Treatment of Addiction in Primary Care

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Heroin Kills
One
Every
Nine Minutes
Resilience in changing environment

Evidence Based Approaches
Why Primary Care?

Only 1 out of 10 people with opioid use disorder get treatment
Primary Care MAT Programs: Ten Elements of Success

California Healthcare Foundation (CHCF)
10 Elements of Success

1) A Champion
2) Staffing for Administrative Activities
3) Team-based Approach
4) Connection to Behavioral Health
5) Mentoring Support for physicians Two Waived Docs per Practice
6) Assessing patient readiness
7) An Induction Approach that fits
8) Pharmacist Willing to Partner
9) Sustainable Financing
Champion

1. Passionate advocate for best practices care
2. Essential to transforming of the clinic culture
3. Emerges naturally in the clinic
4. Support from clinic administration
Champion educates and supports clinic staff

1. **Identifying the barrier of stigma within the clinic**
   - Belief, Language, Attitude

2. **Reach into all departments, cultivate allies**
   - Front desk staff, Medical Assistants, Billing and coding

3. **Community allies and alliances**
   - Participate in opioid coalitions and SUD collaborations
Integrating Addiction Medicine into Primary Care Practice Requires Staff!

Or Does it?
COMPLIANCE

Are you within your waiver limit?

Are you ready to report to DEA?

Are your medical records organized?
To save one Life
It takes a Village
Team @ Work

Case Managers
Nursing, Counselors, Medical Assistants
All can get INVOLVED

Administration
IT Support
Run the Business

Providers
Waivered or NOT
All Specialty Areas

Office Assistants
Answer the Phone
Wrangle the Schedule.
Team-based approach for MAT programs

The flow of patient care from screening to intake to induction to stabilization involves a team-based approach.

1. Wrap-around services within the clinic or refer to community resources.

2. Early stabilization requires close monitoring, dose management and supportive care.
MAT Program Manager

1. Develops patient pathways, program policies & procedures & structure.

2. Supports team processes and maintains communication with Medical Director and clinic administrators.

3. Program Manager usually holds another role on the MAT team such as RN, SUD counselor or BH therapist.
DEA waived prescriber (MD, NP, PA)

1. Leads patient care
2. Conducts weekly case reviews
3. Makes referrals for all medical and behavioral needs.
4. Works closely with RN Case Manager for safe inductions, dosing and stabilization.
RN Case Manager

1. Screens and assesses for MAT admission
2. Works with prescriber for induction planning and care
3. Stabilization, assessment of buprenorphine dosing
4. Management of side effects.
5. Treatment planning including BH and SUD counseling needs.
SUD Counselor (CAADC I-II; LAADC)

1. Partners with patient with treatment goals

2. Treatment planning, program adherence, ongoing interventions and follow-up.

3. Works with community treatment resources access Outpatient, Intensive Outpatient and Residential levels of care.

4. Utilizes ASAM whole-person criteria for appropriate level of care.
Behavioral Health Therapists (LCSW, LMFT, PhD, PsyD)

1. Collaborates with MAT team for all therapeutic needs.
2. Participates in case reviews.
3. Refers to psychiatry if needed.
4. Facilitates and develops curriculums for Refill/Stabilization groups.
Medical Assistants

1. Supports inductions and weekly groups
   a. Collecting of urine drugs screens
   b. Vitals
   c. Manages patient flow at group visits

2. Can also function as patient navigators
Stop Filling the Hole, Heal the Hole

Jerry Moe, National Director of the Children’s Program at the Betty Ford Center
Behavioral Health Specialists Can...
Matching Patients with EtOH Use Disorder to treatment (N=1726)

Cognitive Behavioral Therapy
12-Step Facilitated
Motivational Enhancement Treatment

All Patients Showed Improvement
Two Waivered Providers

For Physicians
Get DATA 2000 8 Hour Waiver Qualifying Buprenorphine Training.
Up to 9 AMA PRA Category 1 Credit™
$199 user fee

For Nurse Practitioners and Physicians Assistants
Part 1 (8 hrs) of a 24 hour credit activity for NPs/PAs.
$199 user fee for all 24 hours
Mentorship for Physicians
Assessing Patient Readiness

Everyone is motivated when they are going through withdrawals
Motivating Factors

Legal - court, probation, jail
Children - Child Protective Services
Family/Friends
Mortality - Overdose, Infectious Diseases, Witness Death of Friends
Financial - “I can’t afford it anymore”
Motivational Question

Determine stage of change

Assess risk level - high level of risk less likely to change

Assess willingness to adhere program requirements
Tools

Readiness To Change Questionnaire (Treatment Version) (RCQ-TV)

Readiness Ruler
The Induction Puzzle, Starting Buprenorphine Without Causing Precipitated Withdrawals
Patient
Motivated and Able
Pregnant or Not

Drugs
Short or Long Acting
Opioids

Timing
Opioid-Free or Not
@Home or Not

Stabilizing
With Time
With other Drugs

References:
The New England Journal of Medicine; “Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure”; 2010; 363:2320-31
https://doi.org/10.1331/108658002763316860
Sustainable Financing

How do we pay for all of the program costs?

- Non billable staff (case manager, program director, counselor, medical assistants, etc.)
- Therapy same day as provider refill visit
- Space
Sustainable Financing (cont.)

- Identify the cost
- Explore community partnerships
- Talk to your payors
El Dorado Community Health Center Project

Collaboration with California Health and Wellness

- Identified patient by insurance
- ~ 57% Medi Cal (large portion California Health and Wellness)
- Reviewed services by complexity
- Selected performance metrics
- Ongoing study by quarter as patient numbers increase and patients move towards sober living
Results of Study

Overall average costs decreased
Inpatient and pharmacy have the greatest costs reduction
ER and specialists costs also decreased
Hospital OP costs, other medical, and primary care costs increased
Primary care costs increase is a desirable effect
Opportunities

Work with payor to offset costs of program

- Provide a case manager
- Contract for behavioral health
- Identify case rate instead of current rate for primary care
SUMMARY of 10 Elements of Success

1) A Champion
2) Staffing for Administrative Activities
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Case Presentations
Opioid Use in Pregnancy

22 yo F G5P2012 presents at 9 weeks to your office. She had started taking pills for chronic pain after an MVA 3 yrs ago and currently taking 180 norcos/month bt sometimes more from a friend.

Past tx: She has tried methadone on the street, tried tapering without success.

Social: She lives with her partner who does not use but they are in the process of becoming homeless because he just lost his job. They don't have insurance.

This is an unintended but desired pregnancy and she would like to hear options for treatment.
What are the options for treatment?

Methadone

Buprenorphine

Taper

Considerations During Pregnancy

1) Social Support
   a) Engaging community programs (home health RN, family, WIC, housing resources)

2) Access to Treatment
   a) Policy implications
   b) System in place for pregnancy and access to MAT

4) Neonatal Abstinence Score (transitions of care)
Neonatal Abstinence Scores

Withdrawal symptoms occur 48–72 hours after birth

1. Tremors, hyperactive reflexes, seizures

2. Excessive or high-pitched crying, irritability, yawning, stuffy nose, sneezing, sleep disturb

3. Poor feeding, loose stools, dehydration, poor weight gain

4. Increased sweating, temperature instability

Hudak ML, Tan RC, Committee on Drugs, et al.
Effects of Opioids on newborn

In utero effects:

1. Poor fetal growth
2. Prolonged hospitalization (including NICU admission)
3. Poor postnatal growth, dehydration, and seizures

Data on long-term developmental outcomes related to NAS are limited.
32 yo unemployed, divorced male presents with alcohol use disorder severe - reports drinking 8 - 12 drinks daily for past five years. Began drinking age 14. History of meth use but no use in past 5 years. Pt reports IV heroin use of ½ - 1 gram daily for past 2 years. Currently living with mother. His mother says he can continue to stay with her if he stops drinking and using drugs. Patient reports a 10-day residential social detox 18 months ago but resumed alcohol and heroin within 24 hours of discharge. He had declined residential treatment following that detox phase. Patient expresses a strong desire to stop drinking and using. Expresses fear of withdrawal from both substances. Adverse Childhood Experiences (ACEs) score is 6/10.
Challenges and Considerations

Safe withdrawal management:

- Home withdrawal management not recommended.
- Hospital withdrawal management rarely available.

Setting - most often a bed in “social detox” with non-medical staff monitoring vitals and assisting patient with self-administration of medication per MD’s protocols.

Risks: withdrawal seizures, delirium tremens from EtOH w/d. **Severe opioid withdrawal symptoms can cause a patient to leave treatment and resume use.**
Strategies and Pitfalls

Use polysubstance withdrawal protocols for safe alcohol withdrawal and comfort through the first days of opioid withdrawal.

Consider initiating low dose buprenorphine on day 2 or 3 of alcohol withdrawal.

Close collaboration with staff of social detox. Follow-up care with prescriber and RN case manager on day 4 or 5 of withdrawal phrase.

Patients with AUD and OUD do best with at least 30 days in residential treatment with continued buprenorphine.
Case of Opioids + BNZ

53 year old woman with lumbar pain following lumbar discectomy with laminectomy presents to you because of worsening pain and to establish care. She is currently taking hydrocodone/APAP 10/325 tablet every 4 hours (6/day) and has been taking it for over 5 years. Two years ago she began taking alprazolam 0.5mg three times per day for anxiety as prescribed by previous primary provider. She is also using zolpidem 10mg at bedtime. Her CURES report shows that hydrocodone is frequently filled a week early. Her urine drug test is consistent except for positive test result for oxazepam. When questioned, she admits to using a friends diazepam when she ran short of her medications. Her pain has been a 9/10 lately and she is feeling depressed.
Step-wise Solution
Pain and Chemical Dependency
Roller-Coaster

1. **STAGE 1**
   Motivate the patient for CHANGE

2. **STAGE 2**
   Promote Chemical STABILITY

3. **STAGE 3**
   Introduce OTHER SOLUTIONS for pain:

4. **STAGE 4**
   Step through the doorway of HEALTH:

5. **STAGE 5**
   Begin a slow TAPER:
Neutralize the Nervous System

The Neutralizing Medications: “calm the nerves”

- Beyond Gabapentin is Zonisamide, Topiramate, Tiagabine and Pregabalin

- TCA = Tricyclic Analgesics (amitriptyline, imipramine, desipramine)

- Baclofen, a muscle relaxant and NMDA antagonist
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Introduce OTHER SOLUTIONS for pain:

STAGE 4
Step through the doorway of HEALTH:

STAGE 5
Begin a slow TAPER:
Anti-inflammationary Diet
Step-wise Solution
Pain and Chemical Dependency
Roller-Coaster

STAGE 1
Motivate the patient for CHANGE

STAGE 2
Promote Chemical STABILITY

STAGE 3
Introduce OTHER SOLUTIONS for pain:

STAGE 4
Step through the doorway of HEALTH:

STAGE 5
Begin a slow TAPER:
Case of Opioids + Stimulants

32 yo female pt with hx of IV heroin use x 4 yrs along with methamphetamines. She is homeless and has a history of diagnosed bipolar and admits to using heroin and meth to keep her mood stable. She uses heroin and meth with her boyfriend. Pt has a history of multiple overdoses
Harm Reduction vs Relapse Prevention or Both?

Barriers to relapse prevention

- Homeless
- Transportation
- Lack of support
- Partner uses
- Multiple substances
Pt was inducted with buprenorphine and was accepted to a residential treatment facility funded by the County coordinated by the Homeless Outreach Program. On the day of admission, the pt did not want to leave her boyfriend and declined. She continued the MAT program and continues to test negative for opioids, but positive for methamphetamines. She continues to decline behavioral health therapy, but agreed to taking lamotrigine, and risperidone.

Do we continue prescribing buprenorphine when she doesn’t follow the requirements of the program?
The Matrix Model

Group Psychotherapy

Individual Counseling

Family Therapy

Contingency Management

Crystal Methamphetamine Anonymous

Treatment of Co-occurring Disorders
Contingency Model

Highly effective in increasing treatment retention and promoting abstinence

Positive reinforcement

- Congratulate on successes
  - Showing up to appointments
  - Highlight urine drug screen free of opioids

Tangible rewards to reinforce positive behaviors

Voucher-based or prize incentives
Why Primary Care or MAT

We see many of these patients in primary care already.

Many have barriers to care (e.g., transportation).

Treat the whole person - one stop shop.

High percentage of co-occurring mental health illness.

Diagnosis and treatment of comorbid diseases such as HIV, Hep C, and STDs.
Which of the following is a removable barrier to integrating SUD treatment into primary care?

a. Induction process
b. Staffing shortage
c. Money
d. Team motivation
e. All of the above
According to Project Match, which behavioral treatment is appropriate for use in a wide range of people with EtOH use disorder?

a. Cognitive Behavioral Therapy (CBT)

b. 12 Step Facilitated Treatment (TSF)

c. Motivation Enhancement Treatment (ME)

d. All of the above
Which of the following is an inferior option for treatment of Opioid Use disorder during pregnancy

A) Buprenorphine
B) Methadone
C) Naltrexone/ Abstinence
D) None of the above
E) All of the Above
True or False?

Group Sessions for Patient slow down the practice, reduce volume, and provide little revenue generation.
Matching Patients with Alcohol Disorders to Treatments: Clinical Implications from Project Match; Journal of Mental Health, 1998

Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure; Jones, H. et al; The New England Journal of Medicine; 2010; 363: 2320-31


Transdermal Buprenorphine, Opioid Rotation to Sublingual Buprenorphine and Avoidance of precipitated Withdrawals: A review of literature and Demonstration of Three Chronic Pain Patients treated with Butrans; Howard, K. et al; Journal of Therapeutics; 2015; Vol 22 Issue 3 pg199-205

