Team Roles for Supporting Patients Experiencing Substance Use and Opioid Use Dependence and Disorder
Kristin Wason, MSN, AGPCNP, CARN
Boston Medical Center,
Boston University School of Medicine

_Incorporating promising practices in SUD treatment in advanced patient centered medical homes_

January 14, 2019
• I have no personal or financial conflicts to report.

• I am supported by grant funding through BSAS, The GE Foundation, Boston Medical Center’s Grayken Center and NIDA

Funding support provided by Massachusetts Department of Public Health, Bureau of Addiction Services and the GE Foundation
AGENDA

• Background: Brief Epidemiology, Laws/regulations, Identified Barriers
• Overview of the Nurse Care Manager Model of Office Based Addiction Treatment (OBAT)
• Expansion to Community Health Centers Across Massachusetts
Drug Overdose Deaths 1999-2017

Drug Overdose Deaths
1999 - 2017 (2017 numbers projected)

Source: CDC WONDER/NVSS
**Drug Addiction Treatment Act (DATA 2000)**

Permitted physicians who met certain qualifications to treat opioid addiction with:

- Schedule III, IV, and V narcotic medications that had been specifically approved by the FDA for that indication

- In treatment settings other than the traditional Opioid Treatment Program ("methadone clinic") settings

Buprenorphine FDA approved to treat OUD in 2002
DATA 2000 – PRACTITIONERS REQUIREMENTS

- Licensed provider with DEA Registration
- Subspecialty training in addictions or completion of an 8-hour course
- Registration with SAMHSA and DEA
- Must affirm the capacity to refer patients for appropriate counseling and ancillary services
- Must adhere to patient panel size limits
  - 30 during the first year
  - 100 during the second year
  - 275 during the third year (in qualified practice setting)
- 2016/2017 CARA legislation passed permitting NP/PAs prescriptive authority to prescribe buprenorphine
  - Requires a total of 24hrs of addiction training for waiver
WAIVERED BUPRENORPHINE PRESCRIBERS: 2018

Total: 58163

- 275 Patient Certified (7.8%)
- 30 Patient Certified (72.7%)
- 100 Patient Certified (19.4%)

MDs: 43,850
NPs: 6,656
PAs: 1,774
(as of Aug 2018)

(SAMSHA, 1/2019)
Barriers to Prescribing Buprenorphine in Office-Based Settings

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

- Insufficient Nursing Support: 20%
- Insufficient Office Support: 19%
- Payment Issues: 17%
- Insufficient Institutional Support: 16%
- Insufficient Staff Knowledge: 12%
- Pharmacy Issues: 8%
- Low Demand: 7%
- Office Staff Stigma: 5%
- Insufficient Physician Knowledge: 3%

55% of waivered providers reported one or more barriers

Nurse Care Manager Model
• Evidence-based model of care to treat substance use disorders
• Addiction trained and specialty licensed providers treating substance use disorders within an office based setting with the help of a “glue person”
• Patient-centered, utilizing medication for addiction treatment
  • Buprenorphine and/or naltrexone formulations
• Collaborative Care / Nurse Care Manager Model developed at Boston Medical Center
  • Nurse care managers (NCMs) work with providers to deliver outpatient addiction treatment with buprenorphine and naltrexone
  • NCM is the primary point of contact for the patient throughout treatment
• More recently dubbed the “Massachusetts Model”
NURSE CARE MANAGER REQUIREMENTS

• Registered Nurse (RN), licensed to practice nursing in the state where they are practicing

• Bachelor of Science in Nursing (BSN) and Certified Addictions Registered Nurse (CARN) recommended

• Complete an initial training curriculum covering OBAT with buprenorphine and naltrexone

Link to exam information:
http://www.cnetnurse.com/certified-addictions-registered-nurse/
Nurse Care Managers increase patient access to treatment and retention in care

- Allows MDs (now NPs and PAs) to better manage complex patients
- NCM role includes:
  - Medical Case management
  - Brief counseling/MI, social support, patient navigation
- NCMs working at full scope of license:
  - Provided Substance Use Disorder treatment oversight
  - Address Urine toxicology
  - Assist with Insurance issues, prescription/pharmacy issues
  - Pregnancy, acute pain, surgery, medical needs
  - Concrete service support: legal/ social/ safety/housing
  - Emergency Contact: Direct Connection to NCM

NUTS AND BOLTS NCM MODEL OF OBAT

- Patient referred to OBAT program
- Initial screening with medical assistant or OBAT nurse
  - Team reviews “screener” for appropriateness
- Nurse: Intake with education, labs, treatment agreements, consent forms
- Provider: Physical Exam, confirms DSM V Opioid Use Disorder and appropriateness for treatment in OBAT setting
- Nurse: oversees medication initiation and titration
- Nurse: follow-up visits: weekly, biweekly, monthly
- Provider visits every 4 months or sooner as needed
NCM FOLLOW UP VISITS

• Assess and address recent substance use
• Assess medication dose, adherence, cravings, withdrawal.
• Provide ongoing education: medication administration, side effects, interactions, support.
• Assess counseling, self help check in
• Arrange for psychiatric evaluation with follow up as needed.
• Medical issues: HIV, HCV, routine health maintenance, acute needs.
• Family Planning.
• Social supports: housing, employment, family, friends.
• Toxicology Screening
• Labs as clinically indicated
• Support the recovery process and build trust
Recovery means to be honest, treat myself and others the right way, and to live myself.

This place here is my oxygen tank.

Clean life is way better 12 yrs.

My children thank the nurses & MD’s for seeing to it that their mom stay healthy & Drug free!!!

-God Bless!!

You don’t have to be alone any more.
Cohort study of patients treated for opioid use disorder with collaborative care between nurse care managers and generalist physicians in an urban academic primary care practice.

From September 1, 2003, through September 30, 2008, 408 patients with opioid addiction were treated with buprenorphine.

Examined patient characteristics, 12-month treatment success (ie, retention or successful taper after 6 months), and toxicology screens.
Of patients remaining in treatment at 12 months, 154 of 169 (91.1%) were no longer using illicit opioids or cocaine based on urine drug test results.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Patients, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful treatment</td>
<td>196 (51.3)</td>
</tr>
<tr>
<td>Treatment retention</td>
<td>187 (49.0)</td>
</tr>
<tr>
<td>Successful taper after 6 months of adherence</td>
<td>9 (2.4)</td>
</tr>
<tr>
<td>Unsuccessful treatment</td>
<td></td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>113 (29.6)</td>
</tr>
<tr>
<td>Nonadherence despite enhanced treatment</td>
<td>46 (12.0)</td>
</tr>
<tr>
<td>Administrative discharge due to disruptive behavior</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Adverse effects of buprenorphine hydrochloride</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Transfer to methadone hydrochloride treatment program</td>
<td>24 (6.3)</td>
</tr>
</tbody>
</table>

EXPANSION OF THE MASSACHUSETTS MODEL OF NURSE CARE MANAGEMENT
In 2007 State Technical Assistance Treatment Expansion (STATE) OBAT Program created to expand BMC model to 14 CHCs across MA

**ACCESS**

Expand treatment & access to buprenorphine

- Increase number of waivered providers
- 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
First 5 years of STATE OBAT outcomes:

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

MODEL EXPANSION INTO STATEWIDE CHCs

# CHCs funded by MA DPH to Implement BMC OBAT Model

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>14</td>
<td>14</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>18</td>
<td>25</td>
<td>34</td>
<td>34</td>
<td></td>
</tr>
</tbody>
</table>

Cumulative No. of Patients Treated by Year at MA DPH Funded Sites

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Treated</td>
<td>178</td>
<td>1,252</td>
<td>2,175</td>
<td>3,030</td>
<td>4,091</td>
<td>5,160</td>
<td>5,896</td>
<td>6,762</td>
<td>7,831</td>
<td>9,727</td>
<td>12,487</td>
<td>16,573</td>
</tr>
</tbody>
</table>

Source: Boston Medical Center, OBAT TTA Program data
RESULTS: IN TREATMENT > 12 MONTHS JULY 2016 – JUNE 2017 (N=3,309)

Time retained in treatment at MA DPH funded OBAT Sites

- Retained in care ≤12 months: 44.8%
- Retained in care >12 months: 55.2%

Source: MA Department of Public Health, Bureau of Substance Addiction Services
Urine Toxicology Outcomes for MA OBAT Sites

<table>
<thead>
<tr>
<th>Substance</th>
<th>In Treatment ≤ 12 mos.</th>
<th>In Treatment &gt;12 mos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit opioids (any past 3 mos.)</td>
<td>25.2%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Cocaine (any past 3 mos.)</td>
<td>15.2%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Benzodiazepines (any past 3 mos.)</td>
<td>23.0%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

P<.01
HEALTH CARE UTILIZATION OUTCOMES MA OBAT SITES

JUL 1 2016 – JUN 30, 2017 (N=3,309)

% of patients in STATE OBAT Program

- 1+ night detox: 6.2%
- 1+ night inpatient hospital: 6.7%
- 1+ ED: 20.5%
- Inpatient hospital: 12.7%

Retention in OBAT

Detox, inpatient, ED admissions

In treatment <= 12 mos.
In treatment > 12 mos.
WE HAVE SHOWN SUCCESS SCALING IN MASSACHUSETTS AND ARE NOW SHARING OUR LEARNINGS NATIONALLY

NIDA CTN-0074: Primary Care Opioid Use Disorders Treatment (PROUD) Trial
- Testing BMC Nurse Care Manager Model against standard of care in 6 health systems nationwide in ~10,000 patients
NMC Model of OBAT Expansion Details
Overview of BMC’s OBAT Technical Training and Assistance (OBAT TTA) Program

- Statewide Live Trainings
- OBAT TTA Website
- National and State-specific Guidelines for NCM OBAT model
- Addiction provider list server
- Addiction Treatment ECHOs
- Addiction Hotline
- On-site technical assistance provided by expert consultant
Support for CHCs Implementing NCM OBAT Model

Trainees

Prescribers

Statewide and Local Waiver Trainings

Advanced topics in addiction practice

Trainings Certified Addiction Nurse Exam

Full-day training on NCM model

Ongoing support and capacity building

On-site TA by expert consultant

OBAT TTA Website and Resources

Addiction list server

Publicly Available Clinical Guidelines and tools for NCM OBAT Model

Addiction-focused Tele-ECHO™ Clinics

Certified Addiction Nurse Exam

Statewide Trainings on Addiction Topics

Other Care Team Members

Nurse Care Managers

Full-day training on NCM model

Trainings Certified Addiction Nurse Exam

Statewide Trainings on Addiction Topics

On-site TA by expert consultant

OBAT TTA Website and Resources

Addiction list server

Publicly Available Clinical Guidelines and tools for NCM OBAT Model

Addiction-focused Tele-ECHO™ Clinics
LEVERAGING TECHNOLOGY: OBAT TTA WEBSITE AND RESOURCES

Between Apr 2017 and Apr 2018..

• 9,222 unique individuals have visited OBAT TTA website (bmcobat.org)
  • 16,293 total sessions
  • 74,012 total page views
• OBAT TTA website visitors from:
  • 58 countries
  • 49/50 of States
  • 222 unique municipalities across Massachusetts
REACH OF BMC OBAT TTA Team

APR 2017 – APR 2018

- Trained over 1,400 individuals at 36 state-wide trainings
  - 13 buprenorphine waiver trainings
  - 7 CARN Review Courses
  - 5 Essentials of OBAT Trainings
  - 4 Advanced Topics in Buprenorphine Practice and Beyond
  - 3 Addiction 101 Trainings
  - 2 trainings for Early Intervention providers
  - 1 Buprenorphine implant training
  - 1 statewide conference
- Provided >140 hours of on site technical assistance to >50 community OBAT sites
Leveraging Technology: Addiction ECHO® (Extension for Community Healthcare Outcomes) Hubs at BMC

- Using teleconferencing technology, providers connect to other learners and expert Hub teams
- Hub and spoke model increases access to specialty care

✓ Community providers learn from specialists
✓ Community providers learn from each other
✓ Specialists learn from community providers as best practices emerge

- Two main components of all teleECHO® clinic:
  1. Brief didactic presentation
  2. Case-based learning (pt. case by spoke participant)
Reach of BMC’s Addiction ECHO Hubs

National Opioid Addiction Treatment ECHO

- 105 participants
- Representing 40 CHCs
- From 17 states

Mass Office Based Addiction Treatment (OBAT) ECHO

- 61 participants
- Representing 29 sites
- From 21 MA towns/cities

A national collaboration between the ECHO Institute, HRSA, the American Society of Addiction Medicine (ASAM), and 5 expert addiction hubs

OBAT ECHO is for Mass cites implementing office based addiction treatment, funded by Opioid STR
The Boston Globe
Salute to Nurses
CONCLUSIONS

• BMC’s NCM OBAT model has been proven to be an efficient and effective utilization of DATA 2000 waivered prescribers
  • Improves patient access to lifesaving medical care
  • Sustainable reimbursement model as providers are able to carry caseload of highly complex patients with SUD and co-morbidities
• Model continues to show scalability, patient engagement, and improved health outcomes
  • Patients served in CHCs increased 9,312 % in a 10 year period
  • Over half of patients engaged in care >12 months
  • Patients in treatment >12 mos had lower health care utilization and fewer toxicology screens positive for illicit substances
RESOURCES

• ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, ASAM

• Informational Bulletin: Medication Assisted Treatment for Substance Use Disorders, Centers for Medicaid and CHIP Services

• Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings, AHRQ
WELLNESS COACH
INTEGRATED BEHAVIORAL HEALTH
A HOLISTIC APPROACH TO PATIENT-CENTERED CARE
History of Behavioral Health Program Development at La Clinica

- 2009 Student Nurse project proposal: Integrated Behavioral Health at La Clinica is born we start with 1 clinic.
- Expansion of IBH 2010 - 2013 placement of IBH in 4 clinics
- 2013 - 2016 Placement of IBH - Coaches in 8 clinics including dental & Mobile Clinics.
- 2017 - Changed title from IBH to Wellness Coach
- 2018 - Mindfulness trained Coach located in the elementary schools.
- 2018 - Began a more formal Coach training to develop core competencies.
Wellness Coach Definition and Profile

- **Coach Definition** - Wellness coaching is a process that facilitates healthy, sustainable behavior change by encouraging patients to develop their inner wisdom, identify their values, and transform their goals into action. Always patient centered.

- **Coach Profile** - AA/BA/BS, 3+ years experience in social service sector. Current: 11 coaches. 8 have BA/BS, 1 has MS, 2 have CADC, 1 CPS, 3 are bilingual/bicultural. All have a minimum of 5 years experience in some social service area - domestic violence, Headstart, addictions, Trauma Informed Care specialist, Child Welfare, Chaplaincy, etc.

- **Most Important Attribute**: Flexibility, curiosity and ability to problem solve, deep love for this patient population, accountable communication beliefs. Skills can be taught but values and beliefs tend to be steady.
Payment and Documentation

- Payment structure: PMPM, Grants, APCM.
- Documentation: Enabling Services - Interim Note with a SOAP format, Care Step (touch).
- Coaches average 8–11 Care Steps (touches) per day. (1600–2500 touches per year)
- Warm handoff, schedule back for follow up, group & phone support.
- Resource experts
- Coaches work 4–10 hour days.
- 1–2 Coach’s + 1 mental health therapist per clinic
- Who can the coaches see? EVERYONE
- Unintended consequences: APCM. Our Coaches have years of experience created care steps and documenting their connection with patients - perfect for alternative payment structures.
- Provider satisfaction - 98% of our providers report that they would not want to manage their practice without the coaches. “They take a burden off my shoulders, and provide a significant value to the patients”.
- Patient satisfaction reports.
Coaches Manage

- Community Resource Experts
- Controlled Substance Program (MAT/pain/anxiety/ADHD)
  - Orientation Groups
  - Case Management
- Individual Support to Patients at Time of Medical/Dental Appointments
  - SBIRT
  - Case Management of patients waiting to get into community supports - MH and Addiction
- Wellness Group (Psycho-educational)
  - MAT
  - WRAP
  - Pain Management
  - Diabetes Management
  - Mindfulness - anxiety/depression
  - Postpartum Depression
  - Living Well with Chronic Illness - English/Spanish
  - Wellness: gardening, water aerobics, walking groups, cooking classes
  - Drop in Art group with an urgent care option
- End of Life - Advanced Directive Planning
Addiction
Levels of Care/Support
Wellness Offerings

Who Facilitates?
WC - Wellness Coaches
PCP - Primary Care
IBC - Behavioral Clinicians

Levels of care act like an elevator - moving up or down based on patient needs

Level 1
Patient attends 1 Wellness Event per Month (example: Relapse Prevention, or Aftercare Therapy Group)
• WRAP - Wellness Recovery Action Plan Group (relapse prevention specific) WC
• Bup Groups: Provider/Wellness Coach lead PCP & WC
• Therapy Groups (Lead by Behavioral Health Clinicians) IBC
• Wellness offerings WC, IBC

Level 2
Patient Attends one Wellness Event per Week
• WRAP WC
• Therapy Group IBC
• Mindfulness WC
• Acupuncture Pain Management
• Zumba/Yoga
• Cooking PCP & WC

Level 3
Patient Attends 2 - 3 Wellness Events per Week
• Therapy Group (Quality of Life, General Therapy) PCP & WC, IBC
• WRAP WC
• Bup Group PCP & WC
• Mindfulness WC
• Zumba/Yoga
• Cooking PCP & WC
• Acupuncture Pain Management
WHAT PEERS DO

Living the Experience and Giving Back
Peer Support Specialist for Chronic Pain
Educate* Support *Hope
Why Peers in Primary Care

- Meeting Patients where they are - living with pain comes with lots of restrictions, effort, cost, energy

- Taking the burden off the already stressed system
  - Primary care is not built for Chronic illness
  - Chronic pain is medically treated, when it is best managed with behavioral health interventions and strong supports.
  - Cost effective, pros and cons – Insurance has not caught up, but fewer patient visits and higher patient satisfaction scores.
Teacher/ Mentor/ Coach

- Clients the example how life can be lived in a different way
  - Motivational interviewing
    - Finding out what are the needs and meeting them when they are.
      - Example – Veteran
  - Life experience- lessons, falls and gathering it all back together
  - Being a stable, positive influence with boundaries
Tapering and Withdrawal Coach

- Lived experience
- Patients and providers caught in the cross hairs
- Lost in Translation and explanation
  - Who, what when where and why
- Tips and Tricks- maybe some fun too.
- Caring and Giving – compassion
- Success and moving forward.
Advocate

- The landscape of living with a chronic illness
- No road maps or how to’s
- Prepping for appointments and difficult conversations
- Unanswered questions
- How can you get the answer if you don’t know what the question is - What are the questions that I should be asking?
Bridging the Gap

- The provider/patient communication break down
- Giving a provider a different understanding of their patients
- Patients feeling heard and understood.
Resource Purveyor

- Gathering resources from the community and a customer service provider
  - Housing
  - Jobs
  - Medical resources
  - Mental Health resources
  - Disability and Senior services
  - Warm handoffs
  - The power of “I don’t know but I will find out”
Resources for Chronic Pain Patients

Oregon Pain Guidance
www.oregonpainguidance.com

Stay Safe Oregon
www.Staysafeoregon.com

American Chronic Pain Association
www.ACPA.com
Resources

- Resources resources, resources, even in rural areas there are good resources i.e. living well

- [https://www.oregon.gov/oha/PH/DiseasesConditions/ChronicDisease/LivingWell/Pages/lwworkshops.aspx](https://www.oregon.gov/oha/PH/DiseasesConditions/ChronicDisease/LivingWell/Pages/lwworkshops.aspx)

- [https://www.retrainpain.org/](https://www.retrainpain.org/) great info and convo starter for taper

- [https://www.theacpa.org/](https://www.theacpa.org/) this is about patients not politics

- Beth Darnell’s book - easy to understand

- [https://www.bullpub.com/catalog/The-Opioid-Free-Pain-Relief-Kit](https://www.bullpub.com/catalog/The-Opioid-Free-Pain-Relief-Kit)