Integrated Addiction & Psychiatry Clinic

— Case Presentation Template —

Date:_____/_____/_____ **Presenter:**_____/_____
FIRST LAST

Hub Name:_____ **Spoke Name:**_____

Patient Pseudonym:_____ **ECHO ID:**_____ **Age:**_____

Gender: _____ **Check if follow-up to a previously presented case** ☐

WHAT ARE YOUR MAIN QUESTIONS?

Mental Health, Substance Use, and Treatment History:

Medical problems (Diabetes, Pancreatitis, Endocarditis, Abscesses, HIV/Hep C):

Current medications:

Toxicology Information and Any Other Pertinent Labs

Pertinent examination findings:

Proposed treatment plan:

CLINICIAN CONSULTATION CENTER
Translating science into care

Substance Use Warmline

Peer-to-Peer Consultation and Decision Support

6 am – 5 pm PT Monday - Friday

855-300-3595

Or

New! Submit cases online at

http://nccc.ucsf.edu/clinician-consultation/substance-use-management

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

Objectives of the Substance Use Warmline:

- Support primary care providers nationally in managing complex patients with addiction, chronic pain, and behavioral health issues
- Improve the safety of medication regimens to decrease the risk of overdose
- Discuss useful strategies for clinicians in managing their patients living with substance use, addiction and chronic pain.

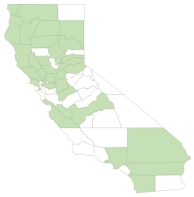
Consultation topics include:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing- when to use it and what it means
- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
- Managing substance use in special populations (pregnancy, HIV, hepatitis)

The CCC's multi-disciplinary team of expert physicians, clinical pharmacists and nurses provides consultation to help clinicians manage complex patient needs, medication safety, and a rapidly evolving regulatory environment.

Learn more at http://nccc.ucsf.edu/clinician-consultation/substance-use-management

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039-01-00 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA Bureau of Primary Health Care (BPHC) awarded to the University of California, San Francisco.

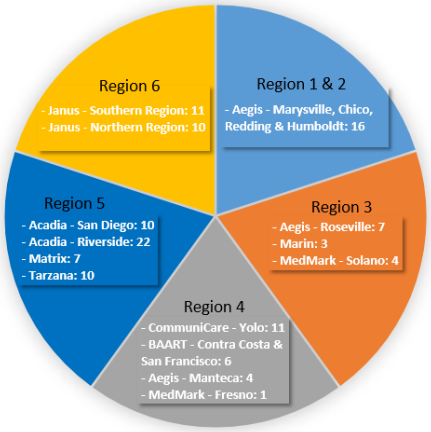


California Hub and Spoke System Newsletter

Face to Face Learning Collaboratives Quarter Two Recap

The CA Hub and Spoke Learning Collaboratives took place in November and December 2017. Thanks to all the participants and staff involved. Each session provided a chance for providers, administrators and potential participants to focus on networking, evaluating capacity and focusing on case-based learning on prescribing buprenorphine. Gloria Miele from UCLA and Mark McGovern from Stanford facilitated and were joined by buprenorphine prescribers Drs. Jeffrey Devido, Michael Parr and Andrew Herring who presented excellent cases and discussion illustrating the nuances of MAT treatment.

Face to Face Learning Collaboratives Quarter 2



Every attendee contributed to this rich learning environment. The figure to the right summarizes attendance across the regions. All materials from the sessions are available **here**.

We encourage Hubs to send as many staff and spoke partners as possible to these regional meetings. Recognizing the tight schedules of our providers, we encourage you to think about what staff to send to the next meetings. A new prescriber? Potential spoke partner? If you have any questions, don't hesitate to contact Gloria **GMiele@mednet.ucla.edu**, **(310) 267-5888**. We also welcome potential spoke partners to attend and experience the benefits for themselves.

Quarter 3 LC's are scheduled! Mark your calendars and spread the word!

Region 3—February 23, 2018
Region 1 & 2—March 5, 2018
Region 5—March 9, 2018
Region 4—March 22, 2018

For more information and to subscribe to the CA H&SS ListServ please contact Patrick Flippin-Weston at **PFlippinWeston@mednet.ucla.edu**.

CA H&SS Steering Committee

Region 5 Learning Collaborative

Resources

UCLA ISAP CA H&SS WEBSITE

DHCS MAT Expansion Project Website

Hub and Spoke Locations Map

UCSF Clinician Consultation Center: Substance Use Warmline

Drug Companies' Liability for the Opioid Epidemic - by Rebecca L. Haffajee, JD, PhD, MPH and Michelle M. Mello, JD, PhD

Opioid Crisis: No Easy Fix to Its Social and Economic Determinants— Nabarun Dasgupta PhD, MPH, Leo Beletsky JD, MPH, and Daniel Ciccarone MD, MPH

County-level Estimates of Opioid Use Disorder and Treatment Needs in California—Fact Sheet— The Urban Institute, Dec. 13, 2017

Face to Face Learning Collaborative Handouts Quarter 2

The California Hub and Spoke System (CA H&SS) FAQs (DHCS)

Motivational Interviewing Training (Self paced)

CSAM MAT Treatment Resources

PSATTC Resources

PCSS MAT Website

Upcoming Events

Intro to MAT Webinar Training
Thursday, January 18, 2018
1:00pm—3:00pm

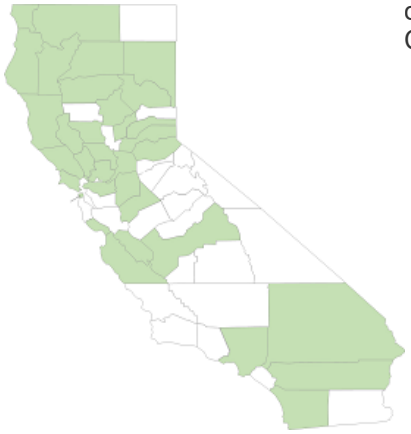
X Waiver Training—Office Based Treatment for Opioid Use Disorder
Friday, January 19, 2018
12:00pm—5:00pm San Rafael, CA

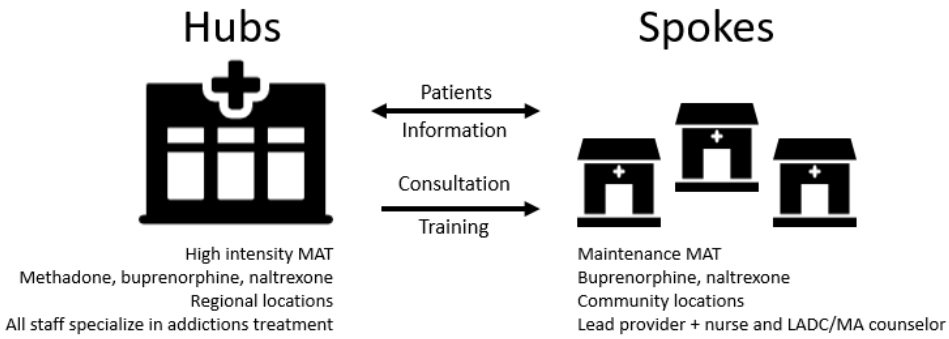
Intro to Project ECHO and to Opioid Use Disorder
Monday, January 29, 2018
12:00pm—1:00pm

Learning Collaborative Region 3: Aegis—Roseville, Brightheart Health, Marin Treatment Center, Medmark—Solano
Friday, February 23, 2018
10:00am—1:00pm Sacramento, CA

CA H&SS Recruitment Tool

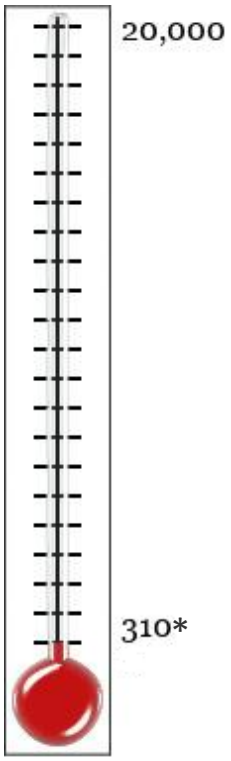
The California Hub and Spoke System is still recruiting Spokes. If you have any healthcare facilities that you think could serve as a Spoke in our system we have created a "What's In It For You" flyer. This flyer was designed to help answer important questions that potential Spokes may have. Breaking down complex concepts, it gives a brief and informative description of what Hubs and Spokes are and our mission during this two-year project. Click on the image to view the full flyer.





Tracking our Progress: New Patients Added

The goal for the CA H&SS is to have 20,000 new patients on MAT during its two year grant period. The goal thermometer below will track our progress throughout the program.



NEW CA H&SS PATIENTS ON MAT AS OF DECEMBER 2017

***Partial data based on 11 of the 19 CA H&SS networks.**

CME'S Available for CA H&SS Training Activities!

We are delighted to be partnering with LA Care to provide Continuing Medical Education (CMEs) for Project ECHO, Learning Collaboratives and many other training activities. Effective immediately, we can provide continuing education units for MDs, PAs, NPs, nurses, psychologists and counselors. Spread the word about upcoming online events, such as ***Introduction to MAT** on 1/18 and **Project ECHO** 1/29. ***Deadline to register for the Intro to MAT Webinar is January 17, 2018.**

CSAM Offers Mentored Learning Experiences

CSAM will be accepting applications for mentored learning scholarships for 72 buprenorphine providers at participating spokes. Scholarships will cover CSAM conference attendance (Aug. 29-Sept. 1, 2018), monthly meetings with a mentor, and a stipend to offset travel costs. Please start identifying potential applicants. More information coming soon! For more information, please contact CSAM Project Manager **Erica Murdock-Waters**.

Evaluation Corner

The UCLA H&SS Evaluation team, along with DHCS, has begun collecting required data from each hub and spoke system via the **Monthly Data Reporting Forms**. So far, 11 of 19 systems have reported. These data are critical to timely statewide tracking and measurement of MAT service delivery and network capacity, and also directly inform quality improvement efforts in Learning Collaboratives. UCLA and DHCS will be following up with systems that have not yet reported, to provide technical assistance. In addition, UCLA is currently developing a new, user-friendly online platform for data reporting, to simplify the reporting process. UCLA anticipates releasing this new web form, along with an instruction guide and FAQ, in early February. H&SS staff can also expect to begin receiving surveys this month. Surveys will add context to monthly-reported data, and potentially inform Learning Collaboratives as well. In the near future the evaluators will also interview a sample of patients and providers, in collaboration with the hubs and spokes. These efforts are part of an ongoing evaluation and quality improvement process aimed at making data -driven improvements to the Hub and Spoke program.

UCLA DHCS

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.

Caring for Ms. L. — Overcoming My Fear of Treating Opioid Use Disorder

Audrey M. Provenzano, M.D., M.P.H.

Ms. L. always showed up 10 minutes early for her appointments, even though I always ran late. Her granddaughter would rest her cheek against Ms. L.'s chest, squishing one eye shut, and scroll through Ms. L.'s phone while they waited. After reviewing her blood sugars, which Ms. L. recorded assiduously in a dog-eared blue diary, we'd talk about smoking cessation. That was a work in progress. "There's just nothing like a cigarette," she'd sigh. "Don't you ever start," she'd admonish her granddaughter, kissing the top of her head.

One day, I knew something was wrong the moment I opened the door. Ms. L. was alone. Sweat dotted her lip and forehead. She closed her eyes and looked away, and tears fell onto her lap. "I need help," she whispered, and it all came out: she had taken a few of the oxycodone pills prescribed for her husband after a leg injury, then a few more from a friend. And like a swimmer pulled into the undertow, she was dragged back into the cold, dark brine of addiction. I tried to hide my shock. I'd known she was in recovery from opioid use disorder (OUD), but it had simply never come up. She hadn't used in decades.

"No one can know that I relapsed," she said. "If my kids find out, they won't let me see my granddaughter." She wanted to try buprenorphine and was frustrated to hear that I could not prescribe it. "Why not?" Annoyed, she rocked in her chair. "I just want to feel normal again, and I know you. I don't want to tell anyone else."

I evaded her question: "I don't have the right kind of license to prescribe it," I said. "Let me refer you to a colleague."

But my incomplete answer gnawed at me. In truth, the reason I didn't have a waiver to prescribe buprenorphine was that I didn't want one. As a new primary care physician, I spent every evening finishing notes and preparing for the next day. Every Friday I left the office utterly depleted, devoid of the energy or motivation it would take to spend a weekend clicking through the required online training.

But more than not wanting to take on the extra work of prescribing a medication for OUD, I did not want to deal with patients who needed it. I knew that for some people with substance use disorders, the relationship with the drug can eclipse all other relationships, leading them to push away family, friends, and caregivers. I had witnessed patients waiting for prescriptions antagonize secretaries and nurses, seen patients try to manipulate toxicology screenings, and heard voices raised in exasperation at colleagues through thin clinic walls. Addiction, according to the American Society of Addiction Medicine, "is characterized by . . . impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response."[1] Already overwhelmed, I did not want to take on patients with needs that I did not know how to meet.

One of my colleagues started Ms. L. on buprenorphine treatment. When I saw her again for her diabetes, a space had opened between us. Then she didn't show up to her next appointment. I called her and sent a letter, but she didn't show up to the next one either. Months passed, and then a year.

The night I found out that Ms. L. had died of an overdose, a heavy, wet snow was falling throughout the city, dampening the sound of traffic. In the quiet,

I was clicking through the usual computer screens, preparing for clinic in the morning. I saw Ms. L.'s name and stopped. I read the text twice, three times, and then again: "brought in by ambulance . . . unable to revive her." At first I felt horror and revulsion at the thought of her lifeless body on a gurney. Then, profound sadness. I thought about her husband, her children, and especially her granddaughter. I wondered how silent their house must be that snowy night, without Ms. L.'s brassy laugh floating through the hallways.

But it was the shame that kept me awake, listening to the plows pass through the streets. This shame didn't just burn red and hot in my face — it burrowed thick and leaden into my chest and stomach. What if I had treated her myself, instead of referring her? I don't flatter myself that I could have provided her better care — I had complete confidence in my colleague. But Ms. L. and I had had a relationship. She had trusted me. And I'd turned her away.

In the ensuing months, I earned my waiver to prescribe buprenorphine. I still harbored apprehensions about caring for patients with addiction, but I also knew that I could not turn away another Ms. L. I now care for a small panel of patients with OUD. It has not been easy, and I could not provide this care without the support of colleagues with expertise in addiction and social work. I quickly grasped the pharmacology of buprenorphine therapy, but learning how to manage other aspects of addiction care, particularly for patients in early recovery, has been formidable.

One patient, Ms. J., has coexisting alcohol use disorder, chronic pain, and severe anxiety. I have practiced harm reduction for years — maximizing oral therapies in a patient with diabetes who declines to take insulin, for example. But navigating the gray shades of harm reduction in caring for Ms. J., who uses alcohol on an almost daily basis and takes several sedating psychiatric medications in addition to buprenorphine, is an entirely new calculus for me.

Beyond these difficult therapeutic questions, many of my patients with OUD have complex social needs. Before Ms. J., I had never cared for a patient whose visitation rights with her children were predicated on her continuing therapy with me. A few of my patients have had difficulties following clinic guidelines; implementing behavior contracts had not previously been a common part of my practice, and learning how to use them with kindness and respect remains challenging.

Colleagues with years of experience managing substance use often advocate: "Everyone should get waivered. OUD is a chronic disease just like any other — when a patient comes in with hypertension, you don't say, 'Oh, I don't treat that.'" This comparison does not capture the whole picture. Of course OUD is a chronic disease and should be managed in primary care as such. But it's also true that patients with addiction often have acute psychosocial needs. OUD can utterly shatter a life; I have never seen hypertension have such an effect. If we do not recognize, name, and talk about the social issues that must be addressed when caring for patients with OUD, we do a disservice to both patients and caregivers and create a significant barrier to more providers getting waivers. I know, because I was one of them. Everyone in primary care should get a waiver, but that is not enough. We must also advocate for team-based behavioral health and social work resources in every primary care setting to support patients and providers in managing all aspects of OUD, just as we have developed team-based protocols for managing hypertension.

Caring for these patients has become the most meaningful part of my practice. Ms. J., who has tested my clinical judgment almost weekly, has also inspired me with her persistence and courage through a grueling recovery. Buprenorphine has allowed her to feel "normal" — at least most days — and to focus on her sons. Providing some sense of normalcy for patients whose lives are roiled by overdose and estrangement is the most profound therapeutic intervention I've engaged in as a caregiver. I did not know what Ms. L. meant all those years ago when she said that she only wished to feel normal again. I wish that I'd listened more closely. I wish that I had not been afraid.

Patients' initials and identifying characteristics have been changed to protect their privacy.

Disclosure forms provided by the author are available at NEJM.org.

From the MGH Chelsea Health Center, Chelsea, and Harvard Medical School, Boston — both in Massachusetts.

1. Definition of addiction. Rockville, MD: American Society of Addiction Medicine, April 19, 2011 (https://www.asam.org/resources/definition-of-addiction).

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