Implementing Medication-Assisted Treatment (MAT): Organizational Considerations and Workflows

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Disclosures

• Nick Szubiak, Director of Clinical Excellence at the National Council for Behavioral Health
  ▪ Mr. Szubiak has no financial relationships to disclose.

• Jeremy Attermann, Project Manager at the National Council for Behavioral Health
  ▪ Mr. Attermann has no financial relationships to disclose.

• Dr. Genie Bailey, Director of Research and Medical Director of the Dual Diagnosis Unit at Stanley Street Treatment and Resources

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
## Disclosures – Dr. Bailey

<table>
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<td>Speaker’s bureau</td>
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Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

• At the conclusion of this activity participants should be able to:
  
• Convey the importance of providing MAT for your patient population in order to secure staff, board, and community buy-in
  
• Identify operational and workforce considerations to successfully implement MAT in a primary or behavioral health practice setting
  
• Describe common models used to implement MAT in a number of practice settings
Medications for Addiction Treatment

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

**Opioids:**
- Methadone
- Buprenorphine (film, pill and implant)
- Naltrexone – oral
- Naltrexone (Vivitrol) – Long-acting, injectable

**Smoking Cessation**
- Varenicline (Chantix)
- Bupropion (Wellbutrin)
- NRT’s
The Case for MAT

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

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

- MAT is the gold standard for opioid use disorder (OUD) treatment:
  - Reduces drug use
  - Reduces risk of overdose
  - Prevents injection behaviors
  - Reduces criminal behavior
Are you Ready Implement MAT Services?
Top Five Barriers to Implementation of MAT in Substance Use Treatment Programs

- State regulations that prohibit using medical staff in certain settings or instances where MAT services may be ideally delivered.
- Primary sources of funding that do not reimburse for all activities related to provision of MAT (e.g., physician time, payment for necessary laboratory tests, or the cost of purchasing medications).
- High cost of the medications for individuals.
- Lack of access to providers with expertise in prescribing medications for substance use disorders.
- Lack of nurses or other medical staff with expertise in using the medications.

**Prior authorization** - Getting an agreement from the payer to cover specific services before the service is performed.

**Step-therapy** - Benefit design that requires patients to try a first-line medication, such as a generic medication, before they can receive a second-line treatment, such as a branded medication.

**Lifetime limit** - Insurers place a dollar limit on what they would spend for your covered benefits during the entire time you were enrolled in that plan (banned under current law)
Organizational Benefit Silos

One challenge to establishing a benefit design for medications to treat alcohol and opioid use disorders is that the medications can involve four different Medicaid operations:

- opioid treatment programs
- pharmacy benefits
- medical benefits
- pharmacy contracting

These areas often function independently in their decision systems, staffing, and approval process (ASAM, 2013).
Getting Ready for Implementation

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

- Organizational readiness
- Economic/regulatory readiness
- Workforce readiness
- Community readiness
- Patient and caregiver readiness
Key Questions to Consider

- Do you have leadership support?
- Who will you offer services to and what MAT services will you offer?
- What do Medicaid and commercial insurers require for the use of MAT in your state?
  - PA, step therapy, lifetime limits
- Typical out-of-pocket cost for the medications, and patient ability to afford these costs?
- Will clinicians be reimbursed for clinical services required for MAT?
- Does your agency have an appropriately trained team to administer medication AND the associated behavioral health services?
Key Questions Continued

• What other treatment programs in your region and state currently provide MAT?
• Do you have relationships with other organizations that can provide additional treatment supports and resources?
• Are there patient/caregiver barriers to the use of MAT?
• How will you educate patients and caregivers about the risks and benefits of MAT and its place within the treatment continuum?
• How do you assess a patient’s support network?
Getting Started with Medication-Assisted Treatment with Lessons from Advancing Recovery

The business case for MAT

The estimated expense to society of opioid addiction nears $20 billion annually, yet the cost of treating an individual addicted to opioids is up to $4,000 per year. If every opioid-dependent person in the United States received treatment, $16 billion would be saved every year.

National Drug Court Institute Practitioner Fact Sheet

Case Study: Changing staff beliefs through education

Advancing Recovery Maine sought to dramatically increase access to and retention in MAT services. The project began by assessing the need for staff education. Maine’s Single State Agency and the state provider association, [www.masap.org](http://www.masap.org) conducted two focus groups on competency and staff buy-in. The first focus group was with program executives and clinical supervisors, and the second was with direct-service staff. The results were aggregated across the state and for each participating organization. They showed that each agency had both supervisory and line staff who were uneasy with MAT services.

http://www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf
Procedures for Medication-Assisted Treatment of Alcohol or Opioid Dependence in Primary Care

Pre-Injection Sample Checklist (Use Pullout Checklists in Appendix A)

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>Criteria</th>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Patient meets DSM-IV criteria for alcohol dependence.</td>
</tr>
<tr>
<td>☐</td>
<td>☒</td>
<td>Patient does NOT require inpatient alcohol detoxification (no current signs of severe alcohol withdrawal; no past history of requiring hospitalization for severe alcohol withdrawal, seizures, or delirium tremens).</td>
</tr>
<tr>
<td>☐</td>
<td>☒</td>
<td>Patient is NOT opioid dependent, is NOT currently using opioids, and is NOT exhibiting signs or symptoms of opioid intoxication or withdrawal (if any doubt, complete naloxone challenge prior to injection).</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>All urine drug screens negative for opioids (if any doubt, complete naloxone challenge prior to injection).</td>
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Who Can Assess This?
- Therapist or physician

1. Remove the carton from refrigeration. Prior to preparation, allow drug to reach room temperature (approximately 45 minutes).
2. To ease mixing, firmly tap the VIVITROL Microspheres vial on a hard surface, ensuring the powder moves freely (see Figure B).
3. Remove flip-off caps from both vials. DO NOT USE IF FLIP-OFF CAPS ARE BROKEN OR MISSING.
4. Wipe the vial tops with an alcohol swab.
5. Place the 1-inch preparation needle on the syringe and withdraw 3.4 mL of the diluent from the diluent vial. Some diluent will remain in the diluent vial (see Figure B).

Proper Storage of Extended-Release, Injectable Naltrexone

- The entire carton should be stored in the refrigerator (2–8 °C, 36–46 °F).
- Unrefrigerated, extended-release, injectable naltrexone microspheres can be stored at temperatures not exceeding 25 °C (77 °F) for no more than 7 days prior to administration. Do not expose unrefrigerated product to temperatures above 25 °C (77 °F). Extended-release, injectable naltrexone should not be frozen.

Detailed, step-by-step instructions for the preparation and injection of extended-release, injectable naltrexone are provided in Appendix C.

Integrated Substance Abuse Treatment: Buprenorphine in a Federally Qualified Health Center

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Associate Clinical Professor
Warren Alpert Medical School of Brown University, Providence, Rhode Island
Introduction

- Overview of SSTAR’s Family HealthCare Center
- Overview of SSTAR’s Office-Based Buprenorphine Treatment Program
- Description of protocols
- Treatment data
Overview of Family Healthcare Centers

- Established as leadership realized our patients were not receiving adequate primary medical care for:
  - diseases related to substance use
  - mental health issues
  - HIV/AIDS

- Opened primary site in 1996; second site in March 2012

- Currently classified as a 330 Federally Qualified Health Center (FQHC)
Overview of Family HealthCare Centers

- **Staffing**
  - 2 Family MDs
  - 3.75 Family nurse practitioners
  - 1 Adult nurse practitioner
  - 2 Psychiatric nurse practitioners
  - 0.2 FTE ID MDs
  - 0.6 FTE Pediatrician
  - 0.2 FTE Psychiatrist
- 118 total employees
- Provides chronic illness case management for diabetes, hypertension, asthma, chronic pain, HIV, and HCV
# HealthCare Center Statistics

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<thead>
<tr>
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<th>2015</th>
<th>2016</th>
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<tr>
<td>Number of unduplicated clients</td>
<td>5,913</td>
<td>6,306</td>
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<tr>
<td>Medical visits</td>
<td>16,544</td>
<td>20,965</td>
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<tr>
<td>Mental health visits</td>
<td>4,272</td>
<td>3,262</td>
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<tr>
<td>Unduplicated mental health clients</td>
<td>1,133</td>
<td>780</td>
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<td>Substance abuse visits</td>
<td>17,598</td>
<td>18,793</td>
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<tr>
<td>Case management visits</td>
<td>7,947</td>
<td>5,853</td>
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<tr>
<td>Relapse prevention groups</td>
<td>1000</td>
<td>1800</td>
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<tr>
<td>Total clinic visits</td>
<td>47,361</td>
<td>50,673</td>
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## Primary Diagnosis: Patients’ Presenting Problems

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<th>Diagnosis</th>
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<th>2016</th>
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<tr>
<td>Alcohol disorder</td>
<td>3%</td>
<td>4%</td>
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<tr>
<td>Substance abuse disorder</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Anxiety disorder and PTSD</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>Other mental disorders</td>
<td>4%</td>
<td>4%</td>
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Why Buprenorphine? How the decision was made

Agency philosophy
  • Utilize evidence-based treatments

Community need
  • High incidence of opiate addiction

Limited treatment access
  • Inpatient detoxification and methadone maintenance only options

Our desire to expand treatment capacity
  • Working people were unable to commit to inpatient admissions

Coverage available
  • Buprenorphine was paid for by Massachusetts Medicaid

First induction: September 2004
SSTAR’s Healthcare Center Model

- Promotes **Medical Home Model**
- Allows substance abuse treatment with increased **privacy and confidentiality**
- Allows **better medical care** for substance abuse-related diseases
- Safe and convenient in-home use allows more normal routines and higher quality of life
- Integrated treatment **decreases** stigma
SSTAR’s Healthcare Center Model

- **SSTAR is committed** to providing buprenorphine to Healthcare Center patients
- SSTAR requires that **every physician hired** obtain or currently possess a DEA waiver to dispense buprenorphine
- SSTAR has also hired:
  - 4 full time RN case managers
  - 2 program assistants
  - 3 medical assistants
  - 1 MSW
  - 2 case managers
SSTAR’s HealthCare Center Model

- Suboxone patients **must also receive their primary health care at SSTAR**
- 91% are self-referrals
- Patients are pre-screened by phone
- Medical clearance required before enrollment
- Nursing intake required before induction
- Induction date and time arranged with patient
- UDS must be clear of non-prescription substances on day of induction (exception: THC)
SSTAR’s HealthCare Center Model

- **Induction day 1:**
  - 2-4 hours at facility
  - Medication obtained from local pharmacy
  - Induction performed by RNs following preapproved protocol
  - All patients seen by physician prior to leaving facility
  - Maximum dose 12 mg, may be given 4 mgs PRN for later

- **Induction day 2:**
  - Patient instructed to medicate with Day 1 dose upon awakening
  - Patient asked to call RN within 2 hours for phone assessment
  - RN, in consultation with MD, will provide script for one week
  - Patient seen weekly by buprenorphine provider or nurse for 12 weeks, with a UDS and pill count at each visit
SSTAR’s HealthCare Center Model

- Client expected to attend weekly relapse prevention group for 12 weeks and then if **abstinent and adherent** may extend to monthly group and clinical visits.

- Once long-term sobriety established, may be given refills and seen every two months.

- Mental health counseling is offered and available to all patients via an open-access outpatient clinic.
SSTAR’s HealthCare Center Model

- Diversion = Immediate discharge
- Illicit use:
  - Random UDS and pill counts
  - Weekly visits
  - Increased dose of SA treatment (1:1, IOP or detox)
  - Eventual taper or referral to methadone or Vivitrol, planning for daily buprenorphine
- Former clients can reapply at any time
Notable Features of SSTAR Model

- Collaborative care model

- On-site induction, not in-home induction

- Significant physician involvement

- Regular multi-disciplinary team meetings

- Psychosocial treatment done within SSTAR system

- Harm reduction philosophy
  - Goal is to keep patients in treatment
Whom Do We Treat?

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau. OBOT Admission/Enrollment Profile. July 1, 2010 - June 30, 2012:

- Female: 40%
- Male: 60%

Age Distribution:
- <25 years: 10%
- 25 to 29: 25%
- 30 to 34: 20%
- 35 to 39: 15%
- >40 years: 5%
Whom Do We Treat?

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau. OBOT Admission/Enrollment Profile. July 1, 2010 - June 30, 2012:

Reported Race
- White: 88.00%
- Black: 2.50%
- Hispanic: 5.00%
- Other: 5.00%

0.00% 25.00% 50.00% 75.00% 100.00%

Reported Race
White
Black
Hispanic
Other
Whom Do We Treat?

75% Medicaid, 5.8% private insurance
26% Employed full- or part-time
55% Unemployed
49% Heroin users
37% Other opiates
47% IV use in last 12 months

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau.
OBOT Admission/Enrollment Profile. July 1, 2011 through June 30, 2012:
Patients receiving outpatient Suboxone, by dose

Dose (mg)

Patients, n=320

1mg 2mg 3mg 4mg 6mg 8mg 12mg 14mg 16mg 18mg 20mg 24mg 32mg

0 20 40 60 80 100 120 140 160

3% 8% 43% 11%
How Are We Doing?

Average Discharge % By Month in Tx 2008-2011

Month: 1 2 3 4 5 6
Discharge %: 6.0% 18.0% 9.0% 6.0% 4.5% 3.0%
How Are We Doing?

Retention Rate 2008 - 2011

- FY2011
- FY2010
- FY2009
- FY2008

Overall retention rate is the # enrollments reaching engagement (> 12 months) / # total enrollments
How Are We Doing?

Disenrollment By Reason, 2008-2011

- Dropout: 49%
- Administrative Discharge: 20%
- Assessment Only: 12%
- Completed: 7%
- Relapsed: 5%
- Other: 5%
- Incarcerated: 2%

Dropout
Administrative Discharge
Assessment Only
Completed
Relapsed
Other
Incarcerated
How Are We Doing?

Disenrollment By Reason By Year

- Administrative Discharge
- Assessment Only
- Completed
- Dropout
- Incarcerated
- Relapsed
- All Other

- 2008
- 2009
- 2010
- 2011
How Are We Doing?

Admission Statistics 2008 - 2012

- Enrollments
- Clients Admitted
- Clients Served
Time in treatment, in months

- More than 24 mos: 64%
- 24-36 mos: 18%
- 36-48 mos: 21%
- 48+ mos: 25%

- 18 - 24 mos: 14%
- 12-18 mos: 11%
- 6-12 mos: 7%
- 0-6 mos: 4%
Questions
PCSS-MAT Listserv

Have a clinical question? Please click the box below!

Ask a Colleague
A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now ›
PCSS-MAT Mentoring Program

- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS-MAT Mentors comprise a national network of trained providers with expertise in medication-assisted treatment, addictions and clinical education.

- Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

- The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit: pcssmat.org/mentoring
PCSS-MAT is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with the: Addiction Technology Transfer Center (ATTC); American Academy of Family Physicians (AAFP); American Academy of Pain Medicine (AAPM); American Academy of Pediatrics (AAP); American College of Emergency Physicians (ACEP); American College of Physicians (ACP); American Dental Association (ADA); American Medical Association (AMA); American Osteopathic Academy of Addiction Medicine (AOAAM); American Psychiatric Association (APA); American Psychiatric Nurses Association (APNA); American Society of Addiction Medicine (ASAM); American Society for Pain Management Nursing (ASPMN); Association for Medical Education and Research in Substance Abuse (AMERSA); International Nurses Society on Addictions (IntNSA); National Association of Community Health Centers (NACHC); and the National Association of Drug Court Professionals (NADCP).

For more information: www.pcssmat.org

Twitter: @PCSSProjects

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