Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

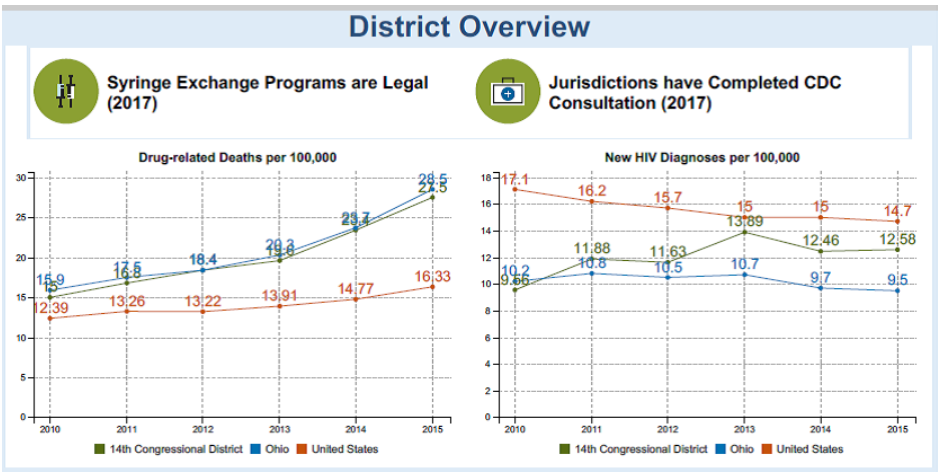
What is the Intervention? An HIV primary care intervention that aligns with the medical home model and follows principles of harm reduction.

Why is the Intervention Needed? Dramatic increases in opioid related fatal overdoses and acute hepatitis C infections in recent years underscore the urgent need to identify and treat opioid use disorder in PLWH. Buprenorphine treatment delivered in HIV clinics is associated with decreased opioid use, increased ART use, higher quality of HIV care, and higher quality of life.

Who Can Deliver the Intervention? HIV primary care providers

Where Can I Access the Intervention? https://nextlevel.careacttarget.org/intervention/buprenorphine

MetroHealth, Cleveland, OH



Source: amfAR, Opioid & Health Indicators Database, Accessed Oct 31, 2017

HIV		OH
Number of People Living with HIV	5,518	19,911
HIV Prevalence per 100,000	259	204.6
Hepatitis C (HCV)		**OH**
Number of People with Hepatitis C	NA	119,000
Estimated Acute Hepatitis C Cases per 100,000	NA	15.29
Drug-related Deaths		**OH**
Drug-related Deaths	710	3,310
Drug-related Deaths per 100,000	27.5	28.5
Healthcare Access		**OH**
Percent of People without Health Insurance	9.55	9.74
Number of 30 Days Supply of Opioids per Part D Enrollee	1.65	2.12
Treatment and Prevention Services		
Syringe Exchange Programs		1
Facilities Providing Substance Abuse Services		85

Barriers and Facilitators to Implementation

Barrier	Facilitator
Time – MD time, Clinical Coordinator time as caseload builds and several patients need multiple visits per week	Support from the Clinical Coordinator (CC): The CC manages program referrals, assists with referrals to detox, inpatient care and IOP treatment centers, accompanies patient throughout induction process, keeps in regular contact with patients (sometimes daily) for patient updates, administers urine screens, completes prior authorizations with insurance companies, facilitates refills and has also assisted with supervising daily dosing. The burden to current staffing would be enormous and we would not have been able to take on MAT without the CC.
Limited space, especially for inductions and for meetings between patients and the Clinical Coordinator	
Complexities of addiction. Concerns about diversion necessitate increased monitoring and patients who are struggling require more support.	
Risk of overdose deaths: When deciding to ween patient off Bup or terminate MAT because a patient is not working the treatment plan or is diverting medications, the risk of overdose increases if the patients' tolerance to heroin has decreased due to MAT.	The intervention has increased retention in care and medication adherence overall. Traditionally this population has high no show rates and are less likely to be adherent to their HIV medications and virally suppressed. Seeing these patients on a weekly basis has now allowed us time to reduce barriers to and encourage medication adherence.
Challenges with prior authorizations	

Intervention in Action: Case Study

Patient X came to us after being released from jail. He was in jail for 6 months for drug related crimes. He identifies as a heroin addict and stated he used anything and everything he could get his hands on and injected heroin in every vein in his body. He cannot believe he is still alive. Patient's girlfriend is also HIV positive and was on Methadone at the time and showed interested in enrolling in our project. We started Patient X on 8 mg daily and eventually enrolled the gf in our study.

Over the course of the following weeks, month, Patient X was doing well. Month 2, patient X had several positive urine screens with no bup in his system. Patient X has not been honest with his heroin use and his diversion of the Bup. He and gf have rocky relationship and gf has serious cardiac issues that have led to long hospitalizations. Gf has two children that Patient X sees as his kids. Gf's urine screens have been negative and she has always had the bup in her system. Encouraging a higher level of treatment was always met with resistance and excuses. Gf is now pregnant. Patient X was now sure that he was ready for sobriety and came to clinic stating that he has a bed at a treatment center an hour outside of Cleveland. He states he would be going there this afternoon and needed a script for a week to enter the program. The next day, the CC called the program to see if he made it. He never showed up. Patient X is currently whereabouts unknown. Gf switched from Bup back to methadone during her pregnancy so we are not in contact with her at this time.

Lessons Learned Through Implementation

- MAT must be accompanied with other forms of addiction treatment: In the beginning, we focused most of our attention on properly prescribing Bup. We worried about dosing, would 16 mg be too much, or 8 mg too little. We gave patients many, many chances after urine tox screens came back positive for opiates and sometimes many other substances. Instead of identifying that these patients were not ready for sobriety, we focused on the Bup and dosing. Then, we turned our focus to our patients' behavior and were met with resistance from many of them. Level of Care assessments indicated detox, inpatient or IOP was needed and patients were not willing to go. Now, we lead with the expectation that patients will enter into IOP, sobriety meetings or detox/inpatient if needed. Additionally, the Clinical Coordinator holds a weekly sobriety meeting with our participants.
- Abstinence only vs. Harm Reduction model: As a staff, we have differing opinions on using a harm-reduction approach vs. an abstinence only approach. This has led to some level of frustration. We are hoping that weekly or bi-monthly short team meetings will allow for improved communications, an agreed upon treatment plan and all staff buy-in.

For More Information, Contact:

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