Creating a Buprenorphine Induction Clinic: Lessons Learned

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Pain Day 2018
Disclosures

I have no financial relationships with commercial entities producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.
Objectives

By the end of this presentation, learners will:

• Distinguish opioid dependence and opioid use disorder, and recognize ways that stigma can impact patient perceptions of pain and addiction care.

• Appreciate challenges in transitions of care to the recovery process, between care settings, and methods to promote patient success in recovery.

• Understand the present challenge of maintaining patients in longer-term care for opioid use disorder, including common reasons that patients stop care.

• Identify situations in which concerns about medication safety and diversion may exclude patients from participation in buprenorphine-based care.
# Accidental Deaths in the US, 2015

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<tr>
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<tbody>
<tr>
<td>36,000+ people</td>
<td>36,000+ people</td>
<td>52,000+ people</td>
<td>43,000+ people</td>
</tr>
</tbody>
</table>

6 of 10 involve an opioid

From CDC, “About Multiple Causes of Death 1999-2015”
Treatment Cascade

Reported Opioid Use Disorder (100%)

Received Treatment (21.5%)

Why People Don’t Get Treated Despite Having Substance Use Disorders

- No Health Coverage and Could Not Afford Cost: 37.3%
- Not Ready to Stop Using: 24.5%
- Did Not Know Where to Go for Treatment: 9.0%
- Had Health Coverage But Did Not Cover Treatment or Did Not Cover Cost: 8.2%
- No Transportation/Inconvenient: 8.0%
- Might Have Negative Effect on Job: 6.6%
- Could Handle the Problem without Treatment: 6.6%
- Did Not Feel Need for Treatment at the Time: 5.0%

https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm
Here’s Looking at You, Primary Care Providers

We Can Do This!

35% of patients received treatment in a physician’s office (e.g. with buprenorphine)

But How Can Primary Care Providers Do “Just One More Thing”?
Thus... the BIC!

Patient Receives Care in Primary Care Medical Home

Patient Stabilized in the BIC

Patient’s Addiction Care Returned to Medical Home

Patient Referred to the BIC (RefTrak)
How Do Patients Get Treatment for Opioid Use Disorder?

No Wrong Door!

A Winding Path (Chronic, Relapsing Condition)
A “Hub and Spokes” Model

- Medical Home
- Emergency Room
- Inpatient Admissions
- ED Bridge Program
- Presumptive Eligibility
- Self-Referral

“SHOUT”
Who We Are

Quick Facts about the Buprenorphine Induction Clinic

• Is located on Highland Hospital’s campus
• Utilizes RefTrak as do other Highland specialty clinics for referrals
• Sees patients who are at least 18 years old who have a diagnosis of opioid use disorder
• Is open to patients with or without chronic pain, though a diagnosis of opioid use disorder is needed for referral
• Creates a medical and behavioral treatment plan for patients during a 1 to 3 month period and then transitions maintenance care back to the patient’s medical home
• Currently open Monday and Friday mornings, will soon expand!

Our Team

• Shawna Adkins, LCSW – Behavioralist
• David Tian, MD, MPP – Medical Director
• Vacant Position – Medical Provider
Of the 224 patients referred to BIC, 77% (173) completed an in person or telephone intake.
57% of patients who completed an intake are currently active in BIC or have been transferred to primary care or another MAT program.
Lesson 1: Stigma is a Barrier to Care

Objective: Distinguish opioid dependence and opioid use disorder, and recognize ways that stigma can impact patient perceptions of pain and addiction care.
Doctors are seeing this...

One-third of long-term users say they’re hooked on prescription opioids

By Scott Clement and Lenny Bernstein  December 3, 2016

UNNATURAL CAUSES I SICK AND DYING IN SMALL-TOWN AMERICA: Since the turn of this century, death rates have risen for whites in midlife, particularly women. In this series, The Washington Post is exploring this trend and the forces driving it.
But What *is* the Overlap Between Pain and Opioid Use Disorder?

“Complex Opioid Dependence” vs. “Mild Opioid Use Disorder”
### Distinguishing by DSM5 Criteria for Opioid Use Disorder

<table>
<thead>
<tr>
<th>The 3 C's</th>
<th>Criterion</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control</strong></td>
<td>Use in larger amounts or for longer periods of time than intended</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unsuccessful efforts to cut down or quit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Excessive time spent using the drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intense desire/urge for drug (craving)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Failure to fulfill major obligations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continued use despite social/interpersonal problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activities/hobbies reduced given use</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Recurrent use in physically hazardous situations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Craving</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recurrent use despite physical or psychological problem caused by or worsened by use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tolerance*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Withdrawal*</td>
<td></td>
</tr>
<tr>
<td><strong>Consequences</strong></td>
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Severity is designated according to the number of symptoms endorsed:
- 0-1: No diagnosis
- 2-3: Mild SUD
- 4-5: Moderate SUD
- 6 or more: Severe SUD

*Criteria 10 and 11 don’t count if a patient develops physiologic tolerance and withdrawal when taking chronic opioid therapy as directed.
## Perceived vs. Actual Risk of Bad Reactions and Overdose, Highland Wellness

<table>
<thead>
<tr>
<th>Attitudes and Experience</th>
<th>Response</th>
<th>n=42</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Felt that taking opioid pain medications could be harmful to their health</td>
<td>17 (40%)</td>
</tr>
<tr>
<td></td>
<td>Average self-perceived risk of having a bad reaction from opioid pain medications on a scale from 1-10</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Average self-perceived risk of having an accidental overdose from opioid pain medications on a scale from 1-10</td>
<td>1.3</td>
</tr>
<tr>
<td>Opioid Use</td>
<td>Average years of opioid use</td>
<td>8.4 years</td>
</tr>
<tr>
<td></td>
<td><strong>Had run out of their pain medications early in the past 3 months</strong></td>
<td>21 (50%)</td>
</tr>
<tr>
<td></td>
<td>Had ever taken opioids that weren't prescribed by their doctor</td>
<td>3 (7%)</td>
</tr>
<tr>
<td></td>
<td><strong>Had ever had a bad reaction to their opioid pain medication</strong></td>
<td>10 (24%)</td>
</tr>
<tr>
<td></td>
<td><strong>Had ever experienced an accidental overdose from their opioid pain medication</strong></td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td>Had ever witnessed an accidental overdose</td>
<td>6 (14%)</td>
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</tbody>
</table>

Preliminary Data from Universal Co-prescribing and K6 Adult Medicine Clinic Patients
Can framing help?

• Externalized risk framing:
  • “I’ve had other patients who...”
  • “Even when patients take medications exactly as prescribed and like you’ve been doing...”

• Calling it “Dependence” vs. “Addiction”
  • Less stigma (?)
  • Diagnosis: “Opioid Dependence without Use Disorder”

Above: Framing naloxone as an in-case safety measure has been shown to promote acceptability.
Lesson 2:
Care Transitions are Hard...

Objective: Appreciate challenges in transitions of care to the recovery process, between care settings, and methods to promote patient success in recovery
We Have an Idealized, Linear Buprenorphine Treatment Workflow

Patient identified in medical home as having moderate to severe opioid use disorder

Patient referred to Buprenorphine Induction Clinic (BIC) and appropriate patients have a Pre-Induction Visit

Patient Scheduled for an Induction Visit

Patient: Stabilized on Buprenorphine Dose
- Develops Behavioral Health Plan
- Works on Psychosocial Needs

Patient Reaches Maintenance Stage

Patient’s OUD Care Passed Back to Primary Doctor

Visit Frequency
- Patient Seen Twice Weekly During First Week
- Patient Seen Every 1 to 2 Weeks During First Months
- Patient Seen Monthly to Bimonthly
- Patient Seen Monthly to Bimonthly

Primary Site of Addiction Care
- Buprenorphine Induction Clinic
- Medical Home
But When We Map It Out in Real Life...
Roughly half of patients seem to remain in treatment regardless of referral source. We are continually surprised by our inability to predict who will remain in treatment.
Opioid Purgatory?

Local Pain Clinic Known for High-Dose Prescriptions Shuts Down

Primary Care Clinic Notifies Patients “We Are No Longer Prescribing Chronic Opioids”

Patient Moves to Another County in California, Medi-Cal Plan Not Accepted

Patient Ready to Transfer Back, but PCP Does Not Have an X-waiver

Patient Splits His Time Between Montana and Oakland

Medi-Cal Doesn’t Cover Buprenorphine for Non-OUD Diagnoses

Patient Moving to Wisconsin, Needs Badger Care
BIC Practices

- “Practicing” succeeding in primary care settings, coaching for self-sufficiency
- Setting up specialty mental health care during the stabilization period
- Scheduling transportation, applying for benefits
- Scheduling a transitional visit
- Sending a “Transfer Summary”

Addiction as a chronic bio-psycho-social-spiritual illness

<table>
<thead>
<tr>
<th>Bio</th>
<th>Psycho</th>
<th>Social</th>
<th>Spiritual</th>
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</thead>
<tbody>
<tr>
<td>Medications to prevent symptoms of addiction and withdrawal</td>
<td>Behavioral interventions, Psychiatric interventions</td>
<td>Reintegration with social networks, Treatment groups</td>
<td>Mindfulness, Religious support</td>
</tr>
</tbody>
</table>
Care Coordination and Capacity Development

- Working with local community health centers
- Providing technical assistance for medical and logistical concerns
- Hosting community physicians through shadowing
- Promoting the UCSF “Warm Line”
Lesson 3: Beware the “Danger Zone” (Months 1-3)

Objective: Understand the present challenge of maintaining patients in longer-term care for opioid use disorder, including common reasons that patients will want to stop care.
The Goal is Maintenance

Because... brief medically assisted withdrawal (“detox”) is ineffective

Currently, 50% of Patients Drop Out of Care

Retention Data – Sept 2017 to August 2018

- MEDICAL HOME: Referred 68, Completed Intake 52, Active or Transferred 33
- ED: Referred 93, Completed Intake 44
- SELF: Referred 16, Completed Intake 10
- OTHER MEDICAL PROV: Referred 24, Completed Intake 16, Active or Transferred 10
- OTHER: Referred 15, Completed Intake 10, Active or Transferred 5
Is Induction Truly the Hardest Part? Should We Change Our Name?

1. Patient identified in medical home as having moderate to severe opioid use disorder
2. Patient referred to Buprenorphine Induction Clinic (BIC) and appropriate patients have a Pre-Induction Visit
3. 90% Out-of-Clinic Inductions
4. Patient: Stabilized on Buprenorphine Dose, Develops Behavioral Health Plan, Works on Psychosocial Needs
5. Patient Reaches Maintenance Stage
6. Patient’s OUD Care Passed Back to Primary Doctor

Visit Frequency:
- Patient Seen Twice Weekly During First Week
- Patient Seen Every 1 to 2 Weeks During First Months
- Patient Seen Monthly to Bimonthly
- Patient Seen Monthly to Bimonthly

Primary Site of Addiction Care:
- Buprenorphine Induction Clinic
- Medical Home
The “Danger Zone” After Induction

Strong desire to taper down immediately (equivalent to detoxification)

Poor fit with care structure, including inability to come to scheduled appointments or adhere with frequency of visits

Strong social forces—including unemployment, housing insecurity, and lack of transportation

Concurrent stimulant use that leads to relapse
The “Secret Ingredient”

Navigation and assistance with logistical challenges seems extremely important.

The LCSW of the BIC is present Monday to Friday 9 am to 5 pm and answers or returns phone calls, responds to text messaging, and helps to navigate these challenges.
Lesson 4: Patients are Rarely Inappropriate for Treatment, But These are Some Cases

Objective: Identify situations in which concerns about medication safety and diversion may exclude patients from participation in buprenorphine-based care.
**Why not start the more freeing option?**

<table>
<thead>
<tr>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Naltrexone</th>
</tr>
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<tbody>
<tr>
<td>Full mu agonist</td>
<td>Partial mu agonist</td>
<td>Mu antagonist (Blocks opioid high)</td>
</tr>
<tr>
<td>Oral (often solution)</td>
<td>Sublingual (tab, film) or implant (probuphine)</td>
<td>Intramuscular (extended release) or oral</td>
</tr>
</tbody>
</table>
Surprisingly, It’s Not Always Benzos That Are a Problem

FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks

This provides updated information to the FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning issued on August 31, 2016.
Diversion and Urine Tampering are Rare, But They Happen

Most often occurs when patients are trying to help another person who is experiencing withdrawal.

We ask that patients bring those people into care when they are ready or just have them call.

Quantitative buprenorphine and norbuprenorphine levels can distinguish:
Norbuprenorphine levels should be several folds higher. If not...

Patient disclosed that he had taken his son’s diluted urine from the toilet to hide ongoing substance use, and he introduced a partial tablet of buprenorphine-naloxone into the urine sample.

This patient was given a warning and remained in treatment before being lost to follow-up months later.
Overall, Is the Patient Better Off?  
Is Continued Treatment Safe?

Compare these two cases:

**Case 1:** Patient entered treatment for opioid use disorder of inhaled heroin. He had repeated missed appointments (over 9 months) despite efforts to arrange transportation, provide drop-in periods, with a history of urine tampering and persistently positive urine testing for opioids. Unclear if patient was functionally better in relationships or life function, reaching self-defined goals, or better in terms of substance use. Patient referred to OTP.

**Case 2:** Patient began treatment with buprenorphine for kratom use disorder. Over time, she has decreased frequency of kratom use to every 3 hours to zero to one time per day. She continues to use and cannot imagine a world in which anything else would make her feel better the way that one dose of kratom at night does. Patient is better off than previous, and continued treatment is safe. Patient continues in care, and visit frequency is spaced out.
Objectives

By the end of this presentation, learners will:

• Distinguish opioid dependence and opioid use disorder, and recognize ways that stigma can impact patient perceptions of pain and addiction care.

• Appreciate challenges in transitions of care to the recovery process, between care settings, and methods to promote patient success in recovery.

• Understand the present challenge of maintaining patients in longer-term care for opioid use disorder, including common reasons that patients stop care.

• Identify situations in which concerns about medication safety and diversion may exclude patients from participation in buprenorphine-based care.
Summary of Lessons

• Opioid use disorder is characterized behaviors that “cause the 3 C’s of addiction” and result in life impairment. DSM5 criteria can help reveal the extent of concerning behavior.

• Patients may underestimate their risk of bad reactions or overdose to opioids, so externalizing risk and using neutral language may help combat stigma.

• A “no wrong door” approach to treatment necessitates many doors and hallways. Coaching patients to navigate health care systems, addressing social determinant of care nonadherence have helped retention.
Summary of Lessons

• Buprenorphine induction is decreasing the major barrier given options such as out-of-clinic (home) inductions, “hub” clinics, and emergency room inductions. Challenges remain in retaining patients in care during the “danger period” 1 to 3 months out from induction.

• Buprenorphine can be a more “freeing” treatment option for many patients. Benzodiazepines are not an absolute contraindication. Medication non-adherence and urine tampering are potential concerns that can be revealed through urine testing. Weighing the benefits and harms to the patient of continued treatment allow balanced clinical decision-making.
Thanks!

- **SASE Team:** Lisa Cooper, Monica Rowden, Kenny Hahn
- **K7 BIC Team:** Shawna Adkins, Lucretia Bolin (formerly)
- **ZSFG Mentors:** Soraya Azari, Diana Coffa, Paula Lum, Scott Steiger, Jackie Tulsky

Questions?