



Medication-Assisted Treatment in Primary Care

*Responding to the Opioid Epidemic,
Improving Access to Care, and Maintaining
Best Practices*

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I have no corporate associations or conflicts of interest

Gianna's Story

- <http://www.lenkalandphotography.com/Client-Albums/Chapa-De/n-L8Hbzn/>

The greatest barriers to care are access and stigma

- Access

- 80 percent of people who are dependent on heroin or painkillers are not getting treatment, according to a new research letter published in the *Journal of the American Medical Association* (October 2015).
- The life expectancy of an IV heroin drug user who goes without treatment is 5 years.



Stigma

“For far too long, too many in our country have viewed addiction as a moral failing. This *unfortunate stigma* has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment. We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.”

- Facing Addiction in America The Surgeon General’s Report on Alcohol, Drugs and Health 2017

Stigma

- “Health professionals may have an avoidant approach to delivery of care with substance use disorder patients compared to other patient groups may result in shorter visits, expression of less empathy, and less patient engagement and retention.” (Kelly, 2016)
- “What to do about stigma: education, personal witness, shift language/terminology.” (Kelly, 2016)

Stigmatizing language

The most commonly stigmatizing terms in medicine and treatment

- Substance Abuse vs Substance Use Disorders
 - Example: “Patient is substance abuser” vs “Patient has substance use disorder”
- Urine Drug Screens – not “clean or dirty” but positive or negative
- “drug-seeking” vs “relief seeking” – relief of withdrawal symptoms, relief of anxiety, relief of physical pain, relief of insomnia, relief of PTSD symptoms
- “addict” - “heroin user” or “addicted person”

Where we are and how did we get here?

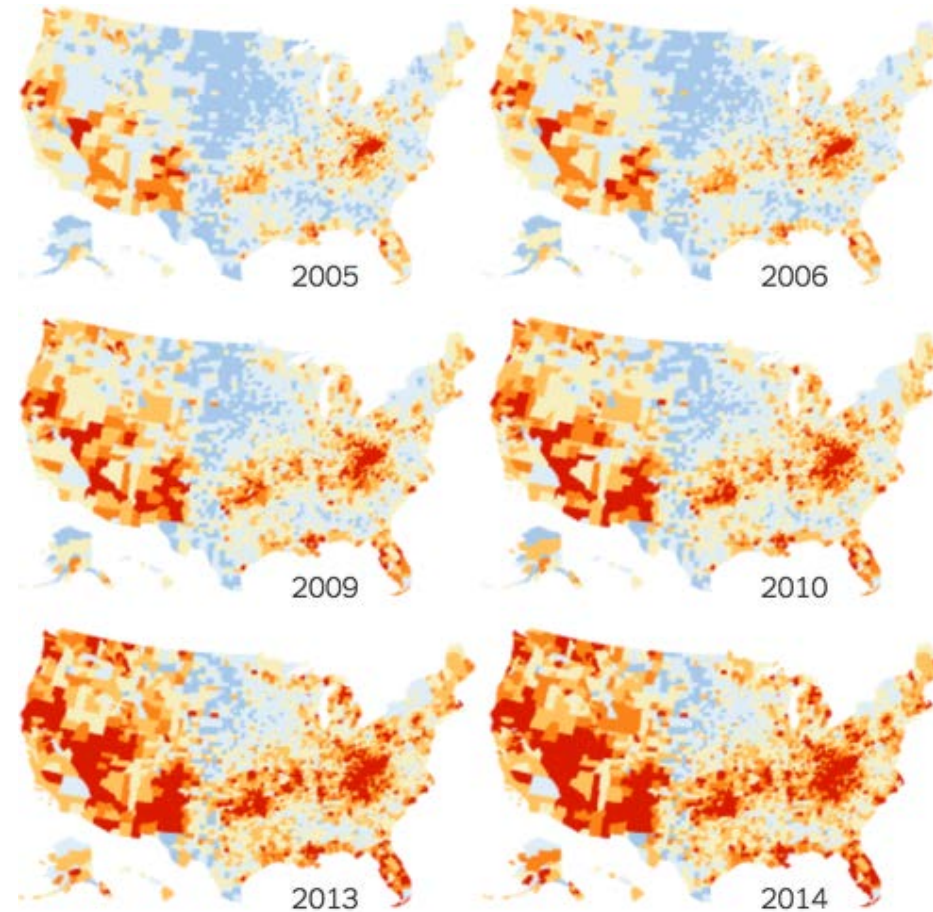
“Worst man-made epidemic in modern medical history.” - CDC



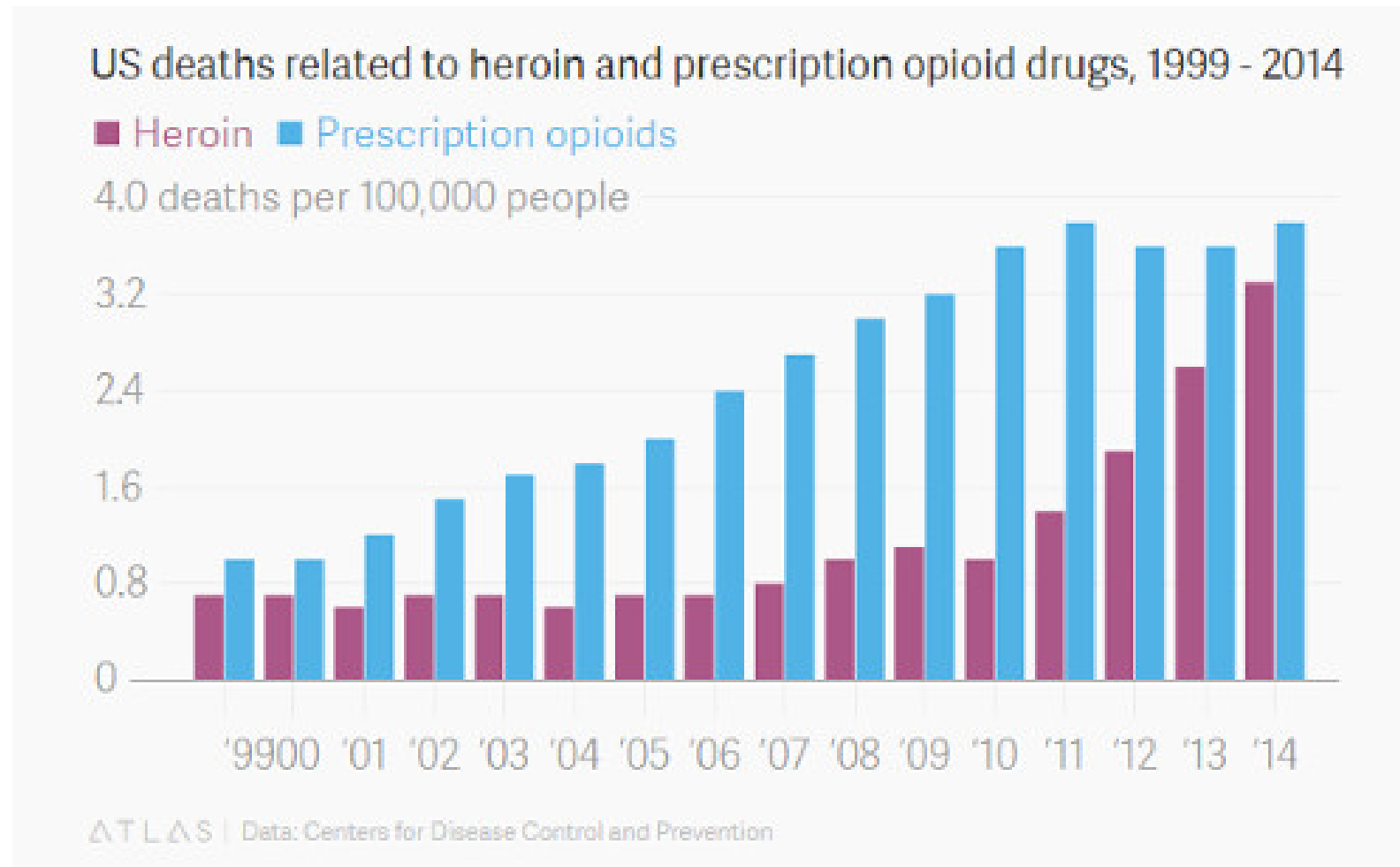
91
AMERICANS

die every day from
an **opioid overdose**
(that includes prescription
opioids and heroin).

Overdose deaths 2005-2014



Overdose deaths

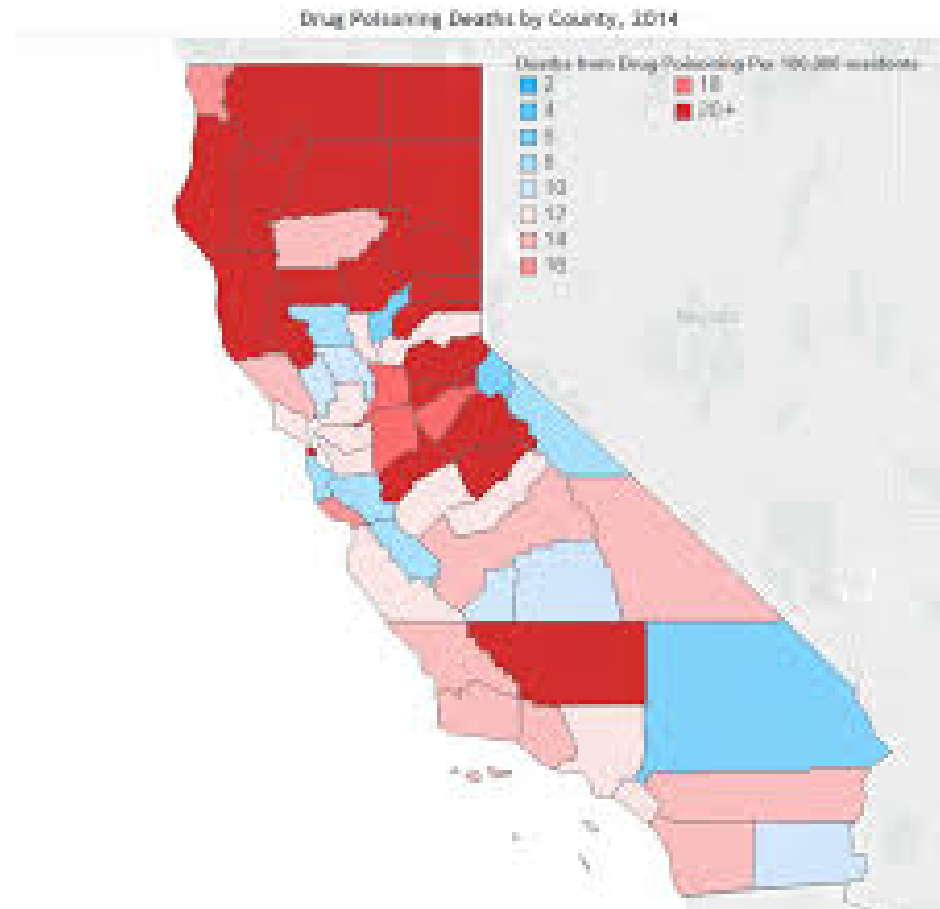


Where we are and how did we get here?

- Roots of the epidemic - changing how we treat chronic pain and palliative care began in the hospice movement of '70's and '80's.
- Pharmaceutical companies became invested in managing chronic pain and began to push into medical approaches to treating pain.
- Early '90's more physicians began to prescribed long-term opioid therapy, encouraged by powerful marketing and weak research.
- Oxycontin in 1996 for malignant pain quickly became 'ground zero' of epidemic.
- VA made measuring pain the 5th vital sign the standard of care in 2000. This approach rapidly gained acceptance throughout medicine.

In California

- In California, some counties are as impacted as the worse states in the nation:



More...

- https://pdop.shinyapps.io/ODdash_v1/

The suffering touches many lives...

“After declining for several years, the number of children in foster care jumped

8 percent nationally, to 428,000, between fiscal years 2012 and 2015, the most recent data available. Experts say opioid abuse accounts for a lot of that increase.”
(NYT 01/2017)



Update on new laws in response to the opioid epidemic

- DATA 2000 Congress passed a law allowing for Office Based-Opioid Treatment (OBOT), required prescribing of buprenorphine/naloxone (suboxone) be MDs only waived by DEA with limits of 30 patients in first year and no more than 100 in the years following. This one rule became an enormous barrier to access and kept the costs of suboxone unnaturally high. Suboxone was available and for the first few years known only to wealthier people with opioid addiction.



Update on Laws

- Comprehensive Addiction and Recovery Act (CARA) July 2016 – improving access by allowing each DEA waived buprenorphine prescriber up to 275 patients. Created a pathway to DEA waiver for Nurse Practitioners and Physician Assistants.
- 21st Century CURES ACT December 2016 – comprehensive healthcare legislation which earmarked \$1 billion to improve access to treatment in response to the opioid epidemic. Because of the severity of the problem in the northern California counties, the disbursement to our state will be around \$44 million.

HRSA GRANT and Foundation Grants

- Federal HRSA grants \$100,000,000 disbursed March 2016 to FQHC (Safety Net clinics) to establish care for those with Opioid Use Disorders. 36 FQHCs throughout California were granted monies to launch Medication-Assisted Treatment programs. The grant money was disbursed March 2016. The trend of providing MAT in primary care clinics has begun to take hold. Doors are open.
- Establishing sustainable MAT programs in Primary Care is full of challenges.
- California Health Care Foundation- multiple programs
- Treating Addiction in Primary Care – Center for Care Innovation

Medications

- Buprenorphine
 - Partial agonist mu receptor
 - High affinity
 - Low activator – ceiling effect
 - Long-acting – half life 37
 - Over time, Less is More
 - Bioavailability through skin – buccal strips, sublingual tabs and film, transdermal patches
- Naloxone
 - Minimal bio-availability through skin
 - bound to buprenorphine to decrease diversion – if changed for injection or insufflating then full antagonist effect

Buprenorphine

Safer profile

- Dose-dependent respiratory depression is an adverse effect mainly of methadone, a full mu-opioid agonist, whereas the partial-agonist properties of buprenorphine prevent dose-dependent respiratory depression greater than 50% reduction of baseline even at IV doses of 2 mcg/kg in opioid-naive healthy volunteers.
- This “ceiling effect” on respiratory depression has obvious benefits for tolerability as well as for accidental or intentional overdose.
- Similarly, buprenorphine’s partial-agonist properties have a protective “ceiling effect” that does not induce euphoria in opioid-tolerant individuals, whereas methadone-induced euphoria may be present in the early treatment of OUD but decreases with steady-state dosing stabilization. (Connery, 2015)

Medications - continued

- Methadone – Opioid Treatment Therapy – Harm Reduction
 - Long-acting, full agonist, effective treatment for those needing daily dosing, intensive monitoring and counseling. Does not block the effect of other opioids.
- Narcan – naloxone reverses opioid overdose. Injectable and nasal Spray. TAR has been removed for easier access.
- Naltrexone
 - 50 mg PO daily for alcohol cravings and to block opioids
 - Vivitrol –naltrexone monthly injectable blocks opioids and offers a safety factor for those with abstinence from incarceration or residential treatment. Decreases Risk of overdose

Medication Assisted Treatment in Primary Care Clinics - models of care

- Nurse case manager model – RN, Prescriber, BH counseling services
- Multi-disciplinary model – RN or LVN, Prescriber, Medical Assistant (MA), non-licensed Case managers, Behavioral Health Therapists, Substance Use counselors, Patient Navigators
- Provider/ MA model – Office Based Opioid Treatment – these patients can adhere to safe use of prescribed buprenorphine with monthly appointments and scripts.

Hub and Spoke Services

- Vermont model currently being adopted by DHCS for California Rural Counties and Tribal Health Settings
- A central hub can be used for stabilizing patients and then referring out to spoke clinics
- Hub team functions as educational and clinical support for Spoke team.
- Grant was submitted on February 17, 2017
- The grant period will begin on May 1, 2017 or after SAMHSA approval
- CA's allocation is \$44.7M for two years (DHCS Webinar 03/27/2017)

Medication-Assisted Treatment (MAT) for Opioid Use Disorder

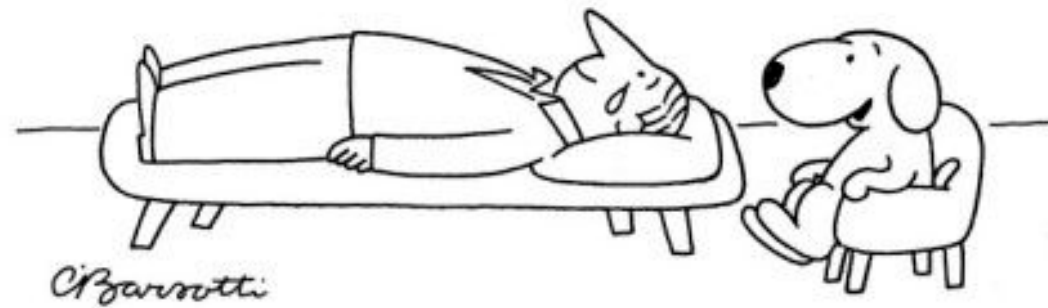
“...buprenorphine has literally saved my life, it has saved my son’s life, it is my saving grace...” - Gianna

- Referrals – can be self-referred or referred by PCP
- Must be a clinic patient. If not then must enroll and make new patient appointment with primary care.
- Screening – current use of opioids and all other drugs, alcohol. Obvious barriers to participating in a MAT program
- Assessment – thorough history of drug and alcohol use, medical and psychiatric hx and social history. Assess for trauma!

MAT for OUD continued

- Admission protocols
 - Medical clearance and labs
 - Team case reviews to ensure the admission is a good fit for the program
- Induction planning
 - Initiating buprenorphine – prepare patient for withdrawal for safe start
 - Precipitated withdrawal –COWS – *see handouts*
 - Day 2 -7 induction follow-up by nurse case manager
 - Treatment Agreement – detailed interventional/therapeutic tool
 - Recovery Treatment Planning

Make sure you find a good therapist...



"Well, I think you're wonderful."

MAT - program structure

- Phases of Care (patient can return to phases I and II if more support or monitoring needed) -
 - Phase I
 - Early Stabilization and Harm-reduction
 - 7 day Rx of buprenorphine/naloxone
 - Weekly UDS
 - MD/staff interventions as needed
 - Meet Recovery Treatment Plan Requirements
 - Health and Behavioral Health
 - Phase II
 - Abstinence-directed
 - Engaged in Recovery Treatment Plan
 - Phase III
 - MD visits only with monthly rx and monthly UDS

MAT for OUD - continued

“There are many paths to recovery. People will choose their pathway based on their cultural values, their socioeconomic status, their psychological and behavioral needs, and the nature of their substance use disorder.” — The Surgeon General’s report on Addiction 2017

- Recovery Treatment Planning is essential to stabilization.
 - Identifying appropriate Level of Care using American Society of Addiction Medicine (ASAM) Criteria Multidimensional, whole person criteria
 - I. Withdrawal II. Medical III. Behavioral Health
IV. Readiness V. Relapse VI. Environment

American Society of Addiction Medicine

Six Dimensions

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT		
ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:		
1	DIMENSION 1	Acute Intoxication and/or Withdrawal Potential Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	Biomedical Conditions and Complications Exploring an individual's health history and current physical condition
3	DIMENSION 3	Emotional, Behavioral, or Cognitive Conditions and Complications Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	Readiness to Change Exploring an individual's readiness and interest in changing
5	DIMENSION 5	Relapse, Continued Use, or Continued Problem Potential Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	Recovery/Living Environment Exploring an individual's recovery or living situation, and the surrounding people, places, and things

MAT for OUD – continued

Develop a patient-centered **Recovery Treatment Plan**:

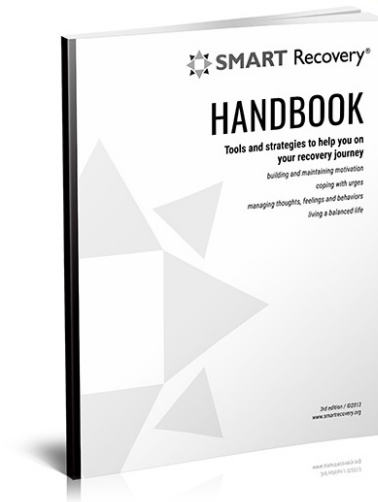
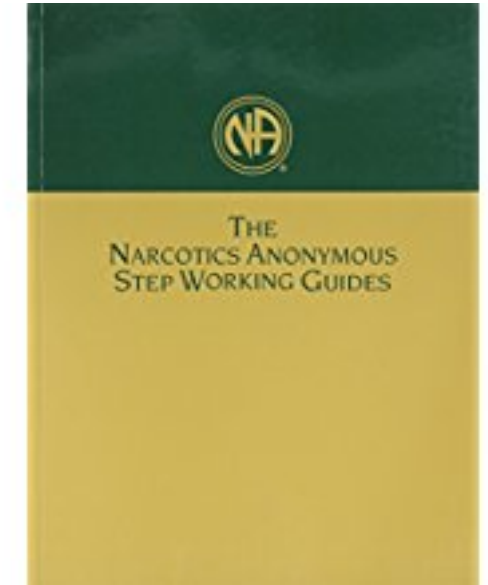
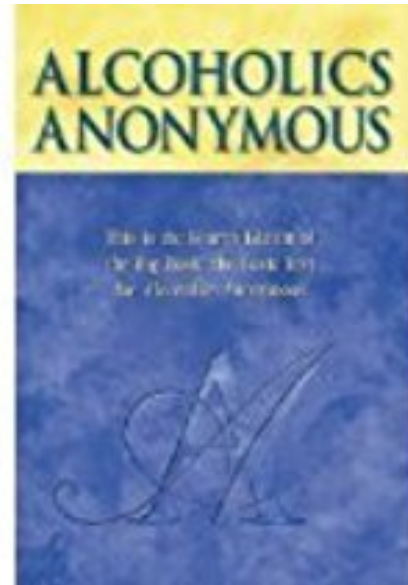
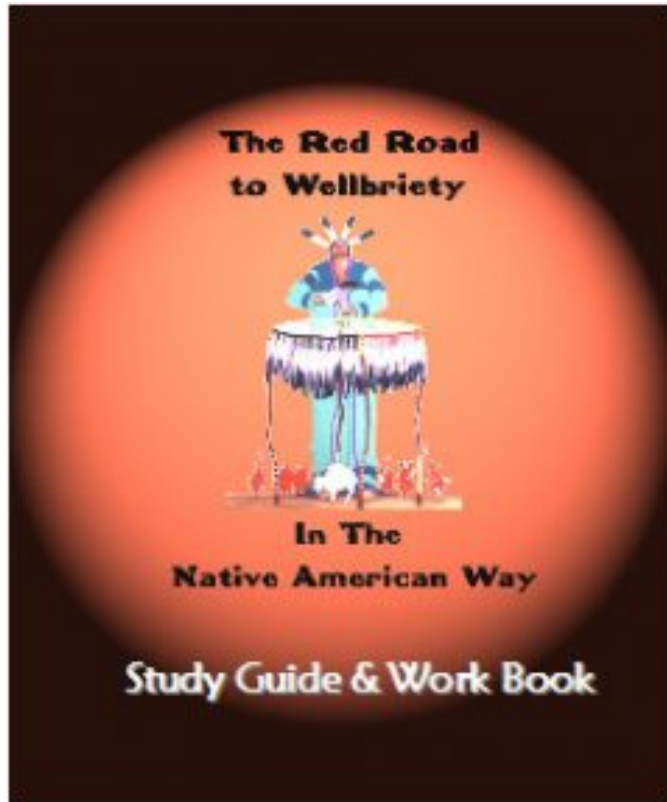
- The appropriate ASAM level of care (if available)
- Take into account barriers or strengths such as shelter, transportation, family and work obligations
- Include the preferences and experience of the patient.
- CPS and probation may be part of their recovery process.
- In a multi-disciplinary program, the substance use counselor or the BH therapist would develop and manage the Recovery Treatment Plan. In our clinic – this is done by Addictions RN

MAT for OUD - continued

- Refill/Stabilization groups
 - Weekly UDS
 - 7 day rx for bup/nx
 - MD available
- Curriculum
 - Weekly quotes
 - Education Modules
 - Recovery Tools
 - Supportive group environment
 - snacks



12 Step and Mutual Aid Recovery Groups



Best Practices – policies, procedures, validated tools

- Assess for trauma use Adverse Childhood Experiences (ACEs)
- Opioids numb the symptoms of trauma. Remind clinicians and patients that buprenorphine allows for the *felt experience* - sensation and the full spectrum of human emotions.
“like coming out of deep freeze”

Best practices, tools, cont'd

- DSM-5 Opioid Use Disorder tool – *see handouts*
- The 4 C's of addiction: **C**raving. Loss of **C**ontrol. **C**ompulsion to use despite **C**onsequences.
- MAT Treatment Agreement – Essential to good care – *see handouts*
- Offer structure and accountability as therapeutic milieu rather than punitive response



Best Practices

- Build best practices into protocols and procedures
- Commit to a disciplined program – clearly defined clinical roles in the team. A program manager is essential for development of program.
- All MAT team members trained in Motivational Interviewing.
- Admission protocol - at least 3 clinicians discuss, review barriers, level of care recommendations and recovery treatment plan
- Weekly MAT team case reviews
- Early assessment of and treatment planning for co-occurring trauma and mental health

Opioid Use Disorder/ Chronic Pain/Safe Prescribing – clear as mud

- Opioid Dependence
 - Screen for OUD using OUD DSM-5 tool
 - Evaluate for safe prescribing – consider Morphine Equivalent Dose and other sedating medications
 - Evaluate for poorly managed pain with long-term opioid therapy
- Pathways of care –
 1. MAT for Opioid Use Disorder
 2. Safe Prescribing for High-utilizers
 3. Buprenorphine for Pain Management



Chronic Pain + OUD

- Chronic pain
 - + Aberrant behaviors (misuse such as self-escalated dose and diversion such as selling, sharing trading)
 - + Opioid induced hyperalgesia – full-agonist opioids increase sensitivity to pain as patient becomes more tolerant: needs more opioids receiving less pain relief
 - + high utilization of multiple opioid prescriptions

High utilizers of prescribed Opioids + prescribed sedating medications



- Often patients with long-term opioid therapy for chronic pain have a long-acting opioid + benzodiazepines + muscle relaxers such as carisoprodol (soma) + sleep meds such as zolpidem(ambien).
- These patients have high tolerance for all of these medications but the combo is dangerous. These patients tend to exhibit fear (and/or anger) when it comes to changing their meds. The most complicated of these patients will initially require weekly dosings and a clear plan for when and how each controlled medication will be tapered and removed from their regimen.

Safe Prescribing

- CDC Guidelines for safe prescribing “start low, go slow”
- Many chronic pain patients on long-term opioid therapy have poor pain management on high doses of one or more opioids.
- Often there are prescribed benzodiazepines r/t to phenomena of low grade opioid withdrawal – anxiety of opioid withdrawal.



Buprenorphine for chronic pain management

“I am so surprised at how good I feel, my pain is managed, I don’t need my cane and my mind is more clear.” - Recent *Chapa-De Bup* for Pain patient.

- No waiver needed
- Opioid Induced Hyperalgesia (OIH) resolves over time
- New formulations for pain:
 - buccal strips in mcg dosing
 - transdermal patches formulated in mcg dosing
- If using buprenorphine for pain management, important to indicate this on rx. Some insurers require prior authorization



Community collaboration and outreach



- Engaging Law Enforcement – are the police trained in Narcan for opioid reversal?
- Drug Courts – do they support MAT?
- Collaborating with Local Hospital Emergency Departments – initiating buprenorphine
- Collaborating with County Jails – decrease high risk of lethal overdose when released
- Participating in RX Safe Coalitions
- Organizing and participating in Substance Use Collaborative
- EDUCATION and PREVENTION

Questions?

Recommended websites and books

Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health:

<https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>

- California Health Care Foundation:

<http://www.chcf.org/topics/opioid-safety>

- Center for Care Innovations:

<http://www.careinnovations.org/programs-grants/treating-addiction>

Recommended books and websites, cont'd

- Motivational Interviewing trainings: <http://www.berg-smithtraining.com/mi.htm>
- Dreamland –The True Tale of America's Opiate Epidemic – Sam Quinones
- Drug Dealer MD – How Doctors were duped, Patients got hooked and why it is so hard to stop – Anna Lembke, MD
- ASAM Levels of Care: <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about>
- Center for Disease Control – new prescribing guidelines

References

Medication-Assisted Treatment of Opioid Use Disorder: Review of the evidence and future directions. Connery, H.S. *Harvard Review of Psychiatry*,

Facing Addiction in America: The Surgeon's General Report on Alcohol, drugs and health 2017

Toward Addiction-ary: Language, Stigma, treatment and Policy, Kelly, J., National Association of Drug Court Professionals(2016)

The Editorial Board, Young victims of the opioid epidemic, *The New York Times* 01/16/17

Center for Disease Control – new prescribing guidelines

<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

Handouts

- Clinical Opiate Withdrawal Scale
- Patient induction planning
- Adverse Childhood Experiences
- Opioid Use Disorder criteria – DSM-5
- Chapa-De MAT Treatment Agreement
- Common Protocols for Urine Drug Screen – MAT program

Table 1

of FDA-Approved Medications to Treat Opioid Use Disorder with Physiological Opioid De			
	MOR intrinsic activity MOR binding	Differential pharmacology affecting MOR activation at therapeutic dose	Mechanism of relapse p
e	Partial agonist High affinity $K_i^* = 0.2 \text{ nM}$	Slow MOR dissociation allows thrice-weekly sublingual dosing and possibility of high-dose weekly formulations ^{13–15} Highest known MOR affinity makes rescue from overdose by naloxone less effective; ¹⁶ rapid precipitation of withdrawal if full agonists present	Reduces opioid craving, wit and stress reactivity Competitively blocks or red reinforcing effects of other o
	Full agonist High affinity $K_i^* = 3.4 \text{ nM}$	Long terminal half-life (up to 120 hours) with delayed steady-state efficacy poses increased MOR toxicity risk during induction phase ¹⁷ Multiple drug-drug interactions pose both opioid-toxicity and withdrawal risks during treatment ¹⁸	Reduces opioid craving, wit and stress reactivity Reduces the reinforcing effe other opioids
	Antagonist High affinity $K_i^\dagger = 0.26\text{--}0.34 \text{ nM}$	Lack of MOR agonism associated with delayed stabilization of opioid craving ¹⁹ Safety concern based on rodent data demonstrating chronic naltrexone exposure increases respiratory-depression risk upon opioid agonist reexposure ²⁰	Competitively blocks reinfor effects of opioid agonists Reductions in craving are psychologically mediated (re anticipatory expectancies)
<p>ssociation constant for the test compound and relative values are from Volpe et al. (2011).²¹</p> <p>ssociation constant is from Yuan et al. (2013).²²</p> <p>d receptor; ER, extended release; nM, nanomoles.</p>			

HARVARD REVIEW OF P

Table 1 Comparison of FDA-Approved Medications to Treat Opioid Use Disorder with Physiological Opioid Dependence