PCSS
Providers' Clinical Support System
Monthly Update

Inside

www.PCSS-O.org
www.PCSSMAT.org

Massachusetts Targets Opioid Overdose Prevention

Healthcare Model Gives More Patients Access to Medication Assisted Treatment

While Massachusetts may have one of the most aggressive programs in the country targeting the opioid overdose epidemic, it is still struggling with what state health officials say is an unacceptable number of opioid-related deaths. In 2014, nearly 1,000 people died from opiate overdose and thus far 2015 is on track to match if not exceed that number.

Despite these grim statistics, Massachusetts is taking aim at the problem through a multi-prong approach including: prevention, intervention, treatment, and recovery. One of the issues it faces like many other states is the lack of physicians who are adequately trained to treat opioid use disorders. Some physicians have taken the eight-hour required training to be considered for a waiver to prescribe buprenorphine, which is one medication that has been shown to be effective. Others have taken the course and have the waiver but are not prescribing.

With the need so great, one might ask why weren't more waivered physicians prescribing?

Many believe that primary care practitioners are not prepared to handle patients with substance use problems and more training is needed on more than prescribing medication and alternative medications to consider. In addition to buprenorphine, other medications are used to treat opioid use disorders including methadone, naltrexone, and vivitrol.

In 2005, the Massachusetts Bureau of Substance Abuse (BSA) surveyed physicians waivered to prescribe buprenorphine in an effort to find out why so few were writing prescriptions. Of the physicians who responded to the survey who are waivered to prescribe, one third were not prescribing.

"It's a challenging disease to treat in any primary care practice," says Colleen LaBelle, BSN, RN-BC, CARN, Program Director for Massachusetts's Technical Assistance Treatment Expansion Office Based Opioid Treatment with Buprenorphine.

Patients with substance use disorders are complex, often with co-occurring mental health and medical disorders with fractured support systems. Physicians are pressured by requirements to see a certain number of patients a day to meet contractual agreements and to sustain their practice. Adding complex patients with substance use disorders takes up more time and resources and is not always feasible. In short, LaBelle said, physicians are overwhelmed. Even with the eight hours of training required to apply for the waiver to prescribe buprenorphine, many physicians in the 2005 survey indicated they needed more training and support to successfully treat opioid-dependent patients.

Meanwhile, waiting lists for those wanting treatment for opioid use disorders but unable to receive it were dramatically increasing. Adding to the problem at the time was the federal restriction that physicians who were waivered were only allowed to have 30 patients prescribed buprenorphine at any one time (now the limit is 100).

"It's a huge education process," LaBelle said, noting programs like the Providers' Clinical Support System for Medication Assisted

Continued p. 2

Massachusetts Targets from p. 1

Treatment, which train healthcare providers in evidence-based practices to treat opioid use disorders, are valuable resources.

Colleen LaBelle BSN, RN-BC, CARN

In Massachusetts, under the leadership of former Director of the BSA, Michael Botticelli (recently named by the Obama administration to serve as Director of National Drug Control Policy); LaBelle; Daniel P. Alford, MD, MPH; and Jeffrey H. Samet, MD, MA, MPH developed an innovative model of care to address this need. Their approach was to create a system of care that relied on a team approach that has made a significant impact on not only the number of physicians willing to prescribe buprenorphine, but also the number of patients being successfully treated.

The concept was to take advantage of health centers in communities and pair nurses trained in addictions and medication-assisted treatment with waivered physicians to care for patients on buprenorphine/naloxone. The nurses provide the screening, assessment, first line intakes, with education, treatment agreements, labs, and urine screens. This information is then handed off to the physician at the initial visit with the patient. Following this intake screening process, nurses and the physicians work as a team, where the nurses see the patients more frequently and handle day-to-day issues to manage this complex chronic relaspsing disorder. It is important to note that currently physician assistants and nurse practitioners cannot prescribe buprenorphine.

Since Massachusetts adopted the model it has worked well both for healthcare providers and patients. In fact, the program has more than paid for itself in cost savings, LaBelle added.

Funding has been provided by the BSA through federal grants, which initially targeted high-incidence areas, and so far the results have been impressive. Those with opioid use disorders are far more likely to go to a community health center for treatment than a methadone clinic because of the stigma associated with methadone clinics, LaBelle said. Since 2007, Massachusetts's health centers have treated more than 8,000 patients. The 16 health centers that are grant recipients (two more will be added this year) are mandated to have a caseload of a minimum of 125 patients, though many exceed this number.

Many parts of the country persist in treating the disease as a personal flaw, rather than a medical condition, LaBelle said, adding that abstinence hasn't worked for the majority. "We need to start treating this as a disease. We need to change the perception. Allowing patients to access care in outpatient settings privately has helped some patients who never would have confronted their addiction. This is a disease that changes the brain and often requires medication to manage it. We need to stop telling people how to treat their addiction based on personal beliefs and philosophies and allow patients access to treatment without judgment. But treatment needs to be accessible; people cannot be waiting for treatment."

PCSS Outreach to Primary Care Providers in Indiana to Address Opioid and HIV Outbreak

Providers' Clinical Support System is working to mobilize experts to help Indiana, which is in the midst of a human immunodeficiency virus (HIV) epidemic, caused mostly by needle sharing.

A small working group with Drs. Michelle Lofwall, David Fiellin, Margaret Kotz, and Adam Bisaga, all addiction specialists and PCSS mentors, joined forces with Tony Campbell, DO, from SAMHSA (Substance Abuse and Mental health Services Administration) and American Academy of Addiction Psychiatry staff to work with local providers, including Indiana family physician William Cooke, MD. The group has scheduled a buprenorphine waiver training for June 2, provided at not cost, and will make available training and resources on prescribing naltrexone and methadone in the treatment of opioid use disorders. The team also has identified mentors in Indiana, the nearby region and nationally to help local primary care and HIV providers address substance use disorders and the use of medication assisted treatment in the population impacted by these epidemics.

Last month, the Centers for Disease Control (CDC) issued a report on a rural southeastern Indiana county of 4,200, which has reported more than 100 (as of April 29) cases of HIV infection. As of May 13, the number was reported to be 153. The majority of cases were linked to needles shared to inject the prescription opioid oxymorphone, a powerful oral semi-synthetic opioid analgesic.

In response to the outbreak, the Indiana State Department of Health created an HIV clinic and instituted a needle exchange program.

The outbreak was first noted last December and health officials in Indiana have been working to test residents for HIV. Last month, Indiana lawmakers passed a measure that would allow communities to implement needle-exchange programs if they can prove they are in the midst of an epidemic tied to intravenous drug use.

Scott County is a poor, rural area with high unemployment and high drug use. The CDC's report described drug use as a "multi-generational activity," with as many as three generations of a family injecting together.

New Steering Committee Member Promotes Efforts at Annual Meeting

Chris Stock, PharmD, shares PCSS Project materials

The College of Psychiatric and Neurologic Pharmacists (CPNP) recently became a member.

Nearly 700 CPNP member pharmacists met for its annual meeting in Tampa, FL, where Chris Stock, PharmD, shared PCSS-O and PCSS-MAT materials with attendees and sought ideas for pharmacists' involvement with the PCSS programs.

The aims of the PCSS programs and CPNP's Substance Use Disorder Task Force are closely aligned. Both support education and training for health professionals including pharmacists to increase patient access to safe and evidence-based pharmacotherapy used to manage substance use disorders including opioid-related disorders.

PCSS Highlights

Both PCSS projects have been extremely busy in 2014-2015.

The new **Providers' Clinical Support System for Opioid Therapies** launched its first trainings in January 2015 and already has provided 14 webinars and trained more than 2,000 clinicians. In total, PCSS-O grants have trained over 22,000 health professionals.

Providers' Clinical Support System for Medication Assisted Therapies will complete year two of the three-year funding and has trained more than 12,000 health professioals. Over the first two years of the grant, PCSS-MAT has provided 143 bupernorphine trainings with nearly 2,273 participants.

Both projects also offer Small Group Discussions, which allow a maximum of 10 mentees to discuss a clinical case with providers to hear a case study from an expert and discuss issues involving treating opioid use disorders and evidence-based opioid prescribing. PCSS-MAT has conducted seven trainings and PCSS-O began offering Small Group Discussions last month, conducting two discussions.

AMERSA Awarded PCSS-O Mini-Grant

Substance Abuse, the official journal for the Association for Medical Education and Research in Substance Abuse (AMERSA), in partnership with PCSS-O, will publish a special issue in 2015 titled "From Education to Implementation: Addressing the Opioid Misuse Epidemic." Those interested in submitting a paper to be considered for publication and for more information, click here.

Rhode Island Coalition Sponsors SBIRT and Pain Conference

Rhode Island has been identified as having one of the highest rates of opioid overdoes in the country. In an effort to address this need, the American Academy of Addiction Psychiatry (AAAP) and Providers' Clinical Support System for Opioid Therapies (PCSS-O) in collaboration with the RI Department of Health, and RI Department of Behavioral Health Developmental Disabilities and Hospitals, Butler Hospital are holding a continuing medical education course: *Safe Opioid Prescribing: Maximizing Benefits and Minimizing Risks.*

The four-hour course, held in Rhode Island and schedued for Saturday, June 6, targets clinicians practicing in Rhode Island, Massachusetts, and Connecticut. The CME course is designed to provide prescribers basic tools to safely prescribe opioids using a Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach.

The speaker for this training is Paul Seale, MD, Professor and Director of Research in the Department of Family Medicine, Medical Center of Central Georgia and Mercer University School of Medicine, is speaker. Funding in part provided by: PCSSO/SAMSHA grant, AAAP, and the RI Department of Health.

Attendees may earn as many as 3.5 *AMA PRA Category 1 Credits™.*

More information and to register.

Announcements and Educational Opportunities

If you have an educational resource or training on opioid sue disorder that you would like to share contact: jane@aaap.org.

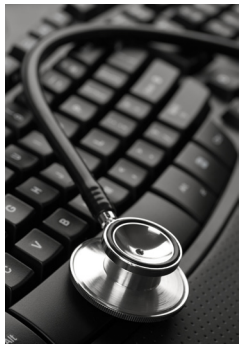
Please limit to 400 words.

Trainings

PCSS-O Upcoming Webinars
PCSS-O Archived Webinars
PCSS-O Online Modules

PCSS-MAT Upcoming Webinars
PCSS-MAT Archived Webinars
PCSS-MAT Online Modules

Upcoming Buprenorphine Waiver Trainings



Small Group Discussions

PCSS-MAT

When to Terminate Buprenorphine Maintenance
Wednesday, May 13, 2015, 12:00 - 1:00 pm ET
Edwin Salsitz, MD, FASAM

PCSS-O

Parental Involvement in Treatment for Adolescents
Wednesday, June 10, 2015, 3:00 - 4:00 pm ET
Sharon Levy, MD, MPH

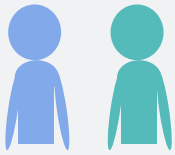
Note: These programs are designed as a coaching session on clinical issues. Invitations are sent to those already enrolled in PCSS-MAT Mentor Program or PCSS-O Colleague Support programs at least three weeks prior to the event.

Case Study: What would you do?

Each month, PCSS Monthly Update provides a case followed by a series of questions. We encourage you to review the case and answer the questions to learn more about treating opioid use disorders. **NOTE:** there are NO CME credits for completing this case.

You have followed a 57-year-old man in your general medical practice for the past 6 years. He had been in treatment at a local methadone clinic for over 15 years and had worked as a counselor at the clinic for a 3-year period when he was in his 40s. About 2 years ago, he had the opportunity to become the manager at a local printing company, but he was worried that he would be fired if the owner found out he was in methadone treatment. He and his wife met with you at that time, and you agreed to treat him with buprenorphine, although you have not treated any previous patients with the medication.

Read complete case study and answer questions



PCSS-MAT Steering Committee Members

PCSS-O Steering Committee Members

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Opioid Therapies (grant nos. 5H79TI023439 and 1H79TI025595) and Providers' Clinical Support System for Medication Assisted Treatment (grant no. 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.