Medication Assisted Treatment Toolkit for Primary Care Providers

DHCS

This resource was created by Harbage Consulting
with support from the Department of Health Care Services

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What is Medication Assisted Treatment (MAT)?

Addiction is a disease. Treatment works. Recovery is possible.

MAT is the use of United States Food and Drug Administration (FDA)-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. MAT is an evidence-based treatment for patients with opioid use disorders (i.e. addiction to heroin, illicit fentanyl or prescription pain medications) and alcohol use disorders. The addition of MAT has been shown to significantly reduce the rate of relapse, compared to patients in abstinence-based treatment. For opioid use disorders, the use of methadone or buprenorphine cuts overdose rates by half or more, and reduces rates of HIV and hepatitis C transmission.[1] While MAT is considered standard of care for patients with opioid use disorders and alcohol use disorders, there is no FDA-approved MAT for other substance use disorders available currently.

WHAT IS MAT?

FDA-approved medication + **Counseling and behavioral therapies** = **Whole patient approach to treatment**

[1] National Institute on Drug Abuse. "Effective Treatments for Opioid Addiction." Available at bit.ly/2ZMYNQG

PART ONE:

Basic Overview of Medication Assisted Treatment

What FDA-approved medications are commonly used in MAT?

MAT FOR OPIOID USE DISORDER

Buprenorphine and buprenorphine products: Partial agonist that inhibits the action of other opioids, prevents cravings and withdrawal symptoms, and dramatically lowers the risk of overdose. Buprenorphine products are sometimes combined with naloxone to prevent misuse of the medication (Suboxone, Zubsolv). Offered as a daily dissolving tablet or film that is placed under the tongue or inside the cheek, a monthly injection, or as a 6-month implant under the skin. Buprenorphine can be prescribed by a properly trained and waivered physician, nurse practitioner, or physician assistant in a primary care office or other setting, as well as in an opioid treatment program. Long-term maintenance (at least two years) cuts overdose rates in half; short-term detox without continued MAT increases overdose rates and is not considered the standard of care.

Methadone: Full agonist that prevents cravings and withdrawal symptoms and reduces the risk of overdose so long as it is administered in a controlled environment (such as an opioid treatment program). Methadone increases overdose risk if used illicitly or when prescribed for pain management, and it does not inhibit the effect of other narcotics. Offered as a daily liquid dispensed only in highly regulated specialty opioid treatment programs (OTPs), also known as narcotic treatment programs (NTPs).

Naltrexone: Antagonist that blocks the effects of opioids while reducing cravings. Offered as a daily pill or monthly injection. Naltrexone has been shown to reduce the risk of overdose in short-term trials; longer term trials do not yet show an impact on mortality. Naltrexone is not a controlled substance and can be prescribed or administered in any healthcare or SUD setting.

MAT FOR ALCOHOL USE DISORDER

Naltrexone: Medication that blocks the euphoric effects and feelings of intoxication and reduces cravings. Naltrexone has proven to reduce drinking days and amount of drinking per episode. Offered as a daily pill or monthly injection.

Acamprosate: Medication to reduce cravings for patients who have already stopped drinking. It does not help with withdrawal symptoms but does reduce cravings. Patients can continue taking this medication during relapse. Offered as a tablet taken three times a day. This medication is preferred if the patient has compromised liver function.

Disulfiram: Medication that acts as a deterrent to drinking since combining it with alcohol causes physical illness. Patients cannot drink while taking this medication, but it can be combined with other forms of treatment. Offered as daily pill. It is best for patient to have accountability partner in order to use this medication successfully.

NOTE: The medications listed above are not inclusive of all the FDA-approved medications used in MAT. Additional information can be found at bit.ly/2PEWa07.

NALOXONE FOR OPIOID OVERDOSE

Naloxone is a life-saving medication that reverses an opioid overdose. Naloxone is safe for anyone to use, as it is harmless if misused, and has no effect on an individual if opioids are not present in their system. Naloxone blocks opioid receptor sites, reversing the toxic effects of the overdose, restarting breathing and waking people up from unconsciousness. Naloxone can be given by intranasal spray or injection (in the muscle, under the skin, or in a vein) and should be given when someone appears to have overdosed (unconscious, with slowed breathing, or if breathing has stopped).

Primary care settings should keep naloxone onsite in the case of emergencies and should prescribe or dispense it to any individual who may be at risk of an overdose, such as those taking prescription opioids or individuals with an opioid use disorder.

How does MAT help the patient?

MAT stabilizes brain chemistry — taking patients out of the cycle of cravings and withdrawal, which can last for years after the last illicit drug use. This allows patients to engage in treatment and benefit from behavioral health interventions, like counseling. Benefits of MAT include:

- Reduce or eliminate withdrawal symptoms
- Reduce or eliminate cravings
- Block the euphoric effects of opioids & alcohol
- Normalize the brain chemistry that drives motivation and bonding with others

In addition to helping to stabilize patients in their recovery process, long-term medication maintenance is important to prevent relapse. Some patients may continue with MAT for the rest of their lives. Others can be tapered off MAT under the supervision of a medical professional after 1-2 years. It all depends on the individual needs of each patient and how severe and long-lasting the opioid use disorder has been.

The rate of relapse for a patient with OUD who attempts to quit without MAT is 85% within a year — this means only 15 out of 100 patients can transition to recovery without using medications (and they are at high risk of death from overdose if they relapse).[2] Buprenorphine and methadone reduce overdose death rates by half or more, lowering opioid use, decreasing rates of HIV and hepatitis C, and reducing arrest and incarceration.[3] Detox alone usually does not work for people with OUD; the longer the patient is engaged in treatment, the greater their chance of long-term survival.[4]

WATCH THIS VIDEO

Understand how MAT works on the brain, and why OUD treatment works better with medications.

YouTube

youtu.be/bwZcPwlRRcc

[2] Bart, Gavin. "Maintenance Medication for Opiate Addiction: The Foundation of Recovery," Journal of Addictive Diseases 31.3 (2012): 207–225. Available at: bit.ly/2ZCkOBD.

[3] American Society of Addiction Medicine, "Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence." Available at bit.ly/Z6fg0n1.

[4] Mathers, Bradley M et al. "Mortality among People Who Inject Drugs: A Systematic Review and Meta-Analysis." Bulletin of the World Health Organization 91.2 (2013): 102–123 bit.ly/r5bx8j.

SPECIAL POPULATIONS:

MAT for pregnant women with OUD[5]

Current medical guidance for treating pregnant women with OUD says that:[6]

- The woman's obstetrician and opioid use disorder treatment provider should work together.
- The woman should receive counseling and services to help her achieve a stable life.
- MAT is the standard of care for pregnant women who have opioid use disorder. Treatment with methadone or buprenorphine during pregnancy is recommended. Treatment with naltrexone is not recommended during pregnancy. Opioid detoxification is not recommended.
- Methadone is the most established treatment of pregnant opioid-dependent women, and recent studies suggest that treatment with buprenorphine can also be successful.

- Babies of pregnant women taking MAT may develop Neonatal Abstinence Syndrome (NAS), but NAS is treatable and is not as harmful as continued use of illicit opioids during pregnancy. Most babies with NAS receive treatment in the hospital after birth, and babies get better in a few days or weeks. Increasingly evidence suggests that the "Eat, Sleep, Console" method of keeping mothers and babies together after the birth and relying less on medical interventions may result in better outcomes.[7]
- Mothers taking medications for OUD are encouraged to breastfeed.

Treating opioid use disorder with co-occurring substance use[8]

Medications for opioid use disorder and alcohol use disorder are only FDA-approved for the treatment of those conditions. Providers should not expect an automatic reduction in the use of other substances simply because a patient begins using a medication for OUD or AUD. If a patient uses other substances or experiences relapses, they should not be discharged from treatment. Below are some key points for treating co-occurring substance use.

For more information, reference "Providing care: Buprenorphine inductions and more" in the Camden Toolkit at bit.ly/2S6qoug.

CONTINUED ON PAGE 6

[5] This guidance summary comes from SAMHSA Tip 63 Part 4, "Partnering Addiction Counselors With Clients and Healthcare Professionals" (bit.ly/2HgVHgX) and "A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders" (bit.ly/2FEb4yR).

[6] M. Grossman et al. "A Novel Approach to Assessing Infants With Neonatal Abstinence Syndrome." Hospital Pediatrics Jan 2018, 8 (1) 1-6; bit.ly/3ckzjQX.

[7] M. Grossman et al. "A Novel Approach to Assessing Infants With Neonatal Abstinence Syndrome." Hospital Pediatrics Jan 2018, 8 (1) 1-6; bit.ly/3ckzjQX.

[8] This guidance summary comes from the Camden Coalition of Healthcare Providers and The National Center for Complex Health & Social Needs toolkit titled "Medications for addiction treatment" (bit.ly/2PAOYBY).

TREATING OPIOID USE DISORDER WITH CO-OCCURRING SUBSTANCE USE CONTINUED FROM PAGE 5

ALCOHOL

- If the patient has alcohol use disorder with opioid use disorder, manage alcohol withdrawal in first 24-36 hours of required opioid abstinence, then initiate buprenorphine for opioid withdrawal.
- If a patient is using buprenorphine and alcohol, generally, it is not recommended to stop buprenorphine as this significantly increases risk of relapse to opioids and potential overdose. Consider increasing level of care and offer MAT for alcohol.
- Consider Vivitrol as an option.

BENZODIAZEPINES

- A prescription for benzodiazepines does not preclude buprenorphine prescribing. However, it is important to be aware that both benzodiazepines and buprenorphine suppress the central nervous system and prescribing both requires additional safety considerations.
- Consider consulting with a psychiatrist or addiction medicine specialist if the patient is on both buprenorphine and a benzodiazepine.

Providers should not expect an automatic reduction in the use of other substances simply because a patient begins using a medication for OUD or AUD.

METHAMPHETAMINE

- Methamphetamine use disorder is a frequent co-occurring disorder with opioid use disorders. Users frequently combine and inject the drugs. It is not unusual to see continued use of methamphetamines in patients who have stopped using opioids.
- Persistent methamphetamine use may require a higher level of care. If possible, refer patient to inpatient setting for detox and stabilization from methamphetamines.
- Depression and anxiety may occur when patients are in withdrawal from methamphetamine, and these symptoms should be treated for maximal beneficial outcomes with MAT.
- Some providers will decrease buprenorphine dose to encourage the patient to change behavior. There is no evidence that this is an effective approach. This approach could increase the risk of death from opioid overdose.

Who pays for MAT?

MAT is covered by public (Medi-Cal/Medicare) and private forms of insurance. It can also be paid for out-of-pocket. For Medi-Cal patients, MAT can be covered in two ways: through an SUD treatment provider in the Drug Medi-Cal program or through the Medi-Cal managed care plan (for the prescriber) and the Medi-Cal Fee for Service Program (for the prescription obtained at a pharmacy). However, it is always important for your practice to have a conversation with the patient to help them explore treatment options that are sustainable and affordable.

Where can patients be referred for MAT if it is not offered at my office?

MAT may be offered in many different places, including:

1 Licensed Narcotic Treatment Programs (NTPs): NTPs provide MAT, as well as medication management, counseling and recovery services. NTPs are the only settings licensed to offer methadone to treat OUD. Many also offer other medications. NTPs often see patients who have had an OUD for a long time or have a moderate or severe addition. NTPs can be the first treatment option for individuals with moderate and severe addiction or an option for individuals who have been enrolled in other treatment programs but are still struggling with OUD.

2 Outpatient SUD Treatment Programs: Outpatient treatment programs operated by the county or private organizations offer counseling and recovery services and may offer MAT. Patients are more likely to receive wrap-around and counseling services in outpatient treatment programs.

3 Primary Care Settings: MAT can be provided in doctor's offices, community clinics, federally qualified health centers, and other primary care settings. Buprenorphine can be prescribed or administered by any licensed prescriber who completes additional training and receives a DATA 2000 waiver. Naltrexone can be prescribed without a waiver. Patients may go to an outpatient setting to receive counseling and recovery services.

4 Emergency Departments (EDs) and Hospitals: Any provider in a hospital or emergency department may administer buprenorphine (give to the patient to take under observation) for up to three days in order to relieve acute withdrawal symptoms and facilitate patient referral to treatment. Providers with the DATA 2000 waiver can prescribe buprenorphine to patients in the hospital or emergency department by phone or through a prescription to be filled at a pharmacy.[9] Emergency Departments can be a stabilization point for patients.

5 Residential Treatment Facilities: Licensed residential treatment programs may offer MAT using incidental medical services (IMS). Patients will generally stay for 30-60 days for this type of all-intensive treatment and highest level of care.

MAT LOCATOR

To search for treatment options available in your zip code, visit: www.choosemat.org/.

DATA 2000 WAIVERS

Clinicians must take a standardized course (8 hours for physicians, 24 hours for nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives) and apply for a federal "waiver" to prescribe buprenorphine for OUD. For more information about DATA 2000 waivers, see Part 3.

[9] Herring, Andrew A. "Emergency Department Medication-Assisted Treatment of Opioid Addiction," California Health Care Foundation, August 2016, bit.ly/edmat-protocol.

80% of people with OUD who receive treatment without MAT relapse within 2 years.[10]

What are some of the common misconceptions about MAT?

Despite research showing the effectiveness of MAT for patients with opioid and alcohol use disorders, stigma against patients using MAT remains prevalent. Some of the common misconceptions include the belief that MAT merely substitutes one drug for another, and that abstinence is a "better" approach (see "Challenging the Myths about MAT"[11] appendix from National Council for research refuting common misconceptions).

Abstinence approaches are two to three times as likely to result in an overdose death, which is why providers should recognize MAT as standard of care for people with opioid use disorder. Only 15% of people with OUD can achieve a year of abstinence without medications, and those who relapse are at high risk of death. Once someone has overdosed just once, the chance of dying in the next year is one in ten.[12] Furthermore, increased access to MAT can reduce a patient's risk of contracting HIV and Hepatitis C.[13]

MAT for opioids and alcohol is no different than medication for other chronic conditions like diabetes or heart disease, where patients may rely on their medications either short term or throughout the course of their lifetime to help them lead healthy, productive lives.

DID YOU KNOW?

Only **15%** of people with OUD can achieve a year of abstinence without medications, and those who relapse are at high risk of death.[10]

WHERE CAN I FIND MORE INFORMATION?

If you are a provider interested in obtaining a DATA 2000 waiver to prescribe buprenorphine, please refer to Part 3: Obtaining a DATA 2000 Waiver.

[10] Bart, Gavin. "Maintenance Medication for Opiate Addiction: The Foundation of Recovery," Journal of Addictive Diseases 31.3 (2012): 207–225. Available at bit.ly/8z3bTk0.

[11] National Council for Behavioral Health, "Challenging the Myths about MAT for Opioid Use Disorder," bit.ly/2TuYSGv.

[12] Mattick, Richard P. et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," Cochrane Database of Systematic Reviews 3 (2009) bit.ly/2ZWbHvV;

Comer, Sandra D. et al., "Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence: A Randomized, Placebo-Controlled Trial," Archives of General Psychiatry 63, no. 2 (2006): 210 218 bit.ly/2JgyGvy;

Fudala, Paul J. et al., "Office-Based Treatment of Opiate Addiction With a Sublingual-Tablet Formulation of Buprenorphine and Naloxone," New England Journal of Medicine 349, no. 10 (2003): 949–58, bit.ly/2Ha2V51.

[13] Schwartz, Robert P. et al., "Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995-2009," American Journal of Public Health 103, no. 5 (2013): 917-22, bit.ly/2UXIDk0.

PART TWO:

How to provide MAT in a primary care setting

How do I provide MAT in my practice?

The California Health Care Foundation has identified 10 elements found in successful programs that have incorporated buprenorphine into their primary care practice.[13]

1 **Having a champion:** Each practice should have at least one champion that is familiar with buprenorphine or MAT services. This champion will provide training and support to staff in order to reduce stigma and help establish processes.

2 **Staff and training:** Training is necessary for staff to ensure medical records are correct. Buprenorphine waivers require detailed documentation. This documentation shows dates and amounts of medication prescribed for each patient. It also keeps track of the number of patients receiving buprenorphine to make sure a provider does not pass their allowed number of patients. Many clinics will assign a staff member to maintain up-to-date records.

3 **Team-based approach:** Patients often choose clinics because of the relationships they build with the staff and provider. Patients will have many care providers (like social workers, nurse practitioners, and physician assistants) that must work together to create the best program possible.

CONTINUED ON PAGE 10

TIPS FOR GETTING STARTED

- Find a mentor or provider for support. Provider support resources listed on Page 19 in Part 3 of this toolkit.
- Build a team approach, including using support staff to assist with the administrative tasks and patient engagement.
- Address stigma in your setting with education.
- Proactively address confidentiality issues by explaining disclosure restrictions and consent requirements at the onset of treatment.
- Build relationships with local SUD providers and a local pharmacy.

Patients often choose clinics because of the relationships they build with the staff and provider. Patients will have many care providers that must work together to create the best program possible.

[13] California Health Care Foundation "Recovery Within Reach: Medication-Assisted Treatment of Opioid Addiction Comes to Primary Care". March 2016. bit.ly/39ju4iM.

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4 **Behavioral health services:** For successful treatment, medications should be combined with behavioral health services like counseling or support groups. Clinics should be aware of local behavioral health providers and provide patient referrals.

5 **Mentoring support:** Expert guidance on the continuous practice of MAT in primary care. Options include:

a) **The Clinician Consultation Center Warm Line (855-300-3595)** provides free phone consultations and advice from addiction specialists.

b) **The Providers' Clinical Support System (PCSS)-MAT Program** is a national mentoring resource designed to match new prescribers with mentors to help them incorporate medication-assisted treatment into their practices. The PCSS-MAT website also includes training and clinical resources. bit.ly/2Vze9IX

c) **Project ECHO (Extension for Community Healthcare Outcomes)** is a video tele-consultation program. bit.ly/3ahCG9p

d) **Waivered Prescriber Support Initiative** is an initiative from UCLA that offers customized support to waivered prescribers providing MAT. bit.ly/3cmdtN2

6 **Two waivered doctors per practice (OPTIONAL):** Having two waivered providers in each primary care setting allows for the prescriber to have backup when they are not available for frequent visits.

7 **Assessment of patient readiness:** Primary care providers should assess if a patient's needs can be treated in their facility, or if the patient should be referred to a more intensive approach. Factors that may require a more intensive approach are alcohol or other substance use disorders and the length and severity of the OUD.

8 **Starting buprenorphine:** A patient may be able to begin buprenorphine at a primary care facility or at home. If the patient is emotionally stable and has support at home, buprenorphine can be started at home.

9 **Establish a relationship with a pharmacy.** Primary care clinics and offices should establish a relationship with a trustworthy pharmacy that understands the need of individuals receiving medication in a timely manner.

10 **Financing:** Medications are covered by Medi-Cal, Medicare and most private insurance plans, but additional services may not be. Primary care providers can pursue grants to fund any services which may not be covered by insurance, or patients who many not have a source of insurance.

For successful treatment, medications should be combined with behavioral health services like counseling or support groups.

BUPRENORPHINE FOR OPIOID USE DISORDER

Buprenorphine is one of the FDA-approved medications for MAT to help people recover from opioid use disorders. Unlike methadone, which can only be administered in an opioid treatment program such as a Narcotic Treatment Program or Medication Unit, buprenorphine can be prescribed and dispensed to patients by physicians, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives and physician assistants that have received a Drug Addiction Treatment Act (DATA) 2000 Waiver. The DATA waiver allows these providers to prescribe buprenorphine and other Schedule III, IV, and V narcotic medications outside of opioid treatment program settings, including medical offices, emergency rooms and hospitals. Buprenorphine is an opioid partial agonist and reaches its ceiling effect at a moderate dose, which means that its effects do not increase after that point, even with increases in dosage. Buprenorphine can cause respiratory depression and euphoria, but its maximal effects are less than those of full agonists.

NALTREXONE FOR OPIOID USE DISORDER

Naltrexone is a medication approved by the FDA to treat opioid use disorders and alcohol use disorders. Naltrexone can be prescribed by any healthcare provider who is licensed to prescribe medications, and special training is not required. Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It works differently in the body than buprenorphine and methadone, which activate opioid receptors in the body that suppress cravings. As with all forms of MAT, medications should be prescribed as part of a comprehensive treatment approach that includes behavioral health services.

MEDICATIONS FOR ALCOHOL USE DISORDER

MAT for AUD can be prescribed by any provider to treat a patient who is dependent on alcohol or who has stopped drinking but is experiencing withdrawal or relapses. Acamprosate, disulfiram, oral naltrexone, and extended-release injectable naltrexone have all been approved by the FDA for the management of AUD. Patients with moderate or severe alcohol use disorder, including those who have physiologic dependence or who are experiencing cravings, could be a strong candidate for MAT.

DID YOU KNOW?

California Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. You can find resources, including clinical guides for starting patients on buprenorphine, at www.bridgetotreatment.org/resources.

If the patient is emotionally stable and has support at home, buprenorphine induction can be started at home.

How do I find other MAT providers in my community?

Many patients with opioid use disorder can benefit significantly from buprenorphine and can be seen in an office setting. However, people with certain conditions may require a higher level of care. A patient that is ready for change and has a low risk of complications can be monitored in an office setting. The more risk that a patient will experience complications during the initial phases of treatment such as severe withdrawal symptoms, medical or psychiatric comorbidities, the higher level of care they may need, such as intensive outpatient treatment or inpatient treatment.

Primary Care Providers play an important role in helping patients find a MAT provider that meets their level of need. For more information on steps you can take, see the insert "Helping Patients Access Medication Assisted Treatment (MAT)" in this toolkit or available online at bit.ly/2RYtdwc. The MAT locator tool can help you find different providers and service settings available near you.

A patient that is ready for change and has a low risk of complications can be monitored in an office setting.

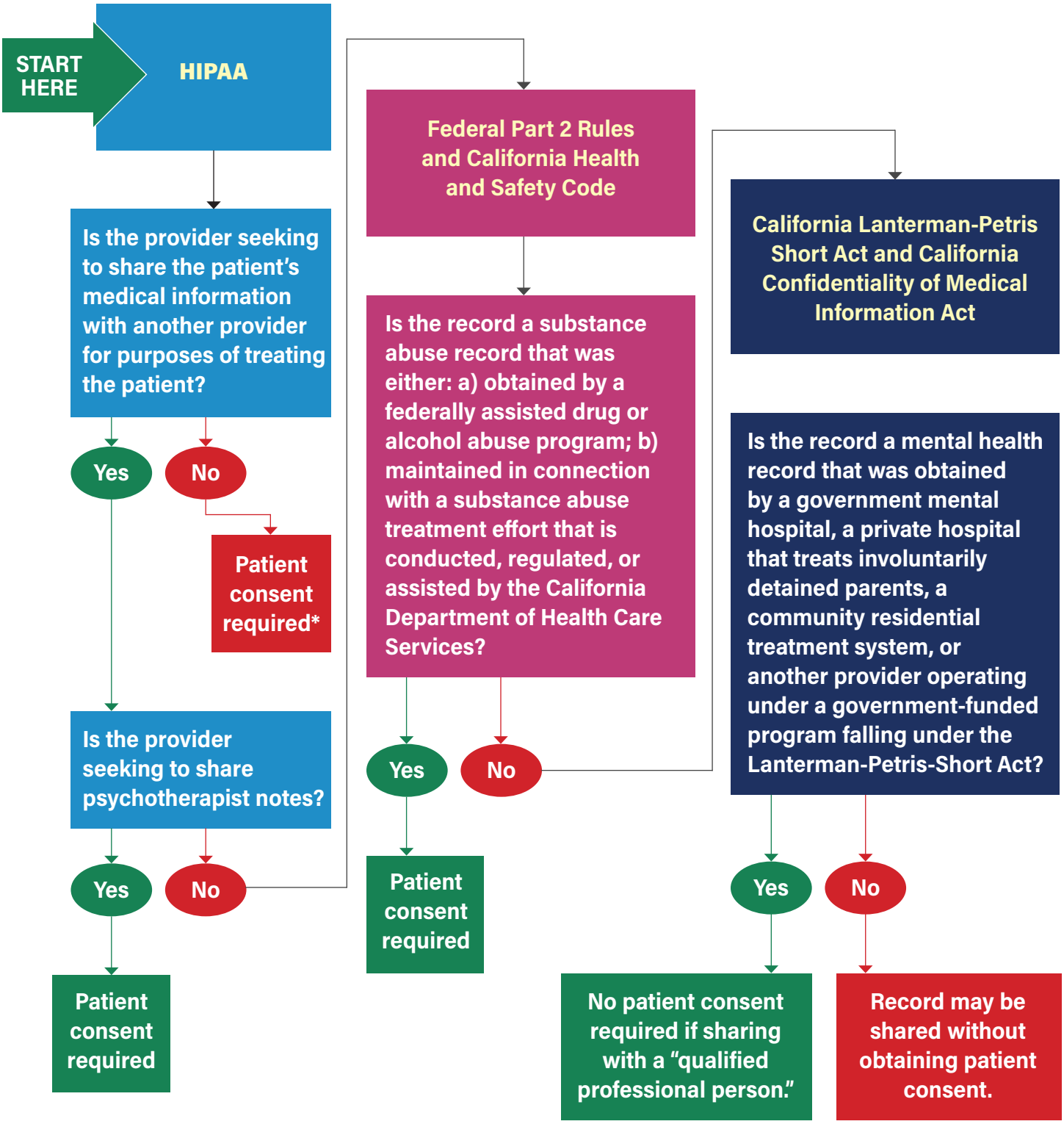
PATIENT CONSENT AND PRIVACY

If a patient requires a higher level of care, or if a primary care provider wishes to communicate with a patient's counselor or other healthcare provider, a provider may need a patient's consent prior to communicating certain information about the patient. Both federal regulations (42 C.F.R. Part 2) and California law (Cal. Civil Code Section 56.11) include restrictions on disclosure of patient information related to substance use disorder treatment that are stricter than those for other health information. The applicability of these rules varies depending on the type of provider and the sources of funding.

The flowchart on Page 13 assumes that the privacy laws apply to the provider and outlines the situations in which patient consent is required when communicating with another provider. For more information on overcoming data-challenges, reference the California Health Care Foundation's resource "Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance-Use Disorder Treatment in Primary Care". bit.ly/2t0YFBy.

Also, reference the following attachment: sample consent form to communicate with another treating provider.

SHARING BEHAVIORAL HEALTH INFORMATION UNDER FEDERAL AND CALIFORNIA LAW



* Patient consent would not be required if the information was being shared for another purposed allowed under HIPAA, such as for payment or health care operations.

SOURCES: 45 C.F.R. Parts 160 and 164, 42 C.F.R. Part 2, California Civil Code Section 56, California Welfare and Institutions Code Section 5328, California Health and Safety Code Section 11845.5. California HealthCare Foundation www.chcf.org/fineprint

How do I talk to my patients about MAT?

Primary Care providers can have an important role in talking to patients about their options for MAT and talking about patients' concerns. Many factors determine what medications may work best for certain patients — these include:

- History of drug and alcohol use
- Treatment history
- Mental and physical health factors
- Family and community support
- Employment responsibilities

HOW TO TALK TO PATIENTS ABOUT MAT

Providers should work with patients on making a treatment plan with the patient's goals in mind. Focusing on the patient's goals can improve engagement in treatment, and lead to better long-term recovery outcomes.[15]

ASK. Ask patients if they have ever considered using medication to stop their cravings for opioids or alcohol. Ask about their feelings toward using medications to help with recovery. Use facts to combat stigma and disprove myths about MAT. See "Challenging the Myths about MAT for Opioid Use Disorder," in this toolkit or available online at bit.ly/2OS3xR5.

INFORM. Describe MAT options that may be available to the patient. Inform them about the benefits of MAT. Discuss their recovery goals to help them make informed decisions about treatment. See "MAT Quick Guide" in this toolkit for quick facts on the different options for OUD and AUD medication. For information about how to talk to a patient about MAT see the "Decisions in Recovery" Handbook (bit.ly/2EMNFuA).

ENCOURAGE. Provide referrals and connect patients to external providers if MAT is not available at your location.

TRAUMA-INFORMED CARE

Trauma is often the root cause, or underlying issue, for many patients suffering from substance use and co-occurring mental health disorders.

The prevalence of early life trauma in patients with OUD and co-occurring mental health disorders is undeniable. One study examining early life trauma and opioid use disorder found 81% of the patients had witnessed or experienced one or more of the following: emotional, physical, or sexual violence

"In the United States, 61 percent of men and 51 percent of women report exposure to at least one lifetime traumatic event, and 90 percent of clients in public behavioral health care settings have experienced trauma. If trauma goes unaddressed, people with mental illnesses and OUD will have poor physical health outcomes and ignoring trauma can hinder recovery. To ensure the best possible health outcomes, all care — in all health settings — must address trauma in a safe and sensitive way."[14]

See this video to learn more about building a trauma-informed practice: bit.ly/2I6sxAj.

[14] MSAMHSA-HRSA Center for Integrated Health Solutions. bit.ly/2Td4cPZ.

[15] National Council for Behavioral Health, "Challenging the Myths about medication assisted treatment (MAT) for opioid use disorder (OUD) available at bit.ly/39jusxK.

PART THREE:

Obtain a Drug Addiction Treatment Act of 2000 Waiver

What are the requirements for physicians to obtain a DATA 2000 Waiver?[16, 17]

MEET THE CRITERIA TO QUALIFY

Physicians must be qualified to apply for the waiver. DATA 2000 defines a "qualifying physician" as a physician that is:

- Licensed under state law.
- Registered with the Drug Enforcement Administration (DEA) to dispense controlled substances.
- Required to treat no more than 30 patients at a time within the first year and may treat up to 100 or 275 at a time (if certain qualifications are met) after that.[4]
- Capable of referring patients to counseling services.
- Completes training and/or certification requirements.
- Additionally, physicians must either be board-certified in addiction medicine, or complete required 8-hour training for the treatment and management of patients with opioid use disorders. Many of these trainings are available free and online.

COMPLETE TRAINING AND CERTIFICATION REQUIREMENTS

Under the DATA 2000 requirements, physicians must complete an 8-hour training to qualify for a waiver to prescribe and dispense buprenorphine. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a list of supported continuing medical education (CME) courses that can help physicians qualify to prescribe buprenorphine in an office setting. See the "Where Can I Find More Information" section belowJ for more details.

APPLY FOR THE WAIVER

Physicians can take the following steps to apply for a DATA 2000 Waiver:

- ☑ Ensure you meet and have documentation showing you are a qualifying physician.
- ☑ Complete the required 8-hour training to prescribe and dispense buprenorphine.
- ☑ Fill out the SAMHSA Buprenorphine Waiver Notification form: bit.ly/2oj0A0D.
- ☑ Send SAMHSA all supporting documentation, including an 8-hour training certificate, via email to infobuprenorphine@samhsa.hhs.gov or via fax to (301) 576-5237.

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[16] Substance Abuse and Mental Health Services Administration, "Buprenorphine Waiver Management," available at bit.ly/2L2vulh.

[17] Substance Abuse and Mental Health Services Administration, "Qualify for a Physician Waiver," available at bit.ly/2nqA8xS.

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WAIT FOR APPROVAL

SAMHSA conducts an application review within 45 days of receipt. Once the application process is approved, SAMHSA will email a letter to the applicant that confirms their waiver and includes a prescribing identification number for the physician to use.

EXPEDITED APPLICATIONS

Physicians may also request to provide treatment while their waiver application ('notification') is under review. To do this:

- Check the box "New Notification, with the intent to immediately facilitate treatment of an individual (one) patient" on the SAMHSA Buprenorphine Waiver Notification form.
- Meet criteria for obtaining a waiver (i.e., valid medical license, valid DEA registration number, completed training requirements).
- Contact the SAMHSA Center for Substance Abuse Treatment (CSAT)'s Buprenorphine Information Center (866)-BUP-CSAT to verify that the notification has been received and inform CSAT of your intention to begin treatment for one patient.

WAIVER RESTRICTIONS FOR PHYSICIANS

Once a physician has been granted a waiver to prescribe buprenorphine, they may have a maximum of 30 patients in opioid use disorder treatment at a time for the first year. One year after the initial notification is submitted, the physician may submit a second notification of the need and intent to treat up to 100 patients. Physicians with board certification in addiction medicine, or those meeting certain requirements (24/7 call coverage, electronic health record use, access to case management services, PDMP registration, and acceptance of third-party insurance payment) may apply to treat 275 patients.[19]

WHY SHOULD I BECOME A WAIVERED PRESCRIBER?

There are still estimated gaps of over half a million people with opioid use disorder in California without access to MAT. In July 2019, only 3.2% of providers in California had a buprenorphine waiver.[18]

[18] Lisa Clemans-Cope, Marni Epstein, Doug Wissoker, and Joshua Aarons. California Opioid Use Disorder and Treatment Needs. The Urban Institute. October 2019.

[19] More information on requirements for providers treating up to 275 patients are available at bit.ly/2vMSrXp.

What are the requirements for nurse practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), and physician assistants (PAs) to obtain a DATA 2000 Waiver?[20]

COMPLETE TRAINING AND CERTIFICATION REQUIREMENTS

☑ Nurse practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), and physician assistants (PAs) are required to complete at least 24 hours of initial training to be eligible for a prescribing waiver for up to 30 patients. The 24 hours of initial training must cover each of the following topics:[21]

- Opioid maintenance and detoxification
- Appropriate clinical use of all drugs approved by the FDA for the treatment of opioid use disorder
- Initial and periodic patient assessments (including substance use monitoring)
- Individualized treatment planning, overdose reversal, and relapse prevention
- Counseling and recovery support services
- Staffing roles & considerations
- Diversion control
- Other best practices, as identified by the U.S. Secretary of Health and Human Services

☑ SAMHSA also requires that the 24 hours of initial training is provided by one of the following organizations:

- The American Society of Addiction Medicine
- American Academy of Addiction Psychiatry
- American Medical Association
- American Osteopathic Association
- American Nurses Credentialing Center
- American Psychiatric Association
- American Association of Nurse Practitioners
- American Academy of Physician Assistants
- Any other organization that the U.S. Secretary of Health and Human Services determines is appropriate.

☑ In addition, NPs, PAs, CNSs, CRNAs, and CNMs may take the following training courses:

- An 8-hour training to qualify for a waiver to prescribe and dispense buprenorphine. SAMHSA maintains a list of supported CME courses that can help providers qualify to prescribe buprenorphine in an office setting. See "Where Can I Find More Information" section for more details.

- An additional 16 hours of free training offered by SAMHSA through the Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT). See the "Where Can I Find More Information" section for more details.

[20] Substance Abuse and Mental Health Services Administration, "Apply for a Practitioner Waiver," available at bit.ly/2TuF7A2.

[21] USC 823(g)(2)(G)(ii)(IV)

APPLY FOR THE WAIVER

NPs, PAs, CNSs, CRNAs, and CNMs can take these steps to apply for a DATA 2000 waiver for up to 30 patients at a time:

- ☑ Complete the 24-hour training to become an eligible prescriber.
- ☑ Fill out the SAMHSA Buprenorphine Waiver Notification form: bit.ly/2oj0A0D.
- ☑ Send SAMHSA all supporting documentation via email to infobuprenorphine@samhsa.hhs.gov or fax to (301) 576-5237.

WAIT FOR APPROVAL

SAMHSA conducts an application review within 45 days of receipt. Once the application process is approved, SAMHSA will email a letter to the applicant that confirms their Waiver and includes a prescribing identification number for the NPs, CNSs, CRNAs, CNMs, or PAs to use.

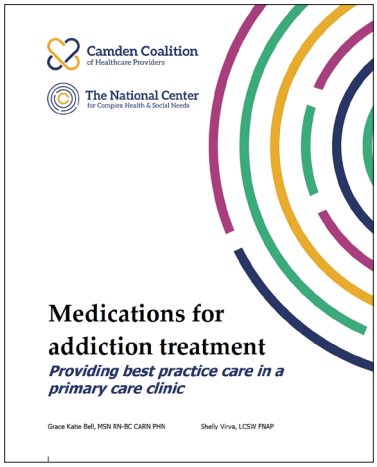
NP, CNS, CRNA, CNM, and PA Waiver applications are forwarded to the Drug Enforcement Administration (DEA) and assigned a special identification number. DEA regulations require both this number and the provider's regular DEA registration number to be included on all buprenorphine prescriptions for opioid dependency treatment.

NOTE: Expedited applications are not available for these providers.

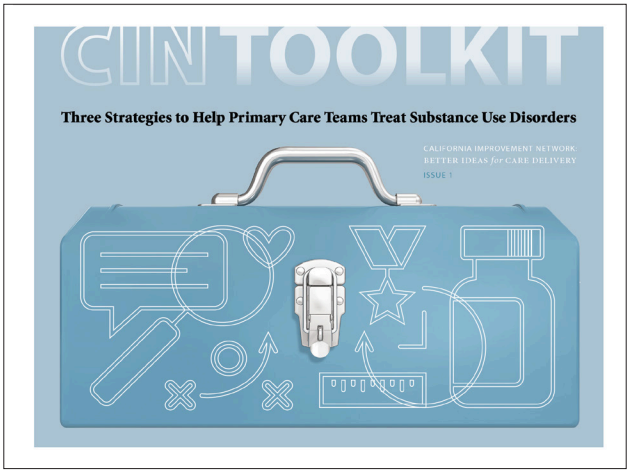
Where can I find more information?

ADDITIONAL TOOLKITS FOR PROVIDING MAT IN A PRIMARY CARE SETTING

Below are two comprehensive toolkits for primary care providers looking to expand their capacity to provide Medication Assisted Treatment:



- "Medications for addiction treatment" by the Camden Coalition.
  — Available at bit.ly/2X3lyyS.



- "CIN Toolkit: Three Strategies to Help Primary Care Teams Treat Substance Use Disorders" by Healthforce Center at UCSF.
  — Available at bit.ly/2rBp3RB.

ADDITIONAL RESOURCES

California Health Care Foundation.
- Recovery within Reach: Medication-Assisted Treatment of Opioid Addiction Comes to Primary Care: bit.ly/39ju4iM.
- Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance-Use Disorder Treatment in Primary Care: bit.ly/2Iqm4AD.
- California Opioid Safety Network: bit.ly/2vC6aAp.

The Clinician Consultation Center Warm Line (855-300-3595) provides free phone consultations and advice from addiction specialists.

The Providers' Clinical Support System (PCSS)-MAT Program is a national mentoring resource designed to match new prescribers with mentors to help them incorporate medication-assisted treatment into their practices. The PCSS-MAT website also includes training and clinical resources. bit.ly/2Vze9IX.

Project ECHO (Extension for Community Healthcare Outcomes) is a video tele-consultation program. bit.ly/3ahCG9p.

Waivered Prescriber Support Initiative is an initiative from UCLA that offers customized support to waivered prescribers providing MAT. bit.ly/3cmdtN2.

California Bridge is a program of the Public Health Institute working to fully integrate addiction treatment into standard medical practice. bit.ly/2TuNY4F.

Decision Support Tool. SAMHSA Decisions in Recovery: Treatment for Opioid Use Disorder: bit.ly/2IuSTwg.

Clinical Guidelines and Research:
- Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide: bit.ly/3a295RG.
- General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders: bit.ly/2UnOSPN.
- Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update: bit.ly/2JbUFTv.
- The ASAM Standards of Care for the Addiction Specialist Physician: bit.ly/2x9863A.

Supported CME Course: bit.ly/32Y3Q2E.

Pocket Guide: SAMHSA Medication-Assisted Treatment of Opioid Use Disorder Pocket Guide. bit.ly/2xP95WZ.

App: SAMHSA MATx Mobile App to support Medication Assisted Treatment of Opioid Use Disorder. bit.ly/2WppSdy.

PRIMARY CARE QUICK GUIDE: MAT Use for Opioid Use Disorder

Implant Pill Patch Liquid Injection

	BUPRENORPHINE	METHADONE	NALTREXONE
COMMON BRANDS	Suboxone, Zubsolv, Bunavail, Subutex, Probuphine, Sublocade	Methadose, Diskets, Dolophine	Vivitrol
TYPE			
HOW IT WORKS	• Partial agonist--does not completely bind to the opioid receptor. As a result, it has a ceiling effect, meaning the effect will plateau and the individual will not experience a high. • Buprenorphine prevents cravings and withdrawal symptoms and reduces the risk of overdose. • Offered as a daily dissolving tablet or film that is placed under the tongue or inside the cheek, a monthly injection, or as a 6-month implant under the skin. • Buprenorphine can be prescribed by a trained provider in a doctor's office or other health care setting, as well as in a narcotic treatment program (NTP). • Studies have found an effectiveness rate for retention in treatment of 52% (range between 40-65%.	• Full agonist — fully occupies the opioid receptor. • Methadone prevents cravings and withdrawal symptoms and reduces the risk of overdose. • Offered as a daily liquid or pill. • Methadone is dispensed only in federally regulated NTPs. • Studies have found an effectiveness rate for retention in treatment of 63% (range between 54-71%).	• Antagonist — naltrexone blocks, rather than activates, the opioid receptor. • Offered as a monthly injection for opioid users. Pill form is not recommended for opioid users. • Naltrexone is not a controlled substance and can be prescribed or administered in any healthcare or substance use disorder (SUD) setting, such as a doctor's office or clinic. • Studies have found an effectiveness rate for retention in treatment of 28% (range between 16-30%).

CONTINUED ON BACK

This resource was created by Harbage Consulting with support from the Department of Health Care Services.
Available online at CaliforniaMAT.org. Last updated March 2020.

CONTINUED FROM FRONT	BUPRENORPHINE	METHADONE	NALTREXONE
THINGS TO CONSIDER	• Treatment can start quickly, as soon as the person enters withdrawal. • Flexible dosing schedule. • Relapse risk increases if the individual forgets or chooses not to take the medication. • Common side effects are headache, nausea, and constipation. • Causes physical dependence. If or when the person wants to come off the drug, they will need to slowly to minimize the discomfort of detox symptoms. • Buprenorphine is sometimes used short term to relieve pain associated with detox, but more often used long term, known as maintenance treatment.	• Treatment can start right away, there is no need for withdrawal or detoxification. • Less flexible schedule. Dosing occurs in early morning and is usually observed. • Side effects include nausea, vomiting, constipation, dizziness, dry mouth, drowsiness, or sweating. • Causes physical dependence. If or when the person wants come off the drug, they will need to do so slowly to minimize the discomfort of detox symptoms • May cause drowsiness at first before maintenance dose is determined. • Methadone is an option for people who have used opioids for a long time or have been unsuccessful with other treatments.	• Less evidence for long-term effectiveness in OUD treatment than buprenorphine or methadone. • 7- to 10-day detox from opioids is required before taking naltrexone. Not recommended for pregnant women. • Does not cause physical dependence, and does not suppress withdrawal or cravings. • Side effects may include stomach pain, nausea, vomiting, headache, joint pain, trouble sleeping and anxiety. • Injection form of the medication lasts for about 30 days before it wears off. • Overdose risk can be higher after naltrexone wears off due to decrease in tolerance.
QUESTIONS FOR PATIENTS	• Can you commit to taking this medication daily? • Are you comfortable with taking a medication that requires time to taper off to minimize the discomfort of detox?	• Have you found other treatments have not worked well for you? • Can you come in the early morning for dosing? • Could your work be affected by possible drowsiness during your initial dosing period? • Are you comfortable with taking a medication that requires time to taper off?	• Have you detoxed from opioids, or would you be willing to detox to take this medication? • Can you commit to making an appointment once every month to continue receiving the injection? • Do you have any medical needs that would be affected by blocking the opioid receptors? For example, do you use opioids to reduce chronic pain?

PRIMARY CARE QUICK GUIDE: MAT Use for Alcohol Use Disorder

Pill Injection

	NALTREXONE	ACAMPROSATE	DISULFIRAM
COMMON BRANDS	Revia, Vivitrol	Campral	Antabuse
TYPE			
HOW IT WORKS	• Medication that blocks the effects of alcohol and reduces cravings. • Offered as a daily pill or monthly injection. • Naltrexone is not a controlled substance and can be prescribed or administered in any health care or SUD setting, such as a doctor's office or clinic.	• Medication to reduce cravings for patients who have already stopped drinking. It does not help with withdrawal symptoms but does reduce cravings. If relapse occurs, patients can continue taking the medication without needing to detox first. • Offered as a tablet taken three times a day. • Acamprosate is not a controlled substance and can be prescribed or administered in any health care or SUD setting, such as a doctor's office or clinic.	• Medication that causes severe vomiting if someone drinks alcohol. • Offered as daily pill. • Disulfiram is not a controlled substance and can be prescribed or administered in any health care or SUD setting such as a doctor's office or clinic.
THINGS TO CONSIDER	• Detoxification from alcohol is required before taking naltrexone. • Relapse risk increases if the patient forgets or chooses not to take pill form of the medication.	• Detoxification from alcohol is not required but is highly recommended before starting on acamprosate. • Relapse risk increases if patients forget or choose not to take medication.	• Detoxification from alcohol is required. • Relapse risk increases if the person forgets or chooses not to take the medication.

CONTINUED ON BACK

CONTINUED FROM FRONT	NALTREXONE	ACAMPROSATE	DISULFIRAM
THINGS TO CONSIDER	• Injection form of the medication lasts for about 30 days before it wears off.	• Common side effects include stomach pain, dizziness or dry mouth; more rarely patients may experience anxiety or depression.	• Side effects are not common but may include headache, drowsiness or rash. • Disulfiram can be a good option for compulsive drinking.
QUESTIONS FOR PATIENTS	• Have you detoxed from alcohol, or would you be willing to detox to take this medication? • Can you commit to taking this medication daily, or would a month-long injection be a better option? • Do you have any medical needs that would be affected by blocking the opioid receptors? For example, do you use opioids to reduce chronic pain?	• Can you commit to taking this medication three times a day? • Do you feel that craving reduction alone is enough to help you stop drinking, or do you need something more? For example, disulfiram makes you vomit if you drink, and naltrexone takes away the pleasurable feeling of drinking.	• Have you detoxed from alcohol, or would you be willing to detox to take this medication? • Can you commit to taking this pill daily? • Do you work in an industry with exposure to alcohol-based products (i.e., paint thinner, varnish, etc.) which could react with the medication? • Are you willing to run the risk of severe vomiting should you relapse?

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