Building Blocks for Successful Care

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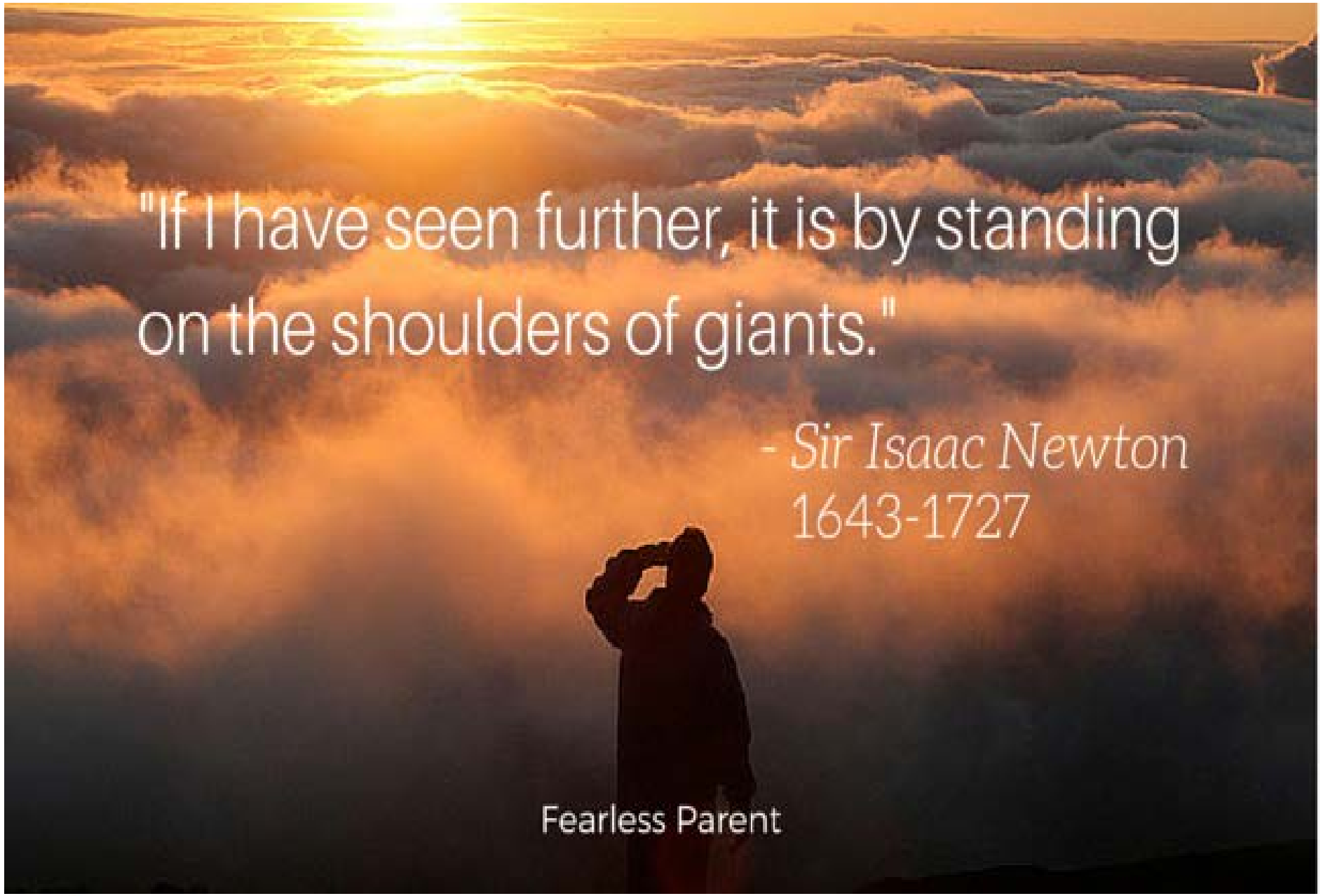
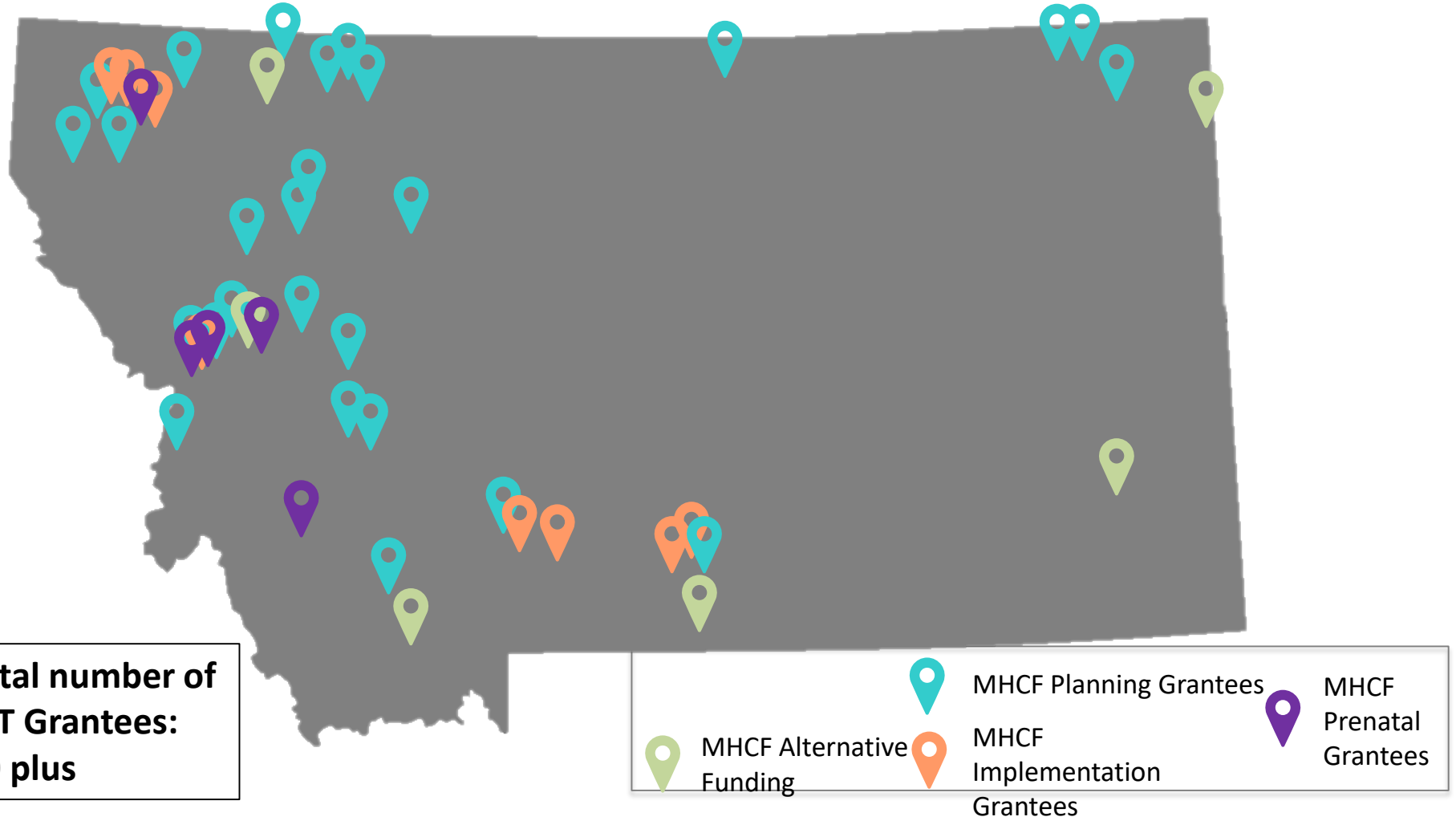
Agenda

- Introduction: building on IBH in Montana
- Components of the approach
- Thinking about culture change: addiction, recovery, and trauma informed care/approaches
- Building the clinical and practice team
- Plan for tomorrow


"If I have seen further, it is by standing on the shoulders of giants."
- Sir Isaac Newton
1643-1727
Fearless Parent

Where have we come so far?



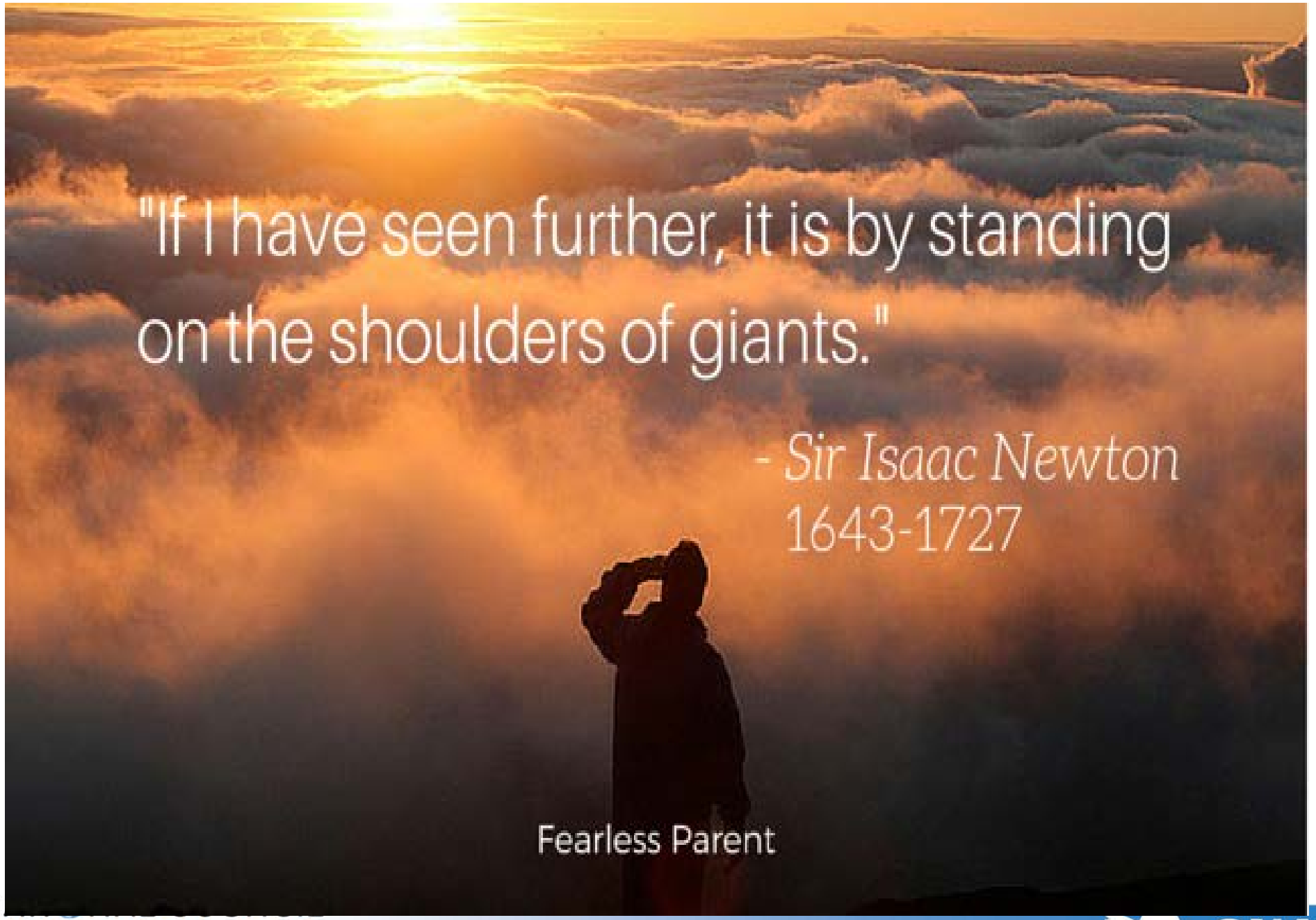
Total number of MT Grantees: 50 plus

What have we learned?

Incredibly simple….

Infinitely complex.

Why is that?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Required Elements

- a. Prenatal providers adopt the routine practice for all prenatal patients of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use disorders (SUD). Training will be provided by MHCF.
- b. A prenatal practice in your community develops a team that includes a behavioral health provider with SUD experience, such as a LAC or LCSW. This team will have the ability to do a “warm handoff” (i.e. immediate, same-visit referral) from a prenatal care provider to the behavioral health provider, and the ability to provide assessment and initial treatment for both SUD and mental illness diagnoses;
- c. The grantee leads development of a community-wide approach to perinatal SUD. This includes leading development of a referral or coordination approach with other prenatal practices in the community. In most cases, the grantee will take the lead on caring for pregnant women with SUD. Successful applicants will demonstrate active collaboration with and a specific referral approach to serve women in other practices in the community.

Required elements (continued)

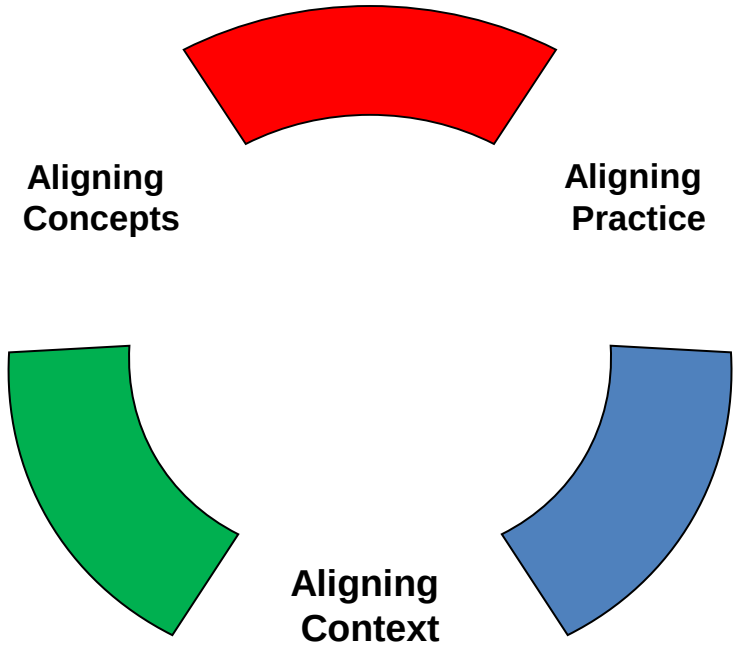
- d. Care coordination that addresses social factors that impede treatment, such as housing, transportation, and family violence.
- e. Medication-assisted treatment (MAT) for opioids and other substances per clinical guidelines for treating pregnant patients.
- f. Outcome tracking using a registry or other clinical data system.
- g. A scope of practice and care pathways that clearly defines when to treat, when to consult, and when to refer individuals to higher levels of SUD treatment.
- h. Referrals to higher-level SUD care (such as inpatient or residential care) when warranted.

All this requires change…

Change requires intentional planning and approaches

One Way to Think About Change:

- Aligning Concepts: Changing how we think
- Aligning Practice: changing how we do our work and talk about our work, bringing vision into action
- Aligning Context: changing regulatory environment, policies and procedures, community support systems in support of the vision and transformed practices.



The nature of the change: Key building blocks: concepts, practices, context

Communication

Collaboration with tribes or UIHC

Sustainability

Clinical team

Community team/ community needs

Recovery oriented, trauma informed, wellness approaches (conceptual and culture change)

Moving to shared understandings of addiction, recovery and trauma informed care and practices

- How do we think about addiction?
  - What are our own internal biases?
- How do we think about substance use in pregnancy?
- Do we believe recovery is possible?
- What is the vision for the change?

- Understanding of medication assisted treatment/recovery
- Understanding the impact of trauma on how a woman seeking care might feel:
  - Historical trauma and its impact on approaching care providers
  - Internalized stigma: broken trust
  - Trouble believing in others
  - Childhood trauma, adult on going trauma

My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.

-- Outreach Worker (Quoted in White, Woll, and Webber 2003)

Addiction is…….

- **not** a moral or spiritual failing
- **not** lack of will or responsibility
- **not** a character defect
- **not an addictive personality type**
- **does not** have personality components such as denial, rationalization, evasion, defensiveness, manipulation, and resistance or any abnormally robust defense mechanisms

1.https://store.samhsa.gov/shin/content//SMA13-4212/SMA13-4212.pdf

How has addiction treatment changed?

- Short-term acute interventions vs. chronic disease (recovery) management model
- Relapse is a part of the disease, **NOT** a failure
  - Similar to other chronic diseases, addiction often involves cycles of relapse and remission
  - Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death

Chronic Illnesses:
Relapse and Compliance Rates

W. White

Addiction/Chronic Illness	Compliance Rate (%)	Relapse Rate (%)
Alcohol	30-50	50
Opioid	30-50	40
Cocaine	30-50	45
Nicotine	30-50	70
Insulin Dependent Diabetes		
Medication	<50	30-50
Diet and Foot Care	<50	30-50
Hypertension		
Medication	<30	50-60
Diet	<30	50-60
Asthma		
Medication	<30	60-80

O'Brien CP, McLellan AT. Myths about the Treatment of Addiction (1996). The Lancet, Volume 347(8996), 237-240.

Treatment: Same but Different

- Treatment is better than no treatment
- Rapid admission improves treatment engagement (warm handoffs, ready availability of BH)
- No single approach is most successful for all (clinical team, multiple interventions)
- Detox alone is not effective
- Effectiveness: enhanced by access, retention in treatment, readiness to change, **client satisfaction**

Treatment – Different?

- Focused on counseling
- Focused on behavioral therapies
- Focused on interventions to ENHANCE readiness to change and engagement (motivational interviewing, brief intervention)
- Medications combined with Interventions (MAT+clinical team)
- Individualized –duration, intensity, lengths of care
- Address multiple co-occurring disorders (screening for depression and anxiety along with substance use)

Outcomes – Different?

- Longer engagement in care = better the outcomes
- Require long-term and/or repeated interventions to reach their goal
- Relapse – lapses – it's ok and to be expected (supporting continued connection)
- Involve Social Supports - family, friends, naturally occurring recovery support, community partners
- Attend to social determinants of health

Substance Use in Primary Care

- We ***now*** understand that addiction is a complex disease which impairs brain functioning.
- Treating addiction as a **neuro-behavioral disorder** is an opportunity to improve the effectiveness of addiction treatment.
- **To support recovery we move** beyond and leave behind the moral outrage and judgements that people are addicted because of character and behavior flaws.

Defining Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Embracing Many Pathways to Recovery

- All patients are offered appropriate MAT
- Patient Centered Care: All patients have an option of any of the appropriate medications to treat SUD. There are pros and cons to each. There should be consideration of where they are in life, phase of treatment, and what the patient needs
- Not all patients will accept MAT, what else is o the menu?
- Effective treatment requires patient buy-in and recognizes their context and influences—start there and walk together

Crosswalk: Recovery and Trauma Informed

Recovery	Trauma-informed
Authenticity of recovery experience and voice	Empowerment, voice, and choice Safety
Recovery visibility and accountability	Trustworthiness and Transparency
Leadership development	Peer Support
Cultural diversity and inclusion	Cultural, Historical, and Gender Issues
Participatory process	Collaboration and Mutuality
Strength-based perspectives	Empowerment, Voice, and Choice
Peer support, volunteerism, and service	Peer Support

The heart of trauma informed practices?

- "Look for what happened to you" and What's strong in you rather than what's wrong with you?
- Understand impact of adverse childhood experiences on health and behavior
- Practice "radical hospitality"

Building Block Two: the clinical team and making it work

The clinical team

A prenatal practice in your community develops a team that includes a behavioral health provider with SUD experience, such as a LAC or LCSW. This team will have the ability to do a "warm handoff" (i.e. immediate, same-visit referral) from a prenatal care provider to the behavioral health provider, and the ability to provide assessment and initial treatment for both SUD and mental illness diagnoses;

MONTANA HEALTHCARE FOUNDATION

Building the comprehensive team: inside

The Team as an Emerging Standard of Care

"The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system."

Source: Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.5.

Cochrane Review of "Shared Care"

"Results from a few of the studies suggested that shared care may be more effective in certain patient groups. These include patients with depression and other serious chronic mental health illness and those with high levels of morbidity at baseline such as the elderly and people with moderate to severe congestive cardiac failure."

Source: Effectiveness of shared care across the interface between primary and specialty care in chronic disease management (Review) 13 Copyright © 2007 The Cochrane Collaboration., JohnWiley & Sons, Ltd

The clinical team exists in a context: strong yet fragile

- Engagement and education from the front door to the back
  - What education does everyone need?
  - What supervision and support?
  - Clear understanding of roles and importance of role
- The power of activated teams: what we know about team based care
- Practices that support team development:
  - Huddles
  - Physical layout
  - Clear processes for connection and warm handoffs
  - Informal communication: “bumpability”
  - Formal team meetings, formal practice meetings
  - Team analysis and management of functioning

Tomorrow

- Building community partnerships:
- Practices to support implementation
  - SBIRT: Pam Pietruziewski
  - The role of data in managing change
  - Building a communication plan
- The role of the implementation team and managing change
- Team and stakeholder reflection and planning

Building Blocks for Successful Care: Activation and Implementation

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Agenda

- Who the grantees are
- Building community partnerships:
- Practices to support implementation
  - SBIRT: Pam Pietruszewski
  - A menu of options: peer support, group support
  - The role of data in managing change
  - Building a communication plan
- The role of the implementation team and managing change
- Work plan key elements
- Team and stakeholder reflection and planning

Quantitative Data

Current Perinatal Data Outcomes					
		grantee 1	grantee 2	grantee 3	grantee 4
	How many years of data are you reporting on?	2.5	2	2	2
	The average number of deliveries at the	484	1158	269	1400
Outcome #1: Infant Drug Screen Data	Number of infants screened for drug exposure:	0	93	24	167
	The number of drug positive newborns:	0	60	21	121
	neonatal drug screen:	0.0%	5.2%	8.0%	8.6%
	Average length of stay for drug positive newborns, in days:	4	15	5	10.74
Outcome #2: Neonatal Abstinence Syndrome	Percent of newborns diagnosed with NAS:	0%	4%	4%	7%
	Number of newborns diagnosed with NAS:	0	50	10	97
	diagnosed with NAS, if treated in your hospital, in days (If you refer all NAS infants to another facility, enter "0"):	0	16	5	27
	level of care for NAS:	0	0	2	0
Outcome #3: Prenatal Care	hospital who received adequate prenatal care (defined as prenatal care begun by the 4th month of pregnancy, and >80% of recommended visits received):	0%	48%	83%	10%
Outcome #4: SBIRT	Percent of prenatal patients receiving	0%	0%	0%	0%
Outcome #5: Child Protective Services	to your facility who are removed by child protective services:	0%	2%	1%	5%

Work Plan Elements

- Begin offering an integrated, team based model of clinical care for pregnant and post-partum women with SUD
- Implementation of SBIRT as a routine part of prenatal care for a majority of patients in the community
- Establish specific treatment targets and manage outcomes using disease registries
- Begin meetings of the community team which will effectively collaborate to manage the care of women with perinatal SUD
- Implement a scope of practice and care pathways that clearly define when to treat, when to consult, when to refer individuals to higher levels of SUD treatment
- Develop a system of care coordination and other measures to effectively address the unmet social needs of pregnant women with SUD
- Complete a sustainability plan for transitioning the program to stable, non-grant funding sources by the conclusion of the MHCF funding (must be completed by month 18)

National Council Technical Assistance

Implications for Child Welfare

- Assertive Linkages
- Assessment of Recovery Capital
- Mobilization of Natural Supports
- Relevance of Recovery Planning
- Graduated Sanctions

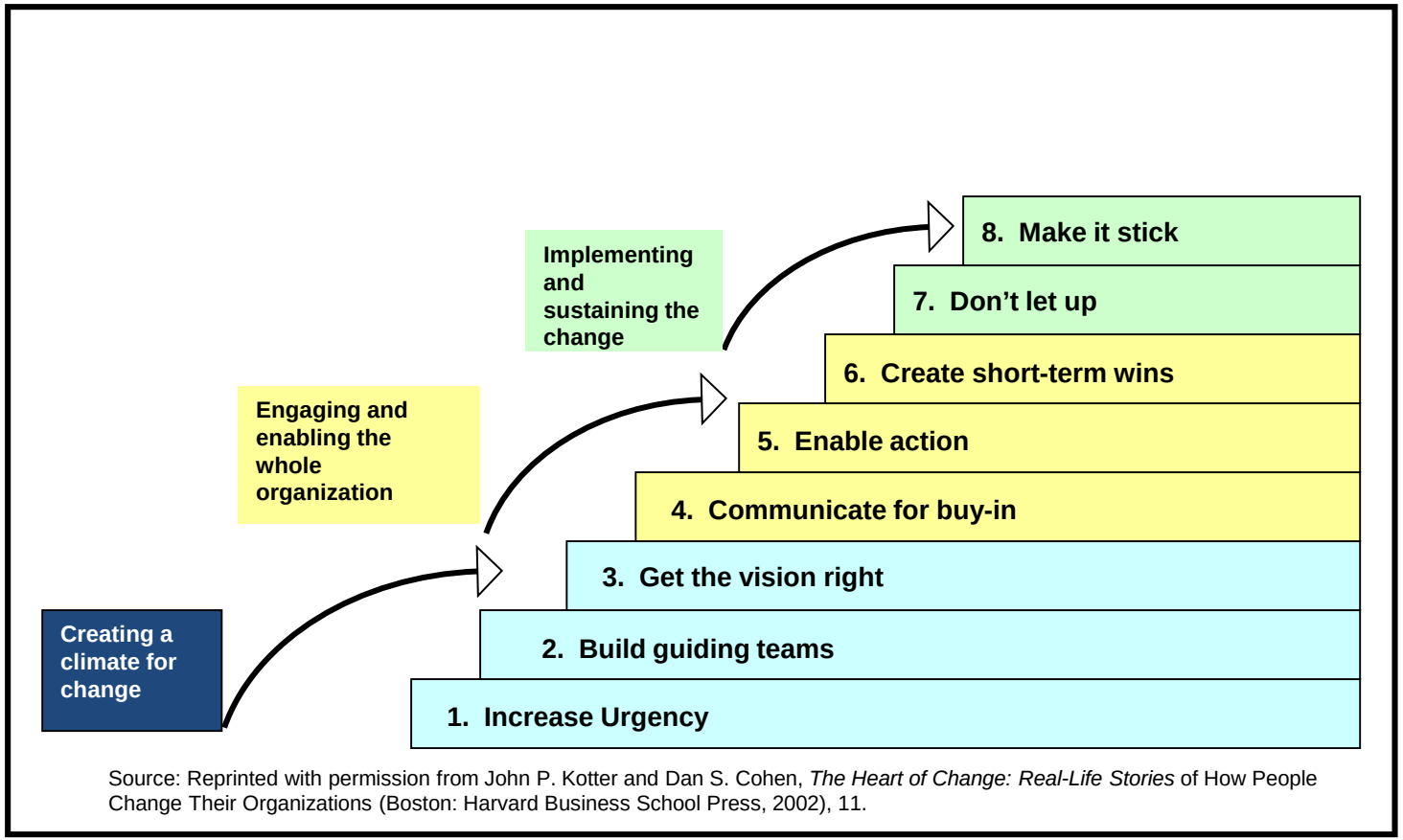
- Peer based recovery supports (doula)
- Parenting education for trauma informed parenting
- Data…how does data drive care, what data drives care?

Cooperation – Talking about the Work

"**Cooperation** is the process of working together to the same end, usually for the betterment of the community."

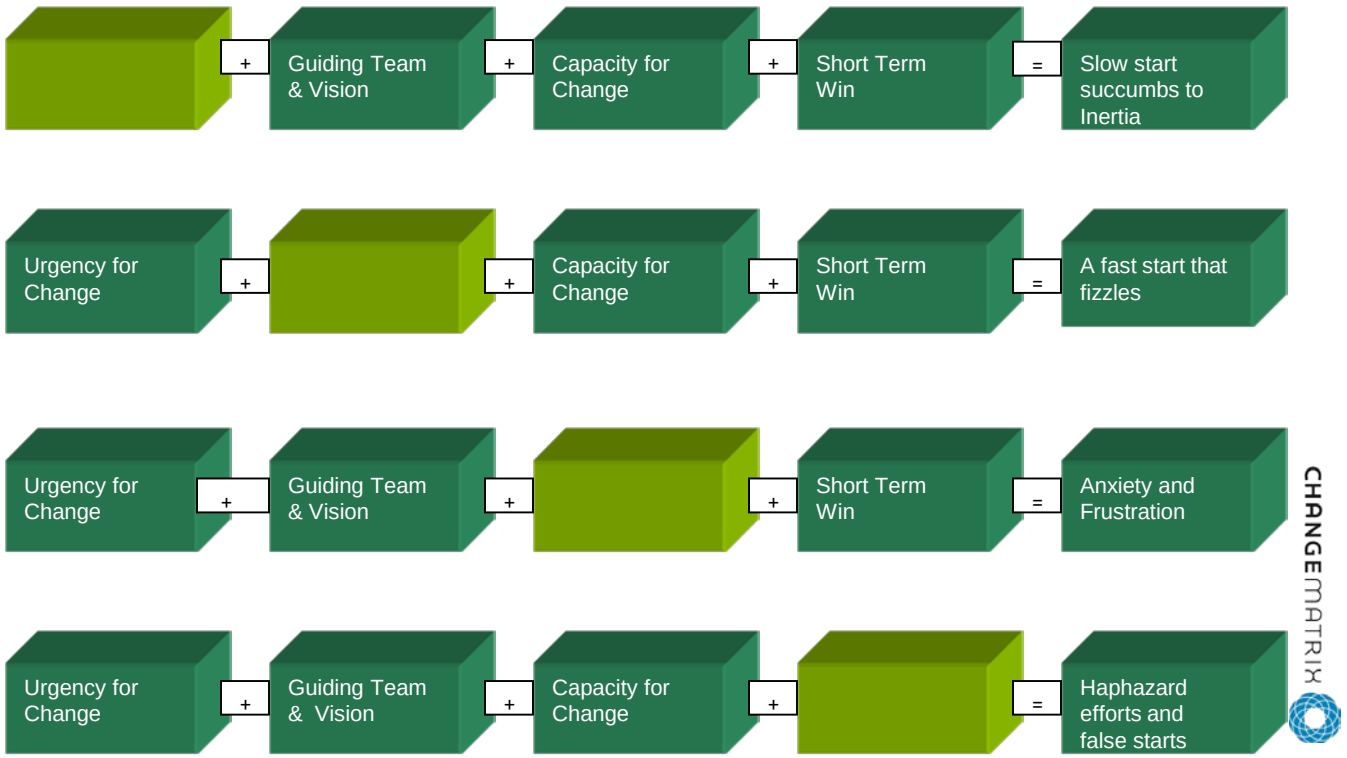
- Community meetings
- Task force / committees
- Alliances / membership
- Idea-oriented

Eight-Step Process for Leading Successful Change



Source: Reprinted with permission from John P. Kotter and Dan S. Cohen, *The Heart of Change: Real-Life Stories* of How People Change Their Organizations (Boston: Harvard Business School Press, 2002), 11.

When Leading Change…Every Step Matters



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Collaboration – Planning the Work

"**Collaboration** is a purposeful relationship in which all parties strategically choose to cooperate to achieve shared or overlapping objectives."

- **Voluntary**
- Built on the strength of the relationship between leaders
- No financial benefit (initially)
- Action-oriented

Partnership – Doing the Work

“Partnership is a collaborative relationship between two or more parties based on trust, equality and mutual understanding for the achievement of a specified goal.”

- **Equality** is a key feature of the relationship.
- There is a shared goal / objective.
- Involves risks as well as benefits.
  - Financial dependencies
  - Outcome dependencies
- Shared accountability
- Goal is attainment of stability

Essential Components of Partnerships

Executive Leadership

- Continuous leadership involvement.
  - Continuing to meet when things are going well
  - A change in leadership may significantly impact the partnership
- Shared interpretation of partnership goals.
- Consistent focus on the vision / values.
- Data indicating outcomes / benefit.
- Everyone doing what was agreed upon.
- Ability to share information (Business Associates Agreement)
- Shared communication to the community.

Essential Components of Partnerships

- Clinic level partnerships
  - Getting the staffing right
  - Communicate expectations and roles clearly
  - Daily huddles
  - Seamless communication
  - Shared messaging
  - Shared decision-making
    - Deliberate open communication with consumer

Create a Steering Committee

- Executive participation is a must
- The Steering Committee is the keeper of the vision
- Create a timeframe that is realistic, not reactive
- Build a team of “do-ers”
  - Executives are not day to day “do-ers”
- Give the “do-ers” the time and responsibility to get it done
- Remove barriers
- Stay involved with monitoring the timeframes / outcomes
- Start up is different than ongoing, so there will need to be different financial considerations after Year 1.

Workspace:

- Each grantee team and their community partners gather at designated tables and identify:
  - 3 most important take aways for your teams as you get started.
  - 2 concrete action steps you will take in the next 30-60 days based on what you have heard over the past two days. These need to be written down and give Joan one copy of your action steps.
- For those of you who are not from grantee teams or communities:
  - DPPHS and other state stakeholders: Identify potential areas that require your planning/attention based on the past two days
  - Others: share around a table what your key take aways are

Workspace: report out

- Hear from each of 4 grantees
- Other comments/questions/discussion

Concluding comments and next steps