Maryland Addiction Consultation Service

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Maryland Addiction Consultation Service (MACS)

Provides support to primary care and specialty prescribers across Maryland in the identification and treatment of Substance Use Disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions, resources, and referral information
- Education and training opportunities related to substance use disorders and chronic pain management
- Assist in the identification of addiction and behavioral health resources that meet the needs of the patients in your community
- Administered by UMB School of Medicine and funded by Maryland Department of Health, Behavioral Health Administration

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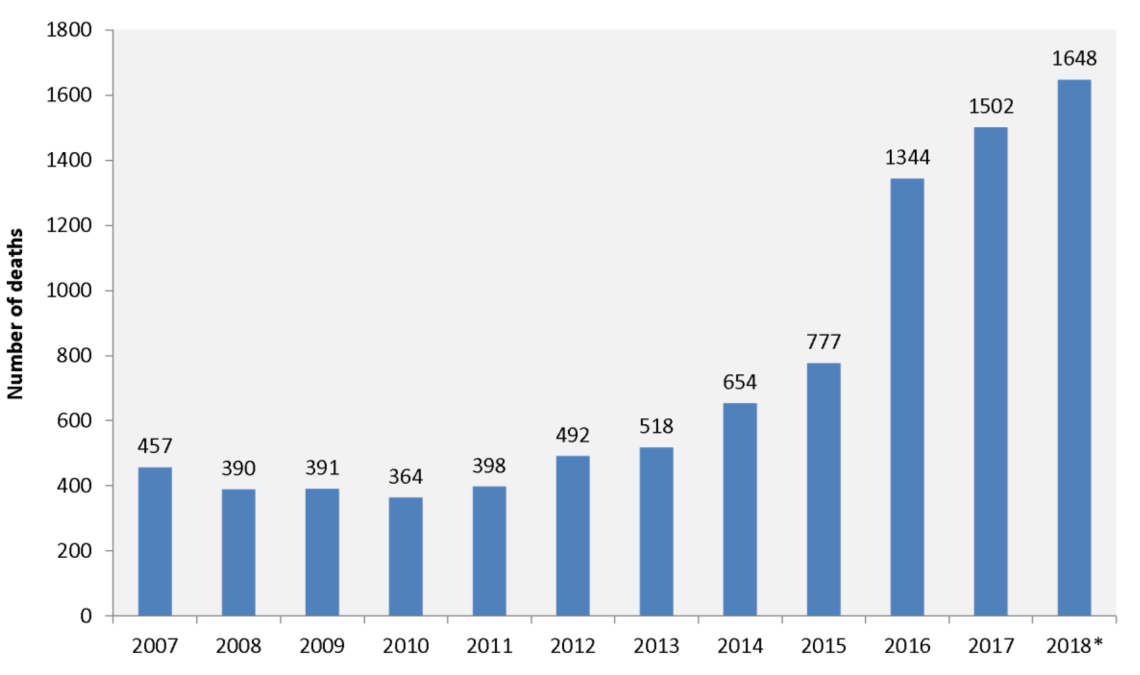
Office Based Opioid Addiction Treatment: I Got My Waiver, Now What?

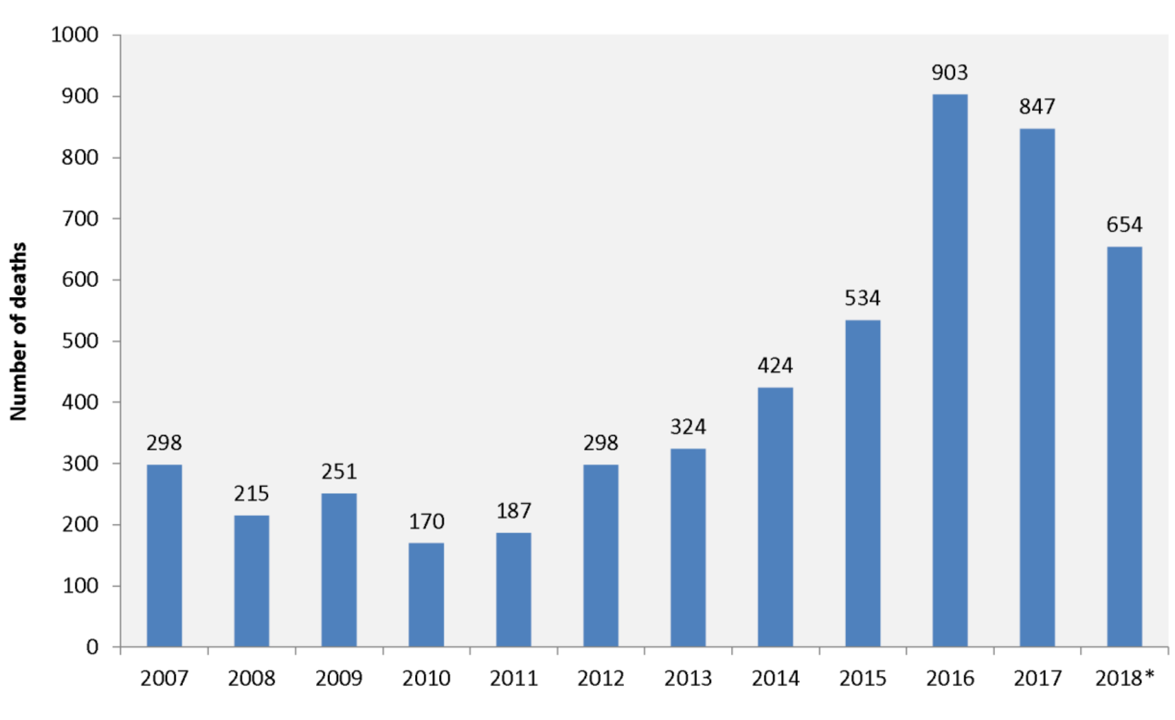
Yngvild Olsen, MD, MPH
Medical Consultant
Maryland Addiction Consultation Service (MACS)
Behavioral Health System Baltimore/Behavioral Health Administration

Outline

- The Landscape
- Getting Started with Prescribing: Think Systems
- Operations and Tracking: Who, What, When, How
- When Enough Is Enough and What to Do
- Take Home Messages

The Landscape of Opioid Addiction in MD





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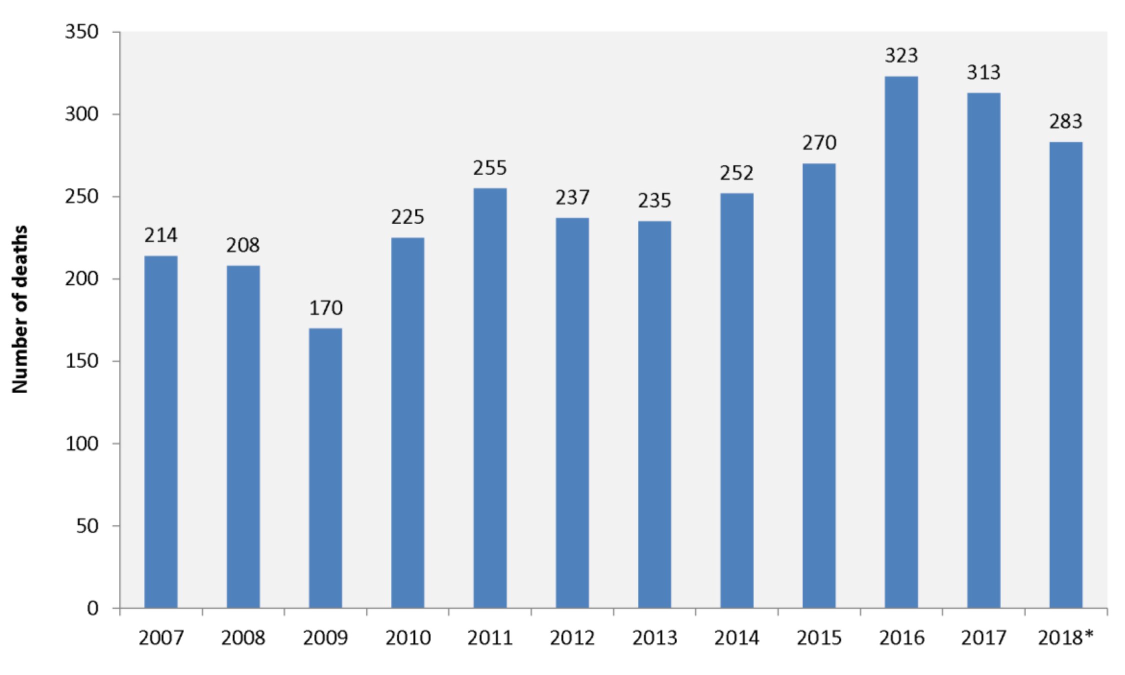

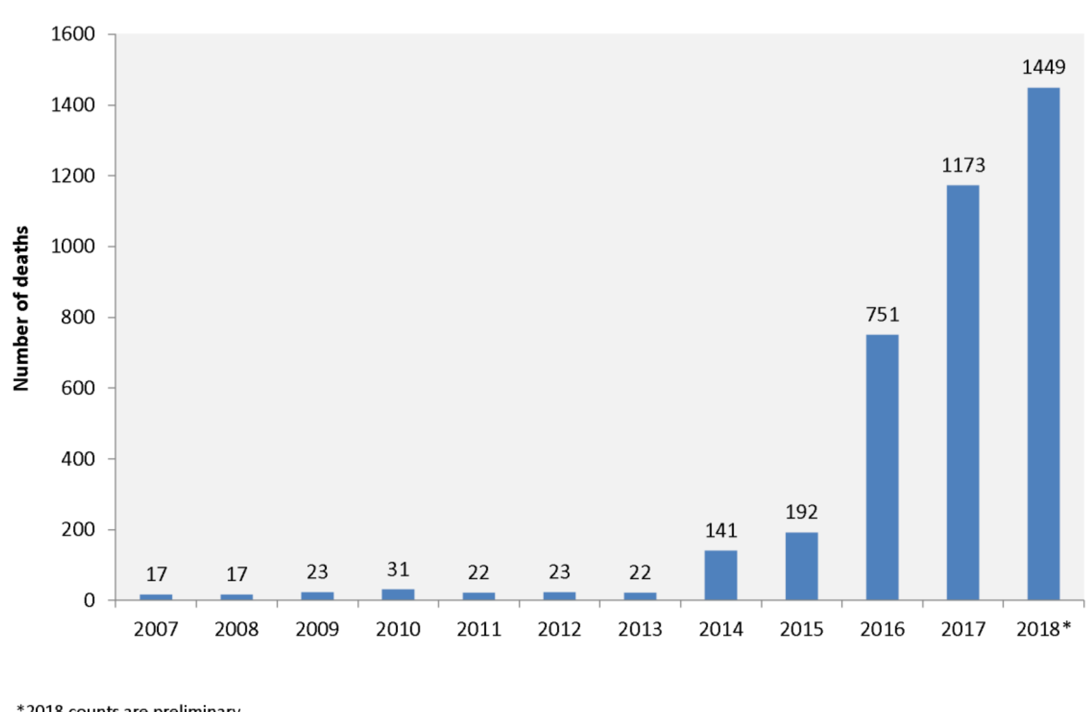

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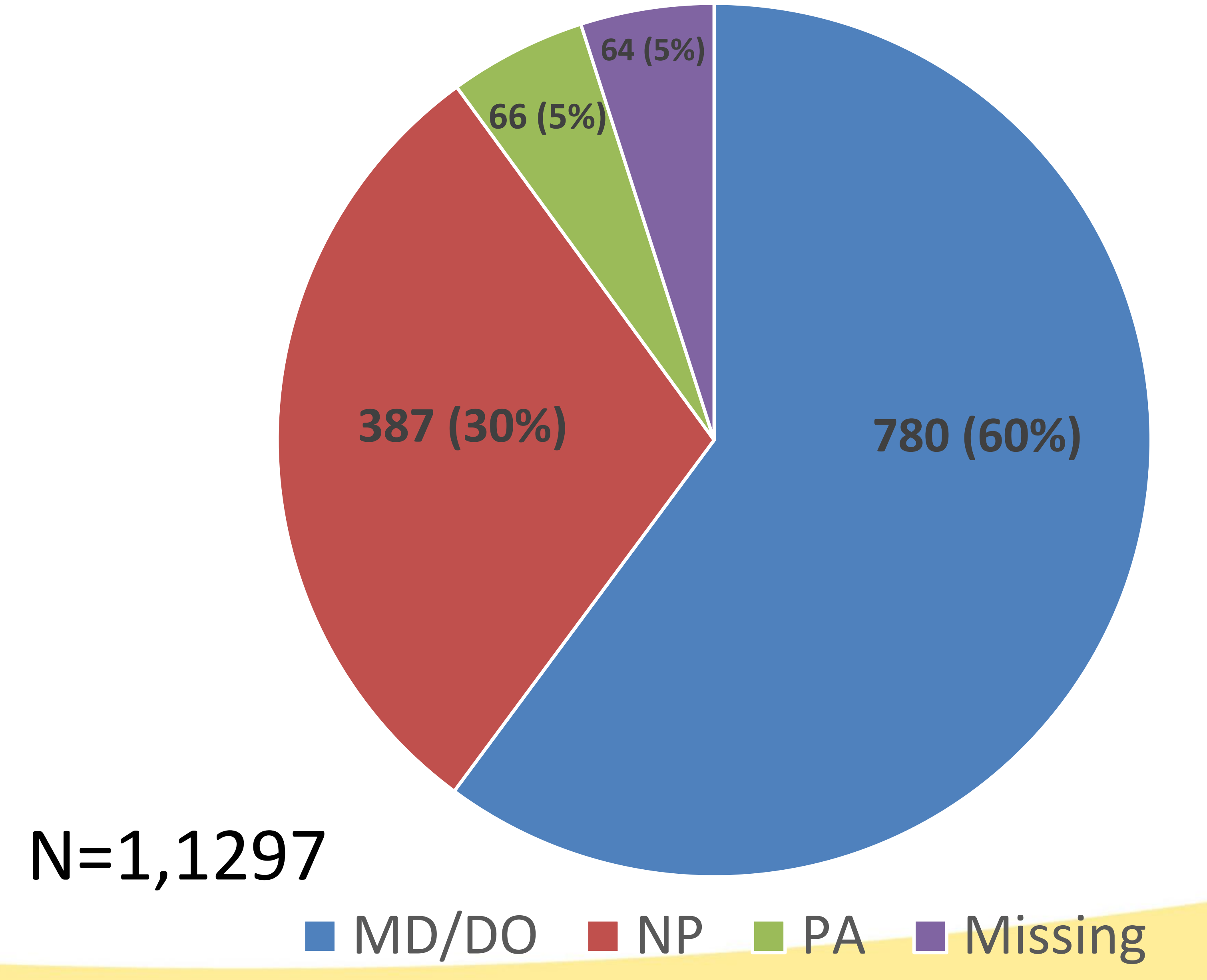
The Landscape of Waivered Prescribers in MD



Data Source: MACS/BHA
Data as of 2/5/19

The Landscape of Waiver Use

- 4225 newly waivered MDs/DOs and NPs/PAs responded to survey
- Goal: to identify clinician characteristics, prescribing patterns, and barriers
- 3181 (75%) reported having used waiver
- 13% of clinicians prescribing at or near limit
- Prescribing to mean 11 patients/month (clinicians with 30 patient limit)

Jones C and McCance-Katz E. Addiction. 2018

Barriers to Using Buprenorphine Waiver

Primary barrier to prescribing buprenorphine	
Insurance reimbursement, prior authorization or other insurance requirements	Ref
Lack of access to psychological services/other behavioral health providers	**0.34 (0.22–0.51)**
Lack of access to addiction specialists for consultation	**0.18 (0.10–0.33)**
Lack of access to psychiatric services for patients with co-occurring mental health disorders	0.99 (0.49–2.03)
Lack of confidence in managing patients with opioid use disorder	**0.17 (0.10–0.28)**
Lack of patient demand	**0.46 (0.33–0.66)**
Do not want to be inundated with requests for buprenorphine	0.62 (0.36–1.07)
Concerned about buprenorphine misuse or diversion	0.76 (0.44–1.31)
Prefer non-buprenorphine treatment options	**0.26 (0.14–0.49)**
Time constraints in my practice	0.75 (0.51–1.11)
Resistance from practice partners/staff or lack of institutional support	**0.14 (0.10–0.21)**
Federal or state regulations related to buprenorphine	**0.45 (0.27–0.76)**
Concerns over DEA intrusion into your practice	**0.51 (0.27–0.96)**
Getting practice started/no current practice site	**0.15 (0.10–0.24)**
Need supervisory physician/protocol for NP/PA	**0.06 (0.02–0.15)**
Other barrier	**0.25 (0.16–0.39)**
No barriers	**5.35 (1.89–15.18)**

Jones C and McCance-Katz E. Addiction. 2018

Getting Started: Think Systems

- Identify your model
  - Fully integrated into existing practice
  - Separate program (consider potential application of confidentiality regulations)
  - Integrated collaborative care models
    - RN Care Manager
    - Behavioral health specialist

Massachusetts RN Care Manager Model

- 2005: Researchers at Boston Medical Center surveyed all 356 waivered physicians*
  - Insufficient nursing support most frequently cited barrier to prescribing buprenorphine
  - If barriers improved 54% of never prescribers and 67% of previous prescribers would do so
- Boston Medical Center started OBOT model in 2003 with handful of physicians and a nurse care manager to support physician prescribers and patients
- Starting in 2007, OBOT-B Collaborative Care Model expanded to community health centers across MA
- 56 healthcare sites received technical assistance on model since 2016

*Walley AY, Alperen JK, Cheng DM. et al. J Gen Intern Med. 2008;23:1393-1398

Work Flow and Staffing

Team:

- About 1 FTE RN to support 3 primary care physicians or 1:125 RN to patient ratio
- 1 medical assistant
- Program coordinator

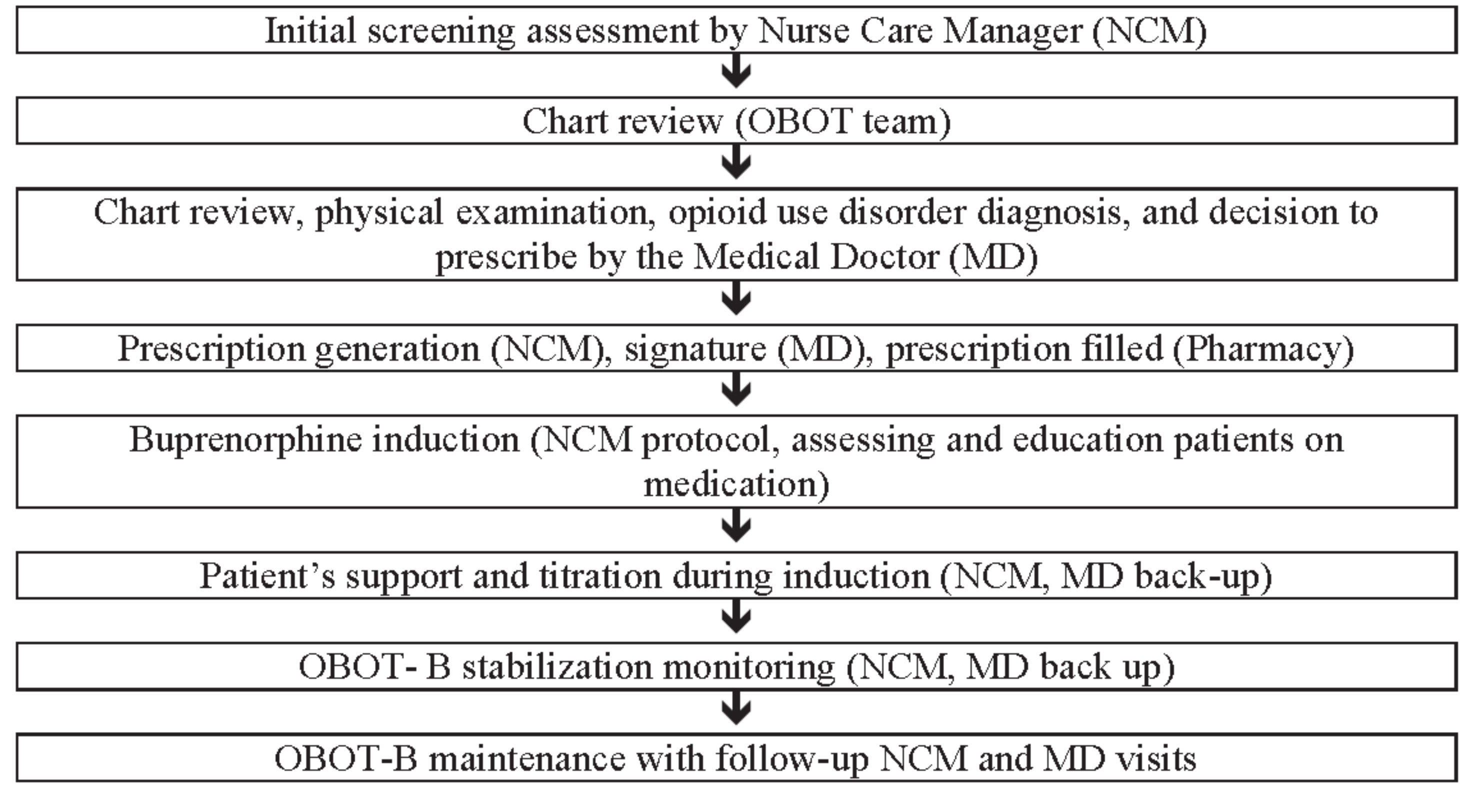


Fig. 1. Patient flow in the OBOT-B Collaborative Care Model.

LaBelle C, Han SC, Bergeron A, Samet JH. JSAT, 2016

Impact of OBOT-B Collaborative Care Model

Table 2. Treatment Outcomes at 12 Months of 382 Opioid-Dependent Patients Entering Office-Based Opioid Treatment in Primary Care

Outcome	Patients, No. (%)
Successful treatment	196 (51.3)
Treatment retention	187 (49.0)
Successful taper after 6 months of adherence[a]	9 (2.4)
Unsuccessful treatment	162 (42.4)
Lost to follow-up	113 (29.6)
Nonadherence despite enhanced treatment[a]	46 (12.0)
Administrative discharge due to disruptive behavior	2 (0.5)
Adverse effects of buprenorphine hydrochloride	1 (0.3)
Transfer to methadone hydrochloride treatment program	24 (6.3)

- Close to 8,000 patients treated between 2007 and 2013.
- Number of physicians waivered to prescribe buprenorphine increased by 375% (24 to 114) over 3 years
- Average hospital admissions and ED visits reduced per OBOT enrolled patient by about 50%

Source: Samet J. How to Build It: The "Massachusetts Model" of Office Based Opioid Treatment (OBOT) with Buprenorphine. https://www.uab.edu/medicine/dom/images/files/MassachusettsModel_OfficeBasedOpioidTreatment.pdf

Alford DP, LaBelle CT, Kretsch N, et al. Collaborative Care of Opioid-Addicted Patients in Primary Care Using Buprenorphine: Five-Year Experience. Arch Intern Med. 2011;171:425-431.

Model Challenges and Successes

- Challenges
- Provider and staff resistance
- Funding often siloed
- Need for initial and ongoing training
- Many other priorities
- Easier to co-locate services

- Successes
- Key champions
- Leverage existing and new resources
- Data drove prioritization of OUD treatment
- Deliberate about integration and models created to foster that

Identify Your Team

- Possible Team Members
  - RN Care Manager
  - Medical Assistant
  - Pharmacy
  - Covering prescriber
  - Behavioral Health Specialist
  - Practice Manager or Other Operations/Admin Role

- Team member functions
  - Manage phone calls from patients and pharmacy
  - Check in with patients between visits and help problem solve unexpected situations
  - Provide additional support to patients on visit days
  - Track urine testing and results
  - Reinforce treatment agreements and expectations
  - Provide back-up coverage for primary prescriber
  - Help develop operations documents and checklists

Physician/NP/PA Role

- Physician/NP sees patient if ready to start medication
- Brief review of recent opioid use history, treatment expectations, how to take medication, and COWs
- Write prescription for buprenorphine/naloxone
  - Expect to start with 4mg/2mg
- Have patient fill at pharmacy
  - Recommend to use on-site pharmacy if available
- Decision:
  - Have patient stay and take medication with nurse or BH specialist
  - Have patient take medication home
- Return to see nurse in about 3-4 days for repeat COWs, medication adjustment if needed, and refill for one week from prescriber

Lay Out Workflows

- Concrete steps with functions to be performed
- Team member responsible
- Decision points and associated actions

Example:

Clinical Pathway for Medication for Addiction Treatment

PATIENT
PATIENT INITIATES CONTACT OR PROVIDER REFERS

NURSE
CHART REVIEW
Assess whether MAT therapy is appropriate for patient
YES → next step; NO → Refer to other resources

COORDINATOR
SCHEDULE INTAKE ASSESSMENT

NURSE
INTAKE ASSESSMENT—NURSE MANAGER
- Nursing assessment
- Complete patient consent, contracts, patient education
- Lab work
- Urine toxicology screen (UTS)

PROVIDER
INTAKE ASSESSMENT—WAIVERED PROVIDER
- Lab/UTS review
- PE as needed
- Prescription to pharmacy for 1 week or less

NURSE
INDUCTION DAY 1
- Patient in early withdrawal
- Medication in hand
- First dose self administered following the assessment

Is a second dose needed? YES → Self administer second dose; NO → Reassess

NURSE
SELF ADMINISTER SECOND DOSE
- 30 to 60 minutes after first dose

NURSE
REASSESS
- 1 to 2 hours after medication administration
- Patient instructions reviewed at follow-up

NURSE
INDUCTION DAY 2
- Assessment of withdrawal symptoms
- Dose adjustment per orders
- Ongoing patient education

Is a second dose needed?

NURSE
STABILIZATION
- Follow up by phone
- Weekly or more frequent (as needed) visits
- Ongoing education
- Mental health concerns addressed?

Ongoing Maintenance

PROVIDER
MAINTENANCE (WAIVERED PROVIDER)
- Patient visits clinic at least once every 4 months or per waiver requirements to review:
- Labs
- UTS
- Prescription dose
- Treatment plan
- Acute issues

NURSE
MAINTENANCE (NURSE MANAGER)
- Follow up as needed (weekly, monthly, randomly)
- Assess medical changes, surgery plans, pain, HCV infection status, pregnancy, medication changes
- Review mental health plan

PROGRAM COORDINATOR
MAINTENANCE (PROGRAM COORDINATOR)
- Verify counseling attendance
- Update contact and pharmacy information
- Assist with team meetings, patient interventions, insurance information, tracking new treatment plans

PATIENT
PATIENT REQUESTS TO TAPER
- Review plan, taper slowly
- Prepare patient for withdrawal symptoms
- Monitor frequently
- Readdress plan as needed
- Resume if patient agrees

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LaBelle C, Han SC, Bergeron A, Samet JH. JSAT, 2016

Operational Steps: Screening/Identification

- Goal: identify new or existing patients with an opioid use disorder
- Process could incorporate a few questions into medical or behavioral health encounter

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?

The following questions are validated as screening tools for alcohol use

AUDIT- C Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL :	

AND/OR…..

- Use diagnostic checklist
- Screening tools/checklists can be completed by patient, provider, or ancillary staff

Opioid Use Disorder Diagnostic Criteria, DSM-5

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- ❑ Often taken in larger amounts or over a longer period than intended
- ❑ Inability to cut down/control use
- ❑ Considerable time spent using/obtaining/recovering
- ❑ Important activities given up/reduced
- ❑ Use despite negative consequences
- ❑ Failure to fulfill role obligations
- ❑ Craving or strong desire to use
- ❑ Recurrent use in hazardous situations
- ❑ Recurrent use despite persistent, related social/relationship problems
- ❑ Tolerance*
- ❑ Withdrawal*

Mild = 2-3, Moderate = 4-5, Severe=6+

*These criteria do not apply for those taking opioids solely under appropriate medical supervision

Operational Steps – Responding to Positive Opioid Screen/Diagnosis

- Provider or nurse reviews responses to screening tools/checklist with patient and offers options
  1. Referral for treatment with medications (either buprenorphine or injectable naltrexone) within your practice
  2. Referral for in-depth assessment and treatment outside your practice
  3. Referral for other behavioral interventions as needed either outside of or at your practice based on insurance, patient choice, and other factors
- If patient selects option 1, recommend reviewing patient/prescriber agreement prior to starting medication

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Patient/Prescriber Agreement

- Outlines expectations of patient and prescriber
- Can serve as informed consent tool
- Identifies alternatives to buprenorphine
- Recommend updating and reviewing at regular intervals (eg annually and if issues arise)

Patient Name: ____________________________ **MR#:** ______________ **DOB:** __________

I am requesting that my doctor prescribe buprenorphine, a controlled medication, to me for treatment of opioid addiction. I freely and voluntarily agree to accept this controlled medication agreement and I understand what is being expected of me and what I can expect of my doctor and my clinic as outlined below:

i. I agree to keep, and be on time for, all my scheduled appointments with the doctor and any of his/her assistants.
ii. I agree to call the clinic ahead of time if I cannot make an appointment or am running late.
iii. I agree to conduct myself in a courteous manner in the doctor's or clinic's office and, in return, I understand that my doctor and other clinic staff will treat me with respect and courtesy.
iv. I agree to have one doctor prescribe buprenorphine for me and I will not seek out other doctors other places for additional prescriptions. My primary buprenorphine prescriber is: _________________
v. I agree to fill my prescriptions at one pharmacy, and I will give my doctor and clinic the name and phone number to this pharmacy. I agree to conduct myself in a courteous manner at the pharmacy, and, in return, I understand that my doctor and/or clinic will assist me if I have trouble there with my prescription.
vi. If I have to change pharmacies, I will let my doctor know and provide him/her with the new pharmacy's information.
vii. I agree that the medication I receive is my responsibility and I will store it in a safe, secure place, away from children and teenagers. I agree that lost medication will not be replaced, unless I have a police report to document that it has been stolen.
viii. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is very serious and likely will result in my being unable to receive any further buprenorphine from my doctor. Instead, I will likely be transferred to a substance abuse treatment program where I will need to attend every day to receive medication until I am stable.
ix. I agree that my doctor will only give me prescriptions for buprenorphine at my regular office visits. If I miss a visit, I likely will not be able to get a prescription until the next scheduled visit. If my doctor has to cancel my appointment, he/she will make sure I receive my prescription in time to not disrupt my treatment.
x. I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my doctor who prescribes buprenorphine. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as Xanax® (alprazolam) or Klonopin® (clonazepam), alcohol, and other drugs of abuse can be dangerous and even lead to death.
xi. I agree to communicate openly and honestly with my doctor and report any use of drugs or alcohol that may negatively affect my recovery. In return, I understand that my doctor will work with me to the utmost of his/her ability to help me maintain and strengthen my recovery.
xii. I agree to take my buprenorphine as my doctor has instructed, and not to change the way I take my medication without first consulting my doctor. I understand that my doctor will prescribe me buprenorphine at an effective dose that helps me with the least amount of side effects. If my doctor determines that buprenorphine is no longer effective for my opioid addiction, I understand that I may be transferred to a substance abuse treatment program where I will receive counseling and be offered other medication options, such as methadone or naltrexone.
xiii. I understand that my doctor or clinic may call me at any time to bring in my medication or provide a urine sample for testing. I understand that not adhering with this may be considered a risk factor for mishandling of my medication and likely will result in changes to my treatment.
xiv. I understand that medication alone is not sufficient treatment for my disease and I agree to participate in counseling and/or recovery-related activities that my doctor either recommends or that he/she and I agree on together.

Patient Signature:____________________________________ **Date:**_______________

Operational Steps – Starting Medication

- Nurse-driven or counselor-driven models are effective
- Schedule slightly longer nurse and physician visits for initial visit to start medication
- Patient is counseled to not take or use any opioids within 12 hours prior to visit
- Nurse with or without counselor conducts and scores Clinical Opioid Withdrawal Scale (COWS)

Operational Steps – Tracking, Urine Testing, and Ongoing Care

- Controlled medication agreements and urine testing are best practices for opioid prescribing for pain and OUD treatment
- Do not need observed urine collection:
  - Use temperature sensitive cups
  - No bags or jackets in bathroom
  - Can test for creatinine and pH if sending sample out to lab
- Testing can be done either onsite (POC) or through commercial lab
- Patients should be seen weekly initially to see nurse or counselor to check on medication adherence
  - If possible, brief check-in with prescriber
  - Buprenorphine dose should stabilize after 2 weeks
  - Refills are given weekly until stable, then every 2 weeks to then once monthly
- Collect urine sample at every visit and randomly send for typical panel including buprenorphine and norbuprenorphine
- Check PDMP and maintain log or easily accessible list of patients receiving buprenorphine

Initial Patient Selection Criteria

- Recommend starting with lower complexity patients:
  - Stable housing
  - Consistent transportation
  - Some level of family or other social support
  - No to minimal benzodiazepine use
  - Minimal other substance use
  - Less severe mental illness, if present

Billing Codes

- Maryland Medicaid covers and reimburses for SBIRT codes
- Maryland Medicaid reimburses for medication for addiction treatment services whether done in primary care or behavioral health setting
  - In primary care, ICD-10 code of opioid use disorder is secondary code
  - Traditional E&M codes are used for billing and claim submitted to patient's MCO with corresponding E&M charge
  - In behavioral health setting, E&M billing is done under corresponding provider type to Beacon Health Options

Recovery Check-Ups

Components

- Assessment of buprenorphine/naloxone efficacy
    - Efficacy of withdrawal and craving suppression
    - Last misuse of other opioids
- Presence of side effects or adverse reactions
- Occurrence of significant life events
- Engagement in recovery-related activities
- Check PDMP and urine test results
- Review concerns or indications of instability

Appendix E: Checklist for Follow-up Visits with Patient on Suboxone®

Pt Name: ______________________________**DOB:** _____________ **Date:** ___________

Has the patient had a complete history and physical examination including medical, psychiatric, and substance abuse history, treatments and patient responses? **Yes** ☐ **No** ☐(if no, complete H+P)

☐ Assess effect of Suboxone®

1. How is your dose of Suboxone® working for you?
2. Are you having any cravings or drug dreams?
3. What do you do when you have cravings or drug dreams?
4. Are you having any withdrawal symptoms? If so, what symptoms?
5. Are you experiencing any side effects from the medication (such as decreased sexual function?)

☐ Conduct recovery check-up

1. How have you been spending your time since I last saw you, both with obligations and free time?
2. Who have you been spending most of your time with?
3. Have there been specific things (stressors or triggers) that have been making it difficult to sustain your recovery? If so, what have they been? How have you been managing them?
4. Have you used any illicit substances or ETOH since your last visit?
5. What recovery-related activities have you participated in since our last visit?
6. How concerned are you right now about your ability to maintain your recovery until our next visit?
7. What recovery-related activities are you going to participate in between now and our next visit?

☐ Note presence of any aberrant drug-taking behaviors and discuss with patient

Clinical Guidelines for Continuing Care Physicians in the Baltimore Buprenorphine Initiative (2013) were developed by the Baltimore City Health Department, Baltimore Substance Abuse Systems, and Baltimore Healthcare Access.

Gather Your Tools: Summary

- Screening Tools
- Diagnostic checklist
- COWs instrument
- Patient agreement template
- Referral resources with contact names and numbers
  - Behavioral health resources including OTPs and addiction medicine consultants
  - Prescriber supports (e.g. MACS, PCSS, MDDCSAM)
- Urine testing and PDMP checking protocol
- Patient selection criteria
- Billing related forms and codes
- Recovery Check up checklist (if used)

Assessing Readiness

- Use current practice transformation or new project processes
- Formal needs assessment
- Readiness checklist
- Practice-driven only vs getting outside help

When Enough is Enough – and What to Do

- Doses need to be adequate

  But……..

- Buprenorphine is not a panacea
  - Other substance use disorders may develop or recur
  - Opioid use disorder may recur or remain unstable
  - Other co-occurring conditions or psychosocial issues may complicate management in office based setting

- Initial reaction and temptation is often to taper/discontinue buprenorphine if patients are not doing well – or doing what they “are supposed to”

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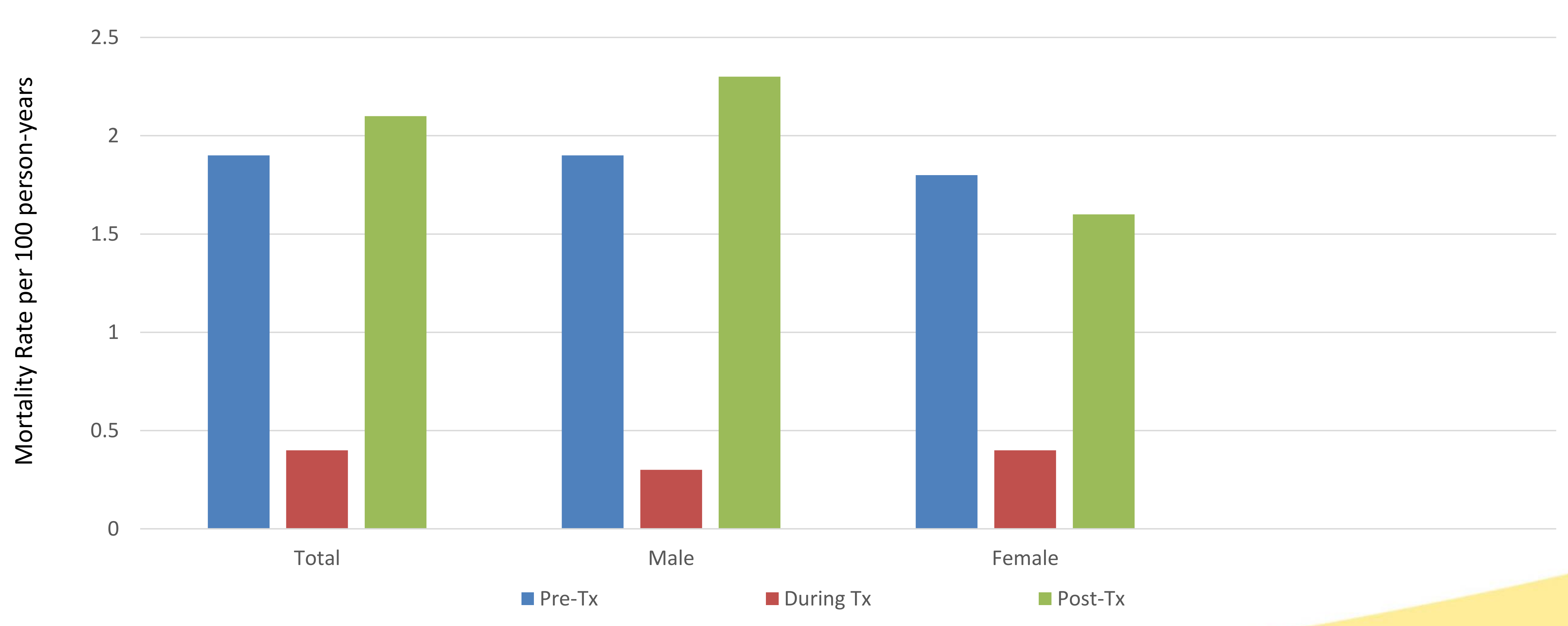
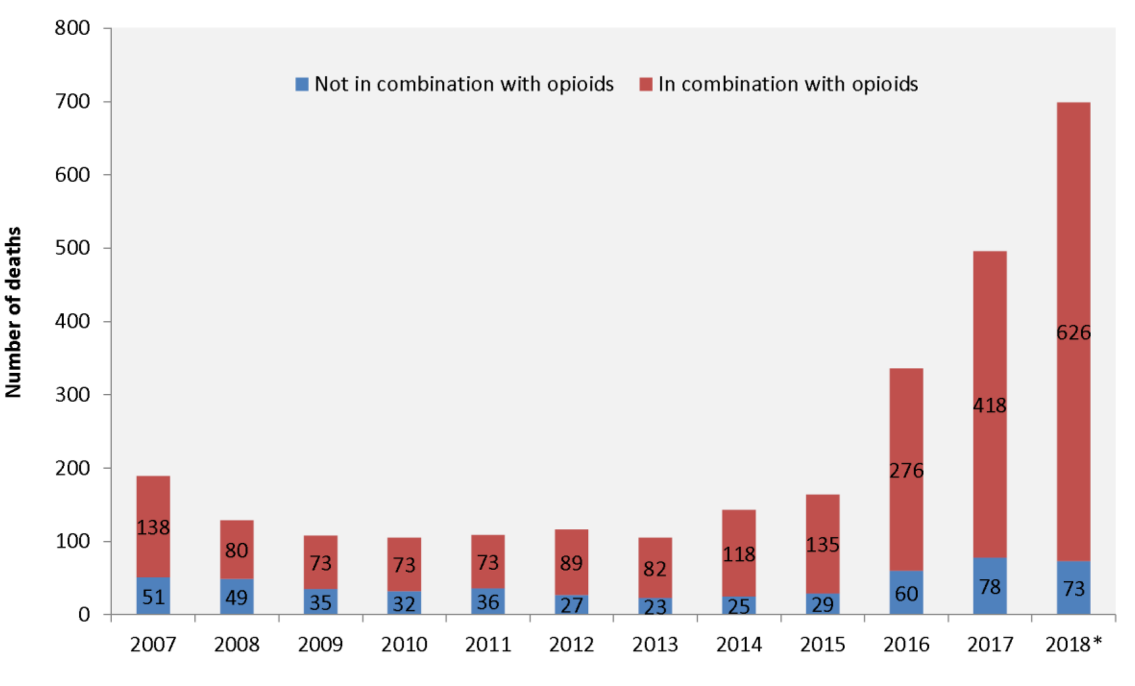
Opioid Overdose Mortality Rates

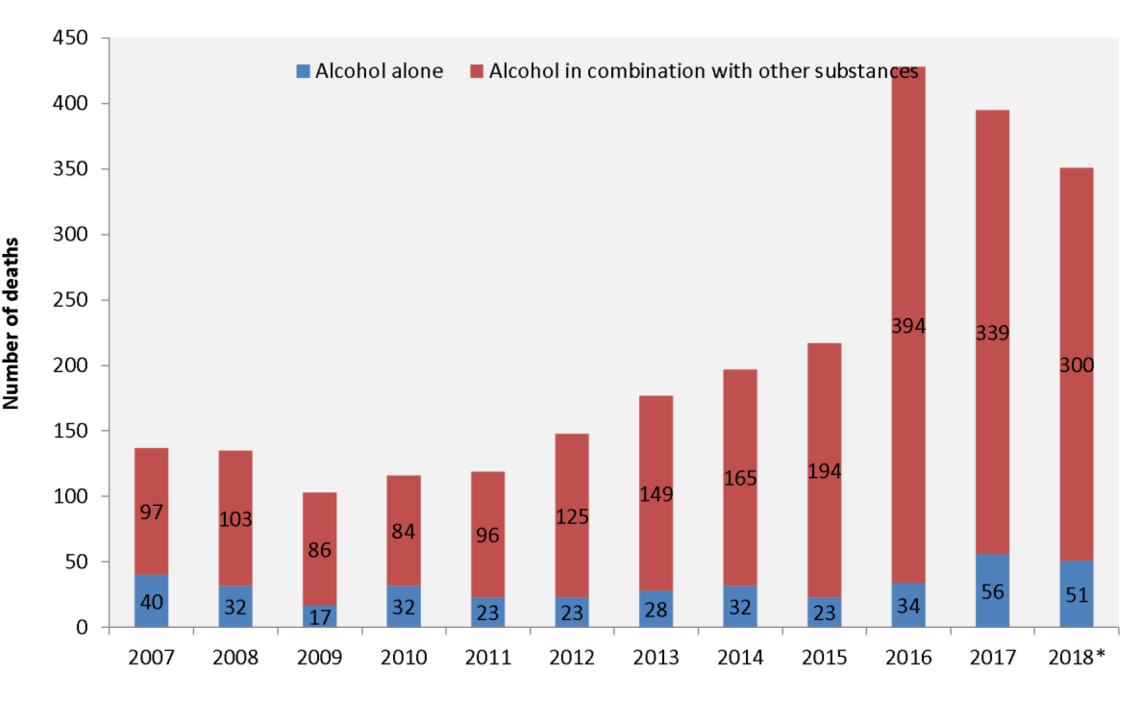
Before, During, and After Treatment with Methadone



Clausen et al, Drug Alcoh Depend 2008

Other Contextual Data to Consider





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When Enough is Enough – and What to Do

- Decide on comfort level caring for complex patients
- Decide on what practice can realistically manage
  - Shorten lengths of prescriptions
  - More frequent visits with urine testing at each visit
  - Check buprenorphine/norbuprenorphine ratios
- Look at patient agreement and review with patient
- Consider risks of discontinuing buprenorphine with risks of continuing office based practice for complex patients
- Use patient and prescriber supports
- Transfer patients to specialty addiction treatment specialists
  - OTP with buprenorphine dispensing capability
  - Residential care if other unstable SUDs present
  - IOP/OP if no OTP available

Take Home Messages

- Integrating opioid addiction treatment into primary care can be done!
- Need supportive systems, not just waivered prescribers
- Have system for identifying appropriate patients
- Plan, plan, plan and have key people at the table
- It takes a team
- Look beyond your own institutions to create networks
- Collect and use data
- Communicate successes

QUESTIONS?

Yngvild.Olsen@gmail.com

Yngvild.olsen1@Maryland.gov

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