INNOVATIVE ADDICTION CARE MODELS: EXPANDING PHARMACISTS' ROLES IN PATIENT RECOVERY

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SESSION OBJECTIVES

1. Review changes in health care delivery that likely impact pharmacy practice.
2. Describe current trends in contemporary pharmacy practice as they relate to interprofessional collaboration.
3. Discuss practice innovations designed to improve health outcomes.
4. Discuss role delineation for pharmacists on the interprofessional health care team.

ADDITIONAL LEARNING OBJECTIVES

1. Review team-based treatment models of opioid use disorder to identify key components and best practices that enhance patient outcomes and collaborative care efforts.
2. Identify common barriers that restrict access to clinical pharmacy services for managing opioid use disorder.

PATIENT M.K.

M.K. is a 34-year-old male who is establishing care today at your family medicine clinic. He has not seen a provider in several years and needs a work physical for his new job

NKDA, he does not take any medications and has no PMH

BP: 145/90, HR: 90, RR: 20, Weight 195lbs, Height: 6'2"

M.K.'s in office urine drug screen is positive for cocaine, oxycodone, and morphine

M.K. expresses interest in getting "off of drugs" so he can hold a steadier job

KNOWLEDGE CHECK #1
WHAT IS THE BEST OPTION FOR M.K.?

A. Go to the emergency department for induction
B. After his appointment, quit all of his drugs of abuse "cold turkey"
C. Referral to psychiatry as medication use disorder is a psychiatric diagnosis
D. Establish at an outpatient treatment facility and start medications if clinically indicated
E. Patient needs to be admitted because of his cocaine use

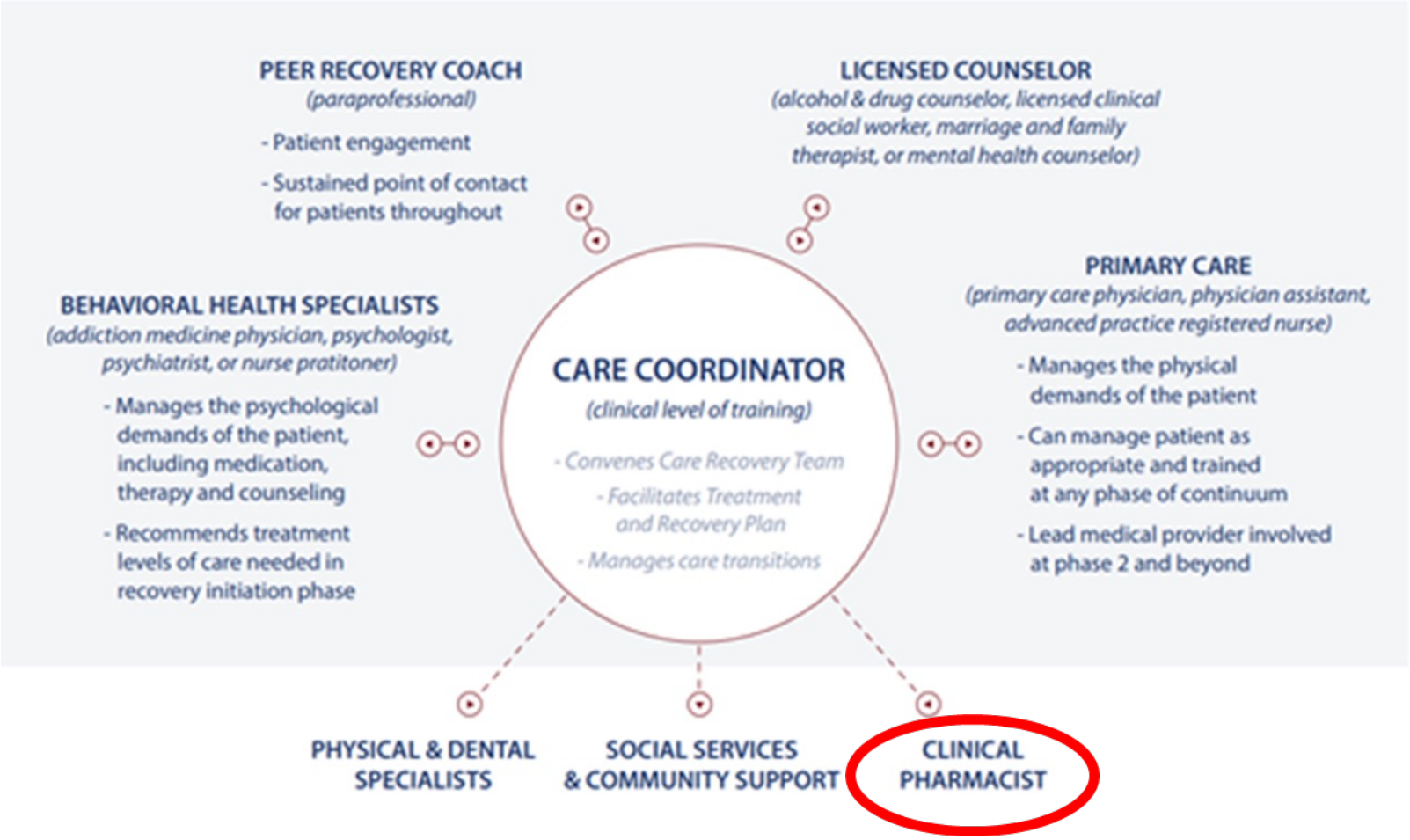
WHAT HAS CHANGED ABOUT THE TREATMENT PLAN FOR M.K. NOW COMPARED TO 2005?

EXISTING TEAM-BASED TREATMENT MODELS

What are we currently doing?

THE CARE RECOVERY TEAM

https://incentivizerecovery.org/wp-content/uploads/AddictionRecoveryMedicalHome-APM-2023.pdf



ADDICTION RECOVERY MEDICAL HOME (ARMH) MODEL

- Goal: organizing care principles for substance use disorder
- Patient-centered, chronic-disease management programs that improve outcomes for patient seeking recovery
- Integrated Treatment and Recovery Networks (ITRN's): network of acute, outpatient, home health, recovery support, virtual services, integrated discharge planning, workflows and technology
- 5 elements:
  1. Quality metrics
  2. Network
  3. Care recovery team
  4. Treatment and recovery plan
  5. Payment model

https://incentivizerecovery.org/wp-content/uploads/AddictionRecoveryMedicalHome-APM-2023.pdf

ROLE OF THE PHARMACIST

- Assist in creating the treatment plan
- Collaborate with other health care professionals
- Monitor and assess medication regimen
- Comprehensive medication management
- List goes on…

Overall optimize medication therapy to improve patient care!

HUB-AND SPOKE MODEL FOR OPIOID USE DISORDER

- Vermont: Brooklyn JR, Sigmon SC. Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. J Addict Med. 2017 Jul/Aug;11(4):286-292. doi: 10.1097/ADM.0000000000000310. PMID: 28379862; PMCID: PMC5537005.
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- Maryland: Stoller KB, Stephens MC, & Schorr A (2016). Integrated Service Delivery Models for Opioid Treatment Programs in an Era of Increasing Opioid Addiction, Health Reform, and Parity. Retrieved from: http://www.aatod.org/wp-content/uploads/2016/07/2nd-Whitepaper.pdf (Accessed January 30 2019).
- Massachusetts: Alford DP, LaBelle CT, Kretsch N, Bergeron A, Winter M, Botticelli M, & Samet JH (2011). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. Archives of Internal Medicine, 171(5), 425–431. [PMC free article] [PubMed] [Google Scholar]
- California: Miele GM, Caton L, Freese TE, McGovern M, Darfler K, Antonini VP, Perez M, Rawson R. Implementation of the hub and spoke model for opioid use disorders in California: Rationale, design and anticipated impact. J Subst Abuse Treat. 2020 Jan;108:20-25. doi: 10.1016/j.jsat.2019.07.013. Epub 2019 Jul 27. PMID: 31399272; PMCID: PMC6893120.

VERMONT EXAMPLE

- HUB = initial assessment, care coordination, methadone, consultations
- Spoke examples:
  - Counselor team that works with prescriber provider
  - Family services
  - Mental Health Services
  - Legal counseling
  - Residential services
  - Outpatient treatment/In patient treatment
  - Medical Home
  - Pain Management

Brooklyn JR, Sigmon SC. Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. J Addict Med. 2017 Jul/Aug;11(4):286-292. doi: 10.1097/ADM.0000000000000310. PMID: 28379862; PMCID: PMC5537005.

OTHER TREATMENT MODELS (ED FOCUSED)

- ASSERT:
  - Peer support staff or community health worker in ED refer patients to local treatment programs
- Bridge Model:
  - ED prescriber providers short term buprenorphine and refers patient to Bridge clinic with a relationship/co-location
- ED-Bridge Model:
  - Prescriber trained in both ED and addiction medicine sees the patient in the ED and then follows patient in the outpatient setting

Martin A, Butler K, Chavez T, Herring A, Wakeman S, Hayes BD, Raja A. Beyond Buprenorphine: Models of Follow-up Care for Opioid Use Disorder in the Emergeny Department. West J Emerg Med. 2020 Nov 2;21(6):257-263. doi: 10.5811/westjem.2020.7.46079. PMID: 33207174; PMCID: PMC7673896.

KNOWLEDGE CHECK #2

WHICH OF THE FOLLOWING STATEMENTS IS TRUE REGARDING HUB AND SPOKE MODEL FOR OPIOID USE DISORDER?

A. Spokes have to be other medical providers
B. The hub is where the patient is being housed
C. The goal is health integration
D. The model is not feasible in every state

MY EXAMPLE

- OASAS accredited addiction program
- Inpatient and ER addiction consult service
- 3 CASAC employees
- Hub-and-spoke to primary care
- Medical group of over 20 primary care and specialist practice
  - Multidisciplinary

OTHER EXAMPLES:
DOES ANYONE WANT TO SHARE THEIR CURRENT ADDICTION CARE MODEL FEATURING A PHARMACIST AS PART OF THE CARE TEAM?

BACK TO M.K.

- M.K. would meet with one of our CASACs for an initial intake and screening for appropriateness to our program
- He would be provided with 5-7 day buprenorphine RX for outpatient induction along with clonidine or gabapentin as needed
- Other options for outpatient induction as needed (loperamide, etc.)
- Provided in home Narcan kit
- COWS assessed
- F/U next week with buprenorphine prescriber
- Weekly meetings with CASAC and every other week apts. with prescriber until stable
- UDS at every appointment

PATIENT M.K.

What works?

- Outpatient induction
- CASAC involvement
- Close monitoring
- Flexible treatment options: therapeutics (buprenorphine, naltrexone, supportive care)

What does not?

- Poor compliance
- High no show rate
- Resistance to program structure
- Need for psychiatry
- Insurance barriers (prior authorizations)

BILLING CODE: 99484

- Behavioral health integration services (fee-for-service/value based payment)
  - Primary care team develops a care plan and coordinates treatment across the health care system
- 99492: initial psychiatric collaborative care management (first 70 minutes)- M.K.'s initial evaluation
- 99493: subsequent psychiatric collaborative care management (first 60 minutes in subsequent month)- M.K. visit one month later *we follow more closely
- 99484: subsequent (or initial) collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities

- Ex: Pharmacists bills 99484 and provider/CASAC/etc. drop 99493

https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/behavioral-health-integration-coding.html

BILLING CODE: 99484

- Requires continuous relationship with the member of our care team
- Coordination of behavioral health with primary care
- Clinical staff providing services are NOT required to have additional education or training
- Patient must have been seen within the year
- Patient consent (verbal or written) documented in the medical record

https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/behavioral-health-integration-coding.html

VALUE BASED CARE

- **Value in Opioid Use Disorder Treatment Demonstration Program 2021**
  - **4 year demonstration program**

- "increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce [Medicare program expenditures]."

https://www.cms.gov/priorities/innovation/innovation-models/value-in-treatment-demonstration

VALUE BASED CARE

- A per beneficiary per month care management fee (CMF)
- A performance-based incentive, that will be payable based on the participant's performance with respect to criteria specified by CMS

- Report from 2022:
  - 943 beneficiaries enrolled
    - Fewer hospitalizations and ED visits
    - Lower Medicare expenditures
      - 15% less than matched cohort!
    - No significant difference in hepatitis C incidence

https://www.cms.gov/priorities/innovation/data-and-reports/2024/vit-intermediate-rtc-aag

VALUE BASED CARE

- What would incentives look like?
  - Need more of a consensus on treatment success
- Care coordination can be difficulty with this patient population with access challenges and communication barriers
- Services are chronically underfunded and understaffed

- Pharmacists are not mentioned…yet

M.K. AS A VALUE BASED CARE PATIENT

- M.K. is started on buprenorphine/naltrexone 8mg/2mg daily and is stable on 16mg/4mg
- COW scores are stable
- Follows with CASAC every other week
- Interested in transitioning to once monthly buprenorphine injection for ease with new job
  - UDS of the past 3 months have been clean

KNOWLEDGE CHECK #3
WHAT IS THE ROLE OF THE CLINICAL PHARMACIST FOR M.K.?

A. Urine drug screen interpretation
B. Designing transition from oral suboxone to injectable buprenorphine
C. Providing education around the buprenorphine injection and associated adverse effects
D. Train nursing staff on how to properly give injection
E. All of the above

M.K. AS A VALUE BASED CARE PATIENT

- M.K. is started on buprenorphine/naltrexone 8mg/2mg daily and is stable on 16mg/4mg
- Clinical pharmacy team sees him to establish
- First visit review medication indication, dosing, side effects and insure adequate drug deliver
- Education provided on buprenorphine injection and insurance coverage process started with specialty pharmacy partners

ALTERNATIVE SCENARIOS FOR M.K.

- M.K. is having a tooth pulled and is concerned about what he can take for pain after the procedure
- M.K. is getting a headache around his buprenorphine dose that is interfering with him driving to work
- M.K.'s insurance no longer covers his generic buprenorphine and prefers the branded generic Bunavil now
- UDS is positive at a monthly visit for cannabis
- Other impacts from various social determinants of health…

BARRIERS THAT LIMIT CLINICAL PHARMACISTS

WHAT IS STOPPING US?

ELEPHANT IN THE ROOM…

RECOGNITION OF PHARMACISTS AS A VALUED MEMBER OF THE HEALTHCARE TEAM!

WHICH STATES CAN PHARMACISTS PRESCRIBE CONTROLLED SUBSTANCES?

- California
- Idaho (collaborative agreement with prescriber)
- Massachusetts (institutional pharmacists only)
- Montana (pharmacy practice agreement)
- New Mexico
- North Carolina
- Ohio
- Tennessee (collaborative agreement with prescriber)
- Utah (collaborative agreement with prescriber)
- Washington

https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf

BUT WHAT ABOUT A CPA…

- Scenario in NY State:
  - Signed collaborative practice agreement between MD and credentialed CPA pharmacist to manage insulin
  - Patient signs a consent form to be enrolled in pharmacist run diabetes clinic
  - Pharmacist follows designed, signed and agreed upon insulin dosing protocol within the clinic
  - Insulin RX sent to pharmacy by CPA pharmacist
  - Not recognized as a provider by the insurance payer

CPA = collaborative practice agreement

ANYONE WANT TO SHARE AN ADVANCED PRACTICE MODEL IN VIRGINIA

BONUS POINTS IF IT INVOLVES SUBSTANCE USE DISORDER!

DO WE HAVE THE TRAINING?

- 30 ASHP accredited pain and palliative care PGY-2 pharmacy practice residencies
- 77 ASHP accredited pain and palliative care PGY-2 pharmacy practice residencies
- Board Certification for pharmacists in ambulatory care, psychiatric, and pain management pharmacy is coming!

- Many states have legislation that allows pharmacists to give long acting injectables

DO WE HAVE THE TIME?

Con

- We are being asked to do more and more…
- How will this fit into the day and current workload
- These patients take TIME

Pro

- Job growth and expansion
- If reimbursement is there, new positions being created
- Further recognition of our clinical value

WHY CLINICAL PHARMACY?

- Could be considered a spoke provider
- CPA protocol with a provider as we do with other disease states-> this is already being done in some states
  - Wu LT, John WS, Ghitza UE, Wahle A, Matthews AG, Lewis M, Hart B, Hubbard Z, Bowlby LA, Greenblatt LH, Mannelli P; Pharm-OUD-Care Collaborative Investigators. Buprenorphine physician-pharmacist collaboration in the management of patients with opioid use disorder: results from a multisite study of the National Drug Abuse Treatment Clinical Trials Network. Addiction. 2021 Jul;116(7):1805-1816. doi: 10.1111/add.15353. Epub 2021 Jan 11. PMID: 33428284; PMCID: PMC8172420.
  - Pals H, Bratberg J, Improving access to care via psychiatric clinical pharmacist practitioner collaborative management of buprenorphine for opioid use disorder, JAPHA 2022 62(4) 1422-1429. https://doi.org/10.1016/j.japh.2022.03.006.
  - Lagisetty P, Smith A, Antoku D, Winter S, Smith M, Jannausch M, Mi Choe H, Bohnert ASB, Heisler M. A physician-pharmacist collaborative care model to prevent opioid misuse. Am J Health Syst Pharm. 2020 May 7;77(10):771-780. doi: 10.1093/ajhp/zxaa060. PMID: 32315401; PMCID: PMC7203632.
  - Mailloux L, Haas M, Larew J, Dejongh D. Development and implementation of a physician-pharmacist collaborative practice model for provision and management of buprenorphine/naloxone. Mental Health Clinician 2021, 11(1): 35-39.
  - DiPaula BA, Menachery E. Physician-pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients. J Am Pharm Assoc (2003) 2015;55(2):187–92.
- Expand patient access

WRAP UP M.K.

- M.K. is now maintained on once monthly buprenorphine injections
- He follows with his prescriber every 6 weeks and his CASAC every month
  - Has had one urine in the past 6 months positive for cocaine and marijuana
- He is curious about tapering off of the injection
- He is curious about pain management around an upcoming ACL repair

What is the role of the clinical pharmacist for M.K.?

LEGISLATIVE UPDATE

SUPPORT RX ACT

THE SUBSTANCE USE PREVENTION AND PHARMACY ORIENTED RECOVERY TREATMENT PRESCRIPTION ACT (SUPPORT RX ACT)

- Sponsor: Senator Cory Booker (D-New Jersey); Cosponsors: Mike Braun (R- Indiana) and Ed Markey (D- Mass)
- Requires HHS to provide demonstration grants for pharmacy-based addiction care programs
  - Recognition of CPAs
  - Community based care
  - Provides training for pharmacist
  - “community fee payments” to providers or clinics
  - Supports HIPPAA-compliant technology for data sharing

BUPRENORPHINE LEGISLATION UPDATE

- Rep. Paul Tonko (D-New York) sponsored the "Mainstreaming Addiction Treatment Act" to eliminate the X-waiver; became effective in 2023
- Expands those who can prescribe buprenorphine from 130K to 1.8 million
- Removes certain barriers for patients to access SUD treatments

BUPRENORPHINE LEGISLATION UPDATE

- Senator Martin Heinrich (D-New Mex.); Draft legislation to "exempt buprenorphine from the Suspicious Orders Report System"
- Suspicious order reporting can create barriers to buprenorphine dispensing
- Under current rules, some pharmacies and distributors do not want to increase buprenorphine orders, for fear they could trigger DEA scrutiny

ASAM POLICY STATEMENT (JUNE 2024)

Supports a strong role for clinical pharmacy in team-based opioid addiction treatment

https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2024/07/22/the-role-of-pharmacists-in-medications-for-addiction-treatment

KNOWLEDGE CHECK #4
WHICH OF THE FOLLOWING IS AN ADVANTAGE TO INVOLVING A CLINICAL PHARMACIST IN OPIOID USE DISORDER TREATMENT?

A. Decrease patient access
B. Improvement patient engagement
C. Increase provider time with patients
D. Delayed interpretation of urine drug screens

SUMMARY

- Research has shown we can effectively engage patients and improve patient outcomes
- Pharmacists could be better utilized in various treatment models for opioid use disorder and other addiction services
- CMS reimbursement and payment for services is a clear barrier
- Education and training programs need to expand to answer this call

THANK YOU!

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