PATIENT MANAGEMENT: CARE FOR SUCCESS IN THE OPIOID EPIDEMIC

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Disclosure Information

David R. Gastfriend M.D., DFASAM

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Options/Stock: Alkermes; Intent Solutions
Consultant Fees: BioCorRx, Indivior, Kaleo, Purdue, RCA
IBM Watson/Truven Health Analytics,
Rand Corp.
Patient management:
**Care for Success In the Opioid Epidemic**

- **9:00-10:15** History of a Crisis (30 slds)
- **10:15-10:30** Break
- **10:30-11:15** Brain Science & Psychoeducation (22 slds)
- **11:15-12:00** Stages of Change & ASAM (22 slds)
- **12:00-1:00** Lunch
- **1:00-2:15** Counseling Models (30 slds)
- **2:15-2:30** Break
- **2:30-3:15** Medical Management, Cases (22 slds)
- **3:15-4:00** Threading Systems & Closing Gaps (18 slds)
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Purpose of the Workshop

- Medication in Addiction treatment (MAT): using meds + counseling to treat substance use disorders (SUD) such as addiction to heroin & prescription opioid pain relievers & prevent opioid overdose.
- We should care about success rates; if we do, care can yield success, even in an epidemic.
- We will review how brain & clinical research elucidate strategies for patient management, specifically for MAT.
- These strategies can improve patient engagement, retention, adherence to counseling and medication, support from families/significant others, completion of therapy, and continuity of care.
Objectives:

As a result of this workshop, participants will be able to:

- Use brain & clinical research to understand behavior in illness & recovery - and how MAT can mediate the illness.
- Anticipate and address key challenges at each stage of the MAT process: to help patients with OUD choose treatment, minimize drop-out and discontinuation, & plan longitudinal care.
- Evaluate recovery in a multidimensional, patient-centered, team – to determine treatment plan revisions – including MAT completion.
Defining Addiction (ASAM)

- A primary, chronic disease
- of brain reward, motivation, memory
- and related circuitry.

Characterized by:
- Inability to consistently abstain
- Impairment in behavioral control
- Craving; or increased “hunger” for drugs
- Diminished recognition of significant problems with one’s behaviors & interpersonal relationships
- Dysfunctional emotional response

[www.asam.org](http://www.asam.org)
Public Health Model of an Epidemic

Addiction:

Agent

Host

Environment
Public Health Model of an Epidemic

Addiction:

Agent

↑: receptor affinity, purity, faster routes of administration
↓: blockade

Environment

↑: access, lower cost, prescribing
↓: culture change, neighborhood policing, PDMPs, sanctions

Host

↑: genetic, congenital & acquired vulnerability, comorbidity
↓: resilience, coping
Brain Reward:
With us throughout evolution
Brain Structure:
Two Regions – Cortex & Limbic

Cortex
Role:
- Decision making
- Thinking
- Reasoning
- Learning

Limbic Region
Role:
- Basic Drives
- Experience of Reward, Euphoria

Crude Opium Latex on Poppy Head
Opioids

- **Morphine**
- **Codeine**

Naturally occurring opioids
- also called opiates

- **Diacetylmorphine (Heroin)**
- **Hydrocodone (Vicodin)**
- **Oxycodone (Oxycontin)**
- **Oxymorphone (Opana)**
- **Hydromorphone (Dilaudid)**

Semi-synthetic opioids
ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter
Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program

Waltham, MA 02154

Industry-funded “educational” messages

- Physicians are needlessly allowing patients to suffer because of “opiophobia.”
- Opioid addiction is rare in pain patients.
- Opioids can be easily discontinued.
- Opioids are safe and effective for chronic pain.
Industry-funded groups pushed more opioids

- Pain Patient Groups
- Professional Societies
- The Joint Commission
- The Federation of State Medical Boards
Opioid Sales, Deaths & Treatment

- 1999–2010

Graph showing trends in Opioid Sales KG/10,000 and Opioid Deaths/100,000 from 1999 to 2010. The graph indicates a steady increase in both sales and deaths over the 12-year period. Source: CDC. MMWR 2011.
Pain Patients & Drug Abusers: NOT Different

Aberrant drug use behaviors: common in pain patients

63% admitted to using opioids for purposes other than pain

35% met DSM 5 criteria for addiction

92% of opioid OD decedents were prescribed opioids for chronic pain.


State interventions: improving outcomes

New York: 75% decrease in patients seeing multiple prescribers for the same drugs, 75% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose. 2012 Action: New York required prescribers to check the state’s prescription drug monitoring program before prescribing painkillers. 2013 Result: Saw a 75% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose.

Florida: 50% decrease in overdose deaths from oxycodone. 2010 Action: Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices. 2012 Result: Saw more than 50% decrease in overdose deaths from oxycodone.

Tennessee: 36% decrease in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose. 2012 Action: Tennessee required prescribers to check the state’s prescription drug monitoring program before prescribing painkillers. 2013 Result: Saw a 36% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose.
Prevention: Education, Monitoring, OD Reversal

- Mandate Training: <1% of US MDs train in addiction medicine
- Develop better abuse-deterrent opioid medicines
- Rx Drug Monitoring Programs: Need a nationwide system

- Naloxone: Can cut U.S. opioid overdose deaths in half
Build evidence base for policy prevention strategies that work like pain clinic laws and regulations, or naloxone access laws.

Prevention for States Program

COMPONENTS

1. Enhance & Maximize PDMPs
   - Universal PDMP registration & use
   - Make PDMPs easier to use & access
   - Real-time PDMPs
   - Expand/improve proactive reporting
   - Public health surveillance w/PDMP

2. Community or Health System Interventions
   - Implement or improve opioid prescribing interventions for insurers, health systems, or pharmacy benefit managers.
     - Prior authorization
     - prescribing rules
     - academic detailing
     - Enhance adoption of opioid prescribing guidelines

3. State Policy Evaluation
   - Build evidence base for policy prevention strategies that work like pain clinic laws and regulations, or naloxone access laws

4. Rapid Response Projects
   - Allow states to move on quick, flexible projects to respond to changing circumstances on the ground and move fast to capitalize on new prevention opportunities
“Ask your doctor if taking a pill to solve all your problems is right for you.”
## Patient management:
### Care for Success In the Opioid Epidemic

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fMRI Cue Activation by Alcohol Images

Social Drinkers  Alcohol-Dependent Individuals


Extended-release injectable naltrexone (XR-NTX) attenuates BOLD signal activation to olfactory and visual cues in detoxified alcohol-dependent volunteers.
Results: fMRI BOLD Signal Activation

XR-NTX Patients: 2 wks Post- vs. Pre-Treatment

XR-NTX appears to maintain abstinence
- Enhanced reactivity to conditioned cues may play a role in relapse
- XR-NTX decreased (blue pixels) cue reactivity to alcohol odors & photos

- Limitations: Modest sample size (N=31), non-clinical measures
Brain Structure: Two Regions – Cortex & Limbic

Cortex
Role:
• Decision making
• Thinking
• Reasoning
• Learning

Limbic Region
Role:
• Basic Drives
• Experience of Reward, Euphoria

Interventions
• Psychosocial Therapies
• 12 Step Programs
• Monitoring

Interventions
• Agonist Medications
• Antagonist Medications

Reward/Motivation ("Go" signals) & Inhibitory Control ("No Go") are disrupted & must be addressed in prevention & treatment.
Healthy Opioid Receptor Activity

Dopamine
- Eating when hungry
- Drinking when thirsty
- Rewards survival behavior

Endorphins
- Pain relief
- Stress relief
- Emotional bonding

Opioid Agonists & Partial Agonists

**Agonists**
- Opioid analgesics
- Illicit opioid (e.g., heroin)
- Methadone
- Activates opioid receptors
- Excess dopamine release

**Partial Agonists**
- Buprenorphine
- Same as agonists, but ceiling effect
Opioid Antagonist

**Antagonist**
- Naltrexone
- Blocks opioid receptor
- Preferentially binds to the opioid receptors
- Displaces opioids
Brain Reward: Clinical Pharmacology

- Ventral Tegmental Area
- Nucleus Accumbens
- Arcuate Nucleus
- GABA (Dopamine)
- Naltrexone
- Opioid Peptides
- Dopamine
Full and Partial Agonists vs. Antagonists

An agonist has an active site of similar shape to the endogenous ligand binding to the receptor and producing the same effect.

An antagonist is close enough in shape to bind to the receptor but not close enough to produce an effect. It also takes up receptor space and so prevents the endogenous ligand from binding.

Log Dose vs. Opioid Effect Graph:
- Full Agonist (Methadone)
- Partial Agonist (Buprenorphine)
- Antagonist (Naloxone)
Neurotransmitter Mediators of OUD: Positive AND Negative Reinforcement

CRF = corticotrophin releasing factor
AMPA = amino-3-hydroxy-5-methylisoxazole-4-propionic acid
GABA = gamma amino butyric acid
NE = norepinephrine

Reward & Positive Reinforcement

- Pain: brain’s natural signal to protect the body
- Proper goal of pain medicine: alleviate *but not eliminate* pain
- Exceeding pain alleviation – risks euphoria
- Euphoria = reward
- Repeated reward → positive reinforcement
- The “Go” System
Withdrawal & Negative Reinforcement

- Opioid drugs all wear off after a while
- When excessive opioid doses wear off, the brain is in withdrawal
- Withdrawal is an uncomfortable, even painful state even worse than the pain preceding the medicine
- This negative effect → wanting to keep taking opioids, known as negative reinforcement
- Disrupted ability of inhibitory control damages the “No Go” system
Neurobiology of Opioid Use Disorder

- Opioids: at substantia nigra & VTA interneurons, rapidly & briefly bind MOP-r, GABAergic inhibition of DA neurons
- **Dopaminergic Reward**: Initial positive reinforcement; later, regulatory changes via mRNA or protein/peptides
- Recurrent withdrawal negatively reinforces recurrent use, via regulatory changes that persist for weeks/months
- **Negative Reinforcement**: mediated via
  - Upregulation of the KOP-r/dynorphin system (may underlie aversion, dysphoria/anhedonia, and depression-like or anxiety-like states)
  - Stress-responsive brain areas via the hypothalamo-pituitary-adrenal (HPA) axis

(Kreek et al., J Clin Investigation 2012)
A Biopsychosocial Disorder: Treatment + Chemistry

Medications (All FDA-approved Agents)

Behavioral Therapies (Including Contingency Management)

Medical Detoxification Services

Recovery Support Services

Sanctions: measured, prompt, scientifically sound
OUD Behavior: Mediators/Moderators

- Maturation, sanctions
- Support, counseling
- Opportunity, Outward Bound
- Contingency Management
Can Treatment Work for All With Addiction?

**Physician Substance Abuse and Recovery**
What Does It Mean for Physicians—and Everyone Else?

David R. Gastfriend, MD

The 10% to 15% prevalence of substance use disorders among physicians is similar to that in the general population, but the quality and intensity of treatment given to physicians may far exceed that available to other individuals with these disorders. Recognition of the impaired physician began to emerge only in the 1970s and has led to the development of physician health programs (PHPs). These are now mature models, available in many states, usually through medical societies, as an alternative to monitoring by state government boards of registration in medicine. In many cases, physicians who voluntarily contract with a PHP may remain anonymous to the state medical board and the National Practitioner Data Bank, a feature designed to promote early intervention in the disease process, i.e., before patients are harmed. Many PHPs now offer services to other health professionals also. Treatment in these programs is probably the most compre-

See also p 1453.

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Substance Use Disorders: DSM-5

Problematic pattern of ≥2 in a 12 mo. period leading to impairment/distress

1. Larger amounts or periods of use than intended
2. Persistent desire or unsuccessful cutting down
3. Excessive time obtaining, using or recovering
4. Craving
5. Recurrent use resulting in failure at work, school or home
6. Continued use despite social/interpersonal problems
7. Important social/occupational/recreational activities given up
8. Recurrent use in physically hazardous situations
9. Continued use despite knowledge of a problem
10. Tolerance* - absolute (or relative)
11. Withdrawal* - characteristic Sxs (or avoided via substance use)
Substance Use Disorders: DSM-5
Problematic pattern of ≥2 in a 12 mo. period leading to impairment/distress

- **Severity Rating:**
  - 2 Criteria: Mild
  - 4 Criteria: Moderate
  - 6 Criteria or more: Severe

- **In Early Remission:**
  No criteria met for 3 to <12 months (except craving)

- **In Sustained Remission:**
  No criteria met for ≥12 months (except craving)

- **In a Controlled Environment:**
  If access to substance(s) has been controlled
Substance-induced Syndromes
list in addition to abuse/dependence

1. Delusional: alc., amphet., cannabis, cocaine, halluc., PCP intox
2. Delirium & Hallucinosis: all intox.; except caffeine & nicotine
3. Withdrawal Delirium: alcohol & anxiolytics (incl. relative WD)
4. Hallucinogen Persisting Perception Disorder: “flashbacks”
5. Mood Disorder: intoxication with all; except caffeine, cannabis & nicotine
6. Anxiety Disorder: either intox or WD; except nicotine & opioids
7. Sleep Disorder: intox or WD, with alc/seds, stimulants, or opioids
The Phases of Treatment

- **Withdrawal Management** – Medical Detoxification
- **Post- Withdrawal Anti-Craving Medication** – stabilizing brain chemistry
- **Counseling** – for the real *work* of recovery
  - Accept the disease
  - Know one’s vulnerabilities
  - Anticipate risk factors
  - Insulate from re-encountering the drug of abuse, even under stress
  - Master new coping behaviors
  - Construct healthy relationships
  - Find purpose in life/spiritual grounding
Goals of Anti-Opioid Pharmacotherapy

- **Withdrawal Management** alone: *inadequate care*
- **Early recovery protection:** period of highest risk for OD
  - Death rates upon prison release = 12-100x that of general population
  - Harm reduction, e.g., from HIV and HEP C transmission
- **Anti-craving:** stabilize urges/impulses to use long enough to permit counseling effects to take hold
- **Stress Response Normalization:** OUD disrupts ACTH/Cortisol
- **Extinction:** of both positive and negative cue response
- **Biological Stabilization:** Eating, diurnal cycle, sexual function, capacity for self-care / activities of daily living / treatment retention, general healthcare, relationship bonding
- **NOT Recovery:** Disease acceptance, coping skills, rehab
The Stages of Change Model of Recovery

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Addiction
- Recovery

Flowing from Precontemplation through Action, leading to Maintenance, transitioning to Preparation, and subsequently entering Contemplation, followed by Action and Maintenance.
The Stages of Change: Therapeutic Work

- **Patient Stage** Therapist’s Motivational Task

- **Precontemplation** ↑ patient’s perception of problems

- **Contemplation** ↑ awareness of risks of no change
  ↑ self-efficacy for change (coercion?)

- **Determination** Help determine course of action

- **Action** Initiate behavioral steps for change

- **Maintenance** Use relapse prevention strategies

- **Relapse** Renew process without demoralization
Motivational Interviewing

A counseling style based on the following assumptions:

- Ambivalence about substance use change is normal and a motivational obstacle.

- Direct argument & aggressive confrontation may increase client defensiveness & reduce the likelihood of behavioral change.

- Ambivalence can be resolved by working with intrinsic motivations & values.

- The alliance between provider & client is a collaborative partnership to which you each bring important expertise.

- An empathic, supportive, yet directive, counseling style provides conditions under which change can occur.
Increased amount of substance or have you used a more rapid route of administration?

"Do you feel you are likely to continue using or, if not using, that you are in danger of relapsing? How soon...? Do you feel at risk, even if you have had some treatment previously?"

"Do you have any concerns about pursuing treatment...? Would anything possibly hold you back, such as money, insurance, schedule, attending groups, having to take medicines, drug tests, or drinking or drug-using friends?"

"How do you think treatment will help? or, if rejects help, Why do you think treatment will not help? If entering or continuing treatment: Do you expect to be in treatment in 3 months?"

"What might cause you to relapse in the future?"

"How do you plan to prevent relapses? After answer, if not mentioned, ask: How about counseling, meetings, a sponsor, or new activities or sober friends? How active have you been..."
Motivational Interviewing

1. Express empathy through reflective listening.

2. Develop discrepancy between clients' goals or values and their current behavior.

3. Avoid argument and direct confrontation.

4. Adjust to client resistance rather than opposing it directly. Roll with resistance, side with the negative ambivalence, reframe

5. Support self-efficacy and optimism.
Screening & Response: SBIRT

Screening, Brief Intervention, & Referral to Treatment
Evidence-based practice to detect, reduce, & prevent problem use.

1. Screening – a healthcare professional assesses patient for risky substance use behaviors using standardized screening tools. Can screen in any healthcare setting.

2. Brief Intervention – engage patient with risky use in a short conversation; provide feedback & advice.

3. Referral to Treatment – provide referral to brief therapy or additional treatment if patient needs additional services.

http://www.integration.samhsa.gov/clinical-practice/sbirt
Overdose Risks & Solutions

- Opioid Risks: Prescriptions, heroin, illicit fentanyl
- Polypharmacy: Benzodiazepines, Alcohol, Stimulants
- Other Risk Factors: switching pain meds, COPD, Sleep Apnea
- Check the PDMP: Rx Drug Monitoring Program
- Address Predispositions: controlled environment re-entry
- Counsel RE “Testing” agonist/antagonist medications
- Narcan & CPR for all opioid users, family/supports, providers – NOTE: 911 Good Samaritan assurances
Overdose Risks & Solutions

- Teach safe use: “IF you’re going to use, use a “Test Shot” & always use with others.”
- Narcan® and CPR for all opioid users
  - Between injection & death \textit{1-3 hours to reverse an OD}
  - San Francisco DPH (2003-09)
    1,942 trained w/naloxone; 24% took a refill
  - 11% used for an OD.
    399 cases, 89% reversed; <1% serious adverse effects.
- 911 Good Samaritan assurances
- Give Narcan to: users, families, 1\textsuperscript{st} responders, bars/clubs
- Train in Rescue Breathing
Google implemented new restrictions on advertising related to searches for addiction treatment after "misleading experiences" involving treatment centers, a company spokeswoman said.

Dominick Reuter/Agence France-Presse — Getty Images
Patient Selection

Patient Assessment: organize with ASAM Criteria dimensions

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications
- Readiness to Change
- Relapse, Continued Use, or Continued Problem Potential
- Recovery/Living Environment
# ASAM Placement Criteria

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<td>Criteria</td>
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<td>Intoxication/Withdrawal</td>
<td>no risk</td>
<td>minimal</td>
<td>some risk medical</td>
<td>severe risk</td>
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<td>Medical Complications</td>
<td>no risk</td>
<td>manageable</td>
<td>monitoring required</td>
<td>24-hr acute med. care</td>
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<td>Psych/Behav Complications</td>
<td>no risk</td>
<td>mild severity</td>
<td>moderate</td>
<td>24-hr psych. &amp; addiction Tx required</td>
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<tr>
<td>Readiness For Change</td>
<td>cooperative</td>
<td>high resist., needs 24-hr motivating</td>
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<td>Relapse Potential</td>
<td>maintains abstinence</td>
<td>unable to control use in outpt care</td>
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<td>Recovery Environment</td>
<td>supportive</td>
<td>less support, w/ structure</td>
<td>danger to recovery, logistical</td>
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<td></td>
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<td>can cope</td>
<td>incapacity for outpt</td>
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# ASAM Placement Criteria

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<th>Levels:</th>
<th>Outpatient</th>
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<th>Day Treatment</th>
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<td>Sub-levels:</td>
<td>Withdrawal Management (L-1, 2.5, 3.2, 3.7, 4)</td>
<td>Biomedical Enhanced (L-3.7)</td>
<td>Co-Occurring Disorders Capable (L-2, 3)</td>
<td>Co-Occurring Disorders Enhanced (L-2, 3)</td>
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<td>2. Biomedical</td>
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<td>6. Environment</td>
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Level of Care for MAT Support

- Based on the ASAM Criteria decision rules
- **Level 3**-Withdrawal Management (WM) Inpatient Care
  Severe withdrawal, with med/psych issues & unlikely to complete
- **Level 2**-WM Intensive Outpatient (IOP) Care
  Moderate, needing daytime support & supervision, But with a supportive evening/night environment
- **Level 1**-WM Outpatient Care
  Mild withdrawal and stability across all 6 dimensions
- **Level OTS** Opioid Treatment Services
  Need for daily opioid agonist meds, plus counseling
  For severe, unstable addiction & chaotic life environment
ASAM Criteria Decision Rules – Mr. D.

- Mr. D. is a 41 y/o MWM unemployed carpenter, referred by his wife, a nurse, who, after a recent relapse, will soon throw him out if he continues his daily 6-pack habit and Percocet.

- His history includes no prior withdrawal symptoms, but + major depression with suicidal ideation, intermittent prescribed opiates for low back injury, & alcoholism in his father.

- He would now accept treatment, including abstinence from any opiates, restarting his antidepressant, & attending some AA meetings.
ASAM PPC Decision Rules – Mr. D.

LEVEL OF CARE

D I M E N S I O N
1  2  3  4  5  6
WD  Bio  Psy  Mot  Rel  Env

1 - Outpatient
2 - Day Tx
3 - Med Mon
4 - Med Mgd

Level 2
Patient management:
Care for Success In the Opioid Epidemic

9:00-10:15  History of a Crisis  (30 slds)
10:15-10:30  Break
10:30-11:15  Brain Science & Psychoeducation  (22 slds)
11:15-12:00  Stages of Change & ASAM  (22 slds)
12:00-1:00  Lunch
1:00-2:15  Counseling Models  (30 slds)
2:15-2:30  Break
2:30-3:15  Medical Management, Cases  (22 slds)
3:15-4:00  Threading Systems & Closing Gaps  (18 slds)
The Phases of Treatment

- **Withdrawal Management** – Medical Detoxification
- **Post-Withdrawal Anti-Craving Medication** – stabilizing brain chemistry
- **Counseling** – for the real *work* of recovery
  - Accept the disease
  - Know one’s vulnerabilities
  - Anticipate risk factors
  - Insulate from re-encountering the drug of abuse, even under stress
  - Master new coping behaviors
  - Construct healthy relationships
  - Find purpose in life/spiritual grounding
Psychosocial Therapy/Support

- Brief interventions
- Motivational Enhancement Therapy
- 12-step programs
- Cognitive-Behavioral Therapy
- Cue exposure therapy
- Behavioral Couples Therapy
- Recovery Support Services: Coaches, Wrap-Around Services
- Contingency Management
Motivational Enhancement Therapy

- Helps resolve ambivalence about engaging & abstaining.
- Aims to evoke rapid, internally motivated change, rather than guide patient stepwise through recovery process.
- After assessment, 2 to 4 sessions (1:1)
  - 1: Feedback, stimulate discussion & self-motivational statements. Use MI to build motivation & a change plan, with coping strategies for high-risk situations.
  - 2-4: Monitor change, review strategies, boost commitment.
- Effective for alcohol, MJ, (with CBT); mixed for other drugs. More effective for treatment engagement than for cessation.
Alcoholics Anonymous – The 12 Steps

1. Admit powerlessness over alcohol
2. Believe in a Power greater than the self
3. Decision to turn to God “as we understood Him”
4. Moral inventory of the self
5. Admit to God, self, & another the nature of one’s wrongs
6. Being ready to have God remove these defects of character
7. Humbly asking Him to remove one’s shortcomings
8. Making a list of persons harmed, & willingness to make amends
9. Making direct amends
10. Continuing to take personal inventory & admit it when wrong
11. Seeking through prayer & meditation to improve
12. Carry this message to alcoholics & practice these principles
Cognitive Behavioral Relapse Prevention

1. Initial abstinence:
   Enforced isolation from drugs, strict cue avoidance

2. Cues partially reintroduced as mental images...
   Developing coping strategies

3. Gradual re-entry to cue-rich environment

4. Continuous, then periodic maintenance therapies
   ▪ Strengthening memories of negative consequences (drug-a-logs)
   ▪ Decreasing external stress

Auricular acupuncture: ineffective in sham- vs. dose- trial
Patient Engagement

- Use a Motivational Interviewing (MI) model of assessment and psychoeducation,
- Advise patients of their options,
- Discuss relative success rates of MAT vs. non-MAT care
- Review the treatment burdens
  - Initial withdrawal management
  - Tapering upon cessation
  - Length of treatment
  - Side effects
  - Contraindications, cautions & warnings
Patient Engagement

[Use your Peer Mentors – by phone & even in person]

- Medical Management
  - Evidence-based, brief counseling model to reinforce:
    - Adherence
    - Counseling participation
    - Mutual-help group activity
    - Recovery

(COMBINE Project, 2004)
Patient Engagement

- Timely communication between teams:
  - Addiction
  - Medical
  - Justice
  - Significant Other(s) & Family

- Re-assess & modify the treatment plan when escalation is needed
  - not just the meds
Incentives WORK!

Contingency Management (CM): Incentives for addiction treatment – effective for all drugs, >40 RCT’s, 5 meta-analyses

Yet over 90% of U.S. addiction treatment programs do not use it!

Barriers to adoption:
- Cost of rewards
- Labor-intensive (drug testing & distributing rewards)
- Lack of training, culture
HOW INCENTIVES CAN WORK

Crowdfunding campaign raises money for incentives

Smartphone app, debit card, & testing device

User gets “random” alerts for drug testing

User performs drug test, Selfie-video verifies it

Funds deposited onto debit card with built-in protections for early recovery
Counsel the Patient Regarding…

- To withdraw or not to withdraw – that is the question
- Tolerance: sensitivity to lower doses of opioids OD risk. Advise the rest of the treatment team too, and inform family/SOs.
- Will opioid analgesics, antidiarrheals, or antitussives work?
- Will patient perceive any effect if they self-administer opioids?
- Using to get high despite MAT may → injury, coma, or death
- Side effects, common/mild & rare/serious
Counsel the Patient Regarding…

- Mood effects: Depression
- Cognitive effects: Slowing, dizziness: initially, avoid driving
- Naltrexone “Flu” and nausea - tend to be mild, for a few days
- Daily reinforcement on methadone & less so, buprenorphine
- MAT best long-term effects expected with counseling
- Notifying prescriber in case of pregnancy/breast-feeding
Psychosocial Therapy/Support

- Psychosocial therapies: dominate in the U.S. as stand alone care – without meds
- This stands in stark contrast to extensive research evidence favoring COMBINED care with medication
Counseling With MAT: WHAT?

- What is the Clinical Benefit?
- Should I Go Through Detox?
- What are the Side Effects?
- What are the Long-Term Effects?
- What Happens to Quality of Life?
- What Happens to Treatment & AA/NA?
- What Happens to Enjoyment & Pleasure?
Counseling With MAT: WHO?

- Who Can Be Considered for Which Meds?
- Who Benefits the Most from Which Meds?
- Who Should NOT Receive MAT?
- Is MAT for Criminal Justice Patients?
- Who Should Be Involved in Care?
Counseling With MAT: HOW?

- How Do You Describe MAT At Intake?
- How Do You Address Ambivalences?
- How Do You Deal With Obstacles?
- How Should Family Be Included?
- Doctors & Other Strangers
- How Will I-We-They Know If It Works?
- How to Contract For Success
Counseling With MAT: HOW?

- Exploring The Patient’s Perceptions
- How Does Craving Change?
- Losing the High/Euphoria
- How Will I Cope?!
- How to Talk About Vivitrol In A.A.
- How Does MAT Promote Acceptance? The 1st Step
Participation in Additional Counseling & Support Groups

Gromov et al., AMERSA 2008
Counseling With MAT: HOW?

- Suffering Real Emotion Without Escape
- Fostering Self-Efficacy
- Remembering Vulnerability
- Is There Spirituality After Technology?
- Setbacks & Contingencies
- How Long Should MAT Be Continued?
- Talking To Offspring Of Risk & Hope
Treatment Program Best Practices

- MAT Adherence Champion – responsible for ongoing adherence monitoring for all patients on MAT
  - Medication Access – get support from sales reps for med availability/reimbursement
  - MAT Patient Tracking System – scheduling/appointment “tickler”
  - Reminder Calls – 3-5 days before the next scheduled injection
  - Missed Appointment Follow-ups – to reschedule
- Referral Affiliation Agreements – for continuity of care
- Opioid Treatment Programs, Buprenorphine & Vivitrol Prescribers, Vivitrol Injectors, Counseling, Psych, Recovery Support Services
Treatment Program Best Practices

- Create relationships with payers and medication distributors
- Secure ordering, tracking & other data procedures
- Set up physical logistics: storage, refrigeration, sharps boxes
- Educate all staff on all agents
- Educate community RE availability of all agents
- Obtain med/nursing resources for care in all agents
- Screen all eligible patients & document patient selections
- Create patient and family education
- Use a Recovery Support Team Agreement (or contract)
## Recovery Support Services

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Description</th>
<th>Peer Support Service Examples</th>
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</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Demonstrate empathy, caring, or concern to bolster person’s self-esteem and confidence.</td>
<td>Peer mentoring Peer-led support groups</td>
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<tr>
<td>Informational</td>
<td>Share knowledge and information and/or provide life or vocational skills training.</td>
<td>Parenting class Job readiness training Wellness seminar</td>
</tr>
<tr>
<td>Instrumental</td>
<td>Provide concrete assistance to help others accomplish tasks.</td>
<td>Child care Transportation Help accessing community health &amp; social services</td>
</tr>
<tr>
<td>Affiliational</td>
<td>Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.</td>
<td>Recovery centers Sports league participation Alcohol- &amp; drug-free socialization opportunities</td>
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</tbody>
</table>
Recovery Support Team Agreement

- We understand how important recovery is to you and how difficult it can be. This agreement lists some of the most important things you can do for your recovery. It is to be signed by you and at least other person who you can count on to support your recovery.

- **Patient Agreement:** I, ____________________, agree that ...

- *I will make my recovery the #1 priority in my life* and be active in my recovery program for at least one year and one month.

- *I will work to abstain from all mood-altering substances* and report to members of my Recovery Support Team any increase in craving, worsening of urges, or plans I might have to drink or use any unprescribed substances.

- *I will promptly let all members of my Recovery Support Team know if I drink or use* any unprescribed substances.

- *I promise to keep whatever agreements* I make with my Recovery Support Team, including the treatment schedule described below. If for any reason I don’t keep some part of this agreement, I will re-schedule quickly so that my recovery is not disrupted.
Recovery Support Team Agreement

- **I will provide accurate information** to members of my Recovery Support Team. I will not let embarrassment or false pride keep me talking about difficulties I may be having. Even if it is difficult for me I will be honest about how I am doing with my recovery.

- **I will report** to members of my Recovery Support Team any significant return of symptoms such as: a) drinking, b) drug use, c) urges to drink or use drugs, d) uncomfortable moods, or e) other disturbing physical or emotional symptoms.

- I can be contacted by [ ] telephone [ ] email [ ] mail and/or [ ] in person by members of my Recovery Support Team including qualified members of their staff. I understand that these contacts will respect my confidentiality and that my privacy will be respected at all times.

- **I will discuss any plans I have to end treatment** with my physician and other members of my Recovery Support Team before dropping out of treatment.

______________________________          ________________________________
Patient Signature                       Support Person/Phone#
Treatment Program Best Practices

- **Support from Current MAT Patients** – may volunteer to provide first-hand accounts to prospective and newly initiated MAT patients.

- **MAT Groups** – Provide educational and emotional support, excellent for patients considering MAT

- **Telephone Support** – to enhance persistence with MAT and counseling retention

- **Ongoing Clinical Self-report Surveys** – e.g., BAM - Brief Addiction Monitor, to clarify to patient his/her own risks AND protections and to objectively guide psychosocial support/counseling
## Patient management: Care for Success In the Opioid Epidemic

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Duration</th>
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<td>9:00-10:15</td>
<td>History of a Crisis</td>
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<td>Threading Systems &amp; Closing Gaps</td>
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Medical Management

- Follow patient throughout treatment, with assessment, support, & direct advice for recovery efforts.
- Appeal to patients’ common sense & reasoning ability, in relation to the goal of preserving or restoring health.
- In expressing concern for patients, be nonjudgmental. Also be friendly, supportive, & optimistic about recovery. Acknowledge & praise accomplishments & steps taken towards recovery.
Medical Record Mishaps:
(Actual doctors’ writings in hospital charts)

- She has no rigors or shaking chills, but her husband states she was very hot in bed last night.
- She stated that she had been constipated for most of her life, until she got a divorce.
- Patient has chest pain if she lies on her left side for over a year.
- On the second day the knee was better, and on the third day it disappeared.
- Rectal examination revealed a normal size thyroid.
- The patient refused autopsy.
- Discharge status: Alive but without my permission.
Medical Management: Initial Session

- Review intake evaluation results
- Present diagnostic information and set treatment goals
- Provide medication information
- Develop Medication Adherence Plan – individualize it
- Discuss counseling & mutual-support group participation
- Seek patient’s questions, concerns, expectations
- Summarize Initial Session & address patient’s concerns
- 40-60 min
Medical Management: Follow-Up Session

- Check Medical Status & Meds Safety & Adherence
  - Status check, incl. drug tests
    - “What was your goal?”, “How did you do?”
    - Avoid disapproval/disappointment – “What went well?”
    - “What didn’t? What were the circumstances?”
    - Don’t signal that s/he will not attain recovery, rather, note any positives & where more/new efforts may help
  - Troubleshoot Outcomes, e.g., revisit motivating reasons
- Make Recommendations:
  - Add Treatment Components/Escalate Level of Care
- 15-25 min
Medical Attention

- For the primary care OUD patient who is not taking MAT
- Brief Assessment:
  - Medical Status
  - Drug Use Check: “What went well? What didn’t?”
- Review Attendance in Counseling & Use of Mutual-Help
- Recommendations/Troubleshooting
  - Review Motivational Reasons & Goals
  - Add Treatment Components/Escalate Level of Care
- Address Coexisting Medical/Psychiatric Problems
- 10-20 min
Attitudes: Harmful & Helpful

- Attitudes that do a disservice to patients:
  - “If you’re using drugs, you’re not really sober; I did it the hard way”
  - “If you just work the program, you won’t need any drugs”
  - “You can’t treat a drug problem with a drug”
  - “If you are on drugs, you can’t speak at a meeting”

- Attitudes that are justified by the science:
  - We don’t withhold medication from heart disease patients, saying: “You have to stop smoking & lose weight on your own, like I did”!
  - Chronic diseases, like hypertension & asthma have meds. If we want addiction to be treated as equal to other medical illnesses, we need to accept the role of medicine in addiction treatment, too.
  - Opioid patient on XR-NTX: “I never understood it before… but now I know how it is that non-addicts can just ignore drugs. And suddenly I see what it means that I really do have an addiction.”
The Message

Achieving Patient Readiness – Key patient messages:
1. Addiction is chronic, relapsing & life-threatening
2. MAT effectively reduces or even prevents relapse
3. Common & critical side effects *can be addressed*
4. MAT eases craving & reduces trigger responses without emotional or cognitive side effects
5. This gives an important sense of *self-efficacy*
6. Gives the brain a foundation to build long-term recovery
Patient Retention

- Help patient understand need for longitudinal care, mutual-help participation
- Help patient anticipate of relapse risks & loss of motivation
- Coordinate messaging & follow-up visit reminding with patient, supportive others, program/med/justice staff
- Co-occurring Disorders Management: Both psychiatric & medical conditions are commonly found in the SUD population and may complicate care and recovery.
Supportive Other/Family Education

- Early identification
- Obtaining consent to involve & be in contact
- With one or more supportive others
- Both initially & throughout follow-up
- Reinforce safety & retention
- With both MAT & counseling
Med Discontinuation & Follow-Up

- Opioid substitution is necessarily a long-term treatment since withdrawal causes frequent relapse upon taper.
- Vivitrol – no withdrawal, used to stabilize craving, establish disease acceptance, & engage in recovery – which may ensue in weeks or months.
- Team should work with patient to determine MAT duration
- MAT should be administered based on the patient’s engagement in psychosocial treatment, recovery efforts and functional progress.
- The assessment model for this is the ASAM Criteria. An MAT Completion Protocol has been developed by Dr. Gastfriend on behalf of FADAA and DCF.
Post Medication Outcome Tracking

- Opioid Use Disorder is chronic & relapsing
- Track after MAT to determine if patient needs to restart
- Preferably before physiological dependence is reinstated
- Before other morbidity occurs,
- During the window of opportunity to quickly re-engage
- Ask for follow-ups reports on post-MAT outcomes
- Advise patient of the need to return for re-assessment and re-initiation of medication
Problem Solving
From Screening to Prescribing

- In medicine, patients accept a majority of treatment recommendations made by their physician.
- In addiction, <50% of eligibles actually get MAT.
- The largest cause of drop-off: lack of readiness for a definitive treatment, due to the motivational disruption of addictive disease.
- This problem is followed by culture obstacles in the treatment environment.
- Patient failure to engage is commonly due to:
  - Delays: insurance, wait-list delays, detox (w/XR-NTX)
  - Stigma
  - Motivational impact of the disease.
Be Vigilant For Risks

- MAT blockade testing & override attempts
- Seeking prescribed opioids (either excessive agonist MAT doses or analgesics) to divert them for income – despite MAT
- Not adhering to prescribed regimens
- Returning late for refills
- Premature discontinuation.
- Address risks proactively: advise patient, supportive others, providers; monitor attendance & drug tests; communicate among addiction/medical/justice teams in timely fashion; re-assess & modify plan/ escalate as needed, over & above MAT
Drug-Drug Interactions

- Few with the current MAT options, but require prospective awareness/monitoring
- **Precipitated opioid withdrawal** – not a side effect, but is an adverse event
- Encourage calls to report; help prescribers improve
Adverse Events

- Side effects can occur with any medication
- AEs fall into basic categories:
  - Serious Adverse Events (SAEs) – rare, but need to anticipate them; may require ED
  - Routinely advise patients to expect common, mild to moderate side effects
- Of greatest concern early; mentoring helps
  - With experience, these become less frequent
- Vivitrol precipitated opioid withdrawal: not a side effect but is an adverse event due to inadequate withdrawal.
- Phone mentors to report these episodes, so they can help improve success with detox and induction.
MEDICATION ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS:

CASES
Case Description Mishaps: Things to Avoid…

• (Actual doctors’ writings from hospital charts)
  • She has no rigors or shaking chills, but her husband states she was very hot in bed last night.
  • She stated that she had been constipated for most of her life, until she got a divorce.
  • Patient has chest pain if she lies on her left side for over a year.
  • On the second day the knee was better, and on the third day it disappeared.
  • Rectal examination revealed a normal size thyroid.
  • The patient refused autopsy.
  • Discharge status: Alive but without my permission.
Patricia: “Hopeless”

- I don’t remember my last arrest for DUI in December of 2009….But I read about it. The police report talked about my 8Th Dui arrest in 11 yrs. I was arrested in 1998 for my 3rd dui before I was sentenced for my 1st. I spent a total of 44 months locked up, 28 months of that was is in Woman’s Prison. Treatment was never an option in MI. From 1998 – 2006, I cost MI $85,000.00 in housing.

- In February 2009 I was arrested for my 7Th Dui in Missouri. I was not registered in the state so…my past went undetected and was charged with a 1st offense dui in Missouri.

- By the fall of 2009 my alcoholism had progressed to Insanity. I would have conversations in my head and sometimes out loud to myself. “I am not going to drink today”, as I was getting into my car heading to the store. On the drive there I would tell myself, “I am not buying alcohol”. In the store as I am buying it I am telling myself “I will put this in the cupboard and not open it”.

- Dec 2009 I was arrested for my 8th dui in Stone County, MO on way to store.
Patricia: “Hopeless”

- Judge Alan Blankenship allowed me to submit an application for Drug/Dui court. I was looking at 7 yrs in a Missouri Prison and the assistant prosecutor wanted nothing less. The Drug/Dui court team recognized my need for treatment, something I had never been given.

- Even with the possibility of 7 yrs in prison as my sentence I could not stop drinking. Physically I cold not get out of bed in the mornings before taking several drinks. I woke frequently in my own vomit. My days ran into weeks, weeks into months. Not showering for days because I was to week to stand.

- By the time I received the call that I was to report to treatment I just wanted God to take me. I had my last drink April 1st 2010. I was so sick that I was taken to the hospital for treatment before detox. I rolled over into a 28 day treatment program and entered drug/dui court upon my commencement.
Patricia: “Hopeless”

- The 8 months in the Vivitrol program allowed my mind to concentrate on recovery. The constant thoughts of drinking were not there, giving me time to develop tools to become a functional, teachable, human being.

- Off Vivitrol for 7 month. Completed 16 months of sobriety on Aug 2, 2011…greatest accomplishment of my entire life. Judge Blankenship and the rest accomplished in 16 months what no other Court system, Jail, Prison, or Dr could….TODAY I DO NOT HAVE TO DRINK!

- I have rebuilt relationships that my alcoholism destroyed. I am for the first time in my life in a healthy relationship. My Husband has lovingly and sometimes not so lovingly given me strength to to live life on life’s terms.

- Going to be a Grandma in Dec. I will be the person in my family who will break this generational cycle of alcoholism.
Case (Part I)

- Johnny is a 34 yo male; hurt back working in the coal mines and was rxed opioids; use escalated and he began using multiple oxycodone with APAP 30/500 mg tabs through IV route daily. Meets criteria for Opioid Dependence, LFTs less than 3x normal.

- Tried buprenorphine from a clinic where he saw a doctor and received a prescription: “It didn’t work for me. I just stopped taking it and used, and took it some more and then stopped and used. It was too easy to game it. I need more. I don’t want that medicine”.

Case (Part II)

• Johnny did extremely well with methadone at a maximum dose of 85 mg per day and began a gradual dose reduction. At 3 years he on 70 mg and has been eligible for 27 take homes per 28 days, but opts to get 13 in 14 days (“I don’t trust myself with more. I need to come here to keep myself honest”.)

• He has an opportunity to change jobs from underground mining to hauling coal locally, which requires a commercial driver’s license. He is willing to change to buprenorphine, recognizing he is now doing well presenting every 2 weeks to clinic.
Case (Part III)

• Johnny made the change from methadone to buprenorphine, stabilized at 12 mg qd for a year and gradually tapered to 4 mg qd. Attempts to lower the dose have failed.

• Continues to choose present q 2 weeks to clinic, although eligible for monthly visits and has been encouraged to find support outside of clinic.

• Local mines have closed, and he has the option for work in another state. Plans to come home once monthly. Will have insurance with new job, and has saved substantial money since he stopped using street opioids and began treatment 6 years ago.
I have a 19 year old son who did the usual progression from marijuana to percs and oxys. He went through several rehabs and relapses and was one week shy of completing an extended care program and hitting his one week clean mark.

He relapsed and spent 5 weeks in a downward spiral that finally reached IV heroin. He reached out for help to his sponsor and others he knew from his program and AA. He went to his psychiatrist who suggested he try Vivitrol.
The doctor first put him on a two week trial of oral naltrexone to see how he would tolerate the drug before committing to the shot. He waited 7 days after his last use before starting, but all the opiates were not out of his system. He went through a bad period of withdrawal, including a psychotic episode.
SoberRecovery : Sunday’s Child

- He made it through the two weeks though and got his first shot mid-June. He's since had 3 shots, and is a little over 3 months clean.

- The stated side effects include depression, and I have noticed that he is a little more "edgy" right about when he gets the shot. When he was considering it, the guys from AA discouraged him, saying it was a crutch. He went ahead anyway, feeling that it was his last shot.

- Some try to beat it with large quantities of dope. The risk of overdose at "regular" dosages is also increased after it is stopped. So an addict needs to be really committed, because if you relapse, you risk death. I was terrified when he told me he was trying it - but - it wasn't my choice, it was his.

- It seems to be working for him. He is working a program of recovery, holding a job, and attending college. He swears by the shots, and says he would recommend them to anyone.
Jordyn  Ashland, KY   @Jenna...:

- I'll be 10 months clean tomorrow. I still struggle with the lack of energy. It takes months to gain back your strength, energy, and stamina.

- I know that energy drinks aren't necessarily the best option..best crutch that I found through the days that I felt drained was Redbull. I now may drink one Redbull every two weeks.. so it is getting MUCH better. I can say that as you get farther into being completely clean & sober, you gain a lot of muscle mass back. Where as, while you're still taking the Suboxone, you continue to lose muscle mass and natural body strength daily. You can do it.

- My recommendation – if you're only taking the small amount that you stated, I would quit completely cold turkey.

- Make sure that if you opt to do Vivitrol, you DO wait the entire period that your doctor recommends before taking the
Today is the 25th day after my vivitrol shot. (it lasts 30+ days)

I also just got 1/2 g uncut #4 straight from the village of Azad Afghanistan. The plan was to wait until like the 35th day so i would get maximum benefit. But my dumb ass decided to try to break through the naltrexone blockade with about 80% pure heroin. I ended up using 3/10 g. i could feel something similar to a rush and could feel the heroin. But as I'm sitting here typing 5 minutes later there is not much euphoria at all. Okay now im starting a slight nod. If anyone has any experience/suggestions on this please comment
Drug Users Forum: Bluelight.ru

Yesterday 02:38     It cant really be done.

- the body buzz/couch lock was like my first time, but no rush or great euphoria. pupils did get smaller.

- Conclusion: Unless you have a few hundred thousand dollars laying around wait until you have no naltrexone in your system
abusing suboxone in my opinion is still safer than trying to shoot ungodly amounts of heroin or fentanyl to break through vivitrol. I do know a person on vivitrol right now who claims that it does help him...he's done suboxone and methadone, and now his job is on the line, so he takes Vivitrol because he knows he will absolutely not get high. I've heard many horror story about the implants, people digging them out of there arms with steak knives, etc.. It just seems crazy and nothing I'd ever want to be put on. It doesn't seem that conducive to harm reduction or recovery IMO to force someone on a medication like this. If you go on it without pressure and it works for you that is great, I just don't like it when rehabs and addiction specialists try to pressure patients on to this medication, it seems unethical.
Patient management:
*Care for Success In the Opioid Epidemic*

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-10:15</td>
<td>History of a Crisis</td>
<td>30 slds</td>
</tr>
<tr>
<td>10:15-10:30</td>
<td>Break</td>
<td></td>
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<tr>
<td>10:30-11:15</td>
<td>Brain Science &amp; Psychoeducation</td>
<td>22 slds</td>
</tr>
<tr>
<td>11:15-12:00</td>
<td>Stages of Change &amp; ASAM</td>
<td>22 slds</td>
</tr>
<tr>
<td>12:00-1:00</td>
<td>Lunch</td>
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<tr>
<td>1:00-2:15</td>
<td>Counseling Models</td>
<td>30 slds</td>
</tr>
<tr>
<td>2:15-2:30</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>2:30-3:15</td>
<td>Medical Management, Cases</td>
<td>22 slds</td>
</tr>
<tr>
<td>3:15-4:00</td>
<td><strong>Threading Systems &amp; Closing Gaps</strong></td>
<td>18 slds</td>
</tr>
</tbody>
</table>
Addressing Culture Obstacles

- Involve both the treatment staff and the patient population
- Two long-established, contradictory expectations:
  1) that only a 12-Step approach is acceptable
  2) every patient “deserves” opioid substitution
- Requires team education on the research that counseling alone is worse than counseling + an FDA-approved med
- Also, team needs to hear health economics findings: Counseling-only care is wasteful, vs. counseling + MAT.
- Teams need to talk with MAT patients who are also engaged in counseling and mutual-help
Logistics & Administration Needs

- Broad range of settings, logistics & supports
- Diverse delivery structures, facilities & provider types
- Complex procedures, e.g., sentencing, contingencies
- Monitoring procedures: Drug screens vs. confirmations, various panels, other lab work
- Systems: Medical, SUD psychosocial, MAT, Recovery Support, Justice, Welfare/Medicaid
- Reimbursement: Project funding vs. Medicaid, Free Care Coverage limits vs. Federal Parity Act
Overcoming Logistic Hurdles

- The preferred situation:
  fully established logistics before patient care
- This is not always the case
- Important to mentor RE key front desk personnel responsibilities, insurance coverage determination/managed care interaction, specialty pharmacy ordering, shipping readiness confirmation, cold storage/shelf-life & product tracking, supply management.
- Prescribers have a leadership role in mobilizing the treatment system to overcome specific logistical hurdles
Systems Communication & Linkages

- Challenges: Approvals, reimbursement, co-pays, privacy, handoffs, ethics
- Prescriber ↔ specialty treatment program staff
- Court ↔ treatment program/Jail to treatment program
- Prescriber ↔ PCP
- Unique/disparate MIS/EHR systems: Courts, DCF, FADAA, programs
- Reporting is also needed to CEOs/Clinical Directors
Managing Growth

- To achieve growth, retention is crucial
- Prescribers need to assure smooth operation of: Scheduling, reminder phone calls, supportive other F/U calls, and justice system communications and tracking
- As prescribers acquire more patients: important to aggregate their care into focused sessions & even med groups in order to increase efficiency, and foster optimal retention and persistence
OSCA Vivitrol Initiative
DCF MAT Prescriber Peer Mentoring Project Plan

David R. Gastfriend MD
Director
Peer Mentoring Project: Purpose

To meet the medication-assisted treatment (MAT) needs of:
- Substance use disorder (SUD) patients
- Treatment programs
- Justice systems

The project provides an ongoing, state-wide network of:
- Trainings, materials
- Online & telephone support
- Via expert peer mentoring to: MDs, DOs, NPs, PAs, etc.

To enhance the success of the Florida MAT initiative, i.e., increase the % of patients prescribed MAT for OUD
Addiction Management & Treatment

Most people with addiction are NOT receiving medication-assisted treatment

Volkow et al. NEJM 2016;370:2063-2066
Culture Change

- Use a *change agent approach*
- Analogous to Motivational Enhancement Therapy
- Utilize the Transtheoretical Stages of Change Model
- Non-judgmental exploration of concerns, needs, goals/objectives and resources
- Establish where the system is, relative to use of MAT
  - Pre-contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
  - Lapse (i.e., withdrawing from active administration of MAT)
Results

- 23 Programs Recruited & Launched
- 86% Caucasian, 55% Male, 87% Non-Hispanic
- 39% Alcohol, 52% Opioids, 9% Both
- FY 2015-2016 Performance: Total Billings $4,317,123
- Individuals Screened/Educated = 2,368
  - 58% got labs
- Individuals Receiving MD Assessment/Labs = 1,376
  - 69% entered injection protocol
- Patients Receiving 1 or More VIVITROL Injections = 951
- Success introducing this MAT into new levels of care
Vivitrol 6-Month Retention: Florida + 3 Studies

- Health Prof'ls Study (N=48)
- 1-Year Safety Study (N=101)
- Phase III (N=126)
Results

- Overall, 38% of patients received 3 injections
  BUT…1 program had 3rd injection rates as high as 65%

- Overall, of 380 patients with only 1 injection, 59% got 1 injection followed by ≥60 days of no add’l services
  BUT…one program had less than 10% of patients getting 1 injection followed by ≥ 60 days of no add’l services
Healthcare Costs with OUD Pharmacotherapies

- MMT, direct = $1/day
- MMT, overall = $10-20/day
- BUP = $4-$30/day
- XR-NTX = $20-40/day

- 6-mo retrospective insurance cost study: all meds + inpt + outpt services (N=10,413) casemix controlled with instrumental variable analysis

(Baser O, Chalk M, Fiellin DA, Gastfriend DR. AJMC 17: S235-S246, 2011)
Conclusions: Opioid Dependence

- OUD: a chronic disease needing long’l rehab with both meds AND counseling.
- Goals of treatment/rehabilitation: saving lives, stabilizing behavior & establishing social function
- Agonists & antagonists are superior to counseling alone
- All FDA-approved agents are appropriate 1st-line approaches
- Therefore, programs should provide ALL options, so that patients can be informed of and offered ALL options
- Low initial costs can become high costs longer-term
  High initial costs can result in lower costs longer-term
  Therefore, cost should NOT be a consideration
- Patient choice may be the BEST basis for drug selection.
- If one agent is unsuccessful, other options should be tried.
Operational Needs for Comprehensive Treatment

- Create relationships with payers and medication distributors
- Secure ordering, tracking & other data procedures
- Set up physical logistics: storage, refrigeration, sharps boxes
- Create patient and family education & contract materials
- Educate all staff on all three modalities
- Educate community RE availability of all three modalities
- Obtain med/nursing resources for care in all modalities
- Monitor for emerging buprenorphine formulations
- Screen all eligible patients & document patient selections
Problem Solving

Addressing Culture Obstacles

- Involve treatment staff, front desk staff, and the patient population
- Overcome 2 long-established expectations:
  1) that only a 12-Step approach is acceptable OR
  2) that every patient “deserves” an opioid substitution medication.
- Provide team education on the research that counseling alone is worse than counseling + an FDA-approved med
- Also, team needs to hear health economics findings: Counseling-only care is wasteful, vs. counseling + MAT.
- Teams need to talk with MAT patients who also engaged in counseling and mutual-help
Crisis Calls for a New Look at Under-utilized Tools

- The research, the clinical issues, and what to do about it all.
- Much is known, but studies don’t examine everything.
- Opinions and attitudes have their flaws, too.
- What do we know and what don’t we know?
- What is the anecdotal experience?
- How do we integrate these facts & beliefs in a coherent framework for saving lives and building recovery?
'IT'S ONE WORD GEORGE!'
Addicted to a Treatment for Addiction

By BETH MACY  MAY 28, 2016

April Hileman of Lebanon, Va., tried to overcome an addiction to opioids with Suboxone.
Seizing on Opioid Crisis, a Drug Maker Lobbies Hard for Its Product

By ABBY GOODNOUR and KATE ZERNIKE  JUNE 11, 2017
Myths & Ethical Conundrums

- “Gold standard” = health, NOT necessarily abstinence
- MAT – “Medication-Assisted Treatment”: stigmatizing perhaps should be “Medication in Addiction Treatment”?
- Lifelong “Endorphin Deficiency”: little or no evidence
- MMT & OBOT “long term treatment” is not the norm
- Reinforcement: Critical & inadequately studied
- When MVAs peaked, U.S. mandated airbags, raising car costs by $1,000; OD deaths now surpass MVAs – what can we spend?
- Would we license autos that omit seat belts or headlights? Do we accredit hospitals for bypass surgery without cardiology?
- If other medical/surgical specialties must report 5-year outcomes, shouldn’t addiction treatment services?
- Is it ethical to mandate treatment + pharmacotherapy in CJ? Is it ethical NOT to?
References


• Hulse GK, Morris N, Arnold-Reed D, Tait RJ. 2009. Improving clinical outcomes in treating heroin dependence: randomized, controlled trial of oral or implant naltrexone. *Arch Gen Psychiatry* 66:1108-15


• Ngo HT, Tait RJ, Hulse GK. 2008. Comparing drug-related hospital morbidity following heroin dependence treatment with methadone maintenance or naltrexone implantation. *Arch Gen Psychiatry* 65:457-65


• Reece AS. 2009. Comparative treatment and mortality correlates and adverse event profile of implant naltrexone and sublingual buprenorphine. *J Subst Abuse Treat* 37:256-65


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• ASAM Criteria. Mee-Lee D, Editor. American Society of Addiction Medicine, 2013