MERCER GOVERNMENT HUMAN SERVICES CONSULTING

PERSON CENTERED MEDICAL HOME PLUS

MEDICATION ASSISTED/ADDICTION TREATMENT

OCTOBER 24, 2019

Laurie Klanchar, RN, MSN

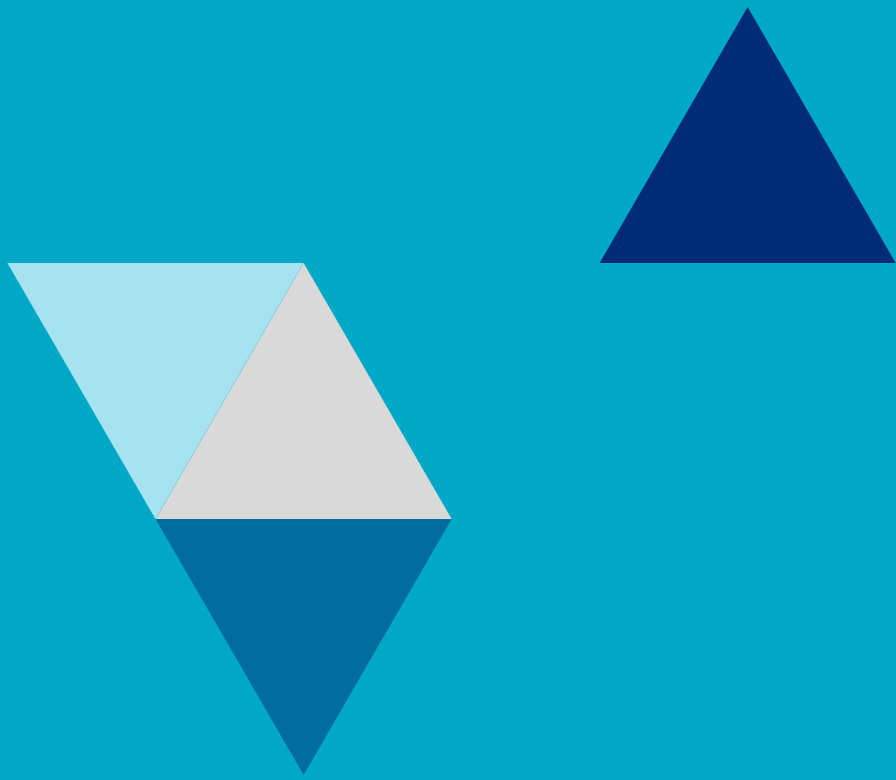
Shawn Thiele-Sacks, LCSW

Connecticut

TRAINING OBJECTIVES

1. The Opioid Epidemic
2. Setting the Stage: Medication Assisted/Addiction Treatment (MAT) Survey Results
3. Implementation
4. Training and Resources
5. Organizational Structures and Workforce
6. Best Practices
7. Special Populations

OPIOID EPIDEMIC: THE CURRENT STATE



THE OPIOID EPIDEMIC

1

RISE IN OPIOID OVERDOSE DEATHS IN AMERICA

A Multi-Layered Problem in Three Distinct Waves

399,000 people died from an opioid overdose (1999–2017)

1990s mark a rise in **prescription opioid** overdose deaths

2010 marks a rise in **heroin** overdose deaths

2013 marks a rise in **synthetic opioid** overdose deaths

Rx OPIOIDS
Include natural, semi-synthetic, and methadone and can be prescribed by doctors

HEROIN
An illegal opioid

SYNTHETIC OPIOIDS
Such as fentanyl and tramadol are very powerful and can be illegally made

Learn more about the evolving opioid overdose crisis: **www.cdc.gov/drugoverdose**

THE OPIOID EPIDEMIC BY THE NUMBERS

130+
People died every day from opioid-related drug overdoses[3] (estimated)

11.4 m
People misused prescription opioids[1]

47,600
People died from overdosing on opioids[2]

2.1 million
People had an opioid use disorder[1]

81,000
People used heroin for the first time[1]

886,000
People used heroin[1]

2 million
People misused prescription opioids for the first time[1]

15,482
Deaths attributed to overdosing on heroin[2]

28,466
Deaths attributed to overdosing on synthetic opioids other than methadone[2]

SOURCES

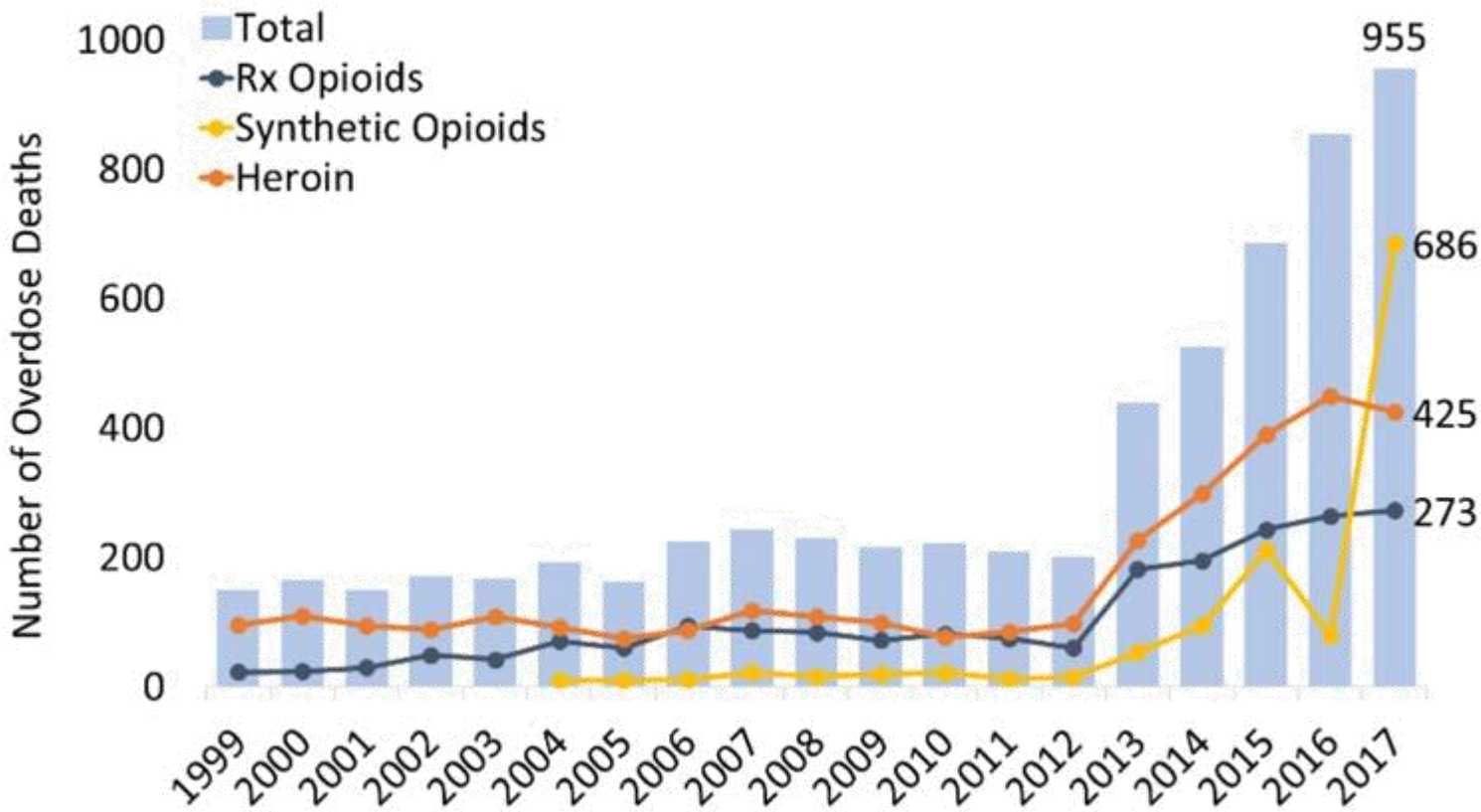
1. 2017 National Survey on Drug Use and Health, Mortality in the United States, 2016
2. NCHS Data Brief No. 329, November 2018
3. NCHS, National Vital Statistics System. Estimates for 2017 and 2018 are based on provisional data.

Updated January 2019. For more information, visit: http://www.hhs.gov/opioids/

HHS.GOV/OPIOIDS

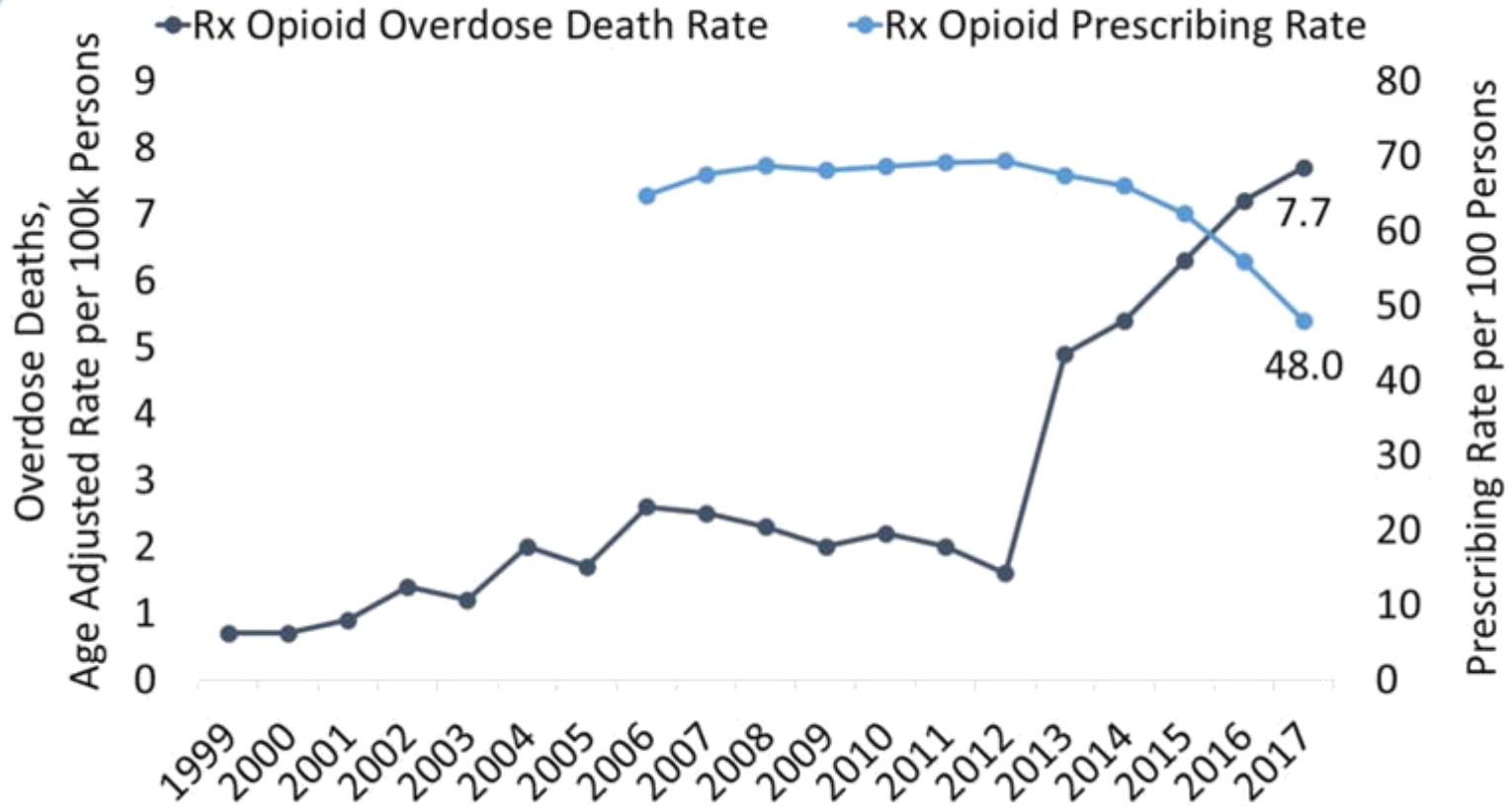
CONNECTICUT FACTS

1



CONNECTICUT FACTS

1



CONNECTICUT FACTS

1

Connecticut Department of Correction Medication Assisted Treatment Programs

- 85% – 90% of the incarcerated population has a substance use disorder requiring treatment.
  - Approximately 20% of the male population and 35% – 40% of the female population with a substance use disorder choose opioids as their primary drug
- In 2012, the Connecticut Department of Correction (CT DOC) working with the state Department of Mental Health and Addiction Services (DMHAS) and the state Department of Public Health (DPH) initiated medication assisted treatment (MAT) for opioid dependence in CT DOC's New Haven Correctional Center, a jail in New Haven
- York Correction Institution (YCI), Connecticut's single female institution, expanded program eligibility for pregnant females with OUD

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) GRANTS

1

- Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity.
- **Connecticut was one of 15 states awarded an 18 month planning grant** to increase the treatment capacity of Medicaid providers to deliver substance use disorder treatment and recovery services.

DEPARTMENT OF SOCIAL SERVICES (DSS) SUPPORT GRANT GOALS

1

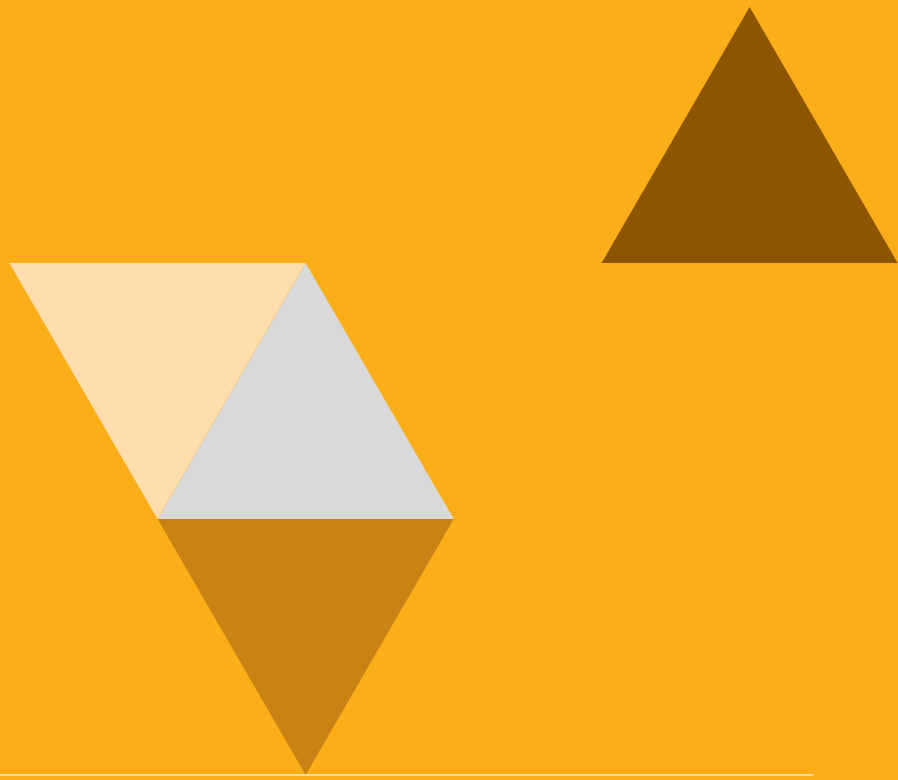
- Assess the unmet need for substance use disorder (SUD) and opioid use disorder (OUD) treatment and recovery services including gaps in services as compared to the general population of the state.
- Assess the unique needs of Medicaid subpopulations, including soliciting input from sub population groups, for age and gender appropriate and culturally relevant SUD and OUD treatment.
  - Pregnant and post partum women
  - Infants, including those with Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid Withdrawal Syndrome (NOWS)
  - Adolescents and young adults ages 12-21
  - American Indians/Alaska Natives
  - People living in rural areas
  - Dual eligible
  - Older adults
  - Persons diagnosed as HIV+
  - High need, high cost cohort

DSS SUPPORT GRANT GOALS

1

- Design activities based on assessment results that will improve state infrastructure for SUD and OUD treatment and recovery services including:
  - Recruitment of new SUD and OUD providers capable of treating special populations;
    - Certified MAT providers
    - Detox service providers
    - Providers serving rural areas
  - Education and training of providers to provide evidence based SUD treatments such as cognitive behavioral therapy (CBT), motivational enhancement therapy and contingency management.
  - Reduction in stigma associated with SUD populations resulting in increased SUD treatment capacity.

SETTING THE STAGE: PCMH+ MAT SURVEY RESULTS



PARTICIPATING ENTITY MAT SURVEY

2

- A survey was distributed to the Participating Entities (PEs) to determine topics of interest.

MERCER
MAKE TOMORROW, TODAY

MEDICATION ASSISTED TREATMENT (MAT) TRAINING

PARTICIPATING ENTITY FEEDBACK SURVEY

In order to ensure the focus of the upcoming MAT training at the October 24, 2019 Provider Collaborative meeting meets your needs, the following survey has been drafted. Please check any areas of interest (choose as many as applicable) to assist you in considering, implementing and/or sustaining MAT in your organization.

IMPLEMENTATION

☐ Guidelines, considerations and tips for implementing MAT

☐ Barriers, opportunities and lessons learned around implementing MAT

☐ Information to help implement MAT at our organization

☐ Information on partnering with another provider to fully implement MAT or assist with a portion (e.g. induction services)

☐ Policies and practices supporting the prevention and treatment of Opioid use and MAT

☐ Role of care coordinators

☐ Information on access to treatment including guidance or practice around equity issues such as rural vs. urban settings, etc.

TRAINING AND RESOURCES

☐ Member education

☐ Provider education

☐ Community resources

FINANCING

☐ Sources of funding

☐ Organizational structure

SURVEY RESULTS

2

IMPLEMENTATION

2

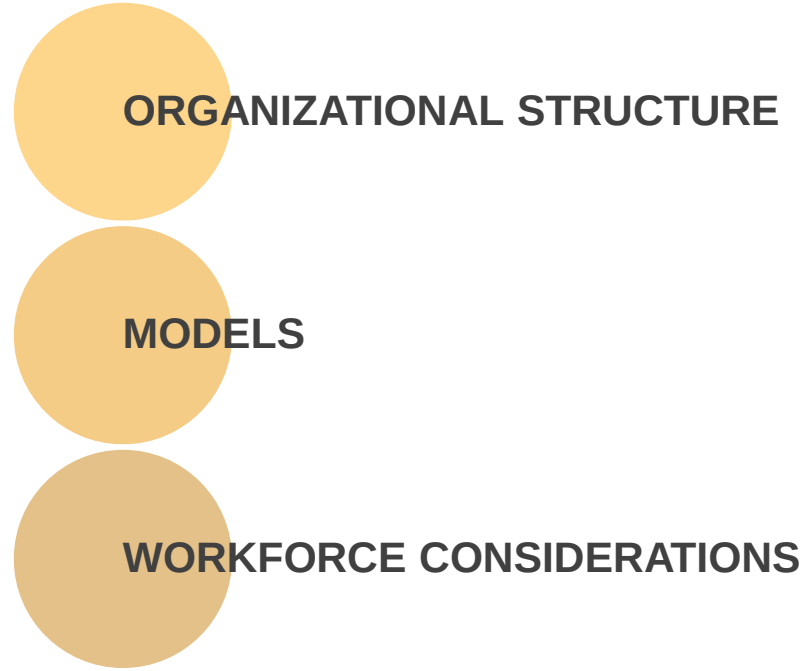
- GUIDELINES, CONSIDERATIONS AND TIPS
- BARRIERS, OPPORTUNITIES
- ROLE OF CARE COORDINATORS
- ACCESS CONSIDERATIONS
- POLICIES AND PROCEDURES
- PARTNERING WITH OTHER AGENCIES

TRAINING AND RESOURCES

2

STRUCTURE AND WORKFORCE

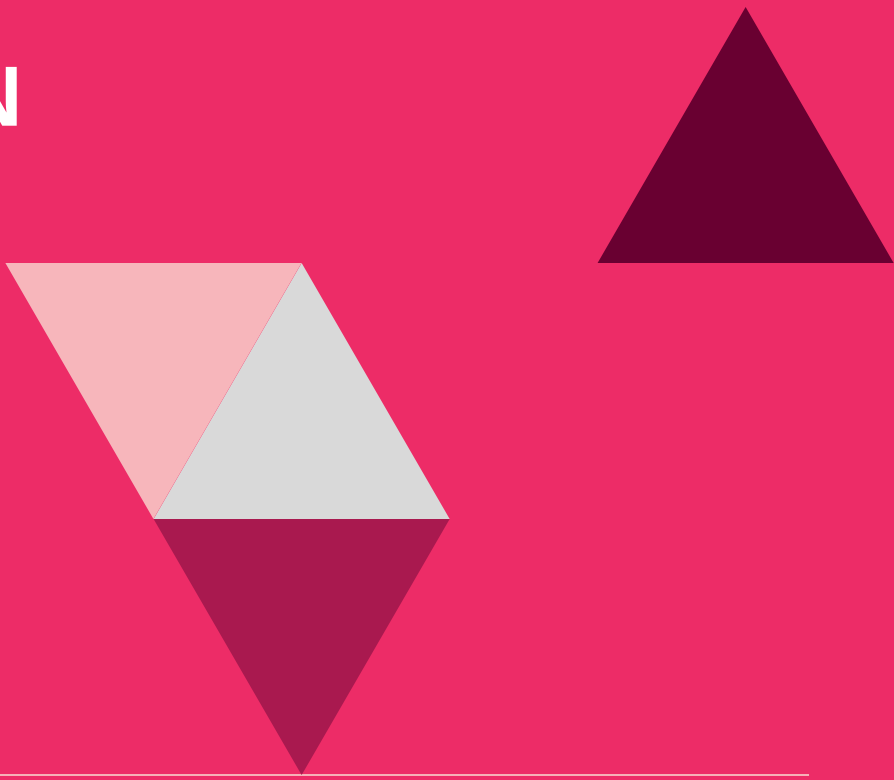
2



BEST PRACTICES

2

IMPLEMENTATION



DEFINING MAT FOR SUD

3

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA)
- **MAT** is defined as the use FDA approved opioid agonist medications and opioid antagonist medications in combination with behavioral therapies, to prevent relapse to opioid use. MAT includes screening, assessment (which includes determination of severity of OUD, including presence of physical dependence and appropriateness for MAT), and case management. It has been suggested that the term MAT is misleading because it implies that medications play an adjunctive role in treatment for OUD, and that it would be more accurate to simply refer to multimodal therapy for OUD that includes use of medications as "treatment."
- Local Connecticut and evolving terminology trend;
  - In treating SUD, similar to the physical health intervention, medication treatment alone is not as effective as when combined with behavioral therapies/treatment. Therefore the trend is shifting to refer to MAT as **Medication Addiction Treatment** and replacing the previous terminology to **Medication Based Treatment (MBT)**

OPIOID WITHDRAWAL MANAGEMENT VS MAINTENANCE TREATMENT

3

Withdrawal Management

- "Detoxification"
- Using an opioid agonist in tapering doses or other medications to help a person discontinue illicit or prescribed opioids.
- Using medications is recommended over going "Cold Turkey".
- Abrupt cessation of opioids can lead to cravings which can lead to relapse.

VS

Maintenance Treatment

- Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint.
- No recommended time limit for treatment.
- Looks at OUD as a chronic illness.

GOAL OF MAT

- American Society of Addiction Medicine **(ASAM)** states:
  - Block the euphoric and sedating effects of opioids –"Get the person to feel normal".
  - Have little to no side effects or withdrawal l symptoms.
  - Have controlled cravings.

SAMHSA
Substance Abuse and Mental Health Services Administration

- **SAMHSA** states:
  - MAT in combination with counseling and behavioral therapies provides a whole person approach to the treatment of substance use disorders.

BENEFITS OF MAT

3

- Reduction in HIV and Hepatitis risk behaviors.
- Decreased risk of overdose death.
- Retains people in treatment.
- Stabilization/improved quality of life.
- Remission of symptoms.
- Reduced expenditures related to decreased crime and use of the justice system.
- Reduced healthcare spending.
- Establish and maintain recovery.
- Chronic care management is effective for many long term medical conditions.
- Science demonstrating the effectiveness of medication for OUD is strong.

MAT IS NOT…
TREATING ONE ADDICTION BY CREATING ANOTHER ADDICTION

3

Dr. Hillary Kunins, a PCSS Clinical expert, dispels the notion that treating an addiction patient with medication is simply exchanging one drug with another

https://addictionmedicineupdates.org/2018/pcss-expert-explains-why-mat-isnt-substituting-one-drug-for-another/

EXHIBIT 4.9. Addressing the Misconception That an Opioid Medication Is "Just Another Drug"

Concerned Colleague:	These patients are just replacing one drug with another. Instead of heroin, they're using buprenorphine or methadone.
Counselor:	Actually, there's substantial research that medication for opioid use disorder helps patients stop feeling withdrawal and craving and allows them to get their life back on track. These medications keep patients in treatment and reduce crime and HIV risk behavior.
Concerned Colleague:	Yeah, but aren't they still addicted?
Counselor:	Physically dependent, yes; but addicted, no. There's an important difference. Someone addicted to heroin has to take the drug several times a day to avoid withdrawal. This usually leads to craving, loss of control, and taking more than intended. Drug-seeking behavior causes loss of family and friends. It makes the person unable to perform daily roles and meet obligations.
Concerned Colleague:	Yes, I know how addiction works. But isn't taking methadone an addiction, too?
Counselor:	Patients only take methadone once a day, and its makeup is different from heroin. Daily methadone lets the body stabilize so patients don't have the highs and lows that come from heroin use. If patients use heroin, the methadone blocks its effects; they don't get high. Methadone is taken orally, so there isn't the same danger of infection that comes with injection drug use. Taking methadone as part of a treatment program lets patients feel normal and focus on changing the other aspects of their lives that led to drug use.
Concerned Colleague:	But you just said they take methadone every day.
Counselor:	Yes. That is true of most medications for any disease, if you think about it. Patients have a physical dependence on the medication but are in remission from addiction.

Reference: SAMSHA Tip 63: Medications for Opioid Use Disorder

POLICIES/PRACTICES SUPPORTING THE PREVENTION AND TREATMENT OF OUD AND MAT

3

- Practice Guidelines and decision making tools can help healthcare professionals with OUD screening, assessment, diagnosis, treatment planning and referrals.
  - Evaluate existing process to see what is working
  - Identify areas to enhance
    - Overdose prevention
    - Signs of withdrawal
    - Medication education
- Provide client and family oriented resources
  - Opioid addiction in general
  - Role of medication
  - Behavioral health (BH) and supportive services
  - Mutual help groups
  - Recovery support services
  - Specialty providers

Reference: SAMSHA Tip 63: Medications for Opioid Use Disorder

GUIDELINES, CONSIDERATIONS AND TIPS FOR IMPLEMENTING MAT

3

- Check Connecticut Prescription Drug Monitoring Program (PDMP) before prescribing.
- Ask individuals to sign a release to speak with other prescribers.
- Develop a diversion control policy.
- Implement a urine drug testing protocol.
- Implement a medication count monitoring.
- Develop a treatment agreement.
- Prescribe an adequate but not excessive dose.
- Provide a limited number of days of medication per prescription until stability and lowered diversion risk is demonstrated.

BARRIERS AND OPPORTUNITIES AROUND IMPLEMENTING MAT

3

MAT Controversies

- Exchange of one substance for another
- Use of naloxone promotes risky drug using behaviors
- Stigma

Lack of Institutional Support

Lack of Prescribing Physicians

Lack of Expertise

Inadequate Reimbursement

ACCESS BARRIERS

3

- Barriers include:
  - Lack of addiction and psychiatric expertise
  - Distances to access care
- Challenges for prescribers:
  - Lack of BH and psychosocial supports
  - Time constraints for providers
  - Concerns for drug diversion and medication misuse
- Lack of buprenorphine waivered physicians
- Negative attitudes and beliefs regarding MAT:
  - Though more may be affected by the opioid crisis

ACCESS SOLUTIONS

3

- Solutions
  - Consider telemedicine
  - Web based learning networks
  - Utilization of non physician providers in key roles
    - NP and PAs prescribing
    - Nurses, case managers
  - Education and outreach
  - Extended release formulations

PARTNERING WITH OTHER AGENCIES

3

- Obtain written consent from individuals to allow direct communication to facilitate information sharing.
- Integrate medical and BH/SUD care to promote whole person treatment and collaborate care;
  - Assess client progress
  - Revise treatment plans if needed
  - Make informed decisions
- Establish regular structured communication with prescribers.

ROLE OF CARE COORDINATORS

3

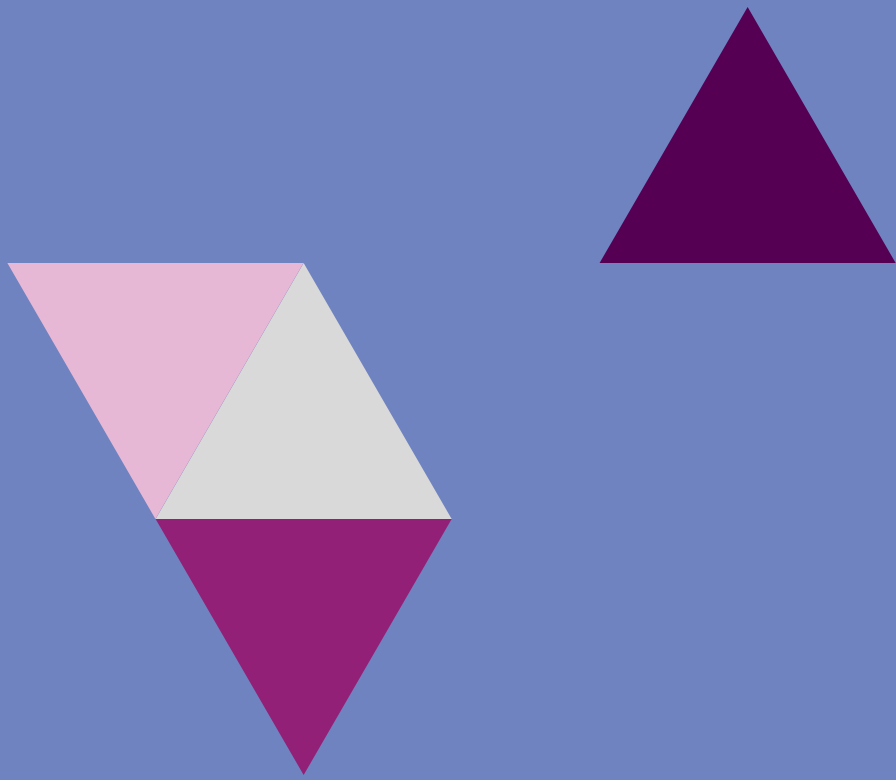
- Psychosocial services are essential to a successful MAT model.
- Link MAT back to the PE goals;
  - Transition age youth (TAY) transition plans
  - Enhanced care coordination
  - Wellness Recovery Action Plan® (WRAP) plans or other recovery tools
  - Psychiatric advance directives
  - BH screening
  - Staff Training
- Help individuals manage stressors and identify triggers.
- Help to develop positive coping strategies.
- Provide trauma informed care.
- Support individuals in access to treatment.

ROLE OF CARE COORDINATORS CONTINUED

3

- Referral to treatment
- Explore level of participation and engagement in recovery support activities.
- Don’t allow personal feelings or opinions to influence the counseling process.
- Educate clients about naloxone and help them obtain it.
- Maintain a therapeutic alliance.
- Know which mutual help groups are accepting of clients using MAT.
- Medication reconciliation (making sure nothing contraindicated with the MAT e.g., benzos)

TRAINING RESOURCES



PROVIDER EDUCATION

4

- ASAM (criteria, practice guidelines)
- SAMSHA (toolkit, Providers Clinical Support System [PCSS])
- Scientific and empirical evidence for the use of FDA approved medications for OUD
- Comparison of medical management and support of persons with OUD to that of persons with other chronic illnesses
- Side effects of OUD medications and how to recognize them
- Effect of OUD and substance use and mental disorders on a person's behavior and how to respond
- Words used to describe OUD are powerful and can reinforce prejudice, negative attitudes and discrimination
  - Person first language
  - Medical terms (not clean or dirty urine)

CLIENT EDUCATION

4

- Addiction as a chronic disease influenced by genetics and environment.
- How medications for OUD work.
- Agree to store medication securely and out of the reach of others. Understand that giving even small amounts of these medications to others may be fatal.
- Inform nursing/medical staff about prescribed and over-the-counter medications and herbs (e.g., St. John's Wort) they are taking, stopping, or changing doses to allow assessment of potential drug–drug interactions.
- Inform other treating healthcare professionals that they are receiving MAT treatment.
- Need for additional psychosocial treatment in addition to MAT

CLIENT EDUCATION CONTINUED

4

- Know that concurrent alcohol, benzodiazepine, or other sedative use with methadone or buprenorphine increases the risk of overdose and death.
- Report pregnancy
- Inform providers of upcoming medical procedures that may require pain meds.
- May be asked to sign a treatment agreement.
- May be subject to drug screening and medication counts.
- Understand that lost medication will not be replaced without an office visit.
- Address diversion of controlled substances.

STORIES FROM THE FIELD

4

Carol (https://vimeo.com/105287902)

COMMUNITY RESOURCES

4

- **SAMHSA TIP 63 Part 5**: Resources related to Medications for OUD for Healthcare Professionals, Policymakers, patients and families
- **SAMSHA Medication Assisted Treatment for Opioid Addiction –** Facts for Families and Friends
- **Connecticut MAT Learning Collaborative:** MAT Tool Box
- **Connecticut Behavioral Health Partnership:** Medication Assisted Treatment (MAT) for Substance Use TOOLKIT
- **Connecticut Women's Consortium:** Medication Assisted Treatment: MAT 8-hour Waiver Training

CONNECTICUT RESOURCES: STATE MAT MAP

4

Select to Highlight (dots may be overlaid)

- Methadone Clinic
- Partial Hospital/IOP with Housing
- Intensive Outpatient (IOP)
- Behavioral Health Outpatient
- Partial Hospitalization (PHP)

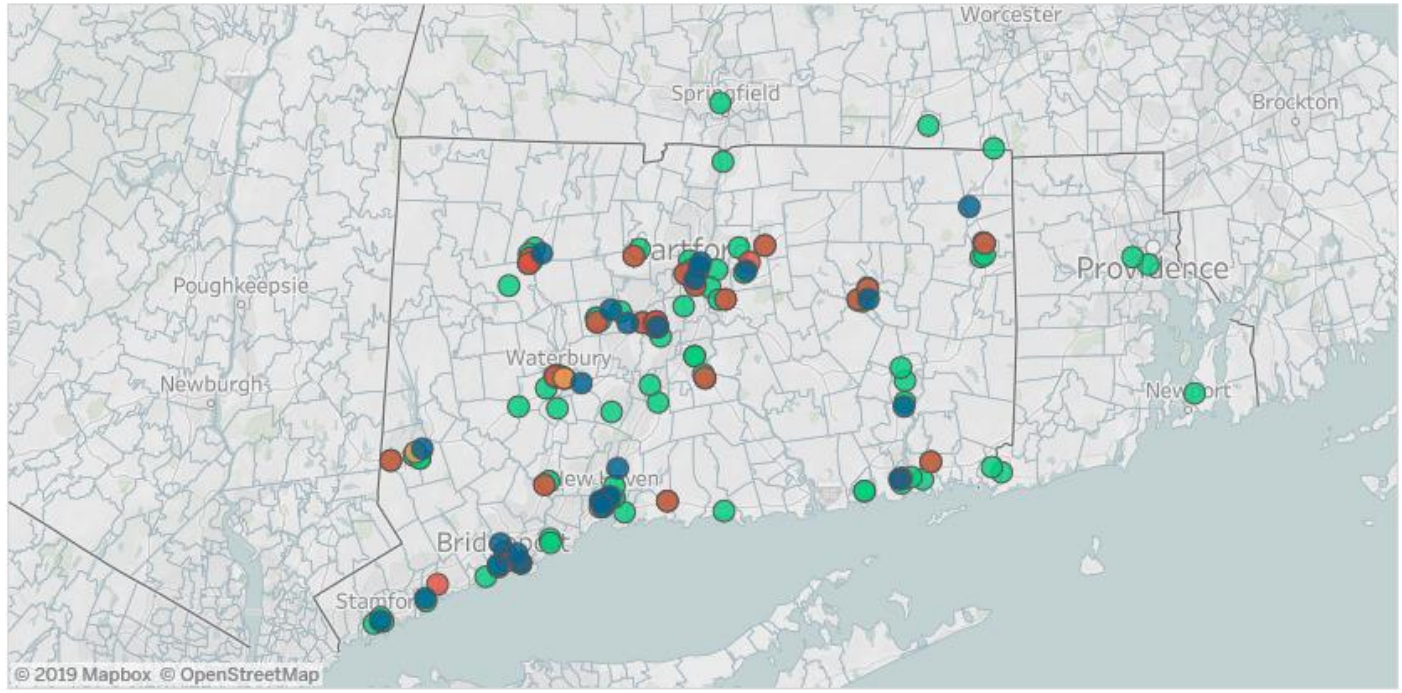
Which medication do you need? (All)

How old are you? (None Specified)

Search by Typing a Provider/Clinic Name

Search by Typing a Town/City

The providers listed below are actively enrolled CT Medicaid behavioral health providers that have requested to be listed on this page. If you would like to be added to the map or update your existing information on the map, please complete the MAT Provider Locator Map Listing Form by clicking here.



Reference: http://www.ctbhp.com/medication-assisted-treatment.html

ORGANIZATIONAL STRUCTURES AND WORKFORCE

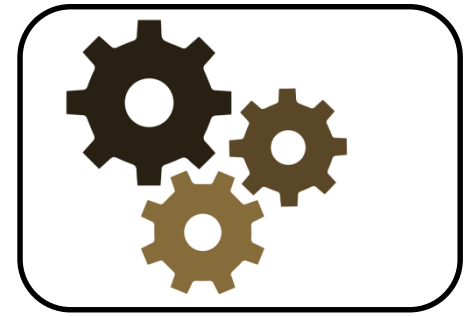
ORGANIZATIONAL STRUCTURE

5

- **Framework components of a program:**

PHARMACOLOGICAL

PSYCHOSOCIAL SERVICES



INTEGRATION/ COORDINATION

EDUCATIONAL OUTREACH

- Use of non physician staff to perform key integration/coordination
- Tiered care management models
- Use of internet based learning models
- Screening and induction in ED, IP or prenatal settings with community follow-up
- Use of peer delivered recovery support services

ORGANIZATIONAL STRUCTURE EXAMPLES

5

Model	Summary	Components				
		Pharmacologic	Education/Outreach	Coordination/Integration of Care	Psychosocial	Other
Practice-based models						
OBOT	Buprenorphine prescribed by primary care providers who complete DATA2000 waiver training	Primarily buprenorphine–naloxone	Not a major component; Provider Clinical Support Service for MAT (PCSS-MAT) available to mentor primary care providers	A non-physician clinic staff member sometimes used to coordinate MAT prescribing and integration with primary and mental health care.	Physician or other onsite or off-site counseling at least monthly; Other psychosocial services vary, including integrated cognitive behavioral therapy and motivational enhancement therapy; some psychosocial services off-site.	–
Buprenorphine HIV Evaluation and Support Collaborative model	OBOT adaptation for providing buprenorphine–naloxone in an HIV primary care clinic setting	Buprenorphine–naloxone	Patient and provider educational material available online	Treatment for OUD and primary care, including HIV care integrated in the same setting. A non-physician clinic staff coordinates care and collaborates with HIV primary care provider.	On-site psychological services vary, including individual and group counseling.	Coordination with OTP for patients switching to or from methadone
One-stop shop model	Integrated model based in mental health clinic to provide "one-stop," comprehensive management of HIV/HCV infection and MAT	Primarily naltrexone	Provider education in MAT, HIV, and hepatitis C management	Treatment for OUD, mental health, and primary care (including HIV/HCV care) provided in the same setting. Peer navigators and social workers provide coordination with primary care providers.	Centered in a mental health clinic that provides comprehensive psychological services; psychiatrist once weekly.	Syringe exchange and other services also available; Model developed to respond to specific outbreak of HIV and Hepatitis C in rural area.

Reference: Agency for Healthcare Research and Quality (AHRQ) MAT models of care for Opioid Use Disorder in Primary Care Settings December 2016

ORGANIZATIONAL STRUCTURE EXAMPLES

5

Model	Summary	Components				
		Pharmacologic	Education/Outreach	Coordination/Integration of Care	Psychosocial	Other
System-based models						
Hub-and-spoke model (Vermont)	Centralized intake and initial management (buprenorphine induction) at "hub"; patients are then connected to "spokes" in the community for ongoing management	Primarily buprenorphine–naloxone	Outreach to prescribers in the community to increase the number of buprenorphine-waivered physicians	Coordination/integration between hub and spoke as well as within each primary care site spoke. Registered nurse clinician case manager and/or care connector (peer or behavioral health specialist) for coordination/integration of care at spokes.	Embedded in spoke sites, including social workers, counseling, and community health teams.	Hubs provide consultative services and are available to manage clinically complex patients; support tapering of MAT; or prescribe methadone, if needed
Medicaid health home model	A flexible model that provides MAT in combination with behavioral health therapies and integrated with primary care	Primarily buprenorphine–naloxone	Provider and community education emphasized to increase uptake and decrease stigma	Required component, but mechanism of coordination varies.	6 core psychosocial services are required: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, and referral to community and social support services.	Some telehealth services offered

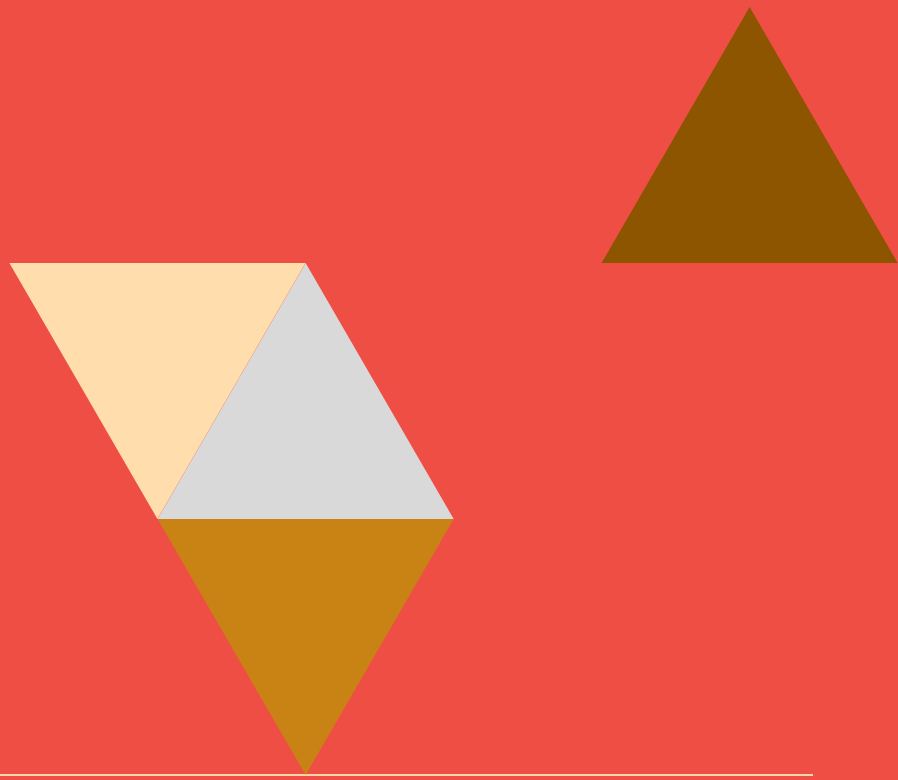
Reference: Agency for Healthcare Research and Quality (AHRQ) MAT models of care for Opioid Use Disorder in Primary Care Settings December 2016

WORKFORCE NEEDS AND ISSUES

5

- Federal regulations impact requirements for prescribers and opioid treatment program providers.
- Physicians are also required to have a certain level of competency in addiction medicine.
  - 2014 study noted that 41% of practitioners that do not actively prescribe MAT reported this as a major barrier
  - Research suggests that the average medical school requires few hours to be devoted to the topic
- A 2010 study –
  - 60% of non-adopting programs identified a lack of “access to physicians with expertise in prescribing medications to treat substance abuse” as an “important” or “very important” barrier.
  - 58% of non-adopting programs in this study identified a lack of “nurses or other medical staff with expertise in implementing medications to treat substance abuse” as an “important” or “very important” barrier.

BEST PRACTICES



ASAM PRACTICE GUIDELINES FOR MAT

6

- **Part 1-2:** Assessment, Diagnosis and Treatment of Opioid Use Disorder
- **Part 3:** Treating Withdrawal
- **Part 4-6**: Drugs used in MAT
  - Methadone
  - Buprenorphine
  - Naltrexone
- **Part 7:** Psychosocial Treatment in conjunction with medications
- **Part 8 -12:** Special Populations:
  - Pregnant Women
  - Individuals with Pain
  - Adolescents
  - Individuals with Co-occurring Psychiatric Disorders
  - Individuals in the Criminal Justice System
- **Part 13:** Naloxone for the Treatment of Opioid Overdose

SAMHSA TIP 63

6

- **Part 1:** Introduction to Medications for Opioid Use Disorders
  - For healthcare and addiction professionals, policymakers, patients and families
- **Part 2:** Addressing Opioid Use Disorder in General Medical Settings
  - For healthcare professionals
- **Part 3**: Pharmacotherapy for OUD
  - For healthcare professionals
- **Part 4:** Partnering Addiction Treatment Counselors with Clients and Healthcare Professionals
  - For healthcare and addiction professionals
- **Part 5:** Resources Related to Medications for OUD
  - For healthcare and addiction professionals, policymakers, patients and families

TREATMENT SETTINGS: OPIOID TREATMENT PROGRAMS

6

- Opioid Treatment Programs (OTP)
  - Certified program with supervised assessment and treatment in an outpatient, residential or hospital setting
  - Methadone, buprenorphine and naltrexone
  - Daily dosing with some take home options
  - Supervision
  - Supportive treatment

- Consider
  - Client preference
  - Treatment history

TREATMENT SETTINGS: OFFICE BASED TREATMENT

6

- Office based opioid treatment (OBOT)
  - Physicians in clinics or private practice authorized to prescribe buprenorphine
  - Provides medication on a prescribed weekly or monthly basis
  - Limited to buprenorphine and naltrexone
  - May not be suitable for persons with active alcohol, sedative, hypnotic or anxiolytic use

- Consider
  - Client preference
  - Treatment history

PHARMACOLOGY OF MAT

6

- The medications used to treat OUD act on the body's opioid receptors in different ways.
- MAT drugs include opiate agonists, partial agonists and antagonists:

FULL AGONIST	PARTIAL AGONIST	ANTAGONIST
• Bind tightly to the opioid receptors to produce a response. • Increasing the dose increases the response.	• Stimulates activity at the opioid receptor but with less effect. • Increasing does may not produce additional effects after a certain point.	• Inhibits the ability of the opiate to bind to the receptor.

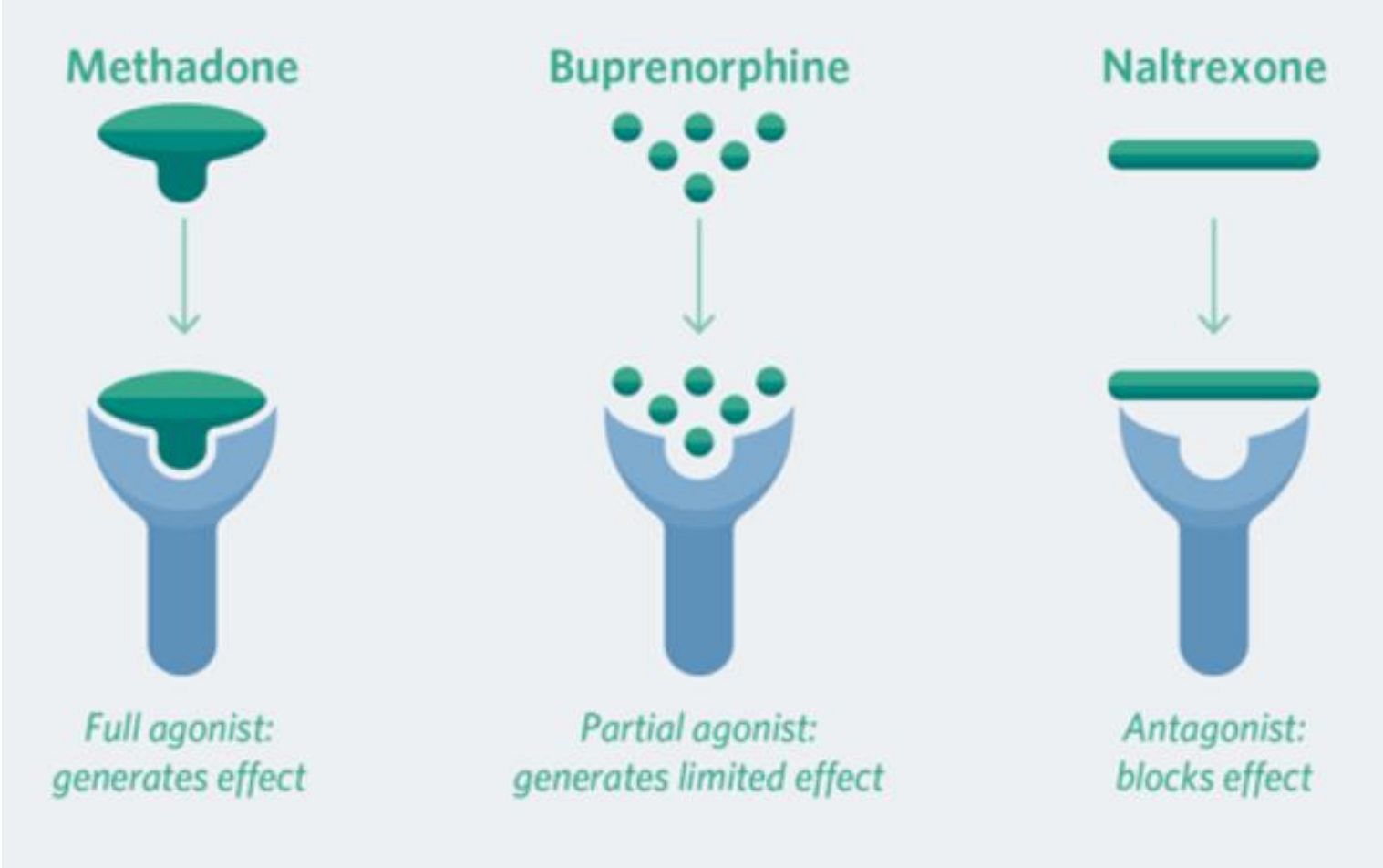
PHARMACOLOGY OF MAT CONTINUED

6

FULL AGONIST	PARTIAL AGONIST	ANTAGONIST
• Heroin • Oxycodone • Morphine • Methadone	• Buprenorphine (Subutex) • buprenorphine/naloxone (Suboxone)	• Naltrexone (vivitrol, Revia) • Naloxone (Narcan)

PHARMACOLOGY OF MAT CONTINUED

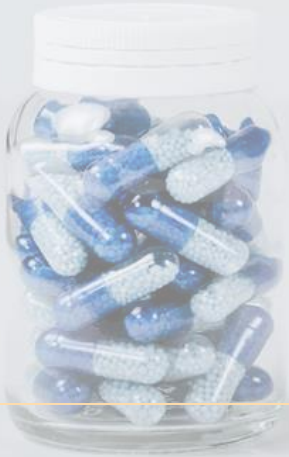
6



METHADONE

6

- Opiate receptor agonist
- Recommended for clients who may benefit from daily dosing and supervision in an OTP.
- For OUD, only prescribed through a OTP.
- Dispensed in tablets or liquids.

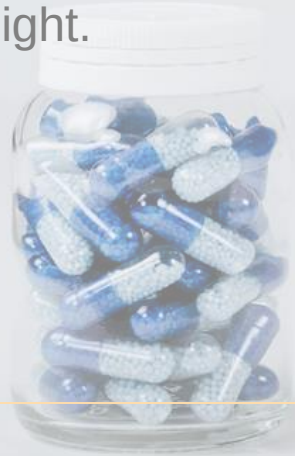


- Taken daily
  - OTP regulations require monitored medication administration until clinical response and behavior are evaluated.
- Inexpensive
- Treatment of choice in pregnant women.
- Risk of overdose with concurrent benzodiazepine use or use of illicit opioids after stopping the MAT medication.

BUPRENORPHINE

6

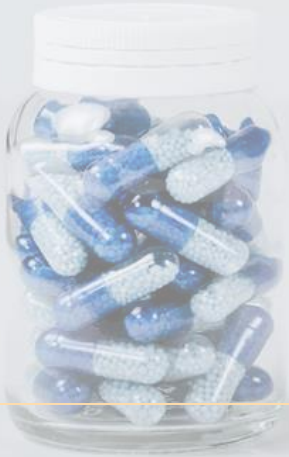
- Opiate receptor partial agonist
- Physician prescriber need to complete an eight hour training course and apply for a special DEA waiver;
  - Limited in first year to 30 patients.
  - 2016 Comprehensive Addiction and recovery Act allows for CRNP and PAs to prescribe.
    - Requires 24 hours of training rather than eight.
- Dispensed in tablets, sublingual film, implants, injections.
- Risk of overdose with concurrent benzodiazepine use or use of illicit opioids after stopping the MAT medication.
- Induction can occur in the office or at home
  - Person must be exhibiting clear signs of opioid withdrawal before first does.



NALTREXONE

6

- Opiate receptor antagonist
- Available as a long acting injection
  - Vivitrol given every four weeks
- Also dispensed in tablets
- Often adversely affected by poor medication adherence

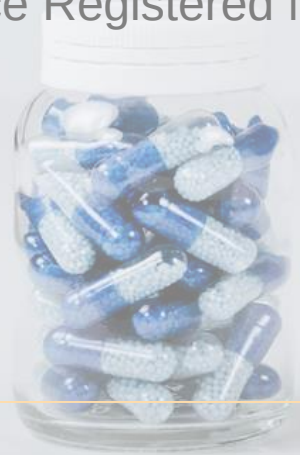


- Can be prescribed by any licensed provider
  - Blocks the effects of opioids
  - Reduces cravings
  - Also used for alcohol use disorder
- Risk of overdose after stopping the medication

NALOXONE

6

- Also known as Narcan
- Available as an intranasal spray and as a solution for intravenous, intramuscular or subcutaneous injection
- Prescription medication that reverses overdoses for opioids
  - Short acting drug which immediately displaces the opiate from the opiate receptor
  - Acute withdrawal syndrome may occur in persons who are physically dependent on opioids
- In Connecticut, authorized naloxone prescribers are physicians, surgeons, PA's, Advanced Practice Registered Nurses (APRNs), dentists, podiatrists and certified pharmacists.



PSYCHOSOCIAL TREATMENT
RECOMMENDED IN CONJUNCTION WITH PHARMACOTHERAPY

6

PSYCHOSOCIAL SUPPORT
RECOMMENDED IN CONJUNCTION WITH PHARMACOTHERAPY

6

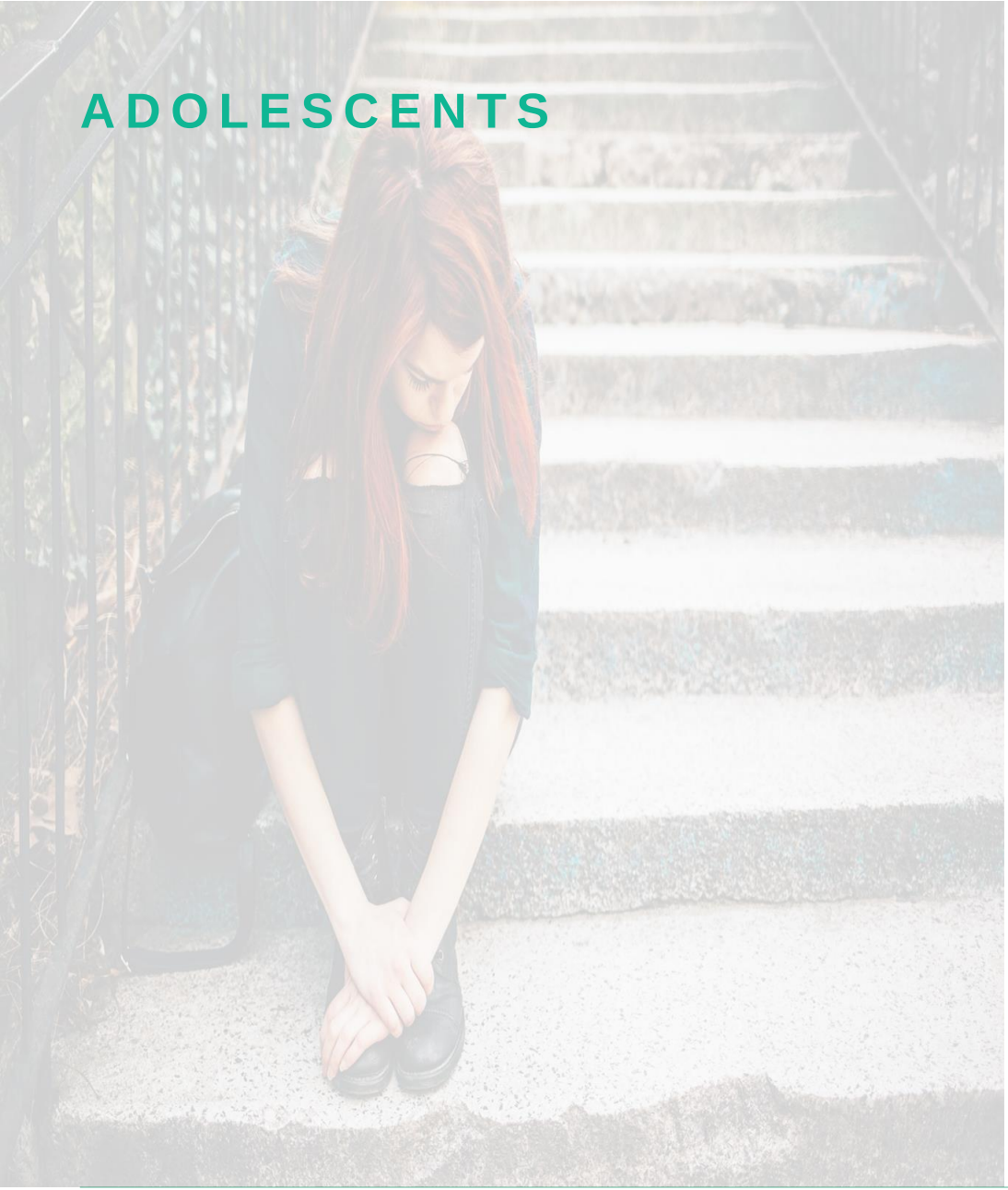
Recovery Support Services	Housing Support	Educational Services	Income Support
Case Management	Employment	Food Assistance Services	

SPECIAL POPULATIONS

PREGNANT WOMEN

- Pregnant women with OUD more likely to:
  - Seek prenatal care later
  - Miss appointments
  - Experience poor weight gain
  - Exhibit signs of withdrawal or intoxication
  - Increased risk for HIV and Hepatitis B & C
- Treat with methadone or buprenorphine rather than abstinence.
- Medically supervised withdrawal during pregnancy is typically not advisable.
- HIV and Hepatitis testing.
- Newborns often show symptoms of NAS which is treatable.
- OK to breastfeed with methadone and buprenorphine+-+.

ADOLESCENTS



7

- Consider all treatment options.
- Psychosocial treatment imperative.
- May benefit from treatment in specialized facilities.
- Opioid agonists and antagonists
  - Buprenorphine is FDA approved for adolescents 16 and older.
- Include other age appropriate considerations — STD testing, vaccinations.

CO-OCCURRING PSYCHIATRIC DISORDERS

7

Comprehensive mental health status assessment

Reduce, manage, and monitor risk of suicide

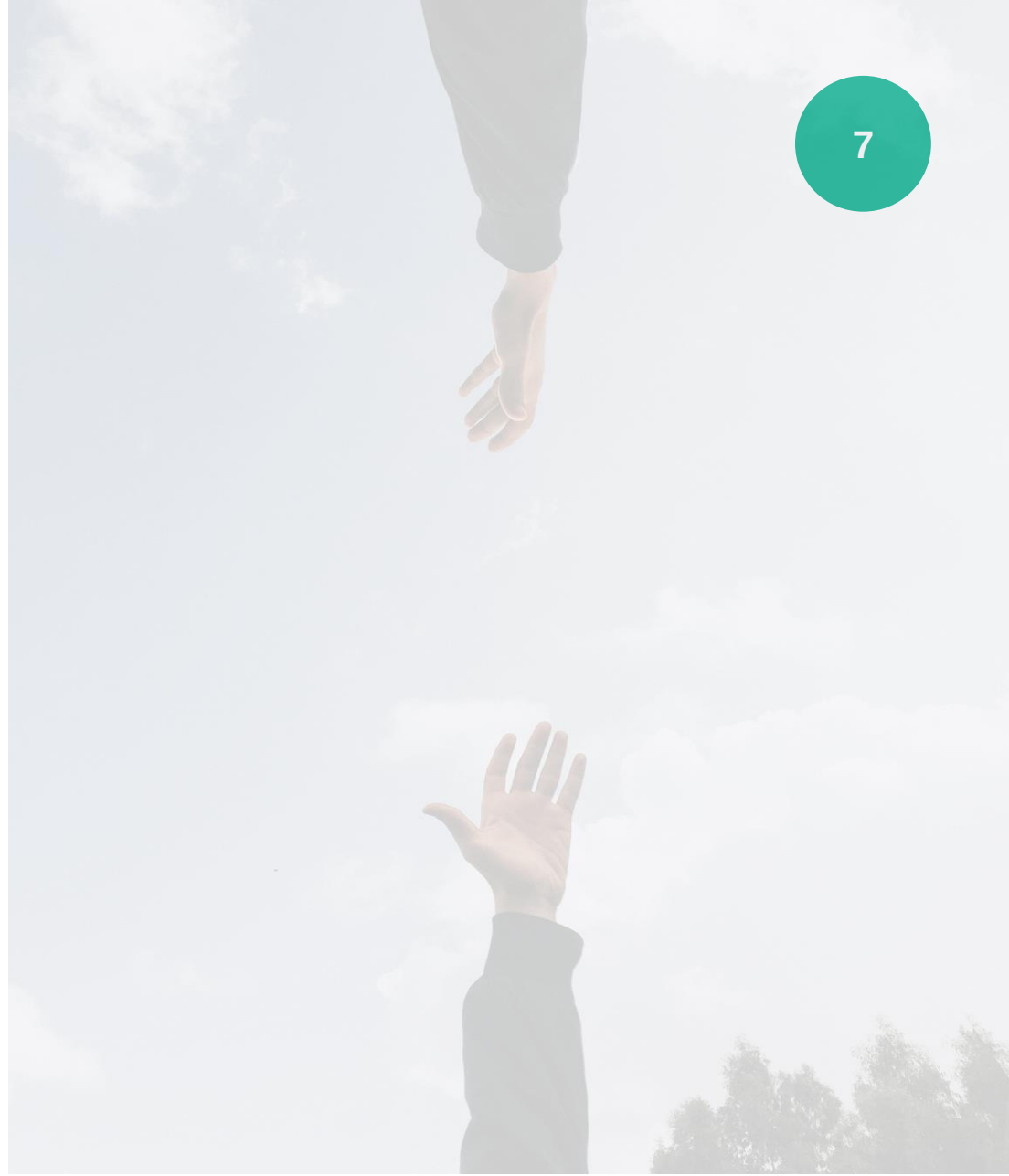
Monitor behavior and presentation at onset of treatment

Requires pharmacotherapy and psychosocial treatment for OUD and co-occurring psychiatric disorder

MAT AND RECOVERY

7

- Clients taking medication for OUD may face challenges in mutual help groups such as NA.
  - NA groups may not consider people taking OUD “clean and sober”



STORIES FROM THE FIELD

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