Collaborative Care: State Targeted Response Technical Assistance for Opioids – How it Works and How It Can Help You

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Kathryn Cates-Wessel

Chief Executive Officer, American Academy of Addiction Psychiatry, East Providence, Rhode Island

Cates-Wessel has more than 30 years of background and experience in the substance use disorder field, including administration, medical education, and policy. In addition to her role at the American Academy of Addiction Psychiatry (AAAP), she is principal investigator and project director for both the Provider’s Clinical Support System (PCSS) and State Target Response-Technical Assistance (STR-TA) grants. Prior to her work at the AAAP, Cates-Wessel was associate director of Brown University's Center for Alcohol and Addiction Studies for more than 19 years. She also previously served as executive director of Physicians and Lawyers for National Drug Policy, a think tank of leaders from law and medicine advocating for prevention and treatment of individuals with substance use and opioid use disorders instead of incarceration. Before that, she was associate director of a residential treatment center for adolescents who had substance use disorders and co-occurring mental disorders.
Molly Rossignol, DO, FAAFP, FASAM

Addition Medicine Physician, Catholic Medical Center, Manchester, New Hampshire

Dr. Rossignol earned her medical degree from the University of New England College of Osteopathic Medicine, Biddeford, Maine. She completed a family medicine residency at Central Maine Medical Center in Lewiston and a fellowship in addiction medicine at the University of Wisconsin-Madison. For 14 years, she worked as a community family physician and as faculty at NH Dartmouth Family Medicine Residency, Concord. In her role with Catholic Medical Center, she has been developing outpatient and inpatient addiction consult services. Dr. Rossignol has been on the New Hampshire Governor’s Healthcare Task Force for Substance Use Prevention, Treatment and Recovery since 2008. She is a contributing author of Guidance Document on Best Practices: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire. In addition, she is on the New Hampshire Medical Society Council, represents the Northern New England Society of Addiction Medicine as an advocacy chairperson in New Hampshire, and is the immediate past president of the New Hampshire Academy of Family Physicians.

Learning Objectives

1. Participants will be become familiar with the STR-TA initiative and its role in addressing the opioid epidemic.

2. Participants will learn how to interact with their local STR-TA team and options for requesting assistance.

3. Participants will understand how to locate resources that are available to them in their area to gain training and education in opioid use disorder prevention, treatment and recovery.

4. Participants will identify most common and challenging issues related to opioid use disorder and receive information and key tips for addressing these issues.
Clinical Case

42 yo male presents with general malaise, muscle aches, abdominal cramping and nausea. He denies fever. States he has been using illicit opioids intravenously for past two years. Decided to stop ‘cold turkey’ when his wife left him and his family refuses to talk to him.

Last use: 1 g IV approximately 18 hours prior to presentation

- Temperature = 98.7 HR=100 R=14 BP=138/88
- Gen: face appears moist, makes little eye contact, wears hoodie over head, moving lower extremities consistently in up and down motion
- Abdomen: soft, general discomfort to palpation, no masses
- Skin: evidence of vein bruising in linear patterns on upper extremities; goose bumps, no evidence of erythema or swelling
Poll Question 1

Based on your current office setting and resources what would you do for this patient?

A) Send him to the ED
B) Give him clonidine, ondansetron, ibuprofen, dicyclomine, immodium and ask him to follow up if worsening symptoms
C) Prescribe buprenorphine for withdrawal management, medications for symptoms and discuss ongoing treatment
D) Call the local Community SUD “Hub” to arrange for evaluation
Family Medicine: Our Role

• Prevention
• Treatment
• Recovery
• This is our time!

Figure 1. National Drug Overdose Deaths
Number Among All Ages, by Gender, 1999-2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018
2017 CDC Data

- 2013-2016: 12% opioid death increase
- 2016-2017: Increase 45.2% fentanyl deaths 59.8% of all opioid related OD deaths
- Remained stable for deaths involving Rx opioids and heroin

2016-2017: death rates involving cocaine and stimulants increased 34.4% from 3.2- 4.3 per 100K

MMWR, 2018 Scholl

My First Patient

- 39 yo male, contractor, using oxycodone 30 mg tabs up to 6 tablets daily; “sniffing”; suicidal
- Brought in by his wife, an ICU RN
- Last use was several hours prior to visit.
- Feeling anxious, irritable, generalized muscle aches; nausea and abdominal cramping
- PE: 98.8 – 138/84 – 102 - 16; appears anxious, sweaty face, nasal stuffiness, no evidence of IVDU on exposed skin surfaces (hands, arms, neck) rubbing legs, able to sit still for short time then shifts on the exam table; rocking self
Clinical Case

Continued

• Diagnosis: Opioid Withdrawal; Opioid Dependence
• Is this Addiction?
• What can I offer this patient?

Opioid Use Disorder

• Craving
• Tolerance
• Withdrawal
• Social ~ change
• Occupational ~ failure to fulfill home/work
• Interpersonal problems

• Using more than intended
• Control
• Use in hazardous situations
• Time spent getting/using recovering
• Continued use despite knowledge of phy/psy effect

DSM 5 2013
ADDICTION

Dysfunction of circuits in the brain leading to:

– Characteristic biological, psychological, social and spiritual manifestations
– Dysfunctional emotional response
– Problems of behavior
– Progressive disability and premature death
– Control, cravings, compulsion, consequences


• The World Health Organization has identified nicotine, alcohol and illicit drug use as top 10 contributors of morbidity and mortality

• Collectively single greatest contributor to poor health, family dysfunction and social problems in U.S. and elsewhere
Figure 1. Number of overdose deaths involving opioids in New Hampshire, by opioid category. Drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Source: CDC WONDER.

citation

How a ‘Perfect Storm’ in New Hampshire Has Fueled an Opioid Crisis

News > State

Report blames carfentanil for 10 overdose deaths in New Hampshire

NYT Sellye, K Jan 21, 2018; Concord Monitor 7/13/2017 AP
Lethal doses of illicit opioids

New Hampshire State Police Forensics Laboratory copyright permission obtained

Quarterly rate of suspected opioid overdose, by US region
Source: Centers for Disease Control and Prevention.10

Stigma

- “Why would you treat her?”
- “You can't prescribe that here”
- “You are just replacing one drug for the other”
- “He will just use the medication for currency”
- “You should have thought of that when you used heroin”
- “Lay down!”

- Expectations of self
- Expectations of healthcare community
- Shame over inability to stop
- Doubt of ability to stop
- Discrimination
- Incarceration

Hope for Our Patients
• **NIH and HHS Goals**
  – Increase access to treatment and recovery services
  – Promote use of OD reversal agent
  – Strengthen understanding through public health surveillance
  – Support for research in addiction and pain
  – Advance better pain management practices

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**AMA: Tangible Actions by Policy Makers to Address Opioid Epidemic**

- Access to MAT without prior authorizations from all third party payers
- MCH: access to treatment without punitive policies
- Justice Reform: treatment options expansion
- Mental Health: Parity Law enforcement
- Comprehensive Pain Care

https://www.end-opioid-epidemic.org/policymaker-recommendations/
What is Best Treatment for Opioid Addiction?

- Medical System/Provider
  - Medication/counseling/wellness promotion
- Behavioral Health
  - Residential Services
  - Varying levels of outpatient services
- Supports
  - Mutual Help
  - Family/Friends
  - Social Determinants (housing, transportation, avoidance of toxic environments)

FDA Approved Medications For Treating Opioid Use Disorders

- Methadone
- Buprenorphine
- Naltrexone
Evolving Evidence, Evolving Management

- Low Threshold Medication treatment
- ED initiation with f/u
- Home induction/initiation
- Buprenorphine in setting of other substance use
- Not mandating counseling while on medication
- No arbitrary lengths of tx
Management Tools

Drug testing
PDMP
Self Report

Models of care set up to create success

Poll Question #2

Of the following, which strategy has been suggested to reduce the risk of OD from illicit opioids by the AMA?

A) Training in pain management to keep mme <= 50 mg per day
B) Treating addiction only and ignore psychiatric disease
C) Increase punitive policies for pregnant women (ie, negative consequences)
D) Demand insurance companies decrease administrative burden and prior authorization requirements for ALL medication for addiction treatment
E) Continue to incarcerate drug users and only address the drug use when they are released
Substance Abuse and Mental Health Services Administration (SAMHSA)

• February 1, 2018 SAMHSA awarded the American Academy of Addiction Psychiatry (AAAP) and a coalition of 22 national healthcare organizations a two-year grant to provide technical assistance to U.S. states and territories to address the opioid crisis.
Overall Mission

To provide training and technical assistance via local experts to enhance prevention, treatment (especially medication-assisted treatment like buprenorphine, naltrexone, and methadone), and recovery efforts across the country addressing state and local - specific needs.

Approach: To build on existing efforts, enhance, refine and fill-in gaps when needed while avoiding duplication and not “re-creating the wheel.”
Our Team

• The American Academy of Addiction Psychiatry (AAAP) is the lead agency for the STR-TA Grant.
• The following CORE Team organizations are responsible for the project’s strategic planning and oversight of the project activities.

**Treatment**
- American Academy of Addiction Psychiatry
- Addiction Technology Transfer Center National Coordinating Center
- Columbia University’s Division on Substance Use Disorders

**Prevention**
- Boston Children’s Hospital – Adolescent Substance Use and Addiction Program
- CADCA - Community Anti-Drug Coalitions of America

**Recovery**
- C4 Innovations – working with FAVOR and Young People in Recovery

**Evaluation**
- Research Triangle International

Collaboration is Key
Partner Organizations and Individuals

- American Academy of Family Physicians (AAFP)
- American Association for the Treatment of Opioid Dependence (AATOD)
- American College of Emergency Physicians (ACEP)
- American College of Physicians (ACP)
- American Medical Association (AMA)
- American Pharmacists Association (APhA)
- American Psychiatric Nurses Association (APNA)
- American Osteopathic Academy of Addiction Medicine (AOAAM)
- American Psychiatric Association (APA)
- Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA)
- Boston Medical Center (BMC)
- Coalition of Physician Education (COPE)
- Council on Social Work Education (CSWE)
- National Association for Community Health Centers (NACHC)
- National Association of Drug Court Professionals (NADCP)
- National Alliance for HIV Education and Workforce Development (NAHEWD / AETC)
- National Council for Behavioral Health (NCBH)
- Physician Assistant Education Association (PAEA)
- National Judicial College (NJC)
- The Police Assisted Addiction and Recovery Initiative (PAARI)
- Strengthening Families

Individuals: Holly Echo-Hawk, MS, Karen Oliver, PhD and Roger Chou, MD

Opioid Response Network

- American Academy of Addiction Psychiatry (AAAP) is the lead organization for the STR-TA grant. AAAP and the coalition of 27 national professional organizations formed the Opioid Response Network to provide training and technical assistance via local consultants across the country and nine territories.
Overarching Message

• Language Matters. Words have power. Use affirmative language to advance prevention, treatment and recovery.

• Provide developmentally and culturally appropriate prevention, treatment and recovery. Implement evidenced-based prevention, treatment and recovery practices.
Guiding Principles: Effective Treatment is Key

- SUD/OUD is a treatable chronic brain disorder.
- Standard medical practice includes identifying, diagnosing and treating patients for SUD/OUD.
- FDA indicated medications are the standard of care and are effective for treating OUD and saving lives.
- All patients with OUD must be offered FDA indicated medications as part of their treatment.

Effective Treatment is Key (continued)

- Evidence-based psychosocial interventions in combination with MAT improve outcomes.
- Address stigma to increase access to care.
- People can and do recover from OUD and other SUDs.
- Effectively treating adolescents and young adults with SUD and OUD starts with seeking, identifying and assessing them for these conditions.
ORN- It’s As Easy As 1-2-3

- **Step 1**: Those seeking technical assistance submit a request form: [https://opioidresponsethenetwork.org/SubmitTARequest.aspx](https://opioidresponsethenetwork.org/SubmitTARequest.aspx)
- **Step 2**: The request will be forwarded to the designated Technology Transfer Specialist (TTS) for each state/territory.
- **Step 3**: Once the request form is submitted, the individual submitting the request will be contacted within one business day to initiate a call to discuss the process and needs of the requestor to move forward.

### Top Three TA Topics by Focus Area

<table>
<thead>
<tr>
<th>Focus Area</th>
<th># of Related TA Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>School/Education Programs</td>
<td>21</td>
</tr>
<tr>
<td>Media/Public Awareness Campaigns</td>
<td>10</td>
</tr>
<tr>
<td>Naloxone Training/Distribution</td>
<td>9</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>General Medication Assisted Treatment (MAT); Including Clinical Mentorship and Implementation Facilitation</td>
<td>77</td>
</tr>
<tr>
<td>Other</td>
<td>60</td>
</tr>
<tr>
<td>Implementation TA/Systems Change</td>
<td>59</td>
</tr>
<tr>
<td><strong>Recovery</strong></td>
<td></td>
</tr>
<tr>
<td>Recovery Coalition/Community Building</td>
<td>27</td>
</tr>
<tr>
<td>Implementation TA/Systems Change</td>
<td>28</td>
</tr>
<tr>
<td>Peer Support/Recovery Coach Models</td>
<td>16</td>
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</tbody>
</table>

Data in these analyses are as of 11/27/2018.
## TA Focus Areas

![Pie chart showing distribution: Treatment 64%, Prevention 16%, Recovery 20%]

## Top 10 TA Implementation Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TA Delivery Method</th>
<th>Number of TA Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organize Clinician Implementation Team Meetings</td>
<td>Virtual</td>
<td>70</td>
</tr>
<tr>
<td>Provide Ongoing Consultation (mentoring or coaching sessions)</td>
<td>Virtual</td>
<td>46</td>
</tr>
<tr>
<td>Conduct Local Consensus Discussions/Stakeholder Engagement/Strategic Planning</td>
<td>Virtual</td>
<td>42</td>
</tr>
<tr>
<td>Distribute Educational Materials or Resources (dissemination)</td>
<td>Virtual</td>
<td>34</td>
</tr>
<tr>
<td>Hold a Training (build skills)</td>
<td>Face-to-face</td>
<td>27</td>
</tr>
<tr>
<td>Facilitate Implementation (interactive problem solving and support at the organizational level)</td>
<td>Virtual</td>
<td>24</td>
</tr>
<tr>
<td>Develop a Formal Implementation Plan</td>
<td>Virtual</td>
<td>22</td>
</tr>
<tr>
<td>Provide Ongoing Consultation</td>
<td>Face-to-Face</td>
<td>20</td>
</tr>
<tr>
<td>Other Implementation Strategy</td>
<td>Virtual</td>
<td>14</td>
</tr>
<tr>
<td>Conduct Consensus Meeting/Strategic Planning</td>
<td>Face-to-Face</td>
<td>13</td>
</tr>
</tbody>
</table>
Examples of Active TA Requests

**Rhode Island:** Grandmother wants help to build necessary network and infrastructure to initiate 12-week support program for grandparents raising grandchildren due to the opioid crisis. Pursuing establishment of website and nonprofit.

**New Jersey:** Implement culturally appropriate SUD/OUD prevention curricula in 13 private schools in the Orthodox Jewish Community.

**North Carolina:** Support the creation of sustainable community OUD prevention programs across ten counties in rural North Carolina. Increase the implementation of MAT across all counties through physician-to-physician peer training.

**Multiple States:** Learn about and implement the nurse care manager model for OBAT.

**California:** Training for pediatric dental residents in opioid prevention to help mitigate the national opioid crisis.

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**Arkansas:** Guide the development of a peer recovery support center to support patients after discharge with both mental health and substance use disorders.

**Missouri:** Assistance toward the establishment of a recovery high school.

**Colorado:** FQHC in rural Colorado seeking support in integrating MAT services, including staff training, developing policies and procedures, ongoing mentorship, and marketing of services.

**Alaska:** Strategic planning to develop model to encourage MAT and psychosocial services among grantees, training and outreach to waivered providers, and marketing plan to promote services and reduce stigma.

**Kentucky:** Learn how other states are using STR/SOR funding to support recovery housing in order to explore what might be adopted in Kentucky.
Impact Thus Far

In the first nine months...

1.5 Million
Minimum number of individuals impacted with a potential impact of 11 million.

3,000+
Educational activities held as a result of requests.

48,740
Number of professional colleagues and staff who benefited from ORN activities

Take Aways...

- **Lessons learned** from prior work are vital.

- **Local** is key to support successful implementation of evidence-based practices.

- **Systems** are essential.

- **Stigma** is everywhere and MUST be addressed at all levels—from the front desk, administration, clinical staff up to CEO in all healthcare settings.
Practice Recommendations

• Implement screening for non medical opioid use or illicit opioid use
• Recognize opportunity (responsibility) we have as family doctors to care for all
• Create a committee to develop this care
• Call on the resources that are available at ORN!!

Together We Can Make a Difference

www.opioidresponsenetwork.org
(401) 270-5900
CDC/NCHS
CDC WONDER, Atlanta, GA: US Department of Health and Human Services

Contact Information

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Questions

References


- Wakeman, Sarah Primary Care and the Opioid-Overdose Crisis – Buprenorphine Myths and Realities NEJM 379;1 July 5, 2018.