Low Threshold Care

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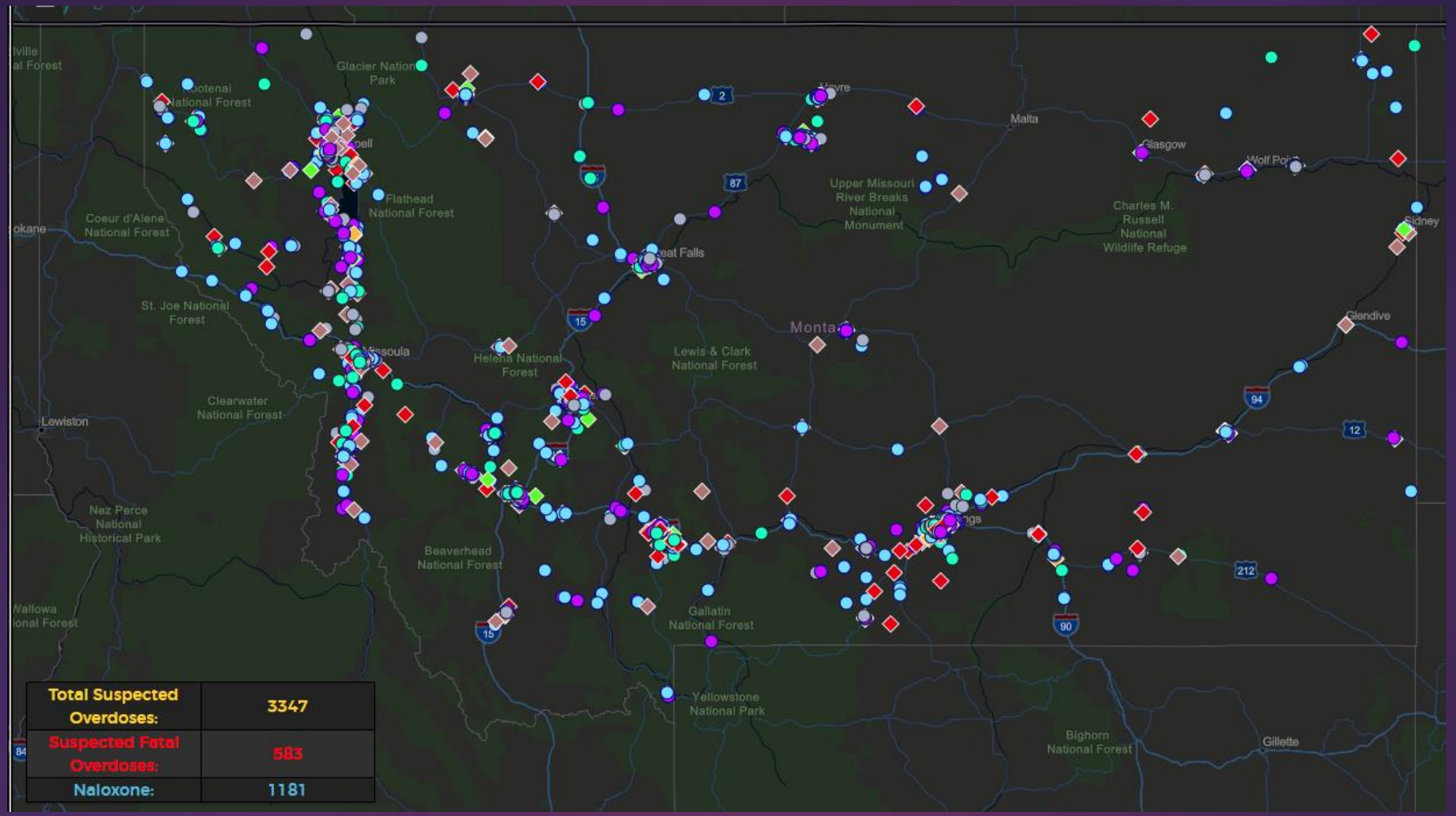
JOINING THE BROAD SCOPE OF TREATMENT FOR CHRONIC DISEASE



Montana January 1, 2020 – January 8, 2024

What is Low Threshold Care?

We do it all the time in primary care, urgi-care, and emergency medicine!

Case

- 56 yo F is your primary care pt with DM and CAD
- HBA1C 13, blood glucose elevated
- BP elevated
- Lipids controlled on statin
- Frequent no shows to your appts, DM nurse educator and nutritionist

How do you manage this?

Tell her that unless she accepts your care and sees the nutritionist, you will need to DC her your clinic and discontinue her insulin, antihypertensive and statin

Understand that her DM will never be controlled, but continue to be her MD and focus on other illnesses

Explore what the barriers are, celebrate the cholesterol control, and see what her goals of care may be

Case

- 56 yo F is your primary care pt with severe opioid use disorder
- Urine tox screens persistently positive for cocaine and buprenorphine, occasional non Rx benzodiazepines, negative opioids
- Cellulitis
- Frequently no shows to your appts and not engaging with therapist

How do you manage this?

Tell her that unless she accepts your care and sees a therapist, you will need to DC her your care and discontinue her buprenorphine

Understand that she will never achieve recovery, but continue to be her MD and focus on other illnesses

Explore what the barriers are, celebrate the negative opioids, and see what her goals of care may be, and deconstruct the role the cocaine and benzos play

Chronic disease management has always had elements of harm reduction

- Diabetes
- Coronary heart disease and other vascular diseases
- Hypertension
- Chronic lung disease

"Strong scientific evidence unequivocally shows that for opioid use disorder, medication is the essential component of treatment, not merely one component. Despite this settled knowledge, some vocal constituents within the addiction treatment community and some policy makers continue to lobby for treatment of opioid use disorder without medication."

Andrew Saxon, Elinore McCance-Katz, Journal Addiction Med, May/June 2016

Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut,2016-2017

HEIMER, ET AL, DRUG AND ALCOHOL DEPENDENCE 254 (2024) 111040

Medication vs. Non-medication Treatment

- Relative risk is reduced following exposure to MOUD treatment, even if treatment was not continued.
- Exposure to non-MOUD treatment provided no protection against fatal opioid poisoning.
- To reduce overdose deaths access to agonist-based needs to expand.
- This is unlikely to succeed if access to non-MOUD treatment is made more available through misappropriation of opioid settlement dollars to non-evidence based intensive outpatient and residential treatment.
  - Heimer, R., et al, Drug and Alcohol Dependence 254 (2024) 111040

MEDICATIONS are the MOST EFFECTIVE Treatment for OUD

- **Opioid use disorder does not respond to the same treatments as alcohol use disorder**.
- **Non-medication therapies generally DO NOT WORK**: ~80 – 90+% annual relapse rate. Incarceration with forced abstinence, also does not work. Both increase the risk of lethal overdose post-discharge. Only 28% of residential programs provide MOUD.
- Twelve Step programs alone, without medications have a LOW rate of patient retention and sobriety at one year, when treating OUD (possibly <10%).*
- Retention rates in MOUD programs vary broadly, dependent upon multiple factors, with 1 year recovery of ~10 to 80%, but average ~40-50%.

Kakko, 2003

*Poor data collection from most of these programs.

What is Low Threshold Care?

- Harm reduction or outcome centered care
- Focus on engaging most marginalized
- Minimal demands on the patient
- Provide services without attempting to control their intake of substance
- Provide counseling when person is ready but do not mandate.
- Patient centered approach
- Positive health outcomes even if not continuous, but cumulative treatment

Kimber J et al BMJ 2010
Peles et al . J Addic Med 2013
Schwartz et al Arch Gen Psychiatry 2006

High Threshold vs Low Threshold Care

PWUD face numerous barriers to engage in services:

- Registration threshold (accessing care and staff)
- Competence threshold (ability to communicate needs)
- Efficiency threshold ("What about those who need 1000 cups of coffee before they start to speak about their needs?")
- TRUST

Low-threshold care aims to reduce barriers ('thresholds') through less stringent eligibility criteria to broaden potential reach

Edland-Gryt M. Int J Drug Policy. 2013 May;24(3):257-64.; Mofizul Islam M. Int J Drug Policy. 2013 May;24(3):220-2.

What is harm reduction?

- Harm reduction attempts to reduce adverse health, social, and economic consequences of substance use while the person may still be using.
- Focuses on keeping people safe and minimizing the negative consequences of risk behaviors both to the individual and the community.

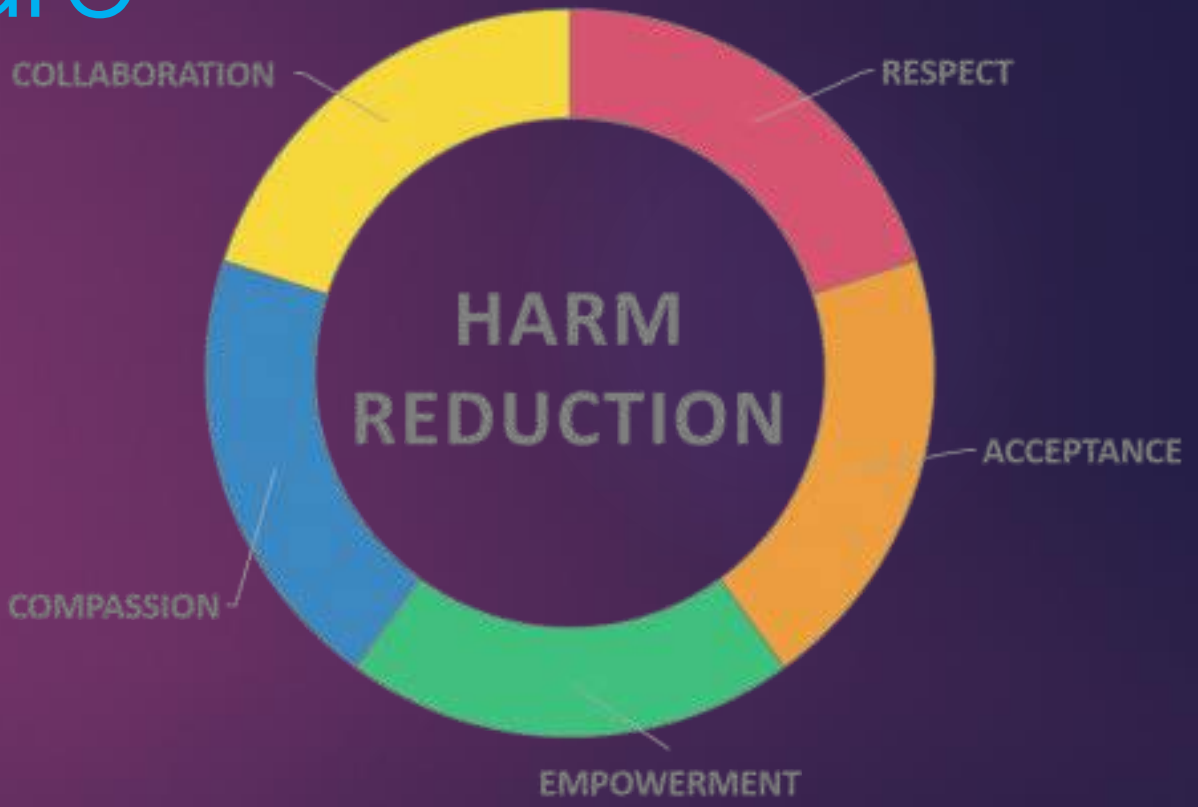
Food for Thought…

"Strong evidence suggests that direct, forceful, aggressive approaches are perhaps the least effective way to help people consider new information and change their perceptions. Such confrontation increases the very phenomenon it is supposed to overcome – defensiveness – and decreases clients' likelihood of change."

- William R. Miller, PhD, the "father" of motivational interviewing

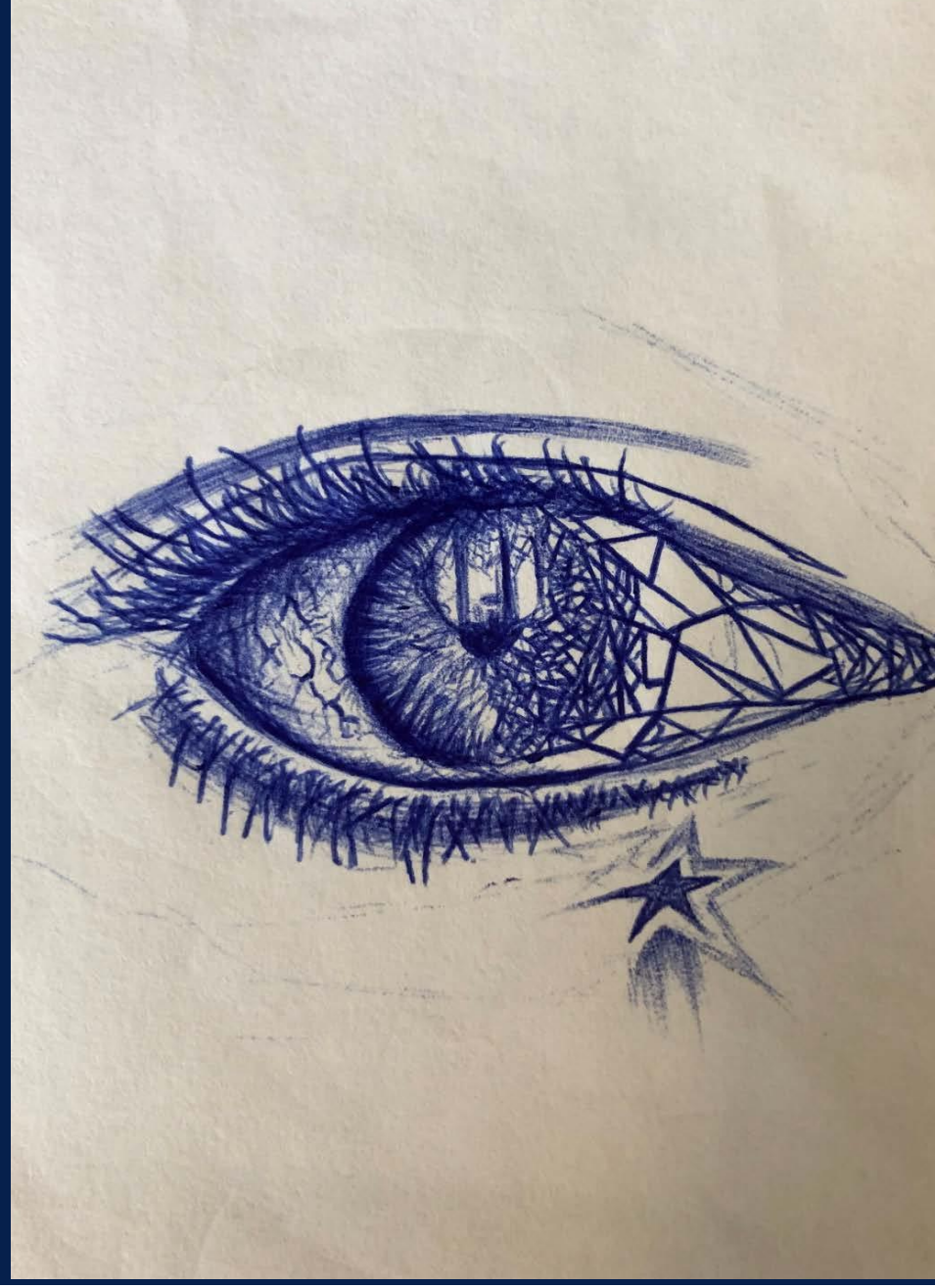
Harm Reduction is Patient Centered Care

- Engagement is primary goal
- Building a trusting and welcoming environment crucial
- Balances risks and benefits



Reducing Negative Consequences

- Congruent with other chronic condition management
- Critical to management of other chronic condition management
- Safer substance use
- Safer injection or use practices
- Intranasal Naloxone for overdose prevention
- **Immediate access to pharmacotherapy**



Meeting People "Where They Are" Can Happen Anywhere

Initial Assessment

- Key point: An extensive assessment is not necessary.
- NYS Best Practices:
  - Assess enough of the patient's history to establish a diagnosis of moderate to severe OUD, other substance use of relevance, e.g., alcohol, benzodiazepines, stimulants, and xylazine, history of treatment, and significant medical and psychiatric history and current acuity.
  - Conduct a focused physical examination.
  - Order relevant laboratory tests—result are not required to initiate prescribing.
  - Review PDMP
  - Initiate treatment.
    - NYS Department of Health

DSM5 interview

- 1. Have you found that when you started using, you ended up using more than you intended to?
- 2. Have you wanted to stop or cut down on using opioids?
- 3. Have you spent a lot of time getting or using opioids?
- 4. Have you had a strong desire or craving to use opioids?
- 5. Have you missed work or school or often arrived late because you were intoxicated, high or recovering from the night before?
- 6. Has your use of opioids caused problems with other people such as with family members, friends, or people at work?
- 7. Have you had to give up or spend less time working, enjoying hobbies, or being with others because of your opioid use?

DSM5 interview

- 8. Have you ever gotten high before doing something that requires coordination or concentration like driving, boating, hunting, climbing a ladder, or operating heavy machinery?
- 9. Have you continued to use even though you knew that the opioid caused overdoses, infections, and emotional problems such as depression, anxiety, agitation, and irritability?
- 10. Have you found you need to use much more drug to get the same effect that you did when you first started using it?
- 11. When you reduced or stopped using, did you have withdrawal symptoms or felt "dope sick" when you cut down or stopped using?
- Mild=2-3, moderate=4-5, severe=6 or more. 1 point for each yes.

Low threshold, outcome-based treatment

- Collaborate with patient to set treatment goals
- Ask about the role/function and effects of drug use in daily lives
- Clinicians and patients should decide on an appropriate level of care
- Offer pharmacologic treatment, provide information, evidence
- Don't discharge patient with return to use, other use.

What are the benefits of low threshold, outcome centered care?

- A continuum of care with no gaps
- Enhanced engagement and treatment retention
- Improved patient and staff satisfaction
- Compassion, " I felt that my life had value"!
- Hope
- Best part of my practice!
- Life saving!

Enabling

- Enabling occurs when your interventions serve to *decrease* a patient's motivation for positive change without providing significant benefit.

- "Merely" keeping a patient alive is a major benefit, even if they don't improve as much as we would like.
- Giving a patient OUD treatment medication is not "enabling."
- Using the dose or withholding of methadone or buprenorphine as "punishment" to motivate change is ineffective and unethical.

TREATMENT GOALS—a Continuum

Goals of Treatment

- To get the patient to stop using drugs and be sober.
- 1) To keep the patient alive (decrease mortality).
- 2) To help the patient repair a life devastated from the effects of an opioid use disorder (decrease morbidity).
  - Decrease criminal activity, stable housing, work, family relationships, regular income, etc.
  - If the patient takes a medication, or has positive UDSs, that is less important.

Outcome Directed Treatment (ODT)

- Focus is on improving outcomes
- Outcomes =

1) Mortality

2) Quality of life
   - Functional/health status
   - Mental/spiritual health
   - Social stability
     - Housing, Transportation, Family, Employment/Income

3) Community impact
   - Overall cost/economic analysis
   - Diversion
   - Effect on clinic and other patients
   - Criminal activity
   - Need for social services

New System of Care

- Inpatient Consult Team
- Integrated treatment in primary care
- Recovery coaches, peer support, substance use navigators
- ED initiated treatment
- Mentoring & support to specialty clinics (oncology, burns & trauma, ID, OB)
- ***Bridge clinic, low threshold, outcome centered care***

Good Retention in Low Threshold Models

- Low threshold methadone:
  - 88% retention at 30 days, 64% at 1 year
  - Significant reduction in heroin & cocaine
  - Increased stable living conditions

- Low threshold buprenorphine:
  - Patient retention similar to "standard" bup
  - 68%, 63%, 56%, 42% retained at 3, 6, 9, 12 mo

Perreault M et al. Can J Public Health. 2003 May-Jun;94(3):197-200
Perreault M et al. Can J Public Health. 2007 Jan-Feb;98(1):33-6.
Stancliff et al. J Addict Dis 2012;31(3):278-87.

Improving Outcomes - Outline

- Thinking about outcomes
  - Choosing the right goals of treatment
- Outcome Directed Treatment (ODT)
- Focus on treatment retention
  - What improves retention – literature review
- Why we get it wrong
- Areas for improvement

“Decisions about treatment should be based on science and data.”

“Decisions about treatment should be based on opinions and bias.”

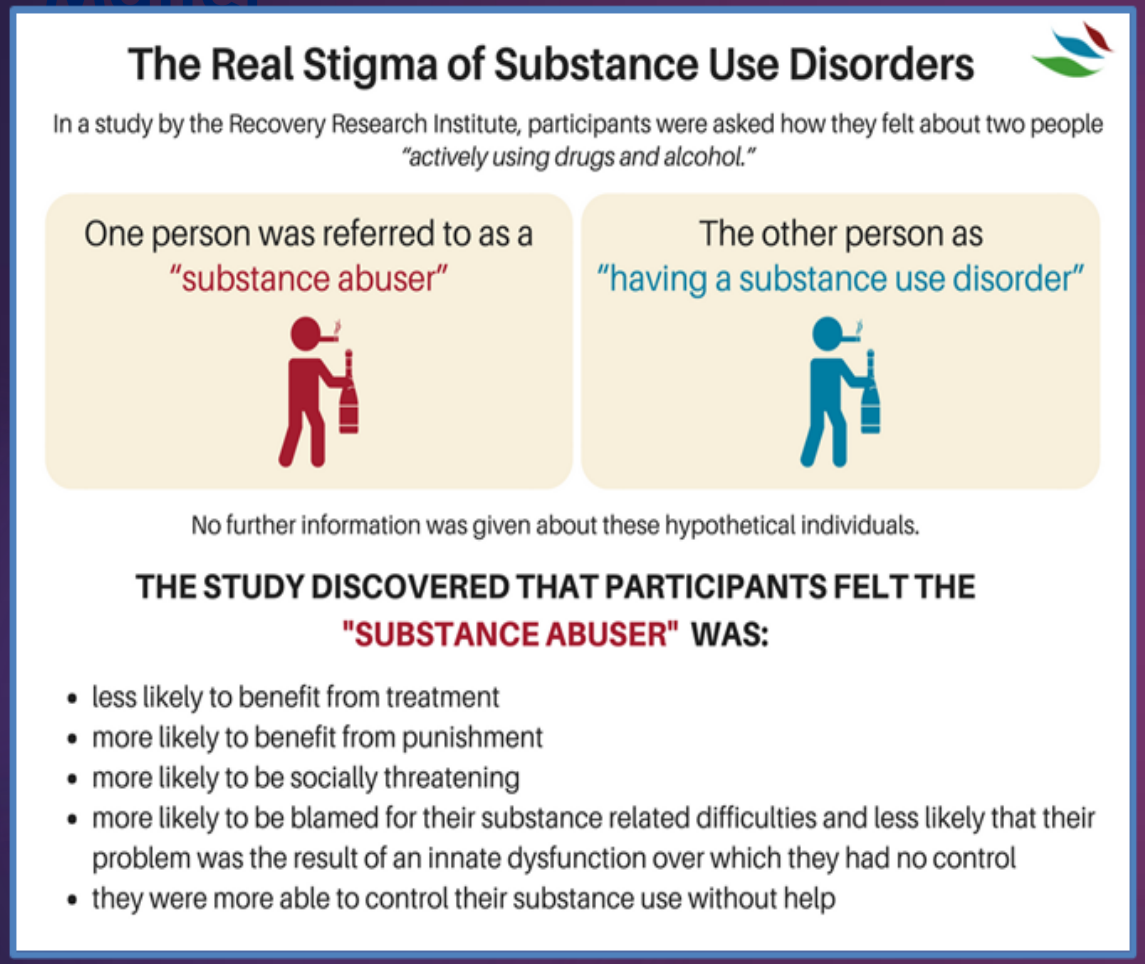
Ethical Imperatives to Overcome Stigma Against People With Substance Use Disorders

"Separation of addiction treatment systems from the rest of health care in the United States both stems from and feeds stigma."

- Jerome M. Adams, MD, MPH and Nora D. Volkow, MD, August 2020


STIGMA

Stigma and Language: What We Say and How We Say It Matter



Three types of stigma

- **Public stigma:** negative attitudes and fears that isolate those with addiction
- **Structural stigma:** excluding those with addiction from opportunities and resources
- **Internalized stigma:** believing negative stereotypes about oneself

https://www.recoveryanswers.org/research-post/the-real-stigma-of-substance-use-disorders/
https://facesandvoicesofrecovery.org/wp-content/uploads/2019/06/Words-Matter-How-Language-Choice-Can-Reduce-Stigma.pdf
https://harmreduction.org/issues/harm-reduction-basics/undoing-stigma-facts/
https://www.asam.org/docs/default-source/default-document-library/nidamed_wordsmatter3_508.pdf?sfvrsn=5cf550c2_2

Stigma

- The "war on drugs" Nixon's political intent, person perceived as enemy
- Persons of color, and Native/Indigenous Americans, despite being minority populations are over-represented in the criminal justice system and suffer more severe sentences for offenses related to substance possession or use and are less likely to receive MOUD.
- Is stigma just part of the human condition or can it be changed through stories that value all lives no matter what external or internal marks they have?

Food for Thought…

"Sometimes I go outside, and I really feel hated, … I thought it must be how I dress or [the] expression on my face or something. You just constantly feel like you've got a big neon sign on your head saying "loser," you know, "contemptible loser." So, when someone actually… in a shop or something they'll actually smile at you or act like you're a normal being, [a] human being, it's really restorative, it cheers me up for days."

— Lachlan, a person who uses drugs

Matthews, S., Dwyer, R. & Snoek, A. Stigma and Self-Stigma in Addiction. *Bioethical Inquiry* **14,** 275–286 (2017). https://doi.org/10.1007/s11673-017-9784

Self-stigma

- Occurs when individuals internalize and accept negative stereotypes
- The "whole person is broken" with little or no self esteem
- Stigma keeps people in the shadows
- Stigma keeps people from coming forward and asking for help
- Stigma keeps families from admitting there is a problem

- Resources: Stigma, Goffman, Erving 1963; Shatterproof.org, Stigma Summit, University of Texas, Shatterproof, National Academy of Medicine, June 2021.

Stigma

Stigma in Health Care Settings

- Stigma includes attitudes, beliefs, behaviors, and structures at multiple levels (e.g., individuals, groups, organizations, systems) and can lead to prejudice or discrimination against people with mental health diagnoses and substance use disorders.
- Perpetuates stereotypes and assigns labels like dangerous, noncompliant or incapable of managing treatment, dirty, at fault, etc.
- Can be internalized to make people feel they are not deserving of being treated with dignity and respect
  - Fear, shame, and isolation
  - Feeling unwelcome, judged, or unworthy of seeking or receiving services
- Limits a person's ability or desire to access services
- Ultimately, stigma contributes to suboptimal (and sometimes traumatic) healthcare experiences and health outcomes

Consider the Relationship of Stigma and Trauma

Realize that most people have experienced trauma

- Personal and/or generational/historical trauma
- People with a substance use disorder (SUD) are more likely to have experienced trauma, including trauma in healthcare or pharmacy settings or social services or criminal justice settings

Recognize how trauma affects people

- Trauma impacts physical health; mental health; neurobiology; and cognitive, social, and emotional functioning
- Perceived "high-risk behaviors" can be a way of coping with trauma

Consider how past histories of trauma, violence, layers of disadvantage and stigma

- Consider how this may affect the way a person engages with providers and authority figures

Commit to not repeating trauma or creating more trauma (re-traumatizing)

https://harmreduction.org/issues/harm-reduction-basics/undoing-stigma-facts/
https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181836/#:~:text=Brain%20areas%20implicated%20in%20the,norepinephrine%20responses%20to%20subsequent%20stressors.
https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
https://traumainformedoregon.org/resource/foundations-trauma-informed-care/

Food for Thought…

"…His leg was severely infected, and I urged him to visit an emergency room—but he refused. He had been treated horribly on previous occasions, so preferred risking his life, or probable amputation, to the prospect of repeating his humiliation."

- Nora Volkow, MD, Director of NIDA,

April 22, 2020, Blog

https://www.drugabuse.gov/about-nida/noras-blog/2020/04/addressing-stigma-surrounds-addiction

MOUD - Best Practices to Improve Treatment Outcomes

- Admit all patients needing treatment
- Consider higher doses and more rapid induction
- Shorten time to admission and first dose [11]
- Do not inappropriately limit the dose or time in treatment [1, 2, 3, 4]
- Do not discharge for lack of counseling engagement [5, 6, 7, 8]
- Do not discharge for positive UDS results (partial response) [10, 11]
- Minimize administrative discharges [9, 10]
- Use Motivational Interviewing as your basic approach to patients [17]
- Express accurate empathy in all patient interactions [12, 13, 14, 15, 18]
- Contingency Management [16]

Reasons we get it wrong

- Thinking of SUDs differently from other diseases
  - Conception of SUDs as moral failings
- Unconscious bias
  - Implicit associations (IAT tests - https://implicit.harvard.edu/implicit/)
- Lack of empathy
  - Inability to understand the life of PWOUD
- Expecting perfect outcomes
- Applying faulty behavioral theory
  - "Punishment" for bad behavior - War on drugs – "Just say no" - "Enabling"
- Interpreting the literature
  - Being aware of the literature – not applying the science to policies
- Not using the appropriate treatment goals

Getting it Right

- MOUD is life-saving therapy, preventing deaths every day with every dose.
- Every patient encounter is an opportunity to help.
- It is critical to provide the highest quality MOUD care possible.
- Low threshold care saves lives and improves outcomes - just like treating any other disease.

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NEW YORK STATE | Office of Addiction Services and Supports

OASAS. Every Step of the Way.

OUTCOME DIRECTED TREATMENT!

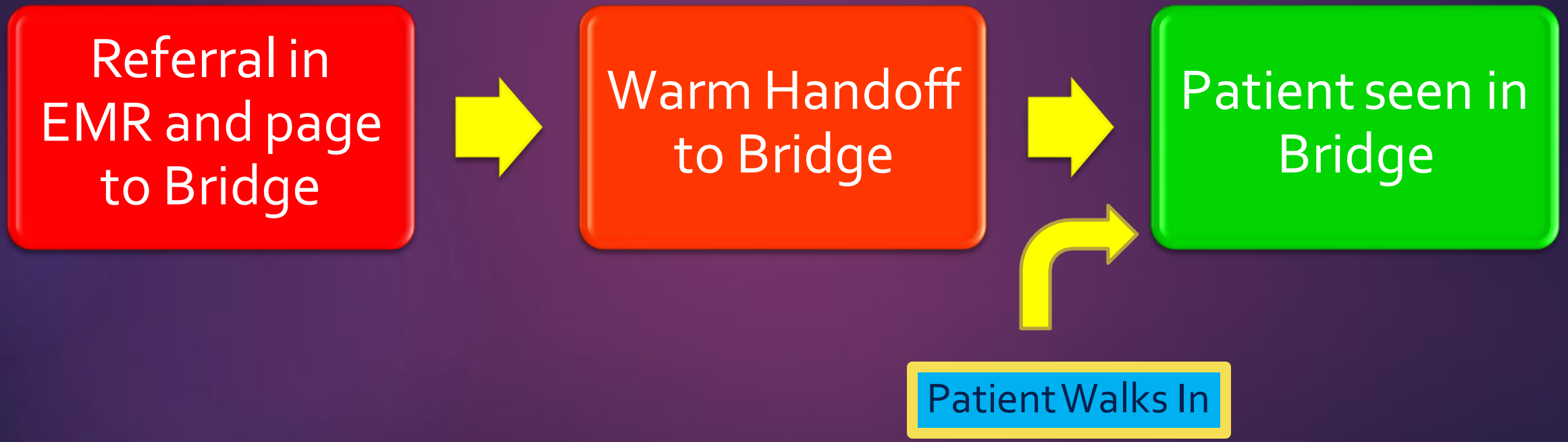
Low threshold care—NO BARRIERS!

Connection to community care—WARM HANDOFFS!

PROMOTE A CULTURE OF HARM REDUCTION!

Long term engagement with motivational enhancement

How Do Patients Get to Bridge?



Why is This Unique?

- On demand, urgent access, individualized
- Warm welcomes, warm hand offs
- Engagement is primary goal
- Same day pharmacotherapy
- Emphasis on education and support, regardless of stage, reduction of harmful consequences and motivational enhancement
- Follow up outreach for no shows, transitions
- ***No one is discharged***

Don't forget naloxone rescue!

But naloxone rescue without treatment engagement only delays death!

Bridge programs with warm hand-offs improve follow through

Low threshold care, diminish barriers

Long term engagement with motivational enhancement

Contingency management (meth and opioids)