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"

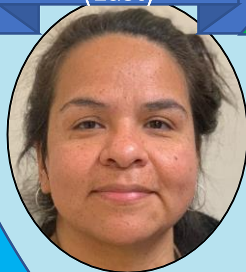
"How do we break the circle of admissions and problems?"

"The attending was frustrated too"

Anne (East)

Olivia (West)

Brenda (East)



Tebei (West)

Jose (East)

Jo (East)

Karla (West)

Manuel (West)

Patient-Centered Medical Home Team

PATIENT

COMMUNITY HEALTH WORKER

RN CARE MANAGER

MEDICAL ASSISTANT

CLERK

CLINICAL PHARMACIST

PSYCHIATRIST

PCP

CORE FACULTY (East)

MEDICAL CASE WORKER

SUD COUNSELOR

CLINICAL SOCIAL WORKER

RN TEAM LEAD

Large academic center
Safety Net
Immigrant
Urban underserved
Diverse
Homeless

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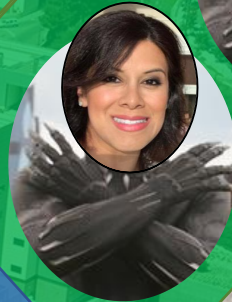
EAST CLINIC

165 Residents, 2 Attendings
3 Core Faculty, 14 Faculty Preceptors

WEST CLINIC

12 Physicians, 1 Physician Assistant,
2 Nurse Practitioners



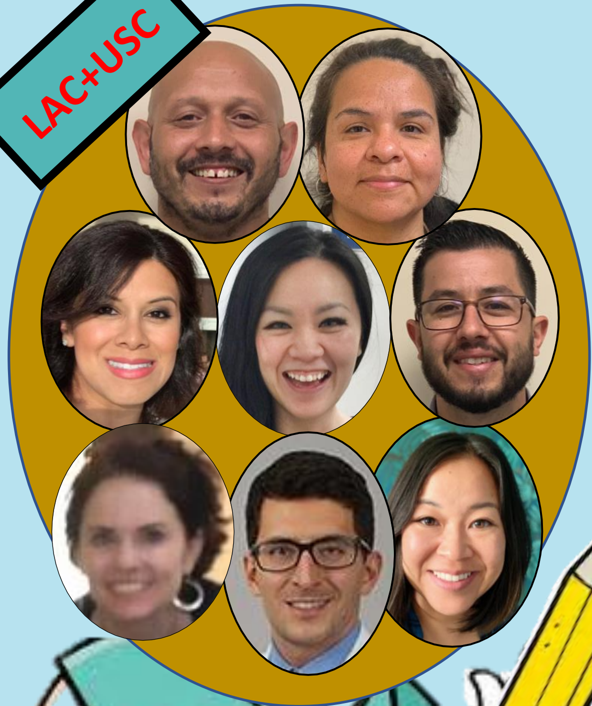
- Waivered Super Heroes

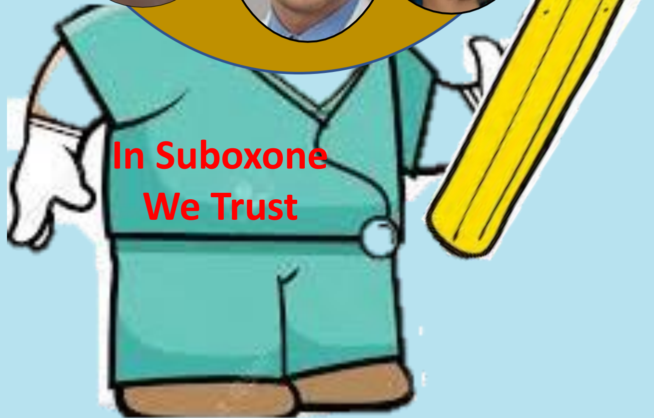
16,298 patients (84% MediCal,
16% Uninsured/ MediCare/ Dual Eligibles)

X-waivered: 4
MAT patients: 0

19,277 patients (61% MediCal, 39%
Uninsured/ MediCare/ Dual Eligibles)

X-waivered: 5
MAT patients: 7





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#GOALS

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

DIMENSION	AVERAGE SCORE
D1. Infrastructure	4.20
D2. Clinic Culture & Environment	2.25
D3. Patient Identification and Initiating Care	2.00
D4. Care Delivery and Treatment Response Monitoring	2.50
D5. Care Coordination	2.33
D6. Workforce	2.80
D7. Staff Training and Development	2.00
Mean Total IMAT-PC Score	**2.58**

STRENGTHS

(score > 2.50)

- ✓ Right team
- ✓ Right people

OPPORTUNITIES

(score ≤ 2.50)

- ✓ Standardized processes and tools
- ✓ Staff attitudes and beliefs?

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Patient Journey Map in Clinic

Transition of Care
Meds availble in pharmacy
Established patient familiar c medical home services
Access to MAT in medical home
Availability of Ψ, SW & wellness Center resources
Screening for MDD/GAD
INDUCTION TODAY? Y or N
READY FOR TX/MAT
"plant THE SEED"
WARM HAND-OFF TO SUD COUNSELOR
SUD is DEDICATED TO HELPING PTS!
PT not ready for TX
STRANGER ASKING VERY PERSONAL QUESTIONS DURING SASH.
Who is setting Goal? SASH TEAM?
PF Office
transport
TOO sick (w/drawal)
NOT ENOUGH TIME ↓ LESS DETAILED SOCIAL Hx
Awareness around PC services
PT
HOME/community
REG. DESK
WAITING ROOM
INTAKE
EXAM ROOM
ANY PHARMACY
Dr. G phone visit 1-3 days
EAST
WEST
PCP
RN
SUD couns.
CMA
OUD ID
OUD ∅ identified or missed
SCHEDULE SUD C. APPT SAME DAY AS PCP
FAMILY

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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?

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Problem Statement Matrix

I AM	TRYING TO	BUT	BECAUSE	WHICH MAKES ME FEEL
PROVIDER (RESIDENT)	Address OUD/SUD for my patients	can't always adequately address OUD in routine visit	ONLY 20 minute visits	? FRUSTRATED (overwhelmed in clinic?)
		don't know available Resources	don't know: - SUD counselor - X-waivered Attendings	? (isolated? not part of team?)
PROVIDER (PA/NP)	get X-waiver	Haven't completed training	16 Hours (vs. 8 for physicians)	?
PROVIDER (X-waivered)	treat OUD appropriately	not sure when to stop/taper meds (MAT)	I need more training (?)	? less confident
CMA/LVN	identify patients with OUD	NOT SURE WHAT IS THE BEST WAY (WE HAVE SH INTAKE FORM)	I THINK IT'S better for the patient to disclose/ to wait for PT to acknowledge; Language Barrier/ translator services	uncomfortable
RN (team lead)	keep track of patients c̄ OUD	where do they go? "lost to follow-up"	· wrong contact info · no tracking system ∅ registry	? WORRIED
PATIENT	improve my HEALTH	I don't like having so many appts	too many clinics too many different people in my business	TIRED EXPOSED

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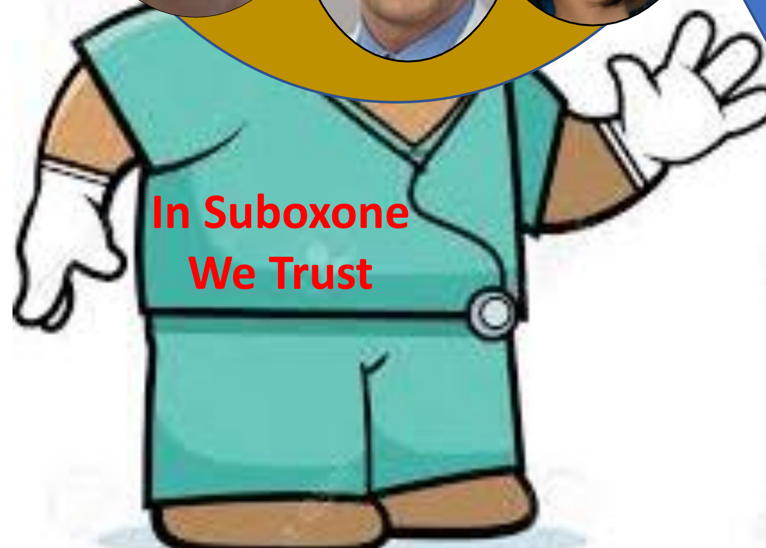
Questions for other teams:

- What does your patient's journey map look like?
- How do you identify OUD patients in 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

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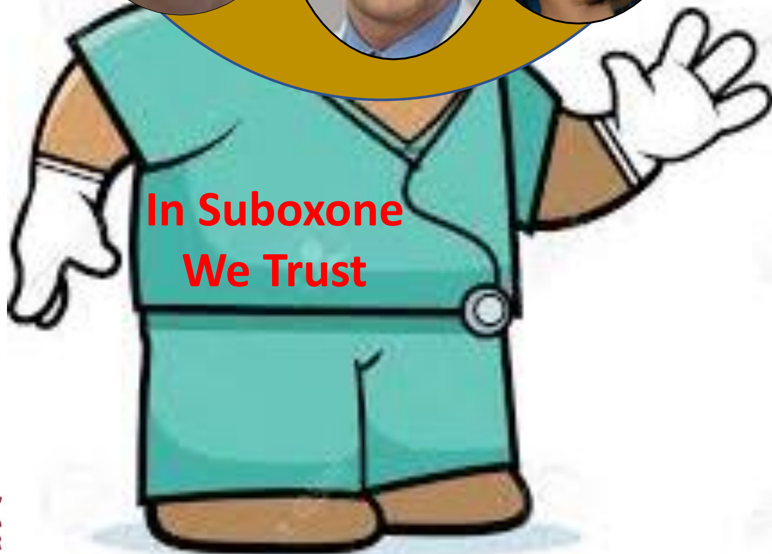

We don't have protocols or tools around OUD treatment (yet).

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!