Session # D5a

# Improving Safe Opiate prescribing: Integrating a Certified Alcohol and Substance Abuse Counselor into a Family Medicine Residency Practice


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CFHA 20th Annual Conference
October 18-20, 2018 • Rochester, New York

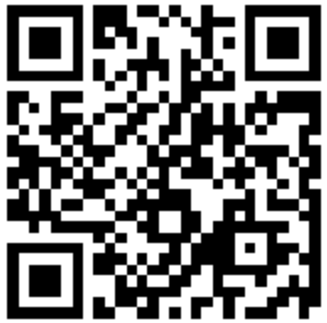

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

# 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. appreciate the impact addiction has on the patient populations we serve.
2. understand the training and abilities of a CASAC.
3. identify the ways in which a CASAC would be a useful partner in primary care.
4. explore the successes and opportunities for growth as well as the pitfalls encountered that have occurred with the Highland Family Medicine practice's integration of a CASAC into our practice.

# Bibliography / Reference

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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.

# Background

- In 2016, there were 42,249 opioid-overdose deaths in the United States
- 28% increase from the previous year
- According to the National Center for Health Statistics, life expectancy in the United States dropped in 2016 for the second consecutive year, partly because of an increase in deaths from unintentional injuries, including overdoses
- The first 2-year decline since the 1960s.

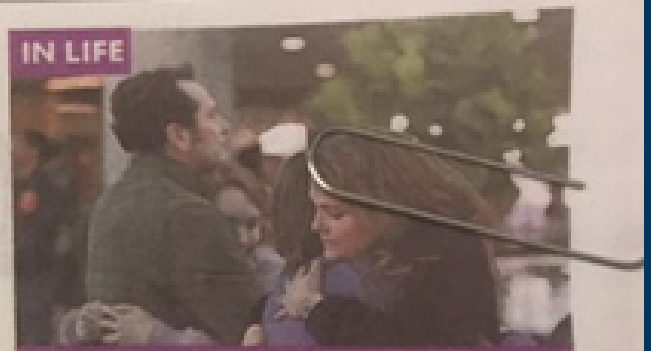
# Historical Perspective

- Increased emphasis on adequate analgesia over past 20 years
- The “fifth vital sign”: American Pain Society in 1995
- Pharmaceuticals eager to help us!
- In early 2000s, double number of sales reps (“pain management specialists”) for opioids
- Issued 7-day and 30-day “starter coupons” for OxyContin
- Sales of opioid analgesics to hospitals/pharmacies/practitioners ***quadrupled*** b/w 1999 and 2010 (Paulozzi, CDC)

# Scope of the Problem

- Americans consume an estimated 80% of the global supply of prescription opioids.
- From 1997 to 2007, average sales of opioid analgesics per person increased 402%.
- Opioid analgesics have become the most misused drug class in the United States—second only to marijuana among all illicit substances.

USA TODAY 03.16.16




PATRICK HARBRON, FX

# Doctors told not to prescribe opiates for chronic pain

## CDC says risks far outweigh benefits

z Szabo
A TODAY

The nation's top federal health ency urged doctors to avoid scribing powerful opiate pain- ers for patients with chronic n, saying the risks from such gs far outweigh the benefits most people.

he Centers for Disease Con- and Prevention in its first guidelines for dispensing the hine-like, addictive drugs, such as Vicodin and OxyContin, said it took the action Tuesday to combat the nation's deadly prescription painkiller epidemic.

The guidelines carve out an exception for patients receiving cancer treatment or end-of-life care. When doctors determine such drugs are necessary in other situations, the CDC advises doctors prescribe the lowest possible dose for the least amount of time.

About 40 Americans die each day from overdosing on prescription painkillers, according to the CDC. In 2013, an estimated 1.9 million people abused or were dependent on prescription opiates.

"We know of no other medication routinely used for a non-fatal condition that kills patients so frequently," said CDC director Thomas Frieden. "We hope to see fewer deaths from opiates."

EPA

**"We know of no other medication routinely used for a non-fatal condition that kills patients so frequently."**

CDC director **Thomas Frieden**

The CDC directed the guidelines to primary care physicians, who prescribe nearly half of opiates. Doctors aren't legally obligated to follow the guidelines, which are intended for adult patients, but such directives often have influence.

The CDC hopes the guidelines will help doctors determine when to begin or continue opiates for chronic pain, which type of painkiller to choose, how long to administer the drugs and how to weigh their risks. Andrew Kolodny, executive director of Physicians for Responsible Opioid Prescribing, called the recommendations a "game changer" that doctors are likely to follow.

"For the first time, the federal government is communicating clearly that the widespread practice of treating common pain conditions with long-term opioids is inappropriate," he said.

American Cancer Society Cancer Action Network President Chris Hansen criticized the m for disregarding the impor role of pain management for cer survivors. "Pain does no when an individual com treatment," he said.

# Background

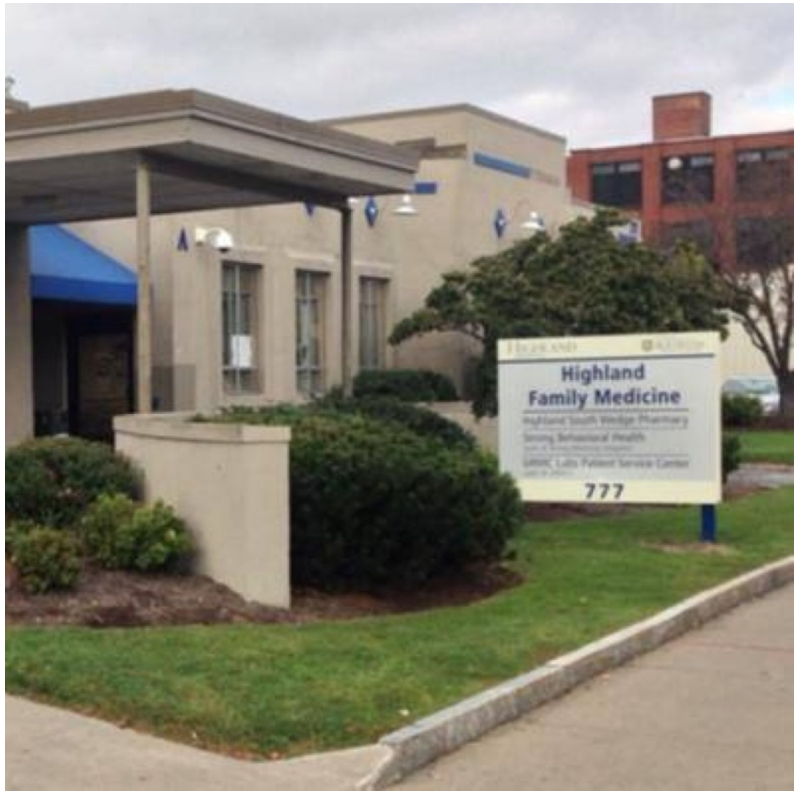
- With well-established medical treatment, opioid use disorder can have an excellent prognosis
- Decades of research have demonstrated the efficacy of medications such as methadone and buprenorphine in improving remission rates and reducing both medical complications and the likelihood of overdose death
- Unfortunately, treatment capacity is lacking: nearly 80% of Americans with opioid use disorder don’t receive treatment

# Role of Primary Care

- The Drug Addiction Treatment Act of 2000 granted a waiver to physicians with certain training to prescribe and administer medications such as buprenorphine for the treatment of addiction or detoxification.
- Since that time, the number of clinicians providing addiction treatment has steadily grown with the fastest growth in primary care
- Once patients are stable management of substance use disorders can and should be the realm of primary care physicians
- Primary care clinicians are struggling with how to manage chronic pain without opioids and how to manage patients who have been on high doses of opioids

# Highland Family Medicine- The Incubator for Integration

- Community-based health center located on S. Clinton Ave, serving a diverse patient population (approx 45% MCD, 10% MCR (and 7% dually enrolled)).
- 22,000 patients served across 7 clinical care teams, each consisting of attending and resident Family Physicians, nurse practitioners and NP residents, care managers, RNs, LPNs, medical assistants, front end secretaries.



# Highland Family Medicine- The Incubator for Integration

- Decades-long history of integration of behavioral health and primary care, as well as interprofessional education and clinical practice along the way.
- Onsite BH presence: approx 4FTE psychotherapist (including MFT and psychology trainees), consulting psychiatrist, depression care management, with social work support.

# How to respond to CDC guidelines?

- The practice developed and convened a an interdisciplinary controlled substances safety committee to develop policies and guidelines.

Members included:

- Associate Medical Director/Chief Quality Officer
- Medical Director
- Behavioral Health
- Suite Leaders (physicians and NPs)
- Clinical Pharmacist
- MD/DO/NP Residents while on psychosocial rotation (all expected to review a case)

# Controlled Substance Safety Committee

- Monthly meetings focusing on controlled substance policy, data review, peer audits, guidance on documentation, tapering, and/or referral suggestions all with multidisciplinary input
- Creation of eRecord smartphrases, letter templates, and documentation standards
- Updated controlled medications agreement
- Generation of data of controlled medications prescribing including MME's
- Policy to write prescription for Narcan for all patients receiveing 90 or > MME
- Coordination with pharmacist/pharmacy on Narcan training, drug disposal, conversion tools
- Guidelines for CASAC consultation for patients receiveing 90 or > MME daily

# CASAC training and abilities

- Credentialed Alcoholism and Substance Abuse Counselor
- Credentialed by New York State/QHP
- Education/Training
  - 350 clock hours in a training program accredited college/university or an OASAS certified education/training program
- Evaluation of Competency and Ethical Conduct
  - Need 3 individuals who have direct knowledge of work experience
- Work experience
  - 6,000 hours of supervised experience in an OASAS licensed program

# CASAC training and abilities

- SUD and COD Screening
- Intake
- Orientation
- Assessment
- Diagnostic Impression
- LOC as determined by LOCADTR
- Treatment Planning
- Individual & Group Counseling
- Family Counseling
- Psycho-education
- Case Management
- Crisis Intervention
- Client Education
- Referral
- Reporting & Recordkeeping
- Care Coordination

# The Next Level of Integration- Substance Use Services

- Early initial discussions between HFM Department Chair and Strong Recovery Director at DSRIP BH PC project meeting
- Mutual interest from which they explored multiple possible options for integrating CD services at HFM over several months
- Breakthrough was when OASAS added In-Community Services in their State Plan Amendment (SPA) and it was approved by CMS effective 7/2016. This allowed CD clinics to provide offsite services in non-OASAS licensed settings.
- HFM and Strong Recovery agreed on a plan to place a Sr. CDC at HFM, supported by Psychiatry Department Leadership and approved by SMH Executives

# The Case for CASAC Integration

- Perfect complement to our existing behavioral health service, and a MUCH needed augmentation to our existing efforts.
- While we already had partnership with University-based SUD treatment center for referrals, our patients demonstrate significant difficulty with follow up for many offsite services.
- Opportunities for expanding our integrative/collaborative framework to more routinely address comorbid SUD.

# Impact of Integrating CASAC

- 11/2016 to 10/2017: 267 referrals, 154 seen
- April 2018; 124 referrals, 24 seen for evaluation by CASAC
- July 2018:  117 referrals, 40 seen for evaluation
- 53 were identified as meeting criteria for a substance use disorder and were referred to treatment

# Impact of Committee

| | Patients on >90 MME | CASAC Appt | % seen | |
|---|---|---|---|---|
| MD/DO Faculty April 2018 | 92 | 21 | 23% | |
| MD/DO Faculty July 2018 | 85 | 23 | 27% | |
| NPs April 2018 | 9 | 4 | 44% | |
| Nps July 2018 | 5 | 5 | 100% | |

# Highland Family Medicine OUD Treatment Model

- Started prescribing buprenorphine routinely March 2014
- Originally two, now 13 waivered clinicians
- 1 -> 3 sessions/week, 6 clinicians doing carve out and 7 integrating into routine primary care
- Have seen close to 180 patients total, have about 110 active patients
- Phase 1;  only HFM patients on stable doses from other providers
- Phase 1b; HFM patients needing inductions
- Phase 2; Outside referrals on stable doses from other clinicians or programs

# HFM Integration of CASAC

- On site evaluation and linkage to care for patients with substance use disorders
- Discuss appropriate levels of treatment and make referrals
- Can meet with pt's up to 3 times to assess motivation and encourage readiness for change
- Assessing patients on high doses of prescribed opioids or the combo of opioids/benzos-looking to rule out misuse/abuse
- Available to consult with providers
- Training patients and family members in Naloxone use

# HFM Integration of CASAC

- Involvement in OUD treatment program
  - New intakes-assessing appropriateness for community based buprenorphine
  - Assessing patients who have relapsed
  - Linking to higher levels of care
  - Leading group visits
  - *Buprenorphine ED bridge program; seeing and evaluating quickly patients who have been started on buprenorphine in ED after non-fatal overdose or withdrawal*

# Opportunities for Growth

- More frequent Naloxone Training
- More involvement in team meetings
- Improved access to medication assisted therapies (naltrexone, methadone, buprenorphine, acamprosate, NRT,)
- Increased group services
- Consulting with other PCP offices to help start and support buprenorphine prescribing

# Financial Considerations

- Current billing structure
  - Fee for service- has some limitations for insurances that won't cover
  - Impact on group visits- cannot exclude certain pts
  - Does not capture services provided on pt's behalf that are not face to face
  - (ex. Consults, time in team meetings)
- Future Billing
  - Values Based Outcomes
  - Ability to provide services in evidenced based ways (ex. Groups)
  - Increasing provider's knowledge and awareness of substance use disorders/treatment will improve patients outcomes

# Acknowledgements


- Kate McKenna- FTS @ HFM OAS Extraordinaire
- The Clinical Support Staff at Strong Recovery
- The Highland Family Medicine practice

# Session Evaluation

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

Thank you!

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