



Case Study of the Bangor Area's Approach to Addressing Substance Use Disorder

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1. Introduction

Like many communities in the United States, Bangor, Maine has been struggling with the opioid epidemic. By 2013, the number of premature deaths in Bangor attributed to opioids, as well as the national and state attention to this issue, created a “tipping point” such that a collaborative group of key local leaders identified substance use disorder as their top priority. This collaborative body, called the Community Health Leadership Board (CHLB), includes top executives from all major healthcare and social service organizations in the region.¹ It is comprised of several work groups and committees to address various health issues, including the oversight of a five-year Drug Free Communities grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and other grants and initiatives. In 2014, the CHLB’s Community Substance Abuse Working Group (CSAWG) released its “Recommendations to Address Local Substance Abuse,”² which created a vision in Bangor to “treat addicted and dependent citizens like any other person who is ill and deserves our care, compassion and support.”

Around this time, organizations within the Bangor community also had planning grants from the Maine Health Access Foundation (MeHAF) via their Access to Quality Care (A2QC)³ and Healthy Community (HC)⁴ initiatives. The A2QC initiative funds communities to develop strategies that increase the coordination between health and social service providers to improve the system of care for individuals who are uninsured and/or have limited incomes. The HC initiative funds communities to collaborate across sectors to improve the health of individuals who are underserved and uninsured. Both initiatives require engaging community members to provide input on grant activities. As part of its planning process, the HC grantee chose substance use disorder as the priority health issue to address along with the CHLB. The A2QC grantee chose to focus on substance use disorder as well, more specifically around opioid use and provider prescribing practices.

The Bangor community’s grant applications identified the systemic problems and gaps regarding prevention, treatment, coordination of care, and recovery from substance use disorder. Providers within and across institutions and specialties did not have a consistent approach to pain management and had been overprescribing opiates, identified as one of

1 <http://www.bangorchlb.org>

2 <http://www.bangorpublichealth.org/substance-abuse-prevention>

3 <http://www.mehaf.org/what-we-do/priorities/access-for-all/access-quality-care-uninsured-individuals>

4 <http://www.mehaf.org/what-we-do/priorities/improved-health/healthy-communities>

the root causes of the epidemic. Individual organizations were pilot testing approaches to address these inconsistencies and gaps in the continuum of care, but these approaches lacked capacity and the ability to expand beyond an institution-specific effort. The A2QC and HC grant partner institutions recognized the complexity of the health and support services needed for an integrated system of care to address the opioid epidemic, which would require multi-institution and multi-sector partnerships as well as community engagement.

This report is a case study of the early stages of how the Bangor community is using two types of MeHAF grant funding to implement several strategies to address some of the most critical gaps related to the opioid epidemic. The strategies of each grantee target different gaps in the continuum of care in the Bangor area. The Bangor case study is based on a two-day visit conducted in January 2017 and is informed by:

- » Review of project documents (grant applications, grant products, and progress reports, including a summary of A2QC partner responses in Year 1 to the Wilder Collaboration Factors Inventory⁵);
- » Meeting observations, and
- » Interviews with project staff, organizational partners, and community members.

This case study provides a profile of three major activities of the A2QC and HC grants in early stages of implementation: pain management/opioid prescribing protocols for providers (A2QC), “warm handoffs” of patients with substance use disorder from the emergency department/urgent care to primary care (A2QC), and recovery coaches (HC). Each profile includes a description of major progress to date, lessons learned, and evaluation. Our report then summarizes how the two grant initiatives were engaging community members in these activities. An overview of the two grants is provided below (see Table 1).

5 Mattessich, P., Murray-Close, M., & Monsey, B. (2001). *Wilder Collaboration Factors Inventory*. St. Paul, MN: Wilder Research. See <https://www.wilder.org/Wilder-Research/Research-Services/Pages/Wilder-Collaboration-Factors-Inventory.aspx>. Grantees are periodically asking partners to complete this survey to assess the development of their collaborations over the course of the grant period.

Table 1 Overview of Two MeHAF Grants in Bangor

	Access to Quality Care	Healthy Community
Lead grantee	Penobscot Community Health Care (PCHC), a Federally Qualified Health Center	Bangor Public Health and Community Services (BPHCS)
Time period	11/1/2015 – 4/30/2018	11/15/2016 – 12/31/2019
Budget	\$225K plus 58K in-kind for a total of \$283K	\$187.5K plus \$33.5K in-kind for a total of \$221K
Goal (from grant application)	Enhance pain management practices, improve clinical outcomes, reduce expensive and inappropriate emergency department (ED) usage	To increase the success of our community's ability to support recovery for people living with substance use disorder
Target Population	Uninsured/low income people who present to EDs and walk-in clinics with substance abuse/chronic pain/opiate addiction issues	Underserved, uninsured, underinsured, those with behavioral/mental health conditions
Main Activities	Pain management toolkit, alternative therapies, revised prescribing practices, warm handoffs to primary care, collaborative care management	Peer recovery coaches and building capacity of recovery center
Geographic Area	Bangor/Central Penobscot area	Greater Bangor focus, including Bangor, Brewer, Holden, Eddington, Veazie, Old Town Orono, Hermon, Hampden, although the project will be open to anyone, regardless of where they live

SOURCES: Grant applications and progress reports for MeHAF

2. A2QC Activity #1: Pain management/opioid prescribing protocols/toolkit

Objective⁶

“Develop, promote, and implement revised pain management/opioid prescribing protocols using pain management toolkit.”

“What helped is we had solid experience...and could speak to how it helped us.”

Clinical leader of the federally qualified health center’s Controlled Substance Initiative (CSI)

Lead Partner

Penobscot Community Health Care (PCHC)

Key Partners

- » Leadership of hospitals and the Federally Qualified Health Center (including their CEOs, chief medical officers, quality departments) from:
 - PCHC
 - Acadia Hospital (psychiatric hospital, member of Eastern Maine Healthcare Systems or EMHS)
 - St. Joseph Healthcare
 - Eastern Maine Medical Center
- » Primary care providers (i.e., family medicine, nurse practitioners, pediatricians)
- » Specialists: pharmacists and clinical pharmacists, psychiatrists, pain specialists, care managers

⁶ From Bangor A2QC Project Work plan, 2015–2018

Progress to Date and Lessons Learned

The prescribing toolkit, entitled *Controlled Substance Clinical Resource Document*,⁷ was completed in November 2015 via funding from a MeHAF planning grant. The Toolkit includes practice standards for pain management, a patient-provider agreement for controlled drug prescriptions, and patient informed consent forms for opioids for chronic pain, benzodiazepines for anxiety disorders, and stimulants for adult attention deficit disorder.

- » The Bangor Area Controlled Substance Workgroup (BACSW),⁸ a collaborative effort of clinical leaders from partner organizations, developed and adopted the prescribing toolkit within 12 months. Key leaders reported that the BACSW accomplished this so quickly due to several factors:
 - **MeHAF funding accelerated the CHLB's efforts to leverage partnerships at all levels (executive to clinical staff) to expand the prescribing protocol beyond PCHC, where it was first developed and implemented.** Led by Dr. Noah Nesin, PCHC's Controlled Substance Initiative (CSI) included a case review mechanism for opioids as well as policies and procedures. After hospital executives on the CHLB identified the opioid crisis as a priority, they encouraged the clinical leaders to get involved and attend monthly meetings to develop the toolkit. Interviewees reported that the MeHAF grant enabled them to bring these clinical leaders, who are usually under-represented, to the table to discuss responsible prescribing. Additional 1:1 outreach by a key pharmacist to partners was also essential.
 - **PCHC's experience using the prescribing protocol gave them the expertise, credibility, and compelling evidence for the other BACSW members to participate in developing the toolkit and adopting the standards.** PCHC pharmacists and the quality department had conducted chart reviews of thousands of prescriptions as part of continuous quality improvement. CSI case reviews also included exploring causes of pain such as early trauma. The BACSW became a natural resource and its members became champions to obtain buy-in from providers in their own institutions.

7 https://www.mainequalitycounts.org/image_upload/B1_BACSWG%20Documents_revised_USE_FINAL2.pdf

8 A subcommittee of the CHLB

- **Providers and partners recognized their contribution to the opioid crisis, and the value of collaboration to develop and implement a solution to the problem—the prescribing toolkit.** Key primary care partners recognized that, despite their desire to help patients, their prescribing practices for the past few decades had a role in creating the opioid crisis due to their inability to effectively address chronic pain and addiction. Having a practice standard “made us feel better to get on top of the problem.” The BACSW also recognized the system’s role in the problem, such as unrealistic institutional expectations of providers to assess pain at every visit, to eliminate pain, as well as time pressure.
- » Provider adoption of the 2015 prescribing standards and toolkit among partner organizations is still in progress and is expanding regionally via primary care practices. PCHC has trained providers via continuing medical education and patient education efforts are also underway (see below). In order for the toolkit to be maximally effective, all providers need to adopt and use the standards and share information to prevent patients from getting prescriptions from different providers in the area. The plan to monitor provider and patient compliance is in progress.
- » “Success breeds success.” After the successful collaboration resulted in the development and early implementation of the primary care prescribing toolkit at PCHC, BACSW members representing specialty groups such as psychiatrists and pediatricians convened to develop a similar toolkit for benzodiazepines and stimulants. Hospital partners developed a prescribing protocol for emergency departments (EDs) and chief medical officers are developing a protocol for surgeons and other specialists as well as dentists. Providers in other regions of Maine and hospitalists at Southern Vermont Medical School have expressed interest in the toolkit.

Evaluation

PCHC has already presented and drafted a publication on early promising results of their use of the prescribing protocol.⁹

- » Data sources: Electronic health records of partner institutions and HealthInfoNet
- » Planned measures:
 - Fully implement toolkit at target sites (additional sites will be on-boarded going forward).
 - Increase percentage of eligible practices implementing each element of common prescribing protocol, including adoption of formal policies, patient-provider agreements, best practices, plus tools for assessment/evaluation of pain.
 - Providers use validated tools for chronic pain assessment and management.
 - Decrease number of narcotic prescriptions and dosing levels (i.e., unnecessary prescriptions).
 - Reduce calculated daily morphine equivalents combined with compassionate tapering that leads to eventual discontinuation of opioid therapy.
 - Patients adhere to patient-provider agreement and patients are satisfied with pain management.

In addition, they are tracking and analyzing the number of people using opioids chronically, as well as premature death rates for those under age 60 and how many are related to opioids.

9 Gernant SA, Bastien R, and Lai A. Development and evaluation of a multidisciplinary controlled substances committee within a patient-centered medical home. *Journal of the American Pharmacists Association*, 55:6 (2015), 2–9.

3. A2QC Activity 2: “Warm handoffs” of patients with substance use disorder (SUD) from ED or urgent care to primary care

Objective¹⁰

“Expand warm hand-offs of patients from emergency department (ED) and urgent/walk-in care settings (where many uninsured seek care) to primary care settings (where their care can be better managed)”

Lead Partners

Eastern Maine Medical Center (EMMC), Clinical Research Center (member of Eastern Maine Healthcare Systems or EMHS) and PCHC

Key Partners

- » EMMC (ED director and nursing director; ED clinicians)
- » EMHS Acadia Hospital (psychiatric hospital)
- » Primary care providers and nurse coordinators, led by EMHS Beacon Health, the Accountable Care Organization (ACO), and including PCHC primary care settings
- » St. Joseph’s Hospital

¹⁰ Grant work plan

Progress to Date and Lessons Learned

- » EMMC conducted an assessment involving 1) interviews with key providers (medical director, director of ED, nursing director) to assess which services were being provided to patients with substance use disorder and mental health disorders and 2) analysis of electronic health records (EHR) to determine the extent to which patients were getting screened and/or having their screening documented, and how many patients received opioids in the ED for acute pain. The main findings from the assessment were that although the EHR already included five screening questions for SUD, not all providers asked patients these questions, and that even when asked, patients may not have consistently answered truthfully. The patient's degree of candor may have depended on which provider asked them. One of the biggest challenges for the ED was what to do with patients who screened positive for SUD.
- » The EMMC team and their partners are developing and pilot testing a "warm handoff" workflow for ED patients to streamline the transition of care from ED to primary care. The workflow will include a way to assess and identify ED patients with SUD and mental health issues and transfer them back to primary care providers to address opioid use and mental health issues. This initiative also aims to provide therapy and care coordination to ED patients if needed, via a behavioral nurse coordinator (from Acadia Hospital). This coordinator will: 1) ensure that ED patients get screened for SUD using the five questions, 2) correct any inconsistencies in patient responses given to the triage nurse vs. the physician and 3) ensure the responses are documented in the EHR so that lead team members can access the data.
- » PCHC began a program to encourage management of chronic care issues in primary care settings and decrease ED/urgent care visits. PCHC's "Care Transitions Program" focuses on the "warm hand off" for inpatients. A pharmacy resident and an RN care manager go to St. Joseph's to assess patients with high risk factors and likelihood of re-admission, and meet with patients in the hospital to help with education and their transition home. Then they meet them at home after discharge.
- » St. Joseph's Hospital is developing a High Utilization Group (HUG), modeled after PCHC's. They also hired two Care Transitions nurses for their ED who work on patient care plans, coordinate care, and work with outpatient care managers. One of the outpatient care managers attends PCHC's HUG.

- » Challenges: Some of the main challenges interviewees cited thus far were:
 - The EHR did not have the data needed.
 - The people they are trying to identify and reach do not necessarily want to be identified.
 - Patients who have access to primary care may not perceive it as their medical home, and therefore do not see the value of a warm handoff.
 - Details about the care coordination via Acadia Hospital have not yet been developed (i.e., number of hours, co-location vs. on-call, etc).
- » For sustainability, partners are trying to identify how to get reimbursed for the behavioral health specialist in the ED beyond the Maine Care (state Medicaid) patients.

Evaluation

- » The EMMC team is taking the lead on the evaluation of this activity, which includes a health economist working with billing staff at EMMC to assess the effects on costs. The team is also collaborating with PCHC and the local evaluation consultant.¹¹
- » The evaluation team is using the RE-AIM Framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance).¹²
- » Data sources: Electronic health records (EHR) and qualitative data
- » Planned measures:
 - Growth in referrals from ED to primary care providers
 - Reduced utilization of ED
 - Reduced costs for EMMC, especially for frequent ED users
 - Percentage of patients adhering to patient-provider agreement
 - Number of patients served in the PCHC Care Transitions Program
 - Reduced rate of re-admissions.

11 From the University of Maine Center on Aging

12 www.RE-AIM.org, and Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *American Journal of Public Health*. 1999;89(9):1322-1327.

4. Healthy Community Activity: Recovery Coaches

Objective¹³

“Collaboratively clarify specifics of plan for implementing recovery coach program”

Lead Partner

Bangor Public Health and Community Services (BPHCS)

Key Partners

- » Bangor Area Recovery Network (BARN),¹⁴ a non-profit community recovery center and membership organization, including Young People in Recovery (YPR). Most BARN board members are people in recovery.
- » University of Maine Black Bears for Recovery (UBBR),¹⁵ a campus wellness center that supports students in recovery
- » Individuals living in recovery who serve on the planning/implementation committee or will serve as recovery coaches
- » Local evaluation consultant from the University of Maine Center on Aging (the same as for the A2QC grant)

¹³ Bangor Healthy Community Grant Application

¹⁴ <http://www.bangorrecovery.org>

¹⁵ <https://umaine.edu/wellness/aod/bbfr>

Progress to Date and Lessons Learned

- » The grant provided the impetus for BPHCS to create an updated map of the continuum of care for substance use disorder in order to identify system gaps and priorities for addressing those gaps with the help of recovery coaches. As stated in the grant proposal, current evidence-based practice calls for using a continuum of care model rather than acute model of care for substance use disorder.
- » The MeHAF grant came at the “right time and place.” The BARN had begun to build its volunteer program but had not fully launched its recovery coaching program. The peer recovery coaching model selected for use is the Connecticut Center for Addiction Recovery Training (CCAR),¹⁶ although the BARN had previously used the Vermont Recovery Network model.¹⁷ BPHCS is building the capacity of BARN via technical assistance for developing a half-time recovery support coordinator position, recovery coach training, and volunteer management.
- » The need for recovery coaches has been increasing, as evidenced by referrals from the medical community, the courthouse, and the Penobscot jail, where volunteers raise awareness of the recovery coaching for after release (which occurs at midnight, presenting a challenge regarding housing and other supports for those with substance use disorder). Several coaches have already been trained to handle the increasing number of referrals. As of spring 2017, BARN had 22 CCAR trained peer recovery coaches but they were still building the infrastructure such as policies and procedures.
- » The HC grant is also starting to address stigma via resources shared by MeHAF. A social work intern at BPHCS is identifying best practices, including reviewing the anti-stigma tool kit that MeHAF disseminated via a learning community meeting. They may package the information into an electronic environment to teach others about using non-stigmatizing language around SUD and tie it to a CEU.
- » One of the challenges the partners will need to address is reimbursement, since the BARN recovery coaching is not currently reimbursable. BPHCS is also providing connections to potential funders for sustainability of the recovery coach program, including recruitment, training, and management.

16 <https://ccar.us>

17 <https://vtrecoverynetwork.org/data/index.php/recovery-coaching-documents>

Evaluation

- » While still in early stages of implementation, the HC grantee plans to evaluate capacity building via assessing to what extent the BARN-trained volunteer base of recovery coaches increases over time. Another major system change the HC grantee envisions is an integrated recovery system of care that includes connections between the medical and behavioral health agencies that provide care with the BARN so that individuals interested in receiving recovery coaching do not experience any barriers.
- » Approach and data sources: The grant proposal described plans to use a self-assessment tool called the “Recovery Outcomes Matrix: Mapping Recovery Outcome Progress.” This tool measures success in recovery and life domains important for recovery (e.g., self-sufficiency, stability, and wholeness). BARN and BPHCS will begin using this tool for evaluating individual recoveries by early fall 2017. Other data sources will include stakeholder interviews and focus groups or surveys to track community awareness and support for peer recovery networks.
- » Planned measures:
 - Short-term Measure: Increased organizational capacity
 - Intermediate Measure: Referral growth to recovery coaching program
 - Long-term Measures: Improved recovery support and engagement; self-sufficiency and wholeness; sustained increased organizational capacity and community support of recovery networks.

5. Community Member Involvement

Access to Quality Care

The local evaluator developed a focus group protocol designed to solicit community member feedback on two A2QC focal areas. The first area is examining perceptions of community members about the reasons behind the implementation of shared prescribing protocols. The second area focuses on evaluating the effectiveness of Adverse Childhood Experience (ACE) educational materials in building an understanding of ACEs and their health implications. A group has been convened with the PCHC Unlimited Solutions Clubhouse,¹⁸ and more community member focus groups are planned through the BARN and populations served by partnering A2QC organizations.

To obtain the feedback and input of those with lived experience in opioid tapering, the partners and local evaluator designed a survey for PCHC patients whose doses of opioids were tapered. The survey will elicit their sense of what factors facilitated this, the challenges they faced, and their satisfaction with the process. For example, the survey will ask whether patients perceive the changes in provider practice as “They are taking away all my pills.”

The A2QC grantee was also considering leveraging the individuals or groups providing input for the HC grant efforts or other A2QC partners.

Healthy Community

The HC grant initiative had a strong history of involvement and input from individuals from all stages of recovery (early, mid- and long-term) during the planning phase, which has continued during their early implementation phase. These include individuals who also serve key roles at local organizations and agencies (either as staff or volunteer) providing support services, advocacy, or healthcare.

The HC grantee recognized that due to the large number of SUD activities in the area, several key individuals in recovery were at risk of getting too many requests for providing input. These individuals had been engaged in the planning phase of the grant and continued to be involved in the implementation phase on the planning/implementation committee or planned to serve as recovery coaches.

¹⁸ <http://www.unlimitedsolutionsclubhouse.com>

Partnering with BARN ensures the involvement of many individuals in recovery via its board members, membership, and recovery coaches.

Strategies to sustain their involvement and engagement include:

- » Offering training on advocacy and/or recovery coaching.
- » Offering opportunities to speak at public forums.
- » Developing recovery coaching opportunities for more individuals in recovery.

6. Summary

At a critical time for Bangor, the MeHAF A2QC and HC implementation grants are furthering the momentum and work of the collaborative of key institutions to address system wide gaps in the continuum of care for substance use disorder.

Partners were motivated to collaborate to address the complexity and urgency of the opioid epidemic, but “Having money to pay people to show up to meetings is really important when they don’t have very much time as it is.”

MeHAF funding accelerated the efforts and facilitated the coordination and collaboration required, especially among clinical partners. The funding also brought together partners who might

not otherwise meet and coordinate on efforts, such as PCHC and EMMC (for evaluation and eliciting community member input), and the University of Maine student recovery group.

During a period of decreased statewide funding that also lacked flexibility, partners appreciated the flexibility of MeHAF funding to meet the local community needs. “We had funding to build the local public health infrastructure’s ability to respond to the opioid epidemic and we went with it. It was flexible.”

The collaboration accelerated by MeHAF funding has already begun to result in systems change in the Bangor area, even though both implementation grants were still in their first (HC) and second (A2QC) years of funding as of January 2017. For example, the funding

allowed comprehensive attention to over prescribing. There are early signs of change in areas that are difficult to change, such as getting providers to do their work differently, and greater consistency in prescribing via the prescribing protocol. Tapering and prescribing protocols were

“In this community we have pockets of champions dealing with the opioid crisis...carving out pieces and coming up with interventions and evaluating them...and all of them require collaboration with institutions that would otherwise not necessarily be working together.”

Local evaluator

“Different health care systems have adopted and shared these new protocols... a testament to Dr. Nesin and the resources that MeHAF and other funding and support have accomplished.”

Local evaluator

fragmented in the past and the prescribing toolkit enabled standardization across different providers and then across institutions and specialties. The grant efforts are also beginning to address gaps in the continuum of care via building capacity of the BARN's recovery coaching. Although each specific activity was making good progress, given that each is being led by different institutions, some interviewees recognized that attaining "seamless coordination" may be limited without concerted efforts to ensure awareness and integration.

"We are hoping to sustain this through shared savings and greater efficiency...everyone will build this into their own budget hopefully."

Grant lead, federally qualified health center

MeHAF funding also encouraged identifying ways to sustain efforts. Partners identified other sources of funding such as federal grants from SAMHSA and the Health Resources and Services Administration (HRSA) as well as other private foundations. In addition, A2QC grant partners recognized the value of savings to their institutions so were building cost savings into evaluation efforts to help justify reimbursement and/or continuation of their activities.