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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

TREATING SUBSTANCE USE DISORDERS IN PRIMARY CARE: TIPS FOR A PROACTIVE TRANSFORMATION

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UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

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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QUALIS HEALTH

Washington State Department of Health

Healthier WASHINGTON

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

DISCLOSURES

- None

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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
    - 73 in 2008 vs 313 in 2015
  - Fentanyl related deaths on rise
    - 28 in 2015 vs 70 in 2016 (84% accidental)

- 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

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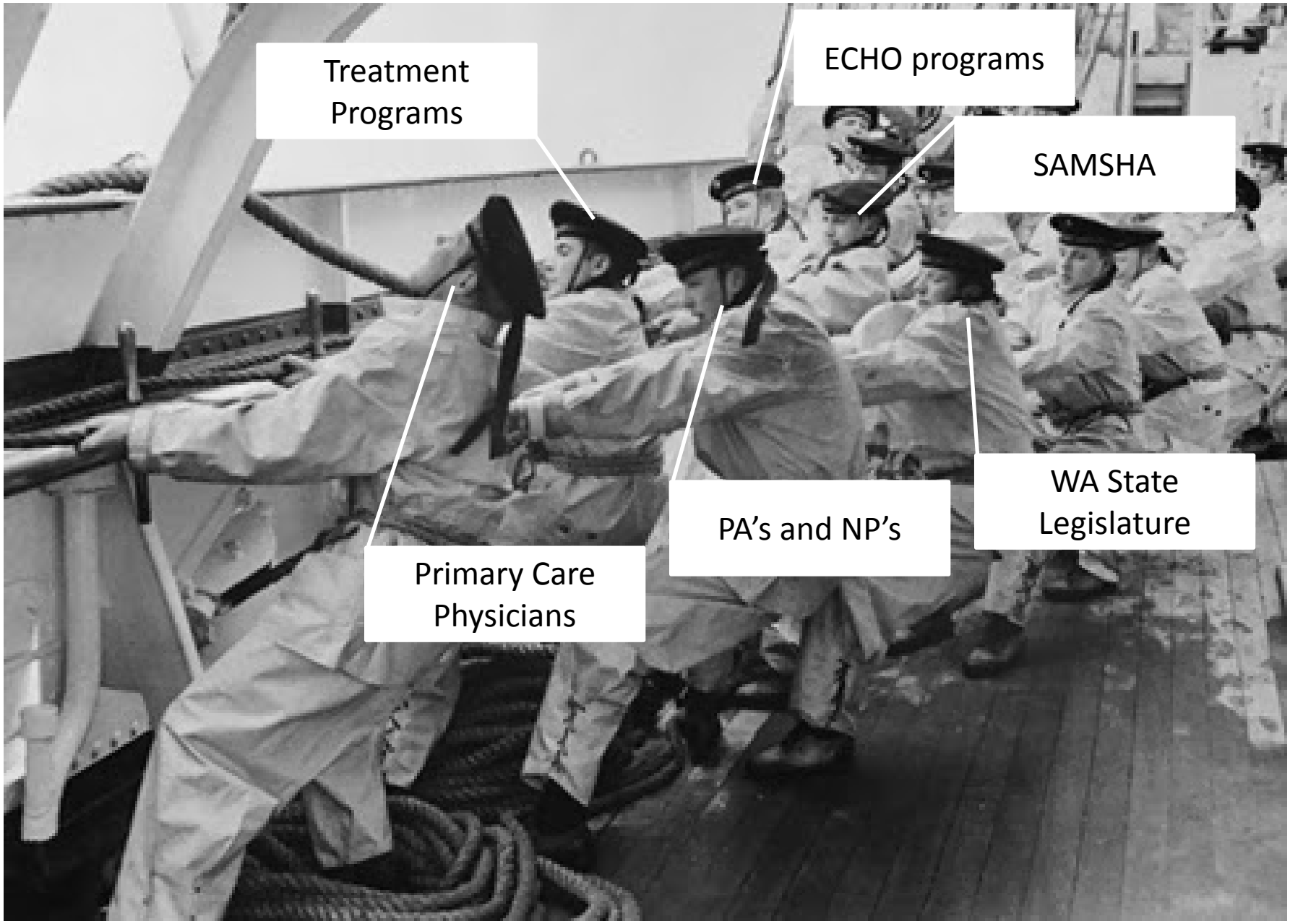

http://bobsjobshandyman.com/wp-content/uploads/2014/06/All-Hands-on-Deck.jpg

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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
- Enhance access to treatment

Alford et at (2011); Babor et al (2007); Cherpitel & Ye (2008); Friedmann et al (2006); Gourevitch et al (2007); Gryczynski et al (2011); Kim et al (2012); Kim et al (2011); LaBelle et al (2016); Lee et al (2015); Madras et al (2009); Oslin et al (2014); Parthasarathy et al (2003); Weisner et al (2001)

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TREATMENT OF SUBSTANCE USE DISORDERS IS EXPANDING-GREAT!

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BUT, IS IT AS EFFECTIVE AS IT COULD BE?

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EVIDENCE-BASED MODELS OF INTEGRATED ADDICTION TREATMENT AND WHAT TO TAKE FROM THEM

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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 ***in***effective

(Angus et al 2014; Glass et al 2015 & 2015; Kim et al 2017; Quinn et al, 2008; Saitz et al 2014; Roy-Byrne et al 2014)

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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

		Treatment Arm	
		ACM (n=85)	**Specialty Clinic (n=78)**
Intervention Characteristics	**Psycho-therapy**	MET with BHP (phone or in-person)	12-step facilitation-based IOP
	Contact Intensity	30 minutes/week (plus PCP appnts)	2-4 half-days X 6 wks; then 1-2 grps/wk (plus individual provider appnts)
	MAT	Naltrexone offered	MAT, per clinic protocols/Drs' preference

Oslin et al. (2013)

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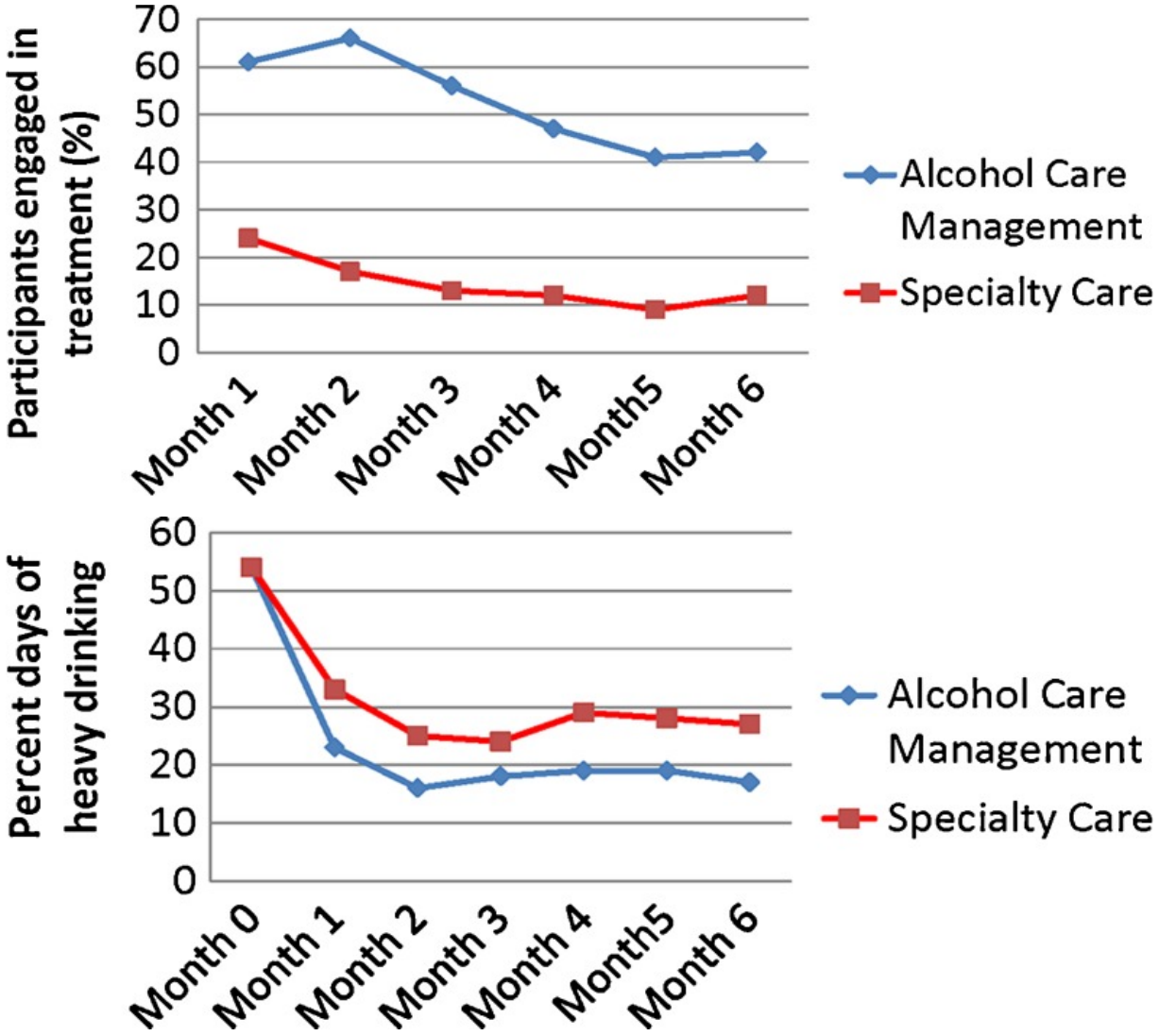
EBMS FOR INTEGRATING ADDICTIONS & PRIMARY CARE:

THE VA'S "ALCOHOL CARE MANAGEMENT"



Other Results:

- AUD Meds Rx (Naltrexone only)
  - ***PC: 65.9%***
  - Specialty: 11.5%

Conclusions:

- PC-based AUD treatment outperformed specialty care

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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 waivered)
- Weekly Caseload Reviews
- Registry
- Measurement based care

Main Outcomes:

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

		Treatment Arm	
		Collab. Care (n=187)	**Usual Care (n=190)**
Intervention Characteristics	**Intervention**	Enrolled, proactively followed in PC by CC team	Pt given info for in-clinic & external specialty SUDs tx
	Contact Intensity	Goal: 6-sesson psychotherapy +/- MAT	Variable
	Psycho-therapy	MET/CBT	Variable
	MAT	XR-NXT (AUD), bup-nalox. (OUD)	Variable, per clinic or provider

Watkins et al. (2017)

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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%)
    P Value < .001
  - MAT CC = UC (13% vs 13%)?
- 30-day Abstinence (self-report)
  - CC > Usual Care (33% vs. 22%)
    [β=0.12, 95 % 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?***

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Integrating Addictions & Primary Care:
Collaborative Care for Opioid Use DOs
The "*Massachusetts Model*" of Collaborative Care for OBB

Nurse Care Manager
- Initial screening

Physician
- Chart review
- Physical Exam
- Dx and Treatment decision

Physician
- Prescription

Nurse Care Manager
- Buprenorphine Induction per protocol
- Patient support and Titration

Nurse Care Manager
- Stabilization monitoring

Physician
- Maintenance and follow-up

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

Alford et al, 2011; LaBelle et al 2016

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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

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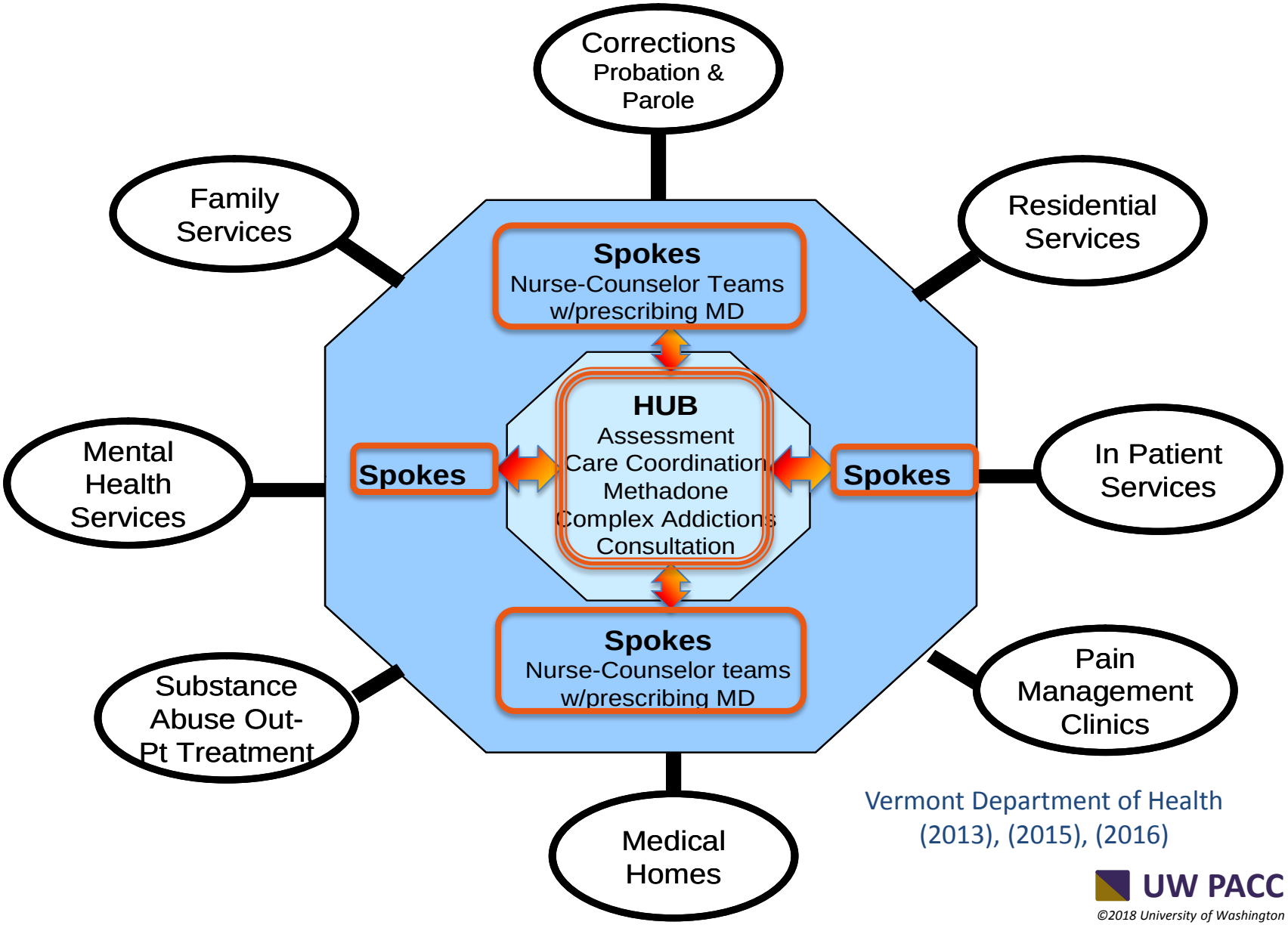
INTEGRATING ADDICTIONS & PRIMARY CARE:

VERMONT'S "HUB & SPOKE" MODEL



Vermont Department of Health (2013), (2015), (2016)

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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

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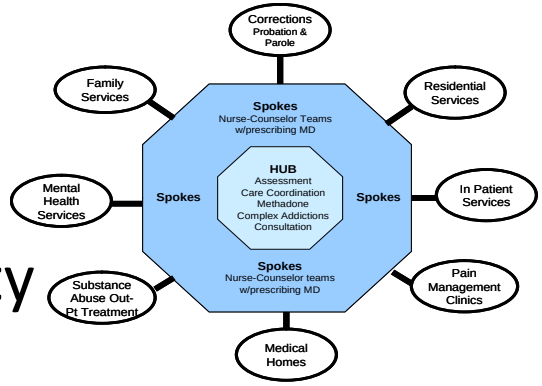

- Learning Collaborative
  - Goal: increase access & improve quality
  - Quality Measures (% of patients)
    - documented dx of OUD
    - unstable patients
    - > 16mg of bup
    - Urine drug screens
    - PMP has been accessed
    - In care x 6 months
    - Documentation of comanagement of other SUDs,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

Vermont Department of Health (2013), (2015), (2016); Nordstrom et al, 2016

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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

SUD TREATMENT KEYS

Retention, Retention, Retention

- Use Evidence Based Treatment
  - MAT
  - Psychosocial Treatment
- Team based-provider support
- Population based

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SO WHAT HAVE THESE MODELS TAUGHT US?

1. HOW EFFECTIVE IS INTEGRATED ADDICTIONS CARE?

Model	Key Studies / Data Sources	Primary SUD(s) Treated	Process Measures				Outcome Measures			
			Enroll-ment in Treatment	Retention in Treatment	MAT Received	BT Received	Mortality	Abstinence	Use-reduction	Improved Function / Symptoms
Chronic Care Mangmnt	ACM (Oslin et al, 2013)	AUD	91%	85% (6mo)	66%	+	?	?	27%	+
"Collaborative Care"	SUMMIT (Watkins et al, 2017)	A/OUD	93%	20% (6mo)	13%*	36%	?	33%	None	None
	"Mass. Model" (Alford et al, 2011; LaBelle et al, 2016)	OUD	?	51% (12mo)	100%	?	?	51%	?	?
Vermont's Hub & Spoke	(VT Dept Health)	OUD	?	95% (6mo)	71%	+++	?	?	?	?

- Observations & Questions:
  - What are the major levers we can pull to improve retention & outcomes?

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SO WHAT HAVE THESE MODELS TAUGHT US?

2. ARE THEIR COMMON ATTRIBUTES WORTH NOTING?

Model	Key Studies / Data Sources	Primary SUD(s) Treated	Common Attributes					
			Patient-centered	Team-based Care	Provides ↑ support to PC Team	Population-based Approach	Direct Access to Evidence-based Treatments	Enables pt's placement in proper LOC
SBIRT	(multiple)	Multiple	+	+/-	+	+	+/-	+
Chronic Care Mangmnt	ACM (Oslin et al, 2013)	AUD	++	++	++	++	++	++
	AHEAD (Saitz et al, 2013)	ASOUDs	++	++	+++	++	++	++
"Collaborative Care"	SUMMIT (Watkins et al, 2017)	AOUDs	+++	+++	+++	+++	++	++
	"Mass. Model" (Alford, 2011; LaBelle, 2016)	OUD	++	++	++	++	++	++
Vermont's Hub & Spoke	(VT Dept Health)	OUD	+++	+++	+++	+++	+++	+++
ECHO	(Komaromy, 2016)	Multiple	++ (*)	+/- (*)	+++	++ (*)	+++ (*)	++ (*)

* Indirect effect

Scale: +++ highest level

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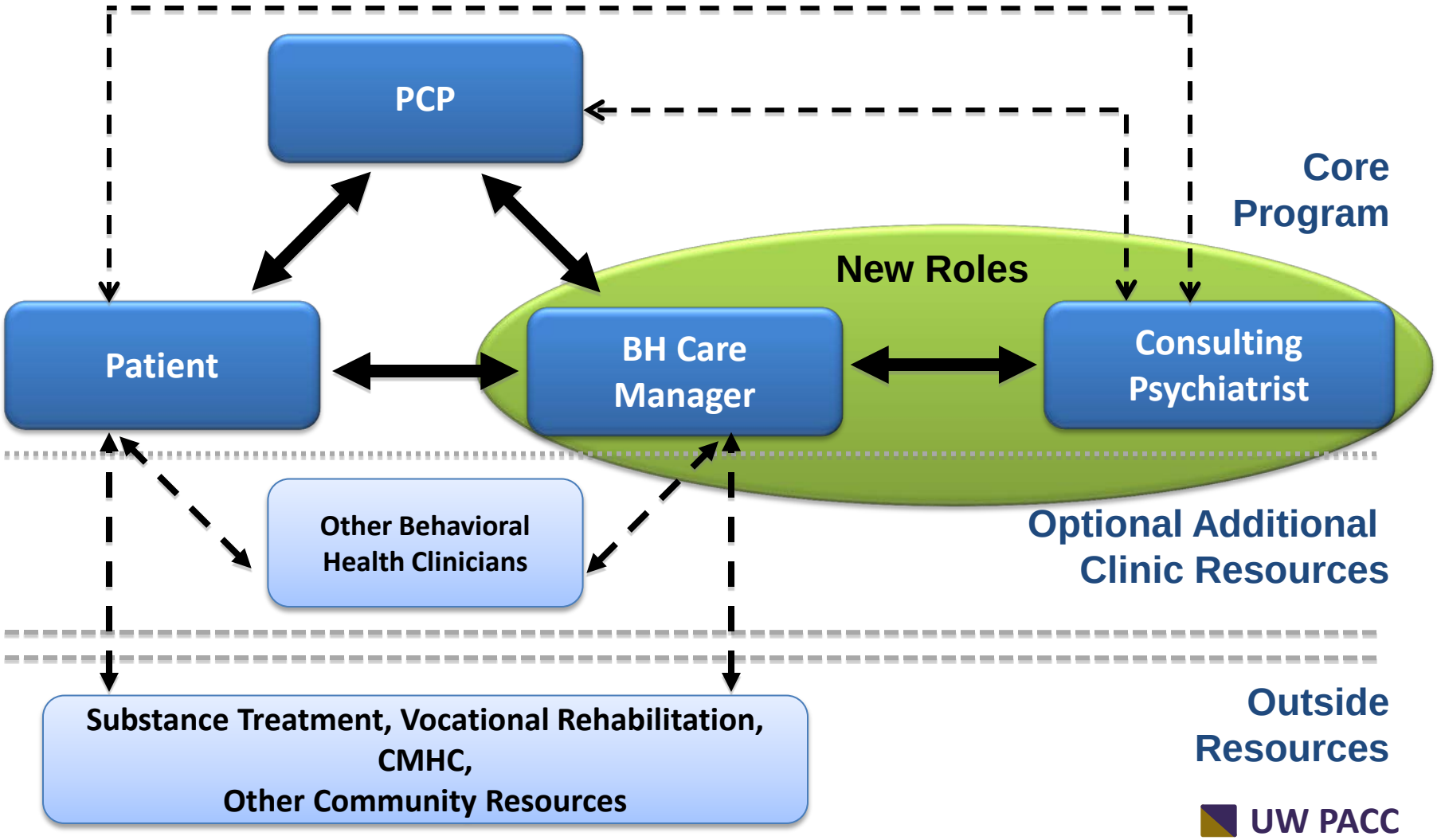
COLLABORATIVE CARE



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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?

AMERICAN PSYCHIATRIC ASSOCIATION

Archer, J. et al., 2012

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COLLABORATIVE CARE PRINCIPLES

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

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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.

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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

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MEASUREMENT BASED CARE DO'S

- Symptom severity should be assessed frequently
- Concurrently with the clinical encounter
- Be able to compare current with passes scores

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MEASUREMENT BASED CARE

Current Possibilities

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

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BRIEF ADDICTION MONITOR

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

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

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

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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)?
     ___ ___

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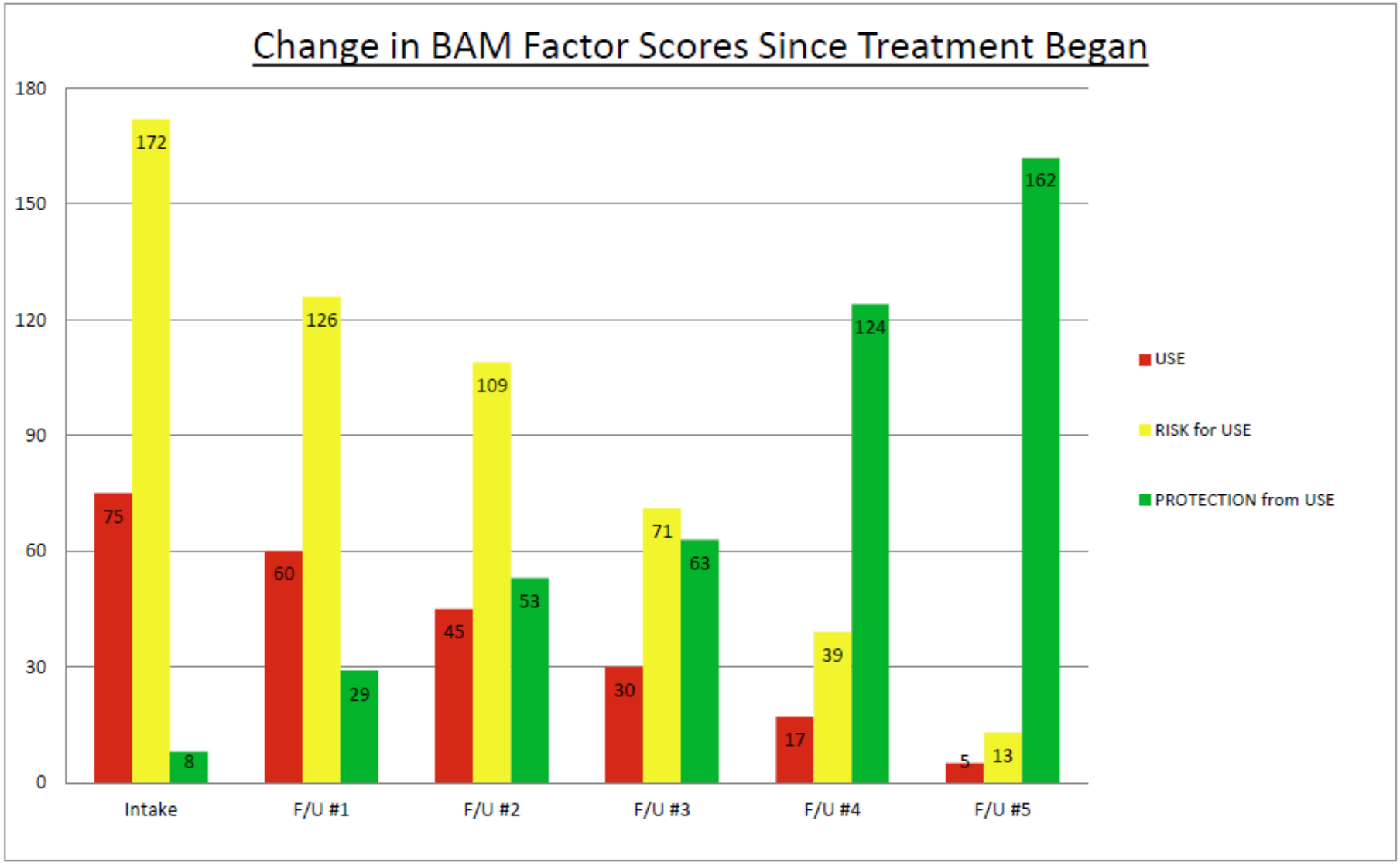
Change in BAM Factor Scores Since Treatment Began



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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

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

- All are blood samples except for Carb-def transferrin

Bottom-line: modestly helpful

https://pubs.niaaa.nih.gov/publications/AssessingAlcohol/biomarkers.htm

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OBOT S

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.

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Population Based Care

Registry Requirements

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

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! ndicates 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					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

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ADDICTION REGISTRY

Name	Treatment Status				Urine Drug Screens		Brief Addiction Monitor						MAT	Last PMP accessed	Addiction Consult
	Initial Assessment	Most Recent	# Sessions	Weeks in Tx	First	Last	First			Last			Med and dose		
							Use	Risk	Protection	Use	Risk	Protection			
Joe	8/25/17	9/21/17	2	4	Opioids, THC, Cocaine	THC	75	172	8	17	39	124	Bup-Nal 16mg	9/21/17	9/1/2017
Sally	6/21/17	8/1/17	3	5	Alcohol, THC	None	50	126	29	45	90	29	Naltrexone 50mg	8/21/17	8/3/2017

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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

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EVIDENCE BASED CARE

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SUD TREATMENT KEYS

Retention, Retention, Retention

- How?
- Use Evidence Based Treatment
  - MAT
  - Psychosocial Treatment
- Team based-provider support
- Population based

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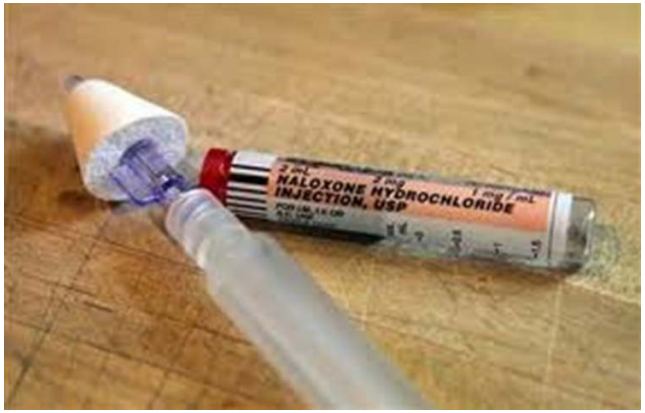
OPIOIDS: NARCAN

- 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
Walley, A, et al, 2013; Giglio, R, et al, 2015

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OPIOIDS: BUPRENORPHINE DOSE AND STABILITY

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

Comer S, et al, 2001; Fareed A, et al, 2012, Hser Y, et al, 2014

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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.

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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

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OPIOIDS: BUPRENORPHINE VS IM NALTREXONE

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

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

Opioid/Benzo Rx Status	12 month Mortality Rate	24 month Mortality Rate
Prescribed	4.3%	8.3%
Not Prescribed	3.1%	6.2%
% Change	29%	27%

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

Watkins, K, et al, 2017

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

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ALCOHOL: MAT

VA Alcohol Care Management

- Naltrexone Rx
  - ***PC: 65.9%***
  - Specialty: 11.5%

- 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

Jonas D., et al 2014

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; Watkins K. et al, 2017

PSYCHOSOCIAL TREATMENT

Alcohol: strong effect

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

Best Practice: Patients should be referred or offerd 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

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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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