TREATMENT OF OPIOID DEPENDENCE:
OUR PROVEN PROGRAM
High Quality, Cost Effective Solutions

Presented by:

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Opioid Addiction is a Chronic Brain Disease

We learned these Triple Aim drivers from treating COPD, CHF, IDDM

- Thorough biospsychosocial assessments and treatment
- Active treatment planning
  - Structured best practices
  - Individualized, patient centered care
- Care coordination
- Measured outcomes (quality, cost experience of care)

→ CleanSlate Centers Program
What actually works?
What are the costs? (OAT = Opioid Agonist Treatment)
CleanSlate Program Outline

**Best-Practice visit frequency and contingency management**

- In-office buprenorphine inductions
- Patients seen weekly advancing to bi-weekly and then monthly,
  - Up to 2x per week maximum frequency
- When patients are struggling with their disease, they move from bi-weekly to weekly, etc

**Utilization of EMR**

- Allows for robust monitoring of contingency management
  - (Patients risk stratified into categories: red, orange, yellow, green)
- All office and all clinicians have access
- Allows for monitoring of "outcomes that matter"
- Rigorous study platform for ongoing research
CleanSlate Program Outline

**Diversion Control Protocols**

- UDS including nor-bup (metabolite confirmation)
- Random call-backs and pill/strip counts
- Monitor med lot numbers
- Med Safe and Digital Observed Med. Admin model pilot in process
- PDMP and Sure-Scripts monitoring (real time data)

**Coordination of care**

- OB-GYN, psychiatry and counsellors, PCP, pain management, hepatology, dental/surgical providers, anesthesia consultations
- Full collaboration with Health Plan case managers
- Social services (enrollment with health plans, transportation, housing, education, etc.)
1. Intensify Patient frequency of Visits when they are struggling with their disease
2. Advance/Increase frequency of Behavioral Health supports
3. Increase frequency of UDT to provide feedback
4. Motivational Interviewing
5. New program for Reward system being Instituted
6. Mobile Applications for MI/CBT and Rewards (Pear Therapeutics)
1. Intensify Patient Care – Outpatient First
2. Review UDT results at every visit, positive reinforcement NOT negative feedback
3. NEVER 3 strikes and you’re out
4. Treat this like a Chronic Disease
5. Ex. Diabetes Management
6. Adjust treatment, add additional supports, Intensify to Inpatient and Residential when needed
7. Patient returns to longitudinal care when stabilized
| 1.   | Stable Housing |
| 2.   | Re-establishment of familial relationships, sober partners |
| 3.   | Parenting (patient may have previously lost custody – DCF) |
| 4.   | Employment |
| 5.   | Engagement in Educational Activities |
| 6.   | Resolution of Correctional issues |
| 7.   | Financial Stability |
| 8.   | Other Medical Illnesses stable/treated |
| 9.   | Other Mental Health Illnesses stable/treated |
| 10.  | Counseling, Participating in Peer Support |
Hepatitis Data:

1. Annual Rate of patient using IV Drugs for Acquiring Hepatitis C in first year = 25%
2. Presumption is that patients who are engaged in MAT programs are less likely to use IV drugs and will have a decreased rate of Seroconversion
   - Patients in Treatment for one year, started Hep C Negative
   - Incidence of becoming Hep C + = 4.5%
1. Patients are Categorized according to Success in Treatment
2. Categories:
   1. **GREEN (22%)**
      1. Success in program for over 6 months
      2. Negative Urines
      3. Participating in Behavioral Health support
      4. Outcomes that matter all Improving
   2. **YELLOW (35%)**
      1. Success in program
      2. No positive Screens
      3. May be Missing Appointments/Rebooking frequently
      4. May not have proven attendance at Behavioral Health
Success Stratification

Categories:

1. **ORANGE (32%)**
   1. New to the Program, Orange at time of induction,
   2. Recent Drug Use (new patient) Or Recent Relapse
   3. Continued use of one or more substances
   4. ? Participating in Recommended Behavioral Health support
   5. Visit Frequency Intensified (seen twice a week)

2. **RED (11%)**
   1. Struggling in Program
   2. Screens remain Positive despite intensification of program
   3. May be Missing Appointments/Rebooking frequently
   4. Has not proven attendance at recommended Behavioral Health
   5. May be time to Advance Patient to a higher level of care if pattern not improving
A Marker for Success? = Patient Retention

1. NIDA studies, Longer retention in treatment = better outcomes
2. National Averages
   1. Buprenorphine treatment
      1. Retention at 6 months = 29%
      2. Retention at 12 months = 19%
3. Retention at CleanSlate (Intensity and Relationship)
   1. Data from 2012/2013
      1. Retention at 1 YEAR = 62%
      2. Retention at 2 YEARS = 50%
4. REMEMBER THE GOAL OF TREATMENT
Current EMR

- 3 years of patient data
- 20,664 patients as of 7/21/2015
- Contains typical EHR variables
  - Medications
  - Immunizations
  - Allergies
- AND many important measures of functional status
  - Social/family history
  - Counseling
  - Financial stability
  - Housing status
  - Employment status
  - Criminal status
  - Many others...
Large number of social/personal indicators allow for identification of risk

- Explored pregnant sample
- Based on SAMHSA’s Recovery Support Strategic Initiative’s 4 dimensions of recovery
  - 1) Health (being healthy physically and emotionally)
  - 2) Home (having a stable place to live)
  - 3) Purpose (having a purpose in life and the ability to participate in society)
  - 4) Community (maintaining relationships).
Focus on Identification of Risk – in Pregnancy

- Explored 102 pregnant women currently receiving treatment
- Computed Total Risk score:
  - 1) contact with family/sober partners (risk=no contact)
  - 2) in counseling (risk=no treatment confirmation)
  - 3) stable housing (risk=no)
  - 4) current criminal activity (risk=yes)
  - 5) stable finances (risk=no)
  - 6) stable employment (risk=no)
  - 7) lost custody of children (risk=yes).
- A score of 2 or less = “low-risk”/ score of 3 or more = “high-risk”
- Compliance with MAT was related to “low-risk” (t = 2.52, p = 0.014)
- Data suggest that Buprenorphine compliance leads to better treatment outcome.
- MAT compliance related to better functional outcome indicators
For Which Patients Does this Treatment work best?

1. Treating this like a chronic Disease Changes the Approach
2. All patients can benefit from Longitudinal outpatient care (MAT)—Any of the medications, but engaged in supervised program
3. Patients with Cardiac Disease – Example
4. Patients need a Continuum of Longitudinal Care
5. Any Isolated Incidences of care should be followed immediately by longitudinal outpatient management
   • Outpatient medically managed MAT
   • Behavioral Health Support
   • Peer Support
How to Coordinate getting a patient into care?

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