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

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A Rural Response
A Call to Action
What caught our attention in our community?

On call narcotic refills
What caught our attention in our community?

Emergency visits
What caught our attention in our community?

Police concerns
What caught our attention in our community?

Overdose deaths in the community

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Community issues require community collaboration.

In 2014, the Morrison County Prescription Drug Task Force formed.
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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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These are NOT solutions to the opioid epidemic and addiction, rather these are reactions to the problem.
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A Real Solution

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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 Methadone, Suboxone, and Narcan out of business.

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

Heather 2.0 vs. Kurt 1.0

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Getting Started

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

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

• Begins with patient meeting with the Nurse Care Coordinator and/or Social Worker
• Care plan signed
• UDAS
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Witnessed
UDAS

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Information Gathering

- Past medication history
- Substance abuse history
- Drug-related convictions
- PDMP
- Family history
- Review of appropriate dosing
- Pharmacy review (if necessary)

- Facebook
- Mental health concerns
- Medication interaction
- ER visits
- Work history
- Diagnosis for medication
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

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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:___________________________________________________________________________
CSCT Review Form
Evaluated at weekly meetings by physicians.

Review Includes
• Previous work-ups
• Scans
• Previous treatments
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)
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
Priority Patients

• Provider or nurse referral
• Drug refill issues (RN reviews)
• Police information
• Pharmacy concerns
• Slowly working the “list”
Changing Physician Culture: Slow and Ongoing

- Unexpected urine testing
- “Good” patients with unexpected findings
- Overdoses and overdose deaths
- Police information
- CDC guidelines information
- State Board interest in this issue
- Minnesota State Prescribing Guidelines, 2018

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

These patient tapers account for 665,300 fewer pills/units prescribed in a year.
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Outcomes

627 total taper patients (narcotics, stimulants, or benzodiazepines)
- Average decrease = 55,441 units/month no longer prescribed

Patient Needs/Support Referrals
- 2016: 146
- 2017: 336

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Schedule 2 units filled each month at Coborn's pharmacy
Schedule 2 Units filled each month at coborn's pharmacy trend
Schedule 4 units filled each month at Coborn's Pharmacy
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Outcomes

Schedule 4 units filled each month at Coborn's Pharmacy (overall trend)
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Outcomes

Reasons for Tapers:

• Dose too high
• Diverting
• No diagnosis/reason for medications
• “Other” – urine drug screen results, self medicating, etc.

*These patients are still treated for their conditions but with other methods*

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Medication-Assisted Treatment
Our choice for MAT

• Buprenorphine-Naloxone
  • Partial agonist
  • Good safety profile
  • Proven effectiveness
  • Easily dosed and available
  • Can be prescribed by primary care *(with waiver)*
Barriers to Treatment

- Distance
- Accessibility
- Stigma
- Accessibility of medication in pharmacy
Why start an MAT program in a rural clinic?

- Patients with underlying opioid use disorder are unable to taper from narcotics
- Large population of patients using heroin
- Overdose deaths
- Standard of care
- Patients like to be treated in their local clinic
Reduce Potential for Relapse

• Behavioral intervention alone- 80% relapse within 2 years
• Methadone and buprenorphine 60% retention in program
• One small study with buprenorphine showed a 1 year retention of 75%, patients on placebo had a retention rate of 0% with 4 deaths at 1 year.

Improving Employment

- We feel buprenorphine has greatest potential to get people back to work
  - Convenient monthly visits- not daily
  - Overall cost likely less
- Anecdotally: less fatigue and increased motivation
  - Out of our 73 patients: 44 working, 7 retired, 22 others in treatment/disabled/not working
MAT and Criminal Justice

• Research based on randomized controlled studies with greater than 3 month follow up show buprenorphine/naloxone is as effective as methadone in:
  • Decreasing opioid use and re-arrest
  • Increase treatment retention
  • Inmates were more likely to report to continued community treatment upon release


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Pregnancy

- Recent study showed lower rate of NOWS (neonatal opioid withdrawal syndrome) at 31.11%
- Duration of NOWS shorter
- No relationship to dose
- No relationship to smoking
- Fetuses, when compared to methadone, had:
  - Higher levels of FHR variability (good)
  - More fetal HR accelerations (good)
  - Greater coupling of heart rate and fetal movement (good)
  - Higher scores of biophysical profiles

Our Workflow

**Patient calls clinic and talks with nurse care coordinator or social worker**
- Drug history
- “Story”

**Doctors review**

**Patient scheduled**

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Initial Visit

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

• Seeing the patient when they are motivated to change
• Treating the condition like it is an emergency
Our Buprenorphine Program Success Thus Far

- Currently Active: 82
- Inactive: 43
Buprenorphine Program: Defining Success

- Time
  - Sobriety
  - Past point of brain healing
- Employment
- Repaired relationships
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Medication-Assisted Treatment

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County Jail Program
What happened?

Learned

• Lose medical assistance
• County responsible for medication cost
Convened a county panel

- Judge
- Sheriff
- Jailor
- Social Services
- Jail doctor
- County attorney
- Drug court
- Probation

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County Jail Program

Initiating and Maintaining MAT
• Maintain stable patients if jail time is <30 days
• In withdrawal and want help, initiate MAT
• Recidivism problem: $120/day for jail vs $8.10/day for buprenorphine

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
44 patients surveyed
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Emergency Room
Goal: Point of care intervention

• Treat like emergency, point of care
• Not about tying up a bed with “these people”
• Just as “standard of care” as ACLS/ATLS
• More common than car accidents
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Duplicating our Program
Through duplicating our program:

- Eight communities have received legislative funding to hire staff to mirror our program.
- Legislation grant money based on our success
- Funding other communities
- Data: pills, tapers, care plans
Can our program work in other communities?

Following our guidelines and model, other communities are seeing decreases in pills:

- Community 1: 258,036/year
- Community 2: 167,472/year
- Community 3: 276,843/year
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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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Project ECHO

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Goals of our ECHO:

• Increasing general knowledge of opioids and addiction
• Demonstrating how to implement our program in rural primary care
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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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One free hour of CME/CEU weekly!
Topics Covered:

- Data Collection
- CDC Guidelines
- Task Force Components
- Care Plans
- Urine Drug Screens
- Thinking About Doing Buprenorphine in Primary Care Clinic
- Changing Physician Culture
- Care Team Functions
- Comorbidities Associated with Opioid Overdose
- ACE Scores
- Overview of Kratom
- Documentation for Patients on Narcotics and Suboxone
- Opioid Use Disorder in Pregnancy
- Marijuana Overview
- PDMP Overview
- The Treatment Experience
- Buprenorphine Intake and Induction
- Motivational Interviewing
- Lumbar Pain
Presenters:

• Family physicians
• Maternal Fetal Medicine Specialist
• Prescription Drug Monitoring Program Administrator
• Director of Minnesota DHS
• Addiction Medicine physician
• Women’s treatment center president
• LADC

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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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*Project ECHO*

**“Multiplication of Force”**

- Little Falls buprenorphine patients
- ECHO Spokes
- Roughly 10 patients per ECHO SPOKE

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New ECHO Program

• Partnering with the University of Minnesota Rural Physician Associate Program (PMP)
  • Nine-month, community-based educational experience
  • For third-year medical students who live and train in rural communities
  • Experience hands-on learning as they care for patients of all ages
  • Supervised by a physician preceptor who is a practicing, board-certified family physicians
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Project ECHO

Communities with an RPAP student

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Recipe for Success

- RPAP students are generally:
  - Motivated
  - Eager to learn
  - Caring about rural health
  - Have the ability to impact local community
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GOAL

Inspire medical student (800% more opioid education)

Family Practice Resident

Addiction Fellowship

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OUR NEW COMMUNITY
FOCUSED ON REDUCING PILLS
AND ENCOURAGING
MAT IN PRIMARY CARE

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THANK YOU!
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