MAT from Primary Care to Federally Qualified Healthcare Center

With a splash of COVID-19

Never judge, takes all those that comes before you!

AN ESTIMATED 97 MILLION ADULTS IN THE UNITED STATES ARE OVERWEIGHT OR OBESE

WEIGHT MANAGEMENT IN PRIMARY CARE

We must treat the primary cause of the disease

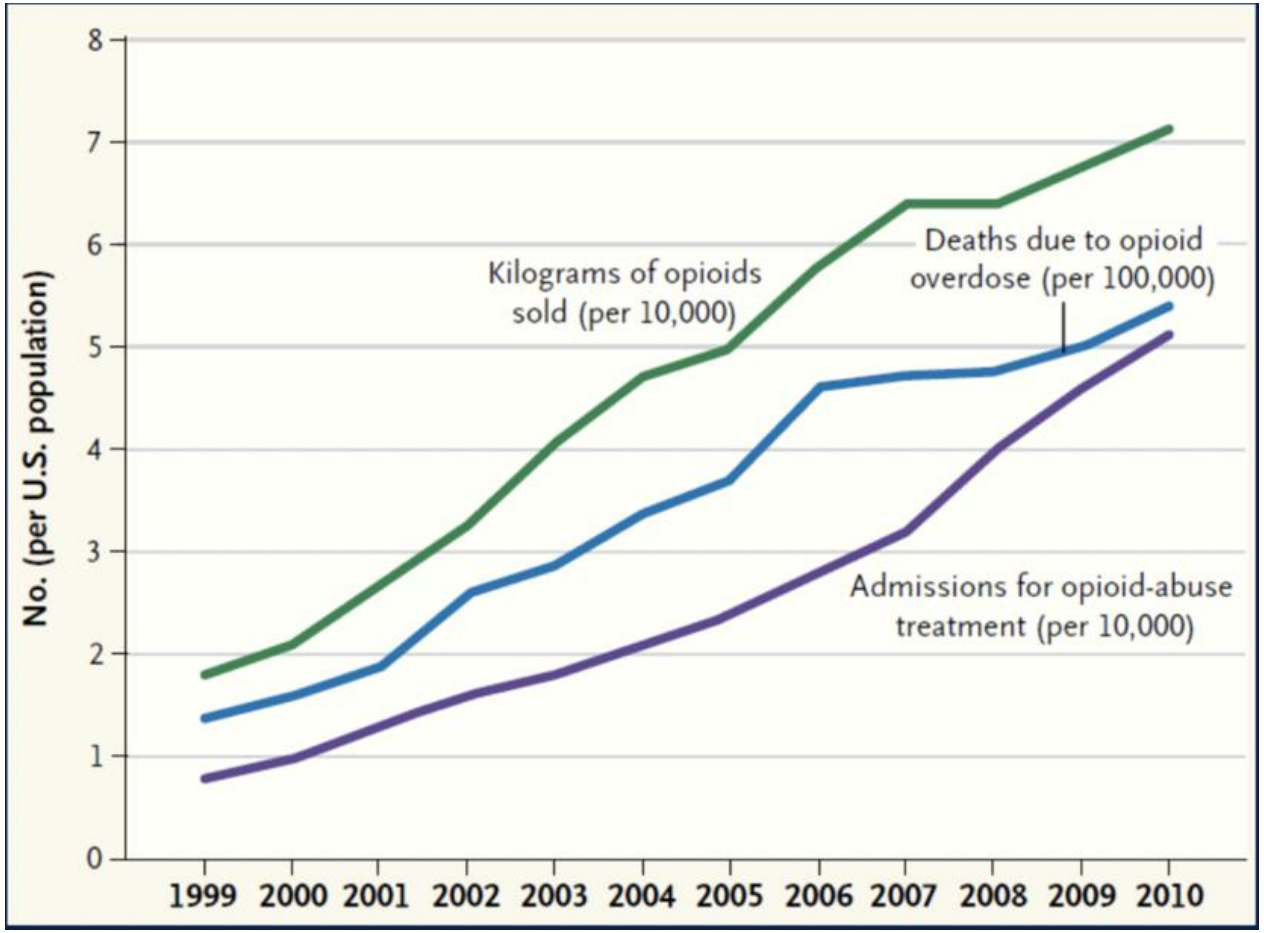
BAYER
PHARMACEUTICAL PRODUCTS.

Send for samples and Literature to

FARBENFABRIKEN OF ELBERFELD CO.

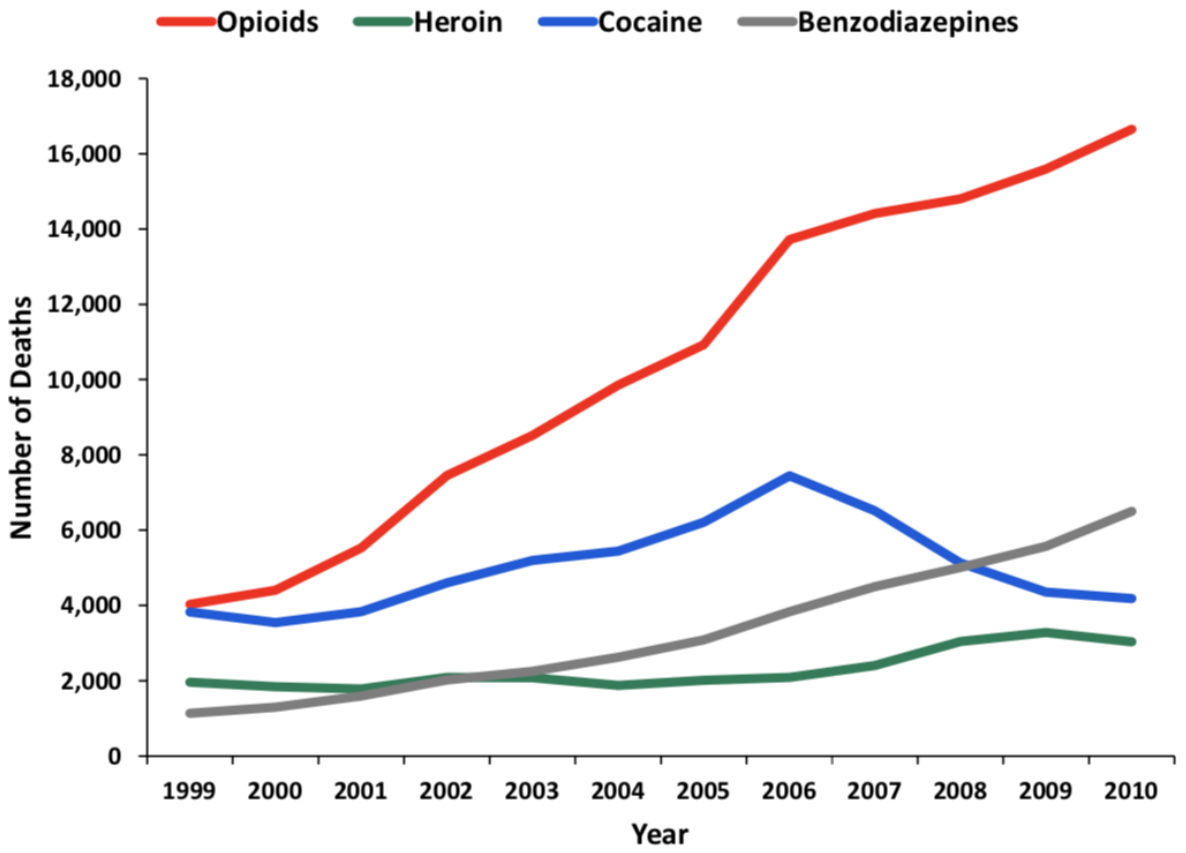
40 STONE STREET, NEW YORK.

Prescription Opioid Trends: 1999-2010

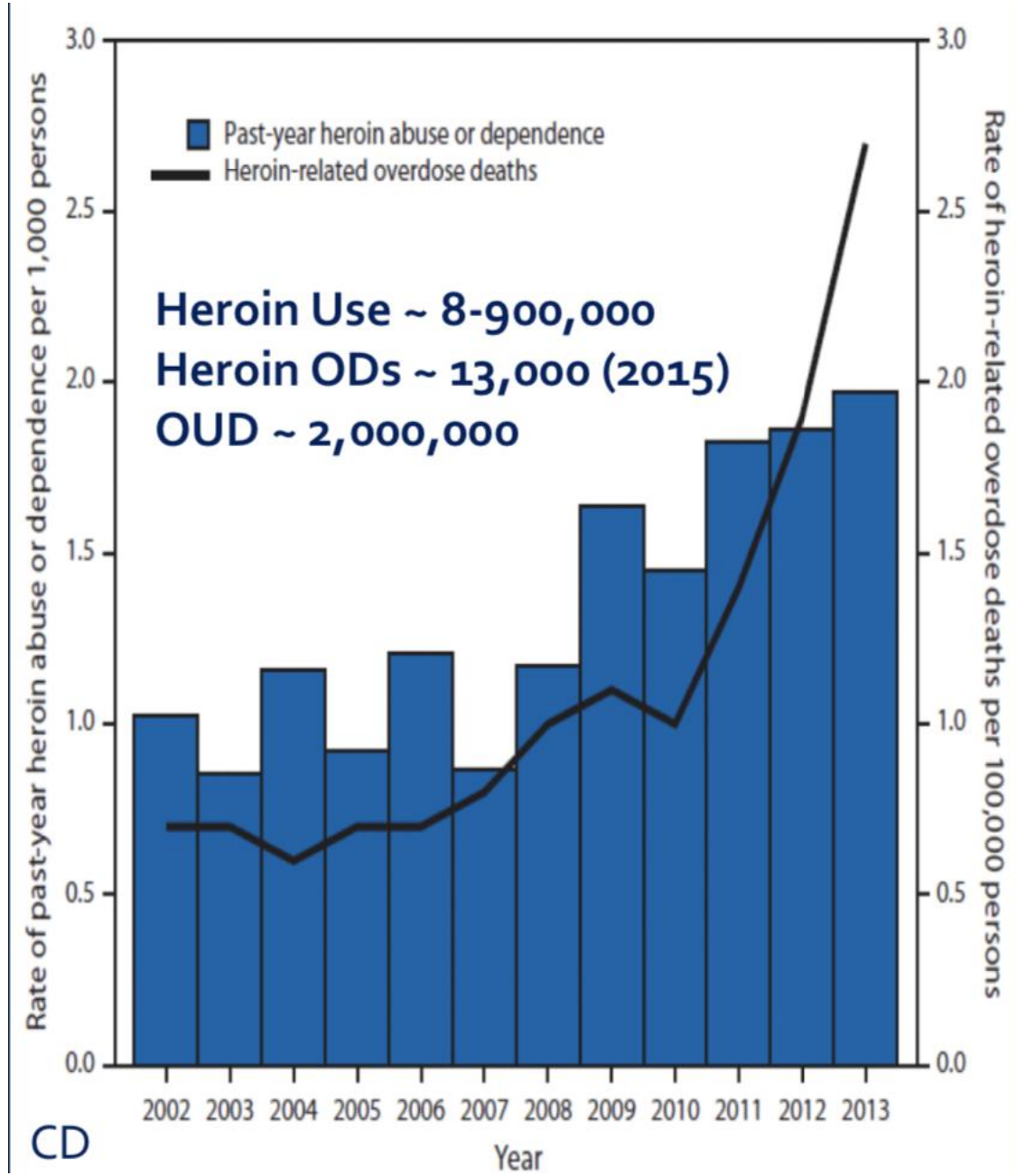


National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System of the DEA; Treatment Episode Data Set

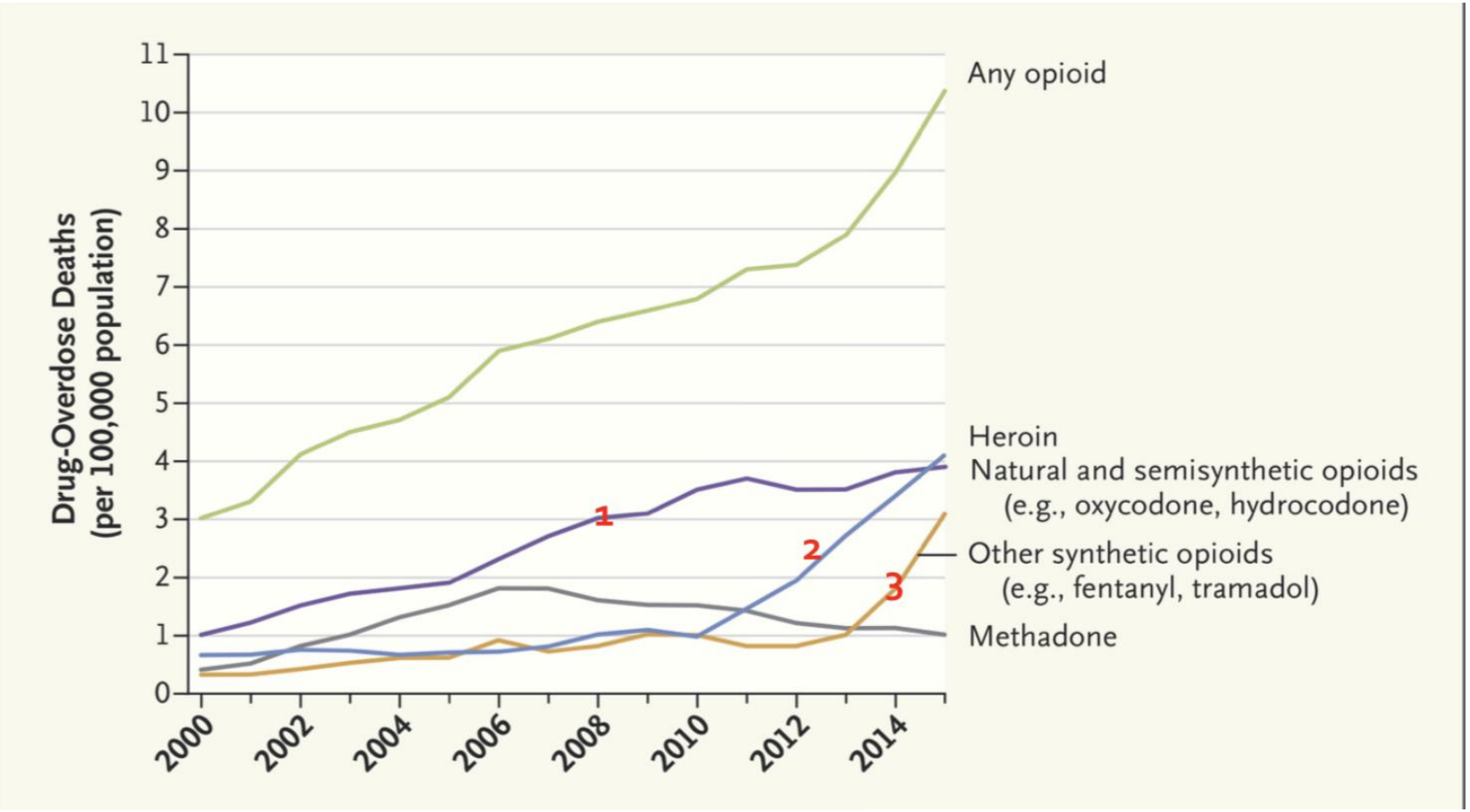
Drug Overdose Deaths by Major Drug Type, United States, 1999-2010



CDC, National Center for Health Statistics, National Vital Statistics System, CDC Wonder. Updated with 2010 mortality data.

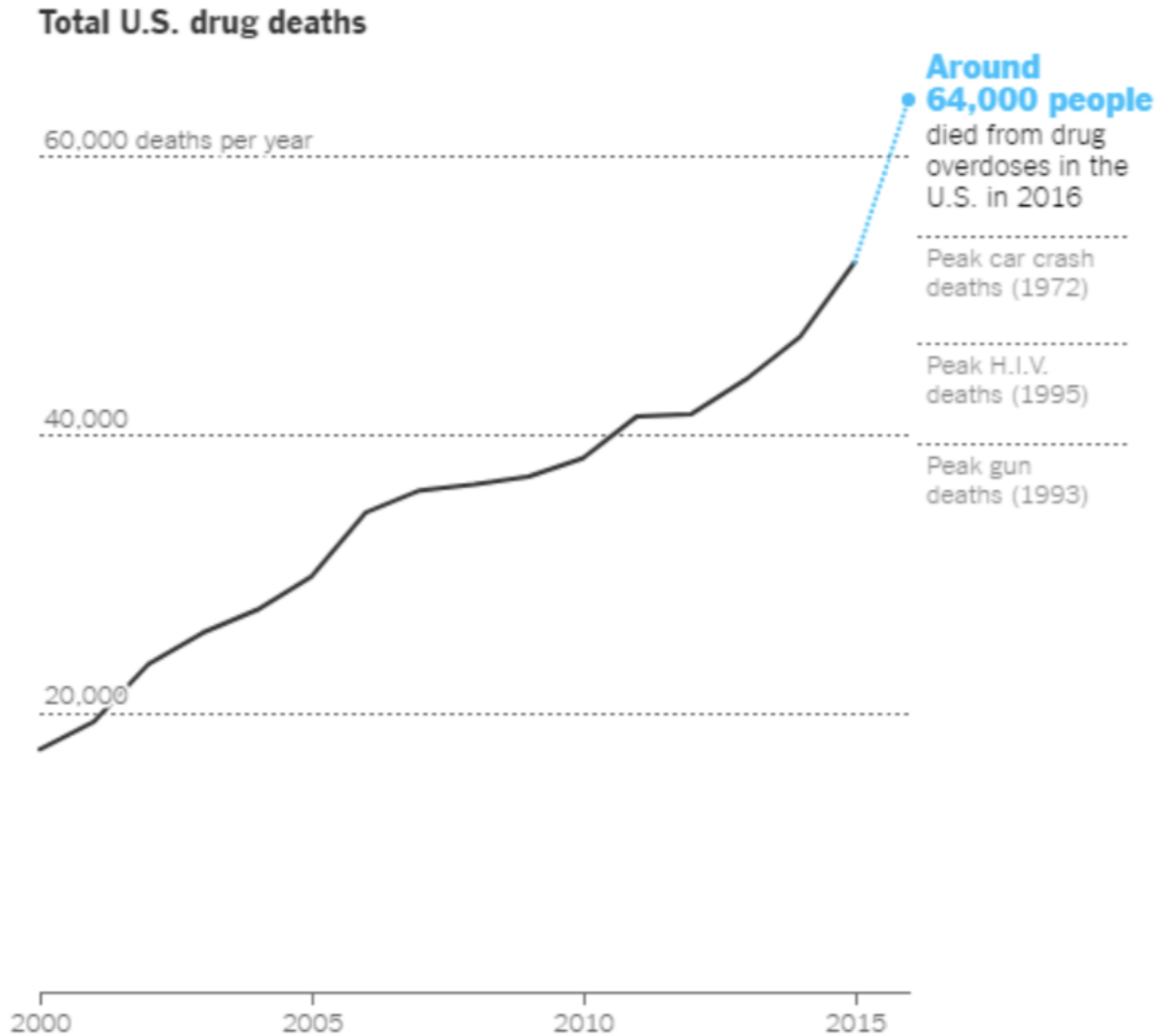

Past-year heroin abuse or dependence
Heroin-related overdose deaths
Heroin Use ~ 8-900,000
Heroin ODs ~ 13,000 (2015)
OUD ~ 2,000,000
Rate of past-year heroin abuse or dependence per 1,000 persons
Rate of heroin-related overdose deaths per 100,000 persons
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013
Year
CD

Drug-Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2014

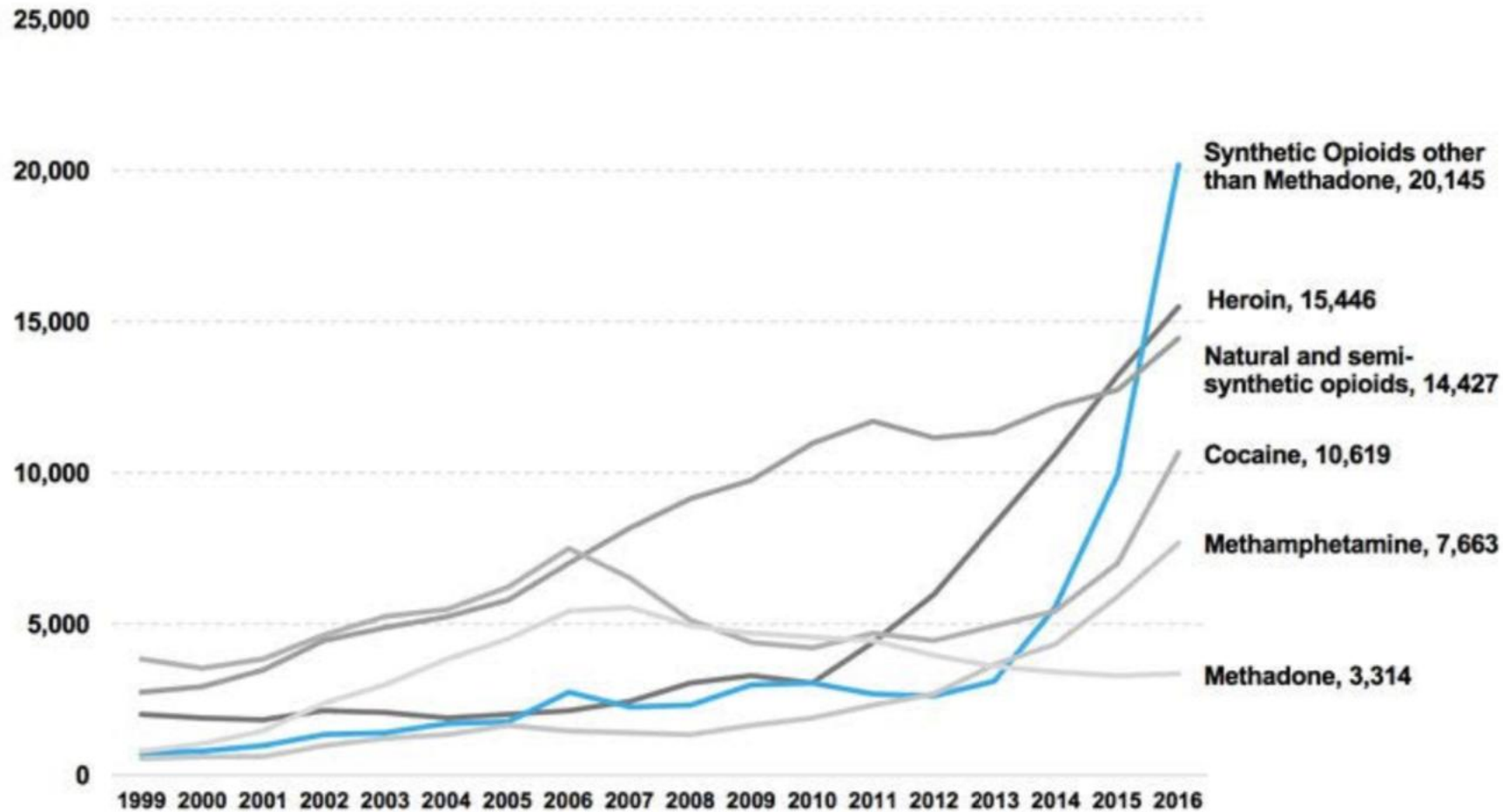


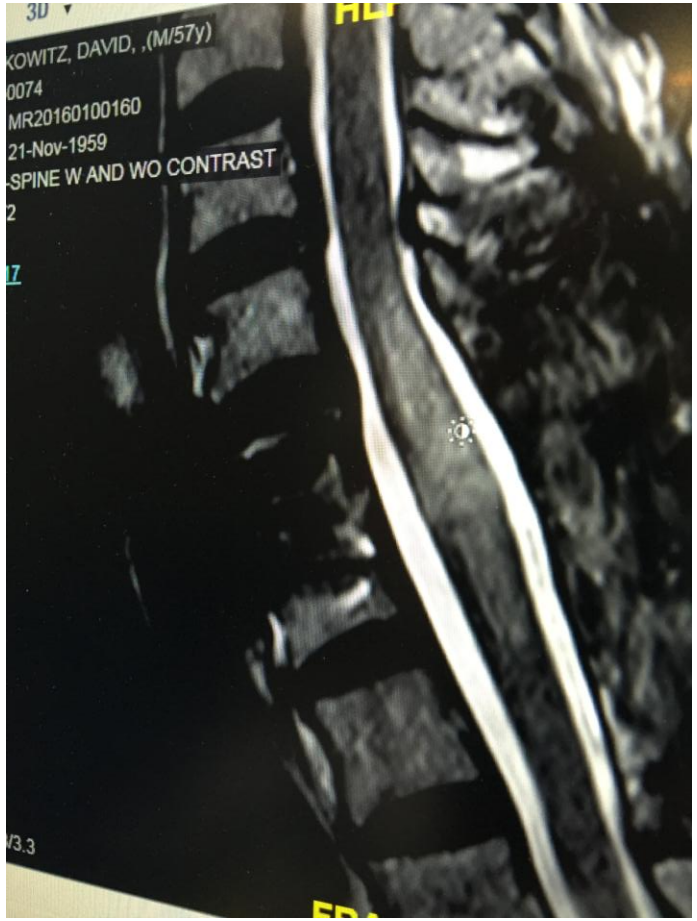
Frank RG, Pollack HA. N Engl J Med 2017;376.605-607

The NEW ENGLAND JOURNAL of MEDICINE


Total U.S. drug deaths
Around 64,000 people
died from drug overdoses in the U.S. in 2016
60,000 deaths per year
40,000
20,000
Peak car crash deaths (1972)
Peak H.I.V. deaths (1995)
Peak gun deaths (1993)
2000
2005
2010
2015

Drugs Involved in U.S. Overdose Deaths, 2000 to 2016




3D
KOWITZ, DAVID, ,(M/57y)
0074
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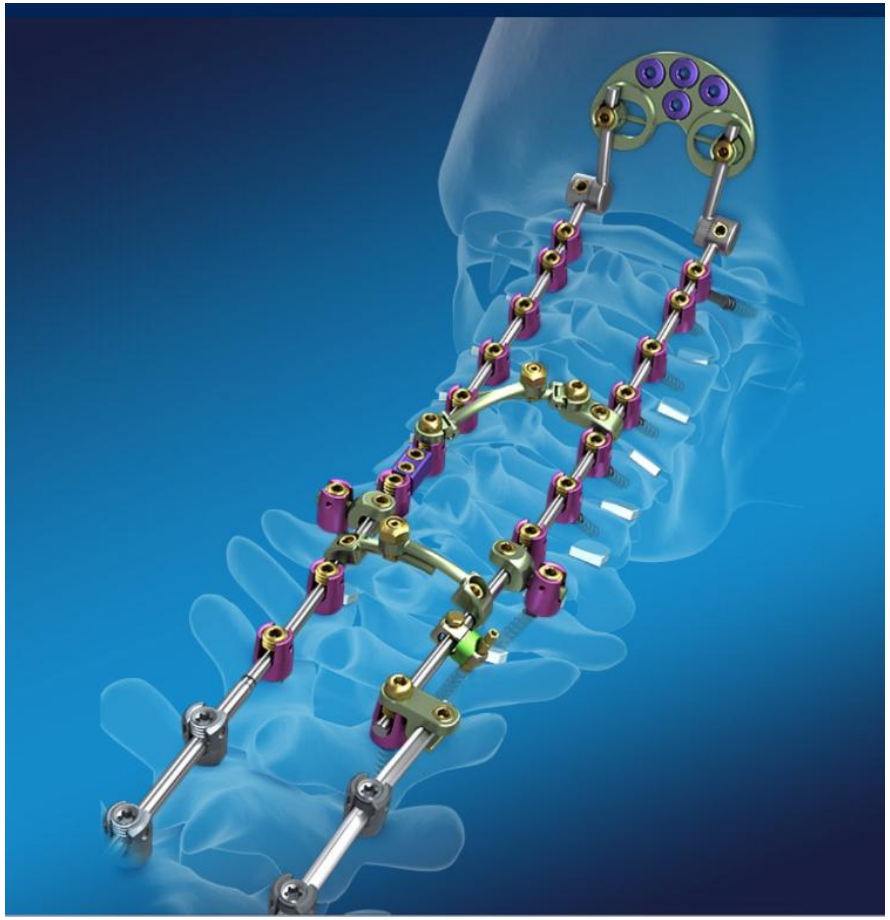
21-Nov-1959
-SPINE W AND WO CONTRAST
2
V3.3



Federally Qualified Health Centers

- 1,400 in US
- 45% are rural health centers
- 115 million visits annually
- 72% of patients at or below poverty level
- Payer Mix
  - 38% Medicaid
  - 36% No insurance
  - 14% Private insurance
  - 10% Medicare

FQHC's in Michigan

- 45 in Michigan
- Serve 709,000
  - 635,916 live in poverty
  - 48,886 are homeless
- 2.7 million patient visits
- Employ 6,000
- $1.3 billion economic impact in MIchigan

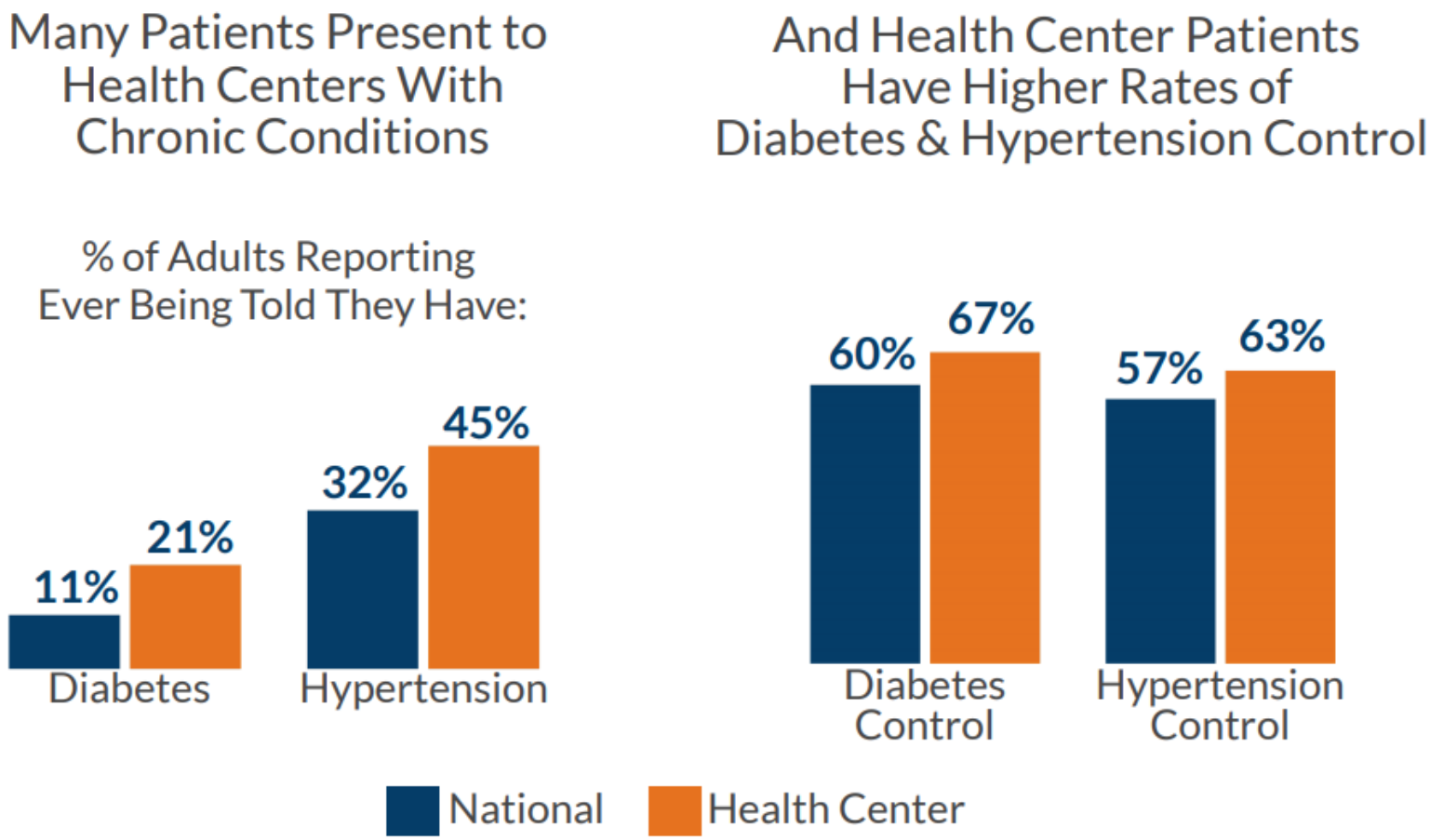
History

- 1960's: Lyndon Johnson's War on Poverty initiative opened Neighborhood Health Centers in Mound Bayou, MS and Boston
- Goal: to provide primary care to underserved rural and urban communities
- 1991: began using term FQHC
  - Added as a Medicaid and Medicare benefit
  - Precisely defined to be safety net centers like public housing or community health centers
- 2010: ACA stated FQHCs need to provide care to all people in a certain area whether they're able to pay or not

Requirements

- Must be in a Health Resources & Services Admin designated underserved area
- Governed by board of directors where 51% of board uses the services of the clinic
- Offer services in addition to primary care
  - Dental
  - OB
  - Behavioral health

FQHC's are treating a sicker population and achieving better outcomes



Importance of integrating MAT with primary care

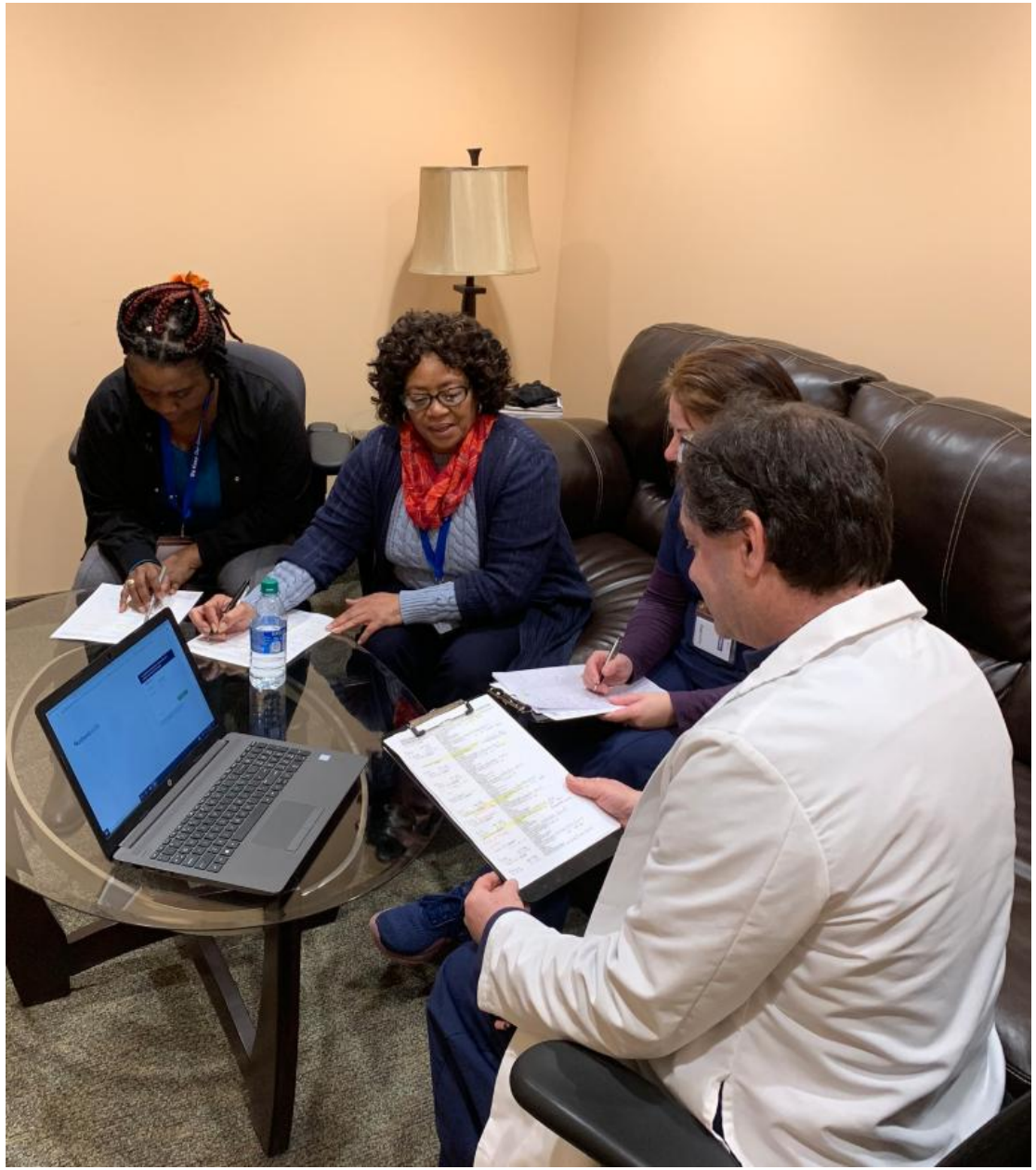
- Individuals with substance use disorders have:
  - 9x greater risk of CHF
  - 12x greater risk of cirrhosis
  - 12x greater risk of PNA
- Poor adherence to DMII medications
- 54% of addiction treatment programs have no physician

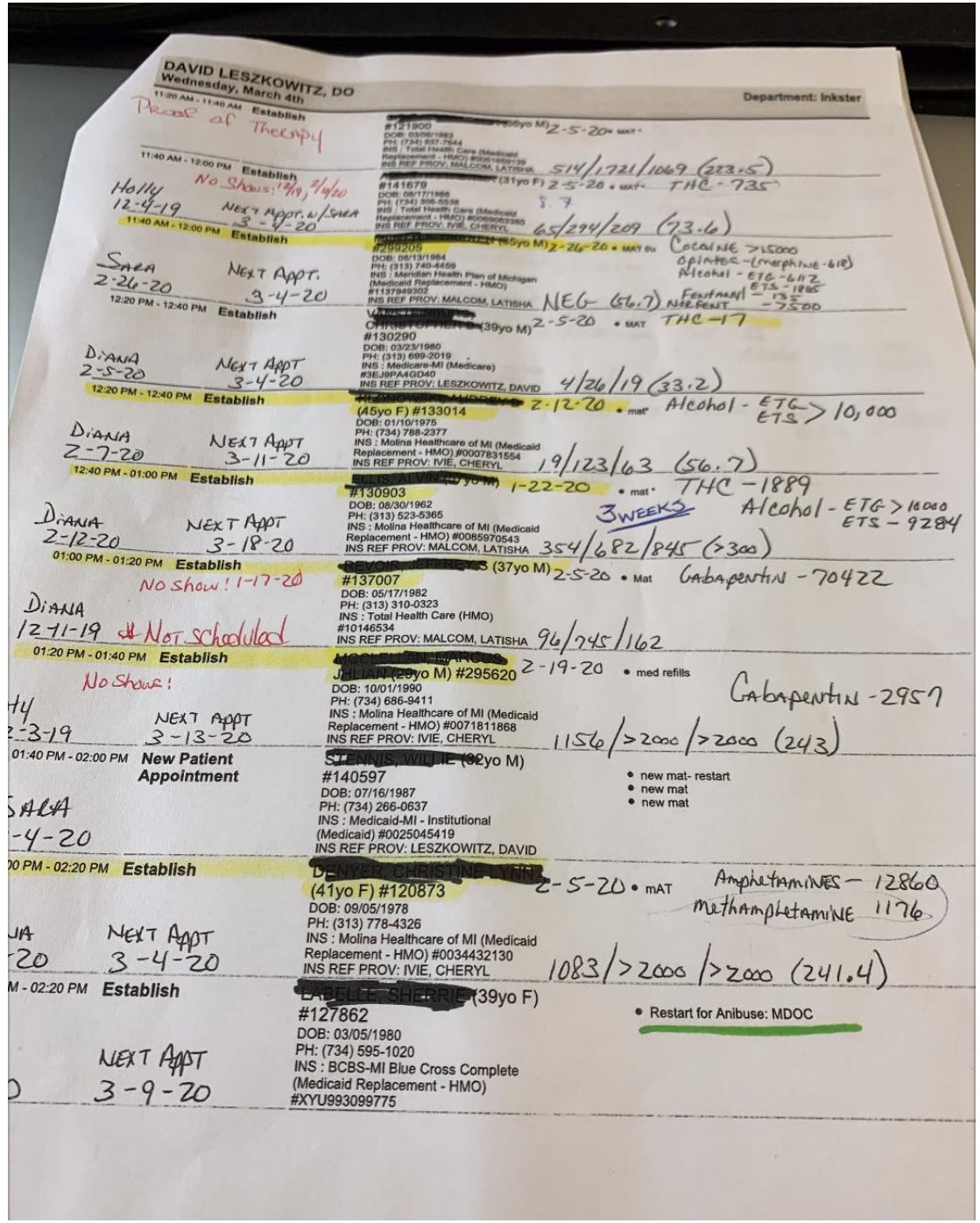
Barriers to implementing MAT in FQHC's

- Only 15% of FQHC's have physicians that prescribe buprenorphine
- Physicians at FQHC's are already treating a panel of difficult patients and reluctant to take on more
- Belief that abstinence is the best treatment for addiction
- Concerns with safety of other patients

FQHC Reimbursement

- CMS 2020 rate: $173.50
- FQHC's can bill for 2 services at same visit
- Therapy and MAT can be provided at same visit increasing compliance





DAVID LESZKOWITZ, DO
Wednesday, March 4th
Department: Inkster

11:20 AM - 11:40 AM Establish — Proof of Therapy
#121900 (36yo M) 2-5-20 • MAT •
DOB: 03/06/1983
PH: (734) 837-7544
INS : Total Health Care (Medicaid Replacement - HMO) #0061469139
INS REF PROV: MALCOM, LATISHA 514/1721/1069 (223.5)

11:40 AM - 12:00 PM Establish — Holly 12-4-19 — No Shows: 1/9, 2/6/20 — Next Appt. w/Sara 3-4-20
(31yo F) 2-5-20 • MAT • THC - 735
#141679
DOB: 08/17/1988
PH: (734) 306-5538
INS : Total Health Care (Medicaid Replacement - HMO) #0060063365
INS REF PROV: IVIE, CHERYL 65/294/209 (73.6)

12:20 PM - 12:40 PM Establish — Sara 2-26-20 — Next Appt. 3-4-20
#299205 (35yo M) 2-26-20 • MAT 6u
DOB: 08/13/1984
PH: (313) 740-4459
INS : Meridian Health Plan of Michigan (Medicaid Replacement - HMO) #1137949302
INS REF PROV: MALCOM, LATISHA NEG (56.7)
Cocaine >15000
opiates - (morphine - 618)
Alcohol - ETG - 6112
ETS - 1805
Fentanyl - 132
Norfentanyl - 7500

12:40 PM - 01:00 PM Establish — Diana 2-5-20 — Next Appt 3-4-20
(39yo M) 2-5-20 • MAT THC - 17
#130290
DOB: 03/23/1980
PH: (313) 699-2019
INS : Medicare-MI (Medicare) #3EJ9PA4GD40
INS REF PROV: LESZKOWITZ, DAVID 4/26/19 (33.2)

01:00 PM - 01:20 PM Establish — Diana 2-12-20 — Next Appt 3-18-20
(45yo F) #133014 2-12-20 • mat • Alcohol - ETG > 10,000 ETS - 9284
DOB: 01/10/1975
PH: (734) 788-2377
INS : Molina Healthcare of MI (Medicaid Replacement - HMO) #0007831554
INS REF PROV: IVIE, CHERYL 19/123/63 (56.7)

01:20 PM - 01:40 PM Establish — Diana 2-7-20 — Next Appt 3-11-20
(yo M) 1-22-20 • mat • THC - 1889
#130903
DOB: 08/30/1962
PH: (313) 523-5365
INS : Molina Healthcare of MI (Medicaid Replacement - HMO) #0085970543
INS REF PROV: MALCOM, LATISHA 354/682/845 (>300)
3 WEEKS

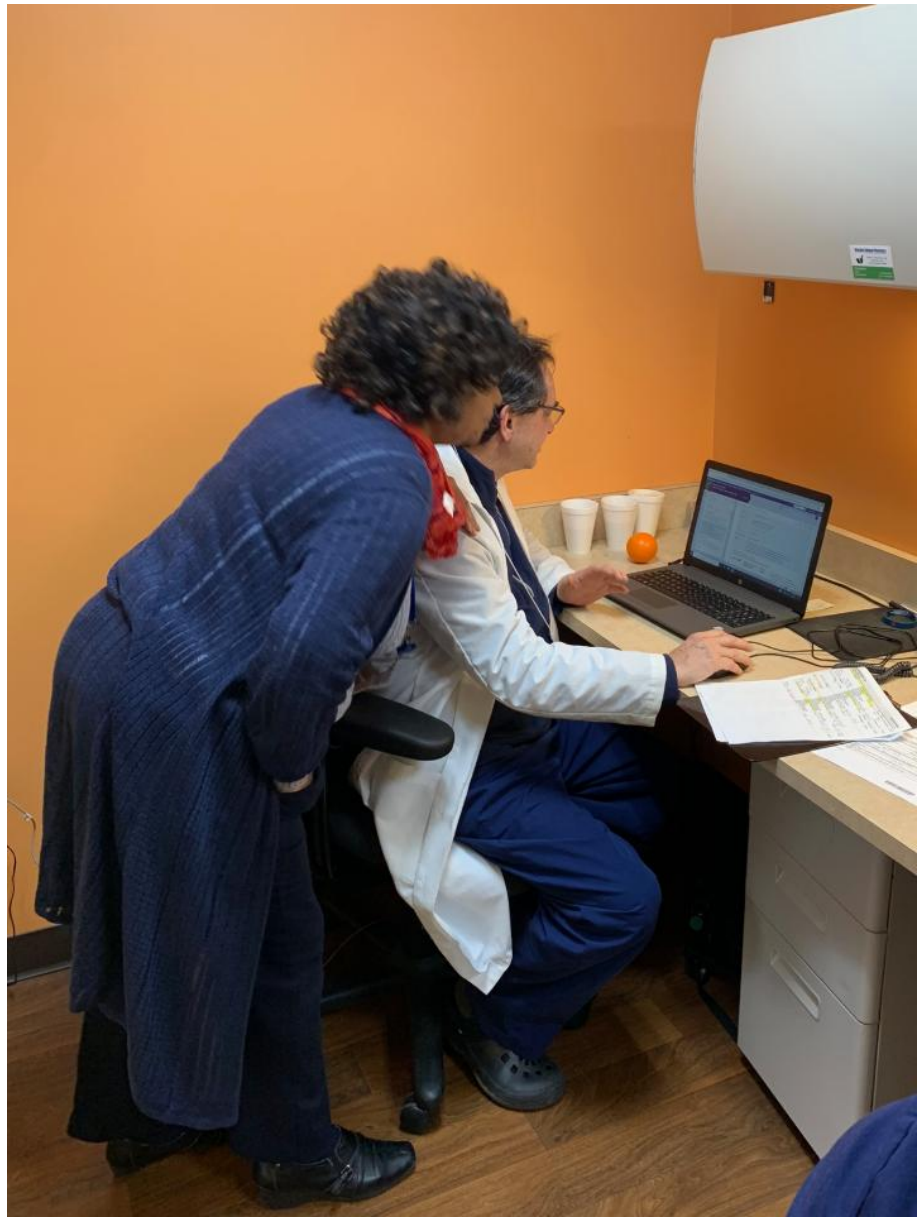
01:40 PM - 02:00 PM New Patient Appointment — Diana 12-11-19 — Not scheduled — No show! 1-17-20 — Next Appt 3-13-20
(37yo M) 2-5-20 • Mat Gabapentin - 70422
#137007
DOB: 05/17/1982
PH: (313) 310-0323
INS : Total Health Care (HMO) #10146534
INS REF PROV: MALCOM, LATISHA 96/745/162

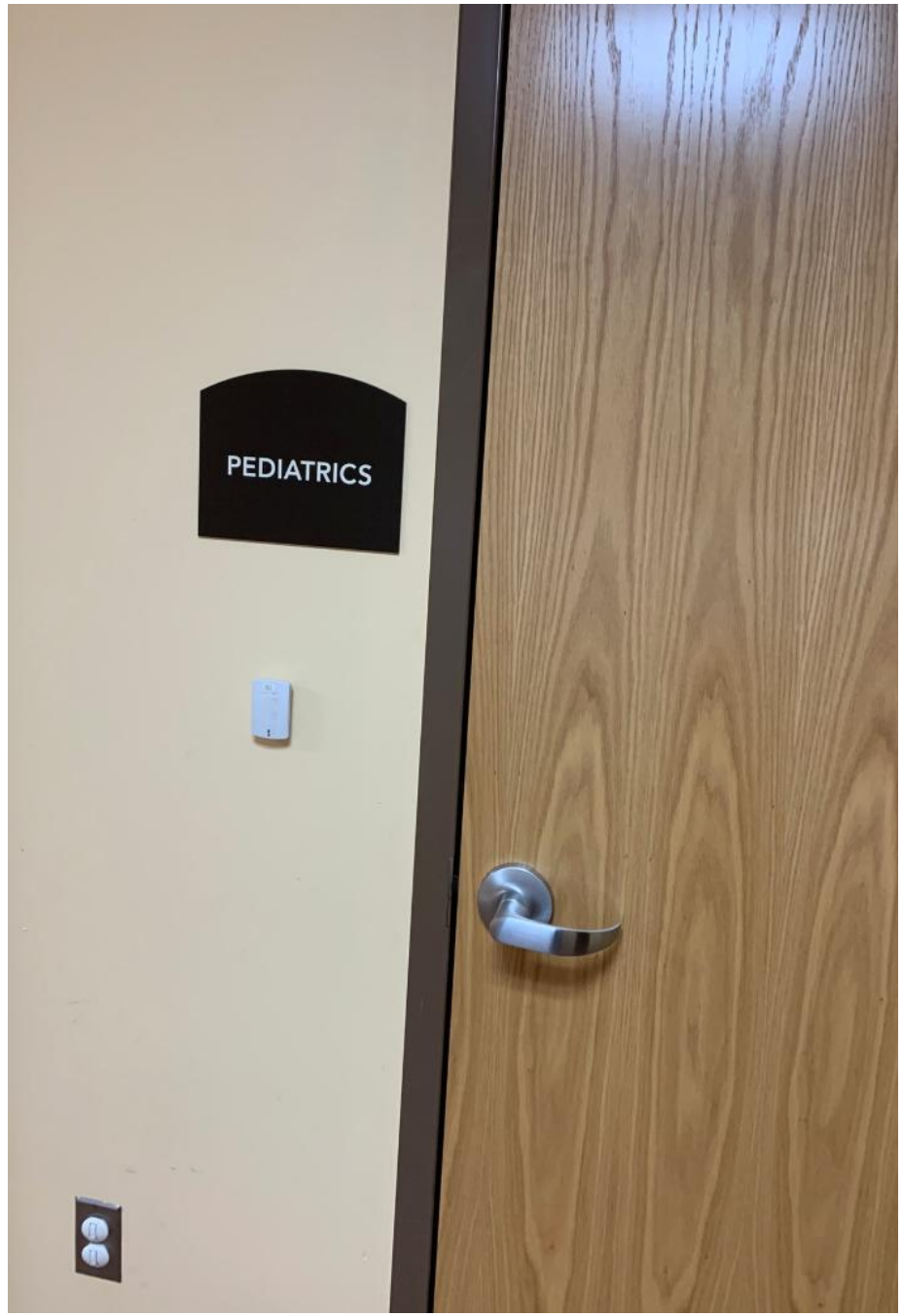
02:00 PM - 02:20 PM Establish — No Show! — Next Appt 3-4-20
(20yo M) #295620 2-19-20 • med refills
DOB: 10/01/1990
PH: (734) 686-9411
INS : Molina Healthcare of MI (Medicaid Replacement - HMO) #0071811868
INS REF PROV: IVIE, CHERYL 1156/>2000/>2000 (243)
Gabapentin - 2957

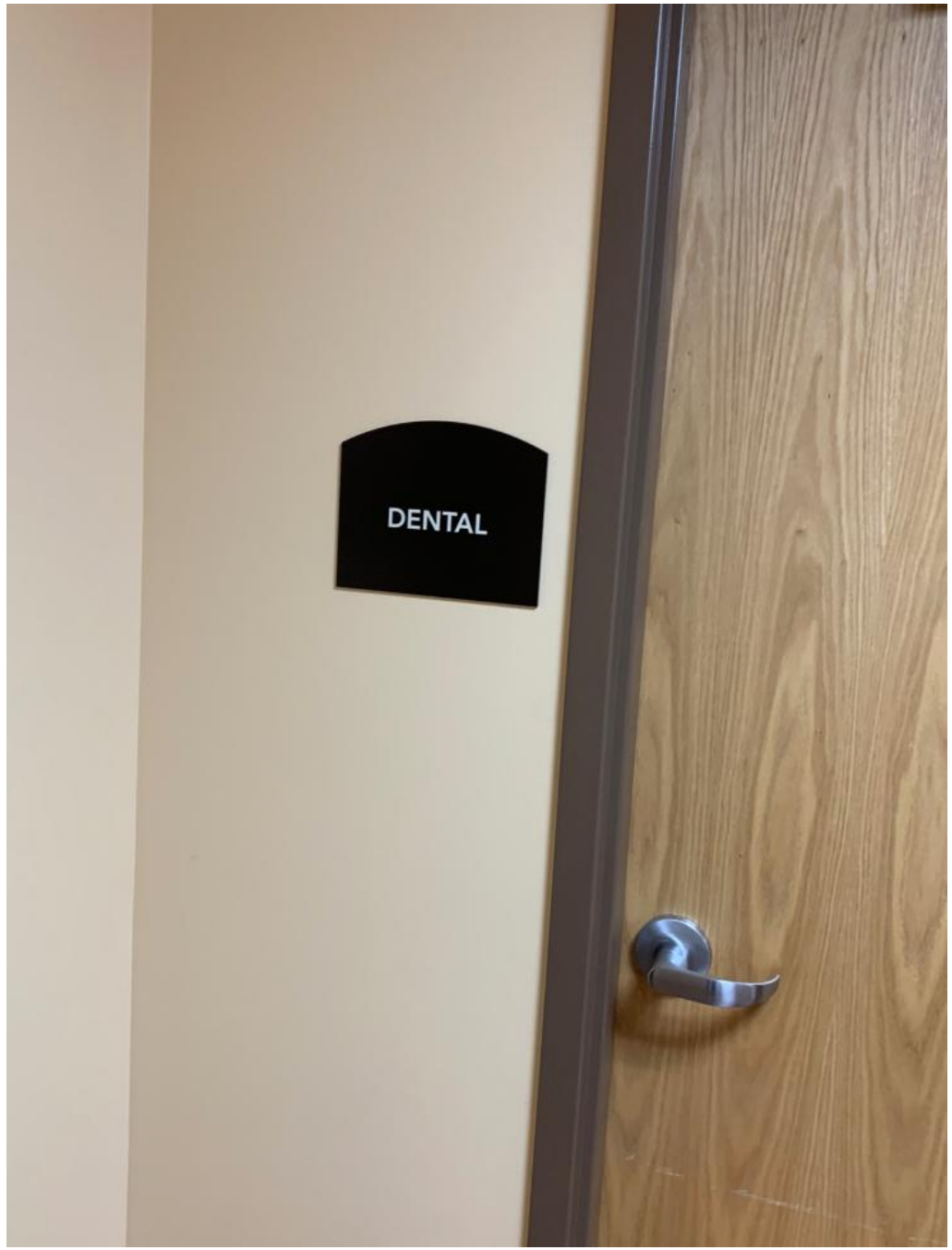
(32yo M)
#140597
DOB: 07/16/1987
PH: (734) 266-0637
INS : Medicaid-MI - Institutional (Medicaid) #0025045419
INS REF PROV: LESZKOWITZ, DAVID
• new mat- restart
• new mat
• new mat

02:20 PM - 02:40 PM Establish — Next Appt 3-4-20
(41yo F) #120873 2-5-20 • mAT
DOB: 09/05/1978
PH: (313) 778-4326
INS : Molina Healthcare of MI (Medicaid Replacement - HMO) #0034432130
INS REF PROV: IVIE, CHERYL 1083/>2000/>2000 (241.4)
Amphetamines - 12860
methamphetamine 1176

02:40 PM - 03:00 PM Establish — Next Appt 3-9-20
(39yo F)
#127862
DOB: 03/05/1980
PH: (734) 595-1020
INS : BCBS-MI Blue Cross Complete (Medicaid Replacement - HMO) #XYU993099775
• Restart for Anibuse: MDOC




PEDIATRICS

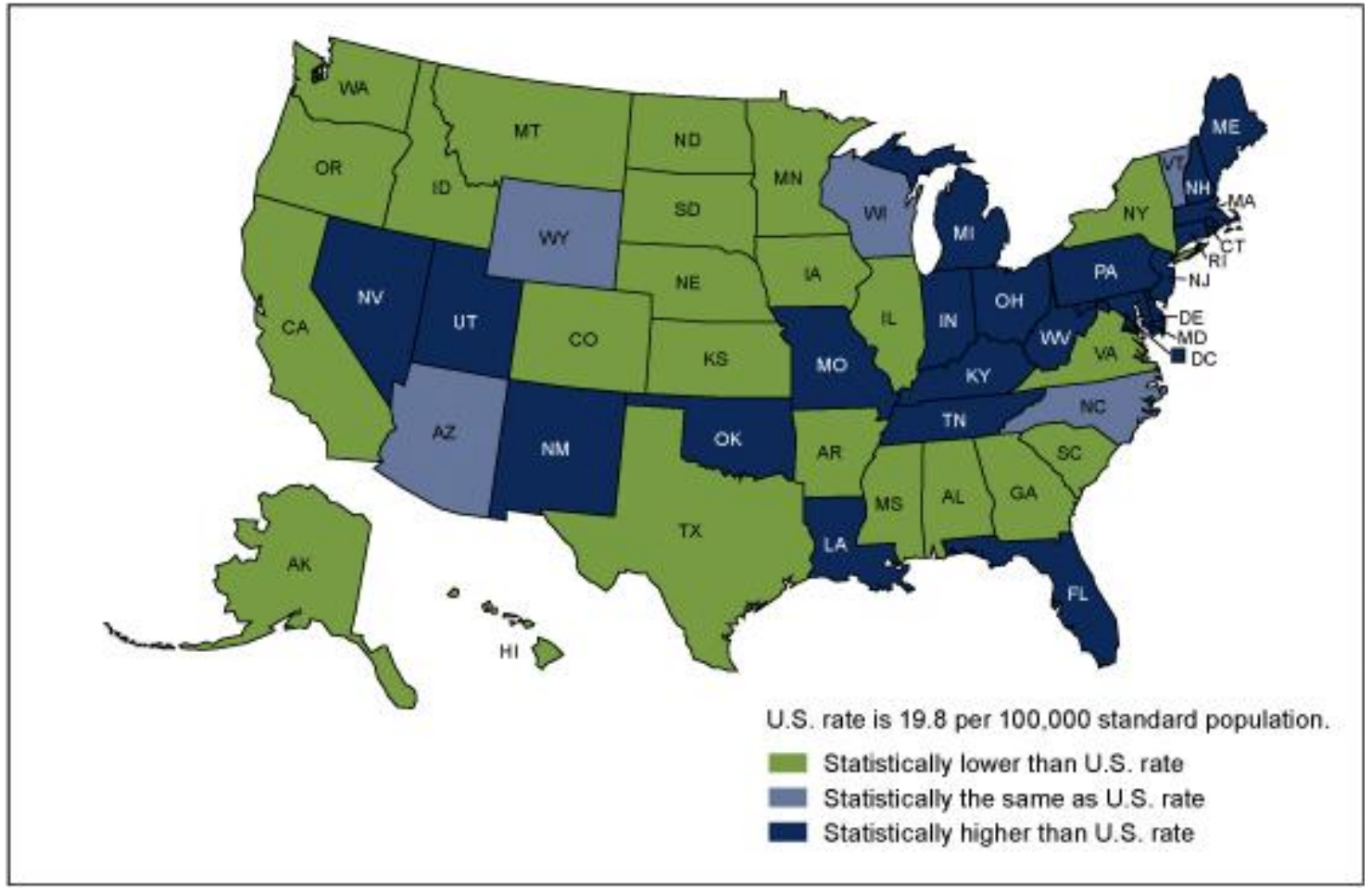

DENTAL

Lethal Dose

Morphine = 1X
Fentanyl = 100X
Carfentanil = 10,000X

Lethal doses of heroin compared to "synthetic" opioids.
New Hampshire State Police Forensic Lab

Drug Overdose Deaths - 2016



Hedegaard et al. Drug Overdose Deaths in the United States, 1999-2016. NCHS Data Brief No. 294. December 2017.

Addiction

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

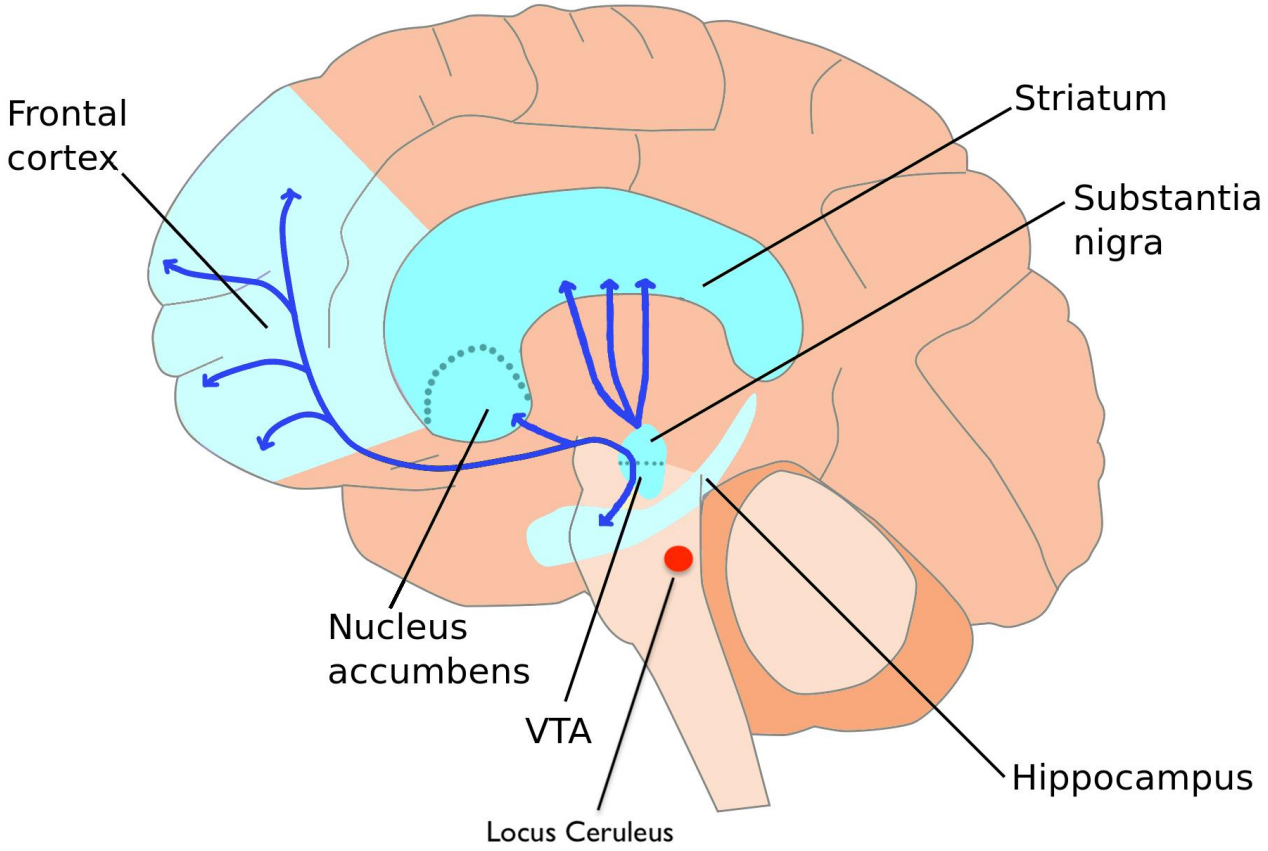
American Society of Addiction Medicine (ASAM). 2011

Opioid Neurobiology and Pharmacology

Opium poppy Plants

Reward/Reinforcement Pathway

- Reward/reinforcement is in part controlled by μ-receptors in the
- Reward pathway:
  - Ventral Tegmental Area (VTA)
  - Nucleus Accumbens with projections to Prefrontal Cortex
  - Dopaminergic system

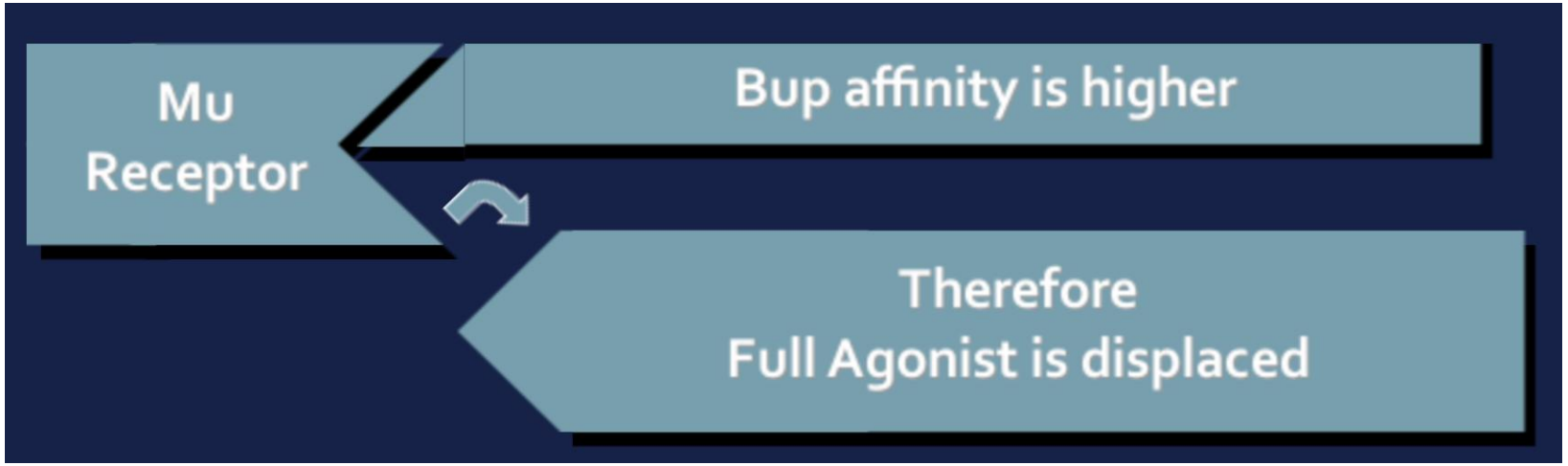


Opioid Tolerance & Physical Dependence

- Both tolerance and physical dependence are physiological adaptations to chronic opioid exposure
- **Tolerance** 
  - Increased dosage needed to produce specific effect. Develops readily for CNS and respiratory depression
- **Physical Dependence** 
  - Sings and symptoms of withdrawal by abrupt opioid cessation, rapid dose reduction, administration of antagonist e.g., Narcan (Naloxone)

Receptor Affinity

- Affinity is the strength with which a drug physically binds to a receptor
  - Buprenorphine's affinity is very strong and it will displace full agonists like heroin and methadone
  - Note: receptor binding strength (strong or weak), is NOT the same as receptor activation (agonist or antagonist)



Medication Comparison

	Methadone	Buprenorphine	ER Naltrexone
Pharmacology	Full agonist	Partial agonist	Full antagonist
Dosing	Daily (but duration often longer)	Daily	*q4wks*
Setting	Specialty licensed OTP	Office-based or OTP, requires "X" waiver	Any medical setting, requires injection
Induction	No time restriction; start low, go slow	Mild-mod withdrawal: > 8-12 hrs after last opioid	>7 days after last opioid
Adherence	Intrinsically reinforcing	Intrinsically reinforcing	Long acting

COVID 19

- Starting and continuing addiction therapy during COVID

RED FLAGS

- Strong preference for specific drug
- Multiple “allergies”
- Multiple Prescribers/Pharmacies
- Frequent visits to the ED
- “Eating”, injecting or snorting meds
- Refusing drug screen

MISUSE

Assessment Overview

- Establish diagnosis of opioid use disorder and current opioid use history
- Identify comorbid medical and psychiatric conditions; how, when, where they will be addressed
- Screen for and address communicable diseases
- Evaluate level of physical, psychological and social functioning or impairment
- Determine patient’s readiness to participate in treatment

Physical Examination

During a standard physical examination, pay attention to:

- Stigmata of injection drug use, e.g., needle tracks, skin and soft tissue infections
- Stigmata of chronic infections, e.g., HIV, hepatitis C
- Neurocognitive function
- Liver disease and dysfunction

Laboratory Evaluation

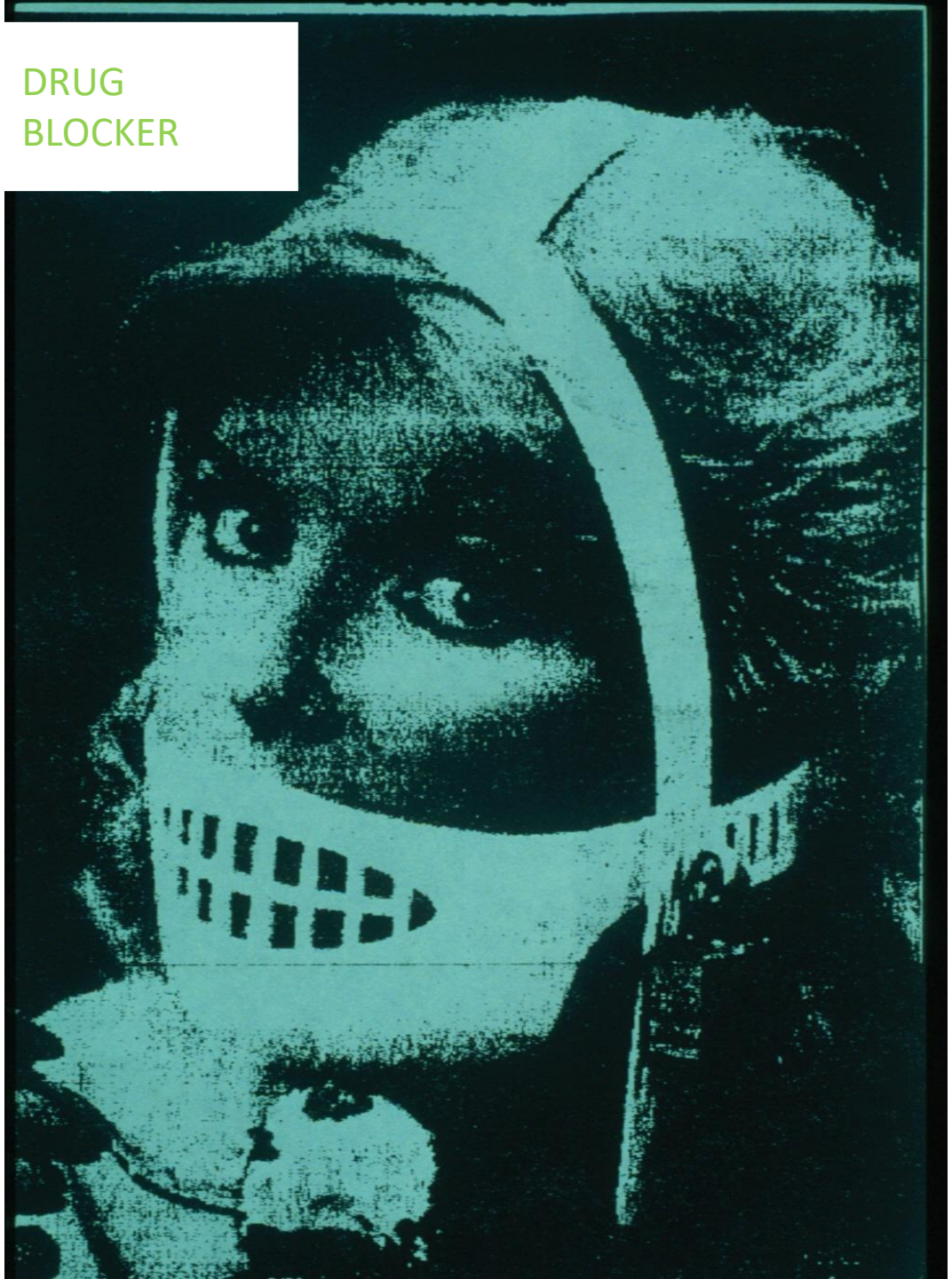
- Liver function tests
- Hepatitis and HIV serologies
- Pregnancy test for women
- Urine drug testing
  - Naturally occurring opiates (morphine, codeine)
  - Synthetic and semisynthetic opioids (methadone, oxycodone)
  - Other commonly used drugs (cocaine, amphetamines, benzodiazepines)

Are you ready to treat your patient?

- Are there resources available in the office to provide appropriate treatment? Medical or psychiatric care?
- On-call coverage?
- Are there treatment programs available that will accept referral for more intensive levels of service if needed?
- Words of wisdom
  - Don’t start with the most complicated
  - Start with 1, not 30
  - Know your limits
  - Don’t be afraid to consult and refer

HARM

DRUG
BLOCKER



Why use medications? Because they work….

- 80-89% relapse to drug use without medication assisted treatment (MAT)
- Increased treatment retention
- 80% decreases in drug use and crime
- 70% decrease all cause death rate

NIH Consensus Statement et al. *JAMA.* 1998.

Medication Assisted Treatment (MAT)

- "**All** Treatments Work for **Some** People/Patients."

- No One Treatment Works for **All** People/Patients."

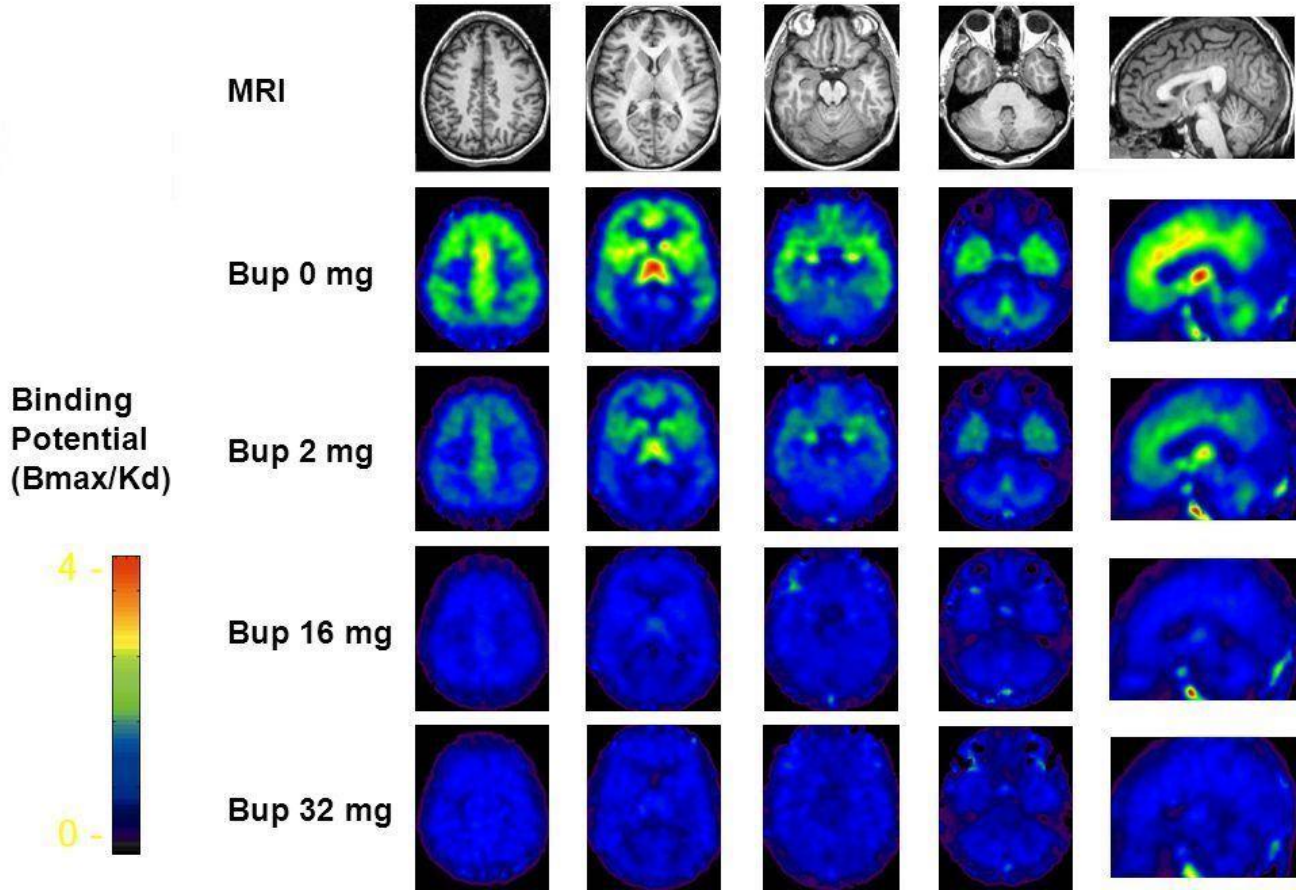
Alan I. Leshner Ph.D

Former Director NIDA

Medication Assisted Treatment (MAT)

- Goals
  - Alleviate signs/symptoms of physical withdrawal
  - Opioid receptor blockade
  - Diminish and alleviate drug craving
  - Normalize and stabilize perturbed brain neurochemistry
- Options
  - Opioid antagonist
    - Naltrexone (full opioid antagonist)
  - Opioid agonist
    - Methadone (full opioid agonist)
    - Buprenorphine (partial opioid agonist)

Effects of Buprenorphine Dose on mu opioid receptor availability in subjects



Zubieta et al. *Neuropsychopharmacology.* 2000; 23:326-334.

Legislation

Drug Addiction Treatment Act (DATA) of 2000

- Signed by President Clinton in October 2000
- Allows prescription of an opioid to an opioid addicted person for the treatment of addiction, with certain restrictions.
- Prior to this Act, only licensed methadone treatment programs

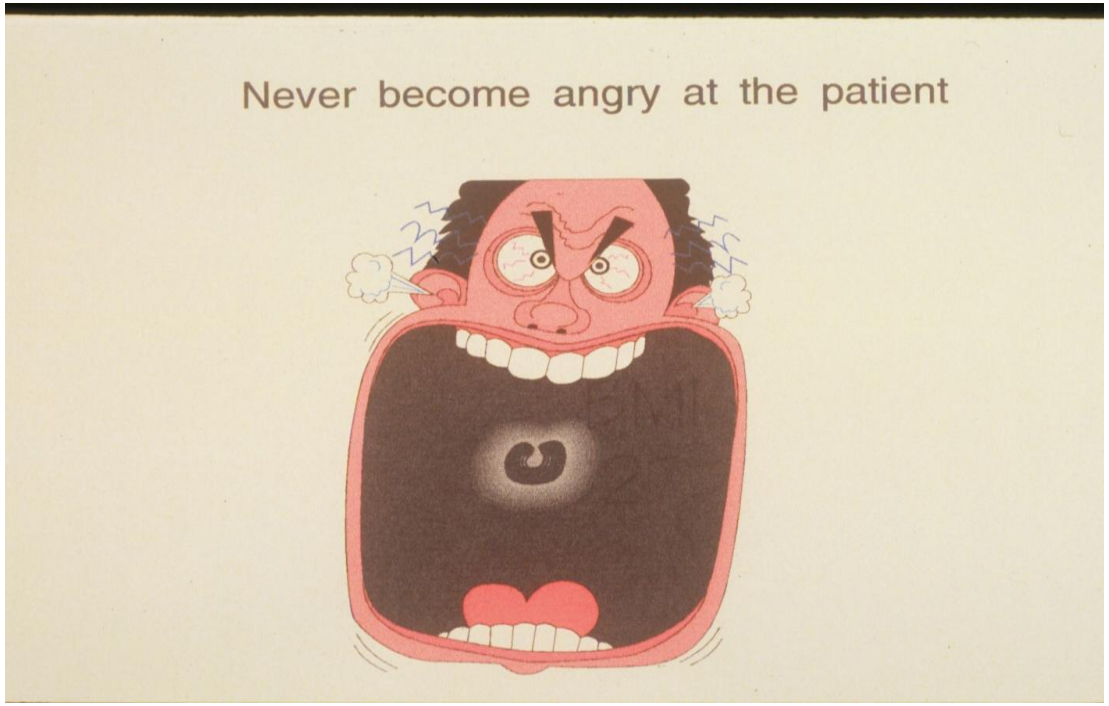
DATA 2000, obtaining Buprenorphine waiver

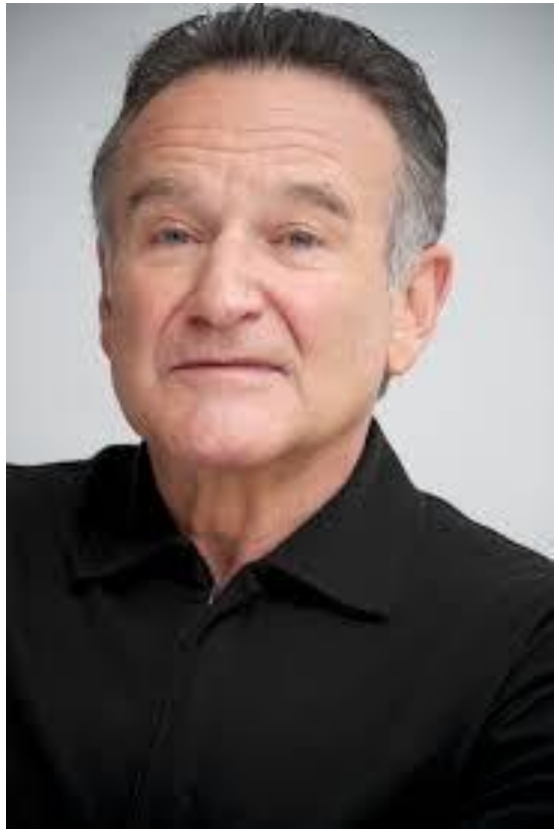
- MD/DO must have 8 hours of training in opioid by AMA, AAAP, ASAM, AOA, APA
- PA/NP must complete an additional 16 hours of training
- Providers must submit notification to Secretary of HHS of intent to prescribe and obtain a new DEA number. The regular DEA is retained for other scheduled substances. The new “X” DEA is used only for buprenorphine prescriptions.

WHIZZINATOR

Never judge, takes all those that comes before you!

- Never become angry at the patient
- Offer easier goals if necessary
- Praise even with moderate improvement
- Manage the patient’s entire care
- Encourage support groups and material
- Encourage the use of different tools





Robin William 1951 - 2014

Seymour Hoffman 1967 - 2014

Questions?