The Case of Betty
Buprenorphine Treatment in a Nurse Care Management Model

May 2018 VIP Chat

May 23, 2018

Noon-12:30

Adam Gordon, Discussant

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A VISN 19 – VA SLC Initiative

The discussant has no conflict of interests to disclose

Vulnerable Veteran – Innovative PACT (VIP) & VIP Chats

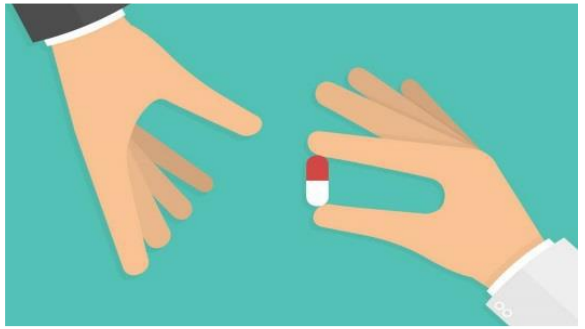
- **VIP Goal:**
  - The VISN 19 VIP (Vulnerable Veteran – Innovative PACT) Initiative's over-arching goal is to **improve the health of veterans who are particularly vulnerable due to medical disease and/or their social determinants in primary care environments**
  - Veterans served by this Initiative include those with unhealthy alcohol and drug use, co-occurring pain and/or addiction disorders, social determinants of health including homelessness, and those who frequently use health care services
- **VIP "Chat" Goal:**
  - **To provide education, mentorship, and foster a learning collaborative to improve the knowledge and skills of health care providers in VISN 19**
- The chats are generally scheduled for the **4th Wednesday of each month**
- All health care providers are welcome to join! – FUN!
- Please note this presentation is recorded
  - VIP sharepoint site: tinyurl.com/ycuh48bh

AGENDA

- Introduction and Case (10 minutes)
- “Bite Sized Teach” (BST or “Beast Mode”) (10 minutes)
- Discussion (10 minutes)
  - Extended discussion (optional) (30 minutes)

youtu.be/dJ_8QmHlNPw.medicine.emory.edu/education/academy-of-medical-educators/bst-mode.html

TODAY's GOALs



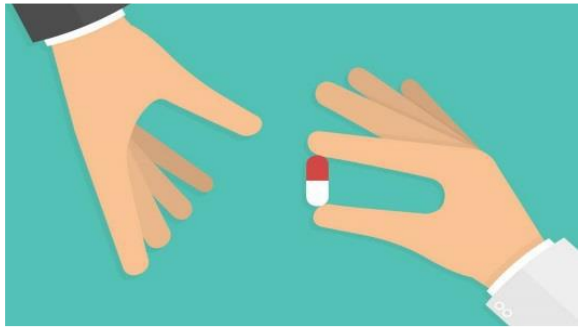
- Examine a nurse care management model of treatment with buprenorphine in office based settings

- Examine how this model may be applied to Patient Aligned Care Teams (PACTs) in the VA

CASE: Betty's Chief Complaint

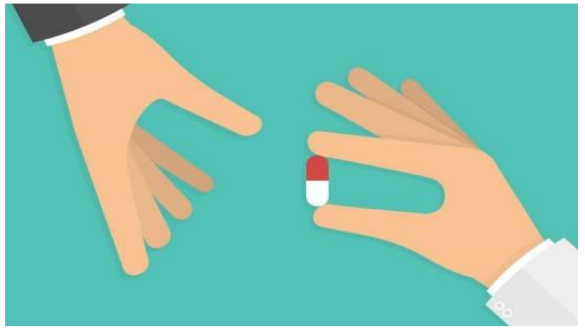
- Betty is a 43 year old female Veteran who presents to your primary care clinic
- She is new to you
- She presents from another VA medical center (Los Angeles, California)
- All her care has been in the VA
- She relates, "I am moving to VISN 19 from SoCal. I really don't have any problems other than a history of illicit drug use. I am in treatment. Can you treat me?"

CASE: Betty's Recent History



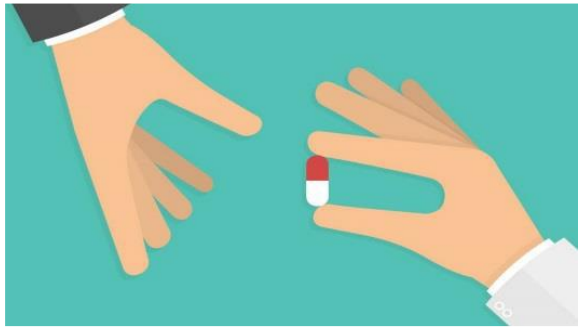
- Betty has a history of opioid use disorder
- She relates that she started on heroin when she was 22.
  - "I had a difficult time transitioning from the service. Everything was just wrong with me. I lost my job and my husband, then took to the streets."
  - "I used to use 2-3 stamp bags a day."
  - "However, the VA provided me with initial treatment in their inpatient addiction rehab program and I improved. I did really well."
  - "I transitioned from heroin to treatment with buprenorphine ("suboxone"). It was a life saver!"
  - "I'm still on it today."

CASE: Betty’ history



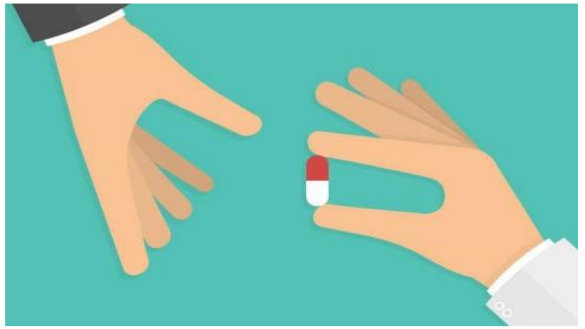
- **Past Medical History:**
  - Opioid Use Disorder (OUD)
  - Nicotine use disorder – she smokes ½ pack per day
- **Social history:**
  - Was in the Army
  - Divorced and remarried
  - Works in telecommunication
- **Family history:**
  - She is adopted
  - No children

CASE: Betty's Medications



- **Allergies:**
  - None
- **Medications:**
  - Buprenorphine/naloxone 8mg/2mg every day
- **Labs/Studies:**
  - Normal
  - No hepatitis C
  - Urine Drug Screen was negative
  - Buprenorphine confirmation

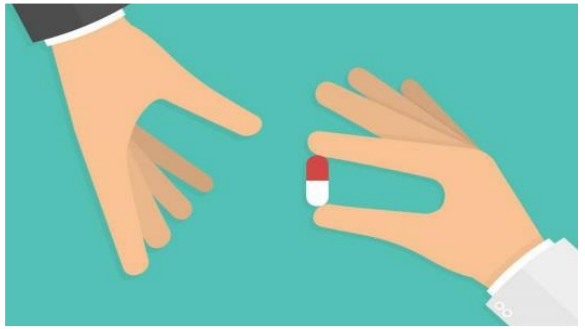
CASE: Betty's conundrums



- **Your consideration:**
  - You have an X waiver to prescribe buprenorphine in primary care
  - You are also credentialed to prescribe buprenorphine in the VA
  - You have yet to do this in primary care, but feel comfortable in doing so
  - Your nurse care manager is willing to help as he has taken affinity to Betty

- **How can you incorporate a primary care Nurse Care Manager into the treatment of patients with opioid use disorder in VA environments using buprenorphine?**

OUTLINE



Examine a nurse care management model of treatment with buprenorphine in office based settings

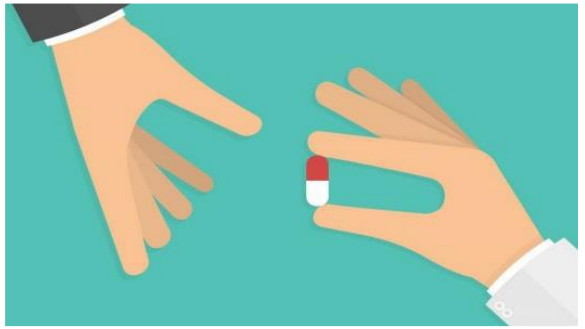
Case for MAT in Office Based Care

Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic

Nora D. Volkow, M.D., Thomas R. Frieden, M.D., M.P.H., Pamela S. Hyde, J.D., and Stephen S. Cha, M.D.

The rate of death from overdoses of prescription opioids in the United States more than quadrupled between 1999 and 2010 (see graph), far exceeding the combined death toll from cocaine and heroin overdoses.[1] In 2010 alone, prescription opioids were involved in 16,651 overdose deaths, whereas heroin was implicated in 3036. Some 82% of the deaths due to prescription

VA Step Care Model



SUD Specialty Care:

Outpatient

Intensive outpatient

Residential

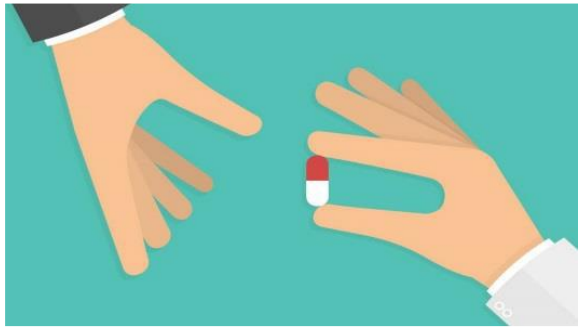
Addiction-focused medical management in PRIMARY CARE, Pain Clinic, Mental Health

Self-management:

Mutual help groups

Skills application

Office Based Treatment
Treatment Models



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Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review

P. Todd Korthuis, MD, MPH[1,2,3], **Dennis McCarty, Ph.D.**[3], **Melissa Weimer, D.O., M.C.R.**[2], **Christina Bougatsos, M.P.H.**[1], **Ian Blazina, M.P.H.**[1], **Bernadette Zakher, M.B.B.S.**[1], **Sara Grusing, B.S.**[1], **Beth Devine, Ph.D., Pharm.D., M.B.A.**[1,4], and **Roger Chou, M.D.**[1,2,5]

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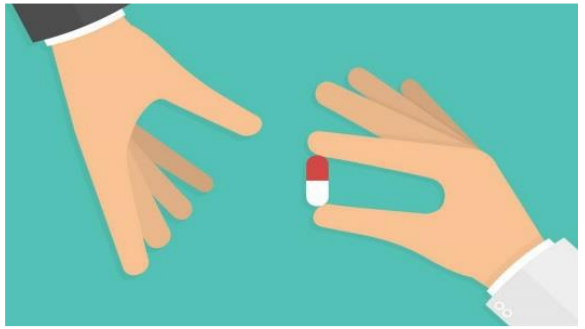
Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

Office Based Treatment

1. Practice-Based Models

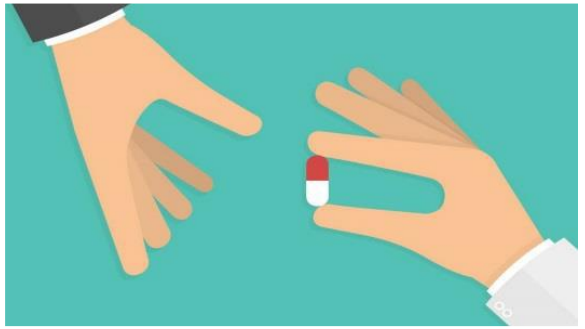


- **Office-Based Opioid Treatment**
- Buprenorphine HIV Evaluation and Support Model
- One Stop Shop Model
- Integrated Pre-natal Care and Medication-Assisted Treatment

Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

Office Based Treatment

2. System-Based Models

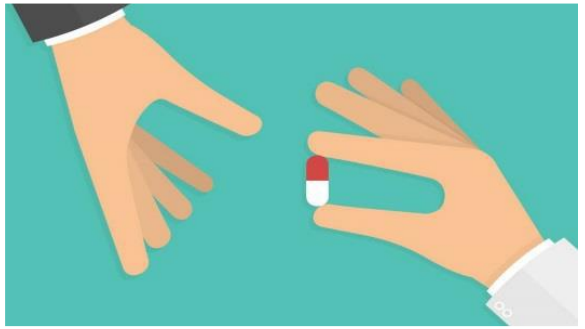


- Medicaid Health Home Model
- Hub and Spoke Model
- Project Extension for Community Healthcare Outcomes
- Collaborative Opioid Prescribing Model
- **Massachusetts Nurse Care Manager Model**
- Emergency Department Initiation of Office-Based Opioid Treatment
- Inpatient Initiation of Medication Assisted Treatment
- Southern Oregon Model

…where are the VA models?

Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

Where are the VA models?



Outpatient Buprenorphine Treatment for Opioid Dependence

Cynthia M.A. Geppert, MD, PhD, Gregory B. Toney, PharmD, BCPP,
Doreen Siracusano, PA-C, MA, and Maleen Thorius, APRN, BC

Office-based pharmacotherapy for opioid dependence holds the potential to close critical gaps in access to care. These VA clinicians explain how to establish a buprenorphine clinic in an existing SUD program.

Models for Implementing Buprenorphine Treatment in the VHA

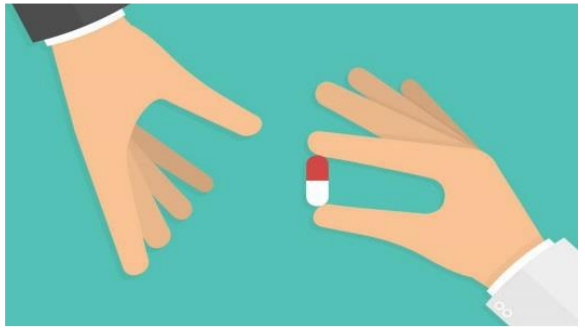
Adam J. Gordon, MD, MPH, Cynthia M.A. Geppert, MD, PhD, MPH, Andrew Saxon, MD, Ann Cotton, PsyD, Timothy Bondurant, MD, Margaret Krumm, BA, Mary Pat Acquaviva, PA, and Jodie Trafton, PhD

Although proven as a cost-effective treatment in VHA settings, buprenorphine currently is underutilized by VA practitioners. These authors review the drug's advantages and describe how some VA programs are employing it successfully.

Geppert CMA, et.al. Fed Pract; July, 2005
Gordon AJ, et.al. Fed Pract. 2009;26(5):48-57

Office Based Treatment

Common elements

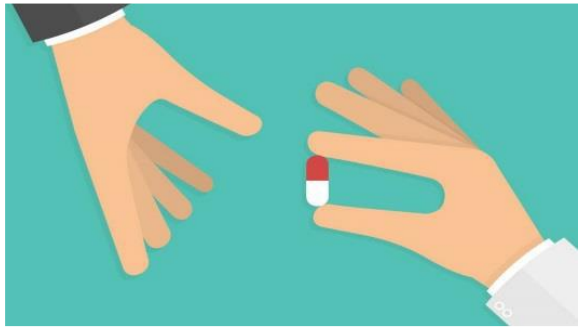


1. Pharmacological therapy
2. Psychosocial services
3. Integration of care
4. Education and outreach

- Models varied on relative emphasis of components
- Reimbursement issues were a big concern
- Combination of models are possible

Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

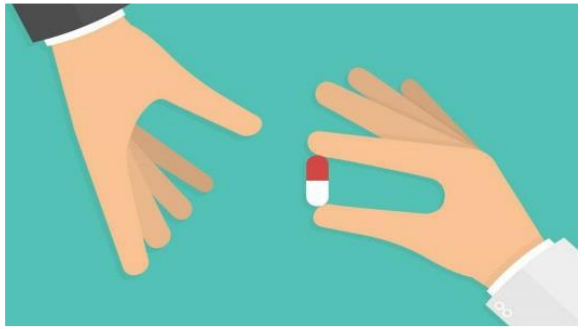
Massachusetts Nurse Care Manager Model



- Primarily relies on Nurse Care Managers (NCM), often in FQHCs where reimbursement services can occur for the NCM
- Primarily a supporting role of prescribers
- NCM performs:
  - Screening, intake, education, scheduling
  - Facilitates ongoing medical and OUD management
- Prescriber:
  - Confirms OUD diagnosis and appropriateness of MAT
  - Co-manages patients with NCM

Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

Massachusetts Nurse Care Manager Model



Arch Intern Med. 2011 March 14; 171(5): 425–431. doi:10.1001/archinternmed.2010.541.

Five Year Experience with Collaborative Care of Opioid Addicted Patients using Buprenorphine in Primary Care

Daniel P. Alford, MD, MPH[1,2], **Colleen T. LaBelle, RN**[1], **Natalie Kretsch**[1], **Alexis Bergeron, MPH, LCSW**[1], **Michael Winter, MPH**[3], **Michael Botticelli**[4], and **Jeffrey H. Samet, MD, MA, MPH**[1,2,5]

[1] Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Department of Medicine, Boston Medical Center, Boston, MA

[2] Boston University School of Medicine, Boston, MA

[3] Data Coordinating Center, Boston University School of Public Health, Boston, MA

[4] Bureau of Substance Abuse Services, Department of Public Health, Boston, MA

[5] Department of Community Health Sciences, Boston University School of Public Health, Boston, MA

From 2003 to 2008, 408 patients with opioid addiction were treated with buprenorphine. Twenty-six patients were excluded from analysis as they left treatment due to preexisting legal or medical conditions or a need for transfer to another buprenorphine program. At 12 months 51% of patients (196/382) underwent successful treatment. Of patients remaining in treatment at 3-, 6-, 9- and 12 months, 93% were no longer using illicit opioids or cocaine based on urine drug tests. On admission, patients who were older, employed, and used illicit buprenorphine had significantly higher odds of treatment success; those of African American or Hispanic race had significantly lower odds of treatment success. These outcomes were achieved with a model that facilitated physician involvement.

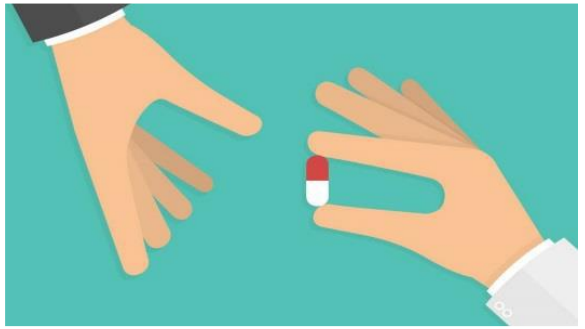
Alford DP, et.al. Arch Intern Med. 2011(171(5):425-431.

Massachusetts Nurse Care Manager Model

- Advantages include:
  - utilization of a skilled non-physician to offload prescribing physician burden
  - an emphasis on provider training
  - financial sustainability through Medicaid-reimbursed nurse care manager visits
- This model may be attractive over a wide range of primary care practices in states with Medicaid programs or other payers that could adopt reimbursement of nurse care manager visits for OUD
- Challenges include variable availability of:
  - Psychosocial services and nurse care managers trained in MAT management
  - In most states, a lack of Medicaid coverage for nurse OUD care management

Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

Massachusetts Nurse Care Manager Model



Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide 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]

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[b] Boston University School of Medicine, Department of Medicine, Section of General Internal Medicine, Clinical Addiction Research and Education (CARE) Unit, 801 Massachusetts Avenue, 2nd Floor, Boston, MA 02118, United States
[c] Boston University School of Public Health, Department of Community Health Sciences, 801 Massachusetts Avenue, 2nd Floor, Boston, MA 02118, United States

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Waivered physicians
Nurse care manager
Access to treatment
Opioid use disorder

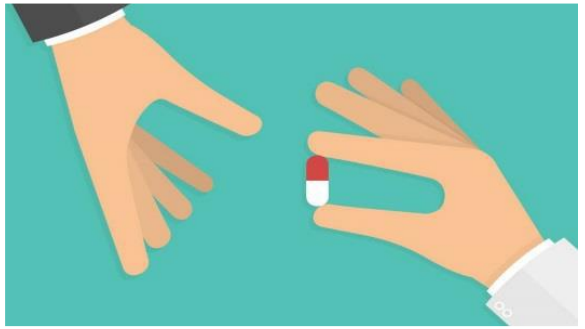
ABSTRACT

We describe a Massachusetts Bureau of Substance Abuse Services' (BSAS) initiative to disseminate the office-based opioid treatment with buprenorphine (OBOT-B) Massachusetts Model from its development at Boston Medical Center (BMC) to its implementation at fourteen community health centers (CHCs) beginning in 2007. The Massachusetts Collaborative Care Model for the delivery of opioid agonist therapy with buprenorphine, in which nurses working with physicians play a central role in the evaluation and monitoring of patients, holds promise for the effective expansion of treatment for opioid use disorders. The training of and technical assistance for the OBOT nurses as well as a limited program assessment are described. Data spanning 6 years (2007–2013) report patient demographics, prior treatment for opioid use disorders, history of overdose, housing, and employment. The expansion of OBOT to the fourteen CHCs increased the number of physicians who were "waivered" (i.e., enabling their prescribing of buprenorphine) by 375%, from 24 to 114, within 3 years. During this period the annual admissions of OBOT patients to CHCs markedly increased. Dissemination of the Massachusetts Model of the Office-Based Opioid Treatment with Buprenorphine employing a collaborative care model with a central role for nursing enabled implementation of effective treatment for patients with an opioid use disorder at community health centers throughout Massachusetts while effectively engaging primary care physicians in this endeavor.

An evaluation of statewide scale-up noted a 375% increase in the number of buprenorphine-waivered physicians within 3 years

Labelle CT, et.al. JSAT. 2016;60:6-13
Korthuis PT, et.al. Ann Intern Med. 2017;166(4):268-278

Massachusetts Nurse Care Manager Model

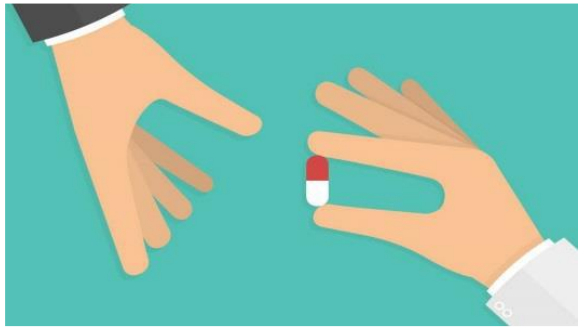


- The staff:
  - The nurse program director (0.40 full time equivalent (FTE))
  - The program coordinator (1 FTE), a former medical assistant – evaluation role
  - Physicians
  - Support staff

(…..sound familiar?)

Alford DP, et.al. Arch Intern Med. 2011(171(5):425-431.

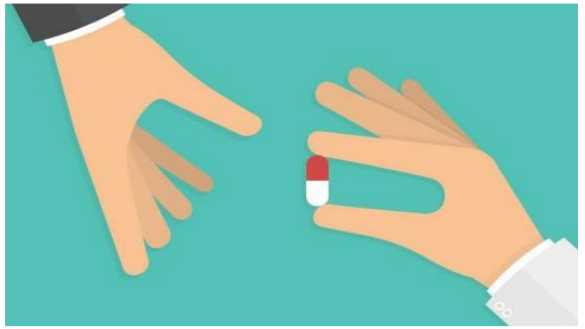
Massachusetts Nurse Care Manager Model



- NCM clinical responsibilities included:
  - assessing for appropriateness for OBOT
  - educating patients
  - obtaining informed consent
  - developing treatment plans
  - overseeing medication management
  - referring to other addiction treatment
  - monitoring for treatment adherence
  - communicating with prescribing physicians, addiction counselors, and pharmacists
- Responsibilities were *in-person or by phone*

Alford DP, et.al. Arch Intern Med. 2011(171(5):425-431.

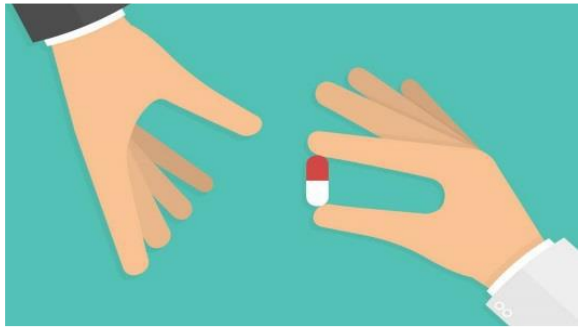
Massachusetts Nurse Care Manager Model



- Three Stages of Treatment:
  1. NCM and physician appropriateness
  2. NCM supervised induction and stabilization (1 week)
  3. NCM supervised maintenance or discontinuation

Alford DP, et.al. Arch Intern Med. 2011(171(5):425-431.

Massachusetts Nurse Care Manager Model



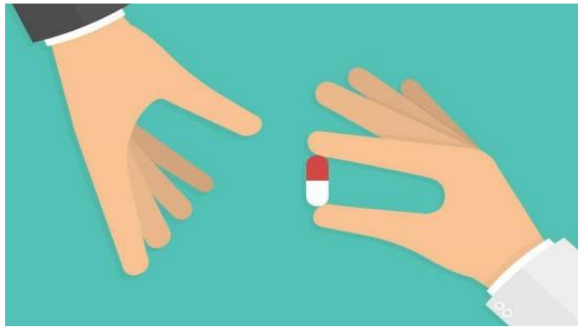
Treating Homeless Opioid Dependent Patients with Buprenorphine in an Office-Based Setting

Daniel P. Alford, MD, MPH[1,2,3], Colleen T. LaBelle[1,3], Jessica M. Richardson[1], James J. O'Connell, MD[4], Carole A. Hohl, MHS[4], Debbie M. Cheng, ScD[1,5], and Jeffrey H. Samet, MD, MA, MPH[1,2,6]

[1]Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Department of Medicine, Boston Medical Center, Boston, MA, USA; [2]Boston University School of Medicine, Boston, MA, USA; [3]Boston Public Health Commission, Boston, MA, USA; [4]Boston Health Care for the Homeless Program, Boston, MA, USA; [5]Department of Biostatistics, Boston University School of Public Health, Boston, MA, USA; [6]Department of Social and Behavioral Sciences, Boston University School of Public Health, Boston, MA, USA.

Alford DP, et.al. JGIM; 2007;22:171-176

Massachusetts Nurse Care Manager Model



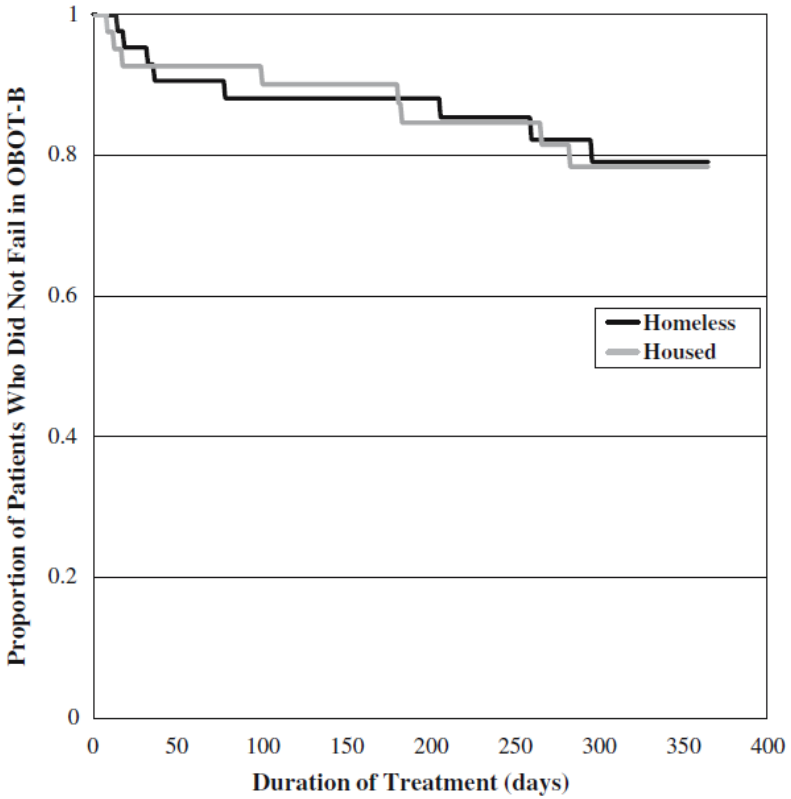


Figure 1. Kaplan–Meier estimates of the proportion of homeless and housed patients who did not fail office-based opioid treatment with buprenorphine. *P*=.94 for the comparison between homeless and housed subjects by the log-rank test.

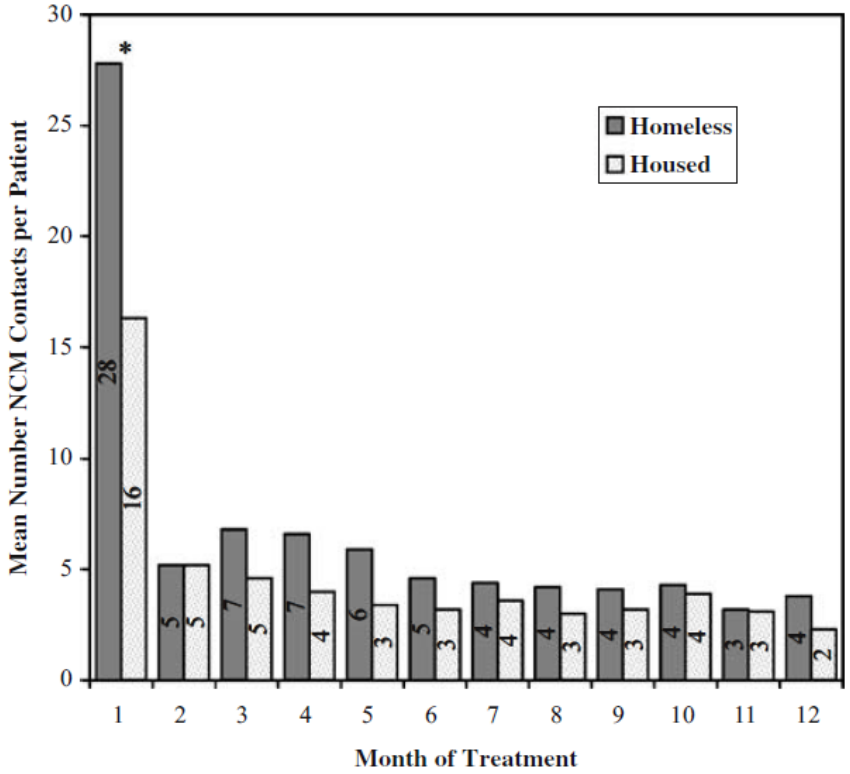
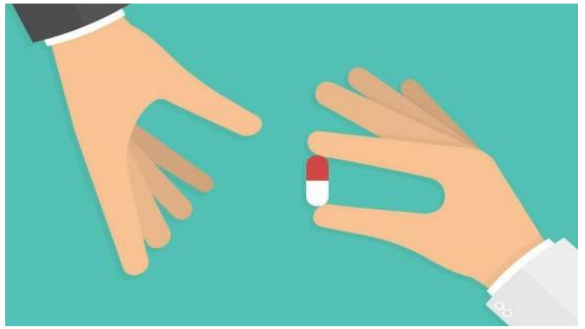


Figure 2. Mean number of monthly nurse care manager (NCM) contacts per homeless and housed patient over 12 months of office-based opioid treatment with buprenorphine. *RR=1.7 (95% CI=1.48–1.95); *P*<.0001 (homeless vs housed in month #1).

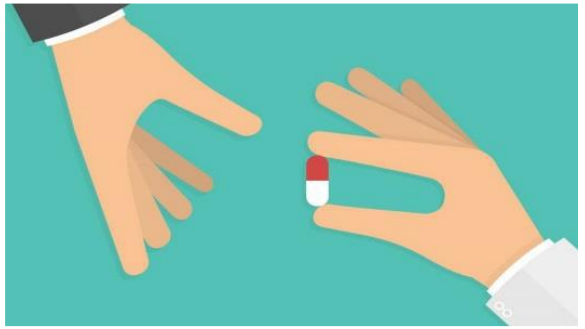
Alford DP, et.al. JGIM; 2007;22:171-176

More material to help



https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

OUTLINE

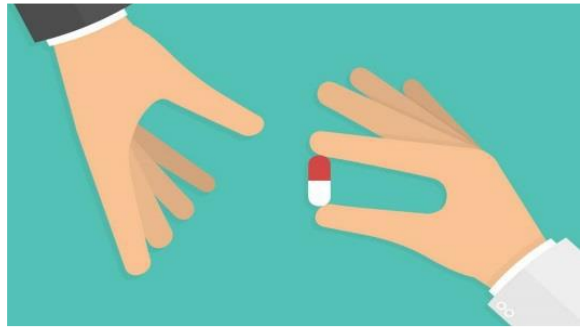


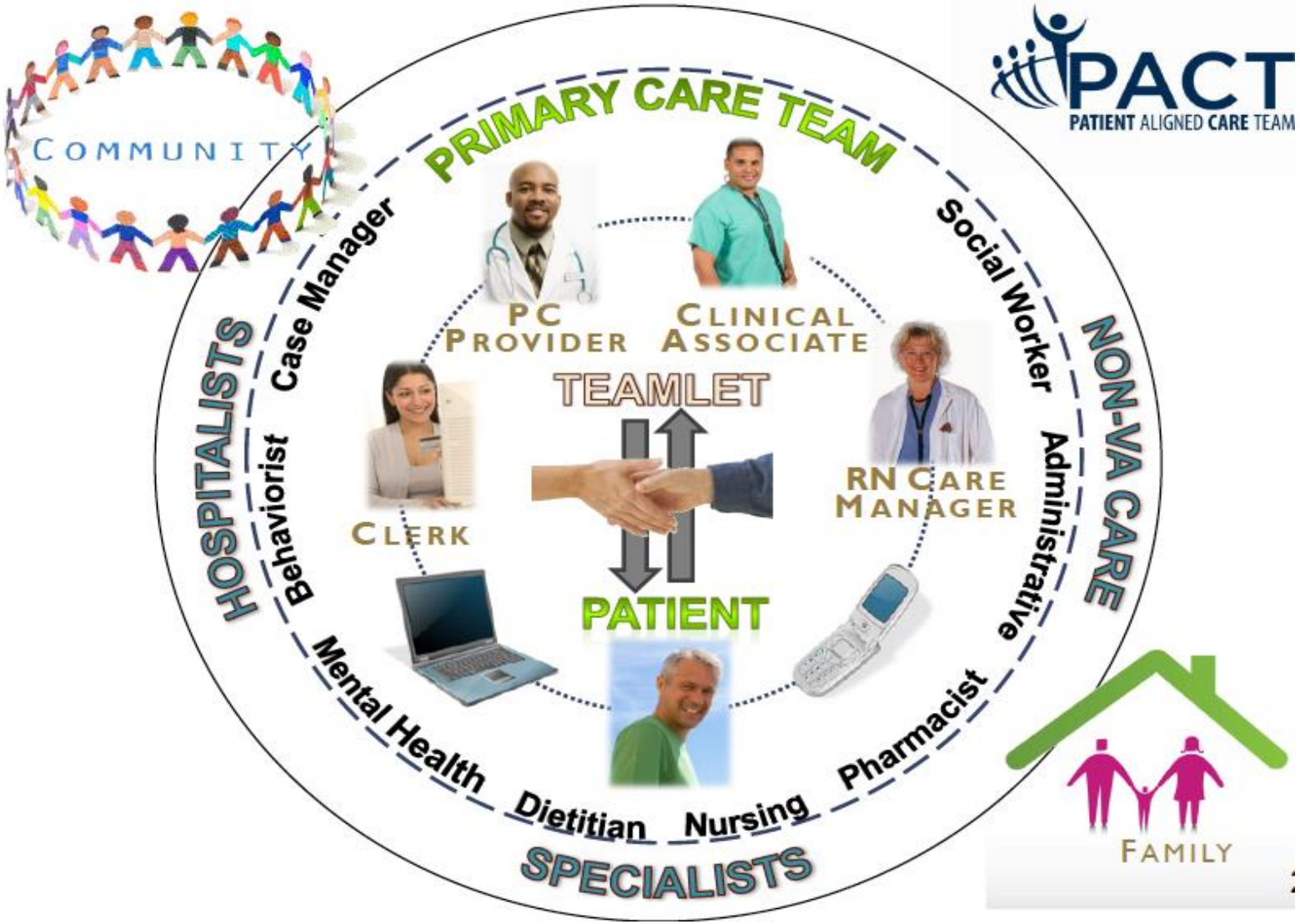
Examine how this model may be applied to Patient Aligned Care Teams (PACTs) in the VA

VA implementation of NCM model

- Addiction or opioid use disorder treatment for can be provided in office-based settings similar to treatments for all other medical and mental health disorders
- Barriers to initiate or provide addiction care occur when providers in office-based settings attempt to make these environments “feel” like formal substance abuse treatment program environments
    - Primary care environments are different than addiction treatment programs!
    - Simply put: It hard to replicate an addiction treatment environment
        - Don’t try to!
    - “Keep it simple” and “grow from experience”

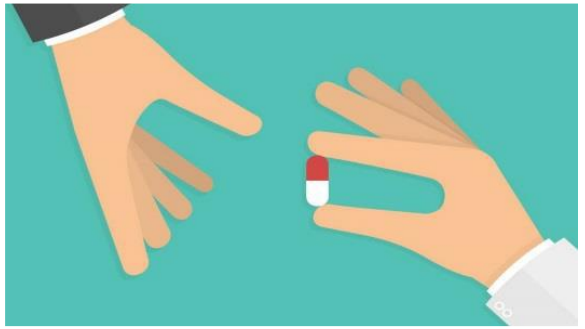
Gordon AJ, et.al. Psychol Addict Behav. 2011;25(2):215-224
Oliva EM, et.al. Curr Psychiatric Rep. 2011:13(5):374-381

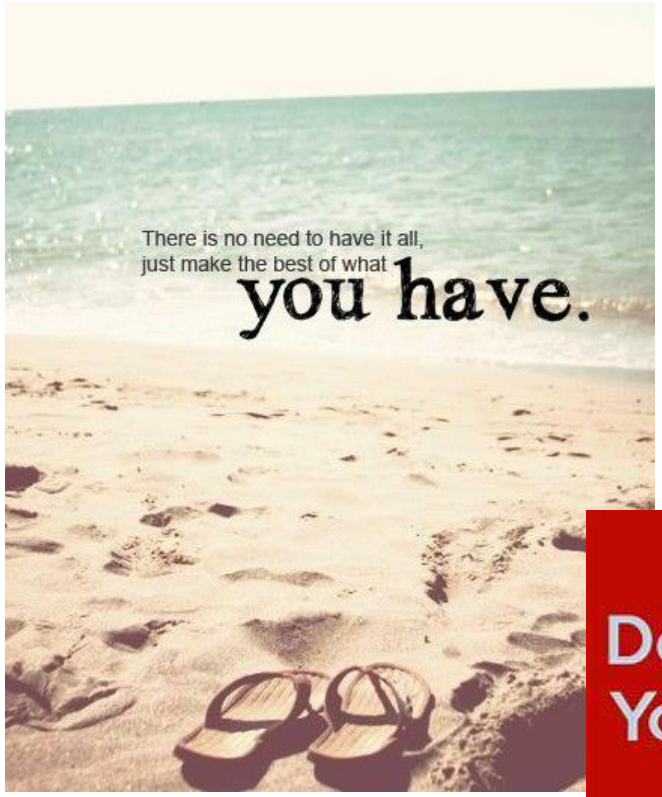



COMMUNITY
PRIMARY CARE TEAM
PACT
PATIENT ALIGNED CARE TEAM
PC PROVIDER
CLINICAL ASSOCIATE
TEAMLET
CLERK
RN CARE MANAGER
PATIENT
HOSPITALISTS
Case Manager
Behaviorist
Social Worker
Administrative
NON-VA CARE
Mental Health
Dietitian
Nursing
Pharmacist
SPECIALISTS
FAMILY

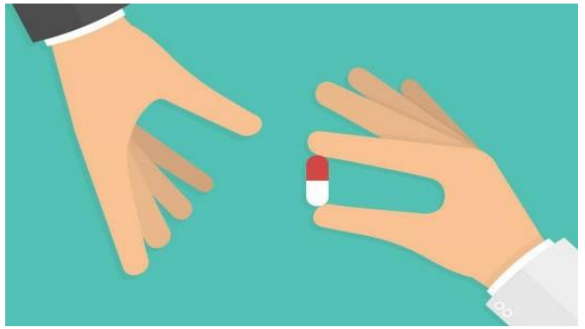
The VA PC already has it all…

- Physician
- Nurse Care Manager
- LPN
- Administrative Assistant
- Pharmacist
- Social Work
- PC-MHI
- Co-located specialty ca
- Patient…





DISCUSSION



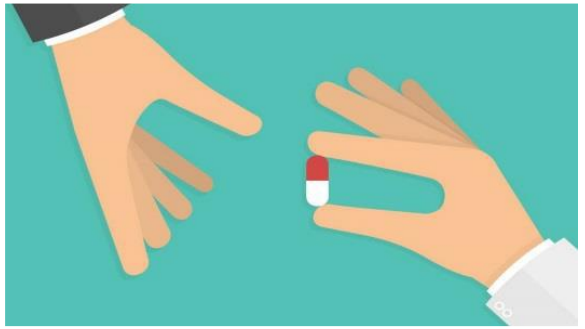
Next VIP CHAT!

Wednesday, June 27, noon-12:30 PM **(ALWAYS 4th Wednesday of the month)**

The Case of Angry Adam – How to correctly interpret a urine drug screen result

EXTRA SLIDES (if needed)

Case for MAT in Office Based Care



- Buprenorphine IV (1981)
  - Indication: **Pain**

- Buprenorphine (2002)
  - Indication: **Opioid use disorder**

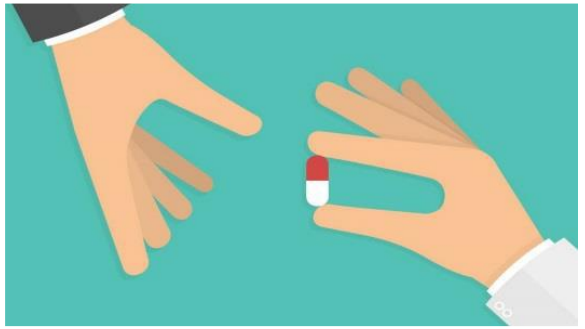
- Buprenorphine/Naloxone (2002)
  - Indication: **Opioid use disorder**
  - SL/Buccal Tablets and Film available

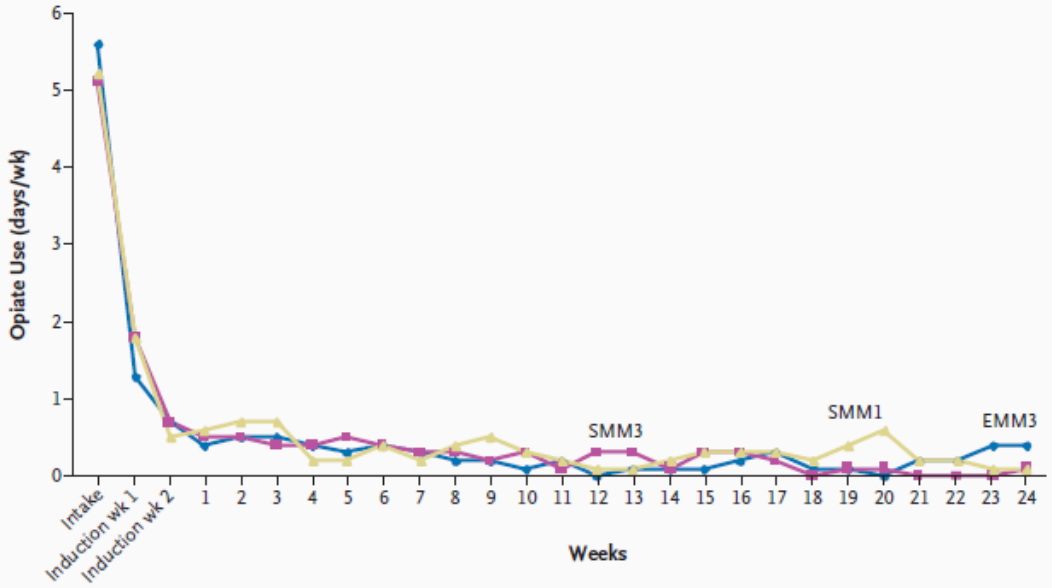
- Buprenorphine Patches (2010)
  - Indication: **Pain**

- Buprenorphine Implants (2016)
  - Indication: **Opioid use disorder**

- Buprenorphine Depot Injections (2018)
  - Indication: **Opioid use disorder**

Evidence for MAT - Office Based Care

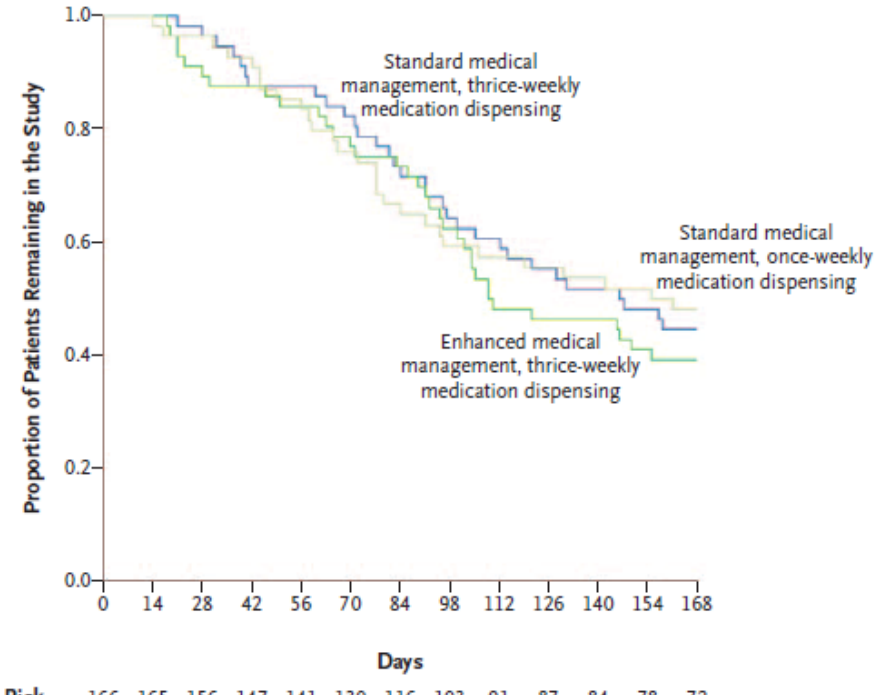




No. Providing Assessments																									
EMM3	56	55	54	54	53	48	46	48	49	47	44	42	40	36	35	34	29	28	29	27	25	25	26	23	21	23	21
SMM3	56	54	52	50	50	46	45	44	44	42	41	40	37	38	33	31	28	24	22	22	21	21	18	20	19	18	15
SMM1	54	53	53	51	48	48	48	44	44	38	39	38	33	34	31	31	28	30	28	27	27	27	28	26	25	24	22

Figure 2. Self-Reported Frequency of Illicit Opioid Use in Opioid-Dependent Patients Receiving Buprenorphine–Naloxone in Primary Care.

SMM1 denotes standard medical management and once-weekly medication dispensing, SMM3 standard medical management and thrice-weekly medication dispensing, and EMM3 enhanced medical management and thrice-weekly medication dispensing.



No. at Risk													
	166	165	156	147	141	130	116	103	91	87	84	78	72

Figure 3. Study Completion among Opioid-Dependent Patients Receiving Buprenorphine–Naloxone in Primary Care.

Study completion was defined as not meeting the criteria for protective transfer, not missing medication for more than seven days, or not missing three or more counseling sessions.