HEALTH MANAGEMENT ASSOCIATES

MASSACHUSETTS HEALTH POLICY COMMISSION

Medication Assisted Treatment in Primary Care

Suzanne Mitchell, MD

AGENDA

- ❑ WHAT IS ADDICTION AND HOW IS IT TREATED?
- ❑ DESCRIBE MEDICATION ASSISTED TREATMENT (MAT)
- ❑ TALKING TO PATIENTS ABOUT ALCOHOL AND OPIOID DEPENDENCE
- ❑ IDENTIFYING PATIENTS WITH ALCOHOL OR OPIOID DEPENDENCE
- ❑ ASSESSING PATIENT FOR MAT TREATMENT
- ❑ GETTING PATIENT INTO TREATMENT
- ❑ TREATMENT OPTIONS

PCMH PRIME Elements Discussed in Webinar:

C2: The practice has at least one clinician who is providing MAT, and providing behavioral therapy directly or via referral, for substance use disorder.

D5: The practice collects and regularly updates a comprehensive health assessment that includes Substance Use Disorder screening for adults and adolescents using a standard tool.

WHAT IS DRUG ADDICTION?

"Drug addiction is a chronic disease characterized by compulsive, or uncontrollable, drug seeking and use despite harmful consequences and changes in the brain, which can be long lasting. These changes in the brain can lead to the harmful behaviors seen in people who use drugs. Drug addiction is also a relapsing disease. Relapse is the return to drug use after an attempt to stop." (NIDA)

HOW IS ADDICTION TREATED?

- Safe Detox
- Medication Assistance
- Behavioral Counseling
- Treatment for Co-occurring mental health issues
- Family and/or community based recovery support

IMPROVING ACCESS TO TREATMENT

- According to SAMHSA, 22.5 million people (8.5% of the U.S. population) aged 12 or older needed treatment for a substance use disorder in 2014. Only 4.2 million (18.5% of those who needed treatment) received any substance use treatment in the same year.

Source: Center for Behavioral Health Statistics and Quality (CBSHQ). *2014 National Survey on Drug Use and Health: Detailed Tables.* Rockville, MD: Substance Abuse and Mental Health Services Administration; 2015.

WHAT IS MEDICATION ASSISTED TREATMENT (MAT)?

According to SAMHSA, MAT is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose.

The prescribed medication:

- normalizes brain chemistry and body functions,
- blocks the euphoric effects of alcohol and opioids,
- relieves physiological cravings,
- prevents the negative effects of the abused drug.

WHAT IS MEDICATION ASSISTED TREATMENT (MAT)?

- FDA-approved medications are now available for primary care providers to use in treatment of substance use disorders.
- Medications can be used to:
  - manage withdrawal symptoms,
  - prevent relapse, and
  - treat co-occurring conditions.
- Options for primary care include:
  - Naltrexone (Revia),
  - Naltrexone ER (Vivitrol),
  - Buprenorphine (Subutex),
  - Buprenorphine/Naloxone (Suboxone).
- Methadone can only be prescribed in the context of an addiction treatment program.
- Use of MAT plus recovery counseling or support groups can increase the success of treatment compared to counseling alone.
- Medication plus brief counseling is an option for patients who are not willing or able to participate in recovery counseling or support groups.

Note: For PCMH PRIME Criteria C2, the practice must have at least one clinician providing MAT and provide behavioral therapy either directly or by referral

TALKING TO PATIENTS ABOUT ALCOHOL/OPIOID DEPENDENCE

"Many people tell me they have trouble controlling their drinking/drug use."

- Build rapport
- Motivational, not confrontational
- Non-judgmental
- Encouragement in the face of setbacks

SCREENING AND ASSESSMENT TOOLS

TOOL	OPIOID USE	ALCOHOL USE	Adolescent use	Adult Use	Self-Administer	Clinician Administer
CRAFFT	X	X	X		X	X
AUDIT		X		X		X
DAST-10	X			X	X	X
DAST-20	X		X		X	X
CAGE-AID	X	X		X		X
CAGE		X		X		X
NIDA Drug Use Screening Tool	X	X		X		X

PCMH PRIME CRITERIA D5: The practice collects and regularly updates a comprehensive health assessment that includes Substance Use Disorder screening for adults and adolescents using a standardized tool

ALCOHOL/OPIOID USE DISORDER DSM V CRITERIA

Identify signs and symptoms of compulsive use or loss of control over drinking or drug use during **past 12 months**.

Patients with **three or more "yes"** responses in the past 12 months meet the DSM–V criteria for SUD.

- Do you feel like you **need to use more** of the drug or alcohol to get the same effect?
- Do you feel ill or have the "shakes" when you don't use alcohol or opioids (i.e., do you have **withdrawal** symptoms?)
- Do you feel like you **can't just have one** drink or end up using more opioids/alcohol than you intended?
- Have you been **unable to stop** or reduce your drinking/opioid use when you have tried in the past?
- Are you **spending more time** getting drugs or alcohol, using drugs/alcohol, or recovering from alcohol/opioid use?
- Does your drinking or drug use **get in the way** of you doing other things like work or family activities?
- Have any **bad things happened** as a result of your drinking or drug use?
- Do **you continue to drink or use drugs even though** it causes these bad things to happen?

MAT EVALUATION FOR ALCOHOL USE DISORDER

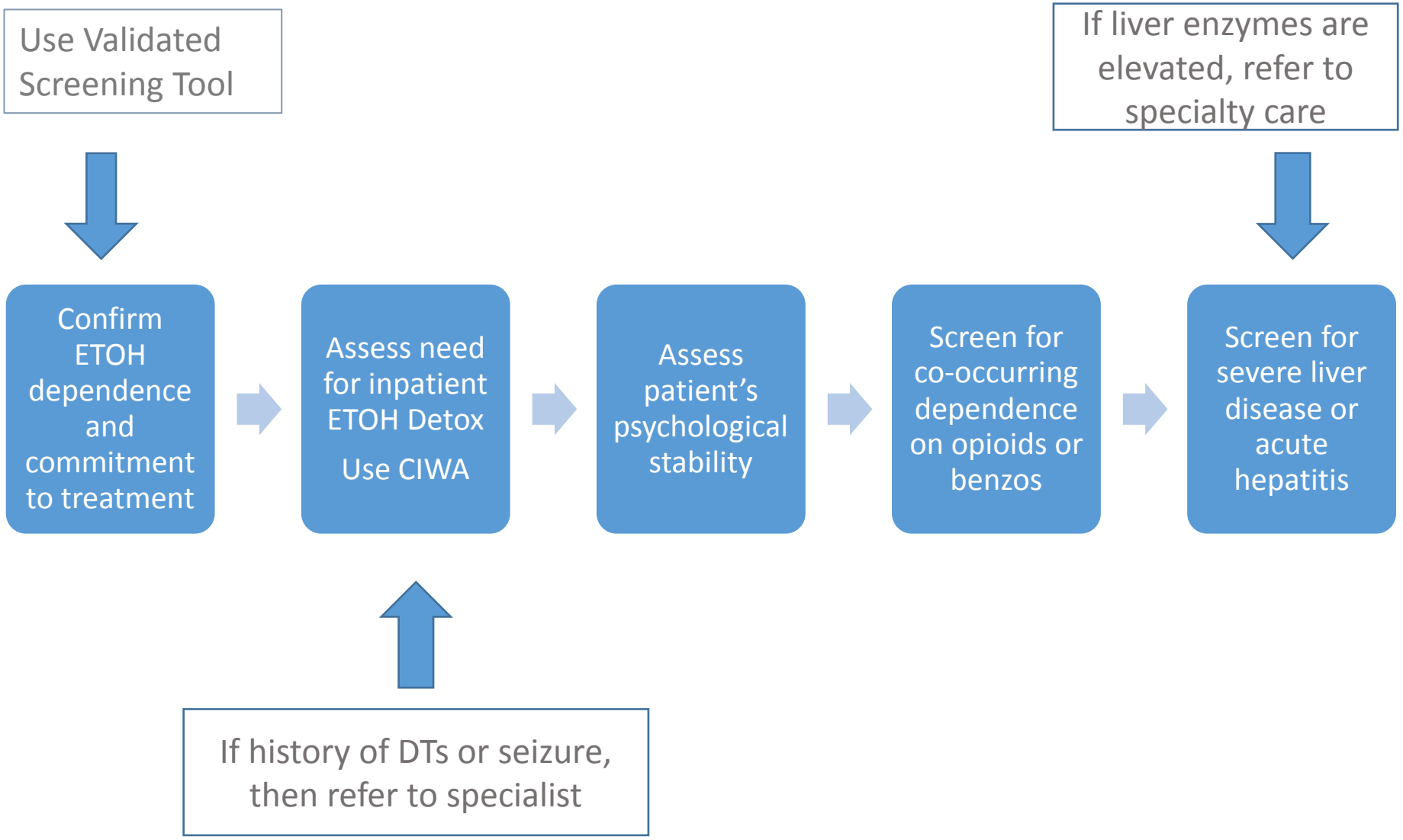
MAT EVAULATION FOR ETOH DEPENDENCE IN A PRIMARY CARE SETTING

- Conduct thorough history and physical
- Assess presence and severity of withdrawal symptoms and need for inpatient detox
- Assess use of benzodiazepine or sedative & need for detox
- Assess potential need for upcoming opioid therapy (i.e. planned surgery or procedure)
- Lab testing:
  - Urine drug screen for opioids and benzos
  - Comprehensive metabolic panel with liver enzymes
  - Pregnancy test
  - CBC, Prothrombin time (PT) and (INR)

ASSESS NEED FOR INPATIENT ETOH DETOX

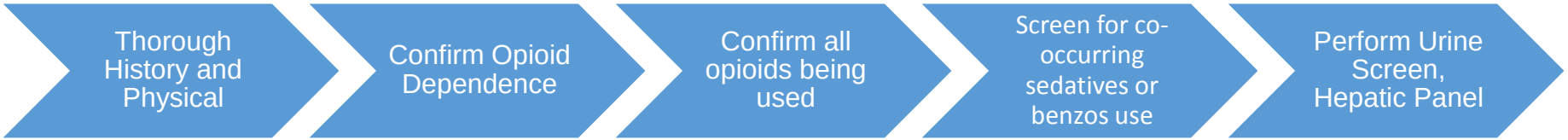
- If patient at-risk of moderate or severe ETOH withdrawal, **treat ETOH withdrawal before starting MAT**
- Withdrawal symptoms may begin within 6-12 hours after last drink but peak in 3-5 days of abstinence.
- Use 10 item validated Clinical Institute for Withdrawal Assessment Scale (CIWA) (Saitz et al 1994) to assess and manage patient for ETOH withdrawal risk.
- Symptom Assessment: Nausea/vomiting, tremor, sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, orientation or clouded sensorium.
- ETOH withdrawal ranges from mild to life threatening.
  - Mild withdrawal score <15, Moderate score is 16-20, Severe score >20
- **CIWA Score >15 should be referred for inpatient detox treatment**

PRIMARY CARE EVALUATION FOR MAT IN ALCOHOL USE DISORDER



MAT EVALUATION FOR OPIOID USE DISORDER

MAT EVALUATION FOR OPIOID DEPENDENCE



Use Validated Screening Tool

If liver functions are 5x normal, refer to addiction specialist

ASSESS NEED FOR OPIOID DETOX

- Clinical Opiate Withdrawal Scale (COWS) (Wesson et al, 2003)
- 11 item scale to rate the common signs and symptoms of opiate withdrawal and to monitor symptom burden over time.
- Used to determine the stage or severity of opiate withdrawal and the level of physical dependence on opioids.
- Symptoms Assessed: Pulse, sweating, restlessness, pupil size, GI upset, tremor, yawning, anxiety or irritability, bone or joint aches, gooseflesh, runny nose or tearing.
- Scoring system:
  - 5-12 = mild
  - 3-24=moderate
  - 25-36=moderately severe
  - more than 36 = severe

BEGINNING MEDICATION-ASSISTED TREATMENT

MAT OPTIONS FOR PRIMARY CARE

- Oral Naltrexone (Revia®)
- Naltrexone ER (Vivitrol®)
- Buprenorphine (Subutex®)
- Buprenorphine/Naloxone (Suboxone®)

ORAL NALTREXONE (REVIA®)

- For Alcohol or Opioid Use Disorder
- Tablet formula
- Full opioid antagonist, metabolized by liver
- Oral therapy found to lack efficacy unless patient is highly motivated
- Blocks opioids without agonist effects
- No tolerance or physical dependence
- Prevents impulsive use of drugs
- Protects against overdose but discontinuation poses higher risk because of lost tolerance
- Requires abstinence from opioid use prior to induction
- Contraindicated in pregnancy and in severe liver failure or acute hepatitis

EXTENDED RELEASE INJECTABLE NALTREXONE (VIVITROL®)

- For Opioid and Alcohol Dependence
- Full mu opioid antagonist – occupies receptor
- Non-narcotic, no abuse concerns
- 30 day injectable formula for IM use
- Blocks opioids without agonist effects – no high
- 380mg dose
- Patient must be abstinent from opioids for 7-10 days before beginning treatment or may precipitate withdrawal
- Patient should not be actively drinking when initiating therapy
- Contraindication in pregnancy, severe liver disease and those on chronic opioids for chronic pain.

MAINTENANCE VIVITROL® THERAPY

- Patients should be seen monthly for each injection, or more often in the event of any possible side effects.
- Brief counseling should be provided at each treatment visit.
- Injectable naltrexone cannot be removed once injected.
- Discontinuation of treatment is achieved by not administering the next injection.
- Naltrexone does not treat alcohol or opioid withdrawal.
  - Patients experiencing severe ETOH withdrawal should be referred to specialty care and considered for inpatient detox;
  - Patients experiencing severe opioid withdrawal may be better candidates for buprenorphine or methadone induction.
  - Patients with mild withdrawal and stable housing and psychiatric state may be treated as outpatients and continue with naltrexone therapy.

COMMON SIDE EFFECTS: ORAL or EXTENDED RELEASE INJECTABLE NALTREXONE

- Mild nausea – usually resolves within days
- Diarrhea
- Headache or myalgias
- Mild dizziness
- Injection site reactions
- Rare side effects: precipitated opioid withdrawal, hepatotoxicity, depression
- Patients with severe acute hepatitis or liver failure should not receive treatment with naltrexone

BUPRENORPHINE (SUBUTEX®)

- Schedule III, Sublingual tablets and films
- Partial opioid receptor agonist, high affinity, low activity and long acting
- Used for Opioid Dependence as Combination or Monotherapy
- Used for opioid detox and relapse prevention
- Poor oral bioavailability if swallowed
- Mu opioid receptor partial agonist - Activates receptor but has ceiling effect
- Less reinforcing and less rewarding
- Less risky for sedation and respiratory depression
- Precipitates opioid withdrawal in opioid tolerant patient
- Safe in Pregnancy: NIDA-funded MOTHER study (Jones et al) found that buprenorphine monotherapy (subutex) is an acceptable alternative to methadone for pregnant women

BUPRENORPHINE/ NALOXONE (SUBOXONE®)

- Schedule III, Combination formula, approved 2002
- Used for opioid detox and relapse prevention
- Sublingual tablets and films dosed once daily
- If taken sublingual – buprenorphine is active and naloxone is not
- If swallowed – buprenorphine is not active and naloxone is not active
- If crushed and injected, buprenorphine is active but attenuated by the naloxone effect - naloxone effect precipitates withdrawal.
- Naloxone will block or attenuate the opioid agonist effect of the buprenorphine if injected
- Naloxone decreases diversion of buprenorphine
- Contraindicated for pregnant patients

COMMON SIDE EFFECTS: BUPRENORPHINE MONOTHERAPY OR BUPRENORPHINE/ NALOXONE (SUBOXONE®)

- Constipation is the most common side effect. Need a bowel regimen, regular physical activity and laxatives as needed to prevent severe constipation.
- Sedation, headache, or nausea may result when doses of buprenorphine are too high.
- Studies have found buprenorphine/naloxone to be safe in patients with chronic hepatitis C, but use caution in patients with acute hepatitis or severe cirrhosis.
- **Warning: Overdose from buprenorphine alone is very rare, but buprenorphine combined with other sedatives (for example, benzodiazepines, alcohol) may result in fatal overdose.**

FOLLOW-UP AND BRIEF COUNSELING IN MAT

Patients in a MAT program should receive brief counseling at each treatment visit.

- Use brief intervention to assess motivation to continue treatment
- Assess alcohol or opioid use since last treatment visits

Assess adherence to treatment

- Urine tests
- Pill counts and pill taking logs
- Direct Observation Therapy
- Assess participation in recovery counseling or support groups

Assess for RED FLAG signs: positive toxicology screen, erratic ability to keep appointments, request for early refills, sudden requests for dose increases, lost prescriptions, multiple prescribers, ongoing ties to opioid dealers or opioid dependent acquaintances

EMERGENCY ANALGESIA

EMERGENCY ANALGESIA FOR PATIENT ON BUPRENORPHINE

- Patients on buprenorphine or combination therapy with buprenorphine and naloxone (Suboxone) may have a diminished response to opiate medications such as used for pain or cough.
- If emergent analgesia is required, management may include:
  - regional analgesia,
  - conscious sedation with benzodiazepine
  - non-opioid analgesics
  - general anesthesia
- If opioids required, need continuous monitoring in anesthesia care setting with qualified personnel trained in use of anesthetic drugs and to provide assisted ventilation if needed.

NALTREXONE THERAPY AND EMERGENCY PAIN MANAGEMENT

- If acute pain management is needed for a patient on naltrexone therapy for MAT, options include:
  - discontinue naltrexone 72 hours before hand, if planned procedure
  - use non-opioid treatment such as IV paracetamol or high dose NSAIDs,
  - local anesthesia such as nerve block, epidurals
  - conscious sedation with benzodiazepine
  - general anesthesia

REQUIRED TRAINING FOR MAT

REQUIRED TRAINING FOR MAT PRESCRIBING

The Drug Addiction Treatment Act of 2000 (DATA 2000) determined that licensed physicians are considered qualified to prescribe buprenorphine/naloxone if at least one of the following criteria are met:

- **Completion of not less than 8 hours of authorized training** on the treatment or management of opioid-dependent patients
- Holds an addiction psychiatry or addiction medicine subspecialty board certification
- Participation as an investigator in one or more clinical trials leading to the approval of a narcotic drug in Schedule III, IV or V for maintenance or detoxification treatment
- Training or other such experience as determined by the state medical licensing board or the U.S. Secretary of Health and Human Services.
- NP/PA may qualify for waiver with 24 hours of training

In addition, practitioners must satisfy ALL of the following criteria:

- Have the capacity to provide or to refer patients for necessary ancillary services, such as psychosocial therapy
- Agree to **treat no more than 30 patients** at any one time in an individual or group practice **during the first year** following certification;
- Physicians who have prescribed buprenorphine to 100 patients for at least one year can apply to increase their patient limit to 275 under new federal regulations.

RESOURCES FOR TRAINING

- SAMHSA Division of Pharmacologic Therapies provides training materials and resources www.SAMHSA.gov
- American Society of Addiction Medicine offers the ASAM Buprenorphine Course for Office-based Treatment of Opioid Use Disorders www.ASAM.org
- Physician Clinical Support System (PCSS) – SAMHSA funded national network of trained physician mentors for MAT prescribers, www.pcssmat.org

SUMMARY

- FDA-approved medications are now available for primary care providers to use in treatment of substance use disorders.
- Medication plus brief physician or non MD counseling is an option for patients who are not willing or able to participate in recovery counseling or support groups.
- Routine screening for alcohol and drug dependence will help identify patients who may benefit from medication assisted treatment.
- Surveillance and ongoing counseling are essential aspects of successful treatment.

REFERENCES AND RESOURCES

- SUMMIT: Procedures for Medication-Assisted Treatment of Alcohol or Opioid Dependence in Primary Care by Keith G. Heinzerling, Allison J. Ober, Karen Lamp, David De Vries, Katherine E. Watkins
- SAMHSA-Sponsored Buprenorphine Physician Clinical Support System
  - http://pcssmat.org/about/goals-objectives/
- MASBIRT Training and Technical Assistance
  - http://www.masbirt.org/
- The Center for Substance Abuse Treatment (CSAT)
  - http://buprenorphine.samhsa.gov/
- UCLA SARx
  - http://www.uclasarx.org/

EVALUATION

- Please take a minute to evaluate this webinar:

  https://www.surveymonkey.com/r/JG3VQL2