Treating Substance Use Disorders in a Patient-Centered Medical Home

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MERIDIAN HEALTH Services
Physical. Mental. Social Well-Being.

Learning Objectives

At the end of this session, attendees will be able to:

- List benefits of integrating substance use disorder therapies into a primary care setting.
- Assess their practice's readiness to implement medication assisted treatments for substance use disorder.
- Identify potential outcomes and measurements to assess the quality of a medication assisted treatment program in their practice.

1 TOBACCO USE

AGES 12 AND OLDER

66.9 MILLION CURRENT TOBACCO USERS

2014

CIGARETTE SMOKERS WITHIN **55.2**

CHEWING TOBACCO

11.7 MILLION USERS OF OTHER TOBACCO PRODUCTS

YOUTH CIGARETTE USE CUT IN **1/2** IN THE LAST **10 YEARS**

DECLINE CIGARETTE USE

2002 **13%** 12–17 YEAR OLDS

2014 **5%** 12–17 YEAR OLDS

2 ILLICIT DRUG USE

AGES 12 AND OLDER

27.0 MILLION PEOPLE OR 1 IN 10 AMERICANS USED ILLICIT SUBSTANCE

PAST **30** DAYS 2014

THIS PERCENTAGE IN 2014 WAS **HIGHER** THAN THOSE IN EVERY YEAR FROM **2002 THROUGH 2013.**

USAGE IN 2014

4.3 MILLION NONMEDICAL PAIN RELIEVER USERS

22.2 MILLION MARIJUANA USERS

ABOUT **435,000** AMERICANS AGED 12 AND OLDER WERE CURRENT HEROIN USERS IN 2014.

3 UNDERAGE AND BINGE DRINKING

AGES 12–20

UNDERAGE ALCOHOL USE AGES 12-20

28.8% 2002

22.8% 2014

UNDERAGE DRINKERS **1 IN 5**

UNDERAGE BINGE DRINKERS **1 IN 7**

BINGE ALCOHOL USE IS DEFINED AS DRINKING FIVE OR MORE DRINKS ON THE SAME OCCASION ON AT LEAST 1 DAY IN THE PAST 30 DAYS

THESE PERCENTAGES WERE **LOWER** THAN THE PERCENTAGES IN **2002 TO 2012,** BUT THEY WERE **SIMILAR** TO THE PERCENTAGES IN **2013.**

4 TREATMENT GAP[1]

AGES 12 AND OLDER

OF THE ESTIMATED **22.5 MILLION** PEOPLE AGED 12 OR OLDER IN 2014 WHO NEEDED TREATMENT FOR AN ILLICIT DRUG OR ALCOHOL USE PROBLEM IN THE PAST YEAR,

ONLY **2.6 MILLION** PERSONS RECEIVED TREATMENT AT A SPECIALTY FACILITY.

SOURCE

Data, except as otherwise noted: Center for Behavioral Health Statistics and Quality (2015). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. http://www.samhsa.gov/data/

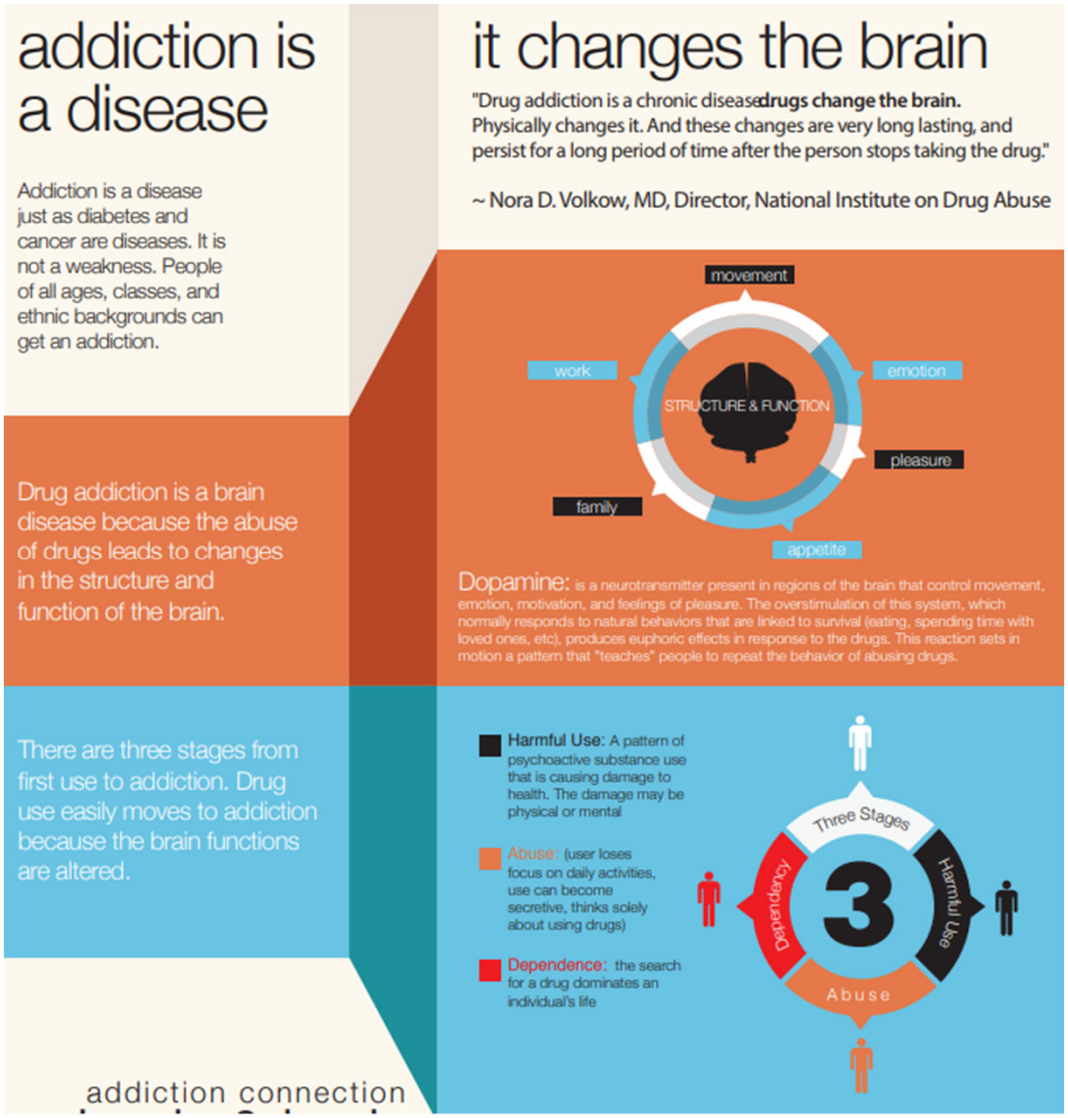
[1] Center for Behavioral Health Statistics and Quality. (2015). Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health. http://www.samhsa.gov/data/

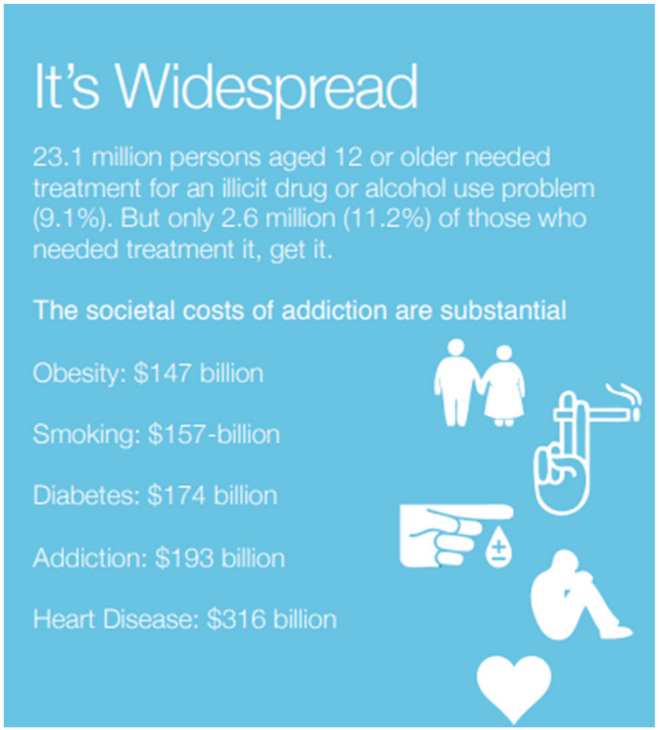
SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

1-877-SAMHSA-7 (1-877-726-4727)
1-800-486-4889 (TDD)
www.samhsa.gov

Substance Abuse and Mental Health Services Administration SAMHSA

DEPARTMENT OF HEALTH & HUMAN SERVICES USA





National Council for Behavioral Health
https://www.thenationalcouncil.org/wp-content/uploads/2016/11/addiction-statistics-infographic.pdf

“I don’t feel comfortable treating substance use disorders in the primary care setting.”

“You are already treating it. You are just doing it badly.”

By creating an intentional model to address substance use disorders in the primary care office, you will be addressing a number of other issues that addiction is causing or exacerbating.

SAMHSA
https://www.samhsa.gov/medication-assisted-treatment

Overview of Medication-Assisted Treatment (MAT) Options

Naltrexone

- Brand Name: Vivitrol
- Office-based non-addictive opioid antagonist that blocks the effects of other narcotics
- Uses: Alcohol Use and Opiate Use Disorder
- Daily pill or monthly injection

Buprenorphine

- Brand Name: Suboxone, Subutex
- Office-based opioid agonist/antagonist that blocks other narcotics while reducing withdrawal risk
- Uses: Opioid Use Disorder
- Daily dissolving tablet, cheek film, or 6-month implant under the skin
- Data-waiver required to prescribe and manage

Methadone

- Clinic-based opioid agonist that does not block other narcotics while preventing withdrawal while taking it
- Uses: Opioid Use Disorder
- Daily liquid
- Designation as a specialty regulated clinic required to use as MAT

SAMHSA
https://www.samhsa.gov/medication-assisted-treatment

Overview of Medication-Assisted Treatment (MAT) Options

Acamprosate

- Brand Name: Campral
- Shown to reduce cravings and likelihood of returning to drinking
- Uses: Alcohol Use Disorder
- Pill taken 3x's daily preferably same time

Disulfiram

- Brand Name: Antabuse
- Unpleasant effects from drinking like nausea, vomiting, headache within 10 minutes lasting up to 1 hour.
- Uses: Alcohol Use Disorder
- Daily tablet which works best with accountability partner

Buproprion SR / Varenicline

- Brand Name: Wellbutrin / Chantix
- Wellbutrin: stimulates dopamine & norepinephrine while inhibiting reuptake
- Chantix: Stimulates nicotine to reduce cravings
- Uses: Tobacco Use Disorder
- May combine with NRT – patches, sprays, gum, or lozenges

National Council for Behavioral Health
https://www.thenationalcouncil.org/wp-content/uploads/2016/10/MF_1_30.pdf

MAT Myths

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 Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment. (8)

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 stress. Above all, MAT helps reduce mortality while patients begin recovery.

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. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (14)

MOST INSURANCE PLANS DON'T COVER MAT: As of May 2013, 31 state Medicaid FFS programs covered methadone maintenance treatment provided in outpatient programs (4). State Medicaid agencies vary as to whether buprenorphine is listed on the Preferred Drug List (PDL), and whether prior authorization is required (a distinction often made based on the specific buprenorphine medication type). Extended-release naltrexone is listed on the Medicaid PDL in over 60 percent of states. (5)

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. (11)

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 (2).

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. (10)

Getting Started with Medication-Assisted Treatment
http://www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf

Business Case for MAT

Findings from 2007 case study at The Addiction Resource Center in Brunswick, Maine:

Prior to implementing MAT on-site

- 20 prospective patients assessed
  - Only 5 completed at least one session of treatment after the assessment
- Basic revenue = $1,541.25
  - 20 assessments
  - 5 IOP days
- Basic direct cost = $1,260
  - 60 hours (assessments, IOP sessions, and follow-up to find an external MAT provider) at average of $21/hr
- **Return on investment = $281.25 or 22.3%**
- **Treatment engagement outcome = 25%**

After implementing MAT

- 34 prospective patients assessed
  - 29 attended first treatment session
- Basic revenue = $6,979.50
  - 34 assessments
  - 29 inductions with MD
  - 29 IOP days
- Basic direct cost = $2,744
  - 34 counselor hours
  - 29 MD hours
- **Return on investment = $4,235.50 or 154.4%**
- **Treatment engagement outcome = 85%**

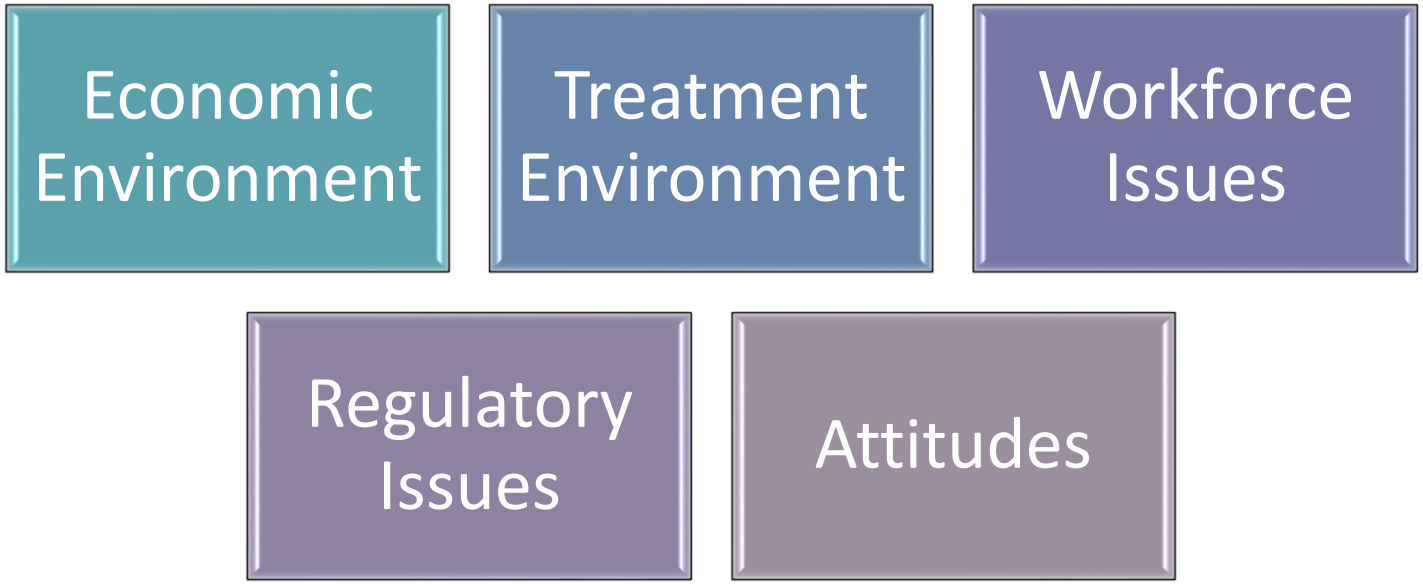
SAMHSA
https://www.integration.samhsa.gov/Expanding_the_Use_of_Medications_to_Treat_Individuals_with_SU_Disorders_in_Safety_Net_Settings.pdf

Barriers to MAT Access

- In 2011, less than 30% of SUD treatment options included the use of medications.
- Of those that did, less than 50% of the eligible patients utilized the medications.
- Barriers that were identified included
  - Lack of prescribers
  - Lack of support for existing prescribers
  - Agency regulatory policies restricting MAT use
  - Workforce attitudes and misunderstandings about MAT
  - Agency-directed limits on prescribing (annual or lifetime limitations)
  - Requiring a “fail-first” approach before using MAT

SAMHSA
https://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Implementation Readiness Assessment



SAMHSA
https://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Economic Environment

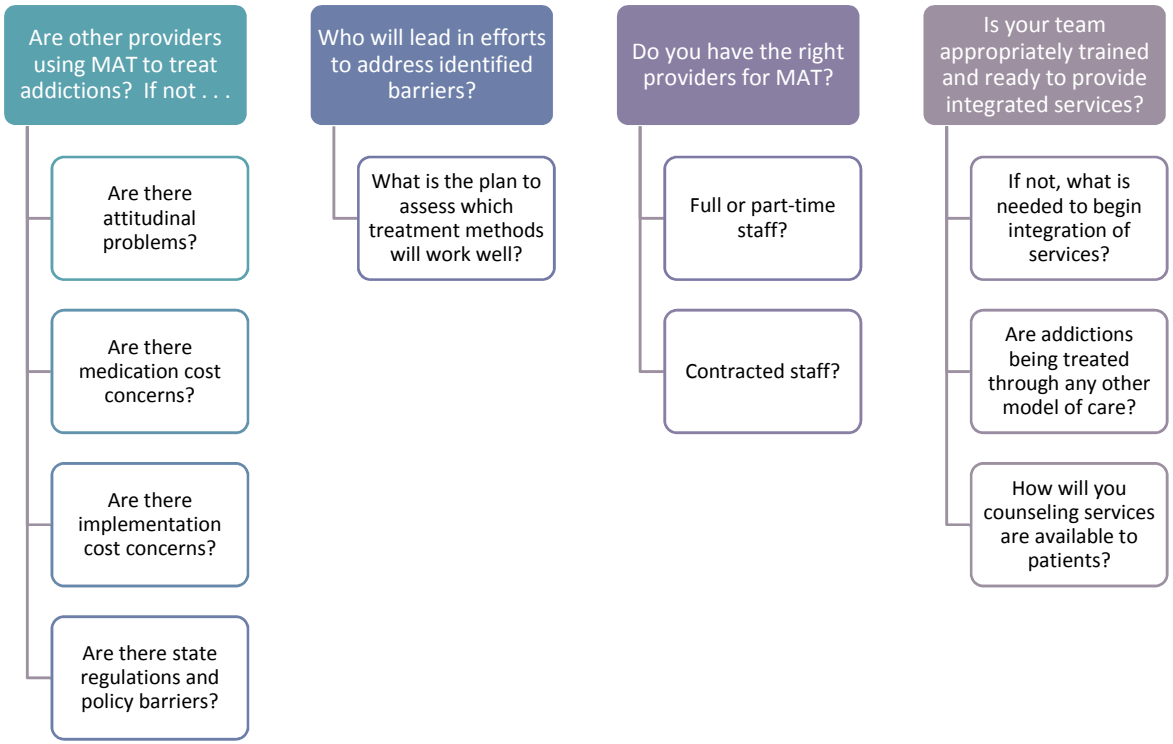
Are medications on Indiana Medicaid formulary list?

Are medications available through 340b program if applicable?

Are medications used in the private sector in Indiana?

SAMHSA
https://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Treatment Environment



SAMHSA
https://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Workforce Issues

Are there enough physicians and nurses to support MAT program?

- If not, what is your plan for assuring staff are trained?

What is the level of acceptance of "medical models" of addiction in your area?

- How do specialty addictions treatment clinicians view use of MAT?

How will you work with clinicians toward to the goal of making MAT available?

SAMHSA
https://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Regulatory Issues

How are regulatory efforts at the state level related to the distribution and use of MAT?

Are governing bodies educated about the use of MAT?

- Have governing bodies intervened to regulate the use of MAT?
- If so, what is the impact on availability and utilization of MAT?

What are the attitudes of governing bodies about increased spending on treatment related to MAT?

- How will you inform governing bodies about advances in treatment options?
- How will you work with governing bodies to improve financing and regulatory environment?

SAMHSA
https://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Attitudes

Are there specific groups outside of addictions treatment that oppose the use of MAT?

If so, how will you work with them to reduce barriers?

How will you work with consumer groups and advocates to increase demand for MAT?

How to Measure Success
NQF and eCQMs

NQF# 3400: Use of pharmacotherapy for OUD

- Patients with opioid use disorder who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measurement year.

NQF# 3175: Continuity of Pharmacotherapy for OUD

- Patients with opioid use disorder and at least one claim for an OUD medication who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.

NQF # 2597: Substance Use Screening and Intervention Composite

- Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results:
  - Tobacco use
  - Unhealthy alcohol use
  - Drug use (nonmedical prescription and illict)

CMS137v8: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- Patients with new episode of alcohol or other drug abuse who
  - Initiated treatment including an intervention or medication for the treatment within 14 days of diagnosis
  - Engaged in ongoing treatment including two additional interventions or a medication for treatment within 34 days of the initiative visit

Care Team Structure

Indiana FSSA
https://www.in.gov/fssa/dmha/2992.htm

Certified Recovery Specialist

- 5-day training provided by Peer Network of Indiana - $35
- Must be at least 1 year into recovery
- Two professional references and phone interview required prior to training
- Exam at end of training to obtain certification
- Billable service through Medicaid MRO package as long as under supervision of licensed professional
- Codes and modifiers – H0038 HW
- Can bill for ages 18+
    - PA required for ages 16-17

Indiana State Department of Health
https://www.in.gov/isdh/24942.htm

Community Health Worker

- CHWs enable patients to adhere to provider recommendations by connecting patients to community-based resources.
- Multiple training options available
  - Mental Health America of Northeast Indiana
  - Affiliated Service Providers of Indiana
  - HealthVisions Midwest
- Billable services
  - Diagnosis-related education
  - Cultural brokering between patient and healthcare team
  - Health education focused on prevention
  - Codes used are 98960, 98961, and 98962

In Summary

- Substance Use Disorder affects more of our patients than we even realize.
- Despite the wide range of myths surrounding MAT, the fact is that MAT helps patients on their journey to recovery.
- Providing MAT combined with therapy services makes sense from a business perspective.
- No two care team models look alike – make your care team structure work for you and your patients.

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