Integrated Care Strategies for Patients with Opioid Use Disorder

Daniel Mullin, PsyD, MPH

Center for Integrated Primary Care
Department of Family Medicine and Community Health
University of Massachusetts Medical School
Faculty Disclosure

The presenter has NOT had any relevant financial relationships during the past 12 months.
Learning Objectives

By the conclusion of this training participants will be able to:

1. differentiate traditional approaches to addiction treatment from primary care approaches that emphasize harm reduction, empathy, and chronic disease management.

2. implement team based approaches to the care of patients with Opioid Use Disorder that include medical, nursing, and behavioral health providers.

3. apply strategies for overcoming common concerns and reservations about providing Medication-Assisted Treatment in primary care.
Drug Dependence, a Chronic Medical Illness
Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O’Brien, MD, PhD
Herbert D. Kleber, MD

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

JAMA. 2000;284:1689-1695
Prescription Opiate Abuse

CDC Data
## Heroin Use Has INCREASED Among Most Demographic Groups

<table>
<thead>
<tr>
<th>SEX</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE, YEARS</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>2002-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17</td>
<td>1.8</td>
<td>1.6</td>
<td>0.8</td>
<td>--</td>
</tr>
<tr>
<td>18-25</td>
<td>3.5</td>
<td>7.3</td>
<td>3.8</td>
<td>109%</td>
</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>0.7</td>
<td>58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANNUAL HOUSEHOLD INCOME</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
</tr>
<tr>
<td>$20,000–$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH INSURANCE COVERAGE</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
<td>--</td>
</tr>
<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
</tr>
</tbody>
</table>

## Heroin Addiction and Overdose Deaths are Climbing

Heroin-Related Overdose Deaths (per 100,000 people)

Heroin Addiction (per 1,000 people)

Fentanyl, a synthetic and short-acting opioid analgesic, is 50-100 times more potent than morphine (CDC).
Deaths from overdoses are reaching levels similar to the H.I.V. epidemic at its peak.

The death rate from drug overdoses is climbing at a much faster pace than other causes of death, jumping to an average of 15 per 100,000 in 2014 from nine per 100,000 in 2003.

The trend is now similar to that of the human immunodeficiency virus, or H.I.V., epidemic in the late 1980s and early 1990s, said Robert Anderson, the C.D.C.’s chief of mortality statistics.
In the US, MAT generally takes the form of:

**Primary Care & Addiction Medicine**
- Buprenorphine (in pregnancy)
- Buprenorphine/naloxone (Suboxone, Zubsolv)

**Extended-release Naltrexone (Vivitrol)**

**Federally-Licensed Centers**
- Methadone
Can generally be cared for successfully in primary care with integrated behavioral health.

Require more intensive forms of treatment:
- Methadone
- Structured outpatient
- Residential (nearby)
- Residential (out of area)
Why Primary Care?
Epidemics require a coordinated primary care and public health response.

Secondary and tertiary care systems cannot adequately respond to epidemics.
Secondary and tertiary care systems cannot adequately respond to epidemics

Detox
Methadone
Residential Treatment
Hospitalization
Partial Hospitalization
Addiction Specialty Care

Necessary but not sufficient
- Can’t be scaled up
- Do not serve many communities
- Do not address chronicity
General Principles of Primary Care

**Accessibility** - First and easy contact with the health care system

**Comprehensiveness** - Accountability for addressing a vast majority of health care needs

**Coordination** - Coordination of care across settings

**Continuity** - Sustained partnership and personal relationships over time with patients known in the context of family and community
MAT and BH Integration

Approaches to Behavioral Health and Primary Care Integration that emphasize
• Accessibility
• Comprehensiveness
• Coordination
• Continuity
are best suited to addressing the Opioid Epidemic
Accessibility to Integrated Care / MAT

- Same day or same week access to services when requested
- Remove barriers such as phone screening and intake appointments
- Extended office hours
- Same day buprenorphine induction
- Coordinated PCP and BHP appointments
- First apt should emphasize engagement NOT assessment
Comprehensive Care of patients w/ OUD

- Long term buprenorphine and counseling as needed
- HIV/Hep C screening and treatment
- Contraception
- Pre-natal care for women/families with OUD
- Management of co-morbid medical and psychiatric conditions, w/ access to consulting psychiatry
- Care, education, and naloxone to family members
Comprehensive Integrated BH Care

- Integrated BH care w/ evidence based treatment
  - Motivational Interviewing
  - Relapse Prevention
  - Couples and Family Therapy
  - Cognitive Behavioral, Solution Focused, and Problem Solving therapies for co-morbid mood, trauma, anxiety
Coordination of Care for patients with OUD

- Specialty services not available in primary care:
  OB, psychiatry, infectious disease
- As needed higher levels of treatment for OUD:
  hospitalization, residential, and partial programs
- Social and Legal Services:
  Child Protection, Probation, Supplemental Nutrition Assistance Program, housing, and medical transportation
- Referral for dental services and associated pain management
Continuity of Care of patients with OUD

- OUD is a chronic condition with frequent co-morbidities
- Continuity of care “team” is valuable
  - Many patients remain in MAT for years
  - Many exit and re-enter treatment multiple times
- For many patients BHPs must provide ongoing care, often beyond 10 sessions
- Most patients will be in treatment for many months or years, occasionally with gaps in treatment
Co-located care of patients with OUD

<table>
<thead>
<tr>
<th>PCP’s responsibilities</th>
<th>BHP’s responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients appropriate for buprenorphine</td>
<td>Address behavioral aspects of substance use disorder</td>
</tr>
<tr>
<td>See patients weekly-monthly for refills</td>
<td>Provide weekly counseling</td>
</tr>
<tr>
<td>Assess risk/benefit of buprenorphine and other medications</td>
<td>Address broader psychosocial context</td>
</tr>
<tr>
<td>(stimulants, benzos)</td>
<td></td>
</tr>
<tr>
<td>Screen for and treat infectious disease; address contraception</td>
<td>Screen for and address mental health co-morbidities</td>
</tr>
<tr>
<td>and prenatal care</td>
<td></td>
</tr>
</tbody>
</table>
# Integrated Care of Patients with OUD

<table>
<thead>
<tr>
<th>Everyone’s responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
</tr>
<tr>
<td>NP/PA</td>
</tr>
<tr>
<td>BHPs</td>
</tr>
<tr>
<td>Nurses</td>
</tr>
<tr>
<td>Medical Assistants</td>
</tr>
<tr>
<td>Dedicated care managers</td>
</tr>
<tr>
<td>Peer support</td>
</tr>
</tbody>
</table>

Everyone
# Integrated, Team Based MAT

## Team’s Responsibilities

<table>
<thead>
<tr>
<th>Identify patients appropriate for buprenorphine</th>
<th>Address behavioral aspects of substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>See patients for regular medication refills and counseling as clinically indicated</td>
<td>Managing transitions of care</td>
</tr>
<tr>
<td>Assess risk/benefit of buprenorphine and other medications (stimulants, benzos)</td>
<td>Address broader psychosocial context</td>
</tr>
<tr>
<td>Screen for and treat infectious disease; address contraception and prenatal care</td>
<td>Screen for and address mental health co-morbidities</td>
</tr>
</tbody>
</table>
Care Management and OUD

- Care Management can be either/both a function and a person
- Practices with ~ 150 patients receiving MAT can likely benefit from a 1.0 FTE dedicated care manager
- Everyone in practice (including PCP and BHPs) will contribute to care management:
  - Coordination of care
  - Addressing psychosocial needs
  - Between visit care (voice or electronic)
Harm Reduction
Top-down, abstinence driven policy with limited integration of user-driven experience

Time and effort spent on eradicating intractable human behaviors can be better spent working with affected individuals to find ways to **reduce the associated negative consequences**.

(Harm Reduction Coalition, 2010)
What is Harm Reduction?

• Appreciation for the complexity and nuance of human behavior
• Meeting patients where they are regarding motivation and ability to change
• Practical approaches to reduce the problematic effects of drug use and other high-risk behaviors and increase a person’s quality of life.
• Empowering patients to devise their own means to reducing harm
• Success in not bound to abstinence, but is defined as any step in the right direction
• An alternative when abstinence-only methods are not effective, desired, or realistic for a certain patient

Marlatt, 1998; Marlatt, Larimer, & Witkiewitz, 2012
Harm Reduction: Clinical Care

- Harm reductions offers health care providers an alternative approach when patients continue to use substances.
- Harm reduction means the health care provider doesn’t see the patient’s situation and treatment options in only black or white, all or nothing terms.
- A harm reduction practitioner seeks out acceptable, feasible, and effective solutions that are applicable to specific situations.
- A harm reduction approach means not withholding access to treatment services when a patient can’t or won’t meet our treatment outcome ideals.
- In certain cases, harm reduction may not be the best or only option.

Marlatt, 2008; Logan & Marlatt, 2010; Marlatt, Larimer, & Witkiewitz, 2012
Abstinence is on the spectrum of Harm Reduction strategies and is a goal that greatly reduces risk of harm.
Common Misconceptions and Challenges in MAT
A Misconception:
The Typical Trajectory of Recovery
Patient enters treatment

Possible, but unusual course

Time
Daily Use of Opioids → Intermittent Use of Opioids → No Use of Opioids

Most frequent course

Patient enters treatment

Time
Daily Use of Opioids → Intermittent Use of Opioids → No Use of Opioids

Patient enters treatment

Easy

Time
Daily Use of Opioids → Intermittent Use of Opioids → No Use of Opioids

Patient enters treatment

Hard Tim e
Duration of treatment (weeks)

Probability that opiate substitution treatment (OST) reduces overall mortality

(Cornish, 2010)
A Misconception:
Buprenorphine is Dangerous
Likely Sources of PCP Fears of MAT

• DEA-X Waiver training - implicitly (incorrectly) suggests danger
• Stigma associated with care of patients with OUD
• Inadequate training in difficult conversations related to controlled substances
• Past 20+ years of misrepresentation of risks associated with prescription opioids
PCPs and Risk / Benefit of Prescribing

- PCPs struggle with prescribing controlled substances
- Risk / benefit analysis of prescribing buprenorphine is very different than other controlled substances, it takes them a while to realize this
- Risk of oxycodone (and similar) > risk of buprenorphine
- Potential rewards to the provider are much greater for buprenorphine
A Misconception:
I should focus on limiting diversion of buprenorphine
Emerging Evidence on Diversion of Buprenorphine

• Culture of sharing
• Buprenorphine on street is gateway to treatment
• Patients with experience with buprenorphine on street prior to treatment, tend to do better once in treatment

(Monico, 2015; Johnson, 2015; Havnes, 2013)
A Misconception:
Everyone with an OUD needs counseling
Emerging Evidence on Counseling and Buprenorphine

• Not all patients need counseling
• Still plenty of work for BHPs
• What patients might be targeted for counseling?
  • Those who ask/agree
  • Co-occurring alcohol, cocaine
  • Trauma
  • Encourage for recent lapse or overdose
A Misconception:
People cannot safely be prescribed stimulants or benzodiazepines with buprenorphine
A Misconception:
People who are using cocaine or alcohol or marijuana are not appropriate for MAT