Project ECHO
Neighborhood Health Centers of the Lehigh Valley
Pennsylvania

Opioid Addiction Treatment ECHO

For Providers and Primary Care Teams at Neighborhood health Centers of the Lehigh Valley

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Office-Based Management of Opioid USE Disorder (OUD): Evaluation of New Patients for Opioid Agonist Treatment (OAT)

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Disclosures

Rachel King has nothing to disclose

Gillian Beauchamp has nothing to disclose

Learning Objectives

1. Identify tools to organize your treatment program

2. Discuss screening of patients for Medication Treatment (MT) for opioid use disorder

3. Review options for buprenorphine/naloxone induction

Keys to Success

- Team-based approach
- Addiction as DISEASE not a character flaw
- Empathy

Patient Materials to Consider

- Informed consent / patient agreement
- Overdose education information
- Handout about induction
- Wallet card
- Information about local recovery resources, including AA/NA meetings

Patient Characteristics

1. Must meet criteria (Diagnostic and Statistical Manual, DSM-5) for opioid use Disorder (OUD)
2. Able to adhere to clinic visits
3. Some clinics require an agreement to stay on treatment for a particular time period, e.g. 6 months
4. Prescribed benzodiazepines should be avoided
5. If transferring from methadone treatment, transition is easier to manage if methadone dose is 35mg or less

Older age, employment, street use of buprenorphine, lack of prior IV or heroin use may be associated with improved retention *

* Alford DP Arch Intern Med. 2011 Mar 14;171(5):425-31. Dreifuss JA Drug Alcohol Depend. 2013 Jul 1;131(1-2):112-8.

Screening

Labs

HIV antibody

HCV antibody

HBV antigen, core antibody, and surface antibody

Liver function tests

TB screen if indicated

Pregnancy test

Urine Drug Screen

- Opiates
- Oxycodone
- Methadone
- Fentanyl
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine
- Barbiturates

State Prescription Monitoring Program (PDMP)

- PDMP is a state-specific database which collects data on controlled substances dispensed in the state
- Check prior to induction for evidence of prior treatment or ongoing benzodiazepine prescriptions
- Limitations: May not connect to other states, does not include methadone maintenance or inpatient treatment.
- Check your state guidelines about legislative requirements for PDMP checks

Screening for Behavioral Health (BH) Conditions

- Over 40% patients with substance use disorder (SUD) seeking treatment also have a mood disorder *
- Screen using validated tools (PHQ-9, GAD-7)
- Serious psychiatric illness associated with higher risk of relapse
- Provide treatment for co-occurring mental health problems

* NESARC-III Data

Informed Consent/Patient-Provider Agreement

Risks	Benefits	Program Expectations
• Precipitated withdrawal • Overdose if combined with sedatives • Withdrawal if abruptly stopped • Not being effective	• Abstain from problem opioid • Treat withdrawal and improve function	• Adhere to clinic visits • Safe storage of medication • No diversion • Counseling? *

* Carroll KM, Weiss RD. Am J Psychiatry. 2016 Dec 16

Screening Checklist Example

- ❑ Labs
- ❑ Urine Drug Screen
- ❑ Urine pregnancy test
- ❑ PDMP check
- ❑ Pt signed informed consent
- ❑ BH treatment plan

Medication Treatment Stages

Induction

- Transition from problem opioid use to treatment

Stabilization

- Close monitoring to ensure treatment is working

Maintenance

- Support recovery and treat co-morbid conditions

Pharmacy Coordination

- Be aware of potential insurance barriers in your state and formulary requirements
- Buprenorphine is schedule III, so may be faxed and can have refills
- Prescriptions usually 7, 14, or 28 day supplies

Induction

- Educate about precipitated withdrawal; timing varies
  - Advise to abstain for roughly: 6-8 hrs for short-acting opioids, 24 hrs for long-acting opioids, and 36-48 hrs for methadone
- Patient should be in mild to moderate withdrawal
- Initial dose can be 4mg max 16mg on day 1
- Office-based vs home inductions are likely equivalent *
- Many patients are not buprenorphine naïve – home induction may be better for these patients

* Sohler NL J Subst Abuse Treat. 2010 Mar

Opioid Withdrawal

Subjective	Objective
GI upset	Pupils dilated
Sweating	Tremor
Anxiety/irritability	Tachycardia
Bone/muscle aches	
Rhinorrhea	
Restlessness	
Yawning	
Piloerection	

COWS scale can be used to measure and track withdrawal signs and symptoms…

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Clinical Opiate Withdrawal Scale (COWS)

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Stabilization Phase

- Most patients stabilize on 16mg/4 mg dose or lower
- Space out visit frequency and increase medication supply as patients stabilize
- Once stable, aim for random visits with pill counts

Transferring from Methadone Maintenance

- Clarify why patient is transferring
- Methadone is especially long-acting opioid; risk of precipitated withdrawal is higher
- Confirm patient is in withdrawal prior to induction – the timeline will vary amongst patients
- Ideally patient should be stable around 35mg, success has been shown for pts up to 80mg
- Patients may need extra support – ok to go back to methadone if buprenorphine fails

Resources

Email: rachel.king@dotwell.org

COWS for opioid withdrawal:
http://www.mdcalc.com/cows-score-opiate-withdrawal/

- Robohm JS. Training to reduce behavioral health disparities: How do we optimally prepare family medicine residents for practice in rural communities? Int J Psychiatry Med. 2017 Jan 1:91217417730294. doi: 10.1177/0091217417730294.
- Wakeman SE. Medications For Addiction Treatment: Changing Language to Improve Care. J Addict Med. 2017 Jan/Feb;11(1):1-2. doi: 10.1097/ADM.0000000000000275
- Livingston JD, et al. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction 2011. 107:39-50.

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OBOT Patient Agreement

Please review below and initial each line.

- I will keep and be on time to all my scheduled appointments with my doctor and nurse. I understand that a missed appointment may mean I don't get medication until the next scheduled visit.
- I will not sell, share or give any of my medication to another person. I understand that would result in immediate discharge from the program.
- I agree that the medication I receive is my responsibility and that I will keep it in a safe secure place. I agree that lost medication may not be replaced regardless of the reason.
- I agree to take my medication as prescribed, and notify my doctor or nurse if I am having difficulties with the medication.
- I agree not to take medications that are not prescribed to me.
- I agree that if I obtain medication from any doctors, pharmacies, or other sources or if I have an upcoming procedure, that I will inform my doctor or nurse.
- I will not tamper with urine screens and if I do so, I understand this may result in immediate discharge.
- I understand that mixing buprenorphine with alcohol or other medications, especially benzodiazepines such as Klonopin, Ativan, Valium, Xanax and other drugs can be dangerous.
- I agree to random urine drug screens and to bring in my remaining buprenorphine to each visit with my doctor or nurse when requested.
- I agree not to consume poppy seeds while in this treatment program. Poppy seed consumption will not be accepted as an excuse for a positive opiate screen.
- I understand that my treatment plan may change to random call back visits only and that I need to have a working telephone and updated contacts. When called for random call backs, I need to respond within 24 hours by telephone. Non-response to call backs will be considered the same as a positive urine.
- I understand that if I continue using opioids or other illicit substances, this issue will be addressed through changes in my treatment plan to help me. If I continue to struggle with ongoing drug use this may be grounds for transfer to other more intense treatment options.
- I understand that the DotHouse OBOT Program will not release the results of my urine drug screens to any other agency, program, or institution. The reason for this policy is that DotHouse does not have a chain of custody over the urines, the purpose of these tests are for my treatment at DotHouse only.

- If at any time I am discharged from this program I may be reconsidered at a future time to see if office based treatment may be an option for me.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education, substance abuse counseling and relapse prevention programs, to assist me in my treatment.
- I understand that my records, course of treatment, and medical care will be kept in an electronic medical record under a confidential filing system. These notes will be visible to any healthcare professional involved in my care.

My signature below indicates that I have read and understand this treatment agreement.

Patient: Printed Name	Signature	Date
Witness	Signature	Date

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Consent for Treatment with Buprenorphine

Buprenorphine is a Food and Drug Administration (FDA) approved medication for treatment of opioid use disorder. Only qualified physicians can prescribe this medication. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. We recommend for a minimum of six (6) months, but most patients will benefit from longer.

Buprenorphine treatment can result in physical dependence. Withdrawal from Buprenorphine is generally less intense than with heroin or methadone. If Buprenorphine is suddenly stopped, some patients have no withdrawal symptoms; others may have as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize this risk, Buprenorphine should be discontinued gradually over several weeks or more under medical supervision.

If you are physically dependent on an opioid, you should be in as much withdrawal as possible when you take the first dose of Buprenorphine. If you are intoxicated with opioids, Buprenorphine can cause severe opioid withdrawal.

It may take several days to get used to the transition from the opioid that you had been taking to Buprenorphine. During this time any use of other opioids may cause an increase in symptoms. After becoming stabilized on Buprenorphine, the use of other opioids will have less effect. Attempts to override the Buprenorphine by taking more opioids could result in an opioid overdose.

You should not take any other medications without first discussing with your health care provider.

Combining Buprenorphine with alcohol or other medications may be hazardous. Combining Buprenorphine with medications such as Klonopin, Valium, Haldol, Librium, Ativan, Xanax has resulted in deaths.

The form of Buprenorphine that you will be taking (Suboxone) is a combination of Buprenorphine with a short acting opioid blocker (Naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid, it would cause severe opioid withdrawal.

Buprenorphine tablets or film **must** be held under the tongue until they completely dissolve. Buprenorphine will not be absorbed from the stomach if it is swallowed.

Additional Comments: _____

_____

Patient: Print Name	Patient: Sign name	Date	Time
Physician: Print Name	Physician: Print Name	Date	Time

6/2016