U.S. Department of Veterans Affairs

Increasing buprenorphine access for Veterans with opioid use disorder in rural clinics using telemedicine

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DISCLOSURES

Project Funding:

VA-QUERI PII 18-178: *Making Medication Assisted Treatment Available to Veterans with Opioid Use Disorder at CBOCs using Telemedicine*

No other disclosures

OPIOID STATISTICS

- Maine fatal overdose rate - nearly 50% greater than the national average
  - National: 19.8 / 100k
  - **Maine: 28.7 / 100k**
  - Most ODs involve opioids

  – **Rates are highest in rural areas**

- Several rural community-based outpatient clinics (CBOCs) lacking on site prescriber of Medication for Opioid Use Disorder (MOUD)

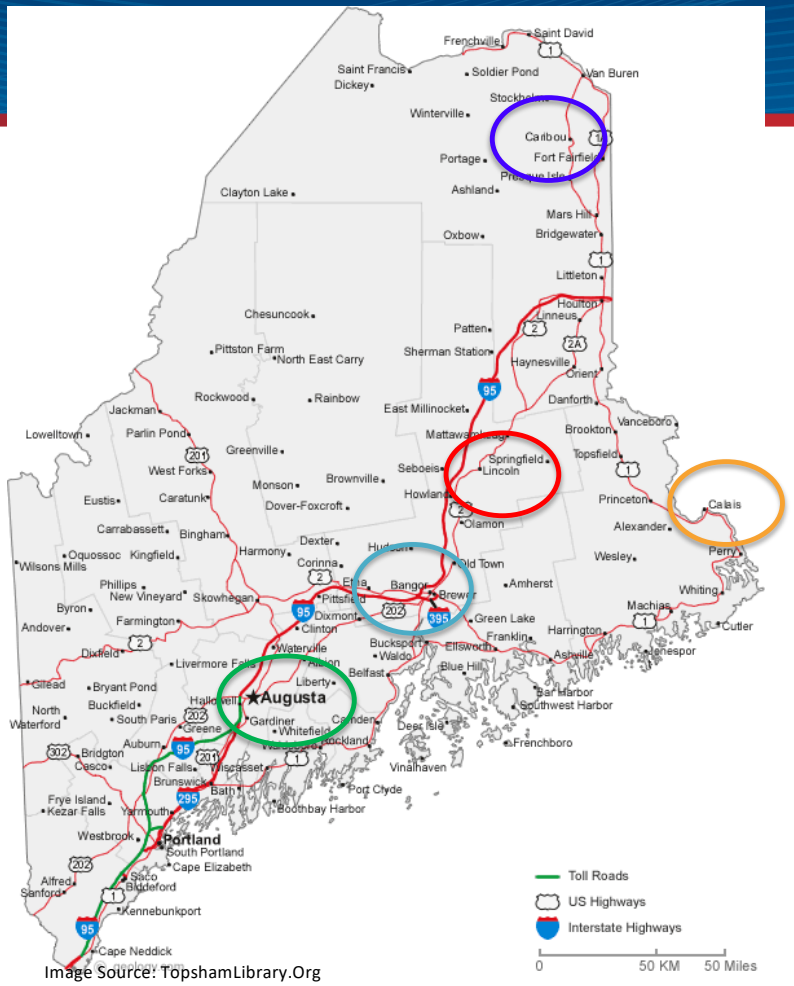
- Treating Veterans will likely improve accompanying conditions, decrease mortality and increase the likelihood of treatment follow-up

VA MAINE HEALTHCARE SYSTEM

- VA Maine Healthcare System's Togus VA Medical Center is a complexity Level 1C facility in Augusta, Maine
- Serves over 42,500 Veterans
- Full-time CBOCs are located in Bangor, Calais, Caribou, Lewiston, Lincoln, Portland, Rumford and Saco
- Part-time clinics are located in Fort Kent, Bingham, and Houlton

MAINE GEOGRAPHY

- Caribou CBOC
  - 252 miles to Augusta (4 hr 1 min)
  - 171 miles to Bangor (2 hr 48 min)
- Calais CBOC
  - 177 Miles to Augusta (3 hr 4 min)
  - 96 miles to Bangor (1 hr 50 min)
- Lincoln CBOC
  - 126 miles to Augusta (1 hr 57 min)
  - 45 miles to Bangor (42 min)



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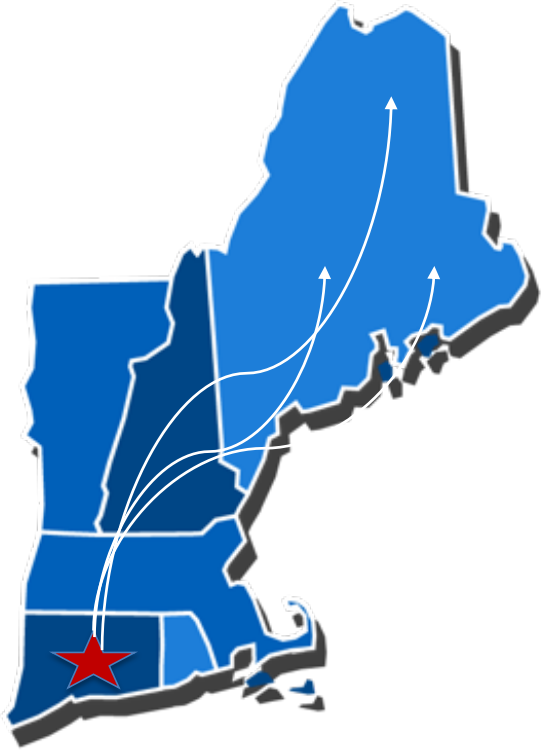
USING A "HUB AND SPOKE" APPROACH



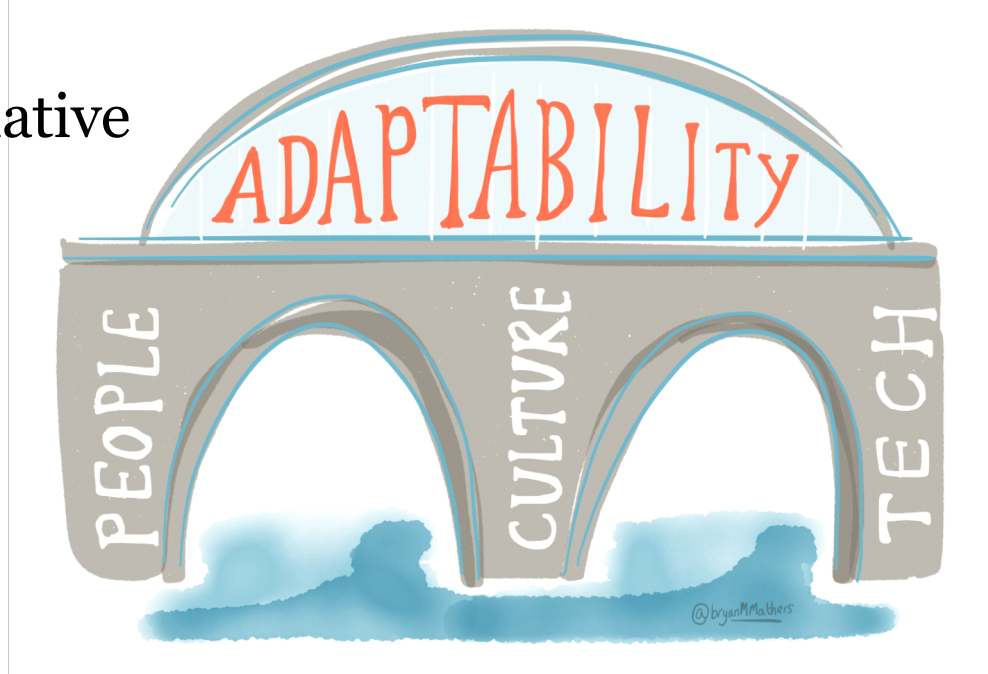
HUB SITE	SPOKE SITES
Evaluates patient	Arrange telehealth session
Explains MOUD treatment	Collect lab work
Obtains consent	Conduct urine drug screens
Prescribes medication	Vital signs
Provides follow-up with patient	Adjunctive counseling
Provides support for CBOC staff	Medical care

IMPLEMENTATION METHODS

- Project funded by the VA's Quality Enhancement Research Initiative (QUERI, PII 18-178)
- Two psychiatrists with expertise in buprenorphine prescribing and a nurse served as external facilitators (Connecticut)
- Clinical pharmacy specialist served as the internal facilitator (Maine)
- Stakeholder assessment qualitative interviews

PILOT WORK : FACTORS FAVORING ADOPTION OF TELE-MOUD

- Need for MOUD
  - "People are dying"
  - "Everybody knows somebody who…"
- Experience with Opioid Safety Initiative
  - Staff knew facilitator
  - Familiar with opioid issues
- Existing telehealth infrastructure
  - Pharmacy arrangements
  - Telehealth logistics
  - Telehealth is accepted



PILOT WORK : BARRIERS TO ADOPTION IN CONNECTICUT (HUB)

- Hiring telehealth prescribers
  - Helped by telework agreements
- Overworked IT department
  - Need to add tele-prescribers to existing service agreements
- Logistics for prescribers
  - Clinic in Maine
  - Maine PDMP access

PILOT WORK : BARRIERS TO ADOPTION IN MAINE (SPOKES)

- Understaffed CBOCs
  - Staff turnover at every level
- Tele-MOUD perceived as primary responsibility of Mental Health
- Will it undermine existing buprenorphine program?
- Urine drug screens

QUALITATIVE INTERVIEWS OF MAINE STAFF

Perceptions and barriers to existing program:

"It seems like a lengthy process for the Veteran to get in… one to four weeks… before they actually start getting suboxone"

Problems with existing telehealth program =

"I think probably just the biggest problem with telehealth would be the nursing support…"

"If you're treating someone through telehealth it's harder to assess people."

"There needs to be some education in Calais and the other rural Maine locations on these patients… they don't have mental health RNs… only primary care"

QUALITATIVE INTERVIEWS OF MAINE STAFF

Primary Care perspectives

"I don't have very many patients on my panel who are overusing…"

"I have not had anybody request [buprenorphine]"

Unique challenges in rural Maine

"We cover a pretty big area up here…. Getting here is part of the problem."

"I have some veterans that live off the grid so to speak… in the woods."

OVERCOMING BARRIERS

- Leadership support
- Patient interest
- Development of a “how to” Tool Kit
- “Spoke” sites choose which patients to refer and when
- Ongoing support in person, phone, email

Patient Results

Patient	Age/ Gender	Chronic Pain (Y/N)	Psychiatric Comorbidities	Substance Use History	Induction Type*	Duration of buprenorphine treatment prior to telebuprenorphine Modality	Total number of video telehealth appointments with hub psychiatrist and frequency (6 months)	Number of Urine drug screens Collected (6 months)	Urine Drug Screen Abnormalities	Status (6 months following initial visit)
1	60 M	Y	MDD	Heroin	Transfer	8 years	6, monthly	0	-	Active
2	66 M	Y	SIMD	Heroin	Transfer	2 weeks	9, weekly for five weeks then monthly	11	Cannabis (+), ETG (+)	Active
3	38 M	Y	PTSD	Heroin	Transfer	2 years	6, monthly	4	-	Active
4	35 M	Y	PTSD	Oxycodone	Clinic	-	9, weekly for five weeks then monthly	8	Benzodiazepine (+)	Active
5	72 M	Y	MDD, GAD	Hydrocodone, Oxycodone	Clinic	-	6, weekly for four weeks then monthly for two months	4	-	Transfer to higher level of care following inpatient admission for SI
6	39 M	Y	PTSD	Heroin, Cocaine, Benzodiazepines	Transfer	1 year	6, monthly	5	-	Active
7	47 M	N	PTSD	Opioid pills, Stimulants, Alcohol	Clinic	-	9, weekly for four weeks then biweekly for two weeks then monthly	11	Buprenorphine (-)	Active
8	52 M	Y		Heroin, Opioid pills, Fentanyl, Buprenorphine	Home	-	10, weekly for six weeks then monthly	6	-	Active
9	53 M	Y	MDD	Heroin, Opioid pills, Benzodiazepines Alcohol	Transfer	2 years	11, biweekly for six months	9	Benzodiazepine(+), Amphetamine (+), Heroin(+)	Active
10	69 M	Y	PTSD	Opioid pills, Alcohol	Clinic	-	3 visits within two weeks	2	ETG (+)	Inactive – patient did not tolerate buprenorphine
11	60 M	Y	PTSD	Prescription opioids	Home	-	8, biweekly for six weeks then monthly	3	-	Active
12	45 M	Y		Heroin	Transfer	5 weeks	4, weekly for four weeks	0	-	Inactive – patient discontinued treatment

CASE EXAMPLE

- Patient with a suicide attempt (~2.5 hours from main facility)
- Patient had been using 3 bags of heroin daily prior to suicide attempt
  - "Heroin owned me"
  - "Nothing to look forward to besides an overdose"
  - Pain/financial problems
- Surgical admission and psych consult at non-VA facility
- Discharged with plan for buprenorphine induction at main facility
- Transferred to teleMOUD program and care at local CBOC
  - Fully engaged in care, psychotherapy, no relapses

LESSONS LEARNED

- Coverage plan when “hub” prescriber is off or unavailable
- Flexibility of prescriber, staff and patient
- Plan for patients that require higher level of care
- Include stakeholders in leadership updates and project meetings/calls
- Sustainability when funding runs out

CURRENT AND FUTURE PLANS

- Tool Kit includes COVID-19 considerations and will continued to be updated as needed

Tool Kit

- Transitioning Maine patients to local prescribers (continue “hub and spoke” model)
  - Facilitation continues

- Expanding to additional sites
  - Thee year extension

PROJECT TEAM

Project Investigator/External Facilitator:
Marc I. Rosen, MD – Connecticut

External Facilitator/MOUD Prescriber:
David T. Moore, MD, PhD – Connecticut

External Facilitator:
Dora Lendvai Wischik, RN MSN – Connecticut

Internal Facilitator:
Nicole Brunet, Pharm D, BCPP – Maine

Interviewer:
Kristin M. Mattocks, PhD, MPH

Stakeholders
Facility leadersip, CBOC staff, Veterans

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Thank you!

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