NEW MEXICO TREATMENT SERVICES

MAKING LIVES BETTER

ENSURING CONTINUED ACCESS TO MEDICATION-ASSISTED TREATMENT

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OPIOID EPIDEMIC FACTS

- On average, 130 Americans die every day from an opioid overdose.[1]
- From 1999-2017, almost 400,000 people have died from an overdose involving opioids.[2]
- This rise in opioid overdose deaths can be outlined in three distinct waves:
  - First wave - 1990s increased prescribing of opioids[3], with overdose deaths involving prescription opioids increasing since at least 1999.
  - Second wave - 2010 rapid increases in overdose deaths involving heroin.
  - Third wave – 2013 significant increases in overdose deaths involving synthetic opioids; particularly those involving illicitly-manufactured fentanyl (IMF). The IMF market continues to change, and IMF can be found in combination with heroin, counterfeit pills, and cocaine. [2,4]

1 Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at http://wonder.cdc.gov.
2 Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths – United States, 2013-2017.https://www.cdc.gov/mmwr/volumes/67/wr/mm6751e1.htm?s_cid=mm6751e1_w. WR Morb Mortal Wkly Rep. ePub: 21 December 2018
3 Kolodny et al 2015. The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. Annual Review of Public Health, 36, 559-74
4 Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. MMWR 2016, 64(50), 1378-82.

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OPIOID USE DISORDER

- Opioid Use Disorder (OUD) is a chronic disease, not a lack of willpower or moral downfall, and is treatable like other chronic diseases (e.g., asthma, diabetes)
- In 2016 an estimated 2.1 million people had an OUD.[5]
- The number of pregnant women with opioid use disorder at labor and delivery more than quadrupled from 1999 to 2014.[6]
- The good news is that Opioid Use Disorder is treatable. Effective and evidence-based treatments do exist.
- Research shows that, for some people, the integration of both behavioral and pharmacologic (medical) types of treatment is the most effective approach for overcoming opioid addiction.[7]

5 2017 National Survey on Drug Use and Health, Mortality in the United States, 2016
6 CDC Morbidity and Mortality Weekly Report (MMWR), Opioid Use Disorder Documented at Delivery Hospitalization – United States, 1999-2014
7 Treatments for Opioid Use Disorder, US Department of Health and Human Services

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MEDICATION-ASSISTED TREATMENT (MAT)

- Simply prescribing medication alone is not MAT. MAT is the use of medications in combination with counseling and behavioral therapies to provide a "whole patient" approach.
  - All federal guidance, including SAMHSA TIPs and accreditation guidelines, require medication and counseling together
- There are 3 medications the Food and Drug Administration (FDA) has approved for use in treating opioid use disorder: methadone, buprenorphine (buprenorphine with naloxone), and naltrexone.
- NIH: "the safety and efficacy of MAT has been unequivocally established. ...[M]ethadone maintenance coupled with relevant social, medical and psychological services has the highest probability of being the most effective of all treatments for opioid addiction."[8]
- Methadone is an "essential medicine" according to the World Health Organization.[9]

8 "Confronting an Epidemic. The Case for Eliminating Barriers to Medication-Assisted Treatment of Heroin and Opioid Addiction," Legal Action Center, March 2015.
9 World Health Organization. Proposal for the inclusion of methadone in the WHO models list of essential medicines (2005)

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WHO WE ARE
OPIOID TREATMENT PROGRAMS (OTPS)

- Opioid Treatment Programs (OTPs) are the federally-certified sites where methadone treatment can be administered
- Roughly 1,500 licensed and certified OTPs in the U.S. serving approximately 400,000 patients
  - Licensed and accredited by SAMHSA approved bodies (e.g. Joint Commission, CARF), Highly regulated by the states and the federal government (HHS, DOJ/DEA)
- NMOTP – The New Mexico Opioid Treatment Providers Association is a state chapter of the American Association for the Treatment of Opioid Dependence (AATOD). AATOD works with federal and state agency officials concerning opioid treatment policy throughout the United States. AATOD is also a founding partner in the development of the World Federation for the Treatment of Opioid Dependence

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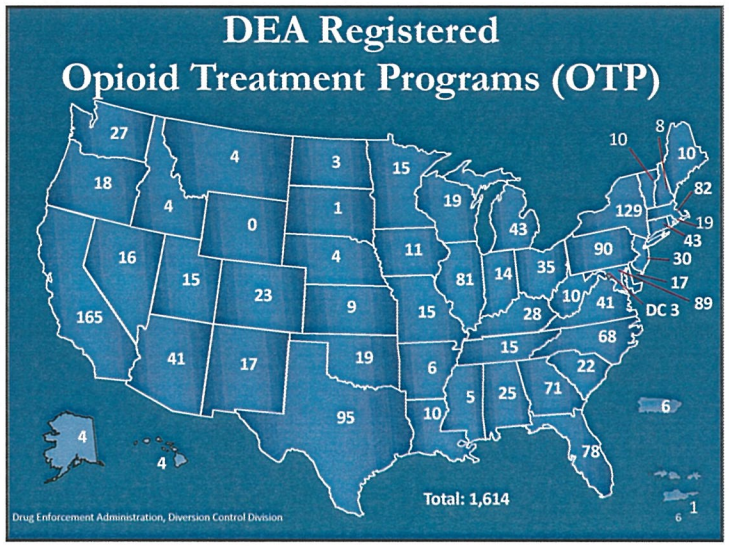

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NEW MEXICO OTPS
OPIOID TREATMENT PROGRAMS (OTPS)

Program Name	City
Metro Treatment of New Mexico	Albuquerque
Recovery Services of New Mexico, LLC	Albuquerque
Albuquerque Treatment Services, LLC	Albuquerque
Addictions & Substance Abuse Program (ASAP)	Albuquerque
Albuquerque Health Services	Albuquerque
Albuquerque Health Services	Albuquerque
Recovery Services of NM MDC, LLC	Albuquerque
Duke City Recovery Toolbox, LLC	Albuquerque
Courageous Transformations, Inc	Albuquerque
Recovery Services of New Mexico, LLC	Belen
New Mexico Treatment Services, LLC	Espanola
New Mexico Treatment Services LLC Farmington	Farmington
ALT Recovery Group	Las Cruces
Rio Rancho Health Services	Rio Rancho
Recovery Services of New Mexico, LLC	Roswell
Santa Fe Health Services	Santa Fe
New Mexico Treatment Services, LLC	Santa Fe

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OTP – DOCUMENTED OUTCOMES

- Methadone treatment has by far the largest, oldest evidence base of all treatment approaches to opioid addiction.[10]
- MAT has been demonstrated to:
  - *Decrease* opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission
  - *Increase* social functioning and retention in treatment
  - *Improve outcomes* for babies born to opioid-dependent pregnant women[11]
- Low diversion rates:
  - Opioid treatment programs are required to maintain and implement robust diversion control plans.
  - Methadone diversion is primarily associated with methadone prescribed for the treatment of pain and not for the treatment of opioid use disorders. [12]

10. TIP 63: Medications for Opioid Use Disorder
11. World Health Organization. Proposal for the inclusion of methadone in the WHO models list of essential medicines. (2005)
12. Medications to Treat Opioid Use Disorder, NIDA National Institute on Drug Abuse

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OTP- SERVICES

- Counseling is required, based on an Individualized Treatment Plan
- Case Management and Coordinated Care with other providers
  - Coordinated referrals to other community services and resources, such as medical and dental care, housing, SNAP, mental health services, screening and treatment for communicable diseases to include HIV and Hep C
  - Coordination of care with primary care physicians (PCPs), mental healthcare providers, psychiatrists, prenatal provider, etc.
- Psychoeducation – HIV/AIDS, Hep C, Risk reduction, and other health education
- Physicals
- Drug-Screening
- Medication
  - Taken once daily for the management of withdrawal and cravings, and stabilization of functioning

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BARRIERS TO TREATMENT ACCESS

- **Reimbursement and policy barriers limit access for those battling addiction**.
- Reimbursement: OTPs have received the same reimbursement rate for basic services since 2014 despite substantial increases in the cost of providing services.
- Policy: OTPs are currently required to employ pharmacists to prepare take-home doses of the same medication that nurses dispense to patients in the OTP.

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SOLUTIONS: REIMBURSEMENT

- **BACKGROUND:**
- The bundled rate for the provision of opioid replacement therapy has been the same since day one of Medicaid coverage of Opioid Treatment Program (OTP) services in New Mexico in 2013;
- OTPs are in the best position to combat the current opioid crisis. The treatment provided is proven to be effective, cost-efficient and both evidence-based and best practice;
- There are currently only 16 OTPs in New Mexico. Expansion of OTPs into more rural areas necessitates an increase in revenue. At the current reimbursement rate, an OTP will need a minimum of 200 patients to be marginally profitable. This makes opening smaller programs in more rural areas cost-prohibitive;

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SOLUTIONS: REIMBURSEMENT

- **No-Shows:**
- No-show rates for OTPs can be as high as 25% on a daily basis due to the nature of the patient population served. Increasing the reimbursement would serve to mitigate the loss of revenue on days when patients no-show. Alternatively, a weekly rate as opposed to the current daily rate would also help to mitigate the effects of patient absences.

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SOLUTIONS: REIMBURSEMENT

- **Increased Staffing Costs:**
- OTPs are required to be staffed by a number of licensed professionals:
  - Counselors: The demand for licensed counselors far exceeds the supply and as a result starting salaries for counselors have increased substantially since the inception of the reimbursement rate in 2013. Also, OTPs typically have to pay above market rate to attract candidates who are willing to work in an OTP setting;
  - Nurses: Starting salaries for nurses (RNs and LPNs) have increased for largely the same reason as counselor salaries, the demand exceeds the supply and OTPs are forced to pay above market rate to attract candidates;
  - Doctors: The specialized nature of addiction medicine dictates that given the current opioid epidemic the demand exceeds the supply of physicians qualified to provide this type of care resulting in salaries above the market rate;
  - Pharmacists: The OTP setting is not a desirable one for pharmacists given that most OTPs use only 1-2 different medications. Most pharmacists consider such a setting to be a waste of their skills and expertise due to the limited nature of the work. Again, this results in OTPs paying above-market rates to fill these positions.

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SOLUTIONS: REIMBURSEMENT

- **Increased Business Costs:**
- The Gross Receipts Tax was lower in 2013;
- Costs of professional liability, medical malpractice, general liability and workers comp insurances have increased an average of 15% since 2013;
- Costs of office and medical supplies have increased approximately 10% since 2013;
- The cost of providing health insurance benefits to employees has increased an average of 25% since 2013. This has forced many employers to increase the employee contributions to their insurance premiums.

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SOLUTIONS: REIMBURSEMENT

- **Other Considerations:**
- Employees desire and often deserve raises. Further, New Mexico OTPs, like many responsible companies, work to provide at least annual cost of living wage increases. This helps to retain good employees and remain an employer capable of hiring. This amounts to approximately a 3-5% annual increase in staffing costs;
- OTPs in New Mexico often deliver care above that required by BHSD or SAMHSA. For many patients, the OTP is their care center where they are seen by the physician for other medical issues and where they are having a growing percentage of their overall care coordinated;
- At no time in the last 15 years has BHSD asked more of the New Mexico OTPs. Regulatory burdens have substantially increased and OTPs are devoting significant resources to maintain compliance;
- OTPs treat some of the very toughest patients that other providers would rather not see. OTPs are at the front lines of the Opioid Epidemic and should be incentivized, encouraged, and fairly compensated for their work.

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SOLUTIONS: POLICY

- **Background:**
- The state of New Mexico and the Board of Pharmacy currently allows an LPN or RN to dispense methadone or buprenorphine to patients enrolled in a licensed Opioid Treatment Program (aka Narcotic Treatment Program) when the dose is ingested in-house;
- However, currently a pharmacist is required in order to prepare any medication that is dispensed as a take-home medication;
- In the entire United States, only 9 states have this restriction. This restriction does not exist in any of our neighboring states, including Texas, Colorado and Oklahoma or larger states with far more OTPs such as California and New York.

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SOLUTIONS: POLICY

- Federal regulations do not require that pharmacists prepare take-home methadone or buprenorphine;
- There is NO EVIDENCE which indicates that allowing nurses to supply take-home methadone or buprenorphine results in an increase in adverse outcomes, presents a public safety concern or increases the probability of diversion;

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SOLUTIONS: POLICY

- **In Fact:**
- Requiring take-home methadone or buprenorphine to be prepared by a pharmacist results in the creation of 2 separate inventories – a bulk inventory and a unit (packaged) inventory. This increases the opportunity for medication errors;
- An LPN or RN providing in-house and take-home methadone or buprenorphine eliminates the need for a unit (packaged) inventory and allows for point-of-service preparation from a single inventory;
- Elimination of the pharmacist requirement for preparation of take-home methadone or buprenorphine would allow OTPs to make medication adjustments in a timely manner. Currently, patient dose adjustments for their take-hone doses are subject to the scheduling and availability of a pharmacist;

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SOLUTIONS: POLICY

- It is a myth that pharmacists provide any meaningful counseling or patient education in an OTP setting. This consists of a one-page handout given to patients (by the nursing staff) which advises them of potential side-effects and interactions. In fact, pharmacists typically have little to no patient contact in this setting;
- Nursing staff operate under the supervision of the clinic Medical Director – a licensed physician – who reviews PMP reports on each patient on a quarterly basis, at minimum, for potential medication interactions. The Medical Director orders the patients medication and the nursing staff carry out the MDs orders. There is no 'prescription' in the same sense as this term is utilized in a retail pharmacy setting;
- The preparation of take-home doses is exactly the same as the preparation of the dosage that a patient is administered in person, and thus requires no additional nursing competencies;
- Requiring a pharmacist places an undue and unnecessary burden on OTPs with regards to staffing and payroll. This creates barriers in terms of expanding OTP services into more rural and underserved areas;

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SOLUTIONS: POLICY

- **The Role of the Pharmacist in the OTP:**
- Allowing a nurse to dispense take-home doses would not eliminate the need for a pharmacist in the OTP setting. Rather, the pharmacist's role would shift to administrative and compliance functions rather than the repetitive and mundane task of preparing take-home doses of a maximum of 2 medications, versus the hundreds of medications that pharmacists deal with in a retail setting. These medications are virtually impossible to get confused as methadone is liquid and buprenorphine is solid form;
- Finally – to re-state – allowing a nurse to dispense take-home doses would align New Mexico with the overwhelming majority of the country – and there is NO EVIDENCE which indicates that allowing nurses to supply take-home methadone or buprenorphine results in an increase in adverse outcomes, presents a public safety concern or increases the probability of diversion.

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THANK YOU

- "Detoxification from heroin is good for many things – but staying off heroin is not one of them"

  – Walter Ling, MD

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