Multidisciplinary Management of Substance Use Disorder in People Living with HIV treated in a Medical Home Model of Care

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Background

- People living with Human Immunodeficiency Virus (HIV) commonly suffer from concurrent substance use disorder (SUD)
- Shortage of behavioral health providers in Wisconsin[1]
- Collaborative care models between physicians and pharmacists have been successful for opioid-dependent patients[2]
- Gap in access to SUD treatment creates an opportunity for new SUD CPA for pharmacists

Primary Objective

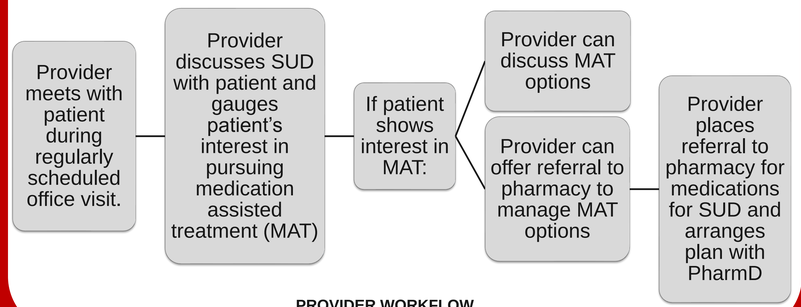
- Determine how a pharmacist CPA for SUD can be implemented into the workflow of a PCMH

Secondary Objectives

- Evaluate the association between the new service and the impact on:
  - Self-reported substance use rates via the AUDIT and TAPS screening tools
  - Interdisciplinary appointment attendance
  - HIV viral load

Methods/Results

Phase One: Concept Development



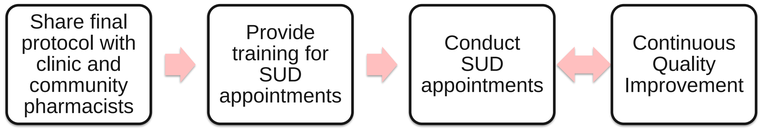
PROVIDER WORKFLOW

Results

Phase One: Concept Development

CLINIC PHARMACIST WORKFLOW

Phase Two: Implementation and Continuous Quality Improvement



7 patients referred	4 intake appointments	6 follow-up appointments	4 patients removed from service
• 3 out of 10 providers used service	• SUD: heroin, alcohol, cocaine, marijuana, prescription opioids • MAT selected: naltrexone po, naltrexone IM, bup/naloxone	• Data from 2 patients • No 3-month follow-up data available	• 1 death • 1 opted out of service • 1 referred to unaffiliated drug treatment program • 1 lost to follow-up

Average Stakeholder Survey Results

Discussion

Strengths	Weaknesses	Opportunities	Threats
Successful implementation within 6 months of conceptualization	Lab and medication storage coordination	Prospective review	Stakeholder awareness
Novel service	Loss to follow-up	Suboxone service	Lab and medication storage coordination
Financial incentive	Poor timing of marketing	Rapid UDS	Transportation barriers
	Non-optimized timing of secondary objectives	Telemedicine visits	COVID-19
		AODA coordination	
		Contingency management service	

Conclusion

Results from the initial patient referrals and stakeholder survey indicate that integrating the pharmacist into the PCMH team for collaborative SUD treatment has been effectively implemented. As more patients are referred, efforts will be focused on optimization of workflow and integration as well as expansion of services.

References

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2. Dipaula BA, Menachery E. Physician–pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients. *Journal of the American Pharmacists Association*. 2015;55(2):187-192. doi:10.1331/japha.2015.14177.

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