REducing Disparities in Addiction Care:
Low-Threshold Buprenorphine for Unsheltered Patients

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OBJECTIVES

- Review role of buprenorphine/suboxone in OUD
- Overview of traditional MAT programs
- HCH low threshold program trials and tribulations and initial data
- Limitations, Future Endeavors
National Overdose Deaths
Number of Deaths Involving All Drugs

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths Involving Opioids

Source: National Center for Health Statistics, CDC Wonder
Opioid Use Disorder and Treatment in Contra Costa County - NEW DATA

2017: 52 deaths (final)

2018: 79 deaths (not complete)

51.9% increase
Black

- 2018: 20.3% of deaths
- 2017: 12.0% of deaths
- 8.3% increase

Females

- 2018: 41.8% of deaths
- 2017: 26.0% of deaths
- 15.8% increase

Males

- 2018: 58.2% of deaths
- 2017: 74.0% of deaths
- 15.8% decrease

- 2018: 26.6% of deaths had recorded homeless note
- 2017: 20.0% of deaths had a recorded homeless note
- 6.6% increase
2018: 81.0% of deaths had multiple drugs in system

2017: 54.0% of deaths had multiple drugs in system

27.0% increase

Opioids + Stimulants

2018: 41.8% of deaths had this combo

2017: 24.0% of deaths had this combo

17.8% increase
DSM-V Criteria for OUD:
1. Unable to fulfill role obligations
2. Social or interpersonal problems due to use
3. Hazardous use
4. Tolerance *
5. Withdrawal/physical dependence *
6. Taken in larger amounts of over longer period
7. Unsuccessful efforts to cut down or control
8. Great deal of time spent to obtain substance
9. Important activities given up or reduced
10. Continues use despite harm
11. Craving

Severity: Mild 2-3 symptoms, Moderate 4-5 Symptoms, Severe >6 symptoms
Treatment for OUD

- Individual and Group Counseling
  - CBT
  - Contingency Management
  - MI
  - 12-step programs (NA, AA, etc)
- Inpatient and Residential Programs
- MAT
  - Agonist
  - Partial agonist
  - Antagonist
- Abstinence
  - “Cold Turkey”
Methadone

Full Agonist

Effective, highly regulated, stigmatized

“the nods”
BUPRENORPHINE

- it’s safe
- it’s safe
- it’s safe
- x-waiver required, 8 hour training, new DEA license
- currently 7% of US MDs are x-waivered providers
Initiating Treatment

1. Establish diagnosis of OUD
2. Explore substance use history, including other substances beyond opioids
   1. Alcohol and benzos NOT a reason to withhold buprenorphine
   2. Upreg on first visit +/- Utox
3. Review treatment history, experience with MAT
4. CURES
5. Review medical and psychiatric co-morbidities
6. Offer screening for communicable diseases when appropriate
   1. HIV, RPR, Chronic Hep panel, GC/CT; PrEP?
7. Review current opioid use and make clear to patient honesty is important to the success of treatment
Accepted any treatment

- 'No
- Yes
- Yes, Early period
- X No-censored
- + Yes-censored
- Yes, Early period-censored

Cumulative Survival

Duration since registration (years)
Opioid Use Disorder and Treatment in Contra Costa County

2016, 5.4% > 12 years old misused opiates (> 50,000 people)

1% of people (9,700) had an OUD

3,562 to 6,597 people with OUD in our county WITHOUT access to MAT

As of 2018, 148 providers are 30-pt, 24 are 100-pt, 6 are 275-pt

5,585 providers, 3.2% are waiverered
CONTRA COSTA CURRENT MAT

- Choosing Change groups introduced in 2013
- Started as 1-2 group visits/week, 1 MD and 1 mental health specialist
- now clinics daily at various sites with PHN network for follow-up, over 100 county-wide X-waiver providers

**Flowchart:**
- Patient interested in MAT → Choosing Change Referral Placed → Nurse Calls Patient to do intake, prescribes induction dose
- Patient arrives at group, does MD intake + withdrawal, attends → gets 1 week refill → Returns to group, attends group up to 1mo refill at a time → Attends monthly, group nurse follow up PRN
BARRIERS

- transportation
- insurance
- phone access
- follow up/lost to follow up
TRIAL 1: REFERRAL

- HCH team attempted to refer patients to choosing change
- Phone intake limitations
- Transportation to clinic (especially IN withdrawal)
- Weekly return
- Results: patient’s were not going to group visits, not getting induction
TRIAL 2: INDUCE + REFERRAL

- attempted to induce patients on the street and refer to Choosing Change groups
- again, limited numbers of patients went to group visits and continued in the groups
TRIAL 3: STREET MANAGEMENT

Current Treatment Flow:

1. Patient expresses interest in OUD
2. Patient screened for OUD by clinician
3. Induction explained, 1mo supply sent (unless pt prefers 2 week)
4. HCH team follows up when time for refill or if pt reaches out earlier

- No initial Utox, ideally one Utox on buprenorphine - and uotox if suspicion for diversion
- only contraindication was < 18yo, on methadone, or receiving buprenorphine from outside provider (per CURES)
- patients received prescription, needles, Narcan, POCT HIV/HCT if desired, and offer to group if desired
- initially provider keeping track of refills, PHN hired now to manage refills/when patients are due for refills
- if medications lost/stolen, one time early refill
STREET INDUCTION

• Keep it SIMPLE

• Precipitated Withdrawal Warning, review withdrawal symptoms, review side effects and how to dose medication

• Handout to review dosing, physician phone number

24hr after last use:

Patient presents to clinic with COWS >12 (i.e. in active withdrawal)

OR

COWS <12 no self-reported opioid use in past 3 days (i.e. already detoxed)
**Clinical Opiate Withdrawal Scale (COWS)**


<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resting Pulse Rate</td>
<td>0-4</td>
<td>beats/minute</td>
</tr>
<tr>
<td>GI Upset over last 1/2 hour</td>
<td>0-5</td>
<td>No GI symptoms to multiple episodes of diarrhea or vomiting</td>
</tr>
<tr>
<td>Sweating over past 1/2 hour not accounted for by room temperature or patient activity</td>
<td>0-4</td>
<td>No report of chills or flushing to sweat streaming off face</td>
</tr>
<tr>
<td>Tremor observation of outstretched hands</td>
<td>0-4</td>
<td>No tremor to gross tremor or muscle twitching</td>
</tr>
<tr>
<td>Restlessness Observation during assessment</td>
<td>0-5</td>
<td>Able to sit still to unable to sit still for more than a few seconds</td>
</tr>
<tr>
<td>Yawning Observation during assessment</td>
<td>0-4</td>
<td>No yawning to yawning several times/minute</td>
</tr>
<tr>
<td>Pupil size</td>
<td>0-5</td>
<td>Pupil pinned or normal size for room light to pupil so dilated that only the rim of the iris is visible</td>
</tr>
<tr>
<td>Anxiety or irritability</td>
<td>0-4</td>
<td>None to patient obviouly irritable or anxious that participation in the assessment is difficult</td>
</tr>
<tr>
<td>Bone or Joint ache if present previously, only the additional component attributed to opiate withdrawal is scored</td>
<td>0-4</td>
<td>Not present to patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
<tr>
<td>Goosed skin</td>
<td>0-4</td>
<td>Skin is smooth to prominent piloerection</td>
</tr>
<tr>
<td>Rhinorrhea or tearing Not accounted for by cold symptoms or allergies</td>
<td>0-4</td>
<td>Not present to nose constantly running or tears streaming down cheeks</td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td>The total score is the sum of all 11 items</td>
</tr>
</tbody>
</table>

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal
Induction

- Patient can take 4-8mg once picked up from pharmacy
- Take initial dose per above, take 4mg as needed q4-6 hours day one up to max 16mg
- Day 2 patient takes single dose of 8mg in morning, repeat 4-8mg if needed in pm
- Day 3 take full day 2 dose in am
INITIAL RESULTS

- First year cohort, 55 patients (63% male, 36% female)
- 69.1% had concurrent chronic medical condition
- 85% had history of incarceration
- Retention in care decreased with time
- 82.7% received at least 1 follow-up prescription
- 47.3% received at least 3
- ONE OD (pt not engaged at the time) NO death

Figure 3: Retention in Care

% Retained in Care

Days Retained in Care

37.5% 31.9% 25.7% 18.2% 16.1% 10.7% 8.3%
A large portion (81%) of the 16 UDS collected did show ongoing methamphetamine use. It is unclear if MAT for OUD had any effect on concomitant methamphetamine use. Future research looking at this question would be valuable given the high prevalence of concurrent methamphetamine use in our study population.
DISCUSSION

• since initial study period, increased providers/outreach days

• currently have 80+ patient enrolled in street buprenorphine induction/maintenance

• word of mouth from patients is spreading, pt approaching medical van with interest in induction

• PHN is engaging and doing warm handoff to work on CM and suboxone follow up

• Diversion?
FUTURE GOALS

• retrospective analysis of HIV/HCT results, working towards 100% HIV/HCT POCT testing with plan in motion to include treatment as well

• PHN to further help with refills/follow-up to increase engagement

• continued research into concurrent methamphetamine use and role of Buprenorphine for methamphetamine use
Questions?