ACCESS TO MEDICATION ASSISTED TREATMENT USING NURSE CARE MANAGERS

Colleen T LaBelle MSN, RN-BC, CARN
Boston University Medical Center
Program Director STATE OBOT

DISCLOSURE

The speakers and planners of this webinar have no relevant financial relationships to disclose.
The Addiction Crisis

Addiction is a Treatable Brain Disease

- Prolonged substance use causes neurochemical and molecular changes in the brain, which alter:
  - Metabolic brain activity
  - Gene expression
  - Receptor availability
  - Sensitivity to environmental cues

1. Leshner AI. Science. 1997;278:45-47.
Opioid Detoxification Outcomes

- Low rates of retention in treatment
- High rates of relapse post-treatment
  - < 50% abstinent at 6 months
  - < 15% abstinent at 12 months
  - Increased rates of overdose due to decreased tolerance

O’Connor PG JAMA 2005
Mattick RP, Hall WD. Lancet 1996
Stimmel B et al. JAMA 1977

Medication Assisted Treatment

- Goals
  - Alleviate physical withdrawal
  - Opioid blockade
  - Alleviate drug craving
  - Normalized deranged brain changes and physiology

- Some options
  - Naltrexone (opioid antagonist)
  - Methadone (full opioid agonist)
  - Buprenorphine (partial opioid agonist)
34,140 BUPRENORPHINE WAIVED PHYSICIANS AS OF NOV 2015

Source: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 2015.

BARRIERS TO PRESCRIBING BUPRENORPHINE IN OFFICE-BASED SETTINGS

N=156 waived physicians; 66% response rate among all waived in MA as of 10/2005

- Insufficient Nursing Support [VALUE]%
- Insufficient Office Support [VALUE]%
- Payment Issues [VALUE]%
- Insufficient Institutional Support [VALUE]%
- Insufficient Staff Knowledge [VALUE]%
- Pharmacy Issues [VALUE]%
- Low Demand [VALUE]%
- Office Staff Stigma [VALUE]%
- Insufficient Physician Knowledge [VALUE]%

55% of waived providers reported 1 or more barriers

ONLY DEA WAIVED PHYSICIANS CAN PRESCRIBE BUPRENORPHINE.  
(NOT FOR LONG!!!!)

HOWEVER...

...IT TAKES A MULTIDISCIPLINARY TEAM APPROACH FOR EFFECTIVE TREATMENT.

A New Law
Drug Addiction Treatment Act (DATA) 2000

- Amendment to the Controlled Substances Act
- Allows physician to prescribe narcotic drugs scheduled III, IV or V, FDA approved for opioid maintenance or detoxification treatment
  - Prior 10/2002 no drug existed
  - Methadone does not qualify
DATA 2000:
Physician Initially ...Soon NP and PA’s

- MD’s: licensed to practice by his/her state
- Have the capacity to refer for psychosocial treatment
- Limit number of patients receiving buprenorphine to 30 patients for at least the first year, file to increase in 1 year
- Can apply for new waiver; expand to 275 patients if addiction certified and work in medical settings for 24 hour services
- CARA: NP and PA will be allowed to prescribe with 24 hours training (8 which includes waiver course)
  - CURES Act: Funding for CARA Implementation
  - SAMHSA: Defining the training requirements
BMC’S OFFICE BASED ADDICTION TREATMENT (OBAT) MODEL

- Collaborative Care / Nurse Care Manager Model developed at Boston Medical Center (BMC)
  - Nurse care managers (NCMs) work with physicians to deliver outpatient addiction treatment with buprenorphine and injectable naltrexone
- More recently dubbed the “Massachusetts Model”
BMC’S NCM OBAT MODEL: 5-YEAR EXPERIENCE

- Patient-level outcomes comparable to physician-centered approaches
- Efficient use of physician time allows focus on patient management (e.g., dose adjustments, maintenance vs taper)
- Improved access to OBAT and daily management of complex psychosocial needs (e.g., housing, employment, health insurance)
- Open communication between NCM and other providers including behavioral health improve compliance

Office-Based Opioid Treatment with Buprenorphine (OBOT-B): State-wide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers

Colleen T. La Belle, BSN, RN-BC, CARN \textsuperscript{a,b,c}, Steve Choongheon Han, B.A. \textsuperscript{b}, Alexis Berenson, MPH, LCSW \textsuperscript{a} Jefferey H. Samet, M.D., M.A. MPH \textsuperscript{a,b,c}


**PATIENTS RECEIVING BUPRENOPHINE IN STATE OBAT CHCS BY YEAR**

Between 2007-2014 >8,000 patients treated with buprenorphine using NCM model in 14 funded CHCs

AVERAGE NO. ED VISITS PER STATE OBAT ENROLLMENT: 2008-2011

Source: Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, MA Department of Public Health. 2014

AVERAGE NO. HOSPITAL ADMISSIONS PER STATE OBAT ENROLLMENT:2008-2011

Source: Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, MA Department of Public Health. 2014
STATE OBAT INITIATIVE IN CHCS:
PROJECT GOALS

ACCESS
Expand treatment & access to buprenorphine
• Increase number of waivered MDs
• Increase number of individuals treated for opioid addiction
• Integrate addiction treatment into primary care settings

DELIVERY
Effective delivery model for buprenorphine
• Modeled after BMC’s Nurse Care Manager Program
• Focus on high risk areas, underserved populations

SUSTAINABILITY
Post-program funding
• Develop a long-term viable funding plan
• Collect & analyze outcomes data

TECHNICAL ASSISTANCE AND TRAINING PROVIDED TO CHCS

NCM Orientation
• *Bupe 101*: 8 hr training on SUDs and OBAT model (RN, MAs, SWs)

Initial on-site TA
• *Addiction 101*: all staff training on OBAT and disease model of addiction
• Meetings with key members of care team (RN, MDs, Mas)
• *Special-topic trainings*: stigma, special populations, etc.

Ongoing provider support (nurses and waivered providers)
• Provided via telephone, email or on-site visits
• Address issues such as: MD or nurse leaving, practice closures, clinical questions (e.g., transfers, surgery, pregnancy, administrative issues, linkage to other treatment options, insurance changes, prior authorizations, etc.)

Quarterly provider meeting
• Opportunity for further education, networking, support

Maintain list server for addiction providers
• Relevant research, news articles, patient resources, group discussions, new clinical guidelines, regulatory issues, job postings, etc.
IN SUMMARY, EXPANSION OF BMC’S NCM OBAT MODEL ACROSS MA HAS...

- Expanded treatment
  - >10,000 patients treated through STATE OBAT since 2007
  - Treatment available in patients’ communities

- Developed a sustainable reimbursement model
  - FQHCs
  - Insurance

- Implemented evidence based treatment for SUDs and best practices as the standard of care

- Supported and engaged CHC providers and staff to treat SUDs
  - Reduced stigma

BMC’S NURSE CARE MANAGER (NCM) OBAT MODEL

**Training**
- Registered Nurses
- 1-day training in addiction and treatment of SUDs

**Fidelity**
- Perform patient education & clinical care following treatment protocols
- Maintain compliance with federal laws

**Collaboration**
- Coordinate care with OBAT physicians
- Collaborate care with pharmacists (refills management)
- Off-site counseling services

**Additional Services**
- Urgent care drop-in hours
- Manage insurance issues (prior authorizations)
WHAT MAKES THE BMC NCM OBAT MODEL SUCCESSFUL

*NCMs increase patient access to treatment!*
- Frequent follow-ups
- Case management
- Able to address
  - positive urines
  - insurance issues
  - prescription/pharmacy issues
- Pregnancy, acute pain, surgery, injury
- Concrete service support
  - Intensive treatment, legal/social issues, safety, housing
- Brief counseling, social support, patient navigation
- Support providers with large case loads

BMC OBOT became known as Massachusetts Model of OBOT

- Program Coordinator intake call
  - Screens the patient over the telephone
  - OBOT Team reviews the case for appropriateness
- NCM and prescriber assessments
  - Nurse does initial intake visit and collects data
  - Prescriber: PE, and assesses appropriateness, DSM criteria of opioid use disorder
- NCM supervised induction (on-site) and managed stabilization (on- and off-site (by phone))
  - Follows protocol with patient self administering medication per prescription
Nurse Care Managers (NCM)

- Registered nurses, completed 1 day buprenorphine training
- Performed patient education and clinical care by following treatment protocols (e.g., UDT, pill counts, periop mgnt)
- Ensured compliance with federal laws
- Coordinated care with OBOT prescribers
- Collaborated care with pharmacists (refills management) and off-site counseling services
- Drop-in hours for urgent care issues
- Managed all insurance issues (e.g., prior authorizations)
- On average each NCM saw 75 patients/wk

Massachusetts Model of OBOT

- Maintenance treatment patient in care (at least 6 months)
  - NCM visits weekly for 4-6 wks, then q2 wks, then q1-3 months and as needed
  - **OBOT prescriber visits at least every 4 months**
- Medically supervised withdrawal considered based on stability if the patient requested to taper
- Transferred to methadone if continued illicit drug use or need for more structured care
- Discharged higher level of care for unsafe behavior
Conclusions

- Patient-level outcomes comparable to physician-centered approaches

- Allows efficient use of provider time to focus on patient management (e.g., dose adjustments, maintenance vs. taper)
  - Allowed prescriber to manage > numbers of patients due to support of NCM

- Improved access to OBOT and daily management of complex psychosocial needs (e.g., housing, employment, health insurance)


TA Support

- Nursing training and ongoing support
  - Phone, email, site visits, chart reviews
  - Quarterly statewide NCM meetings:
    - addiction education, support, networking

- Site support:
  - Education all providers
    - Trainings: addiction, buprenorphine, stigma, management, set up
  - Support practice: providers and nursing issues
  - Care for or triage patients to other sites due to closures, staff changes, emergency issues
  - DEA Support: Education and preparation, support at visits
  - Waiver assistance, insurance support, coverage, carrier issues

MA Department of Public Health Bureau of Substance Abuse Services 2007
**UMass Study Findings in Massachusetts**

- Studied 5,600 Mass Health Clients prescribed buprenorphine and methadone (2003-2007)
- Overall Mass Health expenditures lower than for those with no treatment
- Clients on Medications had significantly lower rates of relapse, hospitalizations and ED visits: no more costly than other treatments
- Buprenorphine attracting younger and newer clients to treatment


**OBOT RN Nursing Assessment:**

- Intake assessment
  - Review medical hx, treatment hx, pain issues, mental health, current use, and medications
- Consents/Treatment agreements
  - Program expectations: visits & frequency, UDT, behavior
  - Understanding of medication: opioid, potential for withdrawal
  - Review, sign, copies to patient and review at later date
- Education
  - On the medication (opioid), administration, storage, safety, responsibilities and treatment plan
- UDT
- LFTs, Hepatitis serologies, RPR, CBC, pregnancy test
Set the stage for ongoing relationship
Clear message about rules
Patient involvement
Behavior is part of treatment

OBOT RN Induction Preparation:

**Review the requirements program:**

- Nurse/ Prescriber Appointments:
  - frequency, times, location
- Counseling:
  - weekly initially
- Urine Drug Toxicology:
  - at visits, call backs
- Abstinence:
  - from opioids is the goal
- Insurance verification:
  - prior authorizations, co-pays
- Safety:
  - medication storage (bank bag)
OBOT Team
Patient instructions for induction day:

- Insurance verification
  - Prior authorizations, co-pays
- Dispose of paraphernalia, phone numbers, contacts
- Medication pick up: 2mg/8mg tabs
- No driving for 24 hours
- Plan to be at clinic or office for 2-4 hours
- Bring a support person if possible
- Discuss potential side effects (e.g. precipitated withdrawal)

OBOT Prescriber

- Review of history
  - Mental health, substance use, medical, social
- Physical Exam
- Lab and urine toxicology results
  - Assess contraindications
- Confirm opioid use disorder diagnosis
  - DSM V criteria
- Confirm appropriate for office treatment
- Signs orders and prescription
- Develop treatment plan with OBOT team
OBOT RN, Prescriber
Planning for Induction:

- Asking patient to show up in withdrawal requires a great deal of TRUST
- Build a relationship: Support
- Review with patient ahead of time usage history, withdrawal and make a plan
- Written materials, ongoing education
- Emergency and contact numbers

OBOT RNs
Initial dose buprenorphine

- COWs >8-12
- Objective signs are key to making dx
- Ask: What they last Used and When
- Start with 2-4mg sl
- Assess 40min-1 hour after dosing
  - Better, worse, or the same
- Repeat dose of 2mg, assess 1 hour
  - Send home with instructions to call RN
OBOT RN

Patient instructions during first dose:

- Put tablet(s) film under tongue (sublingual) or buccal mucosa
- Don’t talk, don’t swallow: saliva pools
- May use mirror, watch the tablet(s) gradually shrink assists with positioning's
- Don’t drink or smoke before or immediately after
OBOT RN
Frequency of Visits:

- Phone contact daily, or daily visits for first few days, assess individual needs
- At least weekly until stabilized (usually 4-6 weeks)
  - dosage, UDT, counseling
- Progress to every two weeks, monthly, random, q3-4 months

OBOT RN
Comfort Measures

- Taste perversion
- Headaches
- Nausea
- Sweating
- Insomnia
  - More common with methadone transfers

Consult with OBOT Prescriber as needed
### OBOT RN/Prescriber

**Prescriptions**

- **Early On:**
  - Small prescriptions 1 week with refills
  - Increase as patient stabilizes (UDT)
  - 2 week prescriptions with refills (cancel PRN)
- **At point of stabilization:**
  - Monthly visits
  - Monthly prescriptions with refills
- **Keep file of pharmacy contact info**
  - Pharmacist part of treatment team

### OBOT RN

**Follow up Visits:**

- Assess dose, frequency, cravings, withdrawal
- Ongoing education: dosing, side effects, interactions, support.
- Counseling, self help check in
- Psychiatric evaluation and follow up as needed
- Medical issues: vaccines, follow up, treatment HIV, HCV, engage in care
- Assist with preparing prescriptions
- Facilitating prior approvals and pharmacy
- Pregnancy: if pregnant engage in appropriate care
- Social supports: housing, job, family, friends..stability
OBOT Team Monitoring

- UDT
- Pill/Film counts??
- Pharmacy Check-in
- Observed Dosing
- Random call backs
- Scheduled visits
- Counseling check in
- Check in with support/family/parent/partner
- Social stability

MISUSE DIVERSION CONCERNS

- Balance clinical safety and risk of diversion vs. concerns of overburdening patient unnecessarily
- Induction or early maintenance period relatively small amounts: next clinical visit
- Rationale/protocol prescribing interval should be documented EMR
URINE DRUG SCREENING

- UDT is important initial comprehensive evaluation
- Compliance with prescribed MAT (methadone or buprenorphine) can be monitored
- Use of other opioids, substances can be detected and treatment plan adjusted accordingly
- Results of urine drug testing and rationale for frequency of testing should be documented in the medical record
- Self-report often insufficient to determine status of substance use
- Other clinical characteristics, e.g., social and occupational functioning, external contingencies, should be considered when determining urine drug testing frequency
- Inappropriately burdensome testing may damage therapeutic alliance
  - Patients may interpret excessive demands for testing as not being trusted or believed

MISUSE RISK REDUCTION STRATEGIES

- Track of medication supply in EMR
- Obtain urine toxicology screens
  - Absence of buprenorphine in urine
- Involve family if appropriate to monitor medication supply
- Emphasize adherence not on "as needed" basis
- Discuss safe storage and not advertising/sharing medications with others
- Clinical follow up
- Call backs/check in’s as needed
- Transfer: Risk outweighs the benefit
DIVERSION CONCERNS

- May divert all or some of medication money, drugs
- Dose of buprenorphine narcotic blockage
  - Patients can lower maintenance dose below that of prescribed dose and divert “extra”
- Signs of misuse or diversion include:
  - Repeated lost prescriptions
  - Discordant pill count
  - Multiple prescribers: PMP
- Beware of misinterpreting pseudoaddiction
  - Patients maybe fearful of disruptions in medication supply and resultant opioid withdrawal

OBOT RN
Random Call Backs

- Urine toxicology screen
- Pill count
- Observed dosing
- Pharmacy confirmation
- Prescription Monitoring Program Review
- Request when to bring pills in, not to each visit due to medication safety
OBOT Team Monitoring: Pharmacy

- Important Collaboration
- Identify one pharmacy for all meds
- Keep record: Name, number, address, fax on file
- Obtain refill history: Prescription Monitoring Program
  - Other controls and prescribers
- Refills allowed on Scheduled III
- Pharmacy alerts you to:
  - Other meds
  - Early refill requests
  - Behavior issues

Patient Safety Education
Clinical Pathway Review

**Maintenance summary:**

- Expect stability
- Expect improvement in drug use, employment, criminality, social supports
- Counseling engagement
- If not abstinent, evaluate progress in treatment:
  - evaluate need change in treatment plan
  - higher level of care
Length of Treatment

- Length of treatment: We ask patients to commit to 6 months on buprenorphine/naloxone and then reassess
- Patients should be actively involved in development of treatment plan
- Everyone is different: Need to meet patients where they are at
  - Individualize treatment
  - How long... Long Enough

Discharge Options from OBOT

- Buprenorphine not the “miracle drug”
  It is a Tool.........
- Establish linkages with programs
- Assist with detox admission
  - Ongoing treatment: holding, residential
- Transfer to Methadone Maintenance
  - Short or Long term option
Next Steps

- Utilizing nurse care manager models to expand treatment to more sites
- Increase level of education among providers in addiction treatment
  - Nurses, doctors, support staff, and administration
- Integrate into the medical home model of care
- Examine and improve retention and sustainability
- ACO model: prevention

Treating the “Whole” Person

- Comprehensive attention to all medical and psychosocial co-morbidities;
- Pharmacotherapy rarely achieves long-term success without concurrent psycho-social, behavioral therapies and social services;
- Special attention to those at risk of misusing their medications or whose living arrangements pose increased risk for misuse or diversion;
- Individualize Treatment............
- No One size fits all
THANK YOU FOR YOUR TIME AND ATTENTION

COLLEEN LABELLE
COLLEEN.LABELLE@BMC.ORG