HealthierHere

Public Health Seattle & King County

Medication Assisted Treatment (MAT) Care Transformation for King County Communities

Process Evaluation of Year 1 (2020/2021)

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Background

In 2019, HealthierHere issued Requests for Applications (RFA) for "Medication Assisted Treatment (MAT) Care Transformation for King County Communities" – one of the Innovation Fund areas sponsored that year. The goal was to fund programs designed to help reduce the care gap for individuals with Opioid Use Disorder (OUD) who have received a Medication Assisted Treatment (MAT) induction in an Emergency Department (ED) or jail, by enhancing warm hand-offs and reducing barriers for individuals to continue their MAT with community-based, low-barrier MAT providers.

The programs proposed by Public Health Seattle & King County (in partnership with Navos) and Country Doctor Community Health Centers (in partnership with Sound and HEP) were selected to be funded.

$595K awarded to organizations in King County

2 programs selected to be funded

2 years of funded activities

Partnership

For grantees, **benefits of being in partnership** include: (i) being able to expand the services provided, (ii) working towards the goals of the MAT Innovation Fund, (iii) testing the desired change of placing a behavioral health specialist in the medical clinic, (iv) exchanging knowledge and resources and improving processes by doing so, and (v) having partner's support to achieve organization's goals.

On the other hand, the **drawbacks** include (i) not having full control over implementation – e.g. hiring process or how services are provided at partner's organization; and having challenges with communication, documentation and coordination - some of which were accentuated by the fact that partners had different electronic health record systems.

> Having healthcare systems that meet patients where they are, whether that be their status of drug use, the time of the day, their physical location... When someone shows up in our project, they don't have to go to 5 different places for services, so that increases the likelihood that people will engage in services. And I wonder if we were to disseminate this all over the US, how much money would we save? How many referrals would be completed? How many people's lives would be dramatically changed faster? And how much money would be saved?
>
> (MAT Innovation Fund grantee)

What factors supported implementation?

- **Teamwork:** having good collaboration, good communication, and team members willing to adapt.
- Having highly **skilled and multidisciplinary teams.**
- Having **champions** at multiple levels in each partner organization.
- Having the **same person as project lead** throughout the project.
- Having **training** for newly hired staff, particularly about the EHR systems.

What factors *could have* facilitated implementation?

- Having a **learning community, a support network or a mentor** to provide guidance throughout the project as part of the grant.
- Having a project lead or project manager to help the team think through how to do **continuous quality improvement.**

What were the main challenges?

- Due to COVID-19, the **number of referrals dropped** as people were not comfortable going to clinics and avoided accessing services.
- The COVID-19 pandemic led organizations to shift focus. It delayed hiring, **reduced staff availability**, created logistical challenges**, increased administrative work** and overall burden for staff.
- The **lack of a shared electronic health record (EHR) system** was reported as a huge barrier. It made it challenging to track referrals and outcomes across both partners, making care coordination more difficult and time-consuming.
- Interagency **coordination** with collective decision making, hiring and overcoming differences in organizational culture was a challenge.
- It was challenging **navigating multiple partnerships** at the same time (primary care partner, behavioral health partner, and referral partners).

What made grantees feel like celebrating?

- Being able to address the needs of clients.
- Implementing proposed activities successfully.
- Having a whole person approach to patient care.
- Having staff be enthusiastic about their role in the project and see the value to patients.
- Collaborating with partners and building on each partner's strengths to serve clients.
- Overcoming data sharing challenges.
- Patient success stories.
- Getting positive feedback from patients.

> ...we receive direct feedback from a number of our patients saying that they come here because they know us, they feel comfortable here, and they feel supported and cared for. And I think this role [of care navigator] has helped augment that.
>
> (MAT Innovation Fund grantee)

> We got together because of the innovation fund and now we are partners, and we work together in new and different ways that may not have happened otherwise without the Innovation funding.
>
> (MAT Innovation Fund grantee)

What were some of the lessons learned?

- **Hiring:** (i) Before starting the hiring process, it is important for partners to thoroughly discuss the work to be done, qualifications and experience or education needed to do the work, and how the new position would fit into current job classes that exist within the organizations. (ii) Hiring a substance use disorder (SUD) specialist for the navigator position is not viable: working as a navigator in the primary care clinic would not allow the newly hired to count their work hours toward their licensing according to state requirements for a SUD specialist, and that would be a barrier to hiring.
- **Quality Improvement:** It might take a few rounds of testing and adjusting workflows to optimize the use of the navigator.
- **Collaboration**: (i) Integrating different organizational models, with different types of sustainable funding and different documentation systems is challenging. But the challenges are worth it. (ii) When partners do not share EHR, coordination takes a lot of face-to-face care management time. (iii) Partners should plan for how they will document their joint work and track outcomes.
- **Staff**: Having a community health worker staff that has first-hand experience with incarceration helped provide quality services.

Some of the key takeaways from the evaluation

COVID-19 had a significant impact on demand for referrals and on logistical aspects of the implementation of services.

For people releasing from jail, transportation does not seem to be a barrier to accessing MOUD/SUD care, but getting their medication is – given it takes 24h for their Medicaid to get unsuspended.

Issues with accessing partner's EHR were one of the main implementation challenges and drawbacks of doing work in partnership.

Grantees reported learning that by combining the services that each partner provides it is possible to deliver an excellence in comprehensive patient care in ways that one provider alone cannot.

Programs strived for health equity through the activities that were implemented, the communities served, and by having cultural competency. One program had a community health worker who has first-hand experience with incarceration.

Grantees believe that the innovations that were implemented could be scaled up or applied in other contexts, and that it would work well for populations who often receive care in a way that is siloed (e.g. pregnant women) or people with significant psychosocial barriers.

A key factor in making programs sustainable is to have an operational model that includes compensating providers for the time spent on team-based care and coordination.

Inspired by their innovation program, a grantee decided to expedite their own internal pharmacies to begin the process of stocking generic buprenorphine tablets.

A grantee is testing a system to retroactively bill Medicaid for medication given to patients on the day they are released from jail – since Medicaid doesn't unsuspend their account until the next day.