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 OPID MILESTONES

1995
INTRACTABLE PAIN ACT PASSED

2009
PDMP LEGISLATION PASSED

2010
# DRUG OD DEATHS SURPASSED MOTOR VEHICLE DEATHS

2014
METHADONE REMOVED FROM MEDICAID PREFERRED DRUG LIST

2015
CDC PDO FUNDING OREGON OPIOID INITIATIVE
OREGON OPIOID MILESTONES

- 2016: OR OPIOID PRESCRIBING GUIDELINES
- 2017: MANDATORY PDMP ENROLLMENT
- 2018: PAIN EDUCATION MODULE FOR PROVIDERS
- 2019: HEALTH PLAN/PAYER ALIGNMENT MEDICAID PROJECT: ACUTE OPIOID PRESCRIBING STATEWIDE MEDIA CAMPAIGN
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

- Practice facilitation (6 Building Blocks)
- Academic Detailing
- Tailored education
- Supports for providers and patients
Why Practice Facilitation combined with AD?

“Facilitative” interpersonal skills

Health IT optimization

Data to drive improvement and research

QI and change management

Image adapted from: Agency for Healthcare Research and Quality (AHRQ), Primary Care Practice Facilitation Curriculum. [www.AHRQ.gov](http://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
Contact: Lisa.m.shields@state.or.us

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 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](http://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.”
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
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No conflicts to disclose
What are the Key Messages?

- Evidence-based
- Prioritized
- Focused
- Intentional
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

- Surgery?
- Imaging
- Opiates will ‘cure’ pain
- Cultural Expectations
- Labeling/Over Diagnosis
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

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

Asthma, Diabetes, HTN, HIV, etc.

Substance Use Disorder

Time

O’Connor, JAMA 1998; Lucas, JAIDS 2005
Solotaroff, Neurobiology of Pain and Addiction, 2017
### Example: Screening Tool

**OARS (Opiate Assessment and Risk Score)**

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

**TOTAL**

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

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Andrew Suchocki, MD, MPH
## Example: Risk Corridors

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

### 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

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**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
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!