MEDICATION ASSISTED TREATMENT
COMMUNITY OF PRACTICE

Discovery, Recovery, Relapse Prevention: Treatment Planning for MAT Care Models

October 10, 2019

Disclosures

No individuals in a position to control content for this activity have any relevant financial relationships to declare.

WELCOME & INTRODUCTIONS

Purpose of MAT CoP

To promote and support the successful implementation of an integrated MAT approach in healthcare settings.

MAT CoP Resources

MAT Google Group

To join discussions about MAT program development, email Adelaide Murray at adelaide_murray@jsi.com.

Resources & Tools

Resources to support implementation of MAT programs can be accessed on the Center for Excellence website: http://nhcenterforexcellence.org/resources/community-of-practice-resources/

MAT Technical Assistance

Submit requests to the Center for Excellence: http://nhcenterforexcellence.org/center-services/request-ta/

Medication Assisted Treatment (MAT) Resources

MAT Community of Practice (CoP)

The CoP intends to promote and support the successful implementation of an integrated MAT approach in healthcare settings.

Opportunities include:

- Group Meetings
  - In-person meetings every other month 2:00pm-4:30pm at the NH Hospital Association, 125 Airport Road, Concord, NH
  - 2019 Meetings: February 14, April 11, June 13, August 8, October 10, December 12
- Clinical Case Conference Calls
- Resources & Tools
  - Includes past meeting materials available on the NH Center for Excellence website (https://nhcenterforexcellence.org/resources/community-of-practice-resources/medication-assisted-treatment-cop-resources/)
- Discussion Group
  - Email-based Google Group to share resources and join discussions
- Technical Assistance

Interested? Contact Adelaide Murray at adelaide_murray@jsi.com

MAT Guidance Document

Compilation of best practice recommendations and resources for the implementation of MAT (https://nhcenterforexcellence.org/resources/reportsplanspublications/mat-best-practice-guidance-document-second-edition/)

MAT Quality Planning Tool

Tool to assess MAT program development and implementation and to inform continual quality improvement. (http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2018/04/FINAL_MAT_Quality_Planning_Tool_3-30-18.pdf)

Buprenorphine Waiver Training

Free 8-hour in-person training for physicians interested in seeking their waiver to prescribe buprenorphine for the treatment of opioid use disorders. For physician assistants and nurse practitioners the eight-hour training counts toward the required 24-hour waiver requirement. More information can be found on the NH Medical Society website (https://www.nhms.org/).

Happy Anniversary!

October 2017	October 2019
24 registrants	53 registrants
120% increase!	
14 organizations	29 organizations
107% increase!	

Objectives

1. Contrast discovery, recovery, and relapse prevention treatment planning.
2. Examine discovery treatment planning within a participant's practice care model.
3. Compare treatment planning among various care models.

TREATMENT PLANNING BASED ON STAGES OF CHANGE

Paul Kiernan, LADC
NH Center for Excellence
paul_kiernan@jsi.com

Good Treatment Planning Begins with Good Assessment

- What are the specific problems that the patient is experiencing?
- Why has the patient decided to seek treatment now?
- What do they hope to get out of treatment?
- Assessment summary should contain problem statement.
- ***If you are having a problem with treatment planning, start by looking at your assessment tool as well as your practice.***

ASAM Criteria Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

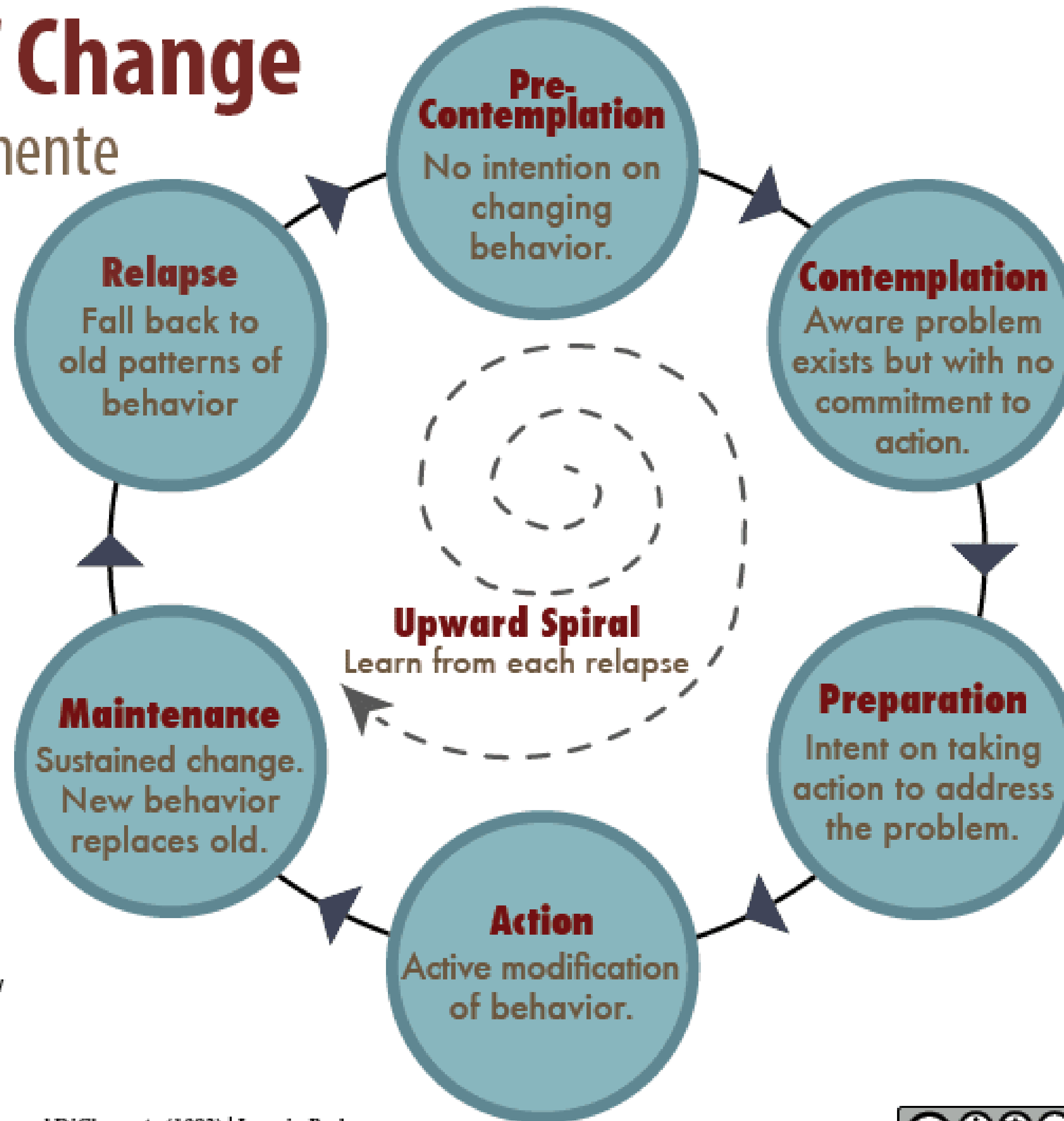
Dimensional Assessment

- What are the patient problems in each dimension?
  - Use motivational interviewing skills to elicit more nuanced features of a patient problem.
- Understand different stages of change for different problems.
  - If the patient has multiple problems, which are the ones that are most important to them? Which ones are driving the need for the current level of care?

The Cycle of Change

Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



The Cycle of Change
Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco

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Stages of Change

Readiness To Change

- Concepts of “readiness to change” and “stage of change” are not person-specific, but problem- or issue-specific.
  - Patients may be at difference stages of change for different issues.
- Attention must be paid to these potentially different and co-occurring stages of readiness in order to sufficiently reduce risk of relapse to addictive disorders.

Readiness to Change

- Understanding variability of readiness to change facilitates more accurate treatment engagement and service matching.
- Assessment of stage of change is designated from the client's point of view:
  - What the individual needs to change and accept as a condition of requiring treatment.
  - ***A patient's motivation may not be what the clinician thinks they should be motivated about.***

Discovery

- For patients with less readiness to change.
- Discovery treatment plans:
  - May be uncomfortable
  - Are more difficult to make “SMART”
  - May be difficult to articulate for the patient and clinician
  - *“Jon will identify how he will continue to use without upsetting his wife”*

Discovery *(Continued)*

- An “unsuccessful” treatment goal may help create movement through stages of change.
- May not require treatment planning in Dimension 5 as the patient is continuing to use.

Recovery

- More familiar, comfortable treatment plans
  - *"Jennifer will identify and demonstrate the use of 4 coping tools to deal with craving, Jennifer will complete a personalized relapse prevention plan"*
- Easier to make "SMART".
- Can be more difficult to make patient specific.
- For patients who are in preparation/action stage.
- Dimension 5 treatment plans.
- Relapse Prevention.

Getting to the Problem – Which is it?

- "I don't really want to stop using but my probation officer told me to come here."
- "I was stopped for DWI and I didn't even feel drunk. I went to the IDCMP and they are making me do 6 sessions."
- "No matter how hard I try, I can't stop thinking about getting high."
- "The only thing that makes me feel better is drinking, but it is affecting my marriage."
- "I want to stop drinking, but I don't want to give up my friends who drink."
- "I tried to cut down my drinking but I always end up drinking more than I intended. I need to find a way to stop."
- "I need to stop smoking pot and drinking while I am on probation or my PO is going to violate me."

Problem Statements

- “I have made repeated attempts to stop using opioids and I can’t stop even after an overdose last week.”
- “I tested positive for Fentanyl. My probation officer is threatening to throw me in jail if I don’t do something.”
- “I got a DWI. I really don’t have a drinking problem, just in the wrong place at the wrong time.”
- “I am afraid to ask for a sponsor because I don’t think anyone would want to sponsor me.”
- “All of my friends use drugs and I don’t have anyone in my life who’s sober”.
- “I want to get off of probation.”
- “I feel helpless and hopeless all the time and I just want to lay in bed all day long.”
- “When my wife makes me mad I lash out without thinking. Sometimes I even break things.”

QUESTIONS?

INTRODUCTION TO CARE MODELS

DR. PETER MASON

CASE STUDY PRACTICE

Case Study Instructions

- Break into groups by your care models
- Work through the case study to answer the questions on the next slide.

In your care model…

- Who completes the assessment of the patient?
- How are co-occurring needs managed with both mental health and behavioral health professionals?
- How does communication work between BH and the practice?
- What are the implications for what happens next with the patient?
- Who is doing the continual assessment for the evolving treatment plan of this patient?
- How will you balance time and relationships with BH services?

CoP Meeting Schedule

Location: NH Hospital Association

From: 2:30pm – 4:30pm

December 12

Final Thoughts

- Utilize Google Group for questions, event/resource sharing, and discussion!
- 2 CEUs and CNEs available
- Please hand in your evaluation!

Thank you for coming!

REKHA SREEDHARA, MPH
REKHA_SREEDHARA@JSI.COM

REBECCA SKY, MPH
RSKY@HEALTHYNH.COM

MOLLY ROSSIGNOL, DO FAAFP FASAM
MOLLY.E.ROSSIGNOL@GMAIL.COM

PETER MASON, MD
PETER.MASON68@GMAIL.COM

LINDY KELLER, MLADC
LINDY.KELLER@DHHS.NH.GOV

ADELAIDE MURRAY
ADELAIDE_MURRAY@JSI.COM

MELISSA SCHOEMMELL, MPH
MELISSA_SCHOEMMELL@JSI.COM

REGINA FLYNN, BS
REGINA.FLYNN@DHHS.NH.GOV