Treating Substance Use Disorders in Primary Care: Tips for a Proactive Transformation

1:10 PM – 2:10 PM
Steering Toward Success: Achieving Value in Whole Person Care
September 25 and October 26, 2017

The Healthier Washington Practice Transformation Support Hub
Steering Toward Success: Achieving Value in Whole Person Care

Treating Substance Use Disorders in Primary Care: Tips for a Proactive Transformation

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

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Matt Iles-Shih, MD
Disclosures

• None
Learning Objectives

• Describe best practices for substance use treatment in a primary care setting.
• Identify challenges and opportunities for offering substance use treatment in a primary care setting
• Give best practice examples from WA State
• List helpful resources and trainings for providers as they set up a MAT program
Substance Use Remains a Problem

• WA State Opioid Related Deaths
  – Unchanged since 2008 → 718 in 2015
  – Heroin related deaths on the rise
    • 28 in 2008 vs 313 in 2015
  – Fentanyl related deaths on rise

• US Alcohol Use Increase 2002 vs 2013
  – 12 month alcohol use → 65% vs 73%
  – High risk drinking → 10% vs 13%
  – Alcohol Use Disorders → 9% vs 13%

WA State DOH, Opioid Overdose Death Report, 2016
WA State DOH, Fentanyl OD Death Report, 2017
Grant et al, 2017
Integrating Addictions & Primary Care: Benefits

On balance, research suggests that the integration of addictions treatment can:

- Improve identification of SUDs & enhance access to treatment
- Improve physical & mental health
- Reduce levels of substance use
- Reduce costs

Integrating Addictions & Primary Care: Benefits

On balance, research suggests that the integration of addictions treatment can:

- Enhance access to treatment
- Improve physical & mental health

Treatment of substance use disorders is expanding—Great!
But, is it as effective as it could be?
EVIDENCE-BASED MODELS OF INTEGRATED ADDICTION TREATMENT AND WHAT TO TAKE FROM THEM
EBMs for Integrating Addictions & Primary Care

SBIRT

- **Screening**: Validated Instruments, risk-stratification
- **Brief Interventions**: Usually Motivational Enhancement & Brief Behavioral therapies
- **Referral to Treatment**: Referral to specialty care if specific threshold criteria are met
EBMs for Integrating Addictions & Primary Care

**SBIRT**

- **The Good News**: Screening & Brief Intervention can:
  - ↓ EtOH-use (esp. male, at-risk drinkers;)
  - ↓ Tobacco (esp with “5-As” plus MAT)

- **Less Encouraging**:
  - +/- for other/illicit SUDs (at least in the US)
  - RT is usually *ineffective*

SBIRT

• SBIRT: good for risky alcohol use, not helpful for drug use or alcohol use disorders

• Takeaway
  – This can be helpful for select populations
  – Helpful in establishing screening workflows
EBMs for Integrating Addictions & Primary Care: VA’s “Alcohol Care Management”

PC-based vs. Specialty Treatment for Alcohol Use Disorders

- VA patients with Alcohol Use Disorders, 6 months

- ACM BHPs
  - psychologists and MH RN’s
  - Also treat depression and anxiety
  - Promote use of Naltrexone
  - Weekly group supervision

- Main Outcome:
  - Treatment Engagement

<table>
<thead>
<tr>
<th>Intervention Characteristics</th>
<th>Treatment Arm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-therapy</td>
<td>ACM (n=85)</td>
</tr>
<tr>
<td></td>
<td>MET with BHP (phone or in-person)</td>
</tr>
<tr>
<td>Contact Intensity</td>
<td>Specialty Clinic (n=78)</td>
</tr>
<tr>
<td>30 minutes/week (plus PCP appnts)</td>
<td>12-step facilitation-based IOP</td>
</tr>
<tr>
<td>MAT</td>
<td>ACM (n=85)</td>
</tr>
<tr>
<td>Naltrexone offered</td>
<td>Specialty Clinic (n=78)</td>
</tr>
<tr>
<td>MAT, per clinic protocols/Drs' preference</td>
<td>MAT, per clinic protocols/Drs' preference</td>
</tr>
</tbody>
</table>

Oslin et al. (2013)
EBMs for Integrating Addictions & Primary Care: The VA’s “Alcohol Care Management”

Conclusions:
- PC-based AUD treatment outperformed specialty care

Other Results:
- Naltrexone Rx
- PC: 65.9%
- Specialty: 11.5%
Alcohol Care Management

- Outcome: improved engagement and better outcomes vs SC

- Takeaway
  - Task sharing with Beh Health and Care Coordinator
  - Patient centered care is essential
  - Make sure to use Naltrexone
  - Better coordination (weekly supervision, in PC)
EBMs for Integrating Addictions & Primary Care: Collaborative Care (CC) for Opioid & Alcohol Use Disorders

The SUMMIT Trial

Collaborative Care for AUD/OUD vs. Usual Care (facilitated self-referral)

- CA FQHC patients with A/OUDs, 49% unhoused, 6 months

Elements

- CC
- Therapists
- Clinicians (12/28 waived)
- Weekly Caseload Reviews
- Registry
- Measurement based care

Main Outcomes:

- Any Evidence-based Treatment
- Self-reported 30 day abstinence

Watkins et al. (2017)
EBMs for Integrating Addictions & Primary Care: Collaborative Care (CC) for Opioid & Alcohol Use Disorders

The SUMMIT Trial

Engagement:

- **Collaborative Care:**
  - 93% met Care Coord. ≥ 1 time
  - 45% had ≥ 1 therapy appnt
  - 22% had ≥2 therapy appnts

- **Usual Care:**
  - Unknown?!

Results:

- **Receipt of any EBT CC > Usual Care:**
  - Beh Th CC > UC (36% vs 11%)
  - **MAT CC = UC (13% vs 13%)?**

- **30-day Abstinence (self-report):**
  - CC > Usual Care (33% vs. 22%)
  - $[\beta=0.12, 95\% \text{ CI}=(0.01, 0.23)]$

Conclusions:

- CC-based AOUD treatment can be more effective than usual care... *though a ↑ effect size would be nice, yes?*
Takeaways: the SUMMIT CC Trial

• Outcome: increased use of therapy for SUDs and increased rates of abstinence.
  – (no change in MAT use)

• Takeaway
  – Task sharing with CC and therapist
  – Registry probably played a positive role
  – Not enough emphasis on MAT
    • Vivitrol as only option for AUD
    • Buprenorphine available
  – Used measurement based care?
The “Massachusetts Model” of Collaborative Care for Opioid Use DOs

**Goal**: increase access to OST by providing clinical support in an clinically & cost-effective manner.

Alford et al, 2011; LaBelle et al 2016
Integrating Addictions & Primary Care: Collaborative Care for Opioid Use DOs

The “Massachusetts Model” of Collaborative Care for OBB

12-month Outcomes

- **Success**: 51%
  - Treatment retention
  - NO illicit drug use x 6 months
- Transfer to Methadone Program:
  - 6%
- Loss to f/u, admin discharge:
  - 42%
- Illicit Drug Use (q3 mo. monitoring)
  - 95% neg. tox screens (for those remaining in treatment)

**Indicators of Success**

- Older age
- Employment
- Illicit Buprenorphine use prior to treatment
Takeaways: the Mass Model

• Outcome: 51% success rate
  – 12 months in treatment
  – No illicit use x 6 months
  – Expanded treatment access

• Takeaway
  – Close (weekly) follow-up at the beginning
  – Task sharing with Nurse Care Manager
  – MAT is key in OUD treatment!!!
Integrating Addictions & Primary Care:

Vermont’s “Hub & Spoke” Model

HUB
- Assessment
- Care Coordination
- Methadone Consultation
- Complex Addictions

Spokes
- Nurse-Counselor Teams w/prescribing MD

Spokes
- Nurse-Counselor teams w/prescribing MD

Spokes
- Nurse-Counselor Teams w/prescribing MD

Spokes
- Nurse-Counselor teams w/prescribing MD

Spokes
- Nurse-Counselor Teams w/prescribing MD

Family Services

Corrections Probation & Parole

Residential Services

Mental Health Services

In Patient Services

Medical Homes

Pain Management Clinics

Substance Abuse Out-Pt Treatment

Integrating Addictions & Primary Care: Vermont’s “Hub & Spoke”: Outcomes

**Changes at the “Spokes”:**
- ↑ 64% MDs/DOs w/buprenorphine waivers
- ↑ 38% in Medicaid OUD pts on OST
- ↑ services provided at Spokes w/additional RN & CM
- ↑ satisfaction among PCPs & improved health outcomes
- Practice improvement w/engagement in “Learning Collaboratives”

**Changes for “Hubs”:**
- Rapid growth to full capacity
- ↑30% clients in Hubs on buprenorphine

**System-wide Changes:**
- Shift to 50:50 OTP vs. OBOT (from 85:15)
- Same-day access w/o waitlists in some regions
- Pts able to migrate HUB ↔ SPOKE (based on status/need)
- Estimated $6.7 million in Medicaid savings

Integrating Addictions & Primary Care: Vermont’s “Hub & Spoke”: Outcomes

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Integrating Addictions & Primary Care: Vermont’s “Hub & Spoke” Model

- **Learning Collaborative**
  - Goal: increase access & improve quality
  - Quality Measures (% of patients)
    - documented dx of OUD
    - unstable patients
    - > 16mg of bup
    - Urine drug screens
    - PMP has been accessed
    - In care x 6 months
    - Documentation of comanagement of other SUDs, psych, and primary care issues
    - Number of pts prescribed Buprenorphine

Integrating Addictions & Primary Care: Vermont’s “Hub & Spoke” Model

- Learning Collaborative
  - Goal: increase access & improve quality

Results: Practice variation reduced on all points

Significant Changes
- ↑ # of patients prescribed buprenorphine
- ↑ urine drug screens done across the sites
- ↑ PMP accessed
- ↑ in Unstable patients seen

No significant change in 6 month retention (already >95%) or specialty co-management
Takeaways: the Hub & Spoke

• Outcome: ↑ 38% in Medicaid OUD pts on OST
  – ↑ services provided at Spokes w/additional RN & CM
  – ↑ satisfaction among PCPs & improved health outcomes

• Takeaway
  – Impressive whole state coordination/commitment
  – Task sharing with Nurse Care Manager and others
  – Promotes MAT throughout the system
  – Monitoring/adhering to quality indicators
So what have these models taught us?

1. How effective is integrated addictions care?

<table>
<thead>
<tr>
<th>Model</th>
<th>Key Studies / Data Sources</th>
<th>Primary SUD(s) Treated</th>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Enrollment in Treatment</td>
<td>Retention in Treatment</td>
<td>MAT Received</td>
</tr>
<tr>
<td>Chronic Care Mangmnt</td>
<td>ACM (Oslin et al, 2013)</td>
<td>AUD</td>
<td>91% (6mo)</td>
<td>66%</td>
</tr>
<tr>
<td>&quot;Collaborative Care&quot;</td>
<td>SUMMIT (Watkins et al, 2017)</td>
<td>A/OUD</td>
<td>93% (6mo)</td>
<td>13%*</td>
</tr>
<tr>
<td>&quot;Mass. Model&quot; (Alford et al, 2011; LaBelle et al, 2016)</td>
<td>OUD</td>
<td>?</td>
<td>51% (12mo)</td>
<td>100%</td>
</tr>
<tr>
<td>Vermont’s Hub &amp; Spoke</td>
<td>(VT Dept Health)</td>
<td>OUD</td>
<td>95% (6mo)</td>
<td>71%</td>
</tr>
</tbody>
</table>

**Observations & Questions:**

– What are the major levers we can pull to improve retention & outcomes?
## So what have these models taught us?

2. Are their common attributes worth noting?

<table>
<thead>
<tr>
<th>Model</th>
<th>Key Studies / Data Sources</th>
<th>Primary SUD(s) Treated</th>
<th>Patient-centered</th>
<th>Team-based Care</th>
<th>Provides ↑ support to PC Team</th>
<th>Population-based Approach</th>
<th>Direct Access to Evidence-based Treatments</th>
<th>Enables pt's placement in proper LOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBIRT</td>
<td>(multiple)</td>
<td>Multiple</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
</tr>
<tr>
<td>Chronic Care Mgmt</td>
<td>ACM (Osling et al, 2013)</td>
<td>AUD</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>AHEAD (Saitz et al, 2013)</td>
<td>ASOUDs</td>
<td>++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>&quot;Collab. Care&quot;</td>
<td>SUMMIT (Watkins et al, 2017)</td>
<td>AOUDs</td>
<td>+++</td>
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<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>ECHO</td>
<td>(Komaromy, 2016)</td>
<td>Multiple</td>
<td>+++ (*)</td>
<td>+/- (*)</td>
<td>+++</td>
<td>++ (*)</td>
<td>+++ (*)</td>
<td>++ (*)</td>
</tr>
</tbody>
</table>

* Indirect effect
SUD Treatment Keys

Retention, Retention, Retention

• How?
• Use Evidence Based Treatment
  – MAT
  – Psychosocial Treatment
• Team based-provider support
• Population based
Collaborative Care

PCP

Patient

BH Care Manager

Consulting Psychiatrist

Other Behavioral Health Clinicians

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program

New Roles

Optional Additional Clinic Resources

Outside Resources
Collaborative Care: The Research Evidence

- Now over 80 Randomized Controlled Trials (RCTs)
  - Meta analysis of collaborative care (CC) for depression in primary care (US and Europe)

→ Consistently more effective than usual care
  - Better faster
  - Stay better longer

Why is this approach so consistently effective?

Archer, J. et al., 2012
Collaborative Care Principles

- Patient Centered Team
- Population Based Care
- Measurement-Based Treatment to Target
- Evidence-Based Treatment
- Accountable Care

Principles icons used with permission from University of Washington AIMS Center, 2016.
Integrated Care Principles in Addiction Treatment

Patient Centered Team
- Works individually in therapy and med support.

Population Based Care
- Use of Registry. Helps identify trends. Avoid losing track of patients.

Measurement-Based Treatment to Target
- Attendance/retention, drug screens, patient goals, brief addiction monitor.

Evidence-Based Treatment
- Evidence based therapy and MAT.

Accountable Care
- How are things going? System QI.

Principles icons used with permission from University of Washington AIMS Center, 2016.
Measurement Based Care

Why?

• Help Improve Patient Outcomes
  – Clinical judgement alone is not always enough
  – Enhanced precision and effectiveness
  – Help overcome clinical inertia
  – Provide providers monitor clinical effectiveness
  – Allow systems the ability to monitor effectiveness
  – Help streamline assessments

Fortney, J et al, 2017
Measurement Based Care Do’s’s

• Symptom severity should be assessed frequently
• Concurrently with the clinical encounter
• Be able to compare current with passes scores
Measurement Based Care

- Retention in Treatment
- Patient Goals
- Brief Addiction Monitor
- Urine Drug Screens
- OBOT Stability Index-???
Brief Addiction Monitor

- 17 item measure of addiction problem severity (5 min)
- Can track past 7 or 30 days
- Assesses

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any alcohol use</td>
<td>• Craving</td>
<td>• Self-efficacy</td>
</tr>
<tr>
<td>• Heavy alcohol use</td>
<td>• Sleep prob</td>
<td>• Self-help</td>
</tr>
<tr>
<td>• Drug use</td>
<td>• Poor mood</td>
<td>• Spirituality</td>
</tr>
<tr>
<td></td>
<td>• Risky situations</td>
<td>• Work/school</td>
</tr>
<tr>
<td></td>
<td>• Family/social problems</td>
<td>• Income</td>
</tr>
<tr>
<td></td>
<td>• Physical health</td>
<td>• Social supports</td>
</tr>
</tbody>
</table>

BAM study results
- all 3 parts were sensitive to change
- excellent test/restest reliability
- Recovery protection and substance use and risk had predictive validity

Cacciola J et al, 2013
Brief Addiction Monitor (BAM)

Participant ID: ___________________ Date: ____________

Interviewer ID (Clinician Initials): ____________

Instructions:
This is a standard set of questions about several areas of your life such as your health, alcohol and drug use, etc. The questions generally ask about the past 30 days. Please consider each question and answer as accurately as possible.

Method of Administration:
☐ Clinician Interview ☐ Self Report ☐ Phone

1. In the past 30 days, how would you say your physical health has been?
   ○ Excellent (0)
   ○ Very Good (8)
   ○ Good (15)
   ○ Fair (22)
   ○ Poor (30)

2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?
   ____ ____

3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?
   ____ ____

4. In the past 30 days, how many days did you drink ANY alcohol?
   ____ ____ (If 00, Skip to #6)

5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer or 5-ounce glass of wine.]
   ____ ____

6. In the past 30 days, how many days did you use any illegal or street drugs or abuse any prescription medications?
   ____ ____ (If 00, Skip to #8)

7. In the past 30 days, how many days did you use any of the following drugs:
   7A. Marijuana (cannabis, pot, weed)?
   7B. Sedatives and/or Tranquilizers (benzos, Valium, Xanax, Ativan, Ambien, barbs, Phenobarbital, downers, etc.)?
   7C. Cocaine and/or Crack?
   7D. Other Stimulants (amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, speed, crystal meth, ice, etc.)?
   7E. Opiates (Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?
   7F. Inhalants (glues, adhesives, nail polish remover, paint thinner, etc.)?
   7G. Other drugs (steroids, non-prescription sleep and diet pills, Benadryl, Ephedra, other over-the-counter or unknown medications)?
   ____ ____
Change in BAM Factor Scores Since Treatment Began

- **Intake**: USE 75, RISK for USE 172, PROTECTION from USE 8
- **F/U #1**: USE 60, RISK for USE 126, PROTECTION from USE 29
- **F/U #2**: USE 45, RISK for USE 109, PROTECTION from USE 53
- **F/U #3**: USE 30, RISK for USE 71, PROTECTION from USE 63
- **F/U #4**: USE 17, RISK for USE 124, PROTECTION from USE 39
- **F/U #5**: USE 5, RISK for USE 13, PROTECTION from USE 162
Substance Lab Monitoring: Opioids

- Urine
- If stable on Buprenorphine, < monthly is reasonable
- Consider regular checking for Buprenorphine Metabolite- Norbuprenorphine to help identify diversion
- Norbup:Bup ratio 0.02 (spec, no sens)
- Bup >700 (spec and sens)

NEW: ASAM Drug Testing Guideline

Donroe J. et al, 2017
Substance Lab Monitoring: Alcohol

Table 1.—Characteristics of traditional markers

<table>
<thead>
<tr>
<th>Marker</th>
<th>Time to return to normal limits</th>
<th>Type of drinking characterized</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamma-glutamyltransferase</td>
<td>2–6 weeks of abstinence</td>
<td>~ 70 drinks/wk for several weeks</td>
<td>Many sources of false positives</td>
</tr>
<tr>
<td>Aspartate aminotransferase</td>
<td>7 days, but considerable variability in declines with abstinence</td>
<td>Unknown, but heavy</td>
<td>Many sources of false positives</td>
</tr>
<tr>
<td>Alanine aminotransferase</td>
<td>Unknown</td>
<td>Unknown, but heavy</td>
<td>Many sources of false positives Less sensitive than aspartate aminotransferase</td>
</tr>
<tr>
<td>Macrocytic volume</td>
<td>Unknown but half–life ~ 40 days</td>
<td>Unknown, but heavy</td>
<td>Slow return to normal limits even with abstinence</td>
</tr>
<tr>
<td>Carbohydrate-deficient transferrin</td>
<td>2–4 weeks of abstinence</td>
<td>60+ g/d for at least 2 weeks</td>
<td>Rare false positives Good indicator of relapse</td>
</tr>
</tbody>
</table>

- All are blood samples except for Carb-def transferrin

Bottom-line: modestly helpful

## OBOT Stability Index

1) Was the patient’s previous urine drug screen positive for illicit substances?
   - [ ] No
   - [ ] Yes

2) If YES to #1 or if the patient was recently started on buprenorphine, does the patient have fewer than four consecutive weekly drug-free urine drug screens?
   - [ ] No
   - [ ] Yes

3) Is the patient using sedative-hypnotic drugs (e.g., benzodiazepines) or admitting to alcohol use?
   - [ ] No
   - [ ] Yes

4) Does the patient report drug craving that is difficult to control?
   - [ ] No
   - [ ] Yes

5) Does the patient endorse having used illicit substances in the past month?
   - [ ] No
   - [ ] Yes

6) Does the query of the Vermont Prescription Monitoring System (VPMS) show evidence of the unexplained, unadmitted, or otherwise concerning provision of controlled substances?
   - [ ] No
   - [ ] Yes

7) Did the patient report their last prescription as being lost or stolen?
   - [ ] No
   - [ ] Yes

8) Did the patient run out of medication early from his/her last prescription?
   - [ ] No
   - [ ] Yes

**TOTALS:** __ No __ Yes

**SCORING:**

If **NO** to all, the patient is “stable” can be seen monthly for prescriptions and urine drug screens.

If **YES** to any of the above, the patient is “unstable” and needs to be seen weekly for prescriptions and urine drug screens.

Additionally, if **YES to 1-6**, the patient should be referred for addiction services.
## Registry Requirements

- Tracks progress at individual level and at caseload level
- Tracks population-based care
- Facilitates efficient systematic case review
- Prompts treatment to target

### Population Based Care

<table>
<thead>
<tr>
<th>View Record</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks in Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/2/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>12/2/2015</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>?</td>
<td>11/2/2015</td>
</tr>
</tbody>
</table>

*Indicates that the most recent contact was over 2 months (60 days) ago

- Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score)
- Indicates that the last available PHQ-9 score is more than 30 days old

- Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score)
- Indicates that the last available GAD-7 score is more than 30 days old

<table>
<thead>
<tr>
<th>Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flag for discussion &amp; safety risk</td>
</tr>
<tr>
<td>Flag for discussion</td>
</tr>
<tr>
<td>Flag as safety risk</td>
</tr>
</tbody>
</table>

**American Psychiatric Association**
# Addiction Registry

<table>
<thead>
<tr>
<th>Name</th>
<th>Treatment Status</th>
<th>Urine Drug Screens</th>
<th>Brief Addiction Monitor</th>
<th>MAT</th>
<th>Last PMP accessed</th>
<th>Addiction Consult</th>
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<tr>
<td>Joe</td>
<td>Initial Assessment</td>
<td>Most Recent</td>
<td># Sessions</td>
<td>Weeks in Tx</td>
<td>First</td>
<td>Last</td>
</tr>
<tr>
<td></td>
<td>8/25/17 9/21/17</td>
<td>9/21/17</td>
<td>2</td>
<td>4</td>
<td>Opioids, THC, Cocaine</td>
<td>THC</td>
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<tr>
<td>Sally</td>
<td>6/21/17 8/1/17</td>
<td>8/1/17</td>
<td>3</td>
<td>5</td>
<td>Alcohol, THC</td>
<td>None</td>
</tr>
</tbody>
</table>
Accountable Care

• The Registry
• Patients individually and the population as a whole

• Start to see trends
  – What is my retention rate as a clinic
  – Is my clinic doing as well as other clinics
  – Are people getting regular follow-up
  – Are people as a whole getting better

• Plan→Do→Study→Act
Evidence Based Care
SUD Treatment Keys

Retention, Retention, Retention

• How?
• Use Evidence Based Treatment
  – MAT
  – Psychosocial Treatment
• Team based-provider support
• Population based
Opioids: Narcan

- Patient at risk themselves to overdose or witnessing an overdose
- Dose dependent trend
- Increased odds of recovery
  – Odds Ratio 8.58

Best Practice: Recommend/Prescribe all OUD patients, including in those in treatment, Narcan

Dowell, D et al CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
The START Trial: N=1,267

- > 16mg
  - Less illicit use
  - Increased retention in treatment
    - Hazard Ratio 3.09 for drop out at < 16mg of Buprenorephine

- 25% of Bup patients dropped out before 1 mo
  - Early regular engagement/monitoring needed

Best Practice: Buprenorphine dosages ≥ 16mg, early engagement is key

24mg...32mg...what?

All of those patients are just diverting, right?

**Bottom-line:** There is no clear evidence that this occurs with all or even most patients. Treat the patient first.
Opioids: Ongoing treatment and Stability

- Relapse rates off Buprenorphine: 50-90%
  - Maintenance treatment should be continued

- Caution: Patient vs Provider view of treatment success can lead to premature termination
  - Patient’s want to remain in treatment

Bentzley BS et al, 2015
# Opioids: Buprenorphine vs IM Naltrexone

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine</th>
<th>IM Naltrexone</th>
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<tbody>
<tr>
<td>Number of studies</td>
<td>31 RCTS</td>
<td>1 RCT (Alkermes funded)</td>
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<tr>
<td>Head to Head Trials</td>
<td>Compared to Methadone</td>
<td>None</td>
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<tr>
<td>Retention Rates</td>
<td>43% dropped out</td>
<td>47% dropped out</td>
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<tr>
<td>No Illicit Opioid Use</td>
<td>64.7% of weeks in study</td>
<td>90% vs 35% of weeks in study</td>
</tr>
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</table>

**Best Practice:** Buprenorphine is 1st Line treatment and should make up the majority of your treatment.

Krupitsky, E. et al, 2011; Soeffling, J. et al 2009
Opioids: Prescribing Opioids and Benzodiazepines in patients with OUDs

• Sample
  – All Veterans (N=32,422) in 2007 with an Opioid Use Disorder Diagnosis

<table>
<thead>
<tr>
<th>Opioid/Benzo Rx Status</th>
<th>12 month Mortality Rate</th>
<th>24 month Mortality Rate</th>
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</thead>
<tbody>
<tr>
<td>Prescribed</td>
<td>4.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Not Prescribed</td>
<td>3.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>% Change</td>
<td>29%</td>
<td>27%</td>
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</table>

Best Practice: Avoid Prescribing Opioids and Benzodiazepines to Patients with Opioid Use Disorders

Opioids: Concurrent Substance Use

- Concurrent substance use can be destabilizing
  - Clearly established: Cocaine & Opioids

Cannabis
- Mixed evidence on impact
- Monitor for use ≥ near daily use
- Use CUDIT-R to screen for use disorder

Alcohol
- Monitor for risky use
- Use AUDIT-C or full AUDIT to assess for use disorder
Alcohol: MAT

1st Line

- Oral Naltrexone (great for Harm Reduction)
  - NNT to prevent return to any drinking: 20
  - NNT to prevent return to heavy drinking: 12

- Acamprosate
  - NNT to prevent return to any drinking: 12

- Disulfiram: works great in monitored setting
- Vivitrol: works well for reduction of heavy drinking

Best Practice: Use the medications

Psychosocial Treatment

Opioids: evidence is mixed on benefit

- VA does not provide recommendation for it
  - But: psychosocial treatment linked to reduced mortality within VA patients with OUD
  - Referral required
  - Most treatment approaches employ it

**Best Practice:** Not necessary in all patients, but patient preference should be considered. Expert opinion would recommend in unstable pts, but I would not withhold Bup if a patient refused

VA SUD Treatment Guidelines
Psychosocial Treatment

Alcohol: strong effect

– Cognitive Behavioral Therapy
– Motivational Enhancement
– 12-step facilitation

Best Practice: Patients should be referred or offered some form of therapy
Alcohol: Harm Reduction Counseling

- 3 month RCT, N=165, Homeless

- **Intervention**: personalized feedback, elicitation of harm reduction goals, discussion of safer drinking strategies

- **Results**
  - 75% completed study
  - 92% positive treatment experience
  - 73% reduction in peak alcohol quantity
  - 68% reduction in alcohol-related problems

Collins, S et al, pending submission
Summary

• It is good to know the evidence to help set quality standards for your treatment approach.

• Population health (registries) and Measurement based care in the setting of EBM will help your patients and practice succeed.
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