Medication-Assisted Treatment (MAT) for Opiate Use Disorder (OUD) and MAT Delivery using Telemedicine

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Medication-Assisted Treatment (MAT)

MAT definition from the CDC opioid guideline webpage:

> "Treatment for opiate use disorder using medications (methadone, buprenorphine, or naltrexone), sometimes in combination with counseling and behavioral therapies."*

*In my experience most physicians don't accept "sometimes" or believe that its acceptable for a MAT provider to simply recommend or refer a patient for behavioral treatment. The provider should insist on ongoing behavioral care and appropriate recovery services as a condition of MAT prescribing. Some are designating this as "integrated MAT" (iMAT).

Facing Addiction in America, The Surgeon General's Report on Alcohol, Drugs, and Health. 2016

Selected Key Findings:

"Well-supported scientific evidence shows that medications [MAT] can be effective in treating serious substance use disorders, but they are under-used…an insufficient number of existing treatment programs or practicing physicians offer these medications."

From *The Surgeon General's Report, 2016*, cont.

"The primary goals and general management methods of treatment for substance use disorders are the same as those for the treatment of other chronic illnesses…Key components of care are medications, behavioral therapies, and recovery support services."

From *The Surgeon General's Report, 2016*, cont.

"Promising scientific evidence suggests that several electronic technologies, like the adoption of electronic health records (EHRs) and the use of telehealth, could improve access, engagement, monitoring, and continuing supportive care of those with substance use disorders."

SAMHSA CBHSQ Report, 2017

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Behavioral Health Statistics and Quality (CBHSQ)

- An effective treatment for opioid use disorder includes medication-assisted treatment (MAT) which combines behavioral therapy and medications.

- **MAT has been found to reduce morbidity and mortality, decrease overdose deaths, reduce transmission of infectious disease, increase treatment retention, improve social functioning, and reduce criminal activity.[5]**

5: Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication-assisted therapies—Tackling the opioid-overdose epidemic. New England Journal of Medicine, 370(22), 2063–2066.

Follow the Evidence to Treat Opioid Addiction. Sarah Wakeman of Harvard and Gary Mendell of ShatterproofHQ.

January 22, 2018

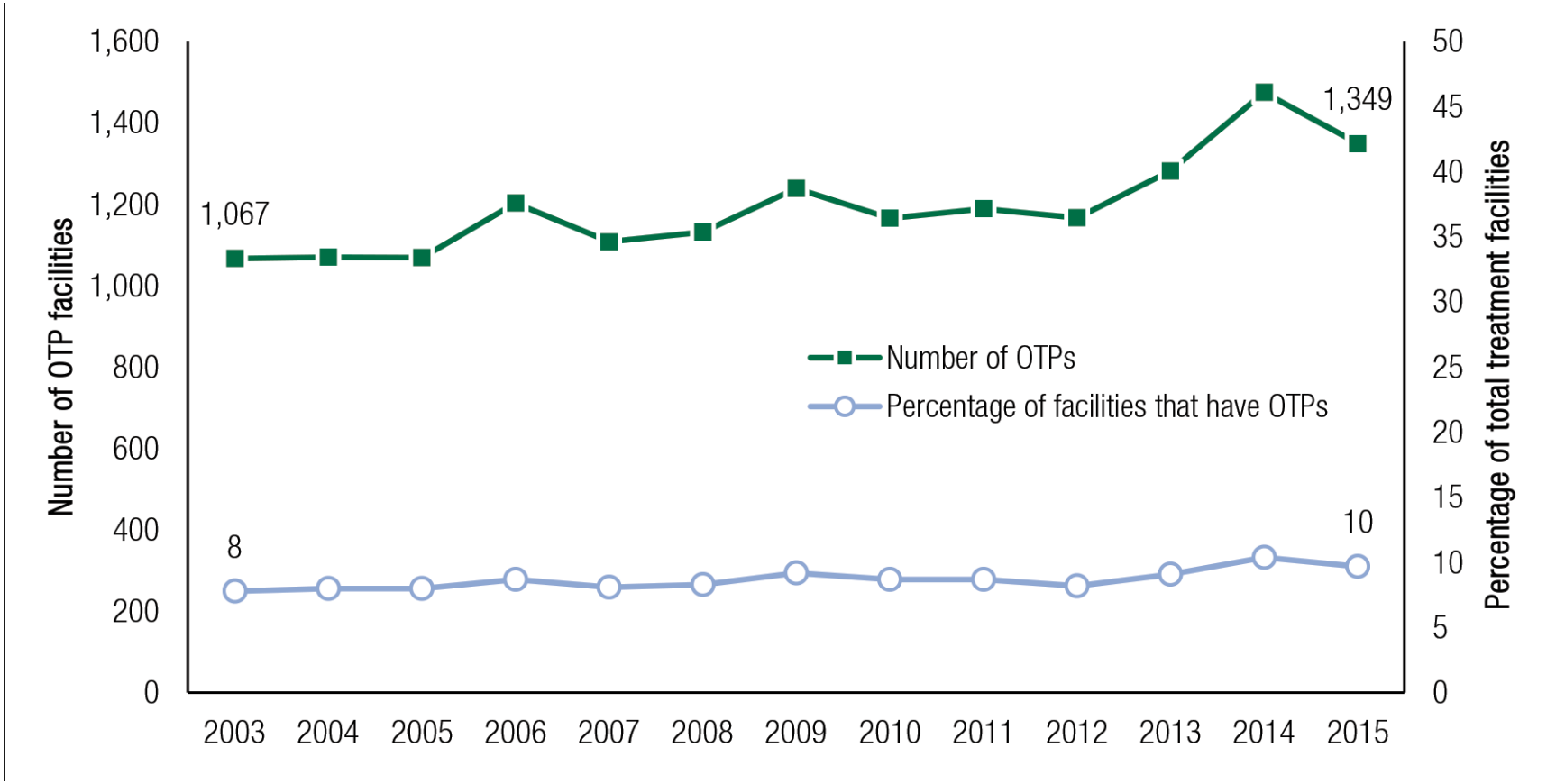
Stat News.com

"Unfortunately, for decades we've largely avoided the science of addiction and its treatment and stigmatized the use of these medications. Today, only a small fraction[10] of programs offer … medications. Far too many people we know, like Gary's son, Brian, experienced this firsthand. He attended eight different addiction treatment programs. Only one of them offered effective medication treatment and a subsequent program stopped the medication. Six months later, Brian took his life, writing in a note about his anger with the treatment industry."

10: https://www.samhsa.gov/data/sites/default/files/report_3192/ShortReport-3192.html

SAMHSA National Survey of Substance Abuse Treatment Facilities (N-SSATS), 2003 to 2015

Figure 1. Number of Opioid Treatment Programs (OTPs) and Percentage of Total Substance Abuse Treatment Facilities that Provided Them: 2003 to 2015



Medications FDA-Approved for Opioid Use Disorder Treatment (MAT)

- Methadone (FDA-approved for opioid use disorders in 1964 when provided through a certified Opioid Treatment Program).
- Buprenorphine (FDA-approved for opioid use disorders in 2002; provider must have extra training and hold an "X-waiver").
- Naltrexone (extended-release intramuscular preparation FDA-approved for opioid use disorders in 2010).

Methadone (FDA-approved for OUD in 1964)

- Pill or liquid (dispensed daily, often with 1 take-home dose per week for Sunday).
- Euphoric and hedonic; high risk for oral and IV abuse; distribution must be tightly controlled.
- Dispensed through certified Opiate Treatment Programs only; not approved for office-based prescribing for OUD.
- Four locations in MT: Kalispell, Billings, Belgrade, Missoula.

Buprenorphine (FDA-approved for OUD in 2002)

- Sublingual buprenorphine tablet (Subutex) and combination tablet or film (Suboxone) including buprenorphine/naloxone; generics available.
- Not euphoric or hedonic when taken orally by experienced users; combination with naltrexone significant barrier to IV use; approved for office-based prescribing with extra training; diversion is an issue.
- Subcutaneous (SC) implant (every 6 months up to 2 years).
- Subcutaneous (SC) injection, Sublocade (monthly), patient must be stable on oral medication for at least 7 days.

Naltrexone (extended-release Vivitrol preparation, FDA-approved for OUD in 2010)

- Oral naltrexone is not FDA-approved for OUD; monthly intramuscular injection may be more effective than oral route by producing higher sustained levels of drug; patient must not have taken an opiate for at least 10 days; office-based prescribing.

- Not euphoric or hedonic; studies show as effective as daily buprenorphine for OUD – i.e. Lancet. Vol 391, No 10118, pp309-318, 27 January 2018.

- May be effective in treating methamphetamine abuse; not approved for this indication – i.e. Neuropsycopharmacology. (2015) 40, 2347–2356; doi:10.1038/npp.2015.83.

MAT Treatment Planning

- Goal (acute withdrawal, sub-acute withdrawal, long-term treatment, relapse prevention)
- Medication choice (methadone, BUP oral, SC or implant, BUP/naloxone or XR-naltrexone)
- Starting dose (for methadone and oral BUP)
- Duration of treatment
- Tapering plan
- Anti-diversion considerations (most important for oral BUP)
- Behavioral Health considerations
- Recovery Support services

Opposition to Buprenorphine and MAT

- In a recent newspaper report an addiction counselor stated: “Trying to throw a drug at a drug to completely fix the problem is ridiculous”.

- Why is it “ridiculous”?

- Street-sourced drugs like heroin, fentanyl, methadone and other opioids are illegal and the substances are dangerous with high risk of medical complications and overdose death. MAT drugs are legal, relatively safe and allow patients to break the cycle of drug seeking, unassisted withdrawal, relapse, financial distress and crime, giving people time to engage in behavioral treatment, recovery processes and minimization or elimination of MAT drug requirements.

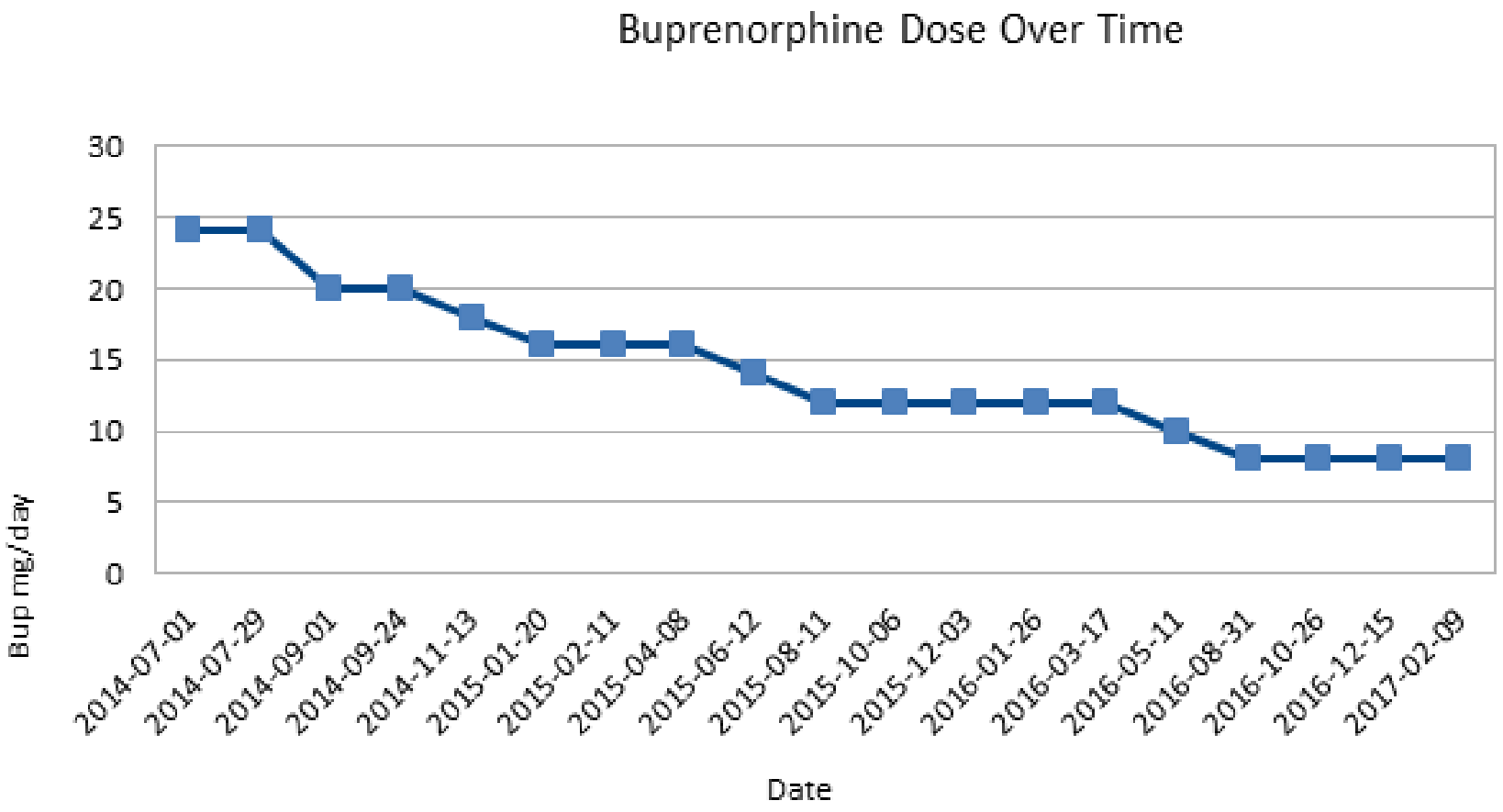
Opposition to Buprenorphine and MAT, cont.

- The same counselor stated: “Providers don’t make their patients taper [buprenorphine], the max dose is abused”.

- In the medical literature and in my experience with MAT provider colleagues this is untrue. Tapering over time to lowest effective dose, including cessation of medication, is the unchallenged consensus.

- Can one ever find an irresponsible provider who by exception proves this rule? Certainly.

Actual example of a patient's buprenorphine dose over time



Opposition to Buprenorphine and MAT, cont.

- In another quotation the counselor stated: “they don’t stop prescribing when their patients test positive for having other drugs in their system”.

- When a patient suffering from OUD is on MAT and follow-up drug testing is negative for opioids but positive for another drug, perhaps methamphetamine or cocaine, a responsible physician would not stop the successful opioid addiction treatment and just kick the patient to the curb. Treatment is continued and adjusted or intensified to address other substances. Does a physician stop treatment for hypertension if a patient develops heart failure? Of course not.

- If drug testing shows that a patient prescribed buprenorphine is not taking the medication properly but still expresses a credible desire for treatment, then buprenorphine by SC injection, implant or controlled withdrawal followed by extended-release naltrexone are all options.

Opposition to MAT

- There remains a continuing challenge to effective treatment of substance use disorders including opioids, methamphetamine and alcohol, presented by a discredited "abstinence only" treatment paradigm.

- To reiterate, for treatment of OUD:
  - **MAT has been found to reduce morbidity and mortality, decrease overdose deaths, reduce transmission of infectious disease, increase treatment retention, improve social functioning, and reduce criminal activity.**

MAT Delivery via Telehealth

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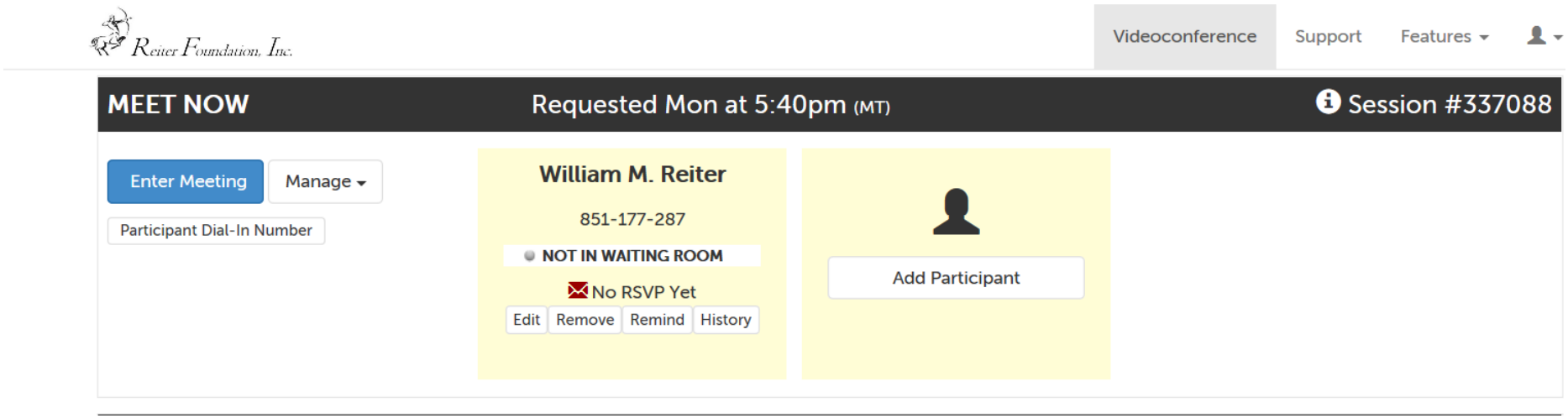
MAT Delivery via Telehealth



Current Telemedicine Program with Billings 13th Judicial District Drug Court

- Operating for approximately one year.
- Patients are referred for MAT consultation by drug court staff.
- Brief summaries of medical and legal history along with relevant records are provided by court staff at time of referral.
- Most patients have been in remission but are at high risk for relapse.
- The leading problem for most has been methamphetamine use, often with concurrent opioid and alcohol abuse.
- Consultation and monthly follow-up visits are conducted by telemedicine using a standard desk-top computer in a court office.

Current Telemedicine Program with Billings 13th Judicial District Drug Court, cont.

- Recommendations to the patient emphasize that treatment options are entirely their choice and require their informed consent.
- Most patients received a recommendation for extended-release naltrexone injections, administered monthly by a contracted nursing agency in a court office following a telemedicine visit.
- Patients receive drug testing, counseling and other recovery services through the court.
- Patients have continued follow-up once discharged from court supervision.

Telemedicine Issues and Opportunities

- Avoid unintended consequences of legislative and regulatory initiatives designed to prevent inappropriate use of telemedicine for opioid prescribing, but actually resulting in diminished access to necessary care.

- Encourage the use of telemedicine for MAT prescribing and addiction counseling when no local services are available.

Telemedicine Issues and Opportunities, cont.

- Expand MAT/telemedicine use in the criminal justice system to address the window of treatment opportunity between release and early relapse. Recent examples from our practice include:
  - Treatment arrangements made prior to release from MSP, with the patient seen second day after release;
  - Consultations performed for two patients while still in custody prior to release to Billings drug court;
  - Referrals from probation and parole are included in our priority populations for expedited initial visits;
  - We are committed to expedited initial visits for all priority populations.

Questions, comments, discussion?

Thank you!

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