

Dr. Shawn Cohen: Hey everyone, and thanks for tuning in. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host, Dr. Shawn Cohen, and I am ecstatic to be joined by two outstanding experts, people I've learned a ton from, and I think friends, although maybe they might dispute that Dr. Stephen Holt and Dr. Carolyn Chan.

Dr. Carolyn Chan: Hey everybody, I'm Dr. Carolyn Chan and I'm happy to be here today and am an addiction medicine physician and an internist.

Dr. Stephen Holt: And hey, I'm Steve Holt. I am also an addiction medicine specialist and internist. And yes, yes, I endorse my friendship to Shawn Cohen. It's confirmed.

Dr. Shawn Cohen: So, today we're all going to talk about something more important than Steve and I's friendship. We will be talking about an especially critical and complex issue, which is how you create a realistic follow up plan for patients that are particularly unstable.

And by this we're talking about whether that's from co-occurring conditions, logistical challenges like transportation, other big social determinants of health that often require us to kind of think of creative collaborative approaches to help people continue to engage in care and continue to be able to get the care that they need.

And so, in this episode, we'll talk about how providers can address these challenges, talk through some common discomfort providers have, and how we can overcome that and create a tailored follow-up plan that really works for patients.

So, let's start things off by talking through a case. Our case today we're going to talk through is a 38-year-old homeless person with opioid use disorder who gets admitted to the hospital.

He has a skin and soft tissue infection. He's previously been on methadone but was unable to access the clinic daily and has previously been treated with buprenorphine as well but is often lost to follow-up after a couple of months. In the hospital, fortunately, there is some good addiction specialty there and he gets started on buprenorphine/naloxone, which is up titrated at 24 milligrams daily, and completes his antibiotic course and is scheduled to follow up in your addiction clinic.

And so, things we're going to touch on are kind of how providers can navigate situations like this to, again, help patients the most and help them continue to engage in care, what role care teams can provide in stabilizing patients, and that's all the kind of stuff we'll talk through.

So, first of all, again, thank you for joining, Carolyn and Steve, but before we even get to this specific patient and how we're going to help this person out, how do you try to make your clinic as low barrier as possible, either for patients coming from the hospital or coming from the community, just ensure that people are able to access it and able to continue care with y'all.

Dr. Stephen Holt: Well, I think a lot of it has to do with investing in relationships with people in all the different sectors in which your patients interface. Obviously, knowing folks on the inpatient side, having close relationships with them, because so much of taking care of folks with substance use disorders is those really warm handoffs, as you know, like Shawn and I, we're exchanging texts all the time about patients you're taking care of the inpatient side and I'm seeing on the outpatient side and trying to find ways to foster some sort of connection, such that, you know, if the patient, for whatever reason, doesn't show up, my team can reach out to them, because we know that it was important for them to come in, it was important for us to get a hold of them and I think, also, of course, having, peer recovery coaches or other sorts of members of the team who are helping to facilitate those transitions, which can be so dangerous.

There's just a lot of dangers in those periods between inpatient to outpatient or outpatient to an IOP or IOP to an inpatient rehab or something like that. So, that's one sort of form of it doesn't really make the barriers go away, but it at least tries to find ways to tether patients from going from [one] place to another, and of course, there's many other forms of low barrier. Simply things like providing buprenorphine over the phone, having telemedicine encounters, and meeting patients where they are and going by whatever their particular goals are rather than physician-centered goals. I think those are all versions of trying to find ways to keep patients in care, keep them retained in care because we know that that leads to good outcomes. What are your thoughts, Carolyn?

Dr. Carolyn Chan: I agree. I think of this in two buckets. I think what you alluded to, the relationship. So, I like to use the line, "Hey, you can come as you are to this clinic. Maybe you're using, maybe you're not using. Maybe you lost all your buprenorphine. Maybe you didn't take any of it. You can totally come as you are to this clinic space and that is okay. We just want you to show up, and we're happy to work with you no matter what the

situation is." So, really thinking about like, hey, let's hype up the space, to really make it welcoming, inviting, no matter what scenario a patient may face, because the truth is a lot could happen, right? As you alluded to in that time, maybe they lost their housing. Maybe, now, all of a sudden, they're couch surfing, right? So, plans can change really quickly for our most vulnerable patients.

And then the second piece is the structure of the clinic. So really looking at, what are the policies that you have in the clinic? Ensure that if a patient does show up, we do the best we can to accommodate them. Some of my patients have to take the bus, and notoriously, bus lines are unreliable.

Some of my patients, you know, are calling their insurance for rides. Similarly, I feel like they should be more reliable than they are, but oftentimes they've done the best they can to get there. So even if they show up 15 minutes late, or later, I do my best to see that patient no matter what. I acknowledge that this may be different depending on the clinic setting you're on, but really again, taking a look at the policies, making sure that if you're integrated within primary care, that if it's different than maybe what the standard primary care policy is, [everyone] at the front desk knows how your clinic structure works and, making sure everybody from the front desk, the M. A. to the folks seeing them on the other end are just really warm, inviting and use patient-centered language.

Dr. Stephen Holt: It's funny when you're talking about, you know, your patients show up 15 minutes late, half an hour late, you'll still see them. Our clinic, it's a FQHC. We have multiple different subspecialty clinics and stuff embedded in our practice and I know that our addiction clinic is the one place that feels more like a walk-in clinic than anything else, even though it is absolutely not a walk-in clinic.

People have appointments. But the word is clearly out that patients can just show up whenever they please and we're going to see them. I mean, it's just too important to not see them, so I echo that sentiment.

Dr. Shawn Cohen: Yeah, number one is the acknowledgment that healthcare systems generally don't work, especially, I think for very stigmatized people who have had these bad experiences, and so much of it is like what you guys were saying of, warm handoffs making them know that this clinic operates differently than probably the clinics that they've seen before and then thinking through each step a patient's going to face when they come into your clinic. Is it the inclusive language? Can they walk in even if it's not officially a walk in and I know there are other models of care like bridge clinics I think

that often have more walk ins and there are some I think that are starting to do like night appointments and weekend appointments, too. I know, Steve, you mentioned, and I know from experience too since we do text in a HIPAA-compliant way about people that are going to follow up between us, but how do you build those partnerships with the community resources that people already trust and kind of get your clinic known out there a little bit, if that makes sense ?

Dr. Stephen Holt: Yeah, I mean, it's just kind of taking that time to dedicate some time to making those phone calls, because it really is, as simple as a phone call, right? Sometimes we sort of make things more complex than they are, but just knowing who is the intake person at your local IOP and knowing that person by name, knowing what the phone number is, knowing what the backline number is, and being able to quickly talk to somebody there, knowing who are the people who staff the addiction medicine consult service, making sure they know you and they have your cell number, and it's easy for them to get ahold of you when your patient, for example, from your outpatient practice ends up in the inpatient side. There's a few people better qualified to comment on what this patient needs than you are. And so, it just comes down to making sure those simple, old-school, cell phone number exchange. It's not complicated. You don't need a special app or anything. It's just having people on speed dial on your phone is, I think, a good way to foster those kinds of relationships.

Dr. Carolyn Chan: And to follow that for some of our patients who may not have a phone number or it tends to change and every time they come in, they're like, hey, I got a new phone. I'm like, that's why, maybe I couldn't get in touch with you, is thinking of other strategies as well. As you said, a lot of our patients get care and different parts, so oftentimes if I know a patient like commonly sees an infectious disease specialist, I may ask permission or have them sign a release "Hey, if I can't get in touch with you and I see you have a follow up with ID, is it okay if I reach out to them?" and try and sort of re-engage that way beforehand, obviously with permission because I think it's really key, depending on our practice settings if some of us fall under 42 CFR. We have to be thoughtful about that, as well as double checking at the end of each visit, "Hey, do you have an updated cell phone number, just to double check?" if it's a person you historically know is challenging to get in touch with. And then I will ask permission as well if a patient has a secondary contact I can reach out to, "Hey, do you have a family member or friend, a place you may float in between where I could also reach out if I'm just trying to get in touch and connect with you?" So, we'll often try to have three strategies, right, for a person who maybe doesn't have a phone. One, making sure I'm checking the number. Two, making sure that I have permission to talk to other specialists

about their addiction care, if it's relevant or I can't get in touch. And three, "Hey, do you have, like, a friend or a family member, too, that would also be okay if they received my calls if I'm just trying to check in?"

Dr. Shawn Cohen: Yes, it sounds like it's about relationship-building, not only within the medical system and the addiction care system, but also relationship-building with your patient, or maybe with their family members, so that you have extra avenues to reach out to them if possible. I know, especially on the consult service, when I'm trying to do a lot of this stuff and figure out where a patient is going to follow up. Maybe 10% more high tech than cell phone is the EPIC chat, where I just make a massive EPIC chat with all of the cons, all of the homeless healthcare providers in the area, certain clinics, so that I can just ping people really quickly and get people back into care, figure out best next steps to.

So, say you've done all of this with this patient that we're following. He makes it to an appointment or two and then keeps missing his appointments. His phone number is changing, but he's calling you in between appointments saying, "Hey, I haven't made it for this reason. I just need a refill of the buprenorphine." How do you troubleshoot that? What's your approach when something like that happens?

Dr. Stephen Holt: It's interesting. So, historically, or maybe not historically, but just in other practices, a lot of patients get discharged, you know, administratively discharged for not showing up, missing a ton of appointments, calling for refills on a Friday at like four o'clock in the afternoon or their urines aren't exactly consistent with what you're doing.

And I think for me, the message here is the problem in those circumstances is not the patient, it's the treatment, right? The treatment is not working. So, the solution is not to discharge the patient, obviously, you know, the, three of us are 110% on board with that, but it's to just regroup, look at the treatment plan. What's missing from the treatment plan? What are the external factors, like Carolyn already alluded to transportation issues and things like that. Maybe what are the internal factors? What is it about, maybe, the medication itself? Maybe they should be on a different formulation of buprenorphine.

Maybe they shouldn't be on bup at all. Maybe they should be in a methadone maintenance program where there's more structure. Or, of course, being on an extended-release buprenorphine formulation would be something to consider. Just looking at the plan and, ideally, in conversation with the patient saying, do we need to

intensify treatment? What do you think about an IOP? What is your goal? And if you want to achieve that goal, we need to revise our treatment plan to help you to achieve that goal. If your goal is perpetuate the chaos that you're in right now, well, we can do that, but we have to put some checks and balances and keep it a bit safer, if that's what you want to do. But either way, it's patient-centeredness and it's revising the treatment plan, I think is, where we are.

Dr. Carolyn Chan: I definitely think this is challenging. I'm thinking of a patient who, curious, on both your approach, honestly, both Steve and Shawn. Say hypothetically a patient exactly as you said, they have missed maybe their past four appointments, but they have reached out to the clinic each time, sort of requesting refills.

You have requested intermittently, hey, can you, like, leave a urine drug screen, based on your own work availability, et cetera, at a time that's convenient for you. They don't do it. How do you approach that scenario where you're like, "Hey, I want you to come in. We really need to chat about this medication. Obviously, we don't like to discontinue buprenorphine if patients say it's working for them, even if they continue to use, but how do you navigate that elusive patient who we can't seem to get back into clinic?"

Dr. Stephen Holt: I feel like I've had two versions of that scenario. One where the patient would eventually provide a urine, somehow we got a urine and there would be like methadone in it and a trace amount of buprenorphine or just something that we haven't even talked about.

And in those situations, and they're asking me for more buprenorphine than I was prescribing before, you know, let's do four eight milligram films a day and there's no buprenorphine in the urine. I think in those situations what's missing is a therapeutic alliance. There's nothing about my relationship with this patient that is working.

I don't trust the patient. Maybe they don't trust me. We're not on the same page about what the treatment plan is. In that situation, this happened not that long ago. I said, "We have really two options. I can either put you on XR-BUP." I know if I inject buprenorphine into your stomach, I know you have it in you for the next month, "Or we have to go to methadone maintenance," and I just don't see another way around it.

Alternatively, a second patient in my mind who, however erratic and chaotic everything was, and so many missed appointments, and problems with transportation, etc., etc.,

whenever I finally would get a hold of them, and they would provide a urine, and we would see them, their urines demonstrated exactly what we were talking about.

Yes, there was fentanyl. Yes, there was cocaine. But yes, there was a bup and norbup level that was consistent with what I'm prescribing, so I know they're safe. And so that patient, I'm still going to very strongly advocate for XR-BUP, and I may ultimately say we have to do XR-BUP, but I'm less likely to say, "I don't know who I'm taking care of."

The first patient, I'm not even sure if I knew who this patient was by the end, so I feel like there's a difference, and it comes down to your relationship with the patient. Is there an actual alliance between you and the patient that is just being met with a very challenging situation or is your relationship a facade and those are the situations where I start to feel really uncomfortable.

Dr. Carolyn Chan: I think my takeaway point on that, and I practice similarly, is it's really context dependent. There's no one size fits all. I know sometimes in healthcare, and in many parts of all of our lives, right, we like to say, "Hey, this is the rule, let's stick to it, no matter what," but these situations are tricky. And I think, as you said, the context of those scenarios matter quite a bit in terms of how you're going to approach that over time.

How quickly are you intervening on this and really sort of moving towards one direction or the other. So, I don't have a golden rule at all here. It really just depends on what's going on with the patient.

Dr. Stephen Holt: It's interesting that, for me, the linchpin is the urine toxicology. And I know there's a lot of debate in the addiction medicine community about the role of urine toxicology and when it's best used, and the fact that it historically has been used in very punitive ways. But I feel like I can't operate with the two patients I just described without a urine toxicology. I just feel like it's an essential part of monitoring, just like, you know, a blood pressure cuff. I would be flying blind without it, and it tells me how much we're on the same page. Just wanted to put that out there. I'm a strong believer that you're in toxicology when used judiciously and in the spirit of building relationships rather than policing it, I think it's an important tool.

Dr. Shawn Cohen: Yeah, I think the intention behind the use is always very important too. Not using it to tell someone that they're not meeting your goals, right? To tell someone we're using this just so we can kind of monitor things together and even check

the drug supply too. I don't work as much in the outpatient setting or at all in the outpatient setting. So, it's hard for me to weigh in on this as much. I'm a bit of a mush in terms of a person, but I feel like I always go back to risk-benefit and the risk of me accidentally judging someone for something, and possibly stopping buprenorphine, which I almost never do, again, inpatient doctor, versus the risk of me continuing to prescribe, in most situations is much, much, much lower than me causing a catastrophe by stopping it. But I completely agree, there are situations where you just have to see someone and get more of a story and kind of think about how to rework the plan.

You talked a lot about long-acting bup, so if someone is seeing you, say our patient again, they're up to 24 milligrams of bup, their goal maybe isn't to stop using but is at least a reduction in use, a reduction in cravings, and they don't feel like they're meeting their goal at 24 of bup. What do you think about for next steps for a person like that?

Dr. Carolyn Chan: First of all, I want to check in and see what their goals are, right? Are their goals to continue to use, to stop using, where are they at? If they say, "Hey, I am meeting my goal right now, my own personal goal of continuing to use, I'm using less on the bup," then I can accept that and acknowledge that, and maybe that's where that person elects to stay.

A second option would be to offer long-acting injectable buprenorphine. I do think that when people use the higher dose of 300 milligram of one of the long-acting formulations, I should say there are two long-acting injectable buprenorphine formulations now, but when it hits steady state, it just seems to really help patients and can achieve higher plasma levels of buprenorphine than people who are just on sublingual when they're at really the highest dose over a period of months on the long-acting buprenorphine.

Three is methadone. Methadone is a great option. I think that if it's possible, and a person isn't meeting their goals, then offering to switch them to that can be really effective for some of our patients.

Dr. Stephen Holt: Yeah. I always think of a patient I've had for several years now who has been on 300 of extended-release buprenorphine and, has been on monthly 300 milligrams for, I'm going to say, 24 months. And this patient continues to use maybe four to six bags of fentanyl every day. And acknowledges that she doesn't even feel anything. It's like this ritual. It's just this thing, she does with another significant person in her life. And, from my perspective, I know she's safe.

I know I'm going to see her a month from now because she is tanked up, on 300 milligrams every month, her serum buprenorphine level is probably somewhere between 7 and 10, milligrams per deciliter. There is nothing that gets past that. That is an iron wall of protection. And, of course, there could be other things in the fentanyl that she's using, you know, stimulants or other substances, but she's not going to OD from an opioid. And so, her goals? She still says she wants to stop using, and I believe that, and we talk about it every time I see her, but from my perspective, keeping her alive is clearly an explicit goal that both of us have and that's one I know that we're achieving.

Dr. Shawn Cohen: Yeah. I love that of like, one, the menu of options, and two, just thinking about longitudinal goals, and I think sometimes people get caught up in people not achieving things as quickly even if they're slow progress, or even not progress, but progress is still coming to your clinic once a month and checking in and having a good relationship.

I think, at worst, small asterisk on the methadone thing, is that Steve and I work in a community that has very, easy, low barrier access to methadone, which is probably not true everywhere and bup might only be an option for some people in some communities too. Do you guys have any big strategies? This patient got switched to long-acting bup, kind of fell off the map after, let's say a couple months of getting the injections.

Do you have any strategies to re-engage him back in care, or kind of keep track of patients that are lost to follow up so you can try to re-engage them?

Dr. Stephen Holt: I struggle with this myself because, we have, I don't know, maybe 45 patients scheduled a week and maybe, 6 to 8 of them are new patients and the rest are follow-ups, and it would be really challenging for my practice to reach out to every patient. Either the new ones we've never met or the established ones if they don't reach out to us.

I aspire to being able to do that, to having a setup where every patient who misses their appointment can be followed up or can be contacted. Mind you, at least half of them, there's no phone number to get ahold of them, but in a world where I can get ahold of them, I really aspire to be able to do that because amongst patients who we have reached out to, for whatever reason, I have found that those patients are so, shocked that somebody gave a damn, , that somebody actually noticed they weren't there, and reached out to them. Because it's often the reverse. It's them reaching out to us because they need their medication. And so, they could view me as sort of a contractual

relationship. They call me to ask for something and I give them something. But for me to reach out to them when they didn't owe me anything and I didn't owe them anything.

I have found it to be a very profound thing that somebody cares about them I'm not trying to pat myself on the back because I told you I almost never do this or I do this with much less consistency than I'd like, but I'm just saying, I think it's really important if you devise a system where, whether it's your medical assistant, your RN, somebody who's a touch point for your clinic, like when patients come to the addiction recovery clinic, that's the place where I work, they know that, "Oh, this is the person who, rooms me, or this is the person who, gets my injectable, XR-BUP or whatever for me," and they know that person. When that person calls them, like two weeks later, because they didn't show up, I just think it's really an important thing.

Dr. Carolyn Chan: I agree. I should say in our clinic we have a pharmacist who's really proactive with our injectable buprenorphine patients who, in many ways, it's a physical thing that pharmacies have to store, so there's kind of this reminder, if you have it, and a need to kind of clear out the fridge as you may say, right? It can be kind of a reminder for people to reach out. So, the pharmacist that works with us has been really helpful at trying to get in touch with patients who just like forgot their appointment and we're due for their injection as well as if you have the opportunity to have a peer support specialist or a case manager or a community health worker, if there are any existing structures in your clinic to try and build it in just because I know we're all incredibly busy and I have clinic sessions in the morning so if I have a no-show at 8 a. m, most of my patients won't answer the phone at 8 a.m. In general, I don't know if I like to answer the phone at 8 a.m., so there's some limitations, but it's good to be creative, see what other options you have, see if you can make sure patients have things such as patient-secure messaging set up, so that way they could reach out to you more easily. I know the phone number for triaging can be hard.

We actually have a separate phone number for our clinic, so they don't have to go through central scheduling, which is helpful as well, because there's just like five options to click, and you worry about it getting lost or if there's language barriers. So, I think be creative, use existing structures and as you said, don't underestimate the power of a simple phone call.

Dr. Shawn Cohen: Yeah, you guys talked about these relationships you've built in the communities too, I think that goes a long way. think a lot of people get re-engaged at Steve's clinic because they wind up seeing me in the hospital sometimes, and so like,

knowing those people and how you can reconnect, and having that, very patient-centered experience when they come to the clinic so people are willing to eventually come back is a big important part about re engaging people too.

Okay, well, I think you guys have really touched on how to really build and kind of run a clinic in a more person centered and I think a little bit more of a harm reduction-oriented way, accepting whatever someone's goals are.

Do you have any other final strategies or extra tidbits about lowering barriers to care and making it a little bit more harm reduction oriented?

Dr. Carolyn Chan: I think it's worth mentioning telehealth. I know currently the status of telehealth for buprenorphine we can still do. I know there are different regulatory limitations at the federal and probably individual state level policies depending on where you practice, but it can be a really helpful way to bridge, to check in with people, have a meaningful conversation, and is a good tool to use in the toolkit. And at the time of recording, we are able to do telehealth at this time, though, encourage people to be familiar with your own local state regulations and keep an eye and see if there are any changes in the federal regulations as time moves forward.

Dr. Stephen Holt: Yeah, this is obviously an area that's very much in evolution. You've got places in the country where you can have safe injection sites. Some are semi-legal, some officials turn a blind eye towards. And then you've got other, simple harm reduction things, whether it's fentanyl test strips, xylazine test strips, other sort of peer-driven partnerships with pharmacies and other community experts in terms of toxicology experts who can actually look at the supply and see what's evolving in the supply, in terms of additional adulterants that are showing up in the community.

So, I just think it's a really very dynamic, evolving thing where there's lots of ways to promote harm reduction and provide information to your patients about these community resources to do your best to, again, just help to keep folks safe. That's ultimately what it's all about. Build those relationships, build trust, and keep folks safe.

Dr. Shawn Cohen: Yeah, I think that has come through ,that both of you really care about the experience patients have in the clinics you work at, but to care about your patients too. Let's revisit the case we talked about earlier. So, this was our 38-year-old homeless person with opioid use disorder who was admitted to the hospital for a skin

soft tissue infection, got started on buprenorphine, but had a history of frequently being lost to follow up, and now is scheduled in one of your addiction clinics for follow up.

And so, can you guys kind of summarize a little bit the key strategies towards linking this person with care, retaining them in care, and everything like that?

Dr. Carolyn Chan: So, I think the first one that we worked on is related to relationships, relationship-building, both with the patient and with other healthcare members and disciplines and different specialties, to help bring the patient into care in a very welcoming environment.

Dr. Stephen Holt: Yeah, exactly. An extension of that reaching out to patients, trying to re-engage them, letting them know that whatever their goal is, that's your goal. You're here to support their goal in a very patient-centered way. And having maybe peer recovery coaches or other members of the team that are positioned to reach out to patients when they do disappear.

And obviously, as we were saying earlier, if the plan isn't working, just come up with a new plan. Meet the patient where they are, figure out what their goals are again, revisit that, and either intensify the plan, pivot, change to extended-release buprenorphine, change to methadone, just be mindful that if the plan ain't working, it's time to change the plan.

Dr. Carolyn Chan: And when you're a clinician navigating uncertain and challenging scenarios, just really remember that there's no one size fits all to how to handle different situations. Just try and think about the context of the situation and use patient-shared decision-making, to try and come up with a plan and strategies for next steps that I think should be really transparent to the patient, and not in a punitive fashion, and we should try to prevent administrative discharges as often as we possibly can, truly.

Dr. Shawn Cohen: Yeah, so it sounds like big takeaways are building those therapeutic alliances and really leaning on them, too, of figuring out how to make a plan that works best for your patient and a clinic that works best for them too.

Well, thank you for joining us on ASAM Practice Pearls. A big thank you to our expert speakers and officially to my friends, as you all heard and is documented here, Dr. Steve Holt and Dr. Carolyn Chan, for sharing their insights and strategies for managing unstable patients and building realistic follow up plans. For more information and

resources on buprenorphine implementation and other important topics in addiction medicine, check out ASAM's Advanced Buprenorphine Education Series.

We'd also love to hear from you. What challenges have you all faced creating follow up plans for your patients? What strategies have worked for you and worked for your patients? Be sure to comment and join in on the conversation, and don't forget to subscribe to this podcast and share this episode with your colleagues if you find it helpful. Thanks again for listening, and we'll see you next time on ASAM Practice Pearls.