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:

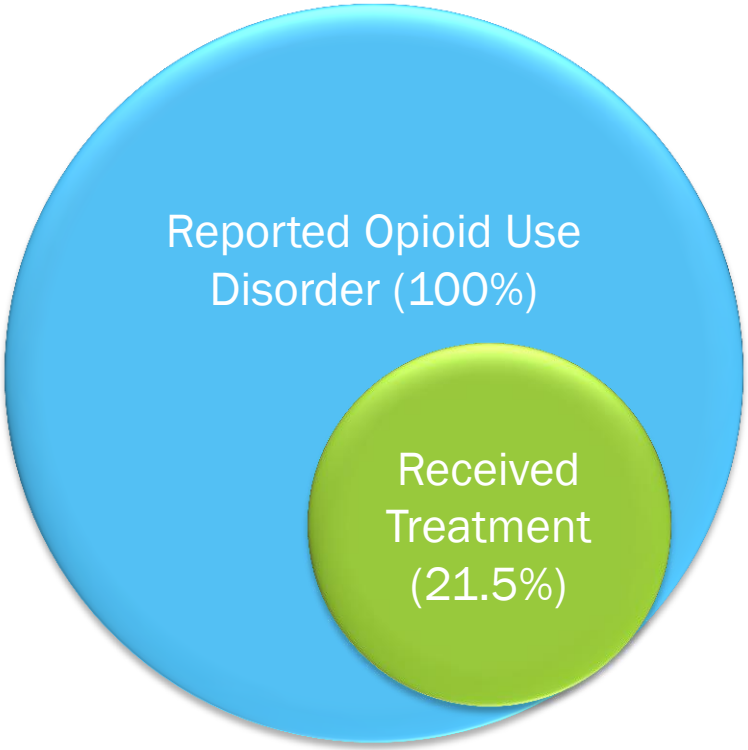
- Distinguish opioid dependence and opioid use disorder, and recognize ways that stigma can impact patient perceptions of pain and addiction care.
- Appreciate challenges in transitions of care to the recovery process, between care settings, and methods to promote patient success in recovery.
- Understand 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

Car Crashes	Gun Violence	Drug Overdose	HIV Deaths (1995)
36,000+ people 	36,000+ people 	52,000+ people  *6 of 10 involve an opioid*	43,000+ people 

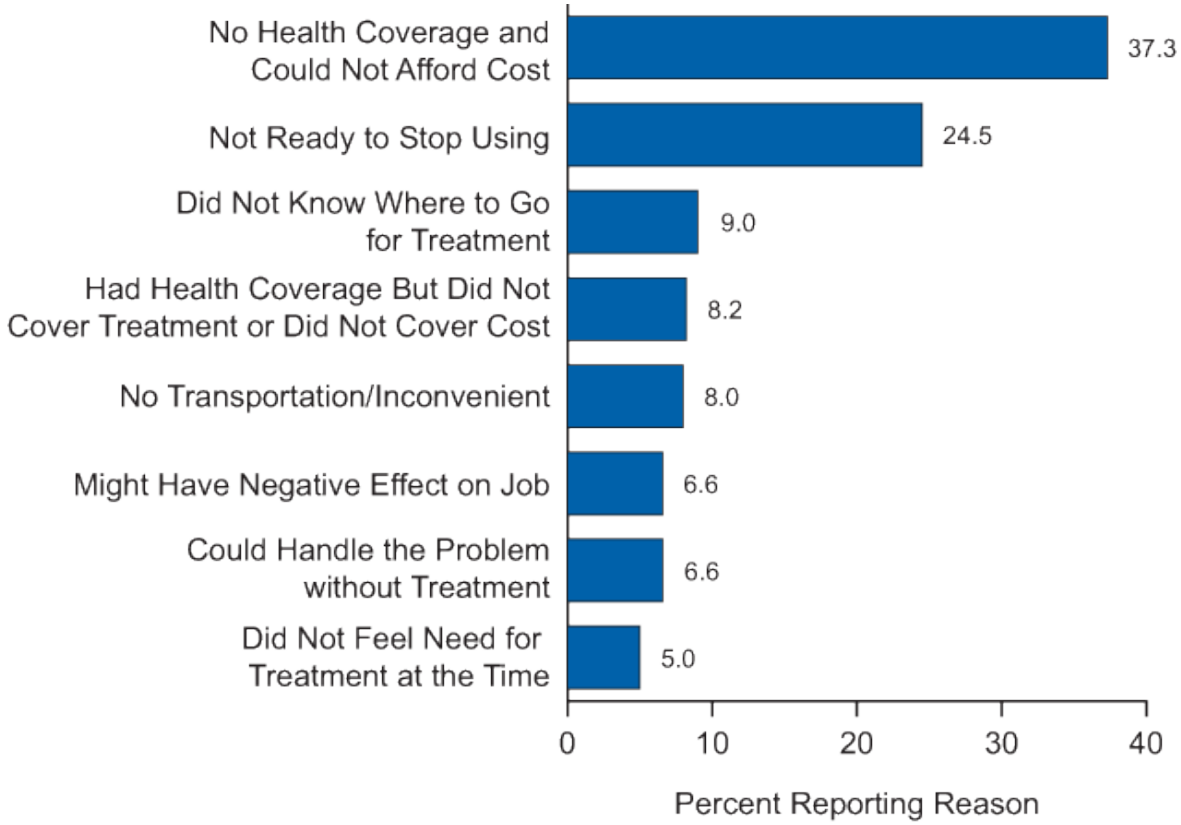
From CDC, “About Multiple Causes of Death 1999-2015”

Treatment Cascade



National Survey of Drug Use and Health (NSDUH) Data 2004-2013, Analyzed by Saloner and Karthikeyan, *JAMA* 2015

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



https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm

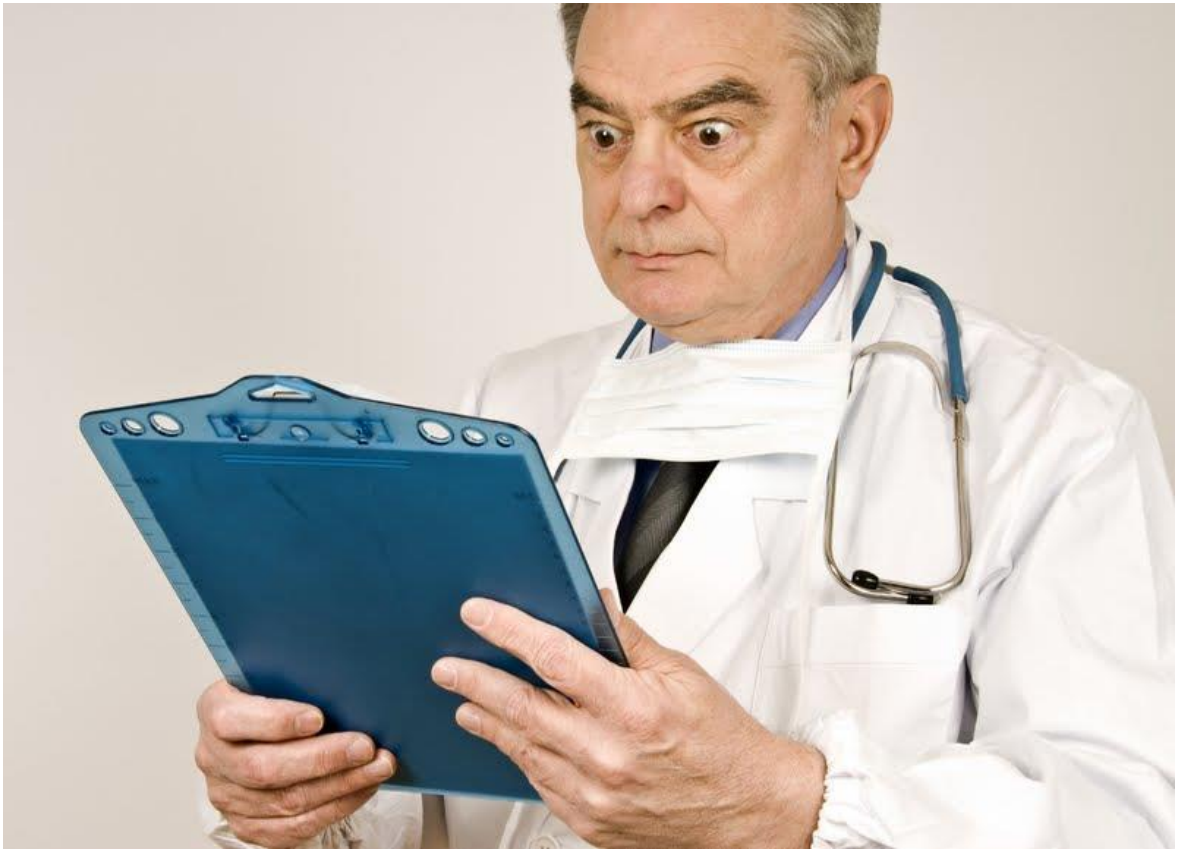
Here's Looking at You, Primary Care Providers

We Can Do This!

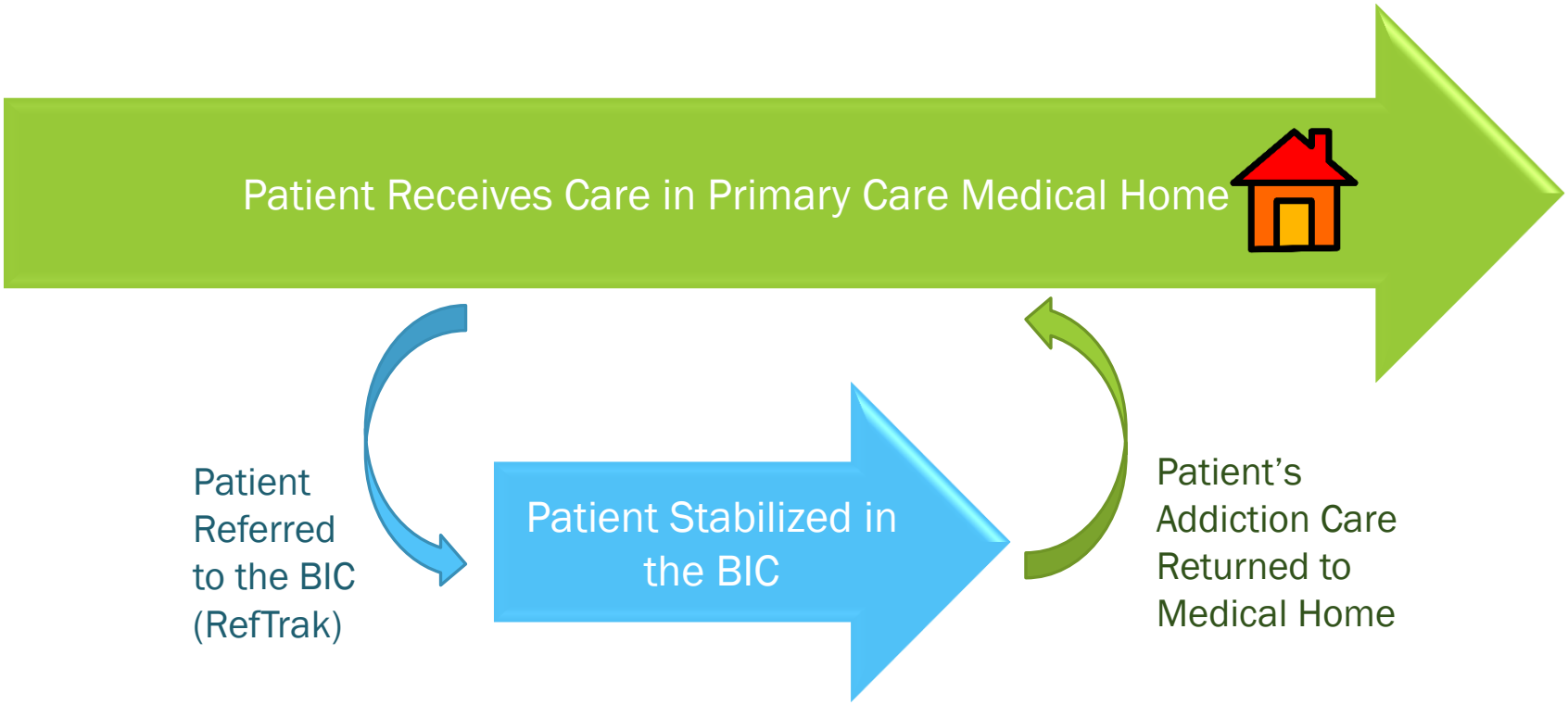
35% of patients received treatment in a physician's office (e.g. with buprenorphine)

National Survey of Drug Use and Health (NSDUH) Data 2004-2013, Analyzed by Saloner and Karthikeyan, *JAMA* 2015

But How Can Primary Care Providers Do “Just One More Thing”?



Thus… the BIC!

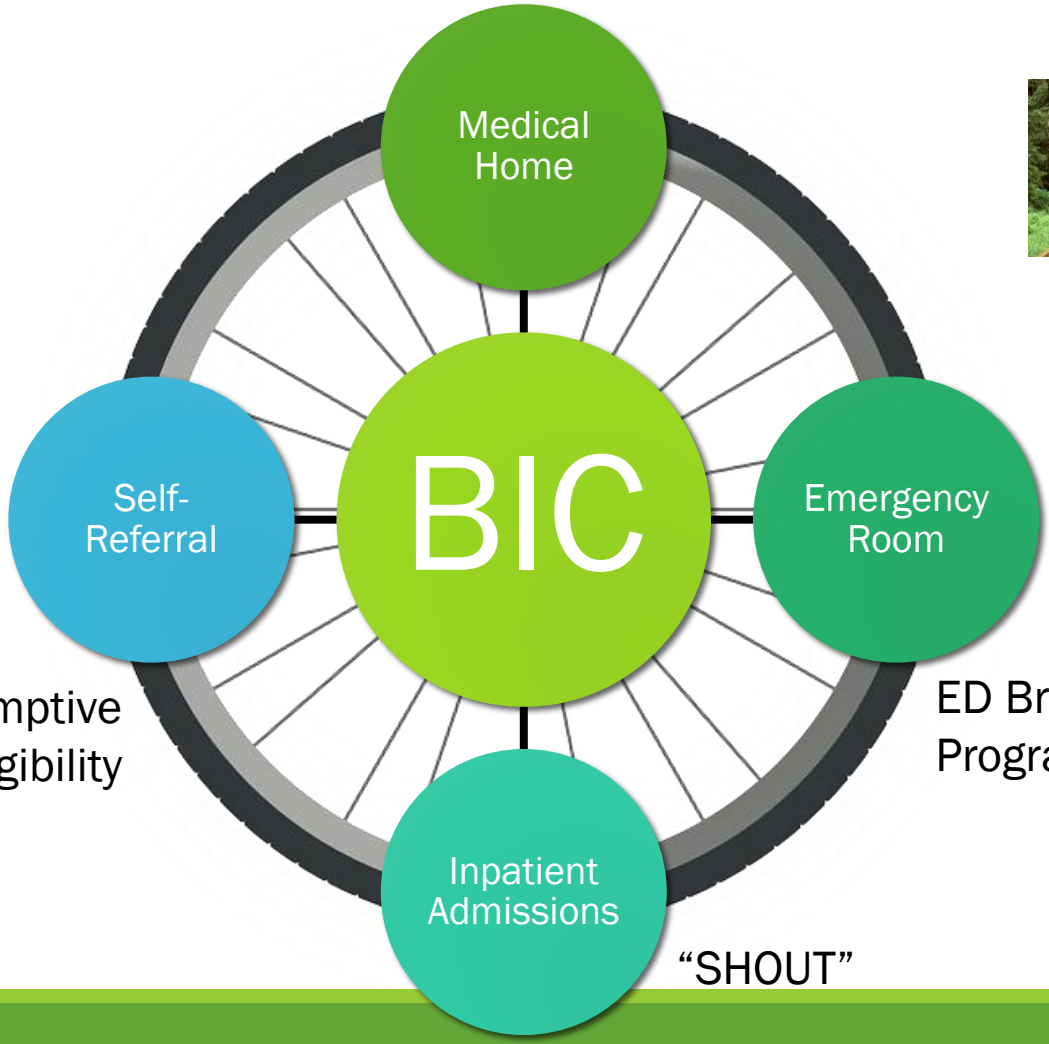

Patient Receives Care in Primary Care Medical Home
Patient Referred to the BIC (RefTrak)
Patient Stabilized in the BIC
Patient's Addiction Care Returned to Medical Home

How Do Patients Get Treatment for Opioid Use Disorder?

No Wrong Door!

A Winding Path
(Chronic, Relapsing Condition)

A “Hub and Spokes” Model



Presumptive Eligibility

ED Bridge Program

“SHOUT”

Who We Are

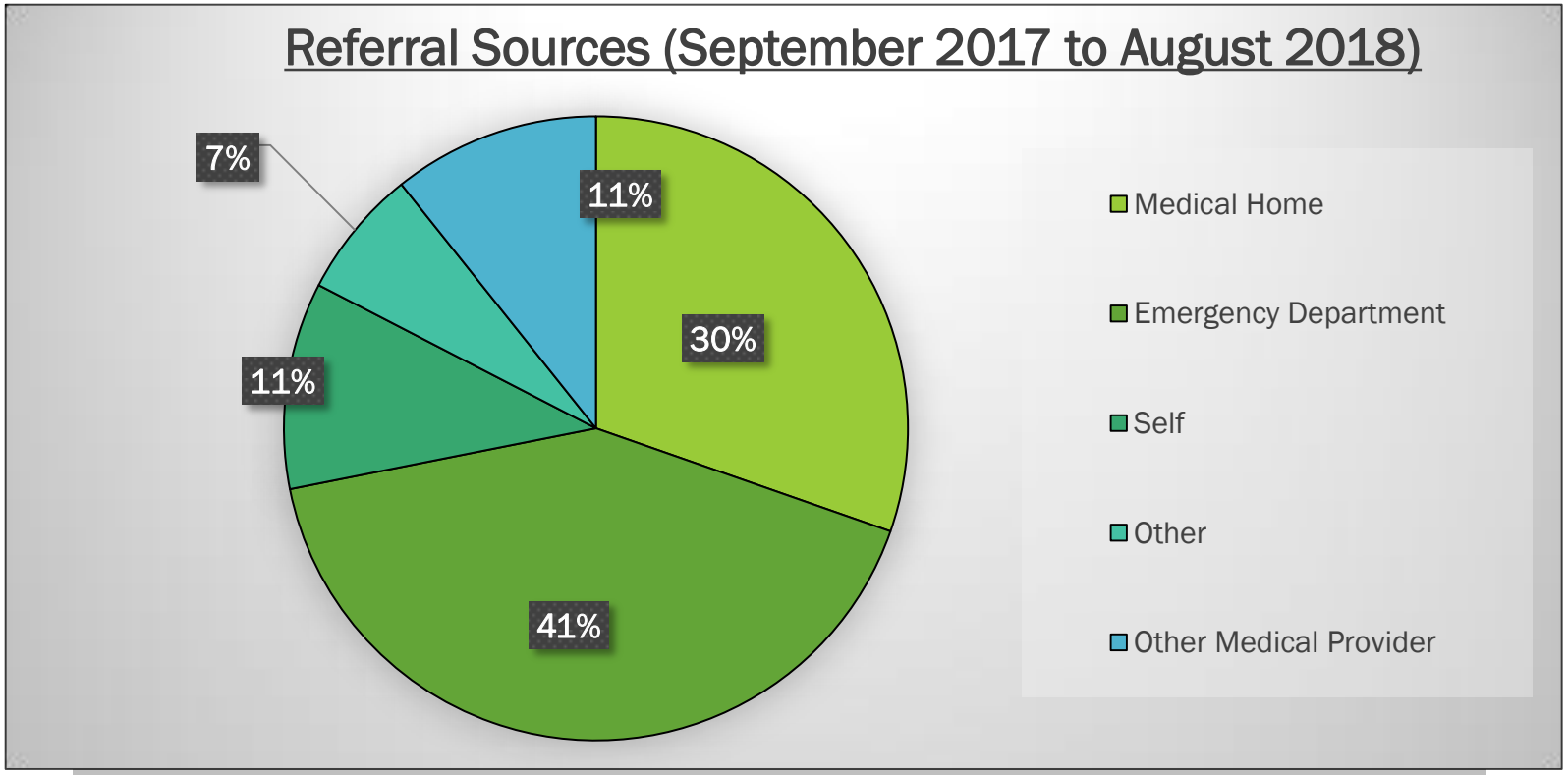
Quick Facts about the Buprenorphine Induction Clinic

- 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

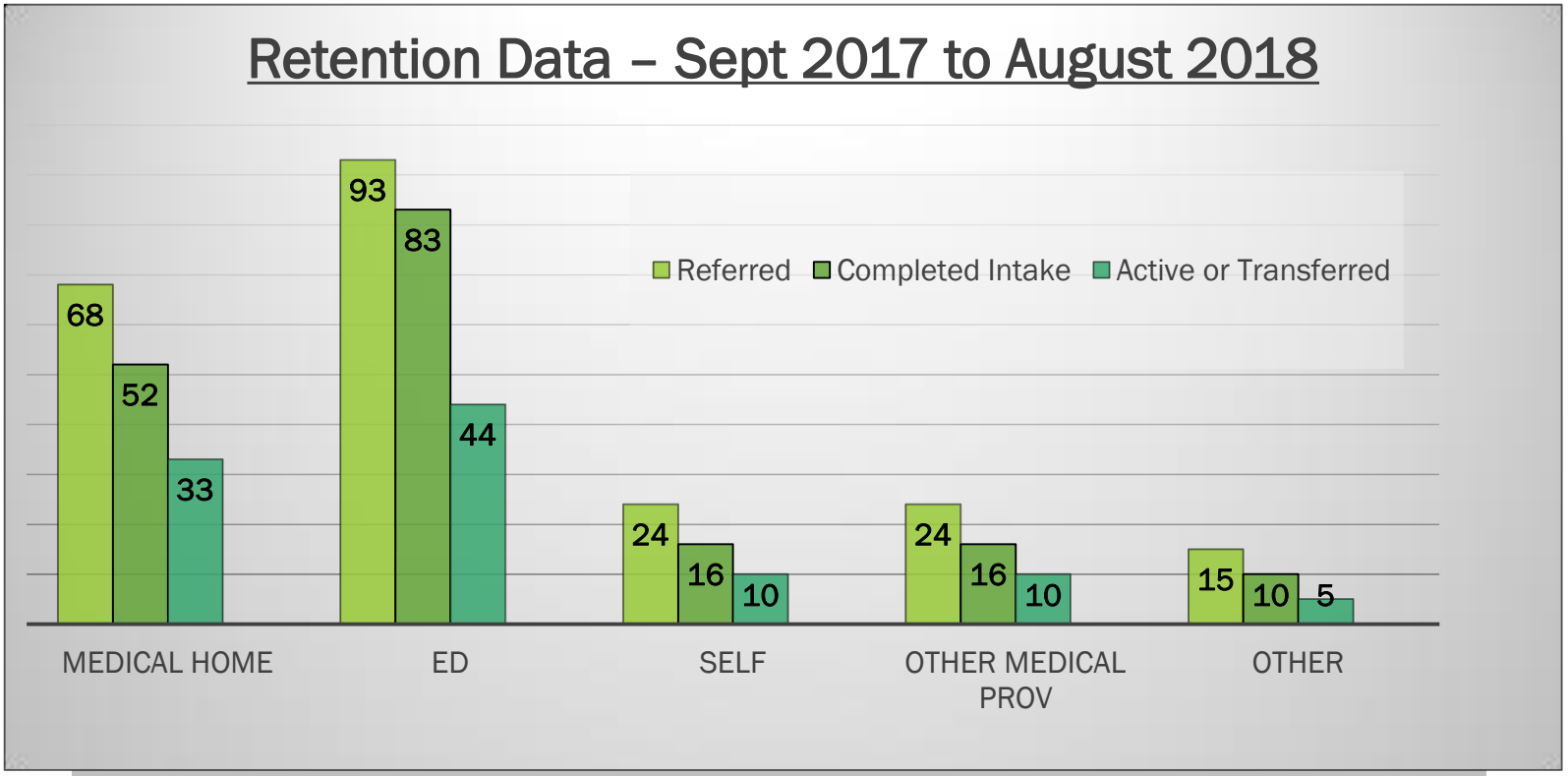
- Shawna Adkins, LCSW – Behavioralist
- David Tian, MD, MPP – Medical Director
- Vacant Position – Medical Provider

BIC Referral Sources



Of the 224 patients referred to BIC, 77% (173) completed an in person or telephone intake.

BIC Treatment Cascade

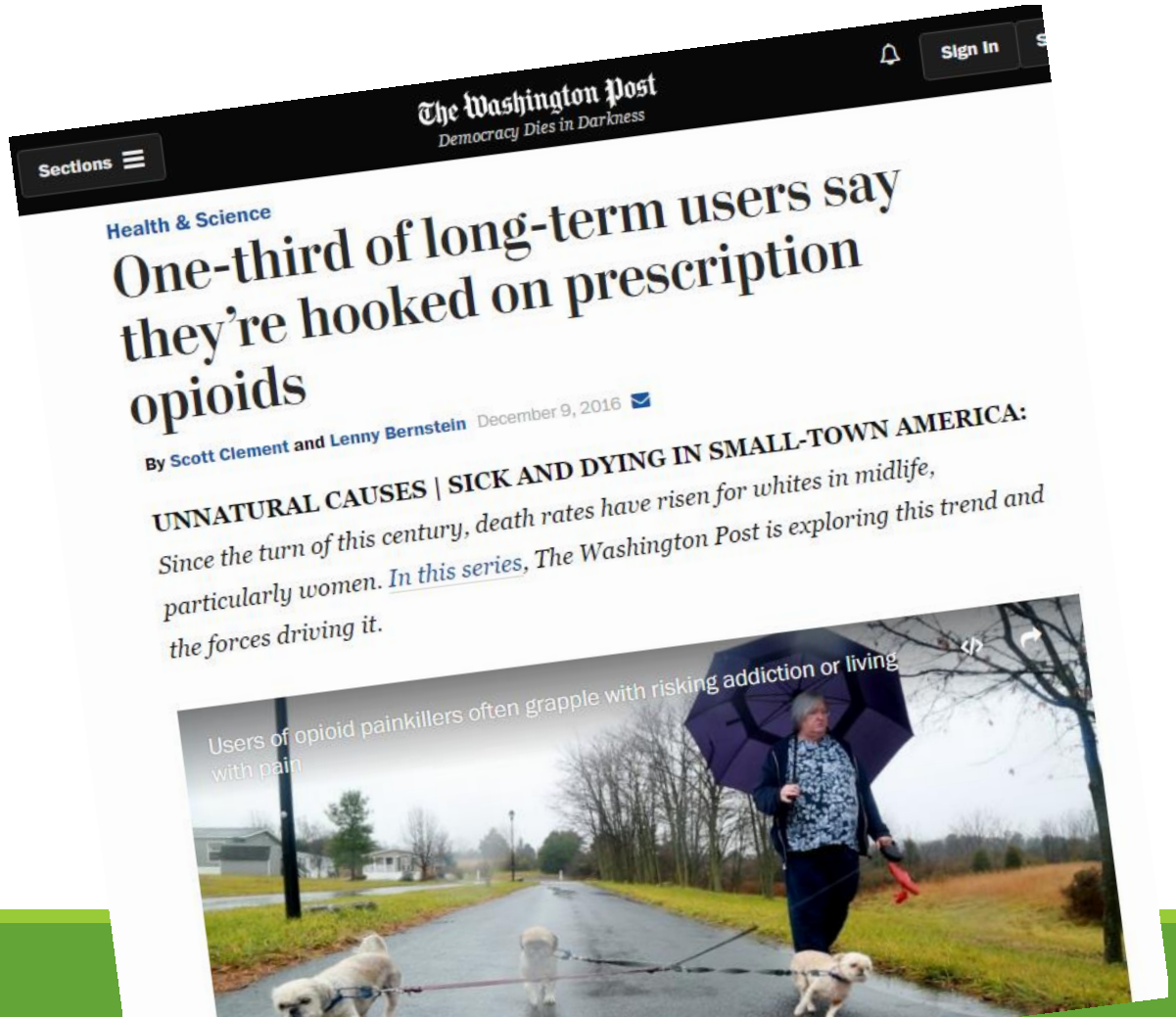


57% of patients who completed an intake are currently active in BIC or have been transferred to primary care or another MAT program.

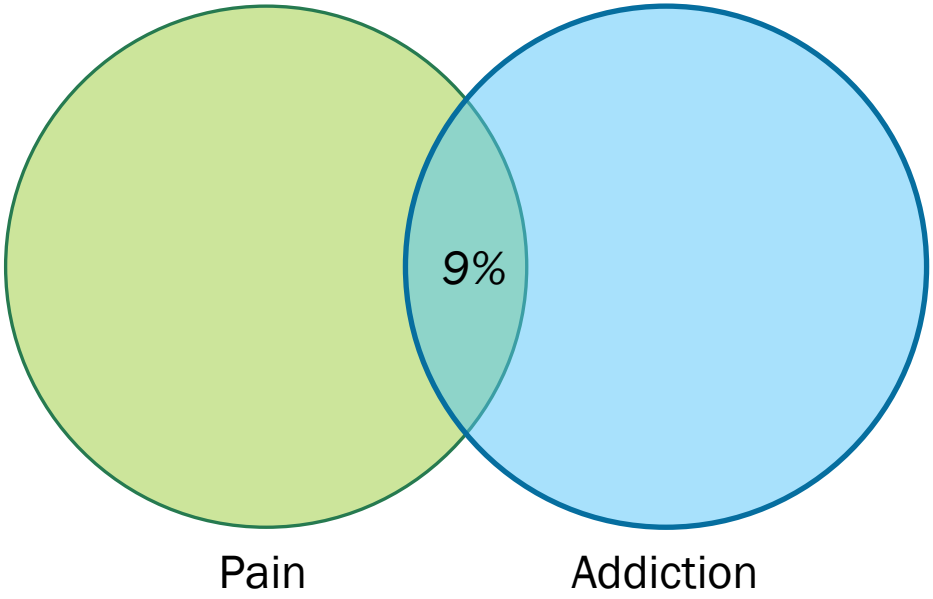
Lesson 1:
Stigma is a Barrier to Care

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

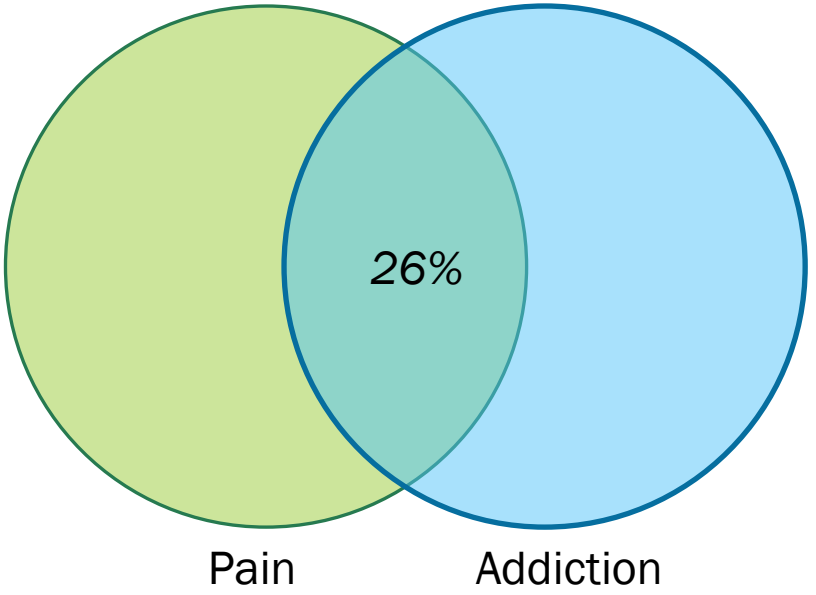
Doctors are seeing this…



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

The 3 C's	Criterion	Severity
Control	Use in larger amounts or for longer periods of time than intended	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
	Unsuccessful efforts to cut down or quit	
	Excessive time spent using the drug	
Craving	Intense desire/urge for drug (craving)	
Conse-quences	Failure to fulfill major obligations	
	Continued use despite social/interpersonal problems	
	Activities/hobbies reduced given use	
	Recurrent use in physically hazardous situations	
	Recurrent use despite physical or psychological problem caused by or worsened by use	
	Tolerance*	
	Withdrawal*	

*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

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

Can framing help?

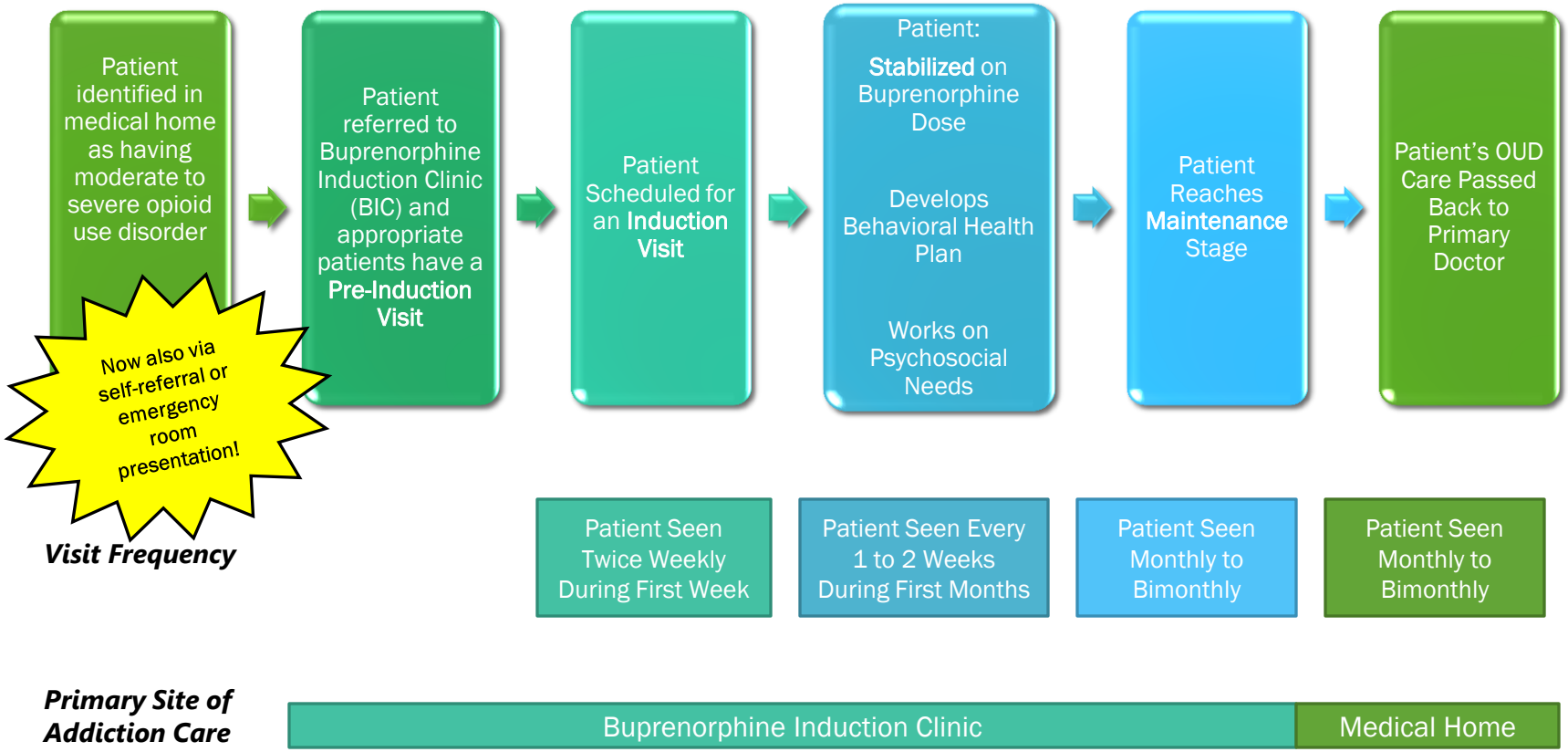
- Externalized risk framing:
  - "I've had other patients who…"
  - "Even when patients take medications exactly as prescribed and like you've been doing…"
- Calling it "Dependence" vs. "Addiction"
  - Less stigma (?)
  - Diagnosis: "Opioid Dependence without Use Disorder"

Above: Framing naloxone as an in-case safety measure has been shown to promote acceptability.

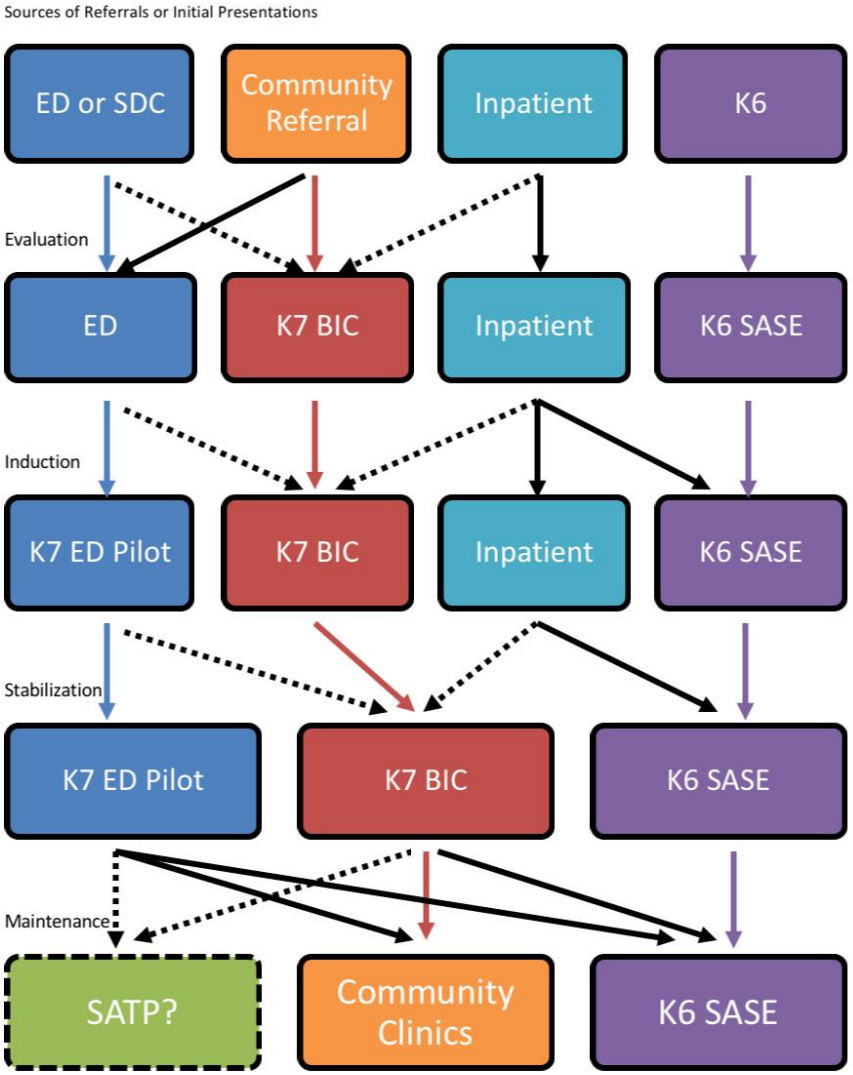
Lesson 2:
Care Transitions are Hard…

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

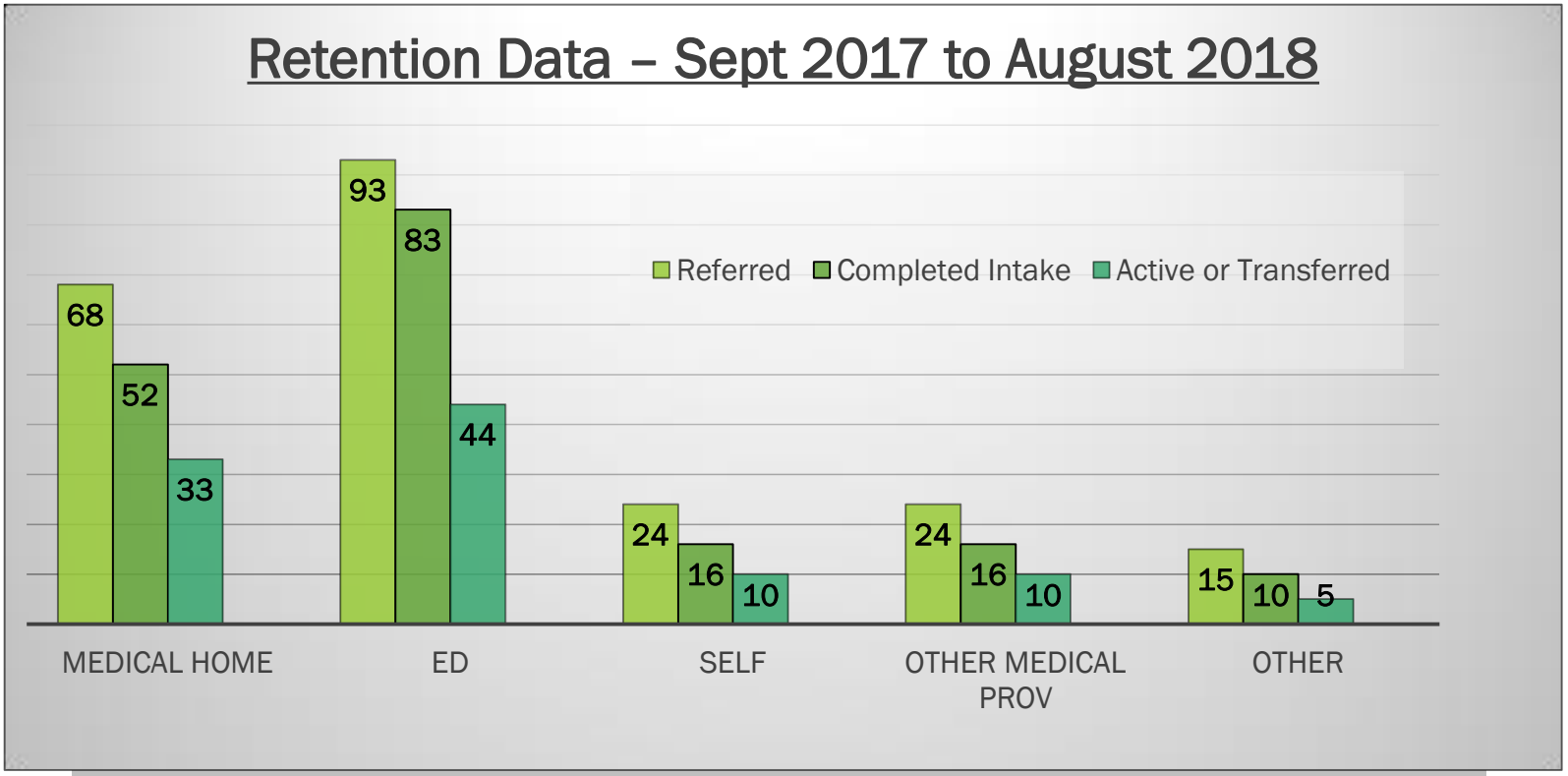
We Have an Idealized, Linear Buprenorphine Treatment Workflow



But When We Map It Out in Real Life…

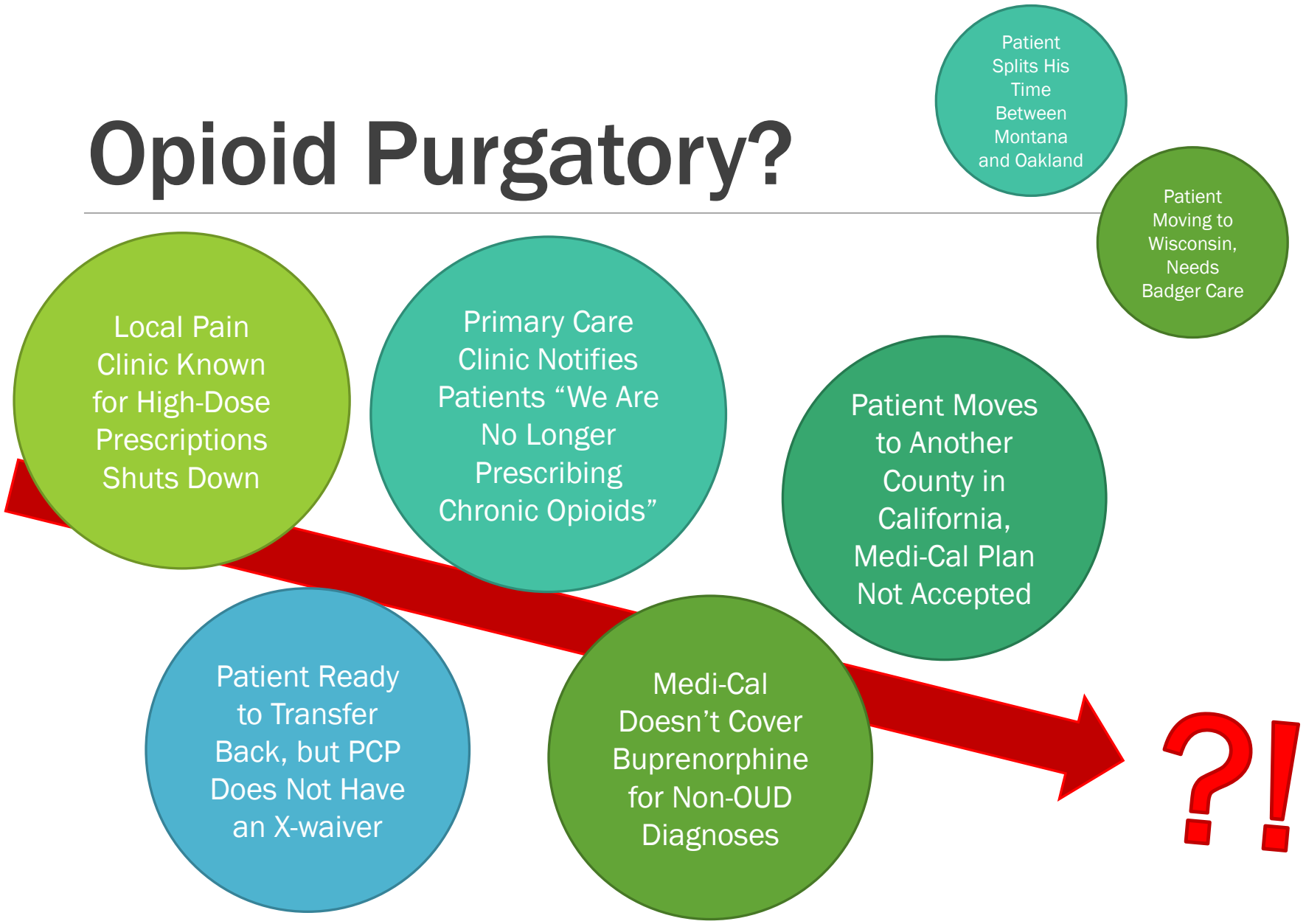


BIC Treatment Cascade



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?



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

Bio	Psycho	Social	Spiritual
Medications to prevent symptoms of addiction and withdrawal	Behavioral interventions, Psychiatric interventions	Reintegration with social networks, Treatment groups	Mindfulness, Religious support

Care Coordination and Capacity Development

Working with local community health centers

COMMUNITY HEALTH CENTER NETWORK

Providing technical assistance for medical and logistical concerns

Hosting community physicians through shadowing

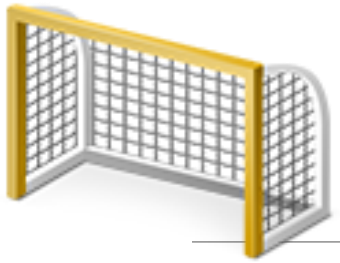
Promoting the UCSF “Warm Line”

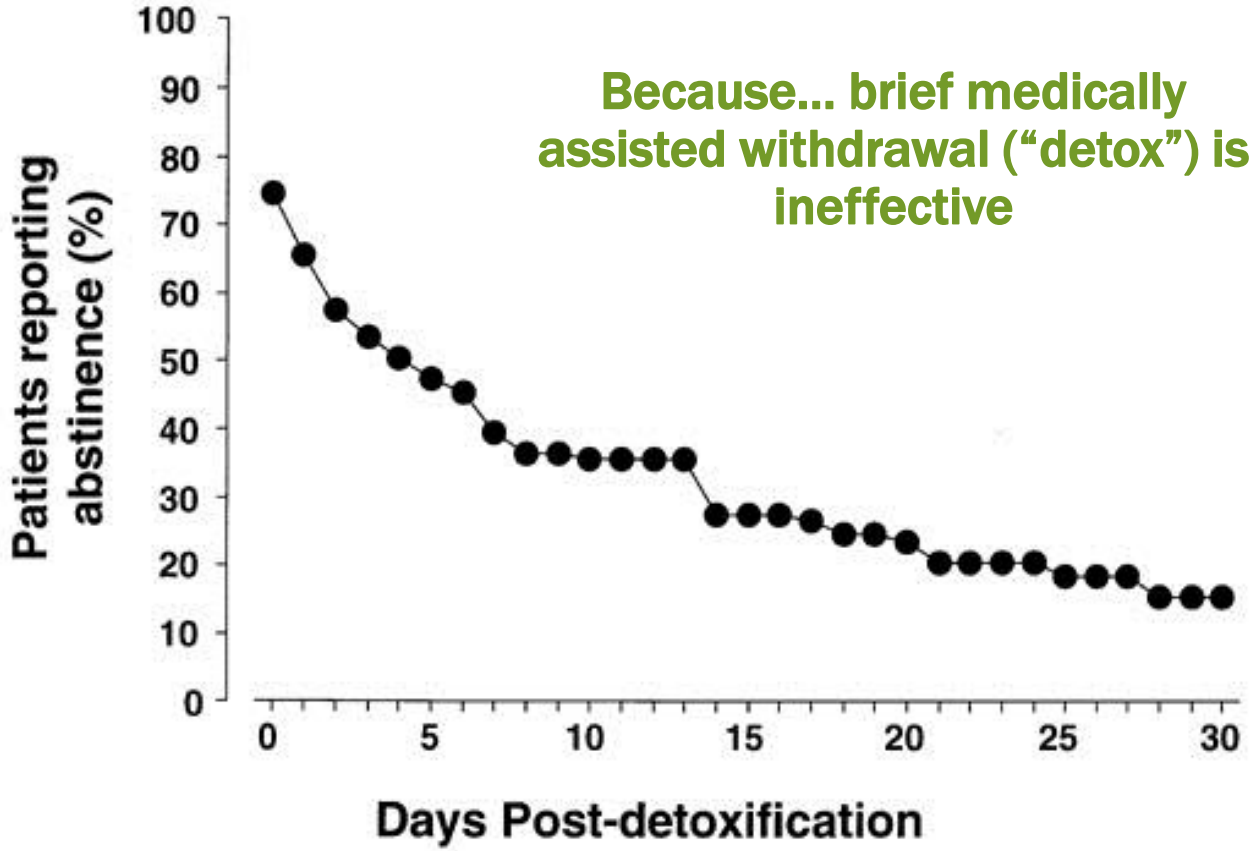
CLINICIAN CONSULTATION CENTER

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

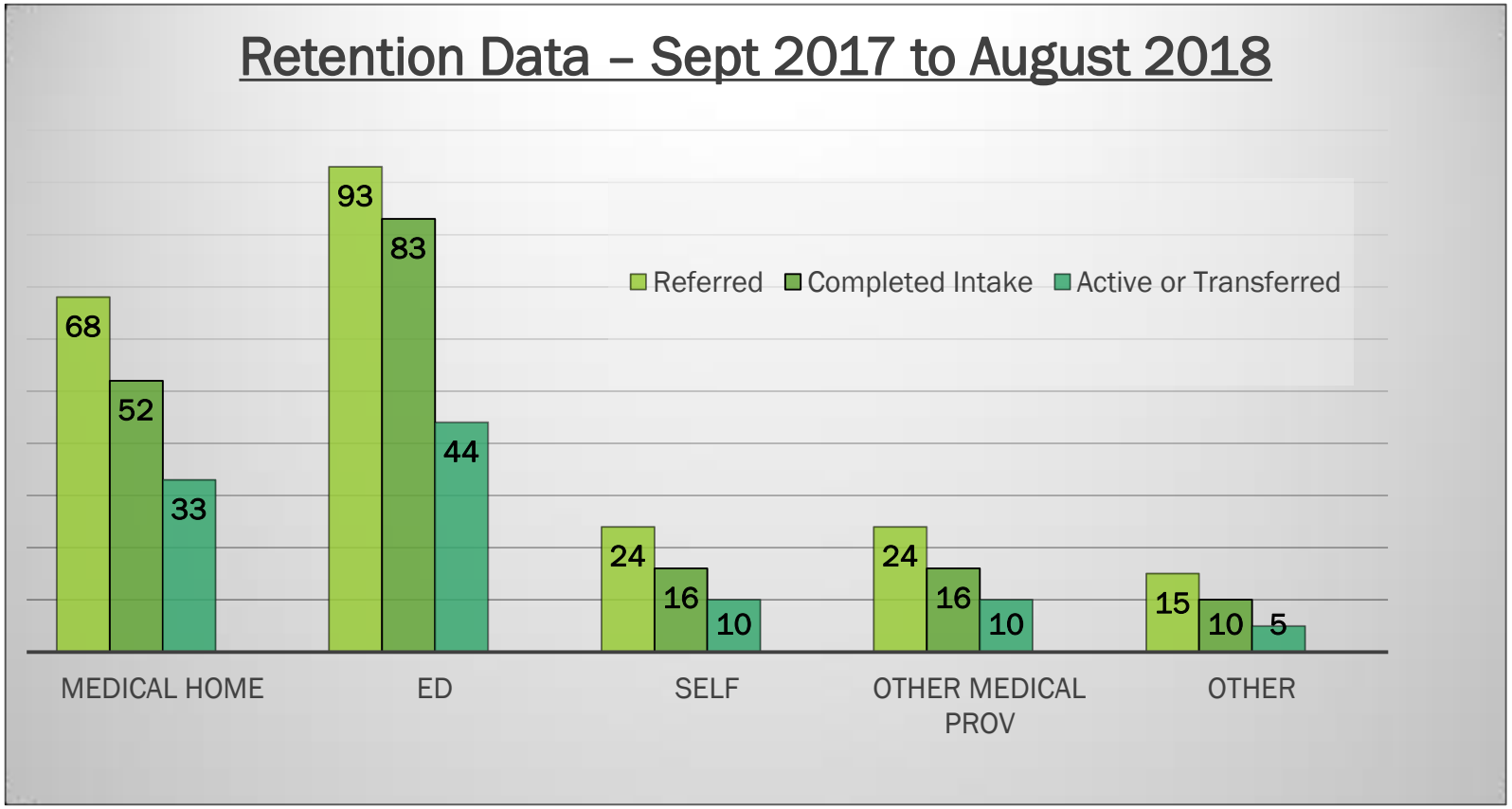




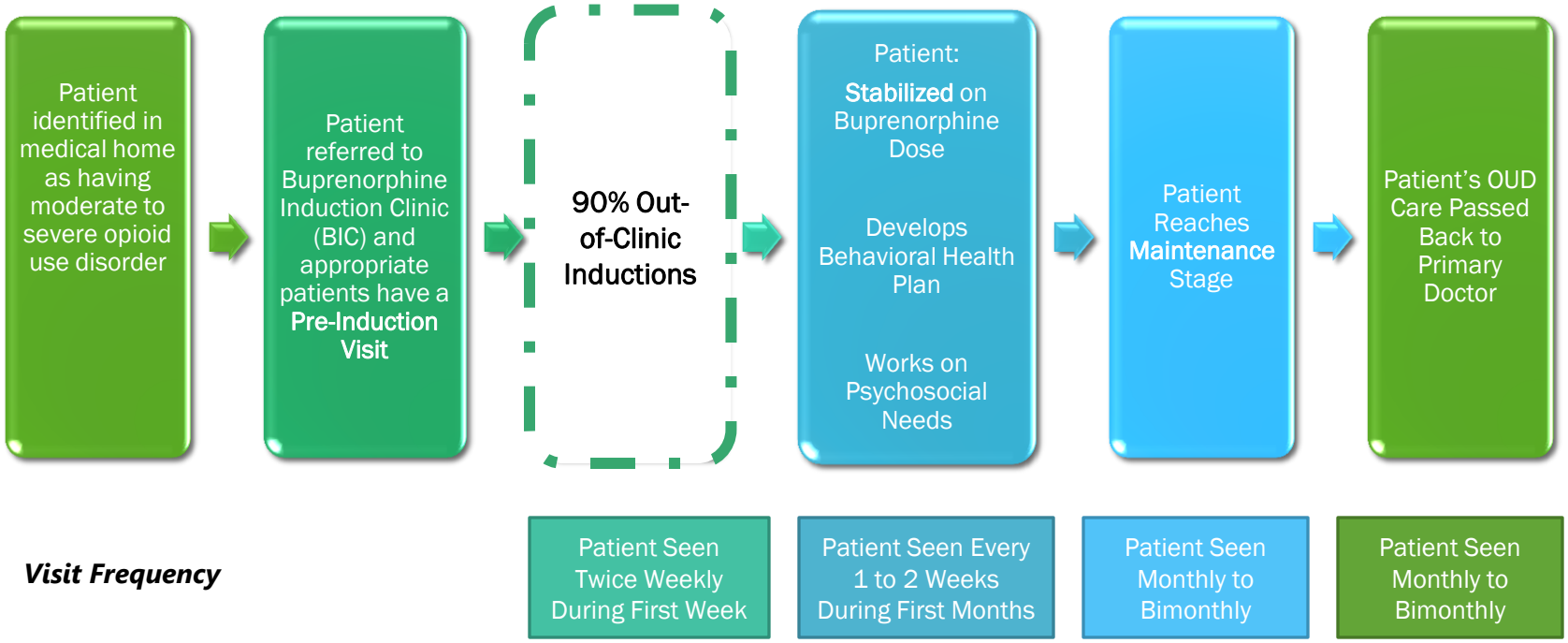
Because… brief medically assisted withdrawal (“detox”) is ineffective

Chutuape, M et al. One-, three-, and six-month outcomes after brief inpatient opioid detoxification. The American Journal of Drug and Alcohol Abuse. Vol 27:1, 2001.

Currently, 50% of Patients Drop Out of Care



Is Induction Truly the Hardest Part? Should We Change Our Name?



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”

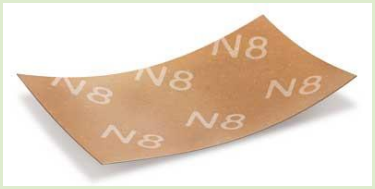
Navigation and assistance with logistical challenges seems extremely important.

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?

Methadone	Buprenorphine	Naltrexone
Full mu agonist  Oral (often solution)	Partial mu agonist    Sublingual (tab, film) or implant (probuphine)	Mu antagonist (Blocks opioid high)   Intramuscular (extended release) or oral

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

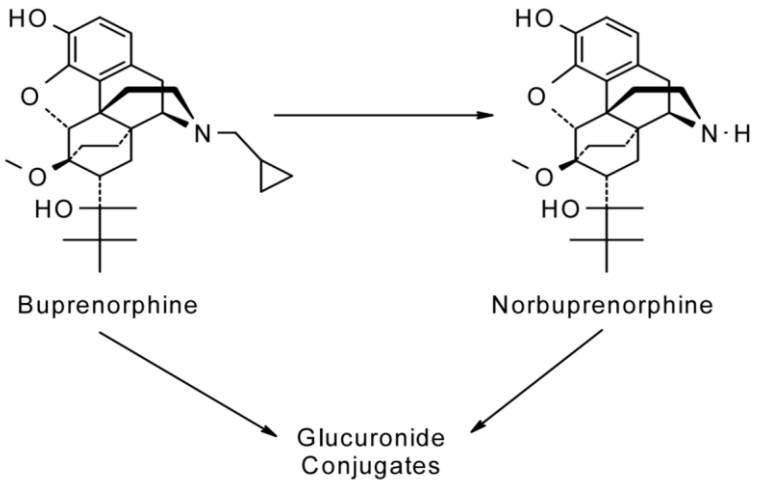
This provides updated information to the FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning issued on August 31, 2016.

Diversion and Urine Tampering are Rare, But They Happen

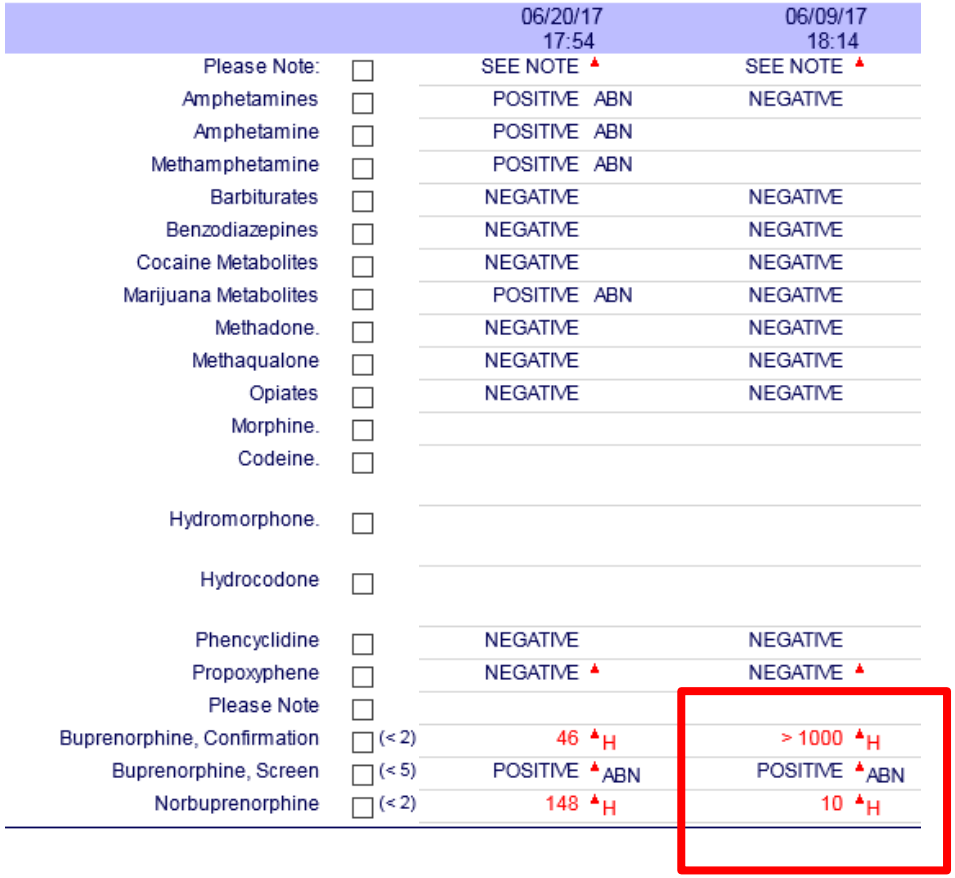
Most often occurs when patients are trying to help another person who is experiencing withdrawal.

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…



			06/20/17 17:54	06/09/17 18:14
Please Note:	☐		SEE NOTE ▲	SEE NOTE ▲
Amphetamines	☐		POSITIVE ABN	NEGATIVE
Amphetamine	☐		POSITIVE ABN	
Methamphetamine	☐		POSITIVE ABN	
Barbiturates	☐		NEGATIVE	NEGATIVE
Benzodiazepines	☐		NEGATIVE	NEGATIVE
Cocaine Metabolites	☐		NEGATIVE	NEGATIVE
Marijuana Metabolites	☐		POSITIVE ABN	NEGATIVE
Methadone.	☐		NEGATIVE	NEGATIVE
Methaqualone	☐		NEGATIVE	NEGATIVE
Opiates	☐		NEGATIVE	NEGATIVE
Morphine.	☐			
Codeine.	☐			
Hydromorphone.	☐			
Hydrocodone	☐			
Phencyclidine	☐		NEGATIVE	NEGATIVE
Propoxyphene	☐		NEGATIVE ▲	NEGATIVE ▲
Please Note	☐			
Buprenorphine, Confirmation	☐	(< 2)	46 ▲H	> 1000 ▲H
Buprenorphine, Screen	☐	(< 5)	POSITIVE ▲ABN	POSITIVE ▲ABN
Norbuprenorphine	☐	(< 2)	148 ▲H	10 ▲H

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:

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- 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?