MAT 101
Building a Program

National Health Care for the Homeless Council: Medication Assisted Treatment & Recovery Symposium
September 16th, 2019

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Objectives

1. Identify two evidence-based, effective treatment models

2. Describe two components that will assist in transforming the practice of addiction medicine

3. Have a general outline for the steps necessary to implement an effective MAT program

Case Discussion

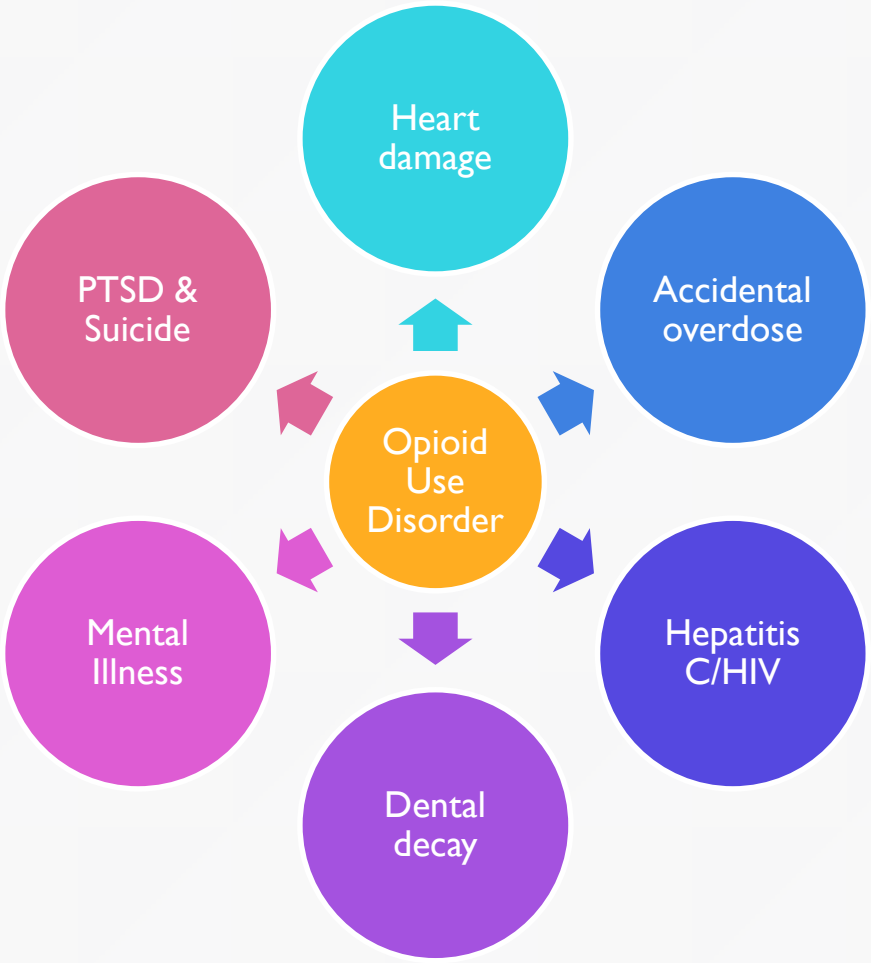
Fred is a 42 year old Caucasian male who has a long history of intravenous heroin use as well as methamphetamines. He has experienced multiple overdoses and was recently hospitalized w/ endocarditis. Fred reports first taking opioids in his late twenties for a work related back injury. Fred complains of chronic pain and has been unable to work due to being "disabled". Fred is homeless and has no family supports. Fred reports trying illicit buprenorphine several years ago, but cited that he stopped due to it making him sick. Fred stated that he would be interested in exploring services to help him manage his pain.

Opiate Use Disorder (OUD)

Validated screening and assessment tools help establish the potential for a SUD diagnosis and its severity. Diagnosis is established based upon DSM 5 Criteria:

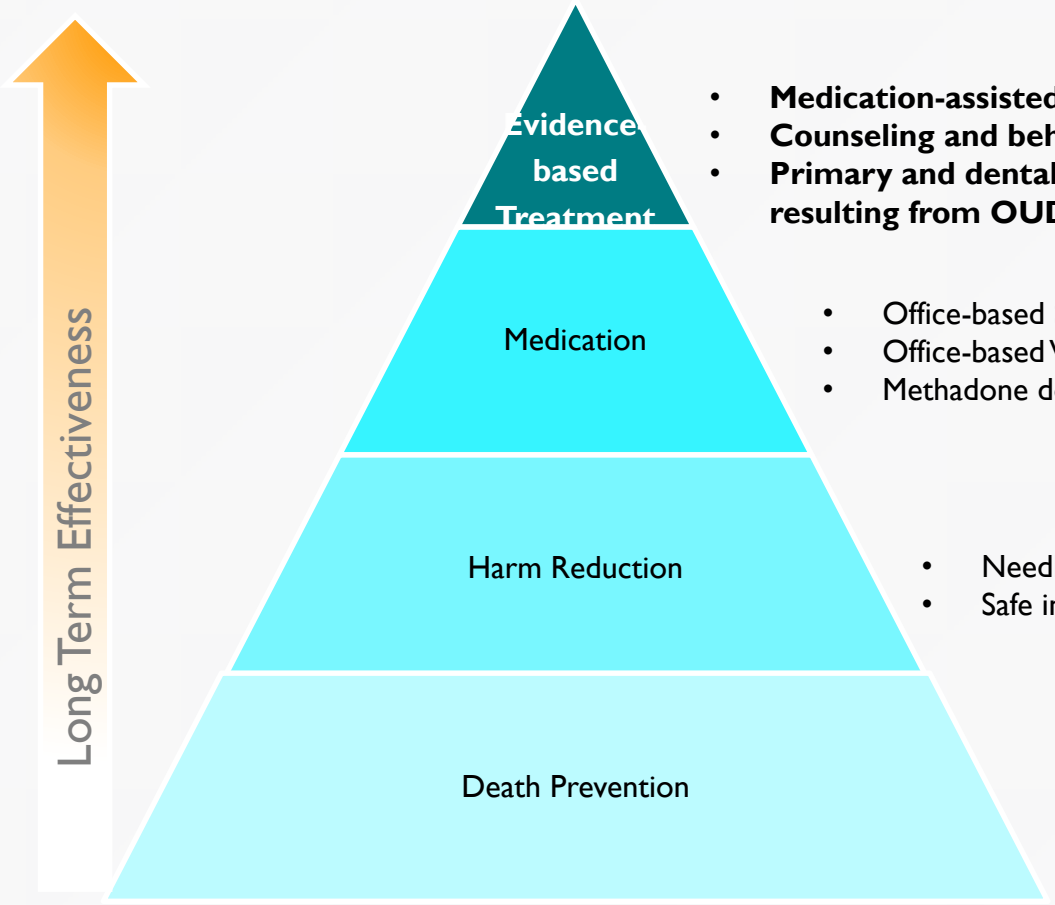
- Opioids often taken in larger amounts or over a longer period of time than was intended.
- Persistent desire or unsuccessful efforts to cut down or control use.
- Great deal of time spent in activities to obtain, use, or recover from DOC effects.
- Craving or a strong desire to use DOC.
- Recurrent DOC use resulting in failure to fulfill major obligations at work, school, home.
- Continued DOC use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of DOC.
- Important social, recreational, occupational activities given up/reduced due to DOC use.
- Recurrent DOC use in situations in which it is physically hazardous.
- DOC use continued despite knowledge of having a persistent or recurrent physical or psychological problem likely to have been caused or exacerbated by DOC.
- Tolerance
- Withdrawal – characteristic withdrawal syndrome for the DOC or use of DOC or a related substance to relieve or avoid withdrawal symptoms.

Opioid Use Disorder Causes High Morbidity and Mortality[1,2]



- Opioid use disorder is a chronic, relapsing medical condition. *Diabetes is an apt correlation.*
- High mortality of OUD stems primarily from complications, such as accidental overdose, trauma, suicide, or infectious disease (e.g., Hepatitis C, HIV).
- There is no known cure. But OUD can be managed long-term with appropriate treatment.

HIERARCHY OF OPIOID USE DISORDER INTERVENTIONS



- **Medication-assisted treatment (MAT), and**
- **Counseling and behavioral therapy, and**
- **Primary and dental care for chronic pain and medical issues resulting from OUD.**

- Office-based Suboxone
- Office-based Vivitrol
- Methadone dose-and-go

- Needle exchange programs
- Safe injection sites

- Naloxone distribution
- ER intervention

Swinomish Didgʷálič

Treatment of OUD

HOW DO WE DEFINE SUCCESS?

Retention in treatment? Medication possession? Definitions are vital. How about the audience?

- Detox and abstinence: Success rate ≈ 10%
- Methadone: Success rate ≈ 60%
- Buprenorphine (Suboxone®) : Success rate ≈ 50%
- Naltrexone injection (Vivitrol®) : Success rate ≈ 10%

When to use what?

- MOST people with OUD should receive MAT.
- Because of it's safety and efficacy, buprenorphine should be the treatment of choice for most people
- XR buprenorphine may be considered if possible
- Methadone should be considered for those who fail bupe treatment if abstinence not a realistic expectation
- XR naltrexone for those who are highly motivated with strong support systems and/or involved with corrections health.
  - Follow these people very closely, abstinence approach
- Detox and abstinence: Rarely successful, similar to XR naltrexone

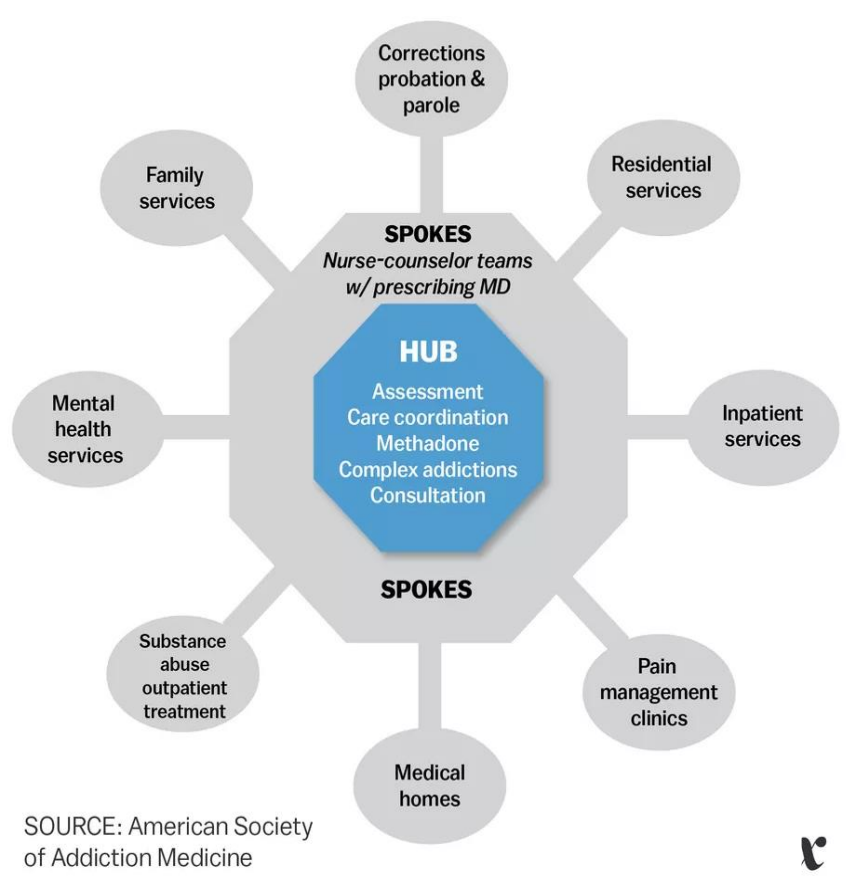
Benefits of MAT[3]

- Adequate doses can help the opiate dependent person improve their physical and psychological health when impaired by opiate dependence.
- The steady state of functioning that MAT provides allows individuals to perform regular activities at work, school, or at home without the constant disruptions of drug seeking behaviors and the compulsion to use other opioids.
- Helps to reverse the reinforcement of addictive behaviors that often accompany opiate addictions.
- Reduces the risk of opiate abuse, overdose, and death
- Reduces the risk of IV use and needle sharing which can lead to diseases and infections.
- Is **in scope** of the primary care medical home model

Program Models

- Hub & Spoke
  - Interagency vs Intra-agency
  - Primary care and specialty addictions
- Collaborative Prescribing
  - INTERagency (group practice, separate prescriber)
- Nurse/BH/Motivated Staff Care Manager
  - Effective independent of program
- Collaborative Care
- Integrated Care

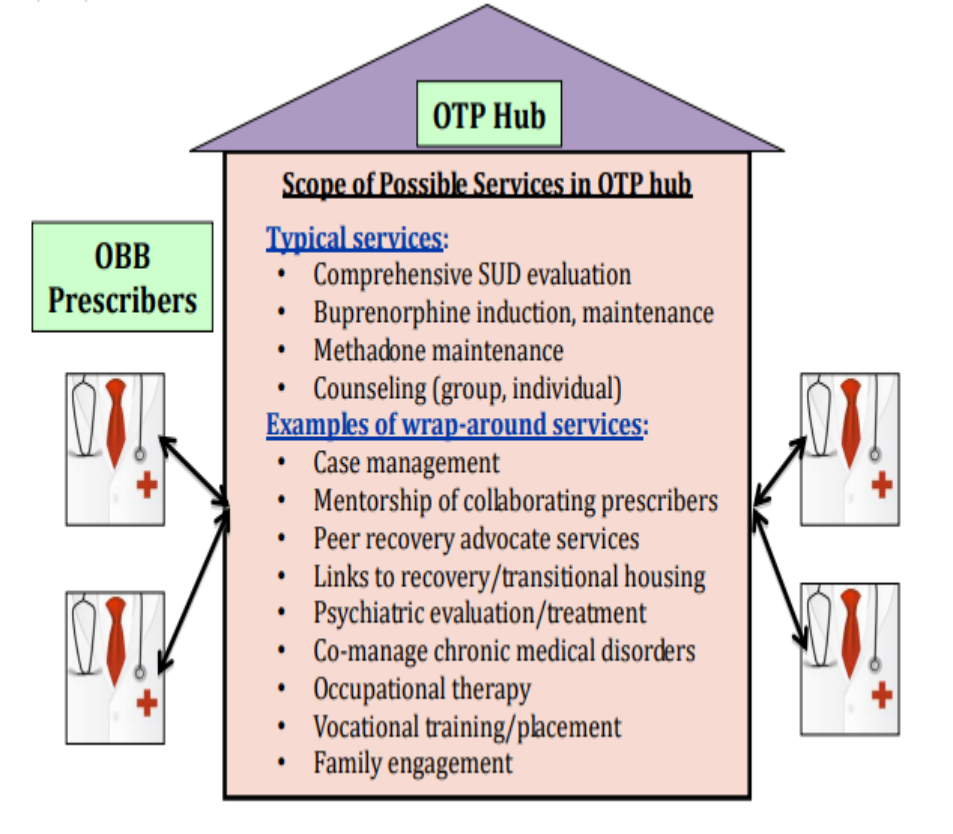
Hub and Spoke Model: Vermont



- Regional coordination between agencies and health systems
- Multiple access points from outside agencies
- Assessment and care coordination and referral to other agencies
- Referral network for all components of treatment (MAT, counseling, primary health care, etc.)
- Large scale health care system coordination

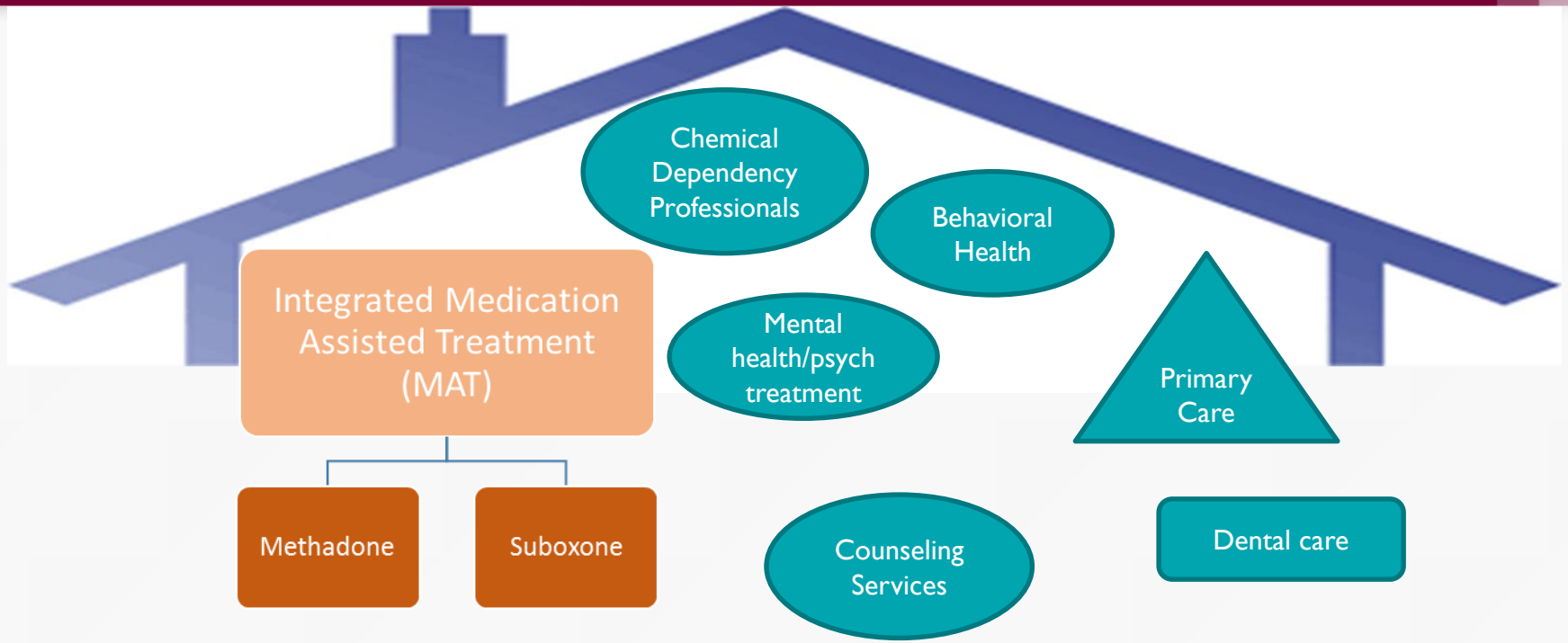
Collaborative Prescribing Model: Johns Hopkins

- Two-tiers of treatment:
- (1) Initial intensive therapy and MAT induction
- (2) After patient is stabilized, patients referred out to office-based prescribers
- Goal is to increase utilization of office-based suboxone for maintenance



Source: Stoller, Kenneth, et. al., Integrated Service Delivery Models for Opioid Treatment Programs in an Era of Increasing Opioid Addiction, Health Reform, and Parity, American Association for the Treatment of Opioid Dependence, July 13, 2016, available at: http://www.aatod.org/wp-content/uploads/2016/07/2nd-Whitepaper-.pdf

Integrated Care Model: **Swinomish Didgʷálič**



MAT in Jail Program

REMOVAL OF BARRIERS TO CARE:
Transportation buses, on-site childcare, case management/social worker, parenting classes, life skills, assistance with housing

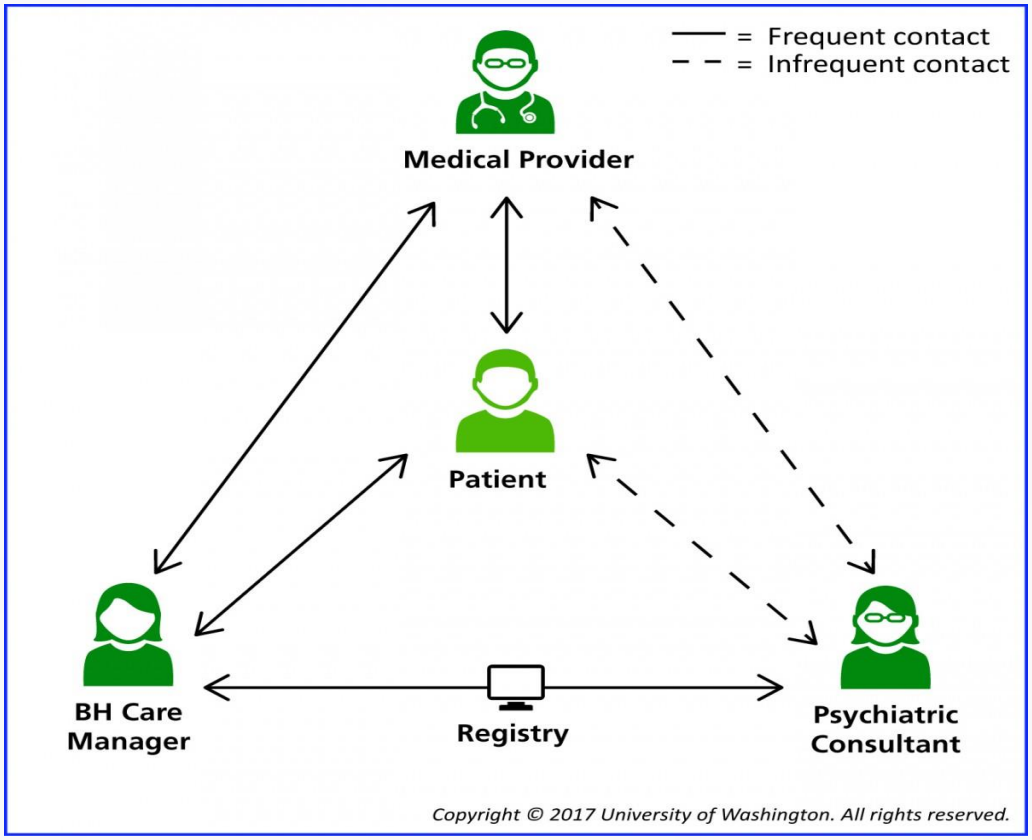
Transitional Housing

Nurse Care Manager Model: Massachusetts

- Registered Nurses by virtue of their training and role in chronic disease management, are ideally suited to serve as the lynch pin in the OBOT program.
- Responsibilities encompass the full breadth of the program components: patient screening, assessment, education, care planning, medication induction, stabilization, and maintenance.
- Are responsible for on-going coordination of follow-up care, close telephone monitoring, relapse prevention, and support for patient self-management.
- Work closely with OBOT staff, and OTP staff at available sites, as needed to complete these essential tasks.

Collaborative Care Model: UW AIMS Center

- Specific type of integrated care that requires systematic follow up
- Focuses on defined patient populations tracked in a registry, measurement based practice, and treatment to target
- Trained primary care providers & embedded behavioral health professionals are supported by regular psychiatric case consultation and treatment adjustment for patients that are not responding



Integrated Care Model: Cherokee Health Systems

- No wrong door for entry into care
- Primary care—behavioral health and medical vitals for all patients
- Positive screens for substance misuse generate behavioral health consultant intervention
- BHC coordinates care—offers initial assessment, evaluation, treatment planning, provides menu of options for available care including IOP, MAT, "not right now"

Sea Mar's MAT Model for Opioid Use Disorder

- **Setting**
  - Behavioral Health Clinics (specialty medicine-until stable)
  - Medical Clinics (medication maintenance)
- **Target population**
  - Adults with opioid use disorder
- **Models of care**
  - Hub & Spoke
  - Nurse Care Manager
  - Collaborative Care Model

Sea Mar's MAT Treatment Team: per 100 patients

- **Waivered Medical Provider:** MAT induction & f/u (.1FTE)
- **Nurse Care Manager (NCM-RN**): screening, intake, orientation, follow up visits, care coordination, data management/patient registry (1.0 FTE)
- **Substance Use Disorder Professional (CDP):** screening, SUD assessment, weekly individual counseling, group counseling (1.0 FTE)
- **Clinical Supervisor:** team lead, administrative oversight, & clinical supervision (.25 FTE)
- **Medical Assistant (MA):** supports NCM, rooming, urinalysis (1.0 FTE)
- **Financial Specialist:** insurance enrollment, verification (.5FTE)
- Designated agency **"Hub"** for referrals and consultation

What Models Are You Seeing?

Model of Care Considerations

- Setting
- Target population
- Evidence based practice
- Staffing
- Treatment philosophy
- Quality Improvement and data management
- Community partners
- Sustainability

Changing the Culture: Stigma & Education

- Administrative buy in
  - Must come from the top
- Staff training
  - Stigma may lurk at all levels
- Provider Workforce
  - Waiver training
  - Mentors
  - Policies and Procedures

Coordination of Care & Care Transitions

- Aftercare appointments
- Low barrier transitional housing
- Release of records/record sharing
- Addressing primary care needs
- Gaps in care

Administrative Considerations

- Population management
  - Identifying both champions and case managers
- Regulatory considerations
  - 42CFR/EHR, DEA compliance
- Quality Improvement
  - What outcomes do you track?
  - What are key performance measures?
  - Who 'owns' the registries

Tools & Strategies

- Describing what 'harm reduction' means to your organization
  - Cannabis? Diversion? Other illicits?
  - No right answer- it's about creating a policy that the team embraces
- Standardizing approach
  - Risk stratification
  - Inductions
  - What happens when things go right and wrong

One Attempt at Standardization

- Developed by Andrew Suchocki at Clackamas Health Centers
- In response to significant variation in provider practice and the behaviorist going: "help!"
- Reviewed other MAT standardizing tools, found
  - Counted the same issues multiple times
  - Exhaustive and not 'in the exam room' friendly
- Initially was rather prescriptive for:
  - Drug screen frequency
  - BH 'requirement'
- Modified based on evidence and harm reduction

1. Medical Risk Stratification Score

Risk Factors	Points	Protective Factors	Points
Co-occuring alcohol disorder	15	Prior MAT experience	5
Significant Psych history, but reasonably stable	5	Active support system- clinical/family/ community	5
No prior addictions treatment	5	Consistent Hx, UDS, PDMP	5
Chronic Pain, poorly controlled	10	ACES* <4	5
Other active substance use	5	Stable housing	5
<25 years old	10	*Adverse Childhood Event Score	
Total		Total	

Medical Risk Score	Risk Total		Protective Total		Score
		-		=	
	_____		_____		_____

Red	>	15
Yellow	<	15
Green	<	5

2. Induction Details

Buprenorphine naive	Prior burprenorpine use
Suggest in-person induction done over 2 days. If not possible, home induction with 24 and 48 hour follow-up	Home induction recommended

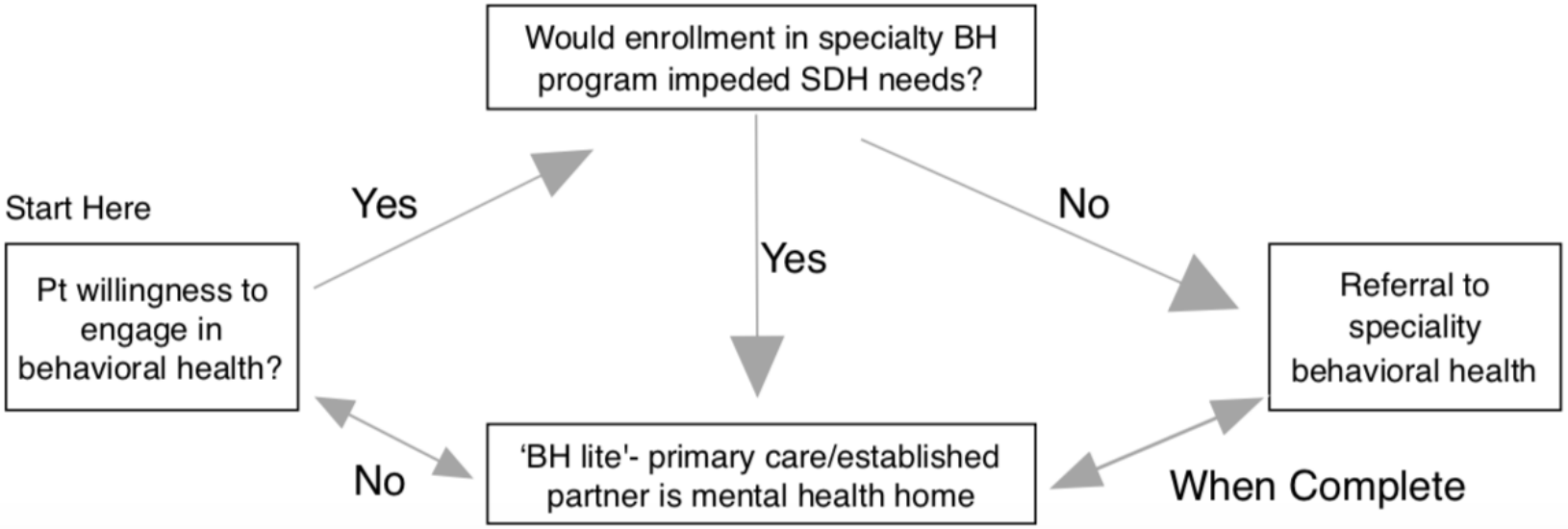
3. Medical Management Details- Based on Medical Risk Stratification Score from #1

	Red (>15)	Yellow (>5, <15)	Green (<5)
Refill Duration	Weekly, add by qWeek as appropriate. Max duration 1 month total (no RF)	Start with 1 week, then 2 weeks, extend to 1 month. Max RF is 2 mos (1 RF)	See Yellow for initation. After 2, 2 month cycles (4 mos total) progress to total duration of 3 mos (2 RF)
Drug Screen(UDS) Frequency	At every appointment in first month, extend to q3 months	At initiation, 1 month follow-up, ok to q6 mos after 3 affirming UDS (q6 applies for Red score graduates)	At initation and 1 month follow-up, consider extend to yearly after 6 mos of affirming UDS
Visit Frequency	Weekly x 2, bi-weekly x 2, monthly if care team in agreement	After initiation, q 2 weeks x 2, monthly, then driven by RF frequency	After initiation, q 2 weeks x2, monthly, then driven by RF frequency

After 3 months or clinical judgement, graduate to lower risk category. If issues, consider increasing risk.

4. Behavioral Health - Independent of Medical Risk Stratification Category and Induction Setting

All patients receiving primary care based MAT should receive a behavioral health and needs assessment



Resources

- Free Waiver Training & Education: https://pcssnow.org/
- SAMHSA: TIP 63 Medications for OUD https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA19-5063FULLDOC
- Facebook: Opioid Treatment Professionals: Support and Collaboration

Who Should Attend?

- Medical & Behavioral Health Provide
- Substance Use Disorder Professiona
- Office Staff
- Anyone who participates in the care of those with pain or addiction

Responding to the Opioid Epidemic: Leveraging Care Integration in the Health Center Setting. Nov 15-16.

Learn How To:

- Better treat pain
- Work with complex patients
- Use medication assisted treatment
  - Break-out tracts will include trauma informed practices & learning to facilitate behavioral interventions for chronic pain

In Addition:

- 14 hours CME/CEU credit & will meet Washington State CME guidelines for prescribing opioids
- More information here: www.nwrpca.org/event/opioidconference

Questions???

References

1. Kosten, Thomas R., M.D. and Tony P. George, M.D, "The Neurobiology of Opioid Dependence: Implications for Treatment," **Science and Practice Perspectives**, July 2002.
2. Schuckit, Marc, M.D. "Treatment of Opioid Use Disorders," **New England Journal of Medicine**, July 2016.
3. Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. SHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, SAMHSA, 2008.