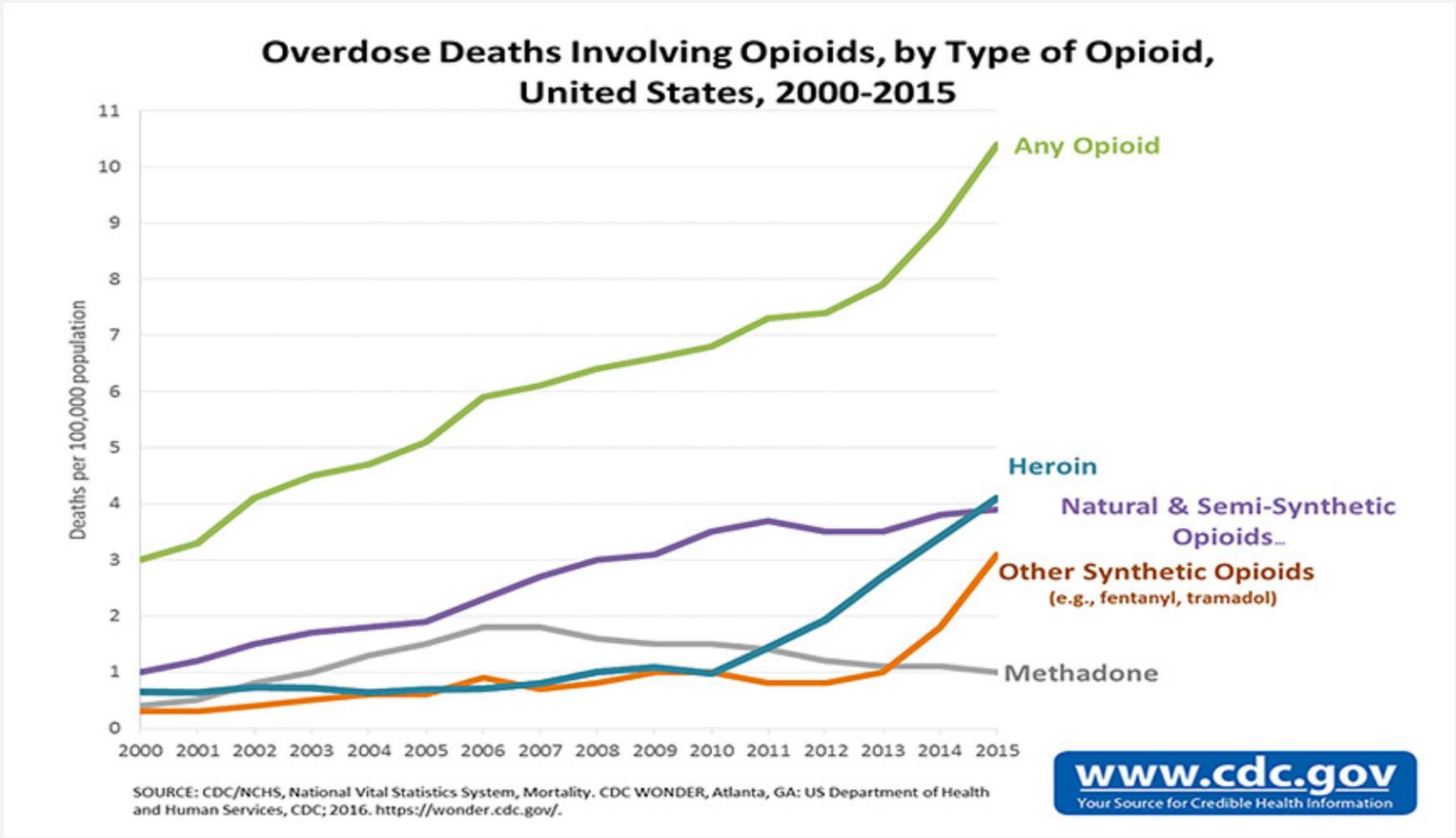
MEDICATION ASSISTED TREATMENT AT FQHCS

JEFFREY NORRIS, MD, FATHER JOE'S VILLAGES
GABRIEL RODARTE, MD, NEIGHBORHOOD HEALTHCARE

OBJECTIVES

NOTE: the vast majority of this presentation is on buprenorphine ("Suboxone")

1) Describe medication assisted treatment (MAT) and why it works
2) Understand the role of counseling and urine drug screens in MAT
3) Compare "low" vs. "high" barrier MAT
4) Compare two models of providing "low barrier" MAT


Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2015
Deaths per 100,000 population
0
1
2
3
4
5
6
7
8
9
10
11
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Any Opioid
Heroin
Natural & Semi-Synthetic Opioids…
Other Synthetic Opioids
(e.g., fentanyl, tramadol)
Methadone
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.
www.cdc.gov
Your Source for Credible Health Information

WHAT IS MAT?

- **Evidence-based approach** to using medication to treat:
  - Opioid use disorders (OUD)
  - Alcohol use disorders (AUD)
- **Medications for OUD**:
  - Buprenorphine (Suboxone, Subutex, Sublocade)
  - Methadone (can only be provided through specific clinics licensed to provide methadone)
  - Naltrexone (oral form or Vivitrol, a monthly injection)
- **Covered by full-scope Medi-Cal and often by Medicare**

WHY DOES MAT FOR OPIOID USE DISORDER WORK?

- **Medications decrease:**
  - **Cravings**
  - **Withdrawal**
  - **Effect of illicit opioids when people relapse** (especially true for buprenorphine and naltrexone)
- Buprenorphine (the focus of this lecture) is partial opioid-agonist:
  - **Stimulates opioid receptors**, but less than other opioids
  - Has a high affinity for opioid receptors, thus knocks off other opioids & doesn't allow them to bind
  - **Has a ceiling effect in the 24-32 mg/day range**, meaning taking more does not result in more effect on body; low risk of overdose
  - Is packaged with naloxone (Suboxone) which minimizes chance people will inject it IV

WHY DOES MAT FOR OPIOID USE DISORDER WORK?

- Helps reframe substance use disorders as a chronic disease
- Allow patients time and space to rebuild their lives
- Decreases overall "costs of care"
- **Buprenorphine and methadone known to reduce mortality rates by 30%-60%**

How many treatments in healthcare can claim this stat or better?

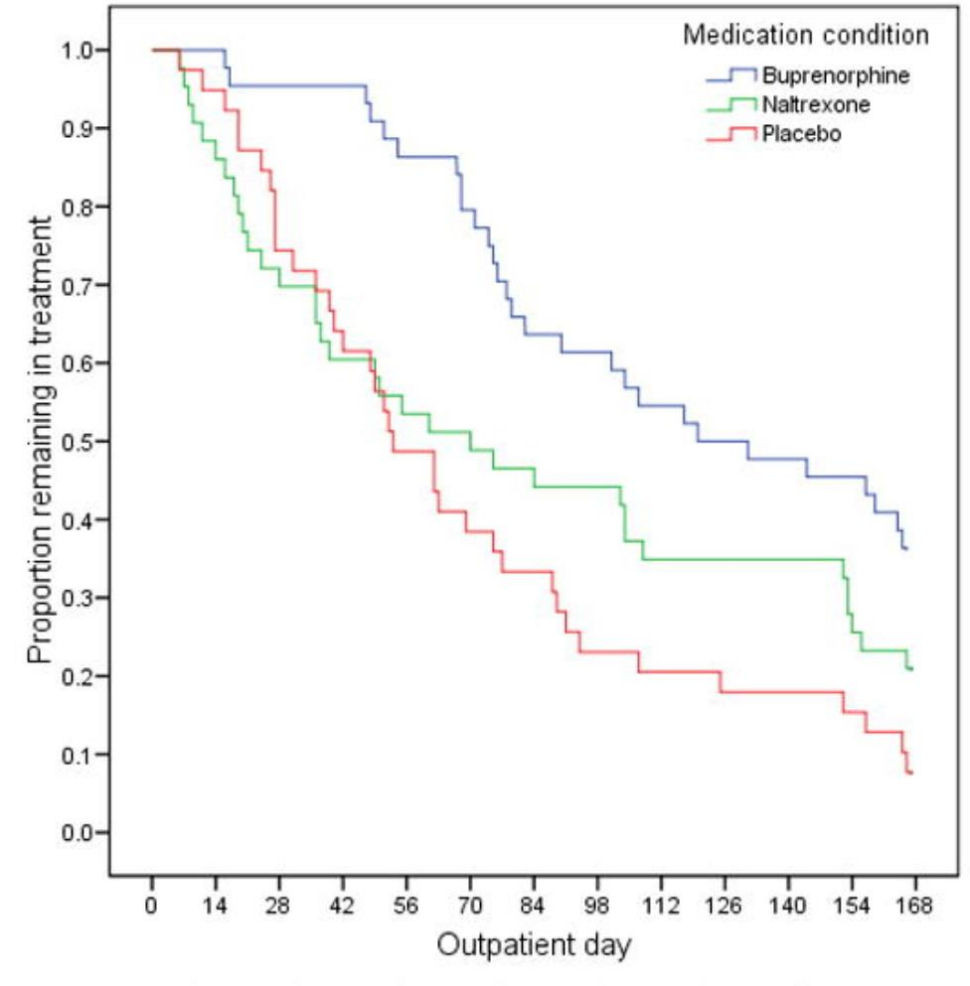
https://www.recoveryanswers.org/research-post/buprenorphine-methadone-treatment-among-medicaid-members-reducing-relapse-health-care-costs/

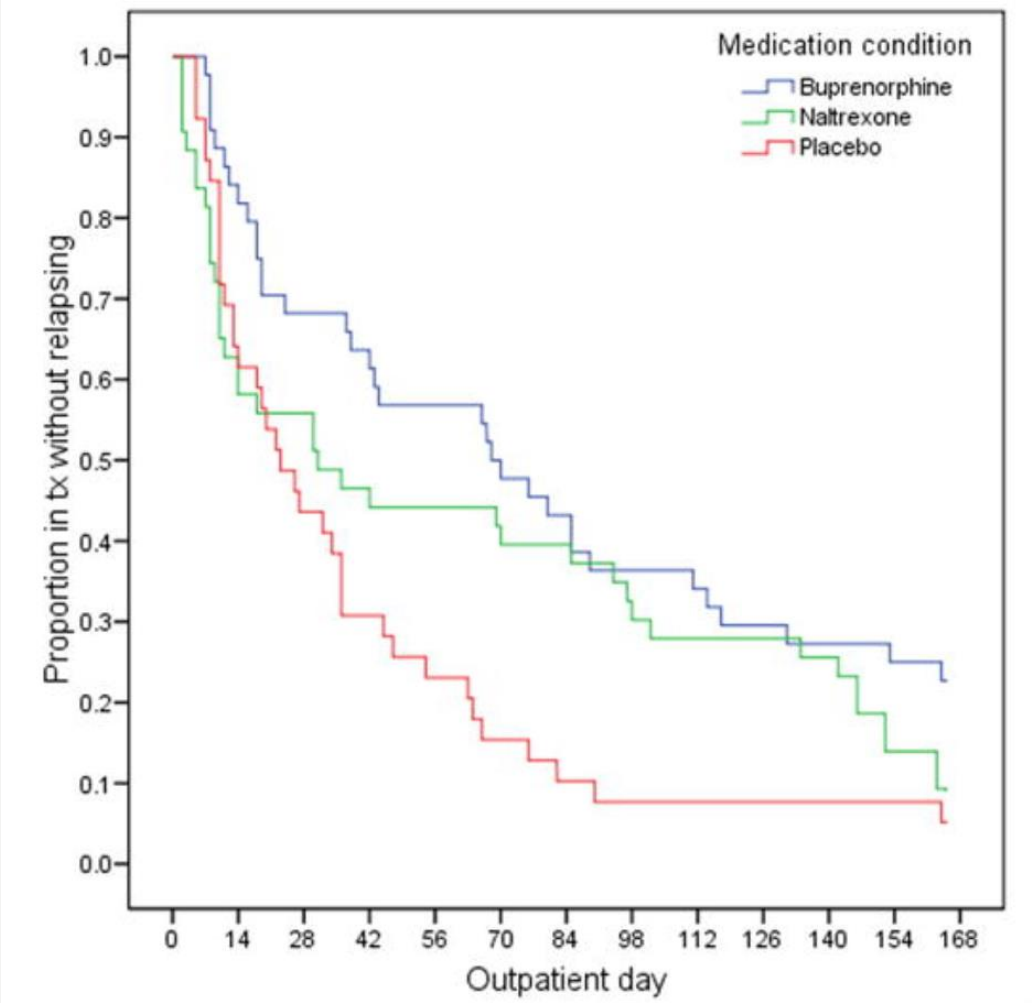
COMMON MYTHS OF MAT

- **MAT replaces one addiction with another:** shooting up and going to the doctor are not the same thing
- **MAT is a bad moral choice, inferior to abstinence only:** would you tell someone with diabetes they don't get insulin unless the change there life and lose weight? OUD is a chronic disease and must be treated as such.
- **MAT doesn't end dependence**: goal is to end addiction and keep people alive, not necessarily end dependence. Dependence just means the body needs a substance to feel "normal".
- **Division is always a bad thing**: while not ideal, diversion means patients often have a chance to try out buprenorphine before getting to a clinic. Most people use buprenorphine from street in order to NOT use other opioids.
- **"I don't want to see too many of 'those patients'":** you're probably already seeing "those patients", and often MAT visits are easier and quicker than typical primary care visits.
- **MAT should only be short-term:** substantial data show long-term treatment works better than shorter-term (weeks) treatment

https://pcssnow.org/resource/myths-and-misconceptions-medication-assisted-treatment-for-opioid-addiction/

HOW LONG TO USE MAT FOR?





https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4041792/

BUPRENORPHINE VS. METHADONE

- 2014 Cochran study evaluates evidence best
- High dose (16 mg/day and above) similar to methadone in terms of retention in treatment and time to relapse
- Flexible dose buprenorphine (especially below 16 mg/day) or lower fixed doses are *inferior* to buprenorphine
- "**Methadone is superior to buprenorphine** in retaining people in treatment, and methadone equally suppressed illicit opioid use"
- **Bottom line**:
  - **Methadone also a good option**, but often maligned in our communities because of inappropriate use in past
  - But methadone more regulated, often less available, and usually requires daily dosing initially

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002207.pub4

WHO IS A CANDIDATE FOR MAT?

- **Anyone who meets the DSM-V criteria** for OUD (which is most people using opioids in a way not recommended or guided by a prescriber)
- Better to MORE rather than LESS inclusive

ROLE OF URINE DRUG SCREENS

- Used to **determine if taking buprenorphine or not**
- Used to **determine if relapse or continued use** other opioids and other drugs is occurring
- Should be used to prompt discussions with patients, not to take a parental approach
- If buprenorphine note in urine (including on formal lab testing of urine), should discuss goals of treatment and "I am your doctor, but I cannot be your dealer" if diversion is concern

ROLE OF COUNSELING

- **Required under Federal law** with buprenorphine prescriptions, though can be delivered in variety of ways (primary care counseling, AOD counselor, BH clinicians, etc.)
- **Mixed data on effectiveness** of counseling more than that provided by a primary care clinician in multiple studies; however, there are some issues:
  - **Doesn't mean some subgroups might benefit** from AOD/BH counseling
  - **Doesn't mean other outcomes, not directly linked to MAT, might not improve** (housing, holding a job, etc.)

https://www.samhsa.gov/medication-assisted-treatment/treatment
https://aspe.hhs.gov/basic-report/psychosocial-supports-medication-assisted-treatment-recent-evidence-and-current-practice#effective
https://www.rehabs.com/pro-talk-articles/can-we-stop-calling-it-medication-assisted-treatment/

ROLE OF COUNSELING

- **Overall message**: getting or not getting AOD/BH counseling shouldn't be a barrier to getting MAT; should individualize treatment plans as much as possible

HARM REDUCTION VS. ABSTINENCE ONLY

- In past most programs abstinence only (AA, NA, recovery homes etc)
- **Harm Reduction**: any intervention that reduces harm from substance use is beneficial even if it does not decrease/stop use.
  - Examples: needle exchange, universal Naloxone, safe injection sites
  - Standard of care in addiction medicine now
  - Exists on a spectrum; different providers will go further when taking harm reduction approach
- Buprenorphine is treatment for OUD but **not** meth, alcohol, benzos, etc. use disorders. Use of other substances should never be a rational for stopping buprenorphine treatment.
- Buprenorphine decreases risk of overdose so if pt is taking it you can justify continuing as harm reduction (decreased risk of overdose)

WHAT IS "LOW BARRIER"?

- **Decrease barriers to receiving treatment**
- **No single definition** across county
- Examples of widely accepted components:
  - Ideally same-day inductions (start buprenorphine same day people present); though this is not always possible
  - Home induction for most patients
  - Initiation of treatment in EDs or inpatient to be continued as outpatient
  - Start buprenorphine regardless of what urine shows
- Educate PCPs on MAT treatment, not enough addiction medicine providers
- Neighborhood has care coordinator that follows up with pt daily till scheduled for induction on buprenorphine

USING SCALES LIKE DAST/AUDIT, ETC.

- **Universal screening in primary care annually**
- Single question with reflex to DAST or AUDIT
- Use score on DAST or AUDIT to guide treatment
- Urge to Use scale: nice for monitoring response to tx in MAT
- COWS: used to determine if the patient is in sufficient w/d to start buprenorphine induction to avoid precipitated withdrawal

RECRUITING PCPS TO DO MAT

- **Lack of addiction medicine providers requires that MAT is done in primary care**
- X-waiver training required (and is often a barrier to prescribers)
  - Free, 8h physician, 24h for midlevels
  - https://pcssnow.org/medication-assisted-treatment/
  - Consider x-waiver status and experience in hiring
  - Allow providers to block clinical time for training
  - Encourage physician leaders to get x-waiver
- Don't forget MAT for alcohol, provide trainings for PCPs on this

COLLABORATION WITH IOPS AND RECOVERY HOMES

- **MAT alone is often not enough to treatment Substance Use Disorders**
- Recovery homes and IOPs can be a good source of referrals for MAT
- Also these programs can be the needed treatment to get your pt on MAT into true recovery
- They provide a level of structure our program cannot for patients struggling to maintain sobriety
- Neighborhood requires open communication with other treatment providers to be in our program

IOP = Intensive Outpatient Program

HUB AND SPOKE GRANT PROGRAMS

- **Opioid Treatment Programs (OTPs, aka "methadone clinics") act as "hubs" to start MAT,** and then once patient stable on dose of buprenorphine, they transition to outpatient clinic for continuation
- **Can also use this model internally** (Neighborhood has few providers that are more experienced and do inductions/stabilization then transfer to other providers that simply do continuation of treatment)
- **OTPs are a great option when pt needs a higher level of care**. They can provide observed daily dosing providing protection from OD and diversion.

OUR MAT PROGRAMS DAY-TO-DAY

SIMILARITIES IN MODEL

- Work to be "low barrier"
- Always try to accommodate walk-in patients
- Always try to start patient same-day when possible
- Provide integrated AOD and BH counseling
- Start patient regardless of urine drug testing results
- Follow-up typically through weekly groups but refills provided even if group missed
- Attempt to also treat comorbid physical health issues (especially Hep C)
- Typically only way people transitioned to other treatments are if they:
  - Repeatedly lose medication (alternatives: OTP, sublocade, detox, etc.)
  - Urine repeatedly negative for buprenorphine (alternatives: consider OTP, sublocade, detox, etc.)

SPECIFICS TO NEIGHBORHOOD MODEL

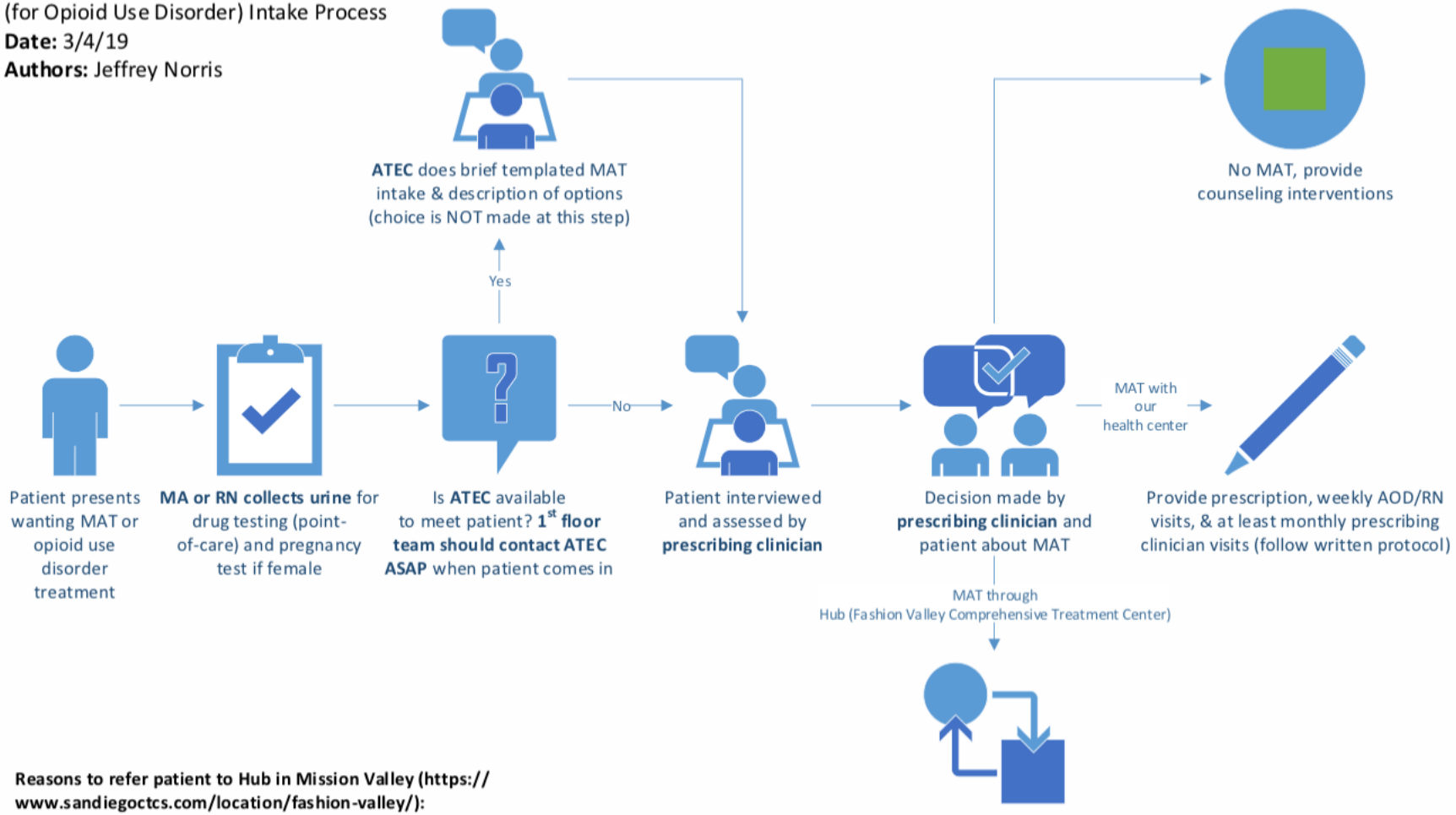
- Generally do not give a refill unless patient is seen by a provider or comes in and provides a UDS and then send enough to last till next available appointment
- We schedule f/u appt before or after weekly group rather than pulling out of group for appt.
- We require a MAT intake appointment with a therapist prior to induction (may happen on same day)
- Our regional MAT program coordinator meets with pt first and administers screening tools that establish OUD DSM-IV criteria met and screens for level of other substance use. Also does social determinants screening and makes referals for Psychiatrist, Therapist, and primary care as needed.

SPECIFICS TO FATHER JOE'S

- Intake:
  - Walk-in patients triaged by RN into open slots with primary care clinicians (main group doing Rxs)
  - Medical Assistant does templated "history of present illness" and shows patient video on our program and expectations
  - Clinician sees patient ideally same-day and writes Rx
- Follow-up:
  - Two groups per week, on Tuesday and Thursday morning (run by AOD counselors)
  - If patient misses group, seen by triage RN and an available provider writes refill through next group
- Have a detailed clinical protocol to support team members (prescribers and other staff)
- Collaborate with McAlister to get detox patients MAT
- Every 1-2 months have to close to new intakes due to capacity limitations

Father Joe's Villages
Village Health Center

Title: Medication Assisted Treatment (MAT) (for Opioid Use Disorder) Intake Process
Date: 3/4/19
Authors: Jeffrey Norris



Reasons to refer patient to Hub in Mission Valley (https://www.sandiegoctcs.com/location/fashion-valley/):
-Patient needs or desires methadone
-Buprenorphine through us not working (repeated relapses)

At Hub, patient should arrive before 11 am, and expect to be there 4 hours minimum.

OUTCOMES MEASUREMENT

- No universally accepted outcomes
- Most common = "retention rate" (% retained in MAT over 3 and 6 months)
- Some focus on negatives on urine drug screen, but others argue this is not "harm reduction"

WHAT SAN DIEGO NEEDS

WHAT DO WE NEED IN SAN DIEGO?

- Still huge lack providers doing "low barrier" MAT
  - Large number of providers, but often with strict requirements
  - Often providers not doing same day inductions
- Need more OB providers to work with pregnant women on MAT
- Need more clinics (especially FQHC) to do "low barrier" MAT
- If you are thinking of doing MAT, then JUST DO IT! (There is a lot of technical assistance available)

CONCLUSION

- MAT SAVES LIVES!
- MAT works to reduce relapse
- More people in San Diego need to provide "low" barrier MAT