Medication Assisted Treatment: Setting Up, Operating, Integrating into Primary Care

Ako Jacintho, MD
Director of Addiction Medicine
HealthRIGHT 360

How do you set up your practice?

- **Staff Needed** - Provider with X waiver license, Medical Assistant, RN, Patient Coordinator*

- **Schedule** - Initial visit should be an extended 30 min, all subsequent visits can be 15 minutes

- **Education** - All staff/providers in practice should know about Buprenorphine/Naloxone, Medical model of addiction. Do an entire clinic in-service.

- **Patient Coordinator* Role** - Monitors patient count, patient agreements, PDMP, helps in scheduling and f/u, interviews/forms relationship with patients, helps guide home induction,template design - BA/Computer skills/MI skills

The Operation

- **Patient is identified by Schedulers**- “Medical Treatment for Opiate Use Disorder”; UDS cup is given to patient on arrival for every visit

- **Patient is brought in and evaluated by the MA** - VS, PHQ2, and an “opiate use disorder” **template** is completed by the MA/ Patient Coordinator, PDMP done prior to visit in chart prep

- Provider takes further history, pt meets criteria in **DSMV for OUD Diagnosis (initial visit), F/U is just around adjusting dose**

- **Home Induction/Maintenance -** with Buprenorphine/Naloxone - F/u 3 days(Induction), 1 week, 2 weeks(Stabilization), 4 weeks(Maintenance), BH/Psych ref, Treatment Program ref

TOOLS

- **Template in your EMR** - Design your own! **What info do you want to know from your patients that supports your diagnosis and treatment decision(inclusion criteria)?** Have your assistant(MA, PC, RN) take that history. You focus on medication management. Make the documentation easy for yourself!

- **Buprenorphine/Naloxone Agreement** - inform patients of risks!

- **Home induction handout** for patients! Include clinic phone number and providers name.

- **Resources** - BH, Addiction Specialists, Champion PCP on OUD

- **P&P** - Outlines your anti-diversion practice(PDMP, UDS, Pill Counts), provision of practice

DO’s and Dont's

- **Do** go slowly ! One patient at a time to get the hang of it. Avoid taking on too many patients early on.

- **Do** reach out to those with experience at the beginning. What dose to start with? What if the patient as started it already? What if they are transitioning from methadone? Heroin vs pills? What if they have chronic pain? Who is your champion?

- **Don’t** fire patients from your practice! If they don’t comply, refer them to a higher level of care, like a residential treatment center, or Methadone clinic.

- **Don’t** think you cannot do this! You are going to save a life!

Home Inductions: Treating the most common Patient Profile types

ACTIVE AND CURRENT USE OF HEROIN AND ILLICIT USE OF PRESCRIPTION OPIOIDS

NON-ACTIVE USERS OF HEROIN PRESENTING WITH CRAVINGS TO USE

PATIENTS ON METHADONE MAINTENANCE WHO WANT TO SWITCH TO BUPRENORPHINE/NALOXONE

PAIN MANAGEMENT PATIENT WITH OPIOID USE DISORDER

ACTIVE AND CURRENT USE OF HEROIN AND ILLICIT USE OF PRESCRIPTION OPIOIDS

- **HPI, PMHx, Drug Hx, PDMP, UDS**

- **Rx Buprenorphine/Naloxone tabs 2-4mg to start 24-36 hours after past drug use, then increase to total of** 8 mg on day 1. Day 2 = 8 -12 mg, Day 3 = up to 16 mg.

- **RX medications for withdrawal including Clonidine, Diphenhydramine, Hydroxyzine, Trazodone**

- **Return to clinic 3 days, Assess, then f/u at 7d,14d, 28d. Each visit with UDS, BH ref**

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PATIENTS ON METHADONE MAINTENANCE WHO WANT TO SWITCH TO BUPRENORPHINE/NALOXONE

- **HPI, PMHx, Drug Hx, PDMP, UDS, ROI**

- **Rx Buprenorphine/Naloxone tabs 1 -2 mg to start 24-36 hours after last Methadone use, then increase to total of 8 mg on day 1. Day 2 = 8 -12 mg, Day 3 = up to 16 mg. Should dose every 2 - 4 hours for w/d Sx**

- **RX medications for withdrawal including Clonidine, Diphenhydramine, Hydroxyzine, Trazodone**

- **Return to clinic 3 days, Assess, then f/u at 7d,14d, 28d. Each visit with UDS, BH ref**

PAIN MANAGEMENT PATIENT WITH OPIOID USE DISORDER

- **HPI, PMHx, Drug Hx, PDMP, UDS, Pain Hx**

- **Rx Buprenorphine/Naloxone tabs 4 mg to start 24-36 hours after last opioid use, then increase to total of 8 mg on day 1. Day 2 = 8 -12 mg, Day 3 = up to 16 mg. May need higher dose due to pain.**

- **RX medications for withdrawal including Clonidine, Diphenhydramine, Hydroxyzine, Trazodone**

- **Return to clinic 3 days, Assess, then f/u at 7d,14d, 28d. Each visit with UDS**

- **Refer to pain specialist, BH**