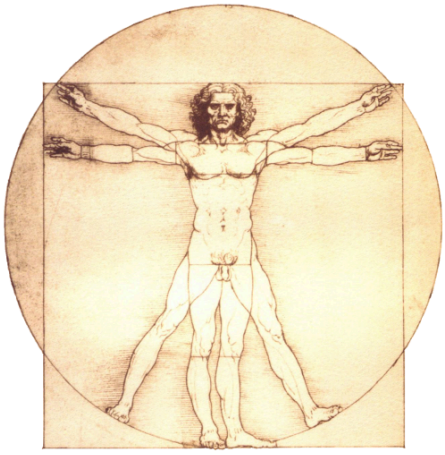
CITIZEN BRIEF:
Opioid Use Disorder
Best evidence for the effective diagnosis and treatment of individuals suffering with Opioid Use Disorders

Vision:
By September 2018 individuals suffering with Opioid Use Disorders are properly diagnosed at the earliest stage and have access to affordable, evidence based treatment.

The challenge: Currently, nearly 2 million people suffer with opioid use disorder, this includes individuals who are dependent on prescription opioids and more than half a million abuse or are dependent on heroin.



Goal:
To provide information, tools and resources to achieve the appropriate diagnosis for individuals suffering with opioid use disorder and to provide an approach to the care journey of the person with opioid dependence that is frictionless, behaviorally informed, simple and appropriate.

Background:
Addressing the needs of this population in of great need as they are at greater risk for relapse. Additionally, they can be involved in public awareness initiatives and may be more motivated to take part in efforts to address the substance use epidemic.

Opioid Use Disorder: Best evidence for the effective diagnosis and treatment of individuals suffering with Opioid Use Disorders (Google Doc)

Opioid Use Disorder Management: causes, evaluation, diagnosis and treatment **(Wix)**

Introduction to the science of addiction in general and opioid use disorder in particular
Best evidence for the effective diagnosis and treatment of individuals suffering with Opioid Use Disorders

Objective:

- To provide information, tools and resources to achieve the appropriate diagnosis for individuals suffering with opioid use disorder.

- To provide evidence based guidelines and tools for the assessment and treatment of opioid use disorders.
- Treatment of opioid dependence with opioid agonist maintenance treatment (also known as “opioid substitution treatment”) reduces opioid overdose risk by almost 90 per cent. We include:
- The approach to the diagnosis of the patient who suffers with opioid use disorder
- Providing optimal care and interventions to treat Opioid Use Disorders.
- To counter public misperceptions about treatment futility, emphasizes showing “hope on the other side” of addiction (http://bit.ly/1OiADRA).
- Promote the proven value of linking people to care through a continuum of services, including medication-assisted treatment (including buprenorphine, methadone, and naltrexone), counseling, and behavioral therapy.

Opioid Use Disorder: Diagnosis

Vision: Diagnosis of Opioid Use Disorder at the earliest stage.

General approach: On the personal level, the care journey of the person with opioid dependence must be frictionless, behaviorally informed, simple and appropriate.

Treatment: Effective treatment of prescription pain meds and related opioid use disorder

Goal: Individuals suffering with Opioid Use Disorders will not experience harm associated with their condition and have access to and will be able to afford evidence based treatment tailored to their need.

Stakeholders and Ecosystem
My Checklist

Opioid Use Disorder: Treatment

Opioid Use Disorder: Best evidence for the effective diagnosis and treatment of individuals suffering with Opioid Use Disorders (Google Doc)

Best practice in drug interventions (European Union)

Management of Substance Use Disorder (SUD) (2015) DOD /VA

The guideline describes the critical decision points in the Management of Substance Use Disorder and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients with substance use disorder.

Disclaimer:This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment.

Outpatient Care

- Medications
- Bio psychosocial
- Group,
- 12 step
- other

Inpatient treatment

- Access
- Quality
- Cost

Reducing the supply of non-medical opioids and preventing the initiation and misuse of nonmedical opioids.

- Medical prescriptions
- Clinician Education
- CME
- FDA
- Board

Medication check
Pharmacy
PBM (Clozaril like)
Multidisciplinary treatment for pain

- Heroin

Preventing and reducing harm associated with opioid use, including eliminating overdose mortality and morbidity associated with opioid use

IV needle exchange
Naloxone availability

Overdose prevention
Drug courts
Prisons
Hospitals and health facilities

The guideline is formatted as two algorithms and 36 evidence-based recommendations:
Module A- Screening and Treatment
Module B- Stabilization
Questions about the SUD Guideline

Background:

Opioid use disorder is a chronic disease that can be effectively treated but it requires ongoing management. Most individuals suffering with opioid use disorders do not benefit from the available treatments. Some choose not to get the proper treatment while others have difficulty accessing treatment. Failure to properly diagnose and choose the best treatment are a frequent barrier. It is well known that more resources need to be devoted to ensure availability of, and access to, evidence-based treatment. A public health-based approach to harmful drug use requires having both broad-based treatment services available for those with opioid use disorders, as well as MAT, and insurance coverage for such treatment. MAT is the use of medications, commonly in combination with counseling, behavioral therapies, and other recovery support services to provide a comprehensive approach to the treatment of opioid use disorders. Food and Drug Administration (FDA) approved medications used to treat opioid addiction include methadone, buprenorphine (alone or in combination with naloxone), and naltrexone. Types of behavioral therapies include individual therapy, group counseling, family behavioral therapy, motivational incentives, and other modalities. MAT has been shown to be highly effective in the treatment of opioid addiction. However, we are deeply concerned by the barriers faced by patients who need treatment and by physicians in finding and placing patients in addiction treatment and recovery programs. Many physicians regularly face this dilemma because there is inadequate capacity to refer patients for

treatment and recovery programs. There are too few physicians and programs offering treatment and recovery services. Physicians who are on the frontlines of this crisis, particularly those in primary care and emergency departments, continue to report challenges in making referrals to meet patient's' needs. As noted by the Washington Post in a front-page article focused specifically on the heroin epidemic, which was published on Sunday, October 4, 2015: Treatment centers are often prohibitively expensive, overcrowded, underfunded and subject to byzantine government rules. Health insurance coverage is stingy to nonexistent. And the social stigma of heroin addiction is still so potent that many users and their families are reluctant to seek help in the first place.

Many states do not offer a full range of MAT for patients in Medicaid programs, or subject Medicaid patients to various prior authorization requirements. Even if a state does cover MAT, some states impose limits on the length of time a patient may receive such treatment. And, despite parity rules for mental health and substance use disorders, some private insurance coverage also imposes limits on treatment, especially long-term coverage. Community-based programs are lacking, and mental health networks and pain or addiction specialists are nonexistent in many areas. In addition, legislative efforts designed to reduce supply or impose restrictions on treatment can make treating patients with a substance use disorder demonstrably more difficult for physicians. Making certain prescription drugs, including those used in MAT, less accessible, however, without policies and strategies to provide treatment and recovery, merely pushes patients out of treatment and toward illegal drugs, such as heroin, that have no legitimate medical use. If the ultimate goal is to provide comprehensive care to our patients and ensure we are doing everything we can as a profession and a society to stop addiction, overdose, and death, a far greater effort is needed to focus on the treatment and recovery side of this crisis.

These guidelines are intended to help healthcare providers improve patient outcomes when providing this treatment, including avoiding potential adverse outcomes associated with the use of opioids to treat pain. Long-term success requires substantially improving treatment capacity that has been chronically under resourced with respect to facilities and trained clinicians. The Affordable Care Act (2010) and the Mental Health Parity and Addiction Equity Act (2008) offer major opportunities to improve insurance coverage and treatment, but barriers for smooth implementation remain. Meanwhile, community-based coalitions, involving local schools, youth groups, law enforcement and faith-based organizations, among others, have heightened public education about the power of prevention.

- Crowd sourcing guidelines
- Engaging with with professional organizations
- Engaging with non profit professional organizations
- Providing transparent information about clinical issues
    - Patient resources for providers who specialize and are competent in addressing substance use disorder issues (County)
    - Resources for the patient and family

- Best practices for the treatment of Opioid Dependence and addiction, (National, Professional, Local)
- A strategy for disseminating such best practices.(Professional organizations)
- Access to best practice medical care
- Insurance coverage
- Treatment courts

Multi-disciplinary approach

Addiction treatment professionals

- Outpatients
- Inpatients

Special populations:

- Pregnant woman
- Teenagers
- Elderly
- Prison

Medication Assisted Treatment: Pharmacologic

- Naloxone
- Methadone
- Buprenorphine (Subaxone) Treatment Physician Locator

Peer support

Community resources (County)
Quality of care at rehabilitation facilities

Contact the governmental stakeholder

- Congressperson
- The Joint Commission
- State Board of Health
- State Board of Professional Services
- State Board of Insurance
- Attorney general

Challenge: Difficulty accessing evidence based, clinically indicated treatment

Opioid use disorder is a chronic disease that can be effectively treated but it requires ongoing management. However, more resources need to be devoted to ensure availability of, and access to, evidence-based treatment. A public health-based approach to harmful drug use requires having both broad-based treatment services available for those with opioid use disorders, as well as MAT, and insurance coverage for such treatment.

Increasing Coverage for and Access to Treatment Programs

Accessing Treatment

- Recognizing that opioid use disorder is a medical condition, reducing the stigma of this disorder, and increasing coverage for and access to medication assisted treatment and related services;
- Treatment physician locator
- Access to quality evidence-based opioid and heroin treatment and interventions
- Community resources (County provided and monitored) Addiction treatment professionals, outpatient & Inpatient programs, peer support, multi-disciplinary approach, pharmacologic
- Quality of care at rehabilitation facilities (Jacoh)
- Evidence-based opioid and heroin treatment and interventions demonstration

- increasing access to treatment programs for opioid use disorders, including medication assisted treatment programs (MAT);
- Insurance companies providing legally mandated addiction coverage
- Treatment courts

Quality of Addiction treatment
Help people get educated and find jobs, not just get sober;
Advocate for recovery programs in colleges, because 85% of students relapse upon returning to school;
Increase training of peer counselors and amp up the selection process;
Motivate those that are struggling with drug use with potential reasons why they should go to therapy—not just the drug use—and convey a positive message about recovery;

The AMA strongly supports increased access to and coverage for treatment for drug addiction and physician office-based treatment of opioid addiction.

From How to stop the deadliest drug overdose crisis in American history

Make addiction treatment easier to access than opioid painkillers and heroin

The primary problem with the opioid epidemic is simple: It is much easier to get high than it is to get help.
“For the people who are addicted, you want the treatment to be much easier to access than prescription opioids, heroin, or fentanyl,” Kolodny said.
He drew a comparison to how New York City dealt with tobacco. In his telling, the city took a two-prong approach: It made tobacco itself less accessible — by banning smoking in public spaces and raising taxes to make cigarettes much more expensive. But it also made alternatives to tobacco more accessible — by opening a phone line that people can use to get in touch with a clinic or obtain free nicotine patches or free nicotine gum.
This is similar, Kolodny argued, to what the US should do with opioids.
So far, the US has tried to make opioids less accessible with prevention strategies, as outlined above.
But the country hasn’t done much to increase access to alternatives to opioids — specifically, medication-assisted treatment, when medicines like methadone, buprenorphine, and naltrexone are used to reduce opioid cravings. There are still places with no treatment clinics whatsoever, much less affordable options.
According to a 2016 report by the surgeon general, just 10 percent of Americans with a drug use disorder obtain specialty treatment. The report attributed the low rate to severe shortages in the supply of care, with some areas of the country lacking affordable options for treatment — which can lead to waiting periods of weeks or even months.

Congress has added some spending to addiction care (including $1 billion over two years in the 21st Century Cures Act), but it's nowhere near the tens of billions every year that Kolodny and other experts argue is necessary to fully confront the crisis. For reference, a 2016 study estimated the total economic burden of prescription opioid overdose, misuse, and addiction at $78.5 billion in 2013, about a third of which was due to higher health care and drug treatment costs. So even an investment of tens of billions could save money in the long run by preventing even more in costs.

"Crises in a nation of 300 million people don't go away for $1 billion," Humphreys said, referring to the Cures Act funding. "This is the biggest public health epidemic of a generation. Maybe it's going to be worse than AIDS. So we need to go big."

So what exactly would all that money go to?

For one, it should go to treatment that has strong evidence behind it. For opioids, that means, above all, medication-assisted treatment.

There is currently a stigma against this kind of treatment — particularly, that using medications, especially opioids like methadone and buprenorphine, to treat opioid addiction is simply substituting one drug with another.

Health and Human Services Secretary Tom Price echoed this myth earlier this year, saying, "If we're just substituting one opioid for another, we're not moving the dial much. Folks need to be cured so they can be productive members of society and realize their dreams." (A spokesperson for Price later walked back the statement, saying Price supports all kinds of drug addiction treatment.)

But this fundamentally misunderstands how addiction works.

The danger isn't whether someone is merely using drugs; most Americans, after all, use caffeine or alcohol regularly throughout their lives with few problems. According to the definition in the Diagnostic and Statistical Manual of Mental Disorders, drug use transforms into addiction when habitual drug use begins hurting someone's function — by, for example, leading them to steal or commit other crimes to obtain heroin, or, in the worst case scenario, resulting in death.

While medication-assisted treatment does involve continued drug use, it turns that drug use into a safer habit. When taken as prescribed, medications like methadone and buprenorphine can eliminate someone's cravings for opioids and withdrawal symptoms without producing the kind of euphoric high that heroin or traditional painkillers can. It addresses the core problem of addiction, even if in some cases it does mean a patient will have to use a certain drug for the rest of his life. But the alternative isn't a drug-free patient; the alternative is a continually relapsing patient — one who has to salve their addiction with dangerous street drugs.

This isn't just hypothetical. Decades of research have deemed medication-assisted treatment effective for treating drug use disorders, with several studies finding it can cut mortality among opioid addiction patients by half or more. The CDC, the National Institute on Drug Abuse, and the World Health Organization all acknowledge its medical value. Experts often describe it as "the gold standard" for opioid addiction treatment — and agree that it needs to be made much easier to obtain.

More money could also go to other kinds of evidence-based treatment, programs that attract more doctors, and policies that create more infrastructure for addiction care.

Anna Lembke, an addiction doctor who wrote Drug Dealer, MD, a book on the opioid crisis, told me of an innovative solution to the problem: what she calls an AmeriCorps for addiction treatment. She explained, “Why don’t we recruit these young people and say, ‘Hey, we’ll pay back your med school loans, in part, if you spend a couple years in rural West Virginia treating people with addiction’? We need to come up with creative ways like that to bring people into the workforce.”

Dr. Leana Wen, the health commissioner of Baltimore, suggested changing the structure of how care is provided. She envisions widespread emergency room services not just for physical health, as is already common, but also for mental health, including addiction.

“In the ER, people will often come in seeking help for their addiction,” Wen said, drawing from her own experience as a doctor. “But we will tell them that, unfortunately, we’re unable to get them into a treatment slot for three weeks or a month. … That individual, if they’re unable to get treatment that day at the time that they’re requesting, may have no other choice but to go out and use drugs [to avoid withdrawal] and maybe overdose and die.”

Responding to drug and alcohol use and related problems in nightlife settings