Wheelhouse: Expanding Recovery Options
Oregon Conference on Opioids, Pain and Addiction Treatment
May 18, 2018

Justine Pope, MPH
Program Manager, Wheelhouse
Disclosure

• No disclosures
Learning Objectives

• Summarize the impact of the opioid epidemic, and lack of access to MAT
• Review "Hub and Spoke" network purpose: design, structure, and function
• Analyze Wheelhouse program impact: early observations, lessons learned
• Imagine future diverse strategies to optimize patient access to MAT
Discussion Points

1. What is a “Hub and Spoke” network?
2. Why does it matter?
3. What is the status of Hub and Spoke network development in the Tri-county area?
4. What are our early observations/lessons learned?
5. What’s next?
Acknowledgement/Thank you
Let’s start with a question:

If you had $100 billion to solve the opioid crisis, what would you do?
MAT: Treatment Gap

• MAT-OAT as evidence-based practice; most effective in the treatment of OUD
  • Increase retention in treatment, reduce risk of overdose (fatal and non-fatal), reduce transmission of infectious disease, reduction in relapse risk

• More people need this treatment than are accessing it
  • Estimates around this vary
What is getting in the way here?

• Lack of availability across health care settings
• Lack of DATA-waivered providers
• Providers with waivers prescribe to few patients
• Geography
• Provider discomfort
• Organizational barriers
• Continued stigma around the use of medications to support recovery
• Separation between physical and BH care systems
A constellation of barriers
What programs respond to these barriers? Why do they matter?

• “Hub and Spoke”: Describes a network where different organizations are formally and logistically connected and work together to provide MAT for people with OUD

• Vermont now has the highest capacity for treating OUD in the US (Brooklyn and Sigmon, 2017)
What about Hub and Spoke in Portland?

• Health Share of Oregon
  • Serves approximately 300,000 Medicaid members in the Tri-county area; approx. 3.5% with OUD
  • 3 year strategic plan to support members in recovery
    • Aim: increase availability and access to MAT
    • Improve SUDS System of Care by promoting best-practice treatment guidelines, and improving care transitions for people with SUDS
  • Dedicated funding for the SBH providers

• Central City Concern (CCC) and CODA proposed a local Hub and Spoke pilot project in Specialty Behavioral Health (SBH)
So… how/where did we start?

• Adapted Hub and Spoke model for Tri-County provider network – called “Wheelhouse”

• Started integrating a community Hub comprised of CCC and CODA – MAT expertise, specialized care, consultation, and patient-sharing

• Invitation to participate in Wheelhouse extended to all SUD providers with a Health Share contract

• Garnered commitment from six providers to build MAT programs – with various ways of joining the network
To address this gap in treatment, Health Share of Oregon is funding a new model of care for opioid use disorder treatment in the Tri-County Area. Referred to as Wheelhouse, the model will be led by Central City Concern (CCC) and CODA, who will work together to increase access to Medication Assisted Treatment (MAT) in Multnomah, Washington, and Clackamas counties, and ensure patients can move seamlessly across levels of care without disrupting access to treatment.

**Community Hub**

**CCC + CODA will...**

- Provide integrated care using MAT that prepares clients for transition to a Spoke.
- Support the creation of pathways to provide seamless patient transition.
- Offer technical assistance and clinical guidance to community providers as they develop or expand MAT programs.
Wheelhouse: Main Objectives

1. Increase access to/utilization of MAT
2. Ensure provision of high-quality, patient-centered care
3. Promote network development and integration of services

*Long term outcome: improved health and well-being of OUD population; high-functioning, integrated system of care*
Tell me about your model design!

- Community **Hub available for induction support, specialized care, patient sharing, and clinical consultation**
- Spoke participation requirements
  - “**Spoke Leadership Team**” – executive, medical, and clinical leadership
- Funding: attainment funds tied to **process and product benchmarks** (participation, program development, MAT patient caseload)
- Learning Collaboratives reduce practice variation, **support spread of best-practices and network development**
- Individualized technical assistance (TA) supports **program development**
- Create and implement a **standardized referral process** – to better coordinate services
"Using common data gathered across practices, and having high outcome performers share their clinical strategies, workflow, and work processes with the group had a dramatic useable impact on the other practices. Unlike many QI approaches, the learning collaborative model is not top-down, not driven by research-based findings exclusively, but rather draws upon systematic evidence and the practice-based experience and reciprocal feedback of frontline practitioners." (p. 6)

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00 am</td>
<td>Registration/Breakfast</td>
</tr>
<tr>
<td>9:00 – 9:15 am</td>
<td>Welcome</td>
</tr>
<tr>
<td></td>
<td>Justine Pope, MPH</td>
</tr>
<tr>
<td>9:15 – 10:05 am</td>
<td>Talking about MAT/MSR</td>
</tr>
<tr>
<td></td>
<td>Think Tank Activity</td>
</tr>
<tr>
<td></td>
<td>Alison Noice, MA, CADC-III</td>
</tr>
<tr>
<td>10:05 – 10:20</td>
<td>Redefining Recovery</td>
</tr>
<tr>
<td></td>
<td>Lynn James, MSW, MAC, CADC-III</td>
</tr>
<tr>
<td>10:20 – 10:30 am</td>
<td>BREAK</td>
</tr>
<tr>
<td>10:30 – 11:10 am</td>
<td>Report Out: Spoke Gallery Walk</td>
</tr>
<tr>
<td></td>
<td>Rebecca Boraz</td>
</tr>
<tr>
<td>11:10 – 12:10 pm</td>
<td>Clinical Support Systems for Prompt Access to Care</td>
</tr>
<tr>
<td></td>
<td>Marcelle Thurston, MS, RDN, CDE</td>
</tr>
<tr>
<td>12:10 – 1:00 pm</td>
<td>LUNCH</td>
</tr>
<tr>
<td>1:00 – 1:30 pm</td>
<td>Lightning Round Presentation: OP scheduling Strategies</td>
</tr>
<tr>
<td></td>
<td>Lydia Bartholow, DNP, PMHNP, CARN-AP</td>
</tr>
<tr>
<td></td>
<td>Bonnie Holdahl, MBA</td>
</tr>
<tr>
<td>1:30 – 2:40 pm</td>
<td>Boundaries, Safety, and Skill: Trauma-Informed SUD Care</td>
</tr>
<tr>
<td></td>
<td>Case Presentations</td>
</tr>
<tr>
<td></td>
<td>Lydia Bartholow, DNP, PMHNP, CARN-AP</td>
</tr>
<tr>
<td>2:40 – 3:00 pm</td>
<td>Wrap Up: Questions, Discussion</td>
</tr>
</tbody>
</table>
Learning Collaboratives and Technical Assistance (TA)
TA Visit: SWOT Analysis
TA: MAT Implementation Checklist
Early Observations

• Strong group cohesion **within and across** organizations
• Learning Collaborative series development
• **Sustained interest** in TA and extending the learning collaborative series
• **Slower movement/intentionality** in terms of program rollout
• Participants are seeing their organizations as part of a larger **System of Care**
• Interest among **providers from other settings** (corrections health, hospital, primary care) in MAT network connectivity
• Systems are changing: program development **and** culture change
• “**When we first started, it felt overwhelming and like we didn’t know how it would happen... but it has!**”
• From competition to **enthusiasm for collaboration**, cooperation
• Setting a community table – **snacks always help**
Challenges

• Integrated Community Hub with many access points
• Working within Fee for Service (FFS) reimbursement structure; reimbursement is not tied specifically to care coordination
• Clarification of authorizations/dual authorizations with payers
• Workforce retention/staffing shortages
• Taxed providers with limited resources
• Technological limitations (EHR, document transfer)
• Clarifying/ensuring compliance with 42 CFR pt. II
• Transitions of care are times of increased vulnerability and risk
• Pilot program just within SBH provider community
• An entirely new way of conceptualizing treatment and access to treatment
• Scarcity of culturally responsive services that offer MAT
• Change is hard
Looking Ahead

• Network Expansion
  • “No wrong door” to access to MAT in a variety of medical settings – what will it take to get us there?

• Authorizations & Care Management – ensure seamless client movement, are clearly communicated

• Enhanced staffing models?

• Rapid access to induction in other settings?

• How do we define, incentivize, and support high-quality treatment and transitions of care?
  • Best practices/Standards of Care
  • Alternative Payment Models (APMs)/Value-based payment
  • Common Quality Improvement metrics
  • Health Information Exchanges?

• Leveraging community supports to reduce stigma and increase access
  • Peer recovery mentors, community health workers, health navigators
Future Implications
Thank you

Let’s talk! justinepope@codainc.org