



# Implementing Technology, Medication Assisted Treatment, Team Training, and Resources

## PRIMARY CARE PRACTICE TEAM TRAINING

### Module 3

### The Practice: supporting and providing MAT



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## Practice team training modules

- Opioids, Receptors, Colorado, and You
- The Patient: *Your role preparing the patient for MAT with buprenorphine*
- The Practice: Supporting and providing MAT**
- MAT during Stabilization & Maintenance and Special Populations
- Methamphetamines and treatment in primary care




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## MODULE 3

### THE PRACTICE


- Team-based care
- Preparing for induction
- Induction steps and protocols
- Introduction to Stabilization and maintenance




## Medication Options

### “M” is for Medication: Three Types

Type	How it's taken	What it does	How often it's taken	Where it's available
Methadone	Liquid, edible wafer, or tablet	Long-acting opioid medication that reduces symptoms of withdrawal and blocks euphoric effects of other opioids	Daily	Certified Opioid Treatment Program (OTP), also known as methadone clinic
Buprenorphine	Tablet, oral dissolving strip, or implant	An opioid medication that weakens euphoric effects of many opioids until the effects eventually level off	<ul style="list-style-type: none"> <li>Tablet or strip: daily</li> <li>Implant: every six months</li> </ul>	Doctor, nurse practitioner, or physician assistant with training to prescribe in office-based setting or some OTPs
Naltrexone	Tablet or injection	After mandatory seven- to ten-day withdrawal from all opioids, this non-opioid drug blocks effects of opioids and reduces cravings	<ul style="list-style-type: none"> <li>Tablet: everyone one to three days</li> <li>Injection: monthly</li> </ul>	Doctor or pharmacist



Website: [www.colorado.edu/med/anschutz/fam\\_medicine/primary\\_care/medication\\_options](http://www.colorado.edu/med/anschutz/fam_medicine/primary_care/medication_options)


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## Buprenorphine treatment

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## Treatment with Buprenorphine: Why are we doing this?

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To find the right dose of buprenorphine at which the patient:

- Has no opioid withdrawal symptoms
- Discontinues or markedly reduces use of other opioids
- Experiences decreased cravings
- Has minimal/no side effects
- Return to usual activities (work, school, family)

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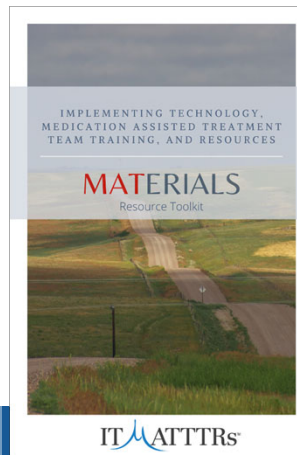
## MAT review appointment

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- ~ 30 minutes, about a week prior to induction Day 1
- Review MAT process and information with patient
  - Buprenorphine information
  - Induction steps
  - Treatment Agreement
  - Consent Form – and expectations for long-term treatment (12 months, recommended)
  - Prescription – how it will be picked up
  - Plans for behavioral health support (will discuss a few weeks down the road, tailor care based on patient's needs)

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## TOOLS

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## Treatment agreement

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### Expectations of patient

- No disruptive behavior
- No medication diversion
- Adherence to treatment protocols
  - Induction, maintenance
  - monitoring strategies (i.e., urine drug tests, pill counts)
  - Additional treatment
  - Appointments and refills
- Contact with other caregivers and pharmacies
- Safe storage

### Expectations of provider

- Scheduling visits
- Medication supply/refills
- Night coverage
- Response to
  - Urine prescriptions
  - Unexpected UDT results
  - Non-adherence or unexpected results
- Maintenance vs. detox

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## Informed consent

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- Physical dependence
- Side effects: sedation, constipation
- Risk of impairment, overdose
- Possible medication interactions
- Limited pain control options
- Neonatal abstinence syndrome
- Other treatments available: naltrexone, detoxification

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## How long should a patient take buprenorphine?

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- Maintenance lasts as long as patient is benefitting from treatment. \*\*\*
  - We recommend at least 12 months. Research supports 18 months of stable time.
  - <16 weeks (4 months) of treatment is associated with high levels of withdrawal (which leads to relapse).
- Consider other drug use, employment, educational goals pursued, improvement in relationships, improvement in medical/mental illnesses, psychosocial treatment.
- Celebrate with patient!



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## Office (observed) Induction Patient Instructions

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- Stop taking opioids 12 – 48 hours prior to arriving at clinic (see "Preparation" section of protocol)
- Arrive at clinic in mild - moderate withdrawal
- Plan to be at clinic for 1.5 – 3 hours (a lot of downtime, waiting for medication to kick-in, check-ins to monitor patient)
- Bring a snack
- Bring buprenorphine medication bottle, or have it delivered if applicable (prescribe vs. dispense)
- Bring a significant other, if possible

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## Induction Day 1

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### Dependent on short-acting opioids (Vicodin, Percocet, heroin):

- Instruct patients to abstain from any opioid use for 12-24 hours (so they are in at least moderate withdrawal at time of first buprenorphine dose).
- Sunday noon is a good time to stop for a Monday induction Day 1.

### Dependent on long-acting opioids (Oxycontin, MS Contin/Morphine, Methadone):

- Oxycontin, morphine, etc: Begin induction  $\geq 36$  hours after last dose of sustained-release opioid
- Methadone: Begin induction at least 48 hours after last dose. Wean down to  $\leq 30$  mg/d.
- Saturday morning is a good time to stop for a Monday induction Day 1.



## Clinical opiate withdrawal scale

### Clinical Opiate Withdrawal Scale (COWS)

Flowchart for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____	Date: _____
Buprenorphine Induction: _____	
Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Times of Observation: _____
<b>Resting Pulse Rate: Record Beats per Minute</b>	
Measured after patient is sitting or lying for one minute	
0 = pulse rate 60 or below	• 2 = pulse rate 101-120
1 = pulse rate 61-100	• 4 = pulse rate greater than 120
<b>Sweating: Check Neck 1/2 Hour and Accounted for by Room Temperature at Patient Activity</b>	
0 = no report of chills or flushing	• 3 = beads of sweat on brow or face
1 = subjective report of chills or flushing	• 4 = sweat streaming off face
2 = flushed or observable moistness on face	
<b>Restlessness: Observe during Assessment</b>	
0 = able to sit still	• 3 = frequent shifting or extraneous movements of legs/arms
1 = reports difficulty sitting still, but is able to do so	• 5 = Unable to sit still for more than a few seconds

- Score of 10-12. We recommend  $>12$ .
- Administering first dose too early could put patient in quick, severe withdrawal (precipitated withdrawal), which is not good.



## Induction Day 1

1. Use COWS to determine withdrawal level. Proceed once score  $\geq 12$ .
2. Give first dose of buprenorphine/naloxone - typically 4/1 mg sublingual. **Let dissolve, do not swallow!**
3. Wait for 30 – 60 minutes. Relief of opioid withdrawal can begin as soon as within 30-45 minutes.
4. Repeat COWS and administer another dose, if needed (most likely). Wait another 45-60 minutes.
5. Repeat process 1-2 more times until COWS  $<6$  (mild). Day 1 max total dose = 16mg.
  - Greatest severity of buprenorphine-related precipitated withdrawal occurs most severely during the first 1-2 hours after a dose, if it happens.
  - Time in practice will vary. The patient needs a place to sit and wait. Patient can move and change rooms, if needed.



## ASAM recommendations: Induction Day 1

- The length of time the patient is monitored in the office varies depending upon:
  - Clinician's familiarity with the patient
  - Clinician's familiarity with using buprenorphine
  - Patient's level of support at home
- Maximum Day 1 dose of buprenorphine/naloxone = 16mg
  - Patient can determine how they feel and take more (every 2-4 hours, if withdrawal reappears).
  - Dose equivalent of other formulations; e.g. 5.7—11.4 mg of branded SL tablets. (Depends on what medication you're using. Just be familiar with it.)
  - Day 2 and beyond dose: 4-24 mg. Adjust dose like you do insulin or hypertension medications!



## Unobserved (home) induction

IT<sup>ATT</sup>RS

- Patient follows the Day 1 induction protocol themselves, *outside* of the clinic setting:
  - Has prescription for buprenorphine
  - Assesses withdrawal level with Subjective Opiate Withdrawal Scale (SOWS) themselves
  - Administers the buprenorphine themselves
- Detailed patient education and contact plan are essential
- Considered safe and effective (but studies had small sample sizes and short-term outcomes)



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## Unobserved (home) induction

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- Are space, logistics, or cost a concern for office inductions at your practice?
- How experienced are your MAT providers? Experienced MAT providers are better suited for unobserved inductions than inexperienced providers.\*
- What type of support system does the patient have?



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## Unobserved (home) induction

IT<sup>ATT</sup>RS

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### Office-based Induction

#### Pros:

- Effective
- Practice can confirm acceptable withdrawal scale score.
- Practice can confirm fidelity to induction protocol.
- Practice can see patient, answer questions, establish trust.
- Potentially, patient can access a peer counselor or behavioral health provider.

#### Cons:

- Space (Does it exist? Is it suitable?)
- Cost (resources)

### Unobserved (home) Induction

#### Pros:

- Effective
- Patient might be more comfortable.
- Practice might find this more convenient.

#### Cons:

- Practice cannot confirm withdrawal level.
- Practice cannot confirm fidelity to induction protocol.
- Communication might be less.



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## Unobserved (home) induction

IT<sup>ATT</sup>RS

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- Discuss the pros and cons of office and home inductions with patients and their support (if possible) to determine preference and fit.
- Provide written instructions about withdrawal assessment, dose timing and amount. (See your MATerials Resource Toolkit) (Who will do that?)
- Maintain and document phone contact. (Who will do that?)
- Schedule a follow-up visit within 4-7 days. (Who will do that?)
- Hybrid model?

(adapted from PCSS MAT Training (Sunderson, MD))



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## Telehealth induction

IT<sup>ATT</sup>Rs

- Patient follows the Day 1 induction protocol, *including contact with the clinic team*, except they are outside of the clinic setting:
  - Patient has prescription for buprenorphine
  - Practice staff and patient have contact by phone or video:
    - ❑ As withdrawal begins
    - ❑ 45-60 minutes later. Practice staff assesses withdrawal level with COWS or SOWS. Repeat until score  $\geq 12$ . Patient administers buprenorphine, monitored by the practice staff on phone/video
    - ❑ 30-60 minutes later (like an office induction). COWS/SOWS completed again, 2<sup>nd</sup> dose taken
    - ❑ 60 minutes later, and again as needed (just like an office visit) until COWS/SOWS score  $< 6$
- Detailed patient education and contact plan are essential



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## Induction: What if patient is not in withdrawal at time of arrival?

- Do not begin treatment. You might cause precipitated acute withdrawal, or the quick onset of withdrawal. The person feels awful.
  - Giving a patient who is high (full active) buprenorphine = crash landing
  - Giving a patient in mild to moderate withdrawal buprenorphine = smooth landing
  - That said, if precipitated withdrawal occurs, you can handle it. No crash cart needed!
- Assess time of last use and consider having patient either:
  1. Return another day
  2. Wait in the office until withdrawal begins
  3. Leave office and returning later in day (with strict instructions to not take opioids while away from the office)

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## Induction: What if patient is not currently dependent?

IT<sup>ATT</sup>Rs

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- Uncommon
- Can still meet DSM-5 diagnostic criteria
- No precipitated withdrawal concerns
- Start low (2 mg); go slow to avoid opioid side effects
- Give the patient general parameters for adjusting buprenorphine dose to find "sweet spot"

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## Induction Day 2

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- On Day 2, be in contact with patient in office or by phone. This should be part of the communication plan discussed at the MAT Review Appointment.
- Adjust dose accordingly based on patient's Day 1 experiences.
  - Lower doses if they have sedation
  - Higher doses if they have persistent withdrawal symptoms
- Determine who will make dosage recommendations to the patient. Just provider? Protocol for RNs or MAs?

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**David**


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**Next phase: stabilization**

- Buprenorphine level is stable after about 5-7 days (or 4-5 half-lives, where typical half-life is 28-36 hours)
- Stabilization lasts for 4-12 weeks, as patient's dose is adjusted and other opioid use (hopefully) resolves
- Regular contact with patient is important! Daily, weekly, and eventually monthly.
- Behavioral health care is introduced.
- Practice checks the Prescription Drug Monitoring Program.
- Don't expect abstinence after first dose of buprenorphine!



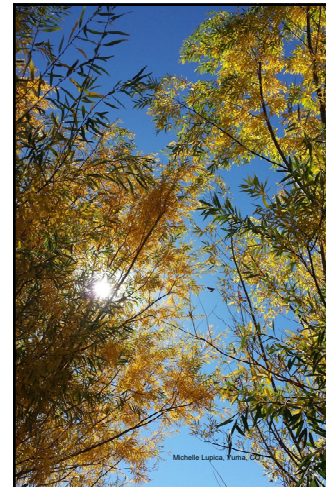
## Maintenance

- Usually begins after initial 4-12 weeks (after Stabilization)
  - Withdrawal symptoms are resolved, cravings are decreasing, side effects are managed
  - Patient is able to start dealing with other stuff that got them to the point of opioid use disorder in the first place
  - Contact: monthly visits typical for stable patients
- 




## MODULE 3 WRAP UP

- OUD is a chronic disease.
- MAT requires team-based care that your practice team can deliver!
- Induction = lasts 1-2 days, Stabilization lasts 4-12 weeks, Maintenance lasts 12+ months, perhaps years







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## MODULE 4, Sneak Preview

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- Practice MAT care during Stabilization and Maintenance
- Duration of treatment and relapse
- Insurance and billing (office management)
- MAT with Special Populations

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## Team discussion and action plan

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- How is everyone feeling? What are you thinking?
- What could be a feasible start?
- Action plan:
  1. ?
  2. ?

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 **ASAM** American Society of Addiction Medicine

 **AHRQ** Agency for Healthcare Research and Quality



 **OpiSafe**

 **PRACTICE INNOVATION PROGRAM**

 **SOuND** Team Training

 **ECHO** COLORADO

 **COLORADO CONSORTIUM** for Prescription Drug Abuse Prevention

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