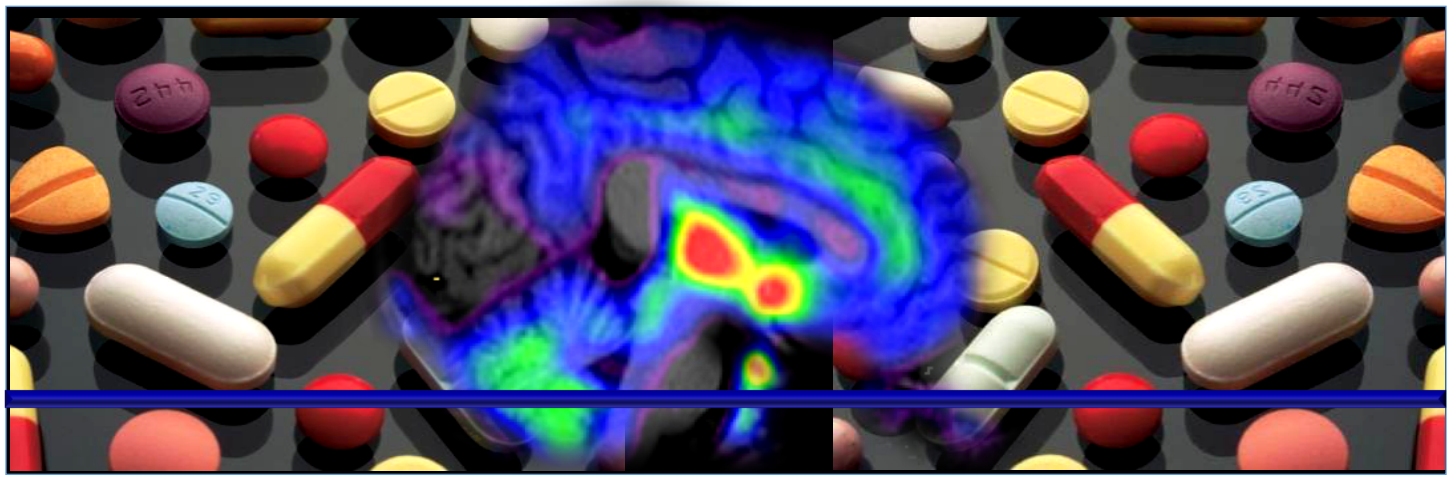
Nurse Care Managers Treating Opioid Use Disorder



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Disclosures

- I have no disclosures or commercial interests to report

What is evidence-based care for Opioid Use Disorder?

- **Methadone:** full opioid agonist
  - Only available in specially licensed opioid treatment programs
- **Buprenorphine/naloxone:** partial opioid agonist, commonly combined with naloxone, an opioid antagonist (to deter injection)
  - Use in office-based setting requires DEA waiver
    - 8 hour training for MDs per DATA 2000 and 24 hrs for NPs and PAs per CARA Act
- **Naltrexone:** opioid antagonist
  - Use in office-based setting without special certification
  - Evidence of efficacy in specific populations
  - Overall efficacy not well established

NIDA (2012). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition).
SAMSHA (2015). Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP.
Kampman & Jarvis (2015). American Society of Addiction Medicine (ASAM) National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. Journal of addiction medicine, 9(5), 358-367.

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JGIM Journal of General Internal Medicine

Office-Based Management of Opioid Dependence with Buprenorphine: Clinical Practices and Barriers

Alexander Y. Walley, MD, MSc,[1,2] Julie K. Alperen, DrPH,[3] Debbie M. Cheng, ScD,[1,4] Michael Botticelli,[2] Carolyn Castro-Donlan,[2] Jeffrey H. Samet, MD, MA, MPH,[1,5] and Daniel P. Alford, MD, MPH[1]

J Gen Intern Med. 2008;23:1393-1398.

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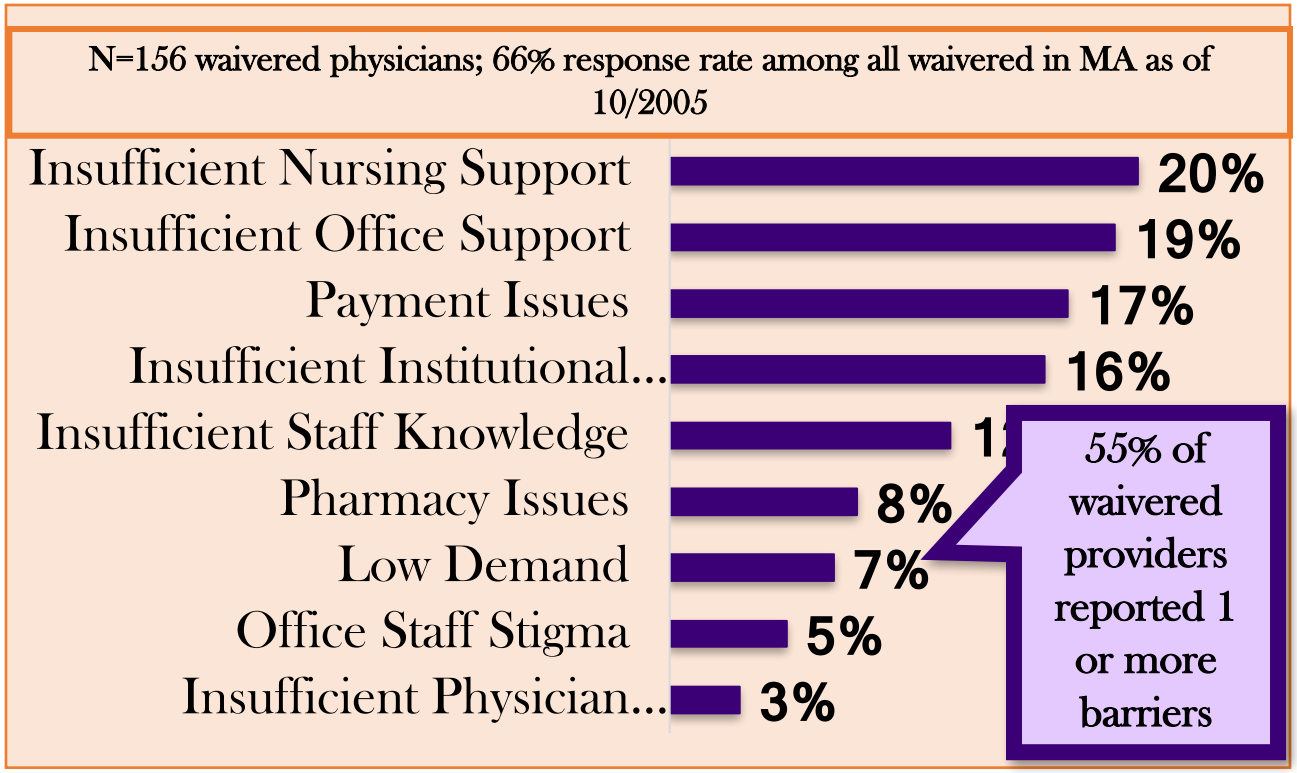
Barriers to prescribing buprenorphine in office-based settings



Walley et al. (2008). Journal of General Internal Medicine. 23(9): 1393-1398.

Only DEA-waivered clinicians can prescribe buprenorphine...

...but it takes a *multidisciplinary team approach* for effective care.

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It takes a Multidisciplinary Team
Approach for effective addiction treatment

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ARCHIVES OF INTERNAL MEDICINE

Collaborative Care of Opioid-Addicted Patients in Primary Care Using Buprenorphine

Five-Year Experience

Daniel P. Alford, MD, MPH; Colleen T. LaBelle, RN; Natalie Kretsch, BA; Alexis Bergeron, MPH, LCSW; Michael Winter, MPH; Michael Botticelli, MEd; Jeffrey H. Samet, MD, MA, MPH

Arch Intern Med. **2011;171:425-431.**

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Table 2. Treatment Outcomes at 12 Months of 382 Opioid-Dependent Patients Entering Office-Based Opioid Treatment in Primary Care

Outcome	Patients, No. (%)
Successful treatment	196 (51.3)
Treatment retention	187 (49.0)
Successful taper after 6 months of adherence[a]	9 (2.4)
Unsuccessful treatment	162 (42.4)
Lost to follow-up	113 (29.6)
Nonadherence despite enhanced treatment[a]	46 (12.0)
Administrative discharge due to disruptive behavior	2 (0.5)
Adverse effects of buprenorphine hydrochloride	1 (0.3)
Transfer to methadone hydrochloride treatment program	24 (6.3)

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

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Urine Drug Tests (UDT)

Month	3	6	9	12
Illicit Opioid NEG	95%	94%	93%	95%
Cocaine NEG	95%	96%	95%	98%

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

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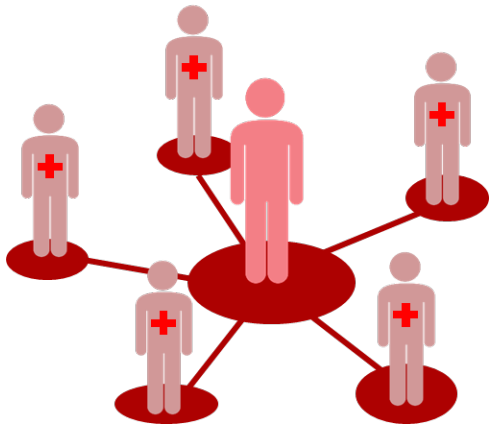
BMC's Nurse Care Manager (NCM) OBAT Model



- BMC OBAT Program serves >600 patients annually
- Fully integrated into primary care

5 years of outcomes:

- Patient-level outcomes comparable to physician-centered approaches
- Efficient use of physician time allowed 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 improved compliance

Alford et al. (2011) *Archives of Internal Medicine*.171:425-431.

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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.**

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A decade of experience: Bringing the BMC model to CHCs across MA

- In 2007 State Technical Assistance Treatment Expansion (STATE) OBAT Program created to expand BMC model to CHCs across MA
- Started with 14 CHCs, now includes >30

Outcomes from first 5 years:

- Between 2007-2013, 14 CHCs successfully initiated OBAT
- Annual admissions of OBAT patients to CHCs increased from 178 to 1,210
- Physicians "waivered" increased by 375%, 24 to 114 over 3 years
- 65.2% of OBOT patients enrolled in FY 2013/2014 remained in treatment ≥ 10 months

LaBelle et al. 2016. Journal of Substance Abuse Treatment. 60: 6-13.
MA Department of Public Health. Bureau of Substance Abuse Services. Office of Data Analytics and Decision Support. 2016.

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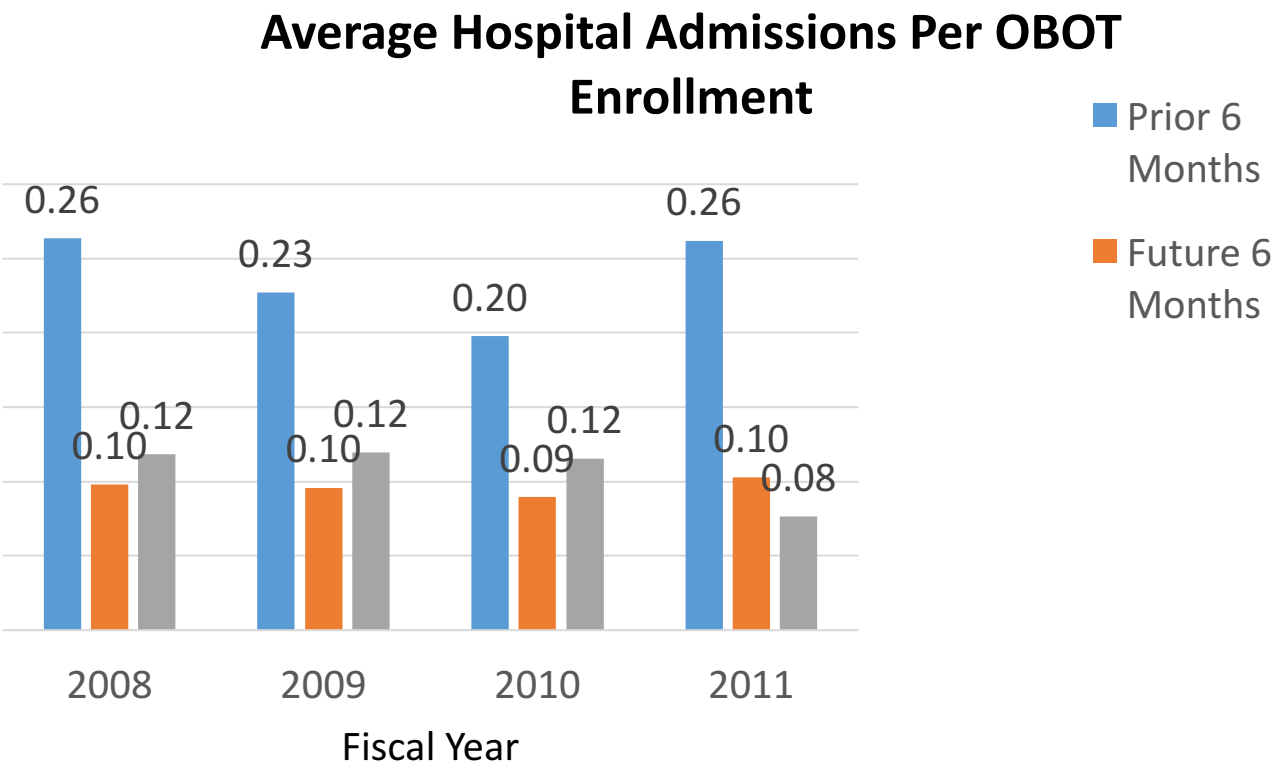
Hospital Admissions



Notes:

- *Hospital data is only available through 9/30/2012*
- *Enrollments must have lasted at least 12 months*
- *Paid amounts are calculated using hospital specific pay to charge ratios*

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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 physician assessments
  - Nurse does initial intake visit and collects data
  - Physician: 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

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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 physicians
- 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

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

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OBOT RN Induction Preparation:

Review the requirements program:

Nurse/ Physician Appointments:
frequency, times, location
Counseling:
weekly initially
UDT:
at visits, call backs
Abstinence:
from opioids is the goal
Insurance verification:
prior authorizations, co-pays
Safety:
medication storage (bank bag)

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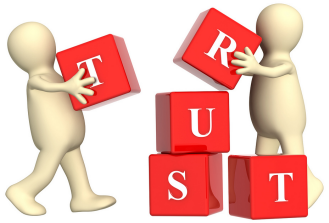
OBOT RN, Prescriber Planning for Induction:

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

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OBOT RN
Patient instructions during first dose:

Put tablet(s)/film under tongue: sublingual

Don't talk, don't swallow: saliva pools

May use mirror, watch the tablet(s) gradually shrink as they dissolve

May drink before and after not during

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OBOT RNs
Initial dose buprenorphine

COWs >8-12

Objective signs are key to making dx

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
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

OBOT RN/Prescriber Prescriptions

Early On:

- Small prescriptions 1 week with refills
- Increase as patient stabilizes (UDT)
- 2 week prescriptions with refills

At point of stabilization:

- Monthly visits
- Monthly prescriptions with refills

Keep file of pharmacy contact info

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OBOT Team Monitoring

UDT

Pill counts

Pharmacy Check-in

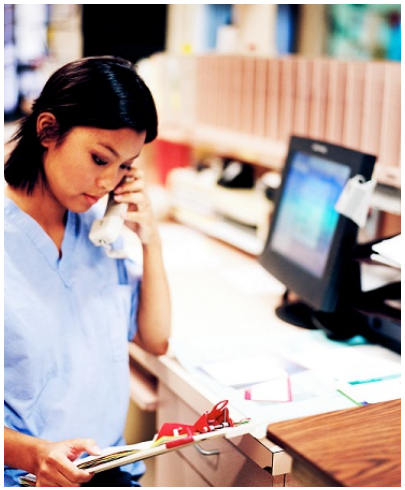
Observed Dosing

Random call backs

Scheduled visits

Counseling check in

Check in with support/family/parent/partner



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Recognizing and Responding to Red Flags

Red Flags

- Missed appointments
- Requests early refills of buprenorphine or other meds with abuse potential
- Decreased social functioning
- Arriving impaired or inappropriate behavior
- Tampered urine screens
- Unable to void, or demanding to void immediately
- Calls or reports that the patient is “selling” medication
- Emergency room visits, hospitalizations

Response to Red Flags

- Address Behavior with Patient: **Quickly**
  - Discuss with patient ASAP
  - Verbalize your concerns
  - Be supportive
- Establish new intensified treatment plan
  - Patient specific: achievable in your setting
  - Signed agreements
  - Involve patient in the process

Revision of Treatment Plan May Include:

- ✓ More frequent visits
- ✓ Shortened prescriptions, without refills
- ✓ Referral to IOP
- ✓ Team engagement with counselor
- ✓ Relapse Prevention Groups or Individual Therapy
- ✓ Psychiatric Evaluation
- ✓ Residential Treatment

Referral to a Higher Level of Care Includes:

- ✓Detoxification/TSS/CSS
- ✓Residential treatment
- ✓Methadone maintenance
- ✓Directly observed buprenorphine/naloxone daily dosing in OTP
- ✓Section 35
- ✓Dual Diagnosis

Maintenance

- Visits every 2-4 weeks, refills coincide with visits
- Goal: monthly or “random” visits
  - Random is more effective in assisting patients in their recovery
- May be stable with more frequent visits

ASAM (2013)

Maintenance

- Expect stability and improved social functioning
- Expect improvement in substance use/misuse
- Early outcomes improve with counseling
- Relapse may still occur
- If unable to move on to maintenance phase of treatment due to continued use: evaluate progress in treatment, potential need for dose change, increased supports, adding structure, alternative treatment setting

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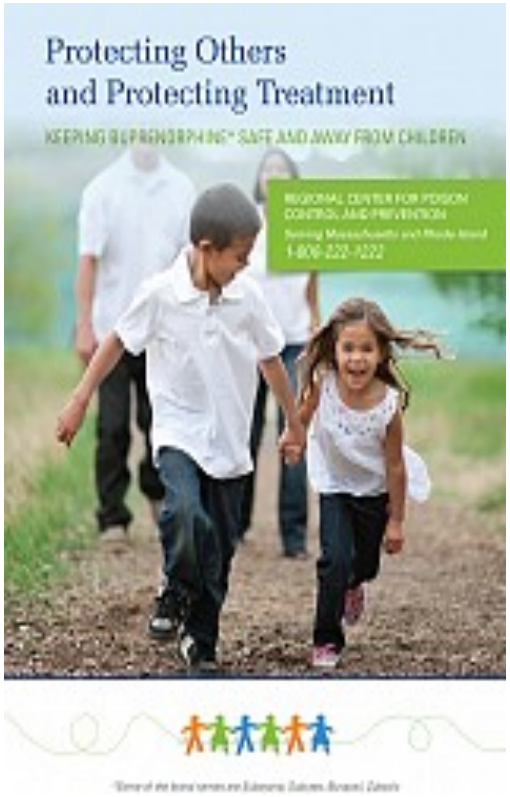
Proper Storage and Handling

- Avoid pediatric exposure
  - Store the medication "out of the sight and reach of children"
  - Keep the medication in the container it came in
  - Never leave tablets out of the container – even for a few minutes
  - Patients should obtain an extra prescription vial that is labeled properly if medication is to be stored in multiple locations
- Never share pills, even with the best of intentions
  - Sharing pills is diversion
  - The patient cannot guarantee the behavior of someone else
  - Provide the Poison Control Center phone number: 1- 800-222-1222

This brochure available for free at:
http://massclearinghouse.ehs.state.ma.us/ALCH/SA1064kit.html



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Handling Resistance to Self Help

- Reframe as response to needs (i.e. feedback, education)
  - Reinforce areas in which patient is doing well, but express concern relapse risks
- Encourage patient to try different meetings
- Use AA/NA slogans to emphasize its practical wisdom
  - "First things first"
  - "Take what you need and leave the rest"
- Emphasize most important goals in AA/NA
  - "Not using and simply attending meetings"

Outcomes

Patient-level outcomes comparable to physician-centered approaches

Allows efficient use of physician time to focus on patient management (e.g., dose adjustments, maintenance vs. taper)

Allowed physicians 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.

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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

Can nurses be a secret weapon against opioid addiction?

by Christine Vestal at the Pew Charitable Trusts

THE ASPEN INSTITUTE

FIVE BEST IDEAS *of the* DAY

Nurses Step In to Boost Treatment for Opioid Addiction

August 31, 2016 | By Christine Vestal

SHARE

e opioid addiction
urse-managed

They already are!

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An evolving epidemic requires...

- ✓ Investment in proven models of care and a workforce to implement them
- ✓ Flexibility
  - Responsive to current and changing needs
  - Change Agents
- ✓ Innovation

Nurses will continue to play key role in addressing the current epidemic of addiction and overdose deaths.

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Facilitators of Engaging RNs, NPs, PAs into Treatment of Patients with SUD/OUD

- Increased public awareness about the opioid epidemic and treatment need
- Increase awareness about costs associated with inadequate treatment
- The collaborative approach is cost effective and sustainable in some states in the FQHC model (CMS Modeling)
- Collaborative approach proven to expand access to care in significant numbers quickly
  - Boots on the Ground…

Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings

Technical Briefs, No. 28

Agency for Healthcare Research and Quality

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National Drug Abuse Treatment Clinical Trials Network

- Design: The Primary Care OUD trial is a cluster-randomized tri

(MA) model of collaborative care to “Usual Primary Care”

- AIM 1: To describe the current state of health care for persons with OUDs in primary care.

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Discussion and Questions

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