Integrated approach to care:
SUD Prevention & Healthcare Partnership

- Mindie Smith, MA LLP CAADC, SWMBH Director of SUD and Integrated Care
- Danielle Sielatycki, Exec. Director, Prevention Works Inc.
- Achilles Malta, SWMBH SUD Prevention Coordinator
Eye-opening stats to start:
Stat #1

US population: 321 million! Approximately how many people in the US do not have health insurance?

When poll is active, respond at PollEv.com/achilesmalta893 or send ACHILESMALTA893 to 22333 once to join.
Eye-opening Stat: #2

How many people in the US are estimated to have a SUBSTANCE ABUSE DISORDER (alcohol and/or other drugs)?

When poll is active, respond at PollEv.com/achilesmalta893
Text ACHILESMALTA893 to 22333 once to join

- 10.6 million
- 21.5 million
- 13 million
- 17.6 million
- 5 million
Eye-opening Stat: #3

What is the average # of units (ex. pills) of Rx. Opioid meds per household in the State of Michigan?

When poll is active, respond at PollEv.com/achilesmalta893  📞 Text ACHILESMALTA893 to 22333 once to join
Eye-opening Stat: #4

How many people in the US are estimated to suffer from ALCOHOL abuse or dependence?

When poll is active, respond at PollEv.com/achilesmalta893

Text ACHILESMALTA893 to 22333 once to join

7 million
10 million
5 million
17 million
13 million
Eye-opening Stat: #5

What is the average number of DOCTOR VISITS per year, per person in the US?

Respond at PollEv.com/achilesmalta893
Text ACHILES MALTA893 to 22333 once to join, then A, B, C, D, or E

| 0.7 visits | A |
| 4.1 visits | B |
| 2.5 visits | C |
| 3.3 visits | D |
| 1.3 visits | E |
• Please get out your phones...

• **Text Number (To):** 22333

• **Text Message:** Achillesmalta893

This will allow you to join the poll

Text **ACHILESMALTA893** to **22333** once to join,
Eye-opening Stats (Answers)

Q1: US Population: 321 million! Approximately how many people in the US do not have health insurance?
Answer: **35.3 million** (11.0%). Source: Gallup - [http://www.gallup.com/poll/193556/uninsured-rate-remains-historical-low.aspx](http://www.gallup.com/poll/193556/uninsured-rate-remains-historical-low.aspx)

Q2: How many people in the US (12 or older) are estimated to have a Substance Abuse Disorder (alcohol and/or other drugs)?

Q3: What is the Average # of units (ex. pills) of Rx. Opioid Med per household in the State of MI?
Answer: **166 units (equivalent of 5.5 bottles)**. Data: MAPS 2015 (Data Study: SWMBH)

Q4: How many people in the US are estimated to suffer from alcohol abuse or dependence?

Q5: What is the average number of doctor visits per person, per year in the US?
WHY?

• We work out of a ROSC Framework
• Knew we could/should reach more people than we currently were
• We were trying to work with physical health and providing integrated interventions
• Prevention is not just for youth and is not just in schools anymore
• Using Prevention to advance the stage of change
WHAT?

- We asked for proposals for Prevention interventions in Health settings
- Must use an Evidenced Based Practice
- Creativity encouraged
- Needed Health practice buy in
Why Prevention and not TX as the SUD discipline for an integrated care effort with Primary Health Care Provider (PHCP)?

1. Non-threatening nature of a Prevention Intervention (PHCP: “Patients are more likely to participate if presented with the option of attending a class on information about how people develop drug problems”)

2. Interactivity of the Class and the use of Motivational Interviewing techniques (built into the PFL curriculum)
Selling Points of a Prevention Class, as explained by PHCP to patient:

a) This is not treatment
b) Class will be held right here on site
c) I (PHCP CM) will be around
d) This class will help you better understand:
   • How “people” develop SA problems
   • How to recognize if “a person” has a SA problem
   • Why “people” who have SA problems need help
   • How “people” with SA problems can be helped
Selecting patients for the program

Criteria for selection:
1) Patients who inquire about SA issues (interest) from PHCP Case Manager (CM): PHCP CM maintains a list of patients/inquiries about SA & uses that to gauge a person’s openness to benefit from program)
2) Recommendations from doctors to CM
3) Other: a) Interviews with patients; b) knowledge of needs of patients
Program at a glance:
How does it operate?
Description of SWMBH’s Prevention/Health Care Integrated Intervention

- Patient ID’d by FHC for SUD Prevention Intervention
- Person referred/linked by FHC to PW
- Person participates in PFL (4.5-hour module)*
  - PW staff conducts one-on-one interview using **NIDA Screening Tool (Quick Screen & NM-ASSIST)** at completion of PFL
  - Recommend action/service based on the **NIDA Tool S.I. Index** (& other factors).

* under age 16, consider other age-specific Selective/Indicated EBP

**Review case with Referral Source**

- Lower Risk SI (0-3)
  - Complete minimum Prevention Program (i.e. PFL 4.5-hour module or other)
  - Review case with Referral Source

- Moderate Risk SI (4-26)
  - SI (4-21): Design additional Prevention Intervention Programming dosage (ex. Full PFL)**
  - SI (22-26): Consider referring to full SUD Assessment in addition to Prevention Intervention**
  - Review case with Referral Source

- High Risk SI (≥27)
  - Review case immediately with Referral Source
  - Help make arrangements for a full SUD Assessment

Follow-up completed by FHC

- SI (4-21): Design additional Prevention Intervention Programming dosage (ex. Full PFL)**
- SI (22-26): Consider referring to full SUD Assessment in addition to Prevention Intervention**
- **Review case with Referral Source

- SI (4-21): Design additional Prevention Intervention Programming dosage (ex. Full PFL)**
- SI (22-26): Consider referring to full SUD Assessment in addition to Prevention Intervention**
- **Review case with Referral Source
Critical factors that facilitated development of this partnership effort:

1. Working with/through the behavioral health specialist (CM) of the PHCP
2. Developing a schedule convenient to the PHCP’s schedule
3. Having PHCP host the sessions
4. Having Prevention Partner develop marketing materials for PHCP to use for recruitment of patients
Critical factors that facilitated development of this partnership effort:

5. Incorporating creative incentives to ensure participants completed program
6. Recruiting participants: Effort conducted by the PHCP (CM, staff)
7. Referral back to PHCP at the completion of program for follow-up on recommendations made by Prevention staff.
Outcomes of program 2015 (First year of program)

a. # of participants: 27 (goal: 15): Exceeded goal by 87%
b. # of participants completing the PFL program: 27/27 (100%)
c. # of persons who accepted to participate in an individualized screening interview using the NIDA tool: 16/27 (59%)
Outcomes of program: Immediate Follow-up efforts

1. Of the 16 people who completed screening interview:
   - 3: Obtained a high SI Index/score of the NIDA tool
   - 9: Obtained a Moderate/High) SI score
   - 4: Obtained a Low SI score

2. Action following completion of PFL program:
   - 3 persons referred to residential SUD program
   - 9 person referred to OT (group therapy) services
Outcomes of program:
Follow-up at 9 months:

a. 3 persons referred to residential program:
   • 1 has been able to maintain sobriety;
   • 1 was in recovery for a long time, until she lost her child and the loss served as a trigger for relapse (currently looking for a residential program).
   • 1 person came out of program doing better: No longer uses heroin, but does smoke marijuana; has maintained contact with CM and has recently joined a community services organization as a volunteer.

b. 9 persons referred to OT: All 9 have done "quite well" since completion of SUD services; some relapses but, overall have done much better than before (all 9 continue to maintain contact with CM)
SWMBH Integrated Care project using Prevention as the primary SUD discipline

Q&A

• Additional Resource: Link to NIDA Quick Screen V1.0 and NIDA-Modified Assist V2.0
• Contact e-mail: Achilles.Malta@swmbh.org