RECADEMY™

The Academy for Improving Substance Use Disorder Treatment: Making Recovery a Reality™

Designing The OUD Cascade Of Care: What Works In Real-World Provider Settings

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Dr. Buttlaire 0:00

Welcome. I'm Dr. Stuart Butler of OPEN MINDS, and our Academy webinar today is initiation of LAI M O U D to demonstrate accelerated onboarding, a best practice case study with Kaiser Permanente Napa Solano service area. One of the continuing challenges in treating opioid use disorder is that the moment when someone is ready for help can be remarkably brief. A person may reach out and say, "I need treatment." We schedule an appointment, but they don't come. They reach out again, perhaps receive a prescription, but they never pick it up. And before long, the patient and the treatment system can find themselves repeating the same cycle. In opioid use disorder, those missed opportunities really matter. Every delay creates the possibility of continued use, further progression of the disorder, and potentially overdose. So, one of the questions for us as treatment providers is how do we design care around that moment when the patient is ready, rather than expecting the patient to fit into the way we traditionally deliver care. That that's really what today's case is about. Dr. Charles Whitehill will take us through the experience of a patient who repeatedly expressed interest in treatment, but had been very difficult to engage through the usual approaches. His team ultimately had to step back and ask a different question: What can we do differently while we still have this opportunity? The answer involved more than simply choosing a different medication, it required rapid access, a multidisciplinary team, pharmacy support, medication availability, and the flexibility to use a long-acting injectable approach in a way that better matched the patient's needs. So, as we go through this case today, I'd really like us to think about three things: How do we recognize and capture that moment of readiness? What has to be in place operationally to act on it quickly? And how can long-acting injectable M O U D help us respond to some of the increasingly complex patients presenting for treatment today. Dr. Whitehill, let's begin with the patient and what was happening before your team decided that the usual approach simply wasn't working.

Dr. Whitehill 2:30

All right, thanks for having me, Stuart. This is a problem I think everybody who practices in addiction medicine is familiar with, and that's when you get a patient that reaches out for help but doesn't connect, or reaches out, shows up but doesn't follow up, doesn't pick up the prescription, or picks up a prescription and then we're unable to contact the patient. Weeks go by and he reaches, you know, the patient may reach out again. This is this is familiar because there's a lot of patients that go through this, and there comes a point when you start to recognize, oh, this person's calling again, and we have had enough contact with this patient. We realized, okay, this is this is just going to keep happening over and over again, and we need to be able to offer something different. What's a what's a way to

get this person, and how do we get this person onto buprenorphine, which is what he was seeking for an opiate use disorder? So this is a reoccurring pattern that we see frequently. We see them in adolescents, more typically male adolescents, but this can be people from all walks of life, and typically they'll outreach in a moment of crisis, and it usually ends up in a no show for an appointment, or they show up for an appointment but don't pick up the medication, or maybe pick up the medication, but then we lose them to contact over the next couple weeks. So we can see this happen with any any age. In this case, it was somebody who was approximately 20 years old. But I have a an appointment later on this afternoon with a woman who's 65 years old and is retired. It typically happens in people who don't have strong routines, community involvements, or a support system, and this creates frustration in the clinical staff, especially when people start to recognize, "Oh, okay, this person's calling again." When you start to experience that frustration, this is when you have to start thinking maybe a little outside the box. So the question becomes: How do we stop this? How do we reduce the number of steps here to actually get somebody to engage in treatment, stop the cycle of failure to connect to treatment? Right. So we start by looking at missed opportunities, and any missed opportunity leads to. The risk of disease progression, or even potentially a fatal overdose. One missed opportunity might seem like a one-off, and it's good to sit up and pay attention. But if we start to see these show up as a pattern, then it should really grab your attention. The longer fentanyl or any other opiate use goes on, their more their disease can progress and increase the risk for that fatal overdose. Our goal is to see patients same day or next day at the most. We're trying to meet people's request as quickly as possible. I think what we found is that we were starting to normalize missing appointments, and our patients start to normalize missing appointments, and there's disease progression going on. And as this goes on, you become harder and harder to treat. So this is something you want to be careful that your clinical staff does not do, and not something that your patient experiences, we have a philosophy of access that is basically yes. If somebody needs to be seen today, even later in the day, our answer is generally yes. There's an opportunity present. Our clinical staff is built around responding people into the same day and next day. So, in order to enable same day, next day access, we have to be able to keep medication in stock for quick access. We have to have staff assigned to be available for these patients as they come in, and have other resources available, such as treatment programs, therapists, and ancillary medical staff. Now you can't get this job done with just one person. We have a what I call the octopus model. Whoever is available at the moment can provide that support, see that patient. Sometimes it's our on-call person, but sometimes it's somebody who just has an available time slot. Our care team includes intake specialists, addiction medicine doctors, nurses, nurse practitioners, physician assistant, and we also have a pharmacist available to assist.

Dr. Whitehill 7:21

So this patient has been falling on a regular basis, but he's never engaged in treatment, and this has been going on for some time. Our goal is harm reduction, and the problem we have to solve is how to get this patient in immediately when they're ready, when they're ready to engage in treatment. We had a pharmacist who had developed a personal relationship with the patient and reached out to suggest a long-acting injectable. Now, traditionally, we've been using sublingual buprenorphine, but this was a new medication that we could maybe try to bridge this gap between his desire for treatment and to actually get the medication on board, he expressed immediate interest in this because it was new and seemed promising, and we were able to provide him same-day appointment to our clinic. So by front-loading treatment delivery, that is having staff, medication, and opportunities

to engage people, we can reduce the barriers to care and increase treatment retention in our program. This patient hadn't previously heard of long-acting injectables, but the idea was more appealing to him than the traditional buprenorphine dosing. We used a strategy using both weekly and monthly long-acting injectable doses. We were able to avoid the significant withdrawal symptoms by beginning day one with a low dose weekly formulation, the eight milligram Brixody injection. The patient was able to follow up the second day to get a second dose of that same eight milligram injection, and he had almost no withdrawal symptoms. And on the third day, we were able to provide a monthly injection. So this patient now has on board a therapeutic dose of buprenorphine that would begin to treat opiate use disorder by reducing craving, reducing and preventing withdrawal, and also reducing and possibly fully preventing overdose. So, when you consider addiction, you have to consider that addiction develops in secrecy and isolation, and it's usually fully developed by the time it becomes apparent to other people in the. Development of your addiction, you've lost your connection to your community. You've lost connection to your family. Sometimes you've lost your job, and the recovery process is learning how to reconnect with families, communities, and jobs. When I joined Kaiser in the substance use disorder program in 2014, we had a very conservative program that was had some fair barriers to treatment, and we weighed our pros and cons. We weighed the opportunities and looked at some of the barriers, and we removed all requirements to get access to buprenorphine. Hence, our philosophy is yes. If you want it, you have it available. So we required no treatment requirements in order to get buprenorphine, and this accelerated the initiation and onboarding for buprenorphine, and also allows continued access to buprenorphine. We used to have a community group for buprenorphine recovery, but however, when we stopped requiring that, the attendance declined, and we eventually had to discontinue that group. Future plans include potentially creating a new recovery group that would be an optional program. One of our greatest strengths is our integrated structure. We have an entire care team under one roof. In the case of this patient, patient A, we have a pharmacist who's developed a relationship with the patient. Our intake team was able to immediately get him in for an appointment, we have nurse practitioners to support and evaluate the patients. We're able to create same day, next day follow-ups to minimize patient disengagement from treatment. In order to provide the long-acting injectable buprenorphine, you need to be able to have some medication on hand for same day, next day service. The medication brixody is covered under a risk mitigation strategy called REMS protocol, and the best option is for your clinical situation to apply for a REMS pharmacy application, or the ability to stock the medication inside your in your clinic. In this case, the manufacturer is able to send directly to your clinic, and you can stock doses to be available. The other option to provide medication is that you have to order individual doses for specific patients for your clinic. And given amount of time, you will eventually start to accumulate some medication doses in a rotating stock that can be used to provide same-day access for some patients, and in order to do this, you have to have a reasonable lead time.

Dr. Whitehill 13:16

You know, usually, like we find in Kaiser, our lead time is like three days from identifying a patient to getting a medication in stock, so we have a running stock of medication assigned to patients that gives us the flexibility to do same day, next day dosing. So some of the factors that made a difference: our ability to say yes to meet that patient where we're at, making working with this timeline, which is usually right now or within the within the hour, the ability to pivot to shift away from sublingual buprenorphine dosing to the long-acting injectable, having a relationship with our

pharmacy team to provide that long-acting injectable buprenorphine, and no requirements, no barriers for this patient to begin treatment. Where do we start? First, you have to start by looking at your missed opportunities. Where do you see the patterns of patient drop off? Are they not making it into clinic? Are they making it into clinic? Are they not picking up their medications? You have to identify areas that you can bridge that gap. You need a collaborative care team that can work together to support the patients, be able to engage them, and that requires at least several providers, maybe a pharmacy or a pharmacy team, to provide the medications. You need a policy of yes to meet patients whenever they're ready to engage in treatment, and that includes having that scheduling. Access the people there, the medications on hand. You also have to be able to pivot, and in this case, the pivot away from sublingual dosing of buprenorphine, the traditional buprenorphine induction, and pivoting towards using a long-acting injectable, which provided us a new opportunity to engage the patient.

Dr. Buttlaire 15:23

Oh, I get to ask you some questions now, Dr. Whitehill. So, why does beginning with the weekly formulation help you initiate treatment more quickly for some patients, rather than waiting until they're ready for a monthly dose?

Dr. Whitehill 15:38

All right. So, the traditional start for the long-acting injectables is to have a dose of buprenorphine on board. They like the therapeutic dose, eight milligrams, 12 milligrams on board, and if that's on board, you can give the long-acting injectable. Well, in the case of this patient, we couldn't get that therapeutic dose started on this patient. So the weekly formulation of the injectable is very slow onset. So if you give a weekly dose, even if somebody has no buprenorphine on board, if they have opiates on board, fentanyl, kratom, morphine, heroin, whatever, the buprenorphine level comes up very slowly with that weekly formulation, and it prevents triggering withdrawal with the patients, and it gets some medication in. Usually, we like to repeat a second dose if we can, and if that goes well, we can go to the monthly dose. And by the time you have the monthly dose on board, there's usually minimal or no withdrawal. Studies have shown that using this method results in usually minimal withdrawal, no withdrawal symptoms in some, and tolerable withdrawal symptoms in in other individuals. So it's a great way to start.

Dr. Buttlaire 17:20

And and sounds like also this individual was a great candidate for that because it was just so hard to connect.

Dr. Whitehill 17:28

Yes, it was hard to connect, hard to meet him at that moment, and being able to say get that one injectable on board sets him down the path of minimizing the withdrawal symptoms, getting the buprenorphine levels up to a therapeutic level pretty quickly.

Dr. Buttlaire 17:52

So my next question for you: Have you used this approach with other patients since then, and can you tell us about how the process varies by patient.

Dr. Whitehill 18:03

Yes, we have used the process since then. It doesn't vary a tremendous amount. We don't use it frequently. Probably the number one disadvantage of the long-acting injectables is the high cost, so you would not start every patient on the long-acting injectable. But particularly if patients seem to be at risk or we're seeing the development of a pattern of not engaging in treatment, then that is an option. I have a patient that I would meet with this afternoon to offer this as she's attempted engagement in treatment, you know, several times without success, and we've done several prescriptions of starting doses of buprenorphine. And as soon as I mentioned this method, she responded with, "I'm interested," and so this is a this is an opportunity. We'll probably still proceed the same way: one or two doses of the weekly long-acting injectable before going to a monthly dose.

Dr. Buttlaire 19:18

So, where are organizations most likely to get stuck trying to implement accelerated LAI M O U D initiation, and and and also what what did you learn that would help them avoid those problems?

Dr. Whitehill 19:36

I think most organizations would get stuck first of all, in just having minimal access for buprenorphine, you have to have dedicated staff time. You have to have qualified individuals. You have to have a an agreed on policy of when you have an opportunity. It's time to move with that. The next area that some organizations would get stuck would be having access or availability to long-acting injectable. I think this is best solved by applying for the REMS certification to be a stocking clinic or pharmacy for this medication. This has the medication on hand so that you could offer this as as an option.

Dr. Buttlaire 20:36

That's a really good point about availability. If you're going to act quickly and engage somebody. You've got to have the medication available to you, so that they don't have to wait. Because that waiting, as you've said before, could lead to actually, you know, delays in treatment and no treatment.

Dr. Whitehill 20:55

Yeah, correct. Our the the retail pharmacy is across the street for sublingual buprenorphine, and that is too much of a barrier for some people. They just don't make it to the pharmacy, or they pick up the medication, but then you know don't follow through. And the this method works because you get a dose on board at that moment that will last days, if not you know weeks, in the patient.

Dr. Buttlaire 21:32

You mentioned something in my earlier question that is kind of stuck in in my mind, and I just wonder how often are are patients telling you, I just can't afford it? Is that something that comes up frequently or not?

Dr. Whitehill 21:51

In our situation, it doesn't come up very frequently. Our patients all have either Kaiser coverage, so they they do have an insurance coverage, or they are Medi-Cal and long-acting injectables are covered on Medi-Cal and and Medicaid. It would be a very different situation if people were paying cash though for these medications, that would certainly, you know, be an issue, and would certainly be a detractor from a successful buprenorphine use.

Dr. Buttlaire 22:33

So, what's the most important operational principle behind this model? what What is it that makes it work so well?

Dr. Whitehill 22:41

I think the most important organizational component is the dedication to providing immediate access without barriers. Just having that as your your model going forward, and having buy-in from your administration, from your pharmacy, you know, from your medical team, this is going to be the most necessary principle for providing buprenorphine successfully to the public.

Dr. Buttlaire 23:11

And I think this question, in my mind, is extremely important because, you know, the case clearly depended on more than just medication. If an organization wanted to adopt this approach, this kind of approach, what what needs to be in place operationally? You know, you talked about the clinical team, the pharmacy relationships, medication availability, and the ability to respond quickly. So, what needs to be in place in order to be able to do this kind of approach,

Dr. Whitehill 23:44

yeah, this is where we have an already existing advantage of having a full team, and that's supported by an administration that include medical providers, and we have everything from M.D.s to nurse practitioners, a P.A., a pharmacist. We needed to have a really good relationship with our pharmacy department. They had to understand what we wanted to do, why we wanted to have this medication available, why we needed to be able to have something in stock regularly to be able to respond and pivot at the moment. You also need to have some tolerance for the the cost of these long acting injectable medications. That the placing the value of getting people safely on the buprenorphine and into treatment as an important goal of having your clinic in in place. So all of these things were in

were in place. We had to develop this relationship with the pharmacy and the the administration. And as long as after we had developed those relationships. And they understood us, and we understood their needs. We were able to proceed,

Dr. Buttlaire 25:06

and that leads us to the next question. So, if you were speaking directly to a CEO or CMO or an addiction program leader who wants to do a better job of capturing these essential moments of patient readiness, what are the few things you would tell them to change first? What are the two or three things you would tell them to change first?

Dr. Whitehill 25:31

I think the first thing to do is would be to have a a conversation of your readiness to provide same day, next day access to treatment counseling. You have to meet people pretty quickly and have minimal barriers. So this requires agreement between from the you know the top of the organization down to all the providers, including you know your medical assistants, the people answering the phone, so that would be the first part. If you have that agreement, you can move forward. The other thing you probably need is some kind of a communications system beyond the phones. We need to be able to communicate directly to the pharmacy and communicate to our team members. So we use a chat, Microsoft Teams, in order to talk back and forth between providers, the pharmacy, ordering prescriptions, ordering refills, this kind of thing. This allows us to respond, you know, quickly across our whole organization. So agreement communications, and then it's somebody taking the responsibility to apply for the REM certification to be the responsible party, you know, for the prescriptions. And this is usually in a physician, MD, or DO of the program.

Dr. Buttlaire 26:58

You know, I'm thinking about the clinics and and not only your clinics but other folks' clinics and and having the availability of staff to meet that patient who may be coming in tomorrow may may come in the next day. I mean that flexibility in terms of staffing and availability of appointments, is that essential?

Dr. Whitehill 27:26

Yeah, absolutely essential. I, you know, sometimes talk to my colleagues in you know other departments that it takes, you know, there's a a couple weeks, you know, or you know, or more, you know, before you can get an intake appointment, you know, and I'm thinking, oh my goodness! Like we couldn't function with that. That would be impossible. So I have been somewhat spoiled by, hey, same day, next day access. We can make this happen. Even if you were to walk in at 4o'clock, there would be an option. You're not going to leave, you know, empty-handed. Not sure we can arrange an injection or something that quickly. You know, however, you're not going to leave empty-handed, and that's an essential part of this being able to respond in the moment.

Dr. Buttlaire 28:12

That's that's very important, and and thank you for that. So this gets back to the treatment progress, and you know, how do you move from successful initiation to sustained engagement. Once the medication is on board, what helps reconnect someone with treatment, family, work, and the broader recovery process? You you mentioned so many of the patients who who come to you don't have those kind of connections, and it's so important to start making them. So, do you have any comments about that?

Dr. Whitehill 28:47

Yeah, I think that's where your your contact with any point in the organization needs to be open, quick, honest, and without judgment. The faster you can get somebody in and connect and start a relationship that doesn't have any judgment attached, I think people with substance use disorders are hyper aware of of judgment, and that is probably one of the biggest barriers to to to to getting care. So if you can connect with a provider that is not going to raise an eyebrow with who you are, what you've been doing, you know what you're you're going through with it, that helps to have that connection and have that ability with each of our team members. And these are the people I I love to work with. Our team members, any one of them can connect. You know, my pharmacist has been working in the background, connecting with the patient. He's been calling the the pharmacist knows the patient. Most of the team members knows the patient, and so we tend to get more follow up through that connection. And that's how we get people to engage.

Dr. Buttlaire 30:04

You know, one of the things I hear you saying is part of maintaining engagement is really overcoming stigma.

Dr. Whitehill 30:14

Yeah, you're right. Like I said, most of our patients are hyper aware of judgment and stigma, and if we can leave that behind and just provide, you know, that access and that connection, sometimes that's such a relief for our our patients. Not uncommon to see a lot of tears shed in the beginning, with all their, you know, frustration and all the the emotions that come with this that they're finally able to relax, open up, you know, be and be honest.

Dr. Buttlaire 30:52

And that non judgmental attitude of the staff must make it possible for the the patient to actually absorb that themselves and accept that and help them make changes.

Dr. Whitehill 31:06

Correct. If if every member of the staff that they connect can be pleasant, non-judgmental, that helps. And this is how the the team can function. As I've used the the metaphor before, like an octopus,

whichever arm is free of the octopus can step in, and you should have the same great experience, non-judgmental healthcare from any member of the team.

Dr. Buttlaire 31:34

We're really now talking about the culture that you know Kaiser and you were able to develop in your clinic,

Dr. Whitehill 31:41

yeah. I don't think it was always that way. You know, most programs, and you know, I can only speak to Northern California were pretty conservative. In the beginning, you had to agree to come into treatment. You you know that was required. You had to go to group, and I was watching this, you know, kind of from the start. Like, okay, I I see people dropping out here and there, here and there, and even with using other substances, using cannabis, continuing use of other substances. Initially, in the early days, we required you to be abstinent from all other substances, meaning not using anything else. And today, we've switched really to this model of harm reduction, whereas we're providing the buprenorphine, we're reducing your risk for complications due to your opiate use disorder, the risk for overdose, the risk for death. We don't recommend your continuing use of other substances, but we will still provide it without judgment if you're using other other substances, and that's called harm reduction.

Dr. Buttlaire 32:45

Those are great points. And for my final question, you and I were fortunate, are fortunate, you know, and have been in Kaiser's system, which is highly integrated clinically With pharmacy for a smaller, less integrated organization, what parts of this model are essential, and what what can realistically be adapted without having all the the resources that that Kaiser has?

Dr. Whitehill 33:16

That's a great question. I would say attitude and communication is all you need, Stuart. You need to have the attitude of we're going to provide access, we're going to provide care, we're going to do it without judgment, we're going to offer same day, next day, whenever we can, and we're going to use our communication skills internally so that our pharmacy or whoever stocks our medicines can align with the need to provide meds, and we'll be able to pivot. We'll provide buprenorphine with without barriers, and if we need to use a long-acting injectable to start it or maintain buprenorphine, we can do that too. So you don't have to have a large organization to do this, just the willingness to provide this kind of care.

Dr. Buttlaire 34:07

And with that, I want to thank you, Dr. Whitehill, for a great presentation, great case, and and answering my questions. So, for those of you who've joined us, thank you very much. And this is part

of Recademy, and you can explore upcoming webinars and resources at Recademy.org. With that, thank you all.

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