HEALTHWEST

Policy

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Subject: Medication Assisted Treatment (MAT)

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I. POLICY

HealthWest Board of Directors, executive leadership, and providers recognize that principles of quality medical practice dictate that our patients have access to appropriate, safe and effective medical care, including the treatment of addiction. The application of up-to-date knowledge and evidence-based treatment modalities can help to restore function and thus improve the quality of life of patients who suffer from addiction. In this context, the Board recognizes the body of evidence for the effectiveness of buprenorphine and naltrexone in the office-based treatment of opioid/alcohol addiction, when such treatment is delivered in accordance with current standards of care.

The goal is to provide appropriate treatment of the patient's opioid/alcohol addiction, while addressing other aspects of the patient's functioning, including co-occurring medical and psychiatric conditions and pressing psychosocial issues.

The diagnosis and medical treatment of opioid/alcohol addiction should be based on current knowledge and research, and should encompass the use of both pharmacologic and nonpharmacologic treatment modalities. Thus, before beginning to treat patients for opioid/alcohol addiction, the provider should become knowledgeable about opioid/alcohol addiction and its treatment, including the use of approved pharmacologic therapies and evidence-based nonpharmacologic therapies.

Physicians who wish to treat opioid addiction with buprenorphine in their medical offices must demonstrate that they have met the requirements of the DATA 2000 legislation and obtained a waiver from SAMHSA. (See federal requirement guidelines)

II. PURPOSE

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement by the patient in recovery activities, addiction is a progressive disease and can result in disability or premature death. Therefore, HealthWest's mission is to care for all chronic diseases including addiction. Recognizing this, the Board approves the use of Suboxone (Buprenorphine and Naloxone), Antabuse, and Vivitrol (Naltrexone) in the Medication Assisted Treatment (MAT) of opioid and alcohol addiction specifically.

III. APPLICATION

All HealthWest employees, volunteers, student interns, interpreters, affiliated providers and persons under contract with HealthWest.

IV. GUIDELINES

A. Patient Assessment: The objectives of the patient assessment are to determine a given patient's eligibility for treatment, to provide the basis for a treatment plan, and to establish a baseline measure for use in evaluating a patient's response to treatment. Accordingly, the treatment should be designed to achieve the following:

1. Establish the diagnosis of opiate/alcohol addiction, including the duration, pattern and severity of opioid misuse; the patient's level of tolerance; results of previous attempts to discontinue opioid use; past experience with agonist therapies; the nature and severity of previous episodes of withdrawal; and the time of last opioid/alcohol use and current withdrawal status.

2. Document the patient's use of other substances, including alcohol and other drugs of abuse.

3. Identify comorbid medical and psychiatric conditions and disorders to determine how, when and where they will be addressed.

4. Screen for communicable diseases and address them as needed. Evaluate the patient's level of physical, psychological and social functioning or impairment.

5. Assess the patient's access to social supports, family, friends, employment, housing, finances, and legal problems.

6. Determine the patient's readiness to participate in treatment.

7. Pregnancy test for all women of childbearing age.

8. Physical exam should focus on evaluating neurocognitive function, identifying sequelae of opioid/alcohol addiction, and looking for evidence of severe hepatic dysfunction.

9. Urine drug screens or other toxicological screens should be part of the initial evaluation to confirm recent opioid/alcohol use and unreported use of other drugs and as recommended by the treating physician on an ongoing basis throughout treatment. This drug screen should include all opioids commonly prescribed and/or misused in the local community, as well as illicit drugs available locally.

10. Access the patient's prescription drug use history through the state's prescription drug monitoring program (MAPS), both to confirm compliance in taking prescribed medications and to detect any unreported use of other prescription medications. Assessment continues throughout treatment.

B. Treatment Planning: No single treatment is appropriate for all persons at all times. Therefore, an individualized treatment plan is critical to the patient's ultimate success in returning to productive functioning.

The treating provider should balance the risks and benefits of medication-assisted treatment against the risks associated with no treatment or treatment without medication. The various options include:

1. Treatment with Buprenorphine/Naloxone, Naltrexone or Antabuse in an office-based setting.

2. Counseling and/or peer support without medication-assisted therapy.

3. Referral to short or long-term residential treatment.

4. Referral to an appropriate clinic for methadone maintenance.

Psychosocial and other nonpharmacological interventions often are useful components of treatment. Such interventions typically work best in conjunction with medication-assisted therapies; in fact, there is evidence that the combination of pharmacologic and non-pharmacologic interventions may be more effective than either approach used alone. Therefore, any patient engaged in Suboxone or Naltrexone therapy at HealthWest must be receiving counseling from a reputable center that adheres to adopted guidelines.

C. Educating the Patient: Every patient to whom MAT is prescribed should be cautioned to follow the directions exactly. Critical issues include when to begin dosing, the frequency of subsequent doses, and the importance of avoiding the use of other illicit or prescription opioids. Concurrent use of non-opioid sedating medications or over-the-counter products also should be discussed, and patients should be advised to avoid the use of alcohol.

Patients should be cautioned about potential sedation or impairment of psychomotor function during the titration phase of induction with buprenorphine and after administration of naltrexone.

Finally, because opioids can contribute to fatal overdoses in individuals who have lost their tolerance to opioids or in those who are opioid-naïve (such as a child or other family member), proper and secure storage of the medication must be discussed. Particularly where there are young people in the patient's home, the subject of safe storage and use should be revisited periodically throughout the course of treatment, with the discussions documented in the patient record.

D. Informed Consent/Medication Assisted Treatment Agreement (C363): A written Informed Consent document, discussed with and signed by the patient, can be helpful with reinforcing and establishing a set of "ground rules." The practitioner will document the informed consent in the patient's medical record.

The Informed Consent will include an acknowledgement of the potential benefits and risks of therapy and the goals of treatment; identification of HealthWest, a PCP and one pharmacy from whom the patient will obtain prescriptions; authorization to communicate with all providers of care and to consult the state's Prescription Drug monitoring Program (MAPS); other treatments or consultations in which the patient is expected to participate, including recovery activities; avoidance of illicit substances; permission for drug screens (of blood, urine, saliva, hair/nails); expected intervals between office visits; and specification of the conditions under which therapy will be continued or discontinued. For Buprenorphine or Buprenorphine-Naloxone combination: Pill or film counts and mechanisms for prescription renewals, including exclusion of early renewals.

The agreement also will include a statement instructing the patient to stop taking all other opioid medications unless explicitly told to continue. Such a statement reinforces the need to adhere to a single treatment regimen.

Finally, the treatment agreement will set forth the objectives that will be used to evaluate treatment success, such as freedom from intoxication, improved physical and psychosocial function, and adherence to the treatment regimen.

Copies of the treatment agreement and informed consent will be provided to the patient and **all other care providers** in order to avoid any potential harmful medication interactions and filed in the patient's medical record. Release of information needs to be completed prior to sharing information. If patient is prescribed opioids from another provider it is their responsibility to make HealthWest aware. The agreement will be reviewed regularly and adjusted as needed. Staff need to assure an additional release for the in-house /Mercy CMH Pharmacy is obtained.

E. Monitoring and Follow-up: Patient monitoring/follow-up visits should address the following points:

1. The Cravings Assessment (Form C377) will be completed during the induction of Buprenorphine until dose stability is achieved and reviewed with the prescriber at these contacts.

2. Whether the patient continues to use alcohol or illicit drugs, or to engage in non- medical use of prescription drugs.

3. The degree of compliance with the treatment regimen, including the use of prescribed medications as directed.

4. Changes (positive or negative) in social functioning and relationships.

5. Avoidance of high-risk individuals, situations, and diversion risk.

6. Review of whether and to what degree the patient is involved in counseling and other psychosocial therapies, as well as in self-help activities through participation in mutual support meetings of groups such as Narcotics Anonymous.

7. The presence or absence of medication side effects.

8. The presence or absence of medical sequelae of substance use and its remission.

Individuals being treated with medication-assisted therapy often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning. Such positive changes should be acknowledged and reinforced by the prescribing physician whenever possible. Reducing the frequency of monitoring visits, with their associated costs, and increasing the patient's responsibility for medications are examples of how positive, responsible behaviors can be reinforced.

F. Adjusting the Treatment Plan: Treatment outcomes typically are positive for patients who remain in treatment with medication-assisted therapies. However, some patients struggle to discontinue their misuse of opioids or other drugs, are inconsistent in their compliance with treatment agreements, or succeed in achieving some therapeutic goals while not doing well with others.

Behaviors that are not consistent with the treatment agreement should be taken seriously and used as an opportunity to further assess the patient and adapt the treatment plan as needed. In some cases, where the patient's behavior raises concerns about safety or diversion of controlled medications, there may be a need to refer the patient for treatment in a more structured environment. However, behavior that violates the treatment agreement or a relapse to nonmedical drug use do not constitute grounds for automatic termination of treatment. Rather, they should be taken as a signal to reassess the patient's status, to implement changes in the treatment plan (as by intensifying the treatment structure or intensity of services), and to document such changes in the patient's medical record.

G. Preventing and Managing Relapse: Patients in relapse vary in the quantity and frequency of their substance use, as well as the accompanying medical and psychosocial sequelae.

Clinical strategies to prevent and address relapse generally encompass the following steps:

1. Identify environmental cues and stressors that act as relapse triggers.

2. Help patients develop skills to cope with or manage negative emotional states.

3. Help the patient work toward a more balanced lifestyle.

4. Understand and manage cravings.

5. Identify and interrupt lapses and relapses. Patients should have an emergency plan to address a lapse so that a full-blown relapse can be avoided. If relapse does occur, be prepared to intervene.

6. Develop a recovery support system. Families are more likely to provide such support if they are engaged in the treatment process and have an opportunity to ask questions, share their concerns and experiences, and learn practical coping strategies and behaviors to avoid.

H. Duration of Treatment: The duration of MAT will be determined on a case by case basis. When the discussion of discontinuation is raised by patients or family members the physician and patient should carefully weigh the potential benefits and risks of continuing medication-assisted treatment and determine whether therapy can be safely discontinued. Available evidence does not support routinely discontinuing MAT once it has been initiated and the patient stabilized.

Therefore, the decision to discontinue treatment should be made only after serious consideration of the potential consequences.

I. Documentation: Accurate and up-to-date documentation protect both the physician and the patient. In the event of a legal challenge, detailed medical records that document what was done and why are essential elements of the practitioner's defense.

Other documents that will be included are:

1. A written informed consent and a treatment plan articulating measurable treatment goals. The treatment plan should be updated as new information becomes available.

2. The documentation should clearly reflect the decision-making process that resulted in any given treatment regimen.

3. Diagnostic assessments, including the patient history, physical examination, and any laboratory tests ordered, with their results.

4. Actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.

5. Authorization for release of information to other treatment providers.

6. Documentation of discussions with and consultation reports from other health care providers including counseling.

7. Medications prescribed and the patient's response to them, including any adverse events.

Physicians who treat patients for addiction must observe the special confidentiality requirements of federal law which addresses the confidentiality of patients being treated for alcohol or drug addiction. 42 CFR includes a prohibition against release of records or other information without the patient's consent or a valid court order, or in cases of a bona fide medical emergency, or in the course of a mandatory reporting of child abuse.

J. Patient's Rights: The rights of all patients receiving substance abuse treatment will be protected in accordance with R 325.1401 to R 325.14306 of the Administrative Rules for Substance Abuse Programs in Michigan and all other applicable laws and/or provisions.

Patients shall not be denied the appropriate service based on race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual preference, or political beliefs.

The admission of the patient to this program shall not result in the recipient being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitution.

A patient may present grievances or suggested changes in program policies and services to the program staff, to government officials, or to another person within or outside the program. This process shall not in any way restrain the recipient.

A patient has the right to review, copy, or receive a summary of his or her program records unless it is determined to be detrimental to the patient.

A program staff member shall not physically or mentally abuse or neglect or sexually abuse a patient.

A patient has the right to review a written fee schedule when patients are charged for services.

A patient is entitled to receive an explanation of his or her bill, regardless of the source of payment.

Should this program engage in any experimental or research procedure, any or all patients will be advised as to the procedures to be used, and have the right to refuse participation in the experiment or research without jeopardizing their continuing services. State and federal rules and regulations regarding research involving human subjects will be reviewed and followed.

A patient shall participate in the development of his or her treatment plan.

A patient has the right to refuse treatment and be informed of the consequences of that refusal. If at any time the patient decides to discontinue the program, this decision will not change the relationship established for primary care.

When refusal of treatment program prevents the program from providing services according to ethical and professional standards, the relationship with the recipient may be terminated upon reasonable notice.

A patient shall have the benefits, side effects, and risks associated with the use of any drugs fully explained in language which is understood by the patient.

A patient has the right to give prior informed consent, consistent with federal confidentiality regulations for the use and future disposition of products of special observation and audiovisual techniques such as one-way mirrors, tape recorders, television, movies, or photographs.

Patients shall receive a copy of the Rights brochure, detailing specific rights and how to contact the Recipient Rights Officer for the organization and the region.

Rights posters with Recipient Rights Officer contact information shall be posted in the facility.

REFERENCES

MDCH Medication Assisted Treatment Guidelines for Opioid Use Disorders, Corey Waller MD, MS

CB/ab

HEALTHWEST

CRAVINGS ASSESSMENT

Date: _____ Name: _____ Case No.: _____

URGE-TO-USE SCALE – OPIATES/ALCOHOL

Instructions: The following questions are designed to help you assess an important aspect of your recovery status – the urge to use opiates/alcohol.

DURING THE PAST WEEK

1. How often have you thought about using opiates/alcohol or about how good using opiates/alcohol would make you feel during this period?

☐	Never	0 times during this period of time
☐	Rarely	1 to 2 times during this period of time
☐	Occasionally	3 to 4 times during this period of time
☐	Sometimes	5 to 10 times during this period, or 1 to 2 times per day
☐	Often	11 to 20 times during this period or 2 to 3 times per day
☐	Most of the time	20 to 40 times during this period or 3 to 6 times per day

2. At its most severe point, how strong was your urge to use opiates/alcohol during this period?

- ☐ None at all
- ☐ Slight, a very mild urge
- ☐ Mild urge
- ☐ Moderate urge
- ☐ Strong urge but easily controlled
- ☐ Strong urge and difficult to control
- ☐ Strong urge and would have used opiates/alcohol if available

3. How much time have you spent thinking about opiates/alcohol or about how good using opiates/alcohol would make you feel during this period?

- ☐ None at all
- ☐ Less than 20 minutes
- ☐ 21 to 45 minutes
- ☐ 46 to 90 minutes
- ☐ 90 minutes to 3 hours
- ☐ Between 3 to 6 hours
- ☐ More than 6 hours

4. How difficult would it have been to resist using opiates/alcohol during this period if you had these substances available to you?

- ☐ Not difficult at all
- ☐ Very mildly difficult
- ☐ Mildly difficult
- ☐ Moderately difficult
- ☐ Very difficult
- ☐ Extremely difficult
- ☐ Would not be able to resist

5. Keeping in mind your responses to the previous questions, please rate your overall average urge to use opiates/alcohol during the past week.

- ☐ Never thought about using opiates/alcohol and never had the urge to use opiates/alcohol
- ☐ Rarely thought about using opiates/alcohol and rarely had the urge to use opiates/alcohol
- ☐ Occasionally thought about using opiates/alcohol and occasionally had the urge to use opiates/alcohol
- ☐ Sometimes thought about using opiates/alcohol and sometimes had the urge to use opiates/alcohol
- ☐ Often thought about using opiates/alcohol and often had the urge to use opiates/alcohol
- ☐ Thought about using opiates/alcohol most of the time and had the urge to use opiates/alcohol most of the time
- ☐ Thought about using opiates/alcohol nearly all the time and had the urge to use opiates/alcohol nearly all of the time