VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

30 YEARS

Clinical Coordinators: The Key to Your Medication-Assisted Therapy Team in HIV Primary Care Settings

Lessons from a HRSA SPNS Implementation Science and Replication Project

Presenters

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  ITAC Program Manager

Abt Associates
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Centro Ararat
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- Ana E. González Gómez, RN, BSN, HIV Nurse

Multnomah County Health Department
- Kristen Meyers, BS, CADCI, Medical Case Manager

HRSA SPNS Project Officer
- Corliss Heath, PhD, MPH, MDiv.

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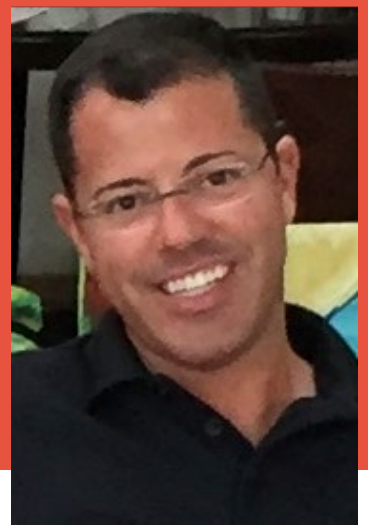
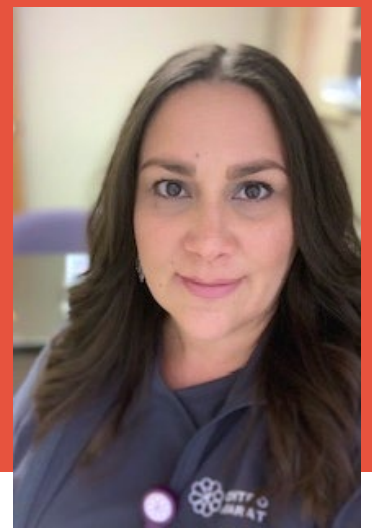
DEII Clinical Coordinating Team




Objectives

1. Describe the role of the Clinical Coordinator as part of the workforce to enhance MOUD and primary care.

2. Disseminate information about HRSA's HIV/AIDS Bureau, Special Project of National Significance on Integrating Buprenorphine Treatment to HIV Primary Care.

3. Share lessons learned for integration of Buprenorphine Treatment into the primary care models.

DEII Initiative Overview

- Replicates 4 previously-implemented SPNS initiatives with the goal of creating Care and Treatment Interventions (CATIs).
- 5-year initiative (2015-2020) represents the first attempt to bring innovative SPNS-supported interventions to scale across the field.
- Two cooperative agreements:
  - ITAC: AIDS United
  - DEC: Boston University and Abt Associates

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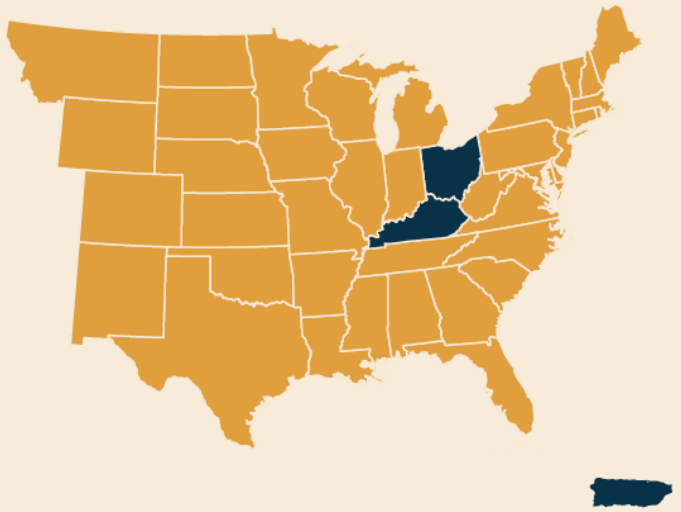
Integration of Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care:

Intervention Overview

Intervention Overview

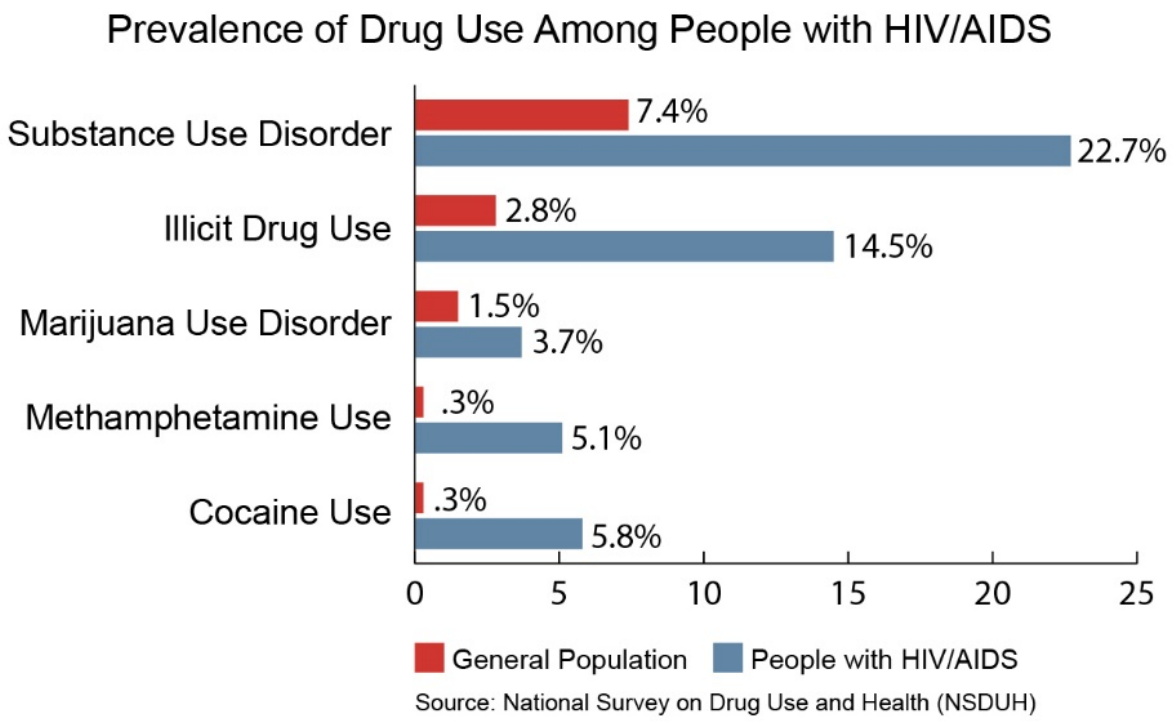
- Intended for implementation in HIV primary care without on-site buprenorphine treatment services.
- Follows principles of harm reduction and creates a “one-stop-shop” model
  - Enables providers to treat substance use disorder along with other chronic medical conditions
- 97 clients received services through this intervention between November 1, 2016 and April 30, 2019.



Three Ryan White HIV care providers implemented the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care intervention through the Dissemination of Evidence-Informed Interventions project:

- Centro Ararat, Inc **(Ponce, PR)**
- The MetroHealth System **(Cleveland, OH)**
- University of Kentucky Research Foundation, Bluegrass Care Clinic **(Lexington, KY)**

Why is this Intervention Needed?



- Opioid use is associated with needle sharing and risky sexual behavior, which increases the risk of contracting HIV
- For people with HIV, untreated opioid use disorder is associated with poor HIV and SUD outcomes

Role of the Clinical Coordinator

1. Support and stabilize patients in buprenorphine care.
2. Work in collaboration with the primary prescriber(s), treatment team, and patient.

The CC may be trained or have knowledge about HIV/AIDS, mental health, and substance use disorders. The clinical coordinator role may be filled by persons in the fields of Social Work, Medical Case Management, Nursing, Addiction Counseling, and Counseling/Therapy.

Other skills important to this role include: communication, collaboration, community networking and linkage, advocacy, harm reduction practice, de-escalation, medical terminology, and ability to work with a large range of service providers.

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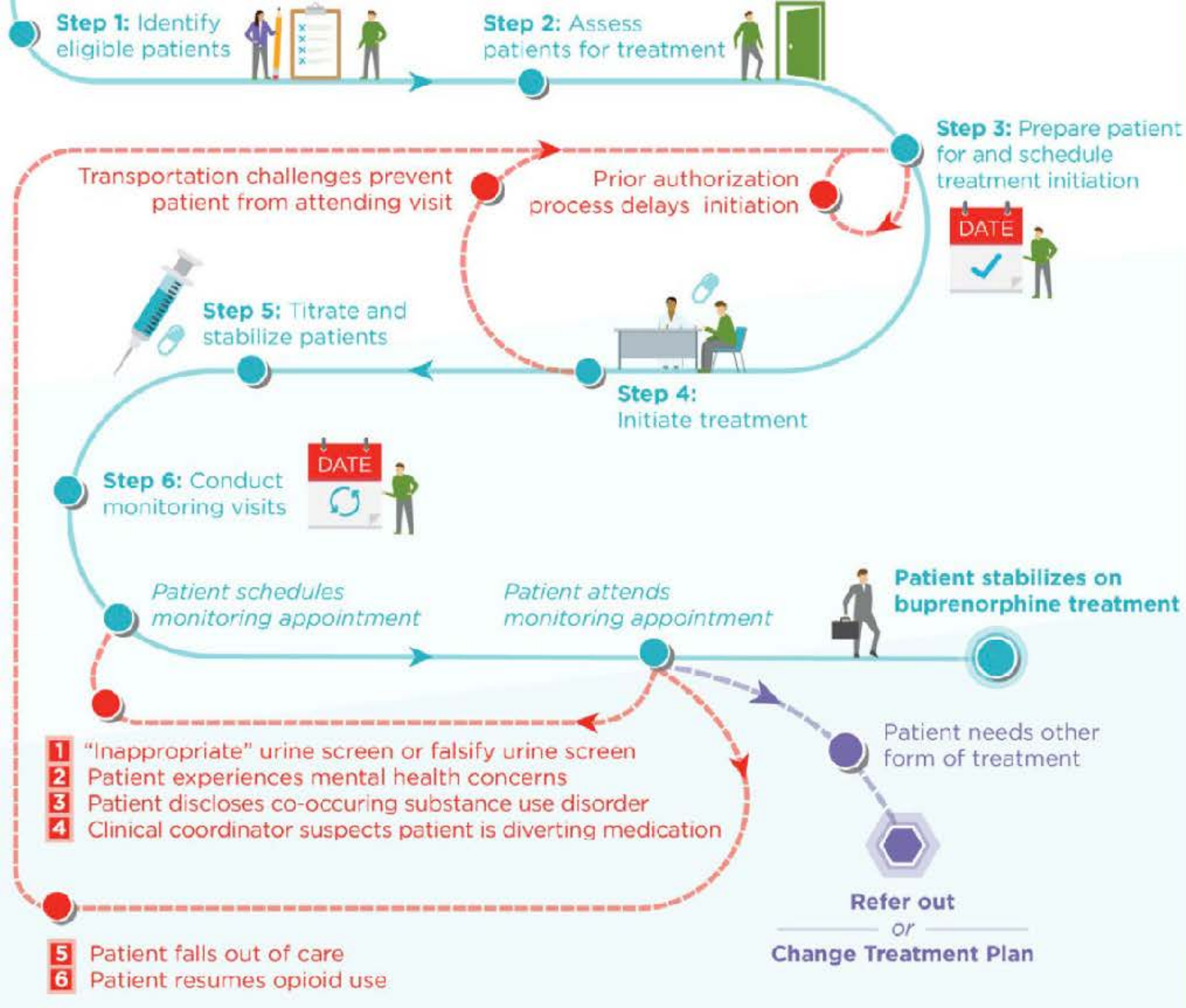
Treatment is non-linear: Ways that clinical coordinators support the treatment path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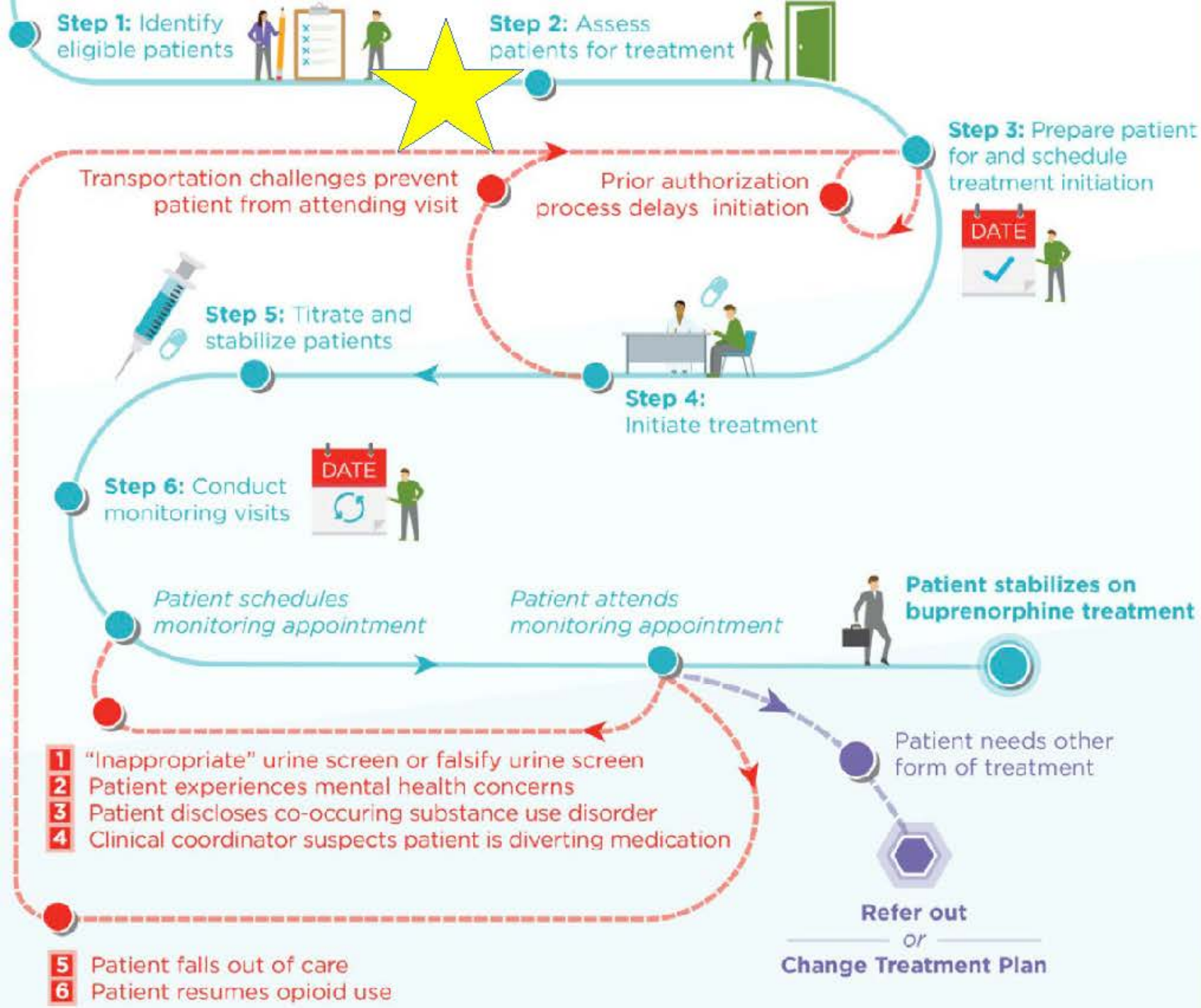
4 Clinical coordinator suspects patient is diverting medication
Refer out
or
Change Treatment Plan
5 Patient falls out of care
6 Patient resumes opioid use

Pre-Implementation Activities

- Assess the clinic and client population
- Get buy-in
  - Start slow, gain success.
  - Early "success" in stabilizing clients makes buy-in easier.
- Identify and assess community partners
- Understand different buprenorphine formulations
- Train all staff
  - Take the time to educate EVERYONE about substance use disorder & MOUD.
  - Discuss as team harm-reduction vs. abstinence: What is your team/clinic philosophy?
- Prepare for insurance issues

Training Topics:

- Pre-implementation system review
- Pre-implementation protocols and materials
- Substance Use Disorder 101
- Selecting, assessing, and preparing patients for treatment
- Initializing, stabilizing, and maintaining patients
- Buprenorphine patient stabilization
- Maintenance visits
- Transitioning patients to the standard of care
- Stigma, shame, and the power of language
- Relapse sensitive environments and strategies to support retention in care
- Referrals to higher levels of care, other treatment options, and tapering off of buprenorphine
- Mental health and SUDs
- Pain and SUDs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Identifying, Assessing and Preparing Patients

- Universal screening for substance use disorder
  - Review DSM V or other diagnostic tools

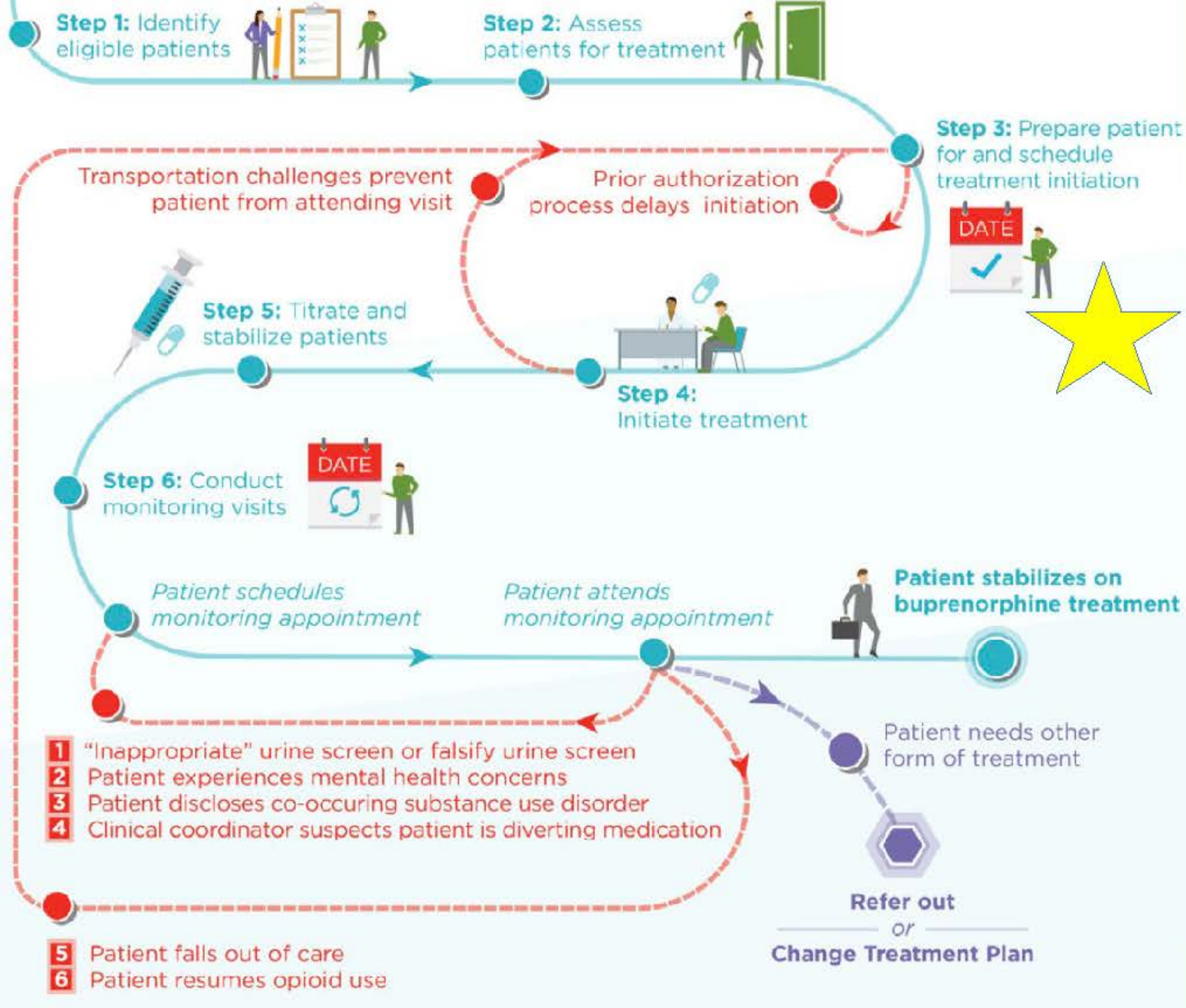
- Assess the following:
  - Medical history
  - Previous attempts at recovery and current recovery activities
  - Prior experience with buprenorphine
  - Existing support system and relationships:
    - Do they live with others who are using?
    - Are they in a relationship with someone who is using?
  - Court involvement
  - Transportation barriers for frequent clinic appts
  - Unmet needs (employment, food security)

- Sign treatment agreement

Treatment Agreements

In collaboration with the patient, create a treatment agreement using motivational interviewing skills and setting goals that mirror the patients' readiness to change

- Patient will:
  - Keep all appointments
  - Attend other treatments as requested
  - Keep meds safe and secure
  - Lost meds will not be replaced early
  - Take medication as prescribed
  - Treat staff respectfully
  - Not sell or share medication
  - Fill prescriptions at one pharmacy
  - Come in for random pill counts, urine screens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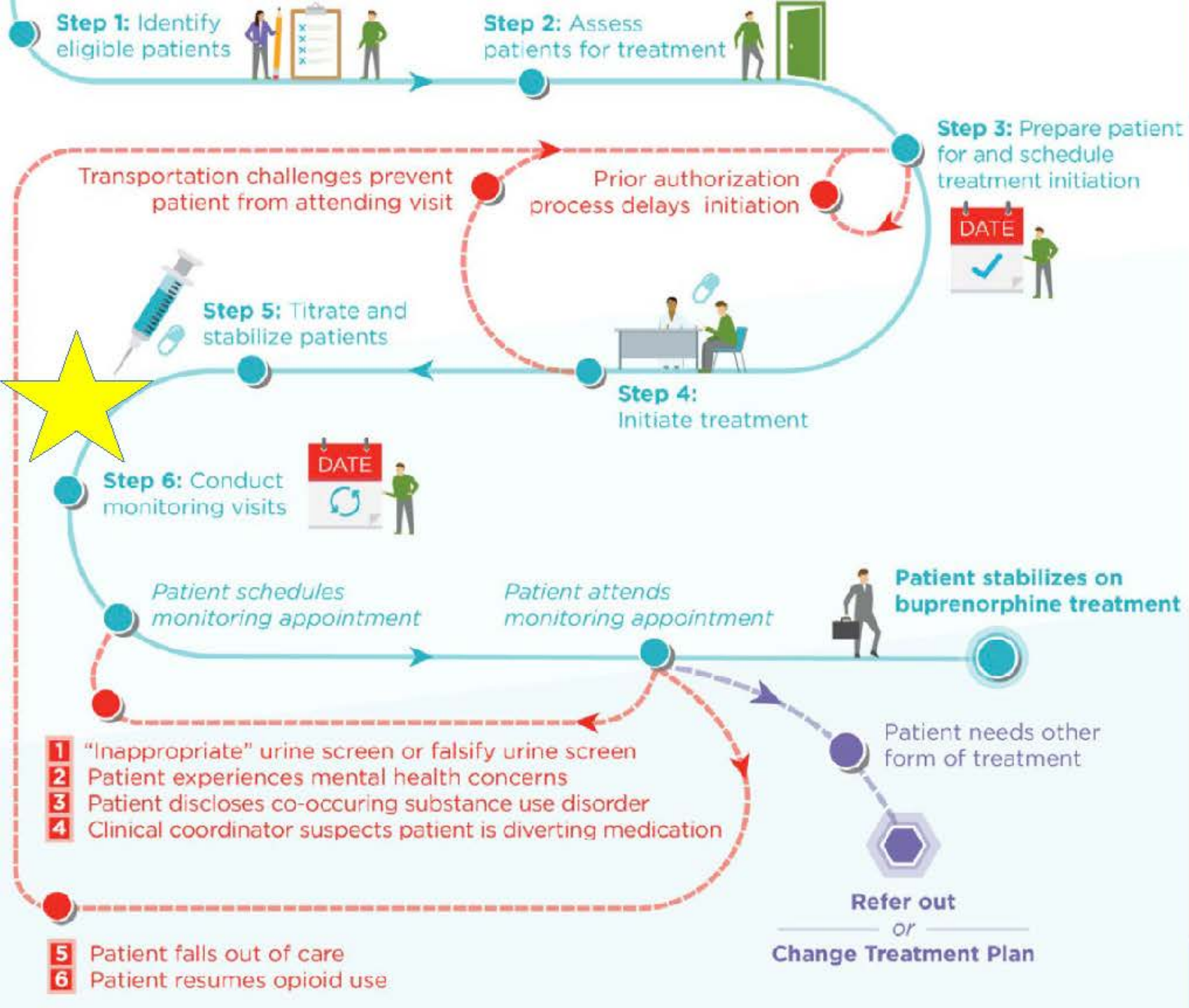
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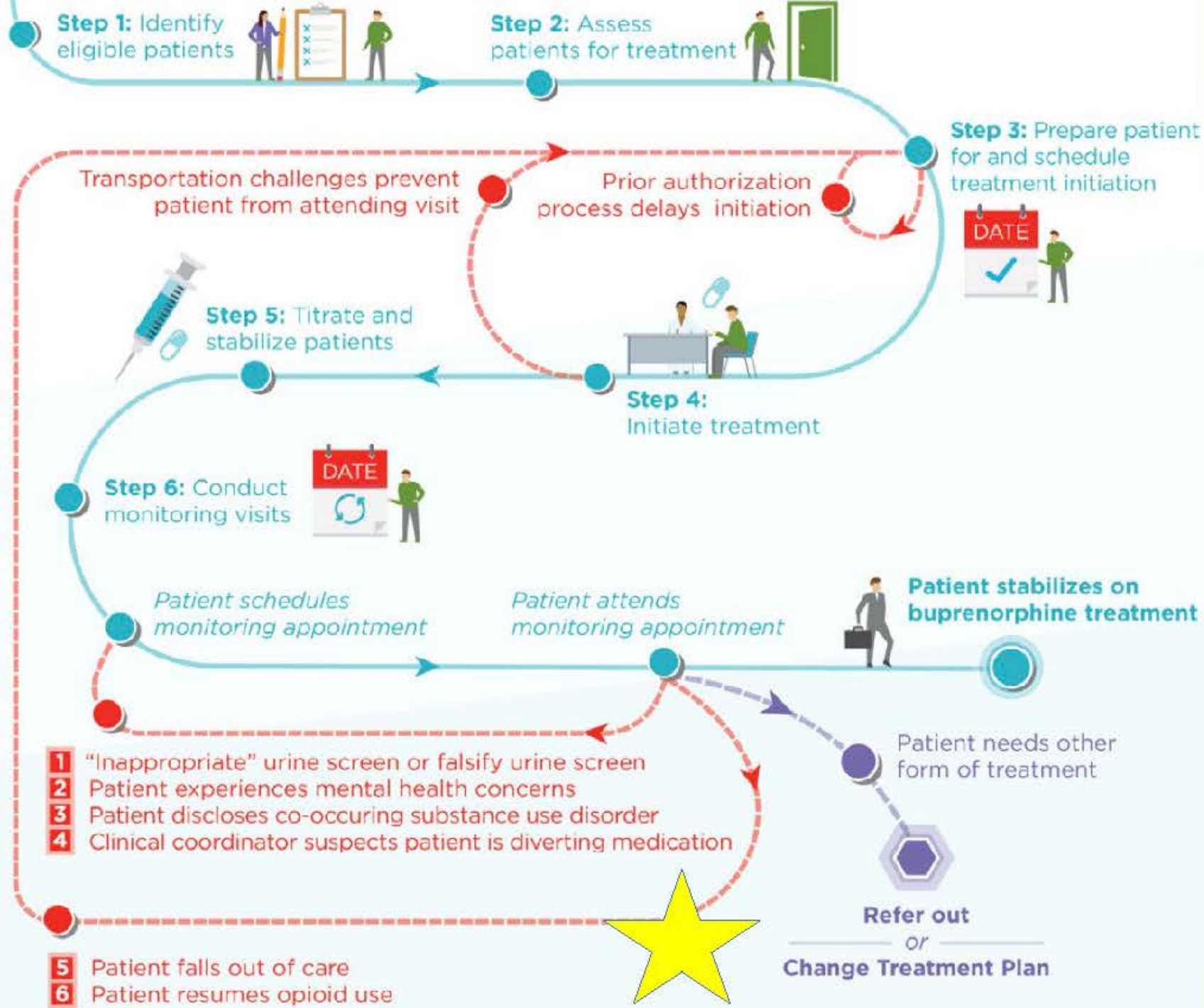
Monitoring Visits

- Clinical coordinator collaborates with patient to create a supportive recovery environment by:
  - Asking the patient if they have any cravings / signs of withdrawal
  - Asking the patient about how they are taking the medication (all at once, breaking it up?)
  - Conduct Tox screen (pain management panel and buprenorphine)
  - Review last Tox screen
  - Build recovery support system
  - Assess home environment
  - Identify medical / social needs that may jeopardize adherence
  - Address behavioral issues of opioid use disorder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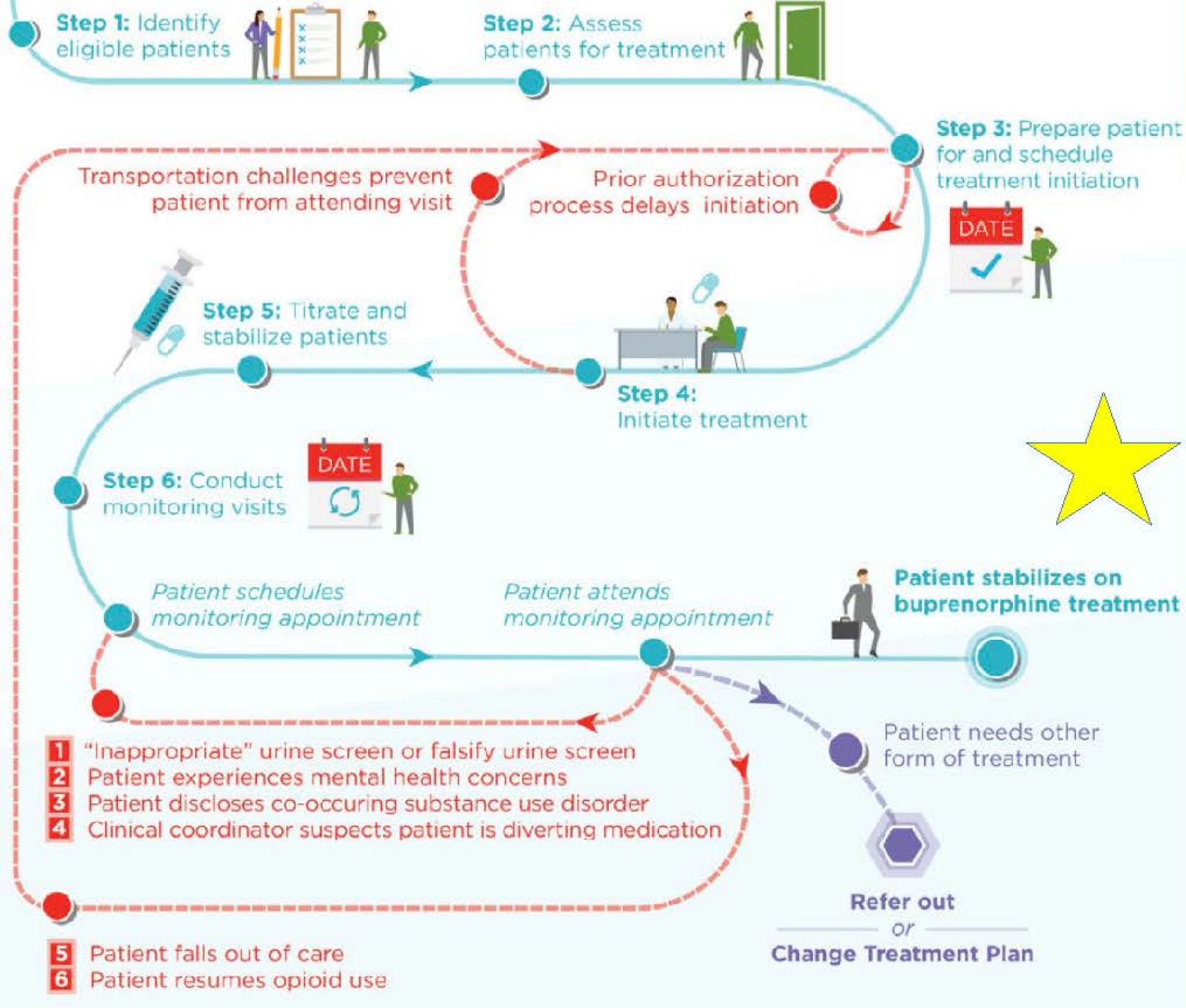
Patient Support Strategies

- Patient education & treatment agreements
- Requiring meetings, sponsor, treatment
- Building recovery skills
  - Prepare patient for taking buprenorphine as prescribed vs old use habits
  - People, places, things
- Determine timing of mental health support (when needed)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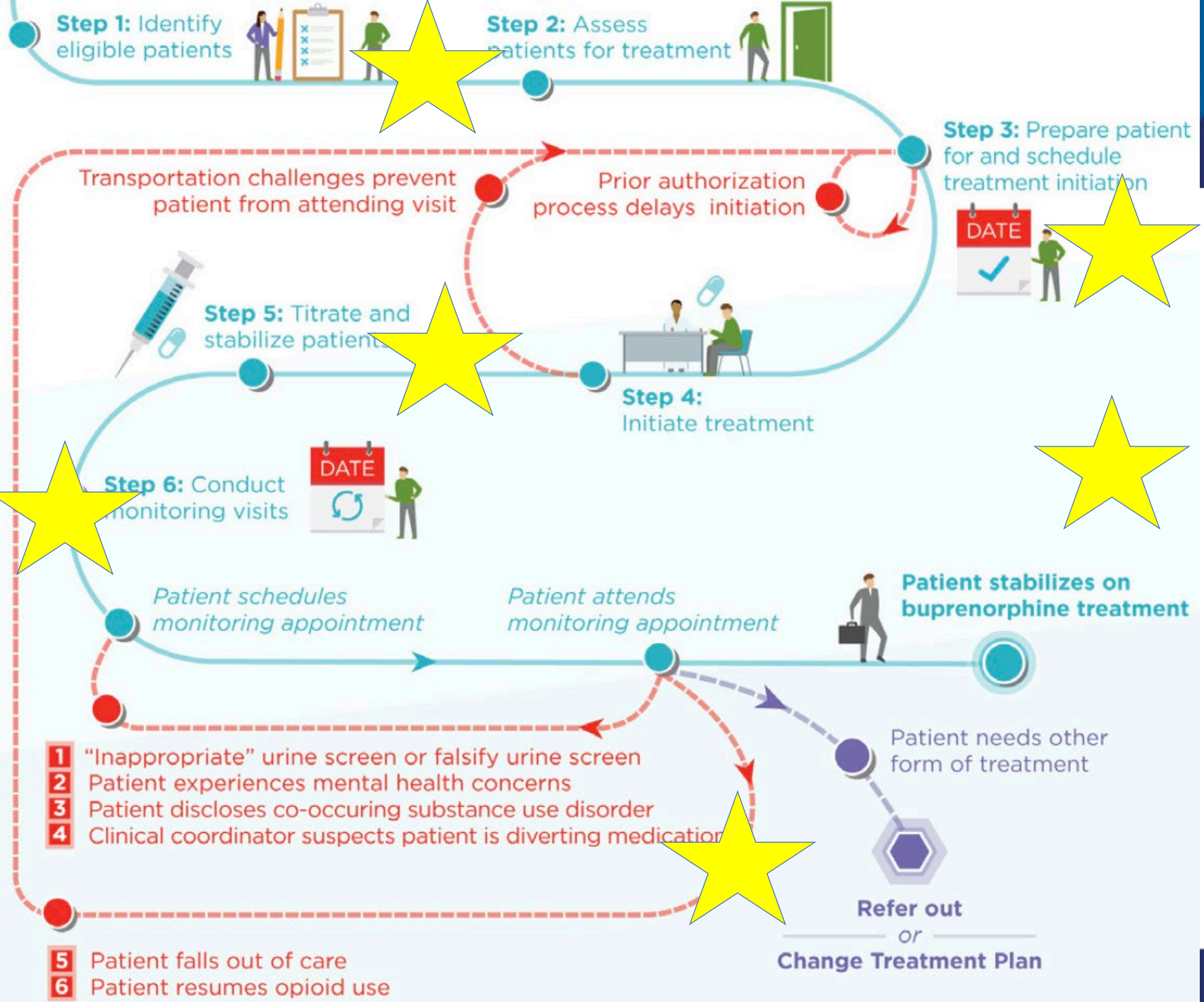

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Clinical Coordinators are involved at every phase of care!

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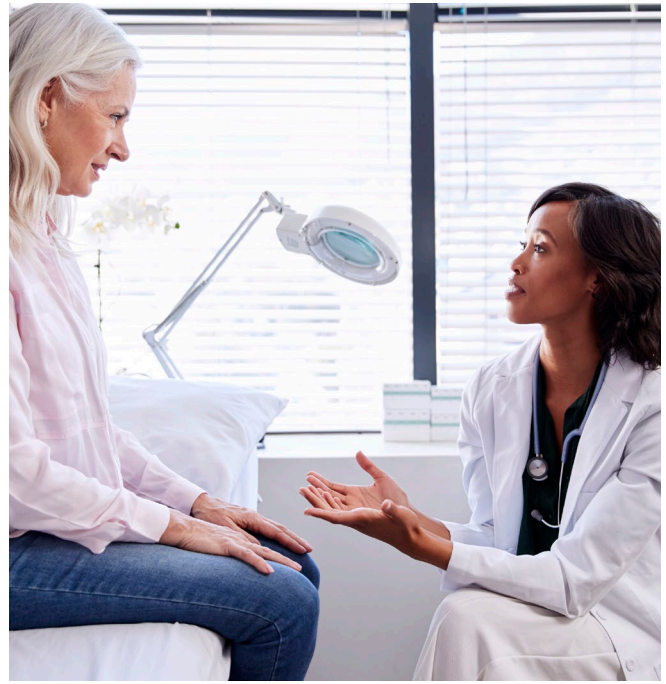
Lessons Learned Across the Buprenorphine Intervention

Client-load

- Dependent on provider and clinical coordinator capacity
- Many patients enrolled experienced high acuity, co-occurring substance use disorders, mental health concerns, and high levels of experienced stigma
- Patients with high acuity need more time and engagement with the clinic staff
  - More time spent with patients may impact clinic/provider schedules and space needed to conduct intervention activities.



The Landscape of MOUD is Consistently Changing

- Clinics need a champion/advocate to make sure they are “at the table” for conversations about expanding MOUD within their clinic/local area
  - Access to multiple forms of MOUD may be necessary as providers assess which treatment options may best facilitate their patients’ success.
  - Access to MOUD for people not living with HIV is a concern, as partners or family members’ opiate use can impact patients’ success.
- Buprenorphine formulations, prescriber guidance, and insurance coverage are changing

The Recovery and Treatment Process is Hard

- We are not a treatment program – we are an HIV clinic
- Patients can feel ready for MOUD, but are not
- Process is hard for patients and providers
  - On average, each individual patient received 23 encounters (range 1-160) with the clinical coordinator. Patient needs varied, and patients who needed more intensive case management and treatment support had up to 160 encounters with the clinical coordinator. The average encounter was 58 minutes (range 8-325 minutes), and addressed 5 needs (range 1-14 needs).

- But the rewards are key!!
  - Frequent contacts with patients, even if they struggle
  - Improved adherence to HIV meds
  - Viral Load suppression
  - Improved health outcomes

Recovery is possible!

- Patient: Oh, I've done a complete--what is it, what do they say, 180? Whatever. I completely turned around. I'm a completely different person now. I've gained... I'm seven months sober. I've gained 60 pounds. I'm not chasing drugs no more. I live pretty much a normal life now…My whole persona, my whole attitude, my whole everything has just completely changed. And it's nice when I hear it because a lot of people notice it, and it's noticed all the time now. It feels really good. And I know that if it wouldn't have been for them and their help and support and everything through all of this that I wouldn't be where I'm at today.

- Interviewer: Okay. And how would you describe yourself at that time? I mean, how did you see yourself at that time?

- Patient: Afflicted, with no desire to live…I said I was a nobody…But not now. I am a person now, I love myself.

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Resources & Next Steps

Care and Treatment Interventions (CATIs)

Care and Treatment Interventions (CATIs): Available in 2020

TargetHIV: The draft intervention manuals, final Training Manuals, project spotlight are available https://nextlevel.careacttarget.org/

Training and TA: Training and Technical Assistance on the intervention available through 2020; Email hbryant@aidsunited.org to learn more

Contact Information

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