Expanding the Use of MAT in a CCBHC

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Learning objectives

1. Understand the CCBHC model of care for complex clients, specifically those with opioid use disorders who may be prescribed MAT.

2. Identify and discover some of the benefits of prescribing MAT in outpatient treatment for OUD’s as well as some of the challenges.

3. Increase knowledge of what is involved with successfully working with and effectively managing an Ambulatory Withdrawal Management program on site in an outpatient mental health facility.
Addiction Treatment: An exciting time to be involved!

Forces driving integration include:
- Legislation → parity of substance use treatment with other medical benefits, increasing the amount of services which can be billed and reimbursed.
  - Medicaid SUD expansion NJ 2017-2019: case management, residential, MAT and OBAT expansion
- More neuroscientific research
- Due to opioid epidemic, increased sources of grant funding for integration of behavioral health and primary care
- Expansion in the availability of buprenorphine for OUD (and other MAT) as well as the evidence to support its use in office-based care, (improved outpatient treatment options) (requires medical staff to take larger role)
Addiction Treatment: An exciting time to be involved!

• Increased opportunities for interprofessional collaboration
• Larger role for primary care and medicine in general
• Harm reduction is at the center of the chronic disease model
Models for MAT delivery

• Inpatient/ detox
• Ambulatory withdrawal management
• Outpatient
• OBAT within primary care
CPC’s model and the CCBHC
Certified Community Behavioral Health Clinic - CCBHC

Services for Children, Adolescents and adults in the CCBHC include:

- Outpatient therapy for mental health (MH) and substance use disorders (SUD)
- Psychiatric care for MH and SUD
- Ambulatory Withdrawal Management (AWM)
- 24-hour crisis hotline and screening
- Community outreach and care coordination
- Peer and family support services
- Screening and monitoring of physical health needs
- Targeted services to veterans and their families
- Evidence Based Treatment practices
CCBHC - Evidence Based Practices (EBP)

Evidence based treatment practices in the CPC – CCBHC includes:

- Treatment of Co-occurring Disorders
- Motivational Interviewing
- Medication Assisted Treatment
- Trauma-informed care
- Smoking Cessation
- Medication Management & Education
MAT

Medications: a mainstay of treatment for OUD
OPIOID use disorder: DSM-V criteria

- **Impaired control**
  - Inability to quit or cut down, using more than intended, time spent, craving
  - Using more than intended
  - Time spent
  - Craving

- **Social (functional impairment)**
  - School, work, home obligations not met
  - Social and relationship problems
  - Occupational, social, recreational activities abandoned

- **Risky use**
  - Hazardous situations
  - Physical or mental illness/psychological problems

- **Pharmacological (physiological)**
  - Tolerance**
  - withdrawal**

Criteria

- 2-3 mild
- 4-6 moderate
- 7-11 severe

**Not applicable if due to a substance prescribed and taken per instructions**
Medications (buprenorphine and methadone) reduce heroin overdose deaths

On the horizon: Heroin assisted treatment?
OUD Medications: a mainstay of treatment

• Goals of pharmacotherapy
  • Alleviate physical withdrawal
  • Alleviate drug craving
  • Normalize deranged brain changes and physiology
  • Opioid blockade

• Antagonist treatment: naltrexone
  • Naltrexone (pure opioid antagonist)
    • Oral or injectable

• Opioid agonist treatment: methadone & buprenorphine
  • increases: employment, treatment retention, survival
  • Decreases: criminal activity, infectious disease, illicit opioid use

TREATMENT:
• Developed in 1947 as a pain and cough medicine
• Studied and shown to be effective in treating opiate addiction in the mid-1960s
• FDA for OUD in 1972
• Federally regulated for treatment of OUD

• Launched in 1978 in UK as a pain medication
• Approved to treat OUD in US in 2002, and allowed it to be prescribed out of outpatient offices (by waivered physicians)
• CARA act 2016: increased rx limits, and included APNs and PA’s (large proportion of primary care→ increased access!)
### Pros and Cons

<table>
<thead>
<tr>
<th><strong>Methadone</strong></th>
<th><strong>Buprenorphine</strong></th>
<th><strong>Naltrexone (vivitrol)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full agonist</td>
<td>Partial agonist</td>
<td>Antagonist</td>
</tr>
<tr>
<td>Daily structure</td>
<td>Convenience/ access</td>
<td>Once monthly dosing</td>
</tr>
<tr>
<td>Pain control</td>
<td>Less sedating</td>
<td>Requires a period of abstinence (7-10 days)</td>
</tr>
<tr>
<td></td>
<td>Lower risk of interactions</td>
<td>Less helpful for cravings (for many)</td>
</tr>
<tr>
<td></td>
<td>May be safer in cardiac and liver disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td>Buprenorphine (Suboxone/ Subutex)</td>
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<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Ideal candidates</td>
<td>Patients with OUD requiring detox and/or maintenance and relapse prevention. Patients who may benefit from daily structure and support. Helpful for co-occurring chronic pain.</td>
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</tr>
<tr>
<td>How it is prescribed</td>
<td>Only administered at certified methadone maintenance programs</td>
<td>Any x-waivered MD/APN/PA may prescribe</td>
</tr>
<tr>
<td>Mechanism of action</td>
<td>Opioid Agonist</td>
<td>Opioid Partial Agonist</td>
</tr>
<tr>
<td>How to initiate treatment</td>
<td>Refer to methadone maintenance program outside of CPC</td>
<td>Refer to Ambulatory Withdrawal Management for induction and stabilization.</td>
</tr>
<tr>
<td>Route of Administration</td>
<td>Oral daily dosing</td>
<td>Sublingual tab or film taken daily (also now available as a monthly injectable once stable)</td>
</tr>
<tr>
<td>Contraindications</td>
<td>Hypersensitivity to methadone</td>
<td>Hypersensitivity to buprenorphine</td>
</tr>
<tr>
<td>Dosing</td>
<td>Protocol based per methadone clinic</td>
<td>Usually requires ≥88mg daily (up to 24 mg). Consider increasing dose by 4-8 mg daily if continued use or cravings.</td>
</tr>
</tbody>
</table>

Harm Reduction Reminder: always prescribe intranasal naloxone (Narcan) to anyone with an OUD.
Medications: a long term treatment

Buprenorphine

- 4 out of 20 deaths in detox group; no deaths in maintenance groups.
MAT in pregnancy

- Methadone
- Buprenorphine
The ultimate goal of MAT is full recovery, including the ability to live a self-directed life.

This treatment approach has been shown to:

• Improve patient survival
• Increase retention in treatment
• Decrease illicit opiate use and other criminal activity among people with substance use disorders
• Increase patients’ ability to gain and maintain employment
• Improve birth outcomes among women who have substance use disorders and are pregnant
• Research also shows that these medications and therapies can contribute to lowering a person’s risk of contracting HIV or hepatitis C by reducing the potential for relapse
"I want to get off methadone/ buprenorphine"

Counseling tips:
• If a diabetic states they'd like to come off their insulin, what would you say?
• What other supports are in place?
• Reasons for wanting to discontinue? Address stigma/barriers
• Explain changes in the brain
• Discuss risk of relapse so the patient can make informed decision
Medication Myths

“you’re just substituting one addiction for another”

• An Addiction to a substance is implies a loss of control, whereas these medications are prescribed in a specific way to TREAT a medical problem, similar to how insulin is used to treat type 2 diabetes.

“you’re not really in recovery if you’re on a medication”

• Medications are an important part of recovery for many people. They are used to treat the chronic disease of opioid addiction, and not to achieve euphoria or sedation.

https://pcssnow.org/resource/mat-handouts-for-patients-and-family-members/
Harm reduction approaches

• Narcan
• Needle exchanges
• Opiate test strips
• Route of administration
• Test doses
Discrimination against MAT patients is also a factor (despite state and federal laws clearly prohibiting it.)

Other factors include

- lack of training for physicians and
- negative opinions toward MAT in communities and among health care professionals.
Lessons learned at CPC:

Ambulatory Withdrawal Management:
• Medication first
• Complexity is the expectation
• Flexibility
• Importance of the interprofessional team
• Value of integrating medical, mental, health, and addiction
• Set expectations at beginning
Phases of treatment on Buprenorphine

- **PHASE 1: Induction**
  - achieved during Ambulatory Withdrawal Management at HHCC
  - The goal of induction is to find the dose of buprenorphine at which the patient discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and minimal craving for opioids.
PHASE 2: **Stabilization**

- weekly appts (RN or APN/MD) with urine drug testing and PMP checks
- Consider dose increases if: patient is taking buprenorphine correctly and still experiencing cravings, withdrawal, or are feeling the “good/high” effect from opioid misuse.
- Stabilization has been achieved when there is evidence of:
  - Markedly reduced or eliminated illicit opioid use (per patient self-report *and* on urine drug testing)
  - Reduced craving.
  - Suppression of opioid withdrawal.
  - Minimal side effects.
  - +/- Patient-reported blunted or blocked euphoria during illicit opioid use.
- If not able to achieve treatment goals within reasonable time (<8 weeks, may consider referral to higher level of care or back to AWM team)
Phases of treatment on Buprenorphine

• PHASE 3: **Maintenance Phase**
  • In order to remain in Phase 3, patients are maintained stable dose of buprenorphine, with no illicit opioid use on self-report or urine drug screens.
  • May decrease visits to biweekly, up to 90 days (RN or MD/APN visits)
  • Patients seen less than monthly may have **up to 6 random callbacks for RN visit per year**
  • Urine toxicology tests for relevant illicit drugs as well as buprenorphine should be administered at least monthly.
  • Monthly visits with urine drug screens and PMP checks are acceptable for patients who:
    • Have no evidence of substance misuse (negative urine toxicology, self-report of stale recovery, no s/s of aberrancy such as requests for early refills of unsafe storage of meds)
Duration of Treatment on Buprenorphine

• Duration of treatment: Patients should take buprenorphine as long as they benefit from it and wish to continue. Gauge treatment progress and success based on patients’ achievement of specific goals that were agreed on in a shared decision-making and treatment planning process.

• For patients who wish to discontinue buprenorphine, national and international guidelines recommend gradual dose reductions and advice to patients that they can stop the taper at any time. Continue to monitor if patient does taper, and consider long active naltrexone injections (vivitrol).
EXHIBIT 3D.6. Adjusting the Buprenorphine Dose

When to increase the dose:

- Are patients taking medication correctly and as scheduled?
  - If patients are taking doses correctly, a dose increase may be indicated, if certain conditions exist.
- Are patients taking other medications that may interfere with buprenorphine metabolism?
- If patients are taking doses properly, increase the dose if they still have opioid withdrawal (document with a clinical tool like COWS), opioid craving, or "good" effects (e.g., feeling "high") from using illicit opioids.
  - Craving can be a conditioned response. It may not decrease with dose increases if patients spend time with people who use opioids in their presence.
  - Dose increases typically occur in 2 mg to 4 mg increments.
  - It will take about 5 to 7 days to reach steady-state plasma concentrations after a dose increase.
  - Offer psychosocial referrals to help decrease and manage cravings.
- Determine whether nonpharmacological problems are contributing to the need for increase.
  - For example, do patients show signs and symptoms of untreated major depressive or generalized anxiety disorders? Are they living in a chaotic household? Do they have childcare problems or financial difficulties? Are they experiencing trauma or trauma-related mental disorders?
  - Address or refer to counseling to address these problems.

When to decrease the dose:

- Decrease the dose when there is evidence of dose toxicity (i.e., sedation or, rarely, clearly linked clinically relevant increases in liver function tests).
- Hold the dose when there is acute alcohol or benzodiazepine intoxication.
Stigma: why words matter
Our language IS our care

“substance abuser”  “person with a substance use disorder”

blame, punishment
<table>
<thead>
<tr>
<th>Marginalizing Language</th>
<th>Replacement Language</th>
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<tbody>
<tr>
<td>Schizophrenic</td>
<td>Person with Schizophrenic Disorder</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Not in agreement with a treatment plan</td>
</tr>
<tr>
<td>Suffering from</td>
<td>Has a history of</td>
</tr>
<tr>
<td>Low functioning</td>
<td>Has difficulty with</td>
</tr>
<tr>
<td>Refused/Declined</td>
<td>Said no</td>
</tr>
<tr>
<td>Resisted</td>
<td>Chose not to</td>
</tr>
<tr>
<td>Manipulative</td>
<td>Seeking alternative methods of meeting needs</td>
</tr>
</tbody>
</table>
Stigma -- why does it matter?

- Historically, addiction has been viewed as a moral issue
  - criminal justice approach → public health approach
- We know that addiction is a chronic illness that we have evidence based medical treatments for
- Stigma perpetuates the adds to the belief and attitude that willpower is the solution to the disease
- 1 in 12 patients with SUD’s get treatment
- The way we speak = the way we think/feel → the way our patients think/feel
Reasons for Changing the Language

- Helps individuals regain self-worth
- Treats individuals with dignity and respect
- More people may come and ask for help
- Allow lawmakers to appropriate more funding
- Help the public to understand this is a medical condition as real as any other
A Brief History

Many derogatory terms were championed throughout the “war on drugs” in an effort to dissuade people from misusing substances.

Education took a backseat—little was known about the science of addiction.

The language should be changed to reflect today’s greater understanding of the science of substance use disorder and the impact on the brain.