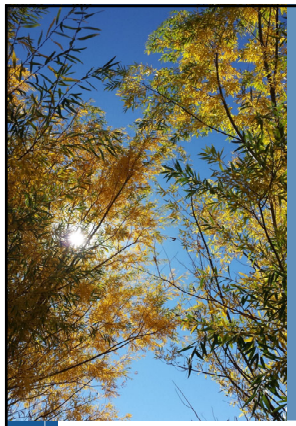

IT MATTTRs

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

1. Opioids, Receptors, Colorado, and You
2. The Patient: *Your role preparing the patient for MAT with buprenorphine*
3. **The Practice: *Supporting and providing MAT***
4. MAT during Stabilization & Maintenance and Special Populations

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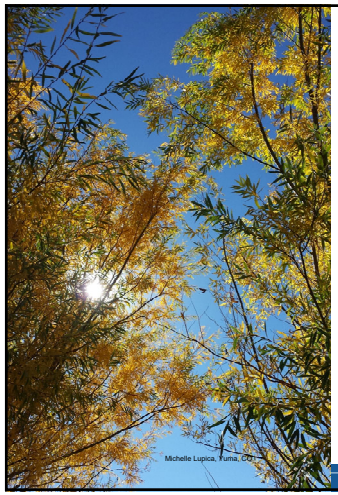

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MODULE 3

THE PRACTICE

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

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David

52 year old male formerly on worker's comp for back injury. Now buying opioid pills and smoking heroin. Recently separated, working day labor "when I can." Currently couch surfing. Stays with friends, many of whom use drugs and drink. Prior DUI arrest, on probation. Here for buprenorphine induction. He complains of irritability, nausea, and leg pains. On exam, he has a fast heart rate, is mildly anxious, and is sweating.

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MAT implementation checklist

	Practices with a MAT Bup prescriber	Practices without a MAT Bup prescriber
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Sdwlhqw#frqvhqw#iruP #iru#exsuhqrusklqh	☐	oo
Sdwlhqw#wuhdwp hqw#djuhhp hqw	☐	oo
Xulqh#guxj#whvwlqj#surwrfro#dqg#v|vwhp	☐	☐
Ghvljqdwhg#P DW#sudfwlfh#whdp #sk|vlfldq/#qxuvhv/#hwf1,	☐	☐
P DW#Whdp #z lwk#uhjxodu/vfkhgxohg#whdp #p hhwlqjv	☐	oo
Hp hujhqf|#p dqdjhp hqw#surwrfro	☐	☐
Hqurodg#rqh#sdwlhqw#lq#P DW	☐	oo
Hqurodg#43#ru#p ruh#sdwlhqwv#lq#P DW	☐	oo
Vwdii#wudlqhg#lq#P DW#+vxfk dv#LW#P DWWWUv Whdp #Wudlqlqj,	☐	☐
Uhihuudo#surwrfro#iru#ehkdylrudo#khdow k +dv#ri#surylghuv#z lwk#frqwdfw#dqg#dssw#lqir,	☐	☐
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Dqg p ruh¤ ¤		

Who are better candidates for MAT with buprenorphine?

- Patients with history of overdoses, particularly following detoxification
- Patients who have been opioid free but never felt "normal"
- Patients in whom mental, emotional, behavioral health illness emerged/worsened after previous detoxes
- Patients who ask for it!

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Maximize collaborative care

Team
- Provider (waivered)
- Nursing staff
- Social worker
- Counselor
- Medical assistant
- Administrative staff
- Peer counselor

Care activities
- Screening and intake
- Pretreatment assessments
- Treatment planning
- Medication management
- Monitoring (UDTs, pill counts, PDMP checks)
- Individual and/or group counseling
- Drop in groups
- Family support
- Relapse prevention
- Recovery Monitoring

Alford DP et al. *Arch Intern Med.* 2011.

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Buprenorphine treatment

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Treatment with Buprenorphine: Why are we doing this?

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)

MAT review appointment

- ~ 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)

How long should a patient take buprenorphine?

- 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!

Office (observed) Induction Patient Instructions

- 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

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 ≥ 36 hours after last dose of sustained-release opioid
- Methadone: Begin induction at least 48 hours after last dose. Wean down to ≤ 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)
Flowsheet 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: | | | | |

Resting Pulse Rate: Record Beats per Minute					
Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below 1 = pulse rate 81-100	• 2 = pulse rate 101-120 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity					
0 = no report of chills or flushing 1 = subjective report of chills or flushing 2 = flushed or observable moistness on face	• 3 = beads of sweat on brow or face • 4 = sweat streaming off face				
Restlessness: Observation During Assessment					
0 = able to sit still 1 = reports difficulty sitting still, but is able to do so	• 3 = frequent shifting or extraneous movements of legs/arms • 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 ≥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

- 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)

Unobserved (home) induction

Ip sruwdqw#frqvlghudwlrqv

- 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?**

Unobserved (home) induction

Surv#dqg#Frqv

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.

Unobserved (home) induction

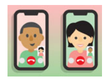
Z kdw#grhv#wkh#sudfwlfh#wkdp #ghhg#wr#grB

- 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 (Gunderson, MD)

Telehealth induction

- 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 ≥12. Patient administers buprenorphine, monitored by the practice staff on phone/video
    - 30-60 minutes later (like an office induction). COWS/SOWS completed again, 2nd 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

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)

Induction: What if patient is not currently dependent?

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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"

Induction Day 2

- 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?

David

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khurlq1#Uhfhqwo|#vhsdudwhg/#zrunlqj#gd|#oderu#zkhq#
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pdq|#ri#zkrp#xvh#guxjv#dqg#gulqn1#Sulru#GXL#duuhvw/#
rq#suredwlrq1#Khuh#iru#exsuhqrusklqh#lqgxfwlrq1#Kh#
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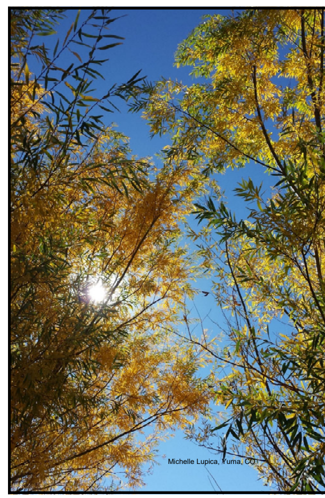
Next phase: stabilization

- 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!

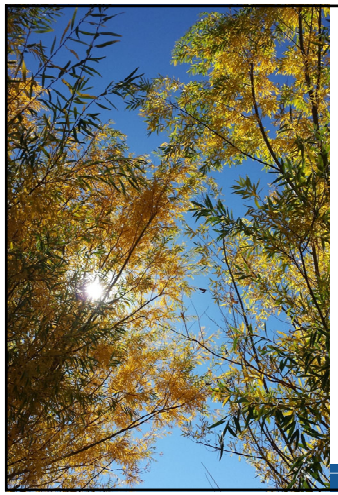
Maintenance

- 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

- 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

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

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HIGHPLAINS RESEARCH NETWORK
ASAM American Society of Addiction Medicine
AHRQ Agency for Healthcare Research and Quality
CaReNet
OpiSafe
PRACTICE INNOVATION PROGRAM
SOuND Team Training
ECHO COLORADO
COLORADO CONSORTIUM for Prescription Drug Abuse Prevention
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