UR Medicine Recovery Center of Excellence

Substance Use Disorder Treatment in Primary Care: An Emerging Model

HRSA Rural Communities Opioid Response Program (RCORP)

Rural Center of Excellence in Substance Use Disorder

October 16, 2020

MEDICINE *of* THE HIGHEST ORDER

UR MEDICINE

Introductions

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  - Disclosures: None

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  - Disclosures: None

Learning Objectives

1. Describe the substance use disorder in primary care (SUD-PC) model
2. List the challenges and barriers of implementing SUD services in primary care settings
3. Identify the benefits of integrating SUD treatment in primary care settings

Overview

- Defining our system needs
- ”SUD-PC” model
- Measuring success
- Discussion

Call to Action

Defining our system needs

UR Medicine Calls for a Coordinated Approach

- In 2018, UR Medicine called for the formation of an Opioid Task Force (OTF).
- It grew out of the recognition that numerous faculty and staff were passionate and engaged in efforts to address the opioid epidemic; however, many programs were “siloed,” and there was not yet a centralized, coordinated approach to the opioid epidemic.
- The Task Force would be chaired by our CMO, Dr. Michael Apostolakos.
- Goal: Survey current programs and then identify gaps, develop guidelines, develop metrics, and create new key recommendations.

UR Medicine Opioid Task Force

- Composed of a multidisciplinary team
  - 80+ members from primary care, behavioral health, pharmacy, inpatient services, subspecialty faculty, nursing, education, AHP, affiliates, and community law enforcement
- Survey of all efforts underway to address the opioid crisis throughout UR Medicine
  - Highland Family Medicine – treatment, education, training, overdose prevention, bridge programs
  - Strong Recovery – treatment, overdose prevention, education, CASAC integration into primary care
  - Strong Internal Medicine – treatment, overdose prevention, education
  - ED programs – SMART opioid programs, bridge program
  - Active toxicology service
  - Pharmacy programs
  - AHP and PCN programs
  - Women's Initiative Supporting Health
  - Enhanced surgical recovery program … and many more

Next Steps …

- Developed three subcommittees to create an institutional approach to **Prevention, Identification, and Treatment**, which produced:
  - High-level institutional guidelines
  - Metrics and measures of success
  - Recommendations for improving performance

Treatment Guidelines

- Emphasized the importance of treatment, continuity of care, and avoidance of interruption in care
  - Every patient identified to have opioid use disorder (OUD) will be linked to evidence-based medication assisted treatment (MAT) if appropriate and the patient agrees.
  - Every patient who presents with an opioid overdose will be linked to appropriate treatment, including MAT if appropriate and the patient agrees.
  - Every patient experiencing opioid withdrawal will receive treatment for opioid withdrawal in the most clinically appropriate setting.
  - Every patient currently receiving MAT for OUD will continue on MAT while hospitalized or in the emergency department if medically appropriate.
  - Every patient on MAT for OUD transferring between levels of care or between services will have continuity of MAT.

Identified Gaps – Treatment

- There is a gap between the number of patients who need treatment, including medication assisted treatment (MAT), for opioid use disorder (OUD) and URMC's current capacity to provide this care.
- Increased screening and treatment of opioid use disorder will increase the number of patients who need treatment at a substance use disorder specialty program.
- There is a gap between the number of patients on buprenorphine maintenance treatment and the number of PCPs with a waiver to provide this care, which leads to stable patients remaining in specialty care centers and increased wait times.

Identified Gaps – Treatment

- Current consultation support for ED and inpatient services is operating at maximal capacity.
- There is a need for ongoing workforce education regarding the evidence-based treatment of opioid use disorder as the evidence continues to evolve.
- There is an addiction medicine workforce shortage.
- There are multiple overdose prevention programs being administered by several different departments, but there is not a similar unified program for the entire URMC.

Monroe Co. Exceeds State Rates in Nearly Every Category

- Heroin overdose hospitalizations are increasing
- **61%** of UR Medicine OUD patients originate from Monroe County*
- Behavioral health patients with OUD were **2.4x** more likely to be hospitalized*
- SMH inpatients with OUD LOS averaged **4.5 days longer**

* Common Ground Health.

Source for original figure: NYS county opioid quarterly report. (2019 July).

Monroe County: Opioid overdoses and crude rates per 100,000 population
(Preliminary data as of May, 2019 - subject to change)

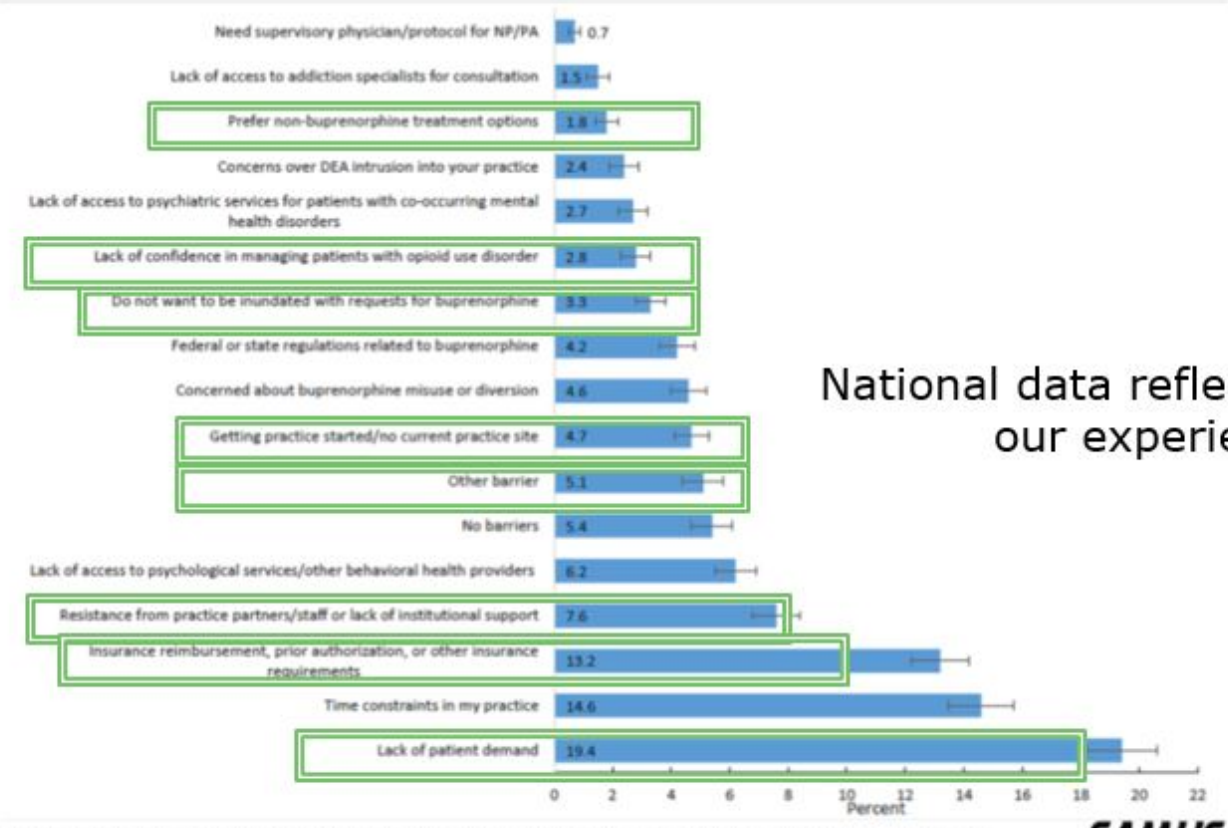
		2017 Total		Jan-Mar, 2018		Apr-Jun, 2018		Jul-Sep, 2018		Oct-Dec, 2018		2018 Total	
Indicator	Location	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Deaths[1]													
All opioid overdoses	Monroe	212	28.4	49	6.6	44	5.9	45	6.0	43	5.8	181	24.2
	NYS excl. NYC	2,170	19.4	464	4.1	464	4.1	438	3.9	340	3.0	1,706	15.2
Heroin overdoses	Monroe	67	9.0	16	2.1	10	1.3	8	1.1	4	0.5	38	5.1
	NYS excl. NYC	793	7.1	163	1.5	172	1.5	144	1.3	121	1.1	600	5.4
Overdoses involving opioid pain relievers (incl. illicitly produced opioids such as fentanyl)	Monroe	196	26.2	48	6.4	44	5.9	44	5.9	43	5.8	179	23.9
	NYS excl. NYC	1,903	17.0	424	3.8	432	3.9	398	3.6	309	2.8	1,563	13.9
Outpatient emergency department visits													
All opioid overdoses	Monroe	719	96.2	131	17.5	141	18.9	169	22.6	137	18.3	578	77.3
	NYS excl. NYC	7,222	64.4	1,334	11.9	1,536	13.7	1,562	13.9	1,195	10.7	5,627	50.2
Heroin overdoses	Monroe	552	73.8	98	13.1	115	15.4	122	16.3	92	12.3	427	57.1
	NYS excl. NYC	5,199	46.4	956	8.5	1,125	10.0	1,111	9.9	843	7.5	4,035	36.0
Opioid overdoses excluding heroin (incl. illicitly produced opioids such as fentanyl)	Monroe	167	22.3	33	4.4	26	3.5	47	6.3	45	6.0	151	20.2
	NYS excl. NYC	2,023	18.1	378	3.4	411	3.7	451	4.0	352	3.1	1,592	14.2
Hospitalizations													
All opioid overdoses	Monroe	191	25.5	44	5.9	46	6.2	45	6.0	49	6.6	184	24.6
	NYS excl. NYC	1,950	17.4	415	3.7	425	3.8	413	3.7	415	3.7	1,668	14.9
Heroin overdoses	Monroe	93	12.4	24	3.2	26	3.5	28	3.7	21	2.8	99	13.2
	NYS excl. NYC	777	6.9	165	1.5	157	1.4	171	1.5	169	1.5	662	5.9
Opioid overdoses excluding heroin (incl. illicitly produced opioids such as fentanyl)	Monroe	98	13.1	20	2.7	20	2.7	17	2.3	28	3.7	85	11.4
	NYS excl. NYC	1,173	10.5	250	2.2	268	2.4	242	2.2	246	2.2	1,006	9.0

[1] Indicators are not mutually exclusive. Decedents and patients may have multiple substances in their system. Thus, overdoses involving heroin and overdoses involving opioid pain relievers will not add up to the overdoses involving all opioids.

s: Data for indicators related to hospitalizations and emergency departments are suppressed for confidentiality purposes if there are fewer than 6 discharges.

What about Treatment?

Reported Primary Barriers to Prescribing Buprenorphine to Maximum Patient Limit



National data reflected our experience

9 Source: Jones, CM, PharmD, MPH, McCance-Katz, EF, MD, PhD (2018) Characteristics and Prescribing Practices of Clinicians Recently Waived to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder, (Unpublished article). Substance Abuse and Mental Health Services Administration, Rockville, MD -

SAMHSA
Substance Abuse and Mental Health Services Administration

Slide from ASAM State of the Art Course in Addiction Medicine.

Addressing the Gaps

After identifying the gaps, we developed the “SUD-PC” model—a model informed not just by the gaps, but also by the many programs our faculty had developed to try and address the care needs they encountered in their specialty/area.

This process led to development of the SUD-PC model: an innovative, mobile, system-wide resource to reduce gaps, delays in care, and hospital utilization while supporting providers and providing efficient use of limited resources.

Recommendations: Next Steps

1. Create centralized SUD-PC hub and deployable treatment resources to increase availability and timeliness of OUD services
    - Patient referral, induction and case management
    - Consultation and support for MAT to OP, IP and ED providers
    - Facilitate transitions between levels of care
2. Increase primary care management of MAT (ex. buprenorphine/naloxone)
    - MAT waiver training
3. Increase hospital services for screening, referral to treatment and to reduce access time to treatment and MAT

SUD-PC

Barriers

Barriers Remain….

In Practice Settings:

- Time constraints – paperwork, diversion control, etc.
- Lack of support staff – care coordinators, case managers
- Lack of behavioral health counseling resources
- Supervision requirements of Nurse Practitioners and Physician Assistants

Education/Training Barriers

- Access to and availability of DATA Waiver Training
- Real time mentorship, including at the start of prescribing and for complex cases
- Address negative attitudes and stigma toward persons with OUDs
- More access via telemedicine.

System Barriers:

- Cost and reimbursement for care
- Medicaid requirements, e.g. prior authorization & lifetime limits
- DEA requirements – regular unannounced inspections
- Limited accessibility in rural and remote locations

SAMHSA

Slide from ASAM State of the Art Course in Addiction Medicine.

Additional Challenges

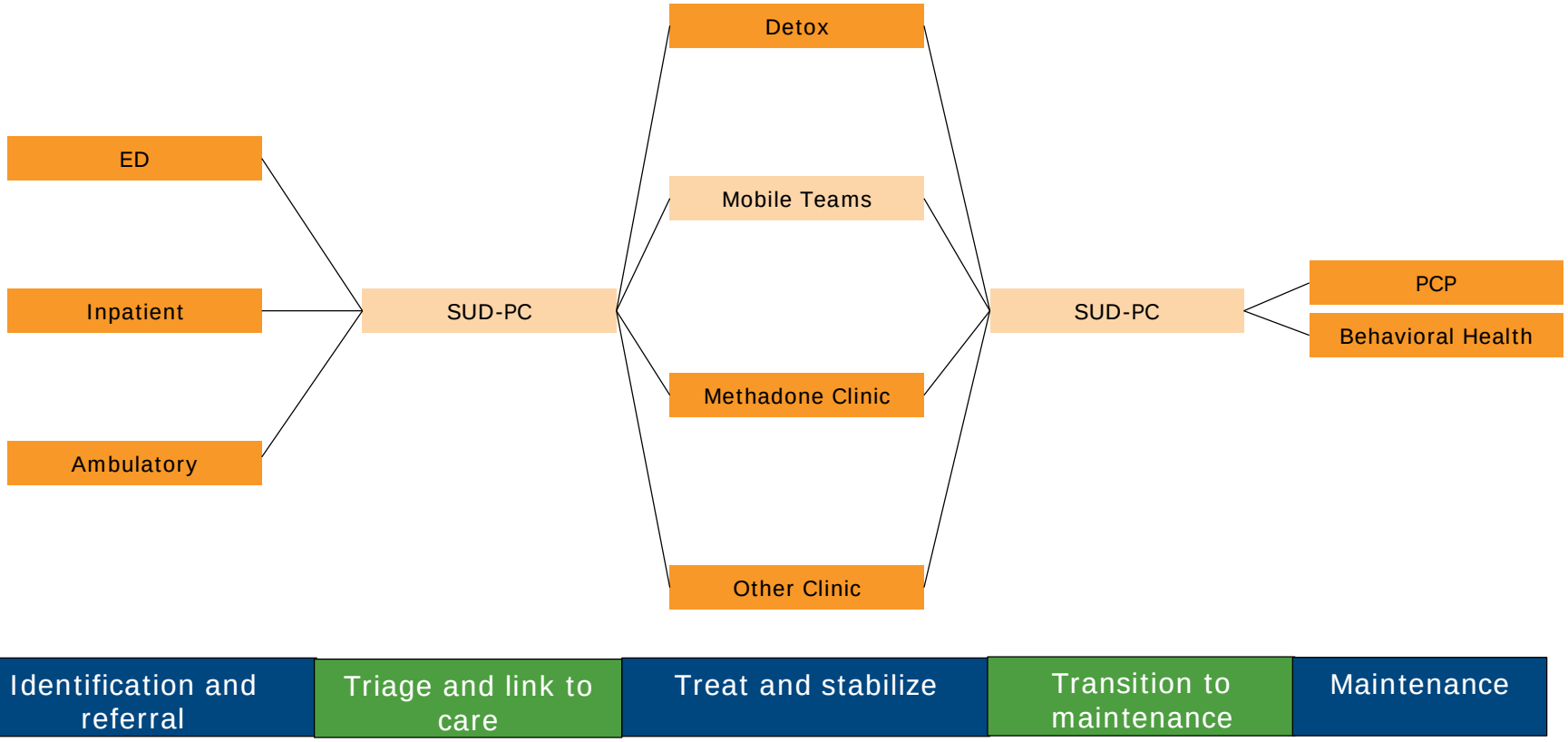
- ❑ Settings and workflows
- ❑ Type of practices
- ❑ Regulations
- ❑ Funding and reimbursement
- ❑ Staffing (scope of practice)

Recommendations: The Plan

Creation of an SUD-PC – Comprehensive, centralized, deployable resource to support the treatment of opioid use disorder. Based out of Strong Recovery.

- Centralized call center with mobile units providing MAT
  - Mobile “teams” and/or “van” units will bring triage, intake, MAT, early interventions, and ongoing treatment to areas on a predetermined schedule, at provider request, areas in need, and/or as part of care management outreach.
- Act as a consultation service for PCPs who provide MAT
- Act as a referral center for PCPs who identify a patient with OUD who is interested in obtaining treatment
- Support toxicology and psychiatry consult liaison teams with CASAC evaluation, discharge planning (for OUD), and provide transitional care (MAT) as needed
- Provide transitional care for patients as they move between different levels and points of care

SUD-PC Program Overview



SUD-PC structure innovates on evidence-based successes for system-wide approach

Addresses key barrier: “lack of institutional support”

SUD-PC Consult

- Provider-to-provider consult for PCPs
  - Clinical staff also available to PCP practice nurses, care managers, etc.
- Also resource to support Toxicology, Psych CL, unit care teams, ED, and inpatient primary teams around treatment and discharge planning

SUD-PC Consult

Mechanics of interface with PCPs and hospital units:

- Guidance for identified SUD issues
  - Screening results
  - Patient report
  - Patient presentation
- Controlled substance Rx monitoring
- Crisis incidents

SUD-PC Treatment

- Patient identification
  - Screening
  - Controlled substance policy
  - Crisis
  - Other

- Contact SUD-PC
  - SUD-PC team will follow-up and collaborate with PC office
  - Multi-level engagement model

SUD-PC Treatment

- **Providers**
  - Addiction Medicine Physician*
  - Psychiatric Nurse Practitioner*
- **Clinicians**
  - CASACs
  - RN
  - MH Therapist

*all waivered

- **Clinical Support**
  - Peer Specialist
  - Targeted Case Manager
- **Front End Support**
  - Financial Counselor
  - Secretary
  - OAS

SUD-PC Treatment

Telehealth: video conference/telephonic

Mobility of clinical teams

Outreach services: Access to resources for patients

SUD-PC Treatment

Provide initial level of care evaluation.

Provide transitional OUD care for patients awaiting an opening/needing intensive outpatient treatment in a specialty clinic.

Provide interim treatment for patients in need of MAT induction and stabilization prior to transitioning care back to a waivered primary care physician.

CASAC and Peers based with mobile capability can be deployed to PCP practices. Provide evaluation and triage for patients receiving MAT in PCP office as needed.

Provide non-intensive ongoing treatment, including MAT, for patients with mild/moderate OUD.

SUD-PC Treatment: Remote and Mobile

Delivery of Care Model:

- Remote
  - Telehealth options
  - Resources
- Mobile
  - Fleet vehicles (and eventually van units)
  - Location flexibility

SUD-PC Treatment

- Mobile clinic van
  - Counseling
  - Telemedicine (utilizing iPads for video conference evaluation of patients)
  - Pharmacy
  - Vans would have patient clinic rooms, a Pyxis with refrigeration capability)
  - MAT induction capable
  - Labs

Vans would also go out into community areas in need.

SUD-PC Treatment

Interface with PCPs and hospital units:

- ❑ EHR messaging
- ❑ Call line
  - ❑ Clinician on duty to initiate consult
- ❑ Collaboration with Psych Consult Liaison
- ❑ Collaboration with Toxicology Consult Service

Key Assumptions of Financial Case

- Business case values are based on Strong Memorial inpatients only; however, the resources of the SUD-PC and education would benefit all UR Medicine affiliated institutions.
- Capacity of SUD-PC will grow as additional PCPs become waivered without adding cost of additional SUD-PC resources.
- Guidelines for acute and chronic pain management, OUD identification, and treatment have recently been released, but not yet implemented with consistency.
- Governance and budget for each program element to be allocated to associated departments outlined in the business case.
- Impact values for years 2 & 3 do not include a change in base population.
- SUD-PC administrative costs assume state requirements for clinic set up which may be waived if discussions with OASAS continue.
- Improved coding of OUD may positively impact billing rates.
- Reputational value of program impacts institution.

METRICS

Success Will Be Measured by Performance to Guidelines

Over 70 measures proposed to monitor outcomes, process and balancing measures, such as:

Prevention

- New and existing prescription patterns (MME, days supply, dx with OUD)
- Naloxone co-prescribing and trigger events
- Overdose events, admissions, and ED visits

Identification

- Encounters and admissions screened
- Positive screens, with referrals and documentation
- Risk scores and prescriptions with risk

Treatment

- Waivered providers (active prescribing MAT and inactive)
- Time from referral to treatment
- Patient MAT patterns (missed doses, retention in treatment, % managed by PCP)

Guidelines and Measures

Guideline	Outcome Measures	Process Measures	Balancing Measures
1. Every patient newly identified to have OUD will be linked to MAT if the patient agrees.	1. Increase in prescribed medication for OUD 2. Increase in number of waivered Suboxone providers 3. Increase in inpatient MAT initiations 4. Increase in inpatient and ED Suboxone initiations	1. % who screen positive who are referred to treatment or peer navigator 2. % of patients who attend an intake visit within 7 days 3. % of physicians, NPs, and PAs who become waivered	1. Patient wait time for appointments
2. Every patient who presents with an overdose will be linked to treatment if the patient agrees.	1. Increase number of patients participating in ED bridge program 2. Reduction in ED overdose visits	1. % linked to treatment or peer navigator 2. % who attend an intake visit within 7 days 3. % prescribed naloxone at ED discharge 4. % who received naloxone from Strong/HH pharmacies	
3. Every patient experiencing withdrawal will receive treatment for withdrawal	1. Increase number of patients appropriately treated for withdrawal	1. % patients with recorded COWS score 2. % patients treated for withdrawal per protocol	

Guidelines and Measures

Guideline	Outcome Measures	Process Measures	Balancing Measures
4. Every patient currently receiving treatment for OUD will continue on that treatment while hospitalized or in the ED at URMC.	1. Increase number of inpatient Suboxone administrations 2. Increase number of methadone administrations 3. Reduction in all cause 7-day, 30-day, and 90-day readmissions (hospital, residential, inpatient addiction)	1. % of patients with OUD who are readmitted 2. % of missed doses 3. % of patients with 7-day follow-up with MAT provider after discharge	
5. Every patient moving between levels of care, or transferring between specialty care, will have continuity of treatment.	1. Increase in primary care provider treatment of OUD 2. Increase in OB/GYN provider treatment of OUD during pregnancy 3. Increase in patients retained in treatment as they move between different patient contact areas	1. % patients transferring Suboxone to primary care 2. % of Suboxone prescriptions at URMC from PCPs 3. % who follow up with PCP within 7 days of discharge from resident or detox program 4. % retained in MAT at 90 days	1. Outpatient treatment program wait times

Questions?

Acknowledgement

URMC Opioid Task Force

URMC Opioid Task Force Treatment Committee

Strong Internal Medicine

Strong Recovery

Department of Psychiatry Collaborative Care Division

UR Medicine Primary Care Network

URMC Leadership

UR Medicine Recovery Center of Excellence

We look forward to your input and questions!

UR Medicine Recovery Center of Excellence

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