An estimated 20.8 million people in our country are living with a substance use disorder. This is similar to the number of people who have diabetes, and 1.5 times the number of people who have all cancers combined. This number does not include the millions of people who are misusing substances but may not yet have a full-fledged disorder. We don't invest nearly the same amount of attention or resources in addressing substance use disorders that we do in addressing diabetes or cancer, despite the fact that a similar number of people are impacted. That has to change.
Agenda

- Evidence-based Treatment
  - The evidence for MAT (Medication Assisted Treatment)
  - The Continuum

- Important Updates
  - Sublocade
  - HR6
  - CMS
  - Criminal Justice & ASAM
DEVELOPMENT OF ADDICTION

- Biology (Genetics)
- Environment
- Exposure
**EVIDENCE-BASED TREATMENT**

**Medical (addiction treatment)**
- Comprehensive assessment & intake – SAME DAY or NEXT DAY
- Outpatient withdrawal management (and ongoing pharmacological management)
- Medical stabilization services (general condition treatment until seen by or referred to PCP)
- Care coordination and monitoring (ex: referrals to other physicians and monitoring of pdmps)

**Psychological**
- Clinical assessment (ASAM PLACEMENT CRITERIA)
- Therapy (individual, group, and family, etc.)

**Social**
- Case management
  - Can include all of the following: crisis support, family services, legal services, vocational services, transportation, housing, etc.
- Involving social support networks – AA, NA, Peer Support, etc.
• Harm reduction strategies can be implemented anywhere along this continuum
  • Help patients enter at the treatment level they are appropriate and ready for – meet the patient where they are at
  • Motivational interviewing and other efforts can be implemented at syringe access points, naloxone distribution efforts, etc.
WHO definition of diabetes type 2: Results from the body’s ineffective use of insulin. This type of diabetes comprises the majority of people with diabetes around the world, and is largely the result of excess body weight and physical inactivity with some predisposing genetic factors.

The disease of addiction is also a state of dysfunction contributed to by genetic factors (obviously not choice) as well as environmental ones such as abuse (mental or physical, again not a choice) and exposure (potentially a choice). Just like diabetes type 2, it is progressive without treatment and potentially life and limb threatening.

The approximate rate of relapse of both diseases is also very similar. 

![Graph showing comparison of relapse rates between drug addiction and other chronic illnesses.](image)
THE EVIDENCE FOR MAT

- **Surgeon Generals Report**
  - Abundant scientific data show that long-term use of maintenance medications successfully reduces substance use, risk of relapse and overdose, associated criminal behavior, and transmission of infectious disease, as well as helps patients return to a healthy, functional life.
  - Use of medications to treat addiction - controversial at times because of a longstanding misconception that methadone and buprenorphine are merely “substitute one addiction for another.”
    - This belief has reinforced scientifically unsound “abstinence-only” philosophies in many treatment centers and has severely limited the use of these medications.

- **VA Clinical Practice Guideline For the Management of Substance Use Disorders**
  - Strong recommendation for patients with OUD
    - Buprenorphine/naloxone or methadone in an opioid treatment program
  - For patients with OUD for whom opioid agonist treatment is contraindicated, unacceptable, unavailable, or discontinued and who have established abstinence for a sufficient period of time:
    - Extended-release injectable naltrexone (Vivitrol)
EVIDENCE FOR AGONISTS

Methadone – full Mu agonist


– Nine studies - High level of evidence for the positive impact of MMT on treatment retention and illicit opioid use

Buprenorphine – partial Mu agonist (Suboxone, Zubsolv, Bunavail, Buprenorphine/Naloxone)


– Sixteen studies - High level of evidence for the positive impact of BMT on treatment retention and illicit opioid use

- MAT is superior to withdrawal alone in multiple studies

Sordo, et al BMJ 2017 - Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies

- **Meta-analysis** - 19 eligible cohorts, following 122,885 people treated with methadone over 1.3-13.9 years and 15831 people treated with buprenorphine over 1.1-4.5 years.

- Retention in MMT and BMT is associated with **substantial reductions in the risk for all cause and overdose mortality**
Generally positive but sometimes mixed evidence

- **Recommended for “Highly Motivated Patients” – Revia (oral)**
  - Extended-Release (Vivitrol) tends to have better efficacy

- **Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders – NEJM 2016, Lee J. et al**
  - Time to relapse was significantly longer in the treatment group
    - 10.5 weeks versus 5.0 weeks
  - Several important secondary outcomes did not differ significantly between the groups

  - In this population it is more difficult to initiate patients to XR-NTX than BUP-NX, and this negatively affected overall relapse. However, once initiated, both medications were equally safe and effective. Future work should focus on facilitating induction to XR-NTX and on improving treatment retention for both medications.
DETOX DOESN'T WORK

- There is NO GOOD EVIDENCE for detoxification alone

**Buprenorphine vs. Placebo for Heroin Dependence**
Kakko, Lancet 2003

- 4 Subjects in Control Group Died

![Graph showing treatment duration vs. remaining in treatment](image-url)
Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients
A Randomized Clinical Trial

Rates of Treatment Continuation after discharge from Hospital

With detoxification alone and no continuation of MAT (medically assisted treatment), patients rarely ever continued their outpatient treatment plan.

Cessation of Illicit Opioid Use

Rates of cessation of Illicit Opioid use at 6 months were much better with linkage to care and continuation of MAT than with detoxification alone.

72% MAT
12% DETOX

38% MAT
9% DETOX
THE CINCINNATI PROJECT

A COHESIVE EFFORT OF MULTIPLE STAKEHOLDERS

Major Components

– Harm Reduction
  • Largest naloxone distribution effort in any county in the US – 30,000 doses in one county
  • Updating and expansion of needle exchange program by Hamilton County Public Health

Naloxone Distributed in Hamilton County*

* NDC Take-Home, First Responder, Prescriptions, Project DAWN

THE CINCINNATI PROJECT

– **Treatment on Demand**
  - In 2013, there was a 6wk-6month wait for treatment in Cincinnati - Especially biopsychosocial treatment including MAT (where insurance was accepted)
  - How to make TOD happen - Make evidence-based treatment readily accessible and affordable
    - Recruit MAT providers to a safe and supportive environment
    - 24/7 hotline with appointments readily available same day/next day
    - Flexible staffing and intake process to meet variable admission needs
    - Admission has to include biopsychosocial assessment, placement in level of care by ASAM criteria, and History & Physical by provider who can prescribe MAT same day

– **Healthcare System Integration**
  - Find committed healthcare partners in the area – who might even host a syringe exchange site
  - Define current gaps/needs – Screening/Identification, Acute Mgmt, Referral to Treatment (& Naloxone)
  - Build the continuum with partners
  - Focus on efficient use of resources – especially technology (EMR, etc.)
Southwest Ohio counties (Hamilton, Butler, Clermont, and Warren)
Important Updates

- **Sublocade – injectable monthly buprenorphine product**
  - Approved November 2017
  - Uptake slow because of regulatory and insurance barriers, but clinically promising

- **H.R. 6 - Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act will help:**
  - Advance treatment and recovery initiatives (changes in data waiver limits, telehealth, funding)
  - Improve prevention (non-opioid alternatives to pain, identify at-risk patients and families, enhance PDMP’s)
  - Protect our communities and bolster our efforts to fight deadly illicit synthetic drugs like fentanyl

- **CMS**
  - Telehealth changes
  - Codes for electronic communication with patients; as well as consulting on patients between medical professionals
  - Bundle payments for OUD treatment

- **ASAM focuses on criminal justice**
  - ACA (American Correctional Association) and ASAM Release Joint Policy Statement on Opioid Use Disorder Treatment in the Justice System – March ’18
  - Webinar jointly sponsored by the National Association of Drug Court Professionals and the American Society of Addiction Medicine – 11/9/18 & 12/12/18
QUESTIONS?