

Northwest Portland Area  
Indian Health Board  
Opioid Training

didg<sup>w</sup>álič Wellness Center

Swinomish Indian Tribal Community  
History/Planning/Operations

Rocky Boy, Montana  
7/31/2019

Swinomish  
didg<sup>w</sup>álic  
Wellness  
Center



John Stephens

EXECUTIVE DIRECTOR

# Swinomish SUD to OTP Program Evolution

\*1976-1997-Typical/Historical I.H.S. Funded Alcohol Program-No State Certification/No Medicaid supplement

\*1997-2006-I.H.S. State Certified Alcohol Program-Medicaid funding/State and I.H.S. data requirements

\*2006-2009-Broader SUD issues evolving/being recognized as significant Public Health/Medical issues

\*2009-2010-Community consensus and awareness and Overdose deaths begin to drive a Tribal government response

2012-Tribal Multi Department Opiate Task Force formed with findings and recommendations

Mid 2012-Office Based Opiate Treatment option developed between Wellness and Medical Departments

2013 Transitional Housing Options Developed

2015-Limitations in service delivery response identified, including mixed households and need for additional Medication Options(ie. More structured daily monitored dosing and methadone)

2017-Property purchased to expand Program, didg<sup>w</sup>álič Wellness Center Program Development begins

2018-State Medicaid agency State Plan Amendments pushed through and didg<sup>w</sup>álič Wellness Center Program initiates Operations

# ADDRESSING THE NEED



The Swinomish Senate ambitiously decides to use their own funds and resources to combat opioid crisis.

Community understands that this is a local and national issue affecting Native and non-Native populations.

# ADDRESSING THE NEED



Property purchased:  
September 28, 2016

Grand opening:  
January 8, 2018

# NEXT STEPS

1

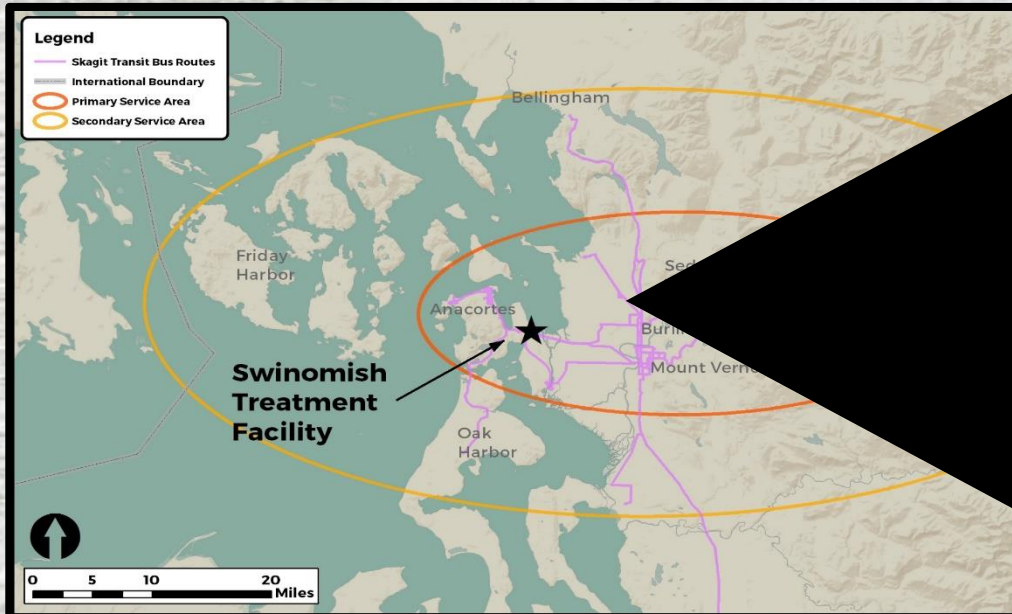
- Initiate long and involved permitting/licensure process

2

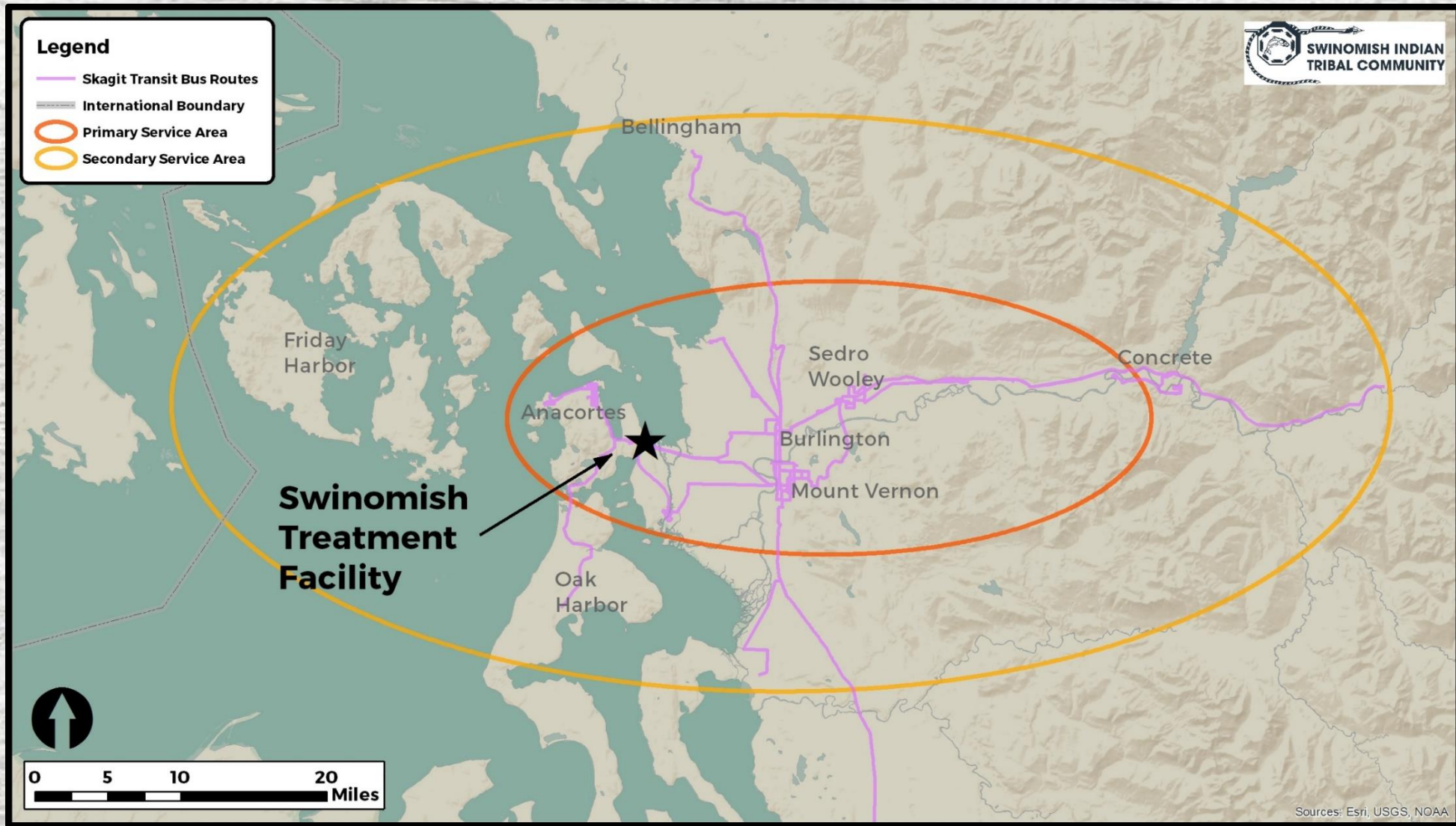
- Convert property to medical facility

3

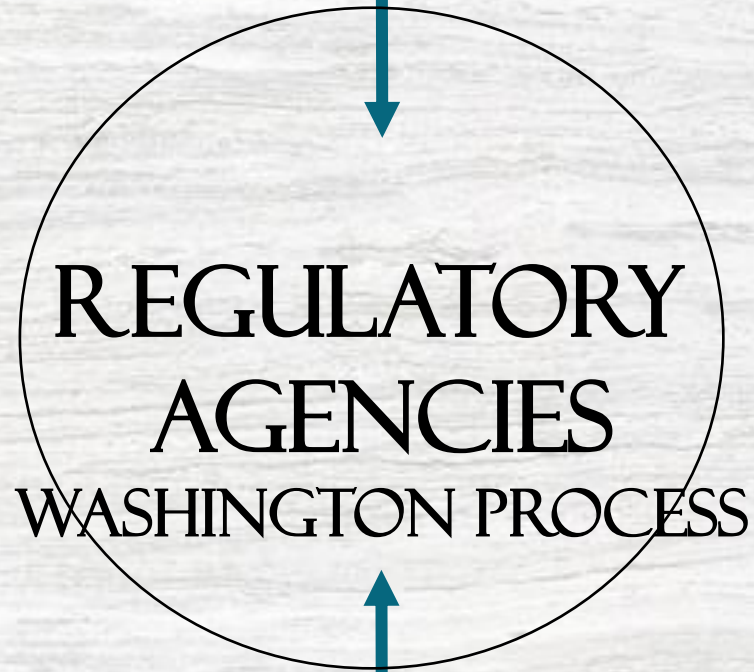
- Hire skilled staff



# SERVICE AREA







1

CITY/COUNTY/TRIBAL AUTHORITY

2

WA STATE DEPT OF HEALTH

3

WA STATE BOARD OF PHARMACY

4

WA STATE HEALTH CARE AUTHORITY

5

U.S. HHS-SUBSTANCE ABUSE & MENTAL  
HEALTH SERVICES ADMIN

6

U.S. HHS-I.H.S. and CMS

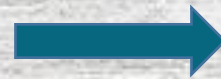
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US DRUG ENFORCEMENT  
ADMINISTRATION

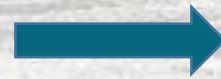
# INVESTING IN *Safer Communities*

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“[M]edication-assisted therapy is associated with reduced general health care expenditures and utilization, such as inpatient hospital admissions and outpatient emergency department visits”  
– Mohlman, et. al.



Swinomish Program will mitigate community impacts of the opioid crisis



Will alleviate burdens on first responders, public hospitals, law enforcement

didg<sup>w</sup>álič provides patients with

*all the tools necessary for success*

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## **SERVICES OFFERED**

OUTPATIENT TREATMENT SERVICES

PRIMARY MEDICAL CARE

MENTAL HEALTH COUNSELING

MEDICATION-ASSISTED THERAPIES

SHUTTLE TRANSPORTATION

ON-SITE CHILDCARE

CASE MANAGEMENT & REFERRALS



# PERSONNEL

*based on 250 patients*

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Social Worker/CDPT

1 FTE

Licensed Mental Health Counselors

3 FTEs

- *Clinical Supervisor, 1 LMHC/CDP, 1 LMHCA*

8 FTEs

Administration

- *Office Manager, 3 Administrative Assistants, 2 Child Watch Attendants, 2 Data Entry/UA Techs*

4 FTEs

Billing – Manager, 2 Specialists, Billing Ass't

Security/Transportation

11 FTEs

- *Manager, 3 Security Guards, 7 Transporters*

# Other Administrative Support

1 FTEs

Human Resources-HR Manager

1 FTE

Accounting-Accountant

1 FTE

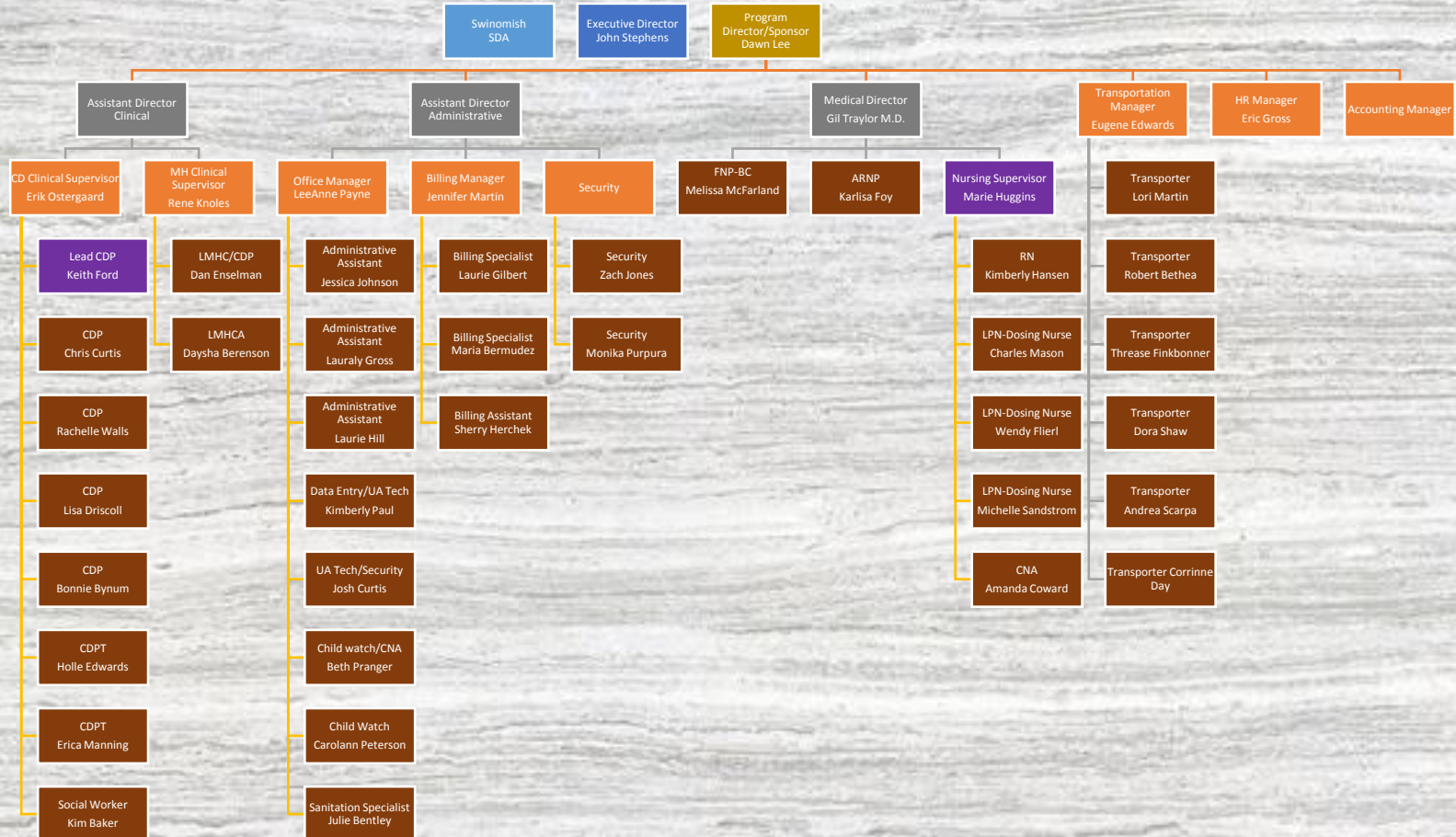
3 FTEs

Information Technology-Chief Information Officer

- Senior IT Tech, IT Developer

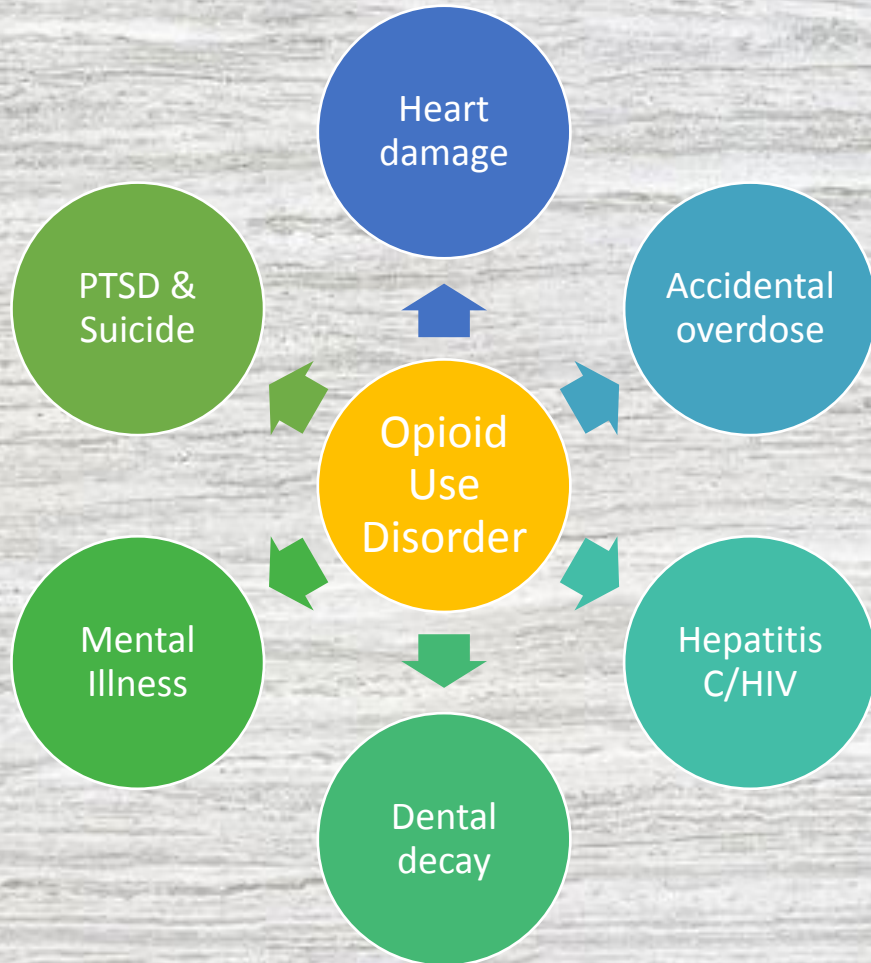
3 FTEs

# Evolved didg<sup>w</sup>álič Org. Chart January 2019





# Opioid Use Disorder Causes High Morbidity and Mortality

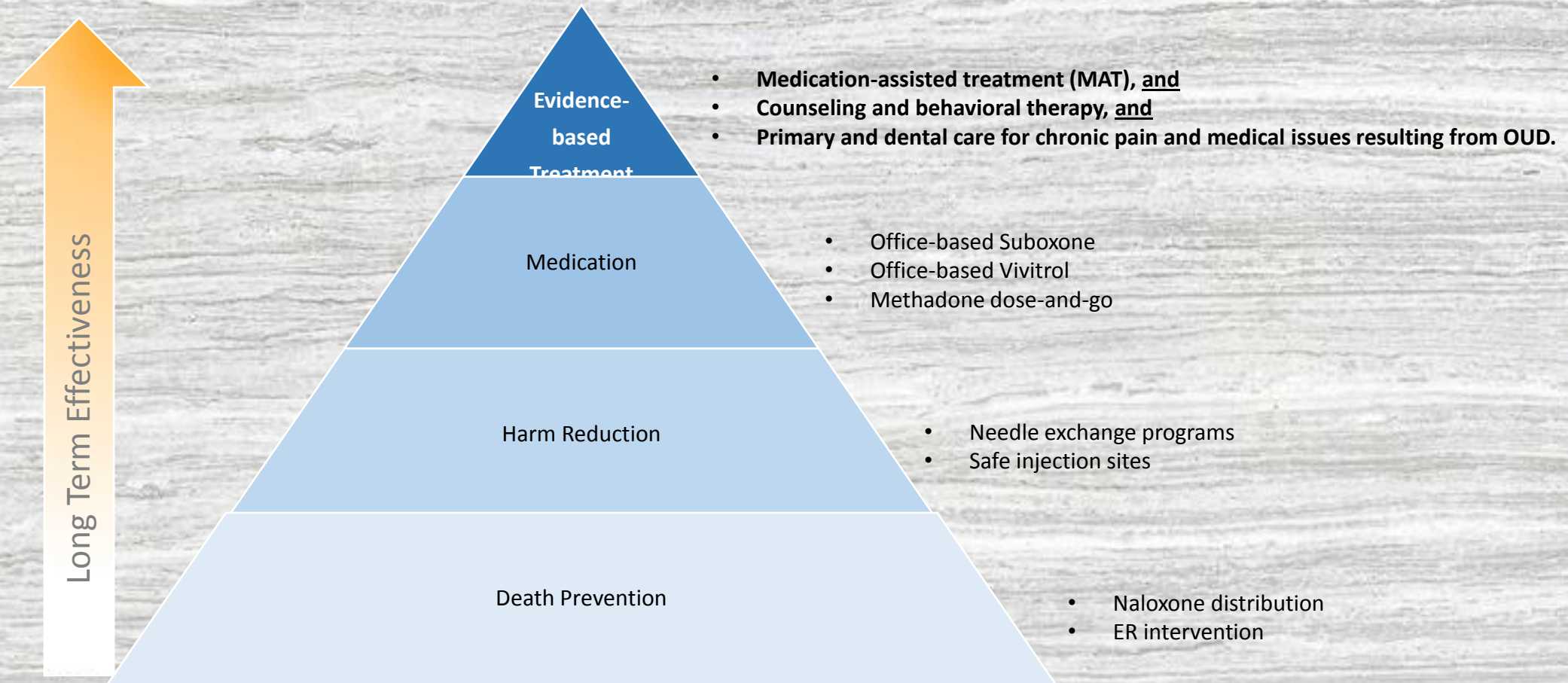


- Opioid use disorder is a chronic, relapsing medical condition.
- High mortality of OUD stems primarily from complications, such as accidental overdose, trauma, suicide, or infectious disease (e.g., Hepatitis C, HIV).
- There is no known cure. But OUD can be managed long-term with appropriate treatment.

Kosten, Thomas R., M.D. and Tony P. George, M.D., "The Neurobiology of Opioid Dependence: Implications for Treatment," *Science and Practice Perspectives*, July 2002.

Schuckit, Marc, M.D. "Treatment of Opioid Use Disorders," *New England Journal of Medicine*, July 2016.

# HIERARCHY OF OPIOID USE DISORDER INTERVENTIONS



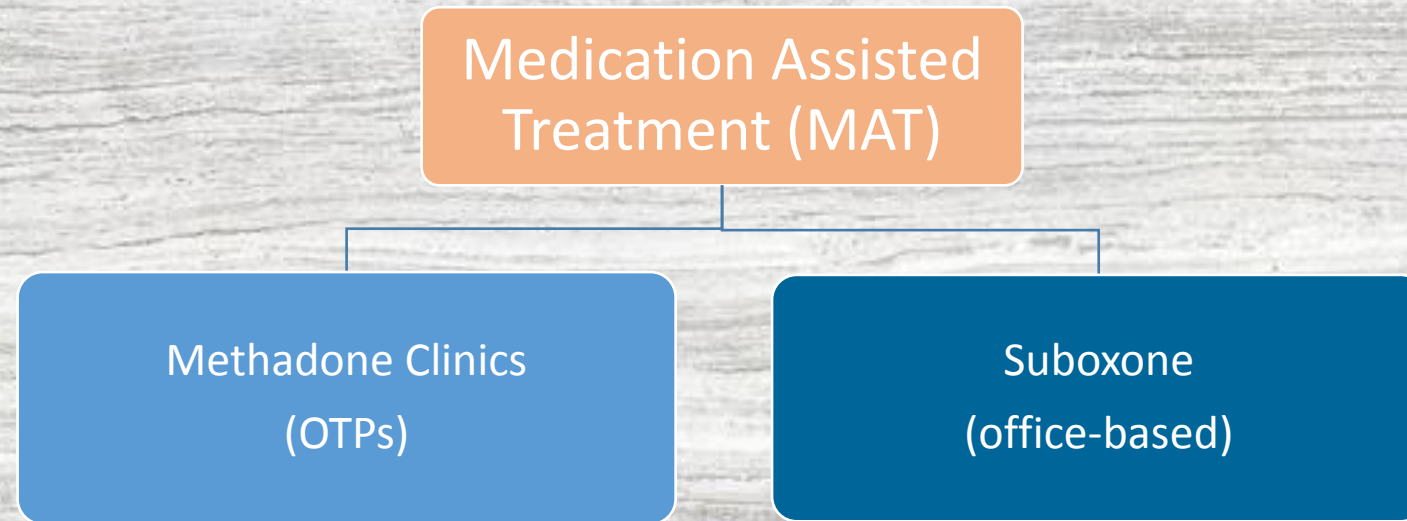
# Health System has not kept pace with available research

*Pharma companies long misrepresented the nature of opioid addiction to doctors, patients and public health policymakers*



# Two Types Of Medication Assisted Treatment (MAT)

- Methadone and suboxone are delivered in two “siloed” environments.
- Methadone is highly regulated and can only be provided through licensed Opioid Treatment Programs (OTPs).
- Under the Drug Addiction Treatment Act of 2000, Suboxone is prescribed by physicians.



# Critical Treatment Gaps in opioid epidemic

**1. MAT is not available for most patients.** Only 23% of publicly funded treatment programs and fewer than 50% of private programs offer MAT.

*American Journal of Public Health*

**2. Most MAT patients don't have adequate access to counseling.** “[B]y itself, medically supervised withdrawal is usually not sufficient to produce long-term recovery, and it may increase the risk of overdose[.]”

*New England Journal of Medicine*

**3. Referrals to primary care are ineffective.** Research demonstrates referrals result in only 35% of patients actually receiving primary care.

*American Journal of Public Health*



Medication assisted treatment - when delivered in conjunction with appropriate supportive counseling and behavioral therapies - has long been recognized as the best and most highly effective, evidence-based treatment for opioid addiction.

*Karen Casper, Ph.D, Models of Integrated Patient Care Through OTPs and DATA 2000 Practices, Published by American Association for the Treatment of Opioid Dependence, Commissioned by Substance Abuse and Mental Health Services Administration, February 2016.*

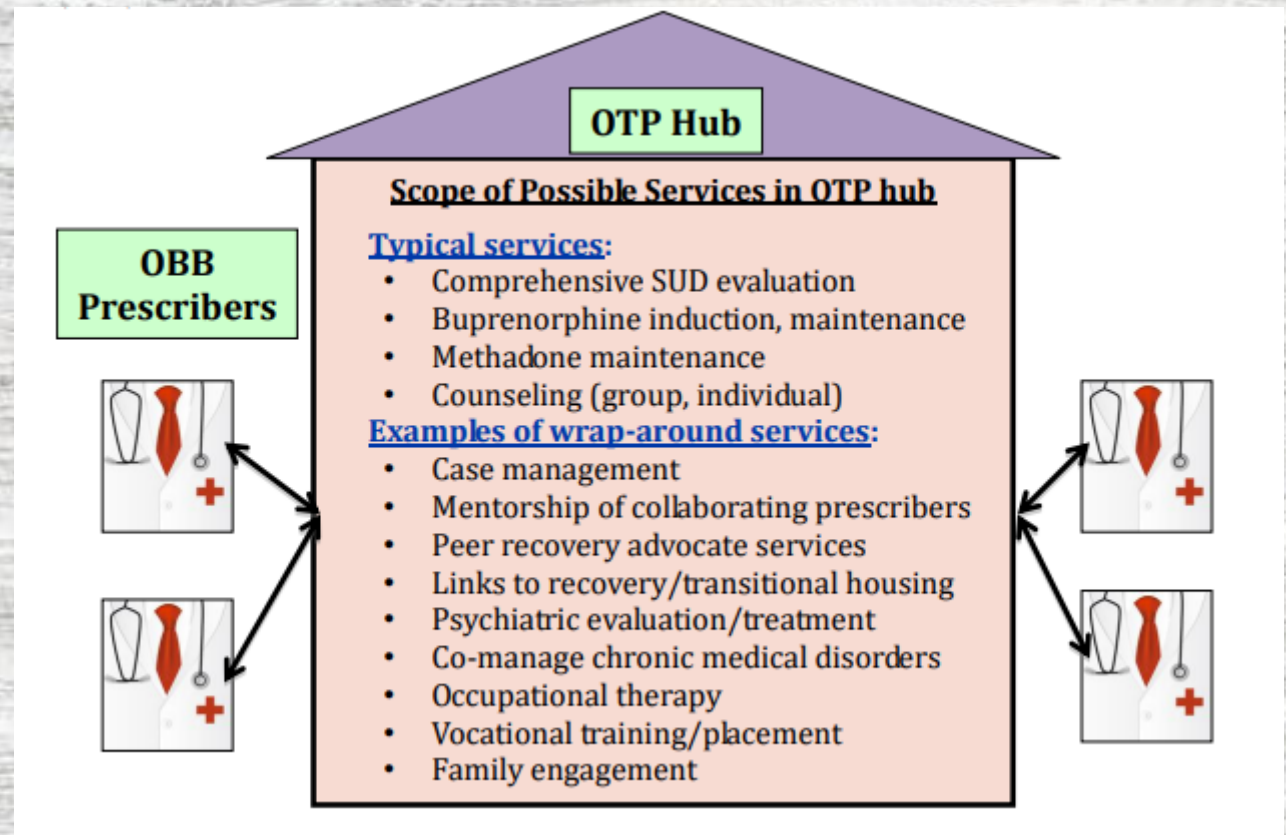
# Solution #1: Vermont “Hub and Spoke” Model



- Regional coordination between agencies and health systems
- Multiple access points from outside agencies
- Assessment and care coordination and referral to other agencies
- Referral network for all components of treatment (MAT, counseling, primary health care, etc.)
- Large scale health care system coordination

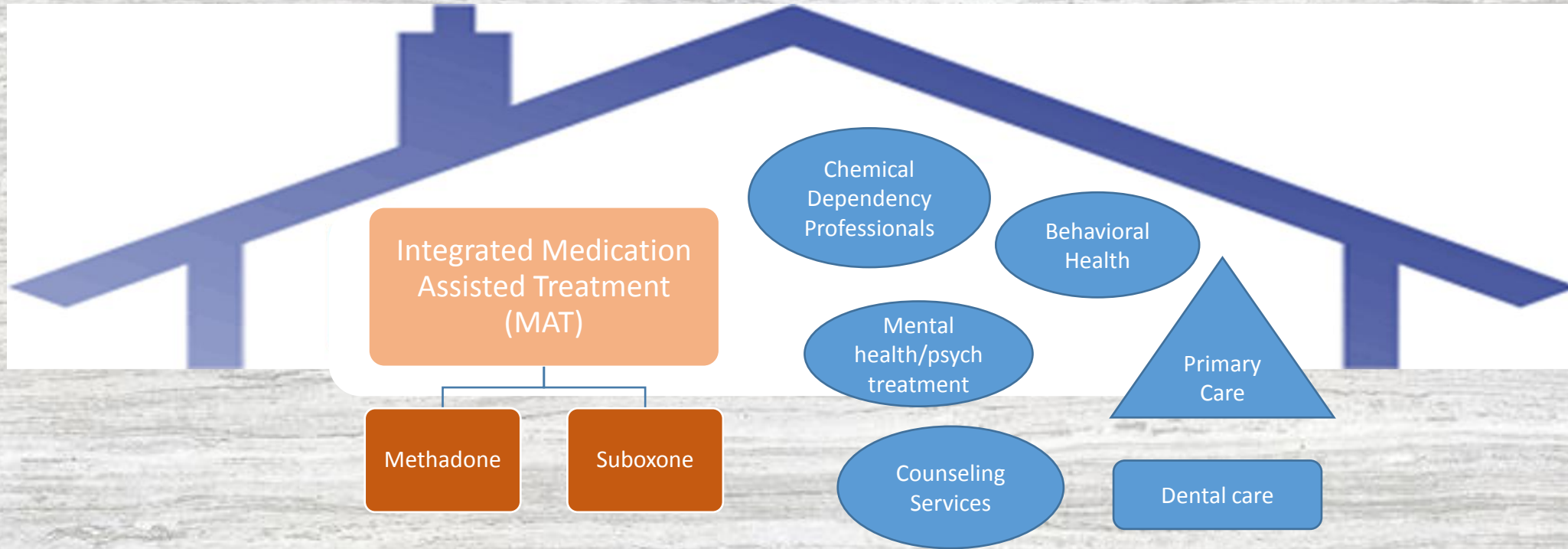
# Solution #2: Johns Hopkins “Collaborative Prescribing” Model

- Two-tiers of treatment:
- (1) Initial intensive therapy and MAT induction
- (2) After patient is stabilized, patients referred out to office-based prescribers
- Goal is to increase utilization of office-based suboxone for maintenance





# SOLUTION #3: SWINOMISH DIDG<sup>w</sup>ÁLIČ “INTEGRATED CARE” MODEL



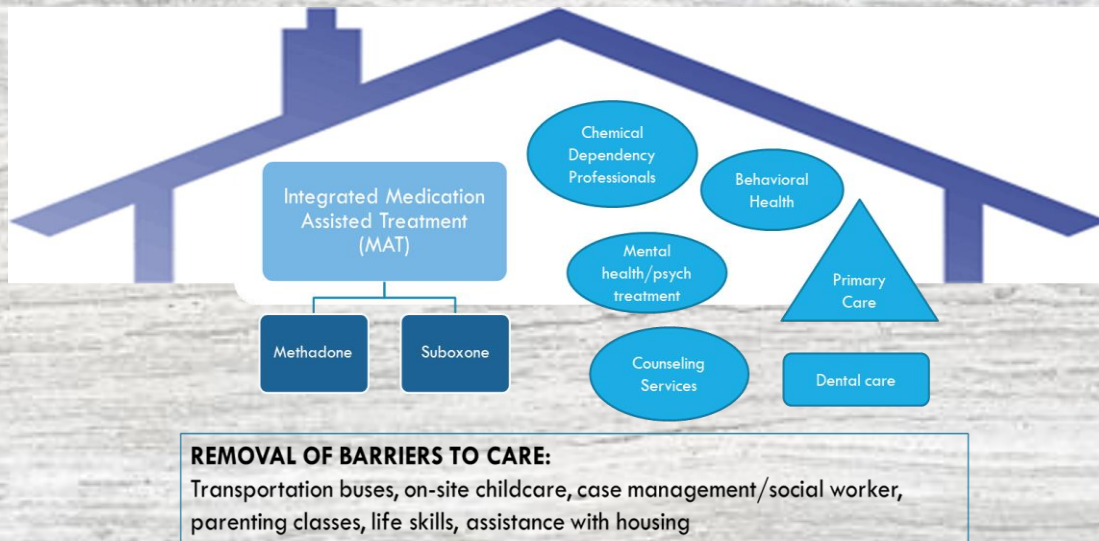
MAT in Jail Program

## REMOVAL OF BARRIERS TO CARE:

Transportation buses, on-site childcare, case management/social worker, parenting classes, life skills, assistance with housing

Transitional Housing

# Swinomish didg<sup>w</sup>álič “integrated care” Model



- Brings all necessary treatment components under one roof
- Integrated care vs. coordinated care
- Not a “triage” model
- Patient-centered – care determined by patient need
- Fully integrated methadone/suboxone/vivitrol options
- Centralized primary care and behavioral health
- Removes barriers that otherwise prevent care
- Adaptive to rural or urban environments
- Adaptive to Vermont or Johns Hopkins eco-system
- Accredited as OTP
- Goal is to remove barriers to care

# didg<sup>w</sup>álič Model

- Holistic – treats the medical and psychological collateral damage caused by opioid use disorder
- Blends best practice, evidence-based treatment with culturally appropriate care
- Eliminates unreliable referrals
- Keeps families together – avoids need to send patients far away for treatment
- Continuity of care within the Tribal wellness eco-system



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