Office based agonist treatment at AMRS KP

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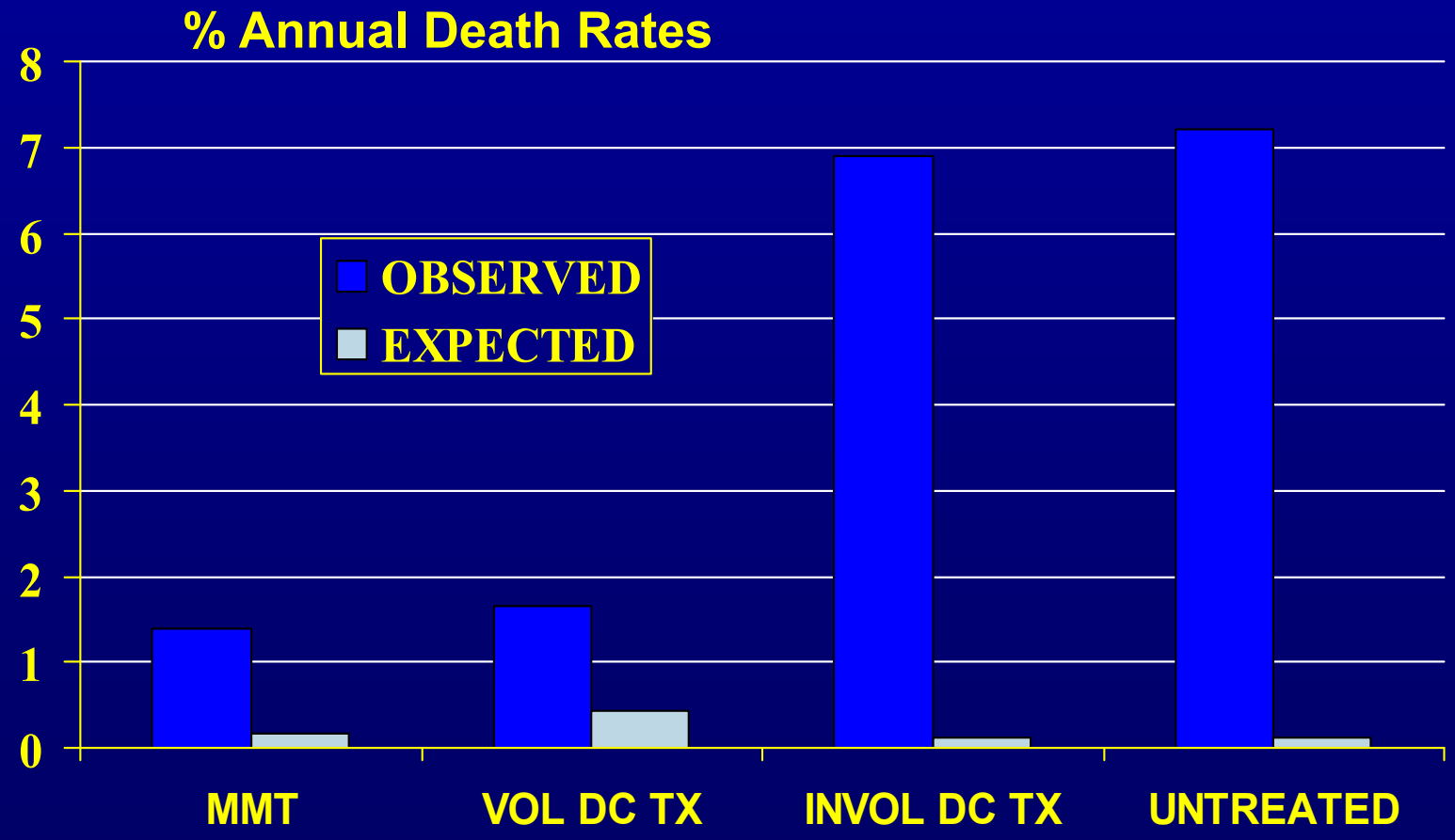
What I will review

- Scope of the problem
- Treatment with buprenorphine
- Treatment at AMRS (fka CDRP)

Opioid Withdrawal

- Patients' worst nightmare – a major barrier to treatment.
- "it doesn't kill, you, just makes you wish you were dead…"
- Objective, subjective and protracted withdrawal.

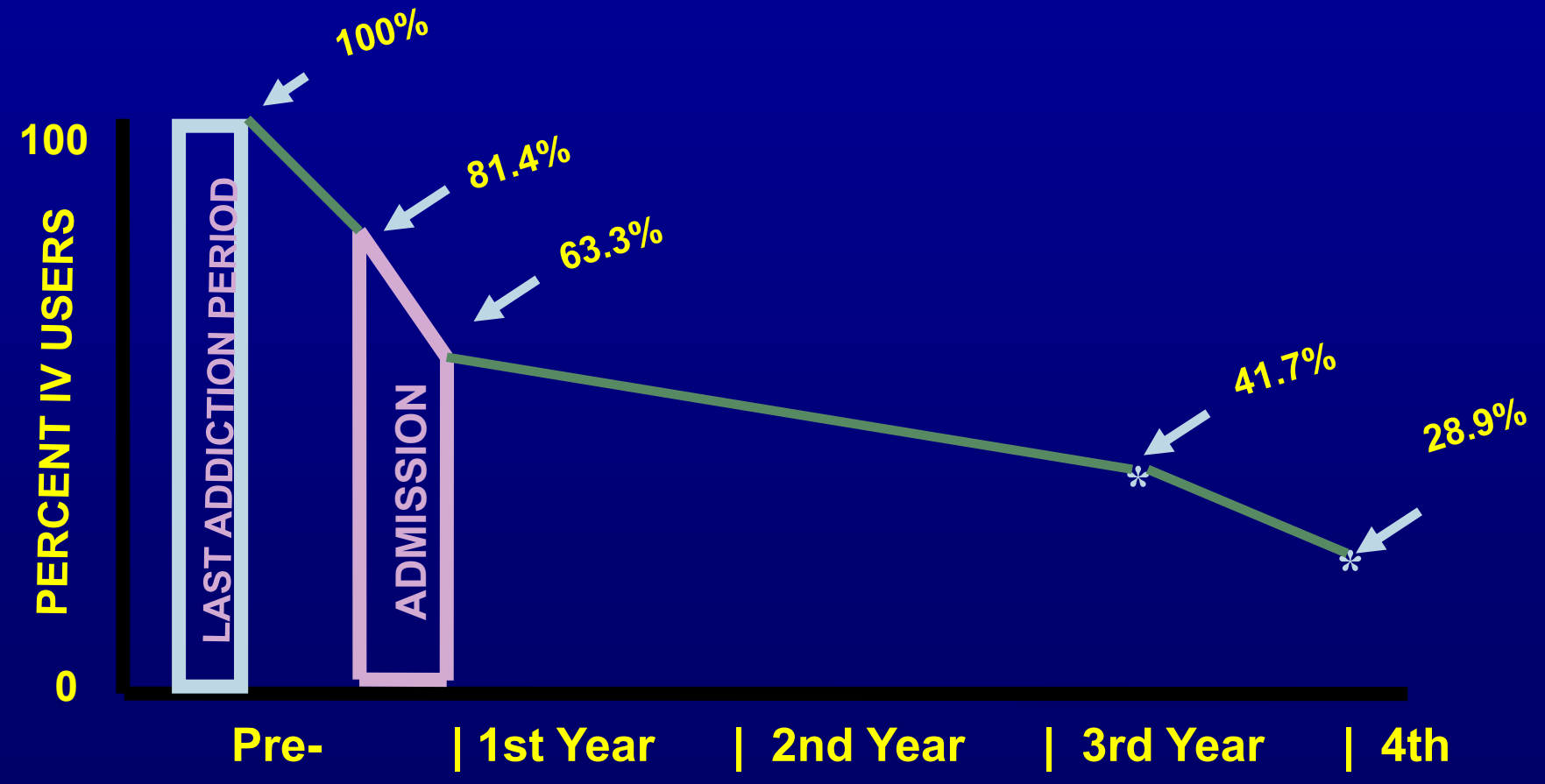
Death Rates in Treated and Untreated Addicts



Slide data courtesy of Frank Vocci, MD, NIDA –
Reference: Grondblah, L. et al. Acta Pschiatr Scand, P. 223-227, 1990

Impact of MMT on IV Drug Use

388 Male MMT Patients in 6 Programs

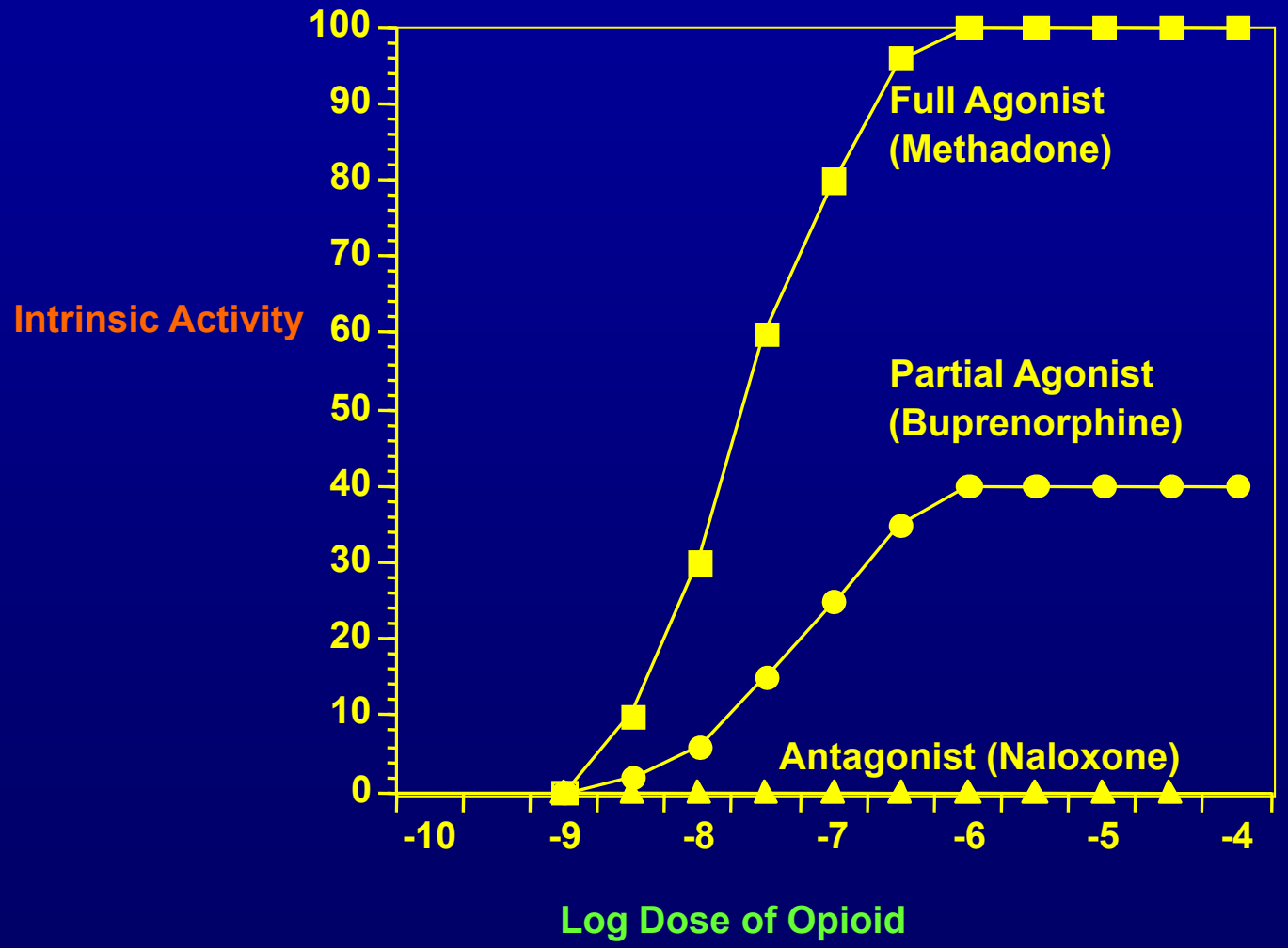


Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991

Opioid Dependence treatment Options

- Social model
- MAT clinics
  - Short-term detox: <30 days
  - Long term detox: 30-90 days
  - Methadone maintenance (“MM”)
- Buprenorphine agonist maintenance
- Antagonist maintenance (naltrexone)
- Gradual taper (prescription opioids)

Intrinsic Activity: Full Agonist (Methadone), Partial Agonist (Buprenorphine), Antagonist (Naloxone)



OBOT at TPMG

- Addiction medicine programs
  - AMRS level 3 (fka CDRP)
  - AMRS level 1 (fka CDS)
- OBOT
  - Started in 2006 in CDRP (Vallejo)
  - More widely adopted in last 10 y, now available in all AMRS programs
  - Since 2017 prescribers include midlevel providers (NP, PA)

OBOT at TPMG

- Acceptance in ADM programs gradual
  - Lectures at most sites by leaders (regional local)
  - Regional consultation
  - Once started, acceptance improves, early patients become ambassadors
  - Buprenorphine guidelines 2012

Guideline Considerations

- Avoid creating too tight program
  - Reduces access and flexibility
  - Requires a lot of staff / time to enforce rules
  - Tight rules in MMT are barrier for OAT patients
- Avoid too little structure
  - Harder to manage complex patients
  - Risk of diversion
  - Psychosocial treatment effective in ADM
  - Easier to start with rules than add later

OBOT at KP NSA

- Medical team
  - 4 MDs, 1 NP, 1 PA, 1 PharmD
  - 2 RN, 2 MA
- Therapy team
- Full spectrum of tertiary outpatient care center
- OBOT groups at each site
- Easy access to other specialties

Current treatment at AMRS

- Self referral or e-consult
- Intake by RN or therapist
- Patients will work with therapist and MD/NP/PA
- Treatment plan options
  - Abstinence based
    - Day treatment -> IRP -> CR -> maintenance
    - IRP (or modified IRP) -> (CR ->) maintenance
  - Non abstinence based
    - BEAP
    - Individual treatment plan

Vallejo

- Ca 160 patients – varies
- OBOT decided by medical provider
- Patients new to OBOT
  - Ideally started in daily visits in groups/provider
  - Usually on site induction
  - Start with week refill and pill count
  - Increase of refill size based on compliance
- Patients returning to OBOT
  - Consider home induction
  - Case by case treatment plan

Vallejo

- Special consideration patients
  - Pain patients – coordination with pain clinic, medical team visits predominant
  - Acute dual diagnosis patients – coordinate with psychiatry as needed
  - MMT transfer – rare, start CDRP and then plan before initiating buprenorphine
  - Start with extended evaluation
  - Goal is to engage and mainstream patient

Vallejo

- Maintenance of stable patients
  - stable and C&S for > 6 m or more
  - Monthly buprenorphine prescriptions
  - See MD 2-3 times per year
  - See therapist 3-4 times per year
  - 1 group per month
  - 3-4 UA per year
  - Consider transfer to psychiatrist or PMD (future)

Vallejo

- BEAP
  - Intended to reduce cannabis use as barrier to OBOT
  - Separate track and groups
  - Start with induction as usual and several visits in first week
  - Weekly groups and refills for 2-3 months, then increase to qow, then to monthly

Pearls

- Medication management vs comprehensive psychosocial treatment requirements
  - None proven superior in OBOT studies
  - MAT studies have shown benefit of weekly counseling
  - Groups foster peer support, reduce isolation
  - ”mainstreaming” fosters acceptance of OBOT

Pearls

- Medication management vs comprehensive psychosocial treatment requirements
  - What are the goals of treatment?
    - Abstinence from illicit opioids?
    - Improvement of legal/vocational/relationship/medical status?
    - OUD remission?

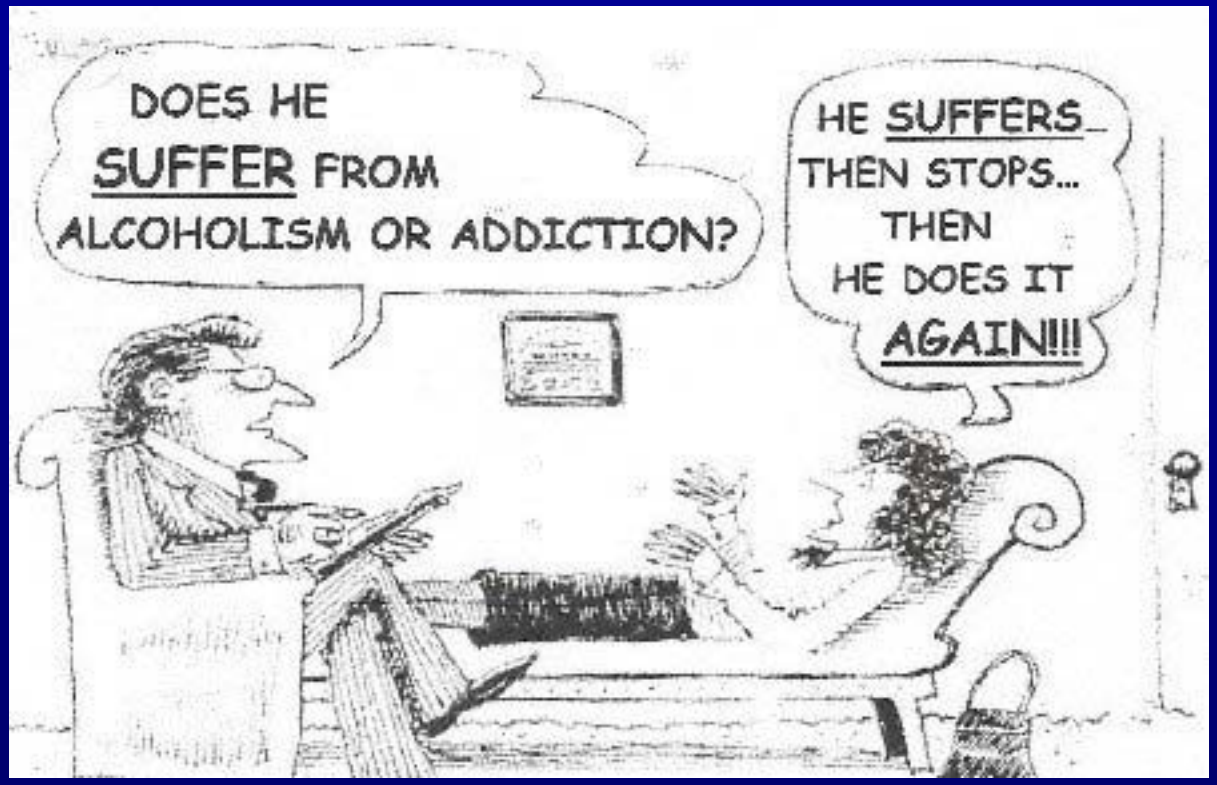
Pearls

- Factors to consider for planning psychosocial treatment
  - Phase of recovery
  - Recovery experience /OBOT experience
  - High risk behaviors
  - Concurrent use of other drugs/alcohol
  - Co-occurring disorders

Pearls

- Ongoing management
  - Stabilization dose is often higher than maintenance dose
  - “Tit for Tat” contingency management
  - OUD is chronic relapsing disease
    - Long term monitoring - Trust and verify
    - Engagement reduces severity of OUD sx relapse and allows for treatment of concurrent disorders

"Could we up the dosage? I still have feelings."


DOES HE SUFFER FROM ALCOHOLISM OR ADDICTION?
HE SUFFERS- THEN STOPS... THEN HE DOES IT AGAIN!!!

Just for today

One day at a time

Work your own program, just do it the way I tell you.

Easy does it

Take my advice, I am not using it.

Call your sponsor

Work the steps