



**ARIZONA SUBSTANCE ABUSE TASK FORCE  
Arizona Medication-Assisted Treatment Work Group**

**May 12, 2016**

**3:00**

**Governor's Executive Tower  
Suite – 230**

**1700 West Washington Street  
Phoenix, Arizona 85007**

A general meeting of the Medication-Assisted Treatment Work Group was convened on May 12, 2016 at 1700 Washington Street, Suite 230 Phoenix Arizona, 85007, notice having been duly given.

**Members Present (9)**

**Debbie Moak**, Governor's Office of Youth, Faith and Family

**Dr. Rick Sloan**, Palo Verde Integrated Medicine

**Doray Elkins**, Community Member

**Reuben Howard**, Pascua Yaqui Tribe

**Haley Coles**, Community Member

**Michael White**, Community Medical Services

**Sara Salek**, AHCCCS

**Dr. Lenn Ditmanson**, COPE Community Services

**Dr. Gagan Singh**, Banner Health

**Staff/Guests Present (6)**

**Theresa Gonzales**, AHCCCS (note taker)

**Sharon Flanagan-Hyde**, Flanagan-Hyde Associates

**Randy Mackey**, Medical student

**Dr. Mary**, Member of the Public

**Alison Morgan**, Member of the Public

**Jeff Dial**, Member of the Public

**Members Absent (1)**

**Peggy Chase**, Terros

**A. Call to Order:**

**Debbie Moak** called the meeting to order.

**B. Welcome and Introductions**

Introduction of members and guests.

**Sharon** went over ground rules and goals of the Task Force and housekeeping tasks.

**C. Volunteer to Report at the Task Force Meeting**

**Haley Coles** volunteered.

**D. Presentation on MAT Modalities: Dr. Rick Sloan**

**Overview**

**Rick** talked about his passion to help addicts get off drugs. His outpatient clinic is based in Glendale and their goal is to help people overcome their addictions and get through the detoxification process using Naltrexone Therapy.

The process starts with a full physical exam, and blood work, including testing kidney function and electrolytes. Naltrexone is a medicine that blocks the opiate receptors in a person's brain to dramatically reduce cravings. It is non-addictive and does not block the body's natural endorphins. If relapse does occur, the medicine prevents the patient from feeling high. Dr. Sloan has seen amazing results and safe use.

The clinic's patient population ranges from 18-79 years of age and all have high success rates. Counselors are also available at the clinic and manage patients with Naltrexone treatment for at least one year.

**Q and A (all responses are from Dr. Sloan):**

**Q Ruben Howard:** What is treatment cost as compared to methadone and other meds?

A: Not sure what Methadone costs, but this is a 1-year program.

**Q Debbie:** What's a price estimate by injection/time period?

A: Depends on the drugs being used and is lot less expensive than an inpatient stay.

**Q: Debbie:** Familiar with 3 different forms of Naltrexone. Which one is used in your clinic?

A: The preferred method is through implants.

**Success stories:**

- 36-year-old female on meth for 6 years and completed a 9-day detox. On the 9<sup>th</sup> day the patient developed abdominal cramping right after an implant. Sent to hospital and did surgery and found a colonic abscess from meth-induced constipation so long that it broke open her colon and if they hadn't detoxed her, she wouldn't have lived more than 2 weeks. The meth was blocking her pain receptors so she wasn't feeling pain.
- DJ in California that has been heroin free for 18 months after using heroin since the age of 14. Had previously gone to 7 different rehabs and never stayed sober; in fact he purchased heroin when he was in the Betty Ford clinic.
- Finished 2 detoxes just this morning before coming to the meeting.

**More Q and A (all responses are from Dr. Sloan):**

**Q: Ruben:** Pascua Yaqui Tribe runs a methadone program and curious what kind of therapy and where is it provided? In facility or somewhere else?

A: When someone detoxes it's mandatory they receive counseling. We have counselors onsite and provided 3 times per week. Vivitrol is also available, a slow release option for detox.

Q: What % of patients are court-ordered?

A: 0.

Q: Where are people from who go to your clinic? Low income?

A: A good mix from everywhere from Paradise Valley to Avondale.

**Q Haley:** You said that as part of the detox process, you put the limbic system to sleep. How do you do this?

A: With medication. The limbic system is part of the inner brain that houses receptors so when put to sleep they don't fire as quickly. When someone is removing opiates from the brain the receptors fire and that is what creates all the withdrawal symptoms. The medication stops that from happening. Patients have sponsors during treatment to give medications at home.

Q: Who are the sponsors?

A: Family members or friends who have been interviewed to ensure they are qualified to help.

Q: How is the 96-98% success rate measured?

A: Relapse. Patients come to the clinic and a bond is built. The clinic is affiliated with The Coleman Institute based in Virginia and has been in Arizona for about 7-8 years.

**Q Michael White:** Is % based on currently being on meds? What about off meds?

A: Yes the success rates are with meds. Lots of studies have been done on the brain and how when someone is using opiates they can't produce endorphins. It's like pulling someone out of a fire. Studies say the brain takes a year to get receptors to normal but could be 3+ years. Would keep someone on meds as long as needed. Remember brains are different. We are trying to give patients the best foundation not to relapse. Been doing this for 10 years and patients are still clean.

**Q Doray Elkins:** You mentioned an opiate brain. What is an opiate brain? Does that mean some people have an opiate deficiency in the brain and need opiates to keep level?

A: Opiate brain is a brain that responds differently to opiates vs. a brain that doesn't have a dependency. Some people can be on opiates and get off with no issues.

Q: How long is the longest someone has been on Vivitrol?

A: I have a patient who has been on for 26 months.

**Q Haley:** What oversight comes from the DEA?

A: Naltrexone is not a controlled substance.

**C: Lenn Ditmanson:** This varies by jurisdiction and agent.

Q: **Michael:** Ever have experience covering pleasure zones to the point of crisis?

A: No. Had a heroin and meth addict. Detoxed the heroin addict with Vivitrol; there's nothing to detox specifically for meth but the Vivitrol worked for that as well.

Q: **Sara:** You said you are prescribing five medications for detox. What are the medications?

A: Olanzapine, Tramadol, Clonidine, Valium, and Baclofen.

Q: **Sara:** What is your outpatient detox protocol?

A: Depends on the patient: varies from 3-9 days plus a 5-7 day taper off period.

Q: **Sara:** Has this detox method been researched and published in any peer-reviewed journals?

A: Coleman has been in Australia. We have anecdotal evidence. Not sure if the program has been peer reviewed. Outpatient detox isn't really recognized yet. It's like using the naltrexone implant.

C: **Sara:** Can you please share any published peer-reviewed journals with the Work Group?

A: Every drug used is OK to use, all are FDA approved for detox. The implant isn't yet.

C **Michael:** ASAM doesn't approve or recognize outpatient detox. Want to get away from referrals to inpatient detox.

A: It's so much less expensive than inpatient detox.

C: **Dr. Gagan Singh:** Correction: ASAM does support outpatient detox.

C **Ruben:** Tribal members come in maybe 2 times if lucky and they never come back. So how do you handle people coming back?

A: The clinic has an addiction coordinator to contact patients every week during the first 6 months. The coordinator is also in touch with parents, sponsors, and counselors. Patients come in once a month for the Vivitrol injection and then a few times per week for the counselor.

Q: **Sara:** Can you give us more information about what is evidence-based and what is published regarding what's safe and effective for medication use during detox period? Are there published protocols of the medications used?

A: Not handy, but there is medication assistant treatment vs. detox. There is a fundamental addiction medicine textbook published by ASAM. And perhaps not utilized enough. Will review and send over.

Q **Michael:** Is the goal to use Vivitrol?

A: Yes. Gives the patient time to heal and understand the disease. Would like to continue utilizing implants.

Q: **Sara:** What's your view on opioid replacement therapy (i.e., methadone, suboxone)?

A: Anything is better than heroin, but we want people drug free. Always have space for suboxone because we put the majority of patients on Vivitrol.

Q: What about when someone can't get off the meds and taper?

A: There are cases where people are resistant and in those cases may never get off. The 79-year-old patient is an example.

Q: **Lenn:** Are most patients that go through detox on Vivitrol self-choosing? How do you decide?

A: A detox consultation is conducted which includes a process overview. Patients choose what they want. Ultimate goal is to get people using Vivitrol. Don't think Methodone is horrible, it's better than the alternative but I don't use on clients.

Q: Is there a % that you can say will do great?

A: My name is on Vivitrol websites so people already have it in their minds to quit. If someone comes in and they're unsure, will guide them to Vivitrol.

Q: **Doray:** Want to learn more about experience from people that are there and longer-term outcomes?

A: Yes, after presentation.

Q: **Doray:** I've only heard only good things about Vivitrol, are there any negative reports?

A: May have side effects on the liver but oral is more dangerous because it goes through the liver. There are reactions if people are allergic, but that's the case with any injectable medication.

Q: What about suppressing and triggering other modes in the body?

A: No.

Q: **Haley:** What about people with Hepatitis C?

A: Not a problem, but I will check liver functionality before starting treatment. Still better than alternatives. All meds have side effects.

Q: **Reuben:** What kind of training is required for physicians?

A: Very minimal but need to make sure patient is detoxed before giving Vivitrol. Doctors typically don't want to touch addiction patients. We do an IV Narcan challenge to see if there are opiates in the brain.

#### **E. Presentation on MAT Modalities: Dr. Ditmanson (COPE)**

Experience in Tucson at COPE.

- Vivitrol has been a difficult compound to get approved through the RBHA in Pima County. May be an issue to be discussed at Medicaid level.
- COPE has been around for 15 years. 955 patients in program. Offer parallel tracks for methadone, suboxone and naltrexone.
- Important pre-selection process. By the time they come to us for treatment, they've been through a variety of attempts at detox and stabilization. So many patients have been through the current standard 3-5 day buprenorphine.
- Can't predict when someone comes in through the door whether they will do well on one vs. the other. At the end of one year success is higher by 50% on methadone treatment.

- When you reverse the opiate in the brain by using buprenorphine you're asking the person to say goodbye to a lover they've known for a long time and they may not be ready to say goodbye that quickly. About 35% using buprenorphine say they don't want it in the first 7 days. Variety of things they describe they still crave. They miss the effect of the opioid.
- 7:2 ratio using methadone vs buprenorphine.
- Length of treatment: Try to establish an entry and plan. It's very typical that people on opioids lose a sense of time. Time seems to disappear and patients don't live by same clock; their clock is based on when is the next dose not, Sunday or Monday. So we incorporate a linear timeline...start methadone and start detox. Done in a nuanced way to allow a soft landing and we don't use hard and fast timeline because of the fear of withdrawal is so compelling and they don't want to hear that.
- Try to start process saying, "OK we are going to start on therapy and within 3-6 months start detox program." As time continued and epidemic advanced, we were seeing more and more people appear to be going down the track that medication-assisted treatment will be a long-term program and acceptance that it may be life-long and they may never recover the endorphin physiology they had before the addiction.
- Counter to view of treatment and addiction, but compare to someone with Type 2 diabetes...someone comes to the office overweight and eating wrong. You can tell them to lose weight, eat right, go to the gym and maybe be cured. Never seen published figures on long-term methadone treatment
- Going forward, try to develop a framework where the medical system has the capacity to manage people in this epidemic over decades or even the lifetime because the levels of opiate dependency are now at a level we haven't seen before, where people are coming in with 10-15 years of dependency. Imagine if diabetic came in with 10-15 years before being treated. Odds are low to cure. So it's a matter of treating with methadone at a level that is the least needed. Look at this treatment like any other treatment for a disease.
- One meeting per week to begin with. Sets the stage for that to be the expectation.
- Buprenorphine drug is also disappointing. Cohort of about 10-15% patients are on 1-2 mg/day. We call them "crummers" because it's so hard to split the pills into halves or quarters. They will report that even stopping .5 or 1 mg dose will result in reoccurrence of withdrawal symptoms.
- Trying to do a protocol on the backside of buprenorphine. Advancing oral naltrexone.
- Average maintenance dose of methadone is 110 mg/day. Buprenorphine is 14 mg/day. Modified with buprenorphine to mimic a front-end loading because if going to ask them to come out of cloud, we need to buffer on the front side. 8-24 mg. Can't be too uncomfortable for too many days in the induction phase.
- Concerned in the long term that MAT will be a maintenance model for majority of people. Reentry rate is high. Relapse after 3-6 months. Maybe shouldn't abandon treatment.
- That's why programs are growing so fast, need more capacity for long term maintenance. Almost at 1,000 people at end of month. Not many designed at that capacity. Intakes keep coming at 5-7/day.
- Holy Cross in Nogales is aggressively requesting us to build there.

Q and A (all responses are from Dr. Ditmanson):

Q: **Debbie:** Would it help if the RBHA paid for Naltrexone/Vivitrol?

A: Some people believe it would help. Taking a pill orally is outweighed by injection therapy. Would result in higher outcomes vs. oral naltrexone.

C: **Lenn:** Cravings are different. There's also the cognitive memory component of the world they were living in. More difficult to address vs. mesolimbic.

C: **Michael:** ASAM doesn't endorse detox for pregnant women. Concern is lack of research. People want there to be a magic bullet. Worth looking into and will compare to methadone. If funding was covered it would probably be utilized but would be a cautious approach. Would start inside jails and have availability of Dr. Alvarez' team to respond to crisis. Think will start with Maricopa County Corrections.

C: **Lenn:** In all the years I've practiced, haven't had one person asking for Vivitrol or naltrexone. Could be lack of awareness, affordability. Fear of antagonist.

Q: **Debbie:** Am I correct that there are very few doctors who are providing detox or medically assisted treatment outside of this room?

A: There are some in Scottsdale. Tucson has 7 providers. SAMHSA says 32 statewide. Not sure.

A: **Sara:** Network capacity depends on what we are referencing in terms of the continuum of care for substance abuse detox services (i.e., support groups, outpatient, IOP, inpatient, detox, MAT).

C: **Sara:** Feedback re RBHAs - as of 7/1/16 AHCCCS will be responsible for oversight of the RBHAs including oversight of the drug list. Already changed prior authorization criteria of Vivitrol to be very broad. *"The patient's clinical status indicates instability or non-adherence such that oral medication will not be taken consistently or a trial will likely fail."*

If encountering issues, AHCCCS needs to know. The P&T is reviewing the substance use disorder class in its entirety including Vivitrol and will look at recommendations regarding prior authorization status.

Q: **Lenn:** Is it still a requirement to fail with oral naltrexone first?

A: **Sara:** No. More broad now. Want to ensure adequate access to appropriate therapies including Vivitrol.

C: **Rick:** Workers comp is covering Vivitrol. Maintenance all covered by insurance. Can do detox at home and get a 40% rate that comes back. Vivitrol requires opiates out of brain. Must do a test to make sure (Narcan challenge)

C: **Lenn:** We are launching an adolescent program. Wouldn't provide for a child without a detox platform.

Q: **Debbie:** What would it take to have Medicaid cover this? Hearing in long run there's a huge savings from someone going to Valley Hope on a behavioral health mode vs. Community

Bridges where the 3 day detox doesn't have long term results.

C: **Mike:** People hear detox and think 3 days and out the door. All those who implement MAT know it's only a tool and need to get at root cause. Haven't been good to partner with other agencies to do therapy.

C: **Debbie:** Point being that 3 day detox isn't working and cost of going to hospital setting without follow up is high. Why not do what Dr. Sloan is doing?

Q: **Sara:** Why aren't outpatient detox options expansive within AZ?

A: **Mike:** When they go to detox at IP they are still under influence and they get turned away.

A: **Lenn:** In opiate treatment, the 3 day IP treatment, they enter in crisis and identified opiate withdrawal and are always in crisis. Protocol of 8 mg, 6, and 2 in a sub IP setting.

C: **Debbie:** Follow up after 3 day isn't happening so that's a big failure. When they hit the street again, they need to detox again and again.

C: **Reuben:** Large tribal population in Guadalupe and the Tribe wants to cover methadone or suboxone and the psychologist is looking where to refer and one program only does intakes from 4-6AM at Valle De Sol with long wait times.

C: **Debbie:** Process is so lengthy people will be lost.

C: **Rick:** The clinic partnered w/ Calvary. Do IP detox and call them. Injections get sent to office. Calvary is a 30 day program.

C: **Debbie:** Calvary is a prime example of continuum of care where everything is in one building and is comprehensive.

C: **Lenn:** In Minnesota, who is prime Betty Ford. 1 OTP in St. Paul and 3 in Minneapolis. So AZ has more availability.

C: **Doray:** Barriers to care and soft hand off. Don't lose sight of 3 day detox piece. Experience of 3 day detox is not sufficient in and of itself. 3 day piece is where the problem is. The drug may be out but not enough to stay put. Opiates vs. something else.

C: **Sara:** Vulnerable time re potential relapse as well.

C: **Rick:** Often people decline detox and the struggle is that they know doing detox and sending out doesn't work. Would prefer to send out to someone with ongoing management. More often patient doesn't have insurance to allow them to get access to that care. That's where the 3 day detox comes in as trying to do something even though something else can do better. At least it's something.

C: DEA and licensure need to be streamlined. Mechanics of licensure is very onerous. Scares off people who might be interested in providing services. DEA requires a lot.

C: **Sara:** Re having Medicaid pay. If there is a policy change that impacts medication utilization, AHCCCS needs to determine if there is an impact on capitation rates since our rates need to be actuarially sound as determined by the financial arm of our agency.

C: **Lenn:** Heard GMH/SA will roll to AHCCCS Plans? It's one thing to negotiate with a RBHA vs. 7 AHCCCS plans for consistency purposes. Very scary to think of that.

A: **Sara:** Only as of 10/1/15, for dual-eligibles, Medicare/Medicaid, we have acute plans managing. No decision for non-duals. Whenever AHCCCS makes any changes, there is stakeholder engagement to get public feedback.

## **F. Question and Answer Session**

Q: **Debbie:** What are the outcomes from Dr. Ditmanson?

A: **Lenn:** Know that people in the program for 3 years are 90% sober but missing people that drop out of treatment so it's a biased number. We are building a database to track 1 year outcomes. Have 3-5 year data at 90%.

Q: How many drop out?

A: Quite a few. Pretty transient population and asking them to come in for methadone treatment every day. Can start treatment right away in jail. There's a time and place for all meds. We shouldn't talk bad about any one. Can be better as industry improves our collaboration. Historically MATs have been treated a certain way, so people react. Could use better oversight and improve processes.

C: **Debbie:** Appreciate populations served. You've been in the trenches to provide services to the most vulnerable of society. But would like to see how to improve, what has been learned? Is there something better? Also looking for next best.

A: Depends on state. Can go to clinic and depends on client's status and what's available for them.

C: **Lenn:** Was at a meeting with the AZ Council of Human Service Providers to talk about Value Based Purchasing (VBP) and what parameters, criteria and metrics would be applied to substance abuse treatment. Still frustrated that GMH/SA is lumped and should not be siloed. Confusing to talk about metrics. Can't lump 2 different categories. But how do you measure success in long term MAT or substance abuse treatment? RBHAs are in charge to decide what they're going to use for VBP and little say for providers as to what's a good outcome (i.e., going back to work, kids out of DCS custody).

A: **Sara:** Still early in the process. RBHA is block payment. Re: performance measures, we understand that relapse is part of recovery. Look more globally around individual's recovery vs. tox screens, etc. Difficult from individualized approach vs. collecting data. Still at initial stages.

C: **Lenn:** Clinic is at 20% from intake. Lose on suboxone vs. methadone. Methadone is instantly very effective which gets a better buy in. Attrition depends on access. Logistics on getting to clinic is huge barrier to retention. Speaks to need for wide based availability.

C: **Reuben:** Interesting to listen to common concerns. Tribes and I.H.S. are responsible for members cradle to grave. Most tribes receive most of care through I.H.S. except for Sells and Gila and now Navajo. Most tribes don't have infrastructure to deal with these issues, so depend on RBHAs. Relationships aren't great and not sure if/when that will change. When there's TC these issues come up. Methadone clinic for over 15 years and used a no harm reduction model, similar to diabetes. Don't have a set time of when they get meds. They get as long as needed. Keeping that in mind should be considered in developing model. Consider the grandmas and grandpas. Issue of stigma has an impact. For Indian Country, there's always that distance between the tribes and state addressing programs. As more are taking over programs need to work with state on these issues. Will take a lot of marketing and communication through the

RBHAs for tribes to buy into the initiatives whatever the outcome is.

Q: **Lenn:** PYT is the only tribe that has methadone and suboxone; is there a stigma?

A: **Reuben:** Yes. When marijuana was passing through, every tribe didn't want it. Lots of denial with medication replacing one narcotic with another.

C: **Lenn:** The fact that this is being sponsored by the Governor's Office is advanced. AZ is ahead of the game.

Final Comment **Debbie:** The Governor signed two bills today:

- 1) CSPMP – doctors must check the Controlled Substance Prescription Monitoring Program data to confirm the patient is not having prescriptions filled from multiple providers, or abusing their medications.
- 2) Naloxone – expanded access to opioid overdose reversal drug those who abuse Opioids and friends and families who could help the patient if they experience an overdose.

**G. Discussion:**

See above.

**H. Review of Questions/Key Information**

None

**I. Call to the Public**

Member of the Public, Dr. Mary Blunt: Very impressed. Been a PCP for most of career and on other side of fence dealing with chronic pain and drug seekers. Got suboxone certification and worked in suboxone clinic and found rewarding but something missing. Worked with Dr. Sloan and would call and ask for info. More interested but thinks that suboxone serves a purpose but is a bandaid and hard to get off of. Had a patient in 60s with wife who just divorced him; he was on narcotics for 5 years. Got off suboxone and went to clinic. Off for 10 days, crying. Dealing with family members is very important to process. Gone through withdrawals. Gave meds to help with symptoms and want to see in 5 days and do screen. Patient returned and wants to do accelerated detox and referred to Dr. Sloan's office and got on Vivitrol and left smiling. Going to counseling and sober doing wonderfully. So much more rewarding.

**J. Adjourn**

C: **Debbie:** Appreciates everyone's time, learning so much and have great hope.

Motion to adjourn from **Doray**. 2<sup>nd</sup> by **Lenn**.

Dated the 12th of May 2016  
Medication-Assisted Treatment Work Group  
Respectfully Submitted By:  
Theresa Gonzales, AHCCCS