Addressing the Opioid Overdose Epidemic

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NatCon17
Seattle, Washington
April 2017
Outline:

• Scope of the opioid overdose epidemic in the USA
• Historical and current barriers to EBPs
• Opportunities under healthcare reform
Scale of Overdose Deaths, United States

- ~52,000 drug overdose deaths in 2015 (CDC)
- Surpassed MVA fatalities ~ year 2013
- Now rivals HIV/AIDS deaths in early 1990s peak

2014: 28,647 total opioid-related
  - ~13,500 illicits/heroin/synthetics
  - ~16,941 prescription opioids (POs)

2015: 33,091 total opioid-related
  - ~ 19,885 illicits/heroin/synthetics
  - ~ 17,536 prescription opioids (POs)
Scale of Overdose Deaths, United States

• 73% increase in deaths involving illicit synthetics

• Only 5-10% of all “ODs” are fatal

• More dangerous if long-acting, combine benzodiazepines, alcohol, etc.
Prescription Painkiller Sales and Deaths

- Sales (kg per 10,000)\(^a\)
- Deaths (per 100,000)\(^b\)

Year


Rate

Sources:
\(^a\) Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2012 data not available.
National Overdose Deaths
Number of Deaths from Prescription Drugs

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths from Heroin

Source: National Center for Health Statistics, CDC Wonder
Opioid Overdose Deaths (USA) 2000-2014
2.4 million individuals with OUD

- 4.3 M individuals with past-year non-medical opioid use
  - 1.9M with prescription opioid use disorder
- 1 M past-year heroin users
  - 586,000 heroin use disorder (relatively stable x 20 years)

NSDUH 2014 data
Heroin use/disorder relatively stable x 20 years
Plateau of PO initiates/users; overdoses keep rising
Reflects:
  - Lack of access to care
  - Lack of EBPs with MAT, especially for those hardest to reach
  - Increased use of synthetic adulterants
MAT pharmacotherapies

- Methadone maintenance programs (MMTPs or OTPs)
- Buprenorphine (OBOT, in some OTPs)
- XR-Naltrexone (monthly injections)
Use of MAT for OUD, 2013
(SAMHSA accredited facilities)

>83% on a given day

Methadone
330,000

Buprenorphine
48,000

XR-Naltrexone
3,800

Not receiving MAT
2,000,000
Use of MAT for OUD, 2013 (SAMHSA accredited facilities)

- Methadone: 330,000
- Buprenorphine: 48,000
- XR-Naltrexone: 3,800
- Not receiving MAT: 2,000,000

66%? on a given day?

+400,000 OBOT?
Most go without treatment

- Only ~ 40% OUD patients receive treatment in a year
- Treatment often is not quality care
  - Many patients detoxed to medication-free programs
  - Under-dosing common with methadone and bup
  - Stein et al (2016) found only 53 days for average OBOT episode
  - Majority patients drop out within 3-6 months
Reasons given for not receiving treatment (NSDUH)

- Did Not Feel They Needed Treatment: 95.0%
- Felt They Needed Treatment and Did Not Make an Effort: 3.3%
- Felt They Needed Treatment and Did Make an Effort: 1.7%

20.5 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

SAMHSA, 2013 NSDUH
National Overdose Deaths
Number of Deaths from Prescription Drugs

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths from Heroin

Total | Female | Male

Source: National Center for Health Statistics, CDC Wonder
Death rates for HIV disease for all ages

NOTE: HAART is highly active antiretroviral therapy.
SOURCE: CDC/NCHS, Health, United States, 2013, Figure 24. Data from the National Vital Statistics System.
# Barriers to MAT

<table>
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<tr>
<th>Barriers</th>
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<th>Buprenorphine</th>
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<tbody>
<tr>
<td>Medicaid coverage limitations</td>
<td>17 states do not cover under FFS</td>
<td>• Lifetime limits (1-3 years)</td>
<td>&gt;10 states cover as a medical benefit: requires buy and bill</td>
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<td>• Only Medicaid providers can Rx</td>
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<td>Medicaid Prior Authorization (PA) restrictions</td>
<td>• Duration limits</td>
<td>48 states require PAs, restricting access (i.e. documentation of counseling)</td>
<td>“Step therapy” requires prior treatment failures</td>
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<td>• Copayments beyond 3-6 months of treatment</td>
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<td>Commercial insurance coverage</td>
<td>No known coverage in the 10 largest states</td>
<td>• Often “step therapy”</td>
<td>• Not “medically necessary” once patient is stable</td>
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<td>• PAs</td>
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<td>• Limit use to detoxification</td>
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# Barriers to MAT

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| **Provider capacity**          | Only allowed in OTPs, not in private offices or pharmacies | • <3% waived so >40% counties without a waived physician  
• Half of waived physicians do not prescribe | Not part of training in med school or GME |
| **Accessibility and finding a provider** | • Rural patients spend >$50/week just on travel to attend  
• Long wait lists | 30% of states have <50% physicians listed on national bup treatment locator, rural areas hard pressed | Providers are exceptionally hard to find |
In 2014 (pre-ACA) 45% paid by state/local (i.e. county or municipal) discretionary sources

SAPT 14%
FIGURE 1. Regression-adjusted use of opioid agonist therapy (OAT) among Medicaid enrollees receiving opioid treatment, by setting a

- Methadone maintenance covered by Medicaid
- Methadone maintenance covered by SAPT block grant
- No public methadone maintenance coverage

Received OAT (%)

- All settings
- Residential
- Intensive outpatient
- Nonintensive outpatient
Addiction Specialist Workforce

- Addiction Psychiatry (ABPN)
  - ~2,200 physicians board certified since inception in 1991
  - ~750 actively maintain certification
  - >80-90+% do not participate with Medicaid

- Addiction Medicine (ABAM)
  - > 2,584 certified through 2012
  - ~1,200 estimated to be actively practicing
  - Only 100 specialists who prescribe bup accept Medicare
Healthcare Reform

• Mental Health Affordability and Parity Equity Act of 2008
  • If insurance covers MH/SUD, must par with general conditions
  • Helps to expand benefits for 30-60M individuals

• Affordable Care Act of 2010
  • ~20 million insured as of 2016
  • Medicaid redesign allows state experimentation
  • Creates ACOs, Health Homes
  • “Essential Health Benefits” include SUD treatment
    • Medicaid FFS plans are exempted
    • CMS yet to mandate MAT maintenance as an EHB

• The Comprehensive Addiction and Recovery Act of 2016
  • Attempts to increase access to substance abuse services
Figure 2. Year-over-year national average charges per patient for private insurance claims for all patients and for patients with opioid abuse or dependence diagnoses during the time period 2013-2015.
Two models for expanding care

• Specialty care
  • Requires specialized providers
  • Linkage and expansion of specialty treatment
  • Hub and Spoke model (i.e. Vermont)
  • Nurse care manager model (i.e. Massachusetts)

• Integration in primary care settings
  • Integrated and collaborative care models
  • Encourage use of MAT in primary care settings
  • Utilize SBIRT to identify prodromal patients sooner
Hub and Spoke Model (Vermont)

- Methadone started late but MAT was rapidly expanded
  - Opened 1st OTP (methadone) in 2002
  - Adopted OBOT (buprenorphine) in 2003 and quickly expanded to become #1 in US for waived MD’s and doses prescribed per capita
  - With high demand and low availability for OTP, OBOT surpassed in # of patients served, currently 30/70 split
- A state-wide attempt to integrate treatment system: Hub and Spoke model

All OTPs (5) became Hubs and most OBOTs (150+) Spokes
Hubs

• Specialty center responsible for coordinating complex cases
  - Comprehensive evaluation
  - Treatment Needs Questionnaire: a screening tool used at all intakes to guide hub/spoke placement
  - Specialty consultations (MH, polysubst, medical)
  - Care coordination
  - Health home services (higher rate)
  - Provides methadone
  - Inducts/stabilizes onto buprenorphine (XR-naltrexone)
  - Reevaluates and re-stabilizes treatment non-responders in spokes
Spokes

- Ongoing care system including physician and collaborating addiction professionals
  - Include: medical homes, FHQC, SA treatment programs, PCPs, independent physicians
  - Provides buprenorphine and naltrexone
  - Provides counselling, recovery supports, and case management
Hub and Spoke model

Promotes coordination and integration (warm handoff), including consultation with the hubs and transfer of care back to the hub as needed.
Outcomes

- Improved access to care
- Improves quality of care
- Cost effectiveness
- Improved treatment safety (decrease in buprenorphine diversion)
Access expanded

Physician Recruitment

- 30 patient
- 100 patient

2003-2012
2013-2016
Access expanded

Number of People Served in Opioid Treatment Hubs and the Number of People Waiting Over Time

Number of MAT patients

2012 OTP 2012 OBOT 2016 HUB 2016 Spoke Medicaid 2016 spoke Total

#NATCON17  #BH365
Medicare, 2013

Figure 2. Ratio of Buprenorphine-Naloxone Claims vs All Drug Claims by State

Claims ratio (per 1000)

#NATCON17 #BH365
Does it make a difference?

Vermont drug overdose deaths per 100,000 people decreased between 2013 and 2014

Percent change in deaths per 100,000 people 2013 to 2014

Source: CDC/NCHS, National Vital Statistics System, mortality data
How was this possible?

• The main barrier to OBOT expansion?
  – Providers do not have time/staff to provide and coordinate care

• ACA provides funding for 2 clinical FTE per 100 patients to provide Health Home Services
  – MAT Team (behavioral health provider and nurse)

• Since implementation there was an increase in the number of waived providers accepting transfers from Hubs
Ongoing support for providers is essential

- **Learning Collaborative** for Hubs and Spokes
  - Practice improvement model
  - Didactics, trainings (in-person, webinars), mentoring
  - Practices present “how to” models
  - Shared clinical tools, referral processes
- Ongoing monitoring of outcomes (e.g. waitlist #s, retention, drug use, diversion)
Challenges Remain

• Demand for treatment exceeds available slots
• Difficulty in changing the culture of “treatment”
  – Requires a significant investment (implementation and clinical support)
  – Need for new workflow protocols (clinical, administrative, billing)
• Workforce limitation (MAT and MH therapists, nurses)
• Physicians as MAT champions and leaders
Summary

- Heroin overdose (esp. males) driving recent mortality
- Such individuals often marginalized, not in primary care
- Few patients receive evidence based treatment on MAT
- Healthcare reform offers states opportunities to reduce barriers, especially through Medicaid redesign
- Lessons learned in other areas of healthcare (i.e. integrating care for depression) may not be as relevant as substance abuse payer mix and patient population differs
Opportunities for Action:
How to expand MAT access near you?

• Reach out and partner with other local providers, agencies
• Teaching and supervision
  • PCSS-MAT, training programs, include allied health professions
• Write to your local newspaper
• Contact state legislature, governor’s office
  • Submit testimony, offer to review strategy
• Attend, submit to professional meetings as treatment advocate
• Anticipatory guidance for patients, families, other providers
• Leverage naloxone advocacy efforts to encompass MAT
Thank You

- Columbia Department of Psychiatry
  - Adam Bisaga MD
  - Edward V. Nunes MD
  - Frances R. Levin MD
  - Mark Olfson MD MPH

- American Academy of Addiction Psychiatry
  - Kathryn L. Cates-Wessel
References


