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 provide support to their patients getting MAT?***
4. Special Populations
5. SBIRT: Screening, Brief Intervention, and Referral to Treatment

IT MATTTRs Colorado™

The Practice

Implementing Office Based Opioid Treatment (OBOT)

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Module III: Treatment – The Practice

- Patient Centered Practice
- Office Management: billing issues
- Medication Management
- Induction and Stabilization
- Role of Non-Pharmacotherapy
- Behavioral health integration
- Patient Monitoring
- Long term follow-up
- Opisafe

David

52 y.o. 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.

Implementation Check Lists

		For practices with a MAT buprenorphine prescriber	*For practices without a MAT buprenorphine prescriber*
1	Physician, nurse practitioner, or physician assistant prescriber with buprenorphine waiver certification	☐	-
2	Patient consent form for buprenorphine	☐	-
3	Patient treatment agreement and contract	☐	-
4	Diversion Control plan developed and in place	☐	-
5	Urine drug testing protocol and system	☐	-
6	Designated MAT practice team (physician, nurses, etc.)	☐	-
7	MAT Team with regular schedule team meetings	☐	-
8	Emergency management protocol	☐	-
9	Enrolled 1 patient in MAT	☐	-
10	Enrolled 10 or more patients in MAT	☐	-
11	Staff trained in MAT (ECHO or SOuND Team Training) & how many? _____	☐	☐
12	Referral protocol for behavioral health (list of providers with contact and appointment information)	☐	☐
13	Behavioral Health – integrated care model, or in house – or signed treatment/management agreements with at least one external behavioral health provider	☐	☐
14	Psychosocial support/connection identified and referrals available (i.e. 12-step, community organizations, faith community)	☐	☐
15	Payment schedule with diagnostic and billing codes	☐	☐
16	Screening process (and screening tool) for patients currently on opioids, new opioid prescriptions, identification of illicit use	☐	☐
17	Patient assessment checklist	☐	☐
18	Opioid registry and tracking system (Internal, PDMP, OpiSafe)	☐	☐
19	MAT resource/protocol book for practice - provided by IT MATTTRs	☐	☐
20	MAT resource book/handouts for patients	☐	☐
21	Opioid overdose prevention kit	☐	☐
22	Side effect management protocol	☐	☐
23	Referral protocol to practice with buprenorphine prescriber	-	☐
24	Signed treatment/management agreement with practice with buprenorphine prescriber	-	☐
25	Referred 1 or more patient for MAT at another facility	-	☐
	Notes:		

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REMINDER:
What will you get from IT MATTTRs Colorado?

Practice Tools and Materials

- ❑ Staff and Prescriber Training
- ❑ Patient consent form and contract for buprenorphine treatment
- ❑ Payment schedule with diagnostic and billing codes
- ❑ Opioid registry and tracking system (Opisafe)
- ❑ Diversion Control plan templates
- ❑ Urine drug testing protocol and system templates
- ❑ MAT resource/protocol book for practice
- ❑ Electronic Health Record documentation templates

Anticipate Insurance Issues

- Is buprenorphine a covered benefit? What tier? What co-pays?
- Is behavioral treatment covered?
- Beware behavioral health carve outs!
- Are lab services covered?
- Restrictions on duration of treatment?
- Anticipate prior approval procedures
  - Collect forms from each payer
  - Submit forms in advance of fill
  - Consider cash for first few days supply
  - Monitor patient's pharmacy benefits
  - 340B coverage in some Community Health Centers

Billing for Office-based Opioid Treatment (OBOT) $$$

- OBOT is standard medical care. Billing procedures are standard. You use codes everyday.
- The ICD-10 Code for opioid dependence is F11.20.
- Physicians billing codes: (CPT, E & M Codes) billing codes, accepted by all payers:
  - 99215: $200 - $250 (or higher)
  - 99354: $150 - $200
  - 99408: $50 - $75
- No specific Addiction Medicine codes. Same codes as other ambulatory care services.
- More information provided in MATerials toolkit.

Maximize Collaborative Care

Team

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

Care responsibilities

- 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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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 mental, emotional, behavioral health illness emerged/worsened after previous detoxes

Buprenorphine Treatment

- Induction
- Stabilization
- Maintenance

Buprenorphine Induction: *Why are we doing this?*

Overall Goals

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)

Buprenorphine Induction:

Patient Instructions

- Come in with moderate withdrawal
- Plan to be at clinic or office for up to 3 hours (may bring a sandwich, book, etc.)
- Bring buprenorphine medication bottle, or have it delivered if applicable (prescribe vs. dispense)
- Accompanied by significant other, if possible

COWS: Clinical Opioid 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				

How one HPRN practice does Day 1:

1. MA does the COWS with the patient.
2. The Informed Consent/Agreement form (which we'll cover later) is done the previous week.
3. Physical. Usually short because the person feels miserable.
4. Provider gets the medication. Open box. Give it to the patient. Make sure they let it dissolve. Tell the patient you'll be back in 30 minutes.
5. Upon return, get more history of why the patient uses? When he/she uses? Confirm past medical history, other conditions. Identify patient's goals. What motivates them? What do they want to get out of this?
6. Come back in another 30 minutes. Complete another COWS. MA can do this. Allows patient to bond with entire team. Administer another dose. Watch for another hour.
7. Complete another COWS. Aim for score between 0-5. Align patient's motivation with feeling better.
8. Send home.

Induction – Day 1, Scenario 1

#1: Patients not currently dependent on opioids
(not on opioids, i.e., just got out of jail, completed detox, no opioids for 30 days)

- 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 1, Scenario 2

#2: Patients dependent on opioids (typical induction case)

- 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 at 12noon is a good time to stop (for a Monday Day 1).
- Dependent on **long-acting** opioids (Methadone, Oxycontin, MS Contin/Morphine):
  - If on methadone, wean down to ≤ 30 mg/d.
  - Begin induction at least **48-72** hours after last dose of methadone, **≥ 36** hours after last dose of Sustained Release (SR) oxycodone or morphine.
  - Saturday at 12noon is a good time to stop (for a Monday Day 1).

Induction – Day 1

- If patient is not in withdrawal at time of arrival, assess time of last use and consider having patient either:
  1. Return another day
  2. Wait in the office until evidence of withdrawal is seen
  3. Leave office and returning later in day (with strict instructions to not take opioids while away from the office)

Induction – Day 1

- Typical first dose: buprenorphine/naloxone 4/1 mg sublingual
  - Monitor in office for 30 minutes to 1 hour after first dose and subsequent dose
  - Relief of opioid withdrawal should begin within 30-45 minutes
- Period of greatest severity of buprenorphine-related precipitated withdrawal occurs in the first few hours (1-2 hours) after a dose
- Practice needs a place for patient to sit and wait.

Sublingual Use & Bioavailability

- Sublingual tablets/film strip must be held under tongue or cheek for several minutes to dissolve

- Instruct patient to:
  - Not talk
  - Keep under tongue or in cheek (1-2 minutes)
  - Don’t swallow until entire tablet/film dissolved.

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
- Patient can re-dose if needed (every 2-4 hours, if opioid withdrawal subsides then reappears).
- Maximum Day 1 dose of buprenorphine/naloxone = 8mg to 16mg
  - Patient can determine how they feel and take more as needed.
  - 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, HTN meds!

Precipitated Acute Opioid Withdrawal

- Precipitated in a physically opioid dependent person, by administration of either:
  - an opioid antagonist drug (e.g. naloxone, naltrexone) or
  - an opioid partial agonist drug (e.g. buprenorphine)
- Similar to spontaneous withdrawal but faster onset
- Duration depends upon half-life of drug

Precipitated Acute Opioid Withdrawal

- **Treatment**
- If a patient has precipitated withdrawal consider:
  - Giving another dose of buprenorphine to provide enough agonist effect from buprenorphine to suppress withdrawal.
  - Stopping the induction, provide symptomatic treatments for the withdrawal symptoms and have patient return the next day.
- Since stopping induction would risk loss of the patient, the first option should be preferred.

Day 2: Stabilization Begins

- On Day 2, be in contact with patient (in office, phone)
- Adjust dose accordingly based on patient's Day 1 experiences
  - Lower doses if they have sedation
  - Higher doses if they have persistent withdrawal symptoms

Day 3 and beyond: Stabilization

- Patient may need daily contact for several days, depending on response
- Stabilization continues for first 4-12 weeks as patient's dose is adjusted and all other opioid use (hopefully) resolves
- *Don't expect abstinence after first dose of buprenorphine!*

The Rest of Stabilization

- Monthly contact
- Behavioral Health
- Buprenorphine level is stable after 4-5 half-lives (28 – 36 hours is typical half-life)

Maintenance

- Usually after initial 4-12 weeks
- Withdrawal symptoms resolved
- Cravings improved
- Side effects managed
- Able to start dealing with other stuff that got them to the point of opioid use disorder in the first place

- Monthly visits typical for stable patients

How Long Should Buprenorphine Maintenance Continue?

- We don't know. No data to provide guidance on how long to treat a patient with buprenorphine/naloxone maintenance.
  - <16 weeks of treatment is associated with high levels of withdrawal
  - Patients can be retained long term; approximately 75% retention at one year with buprenorphine maintenance (Kakko et al., 2003)
- Continue maintenance as long as patient is benefitting from treatment (opioid/other drug use, employment, educational goals pursued, improvement in relationships, improvement in medical/mental illnesses, engaged in psychosocial treatment).
- Celebrate with patient!

Buprenorphine Discontinuation

- First question is “Why discontinue?”
- Comprehensive discussion with patient and significant others to explore reasons for discontinuation
- Naltrexone therapy might be considered (deterrent; “sick high”)
- Psychosocial treatments should continue
- Patients should be followed by provider after discontinuation
- Patients should be told they can resume buprenorphine treatment if cravings, lapses, or relapses occur

Role of Non-Pharmacological Treatment

Opioid Use Disorder (OUD): Behavioral Treatment Components

- Psychosocial Services:
  - Often helpful for treatment of OUD.
  - Can be delivered directly by physician and/or by referral when needed.
- The DEA waiver law (DATA 2000): "…the practitioner has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services."
- Refer patient as clinically determined to individual and group therapy, family therapy, 12 Step
- Higher psychiatric severity patients are more responsive to increased services.
- DEA recognizes that MAT is not just a pill

Primary Care Management

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Critical Elements: Medical Care Team

- Monitoring compliance with buprenorphine maintenance
- Monitoring of patients' drug use, symptoms, and progress
- Education regarding opioid use disorder and buprenorphine maintenance treatment
- Encouragement to achieve abstinence from illicit opioids and to adhere to all treatment recommendations
- Identification and treatment of side effects and complications of opioid use

Primary Care Management

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Critical Elements: Behavioral Care Team

- Encouragement to attend self-help groups
- Cognitive behavioral therapy (CBT / DBT)
- Addiction counseling
- Lifestyle changes that support recovery and to avoid potential triggers of drug use
- Relapse prevention
- Peer counseling

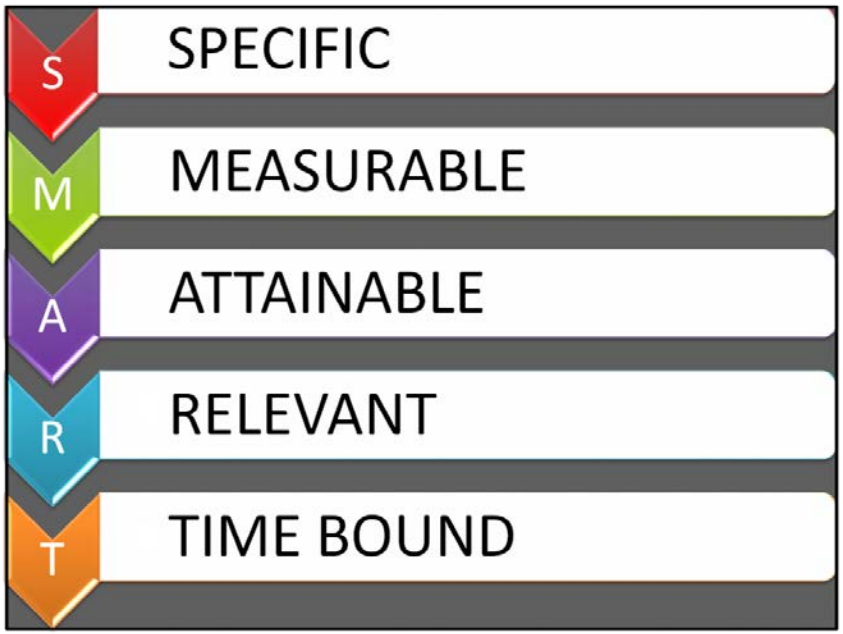
Medication Monitoring Visits – Part 1

- Face to face visits to check safety, adherence
- Initial frequency every 2-4 weeks until stable; monthly once stabilized
- Check dosing, intervals, sublingual technique
- Safety issues: Side effects, safe storage
- Tobacco, alcohol, and other drug use
- Urine drug tests (UDT)
  - Frequency varies with treatment stage and the systems the practice has available. Some patients will already be dropping UAs, (i.e., at parole officer)

Medication Monitoring Visits – Part 2

- Confirm behavioral treatment
- 12 step facilitation
- Medical problems & symptoms
- Psychiatric problems & symptoms
- OpiSafe (accesses prescription drug monitoring program and more)
- Outside medications and providers
- Withdrawal/craving/triggers
- Housing
- Employment
- Family/Relationships
- Legal issues…

Setting and Monitoring Treatment Goals



- Discuss and document specific, simple goals
- Set specific time periods
- Document progress on goals at each visit
- Examples:
  - Achieve abstinence from illicit and non-prescribed drugs
  - Meet with clinician
  - Attend meetings
  - Job applications

Relapse: Consider Goals of Treatment

- Abstinence from illicit and non-prescribed drugs
- Identification and diagnosis
- Engage/retain in treatment
- Facilitate and accelerate behavior change
- Treatment/prevention of medical co-morbidities
  - Harm reduction
- Identification and treatment of psychiatric co-morbidities
- Decrease impact on society
- *To what degree is patient meeting treatment goals?*

Urine Drug Testing (UDT)

(for use of non-prescription illicit drugs)

- Monitoring of treatment progress and safety
- Reinforces success with treatment
- Part of standard of care for:
  - Monitoring for ongoing opioid use
  - Monitoring for use of non-opioids
  - Monitoring for adherence with buprenorphine medication administration
  - Identifying those who may need higher level of care
  - Every 1-2 weeks early in treatment; monthly after
- You want to find buprenorphine and nothing else!
- Don’t find bup? Patient might be diverting (selling) medication.

Pill/Film Counts

This is standard care.

- Have the patient bring in all their medicines at first visit
- Frequency varies with patient progress
- Best option when diversion suspected
- Patient brings in medication supply
- Confirm patient ID and fill date on bottle/box
- Have patient count them in front of staff member
- All tablets/film should be identical
- Amount should match expected quantity

Prescription Drug Monitoring Program (PDMP)

- State-wide system tracks controlled substance prescriptions
  - Requires DOB, SSN. Patient can change name, but other information will ID patient.
  - Detect doctor shopping
  - Improving clinical decision making
- Colorado PDMP sends “push notifications” to providers regarding patients with certain high-risk features
- Staff can be authorized to check the PDMP.
- Colorado has relationship with Utah, Wyoming, Nebraska

OpiSafe: Your one-stop shop!

- Developed by RxAssurance, in partnership with the Skaggs School of Pharmacy, to make it easier for physicians to safely prescribe opioids and monitor prescriptions.
- Comprehensive opioid management program
- Comprehensive assessment and risk stratification (risk for addiction)
- Check every patient's PDMP report automatically
- You can set custom parameters for notification, patient by patient:
  - Number of prescribers
  - Number of pharmacies
- Track urine toxicology results and frequency (if using OpiSafe collaborative lab)

David

1. Is he ready for buprenorphine induction?
2. Why is his prior DUI concerning?
3. How will you manage him today?
4. When will someone in your office see or speak with him again?
5. What other services will you offer?

Module III Wrap-up

- Time frame:
  - Induction = Day 1
  - Stabilization Phase generally lasts 1-4 weeks
  - Followed by Maintenance Phase
- OUD is a chronic disease.
- Regular monitoring with frequent follow-up, urine toxicology testing, OpiSafe.
- Practices must have the ability to refer for counseling.
  - Though robust counseling is ideal, studies show good outcomes even with low intensity models.
- Optimal duration of buprenorphine therapy isn't known but longer probably better.

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