California's Hub and Spoke System Learning Collaborative Q2

BUILDING A SYSTEM OF CARE FOR PERSONS WITH OPIOID USE DISORDER

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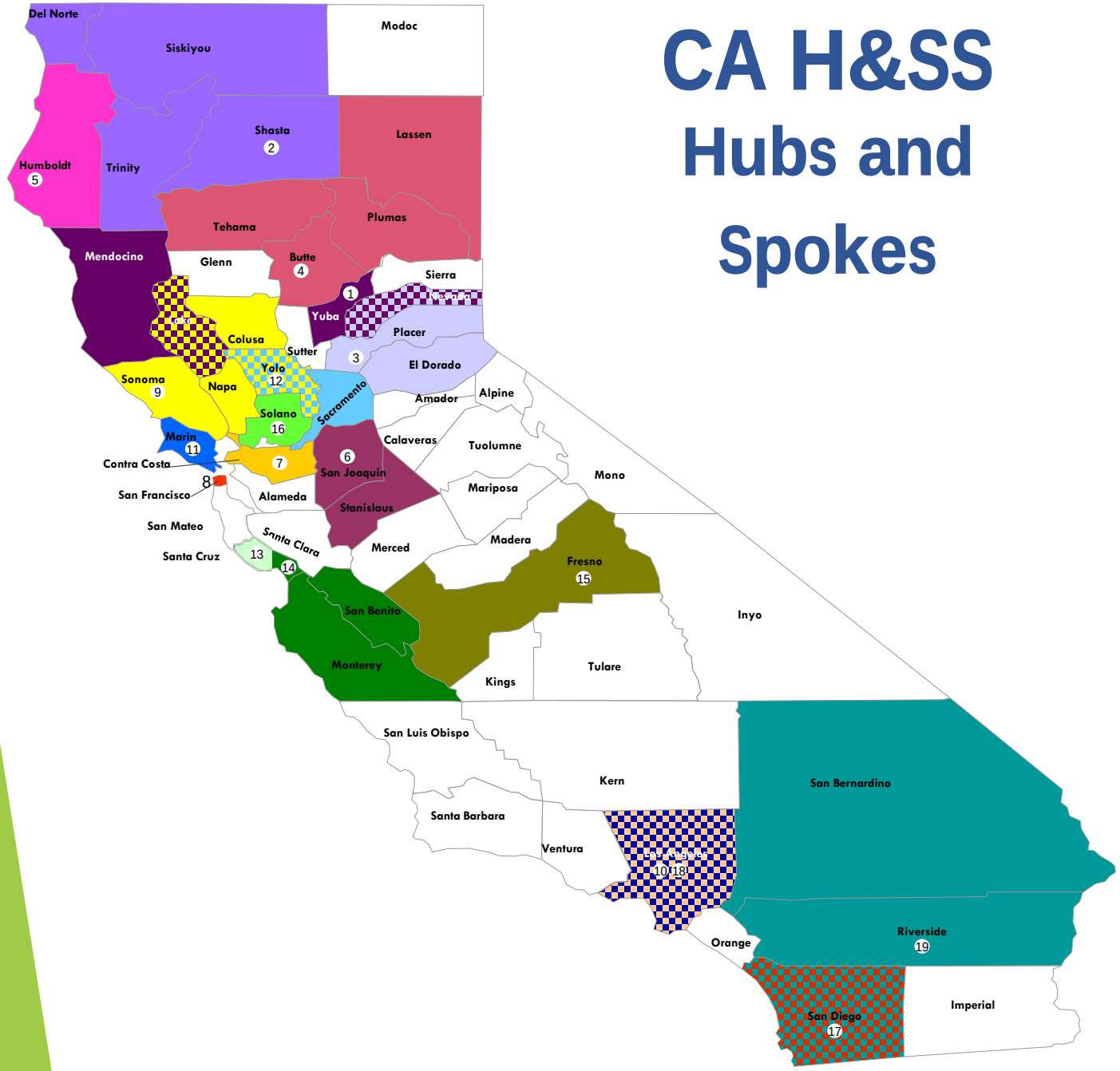
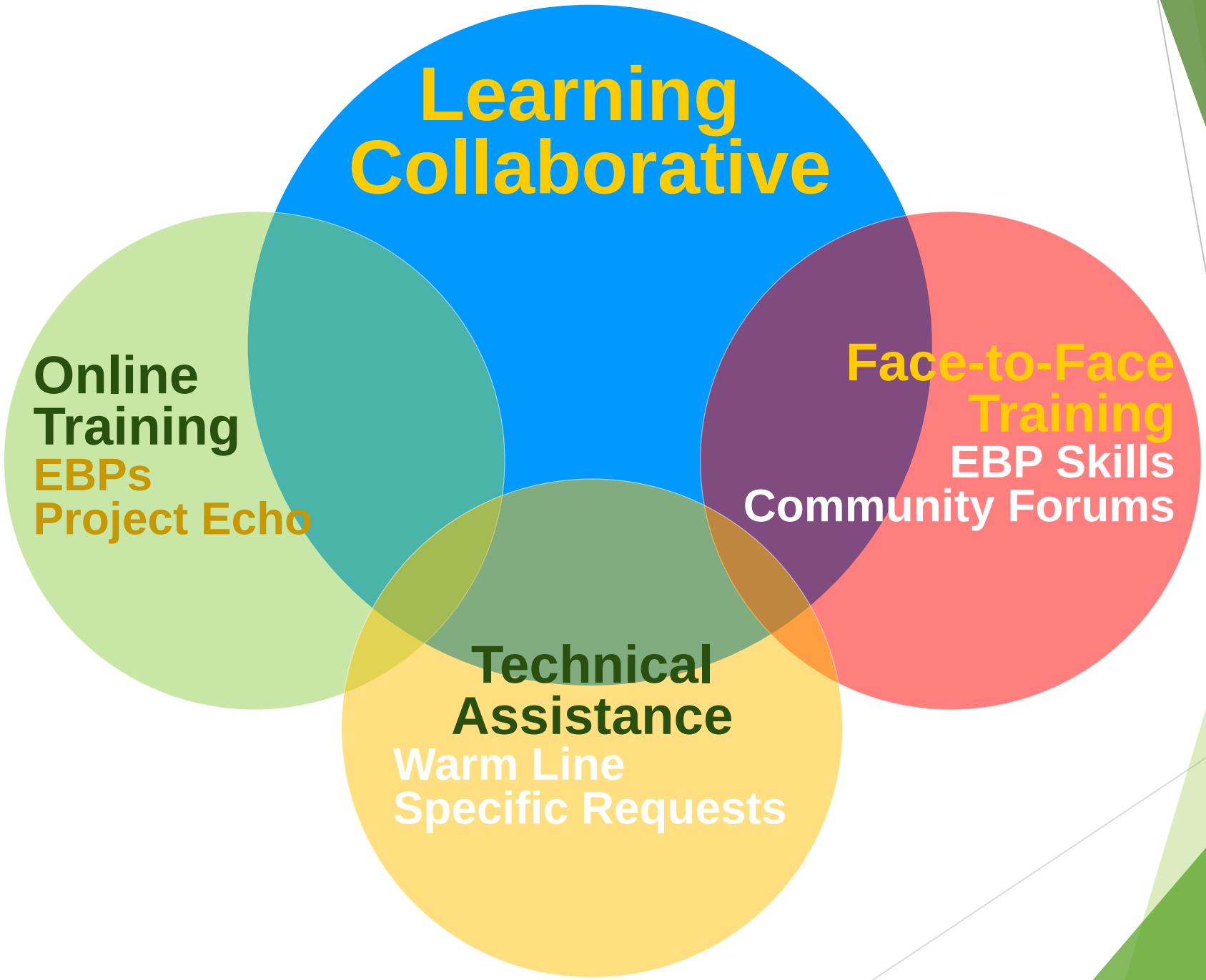
Agenda

- Welcome, introductions
- Hub and Spoke Network- Building your system
- Treatment appropriateness case presentation
- Network building exercise
- Instruction to QI measures data gathering, reporting for future sessions, PDSA
- Action planning – what's next, including schedule for ongoing LC sessions

CA H&SS Hubs and Spokes



Network # & Hub location	Spokes
1	Lake County (1)
	Mendocino County (2)
	Nevada County (1)
2	Siskiyou County (2)
	Trinity County (1)
	Del Norte County (1)
3	El Dorado County (1)
	Placer County (1)
	Nevada County (1)
4	Butte County (2)
	Lassen County (1)
	Tehama County (1)
	Plumas County (1)
5	Humboldt County (6)
6	San Joaquin County (1)
	Stanislaus County (1)
7	Contra Costa County (TBD)
8	San Francisco County (TBD)
9	Sonoma County (1)
	Lake County (1)
	Yolo County (1)
	Colusa County (1)
	Napa County (1)
10	Los Angeles County (10)
11	Marin County (8)
12	Yolo County (2)
	Sacramento County (1)
13	Santa Cruz - N County (6)
14	Santa Cruz - S County (4)
	San Benito County (1)
	Monterey County (1)
15	Fresno County (TBD)
16	Solano County (TBD)
17	San Diego County (7)
18	Los Angeles County (10)
19	San Bernardino County (1)
	Riverside County (6)
	San Diego County (2)


Learning Collaborative
Online Training
EBPs
Project Echo
Face-to-Face Training
EBP Skills
Community Forums
Technical Assistance
Warm Line
Specific Requests

California Opioid Hub and Spoke Project Learning Collaboratives

- Engage H&SS participants in process of shared learning and experience to facilitate implementation of services, assist with procedural changes, and provide opportunities for interactive problem solving

Learning Collaborative

California Opioid Hub and Spoke Project
CSAM Mentored Learning Experiences

- 72 prescribers will receive scholarships
- Mentored learning experiences and CSAM Annual Conference (Aug. 29-Sept. 1 in San Francisco)
- Application process TBA early 2018

CME Topics
Year 1

SESSION 1	***The Hub and Spoke Model: Expanding Access to Care***
SESSION 2	***The Evidence for Addiction Medication in General and Specialty Health Care***
SESSION 3	***Team-Based Care Using MAT in General and Specialty Practice***
SESSION 4	***Treatment Response Monitoring***

Learning Collaborative

TRADITIONAL SYSTEM OF CARE
FOR PATIENTS WITH OPIOID USE DISORDERS

- Opioid Treatment Programs (OTPs): Federally-licensed clinics dispense methadone under highly regulated conditions
- Office-based opioid treatment (OBOTs): With DATA2000, a physician with specialized training can get certified and obtain a “X” on his/her DEA license to prescribe buprenorphine; Recently nurse practitioners and physicians assistants have been given ”X” waiver privileges
- Any licensed prescriber can prescribe naltrexone (or hydrocodone, oxycodone, dilaudid or percocet)

“PERFECT STORM”

HIGH RATES OF DEATH AND DISEASE BUT SO MANY BARRIERS

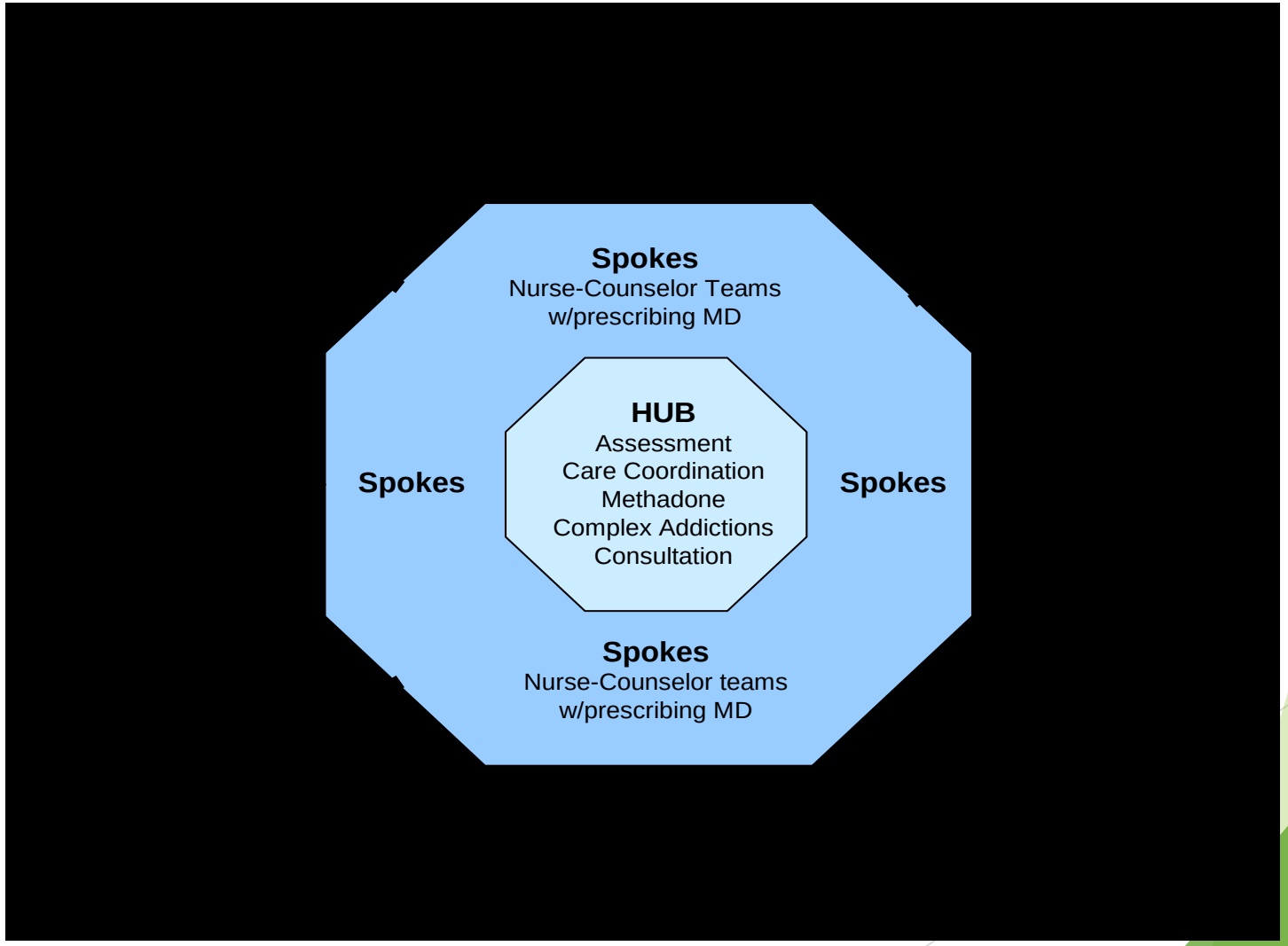
- OTP barriers
- OBOT barriers
- System barriers

HUB & SPOKE MODEL
TREATING OUD LIKE ANY CHRONIC DISEASE

- Unprecedented opportunity thru convergence of opioid overdose epidemic, federal health care legislation (ACA; Parity), population health, & chronic disease management approaches
- Addiction medicine and services join mainstream health care
- Recognition that some OUD patients are complex and may require a network of health care and social services over the course of their illness
- Simplify for patients and families

OTPs

HUBS ARE SPECIALITY CARE CENTERS



OBOTs
SPOKES ARE WELL-CONNECTED

Spoke: The ongoing care system comprised of a prescribing physician & collaborating health & addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, & provide counseling, contingency management, & case management services

Practice Settings

- Blueprint Advanced Practice Medical Homes
- Outpatient Substance Use Treatment Providers
- Federally Qualified Health Centers

- Primary Care Providers
- Independent Psychiatrists

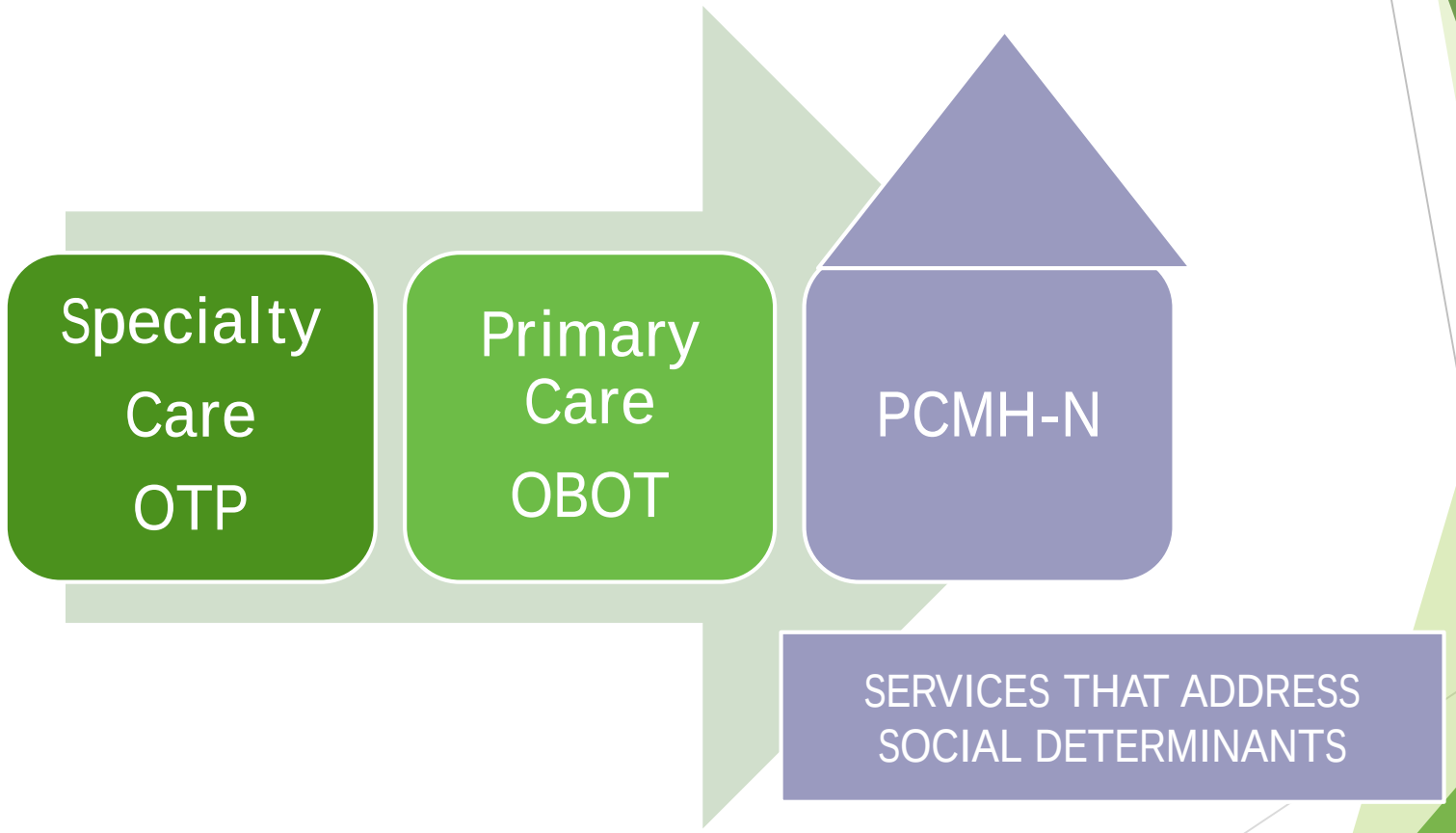
HUB (OTP) AND SPOKE (OBOT) NETWORK
A PATIENT-CENTERED MEDICAL NEIGHBORHOOD

- Patient Centered Medical Home (PCMH) vs. Patient Centered Medical Home-Neighborhood (PCMH-N) for complex patients
- Focus on whole-person care and minimizing duplication of services, reduced conflict across service providers, better outcomes and patient experience
- Care coordination, communication and a common sense of mission
- OUR patients (not yours or mine)

Agency for Healthcare Resources and Quality, 2011; Fisher, 2016

PATIENT-CENTERED MEDICAL HOME/NEIGHBORHOOD

ADDICTION AS A CHRONIC MEDICAL CONDITION



AHRQ OUTLINED
KEY ACTIVITIES FOR PCMH-N SUCCESS

- Workflow/workforce: Dedicated care coordination staff
- Clearly defined roles about what practices do and don't do
- Clear and documented procedures for consultation or co-management
- Metrics for care transitions and intensity
- Patient and family engagement & shared decision making
- Performance reporting and tracking systems for care coordination
- Philosophical shift in perspective

Case Example

CA H&SS TOOLS

METRICS FOR CARE TRANSITIONS AND INTENSITY

- Optimal level of care setting, Hub or Spoke
  Treatment Needs Questionnaire (TNQ)
- Adjusting treatment intensity in Spokes
  OBOT Stability Index
- Determining efficacy/comfort range in practice scope
  Treatment of OUD Severity Index (TOCI)

Determining Setting of Care: Hub or Spoke?

- Treatment Needs Questionnaire (TNQ)
- OBOT - office based opioid treatment with bup at spoke
- OTP is opioid treatment program with methadone or bup at Hub
- Required for Hub providers, encouraged for Spoke providers to develop consistent triage screening process
- Does not consider ER-Naltrexone

Scoring

Scores up to 26 with lower scores predicting better OBOT outcomes

- **0-5:** Excellent candidate for OBOT
- **6-10:** Good candidate for OBOT with integrated behavioral health services
- **11-15:** Candidate for OBOT by board certified addiction physician in a tightly structured program with supervised dosing & on-site counseling or in OTP (Hub)
- **16-26:** OTP (Hub) candidate (or residential or inpatient)

TREATMENT NEEDS QUESTIONNAIRE ©

	YES	NO
Have you ever used a drug intravenously?	2	0
If you have ever been on medication-assisted treatment (e.g. methadone, buprenorphine) before, were you successful?	0	2
Do you have any legal issues (e.g. charges pending, probation/parole, etc)?	1	0
Are you currently on probation?	1	0
Have you ever been charged (not necessarily convicted) with drug dealing?	1	0
Do you have a chronic pain issue that needs treatment?	2	0
Do you have any significant medical problems (e.g. hepatitis, HIV, diabetes)?	1	0
Do you have any psychiatric problems (e.g. major depression, bipolar, severe anxiety, PTSD, schizophrenia, personality subtype of antisocial, borderline, or sociopathy)?	1	0
Do you ever use cocaine, even occasionally?	2	0
Do you ever use benzodiazepines, even occasionally?	2	0
Do you have a problem with alcohol, have you ever been told that you have a problem with alcohol or have you ever gotten a DWI/DUI?	2	0

TREATMENT NEEDS QUESTIONNAIRE ©

	YES	NO
Are you motivated for treatment?	0	1
Are you currently going to any counseling, AA or NA?	0	1
Do you have 2 or more close friends or family members who do not use alcohol or drugs?	0	1
Do you have a partner that uses drugs or alcohol?	1	0
Are you a parent of a child under age 18? If so, does your child live with you?	0	1
Is your housing stable?	0	1
Do you have a reliable phone number?	0	1
Are you employed?	0	1
Do you have access to reliable transportation?	0	1
Did you receive a high school diploma or equivalent (complete 12 yrs of education)	0	1

OBOT STABILITY INDEX
RISK STRATIFICATION FOR CARE

- Developed by Nordstrom et al (2016)
- 8-item checklist of risk factors
- Scored “Yes” or “No”
- If all “No” good candidate for monthly visits (exam, UDS, CURES, prescription)
- If any “Yes” good candidate for weekly visits
- If “Yes” to all items 1-6, good candidate for Hub or specialty addiction care referral

OBOT STABILITY INDEX

OBOT Stability Index

1) Was the patient's previous urine drug screen positive for illicit substances?
   - ☐ Yes
   - ☐ No

2) If YES to #1 or if the patient was recently started on buprenorphine, does the patient have fewer than four consecutive weekly drug-free urine drug screens?
   - ☐ Yes
   - ☐ No

3) Is the patient using sedative-hypnotic drugs (e.g. benzodiazepines) or admitting to alcohol use?
   - ☐ Yes
   - ☐ No

4) Does the patient report drug craving that is difficult to control?
   - ☐ Yes
   - ☐ No

5) Does the patient endorse having used illicit substances in the past month?
   - ☐ Yes
   - ☐ No

6) Does the query of the Vermont Prescription Monitoring System (VPMS) show evidence of the unexplained, unadmitted, or otherwise concerning provision of controlled substances?
   - ☐ Yes
   - ☐ No

7) Did the patient report their last prescription as being lost or stolen?
   - ☐ Yes
   - ☐ No

8) Did the patient run out of medication early from his/ her last prescription?
   - ☐ Yes
   - ☐ No

TREATMENT OF OUD COMPLEXITY INDEX

ASAM CRITERIA BASED

- Six dimensions of American Society of Addiction Medicine Criteria for patient placement
- Useful for inter-practice communication, treatment planning, measurement-based care
- Most useful to define scope or risk tolerance at the practice level
  - Defines who we can effectively treat and what kind of patients we might consider for consultation or co-management

PCMH-N INTERFACE COHESION
FOSTERS A GOOD PATIENT EXPERIENCE

- Network level: Inter-Agency Agreements (Charter or Mission Statement)
- Practice level: Clear specifications on admission and transfer criteria and procedures, and types of services actually offered
- Patient level: Shared care plans, nformational materials
- Patient consent for exchange of information forms (omnibus—opt out and/or practice specific)
- Solicit and welcome patient and family feedback

CALIFORNIA HUB AND SPOKE NETWORK

COMMON SET OF QI & PERFORMANCE MEASURES

QI AND PERFORMANCE MEASURES
DESIGNED TO BE FEASIBLE & USEFUL

- Collected monthly from hubs and spokes by UCLA Evaluation Team (Accompanies monthly invoice to State)
- Aggregated by UCLA evaluation team quarterly, in advance of in person learning collaborative sessions
- Hub & Spoke practices receive summaries of own data relative to average
- At learning collaborative session, some Hub and/or spoke practices *volunteer* to present their QI data and interpretation for lessons learned
- QI data are for IMPROVEMENT using own practice over time as comparator

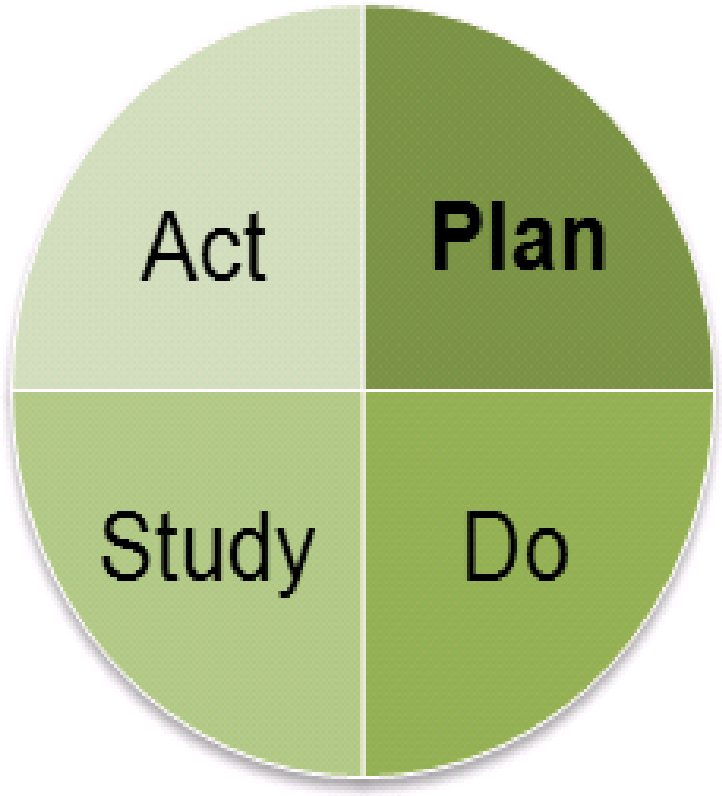
QI MEASURES

- Number of new patients initiating care by medication type at each practice location
- Number of patients linked/referred across practices within network
- Number of Spoke practices in network
- Number of waivered prescribers in network
- Six-month retention rates within practices

LEVERAGING CHANGE ON QI MEASURES
USING RAPID CYCLE CHANGE TECHNIQUES

- PLAN-DO-STUDY-ACT
  - Evidence—based approaches to QI in health care
- Recommended components: multi-disciplinary change team, champion, regular meetings, executive sponsor, measurement, and reporting
- Keep it simple

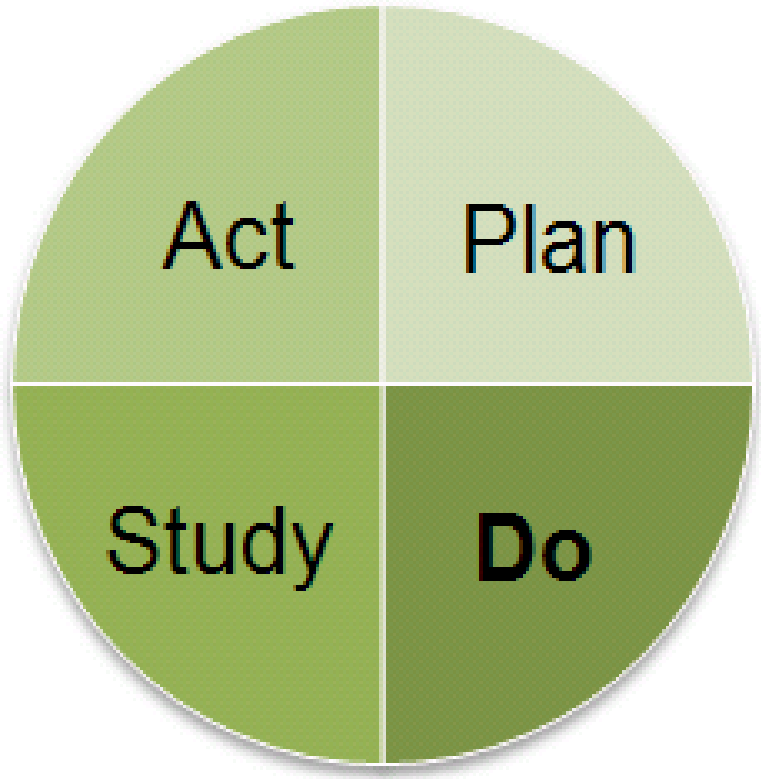
PDSA CYCLES



PLAN

What are you testing?
Who is conducting the test?
Who are you testing the change on?
When and where are you testing?
What do you predict will happen?
What data do you need to collect?
Who will collect the data?

PDSA CYCLES



DO

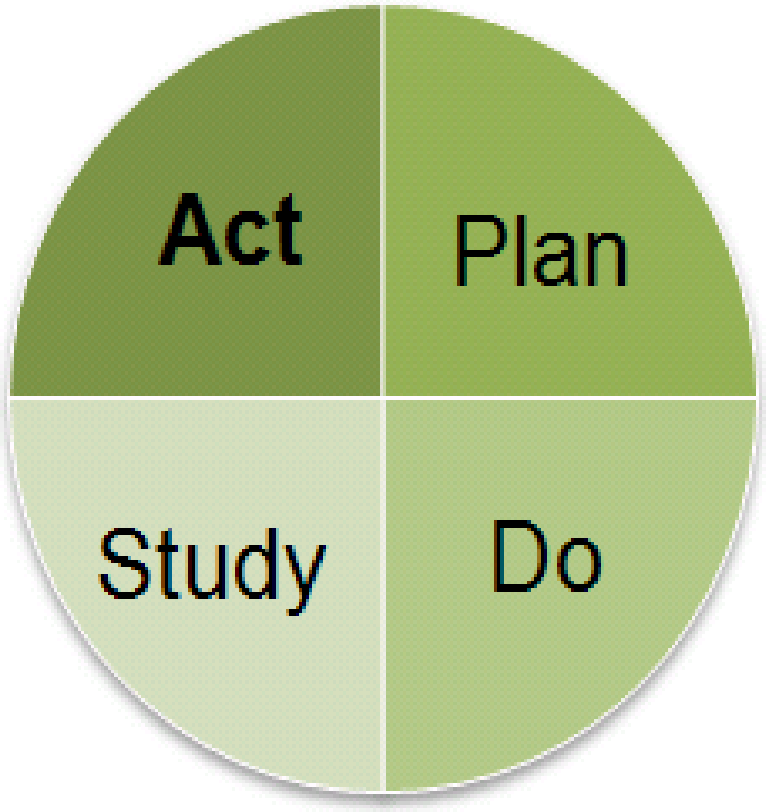
What happened?
List observations.
Note problems or surprises.

PDSA CYCLES

STUDY

Summarize the data.
What did you learn?
Compare results to your predictions.

PDSA CYCLES



ACT

Are you ready to implement change?
What will you do before the next cycle?
What will be the next cycle?

Date:

Plan-Do-Study-Act (PDSA) Worksheet

	Tasks to be completed to run the test of change:	
	Who:	
	Due when:	
	Tools needed:	
	Measures:	
	What are we learning as we do the pilot? What happened when we ran the test? Any problems? Any surprises?	
	As we study what happened, what have we learned? What do the measures show?	
	As we act to hold the gains or abandon the pilot efforts, what needs to be done? Will we modify the change?	
Make a plan for the next cycle of change.		

NEXT STEPS

SHAPE YOUR NETWORK, PCMH-N AND LEARNING COLLABORATIVE

- What type of neighborhood will you develop?
- What step would you like to complete before the next LC?

NEXT STEPS

SHAPE YOUR NETWORK, PCMH-N AND LEARNING COLLABORATIVE

- Next quarterly LC session
  - Monday, February
  - Content/process suggestions for LCs
- Content/process suggestions for ECHO and webinars
  - Jan 18 – Intro to MAT webinar
  - 2018 ECHO starts Jan 29th and continues 4th Monday of the month through November
- Thank you!

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Join the CAHSS ListServ

- Email Patrick (pflippinweston@mednet.ucla.edu) to join!

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Supplemental Info: TYPES OF PCMH-N INTERFACE

NOT SIMPLY ABOUT REFERRAL

Type	Definition	Information
Pre-Consultation exchange	Expedite/prioritize care; Answer special clinical question; "curbside consultation"	General referral guidelines
Formal consultation	Formal consultation visit (1 or a "few") focused on discrete question	Question/answer, report and recommendation
Co-management options		
Shared management of the disease	Specialty provides expert guidance and f/u for 1 specific condition (not day-to-day management)	Ongoing communication on status/progress (Both are responsible but with clear delineation of expectations and roles)

American College of Physicians: Patient-Centered Medical Home – Neighbor Interface (2010)

TYPES OF PCMH-N INTERFACE

NOT SIMPLY ABOUT REFERRAL

Type	Definition	Information
Co-management (continued)		
Principal care for the disease	Both PCMH and specialty care are active, specialty care is limited to discrete set of problems; PCMH responsible for all aspects of care and is first contact	Ongoing communication on status/progress (Both are responsible but with clear delineation of expectations and roles)
Principal care of illness for limited time	Specialty care first contact for limited time	PCMH receives ongoing reports, retains input on referrals, and may provide certain other care
Transfer to specialty PCMH-N for entirety	Specialty care becomes medical home (NCQA-PPC-PCMH recognition)	E.g. ID practice for complex HIV/AIDs patient. PCMH receives updates on status/progress