3.7R Medically Monitored Residential: Creating a Critical Service for Complex Patients

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Disclosure Information

- Charlotte VanCleve MSN, PMHNP, CARN-AP
  - No disclosures
- Eowyn Rieke MD, MPH, FASAM
  - No Disclosures

Case #1

- 24 yo female identified patient
  - Severe MethUD
  - Schizophrenia
  - 12 weeks pregnant
  - Unhoused, limited social support
  - Currently in inpatient psych
  - Recently started on a long-acting injectable antipsychotic
  - Persistent hallucinations focused on history of sexual trauma and danger to fetus
  - Court ordered substance use treatment for the duration of her pregnancy

Case #1

- In your community could this person access residential substance use care?
- What resources are necessary to support this patient in substance use care?

Learning Objectives

- Understand why 3.7R is an important part of the substance use continuum of care
- Appreciate nuances of program design to maximize patient satisfaction, access to care, and improvement of complex substance use, medical and psychiatric conditions
- Discern challenges to building 3.7R programs and strategies to overcome them

Agenda

- Program Description
- Beginnings
- Model
- Staff
- Admissions criteria
- Specific services
- Care Coordination
- Transitions
- Group activity

3.7R Medically Managed Residential

- Provides residential substance use care for complex people who otherwise would not be able to access this care
- Short-term intensive intervention focused on highest health care utilizers with anticipated long-term reduction in total costs of care
- Comprehensive, hands-on services increase likelihood of significant improvement in long-standing medical and psychiatric conditions while in substance use residential treatment

3.7 criteria changes

- Our model is based on ASAM 3rd addition criteria
- 4th edition will require significant staffing changes and model re-development
- We're not sure if the ASAM 4th edition 3.7 criteria will be a sustainable model

Why is 3.7R Important

- People with substance use conditions have increased incidence of medical and psychiatric conditions, some of which are directly related to substance use.
- People with complex medical and psychiatric conditions may not be eligible for standard 3.5 residential. Even when accepted they may need additional support to succeed in treatment.
- Reduction in use of substances has a corresponding reduction in morbidity and mortality from medical and psychiatric conditions.
- Reimburses programs for work that often they are already doing for complex patients and provides resources and support for overwhelmed staff.

> So many of the patients in 3.7 have been turned away and had PCPs not listen to them because they were using substances. They haven't been heard.
>
> *Fora Staff*

Andersson 2023, Bech 2019, Fleury 2023, Ingram 2023, Laramée 2015, Roerecke 2014, Schwarzinger 2017, Scott 2011, Sohi 2016, WHO 2018

How did our 3.7R program come to be?

Fora 3.7R Beginnings

- 2014 – our local Medicaid payor identified 500 most expensive members
  - only 8 people had gotten SUD treatment despite high prevalence co-occurring SUD and MH treatment in that group
  - Wanted to address the gaps for those patients
- Goal: save money to the healthcare system and improve member health
- Solicited applications and our organization applied!

Fora 3.7R Complex = $$

- Complex patients require specially designed services to manage the intersection of their medical, psychiatric and substance use conditions.
- Many of these patients are also struggling with significant social and financial challenges: lack of housing, food, transportation, financial resources, inadequate community and social support
- Recent data from a local CCO shows that 10% of patients, most with SUD conditions, account for 40% of total health care costs.
- Addressing substance use along with medical/psychiatric conditions may reduce cost and improve health and wellbeing

Fridell 2019, Jewell 2013

Case #2

- 30 yo female-identified patient with Opioid Use Disorder and Alcohol Use Disorder
  - 2022 9 month hospitalization for necrotizing wounds
  - 2023 referred to residential after 6 month hospitalization for same
- Ongoing care
  - 2x/week wound care (2+ hours/session)
  - Regular appointments with primary care
  - Ongoing support to build independence and self-confidence with health needs
  - Started long-acting injectable buprenorphine, long taper of SL bupe

Fora 3.7 Model

- Residential SUD care for people who have
  - complex medical and/or psychiatric conditions
  - conditions interfere with engagement in treatment
- We provide
  - trauma-informed care with a harm reduction focus
  - close collaboration with residential staff
  - care coordination and case management to
    - improve medical and psychiatric conditions
    - support completion of treatment activities
    - increase likelihood of completing treatment
    - build self-efficacy, health literacy and systems navigation skills

With 3.7 we are able to provide ongoing support through managing stress of medical/psychiatric conditions.
Fora Staff

Mee-Lee 2013, Bjornstad 2019

Fora 3.7R Model continued

- Built in an established 3.5 residential SUD program that incorporates dual diagnosis counselors, alcohol and drug counselors, limited psychiatric and medical services including medication for addiction treatment (MAT)
- People move between 3.7R/3.5 as medical and/or psychiatric conditions stabilize or destabilize while in residential

Fora 3.7R Staff

- 3.7 dedicated full-time staff
  - Patient Care Support, medical assistant or similar
  - Case Manager, ideally with peer credentials
- Other staff part-time 3.7
  - Medical Director: MD addictions specialist
  - Medical Manager: PMHNP addictions specialist
  - Psychiatric Addiction Fellows
  - Residential Leadership
  - Counseling Staff
    - Drug and alcohol counselors and/or dual diagnosis counselor (masters in counseling)
  - Peer Mentors
  - Residential Counselors: front line 24/7 staff
    - Additional support in the milieu: daily tasks, emotional support
    - Medication pass – reminding patients to take medications

Some patients are afraid of going to appointments. Peers help patients with transportation and support during those appointments. *Fora Staff*

Be prepared for the unexpected. Have lots of flexibility in staffing. *Fora Staff*

Fora 3.7R Admissions Criteria

- Has changed over time as we've refined the process
- Created collaboratively with residential staff with close attention to individual patient needs plus impact on other patients and staff
- Balance need for programmatic stability with access for patients without other options for residential care
- Ongoing staffing shortages impact level of complexity we can manage
- Consider need for clear criteria vs flexibility and case by case review

Fora 3.7 Admissions: Challenges

- When is someone too acute?
  - Suicide risk (plan or intent?)
  - Psychosis, mania and mental health stability
  - Severe eating disorder
  - Untreated seizures
  - Regular outside medical visits >2/week
    - Wound care, physical therapy
    - Other complex procedures/surgery

Everyone in the community says: are they super complicated? Send them to Fora! *Fora Staff, recently employed by a community partner*

Fora 3.7 Admissions: Challenges

- Complex referral process involving significant medical records
  - Robust admissions team
  - Extensive time spent in records review
- When we deny a patient for being too complex, where can they go?
  - Often there are no other options
  - Causes community partner frustration

Fora 3.7 Admissions: Learnings

- Collaborative decision making between medical and residential staff on complex admissions
- Have clear criteria, add as you learn
- Ensure partners understand reasons for admissions criteria
- Patients must be motivated to be in residential treatment
- Create a referral form with clear rule outs (for example ADLs), designed with community partner feedback
- Admissions timeline may not line up with hospital discharge planning

Englander 2018, Fanucchi 2018, Velez 2016

Fora 3.7R Services

- 3.7R at Fora
  - Medical/psychiatric assessment on day of admission
  - Psychiatric patients: at least weekly medication management visits, 1 – 2 weekly appointments with addictions counselor and/or dual diagnosis counselor
  - Case Manager providers daily check-ins and regular care coordination with primary care provider, specialists, wound care nurses, etc.
  - Daily 3.7 Group – coffee, community, care coordination
    - Build self-efficacy, health literacy and system navigation skills

> By the time they transfer out [of 3.7] they are more comfortable talking about their needs. That empowers them to continue to advocate for themselves.
> *Fora Staff*

Fora 3.7R Services: Challenges

- At what point are medical and psychiatric issues so complex or distracting from substance use treatment, that we consider discharge?
- Medical issues become primary focus, rather than substance use
  - Sometimes driven by medical need, sometime patient focus
- Patients gain from self-identification as 3.7R
- Staff and patient confusion about levels of care
- Where to send patients once they graduate from residential?

Sometimes staff are overwhelmed with medical concerns of patients. Clear staff training on boundaries is important.
Fora Staff

Fora 3.7R Services: Learnings

- Do not provide direct care
  - Establish all patients, including psychiatric 3.7R with primary care
  - Intensive care coordination rather than medical services
  - Build skills to care for and advocate for self when in community
- Team communication
  - Large team caring for patients can result in mixed messages with patients, can lead to triangulation, conflict and confusion

Fora 3.7R Intensive Care Coordination

- Contact community providers (PCP, specialists) at admission and ongoing, often 1+/week
- Daily huddle (15 – 30 min): 3.7R medical/psychiatric team
- Weekly care coordination with Residential Counselors and Leadership
- Weekly Systems of Care meeting, many residential staff plus medical

Fora 3.7R Care Coordination Challenges

- Lack of primary care access
  - Weeks to months wait for appointments, esp new patients
- Medical providers too busy to coordinate
  - Even when we have information critical to patient care
- Psychiatric services at discharge
  - Lack of access in the community, especially for higher level mental health needs such as Assertive Community Treatment (ACT)
- Time, time, time
  - Wait on hold, unclear communication timeline
  - Often need quick access to records

Fora 3.7R Care Coordination Learnings

- Build relationship between patient and primary care
  - Often they have only seen each other when substance affected or in crisis
- Patients from out of area: work with insurance companies to access local medical services
- Consider working primarily with 1 primary care clinic and developing a complex care program
  - Insurance barriers

"The communication has been wonderful and I've gotten to know the patient better. The Fora team has been super proactive about the plan of care" *Community Partner*

Case #3

62 yo male-identified African-American unhoused veteran with AUD

- no known medical or psychiatric conditions
- first night in res wandered the halls talking about killing people
- Initial intervention:
  - next day psychiatric assessment
  - diagnosis of complex PTSD
  - initial medication management
  - close collaboration with res staff

Case # 3

- Ongoing support
  - 1 – 2 psychiatric visits/week, 2 sessions/week with dual diagnosis counselor plus 4 mental health groups/week
  - Ongoing support from 3.7 staff when he became frustrated or escalated and wanted to leave
  - Expedited connection to PCP to address long-standing health needs which were contributing to emotional lability
  - After 3 weeks stabilized and returned to 3.5
- Graduated from residential
  - connected to long-term housing
  - enrolled in OP services
  - recently finished Certified Peer Mentor training

Fora 3.7R Transitions

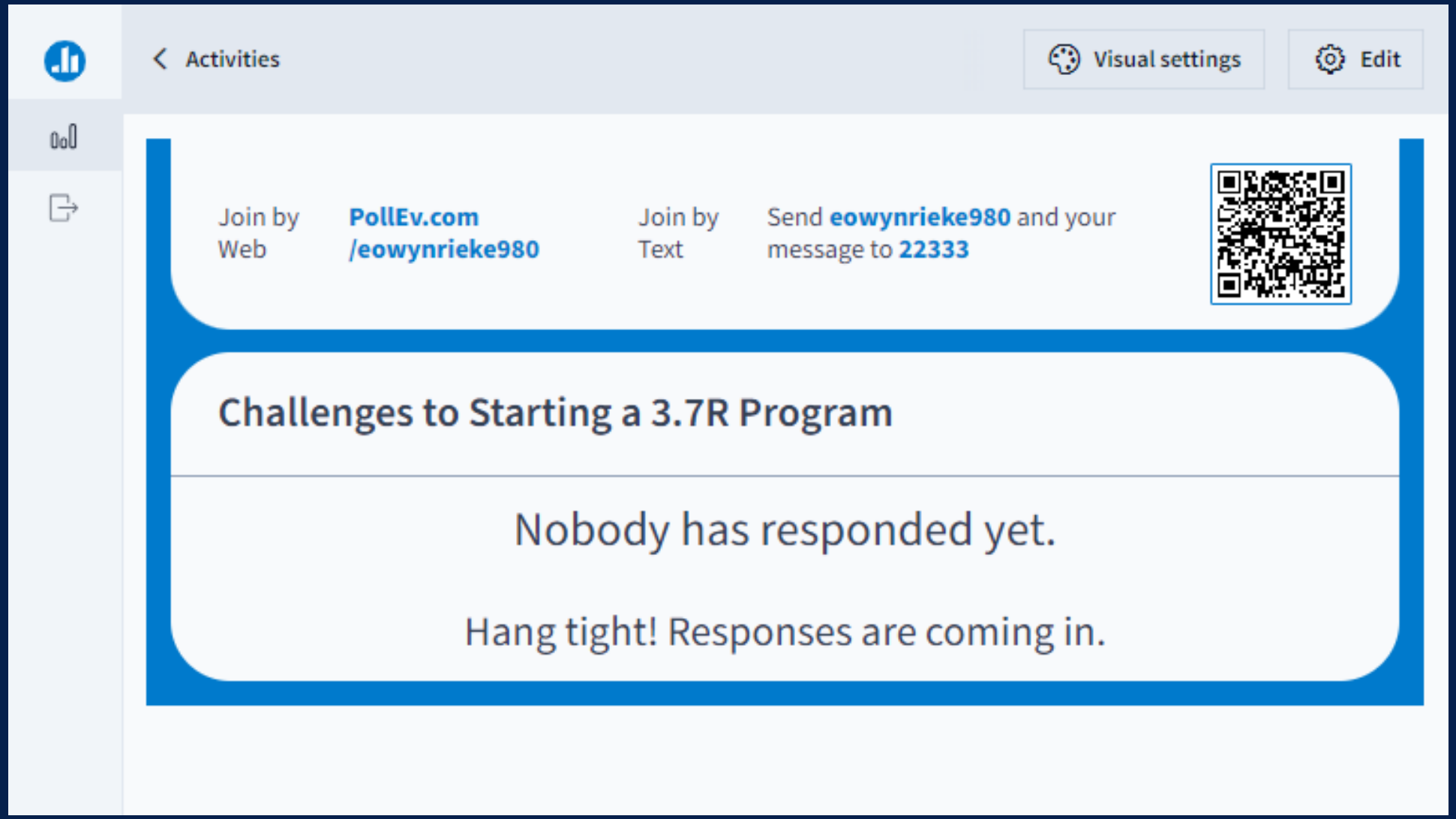
- Collaborative decision with res and medical staff on 3.5/3.7R changes
- Challenges
  - Patients don’t want to lose connection and support when move to 3.5
  - Housing at graduation a greater challenge for complex patients: increase length of stay in residential, often past curriculum completion
- Learning
  - Celebrate graduating to 3.5
  - Meet individually with patients to discuss transition
  - Continue to invite to 3.7R Daily Group
  - Work proactively on housing

Small Group Actvity

- Hopefully you are now interested in starting a 3.7R program in your community. Let's talk about that!
- Small group activity time!

Small Group Activity

- What are barriers to 3.7R in your community or setting?
- If you work in a current 3.5 residential SUD program, what are some of the opportunities and challenges to bringing 3.7R to your setting?
  - 5 -10 minutes individual reflection and brainstorming
  - 10 - 15 minutes to discuss with people at your table greatest challenge and opportunities.
  - We'll come back to the larger group to talk about your findings.


Activities
Visual settings
Edit
Join by Web
PollEv.com /eowynrieke980
Join by Text
Send eowynrieke980 and your message to 22333
Challenges to Starting a 3.7R Program
Nobody has responded yet.
Hang tight! Responses are coming in.

Join by Web **PollEv.com/eowynrieke980** Join by Text Send **eowynrieke980** and your message to **22333**

Strategies to address these challenges

Nobody has responded yet.

Hang tight! Responses are coming in.

Take aways

- 3.7R is a critical part of the substance use continuum of care
- A 3.5 residential program is a critical partner to 3.7R level of care.
- Think carefully about admissions criteria, community partner communication, staff training and support, patient education and support, transitions and ongoing care.
- When it works, it is beautiful. Humans are incredibly resilient. People get better and staff feel an amazing sense of accomplishment.

THANK YOU

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- Our patients!

Q&A

- Please contact us!
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Thank you!!

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