Pediatric primary care could be key to solving teen opioid crisis

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A new primary care pediatric practice model designed to treat teens with substance-use disorder is showing promise, even as a disturbing new federal report finds that drug-overdose deaths increased in 2015 among U.S. adolescents aged 15–19.

The opioid-related drug-overdose death rate of 15- to 19-year-olds rose from 0.8 per 100,000 in 1999 to 2.7 in 2007. Then the rate fell to 2.0 between 2012 and 2014 before rising to 2.4 by 2015, said a data brief recently released by the Centers for Disease Control and Prevention's National Center for Health Statistics.

The nation's health system is struggling to cope with the toll of substance-use disorder as there are too few pediatric or adolescent medicine physicians specializing in addiction medicine and too few inpatient treatment beds, according to Sharon Levy, MD. She is director of the Adolescent Substance Abuse Program at Boston Children's Hospital and represents the American Academy of Pediatrics (AAP) membership on the AMA Opioid Task Force.

One solution that is starting to gain momentum is integrating treatment programs into pediatric primary care, Dr. Levy said in an interview with *AMA Wire*® and, previously, in an essay she co-wrote for *The Lancet*.

"Dramatic rethinking" in pediatrics

"Addressing the opioid crisis will require innovative strategies, including some that should prompt dramatic rethinking of the role and training of pediatric generalists," Dr. Levy and her colleagues wrote. "With its neurobiological, molecular and genetic aspects, addiction is a disorder that falls squarely into the set of common conditions in which pediatric providers should have competency. It is incumbent on providers who care for young people to do their part to address the opioid crisis before

more young lives are lost."

A major component of Dr. Levy's primary care strategy includes medication-assisted treatment (MAT) and having prescribers in a practice undergo the eight-hour training course that is required by the Drug Enforcement Administration (DEA) before a health professional can prescribe or dispense buprenorphine. (Find education resources at the AMA Opioid Task Force website.)

Since it is often hard to find a substance-use counselor to refer patients to, another component is to have a licensed independent clinical social worker on site in the practice. And while the social worker can maintain independence for billing purposes, that professional's work is fully integrated into the practice.

Dr. Levy explained that the idea is not to co-locate a social worker in the practice who then sees patients in parallel to the rest of the staff, but to create a "practice-wide multidisciplinary effort" and "a complete ecosystem for substance-use disorder in pediatric primary care" with everyone on board—including nursing, support and administrative staff.

"It's fully integrated and everyone holds a piece of the puzzle," she said.

This approach is being piloted at Wareham Pediatric Associates (WPA) in southeast Massachusetts. The pilot is a partnership between the Pediatric Physicians' Organization at Children's (PPOC), a network of 90-plus independent practices of which WPA is a member, and the Adolescent Substance Abuse Program at Boston Children's. In January, the model will be expanded to a second practice in the PPOC network.

The pilot is supported by a Blue Cross Blue Shield of Massachusetts Foundation grant. Dr. Levy noted that the support services that she and her colleagues provide do not fall into traditional billing systems, but she believes these types of programs are well tailored for medical home and accountable care organization models of care.

"This is what the architects of those systems were thinking of," she said. "This is exactly in the bull's-eye."

As part of the grant, the team is developing a procedure manual for others to follow when developing the program for their own practices.

"You can't just walk in and open this thing," Dr. Levy said. Preparation activities the Wareham practice undertook included buprenorphine waiver training, staff orientation on the treatment model, educating staff on confidentiality issues, creating a nurse triage guide including advice on handling telephone inquiries andbuilding a local referral network for patients who need more intensive or additional services. A substantial amount of effort has also been required to advertise the services in order to

encourage youth with opioid-use disorders to seek treatment. .

That said, the AAP and Dr. Levy's group are receiving an increasing number of requests to teach the buprenorphine waiver training course, including from practices in New York, Washington and other parts of Massachusetts. Keys to this growth include raising awareness that the practice model can be effective and removing the stigma attached to treating patients with substance-use disorders.

Removing "all flavors" of stigma

"Stigma comes in all flavors," she said, explaining that this includes those with a "not in my back yard" attitude toward treatment. But more pervasive is a stigma created by what she calls the "unintended consequences of well-intentioned regulations" that result in barriers to treatment. This includes the requirements for DEA waiver training for buprenorphine prescribing.

"It results in folks thinking, 'This must be hard to do,' or 'It must be too complicated,'" Dr. Levy said. "But pediatricians take on other challenging patient issues with large psycho-social components all the time."

Medical decision-making with buprenorphine is "relatively simple," she added. "The risk of overdose or other complications is low and there are few medications, other than other sedatives, that are contraindicated in combination."

Regulatory barriers came into play when the Wareham practice had to pay the cost for their patient's initial buprenorphine prescription. The second patient in the program is a Medicaid enrollee, but Medicaid wouldn't pay for his medication because the physician who wrote the prescription hadn't filed his DEA waiver number with the proper authorities.

"It wasn't that the pharmacy wouldn't fill the prescription, but that Medicaid wouldn't pay for it," Dr. Levy said. In the meantime, the patient—who couldn't afford to pay for the drug himself—was starting to have withdrawal symptoms, so the practice used its own money to get the patient started on his medication that day.

"Those types of barriers are challenging," she said. "There is a lot of room for advocacy in this field."

Patrice A. Harris, MD, immediate past chair of the Board of Trustees and chair of the AMA Opioid Task Force, lauded "the complicated, essential work being done by Dr. Levy, her colleagues and their stakeholder partners." She said it "demonstrates how we must all work together to reverse this epidemic."

"Children and young adults with substance-use disorders can be treated successfully, and we all

could learn a few things from Dr. Levy's leadership to help her patients overcome stigma and lead successful lives," Dr. Harris added.

The AMA offers online CME to expand your understanding of the opioid epidemic. Explore educational content such as "A Primer on the Opioid Morbidity and Mortality Crisis: What Every Prescriber Should Know."

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