Treatment for Substance Use Disorders: COSAM and CeDAR Provider Perspective

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CeDAR (Center for Dependency, Addiction and Rehabilitation): Clinical Services

- All patients at CeDAR benefit from a multidisciplinary approach that includes team members from Addiction Medicine, Addiction Psychiatry, Nursing, Counseling, Psychology, Spirituality, Nutrition, Fitness, Recovery Support and the Family Program.
- Specific CeDAR services include alcohol and drug detoxification treatment (10 beds), residential treatment (68 beds), a consultation-liaison service for the University of Colorado Hospital (600+ consults per year), intensive outpatient programs, other outpatient groups, addiction psychiatry and addiction medicine clinics (in all 3900 visits in 2016).
- Our services are provided in a trauma-informed manner and include both gender specific and trauma integrated care
- Specialized addiction services are available for professionals in safety sensitive positions (e.g. health care workers and pilots), other professionals, and athletes
- Specialty Controlled Substances Support Clinic serving opioid addicted patients from AF Williams Family Medicine to reduce opioid equivalents and identify behavioral health treatment needs (75 patients in 2016)
- Integrated Addiction Services providing care in two primary care clinics (A. F. Williams and Boulder Campus) and one general psychiatry clinic (AMC campus)

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CeDAR Strength: Support of Medication Assisted Therapies

- For most patients with an opioid use disorder, the use of medications with psychosocial treatment is superior to withdrawal management and/or psychosocial treatment on its own
- Methadone (opioid receptor full agonist), buprenorphine (opioid receptor partial agonist) and naltrexone (opioid receptor antagonist) all reduce morbidity and mortality and are safe and cost-effective strategies
- On a national basis, less than 20% of patients with an opioid use disorder receive any treatment
  - Of the 20% who make it to a treatment center, only 30% of the treatment centers offer medication assisted treatment
  - Only 50% of individuals who are eligible for medication within the treatment center that offers it receive the medication.
  - CeDAR, which is a very pro-MAT treatment center, has a 50% prescription rate at discharge, similar to the national numbers, likely due to patient preference and lack of discharge treatment centers that support medication assisted treatment

Saloner et al 2013; Knudsen et al 2011

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National Opioid Research Trends

- Women 1.6 times more likely to have a co-occurring disorder*
- OUD pts with a co-occurring disorder have greater baseline impairment.*
- OUD pts receiving buprenorphine-naloxone treatment are 1.6 times more likely to have a successful opioid use outcome.*
- At 42 month follow-up in multi-site National Drug Abuse Treatment Clinical Trials Network research project: opioid agonist therapy pts show statistically greater likelihood of illicit-opioid abstinence. **
- Pts utilizing Injectable Extended-Release Naltrexone (XR-NTX) demonstrated statistically significant increases in Alcohol Severity Index scores on Drug, Psychological, Legal, and Family domains when compared to non medication group. ***
- Significantly more XR-NTX patients achieved 90% abstinence versus placebo.***

*Griffin, et al., 2013
**Weiss, et al., 2015
***Nunes et al., 2015

Natural History of Opioid Use Disorder

Euphoria
Normal
Withdrawal
Tolerance & Physical Dependence
Acute use
Chronic use

Opioid Agonists and Antagonists

% Mu Receptor Intrinsic Activity
Full Agonist (e.g. heroin)
Partial Agonist (e.g. buprenorphine)
Full Antagonist (e.g. naloxone)
no drug
low dose
high dose

Acute Opioid Withdrawal

0	Anxiety, Drug Craving
1	Yawning, Sweating, Runny nose, Tearing eyes, Restlessness Insomnia
2	[illegible]

Clinical Opiate Withdrawal Scale (COWS):
pulse, sweating, restlessness & anxiety, pupil size, aches, runny nose & tearing, GI sx, tremor, yawning, gooseflesh

5-12 mild,
13-24 moderate
25-36 moderately severe
>36 severe

Adapted from ASAM Treatment of Opioid Use Disorder Course

Spontaneous Acute Alcohol Withdrawal

- Develops spontaneously in a physically dependent person who suddenly stops, or markedly decreases, the opioid
- Severity is usually less with longer half-life drugs
- Duration depends on half-life of opioids the person is physically dependent on
- Despite common public and medical opinion, opioid withdrawal is life threatening
- Remember that the rule is more than one drug than just opioids and there is high risk of co-occurring sedative use disorder or alcohol use disorder and withdrawal from these often non-identified substances is life threatening

	Onset	Peak	Duration
Heroin	4 - 6 hours	~3 days	4 - 7 days
Methadone	1 - 2 days	~7 days	12 - 14 days

Adapted from ASAM Treatment of Opioid Use Disorder Course

Opioid Agonist Therapy (Methadone and Buprenorphine)

Euphoria
Normal
Withdrawal
Tolerance & Physical Dependence
Opioid Agonist Therapy
Acute use
Chronic use

Adapted from ASAM Treatment of Opioid Use Disorder Course

CeDAR: Training Mission

- **Medical Students.** Rotate through most of our clinical services, typically 12 per year.
- **General Psychiatry, Internal Medicine, Family Medicine Residents.** Rotate through our residential, outpatient services, integrated and consultation-liaison services, typically 12 per year.
- **Addiction Psychiatry Fellows.** Rotate through our residential and consultation-liaison services, typically 2 per year.
- **Addiction Medicine Fellows.** Rotate through our residential, outpatient services, integrated and consultation-liaison services, typically 2 per year. This fellowship is run by CeDAR and supported through UCHealth and the Department of Family Medicine
- **Psychology Training.** A major rotation associated with an American Psychological Association Accredited Pre-Doctoral Internship. Funded through CeDAR.
- **Chaplain Residency.** One year major rotation for specialized addiction training on our residential service
- Other professionals trained at CeDAR include nurses, social workers, licensed professional counselors, and addiction counselors.

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CeDAR: Research Mission

- CeDAR supports faculty research, quality improvement, program evaluation, and scholarship.
- Integrated Assessment and Outcomes Tracking Initiative
- Primarily non-funded quality improvement initiatives or book chapters:
  - **Pade, P., Fehling, P., Collins, S., & Martin, L.** (2016). Opioid overdose prevention in a residential care setting: Naloxone education and distribution. *Substance abuse*, 1-5.
  - Richey R, Garver-Apgar C, **Martin LF**, Morris C, Morris C, Intention to Quit and Census Outcomes Following an Inpatient Addictions Facility's Tobacco Free Policy, (2017) Health Promotion Practices
  - **Pade P, Collins S and Martin LF.** (2016) Integrating Substance Use Disorder into Primary Care Settings. In Integrating Behavioral Health and Primary Care, Oxford Press.

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CeDAR: Community Outreach and Advocacy

- Speakers Bureau of subject matter experts:
  - local and national training opportunities
  - prevention efforts in schools
  - other public speaking opportunities
  - education of press
  - education of legislators on a local and national basis.
- Free use of CeDAR facilities provided to 12 Step and other mutual support groups for hosting recovery related meetings
- Involvement in Specialty Societies

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COSAM (Colorado Society of Addiction Medicine)

Colorado Chapter of the American Society of Addiction Medicine: 48 members
as a comparison there are 6,700 Colorado Medical Society members

American Society of Addiction Medicine was technically founded in 1954, and only recognized by the American Medical Association as a specialty organization in 1988

Despite the youth of this organization, current national membership is 4,300 physicians and associated members

Colorado Chapter does have full support from ASAM to partner in assisting states in efforts to support access to evidenced based treatments for individuals with substance use disorders

Why haven't we been at the table?

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CeDAR Treatment Demographics

Average Census is 45 patients (in a 78 bed treatment facility)
Average age: 37 years old
65% Male, 35 % Female
94% Caucasian, 2% Hispanic, 1% African American, 2% Other
80% have an alcohol use disorder, 40% have a tobacco use disorder, 30% have an opioid use disorder, 28% have a cannabis use disorder, 20 have a benzodiazepine use disorder, 15% have a cocaine use disorder, 15% have a stimulant use disorder and 5% have a hallucinogen disorder
In addition to their presenting "drug of choice," patients have:
2 additional non-substance use disorder diagnoses
(50% have a depressive disorder, 60% have an anxiety disorder)
1.5 additional substance use disorder diagnoses

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CeDAR Treatment Demographics: Patients with Opioid Use Disorders

- Average age is 31 years old (younger than those without an opioid use disorder, 40 yo)
- 30% male and 30% female (unlike most substance use disorders where there are more men in treatment)
- Make up 30% of our residential treatment population
- Patients with an opioid use disorder have more significant impairment in their medical problems, employment problems, legal problems, family problems and psychological problems.
- Patients with an opioid use disorder have significantly more co-occurring substance use disorders (4 versus 2) and behavioral health disorders (2.5 versus 2)
- Patients with an opioid use disorder enter treatment with lower levels of spirituality and leave treatment with lower levels of spirituality than other patients, but do change over the course of treatment at the same rate as other patients
- Patients with an opioid use disorder enter treatment with lower levels of recovery capital and leave treatment with a lower level than other patients, but do change over the course of treatment at the same rate as other patients
- Treatment admissions for our residential program have been steady over the past three years at 35 to 37%

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Challenge: CeDAR Treatment Outcomes

Statistically significant improvement following residential treatment as measured by the Addiction Severity Index (measures medical, work, alcohol, drug, legal, family and psychological problems), Recovery Capital Scores (measures substance use, psychological health, physical health, social support, meaningful acts, risk taking and recovery experience), Spirituality Scores, Depression symptoms, Anxiety Symptoms, and PTSD symptoms

Due to episodic and non-established networks of care, challenges in extracting data on outcomes from electronic records, and no support mechanisms for tracking long term outcomes our 1 year follow-up is 5% and this does not allow us to understand long term survival rates and study quality improvement activities that enhance prognosis

Clinical services so busy that time to conduct chart reviews to determine outcome effects of environmental factors such as insurance payment on treatment outcomes are difficult/impossible to perform

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Challenge: Providers and Clinic Support

- Not enough qualified physicians, mid-level practitioners, other behavioral health clinicians and case management services to treat individuals with substance use disorders
- Behavioral health treatment settings can increase anxiety and trauma responses
- Due to increased practitioner concerns about opioid prescribing, hospitalized patients with pain and substance use disorders are receiving too little pain medication and withdrawal management, which contributes to poor outcomes and early discharges
- Lack of involuntary treatment options even though judgment and insight impaired as much as other severe behavioral health conditions
- Really, really hard work that is underpaid and rarely rewarded by the patient who is most frequently avoiding you or attacking the treatment because you are between them and what their brain is telling them they will die without

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Challenge: Insurance Coverage

- Buy and Bill Practices
- Prior Authorization Practices
- Extensive and Repeated Utilization Review Processes that violate parity
- Inappropriate Medical Necessity Criteria
- Potential Conflicts of Interest with Insurance Reviewers and Insurance Reviews completed by non-experts

Cost of treatment:

Brain Failure (addiction): 25k hospitalization 30 days, 2-5k for 1 year methadone

Heart Failure: 23K, annual cost 50k

Asthma exacerbation: 6K, annual cost 3k

Kidney Failure: 89k per year for hemodialysis

Alzheimers (another form of brain failure): 12k/year

Liver Failure: 17-60k per year

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Challenge: Health System Support

Lack of support for services that generate less profit (e.g. behavioral health treatment)
Lack of support for services that don't have quality measures that the system is judged for (e.g. joint commission or CMS mandates regarding falls, pain screening, tobacco use disorder screening)
Lack of support for services that treat stigmatized populations
Electronic Health Records
Lack of National Quality Health Measures

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Challenge: Co-occurring Behavioral and Medical Health Conditions

19% of adults with behavioral health disorders use prescription opioids
51% of prescribed opioids are prescribed to individuals with behavioral health disorders

- Addiction Medicine and Medicine providers often not trained in the treatment of co-occurring behavioral health conditions or pain and have difficulty coordinating that care for patients due to limited number of providers and lack of integrated/co-located services
- Substance Use Disorder Treatment Facilities are limited in the severity of behavioral health and medical conditions they can treat and don't treat pain (physicians and nursing staff are expensive, may not be in line with their philosophy)
- Patients are more likely too seek treatment for their medical or non-substance use disorder behavioral health symptoms (eg hypertension, anxiety, insomnia) and those providers are not trained sufficiently to identify and treat substance use disorders

https://www.painnewsnetwork.org/stories/2017/7/28/indiana-doctor-killed-in-dispute-over-pain-meds

Owens et al 2017

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Challenge: Episodic (non-chronic illness) Treatment Model

Very few treatment centers (to none) provide a full continuum of services from outpatient to residential

Insurance status frequently changes for patients, and thus the treatment providers change

42cfr privacy restrictions prevent collaboration between addiction treatment providers and medical providers

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Challenge: Lack of Therapeutic and Supportive Housing Options for Patients on Medications or who don't use Tobacco

- In Colorado, most sober living facilities and many intensive outpatient programs do not allow individuals on suboxone into their treatment programs
- In Colorado, many residential treatment programs will say they support suboxone treatment but taper patients off prior to discharge
- In Colorado, some residential treatment programs will not even support the use of naltrexone, an opiate receptor antagonist
- In Colorado, many for-profit treatment centers allow tobacco use (despite this being associated with 20% lower recovery rates and 5% of non-tobacco users in treatment starting tobacco use)

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Policy Recommendations

- Avoid legislation that heavily regulates treatment of opioid use disorders (MAT treatment limits in daily dosing, specialized licensing for prescription, specialized licensing for buprenorphine treatment centers, regulations regarding type of additional treatment required- eg therapy versus housing/educational assistance)
- Promote legislation that incentivizes the treatment of opioid and other substance use disorders (enforcement of parity in insurance companies and health treatment systems, development of full continuums of care within networks, training of addiction providers above and beyond buprenorphine only, removing buy and bill requirements for medications)
- Promote legislation that supports studies to remove barriers to treatment and to measure outcomes (eg partnerships between ED's/Hospitals and addiction treatment providers, model primary clinics that have successfully integrated addiction treatment, requirement of outcomes reporting of addiction treatment centers and infrastructure support to do so)
- Promote legislation that reduces harm (illness and death) to keep people healthy enough until treatment becomes more effective (supporting long term MAT, injection sites with oversight)
- Promote legislation that better regulates the use of non-evidence based and potentially harmful practices
- Promote legislation that incentivizes tobacco free treatment
- Promote legislation that incentivizes integration of treatment of substance use disorders in psychiatric treatment centers, vice versa, and addiction treatment within primary care clinics
- Promote legislation that incentivizes training for behavioral health providers in the treatment of chronic pain

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