Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

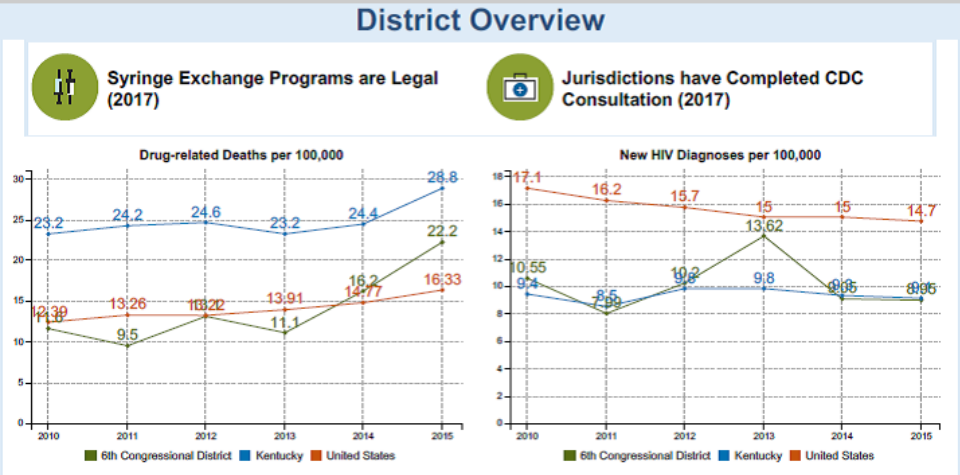
What is the Intervention? An HIV primary care intervention that aligns with the medical home model and follows principles of harm reduction.

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

University of Kentucky Bluegrass Cares Clinic, Lexington, KY



HIV		KY
Number of People Living with HIV	1,196	6,511
HIV Prevalence per 100,000	190	176.7
Hepatitis C (HCV)		**KY**
Number of People with Hepatitis C	NA	54,200
Estimated Acute Hepatitis C Cases per 100,000	NA	37.53
Drug-related Deaths		**KY**
Drug-related Deaths	174	1,273
Drug-related Deaths per 100,000	22.2	28.8
Healthcare Access		**KY**
Percent of People without Health Insurance	11.41	11.34
Number of 30 Days Supply of Opioids per Part D Enrollee	2.71	2.76
Treatment and Prevention Services		
Syringe Exchange Programs		5
Facilities Providing Substance Abuse Services		50

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

Barriers and Facilitators to Implementation

Barrier	Facilitator
Rural population / several patients have a long distance to travel to the clinic.	Providing transportation assistance
Limited access to methadone in the community.	Buprenorphine is more accepted in the community
Operational challenges to program implementation including clinic space, electronic medical records template, billing questions.	Once we established these processes, our program will help facilitate the process of implementation in other sites at UK.
Patients with multiple substance use disorders, not only opioid use disorder.	Opportunity to develop protocols that allow for increased supervision of patients as well as increased counseling and mental health support.
Residential treatment programs are often not the preference of the patient.	There is relatively less stigma surrounding opioid use disorder than around HIV in more rural Kentucky communities.
Cultural stigma around opioid use disorder and treatment.	

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Intervention in Action: Case Study

32 year old man with HIV, opioid, cocaine, and alcohol use disorders presents for evaluation to start buprenorphine/naloxone (bup/nx) treatment. He had previously used prescription opioids recreationally by mouth, and then progressed to intranasal use. In the past year has been using IN heroin daily. Does not inject. No history of overdoses, but has 'blacked out' from drinking. Alcohol use is in a binge pattern with cocaine on the weekends and he feels it allows him to be more social and enjoy the evening. He is in a relationship with a man who also has opioid use disorder. He has not disclosed his HIV status or sexual preference to his family or many of his friends. He is currently on parole.

He is opioid, but not alcohol dependent, and he completes a scheduled in-office bup/nx induction. He does well initially, and is able to stop illicit opioid use. He considers volunteering as a peer support for other patients. The cocaine and alcohol use continue intermittently, but then worsen while he had problems with his significant other. He frequently responds to interpersonal stressors by binging. We resume weekly visits, along with starting an SSRI for anxiety and he again improves, with decreased alcohol and cocaine use, and he progresses to every two week visits. Then he is incarcerated for a few weeks for a parole violation and goes through withdrawal in jail. He emerges with a renewed plan to get his life together, but because of more family and social stressors, and lack of employment, the restart of treatment is rocky. Eventually, he was able to get another job and move into a more stable living environment. The structure of that helped him set more limits in his interpersonal relationships and gain more control over his circumstances.

Lessons from this case study: Psychosocial and interpersonal stressors are major triggers of relapse and barriers to doing well in treatment. Incorporating 'wrap around' services that assist patients with these challenges are key elements of comprehensive substance use disorder treatment. Treatment does not follow one prescribed path, and patients are likely to have periods of relapse. It is important for the treatment team to continue to try to engage the patient and welcome the patient back into treatment. Offering more treatment (increased supervision, different level of care) is the best response to a patient not doing well.

Lessons Learned Through Implementation

- Office-based treatment of opioid use disorder is complicated by other comorbid substance use disorders, particularly methamphetamine use.
- Very few community buprenorphine treatment providers in Kentucky accept Medicaid, which makes access outside of our clinic challenging.
- Treatment must be flexible to allow patients to step-up and step-down the intensity of care and supervision based on clinical need.
- It is essential to have buprenorphine as a treatment option for patients with opioid use disorder

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