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Remote attendees, please **mute your phones** as a courtesy – thank you!

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MEDS Ed™

Effective Substance Use Treatment: From Stigma to Tipping Point

CareOregon Pharmacy

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Today's Agenda

Public Health Overview – 8:00 am

MAT Value – 8:45 am

Break 9:30 am

Medication Supported Recovery – 9:45 am

On the Front Lines – 10:30 am

Break 10:45 am

Successful Implementation – 11:00 am

Panel Q&A – 11:20 am

Summary and Next Steps 11:40 am

Learning Objectives

- Gain an understanding of the science and use of medications as best-practice for the treatment of opioid and alcohol use disorders
- Distinguish the barriers and myths about recovery treatment from evidence and effective treatment
- Understand the guidelines for effectively navigating high-risk patient referrals with a special focus on coordination between behavioral health and primary care
- Plan next steps to support further implementation and improved access of MAT in our network

Poll Everywhere Instructions

Poll Everywhere

Registration:

Text
PAULCARSON518
to **22333** once to join – you will then text your answers!

Opioid Misuse in Portland Metro – Causes and Consequences

Paul Lewis, MD, MPH
Multnomah County Health Officer

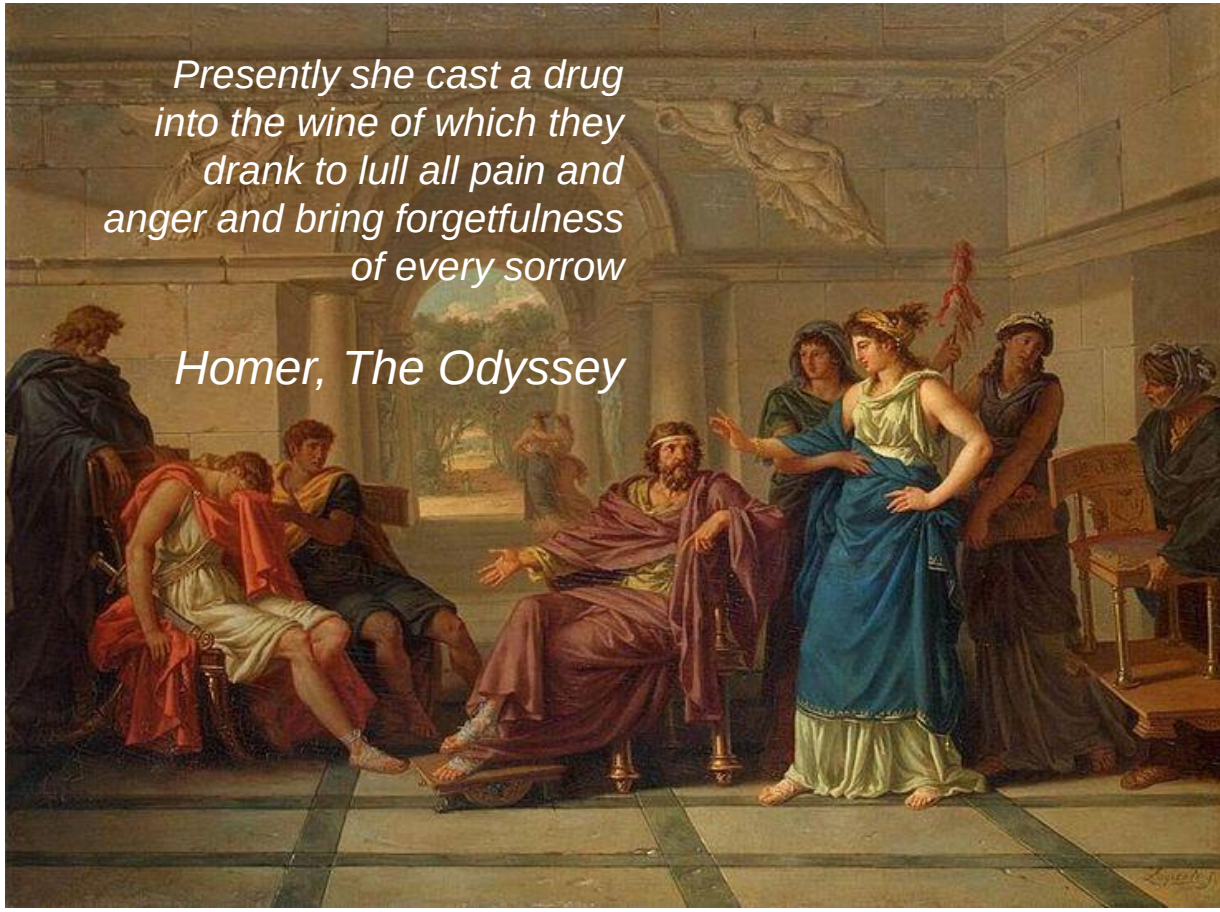
Multnomah County Health Department

CareOregon

MEDS Ed

Substance Misuse – A Few Things to Ponder

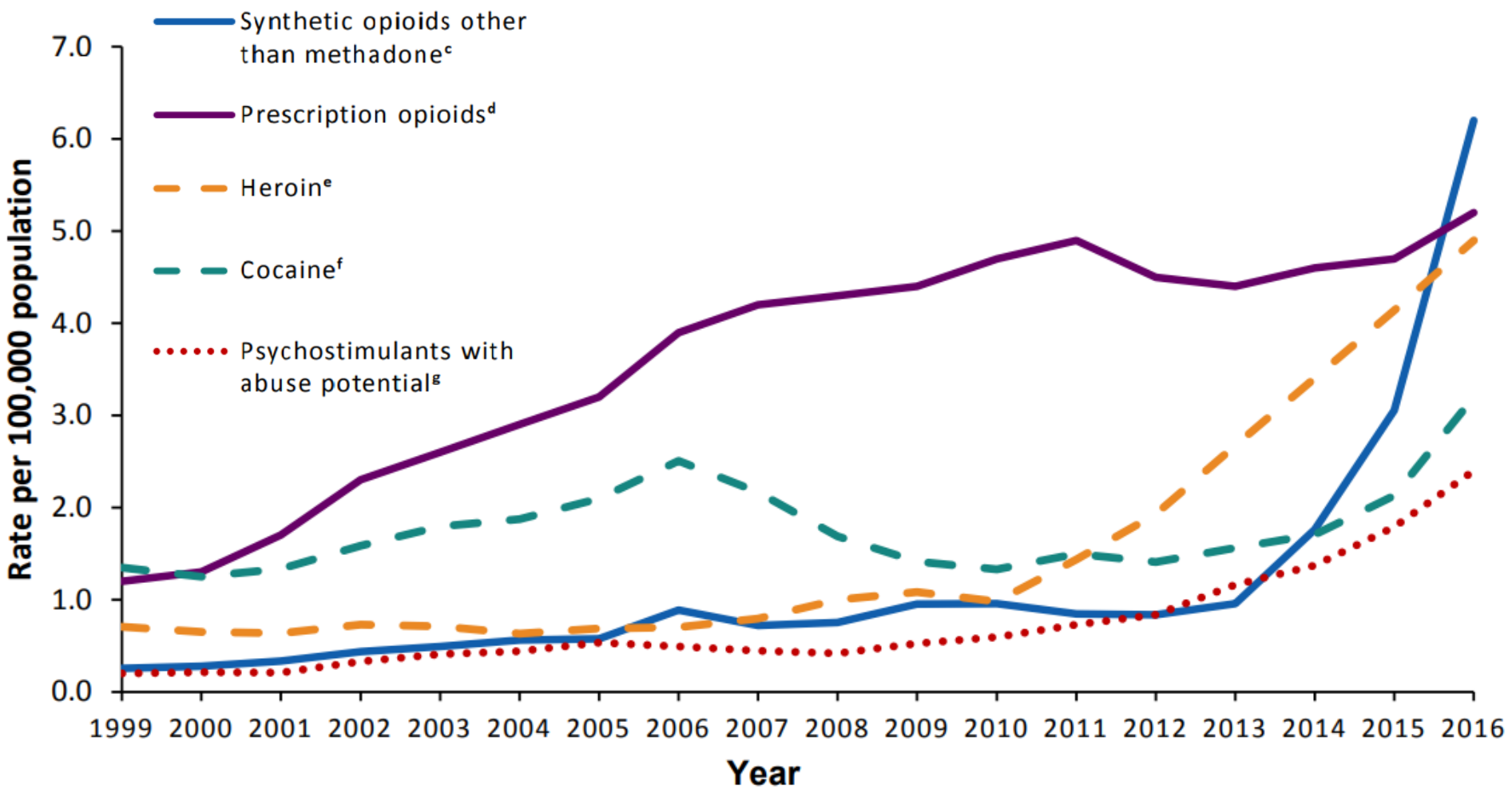
- Racial inequity in drug policy
- Many substances are misused, especially alcohol
- Biologic and social risks are common to all substance misuse
- Housing and mental illness have a complex relationship with substance misuse



Presently she cast a drug into the wine of which they drank to lull all pain and anger and bring forgetfulness of every sorrow

Homer, The Odyssey

Age-adjusted rates of drug overdose deaths 1999-2016



CDC Annual Report of Drug-Related Risks and Outcomes United States 2018

Opioid Crisis

Causes

- Abundant, cheap opioids
- Human susceptibility
- A small overdose can kill
- Opioid Use Disorder (OUD) is a chronic, relapsing disease
- Poverty, inequality, hopelessness, genetics and adverse childhood experiences (ACEs) underlie OUD

Black Tar Heroin

$100/balloon or ~ $10 per dose

Chemists and Pharma

30% of world production

Oxycontin
Percocet
Vicodin
Others

Pain Pills

Chemists and Pharma

Fentanyl and analogs
Powder or (mostly) counterfeit pills

$40/gram or ~$4/dose

Chemists and Pharma

Oxycontin
Percocet
Vicodin
Others

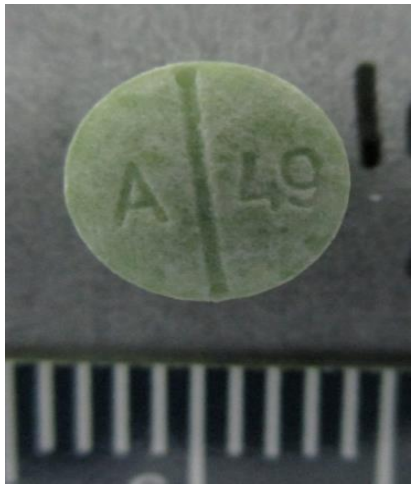
Black Tar Heroin

Fentanyl and analogs
Powder, counterfeit pills

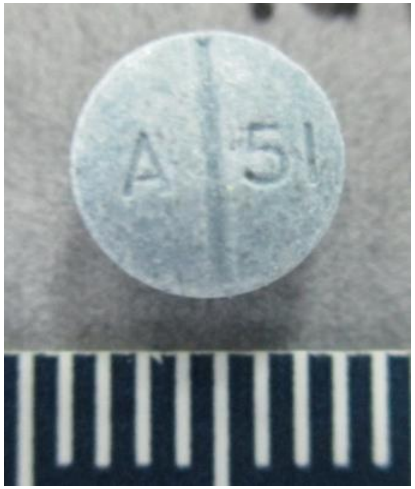
Pain Pills

Cases in Portland, OR – OR State Police Lab, 2017

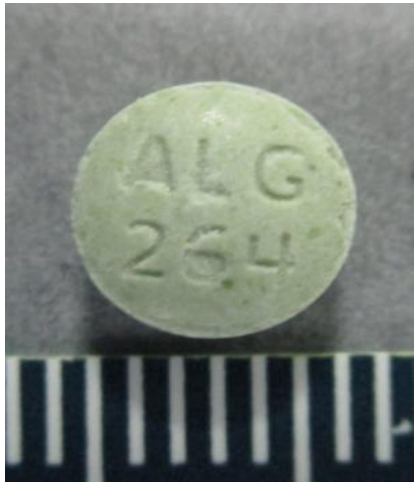
Typically seen in solid dose form as counterfeit oxycodone tablets



Alprazolam
U-47700



Heroin
Oxycodone
Furanyl Fentanyl

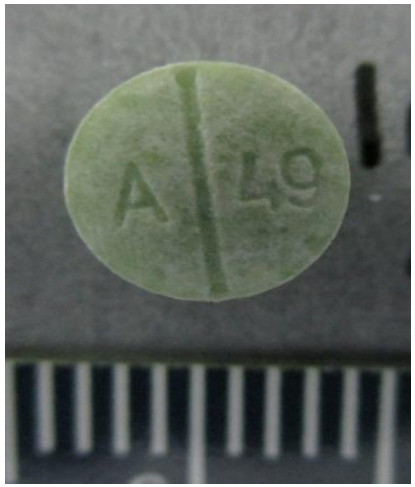


Heroin
Oxycodone
Tramadol
Alprazolam
U-47700

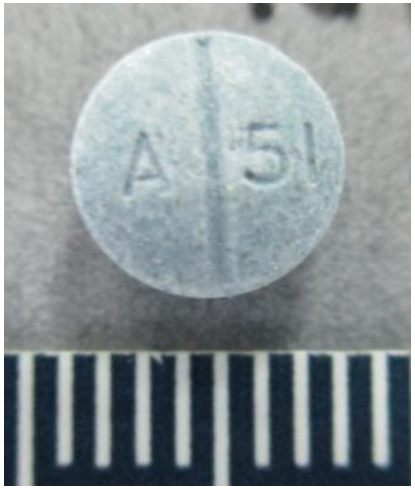
All 3 tablets are MTC: Oxycodone

Cases in Portland, OR – OR State Police Lab, 2017

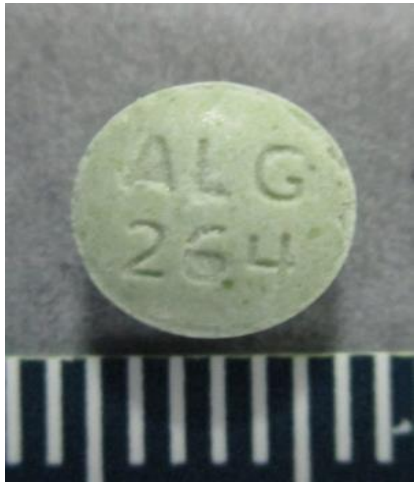
Typically seen in solid dose form as counterfeit oxycodone tablets



Alprazolam



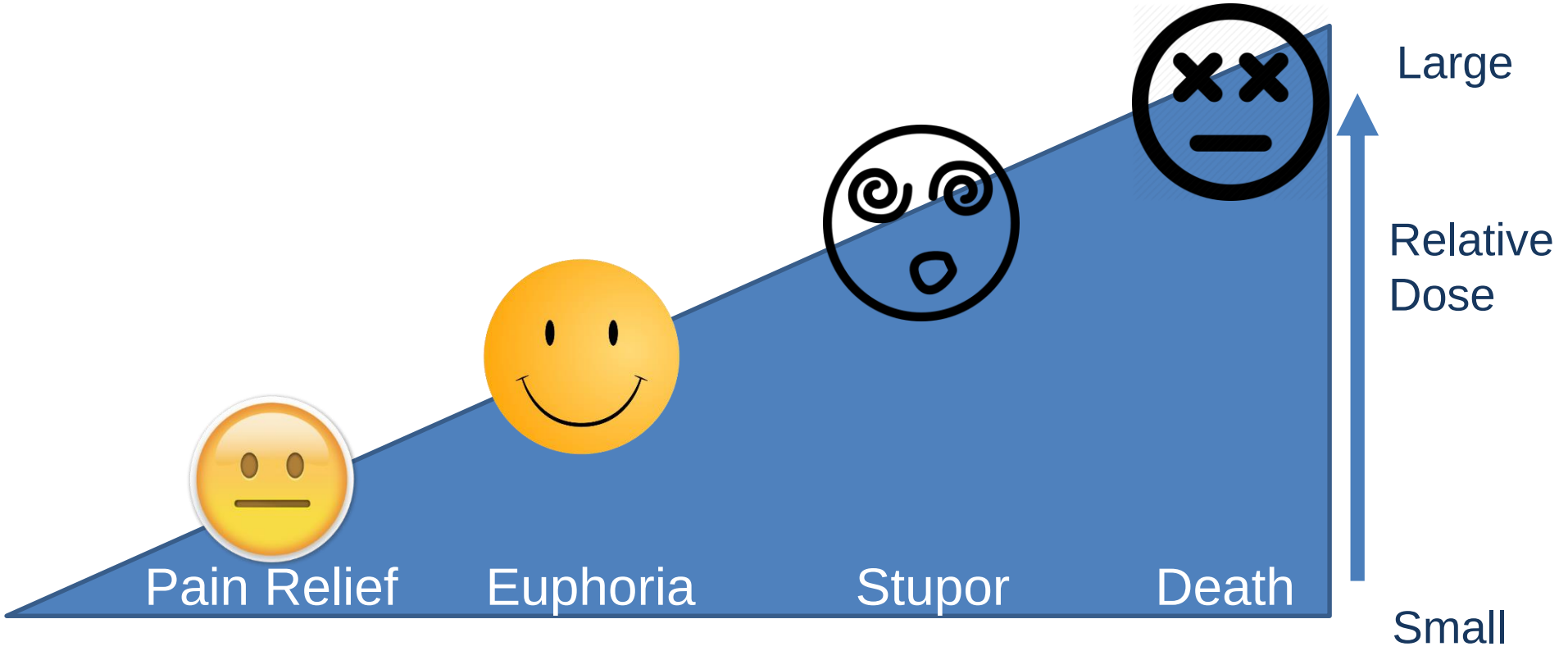
Heroin



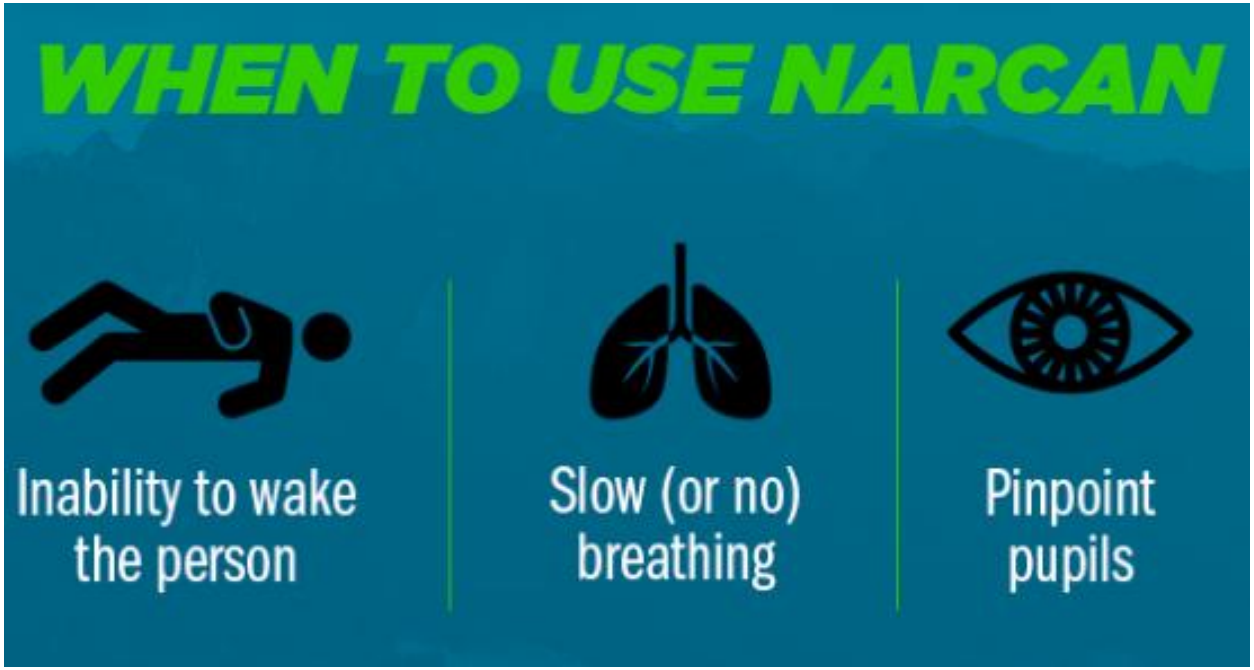
Heroin
Oxycodone
Tramadol
Alprazolam
U-47700

"About 100% of pill seized in 2018 are counterfeit" – Portland Police

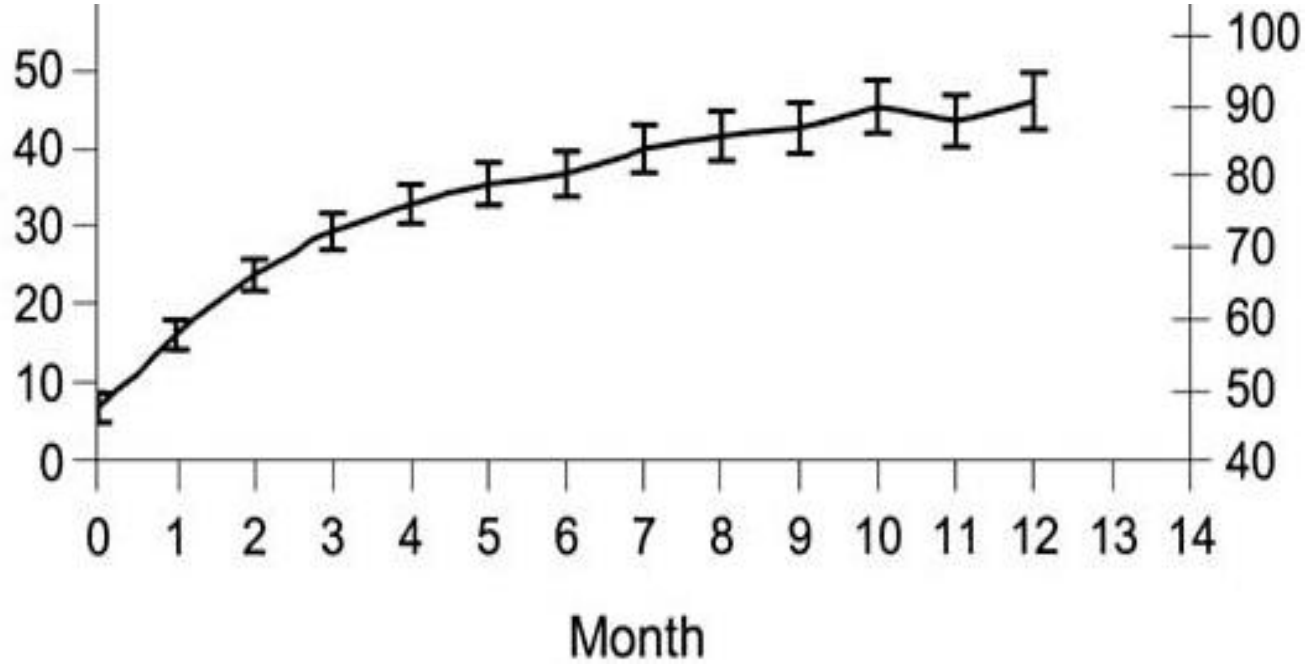
Problem 1: Large Opioid Doses Do More Than Reduce Pain



Naloxone is an antidote



Problem 2: Higher Opioid Dose Needed Over Time For Same Effect



Miligan et al Evaluation of long-term efficacy and safety of transdermal fentanyl in the treatment of chronic noncancer pain
The Journal of Pain, Volume 2, Issue 4, August 2001, Pages 197-204

Problem 3: Chronic Use Causes Physical Dependence; Halting Drug Causes Withdrawal, an Illness

https://opiateaddictionsupport.com/heroin-withdrawal-symptoms/

Mood Swings
Anxiety
Shakes, Chills, Sweats
Tears, Runny Nose
Bone Pain
Vomiting
Diarrhea
3-7 day duration

I’m Withdrawing: What are my Options?

1. Use a drug again (8-12 hrs. of relief); use less over time (taper)
2. Suffer without treatment (cold turkey)
3. Medicine to treat symptoms, not disease
4. Begin Medication Assisted Treatment (MAT) to treat symptoms AND disease

“The choices you make are the choices you have”

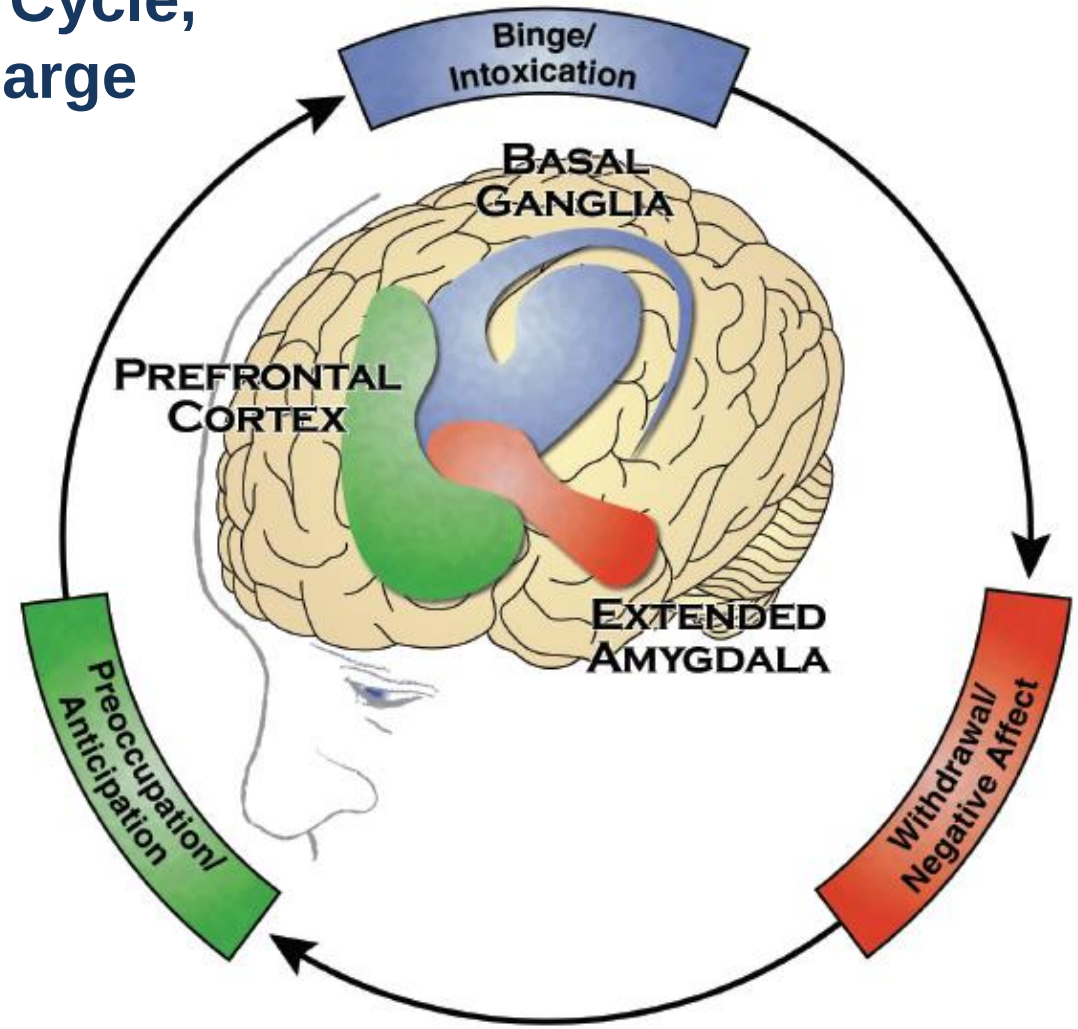
Problem 4:

The Opioid Use Disorder Cycle, The Primitive Brain in Charge

The addiction cycle is triggered by intoxication and pleasure (blue)

When intoxication wears off, the Individual feels worse (red)

More substances are sought (green) to relieve distress, the cycle continues



Opioid Misuse: Risk Factors

Fixed

- Male> Female
- Youth> Older Adult
- Genetic Variants
  - Dopamine, GABA, serotonin, opioid receptors, enzymes, transporters

Changeable

- Education
- Poverty
- Length of exposure to opioids
- Adverse Childhood Experiences

Opioid Misuse: Risk Factors

Fixed

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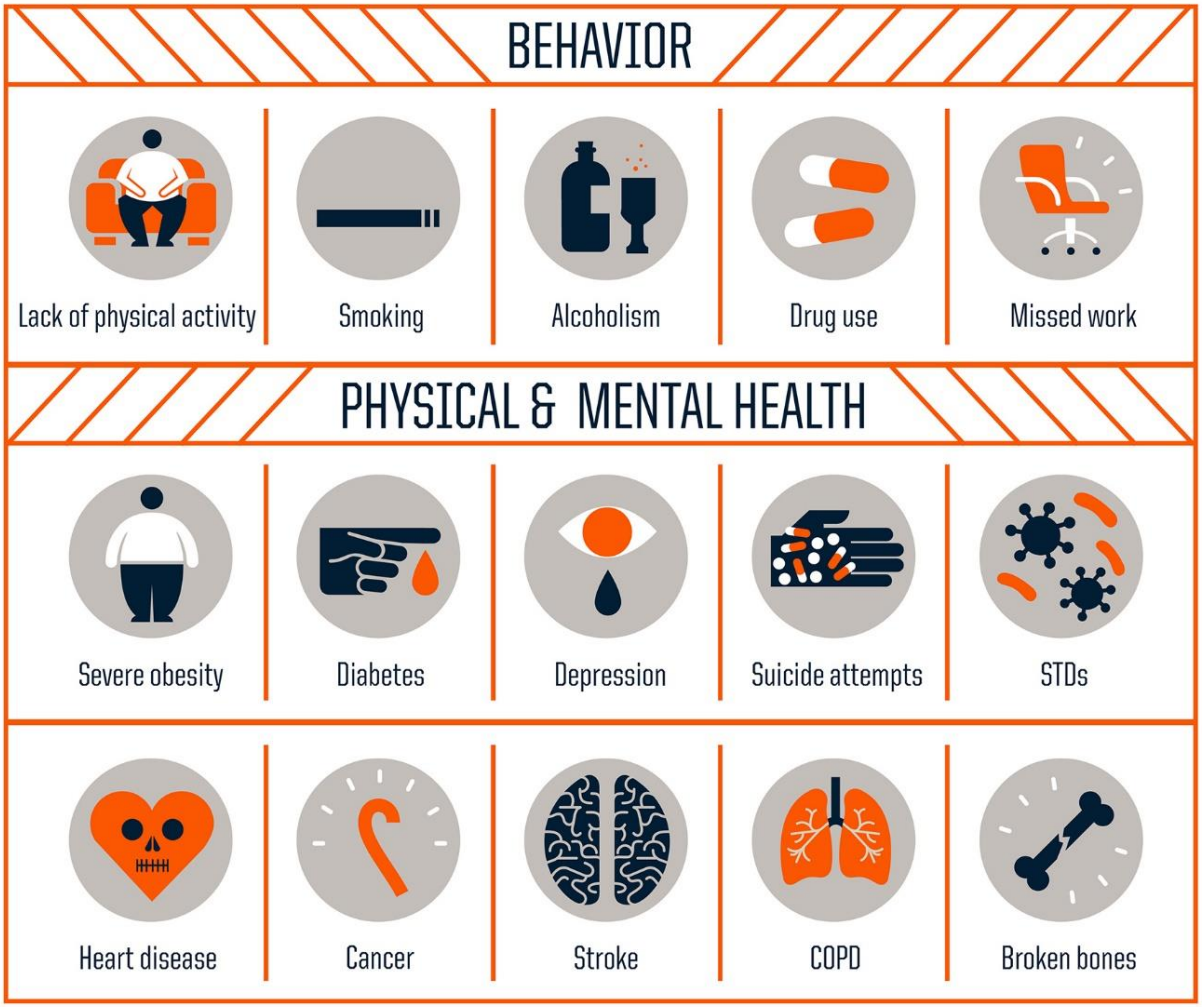
- Length of exposure to opioids
- Adverse Childhood Experiences

What are Adverse Childhood Experiences (ACEs)?

- Abuse
  - Emotional
  - Physical
  - Sexual
- Neglect
  - Emotional
  - Physical

- Household Challenges
- Mother treated violently
- Household substance abuse
- Mental illness in household
- Parental separation or divorce
- Criminal household member

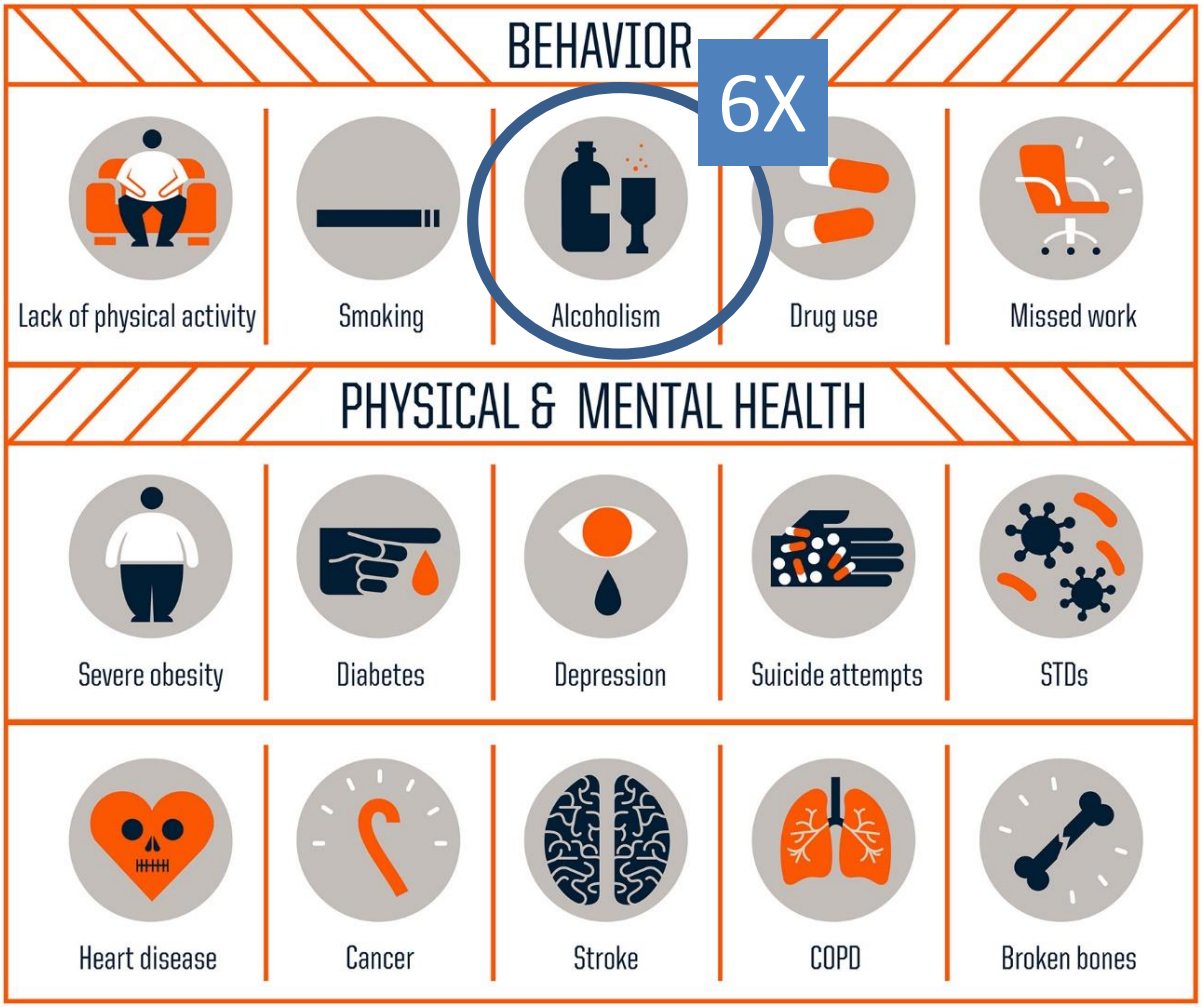


https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean

ACEs are not Destiny

ACES are Risk Factors
- Health Behavior
- Health Outcomes

High (>=4) vs Low (0)
- Alcoholism 6X
- SUD 10 X



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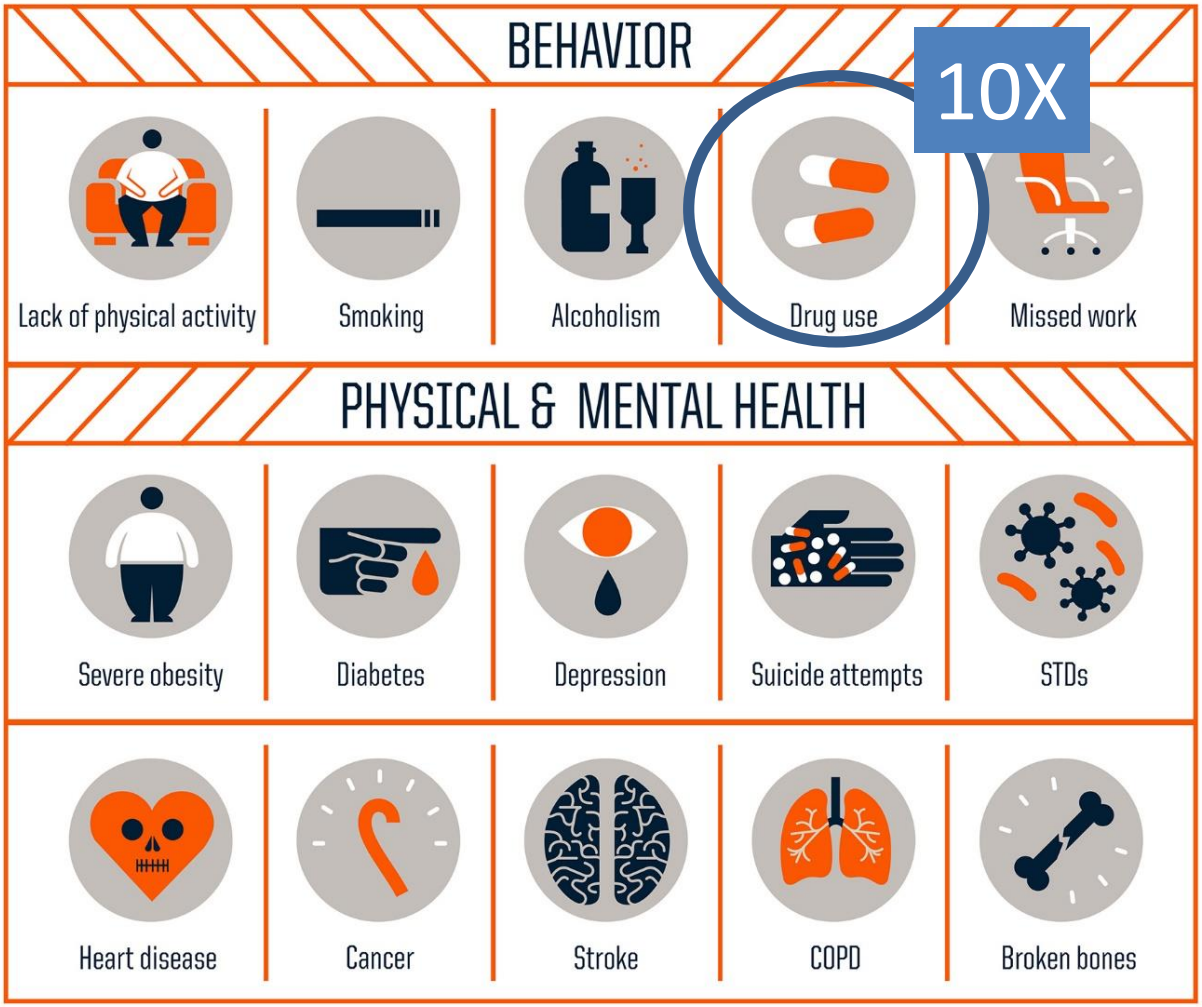

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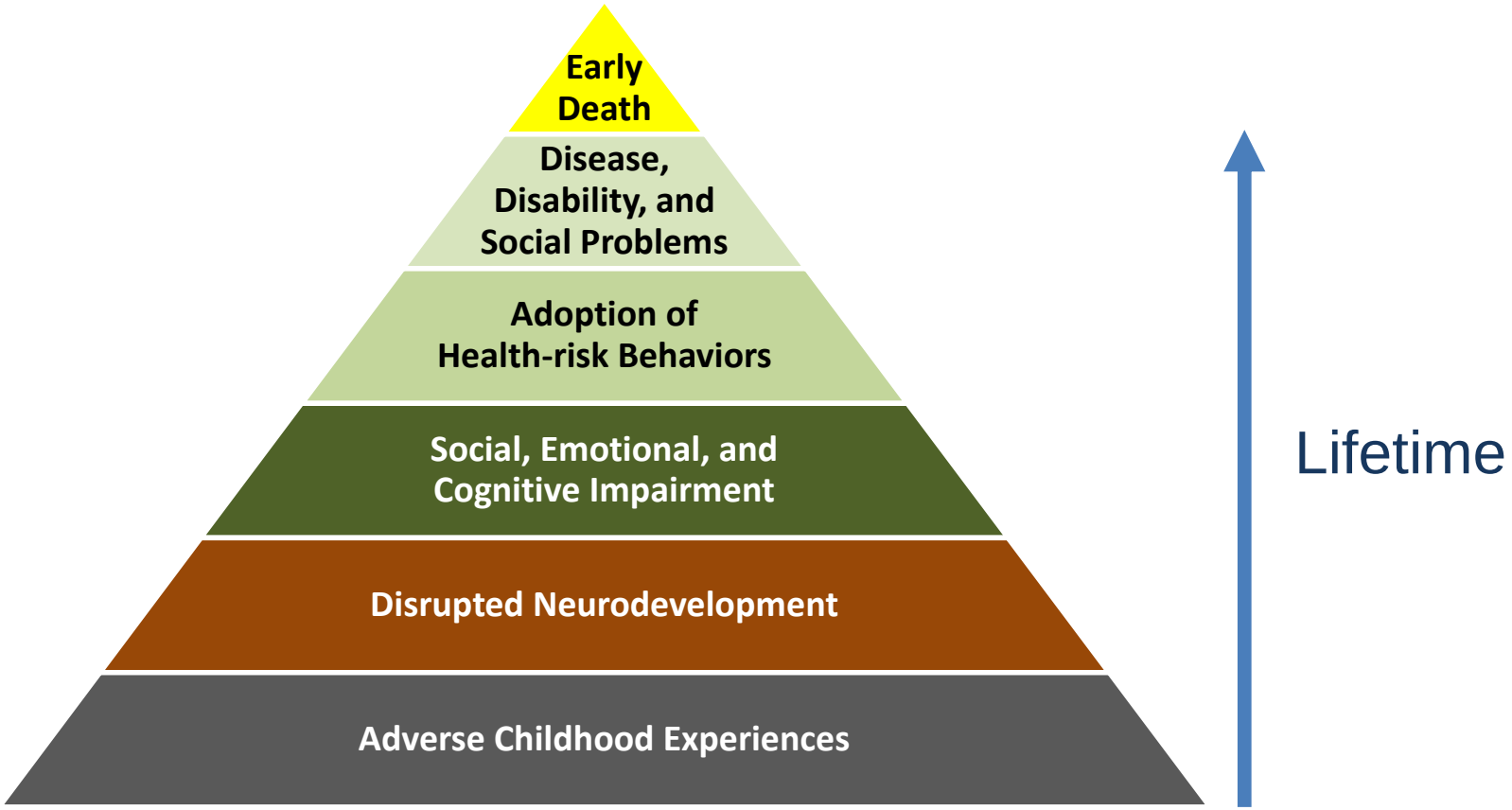
ACEs are not Destiny

ACES are Risk Factors
- Health Behavior
- Health Outcomes

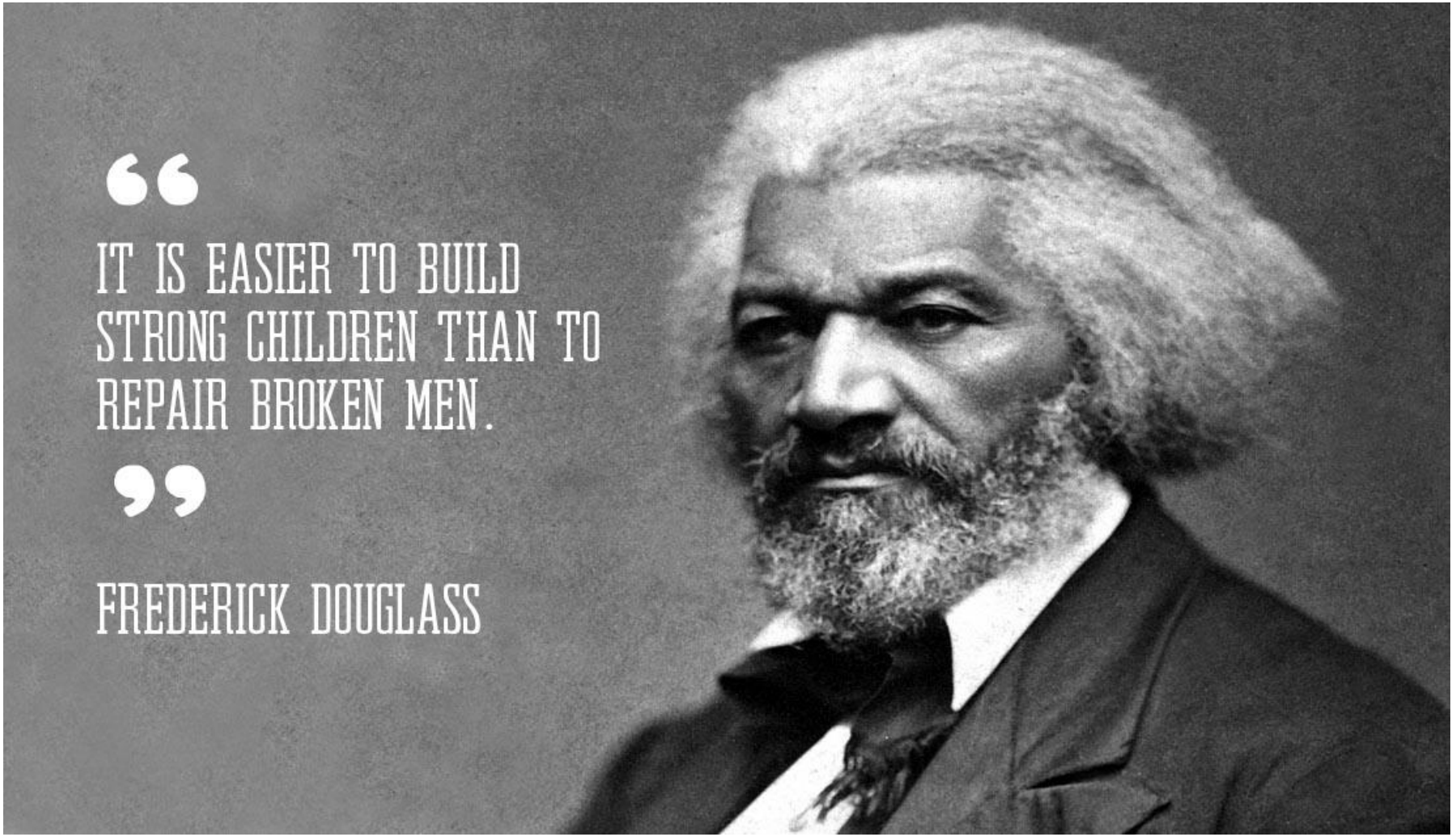
High (>=4) vs Low (0)
- Alcoholism 6X
- SUD 10 X

How do Adverse Childhood Experiences (ACEs) Hurt?



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

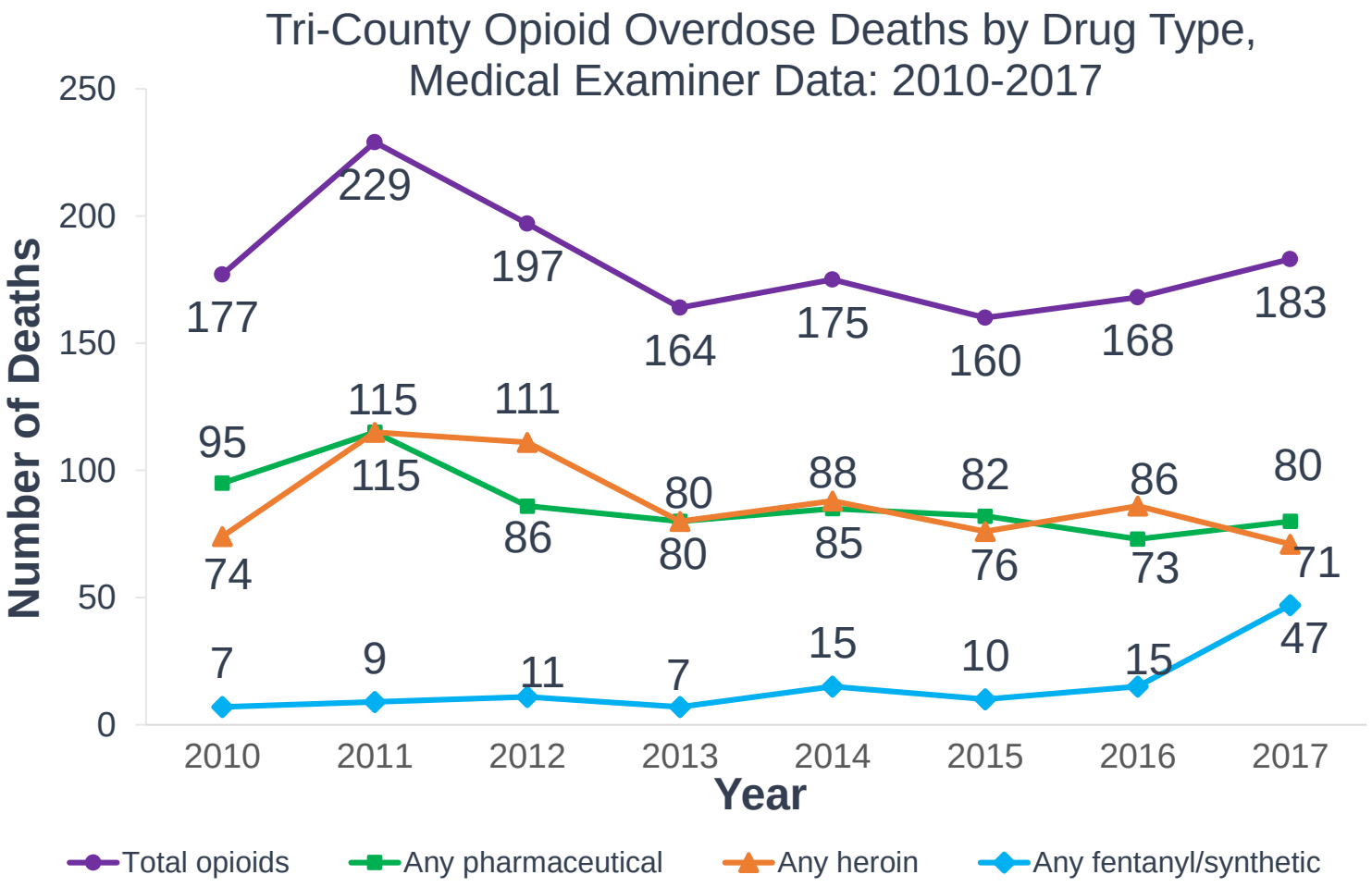
Pediatrics March 2003, VOLUME 111 / ISSUE 3


“
IT IS EASIER TO BUILD
STRONG CHILDREN THAN TO
REPAIR BROKEN MEN.
”
FREDERICK DOUGLASS

Report Card on Fatal and non-fatal Overdose

- Summary
  - Stable, high death rate
    - Worse in 2017 because of fentanyl
  - Broad age range in fatalities
  - Death rates highest in Native American, White, African-American > Hispanic and Asian/PI
  - Mostly accidents; up to 20% suicide
  - ~40% multiple substances

Regional Opioid Deaths – Trending Up



Other Associated Medical Conditions

HIV

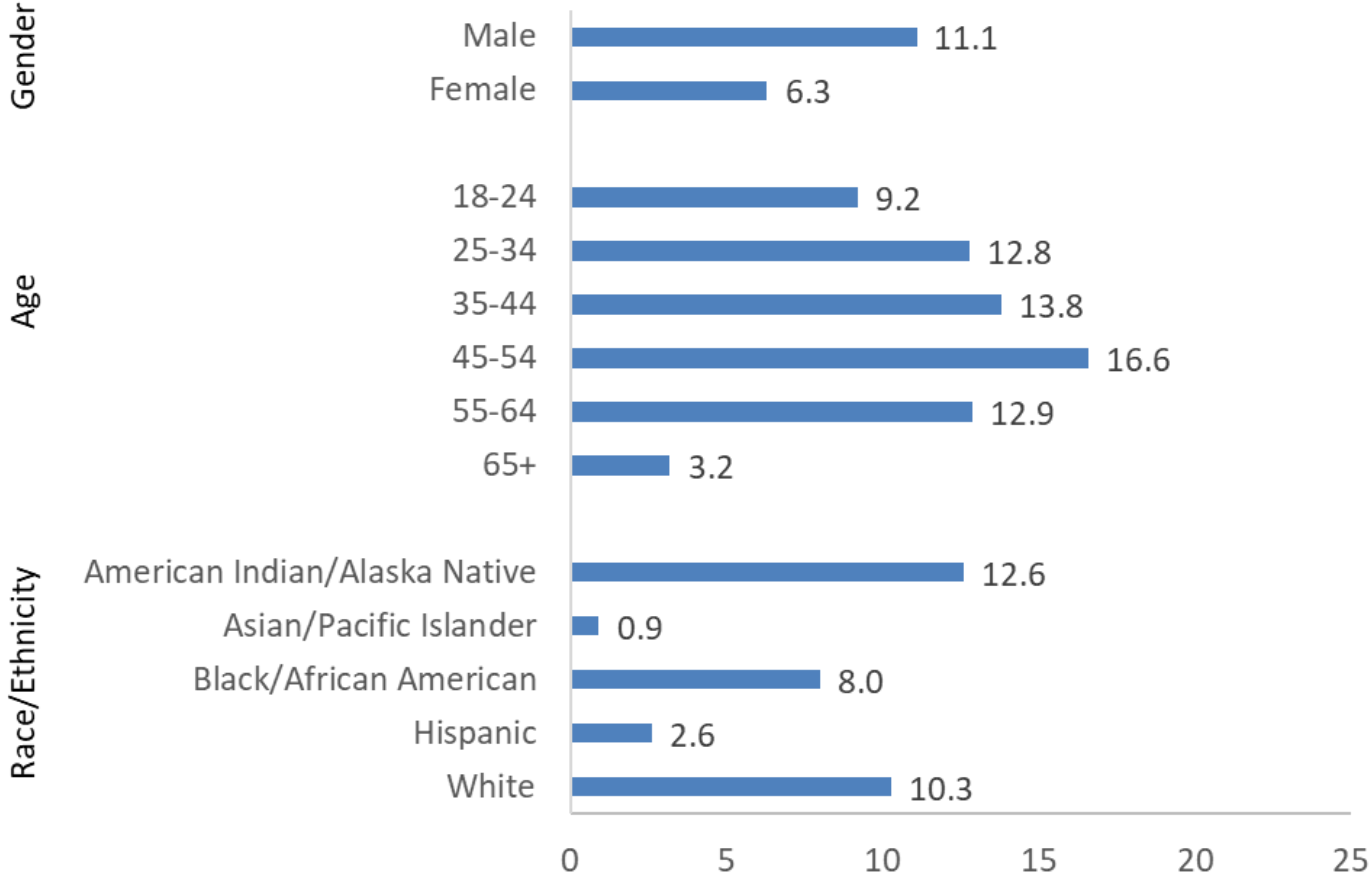
Hepatitis B, C

Heart Infections,

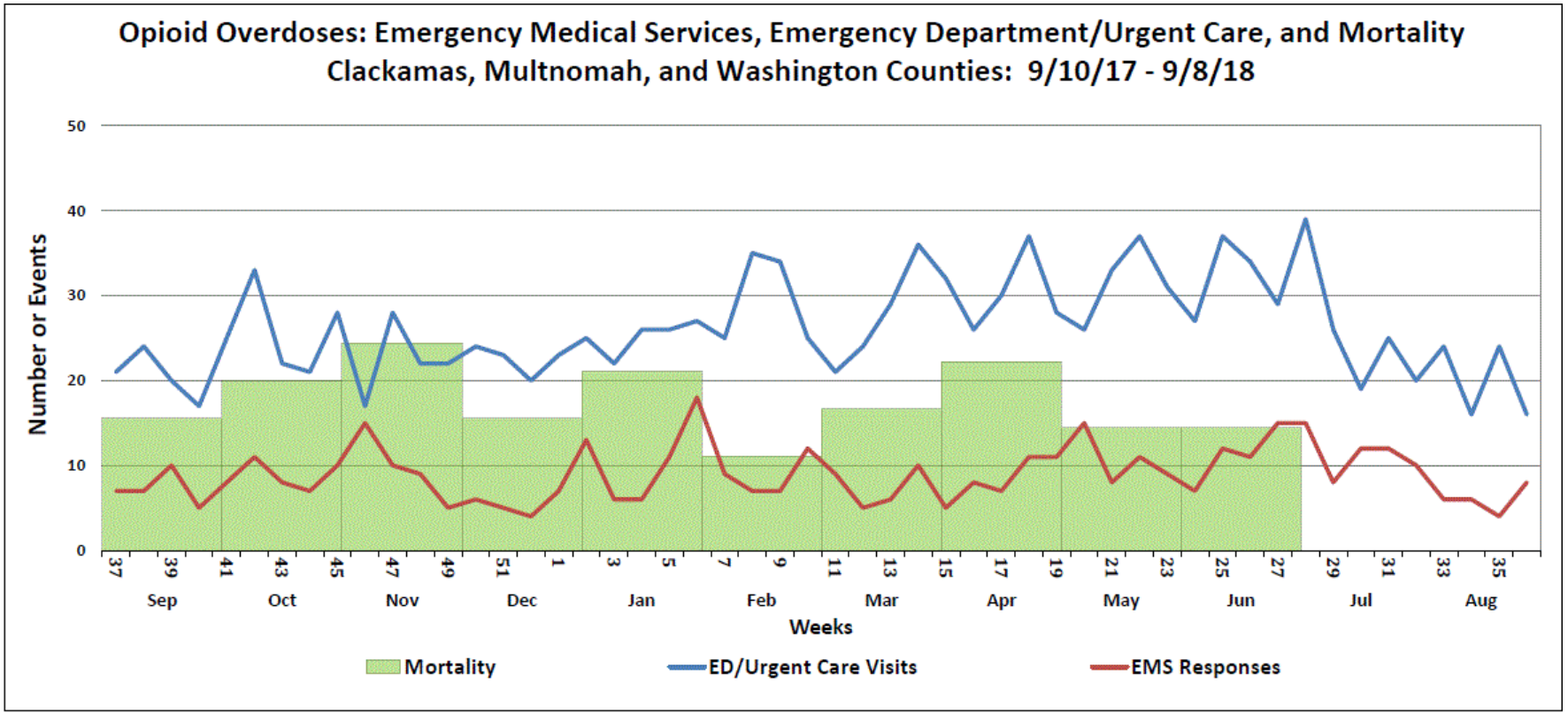
Skin infections and abscesses

Oregon State Medical Examiner data

Figure 11 - Tri-County Opioid Overdose Death Rate by Gender and Age (2010-2016) and Race/Ethnicity (2000-2016), CDC WONDER data



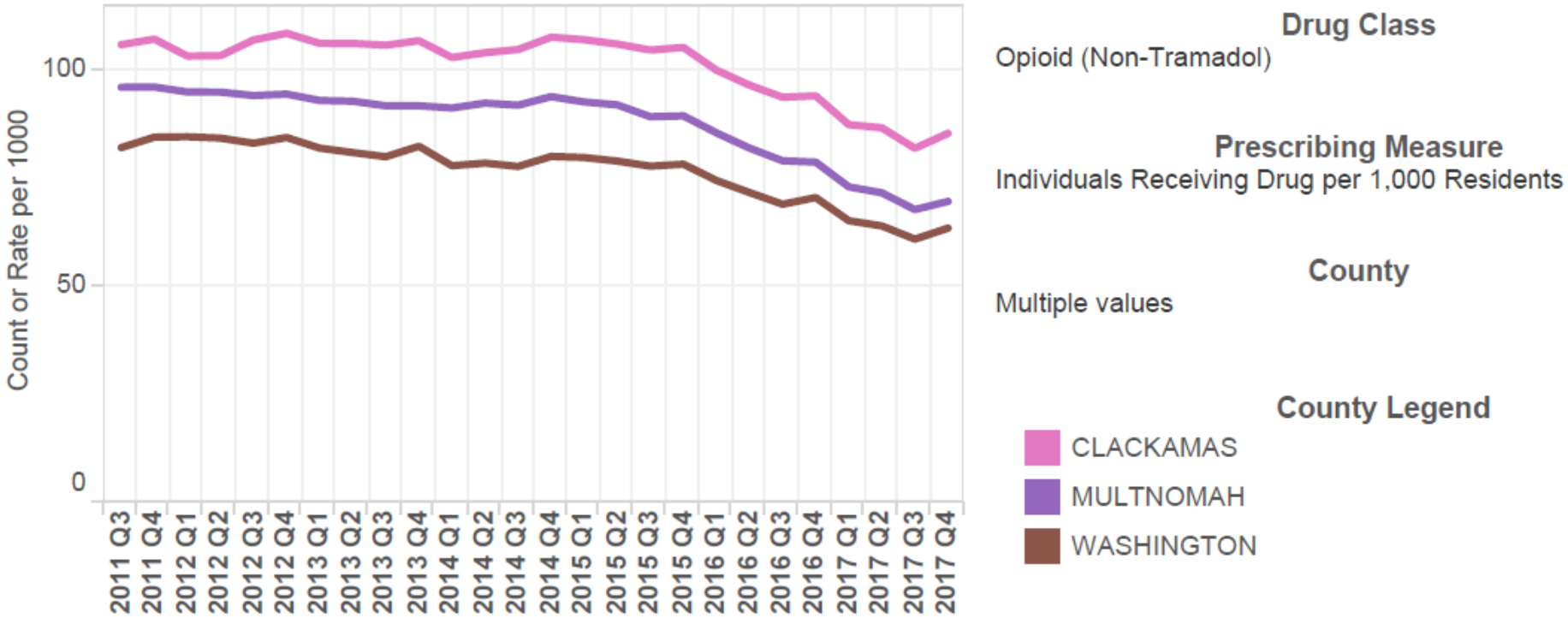
Fear of Fentanyl – Realtime Overdose Surveillance



Some Good(ish) News

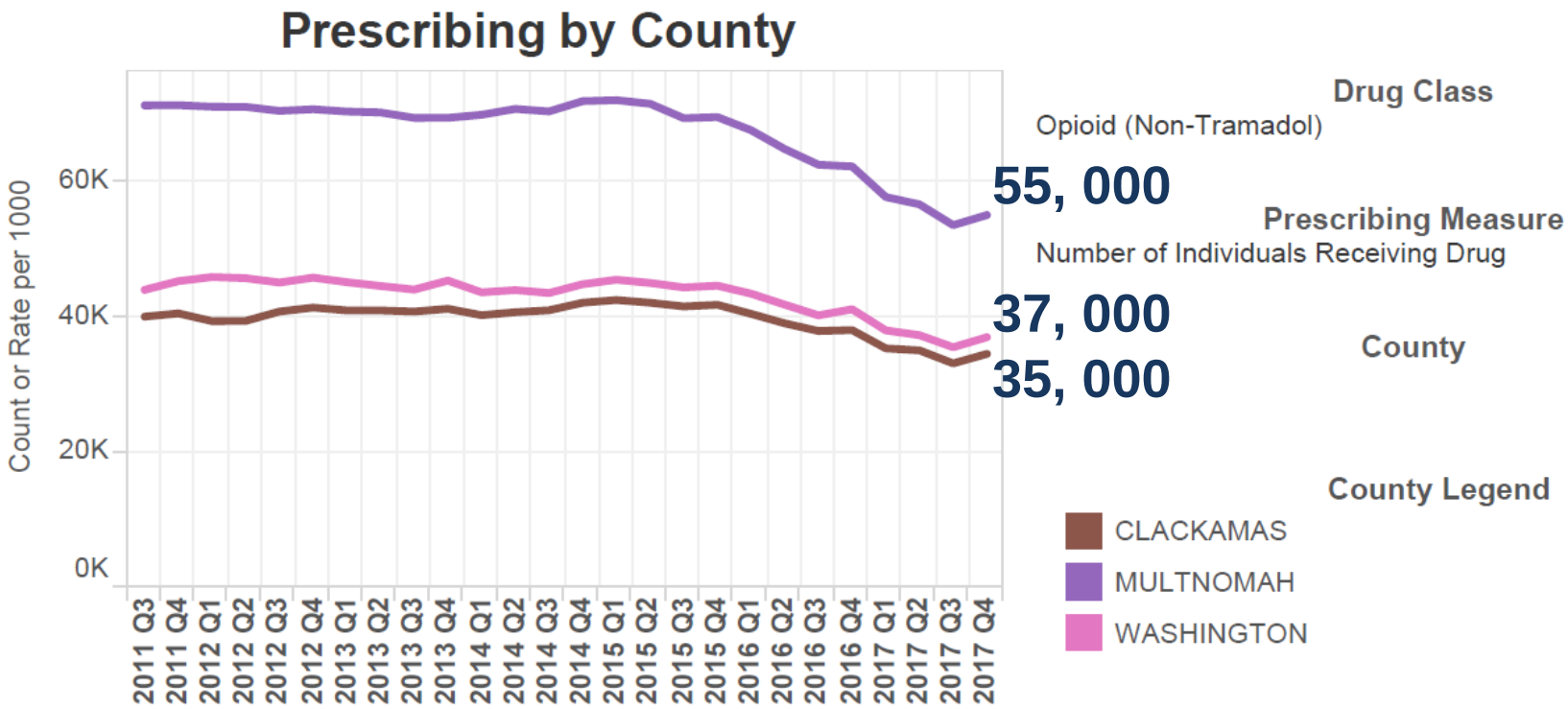
- Excess Prescribing is decreasing
- Chronic Disease Model is being accepted
- We know where to find patients in need of treatment

Prescribing is down for more than 2 years!



http://www.oregon.gov/oha/ph/preventionwellness/substanceuse/opioids/pages/data.aspx accessed 3/14/18

But >120,000 separate people still get opioids every quarter in the Tri-County Region!



Good News 2:

- Chronic Disease Model is Taking Hold
  - Relapses and recovery
  - Evidence-based treatment
  - Combined Medical and Social Components of Recovery

Call **800-923-4357 (HELP)**

We Know Where We Encounter People Needing Treatment

Site	Estimated Number per year
Detox	2500 (Hooper, CODA, DePaul)
Emergency Room Overdose	1000+
Jail Booking	>10,000 encounters (All substances, Multco only)
Total	> 13,000 opportunities

How Many People Need Treatment for OUD?

- Older Survey Data* (likely worse now)
  - 0.3% used heroin in last year
  - 1.4 % misused prescription opioid
- Estimate: Total Tri-County >25,000 people

*2012/3 (landline) or 2014 (face to face, housed only)

Final Thoughts

Everyone is Susceptible

- Supply of drugs is abundant
- Social conditions are a major risk

Opioid Use Disorder is a Chronic Medical Condition

Opioid Misuse Can Be Prevented

- Eliminate adverse childhood experiences
- Reduce poverty
- Enhance education

Final Thoughts

Short-term Local Policies Can Address:

Justice-related pathways to recovery

Lowering barrier access to effective treatment; integrating recovery system; Office-Based Treatment with buprenorphine

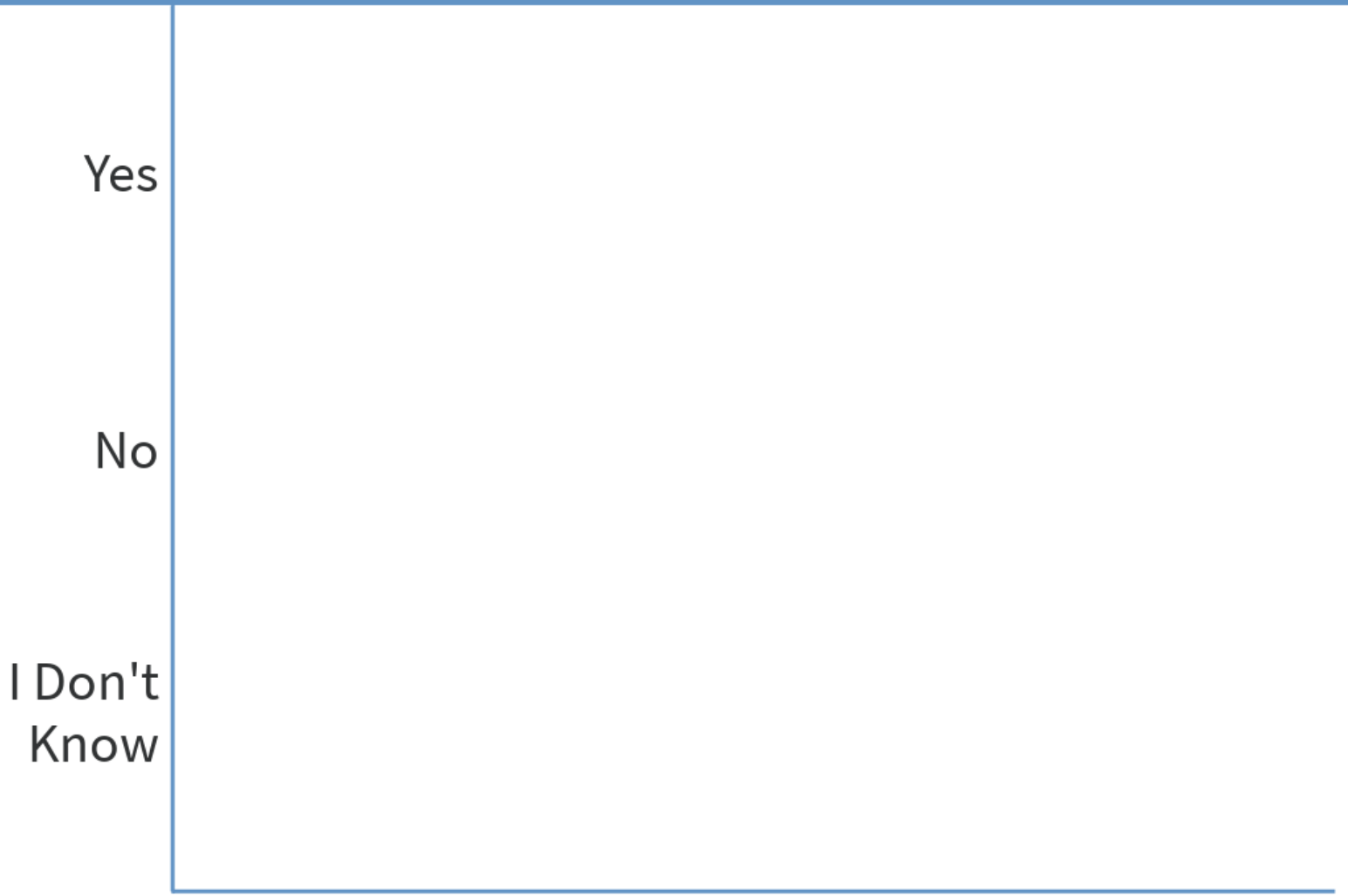
Integrated approach to recovery including housing, employment, social support, and medication

Poll Everywhere: Alison Noice

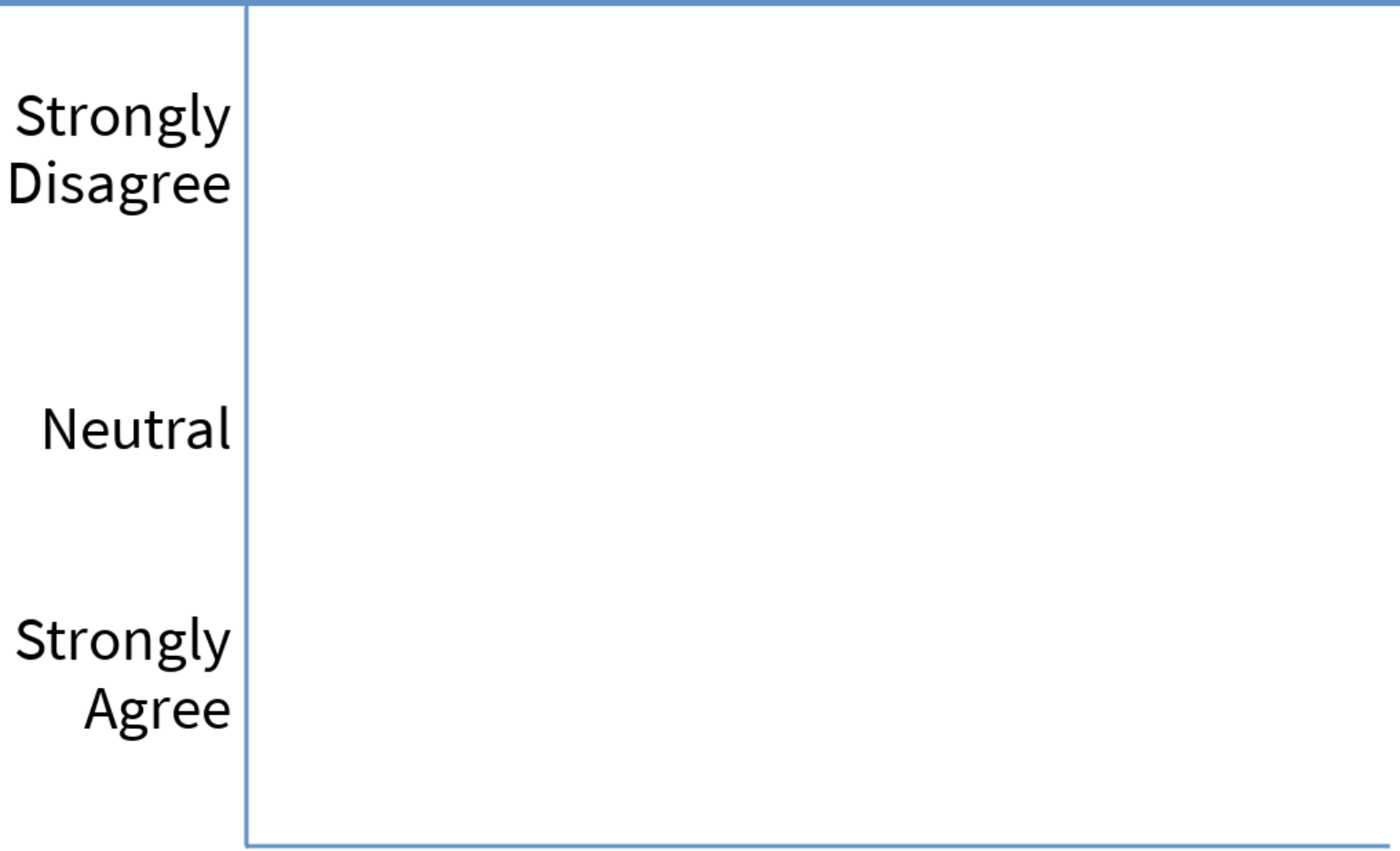
Poll Everywhere

Text
PAULCARSON518
to **22333** once to join – you will then text your answers!

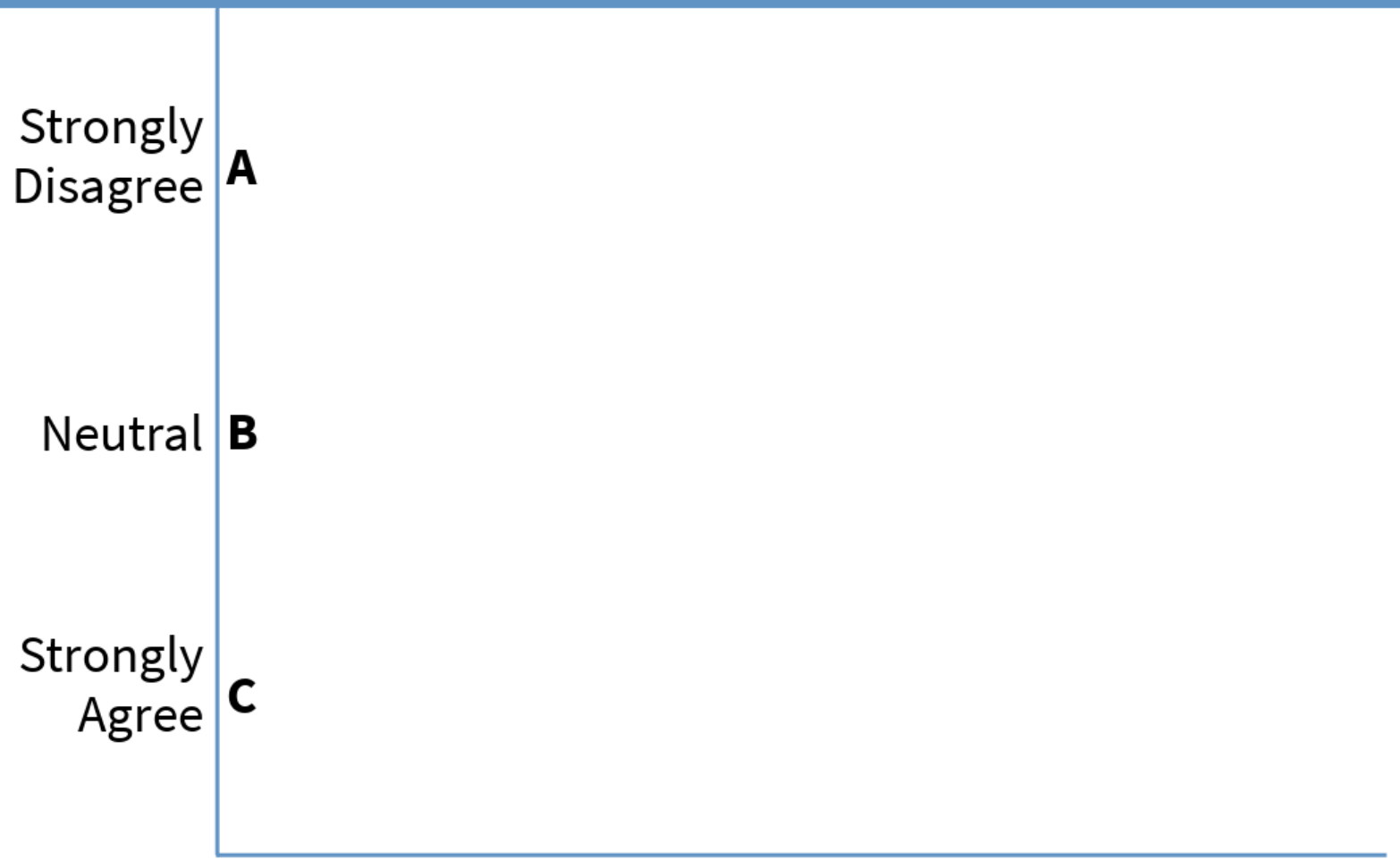
Test Question: I have a Current DATA Waiver



Question #1: Substance use disorders are chronic health conditions, not moral failings or character flaws



Question #2: Medication-Assisted Treatment is fine, but it should be time-limited



Medication Supported Recovery – A Clinical Opportunity Within Primary Care Medical Practice

Andrew Mendenhall, MD, DABAM, DABFM

Senior Medical Director, Substance Use Disorder Services – Central City Concern

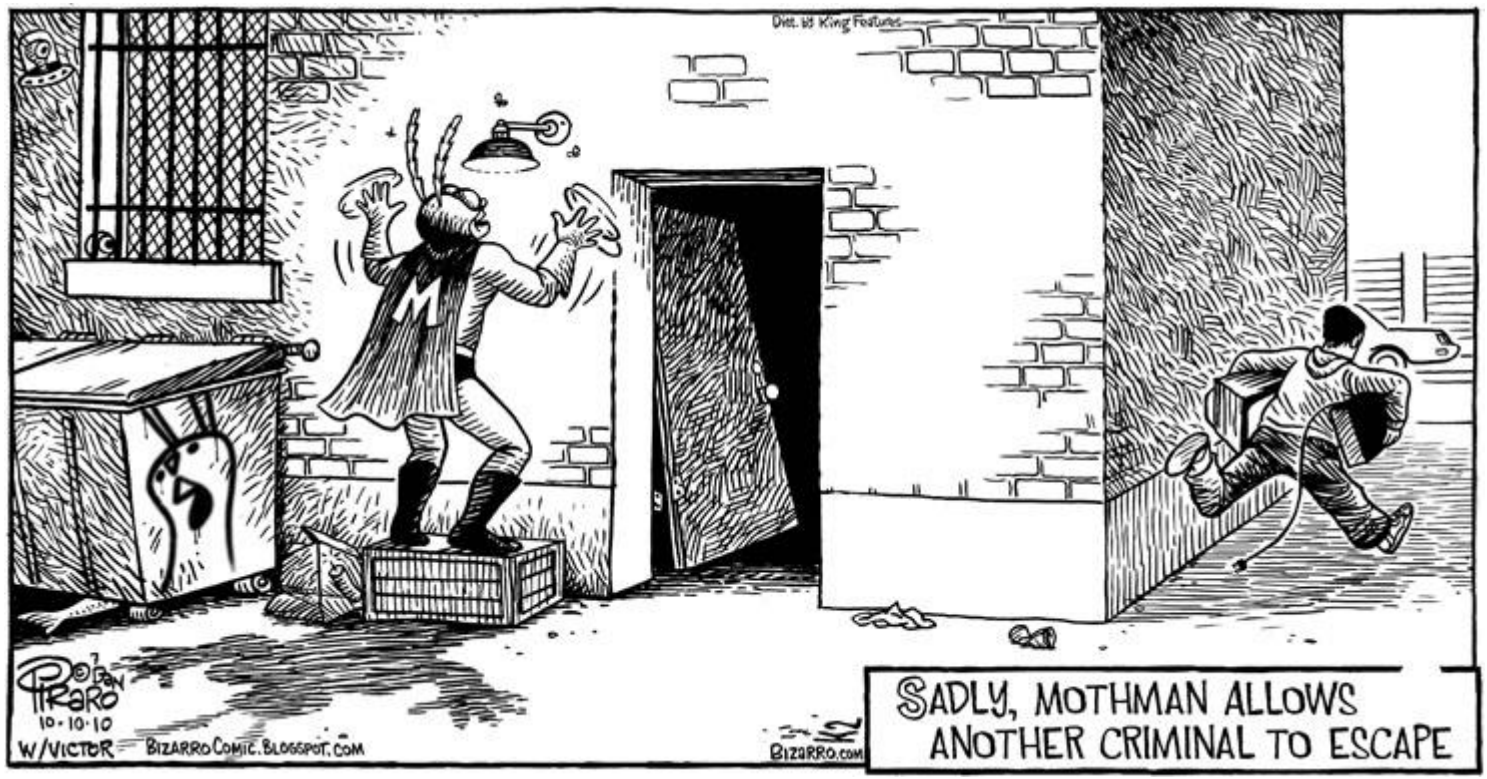
CareOregon

MEDS Ed

Objectives

1. Discuss the disease of addiction from the perspective of how a primary care physician can make an impact.
2. Review opportunities for Alcohol Use Disorder and Opioid Use Disorder.
3. Talk a little bit about the science.
4. Talk about population sub-sets that are less difficult to work with.
5. Ask you to be creative and curious in your thinking about caring for patients.

This is Addiction



Broad Philosophic Context

Diabetes Tight Glycemic Control	**A1C<7.0%**	**NNT 250**	**NNH 6**
Hypertension		**NNT 29-118**	
Hypercholesterolemia	**Primary Prevention** **Secondary Prevention**	**NNT 22-80** **NNT 7-9.1**	**NNH 63-167**
Alcohol Use Disorder	**Acamprosate Total Abstinence** **Naltrexone Total Abstinence** **Naltrexone Zero Heavy Drink**	**NNT 12** **NNT 20** **NNT 12**	
Buprenorphine	**Retention in Treatment**	**NNT 2-4**	

JAMA Network: Jonas and Hughes 5.13.2014 doi:10:1001/jama/2014.3628

Am. Fam. Physician. Raleigh M.F., 2017, March 1:95(5) online

The Medical Literature

1. Supports the use of medication to help patients improve their probability of abstinence.
    - Data has been around for nearly 50 years.
    - Alcohol Use Disorders
    - Opioid Use Disorders

2. Supports the attendance of fellowship groups as increasing the probability of sustained abstinence.
    - Less than 15% of patients who attend 12-step meetings will continue to be active at 12 months.
    - 90 meetings in 90 days is as effective as a 28 day residential treatment.
        - Very poor outcomes data-self reported “success” rates of 80% or more

www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

The Medical Literature

3. Demonstrates that treatment of Depressive Disorders markedly reduces substance use but have a minimal effect on the probability of total abstinence.

4. Informs clinicians that the disease of addiction is a chronic relapsing brain disease.

- Spectrum Disease – Mild, Moderate, Severe
- Vastly less expensive to treat than it is to ignore or to provide less effective treatment modalities.

- Edward V. Nunes, MD; Frances R. Levin, MD
- *JAMA.* 2004;291(15):1887-1896. doi:10.1001/jama.291.15.1887

VAST Chasm between NEED and ACCESS

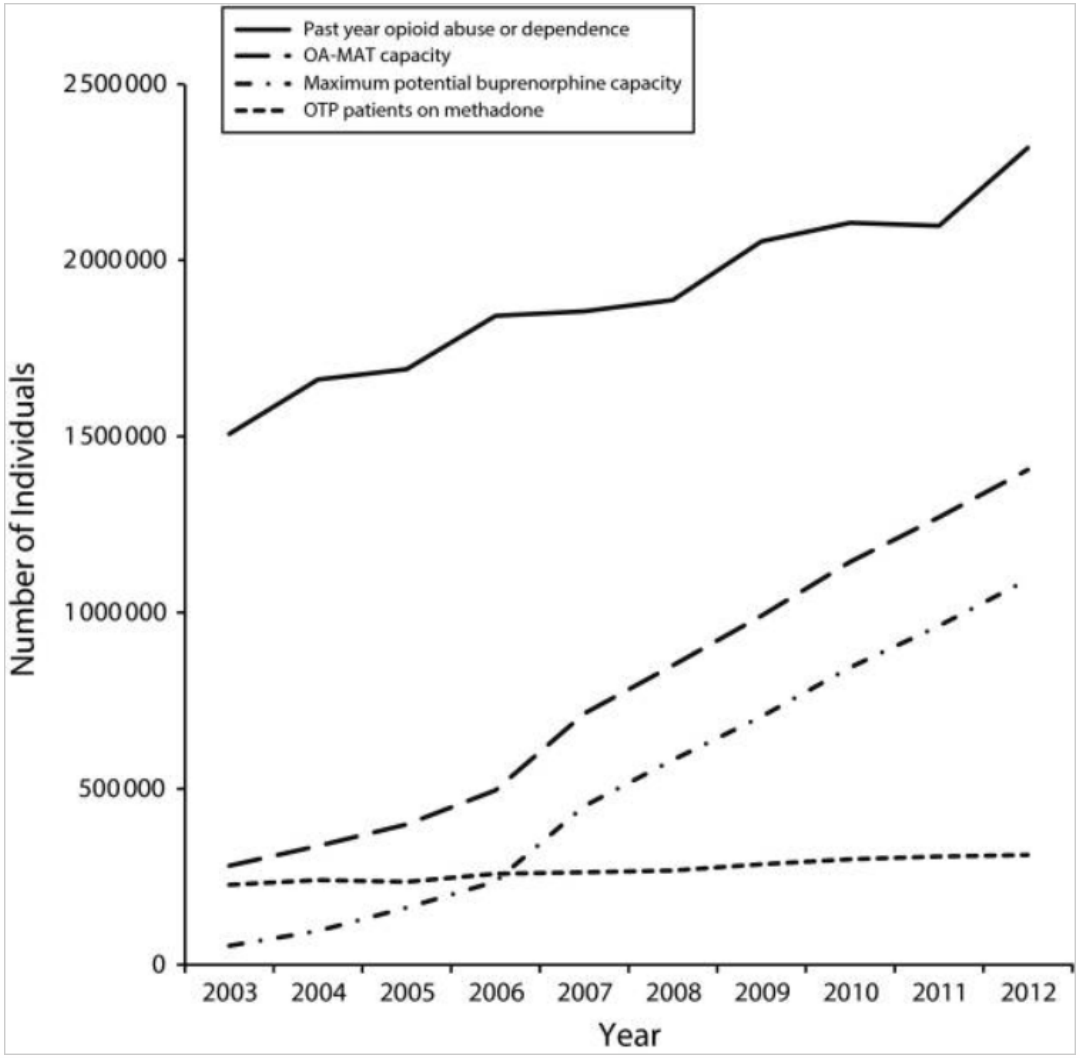


Figure 1 – Trends in past-year opioid abuse or dependence and opioid agonist medication-assisted treatment capacity: United States, 2003–2012.
Note. OA-MAT = opioid agonist medication-assisted treatment; OTP = opioid treatment program.

Jones et. al. American Journal of Public Health, June 11th,2015 Electronic Publication-Peer Reviewed.

State-by-State Access Regression Analysis

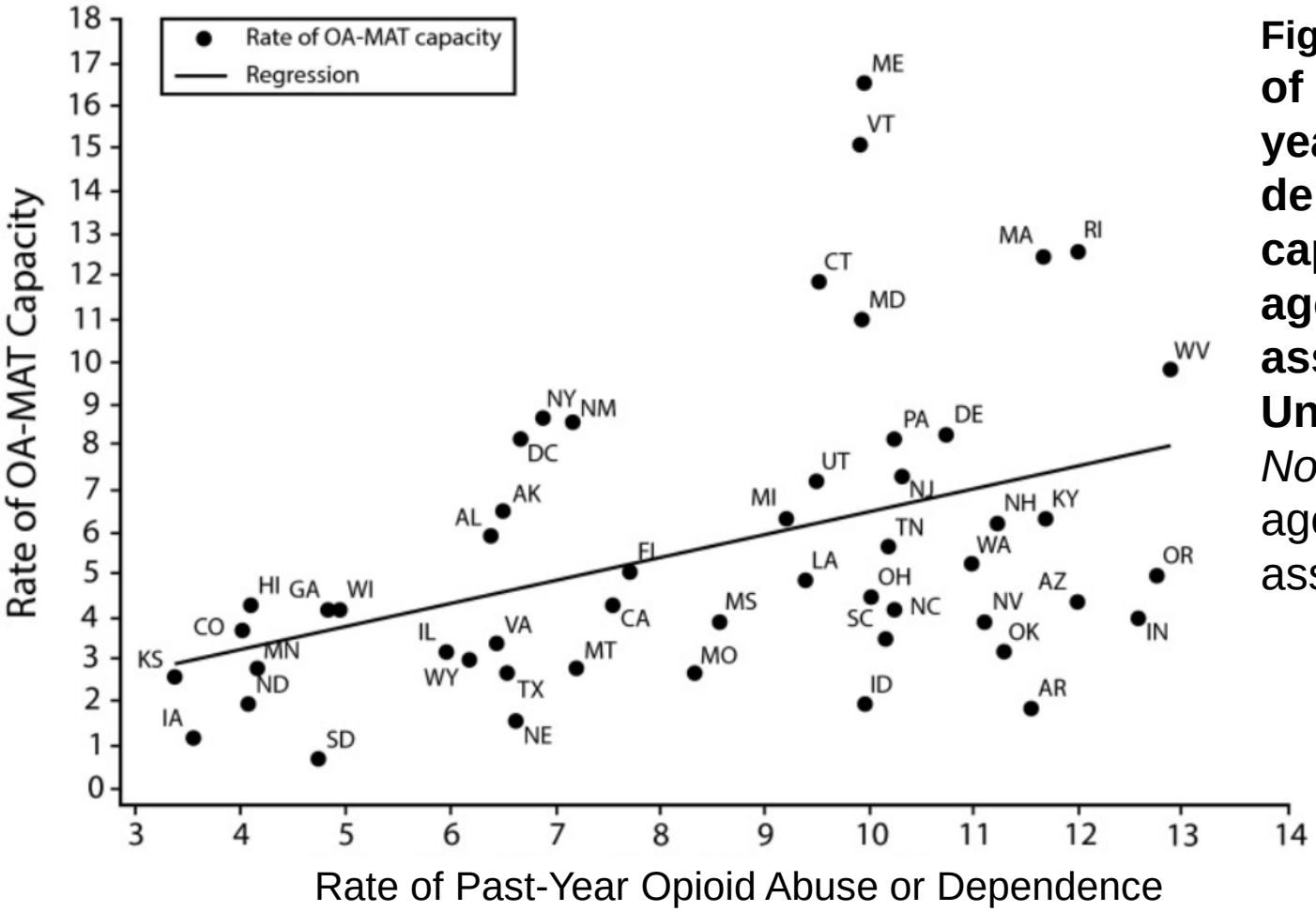
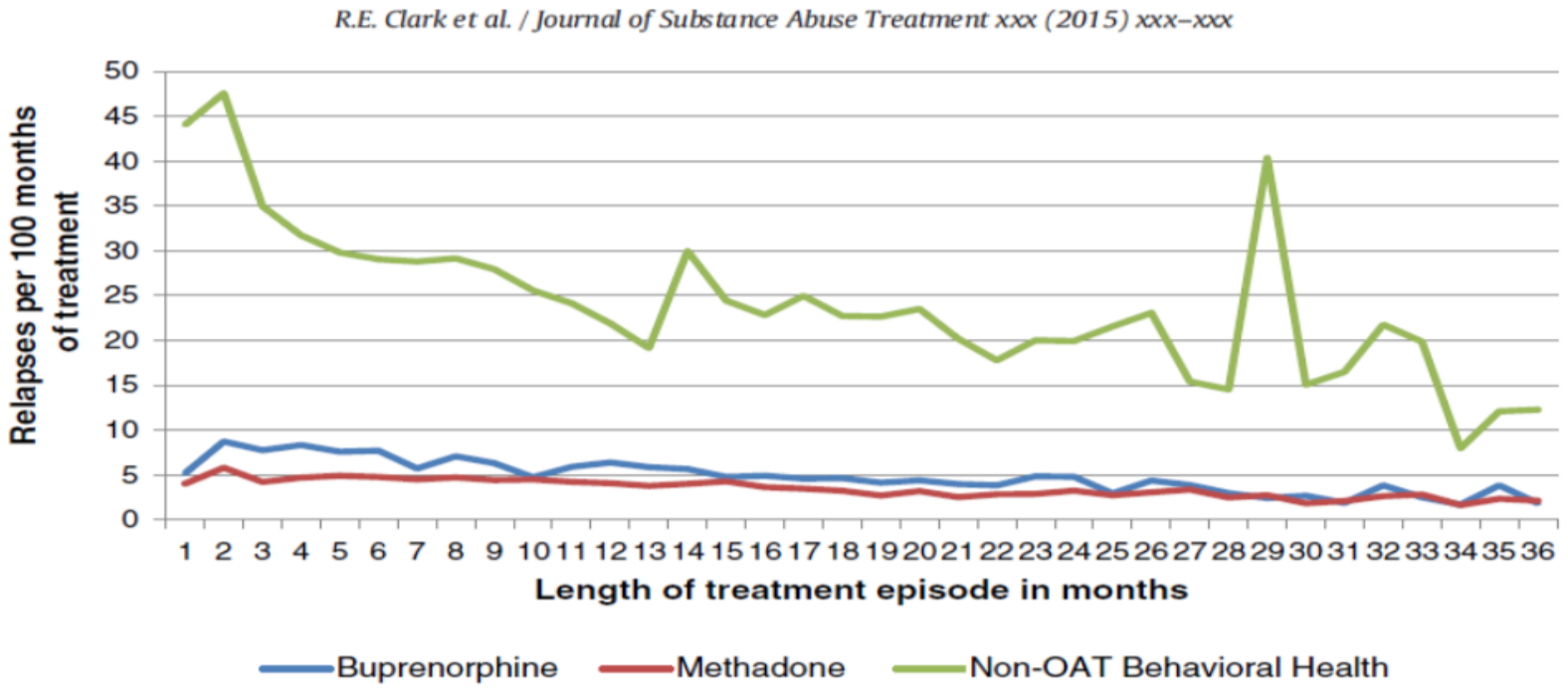


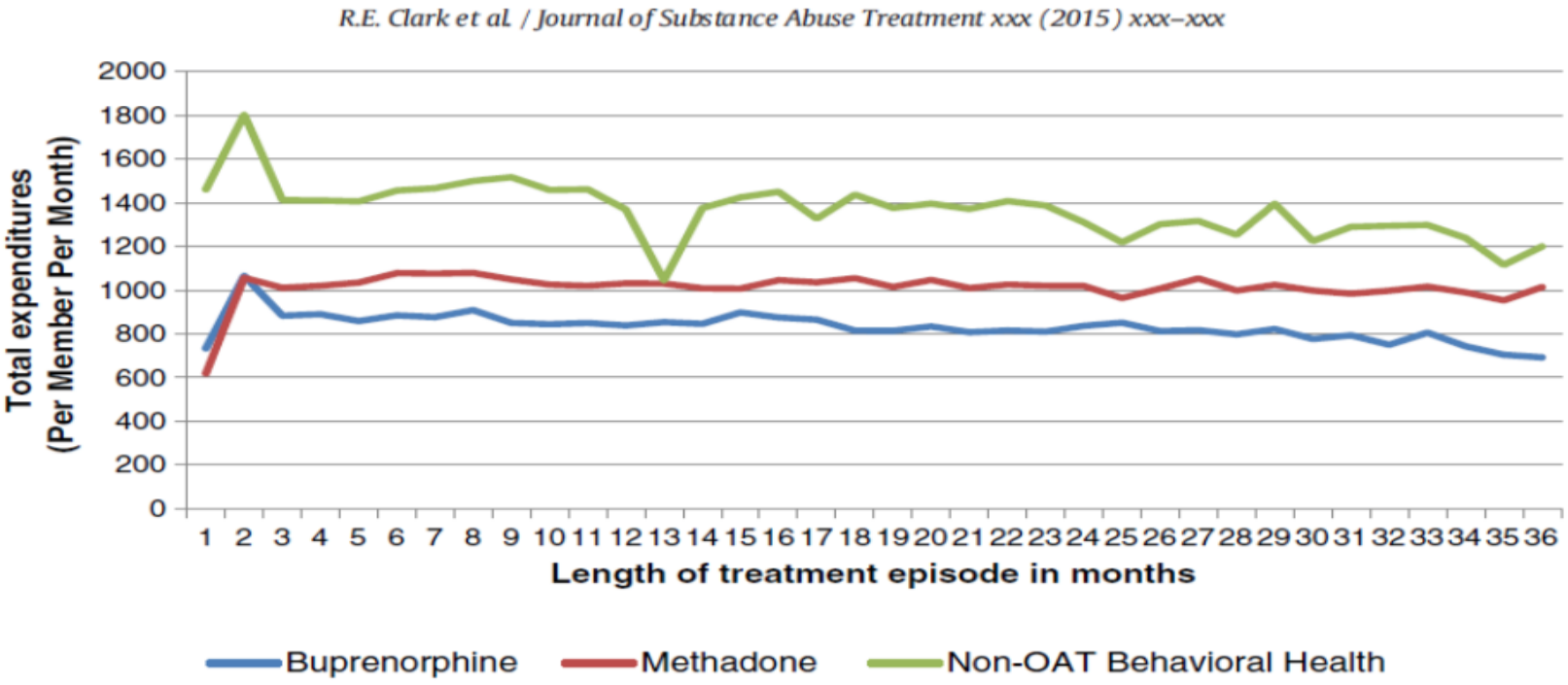
Figure 2 – Comparison of state rates of past-year opioid abuse or dependence and capacity for opioid agonist medication-assisted treatment: United States, 2012.
Note. OA-MAT = opioid agonist medication-assisted treatment.

Jones et. al. American Journal of Public Health, June 11th,2015 Electronic Publication-Peer Reviewed.

Patients Maintained with OAT Demonstrate VASTLY Less Relapse with Opioids. (OAT = Opioid Agonist Treatment)

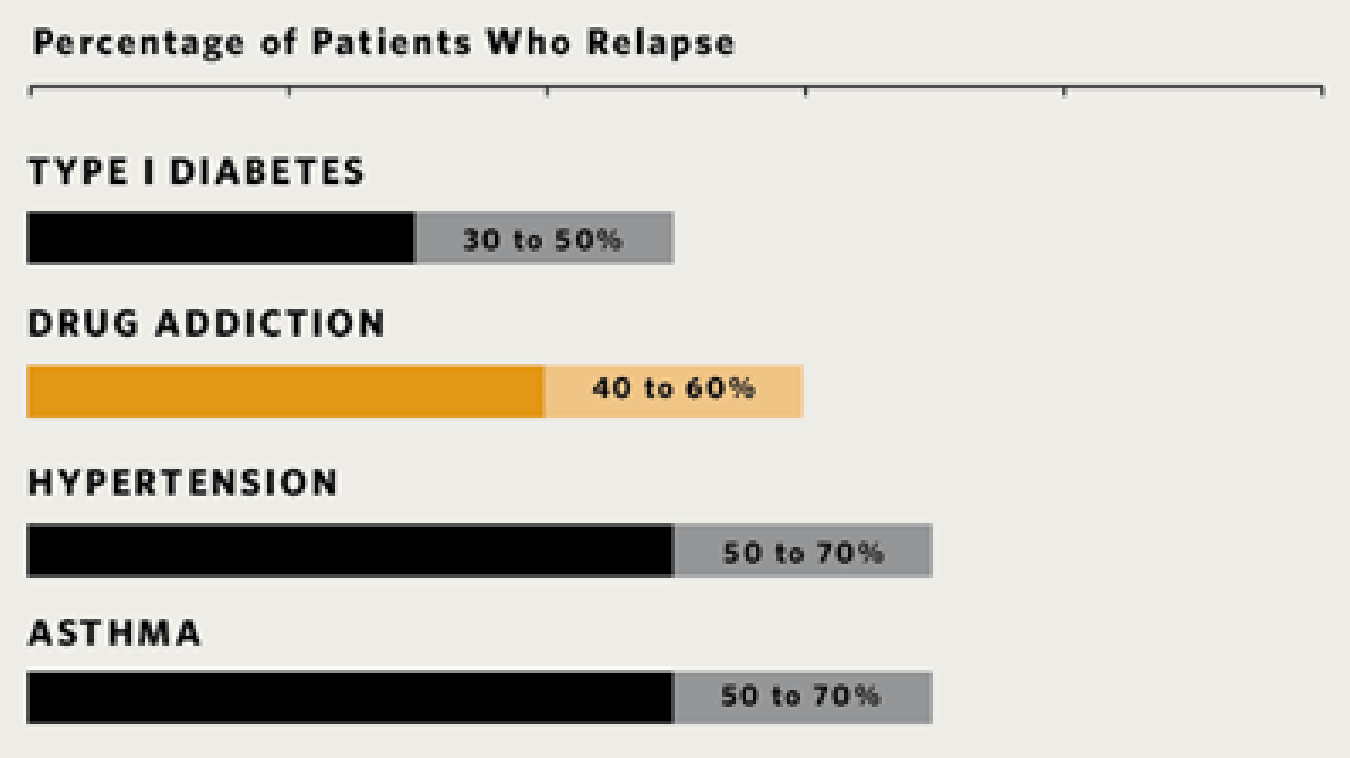


What are the costs of caring for patients? (OAT = Opioid Agonist Treatment)



Substance Use Disorders are Chronic Disease States

Courtesy: Dr. Paul Lewis



Genetic factors	Environ Factors	Chronic	Various Meds
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics

So Where Does This Fit Into My Practice?

- Single Question SBIRT for Alcohol Use
- “How many times in the last year have you had 4 or more (women) or 5 or more drinks (men) in a drinking session?”
  - 80% PPV for the presence of at least a mild use disorder
  - Clinically effective to simply make a recommendation that when a person consumes alcohol that they consider they drink a little less.
  - Effective at reducing risky drinking.

SAMHSA.GOV/SBIRT in Behavioral Healthcare

M.K. 46 y.o. Male General Contractor

- Persistent Hypertension
- Mild Hypertransaminasemia
- Mild Dyslipidemia
- Tobacco ½ ppd, 20-30 pack years.
- Anxious about work, kids, spouse and money

- Referred by spouse for general health and physical examination

M.K. Historical Review

- Drinks alcohol daily
- 1-3 beers (16 oz. steel ice) on weeknights and up to a six-pack on the weekend.
- Rare liquor – reports he used to drink too much before he got married in his late 20's.
- DUI-I history x1
- Gambles $40-60 a week and goes out to a bar on Thursday and Friday nights.
- Drinks more than he intends 2-3 times a month over the past year.

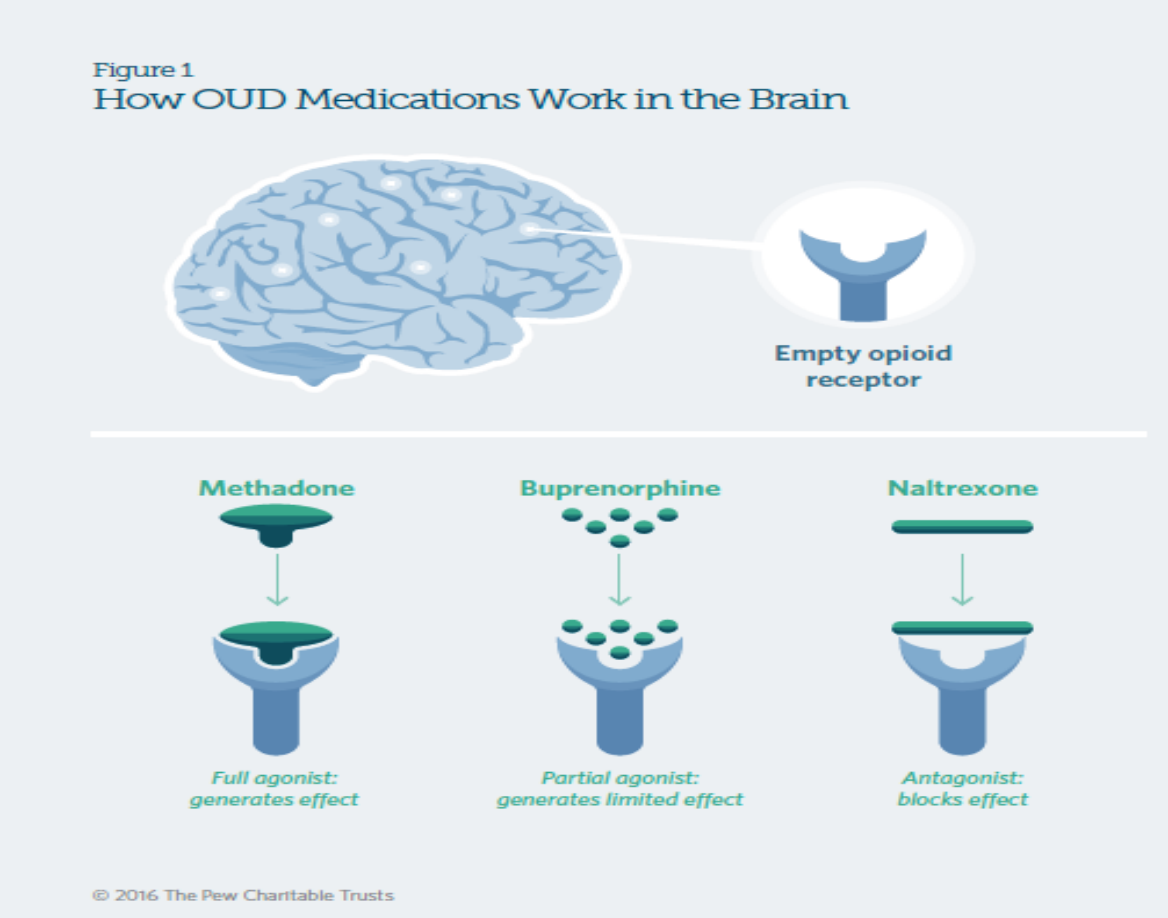
M.K. Interventions

- Have you thought about what drinking less might do for your health?
  - Sleep?
  - Mood?
  - Relationships?
  - Finances?

- How does it feel/what do you think about when considering drinking less?
- Would you be interested in taking a medication that might help you be less interested in alcohol?

What About Opioid Use Disorder?

- How do I care for patients with OUD?
- What type of supports do I need?
- What type of clinical standards mean that my practice is a quality practice?
- How much workload?
- What type of clinical or regulatory or oversight risk?



Courtesy: Dr. Paul Lewis

1. Buprenorphine → Thebaine derived opioid that has been around since the 1960's.

- Very potent 1mg sl = 20-30 MED's.
- VERY high binding affinity to the Mu-receptor, Kappa receptor antagonist.
  - Only Fentanyl and hydromorphone will competitively agonize the mu receptor.
- Long half-life 18-24 hours.
- Very safe → Maximum VO2 suppression.

- Clinical Indication in the sublingual formulation: Opioid Dependency/Opioid Use disorders.
  - Off-label for pain.
  - The transdermal product is on-label for pain.

- What does this medicine do?
  - Stabilizes opioid withdrawal and reduces craving.
  - Blunts opioid response if relapse occurs.
  - Improves retention in addiction treatment, improves abstinence from opioids, reduces cost of the complications from continues opioid use.
  - Compared to methadone, buprenorphine is favorable in terms of reduced neonatal abstinence.

1. In order to treat Opioid Use disorder from an office-based setting you must take an online course, register with SAMHSA and the DEA via your Notification to Treat.

www.samhsa.gov/buprenorphine/DATA2000

2. DATA 2000 was the law that made OBOT possible with Buprenorphine.

3. Waiver Limits- MD, DO, NP or PA with a standard DEA License for Schedule III Prescribing.

30 patients for the first 12 months.

100 patients if you provide a second notification and have the ability to provide treatment resources (groups or therapy) and/or refer patients to those services.

4. Modest acceptance is gaining in the traditional Recovery Community of AA/NA.

5. Unfortunately, buprenorphine mills exist.

Not all cash-practices are buprenorphine mills.

6. Good payor coverage exists in Oregon for generic products (not true in all states).

2. Methadone→ synthetic opioid that was invented in the 1940's.

- Potent 1mg = 7-20 MEDs depending on pharmacogenetics, drug interactions.
- Moderate binding affinity to the Mu-receptor. Other interesting receptor interactions.
- Very Long half-life 24-36 hours.
- Not Safe, the most frequent cause of unintentional overdose in many states.
  - Includes both prescribed methadone, and illicit use of methadone.
  - Very small number of patients represented from MMTP/OTP's.

- Clinical Indications
  - The treatment of chronic nonmalignant pain.
  - The treatment of opioid use disorders/opioid addiction from a Federally Certified dispensing program.

- What does this medicine do?
  - Stabilizes opioid withdrawal and reduces craving.
  - Improves retention in addiction treatment, improves abstinence from opioids, reduces cost of the complications from continues opioid use.
  - Compared to buprenorphine, methadone is similar in terms of the above factors.
  - Anecdotally, some IV opioid patients do better with methadone.
    - Pharmacology, and the structure of the clinic.

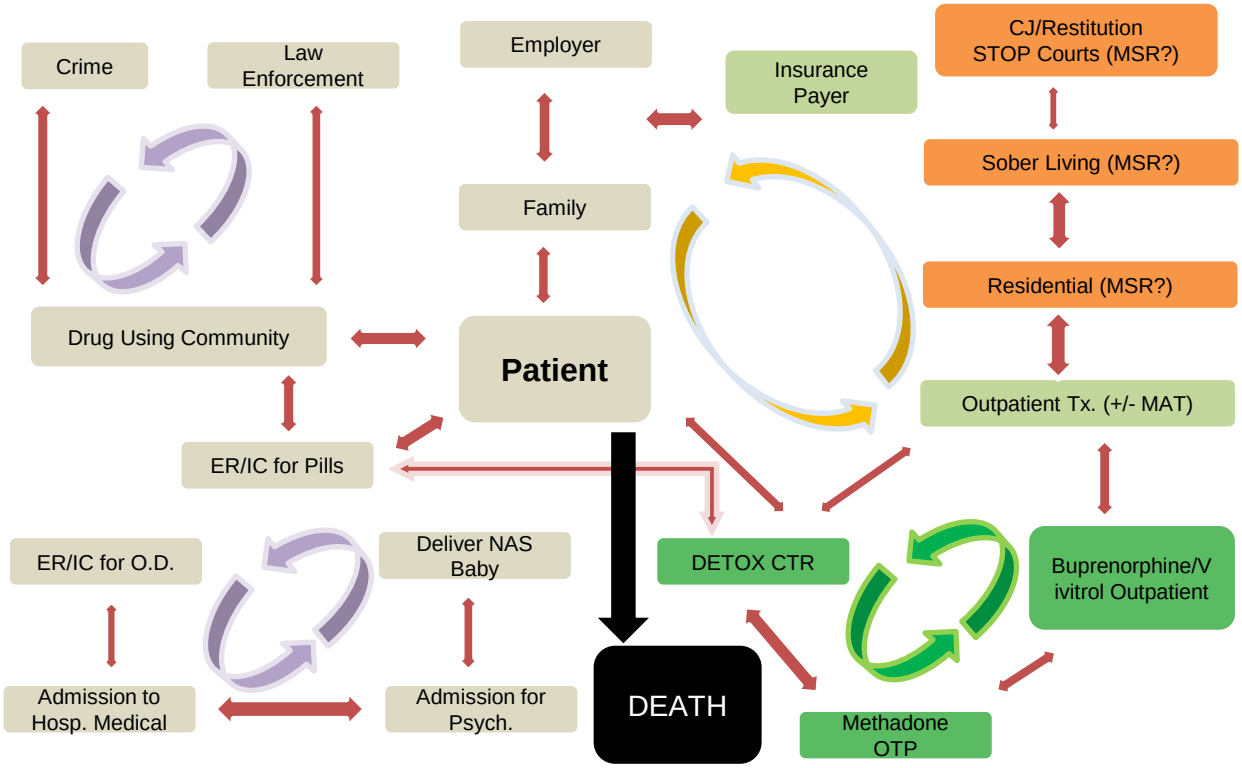
3. Naltrexone (Revia-oral) Vivitrol (injectable depo-naltrexone)

- Potent mu receptor antagonist.
- Short half-life 8-12 hours.
- The drug is safe, but use of this medicine in certain populations increases mortality due to unintentional overdose risk in the setting of reverse tolerance.

- Clinical Indications
  - The treatment of opioid or alcohol addiction.
  - Gambling disorders.
  - CPSS/Fibromyalgia in low doses.

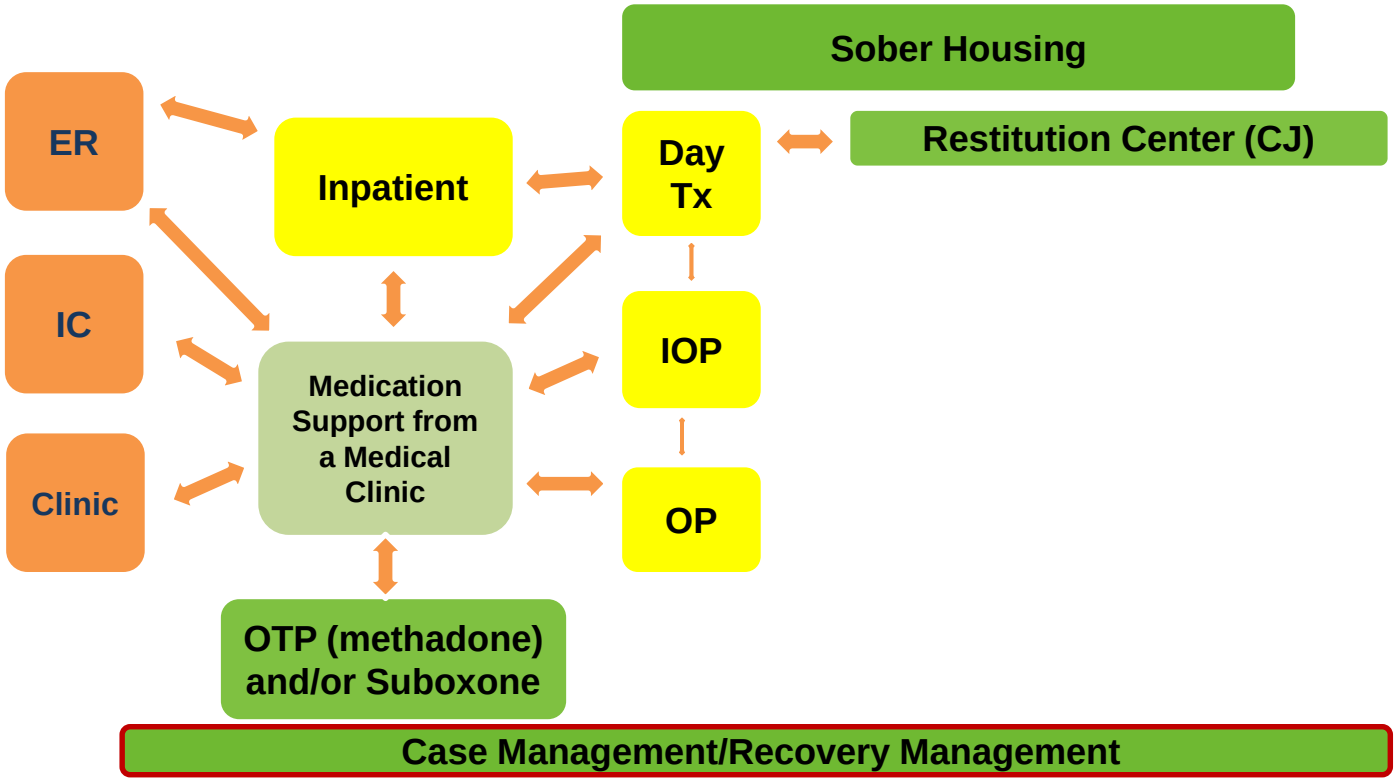
- What does this medicine do?
  - Reduces craving.
  - May induce withdrawal, precipitated withdrawal if administered to a patient who is still physiologically dependent on opioids.
  - The injectable form is a chemical restraint against opioid relapse for between 21-28 days.
    - Increases the post-discharge death rates of IVDA-opioid patients.
  - Nobody with Opioid Use Disorder will take the oral version.
  - PATIENTS NEED TO WEAR A MEDICAL ALERT BRACELET FOR EMS.

Severe SUD Patient Experience



A Fully Integrated Medical Home for Recovery

A FULLY DEVELOPED SYSTEM: Accountable Care Organization



Additional Challenges

- "Low-quality MAT programs" that do not hold patients accountable.
  - Cash for buprenorphine programs
  - No Urine Monitoring
  - Infrequent follow-up visits

- "Rigid/Inaccessible programs" that provide access to medication support in exchange for rigid standards around total abstinence.
  - Stage-of-change mismatch
  - Mandatory Tapering – *Punitive* Tapering
  - Barriers to real-world engagement- like employment
  - Often abandon patients who are not successful
    - Blaming the patient who is "not ready"

Additional Challenges

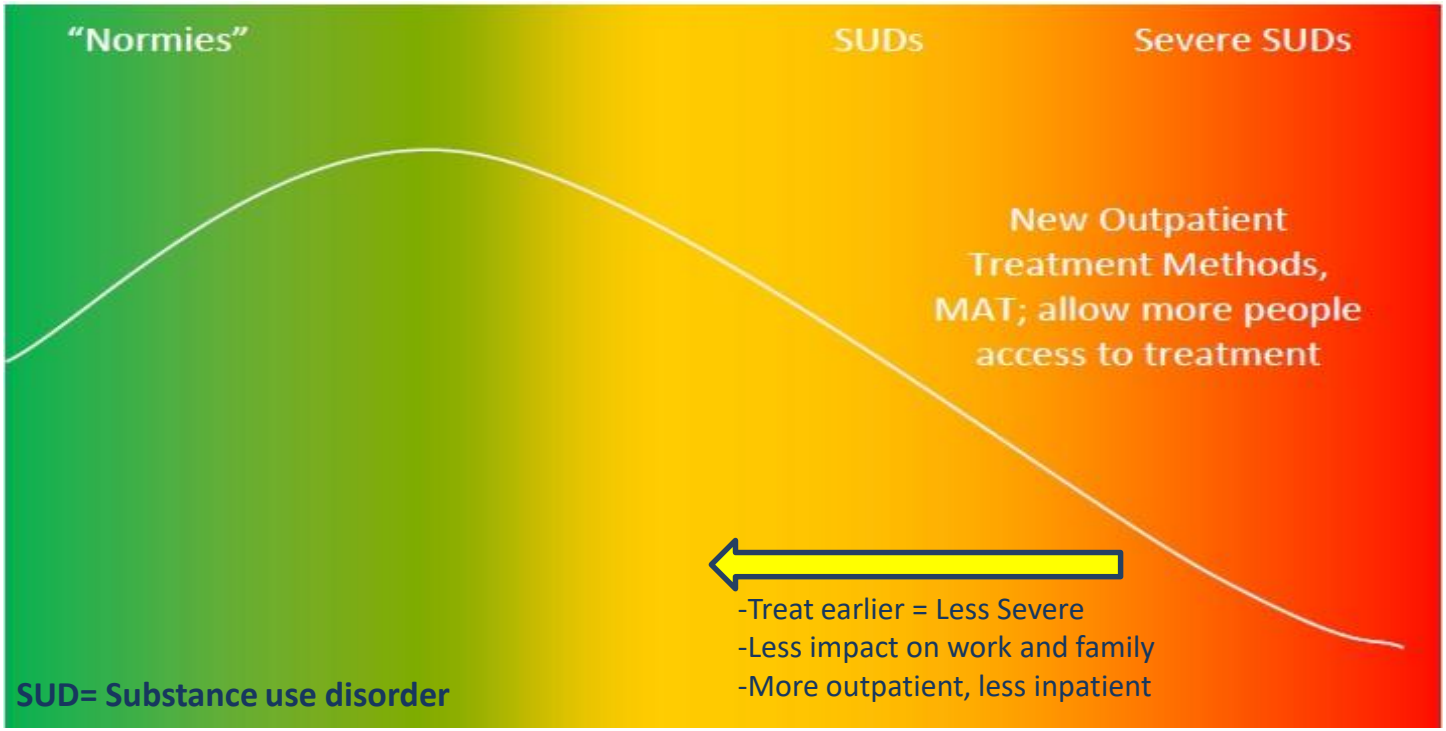
Ok- I am a prescriber but I don't just want to prescribe. The patient needs treatment and…

- I don't know anything about addiction treatment.
- I am willing to do this but I don't want to do it alone.
- When to treat and when to refer?

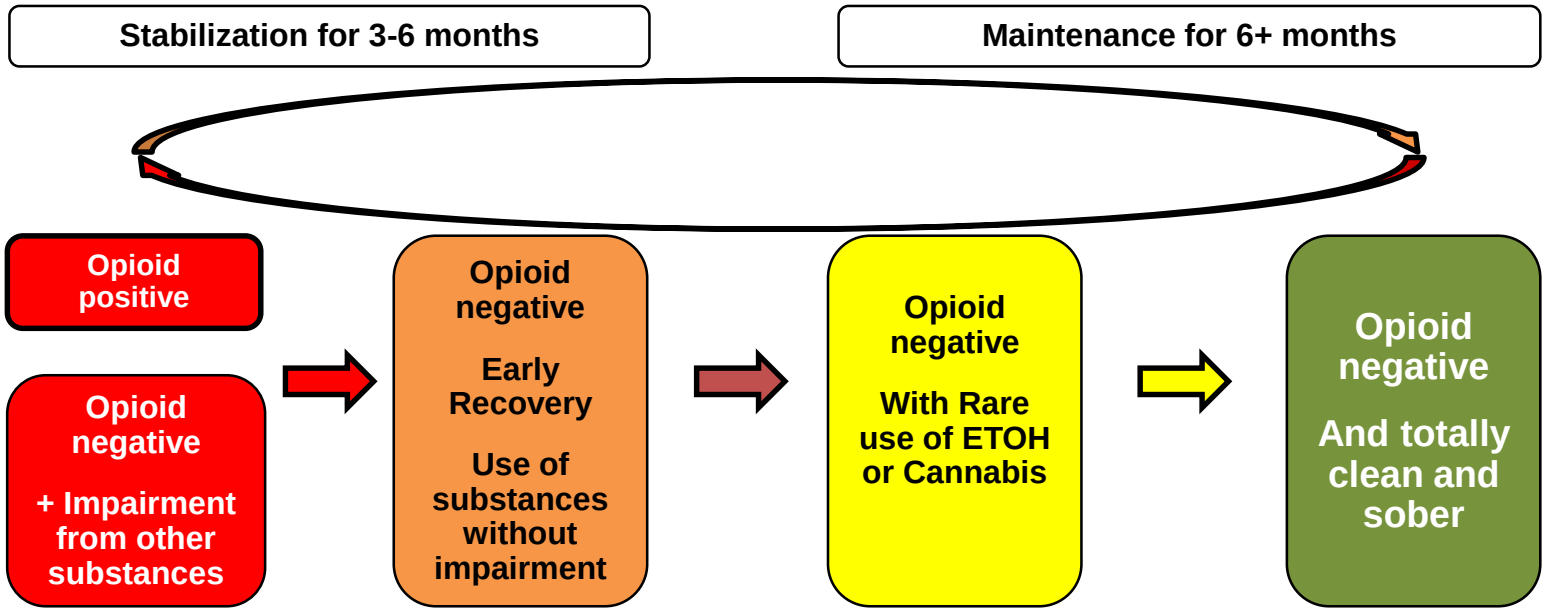
Who to Care for and How to care for Them?

- What segment of the SUD population are you capable of helping?
- Who can help you help?
- Who doesn't want to do anything differently?
- How can you work together to collaboratively care for more patients?

Medication Support Allows More Patients To Enter Treatment:



Defining Treatment Phases/Programming

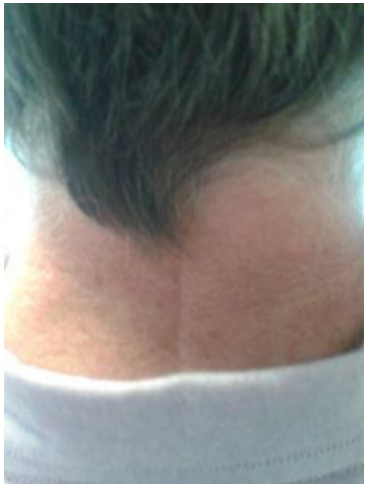


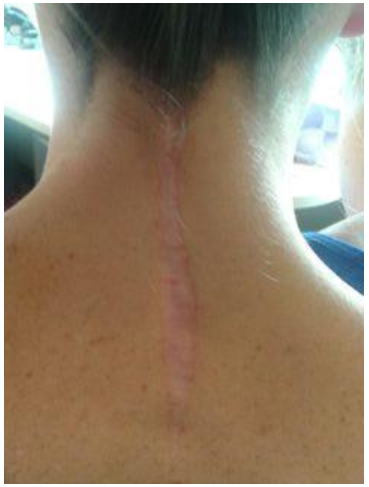
It is critical to consider clinical stage of change and your program's threshold for management of a pre-contemplative patient population. This is particularly important considering cannabis and/or episodic alcohol use.

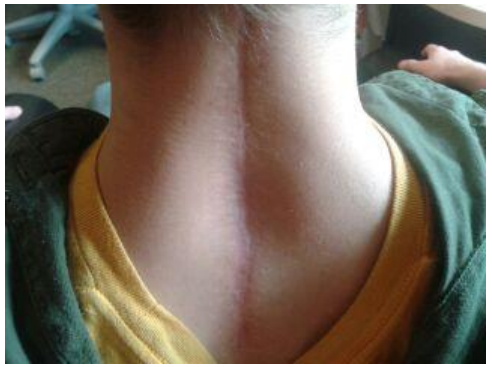
It is ALSO critical to have an expedited pathway for clinical non-responders to Medication Support

What About Patients with Pain Issues and Co-Occurring Addiction?

Which One Has a Substance Use Disorder?



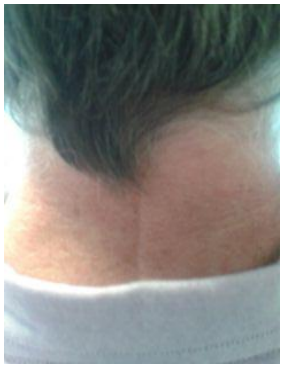




Why does that matter?

Where do issues/challenges overlap?

Who Has a Substance Use Disorder?



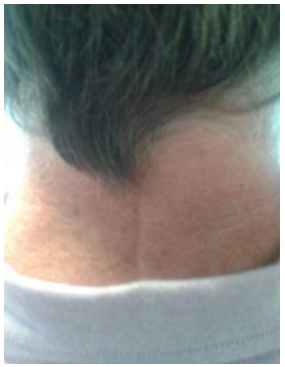
Patient #1
Disabled 58 y.o.
Six Cervical and Lumbar spine surgeries
Asperger's syndrome
Axial spine pain
Cervical and Lumbar Regions with radiculopathy

4 years of opioid acceleration
- 100mcg/h fentanyl q48h
- 15mg oxycodone 1-2 q4h

Insomnia, Flushing, sweating and mood changes.
"I don't like how I feel, I Hurt and my memory is changing."

"I want to try something different."

Who Has a Substance Use Disorder?



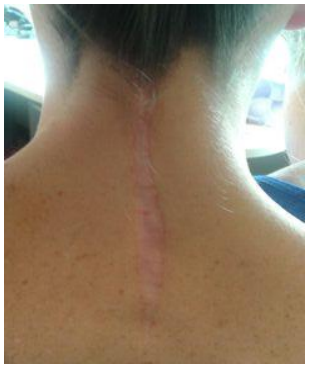
Patient #1

PDMP Report: Compliant
PMD: Compliant
Salience: None
Withdrawal Yes

Diagnoses: Cervical Spondylosis 722.10
Lumbar Spondylosis 752.20
-Phys. Opioid Dependency

Medication Package:
Buprenorphine 4mg sl bid
Hydromorphone 4mg bid prn
Lyrica 100mg bid
Cymbalta 90mg qhs
Tizanidine 4mg qhs prn Topical NSAID prn

Who Has a Substance Use Disorder?



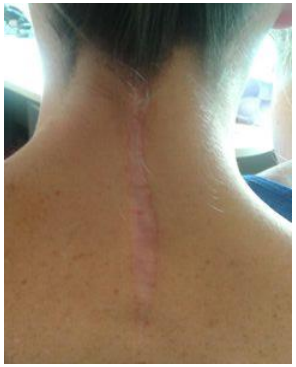
Patient #2
Divorced 37 y.o. 2 kids- Manages Retail Store
L-Spine w a/p Fusion – (total of 3 surgeries)

Previous medication package:
Hydrocodone/APAP 10/325 qid
Cyclobenzaprine 10mg bid

Divorce → Loss of insurance → meds stopped

"I'm sick and by back hurts, I can't stand on my feet all day to go to work" – No insurance

Who Has a Substance Use Disorder?



Patient #3

PDMP Report:	Compliant	
PMD:	Compliant	
Salience:	None	
Withdrawal	Yes	
Diagnoses:	Lumbar Spondylosis	752.20
	-Phys. Opioid Dependency	

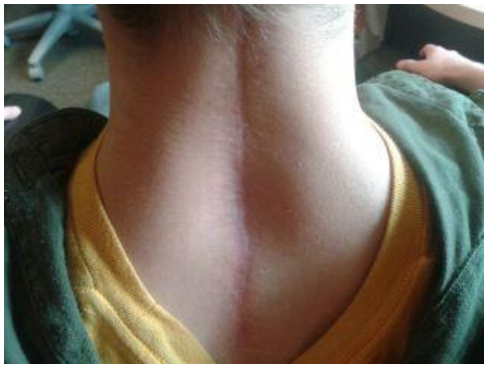
Initial Treatment Plan: Buprenorphine 1mg sl bid
Cyclobenzaprine 10mg bid

New Insurance → Butrans 20mcg/h, Lyrica 100mg bid, Tizanidine 4mg

Arms/Hands go numb → Severe multi-level Cervical DDD/DJD → 4 level C Lam

Post-op → Rotate to pre-op regimen → Insurance change → s.l. bupe+CBP
Key Outcome is FUNCTIONALITY

Who Has a Substance Use Disorder?



Patient #3
College-bound 26 y.o.
C4-T2 bilat laminectomies with
Posterior fusion of all levels

Why?

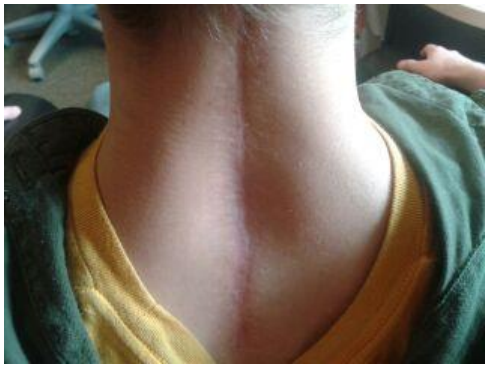
Presented with fever and progressive dyspnea…

6th month of IVDA → C4 Epidural Abscess

4 week hospitalization → 6 week SNF → 10 months of rehabilitation

Spastic quadriplegia – ambulatory, loss of all fine motor
– neurogenic bladder, and L. ext. spasticity

Who Has a Substance Use Disorder?



Patient #3
PDMP Report: Didn't have one
PMD: Didn't have one
Salience: Yes – Opioids, THC, Alcohol
Withdrawal: Yes
Diagnoses: **Substance use disorder-Severe**
-Opioid w physiological dep.
Quadriplegia

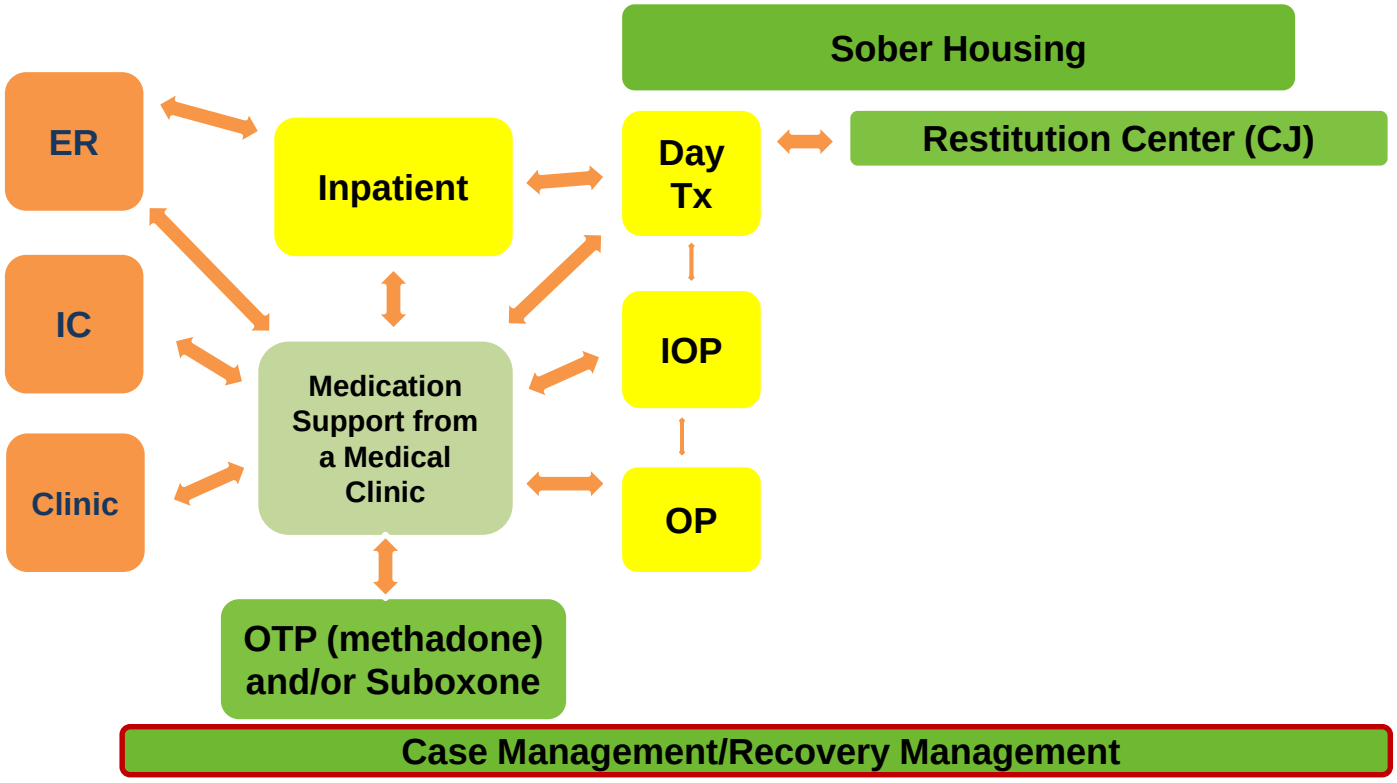
Reports persistent craving for opioids with extremity pain/spasticity
ZERO pain – at his operative site

Referred on Suboxone 24mg, Diazepam 10x3, Baclofen, Vistaril,

Month 29- Suboxone 1mg/day, Clonazepam 0.5mg qhs, escitalopram 20
Baclofen 10mg tid
Stressors → Relapse, Methamphetamines, Psychosis, Back to Treatment and now in Recovery 5 years after initial presentation.

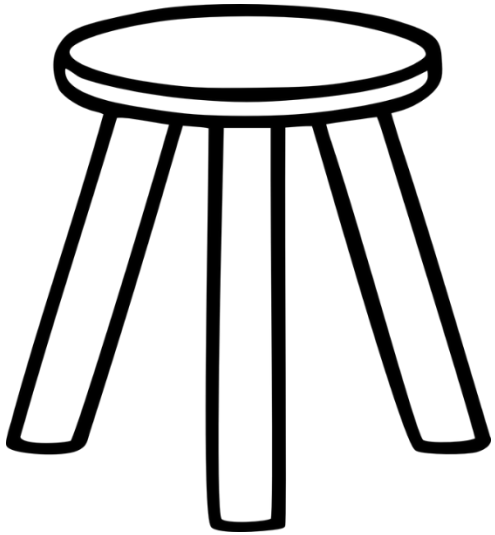
A Fully Integrated Medical Home for Recovery

A FULLY DEVELOPED SYSTEM: Accountable Care Organization



Integrated Components of Successful OUD Treatment

- Medication to break the intoxication-withdrawal-craving cycle
- A Safe Place to Call Home
- Living Wage Employment
- Meaningful Relationships
- Behavioral Therapy



Courtesy: Dr. Paul Lewis

Concluding Thoughts

1. What can you do to provide increased access to evidence-based practices for the treatment of substance use disorders?

2. What are the barriers that exist for you to successfully achieve the above?

3. Who can you ask for support and development of these services within your regional continuum?

Thank You

- Andy Mendenhall M.D.
- Andrew.mendenhall@ccconcern.org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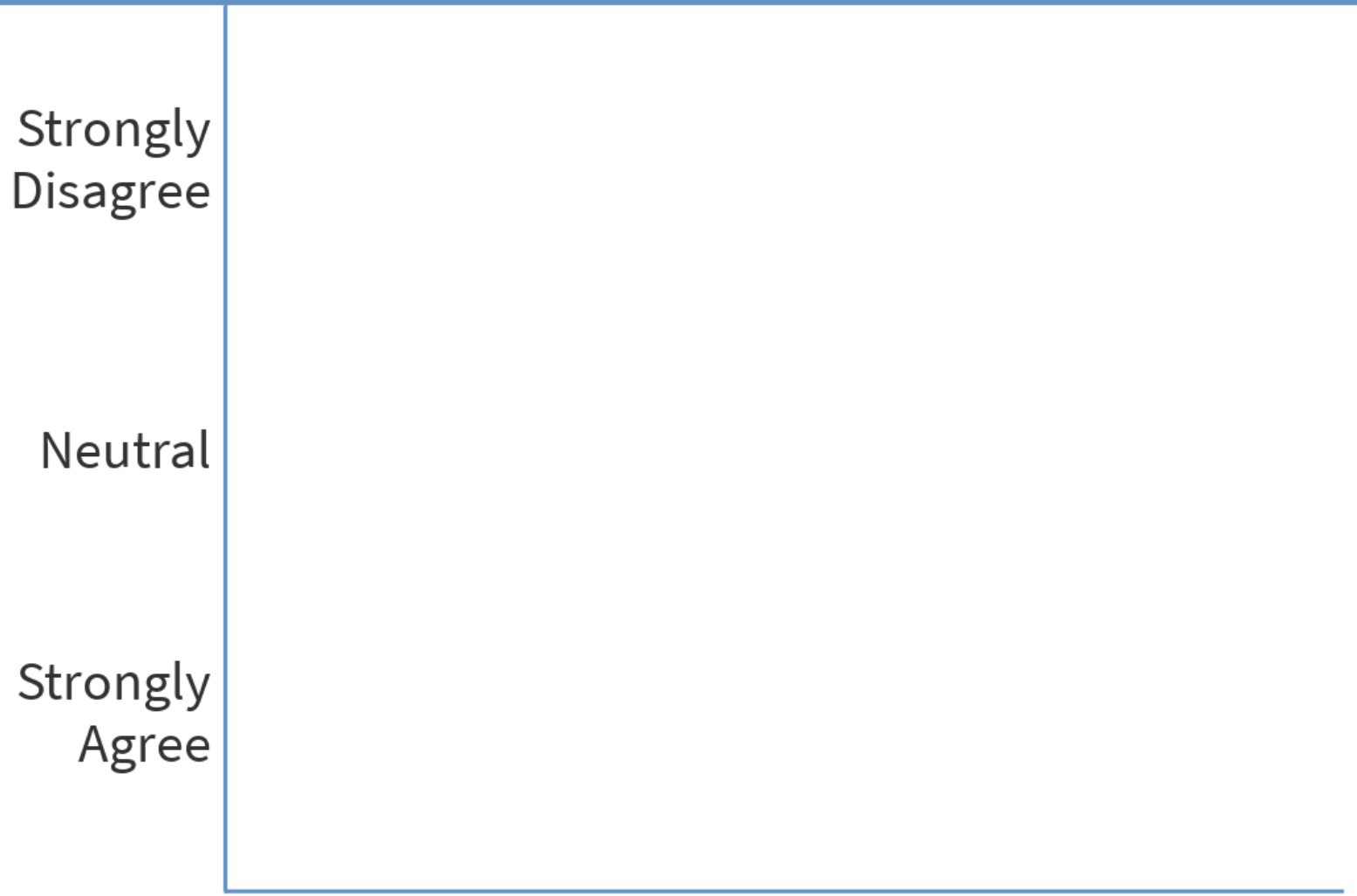
Question #3: My patients on MAT are just not ready to be sober



Medication Supported Recovery For Opioid Use Disorders

Alison Noice, MA, CADC III

Deputy Director, CODA

CODA™ health - recovery - community

CareOregon®

MEDS Ed™

Agenda

- MAT Across Treatment Settings
- Changing Our Expectations and Practices
- Changing Our Environment

Medication Overview

Methadone

- Most common
- Highly regulated
- OTP based

Buprenorphine

- Brand name: Subutex or Suboxone
- Less regulated
- Physician prescribed (MD/DO/NP/PA)

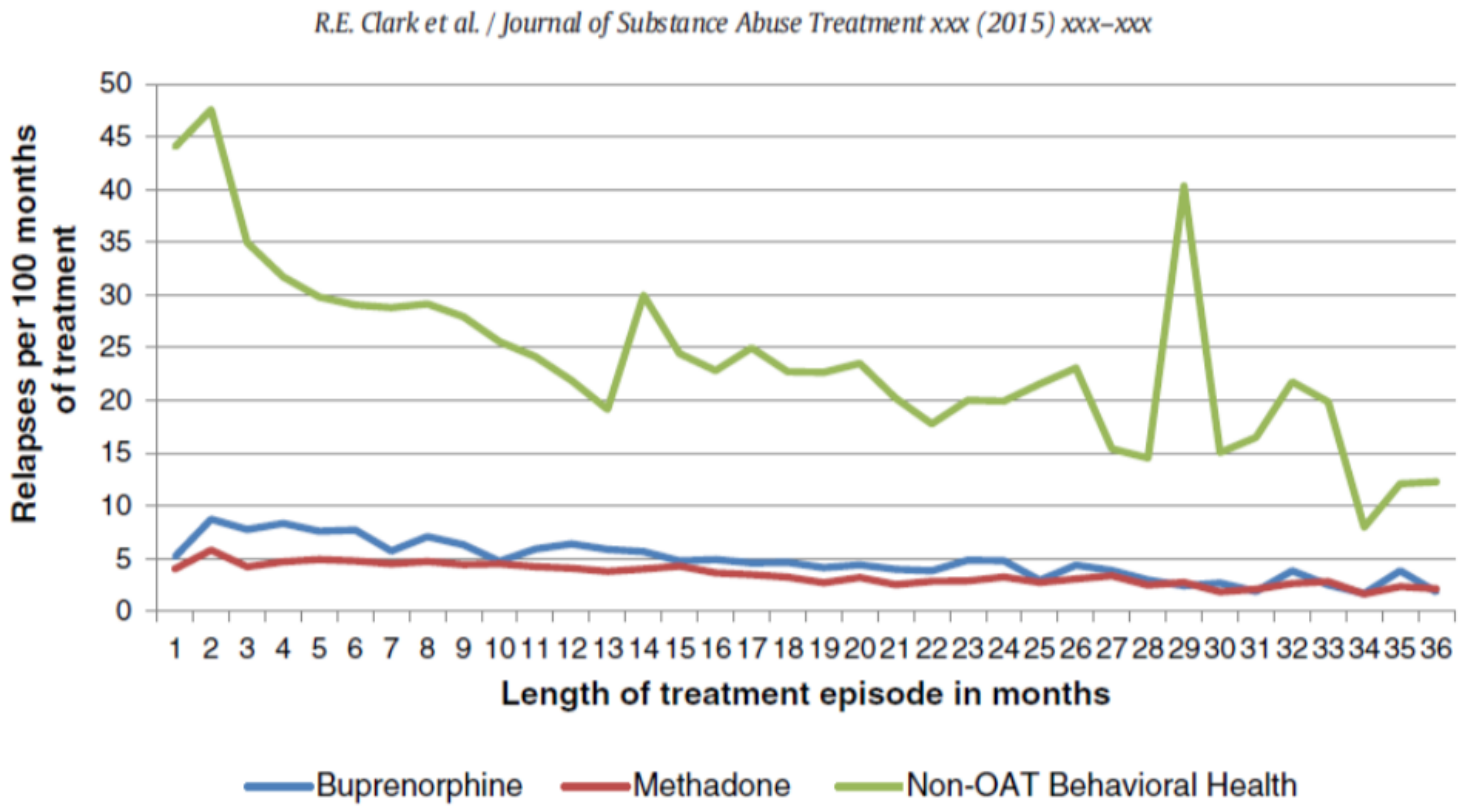
Naltrexone

- Opioid & alcohol
- Once daily tablet
- Vivitrol

	Key Components	Medications Available	Recommended For
Opioid Treatment Program (OTP)	• Daily dispensing of medications by nursing staff • Federal/State/Accrediting requirements of: > Admissions > Take Home dosing > Psychosocial treatment support	• Methadone • Buprenorphine • Naltrexone	• Needing daily contact or structure • Pregnant • Long history of opioid use disorder • Primary intravenous use • Homeless with little/no recovery support
Office-Based Opioid Treatment (OBOT)	• Physician-driven prescriptions and refills • Minimal regulation of associated behavioral health treatments • Lesser capacity for monitoring prescription adherence	• Buprenorphine • Naltrexone	• Motivated for treatment • Peer or Family recovery support • Shorter duration of opioid use disorder

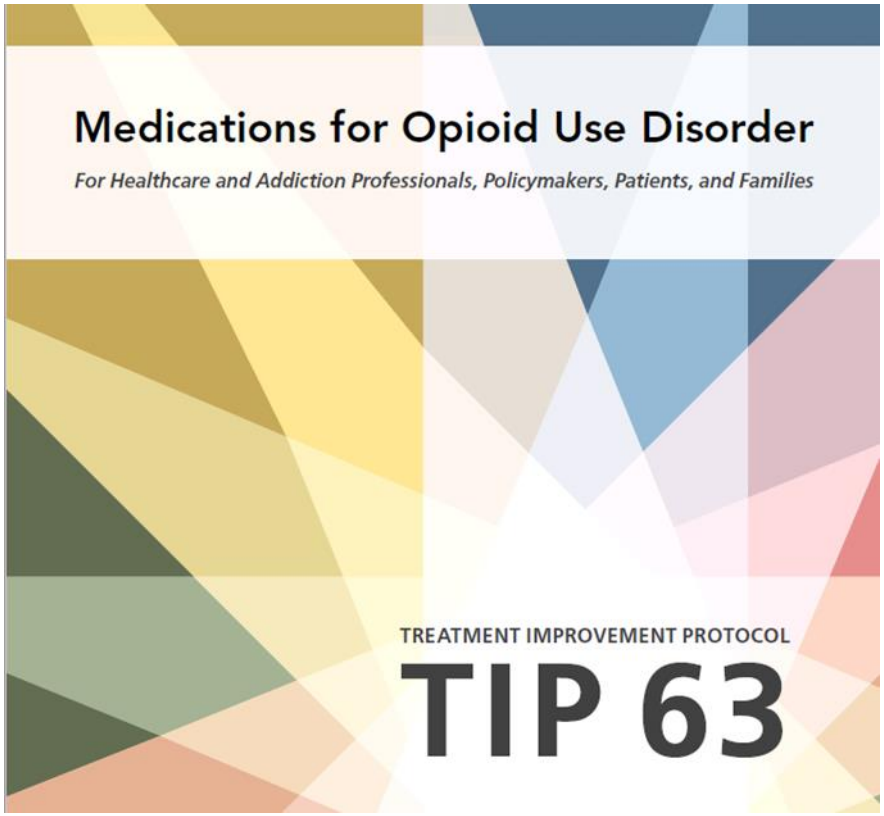
Question #4: When I think about adding MAT to my clinic, this is how I feel (text any word or phrase)

When Do We Recommend Medications?

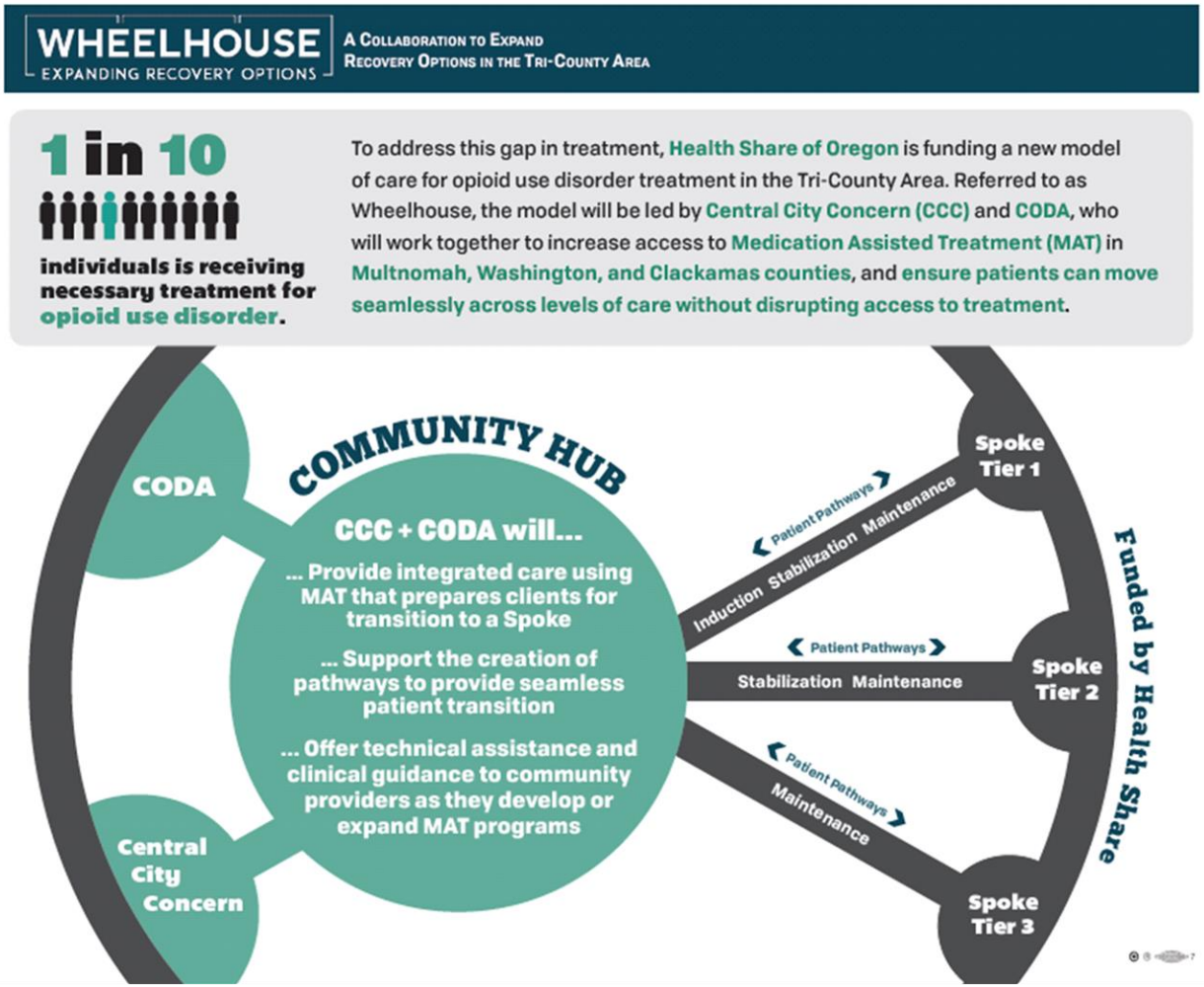


The Changing Landscape: Beyond “Fail First”

TIP Expert Panel: All patients with OUD should be informed about risks/benefits of medications



The Changing Landscape: Expanding MAT in Behavioral Health



The Changing Landscape: Expanding MAT in Behavioral Health

Phase One: Understanding the Environment and Generating Commitment October 2016 – March 2017	Phase Two: Resourcing the Community April 2017 – March 2018	Phase Three: Incentivizing MAT Continuity April 2018 – September20 18
• Environmental scan and resource assessment • Conceptualization of inter-agency, community Hub • Definition of participation requirements and program structure • Initial outreach to all Tri-County SUDS providers • Create logic model/conceptual framework • Determine program reporting: outcomes and evaluation plan (short-term outputs and long-term, global outcomes) • Program introduction/Spoke recruitment (Phase 1)	• Continued Spoke recruitment (Phase 2) • Create weighted attainment funding model and start distributing funds • Community DATA Waiver training • MOU's/inter-agency agreements establish membership in WH network • Model development: learning collaborative strategy as method for information dissemination and network development • Individualized technical assistance (TA) to Spokes • Hub shadowing opportunities • Integrate relevant services and establish pathways for patients in the community Hub • Partnership with CareOregon to assist with Learning Collaboratives	• Maintain network development and reduce practice variation via learning collaboratives and common data gathering • Pilot MAT programs • Potential for inter-agency ROI/data-sharing • Continued funding contingent on attainment benchmarks (Health Share presentation) • Propose/develop sustainable funding model • Continue spread of Hub and Spoke model, with potential for community expansion • Initial evaluation

The Changing Landscape: Regulatory Shifts

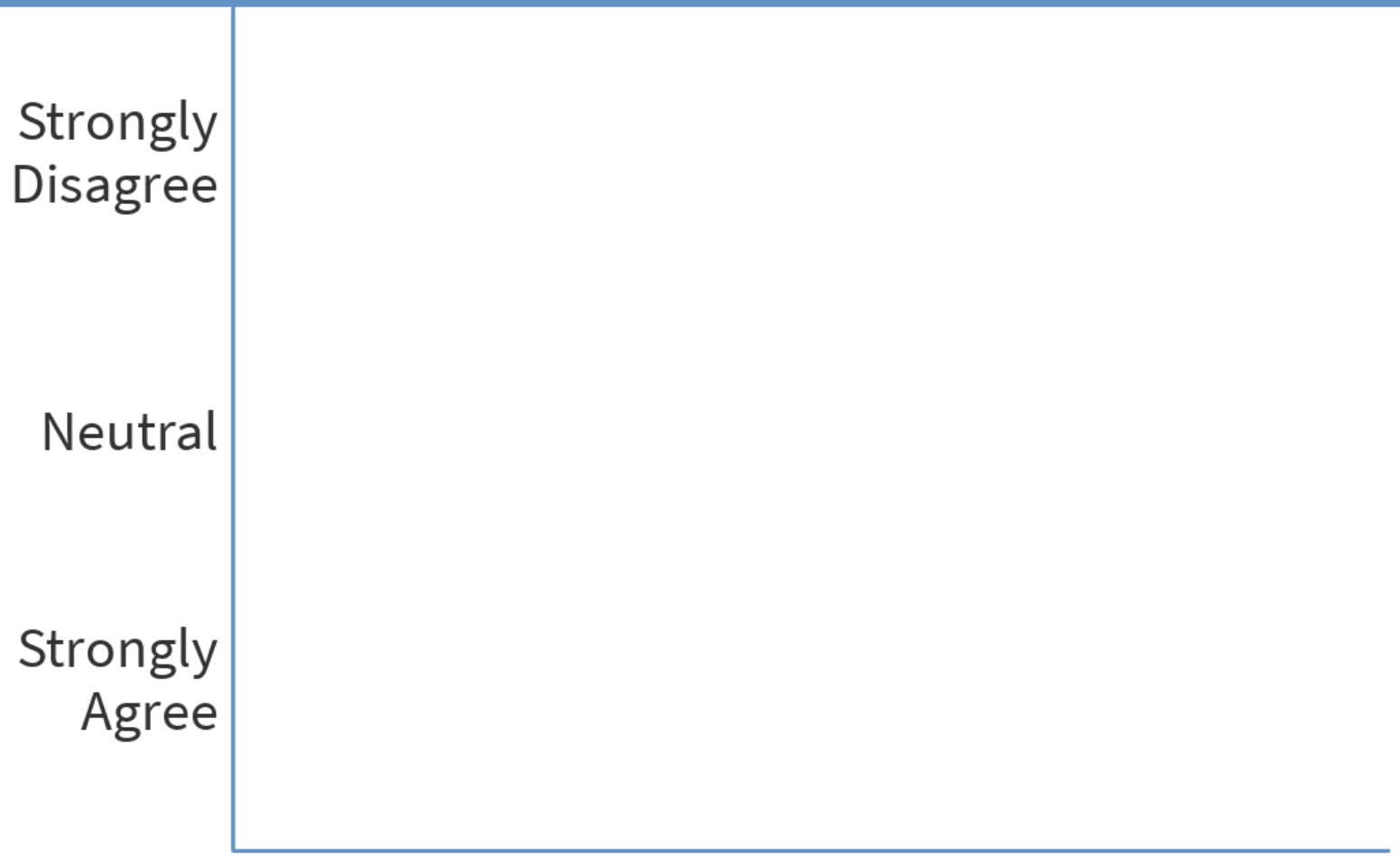
- Oregon Administrative Rules (OARs)
  - Prohibit policies that require titration as condition of entering or continuing treatment
  - Allow continuation of MAT based on patient choice and provider recommendation
  - Prohibit transfer of patients based on desire to initiate or continue medication

- Health Evidence Review Commission (HERC)
  - Programs must inform, offer access to, and support MAT (*including at least one agonist therapy*)
  - Detoxification alone is likely ineffective for long-term benefit

How Can You Help?

- Changing a “Fail First” mentality
- Medication ≠ Motivation
- Patient preference isn’t suspect
- Accepting what the science (and our patients) tell us
- Look for partners and ask questions!

Question #5: Methadone is for people who just can't do it any other way



On the Front Lines

Amy Jo Cook
Dan Hall
Community Paramedics
Clackamas Fire District #1

NBC News with Lester Holt

Project Hope

Recovery Supports for Overdose Survivors

Clackamas Fire District #1, AMR Clackamas County, Clackamas County Public Health

CLACKAMAS FIRE DISTRICT #1

AMR

Health, Housing & Human Services
CLACKAMAS COUNTY

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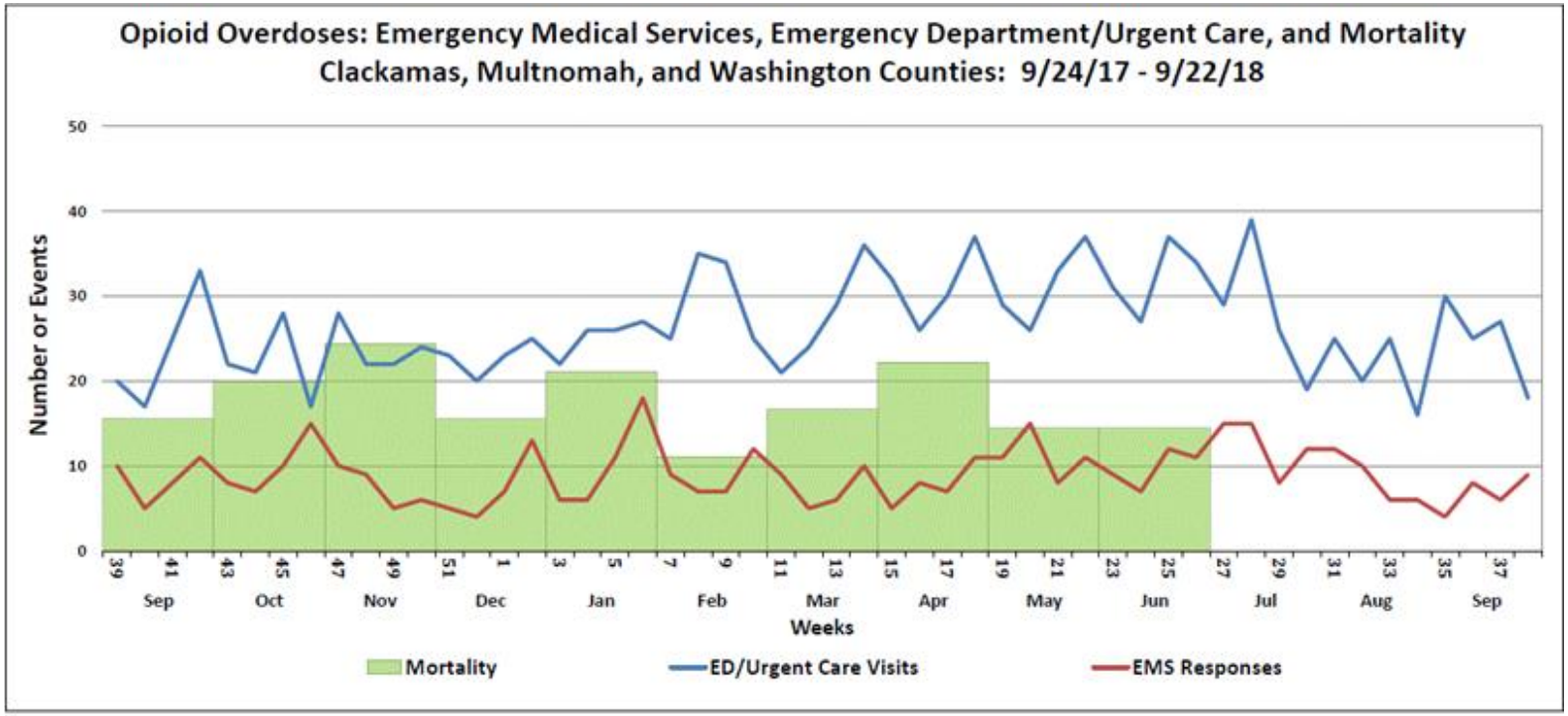
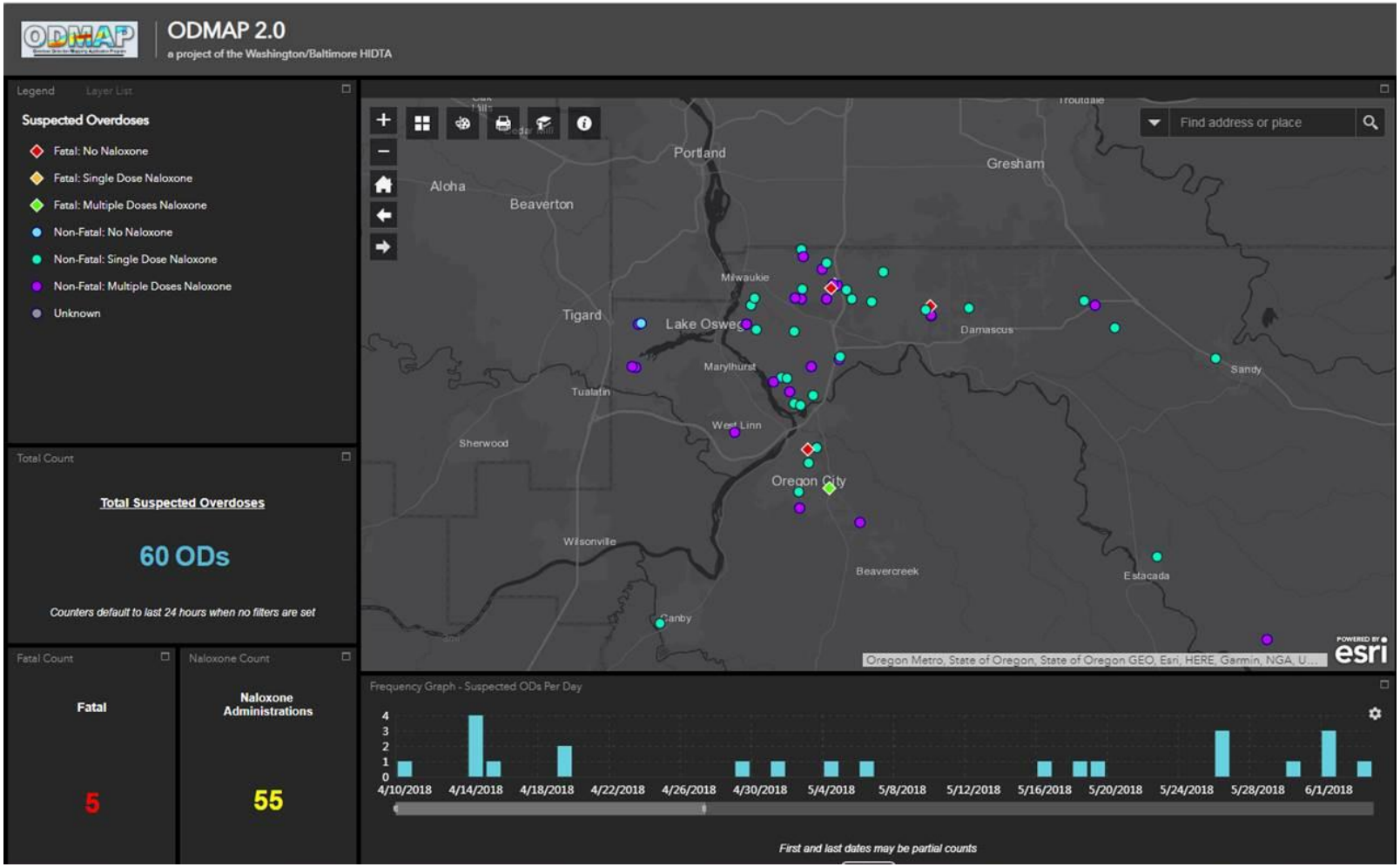
Overdose Surveillance – Tri-County



Overdose Surveillance in Clackamas County



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Resuscitate Then Navigate

- Although naloxone is an effective agent for reversing the physiological effects, it has no long-term impact on the patient's desire to use opioids again.
- EMS agencies play a critical role in their communities' response to the opioid epidemic and its time we switch our approach by transitioning to a recovery-oriented system of care.
- This includes expanding the focus to include opportunities to help the patient by providing a warm handoff from the 9-1-1 response to the systems available to help with recovery.

A recovery-oriented approach

- Through an innovative pilot project, Clackamas County agencies are partnering to build a more comprehensive response model in our county.
- Follow-up by a Community Paramedic in the home setting shortly after the overdose occurs.
- After an assessment is completed, patients will be navigated to treatment and recovery services in the community (inpatient, outpatient and community-based services) with a longer-term plan established.
- MAT is a tool in our toolbox that has been effective for folks we engage with.

Goals of the project:

- Reduce the number of people who overdose on opioids, thereby decreasing future 911 calls and hospital readmissions.
- Improve the quality of life for patients with substance use disorders.
- Bridge gaps in care by connecting vulnerable patients to treatment and other critical resources.


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Successful Implementation

Anthony Cheng, MD
OHSU South Waterfront
Stacie Andoniadis, CareOregon,
Primary Care Innovations Specialist

Why I began to treat and implement treatment within Primary Care

- Saw value in treating my patients holistically
  - Created trust and safety for patients
  - Appropriate patients were able to seek treatment in one place
- It wasn't scary – inductions and patient care was easier than I thought

- Reduce some barriers my patients were experiencing
- Found value in teaching fellow clinicians, residents
- Doing my part related to opioid epidemic and complex pain

What we did: Over the course of several years

- Created workflows and policies
  - Standard timing between intake and prescribing
  - Utilizing EPIC pools and tools for population patient mgt, DEA requirements
- Utilized Team-Based Care and leveraged current staff interested and abilities
  - BH team complete intakes saw pt before or after PCP for warm hand off/ brief check-in or referral to SBH
  - Allocated staff time for patient access specialists to complete prior auths (as needed) ROI's, requests for records
- Implemented multi-disciplinary team meetings (PCP, support staff, BH team) to review pt care, complex patients, best practices and workflows
- Created and utilized MAT SmartSet to assist providers with safe and efficient patient care
  - Labs
  - COWS scores
  - Specialty referrals
  - Resources for tapers, anxiety, sleep

What we suggest when thinking about implementing in primary care

- Have a clinical, operational and support staff champion team
- Leadership buy-in is key: Medical director and clinical manager support
- Address provider and staff educational and bias barriers
  - Fear of patient population
  - Fear of inductions- its not that bad
- Decide which tools, policies, workflow align with your clinic's staff and population prior to prescribing
  - What basic safety pieces need to be addressed?
- Standardize what you can, and leave room for Provider discretion

Panel Q&A

CareOregon Metro strategy and next steps for MAT, opioids and SUD

Tanya Kapka, MD, MPH
Metro Medical Director, CareOregon
Network and Clinical Support

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CareOregon Metro: Intentionally Aligning Regional Strategies, Priorities and the Quadruple Aim

- **Enhancing Patient Experience**: **payment models** supporting team-based care, BH integration, and health care transformation
- **Improving Population Health**: Focusing on ED and hospital **transitions**, **population segmentation** models for targeted interventions, PreManage and enhanced **care coordination**
- **Reducing Costs**: specialty **behavioral health coordination**, **Trauma Informed Care** spread, **reducing waste** to allow funding for higher priorities, enhancing **health care transformation**
- **Reducing Provider Burnout**: optimizing **team-based care**, staff working to **top of license**, support for ongoing **education, training and specialty support**, coordination for **social needs**.

MAT: An Intervention to Help Meet the Quadruple Aim!

1) Enhance Patient Experience

- Helps manage chronic SUD so people can improve function and more effectively engage in their health care goals

2) Improve Population Health

- Improves outcomes (death, disability, and social dysfunction) for those suffering from SUD's complex social and neurological interplay

3) Reduce Costs

- MAT is associated with reduction in ED and hospital utilization, allowing funds to be redirected towards care coordination, peers, and other BH and social determinants support

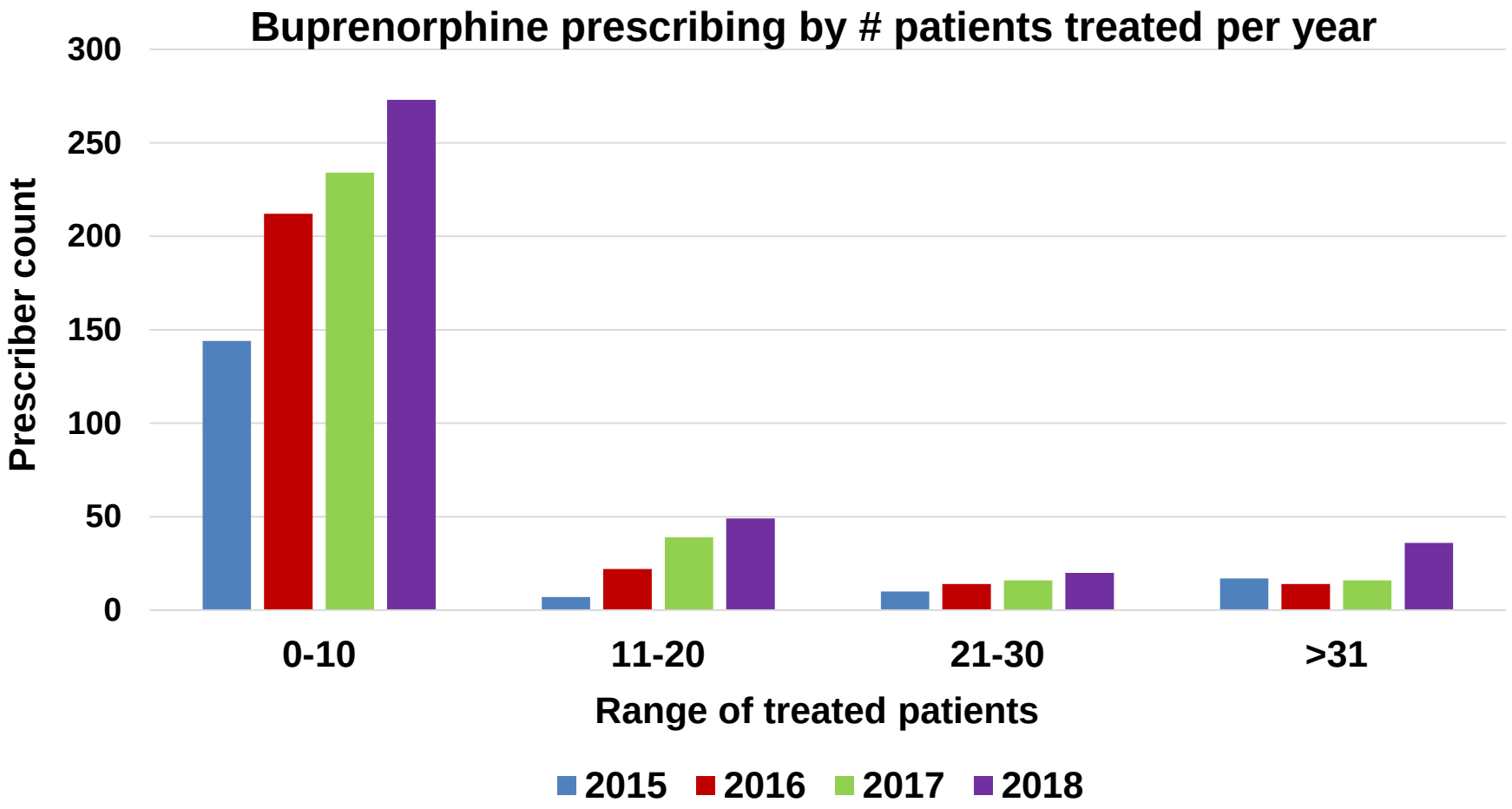
4) Reduce Provider Burnout

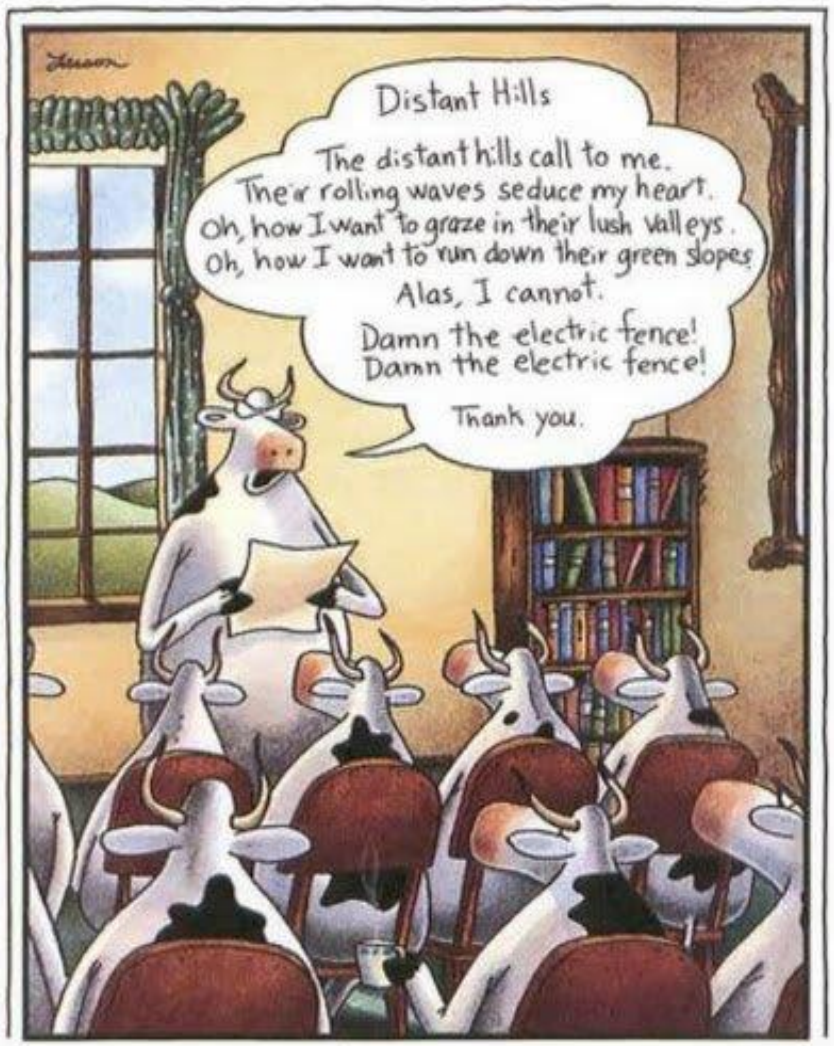
- MAT in appropriate environment (primary care or specialty behavioral health) for appropriate patients can allow for better relationships with the health care system and providers via trauma informed care and improved outcomes

"If we lose love and self respect for each other, this is how we finally die"
-Maya Angelou

Current Happenings: Collaboration and Alignment: Primary Care, MAT, SUD, BHI

- Ongoing support for health care transformation, team-based care, integrated behavioral health in clinics
- Implementation guide to aid operationalizing MAT in Primary Care in development
- EMR tools development support for MAT
- Oregon ECHO Network: upcoming session on MAT implementation
- Collaboration and funding support from CareOregon and Health Share for hospital programs, clinic based interventions, and specialty BH bridge clinics and care coordination models/staffing
- Payment model new steps towards PH/BH alignment in 2019
- CareOregon Social Workers at Unity PES now connected to Hooper and DePaul, to support referral pathways
- Opioids: quarterly review with CO network clinics, consistent focus on highest risk targets: high MED and benzo co-prescribing, steps to limit new acute prescribing


Buprenorphine prescribing by # patients treated per year
300
250
200
150
100
50
0
Prescriber count
0-10
11-20
21-30
>31
Range of treated patients
2015
2016
2017
2018


Distant Hills
The distant hills call to me.
Their rolling waves seduce my heart.
Oh, how I want to graze in their lush valleys.
Oh, how I want to run down their green slopes.
Alas, I cannot.
Damn the electric fence!
Damn the electric fence!
Thank you.

Cow poetry

Next Steps: Supporting MAT for Primary Care Providers and Clinics...

I want to Prescribe Medication Assisted Treatment and need technical assistance getting started

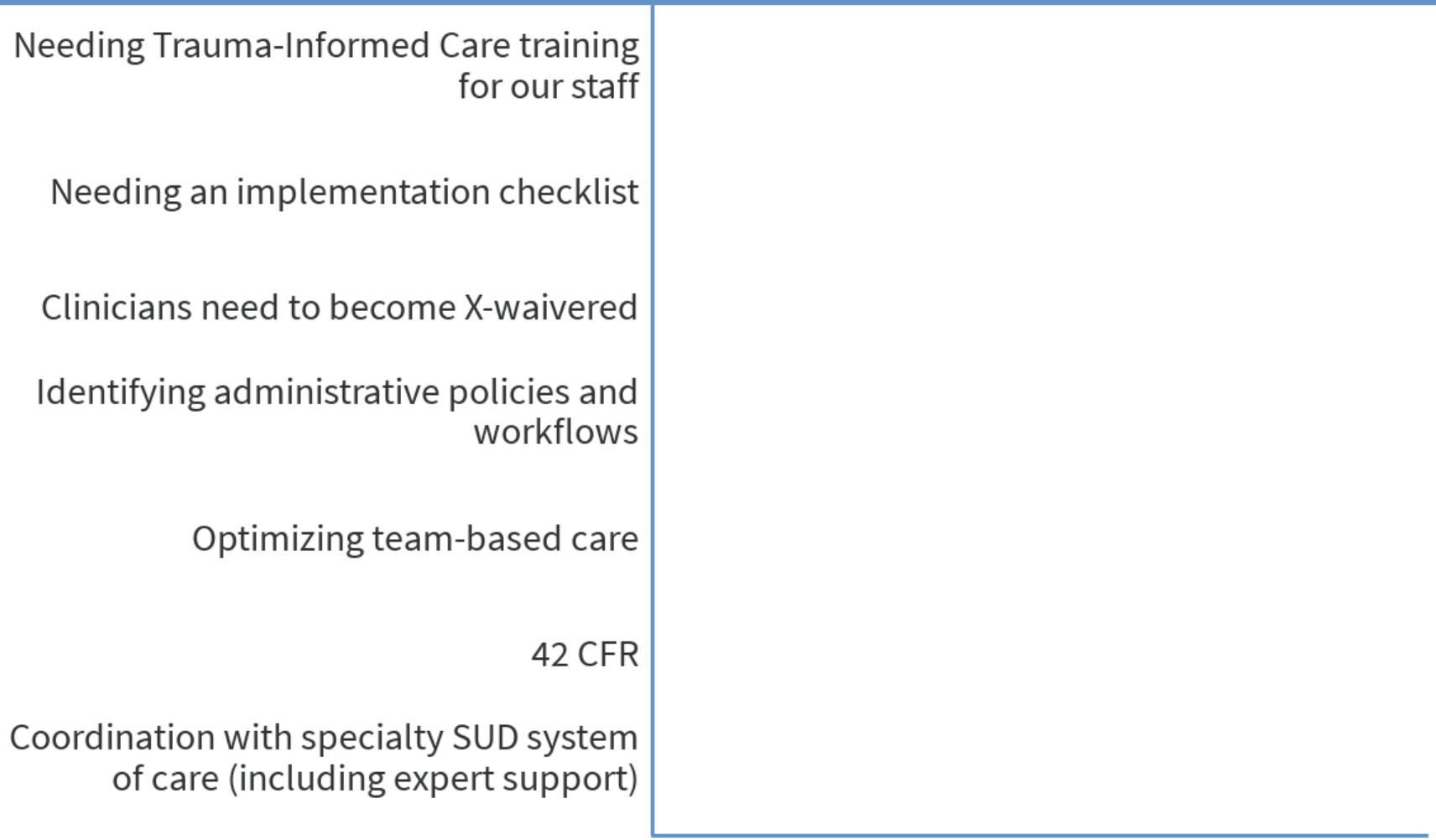
I am unsure if I want to prescribe Medication Assisted Treatment and need more information to decide

I want to better understand who to refer my patients to for evaluation and possibly induction

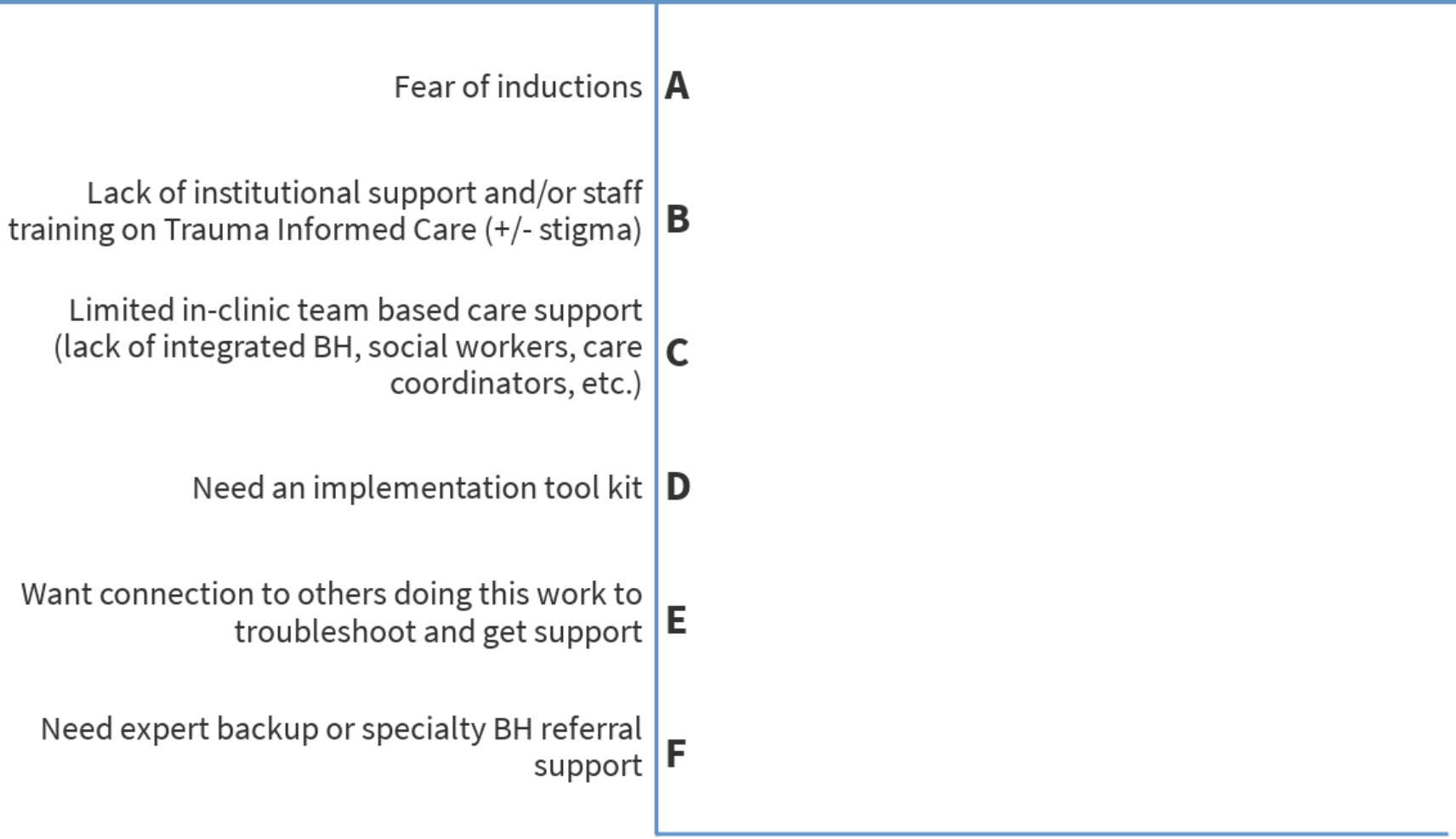
I/my clinic is currently prescribing and believe we need additional staffing or to upscale current staff to make it work

We are currently providing MAT and things are going pretty well

I want to Prescribe Medication Assisted Treatment and need Technical Assistance getting started. Common Technical Assistance needs could be:



I am unsure if I want to prescribe Medication Assisted Treatment and need more information to decide. Common concerns/barriers could include:



I want to better understand who to refer my patients to for evaluation and possibly induction

- Local organizations are available to partner
- The behavioral health system has a relatively new program in the metro area (Wheelhouse "hub and spoke model") that aims to be a coordinated system of care for evidence-based SUD treatment through specialty BH
- Goal for population segmentation for referrals into Specialty Behavioral Health or Primary Care based upon patient need, with standard handoffs between the two as appropriate.

I/my clinic is currently prescribing and feel we could help support a peer primary care provider

Are you currently prescribing and feel you could help support a peer primary care provider?

If yes, we would love to hear from you!

Name

Clinic

Current # of MAT patients

Email questions and technical assistance requests to **Stacie Andionadis**, CareOregon Metro Primary Care Innovation Specialist Andoniadiss@careoregon.org

Selected MAT implementation resources:

Oregon Pain Guidance:
https://www.oregonpainguidance.org/

American Osteopathic Academy of Addiction Medicine trainings:
https://education.aoaam.org/

American Society of Addiction Medicine (SAMSHA):
https://www.asam.org/education/resources/pcss-mat

Provider Clinical Support System Clinical Coaching:
https://pcssnow.org/mentoring/

ASAM/PCSS Clinical Resources:
https://pcssnow.org/resources/resource-category/clinical-resources/

“Quality means doing it right when no one is looking.”
– Henry Ford (attributed)

Additional Resources for Primary Care:

Trauma informed Oregon
https://traumainformedoregon.org/

Oregon Health Leadership Council HIT Commons (EDIE/PreManage)
http://www.orhealthleadershipcouncil.org/hit-commons/

Choosing Wisely
http://www.choosingwisely.org/

OPCA
https://www.orpca.org/

JAMA article on health care waste in Washington state:
https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2695505

Institute for Healthcare Improvement
http://www.ihi.org/resources/Pages/Publications/10-IHI-Innovations-to-Improve-Health-and-Health-Care.aspx

“Although the world is full of suffering, it is also full of the overcoming of it.”
– Helen Keller

Next Session:

COPD

January, 2019

Thank you!