UNC ECHO

FOR MEDICATION ASSISTED TREATMENT

THE UNIVERSITY *of* NORTH CAROLINA *at* CHAPEL HILL

The UNC Extension for Community Healthcare Outcomes for Rural Primary Care Medication-Assisted Treatment (UNC ECHO for MAT)
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The University of North Carolina at Chapel Hill

Opioid Addiction Treatment ECHO

For Providers and Primary Care Teams

UNC

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Office-based management of OUD: Evaluation of New Patients for OAT

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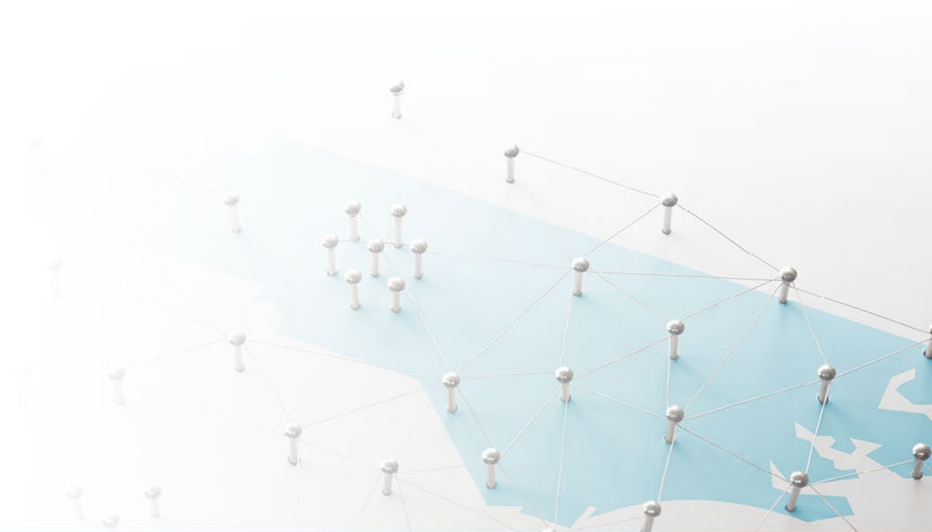
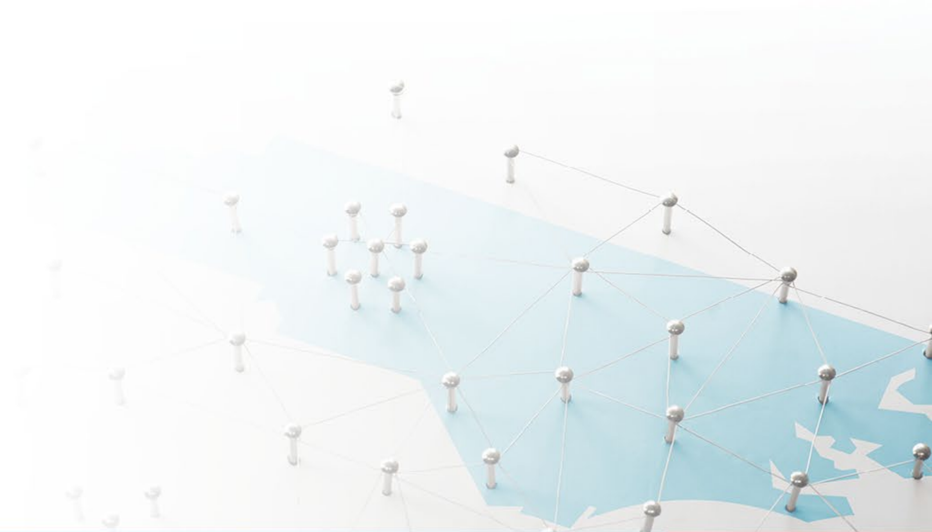


Learning Objectives

1. Identify tools to organize your treatment program
2. Discuss screening of patients for Opioid Agonist Treatment (OAT)
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 AA/NA meetings and other local recovery resources
- *Local Management Entity-Managed Care Organization 1800 #*

Patient characteristics

1. Must meet DSM-V criteria for OUD
2. Able to adhere to clinic visits
3. Agrees to stay on maintenance for at least 6 months
4. Prescribed benzodiazepines should be avoided
5. If transferring from methadone treatment, dose should be 35mg or less

Older age, employment, street use of bupe, 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	Urine Drug Screen
HIV antibody	• Opiates
HCV antibody	• Oxycodone
HBV antigen, core antibody, and surface antibody	• Methadone
Complete Blood Count	• Fentanyl
Liver function tests	• Benzodiazepines
TB screen if indicated	• Cocaine
Pregnancy test	• Amphetamine
	• 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 BH conditions

- Over 40% of patients with 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

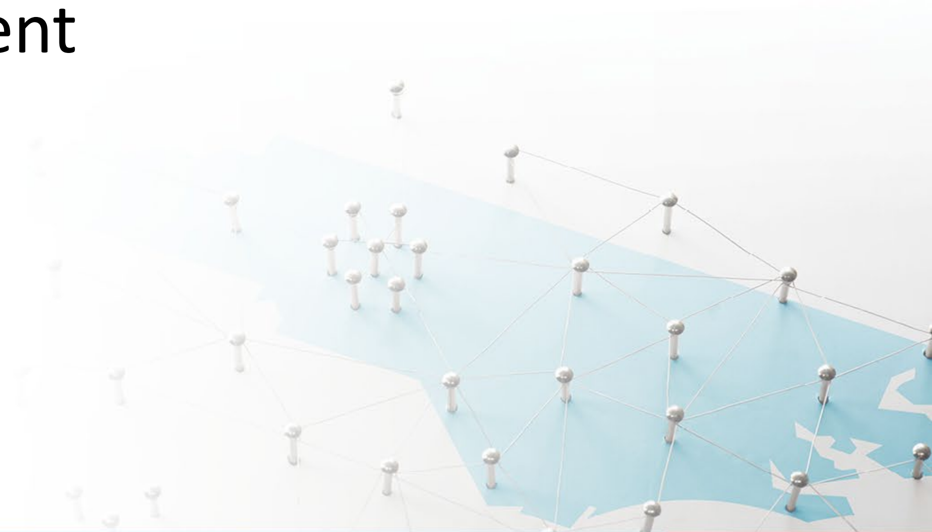
Informed consent/Patient agreement

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

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



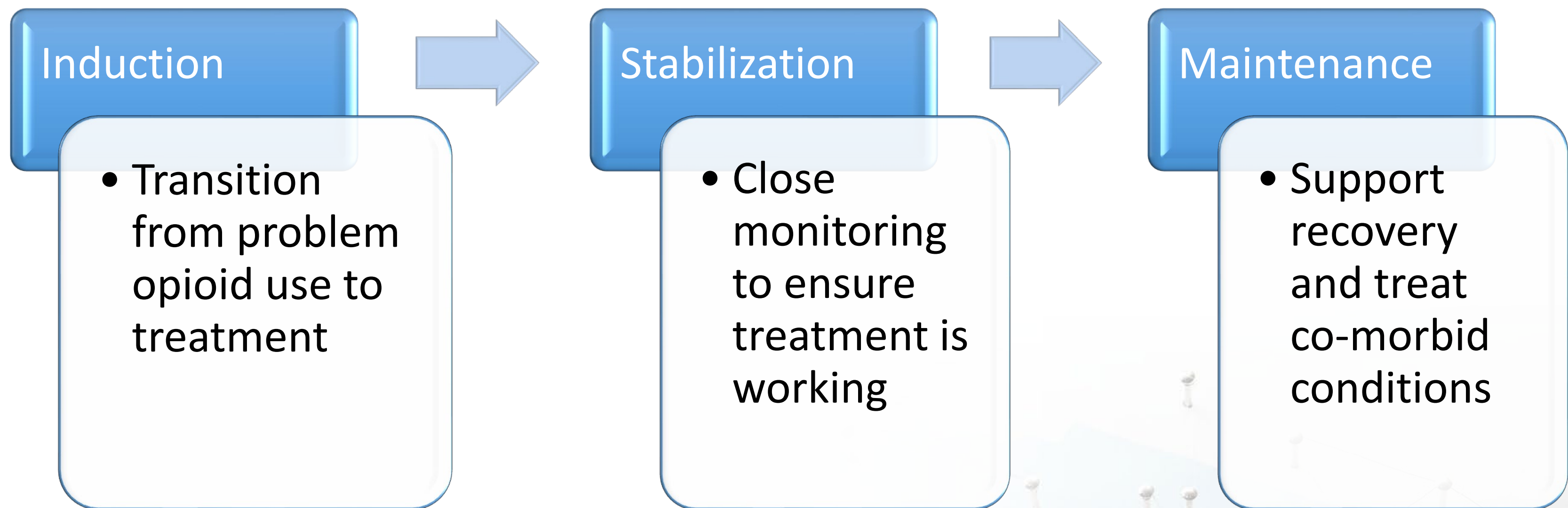
Substance Use Disorder Counseling, Co-occurring disorder Counseling

A comprehensive clinical assessment done by a licensed behavioral health professional should determine the best fit for level of treatment (outpatient, intensive outpatient, residential, etc) based on American Society of Addiction Medicine (ASAM) criteria.

Individuals insured with Medicaid or no insurance can access assessment through the Local Management Entity-Managed Care Organization (LME-MCO) for their area *https://www.ncdhhs.gov/providers/lme-mco-directory*

Individuals insured with private insurance can access assessment through their insurer- see insurance card for Behavioral Health benefit contact.

Treatment stages



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

Resources

Email: paula_bell@unc.edu

COWS for opioid withdrawal:

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

Mee-Lee, D. (2013). *The ASAM Criteria; Treatment criteria for addictive, substance-related, and co-occurring conditions (3rd ed.). American Society of Addiction Medicine.*

Induction

- Educate about precipitated withdrawal
  - Advise to abstain for: 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

GI upset

Sweating

Anxiety/irritability

Bone/muscle aches

Rhinorrhea

Restlessness

Yawning

Piloerection

Objective

Pupils dilated

Tremor

Tachycardia

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

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Stabilization Phase

- Most patients stabilize on 16mg 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 bupe fails

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.

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

DotHouse Health
We keep you well

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