



Public Health, Pharmacy and Behavioral Health Walk into a Club...

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Disclosures

- The funding for this project was made possible by the Tribal Opioid Response Grant #6H79TI081769 from the Substance Abuse and Mental Health Services Administration (SAMHSA). The views expressed in written materials or publications do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices or organizations imply endorsement by the U.S. Government.
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Learning Objectives

1. Describe the developmental and workflow processes used to build and enhance the capacity, collaboration and infrastructure across the health system and broader tribal systems involved.
2. Identify all elements of the Pharmacy Led Medication Assisted Treatment (MAT) service delivery model.
3. Identify the challenges and unknown bias as various components for applicability to your own tribal health and/or behavioral health systems.



Overview

- What, Why, Who, Where
- Strategic planning
- Collaboration and capacity
- Integrated care
- Pharmacy Based MAT Clinic
- Attitudes and Beliefs
- Challenges and future plans





What, Why, Who, Where

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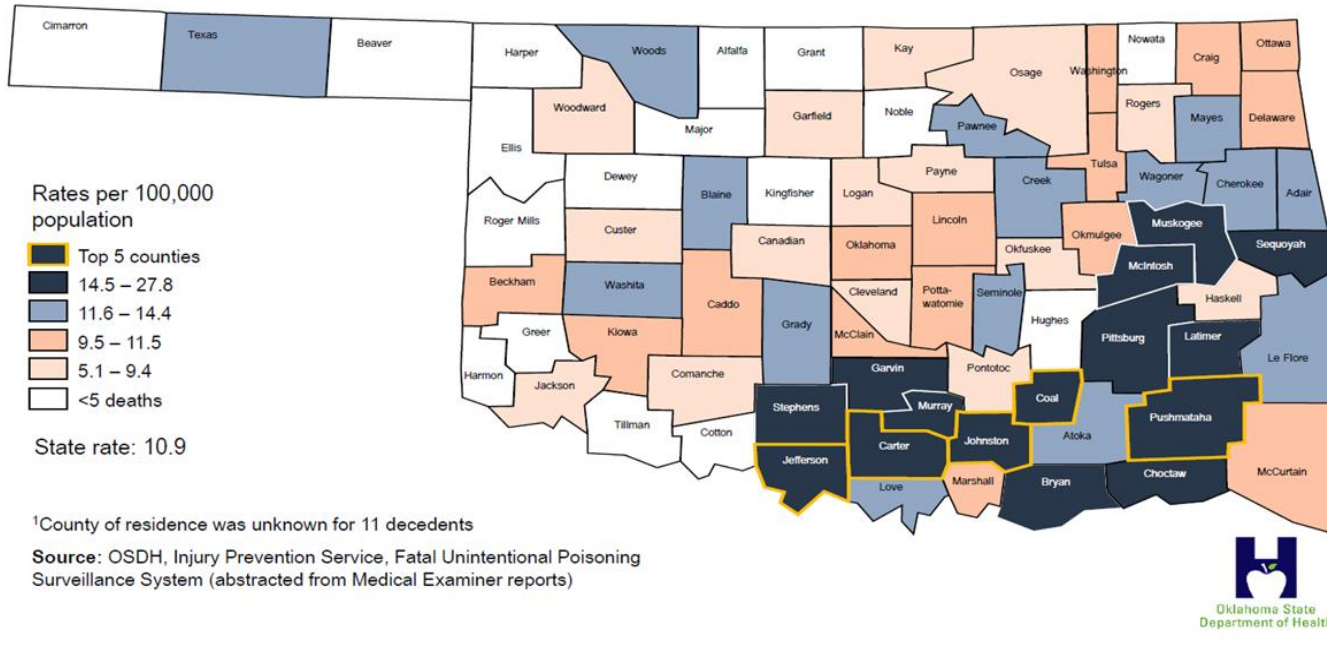
What's the Problem

- Since 2014, Oklahoma ranks in the top five for per capita for distribution of many common opioids
- In 2016, enough painkillers were prescribed in Oklahoma to give every adult 110 pills
- Not enough treatment beds or programs to meet the demand for Substance Use Disorder including Opioid Use Disorder
- With Oklahoma legislative changes the risk for illicit opioids and heroin use is on the rise



Why do we care?

Unintentional Poisoning Death Rates Involving at Least One Prescription Opioid by County of Residence¹, Oklahoma, 2012-2016

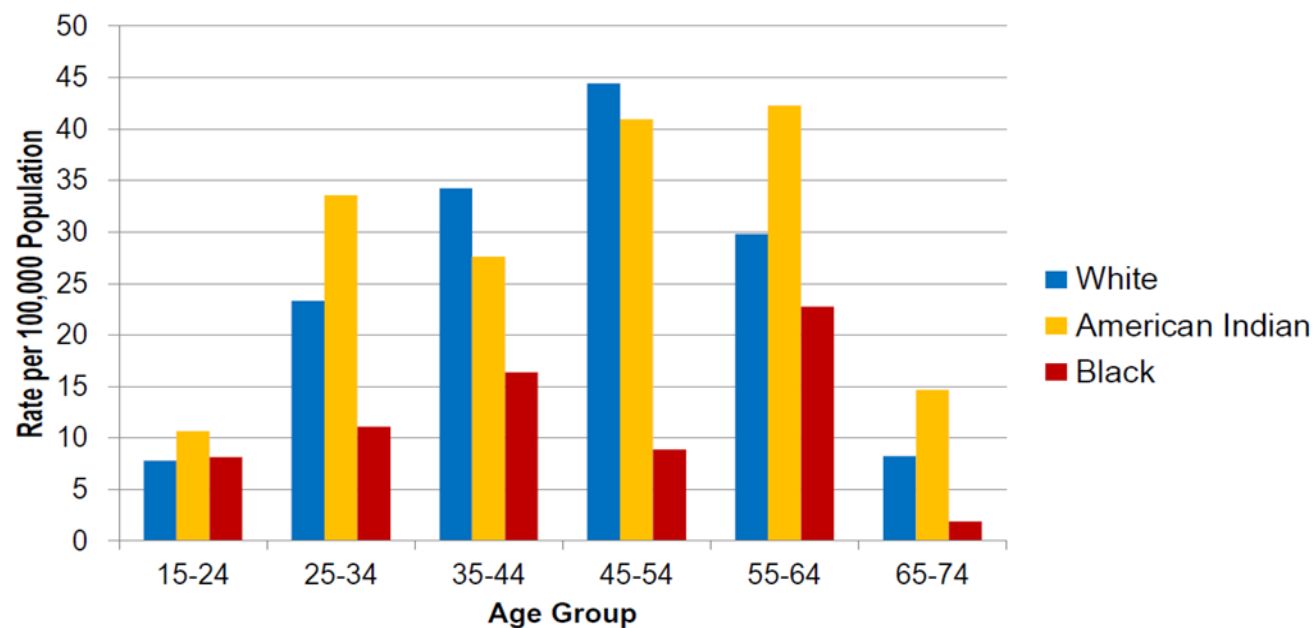


- 67% of accidental poisoning from prescription drugs
- Of those 64% Opioid; 18% Benzo
- 3 of the top five are Counties in the Chickasaw Nation



Who are we talking about?

Unintentional Prescription Opioid Overdose Death Rates by Age Group* and Race, Oklahoma, 2012-2016



*Decedents under age 15 and over age 74 were excluded due to small number of cases (<1% of all UP deaths)

Source: OSDH, Injury Prevention Service, Fatal Unintentional Poisoning Surveillance System (Abstracted from Medical Examiner reports)



Where are we?

HAVE

- Integrated care
- Outpatient mental health services
- Residential treatment
- Psychotherapy
- Support groups
- Drug court collaboration

HAVE NOT

- MAT options
- Rapid onboarding for mental health services
- DATA Waiver Providers (DWP)
- Screening process
- Unified Nomenclature
- Coordination of care for SUD patients





Strategic Planning

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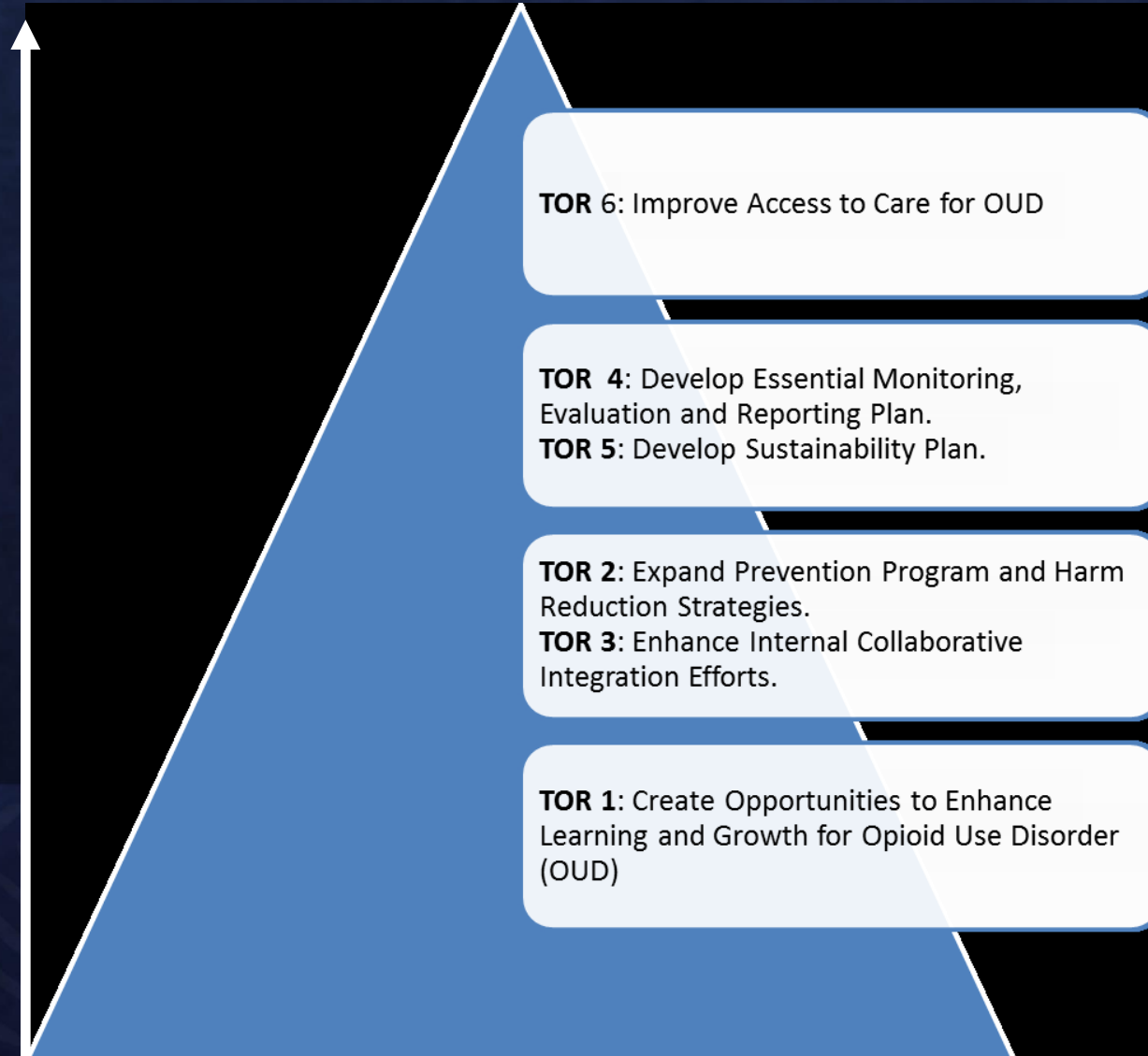
Setting the stage

‘One Tribe with One Mission’

- Leadership support
- Cross-departmental work group with key stakeholders
 - Consistent meetings
 - Open discussion of service gaps and opportunities
 - Aligned to improve communication
- Discussed collaborative efforts with multiple levels of care
- No wrong door



Strategic Plan





Integrated Care

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Medical Family Therapy (MedFT)

“The practice of MedFT spans a variety of clinical settings with a strong focus on the relationships of the patient and the collaboration between and among the healthcare providers, the patient and the patient’s family/support system.”

Tyndall, L.E.



Integrated Care

Integrated Care & Tribal Populations

- Realizing the perfect fit
- Bypasses seeking services separately
- Reduction of stigma
- High prevalence of MH concerns
Impact physical health & vice versa
- Addictions that affect health
- Shared record

“Medical family therapy is a form of professional practice that uses the biopsychosocial (BPSS) model and systemic family therapy principles in the collaborative treatment of individuals and families dealing with medical problems.”

McDaniel, Doherty, & Hepworth, 2014, p.5



Integrated Care

Biological

- Physical Health
- Disease
- Illness
- Wellness

Psychological

- Mental health
- Self esteem, self worth, self efficacy, etc.
- Depression/Anxiety most common

Biopsychosocial-Spiritual (BPSS)

Social/Relational

- Marriage
- Friendships
- Social support

Spiritual

- Relationship with God
- Values and priorities
- Sense of “something else”



MAT Workflow

How is Medical Family Therapy integrated into MAT programs?

- A. MedFT initiates screening and assessment for Opioid Use Disorder within the clinics.
- B. MedFT administers DAST-10 and Readiness Screeners.
- C. If screeners are positive and patient meets criteria, MedFT places referral to DWP.
- D. MedFT links appropriate services (primary care, recovery resources, follow-ups and clinical staffing).



Collaboration and Follow-Up

- **Brief MedFT follow ups after MAT appointments**
- **Team-based approach to health care**
- **Weekly huddles to staff cases and progress**
- **Continued assessment and linking to additional resources**



Mental Health Services

- **Integral to treatment**
 - **Psychoeducation**
 - **Supportive Therapy**
 - **Motivational Therapy**
 - **Psychotherapy**
 - **Support Groups**
- **Patient specific plan will be developed**
 - **Adjust as needed throughout treatment**
 - **Goal is to treat the WHOLE patient**





Pharmacy Based MAT Clinic

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Referral Process

- Primary Care/CNMC
 - Patient identified by provider and referred to MedFT and DWP
 - DWP refers to pharmacist
 - MedFT will also follow-up at initial MAT appointment
 - Pharmacist and therapist will update one another weekly
 - Pharmacist will tag DWP in notes for updates



Inclusion Criteria

- Patient must have documented diagnosis of Opioid Use Disorder
 - NOT for pain management
- MAT clinic is not suitable for polysubstance use
- Patient must be willing participant
 - Readiness for Change Assessment

*Suboxone® will be restricted to MAT clinic on CNDH formulary



Buprenorphine/Naloxone

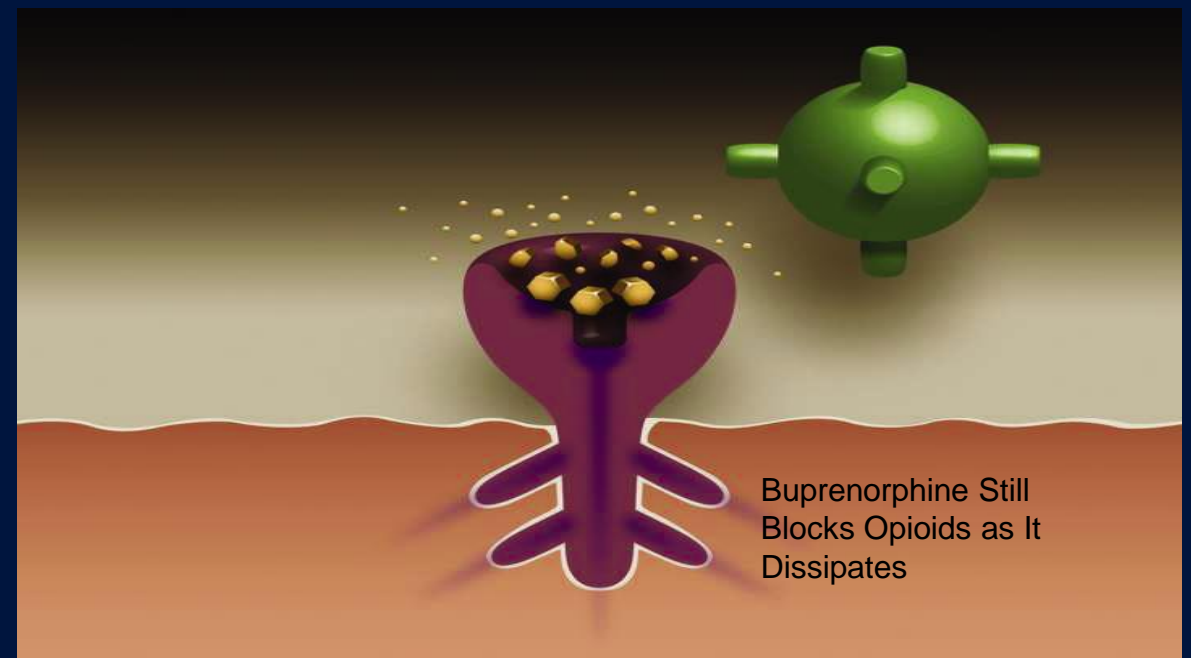
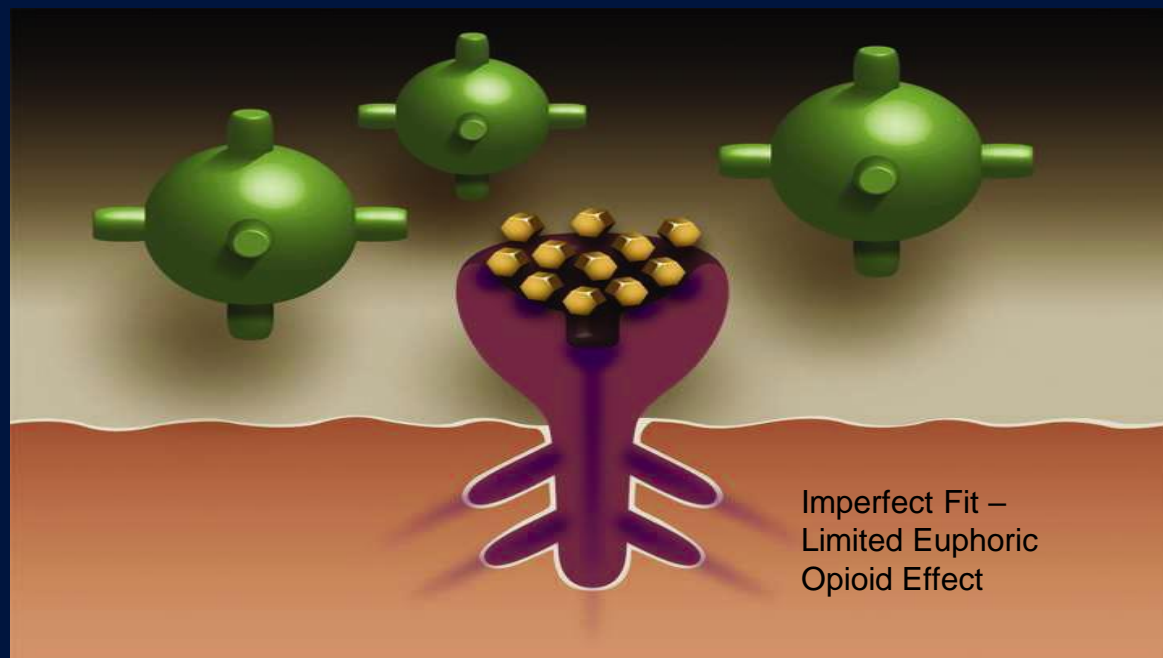
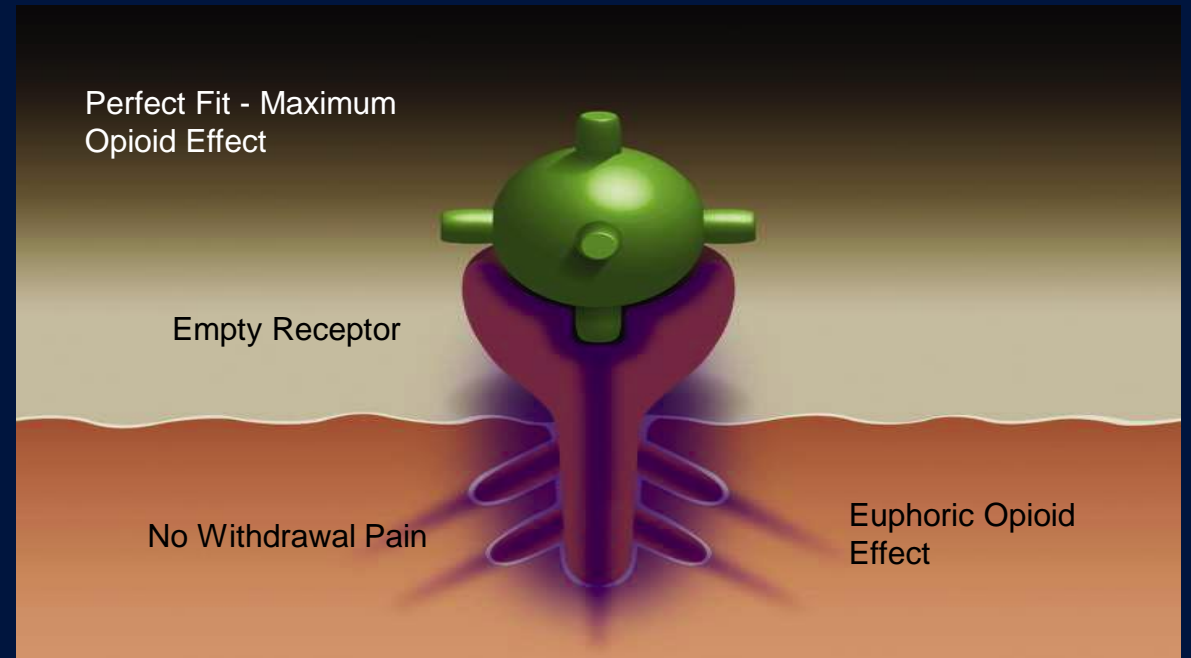
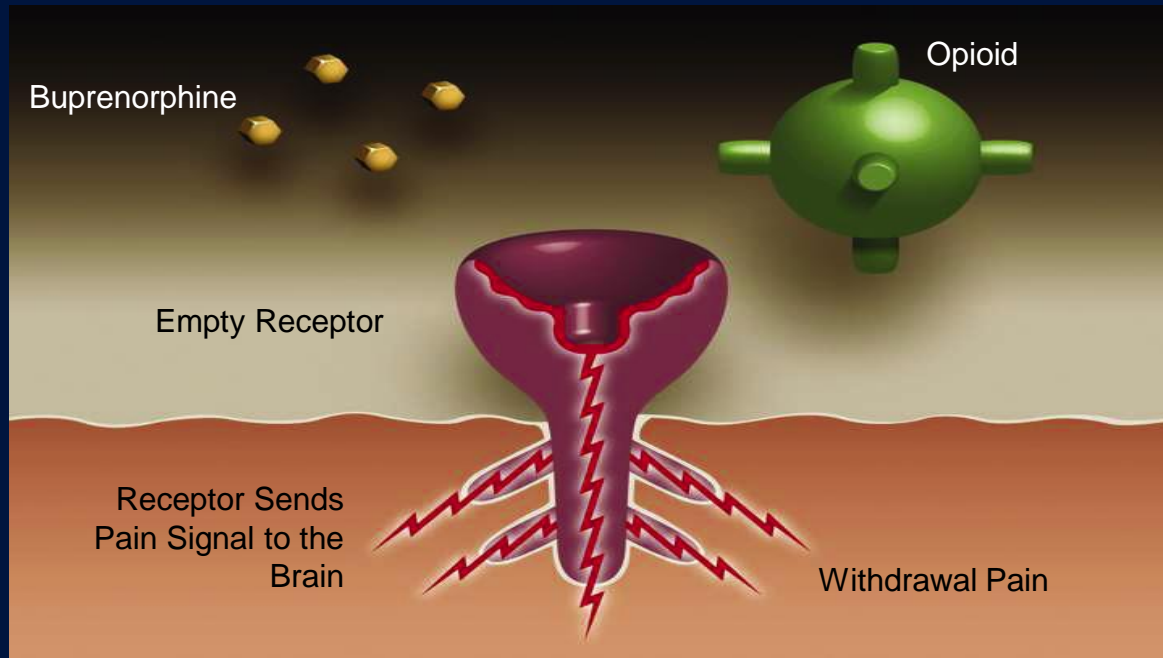
- Buprenorphine

- Mu-opioid receptor partial agonist
- Ceiling effect – no more benefit past a certain dose
- High affinity for opioid receptors
 - Will precipitate withdrawal if other opioids are present

- Naloxone

- Mu-opioid receptor antagonist
- Poor oral bioavailability
- Diversion deterrent





Buprenorphine/Naloxone

- Counseling points
 - May take five to 10 minutes to dissolve
 - Dissolves faster/easier if mouth is moist
 - Needs to dissolve completely before drinking
 - Avoid caffeine and smoking 15 to 30 minutes before dose



Buprenorphine/Naloxone

- Side effects
 - Withdrawal symptoms
 - Constipation
 - Headache
 - Nausea/vomiting
 - Anxiety



Medication-Assisted Treatment

- Four main stages:



Induction

- Patient must be in active withdrawal
- Patient must abstain from opioids for one to 7 days before induction can begin
 - Short-acting opioids usually 24 hours to withdrawal symptoms
 - Long-acting opioids can take up to five to 7 days to show withdrawal symptoms
- Clinical Opiate Withdrawal Scale (COWS)



APPENDIX 1

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/____:_____	
Reason for this assessment: _____	
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: over last 1/2 hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: over past 1/2 hour not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor observation of outstretched hands 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for roomlight 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<div style="text-align: right;">Total Score _____</div> <div style="text-align: center;">The total score is the sum of all 11 items</div> Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.



Induction

- Patient is started on buprenorphine/naloxone and tapered over several days
- Patient may begin other withdrawal symptom medications as needed
 - Acetaminophen
 - Nausea medications
- Follow-up scheduled every one to three days
- Mental health and social services initiated, based on patient need
- Patients advised to abstain from all substances



Stabilization

- Patient further titrated to personalized dose over two to three weeks
- Follow-up scheduled every one to two weeks
- Withdrawal symptoms medications may be continued if needed
- Drug screens may be performed at each visit
- Mental health services continued
- Patients advised to abstain from all substances



Maintenance

- Patient will continue on dose that was established during stabilization
- Follow-up scheduled every two to four weeks
- Drug screens may be performed at each visit
- Longest period of treatment, will last approximately 6 to 9 months
- Mental health services will be continued
- Patients advised to abstain from all substances



Taper

- Taper will begin when patient and treatment team agree patient is ready
- Slow taper, decrease by 2mg/0.5mg from previous total daily dose per time period
- Decrease dose every two to four weeks, at scheduled follow-up appointments
- Mental health services will be continued
- Patients advised to abstain from all substances



Lab Considerations

- Urine drug screen
 - Specific for buprenorphine/norbuprenorphine
 - Positive screen results require further testing for verification
 - Gas Chromatography-Mass Spectrometry (GC-MS)
 - Implemented organization wide





Attitudes and Beliefs

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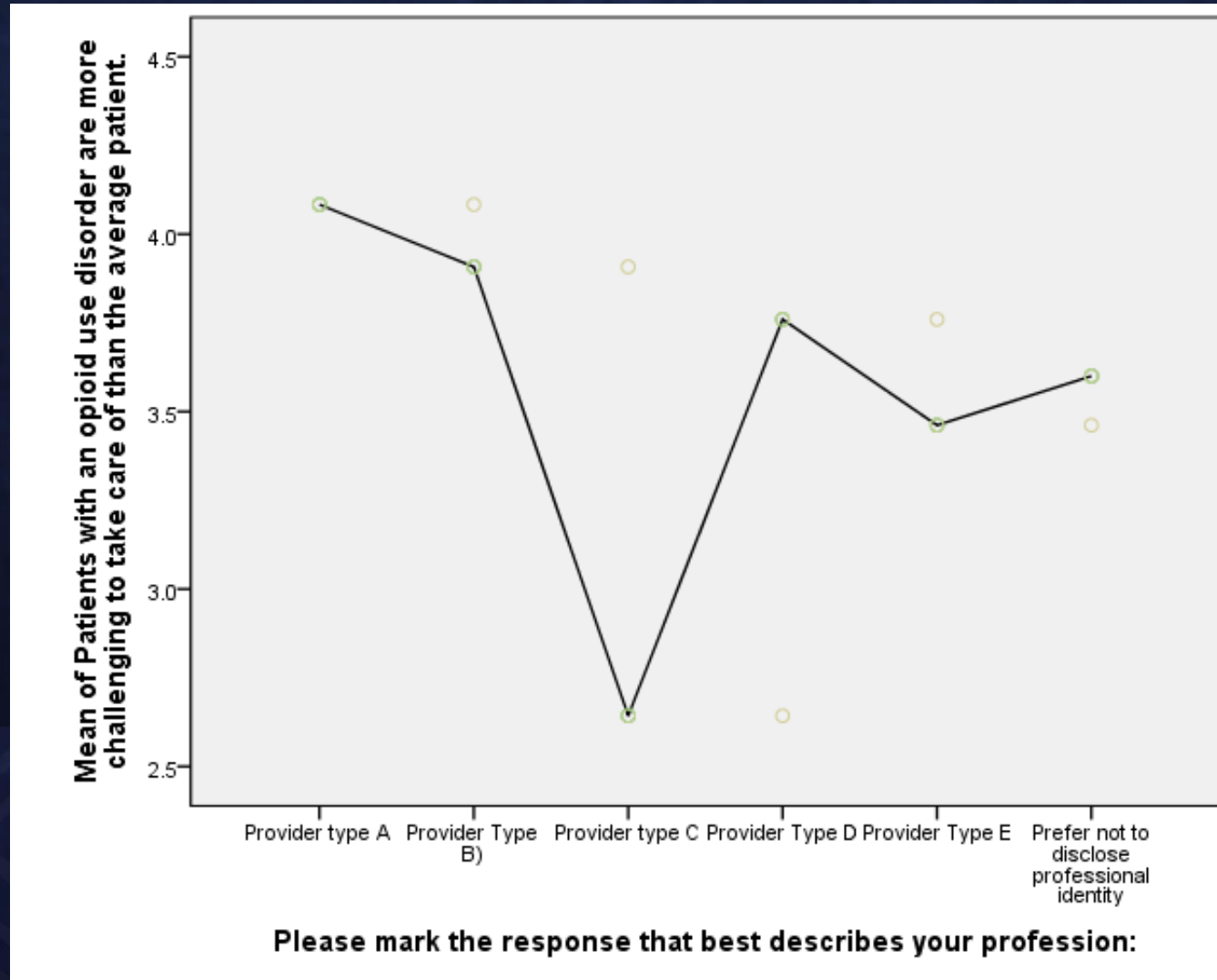
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We are understanding that team members are in very different places re: treating OUD (see handout).

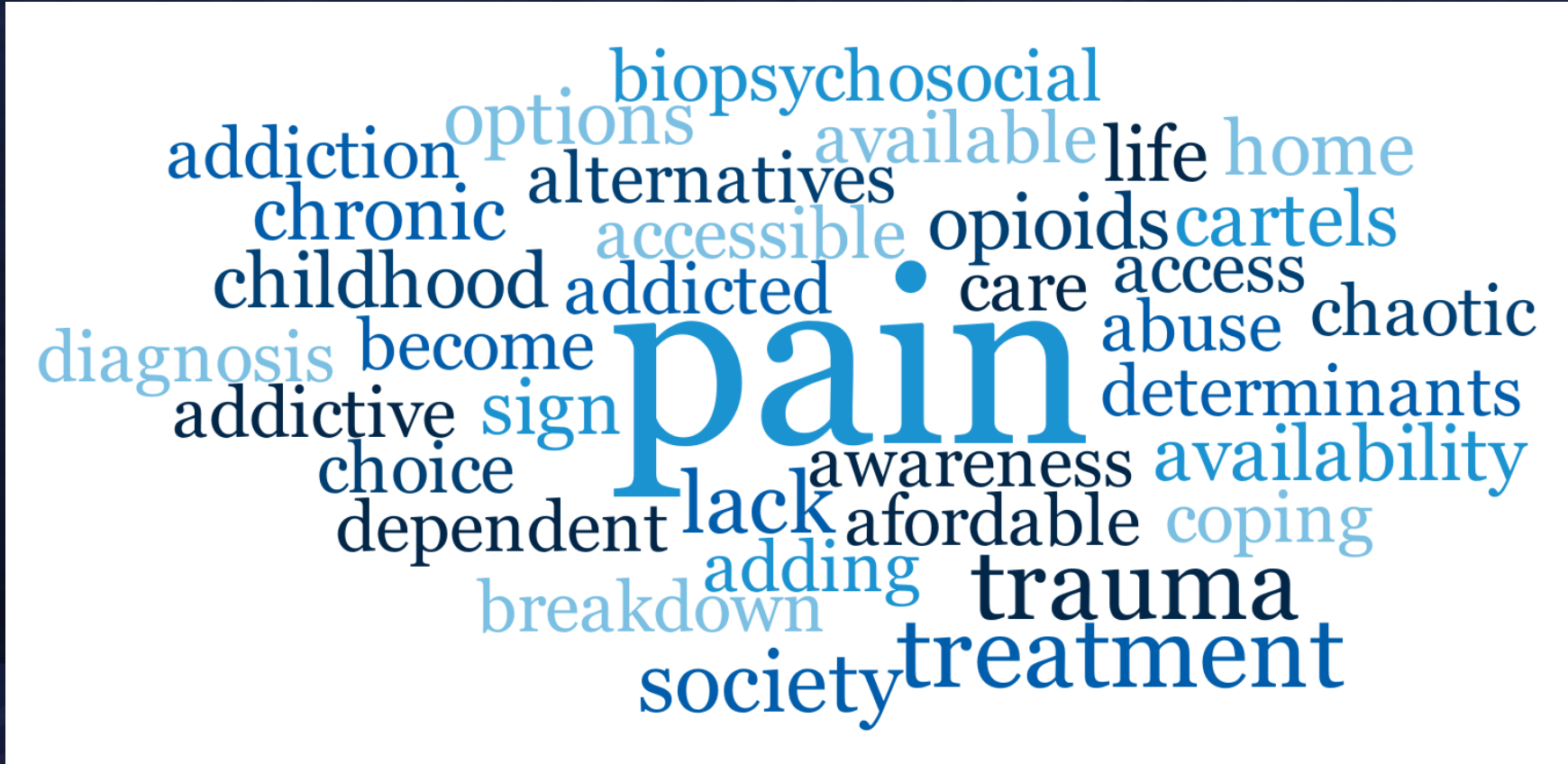


We are learning about what our providers need, or need to learn...

“I need expanded clinic time for these patients when discussing/initiating treatment.”

“I need to learn how to better gauge real pain from medication induced pain; also about treatment support.”

Other Factors





Challenges and Future Plans

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Challenges and What the Future Holds

- Education -buy-in and bias
- ASAM Levels of Care/treatment community supports.
- Finding and cultivating new prevention partners
- Naloxone hesitancy
- 42 CFR Part 2
- Expansion capability and sustainability



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Questions





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