WISAM Newsletter: Teleconference Minutes
June 23, 2016

Moderator: Aleksandra Zgierska (WISAM President; Madison)

Present: Joe Blustein (Madison), Nameeta Dookeran (Oconomowoc, Chair of WISAM's Education and Program Committee), Michelle Bensen (Minocqua), Matthew Felgus (Madison, WISAM's Vice-President), Subhadeep Barman (currently still in Maine, moving soon to Waukesha, WI), Mary Anne Kowol (Milwaukee), Agron Ismaili (Oak Creek)

Main topics addressed at tonight's teleconference:

Treating patients with Vivitrol® (or Probuphine®) outside of "medical practice" settings – how to do it…?

It is challenging to administer injections or place an implant in the settings of a psychiatry or counseling practice, a non-medical office without nursing. How can one successfully do it..?

Dr. Zgierska discussed the example of Sauk County's initiative, which, with the grass-roots support of diverse community-based stakeholders, re-structured the existing resources to facilitate medication-assisted treatment (MAT) for opioid dependence. They engaged, motivated and trained primary care providers to provide MAT – including Vivitrol® - while the behavioral AODA programs provide counseling and case management. They implemented Vivitrol® in correctional settings, offering it to all opioid-dependent individuals, who completed at least 7 days of opioid withdrawal, who are "eligible" for it (cleared by the jail physician) and agree to it, prior to the release back to community where AODA and primary care / specialty providers take over.

Considering this approach, it might be reasonable and feasible (yet a slow process) to develop working relationships with primary care providers who are the PCP for a given patient, so that the PCP provides Vivitrol®, while the psychiatrist / counselor, provide psychotherapy.

Dr. Zgierska also mentioned that she has not had problems with insurance coverage for Vivitrol® in general (which is not a uniform experience of other clinicians); however, Unity requires a PA and stipulates the patient first needs to fail an oral naltrexone. Reimbursement for Vivitrol® comes from medical benefits, with charges placed for both the medication and the injection itself (in addition to an office visit charges). Engaging PCPs may be a great way to substantially expand the base of providers who are comfortable doing it; it often takes just one provider in a clinic, for others to become comfortable with Vivitrol® injections to administer them to patients and cross-cover for each other.

Changing (increasing) level of care for patients who are not doing well in the current settings.

Transferring the patient to a higher level of care is challenging. It is often hard to convince patients that they need to intensify care, e.g., go for a daily treatment at the methadone/suboxone federally-funded programs. It is hard to establish when to draw the line, as each patient's circumstances are individual and should be considered individually.

Overall, it is difficult to decide when to make a big change; while some clinicians said they have become more "forgiving" over the years, and try to intensify treatment within their own resources (e.g., seeing the patient more frequently, such as weekly), others said that over time they have become more prone to "cut" patients lose earlier than before, if they do not make progress. Introducing early on (and sticking to) some level of accountability can help; establishing at the outset what the rules (contingencies) are, and writing them up is used by some. If the patient is not making progress, framing the conversation in the context of "I'm not really helping you," while discussing transfer to a more intensive level of care, can also be useful. Diverting medications is usually a reason for discharge.

Clinicians described mixed experiences with the methadone maintenance programs, which often have long waiting lists before the patient is assessed by the physician and able to start MAT. Dr. Zgierska described a change in the ability to use so called "courtesy dosing" forms. She and Dr. Blustein (who at that time directed Madison Health Services) successfully used such forms for patients who needed a transfer from Dr. Zgierska's primary care based MAT to the MHS settings. After the form was filled out and taken to the MHS clinic, the clinic's staff would enter the info, checked and established the insurance coverage vs out of pocket costs, then within 1-2 days started dosing the patient daily with the dose specified by Dr. Zgierska. This scenario would continue until the patient was able to see Dr. Blustein who would then take over the patient's care (the courtesy doing was completed). Unfortunately, per experience with her recent patient, Dr. Zgierska was told that courtesy doing is not honored now unless the patient is transferred from a different federally-funded program. Should the referral pathways be simplified and courtesy dosing re-instated, it could significantly help with encouraging clinicians to engage in addiction care, knowing that, if the patient needs a higher level of care, there are easy and swift processes to make it happen – both for patient safety and sustainability of PCP-delivered care.

While discussing the federally-funded programs, Dr. Blustein mentioned that the state maintains the list of such programs. If the patient is admitted to the hospital or the ED, and his/her methadone or suboxone maintenance dose needs to be confirmed, there is a number to call after hours to verify the dose. The state opioid authority, Elizabeth Collier (ph. 608-267-7707; Elizabeth.Collier@dhs.wisconsin.gov), should have this information. She is also the contact person for questions re: agonist maintenance.

Generally, the participating clinicians agreed that, if the patient is doing well and well-established in a long-term recovery, they do not force their patients to taper off Suboxone without the patient's buy-in and willingness.

The question was raised whether there is a central list of resources available for the treatment of addictive disorders in Wisconsin.

Participating clinicians agreed it'd be good to have access to such a list, but there are many differences between counties / regions in WI in how treatment is delivered and covered that even having county-level list of resources would be a good starting point. As a part of the Sauk County initiative, they created a single-entry referral structure. They contracted with Tellurian to provide on-call AODA counselors; the region was divided into 4 sections, staffed by separate counselors. The patient can now simply call one number and access the information about best treatment options. This has simplified referral –police officers, clinicians, clergy, etc, can now simply give a small wallet-size card with one phone number for patients to call. Citizens started approached police officers at the station and on the street asking for treatment info.
Dr. Bensen mentioned that they recently put together a list of regional resources (Hope Consortium: http://www.rivernewsonline.com/main.asp?SectionID=6&SubSectionID=59&ArticleID=71352).

Implantable buprenorphine (Probuphine®).
At the end of the teleconference, the discussion shifted toward implantable buprenorphine. Dr. Bahrman just completed training in implanting it. The recommendations describe it as a product for patients who are stable in recovery and treated with not more than 8mg buprenorphine per day. It is not clear whether it'd be appropriate for patients treated with a low daily dose of buprenorphine (would the implant deliver too much medication – more than they need..?). There is only one dose / preparation of Probuphine®. It seems that it will be 'routinely' covered 1-2 times per patient (each implant costs ~ $5,000 and lasts for 6 months).

Teleconference adjourned at 8:12 PM.

The next WISAM Teleconference will take place on Thursday, October 27, 2016, 7-8 PM.

The monthly teleconferences will break for summer (no teleconferences in July or August); we will not hold it in September as well as we can meet at the WISAM Annual Conference.)

Please let Cindy Burzinski, WISAM's Executive Administrator, know if you have suggestions for topics to discuss at the upcoming teleconferences, or if there are any errors in the current document: Cindy.Burzinski@fammed.wisc.edu

WISAM 2016 Annual Conference, Sept 29-30, Madison, WI, Pyle Center
Post-Conference Workshops, Oct 1, 2016, Madison, WI, Pyle Center

The conference, open to WISAM members and non-members, is scheduled for **Thursday September 29 – Friday September 30, 2016**. We will also hold two post-conference workshops on **Saturday, October 1, 2016**: *Scope of Pain* on safe and competent opioid prescribing, sponsored by Boston University; and the ASAM's Buprenorphine Certification training for physicians. The conference brochure will be emailed out shortly.

Please remember to **renew your ASAM / WISAM membership** or consider becoming a member. More details can be found at: http://www.asam.org/membership

Existing available resources to enhance clinical care related to addiction medicine:

FREE Provider's Clinical Support System (PCSS) for Medication-Assisted Treatments (PCSS-MAT: http://pcssmat.org) and Opioid Prescribing (PCSS-O: http://pcss-o.org): excellent free resource, funded by a grant from SAMHSA; it offers free webinars available "real-time" or via the archived library. One can sign up for regular news emails from them.

FREE David Mee-Lee's monthly Tips and Topics, sent via email (one needs to sign-up to it), it is an excellent resource:
dmeelee@changecompanies.net
http://www.changecompanies.net

FREE Join Together Daily News is a news service from the Partnership for Drug-Free Kids that provides daily or breaking news on the top substance abuse and addiction news that impacts our work, life and community. It also provides original reporting and/or commentary features published every Wednesday by influential thought leaders in the addiction field or staff.
http://www.drugfree.org/join-together/

PAID The Carlat Report: Addiction Medicine (however, it appears to be a paid resource, ~$109/year); a link to the copy of the recent report is attached so that you can get a flavor of what it is: http://carlataddictiontreatment.com/sites/default/files/CATR_May2016.pdf