Treating Opioid Use Disorder in A Community Health Center

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October 20, 2017

No financial disclosures

My background

- Family Medicine
- Preventive Medicine
- Addiction Medicine
- Clinical Experience has been in FQHCs

Goals

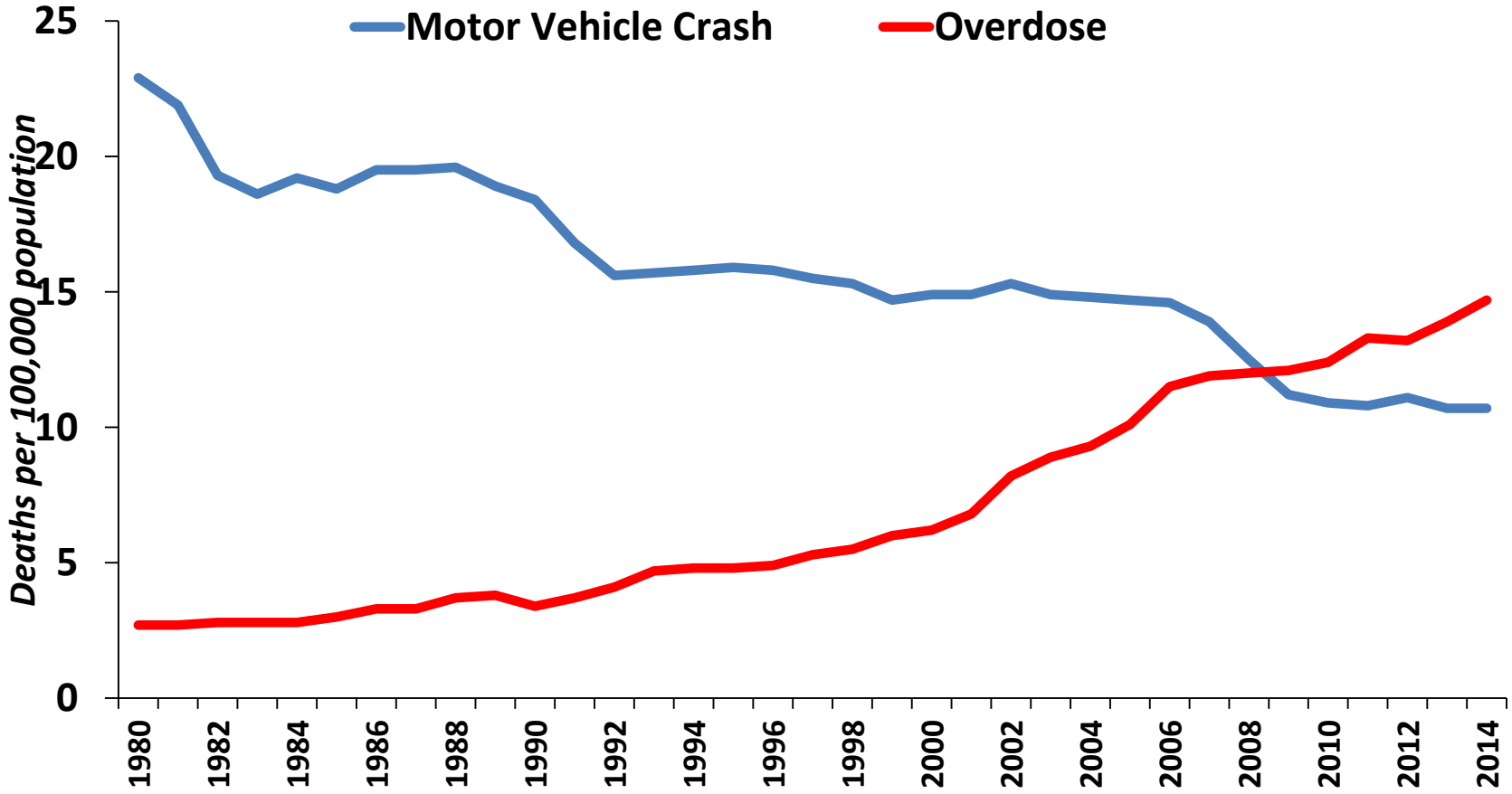
- Epidemiology of Opioid Use and Overdose
- Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)
- Primary Care OUD Treatment Models
- Operational and Workforce Considerations

What is a Community Health Center?

"There are three words in community health center and we tend to talk a lot about health and center, and not as much about community."
-Jack Geiger

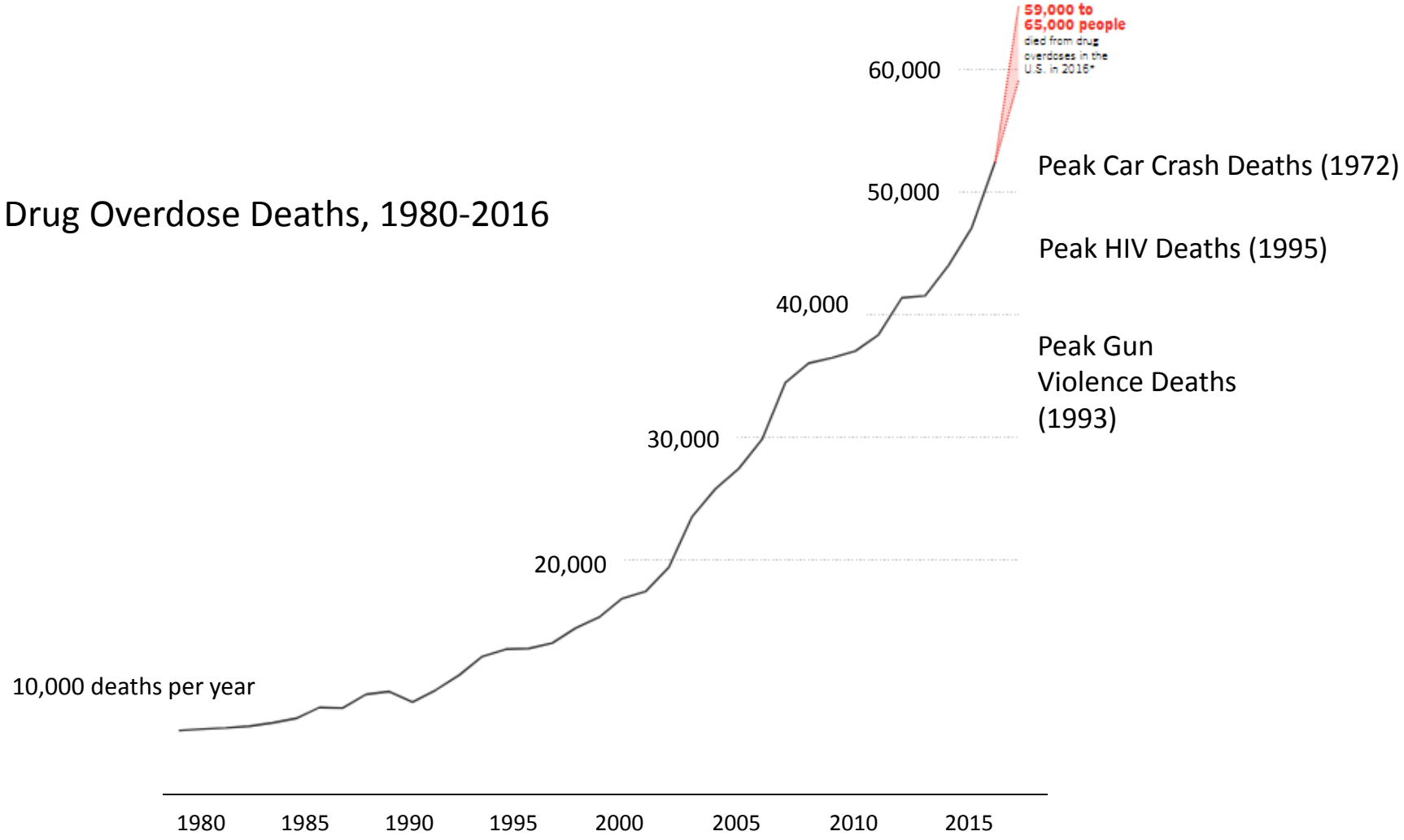
EPIDEMIOLOGY OF OPIOID USE DISORDER/OVERDOSE

Overdose Deaths in US- all types



Source: National Center for Health Statistics

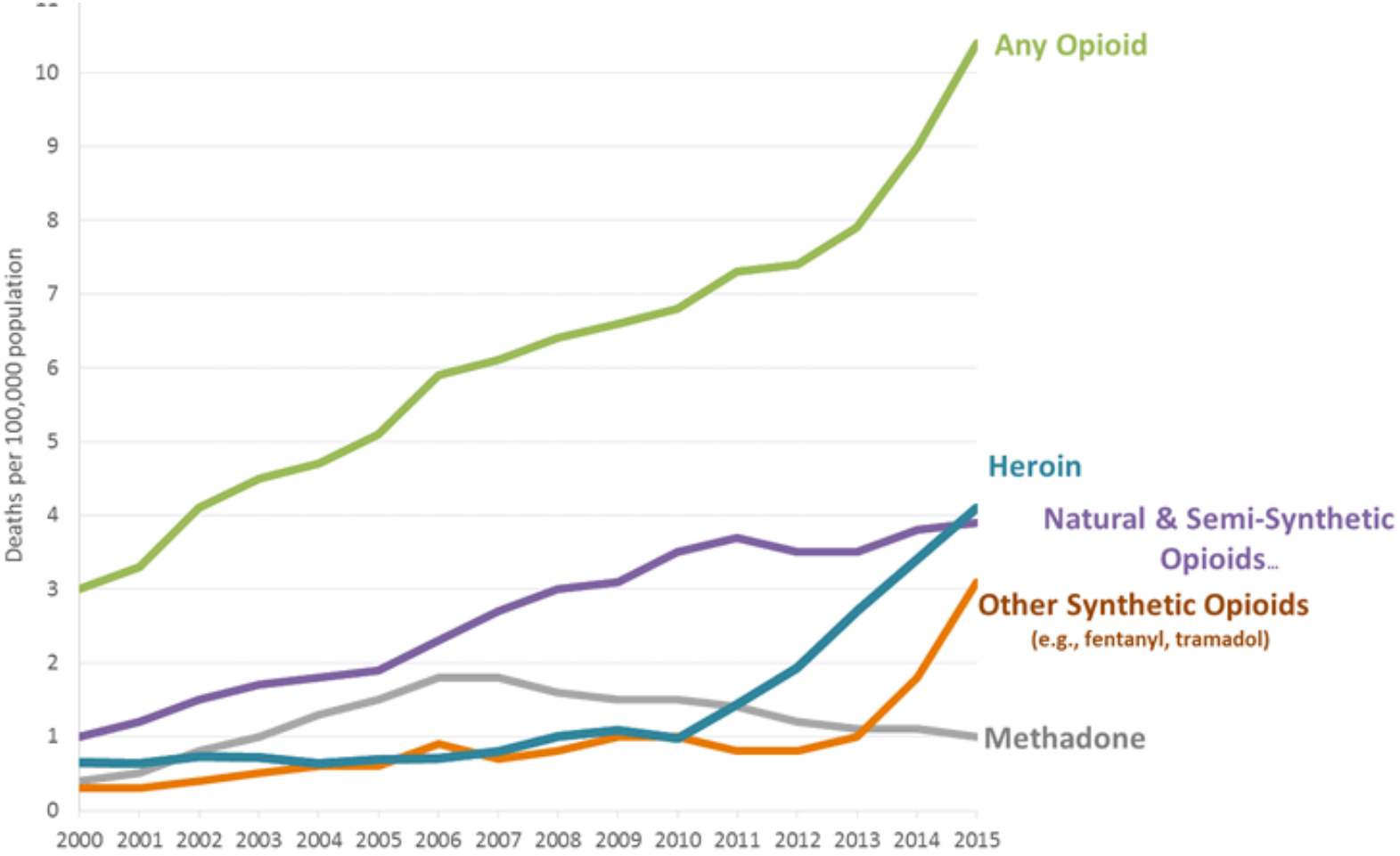
“Drug Deaths in America Are Rising Faster than Ever”



*2016 estimate based on preliminary data

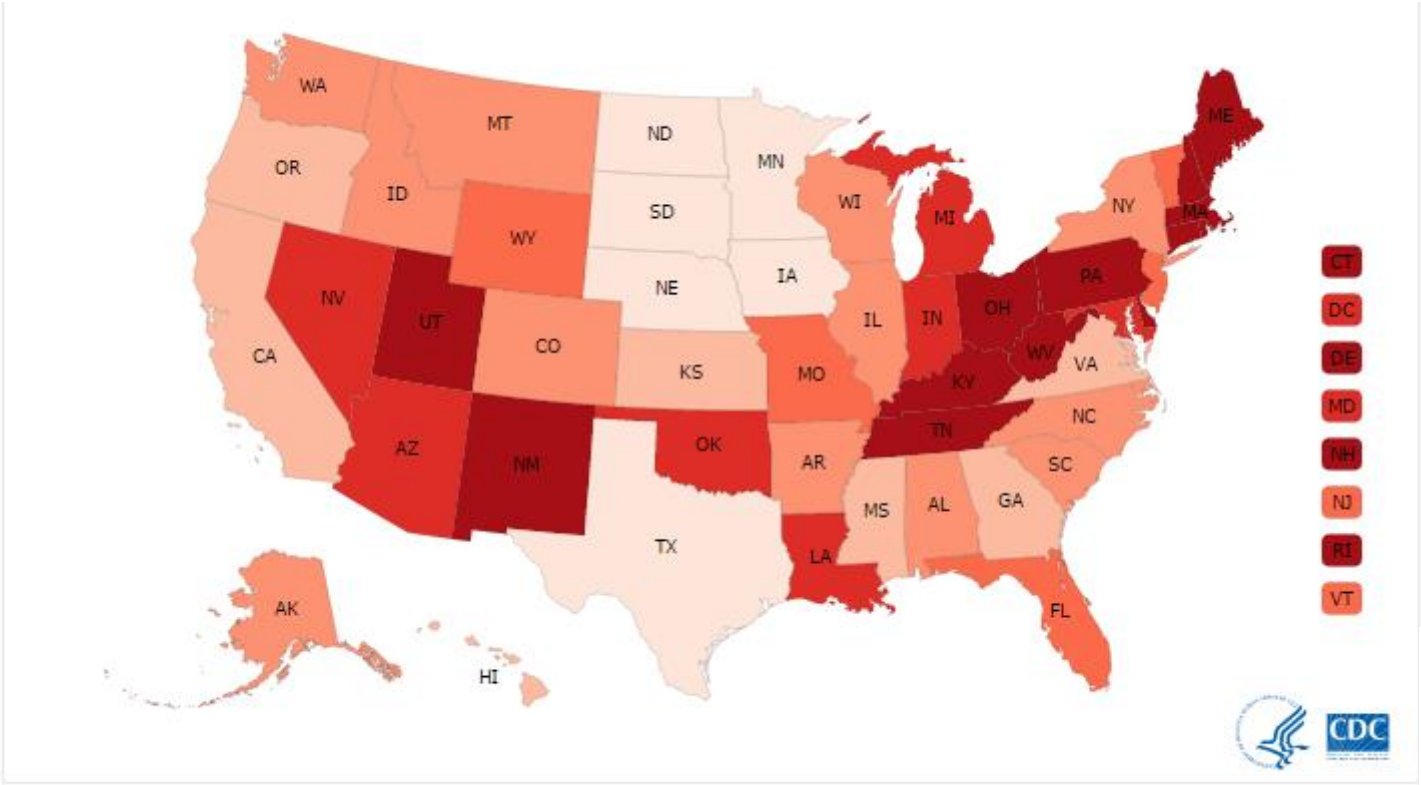
Source: New York Times, June 5, 2017

Overdose Deaths Involving Opioids by type, US 2000-2015



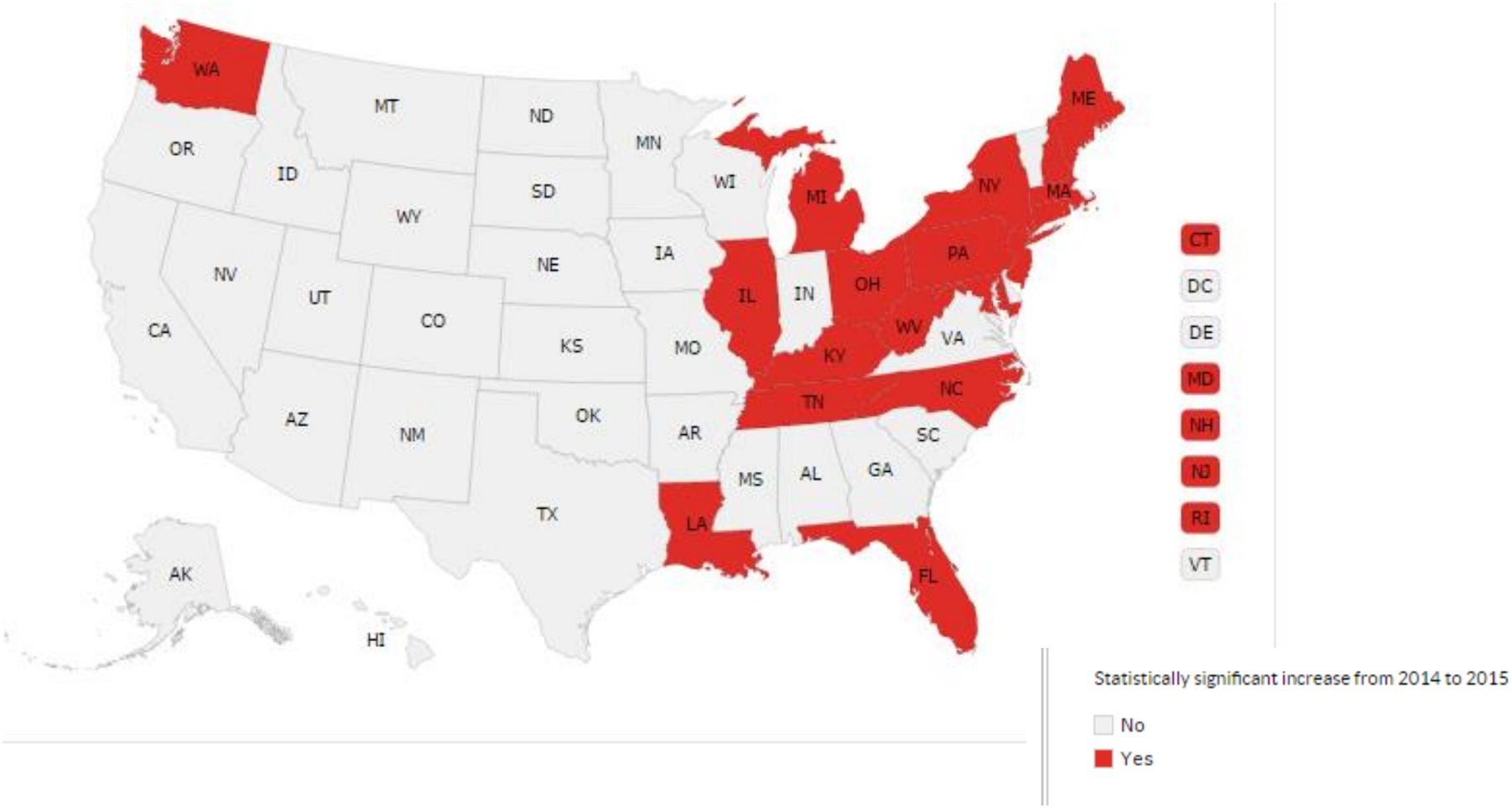
https://www.cdc.gov/drugoverdose/data/analysis.html

Rates of Drug Overdose Deaths, 2015



Source: https://www.cdc.gov/drugoverdose/data/statedeaths.html

Significant Increase in OD Death Rate from 2014-2015



Source: https://www.cdc.gov/drugoverdose/data/statedeaths.html

Public Health Approaches to Opioid Crisis

- Primary prevention school education programs
- Safe opioid prescribing & disposal
  - Prescription Drug Monitoring Programs*
  - Drug take-back initiatives
  - Provider education (and education mandates)
  - Regulation and legal action around “pill mills”
  - Opioid prescribing limits (insurance and legislation)
- Screening, Brief Intervention and Referral to Treatment
- Abuse-deterrent opioid formulations
- Opioid Use Disorder (OUD) treatment with agonist therapy*
- Overdose response education and naloxone distribution*
  - Good Samaritan Laws
  - Laws to allow access without a prescription
- Safe Injection/Consumption Facilities*

OPIOID USE DISORDER TREATMENT

Opioid Use Disorder is a Chronic Condition

- Genetic component
- Environmental component
- Behavioral component
- Treatment can include behavioral interventions as well as medications
- Long-term treatments are effective at managing, not curing

Source: McClellan et al. Public Health Review 2014

Substance Use Disorder Treatment

From Acute Care Model

- Enters Treatment
- Completes Assessment
- Receives Treatment
- Discharged

To Chronic Care Model

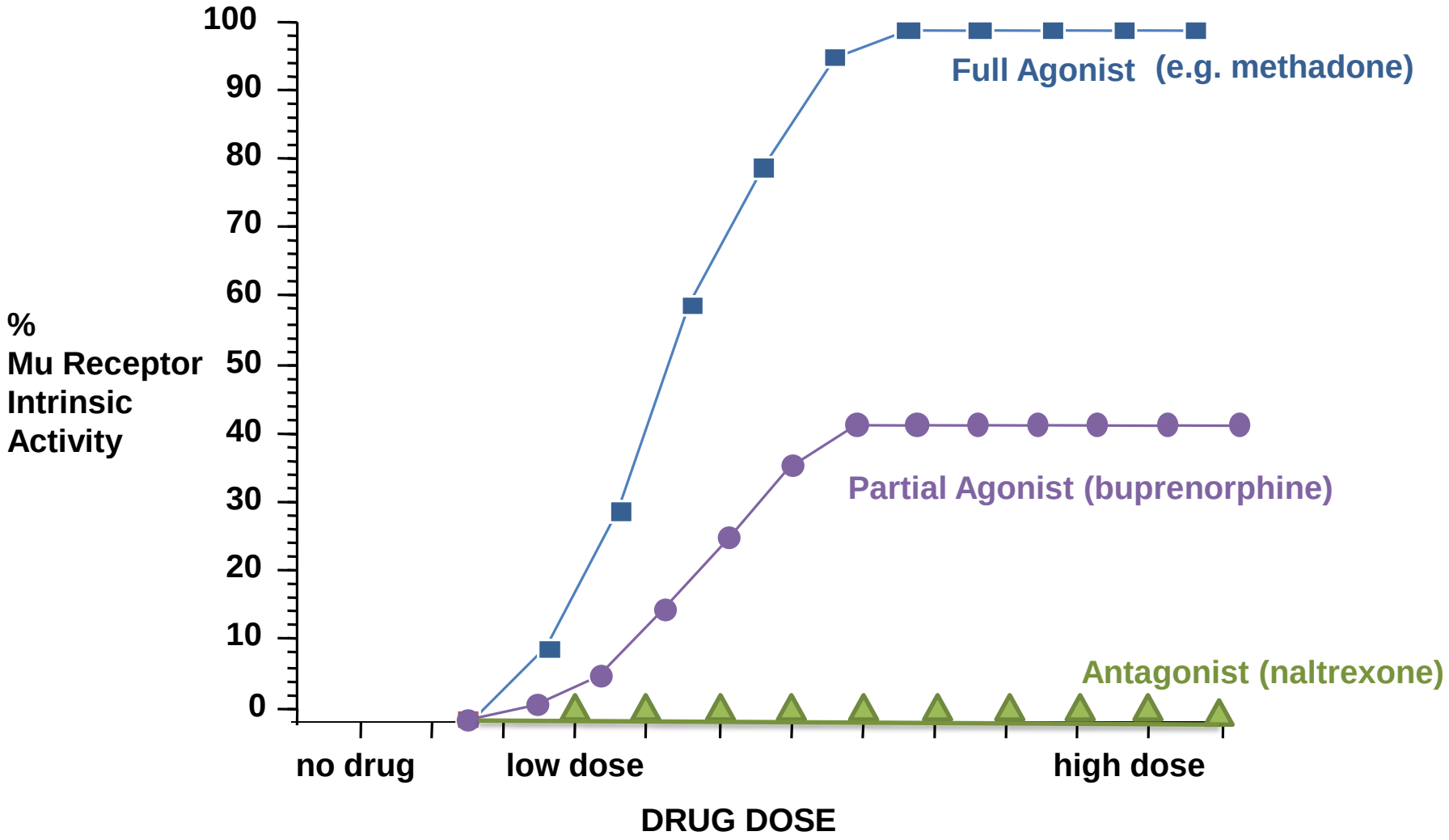
- Prevention
- Early Intervention
- Treatment
- Recovery Support Services

Source: McClellan et al. Public Health Review 2014

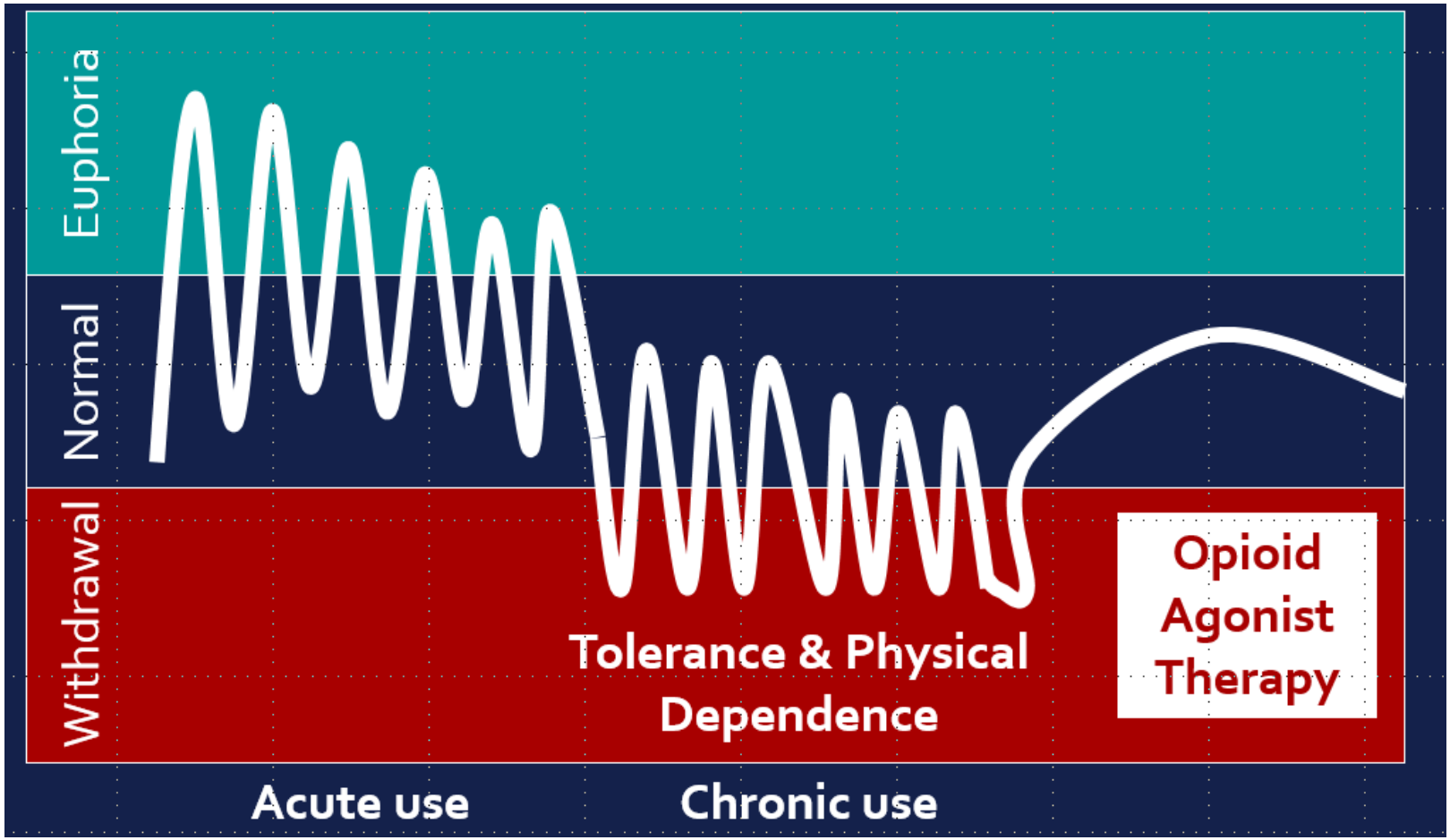
Opioid Use Disorder Treatment

- Counseling and Community Support (without medication)
- Medication assisted treatment (MAT):
  - Methadone
    - Only available in Opioid Treatment Programs ("methadone clinics")
  - Buprenorphine
    - Prescriber must have "waiver" to be able to prescribe and there are limits on size of patient population
  - Injectable extended release naltrexone
- Detox alone is not treatment!

Receptor Activity Levels



Opioid Agonist Therapy (Methadone and Buprenorphine)



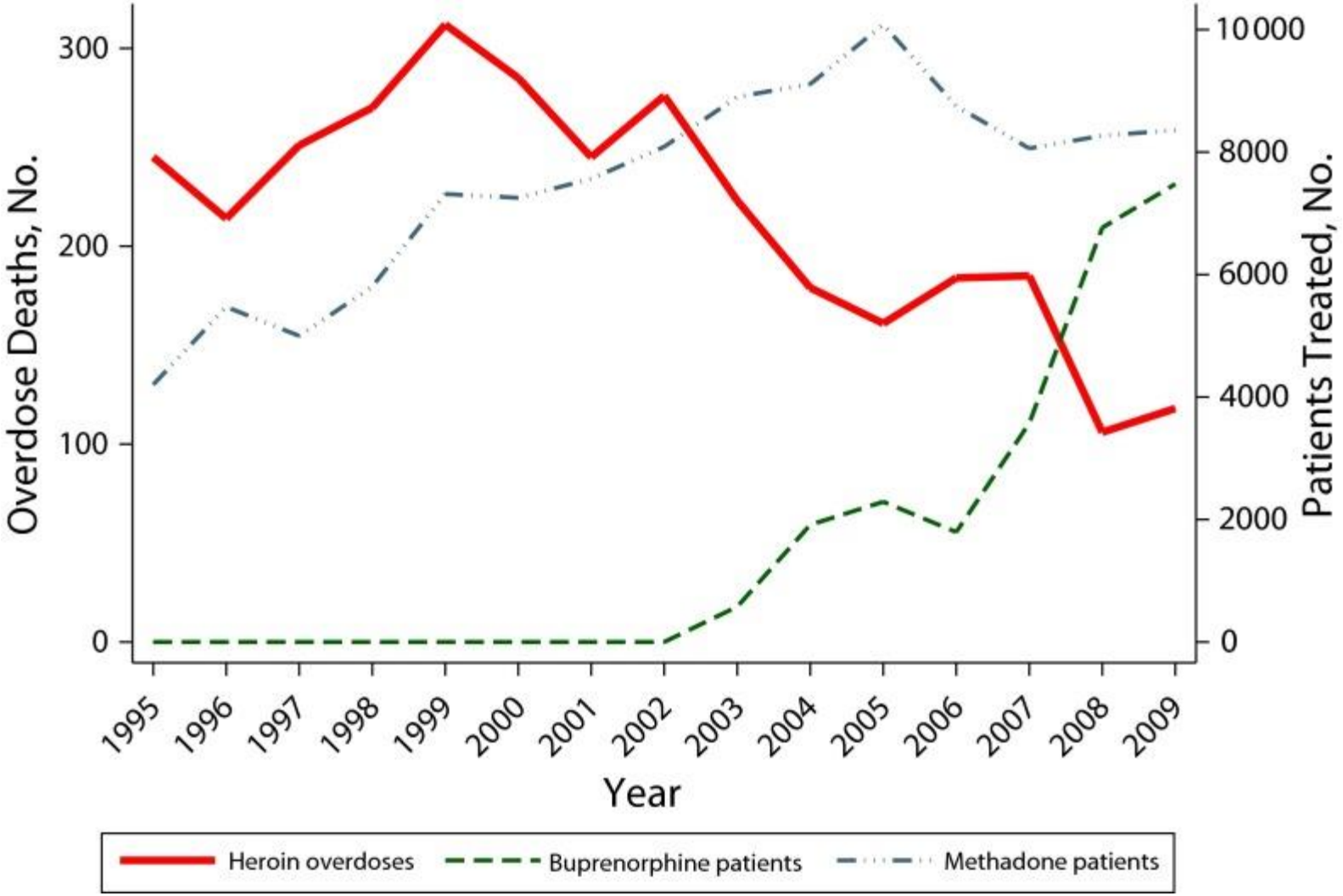
Indications for Medications

- All patients with opioid use disorder should be offered medication as a component of treatment
  - Only 10% of patients with OUD in addiction treatment programs were actually receiving medication

Benefits Of Agonist (Methadone and Buprenorphine) Treatment

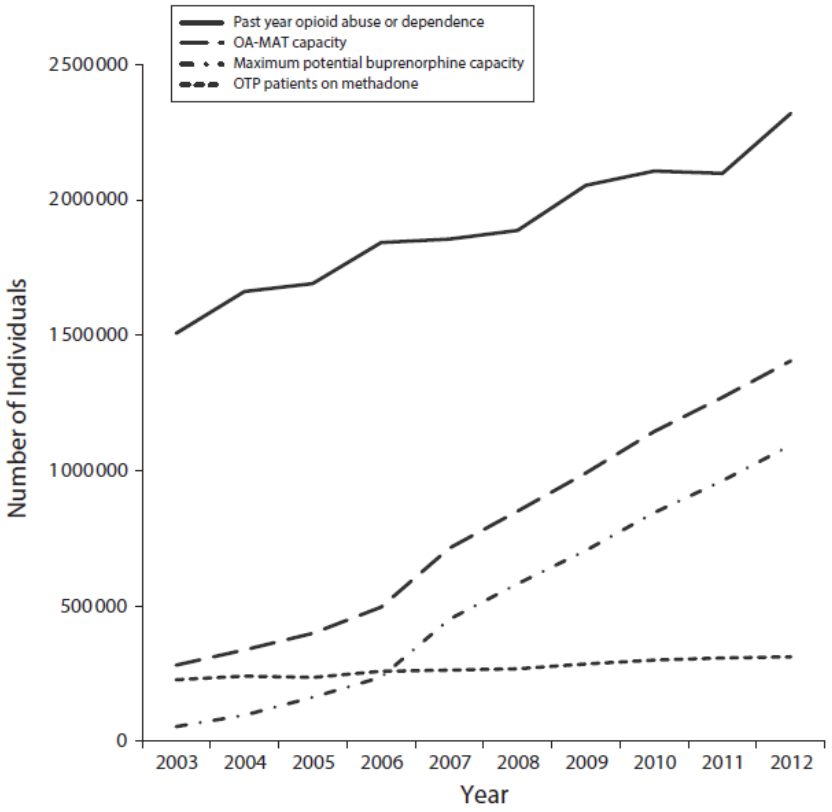
- Increases retention in treatment
- Reduces illicit opioid use
- Reduces risk of overdose
- Reduces risk of HIV infection
- Reduces risk of HBV and HCV infections
- Increases rates of employment
- Decreases crime
- Increases length of life

Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore 1995-2009



Schwartz et al. Am Journal of Public Health. 2013; 103(5):917-922

Access to opioid use disorder medication assisted treatment in US



Note. OA-MAT = opioid agonist medication-assisted treatment; OTP = opioid treatment program.

FIGURE 1—Trends in past-year opioid abuse or dependence and opioid agonist medication-assisted treatment capacity: United States, 2003–2012.

Jones CM, Campopiano M, et al. Am Journal of Public Health. 2015; 105(8):e55-e63

PRIMARY CARE MODELS FOR OPIOID USE DISORDER TREATMENT

Primary Care Models for Opioid Use Disorder Treatment

- Many different models of care
  - Practice Based models:
    - OBOT model (+/- care coordinator)
    - Specialty models (pregnancy, HIV-specific, “one stop shop”)
  - Health System models:
    - Hub and Spoke
    - Health Home
    - New Mexico ECHO
    - Collaborative Opioid Prescribing Model

Source: Korthuis et al. Annals of Internal Medicine. 2017

Practice Based Models

- Typically involve a prescriber and at least one other “glue” person +/- behavioral health
- “Glue person” could be an RN, care coordinator/case manager
  - Assists with orientation to program, intakes
  - Manages referrals/coordinates care
  - Facilitates prior authorizations
  - May or may not provide some counseling
  - Documents behavioral health if offered off-site
- May or may not have behavioral health staffing on-site

Source: Korthuis et al. Annals of Internal Medicine. 2017

Health System Models

- Typically the induction and stabilization is done at another location (usually an addiction treatment center)
- Once patient is stabilized (stable dose, less frequent visits), is then referred to the primary care setting
- Patients can be referred back to other location if increased support is needed

Source: Korthuis et al. Annals of Internal Medicine. 2017

Buprenorphine in Primary Care- How does it work?

- Intake Assessment (Majority can be done by "glue" person, BH staff, RN, etc):
  - Confirm patient wants treatment with buprenorphine and understands program
  - Review how the medication works
  - History: meds, allergies, past med history, past treatment episodes, social history, etc
  - Document diagnosis of OUD (Mild, Moderate, Severe)

Buprenorphine in Primary Care- How does it work?

- Medical Examination:
  - Review documented history
  - Urine Drug Screen
  - Labs (LFTs, HIV, hepatitis)
  - Physical Exam
  - Develop treatment plan that incorporates behavioral intervention (individualized)- could be onsite or off-site

Buprenorphine in Primary Care- How does it work?

- First dose of medication:
  - Patient must be in moderate withdrawal
  - First dose of medication can be given on-site or off-site (home)
  - Typically some type of check-in done within 1-3 days (can be phone or in person)
  - Subsequent in-person visit within one week

Buprenorphine in Primary Care- How does it work?

- Visit Schedule
  - Typically weekly visits for at least one month
  - If patient is “stable” visits then start to reduce in frequency
  - Stable patients are typically seen by prescriber at least monthly
  - Behavioral intervention dependent on patient stability and available resources

Buprenorphine in Primary Care- How does it work?

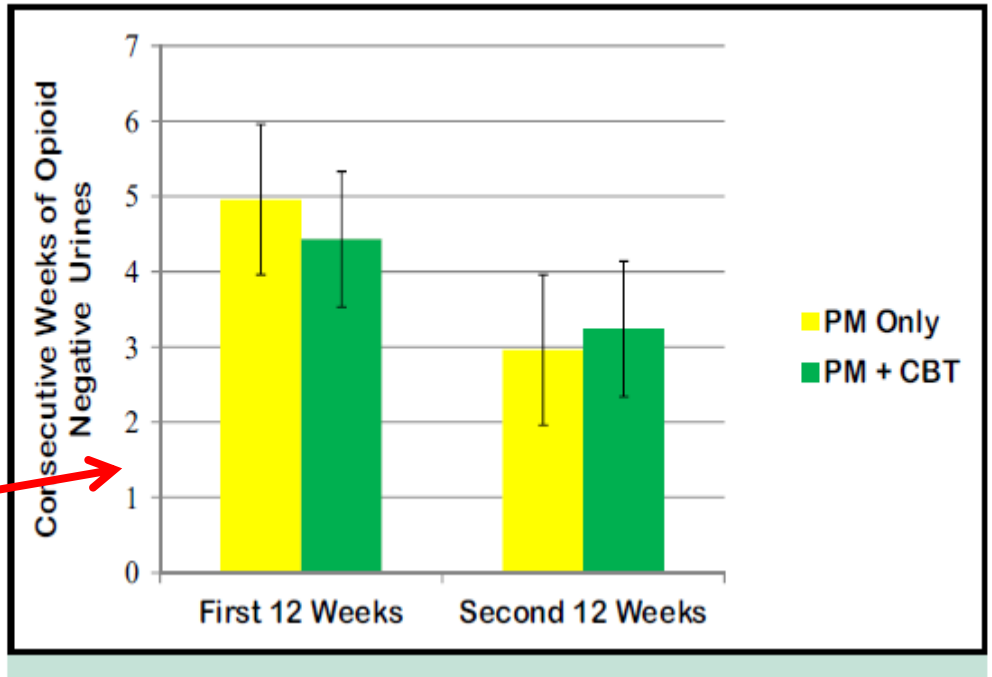
- Behavioral Health Support
  - May include:
    - Individual therapy- often CBT
    - Group sessions
    - Engagement in peer recovery groups (NA, AA, Smart Recovery, etc)
    - Other types of life skills, anger management, etc.
  - Could include participation in formal (licensed) outpatient or intensive outpatient program

Buprenorphine for OUD: Behavioral Treatment Components

- DATA 2000: "…the practitioner has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services."
- Psychosocial Services: often helpful for treatment of OUD
  - Can be delivered directly by physician and/or by referral when needed
- Outside referrals could include:
  - Individual and group therapy
  - Family therapy
  - 12 step

Behavioral Treatment in Office Based Opioid Treatment

- Three trials show that additional behavioral therapy (i.e., CBT, drug counseling) did NOT significantly improve outcomes over that achieved by buprenorphine PLUS medical management or "medical counseling" (outcome= opioid negative urines)



Weiss RD et al. *Arch Gen Psychiatry.* 2011.
Fiellin DA et al. *Am J Med.* 2013.
Ling W et al. *Addiction*. 2013.

OPERATIONAL AND WORK FORCE CONSIDERATIONS

Considerations

- Staffing Plan
  - Buprenorphine prescribers (and back-up coverage)
  - Behavioral Health Staffing vs. Linkage to addiction treatment program
  - Access to psychiatric care
  - Other staffing (“glue person”)
- External partnerships (higher levels of care, pharmacies, etc.)
- Hiring and education/training for existing staff
- Policies and Procedures
- Reimbursement & Costs

Staffing Plan

- Difficult to have a robust MAT “program” with only a prescriber
- Will need additional support from someone who is trained (“glue person”)
  - MA
  - RN
  - Care coordinator
  - Recovery Coach/Peer Health Worker

Identifying Buprenorphine Prescribers

- MD, DO, NP, PA can prescribe
  - Must complete an approved training
  - 8 hours for physicians; 24 hours for NP/PA
  - First year cap is 30 patients; subsequent years cap is 100 patients (for addiction specialists, can be increased to 275 patients)
- Many online resources for continuing education (ECHO for health centers with HRSA grants)
- Formal mentorship programs are available
- Very important to ensure that there is backup coverage

Behavioral Health Staffing vs. Linkage

- Ideal to have behavioral health staffing within your health center
  - Improves ability to coordinate care
  - Documentation in single EHR
  - Permits team-based care
  - Some health centers have formal outpatient and/or intensive outpatient programs which allow them to bill for CADC and other wrap around services (case management, peer coaching, etc)

Behavioral Health Staffing vs. Linkage

- If not able to have behavioral health services on-site, consider:
  - Identifying nearby treatment program you could partner with (outpatient, intensive outpatient, residential)
    - Importance of ensuring program is open to MAT
    - Necessary releases (42CFR and HIPAA)
    - Clear expectations outlined on both sides with regard to communication
    - This can also be a good referral source!
  - Helping participants find NA/AA meetings near by
    - Importance of identifying which meetings are supportive of MAT (participants can help to identify)

Access to psychiatric services

- High rates of co-occurring mental illness
  - Study of 716 patients with OUD seeking methadone treatment found lifetime rate of any psychiatric disorder of 47% and current rate of 39% [a]
  - Rates of MDD, AUD, antisocial personality, “minor mood disorders” and anxiety disorders are more common among patients with OUD than general population[b]
  - Rates of schizophrenia and mania were not more common as compared to general population[b]

a- Brooner, et al. Archives of general psychiatry. 1997.
b- Rounsaville et al. Archives of General Psychiatry 1982.

Hiring and Staff Training

- Helpful to identify several staff who will work closely with program (MA, RN, care coordinator), and can trouble shoot when problems arise
- Train Entire Staff:
  - OUD as chronic medical condition
    - Aberrant behavior is a symptom of the condition
  - MAT as a form of chronic disease treatment that is evidence-based
    - Important to know that many in the field of addiction have been historically anti-medication (Important to consider this when hiring)
  - Ensure that staff understand processes for entry into buprenorphine maintenance treatment program

External Partnerships

- Addiction Treatment Centers (bi-directional referrals)
  - Outpatient (OP), Intensive Outpatient (IOP), Residential, Recovery Homes, Methadone Maintenance, Detox programs (particularly for alcohol)
- Pharmacy
  - 340B program for uninsured
  - To ensure they are stocking the medication
  - To ensure they are dispensing naloxone
- Local hospitals (consideration of ER-based induction)

Establishing Office Workflows

- Work flow for intake assessment and medication induction
- Standard follow up schedule
- PMP checks
- Overdose Prevention Education/Naloxone Distribution
- Team-based care

Developing Clinical Tools

- Intake assessment tool
- Identification of urine drug screen to be used
- EMR decision support (quick texts, flowsheets to view urine drug screens and lab results)
- After-hours guidance to on-call providers

Costs and Reimbursements

- Provider and LCSW/LCPC visits are reimbursable in IL FQHC structure
- Grant funding may help with non-reimbursable costs:
  - Rapid urine drug screens
  - Labs & medication for uninsured
  - Other staff: recovery coaches, CADC, case manager, RN

Resources

- PCSS-MAT webinars
- SAMHSA TIP 40
- Buppractice.com
- New Mexico Guidelines
- Technical assistance from other clinics/experts
  - Chicago MAT LC
  - ECHO Series- open to FQHCs who received grant funding
- Many more!

Questions

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