Colorado Consortium for Prescription Drug Abuse Prevention

Treatment Work Group Meeting Minutes

August 25, 2022 via Zoom

Present:
Steve Young, MD, Angela Bonaguidi, Co-Chairs
J.K. Costello, MD, The Steadman Group
Sabine Dordick, Sober AF Entertainment
Donna Goldstrom, Front Range Clinic
Allyson Gottsman, UC School of Medicine, Practice Innovation Center
Lauren Quintana, UC School of Medicine, Practice Innovation Center
Amy Breen, Clinix Center for Health
Sarah Axelrath, MD, Stout Street Health Center
Justin Upwell, LPC, LAC, Denver Health
Shannon Jenkins
Consortium: Jen Place
Absent: See attached roster.

Co-chair Angela Bonaguidi called the meeting to order at 12:05 p.m.

Approval of Minutes:

A motion was made to approve the May 2022 meeting minutes. Motion approved.

Co-chair Updates (Angela Bonaguidi and Steve Young):

The Consortium and the Treatment Work Group Co-chairs recently met with HCPF to address reimbursement barriers to opioid treatment programs, including programs that are mandated within the criminal justice system. Recent legislation requires jails to provide medication assisted treatment. Implementation discussions are ongoing, particularly with smaller jails concerned with the ability to meet the mandate.

Tyler Coyle, MD, recently contacted the FDA requesting an increase in the buprenorphine limit from 24 to 32 milligrams.

The Role of Primary Care in Treating Opioid Use Disorder:

Allyson Gottsman, University of Colorado School of Medicine, Practice Innovation Center:

Allyson provided a summary of the CU Practice Innovation Program and its role in helping practices achieve goals. The program provides resources and assistance in implementing sustainable programs via a team-based care approach. The program is also focused on supporting practices in the use of medication assisted treatment for opioid use disorders.

Allyson reviewed the implementation plan, including screening, patient consents, agreements, educational materials, behavioral health support (in-house or referral), contingency management considerations, coding, billing, and other administrative functions. See website for links to the foregoing - https://medschool.cuanschutz.edu/practice-innovation-program/current-

initiatives/opiods/resources-for-your-office-and-patients For additional information: allyson.gottsman@cuanschutz.edu.

Sarah Alexrath, MD, Stout Street Health Center:

Dr. Alexrath's presentation covered opioid use disorder treatment from the provider's perspective. She provided an overview of the nationwide prevalence of opioid use disorder and the current treatment methodologies. She stressed the importance of treating the disorder in a primary care setting. Her first slide listed medications available to treat substance use disorders, which are medications that are already familiar to primary care providers. Presentation highlights:

- Most primary care practices are already treating patients for alcohol and nicotine use disorders.
- The practice advancements related to alcohol and nicotine use disorders over the past several decades can be applied to opioid use disorders, i.e., the use of buprenorphine and suboxone.
- Within the past 12 months, seven million people in the United States met the criteria for opioid use disorder.
- In the same period, there were more than 100,000 overdose deaths. That number has been increasing year by year for approximately 20 years.
- In 2018, 40 US counties did not have buprenorphine waivers. The data is stratified along class and racial lines as well as urban and rural areas.
- Statistics show that many individuals diagnosed with OUD do not continue to a specialty addiction treatment program, which illustrates the importance of integrating treatment for opioid use disorder into the primary care setting where most people are likely to access care and where their condition can be managed much like any chronic condition.
- Most people do not actually require a specialty treatment program.
- Data show that doses of 16 milligrams per day or greater suppresses illicit substance use and decreases the rates of all the negative health consequences, i.e., HIV, hepatitis, non-fatal and fatal overdose, and serious bacterial infections.
- One of the main benefits of buprenorphine treatment is that it significantly reduces both general all-cause mortality as well as opioid-specific mortality from overdose within a year of treatment by about 37 percent.
- Data indicate that buprenorphine treatment for opioid use disorder is effective with or without adjunctive behavioral therapy. While many may want behavioral therapy, there is sufficient data to suggest that it should not be a mandated part of office-based treatment.
- Institutional and provider-specific barriers exist. Not all providers are interested in treating opioid use disorder.
- Providers are needed who are willing to accept a certain amount of self-directed learning since SUD treatment is more nuanced than statin treatment, for instance.
- Overall, buprenorphine prescribing is no more difficult than titrating insulin and is significantly safer.
- It is helpful to have some mentorship to assist with questions that might arise.
- Practices need a way to monitor for medication safety and diversion, such as drug screening or medication counts. The actual method can vary by practice.
- It is helpful to have a colleague who can cover for prescriptions.

- As of April 2021, all licensed prescribers, including MDs and PAs, can submit a notice of intent to prescribe for up to thirty patients at a time, which can be submitted via the SAMHSA website.
- An X waiver is required to prescribe buprenorphine for more than thirty people. There is still required training as well as other practice conditions that must be met.

Dr. Axelrath can be reached at saxelrath@coloradocoalition.org.

Justin Upwell, LPC, LAC, Denver Health Webb Center for Primary Care:

Justin provided a summary of his background and employment as an integrated behavioral provider within primary care at Denver Health. Substance use treatment has been the focus of his entire career.

Denver Health employs waivered providers who prescribe medication assisted treatment for SUDs. Clinics have a substance treatment counselor who works collaboratively with primary care providers to support recovery and substance use-related needs for all patients.
The behavioral health provider is the first contact for many patients considering suboxone.

A thorough history is compiled of patients' substance use and mental health. In order to provide the necessary level of care, the history also includes standardized assessments that help identify if primary care is an appropriate setting for their specific needs.

Once intake is completed, patients are educated on the program process, protocols, and expectations. Primary care and behavioral health appointments are scheduled jointly or, on occasion, separately. Justin outlined the appointment frequency. He indicated that patients often view their behavioral health visit as a part of their medical appointment rather than therapy. Justin spoke about challenges related to patient resistance to peer support, recovery specialists, or twelve-step meetings. He concluded by saying that the team approach in addressing substance use disorders. i.e., primary care collaboration with behavioral health providers, can be incredibly effective in addressing patients' needs.

Justin can be reached via email at justin.upwell@dhha.org.

Questions/Comments:

Steve Young asked about patient assessment. Justin said new patients are assessed by a team of behavioral health educators available to explain the different levels of care and treatment within Denver Health. Different treatments are also discussed (methadone or suboxone, for example). Patients are asked about co-occurring substance use, employment, chronic pain, legal system involvement, or other serious psychiatric conditions. The Vermont treatment needs questionnaire is used as is the EHR system. Since each patient presents with complex issues, a general clinical impression is an important part of the assessment.

Sarah Axelrath spoke further about Stout Street's model of integrated healthcare, including patient navigation, behavioral healthcare, and case management. Behavioral healthcare is a crucial part of the system, as patients are "high need" and very complex.

Justin concurred, indicating that all the Denver Health primary care clinics have at least one or two full-time medical social workers and separate substance and treatment counselors. Some of

the substance treatment counselors are certified addiction specialists and are grant funded. Other counselors bill Medicaid or commercial insurance companies.

Donna Goldstrom, Front Range Clinic Director of Behavioral Services, said that Front Range has also shifted their model to one that is more integrated. They are seeing more successful outcomes as a result.

Work group members discussed how information about patients is handled between treatment providers and primary care. Sarah Axelrath said it is important to keep abreast of a patient's ongoing medical treatment, including methadone, HIV, and hepatitis treatment, to avoid duplications. She suggested such communications could be improved.

Steve Young mentioned that there might be a hesitation among OTPs due to privacy issues that inhibit information sharing.

Angela Bonaguidi said SAMHSA has relaxed the requirement prohibiting OTP medication from listing medications in the PDMP, and that it would be helpful for practitioners to be able to log into the PDMP to check a patient's medication and dosage. She felt this subject would be worth further discussion.

Work Group Member Announcements:

The Consortium's 10th annual meeting will be held virtually this year. The meeting is scheduled to be held on Thursday, October 27th

The 5th Annual Provider Education Symposium (in-person event) will be held on Friday, October 28th. The event will feature a presentation and book signing by author Maia Szalavitz: https://maiasz.com/

The Treatment Work Group co-chairs are planning an opioid treatment training workshop on September 29th. A DEA representative will be speaking about narcotic treatment programs, including how the VA conducts program oversight.

Adjournment and Next Meeting:

The meeting adjourned at 1:00 p.m. The next work group meeting will be held on Thursday, September 22, 2022 from 12–1:00 p.m.

Attachments: Work group roster, Presentation slides