ADAI
ADDICTIONS, DRUG & ALCOHOL INSTITUTE
CENTER FOR COMMUNITY-ENGAGED DRUG EDUCATION, EPIDEMIOLOGY, AND RESEARCH

Health Support Teams Evaluation Report

July 1, 2022 – June 30, 2023

The Health Support Team (HST) model provides a single, easy to access care hub for low-barrier substance use, mental health, and basic medical services, co-located with syringe services programs (SSPs). A Health Support Team includes a prescriber, nurse care manager, care navigator, and a mental health coordinator. HST sites operate with SSPs in **Tacoma, Centralia, Kennewick,** and **Walla Walla**.

This model began to be implemented in July 2021 and built upon a prior model that focused on treating opioid use disorder with low barrier access to buprenorphine. The addition of new mental health care coordinator staff and new services such as contingency management took place at different times throughout the first year and varied by location. Therefore, the most recent year of data provide the best sense of service utilization for mental health related services.

We use several quantitative and qualitative tools and processes to monitor program activities, inform implementation, and evaluate outcomes, including:

- Monthly reporting of site-level activities.
- Bi-weekly meetings for specific HST roles (site leads, prescribers, nurses and care navigators, mental health coordinators).
- Periodic review of de-identified data from site-based electronic health records.
- Qualitative interviews with clients and staff.

The results enable us to answer the following questions at the site and program level:

- **Who are the individuals using HST services?**
- **What services are clients using?**
- **What are the patterns of service utilization?**
- **What has been the experience of clients and staff?**

1. Who are the individuals using HST services?

Between July 1, 2022 and June 30, 2023, the HST program served **523 new clients** (Centralia: 166; Walla Walla: 173; Tacoma: 137; Kennewick: 47). The majority were male (57%), White (75%), and between the ages of 30-39 (38%). Both the number and proportion of non-White clients (among clients with known race/ethnicity) increased to 103 non-White clients (21%) from 83 non-White clients (15%) in the previous period (July 1, 2021-June 30, 2022). About half of clients (51%) had permanent housing, down from 60% the previous period (Table 1).

Table 1. Demographics of HST clients n=523 (7/1/22-6/30/23)					
Gender	n	%	**Housing status**	n	%
Male	298	57%	Permanent	268	51%
Female	220	42%	Unhoused	127	24%
Trans man or woman/another gender	4	<1%	Temporary	112	22%
Unknown	1	<1%	Unknown	16	3%
Race/ethnicity *(multiple allowed)*			**Age**		
White	391	75%	<20	11	2%
Latino/Hispanic	39	7%	20-29	109	21%
Black/African American	25	5%	30-39	198	38%

American Indian/Alaska Native	18	3%	40-49	103	20%
Asian/South Asian	6	1%	50-59	66	13%
Native Hawaiian/Pacific Islander	5	<1%	60+	34	7%
Another race/ethnicity	10	2%	Unknown	2	<1%
Unknown	29	6%			

Table 2 shows that the majority of participants (n=277, 53%) identified fentanyl as their primary substance, followed by methamphetamine (n=80, 15%). This is a significant shift from the previous evaluation period (July 1, 2021 - June 30, 2022), where the highest proportion of clients (40%) identified heroin as their primary substance and only 5% identified methamphetamine as their primary substance (Figure 1). This mirrors recent drug market changes where fentanyl has replaced heroin as the main opioid available in the local drug supply.

Table 2. Primary substance *(multiple allowed) n=523*		
Fentanyl	277	53%
Methamphetamine	80	15%
Other/unknown substance	75	14%
Heroin	48	9%
Buprenorphine	38	7%
Heroin and meth together	4	1%
Cocaine	1	<1%

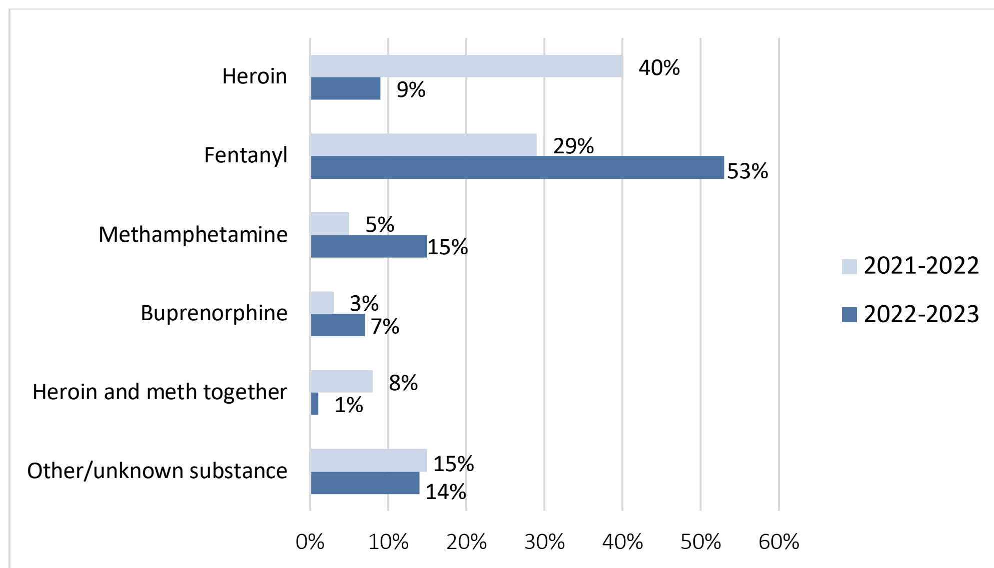


Figure 1. Primary substance of clients at initial visit. n=523

2. What services are clients using?

Entry into HST services

At their initial HST visit, clients reported they had heard about the program through a variety of sources (Table 3). As in past years, **peers/word of mouth remains the most common referral source**; nearly half (47%) of clients heard about the HST program from someone they knew. The prominence of this referral source over time is another indication that clients are having positive experiences with HST staff and services. Other referral sources included the agency's SSP (18%) or another program or service within that agency (12%).

The vast majority of clients (79%) stated their **main concern at their initial visit was to get help with their opioid use**. However, there was a roughly three-fold increase from the previous period in both the number and percentage of clients whose primary concern was getting help with their stimulant use. While still substantially lower than opioid concerns, this was the only category of primary concern that actually *increased* from the last period. Along with the increase in the number and percentage of clients who reported their primary substance to be methamphetamine, these data clearly indicate that **HST sites are engaging more people who use stimulants**. Yet it remains unclear if this increase simply reflects a change in local drug use or attraction to the new Contingency Management program (more discussion of Contingency Management below).

Table 3. Entry into HST services				
Primary referral source	**Current period 2022-2023** n=523		**Previous period 2021-2022** n=630	
	n	%	n	%
Friend, word of mouth	245	47%	202	32%
Agency's syringe service program	93	18%	96	15%
On-site program, not SSP	64	12%	112	18%
Court, jail, prison	29	6%	25	4%
Opioid/substance use treatment program	25	5%	38	6%
Other/unknown source	67	13%	151	24%
Primary concern at initial HST visit	**Current period 2022-2023**		**Previous period 2021-2022**	
Help with opioid use	414	79%	476	76%
Help with stimulant use	78	15%	23	4%
Help with other drug use (not opioid or stimulant)	30	6%	41	7%
Help with mental health	28	5%	49	8%
Practical support*	21	4%	24	4%
Other/unknown concern	14	3%	22	2%

**Food, housing, ID, legal, child/family, transportation, etc.*

Service encounters

Sites documented a total of **10,341 service encounters** during this period, of which 4,780 (46%) were with a nurse care manager/prescriber; 3,623 (35%) were with a care navigator; and 1,938 (19%) were with a mental health coordinator (Table 4). The majority of the 4,780 nurse care manager/prescriber encounters (80%) concerned follow up on medications for opioid use disorder (OUD) or transfer of maintenance care to a community provider.

Most of the 3,623 care navigation encounters concerned retention in OUD care (34%) or general motivational or emotional support (27%). These percentages reflect the proportion of encounters within that staff role, not the proportion of clients who had that type of encounter and are similar to percentages from the previous period.

Sites documented 1,938 encounters with mental health coordinators, with over half (53%) of those encounters related to general emotional support. Over a quarter of mental health coordinator encounters (26%) involved care coordination with a community mental health provider.

Table 4. Main topics of encounters by HST role *n=523* (7/1/22-6/30/23)		
Nurse Care Manager/Prescriber	n	%
OUD medication follow-up or transfer	3,840	80%
OUD medication induction	457	10%
Other medical concern	113	2%
Mental health concern	84	2%
Medication reconciliation	75	2%
Other medication follow up	74	2%
Other medication start	43	1%
Contingency management	43	1%
Medical screening (e.g.,HIV, hepatitis, STI)	35	<1%
Wound care	16	<1%
Category total	**4,780**	**100%**
Care Navigator	n	%
Supporting retention in care	1,235	34%
Motivational/emotional support	983	27%
Linkage to other service/program	615	17%
Contingency management	420	12%
Care navigation needs assessment	245	7%
Harm reduction education/counseling	99	3%
Other care navigation issue	26	<1%
Category total	**3,623**	**100%**
Mental health coordinator	n	%
Emotional support	1,024	53%
Care coordination with mental health provider	499	26%
Brief motivational intervention	181	9%
Contingency Management session	102	5%
Other mental health support	60	3%
Group session	58	3%
Mental health screening	14	<1%
Category total	**1,938**	**100%**
	All encounters 10,341	

3. What are the patterns of service utilization?

Encounters in first 3 months

Table 5 shows the utilization data for those who had at least three months elapse since they started care, by staff type. The median (50th percentile) number of *days* in which clients saw at least one of the three staff types was three days (mean 4.2 during the three-month period. The median number of *encounters* was four; therefore, a substantial minority of people saw at least two types of staff during a clinic visit. The median number of *encounters* with nurse care managers was two. The median number of encounters with a care navigator was one; however, the mean was larger, 2.8 encounters, indicating that some people saw care navigators much more

frequently than others. For mental health coordinators, the average number of encounters was 0.9 days, while the median was 0, indicating far fewer people saw the mental health coordinator.

Table 5. Encounters first 3 months, among those with at least 3 months of potential duration						
	Encounters			**Encounters by staff type**		
	# of visit days	# of encounters	Encounters per visit	Nurse care manager	Care navigator	Mental health coordinator
Minimum	1	1	1	0	0	0
1st quartile	1	2	1	1	0	0
Median	**3**	**4**	**1.1**	**2**	**1**	**0**
Mean	**4.2**	**5.8**	**1.4**	**2.8**	**2.0**	**0.9**
3rd quartile	6	8	1.8	4	2	1
Maximum	28	47	4	21	28	47
Not available				9	9	9

Contingency Management

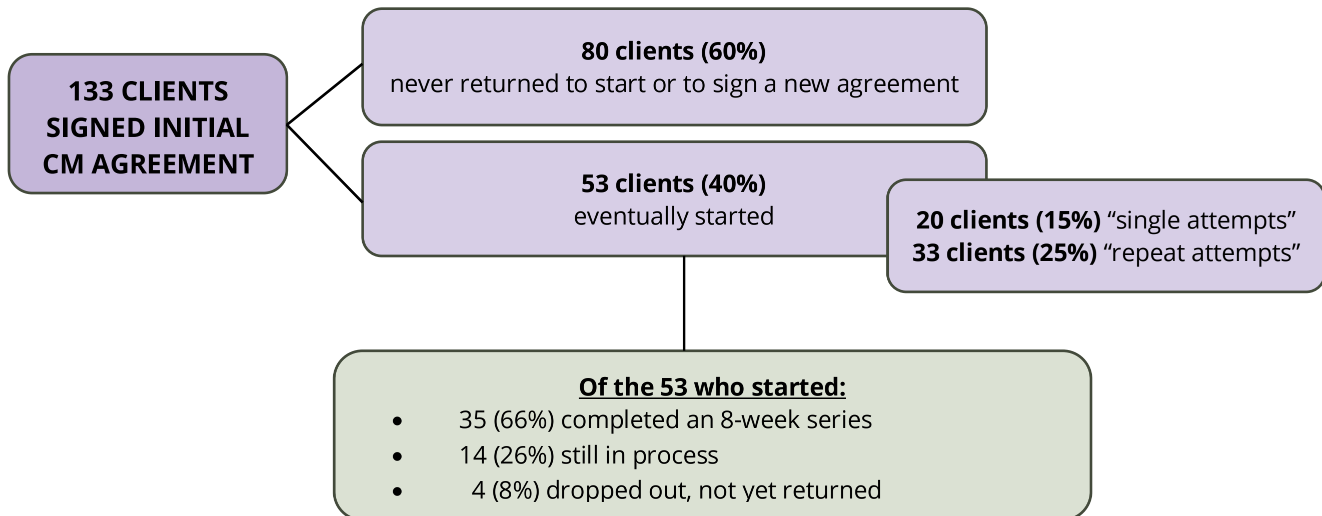
Most HST sites began offering Contingency Management (CM) in November 2021, which added a service component specifically for individuals who use stimulants. These individuals could be current HST clients receiving medications for OUD or could be completely new to the HST program. Depending on the site, CM sessions could be led by the nurse care manager, care navigator, and/or the mental health coordinator.

Clients begin the process by signing a "Contingency Management Agreement" which describes the program and demonstrates their commitment to participate. Then they must provide a stimulant-positive urine drug screen (UDS) within two weeks of signing the agreement. If they do not return within the two-weeks, clients may re-sign a new agreement to try another start. Once the client signs the CM agreement, they are committed to the 8-week series, even if they miss several visits during the 8-week period. During this period, the client engages in twice weekly urine drug testing and receives escalating amounts of gift card incentives for each stimulant-negative UDS.

Interest in Contingency Management has grown steadily and substantially. HST staff provided 565 CM sessions in this period for an average of 47 sessions per month (Table 6). Most of these sessions were led by a care navigator.

Table 6. Contingency management sessions	Current period **7/22-6/23** (12 months)	Previous period **12/21-6/22** (7 months)
Care navigator	420	55
Mental health counselor	102	17
Nurse care manager/prescriber	43	1
Total sessions	**565**	**73**
Average per month	**47 per month**	**10 per month**

Since the start of Contingency Management in November 2021, **133 individuals signed an initial agreement** with the intent to begin the 8-week CM series. About half were engaged in OUD treatment with buprenorphine (either in HST or elsewhere) and the other half were not. Sixty percent (60%, n=80) of these 133 individuals never returned to provide a UDS or to sign a new agreement, while the remaining 40% (n=53) went on to begin with an initial UDS. Of these 53 individuals, 20 began after signing their initial agreement (i.e., "single attempts) whereas 33 individuals needed to re-sign a second, third, or even fourth agreement (i.e., "repeat attempts") before they actually started.



Of the 53 individuals who started, 35 (66%) completed the 8-week series, and 14 (26%) were still in process at the time of this report. Only four individuals had dropped out and not yet returned. Ten individuals (19%) completed a second 8-week series. There was no difference in completion rate between those who were on buprenorphine at the start and those who were not. Overall, of the 133 clients who signed an initial agreement, 35 (26%) completed an 8-week contingency management series eventually.

Of the 35 individuals who completed an 8-week series, 13 of those individuals needed to re-sign a CM agreement at least one to three more times before they actually started with an initial UDS. Allowing people to re-sign was important as it allowed these individuals to complete, which may not have been possible if they had been allowed only one opportunity.

4. How are clients and staff experiencing HST and CM implementation?

Between September and December 2022, we conducted interviews with 15 staff and 27 clients to learn more about their experiences with using and providing HST services, and CM in particular. Between January and June 2023, the research team completed transcription of audio recordings, cleaning of transcripts for accuracy, and coding for inter-rater reliability. Although results are not yet finalized, we present some preliminary results here, ahead of the final report that will be released soon.

Interviews with staff

Among staff interviewed, these themes arose related to **CM implementation**:

- Staff support for CM and its integration with HST is strong.
- CM is an important additional tool to engage with clients.

> *“I think that initially, I was thinking of CM as an add-on to a previously existing case-managed relationship, like as another thing that we do for people already engaged in our case management, and whether they're case managed through our HIV side or the SUD side or whatever.* ***But I think that actually CM could function in multiple ways, and it could be like the entry point for people.*** *It could be maybe the only thing they're doing with us if they don't want to do anything else with us, or it could be like we can start with CM and then move into these other services.”*

- Interest among clients is strong.

> *“I just feel like people are really interested. They're excited about it.* ***They're glad to know. They feel relief to know that they can pick the program back up again if they fall off.*** *That's a big thing because they are-- engaging the pre-pre-contemplators does come with a caveat that they probably are going to fall off a few times in between and keeping them engaged is really important. I love that.”*

- Warm relationships, non-judgmental approach, and rapport with staff are critical to client engagement in HST and CM.
- CM success should be measured through client experience, engagement, *and* retention, not just abstinence.

Themes on **barriers to CM implementation** from staff included:

- Implementation was slower than expected and involved challenges in managing agency guidelines and workforce shortages.

> ***“It took us a long time to get even the program off the ground. And that was very much a lot of bureaucratic barriers that were coming up****. It took us months to get our agency to allow us to do it. It took months to get our agency to allow us to keep cards and keep a stock of cards instead of having to go and buy one every time we expected someone to come in. And then it became even more difficult because the other person who was working with us doing contingency management left suddenly, and we were trying to figure out how to implement it with one less person. So that has been really difficult.”*

- Client’s needs are complex and other basic health and safety needs often override interest in CM. Clients may like the idea of CM but may not be ready to stop their use.

> *"****In the middle of winter, good luck trying to get someone in the middle of our rain to stop smoking meth every day.*** *Good luck getting someone whose partner is trafficking them to stop smoking meth every day when it just helps them kind of manage to get through whatever they're going through. And good luck trying to get those people into a place where they can feel comfortable and also have some freedom.”*

- Requiring a stimulant-positive UDS to be eligible for CM prevented clients who had past problematic stimulant use from participating.

> *“…****Folks who had kind of wanted to be part of this program that had actually already stopped, and one of the criteria was you had to have a positive UA. Your first UA had to be positive. And they were like, "I don't want to go out and use again because I've already stopped.*** *I know I could use some help with stopping, and this would be a good program for me, but if I have to go out and use again so that my first UA is positive, that puts me back in terms of, I guess, my road to sobriety,”*

Interviews with clients

Among the 12 clients we interviewed **who had not participated in CM**, more than half (n=7) expressed interest in participating in CM soon. Starting CM was supported by:

- the need for social and clinical support.
- having clearly articulated recovery goals.
- a positive relationship with HST staff.

> *"I plan on kind of officially stopping my use of methamphetamine and fentanyl. Suboxone does a pretty good job but it's all about the craving.* ***Sometimes it's kind of hard to not crave it, so you have to have-- you have to be in a good environment. I want to put myself in a better environment so that I don't have to worry about--*** *I don't know. I'm an emotional person. I'm very emotional, so I get in a depressed state every once in a while. I don't know. I guess I just got to get help for that, I guess. I don't know.* ***I just need somebody-- like I said, I need somebody on my side to push me."***

Barriers to participating in CM included:

- lack of transportation.
- frequency of program requirements to provide UDS in person (twice weekly).
- not being ready to stop stimulant use completely.

> *"I want to try to sign up for it, I think. I mean, it is a cool idea. But I live a half an hour from the clinic,* ***so to make a trip just for that [contingency management]*** *is hard-- you know what I mean?"*

The 15 clients interviewed **who are participating in CM** shared these themes:

- Interest in a longer CM program (longer/more time than the current 8-week cycle).
- CM provided monetary support for essential needs and could also be used for transport.
- Participating in CM provided them with a sense of personal responsibility and accountability. This helped facilitate their goals around stopping and reducing stimulant use.

> *"It kind of gives you a-- it makes you kind of have to be responsible in a sense. Because you've got to make sure that you show up. I mean, even though it's not a big deal if you fail a drug test or whatever, that's one of those things where it's okay if you falter, but it gives you that-- makes you have to have that sense of responsibility***."**

- Accountability *to* and encouragement *from* HST staff helped clients stay engaged with the program, even when it was difficult or they "failed" a urine drug test.

> ***"Well, I mean it's working so far. I mean I've had a mess up-- so yeah, maybe four weeks in…****I'd rather mess up now though than in the end there or something because that'd be detrimental to all this work."*

Preliminary thematic analysis of client interviews identified substantial challenges around readiness to engage in the intervention. Findings point to a high degree of satisfaction with the HST programs overall, especially with the non-judgmental approach agencies employ. A more complete report will be available soon.