MEDICATIONS FOR ADDICTION TREATMENT GUIDE

Key components for delivering community-based, medications for addiction treatment services for opioid use disorders in Alaska.

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Second Edition

CONTENTS

INTRODUCTION

While writing the second edition of the MAT Guide, the editing team would like to pause and recognize COVID-19's impacts on the delivery of services in the medical and behavioral health fields. More than ever, providers are adapting to a world of telemedicine, to tailoring interventions for patients with increased comorbidity and polysubstance use, and to increased patient isolation. We want to extol providers for rising to the challenges inherent with the pandemic and we would like to acknowledge the vital role you have in keeping Alaskans healthy.

This revision incorporates several updates, including the new 2020 ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (OUD), a chapter on medications for alcohol use disorder (AUD), and the emphasis on a non-stigmatizing approach. To reflect these changes, the MAT Guide has been renamed Medications for Addiction Treatment Guide from the previous Medication-Assisted Treatment Guide. While "Medication-Assisted Treatment" is widely used to describe the use of opioid agonist therapy, we believe that it underestimates the effectiveness of medication, overlooks the significant research supporting the effectiveness of medication for the treatment of addictions, and it creates an unintentional double standard since no other medication used to treat health conditions is referred to as "assisted" treatment.[1] The field of addiction medicine has advanced and understands MAT as medications for addiction treatment, but for the purposes of this guide the older terminology will be used in reference to previous publications and research.

The MAT Guide will attempt to reduce stigma whenever possible and use medically accurate and person-first language. The MAT Guide defines addiction as a treatable chronic medical disease. Research has repeatedly shown that pharmacotherapy can be effective as a stand alone intervention; however the current evidence supports the effectiveness of MAT for individuals experiencing OUD with addressing necessary psychosocial and recovery supports. The editing team reorganized the sections for better flow and for providers to find information easier. We made a conscious effort to pair our multiple links to up-to-date resources most pertinent to health care providers and increase Alaska-specific resources.

Section 1, *MAT Implementation or Expansion*, contains practical material on how to start office-based opioid treatment, including relevant federal and state requirements, the buprenorphine waiver process, billing and telemedicine. Due to an increase in provider and legal team questions regarding the interpretation of the current Alaska state statues regulating the practice of telemedicine, the Alaska State Medical Board is currently reviewing the regulations and plans to issue a clarifying statement to assist providers in understanding these regulations. Their final statement was still pending at the time of publication of this guide. The medical board did review and approve of the interpretation of the statues as written in this guide.

Please check the State Medical Board website for updates.

On January 14, 2021, the U.S. Department of Health and Human Services announced forthcoming Practice Guidelines for the Administration of Buprenorphine for Treatment Opioid Use Disorder. Unfortunately, the announcement was made prematurely. Therefore, the Guidelines previously announced cannot be issued at this time. However, HHS and ONDCP are committed to working with interagency partners to examine ways to increase access to buprenorphine, reduce overdose rates and save lives.

Section 2, *Clinical Considerations*, addresses topics essential to providing services to meet the current standard of care for MAT. A new chapter, Patient Communications, focuses on the barriers to effective patient communication and methods to avoid them. Another new chapter, Understanding and Preventing Buprenorphine Diversion, has strategies and resources to reduce diversion of medications.

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1 Wakeman, SE. Medications for addiction treatment: changing language to improve care. J Addict Med. 2017: 11:1-2. doi: 10.1097/ADM.0000000000000275.

Section 3, *Medications,* has been revised to reflect new information about the various medications used in addiction treatment. A new chapter, Overview of Alcohol Use Disorder Medications, has been added to reflect the importance of addressing co-occurring OUD and AUD.

Section 4, *Targeted Topics and Populations*, has been expanded to include relevant topics like Patients with Pain, Hepatitis C and MAT in Rural Alaska.

We hope that you find the second edition more user-friendly and more Alaska-centered. We welcome any input you may have for the third edition. Questions about the MAT Guide can be sent to Heather Phelps at heather.phelps@alaska.gov.

Finally, we would like to thank the following professionals for taking time away from their busy schedules to help with the creation of the second edition:

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SECTION 1

MAT IMPLEMENTATION OR EXPANSION

CHAPTER I: GETTING STARTED

Office-based opioid treatment (OBOT) refers to outpatient treatment services provided outside of licensed opioid treatment programs (OTPs) by providers to patients with addiction involving opioid use. OBOT in Alaska most typically includes a prescription for the partial opioid agonist buprenorphine or the provision of naltrexone with other medical and psychosocial interventions to achieve and sustain remission.[1] OBOTS do not dispense methadone for of OUD. Methadone is dispensed by an OTP.

Many components are involved in the development, implementation and integration for OBOT. Formal structuring of office systems facilitates efficient patient care. Federal and state requirements, best practice recommendations, and resources are identified in this section to assist with the initiation or expansion of office-based opioid treatment programs. Alaska also has a Statewide Opioid Action Plan which identifies promoting responsible prescribing and dispensing policies and practices.

Federal and State Requirements and Recommendations

Federal and State Requirements and Recommendations	Alaska Recommendations

▪ Obtain buprenorphine waiver to prescribe
▪ Conduct full evaluation and medical exam
  ▪ Verify patient meets criteria for an opioid use disorder
  ▪ Verify patient is appropriate for MAT
▪ Provide regular office visits
▪ Document care properly (e.g. treatment plans, confidentiality)
▪ Ensure capacity to refer patients for appropriate psychosocial counseling and other recovery support services
	▪ Enroll and credential with managed care organizations, qualified health plans, and other insurers
	▪ Query the prescription drug monitoring program (PDMP) each time a prescription for a federally Scheduled II or III controlled substance is written, administered or directly dispensed
	▪ Perform routine and random drug tests
	▪ Perform routine and random pill/film counts
	▪ Practice timely communication among the MAT provider, the patient and other providers
	▪ Establish a core team of qualified staff to deliver MAT
	▪ Provide initial and on-going training and resources to all staff

Buprenorphine Waiver Process

To receive a waiver to practice OUD treatment with approved buprenorphine medications, a provider must notify the SAMHSA Center for Substance Abuse Treatment (CSAT) of their intent to practice this form of MAT. Information about applying for a practitioner waiver is found on the SAMHSA website.

Qualified practitioners consist of physicians, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse-midwives (CNMs).

After approval, qualifying practitioners can treat up to 30 patients using buprenorphine for the treatment of opioid use disorder in the first year. Certain providers may immediately begin treating up to 100 patients if they hold specific board certifications, or if they provide medications for the treatment of opioid use disorder in a qualified practice setting. After one year at the 30-patient limit,

1 American Society of Addiction Medicine. Public Policy Statement on the Regulation of Office-Based Opioid Treatment. www.asam.org/docs/default-source/public-policy-statements/statement-on-regulation-of-obot.pdf?sfvrsn=df8540c2_2. Published Jan. 17, 2018. Accessed Nov. 24, 2020.

qualifying practitioners can apply to increase their patient limit to 100, and again after the second year to 275.[2] 42 CFR 8.655 defines circumstances in which qualifying practitioners may request a temporary increase to treat up to 275 patients to address emergency situations.

Physicians do not need a waiver to prescribe buprenorphine for pain in a patient without OUD, however, the medication may not be covered by the patient's insurance.

Resources for the Buprenorphine Waiver and Patient Limits

- Buprenorphine Waiver Management ASAM
- Buprenorphine Patient Limits History and Overview

Buprenorphine Waiver Trainings

Under the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians are required to complete an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine.

NPs, PAs, CNSs, CRNAs, and CNMs must obtain no fewer than 24 hours of initial training or they may take both the eight-hour DATA-waiver course and the additional 16-hour course offered for free by SAMHSA through the Providers Clinical Support System.

- American Society of Addiction Medicine (ASAM)
  ASAM also offers waiver courses with a focus on OB-GYN and criminal justice populations
- Providers' Clinical Support System for Medication for Addiction Treatment (PCSS)
- Harvard Medical School OUD Courses
  Harvard has partnered with PCSS and SAMHSA to approve two of their OUD courses to count toward the 24-hour requirement (8 hours for each course) for NPs and PAs
- American Psychiatric Association

Starting an OBOT

Further steps required to establish an OBOT include:

- The individual provider will need a professional license to practice the medical profession in the state of Alaska. The individual provider or the entity employing the provider needs a business license. The State Medical Board also has detailed information for this process.
- To bill Medicaid, the provider will need to enroll in the Alaska Medicaid Program. The Division of Health Care Services has information and resources for this process.
- The Division of Behavioral Health manages Behavioral Health Medicaid. If the provider wants to bill for provided behavioral health services, contact mpassunit@alaska.gov. Providers will need to be familiar with the Alaska Behavioral Health Provider Standards and Administrative Procedures Manual for SUD and for Behavioral Health Treatment.

The DBH website has information about evidence-based practices for MAT.

The PCSS has a Business Plan for Medication-Assisted Treatment. This document is a helpful resource to assess organizational readiness, provide an overview of clinical best practices, develop the timeline for services, and establish a financial plan.

2 Medication assisted treatment statutes, regulations, and guidelines. U.S. Substance Abuse and Mental Health Services Administration. Updated October 7, 2020. Accessed November 24, 2020. www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines

In the appendix section of this guide is a MAT Quality Planning tool. Providers may use the MAT Quality Planning tool to assist in developing an OBOT.

Prescription Drug Monitoring Program (PDMP)

The Alaska PDMP grants access to system accounts to practitioners and approved delegates to enter and review controlled substance dispensing information for their patients. Per Alaska law:

1. Prescribers review data prior to prescribing, administering and directly dispensing a schedule II or III controlled substance to ensure appropriate treatment according to established safe standards of practice. Per federal standards 85 FR 42015, Opioid Treatment Programs should enter data in the PDMP. At this time, the state is determining a process for this.
2. Each dispenser is required to submit information into the PDMP regarding every prescription dispensed for a Schedule II, III, or IV controlled substance. In accordance with transmission methods, information is submitted daily by the close of business on the next business day from the date the prescription was dispensed.

Register with the Alaska Prescription Drug Monitoring Program

Visit the Alaska Department of Commerce, Community and Economic Development's website for detailed instructions on how to sign up and use Alaska's PDMP.

Staffing: The Core Team

Establishing a core team dedicated to patient care and service coordination is fundamental for MAT.[3] The core team is comprised of interested and qualified staff who embrace the attitudes, values, and competencies associated with treating patients with substance use disorders. The team may also partner with other agencies to provide comprehensive treatment services to meet individualized patient's needs.

The core team ideally contains a provider, a care coordinator, a qualified addiction professional, and non-clinical administrative staff. If the MAT program does not have SUD treatment services on-site, it is recommended that formal agreements be established with SUD services to further support a patient's recovery.

It's recommended that all of the core team have the same basic training about addiction being a treatable, chronic medical disease, available pharmacotherapy, and addressing stigma around SUD. Staff also need ongoing confidentiality training. Resources for training staff and developing the core team can be found at Care Innovations.org and Providers' Clinical Support System Developing a Behavioral Treatment Protocol in Conjunction with MAT.

Provider

The provider is a DEA licensed prescriber (MD/DO/NP/PA) holds a waiver to prescribe buprenorphine. Their duties consist of diagnosing SUD, reviewing an intake history and performing physical exams. The provider works with the patient to choose the most appropriate medications for addiction treatment, develops a treatment plan with the patient, and supervises the initiation onto MAT. The provider performs routine follow-up visits, monitors treatment progress and reevaluates the treatment plan.

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3 U.S. Substance Abuse and Mental Health Services Administration. Medication assisted treatment for opioid addiction in opioid treatment programs (Treatment Improvement Protocol Series, No. 43.) https://store.samhsa.gov/product/Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4108. Published January 2012. Accessed November 25, 2020.

Care Coordinator

The care coordinator facilitates communication between the provider, the qualified addiction professional, and the patient. Duties include routine support to patients outside of office visits, conducting drug testing and pill/film counts, and linking the patient to recovery support services. Additionally, the care coordinator monitors SUD treatment attendance and routinely provides and obtains updates from external providers. Depending on the structure and capacities of the MAT setting, a case manager, medical assistant, physician's assistant, nurse, or another staff member may assume the role of care coordinator.

Qualified Addiction Professional (QAP)

Studies have found that MAT programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.[4] An on-site qualified addiction profession (QAP) will help promote and support behavior change. A qualified addiction professional is a licensed behavioral health clinician or certified chemical dependency counselor who provides SUD counseling (individual, group and family), reviews treatment progress as identified on the treatment plan and assists with linkages to recovery supports in the community.

Administrative Staff

Administrative staff are frequently responsible for obtaining patient intake information and consents, handling the billing, and other accounting procedures. Most importantly, they are the first person the patient comes in contact with and can establish a welcoming and non-stigmatizing tone for the patient's experience of the OBOT.

CHAPTER 2: BILLING INSURANCE COVERAGE AND TELEMEDICINE

MAT can be covered through different payer/payment mechanisms to include cash and third-party payers. It is recommended that office-based opioid treatment programs credential with third-party payers to ease patients' ability to access and pay for rendered services. For non-insurance patients, providers will need to establish the cost of services, when and how payment will be collected, and a protocol to address late payments and partial payments.

Insurance/Third-Party Payer Reimbursement

Providers will need to enroll and credential with managed care organizations (MCOs), qualified health plans (QHPs), and other insurers. The MCOs and other third-party carriers use specific strategies to help manage the prescribing of addiction medicines. Providers will need to be familiar with the requirements of each carrier and the time it takes to meet requirements prior to prescribing medication. This will decrease the possibility that the patient is responsible for unpaid claims. Providers also should review payer billing standards and rules with respect to office visits, travel, medication quantity limits and preferred agents.

Medicaid

Buprenorphine

Alaska Medicaid currently covers all forms of buprenorphine, although sublingual mono-buprenorphine is covered only for pregnant and lactating females. No prior authorization is required for the first 30 days of buprenorphine for patients new to treatment (who have not filled a buprenorphine prescription within the last 60 days). Providers need to complete a prior authorization (PA) to continue the patient's buprenorphine prescription past the first month and the PA needs to be renewed every six months.

Prior authorization may also be completed more quickly over the phone by calling:

Magellan Medicaid Administration at 800-331-4475

A provider may be granted a waiver for completing prior authorizations for buprenorphine by completing an Alaska Medicaid MAT Provider Standards of Care Attestation form.

Monthly injectable XR buprenorphine (Sublocade) prescriptions should be faxed or called into Magellan Specialty Pharmacy. The pharmacy will then ship the medication directly to the clinic for administration.

Magellan Specialty Pharmacy at 866-554-2673, Fax 867-364-2673

Other MAT Medications

Alaska Medicaid covers both oral and injectable naltrexone, naloxone nasal spray, disulfiram and acamprosate, all without prior authorization.

As formularies may change over time, check the Alaska Division of Health Care Services website for current medications covered.

Urine Drug Testing

Alaska Medicaid covers urine drug testing with limitations on quantities. Currently Medicaid covers 20 presumptive (screening) tests and 20 definitive (confirmatory) tests per calendar year. For more information on coverages and billing codes read the Alaska Medicaid Policy Update on Drug Screening/Testing.

Telemedicine in Alaska

Telemedicine is the delivery of health care services using the transfer of medical data through audio, visual, or data communications that are performed over two or more locations by a provider who is physically separated from the recipient of the health care services (AS 44.33.381). Standards of practice for telemedicine can be found at 12 AAC 40.943. Information about telemedicine in Alaska is located in the Division of Public Health's Telehealth in Alaska and Telemedicine webpage. Recently, two small pilot studies demonstrated that MAT provided via telemedicine modalities is equally as effective as face-to-face MAT for individuals diagnosed with opioid use disorder.[4] More research is needed to examine the effectiveness of telemedicine in rural areas.

Before providing telemedicine services to a patient located in Alaska, the business providing telemedicine services must register on the telemedicine business registry and have a valid Alaska business license.

Medicaid Coverage of Telemedicine in Alaska

Required documentation for a telemedicine visit:

Distant site (patient not at the clinic)

1. Statement that the service was provided using telemedicine
2. Physical location of the patient
3. Location of the provider
4. Names of all persons participating in the telemedicine service and their role in the encounter
5. Documentation must meet current procedural terminology (CPT) guidelines

Patient site (patient in the clinic)

1. Date of service
2. Name of patient
3. Name of distant site provider
4. Name of the patient-site presenter
5. Documentation must meet CPT guidelines

For Medicare telemedicine billing information, visit the Centers for Medicare and Medicaid Telehealth Services Booklet.

Alaska State Medical Board Telemedicine Guidelines

The Alaska State Medical Board's policies and procedures for telemedicine can be found at Board Guidelines and Policies and at Alaska Administrative Code 12 AAC 40.943. Physicians may render a diagnosis, provide treatment, or prescribe, dispense or administer a prescription drug that is a controlled substance, to a patient with whom they do not have an established relationship with on the initial visit, without first conducting a physical exam; however:

4 Yang YT, Weintraub E, Haffajee RL. Telemedicine's role in addressing the opioid epidemic. Mayo Clin Proc. 2018;93(9):1177-1180. doi:10.1016/j.mayocp.2018.07.001

- The treating physician must be licensed by the Alaska State Medical Board.
- The treating physician, another licensed health care provider, or a physician in the treating physician's group practice must be available to provide follow-up care.
- The treating physician must request that the patient consent to sending a copy of the records to the patient's primary care provider (if the treating physician is not the primary care provider).
- A physically separated physician may prescribe, dispense or administer a controlled drug only if an appropriate licensed health care provider (MD, DO, PA or NP) is physically present with the patient.

A physician may not prescribe, dispense, or administer:

- A prescription drug in response to an internet questionnaire or electronic mail message to a person with whom the physician does not have a prior physician-patient relationship.

Due to an increase in provider and legal team questions regarding the interpretation of the current Alaska state statues regulating the practice of telemedicine, the state medical board is currently reviewing the regulations and plans to issue a clarifying statement to assist providers in understanding these regulations. The medical board did review and approve of the interpretation of the statues as written in this guide.

Physicians who work for the Indian Health Service/Alaska Native Tribal Health system can apply for a special IHS designation to be exempt from the in-person examination requirement with more information at the Indian Health Service webpage for the Internet Eligible Controlled Substance Provider Designation.

The federal government is also in the process of establishing a Federal Telemedicine Registry that will allow eligible registered prescribers to be exempt from the initial in-person examination requirement, expected to be released in late 2020 or early 2021.

For details about providing telemedicine visits to rural Alaska locations please see section on Rural MAT.

Prescribing Buprenorphine via Telemedicine

On May 15, 2018, the U.S. Drug Enforcement Agency issued the "Use of Telemedicine While Providing Medication-Assisted Treatment" statement to clarify how providers can use telemedicine as a tool to expand buprenorphine treatment for opioid use disorder under current DEA regulations.

- **U.S. Department of Health and Human Services:** Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder
- **Congressional Research Service:** Telehealth and Telemedicine: Frequently Asked Questions

SECTION 2

CLINICAL CONSIDERATIONS

CHAPTER 3: THE ASAM CRITERIA

The American Society of Addiction Medicine (ASAM) Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer or discharge of patients with addiction and co-occurring conditions. Required in over 30 states, including Alaska, the ASAM Criteria provides a nomenclature for describing the continuum of addiction services. The ASAM Criteria's multidimensional assessment accounts for a patient's needs, obstacles, and liabilities, as well as their strengths, assets, resources, and support structure. This information is used to determine the appropriate level of care across a continuum.[1] A qualified addiction professional (typically a licensed behavioral health clinician or certified chemical dependency counselor) will complete a substance use disorder assessment using the ASAM Criteria.

Reasons to use the ASAM Criteria:

- It is the universal standard used by insurance companies to categorize care types and determine coverage.
- It uses a holistic approach to determine individualized and outcome-driven treatment plans for patients.
- It covers a service spectrum from assessment through treatment.
- It provides one common language for assessing patient needs.[2]

The Six ASAM Dimensions

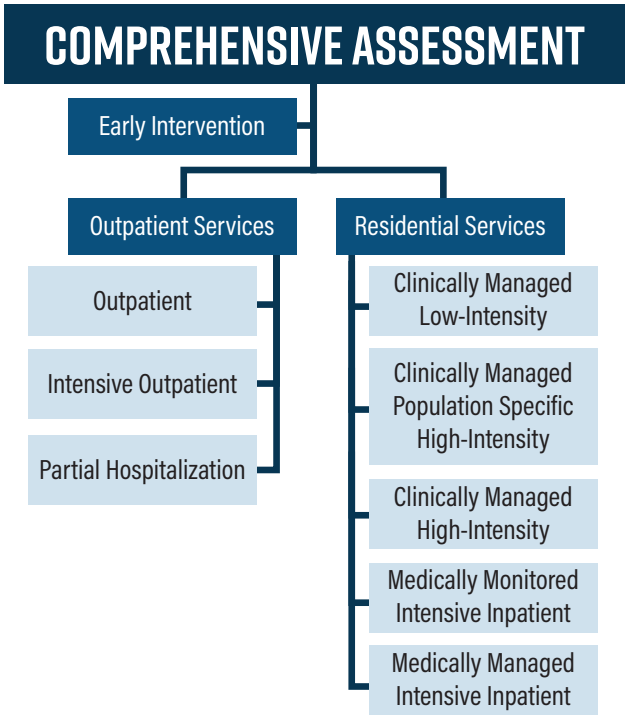
The ASAM explores six different dimensions to create an all-inclusive and comprehensive assessment used for service planning and treatment.

Dimension 1	Intoxication and/or withdrawal potential
Dimension 2	Biomedical conditions and complications
Dimension 3	Emotional, behavioral, cognitive conditions and complications
Dimension 4	Readiness to change
Dimension 5	Relapse/continued use/ continued problem potential
Dimension 6	Recovery environment

Alaska Levels of Care

The ASAM Alaska Levels of Care describe a continuum of clinical addiction treatment services, increasing in intensity from level 1 to level 4. Each level of care refers to a broad category of services and treatment formats offered to patients. For a handout that describes the levels of care, please visit recoveryanswers.org.

The Alaska Levels of Care are defined in the Alaska Behavioral Health Provider Service Standards and Administrative Procedures for SUD Provider Services.



1 About the ASAM Criteria. American Society of Addiction Medicine. Accessed January 5, 2021. www.asam.org/asam-criteria/about?gclid=EAIaIQobChMIz-PD-tbzw6gIVWR-tBh2e2A2CEAAYASABEgJQ7_D_BwE

2 About the ASAM Criteria.

CHAPTER 4: SCREENING, ASSESSMENT AND TREATMENT

When meeting with a patient, it is essential to determine the extent of the substance use disorder. After a diagnosis is determined through a comprehensive assessment, a course of treatment is developed based on the patient's individual needs in collaboration with the provider's clinical expertise. If the patient has co-occurring disorders and/or comorbid medical conditions, referrals to psychosocial and/or medical services are recommended. While in treatment, the provider and patient continually assess treatment progress and adjustments to pharmacotherapy as indicated. The majority of this section is based on SAMHSA's TIP 63: Medications for Opioid Use Disorder and on the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.

SCREEN

- Use validated screening tools
- Alcohol, tobacco, and substance misuse (including opioids)
- If individual screens positive for risk of harm from substance use, then assess

ASSESS

- Determination of OUD and/or AUD diagnosis and severity, including intoxication or withdrawal
- Include patient medical, social, psychiatric, SUD and family histories
- Laboratory and drug testing
- Query the PDMP

TREATMENT OR REFERRAL

- Determine treatment plan
- Offer or refer for psychosocial treatment based on individual need
- Refer to SUD treatment if applicable

Screening

"An evidence-based method used to detect, reduce, and prevent problematic substance use and substance use disorder." [3] Please note that including tobacco use disorder as part of the medical assessment for substance misuse is recommended. Tobacco use disorder causes significant morbidity/mortality, and medications are also available for treating this disorder.

- SAMHSA recommends that health care professionals screen patients for alcohol, tobacco, prescription drug, and illicit drug use at least annually.
- Examples of screening tools: AUDIT, NIAAA, TAPS
- Screening can identify substance misuse or indicate a possible substance use disorder.
  - For substance misuse:
    - Brief counseling and monitoring/follow up may be indicated.
  - For a possible substance use disorder:
    - Conduct an assessment to determine if the patient meets criteria for an SUD.
    - Brief counseling/treatment referral and consideration for pharmacotherapy may be indicated.

Assessment

"An ongoing process used to determine the medical, psychological, and social needs of individuals with substance-related conditions and problems. It can take the form of biological assays (e.g., blood or urine samples), as well as clinical diagnostic interviewing and the completion of self-report measures to determine the presence of a substance use disorder or other mental health condition, and other symptoms and challenges with the ultimate goal of developing a fully informed and helpful treatment and recovery plan."[4]

An assessment is conducted if any of these conditions are present:

- Patient screens positive for substance misuse.
- Patient discloses substance misuse.
- Signs and symptoms of substance misuse are present.
- Patient asks for an assessment or for treatment.

The extent of an assessment depends on a provider's ability to

3 Addiction-ary. Recovery Research Institute. www.recoveryanswers.org/addiction-ary. Accessed January 5, 2021.

4 Addiction-ary. 3.

treat patients directly:

- If a provider does not offer pharmacotherapy, the focus is on medical assessment, making an OUD and/or AUD diagnosis, and patient safety.
- If the provider offers pharmacotherapy, a comprehensive assessment is initiated.
- Completion of the assessment should not delay or preclude initiating pharmacotherapy for OUD or AUD.

A comprehensive assessment includes:

- Determination of OUD and/or AUD diagnosis and severity.
- Obtaining the patient's history and current information in the medical, social, mental health, family and substance use domains.
  - Identification of co-occurring mental health disorders.
  - Identification of contraindicated medications.
  - Identification of psychosocial issues.
- Physical examination.
- Laboratory and drug testing.
- Querying the Prescription Drug Monitoring Program (PDMP).

Determination of OUD and/or AUD Diagnosis and Severity

OUD and/or AUD diagnosis is primarily based on patient history and the comprehensive assessment, including a physical examination. Validated clinical scales to measure withdrawal symptoms and drug testing may also be used. The provider must confirm the OUD and/or AUD diagnosis before pharmacotherapy starts.[5] The use of cannabis, stimulants, and/or other addictive drugs should not be a reason to withhold or suspend MAT.[6]

Does my patient have an opioid use disorder? American Psychiatric Association DSM 5

- Tolerance*
- Withdrawal*
- Use in larger amounts or duration than intended
- Persistent desire to cut down
- Giving up interests to use opioids
- Recurrent use resulting in failure to fulfill major role obligations
- Recurrent use in hazardous situations
- Continued use despite physical or psychological problems
- Mild OUD is 2-3 criteria, moderate OUD is 4-5 criteria, severe OUD is 6 or more criteria

**This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision*

Withdrawal Signs and Symptoms

If the patient is experiencing severe withdrawal symptoms, they may be unable to participate or complete the comprehensive assessment process. To manage and treat withdrawal symptoms for OUD or AUD, the patient may require a stabilizing dose of buprenorphine for opioid withdrawal and/or a prescription for benzodiazepines for alcohol withdrawal. Alcohol withdrawal syndrome can be severe and potentially fatal, so it is particularly important to assess the need for medically managed withdrawal.[7] Patients who need medically supervised detoxification may need to be referred to an addiction specialist or addiction treatment program that can provide medically monitored withdrawal treatment.[8]

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5 American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. www.asam.org/Quality-Science/quality/2020-national-practice-guideline. Published March 2020. Accessed January 5, 2021

6 *ASAM National Practice Guide.*

7 U.S. Substance Abuse and Mental Health Services Administration. *Detoxification and Substance Abuse Treatment* (Treatment Improvement Protocol Series, No. 45.) store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131. Published October 2015. Accessed January 5, 2021.

8 U.S. Substance Abuse and Mental Health Services Administration. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*. store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907. Published October 2015. Accessed January 5, 2021.

Examples of two validated clinical scales to measure withdrawal symptoms:

- Clinical Opiate Withdrawal Scale (COWS).
- Clinical Institute Withdrawal Assessment of Alcohol Revised Scale (CIWA-Ar).

Patient History

Part of the comprehensive assessment incorporates the patient's substance use history and related disorders, medical history, mental health history, family and social networks, and assessment of available recovery resources ("recovery capital"). "These endeavors help uncover the many interrelated factors affecting the patient's functioning and life and assess a patient's readiness to change. This careful and comprehensive assessment can help prevent missing aspects or minimizing important aspects of a person's life, such as trauma or chronic pain, inattention to which could compromise recovery success."[9]

An intake questionnaire can assist with collecting social information, and intake history and physical templates can assist providers with their documentation.

Physical Examination

- Concomitant medical conditions.
- Infectious diseases (tuberculosis, hepatitis B and C, HIV).
- Pregnancy .
- Signs and symptoms of SUD withdrawal or intoxication.
- Any acute trauma.
- Any medical consequences of misuse.

Laboratory Testing

If possible, pregnancy and drug urine tests should be run before starting pharmacotherapy. Additional lab testing may be collected in the following few weeks of initiation and stabilization. Depending on the results of these tests follow up may be required.

- Liver function tests.
- Infectious disease (tuberculosis, hepatitis B and C, HIV).
- Sexually transmitted diseases.
- Pregnancy test.

Query the PDMP

Providers review data prior to prescribing, administering and directly dispensing scheduled medications to ensure appropriate treatment according to established safe standards of practice.

Treatment/Referral

Providers consider the patient's preferences, past treatment history, current state of illness, and treatment setting when deciding which medication to prescribe.[10] Discussing the risks and benefits of each medication, medication costs, and alternatives to pharmacotherapy can assist in determining the most appropriate course of treatment. Informing the patient of what treatment will entail and the expectations of treatment is also important. A MAT treatment plan or agreement can be a helpful tool to document and clarify treatment expectations and promote treatment engagement. The plan can identify the length and frequency of office visits, the length of time between prescriptions or injections, the frequency of drug testing, and psychosocial/medical treatment and referrals.[11] MAT treatment plans are reviewed and amended with the patients periodically as patients progress/destabilize and new goals emerge.

A treatment plan is educational and informational, promotes treatment engagement and identifies:

- Treatment goals.
- Conditions for changing or stopping treatment.
- Therapeutic contingencies for nonadherance and failure to meet initial goals.
- Expectations.

9 Guide: 11 Indicators of Quality Addiction Treatment. Recovery Research Institute. www.recoveryanswers.org/resource/effective-addiction-treatment-what-makes-a-good-addiction-treatment-program/. Accessed January 5, 2021.

10 *ASAM National Practice Guide*. 5.

11 U.S. Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder* (Treatment Improvement Protocol Series, No. 63.) www.samhsa.gov/ebp-resource-center/tip-63-medications-opioid-use-disorder. Published June 1, 2019. Accessed January 5, 2021.

Treating the whole person will improve the likelihood of substance use disorder recovery and remission. Integrated medical and behavioral health care delivery can effectively provide patient-focused, comprehensive treatments that address the full range of symptoms and service needs that patients with OUD frequently have.[12] Ideally, treatment comprises a comprehensive approach to directly address co-occurring mental health disorders and/or co-morbid medical concerns. If this is not available, the provider refers the patient to the needed services. If the provider refers the patient to mental health and/or SUD treatment, the following are suggested:

- Establish strong working relationships or formal agreements with providers offering different levels of care and recovery support services.
- Review psychosocial treatment expectations and responsibilities with the patient.
- Obtain signed releases of information from the patient for open communication.
- Routinely provide and obtain updates from the other providers to consistently monitor treatment adherence and progress.

Because OUD is often a chronic and relapsing illness, patients may have different types and durations of treatment over their lifetimes.

Referral to psychosocial services and SUD treatment are covered more in depth under Psychosocial Treatment and Recovery Support Services in chapter 4. For more information about SUD treatment services in Alaska, the appendix has a resource page on Finding SUD Treatment in Alaska.

Monitoring Treatment Progress

Per the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, there is no recommended time limit for pharmacological treatment. The best results occur when a patient receives medication for as long as it provides a benefit. This approach is called "maintenance treatment." [13, 14]

Office visit frequency should not depend only on dosing schedule for long-acting OUD/AUD medications. It is recommended that patients be seen approximately once a week until they demonstrate significant reductions in or abstinence from illicit substance use. After a patient regularly demonstrates treatment adherence to therapeutic doses of OUD/AUD medication, decreases in illicit drug and alcohol use, and increases in negative opioid and/or alcohol drug screen results, consider less frequent office visits. As office visits become less frequent, consider random urine drug testing, medication counts, and involvement of recovery supports if available.[15]

When in maintenance treatment, the provider:

- Assesses medication effectiveness and side effects.
- Assesses medication adherence, including drug testing and checking the PDMP.
- Assesses functional status (home, work, school).
- Monitors use of alcohol and illicit drugs.
- Provides brief supportive counseling.
- Refers/follows up on recovery support services.
- Refers/follows up on mental health disorder, substance use disorder and medical treatment.
- Adjusts the frequency of visits based on individual need.
- Engages and educates family members with patient's permission.

Monitoring Progress Indicators

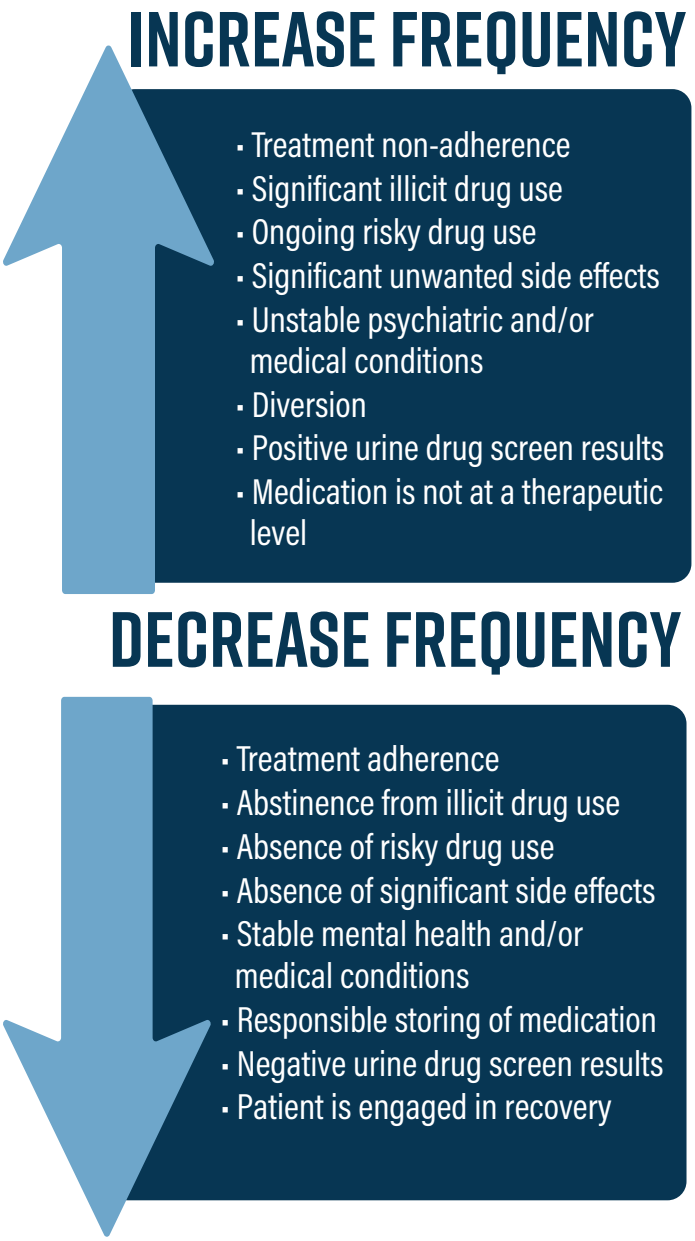
The chart illustrates typical indicators when to increase or decrease the frequency of office visits.

12 Chou R, Korthuis PT, Weimer M, et al. *Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings.* Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Dec. (Technical Briefs, No. 28.) https://effectivehealthcare.ahrq.gov/products/opioid-use-disorder/technical-brief/

13 Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews.* 2009(3), 1–19. DOI: 10.1002/14651858.CD002209.pub2.

14 Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews*. 2014(2), 1-84. DOI: 10.1002/14651858.CD002207.pub4

15 *Medications for Opioid Use Disorder*. 7.



Before increasing the frequency of office visits with a patient, it is important to find out the underlying reasons a patient is engaging in a behavior. For example, a patient may not attend appointments consistently due to a transportation or child care issues. This is very different than a patient missing appointments because they are ashamed of misusing an opioid one time to alleviate a migraine or missing appointments because they have been injecting heroin on a daily basis and are afraid of legal ramifications. Having an open and honest discussion to find out a patient's motivation for treatment nonadherence, illicit drug use, or a positive urine drug test can increase the likelihood for patient re-engagement.

In addition to increasing the frequency of office visits with a patient, the provider may employ other strategies to increase treatment engagement and medication adherence:

- Adjust medication dosage.
- Switch to extended release injectable medication.
- Shorten prescriptions.
- Increased urine drug tests and medication counts.
- Increased recovery support services.
- Increase family/primary support involvement.
- Refer patient to a more intensive level of care.
- Initiate contingency management.

Medication may need to be adjusted in certain situations. Prescriptions from another medical or psychiatric provider are reviewed to determine if they may negatively interact with the current pharmacotherapy regimen. Pregnancy, surgery and a significant increase in life stressors are also examples of events that may trigger the need for medication adjustment.

Treatment Discontinuation

A patient may request to stop pharmacotherapy for many reasons, and it is essential that providers discuss the risks and benefits of discontinuing treatment. Providers should work to counsel patients against discontinuation of MAT during the following high-risk situations:

- During pregnancy or early postpartum.
- During high stress times.
- During surgery/hospitalization.
- Due to pressure from family and/or friends.

If, after counseling the patient about the risks of discontinuing MAT during these high-risk times, the patient still requests to stop MAT, that is ultimately the patient's choice. Providers are encouraged to 'keep the door open' if the patient changes their mind and decides to restart pharmacotherapy in the future.

If the patient requests to discontinue AUD MAT, the provider helps the patient taper from the AUD medication at an appropriate pace and, as indicated, encourages the patient to continue with psychosocial therapies and participation in mutual-help groups.[16] For patients with OUD, caution unstable

16 *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.* 5

patients from discontinuing treatment because of high rates of return to illicit opioid use and increased chance of overdose death.[17] If the patient is unstable, consider offering another MAT medication as an alternative prior to discontinuing MAT altogether. If the patient still wishes to discontinue pharmacotherapy for OUD and/or AUD:

- Taper the medication as appropriate.
- Encourage the patient to attend psychosocial treatment and recovery support services.
- Give information about overdose prevention.
- Prescribe naloxone (OUD specific).

Psychosocial Treatment & Recovery Support Services

Pharmacotherapy is often combined with other therapies to enhance treatment efficacy and remission outcomes. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.[18] Per the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, the patient is offered or referred to psychosocial treatment based on their individual needs.

Psychosocial Treatment

Psychosocial treatment encompasses non-pharmacological treatments, or 'talk therapies,' found in counseling and psychotherapy. Psychosocial treatment can be offered to an individual, to a group, and/or to a family. This can be done in either an outpatient setting or within a residential treatment setting. These types of treatments:

- Help people attain and maintain motivation to change addictive behaviors (e.g., motivational interviewing, motivational enhancement therapy, contingency management).
- Teach skills to help prevent recurrence of substance use (e.g., cognitive-behavioral therapies (CBT)).
- Link patients to community-based resources to help sustain remission and enhance recovery over time (e.g., Twelve-Step Facilitation).
- Can also involve significant others such as a marriage or domestic partner (e.g., behavioral couple's therapy) or one or more family members (e.g., family therapy) in an attempt to help attain and sustain remission from a substance use disorder. [19]

The Patient Communications chapter has more detailed information about psychosocial therapies.

Group Visits

A group visit integrates psychosocial treatment with the medical office visit. A group visit involves the provider and a behavioral health counselor co-facilitating a group with a ten-minute individual medical appointment preceding or following the group. These visits can offer mutual support to the patients as well as facilitated therapeutic discussions and education. They may also allow the provider to consolidate their appointment schedule and provide treatment services with more time efficiency. For more information about group visits check the Care Innovations website for a section on group visits and refill visits.

Recovery Support Services

Recovery-oriented care and recovery support systems help people with mental and substance use disorders manage their conditions successfully.[20] The belief that people can overcome their substance use challenges is the foundation of recovery. Recovery addresses the whole person and their community and is supported by peers, friends and family members.[21] In recovery-oriented systems of care, the expectation is that contact with the patient will continue after the acute stage of treatment is completed and that recovery support services are

17 Gibson A, Degenhardt L, Mattick RP, Ali R, White J, O'Brien S. Exposure to opioid maintenance treatment reduces long-term mortality. *Addiction*. March 2008;103(3):462-8. doi: 10.1111/j.1360-0443.2007.02090.

18 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Treatment Improvement Protocol (TIP) Series, No. 43.) Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. www.ncbi.nlm.nih.gov/books/NBK64164/

19 Involving family members in substance use disorder treatment can enhance patient outcomes. RecoveryAnswers.org. www.recoveryanswers.org/research-post/involve-family-in-treatment-enhance-substance-use-disorder-outcomes/. Accessed January 6, 2021.

20 Recovery and Recovery Support. samhsa.gov. www.samhsa.gov/find-help/recovery. Updated April 23, 2020. Accessed January 6, 2021.

21 What is Recovery? hhs.gov. www.hhs.gov/opioids/recovery/. Reviewed August 30, 2020. Accessed January 6, 2021.

extended to family members and to people who may not have remained in treatment.[22] Recovery support services can be accessed at community-based recovery centers or recovery community organizations like Recover Alaska and Recovery Support Alaska.

Alaska Community-Based Recovery Centers

- The Bridge Fairbanks
- Alaska Mental Health Consumer Web
- Alaska Youth and Family Network
- CHOICES Inc.

Peer Support Groups (not an exhaustive list)

- Alcoholics Anonymous (AA)
- 12 Step Recovery Groups in Alaska
- Alaska Dream Center (faith based)
- SMART Recovery
- Women for Sobriety
- Alaska Women's Recovery Project

Peer Recovery Support Services

Peer recovery support services provide non-clinical peer support that help engage, educate and support the patient as they make the necessary changes to recover from SUD.[23]

State grant funded peer support programs:

- Set Free Alaska
- Central Peninsula General Hospital
- JAMHI Health and Wellness
- Interior Alaska Center for Non-Violent Living

Recovery Residences

Recovery residences are alcohol and drug free living facilities for individuals recovering from alcohol or other drug use disorders that serves as an interim living environment between withdrawal management experiences or residential SUD treatment and mainstream society. These are known as sober houses, sober living houses, sober living homes, or sober living environments. Alaska currently has eight grant funded recovery residence homes located in Fairbanks, Anchorage, Wasilla, Seward and Kenai. Click on this link to find more information about sober housing in Alaska.

22 The Role of Recovery Support Services in Recovery-Oriented Systems of Care. Rockville, MD: Center for Substance Abuse Treatment. 2008. U.S. Dept. of Health and Human Services. facesandvoicesofrecovery.org/wp-content/uploads/2019/07/The-Role-of-Recovery-Support-Services-in-Recovery-Oriented-Systems-of-Care-.pdf. Accessed January 6, 2021.

23 What is the Evidence for Peer Recovery Support Services? RecoveryAnswers.org. www.recoveryanswers.org/research-post/what-is-the-evidence-for-peer-recovery-support-services. Accessed January 6, 2021.

CHAPTER 5: DRUG TESTING

Drug tests are designed to measure whether a substance has been used within a particular window of time and are only one of several methods for detecting substance use or monitoring treatment.[24] Drug testing is a therapeutic tool and is not performed as a punitive measure. Results can be shared to enhance treatment motivation, to reinforce abstinence and to discuss discrepancies between self-reported substance use and substances detected during testing. As drug testing is a complicated topic, this guide will highlight key concepts. Providers requiring more detailed information about drug testing are referred to the following links:

- Appropriate Use of Drug Testing in Clinical Addiction Medicine
- Urine Drug Testing in Clinical Practice
- ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine Pocket Guide

Drug testing can inform the provider of vital information about the efficacy of pharmacology, treatment adherence and opportunities for patient engagement.

MONITORS
- Abstinence
- Response to medication treatment

DETECTS
- Nonadherence
- Return to illicit opioid use or other substance use

PROVIDES
- Information to supplement patient's self-report
- Information to improve treatment plans

Testing Types

Urine samples are the easiest to obtain, therefore are the biological sample that is most widely utilized, although tests using other samples such as blood, hair, saliva, sweat and nails (toenails and fingernails) exist. Oral fluid drug tests (available as confirmatory send-out test only) are beneficial in situations when the patient is unable to produce a urine specimen. Oral fluid drug tests can be witnessed and collected over a telemedicine visit and mailed for processing.

APPROXIMATE DRUG TESTING DETECTION TIMES

Substance	Urine	Saliva
Alcohol	3-5 days (ETG metabolite)	12-24 hours
Amphetamines	1-5 days	12 hrs-3 days
Benzodiazepines (short-term use)	7 days	6-48 hours
Benzodiazepines (chronic use)	4-6 weeks	6-48 hours
Cannabis (intermittent use)	2-7 days	2-24 hours
Cannabis (chronic use)	30 days	2-24 hours
Opioids (short acting)	2-4 days	1-3 days
Opioids (methadone/buprenorphine)	3-7 days	1-3 days

Actual detection times vary depending on the limit of detection for the test used. In general, hair follicle testing detects most substances used in the past 90 days. The detection time for substances in oral fluid is much shorter than in the urine.

Testing Categories

Presumptive (Rapid Screening) Tests

Rapid urine drug screening tests (available both in hospital settings and CLIA-waived for in-office use) use immune assays to provide simple and rapid positive/negative results. Presumptive tests are helpful to guide the discussion with a patient in the office and for routine monitoring and assessment. They provide quick results and are very inexpensive, however they have very high rates of false positives and false negatives. The following table gives examples of some possible causes of a false positive result.[25]

24 *ASAM National Practice Guide*. 5.

25 Pawlowski J, Ellingrod VL. Urine drug screens: When might a test result be false-positive? *Current Psychiatry*. 2015 October;14(10):17,22-24. www.mdedge.com/psychiatry/article/103088/urine-drug-screens-when-might-test-result-be-false-positive

Prescription drugs, over-the-counter products, and foods that could trigger a false-positive result in urine immunoassays[26]

PRESCRIPTION DUGS, OVER-THE-COUNTER PRODUCTS, AND FOODS THAT COULD TRIGGER A FALSE-POSITIVE RESULT IN URINE IMMUNOASSAYS	
Amphetamines	Amantadine, brompheniramine, bupropion, chlorpromazine, desipramine, desoxyephedrine, ephedrine, isometheptene, isoxsuprine, labetalol, phentemine, phenylephrine*, phenylpropanolamine, promethazine, pseudoephedrine*, ranitidine*, selegiline, thioridazine, trazodone, trimethobenzamide, trimipramine
Barbiturates	Ibuprofen*, naproxen*
Benzodiazepines	Oxaprozin, sertraline
Cannabinoids	Dronabinol, efavirenz, hemp-containing foods*, ibuprofen*, ketoprofen, naproxen*, piroxicam, promethazine*, proton pump inhibitors*, sulindac, tolmetin
Cocaine	Coca leaf teas (de-cocainized)*
LSD	Amitriptyline, dicyclomine, ergotamine, promethazine, sumatriptan
Methadone	Chlorpromazine, clomipramine, diphenhydramine*, doxylamine, ibuprofen*, quetiapine, thioridazine, verapamil
Opiates	Dextromethorphan*, diphenhydramine*, fluoroquinolones, poppy seeds and oil*, rifampin
Phencyclidine	Dextroamphetamine, dextromethorphan*, diphenhydramine*, doxylamine*, ibuprofen*, imipramine, ketamine, meperidine, thioridazine, tramadol, venlaxfaxine
Tricyclic antidepressants	Carbmazepine, cyclobenzaprine, cyproheptadine, diphenhydramine*, ibuprofen*, hydroxyzine, quetiapine
** Can be purchased over-the-counter in some states or through internet sources*	

When an unexpected positive or negative result is found on a screening test (a result that is incontinent with the patient report) and the result either impacts the treatment plan, the medication choice, or has legal ramifications, then the sample should be sent out for confirmatory (definitive) testing. Avoid making changes in treatment plans without definitive/confirmatory results.

Definitive (Confirmatory Send-Out) Testing

Confirmatory testing is generally performed at specialty labs via gas chromatography. The tests measure the exact amount of the drug and its metabolites present in the urine/oral fluid. Uses of confirmatory testing include:

- Confirming a positive or negative result that does not agree with the patient report.
- Identifying substances that are not easily identified on standard rapid tests (such as kratom, tramadol and gabapentin).
- Identifying specific medications within a larger drug class (such as differentiating alprazolam from clonazepam in a patient testing positive for benzodiazepines).
- Identifying drug metabolites to ensure patient compliance and reduce diversion (such as checking for the presence of norbuprenorphine in a patient prescribed buprenorphine). See Chapter 6: Understanding and Preventing Buprenorphine Diversion.
- Monitoring drug levels during taper or after cessation (for example, when a patient has stopped using a long-acting drug such as cannabinoids or benzodiazepines).
- Building an accurate medical record for a patient with ongoing legal concerns (such as probation or Office of Children's Services cases), the provider should send out for confirmatory testing more frequently as the results may be critical to a patient's legal case.

26 Urine drug screens: When might a test result be false-positive? 14.

Confirmatory testing takes 5-10 days to obtain results, and the test can be expensive. It is important to know if the patient's insurance covers this testing and if they impose limits on the numbers of tests allowed per year. See Chapter 2: Billing Insurance Coverage and Telemedicine.

Confirmatory tests are performed by outside labs that are supervised by medical review officers (MROs). MROs are physicians with special training in interpreting drug testing results, and most lab reports will include a phone number to contact the MRO. The MRO can be an excellent resource to help explain any confusing lab results and they can answer questions regarding the lab results.

Confirming Medication Compliance through Drug Testing

Buprenorphine is metabolized to norbuprenorphine, and both will always be present in a urine sample from a patient taking buprenorphine. Norbuprenorphine is only detectable with confirmatory laboratory testing (send out).

A urine sample positive for buprenorphine, but negative for norbuprenorphine is consistent with tampering (a buprenorphine film/tab dipped into a negative urine sample to make it appear as though the medication was taken). This is particularly likely in the case of extremely elevated buprenorphine levels (over 1,000).

Patients may tamper with their urine for a variety of reasons. When a tampered specimen is discovered it is important to discuss with the patient why they altered their sample.

- Is the patient not taking their medications, and if so, why not?
- Is the patient substituting their urine to conceal other drug use?
- Is the patient diverting medications?

Monitoring Alcohol Use through Drug Testing

Urine ethyl glucuronide (EtG) and ethyl sulfate (EtS) are alcohol metabolites that can identify recent alcohol consumption within the past 72 hours. EtG can be produced by alcohol-producing bacteria in the gut and the addition of EtS (which is more specific) to the testing ensures better test validity. This is useful when monitoring for abstinence, but the test cannot differentiate between light or heavy drinking. Food containing alcohol and some medications can cause false positives. These urine tests are available by send-out laboratory confirmation only.

Alcohol breath testing devices are available for in-office use and for home use. Home devices can link to a phone or tablet and incorporate facial recognition or video monitoring to perform witnessed breath alcohol testing outside of the office. This testing is beneficial for patients who are required to demonstrate abstinence for legal purposes.

Responding to Drug Test Results

No matter what the results of a drug test are (positive, negative, unclear), the provider presents the test results in an objective manner, focusing on the therapeutic response of the results. Avoid using terms like "dirty UA" or "dirty urine drug screen." The term "dirty" is a reference to a urine test that is positive for substance use. This term is viewed as stigmatizing because of its pejorative connotation. Proper medical terminology such as "an individual having positive test results" or "currently exhibiting symptoms of substance use disorder" is preferred.[27]

Ongoing positive drug test results during treatment indicate the need to reassess the patient and revise the treatment plan. Repeated positive results may indicate the following:

- Patient is taking the medication incorrectly.
- Patient is not taking some or all of their medication.
- Patient may need a different medication.
- Patient may need to have directly observed medication administration.
- Medication may need to be increased or decreased.
- Patient may need more psychosocial treatment or referral to a SUD treatment program.
- Patient may need more recovery support services.

If a patient refuses a drug test, this refusal can be an area of focus on the patient's treatment plan.

27 Addiction-ary. 3.

CHAPTER 6: UNDERSTANDING AND PREVENTING BUPRENORPHINE DIVERSION

Buprenorphine is a controlled substance with potential for misuse and diversion. Drug diversion is a medical and legal issue, where legally prescribed controlled substances have been transferred from the person for whom it was prescribed to another person for illicit use. Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.[28] Providers who take steps to proactively address diversion may reduce the incidence of inappropriate use of prescribed buprenorphine. The use of diverted buprenorphine is commonly reported in patients presenting for OUD treatment. Studies evaluating the use of diverted buprenorphine found that more than 90% of patients reported using illicit buprenorphine to relieve withdrawal symptoms, reduce cravings and avoid opioid use.[29] Buprenorphine was reported as a drug of misuse to "get high" in less than 5% of patients.

Buprenorphine has a lower abuse risk than a typical full opioid agonist because it is a partial agonist. As a partial agonist, it only activates the opioid receptors enough to remove withdrawal symptoms and cravings and does not activate the opioid receptors enough to get "high" (in patients with opioid tolerance). It has a long half-life and high receptor affinity (binds very strongly to receptors and blocks them for over 24 hours). The mono product (plain buprenorphine) is three times more likely to be diverted than the combo product (buprenorphine/naloxone). The presence of naloxone in the product does not alter its clinical effect, but it does act as an abuse deterrent by reducing the effect of any injected or insufflated buprenorphine, and potentially leads to precipitated withdrawal if misused. Buprenorphine is typically more expensive and harder to obtain than heroin, and if an individual who is dependent on opioids injects the combo product, they risk precipitated withdrawal.

Buprenorphine can cause intoxication in an opioid naïve patient, therefore strategies to reduce diversion are especially important to prevent youth and opioid-naïve individuals' exposure to its opioid effects.

Although methadone is also a medication subject to diversion, it is only available through an OTP and there are specific federally mandated procedures in place to limit diversion of methadone dispensed from an OTP. For more information about OTP federal regulations see section on diversion in the Federal Guidelines for Opioid Treatment Programs handbook at store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf.

Strategies to Reduce Diversion

- Urine drug screens to identify buprenorphine and other substances used with random confirmation testing to confirm presence of norbuprenorphine metabolite. See Chapter 5: Drug Testing.
- Medication counts, random if possible, that may be done virtually.
- Short prescriptions for patients who tend to run out early.
- Query PDMP for other prescriptions of controlled substances.
- Directly observed therapy (in person or video chat observation of patient taking their medication) for patients who struggle with compliance.
- Consider changing to injectable XR forms for patients who continue to be at risk for diversion.

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28 *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington D.C.: Office of Surgeon General. November 2016. U.S. Dept. of Health and Human Services. addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf. Accessed January 6, 2021.

29 Cicero TJ, Ellis MS, Chilcoat HD. Understanding the use of diverted buprenorphine. *Drug and Alcohol Dependence*. 2018;193(0376-8716):117-123. doi.org/10.1016/j.drugalcdep.2018.09.007.

- Deter patients from sharing medications with friends and family.
- Prescribe combo products (buprenorphine/naloxone) rather than mono product (plain buprenorphine) whenever possible.

Resources About Diversion

- Diversion Control Protocol Template for Opioid Use Disorder Treatment Providers
- PCSS Guidance on Adherence, Diversion and Misuse of Sublingual Buprenorphine
- Reducing Risk of Misuse and Diversion from Great Lakes ATTC

CHAPTER 7: PATIENT COMMUNICATIONS

This chapter focuses on the barriers to effective patient communication and methods to avoid them. Stigma is one of the main barriers of patients seeking medications for addiction treatments. Providers are in the unique position to educate and guide patients about MAT and the chronic medical disease of addiction. Providers can educate and include family members in MAT to enhance the patients' recovery process. Also contained in this section is an overview of confidentiality as it relates to substance use disorder treatment and the voluntary non-opioid directive.

Stigma

People hold beliefs that form the basis of attitudes and judgments, which in turn, impacts how people react and interact with others. Sometimes the foundation of beliefs may be faulty due to misinformation or myths.[30] Stigma represents the negative attitudes and behaviors demonstrated toward a circumstance or person.

Stigma is a primary barrier to effective prevention, treatment and recovery efforts at individual, family, community and societal levels. It prevents many people from getting the help that they need.[31] Many of the negative, stigmatizing symptoms associated with addiction tend to diminish when appropriately addressed and managed in recovery.

Stigma may be reinforced by past treatment, thus making patients cautious about trusting and having open communication with their provider. Patient mistrust and reluctance can be decreased by recognizing that addiction is a chronic medical disease. Providers reinforce that the patient's SUD disease can be treated with medication much like diabetes, hypertension or other chronic conditions.

Watch Decreasing Stigma Involving Addiction Begins with the Medical Profession

Methods to Address Stigma

Addiction does not describe what a person is, addiction describes what a person has. Avoid labels like "addict" or "drug user." Instead use people-first language, for example, "a person with an opioid use disorder."

For a more in-depth resource, Reducing Discriminatory Practices in Clinical Settings is an hour-long video on addressing stigma and discrimination available at www.youtube.com/watch?v=BWfbgJZ2ros&t=2s.

Dr. Yngvild Olsen and Dr. Joshua Sharfstein wrote an essay "Confronting the Stigma of Opioid Use Disorder—and its Treatment" and identified ways on how to overcome stigma.

"We must all confront the intangible and often devastating effects of stigma," according to Patrice A. Harris, MD, the AMA's president-elect and chair of the AMA Opioid Task Force. "The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment."

Disease vs. moral weakness: Understanding that substance use disorders are a medical illness and are related to changes in the brain chemistry combats the common misconception that substance use is a willful choice or a moral weakness.

Language mirrors and perpetuates the stigma related to treatment of opioid use disorder with medications. The public and therefore the health care system, does not routinely talk about opioid use disorder and its treatment as medical care, but rather often may assign judgmental, pejorative terms.

30 *Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma*. Silver Spring, MD: Central East Addiction Technology Transfer Center Network. Revised 2012. Accessed January 6, 2021. attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf.

31 Smashing the Stigma of Addiction. HazeldenBettyFord.org. www.hazeldenbettyford.org/recovery-advocacy/stigma-of-addiction. Accessed January 6, 2021.

Talking to Patients about MAT

Decreasing addiction stigma begins with the medical profession. Providers can create opportunities to educate and guide patients about MAT and the chronic medical disease of addiction. Although sometimes these discussions may be difficult, they are the most important since they can assist a person to start (or continue) their recovery. Below are some suggestions from the Provider Clinical Support System on how to approach talking to patients about MAT.

Use medically accurate, person-first, non-stigmatizing language.

Be aware of one's own anxieties, feelings and non-verbal communication.

Convey warmth and care for a patient's well-being.

Ask permission to discuss sensitive topics.

Reflect on treatment progress thoughtfully, using language that demonstrates respect.

Use open-ended questions.

Engage with the patient as a partner in treatment planning.

Motivational Interviewing (MI)

Patients have many reasons, spoken and unspoken, to be reluctant about starting MAT. When patients are faced with a major life change, a normal response is to be ambivalent about the change. Motivational Interviewing is an evidence-based approach to behavior change that works well in a clinical setting. Motivational interviewing is an intervention which has shown good applicability to individuals from a variety of cultural backgrounds and is recognized as a behavioral counseling treatment modality in the National Institute on Drug Abuse's *Treatment Approaches for Drug Addiction* fact sheet.[32] It is not a counseling technique, but a way to structure conversations to engage the patient. By using MI, the patient makes their own argument to change the behavior through weighing the advantages of the change over the disadvantages of not changing. The provider uses open-ended questions and reflective listening as a way to guide the patient through the change process and to fortify the patient's thinking towards making positive change.

The Provider's Clinical Support System has several resources to help providers become proficient at MI, including a thirty minute podcast, Addressing Patient Resistance to Medication-Assisted Treatment. This podcast discusses the importance of directly addressing ambivalence and offers suggestions on how to enhance treatment motivation.

Family Involvement

For MAT to be successful, support from family and friends is necessary. Family members are a powerful resource who can support the patient in treatment and can provide insight about SUD symptoms and MAT adherence. Family members are also a strong source of health-related beliefs and behaviors that can support and/or hinder treatment. If they have misconceptions about medications or about addiction, it is important that the provider can point family members to accurate MAT resources. Family members often have questions about medications for addiction treatment and want to know how to support their loved one in recovery. Family members may also want some support and resources for themselves while their loved one is in treatment. Below are links for resources for families.

- MAT Handouts for Patients and Family Members
- Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends
- Recovery Research Institute's Guide for Family Members
- SAMHSA's Decisions in Recovery: Treatment for Opioid Use Disorder
- ASAM's Opioid Addiction Treatment: A Guide for Patients, Families and Friends

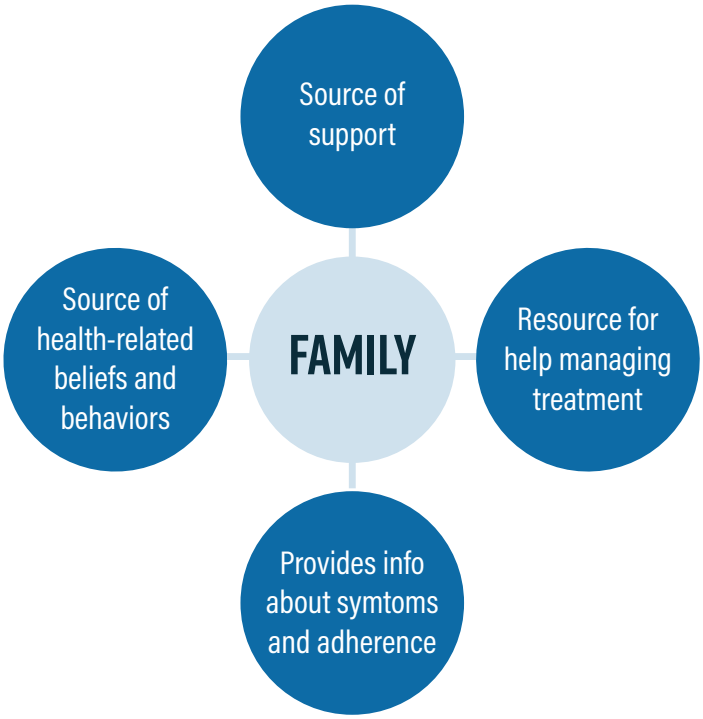
Family members can be included in the treatment process. For example, with the patient's consent, families can find ways they can help support the patient's treatment goals. Providers can invite family members to office visits to discuss strategies to support patients. Also, providers can engage and educate family members who are reluctant to accept the role of medications in treatment. For a short overview about family involvement, watch "Addiction Impacts the Entire Family: Pearls for Providers".

32 National Institute on Drug Abuse. Drug Facts: Treatment Approaches for Drug Addiction. National Institutes of Health. www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction. Published January 2019. Accessed January 6, 2021.

Referrals to family therapy can address SUDs and various other family problems. Family therapy can be an effective intervention to: a) address family members' biases about medication for OUD; b) heal family relationships; c) systemically address how a patient's substance use has impacted family dynamics; and d) allow the family to recover with their loved one.

Benefits of Family Involvement

Confidentiality and 42 CFR Part 2



SUD treatment confidentiality is regulated by state statutes (AS 47.30.590), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and by 42 CFR Part 2. 42 CFR Part 2 are federal substance use disorder confidentiality regulations issued by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). They were developed to protect patients from unintended bias associated with SUDs. The 42 CFR Part 2 non-disclosure requirements are stricter than HIPAA. Thus, SUD providers must handle treatment information about SUD patients with heightened confidentiality. ***Please be aware that the 42 CFR Part 2 had revisions that went into effect August 2020.*** Effective and timely communication among the prescriber and other providers and the patient is critical. The communication must be documented and confidential, consistent with SAMHSA confidentiality regulation Title 42 Part 2 of the Code of Federal Regulations (42 CFR Part 2). It is recommended that policies and practices be established for each level of communication to ensure that care is well coordinated and aligned with patient needs.

To learn more about 42 CFR requirements:

- Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule
- Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to me?
- Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?
- SAMHSA FAQ about Confidentiality Regulations
- American Society for Addiction Medicine Primer on 42 CFR Part 2

Voluntary Non-Opioid Directive (VNOD)

Under direction of Alaska Statute 13.55.010, the Alaska Department of Health and Social Services (DHSS) has developed a Voluntary Non-Opioid Directive (VNOD) form. The VNOD aims to prevent providers from inadvertently offering certain controlled substances to those who could be adversely affected. It also empowers patients to proactively inform their provider that they do not wish to receive opioids for any reason.

DHSS encourages patients to complete the Voluntary Non-Opioid Directive in consultation with their primary care provider or behavioral health treatment provider. A signed VNOD should be given to a health care provider and recorded in the patient's medical record.

The existence of a signed VNOD:

- Does not alter an advance health care directive.
- Does not limit the prescribing, dispensing, or administering of an opioid overdose drug.
- Does not prohibit offering, prescribing or administering opioid medications for the purpose of medications for addiction treatment, as approved by the FDA.

SECTION 3

MEDICATIONS

CHAPTER 8: OVERVIEW OF OPIOID USE DISORDER MEDICATIONS

About Opioids

Opioids are a class of drugs that include the illicit drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription such as oxycodone, hydrocodone, codeine and morphine. Opioids are prescribed as medicines because they contain chemicals that relax the body and can relieve pain. Prescription opioids are used mostly to treat moderate to severe pain, though some opioids can be used to treat coughing and diarrhea.[1]

Patients may misuse a prescribed opioid. Misuse is taking the medicine in a way or dose other than prescribed, taking someone else's prescription medicine, and/or taking the medicine for the effect it causes (to get high).[2] When misused, opioids increase the risk of certain infections, accidents and death. Misuse of prescribed opioids is often linked to use of illegal opioids. Patients may become dependent on, or addicted to, prescription opioids. Dependence and addiction are frequently confused.[3] A patient taking an opioid as prescribed can become physically dependent on the medicine. Physical dependence is when the body requires a specific dose of a particular drug to prevent withdrawal symptoms. This typically happens when a patient uses an opioid long term (six months or longer), but can happen in as little as three weeks.[4] With physical dependence, the patient may experience some euphoria, but the patient is capable of managing impulses and has control over their use.

An addiction, or opioid use disorder (OUD), occurs when the patient's brain has an overwhelming need to continue the use of the opioid despite negative consequences. The brain's chemistry changes over time and decision-making becomes impaired. When a person becomes addicted, they begin to experience cravings for opioids, as well as a loss of control over their use. Patients with both physical dependence and OUD develop a tolerance or a diminished response to the drug, but with OUD the patient has an inability to control drug use, has uncontrollable cravings, compulsively uses the drug, and continues to use the drug despite harmful consequences to oneself or others.

According to the American Society of Addiction Medicine (ASAM), addiction is defined as:

A treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

1 Opioids. National Institute on Drug Abuse. www.drugabuse.gov/drug-topics/opioids. Accessed January 11, 2021.

2 Opioids. NIDA.

3 Opioids: Understanding Addiction Versus Dependence. Hospital for Special Surgery. www.hss.edu/conditions_understanding-addiction-versus-dependence.asp. Published May 2, 2018. Accessed January 11, 2021.

4 Severino KA. Opioid withdrawal in adults: Clinical manifestations, course, assessment, and diagnosis. *UpToDate*. July 2019. www.uptodate.com/contents/opioid-withdrawal-in-adults-clinical-manifestations-course-assessment-and-diagnosis.

MAT for OUD

According to SAMHSA's MAT website, MAT is defined as:

The use of medication with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose.

MAT treats OUD by using medication to ease withdrawal and ongoing cravings. Prescribed medication to treat opioid use disorder is comparable to prescribed medication to manage diabetes or heart disease. Appropriate use of medications for OUD greatly improves treatment outcomes and the quality of life for patients. The length a patient is prescribed medication is dependent on several factors and some patients may participate in MAT for several years.

MAT is part of a comprehensive treatment plan to support patients functioning in all aspects of their lives. Psychosocial needs are assessed and patients are offered or referred to psychosocial treatment based on their individual needs; however, if a patient decides to decline psychosocial treatment or psychosocial treatment is unavailable, pharmacotherapy should not be delayed or precluded.[5] Medication, counseling and positive social support are all important factors that contribute to success in recovery.

MAT is linked to many positive outcomes including:[6]

Medications for OUD

Three medications are approved by the U.S. Food and Drug Administration (FDA) for treating opioid use disorders: methadone, buprenorphine, and naltrexone. Most of these medications have several products or formulations available.

Though all three pharmacotherapies are approved options with different indications and contraindications, this MAT Guide focuses primarily on the following medications.

These two medications may be prescribed in an office-based setting, unlike methadone which, per federal regulation, must be dispensed at certified opioid treatment programs (OTP). Methadone will only be described briefly in this guide.

5 American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. www.asam.org/Quality-Science/quality/2020-national-practice-guideline. Published March 2020. Accessed January 11, 2021.

6 Oesterle TS, Thusius NJ, Rummans TA, Gold MS. Medication-Assisted Treatment for Opioid-Use Disorder. *Mayo Clinic Proceedings*. 2019;94(10): 2072-2086. https://doi.org/10.1016/j.mayocp.2019.03.029.

Buprenorphine	Naltrexone
(Suboxone, subutex, Zubsolb, Bunavil, Probuphine, Sublocade)	*(Vivitrol)*
An office-based opioid agonist and antagonist that blocks other narcotics while reducing withdrawal risk. Prescribed as a daily dissolving film or tablet, cheek film, monthly injection or six-month implant under the skin.	An office-based non addictive opioid antagonist that blocks the effects of other narcotics. Prescribed as a daily pill or monthly injection.

Choosing the Most Appropriate Medication

All FDA approved medications for the treatment of OUD should be available to all patients. Providers consider the patient's preferences, past treatment history, current state of illness and treatment setting when deciding between the use of methadone, buprenorphine and naltrexone.[7] Having a thorough understanding of each therapeutic medication aids in the identification of which pharmacotherapy will be the best treatment option for the patient. Additionally, patients are offered or referred to psychosocial treatment based on their individual needs. For more detailed prescribing information, please refer to the ASAM National Practice Guidelines.

Buprenorphine

Buprenorphine is a partial agonist which has a "ceiling effect," meaning larger doses do not generally increase the effect of the medication. Because buprenorphine patients generally experience weaker effects of euphoria than methadone or heroin, buprenorphine has a lower potential for misuse and it diminishes withdrawal symptoms and cravings. It provides both positive reinforcement by relieving withdrawal symptoms and negative enforcement (if patients stop their medication, they experience withdrawal symptoms) which promotes treatment retention.

Buprenorphine initiation can be performed in an outpatient setting, in the emergency department or at a person's home. Buprenorphine may be prescribed without first requiring the patient to complete withdrawal. Buprenorphine can also be used for medically supervised withdrawal. For most patients treated with medication for a moderate to severe opioid use disorder, buprenorphine is a good first-line choice. If the patient chooses to stop buprenorphine, the provider will need to monitor the patient for withdrawal.

Many formulations of buprenorphine include the misuse deterrent naloxone (Suboxone, zubsolv, bunavail etc). Naloxone (Narcan) is an antagonist, which means that it blocks the effect of opioids if the drug is misused by injecting it, making it less likely to experience a high. Injection of the combination product can also cause precipitated withdrawal. This discourages patients from misusing their buprenorphine and reduces the risk of medication diversion. For patients who struggle with medication adherence or diversion, monthly injectable buprenorphine (Sublocade) can be offered. For patients with moderate to severe opioid use disorder who continue to use opioids while receiving buprenorphine, have a history of a prior poor response to buprenorphine, or misuse or divert buprenorphine, methadone might be a better fit. [8]

READ MORE: Highlights and full prescribing information for Suboxone.

7 *ASAM National Practice Guide.*

8 Saxon AJ, Strain E, Peavy KM. Approach to treating opioid use disorder. *UpToDate*. May 2019. www.uptodate.com/contents/approach-to-treating-opioid-use-disorder.

Extended Release Naltrexone (Vivitrol)

Extended release naltrexone is injected once a month and helps prevent relapse to opioid dependence after withdrawal management. Extended release naltrexone is an opioid antagonist and it completely blocks the effects of opioids. This means if a patient attempts to abuse opioids, they do not experience a high. As extended release naltrexone does not provide any positive reinforcement (doesn't treat withdrawal symptoms), or negative reinforcement (patients don't experience withdrawal symptoms when they stop their medication), it is best suited for patients who are highly motivated to stay in treatment. Before starting extended release naltrexone, the patient must be opioid-free for a minimum of 7 to 14 days to avoid sudden opioid withdrawal.

This medication may be a good first-line therapy in most patients with a mild opioid use disorder. Extended release Naltrexone is suggested as second line medication treatment for moderate to severe opioid use disorder in patients who have had poor responses to buprenorphine and methadone.[9] Extended release naltrexone is considered a good option for patients with comorbid alcohol use disorder and opioid use disorder.

READ MORE: Highlights and full prescribing information for Vivitrol.

Methadone

Methadone is a long-acting full opioid agonist used to treat OUD. Methadone reduces opioid craving and withdrawal and blunts or blocks the effects of other opioids. Methadone is safe and effective, when taken as prescribed. By law, methadone is only dispensed through a SAMHSA-certified opioid treatment program. Methadone medication is specifically tailored for the individual patient (as doses are commonly adjusted and readjusted).[10]

Patients taking methadone to treat OUD must receive the medication under the supervision of a physician at the OTP. After a period of stability (based on progress and proven, consistent adherence with the medication dosage), patients may be allowed to take methadone at home between program visits.[11]

Federal OTP regulations mandate that patients must be provided with broad support, and many clinics offer family therapy, employment assistance, counseling and regular medical and mental health care. For patients with moderate to severe opioid use disorder who require high levels of support, methadone is a good choice. Methadone may also be a good choice for patients with severe chronic pain whose pain is not adequately controlled on buprenorphine. Methadone has multiple drug-drug interactions so may not be appropriate for some patients with complicated poly-pharmacy. Although methadone may have slightly better capacity to retain patients in treatment, it has a higher risk of lethal overdose and drug-drug interactions, and is not available in rural areas. Visit this SAMHSA resource to find an OTP in Alaska.

Approach to Medications for Addiction Treatment of OUD

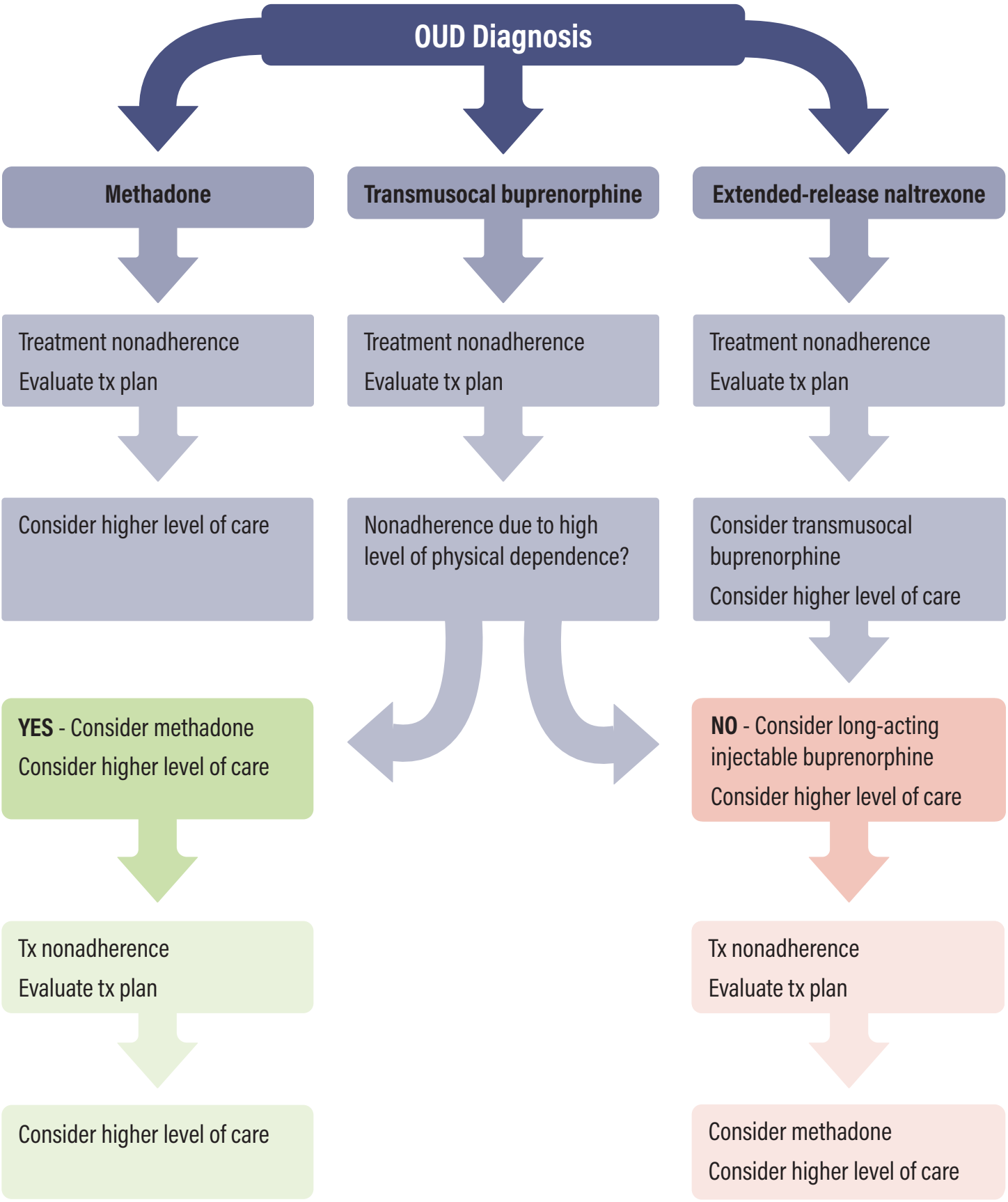
MAT is individualized. The most appropriate medication is determined based on a discussion between a provider and a patient. The below flow chart is an example of a MAT progression approach. Treatment nonadherence is defined in the monitoring progress indicators chart in Chapter 4: Screening, Assessment and Treatment. Whenever treatment nonadherence is encountered, it is an opportunity to reevaluate the treatment plan with the patient. Referral to additional psychosocial treatment, recovery support services or to another level of care are all options when reevaluating the treatment plan.

9 Approach to treating opioid use disorder. *UpToDate*.

10 Methadone. Substance Abuse and Mental Health Services Administration. www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone. Updated September 8, 2020. Accessed January 11, 2021.

11 Methadone. SAMHSA.

MAT Progression Approach



Opioid Use Disorder Medication Differences

The following table provides a brief overview of the differences between the three OUD medications.

Prescribing considerations	Methadone	Buprenorphine	Naltrexone
Product/ Formulation		Suboxone,* Subutex, Zubsolv,* Bunavail,* Probuphine, Sublocade	Extended-release injectable/ depot/XR-NTX; Vivitrol
Mechanism of Action	**Full agonist:** Binds to and activates receptors. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	**Partial agonist:** Binds to and partially activates opioid receptors. Long-acting, providing steady blood levels which avoid reward (euphoria) due to peak effects and avoids withdrawal or craving due to low blood levels.	**Antagonist:** Binds and competitively blocks opioid reward effects.
Uses of Medication	Withdrawal and treatment	Withdrawal and treatment	Treatment
Route of Administration	Oral tablet or liquid	Sublingual tablet, sublingual or buccal film, implant, injection	Intramuscular (IM) injection
Frequency of Administration	Daily	Based on formulation and clinical needs of the patient.	Monthly
Dosage	Based on formulation and clinical needs of the patient.		
Regulatory Context	May only be dispensed at a certified opioid treatment program (see He-A 300 rules, part 304).[1]	Any licensed prescriber with a DEA registration and a buprenorphine waiver.	Any health care provider who has a license to prescribe (e.g., physician, nurse practitioner, physician assistant).
Typical Visit Requirement	Initial: Daily	Initial: Weekly *Interval may change based on course of treatment*	Monthly
Cost of Medication	Low	Depends on product	High
Controlled Substance Schedule	Schedule II	Schedule III	Not a scheduled medication
Diversion Value	High	High	Low
Discontinuation of Medication	Tapering required	Tapering required	No tapering required

**Suboxone, Zubsolv and Bunavail contain both buprenorphine and naloxone. Naloxone is an antagonist and is used to decrease potential for diversion and misuse. If used intravenously a person will experience immediate withdrawal as a result of the naloxone.*

1 New Hampshire Code of Administrative Rules. Chapter He-A 300 Certification and Operation of Alcohol and Other Drug Disorder Treatment Programs, Part He-A 304 Operational Requirements for Opioid Detoxification and Methadone Maintenance, Treatment, and Rehabilitation Programs. https://www.dhhs.nh.gov/dcbcs/bdas/documents/300-rules.pdf. Accessed July 10, 2019.

CHAPTER 9: BUPRENORPHINE

Basic instruction for prescribing and managing buprenorphine is covered in all waiver training courses, so this guide will focus on presenting updated recommendations to address common concerns providers have when starting a patient on buprenorphine. Choosing the setting of medication initiation, providing patient education, using extended release buprenorphine, and maintaining and discontinuing buprenorphine therapy will be addressed.

Starting Patients on Buprenorphine

Initiation (also called induction) is the process of starting buprenorphine medication for addiction treatment. Initiation includes starting buprenorphine without causing precipitated withdrawal, managing any side effects, and adjusting the dose to minimize the patient's cravings and withdrawal symptoms without causing sedation. The provider considers the patient's previous experience with buprenorphine, their ability to understand and follow instructions, their living situation and their medical comorbidities to create a suitable initiation plan.

The provider establishes the timing, setting and dosing instructions for buprenorphine initiation and is responsible for evaluating and monitoring the patient during the initiation. The use of case managers or nurses to assist with patient education and follow up is suggested.

To determine the appropriate initiation procedure, the provider assesses whether the patient is currently physically dependent on opioids. Patients may present with one of the following scenarios:

- Currently dependent on short-acting opioids (such as heroin and immediate release prescription opioids).
- Currently dependent on long-acting opioids (such as methadone or extended-release prescription opioids).
- History of opioid dependence but currently abstinent.
- Currently taking buprenorphine, either from another provider or illicitly.

Patients who are currently abstinent from opioids are generally started at lower doses of buprenorphine to avoid over sedation. Patients with high levels of opioid tolerance may need higher initial doses to control their symptoms. Patients currently taking buprenorphine can usually be continued on their current effective dose.

Understanding Precipitated Withdrawal

Precipitated withdrawal is a sudden onset of worsening withdrawal symptoms after a patient takes their first dose of buprenorphine too soon after taking another opioid. To prevent precipitated withdrawal, patients must wait until they are in moderate withdrawal, usually 12-36 hours since their last use of opioids, before they take their first dose of buprenorphine.[2]

Buprenorphine Initiation Withdrawal Timing

Opioid	How long to stop before buprenorphine initiation
Short-acting (heroin, IR oxycodone, hydrocodone)	12-24 hours
Long-acting (XR oxycodone, XR morphine)	24-36 hours
Methadone (30 mg/day or less)	48-72+ hours

Precipitated withdrawal is more commonly experienced by patients taking buprenorphine illicitly. Patients who experience precipitated withdrawal often leave treatment, so it is important to try to prevent this from occurring. Patients who are at high risk for precipitated withdrawal should be offered office-based initiation when possible.

Patients for high risk of precipitated withdrawal:

- Recent use of prescribed methadone or those taking long-acting opioids.

2 IT MATTRs. *A Patient's Guide to Starting Buprenorphine at Home*. American Society of Addiction Medicine. www.asam.org/docs/default-source/education-docs/unobserved-home-induction-patient-guide.pdf. Accessed January 11, 2021.

- Recent benzodiazepine use.
- No prior experience with buprenorphine.

Patients who are at higher risk for initiation-related complications and may be better suited to inpatient initiation with possible addiction specialist consultation:

- Simultaneous withdrawal management for alcohol or benzodiazepines.
- Transitioning from high dose methadone (over 30 mg/day).
- Severe medical comorbidities (such as end-stage organ failure).
- High risk pregnancy greater than 20 weeks gestational age.

It is a common misconception that the naloxone in Suboxone initiates precipitated withdrawal. This is false. The naloxone can only initiate precipitated withdrawal if injected into a person tolerant to opioids. Taken sublingually the naloxone has virtually no effect.

- National Alliance of Advocates for Buprenorphine Treatment

Management of Precipitated Withdrawal

"The best way to avoid precipitated withdrawal is through patient education. Prior to initiation, the patient is informed of what precipitated withdrawal is and how they can avoid it. The patient who understands that underreporting their last use puts him/her at high risk for rapid and intense onset of the withdrawal syndrome, is more likely to accurately report last use."[3]

Precipitated withdrawal is managed with supportive medications. These medications can be helpful for patients to manage withdrawal symptoms during the first few days prior to starting their buprenorphine.

Supportive medications for opioid withdrawal management:[4]

- Myalgias: NSAIDs and acetaminophen
- Muscle spasms: tizanidine
- Nausea: ondansetron or promethazine
- Restlessness and sweating: clonidine
- Anxiety and rhinorrhea: hydroxyzine
- Insomnia: trazodone

Supportive care for precipitated withdrawal is generally continued for 4-8 hours for patients transitioning from short-acting opioids, or 24 hours for patients transitioning from long-acting opioids, before further buprenorphine dosing attempts are made.

Another strategy that has been gaining popularity is to treat precipitated withdrawal by giving larger doses of buprenorphine. Sometimes low doses of buprenorphine may displace opioids but not provide a strong enough agonist effect to prevent withdrawal symptoms. Giving higher doses of buprenorphine may provide enough agonist effect to relieve symptoms.

Benzodiazepines are generally avoided in outpatient settings as they increase the risk of overdose death if the patient relapses to full opioid agonist use.

Choosing the Most Appropriate Initiation Setting

Office-based opioid treatment (OBOT) commonly refers to outpatient treatment services provided by providers to patients with addiction involving opioid use. The provider typically prescribes a partial opioid agonist buprenorphine in concert with other medical and psychosocial interventions to achieve and sustain remission.[5]

Both office-based and home-based initiation are considered safe and effective. Buprenorphine can also be initiated in the

3 What is Precipitated withdrawal? National Alliance of Advocates for Buprenorphine Treatment. www.naabt.org/faq_answers.cfm?ID=70. Accessed January 11, 2021.

4 Mauger S, Fraser R, Gill K. Utilizing buprenorphine-naloxone to treat illicit and prescription-opioid dependence. *Neuropsychiatr Dis Treat*. 2014;10:587–598. doi:10.2147/NDT.S39692.

5 American Society of Addiction Medicine. *Public Policy Statement on the Regulation of Office-Based Opioid Treatment*. Rockville, MD. 2018. www.asam.org/docs/default-source/public-policy-statements/statement-on-regulation-of-obot.pdf. Accessed January 11, 2021.

emergency room or inpatient hospital setting. The provider is recommended to select the setting which best matches the patient's individualized needs. The provider has a conversation with the patient to discuss the risks and benefits of initiation setting.

Office-Based Initiation

In an office setting, the patient is provided a supportive environment in which the patients' withdrawal symptoms can be monitored in real time. Supportive medication can be provided in the event of a precipitated withdrawal. Office-based initiation can be helpful for patients who are nervous about initiation or who are at elevated risk of precipitated withdrawal.

Pros and Cons of Starting Buprenorphine in the Doctor's Office

Pros	Cons
▪ Medical team is available to check on the patient and provide comfort medications ▪ Medical team verifies patient's readiness to start and to ensure medication is taken properly ▪ Reduced risk of precipitated withdrawal	▪ Patient may have to make multiple visits to the office the first week ▪ Patient may have transportation issues ▪ Patient may not be as comfortable as they would be at home

Sample Buprenorphine Initiation Dosing Protocol

Day	Dose of sublingual buprenorphine
Day 1	Start with 4 mg, repeat 4 mg dose every 1-2 hours for COWS>5, maximum dose 8-16 mg
Day 2	Start with total dose given on day 1, then give 4 mg every 1-2 hour for COWS>5, maximum dose 16-24 mg
Day 3	Start with total dose given on day 2, give additional 4 mg doses as needed, maximum dose 24 mg.

Opioid naïve patients may need lower doses, patients with high opioid tolerance may need higher doses. Most patients stabilize on 16 mg of buprenorphine.

At-Home Initiation

For patients with a good support system, home initiation may be appropriate. In some cases, the patient may be evaluated via telemedicine without an in-person visit (see the Telemedicine in Alaska section in chapter 2), however the law generally requires that the patient must have an in-person visit with the provider to establish care before buprenorphine can be prescribed. IT MATTTRs has an outstanding clinical checklist for providers to help guide providers through home initiation procedures.

The patient is given an instruction guide that explains the at-home initiation protocol such as this one found on the ASAM website:

- A Patient's Guide to Starting Buprenorphine at Home

A provider, nurse or case manager calls or texts the patient daily to check on the patient's progress and symptoms. If possible, the patient has access to an after-hours number to call in case of urgent medical questions. The patient is scheduled to return to the office in a week or less to reevaluate.

Pros and Cons of Starting Buprenorphine at Home

Pros	Cons
▪ More flexibility in timing patient's first dose ▪ Patient may be more comfortable at home ▪ Patient doesn't need to drive anywhere	▪ Waiting for the patient to be experiencing enough withdrawal to start buprenorphine may be difficult ▪ Medical team is unavailable to assist patient in person

Emergency Department Initiation

Emergency department (ED) initiation of buprenorphine is rapidly becoming the new standard of care. Federal law allows an ED provider who is not waivered to administer buprenorphine for patient stabilization for up to 72 hours in the ED. Patients cannot be given take-home doses or a prescription from a non-waivered ED provider, however, after discharge on day 1 from the ED, they may return on days 2 and 3 to be administered (under an outpatient order) a directly-observed dose of buprenorphine by a nurse. This allows patients 3 days of medically stabilizing treatment while they are waiting for an appointment with an OBOT.

There are excellent toolkits available online that contain program development guidance, pre-made algorithms, patient instructional handouts, and educational materials for physicians.

- American College of Emergency Physicians "BUPE" Buprenorphine use in the Emergency Department Tool
- Alaska Emergency Department Buprenorphine Guide

Referrals from the ED should be followed up within three days. Providers are encouraged to reach out to their local hospital ED to establish clear policies for referral and follow-up care. After-hours case management or peer support can ease the transition from the ED to outpatient care, by providing a "warm handoff." If the patient prefers to text message a support number, this can be provided to them in the ED.

Initiation of Extended-Release Injectable Buprenorphine (Sublocade)

To start a patient on extended-release buprenorphine, the patient must first be stabilized on sublingual buprenorphine for one week at 8 mg or higher, following one of the initiation strategies above. The medication is ordered from a specialty pharmacy and shipped directly to the clinic. The patient's insurance company determines which specialty pharmacy the prescription is delivered to. The medication may not be in the possession of the patient at any time due to the risk of thromboembolism if injected intravenously.

After at least one week of sublingual buprenorphine, the patient is given the subcutaneous injection in the abdomen, following packaging instructions. Local anesthesia with topical or injectable lidocaine is useful prior to injection to reduce the pain associated with the large 19 g syringe and viscous medication. Site injection pain, swelling and itching occur in about one in five patients and are managed supportively. Cold packs are preferred to heat as the application of heat to the site will cause increased blood levels of buprenorphine. After injection, the depo is palpable as a firm 3 cm subcutaneous mass that will slowly shrink in size to about 1 cm over the next 4 weeks, and then gradually dissolve completely over 2-3 months.

Immediately after injection, the patient will no longer need to take any more sublingual buprenorphine as the blood levels after the first injection are quite high, similar to levels achieved by 24 mg/day sublingual dosing. However, it can take time for drug levels to stabilize, and towards the end of the first month a drop in levels can cause patients to have increased cravings requiring use of supplemental sublingual doses.

Injection is repeated every 4 weeks, the first 2 months being loading doses at 300 mg/month, then 100 mg/month thereafter to maintain levels at a steady state. Injection sites are alternated monthly. Patients whose symptoms are uncontrolled at the 100 mg dose may return to the 300 mg dose. Patients who continue to inject intravenous drugs and are at risk for fentanyl exposure may be better suited to maintenance at the 300 mg level, as the higher serum drug levels provide a better opioid blockade.

After the medication levels reach a steady state at 3-4 months, the patient may be able to extend the time between injections up to 6 weeks without experiencing significant withdrawal symptoms. This flexibility in timing of administration can be well suited to patients who live in remote areas where travel to appointments can be challenging, or who work in occupations such as fishing or oil field work, when they are away from home for long periods of time.

Another drug currently undergoing FDA review, Brixadi, which is an extended-release weekly (8 mg, 16 mg, 24 mg, 32 mg) and monthly (64 mg, 96 mg, 128 mg) injection. This formulation will reportedly offer more flexible dosing, the ability to start without a need for an initial week of sublingual therapy, and safer for use in pregnancy. Full prescribing information was not available at the time of this edition.

"Evidence suggests that buprenorphine doses of 16 mg or more per day may be more effective than lower doses at suppressing illicit opioid use."

- ASAM

Maintenance Prescribing of Buprenorphine and Discontinuation

During follow-up visits patients are evaluated for effectiveness with their buprenorphine dose. Uncontrolled cravings or continued opioid use generally indicate that an increased dose is warranted. Doses may be increased as needed by 2-4 mg per visit and reevaluated weekly to reassess effectiveness. Stabilization/maintenance dosing is variable but generally falls between 12-20 mg daily, however some patients require up to 24 mg daily for adequate control of cravings.

Patients who have had low levels of opioid tolerance may stabilize on doses below 12 mg daily. Although there are some reports of patients having improved pain control at dosages above 24 mg/day, insurance companies generally will not cover doses greater than 24 mg daily as there is little evidence to support higher doses, and the risk of diversion may increase at doses above 24 mg. Patients who continue to use at 24 mg/day may be better suited to monthly injectable buprenorphine which provides higher serum drug levels, or referral to a methadone OTP if available. It is important to note that doses below 16 mg may not be as effective at blocking the effect of illicit opioids, so patients with more severe OUD who are at high risk of relapse may be better suited to higher buprenorphine doses.

All forms of MAT (including buprenorphine), are intended to be taken for a long period of time. Patients who continue MAT for less than a year have very high relapse rates and high risk of overdose. There is no limit on how long a patient can take buprenorphine, and some patients require a lifetime of treatment.[6] The Surgeon General has recognized that patients who are treated for at least 3 years have lower rates of relapse.

When patients express a desire to discontinue buprenorphine, the provider discusses this option with the patient including their reasons for discontinuation. Sometimes reasons may be related to pressure from loved ones to discontinue their medications before it is medically appropriate, and the provider should explore this further with the patient. Tapering medications should always be patient initiated, and providers should counsel patients to have the following criteria met before stopping their medications:

- Relapse free for a year
- Stable housing, job, family life
- No major stressors (legal, financial)
- Stable mental health
- Actively engaged in strong recovery support system

Tapering of all chronic opioid agonists occurs slowly, if possible, with a reduction of 10% or less in the dose per month. Faster tapers can be negotiated with the patient depending on their needs and readjusted as needed. See the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics for more information.

If a rapid taper is unavoidable, the safest avenue is to have this occur with inpatient withdrawal management. A recent study showed that patients who had opioid tapers over less than 21 days had a 50% chance of needing hospital care to manage withdrawal symptoms.[7]

If a patient stops taking their buprenorphine, and is abstinent from opioids, a transition to monthly naltrexone injections can act as a safety net to help protect against overdose and return to use.

Patients who discontinue buprenorphine should be warned that overdose risk after stopping MAT can be very high. It is recommended that patients be provided education about overdose prevention and a naloxone rescue kit.

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6 U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America*: *The Surgeon General's Spotlight on Opioids*. Washington, DC: HHS, September 2018. addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf. Accessed January 11, 2021.

7 Mark TL, Parish W. Opioid medication discontinuation and risk of adverse opioid-related health care events. *Journal of Substance Abuse Treatment*. August 1, 2019(103), 58-63. https://doi.org/10.1016/j.jsat.2019.05.001.

CHAPTER 10: EXTENDED-RELEASE NALTREXONE (VIVITROL)

Naltrexone is an opioid antagonist, meaning that it binds strongly to and blocks the mu opioid receptors. It may help reduce cravings and blocks the effect of opioids if they are used. This medication may be prescribed by any health care provider (e.g., NP, PA) licensed to prescribe medications. There is no limit on the number of patients for whom this medication may be prescribed. It may be ordered and picked up at a local pharmacy by the patient, but the patient must be cautioned not to self-administer the medication at home.

Starting Extended-Release Naltrexone (Vivitrol)

The recommended dose of XR-naltrexone is 380 mg delivered intramuscularly every 4 weeks. The injection should be administered by a health care provider as an intramuscular (IM) gluteal injection, alternating buttocks for each subsequent injection. It is important to use a long enough needle for the injection to ensure intramuscular administration, as injection of the depo into the fatty tissue can cause severe injection site reactions.

Naltrexone may rarely cause hepatic dysfunction, and so it is recommended to check the patient's liver function tests prior to first injection, and then again after the first month of therapy. Transaminase elevations of up to 5 times normal are tolerable. If elevations exceed this, then naltrexone is discontinued and transaminase levels should spontaneously return to baseline without long-term hepatic damage.

Prior to initiating XR-naltrexone, an opioid-free duration of a minimum of 7–10 days is recommended for patients, to avoid precipitation of opioid withdrawal that may be severe enough to require hospitalization. Patients who are taking long-acting agonist medications such as methadone or buprenorphine may require 14 days or longer of abstinence before they can receive XR-Naltrexone.

This extended period of abstinence can be very difficult for patients to achieve and is most easily accomplished in an inpatient or residential setting. Even with inpatient withdrawal management, up to one-third of patients have uncontrolled symptoms or cravings and will leave treatment prior to receiving their naltrexone injection. It is important to offer the patient medications for relief of withdrawal symptoms, and that "Abrupt cessation of opioids may lead to strong cravings, and/or acute withdrawal syndrome which can put the patient at risk for relapse, overdose, and overdose death".[8] It is also important to remember that the use of buprenorphine warrants establishing a safety plan with the patient in case of return to opioid use, including prescribing a naloxone rescue kit.

Prior to the first injection, the patient's urine must be free of all opioids and the patient must undergo a naloxone challenge test. The test is considered positive if there is a COWS increase of 2 or more from the pre-injection score. In case of positive challenge, do not administer XR-naltrexone, wait 1-2 days and repeat the challenge. Additionally, patients may also undergo an oral naltrexone challenge test where oral naltrexone is given instead, which may be a more accurate test of readiness for patient's switching from buprenorphine.[9]

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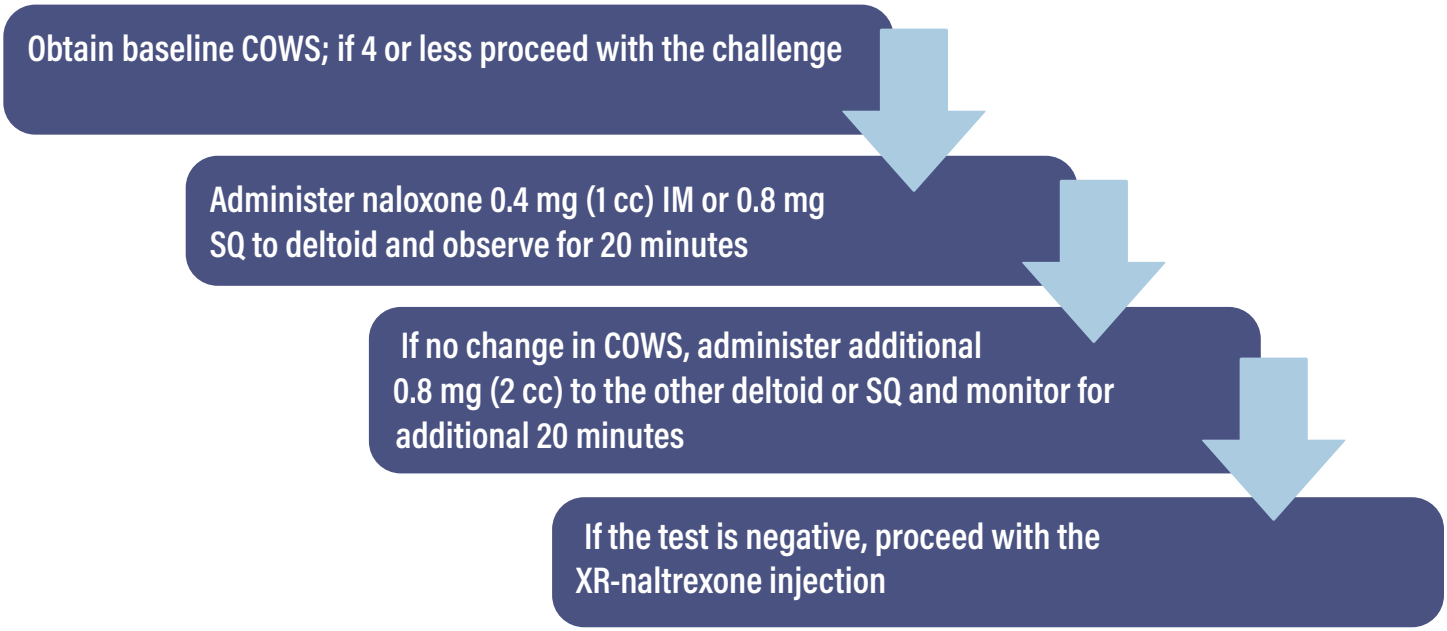
8 *ASAM National Practice Guide.*

9 U.S. Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder* (Treatment Improvement Protocol Series, No. 63.). [Box], EXHIBIT 3C.1. Naloxone Challenge. www.ncbi.nlm.nih.gov/books/NBK535266/box/p3.b36/. Published June 1, 2019. Accessed January 11, 2021.

Naloxone (IM) Challenge Procedure



This testing does not need to be repeated prior to subsequent monthly injections unless the patient is 2 weeks late or more for their injection and reports opioid use or has a UDS positive for opioids.

The Providers Clinical Support System MAT program offers a concise Guide to Initiating XR-Naltrexone. SAMHSA offers a brief guide, Clinical Use of Extended Release Injectable Naltrexone in the Treatment of OUD.

Naltrexone Maintenance and Discontinuation

Patients should receive their naltrexone XR injections every 4 weeks. To increase treatment adherence, the following are recommended: family involvement, motivational incentives, and active outreach by case managers and peer support specialists.

Although research is limited on the length of time for naltrexone treatment, general consensus is that longer courses of addiction treatment have better outcomes. Most patients are recommended to continue naltrexone for a year or longer, until they are stable in long term recovery.

When patients discontinue naltrexone, they are at higher risk of overdose with return to opioid use. It is critical to provide overdose prevention education and naloxone rescue kits to all patients discontinuing naltrexone therapy.

Patients who fail to tolerate opioid withdrawal can be offered opioid agonist therapy (buprenorphine or methadone).

CHAPTER II: OVERVIEW OF ALCOHOL USE DISORDER MEDICATIONS

About Alcohol

Alcohol use disorder (AUD) is a treatable chronic medical disease. Current evidence shows that medications are underused in the treatment of AUD despite the high prevalence of alcohol problems in the general population.[10] AUD is a common comorbidity affecting patients with opioid use disorder (OUD). In patients with chronic pain and OUD, up to one third of patients also have AUD.[11]

"Medication-Assisted Treatment has shown much promise in reducing alcohol use and promoting abstinence in patients diagnosed with alcohol use disorder. Considerable research evidence and consensus among experts support the use of pharmacologic treatments in primary care settings. A number of FDA-approved medications have been shown to be important elements of such treatment."

- SAMHSA

MAT for AUD

Current ASAM guidelines state that opioid agonist treatments are not withheld from patients with AUD or sedative (benzodiazepine) use disorders. Although there is some risk of respiratory suppression when patients combine buprenorphine with alcohol or benzodiazepines, the risk of overdose related to full opioid agonist use in a patient with untreated OUD is much higher. The previous hesitancy to offer buprenorphine to patients with co-morbid AUD now is replaced with the clarifying ASAM guidelines.

Medications for AUD

There are currently three FDA-approved medications to treat AUD: disulfiram, naltrexone and acamprosate. Medications can help patients with AUD increase days of abstinence and reduce heavy drinking days. SAMHSA has published a helpful guide to Managing Medications for AUD (pages three to six has a very good table that compares medications) and a pocket guide called Medication for the Treatment of Alcohol Use Disorder. As with all medications to treat SUD, these medications should be prescribed for a year or longer to ensure the patient achieves long-term abstinence and risk of return to use is decreased.

Disulfiram

Disulfiram's mechanism of action is disruption of alcohol metabolism, causing unpleasant side effects if alcohol is consumed (such as flushing, nausea and palpitations) that can sometimes be severe. It is prescribed for patients who are abstinent from alcohol and plan to maintain abstinence. The patient's alcohol level must be zero prior to first dose. It is dosed orally, usually at 250 mg daily, though some patients need a dose of 500 mg daily for full effect. As compliance is the major barrier to efficacy, it is recommended to have a support person assist the patient with accountability to take their medication daily. Disulfiram has a number of medication interactions; therefore, patients must always have their provider or pharmacy check for drug-drug interactions prior to prescribing. Patients need to avoid all foods, drinks, medications and other substances that contain any alcohol.

Naltrexone

Naltrexone is an opioid antagonist and is useful in treating patients with comorbid AUD and OUD, but it cannot be combined with buprenorphine or methadone. The mechanism of action is not entirely understood, but it appears to reduce

10 U.S. Substance Abuse and Mental Health Services Administration. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*. store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907. Published October 2015. Accessed January 11, 2021.

11 Witkiewitz K, Vowles KE. Alcohol and Opioid Use, Co-Use, and Chronic Pain in the Context of the Opioid Epidemic: A Critical Review. *Alcohol Clin Exp Res*. 2018;42(3):478-488. doi:10.1111/acer.13594

cravings for alcohol as well as enjoyment of alcohol, but it does not block the effect of alcohol. It is available in oral daily dosing 50 mg/day, or once monthly IM injection of 380 mg (Vivitrol). Although it may be used in patients who are still drinking, it is most effective in patients who have been abstinent from alcohol for 4-7 days prior to first dose. As it can cause hepatic side effects, liver function tests need be checked prior to first dose, after 1 month and periodically thereafter. Transaminase elevation of >5 times upper limits of normal is an indication to avoid or discontinue treatment.

Acamprosate

Acamprosate works on GABA receptors to lessen some of the negative post-acute alcohol withdrawal symptoms, such as anxiety, that can trigger cravings and return to use. It can be used in patients who are still drinking, but is more effective in patients who have been abstinent for 4-7 days prior to first dose. It is safe to use in hepatic impairment, but the dosage should be adjusted in renal impairment. It requires three times a day oral dosing (666 mg each) which can be a barrier to compliance with some patients.

Alcohol Use Disorder Medication Differences

The following table from SAMHSA's Medication for the Treatment of Alcohol Use Disorder: A Brief Guide provides an overview of the differences between the AUD medications. View the full table for additional information about contraindications, warnings, and use in pregnant and postpartum women.

SECTION 4

TARGETED TOPICS AND POPULATIONS

CHAPTER 12: PRACTICING MAT DURING A PUBLIC HEALTH EMERGENCY

The anxiety and stress associated with the COVID-19 pandemic has exacerbated symptoms of SUD for many people. The societal response to COVID-19 has resulted in an increase of isolation and difficulties for those needing MAT. Abrupt discontinuation of medications for OUD can lead to withdrawal as well as return to pretreatment substance use, overdose and overdose death.[1]

"Every effort should be made to ensure that patients currently taking buprenorphine have timely access to refills of this medication and that any new patients in need of treatment for opioid use disorder can initiate treatment in a timely manner."

-ASAM

On March 6, 2020, the Centers for Medicare and Medicaid Services agreed to pay for telemedicine encounters during the COVID-19 public health emergency.[2] Federal policies expanded access to MAT during COVID-19. Below is a summary of federal changes during the public health emergency.

ASAM recommendations for providing care for patients with OUD during a pandemic include:[3]

- Maximizing the use of telemedicine to reduce in-person interactions, especially for patients at risk of complications from COVID-19, or when PPE supply is limited.
- Consider deferring in-person drug screening, especially for stable patients, and consider the use of at-home testing options such as virtually observed oral fluid collection.

BUPRENORPHINE

Allows providers to prescribe via video technologies and telephone without an initial in-person medical evaluation

METHADONE

- Take home doses (up to 28 days for stable patients, up to 14 days for less stable patients)
- Home delivery

- Consider offering longer prescription quantities and refilling medications without an in-person visit, especially for stable patients.
- For patients in early treatment, those with polysubstance use, unstable housing or other risk factors for return to use, overdose or diversion, consider increasing frequency of contact with patients via telemedicine and shorter, more frequent medication refills. Telehealth technologies can also be used for observed medication dosing and medication counts in high risk patients.
- Consider switching patients from monthly injectable MAT to daily dosing if risk factors for COVID-19, local pandemic conditions or PPE availability make in-person visits inaccessible. Consider changing from daily dosing to monthly injection if the risk of a monthly in-person visit outweighs the risk of more frequent visits for patients who are unstable or do not have access to a local pharmacy for frequent refills. The decision to change medication

1 American Society of Addiction Medicine. *Caring for Patients During the COVID-19 Pandemic: Access to Buprenorphine in Office-Based Settings*. www.asam.org/Quality-Science/covid-19-coronavirus/access-to-buprenorphine. Updated November 13, 2020. Accessed January 13, 2021.

2 U.S. Centers for Medicare and Medicaid Services. *Medicare Telemedicine Health Care Provider Fact Sheet*. www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. Published March 17, 2020. Accessed January 13, 2021.

3 American Society of Addiction Medicine. *COVID-19 Guidance & Resource Update*. www.asam.org/Quality-Science/covid-19-coronavirus. Updated September 18, 2020. Accessed January 13, 2021.

formulations in a patient who is currently stable should include the patient in a discussion of risks and benefits that these changes pose.

- Patients should have increased access to telemedicine psychosocial supports such as counseling, peer support and mutual support groups, especially as the increased stressors associated with the pandemic may put people at risk for exacerbations of behavioral health problems.

State Resources

- For information about telehealth and licensing during COVID-19, please read this guidance document and visit the State Medical Board website.
- For information about COVID-19 mandates and guidance, please visit the Alaska Division of Corporations, Businesses, and Professional Licensing's COVID-19 information website.

MAT Provider Resources

- Yale Program in Addiction Medicine has a COVID-19 Guidance: Hospital-Based Addiction Treatment document.
- Center for Care Innovations has Key Resources for the COVID-19 Pandemic.
- ASAM has a COVID-19 Guidance and Resource Update.
- SAMHSA has FAQs: Provision of methadone and buprenorphine for the treatment of OUD in the COVID-19 emergency.

CHAPTER 13: PATIENTS WITH PAIN

Patients with Pain

Nearly two-thirds of patients with OUD have a comorbid chronic pain condition; therefore it is critical for providers to understand the appropriate treatment of pain with patients on MAT.[4] Uncontrolled pain can trigger cravings to return to opioid use. The ASAM guidelines recommend opioid agonist therapy (with methadone or buprenorphine) as the medication of choice for most patients with chronic pain as they also serve to provide analgesic relief. Since the analgesic response to methadone and buprenorphine only lasts about 6-8 hours, patients will have improved pain control with three-times-daily split dosing of their medication.

All patients with chronic pain should be offered non-opioid pain management options. The Veterans Administration has an exceptional guide to Chronic Pain Management.

Patients with an untreated OUD who previously responded poorly to non-opioid pain management should be offered these therapies again after being stabilized on MAT. They may experience an improved response.

Non-opioid medications[5]

Medication	Magnitude of Benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/ pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/ norepinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safe than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

4 Hser YI, Mooney LJ, Saxon AJ, Miotto K, Bell DS, Huang D. Chronic pain among patients with opioid use disorder: Results from electronic health records data. *J Subst Abuse Treat*. 2017 Jun;77:26-30. doi.org/10.1016/j.jsat.2017.03.006.

5 U.S. Centers for Disease Control and Prevention. *Nonopiod Treatments for Chronic Pain, Table: Nonopioid Medications*. www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf. Accessed January 14, 2021.

Patients with Acute Pain

When a patient experiences an acute pain event, they may benefit from a temporary increase in their agonist medication. A patient who is taking 16 mg of buprenorphine daily and has an outpatient surgical procedure will likely have appropriate analgesia by increasing their buprenorphine dose to 24 mg a day, divided every 8 hours along with scheduled ibuprofen plus acetaminophen. Although insurance may only pay for 24 mg of buprenorphine daily, patients may benefit from higher doses of 32 mg/day for acute pain control. Stopping buprenorphine prior to surgical procedures is no longer recommended. Buprenorphine should be continued and high dose IV opioid analgesics (typically fentanyl or hydromorphone) may be used in the inpatient setting to manage severe acute pain. The outpatient use of full opioid agonists should be done very cautiously with close monitoring and with a safety plan in place to address risks of relapse and overdose.

Patients on Naltrexone

Acute pain control for patients on naltrexone can be challenging, due to the strong opioid blockade present. If opioids are needed for a planned surgical intervention, oral naltrexone should be discontinued 3 days prior to surgery and extended-release injectable naltrexone should be stopped at least 30 days prior to surgery. In an emergency, hospital providers should first use non-opioid interventions such as high dose NSAIDS, local nerve blocks, conscious sedation, nitrous oxide and ketamine. If a patient's pain remains uncontrolled, the provider may attempt to override the antagonist effect with high dose, high potency opioids with close cardiorespiratory monitoring.

Patients with Complicated Opioid Dependence without OUD

Since CDC recommendations on safe opioid prescribing were released in 2016, many providers have reduced their opioid prescribing, sometimes requiring patients on high dose opioids to taper or stop their medications, or refusing to accept new patients to their practice who are on opioids. Increasingly, patients who have been on long-term high dose opioids for chronic pain may suddenly find that their prescriber is no longer willing to continue their medication or be unable to locate a new prescriber. These patients, sometimes called "opioid refugees," are at risk for severe opioid withdrawal if their medications are reduced abruptly, which can lead to hospitalization. Patients who have opioid dependence but who do not meet criteria for opioid use disorder may be referred to a buprenorphine provider to assist with withdrawal management or to consider transition to buprenorphine for chronic pain management. Buprenorphine can be used with these patients to treat withdrawal symptoms and may also be prescribed for chronic pain. Some advantages to using buprenorphine for chronic pain include reduced overdose risk, reduction in escalating opioid tolerance and possible reduced risk of opioid-induced hyperalgesia. See the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics for more information.

CHAPTER 14: HARM REDUCTION AND POLYSUBSTANCE USE

Harm Reduction Information for Health Care Providers

Harm reduction refers to interventions aimed at reducing the negative effects of health behaviors without necessarily extinguishing the problematic health behaviors completely. Applying harm reduction principles in health care settings may improve clinical care outcomes as these principles enhance the quality of the provider-patient relationship. An enhanced provider-patient relationship positively impacts health outcomes and treatment adherence. Harm reduction strategies include prescribing naloxone, syringe exchange programs, safer injection facilities, overdose prevention programs and policies, and medications for addiction treatment. Harm reduction as an approach is fundamentally different than the traditional medical model of addiction which labels any illicit substance use as "abuse."[6] To learn more about harm reduction, the National Harm Reduction Coalition offers on-demand courses.

Harm reduction principles, definitions and approaches for health care settings [7]

Principle	Definition	Approaches
1. Humanism	▪ Providers value, care for, respect, and dignify patients as individuals. ▪ It is important to recognize that people do things for a reason; harmful health behaviors provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits. ▪ Understanding why patients make decisions is empowering for providers.	▪ Moral judgments made against patients do not produce positive health outcomes. ▪ Grudges are not held against patients. ▪ Services are user-friendly and responsive to patients' needs. ▪ Providers accept patients' choices.
2. Pragmatism	▪ None of us will ever achieve perfect health behaviors. ▪ Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum.	▪ Abstinence is neither prioritized nor assumed to be the goal of the patient. ▪ A range of supportive approaches is provided. ▪ Care messages should be about actual harms to patients as opposed to moral or societal standards. ▪ It is valuable for providers to understand that harm reduction can present experiences of moral ambiguity, since they are essentially supporting individuals in health behaviors that are likely to result in negative health outcomes.
3. Individualism	▪ Every person presents with his/her own needs and strengths. ▪ People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options.	▪ Strengths and needs are assessed for each patient, and no assumptions are made based on harmful health behaviors. ▪ There is not a universal application of protocol or messaging for patients. Instead, providers tailor messages and interventions for each patient and maximize treatment options for each patient served.

6 Hawk, M., Coulter, R.W.S., Egan, J.E. et al. Harm reduction principles for healthcare settings. Harm Reduct J. 2014;14, 70 (2017). doi.org/10.1186/s12954-017-0196-4.

7 *Harm reduction principles for healthcare settings. Table 1.*

Principle	Definition	Approaches
4. Autonomy	▪ Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors to the best of their abilities, beliefs, and priorities.	▪ Provider-patient partnerships are important, and these are exemplified by patient-driven care, shared decision-making, and reciprocal learning. ▪ Care negotiations are based on the current state of the patient.
5. Incrementalism	▪ Any positive change is a step toward improved health, and positive change can take years. ▪ It is important to understand and plan for backward movements.	▪ Providers can help patients celebrate any positive movement. ▪ It is important to recognize that at times, all people experience plateaus or negative trajectories. ▪ Providing positive reinforcement is valuable.
6. Accountability without termination	▪ Patients are responsible for their choices and health behaviors. ▪ Patients are not "fired" for not achieving goals. ▪ Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own.	▪ While helping patients to understand the impact of their choices and behaviors is valuable, backwards movement is not penalized.

Naloxone for Overdose Prevention

Naloxone is a medication which temporarily blocks or reverses the effects of opioids and is used in response to an opioid overdose. Patients who have been abstinent from opioid agonists for an extended period are at particular risk for overdose death if relapse occurs. After a few weeks of abstinence, tolerance to the respiratory depressive effects of opioids is decreased. When patients return to use at the same dosages as prior to abstinence, they may suffer fatal respiratory depression.

Naloxone administration is a safe and cost-effective way to reduce overdose mortality.[8] In most cases the effect is immediate (within 30 to 40 seconds), reversing the effects of the overdose and respiratory depression. This gives time to seek emergency medical assistance. Its use is supported by many organizations, including the Office of National Drug Control Policy and the World Health Organization. Nasal naloxone is generally well tolerated, inducing less severe withdrawal symptoms than IV naloxone, making it well suited to use in community settings.

As relapse is common with individuals with an OUD, it is critical to educate patients and their family members to recognize and respond to overdose. Per ASAM, naloxone for the reversal of opioid overdose should be provided to patients being treated for, or with a history of, OUD. Patients and family members or significant others should be trained in the use of naloxone in overdose. Naloxone training and distribution does not promote drug use and has been shown to reduce risk-taking behavior in high-risk patients. All patients who come for an intake appointment for MAT are recommended to be provided with naloxone training and a free nasal naloxone kit or prescription to fill at a local pharmacy. It takes less than five minutes to train a person to safely use naloxone and many training resources are available.

- Instructional handout for patients: Narcan Nasal Spray Quick Start Guide
- Instructional video for patients and family: Narcan Nasal Spray 4 mg Instructions for Use

The State of Alaska offers free naloxone rescue kits through Project HOPE. Narcan nasal spray kits can be obtained by patients and family through public health offices free of charge. Clinics and providers can sign up to be an overdose response program (ORP) and order free Narcan nasal spray kits and educational materials through Project HOPE. These materials can be distributed free to patients, friends and family who are at risk of witnessing an overdose.

8 Indiana State Department of Health. Naloxone Myths Debunked. www.in.gov/isdh/files/47_naloxone%20myths%20debunked.pdf. Accessed January 21, 2021.

Naloxone nasal spray is covered by most public and private insurances and is available at most pharmacies. Naloxone may be purchased for approximately $150 without a prescription at the pharmacy after a brief consultation and training with the pharmacist.

As part of providing naloxone education, the provider may also counsel patients on other harm reduction measures:

- Never use alone
- Use a smaller dose or "test shot"
- For route of administration, smoke rather than inject
- Don't mix drugs
- Always have a naloxone kit on hand

Fentanyl Strips

Fentanyl test strips can identify the presence of fentanyl in unregulated drugs. They can be used to test injectable drugs, powders and pills. Being aware if fentanyl is present allows people to implement appropriate harm reduction strategies to reduce the risk of an overdose.[9] Several harm reduction focused agencies throughout the state distribute fentanyl testing strips.
Contact ProjectHOPE@alaska.gov in Alaska for fentanyl test strips.

Syringe Access

By Alaska state law, a prescription is required to purchase syringes at a pharmacy or through mail order, however, a pharmacist may dispense syringes at their discretion without a prescription. A provider may also choose to purchase syringes in bulk to distribute to patients at their clinic. The cost of syringes purchased through a nonprofit buyer's club can be significantly lower than retail, as little as $40 per case of 500.

Pharmacies can be an alternative access point to obtain clean injection supplies when syringe access programs are unavailable. Some pharmacies that sell syringes may limit the number a patient can purchase and may require patients to sign a logbook. Providers may talk with a local pharmacist about allowing patients to purchase syringes anonymously.

Alaska currently has four active syringe access programs (SAPs). At SAPs, people may bring in used syringes for the exchange of new syringes and supplies. Syringe access programs and peer support groups provide opportunities for individuals who inject drugs to access information and referral to medical care to prevent HIV. People who inject drugs are offered access to hepatitis vaccination and PrEP to reduce the spread of viral disease. The CDC has a resource list for information about PrEP.

- 4 A's in Anchorage and Juneau
- Interior AIDS Association in Fairbanks
- The Exchange in Homer

The Alaska Native Tribal Health Consortium has a harm reduction program that distributes safety kits with clean injection supplies, condoms, STD testing information and needle disposal systems. They also have an outstanding harm reduction toolkit to help clinics incorporate harm reduction into their services. Contact ANTHC to ask about enrollment in the I Know Mine program. Another available resource for mail order harm reduction supplies is the North America Syringe Exchange Network which offers start-up kits and grants.

9 National Harm Reduction Coalition. Fentanyl. harmreduction.org/issues/fentanyl/. Accessed January 13, 2021.

MAT as a Form of Harm Reduction in Patients with Severe Polysubstance Use Disorders

Polysubstance use involves the consumption of more than one drug at once. Although polysubstance use often refers to the use of multiple illicit drugs, it is also inclusive of prescription medications used in nonmedical circumstances.[10] Polysubstance use is common: the prevalence of AUD in patients with other SUDs is over 30%.[11] Polysubstance use increases the dangers of drug use by increasing the severity of side effects, increasing health problems, and increasing the likelihood of overdose.

Medications for addiction treatment is one of the most commonly used and most effective forms of harm reduction for OUD with polysubstance use. Patients who have a comorbid SUD with an OUD may reduce their use of opioids by taking methadone, buprenorphine or naltrexone, while they continue to use other drugs. Buprenorphine and naltrexone both act as opioid blocking agents, helping to protect the patient from overdose if they do use an opioid. This is especially true for patients who use central nervous system (CNS) depressants such as alcohol or benzodiazepines with opioids, which can be a particularly deadly combination.

The FDA advises that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks.[12]

MAT is a useful method of harm reduction for patients with severe OUD who struggle with engagement in treatment. MAT can keep a patient alive so that they can access treatment when they are ready. The use of cannabis, stimulants, alcohol and/or other addictive drugs should not be a reason to withhold or suspend OUD treatment. However, patients who are actively using substances during OUD treatment may require greater support including a more intensive level of care.[13] Based on their ASAM assessment, providers can use motivational interviewing to encourage patients to follow recommendations for a more intensive level of care (SUD intensive outpatient, SUD residential treatment), but refusal to engage in these services does not disqualify them from receiving outpatient MAT services.

10 American Addiction Centers. Polysubstance Use and Abuse: The Unique Treatment Needs of Polydrug Users. americanaddictioncenters.org/polysubstance-abuse. Updated February 3, 2020. Accessed January 13, 2021.

11 Stinson FS, Grant BF, Dawson DA, Ruan WJ, Huang B, Saha T. Comorbidity Between DSM–IV Alcohol and Specific Drug Use Disorders in the United States: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *Alcohol Res Health*. 2006;29(2):94-106. doi.org/10.1016/j.drugalcdep.2005.03.009.

12 U.S. Food & Drug Administration. FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks. U.S. Food & Drug Administration. www.fda.gov/Drugs/DrugSafety/ucm575307.htm. Published Sept. 26, 2017. Accessed January 13, 2021.

13 American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. eguideline.guidelinecentral.com/i/1224390-national-practice-guideline-for-the-treatment-of-opioid-use-disorder-2020-update/13?. Published March 2020. Accessed January 13, 2021.

Addressing Stimulant Use Disorders

Stimulant use disorders (involving drugs such as cocaine, methamphetamines and prescription amphetamines) have no FDA approved medications for treatment. A recent trial using mirtazapine demonstrated a 20% reduction in methamphetamine use.[14] Naltrexone, bupropion and topiramate are other investigational treatments being studied, but have not shown consistent results. Although extended-release amphetamines are also being studied to treat stimulant use disorders with mixed results, they have a high risk of misuse and should not be used outside of the research setting at this time. Symptoms associated with stimulant use, such as depression and insomnia, should be treated with non-narcotic medications to help improve quality of life.

The most effective treatment for stimulant use disorders is a combination of contingency management and a community reinforcement approach to enhance motivation and make abstinence more rewarding to the patient.[15,16] Patients who participate in programs that combine both, experience reduced drug use, increased retention in treatment and reduction in anxiety levels. HealtheKnowledge has a self-paced course for Contingency Management for Health Care Settings.

Community Reinforcement Approach

Contingency Management Examples

Behaviors Rewarded

- Attending counseling
- Arriving on time for scheduled appointments
- Drug free urine test
- Following MAT prescription

Rewards Offered

- Gift cards
- Draw ticket for prize
- Useful items (clothing, hygiene)

14 Coffin PO, Santos G, Hern J, et al. Effects of mirtazapine for methamphetamine use disorder among cisgender men and transgender women who have sex with men: A placebo-controlled randomized clinical trial. *JAMA Psychiatry*. 2020;77(3):246–255. doi.org/10.1001/jamapsychiatry.2019.3655.

15 Stitzer, M. L, Jones, H. E., Tuten, M., & Wong, C. Community reinforcement approach and contingency management interventions for substance abuse. In W. M. Cox & E. Klinger (Eds.), *Handbook of motivational counseling: Goal-based approaches to assessment and intervention with addiction and other problems*. John Wiley & Sons, Ltd.; 2011: 549–569). doi.org/10.1002/9780470979952.ch23

16 Meyers RJ, Roozen HG, Smith JE. The community reinforcement approach: an update of the evidence. *Alcohol Res Health*. 2011;33(4):380-388. PMID: 23580022

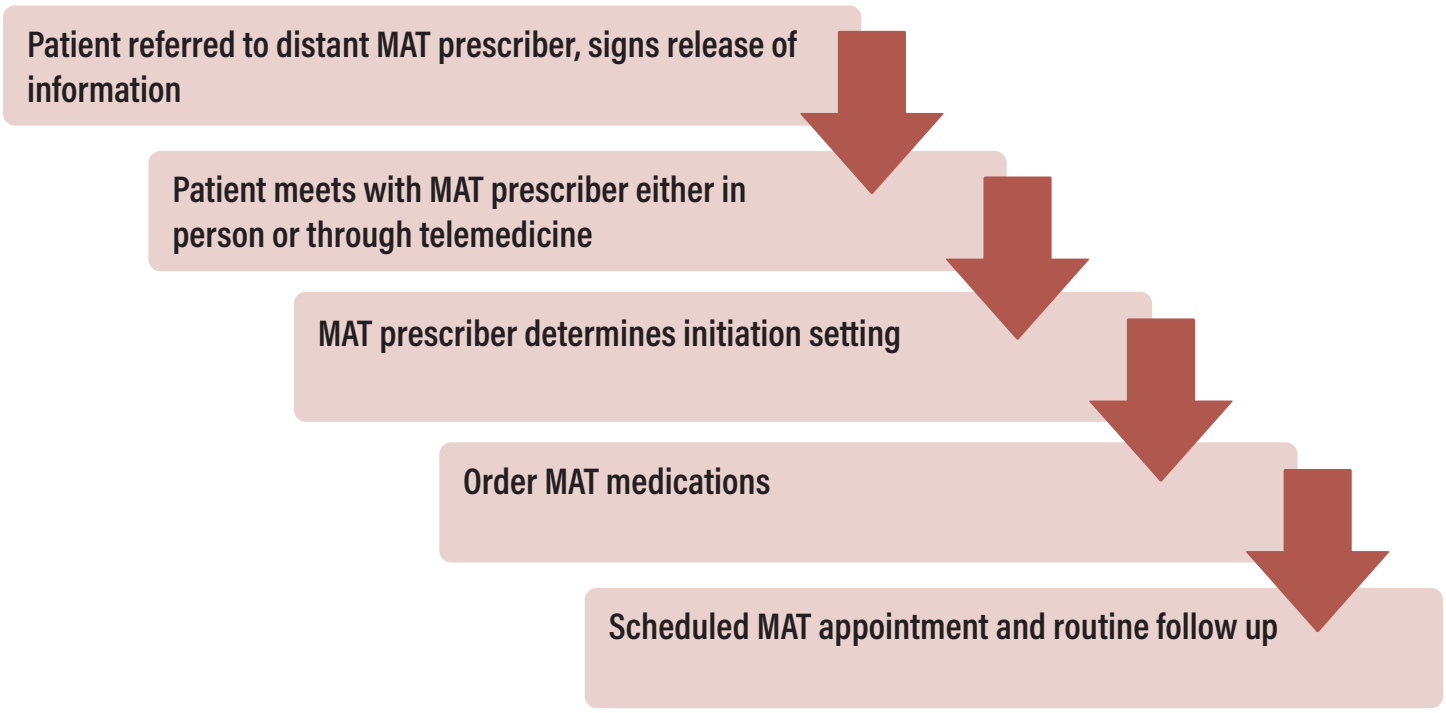
CHAPTER 15: MAT IN RURAL ALASKA

Providing MAT for OUD in rural Alaska poses several challenges, including:

- Limited number of addiction medicine specialists
- Lack of consistent access to onsite licensed medical providers
- Long distance travel to access specialty care, which is subject to weather cancellations
- Limited pharmacy access with mail delivery of prescriptions subject to delay/interruption
- Limited local access to behavioral health care

Patients who live in remote areas may be able to access MAT through telemedicine services. Alaska has a well-established telemedicine system through the Alaska Native health care system. Nearly every Alaska Native village health clinic has telemedicine equipment (such as AFHCAN carts) that can connect via secure video conferencing software to any other Alaska Native clinic or hospital in the state. Most secure telemedicine conferencing applications can also be used with laptops, tablets and smartphones. Native village clinics are typically staffed with a community health aide/practitioner (CHA/P) and many villages have behavioral health aide/practitioners (BHA/P).

Alaska Native Tribal health organizations, as well as private rural clinics or federally qualified health centers, may contract with or develop memorandums of agreements (MOAs) with remote providers who prescribe MAT. MOAs may include details on frequency of visits, random urine drug screens, medication counts and behavioral health services expectations. It is recommended that part of the MOA includes staff education about SUD and MAT. Rural communities have found it beneficial to hold community education about MAT to reduce stigma and to encourage community engagement.



Example of a Model of Care for a Rural MAT Telemedicine Program

Initiation Setting

If an office-based initiation is determined, the patient may need to stay in town for a few days to stabilize on medication before returning home. Home initiations may allow for easier access to care for patients who find it difficult to schedule a longer trip away from home.

Ordering MAT Medications

If the prescriber works for the Alaska Native health care system, they can order MAT medications to be mailed to the patient's home or village clinic from the Alaska Native Medical Center (ANMC) pharmacy. Many commercial pharmacies will also mail medications. Sublingual buprenorphine is available through ANMC pharmacies. ANMC recently added monthly injectable buprenorphine (Sublocade) to its formulary, however they are still in the process of developing policies, procedures and staff training on the use in remote clinics.

Scheduled MAT Appointment

The local provider, medical assistant or community health aide/practitioner (CHA/P) collects vital signs, urine for drug screening and other labs as indicated. The patient is connected via video conference (Vidyo or similar application) to the MAT provider at the distant site. Concluding the telemedicine session, the MAT prescriber communicates with the local provider regarding the treatment plan and sends a copy of the visit note to the village clinic with the patient's permission.

Routine Follow-up MAT Appointments

A licensed provider is not required to be physically present with the patient at a follow-up visit (see telemedicine section for more information). The local provider, medical assistant or community health aide/practitioner collects vital signs, urine for drug screening and other labs as indicated, and performs medication counts. The patient is connected via video conference (Vidyo or similar application) to the MAT provider at the distant site. Concluding the telemedicine session, with the patient's permission, the MAT prescriber communicates with the local provider regarding the patient's progress/treatment adherence with the treatment plan and sends a copy of the visit note to the village clinic.

If an initial in-person visit is not possible, see the section on telemedicine regulations on prescribing without an in-person visit and the Indian Health Services' Internet Eligible Controlled Substance Provider Designation guidance for IHS facilities.

Behavioral health support can be offered by a local BHA, via phone-in and online mutual support groups (such as AA), and via tele-behavioral health visits.

Resources

- IHS Tele-MAT Toolkit
- Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan Volume 1
- Rural Health Information Hub: MAT for OUD in Rural America
- HSS Rural Action Plan

CHAPTER 16: PATIENTS WITH CO-OCCURRING MENTAL HEALTH DISORDERS

Co-occurring disorders (COD) are defined as concurrent substance use and physical or mental disorders. Other terms used to describe co-occurring disorders include dual diagnosis and comorbid disorders. Per ASAM, use of the term co-occurring does not identify which disorder is primary and which is secondary, which disorder occurred first, or whether one disorder caused the other.[17] Treatment that integrates addiction and mental health care is the most effective. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of an opioid use disorder, with appropriate medication management.[18]

Co-occurring mental health conditions are frequently seen in patients with SUD.[19] Providers benefit from knowing the signs and symptoms of common mental health disorders. Depressive disorders and anxiety disorders (including post-traumatic stress disorder) are the most common co-occurring conditions, although ADHD is often encountered across the range of substance use disorders.[20] Nearly 40% of patients with SUD also have a mental health disorder, and nearly two thirds of patients with OUD have experienced mental illness in the past year.[21] Mental health and substance use disorders have common risk factors such as adverse childhood events and genetic vulnerabilities, and patients with mental health disorders may use substances to self-medicate. Some experts favor renaming addiction as "ritualized compulsive comfort seeking" as a common response to the adversity experienced in past trauma.[22] Patients with mental health disorders experience challenges that can result in lower rates of retention in SUD treatment programs, and may need more support services to succeed.[23]

Assessment for mental health disorders should occur at the onset of agonist or antagonist treatment, however, the completion of the assessment should not delay or preclude starting MAT.[24] Pharmacotherapy for individuals with COD is optimally delivered by providers in a context of a broad range of treatment and services to address the needs of the individual. These services may include psychosocial treatment, recovery support and case management. Providers may not have all these resources; therefore, it is recommended that providers develop partnerships with behavioral health agencies and recovery support systems to refer patients with COD.[25]

SUD patients with co-occurring mental health disorders will respond to most standard psychological and pharmacological treatments for psychiatric conditions, although providers

17 *ASAM National Practice Guide.*

18 *ASAM National Practice Guide.*

19 National Institute on Drug Abuse. Comorbidity: Substance Use and other Mental Disorders Infographic. National Institutes of Health. www.drugabuse.gov/drug-topics/trends-statistics/infographics/comorbidity-substance-use-other-mental-disorders. Published August 15, 2018. Accessed January 13, 2021.

20 Renner Jr, JA. Boston University School of Medicine. Module 15: *Managing Common Psychiatric Conditions in Patients with Substance Use Disorders. Providers Clinical Support System*. learning.pcssnow.org/p/ManagingCommonConditions. Released July 26, 2019. Accessed January 13, 2021

21 Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug Alcohol Depend*. 2019 Apr 1;197:78-82. doi.org/10.1016/j.drugalcdep.2018.12.030.

22 Stevens JE. Addiction doc says: It's not the drugs. It's the ACEs…adverse childhood experiences. ACES Too High News. acestoohigh.com/2017/05/02/addiction-doc-says-stop-chasing-the-drug-focus-on-aces-people-can-recover/. Published May 2, 2017. Accessed January 13, 2021.

23 Krawczyk N, Feder KA, Saloner B, Crum RM, Kealhofer M, Mojtabai R. The association of psychiatric comorbidity with treatment completion among clients admitted to substance use treatment programs in a U.S. national sample. *Drug Alcohol Depend*. 2017;175:157-163. doi.org/10.1016/j.drugalcdep.2017.02.006.

24 *ASAM National Practice Guide.*

25 Substance Abuse and Mental Health Services Administration. *General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occuring Mental and Substance Use Disorders*. HHS Publication No. SMA12-4689, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. store.samhsa.gov/product/general-principles-use-pharmacological-agents-treat-individuals-co-occurring-mental-and-Substance-Use-Disorders/SMA12-4689

should avoid the use of medications with a potential for misuse.[26] Providers should also be aware of potential interactions between medications used to treat co-occurring mental health conditions and opioid use disorders.

MAT patients with OUD respond to medications for depression and anxiety at rates similar to those without opioid use disorders. The same core medications used in the general population (such as SSRIs), are used in patients on MAT, with a few special considerations:

- Methadone has many drug-drug interactions, especially with certain antipsychotic medications.
- Patients on naltrexone should be monitored for adverse events, as increased rates of depression and suicidality have been reported.
- Extended release MAT formulations may be useful in patients with comorbid mental health disorders who have difficulty adhering to daily dosing.
- Initiation of benzodiazepines should be avoided whenever possible due to risk of misuse and association of increased overdose mortality when combined with opioid agonists. Patients taking chronic or illicit benzodiazepines should not be denied treatment with methadone or buprenorphine.[27] Patients who are taking benzodiazepines should be monitored closely due to increased overdose risk should the patient return to illicit opioid use. If it is determined that the patient is likely to benefit from the discontinuation of the benzodiazepine, it is important to remember that sudden discontinuation of benzodiazepines in physically dependent individuals can result in life-threatening seizures. A slow benzodiazepine taper should generally be followed, and if a rapid taper is required it should generally be performed in the inpatient setting. For an excellent brief guide, use Helping Patients Taper from Benzodiazepines.
- Non-benzodiazepine treatment for anxiety (such as SSRIs, SNRIs, buspirone, hydroxyzine) and insomnia (doxepin, trazodone, melatonin, TCAs, and CBT-I) are preferred to the use of benzodiazepines.
- Patients with mania or psychosis related to amphetamine use may show complete or partial resolution of these symptoms with cessation of use, although symptoms may be prolonged for weeks or longer some patients. Unstable patients or those with bipolar disorder or schizophrenia may require treatment with mood stabilizers or antipsychotics.
- For patients with attention deficit disorders (such as ADHD), non-amphetamine treatments such as atomoxetine are preferred. Amphetamines carry the risk of misuse and addiction, especially in patients with stimulant use disorders. Stable patients with ADHD who require prescription amphetamines for school or work performance should be closely monitored.

Periodic reassessment is necessary when working with patients with COD. After a patient has been medically stabilized on MAT, it is common for symptoms of mood disorders to improve, and patients should be reassessed when stable. Uncontrolled symptoms of mental health disorders may be a trigger to return to use, therefore patients should be offered appropriate pharmacotherapy and psychosocial therapy for their mental illness.

Patients with Suicidal Ideation

A comprehensive assessment including evaluation of mental health status and suicide risk helps determine whether the patient is psychiatrically stable. Patients with suicidal or homicidal ideation should be referred immediately for treatment and possible hospitalization. Patients with a history of suicidal ideation or attempts should have their medication adherence for the treatment of their opioid use disorder and mental health disorder monitored more closely. MAT may need to be started in the inpatient setting if appropriate.

Resources

- ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update
- TIP 42: Substance Use Treatment for Persons with Co-Occurring Disorders
- General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders

26 *Module 15: Managing Common Psychiatric Conditions in Patients with Substance Use Disorders.*

27 *ASAM National Practice Guide.*

CHAPTER 17: HEPATITIS C TREATMENT

Many patients with a history of intravenous drug use become infected with hepatitis C. Screening for hepatitis C is recommended for all patients with an opioid use disorder. If a patient screens positive for hepatitis C antibody, a follow up test for viral load is recommended to confirm that the patient has active infection.

Alaska Native Tribal Health Consortium has an exceptional toolkit to guide diagnosis and treatment considerations for hepatitis C.

Many insurances now provide good coverage of antiviral medications to cure hepatitis C, even in the absence of liver fibrosis. The Alaska Medicaid coverage criteria and Alaska Medicaid Prior Authorization Form for Antivirals are available from the Alaska Division of Health Care Services. For more resources, please visit the Alaska DHSS Epidemiology website for Hepatitis C.

Hepatitis C Treatment for Individuals who Intravenously Inject Drugs

Active drug use is no longer a contraindication to initiating hepatitis C treatment.

Although guidelines recommend HCV treatment for drug users, 'stigma … has resulted in insurance restrictions and reluctance from providers to offer appropriate medical therapy.' They conclude that HCV-infected injection drug users 'can and should be treated with direct-acting antivirals.'[28]

Studies have shown that individuals who inject drugs are no less likely than others who do not use drugs to achieve success in HCV treatment, with over 90% of patients achieving sustained virologic response at 12 weeks, and with re-infection rates being low. Prior to initiation of treatment, patients should be educated on safer injection practices and have access to clean injection supplies. Targeting treatment to individuals with active intravenous drug use can be an excellent way to reduce the spread of this virus among the highest risk population.

28 Grebely J, Dalgard O, Conway B, et al. Sofosbuvir and velpatasvir for hepatitis C virus infection in people with recent injection drug use (SIMPLIFY): an open-label, single-arm, phase 4, multicentre trial. *Lancet Gastroenterol Hepatol*. 2018;3(3):153-161. doi.org/10.1016/S2468-1253(17)30404-1.

CHAPTER 18: PREGNANCY

For this population, the MAT Guide would like providers to consider women who are pregnant, women who have a newborn child, and women of child-bearing age. Pregnant women with SUD are likely to face more intense stigma compared to women who are not pregnant. Pregnant women with SUD are often reluctant to seek help due to fear of negative judgment or hostile reactions from caregivers.[29] For more information about stigma regarding pregnant woman with SUD, the article "Should Pregnant Women with SUD be Managed Differently" is a great resource.

Opioid use in pregnancy and the increase of newborns effected by prenatal exposure has escalated dramatically in recent years, paralleling the epidemic observed in the general population. Although 31% to 47% of U.S. pregnancies are unintended, research suggests that for women with opioid use disorder, the proportion of unintended pregnancies is higher than 85%.[30] Pregnancy provides an important opportunity to identify and treat women with substance use disorders.[31] The American College of Obstetricians and Gynecologists has several recommendations about pregnant women with an OUD, including screening for substance use disorders, the use of opioid agonist pharmacotherapy, modifying some elements of prenatal care as appropriate, and access to adequate postpartum psychosocial support services.

Prior to initiating treatment, all women of childbearing age should be tested for pregnancy, and when testing is negative, asked about their desire for pregnancy in the coming year. Among women who do not want to become pregnant, support to access effective contraception should be offered as soon as feasible. Women of childbearing age commonly underestimate their risk of pregnancy. Each woman's treatment plan should support her understanding of her risk for conception in the context of her need for MAT. The American College of Obstetricians and Gynecologists supports reliance on a tandem approach of focusing on preventing unintended pregnancy with access to voluntary reversible long-acting contraception and provision of MAT.[32]

MAT with opioid agonist treatment has multiple benefits in pregnancy, including reduced overdose risk, improved engagement in prenatal care, access to SUD counseling and social services, and reduced risk of obstetrical complications. Per the ASAM Guide for the Treatment of Opioid Use Disorder, treatment with methadone or buprenorphine is recommended and should be initiated as early as possible during pregnancy. Medically supervised withdrawal is generally not recommended in pregnancy due to high risk of relapse (50-90%). Relapse jeopardizes both mother and baby with heightened potential to overdose, infectious disease exposure, lack of prenatal care, and pregnancy complications such as preterm birth.

Although methadone historically has been the first line treatment in OUD in pregnancy, buprenorphine is becoming much more widely used due to its availability and research demonstrating that neonatal opioid withdrawal syndrome is less severe. Buprenorphine mono-product (Subutex) has been preferred in pregnancy, rather than the combination buprenorphine/naloxone (Suboxone) product to avoid the infant exposure to naloxone, however absorption of naloxone sublingually is very low and maternal drug levels are not felt to be clinically significant. Recent reviews of the use of the combo product (bup/nalx) in pregnancy has shown it to be safe

29 Olszewski D, Giraudon I, Hedrich D, Montanari L. EMCDDA thematic paper – women's voices: experiences and perceptions of women who face drug-related problems in Europe. European Monitoring Centre for Drugs and Drug Addiction. Office for Official Publications of the European Communities; Luxembourg: 2009. www.emcdda.europa.eu/publications/thematic-papers/womens-voices_en

30 Heil SH, Jones HE, Arria A, et al. Unintended pregnancy in opioid-abusing women. J Subst Abuse Treat. 2011;40(2):199-202. doi.org/10.1016/j.jsat.2010.08.011.

31 American College of Obstetricians and Gynecologists and American Society of Addiction Medicine. ACOG Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy. No. 711. August 2017. www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy. Accessed January 13, 2021.

32 Patrick SW, Schiff DM, Committee on Substance Use and Prevention. A public health response to opioid use in pregnancy. Pediatrics. 2017 Mar;139(3):e20164070. doi.org/10.1542/peds.2016-4070.

and may be a better choice for some women than the mono product.[33]

"While the evidence on the safety and efficacy of naloxone in pregnant women remains limited, the combination buprenorphine/naloxone product is frequently used and the consensus of the guideline committee is that the combination product is safe and effective for this population." [34]

-ASAM

It is important to warn women that there is increased risk of precipitated withdrawal with the combination product if women misuse their medication – through intravenous, insufflated and smoking routes – which could cause fetal stress. For most pregnant women, buprenorphine can be initiated in an office setting. Hospitalization during the initiation of methadone or buprenorphine may be an option for those with co-morbid medical or psychosocial issues due to the potential for adverse events, especially in the third trimester.[35] Naltrexone is not approved for use in pregnancy. There is less data on naltrexone use in pregnancy, and careful consideration of both potential benefits versus risks must be considered for each individual patient. If a woman becomes pregnant while she is receiving naltrexone, it may be appropriate to discontinue the medication if the patient and provider agree that the risk of relapse is low.[36]

Neonatal opioid withdrawal syndrome, sometimes referred to as neonatal abstinence syndrome or NAS, is a result of the sudden discontinuation of fetal exposure to substances that were used or misused by the mother during pregnancy.[37] It is a treatable condition occurring in 30-80% of exposed infants during the first two weeks of life. The Neonatal Abstinence Evaluation Support Treatment (NEST) program at Alaska Regional Hospital has a high nurse-to-patient ratio for medically controlled withdrawal management in an environment that simulates a home nursery with low lighting and reduced sound. Each private space includes sleeping accommodations for one parent.

Unless otherwise contraindicated, mothers receiving methadone or buprenorphine for treatment of OUD are generally encouraged to breastfeed.[38] Long term outcomes are good and most studies have shown no statistical difference in development to age five in babies exposed to methadone.

Naloxone is recommended for use in pregnant women to reverse life-threatening opioid overdose. All pregnant women with OUD need overdose response training and a naloxone kit.

Provider resources:

- Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants
- Opioid Use and Opioid Use Disorder in Pregnancy

Patient handouts:

- Pregnancy: Methadone and Buprenorphine
- Childbirth, Breastfeeding and Infant Care: Methadone and Buprenorphine
- The Perinatal Health Program under the Alaska Division of Public Health has a NAS Patient Booklet that the provider may give to pregnant patients and their families.

33 Use of Buprenorphine-Naloxone (Suboxone) in Pregnancy. Dartmouth-Hitchcock Health, Center for Addiction Recovery in Pregnancy and Parenting. med.dartmouth-hitchcock.org/documents/Use-of-Buprenorphine-Naloxone-in-Pregnancy.pdf. Accessed January 13, 2021.

34 *ASAM National Practice Guide.*

35 *ASAM National Practice Guide.*

36 *ASAM National Practice Guide.*

37 Patrick SW, Barfield WD, Poindexter BB, Committee on Fetus and Newborn, Committee on Substance Use and Prevention. Neonatal opioid withdrawal syndrome. *Pediatrics*. Nov 2020, 146(5) e2020029074. doi.org/10.1542/peds.2020-029074.

38 *ASAM National Practice Guide.*

CHAPTER 19: CRIMINAL JUSTICE

The substantial prison population in the United States is strongly connected to drug-related offenses. The exact rates of inmates with substance use disorders is difficult to measure, however, some research shows that an estimated 65% percent of the United States prison population has an active SUD.[39]

Inmates with opioid use disorders pose a particular challenge. During their time in prison, many untreated inmates will experience a reduced tolerance to opioids due to forced abstinence. Upon release, many will return to levels of use similar to what they used before incarceration, not realizing their bodies can no longer tolerate the same doses, increasing their risk of overdose and death.[40]

Extended release forms of buprenorphine (Sublocade) and naltrexone (Vivitrol), may have multiple advantages for patients involved in the criminal justice system. When SUD treatment is court mandated, monthly injectable MAT allows easy documentation of patient compliance, and avoids any concern about medication diversion. Also, if a patient returns to incarceration in the future, XR buprenorphine will provide long lasting opioid agonist effect, even beyond the one-month timeframe, which can reduce the risk or severity of withdrawal symptoms and relapse to illicit use while incarcerated.

Obtaining a release of information (ROI) with the patient's parole or probation officer can be useful in maintaining open communication on a patient's progress in treatment and can improve patient accountability.

Alaska Department of Corrections

The Alaska Department of Corrections (DOC) processes approximately 29,000 remands annually throughout the state. On any given day there are approximately 5,000 offenders housed within 13 facilities statewide. It is estimated that approximately 15% of offenders assessed within the Alaska Department of Corrections use opioids as their drug of choice. The Alaska DOC offers medication for opioid use disorder (MOUD) that is aligned with evidenced-based treatment practices for individuals entering the correctional setting with a diagnosed opioid use disorder. DOC has a comprehensive screening, assessment, intervention and education model available to all incarcerated individuals. The following is a brief description of the MOUD intervention and treatment options the department offers:

- Screening of all individuals entering a DOC facility for an OUD.
- SUD assessments as needed to further determine seriousness of OUD needs.
- Methadone and buprenorphine bridging for up to 30 days for all individuals remanded with a verified community prescription.
- For individuals expected to be incarcerated for more than 30 days, tapering of methadone and buprenorphine is initiated.
- Pregnant women with an OUD will be offered the opportunity to continue MOUD and pharmacotherapy for as long as therapeutically necessary.
- DOC provides resources for individuals while incarcerated and when returning to the community (education, counseling, help with housing, connection to government benefits, etc.).
- Extended release naltrexone is available to all inmates meeting criteria prior to being released back into the community.
- All individuals released back into the community are offered a Narcan rescue kit.
- DOC is currently piloting the use of buprenorphine for individuals who may be incarcerated for more than 30 days.

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39 National Institute on Drug Abuse. *Criminal Justice DrugFacts*. National Institutes of Health; U.S. Department of Health and Human Services. www.drugabuse.gov/publications/drugfacts/criminal-justice. Published June 2020. Accessed January 13, 2021.

40 Krinsky CS, Lathrop SL, Brown P, Nolte KB. Drugs, detention, and death: a study of the mortality of recently released prisoners. *Am J Forensic Med Pathol*. 2009 Mar;30(1):6-9. doi.org/10.1097/paf.0b013e3181873784.

For further information regarding SUD treatment and services at DOC, contact the criminal justice planner for substance abuse treatment.

Alaska Therapeutic Courts

It is the policy of the Alaska Therapeutic Courts (TC) to incorporate evidenced-based practice for drug courts which includes the use of medications for addiction treatment in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders.

The therapeutic model is not an "easy way out" of a felony or misdemeanor, but an alternative justice model in which a collaborative court team made up of a supervising judge, district attorney, defense counsel, probation officer and/or substance use or behavioral health treatment provider, oversees and closely monitors participants who chose the treatment program in lieu of incarceration. The court team meets weekly to review their progress, and to suggest incentives or sanctions that may best encourage the participants' success. When individuals are accepted into a therapeutic court, participants are required to:

- Have an assessment conducted by a contracted substance use disorder treatment provider.
- Be screened for MAT participation. If appropriate for MAT, the participant will be referred to a MAT provider for a medical assessment for MAT and a MAT prescription.
- Attend court status hearings weekly, bi-monthly or monthly depending on their stage in the program.

The court team relies on the medical provider's treatment plan and recommendations for MAT. MAT is included as a condition of the participant's participation in the therapeutic drug court. If a participant refuses to comply with the medical recommendations it may result in a participant's discharge from the TC program.

Therapeutic courts exist in Anchorage, Bethel, Fairbanks, Juneau, Kenai and Palmer. Visit the Alaska Therapeutic Courts website for more information.

CHAPTER 20: YOUTH

Substance use by adolescents has an enormous impact on their health and well-being. It impairs healthy growth and development, is associated with risky behaviors such as unprotected sex and dangerous driving, and contributes to the development of many other health problems.[41] Currently, less than 25% of adolescents and young adults identified as having OUD are prescribed medications, and for those younger than 18 years old, less than 2% receive MAT.[42,43]

The American Academy of Pediatrics recommends that pediatricians consider offering medications for addiction treatment to adolescents with severe opioid use disorders or discuss referrals to other providers for this treatment.[44] Pediatricians have access to an AAP endorsed buprenorphine waiver course.

When prescribing medications for OUD in adolescents, providers need to be familiar with the clinical practices unique to adolescents. For example, providers need to be comfortable providing family-based overdose prevention education, have knowledge of effective treatment engagement strategies based on adolescent development and have a strong understanding of the confidentiality practices regarding minors.[45]

Medications

Buprenorphine: Approved for use in ages 16 and older. Due to reduced medication compliance seen in adolescents, monthly injectable buprenorphine may result in better adherence.

Naltrexone: Approved for use in ages 18 and older, however a provider may choose to use it off label for an adolescent if it is the best available treatment option. Naltrexone may be the medication of choice in youth who have less than one year of opioid dependence. Naltrexone, which also reduces alcohol cravings, may be a good therapeutic option for adolescents and young adults with co-occurring alcohol use disorder.

Methadone: Because of various restrictions, including the requirement for written consent from a parent/guardian and documentation of at least two prior treatment failures by detoxification and/or outpatient treatment within 12 months prior to methadone admission, methadone is infrequently used in adolescents.[46]

The safety and effectiveness of acamprosate and disulfiram have not been studied in the pediatric population.

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41 Fetal Alcohol Spectrum Disorders Program. *Substance Use Screening and Intervention Implementation Guide. American Academy of Pediatrics.* www.aap.org/en-us/Documents/substance_use_screening_implementation.pdf. Accessed January 13, 2021.

42 Hadland SE, Wharam JF, Schuster MA, Zhang F, Samet JH, Larochelle MR. Trends in receipt of buprenorphine and naltrexone for opioid use disorder among adolescents and young adults, 2001-2014. *JAMA Pediatrics*. 2017;171(8):747–755. doi.org/10.1001/jamapediatrics.2017.0745.

43 Feder KA, Krawczyk N, Saloner B. Medication assisted treatment for adolescents in specialty treatment for opioid use disorder. *J Adolescent Health*. 2017;60(6):747–750. doi.org/10.1016/j.jadohealth.2016.12.023.

44 Levy S, Ryan SA, Gonzalez PK, et al. Medication assisted treatment of adolescents with opioid use disorders. *Pediatrics*. 2016;138:e20161893. doi.org/10.1542/peds.2016-1893.

45 Camenga DR, Colon-Rivera HA, Muvvala SB. Medications for maintenance treatment of opioid use disorder in adolescents: A narrative review and assessment of clinical benefits and potential risks. *Journal of Studies on Alcohol and Drugs*. 2019; 80:4, 393-402. doi.org/10.15288/jsad.2019.80.393.

46 Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Treatment Improvement Protocol (TIP) Series, No. 43.) Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. www.ncbi.nlm.nih.gov/books/NBK64164/

Retention in Treatment

Adolescents and young adults typically have poor retention in treatment. Keeping young people engaged in their medical appointments is crucial to long-term recovery success. Programs that actively engage youth through parental involvement, active outreach via text messaging and rewarding medication compliance with incentives have demonstrated much higher medication compliance and lower dropout rates than treatment as usual.

Minor Patients and Confidentiality

Providers working with youth need to be familiar with confidentiality laws for minors. This includes Alaska state statutes, HIPAA, and 42 CFR 2.14. This guide cannot deliver legal advice and providers who have questions about minor patients and confidentiality should seek legal counsel.

As a general rule, a health care provider may not provide health care to a minor (under age 18) without the consent of the minor's parent or legal guardian, however, there are several important exceptions to this rule. See AS 25.20.025 Examination and Treatment of Minors for some of these exceptions.

HIPAA generally allows a parent to have access to a child's medical records as the minor child's personal representative, as long as the access is not inconsistent with state or other laws (see AS 25.20.025 for state laws). For more information about HIPAA and minor consent visit the U.S. Department of Health and Human Services' Health Information Privacy webpage.

42 CFR Part 2.14 specifically addresses confidentially with substance use treatment as it relates to minor patients. It covers three topics: state law not requiring parental consent to treatment, state law requiring parental consent to treatment, and minor applicant for services lacks capacity for rational choice.

Another helpful resource is the handout Confidentiality Laws, Alaska-Specific. This is part of the Spark Training developed by the Adolescent Health Initiative at Michigan Medicine; February 2019; Ann Arbor, MI.

APPENDICES

APPENDIX I: ABBREVIATIONS

ANTHC	Alaska Native Tribal Health Consortium
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
COD	Co-Occurring Disorder
COWS	Clinical Opiate Withdrawal Scale
CPT	Current Procedural Terminology
DEA	Drug Enforcement Agency
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
FDA	Food and Drug Administration
HIPAA	Health Insurance Portability and Accountability Act of 1996
LOC	Level of Care
MAT	Medications for Addiction Treatment
MCO	Managed Care Organizations
MRO	Medical Review Officers
OBOT	Office-Based Opioid Treatment
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
QAP	Qualified Addiction Professional
QHP	Qualified Health Plans
PA	Prior Authorization or Physician Assistant
PCSS	Provider Clinical Support System
PDMP	Prescription Drug Monitoring Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SUD	Substance Use Disorder

APPENDIX 2: MAT QUALITY PLANNING TOOL

Organization/MAT Program Name: _____ **Date:**_____

Contact name: _____ **Email address:**_____ **Phone number:**_____

This MAT Quality Planning Tool is intended to be used by MAT programs to review and assess their progress related to the development and implementation of the recommended best practices. Periodic use of this tool is encouraged to inform continual quality improvement. The tool is organized into two sections: **Program Development** (staffing, training, policies and procedures, and other infrastructure needs) and **Program Implementation** (staffing, training, treatment delivery). Suggested measures are provided for each recommendation to help programs assess the extent of their implementation of best practices. The page numbers referenced for each best practice recommendation indicates the section in the Alaska Medications for Addiction Treatment Guide where more detail is available.

Program Development: Staffing

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
1. Establish a core team to deliver MAT (to include at least one prescriber, behavioral health clinician, care coordinator, administrative support)	# of Prescribers # of Non-prescribing health care providers # of BH clinicians # of Care coordinators	☐	☐	☐	☐	☐		13
2. Develop clearly defined, written roles and responsibilities for each member of the MAT team	Written protocol (e.g. workflow, job descriptions)	☐	☐	☐	☐	☐		13

Program Development: Training

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
3. Ensure prescribers become waivered to prescribe buprenorphine	Total # of waivered prescribers # of MDs/DOs	☐	☐	☐	☐	☐		10
4. Provide training to each prescriber on FDA-approved opioid and alcohol use disorder medications (e.g. pharmacotherapy, contraindications)	# and types of trainings % of providers in attendance by provider type	☐	☐	☐	☐	☐		10
5. Provide initial training and resources related to substance use disorders and MAT to all staff, including administrative staff	# and types of trainings % of staff in attendance	☐	☐	☐	☐	☐		10

Program Development: Policy and Procedure

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
6. Develop procedures to evaluate patients for eligibility onto MAT (e.g. screening, assessment, physical exam)	Documentation of procedures Assessment instrument identified Screening tool identified	☐	☐	☐	☐	☐		19
7. Establish a process to routinely review and share PDMP data with prescriber (e.g. frequency, person responsible for checking PDMP)	Written procedure Documentation of checklist of items to review in PDMP Role identified for checking and sharing data	☐	☐	☐	☐	☐		12
8. Develop drug testing policies and procedures (e.g. frequency, testing type, responding to expected and unexpected test results, method of collection)	Documentation of drug testing policy	☐	☐	☐	☐	☐		26
9. Develop written initiation procedures	Documentation of initiation procedures	☐	☐	☐	☐	☐		41
10. Establish billing policies and procedures	Documentation of billing policy	☐	☐	☐	☐	☐		14
11. Establish policies and procedures specific to communicating with team, external providers, and patients (e.g. confidentiality, documentation)	Documentation of communication policies	☐	☐	☐	☐	☐		31, 33
12. Develop diversion control policies and procedures	Documentation of diversion policy	☐	☐	☐	☐	☐		29
13. Create patient consent form that is compliant with 42 CFR Part 2 requirements	Consent form	☐	☐	☐	☐	☐		
14. Create patient treatment agreement	Treatment agreement	☐	☐	☐	☐	☐		21
15. Establish continued patient practice participation guidelines (including for non-adherent patients, voluntary discharge, treatment completion)	Documentation of continued patient practice participation guidelines	☐	☐	☐	☐	☐		23

Program Development: Other Infrastructure Needs

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
16. Make modifications to electronic health record to collect, track, and measure patient outcomes	Description of new fields added Successful retrieval of data (e.g. data reports)	☐	☐	☐	☐	☐		
17. Establish agreements with external behavioral health providers	Written agreement(s)	☐	☐	☐	☐	☐		13
18. Establish agreements with external peer recovery support service providers	Written agreement(s)	☐	☐	☐	☐	☐		13
19. Establish collaborative relationships with ancillary service providers (e.g. transportation, childcare)	Written agreement(s)	☐	☐	☐	☐	☐		
20. Identify process for determining treatment and recovery support and social service resources	Written agreement(s)	☐	☐	☐	☐	☐		24
21. Determine mechanism for referring patients to higher levels of care and other supports, as needed	Role identified for managing referrals	☐	☐	☐	☐	☐		

Program Implementation: Staffing

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
22. Establish team meetings at least once a week	Regular meeting time # of meetings held	☐	☐	☐	☐	☐		

Program Implementation: Training

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
23. Provide ongoing training and resources related to substance use disorders and MAT to all staff, including administrative staff	# and types of trainings % of staff in attendance	☐	☐	☐	☐	☐		10

Program Implementation: Patient Evaluation

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
24. Assess patients using ASAM dimensions	Assessment instruments used	☐	☐	☐	☐	☐		18
25. Screen patients routinely for co-occurring diseases	Screening tool(s) used Documentation of screening results	☐	☐	☐	☐	☐		19, 21
26. Conduct physical exam, at a minimum identifying for intoxication, impairment or withdrawal	Documentation of physical exam Documentation of withdrawal risk assessment(s)	☐	☐	☐	☐	☐		21
27. Draw labs to include testing for infectious disease, pregnancy, liver function and blood counts	Documentation of lab results	☐	☐	☐	☐	☐		21
28. Conduct drug tests	Documentation of test results	☐	☐	☐	☐	☐		26
29. Determine diagnosis of opioid use disorder	Documentation of diagnosis	☐	☐	☐	☐	☐		19. 21
30. Query PDMP	Documentation of PDMP Review (e.g. field in HER, administrative note)							12, 21
31. Inform patients about MAT medications available and recommended as most appropriate	Documentation of discussion							21, 35, 37

Program Implementation: Treatment Delivery

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
32. Develop written individualized treatment plan with each patient	Documentation of treatment plan	☐	☐	☐	☐	☐		21
33. Obtain signed treatment agreement from all patients	Signed agreement	☐	☐	☐	☐	☐		21
34. Obtain signed 42 CFR Part 2 compliant consent forms from all patients to allow for communication with external providers	Signed consent forms	☐	☐	☐	☐	☐		16
35. Start patient on medications for addiction treatment (induct as needed)	Documentation of initiation	☐	☐	☐	☐	☐		41, 46
36. Schedule patients with routine prescriber visits based on treatment progress/ recovery status and other factors	Documentation of initiation	☐	☐	☐	☐	☐		22
37. Query the PDMP each time a prescription is written	Documentation of PDMP check	☐	☐	☐	☐	☐		10, 12, 22, 29
38. Conduct drug tests	Documentation of drug results	☐	☐	☐	☐	☐		10, 26, 29
39. Conduct random drug tests	Documentation of drug results	☐	☐	☐	☐	☐		10, 22, 26, 29
40. Conduct random pill/film counts	Documentation of random check	☐	☐	☐	☐	☐		10, 22, 26, 29
41. Review treatment plan at every visit for each patient	Documentation of review	☐	☐	☐	☐	☐		21, 31
42. Update treatment plan as needed for each patient	Documentation of updated treatment plan	☐	☐	☐	☐	☐		21, 28, 38
43. Actively refer patients to SUD treatment services as needed	Documentation of treatment services # or % of patients referred to treatment services # or % of referrals by level of care	☐	☐	☐	☐	☐		21, 28, 32

Best Practice Recommendations	Measures	Implementation Status					Comments	Page #
		Not Developed	In Development	Developed	Developed and regularly implemented	Not Applicable		
44. Actively refer patient to peer recovery support services as needed	Documentation of recovery support services # or % of patients referred to recovery support services	☐	☐	☐	☐	☐		24, 25
45. Provide care coordination to patients for other needs (e.g. mental health provider, primary care services)	Documentation of care coordination # or % of patients referred to other services # or % of referrals by service type	☐	☐	☐	☐	☐		13
46. Communicate regularly with external provider(s)	Documentation of communication with external providers	☐	☐	☐	☐	☐		13
47. Provide routing support to patients outside of office visits (e.g. phone check-ins)	Documentation of communication	☐	☐	☐	☐	☐		13

APPENDIX 3: FINDING SUBSTANCE USE DISORDER TREATMENT IN ALASKA

Below are some links for SUD treatment in Alaska. These links are for approved Alaska Department of Health and Social Services, Division of Behavioral Health programs. Many other programs exist in the state, but they do not fall under the state's purview since they are not state funded and/or are not billing Medicaid through the state.

- **Medications for Addiction Treatment Providers**
  dhss.alaska.gov/dbh/Documents/TreatmentRecovery/SUD%20Providers/Medication%20Assisted%20Treatment%20Providers.pdf
- **Outpatient & Residential SUD Providers in Alaska**
  dhss.alaska.gov/dbh/Documents/TreatmentRecovery/SUD%20Providers/Substance%20Use%20Disorder%20Treatment%20Providers.pdf
- **Residential Substance Use Disorder Treatment Bed Availability**
  dhss.alaska.gov/dbh/Pages/ResidentialSUD/
- **Residential Withdrawal Management and Detoxification Services**
  dhss.alaska.gov/dbh/Documents/TreatmentRecovery/MAT/Withdrawal_Management_and_Detoxification_Services.pdf
- **Opioid Treatment Programs in Alaska**
  dpt2.samhsa.gov/treatment/directory.aspx
- **SAMHSA's Buprenorphine Practitioner Locator for Alaska**
  www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator?field_bup_physician_us_state_value=AK
- **DHSS Directory of Private Substance Abuse Treatment Agencies Approved by DBH to Receive ASAP and other Criminal Justice Referrals**
  dhss.alaska.gov/dbh/Documents/Prevention/programs/asap/DBH-Private-Referral-List.pdf

APPENDIX 4: MAT RESOURCES

Alcohol | Buprenorphine waiver trainings | Diversion | Drug testing | For patients, friends and family | General resources | Initiation/induction | Naltrexone

Alcohol

- **Medications for the Treatment of Alcohol Use Disorder: A Brief Guide**
  store.samhsa.gov/sites/default/files/d7/priv/sma15-4907.pdf
- **SAMHSA Medication Assisted Treatment of Alcohol Use Disorder: Pocket Guide**
  store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-Pocket-Guide/SMA15-4907POCKETGUID

Buprenorphine Waiver Trainings

- **American Society of Addiction Medicine (ASAM)**
  www.asam.org/education/live-online-cme/waiver-qualifying-training
- **Providers' Clinical Support System for Medication Assisted Treatment**
  pcssnow.org/medications-for-addiction-treatment
- **Harvard Medical School OUD Courses**
  cmeregistration.hms.harvard.edu/events/identification-counseling-and-treatment-of-oud/custom-39-fdaa0a8f057049f5821fce69c22ca9c2.aspx
- **American Psychiatric Association**
  www.psychiatry.org/psychiatrists/education/signature-initiatives/buprenorphine-prescriber-training

Diversion

- **Diversion Control Protocol Template for Opioid Use Disorder Treatment Providers**
  media.campaigner.com/media/33/333080/MAT-PDOA%206-28-17/MAT_PDOA_DiversionControlTemplate.pdf
- **PCSS Guidance on Adherence, Diversion and Misuse of Sublingual Buprenorphine**
  pcssnow.org/wp-content/uploads/2014/02/PCSS-MATGuidanceAdherence-diversion-bup.Martin.pdf
- **Reducing Risk of Misuse and Diversion from Great Lakes ATTC**
  www.niatx.net/wp-content/uploads/2020/03/2MAT_Diversion.pdf

Drug Testing

- **Appropriate Use of Drug Testing in Clinical Addiction Medicine**
  1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/11/appropriate_use_of_drug_testing_in_clinical-1-7.pdf
- **Urine Drug Testing in Clinical Practice**
  1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/07/2012-GourlayHeit-UDT-monograph.pdf
- **ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine Pocket Guide**
  eguideline.guidelinecentral.com/i/840070-drug-testing-pocket-guide/0?

For Patients, Family and Friends

- **SAMHSA Decisions in Recovery: Treatment for Opioid Use Disorder**
  store.samhsa.gov/product/Decisions-in-Recovery-Treatment-for-Opioid-Use-Disorders/SMA16-4993
- **ASAM Opioid Addiction Treatment: A Guide for Patients, Families and Friends**
  www.asam.org/docs/default-source/publications/asam-opioid-patient-piece_-5bopt2-5d_3d.pdf
- **Recovery Research Institution Guide for Family Members**
  www.recoveryanswers.org/resource/guide-family-members
- **MAT Handouts for Patients and Family Members**
  pcssnow.org/resource/mat-handouts-for-patients-and-family-members
- **Medication-Assisted Treatment for Opioid Addiction**
  www.californiamat.org/wp-content/uploads/2019/06/MAT-InfoFamilyFriends.pdf

General Resources

- **ASAM National Practice Guidelines for the Treatment of Opioid Use DIsoder-2020 Focused Update**
  Guideline: www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf
  Pocket Guide: eguideline.guidelinecentral.com/i/1224390-national-practice-guideline-for-the-treatment-of-opioid-use-disorder-2020-update/0?
- **SAMHSA TIP 63: Medications for Opioid Use Disorders**
  store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006
- **Providers' Clinical Support System**
  www.pcssnow.org
- **Center for Care Innovations**
  www.careinnovations.org/atshprimarycare-teams/resource-hub
- **Opioid Response Network – STR-TA**
  opioidresponsenetwork.org
- **Continuing Education Options on Opioids, Pain Management and Addiction for Alaska**
  dhss.alaska.gov/dph/Director/Pages/opioids/education.aspx
- **Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals**
  attcnetwork.org/centers/global-attc/product/buprenorphine-treatment-training-multidisciplinary-addiction
- **U.S. Department on Health and Human Services Resources for Opioid Treatment Providers**
  www.hhs.gov/opioids/treatment/resources-opioid-treatment-providers
- **Drugs of Abuse: A DEA Resource Guide 2017 Edition**
  www.dea.gov/sites/default/files/2018-06/drug_of_abuse.pdf
- **Addictionary**
  www.recoveryanswers.org/addiction-ary

Initiation (Induction)

- **A Patient's Guide to Starting Buprenorphine at Home**
  www.asam.org/docs/default-source/education-docs/unobserved-home-induction-patient-guide.pdf
- **PCSS Buprenorphine Induction**
  pcssnow.org/education-training/training-courses/buprenorphine-induction
- **Alaska Patient Guide for Beginning Buprenorphine Treatment**
  dhss.alaska.gov/dbh/Documents/Resources/initiatives/ebp/MAT-ED-Patient-Guide.pdf
- **Alaska Emergency Department Buprenorphine Guide**
  dhss.alaska.gov/dbh/Documents/Resources/initiatives/ebp/MAT-ED-Physican-Guide.pdf

Naltrexone

- **Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide**
  store.samhsa.gov/product/Clinical-Use-of-Extended-Release-Injectable-Naltrexone-in-the-Treatment-of-Opioid-Use-Disorder-A-Brief-Guide/SMA14-4892R
- **XR-Naltrexone: A Step-by-Step Guide**
  pcssnow.org/wp-content/uploads/2017/02/Naltrexone_Step-by-Step_Virtual_Brochure-1.pdf