Beginning MAT at this office

Our office follows the ER fast start guide for prescribing medication assisted treatment (MAT) for individuals diagnosed with opioid use disorder (OUD).

The purpose of this policy is to expand access to treatment of OUD in order to reduce drug overdose deaths in our community. The American Medical Assn has recommended the integration of the treatment of OUD with primary care (Henry, 2020). Moreover, research has shown that access to primary care is associated with reduced rates of relapse for individuals in treatment for OUD (Hancock, 2017).

Patients will be asked the following questions to determine safety for proceeding with MAT:

- The following conditions are CONTRAINDICATED for prescribing MAT at our office:
    - Any Methadone use
    - Any Benzodiazepine use without approval of a psychiatrist or PMHNP
    - DSM-5 criteria for alcohol use disorder
    - Active suicidal ideation
    - Psychiatric impairment that impedes ability to provide informed consent to make decision regarding their own care(dementia, delusional, actively psychotic)
    - Patients with acute or chronic pain syndrome requiring chronic use of opioid analgesics
- If the patient denies all of the above conditions, proceed with the following:
    - Urine drug check: if positive for benzodiazepines or methadone, pt cannot begin treatment today.
    - Check the state of Maryland PDMP: if currently being prescribed benzodiazepines or opiates, the patient cannot begin treatment today.
    - Pregnancy test: if pregnant, do not prescribe suboxone. Obtain prior authorization for Subutex.
    - Skin check for IV drug users: screen for abscesses, cellulitis as the patient may need to be referred to a local emergency room for a higher level of care. Cellulitis or abscess from IV drug use places the individual at increased risk for life threatening sepsis and bacterial endocarditis (Lewer, et al, 2017).
    - Perform a psychosocial assessment to identify comorbid conditions including mental health conditions. If deemed necessary, the provider will refer the patient for psychiatric evaluation.
    - Ensure Buprenorphine MAT Consent Form has been reviewed and signed
    - Refer patient for counseling services
    - Safe and proper storage of medication has been reviewed, and information on obtaining for naloxone (Narcan) has been provided.
    - Prescribe the initial 7 day course of MAT: Suboxone 8 mg tabs Sig: ½ tab SL QID as needed x 7 days. Dispense 14 tabs
    - Patients with a history of IV drug use will be given a lab slip for hepatitis screening

Ensure follow up appt is scheduled in 5 to 7 days and review the following with the patient:

- Buprenorphine (Suboxone, Subutex) is an opioid medication for treatment of opioid use disorder.
- Precipitated (i.e. sudden) withdrawal may occur if the patient has other opioids in their system when initiating buprenorphine / naloxone.
- If a person abruptly stops or tapers the medication, withdrawal will likely occur.
- Like all opioids, buprenorphine is potentially lethal if taken by children or others. Buprenorphine requires safe storage, handling and usage. Keep medication out of sight and reach of children in a locked box, bag, or cabinet. Do not put tablets or film strips on counters, sinks, dressers, or nightstands. It is easy for children to put small pieces and crumbs in their mouth; to prevent breakage, keep cotton or tissue in the buprenorphine-naloxone bottle. Always keep the medication in a labeled prescription bottle with a child proof cap.
- Avoid carrying buprenorphine in your pocket, bag, purse, or backpack. Avoid leaving the medication in the bathroom, car, or public space. Call 911 if an accidental exposure occurs.
- Patients will be given information on obtaining naloxone (Narcan) and have its use reviewed (available at Walgreens, Genoa, and CVS pharmacies in RI, without a prescription.
- Side effects of buprenorphine may include constipation, insomnia, precipitated opioid withdrawal and opioid dependence.
- Weekly visits are required until the patient has 8 urine drug toxicity screening tests that are negative for illicit substances and positive for buprenorphine. Then visits move to bi-weekly visits.

Beginning treatment protocol

This office has adopted a home induction treatment protocol, which eliminates the need for daily office visits, which can be a barrier to treatment of opioid use disorder in rural areas (Hancock, et al, 2017). Evidence based practice guidelines have found home induction to be a safe and effective practice, that reduces the need for daily office visits, which can be a barrier to treatment in rural settings (Hancock, et al, 2017 and Heinzerling, et al, 2016).

- Prior to induction with buprenorphine, The MAT clinician should confirm the following:
- The patient knows the clinic hours and understands requirements for frequent appointments, phone contact, and call-backs for random pill counts and drug screens.
- Safe and proper storage of medication has been reviewed, and information on obtaining for naloxone (Narcan) has been provided.
- Point-of-care urine drug screens are negative for methadone and benzodiazepines.

Patient will receive information about withdrawal self-assessment, dose timing and amount.

Day 1

May not be the same day as the appointment. Patients may begin 1-2 days later however.

The patient needs to be in moderate to severe withdrawal to avoid precipitated withdrawal. This will require abstinence of approximately 16/24/36 hours for short-acting opioids, like heroin and 48 to 72 hours for long-acting opioids like methadone. Urine drug screening must be negative for methadone before starting MAT.

Subjective Opioid Withdrawal Scale (SOWS) score >16 prior to first dose:

- Begin with no more than ½ tablet or film (4mg) as initial dose. Wait 30 minutes.
- If any increase in withdrawal symptoms, do not take more buprenorphine. Wait until the next day.
- If not worse or slightly better, the patient may take another 1/2 tablet or film.
- If symptoms are much improved, patients can wait until later in the day.
- Patients may require another dose if their withdrawal symptoms return. They should contact the MAT provider if they have any questions or concerns.

Day 2

Dose determined by the amount of medication required on Day 1.
Once daily dose requirement is determined, the patient should no longer wait for symptoms of withdrawal to occur. Rather, take medication on a schedule, usually once or twice daily.

The patient should contact the MAT team with an update on their condition on Day 2. Their clinical response should be recorded in their record.

Day 3

The right dose for the patient on Day 3 depends on how the patient felt on Day 2. The dosage will be somewhere between 8 mg and 12 mg. See Appendix C.

Day 4 - 7

On Day 4 and beyond, the patient will take the dose used on Day 3. This is now their total daily dose. If a dosage increase is needed, it should not be changed by more than 4 mg per day.

The provider will be available to the patient 24 - 7 during the first month of beginning MAT treatment.

Stabilization Phase and Risk Tiering

The stabilization phase begins when the patient is experiencing minimal or no withdrawal symptoms, and no longer has uncontrollable cravings for opioids. This phase generally lasts 1 -2 months. During this time, weekly office visits are the norm.
Goals during the stabilization phase:

- Eliminate outside opiate usage (negative toxicology)
- Reduction of self-reported cravings and usage if illicit opioids
- Engagement with counseling

MAT clinicians should use prescriptions with 7, 14, or 28 days of duration. These intervals can help both the team and the patient understand exactly when the next refill is due and avoid needing a refill on a weekend or holiday.

If a patient fails to meet the stabilization goals (i.e. continued opioid or substance use) despite the maximal treatment dosage and outpatient interventions, the MAT physician should consider referring the patient to a more intensive therapeutic environment, or a higher level of care, such as a regional center of excellence, or OTP.

During the stabilization phase, all patients begin at the highest Risk Tier (4) and proceed to lower levels as appropriate. Risk Tiers define the usual and customary frequency of visits, and random drug screenings and call-ins for pill counts. The transition to lower risk tiers is done no faster than the minimum specified intervals - provided the patient has no aberrant behaviors (see Appendix F).

At each clinical visit, the MAT provider will assess and document the patient's progress in achieving physical, emotional, and social (home and work) goals, as well as any adverse effects and aberrant behaviors. Visits should also be used to promote healthy behaviors.

Our office will carry out scheduled and random urine drug screens and pill counts according to the Risk Tier Table.

At all Risk Tiers, the team should monitor for behaviors that are red flags for relapse (i.e. illicit substance use, missed appointments, refusal to give urine samples, failed pill counts, abnormal drug screens, lost prescriptions or lying). Patients must be free of these behaviors for the minimum specified interval before moving to a lower Risk Tier.

Maintenance Phase

Maintenance is the longest phase of a treatment plan. It may last 6 months to an indefinite amount of time. Patients may be maintained on a stable dose of buprenorphine for years, depending on the complex nature of their addiction, psychological and medical comorbidities, and social environment.

During this phase, office visits are scheduled according to the patient’s Risk Tier. While visits with the MAT clinician may decrease, random pill counts and urine toxicology screens are performed at the recommended intervals for a client’s Risk Tier. Failure to maintain a negative toxicology or self-reported cravings /opioid use during the maintenance phase should lead the

provider to consider moving the patient back to a higher tier of care or to restart the stabilization phase.

Counseling during the maintenance phase should address multiple issues:
Psychiatric comorbidities
Family and support issues
Structuring of time in pro-social activities
Employment and financial issues
Legal consequences of drug use

During the maintenance phase, if the patient is at Risk Tier 1, they may be seen at least every monthly the MAT provider. More frequent provider visits will be necessary for patients at higher Risk Tiers.

Buprenorphine is listed as a Category C medication in pregnancy. Naltrexone is likewise a Category C medication. Pregnancy tests will be done as clinically indicated. Patients not wishing to conceive should be proactively routed to their PCP or a Family Planning counselor to discuss the matter. During pregnancy a patient may be switched to buprenorphine without naloxone (Subutex). Following delivery, the patient will be transitioned back to buprenorphine with naloxone (Suboxone).

If a patient's buprenorphine prescription or medication is lost, stolen, or damaged, they will generally not be given an early refill. If an exception is granted (at the discretion of the MAT team) only one shall be allowed per year. The patient may need to revert to weekly visits until re-stabilized.

As addiction often tends to take a relapsing and remitting course, patients may occasionally need more intensive support or intervention. Problematic situations that the MAT prescriber should recognize include:

- Ongoing abuse of opioids despite an adequate buprenorphine dose
- ·Ongoing abuse of cocaine, alcohol, barbiturates, amphetamines, benzodiazepines or other illicit drugs
- Problematic use of prescription benzodiazepines characterized by impairment, sedation, overdose, adverse medical events or unsafe behaviors
- Failure to adhere to call in policy for random pill counts or drug screens
- Failure to keep counseling appointments

MAT intensification strategies for struggling patients may include:

- Raising the Risk Tier and requiring shorter medication refills, and more frequent visits, drug screens and pill counts
- Requiring participation in an Intensive Outpatient Program (IOP), collaboration with a counselor and psychiatry, attendance at AA or NA meetings.
- Referring a patient to a regional center of excellence

Discharge from MAT Program

Patients have the right to self-discontinue treatment at any time. They should be advised to communicate with office staff to facilitate a taper from the medication. Patients who have voluntarily discharged themselves from MAT may request re-enrollment at any time

MAT program patients should not be discharged from the program unless they have threatened the safety and well being of the office staff. Every other obstacle will be tackled with love and creativity in effort to keep the patient engaged in treatment. There us, however, a subpopulation of patients that may be resistant to treatment (Wolf, et al, 2020). For example, if a patient is consistently positive for an illicit substance or negative for the prescribed buprenorphine, then the patient may need to be discharged to a higher level of care at a residential rehabilitation program.

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