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Integrating Substance Use Disorder Interventions Across Colorado

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MONIKA SARAN
We're gonna presenting on integrating substance use disorder interventions across Colorado. So to start, we don't have any disclosures to disclose and sort of what we wanted to touch on during today's slideshow was reviewing the scope of need for substance use, education and access to treatment within primary care across Colorado. We're gonna also describe several models for integration of substance use and primary care on primary care across variety of clinical settings. And we're also gonna describe tools interventions for practice facilitators can use when they're doing similar work. So I'll pass it on to Cathy.

KATHY CEBUHAR
Thanks, Monica. Hi, I'm Kathy Cebuhar. She/her and I always like to start this presentation by level setting, what we saw in Colorado or what we've been seeing in Colorado in terms of opioid deaths. So this map I just downloaded this morning actually and updated it. So this is current as of today and you can see the total number of drug overdoses due to any opioid over the years starting in 2002. Now, in 2023 had a pretty gradual uptick until what happened in 2020? COVID. We saw this just enormous spike in deaths and we knew we had to have some sort of coordinated response and efforts. So what we're gonna talk to you about today is some of the, the programs that we have developed and the tools that we put together for practices and practice facilitators to use to address these issues. And I was so delighted to see that they had updated numbers and we're starting to see a downtrend. So, ok, our work is working you guys. Ok. So the programs that we wanted to highlight for you today are six building blocks implementation and supports for medications for opioid use disorder. The shorthand for that is ISM. Integrated care for women and babies, improve perinatal access coordination and treatment for behavioral health. That's a mouthful. We call that impact or Impact BH and then FAST, facilitating alcohol screening and treatment. And we are lucky enough to also have Carolyn here with us who helps us with that, that project in Colorado. So in Colorado, in the Practice Innovation Program, we really approach all of our projects from a very standard space of creating a comprehensive change package for practice facilitators to be able to take and utilize in practices. And that generally starts with some milestones, some benchmarks based on the 10 building blocks of high performing primary care teams based on the Tom Bodenheimer paper, if anyone is familiar with that, and then we have pretty clear steps that we lay out for people so that the work feels manageable. So in ISM what practices, what we kind of sold to them was you're gonna get all of this support and help to address this because providers were like we're

overwhelmed, we don't know what to do. My MME prescribing is like super duper high. How do you expect me to get somebody to 90 morphine equivalents when they're in the hundreds or, or, you know, quite high? So we made sure that they had access to other provider experts in this. We facilitated monthly for s for them and team trainings on evidence-based tools and resources. The, the orange squares here, I really went with the Broncos colors. I guess. I'm really, I'm ready for football to start, I think. So they, these practices received nine months of practice facilitation with a one on one...with one practice facilitator that would meet with them monthly and go through the change package of materials with them. They could attend the monthly trainings and forums, they would receive funding. So when they would achieve their milestones, we would give them some money to be like, ok, you know, like, I mean, it wasn't like a now you get your money because you've done this work. But it was a little bit of an incentive to really dig in and start to do this work and have protected time to be able to do that. We hear often from providers. I don't have time to have a meeting. I'm just like eating a sandwich as quickly as I can in between seeing patients. So giving them some resources to protect their time to be able to meet was hugely helpful. And then access to content experts on those who help prescribe medication for opioid use disorder. We found the providers had some reluctance around that. So we wanted to make sure that they were hearing what they needed to hear from providers, making those connections. And making sure our facilitators that we support, knew who to link their providers with in their own communities because I'll show you in a second the spread we had across the state for this. All of the materials that we built for this, if you want to scan the QR code, it will take you to our website and you can access that change package material and take a look around and see if that is something that would be useful if you're doing similar work or it's a structure that you just might like to kind of develop for other projects, other QI projects that you take into your clinics, I'll give you a second. I see phones popping up. There will be a few QR codes too. Just to FYI, we didn't want to bog down the slides too, too much with information. So we wanted to drag you to the website. So this was the 15 practices that engaged in ISM. And we were really delighted to see that we had a big spread across the state. The state of Colorado is just a big square and of course, this is all rocky mountains. So it's hard to get a lot of clinics engaged there. They're pretty rural and remote. But we had from the Denver corridor all the way out west, which was great and then down to Durango and, and to the new New Mexico border. So we were really, really pleased with how many practices were able to engage. And this is some of the data from our first cohort of practices. So it's a fairly small N, only 15 practices. But the core aims that we created for this one, we're building your team, making sure your leadership isn't really involved and, and like on board with doing this work and then pulling in the relevant team members to be able to help support this work. Is it an RN champion? Is it a medical assistant champion? Is it the front desk person who is really tired of fielding the phone calls on Friday afternoon from a panicked patient thinking they're gonna run out of their opioids over the weekend and they are freaked out. You know, bring the team together. So they found that that was really helpful that we were thinking about it in a team approach and then, oh, let's engage the patients. What do they have to say about it? You know, bringing them into the conversation. How are we bringing into the conversation? How are we screening, how is that getting documented? How often are you checking the PDMP to

see if patients are maybe going to other providers to get prescriptions and things? So, really having comprehensive coordinated care. And then connecting with recovery services, understanding that primary care cannot do all of the work alone within their four walls. And so how are they connecting people within their own respective communities for wraparound services? So, not too bad for our first go at it. The next project that we really wanted to take a look at was how are we going to support pregnant and parenting people who have a substance use disorder, specifically opioid use disorder. So, this started as a pilot project and we got money from the Colorado legislature to improve outcomes for pregnant and parenting people in Colorado with an opioid use disorder and very similar structure in the change package materials that we put together for this, this project and practices received a lot of support too. They get monthly practice facilitation support from me. Monthly shared learning calls where we have addiction trained family medicine docs who come in and do sort of like a didactic time with them or clinics bring in patient cases that they're struggling with and can get some real time connection and problem solving. We support them as they're pulling their data and reporting on their measures and their evaluation support and then they also get a good amount of money too to hire and get more depth on the bench for who they need on their teams. We also have created a really robust contingency management program. Within almost each one of the clinics---who here is familiar with contingency management, to help with a substance use disorder? Essentially, this is tapping into the same parts of the brain that in an addiction, you know, our brains get hijacked. And so we're thinking about how are we gonna get the next thing so I don't feel terrible anymore? This is sort of a reward system, an incentive system that fires in the same parts of your brain. So when patients are showing up to meet with their, their OB and they are meeting with the social worker or a peer support specialist, they get to draw out of a fish bowl and then they get to pick up out of the closet that might have personal items or baby items and some clinics like give them pack and plays and car seats and strollers and things and patients are like, oh my gosh, you do care. Like this, this feels great. Look at me achieving my health goal and I get this really rad stroller too that I could never afford and some fuzzy socks and lotion that I would never spend my own money on for myself. Like, so that, that has been a really, really fascinating thing to watch patients enjoy and practices be able to do. And then again, access to experts. We we realize that providers here best for one another. So we make sure that there's always time for that connection. So here are the sites across Colorado. Six were in our, our pilot site and then we received extra funding so we could expand to nine and again, a fairly good spread. I'd love it if we could see more folks served on the eastern plains of Colorado. That that's one of my personal goals up next. Ok. I'm gonna stop and pass over to my colleague Lauren to talk us through six building blocks.

LAUREN QUINTANA
Thank you, Kathy. Kathy actually introduced herself wrong. We've been referring to her as Narcan Santa. She quite literally flew and drove across Colorado recently to deliver Narcan. So, one of our favorite things is to put everybody on the spot who has their Narcan with them today? All right, you guys, that is your first goal when you get home. You need to have on you at all times, it's better to have it and not use it. So as Kathy mentioned, I'm Lauren

Quintana. I'm actually a project manager, but the PFs let me hang out with them. So even though I annoy them and ask for data and deliverables so we keep getting funding. But our next project is six building blocks and this is a collaboration between the Colorado Community Health Network and our department, the CU Department of Family Medicine. And the goal of this is we support our implementation of opioid prescribing guidelines to decrease risky opioid prescribing for chronic non cancer pain patients. And we increase the utilization of behavioral health interventions for patients with chronic pain. We do this through our two evidence-based care models, which is the six building blocks of prescription opioid management along with the integration of behavior health and the primary care sites. And our funding comes from CE PHG the Colorado Department of Public Health and Environment. And these are our three primary outcome goals. We want to reduce the percentage of noncancer chronic pain patients on COT with a morphine equivalent dose of 90 or higher by 5%. For all patients on cot participating clinics, evidence based behavioral health services. And finally to increase the numbers of COT patients participating in longitudinal behavioral health services by five percent. And COT is chronic opioid therapy. Thank you Kathy. And then these are the practice benefits. This is the good stuff. They receive a monthly one-on-one practice facilitation, Cathy and Monica both are practice facilitators on this project. They get a bimonthly shared learning call with all of the participating practices. They all come to the Zoom call and our one of our subject matter experts will present on a topic and then we'll have a very robust discussion. We have been told this is their favorite part of the project. They really, really enjoy it and they get access to clinical content experts, toolkit materials, patient agreement workflow that should be EHR but always auto corrects to her. Documentation examples, financial content compensation for participation, metric reporting support and PDMP support. And one of my favorite things about this project is every time I get ready to pay a practice, they say, oh, we didn't even realize we got compensation, they just wanted to do it to get better. And then here are the maps of our cohorts. We only have cohort two and cohort three on here. We started in 2020 with cohort one and COVID just really unraveled us, but it ended up being great. We extended that cohort for a few extra months and then CDPEG gave us more funding. So it must have been all right. But you can see kind of our spread. We had a better spread and cohort three, but we did hit some high area needs in cohort two. And that's all I got.

JENNIFER HALFACRE

And I'm Jennifer Halfacre, I am a practice facilitator. And I work on IMPACT which is improve access coordination and treatment for brain and behavioral health, which we call IMPACT BH because it's just a big mouthful of a thing. This is, this is kind of a carryover from ICWV. That one was considered a success. So we have another project that we started with, this one has a little bit different flair where it's really focused on the community. So we, he project is pretty small. It's only five practices and it's in a specific, it's in the mountain community and I'll show you a map here in a minute. We started in March of 2022 and we should be completing work in June of 2024. And like I said, this is really around the community and making it kind of wrapping around the patients to make sure they have everything that they need from hospitals to navigation to pediatric care for the baby after they're born, that the one that the parenting person goes on to primary care afterwards.

And really just kind of for sustainability, making sure everything was set up in the community. So some of our practice facilitation strategies: we have monthly meetings and we have what we call a milestone attestation checklist, which is just kind of a MAC it's kind of those things that Kathy talked about the structure of high performing practices that they can continue. Facilitation is mostly virtual, really kind of due to the practice choice, but there is some in person. We use quality improvement strategies. CQMs, we struggled a little bit with CQM wise, our practices aren't paid to participate in this project specifically. So we kind of have a new strategy for our last year, kind of made it a little bit easier for the practices. And I think we'll get some good data. Community coordinator is new also for the sustainability. Here's some of our outcomes. We did do some surveys for the practice for practices and it was very, very successful. They agreed that it was improving their care. They approve, they agreed that it was the work that they needed to be doing and they agreed that it was like they would recommend us to a colleague. And then this is just kind of our map. We had growth in pretty much every area. One was just kind of sustainable service coordination since it was, they're all in the mountains are very tight knit community. And then here's our map. We have five clinics but they're kind of two were all in kind of the same area. You can see we're all in the mountain area and Then I'll also talk about FAST, which was facilitating alcohol screening and treatment. This was funded by AHRQ and Colorado was one of six sites nationally that was chosen. It was really to increase Colorado's efforts to address unhealthy alcohol use and to improve screening, brief intervention and referral to treatment. We have 43 practices complete FAST. We started in June of 2020 completed that this last March and really it was helping practices identify unhealthy alcohol use or potentially unhealthy alcohol use patterns. And we use evidence based interventions. They had six sessions and then they, with their practice facilitator, then they would do three months of work and then the practice facilitator would come back and kind of do final assessments see if things were sticking sustainability wise. Everything was virtual. And then PFs were randomized into either e-learning or practice facilitation only. They had e-learning and PF or PF only. The sessions kind of were the same. They covered the Esper MAT team based care. There was space for pre and post planning. The resources were available to every practice and then here are some of our data. As you can see, like the numbers might be a little small for you guys, but like we had a huge, huge growth in screening huge growth. Obviously, when we're screening more, we found more positive patients. And then also the brief interventions was a huge jump as well. And then here was our map of everybody in, in Colorado as well. That kind of did. We had a pretty good spread. Same thing we're missing a little on the eastern half, but it's a pretty...not as many were populated there. And here are some of our future initiatives. We're going to continue. We have state Medicaid funds for the six building blocks. We have pain management conferences for CU, the CU Family Medicine Practices. We have a new state project that's funding behavioral health and SUV care. We have Impact BH which is entering its last year. So we're not sure if they'll continue to, we're not sure what's gonna happen with that, but we still have another year left. And then we have ISM is anticipating more funding and Esper is really, is really supported in Colorado with virtual and in learning trainings. Now I pass it back to Monika.

MONIKA SARAN
Thanks. So now I want to get to the part where we learn about your guys' work and in your community. So I'm gonna pass on some questions to you. But first does anybody want to talk about the substance use disorder work that you're doing as a practice facilitator in your community? Your experiences?

AUDIENCE MEMBER
Sure. We got a big NIMH grant to do a collaborative care for opioid use disorder and co-occurring mental health disorders in primary care. And wow, we couldn't find patients in primary care clinics unless that clinic was known for treating opioid use disorders. They just, patients weren't gonna be honest on their screens or they just weren't going there and they're like, Oh, I, my friend goes to the methadone Clinic. So I'll go to that. So it was a big eye opener that our screening and primary care for opioid use disorder did not work.

MONIKA SARAN
OK. What state were you? Where are you, where are you from?

AUDIENCE MEMBER
Oh, I'm in University of Washington, but we tried this in states all over the country.

MONIKA SARAN
Did you guys test out or implement any changes to try to address that?

AUDIENCE MEMBER
Yeah, we changed the screener that we used to be two questions rather than 4, to much more slang language questions. I think we saw some improvements there but again, it was just the clinics. If they were known to treat it already, then we were finding patients and if they just, people don't even know what cefaxone is. Yeah, that's what we found. The education and the stigma around it where we have

MONIKA SARAN
to get through that big hump for sure.

AUDIENCE MEMBER
Stigma is a giant part of why our screening fails. That's one of the things we're really focusing on too in the projects is the stigma and sort of talking with practices about really looking at their own implicit biases around people who use substances. And I'm totally going to borrow your empathy mapping. I feel like I zeroed in on that, oh, that would be such a great exercise to do with practices and put the patient in the middle. What might they be seeing? Feeling, et cetera, et cetera. So that, that stigma is very, very hard but such a necessary thing. And I think as practice facilitators, we have a unique seed for that. You know, we can, we can sort of see the hotspots and the flare ups in practices when we go in there and we can see where they would maybe benefit from some trainings and resources.

KATHY CEBUHAR
So yeah, we, we have quite a few on our website and so great and plug for the next session. We're doing our DEIA chat next. Yeah, so, yeah. Ok.

MONIKA SARAN
Ok. I just got a time warning. So the next question you want to hit on a few, but you guys, what are the harm reduction strategies or resources that are available in your communities? Do you have any that you can that are available already or you wish were available?

AUDIENCE MEMBER
You know, of any in Colorado, some counties will send you naloxone for free if you sign up for it, we have a standing order of pharmacies to go pick it up. Anybody can grab it or is that common or what's

MONIKA SARAN
happening in your area?

JENNIFER HALFACRE
That's why we're trying to normally, right? Everyone should carry it too. I feel like it's for everybody. It just means like there's, we've had a lot of clinics that just put it in the waiting rooms now too or like in the waiting room or in the exam rooms because like we've had people like the IMPACT since it's perinatal, you know, like sometimes provided, we were like, we didn't really want to prescribe it since it's part of the record. And if it gets subpoenaed in custody battles, like the people were very nervous about it. So they just started stocking like that. We have a Colorado lockdown project. So we just, they just stocked it in the room. Yeah. Or they can take it as they want.

AUDIENCE MEMBER
Coming from Massachusetts, I'm increasingly seeing more visual, I think kind of prompts for people, more people to carry it. I'm not sure whether I'm hearing as much it's spoken out loud. But visually, I feel like, you know, around town, of course, at the medical centers, et cetera, seeing more , of the reminders of theirs to carry. I'd echo that in Chicago too. I feel like I, I see the words but I don't know that I've heard a lot. Yeah.

MONIKA SARAN
How about fentanyl testing strips? How accessible are those in your communities? Not very or unsure?

KATHY CEBUHAR
Yeah. And so that's like part of our education. We're on this total like soapbox mission. Finding what those resources are in your respective communities are super essential. And again, as practice facilitators, I think it's great that if we take this knowledge to our practices and whether or not they're, you're working with them specifically on SUD, maybe

just plant the seed about, What are you doing to carry? Naloxone. How do your patients access fentanyl testing strips? How, how do your patients get clean cookers? Do you know if they do? Do you have harm reduction centers in your community that you can point patients to? because people need these, these resources. OK. Sorry. Problems.

MONIKA SARAN
Well, so I guess our next question is related to that. I know that we mentioned that maybe we're unsure but do any of, you know, if your practices are stocking naloxone or what patients would do to be able to access it?

JENNIFER HALFACRE
Something I have on the six building blocks website is I created a naloxone printout for doctors and patients and they can just leave that in the exam rooms and it tells them where they can access it or other resources that they might need. And I think that's been helpful.

MONIKA SARAN
I guess our last question before we sort of go in, we'll show you where to get those resources that we're talking about as well. But what resources would you highlight that you need the most?

KATHY CEBUHAR
That's a two-parter for me: as a PF what resources do you feel like you need specifically? And then what do you think your practices need?

AUDIENCE MEMBER
Conversation scenarios would be helpful.

MONIKA SARAN
Ok.

AUDIENCE MEMBER
Practice facilitators, you're probably speaking with a lot of different people about this to get this as a normalized. And so what kind of conversation, what words do you use? Having a script I think would be ok.

MONIKA SARAN
Great.

AUDIENCE MEMBER
Yeah, I think that I like the idea of naloxone for everyone. Everyone. Is it, it doesn't mean that you use it or?

KATHY CEBUHAR
Right. Yeah. It's doesn't matter. There's no shame it's not being there.

AUDIENCE MEMBER
I could just put it on my [inaudible]. Yeah. Yeah.

KATHY CEBUHAR
You said you naloxone.

MONIKA SARAN
Ok. I did wanna highlight the QR code that will lead to the practice transfer--innovation team website that has some of the resources that you were talking about earlier. So you guys can definitely look for that on your phones and there's also the contact information for the team if you want to reach out. Thank you guys for listening and also please complete your evaluations that I believe you'll get after this. So, for our presentation. Yeah, thanks.

LAUREN QUINTANA
Thank you.