CHANGING CULTURE, BUILDING A SYSTEM, SUPPORTING PATIENTS AND STAFF

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DISCLOSURES

None.
OVERVIEW

Basic description- context and system overview

Our journey
  • How issue was addressed- culture, collaborations, support

Where we are now
  • MAT
  • Data!

Summary
Clackamas County Health Centers is a county-run FQHC with 4 primary care clinics and 3 school-based health centers serving low-income Medicaid, Medicare, and uninsured patients across Clackamas County.

- Integrated Dental
- Onsite MAT
- Integrated Behavioral Health
  - ACT/SPMI/Drug Court
  - A+D
  - Child and Adolescent Psychiatry
- Title X and other public health functions
THE CHRONIC PAIN CYCLE

Goals

• Empower providers and staff to break the cycle many of our patients were in
• Ensure new policy changes minimized patient trauma/stress
• Be vigilant for ‘red flags’ for diversion or frank abuse
• Support our staff at all levels
Patients with chronic pain experience stigma in a variety of care settings

- This can be difficult for providers and staff, but can also be an opportunity

Fire hydrant = chronic pain patient
Cars = medical establishment

Reminder: this is a patient population that we all created. The key is to keep staff as resilient as possible to ensure every patient is treated with empathy and equity. This was the driving principle behind our system change.
Reverse the opioid crisis in a community

Measures:
- Overdose rate
- Fatal overdose rate
- Individuals in treatment
- Prescription opioid rate

Limit supply of opioids*

- Prescribing practices
- Dispensing practices
- Diversion
- Pharmaceutical production
- Availability of alternative pain management treatment

Raise awareness of risk of opioid addiction

- Identification and education of patients at greater risk for addiction
- Provider education
- Adolescent education
- Adult education
- Reducing stigma around substance abuse

Identify and manage opioid dependent population

- Compassionate, consistent care
- Tapering
- Pain management education
- Availability of alternative pain management treatment
- Education of patients and families

Treat opioid-addicted individuals

- Identification of opioid addicted individuals
- Availability of detox facilities
- Availability of long-term ongoing, comprehensive addiction treatment
- Availability of supportive social services
- Prevention of fatal overdose

*This effort seeks to address treatment of both prescription and non-prescription opioids, however it will not address supply of non-prescription opioids (namely heroin).
OUR JOURNEY

2013:
- System not following best practice guidelines in relation to opiates, existing policy not being followed, low morale, high turnover
- One clinic (newest) reasonably adherent

2014:
- Provider turnover - locums and attrition
- Enacting reasonable guidelines, training up the staff - messaging and presence from leadership, engaging existing staff

2015:
- Use of locums continues, ongoing individual provider improvement plans
- Looking at data - from CCO and EHR
- OHP Benefit expansion - PT, acupuncture, chiropractic
- Two community collaborations:
  - Embedded acupuncture
  - ‘Hub and Spoke’ model with Suboxone
OUR JOURNEY CONTINUED

2016:
- Provider termination or attrition, new hires
- True change in practice starts to occur in highest prescribing pod
- MAT expansion continues- expanded beyond hub and spoke

2017:
- Provider turnover- locums and attrition
- Start of Clackamas Pain Collaborative
- Grant application, community collaboration
- Partnering with corrections in providing Vivitrol

2018:
- HRSA funded opiate coordinator begins
- On-site community-based, non-opiate providing pain clinic- Quest Center
- ‘Dialing in’ our MAT services- standardizing message and practice
- Addressing ‘final legacy site’- rural clinic- enrollment in PDO OHA grant
THREE MODELS OF MAT DELIVERY IN PRIMARY CARE

1. ‘Hub and Spoke’ model
   - Primary care identifies patient with an OUD (mild-severe) and patient willing to address disorder.
   - Addictions center (AC) does intake, determines optimal treatment (detox, MAT, etc) based on history.
   - If patient is identified as an MAT (Buprenorphine in this case) candidate, AC performs induction, stabilization, and core addictions work.
   - After time (> 4mos typically) patient ‘graduates’ back to medical home and AC ‘signs off.’
     - NOTE: AC will offer continuing behavioral health work, patient usually not required to attend.
   - PCP assumes MAT ongoing.

Infrastructure required:
   - Willing partners
   - Monthly care calls to "run the list"

Issues:
   - Insurance coverage (straight Medicare or self-pay is not covered)
   - Patient acceptance/showing up to AC
2. Housed within the patient’s medical home
   - PCP does induction and management- protocols required
   - Integrated or close behavioral health relationships essential
   - Requires being firm on severity of OUD system agrees to manage
     - Aim for minimizing variation amongst MAT prescribers
   - Best for patients with mild-moderate OUD
### MEDICATION EFFICACY, OUD

<table>
<thead>
<tr>
<th>Treatment Program Retention</th>
<th>Opioid Misuse</th>
<th>Criminal Activity</th>
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</thead>
<tbody>
<tr>
<td><strong>Methadone</strong></td>
<td><strong>↑</strong> (n=3)&lt;sup&gt;a&lt;/sup&gt;</td>
<td><strong>↓</strong> (n=6)&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td><strong>Buprenorphine</strong></td>
<td><strong>↑</strong> (n=4)&lt;sup&gt;b&lt;/sup&gt;</td>
<td><strong>↓</strong> (n=2)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PO NTX</strong></td>
<td>No effect (n=2)&lt;sup&gt;c&lt;/sup&gt;</td>
<td><strong>↓</strong> (n=4)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>XR NTX</strong></td>
<td><strong>↑</strong> (n=2)&lt;sup&gt;d&lt;/sup&gt;</td>
<td><strong>↓</strong> (n=2)&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
</tbody>
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*Note: Suboxone = buprenorphine/naltrexone. Subutex = buprenorphine*
DATA! CHANGES ON ONE TEAM OVER TWO YEARS

Any patient, any opioid Rx written in a year (acute and chronic included)

<table>
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<tr>
<th>Age Category</th>
<th>2016</th>
<th>2017</th>
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<tr>
<td>18-24</td>
<td>15.4%</td>
<td>0.00%</td>
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<tr>
<td>25-34</td>
<td>40.7%</td>
<td>10.8%</td>
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<td>35-44</td>
<td>31.5%</td>
<td>14.0%</td>
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<td>45-54</td>
<td>43.1%</td>
<td>22.9%</td>
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<tr>
<td>&gt;=55</td>
<td>47.7%</td>
<td>38.2%</td>
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</table>

Patients on chronic opioid therapy

Chronic Opioid Therapy (COT) defined as \( \geq 60 \) pills in any 90 day period, or any order of fentanyl patch

<table>
<thead>
<tr>
<th>Year</th>
<th>% adult patients on COT</th>
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<tbody>
<tr>
<td>2016</td>
<td>18.7%</td>
</tr>
<tr>
<td>2017</td>
<td>5.6%</td>
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IN SUM

Understanding the scope of the issue
Identifying what is foundational - policy, consistency, culture, resiliency
Assess what is needed - collaborations, partnerships, infrastructure
Leadership engagement - from the board room to on site support
Keep changes patient centered, knowing it will be difficult
Focus on supporting the staff - all levels
Coaching providers and know when attrition is ideal (though stressful)
Mind thy locum tenens
It can only get better