Clinical Track

A Rural Primary Care Clinic's Successful Response to the Opioid Epidemic

David Baker, Minnesota State Representative, Chief Executive Officer, Baker Hospitalities, Inc.

Heather Bell, MD, Family Physician, Family Medical Center, CHI St Gabriel's

Kurt DeVine, MD, Family Physician, Family Medical Center, CHI St Gabriel's

Moderator: John J. Dreyzehner, MD, MPH, FACOEM, Commissioner, Tennessee Department of Health, and Member, National Rx Drug Abuse & Heroin Summit Advisory Board

#Rx Summit   www.NationalRxDrugAbuseSummit.org
Disclosures

- Dave Baker; Heather Bell, MD; Kurt DeVine, MD; and John J. Dreyzehner, MD, MPH, FACOEM, have disclosed no relevant, real, or apparent personal or professional financial relationships with proprietary entities that produce healthcare goods and services.
Disclosures

- All planners/managers hereby state that they or their spouse/life partner do not have any financial relationships or relationships to products or devices with any commercial interest related to the content of this activity of any amount during the past 12 months.

- The following planners/managers have the following to disclose:
  - Kelly J. Clark, MD, MBA, FASAM, DFAPA – Consulting fees: Braeburn, Indivior
Learning Objectives

- Describe a patient-centered model to reduce opioid prescriptions in the community.
- Explain how to use medication assisted treatment part of a normal primary care clinic in a rural community to treat patients with opioid use disorder.
- Identify local and state resources to engage in order to address the opioid epidemic collectively.
MORRISON COUNTY DEMOGRAPHICS

Population (as of 2016): 32,821

Little Falls Population: 8,689

Race: 97.3% white alone

High School Graduate or Higher: 89.4%

Bachelor’s Degree or Higher: 16.2%

Persons without Health Insurance, Under 65: 5.8%

Percentage of County on Medical Assistance: 22% (7,278 residents)

Median household income: $51,456

Persons in poverty: 11.9%

https://www.census.gov/quickfacts/fact/table/morrisoncountyminnesota/PST045217
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Call to Action
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Call to Action

What caught our attention in our community?

- On call narcotic refills
- Emergency room visits
- Overdoses deaths in the community
- Police concerns
Community issues require community collaboration.

In 2014, the Morrison County Prescription Drug Task Force formed.
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A Real Solution
A Rural Response
A Real Solution

Prescription Drug Task Force functions:

- Community education
- Drug take-back events
- Community forums
- Coffee with a Cop
- Information sharing
- School Programs
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- Task forces
- Narcan
- Drug Treatment
- Medication Assisted Treatment
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These are NOT solutions to the opioid epidemic and addiction, rather these are reactions to the problem.
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Our pharmacy data showed 100,000 narcotic pills were coming out of our local pharmacies each month. (Jan 2015)

The task force could not solve this issue.
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Our initial focus:
Decreasing the narcotics leaving clinics and hospitals.

Our new goal:
Put drug treatment centers and the manufacturers of Meathadone, Suboxone, and Narcan out of business.
Most patients addicted to heroin started on pills, and many times first exposure was legally prescribed.
In 2015, a Controlled Substance Care Team (CSCT) was formed within our primary care clinic.

SIM (State Innovation Model) grant received for $360,000 helped fund efforts.
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Initial Goals

- Avoid early refills
- Encourage doctors to sign up for Prescription Drug Monitoring Program (PDMP)
- Review patient charts
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Initial Goals

- Ensure urine screens and pill counts are completed
- Support providers by establishing care plans for all patients on controlled substances
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Early Workflow Development

- One physician
  - Patient selection, implementation, guidelines (120 MME)
  - Process flow, workflow
- RN Care Coordinator
  - Meetings with patients for goals and care plans
  - Care plan and protocol writing
  - Initial physician discussions
- Administrator
  - Oversee the process
- Weekly meetings
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March 2016:
CDC 90 MME
Top 3 Things Physicians Love to Hear:

1. More documentation
2. More time required (care plans)
3. Told how to manage their patients
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Team Advancement:
- Social Worker
- Patient Centered Med. Home Physician

Heather 2.0 vs. Kurt 1.0
Getting Started

- Data gathering
- Making the “list”
- Working the “list”
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Criteria for the List

- Narcotics
- > 3 months consecutive prescriptions
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Benzodiazepines
Comorbidities
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Initial Evaluation

- Begins with patient meeting with the Nurse Care Coordinator and/or Social Worker
- Care plan signed
- UDAS
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Information Gathering

- Past medication history
- Substance abuse history
- Drug-related convictions
- PMP
- Family history
- Pharmacy review (if necessary)
- Review of appropriate dosing
- Facebook
- Mental health concerns
- Medication interaction
- ER visits
- Work history
- Diagnosis for medication
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Process Flow Adaptation

- Highlight pertinent issues from nurse and social worker onto “user friendly” form for easy review
- Efficiency!
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MD Recommendations

CSCT REVIEW
Dr. ___________________________ Date: ___________________________

The CSCT has reviewed the following patient:

Patient Name: ___________________________ DOB: ___________________________ MRN: ___________________________

Diagnosis: ___________________________

Medication Agreement/Care plan signed: Y/N, Date: ___________________________

Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N,
Mental Health Provider/Therapist: ___________________________

Current Medications of Concern:

Images Reviewed: Y/N

Other Modalities attempted:

UDAS in past year: Y/N, Date of most recent UDAS: ___________________________

UDAS Findings:

- ___________________________
- ___________________________

Pill Counts: ___________________________
PMP Reviewed: Y/N, Findings: ___________________________
Social History: ___________________________

Social Needs identified: ___________________________

Recommendations: ___________________________

Form scanned in to EMR: Y/N

Signed: ___________________________
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CSCT Review Form
Evaluated at weekly meetings by physicians.

Review Includes
- Previous work-ups
- Scans
- Previous treatments
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Recommendations

- Formulated based on review
- Discussed with primary provider
Components of Recommendations

- Dose reductions
- Further work-up or updated work-up
- Discontinuation of other medication due to risk (benzodiazepines)
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Components of Recommendations

- Physical therapy or occupational therapy
- Taper if medical condition doesn’t warrant pain medication
- Discontinued if proven diversion or no if no evidence that the patient is taking the medication
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Priority Patients

- Provider or nurse referral
- Drug refill issues (RN reviews)
- Police information
- Pharmacy concerns
- Slowly working the “list”
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- These are the patients that make the biggest impact on physician culture change
  - Best opportunity for MD-MD discussion
- CDC guidelines didn’t change prescribing habits until something unforeseen happened
  - Program evolution
  - Overdoses, pill mill, diversion, “good” patients, urine results
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Changing Physician Culture: Slow and Ongoing

- Unexpected urine testing
- Overdoses and overdose deaths
- Police information
- CDC guidelines information
- Minnesota State Prescribing Guidelines, 2018
- State Board interest in this issue
What does the board expect?

- Evaluate patient history and physical
- Document treatment plan
- Check the PDMP
- Informed consent and medication agreement
- Periodic review-functional improvement?
- Consultation/referral if appropriate
- Medications-attempt to decrease and pill counts, drug screens
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Outcomes

In 2014, the #1 Emergency Department diagnosis was therapeutic drug monitoring

As of Nov. 2015, Emergency Department diagnosis for therapeutic drug monitoring is no longer on the top 20 list
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Outcomes

438 patients had opioids, benzodiazepines, or stimulants discontinued by a Controlled Substance Care Team intervention.

These patient tapers account for 500,228 fewer pills/units prescribed in a year.
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Outcomes

- **438** total taper patients (narcotics, stimulants, or benzodiazepines)
  - Average decrease= **41,685** units/month no longer prescribed
  - Approx. $7/pill= **$3.5 million per year**

- Patient Needs/Support Referrals
  - 2016: 146
  - 2017: 336
Schedule 2 units filled each month at local pharmacy

- January 2015: 30000
- February 2015: 20000
- March 2015: 40000
- April 2015: 30000
- May 2015: 20000
- June 2015: 40000
- July 2015: 30000
- August 2015: 20000
- September 2015: 40000
- October 2015: 30000
- November 2015: 20000
- December 2015: 40000

- January 2016: 2015
- February 2016: 2016
- March 2016: 2017
- April 2016: 2018
- May 2016: 2015
- June 2016: 2016
- July 2016: 2017
- August 2016: 2018
- September 2016: 2015
- October 2016: 2016
- November 2016: 2017
- December 2016: 2018
Schedule 2 Units filled each month at local pharmacy trend
Schedule 4 units filled each month at local pharmacy
Schedule 4 units filled each month at local pharmacy (overall trend)
Outcomes

- Reasons for Tapers:
  - Dose too high
  - Diverting
  - No diagnosis/reason for medications
  - “Other” – urine drug screen results, self medicating, etc.
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Medication Assisted Treatment
A Rural Response
Medication Assisted Treatment

Why start an MAT program in a rural clinic?

- Patients presenting with opioid use disorder are unable to taper from narcotics
- Large population of patients using heroin
- Overdose deaths
- Barriers to treatment
  - Distance
  - Accessibility
Patients like to be treated in their local clinic
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Physician barriers to providing MAT rurally
- Lack of mentors
- Prior authorizations
- Untrained staff
- Availability of medication in pharmacies

Education (Atlanta 2016)
- Decrease deaths
- Relapse rate
- Decrease crime
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Physiology of Opioid Use Disorder
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Medication Assisted Treatment

Our Process:
- Waivered
- Visited a buprenorphine clinic
- Protocols
- Developed intake form
- Patient packet

Patient #1

Substance Use Assessment

Instructions: Fill out the section for each of the drugs that you have used, even if that substance was not for you. If you do not remember specifics, give your best estimate.

<table>
<thead>
<tr>
<th>Substance</th>
<th>When did you last use it?</th>
<th>Frequency of most recent use. (ex. 3x per week)</th>
<th>Was this substance ever a problem? (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (list)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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Medication Assisted Treatment

Our Workflow

Patient calls clinic and talks with nurse care coordinator
• Drug history
• “Story”

Doctors review

Patient scheduled
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Not appropriate for our program

- Drug of choice
- High risk
- Distance
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Medication Assisted Treatment

Appropriate and NOT sick

- Forms filled out: consents, contract/care plan, releases
- UDAS
- Overview
- Social Worker: insurance, talk about Rx
- Medication called in: PA
- Schedule for induction
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Medication Assisted Treatment

Appropriate and sick

- Forms filled out: consents, contract/care plan, releases
- UDAS
- Medication called in: PA, foundation
- Go pick up meds and come right back
- Induction
- Social Worker: insurance, talk about Rx
- Follow up next day
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Medication Assisted Treatment

Follow ups
- Frequent
- UDAS
- Social worker
- Work toward Rx
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Witnessed UDAS
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Problems

Dirty UDAS

Don’t follow-up

Police
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Our Buprenorphine Program Success Thus Far

- Total considered for program: 110
- Total enrolled: 76
- Currently Active: 53
- Inactive: 23
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Medication Assisted Treatment

Buprenorphine Program: Defining Success

- Time
- Employment
- Repaired relationships
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County Jail Program
A Rural Response
County Jail Program

- What happened?
  - JW

- Learned:
  - Lose medical assistance
  - County responsible for medication cost
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County Jail Program

- Convened a county panel
  - Judge
  - Sheriff
  - Jailor
  - Social Services
  - Jail doctor
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County Jail Program

- Maintaining MAT
  - Stable on buprenorphine
  - < 30 day jail time
  - Go in with one month of meds
  - 2 patients

- Obstacles
  - Department of Corrections
  - Cost → county
  - Controlled substance in jail
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County Jail Program

- Initiating MAT
  - In withdrawal
  - Want help
  - Recidivism problem: $120/day vs $8.10/day

- Barriers
  - Significant cost to county
  - Waivered doctor/training
  - Staff education
  - Strict protocols
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County Jail Program

Current Life Activity
- Full time employment
- Retired
- Stay at home mom
- Unemployed for treatment

Average Days Spent In Jail from January 2015 Until Patient Started Buprenorphine vs. After Buprenorphine
36 patients surveyed
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Emergency Room
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Emergency Room

**Goal:** point of care intervention

- Interact with overdose patients or patients in withdrawal
- Flyer with controlled substance care team phone number
- Referral process for buprenorphine treatment
- High risk of death if discharged
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Duplicating our Program
A Rural Response
Duplicating our Program

Same program, bigger community
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Duplicating our Program

- Can our program work in other communities?
  - Following our guidelines and model, a community with one nurse without funding decreased 111,552 pills in one year
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Duplicating our Program

Through duplicating our program:

- Eight communities will receive legislative funding to hire staff to mirror our program.
- Legislation grant money based on our success
- Funding other communities
- Data: pills, tapers, care plans

SEVEN MILLION DOLLARS SAVED
ONE MILLION PILLS
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Project ECHO
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Project ECHO

Our communication throughout our state and further.

Moving Knowledge Instead of Patients and Providers

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ECHO model is not “traditional telemedicine.”
Treating physician retains responsibility for managing patient.
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Goals of our ECHO:

- Aid providers in the appropriate management of narcotic prescribing.
- Give providers the ability to identity patients that are not appropriate for opioids, through things such as chart reviews.
- Be able to identify comorbidities that put patients at higher risk of death.
Goals of our ECHO:

- Collect data for the state that will demonstrate improvement in prescribing practices and decreases in the number of pills being prescribed.
- Educate physicians on the CDC and new state guidelines.
- Increase the number of buprenorphine providers in rural Minnesota.
- Decrease OD deaths
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Project ECHO

ECHO Clinic Format

- Attendance
- Didactic
- Case discussion/reviews
- Specialist partners
  - Addiction specialist
  - Pain doctor
  - Toxicologist
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Project ECHO

Little Falls Hub

ECHO Spoke Locations
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Little Falls HUB

ECHO Participants
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“Multiplication of Force”

Little Falls
buprenorphine patients

ECHO Spokes

Roughly 10 patients per ECHO SPOKE
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What we’ve done in three years:

- **438** patient tapers
- Cut out **500,228** pills a year so far
- **53** active buprenorphine patients
- Gold card for prior authorization
- First ECHO in the state of Minnesota
- First provider of buprenorphine in a county jail
- Changed ER process for overdose
- **8** communities a part of legislative grant
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OUR NEW COMMUNITY
FOCUSED ON REDUCING PILLS
AND ENCOURAGE
MAT IN PRIMARY CARE
THANK YOU!

Heather Bell MD: 
heatherbell2@catholichealth.net
Kurt Devine, MD: 
kurtdevine@catholichealth.net
Dave Baker 
Rep.Dave.Baker@house.mn

Phone: 320-631-7239
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THANK YOU

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