Patient Retention in Medication Assisted Treatment

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Sponsored by the Florida Alcohol and Drug Abuse Association and the Florida Department of Children and Families
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Learning Objectives

Attendees will be able to:

• Understand how to more effectively engage individuals prior to treatment onset.
• Learn how to increase retention in individuals with Opioid Use Disorders receiving medication assisted treatment (MAT).
• Challenge reasons for administrative discharge from opioid use treatments.
Opioid Epidemic - Treatment

- Department of Health and Human Services
  - Five Point Opioid Strategy
  - Better addiction prevention, treatment, and recovery services
  - Retention improves treatment and recovery outcomes

**HHS 5-POINT STRATEGY TO COMBAT THE OPIOIDS CRISIS**

1. Better addiction prevention, treatment, and recovery services
2. Better data
3. Better pain management
4. Better targeting of overdose reversing drugs
5. Better research
Opioid Epidemic Stats

- 2.5 million Americans meet criteria for Opioid Use Disorder (OUD)
- 20% receive specialty addiction treatment
- Over 63,632 drug overdoses in 2016
  - 24,249 (66%) involving an opioid
- 11.8 million people with opioid misuse
  - 4.4% of total population - 12 or older
- Heroin use and related deaths rising

(McCance-Katz, 2018 March 14)
Opioid Epidemic Stats - Florida

- 6,178 opioid-related deaths
  - Either the cause or present
- 4,280 opioid-caused deaths reported
- 1,566 synthetic opioid-related deaths in 2016
  - 200 in 2013
- Neonatal Abstinence Syndrome
  - Increased from 0.4 per 1,000 births in 1999 to 6.3 per 1,000 in 2013

(NIDA, February 2018)
(Florida Department of Law Enforcement, 2018)
# Opioid Epidemic Stats - Florida

<table>
<thead>
<tr>
<th>DRUG PRESENT IN BODY</th>
<th>2016</th>
<th>2017</th>
<th>PERCENTAGE CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>135</td>
<td>161</td>
<td>19.3%</td>
</tr>
<tr>
<td>Codeine</td>
<td>507</td>
<td>562</td>
<td>10.8%</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>1,644</td>
<td>2,088</td>
<td>27.0%</td>
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<tr>
<td>Fentanyl Analogs</td>
<td>1,026</td>
<td>1,685</td>
<td>64.2%</td>
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<td>Heroin</td>
<td>1,023</td>
<td>1,057</td>
<td>3.3%</td>
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<tr>
<td>Hydrocodone</td>
<td>692</td>
<td>732</td>
<td>5.8%</td>
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<tr>
<td>Hydromorphone</td>
<td>595</td>
<td>589</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Meperidine</td>
<td>6</td>
<td>20</td>
<td>*</td>
</tr>
<tr>
<td>Methadone</td>
<td>499</td>
<td>420</td>
<td>-15.8%</td>
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<tr>
<td>Morphine</td>
<td>2,040</td>
<td>1,992</td>
<td>-2.4%</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1,382</td>
<td>1,282</td>
<td>-7.2%</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>562</td>
<td>526</td>
<td>-6.4%</td>
</tr>
<tr>
<td>Tramadol</td>
<td>510</td>
<td>483</td>
<td>-5.3%</td>
</tr>
</tbody>
</table>

(Florida Department of Law Enforcement, 2018)
Treatment Provider Goals

- Retention in treatment is based on provider goals.

- Primary goal for treatment:
  - Reduce deaths
  - Reduce hospitalization
  - Reduce incarceration

- When these basics are met, the individuals have an opportunity for secondary goals.
Treatment Provider Goals

- Secondary goals – “Building a purposeful life”
  - Medical stability
  - Improved relationships
  - Stable housing
  - Employment
  - Happiness
  - Hobbies
  - Building a community
Pre-Treatment Engagement

A Case Study

Male who uses opioids presents to acute care
Admitted for detox then transferred to residential
Cravings continue
Family recommends methadone
Residential doesn’t support MAT
Linked to case management and then methadone
The individual attends methadone orientation
The individual referred to buprenorphine treatment
Case Study

- What happened to the individual?
- What could have improved?
- Who is responsible for the individual?
Who Receives MAT

- **Individuals with Opioid/Alcohol Use Disorders**
  - Adults
  - Prior treatment attempts should be *considered*
  - Priority populations
    - Pregnant Women
    - IV drug users
    - Child welfare
    - Incarcerated/recent release
- **MAT vs Abstinence**
What Services

• Medication Assisted Treatments
  • Methadone
  • Buprenorphine
  • Naltrexone
• Traditional “abstinence-based” treatments
  • Residential
  • Intensive outpatient
  • Outpatient
• Combined MAT and traditional
• Naloxone
Standard of Care – SOR Guidelines

- Medical withdrawal/detoxification
  - Detox is not the standard of care
  - Associated with higher rate of relapse
  - Significant risk for opioid overdose and death
  - Permissible when accompanied by long-acting naltrexone

- Denial of Care
  - FDA-approved medications should be accepted at all levels of care.
Emergency Department Peer Support

- Emergency Department
  - Linking with buprenorphine community providers
  - Standard component of the system of care
    - Eliminate “pilot”
  - Link with peers
- Recovery Peer Program
  - On-call and available 7 days a week
  - Engage overdose victims in hospital
  - Bridge between emergency department and treatment

State Opioid Response Grant Guidance
Methadone

- Full opioid agonist
- 50+ years of practice
- Used orally in practice setting
- On site daily dosing *
- Highest retention rates of medication alone

(Timko, Schultz, Cucciare, Vittorio & Garrison-Diehn, 2016)
Buprenorphine

- Partial opioid agonist
- Increased use in last two decades
- Sublingual, implant, or injectable dosing
  - Naloxone
- Waiver required to prescribe in office based setting
- Take home prescription up to 30 days
Naltrexone

- Opioid antagonist
- Alcohol treatment
  - Reduction in cravings and intensity of consumption
- Approved for medical use in 1984
- Oral, injectable, or implant
  - Injectable approved for opioid use treatment in 2010.
  - Injectable approved for alcohol use treatment in 2006.
Comparisons

- Methadone
  - Comparing methadone to buprenorphine
    - Four month review periods: 73.9% compared to 45.9%
    - Six month review periods: 74% compared to 46%

- Buprenorphine
  - 65.7% retention compared to placebo (30.9%)

- Transition from buprenorphine to naltrexone
  - A four week taper prior to naltrexone increases retention (50%) compared to placebo

- Cost consideration

(Timko et al., 2016)
The Right Service

- Screening
- Will the individual commit to the service?
- Users of heroin compared to users of prescription only
  - Users of heroin (with or without prescription use)
    - Less formal education and income
    - Higher risk of disengagement
    - More likely in engage in non-MAT with less retention
  - Users of prescription only
    - More likely to engage in MAT and be retained

(McCabe, Santisteban, Mena, Duchene, McLean & Monroe, 2013)
The Right Service

- Barriers
  - Location
  - Costs
    - Will this become a barrier in the future?
  - Clinic hours
  - Housing
  - Transportation

(Photo: Gregg Pachkowski/gregg@pnj.com)
Pre-Engagement Staff

- Customer service
- The individual who uses opioid’s first interaction will set the tone for treatment.
  - Admissions, administration, front desk staff play pivotal role

- Single point of access
  - Alleviates confusion
  - Coordinates care
  - Reduces risk of getting “lost in shuffle”
Engagement in Treatment

- Initiating medication
- Engaging staff
- Behavioral therapies
- Drug screens
Medication Initiation

- Buprenorphine and Methadone
  - Early as possible
  - Treatment goals
  - Counseling in conjunction with medication
- Naltrexone
  - Delayed initiation
  - Counseling services earlier
    - Anecdotal evidence: Lakeview’s model

(Timko et al., 2015)
Engaging Staff

- Knowledge of Opioid Use Disorder
  - Current standards
  - Withdrawal symptoms
    - How this could present as behavior issue
- Flexible
  - “This is how it’s always been.”
  - Integration of other practices
  - Harm reduction
Engaging Staff

- Trauma-informed care
  - Recognizing trauma
  - Assuming everyone has trauma history
- Working referrals
  - Transportation
  - Employment
  - Housing
  - Medical/Dental
  - State agencies
Engaging Staff

- Use recovery oriented language
  - Consistently use person-first language
    - “An individual who uses opioids” versus “an opioid addict”
  - Positive words such as “hope” and “recovery”
  - Descriptive versus general labels
    - “She’s an addict.” versus “She has struggles with returning to heroin use because her environment is a barrier at this time, although she has a desire to improve.”
  - Recognizing strength over what is wrong

(Tondra, J. 2018)
Standard of Care - SOR

- Meeting individuals where they are
- Accept any positive changes
- Prevent barriers to admission or retention
  - Medication supports primary goals
  - Counseling and support services support secondary goals
- Relapses and rule violations
  - Symptom of the disease
  - Should not result in immediate discharge
Behavioral Therapies

- Medications alone
  - Methadone retains better
- Medications with therapy
  - Increased retention
  - Buprenorphine and methadone similar
    - 85% at three months

(Timko et al., 2016)
(photo: Courtesy of elakeviewcenter.org)
Behavioral Therapies

- Contingency Management
  - Studies show that incentive-based interventions are highly effective for retention
  - Voucher-based systems
  - Prize incentives
  - Controversial
  - Sources of reward difficult to obtain

(NIDA, 2018 January 17)
Behavioral Therapies

- Retention increased when engaged
  - Style of therapy – little to no effect
- Supervision of medication consumption
- Additional counseling, education, or support
- Phone support
Case Study

- Working with drug screens
  - History: opioid, methamphetamines, cocaine
  - Injectable naltrexone
    - Initiated in residential treatment
  - Third injection (2\textsuperscript{nd} in community)
  - Positive: meth and cocaine – coworkers
    - Negative for all opioids
  - Fourth injection
  - Positive: meth and cocaine – coworkers
Case Study

- Is this a successful individual?
- If he didn’t return to treatment, how long should be treated with injectable naltrexone?
- Who was in control?
Drug Screens

- Why are we testing?
  - Requirement of governing agencies/funding streams
  - Diversion
  - Medical risks
  - Punishment
  - Intervention

(Photo: pharmacyforme.org)
Drug Screens

- Significant medical interactions with opioid replacements
  - Opioids
  - Benzodiazepines
    - More than 30% of overdoses involve benzodiazepines
    - 17% prescribed opioids and benzodiazepines
    - Nonmedical use higher risk with methadone than buprenorphine
  - Alcohol

(Lee, Klein-Schwartz, Doyon, & Welsh, 2014)
(NIDA, 2018 March)
(McCance-Katz, Sullivan, & Nallani, 2010)
Drug Screens

- Less significant medical interaction with opioid replacements
  - Cocaine
    - Can diminish buprenorphine concentrations
    - Lower rates of retention in treatment
  - Marijuana
    - Prescribed
  - Amphetamines
    - Prescribed
  - Methamphetamines
  - Bath salts/spice
  - Others

(McCance-Katz et al., 2010)
Drug Screens

- **Primary goals for treatment:**
  - Reduce deaths
  - Reduce hospitalization
  - Reduce incarceration
- Illegal substance use puts the primary goals at risk
- Primary goals at greater risk without MAT
  - Increase interventions
    - Wrap-Around services – clinicians, case managers, peers
    - Frequent physician services
End of Treatment

- Successful completion
  - Transfer
  - Moved
- Inability to pay
- The individual leaves abruptly or against staff advice
- Administrative discharge
Successful Completion

- Customer service
- Available to return
  - Share your story
  - If you need support
  - If you relapse
- Encourage referrals
  - Friends
  - Family
  - Coworkers

(photo: Courtesy of elakeviewcenter.org)
Inability to Pay

- Lost fund stream: insurance, family support, or employment
- Unethical to discharge immediately
- Payment plans
- Work programs
- Financial detox
- Alternative funding sources
  - STR, SOR, DCF, OSCA
Individual Stops Treatment

- Individual doesn’t return to treatment
- Individual leaves despite staff recommendations to remain in services
- Follow-up
  - The therapeutic alliance does not end when the individual leaves treatment
  - Why did the individual leave?
  - Can it be resolved?
  - Referrals

(Alfandre 2009)
Administrative Discharge

- Rates of administrative discharge by level of care
  - 30.7% methadone maintenance
  - 24.8% long-term residential
  - 23.7% outpatient
  - 19.8% intensive outpatient
  - 9% detox and short-term residential
  - 4.6% inpatient hospital treatment

(White, et al. 2015)
Administrative Discharge

- 5 consistent reasons for administrative discharge
  - To preserve integrity of the treatment milieu
  - To use the limited services to the best of our abilities
  - To protect the reputation of the treatment program
  - To prevent enabling from the treatment provider
  - To fulfill the ethical obligation of terminating and referring those who fail to respond.

(White, et al. 2015)
Administrative Discharge

- Arguments against the use of administrative discharge – how to retain individuals
  - Admin discharge for the use of alcohol or other drugs is illogical and unprecedented in the health care system
  - Admin discharge casts the treatment provider as persecutor and misjudges consequences of admin discharge on the client.
Administrative Discharge

- Arguments against the use of administrative discharge – how to retain individuals
  - Admin discharge for rule violations is often the endgame in a process of escalating negative transference
  - Admin discharge for behaviors that are unrelated only have a weak connection to recovery of safety issues within the treatment milieu
  - Admin discharge casts the blame on the client and prevents the program from evaluating or refining practice.
How to Improve

- First contact
- When to initiate treatment
  - Medications
  - Counseling
  - Wrap-around services
  - Accessing all levels of care
- Review administrative discharge policies
  - Business as usual
  - Centered around individual
How to Improve

- Take advantage of partnership with Managed Care Program
- Peer integration
- Improve relationship with emergency department and justice system for access
How to Improve

- Evaluate your staff
- Consider one contact for early recovery
- Revisit relationship with emergency department and justice system for access
- Provider prescribing preferences
  - Is the client receiving the right dose?
  - Are behavioral concerns a symptom of inadequate dosing?
- Leave the door open
References

References