Community Induction Sites

Herbert D. Kleber, M.D.
Professor of Psychiatry
Director, Division on Substance Abuse
Columbia University/NYSPI

NIDA/SAMHSA Buprenorphine Summit
May 10, 2010
Washington, DC

Community Induction Sites
The Initial Need

- Many physicians – especially if inexperienced in treating addicts – may be willing to maintain patients on buprenorphine but not induction
- Induction seen as problematic because:
  - Patient needs to be in withdrawal (or abstinent) to begin
  - Two-stage process: evaluation & education; actual induction
- Office may not be set-up to have patients remaining for hours – especially if not feeling well
- Office staff, especially of primary care doctors may be concerned about possibility of acting-out behavior

The Columbia Buprenorphine Program

- Began in September 2003
- Started because belief that office-based treatment with buprenorphine was most significant innovation in decades & patients should have ready access to this potential life-saving medication
- Has served as model for other such programs & prior to PCSS was important advisor to doctors wishing to begin buprenorphine treatment
- Original intent was to induct patients & then refer back
- However, many patients were self-referred or from other patients, or wanted to continue with the program so began ongoing maintenance

The Columbia Buprenorphine Program

cont.

- Multidisciplinary team includes psychiatrist, internist, psychologist, & psychotherapist, all part-time
- Located on the Columbia University Medical Center Campus on 168th Street easily reachable by both bus & subway or by car
- Program provides buprenorphine treatment for dependence on prescription opioids or heroin
- Also accepts patients who wish to transfer from methadone maintenance but dose must be 40 mg or less

The Columbia Buprenorphine Program

cont.

- Also uses long acting naltrexone injection (Vivitrol) for patients who want to transition off buprenorphine to naltrexone or who are primary alcoholics
- We also treat certain opioid dependent patients with chronic pain if adequately covered by buprenorphine
- Treatment is tailored to each patient
- Can include both individual & group psychotherapy in addition to buprenorphine
- Will be starting Women's Group soon

The Columbia Buprenorphine Program
Financial Aspects

- Initially unable to accept Medicaid, Medicare, or other third party payments so all patients had to pay out of pocket
- One year ago able to work out arrangements to accept United Healthcare, Oxford, & Aetna – but will discontinue soon because of low level of remuneration – less than half of usual fee
- Other than first 2 years, program has been consistently a money loser with deficit made up from non-federal sources
  - Unable to raise fees because of large number of registered physicians in Manhattan compared to number of patients seeking treatment
- May need to open midtown site

Phases of Treatment
Evaluation

- Patients call & make initial appointment after receiving information about program
- Evaluation visit approximately 1 hour: patient meets with treating physician to discuss treatment needs & information regarding medication & choices
- Family members are welcome to come if the patient wishes
- Patient makes the initial decision as to whether they want detoxification or maintenance
- Patient told must be in moderate withdrawal from short acting opioid - usually 12-15 hours (or 24-36 hours from methadone)

Phases of Treatment
Induction

- Usually takes 2-4 hours; patient warned not to drive home himself
- Patient in private space, not waiting area
- Withdrawal checked by COWS scale
- Started on 2-4 mg Subutex sublingual dispensed by program
- Observed by physician for next 20-30 minutes; should either have no effect or feel somewhat better

Phases of Treatment
Induction
cont.

- If not precipitated withdrawal, another 2-4 mg given 1 hour after initial dose
- If no problems, sent home within one hour & instructed about dosing for next few days
- Encouraged to call in daily for next few days
- Patient is given an Rx for Suboxone to fill at a pharmacy

Phases of Treatment
Stabilization

- Post induction, patient calls program daily for a few days
- Patient comes into program a few times over the next weeks to see how things are progressing
- During this time, stabilization dose is agreed upon depending on variety of factors, the dose is usually 8-24 mg Suboxone
- Key decision made over next few weeks – whether patient wants maintenance or detox
  - Most choose maintenance, some want off all opioids

Phases of Treatment
Maintenance

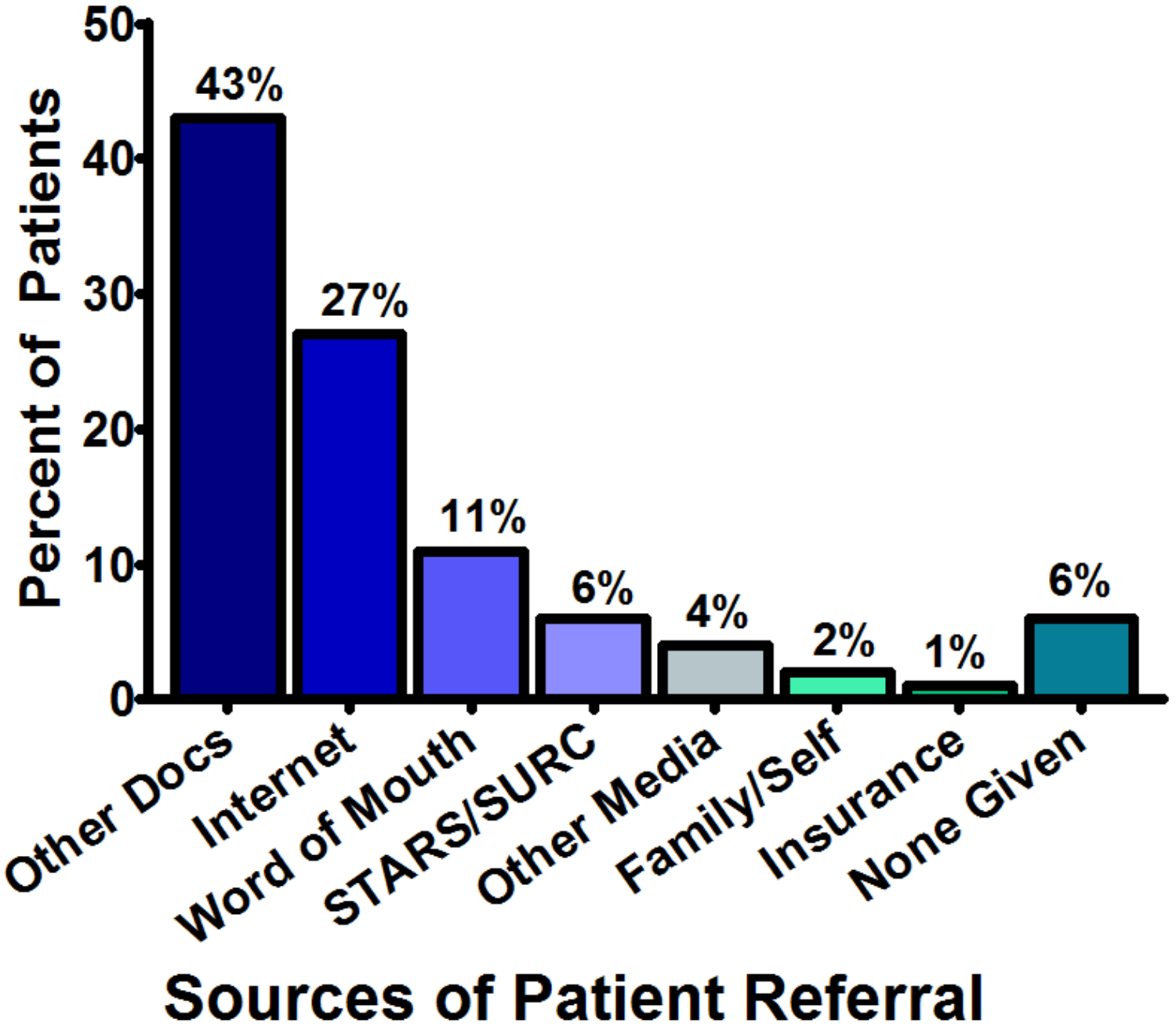
- Also to be decided is whether patient wants to continue with our program, referred back to referring physician, or referred to a physician closer to their work or home
- After the patient is maintained, they are required to come in at least monthly. Individual therapy is offered for a fee & group therapy without additional cost

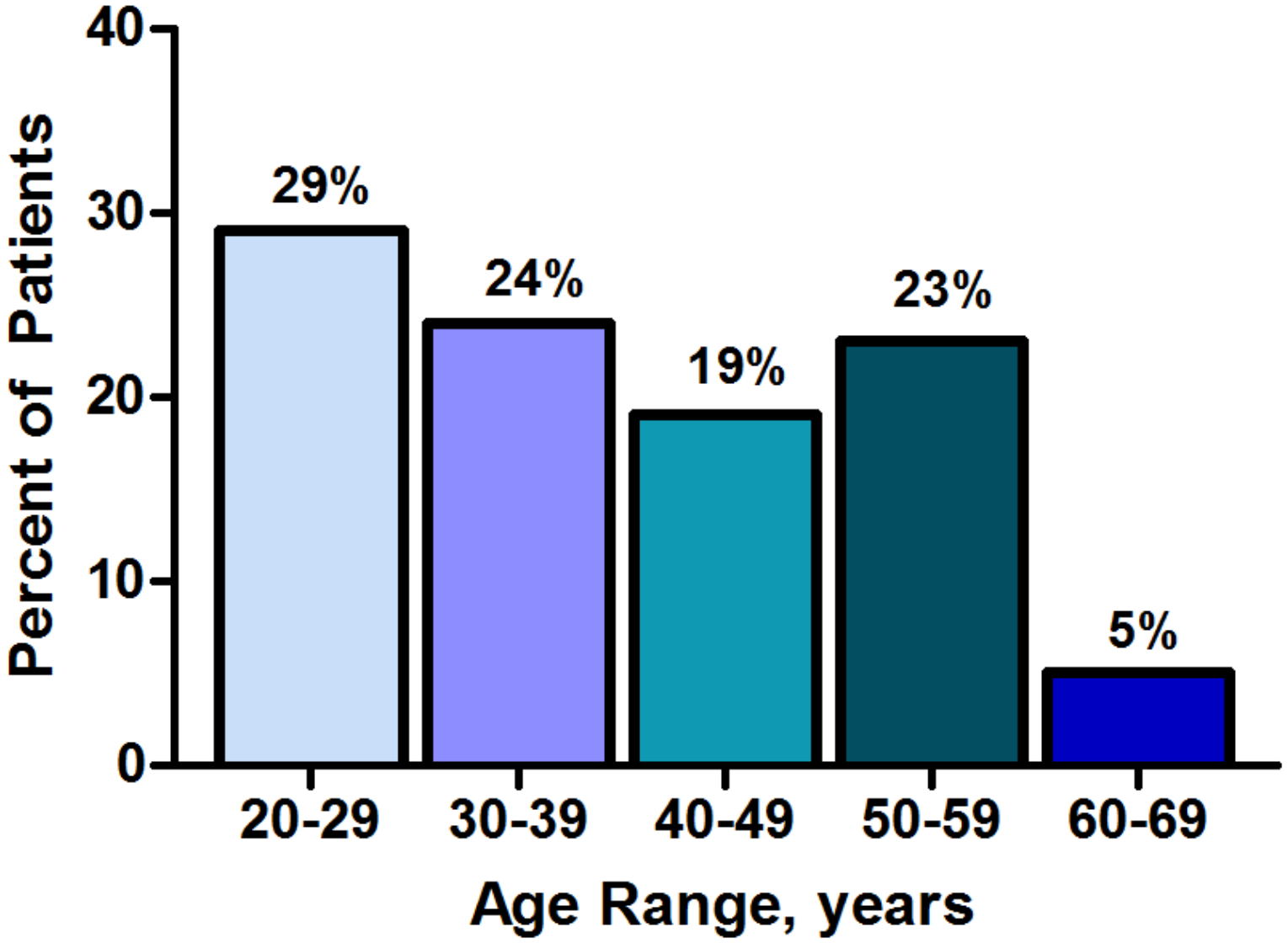
Buprenorphine Group

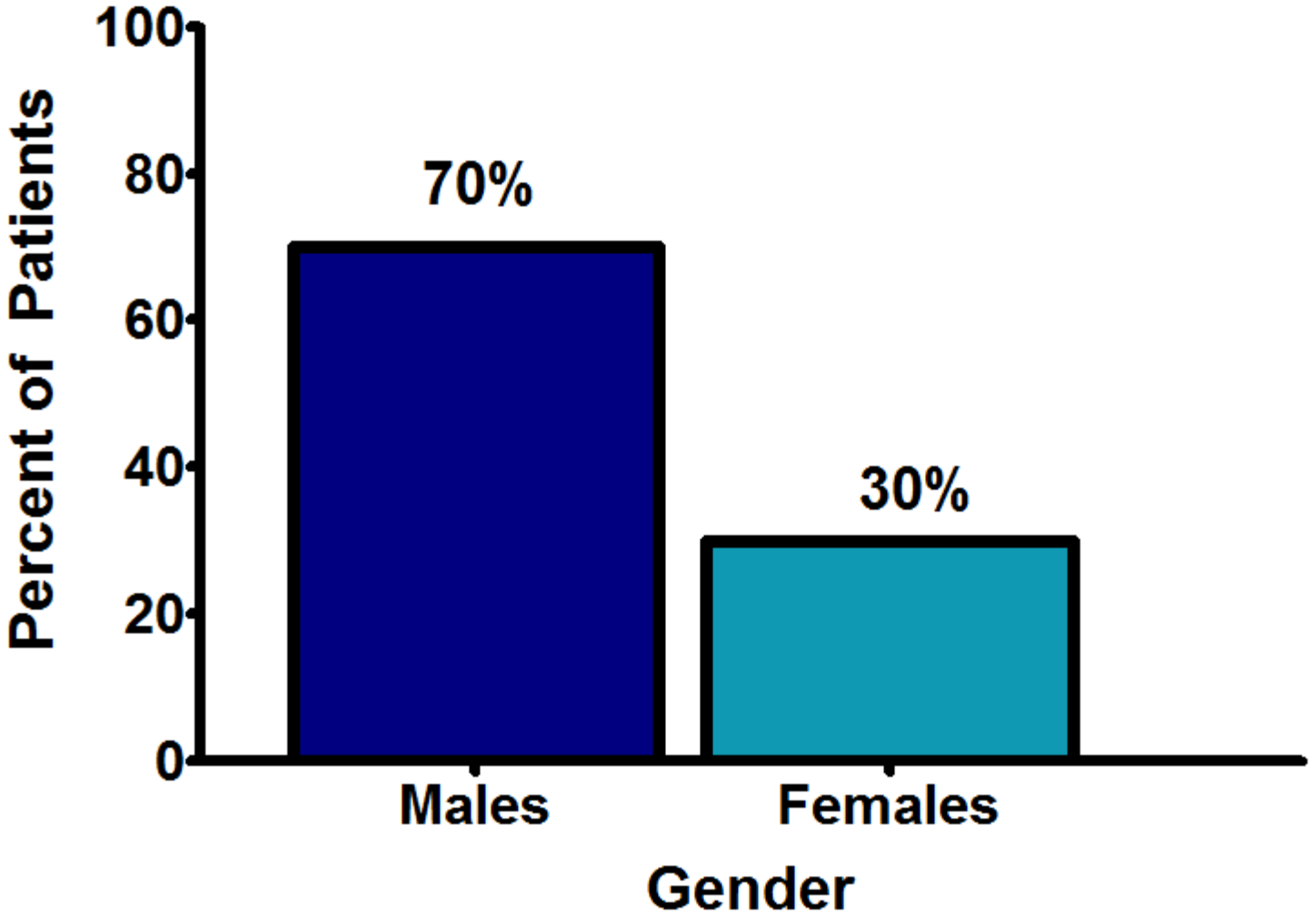
- The Columbia University Suboxone Support Group will begin December 1, 2009. The group's goal is to maximize the buprenorphine treatment experience. Enrollment is free. Potential topics include:
  - Differences between abuse & dependence
  - Identification of craving & drug use triggers
  - Coping skills & relapse prevention
  - Peer support & supportive networks
  - Stress management, e.g., relaxation techniques & mindfulness meditation
  - Pain management issues
  - Relationships
  - Anxiety & depression
  - Challenges as well as success in tapering off buprenorphine
  - Cognitive-behavioral topics & techniques

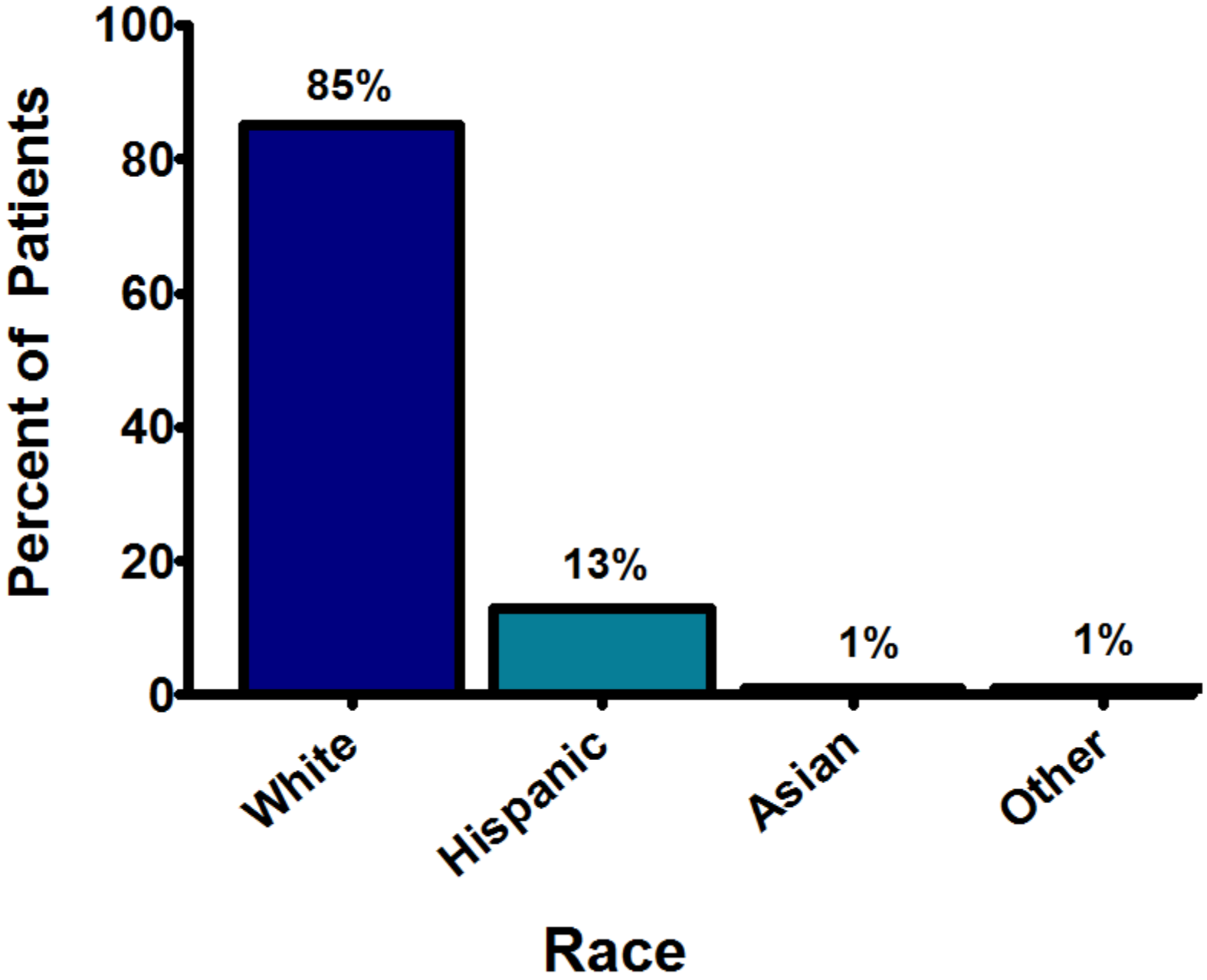
Phases of Treatment
Maintenance
cont.

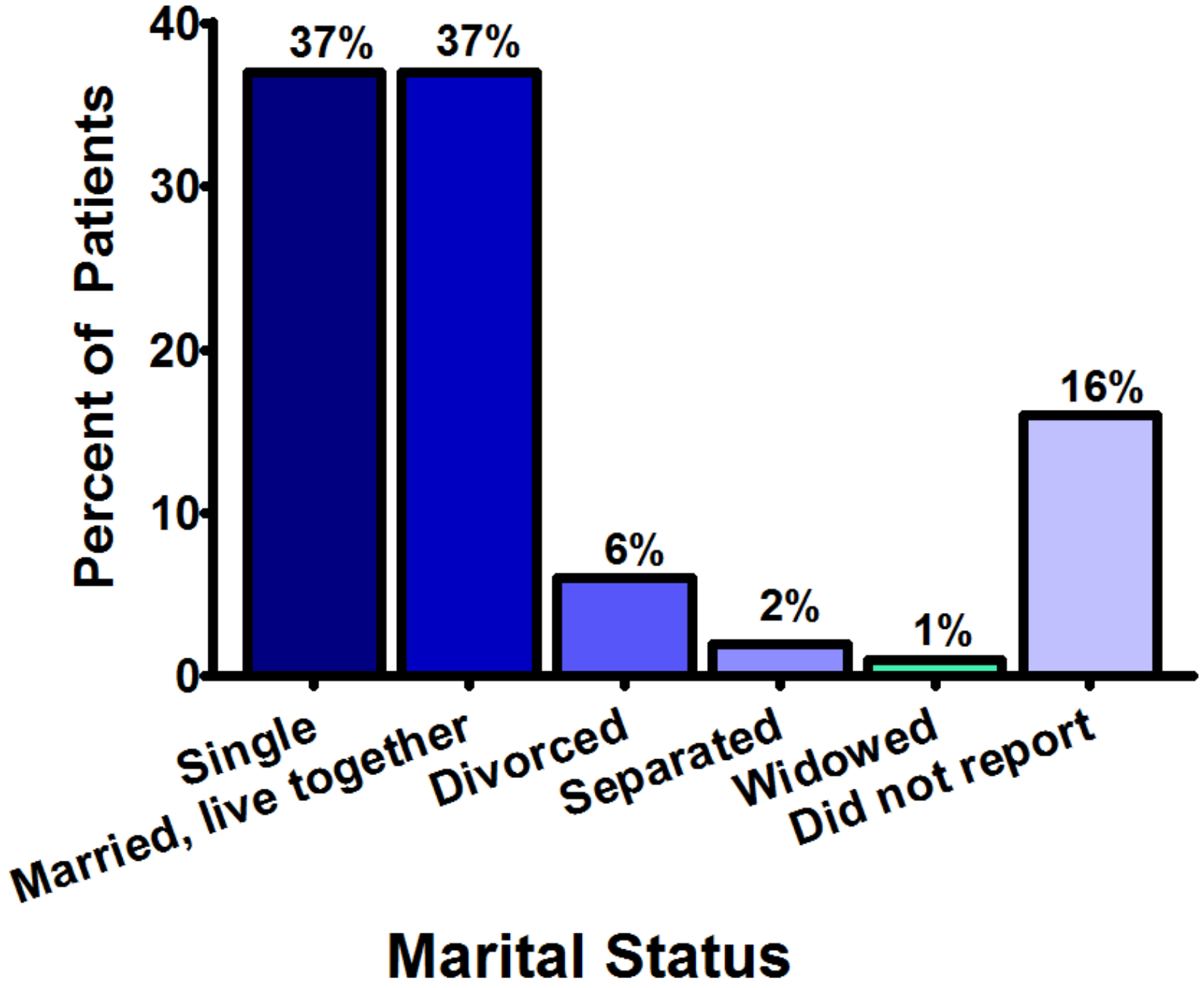
- Withdrawal from buprenorphine during first few months is considered short-term detoxification
  - It can be as quick as 3-4 visits post stabilization or as long as months
- Patients are offered option of the long-acting 1 month naltrexone injection (Vivitrol) which we recommend post detoxification

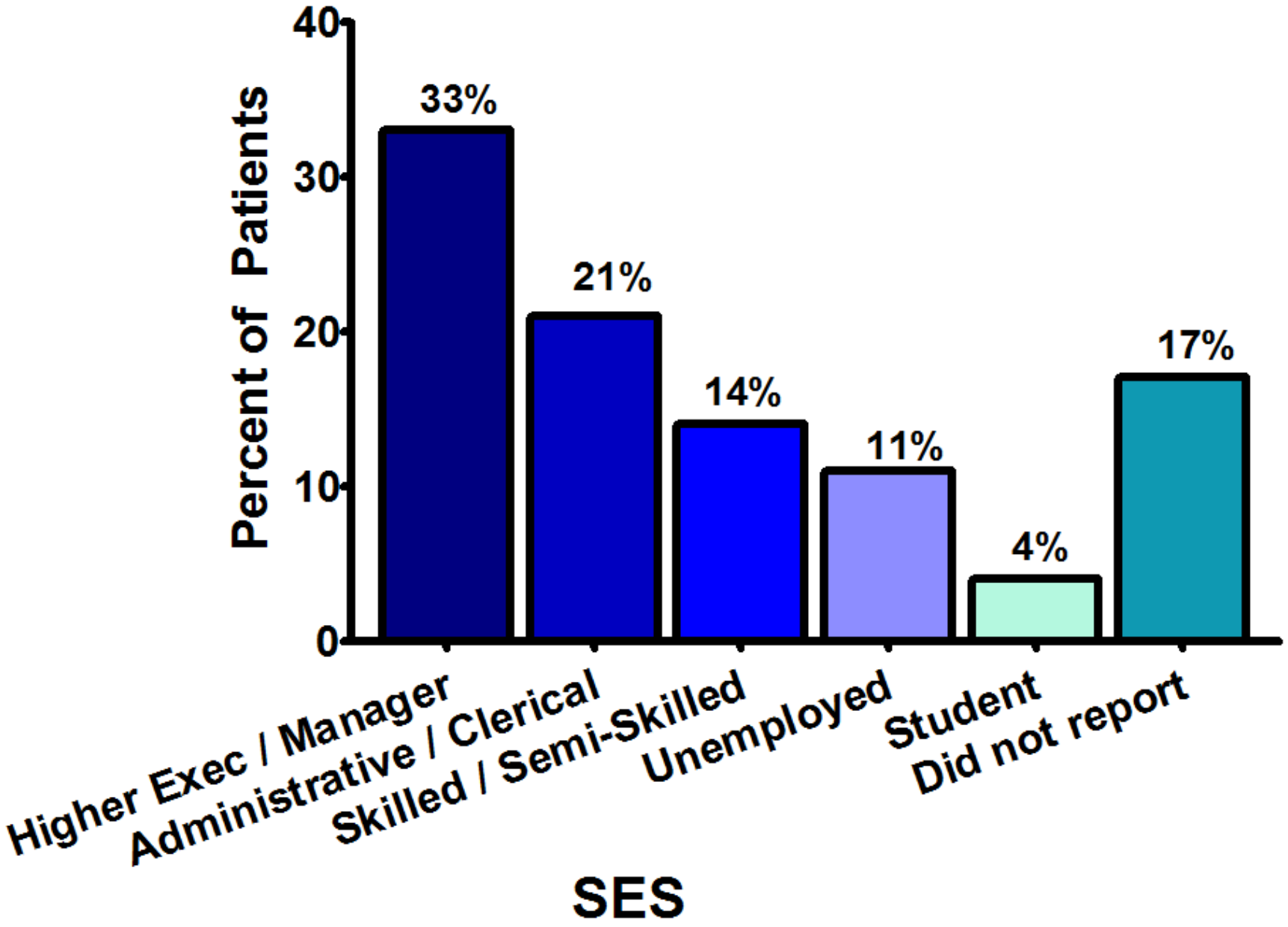

Percent of Patients
50
40
30
20
10
0
43%
27%
11%
6%
4%
2%
1%
6%
Other Docs
Internet
Word of Mouth
STARS/SURC
Other Media
Family/Self
Insurance
None Given
Sources of Patient Referral

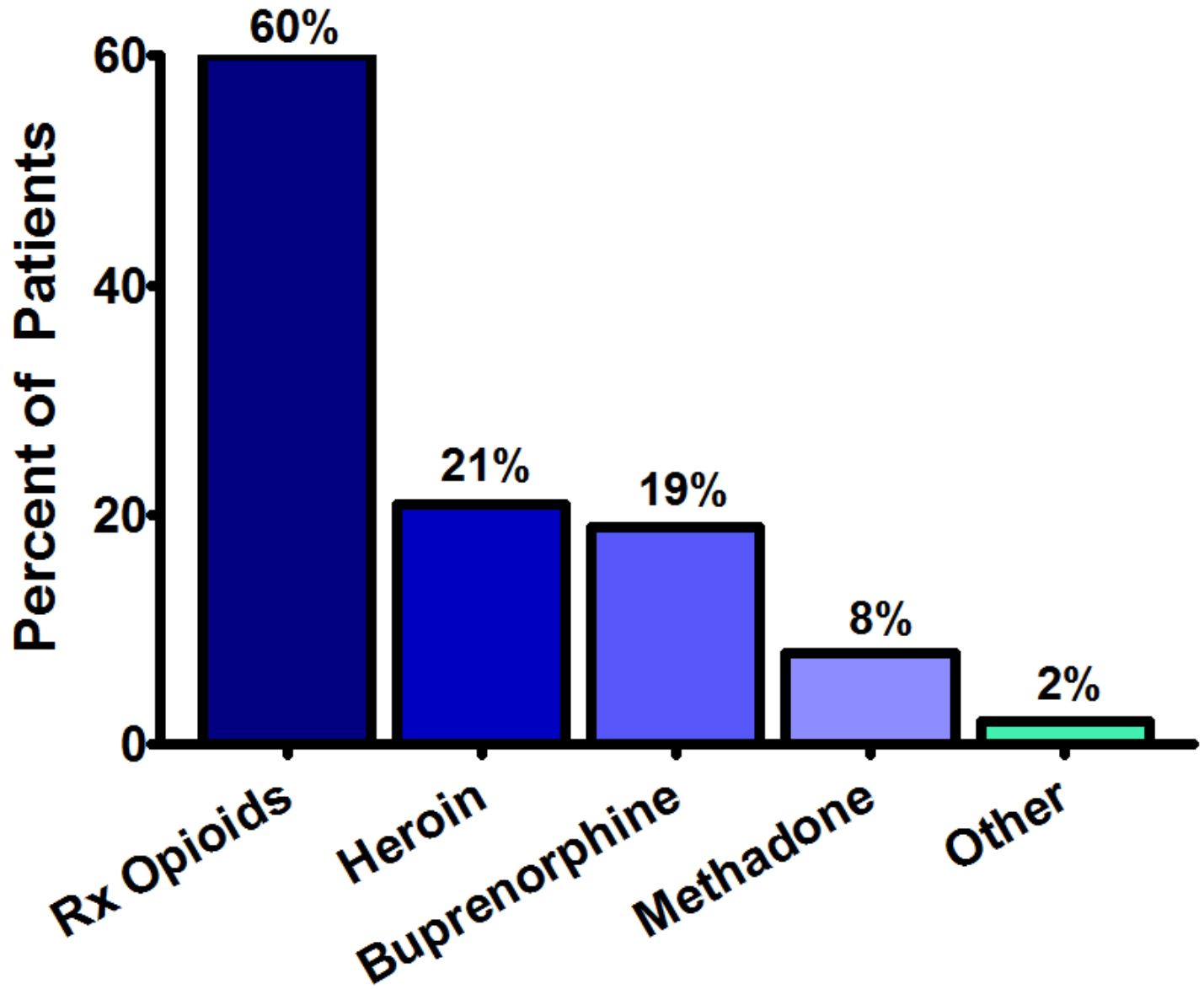

Percent of Patients
40
30
20
10
0
29%
24%
19%
23%
5%
20-29
30-39
40-49
50-59
60-69
Age Range, years


Percent of Patients
100
80
60
40
20
0
70%
30%
Males
Females
Gender

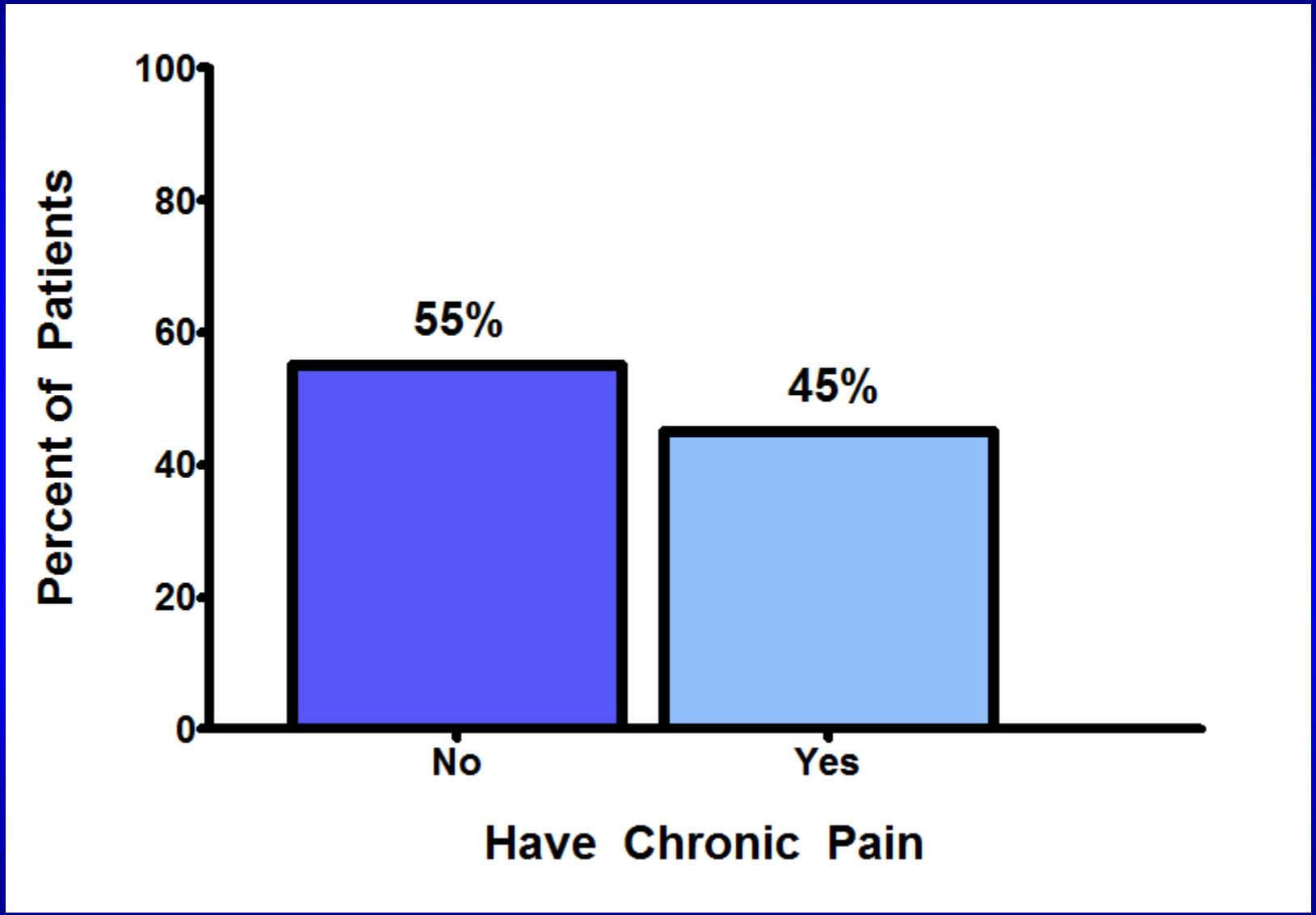

Percent of Patients
100
80
60
40
20
0
85%
13%
1%
1%
White
Hispanic
Asian
Other
Race

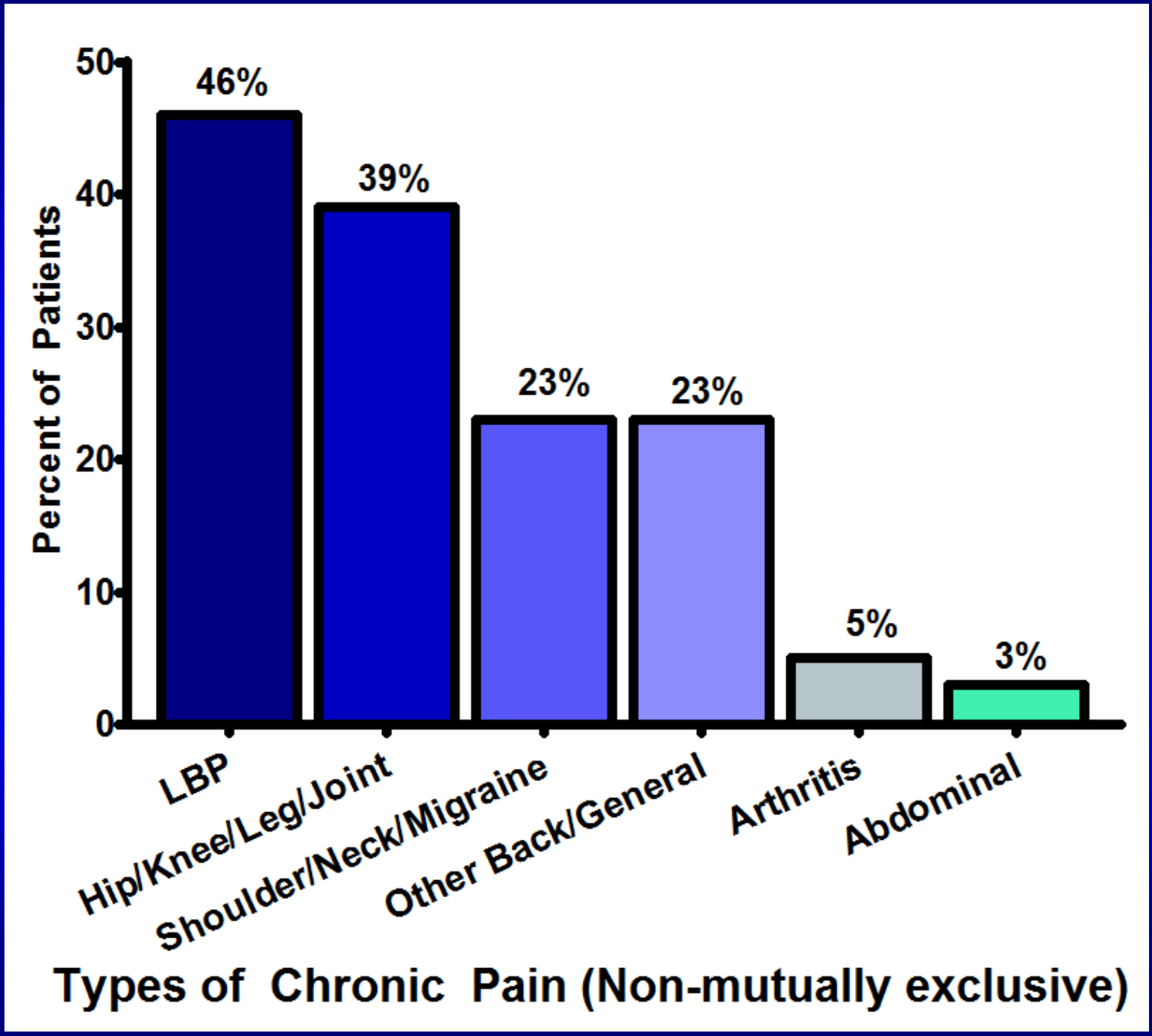

Percent of Patients
40
30
20
10
0
37%
37%
6%
2%
1%
16%
Single
Married, live together
Divorced
Separated
Widowed
Did not report
Marital Status

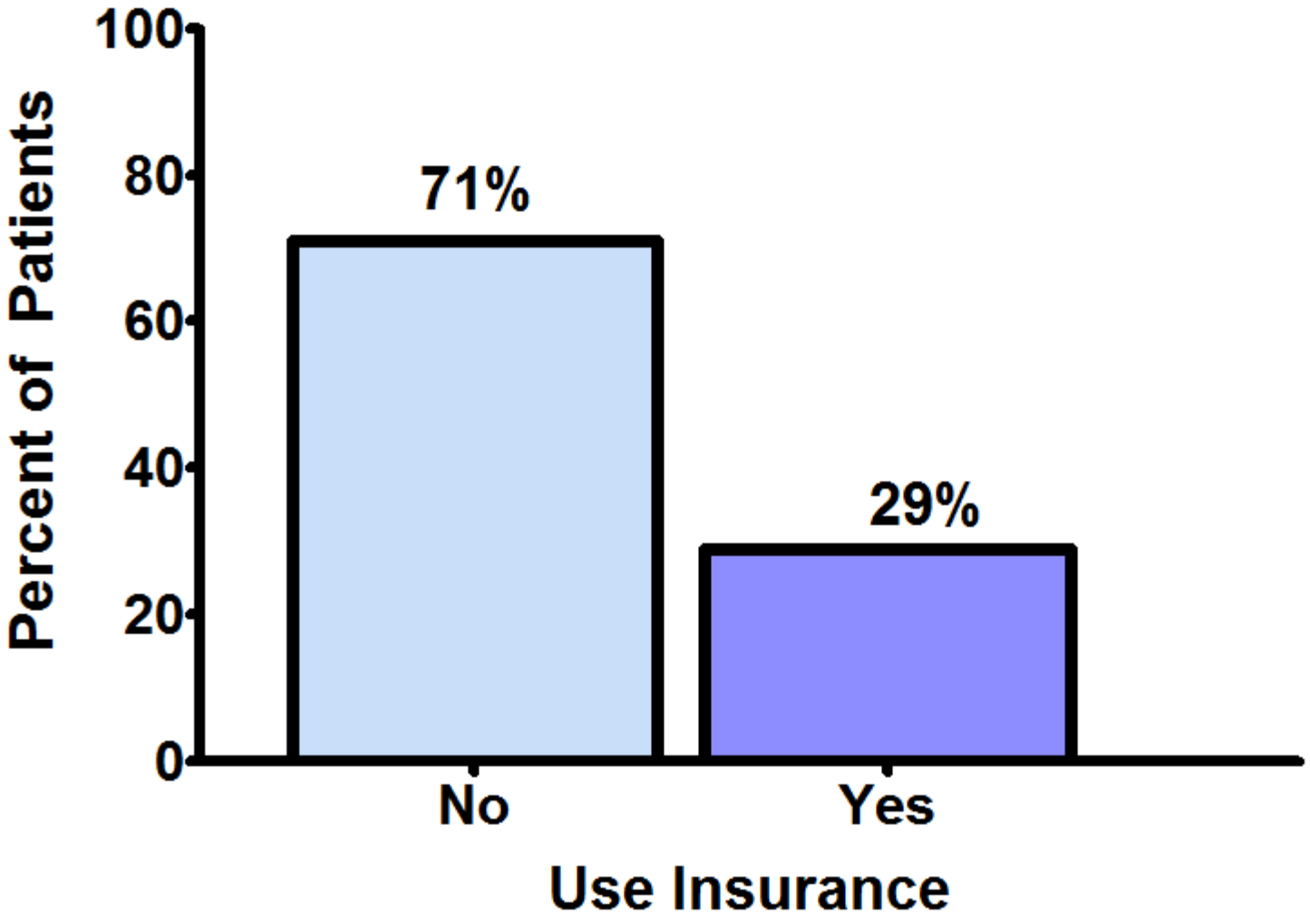

Percent of Patients
40
30
20
10
0
33%
21%
14%
11%
4%
17%
Higher Exec / Manager
Administrative / Clerical
Skilled / Semi-Skilled
Unemployed
Student
Did not report
SES

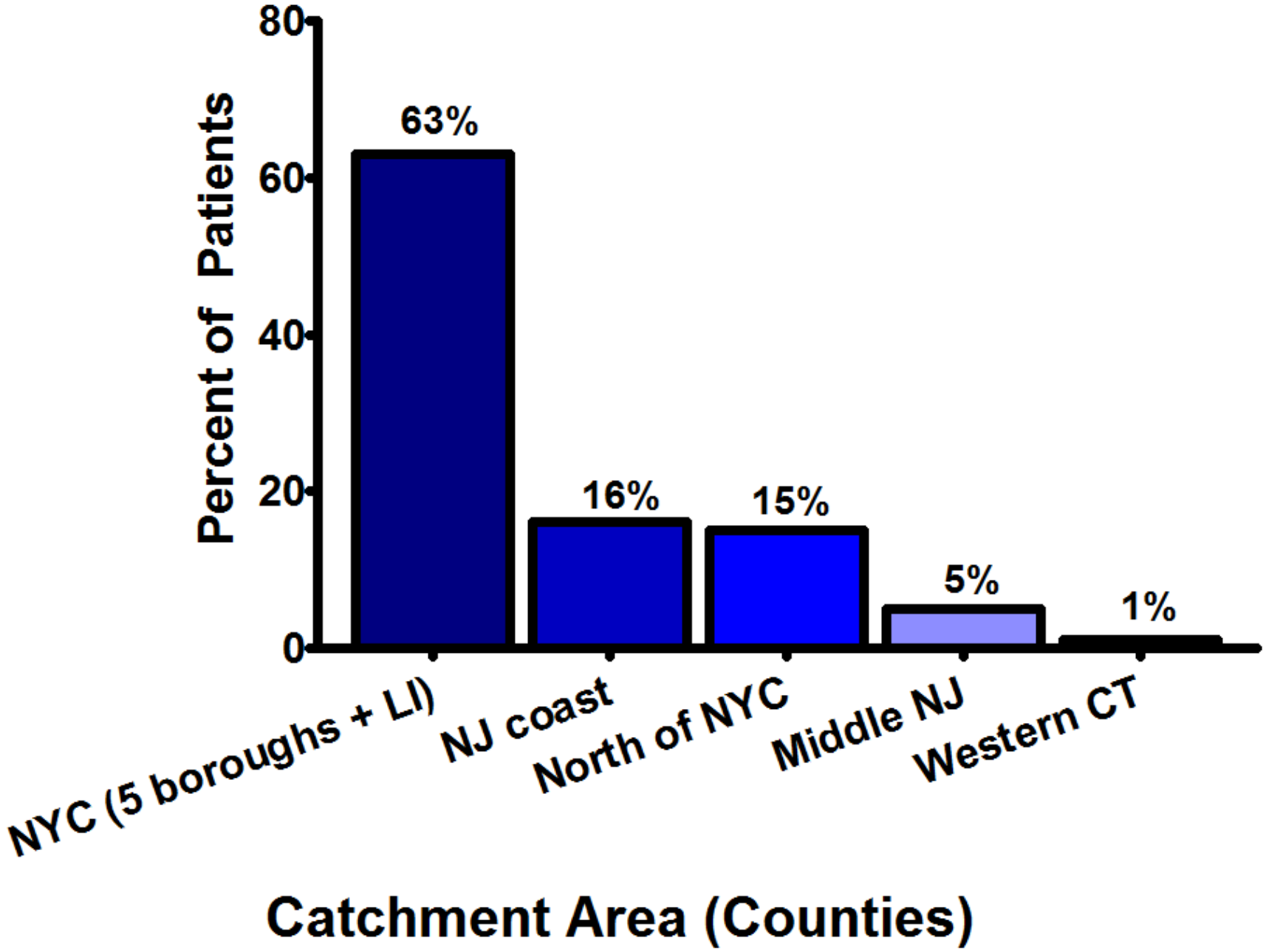


Opioid Inducting From (Non-mutually exclusive)


Percent of Patients
100
80
60
40
20
0
55%
45%
No
Yes
Have Chronic Pain


Percent of Patients
50
40
30
20
10
0
46%
39%
23%
23%
5%
3%
LBP
Hip/Knee/Leg/Joint
Shoulder/Neck/Migraine
Other Back/General
Arthritis
Abdominal
Types of Chronic Pain (Non-mutually exclusive)


Percent of Patients
100
80
60
40
20
0
71%
29%
No
Yes
Use Insurance


Percent of Patients
80
60
40
20
0
63%
16%
15%
5%
1%
NYC (5 boroughs + LI)
NJ coast
North of NYC
Middle NJ
Western CT
Catchment Area (Counties)

Statistics

- Total patients since opening - 475
- Current census – 86
- Outcome on last 200 patients:
  - 65% Ongoing treatment
  - 12% Lost to follow up
  - 11% Tapered/completed treatment (average 1½ years)
  - 6% Found better treatment option or moved
  - 5% Other (e.g., non-compliant, ambivalent about maintenance)
  - 1% Felt buprenorphine was ineffective

Conclusion

- A number of changes since began in 2003:
  - Referrals for only induction sharply decreased as doctors became more comfortable doing their own induction
  - Competition for patients sharply increased as most doctors with “X” number in NYC area are not even at limit of 30
  - Increased percent of pain patients necessitating staff gets more training in that area

Conclusion
cont.

- Will need to develop new model if clinic is to continue, e.g.:
  - More focus on research
  - Developing improved model for withdrawal of long term patients if that is an option (maintenance – terminable or interminable)