CHAMPS Substance Use Disorder Best Practices Podcast Series
Episode 2: Interview with Dr. Mulvehill and Ms. Larsen, M.Ed., LCPC, LAC
From RiverStone Health
Interview Date: December 17, 2018

Rachel Steinberg: Welcome to the second episode of the Substance Use Disorder Best Practices Podcast Series, produced by Community Health Association of Mountain/Plains States, or CHAMPS. I'm your host, Rachel Steinberg, the CHAMPS Substance Use Disorder Program Specialist. In this series, we're highlighting the many interesting and innovative ways that health centers in Region VIII are addressing substance use disorders. We think the best way to share these ideas is to speak directly with the health center staff who are providing these services and running these programs.

Today I'm thrilled to be talking with Dr. Sharon Mulvehill and Sandi Larsen from RiverStone Health in Montana. Thank you both for being here!

Dr. Mulvehill: Good morning, and thank you so much for having us.

Sandi Larsen: Yeah, we're happy to be here this morning.

Rachel Steinberg: So, can you talk a little about RiverStone and the community you serve?

Sandi Larsen: Well, RiverStone Health is a Federally Qualified Health Center in Billings, Montana. We have a large area that we serve, primarily rural, but we would define our health center as urban – Billings, we're pretty much the medical hub. Our patients make up many types of payor sources. We feel that we have a very robust program, and we serve pharmacy, dental. We also have integrated behavioral health that we're going to talk a little bit more about, and we also have our primary care clinics, which encompass a lot of different programs. So, we're happy to talk a little bit more today about the work that we've done on substance use disorders in our clinic.

Dr. Mulvehill: Good description, Sandi. I'd just like to add that RiverStone Health, as a Federally Qualified Health Center, treats all patients regardless of their ability to pay. So that means, for many patients, this is the only place that they have to come, and it is a challenge for us to provide all the care they need, but we have a lot of resources and work as a team.

Rachel Steinberg: Great, and Dr. Mulvehill, can you tell me a little about your role at RiverStone?

Dr. Mulvehill: Yes. RiverStone is a teaching health center, so we include a residency program in family medicine. My time is shared as Assistant Medical Director of the clinic, and also faculty member with the residency program. So I teach, I see patients, and I supervise residents, both in the clinic and in the hospital.

Rachel Steinberg: And Sandi, what about your role?

Sandi Larsen: I'm a Licensed Clinical Professional Counselor [LCPC] and a Licensed Addiction Counselor [LAC], and I, like Dr. Mulvehill, have a teaching role with our residency and medical staff on behavioral health issues. I supervise a team of nine counselors, and we also work towards just providing care, overall care, integrated into our primary care clinic.

Rachel Steinberg: I know that a lot of primary care providers have struggled – and continue to struggle – to get involved in addressing substance use disorders. Can you tell me a little about how you each got involved in this work?

Dr. Mulvehill: Yes. I think working at a Federally Qualified Health Center for years, both in the clinic and the hospital, and living through what can only be termed "the opioid crisis" has presented me with questions I didn't know the answers to. Reaching out to other providers, I saw a lot of different answers being given – you know, mixed opinions, not good science was quoted – and so the patients were left with a variety of recommendations. And so that really empowered and challenged me, and called me, to go and get additional training. Also, when you see people that get better from a substance use disorder, it's life-changing. It truly saves their life, saves their family, and it's some of the most gratifying work I've actually done in medicine.

Sandi Larsen: My mission for how we provide care has always been to treat the whole person, and I have always felt that substance use disorders are another disorder that patients need to be treated for in a primary care setting. We often were referring patients out for specialty care, which is still needed, but we felt like we wanted to keep our patients in the care of their primary care doctors, their counselors, their substance use disorder counselors. And so that became a passion of mine: to be able to work together as a collaborative team and keep that patient here in the clinic and refer out for specialty care only when needed, so that we could still continue to do a collaborative model and treat patients as a whole person at our clinic.

Rachel Steinberg: I know RiverStone has a really robust SBIRT process – that is, Screening, Brief Intervention, and Referral to Treatment. Can you tell me a little about how SBIRT works and how it got started at RiverStone?

Sandi Larsen: How we got started with our SBIRT process – so really that's, like you said, Rachel, a process to capture those patients that might be struggling or are early on in a substance use disorder – we decided that we would look at how we were doing. We did a little hand audit of charts, we looked at our screening – we've always been doing that. But we found that we weren't where we wanted to be with actual interventions and trying to do some more prevention work. So our process came about to do standardized screening for all of our patients, and then we have a workflow that incorporates even up to our front desk knowing when to give it, our MAs [Medical Assistants], our medical providers, and then an on-site referral to behavioral health when those are positive so that we can have a shared decision-making and a workflow that works quite well in a very busy clinic, because each person on the care team has a role, a specific role.

Dr. Mulvehill: From my standpoint, as a provider, it was a real challenge to balance all the screening we try to do for patients and keep the providers satisfied and able to meet the needs that the patient came in for. An example would be a patient out of their high blood pressure medicine, where we screen them, the SBIRT is positive, and maybe they screen positive for symptoms of depression or anxiety. The provider can be very challenged and overwhelmed with all the material there is to deal with and setting priorities. So, we worked really hard as a team to allow and teach providers to understand that if a patient's mental health is not well controlled you can't get their blood pressure controlled. It's all integrated. It continues to be a challenge, but we really do shared decision making with the patient for the priority for the day, and many times if the patient is not in crisis, it may be better to refill the blood pressure medicine and have them come back the next week. But we've already identified the issues and sort of gotten them scheduled to deal with. So that's been my big problem, is helping the providers on the follow-through for screening.

Sandi Larsen: I would add to that one additional barrier was just coordinating and carving out time to do a lot of training and education. I think that's one of the biggest things to do is have a pretty robust training on how to

have these difficult conversations, how to use MI [Motivational Interviewing], and so before implementation we did a lot of education and training with our medical staff in clinic.

Dr. Mulvehill: Sandi just mentioned MI – I just want to mention for those who might not know and love this wonderful term, that's Motivational Interviewing, which can really help the providers meet the patients where they are and try to nudge them just a little more forward towards wellness.

Rachel Steinberg: Dr. Mulvehill, you've said before that poly-substance use is the norm in your community, and I know RiverStone is doing some interesting work around Medication Assisted Treatment for substance use disorders other than opioid use disorder. Could you talk a little about that, especially what makes that kind of treatment different?

Dr. Mulvehill: Sure, Rachel, and thanks for that question – that's actually a great question because, you know, what's evolving in the nation is the science on addiction disorders. And what is does is classify substance use disorders into a big box. And so, then you, as a provider and as a behavioral health provider, you look at what is their main drug of abuse and target your main therapy on that. In addition, we try to – to the best of our abilities – identify if the patient has a mental health condition that preceded the substance use disorder, and if so that needs to be treated concurrently. In many cases patients develop a variety of mental health symptoms after starting with substance use disorder, including anxiety, some people will have thought disorders, etcetera. So when you identify the main substance of abuse, then you look at what works for that substance. In many cases, patients have a predominant substance that they would prefer to use, and that's where we mostly target our therapy. About a year ago we began a very robust treatment for alcohol use disorder. Using our SBIRT screening we identify patients that are appropriate for Medication Assisted Treatment [MAT] and evaluate them and get them started – and this occurs with behavioral health treatment and support so that there is a robust attempt to help them with all their social stressors and mental health issues, all the parts that are needed for recovery but years ago primary care didn't really think about so much. It was all outsourced. And so now we kind of create this package of services, with Medication Assisted Treatment being part of the package, and we tailor the medication towards the main drug of abuse, but also, at the same time, look at what other mental health issues might occur: PTSD – Post Traumatic Stress Disorder, you know, a history of trauma. All these things will make substance use more likely, and also inhibit recovery if they're not addressed.

Sandi Larsen: On that note, I feel like with our treatment at our clinic – that's another thing Dr. Mulvehill mentioned, trauma disorders – we've found that a lot of our patients have a history of Adverse Childhood Experiences [ACEs]. So we do really try to incorporate a trauma-informed care approach to all of our treatment here at RiverStone. That is just understood as written into our model.

Rachel Steinberg: Can you talk a little bit about how RiverStone funds its SBIRT and other substance use disorder-related work – I think you received a HRSA [Health Resources and Services Administration] expansion grant, is that right?

Sandi Larsen: We did. Early on in our efforts, as Dr. Mulvehill and I were talking about how we envisioned this to go, we realized that we needed to set a good foundation. And with that, if you want to do Medication Assisted Treatment and SBIRT then you really need a good core group of people. So, we decided to apply for a HRSA expansion grant and with that money we wanted to be able to start another full-time addiction counselor in clinic for point-of-care referrals and a behavioral health care manager for the team to help monitor and supplement that care when they're not seeing providers. And the program is sustainable because even our fiscal does a really good job credentialing providers, and they're billable services, so we work really hard to stay on

top of codes and keep learning. So really the money is used for start-up costs and just working through that sustainability plan. Then, in order to keep providing services, we just stay busy and working as a care team in clinic.

Dr. Mulvehill: I want to add that all the work that we've been able to generate and do related to substance use disorders is directly in response to our robust screening with SBIRT, because if you don't ask patients won't tell you. And if you don't identify it as a problem, you can't help them. I tell patients, it's just like diabetes, except it's a little different. It's just another thing. I try to de-stigmatize it. Diabetes, we can do a blood test to do the diagnosis. For substance use disorders, you have to ask questions and you have to do it carefully. You have to do it in a systematic way, so all patients are screened. We also screen all new pregnant patients again, because if you're drinking a couple beers a week or a day and you're not pregnant, well, it's just a different equation. When you are pregnant, you're re-screened, and now there's an opportunity for education. The more you screen, the more work you'll have to do. When clinics and organizations apply for these grants, at first blush it might seem that you're not going to have enough work to do, and in fact the more screening you do the more work you have to do, and follow-up.

Rachel Steinberg: Sandi, you've said before that it's important to implement other services in conjunction with SBIRT and with substance use disorder treatment, and one of those you mentioned is care coordination services. Why is that, and what should that look like?

Sandi Larsen: Well, we just feel that there's so many components that go along with a recovery plan. It's not just about stopping use and taking medicine or seeing even the on-site counselor, it really is an overall wellness and recovery plan. So our goal was to put services in place to support that overall wellness plan, to really incorporate that into patients' lives, and that means their basic needs need to be met. They need to know that they have housing and that they have food and that they have the things they need to just achieve that. Some of our patients are coming to us without even having those basic needs met. Our care management, our care coordination services, will meet patients at whatever level that they're at. Maybe your need is to go to school, or maybe your need is a higher level. At any level we can support and help you with your overall wellness recovery plan, and I think that's the key to really having a good program.

Dr. Mulvehill: I just want to add that as patients move along through their recovery process, we help them, you know, get to medical care. At the beginning, patients' lives in general are somewhat fragmented. They have a very close circle of friends who often times are substance use disorder clients as well. They may be estranged from their families. They may be unemployed. They may be living on someone's couch. All of those things really need to change. They need a recovery network that is healthy. They need to address transportation – many of these patients, they didn't really care if they showed up for things before. Now – you know, they've never been on the bus, or we'll get them a taxi voucher. We teach them how to use Uber which, for many patients it's like four or five dollars. We live in a pretty small community but we're very north, we're in Montana, so walking to clinic doesn't work in the winter. What patients see over time is this just really gentle care that we give them in a really consistent, respectful way, and that is so powerful for many of these patients, who really haven't had that in a long time. As they move through recovery, we see them miss fewer appointments, we see them come early and stay late. They're the people that are in the waiting room an hour early talking to the guy that is out there in the waiting room, you know, straightening magazines. This becomes part of their life, is coming to clinic, as they transition through recovery. And then, funny as it may seem, we become less of their life as they move on. So they end up being very dependent on us – some of them are in and out of here every week: "Oh, I just want to check that I do have refills. Oh, I do? Oh, okay." "How's everything going?" They see this as a safe, kind

place, and that can be so heartening for someone that's still struggling with, do I use, do I not use? Where do I go hang out? Then when you see the patient on the other side of recovery, making good life choices, it's amazing that we were part of that.

Rachel Steinberg: Are there any experiences you'd like to share that show the impact your substance use disorder work has had on the community?

Dr. Mulvehill: Let's see. I think, you know, one of the things that's happening is the providers' perspective on this: rather than judging people and seeing it as a moral failure, we are seeing providers shift their mentality that this is another thing, and that patients are really, in the community, feeling that they're not going to be treated with stigma or, you know, an approach that doesn't feel welcoming. That empowers them to bring their friends and family. We are now treating Hepatitis C in our clinic, and I am getting a lot of referrals from the patients of their friends and family, because many of them are users or ex-users, and they tell them we're cool. We're not going to get in their face. We're going to help them. And if they're – we call it lapsing. Once a patient has been engaged in treatment and has had some success, well, the odds are at some point there's going to be a lapse. And we have a conversation about, okay, what happened? Let's break this down. How can we – thanks for coming to your clinic appointment. So good to see you. I'm so glad you're here. Let's just break this down. That for them is a conversation many of them have never had with a healthcare provider. In the past it's been more about, you know, don't do that, or, I can't continue to see you, or, I can't continue to treat you, or, I can't continue to give you these medicines if you're going to do that. And it's not just us changing – we're all changing. Healthcare is learning more about this. I just think we're a little ahead of the game.

Sandi Larsen: Something else that's really exciting that we're doing as far as our goal in the community is that we're having great conversations on transitions of care from our specialty providers. Our local inpatient treatment facility, the Rimrock Foundation, has met with us, and they do a lot of work inpatient, and they're physicians provide Medication Assisted Treatment as well. There's not in the past been a lot of transition of care, so they've met with us. We're developing discharge plans so that all of that foundational work that they've set can be continued in our primary care clinic. So, there's a transition, there's not a discontinuation of care and then things kind of unravel and then we've got to do inpatient again. It's just a continuum of care, and it's really exciting to be able to work together with those specialty community partners who offer that in our community. Also, patients need primary care – so then they come in and again that wholistic approach.

Dr. Mulvehill: Can I just comment briefly on one thing that Sandi said about the continuum of care. In addiction medicine we talk about looking for the best type of treatment for the patient based on how severe the substance use disorder is and their prior experiences with treatment. Primary care for the treatment of substance use disorder is not the best choice for everyone. Really what we're teaching patients and other providers is to think about where this patient fits on the continuum of the treatments that are available, and then trying to get them to that best treatment, okay? So, for some people, for a lot of people, we can do it in primary care, but not everybody, and teasing that out is what Sandi and I do together. And sharing that with the patient and getting them to work it through so that they can participate in the shared decision-making. Very few people ever want to go inpatient for substance use disorder treatment. I mean, think about the stigma, you know? But for many – I had one patient that really needed to go inpatient, and he did, and he's doing great now. But when I first told him he was failing outpatient treatment and I said he needed to go inpatient, he said, "I don't want to go in there, there's a bunch of drug users in there." That was his own place. He wasn't really willing or ready to accept that diagnosis. And so, I just had to help him work through the stages of change until

he realized, yeah, that's where he needed to be. It's challenging, but that continuum of care and working with our community partners is huge to providing whatever the patient needs at that point in time.

Rachel Steinberg: What does the future of substance use disorder work look like at RiverStone?

Sandi Larsen: We are hoping to really just continue to maintain, educating new providers as they come in, and new residents each year as they come in, creating just that culture of "this is another part of our clinic, this is another part of your treatment." I think that we could do better, even more collaboration with our community partners, having a little bit of – our care manager, our goal going into this next year is to have them see more patients and be involved more collaboratively in their care, following up with them when they're getting medication management, things like that. I think that right now we're kind of in the maintenance phase of things, as you'd say. I'll let Dr. Mulvehill talk about some future projects that we're working on, or a big future project that we're working on.

Dr. Mulvehill: Lots of new things. I'm meeting with the director of the emergency room at one of the hospitals in the first week of January actually to talk about transitions of care. Many patients that go to the emergency room are identified as having a substance use disorder and are not admitted, and there's not a good transition of care. For many patients, they've come into the ER because they're sick from sequela of substance use disorder, or there's trauma, you know, they may have fallen or gotten in a fight. They may have been arrested and been brought in. But regardless, if those patients are using opioids, the better, more aggressive treatment programs in the United States identify them and start them on medication at that point, if they're willing. This is a big deal, but emergency room physicians have been some of the leaders in the community, because if you can imagine how tragic it would be to see someone in the emergency room two or three times, and then find out that they've died. So, transitioning, offering those services – I really, really, really want to get involved in that.

Another big thing is transitioning out of criminal justice. Most criminal justice facilities do not provide Medication Assisted Treatment, and patients, for the most part, are sober in criminal justice. When they're released, that's a real danger point for re-use and death. So, I would like to transition all those patients. I'd like to have all the patients with opioid use disorder receive Medication Assisted Treatment in criminal justice and then transition out. I think it'll save lives. I think it will decrease reincarceration. And I think it will increase the ability to treat these patients for their substance use disorder.

And lastly, I just recently took the board to become board-certified in addiction medicine, and we have the benefit of having another addiction medicine-trained physician on our staff, and so we're looking at an addiction fellowship. We really, really, really need more people that are invested in the information, the best practices, evidence-based guidelines, to share this information with others, and help others sort of change the philosophy that this is moral failure, and look at how we can help people, how we can save lives, and how we can help people along the road to recovery.

Rachel Steinberg: What advice would you give other health centers that are dealing with substance use disorders?

Sandi Larsen: I would say, start small and really get a good groundwork and foundation laid with that screening. I think that when you get good at that, and you start with that, then everything flows from there. The other thing that I highly recommend for other health centers is to really network with your community partners for a couple reasons: one, so that they know what you're offering at your clinic, and two, so that we know what they're offering in their facilities. I'm talking specialty treatment centers, even our AA [Alcoholics Anonymous]

groups, our adult ed, our ERs, the psych centers – all of those that are providing services in the community, they can support and help, again, lay a great foundation for your program so that we can really focus on overall wellness and have those tools that we need. So, start small, have a good screening process, do a good workflow. Of course, consult with other community health centers. We learned to do this work by attending regional trainings and implementing things with our primary care association, so networking I think is the biggest tool that you can use to start but start small.

Dr. Mulvehill: I agree with everything Sandi said. I think the Regional Primary Care Association meetings, across the United States, your region – hot topic. The last meeting, I went to in Denver, every single day there was a different talk on this subject, and most of the people who are highly interested are up at the speaker's stand at the end of the talk trading emails. From the last meeting I've probably gotten 10 emails from people: "Hey, can I ask you questions?" Things like that. In addition, training is everywhere right now. I mean, we are in the middle of a national crisis. The opioid overdose deaths in the United States have gone up every year. This is really an unprecedented public health nightmare. And so, the CDC [Centers for Disease Control and Prevention], the federal government, are responding, and they're making training available at very low cost in a variety of ways. So, reach out to leaders in the field, they will point you in the right direction. The American Society of Addiction Medicine, the American Psychiatric Association, the CDC, SAMHSA [Substance Abuse and Mental Health Services Administration], and your local Primary Care Association – all these places are just a click away, and they have webinar training. The thing that happened with me is, the first few trainings I did, two or three, it brought forth more questions than answers. I was overwhelmed, both with information and how to proceed. But there's a ton of people available now to network with and to support you along the voyage. It's just like diabetes, you know – there's a skillset that you need to learn, and it takes some time and training, but it's not impossible, there's other people to help you, and once you learn this information and how to treat addiction you can help a lot of people.

Rachel Steinberg: Well thank you for sharing that advice with our Region VIII health centers, and thank you for joining us today for our second episode of this new Substance Use Disorder Best Practices Podcast Series.

Dr. Mulvehill: Thank you so much, Rachel, for having us, and thank you for doing a focused podcast on this topic.

Sandi Larsen: Yeah, I'm really excited to hear some of the other podcasts and join in future opportunities to share our program.

Rachel Steinberg: On that note, this and other episodes in our series are available for free download at www.champsonline.org on our Events & Trainings webpage in the CHAMPS Clinical Podcasts section, and typed transcriptions of each episode are also available. If you're interested in recording an interview for our series, please let us know by sending me an email at rachel@champsonline.org. Thanks for listening!