Addiction Treatment Starts Here: Primary Care

LAC+USC Primary Care
Adult East + West Clinics
Our Core Team: What brought us here

“I didn’t have the tools”

Why do we criminalize addiction and not treat it as a disease?”

“I want to do better, offer more”

“The patient cried at every visit”

“How do we break the circle of admissions and problems?”

“The attending was frustrated too”
Waivered Super Heroes

Urban underserved

Large academic center

Safety Net

Immigrant

Homeless

Diverse

EAST CLINIC

165 Residents
2 Attendees
3 Core Faculty
14 Preceptors

West CLINIC

12 Physicians
1 Physician Assistant
2 Nurse Practitioners

197 Patients
10-11 Medical
39% Uninsured

MAT patients: 7

X-waivered: 5

16-295 patients
85% Medical

MAT patients: 0

X-waivered: 4

15% Uninsured

Welcome to LAC+USC Medical Center

Maligayang pagdipa
Develop standardized processes and workflows to facilitate coordinated care

Seamless overlap with concurrent behavioral health integration initiative

Increase staff awareness and culture change

Increase patient awareness of these services and treatment

Personal growth as health care providers - Continuous learning!

Team work! Fun work!
## CAPABILITY ASSESSMENT: What We Learned

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>AVERAGE SCORE</th>
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<tbody>
<tr>
<td>D1. Infrastructure</td>
<td>4.20</td>
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<tr>
<td>D2. Clinic Culture &amp; Environment</td>
<td>2.25</td>
</tr>
<tr>
<td>D3. Patient Identification and Initiating Care</td>
<td>2.00</td>
</tr>
<tr>
<td>D4. Care Delivery and Treatment Response Monitor</td>
<td>2.50</td>
</tr>
<tr>
<td>D5. Care Coordination</td>
<td>2.33</td>
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<tr>
<td>D6. Workforce</td>
<td>2.80</td>
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<tr>
<td>D7. Staff Training and Development</td>
<td>2.00</td>
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<tr>
<td><strong>Mean Total IMAT-PC Score</strong></td>
<td><strong>2.58</strong></td>
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### STRENGTHS

- Right team
- Right people

### OPPORTUNITIES

- Standardized processes and tools
- Staff attitudes and beliefs?
Patient Journey Map in Clinic
Reading our Patient’s Journey Map:

- The journey a patient with OUD takes from their home/community to our clinic, and back
- **STICK FIGURE**: every human contact in this journey
- **STAR**: point when OUD is identified
- **GREEN sticky notes**: Positive experiences/feelings/resources
- **PINK sticky notes**: Negative experiences/feelings/lack of resources

QUESTIONS OUR TEAM HAS...

- How do we identify OUD as early as possible?
- How do we catch missed diagnoses?
- How do we partner with Pharmacy more effectively?
- How do we engage the SUD Counselor earlier in the patient’s journey?
- How do we increase warm hand-offs with SUD Counselor for patients who are not ready for MAT? How do we meet the patient where they are?
<table>
<thead>
<tr>
<th>I AM TRYING TO</th>
<th>BUT</th>
<th>BECAUSE</th>
<th>WHICH MAKES ME FEEL</th>
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<tbody>
<tr>
<td>PROVIDER (RESIDENT)</td>
<td>PROVIDER (RA/NT)</td>
<td>PROVIDER (X-WAIVERED)</td>
<td>PROVIDER (CMA/LVN)</td>
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<tr>
<td>PROVIDER (X-WAIVERED)</td>
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- **Provider (Resident)**: Address OUD/OD for my patients.
- **Provider (RA/NT)**: Get X-waiver appropriately.
- **Provider (X-Waivered)**: Treat OUD appropriately.
- **CMA/LVN**: Identify patients with OUD.
- **RN (Team Lead)**: Keep track of patients with OUD.
- **Patient**: Improve my health.

- **I Can't always adequately address care in primary visit**
- **I don't know available resources**
- **I haven't completed training**
- **I'm not sure when to stop/OUD taper**
- **I don't know what is the best way (we have no impact)**
- **I don't like having so many apps**

- **Only 20 minute visits**
- **Only don't know: 1-2 counselor, 1-2 waived attendings**
- **16 hours (of a program)**
- **I need more training (?)**
- **Need more counseling**
- **Uncomfortable**

- **Tired/Exposed**
- **Worried**
- **Anxious**
- **Overwhelmed in clinic**
- **Isolated? (no part of team)**
- **Confused**
Questions for other teams:

- What does your patient’s journey map look like?
- How do you identify OUD patients in a sensitive manner?
- What do your workflows look like?
- What does your patient registry look like?
- What are different models for MAT in residency clinics?
- How have you used team-based approach to MAT?

Questions for coaches/faculty:

- What’s the most impactful first step?
- Do’s and Don’ts from past experiences?

We need support:

- Population Health management tools (via ELM? SAGE?)
- Training resources for staff around attitudes/bias/stigma/harm reduction model
We don’t have protocols or tools around OUD treatment (yet).

However, we have developed screenings and workflows around various social determinants of health including depression, food insecurity, housing insecurity, and transportation, and are happy to share what we have learned!