Medicaid Innovation Accelerator Program (IAP)

Substance Use Disorders (SUD)
Targeted Learning Opportunities (TLO)

TLO10: Best Practices and Strategies for Medication-Assisted Treatment
Logistics

• Please mute your line and do not put the line on hold

• Use the chat box on your screen to ask a question or leave comment
  – Note: chat box will not be seen if you are in “full screen” mode
  – Please also exit out of “full screen” mode to participate in polling questions

• Moderated Q&A will be held periodically throughout the webinar

• Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience
Moderator

- David Gastfriend, MD
- Scientific Advisor
  - Treatment Research Institute
- Chief Architect, CONTINUUM – The ASAM Criteria Decision Engine
  - American Society of Addiction Medicine
- Vice President
  - Washington Circle Group
Speakers (1/3)

- Colleen Labelle, RN, CARN
- Program Director, State Technical Assistance Treatment Expansion Office-based Opioid Treatment with Buprenorphine
  - Boston Medical Center
Speakers (2/3)

- Marla Oros, RN, MS
  President, Mosaic Group
Speakers (3/3)

• Desirée Crèvecœur-MacPhail, PhD, MA
• Principal Investigator, UCLA Integrated Substance Abuse Programs

UCLA
Webinar Agenda

- Introduction
- State Experience: Massachusetts
  - *Break for Discussion*
- City Experience: Baltimore
  - *Break for Discussion*
- County Experience: Los Angeles County
  - *Break for Discussion*
- Wrap Up & Sharing of Resources
States will discuss best practices in the management of beneficiaries receiving medication assisted treatment for SUD.

States will discuss various strategies of effective benefit design for beneficiaries with SUD treatment needs.
Current Issues in SUD MAT

David Gastfriend, MD
Chief Architect, CONTINUUM – The ASAM Criteria Decision Engine, American Society of Addiction Medicine
Vice President, Washington Circle Group
Agenda

- Psychophysiology of SUD treatment
- FDA Approved Agents for Opioid Dependence
- Challenges in Opioid Medication Assisted Treatment
- Best Practices in Opioid Medication Assisted Treatment
- The Role of Insurance
Psychophysics of SUD treatment

- Cortex
  - Decision making
  - Thinking
  - Reasoning
  - Learning

- Limbic Region
  - Basic Drives
  - Experience of Reward, Euphoria

Interventions
- Psychosocial Therapies
- 12 Step Programs
- Monitoring

Interventions
- Agonist Medications
- Antagonist Medications

## FDA Approved Agents for Opioid Dependence

<table>
<thead>
<tr>
<th>Prescribing Considerations</th>
<th>Extended-Release Injectable Naltrexone</th>
<th>Buprenorphine</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Administration</td>
<td>Monthly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Route of Administration</td>
<td>Intermuscular injection in gluteal muscle</td>
<td>Oral tablet or film is dissolved under tongue</td>
<td>Oral liquid</td>
</tr>
<tr>
<td>Restrictions on Prescribing or Dispensing</td>
<td>Any individual licensed to prescribe, may be dispensed by qualified staff</td>
<td>Licensed, DEA waivered physicians or physicians who work at an OTP</td>
<td>Licensed physicians who work at an OTP, must be dispensed at the OTP</td>
</tr>
<tr>
<td>Abuse &amp; Diversion Potential</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Requirements</td>
<td>None. Any pharmacy can fill the prescription</td>
<td>Physicians must complete training to qualify for DEA waiver, any pharmacy can fill</td>
<td>Can only be purchased by &amp; dispensed at certified OTPs or hospitals</td>
</tr>
</tbody>
</table>

**FDA Approved Agents for Opioid Dependence**
Challenges in Opioid Medication Assisted Treatment

- Denial
- Access
- Adherence & retention
- Recovery
- Relapse
- Diversion
Screen

• Offering all options & key information for patients to make decisions

Desegregate Care

• Programs must offer ALL options (directly or via affiliations)

Cover All Medications & Doses

• No prior authorizations, fail first, time limits, medical benefit restrictions

Provide Withdrawal Management

• Include specialty induction-initiation
Best Practices in Opioid Medication Assisted Treatment (2/2)

Individualize Level of Care

- Structured assessment per ASAM Criteria

Rebuild Lives

- Require counseling, monitoring & recovery supports

Credential

- Institute training for counselors to work with MAT
Medicaid & private insurance are vital in making MAT access easy for clinicians & patients who are – by the disease’s nature – ambivalent.

- **Don’t require fail first, limits on dose, time, or medical benefits**
  - Patients will fail
  - Requirements are futile & destructive

- **Don’t require prior authorizations**
  - Patients end up waiting
  - Discourages patients
  - Promotes drop-out

- **Link treatment programs to primary care**
  - Eases access to longitudinal/maintenance medical services
  - Reduces stigma
  - Decreases specialty program caseload burden
Polling Question (1/4)

• Does your state Medicaid program impose any of the following practices related to the use of MAT? Select all that apply.
  – Step Therapy / Fail First
  – Prior Authorization
  – Dose Limitations
  – Time Limits (months, years)
  – Other
Polling Question (2/4)

• Does your state Medicaid program use any of the following best practices with MAT clients? Select all that apply.
  – Screening & Assessment
  – Induction in Specialty Treatment Programs
  – Counseling Requirement
  – Additional MAT Credentialing Requirements for Counselors
  – Other
State Experience: Massachusetts
Integrated Approach to Treatment Expansion

Colleen Labelle, RN, CARN
Program Director, State Technical Assistance Treatment Expansion Office-based Opioid Treatment with Buprenorphine
Boston Medical Center
Agenda (Massachusetts)

- BMC Collaborative Care Model
- Barriers to Prescribing Buprenorphine
- Statewide Initiative and Support
- Successes
- Challenges
BMC Collaborative Care Model (1/2)

- **Training**
  - Registered Nurses
  - 1-day training

- **Fidelity**
  - Perform patient education & clinical care by following treatment protocols
  - Maintain compliance with federal laws

- **Collaboration**
  - Coordinate care with OBOT physicians
  - Collaborated care with pharmacists (refills management) & off-site counseling services

- **Additional Services**
  - Urgent care drop-in hours
  - Manage insurance issues (prior authorizations)
BMC Collaborative Care Model (2/2)

Communication

Open communication between nurse care manager and other providers including behavioral health improved compliance

Patient Focus

Allows efficient use of physician time to focus on patient management
- Dose adjustments
- Maintenance versus tapering

Patient-level outcomes comparable to physician-centered approaches

Collaborative Care

Outcomes

Addressing Needs

OBOT & daily management of complex psychosocial needs
- Housing
- Employment
- Health insurance
Barriers to Prescribing Buprenorphine (1/2)

Barriers to Office-Based Buprenorphine Prescribing for Opioid Dependence

- Insufficient Nursing Support: 20%
- Insufficient Office Support: 19%
- Payment Issues: 17%
- Insufficient Institutional Support: 16%
- Insufficient Staff Knowledge: 12%
- Pharmacy Issues: 8%
- Low Demand: 7%
- Office Staff Stigma: 5%
- Insufficient Physician Knowledge: 3%

55% reported 1 or more barriers

Only physicians can prescribe...

However, it takes a multidisciplinary team approach to create effective treatment.
Building a Response to Massachusetts’ Unmet Need

• MA Department of Public Health Bureau of Substance Abuse Services
  – Two requests for response:
    • Nurse Care Manager Model in 19 community health centers
    • Training and technical assistance to the community health center OBOTs (Office Based Opioid Treatment)
  – Funding awarded 8/2007 for 3 years, renewable for a total of 7 years
Technical Assistance & Training to Funded Sites (1/2)

**Training**
- RNs & MAs complete 1-day buprenorphine training

**Site Visits**
- Conducted w/ RN, MDs, team members
- Trainings in addiction MAT, stigma, management, start-up

**Quarterly Meetings**
- Educational, networking, support

**Support for RNs, Waivered MDs**
- Navigate prior authorization, insurance, DEA
- Leaving providers/practice closures
- Patient issues

**Facilitating Listserv for Addiction Providers**
- Relevant articles, resources, group discussion
- Regulations, reimbursement, jobs
Technical Assistance & Training to Funded Sites (2/2)

• Buprenorphine nurse trainings
  – Booster trainings

• Support new & current practices
  – Provide technical support
  – Prevent gaps in treatment by triaging patients to other sites when practices close/staff changes/emergencies occur

• Statewide addiction nurse chapter (MA IntNSA)
  – Networking
  – Annual statewide conference
  – Monthly meetings
  – Support addiction certification
OBOT Goals with Federally Qualified Health Centers

**Access**
- Expand treatment & access to buprenorphine
  - Increase the number of waived MDs
  - Increase the number of individuals treated for opioid addiction
  - Integrate addiction treatment into primary care settings

**Delivery**
- Effective delivery model for buprenorphine services
  - Modeled after BMC’s Nurse Care Manager program

**Sustainability**
- Post-program funding
  - Develop a long-term viable funding plan
  - Collect & analyze outcomes data
Successes (1/2)

- Nurse Care Model housed in community health centers has
  - Expanded treatment
    - More than 8,000 patients since 2007 (82% Medicaid)
    - Treatment available in patients’ communities
  - Developed a sustainable reimbursement model
    - FQHCs
    - Insurance
  - Implemented best practices standards as the standard of care
  - Supported & engaged with providers & health center staff to do this work
    - Reduced stigma
Successes (2/2)

• Other outcomes
  – Decreased mortality
  – Lower cost to Medicaid for those on buprenorphine versus those not in care
Successes: ER Visits

Average ER Visits per OBOT Enrollment

- 6 Months Prior to Program
- First 6 Months Past Program Initiation
- 6-12 Months Past Program Initiation
Successes: Hospital Admissions

Average Hospital Admissions per OBOT Enrollment

- 6 Months Prior to Program
- First 6 Months Past Program Initiation
- 6-12 Months Past Program Initiation
Why the Nurse Care Model Works

• Increased patient access
  – Frequent follow-ups
  – Case management
  – Able to address
    • positive urines
    • insurance issues
    • prescription/pharmacy issues
  – Pregnancy, acute pain, surgery, injury
  – Concrete service support
    • Intensive treatment needs, legal/social issues, safety, housing
  – Brief counseling, social support, patient navigation
  – Support providers with large case loads
Why the Technical Assistance Initiative Works

- Statewide provider network
  - List server, resources, support
  - Phone/email support
  - Trainings

- Statewide engagement

- Support practice closures, providers leaving, patients relocations, higher levels of need

- Hotline
  - Access, support, referral to treatment
  - Assist in site closures
Challenges

- **Access restrictions**
  - Only physicians can prescribe
    - Less than 5% of physicians are waivered
  - Limit on number of patients physicians are allowed to treat

- **Stigma**
  - Not wanting to: “treat those patients”
  - Addiction not accepted as disease
• Using the ‘Raise your hand’ option on ReadyTalk, please let us know if your state is providing or coordinating any provider training programs related to SUD MAT.
City Experience: Baltimore Buprenorphine Initiative

Marla Oros, RN, MS
President
Mosaic Group
Agenda (Baltimore)

- Overview System Structure
- Implementation Steps
- Funding
- Results
- Lessons Learned
System Structure: Three Agency Collaboration

Behavioral Health Systems Baltimore

- Initiative oversight
- Substance abuse treatment oversight

Baltimore City Health Department

- Training and recruitment of physicians
- Initiative launch

Health Care Access Maryland, Inc.

- Health insurance assistance
- Case management services
System Structure: Three Step Approach

Step 1
- Buprenorphine induction at treatment program
- IOP/OP services provided

Step 2
- Assistance with obtaining health insurance
- Assessment of recovery support needs & case management
- Transition to primary care

Step 3
- Continued buprenorphine therapy in primary care
- Ongoing counseling & case management
System Structure: Patient & Agency Process

1. Patient starts buprenorphine in SUD program

BSAS oversees contracts w/treatment

BHA social workers arrange insurance & transfer

2. Patient continues to receive BUP from primary care physician

BCHD supports training for doctors in medical system

3. Patient transitions to medical system
Implementation: Organizational Steps

• Form core group of Initiative coordinators
• Choose providers
• Hold regular roundtable meetings with providers
• Produce written policies & guidance
  – BBI Clinical Guidelines
• Oversee buprenorphine providers
• Conduct quality improvement monitoring
• Coordinate swift responses to all problems
• Track patient outcomes
Implementation: Case Management Steps

• Case worker involved in treatment from the start
  – Special referral consent signed by patient

• Help with obtaining necessary documentation & services
  – Health insurance application
  – Application tracking
  – MCO/PCP selection

• Facilitate transition to primary care
  – Provide care management for 6 months after transfer to primary care
  – Patient tracking
Implementation: Transferring to Primary Care

• Patient must meet transfer criteria
  – Two consecutive urine tox screens without opioids
  – Ability to manage prescription
  – Met treatment programs counseling goals

• Case worker facilitates transfer to certified PCP
  – Makes appointment with selected PCP
  – Sends transfer summary to PCP before appointment
  – Assures transportation for patient
  – Sets up co-pay vouchers for patient, as needed

• Case worker follows up on PCP visit with patient & PCP

• Patient tracking
Implementation: Continued Service Through Primary Care

- Buprenorphine and medical care provided by PCP
- Continuation of outpatient treatment 3 months post transfer, as needed
- Patient tracking 6 months post transfer
- Free training for all Baltimore physicians
  - Online training for un-waivered PCPs
  - Annual CMEs for continuing care physicians
  - Practice-specific training as requested
  - Continuing care clinical guidelines
**Funding**

- **Grant Funds**
  - Case management services

- **Medicaid Reimbursement**
  - Medication
  - PCP for continuing care

- **Block Grant & City Funds**
  - Supports MDs, RNs in treatment programs

- **SUD Carve Out (as of January 2015)**
  - Reimbursement for MD in treatment programs
  - Grant funds still needed for RNs, CMs

**Financial Support for BBI**
Results

Providers
• 10 participating BBI treatment providers
• Over 75 active BBI continuing care MDs

Patients
• Over 9,000 patients entered the BBI since October 2006

Retention
• 55% of patients remain in treatment for 90+ days
• 80% of post-transfer patients remain in treatment 6+ months
Lessons Learned (1/2)

**Lead**
- Maintenance therapy represents a philosophical shift
- Providers need to be change leaders

**Plan**
- Set specific goals, expectations, benchmarks
- Develop written protocols & procedures early
- Train treatment providers & PCPs
- Know MCOs’ coding & billing procedures

**Share**
- Hold regularly scheduled provider meetings to share information
- Ensure communication between all parties
Lessons Learned (2/2)

Case Workers
- Case management is extremely important
- CMs hold the system together

Tracking
- Set-up patient tracking system to measure benchmarks & goals
- Essential for CM

Strategize
- Anticipate problems & actively seek solutions
- Documentation requirements, delay in insurance coverage, medication purchasing, co-pay coverage, urine tests, clinical inconsistencies
Polling Question

• Which funding streams does your state utilize to finance SUD MAT? Select all that apply
  – Block grant funds
  – Other grant funding
  – State funding
  – Medicaid reimbursement
  – Other
Discussion and Questions (2/3)
County Experience: Los Angeles County Implementation of Extended-Release Naltrexone

Desirée Crèvecœur-MacPhail, PhD, MA
Principal Investigator
UCLA Integrated Substance Abuse Programs
Agenda (UCLA)

- Overview of Naltrexone
- Strategies for Introduction
- Implementation Process
- Evaluation
- Lessons Learned: Keys to Success
Overview of XR-Naltrexonone (XR-NTX)

• What it is
  – Opioid receptor antagonist that blocks mu-opioid receptors in the brain
    • Targets receptors that produce the “buzz” or “high” people feel when alcohol & opioids are consumed

• FDA approval
  – 2006: alcohol addiction
  – 2010: opioid addiction

• LA County Pilot Precautions
  – Not approved for
    • Anyone under age 18
    • Pregnant/nursing women
    • Individuals with active hepatitis or clinically elevated liver enzymes
  – Client should abstain from alcohol for 7 days prior
  – Client must abstain from all opioids for 10 days prior
Overview of XR-Naltrexone: Why Implement a Program for this MAT?

**Goal**
To increase the number of tools providers have access to in order to increase the effectiveness of treatment

**Antagonist**
Better acceptance with criminal justice departments and other groups

**Increased Options & Access**
Decrease the economic disparity in access to medications
Implementation Process (1/2)

Informed

- Over 60 site visits conducted at 25 sites over 9 months
- Told providers about the drugs’ availability
- Meetings with stakeholders and community members

Educated

- Conducted trainings, educational site visits to address counselor questions & concerns
- Discussed differences between XR-NTX and other MAT options
- Required integration with psychosocial treatment
Implementation Process (2/2)

Model
- Set-up MAT hubs using “Hub and Spoke” model
- Allowed access to every client in LA County if s/he was enrolled in treatment at SAPC contracted program

Funding
- Provided additional funding to MAT hubs

Guidance
- Guided providers in development of memorandum of understanding process

Evaluate
- Developed evaluation plan post-implementation
Evaluation Questions

Do patients remain on XR-NTX after 1st dose?

- Does medication affect client outcomes?
- Length of stay, reported alcohol use, retention, engagement

What do the patients “look like” once they are no longer taking medication?

- Do urges return?
- Do clients relapse?

How have staff attitudes changed following trainings?

- How has staff knowledge of XR-NTX changed?
- How have staff attitudes toward clients’ use of MAT and specifically, XR-NTX changed?
Evaluation Methods

**Data Sources**
- Los Angeles County Participant Reporting System
- Medication-Assisted Treatment Survey (MATS)
- Urge to Drink Scale (UDS)
- Counselor attitudes

**Data Collection**
- Baseline (prior to first dose)
- Weekly for the first 3 weeks
- Monthly throughout patient’s treatment
- Follow-up at 30 and 60 days post final dose
- Counselor attitude assessed at baseline and 4 months
# Evaluation Results: Treatment Type & Dose

<table>
<thead>
<tr>
<th>Treatment *</th>
<th>Alcohol (n=931)</th>
<th>Opioid (n=352)</th>
<th>Total (n=1,283)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>34.9% (325)</td>
<td>27% (95)</td>
<td>32.7% (420)</td>
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<tr>
<td>Residential</td>
<td>42.9% (400)</td>
<td>48% (169)</td>
<td>44.4% (569)</td>
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<tr>
<td>Detoxification</td>
<td>21.3% (198)</td>
<td>23% (81)</td>
<td>21.7% (279)</td>
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<tr>
<td><strong>Total Doses, Mean (SD), range 0-16</strong></td>
<td><strong>2.6 (2)</strong></td>
<td><strong>2.5 (1.8)</strong></td>
<td><strong>2.6 (1.9)</strong></td>
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<td>1</td>
<td>37.7% (351)</td>
<td>34.4% (135)</td>
<td>35.9% (486)</td>
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<td>2</td>
<td>22.7% (211)</td>
<td>23% (81)</td>
<td>22.8% (292)</td>
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<tr>
<td>3</td>
<td>16% (149)</td>
<td>15.1% (53)</td>
<td>15.7% (202)</td>
</tr>
<tr>
<td>4 or more</td>
<td>23.6% (220)</td>
<td>23.6% (83)</td>
<td>23.6% (303)</td>
</tr>
</tbody>
</table>

Data presented reflects self-reports on LACPRS treatment admission records available up to May 2015.

*Treatment data missing for some cases.*
Evaluation Results: Side Effects

Proportion of clients reporting *specific* side effect for weeks 1-3 after first dose

- Fatigue
- Headache
- Injection Site
- Nausea

Week 1 (n = 402)  Week 2 (n = 372)  Week 3 (n = 402)
Evaluation Results: Patients Treated for Alcohol Dependence

**Reduced Urge to Drink Alcohol**

- **Week 0**: 18.0
- **Week 1**: 8.4
- **Week 2**: 6.5
- **Week 3**: 6.8

Scores of 10 or more indicate danger of relapse.

**Abstinence Rates Among Alcohol XR-NTX Treatment Patients**

- **Residential**
  - County Average: 83.2%
  - XR-NTX Patient: 93.9%
- **Outpatient**
  - County Average: 77.1%
  - XR-NTX Patient: 82.8%
- **Overall**
  - County Average: 78.9%
  - XR-NTX Patient: 88.4%

Percent of Individuals Remaining Abstinent from Alcohol
Evaluation Results:
Patients Treated for Alcohol Dependence (1/2)

Engagement in Alcohol XR-NTX Treatment
- Residential: County Average 71.9%, XR-NTX Patient 93.7%
- Outpatient: County Average 74.2%, XR-NTX Patient 92.5%
- Overall: County Average 73.5%, XR-NTX Patient 93.2%

Completion of Alcohol XR-NTX Treatment
- Residential: County Average 59.3%, XR-NTX Patient 79.8%
- Outpatient: County Average 50.1%, XR-NTX Patient 71.9%
- Overall: County Average 52.8%, XR-NTX Patient 76.6%
Evaluation Results:
Patients Treated for Opioid Dependence (2/2)

**Reduced Urge to Use Opioids**

Scores of 10 or more indicate danger of relapse.

**Abstinence Rates Among Opioid XR-NTX Treatment Patients**

- **Residential**:
  - County Average: 82.6%
  - XR-NTX Patient: 91.8%
- **Outpatient**:
  - County Average: 79.9%
  - XR-NTX Patient: 80.8%
- **Overall**:
  - County Average: 81.3%
  - XR-NTX Patient: 88.3%
Evaluation Results:
Patients Treated for Opioid Dependence

**Engagement in Opioid XR-NTX Treatment**
- Residential: County Average 87.3%, XR-NTX Patient 71.2%
- Outpatient: County Average 95.8%, XR-NTX Patient 73.3%
- Overall: County Average 89.9%, XR-NTX Patient 72.2%

**Completion of Opioid XR-NTX Treatment**
- Residential: County Average 77.1%, XR-NTX Patient 60.3%
- Outpatient: County Average 80.6%, XR-NTX Patient 46.9%
- Overall: County Average 78.2%, XR-NTX Patient 53.8%

County Average  Orange  XR-NTX Patient  Blue
Evaluation Results: Urge to Drink/Use Opioids

Urge to Drink & Use Opioids Over Follow-Up Period

Average Urge to Drink/Use Score (0-30)

- **Week 0**: 18.7 (n=114)
- **Week 1**: 7.4 (n=104)
- **Week 2**: 5.3 (n=99)
- **Week 3**: 5.7 (n=104)
- **Week 8**: 6.6 (n=50)
- **Week 12**: 7.0 (n=30)
- **Follow Up 1**: 7.4 (n=114)
- **Follow Up 2**: 9.2 (n=114)

- **Alcohol Patients**
- **Opioid Patients**
### Evaluation Results: 30 & 60 Days After Final Dose

<table>
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<tr>
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<th>Alcohol (n=81)</th>
<th>Opioid (n=33)</th>
<th>Total (n=114)</th>
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<tbody>
<tr>
<td><strong>Mean Doses (SD)</strong></td>
<td>2.6 (1.6)</td>
<td>2.2 (1.5)</td>
<td>2.6 (1.9)</td>
</tr>
<tr>
<td><strong>Remained Sober</strong></td>
<td></td>
<td></td>
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<tr>
<td>Follow Up 1</td>
<td>80.8%</td>
<td>90.9%</td>
<td>85.9%</td>
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<tr>
<td>Follow Up 2</td>
<td>77.8%</td>
<td>81.3%</td>
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<td><strong>Treatment</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Residential</td>
<td>44.7%</td>
<td>49%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>35.2%</td>
<td>27.5%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Detoxification</td>
<td>21.1%</td>
<td>23.5%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>
Evaluation Results: Counselor Attitudes

• Post training, self-report of counselor attitudes showed improvement with regards to medications overall, and with regards to XR-NTX

• However, difficult to say if these changes are the result of true attitude changes, something from the data collection process that encouraged such responses or a desire by the counselors to “look good” to the evaluators
Lessons Learned: Keys to Success

- Verify treatment admission prior to provision of medication
- Encourage step down from higher level of care to lower level of care (e.g., RS to OC)
- Training and educating providers about XR-NTX is critical
- Funding to support infrastructure is necessary
- Cross-program collaboration
Polling Question (3/4)

• What are your state's biggest challenges with regard to SUD MAT? Select all that apply.
  – Stigma around treatment options
  – Training providers
  – Reimbursement for MAT
  – Funding new treatment programs/options
  – Other
Discussion and Questions (3/3)
Polling Question (4/4)

- Would your state be interested in having a post-webinar discussion with the speakers to address any additional questions or reflections on today’s webinar?
  - Yes
  - No
Resources (1/2)

• The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine.
  – Full Guideline
  – Pocket Guideline

• An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence. Substance Abuse and Mental Health Services Administration.
  – Advisory
Resources (2/2)

- **Centers for Medicaid and CHIP Services Informational Bulletin on Medication-Assisted Treatment for Substance Use Disorders.** Centers for Medicaid and Chip Services.
  - Informational Bulletin
- **Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain – United States, 2016.** Centers for Disease Control and Prevention.
  - Comment on Draft Guidelines
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  – 310-267-5207