



CHAMPS Substance Use Disorder Best Practices Podcast Series
Episode 1: Interview with Dr. Johnson-Esparza and Dr. Noonan
From Salud Family Health Centers
Interview Date: November 30, 2018

Rachel Steinberg: Welcome to the first episode of the Substance Use Disorder Best Practices Podcast Series, produced by [Community Health Association of Mountain/Plains States](#), better known as CHAMPS. I'm your host, Rachel Steinberg, the CHAMPS Substance Use Disorder Program Specialist. In this new series, we're highlighting the many interesting and innovative ways that health centers across Region VIII are addressing substance use disorders in their communities. And we think the best way to share those ideas is to speak directly with the health center staff themselves.

Today, in our inaugural episode, we'll be talking with Dr. Yajaira Johnson-Esparza and Dr. Michael Noonan from [Salud Family Health Centers](#) in Colorado. Thank you both for being here!

Dr. Johnson-Esparza: Thanks for having us.

Dr. Noonan: Yeah, thank you for having us.

Rachel Steinberg: So tell me a little about Salud and the community you serve at the Commerce City Clinic.

Dr. Noonan: Salud is a Federally Qualified Community Health Center. We serve northeastern Colorado, everywhere from very rural locations, such as Sterling or Fort Morgan, where folks make their living ranching or farming, to Estes Park, a tourist and outdoors community in the Colorado mountains, down to our site in Commerce City. We're just north of Denver – it's a mixed residential and industrial community, including oil refineries and light industrial factories. And we're very diverse; 50 percent of our population identifies as Latino. But also, almost 20 percent of our community members are living below the Federal Poverty Line.

Rachel Steinberg: What kinds of effects are substance use disorders having on your community?

Dr. Johnson-Esparza: Commerce City is in Adams County, and like many other counties in the state of Colorado it's been hard hit by the opioid epidemic. To give you an idea of the magnitude of the problem in Adams County, of the 64 counties in Colorado, Adams County alone accounted for close to 15 percent of opioid-related deaths in a timespan from 2012 to 2017. And it's really not uncommon for us at Salud to come in contact with patients who have been affected by opioids, whether they themselves have had or have problems with opioids, or maybe their relatives are the ones who are having these problems. It's definitely something pervasive that we see in our clinic.

Rachel Steinberg: Dr. Johnson-Esparza, can you tell me a little about your role at Salud?

Dr. Johnson-Esparza: I'm a psychologist at Salud, and I'm also the director of Medication Assisted Treatment, or MAT, which means I oversee buprenorphine treatment for opioid use disorder across the Salud system. Early on, Salud made the decision that they wanted behavioral health to play a pretty significant role in our MAT services and brought me on to integrate these services into our current model of care.

Rachel Steinberg: And Dr. Noonan, can you tell me about your role?

Dr. Noonan: I started at Salud as a primary care provider in 2014, and I pioneered our convenient care clinic. It's a walk-in clinic where we make sure that patients can be served 12 hours a day, 6 days a week for everything from minor infections to chest pain to medication refills. It's a way to make sure that patients always know there's a place to go and place to get what they need without having to resort to going to the emergency room or just going without. In 2016, as our opioid use disorder treatment program started to ramp up, we received a grant for treatment and we worked to recruit primary care providers. I thought I was specially placed – both because I have an interest in behavioral health and in opioid use disorder, alcoholism, just substance use disorders in general, and because I had a different sort of practice schedule than other primary care providers – I thought I was well positioned to be the first medical provider to start working on [Medication Assisted Treatment \[MAT\]](#).

Rachel Steinberg: How are you tackling challenges around substance use disorders?

Dr. Johnson-Esparza: Well, a few years ago Salud received some grants to provide SBIRT services – so that's Screening, Brief Intervention, and Referral to Treatment – and we hired several SBIRT educators at the bachelor's level to screen our patients. And through these screenings, through these SBIRT initiatives, we were able to identify a need that many of our patients had. Many of our patients were on high morphine equivalents, they sometimes also presented with addiction, and so Salud realized that this was something it also needed to address. So Salud sought funding to expand our substance use services, and we were awarded a [HRSA \[Health Resources and Services Administration\]](#) grant. With that grant we were able to hire some masters-level behavioral health providers who would focus on providing these MAT services to our patients, but also when not providing MAT services they would function as general behavioral health providers. I would also add that to do this, we did do a lot of consultation with health centers that are currently providing MAT services. One of the health centers that was instrumental in the development of our MAT services is [Sunrise \[Community Health\]](#) up in Weld County. They were great at helping us identify tools that we can use and how to go about setting a protocol that would make the delivery of MAT services as effective as possible.

Rachel Steinberg: So I know you avoid calling this a "MAT Program" – why is that?

Dr. Johnson-Esparza: I think that's because MAT at Salud is not really a program, but rather part of our comprehensive services. We made it a point not to make a distinction between addiction and other chronic conditions like diabetes or hypertension or asthma. MAT is simply what we do to meet the needs of our patients, with as few barriers as possible. We know that one of the barriers to substance use treatment is the stigma associated with it, and by providing MAT for substance use disorder in our primary care setting we really help reduce this stigma because it's like any other service we offer. Patients don't have to worry about others finding out that they're struggling with an addiction. That said, there are definitely patients who do require more intensive services, in which case we will refer them to an opioid treatment program. Treating OUD in primary care is, I think, really analogous to treating a heart condition – in some instances it's completely appropriate to treat in our setting. And then there are other instances in which it's most appropriate to refer a patient to a cardiologist or a specialist, and that's really how we've gone about addressing opioid use disorder [OUD] at Salud.

Dr. Noonan: Another thing about not calling it a MAT program is it helps keep it integrated with our regular treatment approach in general. Our medical providers are available to our behavioral health providers, and our behavioral health providers are available to our medical providers. We concentrate on making warm handoffs and team-approached diagnosis whenever appropriate. So rather than separating this out and putting a certain number of providers in a silo, we continue our group and team-based care and management all the way through the Medication Assisted Therapy.

Rachel Steinberg: It sounds like you've identified stigma as one of your barriers – what other barriers have you faced, and how do you work through those?

Dr. Johnson-Esparza: I'd say that stigma is part of really changing the culture in which addiction is really seen as a very negative condition. We would never treat patients with diabetes the way we treat patients with addiction. So challenging these conceptions and beliefs around what addiction is I think is one of the biggest barriers to implementing MAT services in a health center. As we went around introducing MAT to our clinics, there were things I would hear that really reinforced the stigma of MAT and a lot of fear about what it would mean to take on this patient population – which, by the way, we've already been working with. These were already the patients we were working with. Concern about bringing individuals who have opioid use problems into waiting rooms where we have children. One of the things we had to talk about was, guess what, those were the parents of the kids we're working with. I think that's one of the most significant barriers, changing that culture. That's actually not just a clinic issue, it's really part of the larger culture in our country. So redefining addiction and what it means, and helping others recognize that it's a chronic medical condition, just like all the other conditions that we're working with. And with that, getting the buy-in from everyone in the clinic, from front desk to support staff to providers.

Dr. Noonan: Some of the earliest barriers were just lack of interest and difficulty recruiting providers. For a good period at the beginning of our program I was the only provider who had shown interest in our clinic. Part of that was the trepidation providers have about people going through withdrawal, the fear of opioid withdrawal, the fear of opioid users. And a bit of just general concern – some of the same concerns that led to people overprescribing opioids to start with – confusion about how they work, what they're for, how to dose them, how to taper off of them. Misconceptions about opioid withdrawal, being concerned that it's a medically dangerous condition, when in fact, although it's excruciatingly painful, and is very difficult for patients, it is not a particularly dangerous medical condition.

Another barrier that was really concerning was retention – making sure people have structure and time in their day to address these problems. Although we work really hard to make sure that this is integrated into our regular primary care program, it's very difficult for a provider who is already seeing 12 to 13 patients each three-and-a-half-hour clinical session to integrate in just a random visit any time during the day for a two to two-and-a-half-hour induction really well and thoroughly for buprenorphine therapy. So some things that we do are really to help make flexibility in the schedule, help encourage scheduling administration to allow for the structure that can make primary care providers successful. And that can be quite a barrier, if you don't have excellent buy-in from your administrators as well.

Rachel Steinberg: Dr. Johnson-Esparza, you've mentioned that behavioral health plays a key role in MAT at Salud. Can you talk a little about what that looks like?

Dr. Johnson-Esparza: This kind of builds on Dr. Noonan's last answer and providing that structure for providers and the additional support that they need. Behavioral health plays a significant role throughout the entire time. Our behavioral health providers are the ones who are doing the intakes and diagnosing patients and collaborating with the medical provider – not to mention that the entire time there is constant collaboration between the two of them, constant communication, so that they're both on board with whether patients should get treatment or not. Even during that initial phase of induction where we are getting the patient on the medication, the behavioral health provider is with the patient throughout the entire process, which sometimes can be a four-hour process. For a patient who's coming in experiencing withdrawal symptoms, our behavioral health provider is with them, assessing them, re-assessing them, providing skills throughout the process so that they can manage those withdrawal symptoms as effectively as possible while they wait for that medication to really have the effect that it needs to have on them. During that initial stage where it can be really challenging for patients, where they're just starting to get sober, helping patients develop relapse prevention plans, helping by connecting them to resources that they might need – whether it's case management, or maybe more intensive behavioral health services out in the community. Our behavioral health providers really try to walk with the patients through this entire process, to be there for the patient but also to be there for the medical provider and provide that support so that the medical provider doesn't feel overwhelmed and really feels that it's a team effort.

Rachel Steinberg: So then, Dr. Noonan, what would you really say the role of the medical provider is in this MAT work?

Dr. Noonan: Ideally, in situations where you have the team support, like some other parts of the [Patient-Centered Medical Home](#) model recommended by the [American Academy of Family Physicians \[AAFP\]](#), the physician is the director, the administrator, the captain of the team. That means that you allow other people to help with the diagnosis – and particularly in opioid use disorder, a correct diagnosis is particularly important. Making sure that someone has taken the time to ensure that someone meets [DSM \[Diagnostic and Statistical Manual of Mental Disorders\]](#) criteria, rather than shooting from the hip and saying: My gestalt, my clinical impression, is that this person has a substance use disorder. It doesn't help the patient very much to start an induction when they're not ready or don't understand, or might be apprehensive, or don't understand what their diagnosis is and what treatment can offer. The medical provider, as director of the MAT team, can keep those things in sharp focus, and make sure that diagnosis has been completed, delegate duties to arranging follow-up, coordinate with the pharmacist to make sure medications are available, write prescriptions correctly, and then also underscore and coordinate with the behavioral health provider to make sure we're all on the same page with steps in the patient's therapy. The best part of MAT, at least in my experience at Salud, is this is when we really blossom into a Patient-Centered Medical Home team-based approach model of care.

We've found that one of the strengths that I have as the provider who works in the convenient care center is that I can always fit a patient in. I am always available. I'm available 8 a.m. to 7 p.m. on the days that I'm working, and there are days when I have fewer sick visits to care for and I can always spend extra time with my MAT patients. When you look around in an organization, not all primary care providers' schedules are created

equal. You can find the people who have the time, tools, and resources to actually lead these teams. And then finding the people who can contribute on an on-and-off basis, the same way that we have.

Rachel Steinberg: I know Salud collaborates with a few other organizations in your area – can you tell me a little what those collaborations look like, and how they’re affecting your MAT work?

Dr. Johnson-Esparza: We do try to be active in the community and collaborate with different organizations throughout the different counties where we are providing these MAT services. Specific to Adams County, we are part of [Tri-Counties Overdose Prevention Partnership](#) – it’s a community-based partnership working toward the prevention of overdose deaths in the tri-county area – that’s Adams County, where Commerce City is, Arapahoe and Douglas Counties, all part of the Denver metro area. This partnership has representation from Community Health Centers, between Salud and other health centers like us, opioid treatment programs, corrections, public health, private citizens, among other organizations. We see these kinds of partnerships as very important because one of their goals is really to increase connectivity, to increase access to treatment for patients, and increase access to other resources that many folks in the community might benefit from. Educating family members, educating the community so that many of the patients who we are working with feel that they have the support of the entire community as well. We also work closely with Community Mental Health Centers. For those patients who we feel might require more intensive services, we do try to work with them to facilitate referrals to and from. More recently we’ve been lucky enough in the Denver metro area to have two emergency departments that are starting to put patients on buprenorphine. We have had conversations with them about what’s the best way to get patients who require primary care services access to our clinic – how can we smooth that referral process, and how can we continue the buprenorphine further for their opioid use disorder and provide the primary care services that they require as well?

Rachel Steinberg: What kind of impact have you seen as a result of your MAT work, both on patients and the wider community?

Dr. Noonan: A number of our patients have come to us at difficult transition points in their life. A couple that stand out to me are a person who had been progressing through their career and reached a certain point where they could no longer spend time both finding, using, planning their life around addiction as well as continue to meet their work goals. This person’s been one of our most successful patients. We were able to provide them a diagnosis, induction, stable treatment, and therapy that not only allowed them to address their opioid use disorder, but to begin to address and unlock obsessive compulsive disorder and other anxiety difficulties they’d been having. This person’s been continually successful and has had a promotion in the time I’ve been working with them. Another patient was working on their training to progress in their career to be a nurse. Currently, I had my last visit with them last week, and they’ve scheduled their board exams, so they’re going to be finishing their studying and taking their exams, something that they confided in me that they never could have done had they still been trying to find their opioid medications, use them, hide their opioid use from their family, all the things that had been going on. And finally, one of our patients has gone through a terrible set of very complicated medical conditions, leading finally to renal failure and dialysis. I’ve been able to manage their dosing through that period. It’s kept them from cycling through pain and withdrawal cycles as they’ve gone through this difficult time. And fascinatingly, although they have started on dialysis and had an amputation, they now are more active, interactive, spending more time with family and friends, and express to us at each visit

how satisfied and happy they are that they've found the program here at Salud and how much it has helped them.

Dr. Johnson-Esparza: I should also add that we're currently looking into how best to measure the impact we're having in our communities at a greater level. That's really the phase in our services that we're in right now – how can we identify the effectiveness and that impact that we're having?

Rachel Steinberg: Dr. Johnson-Esparza, you've said that one of Salud's goals is for opioid use disorders to be treated like any other chronic condition – what does that look like to you?

Dr. Johnson-Esparza: Nobody thinks twice about treating patients with diabetes or hypertension. It's part of what we do in primary care. Nobody flinches at the idea of it. There aren't concerns about the complexity of these patients, or of becoming a niche provider, or of opening up the floodgates so to speak. And that's because these conditions are seen as conditions that really should be managed in primary care. So our long-term goal in MAT for OUD is to treat OUD and any other substance use disorder the same way as we would treat these, as a chronic medical condition. And for that it's important that all our providers – whether they're behavioral health or medical providers – are really equipped to participate in the delivery of these services. We want our patients to be able to get treatment for their substance use disorder from their PCP, or their primary care provider, the same way that they would go to their primary care provider for their treatment or management of their diabetes or their asthma or whatever other comorbidity they might be having. That's really long-term where we want to be as a health system.

Dr. Noonan: One thing along those lines is that as more providers are trained, we don't expect everyone to carry a full load, whatever that might be, of patients with opioid use disorder and treatment, but that we can all share the load together. People can receive their primary care patients back to them to continue their long-term treatment. There are many different ways to be a Medication Assisted Therapy provider. One thing that we're working on at Salud, and that I really feel that we've had great buy-in and collaboration, is all of us working together as a team, for all of us to share multiple roles, in opioid use disorder treatment.

Dr. Johnson-Esparza: I would add, with that goal in mind, we have been working toward training all our practices in MAT with the help of [IT MATTTRs Colorado](#). IT MATTTRs is a statewide initiative that trains practices and provides tools to adopt comprehensive MAT services through practice support and facilitation. We have also begun training our behavioral health providers in MAT, also through IT MATTTRs, so that they feel more equipped to work with patients with opioid use disorder in an integrated primary care setting such as ours. I think it's important that our behavioral health providers be trained and equipped to work with this population because then medical providers also feel that they have that level of support in treating these patients and recognize that they're not going at this all by themselves.

Rachel Steinberg: Dr. Noonan, what advice would you give to medical providers, especially those who are apprehensive about MAT? What is the benefit?

Dr. Noonan: First I'd like to touch back on a couple of things that I'd said earlier. Within your organization, you should be able to find people who have interest, should be able to find people who have maybe different scheduling needs, openings, the ability to take the lead in this project. And ideally, once someone takes the lead,

you'll find more and more people who express their interest. Part of the reason people express their interest is the benefit. It's a bit of a fantasy to think that if you deny people treatment, they will not seek treatment. By engaging in a MAT program, you'll be able to have an answer, have something to offer patients that will make a difference, and you'll find eventually that it'll actually save you time, compared to the time you spend, at the very worst, arguing, but at the very best just missing opportunities and giving patients wasted visits. When you have a streamlined approach, providers who have buy-in, mental health providers who can support you, it really changes the entire tone around the discussion of opioid use disorder in your practice.

Lastly, I think the most important piece of advice I think some people need to touch on a little earlier is to make sure you're correctly diagnosing your patients. Misdiagnosis, overprescribing, are some of the issues of the opioid addiction problem in the United States. Transitioning into an approach where everyone simply receives a prescription for suboxone not tailored to their needs, not appropriate to their diagnosis, isn't going to be the solution. Making sure you have the tools and the partners to get the correct diagnosis before you start treatment, I think will be the cornerstone of an approach that will be more helpful for your patients, and absolutely more satisfying and safe for your providers.

Rachel Steinberg: Dr. Johnson-Esparza, what advice would you give?

Dr. Johnson-Esparza: One, I would echo everything Dr. Noonan said. And secondly, don't reinvent the wheel. There are many practices who have been providing these MAT services effectively to the patients they serve. Consult with these practices – and not just one, consult with many to pull what you think is going to be most effective for your practice. Like Dr. Noonan mentioned, providers have different schedules, practices function a little differently, so it's best to try and really analyze what's going to be most effective given the priorities of your practice and the current workflow of that practice. Take advantage of opportunities that are out there, whether it's grants or other resources. Practice facilitation is huge, and fortunately there are opportunities for practice facilitation through some federal organizations like [SAMHSA \[Substance Abuse and Mental Health Services Administration\]](#). Taking advantage of state initiatives. Like I mentioned, IT MATTRs Colorado is one of the state initiatives we have decided to use to help us out as we continue to expand MAT services across the entire system.

A team-based approach is important. Don't try to do this all by yourself. It's really challenging to be the sole provider of MAT services. It's really important to incorporate other members of the team, whether it's support staff – even the front desk can be very effective, and we often forget that they are the first ones to have contact with our patients. Therefore they're also very equipped to help with the management of these patients, and the identification of patients who might benefit from these services.

Lastly, I'd say that it's really important that we redefine success, and that as a practice one recognizes that success, when it comes to opioid use disorder or any substance use disorders, should be seen differently from the way that we've been seeing it for many years. Relapse is something that is part of the illness. It is something that is sometimes inevitable. And the same way that we wouldn't fire a patient who has diabetes because they're not adhering to their treatment or to their medication, or they're not adhering to a healthier lifestyle, we shouldn't be firing patients who have a substance use disorder because they relapse. We should be recognizing that these are the times when our patients might require more hands-on, more resources, more support from us, rather than to be pushed away. So I think taking this harm-reductionist approach and

recognizing that success is very different from the way that we've treated it historically is very crucial to successfully providing these services to our patients.

Rachel Steinberg: Thank you both very much for sharing that advice with our Region VIII health centers and thank you for joining us today for our very first episode of this new Substance Use Disorder Best Practices series.

Dr. Johnson-Esparza: Thanks, it's been a pleasure. Thanks for having us.

Dr. Noonan: Yeah, thank you very much for having us.

Rachel Steinberg: This and future episodes will be available for free download at www.champsonline.org. 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. Thanks for listening!