



Frequently Asked Questions The Medications for Addictions Treatment (MAT) Program

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1. What is MAT?

Medication Assisted Treatment, also known as Medications for Addiction Treatment, is a program in our clinic developed as a response to the Opioid Epidemic. In our MAT program we offer medications to stabilize the brain and provide whole person recovery support. Our MAT Program is RN Case Managed with a waived provider, SUD counseling and Integrated Behavioral Health care. Our MAT program offers Phased Care and a weekly MAT Refill/Stabilization Group along with specialty groups, counseling and referrals to recovery providers in our communities.

2. What is a waived or x-waived provider?

A waived provider refers to a physician, nurse practitioner, or physician assistant who has undertaken required training in order to prescribe buprenorphine to treat Opioid Use Disorder (OUD).

3. What is Opioid Use Disorder?

Tolerance to opioids and withdrawal symptoms are the primary signs of physiologic opioid dependence. Opioid Use Disorder is the physiologic dependence on full-agonist opioids *plus* the behaviors of compulsive misuse and continued misuse in the face of ever-increasing consequences. These consequences can lead to losses, poor health, overdose and death by overdose. The consequences of opioid use disorder also impact the user's family and community.

4. What are some commonly known full-agonist opioids?

A full-agonist opioid attaches to the opioid receptors in the brain and activates effect. Some full-agonist are long-acting such as Methadone or short-acting such as heroin. Oxycodone (OxyContin, Percocet), hydromorphone (Dilaudid), and fentanyl are also commonly prescribed full-agonist opioids. Heroin is the most common illicit full-agonist opioid. The prescription opioid medications can also be diverted and illegally circulated for misuse.

5. Is it possible to be Opioid Dependent and not have Opioid Use Disorder?

Yes, opioid dependence can occur when prescribed full-agonist opioid medication to manage pain and when taken as prescribed. Daily use of prescribed opioids for pain management will cause opioid dependence which includes tolerance and withdrawal symptoms if the opioids are abruptly stopped. Please see the new Center for Disease



Control and Prevention (CDC) guidelines for opioids and pain management. Long-term opioid therapy for management of chronic pain places the patient at risk for opioid use disorder and requires monitoring and care by their provider

6. What are the medications utilized to treat Opioid Use Disorder?

Buprenorphine – is a partial agonist synthetic opioid developed in the '70's. In 2002, the FDA approved the prescribing of Buprenorphine combined with **naloxone** for the treatment of opioid use disorder. Buprenorphine/Naloxone combo medication brand name is Suboxone. The properties of high affinity for the opioid mu receptors, 37-hour half-life and a ceiling effect can bring full relief to opioid cravings and opioid withdrawal symptoms without euphoria. When prescribed appropriately, Buprenorphine rapidly normalizes the brain. Buprenorphine is best absorbed through the skin. Buprenorphine comes in various doses as sublingual tabs, sublingual film, a weekly transdermal patch and as a subcutaneous monthly injection. When combined with Buprenorphine, naloxone, an opioid antagonist is mostly an inactive ingredient as it does not have bioavailability when taken through skin. The naloxone has been combined with buprenorphine to decrease misuse and diversion. Buprenorphine only has a brand name of Subutex. Buprenorphine/naloxone is now available as a generic medication.

XR- Naltrexone – is known by the brand name Vivitrol. Naltrexone is a full antagonist, so it protects the receptors from being occupied by full agonist opioids. Naltrexone does not manage opioid cravings but since naltrexone is a common treatment for alcohol cravings, this is an excellent option for patients with both Alcohol Use Disorder (AUD) and OUD. XR- Naltrexone is a monthly IM injection. As a once-a-month treatment, XR- Naltrexone can offer protection for patients who have barriers to getting to clinic and pharmacy or difficulty adhering to other medications.

Methadone – methadone is a long-acting full-agonist opioid dispensed by Opioid Treatment Programs (OTP), federally-regulated clinics which dispense daily doses of methadone for OUD treatment. Many people choose this option of treatment over buprenorphine. Regulations make this a less convenient option, but daily dosing can make it the appropriate level of care. As patient stabilizes with Methadone treatment, they can progress to graduated 'take-homes' thus not required daily at the methadone dispensary.

Naloxone – Naloxone, a full-antagonist, is commonly known by the brand name NARCAN. NARCAN is delivered via an intranasal spray to rapidly reverse opioid overdose. Every patient in our MAT program is prescribed NARCAN. NARCAN is also available to all Chapa-De staff through staff trainings or upon request from the MAT RN Case Managers. California state law requires that any patient receiving prescriptions for any opioid medication 90 mg daily or higher MUST be prescribed Naloxone (NARCAN).



7. What is Substance Use Disorder?

Substance Use Disorder is a chronic progressive relapsing disease of misuse of addictive substances. Substance use disorders are measured on a continuum of mild to moderate to severe. The criteria for a SUD diagnosis can be found in the DSM-5, the diagnostic manual for Psychiatry and Behavioral Health. Common substance use disorders: tobacco use disorder, alcohol use disorder, stimulant use disorder, opioid use disorder, sedative hypnotic use disorder.

8. How does someone enter our MAT Program?

We are committed to easy and rapid access to our program. We respond to referrals from providers, behavioral health, dental, county programs, drug court, Child Protective Services and self-referrals. We adhere to the “no wrong door” approach to access for MAT care. All referrals will go to the MAT RN Case Manager for assessment and planning.

9. Important things to know about our MAT Program.

Our patient-centered MAT program offers medications, primarily Buprenorphine in its various formulations. Every MAT patient starts in the program in Phase 1 which requires weekly group attendance including provider visit, weekly Urine Drug Screens and weekly Buprenorphine prescriptions. Our Phase 1 provides care for both harm reduction and abstinence-directed patients. Once a patient is stable, they progress at their own pace to Phase 2 (every 14 days) and monthly Phase 3. All MAT care is integrated with medical, nursing, SUD and Behavioral Health. Groups are managed by the MAT team. This group visit includes brief encounter with our MAT provider.

10. Can Buprenorphine be helpful with managing chronic pain?

We provide a Buprenorphine for Pain Management pathway care for our patients who do not meet the criteria for OUD diagnosis. There may be another co-occurring substance use disorder such as alcohol use disorder which we will treat along with pain management. Many of our patients living with chronic pain find improved pain management with Buprenorphine.

11. What is stigma?

Stigma is a barrier to care communicated by language, tone and judgmental attitude. Because of this judgment, there can be a decrease in quality of care. Stigma is a form of discrimination. *Stigma injury* is a wounding which occurs over time when a person seeking care for SUDs develops fear and distrust of medical care because of repeated exposure to stigmatizing attitudes and language. Stigma shows up in Drug and Alcohol Treatment programs, public policies, insurance disparities and even in our screening tools.



It is not unusual to find the strongest stigma expressed towards persons with addictions within the walls of care, within our clinic and medical cultures. Most of us have been directly touched by alcohol use disorder and other substance use disorders – there are often feelings of frustration, anger, grief and loss which can color an individual’s attitudes towards our patients who suffer with the diseases of addiction.

11. How can we change stigma and provide a safe, welcoming clinic for people seeking help for opioid use disorder and substance use disorders?

Remove stigma in our language. We encourage all of our staff to change stigmatizing language. The easiest are the most common. Eliminate drug-related street language. Appropriate language conveys respect and dignity. A few examples:

- “Abuse” as in Substance Abuse is no longer used in medical lexicon or in any professional way. Instead, we say “substance use” or “misuse” or “use”.
- “Addict” – instead you can say *person with substance use disorder* or *people who inject drugs* or *opioid users*. There is never any good reason to use the term “Drug Addict”.
- Self-identifying as “alcoholic” or “addict” in 12 Step meetings is still considered acceptable by those communities.
- “Drug-seeking” or “med-seeking” – can be re-framed as “relief-seeking”. Focus on the person rather than the behavior.

Most common and possibly, the most pejorative:

- In medicine, we do not refer to lab results, such as the results for Urine Drug Screens as “clean” or “dirty”, we use medical language at all times to support the dignity of our patients. We describe results as positive or negative.

Rather than correcting others, model the use of non-stigmatizing language.

It is important to offer positive **body language, attitude and tone**: respectful eye contact, warm smiles and appropriate voice. Studies have shown that when patients are identified as “drug addicts” in Emergency Departments, their care is diminished and shortened in time. There is a high correlation between childhood trauma and opioid use disorders and all substance use disorders.

A trauma-informed environment provides a sense of safety and comfort. Developing trauma-informed programs and a trauma-informed care environment requires training.

Recommended links: <https://www.cdc.gov/drugoverdose/epidemic/index.html>