Treating Opioid Use Disorder with Evidence Based Treatment

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Section 35 Commission

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Disclosures

- I have no personal or financial conflicts of interest to disclose

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A WORD ABOUT DETOXIFICATION TREATMENT FOR OUD:

- Detox = short course of treatment (+/- 5 days) to manage acute intoxication and withdrawal
- Detox is not recommended as stand-alone treatment
  - Relapse rate >90%
  - Increased rates of overdose due to decreased tolerance
  - Protracted abstinence syndrome

(ASAM, 2015)

What Is Evidence-Based Care for Opioid Use Disorder?

- Methadone: full opioid agonist
  - Available only in specially licensed opioid treatment programs
- Buprenorphine: partial opioid agonist
  - Commonly combined with naloxone, an opioid antagonist (to deter injection)
  - Use in office-based setting requires Drug Enforcement Administration waiver
    - 8-hour training for physicians (MDs) per the Drug Addiction Treatment Act of 2000 (DATA)
    - 24 hours of training for nurse practitioners (NPs) and physicians assistants (PAs) per the Comprehensive Addiction and Recovery Act (CARA)
- Naltrexone: opioid antagonist
  - Use in office-based setting without special certification
  - Evidence of efficacy in specific populations
  - Overall efficacy not well established

National Institute on Drug Abuse. Principles of Drug Addiction Treatment: A Research-Based Guide, 3rd ed. 2012.

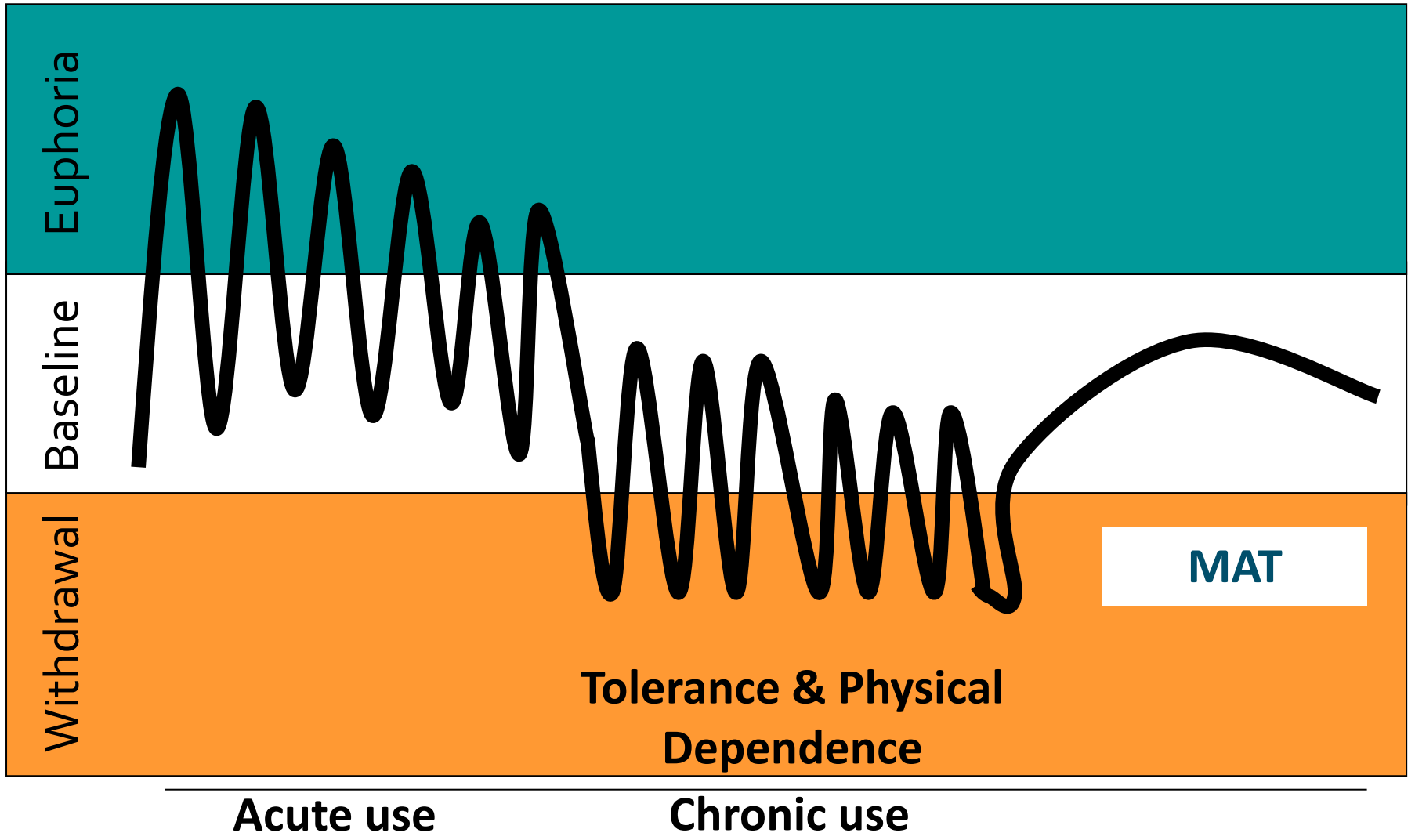
Substance Abuse and Mental Health Services Administration. Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. 2015.

Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. Journal of Addiction Medicine, 2015;9(5):358-367.

Buprenorphine Induction :

- Pt mild-moderate withdrawal. (8-12 hours after short acting opioid)
  - COWS of 8-12.
- Patient self-administers 2-4mg initially.
- Reassess patient 40 minutes to 1 hour after first dose.
- Continue to reassess and titrate over the next few hours.
- Stabilize day one around 8-16mg or per your protocol.

Goal of Medication Treatment for OUD



MOUD: Medication for Opioid Use Disorder

Goals:

- Alleviate physical withdrawal.
- Alleviate substance craving.
- Opioid blockade.
- Normalize disrupted brain changes and physiology.

Expect improvements in:

- Substance use.
- Criminal activity.
- Needle sharing: HIV/HCV.
- Pro-social activities.
- Employment.
- Physical and mental health.

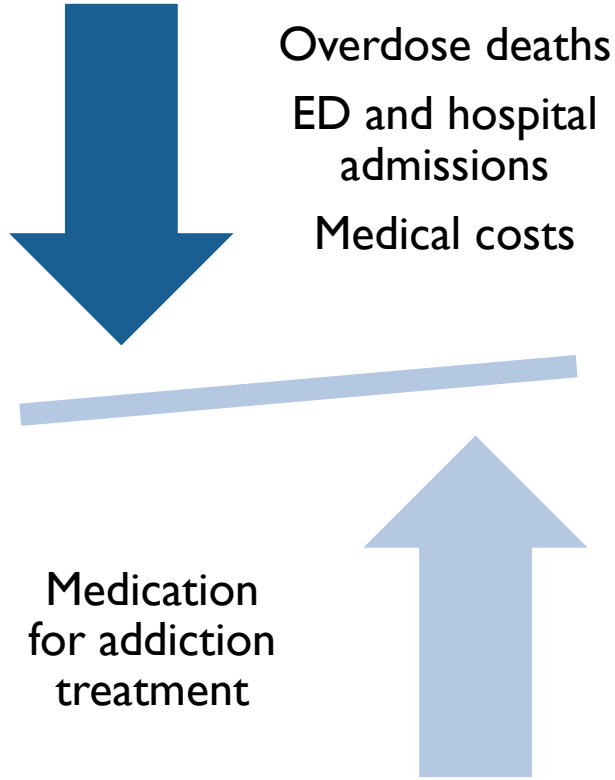
Medications For Addiction Treatment

	Patient selection	Pharmacology	Administration	Treatment Setting	Prescribing
Methadone	OUD that meet federal criteria for OTP admission.	Opioid receptor full agonist.	Daily oral administration at OTP. **patients may also have take home medication.*	Opioid Treatment Program	Only OTPs.
Buprenorphine	OUD	Opioid receptor partial agonist.	Transmucosal, implant or injection. Can be filled at pharmacy.	No limitation to treatment setting	Physicians, PAs, NPs who have a waiver to prescribe.
Naltrexone	OUD or ETOH use d/o abstained from opioids 7-14 days.	Opioid receptor antagonist.	Daily tablet or once per 28d IM injection.	No limitation to treatment setting	No special waiver required.

VALUE OF MEDICATION FOR ADDICTION TREATMENT

- Medicaid medical costs decreased by 33 % over 3 years following engagement in treatment
  - Decline in expenditures: hospitals, emergency departments, and outpatient services
- Baltimore study 50% decrease mortality with buprenorphine and methadone treatment
- Massachusetts decrease ED, and hospital admissions with retention in treatment

Alford DP, LaBelle CT, Kretsch N, et al. *Arch Int Med.* 2011;171:425-431
Walter, L. et al (2006). Medicaid Chemical Dependency Patients in a Commercial Health Plan, Robert Wood Johnson Foundation, Princeton, New Jersey
Schwartz et al. American Journal of Public Health. 2013; 103(5): 917-922



Background: Nurse Care Manager Model for OBAT

Nurse Care Managers increase patient access to treatment and retention in care

- Efficient and effective utilization of waivered prescribers

- High quality management of chronic medical condition

- Able to address social determinants of health

Alford et al. *Arch Int Med.* 2011;171:425-431

BMC's NCM OBAT Model: 5-Year Experience

ARCHIVES OF INTERNAL MEDICINE

Collaborative Care of Opioid-Addicted Patients in Primary Care Using Buprenorphine

Five-Year Experience

Daniel P. Alford, MD, MPH; Colleen T. LaBelle, RN; Natalie Kretsch, BA; Alexis Bergeron, MPH, LCSW; Michael Winter, MPH; Michael Botticelli, MEd; Jeffrey H. Samet, MD, MA, MPH

Arch Intern Med. 2011;171:425-431.

- Patient-level outcomes comparable to physician-centered approaches
- Efficient use of physician time allows focus on patient management (e.g., dose adjustments, maintenance vs taper)
- Improved access to OBAT and daily management of complex psychosocial needs (e.g., housing, employment, health insurance)
- Open communication between NCM and other providers including behavioral health improve compliance

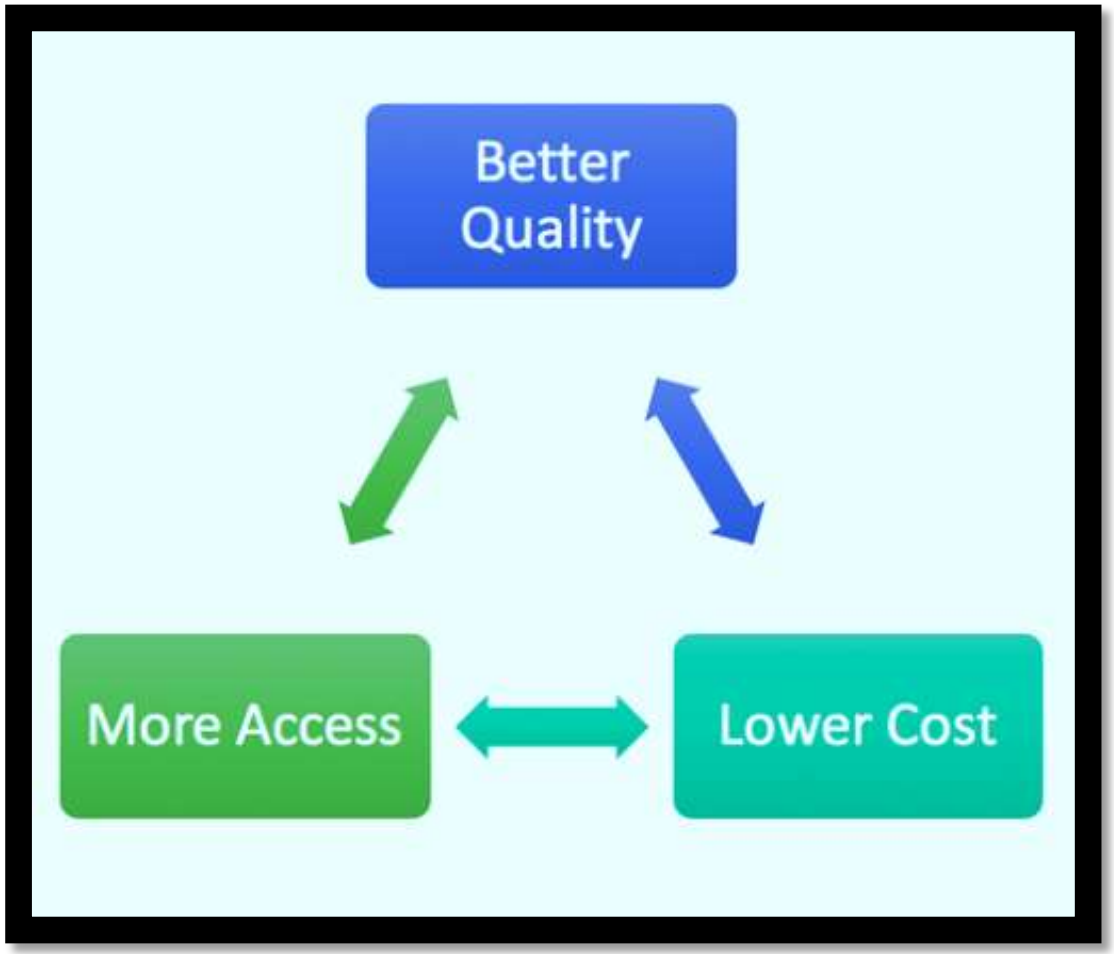
Table 2. Treatment Outcomes at 12 Months of 382 Opioid-Dependent Patients Entering Office-Based Opioid Treatment in Primary Care

Outcome	Patients, No. (%)
Successful treatment	196 (51.3)
Treatment retention	187 (49.0)
Successful taper after 6 months of adherence	9 (2.4)
Unsuccessful treatment	162 (42.4)
Lost to follow-up	113 (29.6)
Nonadherence despite enhanced treatment	46 (12.0)
Administrative discharge due to disruptive behavior	2 (0.5)
Adverse effects of buprenorphine hydrochloride	1 (0.3)
Transfer to methadone hydrochloride treatment program	24 (6.3)

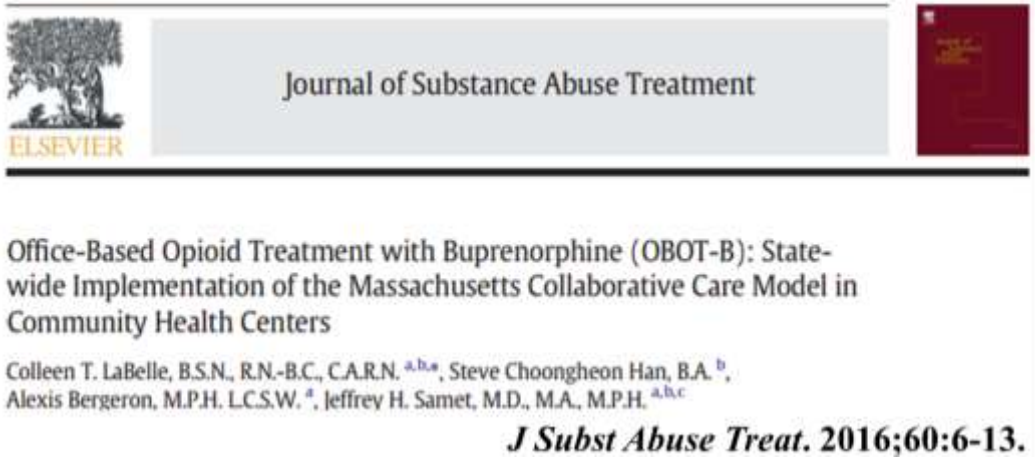
BACKGROUND

Due to the success of the Nurse Care Manager OBAT Program at BMC…

..in 2007 the MA Department of Public Health (DPH) funded BMC to expand access to addiction treatment across the state using the nurse care manager or "Massachusetts Model"



Increasing Access to Life-Saving Medication: Creating a Network of OBAT Providers Across Massachusetts

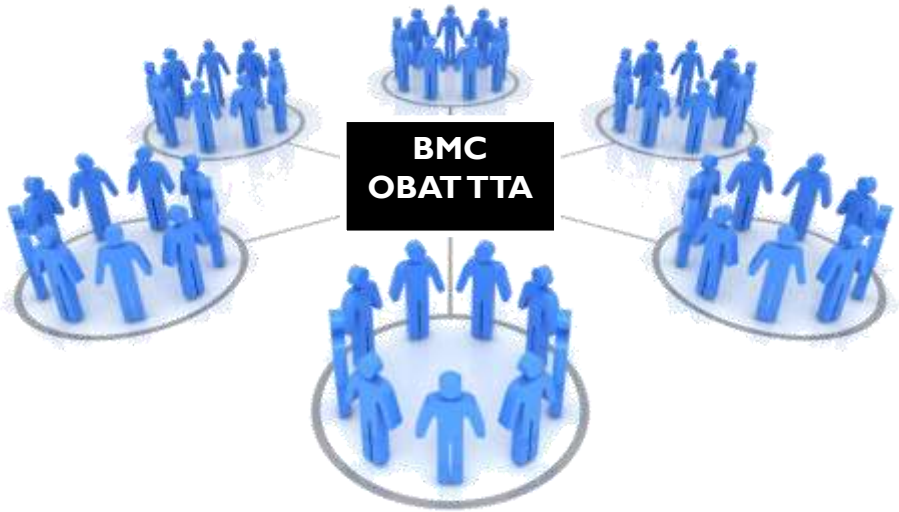


Journal of Substance Abuse Treatment

Office-Based Opioid Treatment with Buprenorphine (OBOT-B): State-wide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers

Colleen T. LaBelle, B.S.N., R.N.-B.C., C.A.R.N. [a,b,*], Steve Choongheon Han, B.A. [b], Alexis Bergeron, M.P.H. L.C.S.W. [a], Jeffrey H. Samet, M.D., M.A., M.P.H. [a,b,c]

J Subst Abuse Treat. 2016;60:6-13.

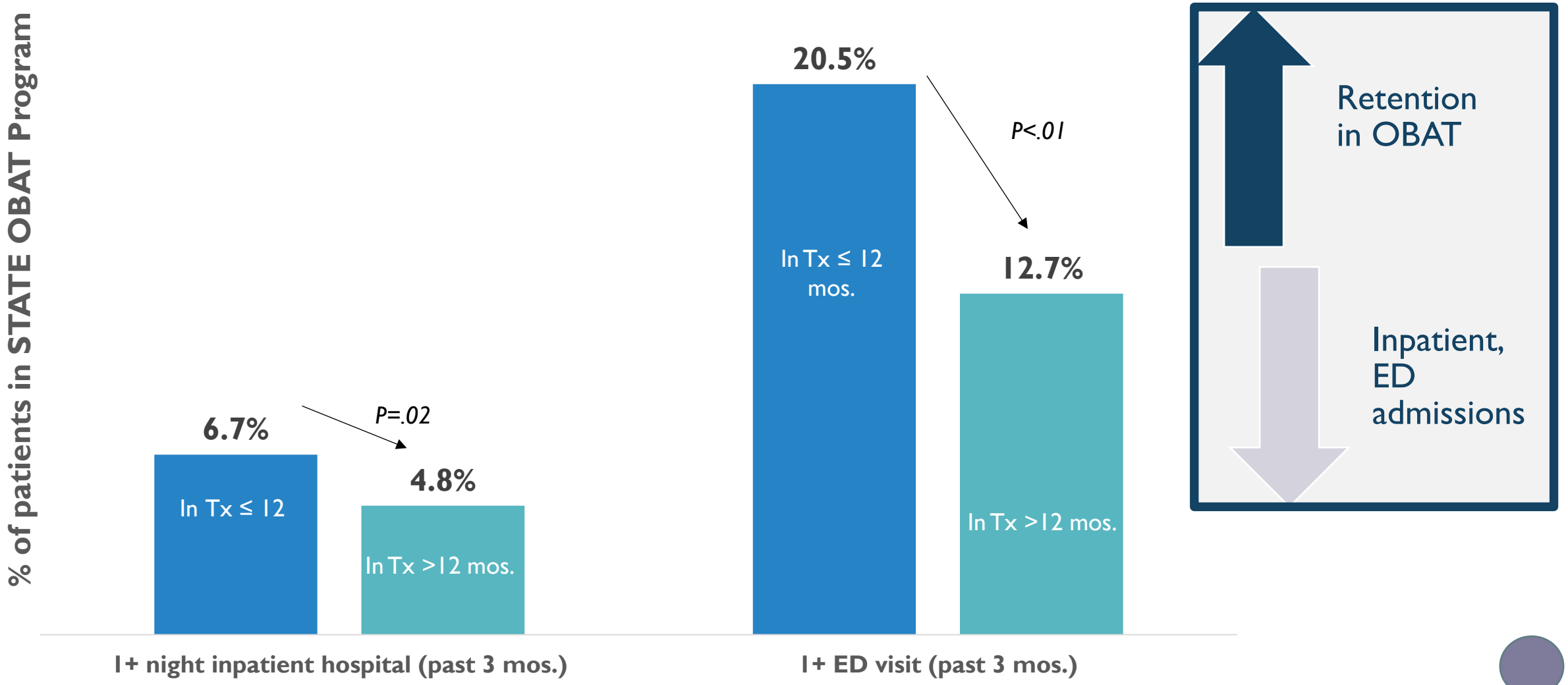


- In 2007 the State Technical Assistance Treatment Expansion (STATE) OBAT Program was created to expand the BMC model to 14 community health centers (CHCs) across Massachusetts

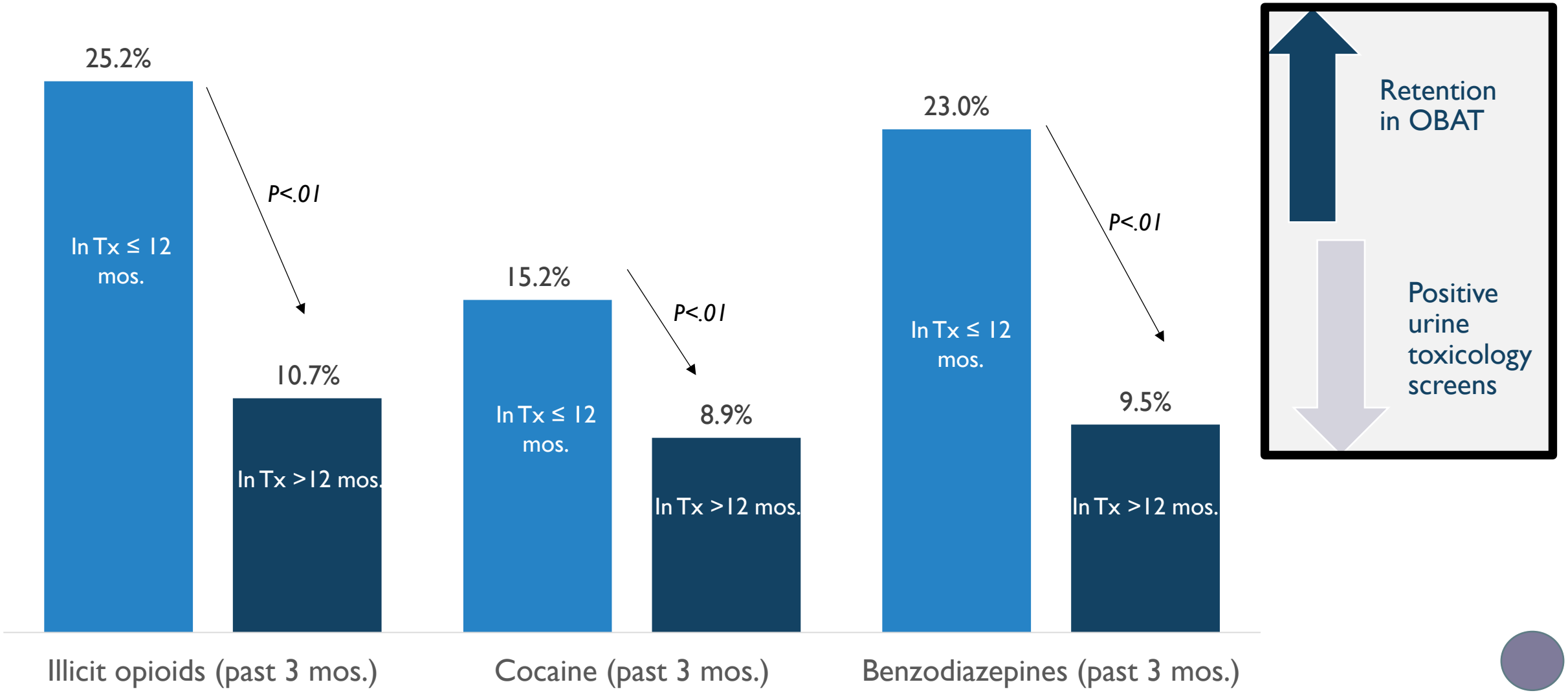
First 5 years of outcomes:

- Between 2007 and 2013, 14 CHCs successfully initiated OBAT
- Physicians "waivered" increased by 375%, increasing from 24 to 114 over 3 years
- Annual admissions of OBAT patients to CHCs increased from 178 to 1,210
- 65.2% of OBOT patients enrolled in fiscal year 2013/2014 remained in treatment ≥10 months

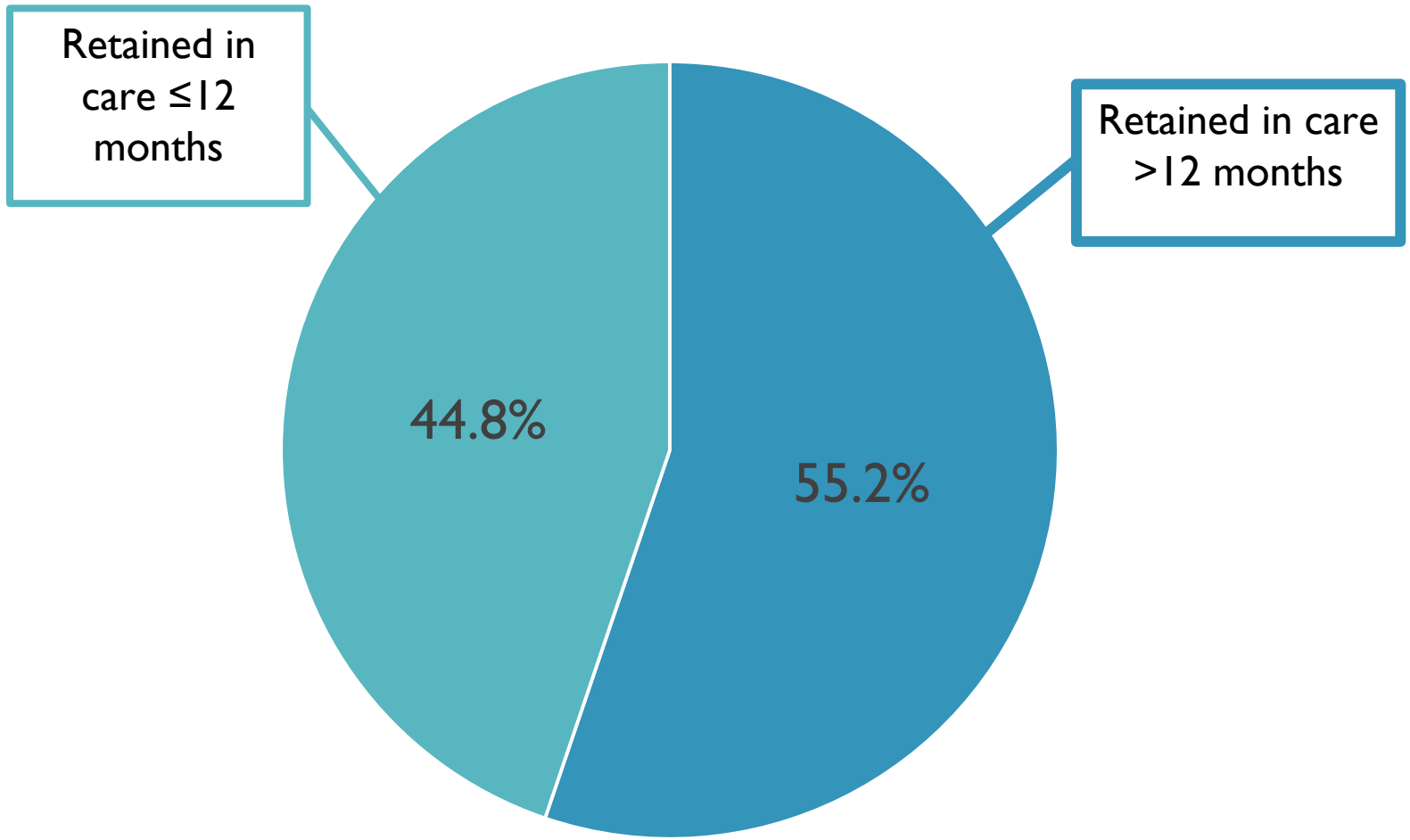
Results: Health Care Utilization Outcomes MA OBAT Sites Jul 1 2016 – Jun 30, 2017 (N=3,309)



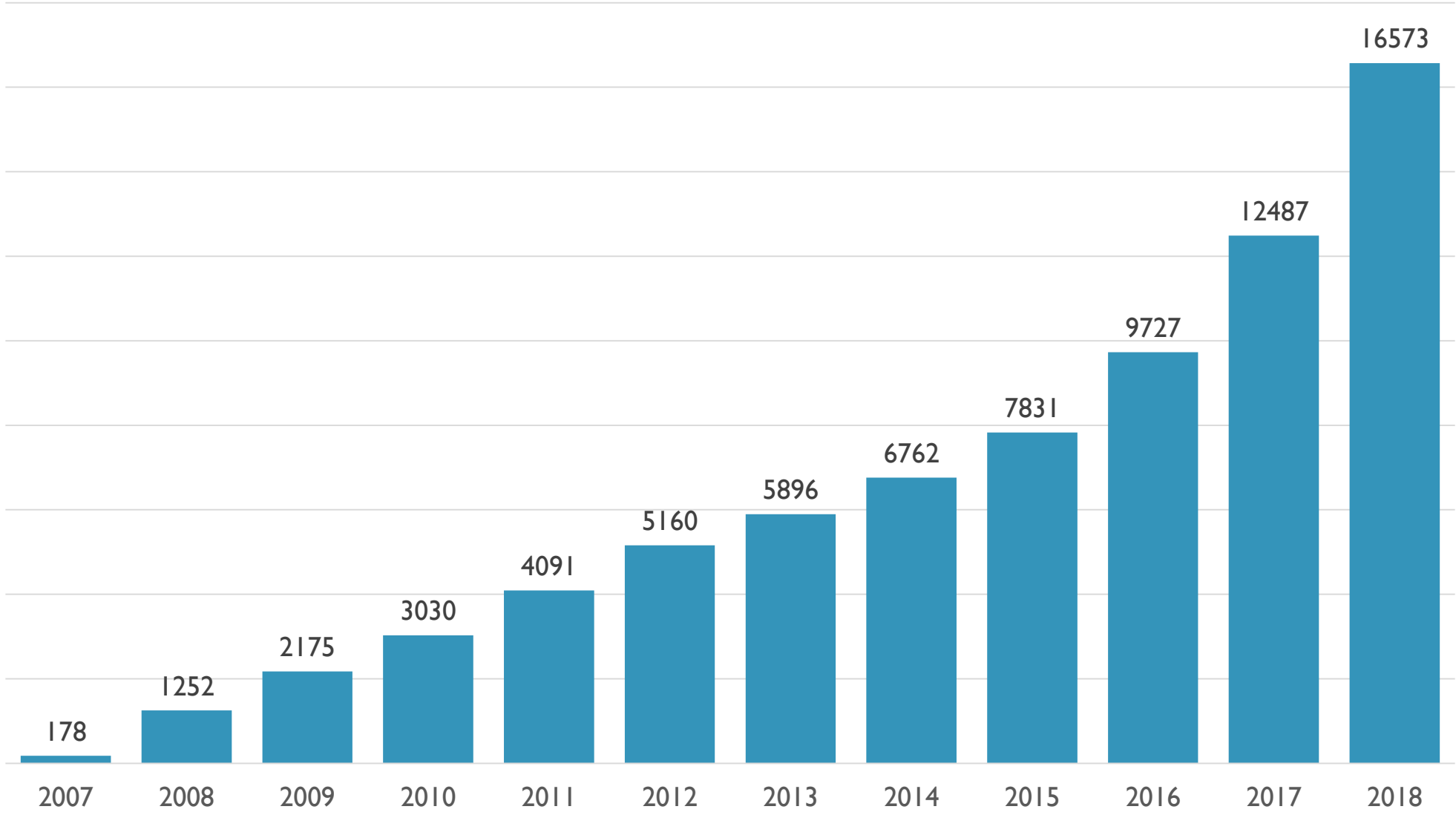
Results: Urine Toxicology outcomes MA OBAT Sites Jul 1 2016 – Jun 30, 2017 (N=3,309)



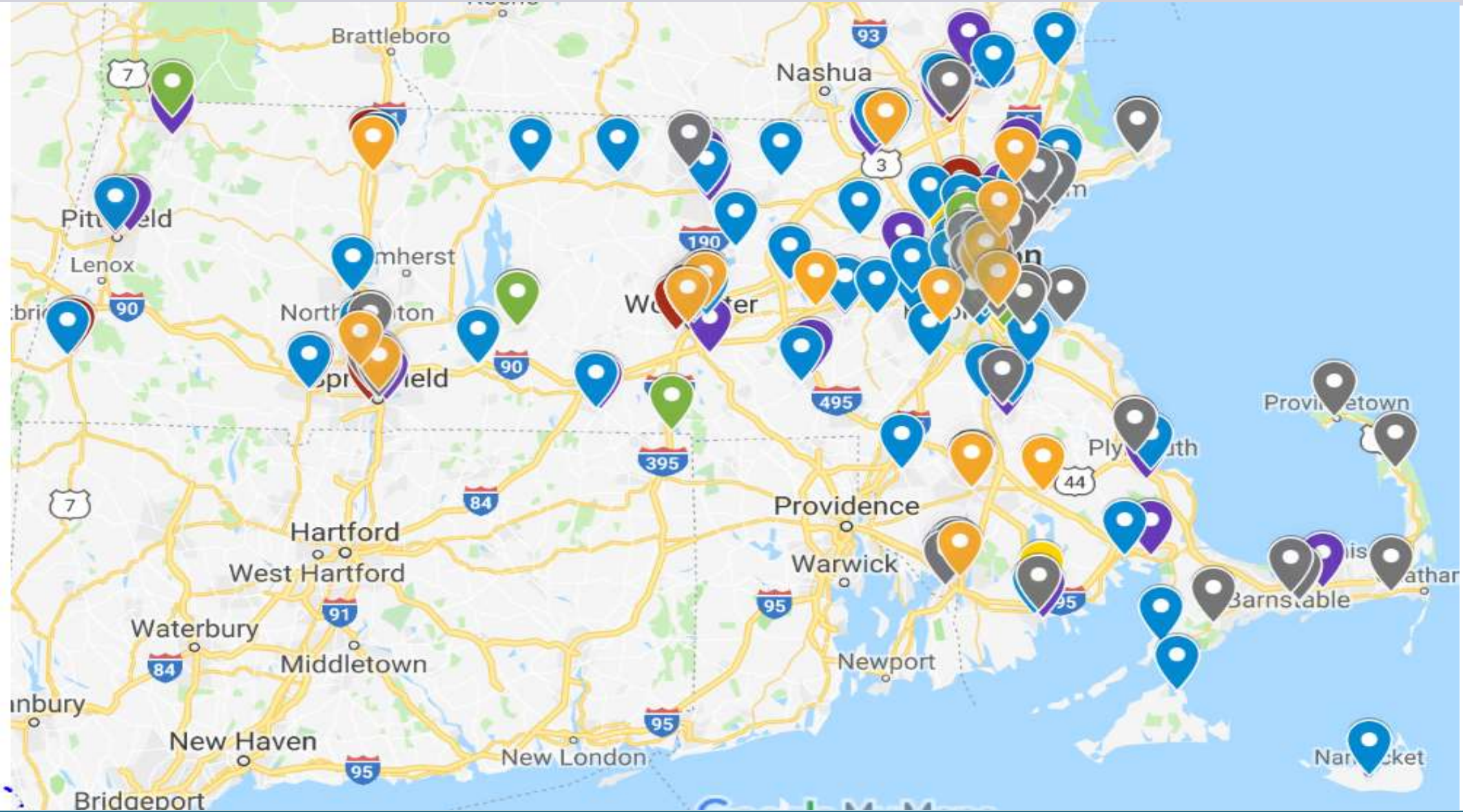
Results: Retention in treatment July 2016 – June 2017 (N=3,309)



Results: Cumulative No. of Patients Treated by Year at MA DPH Funded Sites



Access to Buprenorphine Treatment in MA



Discussion and Questions

Thank you for your time and attention

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