Barriers to Implementation
Part I

Evolution of One Medication Assisted Treatment Program

Y • A • K • I • M • A
Neighborhood
HEALTH

Where in the World is Yakima County

- Yakima County
  - 250,000 people
  - 466 Square miles
  - Metropolitan and Rural
  - Touching King County but SO FAR AWAY

Welcome to
YAKIMA
The Palm Springs
OF WASHINGTON

COMPARED TO WA STATE -

- 30% Lower Per Capita Income
- 1 in 4 Adults Do Not Have a High School Degree
- Twice the number of Drug Crime Arrests Per 1000 Adults than the State Average

Partnering in Our Communities – Rural and Metropolitan Locations

YNHS – Sunnyside Campus

Henry Beauchamp Community Center

Comprehensive Health Services

Neighborhood Connections Medical/Dental

Granger Dental

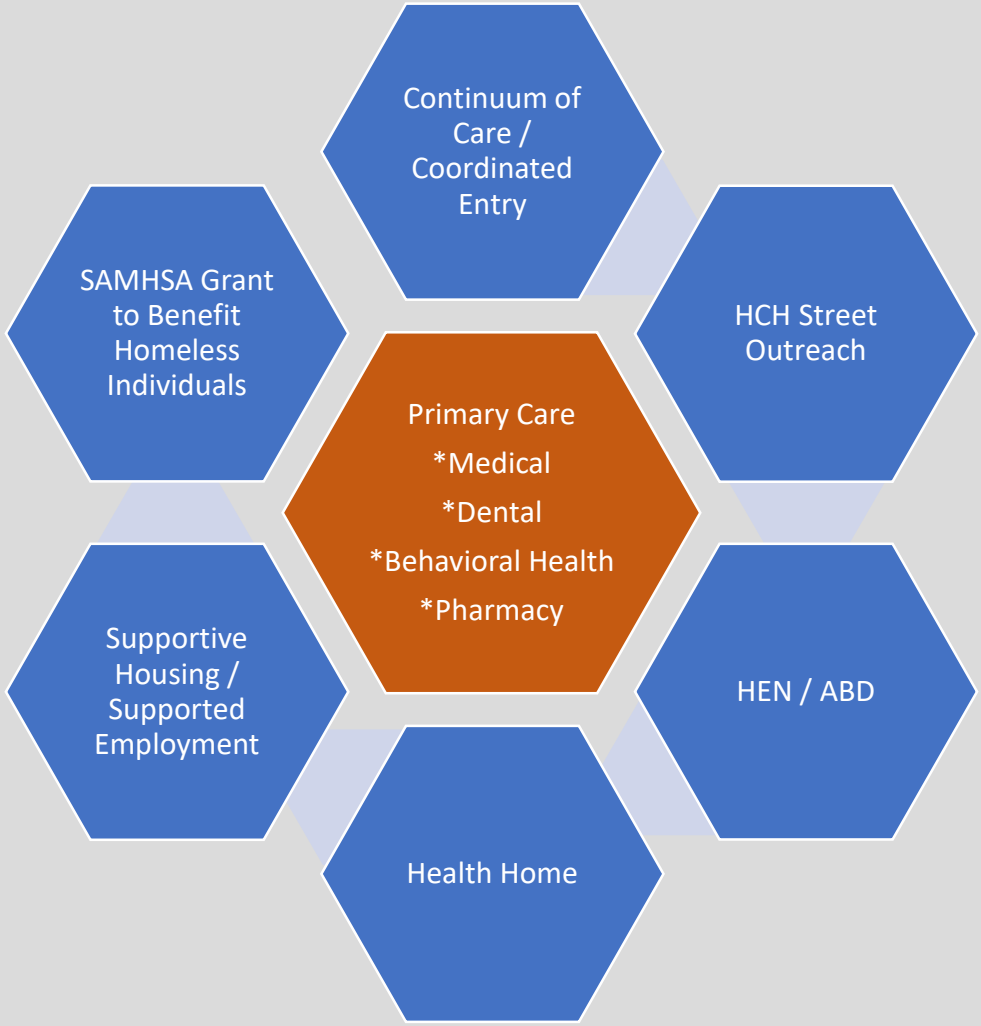
Granger Medical

Sunnyside Walmart Plaza

Neighborhood Connections HRC

Lower Valley Mobile Unit

Housing & Health
YNHS Internal Integration



Yakima Neighborhood Health
Neighborhood CONNECTIONS

102 South Naches Ave, Yakima
Phone (509) 249-6232

- ✓ **Health Care for the Homeless**
  - Medical
  - Dental
  - Behavioral Health
- ✓ Washington HealthPlan Finder Application Help
  - Apple Health, Managed Care Plans
  - Medicare, SSI / SSDI
- ✓ Homeless Prevention Assistance
- ✓ Transitional and Permanent Supportive Housing
- ✓ Medical Recuperative Respite Care
- ✓ Transportation Help
- ✓ Self Sufficiency Help
  - Supportive Housing Services
  - Supported Employment Services
- ✓ Basic Needs and Hygiene Items
- ✓ Housing and Essential Needs (HEN)
- ✓ Coordinated Entry

Demographics of our Populations

All YNHS Patients	23,514
3,221 Homeless	14%
Primarily White	94%
Majority Hispanic	63%
Medicaid	63%
Uninsured	17%

Patients Entering MAT Program	281
All Homeless	40%
Literally Homeless (Street, shelters, encampments)	23%
Primarily White	90%
Hispanic	20%
Medicaid	74%
Medicare	15%
Uninsured	3%

Our Chronic Pain Population in 2017

Close to 400 patients on chronic opioids

12% w/MED >=120

Tackling the Problem

- QA Process: Peer review by non- YNHS Family Practice physician

Early Results of External Peer Review

Is this a continuation from a previous outside provider's treatment plan?

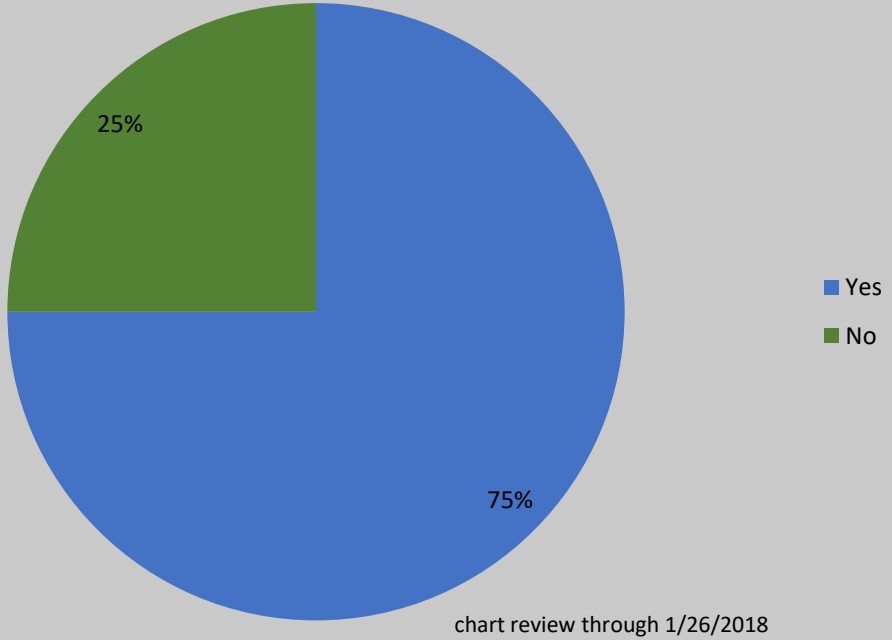
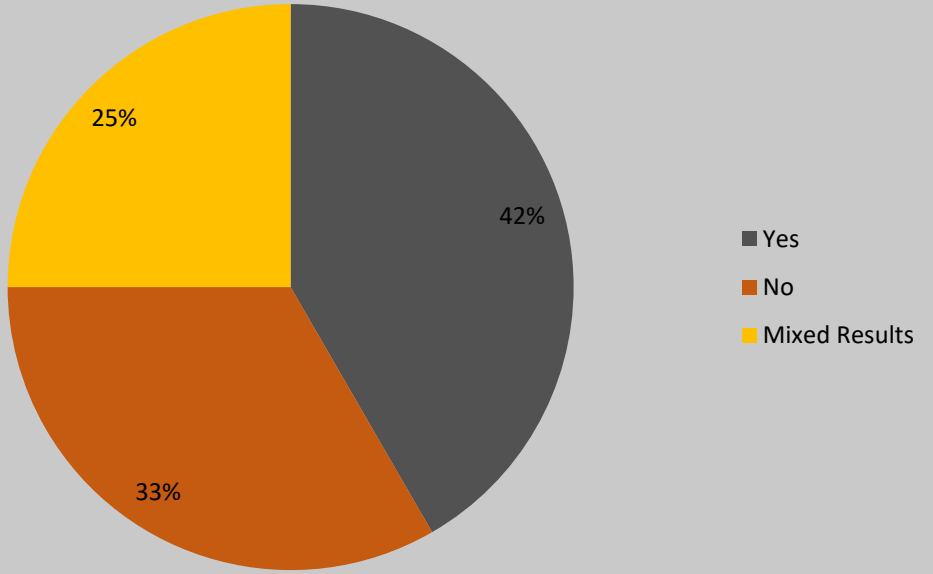


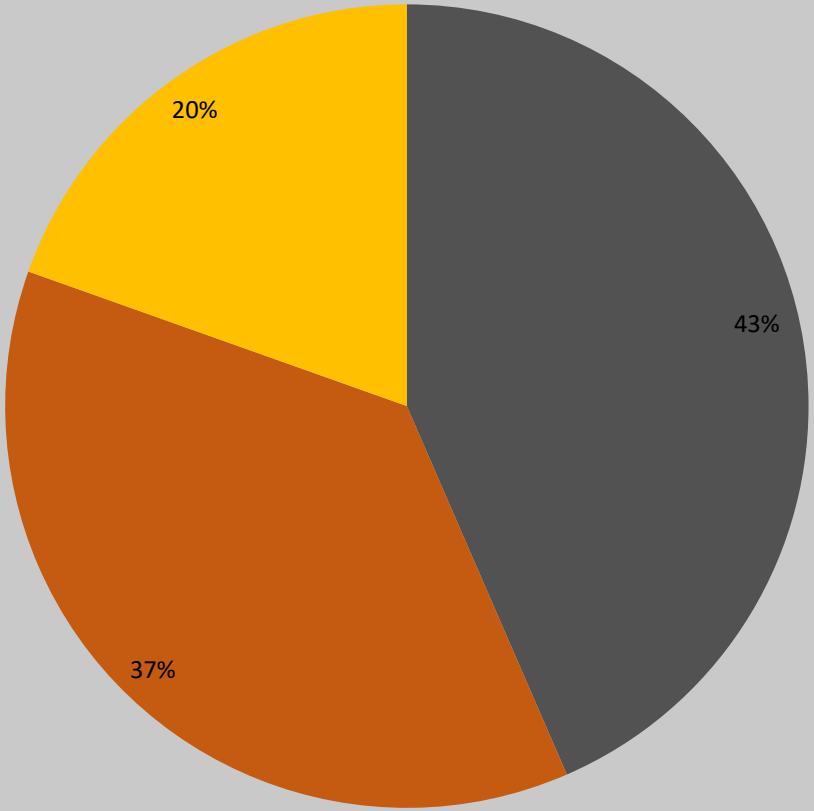
chart review through 1/26/2018

Is the use of opioids a reasonable approach given the diagnosis and clinical picture?

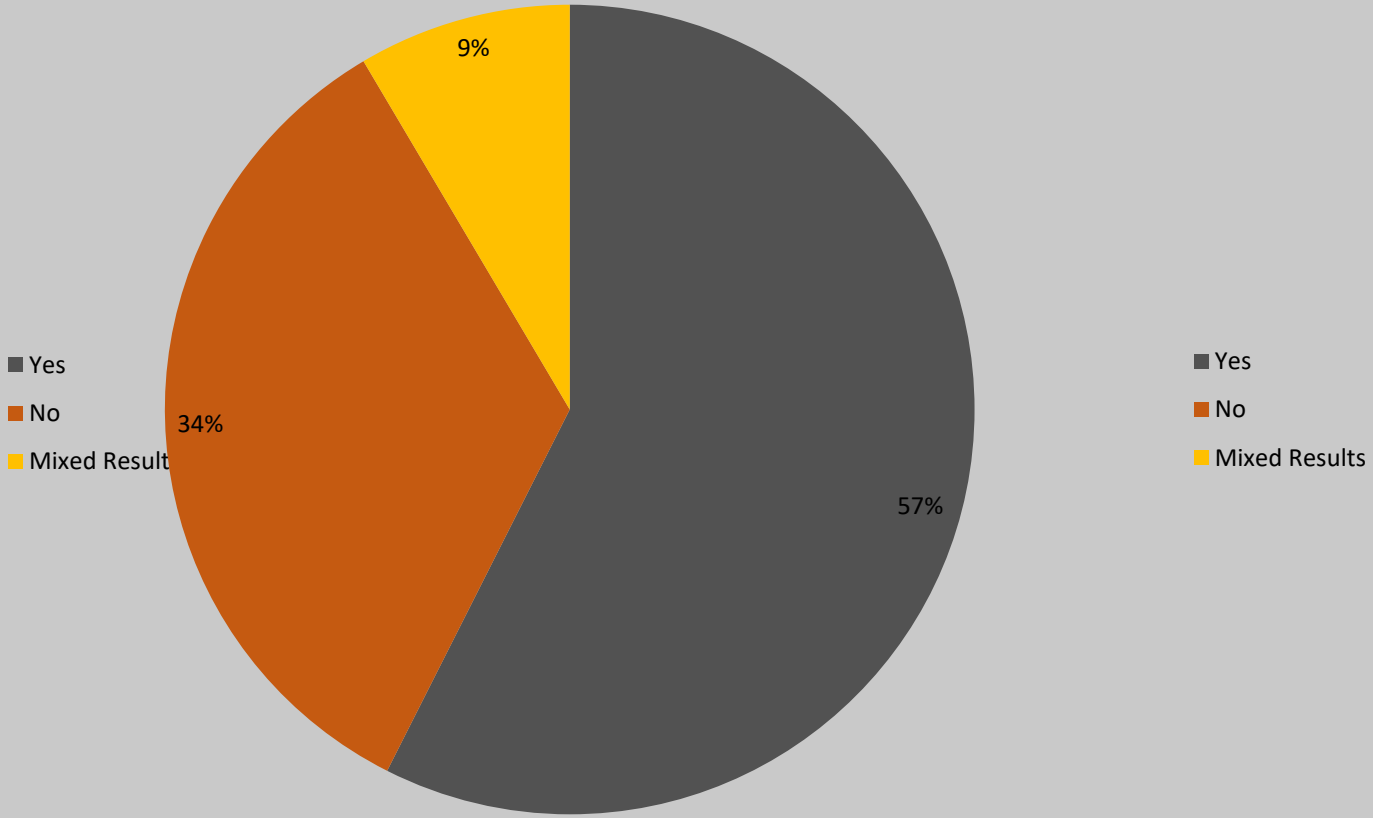


Early Results of External Peer Review

Does the condition have a good prognosis with appropriate evaluation/treatment?

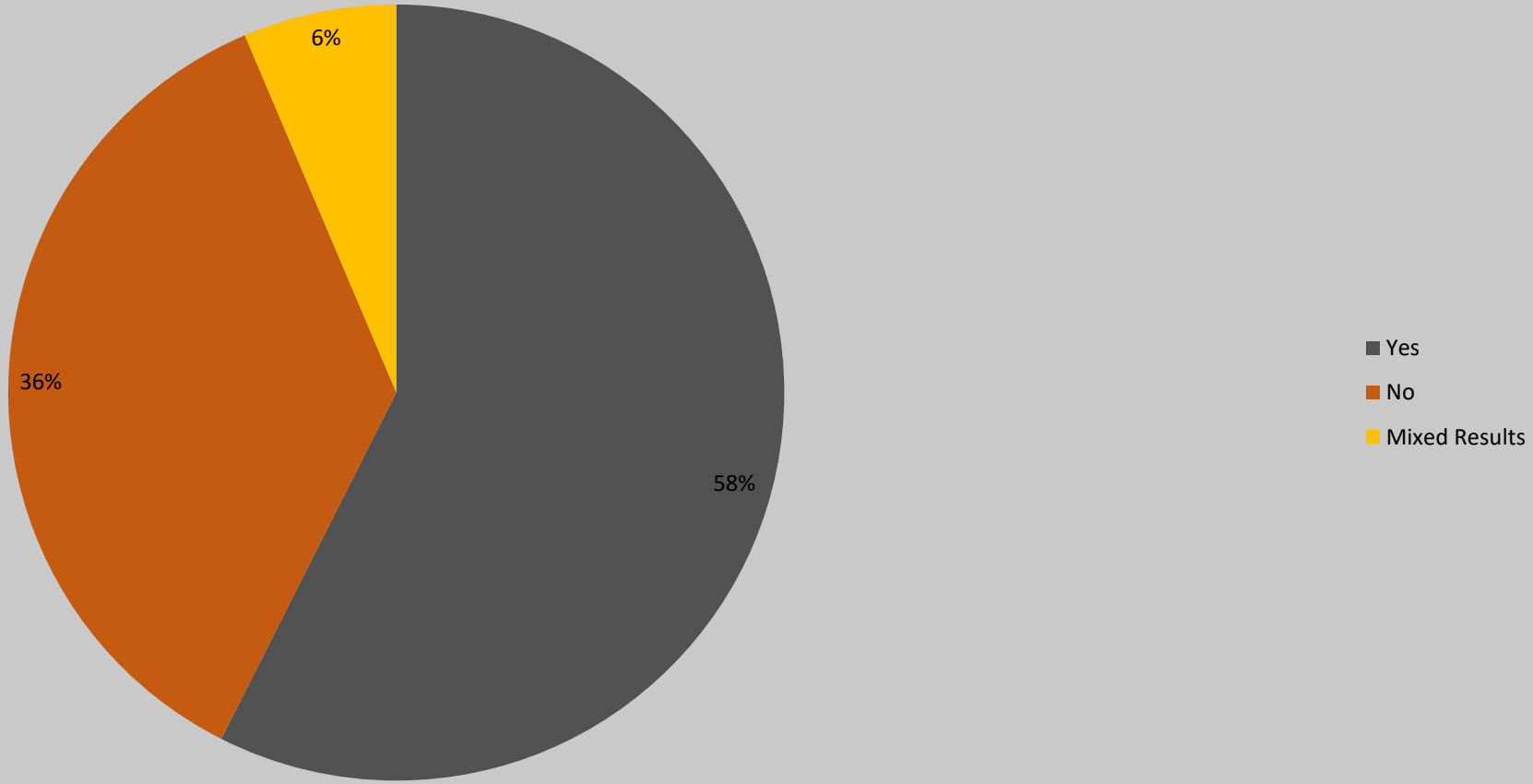


Has this evaluation/treatment been done?



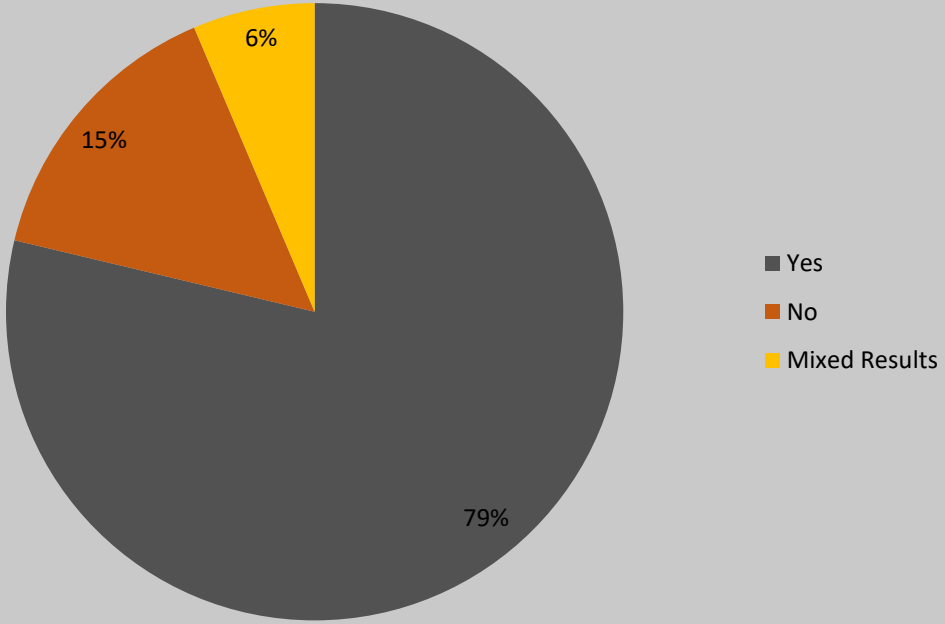
Early Results of External Peer Review

Is there evidence of extensive trial of non-opioid therapies (medication, therapies, injections, etc.)?

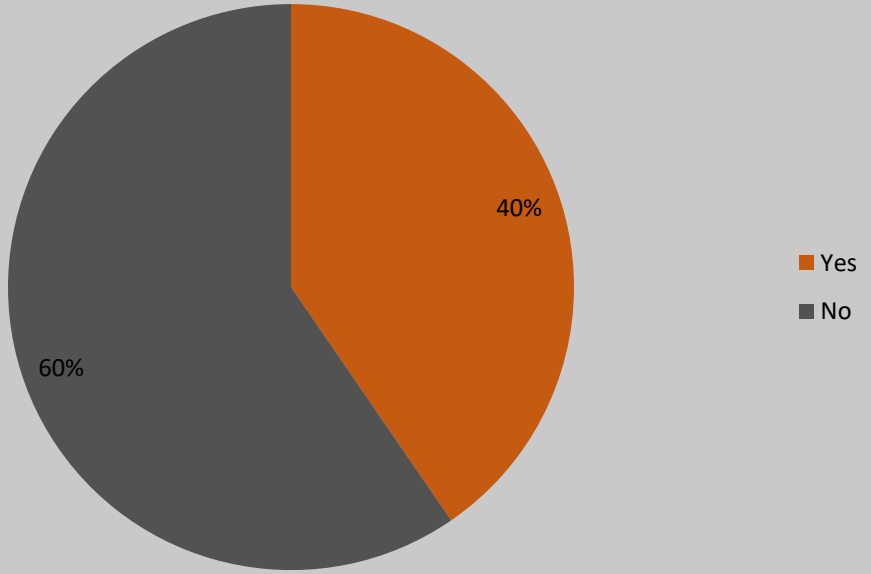


Early Results of External Peer Review

Are previous UDSs consistent with opioid prescription?

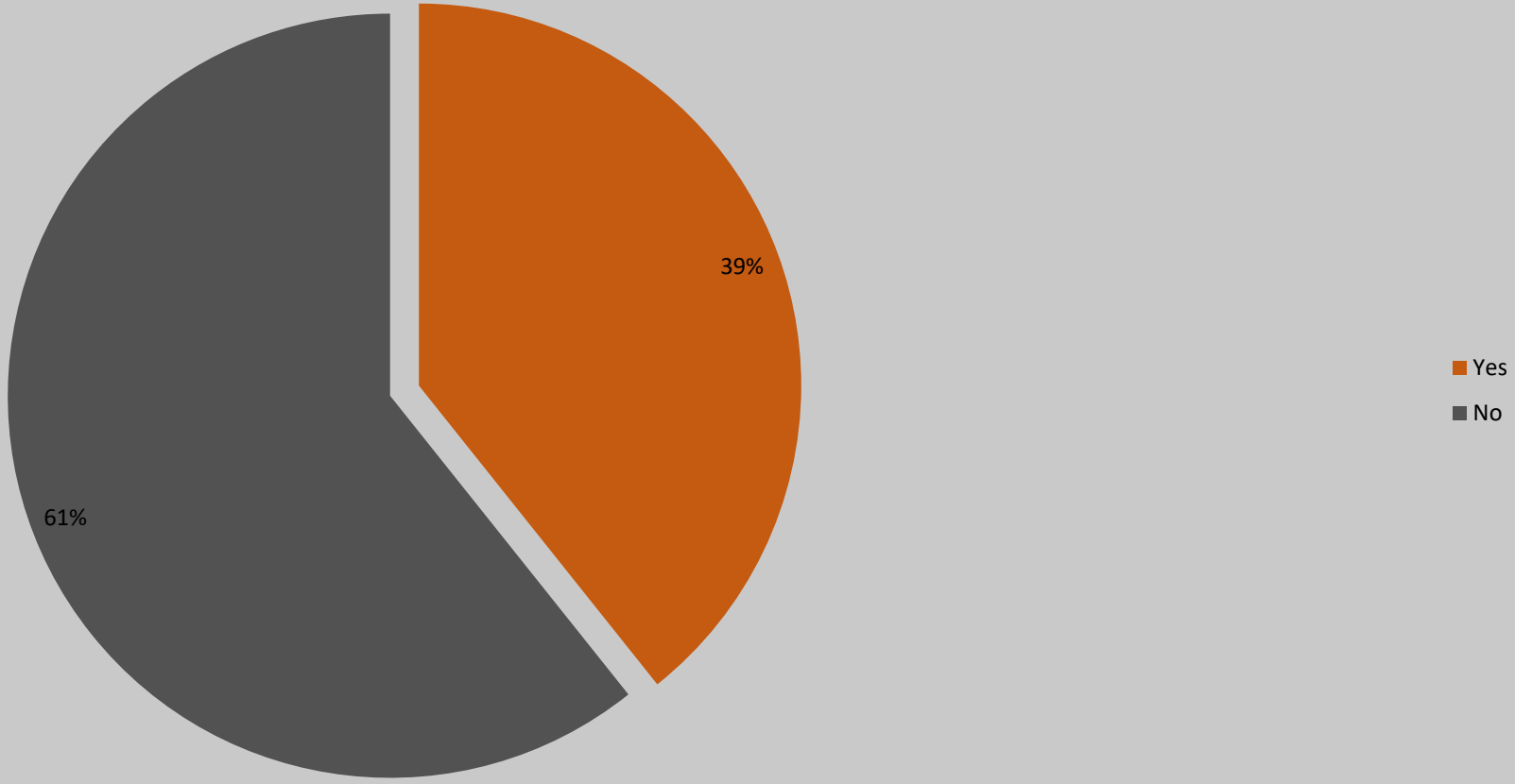


Has there been evidence of use of other drugs concurrently (including THC and ETOH)?



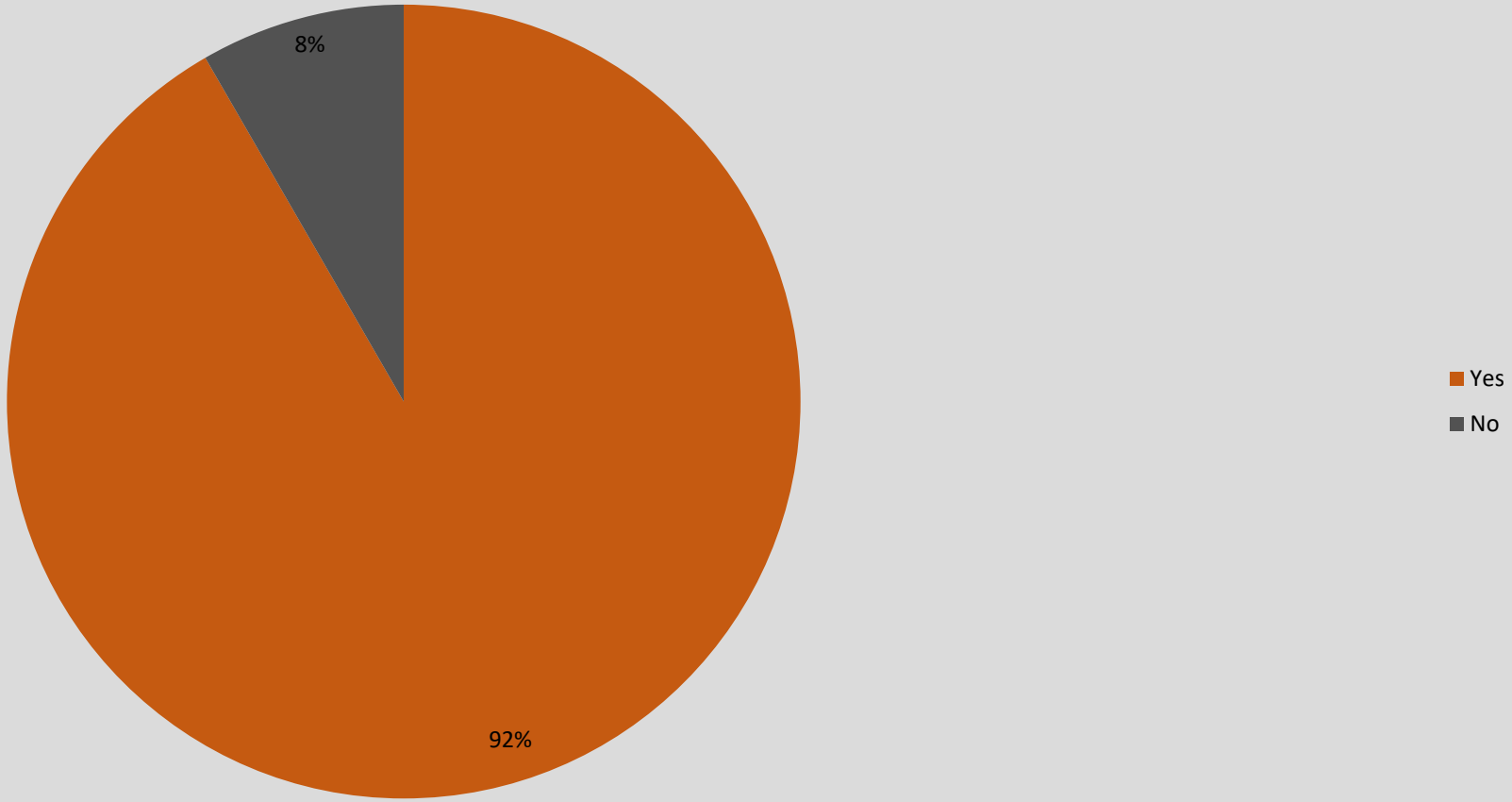
Early Results of External Peer Review

Does a Prescription Monitoring Program (PMP) review show any drug seeking from multiple providers?



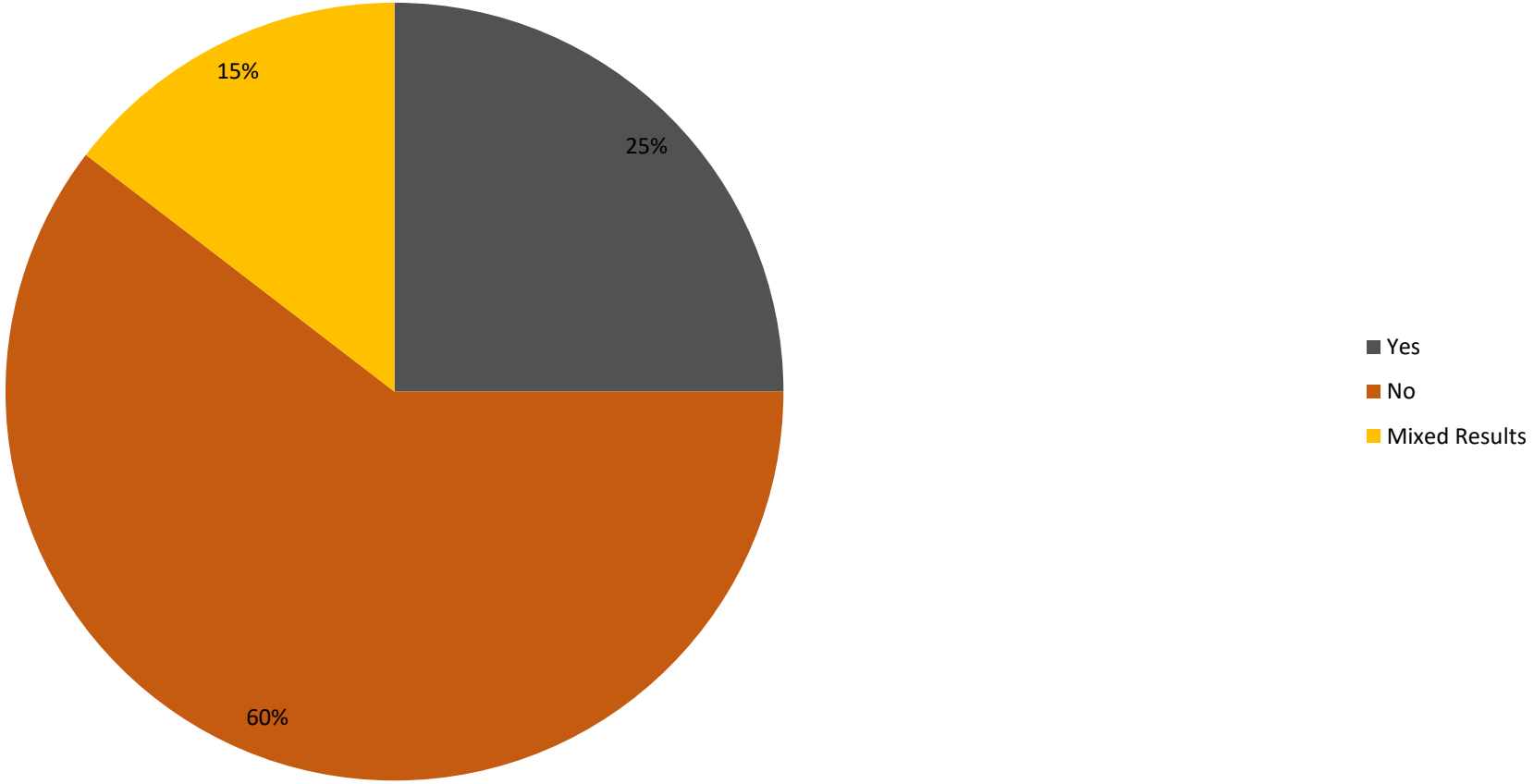
Early Results of External Peer Review

Does there exist any comorbidities that increase risk of overdose (OSA, COPD, TAD, mental health disorders)?



Early Results of External Peer Review

Do you feel the current treatment plan is appropriate for this patient (benefits outweigh the risks, consistent with CDC guidelines)?



MRN Reviewed: 64025 67 y/o diabetic woman with CKD3, BMI 47 and back pain

◊ Recommendations from Chart Review

I think it's ok to continue hydrocodone as you are, but I'd do a couple other things.

Refer for sleep apnea evaluation – she is high risk of having it, and her resistant HTN/BMI 47 are suggestive of it. Having OSA would increase her risk of overdose, make it difficult to lose weight, increase pain/BP. Sleep testing has been mentioned before in specialist notes, so it's important to have her complete it.

- **Also screen for depression**

What is causing all her pain? Is this all from the severe L & moderate R neural foraminal stenosis at L5-S1? Or obesity-related muscular low back pain?

Is there specific treatment for her pain? It's curious she never followed up with 2018 neurosurgery referral. It's possible an interventional pain procedure would help.

- **Consult with neurosurgery**.
- **Refer for physical therapy** (never gone)
- **Trial** of OTC **lidocaine** 4% **patches** or prescription 5% lidocaine patches (it'll never be covered by insurance and will be about $45 per 30 patches with your 340B pharmacy but probably worth it for her).

Prescribe naloxone for overdose prevention – I would consider her medium to high risk with BMI & probable OSA, and it's best practice to give naloxone for emergency use in these circumstances
WAC 246-919-980 • Confirm or provide naloxone when prescribing opioids to a patient • MD: high risk • DO: high dose • ARNP: > 50 MED

She is losing weight. Bravo!

Primary Care Considerations

- Her metoprolol succinate 50mg is dosed twice daily. Succinate is the once daily version and could be consolidated into 100mg once daily dosing
- Consider Januvia 50mg once daily. This agent is weight neutral, has no hypoglycemia risk and is easier to take than the twice daily glipizide, which has those risks.
- Evaluate need for gemfibrozil. The highest TG I saw was 368. My recall of the latest thoughts on fibrates is that they reduce pancreatitis risk if TGs>600 but have little other improvements in patient oriented outcomes compared to statins at TGs<600. May be able to stop it?

If she had sleep apnea or an event that made you want to decrease her risk, you could consider changing to buprenorphine. It doesn't look like she has opioid use disorder (OUD), so you could give Belbucca (plain buprenorphine) sublingually or generic buprenorphine (subutex). OUD patients need much higher doses than non-OUD pain patients for whatever reason. If you wanted to switch, I'd have her stop hydrocodone for 12 hours and then start buprenorphine.
Belbucca (plain buprenorphine) sublingually she'd probably need 0.75mg SL TID.
Or generic buprenorphine (subutex) 2mg tablets – have her use ½ tablet SL TID (1mg TID) –*this is about $26/month with 340B pricing.*
The advantages of bupe are less sedation, less risk of overdose, no renal dose adjustments and longer acting/no opioid withdrawal between dosing. It's probably ok to stay on hydrocodone if you'd like.

Documentation Compliance with House Bill 1247 (effective 1/1/2019): good

Document PMP checks
Document risk assessment with a professionally developed screening tool, like POMI (see addendum), Opioid risk tool, or COMM. PMP checks & urine drug screens every 12 months low risk, every 6 moderate, every 3 high risk
ORT: http://www.agencymeddirectors.wa.gov/files/opioidrisktool.pdf
COMM http://mytopcare.org/wp-content/uploads/2013/05/COMM.pdf

1.	When was opioid started by the YNHS provider?	Date: 1/2018 hydrocodone	
Comments/Explanation: Click or tap here to enter text.			
2.	Is this a continuation from a previous outside provider's treatment plan?	Yes ☐	No ☐
Comments/Explanation: Click or tap here to enter text.			
2b	If yes, why did they leave the previous provider?		
Comments/Explanation: Click or tap here to enter text.			
3.	Has there been a request and review of records to confirm consistency with reported history and to rule out history of aberrant behavior?	Yes ☐	No ☐
Comments/Explanation: Click or tap here to enter text.			
4.	What is the condition requiring chronic opioids?	Condition: Chronic back pain	
Comments/Explanation: Click or tap here to enter text.			
4b.	Is the use of opioids a reasonable approach given the diagnosis and clinical picture?	Yes ☒	No ☐
Comments/Explanation: Click or tap here to enter text.			
5.	Does the condition have a good prognosis with appropriate evaluation/treatment?	Yes ☐	No ☐
Comments/Explanation: Click or tap here to enter text.			
5b.	Has this evaluation/treatment been done? Click or tap here to enter text.	Yes ☒	No ☒
Comments/Explanation: Had MRI showing issues, but pt didn't follow up with neurosurg. No referrals to PT made			
6.	What is the evolution frequency and dosing of opioid use?		
Comments/Explanation: Fairly stable			
7.	What is the current morphine equivalent dosing per day?	Dosing: 20 MED http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm	
Comments/Explanation: Hydrocodone 5mg QID			
8.	Is there evidence of extensive trial of non-opioid therapies (medication, therapies, injections, etc.)?	Yes ☐	No ☐
Comments/Explanation: Click or tap here to enter text.			

9.	Has patient ever been referred to pain management?	Yes ☐	No ☒
Comments/Explanation: Click or tap here to enter text.			
9b.	If so, what was their recommendation or treatment plan? Click or tap here to enter text.		
Comments/Explanation: Click or tap here to enter text.			
10.	Is there Controlled Substance Agreement (CSA)?	Yes ☒	No ☐
Comments/Explanation: Click or tap here to enter text.			
10b.	If so, has it been renewed within last 12 month by active prescriber?	Yes ☒	No ☐
Comments/Explanation: Click or tap here to enter text.			
11.	Has there been a Urine Drug Screen (UDS) within the last 12 months?	Yes ☐	No ☐
Comments/Explanation: Click or tap here to enter text.			
11b.	Are previous UDSs consistent with opioid prescription?	Yes ☒	No ☐
Comments/Explanation: Click or tap here to enter text.			
11c.	Has there been evidence of use of other drugs concurrently (including THC and ETOH)?	Yes ☐	No ☒
Comments/Explanation: Click or tap here to enter text.			
12.	Does a PMP review show any drug seeking from multiple providers?	Yes ☐	No ☐
Comments/Explanation: Click or tap here to enter text.			
13.	Does there exist any comorbidities that increase risk of overdose (OSA, COPD, TAD, mental health disorders)?	Yes ☒	No ☐
Comments/Explanation: Morbid obesity BMI 48			
14.	**Do you feel the current treatment plan is appropriate for this patient (benefits outweigh the risks, consistent with CDC guidelines)?**	**Yes ☒**	**No ☐**
14b.	Why or why not? See above discussion		

I'd be happy to discuss the review of this patient. This was only a chart review, which cannot replace your face to face time with the patient. I have not seen the patient and appreciate the complexities and limitations of this medium for review for providing suggestions to your clinical care.

UW telepain is a great resource to discuss complex patients as well. You can contact telepain@uw.edu

http://depts.washington.edu/anesth/care/pain/telepain/index.shtml

Appendix:

Prescription Opioid Misuse Index (POMI)

Two (2) Yes answers indicates a positive screen (possible diagnosis of Opioid Use Disorder)

yes/no

1 Do you ever use more of your medication, that is, take a higher dose, than is prescribed for you?
2 Do you ever use your medication more often, that is, shorten the time between doses, than is prescribed for you?
3 Do you ever need early refills for your pain medication?
4 Do you ever feel high or get a buzz after using your pain medication?
5 Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?
6 Have you ever gone to multiple physicians, including emergency room doctors, seeking more of your pain medication?

(From Knisely. Journal of Substance Abuse Treatment. 2008 Dec;35(4):380-6. [AppendixI]

Tackling the Problem

- QA Process: Peer review by non- YNHS Family Practice physician
- Revised YNHS Chronic Pain protocol based on CDC guidelines, and vetted by lead physician at local pain clinic (Water's Edge)
- November 2017: Providers advised against starting additional patients on opioids on an ongoing basis unless approved by CMO or Adult Medical Team lead; co-management w/ Pain specialty expected

YNHS MAT Program - Timeline

Spring 2016

– protocol design meetings

- MAT training offered to providers regardless of degree/specialty (free to provider)

4/2016: MAT Provider invited to speak at provider meeting

In Person Training for providers : 8/2016

3/2017: first YNHS MAT patient

“Looks Great on Paper…” Then and Now

2017

Patient identified

Screened by Care Coordinator

Meet w/ CDP and BH

Overview visit w/ Psychologist

Meet w/ pharmacist

Meet w/ provider for induction

2018

Patient identified

Meet w/ Care Coordinator

Meet w/ provider for induction

CDP/BH/Psychology/Pharmacist support as needed

Early / Current Barriers

2017

- Marijuana, meth
- Streamlining workflow
- Mentorship for providers
- Tracking patients
- Diversion monitoring
- Naloxone – overdose prevention
- Quality Assurance - reporting

2019

* Missed diagnoses of OUD

- Slow transition of current chronic opioid patients w/ OUD to MAT
- Attrition due to missed appointments
- Quality Assurance-reporting
- Provider turnover

Team Based Approach

- Patient
- Care Coordinator
- Provider
- CDP
- Behavioral Health Provider
- Psychologist
- Pharmacist

MAT Case Conferences

Lessons Learned at Case Conferences

HARM REDUCTION

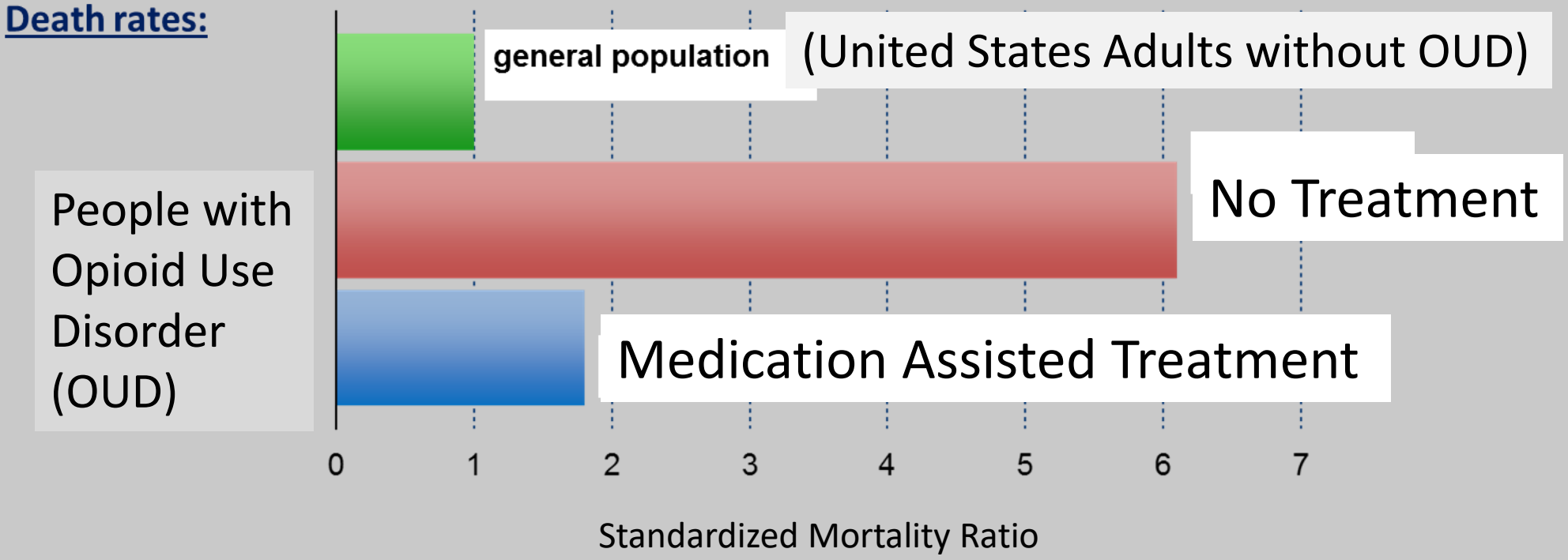
DIVERSION PREVENTION

BEST PRACTICES TO DEAL WITH LOST PRESCRIPTIONS

WORKFLOW EFFICIENCIES

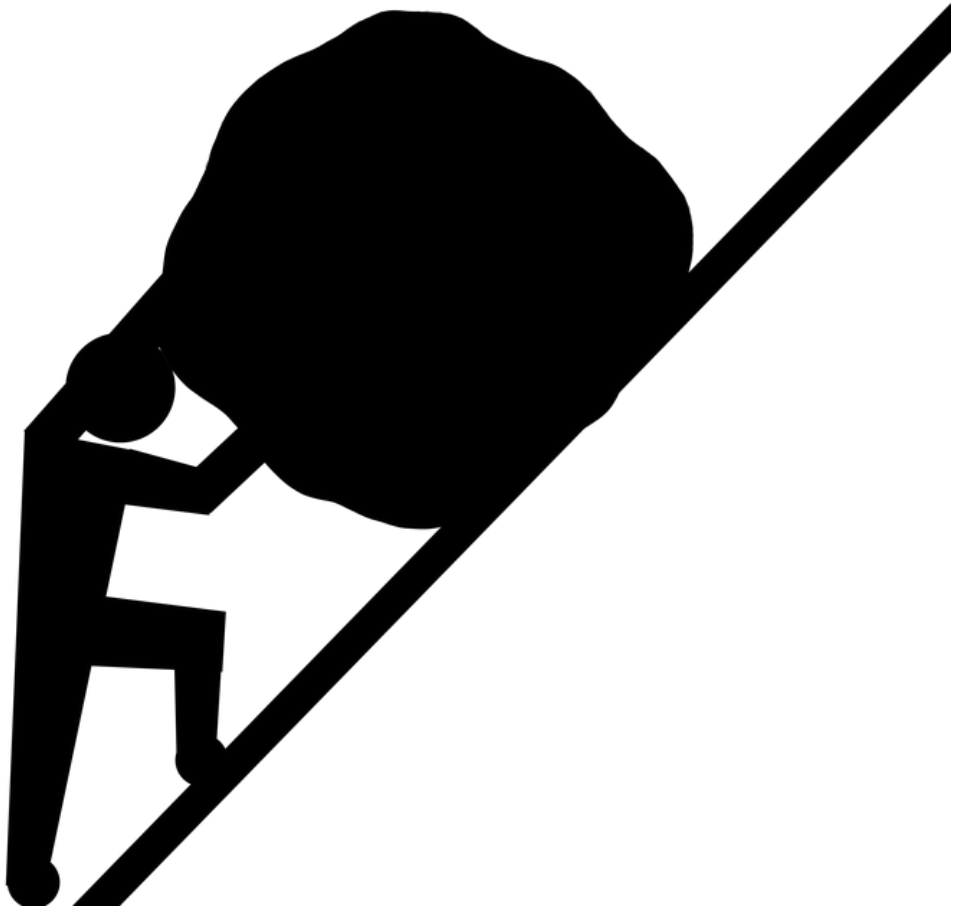
MOTIVATIONAL INTERVIEWING

Benefits of MAT: Decreased Mortality

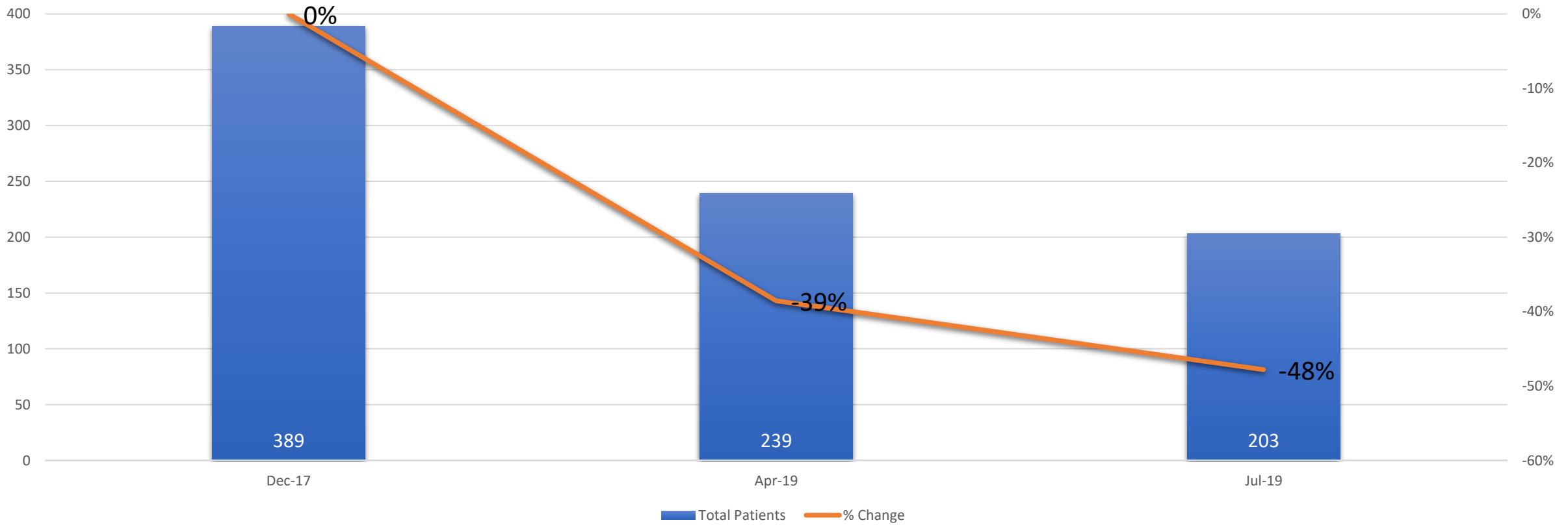


Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

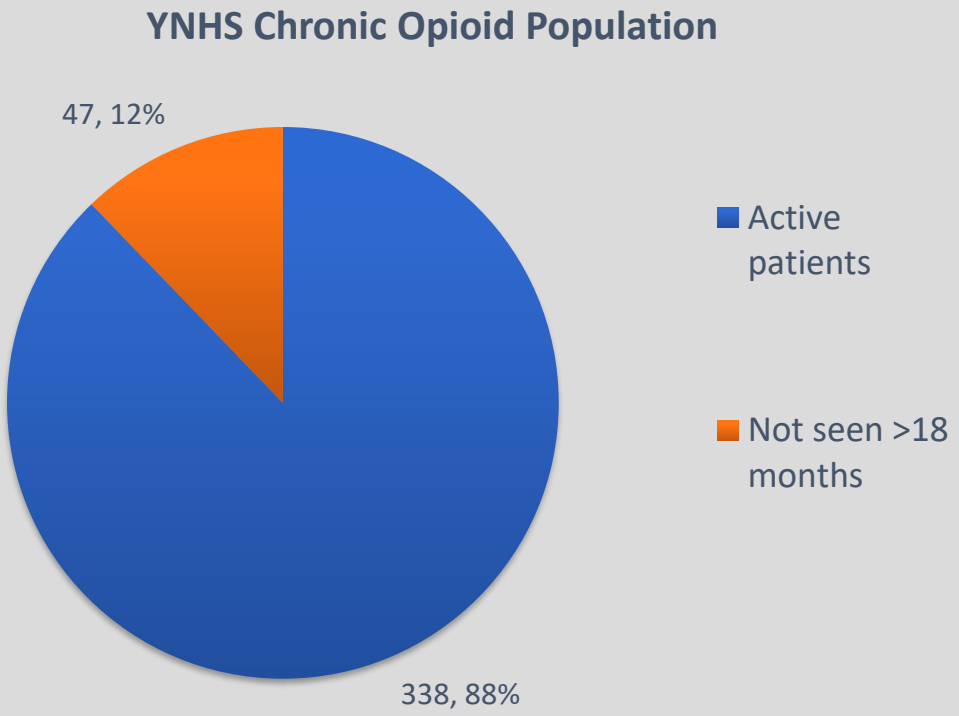
Progress Over the Years

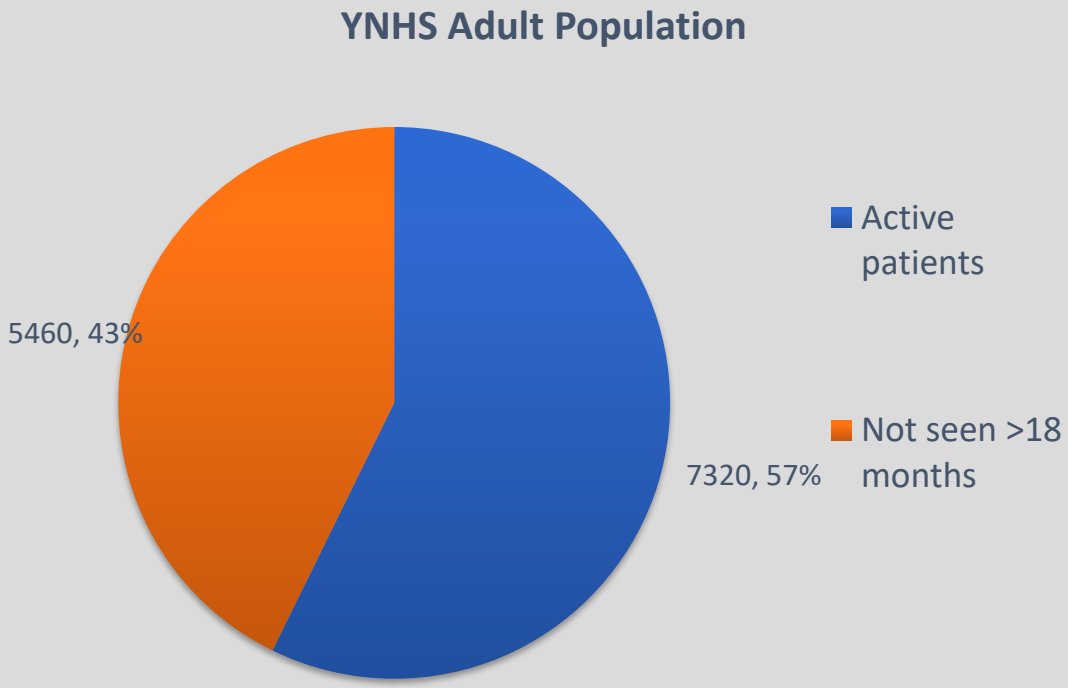


What's Happened to our Chronic Opioid Patients?

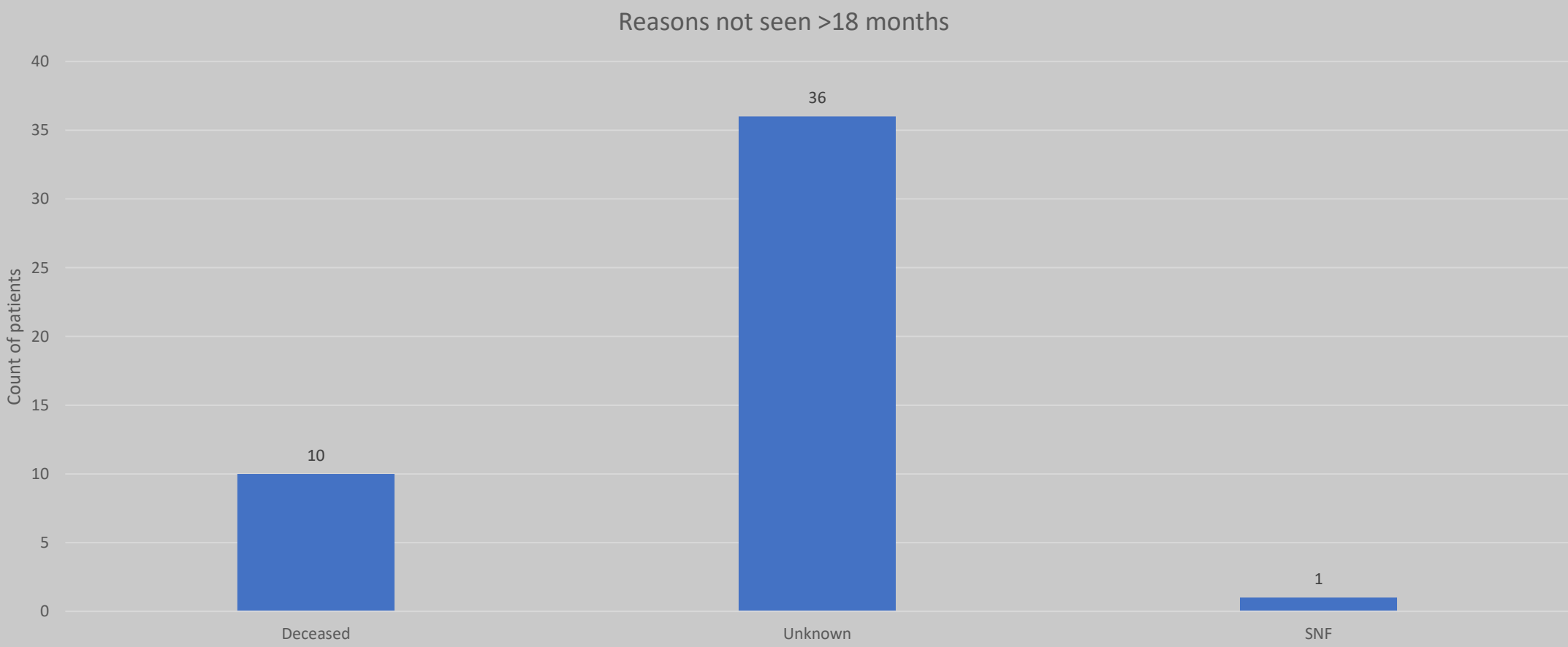


But Did We Lose Them??





Reasons Not Seen for > 18 mos

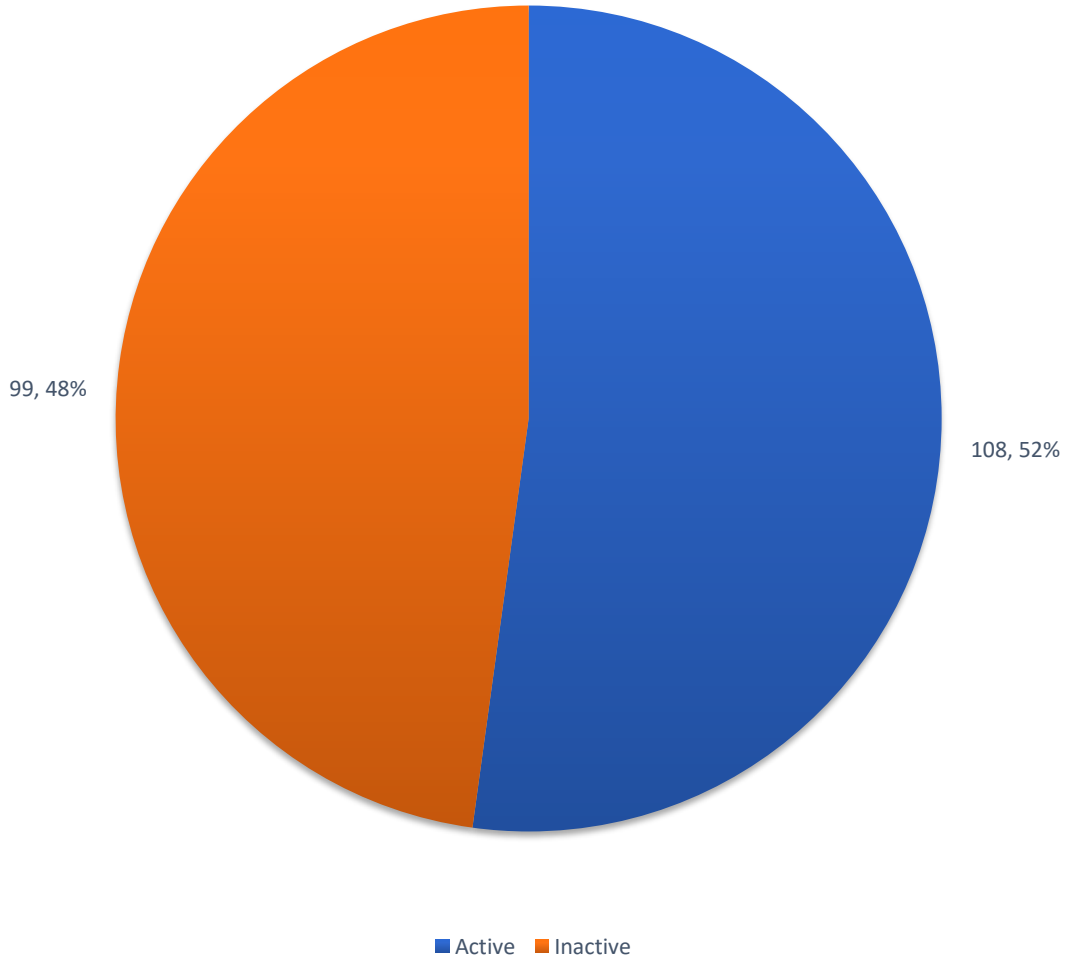


Who are our MAT Patients?

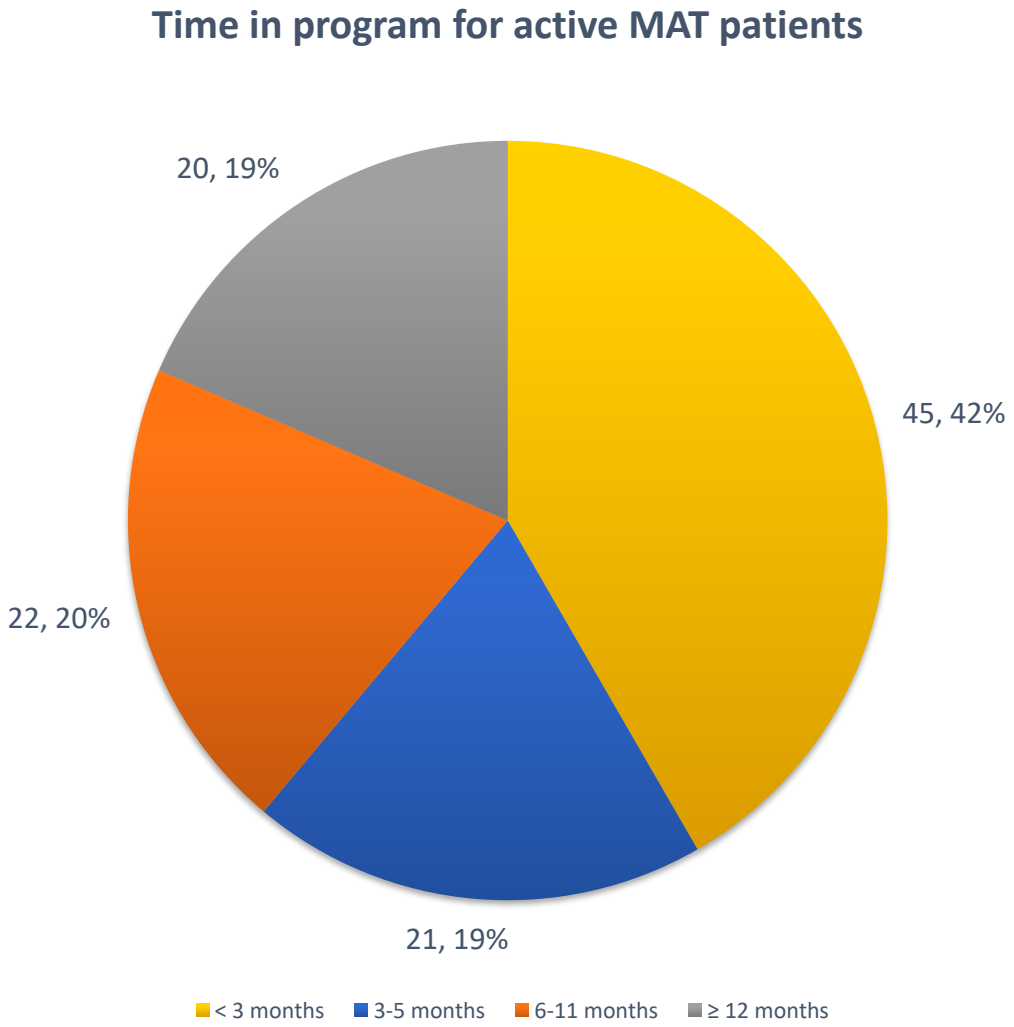
Our MAT Population

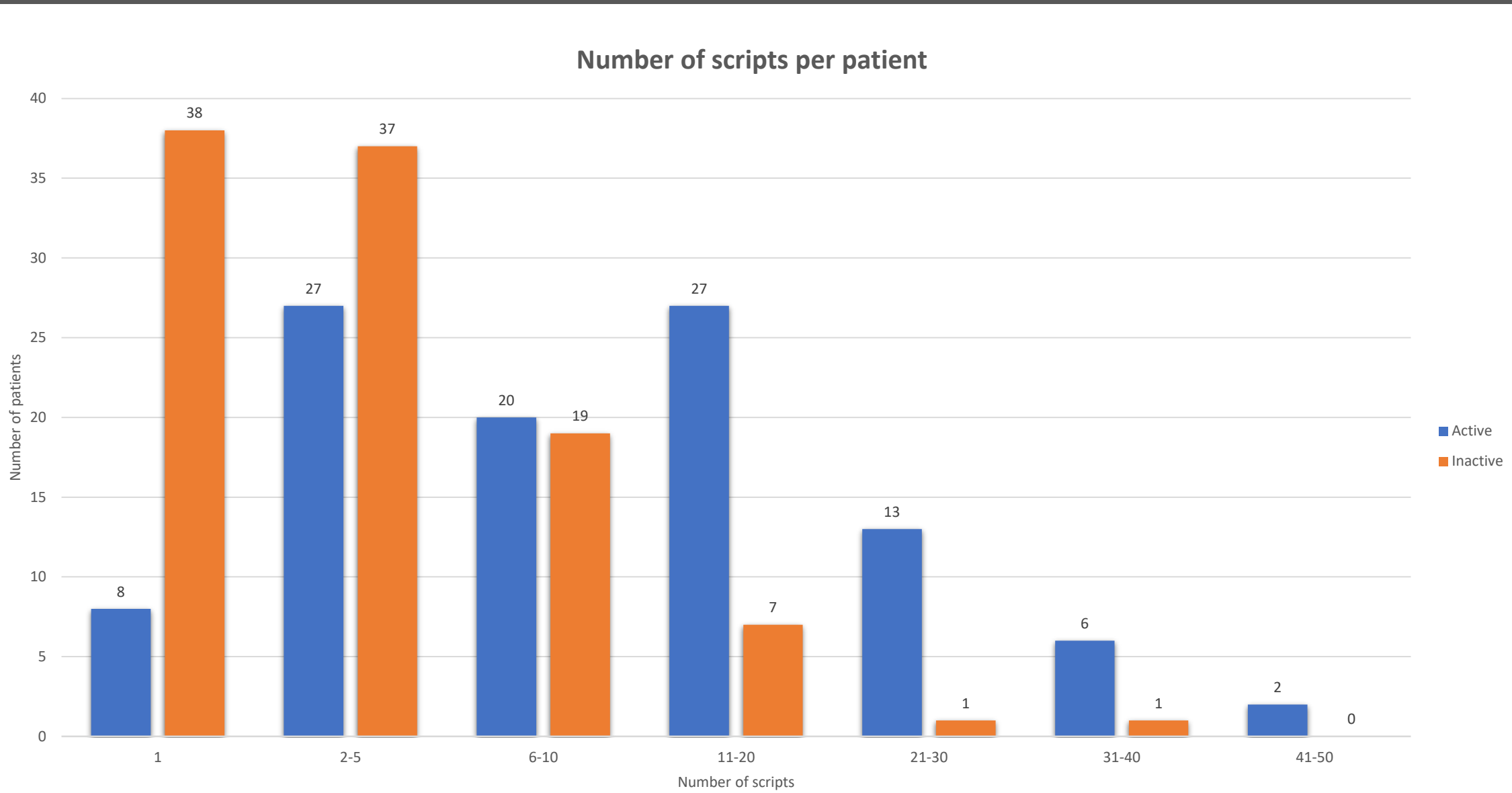
All Homeless	40%
Literally Homeless (Street, shelters, encampments)	23%
Primarily White	90%
Hispanic	20%
Medicaid	74%
Medicare	15%
Uninsured	3%

Retention



Active Patients




Number of scripts per patient
40
35
30
25
20
15
10
5
0
Number of patients
38
37
27
27
20
19
13
7
6
1
2
1
0
1
2-5
6-10
11-20
21-30
31-40
41-50
Number of scripts
Active
Inactive

Hub and Spoke

Provider Feedback

- It takes several months for a provider to feel comfortable prescribing MAT
- Surprises
  - How effective MAT is in improving someone's quality of life
- Barriers
  - - Lack of transportation leading to missed appointments
  - - Appointment availability
  - - Patients' continued exposure to opiates in their environment
  - - Lack of stable housing
- What helps:
  - Case conferences
  - Team based approach (behavioral health, care coordinators, CDP)

Provider Feedback

- Challenges
  - Scheduling flexibility to be able to address medical and social complexity
  - Learning curve: understanding dosing and managing side effects
- Homelessness:
  - - Safe medication storage
  - - Peer support
  - - Lost prescriptions
  - Rewards
  - - Forming a trusting relationship with the patients
  - - Seeing patients thrive, be happy, and able to function
  - - Helping someone who few people want to help

Relationships in the Community

- Medical respite
- Treatment programs

Early wins

- ✓Is a PCP (FP)
- ✓Works at a CHC
- ✓Has homeless patients
- ✓IS A SUBSTANCE ABUSE EXPERT
- ✓VERY KNOWLEDGEABLE IN THE MANAGEMENT OF CHRONIC PAIN AND MEDICALLY COMPLEX PATIENTS
- ✓ROLE MODEL FOR MOTIVATIONAL INTERVIEWING
- ✓He uses the same EMR as we do

Financing / Billing

- MD / DO / ARNP visits
- Behavioral Health visits
- Care Coordinators:
  - Health Home (Medicaid/Medicare)
  - SUD-MH grants (BPHC)
- Pharmacist
  - SUD-MH grant (BPHC)
  - IBHS grant

42 CFR Part 2

The Office of the National Coordinator for Health Information Technology

Substance Abuse and Mental Health Services Administration SAMHSA

Disclosure of Substance Use Disorder Patient Records:

Does Part 2 Apply to Me?

Are you a SUD Program ?

Licensed to provide SUD services

Advertises SUD services

Consults to non “program” practitioners

Program can be :

- Individual / entity
- Identified unit within a facility
- Personnel whose primary unction is providing SUD

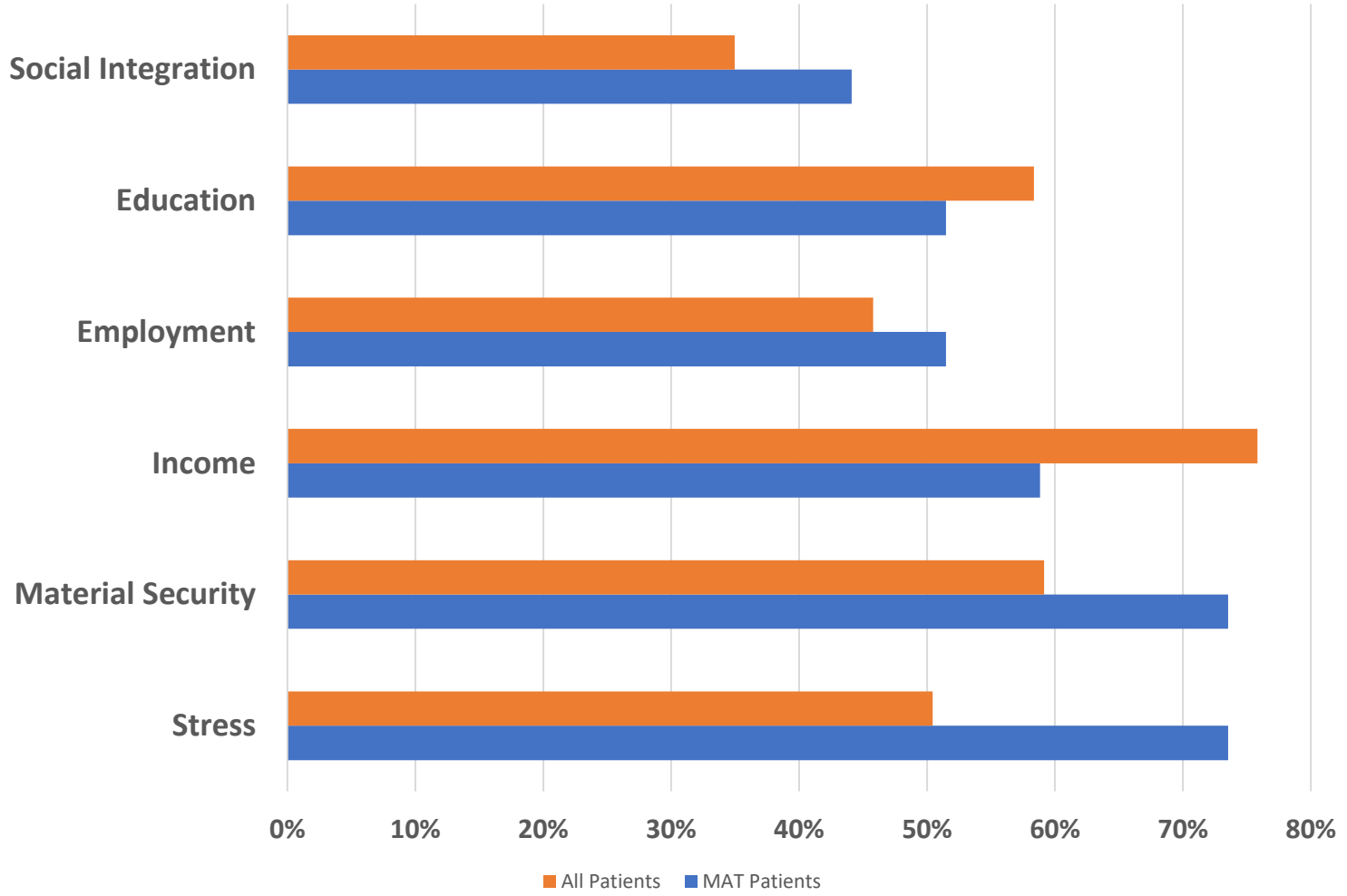
“Federally Assisted”

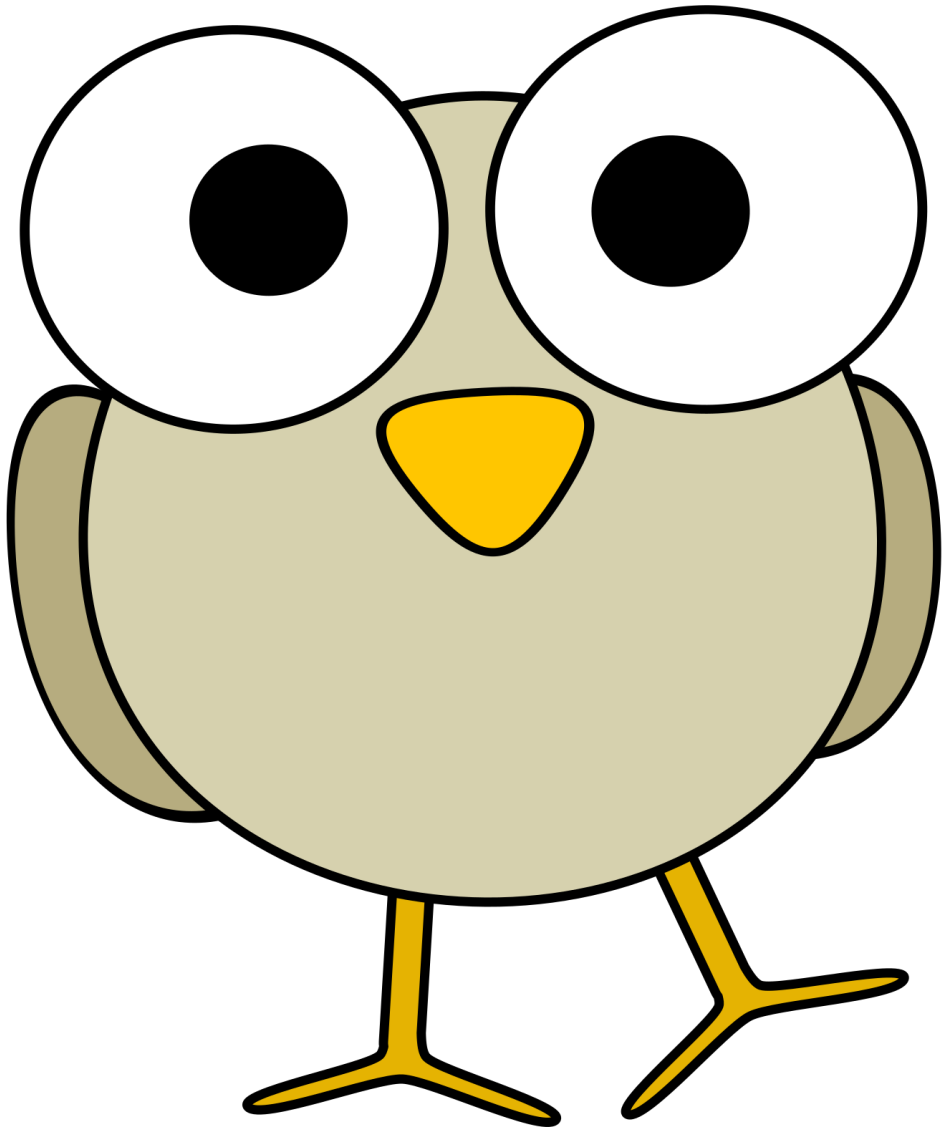
- Medicare / Medicaid participating
- Authorized to tx or withdrawal mgmt
- DEA registered to dispense controlled substance for TX of SUD

Scenario from SAMSHA Integrated Care Setting

- "Dr. Pierce is a physician at Blue Mountain Physician Group", a group that treats patients in an integrated setting. They do not advertise they provide SUD services, and several of their providers have received waivers from SAMHSA to prescribe buprenorphine for OUD. Dr. Pierce prescribes MAT services, but this does not constitute his primary function.
  - ✓ Yes he is federally assisted (registered with DEA, waiver from SAMHSA)
  - ✓ No, he does not advertise to be a SUD provider
  - ✓ No, his patients are not readily identifiable as SUD patients
  - ✓ No, he is not subject to Part 2 disclosure , but is subject to HIPAA disclosures

Social Determinants





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Rhonda Hauff, COO / Deputy CEO rhonda.hauff@ynhs.org

Yakima Neighborhood Health Services