



CHAMPS Substance Use Disorder Best Practices Podcast Series
Episode 3: Interview with Robin Landwehr, DBH, LPCC, NCC
From Valley Community Health Centers
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Rachel Steinberg: Welcome to the third 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 interesting and innovative ways that health centers in Region VIII are addressing substance use disorders, and 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.

In our first two episodes, we talked a lot about the basics of integrating Medication Assisted Treatment, or MAT, in a primary care community health center setting. Today, we'll hear from a health center that has drawn on a variety of local partnerships to build and grow a truly unique MAT program that is founded on collaboration. I'm so excited to welcome Robin Landwehr of [Valley Community Health Centers](#) in North Dakota. Thank you for being here, Robin.

Robin Landwehr: Thank you, I'm glad to be here.

Rachel Steinberg: So tell me a little about Valley Community Health Centers and the people you serve, and how substance use disorders are affecting your community.

Robin Landwehr: Sure, absolutely. So, VCHC, or Valley Community Health Centers, is a [Federally Qualified Health Center](#). We have a couple of different locations. We have one that's in rural – excuse me, urban Grand Forks, and then we also have a location in rural Larimore. We offer primary care services, dental services, and then also behavioral health services. And about four years ago I would say, our agency really decided that we were just going to make it a standard practice to have behavioral health integration in our clinic. And since that time the behavioral health department and the things that we've done have really grown, and we are excited to be able to offer that as part of our community.

We, you know, what we try to do as a community health center is really take a reading on what's going on in our communities, and how does the community health center fit in that? And so, what we've found is that there were several things that we really needed to be involved with – whether it was poverty and working with folks that are in poverty, or working on suicidality, which is also something that was going on in our state, and then most recently our work in substance use disorders. And we saw that there was really a need and began to research it, and this month is actually one year that we've been doing [Medication Assisted Treatment](#) [MAT].

Rachel Steinberg: So I know you experienced some challenges when you tried to begin developing your MAT program. Can you tell me what happened?

Robin Landwehr: Well, you know, there were quite a few challenges. But I think initially – and this may not be the same in every community – but for us, you know, initially there wasn't a lot of community support for Medication Assisted Treatment. There are a lot of myths and a lot of stigma surrounding this. And so, when you'd first go to meetings and start talking about the opioid use disorder crisis that was going on, MAT may not have been talked about at all, and if it was it might have been disparaged a little bit – and not even necessarily

just with lay folks that were showing up interested in it, even within the addiction community. Some folks have been doing addiction work for a very long time, and this is kind of – well, certainly not new, because methadone and other things have been used for a long time – but some folks just really didn't like to think that they wanted to incorporate that in their addiction treatment work. So even within the addiction community, we had some push back a little bit. But we have a fantastic crusader in our county, which is our public health director, who showed up all these places and says, "I'm sorry, but this is really an evidence-based treatment, and it's really important, and if we want to do something about this crisis this is something we need to consider."

And as a community health center who wants to be part of solutions, our Chief Medical Officer really began to take a look at this and say, "Well, you know, it's not something we're doing. Maybe it's something we need to consider." Because no other primary care office, no other provider in this area was offering it. So they began to look into it. I had had some experience doing Medication Assisted Treatment in another state. And our leaders have guts, and they decided to do some research on this and said, "You know what, I think we can do this. Let's go ahead and give it a shot." The challenges were stigma, but then other things come up too, like how do we address our Electronic Medical Record now that we're doing this kind of work. How do we deal with confidentiality, does that change what we have to – how we have to address confidentiality issues. Scope of practice issues – so there are a lot of things to think about when you begin to do it.

Rachel Steinberg: You've mentioned that you were able to draw on existing partnerships with the [University of North Dakota](#) to help you address some of those challenges – what does that partnership look like, and how has it evolved over time to really address substance use disorders?

Robin Landwehr: Yes, you know we're very fortunate where we're at. The University of North Dakota – we specifically work with both the social work department and the counseling psychology department. So we've had doctoral students in counseling psychology working with us for several years, and most recently social work. And so they've been primarily doing the behavioral health integration piece of it – going into exam rooms, seeing patients, etcetera. And then when we started to do Medication Assisted Treatment, the team got together and sat down. You know, how is nursing involved? And we created an MAT team that included our providers, that kind of thing, and we just included our interns into that.

So when patients come in for an intake, they see the nurse for the intake, and then they see a behavioral health provider for an intake. And we're not licensed addiction counselors, so we don't do addiction counseling, but we still do an intake with the patient because we want to know, are there other behavioral health issues that are going that we need to know about with this patient, since they're going to be doing MAT? Do they have another mental health – is there another mental health issue to consider? All of our patients that come in for MAT are screened. They're given a depression screen, they're given an anxiety screen, and I also have – and we also do the [PCPTSD screener](#), or the Primary Care PTSD screen, for all patients doing MAT. And that's part of our [trauma-informed care](#), because we know that there's a huge intersection between substance use disorders and with trauma. And so our interns are trained to do that as well. So we use them in a lot of different ways, and that would be one of them.

Rachel Steinberg: What barriers did you face as you started to incorporate the students into MAT treatment?

Robin Landwehr: Well I think part of it is that, you know, different students are going to have different levels of knowledge when it comes to addiction services, to substance abuse disorders or substance use disorders. You know, some folks, some interns that have come to us have actually worked in the area of addiction, have worked in Medication Assisted Treatment. And then I've also had some interns who had never even heard of

suboxone. So that is something that as a supervisor you need to be prepared to do some extra training with your interns. And then of course there are personal biases when it comes to substance use disorders. This has touched a lot of people's lives, and that includes us as professionals. And so we certainly can't approach this if we have a lot of biases that we need to take into consideration whenever we're trying to train folks.

But something about that, too – I mean, the interns, training them is one thing, but behavioral health is actually kind of broader than that, because we also have them do training with all of our staff about biases and about Medication Assisted Treatment. For example, one of the things that we did was we sent out [SAMHSA \[Substance Abuse and Mental Health Services Administration\]](#) information to our entire staff about buprenorphine, and we talked to them all about the fact that we were considering doing this, and if you have questions or if you've heard any of these myths we want you to talk to your supervisor about it. So while our interns touch – you know, they work with – our patients, well, so do our billing people and our front desk people. So you actually have to think broader than that when you're thinking about addressing biases. Not just our interns, the people who are directly working with these patients, but anybody that the patient comes in contact with.

Rachel Steinberg: I know you also offer many alternative pain management treatments. Can you tell me a little about the partnerships that allow you to offer so many great options to your patients?

Robin Landwehr: Sure. This is really important when it comes to the issue of prevention. A lot of the time when we think about this it's all about treatment, and obviously treatment is really important. But we also need to be thinking broader about what can we do about this in terms of prevention. So we actually do a few different things. For one thing, we began a partnership with a chiropractor who works for us about one day a week in our rural clinic, and he provides chiropractic care out there, which is a non-pharmacological way of dealing with pain. And that's really important – giving people other options to address chronic pain that are not necessarily medication-related.

Another partnership that we developed also through the University of North Dakota was we have physical therapy students that come to our Grand Forks clinic once a week, and they only see patients that don't have access to health insurance. So for folks that can't get health insurance, our physical therapy students see them and provide treatment. And that's also another fantastic way of trying to address pain that doesn't include pharmacy, that doesn't include medication. Because as you know, a lot of folks that have begun to abuse opioids point to chronic pain as being the thing that got them started down that path in the first place. Not everybody, but many people, will say, "I had an accident," "I had a fall," "I have some degenerative thing," "and then I started on, you know, pills, and then it just kind of got worse." So having alternatives is kind of important. So we have the physical therapy students, and right now me and two of the interns that we have are actually working on a group curriculum for chronic pain. I actually have a 12-session individual program that I can use for chronic pain with patients, but we're working on figuring out how can we actually make this a group program for more of a population-based focus? You do individual, you're working with one patient at a time, but we might be able to figure out a way with five patients at a time and give them this really useful information about addressing pain in some other way.

And then the other thing is that me and the chiropractor are also talking about, how can we do screening for his patients for behavioral health issues. Because we know that other things also relate to substance use disorders, like social determinants of health, other psychosocial factors that are happening to our patients, how do we screen for these things so that we can do interventions to try and prevent problems, rather than trying to address them from the back end?

Rachel Steinberg: I wonder if there are any stories you can share from the students, the other providers, the patients, that really get at the impact of how that's working for you?

Robin Landwehr: Well I think, you know, for one thing, seeing some of the patients – you know, I've been privileged to do this in two different states now, so I've been able to see the difference that MAT makes in people's lives. You know, just thinking about some of the patients that we have. And one in particular that I'm thinking about came to us – I might talk a little bit about [Project ECHO](#) down the road – but we've actually seen patients who have come in who have been homeless, they have been hopping from, you know, couch to couch, different places, not necessarily working. And then also just not addressing their chronic diseases, which is generally not something that folks really think about doing when they're active in their using of substances. And it's nice to see how people now, you know, they're addressing these chronic health issues that they weren't addressing before. Like they're going and they're doing something about their diabetes. They're also seeing other folks about their high blood pressure. They're getting housing. They're getting jobs.

And one person that I'm thinking about in particular, we found out that she was pregnant not very long after she started the program. And we were able to start – you know, we were able to get some expert advice about how to address that, and then this person went on to shift her care over to an obstetrician, and then we were able to partner with that person while the patient was still seeing us for medication. You know, it's been – not only just seeing the patients get better, but then also our ability to be able to influence other health systems because of what we're doing.

Rachel Steinberg: So you mentioned Project ECHO – is that something that you think is having an impact on your MAT services as well, and how are you utilizing that?

Robin Landwehr: Absolutely. So we actually serve as both a spoke-site, because we're absolutely interested in learning as much as we can, too – but then we also participate getting a little bit of some expert advice, especially about healthcare integration. And you know, the patient that I was mentioning, the patient who was pregnant, that actually was something that came up during Project ECHO. We hadn't actually been doing MAT for very long, and we had a new patient, and we started her with MAT, and very shortly after that she became pregnant. And the protocol is generally, if they're pregnant you take them off suboxone and they go straight to buprenorphine, but there's some risks to that. And it just so happened that because of our involvement with Project ECHO, one of the experts that's on there was not only an OB-GYN but also an expert in MAT. So our provider was able to say, "Hey, we have this patient, and we're not quite sure what to do – you know, there's risks to doing this, there's risks to doing that, what would be something that we could do?" And so they were able to get – our provider was able to get some really good, solid expert advice that would help them be able to address and help this patient. So it's really great in terms of being able to get real-time information on something.

And then it's also good to be able to share your own experiences. Essentially the way it's set up, there's like a 20-minute didactic on a topic, and then after that you give a case study, and some of those have been fantastic. Not just our own that we've received information on, but listening to what's going on in other people's programs and what challenges they've had and how they've corrected them, or what they've done to work through them.

Rachel Steinberg: What does the future of MAT services at Valley Community Health Centers look like?

Robin Landwehr: Well recently we did secure a grant that's going to allow us to hire a licensed addiction counselor, because that is an important piece to this. You know, some folks start off, they've got an LAC and then they go on to MAT. And we never do anything exactly the way others – you know, we're doing it backwards, I guess, maybe than other folks have done, when we started MAT. But we realized there's really an important need for that expert counselor in there to work with addiction. So we were able to get a grant, so we will be hiring a licensed addiction counselor [LAC] who will be able to see our patients who are in our MAT program, and do a real assessment with them and some counseling as needed in groups. And then just be part of our MAT group that we have – every week we meet and we talk about patients, and they would be part of that and able to provide some expert information. So that's one thing.

But other areas – you know, we're also trying to expand places like our social work department. We're talking about [the social determinants of health](#) – if you're going to do something about substance use disorders, and not just the treatment end but looking at prevention, you can't leave out the social determinants of health. So we have a grant where we're able to bring in two new social workers who are going to be working with serious mental illness and then also homelessness. And while that's not specific to substance use disorders, there's no way you can't see a link between all of that. So you know, getting those folks on board to address those psychosocial issues is also going to be something we're really going to push for. We also do specialty mental health, and we've secured some funds to be able to allow us to have greater space for that, so that we could do more traditional-type therapy for patients. And that extra space will allow us to do more groups, will allow us to have more capacity for those kind of programs.

And then also just those partnerships, like me working with our chiropractor. Figuring out other ways that we can use our students, like they're helping me with the chronic pain group. All of those are going to be part of our future in MAT. And you know, the Medication Assisted Treatment part of it is critical, but all of these other things around it are just as important.

Rachel Steinberg: What advice would you give to other health centers that are dealing with substance use disorders, especially in terms of either how to build new collaborations or how to maybe get past some of these barriers to collaboration?

Robin Landwehr: Sure. Honestly, I think one thing that is really important is that you take your own temperature of your own organization. Like I said, you know, we knew that in an organization of 70 folks somebody is going to have a feeling about MAT that may not be positive. So we tried to address that by giving literature and information to our own staff first and begin the process of educating from within. We even had an expert come for one of our all-staff training days to talk about MAT, long before we actually started to do it. So kind of getting an idea of, how does your leadership feel about it? Like I said, our leadership is kind of fearless, and they're at the head of things, so I feel very fortunate about that. How does leadership feel about it, your board feel about it, all of those kind of things. And then after that, you know, if you decide, "Okay, this is something that we feel called to be involved in," I would see if you can find something like a Project ECHO so that you don't feel like you're a lone wolf out there. Especially if you're in a rural area, something like Project ECHO would be a great thing to be able to do. Even if you're not currently doing MAT, or even if you're not thinking you're wanting to do it right away, it's still not a bad thing to do.

And then the other thing I would say is, you know, please consider doing Medication Assisted Treatment. Yes, there are challenges. There are also a lot of rewards from doing it as well. And when I've talked to folks about it, I think it's important to remember that you're treating these patients anyway. It's not like if we build it, they will

come – they’re coming anyway. Like, they’re there. And I’ve heard, especially some of our waived providers, folks that didn’t think they would like doing MAT but then they started doing it, say that it’s actually sort of refreshing to be able to offer something to these patients that are coming into your clinic anyway. So rather than just kind of putting the blinders on and pretending, it’s actually kind of nice to be able to say, “Hey, this is a problem. We know that this is happening. We’ve actually got some tools to be able to deal with it.” Because these are our patients. They’re all of our patients.

And then see if you can use interns. See if there’s a university. And if there isn’t, see if you can talk to your universities about encouraging the school, the university to try to build some kind of integration into their curriculum. Because that’s what our university did – they actually have that behavioral health integration in primary care built into their curriculum. If they could do something like that, that would be fantastic, because then you can use interns just like we are to be part of it.

And then the last thing I would say is, talk to other MAT providers. I can’t even tell you how helpful they were whenever we began to do this. We talked to folks in Minnesota, in South Dakota, all over North Dakota, and they were so open to sharing everything they had because – there was no turf thing about that. Everybody knows that the need is there and they want everybody on board. So if you’re worried about it or have questions, I promise you there are people out there that are willing to answer it and help.

Rachel Steinberg: Thank you for sharing that advice with our Region VIII health centers, and for joining us today for this third episode in our Substance Use Disorder Best Practices Podcast Series!

Robin Landwehr: I appreciate it. It’s been great.

Rachel Steinberg: This and other episodes in our series are available for free download at www.champsonline.org on our Events and Trainings webpage in the CHAMPS Clinical Podcasts section. 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 an email to rachel@champsonline.org.

As always, thank you for listening!