Treating the Whole Patient, Addiction Medicine is Primary Care Medicine

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- I have no commercial interests to disclose

Personal Disclosure

Learning Objectives

- Why addiction treatment belongs in the primary care home
- Perceived barriers to being treatment provider
- Defining the elements of an integrated, humanistic, high quality primary care MAT program
- Relapse, pitfalls, firing patients, other pearls and sticky wickets

MAT is a tool, not recovery

- Blocks the effects of opioids
- Suppresses opioid withdrawal
- Reduces craving and stops or reduces the use of opioids
- Facilitates engagement in recovery oriented activities

Why Treat Addiction in Primary Care?

Primary Care specializes in care that is:

- Accessible
- Comprehensive
- Continuous through ages and stages
- Family Centered
- Coordinated with community resources
- Culturally relevant

Why Treat Addiction in Primary Care?

- Patients with addiction have high rates of co-morbid illness/risky behaviors including:
  - Tobacco use/COPD
  - Hepatitis C/HIV
  - DVT/peripheral arterial thrombosis/peripheral neuropathy
  - Mental illness (Depression, ADHD, Bipolar, Anxiety)
  - Chronic infections (skin/oral/bone)
  - Hypertension & Diabetes

1. Lawson E, Br J Gen Pract. 2013 May;63(610):231-2. Management of opioid addiction in primary care: a pragmatic approach prioritising well-being not ideology.
2. Rowe TA1, Jacopraro JS, Rastegar DA. Addict Sci Clin Pract. 2012 Oct 29;7:22. Entry into primary care-based buprenorphine treatment is associated with identification and treatment of other chronic medical problems.

Why Treat Addiction in Primary Care?

- Addiction is a ***chronic relapsing, remitting disease*** that requires a comprehensive approach to treatment
- Treatment goals:
  - *Optimize the patient's chances for productive life
  - *Manage symptoms and co-morbid conditions
  - *Improve birth outcomes
  - *Reduce mortality
  - *Harm Reduction
  - **Bottom line**: not everyone will be substance free

Why Addiction Treatment in Primary Care?

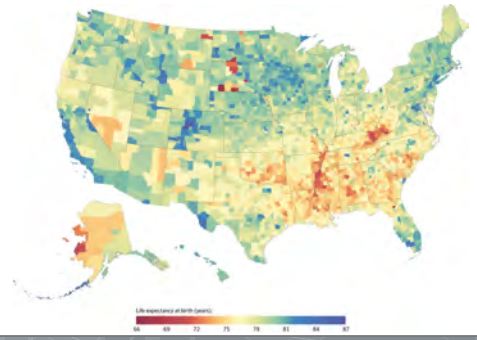
- Often patients with addiction are already our patients, who, given the opportunity, want to tell us about their addiction and prefer to keep their treatment in their medical home.

Why Treat Addiction in Primary Care?

- Because addiction treatment reduces:
  - Unplanned pregnancy
  - Transmission of Hepatitis B, C, HIV and STIs
  - Child Abuse/Neglect
  - Family Disruption
  - Untreated Mental Illness
  - Overall Mortality
  - Crime
  - Babies born dependent on substances
- These are all primary care issues.

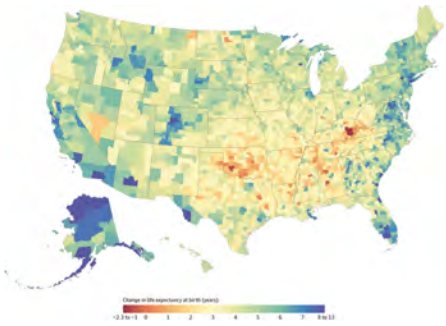
US Life Expectancy by County, 2014

(IHME, May 8, 2017)

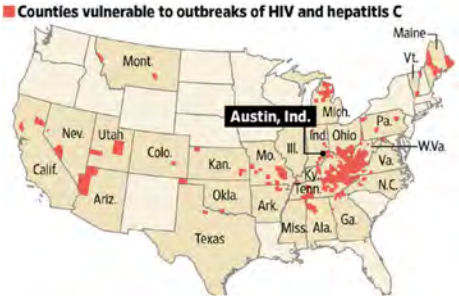


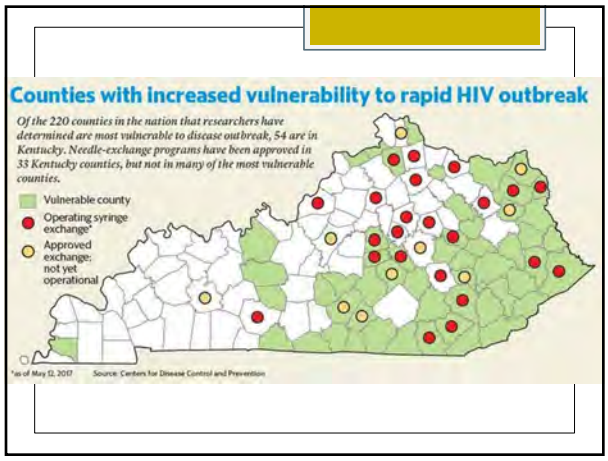
Change in Life Expectancy in US 1980-2014

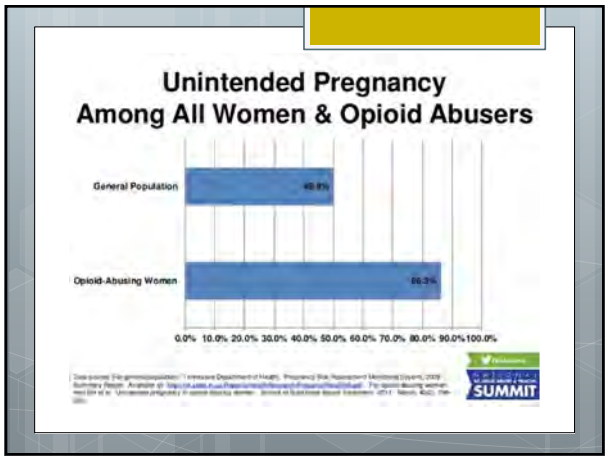
(IHME, May 8, 2017)

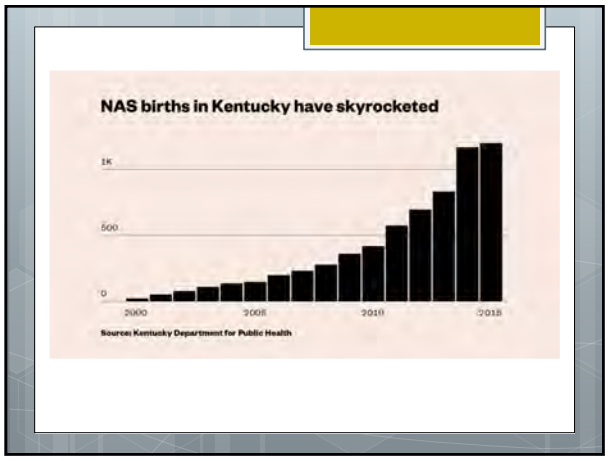


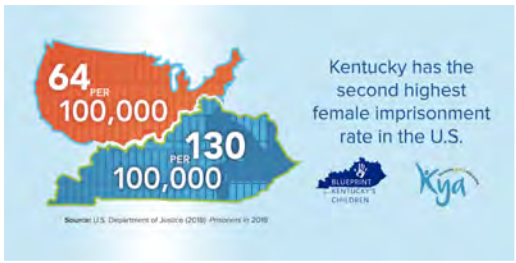
Counties vulnerable to outbreaks of HIV and hepatitis C




Counties with increased vulnerability to rapid HIV outbreak
Of the 220 counties in the nation that researchers have determined are most vulnerable to disease outbreak, 54 are in Kentucky. Needle-exchange programs have been approved in 33 Kentucky counties, but not in many of the most vulnerable counties.
Vulnerable county
Operating syringe exchange*
Approved exchange; not yet operational
*as of May 12, 2017
Source: Centers for Disease Control and Prevention


Unintended Pregnancy
Among All Women & Opioid Abusers
General Population
Opioid-Abusing Women
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%
SUMMIT


NAS births in Kentucky have skyrocketed
1K
500
0
2000
2005
2010
2015
Source: Kentucky Department for Public Health



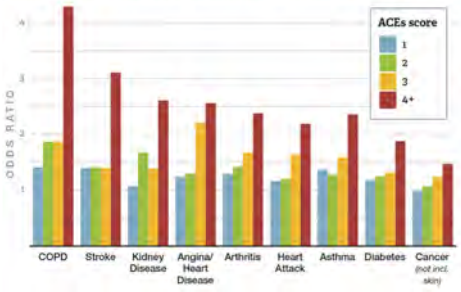
Child Neglect

- Kentucky has the highest rate of children in foster care in the country (more than 8,200 in care now)
- More children enter care than exit
- 1/3 are eligible for adoption and only 1/3 of those got adopted last year
- at least 40% of cases involve parental substance use

THE 10 ADVERSE CHILD EXPERIENCES

1. Physical abuse
2. Emotional abuse
3. Sexual abuse
4. Physical neglect
5. Emotional neglect
6. Alcohol or drug abuse by a parent
7. Mentally ill parent
8. Divorce
9. Incarceration of parent
10. Childhood Domestic Violence

LIKELIHOOD TO DEVELOP HEALTH CONDITIONS BASED ON ACES



This chart represents odds ratios, or how many times more likely an adult with ACEs is to experience a given health outcome compared to those without ACEs. For example, those with four or more ACEs are 4.3 times more likely to have chronic obstructive pulmonary disease (COPD), 2.4 times more likely to develop asthma, and 2.2 times more likely to have a heart attack than those without ACEs.

Perceived Barriers to Prescribing MAT

- More than 80% of family physicians feel they regularly see patients addicted to opiates.
- The majority (70%) feel that they, as family physicians, bear responsibility for treating opiate addiction.
- But only 10% are buprenorphine prescribers.

- Rural Remote Health. 2015;15:3019. Epub 2015 Feb 4. Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. DeFlavio JR1, Rolin SA2, Nordstrom BR3, Kazal LA Jr4.
- Ann Fam Med. 2014 Mar-Apr;12(2):128-33. Barriers to primary care physicians prescribing buprenorphine. Hutchinson E1, Catlin M, Andrilla CH, Baldwin LM, Rosenblatt RA

Perceived Barriers to Prescribing

MAT by PCPs in FQHCs

- Patients with SUD had significant co-morbid disorders and seeking treatment got them into care
- Patients with HIV were more likely to stay on meds and stay virally suppressed
- ER visits were reduced
- Retaining patients in MAT for as little as 3 months increased the likelihood that recommended preventive screenings were performed
- Patients averaged 3.1 visits/month to the FQHC
- A6 months > 50% were still in treatment; dosing was individualized

MAT by PCPs in FQHCs

Two factors were found to be significantly associated with improved retention on buprenorphine at both 6 and 12 months:

✓ Receiving on-site substance abuse counseling

✓ Receiving psychiatric medication

BOTTOM LINE:
Concomitant treatment of mental illness is critical for MAT retention.
Corollary: The relationship with the physician improves outcomes

DSM V Criteria for OUD (2/4 in 12 months)

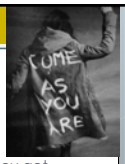
- Have you tried to quit before? (impaired control)
- How did you start and end up here? (impaired control)
- Do you crave the drug? (impaired control)
- Have you had any legal/DCBS issues b/c of drug use? (Social impairment)
- How much time do you spend looking for the drug? (Social impairment)
- What have you lost as a result of drugs? (Social impairment)
- Do you ever inject, crush, snort or chew drugs? (risky behavior)
- Do you have recurrent infections from using? (risky behavior)
- How do you feel physically when you can't access to the drug? (withdrawal)
- How much does it take to prevent withdrawal? (withdrawal)

Who's not appropriate?

- They're not dependent on opiates
- They're mentally unstable
- They want buprenorphine for pain relief
- They're not motivated for recovery

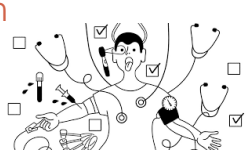
- Showing up to the initial interview intoxicated is not a reason to deny treatment

The Initial Visit - H&P



- **HPI:** DSM V criteria for opiate use disorder; How did they get here? Why are they here now? And what do they want their life to look like?
- **FHx:** addiction, mental illness
- **PMHx:** psych and sexual history, trauma, last age appropriate screenings and vaccinations, other substance use
- **For women:** are they pregnant? Birth control?
- **SHx:** living sit, transportation, education, hx of abuse, Tb risks, CPS and legal system interactions

Physical Exam



- Look for signs of:
  - Opiate withdrawal
  - Intoxication
  - Injection drug use
  - Hepatitis
  - Mutilation/abuse/past trauma
  - Non-Professional tattoos
  - Abscess/Infection

Initial Laboratory Work up

- CMP
- Urine Drug Screen
- Urine Pregnancy
- Hepatitis Serology
- RPR
- HIV
- Other labs as appropriate

Urine Drug Testing

- Just one tool in your complete assessment
- Not necessary at every visit
- Confirm presence of BUP and absence of other drugs of abuse. It's either appropriate or it's not.
- In office testing is a qualitative SCREEN, many False positives
- Send out for quantitative confirmation
- Randomly witness UDS

Follow up visits

- at least weekly for the first month
- at least every two weeks for the second month
- at least every four weeks thereafter
- Very individualized
- Length of visit is as long or as short as necessary for the patient's well being

- NOTE: I book new patients for thirty minutes and follow up patients for fifteen. On average for my entire practice I see 20-25 patients a day, and work about 730 - 530.

The Patient's Goals for Treatment

- Reduce/eliminate use of illicit drugs
- Reduce criminal activity & involvement w criminal justice system
- Reduce behaviors contributing to spread of infectious diseases
- Improved quality of life such as physical and mental health & functioning
- Retention in treatment
- Family reunification
- Employment
- Engagement in recovery support services
- Completion of education
- New relationship and reparation of old ones

Addressing other health issues

- **Abscess/infection - skin/teeth/bone/heart**
- **Mental Health**
- **Birth Control**
- **Thrombosis – arterial and venous**
- Acute illness
- Hypertension
- COPD
- Diabetes
- Tobacco use
- Vaccination
- Unintended Pregnancy

J Urban Health. 2015 Feb;92(1):193-213. Buprenorphine maintenance treatment retention improves nationally recommended preventive primary care screenings when integrated into urban federally qualified health centers. Haddad MS1, Zelenev A, Altice FL.

Other considerations

- Family visits
- Family members with addiction
- Diversion
- Side effects
  - weight gain, constipation, fertility

How Does it End?

- Mutual decision between provider and patient
- Patient has met and sustained their goals through life's challenges

- Encourage persistent engagement in treatment for ongoing monitoring after medication discontinuation

Patients who relapse after MAT has stopped (up to 80%) should be restarted on buprenorphine.

There is no recommended time limit for treatment with buprenorphine. Buprenorphine taper and discontinuation is a slow process

Nobody's Perfect. Dismiss bad behavior, not relapse

- Substance use isn't a reason to dismiss a patient, it's a reason to reassess the situation
- Follow the rules of the program - don't be habitually late, don't miss pill counts and keep a phone # on file that works
- Don't threaten me or the staff
- Don't be disruptive
- Don't lie/swap urine or fake proof of counseling
- Don't fill narcotics
  - be clear about extra-ordinary circumstances
- Don't be rude and don't steal from my sharps container
- Incarceration — case by case basis

Relapse

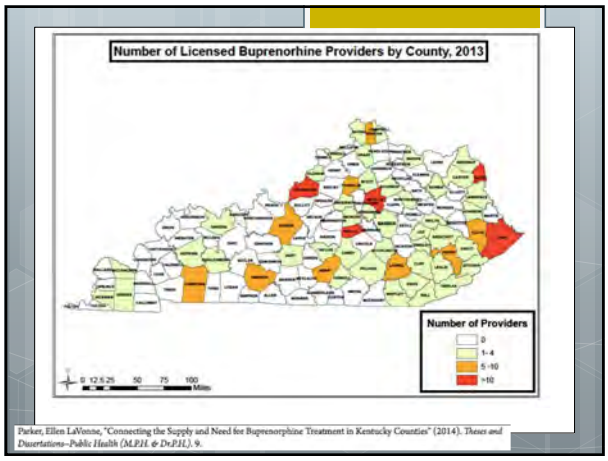
- What did they take?
- What was the circumstance?
- What did it do for them physically?
- How did they feel emotionally/mentally?
- What could they have done differently?
- How can they avoid same situation?
- What's at stake?
- Is anything needed from me? Dose adjustment? Counseling change? Psych med?

Stumbling Blocks for Patients

- Worthiness/Self Esteem
- Finding a meaningful substitute
- Coping Skills
- Their environment and culture
- Transportation
- Access to Birth Control
- Mental Illness
- Pain
- The Legal System
- The healthcare system

A few last thoughts….

- Have a program coordinator



Parker, Ellen LaVonne, "Connecting the Supply and Need for Buprenorphine Treatment in Kentucky Counties" (2014). *Theses and Dissertations--Public Health (M.P.H. & Dr.P.H.)*. 9.

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For More Information

- DEA's DATA waiver home page:
  - http://www.deadiversion.usdoj.gov/faq/waiver_1301_76.htm
- SAMSHA's buprenorphine homepage:
  - http://buprenorphine.samhsa.gov
- SAMSHA's buprenorphine guidelines
  - http://buprenorphine.samhsa.gov/tip43_curriculum.pdf
- APA webinar on DEA waivers:
  - https://education.psychiatry.org/Users/ProductDetails.aspx?ActivityID=416

For more information

- Provider's Clinical Support System for MAT (SAMSHA approved training:
  - http://pcssmat.org/
- ASAM home page:
  - http://www.asam.org/
- KYSAM Facebook page:
  - https://www.facebook.com/KYSAM-865335530242448/?fref=ts
- ASAM consensus guideline on MAT for opioid use disorder:
  - http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-jam-article.pdf?sfvrsn=0
- KBML Buprenorphine prescribing standards:
  - http://www.lrc.ky.gov/kar/201/009/270.htm

For More Information

- AAAP Buprenorphine Waiver Training
  - http://www.aaap.org/education-training/buprenorphine/
  - ASAM Buprenorphine Waiver Training
    - http://www.asam.org/education/live-online-cme/buprenorphine-course

One question substance abuse screening

- How many times in the past year have you
  - Used an illegal drug or
  - Used a prescription medication for a non-medical purpose (e.g. the feeling that the medication caused)
  - Positive screen is one time or greater
- Efficacy
  - Test Sensitivity: 90-100%
  - Test Specificity: 74%
- References
  - Smith (2010) Arch Intern Med 170(13): 1155-60

Physical Exam - template

- GEN: Intoxication, sedation, appearance
- HEENT: icterus, pupil size, tearing, dentition, rhinorrhea, teeth
- Chest: HR, murmurs
- ABD: hepatomegaly
- Neuro: tremor
- Psych: restlessness, anxiety, level of cooperation, speech, behaviors
- SKIN: jaundice, track marks, non-professional tattoos, abscesses, diaphoresis, excoriations, piloerection

Follow up visits - template

- Vitals
- How long have they been in treatment
- How long have they been on current dose
- Urine drug screen (discretionary)
- Review KASPER
- Counseling up to date
- Last liver screening
- Document any craving, withdrawal or relapse
- Last time readiness for taper was assessed and rationale for dose (at least q 3 mo)
- Note any withdrawal symptoms - COWS score
- Comment on big stressors, progress toward goals