Using Telehealth to Provide Medication-Assisted Treatment for Opioid Disorders

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Mark Luckner, Executive Director, Maryland Community Health Resources Commission
Our Presenters

- Kathy Beals, LCSW-C: Substance Abuse Clinical Supervisor at the GC Health Department
- Mark Luckner, MA: Executive Director of the Maryland Community Health Resources Commission
- Eric Weintraub, MD: Director of the Division of Alcohol Abuse at the Univ. of Maryland
- Bob Stephens, MS: Garrett County Health Officer
The Identified Problem

- Garrett County and Maryland are in the midst of a nationwide heroin epidemic.
- The number of persons in treatment with a primary diagnosis of opioid addiction will increase from 12% in 2012 to 31% in 2017.
- To treat opioid addiction it is important to have access to medication assisted treatment.
- Maryland has 630 physicians on the SMAHSA registry to prescribe buprenorphine; Garrett County only has one physician who is prescribing buprenorphine.
- Persons unable to be seen by that physician have to travel up to 120 miles daily to obtain medication assisted treatment outside of Garrett County.
The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities.

Eleven Commissioners of the CHRC are appointed by the Governor.

Since 2007, CHRC has awarded 190 grants totaling $60.3 million. Ninety-nine grants (totaling more than $26 million) have supported programs in rural areas.

CHRC has supported programs in all 24 jurisdictions, which have served over 332,000 Marylanders.

$60.3 million has leveraged $20.3 million in additional federal, private/non-profit, and other resources.
Overview of the Project

Demonstrate a Tele Buprenorphine Expansion Program that will:

- Increase access to medication assisted treatment for persons with opioid addictions
- Provide a collaborative treatment approach that combines medication for the treatment of opioid disorders with supportive out-patient counseling
- Improve patient compliance for medication assisted treatment
METRICS FOR GARRETT TELEHEALTH PROJECT

• **Process metrics**
  • Number of providers newly licensed to provide buprenorphine treatment
  • Number of new patients in medication-assisted treatment through Garrett County Health Department program
  • Number of patient treatment sessions

• **Outcome metrics**
  • Number of ED visits due to opioid addiction related overdose of program participants
  • Number of hospital admissions due to opioid addiction related overdose of program participants
  • Number of deaths due to opioid addiction related overdose of residents of Garrett County
The grant with Garrett County is one of four programs participating in an assessment by the Hilltop Institute at UMBC to determine the extent to which the interventions had an impact on health care utilization and costs for participating Medicaid beneficiaries.

An interim report on basic demographic and Medicaid eligibility information for participants enrolled in the four projects is due November 30, 2017.

The final report on the four project is due June 30, 2018.
Opioid Epidemic

- 2 million Americans with substance use disorder due to prescription pain pills/2015

- 591,000 Americans with substance use disorder due to heroin/2015
They’re the most powerful painkillers ever invented.
And they’re creating the worst addiction crisis America has ever seen.

By Massimo Calabresi
- Opioid overdose deaths have quadrupled since 1999
- 33,091 died of an opioid OD in 2015
- 91 Americans die of an overdose every day
Opioid Overdose

- Drug overdose is the leading cause of death in the United States for individuals under 50

- Marked increase in middle-aged (45-54) mortality for white non-Hispanic men and women in US between 1999-2013

- Deaths from drug overdose now exceed those from firearms, motor vehicle accidents and the AIDS epidemic during its peak in the 1990’s
Causes of Rapid Rise in Opioid Overdose

- Increase in prescription opioid availability

- Significant increase in supply of heroin and decrease in cost

- Increased availability of high potency synthetic opioids such as fentanyl
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2015

- Any Opioid
- Heroin
- Natural & Semi-Synthetic Opioids
- Other Synthetic Opioids (e.g., fentanyl, tramadol)
- Methadone

Opioid Overdose Deaths 2016

✦ Prescription opioids 14,400
✦ Heroin 15,400
✦ Fentanyl and its analogues 20,100
  1. Doubled in one year
  2. Increased from 3,000 to 20,000 in 3 years which is a 540%
Impact of Epidemic

- Acute care medical costs
- Children and families of overdose victims
- Pregnant addicted women
- Significant increase in rates of Hepatitis
Opioid deaths in 2015

Age-adjusted death rates (per 100,000) for overdose deaths from all opioid drugs

Source: CDC WONDER
Prescription Opioids

- In 2012, 259 million prescriptions were written for opioids, enough for one bottle for each adult in US

- 80% of all opioids are prescribed in the US (4.6% of the world's population)
Opioid Rx Dispensed by US retail pharmacies.
2010 US Consumption

- 99% Hydrocodone Consumption
- 80% Oxycodone Consumption
- 65% Hydromorphone Consumption
After surgery, more than two-thirds of patients wind up with leftover prescription opioids, study finds

By Karen Kaplan
AUGUST 2, 2017, 8:00 AM

Surgical patients who are prescribed opioids for their pain are frequently left with unused pills, a new study finds. (John Moore / Getty
Rise In Opioid Prescribing

- 1980 NEJM Letter to Editor
- Russell Portnoy MD
- Pain is the fifth vital sign
- Use of opioids to treat non-malignant pain
- Long acting opioids non-addictive
- Big Pharma
- OxyContin
- Patient satisfaction
BUSINESS DAY

In Guilty Plea, OxyContin Maker to Pay $600 Million
Heroin

- Users of heroin have approximately doubled since 2008
- Price of heroin has decreased dramatically since the 1980’s and continues to drop (halved again between 2010-14)
- Supply has increased/seizures were up close to 150% between 2010-15
- Source has changed and now 80% of US heroin is being imported from Mexico
- Potency of heroin purer and more potent
Median bulk price of heroin per pure gram

Source: Office of National Drug Control Policy
OPIOID POTENCY

Carfentanil: 10,000x
Fentanyl: 100x
Heroin: 2x
Morphine: 1x
Maryland governor declares state of emergency for opioid crisis

At a news conference on March 1, Maryland Gov. Larry Hogan (R) said he will sign an executive order to declare the state’s opioid crisis a “state of emergency,” a legal step that will allow state agencies to better coordinate their response to the growing opioid addiction crisis. (Facebook/larryhogarimid)

By Bill Turque  March 1
Deaths from drug, alcohol overdoses skyrocket in Maryland
Maryland health officials reported Thursday that fatal overdoses
are up 66 percent from 2015 to 2016.

Meredith Cohn Contact Reporter The Baltimore Sun

Total drug and alcohol intoxication deaths for 2016
State: 2,089
Baltimore City: 694
Baltimore County: 336
Anne Arundel County: 195
Prince George's County: 129
Montgomery County: 102
Frederick County: 88
Harford County: 84
Washington County: 66
Allegany County: 59
Wicomico County: 48
Carroll County: 47
Howard County: 46
Charles County: 45
Cecil County: 30
Worcester County: 28

Source: Maryland Department of Health and Mental Hygiene
PROVISIONAL COUNTS OF DRUG OVERDOSE DEATHS, as of 8/6/2017

CDC • National Center for Health Statistics • National Vital Statistics System
<table>
<thead>
<tr>
<th>Selected Jurisdictions</th>
<th>Drug overdose deaths</th>
<th>Data quality</th>
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<td>Number of deaths for 12 month-ending</td>
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<tr>
<td></td>
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<td>Jan-16 Jan-17</td>
<td>Jan-16 Jan-17</td>
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<td>85 99</td>
<td>83% 90% % 90% 99% 99%</td>
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Figure 2. Number of Heroin-Related Deaths Occurring in Maryland from January through September of Each Year.*

*2016 counts are preliminary.
Figure 3. Number of Fentanyl-Related Deaths Occurring in Maryland from January through September of Each Year.*

*2016 counts are preliminary.
THE BALTIMORE SUN

“Opioid users filling Maryland hospital bed and emergency rooms”
Opioid Usage Impact in Maryland

- Maryland ranked #1 among all states in 2014 in rate of opioid related inpatient hospital stays

- Maryland ranked #2 among all states in opioid related Emergency Department visits

*Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project*
Medication Assisted Treatment

- Combination of medications with counseling and behavioral therapies to treat substance use disorders
Medication Assisted Treatment

**FDA Approved**

- Methadone (Methadose; Dolophine)
- Buprenorphine (Suboxone; Suboxone Film; Subutex; Bunavail; Zubsolv)
- Naltrexone (Trexan; Vivitrol)
Medication Assisted Treatment

- Recommended as treatment for opioid use disorders by the following:

  United States Federal Government
  American Society of Addiction Medicine (ASAM)
  World Health Organization
  United Nations
Barriers to Medication Assisted Treatment

- **Stigma**
  - addicted to another drug
  - covering up the addiction
  - personal bias based on experience
  - adherence to abstinence based treatment
  - negative attitudes towards individuals with addiction disorders.
Medication Assisted Treatment

- Decreases rate of overdoses
- Increases retention in treatment
- Decreases illicit opioid use
- Improves social functioning
- Decreases transmission of infectious diseases
- Decreases criminal activity
Rural America

- Disproportionally impacted
- Higher rates of opioid prescribing
- Demographic, economic and environmental factors
- Higher overdose rates
- Higher rates of neonates in withdrawal
- Physical jobs with more injuries
- Larger social networks
Barriers to Medication Assisted Treatment in Rural Areas

- Lack of methadone programs/less than 5% in rural areas
- Methadone programs are highly regulated and require frequent attendance
- Geography/transportation/weather
- Lack of buprenorphine waived physicians/less than 2% in rural areas
Using Tele-Health for MAT
The Mechanics

- Intake Process
- Rules and Guidelines
- Treatment Agreement
- Paperwork
- Personnel
GCHD-SRD MAT Program Guidelines

1. Intake assessment with a therapist to establish an opiate related disease diagnosis, moderate or severe.
2. A urinalysis will be done at intake. If client is positive for other illicit drugs, a contract will be made to begin weaning off those substances.
3. Client must attend IOP or designated plan without any absences for a minimum of one week.
4. Client will sign a treatment contract.
5. Client will be seen by the nurse, prior to acceptance in the program, for a medical assessment.
6. Client will meet with the physician, prior to acceptance in the program, for a medical assessment.
7. Client, nurse, and physician to start induction.
8. After induction and stabilization, the nurse will meet with the client one time per week, or at the discretion of the treatment team.
9. The therapist will meet with the client to discuss any changes in the level of care recommended.

Criteria for entering the program:

- Client must attend IOP or designated plan, as designed by the Clinical Supervisor, without any absences for a minimum of one week prior to admission to the MAT Program.
- Opioid use disorder diagnosis, moderate to severe.
- Client UA for other medications or illicit drugs other than opiates need to be assessed.

Induction Phase:

- Doctor will write a prescription.
- Client will get the prescription filled at the Walgreens pharmacy and return to the Health Department Behavioral Health SRD.
- The induction phase will be 2 days where the client comes in to meet with the nurse to receive their dose and be monitored by the nurse and trained therapist for 2-4 hours each day to determining the milligrams needed for each patient.
- Urinalysis

Client will remain in one of the group rooms during the induction phase and be monitored by the nurse.

Client will bring a lock box for their medication.

After Induction Phase:

- Client will see the doctor one time per week, or less, at the discretion of the doctor.
- Client will remain in IOP, or designated plan, until the treatment team feels they are ready to step down.
- The treatment team will determine the number of times the client will continue to attend per week.
- Continued weekly random urinalysis.
- Random pill count. If the client does not present on the day they are called for a pill count, they do not get their medication refill.

Criteria for staying in the program:

- Follow all the guidelines of the program stated in the treatment agreement signed by the client at admission into the program.
- Follow all treatment recommendations of the treatment team like referral to a higher level of care like:
  1. Return to IOP
  2. Inpatient treatment
  3. Outside support group attendance.

Criteria for discharge from the program:

- Refusing to follow through with treatment recommendations.
- Continued positive UA results for illicit drugs.
- Missing counseling or doctor's appointments.

Client Signature: __________________________ Date: _____

Therapist Signature: _________________________ Date: _____
Medication Assisted Treatment Program Agreement

As a part of participating in the buprenorphine protocol for treatment of opioid addiction, moderate to severe, I freely and voluntarily agree to accept this treatment agreement/contract as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor, nurse, and counselor.
2. I agree to conduct myself in a courteous manner.
3. I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor, nurse, or therapist will not see me, and I will not be given any medication until my next scheduled appointment.
4. I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling is a serious violation of this agreement and would result in my treatment being terminated without recourse appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activity in/on the Garrett County Health Department property.
6. I agree that my medication (or prescription) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get my medication until the next scheduled appointment.
7. I agree that the medication/or prescription I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reason for such a loss.
8. I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treatment team. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs of abuse can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.
9. I agree to take my medication as the doctor has instructed and not alter the way I take my medication without first consulting the doctor.
10. I understand the medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.
11. I agree to submit to supervised urinalysis and breathalyzer testing upon request with no exceptions. I understand that failure to submit requests for testing will result in an automatic positive status. I understand that positive results from testing may result in modification of my treatment.

Client name: ___________________________ Date: ______________
Witness: _______________________________ Date: ______________

Approved: 11/6/16
P/Forms/MAT/Treatment Agreement

Medication Assisted Treatment

Patient Rights Statement

The medication treatment service you have enrolled in supports and protects the fundamental human, civil, constitutional and statutory rights of each patient. You have the right to:

1. Impartial access to treatment regardless of race, religion, sex, ethnicity, age, or handicap.
2. Be treated in a fashion that recognizes your personal dignity in all aspects of care.
3. Have your confidentiality protected in accord with federal and state statutes and regulations.
4. Request the opinion of a consultant or request staff to review your treatment plan.
5. Not to be subjected to experimental or unusual procedures without your expressed informed consent.
6. Know the risks, side effects and benefits of all medication and treatment procedures. If these are not explained to your satisfaction, please ask the physician, nurse or counselor at your treatment location for additional information.
7. Be informed of other procedures available in addition to those you are currently receiving.
8. Refuse specific medication and treatment procedures, to the extent permitted by law.
9. Know that if you refuse medication or treatment, the clinic may terminate its relationship with you upon reasonable notice.
10. Know the cost of your care and the source and limitations of your funding (contact your primary counselor who can refer you to the Fiscal Department).
11. Know the reason for any proposed change in professional staff responsible for your care or for transfer either within or outside the facility.
12. Initiate a complaint or grievance procedure and obtain a hearing or review of the complaint.
13. Participate in the formulation of your treatment plan.
14. Participate in the formulation of your discharge and aftercare plans.

Patient signature: ___________________________ Date: ______________
Treatment Contract

By signing below, I agree to the following:

1. Buprenorphine treatment for opiate dependence is most effective when combined with drug abuse counseling 12-step recovery work, and/or a recovery support group. During my treatment with buprenorphine, I agree to attend counseling and to work on a program of recovery.

2. I understand that buprenorphine itself is an opiate (or “narcotic”) and can produce “physical dependence,” meaning that stopping it suddenly is likely to cause physical withdrawal symptoms similar to stopping heroin or opiate pain medication (but generally less severe).

3. I understand that on the day I start buprenorphine, I should go to the doctor’s office and begin on opiate withdrawal. I will not use any opiate (heroin, methadone, codeine, or other opiate-containing medications) after 6:00 p.m. before I begin induction. If I do not have any observable signs of opiate withdrawal, induction onto buprenorphine may be delayed a day or more.

4. I understand that taking doses and frequency of visits will be determined by how well I am doing.

5. I agree to take buprenorphine as prescribed at the dosage determined by my physician, and to allow another physician to take responsibility for the medication if I need a change in dosage.

6. I understand that I must have a means of storing, using, and disposing of prescribed buprenorphine safely, where it cannot be seen or taken by children, pets, or any unauthorized users.

7. I agree that if my buprenorphine pills or film are swallowed by anyone besides me, I will call 911 or Poison Control.

8. I understand that on buprenorphine or otherwise in treatment for addiction, I agree not to use any alcohol, any benzodiazepine medicine, sedatives, any illegal substances, or any opiates medication without prior permission from my doctor (the doctor who prescribes my buprenorphine). If I have been taking regular long-term doses of benzodiazepines and am showing signs of addiction, a plan will be developed to slowly decrease these medicines with the goal of eventually discontinuing them, in a way that avoids any significant benzodiazepine withdrawal symptoms. If any opiate medicines may be needed, I agree to discuss this with my substance abuse doctor in advance, before accepting or filling any prescription.

9. I agree to take each dose of buprenorphine within 24 hours of the previous dose in any emergency.

10. I understand that if I continue to consistently use opioids despite buprenorphine treatment, it will be taken as an indication that buprenorphine treatment has not been successful, and I will be tapered off buprenorphine and transferred to another form of treatment.

Garrett County, a healthier place to live, work, and play!
garretthealth.org

Approved 11/17/14
P: Form/MAT Treatment Agreement

Garrett County, a healthier place to live, work, and play!
garretthealth.org

Signature of patient: ____________________________ Date: ________________

Signature of provider obtaining consent: ____________________________ Date: ________________
Induction

- What treatment staff do the first day
- What Eric does
- Follow up
- Stabilization
Successes

- Data from across the State and for GC
  - Number of patients
  - Number who are now working
  - Number who are in therapy ≤ weekly
Challenges

- Diversion
- Stigma
- Political environment
- Staffing
Opportunities for replication
Questions

Thank You