ACCESS TO MEDICATION ASSISTED TREATMENT USING NURSE CARE MANAGERS

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DISCLOSURE

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

The Addiction Crisis

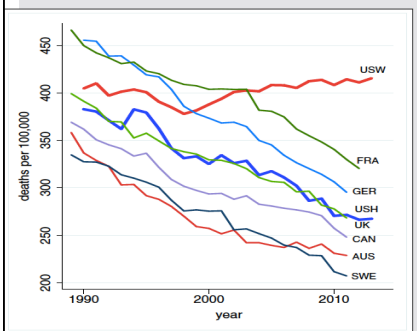
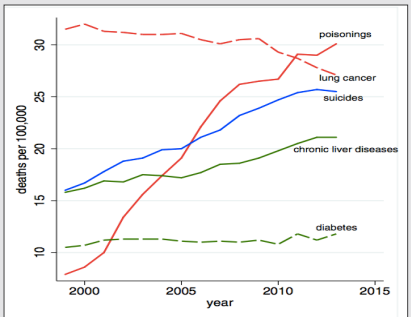


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).



anics ages 45–54.

PNAS

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case[1] and Angus Deaton[1]

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

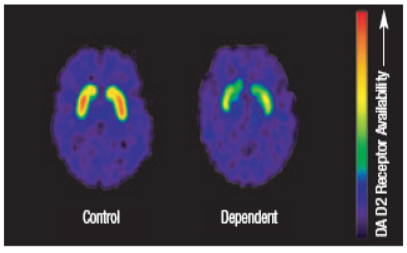
Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Addiction is a Treatable Brain Disease

- Prolonged substance use causes neurochemical and molecular changes in the brain, which alter[1]:
  - Metabolic brain activity
  - Gene expression
  - Receptor availability
  - Sensitivity to environmental cues

Effects of Heroin Dependence on Brain Dopamine D_2 Receptors[2]



1. Leshner AI. *Science*. 1997;278:45-47.
2. Wang GJ et al. *Neuropsychopharmacology*. 1997;16:174-182.

CENTER BOSTON MEDICAL
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Opioid Detoxification Outcomes

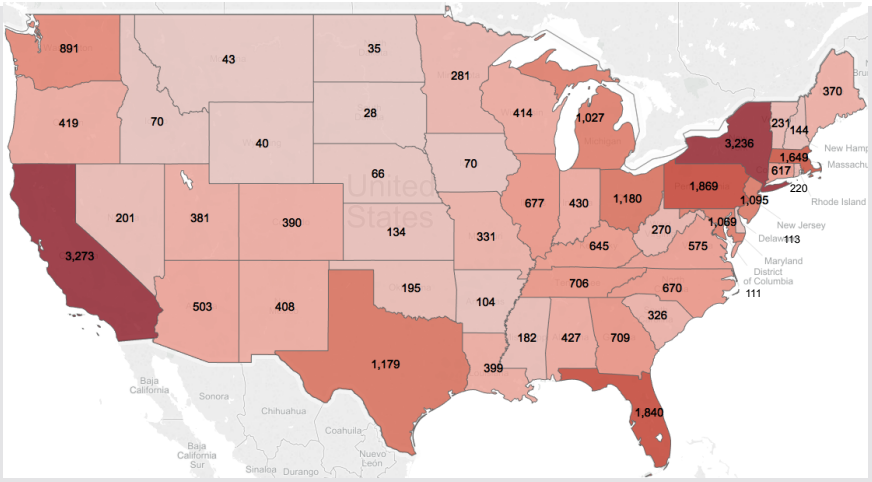
- Low rates of retention in treatment
- High rates of relapse post-treatment
  - < 50% abstinent at 6 months
  - < 15% abstinent at 12 months
  - Increased rates of overdose due to decreased tolerance

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)

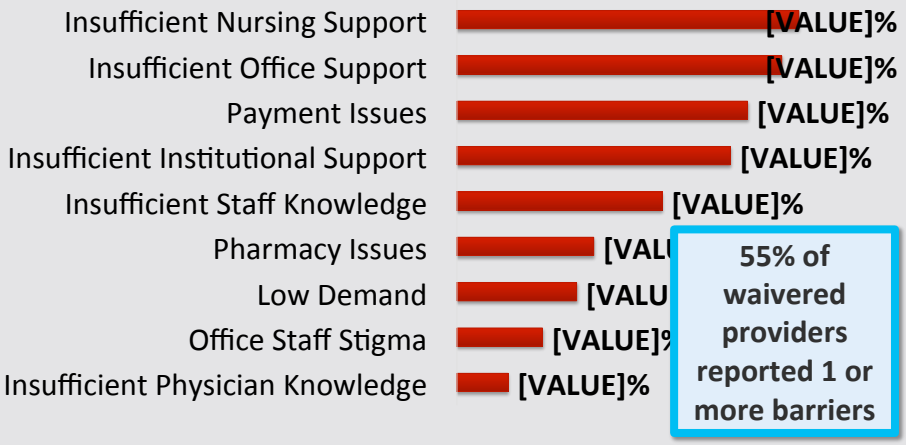
34,140 BUPRENORPHINE WAIVERED PHYSICIANS AS OF NOV 2015



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

BARRIERS TO PRESCRIBING BUPRENORPHINE IN OFFICE-BASED SETTINGS

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



Source: Walley et al. *J Gen Intern Med.* 2008; 23(9): 1393-1398.

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

HOWEVER…

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

A New Law

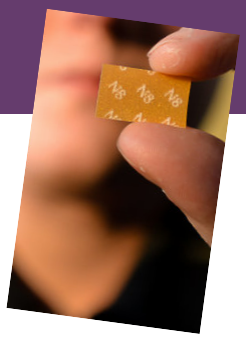
Drug Addiction Treatment Act (DATA) 2000

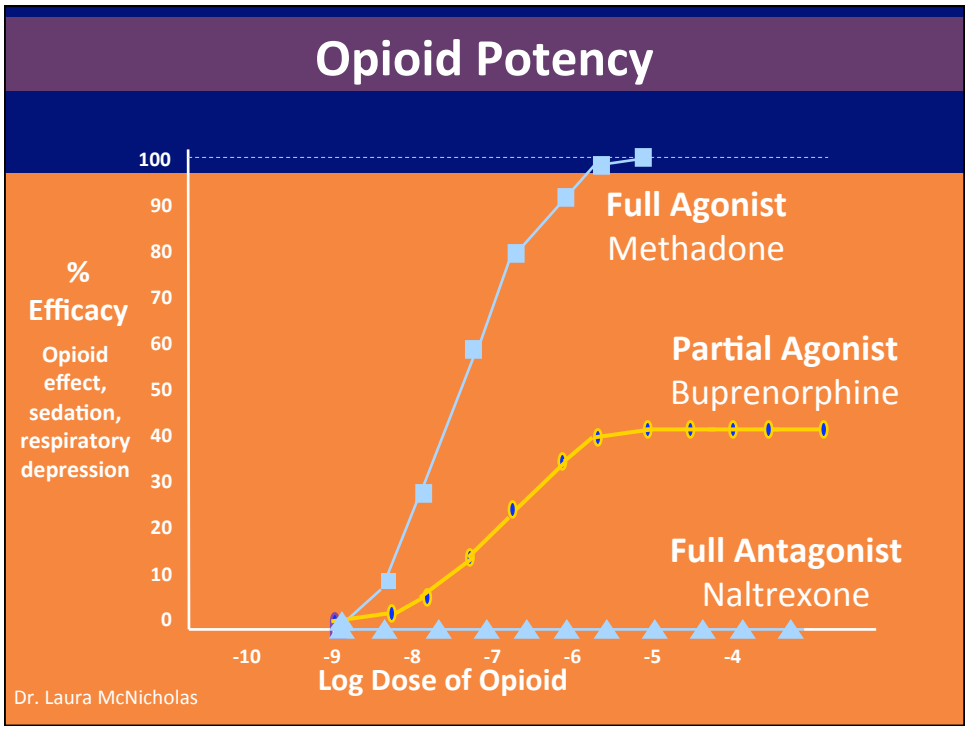
- Amendment to the Controlled Substances Act
- Allows physician to prescribe narcotic drugs scheduled III, IV or V, FDA approved for opioid maintenance or detoxification treatment
  - Prior 10/2002 no drug existed
  - Methadone does not qualify

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

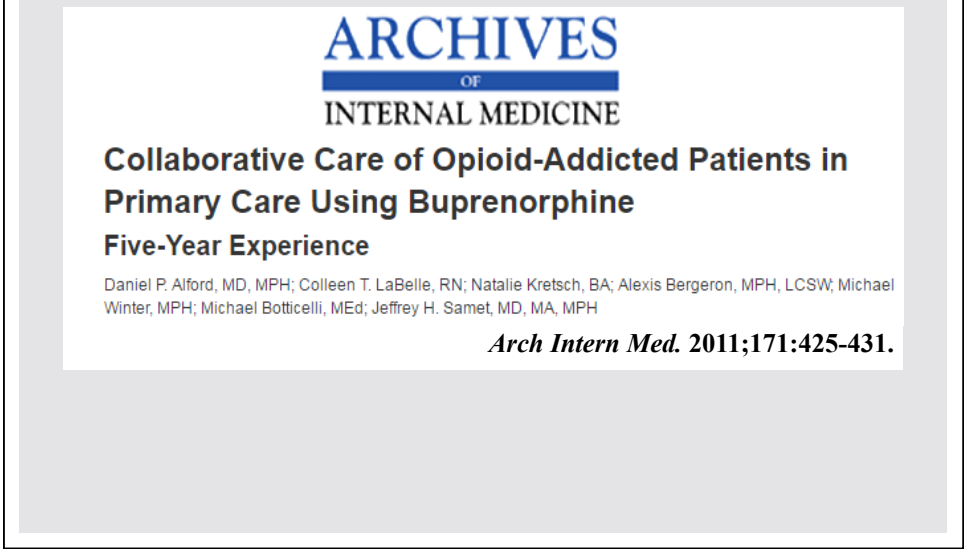
BUPRENORPHINE





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

Source: Alford et al. *Arch Intern Med*. 2011;171:425-431.

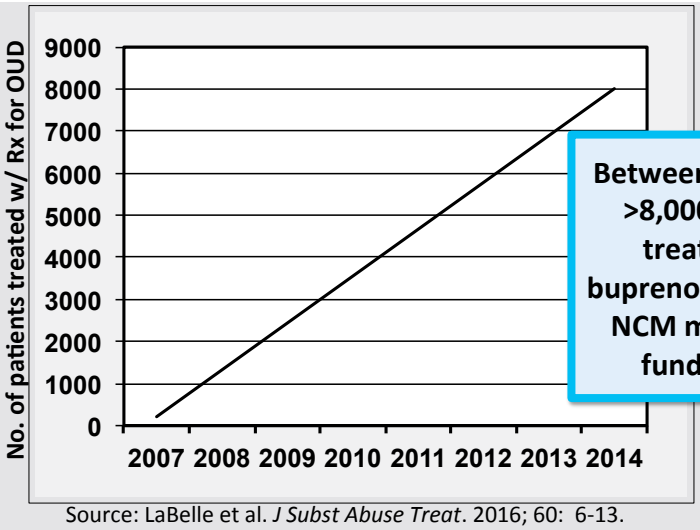
Journal of Substance Abuse Treatment

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

Colleen T. LaBelle, B.S.N., R.N.-B.C., C.A.R.N. [a,b,*], Steve Choongheon Han, B.A. [b], Alexis Bergeron, M.P.H. L.C.S.W. [a], Jeffrey H. Samet, M.D., M.A., M.P.H. [a,b,c]

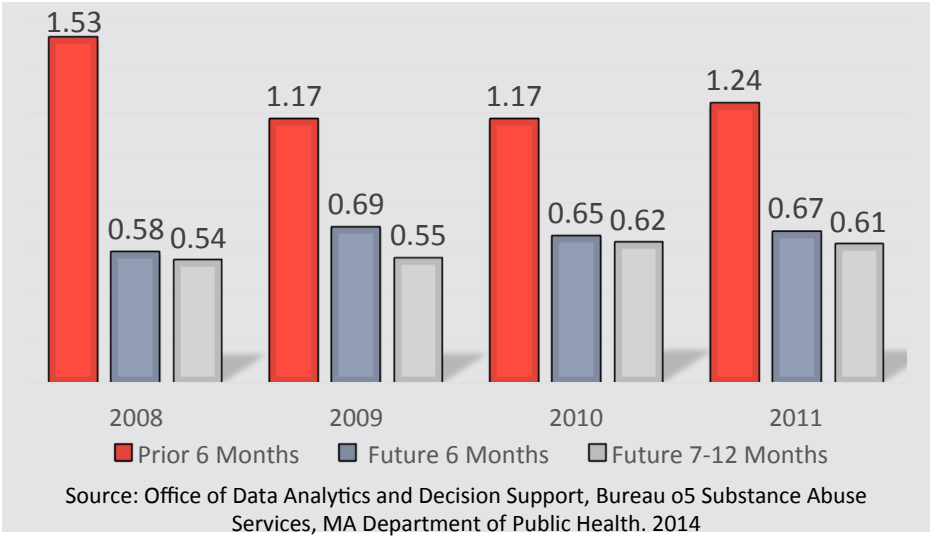
J Subst Abuse Treat. 2016;60:6-13.

PATIENTS RECEIVING BUPRENORPHINE IN STATE OBAT CHCS BY YEAR



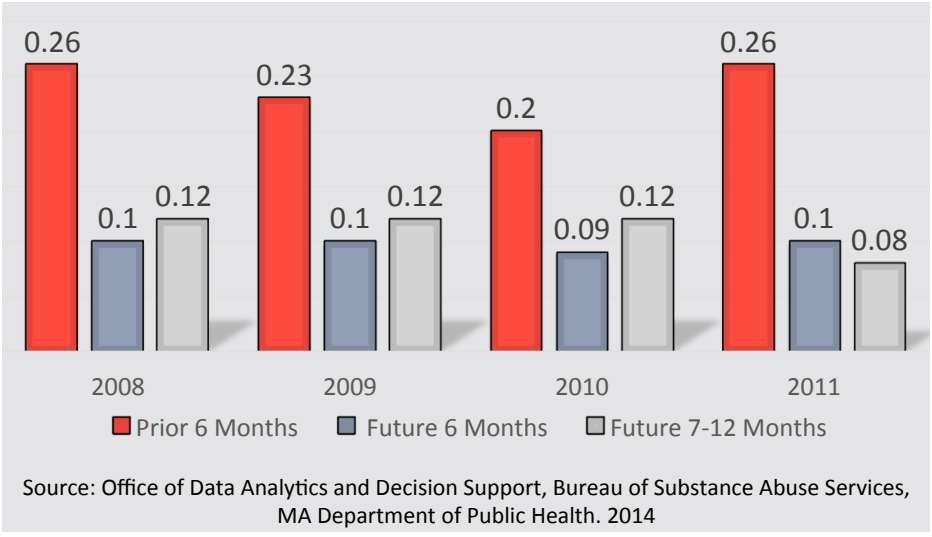
Source: LaBelle et al. *J Subst Abuse Treat*. 2016; 60: 6-13.

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



Source: Office of Data Analytics and Decision Support, Bureau o5 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 (RNs, 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

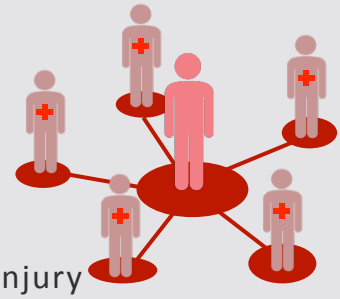
BMC'S NURSE CARE MANAGER (NCM) OBAT MODEL

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 managed > 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)

Alford DP, LaBelle CT, Kretsch N, et al. *Arch Int Med.* 2011;171:425-431.

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

Clark RE, Samnaliev M, Baxter JD, Leung GY. *Health Aff.* 2011;30:1425-1433.

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

Patient Agreement

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 withdr

OBOT Prescriber

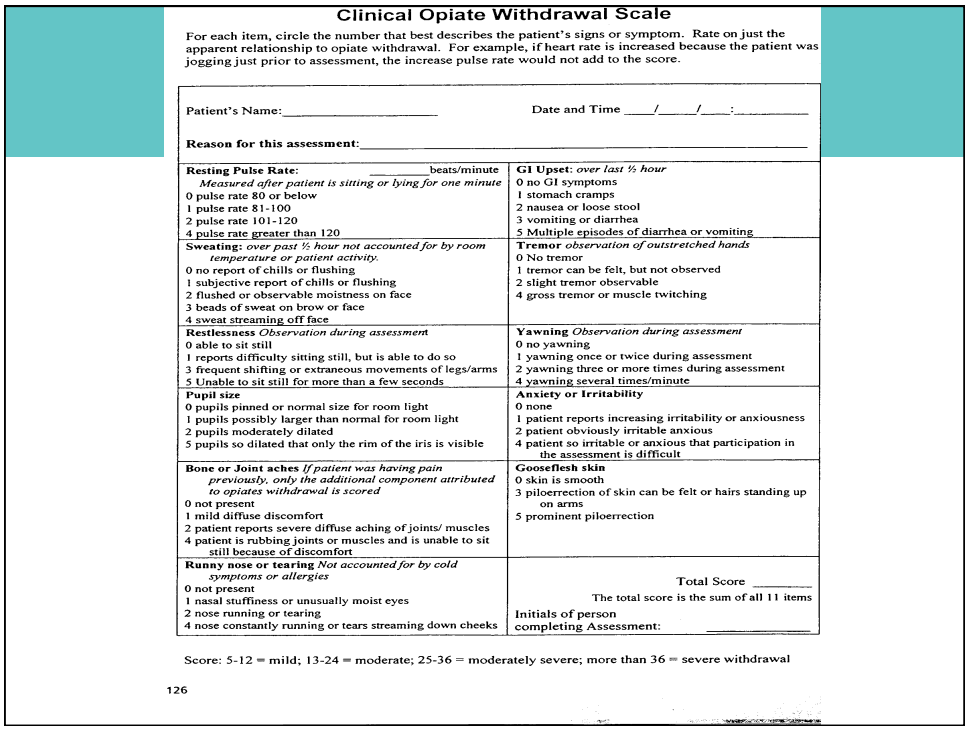
- Review of history
  - Mental health, substance use, medical, social
- Physical Exam
- Lab and urine toxicology results
  - Assess contraindications
- Confirm opioid use disorder diagnosis
  - DSM V criteria
- Confirm appropriate for office treatment
- Signs orders and prescription
- Develop treatment 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



Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/_____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

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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

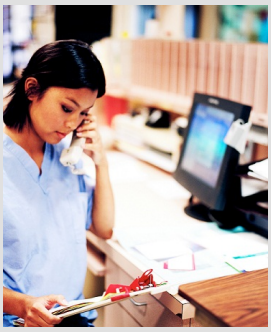
- Early On:
  - Small prescriptions 1 week with refills
  - Increase as patient stabilizes (UDT)
  - 2 week prescriptions with refills (cancel PRN)
- At point of stabilization:
  - Monthly visits
  - Monthly prescriptions with refills
- Keep file of pharmacy contact info
  - Pharmacist part of treatment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

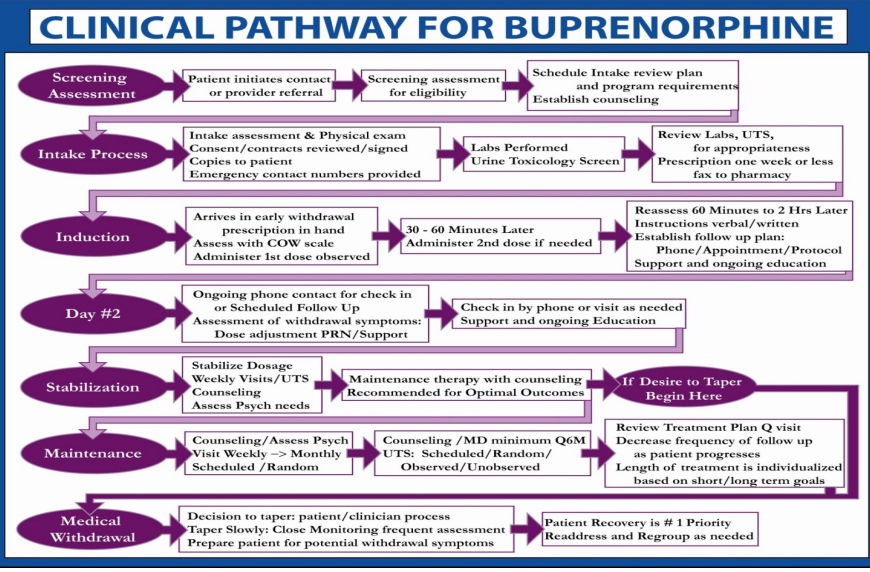
- Urine toxicology screen
- Pill count
- Observed dosing
- Pharmacy confirmation
- Prescription Monitoring Program Review
- Request when to bring pills in, not to each visit due to medication safety

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 Enought

Discharge Options from OBOT

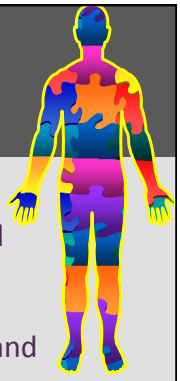
- Buprenorphine not the "miracle drug"

  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
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