OPIOID HEALTH HOME UPDATE AND CASE STUDIES

DAVID BEST, DO, MS, ABAM

MOA SPRING SCIENTIFIC CONFERENCE

MAY 21, 2023

BACKGROUND/DISCLOSURES

- Relevant Experience
  - Bellaire Family Health Center 2005-2012
    - Bellaire, MI
  - Heartland Hospice Physician 2013-October 2021
    - Traverse City, MI
  - Best Medical Services 2012-present
    - Traverse City, MI
- Board Certified in Family Medicine, 2005
- Board Certified in Addiction Medicine, 2014
- President, Michigan Osteopathic Association, 2020-2021
- Board Member, Des Moines University Alumni Association, July 2022 – present
- Board Member, Novello Health Provider Organization, December 2022 - present
- Disclosures
  - None

OBJECTIVES

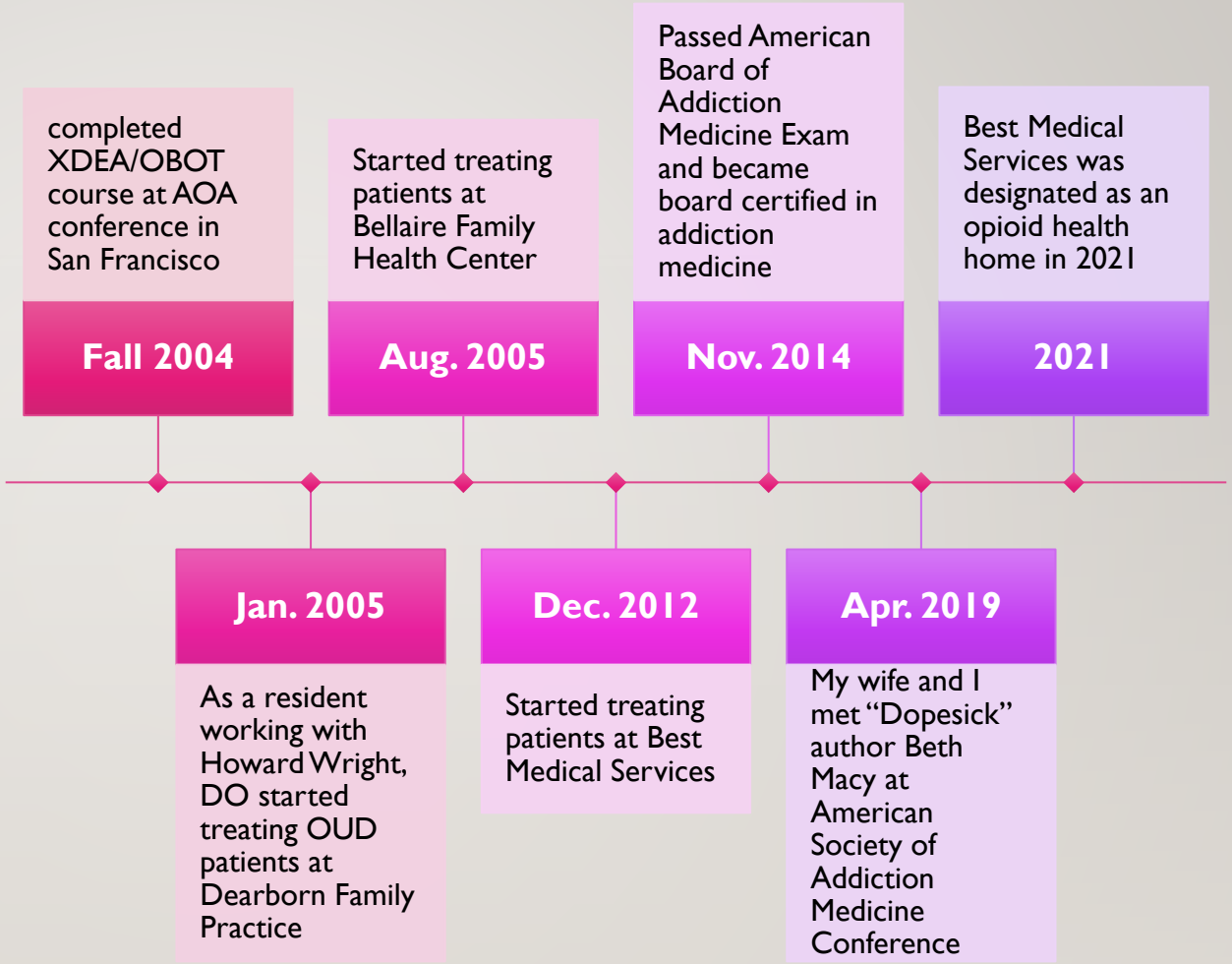
- To advocate for treatment of opioid use disorder (OUD) with medication (M-OUD)
- Provide information about Opioid Health Home (OHH) Program
- Discuss need to improve access and primary care services for patients with OUD
- Review available M-OUD options and present case studies

ADVOCATE FOR INCREASED ACCESS FOR M-OUD

Opioid Safety is a high priority topic for the Michigan Osteopathic Association (MOA) and I made special mention of this in my MOA presidential address in May 2021.

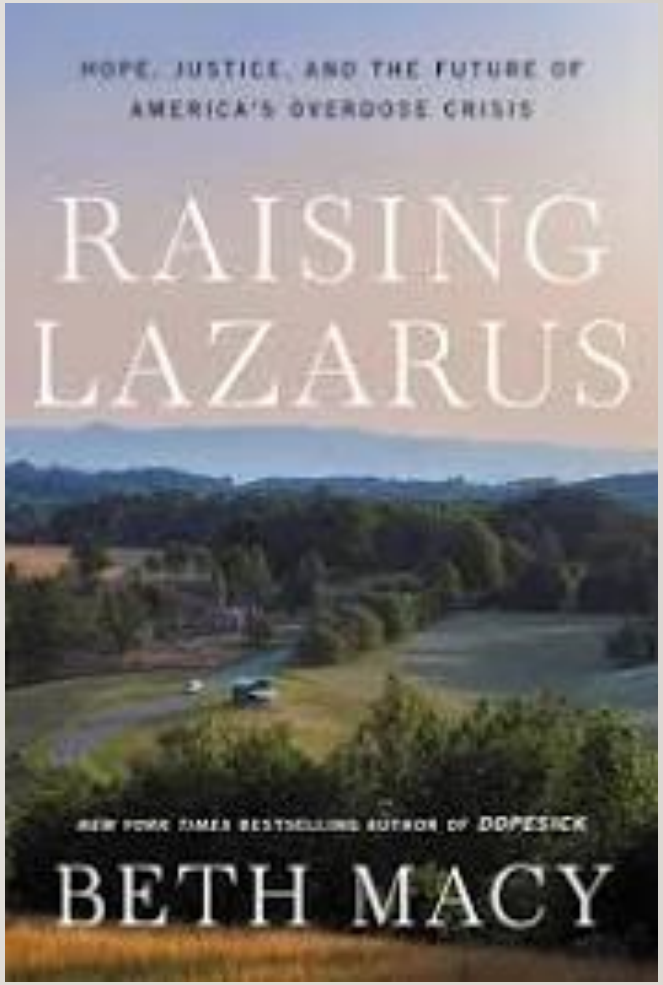
- American Osteopathic Association Resolution passed at 2021 House of Delegates:
- "M-OUD availability for Incarcerated Individuals Under Correctional Control"
- Drug Treatment Court Virtual Seminar, Sept 24, 2021
  - Education for Grand Traverse County Treatment Court
  - I presented on M-OUD and participated in case study review
- Drug Treatment Court Seminar planned for June 1, 2023
  - Crystal Mountain Resort

MY M-OUD PRACTICE TIMELINE




Share Your
Conference Experience!
#ASAM2019
/AddictionMedicine
@asamorg
DOPESICK
BETH MACY

ADDITIONAL RECOMMENDED READING



BEST MEDICAL SERVICES PATIENT DATA 2015-2023 N=OUD PATIENT

Date	N	Bup dose (mg)	Avg Age	% on Benzo	% Working
2-16-23	267	13.6	42.8	18.4	54.7
12/1/2021	263	13.7	42.0	14.4	52.1
12/1/2018	227	14.0	43.7	11.0	65.2
2/1/2016	97	13.5	38.0	27.0	58.0
12/1/2015	93	11.3	37.2	21.5	58.0

7 DIFFERENT COUNTIES WITH 10 OR MORE PATIENTS

- Grand Traverse: 82
- Wexford: 55
- Antrim: 27
- Charlevoix: 19
- Manistee: 11
- Benzie: 11
- Roscommon:10

NEED TO REDUCE TREATMENT GAP.

- Evidence based treatments are not routinely used for alcohol, drug, and mental health conditions.
- The Institute Of Medicine (IOM) has noted that health policy has more impact on patient outcomes than variation in individual practitioner abilities.
  - Examples of system improvements are:
    - Elimination of XDEA waiver requirement,: announced in April 2021, Enacted in 2022!
    - Some Drug treatment courts, jails, prisons allowing for M-OUD
    - Comprehensive Addiction and Recovery Act (CARA); enacted in 2018
      - More funding, new limit for providers is 275 buprenorphine patients
    - Medicaid Expansion and better coverage for buprenorphine; started in Michigan in 2014
    - Mental Health Parity and Addiction Equity Act, passed in 2007

“STATE OPTIONS TO EXPAND BUPRENORPHINE TREATMENT FOR OPIOID USE DISORDER”

POSTED ON APRIL 13, 2023

BY *KAMREN GILBARD AND JANE KOPPELMAN*

- Only 22% of people with OUD received any form of medication in 2021.
  - National Survey on Drug Use and Health, SAMHSA 2021
- As of 2018, 16 states required patients to undergo counseling as a condition of receiving buprenorphine, despite research showing that medication alone — even without counseling — lowers OUD overdose death rates and improves treatment retention.
- Some public and commercial state insurers require patients to receive preauthorization from their health care provider to obtain buprenorphine, which delays immediate access to medication.

ELIMINATION OF XDEA WAIVER

- Practice guideline signed by HHS Secretary Xavier Becerra on 4-27-21
  - Exempt eligible (clinicians) from federal certification requirements.
- The DATA-Waiver (X-Waiver) Program was eliminated on December 29, 2022, with President Biden's signing of the Consolidated Appropriations Act of 2023, which contains the Mainstreaming Addiction Treatment Act (MAT Act).
- 8 hour training now needed for license renewal (every 3 years)

REBUILDING LIVES AND REGAINING FUNCTION,

- Patients suffering with addiction disorders often have very chaotic, disordered lives
- Entropy definition

1. a thermodynamic quantity … often interpreted as the degree of disorder or randomness in the system:
    1. *"the second law of thermodynamics says that entropy always increases with time" · "the sum of the entropies of all the bodies taking part in the process"*
2. lack of order or predictability; gradual decline into disorder:

TREATMENT CAN PROVIDE STABILITY AND REDUCE DISORDER/CHAOS

- Person in active addiction: a lack of order or predictability
- It takes energy to counteract entropy in a system.
- M-OUD allows patient to gain control of their life and reduce chaos!
- OHH allows for strengthening treatment plans.

ENERGY IS NEEDED TO HELP REBUILD, PROVIDE STRUCTURE

- Rational treatment strategy
- Access to quality care that meets appropriate standard
- Use resources for what works
- Have compassion and intelligence
- "… scientifically there is no debate about the efficacy and safety of maintenance treatment with opioid agonist therapy."
  - Sarah Wakeman, MD: "Using Science to Battle Stigma in Addressing the Opioid Epidemic", May 2016, The American Journal of Medicine.

OPIOID REPLACEMENT THERAPY AND THE "LAZARUS LIKE EFFECT"

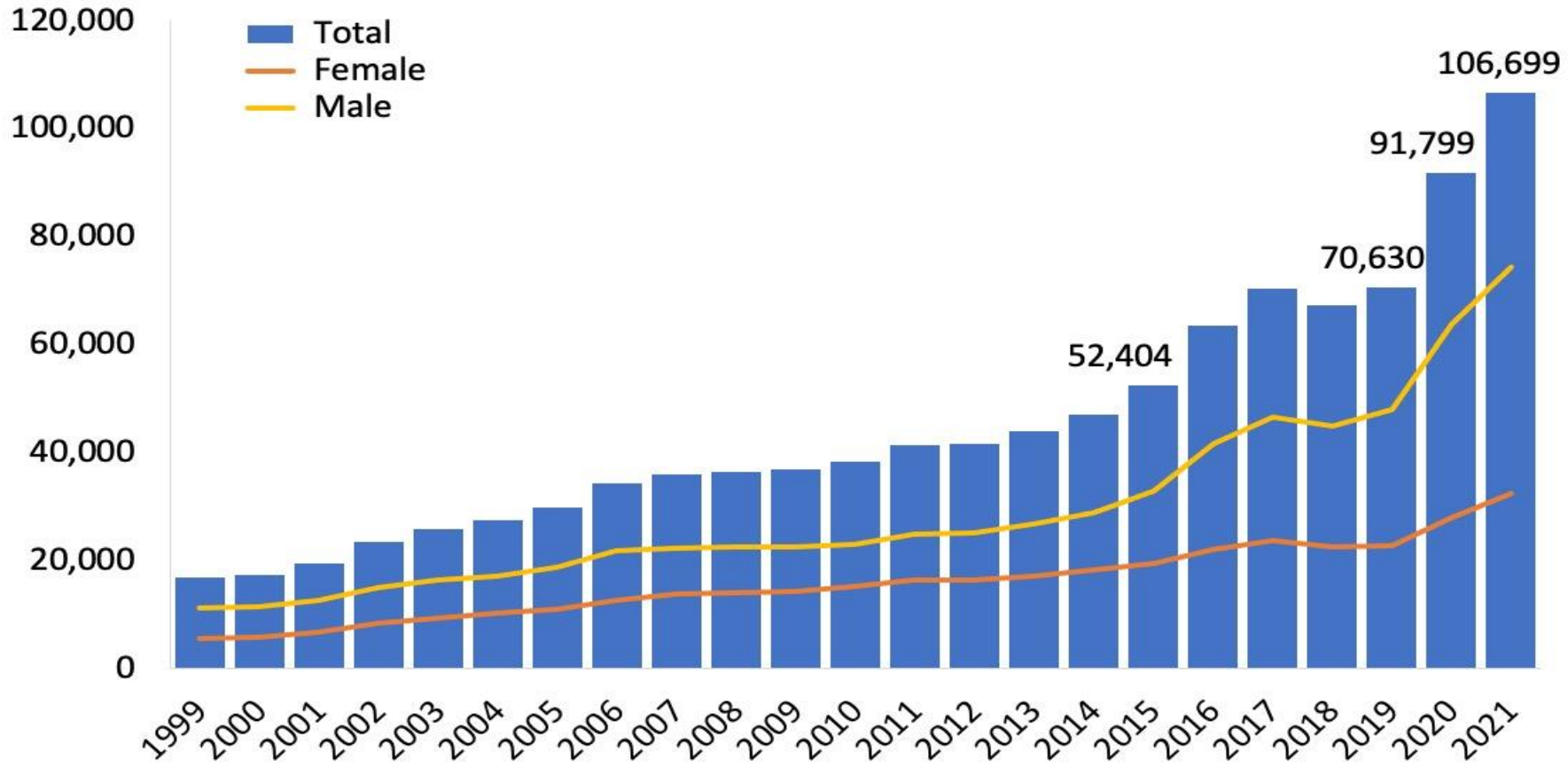
- Demonstrated as early as 1965 with methadone maintenance treatment (and since 2002 with buprenorphine maintenance treatment)
  - Craving relief
  - Blockade of the euphoria of heroin (or other opioid use)
  - Improved Psychosocial functioning (and success!) in work, school, relationships.

    - Sarah Wakeman, MD: "Using Science to Battle Stigma in Addressing the Opioid Epidemic", May 2016, The American Journal of Medicine.

WHY IS TREATMENT NEEDED?: PUBLIC HEALTH EMERGENCY CONTINUES

- The 2.7 year drop in life expectancy in 2020- 2021, was the biggest two-year decline in life expectancy at birth in the U.S. since 1921-1923.
- Much of the drop due to COVID pandemic (50% or more) but overdoses contributing significantly as well.
- An estimated 16% of the decline in life expectancy from 2020 to 2021 can be attributed to increases in deaths from accidents/unintentional injuries.
- Drug overdose deaths account for nearly half of all unintentional injury deaths.
  - > 109,000 overdose deaths in the one-year period ending in March of 2022.
- CDC, August 2022 report

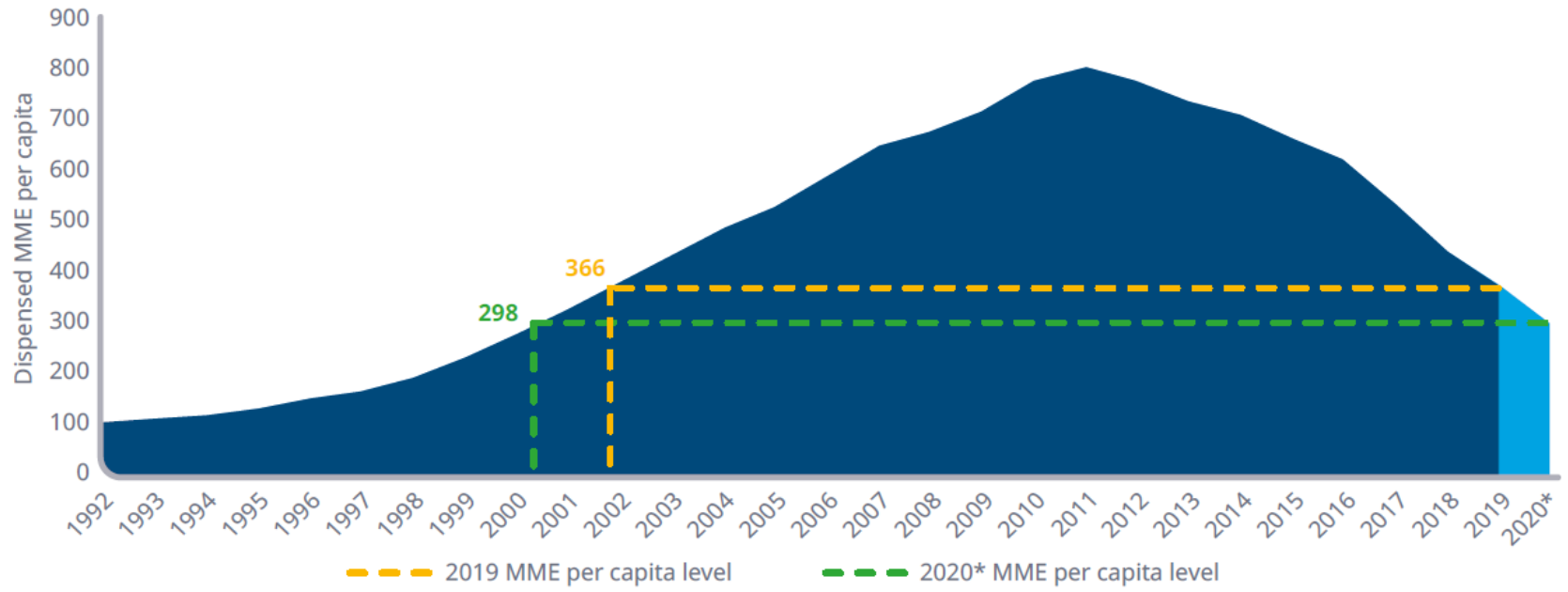
Figure 1. National Drug-Involved Overdose Deaths*, Number Among All Ages, by Gender, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

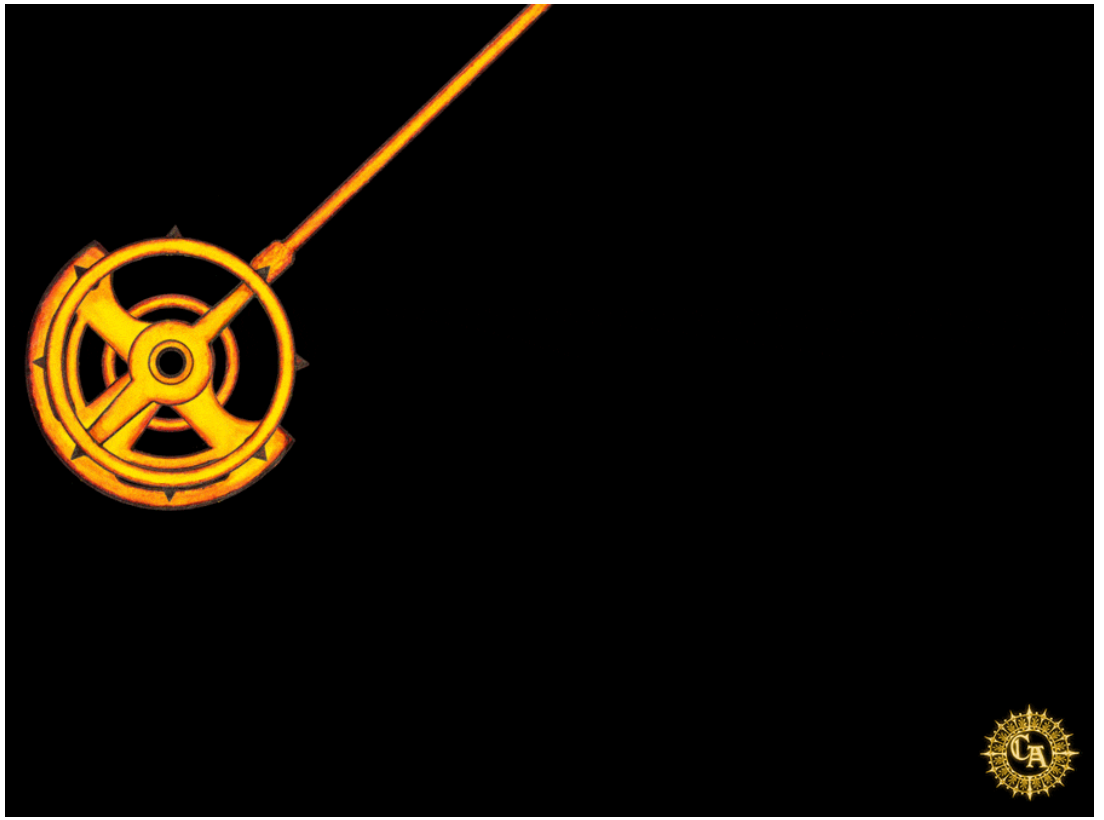
Continued declines have brought normalized per capita prescription opioid use below the 2001 level

Exhibit 2: Prescription Opioid Use in Morphine Milligram Equivalents (MME) per Capita, 1992–2020*



Source: IQVIA Xponent, Mar 2020; IQVIA National Prescription Audit; IQVIA Institute, Nov 2020

IF SUPPLY OF PRESCRIPTION OPIOIDS IS DOWN 60%, WHY ARE OVERDOSES STILL INCREASING?



ILLICIT DRUGS ARE FLOODING INTO OUR COMMUNITIES

OPIOID PRESCRIBING IS WAY DOWN, OVERDOSE DEATHS CONTINUE TO GO UP

What is the solution to this problem?

Reducing demand!!!

- Prevention
- Treatment for opioid use disorder

And of course, continue efforts to reduce supply

- Safe prescribing
- Reducing illicit trafficking

CLEAR JUSTIFICATION FOR USE OF M-OUD

If my patient is on buprenorphine maintenance treatment this is documented in their plan:

"Harm reduction approach with buprenorphine maintenance treatment continues to effectively reduce risk of toxic opioid exposure."

MAKING THE RIGHT DIAGNOSIS

Not all patients taking opioids for pain have OUD!

Use DSM 5 Criteria to make diagnosis of OUD.

Opioid Use Disorders – DSM V

The diagnosis of Opioid Use Disorder under DSM V can be applied to someone who uses opioid drugs and has at least two of the following symptoms within a 12 month period:

- Taking more opioid drugs than intended.
- Wanting or trying to control opioid drug use without success.
- Spending a lot of time obtaining, taking, or recovering from the effects of opioid drugs.
- Cravings opioids.
- Failing to carry out important roles at home, work or school because of opioid use.
- Continuing to use opioids, despite use of the drug causing relationship or social problems.
- Giving up or reducing other activities because of opioid use.
- Using opioids even when it is physically unsafe.
- Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway.
- Tolerance for opioids.
- Withdrawal symptoms when opioids are not taken.

SAMHSA

OUD SEVERITY

Mild: 2-3 symptoms.

Moderate: 4-5 symptoms.

Severe: 6 or more symptoms

CHRONIC DISEASE MODEL NEEDS TO BE FOLLOWED!

- Addiction Treatment faces challenges that other chronic illnesses do not
  - Impact of addiction is more visible and less socially acceptable (stigma of OUD).
  - Expectation that patients with OUD will remain symptom free after treatment ends

- Chapter 31: Quality Improvement for Addiction Treatment; Principles of Addiction Medicine The Essentials; 2011.

FOLLOW THE CHRONIC DISEASE MODEL

- Treat OUD the same as you would with any other chronic illness
- M-OUD should be continued as long as symptoms of OUD are reduced.
- Unfortunately, there is a treatment gap and patients are not getting treatment despite the drastic reduction in risk factors and the vastly improved function when in remission from OUD with the use of buprenorphine or methadone.

JUSTICE DEPARTMENT STATES DISCRIMINATION AGAINST PEOPLE UNDERGOING TREATMENT FOR OPIOID USE DISORDER VIOLATES ADA (AP REPORT)

- **“Treatment for opioid addiction often brings discrimination”**
- By GEOFF MULVIHILL and CLAUDIA LAUER
- April 9, 2022
- “It’s a problem people in the addiction recovery community have dealt with for decades: On top of the stigma surrounding addiction, people who are in medical treatment for substance abuse can face additional discrimination — including in medical and legal settings that are supposed to help.”

CASE 1

- 32 year-old male seen on 1-17-23 for new patient visit at Catholic Human Services (CHS) office in Cadillac. He is on parole after serving much of last 10 years in prison.
- He was on M-OUD the last couple of years while in prison and had last buprenorphine monthly injection on 12-19-23 and was released from prison just before Christmas.
- He is living with his Dad in Cadillac
- Referral from CHS
- Drug of choice: heroin
- Using opioid since age 16 when he would use Vicodin recreationally; IV heroin started at age 20

MORE HISTORY

- Unemployed but looking for factory work or any job
- Reviewed standard intake paperwork including:
  - Detailed history and other forms
  - buprenorphine treatment agreement,
  - Adverse Childhood Experience (ACE) Score
  - MAPS
  - DSM-5 criteria
  - Patient Centered Medical Home (PCMH)
  - Social Determinates of Health (SDOH) questionnaire

PAST MEDICAL HISTORY

- PMH: Alcohol Use Disorder (AUD), OUD, History of Hepatitis C (treated in 2021)
- PSH: Myringotomy tubes as a child
- Family History: Dad with AUD
- Smokes 1/2ppd for 10 years
- No alcohol since 2020

ASSESSMENT

- Opioid Dependence on Agonist Therapy (F11.20)
- Tobacco Use (Z72.0)
- Screening of Lipoid disorders (Z13.220)
- History of Hepatitis C (Z86.19)
- History of alcoholism (F10.21)

BUPRENORPHINE INJECTION GIVEN

- Procedure: Patient in supine position. Injection site cleansed with alcohol swab. 1cc of 1% lidocaine used for local anesthesia prior to injection. Buprenorphine 100mg injection given without difficulty and patient denies pain from injection. Band-Aid applied to site. No complications.
- PROVIDED: Patient Education (1/17/2023)
- Harm reduction approach with buprenorphine maintenance treatment continues to effectively reduce risk of toxic opioid exposure.
- Offered Naloxone injection kit and discussion about harm reduction.

PLAN

- ORDERED/ADVISED: Order Date 01-17-2023
- - CMP (Complete Metabolic Panel) (Z86.19, F11.20, Z13.220)
- - Lipid Panel (Z86.19, F11.20, Z13.220)
- Come in for next buprenorphine monthly injection in 1 month
- Custom Order (Catholic Human Services referral for counseling, recovery coach and life coach services today.) (F10.21, F11.20)

1 MONTH FOLLOW-UP ON 2-17-23

- Telehealth; M-OUD; he was not able to get out of work to come in for buprenorphine injection
- History of Present Illness: Patient denies relapse or cravings. Mood is stable overall.
- Support for recovery includes: Checks in regularly with parole office. He will have CHS intake at 3:15 on 2-21-23. It sounds like he has been adjusting well since getting out of prison last month.
- Working status: Employed at factory and is doing training there now on day shift; He will be starting on 3rd shift within a couple weeks after training is complete. He has been working at a restaurant a couple hours away on weekends and stays down there for that.

ASSESSMENT & PLAN:

- # Opioid dependence, on agonist therapy (F11.20):
- PROVIDED: Patient Education (2/17/2023): He should not need supplemental buprenorphine as the Sublocade is still working and he is not having cravings.
- I explained how he can go as long as 8 weeks between injections and likely not have an issue. He will follow-up at CHS office on 3-7-23 for next Sublocade 100mg.

OFFICE VISIT ON 3-7-23

- Patient denies relapse but he has had some cravings the last three days or so. He had last shot 6 weeks ago and would like to get one every 4 weeks again. Mood is stable overall.
- Support for recovery includes: CHS; he is on parole now for another 2 years.
- Working status: Employed at factory where his Dad works and is on 3rd shift; also working at a restaurant and has worked 25 days in a row now.
- Had buprenorphine 100mg injection without difficulty today

OFFICE VISIT ON 4-4-23 GIVEN BUPRENORPHINE 100MG INJECTION

History of Present Illness: Patient denies relapse or cravings. Mood is stable overall.

Support for recovery includes: CHS and he is on parole

Working status: Employed and is working 60-78 hours per week. He is glad to have money in the bank and feels secure financially and is looking forward to buying a new car and then being able to give his son a car when his son turns 16 next March.

OFFICE VISIT ON 5-2-23
GIVEN BUPRENORPHINE 100MG INJECTION

- History of Present Illness: Patient denies relapse or cravings. Mood is stable overall.
- Support for recovery includes: CHS and he is on parole now in a different county where he is working now. at the restaurant his girlfriend and her mom own. He is no longer working at the factory and states the 12 hour days, 6 days per week was not leaving him time to spend with family and he was getting burned out. He wants to be more available to spend time with his 12, 13, and 15 year-old children (who were adopted by their aunt).
- He is also glad to get away from the PO who was constantly threatening him with going to jail if he missed a recovery coach meeting, a supervision payment, or some other meeting.
- Working status: Employed and works 40-50 hours per week as a cook and he is also doing maintenance and landscaping

WILLIAM JAMES QUOTE

- “A great many people think they are thinking when they are merely rearranging their prejudices.”

OPIOID HEALTH HOME (OHH)

- Under Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA), the Health Home service model is meant to help chronically ill Medicaid and Healthy Michigan Plan beneficiaries manage their conditions through an intensive level of care management and coordination.
- The OHH is centered on whole-person, team-based care.
- The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder.
- MDHHS distributes payments through Prepaid Inpatient Health Plan (PIHP)
- $328 per patient per month for enrolled patients
- www.michigan.gov/mdhhs/assistance-programs/medicaid/opioid-health-home


Connecting enrollees with
recovery-centered care.

PIHP MEMBERS IN MICHIGAN

- NorthCare Network
- Northern Michigan Regional Entity (NMRE)
- Lakeshore Regional Entity
- Southwest Michigan Behavioral Health
- Mid-State Health Network
- CMH Partnership of Southeast Michigan
- Detroit Wayne Mental Health Authority
- Oakland County CMH Authority
- Macomb County Mental Health Services
- Region 10

OHH MEMBERS IN NMRE

- Alcona Health Center
- Addiction Treatment Services
- Bear River Health
- Best Medical Services, ☺
- Centra Wellness Network
- Catholic Human Services
- Grand Traverse Women's Health Clinic

OHH MEMBERS IN NMRE (CONTINUED)

- Harbor Hall
- Mid-Michigan Community Health Services
- NMSAS Recovery Center
- Thunder Bay Community Health Services
- Traverse Health Clinic

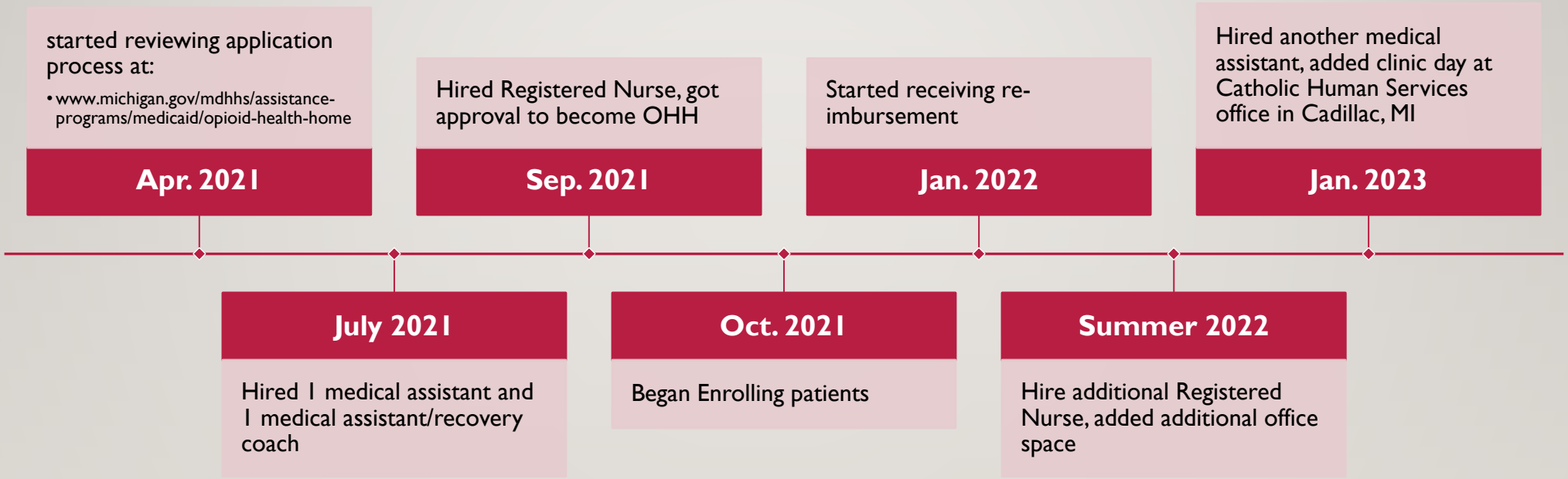
OHH SERVICES

- OHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions.
- Address Social Determinates of Health
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services

SPECIFIC MINIMUM REQUIREMENTS FOR EACH HHP (PER 100 BENEFICIARIES)

- HHP=Health Home Provider
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

TIMELINE FOR BEST MEDICAL SERVICES BECOMING AN OHH



COLLABORATING WITH BEST MEDICAL SERVICES

- Catholic Human Services
- Harm Reduction Michigan
- Old Town Psychological Services
- Northern Michigan Regional Entity

ADDED SERVICES AND STAFFING FOR BEST MEDICAL SERVICES SINCE JULY 2021

Staffing

- 1 full time and 1 part time RN added
- Added 2 full time employees who fulfill the following roles: medical assistant, referrals, recovery coach, phlebotomy
- Increased physician hours and administrative time

Services

- PCMH capability
- Immunizations
- Sublocade injections more available
- Case conferences

CASE STUDY 2

- 34 Year-old female seen as a new patient in January 2021. She had been on buprenorphine maintenance treatment from 2010 until 2019 when she was discharged from another practice for telling prescriber she was shooting up the Ritalin he was prescribing her. Last was doing IV drugs in January 2020.
- Residential twice for 30 days in early 2020. Vivitrol injection given upon discharge but she did not follow-up for the next one.
- For previous 6 months she has been taking buprenorphine 8-10mg daily that she gets illicitly and is spending about $20 per day for this.

PAST MEDICAL AND SOCIAL HISTORY

- Depression, OUD (severe with 11/11 DSM5 criteria)
- Mother: AUD, depression, lupus
- Father: schizophrenia, AUD, OUD
- 29 year-old sister with OUD and meth addiction
- Smokes 1/2ppd; no alcohol
- Unemployed, HS grad

RE-STARTING M-OUD

She was given Rx for #7 buprenorphine-naloxone 8/2 film to take once daily

Buprenorphine 300mg injection ordered

She was given this injection at follow-up and had another Buprenorphine 300mg injection 1 month later

Sounds pretty simple, right?

CHALLENGES TO WORK THROUGH

Between initial visit and 1st buprenorphine injection she had ER visit following relapse on what she thought was cocaine but it also contained meth and opioids

She left her boyfriend's house and states he was verbally abusive.

She had period of homelessness

She went to Women's Resource Center and has contacted Catholic Human Services counselor that we gave her number for.

MORE CHALLENGES, MARCH 2022

She did not make it to appointment for 2nd buprenorphine (300mg) injection because she was now out of town and had no ride to get to clinic. Rx for buprenorphine-naloxone films sent in and follow-up scheduled in 2 weeks

Had hepatitis C diagnosed in 2020 and labs have been completed and treatment will be ordered. We discussed how HCV is likely contributing to her fatigue.

FAST FORWARD A COUPLE OF MONTHS

- On buprenorphine-naloxone daily dosing per patient preference
- New diagnosis of bipolar disorder ➔ lamotrigine has been working well for her
- She has started on Mavyret for her HCV

JUNE 2021-APRIL 2023

- She transferred to another M-OUD clinic about 1 hour north and was prescribed daily dosing until she went to jail in March 2022 for 2 months. She had bad withdrawals while in jail and had office visit with me in May 2022.
- Re-started on daily dosing for 1 week. She ended up going to other M-OUD clinic until April 2023 for monthly injections.
- Moved to Traverse City again to start at cosmetology school; she had buprenorphine injection at my office in April 2023

NEED TO IMPROVE PRIMARY CARE ACCESS (AND RETENTION IN TREATMENT) FOR PATIENTS WITH OUD

- Treat patients with respect
- Have understanding and empathy
- Education on mental health and addiction disorders needed
- Be consistent in how chronic illness is treated

HARM REDUCTION APPROACH IS NEEDED

Harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws.

Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.

RISK FACTORS FOR OUD

- Family History of substance use disorder
- History of anxiety, depression, ADHD
- Adverse Childhood Experiences (ACE)
- Environment and socioeconomic stressors
- Chronic Pain: 11% who use prescribed opioids have Opioid Use Disorder

- Gavin Bart, MD (2012): Medication Maintenance for Opiate Addictions: The Foundation of Recovery, Journal of Addictive Diseases, 31:3, 207-225

USE EVIDENCED BASED TREATMENT

- Expanding access to addiction treatment services is an essential component of a comprehensive response.
- Like other chronic diseases (diabetes, HTN), addiction is generally refractory to cure but effective treatment and recovery are certainly possible.
- Medication Assisted Therapies (MAT) are available and need to be used more to save lives.
  - 50% fewer heroin overdoses in Baltimore from 1995-2009 when methadone and buprenorphine treatment availability was increased.
- NEJM 2014; 370:2063-2066

KNOW WHAT DOESN'T WORK

- Behavioral interventions alone have extremely poor outcomes
- 80% returning to drug use
- Poor results with medication assisted detox
- Behavioral intervention alone is not 1st line treatment (despite conventional wisdom that it is)!

  - Gavin Bart, MD (2012): Medication Maintenance for Opiate Addictions: The Foundation of Recovery, Journal of Addictive Diseases, 31:3, 207-225

EXAMPLES OF PATIENT GOALS

- Get Back to Work
- Stop wasting all my time and money on drugs (and chasing drugs)
- Be a better parent and partner
- To not die and get back to "normal life"
- Have integrity

WHY USE M-OUD?

Prevention of overdose deaths, prevention of: HIV, HCV

Improved Quality of life for patients and families.

M-OUD needed due to poor success rate of abstinence-based treatment.

WHY IS ORT BEST CHOICE FOR M-OUD?

- 12 Month Retention in treatment >60% with Opioid Replacement Therapy
  - Methadone maintenance treatment (MMT) or buprenorphine maintenance treatment (BMT)
- 6 Month Retention in treatment is 53% with IM Naltrexone injection (vivitrol)
  - (Extrapolate to 30% or so at 12 months?)
- When Patients stay in treatment they are at lower risk for relapse, co-morbidities, and death

MORTALITY RISK REDUCTION WITH M-OUD

- Data from systemic review and meta-analysis of 122,885 people treated with MMT and 15,831 with BMT
- All cause mortality rate per 1000 person years
  - 11.3 during MMT and 36.1 after MMT
  - 4.3 during BMT and 9.5 after BMT
- Overdose mortality rate per 1000 person years
  - 2.6 during MMT and 12.7 after MMT
  - 1.4 during BMT and 4.6 after BMT
- Note: MMT patients typically with more severe OUD
- BMJ2017:357:j1550 (April 26, 2017)

STOPPING TREATMENT INCREASES OVERDOSE RISK

5 times higher risk of overdose death when methadone maintenance treatment is stopped

3 times higher risk of overdose death when buprenorphine maintenance treatment is stopped

Does it get any clearer than that?

PROS AND CONS BMT

Advantage of BMT

- Greater access and lower barrier to treatment
- Weekly to monthly appointments typically
- Well-tolerated

Disadvantage:

- Less structured environment for high-risk patient

PROS AND CONS MMT

Advantage of MMT

- Provides more structure and potentially less diversion risk
- Dispensing of med at OTP
- Medication is cheaper

Disadvantages of MMT

- Requires much more staff and high regulatory barrier to start OTP
- More side effects with full agonist opioid
- Sedation, lack of 24-hour coverage with daily dosing
- Travel to clinic daily can limit job opportunities especially in rural communities
- Access not evenly distributed
  - e.g. 2 OTPs in Otsego County, population 23,000
  - No OTPs in Grand Traverse and surrounding 6 counties, population 230,000

RATIONALE FOR MONTHLY INJECTION VS. DAILY DOSING

- Tapering off buprenorphine can be challenging due to withdrawal symptoms, including malaise, anxiety, and dysphoria.
- A single dose of extended-release buprenorphine may facilitate discontinuation of buprenorphine by mitigating prolonged, debilitating opioid withdrawal symptoms.
- Minimal to no withdrawals with several patients I have who had injection prior to being incarcerated.
    - Note: symptoms of OUD returned upon release and MOUD generally is re-started.

NALTREXONE

- Oral and IM dosage forms indicated for both alcohol and opioid use disorder.
- Less clear evidence than MMT or BMT
- Potential Benefit for oral formulation vs. placebo for patients who have external mandates (legal requirements)
- Injectable naltrexone trial demonstrates benefit vs. placebo. However, high drop-out rate of 45% at 6 months.
    - ASAM National Practice Guideline, 2015
- IM form with 53% retention in treatment at 6 months
- 20% treatment retention at 1 year with oral naltrexone
    - Bart (2012)

CASE STUDY 3
NEW PATIENT VISIT ON 7-21-21

- 24 year-old female with OUD: She has been illicitly taking 1-2 suboxone daily that she pays about $150 per week for. It is getting harder to find the drug and wants to stop having to chase around for Suboxone.
- Referral from: a friend (her ex-boyfriend is a patient)
- Drug of Choice is: Percocet; she was taking up to 10 per day as recently as 2018 when she got started with Suboxone off the street
- Using opioid since age 17.
- Previous treatments: none
- UDS today: +BUP
- Reviewed Intake paperwork including: history, buprenorphine treatment agreement, ACE score, MAPS, DSM 5 criteria.

HISTORY

- Past Medical History: Depression and anxiety; OUD
- PSH: benign bone growth removed from behind left ear in 2014
- Family History: Mother: SUD and Depression; she committed suicide at age 43
- Social History: [Tobacco: Former smoker (3 pk yrs. / 1 yrs. quit)
- no alcohol
- Lives with her Dad and her 2 year-old son
- Works as a teacher's aide

ASSESSMENT AND PLAN

- # Continuous opioid dependence (F11.20): severe
  - PRESCRIBE: Zubsolv 8.6 mg-2.1 mg sublingual tablet, take 1 tab daily, # 9 , RF: 0. (XB8551170)
  - Offered Naloxone injection kit and discussion about harm reduction.
- ORDERED/ADVISED: Order Date 07-21-2021
- - CHS counseling available via telehealth (F11.20)
- Supportive counseling and education for >45 minutes
- Follow-up in 9 days at Harm Reduction Michigan Office in Cadillac

4 MONTHS LATER, M-OUD WORKING WELL PATIENT STABILIZED AND HAS MONTHLY VISITS

- Mood is more down and depressed and she asks about getting started on antidepressant. She has taken Paxil and other meds that did not seem to do anything in the past. She states she has low motivation to do anything when she gets home from work. She has had crying spells. PHQ-9 score is 16.
- She has not started phone counseling with Amanda (CHS Social Worker) and states that she would prefer in person counseling and is looking forward to meeting Erin today (at HRMI office)
- Start buproprion XL 150mg daily for 1 week then 1 tab bid

6 WEEKS LATER PHQ-9 SCORE IS 22

12mg buprenorphine-naloxone daily working very well. She has 2 weeks left as expected. Mood is still depressed and she has low energy.

Support for recovery includes: HRMI with Erin and she has had three sessions so far.

She has been taking wellbutrin for the last month and has not noted any benefit.

Added citalopram 20mg daily

6 WEEKS LATER

- Patient denies relapse or cravings for opioids. She does not drink or use drugs. Mood is stable overall, but she still feels like sleeping all the time and has little interest in activities. She did not tolerate citalopram stating it made her feel weird. She has been taking buproprion for 3 months without any benefit. She has taken paroxetine before with no effect.
- PHQ-9 score 17
- Stopped citalopram and buproprion; start sertraline 50mg daily for 1 week then 100mg daily
- ORDERED/ADVISED: Order Date 01-28-2022
- - CBC with diff (automated) (F32.9, F11.20)
- - CMP (Complete Metabolic Panel) (F32.9, F11.20)
- - vitamin B12 (F32.9, F11.20)
- - Lipid Panel (F32.9, F11.20, Z13.220)

4 WEEKS LATER TELE-HEALTH VISIT

- Patient denies relapse or cravings. Mood is stable overall. She feels like sertraline has helped her mood significantly and she is more active and enjoying life more. Prior to starting this she tended to stay in bed a lot and did not want to do anything.
- Her labs were normal.
- Support for recovery includes: HRMI; lives with her Dad and has supportive family.
- Working status: Employed as teacher's aide; she works Mon-Thursday; she normally has her child in daycare on Friday to come to her appointment but her daycare was cancelled today and she requested telehealth.

2 MONTHS LATER
ADHD TREATMENT STARTED

- She started having weird dreams when she increase sertraline 100mg to 1.5 tabs daily. She still has pretty low energy. She has poor focus and attention and this has been a problem since childhood. She has other family members with ADHD.
- I reviewed Erin's note and ADHD eval from last month. She has never been on stimulant med in the past.
- Start Adderall XR 10mg daily

ADHD FOLLOW-UP
MAY 2022

- UDS + Amp, + BUP as expected (T-98 degrees)
- Patient works at the learning center and she feels like starting on Adderall has helped her focus, attention and ability to stay on task. She states her energy and mood is better overall.

COMPREHENSIVE TREATMENT, PRIMARY CARE!

- She continues to have success with M-OUD, treatment for depression, and ADHD
- She greatly benefitted from 8 counseling sessions between November 2021 and April 2022
- She has changed jobs and is now working full-time at a credit union.
- Her PHQ-2 screen is negative; will check PHQ-9 at follow-up in May 2023

MEDICINE IS AN ART, AND A SCIENCE

- Get started with treating OUD patients and use skills already at hand while you develop more skills and expertise specific to addiction medicine.
- The need for experiential learning as expressed by Leonardo da Vinci (1452-1519):
  - "They will say that because I have no book learning I cannot properly express what I desire to describe – but they do not know that my subjects require experience rather than the words of other."
  - "The Last Leonardo" written by Ben Lewis (2019)

CASE STUDY 4

PATIENT ON LONG TERM OPIOID PRESCRIPTION AND STARTED ON BMT

- 72 year-old male presents for new patient visit on 4-10-23 who is having withdrawals from tapering off prescribed opioids. His long-term doctor has retired.
- Chronic back pain due to DDD and he required L5 discectomy 27 years ago. Not a candidate for further surgery. He has managed pain with opioid pain medication, ibuprofen and marijuana edibles.
- He is glad to have opportunity to change to different treatment stating opioids have side effects that he does not like (sedation, emotional restriction)
- Diagnosis: Moderate OUD (4 of 11 DSM5 criteria)

FULL AGONIST OPIOID TO PARTIAL AGONIST

- Previous RXS: MS Contin 60mg 2 tabs q8, MSIR 30mg q6, valium 10mg 2 tabs tid
- PMH: CAD, DDD, history of HCV (took Mavyret in 2021), History of AUD (quit in 1992), constipation
- PSH: L5 Discectomy 1996, angioplasty with stents in 2019
- Retired from gas station work in 2022
- Enjoys playing golf and going for walks

MED CHANGES

Started on Suboxone 8/2 one film for 1 day then 1-2 films daily

Changed from valium to clonazepam 1mg three times daily

Plan for phone visit in 2-3 days and office visit in 1 week

- He has been talking with recovery coach (who happens to be similar age) and this has helped

1 WEEK LATER

He has struggled in this first week with transition

He has been more emotional and states this is a good thing. He has been a widower for 20 years.

He required going up to 3 Suboxone daily and has reduced clonazepam to 0.5mg 2-3 times daily

He has had some weight loss and feels like he is getting his appetite back

2 WEEKS LATER

- He is beginning to adjust to buprenorphine maintenance treatment better
- Brighter affect; looks younger
- He had stopped drinking coffee when first started on buprenorphine stating he did not like the taste. He came to conclusion that caffeine withdrawal was contributing to him not feeling so good during part of the last 2 weeks.
- Basically feels back to normal
- Will have re-check in 2 weeks and then every 4 weeks.

FOOD FOR THOUGHT: RELATIVE RISK OF ADDICTIVE SUBSTANCES

480,000 Tobacco related deaths in 2017

- CDC

119,909 Excess deaths from obesity

- 2005 JAMA 293 (15):1861-1867

88,000 alcohol related deaths in 2017

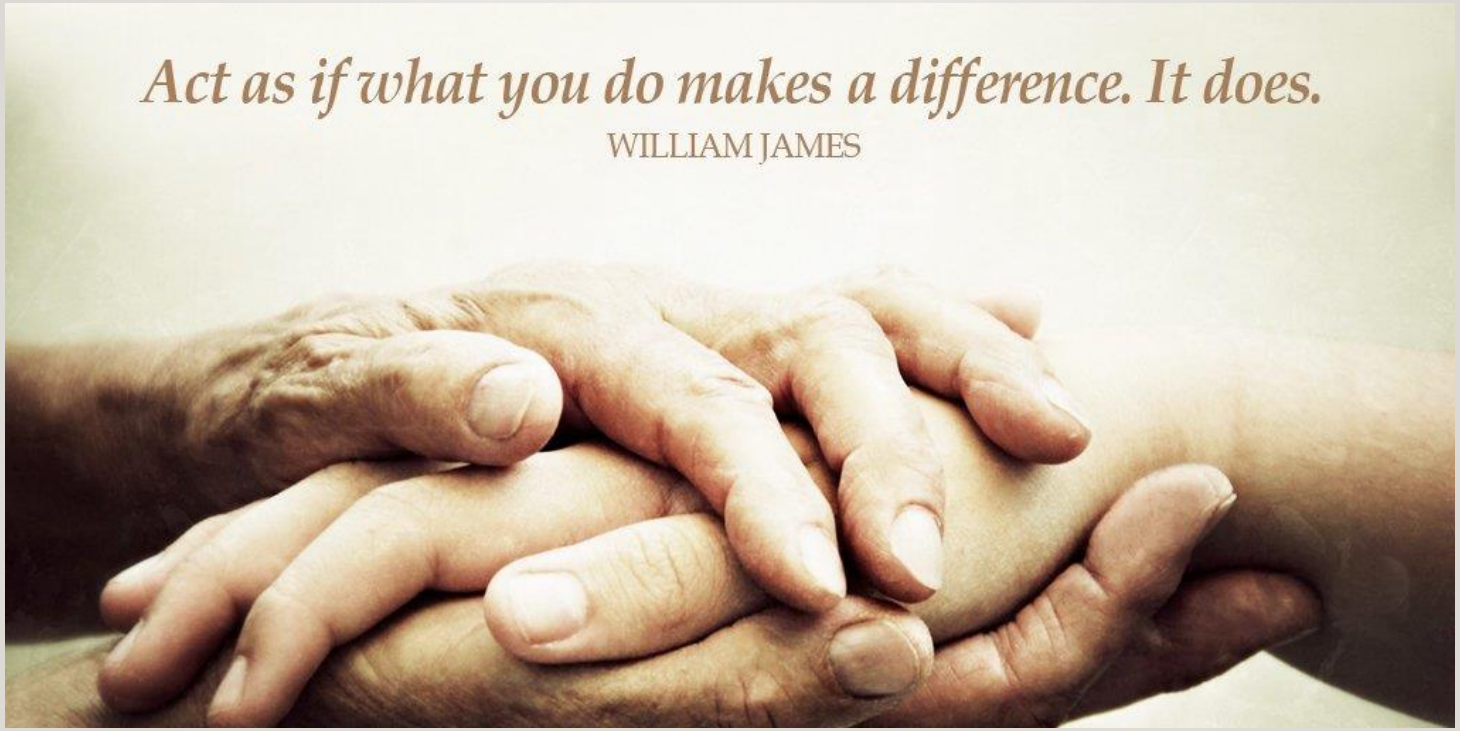
- National Institute on Alcohol Abuse and Alcoholism

70,200 Drug overdose deaths in 2017

- CDC

Few reports on deaths linked to marijuana

WE CAN DO THIS!



THANK YOU

- David Best, DO, MS, ABAM
- dkbest_2000@yahoo.com

- www.asam.org
- www.aatod.org
- www.aoaam.org