

MASSACHUSETTS NURSE CARE MANAGER MODEL OF OFFICE BASED ADDICTION TREATMENT: DEEPER DIVE IN NCM ROLE

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*Incorporating promising practices in SUD treatment in
advanced patient centered medical homes*

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DISCLOSURES

- I have no personal or financial conflicts of interest to disclose

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GE Foundation

NCM MODEL OF OBAT TREATMENT PHILOSOPHY

- A substance use disorder is a chronic, relapsing medical condition that responds best when treated with evidence-based, patient-centered, comprehensive medical care.
- Patients with OUD deserve to be treated with dignity and respect.
- The goals of treatment include:
 - Cessation or reduction in harmful substance use
 - Active participation and engagement in treatment
 - Reduction or elimination of cravings and withdrawal
 - Restoration to optimal physiologic functions, and
 - Improvement in one's quality of life.

AN EVOLVING EPIDEMIC REQUIRES FLEXIBILITY AND INNOVATION

- Flexibility: Responsive to current and changing needs
- Harm reduction approach
- Treatment on demand: walk in, open access
- Interventions targeted to needs of high-risk populations
- Investment in proven models of care and a workforce to implement them
- Nurses can and do play key role in addressing the current epidemic of addiction and overdose deaths.



PATIENT INITIATION ROADMAP

1. Initial screening by OBAT staff
2. Intake
3. OBAT provider visit
4. Initiation
5. Stabilization
6. Maintenance

OBAT SCREENING

Phone or in person screening:

- Collect Substance Use, Medical and Mental Health histories
- Social determinants: living conditions, employment, legal issues, insurance, support persons, logistics such as mode of transportation
- OBAT team reviews initial screening information and makes decision about potential appropriateness of patient receiving treatment in an office based setting.
- Appropriate candidates proceed to OBAT intake.

A WORD ABOUT SCREENING

- We support a low threshold for a trial of medication treatment in OBAT.
- While screening tools are useful and should be used, it is extremely difficult to distinguish which patients will succeed in an OBAT setting.



CANDIDATES FOR OBAT NCM TREATMENT

- Patient must have a *DSM-5* diagnosis of Opioid Use Disorder
- Patient is able to come to visits during office hours of operation.
- Chronic pain must not be so severe that a full agonist is needed.
- Patient is able to be treated in clinic 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 and deemed appropriate for medication treatment in a specified setting.
- If unable to meet the patient's needs: assist in referring the patient to another treatment setting.

PATIENT INITIATION ROADMAP

1. Initial screening by OBAT staff
- 2. Intake**
3. OBAT provider visit
4. Induction
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OBAT INTAKE WITH NURSE CARE MANAGER

- Intake assessment
 - Review/Obtain Bio-Psycho-Social and SUD history
 - Identify patient motivation for recovery and treatment goals
- Education
 - Medication: indication, effects, administration, storage, safety
 - Overdose prevention and reversal education, ensure access to naloxone
- Introduction to Treatment Team and Program
 - Introduce patient to team members and role
 - Program treatment philosophy
- Consents/Treatment agreements
 - Program expectations: visit frequency, when and how to contact the office, toxicology policy, prescription policies, behavior policies
 - Consent for ROI as needed to outside providers, support persons, others

OBAT INTAKE

Lay the groundwork for a therapeutic relationship with the patient:

- Attitude is important
 - Non-judgmental - Matter-of-fact
 - Respectful - Professional
 - Curious - Interested
- Acknowledge some information is difficult to talk about.
- Assure the patient that you are asking because of concern for his/her health.
- Assure confidentiality (as long as no one is at risk of being harmed).

INTAKE: SETTING THE RIGHT TONE FOR TREATMENT

- Clear expectations set the tone for ongoing relationship.
 - Patient involvement is a two-way street.
 - What patient can expect of you and staff.
- Provide clear guidelines and behavioral expectations
 - Rules must be clear, concrete, logical and justifiable.
 - Must clearly define possible consequences of infractions.
 - Verbal and in writing
 - Patient Agreement – Review and give patient a copy.

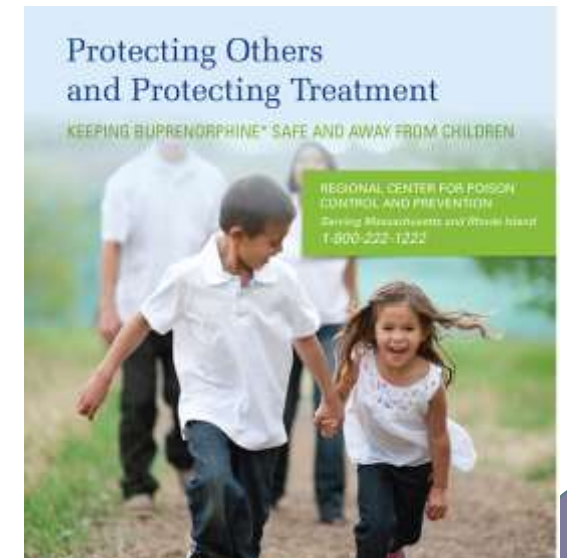


OBAT INTAKE LABORATORY TESTS

- Standing panel of orders
- Screening at time of intake should include:
 - Toxicology screening and pregnancy testing
 - HIV testing strongly recommended
 - Ensure PPD screen is up to date per institution's protocol
 - Consider: complete blood count, comprehensive metabolic panel, hepatic function, RPR, hepatitis A, B and C serologies
- Obtain laboratory tests as clinically needed.

PATIENT EDUCATION: PROPER STORAGE & HANDLING OF MEDICATION

- Avoid pediatric exposure
 - Store the medication “out of the sight and reach of children.”
 - Keep the medication in the container it came in.
 - Never leave tablets out of the container – even for a few minutes.
 - Patients should obtain an extra prescription container and/or label if medication is to be stored in multiple locations.
 - Consider developing a medication-safety tool/brochure (see resources slide for example)
- Never share pills, even with the best of intentions.
 - Sharing pills is diversion.
 - The patient cannot guarantee the behavior of someone else.
 - Provide the Poison Control Center phone number: 1- 800-222-1222



NALTREXONE CONSIDERATIONS

- Nurses provide education regarding naltrexone including safety/medical alert information

⚠ Important Information For Emergency Pain Management ⚠

I am currently taking VIVITROL® (naltrexone for extended-release injectable suspension), an opioid antagonist. Please see the back of this card for important information about pain management.

My Name: _____

Emergency contact name: _____

Emergency contact number: _____

My doctor: _____

My doctor's phone number: _____

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Call 1-888-235-8008

For Prescribing Information and Medication Guide, please visit www.us.mylan.com

Vivitrol
naltrexone for extended-release injectable suspension



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2. Intake performed by OBAT NCM
3. **OBAT provider visit**
4. Initiation
5. Stabilization
6. Maintenance

VISIT WITH OBAT PROVIDER

- Provider assessment visit:
 - Physical examination if needed
 - Review of laboratory test results
 - Provider assesses and documents diagnosis of substance use disorder
 - Assessment of appropriateness for specific medication treatment and treatment setting
- OBAT NCM will manage the patient under the guidance of the provider.
- Follow-up visits with waived provider occur at a minimum of once every four months.

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BUPRENORPHINE INITIATION: GOALS

Overall goal:

- Assist patients begin the process of switching from illicit or non-prescribed opioids to prescribed buprenorphine

To find the dose of buprenorphine at which the patient:

- Has no opioid withdrawal symptoms.
- Experiences no cravings.
- Discontinue or markedly reduce use of other opioids.
- Has minimal or no side effects.

INITIATION: NCM ROLE

Under guidance and according to care plan from waived prescriber:

- **Instruct:**
 - Instruct patients on proper administration of buprenorphine;
 - Discuss dosing limits according to protocol/prescription order.
- **Educate:**
 - Educate patients about proper storage and handling of medication.
- **Assess:**
 - Signs and symptoms of opioid use and/or withdrawal before, during, and after induction process;
 - Assess that patient is able to properly self-administer and tolerate medication.

THREE METHODS OF BUPRENORPHINE INITIATION

Method	Description
In-office Initiation	<ul style="list-style-type: none">• Patient fills a prescription for the first day's dose and brings the medication to the office where it will be self-administered.
Home Initiation	<ul style="list-style-type: none">• Patient fills a prescription for home induction.• Close contact by phone day of initiation.• Appointment scheduled for office check.
In-office Dispensing	<ul style="list-style-type: none">• A supply of medication is kept in the office for initiation.



NCM ROLE IN MANAGING PRESCRIPTIONS

- Prescriptions are processed following a scheduled office visit or phone encounter.
- Prescriptions ideally last until the next scheduled appointment.
- NCM Process prescriptions:
 - Review the medication record;
 - Consult with provider, pharmacy and check the prescription drug monitoring program (PDMP).
- Check insurance coverage, preferred covered medication formulary.
- Assist with Prior Authorizations as necessary
- Prescription records are maintained in the electronic medical record for review by clinician as needed and for DEA regulatory purposes.
- Follow state and organization policy and procedure for management of schedule 3 medications.

BUPRENORPHINE INITIATION DAY 1:

- Induction planned for early in day, early in week (ideally).
- NCM confirms patient to be in mild-moderate withdrawal using the Clinical Opiate Withdrawal Scale (COWS).
- NCM observes the patient self-administer 2-4mg initially.
- Reassess patient 45 minutes to 1 hour after first dose.
- Continue to reassess and titrate over the next few hours.
- Stabilize day one around 8-12mg or per provider protocol.

BUPRENORPHINE INITIATION- DAY 2

- Check in with patient: office visit or by phone contact.
- NCM assesses opioid use and symptoms since first dose.
- Adjust dose accordingly:
 - Higher dose if there were withdrawal symptoms
 - Lower dose if patient was over-medicated
- Continue adjusting dose by 2 - 4 mg increments until an initial target dose of 12 - 16 mg is achieved per protocol or prescription order.

BUPRENORPHINE INITIATION- DAY 2 AND BEYOND

- If continued dose increases are requested after reaching 16 mg, wait for 5-7 days to reassess before any further dose increase.
 - Reassess administration technique.
- Most patients can be stabilized between 12 mg and 16 mg.
- The standard range is 8 mg to 24 mg.

NALTREXONE INITIATION

- Insurance prior authorization completed and medication ordered
- Ensure opioid-free status, assess level of alcohol dependence
- Start with oral formulation, if tolerated proceed to injectable formulation
- A naltrexone (or naloxone) challenge test is performed whenever there is a risk of precipitating a withdrawal reaction:
 - Prior to initial injection or with any lapse in treatment
 - In office, patient self-administers 25 mg oral naltrexone
 - Observe patient for withdrawal signs for minimum of 45-60 min.
 - In dependent individuals, opioid withdrawal syndrome occurs – these patients do not receive a naltrexone injection at this time

ER INJECTABLE NALTREXONE

- Keep refrigerated.
- Needs to come up to room temp prior to administration
 - Can stay out for a total of 7 days. Label each removal/return to refrigerator.
- Reconstitute medication after patient arrives for visit and is determined to be appropriate for naltrexone administration.
- Once mixed, give injection immediately so that the medication does not solidify.
- Alternate sites.
- Document clearly



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STABILIZATION

- Initially weekly visits and weekly prescriptions
- Stabilizations goals: appropriate toxicology screens, stable dose, engagement, adherence.
- Chronic disease management.
- As patient stabilizes, visit frequency decreases with coinciding prescription frequency



PATIENT INITIATION ROADMAP

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MAINTENANCE

- Visits every 2-4 weeks, refills coincide with visits.
- Goal: 4 week or “random” visits.
 - Random is more effective in assisting patients in their recovery.
 - Every 28 days on day of naltrexone injection
- May be stable with more frequent visits.



MAINTENANCE



- Expect stability and improved social functioning.
- Expect significant improvement in substance use/misuse.
- Early outcomes improve with counseling.

NCM FOLLOW UP

- Assess medication adherence, cravings, withdrawal.
- Assess for recent substance use
- Provide ongoing education: medication administration, side effects, interactions, support.
- Assess counseling, self help check in
- Arrange for psychiatric evaluation with follow up as needed.
- Medical issues: HIV, HCV, routine health maintenance, acute needs.
- Family Planning
- Social supports: housing, employment, family, friends.
- Toxicology Screening
- Labs as clinically indicated

WOMEN OF CHILDBEARING AGE

- Empower patients as partners in care
- Assess pregnancy and contraception status regularly
- Collaborate with OB/GYN providers as needed
- Agonist treatment during pregnancy is the gold standard and highly recommended by ACOG, AAP, AAFP, WHO, AMA, ASAM, and on and on....
 - Work with patients and other providers to reduce or discontinue use of other substances that are contraindicated during pregnancy
- Discuss expectations regarding social services, provide reassurance
- Fight stigma, which can result in: late or no prenatal care, less likely to seek or report SUD, vilification of the mother, inappropriate child welfare interventions.



PAIN MANAGEMENT: GENERAL PRINCIPLES

- Reassure, support, communicate and set clear expectations with patient
- Collaborate with surgical/procedural teams, outside providers, pharmacies
- NCM Recognizes that:
 - Opioid debt must be satisfied before any analgesia can occur
 - Unrelieved pain can contribute to relapse
 - Opioid tolerance impacts analgesic requirements
 - MOUD treats addiction and not pain



STEPPED APPROACH TO PAIN MANAGEMENT IN BUPRENORPHINE MAINTAINED PATIENTS

- Continue buprenorphine maintenance dose, add non-opioid analgesics
- Divide buprenorphine dose to tid or qid dosing
- Increase buprenorphine maintenance dose, continue divided dosing
- Add short-acting opioids in addition to usual buprenorphine maintenance dose
- Stop buprenorphine and initiate full agonist therapy dosed to effect



NALTREXONE AND ACUTE PAIN

- If a patient on extended-release injectable naltrexone requires surgery
 - Advise patient to alert staff as soon as surgery date is known
 - Best to have procedure 4-6wks after most recent ER naltrexone injection
 - OK to bridge with naltrexone tablets leading up to planned procedure
 - Stop tablets 3 days prior to procedure
- In unplanned, emergency situations, anesthesia will need to be consulted
 - Can be overcome with certain medications and procedures



Addressing Substance Use During Treatment and Non-Adherence

PURPOSE OF MONITORING

- Monitoring may include: clinical assessment, toxicology screens, call-back visits, observed dosing, medication counts, confirmatory testing of toxicology sample
- Assess treatment effectiveness.
- Identify and reduce threats to progress.
- Evaluate risk for misuse and diversion.
- Encourage self-monitoring.
- Intervene if relapse seems likely.
- Facilitates conversation with patient.



URINE TOXICOLOGY COLLECTION

- Supervised, not observed – trauma informed approach
- No personal belongings in bathroom aside from cell phone, wallet
- Trash receptacle kept outside of the bathroom, no flushing toilet until sample is handed to attendant
- Consider adding coloring agent to toilet water
- Do not send suspicious samples for testing
- If concerned: communicate with the patient, obtain repeat sample.
 - Consider checking specific gravity (1.002-1.03) or creatinine (>20mg/dL)
- Oral swabs: more tamper resistant, but generally less reliable compared to urine toxicology.

RESPONDING TO PATIENT STRUGGLES

- Address behavior with patient
 - Discuss with patient ASAP.
 - Verbalize your concerns.
 - Be supportive.
- Establish new intensified treatment plan:
 - Patient-specific and achievable in your setting.
 - Signed agreements.
 - Involve patient in the process.



REVISION OF TREATMENT PLAN MAY INCLUDE:

- More frequent visits
- Buprenorphine dose adjustment
- Shortened prescriptions
- Loss of refills
- Team engagement with counselor
- Increased counseling: Relapse prevention groups, individual therapy, IOP.
- Clinical team meeting with patient
- Psychiatric evaluation
- Residential treatment
- Involvement of social services
- Increased provider collaboration
- Family/support involvement

REFERRAL TO A HIGHER LEVEL OF CARE:

- Acute treatment services: detoxification, crisis stabilization, transitional support services
- Residential treatment
- Methadone maintenance
- Directly observed buprenorphine in OTP
- Dual diagnosis

TRANSFERRING TO HIGHER LEVEL OF CARE

Communication is key: provider to program

- Warm hand-off whenever possible
- Confirm last prescription – consider bridge script
- Support through the transfer process
- Discuss if patient may return for re-evaluation at future date



OVERDOSE PREVENTION

- Risk/Harm reduction education
 - Never use alone
 - Do not lock the door
 - Same dealer
 - Potency check
 - Aseptic technique
- Refer to appropriate treatment
- Naloxone for patient and supports



YOU MAY
HAVE TO
FIGHT A
BATTLE
MORE THAN
ONCE TO
WIN IT.

-Margaret Thatcher

recoveryexperts.com

Nurse Care Manager Model

Caring for Special Populations

CATALYST CLINIC AT BOSTON MEDICAL CENTER

(CENTER FOR ADDICTION TREATMENT FOR ADOLESCENT/YOUNG ADULTS WHO USE SUBSTANCES)

Multidisciplinary team consisting of physicians, a nurse, social worker, patient navigator and outreach worker. The team is specially trained and adept at working with young patients struggling with substance use.

Catalyst is for any patient (25 years old and younger) who has started to use substances.



PROJECT RESPECT

NCM MODEL OF OBAT IN PREGNANCY

Project RESPECT (Recovery, Empowerment, Social Services, Prenatal care, Education, Community and Treatment), is a high risk obstetrical and addiction recovery medical home at Boston Medical Center and Boston University School of Medicine.

Project RESPECT provides a unique service of comprehensive obstetric and substance use disorder treatment for pregnant women and their newborns.



“We know that timely access to treatment is crucial to saving lives”

- Faster Paths to Treatment: BMC’s substance use disorder urgent care center. It is a judgment-free home for people suffering with addiction.
- Care connection through BMC’s Emergency Department
- Serve as a central intake for substance use and behavioral health treatment. “Bridge” treatment.

BMC OBAT PARC CLINIC: ENGAGING INCARCERATED PERSONS AT TIME OF RELEASE

South Bay House of Corrections Partnership

- Services advertised throughout HOC
 - Providers present inside HOC during community meetings
- For those interested, providers meet with people incarcerated inside the HOC
 - Establishes relationship
 - Documentation of substance use history
 - Medical clearance
 - **Aim: direct linkage upon release**
- Clinic will accept and prioritize post-release walk-ins during all clinic hours



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

**BOSTON MEDICAL CENTER
HAS A TEAM OF PRIMARY CARE
AND ADDICTION SPECIALISTS
WHO PROVIDE ADDICTION
TREATMENT AND ADDRESS
OTHER HEALTH NEEDS**



NCM MODEL FOR CHRONIC OPIOID PRESCRIBING

TOPCARE (Transforming Opioid Prescribing in Primary Care)

TOPCARE NCM manages patients with chronic pain and chronic opioid prescriptions to ensure proper monitoring occurs and safety measures are followed.

Team-Based Model Reduces Prescription Opioid Use among Patients with Chronic Pain by 40 Percent, Study Finds (JAMA 2017)

- Patients were also 6x more likely to receive care adhering to the AAPM opioid monitoring guidelines.
- “The TOPCARE model was so effective in lowering opioid use that two of the study sites hired nurse care managers to continue the intervention and expand services to their primary care providers.”

Can nurses be a secret weapon against opioid addiction?

by Christine Vestal at the Pew Charitable Trusts



FIVE BEST IDEAS *of the* DAY

Published each weekday, at noon.

They already are!

Nurses Step In to Boost Treatment for Opioid Addiction

August 31, 2016 | By Christine Vestal

SHARE      



opioid addiction
se-managed

Clinical Guidelines available for free download at www.bmcobat.org/

Includes:

- Team Roles/Requirements
- Program Requirements
- Treatment Agreement and Consent forms
- Protocols:
 - Medication initiation, stabilization, maintenance, addressing recurrent substance use, diversion, special populations
- Note Templates for EMR
- Appendices with Resources



OFFICE BASED
ADDICTION TREATMENT
CLINICAL GUIDELINES

CLINICAL GUIDELINES OF THE
OFFICE BASED ADDICTION
TREATMENT PROGRAM FOR THE
USE OF BUPRENORPHINE AND
NALTREXONE FORMULATIONS
IN THE TREATMENT OF
SUBSTANCE USE DISORDERS

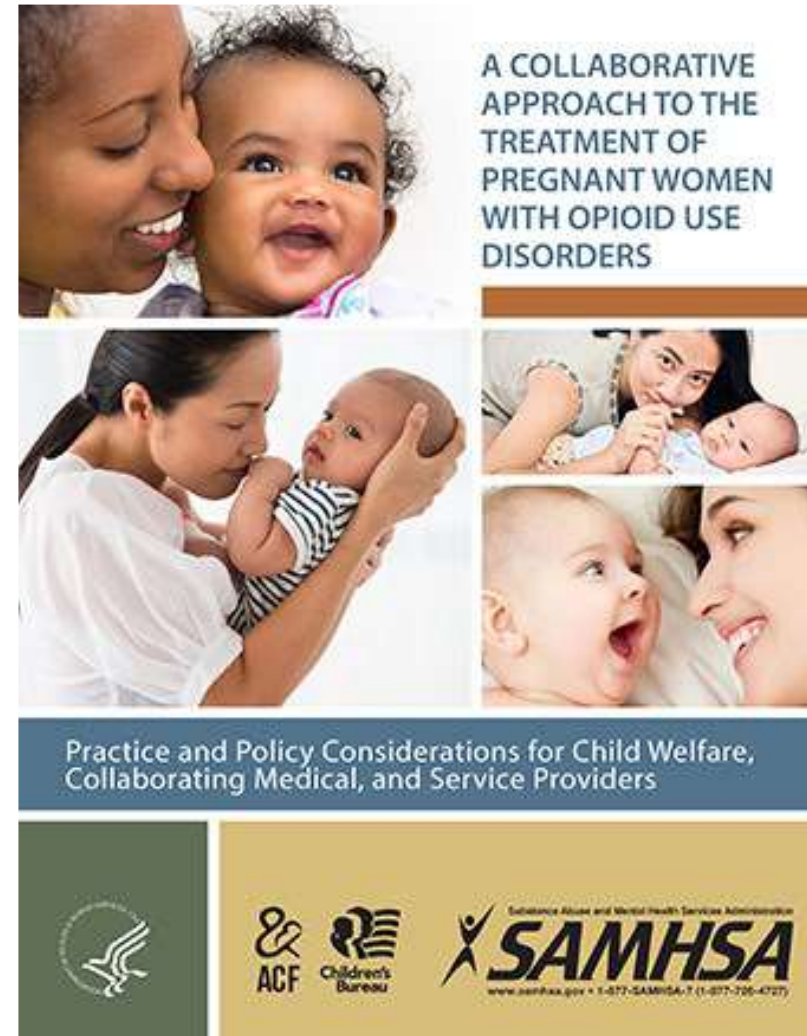
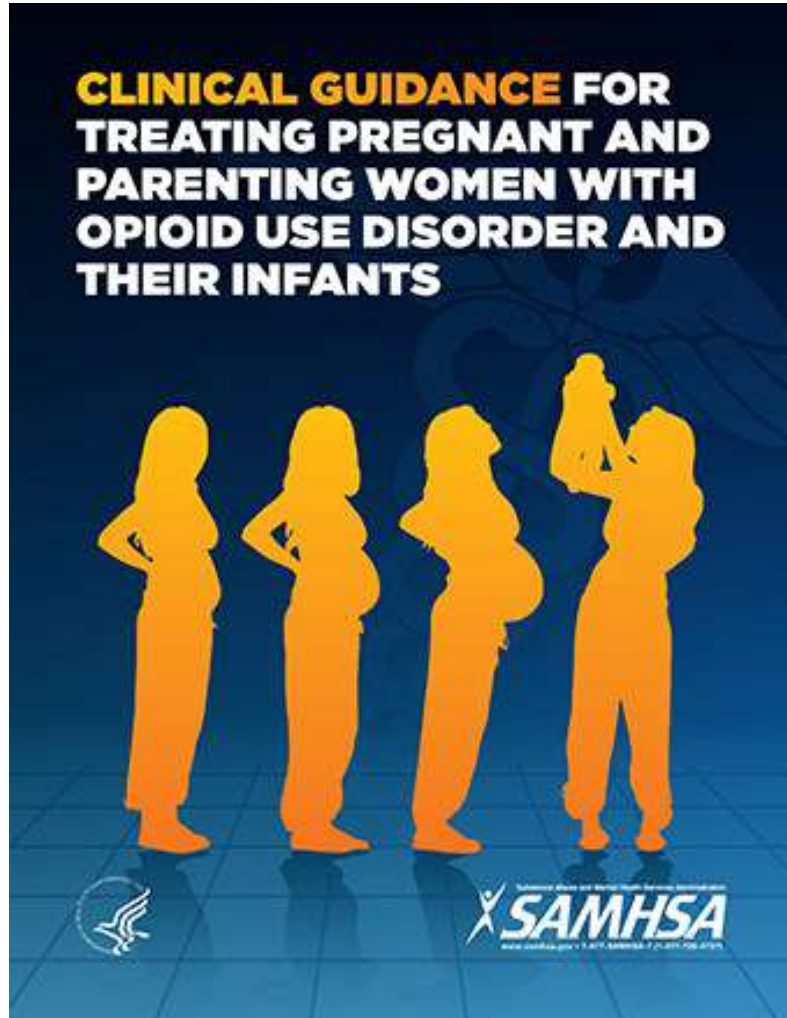


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RESOURCES

- OBAT TTA: <https://www.bmcobat.org/>
- Scope of Pain: <https://www.scopeofpain.com/>
- CDC Guideline Opioid Overdose and Prescribing:
(<https://www.cdc.gov/drugoverdose/prescribing/guideline.html>)
- TOPCARE: (Safe Opioid Prescribing NCM Model): <http://mytopcare.org/>
- Provider Clinical Support System: <http://pcssnow.org/>
- Prescribe to Prevent: <http://prescribetoprevent.org/>
- Injectable naltrexone administration video:
<https://www.youtube.com/watch?v=IZBaDCIWSwg>
- Example of medication-safety brochure:
<https://massclearinghouse.ehs.state.ma.us/ALCH/SAI064kit.html>

RESOURCES



<https://store.samhsa.gov>

WELLNESS COACH INTEGRATED BEHAVIORAL HEALTH

A HOLISTIC APPROACH TO PATIENT-CENTERED CARE

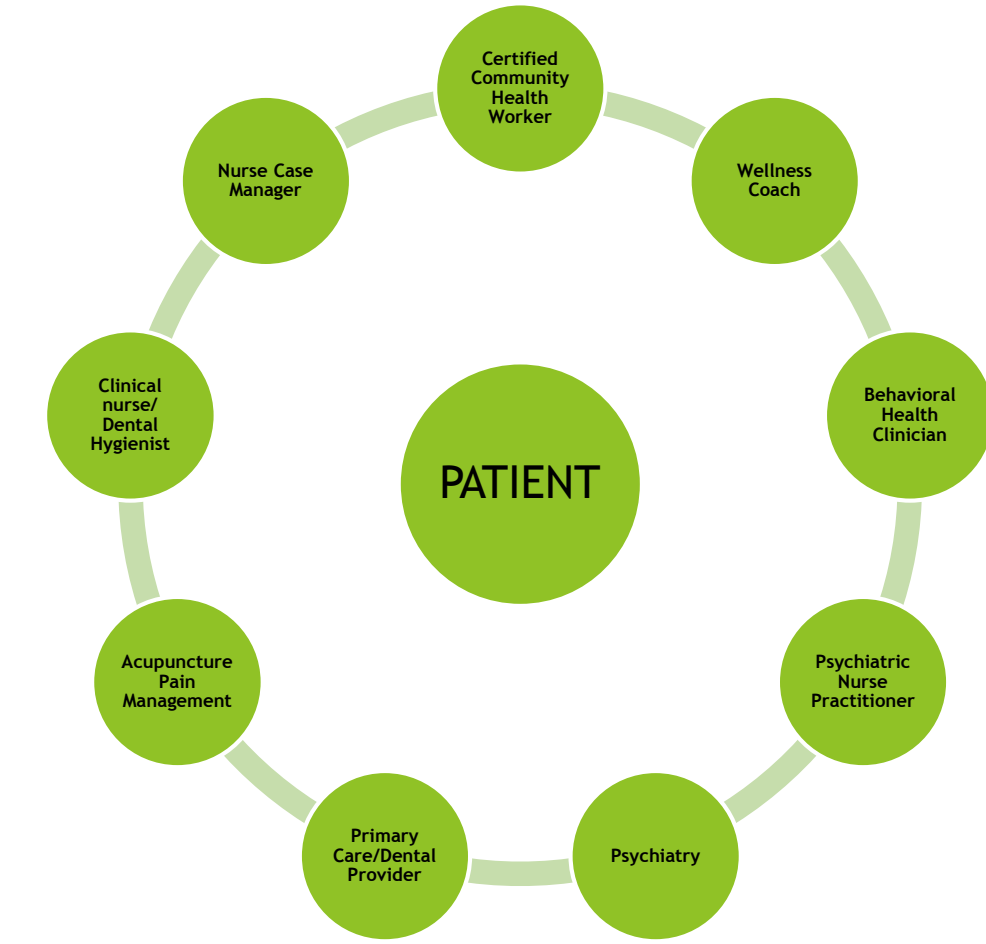


LA CLINICA

AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

SOCIAL
DETERMINANTS OF
HEALTH

INDIVIDUAL
DETERMINANTS OF
HEALTH



BIOLOGICAL
ASPECTS OF
HEALTH

PSYCHOLOGICAL
/BEHAVIORAL
ASPECTS OF HEALTH

Wellness Team

- We are a part of the patients care team.
- We collaborate with a multidisciplinary focus.
- We address the relationship of biological, psychological and behavioral aspects of health and wellness.
- There are no wrong doors.
- We engage a patient at any stage to find their best support

Coaches Support Patient Outcomes

- Naloxone Rx - Adapted One Key Question concept
- SBIRT as a CCO Clinical Outcome Measure
- PHQ9 - Depression Screening
- Edinburg - Postpartum Depression
- Social Determinants of Health
 - Availability of resources to meet daily needs ie education, job opportunities, living wage, food, transportation, safe housing.
 - Exposure to crime, violence
 - Barriers to accessing health services: addiction tx, mental health
- Readiness to Change - all MI trained
- Health Education and Supportive Counseling
- Built Super highways to our social services community partners
- Crisis Management

Core Competencies

- ▶ **A. Setting the Foundation**
 - Meeting Ethical Guidelines and Professional Standards
 - Establishing the Coaching Agreement
- ▶ **B. Co-creating the Relationship**
 - Establishing Trust and Intimacy with the Client
 - Coaching Presence
- ▶ **C. Communicating Effectively**
 - Active Listening
 - Powerful Questioning
 - Direct Communication
- ▶ **D. Facilitating Learning and Results**
 - Creating Awareness
 - Designing Actions
 - Planning and Goal Setting
 - Managing Progress and Accountability

Note: AIMS
Grant
supported

Certifications for WC and/or IBC

Certified Coach

- Supporting patients toward long term, lasting, lifestyle behavior change.
- Promoting resilience, strength based, trauma informed care.

Certified Alcohol & Drug Counselor

- Support MAT or other patients in their A & D recovery.
- Provide more expertise to providers allowing them to carry more MAT patients if desired.
- Provide Case Management for MAT patients (possibly)

Certified Wellness Recovery Action Plan WRAP

- Develop a strong wellness program (formerly known as relapse prevention) for MAT and other addictions
- Support patients with any chronic illness that has a mental health component by developing clear wellness plans
- Develop wellness recovery plans for patients entering PES