Role of OBOT Nurse Care Manager in Federally Qualified Community Health Centers

Colleen T LaBelle, BSN, RN-BC, CARN AMERSA
Colleen T. LaBelle, BSN, RN-BC, CARN has no financial relationships with an ACCME defined commercial interest.
AAAP aims to provide educational information that is balanced, independent, objective and free of bias and based on evidence. In order to resolve any identified Conflicts of Interest, disclosure information from all planners, faculty and anyone in the position to control content is provided during the planning process to ensure resolution of any identified conflicts. This disclosure information is listed below:

The following developers and planning committee members have reported that they have no commercial relationships relevant to the content of this module to disclose: PCSSMAT lead contributors Maria Sullivan, MD, PhD, Adam Bisaga, MD; AAAP CME/CPD Committee Members Dean Krahn, MD, Kevin Sevarino, MD, PhD, Tim Fong, MD, Robert Milin, MD, Tom Kosten, MD, Joji Suzuki, MD; AMERSA staff and faculty Colleen LaBelle, BSN, RN-BC, CARN, Doreen Baeder and AAAP Staff Kathryn Cates-Wessel, Miriam Giles and Blair Dutra.

Frances Levin, MD is a consultant for GW Pharmaceuticals and receives study medication from US Worldmed. This planning committee for this activity has determined that Dr. Levin’s disclosure information poses no bias or conflict to this presentation.

All faculty have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis. Speakers must inform the learners if their presentation will include discussion of unlabeled/investigational use of commercial products.
Accreditation Statement

• This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of American Academy of Addiction Psychiatry (AAAP) and Association for Medical Education and Research in Substance Abuse (AMERSA). American Academy of Addiction Psychiatry is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
Designation Statement

- American Academy of Addiction Psychiatry designates this enduring material for a maximum of 1 (one) AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
  - Date of Release October 21, 2014
  - Date of Expiration October 21, 2014
System Requirements

- In order to complete this online module you will need Adobe Reader. To install for free click the link below:
Target Audience

• The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

• At the conclusion of this activity participants should be able to:
  ▪ List barriers reported by physicians to prescribing buprenorphine in an office based setting
  ▪ Describe a collaborative care model for OBOT expansion
  ▪ Identify the benefits of FQHC model to expand OBOT
  ▪ List functions of the NCM in an OBOT setting
Drug Addiction Treatment Act (DATA) 2000

- Amendment to the Controlled Substances Act
- Allows physician to prescribe narcotic drugs scheduled III, IV or V, FDA approved for opioid maintenance or detoxification treatment
  - Prior 10/2002 no drug existed
  - Methadone does not qualify
DATA 2000: Physician Qualifications

Physicians must:

• Be licensed to practice by his/her state
• Have the capacity to refer patients for psychosocial treatment
• Limit number of patients receiving buprenorphine to 30 patients for a least the first year
• File for a new waiver after first year to increase their limit to 100 patients.
• Be qualified to provide buprenorphine and receive a license waiver
BUPRENORPHINE
Opioid Potency

% Efficacy

Opioid effect, sedation, respiratory depression

Log Dose of Opioid

Full Agonist
Methadone

Partial Agonist
Buprenorphine

Full Antagonist
Naltrexone

Dr Laura McNicholas
How Does Buprenorphine Work?

- “Ceiling effect” on opioid effects
- High affinity for opioid receptor
- Slow dissociation from opioid receptor
- Formulated with naloxone
  - Naloxone blocks opiate effect if injected
  - Naloxone is degraded (inert) if taking orally
Goals of Pharmacotherapy with Buprenorphine:

- Prevention or reduction of withdrawal symptoms
- Prevention or reduction of drug craving
- Prevention of relapse to use of addictive drug
- Restoration to or toward normalcy of any physiological function disrupted by drug abuse
Only 4% of Eligible US Doctors are Certified to Prescribe Buprenorphine

May 2014

Center For Substance Abuse Treatment
CSAT 2014
Needs Assessment in MA with Bureau of Substance Abuse Services

- High rate of opioid addiction
- High number of fatal and non-fatal opioid overdoses
- Long waits for opioid treatment, both methadone and buprenorphine
- Some people refuse Methadone maintenance
- Not enough MA physicians had waivers
- Some waived physicians were not prescribing
Surveys mailed to 356 addresses

256 respondents

20 not at address

80 non-respondents

21 excluded
No office-based practice

235 included

156 (66%) prescribers

79 (34%) non-prescribers

October/November 2005
MDPH sent survey to all 356 waived physicians

Walley AY et al. J Gen Intern Med 2008; 23(9): 1393-8
Barriers to Prescribing Office Based Treatment with Buprenorphine
### Prescriber Status and Specialty (n=235)

<table>
<thead>
<tr>
<th>Prescriber Status</th>
<th>Total (N=235)</th>
<th>Prescriber N=156</th>
<th>Non-prescriber N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>235 (100)</td>
<td>156 (66)</td>
<td>79 (34)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>126 (54)</td>
<td>74 (47)</td>
<td>52 (67)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>102 (44)</td>
<td>78 (50)</td>
<td>24 (31)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (3)</td>
<td>4 (3)</td>
<td>2 (3)</td>
</tr>
</tbody>
</table>

Walley AY et al. J Gen Intern Med 2008; 23(9): 1393-8
# Barriers to Buprenorphine Prescribing

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient nursing support</td>
<td>20%</td>
</tr>
<tr>
<td>Insufficient office support</td>
<td>19%</td>
</tr>
<tr>
<td>Payment issues</td>
<td>17%</td>
</tr>
<tr>
<td>Lack of institutional support</td>
<td>16%</td>
</tr>
<tr>
<td>Insufficient staff knowledge</td>
<td>12%</td>
</tr>
<tr>
<td>Pharmacy issues</td>
<td>8%</td>
</tr>
<tr>
<td>Low demand</td>
<td>7%</td>
</tr>
<tr>
<td>Office staff stigma</td>
<td>5%</td>
</tr>
<tr>
<td>Insufficient physician knowledge</td>
<td>3%</td>
</tr>
<tr>
<td>One or more barriers</td>
<td>55%</td>
</tr>
</tbody>
</table>

Walley AY et al J Gen Intern Med 2008; 23(9): 1393-8
Non-prescribers

If barriers improved:

• 54% (33/61) of those who had never prescribed buprenorphine, will prescribe

• 67% (10/15) of those who had prescribed, will prescribe

Walley AY et al J Gen Intern Med 2008; 23(9): 1393-8
Only physicians can prescribe.

However, it takes a Multidisciplinary Team Approach for effective addiction treatment.
Boston Medical Center Collaborative Care Model in General Internal Medicine

- **5/2003**
  - 1 patient, 1 physician and 1 RN

- **7/2010**
  - 425 patients (3-6 admissions per week)
  - 9 physicians
    - 1 medical director
    - 3 ABAM certified
    - Part-time clinical practices – mean 3 half day sessions/week (range 1-6 sessions)
  - 3 RNs (3 FTE)
  - 1 medical asst (1 FTE)
  - 1 program coordinator (1 FTE)
  - 1 program director (.4 FTE)

Alford DP et al. Arch Intern Med. 2011
BMC Collaborative Care Model

- Program Coordinator intake call
  - Screens the patient over the telephone
  - OBOT Team reviews the case for appropriateness
- NCM and physician assessments
  - Nurse does initial intake visit and collects data
  - Physician: PE, and assesses appropriateness, DSM IV criteria of opioid dependence
- NCM supervised induction (on-site) and managed stabilization (on- and off-site (by phone))
  - Follows protocol with patient self administering medication per prescription

Alford DP et al. Arch Intern Med. 2011
BMC Collaborative Care
Nurse Care Managers (NCM)

- Registered nurses, completed 1 day buprenorphine training
- Performed patient education and clinical care by following treatment protocols (e.g., UDT, pill counts, periop mgnt)
- Ensured compliance with federal laws
- Coordinated care with OBOT physicians
- Collaborated care with pharmacists (refills management) and off-site counseling services
- Drop-in hours for urgent care issues
- Managed all insurance issues (e.g., prior authorizations)
- On average each NCM saw 75 patients/wk

Alford DP et al. Arch Intern Med. 2011
BMC Collaborative Care

- Maintenance treatment patient in care (at least 6 months)
  - NCM visits weekly for 4-6 wks, then q2 wks, then q1-3 months and as needed.
  - Patients seen less than monthly had up to 6 random callbacks/yr
  - OBOT physician visits at least every 6 months
- Medically supervised withdrawal considered after 6 months of stability if the patient requested to taper, paced with patient needs and stopped if patient requested
- Transferred to Methadone if continued illicit opioid use or need for more structured care
- Discharged if continued non-adherence or disruptive behavior

Alford DP et al. Arch Intern Med. 2011
# Preadmission Factors Associated with Treatment Success

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older age</td>
<td>1.40 (1.09-1.80)</td>
</tr>
<tr>
<td>Employed</td>
<td>2.24 (1.33-3.77)</td>
</tr>
<tr>
<td>Illicit buprenorphine use</td>
<td>3.04 (1.32-7.00)</td>
</tr>
<tr>
<td>African American</td>
<td>0.50 (0.26-0.99)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>0.45 (0.22-0.93)</td>
</tr>
</tbody>
</table>

Alford DP et al. Arch Intern Med. 2011
## Urine Drug Tests

<table>
<thead>
<tr>
<th>Month</th>
<th>3</th>
<th>6</th>
<th>9</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit Opioid NEG</td>
<td>95%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
</tr>
<tr>
<td>Cocaine NEG</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>98%</td>
</tr>
</tbody>
</table>
Table 2. Treatment Outcomes at 12 Months of 382 Opioid-Dependent Patients Entering Office-Based Opioid Treatment in Primary Care

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

\(^a\) Denotes outcomes that may require additional follow-up clinical support and evaluation before continuing the treatment.
Conclusions

- Patient-level outcomes comparable to physician-centered approaches
- Allows efficient use of physician time to focus on patient management (e.g., dose adjustments, maintenance vs taper)
  - Allowed physicians to managed > numbers of patients due to support of NCM
- Improved access to OBOT and daily management of complex psychosocial needs (e.g., housing, employment, health insurance)
- Open communication between NCM and addiction counselors improved compliance

Alford DP et al. Arch Intern Med. 2011
MA STATE OBOT B: Nurse Care Manager Model in FQHCs
State Initiative Project Goals in Federally Qualified Health Centers FQHCs

- Treatment expansion and access to buprenorphine
- Create a model for the effective delivery of buprenorphine services:
  - Modeled after BMCs Nurse care manager program
- Integrate addiction treatment into primary care settings
- Increase the number of MD’s with waivers
- Increase the number of individuals treated for opioid addiction
- Focus on high risk areas, homeless individuals and pregnant women, Latino, African American
- Collect and analysis data
- Sustainability of project after funding ends
MA Department of Public Health Bureau of Substance Abuse Services Released two RFR’s: In Response to Unmet Need

- Funding for a Nurse Care Manager Model in all Community Health Centers (CHC) in the state who submitted responses to RFR

- Required CHC to partner with addictions counseling service providers

- Funding for training and technical assistance to the CHC OBOT’s and to all nonprofit providers interested in providing OBOT or needing support/consult

- Funding awarded for 3 years with an 8/07 start date, renewable for a total of 7 years and has since been extended using Block grant and state funds

- Modeled after Boston Medical Centers Nurse Care Manager Model
RFR Funding

- $270,000 per year for Technical Assistance: training, booster sessions, quarterly state educational sessions, conference calls, site visits, support staff and admin assistance, support to statewide providers in nonprofits, accountability of grant deliverables.

- $100,000 per CHC for Nurse Care Manager
  - 1 full time RN
  - 1:100 staff to patient ratio
    - Rolling admission of new patients each week to reach the 100
  - 1:125 with addition of Medical Assistant in year 4 of the grant, and less funding to support NCM

- Funding allowed billing for
  - Nurse Care Manager Salary initially
    - In year 4, 25% to nurse salary the remainder to MA as the NCM is reimbursable, the MA allows for additional patients and transfer of non nursing tasks to MA
  - Fringe
  - Transportation
  - Supplies
TA Support

• Nursing training and ongoing support
  ▪ Phone, email, site visits, chart reviews
  ▪ Quarterly statewide NCM meetings:
    – addiction education, support, networking

• Site support:
  ▪ Education all providers
    – Trainings: addiction, buprenorphine, stigma, management, set up
  ▪ Support practice: MD and nursing issues
  ▪ Care for or triage patients to other sites due to closures, staff changes, emergency issues
  ▪ DEA Support: Education and preparation, support at visits
  ▪ Waiver assistance, insurance support, coverage, carrier issues
What is a Federally Qualified Community Health Centers (FQHCs)

- In 1965, federal government created a demonstration project funding CHC’s
  - Current model was established in 1975
  - 1996 funding streams merged to create health center grant program under Section 330 of the Public Health Act
  - Health Resources and Service Administration (HRSA) distributes grant funding to FQHC’s
- FQHC’s are nonprofit organizations delivering Team based integrated care with physicians, advanced practice nurses, physicians assistants, nurses and other non-physician practitioners.
- Tasked with caring for medically underserved patients in underserved areas

Health Resources and Services Administration HRSA
### Benefits Provided at FQHCs

<table>
<thead>
<tr>
<th>Services FQHCs are required to provide that are not reimbursed by Medicare</th>
<th>Included in the Medicare FQHC all-inclusive payment rate</th>
<th>Separately billable by the FQHC provider under Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management</td>
<td>Visiting nurses to the homebound</td>
<td>Technical components of lab tests</td>
</tr>
<tr>
<td>Translation/Interpretation services</td>
<td>Incidental services, supplies, and overhead</td>
<td>Durable medical equipment</td>
</tr>
<tr>
<td>Preventive dental care</td>
<td>Primary and preventive services provided by physicians and nonphysician practitioners</td>
<td>Ambulance services</td>
</tr>
<tr>
<td>Transportation</td>
<td>Otherwise covered drugs that are not self-administered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes self-management training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical nutrition therapy</td>
<td></td>
</tr>
</tbody>
</table>
Comparing Medicare’s FQHC and RHC payment to physician office visit and hospital outpatient visit, 2011

<table>
<thead>
<tr>
<th>Payment limit</th>
<th>Medicare payment amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC, rural</td>
<td>$109.24</td>
</tr>
<tr>
<td>FQHC, urban</td>
<td>126.22</td>
</tr>
<tr>
<td>RHC</td>
<td>78.07</td>
</tr>
</tbody>
</table>

**Physician office**

Physician fee schedule, office visit by an established patient

- 68.97

**Hospital outpatient department**

- Facility: 75.13
- Physician work: 49.27
- Total: 124.40

*Level 3 Visit*

Note: FQHC, RHC, the physician fee schedule and outpatient department (OPD) figures are the national payment amount. Healthcare Procedure Coding System code 99213 for the physician fee schedule and OPD payment amounts. Medicare’s payment rate for a physician office visit includes the practice expense (i.e facility-level) payment.
Public Health Service Act (defines FCHC)

Benefits Improvement and Protection Act 2000

- Establishes payment requirements for Medicaid
- Federally mandates paying FCHC’s “average reasonable costs” to service medically under-served populations
- Gives each state the authority and flexibility to define services, providers, and rates

Section 330(a) of the PHS Act

- Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)
Cost Modeling in FQHCs in MA

Concluded:

- Allows RN’s to bill for an “Individual Medical Visit”
- Rate is the same as for an MD visit
- Assuming a nurse to patient ratio of 1:100
  - 90% utilization for a mixed frequency caseload
  - Included overhead and administrative costs
  - Federally QHC would make a profit of approximately $180,000 per fulltime NCM
  - NCM providing OBOT is sustainable and viable in a Federally Qualified Community Health Center

MA Department of Public Health Bureau of Substance Abuse Services 2010 Cost modeling report by Paul Cote
UMass Study Findings in Massachusetts

- Studied 5,600 Mass Health Clients prescribed buprenorphine and methadone
- Overall Mass Health expenditures lower than for those with no treatment
- Clients on Medication Assisted Treatment (MAT) had significantly lower rates of relapse, hospitalizations and ED visits: no more costly than other treatments
- Buprenorphine attracting younger and newer clients to treatment

R.E. Clark; Health Affairs, August 2011
Nurse Care Manager Model

- Screener by coordinator or nurse
- RN intake: labs, UTS, contracts, education
- Counselor - intake, refer to psych if warranted
- Intake reviewed by the OBOT team (RN, MD)
- Bupe MD visit: review, assess, clear for treatment appropriateness with DSM IV Dx Opioid Dependence
- Induction: stabilization, maintenance
  - Management by RN with waivered prescriber
    - Visits, assessments, education, UDS, labs, MD contacts
    - Facilitate prescription refills, medical monitoring, relapse, surgery, pregnancy, mental health needs, social supports, treatment plans
OBOT RN
Nursing Assessment:

- Intake assessment
  - Review medical hx, treatment hx, pain issues, mental health, current use, and medications
- Consents/Treatment agreements
  - Program expectations: visits & frequency, UDS, behavior
  - Understanding of medication: opioid, potential for withdrawal
  - Review, sign, copies to patient and review at later date
- Education
  - On the medication (opioid), administration, storage, safety, responsibilities and treatment plan
- Urine toxicology screen
  - Screen drug of use and ? Others: If positive what that may mean for treatment
- LFT’s, Hepatitis serologies, RPR, CBC, pregnancy test
OBOT MD

- Review of history
  - Mental health, substance use, medical, social
- Physical Exam
- Lab and urine review
  - Assess contraindications, toxicology
- Confirm Opioid Dependence diagnosis
  - DSM IV criteria
- Confirm appropriate for office treatment
- Writes the orders and prescription
- Develop Treatment Plan with OBOT Team
OBOT RN Role In FQHC’s

- Review and support program requirements:
  - Nurse/ Physician Appointments:
    - Frequency, times, location
  - Counseling:
    - Weekly initially, self help, mental health as needed
  - Obtain urine toxicology:
    - At visits, call backs, as needed and follow up
  - Support abstinence/ harm reduction
    - Abstinence from opioids is the goal
    - Safety with the goal to minimize substance use
  - Educate and monitor for Safety:
    - Medication storage, management, adherence
    - Relapses, assess risk benefit
OBOT RN
Follow up Visits:

• Assess dose, frequency, cravings, withdrawal
• Ongoing education: dosing, side effects, interactions, support.
• Counseling, self help check in
• Psychiatric evaluation and follow up as needed
• Medical issues: vaccines, follow up, treatment HIV, HCV…Engage in care
• Assist with preparing prescriptions
• Facilitating prior approvals and pharmacy
• Pregnancy: if pregnant engage in appropriate care
• Social supports: housing, job, family, friends
NCM Model in FQHC Allows:

- Greater numbers of patients able to access treatment
- Supports complex patient needs without burdening providers
- Allows patients to access treatment in their community
- Integrated within primary care therefore supports primary care needs: HTN, HCV, HIV, DM, etc.
- Integrates addictions care into medical treatment
- Individualizes treatment
- Removes Stigma
- Engages providers
- Is financially sustainable
STATE OBOT B MD’s Waivered in Community Health Centers:
Hospital Admissions

Average Hospital Admissions Per OBOT Enrollment

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Prior 6 Months</th>
<th>Future 6 Months</th>
<th>Future 7 to 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>0.26</td>
<td>0.10</td>
<td>0.12</td>
</tr>
<tr>
<td>2009</td>
<td>0.23</td>
<td>0.10</td>
<td>0.12</td>
</tr>
<tr>
<td>2010</td>
<td>0.20</td>
<td>0.09</td>
<td>0.12</td>
</tr>
<tr>
<td>2011</td>
<td>0.26</td>
<td>0.10</td>
<td>0.08</td>
</tr>
</tbody>
</table>

Notes:
- Hospital data is only available through 9/30/2012
- Enrollments must have lasted at least 12 months
- Paid amounts are calculated using hospital specific pay to charge ratios

2008: N=296  
2009: N=595  
2010: N=582  
2011: N=458
ER Visits

Average ER Visits Per OBOT Enrollment

- 2008: N=296
- 2009: N=595
- 2010: N=582
- 2011: N=458

Notes:
- Hospital data is only available through 9/30/2012
- Enrollments must have lasted at least 12 months
- Paid amounts are calculated using hospital specific pay to charge ratios
ER Expenditures

Total ER Expenditures: % Difference From Prior 6 Months

Notes:
- Hospital data is only available through 9/30/2012.
- Enrollments must have lasted at least 12 months
- Paid amounts are calculated using hospital specific pay to charge ratios
STATE OBOT B Physicians waived in CHC’s pre and post grant:

Providers waived to prescribe buprenorphine pre and post NCM model in funded CHC’s in MA
STATE OBOT B Patients receiving buprenorphine in CHC’s:

Patients treated with buprenorphine pre and post NCM model in funded CHC’s in MA
Challenges for Addiction Nurses in FQHC’s

- Many with limited to no addiction experience
  - Require initial training; booster sessions, educational opportunities
  - Ongoing support, training, mentoring
    - Need access to addiction providers: cell phone, email, meetings, site visits
- Difficult to hire experienced addiction nurses into health center
  - Salary
  - Environment: isolated, limited addiction colleagues
  - Support network: doing this alone within center
  - Many doctors turn to RN: have waiver limited experience
Challenges in FQHC’s Waivered Physicians:

- Physicians with limited addiction experience or support
  - Mentors, resources are key
- Limited waivered providers
  - Back up support: vacation, moves, leaves
  - Try to engage and enlist other providers
- Physician leaves practice
  - Need to train and enlist other MD’s
  - Back up of waivered providers
  - Providers at cap: State support network allows for transfer to other practice
- Health center has minimal buy in
  - May not require providers to be waivered, limiting numbers of providers
Next Steps

• Utilizing nurse care manager models to expand treatment to more sites
• Increase level of education among providers in addiction treatment
  ▪ Nurses, doctors, support staff, and administration
• Require all physicians to obtain and X number
• Integrate in to the medical home model of care
• Look at drop out rates and reasons: improve retention
• Follow treatment and prevention outcomes when patients are in care for addiction
References

- Alford DP, LaBelle CT, Kretsch N, Pierson A, Botticelli M, Winter M, Samet, JH. Collaborative Care of Opioid Addicted Patients using Buprenorphine in Primary Care: Five Year Experience. Archives of Internal Medicine 2011;171(5) 425-431


- Center for Medicare & Medicaid Services, Department of Health and Human Services, 2011d. Rural health clinics and federally qualified health centers billing guide. MLN Matters no. SE1039.

References


- Clark, R.E., Samnaliev, M., Baxter, J.D., & Leung, G.Y., (2011). The Evidence Doesn’t Justify Steps By State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine. 30(8), 1425-1433.


References


- Massachusetts Department of Public Health Bureau of Substance Abuse Services Office Based Opioid Treatment RFR, 2007

- Massachusetts Department of Public Health Bureau of Substance Abuse Services, Cost modeling analysis by Paul Cote on FQHC sustainability and billing OBOT in CHCs, 2010.


PCSS-MAT Mentoring Program

- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS-MAT Mentors comprise a national network of trained providers with expertise in medication-assisted treatment, addictions and clinical education.

- Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

- The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit: pcssmat.org/mentoring
PCSSMAT is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA) and American Society of Addiction Medicine (ASAM).

For More Information: www.pcssmat.org

Twitter: @PCSSProjects

Funding for this initiative was made possible (in part) by Providers’ Clinical Support System for Medication Assisted Treatment (5U79TI024697) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Please Click the Link Below to Access the Post Test for this Online Module

Click here to take the Module Post Test

Upon completion of the Post Test:
• If you pass the Post Test with a grade of 80% or higher, you will be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

• If you received a grade of 79% or lower on the Post Test, you will be instructed to review the Online Module once more and retake the Post Test. You will then be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

• After successfully passing, you will receive an email detailing correct answers, explanations and references for each question of the Post Test.