Treat Addiction like a Chronic Disease in Ambulatory Care - with Confidence and Compassion

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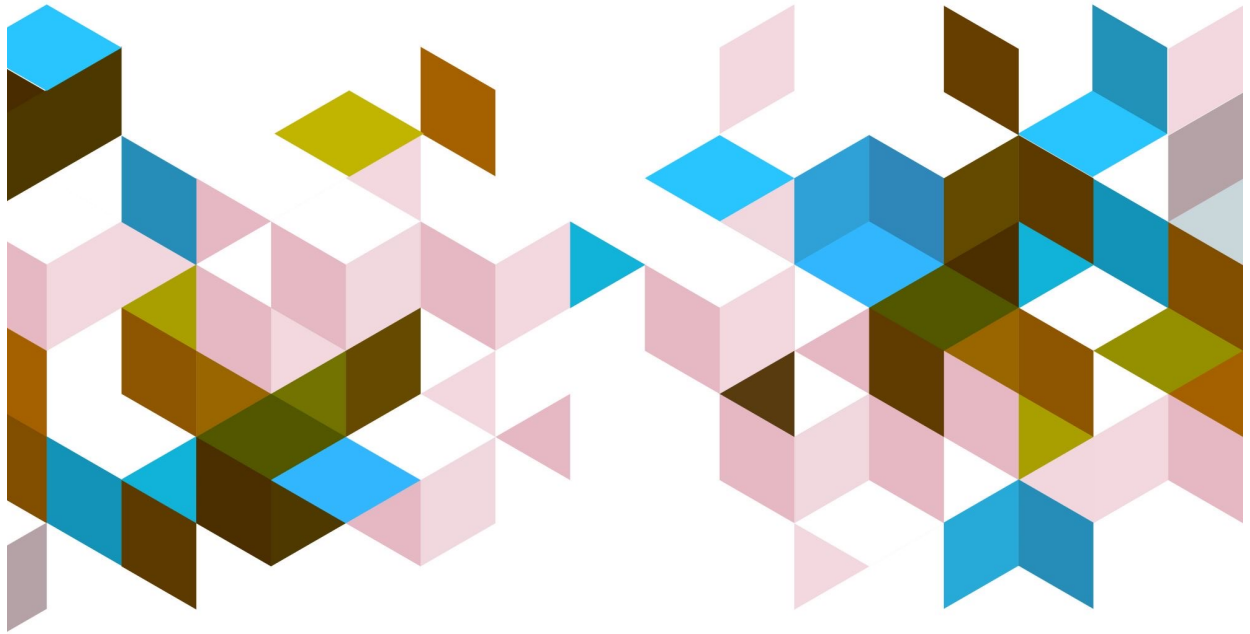
Indian Country ECHO

Jeffrey Bratberg, PharmD, FAPhA

Clinical Professor of Pharmacy Practice and Clinical Research

University of Rhode Island College of Pharmacy



Disclosures

- No conflicts of interest to disclose.

The University of Rhode Island (URI) Land Acknowledgement

The University of Rhode Island occupies the traditional homelands of the Narragansett Nation. What is now the state of Rhode Island occupies the traditional homelands and waterways of the Narragansett Nation and the Niantic, Wampanoag and Nipmuc Peoples.

We honor and respect the enduring and continuing relationship between these nations and this land by teaching and learning more about their histories and present-day communities, and by becoming stewards of the land we too inhabit.

In addition, let us acknowledge the violence of conquest, war, land dispossession and of enslavement endured by Black and Indigenous communities in what is now the United States. Their contemporary efforts to endure in the face of colonialism must be acknowledged, respected and supported.

https://web.uri.edu/artsci/diversity/

Learning Objectives

1. Understand how to integrate addiction screening, treatment initiation, maintenance, and monitoring into ambulatory care setting workflow.

2. Identify, evaluate, and publish patient and clinical outcomes related to addiction care.

3. Compare and contrast potential reimbursement pathways for ambulatory pharmacy addiction services.

“To know thyself is the beginning of wisdom.”

Socrates (477-399 BCE)

EDITORIAL

Preserving dignity through expanded and sustained access to buprenorphine

Pharmacists, prescribing clinicians, and other treatment advocates are called to act by implementation solutions that directly improve and sustain access to **high quality [behavioral healthcare]**, including:

-Education
-Regulatory changes
-Scope of practice expansion
-Payment reform

"Medication first" advocates need to go beyond hurdles to stocking, dispensing, insurance limitations, and communication **and implement solutions that directly expand equitable access to addiction care.**

All pharmacists should advocate for permanent changes to their state collaborative practice and telehealth policies to permit collaborative controlled substance initiation and maintenance

Bratberg JP, Falleni A. Preserving dignity through expanded and sustained access to buprenorphine. *Journal of the American Pharmacists Association*. 2023;63(1):220-223. doi:10.1016/j.japh.2022.12.026

Exploratory Questions:

Understand how to integrate addiction screening, treatment initiation, maintenance, and monitoring into ambulatory care setting workflow.

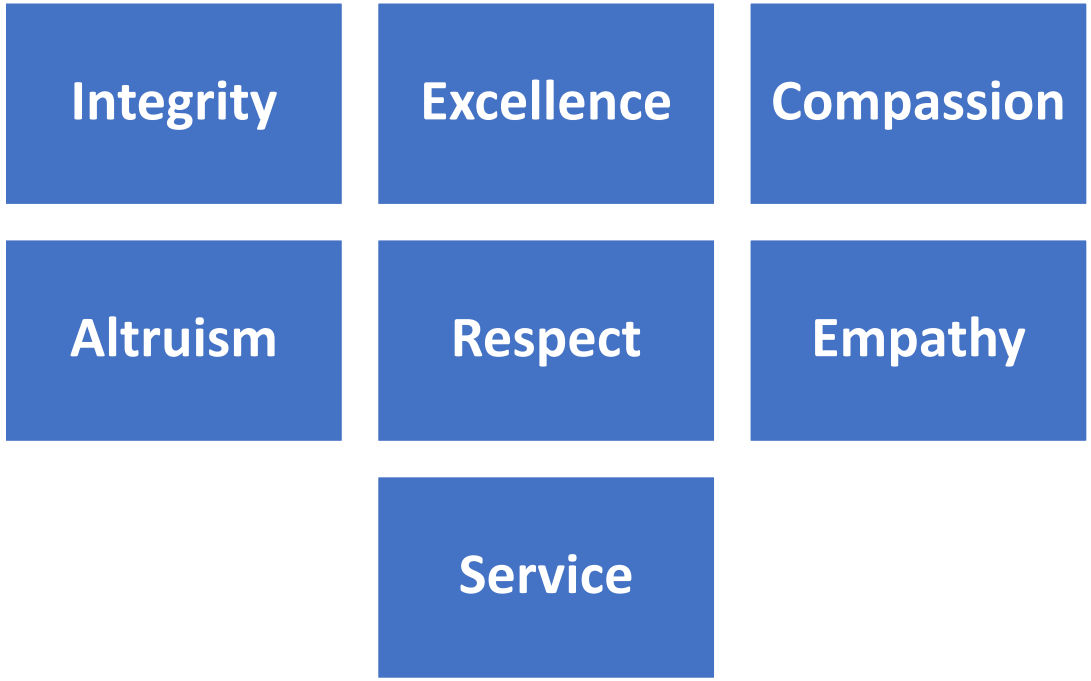
How would YOU want to experience this process?

How do we make this a compassionate experience for our patients?

What questions do you have about this?

Compassionate Care Components

Attributes



Hallmarks

- A strong desire to help patients, families, and colleagues.
- The ability to collaborate, communicate, and partner with patients and family members to the extent they need and desire.
- A commitment of all who provide and support healthcare to communicate and collaborate with each other.
- The well-being and resilience of the healthcare professional.

https://www.aacnnursing.org/5b-tool-kit/themes/compassionate-care#:~:text=Programs%20&%20Events-,Contact%20Us,exhibit%20the%20following%20seven%20attributes:

Case Part 1A

A 45 year old man presents for a 3-month follow-up appointment for his Type 2 diabetes. He arrives 30 minutes late, he forget his meter, and missed his lab draw for HbA1c, CBC, and Chem-7.

What are the best next steps? What questions do you have for him?

Case Part 1B

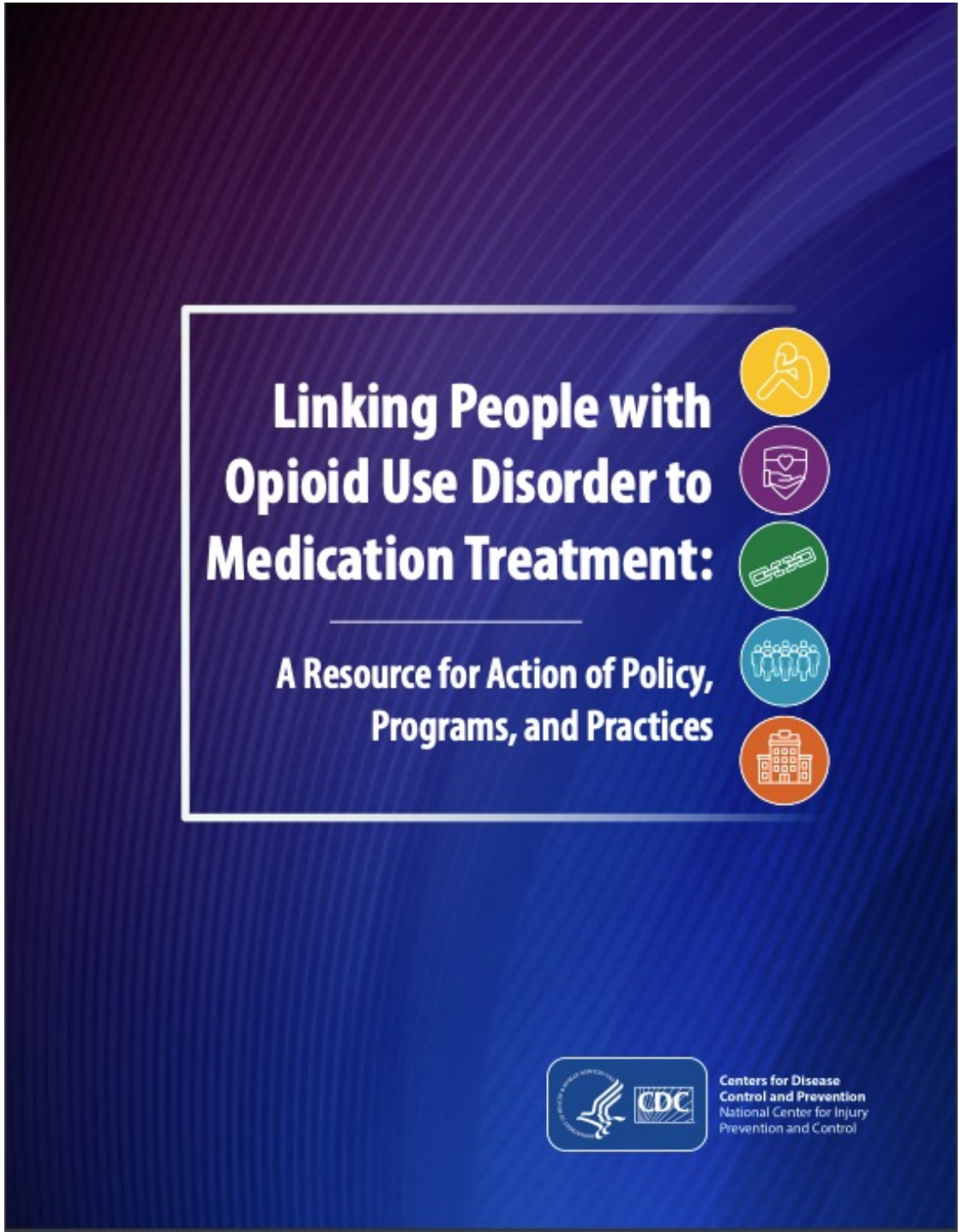
A 45 year old man presents for a 3-month follow-up appointment for his **opioid use disorder**. He arrives 30 minutes late, he forget his **buprenorphine/naloxone strip wrappers**, and missed his **urine toxicology test.**

What are the best next steps? What questions do you have for him?

Case Part 1C

A 45 year old man presents for a 3-month follow-up appointment for his Type 2 diabetes and **opioid use disorder**. He arrives 30 minutes late, he forget his meter, and missed his lab draw for HbA1c, CBC, and Chem-7, and his **urine toxicology test**.

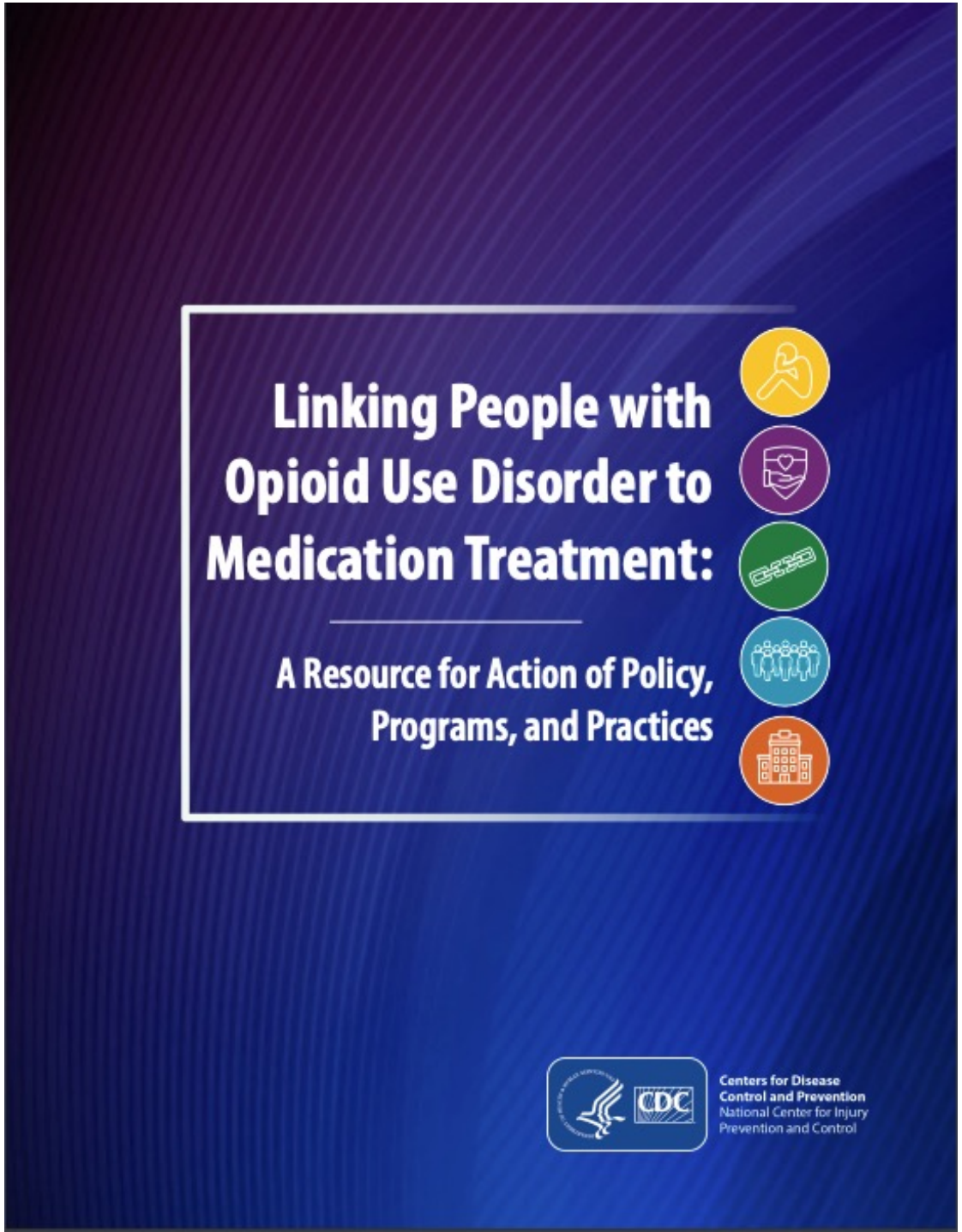
What are the best next steps? What questions do you have for him?



Linkage to care via primary care settings

- The primary care setting is welcoming, nonjudgmental, respectful, and empathetic.
- Screening for OUD is universal: all patients receiving services from a primary care practice are screened for opioid use using a validated screening tool, not tested through urine or blood toxicology.
- Patients reporting polysubstance use, previous substance use treatment, or co-occurring mental disorders are assessed to determine whether higher levels of treatment or more substantial support in treatment engagement are needed.

https://www.cdc.gov/overdose-prevention/media/pdfs/pubs/Linkage-to-Care-Resource-for-Action-508.pdf



Linkage to care via primary care settings

- Medical issues often associated with opioid use or other substance use are followed with screening, assessment, and appropriate care.
- High risk patients are trained and provided with naloxone.
- MOUD, when indicated, is provided at the index visit— the visit when OUD is identified—and patients begin induction onto MOUD immediately, or, in the case of home induction, as soon as reasonably possible.
- Ongoing MOUD is integrated into primary care rather than offered through referral to a specialist or outside facility.

https://www.cdc.gov/overdose-prevention/media/pdfs/pubs/Linkage-to-Care-Resource-for-Action-508.pdf

Table 1 Strategies Participants Identified as Effective in Expanding Access to Buprenorphine within Primary Care

Strategy	Northwest	South	Lower Midwest	Upper Midwest	Northeast	West
1:1 outreach from champion (describes benefits, supports)	X	X	X	X	X	X
1:1 leadership outreach to providers				X		
Clinical pharmacists hired to address SUD[1]	X		X	X	X	
Develop a clinician-pharmacist partnership	X	X		X	X	X
Approve and develop standalone clinics for buprenorphine prescribing				X	X	X
Develop a cross-clinic bridge (individual or consult group)	X			X	X	X

[1]*Substance use disorder*

Wyse JJ, Eckhardt A, Newell S, et al. Integrating Buprenorphine for Opioid Use Disorder into Rural, Primary Care Settings. *Journal of General Internal Medicine*. Published online 2024. doi:10.1007/s11606-024-08898-1

Champions Among Us: Leading Primary Care to the Forefront of Opioid Use Disorder Treatment

- Champions are facilitators and peer mentors to catalyze treatment adoption (buprenorphine formulations and ER naltrexone)

- A 2020 systematic review of 14 studies that evaluated the impact of clinical champions showed that they:
  - Inspire local culture change
  - Increase high-value care
  - Expand access to MOUD

Incze MA, Kelley AT, Gordon AJ. Champions Among Us: Leading Primary Care to the Forefront of Opioid Use Disorder Treatment. *J Gen Intern Med*. 2022;37(7):1771-1773. doi:10.1007/s11606-021-07355-7

Table 2 Roles and Care Models for Primary Care–Based Buprenorphine

Clinic site	Role of primary care	Care model	Standalone clinics (under primary care)
Northwest	Initiate, stabilize, maintain patients	Pharmacy care manager model	No
South	Maintain stable patients	Physician-pharmacy collaborative care model	No
Lower Midwest	Initiation and short-term management (pain clinic)[1] Maintain stable patients	Physician-driven model	No
Upper Midwest	Initiate, stabilize, maintain patients	Physician-pharmacy collaborative care model	• Buprenorphine clinics hosted in 3 CBOCs[2] • Dedicated time 1–2 days/week • Inductions in clinic or home inductions
Northeast	Initiate, stabilize, maintain patients	Pharmacy care manager model	"Walk-in" behavioral health clinic located in main medical center; primary care prescriber located in a residential treatment center (domiciliary)
West	Initiate and stabilize patients (pain clinic) Maintain stable patients	Physician-pharmacy collaborative care model	Buprenorphine clinic hosted within the interdisciplinary pain clinic

[1] *Pain clinics* are staffed by interdisciplinary pain management teams and provide evidence-based behavioral, physical medicine and rehabilitation therapies, as well as treatment for patients tapering off of long-term opioid therapy and patients with OUD

[2] *Community-based outpatient clinic*

Wyse JJ, Eckhardt A, Newell S, et al. Integrating Buprenorphine for Opioid Use Disorder into Rural, Primary Care Settings. *Journal of General Internal Medicine*. Published online 2024. doi:10.1007/s11606-024-08898-1

Common Pre-screening Tools:

AUDIT-C - consists of three questions related to drinking frequency and quantity. The higher the score, the more likely alcohol is affecting the individual's health and safety. Audit-C questions are a subset of the full 10-question Audit | AUDIT-C in Spanish | Full 10-question Audit in Spanish

DAST 1: The DAST-1 refers to the first question of the DAST-10. It asks: "In the last 12 months, have you used drugs other than those required for medical reasons?" Positive responses should be followed up with the full DAST-10 also available in Spanish.

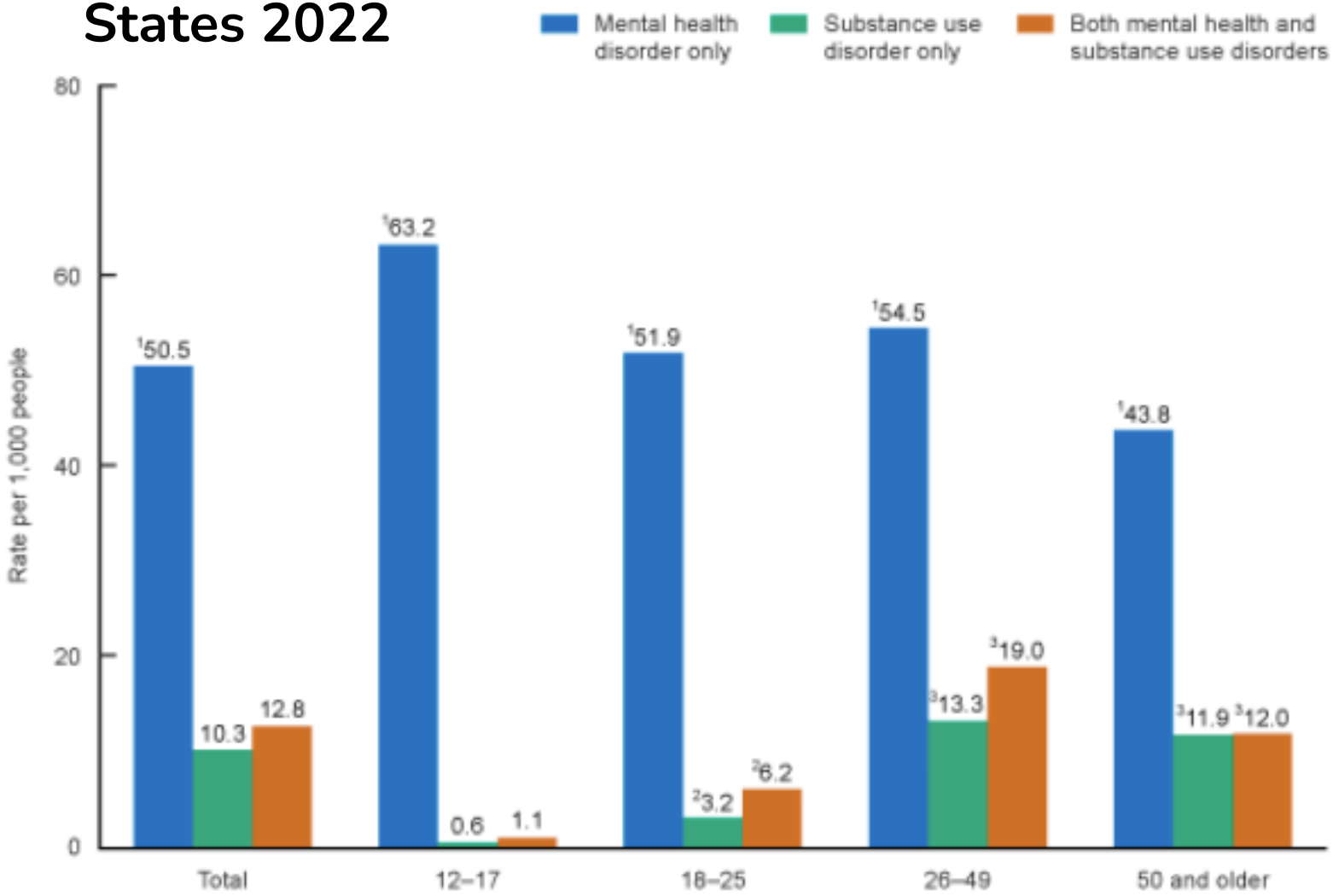
NIAAA Single Alcohol Screening Question (SASQ): "How many times in the past year have you had (4 for women, or 5 for men) or more drinks in a day?" Responses of one or more should be followed by full screen.

NIDA Single Question Screening Test for Drug Use: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?" Responses of one or more should be followed up by full screen.

Substance Use Brief Screen (SUBS): "How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?" Responses of one or more should be followed by full screen.

https://oasas.ny.gov/sbirt#:~:text=NIDA%20Single%20Question%20Screening%20Test,followed%20up%20by%20full%20screen.

Visit rate for adolescents and adults with mental health disorders, substance use disorders, or both disorders at health centers, by age group: United States 2022



In 2022, more than 84 million adults and 6.1 million teenagers were diagnosed with a mental health or substance use disorder.

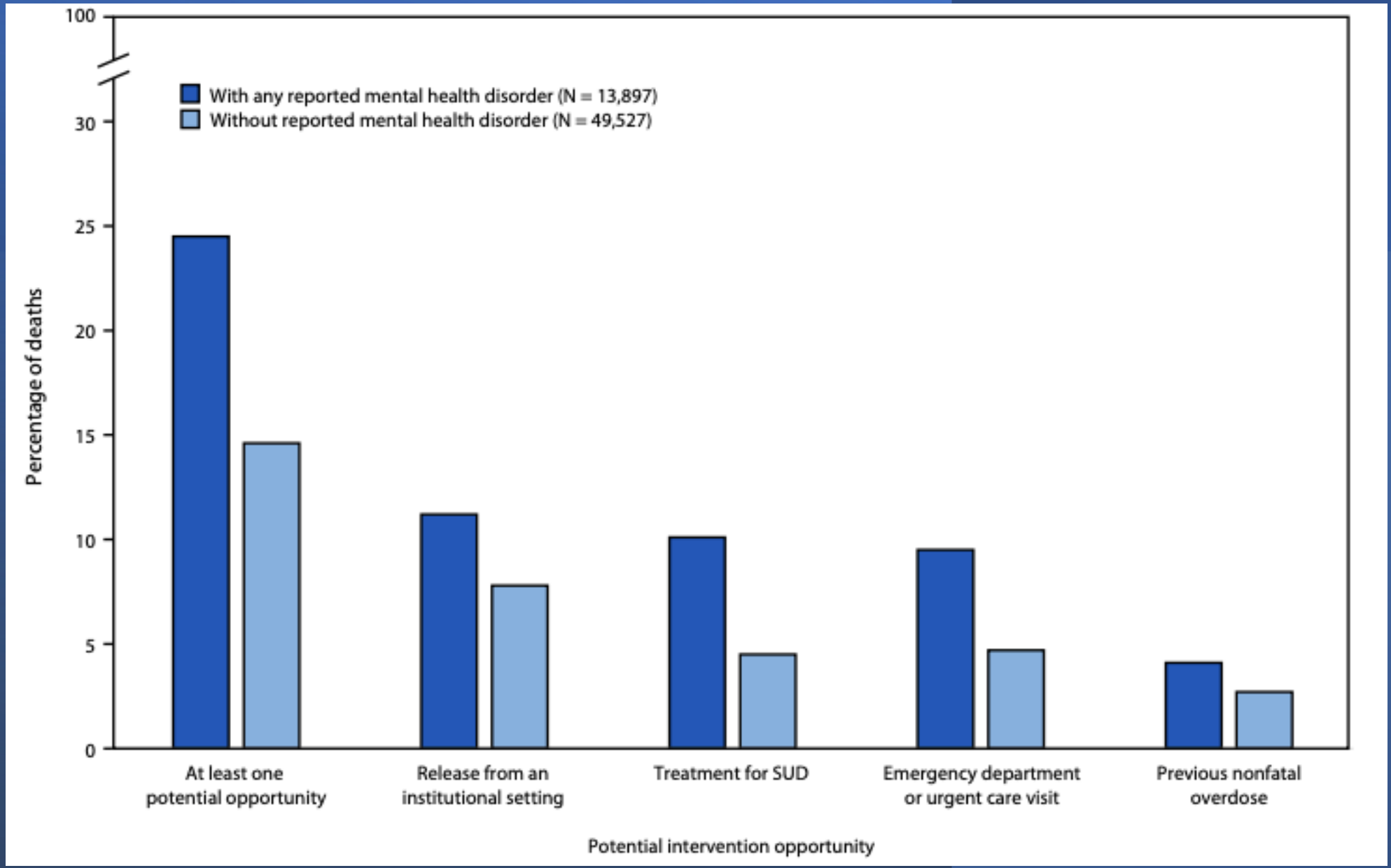
Santo L, Guluma L, Ashman JJ. Visit rates for adolescents and adults with mental health disorders, substance use disorders, or both disorders at health centers, by age: United States, 2022. NCHS Health E-Stats. 2024.
DOI: https://dx.doi.org/10.15620/cdc/160501.

Reported Non–Substance-Related Mental Health Disorders (MHD)Among Persons Who Died of Drug Overdose — United States, 2022

- In 2022, 21.9% of persons with fatal overdoses had an MHD
  - More likely to be female, non-Hispanic White, and have a history of known opioid use or misuse.
  - 82.2 % **(>4/5)** of overdose deaths involved opioids, but among those with an MHD, a greater proportion involved
    - Antidepressants (9.7% vs 3.3%)
    - Benzodiazepines (15.3% vs 8.5%)
    - Prescription opioids (16% vs 11.6%).
  - 24.5% **(~1/4)** of those with an MHD had **at least one interaction** with potential for intervention within the month prior to overdose.

Dinwiddie AT, Gupta S, Mattson CL, O'Donnell J, Seth P. Reported Non–Substance-Related Mental Health Disorders Among Persons Who Died of Drug Overdose — United States, 2022. *MMWR Morb Mortal Wkly Rep*. 2024;73(34):747-753. doi:10.15585/mmwr.mm7334a3

Potential opportunities for intervention* within 1 month of death among persons who died of unintentional or undetermined intent drug overdose, by non–substance-related mental health disorder status† — State Unintentional Drug Overdose Reporting System, United States,§ 2022¶



Dinwiddie AT, Gupta S, Mattson CL, O'Donnell J, Seth P. Reported Non–Substance-Related Mental Health Disorders Among Persons Who Died of Drug Overdose — United States, 2022. *MMWR Morb Mortal Wkly Rep*. 2024;73(34):747-753. doi:10.15585/mmwr.mm7334a3

Stigma and Discrimination Limits Buprenorphine Access Most Significantly

Patient

Prescriber

Pharmacist

Policy

THINK BIG WE DO℠

Morgan JR, et al. Journal of Substance Abuse Treatment, https://doi.org/10.1016/j.jsat.2021.108540. Kazerouni NJ et al. Drug and Alc Dependence, 2021 (224), Article 108729. doi:10.1016/j.drugalcdep.2021.108729, Kim HS, Samuels EA. *JAMA Netw Open.* 2020;3(5):e204996. doi:10.1001/jamanetworkopen.2020.4996. Haffajee RL,et al, Am J Prev Med. 2018 Jun;54(6 Suppl 3):S230-S242. doi: 10.1016/j.amepre.2017.12.022. PMID: 29779547; PMCID: PMC6330240. Khan A, et al. J Subst Abuse Treat. 2021 Apr;123:108256. doi: 10.1016/j.jsat.2020.108256. Epub 2020 Dec 18. PMID: 33612191.

Participants shared these sentiments:

Help patients find and use their voice. Give them education and options, not ultimatums.

I deserve privacy.
I deserve dignity.

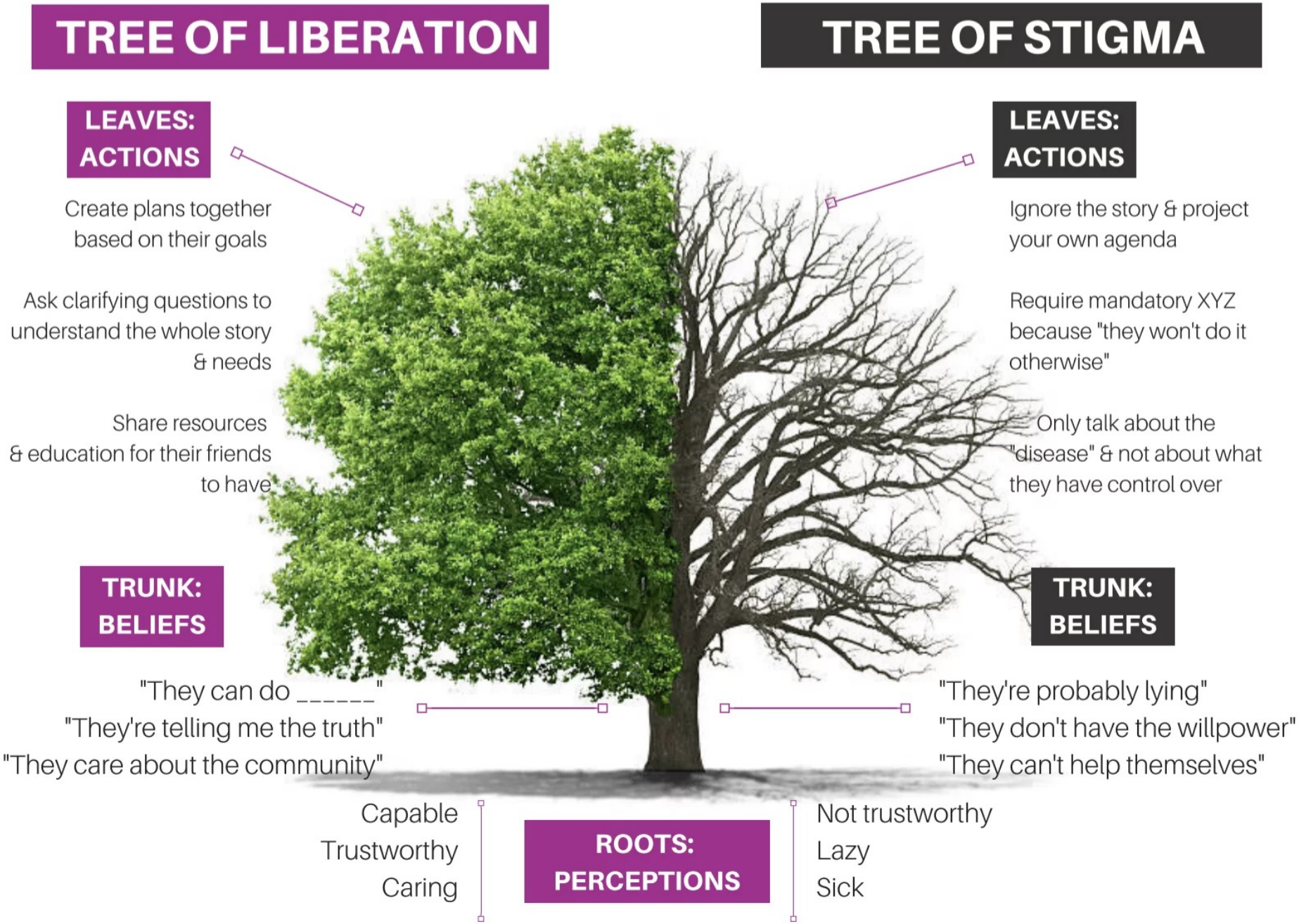
Get to know me. **I am a patient, not a problem.**

Not being able to access prescribed opioid medication is not just an inconvenience—**it could mean life or death.**

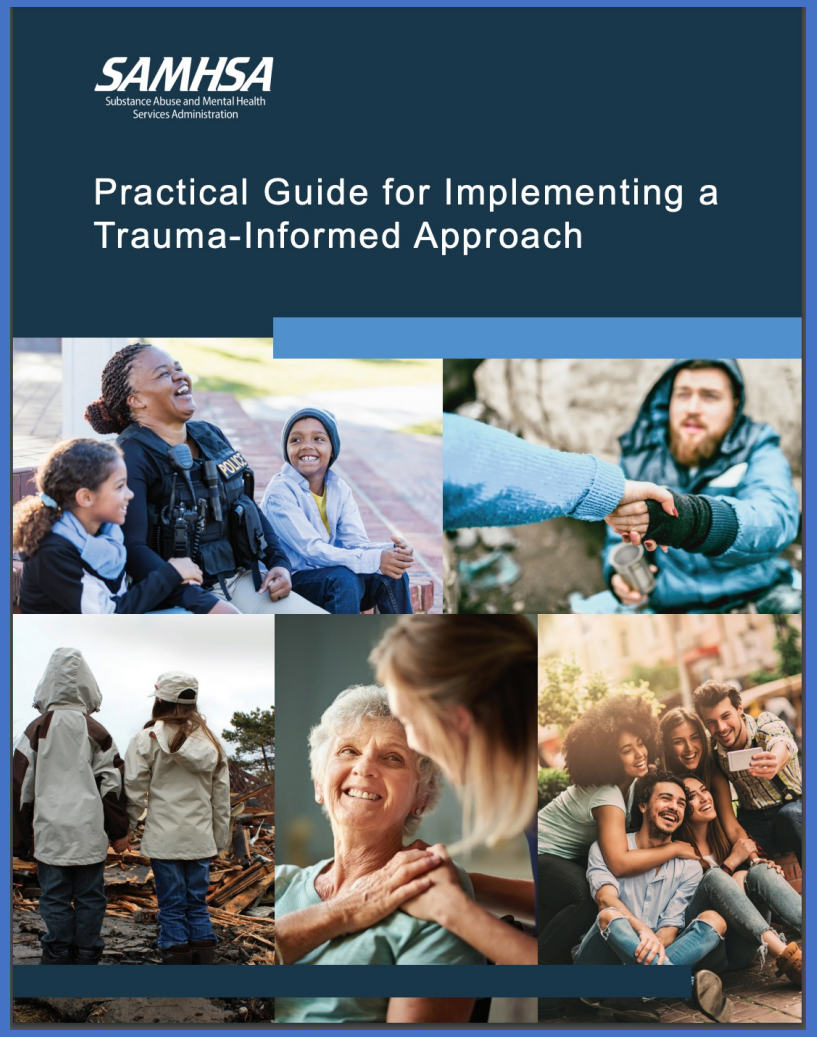
Patients are not just falling through the cracks—they are dying. **Pharmacy staff can be allies, or they can be part of the problem.**

When we stigmatize people, we decrease their chances for a long and healthy life.

Addressing opioid stigma in pharmacies



https://harmreduction.org/issues/harm-reduction-basics/undoing-stigma-facts/



Safety

Throughout the organization, patients and staff feel physically and psychologically safe

Trustworthiness + Transparency

Decisions are made with transparency, and with the goal of building and maintaining trust

Peer Support

Individuals with shared experiences are integrated into the organization and viewed as integral to service delivery

Collaboration

Power differences — between staff and clients and among organizational staff — are leveled to support shared decision-making

Empowerment

Patient and staff strengths are recognized, built on, and validated — this includes a belief in resilience and the ability to heal from trauma

Humility + Responsiveness

Biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical trauma are recognized and addressed

https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

PRINCIPLES OF HARM REDUCTION

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Harm Reduction Coalition. Principles of Harm Reduction. Harm Reduction Coalition website. Updated 2020. Accessed April 17, 2021. https://harmreduction.org/about-us/principles-of-harm-reduction/

Pharmacist Harm Reduction

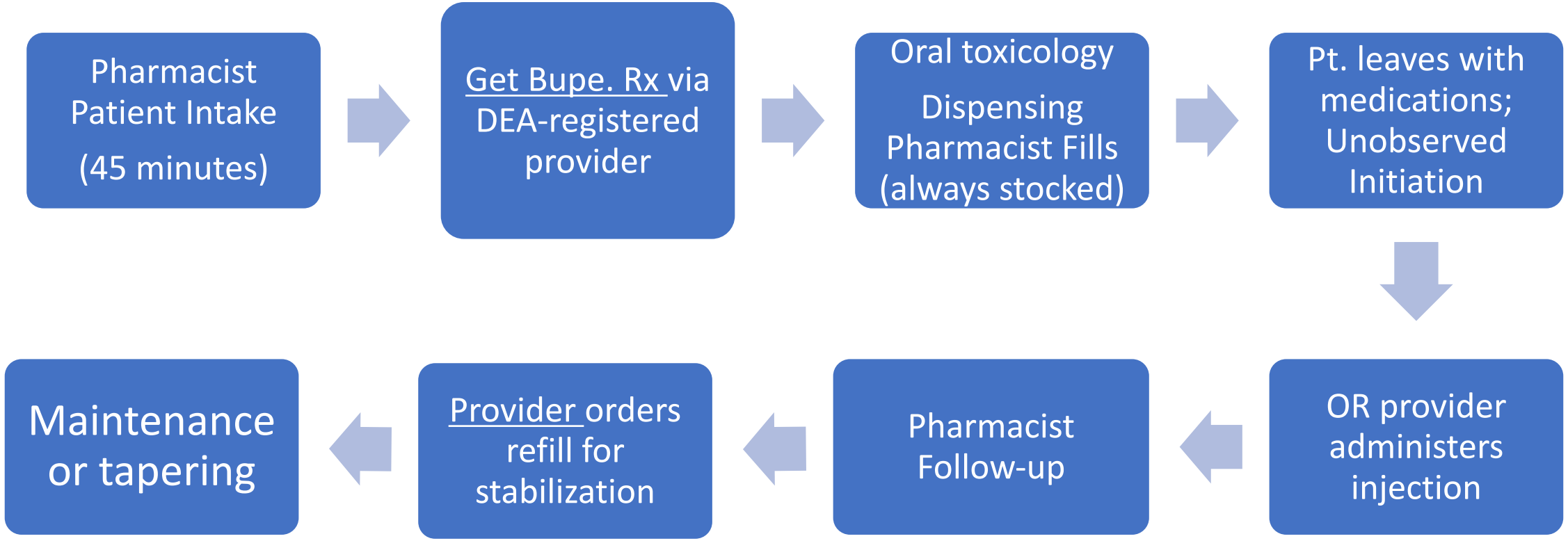
- Referrals to social services
- HIV/HCV testing and evaluation
- Rx /administer HIV Pre-exposure prophylaxis (PreP)
- Rx HIV Post-exposure prophylaxis (PEP)
- Rx / administer contraceptives
- Distribute condoms
- Administer vaccinations
- Distribute naloxone and syringes
- Rx and administer medications for opioid use disorder (MOUD)

Building Pharmacist Confidence Through Education: DEA MATE Act and More

- ASAM – Treatment of Opioid Use Disorder Course
- ASHP – MOUD Training Program
- APhA – Initiating Buprenorphine Certificate Training
- PCSS – Online 8-hour MOUD Training
- Greyken Center (BMC) - Advancing Addiction Treatment: Building Knowledge of Substance Use and Specialty Topics

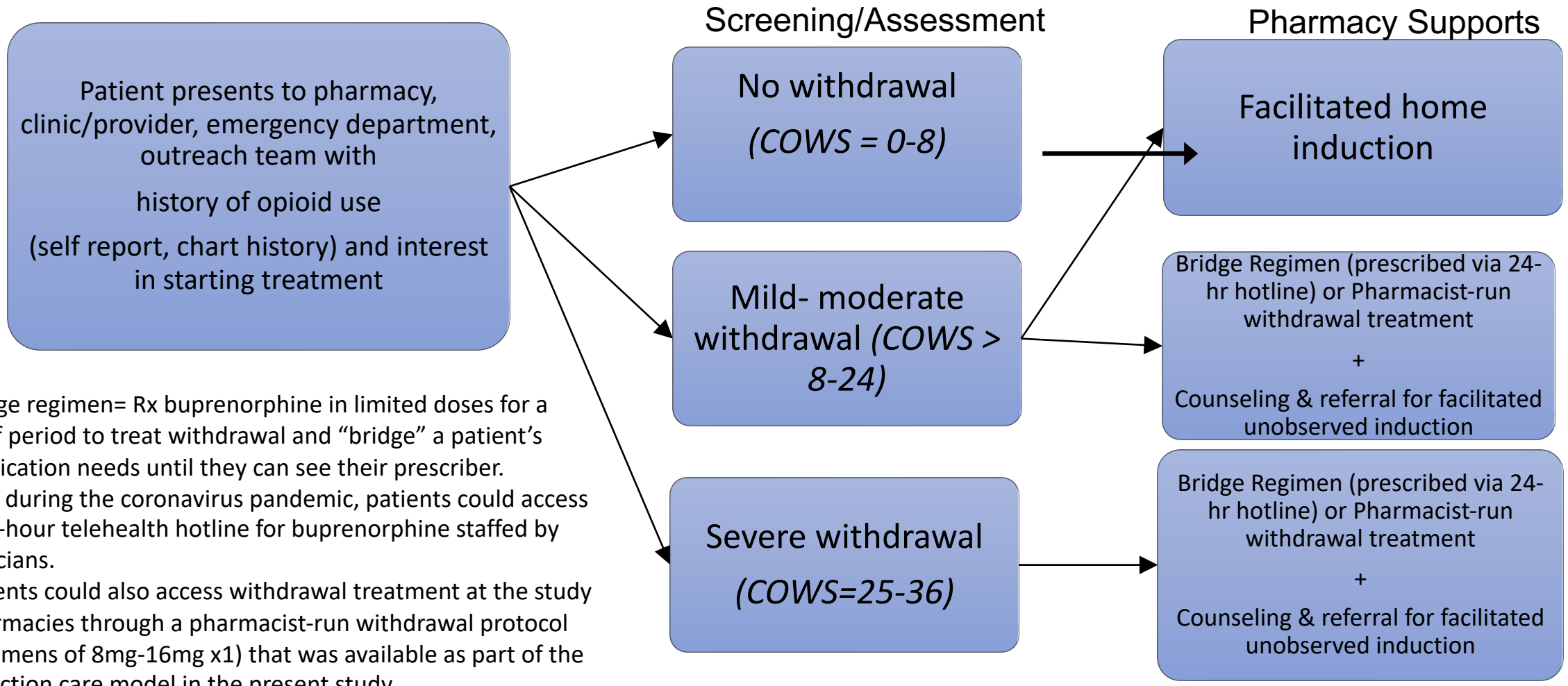
- North Carolina – Caring For Patients with OUD: Optimizing Interprofessional Care

“No-Barrier” Pharmacist-Based MOUD



MATPharm Study

Eligible: Any Opioid Hx,18+ years old, On treatment or Interest in MOUD



Bridge regimen= Rx buprenorphine in limited doses for a brief period to treat withdrawal and "bridge" a patient's medication needs until they can see their prescriber.
In RI during the coronavirus pandemic, patients could access a 24-hour telehealth hotline for buprenorphine staffed by clinicians.
Patients could also access withdrawal treatment at the study pharmacies through a pharmacist-run withdrawal protocol (regimens of 8mg-16mg x1) that was available as part of the induction care model in the present study.

COWS: Clinical opiate withdrawal scale (scores 0 to 36)
Treatment=medication treatment with Rx buprenorphine

Green TC, Serafinski R, Clark SA, Rich JD, Bratberg J. Physician-Delegated Unobserved Induction with Buprenorphine in Pharmacies. *N Engl J Med*. 2023;388(2):185-186.

EXAMPLE Pharmacist Visit Steps

PRIOR TO VISIT: Notes Reviewed, toxicology reviewed, PMP check, Medication regimen review, medication stock checked (community pharmacy), social drivers assessed.

First Visit

-Patient interview
-Policies reviewed
-Social drivers assessed
-Physical Exam / vital signs
-Referrals
-Patient education
-Toxicology testing & other testing as necessary

-<u>Prescribe/Administer MOUD</u>
-Provide naloxone & harm reduction supplies & education
-Prescribe adjunctive withdrawal medications PRN
-Documentation

Next Visit

-Patient interview
-Social drivers assessed
-Physical Exam/vital signs
-Referrals
-Patient education
-Toxicology testing & other testing as necessary

<u>Prescribe/Administer MOUD</u>
-Provide naloxone & harm reduction supplies & education
-Prescribe adjunctive withdrawal medications PRN
-Documentation

Visit Frequency/ Regimen dispensed
-Daily
-2X/week
-Weekly
-2x/month
-Monthly
Determined by:
-Life situation
-Physical/Mental Health
-Social drivers
-Toxicology
 -**Buprenorphine**
 -Opioids
 -Benzodiazepines
 -Cocaine
 -Alcohol

Pharmacists may monitor/interpret results from laboratory tests and evaluation procedures commonly used for management of OUD patients:

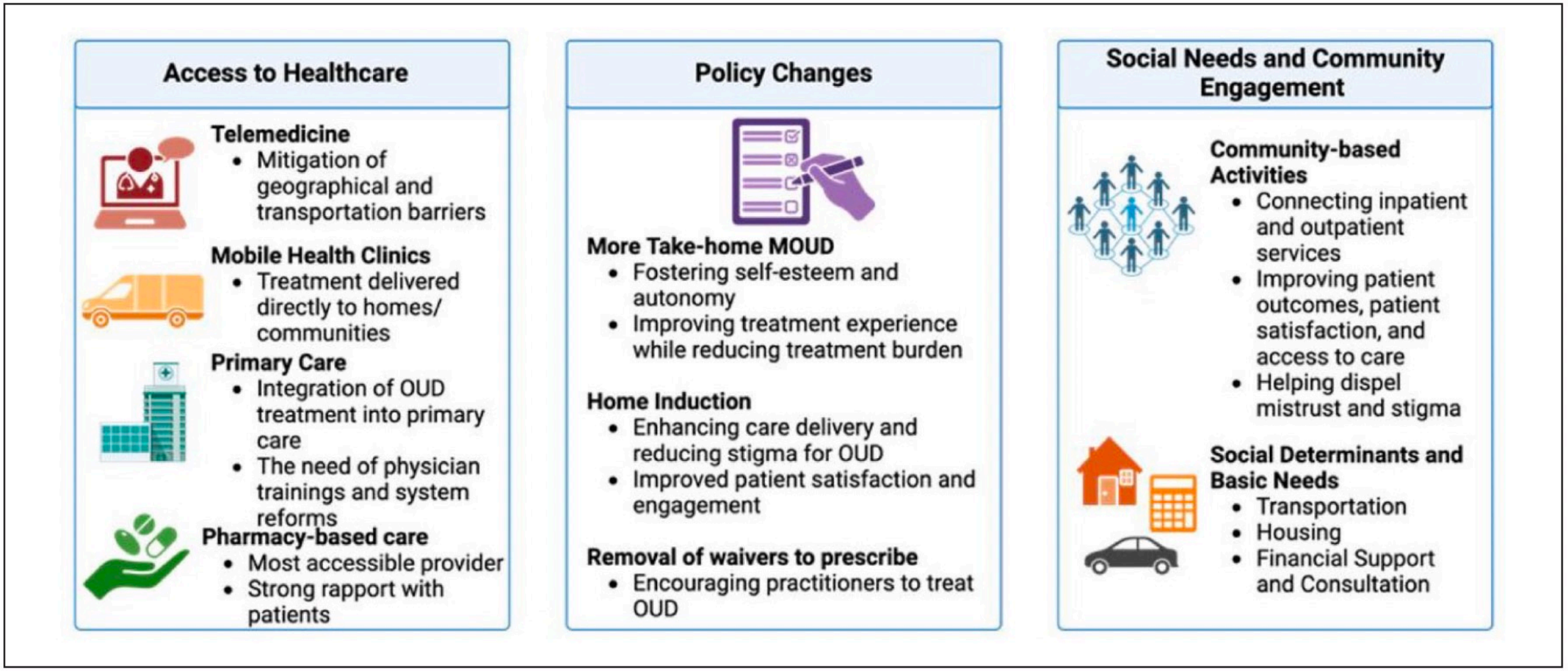
- ✓ Physical examination
  a. Visual inspection of the skin
  b. Vital signs
     i. Blood pressure
     ii. Heart rate
     iii. Respiratory rate
     iv. Temperature
     v. height/weight

- ✓ Laboratories
  a. Liver function tests
  b. Urinalysis
  c. Pregnancy test
  d. Urine and **saliva toxicology**
  e. Hepatitis B & C screening
  f. Rapid HIV/HCV testing
  g. Alcohol breathalyzer

Pharmacists may monitor/interpret results from laboratory tests and evaluation procedures commonly used for management of OUD patients:

- ✓ Psychiatric/mental safety assessments
- ✓ **COWS (Clinical Opiate Withdrawal Scale)**
- ✓ Patient history
- ✓ Current and past medications
- ✓ Current and past substance use and treatment
- ✓ Family history
- ✓ Medical history
- ✓ Social history
- ✓ Diversion assessment
  a. Observed dose administration
  b. Medication supply follow up with patient and pharmacy
  c. Appointment attendance monitoring
  d. State prescription drug monitoring program
  e. Pill counts

Strategies to Improve Access to Care for Patients with OUD



Liu L, Zhang C, Bonny AE, Nahata MC. Strategies to Improve Access to Care for Patients With Opioid Use Disorder. *Annals of Pharmacotherapy*. Published online 2024. doi:10.1177/10600280241273258

Examples of State Buprenorphine Access Barriers

Non-Evidence-Based Policies

- Maximum dose thresholds
- Mandated initial in-person visits
- Prohibition on in-office initiation
- Forced tapering after duration limits
- Obstacles to delivery of SUD & mental health care
- Patient discharge for another substance use
- Counseling requirements

https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/11/state-policies-can-expand-access-to-buprenorphine-for-opioid-use-disorder

Sharing:

Understand how to integrate addiction screening, treatment initiation, maintenance, and monitoring into ambulatory care setting workflow.

How would YOU want to experience this process?

How do we make this a compassionate experience for our patients?

What questions do you STILL have about this?

Exploratory Questions:

Identify, evaluate, and publish patient and clinical outcomes related to addiction care.

What outcomes do YOU want from the healthcare system?

What questions do you have about this?

Case Part 2

The 45 year old man with diabetes and OUD asks you

”How am I doing?” His HbA1c is 14, he has no buprenorphine or metabolites in his office urine toxicology test. Upon review of his documents, he was seen in a local ED for a suspected opioid overdose a week ago.

What other questions do you have for him?

Only 1 in 4 adults who need opioid use disorder (OUD) treatment receive medications for OUD*

OUD medications† prevent overdoses and save lives

Providers should offer effective treatment, including OUD medications

Pharmacists and payors can support making these medications available without delays

CDC

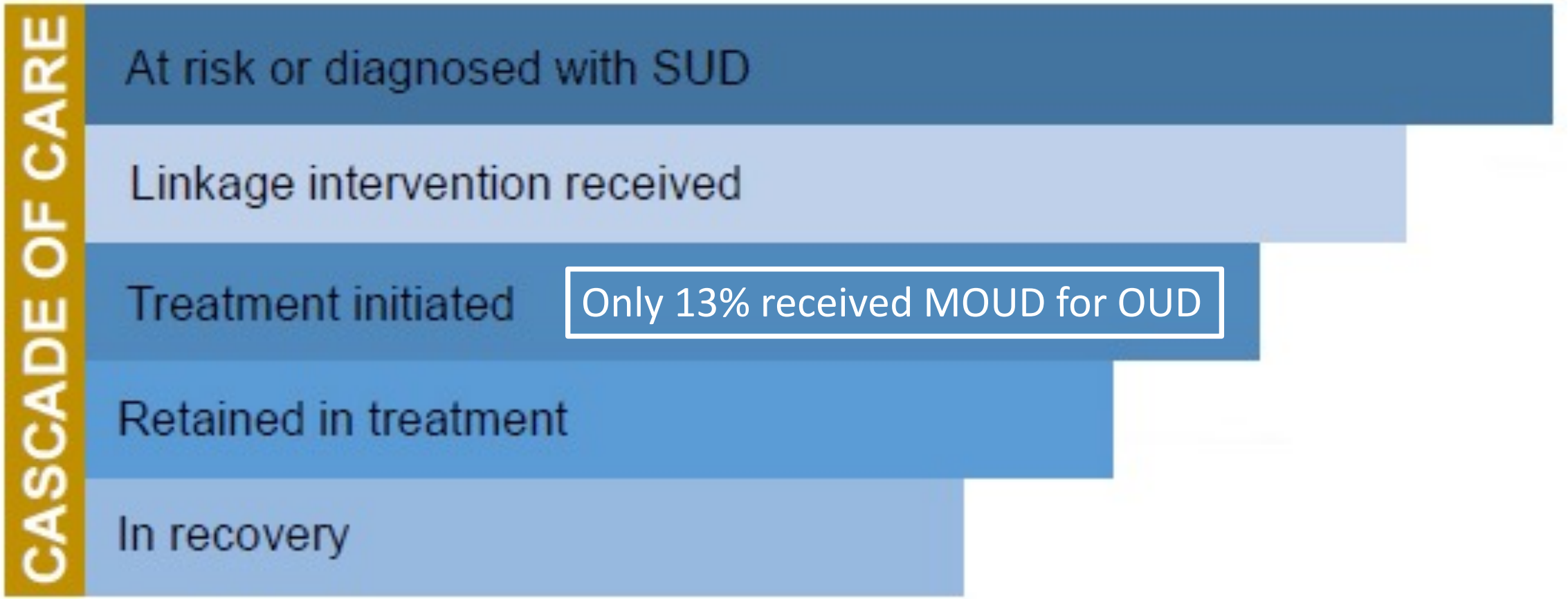
*National Survey on Drug Use and Health, 2022

†FDA-approved medications for OUD are buprenorphine, methadone, and naltrexone

bit.ly/mm7325a1

Dowell D. Treatment for Opioid Use Disorder: Population Estimates — United States, 2022. *MMWR Morb Mortal Wkly Rep*. 2024;73. doi:10.15585/mmwr.mm7325a1

Figure 1. Cascade of SUD Care (adapted from NIDA)



Krawczyk N, et al *International Journal of Drug Policy*. Published online August 2022:103786. doi:10.1016/j.drugpo.2022.103786

The Cascade of Care Can Help Tailor Substance Use Disorder Interventions
https://www.hsrd.research.va.gov/publications/forum/spring20/default.cfm?ForumMenu=spring20-2

Pharmacy care has high induction rate, engagement comparable to usual care, no safety concerns

Induction success rate: **58%** (58 of 100) stabilized (≥2 pharmacy visits) and enrolled in maintenance phase

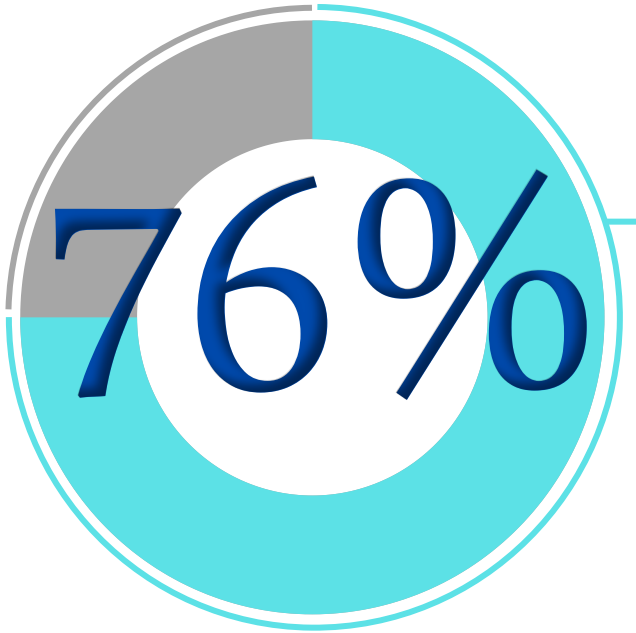
Initial engagement in care on MAT (≥1 visit in first 30 days post stabilization)

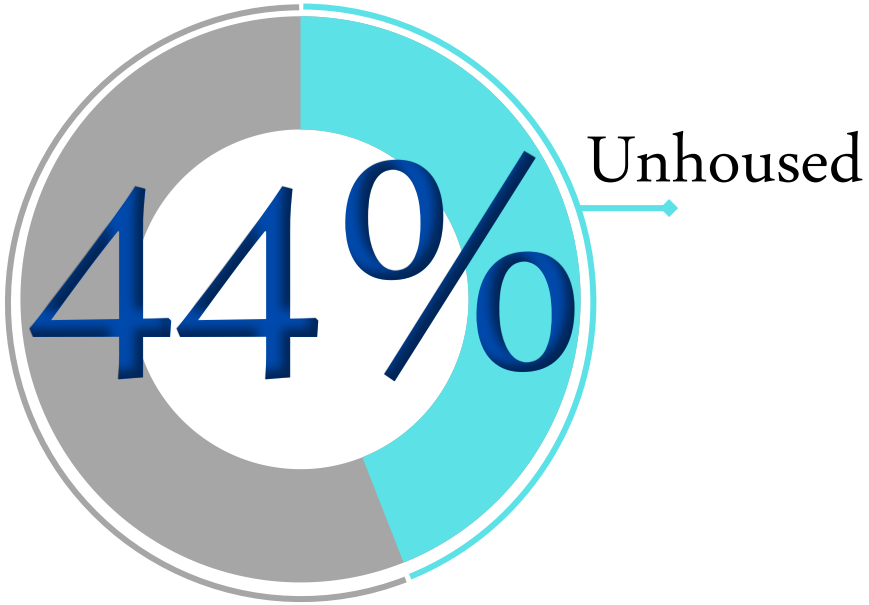
- Pharmacy Inducted — 89% pharmacy care, 17% usual care **NEJM**
- Maintenance (Pharmacy inducted & stabilized + Already on maintenance dose) — 93% pharmacy care, 40% usual care @ 1 month; 64% pharmacy care, 28% usual care @ 3 months ***under peer-review**

Safety concerns: 0 deaths, 0 unanticipated severe adverse events, +36 inducted patients dispensed naloxone

Pharmacy induction promotes racial and economic equity and access to care

Rhode Island adult, state	Induction patients
White: 80.5%	**White: 66%**
19.5% BIPOC: Black or African American: 6.77% Other race: 5.47% Asian: 3.40% Two or more races: 3.33% Native American: 0.50% Native Hawaiian or Pacific Islander: 0.08%	**34% BIPOC:** Black or African American: 12% Other race: 11% Asian: 0%, Two or more races: 8%, Native American: 3%, Native Hawaiian or Pacific Islander: 0%
15% Hispanic	**15% Hispanic**





Green TC, Serafinski R, Clark SA, Rich JD, Bratberg J. Physician-Delegated Unobserved Induction with Buprenorphine in Pharmacies. *N Engl J Med*. 2023;388(2):185-186.

Draft OUD Pharmacist CPA Goals

Improve	Improve patient survival
Increase	Increase retention in treatment
Decrease	Decrease illicit opiate use and other criminal activity among people with substance use disorders
Improve	Improve birth outcomes among women who have substance use disorders and are pregnant
Optimize	Optimize medication management for patients with opioid misuse, withdrawal, and opioid use disorder
Monitor	Monitor for and mitigate adverse drug events from buprenorphine and naltrexone
Prevent	Prevent adverse outcomes of OUD and opioid withdrawal, including nonfatal and fatal overdose

Draft OUD Pharmacist CPA Goals

Reduce acute care and emergency department utilization related to OUD and overdose.

Prevent return to use of unregulated opioids.

Mitigate geographical and stigma barriers to improve and sustain access to buprenorphine

Improve quality of life (QOL) as it related to overall physical and mental health, employment, relationships,criminal-legal issues, and living conditions

Address any comorbid conditions such as sexually transmitted bacterial and viral infections.

Refer patients to appropriate providers.

June 2024 National Outcome Measures

All cause readmission 90 days after episode
Discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18–64, that were followed by a treatment service for SUD (including the prescription or receipt of a medication) within 7 or 14 days after discharge.
Follow-up care for a behavioral health service 7 and 30 days after hospitalization for substance use disorder.
Follow-up care for a behavioral health service 7 and 90 days after, inpatient detox for alcohol use disorder and opioid use disorder.
Medication-assisted treatment (MAT) prescribed for opioid use disorder OUD 30, 60, and 90 days after episode.

https://incentivizerecovery.org/wp-content/uploads/AAPR-National-Outcome-Measures-2024.xlsx
https://incentivizerecovery.org/armh-apm-model/

June 2024 National Outcome Measures

Percentage of individuals who initiate SUD treatment within 14 days of an OUD diagnosis.

Percentage of individuals who had two or more additional SUD services within 30 days of the individual SUD treatment encounter.

Inpatient admission rates for SUD: Total inpatient stays per 1,000 beneficiaries in the measurement period.

Medication-assisted treatment (MAT) for opioid use disorders (OUD) is available at the applicant facility.

Percent of individuals with an OUD diagnosis who filled a prescription for or were administered or dispensed an MOUD, overall and by type of MOUD (methadone, buprenorphine, naltrexone).

Percent of individuals who were screened/assessed for SUD treatment needs using a standardized screening tool.

https://incentivizerecovery.org/wp-content/uploads/AAPR-National-Outcome-Measures-2024.xlsx
https://incentivizerecovery.org/armh-apm-model/

Substance Use: How are you doing with substance use? Consider the frequency and amount of use, money spent on drugs and alcohol, amount of drug craving, time spent being high/drunk, being sick, in trouble, and in other drug-using activities, etc.

Not well at all .....*Fair*.....*Extremely well*

1 2 3 4 5 6 7 8 9 10

Remarks:

Health: How are you doing with your health? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc.?

Not well at all .....*Fair* .....*Extremely well*

1 2 3 4 5 6 7 8 9 10

Remarks:

Lifestyle: How are you doing in terms of your personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

Not well at all .....Fair.....Extremely well

1 2 3 4 5 6 7 8 9 10

Remarks:

Community: How are you doing in the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

Not well at all .....Fair.....Extremely well

1 2 3 4 5 6 7 8 9 10

Remarks:

Sharing:

Identify, evaluate, and publish patient and clinical outcomes related to addiction care.

What outcomes do YOU want from the healthcare system?

What questions do you STILL have about this?

Case: What to do for our 45 yo person?

Exploratory Questions:

Compare and contrast potential reimbursement pathways for ambulatory pharmacy addiction services.

How do YOU want to be reimbursed?

What questions do you have about this?

Potential Reimbursement Pathways

- Indirect
  - “Incident-to” billing
  - Time and resource savings
  - Meeting quality measures
  - Prevention of expensive healthcare utilization
    - ED visits
    - Inpatient stays
  - Bundled payments

- Direct
  - provider status + credentialling + support to maximize payments →
  - Opioid settlement funds

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DOI: 10.1002/jac5.2008

jaccp Journal of the American College of Clinical Pharmacy

CLINICAL PHARMACY FORUM

State of the union: A review of state-based laws and regulations supporting pharmacist payment for clinical services

Jonathan Hughes Pharm.D. | Advancing Pharmacist Payment Parity Workgroup

Ascension Saint Thomas, Murfreesboro, Tennessee, USA

Correspondence
Jonathan Hughes, Ascension Saint Thomas, 1020 N Highland Avenue, Murfreesboro, TN 37130, USA.
Email: jonathan.hughes@ascension.org

Abstract

Integrating pharmacists into interdisciplinary care models is essential for achieving the Quintuple Aim in health care, which emphasizes improving patient outcomes, enhancing patient and provider experiences, reducing costs, and advancing health equity. Despite expanded scopes of practice that facilitate collaborative models, pharmacists often face significant barriers due to inconsistent and insufficient reimbursement for their clinical services. This review seeks to address these challenges by focusing on state-based legislation and regulations that establish payment parity or create pathways for reimbursing pharmacist clinical services. Through a narrative review, this article systematically compares different states' approaches to pharmacist reimbursement by examining affected payers, billable services, and other pertinent details. The ultimate goal is to propose model characteristics for states considering the enhancement or development of legislation and regulations to ensure equitable payment mechanisms for pharmacist services. By providing a comprehensive overview of existing models and identifying effective legislative characteristics, this review aims to inform and empower pharmacists and their advocates with a better understanding of reimbursement regulations and to inspire community-driven advocacy for equitable compensation, thus supporting the integration of pharmacists as essential health care providers.

KEYWORDS
health care, legislation, parity, regulations

DOI: 10.1002/jac5.2008

Examples of State Buprenorphine Access Barriers

Financial/Reimbursement

- State didn't expand Medicaid
- Poor reimbursement rates for addiction services
- Telehealth reimbursement inequity
- Opaque opioid settlement fund processes
  - https://www.opioidsettlementtracker.com/

https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/11/state-policies-can-expand-access-to-buprenorphine-for-opioid-use-disorder

https://www.pswi.org/Portals/94/Resources/Toolkits%20and%20Manuals/Opioid%20Toolkit_FINAL.pdf?ver=ndJ6sO7Tral1-evAWPd_EA%3d%3d

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Creation of this toolkit was supported by funding from the Cardinal Health Foundation.

Booker, Braun Introduce Bipartisan Bill to Combat Opioid Crisis, Increase Access to Care

MAY 23, 2024

WASHINGTON, D.C. – Today, U.S. Senators Cory Booker and Mike Braun (R-IN) introduced legislation to establish a pharmacy-based addiction care pilot program. The *Substance Use Prevention and Pharmacy Oriented Recovery Treatment Prescription Act* (SUPPORT Rx) would increase access to lifesaving addiction services provided by pharmacies, including low-barrier treatment and buprenorphine, a medication used for opioid use disorder.

The opioid crisis continues to escalate, with drug overdose deaths reaching alarming levels. Synthetic opioids like fentanyl have exacerbated the crisis, contributing to over 82% of all opioid-involved deaths in 2020. This legislation emphasizes the importance of medication-assisted treatment, combining prescription medication, counseling, and behavioral therapy to address opioid use disorder effectively.

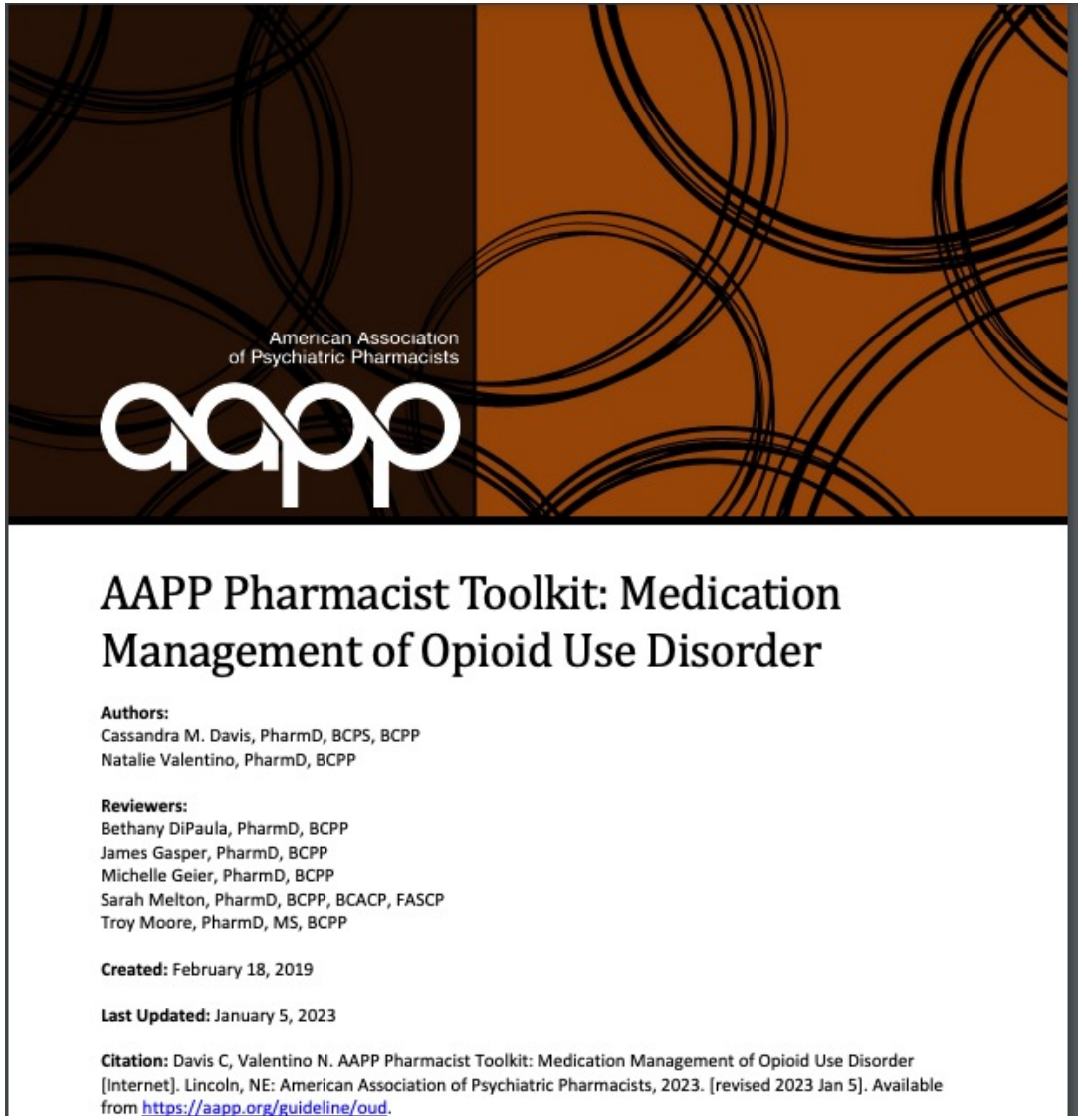
Sharing:

Compare and contrast potential reimbursement pathways for ambulatory pharmacy addiction services.

How do YOU want to be reimbursed?

What questions do you STILL have about this?

More Resources



AAPP Pharmacist Toolkit: Medication Management of Opioid Use Disorder

Authors:
Cassandra M. Davis, PharmD, BCPS, BCPP
Natalie Valentino, PharmD, BCPP

Reviewers:
Bethany DiPaula, PharmD, BCPP
James Gasper, PharmD, BCPP
Michelle Geier, PharmD, BCPP
Sarah Melton, PharmD, BCPP, BCACP, FASCP
Troy Moore, PharmD, MS, BCPP

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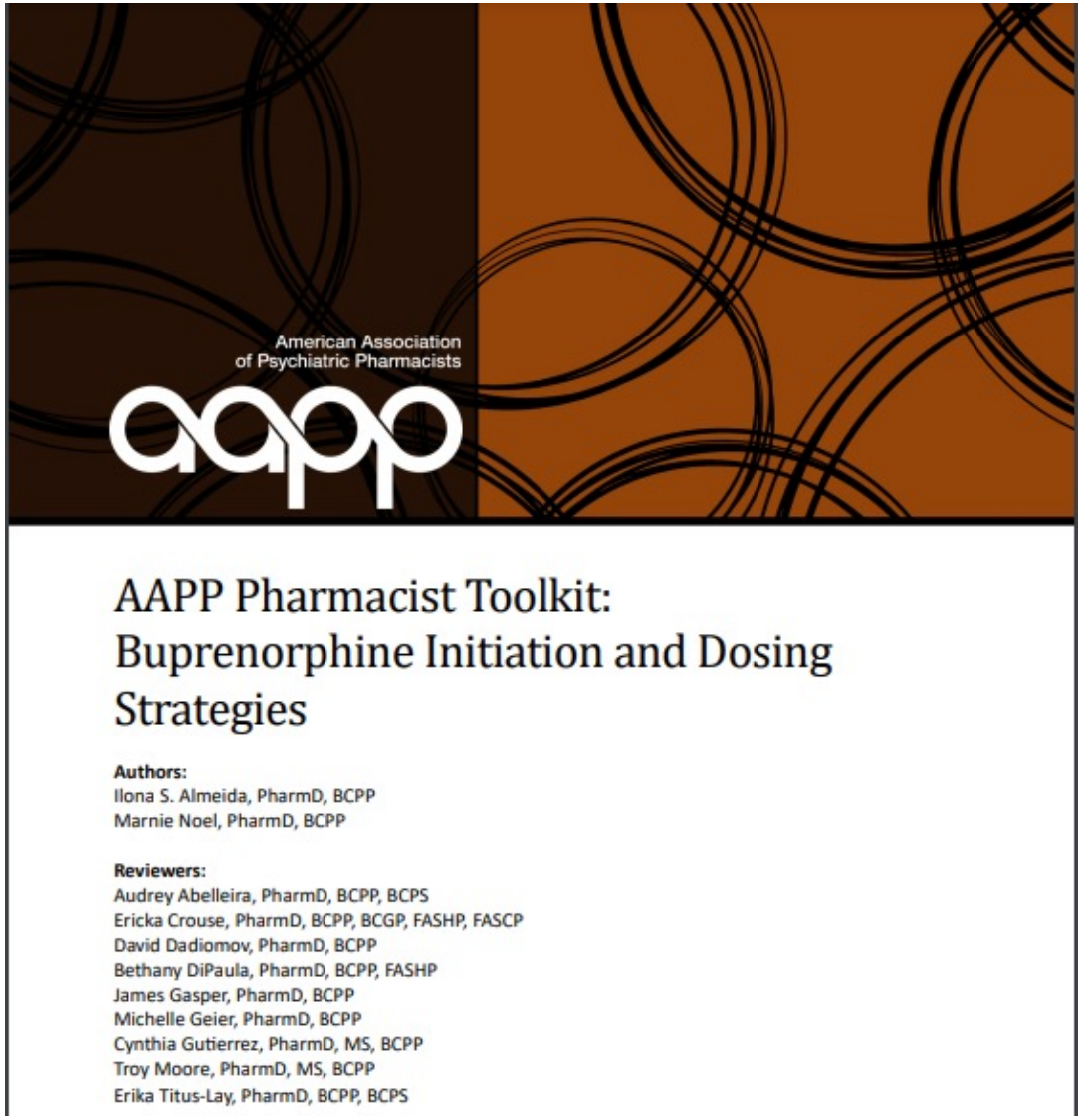
https://aapp.org/guideline/oud/pdf?view=link-0-1530209527&.pdf



AAPP Pharmacist Toolkit: Buprenorphine Initiation and Dosing Strategies

Authors:
Ilona S. Almeida, PharmD, BCPP
Marnie Noel, PharmD, BCPP

Reviewers:
Audrey Abelleira, PharmD, BCPP, BCPS
Ericka Crouse, PharmD, BCPP, BCGP, FASHP, FASCP
David Dadiomov, PharmD, BCPP
Bethany DiPaula, PharmD, BCPP, FASHP
James Gasper, PharmD, BCPP
Michelle Geier, PharmD, BCPP
Cynthia Gutierrez, PharmD, MS, BCPP
Troy Moore, PharmD, MS, BCPP
Erika Titus-Lay, PharmD, BCPP, BCPS

https://aapp.org/guideline/buprenorphine/pdf?view=link-9a3ef504-e6a3-11ec-b5d3-bd0a0de7565a&.pdf

Stigma Training Resources

- Reducing Stigma Surrounding Substance Use Disorders: Harm Reduction Coalition Training Program
- Addressing Stigma and Substance Use Disorders: A HealtheKnowledge Course
- ”Overcoming Stigma, Ending Discrimination”- SAMHSA Resource Guide
- Talking Points: The Resource Guide for Facilitating Stigma Conversations

Respect everyone equally

Treat people who use opioids with the same level of respect and consideration that you give to everyone who accesses the pharmacy. Respecting their time, questions, and concerns fosters an environment that values their well-being.

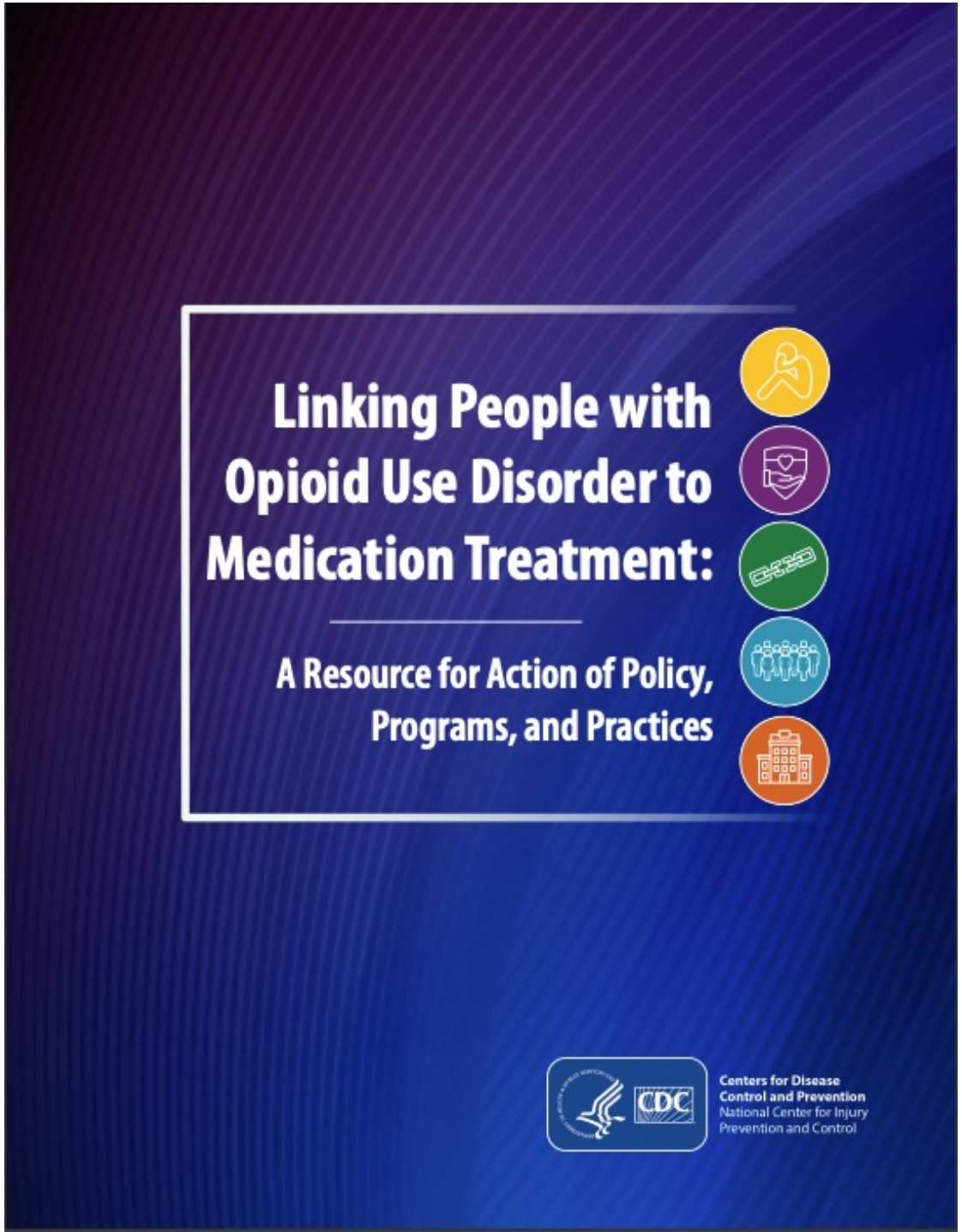
Get to know each person you serve

Form a relationship with the people using your pharmacy. Take the time to understand each person’s circumstances, background and experiences. Simple things like remembering their name and asking how they’re doing today can help build a bond of respect and trust. People may not want or need to share their experiences, but learning about trauma-informed care will help tailor your support and demonstrate your commitment to holistic care. Ensure appropriate clinical documentation so that pharmacy staff do not have to ask people to share sensitive information repeatedly, or so they don’t offer the same advice at every visit.

Offer support through education

Empower people by offering them educational resources about opioid therapies. Give people clear options and information that respects their existing knowledge and experiences and that helps them make informed decisions about using opioid medications.

Above from: Addressing opioid stigma in pharmacies



Box 2.3 Additional Resources for Clinicians offering MOUD

American Society of Addiction Medicine National Practice Guideline for the Treatment of Opioid Use Disorder[141]

This treatment guideline is for clinicians, health systems administrators, criminal justice system administrators, and policymakers. The guidelines are regularly updated and offer practical and evidence-based recommendations for patient assessment, OUD diagnosis, and treatment, with additional suggestions for specific medications, psychosocial treatment in conjunction with MOUD, and care for special or vulnerable populations.

American Society of Addiction Medicine Standards of Care for the Addiction Specialist Physician[142]

This document offers practical guidance for healthcare professionals engaged in the diagnosis of substance use disorders, treatment planning, treatment initiation, care coordination, and continuing care management for persons with substance use disorders.

SAMHSA Treatment Improvement Protocol 63[54]

This Treatment Improvement Protocol (TIP) offers clinically relevant descriptions of the three FDA-approved medications for OUD (methadone, buprenorphine, and naltrexone), including mechanism of effect, route of administration, adverse effects, possible drug-drug interactions, and more. It also provides best practices for collaborating with counselors and other ancillary behavioral health care professionals and resources available to patients living with OUD and their families.

Prevention Research Synthesis Criteria for Evidence-Based Interventions for Linkage to, Retention in, and Re-engagement in HIV Care[143]

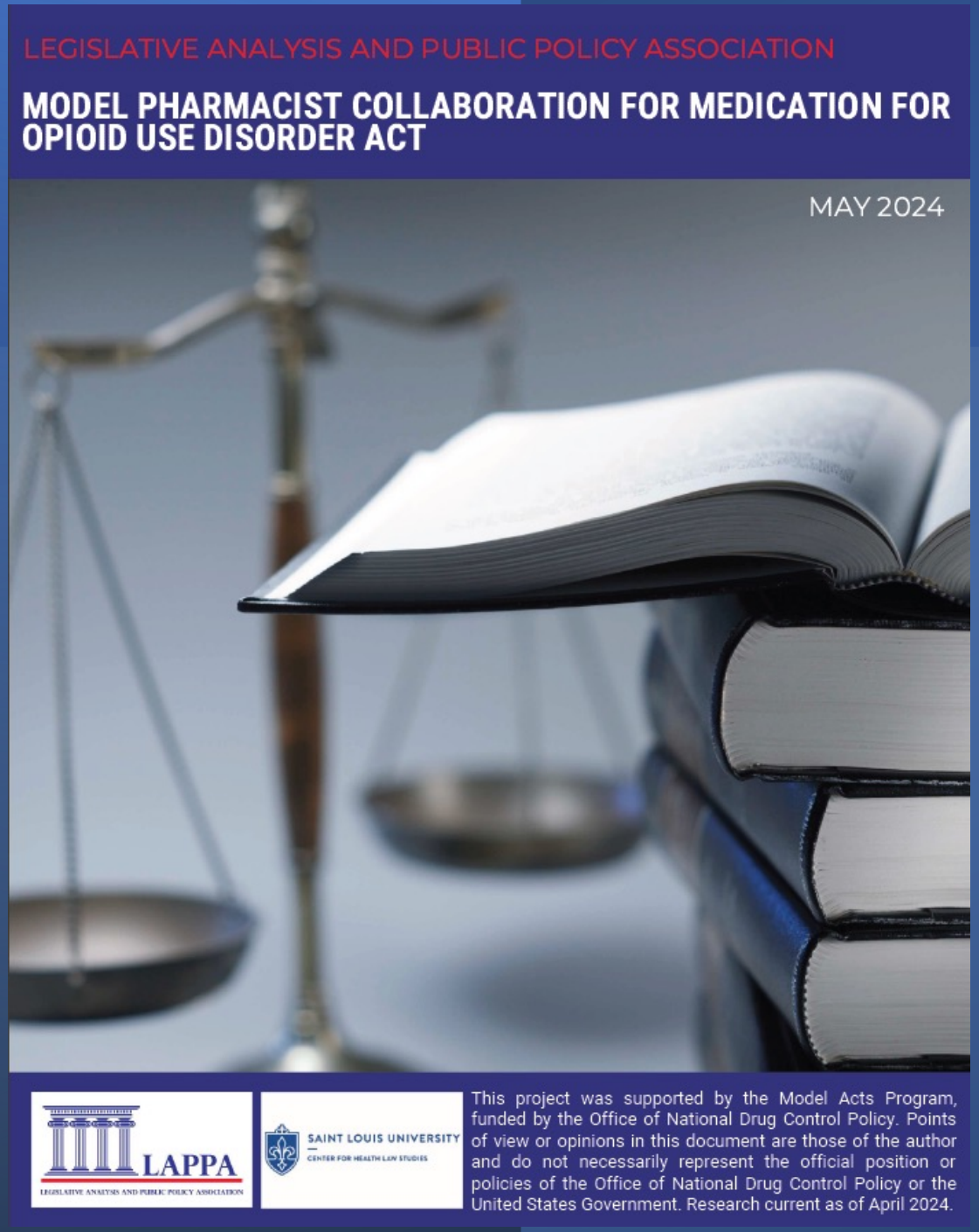
Program evaluation is one of the three key components of evidence-based strategy, along with the expert opinions of clinical professionals and the values, desires, and perspectives of people affected or targeted by the program.[144] In this resource, the Centers for Disease Control and Prevention offers suggestions for assessing linkage to care, including outcomes for program evaluation.

https://www.cdc.gov/overdose-prevention/media/pdfs/pubs/Linkage-to-Care-Resource-for-Action-508.pdf

The Model Pharmacist Collaboration for Medication for Opioid Use Disorder Act authorizes pharmacists to:

1. Prescribe medications for OUD for treatment and refer patients for long-term treatment
2. Prescribe, initiate, monitor, and adjust long-term treatment pursuant to collaborative practice agreements for collaborative drug therapy management.

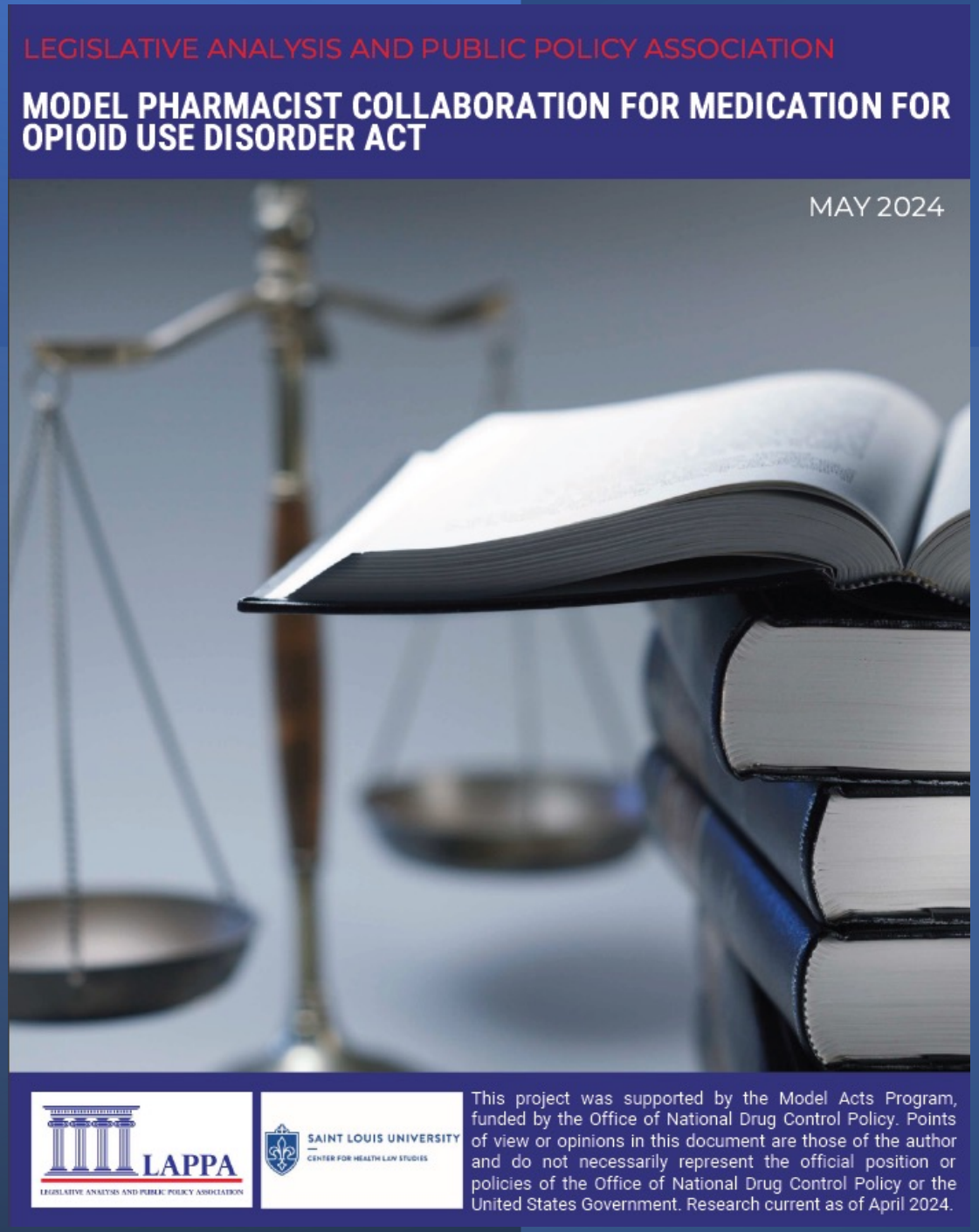
https://legislativeanalysis.org/model-pharmacist-collaboration-for-medication-for-opioid-use-disorder-act/

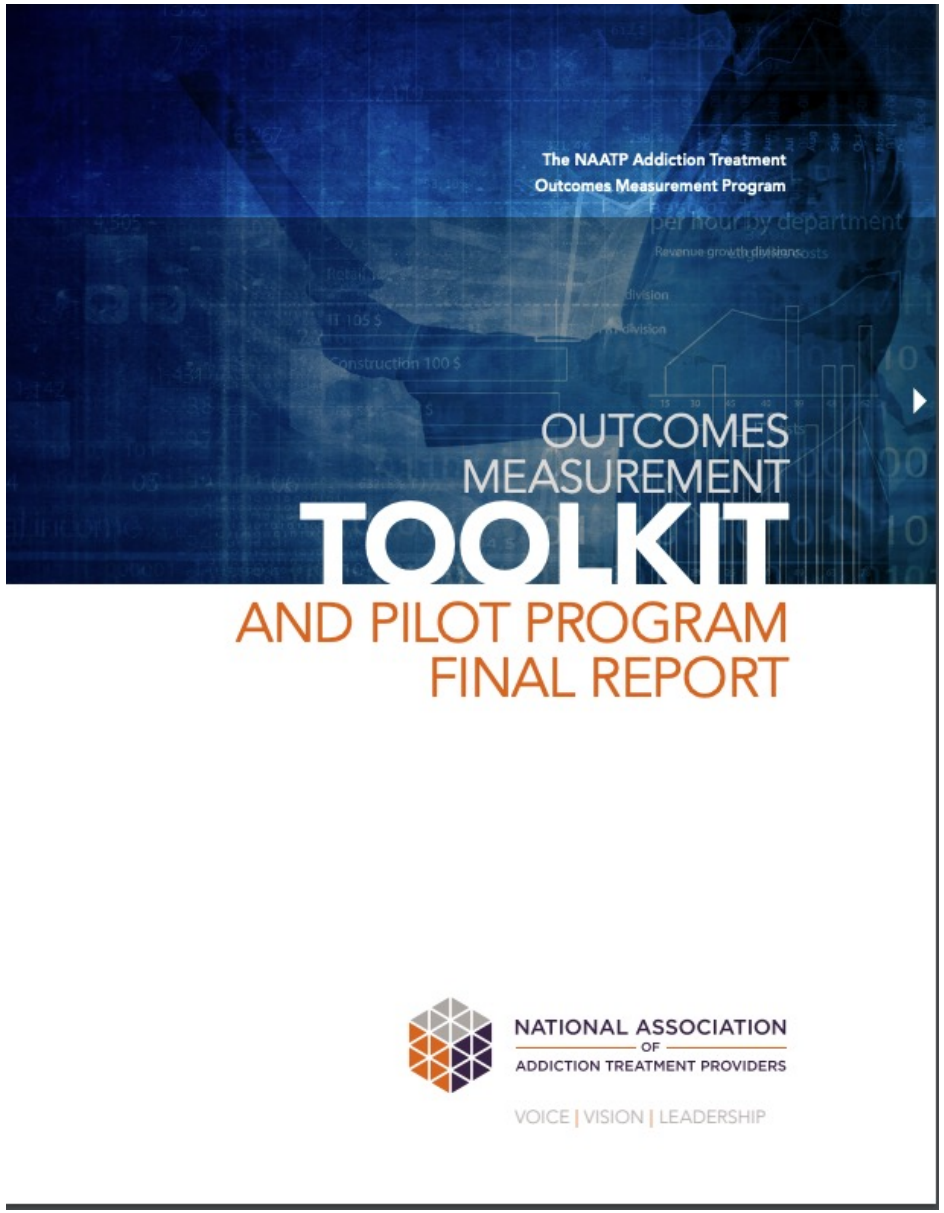


The Model Pharmacist Collaboration for Medication for Opioid Use Disorder Act authorizes pharmacists to:

3. Requires Medicaid and private health insurance coverage for pharmacists' comprehensive patient care and medication management services provided as part of a standing protocol or drug therapy management collaborative practice for medication for OUD.
4. Provides for the establishment of a grant program to incentivize and sustain interprofessional collaborations that include pharmacists through educational programs, statewide initiatives, community programs, and pilot programs.

https://legislativeanalysis.org/model-pharmacist-collaboration-for-medication-for-opioid-use-disorder-act/





https://www.naatp.org/sites/naatp.org/files/OutcomesToolkitandReport.pdf

OUTCOMES MEASUREMENT TOOLKIT

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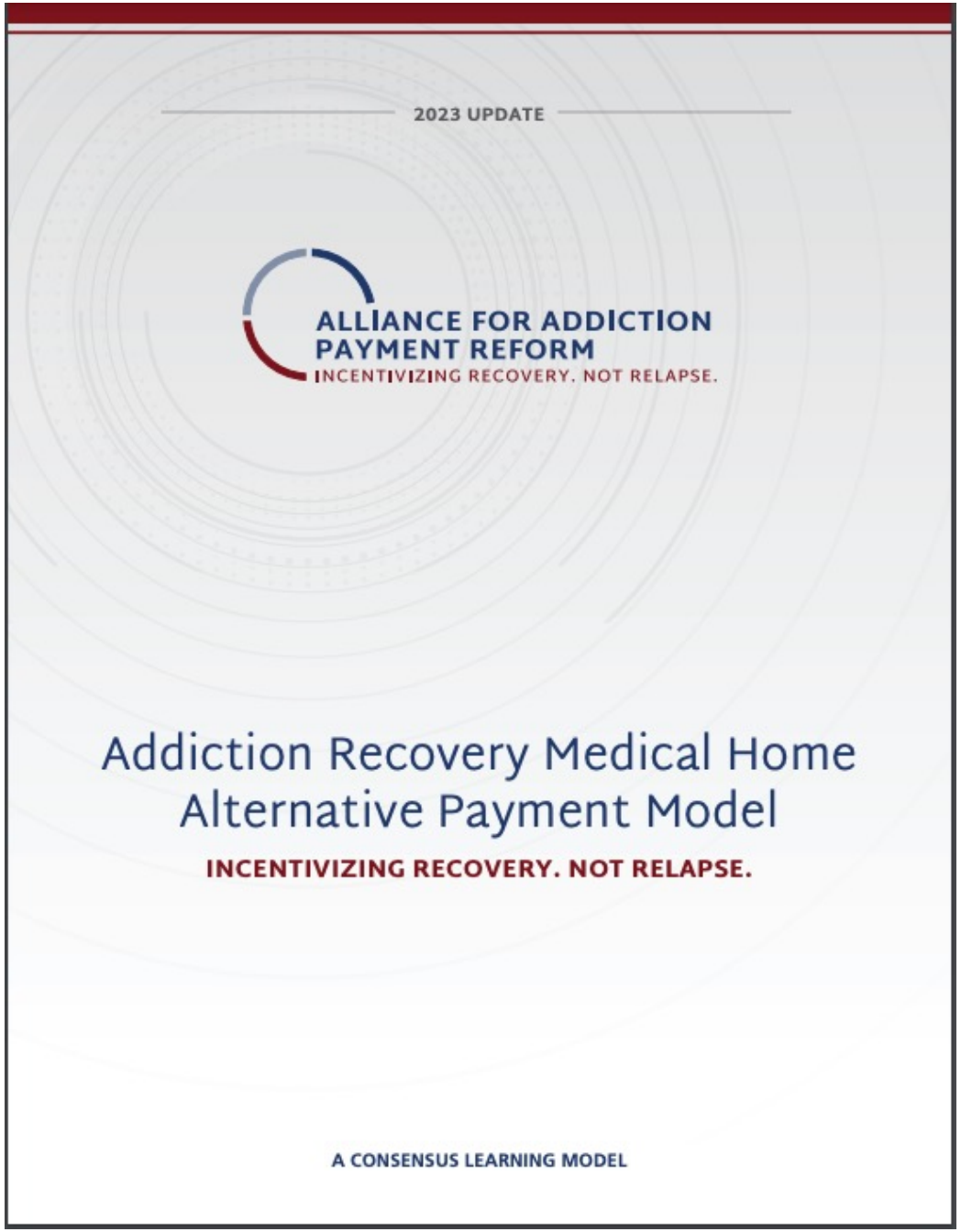

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