Session # C3a

Interprofessional Buprenorphine Team

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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

1) Understand the current regulations for buprenorphine management.

2) Describe importance of an interprofessional team in treating opioid use disorders.

3) Describe the value of incorporating MAT in the primary care setting.

Bibliography / Reference

Results from the 2016 National Survey on Drug Use and Health: summary of national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017. Available at: http://www.samhsa.gov/data.

Veilleux, J.C. et al. A review of opioid dependence treatment: Pharmacological and psychosocial interventions to treat opioid addiction. Clinical Psychology Review, 30 (2010) 155-166

Han B, Compton WM, Jones CM, Cai R. Nonmedical Prescription Opioid Use and Use Disorders Among Adults Aged 18 Through 64 Years in the United States, 2003-2013. *JAMA.* 2015;314(14):1468-1478. doi:10.1001/jama.2015.11859.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Questions to the Audience

- Is anyone currently waivered and prescribing buprenorphine?
- What are the barriers that you have encountered (or expect to encounter) with incorporation of OUD training into your primary care practice?

Our Interprofessional Team

Co-Directors: Holly Russell MD, Elizabeth Loomis MD, and Kristin Smith, DNP,

Coordinator: Melissa Jenks

Administrator: Ann Stoutenburg

Substance abuse counselor: Samantha Roll, LMHC, CASAC

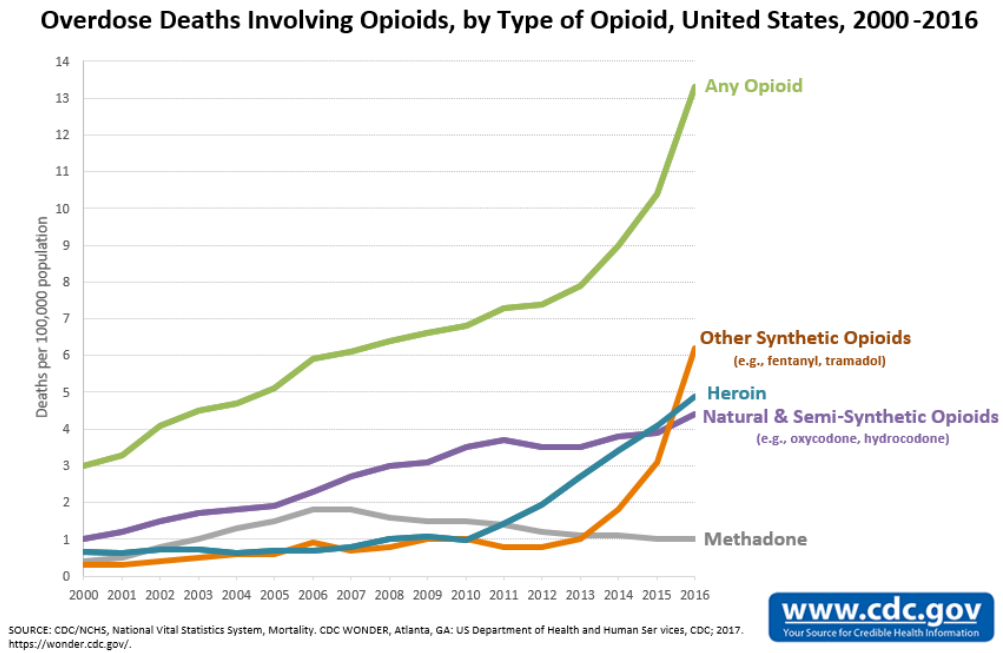
Consultant Trainers: Norm Wetterau, MD, Tim Wiegand, MD

Project Director: Thomas Campbell, MD

We would like to acknowledge Drs .Tom Campbell and Collen Fogarty, Jamie Bishop, Senior Program Administrator, and the entire administration and staff at Highland Family Medicine for supporting and encouraging this program.

Scope of the Problem

- In the United States there has been a nearly 200% increase in the rates of death from opioid overdose in the last 5 years
- In the area surrounding Rochester, NY there were over 150 heroin/fentanyl deaths in 2016
- There are waiting lists of up to 3 months at local practices providing MAT
- Less than half of the 2.2 million Americans who need treatment for opioid use disorder are receiving it
- Once patients are stable management of substance use disorders can and should be the realm of primary care
- A recent Council of Academic Family Medicine Educational Research Alliance study concluded few residencies include addiction in their curriculum



We may not have seen the worst of this epidemic yet:

Lethal doses of heroin compared to "synthetic" opioids.
New Hampshire State Police Forensic Lab

Morphine = 1 X
Fentanyl = 100 X
Carfentanil = 10,000 X

The role of medical education

- A recent study out of Massachusetts found that 91% of medical students strongly endorsed the importance of being able to treat SUD
- only 14% strongly agreed that their medical school had sufficiently trained them to treat patients with SUD.
- Having clinical training, faculty mentors specializing in addiction, or faculty frequently teaching about SUD significantly increased the likelihood that a student felt prepared to treat SUD.
- 37%strongly agreed that individuals with SUD were more difficult to treat than other patients
- 65% strongly agreed that SUD is a treatable illness.

Objectives:

- With the support of a HRSA supplemental grant we set out to develop a primary care team-based program to overcome barriers and increase access to treatment for patients with Opioid Use Disorder (OUD).
- This was to be accomplished by:
  1. Increasing the number of primary care clinicians able and willing to prescribe buprenorphine as part of their primary care practice
  2. Providing in-person CASAC consultation services to ease set-up/implementation of OUD in primary care
  3. Implement a requirement that all MD/DO and NP Residents completing training at Highland Family Medicine acquire the training needed to apply for their X waiver
  4. Create a community wide referral network to ease access to higher level of care

Common Barriers to Treatment of OUD in Primary Care

- Brainstorm possible barriers

Common Barriers to Treatment of OUD in Primary Care

- Gaining acceptance that this is a reasonable thing to do
- Worry about bringing “those patients” into our office
- How do we bill and code for it?
- If you have to get a special DEA waiver isn’t it a dangerous and highly specialized thing to try?
- What do we do if a patient relapses?

Emerging Themes from the CASAC Consultations

- Themes & Solutions
  - The Importance of customizing the consultation
    - What time is best to meet with the practice?
    - Who is the audience ?
    - In what area is the practice located?
    - How will prescribing look at this practice Barriers or misconceptions played a key role in resistance
  - Barriers or misconceptions across practices were similar
    - Stigma about addiction
    - Concerns with specialized DEA number and being fearful of being audited
    - Concerns with Use and Screening procedures
    - Concerns on how to implement in a different type of setting (i.e. rural areas with less resources)
    - Concerns with continued use (especially marijuana)

Overcoming Barriers to Treatment of OUD in Primary Care

Gaining Acceptance:

- Introducing and explaining PCP based care of OUD with buprenorphine at clinician training programs
- CASAC available to consult with office administration to go over impact to routine patient care as well as budget.
- CASAC available to consult with administrative and clinical support staff to explain the model and to help overcome any bias against treating patients with addiction.

Overcoming barriers

Workflow:

- Shared all of the work flow , paperwork and templates we developed and fine-tuned over the four years of our clinical program.
- CASAC available to consult with office managers to set up clinical work flow that would be appropriate for each individual office
- Reviewed setting up and maintaining a patient registry for possible DEA audit at clinical training program and clinicians available for consultation to help with this.
- Clinician to clinician support available via email, EHR, telephone
- Network developed for easy referral to higher level of care if patient becomes unstable

Methods/Outcomes

- 3 of us at our practice (2 MDs, 1 DNP) became ASAM approved trainers by studying with 2 local experts
- Our goal was to train 30 clinicians over the course of 3 trainings > *with overwhelming response from the community we trained 85 clinicians during those first 3 trainings then added a 4th training*
- CASAC provided in-person consultation at 6 different offices
- 13 physician residents completed their 8 hour training
- 5 NP residents have completed their 24 hour training (1 actively prescribing; 2 awaiting DEA X and to be assigned a panel of patients)
- In total 117 clinicians trained
- 45 Clinicians confirmed they received their waiver and 33 actively prescribing

Expanded Goals: Bridge Program

- Developed relationships with peer run programs in the community to provide direct access into a buprenorphine bridge program for interested individuals
- Developed an ED-bridge program: interprofessional team of clinicians have volunteered to take call responsibilities to bridge individuals who arrive to the ED with a non-fatal overdose and with to engage in buprenorphine assisted treatment while awaiting a higher level of care
- Eventual goal is to train ED clinicians to write for 3-5 day RX in order to bridge to outpatient appointment
- Internal clinicians have also taken advantage of the on-call system to offer immediate access to MAT for patients who present to outpatient clinic asking for help getting off opioids

Expanded Goals: Training

- In the upcoming year, will train 10 additional clinicians to become ASAM approved trainers
- Will conduct 8 more trainings across the community, including 2 in rural areas where access to care is of even greater challenge
- We will expand our training to other residency and fellowship programs including OB/GYN, Internal Medicine, and Geriatrics

Expanded Goals: Telemedicine

- Plan to offer telemedicine MAT to two rural sites where access to long term maintenance treatment is low
- This will help increase access to acute maintenance treatment as well if chronic stable patients can be taken care of in a primary care setting in person or via telemedicine
- CASAC role is critical in telemedicine as will be the in-person link to clinician providing the RX.

Conclusions

- Interprofessional teams increase access to OUD treatment
- The role of a CASAC is vital in the success in our program by providing office based support to newly waivered clinicians
- Curriculum changes in residencies which support and require clinicians in obtaining training in OUD and provide for protected time for waiver training completion, will assure a future of well-rounded clinicians ready to respond to the opioid overdose crisis

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

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