Recovery Oriented Medication Assisted Treatment: *Approaches to integrating MAT with Traditional 12 Step Addiction Treatment Programs*

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Learning Objectives

1. Understand and demonstrate how to use MAT with Clients diagnosed with Alcohol or Opioid Use Disorders
2. Identify and develop tactics to address workforce, organizational, environmental or regulatory issues.
3. Gain tools to develop implementation framework that can be applied to a variety of treatment settings.
4. Gain strategies for communication about MAT for use with clients, their families and the community.

Overview

Examine the various medications that assist recovery

Examine 2 Agencies that have implemented the use of MAT within traditional 12 Step settings.

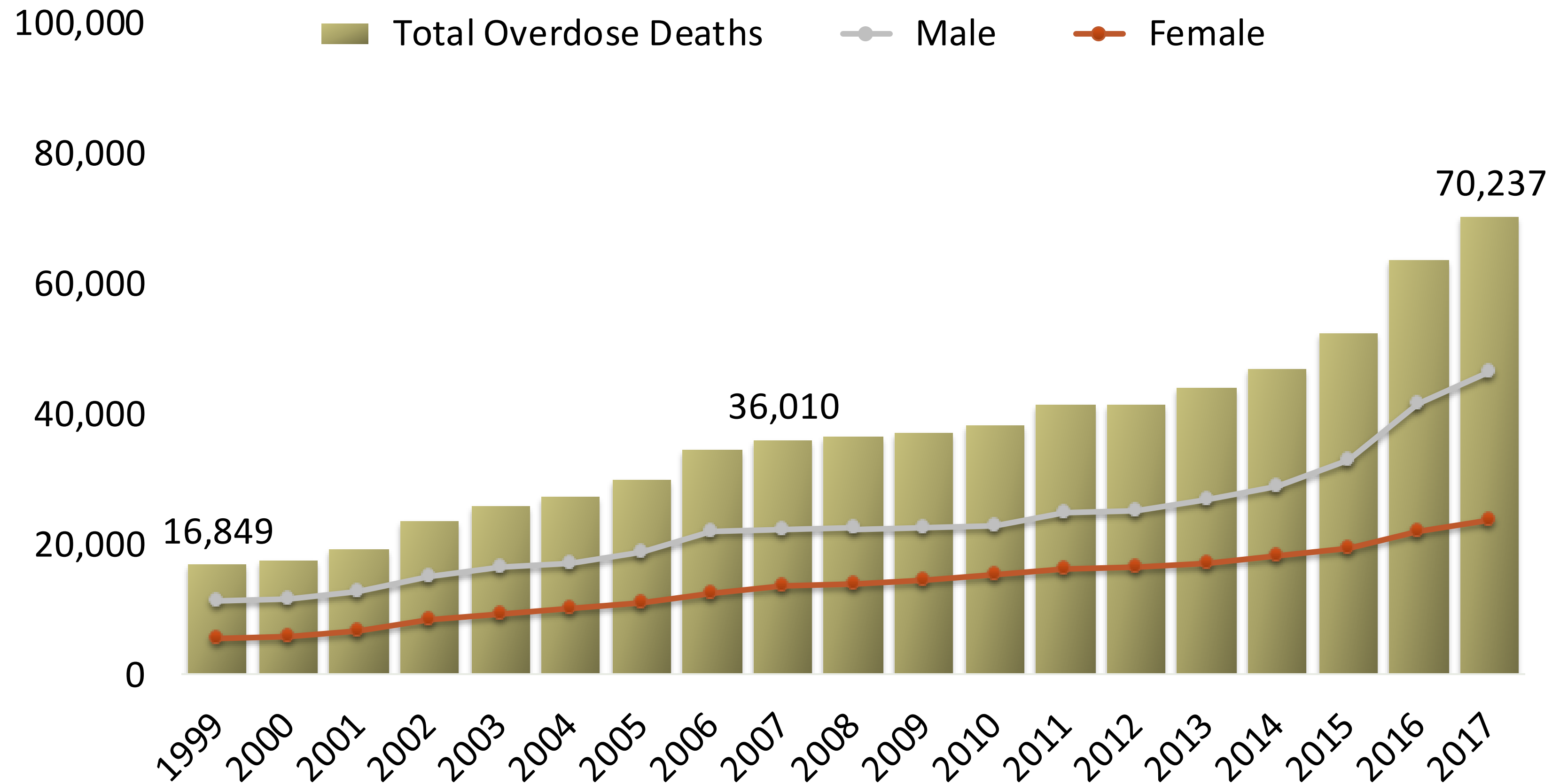
Review some of the messages and controversy surrounding the use of medications in combination with treatment services.

Develop an implementation framework that can be utilized in variety of settings.

Develop tactics to address workforce, organizational and environmental/regulatory challenges.

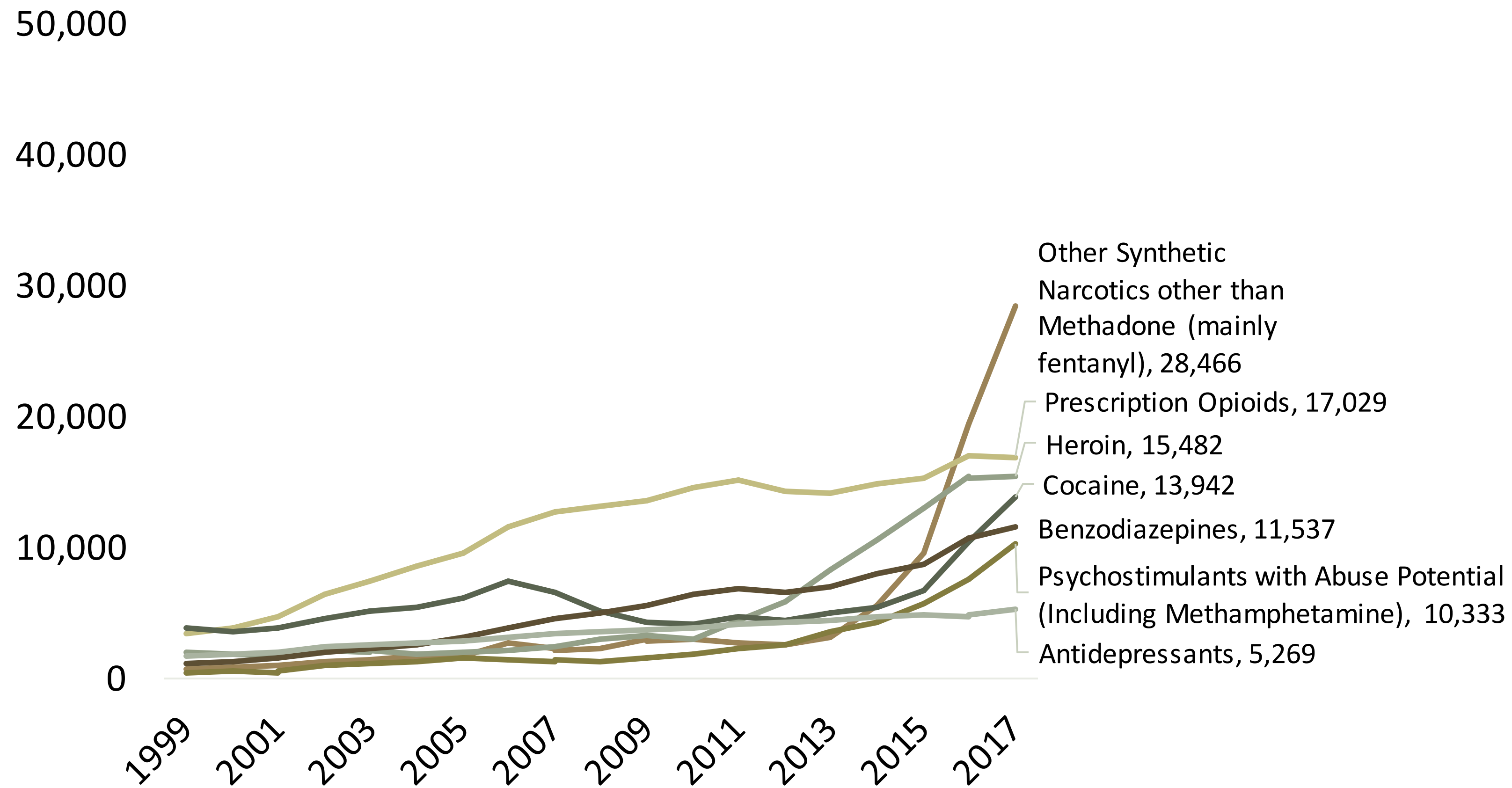
Develop communication strategies and tools that can be utilized with individuals, families and communities we serve.

Figure 1. **National Drug Overdose Deaths**
Number Among All Ages, by Gender, 1999-2017



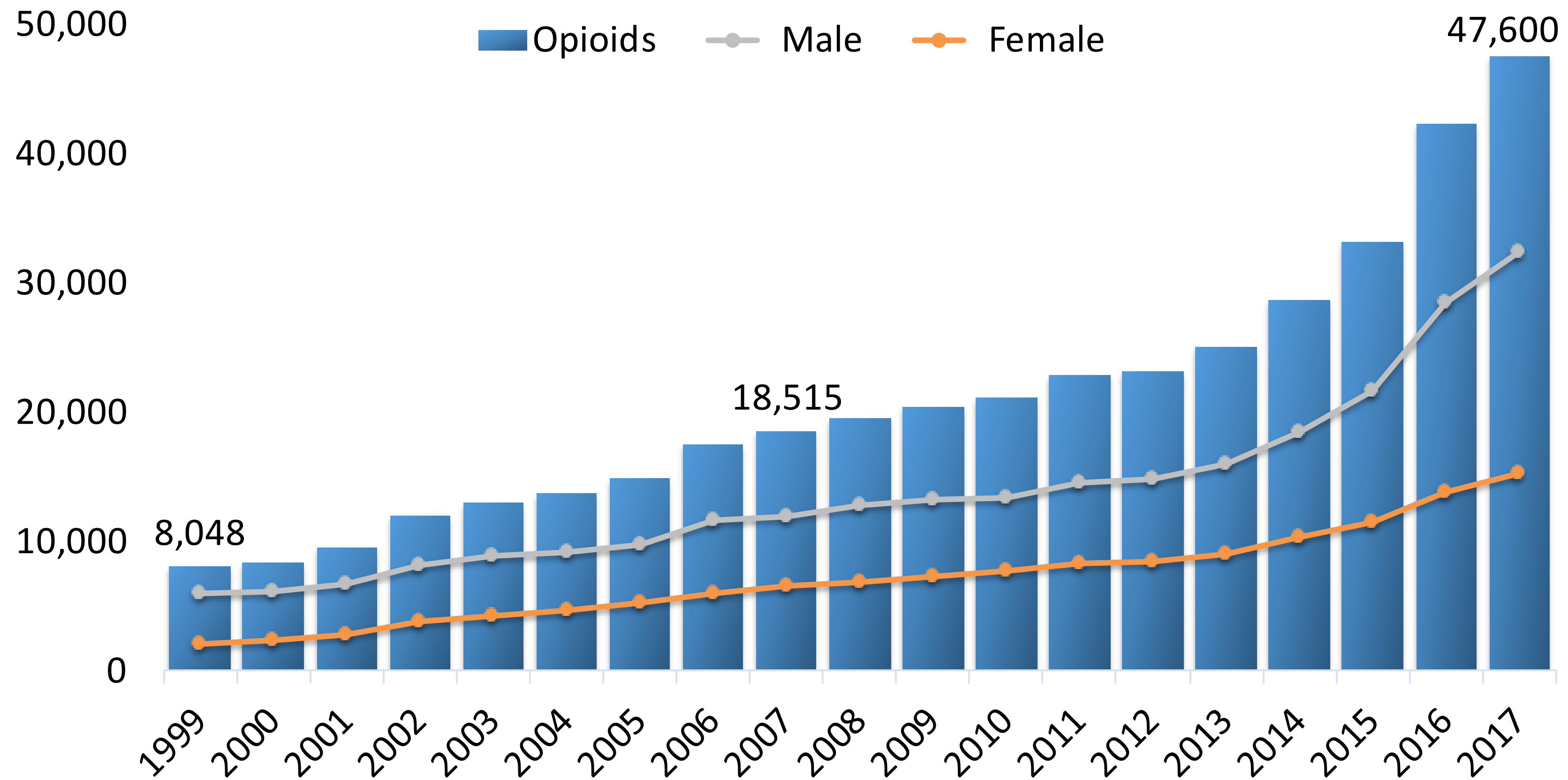
Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Figure 2. **National Drug Overdose Deaths**
Number Among All Ages, 1999-2017



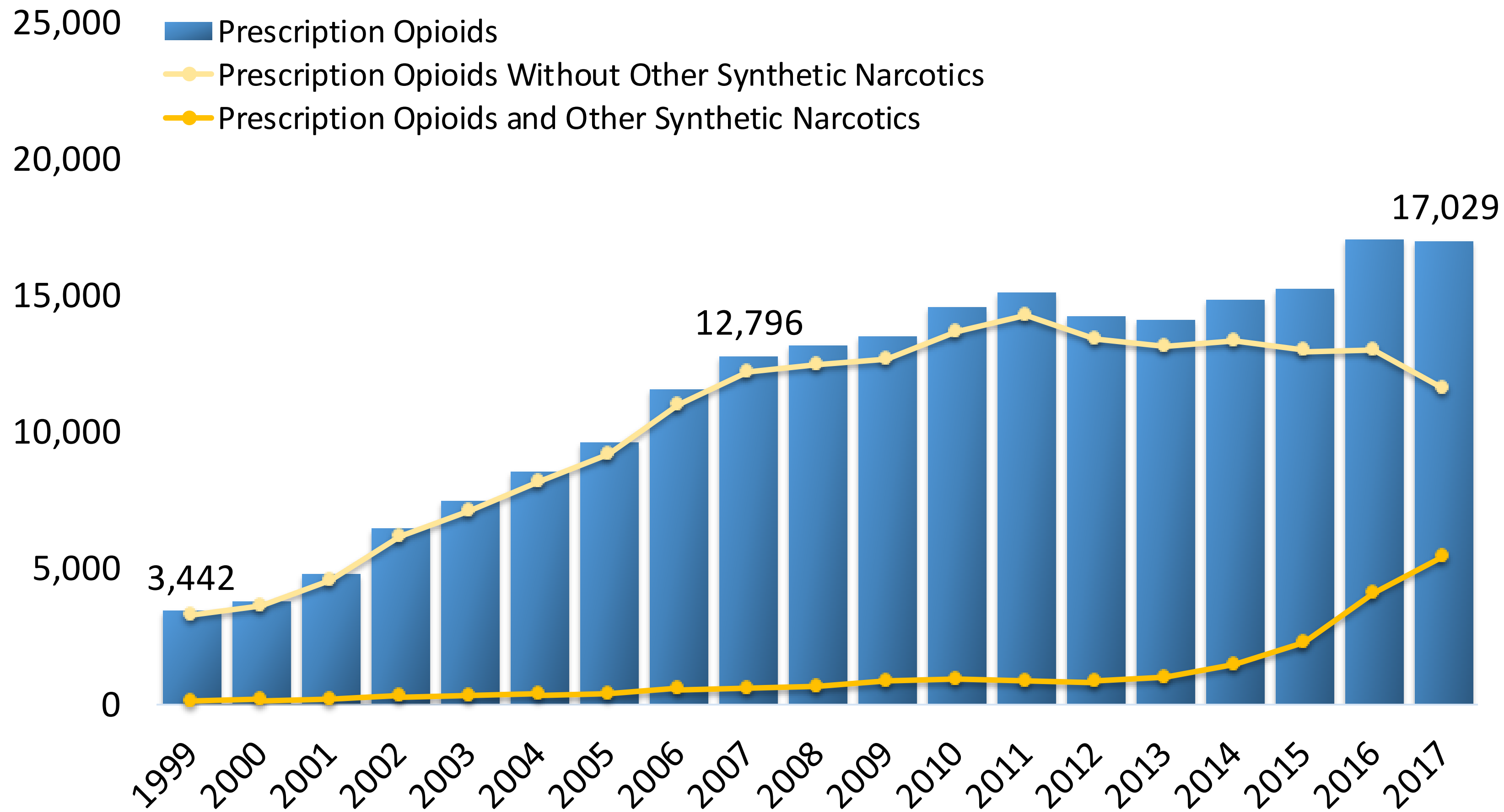
Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Figure 3. **National Drug Overdose Deaths Involving Any Opioid,** Number Among All Ages, by Gender, 1999-2017



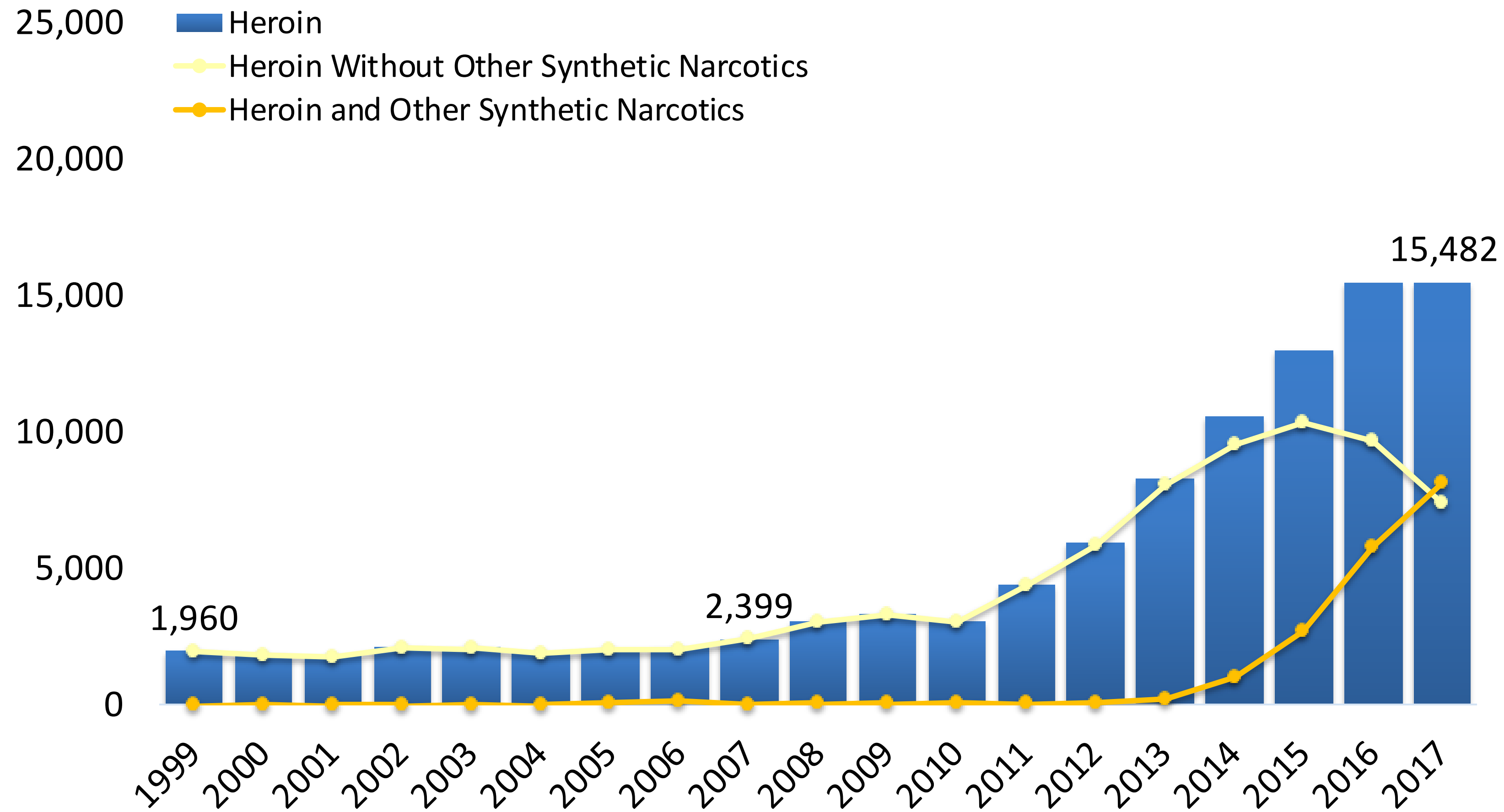
Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Figure 4. **National Drug Overdose Deaths Involving Prescription Opioids,** Number Among All Ages, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

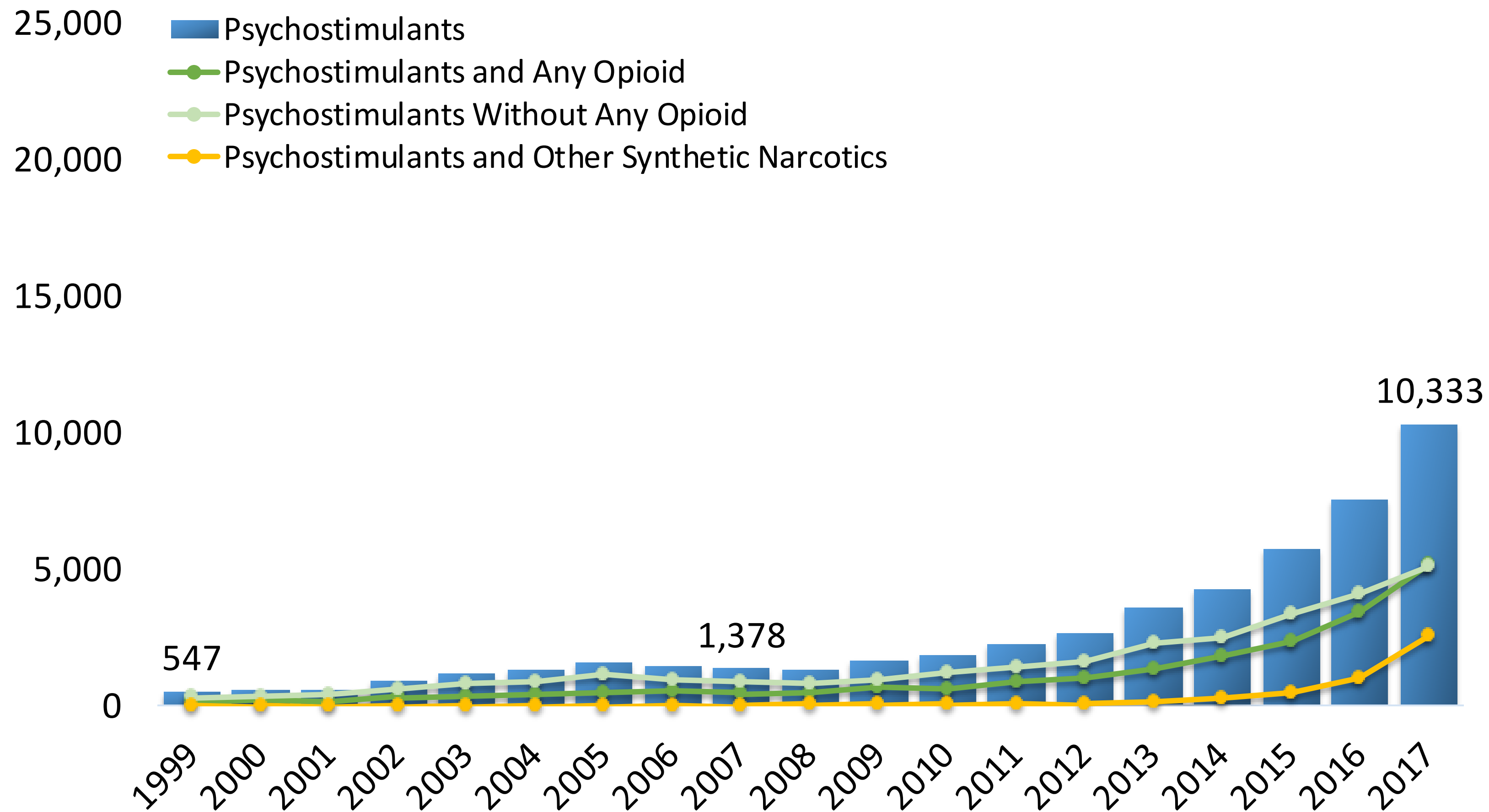
Figure 5. **National Drug Overdose Deaths Involving Heroin**
Number Among All Ages, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Figure 6. **National Drug Overdose Deaths Involving Psychostimulants With Abuse Potential (Including Methamphetamine), by Opioid Involvement**

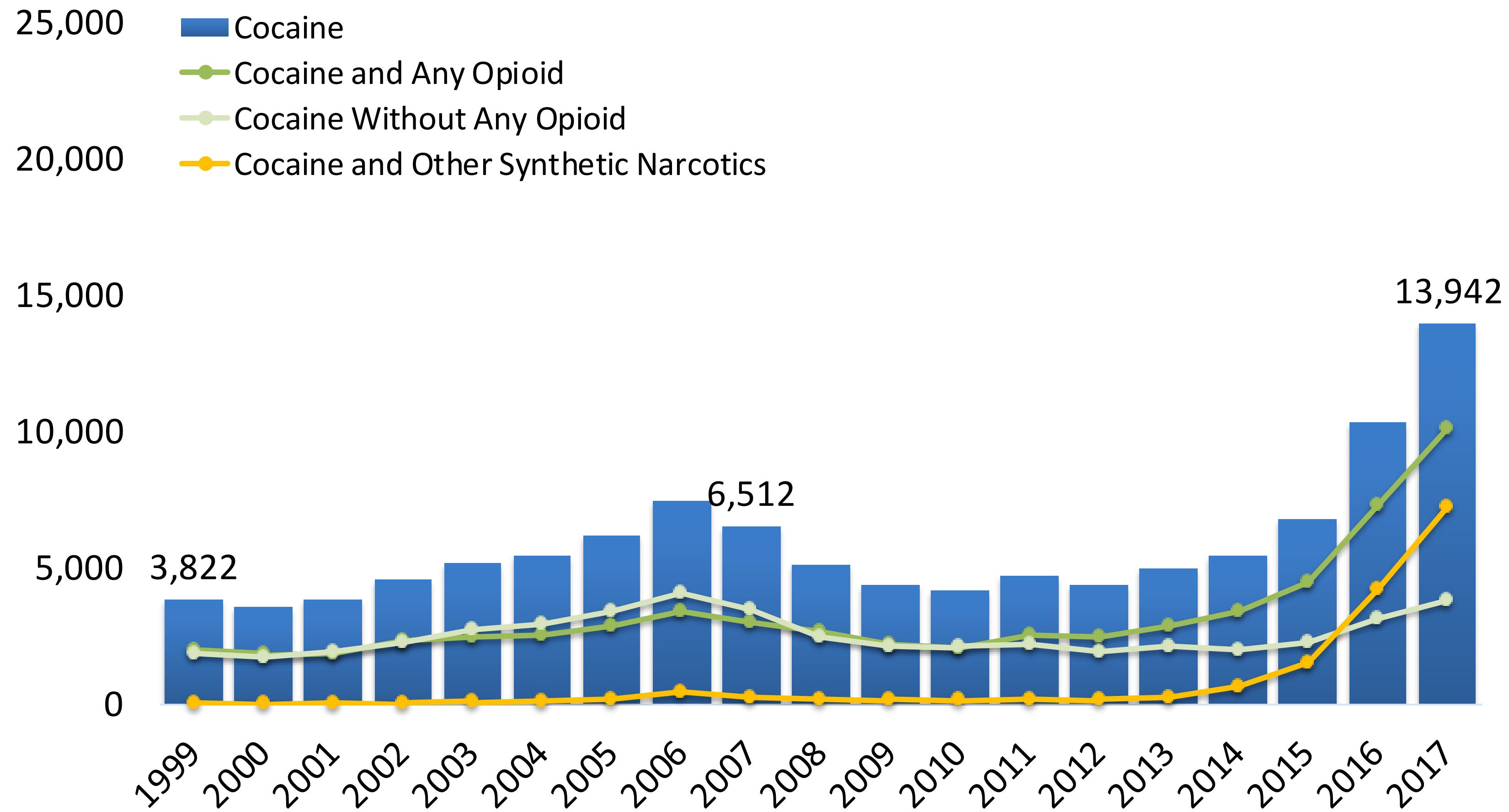
Number Among All Ages, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

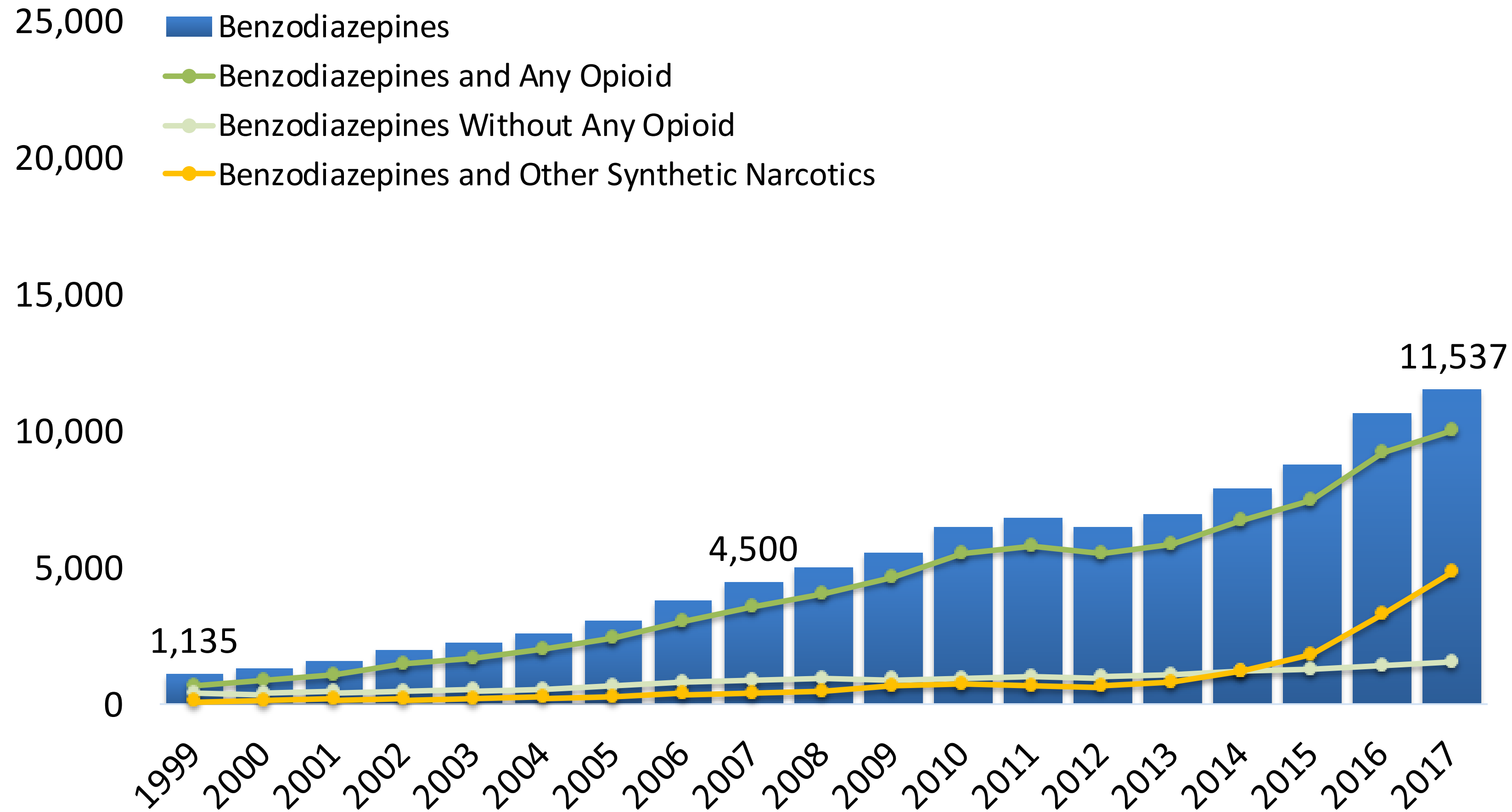
Figure 7. **National Drug Overdose Deaths Involving Cocaine, by Opioid Involvement**

Number Among All Ages, 1999-2017



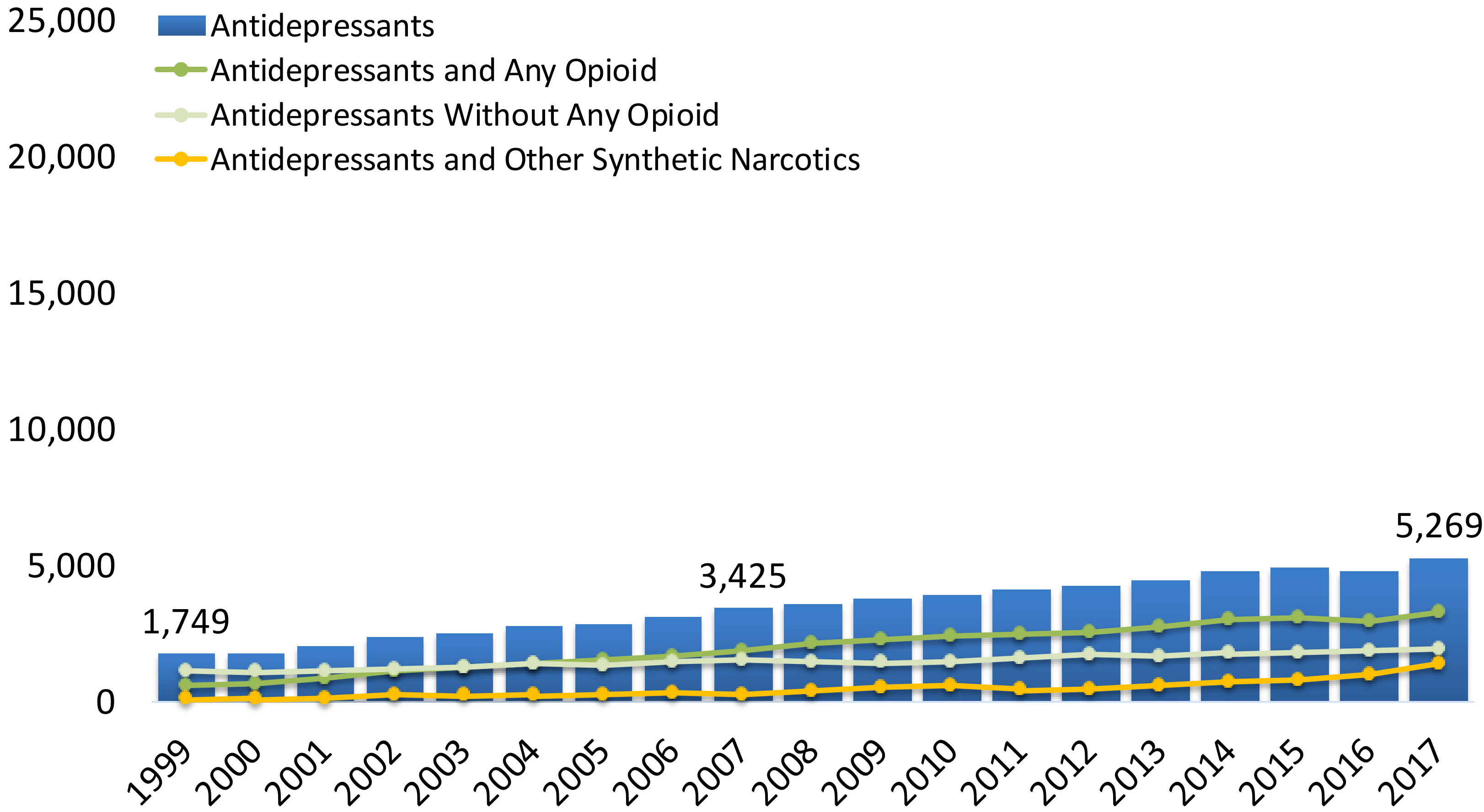
Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Figure 8. **National Drug Overdose Deaths Involving Benzodiazepines, by Opioid Involvement,** Number Among All Ages, 1999-2017

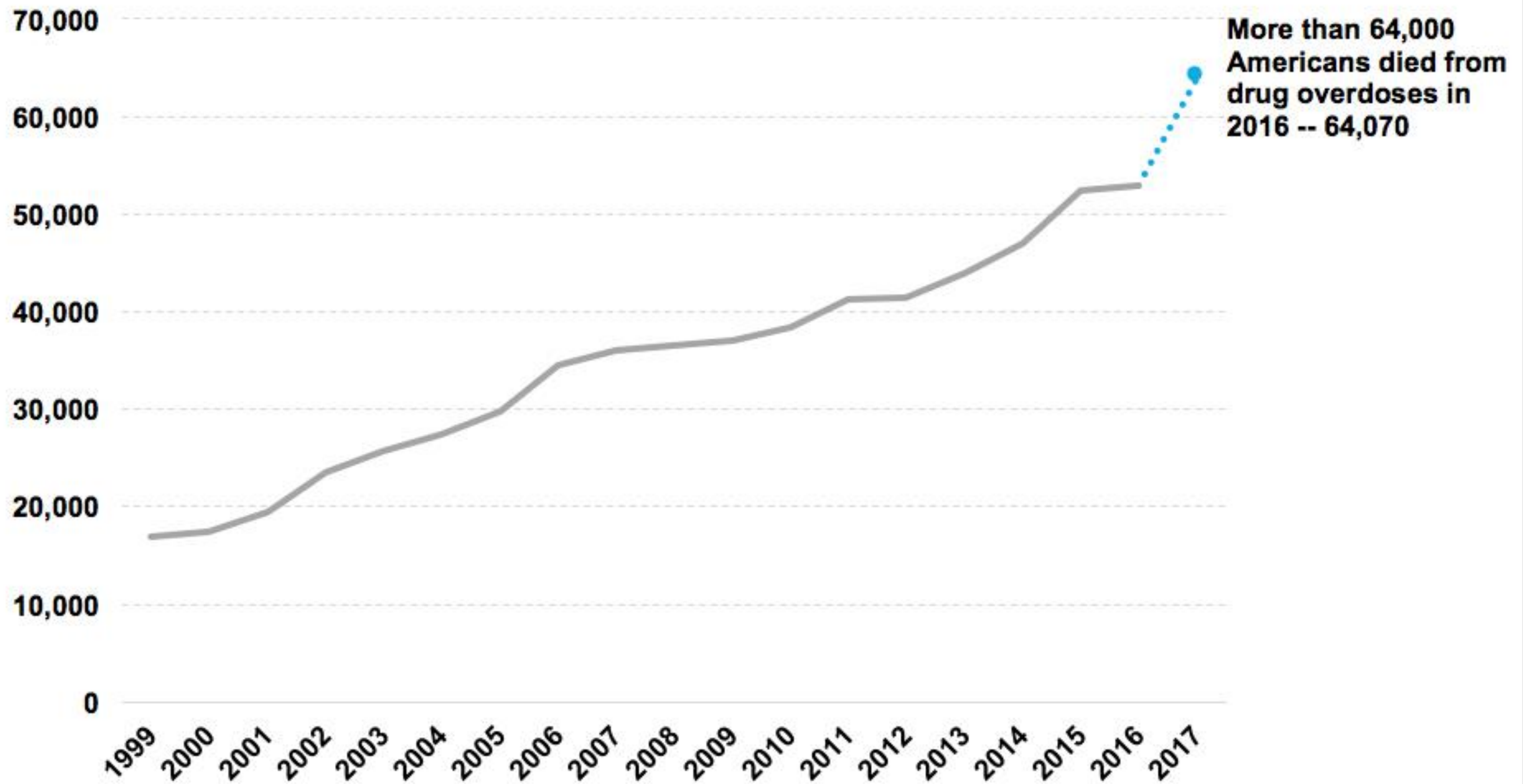


Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

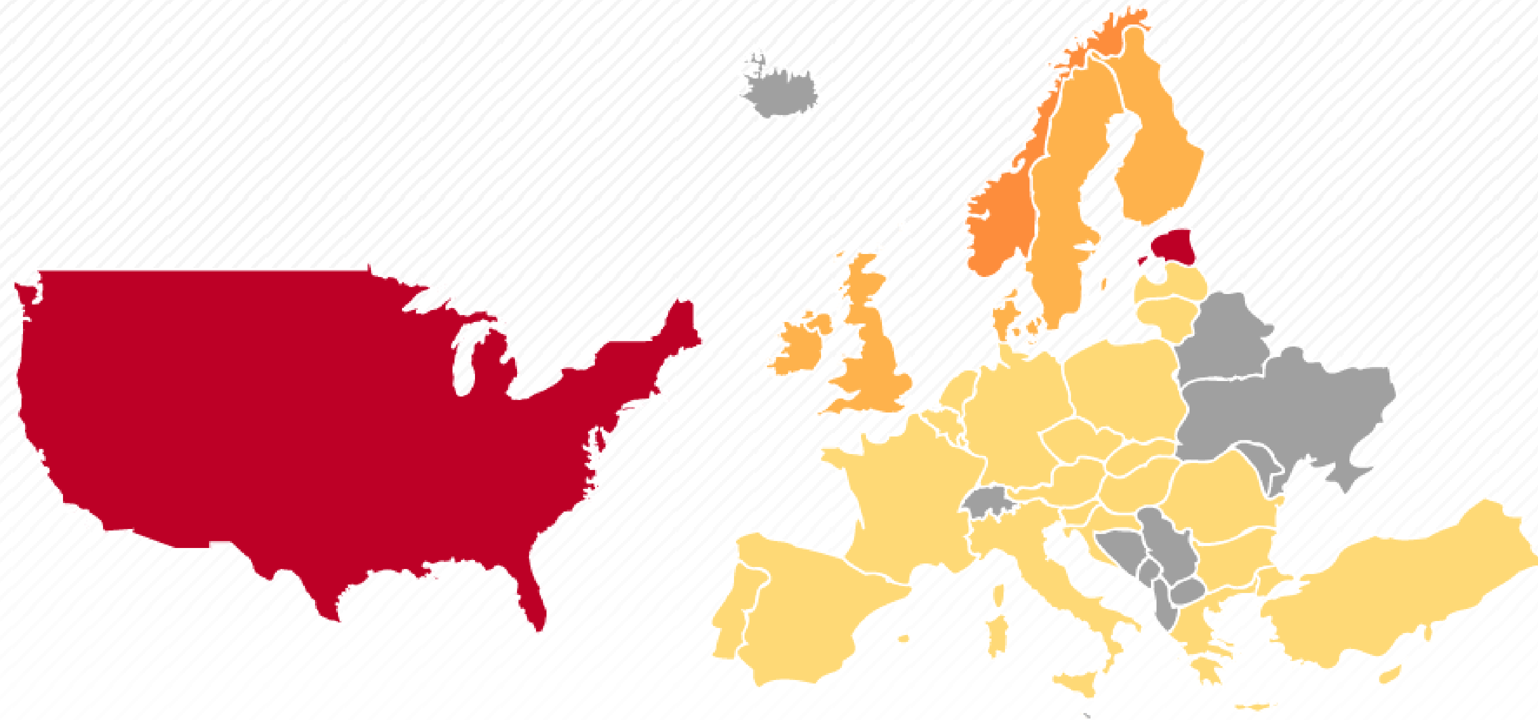
Figure 9. **National Drug Overdose Deaths Involving Antidepressants, by Opioid Involvement,** Number Among All Ages, 1999-2017



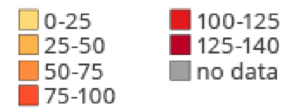
Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018


Total U.S. Drug Deaths
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
More than 64,000 Americans died from drug overdoses in 2016 -- 64,070

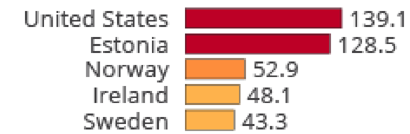
Drug overdose deaths per year



Deaths per 1,000,000 population



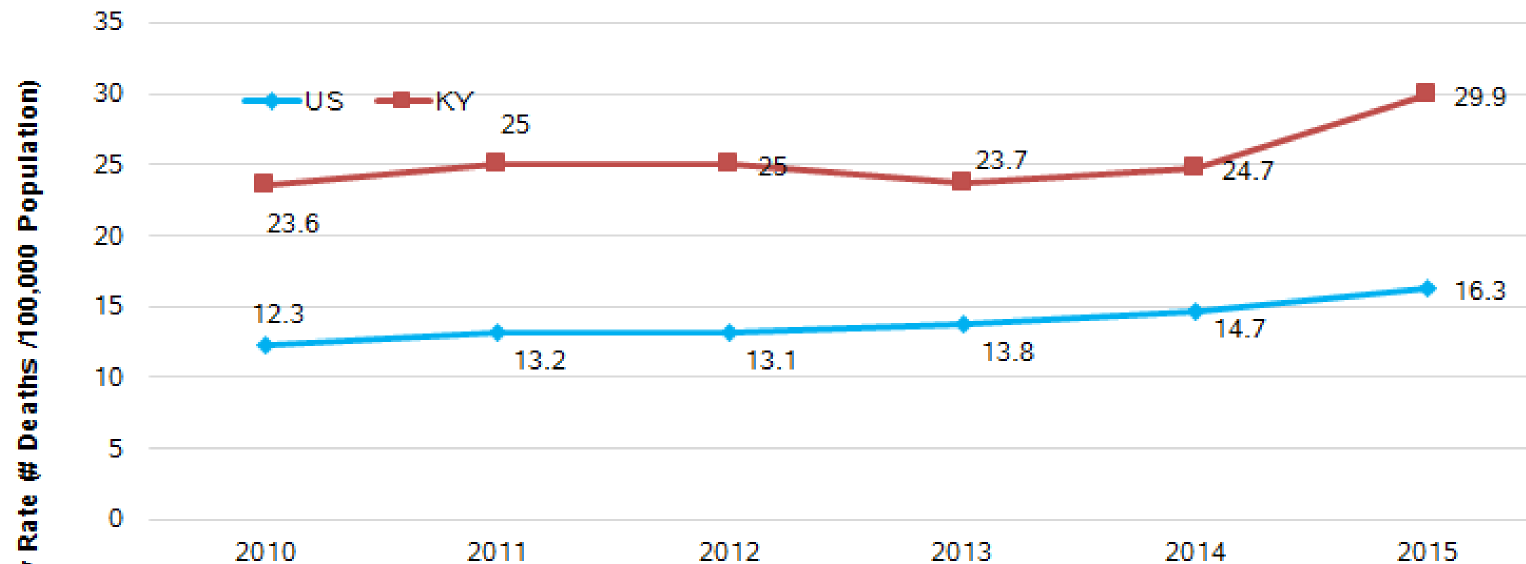
Top 5 countries



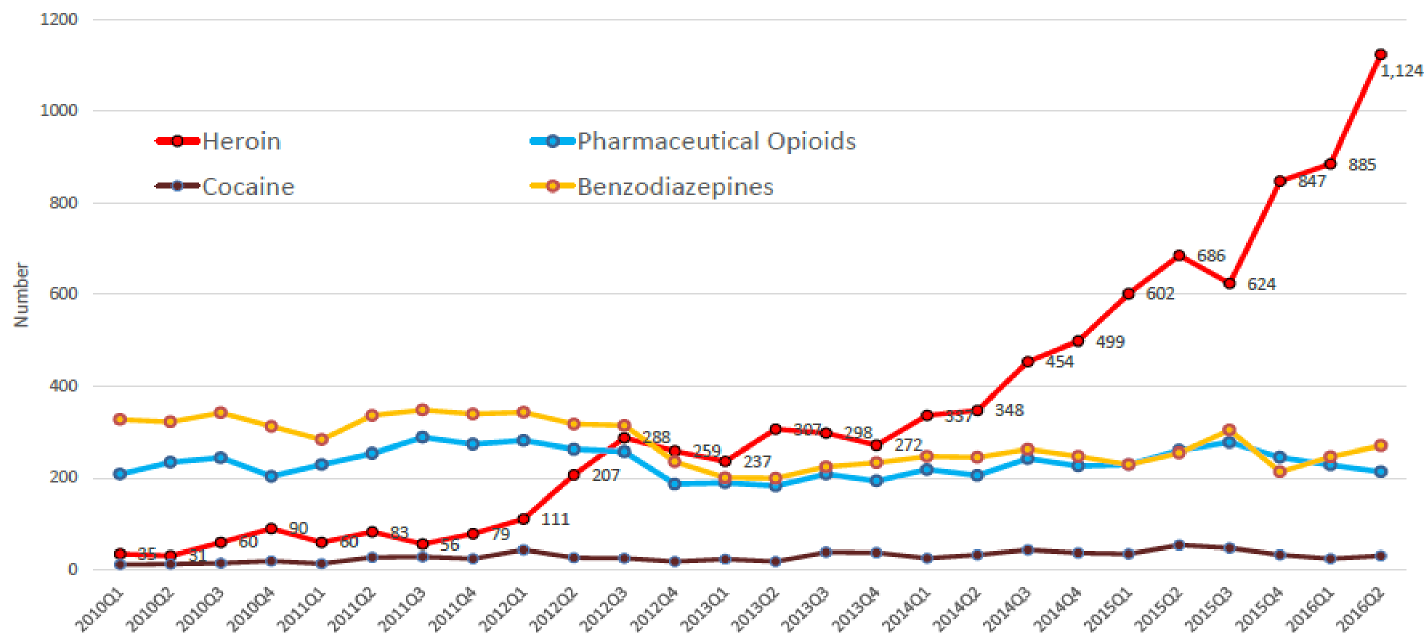
RecoveryBrands.com

Sources: http://www.emcdda.europa.eu/about/partners/reitox-network, 2014 · http://www.samhsa.gov/data/population-data-nsduh, 2013

KENTUCKY



KENTUCKY



Note: An overdose that involved multiple drugs was counted under each relevant drug category.
Produced by the Kentucky Injury Prevention and Research Center, a bona fide agent for the Kentucky Department for Public Health. December 2016. Data source: Kentucky Outpatient Services Claims Files, Office of Health Policy, Cabinet for Health and Family Services. Data are provisional and subject to change.

KY Specific Data

Etiology of the Epidemic

1990's Pain becomes the 5th Vital Sign

Principles used in the hospice movement 2 decades earlier are extrapolated to suffering of other sorts

New High Potency Opioids are brought to market

Rx opiate abuse and dependence rise at alarming rates

Medical and Psychological Effects of Alcohol and Opioids: *The Basics of Brain Functioning in Relation to MAT*

More than half of the 4.2 million people who misuse prescription opioids in the U.S. also binge drink.

www.cdc.gov/alcohol

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS 306178-A

ALCOHOL

https://www.youtube.com/watch?v=vkpz7xFTWJo

- As a person drinks the brain balances alcohol induced sedation with excitatory glutamate activity.
- Chronic Alcohol Use the GABA/Glutamate system becomes unbalanced.
  - It takes more ETOH to override the Glutamate system to feel intoxicated which is commonly known as Tolerance.
  - If someone stops drinking abruptly withdrawal can occur, potentially fatal and requires medical attention.
  - Safe medical detox utilizes benzodiazepine and other medications that moderate safe Glutamate activity.
  - After detox the Glutamate system continues to be overactive contributing to Post Acute Withdrawal Syndrome (PAWS); can cause a person to feel anxious and agitated contributing to cravings and relapse.

OPIOIDS

Opiates vs. Opioids

Opiates: are derived directly from the opium poppy by leaving and purifying the various chemicals in the poppy.

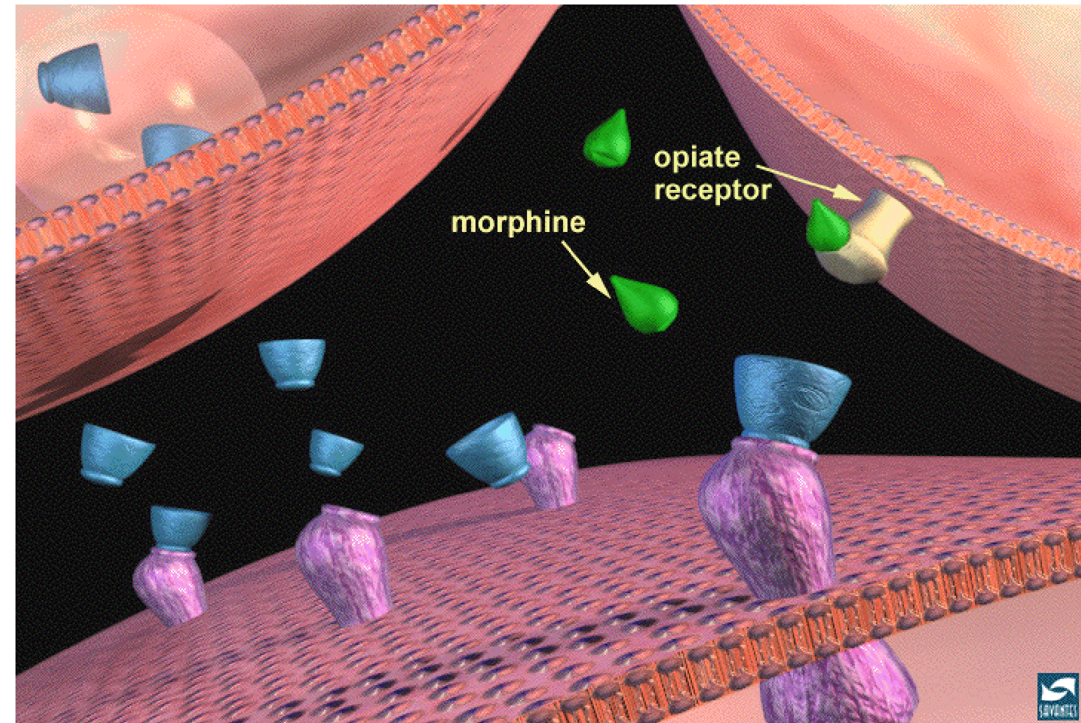
Opioids: include opiates but also include chemicals that have been synthesized in some way

- **Morphine** is an opioid and also an opiate
- **Methadone** is an opioid but not an opiate

Opioids and opium-derived or synthetic compounds that relieve pain, produce morphine-like addiction, or relieve symptoms during withdrawal from morphine dependency.

Opioids and Reward

- Opioids all work in the same way, they bind to opioid receptors on neurons located in the brain causing the release of more Dopamine.



Effects of Opioid Use Disorder

Physical Effects Include:

- Cellulitis
- Liver Disease
- Pulmonary complications
- Respiratory problems
- Pregnancy issues
- Clogging of blood vessels
- HIV/Hepatitis C
- Malnutrition
- Bacterial Infections
- Abscesses
- Blood infections
- Endocarditis

Opioid Withdrawal Facts

Intensity dependent upon level and chronicity of use

Cessation causes a rebound in functions depressed by chronic use

First signs occur shortly before next scheduled dose

For short-acting (Heroin) peak of withdrawal occurs 36-72 hours

Acute symptoms subside over 3-7 days

Ongoing symptoms may linger for months

Opioid Withdrawal

Symptoms Include:

- Dysphoric mood
- Nausea or vomiting
- Diarrhea
- Tearing or runny nose
- Dilated pupils
- Muscle aches
- Goosebumps
- Sweating
- Fever
- Insomnia

WHY MEDICAITON ASSISTED TREATMENT?

MAT can help the person function more normally

Medication can address many of the changes caused in the brain

Medication allows for stabilization from biological symptoms of addiction so an individual can access treatment process

Medicines can facilitate the process of recovery

Goal of MAT in Treatment

As part of comprehensive treatment plan for someone with a substance use disorder, the goals of MAT are:

- Restore normal physiology
- Promote psychosocial rehabilitation and non-drug lifestyle
- Reduce symptoms and signs of withdrawal
- Reduce or eliminate craving
- Block effects of alcohol or opioids

What is Medication Assisted Treatment?

Combines behavioral therapy, medication, and support from family and friends. All three components are equally important and the likelihood of achieving sobriety is much higher when all three are combined (SAMSHA).

Treatment that includes medication is often the best choice for opioid addiction (SAMSHA).

Types of MAT Used

Detoxification

Medically Supervised Withdrawal Treatment

Maintenance Treatment

Medical Maintenance Treatment

- Prevents opioid withdrawal and reduces cravings by activating the opioid receptors in the brain.
- Produces physiological tolerance in which body gets used to the medication so discontinuing would produce withdrawal.
- Long acting (24-30 hours)

Medication Assisted Treatment

Medications can be used to re-establish brain function, reduce cravings and relapse.

Opioids

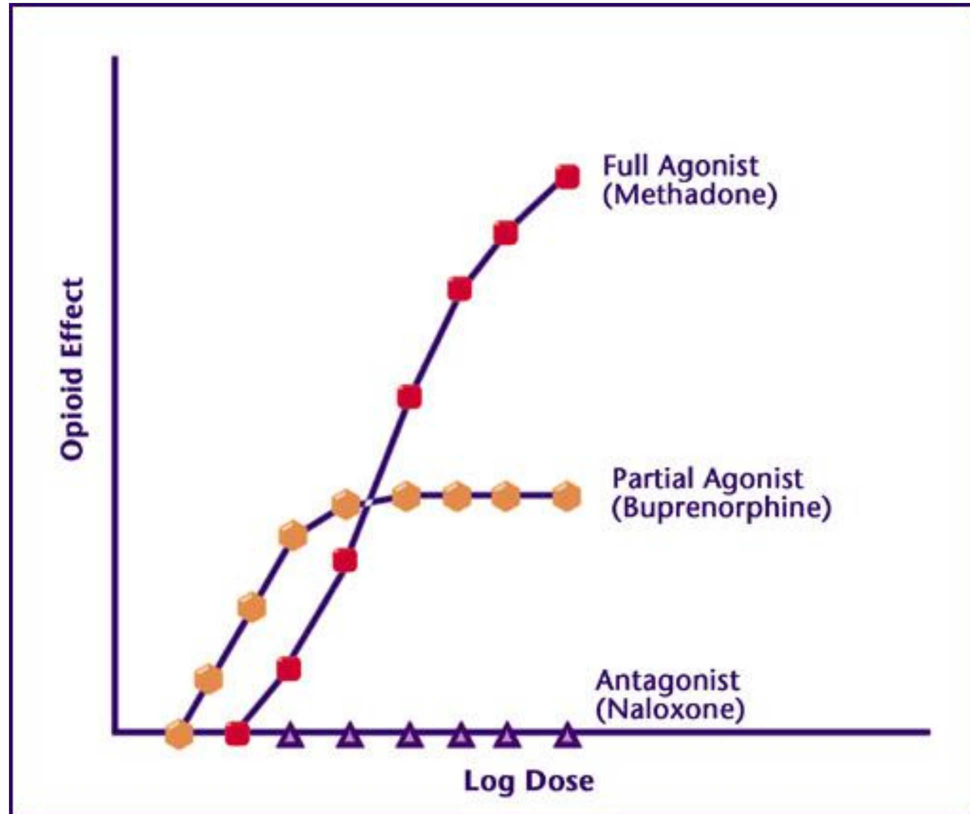
- Methadone
- Buprenorphine - suppresses withdrawal symptoms and relieve cravings.
- Naltrexone works by blocking the effects of opioids at receptor sites

Alcohol

- Topiramate not approved yet but is showing encouraging results in clinical trials.
- Naltrexone blocks receptors that are involved in the rewarding effects of drinking and in the craving for alcohol. It reduces relapse to heavy drinking and is highly effective in some but not all patients—this is likely related to genetic differences.
- Acamprosate reduce withdrawal symptoms, such as insomnia, anxiety, restlessness, and dysphoria.
- Disulfiram - produces a very unpleasant reaction that includes flushing, nausea, and palpitations if the patient drinks alcohol

Still developing treatment for cocaine and methamphetamine.

Chemistry



3 drugs have been approved by the FDA:

- Methadone
- Buprenorphine (Suboxone)
- Naltrexone (Vivitrol)

Methadone

- Prevents opioid withdrawal and reduces cravings by activating the opioid receptors in the brain.
- Produces physiological tolerance in which body gets used to the medication so discontinuing would produce withdrawal.
- Long acting (24-30 hours)

Suboxone®: Buprenorphine/Naloxone

A partial opioid agonist, a maintenance treatment

Administered sublingually (film) on a daily basis

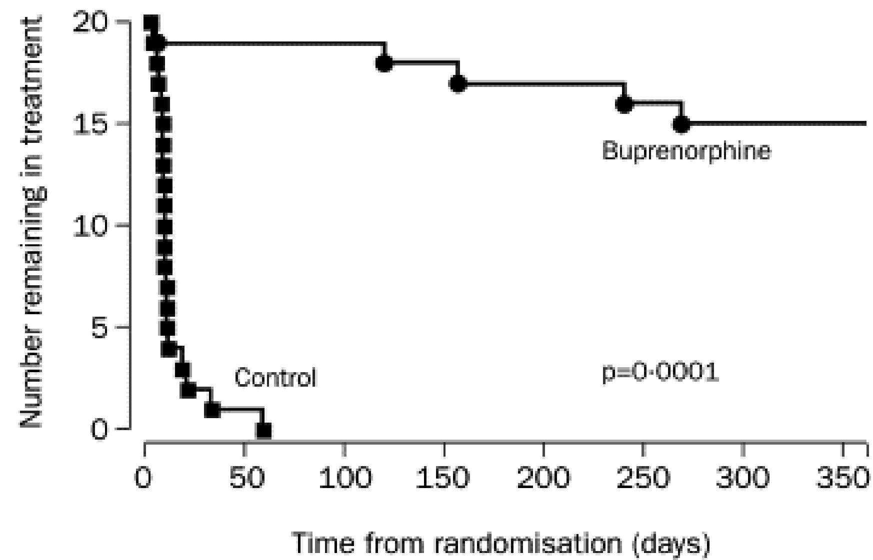
Binds to and activates opioid receptors, but not to the same degree as true opioid agonists

Improves treatment retention, and reduces craving and relapse

Illicit use and diversion does occur and there is a processes in place to prevent/combat this

Suboxone®

Suboxone (Buprenorphine)



Vivitrol®: Extended Release Injectable Naltrexone

Opioid receptor blocker (opioid antagonist)

Administered by intramuscular injection, once a month

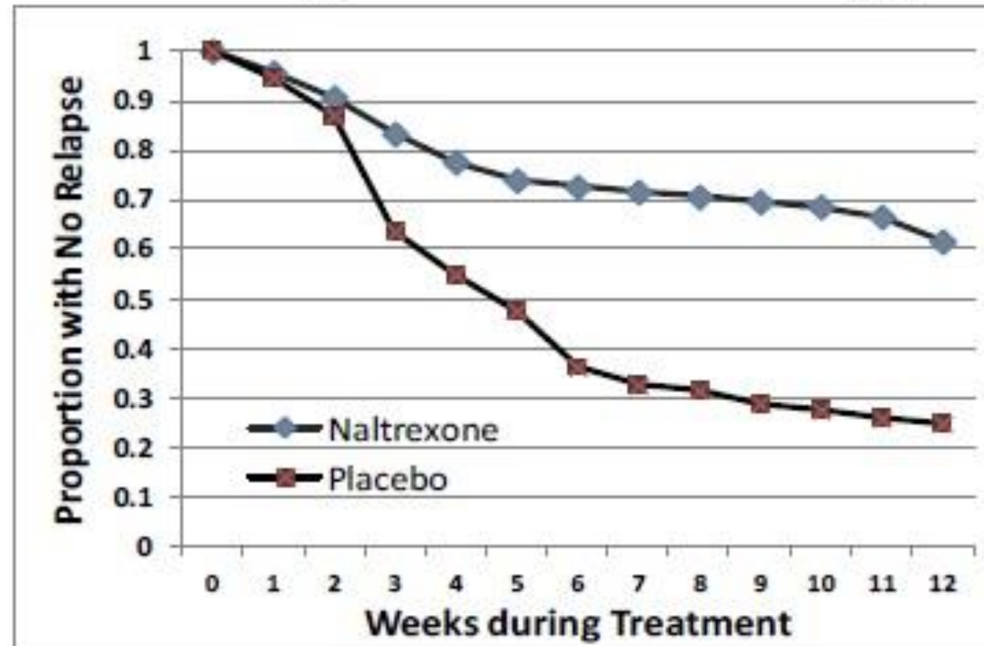
Prevents binding of opioids to receptors, eliminating intoxication and reward

Has been shown to reduce craving and relapse

Has no abuse potential

Licensed Provider
Vivitrol®

Vivitrol (Naltrexone)



Where is MAT offered

Buprenorphine Providers in the US

Training and certified

Apply for authorization to have 275 (2016)

Number of prescribers has increased:

- 2005 approximately 1300
- 2015 approximately 4500

Numbers Accessing MAT is Limited

- Both SAMHSA and ASAM endorse MAT as an essential component to treatment the number of patients offered MAT is limited.
- In 2012 only 1 in 4 people entering treatment for Heroin Use Disorder received MAT, access varied widely by state.
- Among those who did not receive MAT 80% had a prior episode of treatment and nearly 30% had 5 or more prior treatment episodes.

Distance Traveled and Cross-State Commuting to OTP's in the U.S.

Study examined commuting patterns of 23,411 clients in 84 OTP's across the U.S.

- 60% of clients traveled <10 miles
- 6% traveled between 50-200 miles
- 8% traveled across a state border to access MAT

Factors associated with distance include:

- Residing in the Southeast or Midwest
- Younger Age
- Non-Hispanic white race/ethnicity
- Misuse of prescription opioid misuse (and no heroin use)

Why is Uptake of MAT so Limited

Geographic access factor in treatment

- Longer travel = shorter length of stay
- Ongoing utilization especially important for methadone clients

Entrenched beliefs and misconceptions

Group Exercise

Group Exercise: What do you think?

Workforce, Organizational, and Environmental/regulatory issues that facilitate or impede the Implementation of MAT

Stigma associated with MAT

Primary Barrier to use of MAT

Too often driven by myths, misunderstandings, and a lack of experience or knowledge

Betty Ford Institute looked this issue and conceptualized it around:

- Acceptance
- Ambivalence
- Antagonism

Betty Ford Institute

Acceptance: essentially full agreement that individuals with SUD who are abstinent from all drugs of abuse but take, for example, prescribed medication like insulin for diabetes or diuretics for hypertension still meet contemporary views about being in recovery.

Ambivalence: medications used for the treatment of addiction have mixed acceptance and there does not appear to be agreement about whether those who take naltrexone, acamprosate, or disulfiram to decrease cravings and alcohol use are in recovery

Antagonism: Concern echoed is replacing one drug for another is undermining the true potential for recovery. More antagonism towards Methadone and Buprenorphine than Naltrexone.

Stigma Management

Healthcare providers have a critical role in increasing access to MAT

MAT is an important evidence based treatment

Stigma about clients with SUD can limit access and willingness to work with the population.

Training improves staff attitudes, reducing stigma and attitudinal barriers to MAT implementation

Experience with MAT leads to more positive perspectives, increasing client access and support.

2011 Stigma Survey Findings

"You are still using Opioids, Methadone is a drug, you are still using drugs, In my eyes you are still using until you are totally off"

Theme expressed was difficulty sharing with family members and a mutual theme was to not discuss.

Clients found physicians were not informed about addiction medications and had an antagonistic position.

Many clients in recovery were made to feel they have a 2nd class recovery.

"Methadone clinics are nothing more than substitution stations, they are a sought out source to find a legal addictive drug."

Define Recovery

3 Core Elements in order to clearly differentiate between substance use disorders and MAT

SAMHSA working definition of recovery:

- *"A process of change through which individuals work to improve their won health and well-being, live a self-directed life, and strive to achieve their full potential"*

Recovery is a process of change to improve and expand health and wellness. The tools that individuals and families use to achieve recovery are just that tools.

Betty Ford Institute Consensus Panel (2007)

It was consensus that those who are abstinent from alcohol, drugs and non prescribed or mis-prescribed medications would meet this criteria of recovery regardless of whether those behaviors were being maintained by a medication, a form of unforced outpatient treatment, support from a recovering peer group, or some alternative lifestyle.

Core Elements of Recovery

Resolution of drug-related problems

Improvement in global health

Citizenship – positive community re-integration.

Group Activity

Agency Assessment Tool

Long Term Recovery

Medical Detoxification

Family Therapy

Peer support participation.

- Primary Care
- General Healthcare

Opioids

- OTP's
- OTP medication unit
- Other healthcare

Psychosocial Interventions

Psychosocial interventions that have been thoroughly researched and have shown good efficacy include:

- Cognitive Behavioral Therapy (CBT)
- Motivational Enhancement Therapy (MET)
- Contingency management/motivational incentives
- Twelve Step Facilitation (TSF)

Project Match

Comprehensive Approaches

How can medications be combined with other interventions to support an individual in recovery?

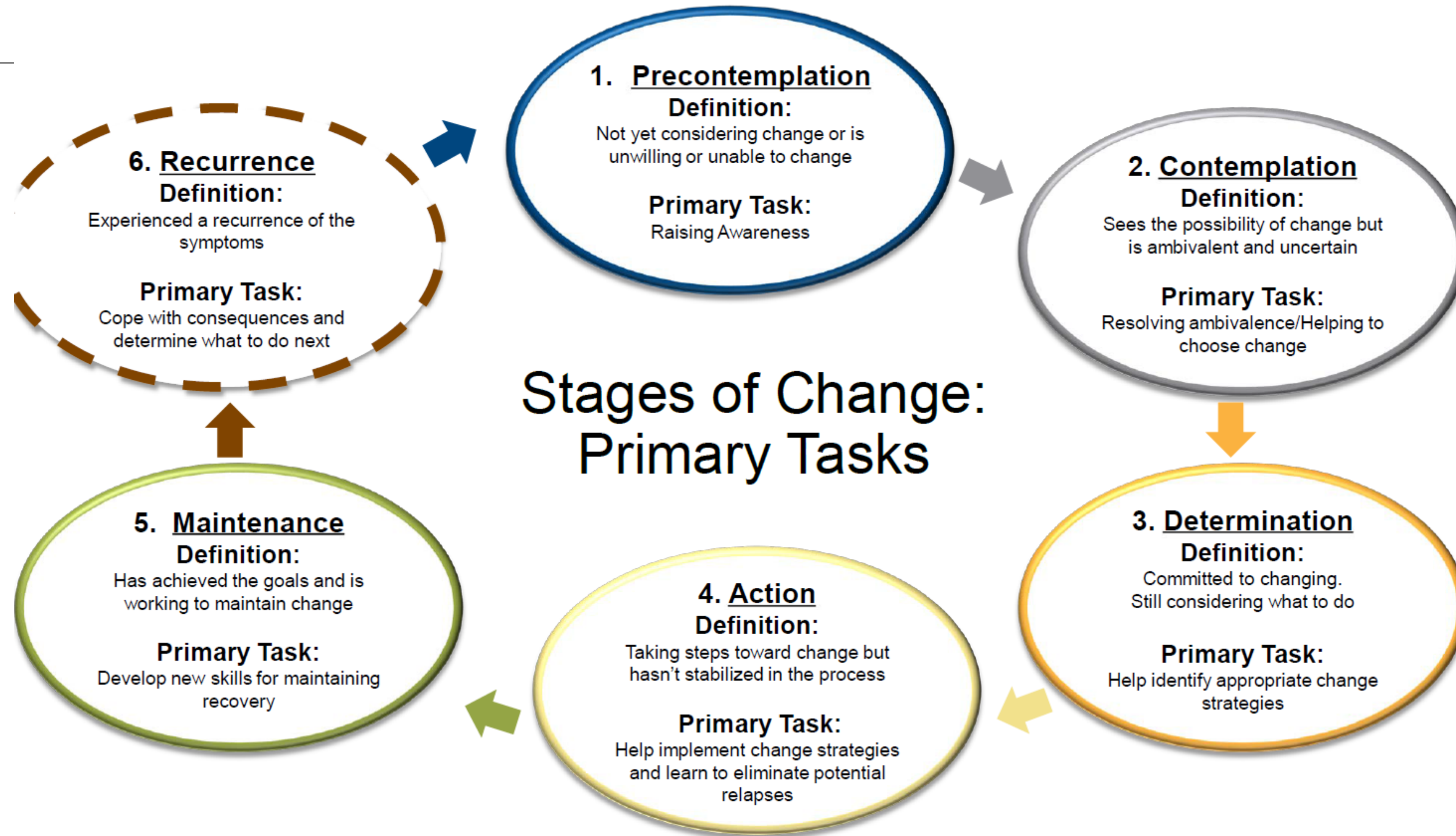
- Evaluation and Diagnosis
- Assessment of Client's stage of change

Prochaska & DiClemente Transtheoretical Model

(aka) **Stages of Change Model**

- 5 Cognitive and Behavioral stages through which clients progress to make significant changes.
- Tailor, Individualize and Target care

Stages of Change Model



Stages of Change: Intervention Matching

Stages of Change: Intervention Matching Guide

Pre-contemplation

- Offer **factual** information
- Explore the **meaning of events** that brought the person to treatment
- Explore **results of previous efforts**
- Explore **pros** & **cons** of targeted behaviors

Medications

- May not be ready to take them
- Knowing there are medications that could help may create an interest in treatment and offer hope

Contemplation

- Explore the person's **sense of self-efficacy**
- Explore **expectations** regarding what the change will entail
- **Summarize** self-motivational statements
- Continue exploration of **pros** & **cons**

Medications

- Could support the notion that change is possible;
- Can be seen as a tool to help them achieve their goals

Determination

- Offer a **menu of options** for change
- Identify **pros** & **cons** of change options
- Identify and **lower barriers** to change
- Help person **enlist social support**
- Encourage **announcement of plans**

Medications

- May promote the patient's commitment to recovery plan;
- Can help to set a timeframe for initiating the plan

Action

- Support change through **small steps**
- Help **identify high-risk situations** and develop **coping strategies**
- Help **find new reinforcers** of change
- Help access family and social **support**

Medication

- Effects can reinforce initial success of treatment;
- Can reduce cravings and post-acute withdrawal symptoms

Maintenance

- Help identify and try **alternative behaviors** (drug-free sources of pleasure)
- Maintain **supportive contact**
- Help **develop escape plan**
- Work to **set new** short and long term **goals**

Medication

- Can prevent relapse and support stabilization;
- Can reduce cravings and post-acute withdrawal symptoms

Recurrence

- Frame as a **learning opportunity**
- Explore **antecedents**
- Develop **alternative coping** strategies
- Encourage person to **stay in the process**
- Maintain **supportive contact**

Medication

- Can support the patient's commitment to change; Can reduce cravings and post-acute withdrawal symptoms

Mixed Messages in the Literature

Some in the field state that counseling and group is ineffective with the Opioid Use Disorder population and all you need is medicine with limited specific behavioral interventions 1x/week first month and 1x/month thereafter.

Some state that CBT and Medication Management shows no benefit over Medication Management alone.

Some state 12 Steps have no research behind them.

Strategies and Barriers

Federal Regulations

Payer Sources

Treatment Ideologies

Paying for MAT

Insurance Coverage: many have 3rd party payer, need to contact payer to check insurance formulary, seen increase in availability and coverage.

Medicaid: Medicaid formularies vary by state, some states require pre-authorization for payment of certain medications like Vivitrol or Buprenorphine. Need to understand medical necessity and authorization process.

Policy and Clinical Guidelines

Often disconnect between policy, standards of care and clinical guidelines

Time-limited medication coverage is not consistent with patient centered care or evidence-based clinical guidelines.

Geographical barriers.

Clinical Barriers

Treatment ideology: 12-Step model treatment programs less likely to adopt MAT medications and even discourage the use of medications.

Physician access: prescribing physicians not accessible.

Many clinical staff have been trained in an abstinence based model that views medication as the substitution of one drug for another.

Staff members may need to be trained in the benefits and limitations of MAT.

Senior clinical staff members are often in position to train new staff and it is imperative new staff receive training about multiple pathways to recovery.

Role of Self-Help Programs

Official positions of 12 Step groups vs. the opinion of members.

Many people require both tools: 12 Step Recovery and Medication to assist that recovery

“The guiding vision of our work must be to create a city and a world in which people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated.” William White

Care, Treatment, and Service

Clinical Sessions:

- Non Judgmental, Unconditional Positive Regard
- Dedicate time (5-10 minutes) every session to discuss medication utilization so it is normalized into the session.
  - *How many doses have you missed?*
  - *Have you felt or acted different on days when you missed your medication?*
  - *Was missing the medication related to any substance use relapse?*
  - *Why did you miss the medication? Did you forget, or did you choose not to take it at that time?*
- Assess milestones to progress; stability across 6 Dimensions
- Readiness to Taper Assessments.

Clients and Medications

For clients who admit to choosing Not to take their medication

- Acknowledge they have a right to choose Not to use any medication
- Make sure their decision is well thought out
- What is the reason for choosing not to take the medication
- Tell them you are sure they wouldn't make such an important decision without having a reason

- Important if possible to include family, provider, and support network in these conversations.

Tips for Communication with Providers

Send written report
- Get concerns included in the client's medical record
- More likely to be acted upon
- Records of phone calls and letters may or may not be placed in the chart.

Make it look like a report and be brief:
- One page
- Date of report
- Client's name
- Client's date of birth

Include prominently labeled sections:
- Presenting Problem
- Assessment
- Treatment and Diagnosis
- Recommendations and Questions

Integration of MAT into Traditional 12 Step Programs

Tip 43

Review COR-12

Review RO-MAT

TIP 43 – Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs

- This manual gives a detailed description of medication-assisted treatment for addiction to opioids, including comprehensive maintenance treatment, detoxification, and medically supervised withdrawal.

- The manual also discusses screening, assessment, and administrative and ethical issues.

Comprehensive Opioid Response with the Twelve Steps (COR-12)

2012 Hazelden Betty Ford Foundation

High incident of death shortly after treatment

Increased patient population with Opioid Use Disorder

Created Steering Committee

Clinical, Medical, Communication, Research

Altered Entire Treatment for Opioid Use Disorder

Integrated MAT with Twelve Step Facilitation

- 3 Distinct Pathways
- Comprehensive Services including Recovery Coaching, IOP and/or therapy

Discontinuation of Medication is Goal

The Hazelden Betty Ford Experience

Increased admissions for opioid dependence

- Adults: 19% (2001) → 30% (2011)
- Youth: 15% (2001) → 41% (2011)

Problems with treatment retention

- Significant rate of ASA discharge
- Risk to patient → Nearly all of these patients leave treatment to relapse

Unit milieu issues

Use of opioids during treatment

Increased incidence of death following treatment

- Ethical imperative to evaluate the treatment model.

This is not your average addiction.

The challenges of treating opioid-dependent individuals are significant, as intense cravings, ongoing stress and anger, and heightened impulsivity are common symptoms that can:

be disruptive to the treatment milieu

undermine their ability to engage in treatment, causing them to leave prematurely and put themselves at risk of accidental overdose when returning to pre-treatment levels of use

The Hazelden Betty Ford Response

We followed the evidence about what works: medication-assisted treatment (MAT) - with buprenorphine (Suboxone™) and naltrexone (Vivitrol™) **in addition to and not as a replacement for**, other clinical interventions

Required a cultural shift within our abstinence-based organization

Needed specific procedures in place to prevent diversion and abuse

Needed psychosocial therapies in place specifically for those using opioids

The goal became full engagement in extended treatment, long-term recovery, and eventual medication tapering to abstinence

Borrowing from Twelve Steps and Twelve Traditions

Tradition 3

- “The only requirement for AA membership is a desire to stop drinking”
- “Nothing seemed so fragile, so easily breakable as an AA group……every AA group had membership rules.” (12x12, p.139)
- “The answer now seen in Tradition Three, was simplicity itself. At last experience taught us that to take away any alcoholic’s full chance was sometimes to pronounce his death sentence, and often to condemn him to endless misery. Who dared to be judge, jury, and executioner of his own sick brother?” (12x12, p.140)

Vivitrol®: Extended Release Injectable Naltrexone

Opioid receptor blocker (opioid antagonist).

- Fentanyl will override the opioid blockade → This can be fatal.

Administered by intramuscular injection, once a month.

- Several steps are involved including patient payment and pharmacy/patient communication in order to obtain the medication.
- Risk for avoiding the injection with the intention of relapse is common.

Prevents binding of opioids to receptors, generally preventing intoxication and euphorigenic reward.

- Many patients report feeling secure knowing that "I can't use" with Vivitrol.
- Patients often test the effect by using intravenously after day 14.

Has been shown to reduce craving and relapse.

- Anecdotally, 25% of IV heroin addicted patients report <u>profound reduction</u> in salience for opioids.
- No data yet exist to determine if these individuals are more successful.

Has no abuse potential.

- Often seen as preferred which can lead to systemic judgment about the 'quality' of an individual's Recovery program.

Suboxone®: Buprenorphine/Naloxone

Buprenorphine is the biologically active agent.

- Partial Mu-receptor activation → Supports midbrain dopaminergic tone.
- Potent Kappa-receptor blockade → Implicated in pain management.

Naloxone is ONLY active if the agent is dissolved and injected.

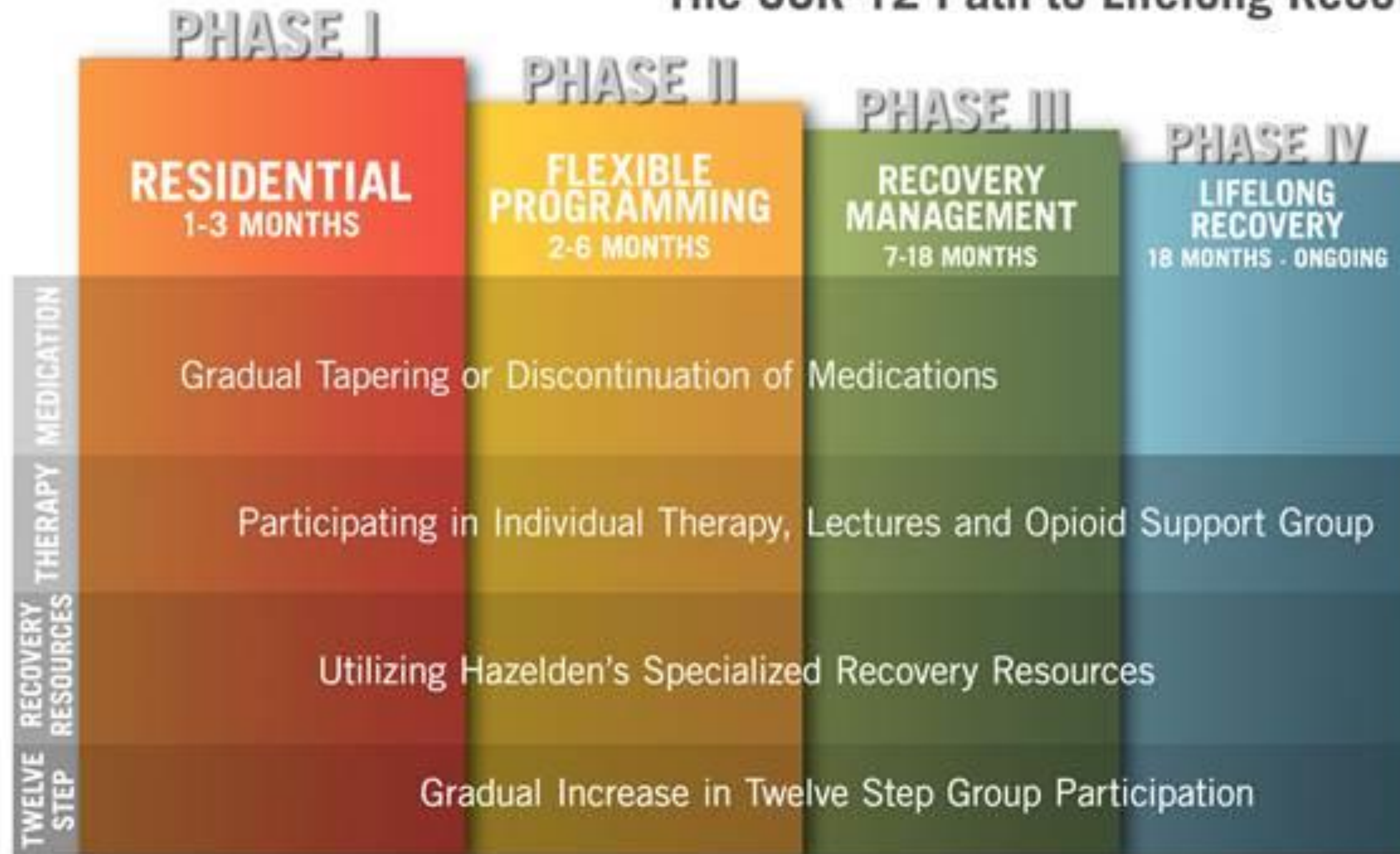
- Bupe/Naloxone preparations are considered less abusable
- Generic Bupe/Naloxone and Generic Buprenorphine exist and are often formulary preferred.

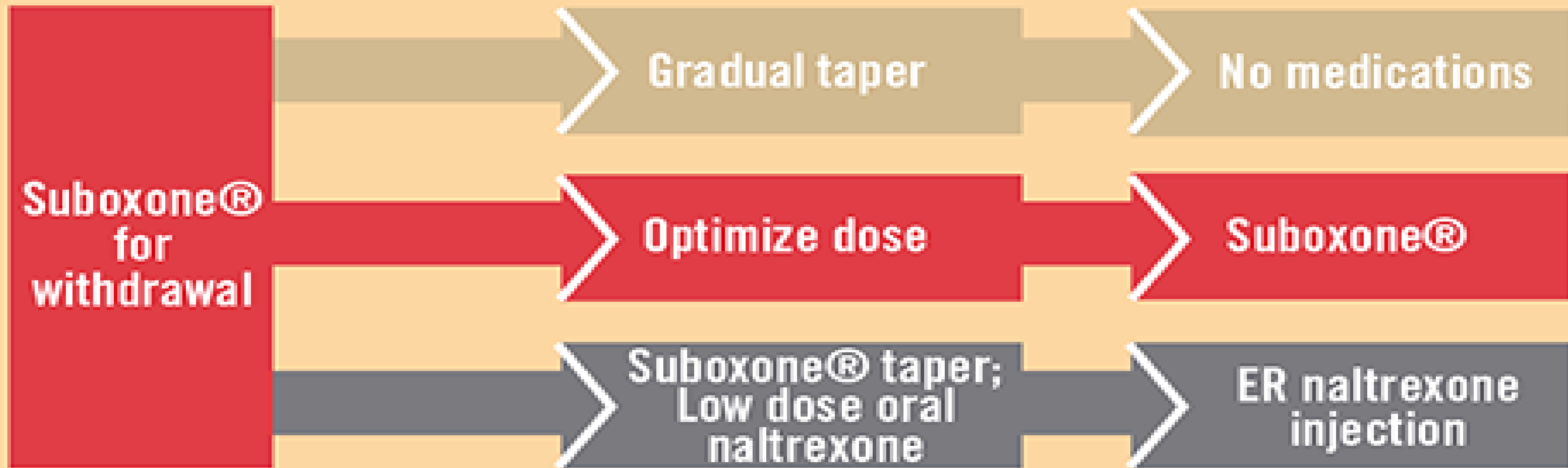
Improves treatment retention, reduces craving and relapse.

- No data are published evaluating 12-Step Facilitation with Bupe/Naloxone
- Longer studies reflect 'maintenance' protocols with rapid tapers at the end of studies.

Illicit use and diversion are common in younger adults.

- Anecdotally, "relapse through" Suboxone is not uncommon.
- Systemic approach to treatment re-engagement, increased level of care.


The COR-12 Path to Lifelong Recovery
PHASE I
RESIDENTIAL
1-3 MONTHS
PHASE II
FLEXIBLE PROGRAMMING
2-6 MONTHS
PHASE III
RECOVERY MANAGEMENT
7-18 MONTHS
PHASE IV
LIFELONG RECOVERY
18 MONTHS - ONGOING
MEDICATION
Gradual Tapering or Discontinuation of Medications
THERAPY
Participating in Individual Therapy, Lectures and Opioid Support Group
RECOVERY RESOURCES
Utilizing Hazelden's Specialized Recovery Resources
TWELVE STEP
Gradual Increase in Twelve Step Group Participation



Medication Pathways
Week 1
Weeks 2–3
Week 4 & Beyond
Suboxone® for withdrawal
Gradual taper
No medications
Optimize dose
Suboxone®
Suboxone® taper; Low dose oral naltrexone
ER naltrexone injection

COR-12 Programming and Pathways

Phase I – Residential: COR-12 Treatment Planning

- Chemical use disorder history and severity
  - Prior treatment history
  - Prior MAT history
- Complicating medical or mental health factors
- Environmental factors
- History of "relapsing through" Suboxone or Vivitrol
  - Must be seen in the context of prior treatment
  - Structure? Monitoring? Patient Centered?

- Individuals involved in treatment planning:
  - PATIENT
  - Interdisciplinary team
  - 3rd Party Referent
  - Family
- Critical components for MAT implementation:
  - Expeditious decision making and communication
  - Begin discharge planning near admission
  - Insurance prior authorization(s)
  - Future prescriber of MAT agent
  - Funding plan
  - Response to patient disengagement from treatment
  - Response to relapse → opioids vs. non-opioids

COR-12 Programming and Pathways

Phase II – Flexible Programming

Options include:

- Intermediate care (halfway house)
- Day Treatment (with or without structured sober living)
- Intensive Outpatient
- Extended Outpatient

* All options required regular urine drugs screens and weekly participation in opioid support group.

COR-12 Programming and Pathways

Phase III – Recovery Management

Continued service options include:

- Sober living
- COR-12 weekly support group
- Weekly continuing care group
- Hazelden Connection
- MORE Recovery Coach
  - My Ongoing Recovery Experience
  - Distance recovery support with monitoring

Additional Components:

- Longitudinal Medical with UDS monitoring
- Developing the discontinuation plan

Discontinuation Elements

Factors continually assessed during phases II – III:

- Strength and stability of recovery program
- Collaboration between patient, physician & 3rd party support
- Goal is for discontinuation of medication by 18 months.

Considering Relapse:

- A percentage of patients relapse during phase II-III
- Reassessment → Appropriate level of care
  - Opportunity to focus on Recovery support
  - Consideration for a different MAT tool, or use a MAT tool if previously a non-medication track patient.

COR-12™ - Integrating Medication-Assisted Treatment with the Twelve Steps for Opioid Use Disorder: Best Practices for Professionals

Overview of how the program works

Preadmission – very different than other preadmissions and a big emphasis on the family

Choosing a pathway – there are three choices

Detoxification (with mild withdrawal vs. severe withdrawal)

Transition to treatment

Continual assessments

Opioid specific recovery support

Lifelong recovery

COR-12™ - Integrating Medication-Assisted Treatment with the Twelve Steps for Opioid Use Disorder: Best Practices for Professionals

Developed and used by HBFF – Now available to all treatment and health care professionals

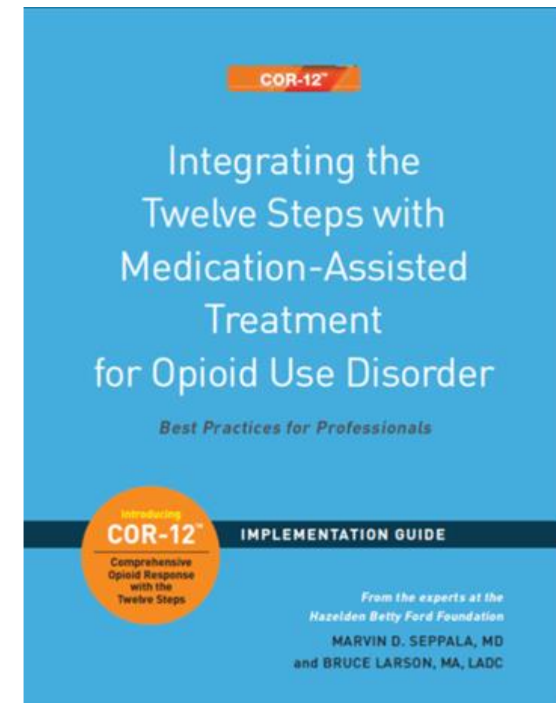
The purpose is to help treatment providers implement a program like HBFF's COR-12™ program

HBFF best practices as they exist today

Gives an overview of the reasons why COR-12™ is needed

Provides step-by-step guidance on to how implement the COR-12™ program

Provides reproducible forms, documents and templates that treatment providers can use to standardize workflows



Compatibility with Centerstone's Addiction Services Model

Vivitrol® is already used for both Opioid Use Disorder and Alcohol Use Disorder

Suboxone® can induce intoxication and can be abused, but primarily for detox or to "get by"

Twelve Step models tend to avoid Suboxone®

Suboxone® For some people these protocols will blur their individual definition of abstinence-based programming

Recovery Oriented focus created multiple access points into the process of recovery.

Our goal will always be discontinuation once recovery is established and consistent recovery behaviors are apparent

Agency Culture Shift

Recovery Oriented Medication Assisted Treatment (RO-MAT) has been guided by Recovery Management principles since inception.

William White is the architect of ROSC and Recovery Management, he defines Recovery Management as:

> *"a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders."*

Agency Culture Shift

Shift aligns with appreciation of addiction as a chronic illness requiring movement from an acute care model to a chronic disease model of care.

Requires programmatic, organizational, and systemic change due to greater understanding of the unique and varied requirements to support the longitudinal process of recovery.

This is a move where we empower the individual and apply a truly patient centered approach, fitting the individual with the skills needed to move from clinical management to self management of their illness.

Recovery Oriented Systems

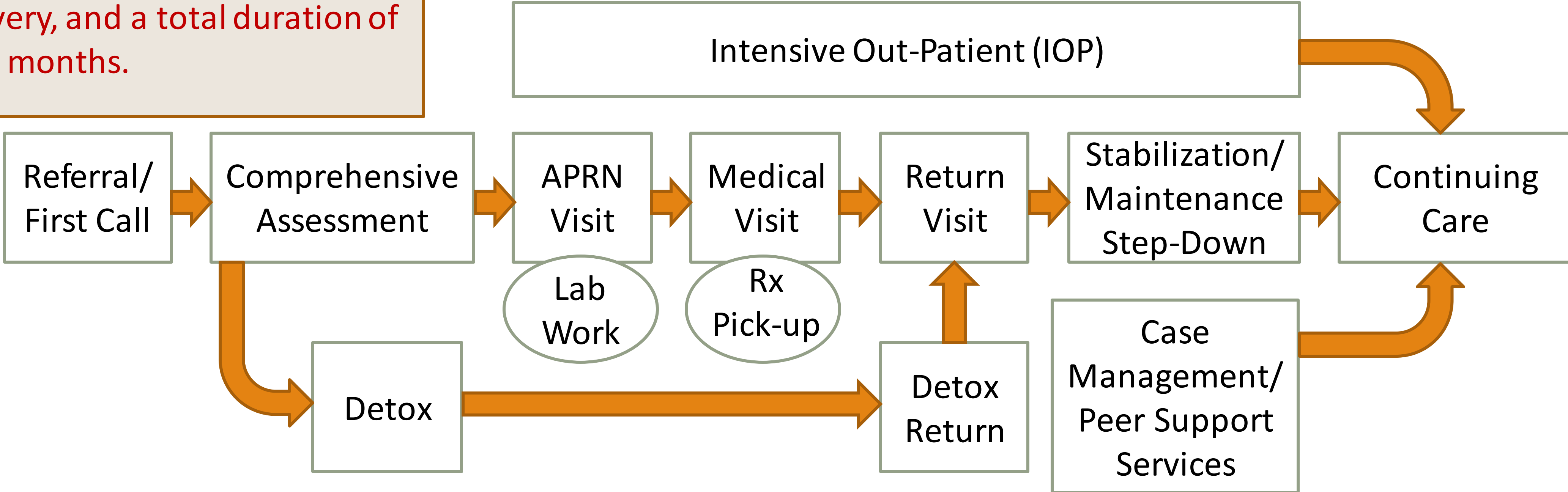
Recovery Oriented Systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems.

Recovery Oriented-Medication Assisted Treatment (RO-MAT)

SYSTEM FLOW AND PROCESSES FOR MULTIPLE TYPES OF SERVICES DELIVERY.

RO-MAT Intensive Outpatient (Satellite Office)

RO-MAT IOP is designed to exist in the community, with a step-down model of services delivery, and a total duration of 8-12 months.



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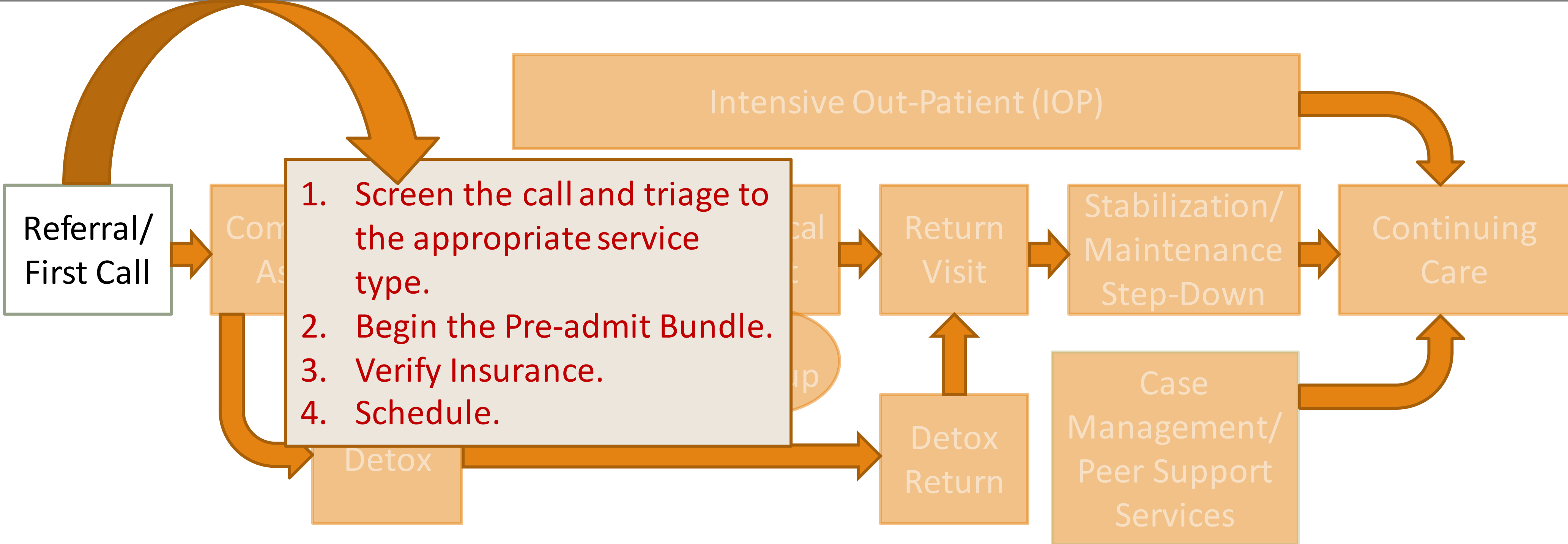

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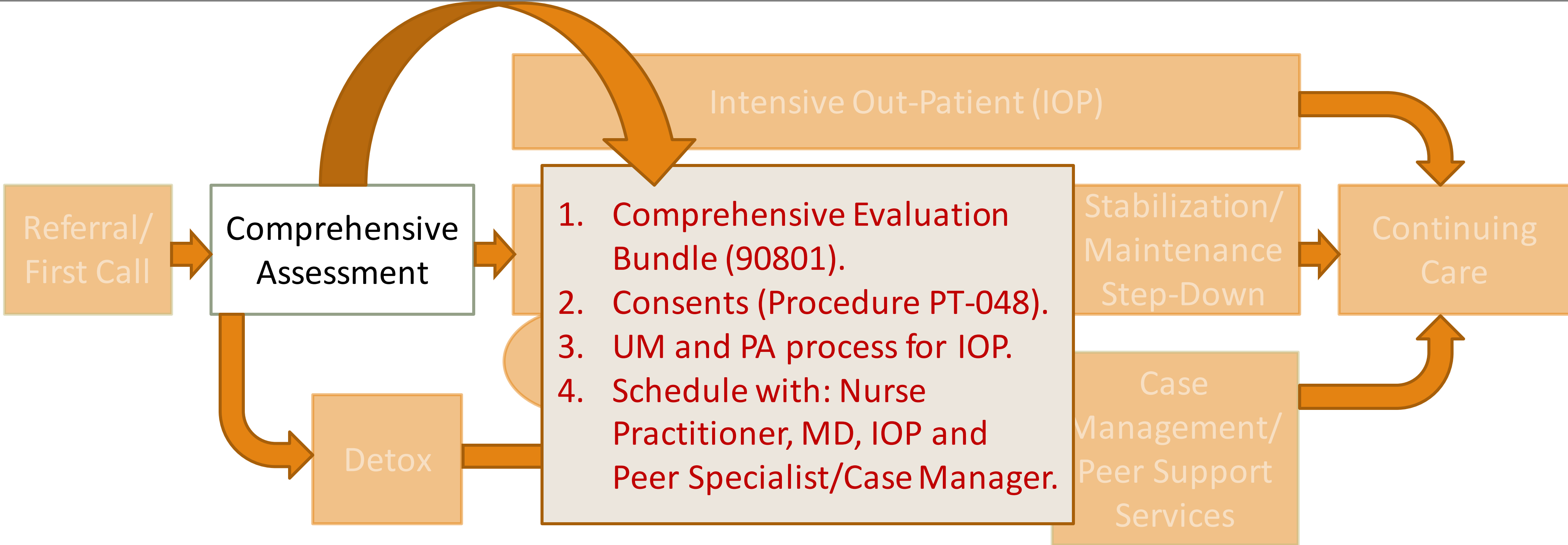

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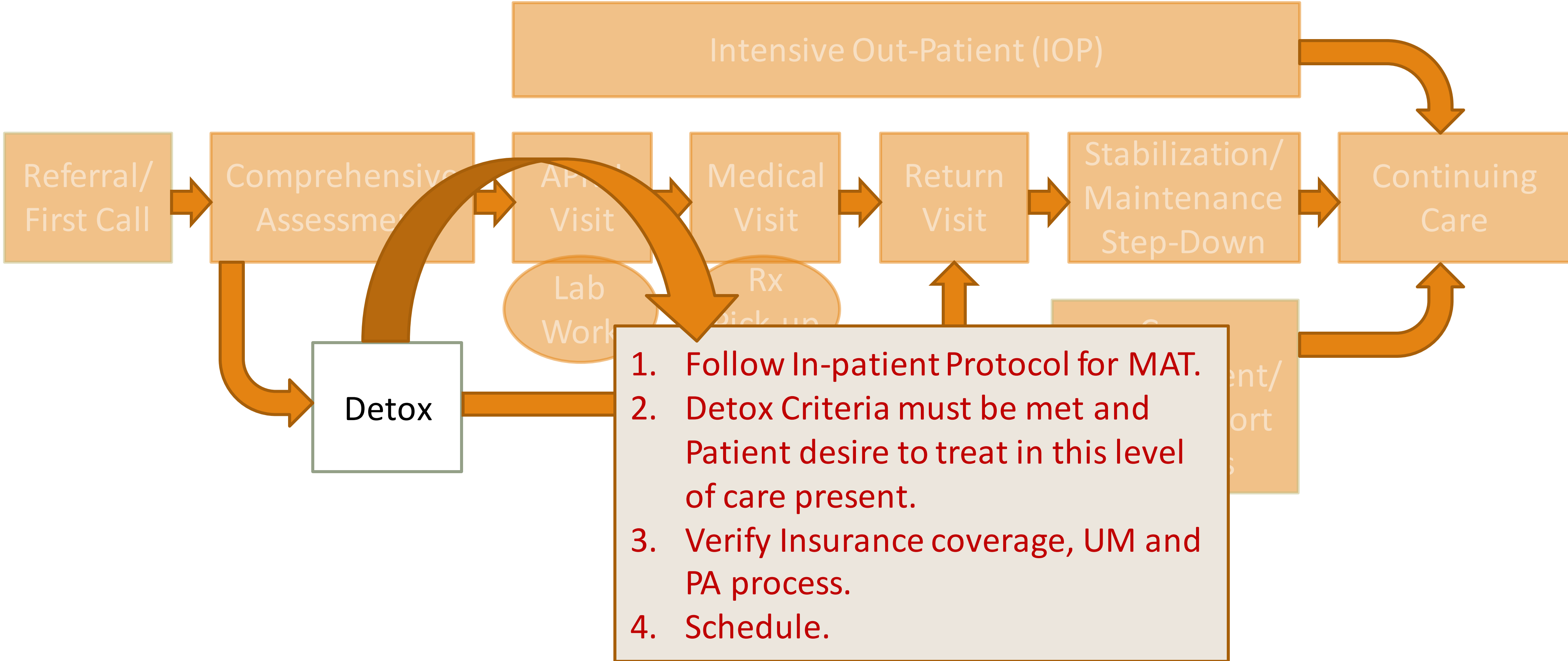
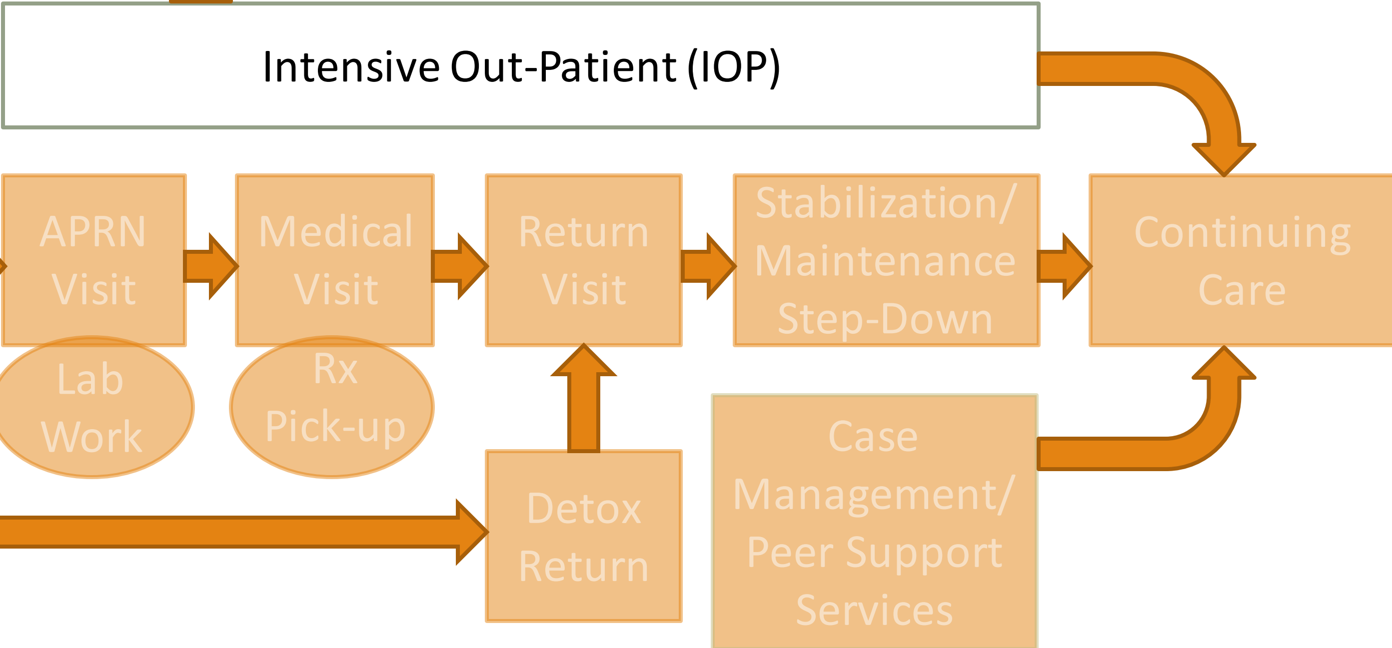


RO-MAT Intensive Outpatient (Satellite Office)

1. IOP begins only if outpatient level of care is the most appropriate and desired patient service.
2. A group and individual format, 8-12 weeks in duration, meeting for 3+ hours per day.
3. Sessions should begin within 3-5 days of the assessment.



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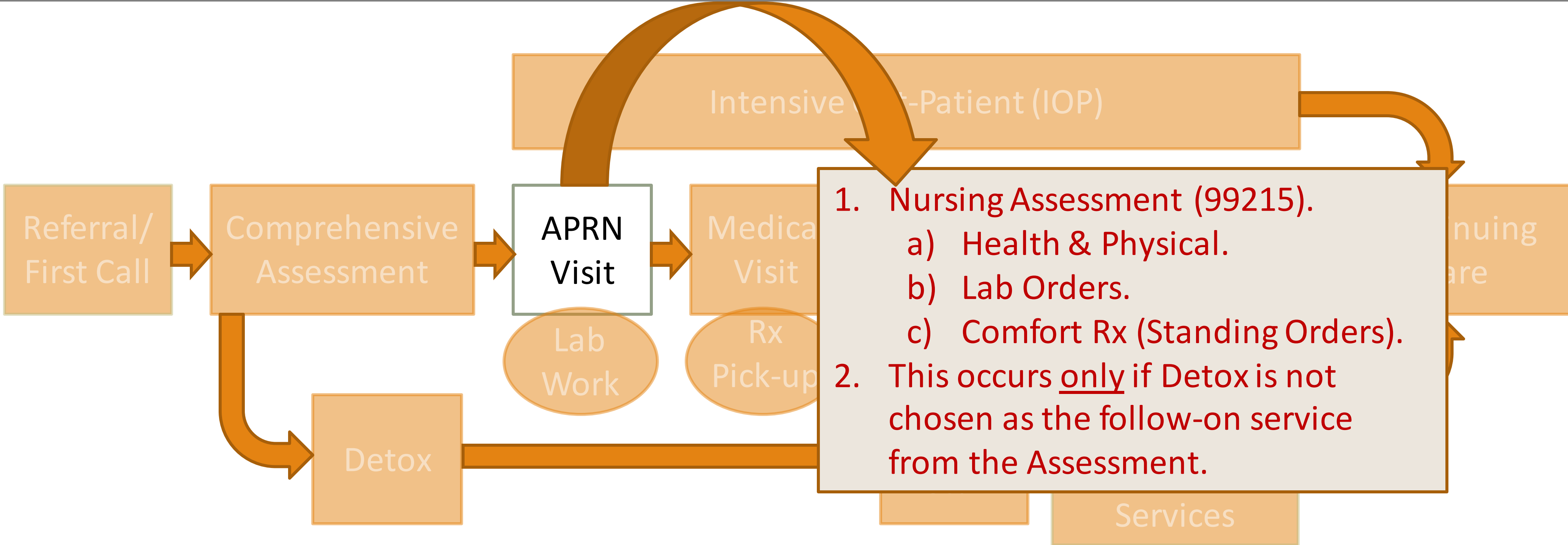

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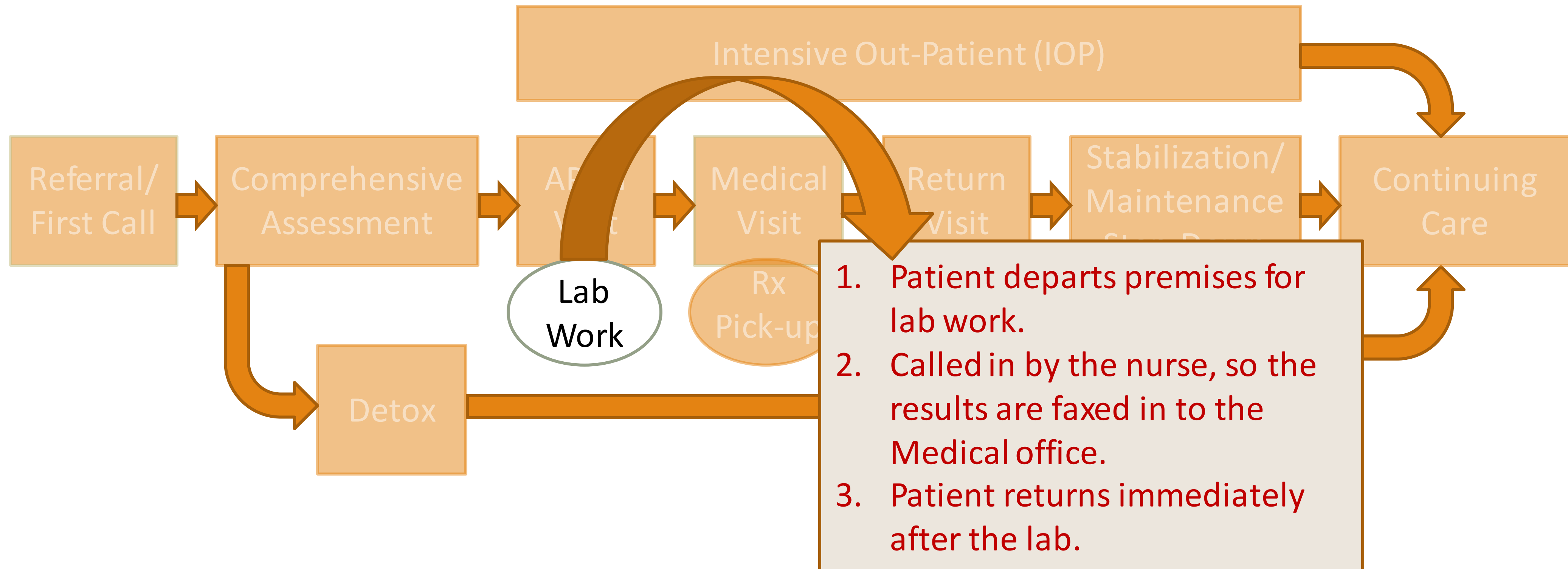

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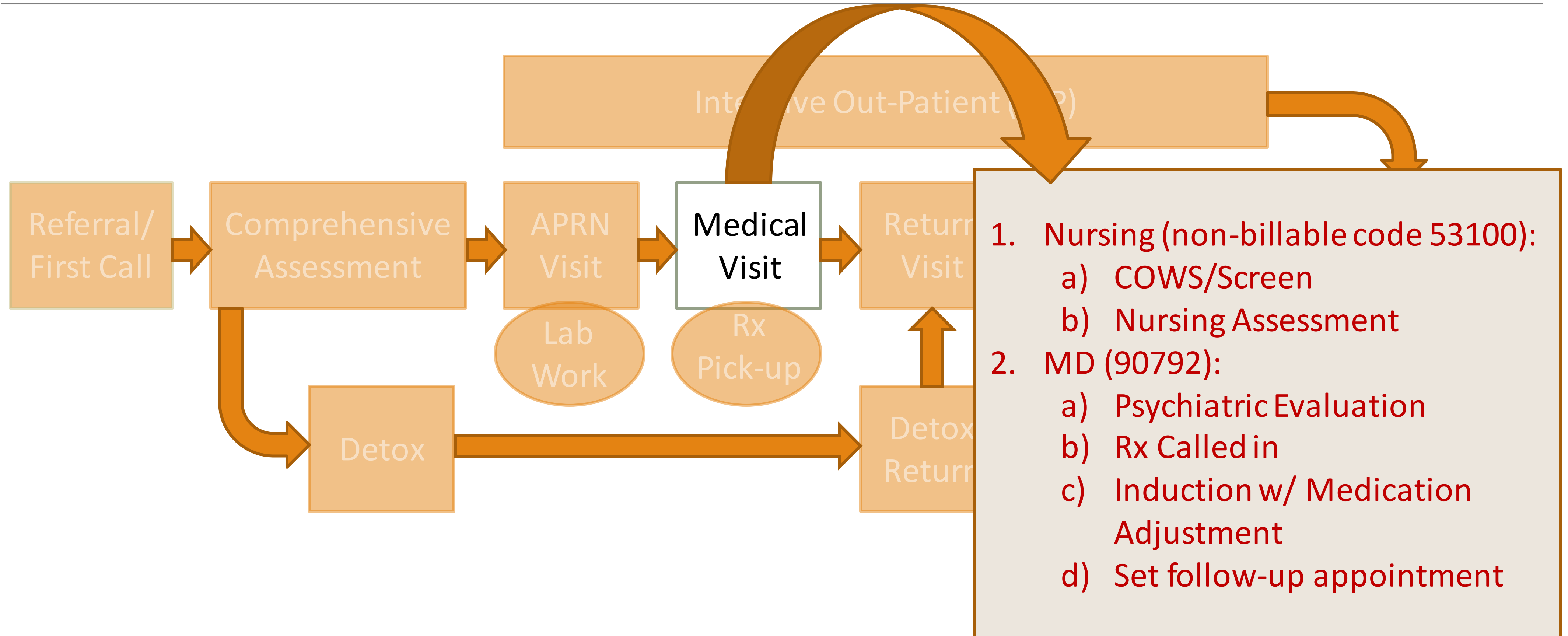

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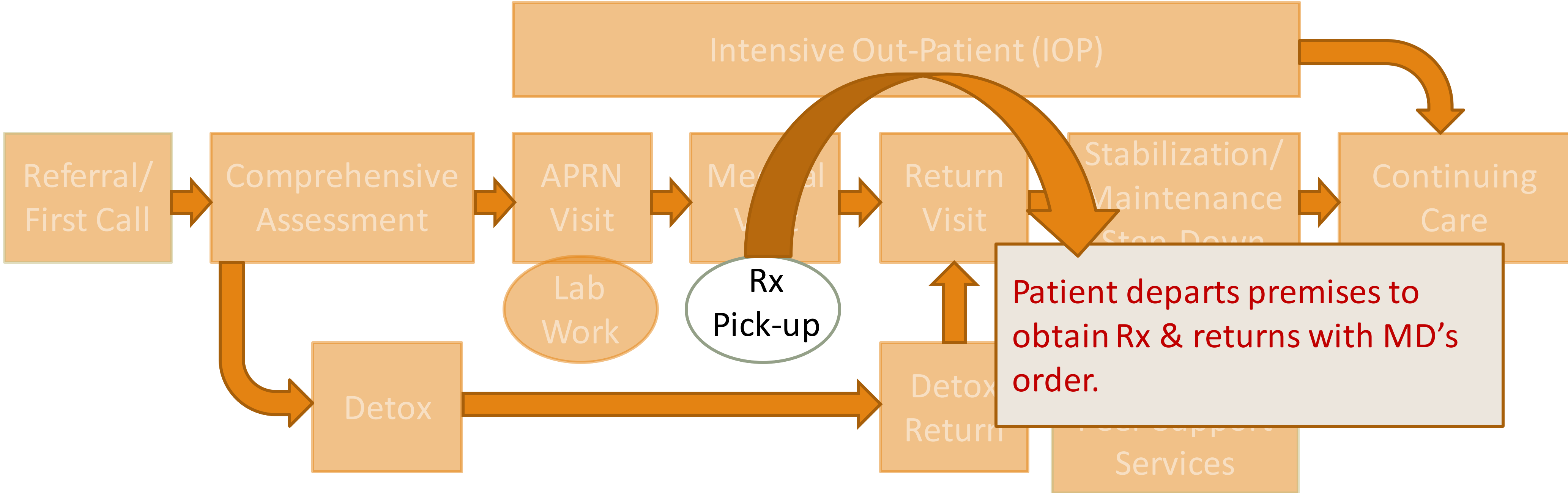

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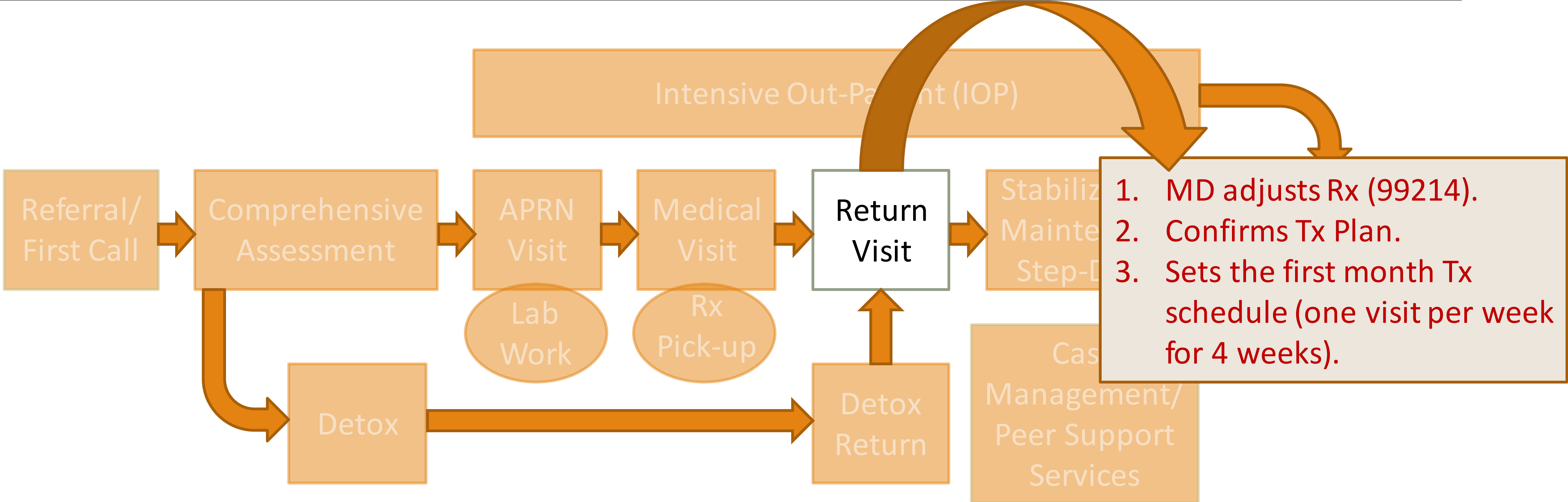

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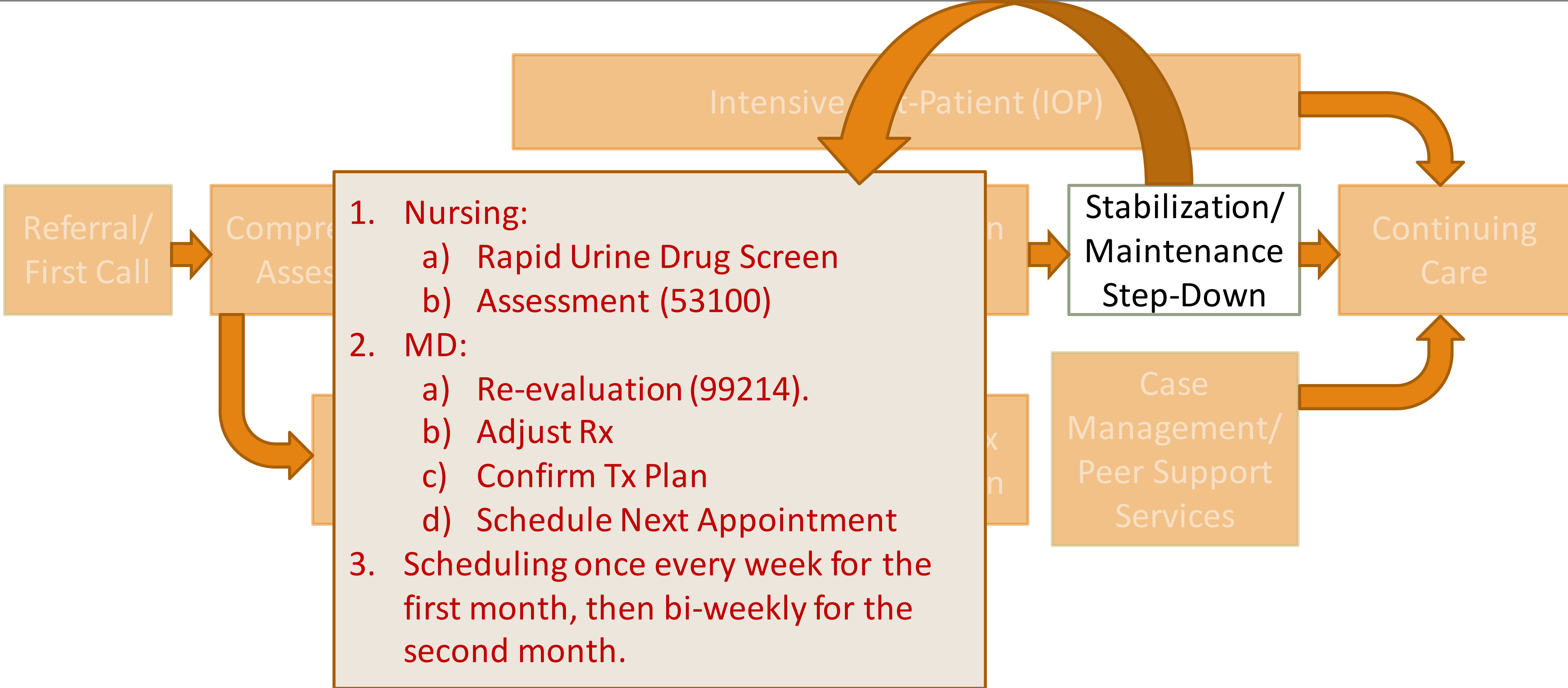

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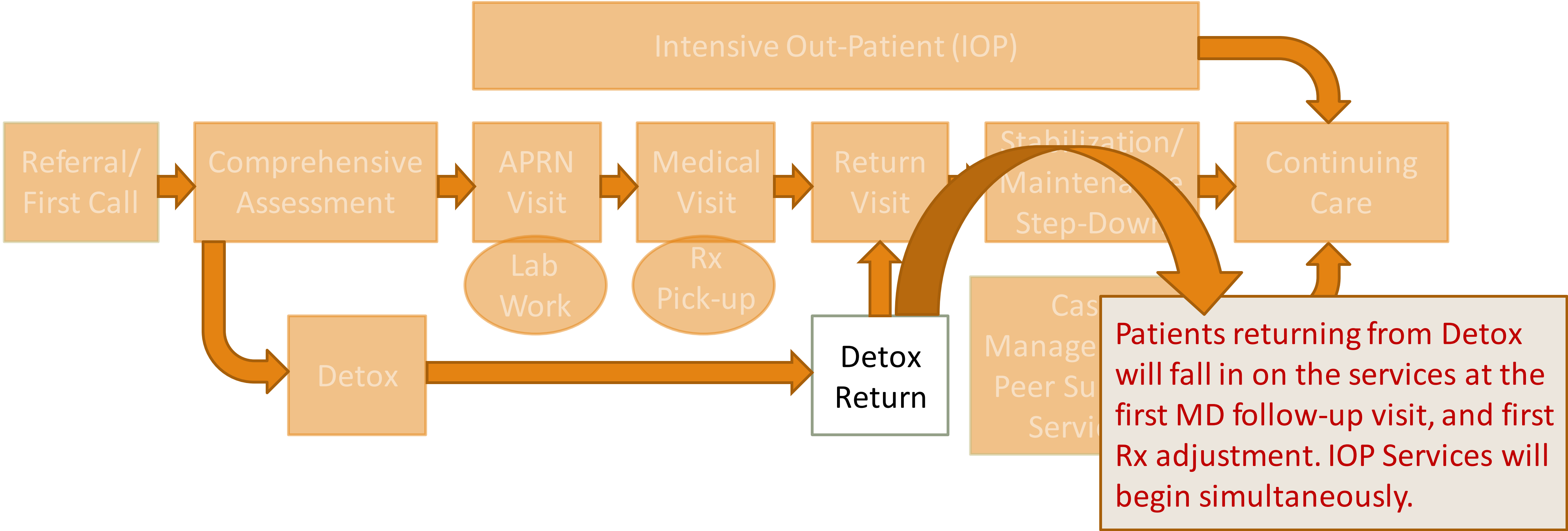

Group Activity

Review Patient Case Studies

Discuss recommended pathway and present

Discontinuation Process

SAMHSA Criteria

ASAM/Stages of Change

Presence of Recovery Program

Discontinuation Process

SAMHSA’S 4 Elements of Recovery

Health – managing medical and MH issues in a healthy way

Home – has a stable and safe place to live

Purpose – has meaningful daily activities, income and resources

Community – has relationships and a social networks that provide support, friendship, love, and hope

Discontinuation Process

Stages of Change and ASAM Dimensions

Evidence of behaviors consistent with the Action Stage across the ASAM dimensions

The presence of action across dimensions for 2 months with a minimum of “staff or other external interventions”

Discontinuation Process

Stages of Change and ASAM Dimensions – Action Behaviors

Intoxication/Withdrawal issues

Medical Stability

Stable and engaged from mental health perspective

Readiness to change behaviors (meetings, sponsorship, family engagement)

Relapse plan, 3rd party support/involvement, awareness about relapse issues

Recovery environment stability, support network

Discontinuation Process

Presence of Recovery Program Indicators

- Strong routine for regular 12 Step meetings
- Benefits from 12 Step meetings
- Works effectively with a sponsor
- Strong connection to the recovery community
- Has strong relapse prevention plan and skills
- Consistently demonstrates responsibility and accountability
- Displays emotional honesty and vulnerability

Group Activity

Develop Workflow for Outpatient

Identify requirements in place and gaps

List 3 actions to close gaps

Implementation Planning

Agency Readiness Assessment

Clinical/Medical Team

Communication Team

Training

Medical Provider Relationships

Case Management/Peer Support

Policies & Procedures

Communication Team

Pre-Admission/Call Center

- Talking Points and Scripts

Family Engagement

- Key Messages and Service Access

Internal Communication Plan

External Communication Plan

Essential Components of Implementation

Call Center/Pre-Entry messaging

- Knowledge of Services Offered
- Explain Assessment Drives Recommendations
- Customer Service and Engagement
- Training in use of Motivational Interviewing:
  - Open Ended Questions
  - Avoid Argumentation
  - Roll with Resistance
  - Support Self Efficacy
  - Express Empathy
  - Reflection of Change Talk

Group Activity

View Pre-Entry Video

- Identify Key Components
- Craft Key Messages/Talking Points for your agency
- Share with small group

SUMMARY

Medications are integral to Comprehensive Recovery Process

- Reviewed The Medications Available and When to Use
- Examined Workforce, Organizational, Environmental and Regulatory issues and opportunities.
- Developed tactics and tools to begin the implementation process in a variety of settings.
- Created key messages and talking points that can be applied at the agency and in the community.

THANK YOU!

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