About MAT for Opioid Use Disorder](#) [next page].

Some organizations develop MAT programs, which are generally a robust and specialized SUD treatment service line incorporating MAT, behavioral health counseling, social services, and case management. This guide is not intended to suggest whether or how organizations develop MAT programs. The recommendation based on key informant experiences is to start with a MAT team, which is simply a willing clinician and medical assistant. A MAT team, as opposed to a full program, is not resource-intensive and allows an organization to develop and refine workflows and patient engagement techniques while gaining the buy-in of other care team members and getting a better sense of the needs within a patient community. Within the accelerate access strategy, the evolution of a MAT team is detailed in three phases, which allows for flexibility to adapt MAT services based on the learnings of early adopters.

MAT Medications

Opioid Use Disorder

- Buprenorphine
- Methadone
- Naltrexone

Alcohol Use Disorder

- Acamprosate
- Disulfiram
- Naltrexone

Tobacco Use Disorder

- Bupropion
- Varenicline
- Nicotine replacement (oral and transdermal)

Medication-Assisted Treatment

National Council for Behavioral Health:

Challenging the Myths About Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

MAT just trades one addiction for another:

MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery.¹

MAT is only for the short term: Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT.²

My patient's condition is not severe enough to require mat: MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient.³

MAT increases the risk for overdose in

patients: MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression.⁴

Providing MAT will only disrupt and hinder

a patient's recovery process: MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.

There isn't any proof that MAT is better

than abstinence: MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Asso-

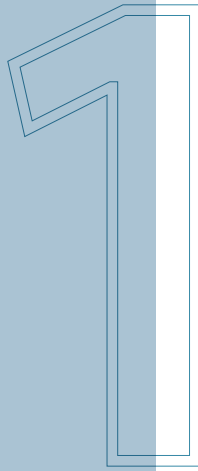
ciation, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment.⁵

Most insurance plans don't cover MAT: As of May 2013, 31 state Medicaid fee-for-service programs covered methadone maintenance treatment provided in outpatient programs.⁶ State Medicaid agencies vary as to whether buprenorphine is listed on the preferred drug list (PDL), and whether prior authorization is required (a distinction often made based on the specific buprenorphine medication type). Extended-release naltrexone is listed on the Medicaid PDL in over 60% of states.⁷

1) Samhsa.gov 2) Samhsa.gov 3) Whitehouse.gov 4) "MAT Maintenance Treatment and Superior Outcomes" PowerPoint, Dr. Arthur Williams 5) Samhsa.gov 6) American Society of Medicine 7) Samhsa.gov

Improvement Strategies and Tactics

Shift Attitudes



DESCRIPTION

Care team members who understand addiction and reflect on their personal biases related to addiction are better positioned to integrate SUD treatment into their primary care practices. Leaders' efforts to collaboratively plan and prepare with care teams instill confidence among staff in the organization's commitment to adequately support care teams as they integrate.

For primary care organizations embarking on the integration of SUD treatment services, culture change begins with integrating SUD treatment into the mission and vision, articulating core values of SUD treatment services, and generating buy-in from providers and staff through empathy and compassion. The initial work focuses on eliminating stigma by changing the hearts and minds of care teams. Staff champions engage others in dialogue and facilitate learning about the basics of addiction as an illness, addiction's personal and community impacts, the harm-reduction approach, alignment with organizational values, and managing one's own reactions to patients with addiction.

As with any change initiative, leaders can mitigate resistance by adequately preparing before initiating any pilot projects so that the change process is incremental and as smooth as possible. Leaders' efforts to marshal financing, develop a plan and timeline, investigate questions around patient privacy and billing, and document workflows will ease the transition and help ensure buy-in from staff.

The initial work focuses on eliminating stigma by changing the hearts and minds of care teams.



STRATEGY

Connect to the Mission

ACTIONS

- Communicate executive leadership commitment to SUD treatment integration.
- Add SUD services and core values of behavioral health integration into the organization's vision and values.
- Emphasize the importance of adopting integration approaches that utilize members of the care team efficiently; emphasize harm reduction rather than abstinence; and address the biological, psychological, and social needs of patients with addiction.

RESOURCES

- [Core Values of SUD Treatment Integration \(PDF\)](#)
 - Person Centered
 - Recovery Based
 - Wellness Focused
 - Family Inclusion
 - Cultural Inclusion and Cultural Humility

STRATEGY

Learn from Others

ACTIONS

- Identify and engage technical assistance providers with experience implementing SUD treatment services.
- Reach out to experienced provider organizations to learn from and observe.

RESOURCES

- [A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration: Observations from Exemplary Sites \(PDF\)](#)

STRATEGY

Give Clear Direction

ACTIONS

- Set a long-term goal of training the entire organization to provide SUD services, rather than limiting SUD services to a specialized team.
- Develop a long-term plan to integrate SUD services incrementally.
- Identify a pilot care team: a clinician champion who is experienced with SUD treatment and a medical assistant champion who can answer staff and patient questions. Give the pilot team time for planning and sharing learnings.

RESOURCES

- [Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams \(PDF\)](#)

STRATEGY

Provide Support

ACTIONS

- Contract with local community and telehealth addiction specialists for patient referral. When care team members know that there are more experienced care providers who can treat patients with complex needs and offer guidance to the primary care team, they are more willing to screen patients and provide services to patients.
- Identify a community network to refer and coordinate care for patients who are transitioned to other settings for appropriate care, including addiction specialists, residential treatment centers, and behavioral health counseling services.

The network should be formalized through agreements and protocols related to care transitions and exchange of patient information.

- Develop a business strategy that establishes funding, reimbursement, and financial sustainability of expanding SUD screening and services, taking into account patient coverage options, billing, and short-term decreases and long-term increases in visit productivity.
- Apply for grant funding to establish a pilot care team and to support planning for billing, internal and external referral paths, and workflows.

- Promote the Substance Use Warmline, which offers free provider-to-provider addiction consultation by experts: (855) 300-3595.

RESOURCES

- [California Opioid Safety Network Coalitions by County](#)
 - [California Hub-and-Spoke System Participating Organizations](#)
 - Telehealth Companies: [Bright Heart Health](#) or [Workit Health](#)
- GRANT FUNDING RESOURCES: CALIFORNIA**
- [California Health Care Foundation](#)
 - [California MAT Expansion Program](#)
 - [California Hub-and-Spoke System](#)
 - [Center for Care Innovations](#)

NATIONAL RESOURCES

- [National Institute on Drug Abuse](#)
- [Substance Abuse and Mental Health Services Administration](#)

STRATEGY

Raise Awareness

ACTIONS

Educate clinicians about:

- SUD prevalence in patient panel and community (particularly for patient populations with private insurance coverage)
- Abstinence no longer being the standard of care
- MAT basics
- Treatment effectiveness
- Treatment gaps

Educate ancillary staff about:

- Addiction basics, with emphasis on:
 - Addiction is an illness, not a choice.
 - Addiction could happen to anyone, we all know someone affected.
- Harm reduction models of care support patients and save lives.

- Treatment effectiveness
- Patient privacy regulations (42 CFR Part 2)
- Successful patient stories

RESOURCES

- [CIN Webinar: Engaging Providers in SUD Treatment](#)
- [Recovery Within Reach: MAT of Opioid Addiction Comes to Primary Care \(PDF\)](#)
- [Principles of Harm Reduction](#)
- [Trauma-informed Care](#)
- [California Society of Addiction Medicine](#)

PROVIDER EDUCATION RESOURCES

- [Buprenorphine: Everything You Need to Know \(PDF\)](#)
- [California County Fact Sheets: Treatment Gaps in Opioid-Agonist MAT](#)
- [CIN Webinar: Engaging Patients in SUD Treatment](#)
- [Effects of Medication Assisted Treatment for OUD on Functional Outcomes: A Systemic Review \(PDF\)](#)
- [The Next Stage of Buprenorphine Care for OUD](#)
- [Primary Care and the Opioid-Overdose Crisis – Buprenorphine Myths and Realities](#)

STRATEGY

Build Skills

ACTIONS

Provide clinicians standardized training on:

- Coding for SUD diagnosis and services
- Treatment services by insurance coverage
- X-waiver certification for interested clinicians

Provide ancillary staff standardized training on:

- Self-management of personal triggers
- Cultivating empathy and compassion through connection to personal values aligned with working in health care
- Dialogue techniques to de-escalate or resolve conflicts
- Patient privacy regulation compliance

RESOURCES

- [Provider- and Practice-Level Competencies for Integrated Behavioral Health in Primary Care: A Literature Review \(PDF\)](#)
- [Medication for the Treatment of Alcohol Use Disorder: A Brief Guide \(PDF\)](#)
- [Online MAT Waiver Training](#)
- [In-person MAT Waiver Training](#)

STRATEGY

Clarify the Process

ACTIONS

- Add SUD diagnosis and services codes to the EHR and practice management systems.
- Detail workflows for external referrals to community and telehealth addiction specialists.
- Specify medications and treatment services by insurance coverage.
- Establish a policy and protocol for patient data sharing in compliance with Title 42 CFR Part 2, if relevant to the practice.

RESOURCES

- [Fine Print: Rules for Exchanging Behavioral Health Information in California](#)
- [Behavioral Health Data Sharing Toolkit](#)
- [Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care \(PDF\)](#)
- [Online Course: Patient Confidentiality and MAT in California Primary Care Settings](#)

STRATEGY

Measure Impact

ACTIONS

- Develop a measurement plan and allocate resources for data collection and reporting.
- Define measure specifications.
- Establish baselines for measures in subsequent phases, particularly the number of patients diagnosed with SUD and number of patients receiving SUD treatment.

COMMONLY USED MEASURES

- Number of staff members participating in education sessions
- Number of clinicians trained in coding and insurance coverage
- Number of X-waivered clinicians
- Number of MAT prescriptions for alcohol, opioid use
- Survey care team members about their capability (willingness and comfort) working with patients with SUD

INTEGRATION IN ACTION

HealthRIGHT 360's journey of integrating SUD treatment services into their San Francisco primary care location began in 2014 as the practice was implementing its electronic health record (EHR) software, shared Dr. Ako Jacintho, director of addiction medicine. After discovering that SUD diagnoses were lower than the perceived number of patients with SUD, management took a deeper look at their patient population and listened to care teams' sentiments about treating SUDs. Like many health care workers, care teams expressed fear and misunderstandings about patients with addiction.

The experiential learning included a dedicated hour at monthly staff meetings and case conferences to discuss what substances are and what they do, why a person uses substances and how recreational use may proceed to addiction, how addiction has impacted the lives of staff, and the prevalence within the community. Connecting with addiction at a human level led to empathy and compassion among staff.

Staff were then trained to identify their own triggers and feelings and to manage their reactions so that they could engage meaning-

“Addressing stigma has been a challenge. Most providers have been affected by addiction somehow and have their own experience and trauma to face in treating others afflicted by this. So, our approach has been a trauma-informed buy-in process... asking providers where they are around the issue and seeing how much capacity they have to do this work.

Treatment of patients with addiction will almost always be met with some type of trauma (sexual, abandonment, loss, tragedy, shame). Providers will have to take this on. Most patients will confide first in providers and will want to develop a conscious relationship with the provider over a therapist. This means the provider must be able to hold this trauma in a 15-minute primary care visit. Primary care providers are not accustomed to dealing with the trauma associated with addiction disorders.

Dr. Ako Jacintho, Director of Addiction Medicine, HealthRIGHT 360



fully with patients. Dr. Jacintho and other leaders provide individual coaching in the form of debriefs after difficult interactions to further build self-management skills.

Treating addiction “involves the most wounded, vulnerable part of ourselves as care providers and patients.” SUD treatment is unpredictable

and cannot be streamlined like diabetes or hypertension care. Dr. Jacintho emphasizes that patients need a care team that cares enough to self-manage their emotions, and care teams need organizations to build in support that recognizes and honors self-management support for care providers.



DESCRIPTION

Organizations wanting to take a gradual approach toward SUD treatment integration can begin by implementing evidence-based SUD screening practices per the US Preventive Services Task Force Recommendation.⁹ Care teams, using tools such as the Screening, Brief Intervention, and Referral to Treatment (SBIRT), identify and engage patients at risk and then refer patients to the appropriate service.

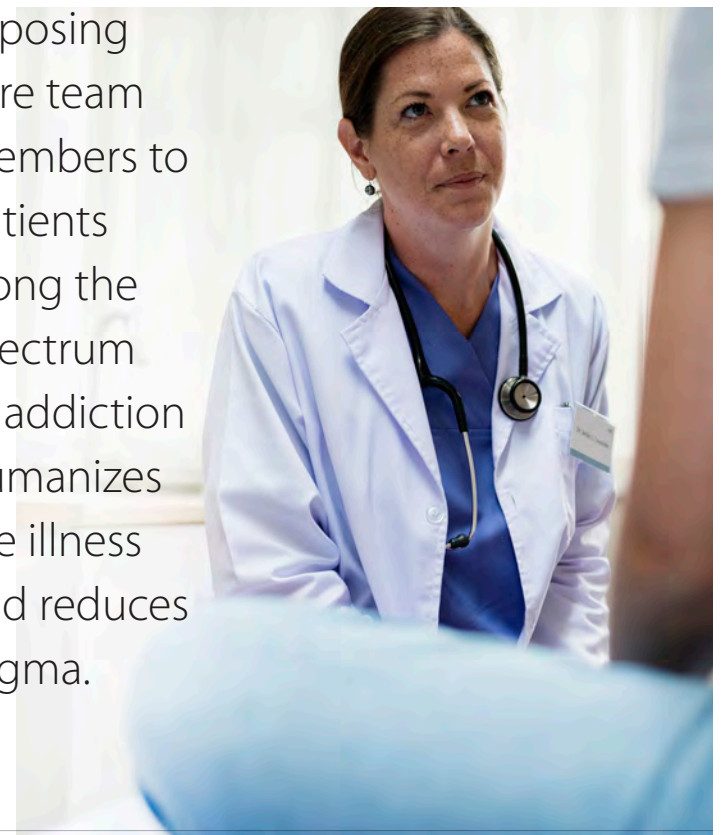
Piloting the systematic screening with a champion's care team will facilitate the development and refinement of workflows and health information technology tools to inform

learning for other care teams who may not be enthusiastic at the outset. As screening spreads to more care teams, so does the knowledge about the spectrum of SUD and the need for treatment services. Exposing care team members to patients along the spectrum of addiction humanizes the illness and reduces stigma while also raising awareness about the prevalence among patients with whom the teams have established relationships.

The opportunities for early intervention from screening are best leveraged by primary care organizations with internal behavioral health personnel who can support patients with dependence and mild to moderate addiction. Small practices may need extra support to immediately connect patients to centralized behavioral health services (through health plans and/or provider organizations,

such as independent physician associations) for full assessments and referral to treatment. Regardless of internal behavioral support, organizations need to define referral criteria and sources for severe addiction prior to screening so that care teams feel comfortable conducting screenings and addressing patient needs. Some organizations also develop a specialized MAT team concurrently to reduce care team resistance to screening by having internal treatment experts within reach.

Exposing care team members to patients along the spectrum of addiction humanizes the illness and reduces stigma.





Increase Awareness

STRATEGY

Give Clear Direction

ACTIONS

- Select standardized SUD screening tool.
- Consider whether to use internal staff and capacity to provide the brief interventions or contract out the brief interventions through telehealth organizations.

RESOURCES

- [SBIRT Opportunities for Implementation and Points for Consideration \(PDF\)](#)
- [Systems-Level Implementation of SBIRT \(PDF\)](#)

STRATEGY

Raise Awareness

ACTIONS

Educate care teams about:

- Spectrum of unhealthy substance use
- Community prevalence
- Reasons for screening
- Referral options by insurance coverage

RESOURCES

- [Substance Use in California: A Look at Addiction and Treatment \(PDF\)](#)
- [California Opioid Overdose Surveillance Dashboard](#)

STRATEGY

Build Skills

ACTIONS

Provide clinicians standardized training on:

- Review screening scores
 - Assess patient's needs and severity of addiction for appropriate referral
- Provide ancillary staff standardized training on:*
- Screen patients with a standardized SUD tool
 - Engage patients and families through motivational interviewing, shared decisionmaking, and patient activation

RESOURCES

- [SBIRT Implementation and Process Change Manual for Practitioners \(PDF\)](#)
- [SBIRT: Clinician's Toolkit \(PDF\)](#)



Increase Awareness

STRATEGY

Clarify the Process

ACTIONS

- Set up billing codes for SUD screening.
- Develop a patient information release form and workflow for obtaining and documenting consent.
- Create EHR templates and workflows for documentation and orders.
- Use tablets to collect patient-reported screening data for direct entry into EHR-defined fields.

RESOURCES

- [SBIRT Financing Resources](#)
- [SAMHSA – HRSA: SBIRT Workflow](#)
- [Optimizing the EHR to Support SBIRT \(PDF\)](#)
- [Sample Forms of Substance Use Confidentiality](#)

STRATEGY

Measure Impact

ACTIONS

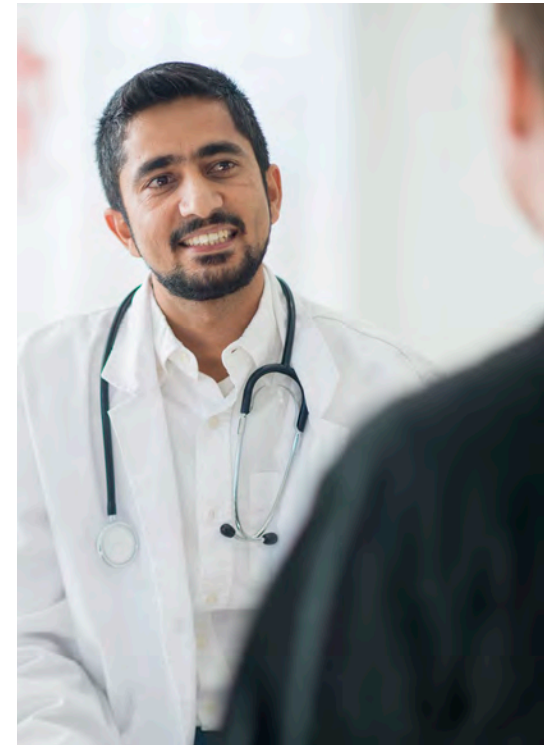
- Define specifications for and measure the percentage of patients receiving screenings and each type of intervention.
- Survey care team members about capability (willingness and comfort) providing SUD screening.

INTEGRATION IN ACTION

Golden Valley Health Centers, a CIN partner with facilities throughout the Central Valley, leveraged a federal requirement of community health centers to regularly screen patients for SUD to engage care teams in the integration of SUD treatment services. While care teams recognized the dire need for SUD services in the community, many were reluctant to provide those services within the primary care practices serving the wider community. In addition, there were very few experienced primary care providers within the Central Valley to provide treatment services or to guide the care teams.

The organization took an incremental approach to integration by thoughtfully implementing SBIRT across its sites prior to offering treatment services. By standardizing screening and linking patients to behavioral health staff for brief interventions, care teams have a better

sense of the spectrum of substance use, the impact among their established patients, the support available to patients within the organization and in the community for treatment referrals, and the demonstrated commitment of the organization to support staff through the integration process. For many care teams, putting a human face of a patient they already know to the diagnosis of addiction in the screening process has reduced stigma and the misperceptions of patients with addiction and nurtured a willingness to provide treatment services after having built the confidence to do so.



Improvement Strategies and Tactics

Accelerate Access



DESCRIPTION

Accelerating access to SUD treatment services happens in three successive phases, in which changes are implemented incrementally to develop and refine workflows while sharing learnings and experiences to motivate and increase confidence in other care teams to provide treatment services. Prescribing MAT for alcohol and tobacco use disorders does not require additional training, and clinicians should be encouraged from the outset to treat these patients on their own panels while learning to prescribe and titrate treatment medication.

Learn From Others

Explore best practices and resources for MAT services:

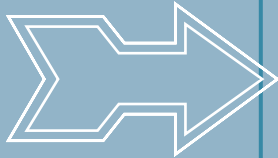
- [MAT Resources: Implementation, Financing, Training](#)
- [Expanding the Use of Medications to Treat Individuals with Substance Use Disorders in Safety-Net Settings: Opportunities and Lessons Learned \(PDF\)](#)

CALIFORNIA-SPECIFIC:

- [Accelerating Opioid Safety: Ambulatory Care Toolkit \(PDF\)](#)
- [California Hub-and-Spoke System Participating Organizations](#)
- [California Opioid Safety Network Coalitions by County](#)
- [MAT Coaching Technical Assistance Providers](#)
- [Primary Care Buprenorphine Programs: Ten Elements of Success \(PDF\)](#)
- [Treating Addiction in the Primary Care Safety Net](#)

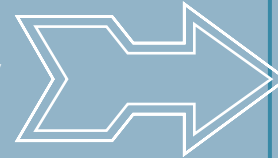
PHASE 1

Establish a MAT care team



PHASE 2

Engage other primary care physicians (PCPs) in maintenance



PHASE 3

Transition to internal SUD specialty team



PHASE 1

ESTABLISH A MAT CARE TEAM

As with most quality improvement efforts, successful organizations pilot small tests of change within a dedicated care team. Patients are referred to a specialized MAT team for stabilization and treatment initiation. Some organizations develop an internal team with a provider champion and grant funding, while others contract with an external addiction specialist provider in the community or via telemedicine. External MAT referral may be best for those organizations without a willing and experienced MAT champion, grant funding, or care teams open to welcoming SUD patients in clinic facilities shared with non-SUD patients.

For internal MAT teams, the specialized care team begins by addressing the biological

needs of SUD patients with one or two providers and a medical assistant with specific MAT clinic hours. Two providers are ideal so that they can support each other and cover each other's patients when needed. In subsequent phases, the MAT team may expand to include psychological and social support for patients with SUD. However, MAT alone is effective and should be initiated regardless of behavioral health and social support availability.^{vi} The MAT team develops and refines workflows for treatment while serving as consultants for other care teams and educators within the organization. When referrals increase, some MAT teams transition to an open schedule for patient convenience; the schedule may be specific appointment slots each day dedicated to MAT or the use of any appointment slot on the MAT provider's schedule.

When using external referral providers for MAT, the patient can immediately access services related to medication treatment as well as psychological and social support. Patients retain their PCP during MAT, and interest in treatment among PCPs grows as providers and care teams witness the positive changes in patients. Telemedicine is a growing but still underused resource for expanding access to

SUD treatment.^{vii} Small and/or rural practices, commercial primary care organizations, and nascent SUD treatment services without grant funding can most effectively leverage the resources and learning available through addiction specialist provider organizations. Often, the contracted addiction specialist can provide guidance on billing and optimal referral workflows. As internal interest for MAT grows among providers, they can leverage the expertise of external referral providers through consults and shift ongoing MAT maintenance to PCPs.

In this initial phase, PCP education about appropriate referrals to MAT is needed for systematic identification of patients who are good candidates for MAT. PCPs also benefit from training about effective communication with patients to help them recognize MAT as a viable treatment option. Many MAT teams report that they were able to grow interest among other providers in treating SUD by observing their peers find joy in the work, in addition to seeing the impacts on their patients. Organizations can leverage this interest by investing in PCPs to obtain X-waiver through organized trainings or by funding individual training.

PHASE 2

ENGAGE OTHER PCPS IN MAINTENANCE

Key informants reported that once specialized MAT teams, whether internal or external, are established, referrals from PCPs and patients themselves increase to the point where access is reduced for new MAT patients because the specialized team is continuing to see established MAT patients for maintenance. When access for new patients is impacted, stabilized patients are transitioned back to PCPs who have X-waiver certifications. The specialized MAT team maintains responsibility for initiating treatment and supports PCPs through consults and peer mentoring as PCPs become more experienced in prescribing.

For internal MAT teams, as the volume of MAT patients grows, the team usually expands to add behavioral health support for patients as well as providing more patient-centered flexible access. Since MAT maintenance appointments tend to be shorter and less complicated than typical appointments for established patients, the revenue generated through increased productivity is re-invested in the team's expansion and the ease of such visits generates additional interest from care teams.

PHASE 3

TRANSITION TO INTERNAL SUD SPECIALTY TEAM

In the final phase of integration, MAT teams transition treatment of mild-to-moderate addiction to PCPs, who initiate MAT and continue maintaining MAT for their own panel of patients. The MAT team serves as a consultant for PCPs and as a referral-based specialty service for patients with severe addiction and for those who are the most unstable. This highly specialized team often expands to include case management to support patients with the highest levels of need for social support.

Full integration across a system means there is no wrong door for accessing SUD treatment – most PCPs have X-waivers (DEA licenses) and are actively prescribing MAT, patients can access MAT on any day at any time and are

not limited to MAT clinics or locations. Patients can start MAT at any point in the health care system and can continue treatment in their primary care home, and organizations rely more on revenue generated through billing as opposed to grant funding to sustain the services. Primary care teams have a core set of skills for screening for and treating SUD: adoption of an evidence-based treatment model and tools; flexibility and barrier reduction for patients; knowledge of community referral criteria and options; MAT titration; and managing care and safety of patients through lab, toxicology, and PDMP monitoring.

3

Accelerate Access

STRATEGY

Provide Support

ACTIONS

Phase 1:

- Establish an internal MAT team of two experienced clinician champions and MA support for cross-coverage and peer support, with dedicated MAT appointment time and reduced primary care panel of MAT clinicians. The team will treat patients referred from PCPs to initiate treatment, complete full intake assessment, and stabilize patients.
- Link to other local MAT access efforts, including [emergency departments](#), [hospitals](#), [jails](#), and [hub and spoke program](#) (linking clinics to opioid treatment programs).

Phase 2:

- Add behavioral health specialists to the MAT team (licensed clinical social worker, certified alcohol and drug counselor).
- Create access to psychiatrist consulting for MAT team.
- Implement group-based visits, in partnership with behavioral health staff, of up to 10 patients over 1.5 hours with a relapse prevention curriculum based on cognitive behavioral therapy and mindfulness techniques, discussion among participants around anticipating triggers and working through them, and completion and provider review of CURES and urine toxicology results.

Phase 3:

- Expand MAT team to include intensive case management and collaboration with psychiatry.
- Make MAT team accessible for consults by primary care teams.
- Embed a certified alcohol and drug counselor among primary care teams for patients with mild to moderate addiction.

RESOURCES

- [Example: Organization Treatment Philosophy Summary of OUD Care Models:](#)
- [Primary Care-Based Models for the Treatment of OUD: A Scoping Review](#)
- [Medication-Assisted Treatment Models of Care for OUD in Primary Care Settings \(PDF\)](#) includes MAT evidence and future directions
- [Webinar Series: Implementing MAT in Primary Care](#)

3

Accelerate Access

STRATEGY

Build Skills

ACTIONS

Phase 1:

- Offer X-waiver certification training to all clinicians.

Provide clinicians standardized training on:

- Initial medical investigation to rule out patients who are not good candidates for MAT team. Current trends may be changing to broaden the groups of patients who can benefit from MAT.
- Treatment intensity levels

Phase 2:

- Use an apprenticeship model for PCPs to learn through experience: PCP starts with inheriting a maintenance patient and a care transfer summary and then obtains peer support and consults from experienced MAT providers.
- Develop formal peer mentoring opportunities at staff meetings, community events, and case conferences.

Provide clinicians standardized training on:

- Documenting notes in EHR templates
- Prescribing and billing MAT by insurance coverage

Phase 3:

Provide clinicians standardized training on:

- SUD diagnosis: DSM criteria, screening, and coding
- Collecting patient intake information
- Counseling treatment options
- Prescribing low-threshold buprenorphine starts
- Completing EHR workflows:
 - Treatment agreement and informed consent
 - Patient release of information
 - Schedule the next appointment

RESOURCES

- [Clinician Consultation Center: Online and Telephone](#)
- [Project ECHO Tele-Learning](#)
- [UCLA MAT ECHO Clinic](#)
- [Clinical Peer Mentoring](#)
- [Medical Education and Research Foundation for the Treatment of Addiction](#)

3

Accelerate Access

STRATEGY

Clarify the Process

ACTIONS

Phase 1:

- Develop a pre-visit questionnaire to obtain patient intake data prior to meeting with the clinician that includes the following patient-reported outcomes: improvement, substance use, medication use, side effects, withdrawal symptoms, health concerns, goal setting, action planning, recovery tools and use these data to obtain necessary information for clinical decisionmaking at each visit.
- Develop a simple standardized home induction guide for use by both clinicians and patients that includes these components: withdrawal symptom guide; first dose and instructions; guidance for day 1, day 2,

and onward; next check-in appointment date, time, and location and the phone number to reschedule.

- Create EHR note templates aligned with patient intake data collection.
- Set up billing codes & EHR workflows and referrals for MAT.
- Define workflows for dissemination, collection, and EHR documentation of:
 - Patient information release
 - Intake data questionnaire
 - Induction plan

Phase 2:

- Define PCP MAT maintenance workflows.
- Set up behavioral health and counseling billing codes.
- Create EHR template for counseling visit.

Phase 3:

- Define PCP SUD intake for mild to moderate addiction.
- Set up case management billing codes.
- Create EHR template for case management.
- Develop a comprehensive MAT toolkit for new clinicians and care team members with organization-specific workflows, coding, care team and patient tools, training resources, and champion contact information.

3

Accelerate Access

STRATEGY

Measure the Impact

ACTIONS

- Survey care team members about capability (willingness and comfort) of providing SUD treatment services, including how they feel patients are responding to treatment.
- Survey clinicians about capability (willingness and comfort) of treating SUD with MAT, by specific MAT medication.

MEASURE

- Retention rate in treatment at six months
- Number of MAT prescriptions by provider
- Percent of patients diagnosed with SUD who are receiving MAT
- Percent of patients with SUD and referrals to external treatment options

INTEGRATION IN ACTION

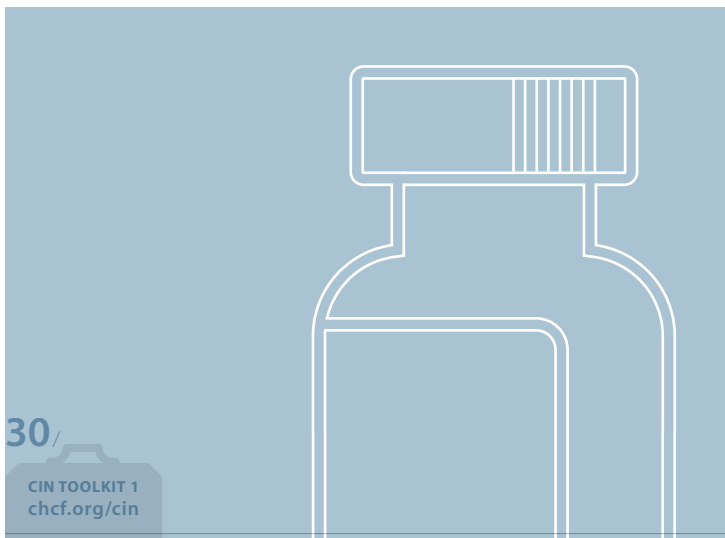
Dr. Tipu Khan, faculty member for Ventura County Medical Center Family Medicine Residency Program (VCMC), is a waived clinician. Soon after joining VCMC, he began getting patient referrals from other clinicians and interest from residents in learning to treat SUD. He took two approaches to increase the number of providers prescribing MAT based on the type of medication.

The MAT team grew organically to a few providers managing about 20 OUD patients, but it quickly ran into challenges in MAT maintenance for patients when prescribers were out of the office or not available after hours. To get more providers waived, Dr. Khan

debunked MAT myths among providers and only requested prescribing coverage for MAT maintenance when the initial prescriber was unavailable. Now, almost 80% of providers are waived; some do not prescribe to their own panel but will cover other providers when absent, and others are expanding their prescribing beyond coverage for peers. VCMC established an addiction medicine fellowship and supports newly X-waived clinicians with medical leadership encouragement and peer support and mentoring.

While OUD receives much more attention and resources given its urgency and fatality rates, organizations can also accelerate access to

MAT for alcohol use disorder (AUD) in parallel with OUD efforts. Dr. Khan says that the options for AUD are clear, providers feel safer with it than buprenorphine for OUD, and there is less of a stigma than with other substances; however, social acceptance of alcohol has led to underscreening and underdiagnosis of AUD and to subsequent undertreatment despite its significantly higher prevalence. VCMC and its affiliated clinics have expanded their use of SBIRT to increase screening for all substances and encourage all providers to prescribe MAT for alcohol, leading to increased MAT prescribing for both alcohol and OUDs.



LEVERAGING TELEMEDICINE

Telemedicine is an alternative to providing SUD treatment services on site, or it can complement on-site care to provide patients access to a spectrum of treatment and recovery services and to provide clinicians access to specialist consultations and support. While telemedicine's use for SUD treatment is increasing, it remains under-utilized compared with telemedicine for mental health. For patients with SUD, it is important to connect them with a clinician immediately; telemedicine can play a pivotal role in connecting patients to treatment where there may be barriers of geography, primary care team capacity and capability, or insurance coverage. The Health Affairs article [How is Telemedicine Being Used in Opioid and Other Substance Use Disorder Treatment?](#) details the many ways telemedicine can support SUD treatment.

Telehealth providers currently active in California include [Aegis](#), [Bicycle Health](#), [Bright Heart Health](#), [e-Psychiatry](#), [Groups](#), [Lion Rock Recovery](#), and [WorkIt Health](#). Several of these providers (Aegis, Bicycle Health, Bright Heart Health, Groups and WorkIt Health) provide services for Medi-Cal and/or uninsured and underinsured patients in select California

counties: check the organization websites for updated information, as access is expanding over time.

Currently, the initial evaluation visit must be in-person; subsequent visits for medication management (including prescriptions) can be done virtually through live video. Telehealth can also offer initial video screening, brief interventions, individual and group counseling, case management, app-based incentives and education, and peer and recovery support through digital apps, phone and live video. Pending federal regulations may waive this in-person requirement, as it is a barrier for patients in rural areas or with transportation challenges. Some organizations offer additional web-based services to help patients stay engaged in treatment.

Telemedicine providers can collaborate with primary care organizations to tailor a package of services including direct patient care and consultation support for PCPs (either real-time, during patient care, or asynchronously), data sharing through secure messaging into the primary care organization's EHR, staff training and materials on workflows such as referral criteria and insurance verification, guidance

on appropriate billing for reimbursement, and outcome measurement. Some telehealth organizations are able to leverage [federal SAMHSA funding](#) to allow free or low-cost care.

Primary care organizations with mostly privately insured patients tend to refer to telemedicine for the whole spectrum of SUD treatment services, whereas community health centers often use telemedicine for patients requiring more intense or frequent support, or patients needing more convenient access due to long travel distances or the need for night or weekend appointments.

The CIN Behavioral Health Integration Action Group, responsible for shaping this toolkit, identified Bright Heart Health as one of the telehealth providers in California who are engaging in this work. In an interview, Bright Heart Health Medical Director Dr. David Kan, explained the organizations best suited to working with a telemedicine provider are those with leaders willing to support the partnership and allocate time for care team training and collaborative workflow development.



Future Opportunities

To continue to strengthen the capability of primary care teams to provide high-quality SUD treatment services, organizations need technical assistance, financing, and advocacy support to address the following needs and challenges:

Provide Support

- Adjust PCP panel sizes in order to accommodate MAT services for patients with SUD
- Tailor support for providers who care for the privately insured, including seed funding to develop internal MAT teams and technical assistance for PCPs
- Provide additional funding beyond small pilot projects so that organizations can test models for scaling up services across systems and invest in outcome measurement

Build Skills

- Develop the workforce to train physician residents in MAT and increase available certified drug and alcohol counselors
- Expand use of tele-medicine for patient convenience within organizations and with external providers
- Guide organizations to leverage economies of scale across their systems for training, education, and collaboration with specialty providers to develop a seamless care continuum

Clarify the Process

- Integrate EHR functionalities of confidential diagnosis and prescription lists and visit notes
- Make EHRs interoperable with patient-facing software and hardware to collect patient-reported data and outcomes
- Align employer benefits and health plans with evidence-based care and primary care SUD treatment for mild to moderate SUD
- Change policies related to reimbursement for MAT-related services, such as case management and counseling, and regulations for patient confidentiality to allow for more effective care coordination.

Measure Impact

- Dedicate quality improvement and data analytics staff and expertise for population management analytics and performance measurement
- Calculate the business case for SUD services and their financial sustainability given that MAT patients are engaged in care and more likely to show for appointments
- Measure quality of care among community specialty providers to ensure patients are referred to high-quality and cost-effective specialists

Conclusion

All primary care organizations can take action now to equip care teams to integrate SUD treatment services.



California can significantly increase needed treatment services for people with SUDs by supporting primary care teams and organizations to integrate these screening and treatment services into their patient-centered models of care. Care teams need organizational resources and infrastructure, skill building, clear workflows embedded in health information technology, and performance measurement to provide accessible

and high-quality SUD care. The primary care team integration journey involves parallel paths to shift attitudes about addiction, increase awareness of people impacted, and accelerate access to treatment. All primary care organizations can take action now to equip care teams to integrate SUD treatment services.

Appendix

STANDARDIZED PERFORMANCE MEASURES

- [Align.Measure.Perform \(California Pay-for-Performance Program through Integrated Healthcare Association\) \(PDF\)](#)
 - [Concurrent Use of Opioids and Benzodiazepines \(PDF\)](#)
- [Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling \(NQF 2152\) \(PDF\)](#)
- Healthcare Effectiveness Data and Information Set
 - [Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment \(NCOA 0004\)](#)
 - [Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence](#)
 - [Unhealthy Alcohol Use Screening and Follow-up](#)
- [Uniform Data Set 2018 \(PDF\)](#)
 - Table 5: Staffing Utilization, Line 21: SUD Services – Personnel FTE, Clinic Visits, Patients
- Table 6A: Selected Diagnoses, Line 18: Alcohol-related disorders; Line 19: Other substance-related disorders (excluding tobacco use disorders)
- Table 8A: Financial Costs, Line 7: Substance Use Disorder – Accrued Cost, Allocation of Facility and Non-Clinical Support Services, Total Cost after Allocation of Facility and Non-Clinical Support Services
- [American Society of Addiction Medicine: Performance Measures for the Addiction Specialist Physician \(PDF\)](#)
 - Percentage of patients prescribed a medication for alcohol use disorder (AUD)
 - Percent of patients prescribed a medication for OUD
 - Seven-day follow-up after withdrawal management
 - Primary care visit follow-up

Appendix

ABBREVIATIONS

ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
CADC	Certified Alcohol and Drug Counselor
CIN	California Improvement Network
CQC	California Quality Collaborative
CURES	Controlled Substance Utilization Review and Evaluation System
EHR	Electronic Health Record
HRSA	Health Resources and Services Administration
LCSW	Licensed Clinical Social Worker
MA	Medical Assistant
MAT	Medication Assisted Treatment
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OA	Opioid Agonist
ODD	Opioid Use Disorder
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SUD	Substance Use Disorder
UCLA	University of California – Los Angeles
VCMC	Ventura County Medical Center

Appendix

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ⁱⁱLisa Clemans-Cope, Marni Epstein, and Doug Wissoker, County-Level Estimates of Opioid Use Disorder and Treatment Needs in California (The Urban Institute: Washington, DC, 2018).

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^{iv}Roger D. Weiss RD and Vinad Rao, "The Prescription Opioid Addiction Treatment Study: What Have We Learned," *Drug and Alcohol Dependence*, 173, Suppl. 1 (2017): S48, doi: 10.1016/j.drugalcdep.2016.12.001

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^{viii}Ibid.

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