Oregon's Comprehensive Approach to Clinical Change for the Opioid Crisis

State Overview

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No conflicts to disclose

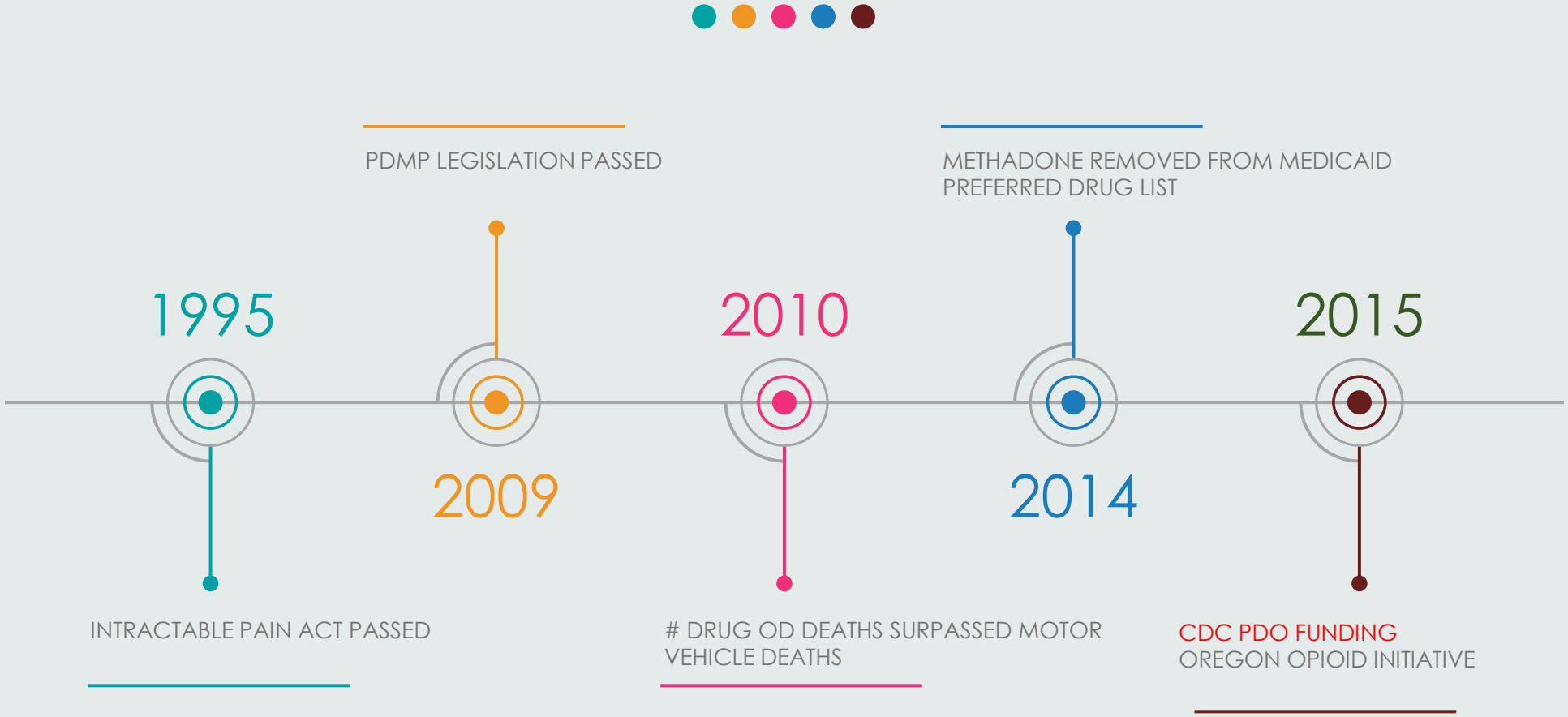
Topics covered

1. Oregon snapshot
2. Prescription Drug Overdose Prevention Project
3. Implementation tools
4. Next steps

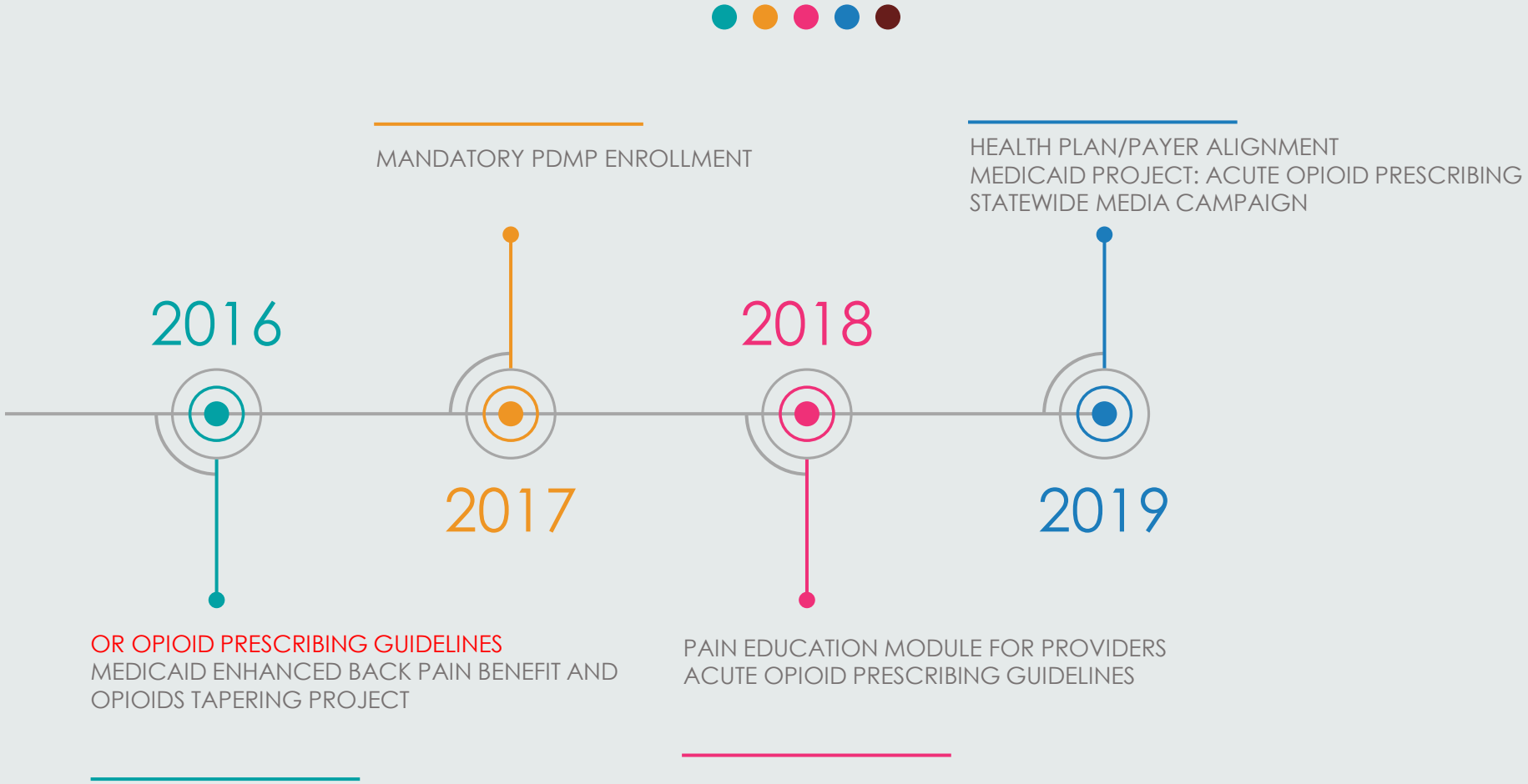
Fun Facts

- 9th largest state in area
- 27th most populous
- 7 diverse regions
- 10 of 36 counties are Frontier
- Coordinated Care Organizations (CCOs) launched in 2012
- 94% of Oregonians have health insurance

OREGON OPIOID MILESTONES



OREGON OPIOID MILESTONES



Oregon Opioid Initiative: Strategies

Pain treatment
- Non-opioid therapies for chronic pain
- Best practices for acute, cancer, end of life pain

Reduce harms
- Ensure availability of treatment for opioid use disorder
- Increase access to naloxone and MAT

Reduce pills
- Decrease the amount of opioids prescribed

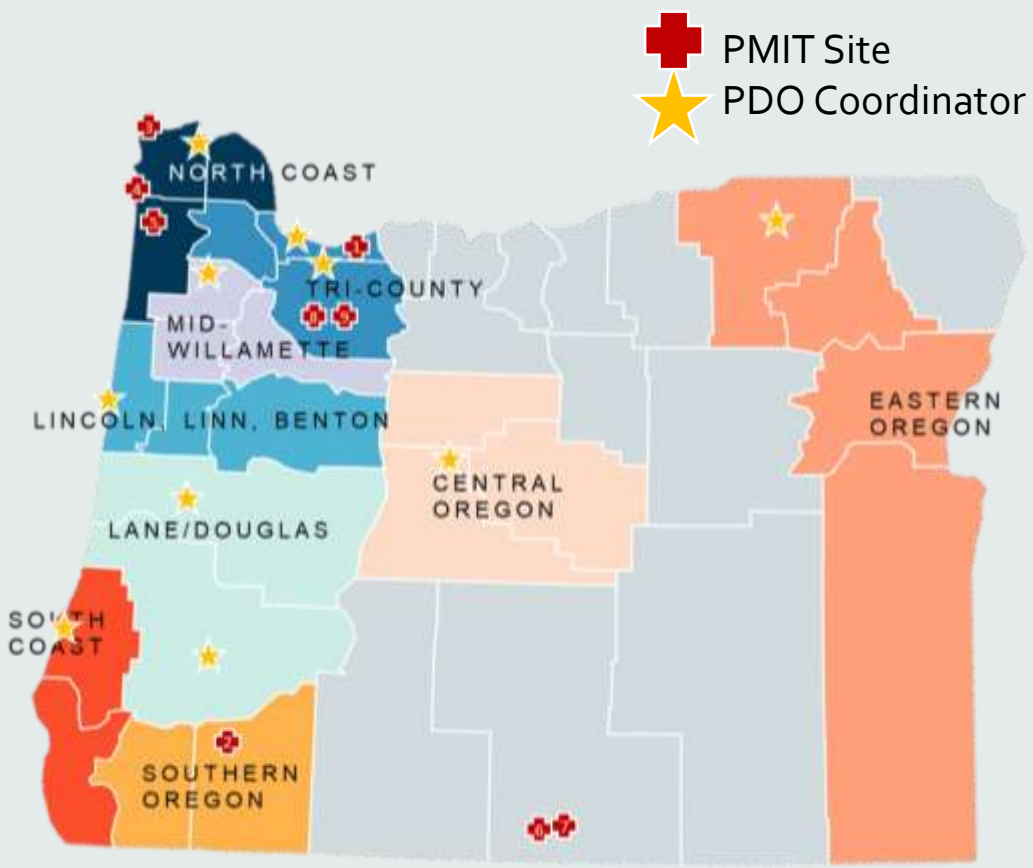
Data
- Use data to target and evaluate interventions

Prescription Drug Overdose (PDO) Prevention 2017-2018

Pain Management Improvement Team (**PMIT**) : AD and practice facilitation

Sites

- ✓ FQHC
- ✓ Coordinated Care Organization
- ✓ Large health system
- ✓ Frontier health system referred by Medical Board



Oregon Clinical Approach

Why Practice Facilitation combined with AD?

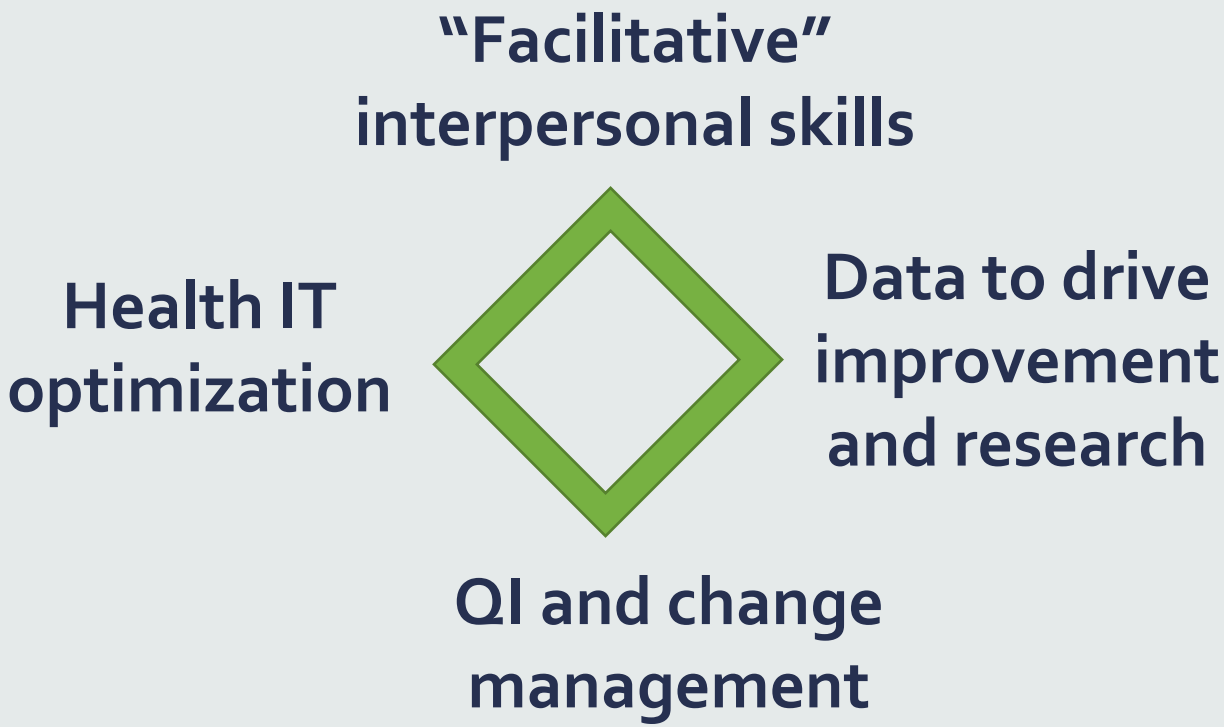


Image adapted from: Agency for Healthcare Research and Quality (AHRQ), Primary Care Practice Facilitation Curriculum. www.AHRQ.gov

Clinical Toolbox: www.oregonpainguidance.org

- Screening and assessment tools
- MED Calculator
- Flow sheets for pain and tapering
- Quality improvement reporting tools
- Patient-provider communication trainings
- Training and education resources
- 6 Building Blocks project tools and guidance
- Patient education: print and videos
- Clinical updates on special topics

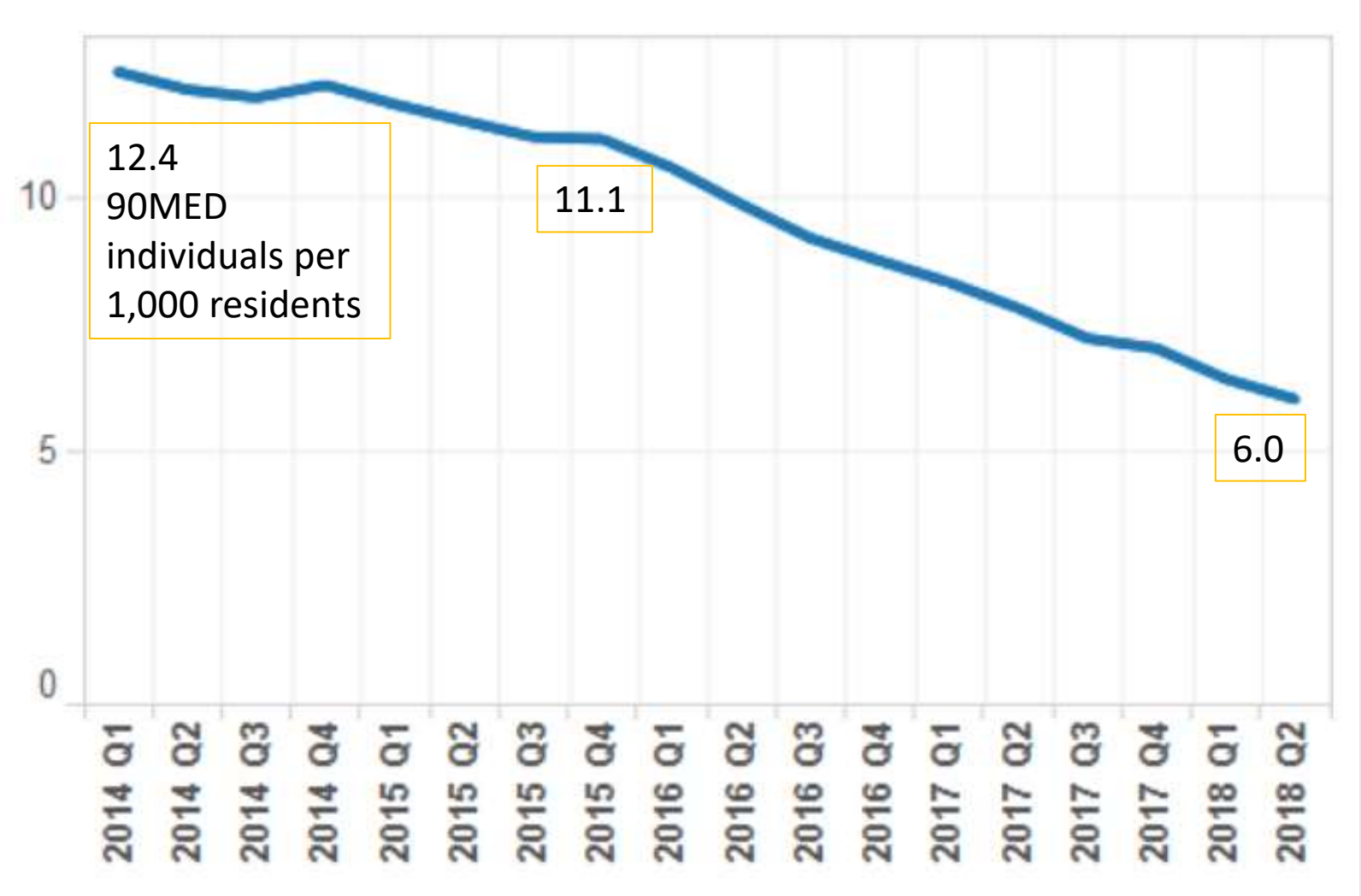
Pain Education Module for Providers

Changing the Conversation about Pain: Pain Care is Everyone's Job

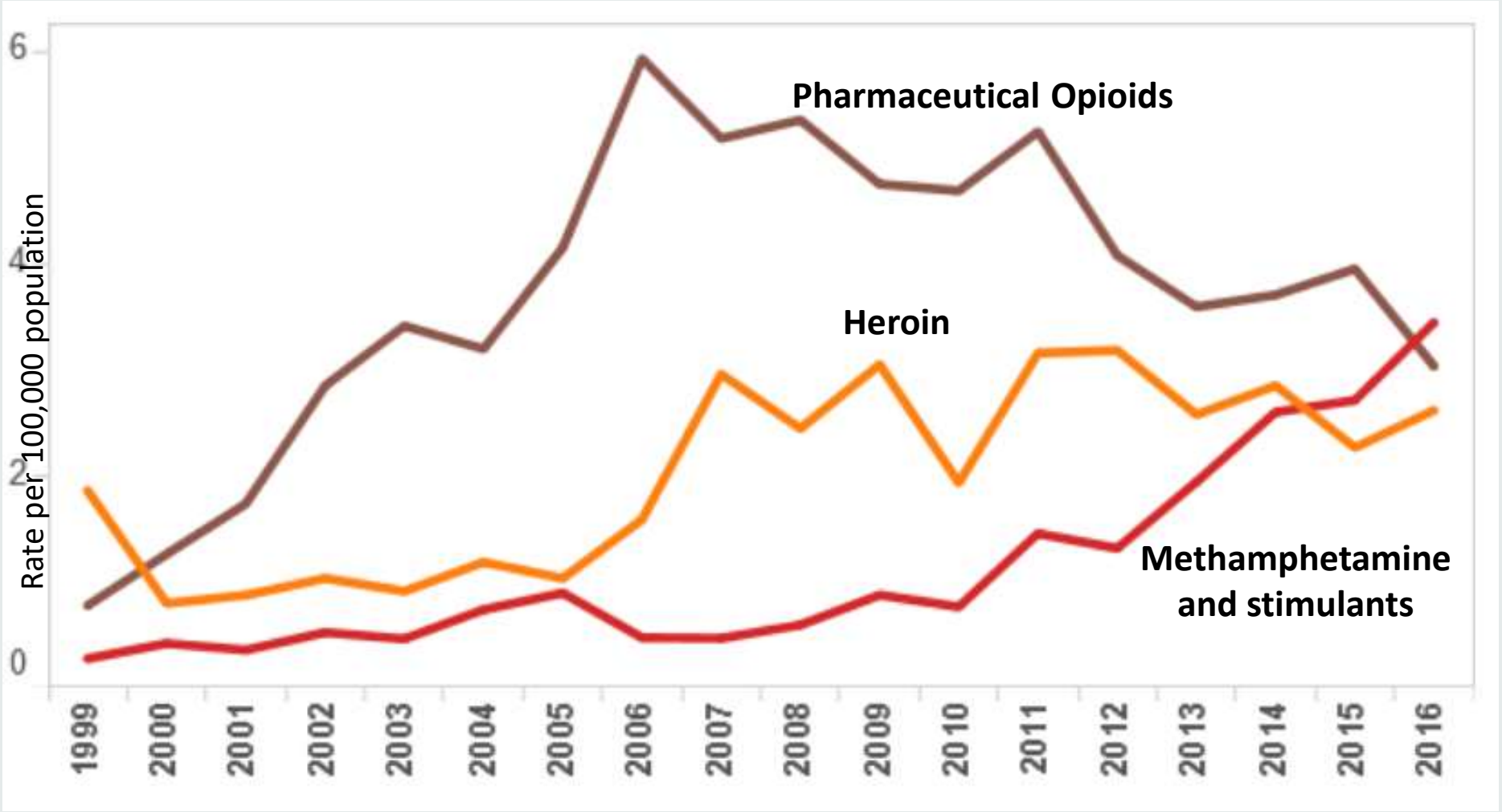
Oregon Pain Management Commission

Oregonpainmodule.com

Oregon high-dose opioid prescriptions (>90MED) declined 51%



Oregon Opioid Overdose Deaths Declined 30% from 2011-2016



What's next

- New patient pain education module and material
- Health insurance alignment project
- Statewide media campaign
- Expanded state strategies framework
- Phase 2 clinic sites
- State Pain/Opioid Conference May 2019
- Oregon NARCAD training in June 2019

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Trillium Lake and Mt Hood photo by www.planetware.com

Adventures Towards Detailing: Chapters 1, 2 and Beyond…

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Practice Facilitator, Behavioral Health Consultant

Synergy Health Consulting

No conflicts to disclose

Rome wasn’t built in a day

Chapter 1: “Once upon a time, a long, long time ago”

Chapter 1: Aug 2016-Aug 2017

In order to better to understand

where to focus our academic detailing efforts (Key Messages),

we used the 6 Building Blocks Needs Assessment to

identify clinic and regional needs &

barriers to making change (Objections).....

Image: NaRCAD (National Academic Detailing Resource Center) www.narcad.org

Six Building Block Needs Assessment

The Six Building Blocks

1. Leadership, goals, and assigned responsibilities
2. Produce policies, workflows, treatment agreements, patient education materials
3. Identify the patient population and develop ways to track progress
4. Planned, patient centered visits
5. Caring for complex patients
6. Measuring success

Benefits of Practice Facilitation & The Art of Listening

“People don’t care what you know until they know that you care.”


OOPS!

Clinical Content Training

Academic Detailing In Sight!

Chapter 2:

Chapter 3: Taking Our Show on The Road……

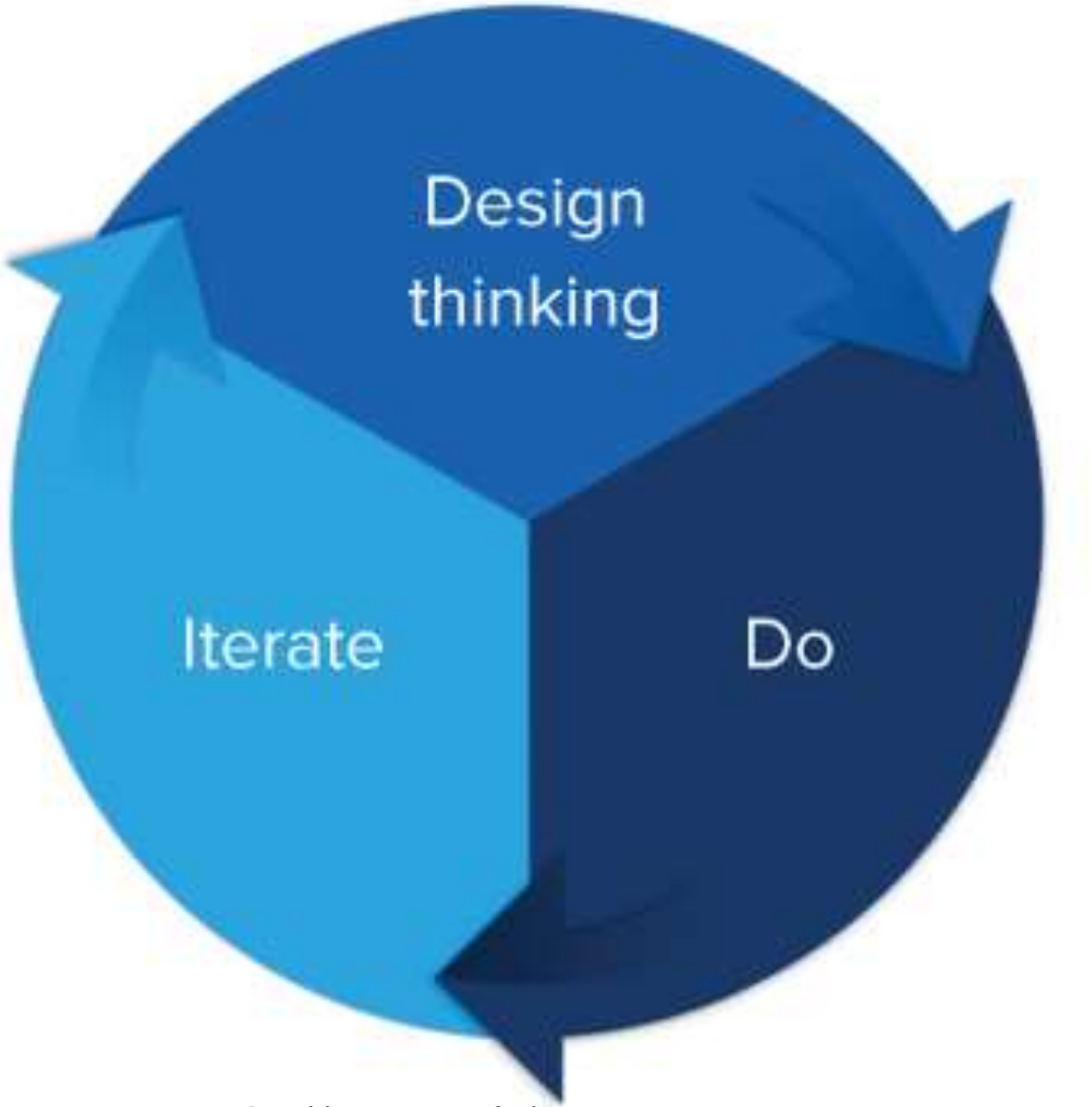
The Nitty Gritty of Developing an AD Tool

Melissa L Cantwell, MHA
Prescription Drug Overdose Prevention Coordinator
Synergy Health Consulting

No conflicts to disclose

What are the Key Messages?

- Evidence-based
- Prioritized
- Focused
- Intentional



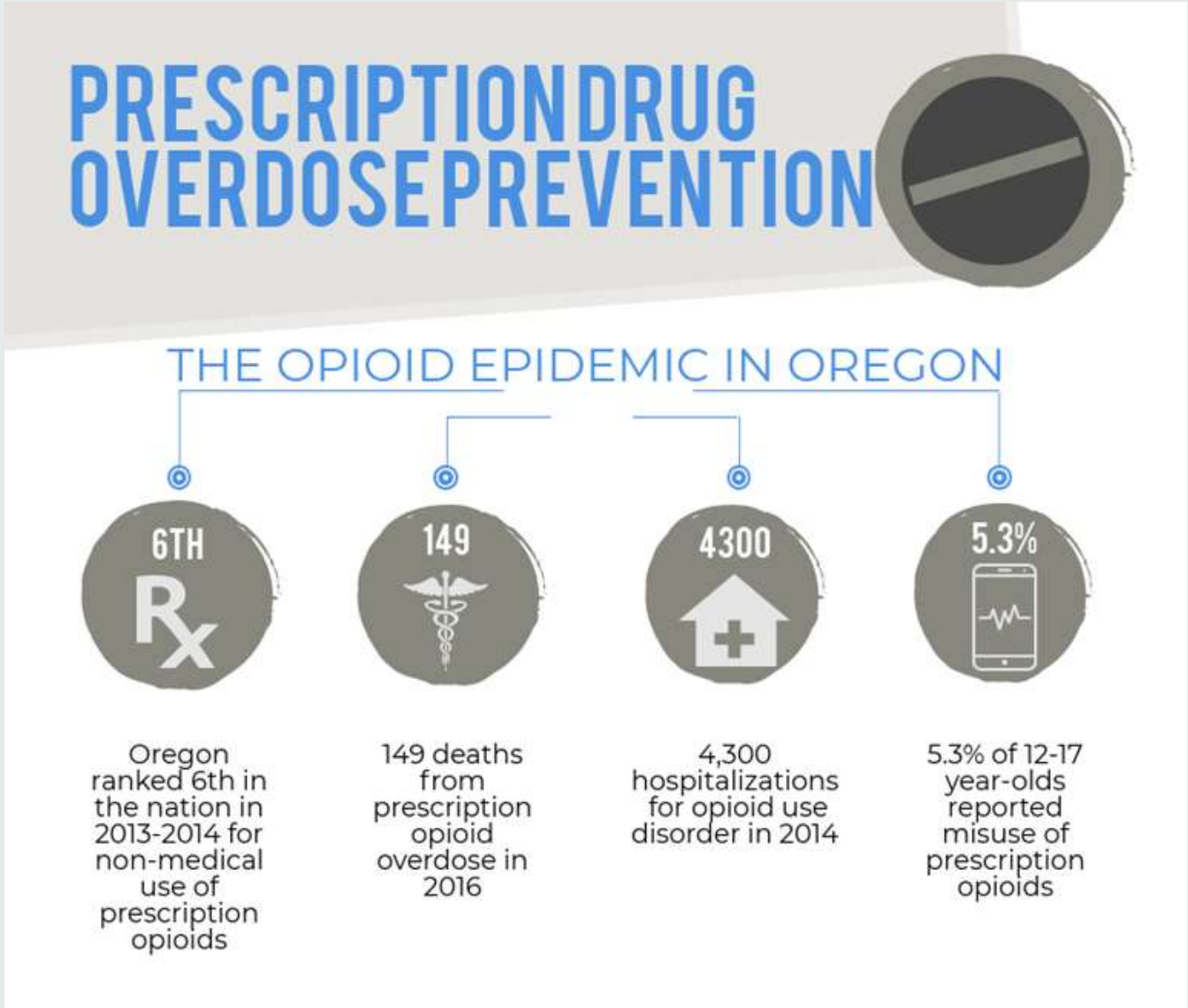
Graphic courtesy of Diagrammer on Duarte.com

Seek Feedback!

- NaRCAD
- OPG
- Physician Champions
- Family

The Final Product

(For now)



Academic Detailing the MD: Chronic Pain Change is… Painful?

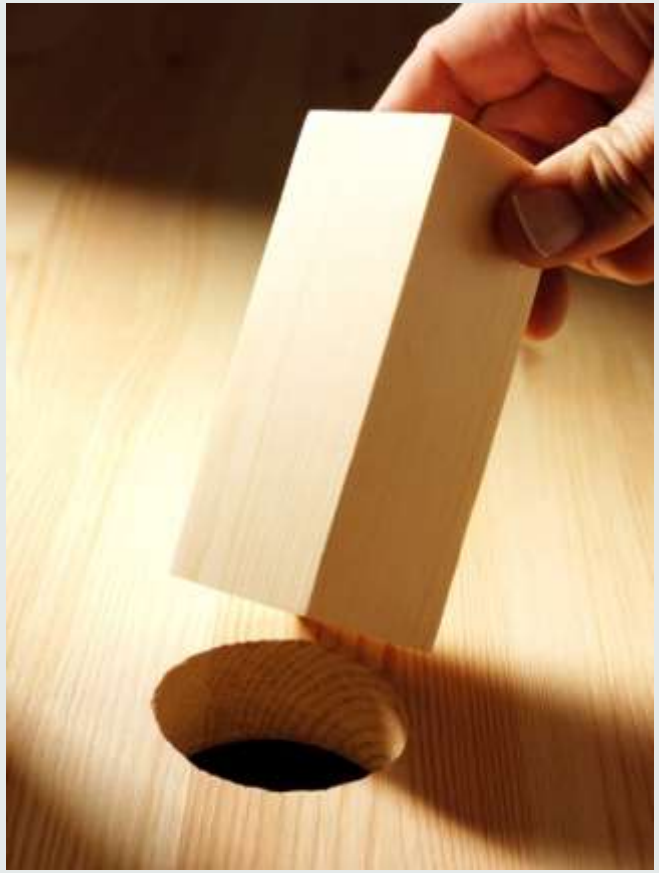
Andrew Suchocki, MD, MPH
Medical Director, Opiate System Change Evangelist
Clackamas County Health Clinics

No conflicts to disclose

How I stumbled on AD: Lived Experience, Knowledge, Evangelism

- Clinical Foundation
- Clinical Journey
- Clinician Support
- The land of the best:
  - THC
  - Clouds
  - Pinot Noir
  - IPAs
  - Coffee
  - Bike. Just everything bike.

A Challenge to Traditional AD Model: Opioids

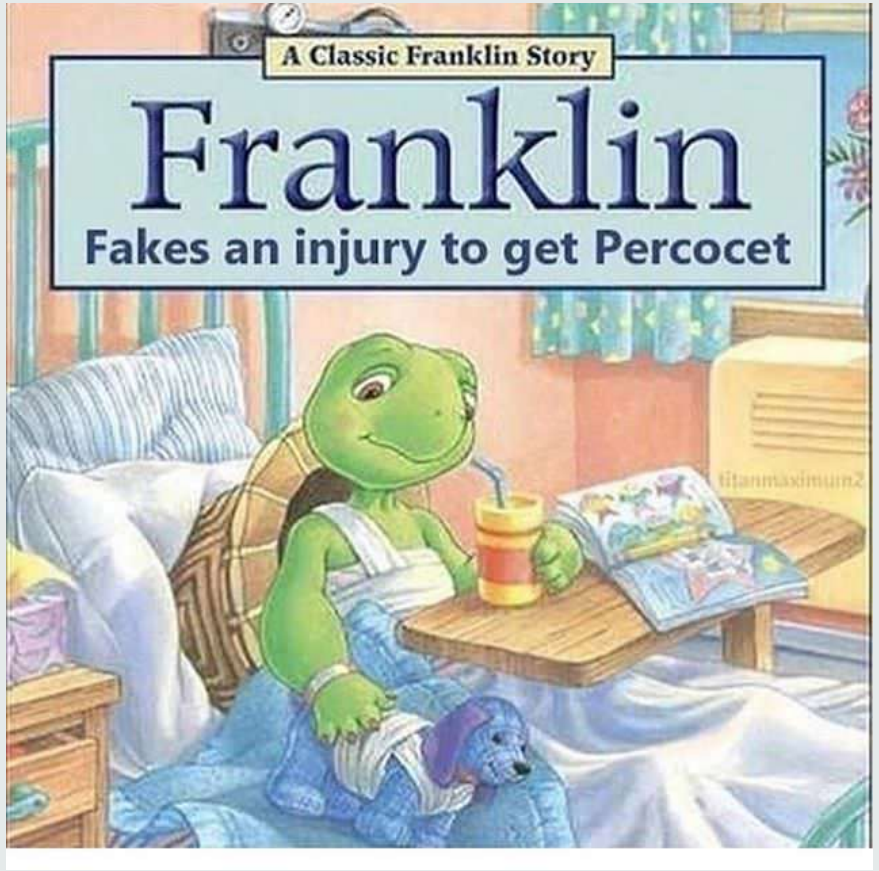


https://www.andylawrenson.com/ministry/square-peg-round-hole/

Challenge: Unintended Consequences

- Traditional AD: Change Clinical Practice=Improve lives
- Non-comprehensive change in opiate prescribing= potential consequences:
  - Increasing disability
  - Heroin use
  - Emergency Department utilization
  - Mental health crises

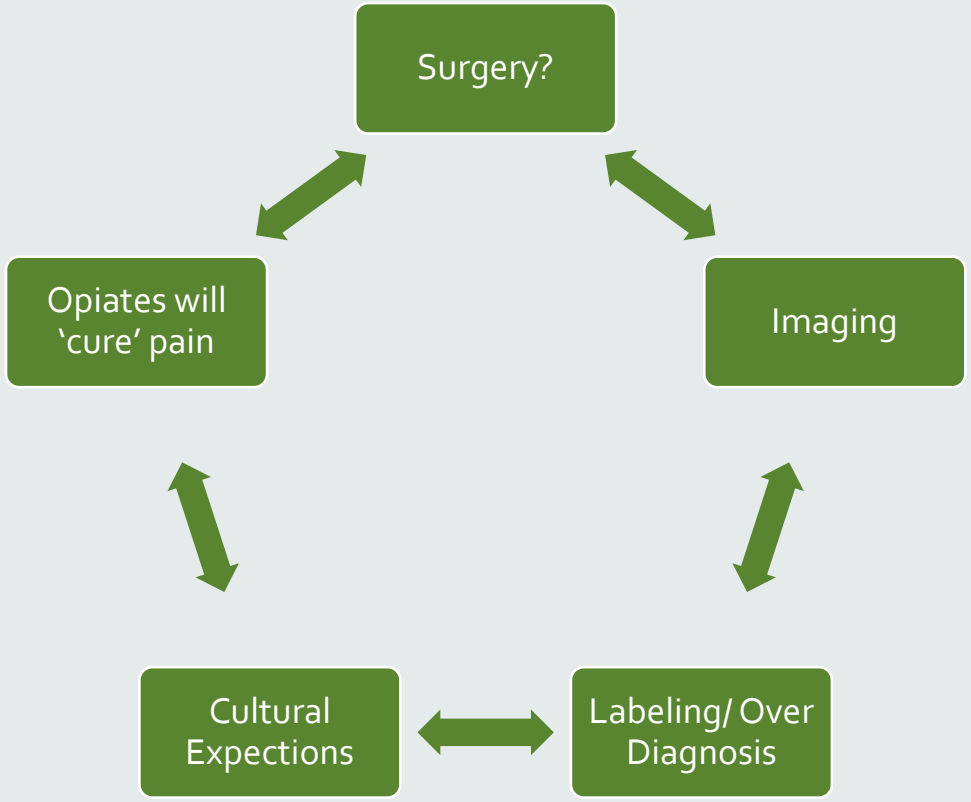
Challenge: Fears



Primary care fears it's Franklin, it reflects our weaknesses:

- treating pain
- opiate use disorder and/or other addictions
- meeting patient needs

Challenge: The Chronic Pain Cycle

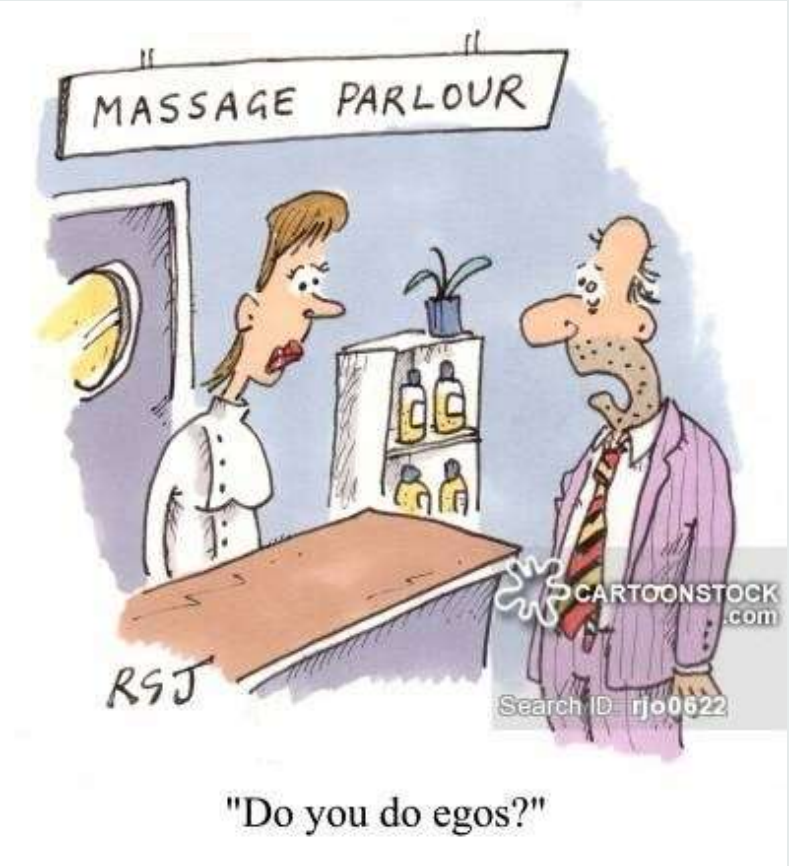


You can prescribe Suboxone, and you can prescribe Suboxone!

1. Significant national push to expand Suboxone prescribing
2. Best practice guidelines exist, but mentorship and simple clinical decision making tools are in short supply
3. New Suboxone prescribers:
   - uncertainty
   - confusion
   - lack of self-confidence early in managing patients

https://www.thefound.com/oprah-you-get-a-car-hh.html

Principles of AD: MD to MD in Chronic Pain/MAT



https://share.america.gov/english-you-will-need-to-take-care-of-business/

https://www.cartoonstock.com/directory/m/massage_parlour.asp

Case Study- Academic Medical Center

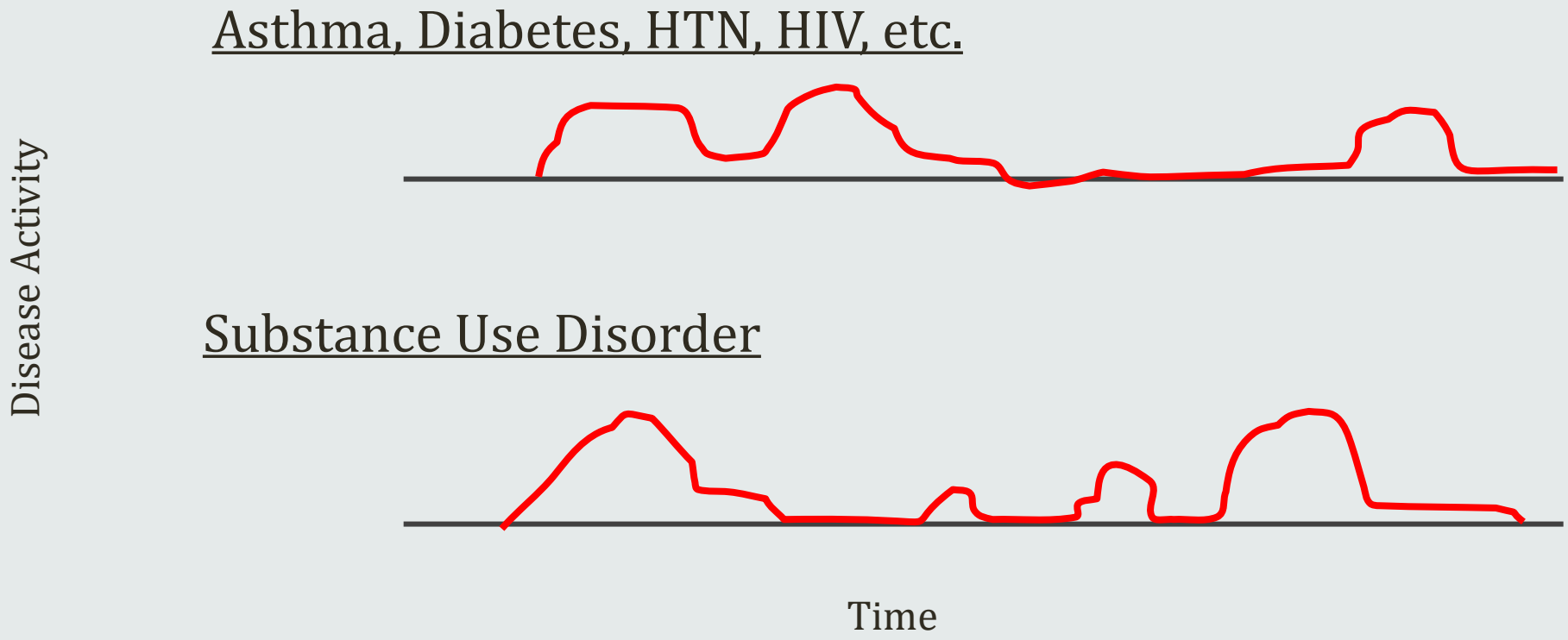
- Identified Problem
  - Heavy opiate Rx
- Pain Clinic
  - Anesthesia staffed
  - No x-waivered Rx
- Addiction Service
  - Primary care rooted
- Local solution
  - Silo in silo?

Role of AD in Academic Medical Center

- Wait around
- Listen
- Build trust
- Needs assessment
- Proposal
- The good work

https://asg-architects.com/portfolio/jhu-bayview-2/

Challenges Continued: Substance Use Disorders



O'Connor, JAMA 1998; Lucas, JAIDS 2005
Solotaroff, Neurobiology of Pain and Addiction, 2017

Example: Screening Tool

OARS (Opiate Assessment and Risk Score)

Challenges	Points	Opportunities	Points
Co-occuring EtOH disorder	15	Prior MAT experience	5
No prior engagement in addictions	5	Stable and engaged support system	2
Centralized Pain d/o | Fibromyalgia	2	Active behavioral health home	5
Sig psych hx (SPMI/Axis I)	5	Pt consistently attends appointments/group	2
Housing instability	5	Consistent UDS, PDMP, Pt Hx	2
Other substance abuse	10	ACES score < 4	5
Chronic pain, poorly controlled	5	(Adverse Childhood Event Score)	
Frequent loss to follow-up/poor prior attendance	5		
Under 25	10		
TOTAL		**TOTAL**	
Points		**Total Challenges- Total Opportunities = _____**	

If no challenges, the opportunity total will be < 0

Note- if patient unable to maintain sobriety for 24 hours, consider categorizing as high risk, regardless of scenario

Andrew Suchocki, MD, MPH

Example: Risk Corridors

Inclusionary Criteria: Drug of Choice is opiates | >18 years old
Exclusionary: Active addiction with little capacity to change | Pregnant | <18
Clinical correlation strongly recommended for all risk categorization

Risk Color	Red	Orange	Yellow	Green
Points	**>25**	**<20**	**<10**	**<0**
Induction Setting (If Applicable)	Strongly Consider Speciality Addictions (SA). If primary care (PC), see Orange	SA preferred. PC is acceptable. Wrap around required (must be specialty), <1 month to establish after induction	SA if pt requests/interested. PC- wrap around PC based, acceptable	PC is optimal. Wrap-around : baseline assessment or ongoing treatment
Behavioral Health	In specialty setting, minimum 12 mos	Specialty setting strongly preferred (essential in PC). PC-based if intensive. 6-12 mos minimum	PC based: intake, assessment, plan (6 mos). Ongoing- pt focused	PC based: assessment. Ongoing is pt. driven
Refill Duration	Weekly, add by qWeek as appropriate. Max duration 1 month total (no RF)	See Red. 60 day duration after 6 mos of 1 month	Start with 1 week, then 2 weeks, extend to 1 month as earned. Max RF is 2 mos	See Yellow. Ok to progress to total Rx duration of 3 mos (2 RF)
Drug Screen(UDS) Frequency	every appointment in first month, extend to q3 months	See Red, expand beyond q3 mos only after 6 mos of affirming UDS	Minimum: At initiation, 1 month follow-up, ok to q6 mos after 3 affirming UDS	Minimum: At initiation, 1 month follow-up, ok to yearly after 6 mos of affirming UDS
Visit Frequency	weekly x 2, bi-weekly x 2, consider monthly	after initiation, bi-weekly x 2, monthly x 2, then extend to 2 mos after RF duration of 60 days achieved	after initiation, 2 weeks, monthly, then driven by RF frequency	after initiation, 2 weeks, monthly, then driven by RF frequency

Indications for risk increase (to Red):
Failed UDS

Early refill request
Clinical judgement

Indications for risk reduction (away from Red):
3-6 months of pathway plan adherence
Reduction in risk factors (improved social support/housing)

Challenge: Lawyers

- Change fear can be rooted in this
- Often misconception/past trauma/ rumors
- Successful intervention rooted in proactive discussion

http://cerebrallemon.com/end-tradition-british-lawyers-stop-wearing-wigs-gowns-court/

Questions?

Thank you!