Aligning Evidence-Based Practices with CCBHC Financing, Operations, and Quality Reporting

October 25th, 2017
2:00pm – 3:00pm
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Today’s Faculty

Dr. Joe Parks, MD
• Practicing Psychiatrist in a Community Health Center
• Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
• Previously Medicaid Director for Missouri and Medical Director at Missouri Department of Mental Health

Nick Szubiak, MSW, LCSW
• Integrated Health Consultant
• Expert on bi-directional integration of behavioral health and primary care, SBIRT, and substance use treatment such as medication assisted treatment (MAT)
Objectives

• Identify organizational processes and workflows that should be put into place to measure and improve EBP fidelity, use outcomes data to track client progress, and use rapid-cycle change principles to make needed adjustments
• Explore in detail the required Evidence-Base Practice of Medication Assisted Treatment (MAT)
• Learn how to Systematically implement MAT in your organization
National Opioid Overdose Epidemic as of 2016

- Drug overdose is the leading cause of accidental death in the US, with 64,070 lethal drug overdoses in 2016 (21% increase from 2015); an estimated 53,332 have been linked to opioids of some type (an increase of 61% from 2015).
- In 2016 an estimated 21 million people aged 12 or older needed treatment for a substance use disorder, and only 3.8 million people aged 12 or older received specialized treatment.

National Opioid Overdose Epidemic as of 2015

• In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.

• 80% of current heroin users started out misusing prescription painkillers.
Conclusion: Rising rate of overdose deaths is driven largely by Heroin and Fentanyl
Integration and Collaborative Care

- Increase our access to patients
- Provide more EBP to our communities
- More effective
- Reduces stigma
- Client Centered – The patients treatment plan

Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care

At 6 months, the proportion of participants who received any OAUD treatment was higher in the CC group compared with usual care: 39.0% vs 16.8%

A higher proportion of CC participants reported abstinence from opioids or alcohol at 6 months: 32.8% vs 22.3%

(https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2652574?resultClick=1)

Katherine E. Watkins, MD, MSHS; Allison J. Ober, PhD; Karen Lamp, MD; et al
Three Stages of Addiction

- Excessive amounts used
- Excessive time spent using/obtaining
- Tolerance

Cravings or urges to use
Unsuccessful attempts to cut down

Response to drug
Prereoccupation and anticipation

Brain regions:
- Thalamus
- Globus pallidus
- Hippocampus
- Amygdala
- Basal nucleus of the stria terminalis
- Orbitofrontal cortex
- Dorsal striatum
- Anterior cingulate cortex

Neuroadaptations:
- Neurocircuits
- Synaptic systems
- Molecules
- Epigenetics

Stage of Addiction
- Binge and intoxication
- Withdrawal and negative affect
- Prereoccupation and anticipation

Shifting Drivers Resulting from Neuroadaptations
- Feeling euphoric ➔ Feeling good ➔ Escaping dysphoria
- Feeling reduced energy ➔ Feeling reduced excitement ➔ Feeling depressed, anxious, restless
- Looking forward ➔ Desiring drug ➔ Obsessing and planning to get drug

Behavioral Changes
- Voluntary action
  - Abstinence
  - Constrained drug taking ➔ Sometimes taking when not intending
  - Impulsive action
  - Relapse
  - Compulsive consumption
- Sometimes having trouble stopping
- Sometimes taking more than intended
- Missed obligations
- Interference with activities
- Personal problems
- Health problems
- Hazardous use

Figure 1: Stages of the Addiction Cycle.
Addiction: Science-based Definition

“Well-supported scientific evidence shows that addiction to alcohol or drugs is a chronic brain disease that has potential for recurrence and recovery.”
Advances in Medication

“We have highly effective medications, when combined with other behavioral supports, that are the standard of care for the treatment of opiate addiction.”

Michael Botticelli, Former Director, ONDCP
Welcome MAT

Medications

Recovery Support

Intensive Psycho, Social and Behavioral Evidenced Based
Medication Assisted Treatment

• MAT is the gold standard for opioid use disorder (OUD) treatment:
  ➢ Reduces drug use
  ➢ Reduces risk of overdose
  ➢ Prevents injection behaviors
  ➢ Reduces criminal behavior

• 20.2 Million People Have SUD
• Only a fraction of those that get treatment get MAT
  ▪ 300,000-400,000 people on methadone in a given year
  ▪ 40,000 on buprenorphine
  ▪ 5-10,000 on Naltrexone

Only 10% of the prospective MAT patients for (OUD) are receiving it
Medications to Treat Opioid Use Disorder

Goals:
- Alleviate signs/symptoms of physical withdrawal
- Feed or block opioid receptors
- Diminish and alleviate drug craving
- Normalize and stabilize perturbed brain neurochemistry
### Medications for Addiction Treatment

#### Alcohol
- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable
- Acamprosate
- Disulfram (Antabuse)

#### Opioids
- Methadone
- Buprenorphine
- (pill and implant)
- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable

#### Smoking Cessation
- Varenicline (Chantix)
- Bupropion (Wellbutrin,)
- NRT’s
• **Methadone** is a full agonist. By fully occupying the mu-opioid receptor, methadone lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of other opioid drugs.

• **Buprenorphine** is a partial agonist, meaning it does not completely bind to the mu-opioid receptor. As a result, buprenorphine has a ceiling effect, meaning that its effects will plateau and will not increase even with repeated dosing.

• **Naltrexone** is an opioid antagonist, meaning that it covers, rather than activates, the mu-opioid receptor, effectively blocking the effects of opioids if they are used.
Medications Are…

• An evidence-based resource for assisting in the treatment of substance use disorders
• A resource to provide higher quality and cost effective care for clients with complex behavioral health needs
• A supplement to existing behavioral health treatments for substance use disorders
• Yet, 54% of addiction treatment programs have no physician.
What Medications Are Not...

• A panacea for the treatment of substance use disorders
• A replacement for behavioral health and recovery support services
• The sole means by which clients recover from substance use disorders
Getting Ready for Implementation

Key areas of consideration before engaging in efforts to increase access to medication assisted treatment (MAT)

- Economic Environment
- Infrastructure
- Regulatory/Policy Barriers
- Cultural (Attitudes, Stigma)
- Environmental Resources

MAT Implementation Check List

https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview#implementation
Shared Decisions between Patient and Professional

- Is medication right for me?
- Which medication is best?
- What is the appropriate dosage for me?
- What is a suitable duration of the medication plan?
- What psychosocial services are available?
- What recovery supports may be helpful?
The Case for MAT

- MAT is “the use of medications, *in combination with counseling* and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.” --SAMHSA

- Research indicates that methadone and buprenorphine have a strong evidence base supporting their clinical effectiveness. Strong support for Vivitrol.

- MAT is the **gold standard** for opioid use disorder (OUD) treatment:
  - Reduces overdose death
  - Reduces risk of overdose
  - Reduces drug use
  - Prevents injection behaviors
  - Reduces criminal behavior
The Bias against MAT

Assumptions that the individual is:

- Using a crutch
- Substituting one drug for another
- Still getting high
- Not abstinent
- Not in recovery
CHALLENGING THE MYTHS ABOUT MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER (OUD)

MAT JUST TRADES ONE ADDICTION FOR ANOTHER: MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery.

MAT IS ONLY FOR THE SHORT TERM: Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT.

MY PATIENT’S CONDITION IS NOT SEVERE ENOUGH TO REQUIRE MAT: MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient.

MAT INCREASES THE RISK FOR OVERDOSE IN PATIENTS: MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose.

PROVIDING MAT WILL ONLY DISRUPT AND HINDER A PATIENT’S RECOVERY PROCESS: MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle.

THERE ISN’T ANY PROOF THAT MAT IS BETTER THAN ABSTINENCE: MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National

Only 1 in 10 people suffering from a substance use disorder receives any type of treatment. That means 90% of people needing help are not getting it.
MAT: Tapering and Stopping

- There is no evidence to support stopping MAT
  - 95% of methadone patients do not achieve abstinence when attempting to taper off (Nosyk, et al. 2013)
  - Over 90% of buprenorphine patients relapse within 8 weeks of taper completion (Weiss, et al. 2011)
- Successful patients are commonly maintained on Methadone for 24+ months, Buprenorphine for 18+ months
- Typically patients with continuous recovery for 1-2+ years have the best outcomes; Treatment <6 months has worse outcomes
Treatment Works, People Recover

- More and more individuals are engaged in MAT
- Over 23 million Americans are in recovery from addiction to alcohol and other drugs
Thank you!

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References


Resources on Opioid Use

- **Centers for Disease Control and Prevention**
  - [Overdose Data](#)
  - [Guidelines for Prescribing Opioids for Chronic Pain](#)

- **Substance Abuse and Mental Health Services Agency**
  - Data on [Prescription Opioid and Heroin Use](#) from the annual National Survey on Drug Use and Health
  - [Medication-Assisted Treatment](#)
    - Information on certification, oversight, DATA-2000 waivers, legislation, regulation, and more

- **Office on National Drug Control Policy** *(archived website)*
  - [National Drug Control Strategy](#)
  - [Data](#) on Methadone, Buprenorphine treatment and drug poisoning deaths

- **National Institutes on Drug Abuse**
  - [Opioid Epidemic Strategies & Resources](#)
PCSS-MAT is a collaborative effort led by American Academy of Addiction Psychiatry in partnership with: American Osteopathic Academy of Addiction Medicine, American Psychiatric Association, American Society of Addiction Medicine and Association for Medical Education and Research in Substance Abuse.

For more information visit: www.pcssmat.org
For questions email: pcssmat@aaap.org

Twitter: @PCSSProjects

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Systematic Implementation of MAT as an EBP

Organized Group Deliberate Intentionality
What MAT Implementation is Not

- Not just the responsibility of the prescriber
- Not just another service on the list
- Not the exception for a few
Implement it Like You Really Mean It

• The standard of Care for Everyone with a Opiate, Alcohol, or Tobacco SUD
• A systematic and automatic part of the intake, assessment, and treatment planning process
• Adherence to MAT medications has the same team priority and effort as sobriety
• Use data to monitor your progress
Intake

• Standard intake patient/client information packet has material stating that MET is an essential part of treatment and providing information about benefits

• Standard Intake Consent for Treatment includes
  – Consent to MAT
  – Consent to share MAT treatment information with all other healthcare prescribers
Assessment

• Includes Insurance coverage/access to MAT medications
• Includes history of medication adherence to other medications
• Includes evaluation of where they get and keep their medications, how many, taken how many times a day, who prescribes, when last filled, what pharmacies use
Treatment Planning

• MAT for Alcohol, Opiates, and Tobacco are part of your standard Treatment Plan template
• Not receiving MAT requires documented justification by SUD counselor and MAT prescriber
• Patient objections to MAT are made the same motivational objective on treatment plan as objections to individual or group SUD counseling
Treatment

• SUD Therapists are trained and competent to address MAT medication adherence as part of the SUD counseling session
• SUD counseling notes document current MAT medication adherence, benefits and side effects
• SUD Peer Treatment workers include Peers MAT lived experience
Treatment

• MAT prescribers are trained and competent in Recovery Paradigm
• MAT prescribers discuss and document benefits of MAT in a manner consistent with the person's individualized recovery goals
• The organization proactively informs PCP and the patient's other prescribing healthcare providers of details of MAT
Administrative Supports

• Organization arranges for access to necessary lab services and incorporates lab results into the clinical record

• Organization provides administrative assistance to the MAT prescribers to facilitate obtaining medication prior authorizations, laboratory orders, and laboratory results.
Administrative Supports

• MAT Prescriber regularly attends treatment team meetings
Data Driven EBP Implementation Process

Benchmarks

• Measure each indicator below for organization as a whole and by individual responsible clinician:
  – Percent of Diagnosis Eligible patients getting MAT
  – Percent of diagnosis eligible patients not getting MAT with appropriate justification and clinical record
  – Percent of diagnosis of patients with MAT appropriately addressed in treatment plan
  – Patient adherence to MAT medications
Questions
Poll
Get Help!

Peer Learning Network Participants

- Listserv Inquiries
  - ccbhc_cop@nationalcouncilcommunities.org

- CCBHC Resource Page
  - https://www.nationalcouncildocs.net/ccbhc-learning-community
Get Help!

Master Class Community of Practice Participants

CCBHC Resource Page
- https://www.nationalcouncildocs.net/ccbhc-learning-community

Sign-Up for Faculty Office Hours
- Dr. Joe Parks 10/26 1:00-3:00p ET

Attend an Affinity Group Call

Request Individualized Coaching
- Sign up here
Webinars

November 15 2:00pm EST
Compliance Hotspots for CCBHCs

Dec 13th 2:00pm EST
Register Here

Jan 17th 2:00pm EST
Register Here

CCBHC Resource Page  https://www.nationalcouncildocs.net/ccbhc-learning-community
Still have Questions?

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