Developing the workforce for integrated care

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Forum on Mental Health, and Substance Use Disorders
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BOSTON MEDICAL CENTER
OBAT TTA Office Based Addiction Treatment Training and Technical Assistance
Grayken Center for Addiction Boston Medical Center
BOSTON UNIVERSITY
CARE Clinical Addiction Research and Education

Conflicts of interest

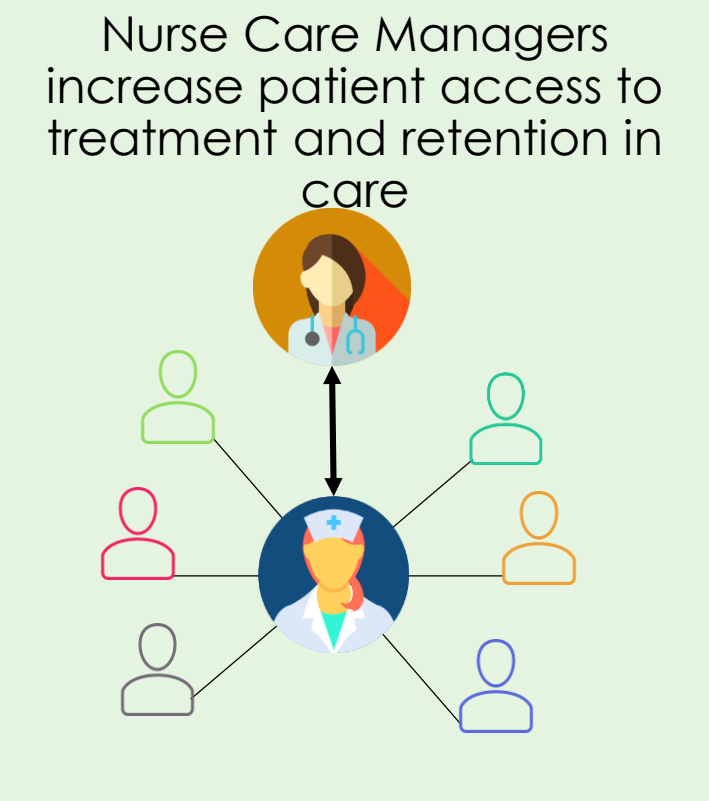
No financial or personal conflicts of interest to disclose.

Majority of funding for Office Based Addiction Treatment Training and Technical Assistance provided by:

GE Foundation

Opioid Response Network STR-TA

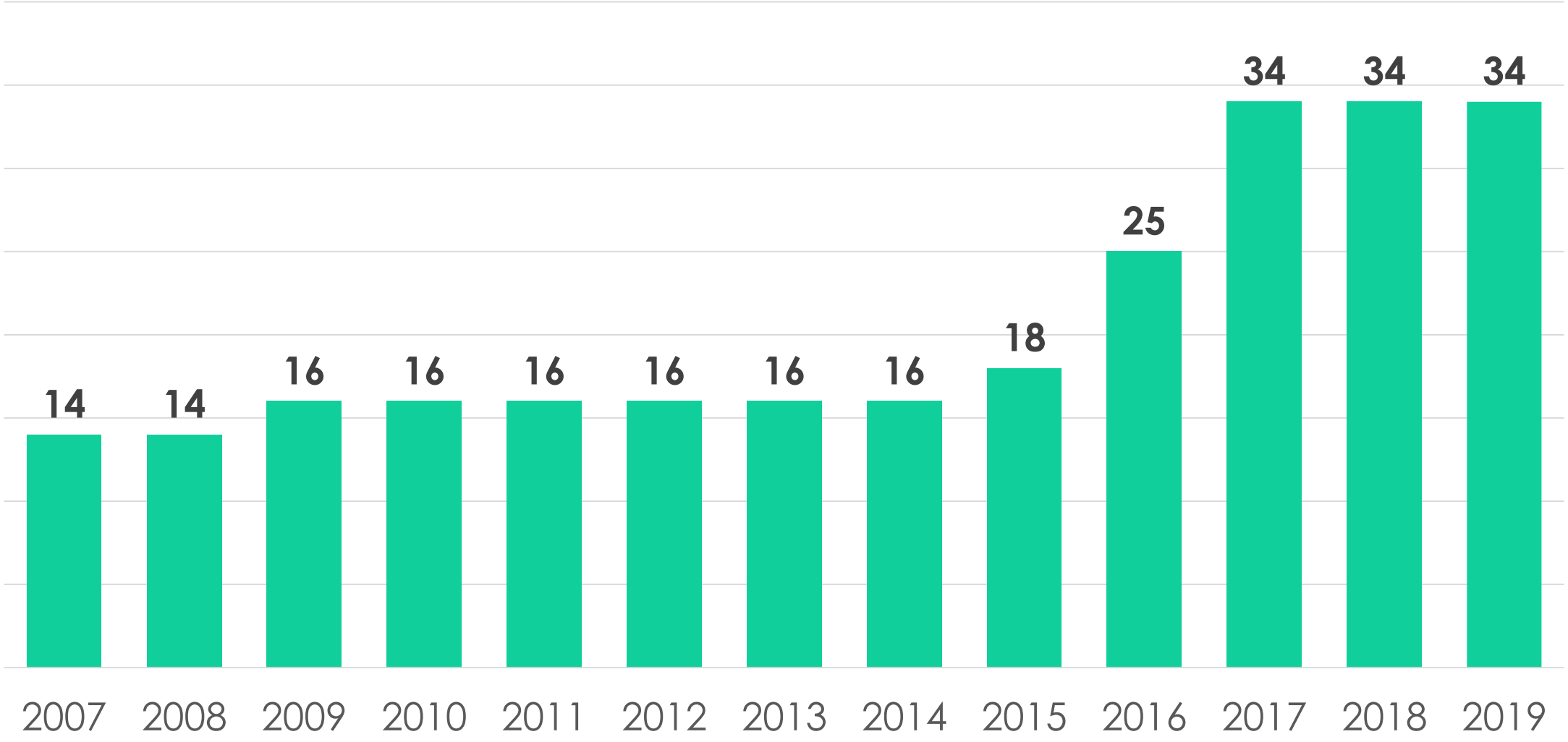
Nurse Care Manager Model for OBAT



Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. Archives of internal medicine, 171(5), 425-431.

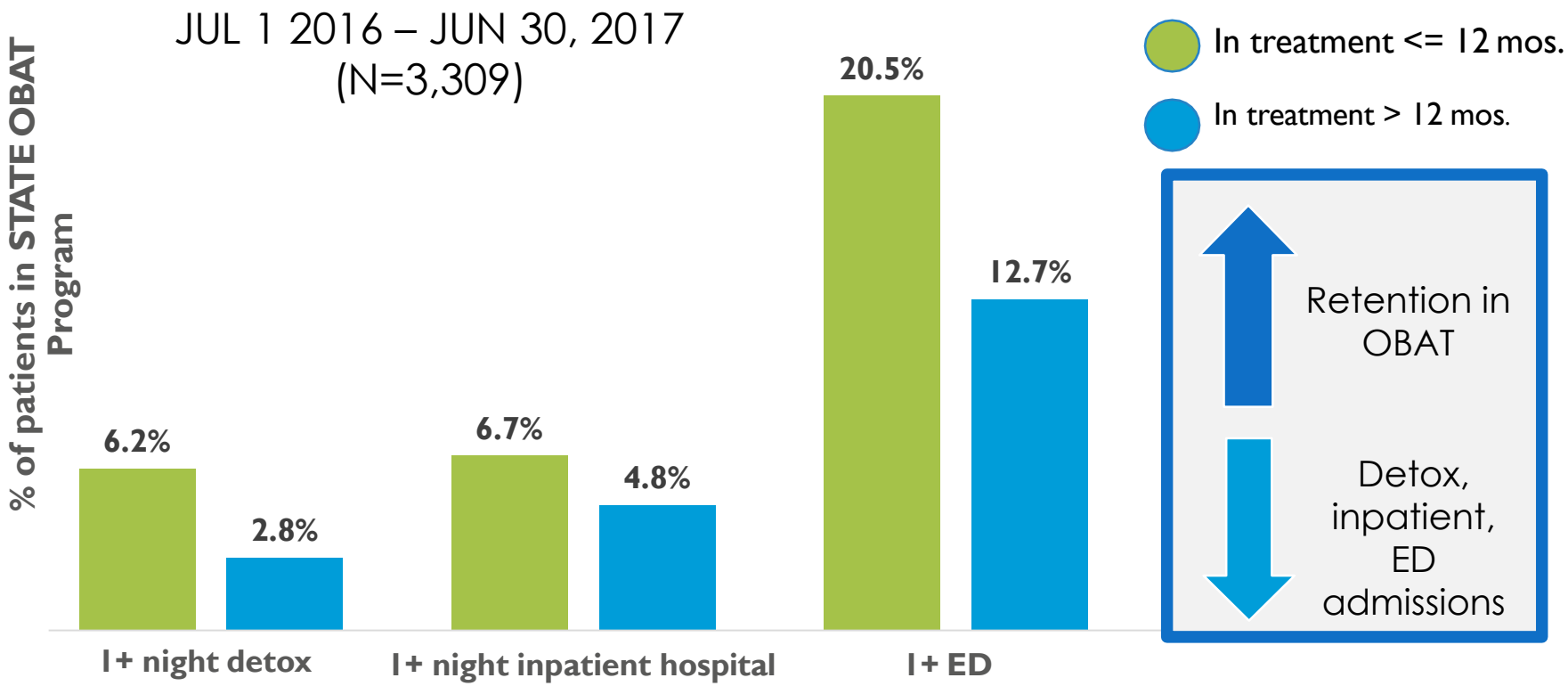
- NCM role includes:
  - Medical Case management
  - Brief counseling/MI, social support, patient navigation
- NCMs working at full scope of license:
  - Provided Substance Use Disorder treatment oversight
  - Address Urine toxicology
  - Assist with Insurance issues, prescription/pharmacy issues
  - Pregnancy, acute pain, surgery, medical needs
  - Concrete service support: legal/ social/ safety/housing
  - Emergency Contact: Direct Connection to NCM

Number of CHCs funded by MA DPH to Implement BMC OBAT Model by Year

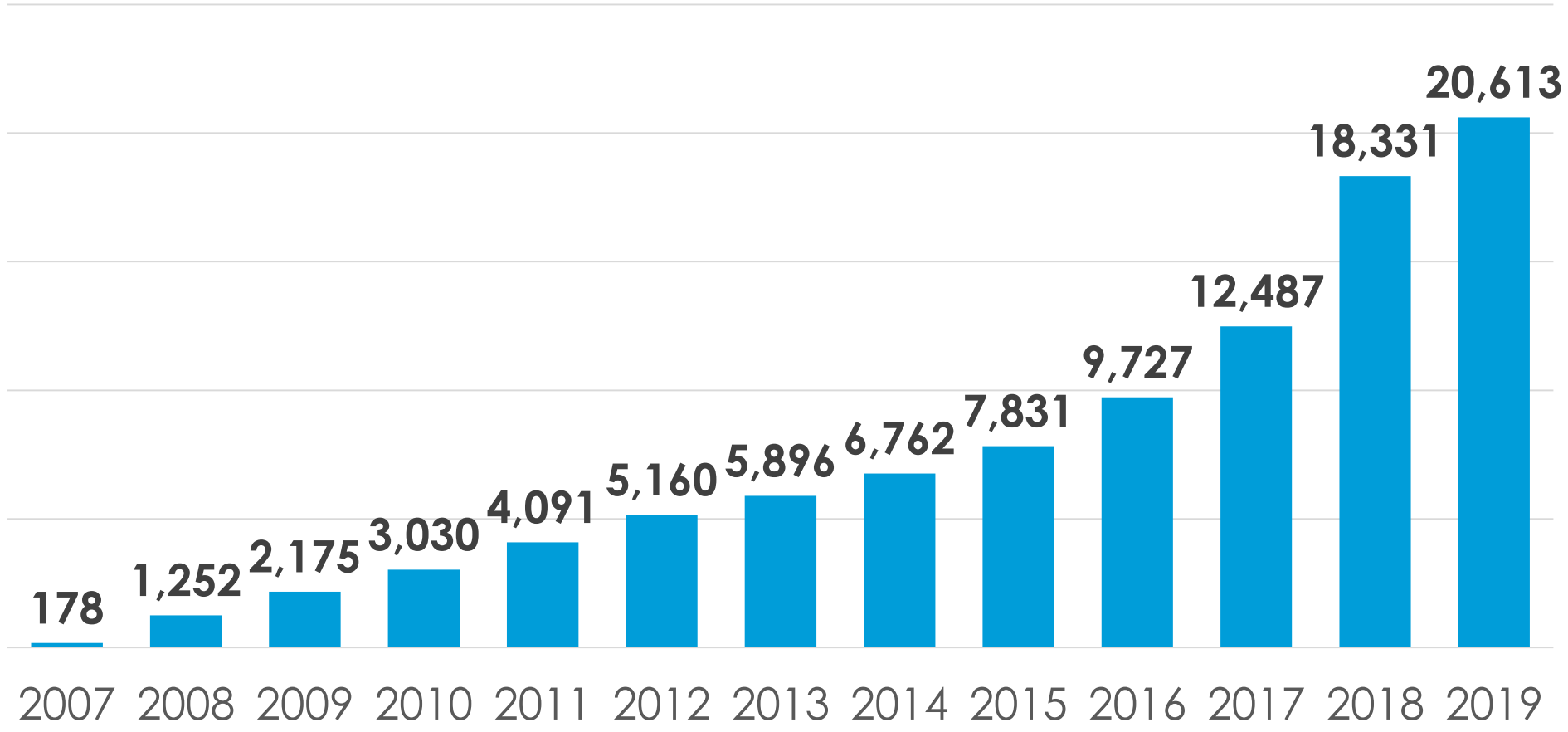


Source: Boston Medical Center, OBAT TTA Program data

HEALTH CARE UTILIZATION OUTCOMES MA OBAT SITES



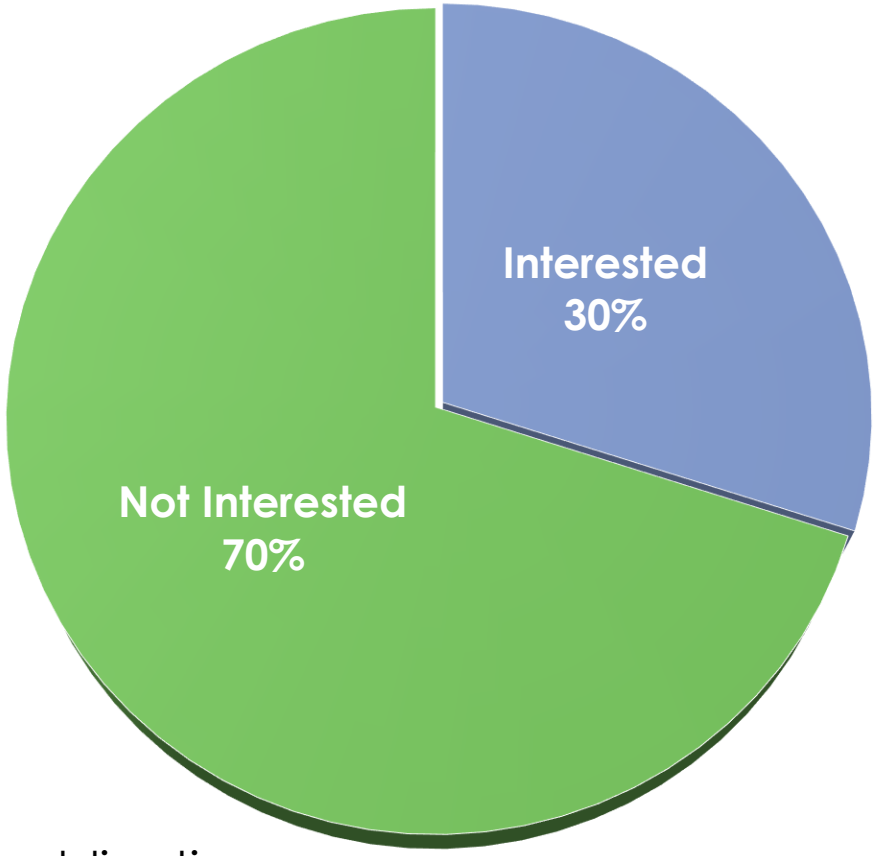
Cumulative Number of Patients Ever Treated by Year at MA DPH Funded Sites



Source: Boston Medical Center, OBAT TTA Program data

Survey after waiver course N 399 Respondents

% of individuals interested in additional support



N= 110 Respondents requested OBAT TTA reach out to them for assistance.

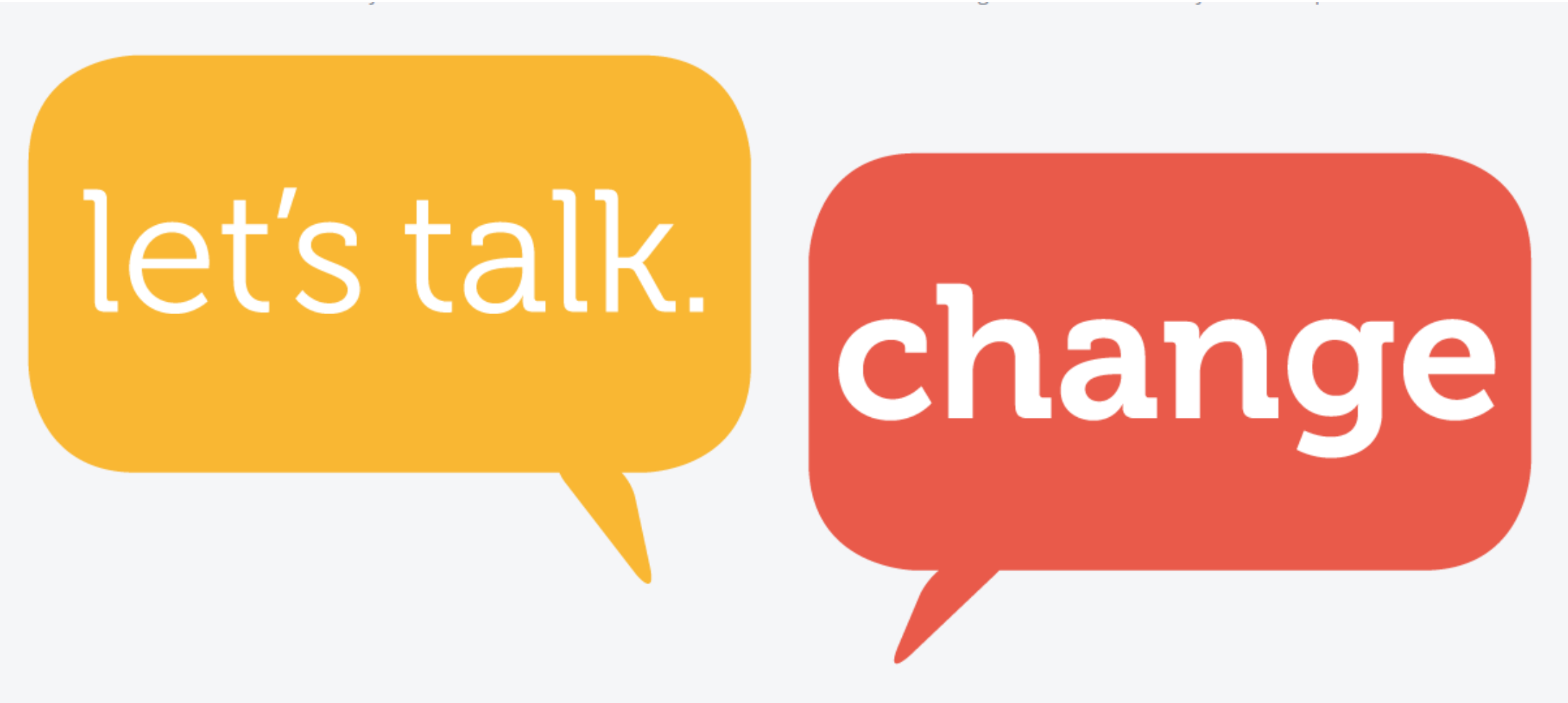
This is preliminary data , pending publication.

Mental Health Parity Act 2008

- *Progress* made in addressing and removing obvious gaps:
  - LImit number of inpatient/outpatient mental health visits
  - Eliminating precertification requirements
  - Separating deductibles with copays
- *Nevertheless,* insurers find ways to restrict MH-SUD services:
  - Disparities defining utilization management and medical necessity
  - Limited behavioral healthcare services within provider networks
  - Lower reimbursement for behavioral healthcare providers

American Counseling Association. ACA Government Affairs Blog. Accessed on October, 9, 2019 at: https://www.counseling.org/news/aca-blogs/aca-government-affairs-blog/aca-government-affairs-blog/2018/10/12/the-mental-health-parity-and-addiction-equity-act-ten-years-later

Moving from *traditional* to *new* ways of educating workforce



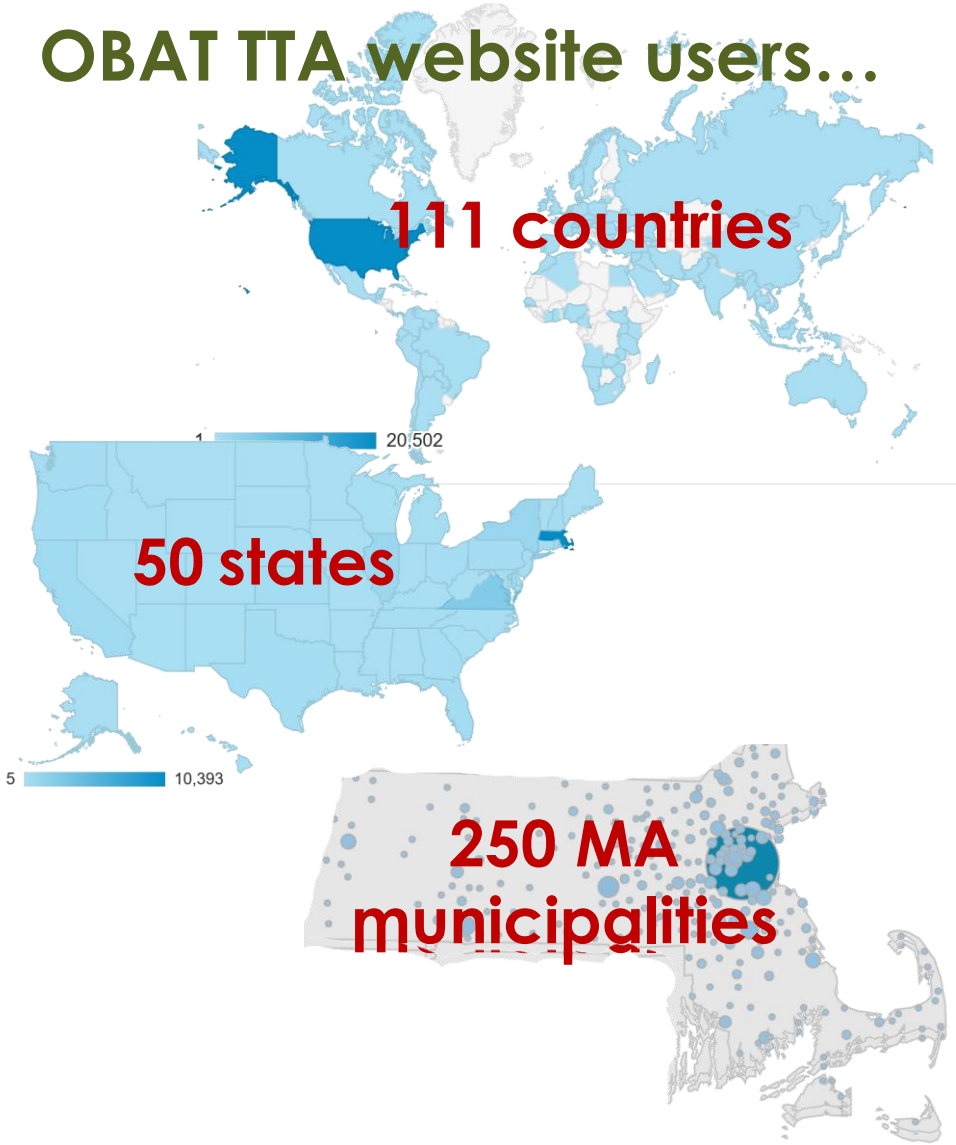
Leveraging Technology: OBAT TTA Website and Resources

Jul 2018 and June 2019..

- 22,000 unique individuals have visited OBAT TTA website (bmcobat.org)
  - 16,293 total sessions
  - 74,012 total page views
- OBAT TTA website visitors from:
  - 111 countries
  - 50 of States
  - 250 unique municipalities across Massachusetts

BMC's OBAT TTA Website: BMCOBAT.ORG

- From Jul 2018 - Jun 2019:
  - **22,000 users = 35,000 unique visits**
- Hosts national and state-specific guidelines, protocols, workflows, and other resources
- Registration, evaluations, and downloadable continuing education certificates for conferences and trainings
- System for tracking TA requests
- Back-end reports for tracking



Free easy to use clinical tools for providers

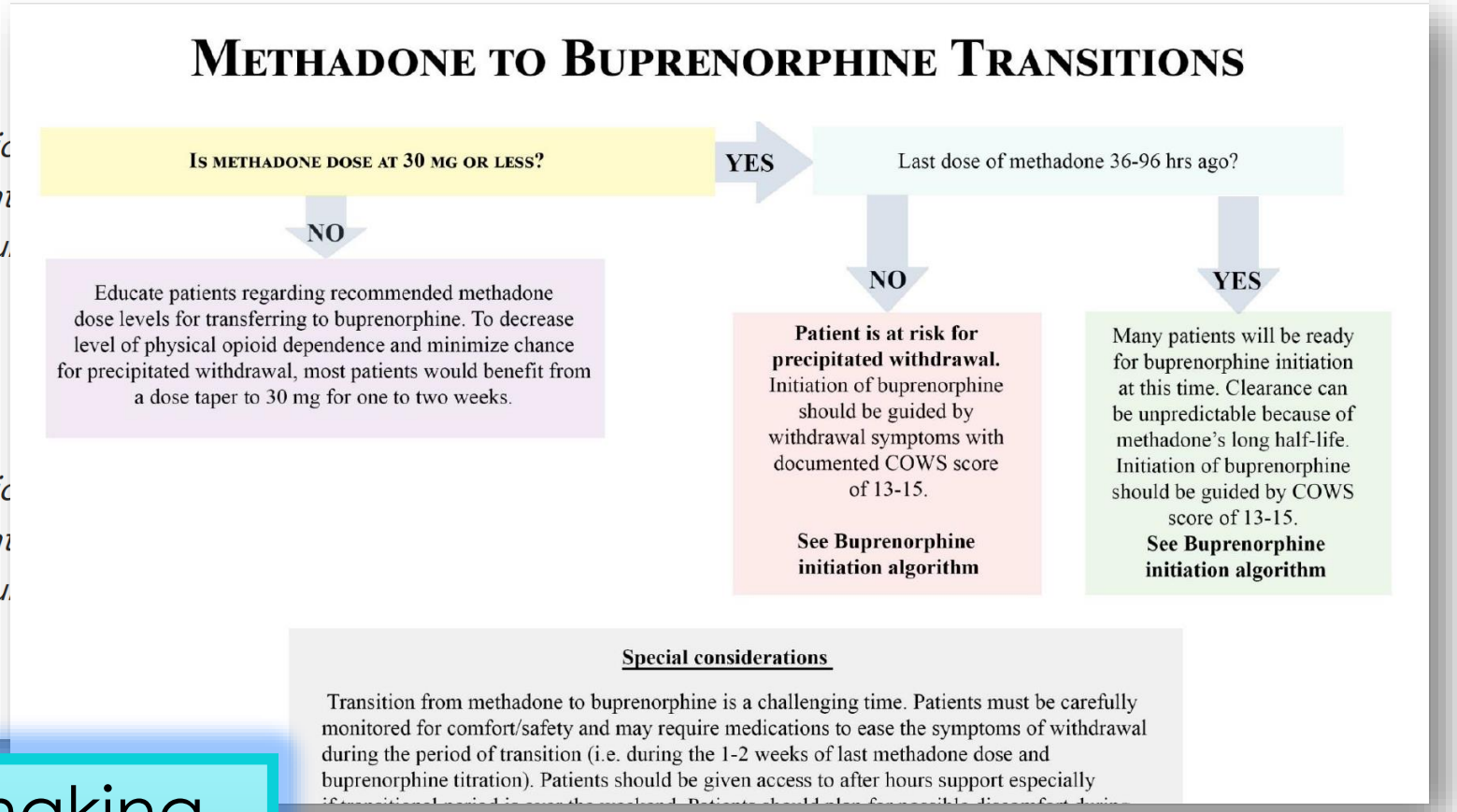
Algorithms

Buprenorphine Initiation

This clinical algorithm is meant to help inform clinic
medications for opioid use disorder. It is not meant
decision making. Please see the Massachusetts Nu
clinical guidelines for further information.
(Download file)

Initiation of Monthly Injectable Buprenorphine

This clinical algorithm is meant to help inform clinic
medications for opioid use disorder. It is not meant
decision making. Please see the Massachusetts Nu
clinical guidelines for further information.
(Download file)



Working on making clinical algorithms interactive

Taking videoconferencing to next level

1. Nurse Chat Live
2. Medication for Addiction (MAT) Chat Live
3. Recovery Coach Live

Come as you are,

with any questions you may have.

No registration necessary,

team is available during specified times.

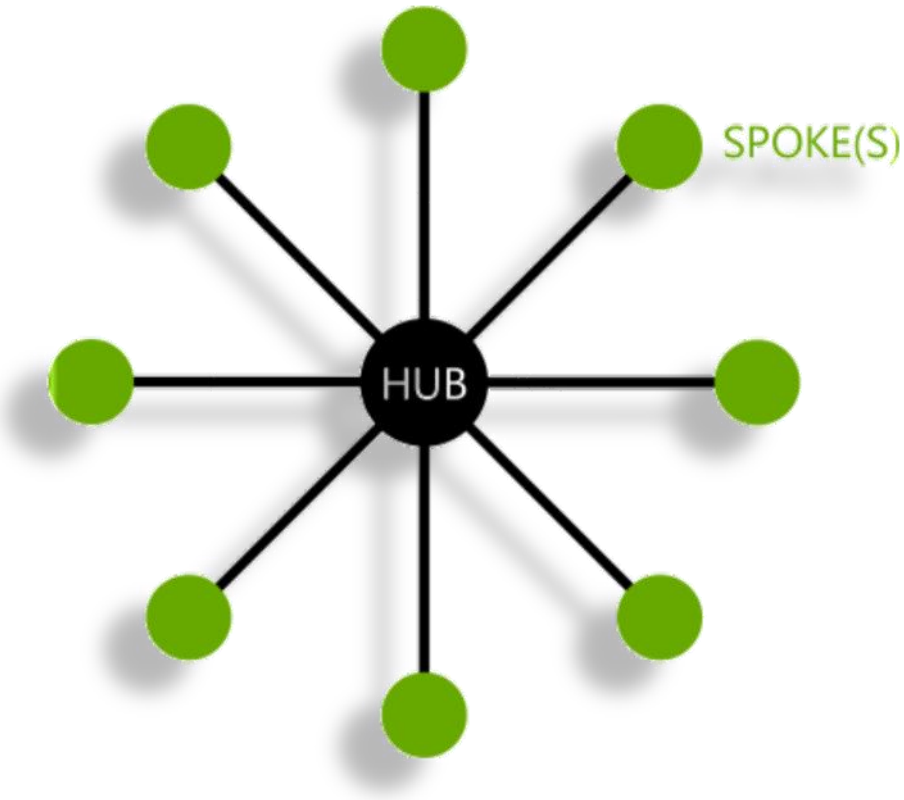
- Virtual trainings for providers on new injectable form of buprenorphine eliminates wait time for trainings and increases patient options

(buprenorphine extended-release) injection for subcutaneous use
100mg·300mg

Moves ideas *not* participants

Project ECHO®
(Extension for Community Healthcare Outcomes)

- BMC OBAT TTA has participated in 4 addiction focused ECHOs (3 ongoing)
- Addiction psychiatrist included on all expert panels
- Opportunity to promote access to OUD[1]



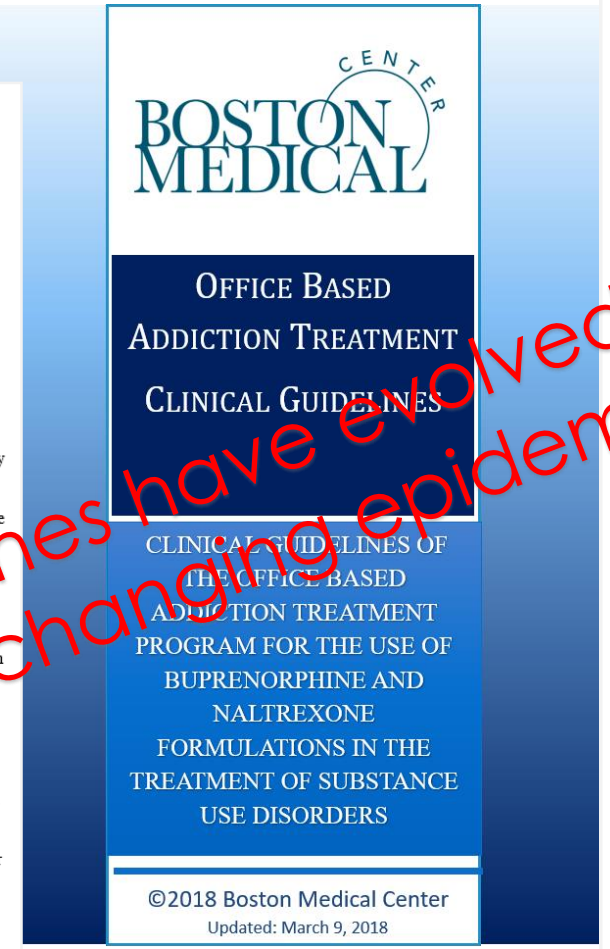
[1] Komaromy et al. (2016). *Substance abuse*, *37*(1), pp.20-24.

Lowering Threshold for treatment in office-based settings

CONSIDERATIONS TO REFER A PATIENT FOR MEDICATION ASSISTED TREATMENT IN OBAT

- Patient must have a DSM V diagnosis of Opioid Use Disorder or Alcohol Use Disorder. *See Appendix 2*: DSM V Criteria/Worksheets
- Patient must be in stable mental and physical health or engaged in appropriate treatment to address these issues.
- Patient must be willing to comply with program requirements.
- Patient must agree with goals of OBAT program:
  - ❖ Prevention/reduction of withdrawal symptoms and cravings for opioids and/or alcohol
  - ❖ Addressing any psychiatric problems through consultation with the multi-disciplinary treatment team and follow through with necessary referrals and treatment.
- Restoration of normal physiological functions that may have been disrupted by substance use and improvement in quality of life.
- Logistics: patient is able to come to required visits during hours of office operation, patient has access to transportation options, patient is able to comply with visit and counseling requirements.
- For patients seeking treatment with agonist medications: they must not have chronic pain requiring opioid management beyond buprenorphine/naloxone.
- For patients seeking treatment with antagonist medications: they must not have acute/chronic pain issues requiring opioid management.
- Patient must not be in need of higher levels of care with more intense management (i.e. daily monitoring and assessment, medication administration due to advanced psychiatric illness, acute or chronic pain requiring ongoing opioid management).
- Patient must be able to be treated in an office based setting safely without harm to self or others.
- Patient must not be actively poly-substance using and if so is willing to engage in Detoxification from other illicit substances not including opioids prior to induction.

Clinical Guidelines have evolved in response to changing epidemic



CANDIDATES FOR OBAT TREATMENT

- Patient must have a *DSM-5* diagnosis of Opioid Use Disorder or Alcohol Use Disorder. See Appendix 1 & 2.
- Patient is able to come to visits during hours of office operation.
- For patients seeking treatment with agonist medications: they must not have chronic pain requiring ongoing opioid management beyond buprenorphine/naloxone.
- For patients seeking treatment with antagonist medications: they must not have acute/chronic pain issues requiring opioid management.
- Patient is able to be treated in an office based setting safely without harm to self or others.
- Patient should be willing to address use of other harmful and/or illicit substances.
- Patient has been assessed by the treatment team and deemed appropriate for medication treatment in an Office Based setting.

Fewer requirements for MAT in **new** BMC Clinical Guidelines

LaBelle, C. T.; Bergeron, L. P.; Wason, K.W.; Ventura, A. S.; and Beers, D. *Policy and Procedure Manual of the Office Based Addiction Treatment Program for the use of Buprenorphine and Naltrexone Formulations in the Treatment of Substance Use Disorders.* Unpublished treatment manual, Boston Medical Center, Mar 2018.

Testimonials and animations: short educational videos for care teams

RESOURCES

Videos from Our Experts

Intersection of Pain and Addiction

By Daniel Alford, MD, MPH

Modernization Professional Nursing Law for Advanced Practice Registered Nurses APRNs

Senator Camera Bartolotta February 2019 Senate Bill 25 will be reintroduce: 2019-2020 Legislative Session.

Allow NP practice independently after three year 3,600hr collaboration physician agreement

- Important to ensuring an adequate primary care workforce to serve this new population
- NPs more likely than MDs to treat patients in settings where provider resources are scarce
- Address workforce shortage in primary care, community health centers, addiction treatment settings, and rural areas

NPs can address shortfall of primary care providers, expanding access to treatment

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2011).
McCleery et al. Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses. 2014 Sep. In: VA Evidence-based Synthesis Program Evidence Briefs [Internet]. Washington (DC): Department of Veterans Affairs (US); 2011.

Other gaps that need to be addressed

- Heath centers are key to dissemination, but…
  - Plagued by
    - High staff turnover
    - Salary and benefits
    - Lack of support, “burnout”
    - Stigma
    - Insurance barriers, prior authorizations
    - Limited educational resources

What can we do to address barriers

- Treatment on demand “every door”
- Implement ”full” parity all insurers including “self pay”
  - Require comparable reimbursement for substance use services
  - Reimbursement regardless of practice setting
- “Ryan White Model” Build off what we have and know works.
  - Add services based on uncovered needs, resources, and disease impact
- Comparable compensation
  - Salary, benefits, insurance, loan repayment (HRSA)
- Job satisfaction
  - Support growth, value (disseminate work, conferences, networking, list servers)

Other possible solutions to barriers

- Increase utilization of telehealth/virtual visits for BH
  - Integrated BH, medical and specialty groups
  - Connect BH/SU care at all touchpoint
- Recovery coaches, peer navigators, Community health workers
- Pharmacies and Pharmacist as "Partners"
  - Pharmacist to "prescribe" buprenorphine, give injections
- Remove co pays/ prior authorizations: agonist treatment
  - Remove co pay on short prescriptions i.e weekly
  - Prevent insurers: dictate "required" length of prescription
  - Interchangeable formula requirement by all pharmacies
  - Ongoing education MH/SUD all disciplines and team members

What we have learned…

- Trainers and trainees are more engaged, efficient and effective when training meets their needs, skill set, and availability
- Online repository of training resources in a variety of formats serves multiple needs and learning styles
  - Quick reference sheets, algorithms user-friendly (less intimidating, practical for quick access)
- Facilitate access to "free" training (BMC TTA, ORN, etc.)
  - Inform clinicians of educational offerings
- Follow up post waiver training with participants
  - Phone, email, booster training "beyond the waiver"
- Ongoing TA support essential staff retention, seamless access
- Change to adapt to changing "learner" i.e. millennium

Where do we go from here?

- Allow providers to practice to their scope of practice
  - Engage pharmacists, PA, CNS, CNM, NP's
  - Utilizers nurses to expand treatment (RN, LPN) as
- Educate and disseminate tools, resources, trainings
  - Engage champions
- Utilize community health centers to expand treatment
  - Train, support teams
- Remove barriers to care
- Utilize technology to reach people
- No need to reinvent the wheel Lessons Learned: HIV, Ryan White, Act Up

Thank You for your commitment to make a difference! ‘Every life matters”

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