Strengthening an Experienced MSR Program

September 16, 2019
Who We Are

- 5,272 individuals received short-term stabilization
- 3,331 residents housed
- 8,796 health patients served
- 1,333 job seekers assisted

Old Town Clinic
Where We Were

• Level 1 outpatient MSR program

• Office-based opioid treatment (OBOT) services provided at Old Town Clinic within primary care, but in an incomplete and inconsistent fashion, creating unnecessary risks and barriers to treatment

• CCC building OBOT services across that agency at Blackburn Center and Hooper Bridge Clinic
Flow of Patients from Hooper Bridge Clinic

Q3 (January 1 2019 – March 28 2019)

Hooper Bridge: 131
Lost to Followup: 71

Rx Transfer: 51

RWNW: 31
CCCRC: 10
CODA: 4
Depaul: 1
ESC: 1
Allied: 1
Lifetime: 1
OHSU Pain Center: 1

Clt Requested Taper: 3
DSC Readmission: 4
Program Discharge: 2
Patients Maintained with OAT Demonstrate VASTLY Less Relapse with Opioids. (OAT = Opioid Agonist Treatment)
What are the costs of caring for patients?
(OAT = Opioid Agonist Treatment)
The Next Stage of Buprenorphine Care for Opioid Use Disorder

Buprenorphine has been used internationally for the treatment of opioid use disorder (OUD) since the 1990s and has been available in the United States for more than a decade. Initial practice recommendations were intentionally conservative, were based on expert opinion, and were influenced by methadone regulations. Since 2003, the American crisis of OUD has dramatically worsened, and much related empirical research has been undertaken. The findings in several important areas conflict with initial clinical practice that is still prevalent. This article reviews research findings in the following 7 areas: location of buprenorphine induction, combining buprenorphine with a benzodiazepine, relapse during buprenorphine treatment, requirements for counseling, uses of drug testing, use of other substances during buprenorphine treatment, and duration of buprenorphine treatment. For each area, evidence for needed updates and modifications in practice is provided. These modifications will facilitate more successful, evidence-based treatment and care for patients with OUD.

**Table:** Buprenorphine Care: Previous Approaches Compared With New Findings and Recommendations

<table>
<thead>
<tr>
<th>Previous Approach</th>
<th>New Findings and Recommendations</th>
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<tbody>
<tr>
<td>A medical setting is needed for induction. Benzodiazepine and buprenorphine coprescription is toxic.</td>
<td>Home induction is also safe and effective (6).</td>
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<td>Relapse indicates that the patient is unfit for buprenorphine-based treatment.</td>
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<tr>
<td>Counseling or participation in a 12-step program is mandatory.</td>
<td>Buprenorphine should not be withheld from patients taking benzodiazepines (6).</td>
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<tr>
<td>Drug testing is a tool to discharge patients from buprenorphine treatment or compel more intensive settings.</td>
<td>Relapse indicates the need for additional support and resources rather than cessation of buprenorphine treatment (6).</td>
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<td>Use of other substances is a sign of treatment failure and grounds for dismissal from buprenorphine treatment.</td>
<td>Behavioral treatments and support are provided as desired by the patient (6).</td>
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<td>Buprenorphine is a short-term treatment, prescribed with tapered dosages or for weeks to months.</td>
<td>Drug testing is a tool to better support recovery and address relapse (56).</td>
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Buprenorphine treatment does not directly affect other substance use, and such use should be addressed in this context (43).

Buprenorphine is prescribed as long as it continues to benefit the patient (6).
Evolution Process

• Leadership buy-in

• Workgroup

• Staff buy-in: CADCs, providers, support staff, pharmacy, etc.

• Patient buy-in

• Building capacity
Patient Characteristics

- **OBOT non-responsive**: no reduction in opioid use despite access to buprenorphine
- **OBOT responsive with impairment***: opioid use decreasing, active impairment from other substances
- **Stabilization**: opioid use decreasing, other substance use may be present without active impairment
- **Maintenance**: cessation of active opioid use, no impairment from other substances

*Criteria for impairment include presenting as intoxicated during office visits, experiencing overdose, complications from substance use necessitating acute medical care (e.g. soft tissue infections, mental health instability), or otherwise meeting DSM-V criteria for substance use disorder.
Where We Are Now

• Recovery diversity and informed recovery decisions

• Bigger container for holding shared risk

• Radical flexibility
Key Questions

• Who are you serving?

• Who are you not serving? Why?

• How do you manage:
  • Ongoing substance use or relapse (opiate/non-opiate, including benzos)
  • Severe mental illness
  • Lack of housing/safe storage

• How do you create access and consistency?

• How do you create culture change within your organization?