An Interview With Constance M. Flynn, MS, ANP-BC, FNP-BC, CARN-AP

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It was such an honor to interview Constance Flynn, an advanced practice nurse, who in her advanced practice role, is not only impacting the treatment of patients with substance use disorders within a community in Massachusetts but also showing leadership in advocating for change in the local policy arena. She was also one of the first nurses in her local hospital to seek a waiver to prescribe buprenorphine. This waiver became a possibility in 2017 with the passage of the Comprehensive Addiction Recovery Act of 2016 (Fornili & Fogger, 2017). Ms. Flynn has been instrumental in the implementation of an innovative team approach in addressing substance use disorders within a health care system. Her Doctor of Nursing Practice (DNP) work on hepatitis has included the development of a coalition resulting in innovative approaches to address Hepatitis C screening and treatment within her community. The changes described are having an impact on the health of her community, achieved through her leadership and advocacy.

As you reflect back on your nursing career, what led to your interest in substance use disorders?

I started my career in medical surgical nursing and critical care and managing a critical care unit. This was followed by 26 years as a nurse educator in an Associate Degree nursing program. During my teaching career, I taught both medical surgical and mental health nursing and spent time with students on the addictions unit. I returned to school 8 years ago to become an adult/gerontology nurse practitioner. Upon graduation, I worked in primary care in a GYN practice. I later secured a position working in transitional care for the local health system/visiting nurse association. The position was a Medicare pilot program designed to decrease readmission rates for patients with high-risk chronic conditions such as heart failure and pulmonary diseases. I helped to develop this program, which included strategies to reduce 30-day readmissions utilizing a multidisciplinary team approach. The program was quite successful in decreasing readmissions; unfortunately, the grant ran out after 18 months, and the program ended. Although it was short lived, it taught me a lot about developing programs and working with a multidisciplinary team approach. I later began a position working in hospital medicine as a nurse practitioner. During this time, I also covered the addiction medicine unit and provided care to patients with substance use disorders. Working in this area has proven to be very rewarding. It is a clinical area where patients appreciate the care they receive, and I have seen the benefit of providing holistic and comprehensive care to patients with substance use disorders.

I know that you have been enrolled in a DNP program and will soon graduate. Can you share how your experience in working on the detox unit led into your scholarly DNP work and your current position?

Since working on the addictions unit, I noticed that I was diagnosing a lot of patients with Hepatitis C-positive antibodies. We were seeing a lot of it—but often, patients would not have follow-up HCV (Hepatitis C virus) testing, which required additional ordering of this test by the provider and another lab draw to obtain a definitive diagnosis. As a result, I decided to work on a scholarly project focused on screening, diagnosis, and follow-up care of HCV.

At the time that I started my project, there was more and more information coming out about an increase in HCV diagnoses in the local area. The hospital is located in Western Massachusetts, in a scenic small town with beautiful mountains and cultural activities that attract tourists from all over the world as well as the New York and Boston areas.

Although the CDC was increasingly concerned about the hidden HCV epidemic in the baby boomer population, the medical community was concerned about the possible increase in Hepatitis C associated with substance use disorders. It was also noticed that more patients were being admitted to the medical units with a co-occurring diagnosis of substance use disorders—both alcohol and/or opioid use disorders. Many of these individuals were being treated for serious medical conditions often associated with the substance use disorder including cellulitis, endocarditis, or septic joints that required long-time antibiotic therapy. The ability to provide optimum care was difficult because of the complicated nature of treating the medical conditions and addressing substance use disorders. Working with the medical staff, we started to explore ways to best serve these patients whose medical needs were too complicated for them to receive care on the addictions unit. The vision of starting a substance disorder consult team was considered, and we began to consider ways to improve care of medical patients with...
substance use disorders. That vision led to my decision to become a part of the proposed substance use disorder team as a full-time nurse practitioner. I was aware that Massachusetts General Hospital offered such a service so I visited this facility to observe their team. I spent time with the nurse practitioner and team members, receiving a lot of valuable information about the success of their program and model of care. At the same time, I obtained my buprenorphine waiver training, which I found very helpful because it also provided a great deal of information on other substance use disorder issues including management of alcohol use disorder (AUD), gambling, and methadone use in opiate use disorder (OUD). Since that time, I also went to Boston Medical Center to observe their substance use team and gained a great deal of valuable information from that visit.

This is so exciting and innovative. Can you tell us more about your role on this team? Who does it consist of and what specifically is your role?

My role is evolving as we speak. Initially, the team consisted of myself as the leader, a registered nurse, and an addictions counselor. I sat for the Addictions Nursing Certification Exam in the fall, and I am now certified as a CARN-AP (certified addictions RN, advanced practice). Going forward, the team will be primarily composed of advance practice providers with experience in addictions and an addictions counselor to help with aftercare arrangements. Our ultimate goal is to have psychiatric and medical residents participating in elective rotations to get training in addictions. We are supervised by my collaborating physician in the hospitalist department with whom we meet on a daily and as-needed basis to discuss patients and plans of care. In addition, he participates in rounding on patients to assist with determining the plan of care. We may consult on up to an average of 20 patients per day with a monthly census of often more than 100 patients. We are consulted to see patients admitted for medical care but have a co-occurring substance use disorder. We also assist with alcohol withdrawal process to make sure the patients are on the right medications.

At the time we started the team, we also started a new alcohol withdrawal protocol. We use the (Prediction of Alcohol Withdrawal Severity Score) PAWSS to determine the patients’ risk and the medication management required to reduce complications. PAWSS is based on 10 questions; anyone who scores 1–3 is of low risk for withdrawal, 4 and above is put on scheduled medications, and if higher (8–9), an even higher level of care is recommended. Since we instituted this, patients have had fewer complicated alcohol withdrawals.

When patients are admitted to the addictions unit, they have determined they want help with their alcohol or opiate use disorder. When patients are admitted to the medical floors, they often come in because of medical problems and associated comorbidities, not necessarily for management of their substance use disorder (SUD). They admit to using substances but end up on the medical floor not anticipating being engaged with the substance use team. Most patients are pleased to be able to utilize the service to assist them with their SUD.

I have had many success stories—our aim is to get patients through the acute phase of their SUD and arrange for appropriate aftercare services. I am aware of the stigma associated with SUD and reinforce use of correct terminology when working with these patients. I have had challenging patients, but most of the time, when you are able to assist them with their SUD, the outcomes are more positive. We need to treat substance disorders like any other disease in order to save people’s lives. In Massachusetts, we currently have the highest rates of overdoses in the country. Unfortunately, this is a growing trend that we feel we can help to manage. I continue to obtain advanced education in addictions by attending training programs on a regular basis. I am excited about my role as a nurse practitioner on the team, and the staff are reporting they are pleased to have assistance in managing patients with substance use disorders.

Do you think that these types of teams are happening across the country?

Yes, definitely. There is documentation of this in the literature, and I was able to observe this firsthand at both Massachusetts General who has had a team for over 2 years and Boston Medical whose team has been in place for 1 year. The composition of the teams is variable, but the overall function, goals, and outcomes are similar.

We are in a crisis in this country, not only with OUD but also with AUD. We work with many international physicians who may have not been exposed to these problems in their own country. The team provides support and education to both providers, nurse, and support services.

In many cases, it is the language we use in referring to patients with SUD that needs to change. This is so important. For example, I was recently at an addictions conference, and a participant kept on asking about “addicts.” The speaker did not use the word addict but instead changed it to substance use disorder each time he replied. Stigma is such an important concern with SUD. We talk about “dirty urines,” for example, and this is so derogatory. Patients can easily be marginalized and stigmatized by the language used to describe their disease.

I know you have mentioned a few challenges that you have faced in this new role. Can you talk a little more about these?

We have talked about the cultural aspects of this, but I think overall the lack of knowledge of these disorders is the biggest challenge. A better understanding of substance disorders as a disease is needed. Trying to get people to realize the disease concept is difficult. There is a frustration with how much time patients with a substance use disorder take. For example, I have heard residents, in identifying barriers, say that a patient withdrawing is taking up so much time while they have sick patients with a heart condition, for example, who need their care. I try to stress that a patient with a substance use disorder is also experiencing a disease and needs treatment. Another challenge is the perception by providers that medications or treatment is just a substitution for drugs. Changing this thinking is hard. I try to explain that it is like treating a diabetic. Then, they may ask how long patients will have to be on it. We don’t ask these questions for those with diabetes.

Have you seen a change in the attitudes of providers?

Yes, I absolutely have. Whenever there is a recent article or resource to increase an understanding of the issues, I forward
these to the providers at the hospital. There was a recent article in the Boston Globe that talked about the need for more providers to get waivers for buprenorphine that I shared. It is important to be able to treat people. The evidence is quite compelling that most patients with substance disorders will benefit from medication for addiction treatment.

What progress has been made in Massachusetts with APRNs getting waivers for prescribing Buprenorphine?

According to recent statistics, there are a lot more APRNs becoming waivered recently as compared with other providers in the state. I was the first NP waivered at my hospital, and several others have since obtained their waivers. Information about the NP waiver process, which has been in existence since January 2017, can be found at https://aanp.inreachce.com/Details/Information/714cb0a9-73b2-4daf-8382-27c6b70ef5a.

To qualify for the waiver, the NP and PAs must
• be aware of any state law regarding the treatment of addiction/OUD;
• be licensed under state law to prescribe Schedule III, IV, or V medications for pain;
• complete not less than 24 hours of appropriate education through a qualified provider;
• through other training or experience, demonstrate the ability to treat and manage OUD;
• if required by state law, be supervised or work in collaboration with a qualified physician to prescribe medications for the treatment of OUD.

I heard you talk about the number of patents you are seeing each day and month. Those numbers are so significant.

Although I don’t have the specific statistics, I would guess estimate that, of all the admissions, probably close to 25% of all admissions to our hospital are directly related to substance disorders. We hear so much about opioids at this time and for good reason. Young people are dying from overdoses. But the leading cause of death from SUD is actually tobacco, followed by alcohol. We don’t have a lot of medical treatments for AUD, so these patients are the biggest challenge. The FDA-approved drugs for AUD include Naltrexone (Vivitrol, Revia), acamprosate (Campral), and disulfiram (Antebuse). The results vary according to the individual, but many report some effect from these medications. For smoking, we offer information about smoking cessation and the nicotine patch. We also use motivational interviewing to determine the stage that the person is in and then try to assist them in establishing goals. The most rewarding part is to be able to engage a person in the recovery process and arrange aftercare services (short- and long-term rehab; referrals for medication for addiction treatment such as naltrexone, methadone, or buprenorphine; and even primary care follow-up).

As we all know, the initial step in treating substance use disorders is only that. Follow-up care is critical. Can you tell me a little more about your community resources.

We are fortunate that we have so many resources in our community. We have tremendous outpatient community support services that include both mental health and addiction treatments. Patients can see a psychiatrist and a counselor, be treated with buprenorphine, participate in day/evening recovery programs, and participate in group therapy. There is an alternative living center, a 30-day program, and we have a lot of community outreach where professionals will go into people’s homes. Our counseling staff are well versed in all the local resources available. Many of the patients are homeless, and we often are able to make referrals to sober living, halfway houses, and other alternative living centers. We have affordable housing units available, and many of the patients will end up staying in the area permanently because of the opportunities.

I would like to return to your work with Hepatitis C.

What did you learn and how did that work for your DNP lead into other work?

For my DNP, I did a quality improvement project in a small clinical primary care practice. It was focused on providing an educational program for providers on the need to screen for Hepatitis C. My screening results did not demonstrate a significant change; however, the project itself resulted in many positive changes in involving the care of patients with HCV infections. The HCV testing procedure was changed to include an automatic “reflex” testing of all patients with HCV-positive antibodies. By having this second portion of the testing occur without the provider having to place an additional order has helped to confirm actual HCV infections. Since 20%–25% of patients exposed to HCV will clear the virus, the confirmatory testing was needed to ascertain who actually required treatment. Once exposed to HCV, a person will always test positive for the antibody, making RNA confirmation essential.

Once reflex RNA testing was in place, there was concern about how to treat the anticipated increases in individuals with confirmed Hepatitis C and how would the cost be covered. Currently, the Massachusetts State Medicaid system will pay for patients to be treated. Therefore, we needed to figure out how to get people treated once we identified them. The department of medicine was instrumental in creating an ad hoc committee consisting of representatives from infectious disease, GI, trauma, and pharmacy. We met twice per month, and we invited community members from the local health system and the Department of Public Health. We all decided we needed to do something to manage this epidemic, and the final outcome was the formation of a clinic at the GI office dedicated to treating those with active HCV infection.

I have since been involved with many efforts to stop the spread of hepatitis and engage providers and other health care professionals about the importance of following the CDC guidelines for the screening, diagnosis, and follow-up care for HCV infections. I presented several HCV information sessions to many advanced practice groups, at the local Infectious Disease Conference to nurses and other allied health personnel, and was interviewed about HCV by the local television station health topics program. The most
recent numbers have demonstrated an increase of 2,000 more HCV screenings compared with last year. We are testing so many people—and hopefully treating them as well. It is amazing how it has taken off. It is really a problem in this community, and the health care system reacted quickly in addressing this concern. Hopefully, getting treatment for HCV infections will be a motivating factor for many SUD patients to also begin therapy for managing their substance use disorder.

REFERENCE