Project REMOTE

- Rural Enhanced Model for Opioid Treatment Expansion
- Department of Behavioral Health and Developmental Services (Through SAMHSA)
- PD1 – Frontier Health, Dickenson County Behavioral Health, and Cumberland Mountain Community Services Board

Street Value

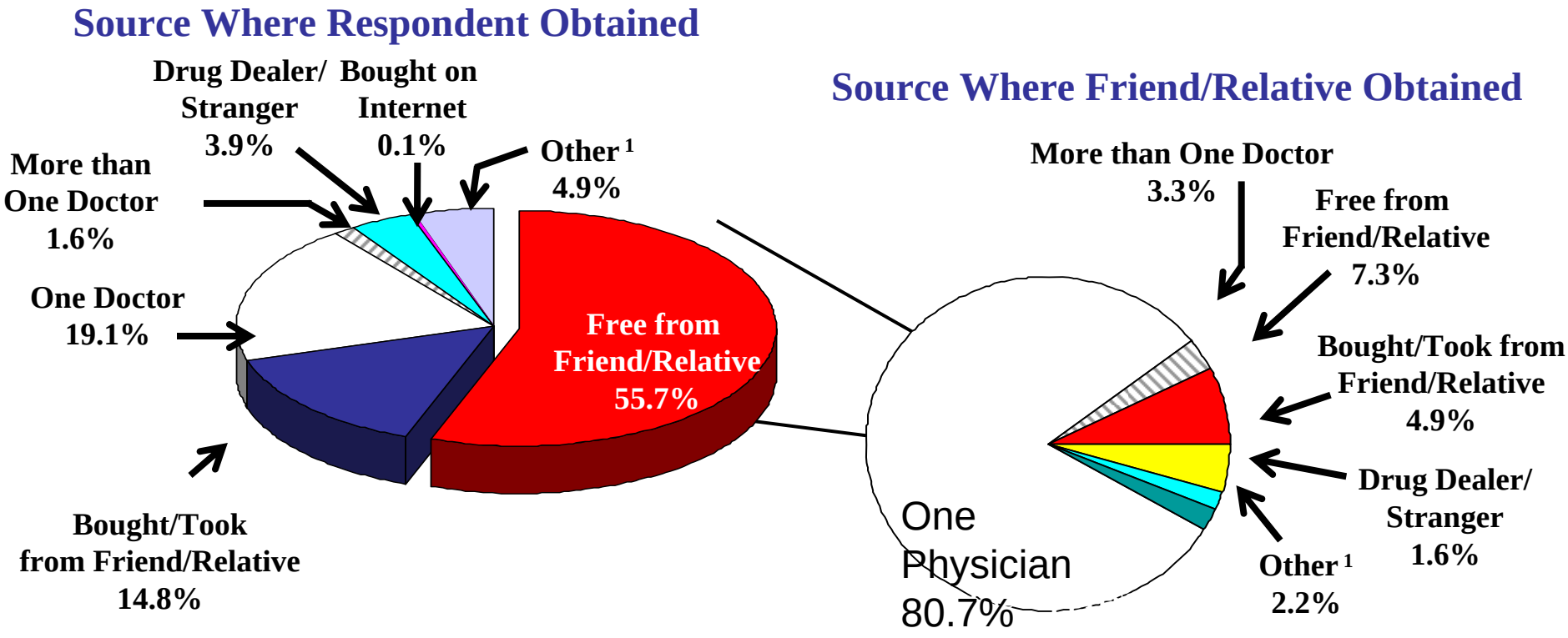
- 100 Vicodin $500-$800
- 100 Xanax 2mg $1,000
- 4 Fentanyl patches 100ug $400
- 100 Dilaudid 8mg $4-8,000
- 100 Oxycontin 80mg $8-16,000
- Methadone 1$ per milligram

* Beard, J Tobias, “Coke is the Real Thing; Fifty bucks and you’re in with Charlottesville’s favorite powder”, C’VILLE CHARLOTTESVILLE NEWS & ARTS, 2/11/2008

Non-controlled substances with street value

- Muscle Relaxants
- Remeron
- HIV medications
- Prednisone

Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2006



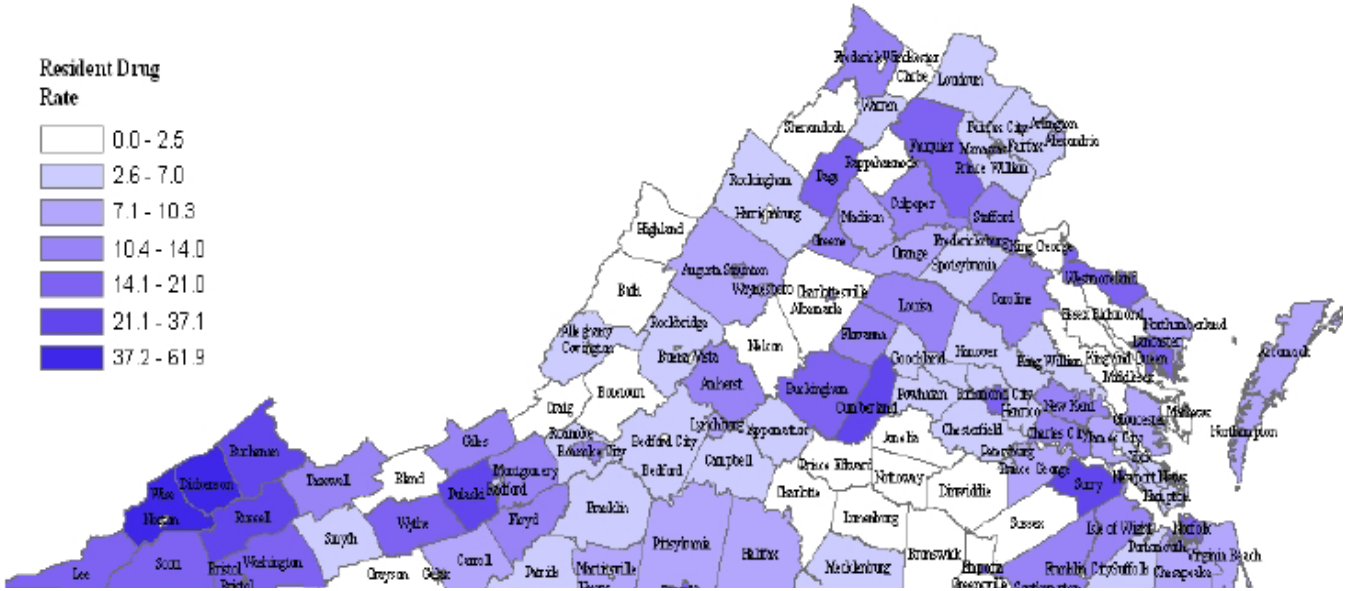
- Epidemiology- we have a staggering epidemic of prescription substance misuse
- Lethality- many people are dying due to substance abuse
- Cost- the price of substance misuse is a major contributor to the national debt
- Legality- prescribers are being scrutinized regarding their prescribing practices
- Pain continues to be poorly managed
- Prescriber Burn-Out

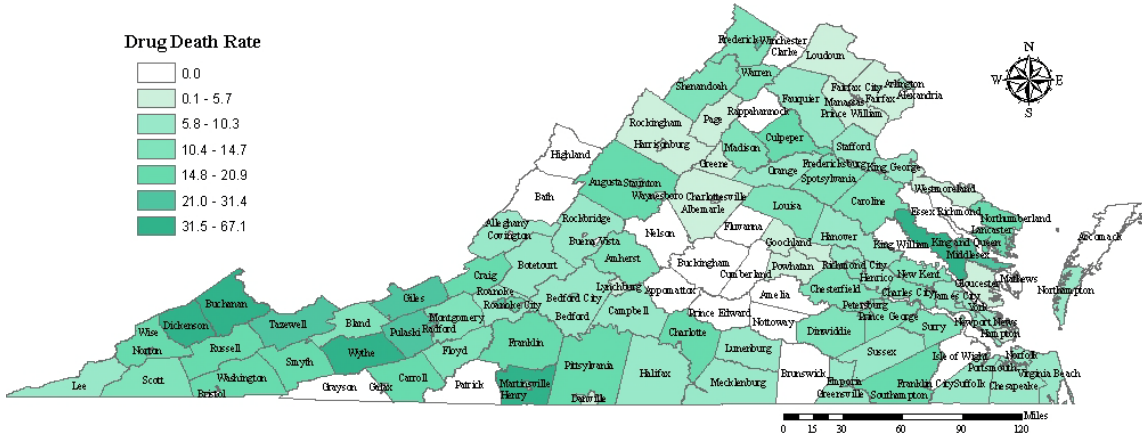
Epidemiology

- While there are more opioid deaths in SW Virginia, no part of the state is immune to the Substance Abuse Epidemic
  - Equal amounts of abuse throughout the state
  - More lethal substances being used in SW Virginia

Drug Death Rates by County
Taken From Virginia Medical Examiner's Office

Figure 81. Drug/Poison Caused Death Rates by City/County of Residence, 2007





Lethality

- In 2006, 12.5/100,000 Virginians died in MVAs*
- In 2007, 11.3/100,000 Virginians aged 35-54 died due to drug poisoning (most polypharmacy deaths involving opioids)**
- opioid dependent patients 13x more likely to die than their age- and sex- matched peers in the general population***
- “Among people age 35 to 54 years old, unintentional poisoning surpassed motor vehicle crashes as the leading cause of death in 2005”****

*Kaiser State Health Facts http://www.statehealthfacts.org/profileind.jsp?cat=2&sub=35&rgn=48
**DAWN https://dawninfo.samhsa.gov/files/ME2007/ME_07_state.pdf
*** Gibson A, Degenhardt L, Mattick RP, et al. (2008). Exposure to opioid maintenance treatment reduces long-term mortality
****Reuters, “Prescription Drug Overdoses on the Rise in U.S.” Tuesday, April 06, 2010, Associated Press FOX News Network

Cost

- Treated and untreated substance use including ETOH: 62 Billion dollars in 2008 for healthcare alone (more in crime and welfare costs)*
- Audit of five large states 2006-7 found 65,000 Medicaid recipients improperly obtained potentially addictive drugs- $65 million dollars**
- 938,586 urine drug screens from over 500,000 patients prescribed chronic opiates showed only 25% taking their medications as directed***

8Chalk, Mady, “Medical Costs of Unrecognized, Untreated substance Dependence: A Case for Health Reform”, Behavioral Health Central, 2009

**Kiely, Kathy, “GAO report: Millions in fraud, drug abuse clogs Medicaid, 2009. http://www.usatoday.com/news/health/2009-09-29-Medicaid-drug-abuse-fraud.htm

***Leider, Couto, Population Health Management 9/3/2009

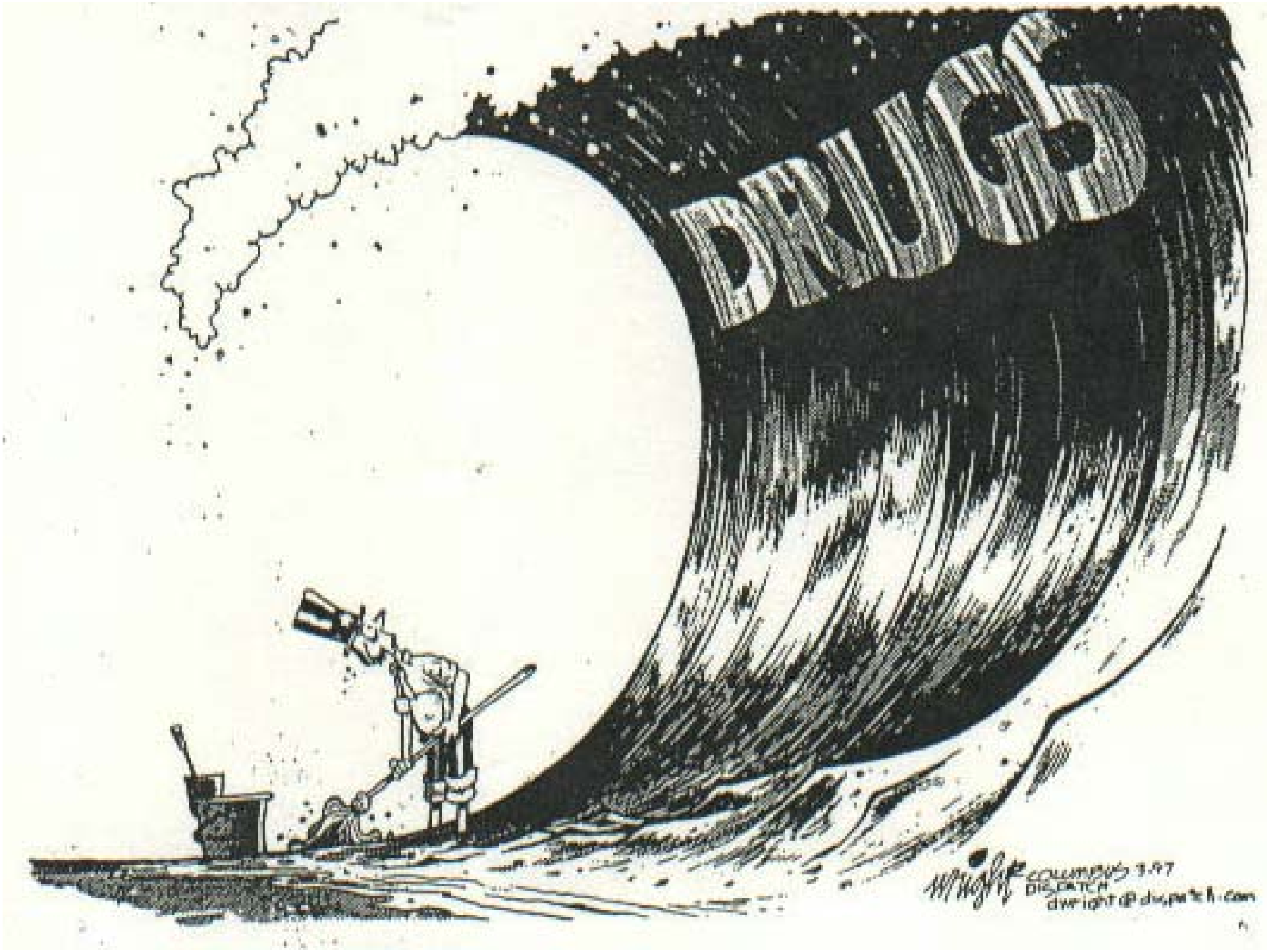
The Economics of active substance misuse

- ***Hundreds*** of dollars per day ($3000-4000/month, $200-300 per day)
  - However, cessation of use often means cessation of money making activities associated with use
- Crime
- Disease transmission
- Disability
- Lack of productivity
- Death

Economics of active substance use con't

(the myth of "self-medication")

- Misdiagnoses
  - DSM: ***NO MAJOR MENTAL ILLNESS CAN BE DIAGNOSED UNTIL A PATIENT HAS BEEN SUBSTANCE FREE FOR AT LEAST SIX MONTHS***
  - Example:
    - Patient admitted for BAD mania
    - No UDS done, no questions asked
    - Using Methamphetamine
    - Cost of admission ???
    - Likely to be readmitted for same thing


DRUGS
COLUMBUS DISPATCH
dwright@dispatch.com

PILL MILLS AND THEIR PROVIDERS

- Patients pay money for the prescribing of controlled substances instead of responsible medical care
- Includes controlled medications for pain, addiction, ADHD, anxiety, etc.
- Very hard to prove- what is the standard of care?
- Cross State Lines- hard to regulate
- Undermines good pain management and addiction treatment
- LUCRATIVE

THE GOOD NEWS

- Substance Abuse and Diversion are preventable
- Addiction is treatable
- Health Care Reform includes measures to address the Addiction epidemic

OUR COMMUNITY…OUR RESPONSIBILITY

Appalachian Substance Abuse Coalition for Prevention & Treatment

TREATING ADDICTION

- THE MAINSTAY OF ADDICTION TREATMENT IS ABSTINENCE COUNSELING
- 12 STEP PROGRAMS ***ARE*** EFFECTIVE AND COST EFFECTIVE
  - FREE
  - WIDELY AVAILABLE
- MEDICATIONS AS ADJUNCT

New Initiatives- Buprenorphine

- 2000 Drug Addiction Treatment Act
  - Exemptions for ***office-based*** opioid agonist treatment
    - DEA Waivered Physicians
      - Special training
      - Special license
    - Buprenorphine
      - Limited # of patients
    - MUST ensure counseling

What to Look For in a Suboxone Provider (or a MMT Program?):

- Follows the Universal Precautions for ALL controlled substance prescribing
- Communicates freely with the court system
- Works as part of a team to devise a treatment plan for the patient/client
- Sets good limits
- Result oriented, not process oriented
- Follows TIPS

Abuse of Suboxone

- Is it REALLY Suboxone being abused???
- SL buprenorphine formulations have a low rate of abuse based on toxico-surveillance data, Smith MY, ABUSE OF BUPRENORPHINE IN THE UNITED STATES:2003-2005, Journal of Addictive Diseases Vol 26 Issue 3, 1055-0887

Abuse of Suboxone con’t

- Increase in abuse, then decrease
  - “the poly-substance-abusing population, for whom buprenorphine is intended, experimented with this medication for its mood-altering effects for a period of time, but presumable because of its lack of euphorogenic properties, its use has now dissipated.” Cicero TJ, Surratt HL, Inciardi J, USE AND MISUSE OF BUPRENORPHINE IN THE MANAGEMENT OF OPIOID ADDICTION, Journal of Opioid Management 2007 Nov-Dec;3(6):302-8

Abuse of Suboxone con’t

- So, if it isn’t a “good buzz”, why is Suboxone on the street?
  - Avoiding withdrawal until the good stuff comes in
  - Stockpiling for dry spells
  - Enables short periods of good functioning
  - Self-treatment of Addiction
- The same reasons most methadone is on the street

Treatment and REMOTE

TREATMENT EFFECTIVENESS

The California Drug and Alcohol Treatment Assessment (CALDATA) Findings on the Effectiveness of Treatment (1994)[i]

- Health care findings included one-third reductions in hospitalizations after treatment
- Criminal activity declined by two-thirds after treatment
- Alcohol and drug use declined by two-fifths after treatment
- Improved employment and economic situations
- Treatment effective for a variety of substances including stimulants (crack cocaine, powdered cocaine, methamphetamines), ETOH, heroin
- No difference in gender, age or ethnicity
- Benefits to taxpayers persisted through 2nd year of follow-up
- Most financial benefits gleaned through reduction in crime

Con't

- Cost-benefits ratio: the benefits of alcohol and other drug treatment outweighed the costs of treatment by ratios from 4:1 to greater than 12:1, depending on the type of treatment.

New York City sees 70% drop in homicides, "New York also turned aggressively to drug treatment and mental health counseling"

[ii]

[i] Gerstein DR, Johnson RA, Larison CL, "Alcohol and other Drug treatment for Parents and Welfare Recipients: Outcomes, Costs and Benefits", USDHHS HHS-100-95-0036, ttp://aspe.hhs.gov/hsp/caldrug/calfin97.htm#Table%20of%20Contents

[ii] Michael Powell, Washington Post Staff Writer,Friday, November 24, 2006; Page A03

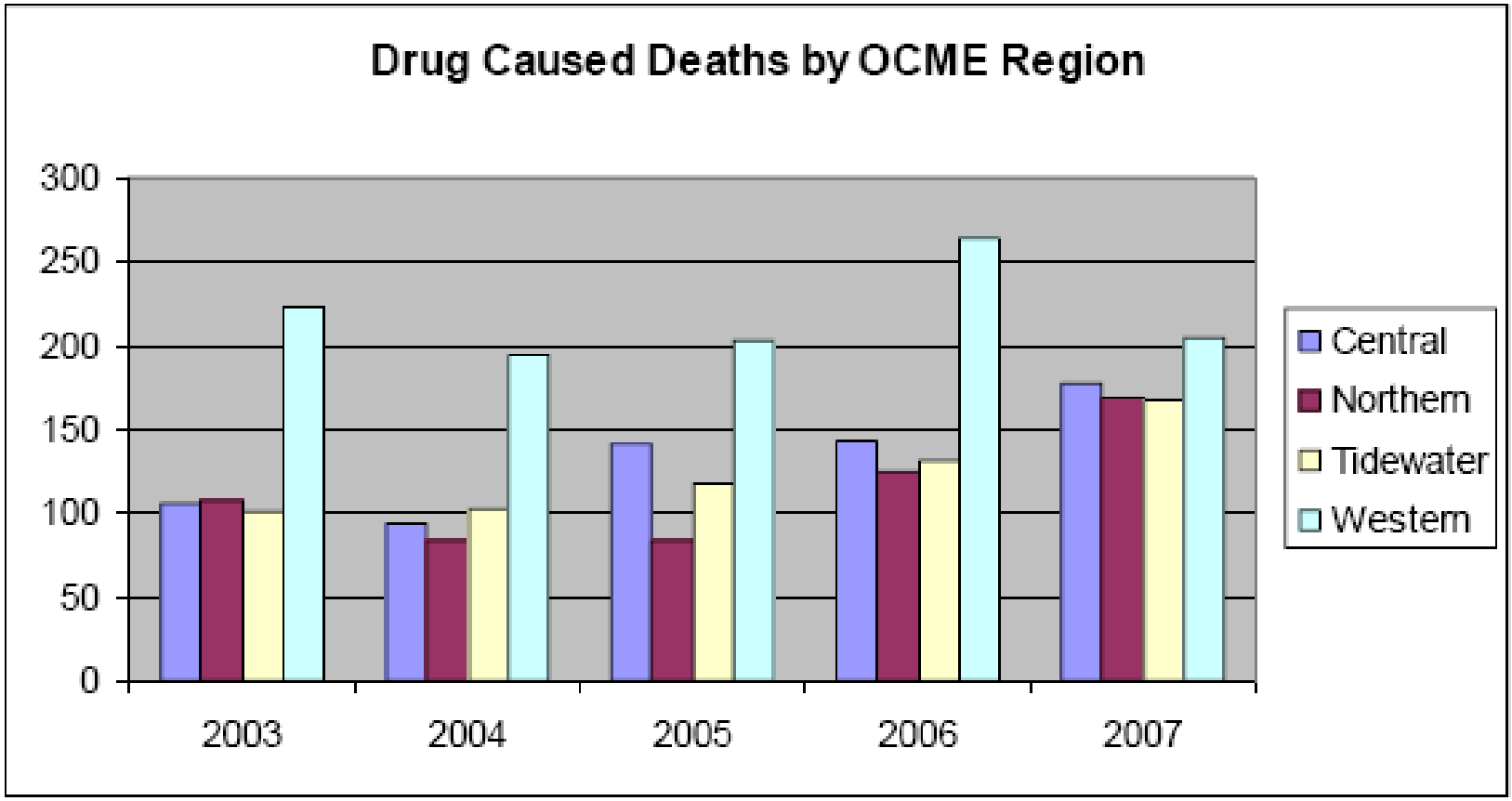
RURAL ENHANCED MODEL FOR OPIOID TREATMENT EXPANSION

- Buchanan, Dickenson, Lee, Russell, Scott, Tazewell, Wise counties, City of Norton
- Improve availability of treatment for addiction and substance abuse
- Recruit and train physicians in addiction medicine
- Increase detoxification services
- Increase outpatient counseling services

Con’t

- Expand peer support and family support groups
- Increase recovery support services to sustain the positive effects of treatment, prevent relapse and facilitate re-entry to a higher level of service if relapse occurs
- Focused on treating persons addicted to opiates through abuse of prescription medications

Virginia SUD Epidemiology



OCME Annual Reports, 2003-2007

DBHDS
Virginia Department of Behavioral Health and Developmental Services

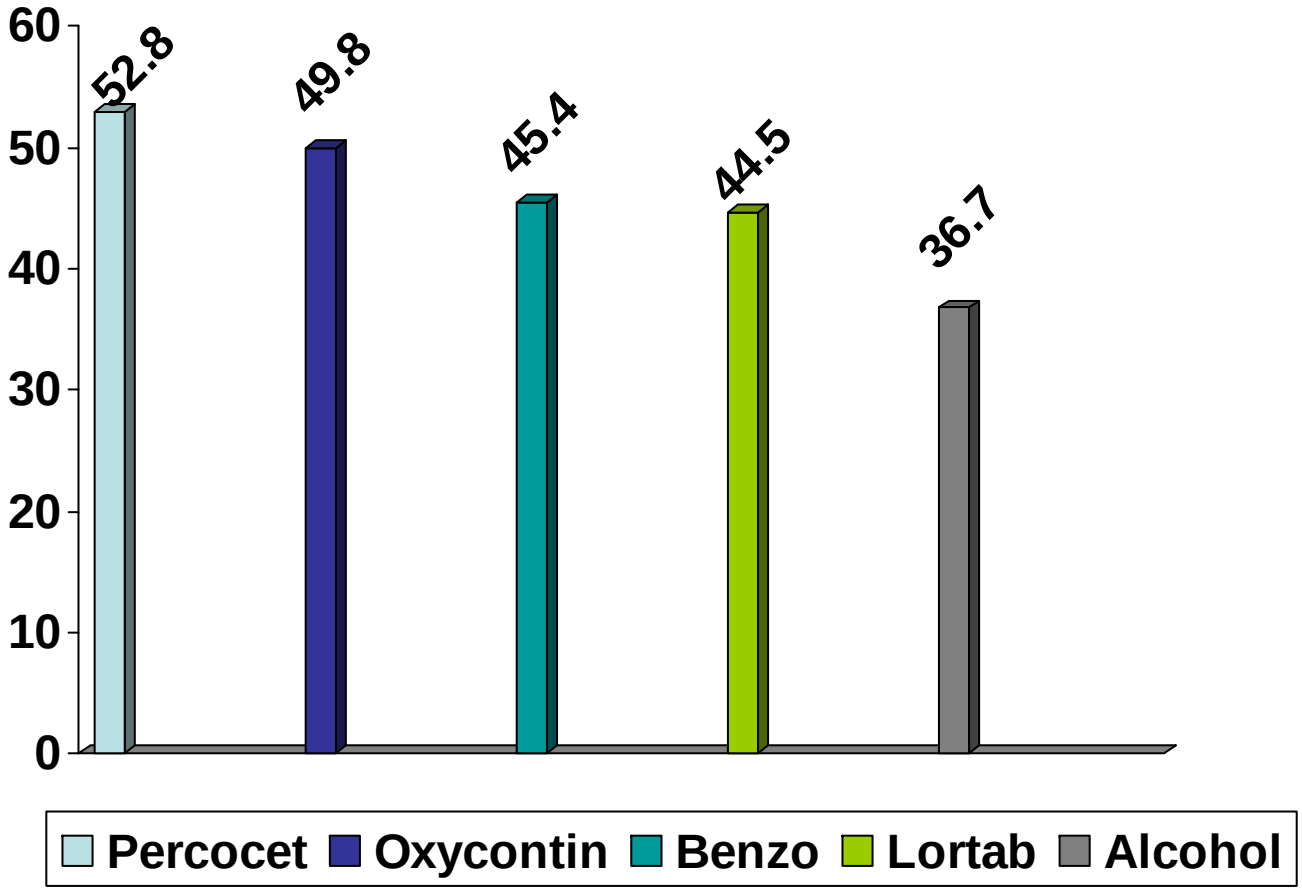
Funding

- SAMHSA Treatment Capacity Expansion grant TI17318 SJ318
- Delivered through publicly funded community service boards in SW VA
- Funded for three years, $500,000 each year 2007-2009
- NOT a research grant though it included stringent outcomes data collection

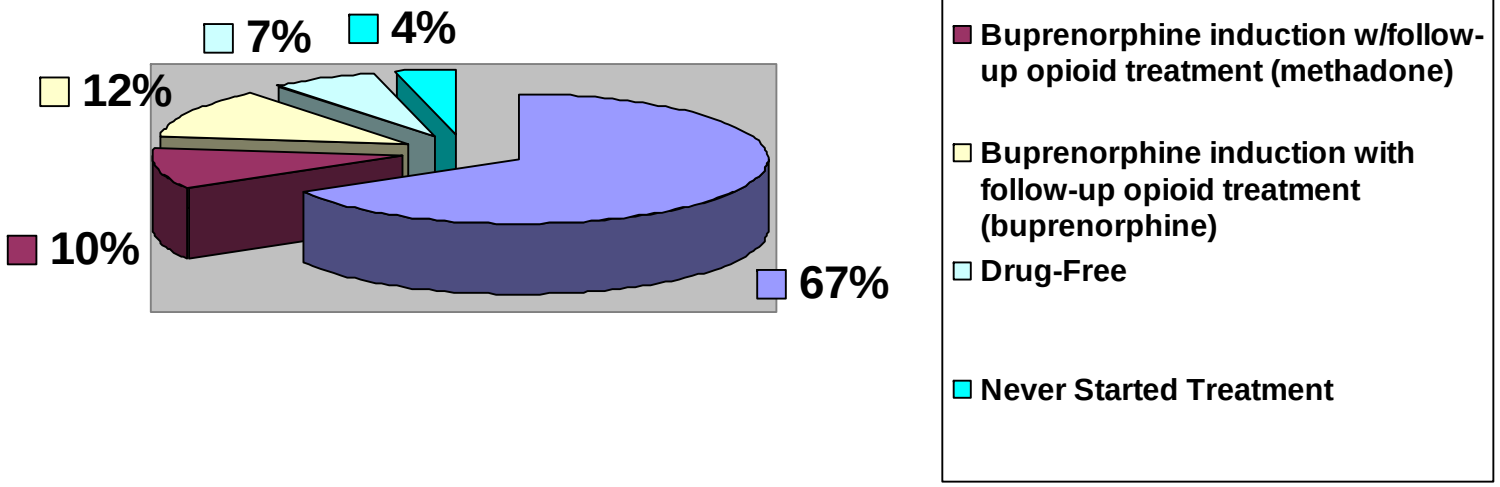
Funding con’t

- Participants paid half, if able
- Utilized Medicaid and private insurance when available
- Unit SAMHSA cost (including other payment options) $3,082

Project REMOTE
Drug Use Report on Intake
229 enrolled
Stats from intake GPRA



Project REMOTE
Treatment Referral Options



Project REMOTE
What services were provided?

- Treatment is not just about medication. It is about changing habits and lifestyles to support recovery.
- A complete continuum of services was available to participants:

  -Outpatient (Suboxone and evidence-based counseling practices) -3,430 hours

Project REMOTE
What services were provided? (continued)

-Case Management (transportation, coordination with physicians, help finding income supports)-3,513 hours

-Opioid Treatment Services (methadone and counseling): 408.75 hours

- Residential detoxification (includes Suboxone): 293 days

Did it Work?

- Goals
  - Increase availability of Addiction treatment
    - Suboxone
      - Increased # providers
  - Decrease deaths
  - Improve functioning among people receiving Suboxone

Increase in Suboxone Providers

- # physicians trained and licensed to provide suboxone treatment in REMOTE service area and “open to all comers”:13
- # physicians trained and licensed to provide suboxone treatment in Albermarle County/Charlottesville and “open to all comers”:1

- From zip code search Buprenorphine Physician Locator, SAMHSA ***and*** categorization by myself and Karen Smith, REMOTE coordinator.

Death Rates
Drug Deaths (actual):Drug Deaths/100,000

COUNTY	2005		2006		2007		2008	
Augusta	2	2.9	2	2.8	6	8.5	11	15.4
Buchanan	11	44.4	8	32.8	7	29.3	10	42.5
Dickenson*	6	36.9	8	49.4	10	61.9	11	67.1
Lee	8	33.8	5	21	4	17	2	8.5
Norton (city)	1	27.2	1	27.4	0	0	2	54.0
Russell	11	38	12	41.7	9	31.2	5	17.3
Scott			0	0	4	17.6	3	13.1
Tazewell		33.5	20	44.8	6	13.7	13	29.7
Wise	10	23.8	21	50.1	25	60	8	19.2

* Did not have a providing physician until last 6 months of the grant

From Annual reports, Virginia Office of the Chief Medical Examiner
http://www.vdh.virginia.gov/medExam/Reports.htm

Percentage Fentanyl, Hydrocodone, Methadone, Oxycodone Deaths

COUNTY 2008

- Augusta55%
- Buchanan70%
- Dickenson73%
- Lee100%
- Norton (city)50%
- Russell80%
- Scott 100%
- Wise63%

From Annual reports, Virginia Office of the Chief Medical Examiner http://www.vdh.virginia.gov/medExam/Reports.htm

Who was Served?

- Served 229 individuals in 3 years
- 46% male, 54% female
- 71% younger than 35
- All opiate dependent due to abuse of prescription pain medication

Project REMOTE
What was the impact of services?

- Decrease in injection drug abuse - 86%
- Increase in abstinence – 405%
- Increase in employment/educational activity – 65%
- Decrease in alcohol or illegal drug-related health, behavioral or social consequences – 138%
- Increase in permanent, stable housing- 15%
- Crime and Criminal Justice – 92.7% had no arrests in the past 30 days.

Project REMOTE
What was the impact of services? (continued)

- Increase in recovery support services in the community (AA/NA, Celebrate Recovery, Al-Anon, and faith based services)
- Increase in Treatment compliance
- Increase in compliance with Probation and Parole (paying fines, etc.)
- No suicides, overdoses or deaths by accident due to impairment while participants were enrolled in REMOTE
- No one involved in accidents or injuries due to impairment while enrolled in REMOTE

Project REMOTE
What made it work?

- Use of evidence-based practices, including:

  - Clinically appropriate medication-assisted treatment

  - Counseling using evidence-based approaches

  - Wrap-around services (case management to access other supports)

  - Involvement with Recovery Oriented Support Organizations such as AA/NA, Celebrate Recovery, Al-Anon and other faith based support systems

  - Strong community involvement (Appalachian Substance Abuse Coalition and other partners)

Project REMOTE
What made it work? (Continued)

- Heavy emphasis on community health professional education about addiction, pain management, use of the Prescription Monitoring Program
- Utilized resources of Recovery Oriented Support Community (i.e. AA/NA, Celebrate Recovery, Al-Anon, and faith based recovery support supports)
- Received referrals from Probation, Drug Court, and Department of Mines, Minerals, and Energy

Project REMOTE
What made it work? (Continued)

- Used Evidence Based Interventions
- Tailored for the community

Project REMOTE
What made it work? (Continued)

ADVISORY BOARD

- Legislators
- Coalfield Coalition
- Other treatment providers
- Local law enforcement and DEA
- Attorney General's Prescription Drug Task Force
- Physicians
- Pharmacists
- Medical Schools and health provider training programs
- Directors of local health departments and community health centers
- Educators
- Faith-based organizations
- Office of Substance Abuse Opioid Treatment Consultant and Pharmacist
- Mid-Atlantic ATTC
- Recovering residents of target communities

References

- All REMOTE data from Karen Smith, CMCSB, PO Box 810, Cedar Bluff, VA 24609, 276-964-6702, ksmith@cmcsb.com
- Anton et al, Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence, The COMBINE Study: A Randomized Controlled Trial, JAMA 2006;295:2003-2017
- Federation of State Medical Boards
  - Report of the Center for Substance Abuse Work Group
  - Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office

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- Heit HA; Dear DEA, Pain Medicine Vol 5 #3, 2004, 303-308
- Buprenorphine in the Treatment of Opioid Dependence, www.aaap.org

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