MEDICATION-ASSISTED TREATMENT:

Changes in Federal Policy Will Help Increase Access to Opioid Treatment in the HCH Community

January 25, 2017
TODAY’S DISCUSSION

• National opioid epidemic is driving myriad of policy changes
  • Access to treatment & prevention
  • Availability of Naloxone/Narcan
  • Needle exchange & other harm reduction approaches
  • Greater emphasis on diversion/alternatives to incarceration

• Medication-assisted treatment (buprenorphine/Suboxone) is one approach to recovery available in primary care setting

• Increasing prescribing rights to a broader range of providers and increasing patient limits are two new ways to enhance access to treatment

• Today: Detail and timeline about changes, resources to support clinicians, and a discussion with HCH providers about impact to programs, quality & access to care, organizational support, and remaining barriers to care

Advocacy note: Medicaid helps pay for a wide range of addiction treatment, to include MAT. Please be vocal about the importance of retaining/gaining Medicaid!
COUNCIL RESOURCES ON OPIOID DISORDERS

- Clinical Guidelines: Adapting Your Practice: Recommendations for the Care of Homeless Patients with Opioid Use Disorders: (March 2014)

- Policy Brief: Medication-Assisted Treatment: Buprenorphine in the HCH Community (May 2016)

- Webinar: The SPOT: Boston’s New Harm Reduction Program for Opioid Users Forges New Ground (July 2016)

- Webinar: Treating Opioid Addiction in Homeless Populations: Challenges and Opportunities Providing Medication Assisted Treatment (Buprenorphine) (August 2016)

SPEAKERS TODAY

- Brian Altman, JD, Director, Division of Policy Innovation, Office of Policy, Planning & Innovation, SAMHSA
- Nilesh Kalyanaraman, MD, Chief Health Officer, Health Care for the Homeless (Baltimore, MD)
- Laura Garcia, FNP, Director of Adult Medicine, Health Care for the Homeless (Baltimore, MD)
- Brianna Sustersic, MD, Senior Medical Director of Primary Care, Central City Concern (Portland, OR)
- Lydia Bartholow, DNP, PMHNP, CARN-AP, Old Town Clinic, Central City Concern (Portland, OR)
- Moderator: Barbara DiPietro, PhD, Senior Director of Policy, National HCH Council
Overview of the Buprenorphine Final Rule

Increases the highest number of patients a practitioner can treat to 275

- Two pathways – Additional credentialing and/or qualified practice setting (§8.610)
- Emergency Situations (§8.655)
- Responsibilities/Reporting Requirement (§8.635)
Expanding Access to Opioid Treatment with NP/PA

11/16/16 HHS Press Release – Nurse practitioners (NPs) and physician assistants (PAs) can immediately begin taking 24 hours of required training to prescribe buprenorphine

- The qualifying other practitioner must be licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain

- Once training completed, NPs/PAs can apply to prescribe up to 30 patients beginning next month

- Training available at now at no cost through SAMHSA PCSS-MAT. Training also available through ASAM, AAAP, AMA, AOA, ANCC, APA, AANP, AAPA
SAMHSA’S Buprenorphine Oversight Guidelines & Resources

https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
SAMHSA Support for Provider Education

PCSS-O
Focus on Safe Opioid Prescribing
www.pcss-o.org

PCSS-MAT
Focus on Treatment of Opioid Use Disorders
www.pcssmat.org

Opioidprescribing.com
Focus on CME-accredited Trainings on Safe Use of Opioids
SAMHSA Clinical Support Tools: Treatment Improvement Protocols & Guidelines

http://store.samhsa.gov/home
SAMHSA MATx

MATx Mobile App to Support Medication-Assisted Treatment of Opioid Use Disorder

http://store.samhsa.gov/apps/mat
Other HHS Activities to Expand Access to MAT

- Approval of Probuphine
- SAMHSA Targeted Capacity Expansion: MAT-Prescription Drug and Opioid Addiction Grants to states in FY15 and FY16
- SAMHSA State Targeted Response to the Opioid Crisis Grants FOA released 12/16/16 in FY 17
- HRSA $94 million for MAT in Community Health Centers
- AHRQ grants for MAT in rural primary care
- Mental Health and Substance Use Parity
Health Care for the Homeless: Baltimore, MD

• FQHC serving over 10,000 people experiencing homelessness a year

• 3 primary care clinics
  – Downtown Baltimore
  – West Baltimore
  – Baltimore County

• Services offered: medical, behavioral health, dental, nursing, case management, outreach, supportive housing

• Treatment philosophy
  – Person centered
  – Trauma informed
  – Harm reduction
  – Multidisciplinary care teams

• Patients served
  – Current MAT initiation: 60
  – MAT in the past year: 500
Entering Care

• No wrong door: addictions counselors and medical providers conduct warm hand offs
• Comprehensive multidisciplinary care
• On-site pharmacy
• Naloxone training
Initiating MAT

- Treatment agreement
- PDMP review
- Most clients have taken buprenorphine in the past
- Client managed induction once in withdrawal
- Daily group meetings
- Weekly individual counselor sessions
- Weekly MAT group for buprenorphine adjustment
- Weekly urine screens
Maintenance

• Transition to primary care provider or psychiatrist
• NPs will be doing trainings in the next few months to prescribe buprenorphine
• Continue individual therapy/counseling
• Dual diagnosis group
Central City Concern: Portland, OR

- **Old Town Clinic** is a Healthcare for the Homeless FQHC primary care medical home, housed within the larger social services agency of CCC.
  - We strive to provide low barrier, patient centered, and holistic care.
- **Our MAT philosophy:** MAT is most effective when offered as part of a comprehensive and individualized treatment program, which includes medication, counseling and community support.
- **SUD treatment is fully integrated into primary care:**
  - Warm hand-offs to addictions counselors
  - Range of SUD treatment groups on-site: dual diagnosis, pain management, understanding addiction
  - Weekly case consultation with provider champions
- **Number of patients being treated with buprenorphine:**
  - > 175 in the last year; > 50 currently active patients
Central City Concern: Portland, OR

• Started MAT program in 2013 with 1 counselor and a couple of prescribers → we now have 3 counselors, 1 clinical supervisor, 1 admin assistant, and 8 prescribers

• Important Features of our program:
  • **Addressing stigma** - changing language and culture around addiction
  • **Monitoring practices**: pill counts, urine drug screens, bubble-packing of meds, treatment agreement, twice weekly group attendance required
  • MAT beds available in supportive housing
  • **Onsite pharmacy** - ongoing collaboration, multiple dispensing options including: bubble packing, daily dispense, weekly dispense
  • **Provider education** – addiction-trained physicians and nurse practitioners, frequent education sessions on substance use disorder topics
  • Other wraparound services: specialty mental health, case management, benefits/employment assistance, housing
  • **Naloxone** training, prescribing
DISCUSSION: PROGRAM IMPACT

How will the federal changes impact our program?

→ Lifting caps may not have large impact
→ Expanded prescribing rights is helpful
→ Training opportunities for primary care providers
→ Greater financial sustainability using NPs and PAs
DISCUSSION: QUALITY & ACCESS

How do these changes improve quality, access and coordination of care?

→ Greater connection to primary care
→ Improved quality of addiction treatment
→ Continuity of care; fewer visits needed
→ Better relationship with provider
→ Increased access to induction and follow-up appointments
DISCUSSION: SUPPORT

How is your organization—or the broader health care community—supporting these changes?

→ Eliminating need for prior authorizations
→ Funding MAT programs (especially in states that did not expand Medicaid)
→ Promoting CME/training opportunities
→ Making opioid addiction treatment part of broader organization/community strategy
DISCUSSION: ONGOING BARRIERS

What barriers to medication-assisted treatment continue to exist?

→ Length of training
→ Differing state laws re: prescriber rights
→ Recordkeeping, DEA audits, etc.
→ Stigma
→ Insurance barriers (prior authorizations, inconsistent coverage, changing formularies, etc.)
→ Federal policy shift: Losing Medicaid eligibility (or moving to block grants) may limit funding available for treatment
QUESTIONS?

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