The Opioid Addiction Epidemic: The Case for Treatment in Primary Care

Marwan Haddad, MD, MPH, AAHIVS
Medical Director, Center for Key Populations
Community Health Center, Inc., Connecticut
January 11, 2016

- Presenter has no financial disclosures to disclose.

Objectives

- By the end of this webinar, you will gain an understanding for
  - Why primary care needs to offer office-based buprenorphine treatment
  - What is needed to establish a buprenorphine maintenance treatment program in primary care

- Q&A/Discussion

IMPORTANCE

- ~4.8 million Americans aged 12+ illicitly used opioid pain relievers or heroin in 2013.
- ~2.5 million were opioid-dependent.
- # received opioid substitution therapy:
  - 330,308 (methadone)
  - 48,148 (buprenorphine)
- Opioid overdose death rates: 7.7 per 100,000

The NSDUH Report, SAMHSA, 2014.
Behavioral Health Barometer: United States, 2014. HHS Publication No. SMA–15–4895, SAMHSA, 2015.

IMPORTANCE

- 86.6% of individuals needing substance use treatment did NOT receive it.
- 8 out of 10 requiring treatment perceived no need.
- Major reason cited for not receiving desired treatment: lack of health coverage

The NSDUH Report, SAMHSA, 2014.
Behavioral Health Barometer: United States, 2014. HHS Publication No. SMA–15–4895, SAMHSA, 2015.

- President Obama unveiled a new plan to combat the rapid rise of opiate overdose deaths – a growing national crisis that has seen deaths from heroin and other opiates quadruple in the past decade.

- The plan calls for doubling the number of approved physicians who can prescribe buprenorphine.

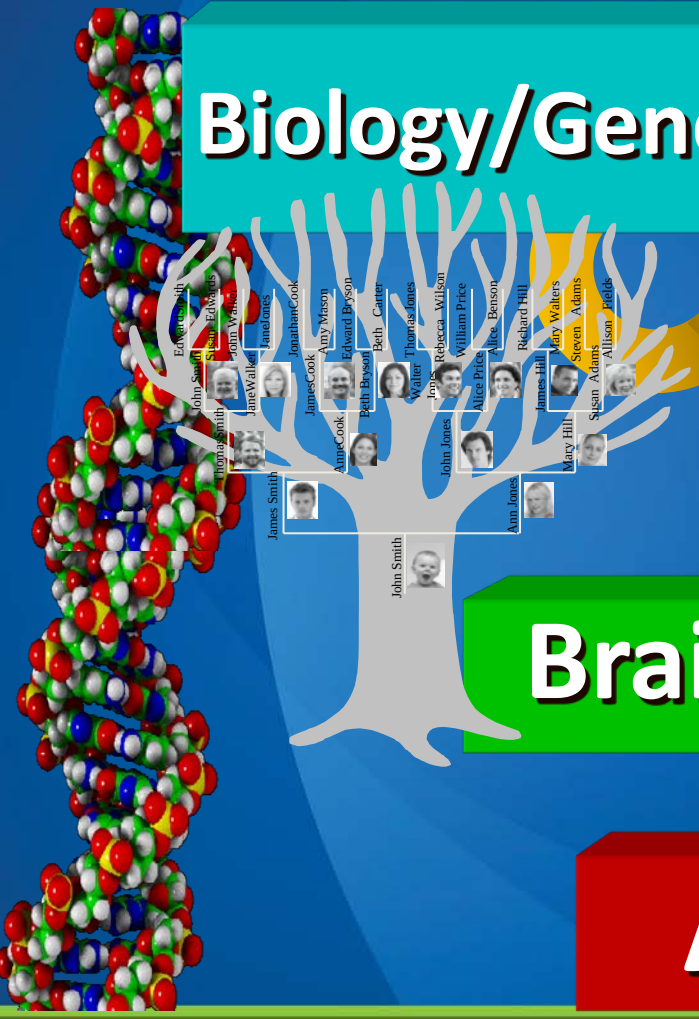
- Yet, many of the current approved physicians are ***not*** prescribing.
  - E.g. Half of approved physicians in CA have prescribed NO buprenorphine.

OUR PATIENTS!

HUGE Contributors to Harm

- We prescribe when there is no indication and when there are contraindications.
- We prescribe to patients with active addiction.
- We prescribe to patients whose problem is non-opioid responsive and places them at high risk for adverse events.
- We ignore recurring non-reassuring behaviors.
- We don't consider the household or community environment into which we place these drugs.
- We devalue effective alternatives.
- We treat "pain" but not addiction.
- We use dangerous combinations of meds.
- We don't like what we're doing and we do little to change it.

ADDICTION IS A CHRONIC DISEASE



Biology/Genes ⟷ Environment

DRUG

Brain Mechanisms

Addiction

	Opioid Dependence	Diabetes Mellitus
Biological basis	Yes	Yes
Behavioral impact	Yes	Yes
Curable	No	No
Replacement Rx	Opioids	Insulin
Responds to Rx	↓ opiate use	↓ glucose
Benefits	↓ transmissions, infections, overdose, crime, hospitalization, mortality; ↑social functioning, employment	↓ damage to heart, kidneys, nerves, hospitalization, mortality

Opioid Substitution Therapy

- Best evidence-based treatment
- Biological rationale
  - prevents withdrawal
  - relieves craving for opioids
  - blocks or attenuates euphoric effect of exogenous opioids
- *Buprenorphine*, Methadone

Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options

Final Report – July 2014

Authored by:

ICER
INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

Table ES1. Summary measures of effectiveness of medications for opioid dependence treatment over 3-12 months of follow-up.

Outcome	Methadone	Buprenorphine/Suboxone	Naltrexone/Vivitrol
Mortality (%)	< 1% (range: 0-6%)	<1% (range: 0-2%)	No deaths reported
Use of Illicit opioids (mean # positive urine tests)	12 (range: 3-25)	12 (range: 3-25)	Not reported (% of patients not achieving abstinence: 40-60%)
Retention in treatment (%)	63% (range: 54-71%)	52% (range: 40-65%)	28% (range: 16-30%)

THE PRESCRIPTION OPIOID ADDICTION TREATMENT STUDY (POATS): TREATMENT STRATEGIES FOR PRESCRIPTION OPIOID DEPENDENCE

- Buprenorphine maintenance at 12 weeks: 50% success
- 8 weeks post taper: 8% success
- Individual opioid drug counseling above standard medical management (once a week MD visit) did not increase success.

Contents lists available at SciVerse ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Integrating buprenorphine maintenance therapy into federally qualified health centers: Real-world substance abuse treatment outcomes

Marwan S. Haddad[a,*], Alexei Zelenev[b], Frederick L. Altice[b,c]

[a] Community Health Center, Inc., Middletown, CT, USA
[b] Yale University School of Medicine, New Haven, CT, USA
[c] Yale University School of Public Health, New Haven, CT, USA

Journal of Urban Health: Bulletin of the New York Academy of Medicine
doi:10.1007/s11524-014-9924-1

Buprenorphine Maintenance Treatment Retention Improves Nationally Recommended Preventive Primary Care Screenings when Integrated into Urban Federally Qualified Health Centers

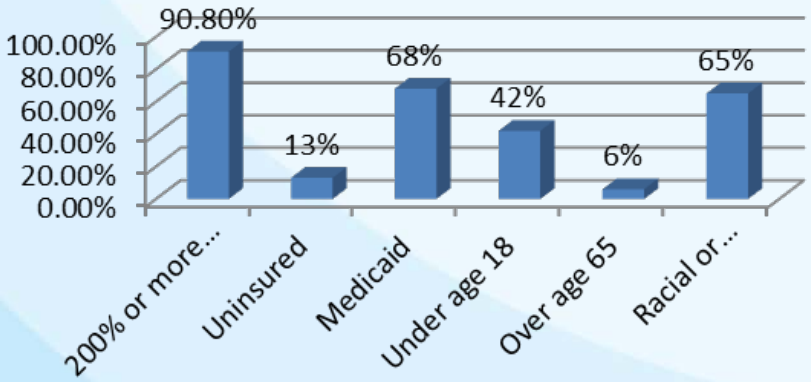
Marwan S. Haddad, Alexei Zelenev, and Frederick L. Altice

Community Health Center, Inc. Where health care is a right, *not a privilege*, since 1972.

Our Vision: Since 1972, Community Health Center, Inc. has been building a world-class primary health care system committed to caring for underserved and uninsured populations and focused on improving health outcomes, as well as building healthy communities.

CHC Inc. Profile:

- Primary Care Hubs – 12
- No. of Service Locations - 251
- Organization Staff – 605
- No. patients – 130,000
- No. visits/year – 429,000
- Medical, BH, Dental Services
- Fully integrated EHR



CHC Locations in Connecticut

Three Foundational Pillars

Clinical Excellence
Research & Development
Training the Next Generation

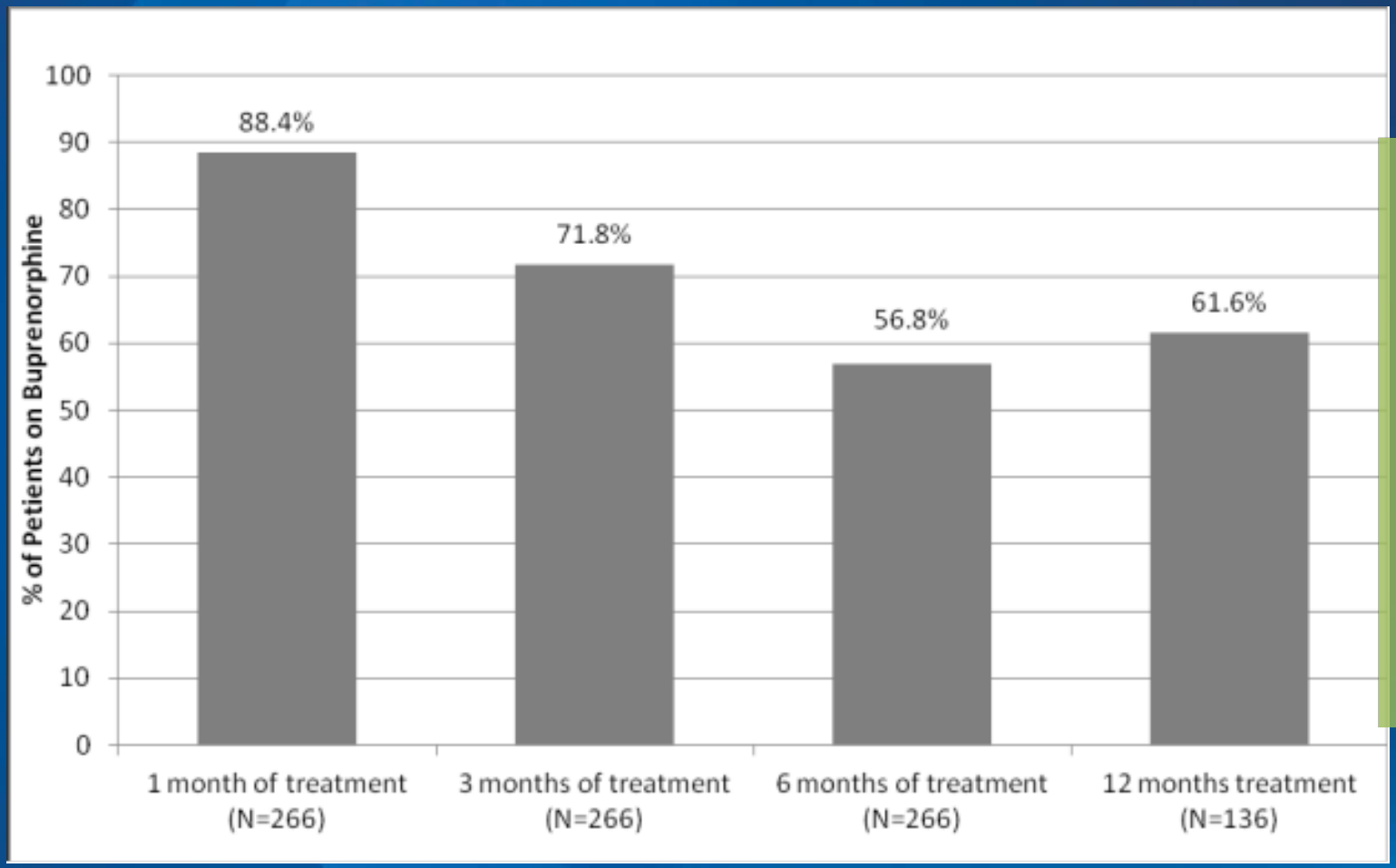
Patient Characteristics

n=266

Characteristic	N(%)
Age, mean	40.1
Male	184 (69.2)
Prescriber	
Primary Care	187 (70.3)
Psychiatry	79 (29.7)
FQHC entry	
BMT	214 (80.5)
Primary care	52 (19.5)
HIV infection	29 (10.9)
HCV infection	159 (59.8)
HBV infection	3 (1.1)
Mood disorder	191 (71.8)
Prescribed psych meds	173 (65.5)
Cocaine use	157 (59.0)

Haddad et al, Drug Alcohol Dependence, 2013;
Haddad et al., Journal Urban Health, 2014

Buprenorphine Retention Rates

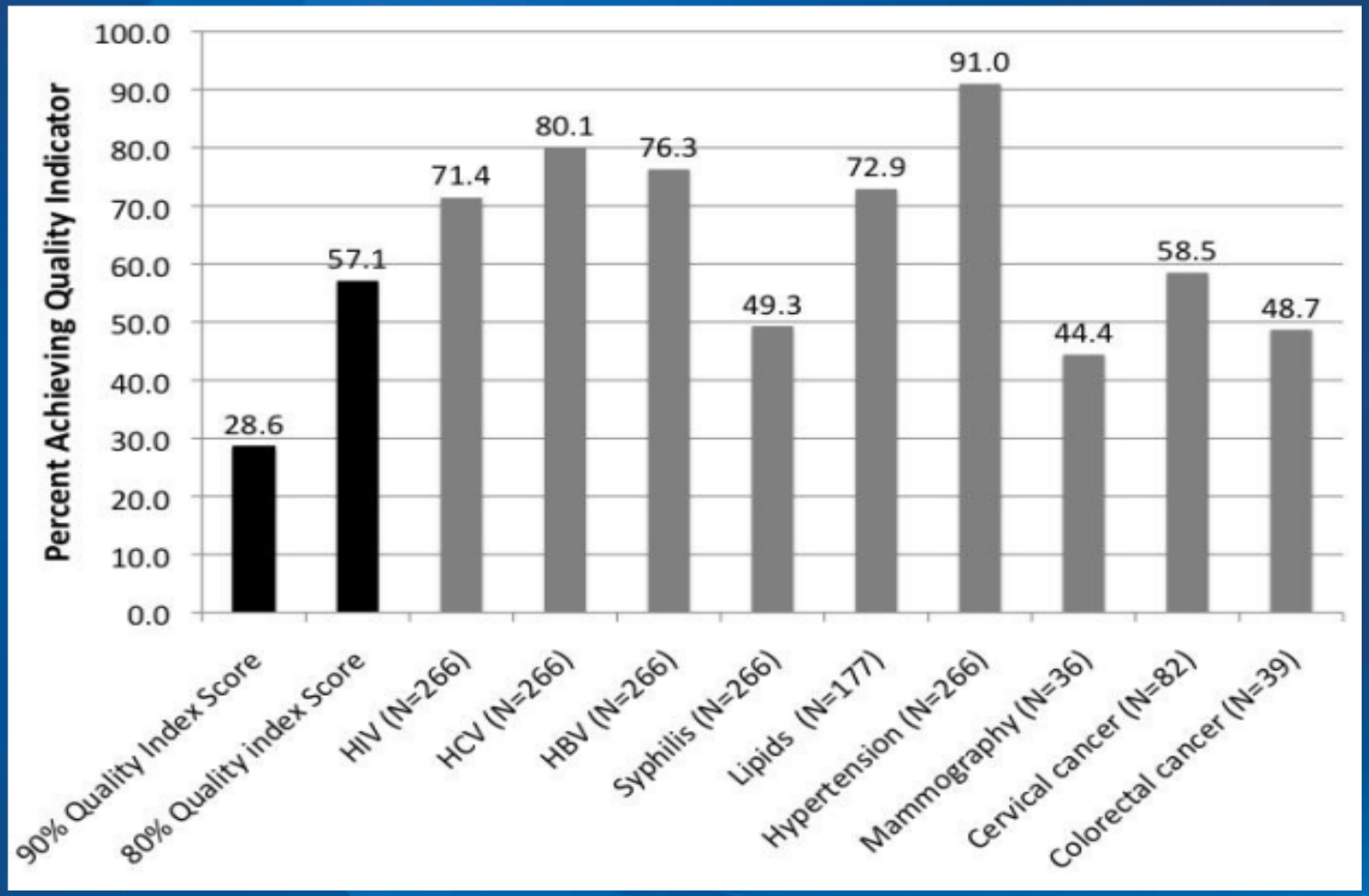


- ✓ Receipt of psych meds
- ✓ Receipt of on-site sub abuse counseling
- ✓ Not using cocaine at baseline

Frequency and Types of Visits

- ✓ Medical:
  - ✓ 90.6% had at least one visit
  - ✓ Mean: 1.7 visits/month
- ✓ Behavioral Health:
  - ✓ 56.3% had at least one visit
  - ✓ Mean: 1.6 visits/month
- ✓ On-site Substance Abuse Counseling:
  - ✓ 53.0% had at least one visit
  - ✓ Mean: 1.2 visits/month
- ✓ Overall Mean: **3.1 visits/month** (range 0.5 – 8.3 visits/month)

Primary Care Screening Rates



- ✓ Male
- ✓ BMT ≥ 3 months
- ✓ Treated by PCP
- ✓ HIV or HCV infected

BMT in Primary Care: Common Challenges

- Buy-In

- Training/Expertise

- Time Constraints

- Diversion

BUY-IN

…from whom?

Senior Leadership

- How?
  - **Clinical champions**
  - E.g. Psychiatrist, PCP, Behavioral health clinician
- Who?
  - E.g. CEO, VP Clinical Services, Chief Medical Officer, Chief Behavioral Health Officer, Chief Nursing Officer, Site Directors
  - Understand the need for our patients and communities
- Business Argument:
  - **Reimbursement++** vs. Capacity

The Clinical Team

- Team-based multi-disciplinary approach
- Provider is key in leading core team
  - May consist of medical assistant and nurse .
  - Exploring personal experiences/attitudes toward addiction.
  - Frequent listening/acknowledging/educating imperative!
- Behavioral health (BH)
  - Find key BH champions, e.g. psychiatrist; clinician running groups
  - Communication through EHR, email, phone, in person
- Front Desk Staff
  - Important to include in communication and education

Training/Expertise

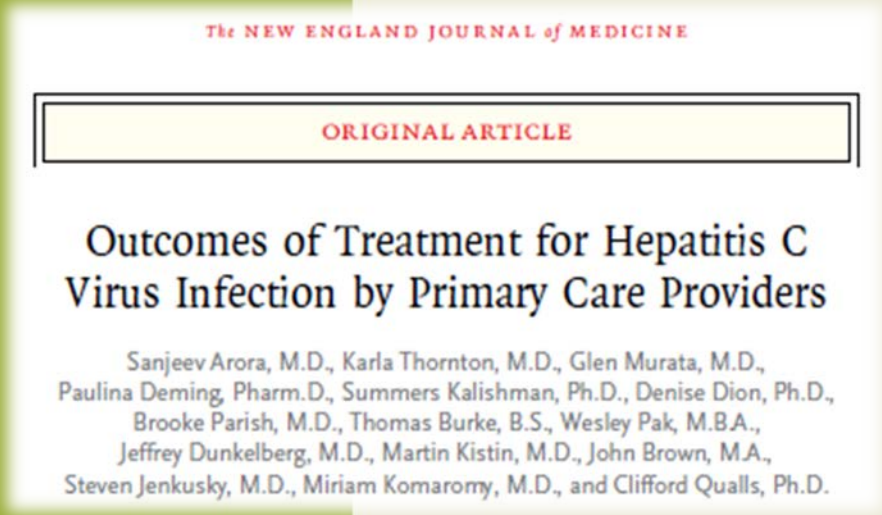
PROJECT ECHO®

weitzman institute
inspiring primary care innovation

Project ECHO Origins

"The mission of **Project ECHO** is to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes."

Dr. Sanjeev Arora, University of New Mexico



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

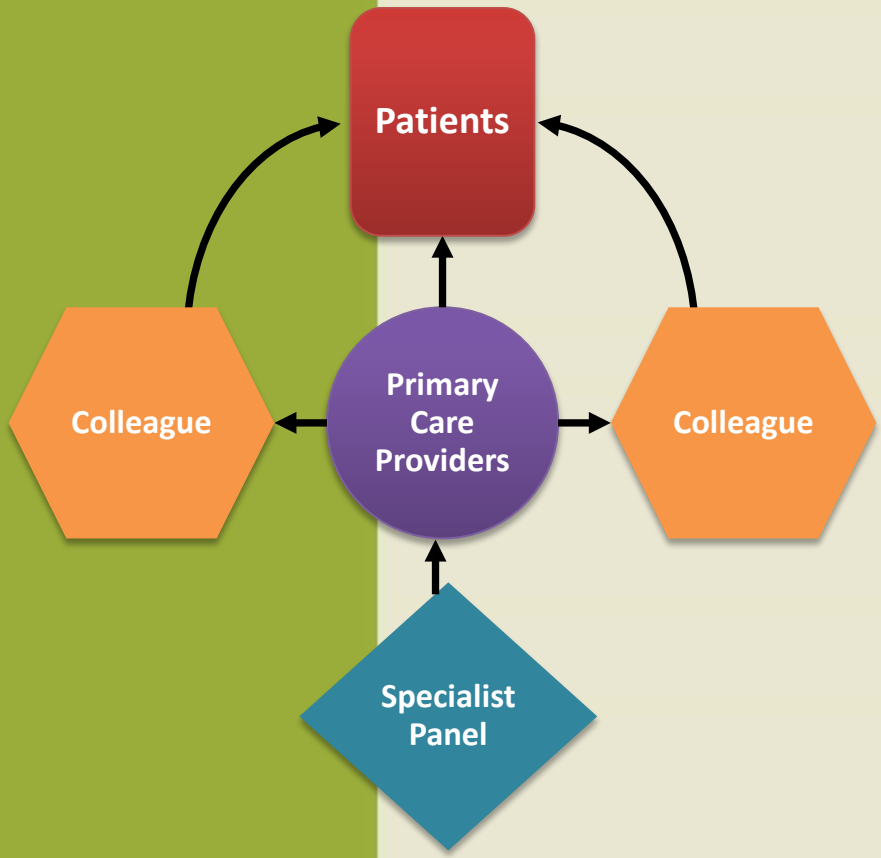
Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers

Sanjeev Arora, M.D., Karla Thornton, M.D., Glen Murata, M.D., Paulina Deming, Pharm.D., Summers Kalishman, Ph.D., Denise Dion, Ph.D., Brooke Parish, M.D., Thomas Burke, B.S., Wesley Pak, M.B.A., Jeffrey Dunkelberg, M.D., Martin Kistin, M.D., John Brown, M.A., Steven Jenkusky, M.D., Miriam Komaromy, M.D., and Clifford Qualls, Ph.D.

NEJM 6/2011

- Prospective cohort study comparing HCV Rx at UNM with Rx by primary care clinicians at 21 ECHO sites in rural areas and prisons in NM.
- 407 patients with no previous treatment
- Primary endpoint was SVR.
- 57.5% at UNM and 58.2% at ECHO sites achieved SVR.
- Serious adverse events occurred in 13.7% at UNM and 6.9% at ECHO sites

The Project ECHO® Model



Benefits

- Increased knowledge and confidence to manage complex chronic conditions in primary care
- Increased patient access to evidence-based treatments
- Increased provider satisfaction and retention
- Reduction in unnecessary imaging and other laboratory services
- Reduction in overuse/misuse of specialty, surgical, and procedural services
- Reduction in inappropriate medication usage

What Does Project ECHO Do?

- Builds communities of practice
- Connects primary care providers and their teams with a panel of expert multidisciplinary faculty
- Improves retention of primary care providers
- Provides brief didactic and case-based learning and management
- Improves health care outcomes with evidence based care plans
- Improves access to specialty care
- Creates a force multiplier

CHC PROJECT ECHO: BUPRENORPHINE

- Launched February 2013
- Monthly 2 hour sessions
- ECHO faculty includes FP MD, psychiatrist, BH clinician, substance abuse counselor, Pharm-D, RN, MA
- Multi-disciplinary ECHOist team includes MD, BH clinician, RN, MA
- 10 CHC sites, DE, NJ, CA, ME

- Format:
  - Brief didactic presentations
  - Case presentations
  - Clinical and programmatic questions

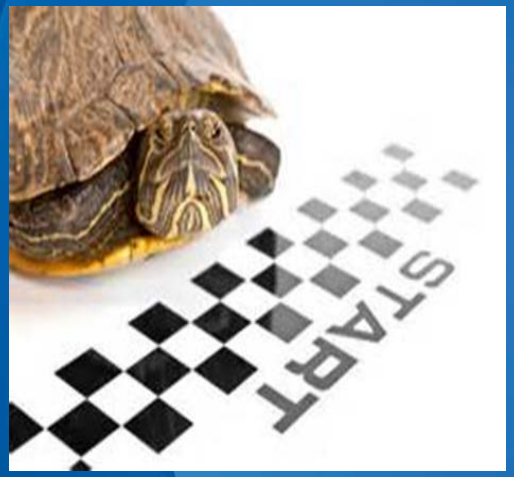
Sample Topics Covered in ECHO

- Induction: home or in-office
- Stabilization/maintenance
- Toxicology screening
  - Urine/saliva
  - Result interpretation
  - Approach to positives
- Strategies to limit diversion
- When to start/stop buprenorphine
- Polysubstance use
  - Benzo use
  - Cocaine use
  - Alcohol use
- Mental health co-morbidities
- Pregnancy
- Pain management issues
- Group counseling dynamics
- Motivational interviewing
- Clinical team roles and dynamics
- Handling of conflicts between team members
- Communication
- Workflow issues
- Time constraints
- Protocols/Patient Agreements

TIME CONSTRAINTS

Can this be done in a busy primary care practice?

CHC Buprenorphine Program



- Providers start slow! Work their way up to an average between 10-30 patients.
- Patients booked as any other patient. No designated day for buprenorphine.
- Provider assesses whether eligible for buprenorphine at first visit. May start patient immediately or bring back for induction visit.
- Weekly visits at first, working up to monthly.
- Providers see patients on average monthly. Nurse or BH clinician (group) sees them weekly.

CHC Buprenorphine Program

- Both in office and home inductions done.
  - No buprenorphine stored on site.
  - In-office: patient picks up bup from pharmacy, brings back for first dose in office with RN/MD. Seen again in 2-3 days. Then weekly.
  - Home: patient receives 3-7 day prescription. Then weekly.
- Toxicology screening done by MAs at provider visits.
- Buprenorphine Treatment Protocol
- Patient Agreement (MA/RN/MD)
- Treatment Linkages
  - List of external resources

CHC Buprenorphine Program

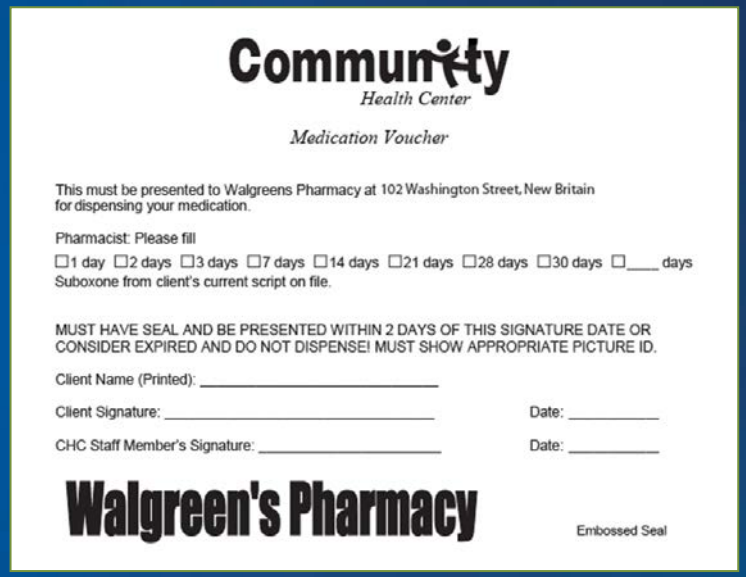
- Follow up on patient accountability to treatment plan
  - Usually done by RN; can be done by MA/MD
- Medication counts/Random tox screens
  - Has been difficult to do; usually RN
- Medication coverage
  - Prior authorizations; done by MA
  - Communication with pharmacies for prescriptions
- Cross Coverage
  - All RNs trained in buprenorphine visits
  - All RNs/MAs trained in tox screen collection
  - Nursing visits/BH group visits
  - Other prescribing providers

Toxicology Screening

and Diversion

Medication Voucher System

- Designed to reduce diversion and improve attendance and retention.
- Allows team members (MD, counselor or nurse) to approve continued buprenorphine treatment based upon contingency management.
- Coordinate with one (or more) pharmacy(ies).
- Voucher is **not** a prescription.
- Prescriptions are sent to pharmacy. Usually one week prescription with 3 refills, since patients are to see providers monthly.



Community
Health Center

Medication Voucher

This must be presented to Walgreens Pharmacy at 102 Washington Street, New Britain for dispensing your medication.

Pharmacist: Please fill

☐1 day ☐2 days ☐3 days ☐7 days ☐14 days ☐21 days ☐28 days ☐30 days ☐____ days
Suboxone from client's current script on file.

MUST HAVE SEAL AND BE PRESENTED WITHIN 2 DAYS OF THIS SIGNATURE DATE OR CONSIDER EXPIRED AND DO NOT DISPENSE! MUST SHOW APPROPRIATE PICTURE ID.

Client Name (Printed): _____

Client Signature: _____ Date: _____

CHC Staff Member's Signature: _____ Date: _____

Walgreen's Pharmacy

Embossed Seal

Medication Counts

- Med counts are the most difficult problem to coordinate and fit into schedules.
- Usually assigned to RN.
- Challenges:
  - Getting in touch with patients.
  - Having them come in same day.
  - Time consuming.

Toxicology Screening

- Lab screening and/or point of care testing.
- MAs collect toxicology screens when patient seeing provider.
- RNs collect screens if nursing visit.
- BH groups send patients to on-site lab for screens.
- Toxicology screens sent out to Quest lab.
  - Extensive drug screening; all GC/MS confirmed.

Strategies to limit tampering and diversion

- Urine cups with temperature gauges
- No jacket, bag, children, etc. with patient during collection
- Tox screen includes creatinine, specific gravity, oxidant to rule out tampering
- Check buprenorphine levels
- Observed urines
  - Challenges: acceptability, discomfort, true observation
- Saliva screening
  - Run as sole screen or in addition to urine for comparison
  - Limitation: accurate for drug use within 36 hours or so
- Random urines
  - Same challenges as for medication counts

weitzman institute inspiring primary care innovation

PROJECT ECHO®

CHC OUTCOMES

ECHO Strategy: Outcomes

	PRE-ECHO	POST-ECHO		
		CHC	DE, NJ, CA	TOTAL
# Health Center Sites	3	10	7	17
# Buprenorphine Prescribers				
PCP	6	17	4	21
Psychiatry	1	3	5	8
Total	7	20	9	29
# BH Clinicians (LADC, LCSW, PsyD, APRN)	3	12	9	21
GRAND TOTAL	10			50

ECHO Strategy: Outcomes

971

Summary

- The opioid epidemic is a major health problem across the U.S. and is a challenge to many states.
- Primary care involvement is essential.
- Primary care providers are at the forefront of this epidemic and can increase access to life-changing, life-saving therapy by prescribing buprenorphine.
- Integrating buprenorphine into primary care can be done successfully.
- Care coordination and chronic care disease model approaches are key and central to primary care.
- Providers do not have to do this alone.
  - Project ECHO
  - PCSS-MAT, etc.

Thank you!

Contact:

haddadm@chc1.com

Bright Spots – Round Robin

Share one strategy you've implemented so far that impacts:

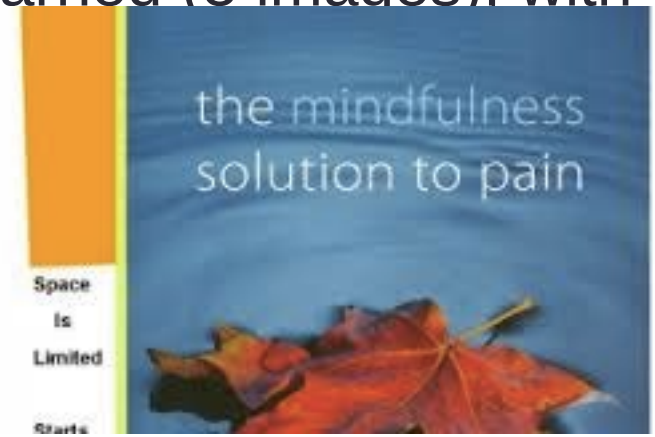
- Infrastructure for safer prescribing culture, e.g., pain squad, EHR template, opioid review committee

- Training for safer prescribing culture, e.g., presented a lecture, developed an educational series

Gearing up for March 24 Convening

Each residency program will have an opportunity to share (5m)

- Pecha Kucha - show 15 images, each for 20 seconds. The images advance automatically and you talk along to the images.
- Share your successes (5 images), challenges (5 images), and lessons learned (5 images), with colleagues.



Important Dates

2/8 webinar, Dr. Scott Fishman, UC Davis Pain Medicine, on non-opioid pain management strategies.

3/24 final in-person meeting in Oakland: 10am - 4pm

CME Credit

For CME credit, please complete evaluation:

http://goo.gl/forms/XQ9LFmC8qq