WEBINAR VIDEO TRANSCRIPT

Opioid Addiction Treatment ECHO

Effective team-based care for OUD (with focus on Nurse-led model) + Care coordination and addressing social determinants of health

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LESLIE: Use disorder. And one caveat I always give whenever I do talk about team based care, I am a big proponent of team based care. I think it's great, but every time I give this talk when I do it in person invariably I will have two or three people come up to me afterwards and say I can't possibly prescribe buprenorphine 'cause I don't have that kind of support, and I think the team really helps but I think if you're the only person in your clinic doing it right now feel free to just go with that, I mean, 'cause for the first two years that I did this I was, you know, it was pretty much me, and I think it is still possible to prescribe and to be able to take care of patients. It definitely makes it easier and I feel like you get a lot out of having a team around it. But if you don't have the team it's still possible to do this, so, next slide. And I have nothing to disclose, next slide.

So, I think we all know about DATA, so I'm not gonna go into it in any detail but basically Drug Addiction Treatment Act in 2000 is what lets us prescribe buprenorphine in the office. And next slide. And we all know that the CARA Act passed a year and a half ago, is what allows nurse practitioners and physician assistants to also prescribe the buprenorphine. So, this particular study was on collaborative care using an approach with a nurse leading the team on providing buprenorphine, next slide.

And it was developed, initially it's called their Office Based Addiction Treatment model and eventually it changed to Office Based Opioid Treatment. So, but it's a collaborative care managed model where they have nurse care managers who work with physicians and they do outpatient addiction treatment with buprenorphine and injectable naltrexone. It's also been called the Massachusetts model. Next slide.

And again, like I said, I couldn't figure out why it suddenly changed from OBAT to OBOT and when I went to look up OBOT to confirm what it meant I actually discovered one of the meanings for it is someone who blindly followed Obama's policies, which was just urban slang, but I thought was kind of amusing, but so in any case, in 2003 they began their outpatient opioid therapy program, and in 2010 they had 425 patients, three to six new patients per week. Nine physicians involved at that time, the medical director, three who were American Board of Addiction Medicine certified, and they all had part time clinical practices. They had three RNs, one medical assistant, one program coordinator, and a program director for this program, next slide.

And in 2016 they were having seven new patients per week. At that time they had 17 waivered physicians, 12 who were American Board of Addiction Medicine certified and they had more RNs, one medical assistant, the program coordinator, and the program director, next slide.

And treatments, and their, these folks are doing pretty well. People will always ask me what the success rate is for medication assisted therapy or methadone or buprenorphine and it really varies depending on

how you define success and what other treatment modalities they're using as well, but this one, 51%. So roughly half of the patients were either still in treatment or had managed to successfully taper after being on the medication for at least six months. So, a fairly good success rate I think. Among people who were not successful about a third were lost to follow up. 12% continued to use despite really very intensive treatment. Two of them were discharged because of disruptive behavior and then one of them had to stop because of adverse effects and then roughly 6% transferred to methadone. And I think, I'm curious to hear what other people think. These numbers are I think reasonably similar to what I have in my program. How do other people feel these numbers compare to theirs? Anybody? Okay. We will move on then, next slide--

WOMAN: It looked like Joshua's trying to--

LESLIE: Oh okay.

WOMAN: Say something, sorry.

JOSHUA: Yeah, the numbers that I see here are pretty typical for what I have seen from experience, just kind of state wide. I have been able to see that the numbers at the clinic that I currently work at are actually pretty, pretty much higher than this which I'm pretty amazed with.

WOMAN: Thank you Josh.

LESLIE: Any particular reason why?

JOSHUA: Well, being a certified peer support worker I'd like to think that it's because of peer support. I definitely advocate for it, but you know, I really think that it's just more meeting them where they're at. If we have somebody who is having trouble making appointments instead of, you know, being a cut and dry oh, they're not making their appointments, so they're gonna end up getting cut from the program, we work with them and figure out is it because they are actually regaining their life back and they have a busy schedule because they're going to school and working and doing all these things, and you know, if they're getting all that stuff in their life back why would we punish them or make it harder for them to be able to fulfill those obligations, you know? So, I mean really just being able to figure out is this person missing because they're using or they're diverting or you know being able to figure out is this person having a trouble making appointments because they have a busy full life.

LESLIE: Yeah, no, I think that's good. I definitely think that makes a big difference, so. All right, next slide. And just in 2015, the number of buprenorphine waivered physicians, and I would love to see how this math has just changed in the last two years just now that mid levels, the nurse practitioners and physician assistants can prescribe, because I'll bet these numbers have gone way up, 'cause I know they have in my community, next slide.

And so this is Office Based Management of Opioid Dependence, another group that's using the nurse care manager, next slide.

So, this particular, this was what started it. This was, excuse me, this was not the study on the team approach, but when they asked what were the biggest problems that people had on prescribing buprenorphine the biggest one was insufficient nursing support and insufficient office support. Payment issues have also been an issue. Institution doesn't support it. Staff doesn't know enough about it. Pharmacy issues. Low demand I was shocked by. I can't believe that's an issue for anybody, but apparently. Office staff stigma, and insufficient physician knowledge is lower than most of them. So, I mean the biggest problem has been the support in the clinic, and I will say one of the ways we addressed that in my clinic was we just started sending everyone who worked at all with the buprenorphine patients, so all of our nursing staff, we sent a lot of our front desk staff actually to the buprenorphine trainings, because I found it made a big difference if they actually sort of knew why we were doing this and why exactly we were doing, so, next slide.

So, only DEA waivered physicians, nurse practitioners, and physician assistants can prescribe buprenorphine. This says it takes a multidisciplinary team approach for effective treatment. I would rephrase it as a multidisciplinary team really does help, but like I said, I'm always hesitant to say you have to have the team becausepeople do an amazing job, seen people do an amazing job just by themselves. Next slide.

So, nurse care managed addiction treatment programs increase patient access to treatment because you can generally, excuse me just a second. You can do much more frequent follow up if you've got the nurse care manager doing it because generally they have the time in their schedule. They can do case management, the things that Josh was talking about, like why are they having trouble making it into the clinic, are there housing issues that's a problem, what else is going on. They're readily able to address positive urines. They can help deal with insurance issues. One of the things we did when Medicaid was such an issue in our state was we had people solely assigned to fill out the prior auth forms and get those taken care of, so all I had to do was do my signature and the other things and to keep track of when were prior authorizations due because Medicaid in New Mexico currently does not require a prior auth but when they did it was probably four to six hours of paper work a week for various people to make sure this was taken care of.

They can help in acute situations such as pregnancy, acute pain, surgery, or injury. They can provide service support such as the intensive treatment. They can help with any legal or social issues. They can help with safety and housing, and I find a lot of times my patients are much more willing to open up to the community health worker about things than they are to me. They wanna, often patients really want

the physicians to think they're doing well. They want us, the medical providers, to think oh, this is a great patient. So they're embarrassed to admit if they're having problems. So they're much more willing to open up to the community health worker. The community health worker can also provide counseling, social support, and they can provide a lot of support for providers with large case loads. Next slide.

And in 2007 in Massachusetts the State Technical Assistance Treatment Expansion OBAT program, so STATE OBAT, was created to expand the model to community health centers across Massachusets, and it was expanded to, federally qualified health centers are mandated by Public Health Service Act to provide mental health and substance use treatment and provide direct service or by written contractual agreement and measure services for effectiveness and quality, which I find interesting that they did this because I work for an FQHC and when we first started doing this we actually had to apply for a whole bunch of extra stuff because they weren't sure that it was part of our scope of care to be providing addiction service. So I'm really happy that it's now changed to this way. So in, Massachusetts has 14 community health centers that provide capacity to over 30 community health centers at this time. They started with 14 and it's now at 30, next slide.

So, the goal of it was to increase the number of waivered MDs, increase the number of individuals treated for opioid addiction and to innovate addiction treatment into the primary care setting. It's modeled after the BMC's nurse care manager program. They focused on high risk areas and under served populations which is who FQHCs take care of, and the idea was once the program was done they wanted to have it continue long term. So, not just during the two years that you had the grant but how you make sure that this works long term, next slide.

And so this was the paper on the opioid based, Office Based Opioid Treatment with Buprenorphine, you wanna say that five times fast, and how they were able to implement this statewide. Next slide. So, this is how their model works. I think a lot of us do things that are similar. Everyone has their own individual variations, but the program coordinator intake call will screen the patient over the telephone and then the team will review the case for appropriateness. The nurse care manager and physician do an assessment. The nurse does the initial intake visit and collects data.

In my clinic we have our community health worker do this and in addition to doing the collecting data they also do a lot of the education. They do harm reduction. They talk about syringe exchange. They make sure the patient has access to Narcan. One of our CHWs, back when benzos were much more of an issue in the community than they are now, and we regularly had to turn away people for benzos, one of the things he would talk to them about was that they couldn't have benzos on their urine drug screen and so he'd say, when was the last time you took a Valium, and they'd tell him, and he'd say, okay, so what we're gonna do is we're gonna schedule your appointment two weeks out, so that we can make sure that your urine doesn't show the benzos, so don't use any between now and then, and they would feel like they were in collusion with the community health worker who was of course reporting this all back to me, but it really did help to make sure that they were doing things appropriately. Then when they see the waivered prescriber the prescriber does the physical exam, again assesses appropriateness, makes sure they meet the DSM criteria for opioid use disorder. And they do nurse care manager supervised induction on site. We do almost all home inductions. How about the rest of you? Do you do home inductions or do you do them in your clinic?

WOMAN: We do ours in the clinic.

LESLIE: I'm sorry. Stephanie?

STEPHANIE: We do home.

LESLIE: Home?

WOMAN: And we do ours in the clinic.

LESLIE: You do yours in the clinic? What are the reason that people choose home versus clinic?

WOMAN: It's just how our, I'm new to prescribing so it's how my, you know, the physicians who are mentoring me do it, but I think you know from what the physician who I've been working with closely explained to me is that it's not really shown to have benefit doing it in the clinic and he really feels like patients know what they're doing in terms of how much they need and can report back on that accurately and know when to take it, so.

WOMAN: I do mine at home and the main reason is access. Some people are coming as far away as three hours. So the back and forth just, it doesn't work. So home works really nicely for access reasons.

LESLIE: Three hours, that is amazing.

MAN: We do all of our inductions in our clinic and the reason for that is 'cause we have a RN who will administer those first several medications and then she will also give thereport just to assess how they're doing.

LESLIE: Okay. All right, and then the nurse care manager also works with stabilization both and on and off--

WOMAN: I'm sorry, sorry Leslie, Josh had something that he wanted to weigh in on.

LESLIE: I'm sorry.

WOMAN: Yeah.

JOSHUA: Sorry, I've been confused about this process and you know, how, do I raise my hand, or what do I do, 'cause if I press the raise hand button it doesn't do anything. So in our clinic we do both supervised inductions and home inductions and it's all case by case depending on the patient. I know that the CEO prefers if we do it in house because you know Medicaid pays more for an in house induction but you know being a certified peer support worker, you know, I'm not focused on what's best for financial but what's best for the patient and what I've seen with the in house is a lot of times the provider is, seems timid and scared to give them too much and will end up actually sometimes sending them home with not enough in their system. They physically look like they're still in withdrawal.

So I've really been trying to push with them to, you know, let's go ahead and give them some more, you know, because we want them to feel stable when they leave, and I prefer the in house really because there's a lot of chance for diversion if they, you know, if they do the take home because typically with the heroin that's been coming around with fentanyl and stuff like that it's a lot harder to do the induction because it seems to last in the system longer and so the buprenorphine takes more time to actually do what it needs to do, and sometimes you know, somebody will have abstained from use for 24 hours and still go into a precipitated withdrawal. So, it's really nice to be able to do that in the clinic so that way, you know, we know what's going on and 'cause typically if somebody who's opiate dependent goes into a precipitated withdrawal they're not gonna wait it out. They're gonna go and they're gonna find some more heroin or some more pills or whatever their particular drug of choice is.

LESLIE: That's interesting what you're saying, that it's taking longer with the fentanyl, 'cause fentanyl has such a short half life I would actually expect it to be out of the system certainly no longer than heroin and probably quicker.

JOSHUA: Well that was just an assumption really of not really understanding how come now it seems to be harder for people to do the home induction, you know? I know five even 10 years ago it seemed like an easier task. So I'm not sure exactly what it is that's going into the heroin that's making it so much harder, and--

LESLIE: Yeah.

JOSHUA: Be that, you know, maybe it's just even stronger heroin.

LESLIE: Who knows, hard to say. I think people are also using more than they used to. So, all right, next slide. So, the nurse care managers that they have are registered nurses who have completed a full day of buprenorphine training. They perform patient education and clinical care by following treatment protocols. They ensure compliance with federal laws. They coordinate care with the OBOT prescribers. They also collaborate care with the pharmacist to make sure the patients have the refills, and help to get the patients into off site counseling services. They also have drop in hours for urgent care issues which I think would be lovely because there's certainly plenty of them and it's always a little challenging for me to work them into my schedule. They also manage all the insurance issues and they saw on average 75 patients a week. So, this is I think would be a real benefit to have these, next slide.

Once the patient is in maintenance which they considered to have been in for at least six months then they would see the nurse care manager and weekly, so, when they first started to see them weekly for four to six weeks then every two weeks then every one to three months as needed, and they see the waivered provider at least every four months. And they consider medically supervised withdrawal if they're stable and the patient wants to taper. Transferred to methadone if they continued to use illegal drug or if they needed more structured care, and discharged for disruptive behavior. Next slide.

And they studied 5600 Massachusetts Health clients who presented for buprenorphine and methadone and they discovered that their overall expenditures were lower than for those with no treatment, which is one thing I think insurance companies can be a little bit short sighted on, you know, saying, oh, the buprenorphine is so expensive and the methadone is so expensive. Well, opioid users are expensive overall and if they're not on treatment then they're having a lot more hospitalizations and ER visits, so. Clients on Medicaid had significantly lower rates of relapse, hospitalizations, and emergency room visits. So they ended up being no more costly than other treatments. Buprenorphine seemed to bring in younger and newer clients into treatment, next slide.

And nursing assessment, they would review the medical history, the treatment history, pain issues, mental health, current use, and medications. They would do the consents and explain the program expectations, how often the visits were, what the visits would entail, the need for urine drug testing, there would be expected behavior, their understanding of the medication, that it's an opioid, there is the potential for withdrawal, and they would review it and have the patient sign it and give a copy to the patient, and education was done on the buprenorphine or methadone, how it's administered, how it's stored, how to use it safely, the responsibilities and the treatment plan. They would do urine drug tests, and they would do liver function tests, hepatitis serologies, RPR, CBC, and pregnancy test. And, next slide.

The provider when they saw them would review the history, mental health, substance use, medical, social. They would do a physical. They would do the lab and the urine test. They would assess for any

contraindications. They would assess toxicology. They would confirm the opioid use disorder diagnosis using DSM criteria. They would confirm that the patient is appropriate for office treatment. They would sign the orders and the prescription and develop a treatment plan with the office based opioid treatment team, next slide.

Wait, looks like we went back. And one more. All right, so, when they were getting ready to do the induction they would again review the program requirements. They would have talked about the frequency for the nurse and physician appointments. They would talk about the counseling which was weekly initially. They would talk about the urine drug test would be done at visits and call backs and that abstinence from opioids is the goal. They would verify the insurance and talk again about medication safety. And they were actually using bank bags, which I thought was interesting. I've never done it that way. I've always had lock boxes, but next slide.

So, they would again for induction they verify the insurance. Instruct people to dispose of all drug paraphernalia. I mean, David you talked about your patient who found the stuff in the house. I find that fairly frequently the patients relapse because they're cleaning up and realize, oh, they still have a stash hidden, you know, in the back corner of their drawer. Phone numbers and contacts, this can be such an issue. I have had so many patients relapse because they still have those contacts in their phone and I cannot convince them that they need to delete them. Medication pick up and we always use the eight milligram tabs for induction. They talked about the two milligrams but I find patients do just fine to do a half of an eight milligram tablet. No driving for 24 hours which I must admit we have not enforced on that. They need to plan to be at the clinic or office for two to four hours. Bring a support person if possible and discuss the possibility of precipitated withdrawal. Next slide.

They'll, at the follow up visits they assess the dose, frequency, cravings, withdrawal. They do ongoing education on dosing, side effects, interactions, and support. They do the counseling and the self help check in. Psychiatric evaluation and follow up as needed. They'd take care of medical issues such as the vaccines, follow up, treatment for HIV and Hepatitis C, engaging in care. Assist with preparing prescriptions. Facilitate prior approvals and pharmacy. If they're pregnant they make sure they're getting prenatal care and make sure they've got the social supports, housing, job, family, and friends. Next slide.

So, this is one that I think is really important and this is why these programs end up despite the fact that Suboxone is quite an expensive medication that these programs end up paying for themselves. It's because you have such a decrease in hospitalization and ER visits once you get somebody on treatment for their opioid use disorder. As you can see, their visits dropped over half once people got on treatments, next slide.

And same thing for ER visits. The ER visits dropped again by roughly half once you get people on treatment. It makes a huge difference. Untreated opioid users are people with a lot of medical complications, so if you can get them on treatment, they're gonna have less abscesses, they're gonna have less endocarditis, and they're gonna have fewer overdoses and so they end up being in the ER and in the hospital much more infrequently, next slide.

And health determinants influence the rate of substance use disorder. So, things like our environment, whether or not we're working, access to health care, if we have insurance or not, social stressors, educational disparities, and occupation, mental health issues, and cultural norms, next slide.

And so working on all of this really can make a difference in treating substance use disorder. So, making sure they've got good housing, certainly getting people out of housing where somebody else is using, or somebody is abusing them, getting them into schooling and job training, universal healthcare which Massachusetts had a version of long before any of us, reinforcing prevention and treatment, working on stressors and complex care management, getting them supports for parenting, education, counseling, and activities, and working on prevention and education. Social connectedness I think is so important, and for many of my patients the only social connections they have are the people that they use with. So, helping them to find other people that they can connect with and do things with who are not using can be really, really important for recovery, next slide.

And the complex care management shows patient level outcomes comparable to physician centered approaches. It allows efficient use of physician time to focus on patient management, and allows physicians to manage physicians, nurse practitioners, and PAs, the slide set was made before anyone else could do this. But anyway, allow providers to manage an increased number of patients because the nurse care managers are providing so much support, and it improves access to office based opioid therapy and daily management of complex psycho social needs such as housing, employment, and health insurance. Next slide. And that is the end, any questions?