IT MATTTRs Colorado

Implementing Technology and
Medication Assisted Treatment and Team Training
in Rural Colorado

Primary Care Practice Training

[Faculty name, credentials]

No disclosures to report

Whole Practice Training Modules

4 modules (1 hour each) + SBIRT Training

1. Opioids, Receptors, Colorado, and You
2. **The Patient:** ***What is your role in helping a patient?***
3. The Practice: *What does a practice need to support a patient getting MAT or provide MAT?*
4. Special Populations
5. SBIRT: Screening, Brief Intervention, and Referral to Treatment

The Patient

Module II: The Patient

- What is your role in helping David or Lauren? What comes next?
- There is a standard process for identifying and diagnosing patients (just like diabetes).
- What does your patient experience on buprenorphine? Like you understand insulin, teams can/should understand how buprenorphine works.
- How does the practice want to define success? Like diabetes, treatment is a lifetime.

Module II: The Patient

- Patient Assessment
- Preparation for Treatment
  - Treatment Agreement
  - Informed Consent
- Buprenorphine efficacy, safety, diversion risk

Lauren

30 year old female with longstanding knee arthritis, depression, anxiety. Escalating doses of opioids over the last year along with ‘red flag’ behaviors including multiple unsanctioned dose escalations. Admits to purchasing additional oxycodone “off the street” when she runs out and to using alcohol to manage her pain and anxiety when opioids aren’t available.

Questions

- Is there an opioid use disorder?
- Is this patient appropriate for outpatient treatment?
- What would you recommend?
- How would you discuss your recommendations with the patient?

What does IT MATTTRs Colorado provide?

Tool/Material	With Bup Prescriber	Without Bup Prescriber
Patient consent form for buprenorphine	✓	
COWS and SOWS, DAST-10 templates	✓	
Patient treatment agreement and contract	✓	✓
Screening process (and screening tool) for patients	✓	✓
Patient assessment checklist	✓	✓
Opioid registry and tracking system (Opisafe)	✓	✓
MAT resource book/handouts for patients	✓	✓
Side effect management protocol	✓	✓
And lots of tools and templates for your practice – Session III		

Assessing Patient for OUD and Need for MAT

Qualities of the healthcare team interviewer:

- Non-judgmental, curious, respectful
- Attentive to responses, persistent
- Follow up on vague or “qualified answers”

To facilitate effective treatment:

- Acknowledge some information is difficult to talk about
- Ask questions out of concern for patient’s health
- Avoid using labels or diagnoses
- Assure confidentiality

Assessment Overview

1. Establish diagnosis of opioid use disorder and current opioid use history
2. Document use of alcohol and other drugs and need for medically supervised withdrawal management
3. Identify comorbid medical and mental, emotional, and behavioral health conditions; how, when, where they will be addressed
4. Screen for and address communicable diseases
5. Evaluate level of physical, psychological and social functioning or impairment
6. Determine patient's readiness to participate in treatment

Practices can observe but can also screen patients for opioid use disorder.

Assessment Step 1a:

Criteria for Opioid Use Disorder - Part 1 (DSM V):

- Who does screening for other conditions in your practice?
- Who can do these screenings? Anyone? Just the prescriber?
- Screening tool(s) are included in your IT MATTTRs MATerials Toolkit.

What are we looking for when diagnosing opioid use disorder?

Assessment Step 1a:

Criteria for Opioid Use Disorder - Part 1 (DSM V):

- Opioids taken in larger amounts or over longer period than intended
- Persistent desire or unsuccessful efforts to cut down or control opioid use
- Great deal of time spent in activities necessary to obtain, use, or recover from effects of opioids
- Craving/strong desire or urge to use (new to DSM-5)
- Recurrent use resulting in failure to fulfill major role obligations at work, school, or home

Assessment Step 1a:

IT MATTTRs Colorado™

Criteria for Opioid Use Disorder - Part 2 (DSM V):

- Continued use despite persistent or recurrent social or interpersonal problems caused by exacerbated by effects of opioids
- Important social, occupational, or recreational activities given up or reduced because of use
- Recurrent use in situations where physically hazardous
- Use continued despite persistent or recurrent physical or psychological problem likely to have been caused or exacerbated by opioids
- Tolerance
- Withdrawal

} ←Not applicable if used as Prescribed in pain program

Opioid Use Disorder = score of ≥4; moderate OUD.

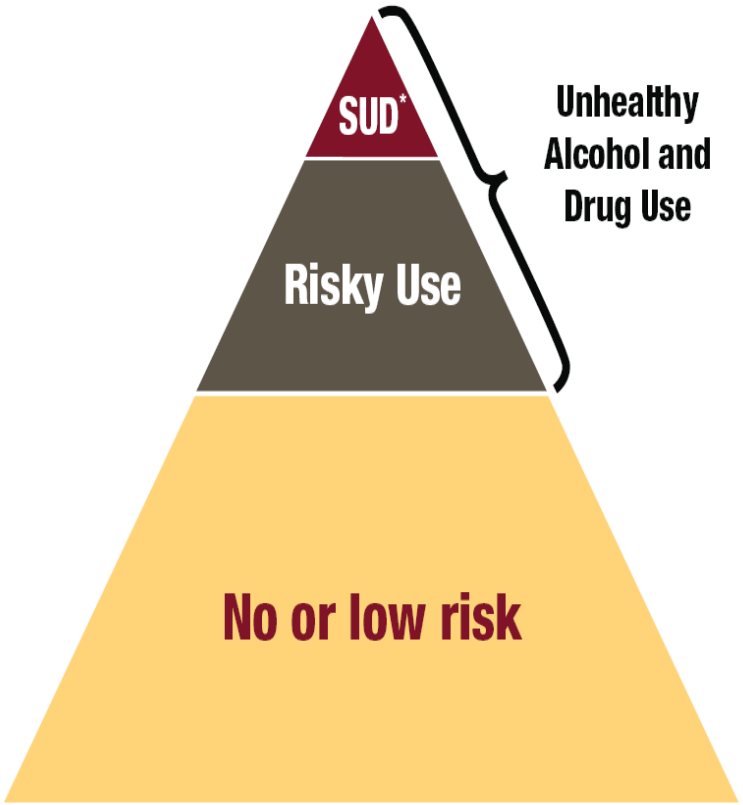
Assessment Step 1b: Opioid use history

- Quantity used per day
- Type: heroin, prescription opioids
- Routes: IV, IM, SC, PO, intranasal, inhaled
- Last used, date and time
- Previous attempts to discontinue
- Past treatment experience
  - Nonpharmacologic
  - Pharmacologic with agonist (methadone, buprenorphine) and antagonist (naltrexone) therapies

Assessment Step 2: Alcohol & other drugs?

- Screen for unhealthy alcohol and other drug use
- Assess for a substance use disorder (DSM 5)
- Assess for other consequences, e.g., medication interactions, medical complications
- Provide feedback and assess readiness for change
  - Enhance motivation in low readiness, support motivation in moderate to high readiness
  - Action plan in high readiness, e.g. MAT?
- **Use of other drugs does not mean patient cannot receive buprenorphine treatment*****

Screening for Unhealthy Substance Use



*Substance Use Disorders

Alcohol

"Do you sometimes drink beer, wine or other alcoholic beverages?"

How many times in the past year have you had 5 (4 for women) or more drinks in a day?"

(positive: > never)

Drugs

"**How many times** in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"

Smith PC et al. *J Gen Intern Med*. 2009; 24(7):783-8.
Smith PC et al. *Arch Intern Med*. 2010; 170(13):1155-60.
Image source: SBIRT Clinician's Toolkit www.MASBIRT.org

Assessment Step 3a: Medical Co-morbidity?

- Past and present medical illnesses, hospitalizations, surgeries, accidents/injuries
- Current medications, drug allergies
- Is the patient taking other medications that may interact with buprenorphine, e.g., opioids, naltrexone, sedative-hypnotics?

Assessment Step 3b: Mental, Emotional, and Behavioral (MEB) Health Problems?

- History of inpatient and/or outpatient treatment
- Untreated episodes of MEB illness
- Treatment adherence to MEB medications
- Is the patient psychiatrically stable?
- Are the psychosocial circumstances of the patient stable and supportive?

Assessment Steps 4 & 5: Physical Examination

- Vital signs
- Standard physical examination
- Pay attention to:
  - Stigmata of injection drug use, e.g., needle tracks, skin and soft tissue infections
  - Stigmata of chronic infections, e.g., HIV, hepatitis C
  - Neurocognitive function
  - Liver disease and dysfunction

Assessment Steps 4 & 5: Laboratory Evaluation

- Liver function tests
- Hepatitis and HIV serologies
- Pregnancy test for women
- Urine drug testing
  - Naturally occurring opiates (morphine (heroin), codeine)
  - Synthetic and semisynthetic opioids (methadone, oxycodone)
  - Other commonly used drugs (cocaine, amphetamines, benzodiazepines)

Assessment Step 6: Is the patient ready to participate in treatment?

- What motivates the patient to do this?
- Patient understands the risks and benefits of (and alternatives to) buprenorphine treatment
- Patient expects to follow safety procedures
- Demonstrates indicators of reliability, e.g., steady employment, adherence to other medications and appointments?

Are you ready to help your patient?

- Are there resources available in the office to provide appropriate treatment? Medical or psychiatric care?
- Behavioral health care?
- Are there treatment programs available that will accept referral for more intensive levels of service if needed?
- Words of wisdom
  - Don’t start with the most complicated patient
  - Start with 1 patient, not 30
  - Know your limits
  - Don’t be afraid to consult with colleagues or other resources

Who are Better Candidates for Agonist Therapy (Buprenorphine?)

- Patients with history of overdoses, particularly following detoxification
- Patients who have been opioid-free but never felt “normal”
- Patients in whom MEB illness emerged/worsened after previous detoxes
- Patients with mild to moderate chronic pain requiring chronic opioid pain treatment

Lauren

Lauren admits she has been unable to take her pills only as prescribed. She has tried to cut back multiple times in the past but has been unsuccessful. Her husband is angry with her constant focus on the medications and he reports that her kids "want their mom back." She spends most of her day on the couch except when she has medical appointments or has run out of medications and has to find extras. She thinks her depression and energy are worse since taking higher doses.

Lauren

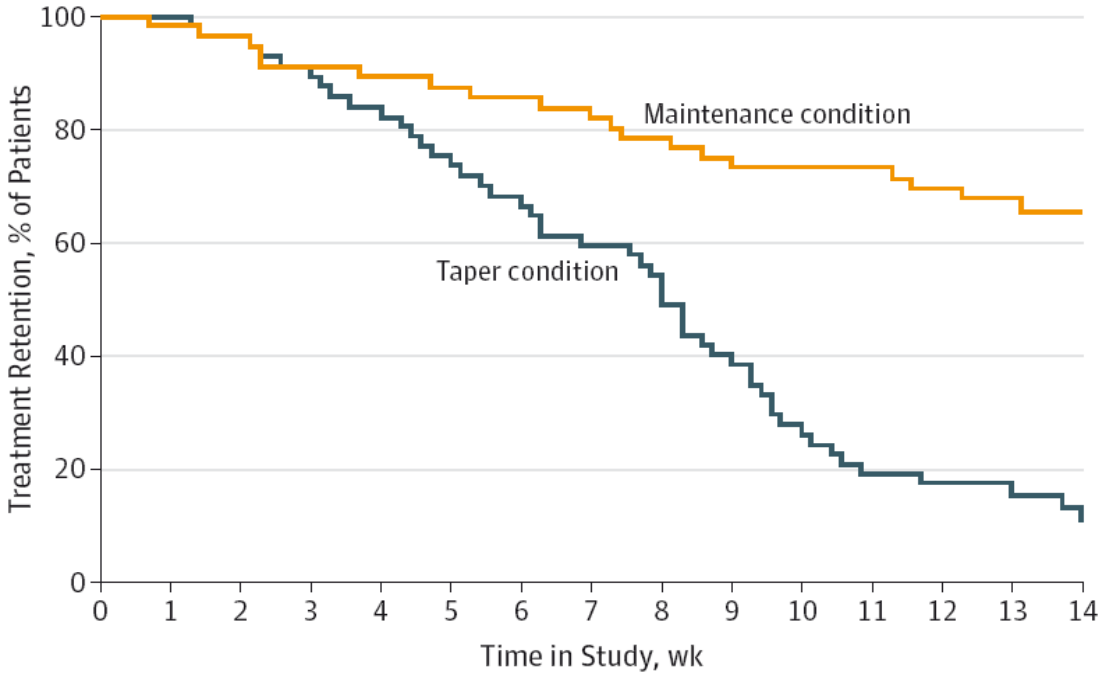
Criterion	Present/Absent
Taken in larger amounts/longer period than intended?	✓
Desire to cut down or unsuccessful efforts to control use?	✓
Great deal of time spent acquiring/using/recovering?	✓
Craving/strong desire or urge to use?	✓
Failure to fulfill major role obligations at work/school/home?	✓
Continued use despite persistent social/personal problems?	✓
Important social, occupational, recreational activities lost?	✓
Recurrent use where physically hazardous?	No
Recurrent psychological or physical problems caused or exacerbated by drugs?	✓
Tolerance	N/A
Withdrawal	N/A
Total Score	**7**

Buprenorphine Safety

- Highly safe medication (for both acute and chronic dosing)
- Primary side effects:
  - nausea and constipation (which are also common with opioids)
- No evidence of significant disruption in cognitive or psychomotor performance with buprenorphine maintenance
- No evidence of organ damage with chronic dosing of Buprenorphine “mono” or “combo” formulations

Buprenorphine Effectiveness:

Treatment Retention in Maintenance vs Taper for Prescription Opioid Use Disorder



dosage, mg/d														
lition	14.9	15.1	15.2	15.3	15.3	16.0	15.9	16.2	16.2	16.6	16.8	16.2	16.1	15.8	14.6
	15.6	15.6	15.4	15.3	14.2	9.7	5.7	3.1	0.6	0.2	0	0	0	0	0

Completion 14 week trial:

- Taper = 11%
- Maintenance (buprenorphine) = 66%

Fiellin DA et al. *JAMA Intern Med.* 2014

HIGHPLAINS RESEARCH NETWORK

SNOCAP State Networks of Colorado Ambulatory Practices & Partners

CaReNet

Potential Abuse of Buprenorphine

- Slight euphoria in non-opioid dependent individuals
- Abuse potential less than full opioid agonists
- Abuse among opioid-dependent people is relatively low
- Combination product theoretically less likely to be abused by IV route
- Most illicit use is to prevent or treat withdrawal and cravings

Yokel MA et al. *Curr Drug Abuse Rev.* 2011.
Lofwall MR, Walsh SL. *J Addic Med*.2014.

Buprenorphine/Naloxone "Combo" to Decrease Diversion

- Naloxone has limited bio-availability orally or sublingually, but is active parenterally (if injected beneath skin, in muscle, or in vein).

- If combo product is crushed, dissolved and injected:
  - Naloxone may cause initial withdrawal if the person is opioid dependent, which decreases diversion and misuse.
  - Naloxone will block, or decrease, the opioid agonist effect of the buprenorphine. A person won't get high. Most people get sick (headache and nausea). Therefore, the combination medication is safer, if it is diverted and misused.

Comer S et al. *Addiction.* 2010

Buprenorphine/Naloxone Bioavailability

- If dissolved sublingually
  - Buprenorphine is active
  - Naloxone is not active
- If swallowed
  - Buprenorphine not active (minimal oral bioavailability)
  - Naloxone not active

Do not swallow!

- If injected
  - Buprenorphine active, but
  - Naloxone active x 20 minutes so attenuates (decreases) the parenteral "rush"

Do not inject!

- Not time-released so tablets/film strip can be cut/split

Alternatives to Buprenorphine

The last section of Module 2 provides information on other medication treatments for your review.

- Injectable Naltrexone
- Methadone Maintenance Treatment
- What they are is, possible benefits, potential candidates, limitations

Tools: Treatment Agreement

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
  - "Lost" prescriptions
  - Unexpected UDT results
  - Nonadherence or unexpected results
- Maintenance vs. detox

Tools: Informed Consent

- 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

Lauren

Lauren asks to be weaned off of opioids. Over a three month period, she is unable to follow the weaning schedule and eventually agrees to a trial of buprenorphine. Physical exam and labs are unremarkable. You explain the risks and benefits, including pregnancy concerns. She signs the consent and agrees to return to the office in active withdrawal for her induction appointment.

Module II Wrap-up

- Patients should be diagnosed with a moderate or severe opioid use disorder (≥4 criteria) to benefit from buprenorphine therapy.
- Assessment includes screening for medical and MEB health issues, other drug and alcohol use, relapse potential, patient motivation, and social supports.
- Physical exam and lab testing to include liver tests, pregnancy, STIs, HIV, and Hepatitis.
- Informed consent/treatment agreements are common.

Module III – Sneak Preview

The Practice:

- What does the MAT Team do?
- Front desk, nursing, prescriber, behavioral health, billing.
- Induction
- Stabilization
- Maintenance
- The full spectrum of MAT
- Who can help?

You can help

Alternatives to Buprenorphine

Injectable Naltrexone (XR-NTX)*

- Multicenter (13 sites in Russia)
  - DB RPCT, 24 wks, n=250 w/ opioid dependence
  - XR-NTX vs placebo, all offered biweekly individual drug counseling
  - Increased weeks of confirmed abstinence (90% vs 35%)
  - Increased patients with confirmed abstinence (36% vs 23%)
  - Decreased craving (-10 vs +0.7)
- Two recent studies showed similar effectiveness for XR-NTX and daily buprenorphine-naloxone (BUP-NX)
  - More difficult to start patients on XR-NTX than BUP-NX

*No Black Box LFTs Warning Label for IM formulation

Krupitsky E et al. *Lancet.* 2011.

Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): A multicentre, open-label, randomised controlled trial. Lee J.D. et. Al. (2017) *The Lancet.*

Naltrexone: Benefits

Benefits

- Good for patients who do no want agonist or partial agonist therapy
- No risk of diversion (not a controlled substance)
- No risk of overdose by drug itself
- Can be administered in any setting (OBOT or OTP)
- Long-acting formulation
- Treats both opioid use disorder and alcohol use disorder

Potential Naltrexone Candidates

- Occupational Obstacles: e.g, HCPs
- Not Interested/Failed Agonists
- High Motivation for AA Model of Recovery
- Currently Abstinent: High Risk for Relapse
- Younger, Lower Duration of OUD
- Don't want to be Physically Dependent
- Tired of regulations, stigma, and SO pressure

Naltrexone: Limitations

Limitations

- Ease of starting—must be fully withdrawn from opioids
  - short-acting (6 days)
  - long-acting opioids (7-10 days)
- Not recommended for pregnant women
  - Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine monopro
- Diminished tolerance to opioids, unaware of consequent increased sensitivity to opioids if they stop taking naltrexone
- Head to Head Studies Buprenorphine versus IM Naltrexone equally effective if able to start IM Naltrexone

Methadone Hydrochloride

- Full opioid agonist
- Oral - 80-90% oral bioavailability
- Tablets, Liquid Solution, Parenteral (↓50%)
- PO onset of action 30-60 minutes
- Duration of action
  - 24-36 hours to treat opioid use disorders (OUD)
  - 6-8 hours to treat pain
- Proper dosing for OUD
  - 20-40 mg for acute withdrawal
  - > 80 mg for craving, "opioid blockade"

Methadone Maintenance Treatment

- Highly regulated - *Narcotic Addict Treatment Act 1974*
  - Created Opioid Treatment Programs (OTPs)
  - Separate system not involving primary care or pharmacists
- Treatment (methadone dispensing) for opioid use disorder limited to licensed OTPs
- It is illegal for a physician to ***prescribe*** methadone for the treatment of opioid use disorders in an office-based practice

Methadone Maintenance in OTP

Highly Structured

- Daily nursing assessment
- Weekly individual and/or group counseling
- Random supervised drug testing
- Psychiatric services
- Medical services

Methadone dosing

- Observed daily ⇒ "Take homes" based on stability and time in treatment. Max: 27 take homes. Varies by state, county and individual clinics

Methadone Maintenance Treatment

Benefits

- Increases overall survival
- Increases treatment retention
- Decreases illicit opioid use
- Decreases hepatitis and HIV sero conversion
- Decreases criminal activity
- Increases employment
- Improves birth outcomes

Methadone Maintenance Treatment

Limitations

- Limited access
- Inconvenient and highly punitive
- Mixes stable and unstable patients
- Lack of privacy
- No ability to "graduate" from program
- Stigma

The IT MATTTRs Primary Care and Behavioral Health Team Training curricula were created with support from the Agency for Healthcare Research and Quality (grant number 5R18HS025056-02)

HIGHPLAINS RESEARCH NETWORK

SNOCAP State Networks of Colorado Ambulatory Practices & Partners

CaReNet