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### Engaging the Nursing Community in Treatment of Opioid Use Disorder

Narrator:

Welcome to CME on ReachMD. This educational activity titled "Engaging the Nursing Community in Treatment of Opioid Use Disorder" is provided by Prova Education, and supported by the National Institute on Drug Abuse. Please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives for this activity. Your host is Nurse Practitioner, Dr. Mimi Secor.

Dr. Secor:

Nurses have always played a key role in the treatment of substance use disorders and with the passage of the Comprehensive Addiction and Recovery Act of 2016, which extends prescription authority to nurse practitioners within the scope of their state laws, their contributions have become even more critical.

In today's discussion, we will explore how nurses and nurse practitioners can help expand patient access to needed medications for the treatment of opioid use disorder or OUD. We will also highlight the benefits of employing a collaborative care approach to facilitate access to opioid therapy with buprenorphine, in an office-based setting.

This is CME on ReachMD and I am Dr. Mimi Secor, nurse practitioner. My guest is Colleen LaBelle, Director of Boston Medical Center's Office-Based Addiction Treatment Program, also known as OBAT, in Boston, Massachusetts.

Colleen, welcome to the program.

Ms. LaBelle:

Thank you, it is a pleasure to be here today.

Dr. Secor:

So, Colleen, can you share with us more about the opioid crisis? It is certainly all over the news headlines.

Ms. LaBelle:

Sure, the opioid crisis, at this point, is impacting everyone. There was a point in time where it was small silos, but now it has impacted everyone across the country and the fact is that more than 90 Americans a day are dying from opioid overdoses. And then, many many more are being impacted by non-fatal overdoses. The CDC is estimating that prescription opioid misuse is costing us roughly \$78 billion a year just in healthcare expenses, let alone the loss of productivity and treatment and criminal justice costs. And since 1999, the amount of prescription opioids has nearly quadrupled. In 2015, approximately 2 million people in the United States had prescription opioid use disorder, and this problem is continuing to climb. And we see prescription opioids is decreasing, but unfortunately, the folks who are using illicit opioids is not decreasing. So, about 80% of those who have begun to use illicit opioids, such as heroin or manufactured fentanyl, first used prescription opioids. There has been a big impact in trying to address the prescription opioids and decrease that, but the epidemic itself has not changed. And so we have treatments for opioid use disorder, which is a really challenging chronic relapsing disease that requires medical attention. We have medications such as buprenorphine, methadone or naltrexone. And combining those with behavioral counseling is the most effective method of treatment for this disease, that we know is chronic relapsing and can be very deadly.

So, accessing medication is really challenging for patients in that there are not many physicians at this point, and now NPs and PAs, that are waived and licensed to do this. You actually have to have specific training to prescribe buprenorphine. So, there is less than 40 thousand waived physicians across the United States as of 2017, and only 8.5% of those 39 thousand physicians can actually treat the maximum number of allowed patients, because you can only treat up to a maximum of 275 patients at one time. So this results in long waiting lists for treatment. Insurance coverage issues are a big issue here. Stigma is a big issue here. So, access to care is really challenging. Some insurers don't cover it, some states don't have coverage that covers it under their Medicaid system or under their private payer system or their self-insured and, therefore, access to treatment is not optional for everybody involved. And in obtaining a waiver to do this, folks have to go through this 8-hour waiver training or they have to have a certification in addiction, such as addiction psychiatry, addiction medicine, Society of Addiction Medicine or osteopathic addiction medicine. So, they either have one of those certifications or they go to an 8-hour approved waiver training that is provided through SAMHSA, and the DEA gives them an additional X-number, is what we call it, but it is another DEA number, to be able to prescribe buprenorphine in somebody's office-based practice. So, because if someone has an addiction, they can't come in and say, "Hey I have an addiction to heroin, can you give me some percs and help me get off it?" You can't do that. It's against the law. So, now we have a medication.

Dr. Secor:

So, Colleen, why are there special requirements for prescribing buprenorphine and how can a medical provider obtain the necessary approval?

Ms. LaBelle:

So, prior to 2000, when the DATA 2000 Act came into play, called Drug Addiction Treatment Act, prior to that, prescribers were not allowed to treat patients with an opioid use disorder in their office practice. The only place where you could get treatment for your substance abuse problem would be in a methadone clinic or in a detox. So, in 2000, the Drug Addiction Treatment Act came along which now allowed physicians at that point to get a waiver to prescribe buprenorphine. And they had to follow certain requirements, they had to be addiction trained, or they had to go through an 8-hour training and then apply to DEA and CSAT, Centers for Substance Abuse Treatment, to obtain that waiver to prescribe the treatment. And nurse practitioners and physician assistants were not included at that point in time.

Dr. Secor:

So, when did that change?

Ms. LaBelle:

So, in July 2017, the CARA Act came about which put legislation in play that nurse practitioners and physicians assistants could now be part of the treatment. So, they could apply for a waiver the same as physicians could, except they had additional requirements in that they couldn't just do the 8 hours of training, they had to do 24 hours of training to be approved to apply for a waiver to prescribe buprenorphine. But this, again, allowed us further access and allowed NPs and PAs to have prescription authority to be able to treat patients with substance use disorder in their office-based practice.

Dr. Secor:

So, Colleen, can you expand a bit on the barriers to treating substance use in primary care office-based settings?

Ms. LaBelle:

Substance use is a complex disease and if providers don't have the specialty in understanding they definitely shy away from doing so. We actually did a barrier study back in 2008 authored by Alex Walley. We surveyed 156 physicians across Massachusetts that actually had their waiver to prescribe buprenorphine, but may not have been doing so or doing so in small numbers. And the number one barrier that providers reported was insufficient nursing support, and the next ones were around office support and understanding the payment issues and their knowledge. And so, those are the really big things of providers just didn't feel like they had the knowledge, they didn't have the support, and they didn't have the nursing support, which is why, I think, we took off with, you know, let's put nurses here because we know when we add nurses to take care of complex diseases, providers are more willing to do it and everybody wins, because the patient gets total care with really comprehensive treatment on all levels as a multidisciplinary approach. So, that's one thing that I think is huge and so, putting nurses, whether it be RNs or NPs, at all treatment settings to help our patients is key in trying to expand access to treatment.

Dr. Secor:

So, with the millions of people suffering from opioid use disorder or OUD, which we know has led many clinicians to change their prescribing practices in an effort to stem this tide, what other strategies can nurses and advanced practice nurses use to make a

positive impact, Colleen?

Ms. LaBelle:

Nurses have a central role in that nurses are essentially at every point of care that a patient typically will encounter at the treatment center. There are more than 3.4 million nurses across the country, and having them have knowledge and insight and ability to treat patients with substance use can make a very big impact, because substance use disorder is complicated. It is a complex disease much like a patient has chronic diabetes or somebody who has HIV with multiple opportunistic infections. Those patients are complicated and they need a treatment team. So having this collaborative care model where nurses work hand-in-hand with prescribers to deliver the care and to provide the concrete care management, and the day-to-day complex care such as pain, and pregnancy, and surgery, or prescription issue, or something that comes about, or getting that person access to the system when and where they need it, is critical to expanding access to treatment.

Dr. Secor:

And how about strategies specific for advanced practice nurses in terms of making a positive impact?

Ms. LaBelle:

So, nurse practitioners are also in the treatment centers. There are more nurse practitioners actually in care now in primary care settings than there are physicians. And there are also higher numbers of physician assistants coming into care. So, you are seeing less and less primary care providers, especially in primary care and in community health centers or in rural areas. So, by empowering those nurses, to train them and to provide them with this tool to prescribe buprenorphine, it is going to further expand access to care for patients. So, we are going to be able to further disseminate treatment and, hopefully, eliminate these waiting lists and the ability for patients to get care when and where they need it, and in their community and their community setting.

Dr. Secor:

Well, that will be fantastic Colleen. So, you talked about getting nurse practitioners waived to prescribe buprenorphine, what do you think will be the end result of increasing the number of waived providers? Will this be enough to turn things around in terms of access?

Ms. LaBelle:

I mean, we are in a pretty tough place right now. We have so many people impacted by this disease, I think it is going to take a while for us to see some really significant impact, but the more and more providers we have out there, the more and more providers we have that are meeting patients in all these areas where they access care, and being able to offer them that care when and where they need it, I think will, in fact, change things. In Massachusetts alone, we have been doing this—we started a nurse care manager model in the state back in 2003 when buprenorphine became licensed and FDA approved in the United States, and from that we have been able to expand access into greater than 40 community health centers so patients can get care when and where they need it. And so, by doing that, we are hopefully going to stem the tide of overdoses and opportunistic infections and recurrent hospitalizations and improve quality of care for the patients, the families and the community.

Dr. Secor:

If you are just tuning in, you are listening to CME on ReachMD. I am your host, Dr. Mimi Secor, nurse practitioner, and with me is Colleen LaBelle. We are speaking about the nursing communities' expanding role for treating opioid use disorder. So, Colleen, let's talk about the Massachusetts model you've led, which provides substance use disorder treatments in primary care settings under the management of a nurse. How has this model performed in clinical practice over the years?

Ms. LaBelle:

It's allowed us to be able to treat our patients in their community health centers and their practice where they get their care. It has allowed us to integrate addiction treatment into the medical setting seamlessly, and as we would any other chronic relapsing disease. And it has helped us to remove the stigma of addiction because we have normalized it and that we are just treating the person and no one knows what that person sitting in the waiting room is waiting for. Why they are there? But they are there to see their nurse or their NP, or their physician or whomever it is, and they are there just to get care like they would anything else.

Dr. Secor:

Given what you've learned from this experience with the Massachusetts model, what would you say are the critical elements a nurse care manager model should include to be successful?

Ms. LaBelle:

Having nurses that are trained in understanding of addiction. I think all of us went to either nursing school, or medical school, didn't learn a whole lot about addiction medicine, because it wasn't something that we actually had really any tools to treating in our practice settings. And so, it was very much treated outside of the medical model. So, training nurses on addiction medicine much like we train

physicians and NPs and PAs with that waiver training, we have actually set up a training that follows along that same line, but it is more nuts and bolts, how do you do this, how do you take care of the patient in your practice? How do you deal with the patient who had a potential relapse or has a medical issue and needs to be hospitalized? Who is pregnant, or a teen, or the Department of Children and Families is contacting you or they have a criminal justice issue? So, having nurses that understand those complex issues and how to get the patient's needs met. Having that frequent followup and that frequent contact and that access to those nurses, I think is critical. And being able to address if something is going on with them and they are struggling with their substance use, being able to grab onto that quickly and early on and addressing that positive urine or that person who is maybe having a problem with the Department of Children and Families or criminal justice early on. So that we can keep them in care and meet their needs and not judge them or stigmatize them and not make it so that they run away in the other direction, not feeling like you understand or care about them.

Dr. Secor:

So, Colleen, do you have any additional closing comments that you would like to share with our listeners?

Ms. LaBelle:

Well, I think it is important that we all try to find whatever it is we can do to impact the opioid epidemic, and I think of it more of the substance use epidemic, because it is not just opioids, but how do we take care of patients as a whole, and how do we provide for all of their needs, and how do we get them to come to care and stay in care? And when they need something to come to us and not to go in the other direction. So, I think it is important that we all learn about addiction, and that we all get some tools in our toolbox to provide wraparound care for our patients, and to remove the stigma and treat it as a disease the same as we treat every other chronic relapsing disease and to not think differently. Remember that that person is a person that is somebody's mom, somebody's dad, somebody's brother or sister, and that this can happen to anyone. And what we need to do is find the tools we have to treat the disease and to treat that individual and to meet them where they are at so that we can keep them alive, to hopefully, to a point where they can get well.

Dr. Secor:

With that, I want to thank you, my guest, Colleen LaBelle, for joining me to discuss expanded nursing roles in treating patients with opioid use disorder. Colleen, it was great having you on the program. You shared so much valuable information with our listeners. I want to wish you well in your continued challenges in working in this very important area.

Ms. LaBelle:

Thank you. Thank you for having me.

Narrator:

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