Treating Opioid Dependence as a Chronic Condition in Primary Care: Implications for the Training and Practice of Medical and Behavioral Health Providers

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.
Learning Objectives

1. Describe the role of primary care and collaborative care teams in responding to the opioid epidemic.

2. Describe a practice-specific model of buprenorphine and counseling services highlighting procedures such as the treatment contract, a tiering system, behavioral health integration, and the role of family support and staff education.

3. Identify the challenges and successes of caring for patients with opioid use disorders in primary care from the perspective of a physician and a behavioral health provider through a case example.


A learning assessment is required for CE credit. A question and answer period will be conducted at the end of this presentation.
Introductions
Your Experience?
Opioid Use Disorder is a Chronic, Lethal, Stigmatized Disease
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

Many expensive and disturbing social problems can be traced directly to drug dependence. Recent studies\(^1\)\(^4\) estimated that drug dependence costs the United States approximately \$67 billion annually in crime, lost work productivity, foster care, and other social problems.\(^2\)\(^4\) These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that requires interdiction and law enforce-

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**

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**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).
Fentanyl reports in NFLIS, by State
July – December 2014
MAT

Medication Assisted Treatment

= medication + behavioral intervention
Epidemics require a coordinated primary care and public health response

Secondary and tertiary care systems cannot adequately respond to epidemics
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
Daily Use of Opioids → No Use of Opioids

Possible, but unusual course

Time
Patient enters treatment

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

Most frequent course

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

Patient enters treatment

Easy

Time
Patient enters treatment

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

Hard

Time
Duration of treatment (weeks)

Probability that opiate substitution treatment (OST) reduces overall mortality

(Cornish, 2010)
G. Alan Marlatt, PhD (1941 – 2011):
Pioneer in the Harm Reduction Movement and Addiction Treatment,
Addiction Behaviors Research Center, University of Washington

Defining Harm Reduction...

“...harm reduction as a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors and improving quality of life (QoL).”

“... harm reduction is more of an attitude than a fixed set of rules or regulations... A humanitarian stance that accepts the inherent dignity of life... And appreciates the complexity and nuance of human behavior.”

“empower patients to devise their own means to reducing harm and defining their own ends as to what harm reduction will comprise... harm reduction approaches can more flexibly accommodate affected individuals’ and communities’ specific needs than other top-down, theory-oriented approaches.”

“Harm reduction... deemphasizes general theory and ideology and seeks out acceptable, feasible, and effective solutions that are applicable to specific situations.”
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) > buprenorphine

Potential rewards to the provider are much greater for buprenorphine
Practice Specific Model of Medication-Assisted Treatment in Primary Care

- Buprenorphine treatment agreement
- Informed consent for buprenorphine treatment
- Tier system
- Role of patients support system in treatment
- Staff education
Initial Visit

- Initial encounter in 2014
- History of polysubstance abuse complicated by psychiatric comorbidities including trauma history
- Multiple attempts at recovery but continues to relapse
- Social support non-existent
- Has not seen a PCP in years
- No income
- No transportation
- Unstable housing
Initial Impression & Plan

- Overwhelmed by the complexity of her history
- Not sure where to begin to address her needs
- Decided to tackle her opioid addiction first
- Needs psychiatric diagnosis clarification
Overview of Patient History
Experimental use of illicit substances, ETOH use, social anxiety, mother’s SUD

Frequent use, leaves home, academic decline, legal issues, drops out of high school, 1st psychiatric hospitalization, sexual assault, sibling rejection

Uses heroin for the first time

Daily heroin use, stealing, prostitution, homeless, methadone tx, another psychiatric hospitalization, illicit use buprenorphine, cycles through use and abstinence

Caught stealing, incarceration 3 months, completes GED

Released, enters treatment in community (buprenorphine), lives independently, stable work, no heroin use for 4 months, uses other substances recreationally

Relapses with heroin, loses job and housing, DUI, homeless

Presents to our health center
History of Substance Use Disorder Treatment

- Residential treatment
- Intensive outpatient treatment: SUD
- Individual and group counseling: SUD
- Buprenorphine (outpatient SUD clinic)
- Methadone
- NA meetings
Mental Health History

**Previous diagnoses:**
- PTSD
- Social anxiety
- Major depression
- ADHD
- Bipolar I disorder
- Borderline personality disorder

**Interpersonal trauma**
Sexual trauma (Ages 18 and 21) and prostitution

**Family maternal history of bipolar disorder, depression, and substance use disorders**

**Genetic predisposition for strong emotional reactivity to environment**

**Severe social anxiety during youth, trouble making and keeping friends**

**Grief**
Barriers

- Employment
- Transportation issues
- Financial issues
- Education
- Pending legal issues
Month 1

- Longer periods w/o heroin and cocaine use
- Verbalizes desire to decrease use of benzodiazepine/stimulant medications
- Starts process for enrolling in college
- Accepted into independent housing
- Spends more time talking about future goals – reasons for sustaining abstinence

Most Recent Encounter

Month 21
Month 1

Stabilize OUD, additional supports, co-occurring psychological symptoms

Section 12: Hospitalized, residential treatment

Robbed, sexual assault

Section 12: Hospitalized

Transition psychiatric medications to outpatient MH clinic

Overdose

Frequent clinic visits appearing under influence

Halfway house

Discussions around benzodiazepine/stimulant medications

Partial Hospitalization program

Family therapy with father

Day program, dual diagnosis

Month 16
Month 1
- Residential Treatment

Month 16
- Inpatient Hospitalization Partial Program

30-days zero use

- Utox screens
- Overdose
- Self-disclosed use
BHP and PCP Partnership

Dual visits
Communication in between visits
Patient’s perception of a team
Keeping an eye on the big picture
Sharing the workload
Support
Preventing burnout
Movement in the right direction...

Discussions about health outside of MH/SUD
One overdose, father had Narcan
Longitudinal relationship – point of care to come back to
Engagement in care
Longest stretches of not using heroin in 2 years
Changes in severity of relapse
Engagement in community MH and SUD supports/ treatment
Self-disclosed relapses, more detail and reflection
Relationship with father
Patient’s Strengths

Resourcefulness
Determination
Openness
Intellect
Sense of humor
Take away points...

- Continuity and the longitudinal relationship
- Understanding and appreciation of harm reduction is important, but doesn’t suffice
- Training PCPs in MAT may be accelerated through collaboration with behavioral health
- Rigid or unrealistic expectations or perceptions, are part of the growing pains of doing this work and are often influenced by our own fear, anxiety, experience, and genuine desire to protect the patient
- “Substance use represents a relationship, an attachment that offers significant support to the person. Treatment must offer that support, as well as respect that maybe we can’t do it as well or with such reliability.” (Harm Reduction: Pragmatic strategies for managing high risk behaviors, 2012, Denning. P.)
Opioid dependence is a chronic, relapsing disease...

- Repeated no-shows
- Relapse
- Kicked out of independent housing program
- Arrested and in jail 3 weeks
Questions and Discussion
Session Evaluation

Please complete and return the evaluation form before leaving this session.

Thank you!