What is the Practice of a Buprenorphine Provider Like?

Learning Objectives

At the completion of this presentation, participants will be able to:

- List the three HHS priorities for addressing opioid abuse.
- Recognize patients who may need medication for OUD.
- Continue to offer evidence based care for your patients with chronic disease including those with OUD.

HHS Priorities

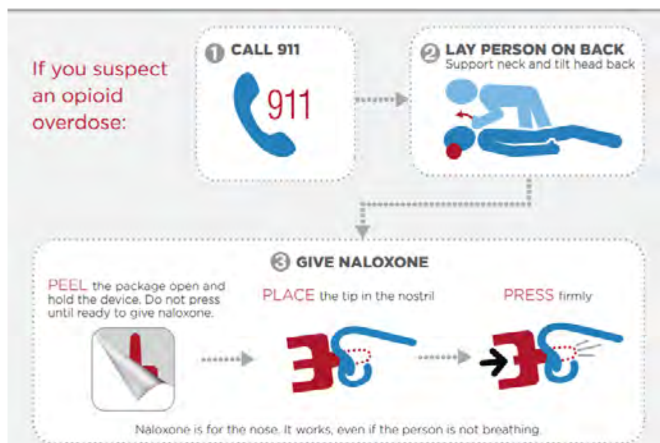
- Safe prescribing
- Access to Naloxone to prevent overdose deaths
- Medication-Assisted Treatment (MAT)
  - ✓The use of medications and behavioral therapies to **treat** substance use disorders and prevent opioid overdose.

Spectra Priorities

- Addiction is a Chronic Brain Disease
- Screen Everyone
- HARM REDUCTION
- No Shame and Blame

We Ditched the Contracts and Implemented Care Plans

We Order Naloxone and Talk About Overdose Risk



http://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/NaloxoneInfographic_English.pdf

We Took The Class and Started Prescribing

https://pcssnow.org/medication-assisted-treatment/

https://www.asam.org/education/live-online-cme/waiver-training

FDA Approved Medications

- AUD
  - Naltrexone
  - Acamprosate
  - Disulfiram
- OUD
  - Methadone
  - Buprenorphine
  - Buprenorphine/Naloxone
  - Naltrexone

OUR OFFICE BEFORE:

OUR OFFICE AFTER:

Process

- Self or Provider referral
- Intake (phone or in person):
  - Medical, psychological, psychosocial, and use history.
  - Trauma history
  - Past treatment experiences and if they are currently engaged in counseling services.
  - "Appropriateness" for Office Treatment
  - Readiness for Treatment
  - COWS score
- ROI, Lab work
- Meet with behavioral health provider
- Meet with provider

Induction - Buprenorphine

In Office or Home Options

Patient in moderate withdrawal (COWS score around 10)

Half of the full dose is given

Reassess after 30-60 minutes

Administer second half if needed.

Follow up within a few days to ensure adequate dosage

Dosing to minimize withdrawal and craving (8-24mg daily)

COWS

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:________________ Date: __________
Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times:	____	____	____	____
Resting Pulse Rate: (record beats per 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				
Sweating: *over past ½ 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				
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				
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				
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				
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				

- At first, the patient comes into the clinic weekly or twice weekly.
- Once stabilized* on a dose of medication, they have appointments every 2 weeks and then monthly.
- We ask that they make contact with behavioral health and participate in bup-group monthly.

Naltrexone

- No opioids in system
- Oral Challenge 50-100mg daily
- IM injection every 28 days (can supplement with oral)

Maintenance

- MAT allows time for the brain to heal so people can work on all aspects of recovery
- 18-24 months recommended as minimum
- Length of therapy varies based on patient – ***there is no right or wrong amount of time*** to be on MAT
- Patient's can remain on buprenorphine indefinitely.
- Safe in pregnancy and with breast feeding
- Surgery/procedures

Urine Drug Screening

“Rules”

- Keep your appointments (medication and BH)
- Routine and Random UDS and pill counts
- Honesty
- Keep Trying
- Monthly appointments at max.

Models of Care to Support MAT

- **Practice Based**
  - OBOT (Office-based Outpatient Treatment)
  - Integrated Care
- **System Based**
  - Hub and Spoke
  - Project ECHO
  - Collaborative Care
  - Nurse Care Manager
  - IP (in-patient) or ED (emergency department) initiation

Our Philosophy

- Chronic Disease Model
- Relapse is expected
- Relapse or supplementing = Need for more services, not fewer
- Value honesty and safety most

MAT Outcomes

- Reduces illicit drug use
- **Reduces** overdose **deaths**
- Decreases transmission of infectious diseases
- Decreases criminal activity
- Increases social functioning and retention in treatment
- Improves fetal outcomes

Stigma