Journal of Substance Abuse Treatment 60 (2016) 6–13

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers

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ARTICLE INFO

Article history:
Received 27 February 2015
Received in revised form 8 June 2015
Accepted 17 June 2015

Keywords:
Opioid agonist therapy
Buprenorphine
Waivered physicians
Nurse care manager
Access to treatment
Opioid use disorder

ABSTRACT

We describe a Massachusetts Bureau of Substance Abuse Services' (BSAS) initiative to disseminate the office-based opioid treatment with buprenorphine (OBOT-B) Massachusetts Model from its development at Boston Medical Center (BMC) to its implementation at fourteen community health centers (CHCs) beginning in 2007. The Massachusetts Collaborative Care Model for the delivery of opioid agonist therapy with buprenorphine, in which nurses working with physicians play a central role in the evaluation and monitoring of patients, holds promise for the effective expansion of treatment for opioid use disorders. The training of and technical assistance for the OBOT nurses as well as a limited program assessment are described. Data spanning 6 years (2007–2013) report patient demographics, prior treatment for opioid use disorders, history of overdose, housing, and employment. The expansion of OBOT to the fourteen CHCs increased the number of physicians who were "waivered" (i.e., enabling their prescribing of buprenorphine) by 375%, from 24 to 114, within 3 years. During this period the annual admissions of OBOT patients to CHCs markedly increased. Dissemination of the Massachusetts Model of the Office-Based Opioid Treatment with Buprenorphine employing a collaborative care model with a central role for nursing enabled implementation of effective treatment for patients with an opioid use disorder at community health centers throughout Massachusetts while effectively engaging primary care physicians in this endeavor.

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1. Introduction

In the United States the number of people with opioid use disorders using prescription opioids increased in 2013 to 1.9 million and for heroin to 517,000. (Substance Abuse and Mental Health Services Administration, 2014b). The 2013 national mortality associated with opioid analgesic overdose exceeded 16,200 deaths (Center for Disease Control and Prevention, 2015). Effective pharmacotherapy exists for people with opioid use disorders but fewer than 24% receive any medication for their addiction. (SAMHSA Center for Behavioral Health Statistics and Quality, 2014).

The contrast of the magnitude of this public health problem with individuals' receipt of efficacious therapy is striking (SAMHSA Center for Behavioral Health Statistics and Quality, 2014). Part of this inadequate response can be explained by the lack of clinical support and infrastructure resulting in difficulty finding a physician who can provide this care (Alford et al., 2011; Walley et al., 2008). Doctors feel that despite appropriate training, the delivery of opioid agonist treatment such as buprenorphine in an office-based setting is difficult (Walley et al., 2008). To address this dilemma, over a decade ago a primary care office-based opioid treatment (OBOT) Collaborative Care Model was created in an academic medical center (Alford et al., 2011). This OBOT approach has been referred to as the Massachusetts model by SAMHSA (Substance Abuse and Mental Health Services Administration, 2014a).

The expansion of the Drug Addiction Treatment Act (2000) allowed a "waivered" physician to prescribe buprenorphine in an office-based setting after a minimum of eight hours of training for up to 30 patients with opioid use disorders. The introduction of the "extended waiver" allowed physicians to apply for approval to treat up to 100 patients per physician after one-year experience with the initial waiver approval. In Massachusetts and nationwide, by 2014, less than 5% of physicians had received such training and were waivered; compounding this physician shortage is that historically, a sizable proportion of the waivered

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http://dx.doi.org/10.1016/j.jsat.2015.06.010
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Table 1
Barriers to treatment and how the STATE OBOT program addressed them.

Barriers	How STATE OBOT program addresses the barriers
Physician competing activities	NCMs meet with patients on a more regular basis and share some of the clinical responsibilities not required to be physician delivered. NCMs routinely confer with physicians regarding patient issues as the need arises.
Lack of support staff	State supported start up funding and integration of NCMs. Integration of Medical Assistants to work with NCMs. Education and engagement of non-medical staff.
Inadequate addiction expertise	TTA educates the staff on buprenorphine treatment through a day-long Buprenorphine-101 training. Continued support is provided as needed. Ongoing quarterly trainings for NCMs and Medical Assistants. Ongoing educational updates and sharing of information via email
Payment issues	FQHCs are able to bill for nursing visits at a comparable rate as they would for other licensed clinical providers. Program revenue provides funding for administrative costs.
Administrative obstacles	Education on disease and stigma TTA for administrative staff helps with the implementation. Assisted with systems for: tracking, reporting and visits.

doctors do not prescribe buprenorphine (Kaiser Family Foundation, 2015). Studies on physicians' willingness to treat such patients reveal several barriers to the office-based treatment of opioid use disorders (Barry et al., 2009; Kissin, McLeod, Sonnefeld, & Stanton, 2006; Turner, Laine, Lin, & Lynch, 2005; Walley et al., 2008) (Table 1).

Recognizing these barriers to Office-Based Opioid Treatment with Buprenorphine (OBOT-B), in 2003, a multidisciplinary team at Boston Medical Center (BMC) created a new model of care to increase access to treatment: the Collaborative Care Model of OBOT, subsequently dubbed the Massachusetts Model (Alford et al., 2007, 2011) (Table 1). This program was supported by the Massachusetts Department of Public Health Bureau of Substance Abuse Services (BSAS), the administrative state agency that oversees addiction prevention, treatment and recovery support services. The OBOT-B Collaborative Care Model at BMC has grown to serve over 450 patients, with nineteen waivered primary care physicians, making this program one of the largest such primary care based programs in the country (Alford et al., 2007). This paper describes the expansion of the Massachusetts model into community health centers (CHCs) throughout the Commonwealth of Massachusetts.

Implementing such a model of care at CHCs has important potential advantages: enables distribution of treatment to a wide geographical area; promotes engagement of marginalized population; and utilizes a facilitative health care reimbursement model. The implementation of this model of care is best explained using the theoretical constructs outlined in the ADAPTS implementation science model (Table 2) (Knapp & Anaya, 2012). We report the process by which this implementation of the OBOT-B Massachusetts Model occurred in CHCs and some metrics of its effectiveness (e.g., annual active admissions, number of waivered physicians).

2. Methods

2.1. State Technical Assistance Treatment Expansion (STATE) OBOT-B

Beginning in 2007, the OBOT-B Collaborative Care Model was implemented in CHCs in Massachusetts (STATE OBOT-B) (Alford et al., 2007, 2011). The goal of the STATE OBOT-B program was to incorporate the OBOT-B Collaborative Care Model into primary care in CHCs, expanding access to buprenorphine treatment. NCMs were hired at CHCs to provide waivered physicians with the clinical support to manage patients on buprenorphine with opioid use disorders. This OBOT-B model was designed to provide treatment to marginalized individuals living in the communities of the CHCs including the homeless, under-insured, uninsured, ethnic and racial minorities and those with co-occurring physical or mental health disorders.

The clinical model consists of four treatment stages: 1) screening and assessment of the patient's appropriateness for office-based treatment; 2) medication induction under a Nurse Care Manager's direct supervision; 3) stabilization; and 4) maintenance. The model adheres to recognized practice standards including SAMHSA's Treatment Improvement Protocol 40 (Center for Substance Abuse Treatment, 2004) and evidence-based treatment guidance for nurses as noted in the Technical Assistance Publications Series 30 (Center for Substance Abuse Treatment, 2009), and practices as described by the Massachusetts Behavioral Health Partnership (Massachusetts Behavioral Health Partnership, 2010).

The Nurse Care Manager (NCM) is central to the OBOT-B Collaborative Care Model (Fig. 2). The NCM is usually the initial contact for patients seeking OBOT-B treatment and acts as the primary liaison between the patient and the OBOT physician throughout the treatment process (Fig. 1). The NCM performs the initial screening, after which a

Table 2
ADAPTS implementation science model of the STATE OBOT-B program.

Step	Action
Assessment	Identified various barriers to physicians regarding providing the office-based treatment of opioid disorders in MA (Walley et al., 2008) BMC developed the Collaborative Care Model of OBOT and has shown success and need (wait list > 300 patients) Training and Technical Assistance needs assessment
Deliverables	Policy and procedures manual, visit templates, educational materials Training and Technical Assistance Increased number of prescribers and increased number of patients treated
Activate	Request-for-response was sent to 36 FQHCs in MA to encourage their applying for the grant Site champions: OBOT nurse and physicians
Pretraining	Each FQHC was given the option to make site-specific changes to the implementation to better integrate the program into their individual site
Training	STATE OBOT Training and Technical Assistance provides training and education to staff regarding OBOT-B and opioid use disorders and integration of buprenorphine treatment Provide ongoing training and support as needed
Sustainability	Ongoing support, updates, trainings and check-ins to maintain quality of care Educate about the billing for NCM services for financial sustainability

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