How the CAM’s Model Allows Adaptation to Address Fentanyl Use

Brooke Bender, MPH; Josh Blum, MD; Jennifer Naeger, LCSW, LAC
Presentation Objectives

By the end of this presentation, we hope you:

- Explain the gaps and facilitators to the CAM model
- Identify new/replicable methods to address the Fentanyl crisis
SECTION 1

The CAM MODEL
CAM: Goal, Vision, Guiding Principles

**Goal**
To coordinate the essential health services for persons with substance use disorders

**Vision**
To be a compassionate model for the prevention and treatment of substance misuse, to transform lives and to educate all

**Guiding Principles**
- Dignity and equity
- Community collaboration
- Passionate and professional
- Innovative prevention, treatment, research and education
CAM: Strategy

Inclusive and Compassionate Care
Ensure inclusive and compassionate care where all health care professionals treat patients with substance use disorders with respect and dignity, and improve patient outcomes.

Full Continuum of Care
Strengthen the continuum of care for people with substance use disorders throughout the Denver Health system and beyond. Ensuring that patients receive the right level of care for their individual needs.

Fiscal Growth and Financial Partnership
Enhance internal and external revenue streams to ensure quality services are accessible far into the future.

Knowledge Management
Establish a comprehensive data interface to support strategic, operational, and managerial decisions, and research and evaluation.

5 Year Strategic Goals

DENVER HEALTH CENTER FOR ADDICTION MEDICINE.
CAM: Hub & Spoke Model

Center for Addiction Medicine Hub & Spoke Model

- Identification/Diagnosis
- Opioid Induction
- Outpatient Behavioral Health Services Intake
- Referral
- Treatment
- Opioid Maintenance

Outpatient Behavioral Health Services

- Emergency Departments
- Corrections
- Family & School Health Centers
- Community Calls & Walk-Ins
- External Primary Care
- External Treatment Program

Inpatient Hospital

Denver CARES (social detox)
HOW DOES THE CENTER FOR ADDICTION MEDICINE ADDRESS CRITICAL NEEDS?

Methods for Implementation

- Innovate
- Secure funding to pilot
- Replicate and build on what has proven to be effective
- Secure funding for sustainability

CONTINUOUS QUALITY IMPROVEMENT
### Initial Data Capture + Evaluation

**Center for Addiction Medicine (CAM) Monthly Metrics**

**Patients Initiating Treatment for Substance Use Disorder**

Click a Box Below to See Data Summarized By

Where Patients Are Referred From

Where Patients Are Referred To

CAM Process (CHS, OBHS, or Treatment on Demand)

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**Select The Data You’d like to See:**

- New Treatment Episodes
- Inductions
- Follow-Up
- Retention at 60 Days
- Retention at 90 Days
- Retention at 1 Year

**Measure: New Treatment Episodes**

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Select Overall or Monthly Goals:

- Overall
- Monthly

Select Y-Axis:

- Number
- Percent

**NOTE:** Patients without opioid use disorder (OUD) are excluded from Induction calculations.
Enhanced Data Capture + Reporting
SECTION 2

TREATMENT ON DEMAND
Treatment on Demand: Then and Now

- 2017: Hub and Spoke (community line, creating DH linkages, Excel tracking)

- 2018: TOD pilot program began 24/7 in ED with Suboxone inductions

- 2019-2020: TOD operationalized and moved beyond ED to IP

- 2020-current: TOD across MED/PES/PEDUC for OUD (induction and post-overdose support) and IP across substances; CAM support in data, process improvement and advocacy
How has Fentanyl changed TOD?

- Patient presentation:
  - Severity of withdrawal
  - Changing self-report re: use (knowing/not knowing)
  - Increased youth (and lack of knowledge re: Fentanyl)
  - Increasing acuity and support needs (MH, Medical, PEH)
Fentanyl and Youth

- Increasing referrals to PEDUC and to STEP
  - Varying awareness re: Fentanyl
  - Increases in youth overdose rates
  - Need for age-appropriate materials re: MAT and harm reduction
  - Need for family involvement
Fentanyl and Youth Case Studies

Denver Health Medical Center: Outpatient Behavioral Health Services

STEP

Substance Treatment for Adolescents
How has Fentanyl challenged Hub + Spoke model?

- Patients increasingly need referrals for medical follow-up, mental health follow-up and community resources related to homelessness
  - Need for simplified follow-up instructions (What is the patient’s very next step?)
  - Need for alternatives to traditional suboxone inductions
  - Need for OTP to provide these services and referrals on-site
  - Need for psychoeducation and awareness of treatment landscape
TOD and Fentanyl

- Need to contextualize Fentanyl use and treatment within larger community needs
  - Increased homelessness, increased MH and SUD needs during COVID
  - Continued need for partnering across city and agencies serving our patients (across jails, hospitals, agencies)
  - Increased need for community outreach (meeting individuals where they are at) and for patient voices
  - Need for increased presence in ED post-overdose
The Patient Perspective on Treatment on Demand

“The compassionate staff at Denver Health saved my life by helping me believe my life was worth saving.”
– Center of Addiction Medicine Patient

“They were super kind and genuinely there to help me. No judgement.”
– Center of Addiction Medicine Patient

“Everything was great. They didn’t make me feel like trash like some places do for being an addict.”
– Center of Addiction Medicine Patient

“The compassionate staff at Denver Health saved my life by helping me believe my life was worth saving.”
– Center of Addiction Medicine Patient

Veronica Oberg was brought to Denver Health’s emergency department, after overdosing on heroin in a bathroom at the city’s Central Library. There she got help through the new Treatment on Demand pilot program. She’s now been sober more than 100 days.
SECTION 3

ED & OBHS FENTANYL RESPONSE
Fentanyl’s Impact on Inductions

- Fentanyl behaves like a long-acting opioid with repeated use.
- Highly lipophilic, large volume of distribution.
- Higher likelihood of precipitate withdrawal.
- Even in presence of moderate withdrawal symptoms.

![Graph showing mu opioid effects vs. dose with different lines for full agonist (e.g., morphine, FENTANYL), partial agonist (buprenorphine), and antagonist (naloxone, naltrexone).]
Precipitated withdrawal with fentanyl

Varshneya NB et al. J Addict Med 2021
## Before and After: Standard versus low-dose

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<th>Low-dose</th>
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<td>• &gt;12 hours from last use</td>
<td>• &gt;24 hours from last use</td>
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<tr>
<td>• SOWS ≥ 17, COWS ≥ 8</td>
<td>• SOWS/COWS not as helpful</td>
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<tr>
<td>• Withdrawal supports meds: often unnecessary</td>
<td>• Withdrawal supports meds: crucial</td>
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<tr>
<td>• Initial dose: 2-4 mg</td>
<td>• Initial dose: 0.5-1 mg</td>
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<td>• Shorter interval</td>
<td>• Longer interval</td>
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<tr>
<td>• Easy to titrate</td>
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<td>• Precipitated withdrawal unlikely</td>
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Responding to fentanyl in the DH ED

- 1/2022: Methadone induction added to ED protocol
- Increasing percentage of inductions
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Impacts of increased ED methadone Inductions

- Patients must follow up in OTP
- Fewer outpatient clinic inductions
  - Decreasing OAT patient census in community health clinics
- Some patients who receive methadone in ED don’t qualify for maintenance
  - Federal requirement: OUD x 1 year, 6 months of dependence
  - State has granted waiver, but requires exception request
- Methadone titration is slow; long period of instability
Responding to fentanyl

- Federal regulations not keeping pace with epidemic
  - Access to methadone
  - Dosing limits
  - Abstinence-based approach to phases
  - First step: make permanent flexibilities allowed by Covid

- Novel induction protocols needed
- Greater access to inpatient OUD management
- Ongoing MOUD expansion in corrections
Questions/Contact Us

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