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BUPRENORPHINE IN NYS: A CLINICAL OVERVIEW

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Buprenorphine in NYS: A Clinical Overview [video transcript]

[00:00:05] Good afternoon everyone. I welcome you to this month in HIV this month of February our presentation is going to be on Buprenorphine in New York State a Clinical Overview and it will be presented by Kelly Ramsey M.D. of Hudson River Health Care and she is the medical director of substance use disorders. My name is Rob I'm a program coordinator with the HIV AIDS education training department with Mount Sinai Institute for Advanced Medicine. And before we officially get started I want to thank our funder who is the New York State Department of Health AIDS Institute and the Clinical Education Initiative and Mount Sinai Institute for Advanced Medicine serves as the co-sponsor for this month and HIV. A few housekeeping notes during the duration of today's presentation. Your lines will be muted to ensure there's no distractions during Dr. Ramsey's presentation. If you have any questions for the end of the presentation or during please make sure and type them into the chat box you should see that active on the screen. There's already been some communication on there. Put that in there and we will provide them to Dr. Ramsey at the end of the presentation today. Before we wrap up. For evaluation after today's program at the end of the presentation you'll receive an email with instructions on how to evaluate the presentation including CME CNE and CPE. Those credits are offered please remember that this month HIV is part of the New York State Department of Health CEI grant and your participation and evaluation helps us keep the program free of charge for attendees. So with no further interruption I am going to introduce Dr. Ramsey and Dr. Ramsey is an internal medicine physician with focus practice on HIV Hepatitis C and substance use disorder including medical assisted treatment for opioid use disorder. She's a medical director for the substance use disorders at H R H care or APS Healthcare Network of Community Health Centers where she's been since 2011 prior to 2011 Dr. Ramsey served as the medical director of the homeless center at Port Morris and a Division of Substance Abuse at the Albert Einstein School College of Medicine and as an attending physician Internal Medicine at Montefiore Medical Center. Dr. Ramsey provides expert advice to New York State Department of Health AIDS Institute by serving on numerous committees including the Quality of Care Committee. Q A C substance use guidelines committee for the HIV clinical HIV clinical practice guidelines drug user anti stigma campaign and the Office of Drug user health. New York State Buprenorphine Advisory Group. So with that I will let Dr. Ramsey take over.

[00:03:01] Hi everyone. Thanks for joining us today. I have a lot of slides per my usual presentation style so I'm gonna quickly get right into them. I don't have any relevant disclosures for this presentation so our objective is just very quickly to identify how Buprenorphine fits into a harm reduction framework to review federal and state requirements for prescribing Buprenorphine and to discuss perceived challenges and Buprenorphine implementation and strategies to overcome them. So first what is harm reduction. So I'm going to read this is very short and poignant definition so harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on I belief in and respect for the rights and people who use drugs is based on a strong commitment to public health and human rights. So what are some of the principles of harm reduction. So basically the the point of harm reduction is recognizing that people will do things that can cause potential harm to themselves. And we are trying to limit the harm in which for example illicit drug use can cause on their body. So the principles of harm reduction recognize that drug use is common and drug use happens and it includes a spectrum of strategies from safer use to abstinence and all stops in between is low threshold meaning that you target your entry requirements

that are appropriate to the group that you are trying to attract to your program and it ensures that people who use drugs have a voice in the creation of programs and policies for example with a advisory board to your references. So it also recognizes that recovery is individualized. So recovery to me is a process of change through which individuals improve their health and wellness live a self directed life and strive to reach their full potential. So you can see there's nothing about abstinence in that definition. So what are some of the categories that we can look at in looking at recovery. So one is health. So overcoming or managing one's diseases or symptoms for example being treated and cured Hepatitis C getting engaged for your HIV care and getting on ART and having an undetectable load. So having a stable and safe place to live a lot of the patients who come into care with us or are homeless or unstably housed having purpose. So I think the purpose and community are the most important parts of an individual's recovery. So what that means is having a purpose in their life that is derived from something that they are hoping to achieve in their life. So that their daily life has a meaning. And then making connections. So unfortunately what happens a lot when people are actively injecting drugs or using drugs in general is they become isolated from family and friends. And so in order to help them achieve recovery or increase functionality in their life it's really important that they create new relationships and new social networks that are healthier for them and provide them with support.

[00:06:10] Sorry.

[00:06:11] So another reminder that drug treatment isn't for everyone. So a reminder that people will use alcohol or drugs and it may not present a health risk at all. You need to find out how much they're using how they're using if they're sharing works et cetera. Not all people who are using drugs want to stop. And we need to accept that that's their decision whether they want to use drugs or not. Not everybody has time to do quote unquote traditional treatment due to work or other obligations. And there's fear of stigma. There's actually a study that came out last year that looked at people with substance use disorder who had never been to treatment meaning detox rehab or outpatient treatment versus people who had been to any of those treatment settings and people who had been to treatment actually had more stigma felt more stigma than persons who had never engaged in treatment. So clearly there's a problem with our treatment model if people entering into treatment feel more stigma than people who do not. So what are some of the bools of harm reduction. So one of them is to decrease from this disease and death. So what I mean by that is we're going to try to decrease the incidence of blood borne diseases such as HIV and Hepatitis C. We're going to also teach people safer injection practices so we decrease the number of abscesses and cases of endocarditis for instance and then ultimately we're trying to prevent mortality. So we're trying to decrease the number of fatal and non-fatal overdoses and harm reduction programs tend to increase engagement in other services and care. So often it's the gateway when somebody is interested in receiving treatment for their substance use disorder of accessing that or getting information about it or accessing other medical or social services such as social services benefits or or getting treatment for their Hepatitis C. So what are some of the vulnerability factors for substance use disorder. So about 50 percent of the propensity for someone to develop a substance use disorder comes from genetic predisposition. So what that means is that a person who has any history a family history of any substance use disorder puts them at markedly increased risk than someone who does not have that in their family history. So there are many common mental health diagnoses that are comorbid with substance use disorder. The most common mental health diagnoses that are comorbid a bipolar disorder generalized anxiety disorder and other anxiety

disorders such as PTSD social anxiety etc. major depression ADD and ADHD specific personality disorders particularly borderline personality disorder and antisocial personality disorder. And regardless of whether those diagnoses are undiagnosed under treated inappropriately treated or untreated you see that a high proportion certain patients in Miami teen program in a community health center setting have high. I have slight mental health diagnoses almost universal among patients with opioid use disorder is a significant trauma history and or abuse history. So for females this tends to be pre-adolescent sexual trauma but it could be witness to violence victim of violence etc. Pretty universally my patients have poor coping mechanisms so life in and of itself is just overwhelming. Perhaps initially it's done for some sensation the pleasure of using or escapism but by the time somebody develops a substance use disorder there's a compulsion to use and they cannot not use. Impulsivity which goes hand-in-hand with a lot of these mental health diagnoses contributes to substance use disorder environmental triggers so we know that all sorts of sensory cues will trigger people to use it could be and a visual cue. It could be a song. It could be a smell and these things will actually trigger physiologic pathways in the brain that compel them to use. And then lastly is the lack of hormonal static award regulation so Reward Deficiency and orientation towards pleasurable rewards. So what all that is saying is that when a brain becomes primed to use on anything that causes a dopamine surge. So that's any drug sex food etc. The brain is primed to expect and want and seek those dopamine surges which are associated with pleasure withdrawal from whatever that input is causes actually a deficit of dopamine down to below normal levels. So a person who is actively using is in a constant cycle of dopamine surges with use and dopamine deficits with withdrawal and actually pathways in the brain.

[00:11:00] Are we ordered to try to serve the pleasure pathway. So we're going to talk about opioids. And so this is a picture of opium poppy plant in its natural setting.

[00:11:12] So what are what is the difference between opiate and opioid. And I'm a real stickler for language so I get very annoyed when I hear people call it the opiate epidemic. It should really be called the opioid epidemic. So let me explain what I mean by that. So an opiate is a term that refers to drugs or medications that are derived from the opium poppy. So when you process opium you make heroin and when heroin metabolizes it metabolizes primarily morphine codeine and some hydromorphone an opioid is a more general term that includes all the natural opiates as well as semi synthetic or synthetic drugs or other opioids. So for example buprenorphine methadone fentanyl produce analgesia. They're similar in effect to morphine but they're completely synthetically made and they don't look like the structure of morphine at all.

[00:12:07] Semi synthetic opioid for example would be Oxycontin. So these are lots of examples of both licit opioids and then pictures of some illicit.

[00:12:20] This is to show you why we're in the crisis that we're in now and this has to do with the potency of fentanyl and fentanyl analogs. So this shows equivalent doses of heroin on the left fentanyl in the carfentanyl one of the analogs on the right. So since there is no regulation obviously of an illicit drug supply. People never know what they're getting and people who use are generally creatures of habit and use about the same amount they use normally. So most people aren't testing doses before they use it. So if a person happened to get a batch that is primarily carfentanyl and not very much heroin they're far more likely to overdose. So why do people like using heroin why is it pleasurable. So it's

extremely lipid soluble and it actually crosses the blood brain barrier within 15 seconds or what is known as that heroin rush and fentanyl actually crosses the blood brain barrier even faster. So if you compare morphine and heroin and you inject both of them almost 70 percent of heroin then gets into the brain versus five. Less than 5 percent of morphine. So it's actually almost designed for misuse and within 30 minutes heroin is metabolized to morphine. So for example you'll never see heroin on the drug screen. You're going to see primarily morphine. So let's talk a little bit about the opioid receptors so most opioids with the exception of buprenorphine are full agonist. So what this means is they fully activate the opioid new receptor. And this is very reinforcing for the reasons I explained previously. So this is the most misused opioid type so full agonist essentially include all opioids except for buprenorphine and what determines the effects of the opioid at the receptor. It has to do with the finity for the receptor the dissociation principles of the drug at the receptor and the intrinsic activity of that drug at the receptor. So this is a pictorial representation of opioids in the brain. And so as you can see the opioids fit perfectly on to the opioid new receptors. So this is what it would look like with a full agonist attached to the opioid new receptor in the brain. And this is why if too many of those receptors are filled with opioids that people will actually unintentionally overdose. So what happens is what I explained previously that you get a surge of dopamine when that opioid attaches to the opioid receptor in the brain.

[00:15:01] There are other effects as well but the primary effect is on on the [unaudible]. So this is illustrating what I was mentioning earlier and that regardless of what substance you're talking about they all caused mean surges. The key and the ebb of that may be different depending on the drug. But they all cause a sharp keep in dopamine. This is to remind us that the opioid epidemic in general and substance use disorder in general really is an equal opportunity disorder. So meaning regardless of your gender your age or race ethnicity your income or your health insurance. We look at this pictorial we can see that in all demographic groups heroin use has increased.

[00:15:51] So the current stats for the opioid epidemic we know that since about 2013 that unintentional drug overdose is the leading cause of accidental death in the United States. So it's surpassed motor vehicle accidents in that last year for which we have data as twenty seventeen or seventy thousand two hundred and thirty seven drug overdose deaths which occurred in the United States and opioid use disorder is clearly driving this epidemic. So particularly with the rates of deaths due to synthetic opioids which include fentanyl analogs. This is aside from methadone. So the deaths due to the synthetic opioids increased by forty five percent from 2016 and 2017. So forty nine thousand sixty eight persons died due to an opioid overdose and 2017. We're going to quickly just look at some of these demographics so you can see this the sharp peaked blue line in synthetic opioids representing fentanyl and fentanyl analogs. This is looking at the adjusted overdose rates in males and females. You can see it's rising in both genders. And this is looking at selected age groups. And you can see that it's particularly increasing quickly among 25 to 34 year olds. But again we've had a higher rate for a long time. We've respected 25 to 54 year olds. This is looking at the increase in emergency department visits and this is showing a sharp increase. This data only goes through 2014 but you can see the sharp increase due to opioid use disorder that happened since 2007.

[00:17:32] And then this is looking at your visits for heroin. And again this is going to vary depending on where you are geographically. So it's important to know what's going on in your local community. So for example in New York state we're primarily seeing deaths due to heroin and fentanyl. However in other parts of the country we're not seeing as much fentanyl or sometimes no fentanyl at all. And some places don't even have access to heroin. They're still seeing opioid prescription overdoses.

[00:18:01] So it's important to know where you are you can do appropriate harm reduction with the patient population. This is looking at the projected costs of the opioid epidemic through 2020. And this is breaking those costs down by our sector of society. So particularly you can see that the child and family assistance in criminal justice. Costs are very high as well as lost productivity.

[00:18:30] And then this is looking at who is bearing that burden. And interestingly you can see that the individual private sector seems to be bearing more of the burden than other groups perhaps. This is looking at data in New York State. So this is looking at the increase in overdose deaths between 1999 and 2015. And as you can see it's been precipitously rising particularly since 2005. This slide is pretty shocking. So on the left we have the view of 1999 looking at opioid overdose deaths. And you can see that in most counties of the state the rate was zero per 100000 residents. When you look at the picture on the right. That's 2015 and you can see that the vast majority of counties actually have a death rate of twelve per hundred thousand. So why are we talking about MAT. So MAT is an unfortunate term. It's medication assisted treatment. We may eventually change that to medication for addiction treatment. That's what SAMHSA is looking to do as well as ASAM. But that's the name we're stuck with now. But the important point of this slide is looking at if we get people on to treatment for opioid use disorder with either buprenorphine or methodone we decrease the rate overdose.

[00:19:53] So what are our goals for MAT. We want to alleviate the physical withdrawal symptoms that people are having due to opioid use disorder because that is what's driving the compulsion to use by the time someone presents to you with opioid use disorder asking for treatment. Most people are no longer getting high. From there opioid use there they're basically preventing withdrawal symptoms and using to feel normal again. We also want to create what's called a narcotic watch keys. So this means that we're saturating enough with the opioid new receptors that we stop sensible withdrawal symptoms and that we stop drug cravings. Drug cravings as the next category drug cravings are really important because even if we block enough of the receptors to stop physical withdrawal symptoms there's still maybe drug cravings going on again that are queued by visual cues smell sounds etc.. And if we don't stop the drug cravings that's eventually going to lead to a relapse. We also want to decrease the risk for overdose so specifically methadone and buprenorphine have extensive evidence showing that they decrease mortality due to overdose and we want to normalize as much as possible the anatomy and the balance of neurotransmitters in the brain. We'll never get them back to pre drug use levels but we want to be able to normalize them as much as possible. And then the most important goals of the patient is increasing their own functionality. So those goals are individualized to what the patient would like to accomplish more or less. So this is looking at percentage of new receptor intrinsic activity. And the main point of this slide is to show you the difference between a full agonist a partial agonist and an antagonist. So a full agonist as I explained which is the top line. And that is all opioids except for buprenorphine will essentially continue to give you euphoria and a high until somebody takes enough that they would go into respiratory depression and die without intervention with naloxone. In contrast

buprenorphine as a partial agonist. So there is a ceiling effect. So when a person who is opioid experienced or opioid dependent takes buprenorphine it stops the cravings and it stops the physical withdrawal symptoms but it doesn't cause them to experience euphoria and they could take more and more and more and it's not going to give them euphoria. And it's not going to cause respiratory depression. So it's very much safer than other full agonists and then an antagonist along the bottom line is like naloxone on naltrexone. And basically that blocks the receptor but it doesn't activate. So this is a picture showing what I just explained. So on the left hand side of the bottom you see a full agonist interacting with the receptor is fully activating. In the middle picture you see buprenorphine depicted as having a limited effect so it doesn't bond in the same way with the receptor as methadone or other full agonists would. And then naltrexone would block the receptor and block the effect of opioids. Interestingly though Naltrexone blocks the receptors so it's like a key analogue without turning it. However it causes decreased dopamine levels. And as I explained earlier decrease dopamine levels are generally not met pleasurably by the body. So this is how buprenorphine works in the brain. So it attaches to that empty receptor and it blocks it. And so when an opioid comes along another opioid meaning somebody who's on buprenorphine has a relapse but they have buprenorphine in their system then that other opioid won't be able to block sorry to interact with receptor.

[00:23:47] So what are some of the effects of buprenorphine at the new receptor based on. So basically the higher dose you go. The more receptors will be blocked. So I think of it as what is sort of the sweet spot for dose.

[00:24:03] So we know basically that 12 milligrams less than twelve milligrams is considered sub therapeutic. So most patients won't do well on on less than twelve milligrams. Most of my patients are maintaining on 16 milligrams. But I do have some patients who continue to have opioid cravings or drug dreams which are a proxy for opioid cravings at 16 milligrams and so sometimes their dose needs to be increased to 20 or even 24 milligrams. I don't have any patients on more than 24 milligrams buprenorphine is actually approved up to 32 milligrams but most insurance companies won't approve more than 24 milligrams and 32 milligrams is probably overkill. Interestingly what we see is that we get a lot of patients in our program who are seeing providers who won't prescribe more than eight milligrams a day for them and they continue to struggle with that and are often supplementing with Suboxone from the street to get some more therapeutic dose based on their own clinical experience. And so when we put them on a dose that's more appropriate for them then they are not supplementing. So how does buprenorphine work at the receptors so its affinity for the receptors is super strong. So it will actually displace full agonists if they're on board and the patient's brain such as heroin or methadone.

[00:25:27] So that's why it's important when you start somebody on buprenorphine that they be in moderate withdrawal and not have opioids in their system and it's dissociation from the receptor is slow. So it therefore prevents other drugs from binding.

[00:25:43] So as I said in the slide where we've looked at the graph it has a low overdose risk so high doses do not produce significant CNS side effects.

[00:25:52] Central nervous system side effects or respiratory depression due to the ceiling effect so this is very different from methadone for instance. The risk is higher with concomitant misuse of other stuff sedatives such as benzodiazepine. But I want to be really clear that benzodiazepine used whether prescribed benzodiazepine or illicit benzodiazepine use is not a contra indication for buprenorphine use. So the FDA came out with a very clear statement in 2017 that patients on the buprenophine should not be denied a benzodiazepine.

[00:26:26] That's the appropriate treatment for say their PTSD and vice versa. A patient on a benzodiazepine should not be denied buprenorphine because of prescribed events benzodiazopine. I still see that in the psychiatric community a lot. My patients will be denied benzodiazepines are prescribed very low dose that isn't therapeutic for their anxiety disorder because that message seems to not have gotten out for there. The only deaths reported from buprenophine from France the mid 90s where with buprenorphine mono tablets. Again this was without the dual dual formulation of buprenorphine naloxone that were dissolved and injected with concurrent high potency of alprazolam. But in the United States we have not seen.

[00:27:15] So again compared to all other opioids very low risk for overdose.

[00:27:22] So what is the efficacy. So this is an old study but I would say that it's it's pretty concurrent with my clinical practice. So after one year patients wherever retained 75 percent of the time when they were on buprenorphine and about 75 percent of the year in drug screenings were negative for other substances and compared to the placebo group. There was a 20 percent mortality rate in the placebo group compared with the buprenorphine rate. So what is the duration of MAT what is appropriate. I must say that this question really infuriates me because this is the only chronic disease where we asked how long should a person be on medication. You take it for granted that most patients with chronic diseases need to be on chronic medication such as anti hypertensive medication or diabetes medication. But somehow we still think that substance use disorder is different. So I always say long enough. So it's different for every patient but we know that recidivism rates are greater than 90 percent when patients are not on treatment and that mortality rates are higher for shorter courses of treatment or no treatment. So you know sometimes patients have a goal to get off of it. But I I really let patients know when they come into care with me the minimum they should be on it is for six months to a year. But in reality it's usually a chronic medication. So I would think of it as either a long term or a lifetime medication and not a short term medication. A recent study came out last year that showed that the average duration on buprenorphine treatment was eight to nine years. So what are the federal regulations around buprenorphine. So prior to the passage of data 2000 which allowed the prescribing of buprenorphine federal law actually prohibited physicians from writing prescriptions for methadone. It is still a felony to do so for opioid use disorder and in a outpatient setting as a post for methodone maintenance treatment program or for any other DEA schedule II medications for detox from or treatment of opioid use disorder except for in as I said a methodone maintenance treatment program or detox rehab etc.. So it's a felony. So with data two thousand what this did was it created the Drug Addiction Treatment Act data. It's an amendment to the Controlled Substances Act. And when it was passed initially it allowed physicians to prescribe narcotic drugs Schedule three four or five for either opioid maintenance or detoxification treatment. So when this law was passed there actually was no drug that fit into this category. Only when buprenorphine was approved was there actually a drug that

fit the law. So the law was passed based on the data from Europe before there was even a drug that was passed by the FDA in the United States. So buprenorphine became the first narcotic drug available for the treatment of opioid use disorders that could be given out in physicians offices or outpatient offices as well as given out in methadone maintenance treatment programs or opioid treatment programs. So since 2002 a licensed physician could take an eight hour course. So this would be online or in person or a half and half course on prescribing buprenorphine and then apply for a data waiver. And in the first year that a physician had the data waiver they had a patient ceiling of 30 patients and then they could apply to increase to 100 patients ceiling in the second year of their waiver and they received a special DEA number which is exactly the same as their DEA number except the first letter was replaced with an "x". And then with CARA so the Comprehensive Addiction and Recovery Act of 2016 this expanded buprenorphine prescribing privileges to nurse practitioners and physician assistants until 2021. An MPs and PAs inexplicably were required to take a 24 hour waiver training instead of an eight hour waiver training and it increased the physician buprenorphine patients cap to 275 in the third year of their waiver if they showed a demonstrated need in their community and they needed to show this annually. And then the update to the federal regulations in 2018. Congress passed support or HR 6 and the Opioid Crisis Response act of 2018 in the Senate and these codify buprenorphine prescribing for MPs and PAs in other words it eliminated the sunset date. It also codified the 275 buprenorphine patient pac for physicians. They no longer need to request it every year and it expanded buprenorphine privileging prescribing priviledges to other advanced practice nurses including nurse anesthetist and certified nurse midwives. So there are some exceptions to the federal regulations. Patients admitted to the hospital maybe continued on their outpatient doses of either buprenorphine or methadone and the emergency department has what's called a three day rule so meaning that not more than one day's medication may be administered or given to the patient at one time. But for instance if a patient overdosed and presented to the E.D. and was in withdrawal or came in and withdrawed they could be dosed with buprenorphine in the emergency department and they could do that for up to 72 hours. They can't write a prescription for it. They can't give the patient doses to go. The patient literally would have to present three days in a row and then that cannot be renewed or extended. So really getting providers in the emergency department waivers so that they can provide bridge scripts are creating bridge clinics as they've done in several locations up upstate such as Buffalo and Rochester is very helpful for getting people straight from the emergency department into MAT programs. So what is the problem. What is going on with buprenorphine treatment and why are more people not getting access to it. So there are several issues so less than 10 percent of people with substance use disorder actually successfully access treatment at all in the United States. Only a quarter of providers who have a waiver to do buprenorphine prescribing actually have ever written a prescription for it and they often have less than 10 patients on their panel. And often there's been a lot of providers in communities say in New York City where where people can have plenty of access but they're not located in rural communities or more remote communities where people need access to them and many buprenorphine providers do not prescribe buprenorphine in a harm reduction context but rather use an abstinence based recovery model and punitive measures with patients with opioid use disorder who quote unquote fail. And what I mean by that is that the person may have one inappropriate urine and they fire them or they have marijuana in their urine and they fire them and don't link them anywhere else and basically send people back out to obviously a high risk of overdose nine. Many buprenorphine providers also have what is

called the high threshold model for entry so that they don't don't accept anybody as poly substance use. They don't set people with comorbid mental health conditions et cetera.

[00:34:35] And some buprenorphine providers do not accept insurance but take cash payments only and obviously desperate people and desperate families will do desperate things and often patients are discharged when they can no longer pay the fees. Personally this may be due because there are low reinsurer low insurance reimbursement rates for patients but also I think some people saw this as an opportunity to make money unfortunately. So what are some of the perceived challenges of buprenorphine treatment. So I'm going to just read through these and we won't be able to address all of them but I will address some of them. So I don't want those patients in my waiting room the floodgates will open. I don't want to be a social worker and don't we need to provide psychosocial counseling in our office setting. Buprenorphine induction is too challenging. I don't know what to do with poly substance use. I don't know how to order and interpret urine drug screens. What about buprenorphine diversion.

[00:35:29] Are people on the street going to get high from my buprenorphine prescriptions there are too many insurance and prior authorizations issues. I need support those patients or too needy and too difficult. Those patients will disrupt the clinic and patient flow. I am not confident in treating opioid use disorder and I don't feel that I received adequate training. So let's look at some of these. So a lot of these barriers have to do with stigma. So how can we reduce stigma. So I think you can see that I'm very very deliberate with the language I use. We need to really get rid of the old stigmatizing language that has been traditional in the treatment world. So we should not be using terms like addict abuser user junky druggie alcoholic drug methhead oxy addict crackhead etc. ex addict former alcoholic and we should never be describing people where urine drug screens as clean or dirty. And I don't even like the word addiction. Addiction is is still going to remain because the actual board certification is for addiction medicine and not for treatment and substance use disorder. But you get my my gist so terms that would be preferable to use. Always start with a person who's not who we're talking about but a person with a substance use disorder a person with an opioid use disorder a person in recovery either appropriate or inappropriate results negative positive results or expected or unexpected results. And I prefer the term substance use disorder. So I'm not going to go into detail on this slide but I just want you to know that the AIDS Institute does have recommendations for improving language and establishing stigma free Supportive Service Delivery environments and you can access that information online. It is basically using a lot of the points that I'm making in this presentation.

[00:37:20] So what about psychosocial counseling. So all that buprenorphine prescriber requires is that patients have access to psychosocial counselling if needed. So that can be done by the provider in the context of the visit with a patient. Or it can be done in more formally with a social worker a CASAC et cetera. But I think the other thing to recognize is that really what's making the difference in people with opioid use disorder as far as decreased mortality and retention in care is the medication. So several studies have shown a lack of effective additional psychosocial treatment with even buprenorphine treatment. So in other words we're not getting much more bang for the buck by adding counseling to the medication that we're already given to people. Now does that mean I'm not a fan of counseling. Of course not. I do 30 minute visits with each of my patients monthly and I do motivational interviewing and are effectively a form of counseling with them every time I see them. Do I think peers would be great to have in your program and recovery coaches in your program. Absolutely. My point is we should

not be requiring it of people if people are on the medication and still struggling with issues then we will link them to the appropriate services that they're on. So again this is looking that intensive counseling does not improve buprenorhine treatment outcomes. And so let's talk about induction for a minute. So my my point I always make is that the only people who are worried about induction are providers who are inexperienced with it. So I've been doing home induction with my patients to start buprenorphine since 2006 office induction it is unnecessary and I think cruel to the patient having a patient in common in withdrawal is going to be terribly uncomfortable for the patient as well as for the staff members who will be interacting with them. The other thing to note is that about 90 percent of patients who present to care for buprenorphine treatment are buprenorphine experienced and know how to take it. So they've gotten me either on the street and have been self medicating. They've gotten it from another provider before they've gotten it in the emergency department. Were in a detox or were in a rehab et cetera. The point is that they already know how to take it. And often they can tell you what dose is the appropriate dose. So this is just more data. Again he's showing efficacy of home versus office space buprenorphine inductions with essentially similar outcomes. So this is looking at poly substance use among patients in Michigan buprenorphine treatment in the Bronx. The point of this slide is to show you that poly substance use is very common. So the other thing to note is when people get in treatment for buprenorphine remember we're only treating their opioid use disorder and actually other than alcohol use disorder. And tobacco use disorder. We have no FDA approved medications for any other substance use disorder. However Incidentally many you met for many people many of their other substance use disorders improve just by being in care and on buprenorphine because of their regular interaction with a provider and stabilizing their life. With respect to the opioid use disorder. So by curbing their opioid use often that curves curbs a lot of the behaviors associated with ongoing drug use. So for many people there are other drug use will improve without specifically treating. However if it doesn't and the person is interested in treatment for the other substance use disorders then you can certainly either co manage them with other medications for instance compensate for alcohol use disorder or topiramate for cocaine cravings or you can refer them to supportive counseling. Again this is looking at buprenorphine treatment retention by baseline marijuana use as you can see in this slide. A lot of people smoke marijuana and people did improve their marijuana use. So this one is really fascinating and I think that this is really important for people to see. So this was looking at providers confidence level at interpreting urine drug screens and then what their knowledge level truly was. So fifty six percent of people in this study were confident. Yet seventy three actually failed the test when they tested. So I think it is really important that if you embark on treating buprenorphine with your patients that you do have a mentor or somebody who really can train you on how to interpret urine drug screens. The other end point is that all urine drug screens is is is another piece data. So we do not use our urine drug screen results to be punitive with our patients. That's not what they're meant to be. Most of my patients if they do relapse they tell me what I'm going to say on the drug screen. It's really important just checking in to see that they're taking their buprenorphine and then occasionally if patients do have a relapse and have an inappropriate urine drug screen and then didn't share that with me I'll talk about that with them at their next visit to sort of problem solve with them what happened that led to their relapse. How do they feel about the relapse. What made them not feel comfortable telling you about that relapse. But it is important because you don't learn this stuff in medical school and certainly not until I worked in a methadone maintenance treatment program did I know how to interpret urine drug screens. This is again to show you that urine drug screens are complex metabolites are complex particularly opioids and

benzodiazepines and so for instance the standard opiate on a emergency department urine drug screen only tests for natural opiates. So it does not test for buprenorphine or methadone or oxycodone or oxymorphone et cetera. So again or fentanyl. So you're missing out on a lot if you're only looking at an opiate on a urine drug screen without looking at those other semi synthetic and synthetic opioids. Same with benzodiazepines a benzodiazepine that pops positive on sort of the standard urine drug screen is only showing diazepam and alprazolam, clonazepam and vorazepam will not show up. So what about diversion. So it happens it happens with many many medications and buprenorphine less so than other opioids. So I think that that's really important to recognize. Do I want my medications diverted. Of course not. I am prescribing them for the patient in front of me but I think given the other information I've given you you can see that why the medication was diverted is to bridge withdrawal symptoms. People self treating who couldn't access a program didn't know how to access a program weren't ready to access any kind of a program. Didn't know there were office AIDS models where they didn't have to attend a program five days a week etc.. And so actually I think diverted buprenorphine is likely decreasing mortality. Having said that of course you don't want your own prescription diverted and that's why we do urine drug screens and check for not only the buprenorphine level but also its metabolite or buprenorphine. So this is basically again showing that yes all opioids are diverted and even our feeling probably less so again because it's not a full agonist. You're not getting the euphoria associated with other opioids. So briefly I'm just going to let you know about our MHC model at our age. There are Hudson River health care where I work so I believe that a multidisciplinary team model is the best model for providing that services. So that consists in our clinical sites of a provider whether it's an M.D. an MP a P.A. you have a social worker ideally with a CASAC a care manager ideally with a CASAC and LPN and then I have a regional program directors in the Hudson Valley and in Suffolk County where we have our clinical sites and then I'm the medical director for all of our states. So we're low threshold for entry meaning we pretty much take all comers regardless of comorbidities and poly substance use. We have a harm reduction focus and of co-trained all my providers to treat hep C as well. We do weekly multidisciplinary multidisciplinary case conferences with each team and each MAT site. And I participate in each of those weekly by Skype business for distance sites. I do individual one on one supervision with each MAT provider on a weekly basis basis. And this is to help mentor them and teach them. Problem solved cases and allow them to vent and get emotional support from me. I created templates for buprenorphine naltrexone and telemedicine discharge templates pregnancy outcome data templates so that we can capture QI data and do research and we are currently running reports and using spot fire to look at our outcomes in the program and then comparing those with the limited benchmarks in the literature and then we can actually drill down to the individual patient and provider level so I can show an individual patient for example who's been in care with me for the last five years for MAT what percentages of his urine negative for opiate opioids and that can be very inspirational for patients. I do chart audits on the map providers quarterly and give them feedback and I do constant ongoing education with them. So we have a shared drive where I put MAT articles and any presentations that are relevant presentations from conferences and I do multiple email blasts weekly on all issues related to substance use disorder people who use drugs and then we do have a map telemedicine project currently at Monticello and we're expanding it to one of our other sites Riverhead and Long Island. Actually should have I have a little bit of newer data that I should realize I should have updated these but this is to just show you the growth of the program and the number of visits generated over time and you can see that the program has been growing every year we currently have over 500 patients in our program

and we have nine sites now this is looking at retention in care over time. So most of the that literature only goes out to twelve months and you can see our 12 month rate of retentional care is seventy six point eight percent which is pretty similar to the study that showed 75 percent that I showed you earlier. However my patient panel goes out to six years all the patients after two years on my patients. And you can see that I still have a high retention rate among patients after much longer amount of time. This is looking again this is this has been updated as well but this is looking at the percentage of positive urines for various substances so positive for opiates. So again that's mostly showing heroin 14 percent total across all the patients and that includes when they first come into care and usually expect to expect a period of instability until people get stabilized. You can see that eighty seven percent of our urines are positive for buprenorphine which is higher than that study I showed you. And about 30 percent of our patients are positive for THC which we certainly don't penalize patients with THC. This is looking at some patient feedback that we have gotten about our program. These are words that patients have used to describe our care. So from excellent caring friendly respectful adequate personal safe warm etc. To some negatives which had very low numbers. This system qualitative patient feedback. So this was. Is there anything you'd like to add about the care you received at the clinic. So thank you for the wonderful care and making me feel like family. I wouldn't change a thing. You have a full spectrum of staff who help me with my dependence and my mental health clinic team is great. I continue to work with another doctor doctors and state because she is medically and emotionally invested in my recovery. So what are some models of care for engaging people with substance use disorder. So it's certainly allowing enhanced clinic access for patients is helpful. So this means have walk in slots same day appointments partnering with your local emergency departments and jails for direct linkage to programs having clinical staff triaged patients to the appropriate level of care for substance use disorder. I would say ninety nine percent of patients who call for care are admitted to our MAT program for the rare person who doesn't. We will link them to a higher level of care if that is what they need. Debunk myths about MAT particularly about the diversion and induction issues. Those really should be not issues. Destigmatize dual diagnosis patients instead of for lack of mental health and substance use issues or triple diagnosis patients with mental health substance use and HIV and decrease barriers to their engagement in care and function as a low threshold settings to really truly meet people when they are at. So what are some of the things we can do to overcome barriers to care. So we really we want to provide non stigmatizing care ideally with multidisciplinary teams. I think that supportive one on one supervision or group supervision with providers and case conferencing really enhances the program. We want to develop relationships with the programs around you so whether those are intensive outpatient substance use treatment programs mental health programs syringe exchange programs etc. And also we want to make sure that we have stopped training on deescalating situations and diffusing anxiety tension and perceived aggression etc.. So what are some of the things that we can do to engage patients around harm reduction in substance use disorder treatment. So we know that patients interface frequently with the health care system whether that's the emergency department or syringe exchange program or community based agencies. So we want to be sure that we engage with those agencies so we can affect linkage to our programs. And then once people engage in services with us whether they're ready for treatment or not we want to treat them with respect dignity and empathy and give them informative care because then they're more likely to come back when we're ready and able to engage around their substance use treatment. Anybody who's hep C positive treat them everybody who has h

Hep C wants to be cured whether they're actively using or not. And certainly there's plenty of data showing that the efficacy rates for DAAS for hep C are equally as effective in people who are actively using versus not using and just recognize that everybody's on a different individualized timeline about when they're ready for treatment or not. So really just recognizing where people are in the stages of change is very important to work successfully with the person who uses. If a person is pretty contemplative it's not good information to let them know about rehab because thats not where they're at. So the most important thing demonstrate empathy and then utilize harm reduction principles. So for instance link people with syringe exchanges. Write them for syringes they can get for for free with their insurance up the pharmacy make appropriate referrals. If patients are ready for other services utilize motivational interviewing and then give them advice that's relevant to the stage of change that they're currently in. Give them a naloxone kit whether they're at risk themselves for experiencing an overdose or witnessing and really trying to truly integrate the services at your site provides it's not just coordination of care co location but actually integration of behavioral health primary care and substance use disorder services. That's the way that we're going to affect change in this epidemic. Think outside the box. So it's really important that we not think that just because it's been done some way or a long time that that's the best way to really push barriers push your administration push your finance people and create a model that's going to work more effectively with patients and then really importantly cultivate a team spirit and support one another. Certainly sometimes people can get burned out especially when their patients fatally overdose. It's really important that you process that with your team as a whole. So what are some of the benefits of doing that in the office. Clearly we're trying to remove the stigma of opioid use disorder. We can e-prescribe prescriptions. Patients are self medicating which is self empowering frees them up from the daily trip to the methadone maintenance treatment program. You're involved in treating their opioid use disorder and it integrates into the medical setting where it's already happening. Patients just may not have disclosed it to you. And that allows for patients who are actively using not engaged in care to get engaged for other issues such as HIV Hep C PrEP PEP contraceptive management etc.. This is my last line. So we know that opioid use disorder is prevalent. We know that it's a chronic disease and should be treated that way. We know that medication particularly methadone buprenorphine are efficacious often means we need to use chronic medication. We know that it's only effective if someone is ready for treatment. So this needs to be something that's internal and motivated not external pressure. Everybody should get harm reduction education and get naloxone kits really important to be non-judgemental. It is not a moral issue or a character defect. It is a medical condition and really incorporating this into general medical practice is the ideal form and it's extremely rewarding. So I think that's it. I'm going to leave my slide up with my resources and be happy to answer your questions.

[00:55:49] OK. Thank you Dr. Ramsey. Sorry my phone is ringing. We'll just let that go. Thank Dr. Ramsey again. We still have about four minutes left.

[00:56:03] So let's take a look at any questions that may have been posed again if you have anything real quick. Type it into the chat box Cheyenne did asked he mentioned creating an advisory board of people who use drugs to shape a MAT program. Do you have any advice about how to go about creating that panel. How do you talk about coping mechanisms with your patients.

[00:56:27] I don't I don't have advice on creating one. I mean I think we can look to the HIV world for that because most HIV practices larger practices currently have two advisory boards.

[00:56:40] So I think we can look at that as as a model for creating a similar structure for MAT programs but also another resource would probably be the Harm Reduction Coalition. They probably do have information with on that I would guess and then coping mechanisms. So this is this is a process of developing over time with patients obviously developing coping mechanisms is one of the key things of doing with patients. So that's not only in developing coping mechanisms for dealing with stressors in life but it's also coping mechanisms for dealing with cues to use for dealing with drug cravings. So think about if you're counseling as somebody who's trying to quit smoking. If that person can can sit with that craving for about five minutes or so the craving is likely to pass. And so it's very similar with patients with other other substance use disorders. If they can sit with the craving and reach out to somebody or think about the consequences which is often challenging for patients to remember the consequences. Often when when people are in early recovery they're sort of gilded by rose colored glasses that people have on with respect to their substance use disorder. So instead of remembering all the consequences of their substance use disorder and what drove them to seek treatment they're remembering the good things that happened substance use disorders so again it's doing skill motivational interviewing with patients looking at the pros and cons of either way and then helping them to process the consequences of what would happen if you relapse. Particularly for say moms and children when sometimes there are very real consequences to a relapse and often once a patient can develop that skill set and be able to look at consequences they're able to say it is not worth the consequences. But remember that any substance use actually affects our frontal lobe development which is how we weigh consequences. So a lot of that youthfulcivity and the failure to be able to process consequences thoroughly has to do with the disruption of frontal lobe development that happened because people were actively using during two developmental time period which is at age 25.

[00:59:05] And there was one other question but I can't see it now so I'm not sure.

[00:59:09] There's a couple and we're getting short on time so I did want to address Rob and one of the participants. So is it alright if we share your slides like a PDF with anyone who needs them. Yes, that's fine. OK. We have another one which might be something you can answer. Is a participant who is in recovery and goes to NA meetings twice as a licensed pharmacist. How do I get a narc kit to carry in my car.

[00:59:33] OK so one thing I just want to say about NA really quick and I didn't have time to mention this but the other thing is that I just use caution when you do refer your patients to 12 step meetings because some 12 step meetings NA more than AA are very judgmental about people who are on buprenorphine or methadone people are told that they're not in recovery unless they get off those medications. And so a lot of my patients like the camaraderie and the support that they get from that group atmosphere. But I let them know you don't need to disclose that you're on buprenorphine or methadone because if you're not going to get that support or you're going to be publicly shamed for being on medication then that may not be the best area for you to go to support. So something like SMART Recovery does not have that more traditional look at people not being in recovery if they're not absolute meaning off medications as well.

[01:00:31] So you should be able to as a licensed pharmacist get an naloxone kit from any opioid overdose prevention program that's not given that designation by the New York State Department of Health and you can actually go online and look up organizations that have that designation or any chain pharmacy also carries Naloxone kits and you should be able to go into a pharmacy that is part of the program and request it.

[01:00:59] Sometimes it will be billed to insurance for the Ncap program will pay for up to 40 dollars of a copay and my suggestion would be not to leave it in your car because actually naloxone should remain temperature neutral so exposing naloxone to too many freezing temperatures or too many hot temperatures will actually decrease the efficacy of it.

[01:01:20] Great. Okay. Thank you Dr. Ramsey. We're a little over time so we're to have to end it there again. I want to thank Dr. Ramsey for presenting today. Also thanking the funding we received from New York City Health AIDS Institute and the Clinical Education Initiative to bring us This Month in HIV. Again please keep an eye out. You will receive emails to evaluate his program as well as claim your CE credit so please don't forget to do that if you have any questions. I sent out the email today. Please respond to me Robert.Walsh@mountsinai.org. Thank you everyone and have a great day. Thanks.

[Video End]