AN INTRODUCTION TO THE TREATMENT OF OPIOID USE DISORDERS IN PRIMARY CARE

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Advances in Primary Care
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Objectives

• Review the basic phases of the treatment opioid use disorders using buprenorphine/naloxone
• Try to alleviate your anxiety
• Discuss ways to integrate buprenorphine/naloxone treatment into a primary care setting
• Review patient logs and DEA requirements

Disclosures

• NONE
Opioid Use Disorder is a problem

Drug Overdose Death Rates
New Mexico and United States, 1990-2013
Focus on Buprenorphine/Naloxone
Phases of Buprenorphine/Naloxone Treatment

- Pretreatment Screening
- Intake
- Induction
- Stabilization
- Maintenance
- Medically Supervised Withdrawal

Meet Jane

- Jane is a 26 yo female who calls your office to discuss treating her heroin use. She found your office information on the web.

Initial Patient Contact

- Pretreatment screening
  - Many patients will call for information on bup/nx.
  - Pretreatment screening is used to determine whether office-based treatment is the best option for the patient.

- Do you want someone in the clinic to do an initial screen of these patients?
- Who should perform the pretreatment screening?
  - Trained office staff
  - Behavioral health specialist
  - Provider
Intake for evaluation

- Intake
  - Primary goal is to establish a medical record for the patient’s suitability for office-based treatment for opioid dependence.
  - Should be done by trained medical staff
  - Behavioral Health providers
  - Residents
  - Mid-levels
  - Attendings

Initial patient contact

- It is common for the pretreatment screening and intake to be done at one office visit
- Some offices have a contact person in the office who can perform the pretreatment screening by phone.
- May be any staff member who is trained to appropriately screen for opioid dependence and discuss whether the patient needs more intensive treatment than your office can offer.

Screening for office based treatment

- Assess for degree of opioid dependence
  - Drug Abuse Screening Test (DAST-10)
  - CAGE-AID
  - TWEAK questionnaire
- Assess for readiness for treatment
- Assess coverage for prescription medication
  - Bup/Nx is fairly expensive for self pay patients
  - Bup/Nx may need Prior Authorization
- Past treatment attempts
  - If many prior attempts, may need a higher level of care
- Desire to get care
Welcome Jane

- Chief complaint
  - "I want to get that prescription to get off drugs"

Intake details

- Full history is important
- Document the patient’s need for office-based treatment of opioid dependence
- Document a diagnosis of opioid dependence
- Assess for any untreated psychiatric conditions that might interfere with treatment

Documenting Opioid Dependence

- DSM-V criteria
- Substance Dependence Assessment form
- Clear documentation using above criteria documented in the progress note
**Intake**

- Thorough medical history, family history and social history should be done
- Drug abuse history
  - When began using drugs
  - What drugs have been used
  - What is the route of administration
    - Smoking, snorting, IVDU
  - Past treatment history
  - Legal or other problems related to drug use

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**Intake**

- Urine drug screen should be done to confirm current opioid use
- Urine drug screen should also be used to screen for polydrug abuse and other medications that may interfere with treatment
- Remember the drug screen is not meant to be punitive

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**Table 1** Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired control</td>
<td>Opium used in larger amounts or for longer than intended</td>
</tr>
<tr>
<td></td>
<td>Unsuccessful efforts or desire to cut back or control opioid use</td>
</tr>
<tr>
<td></td>
<td>Excessive amount of time spent obtaining, using, or recovering from opioids</td>
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<tr>
<td></td>
<td>Craving to use opioids</td>
</tr>
<tr>
<td>Social impairment</td>
<td>Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use</td>
</tr>
<tr>
<td></td>
<td>Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems</td>
</tr>
<tr>
<td></td>
<td>Reduced or given up important social, occupational, or recreational activities because of opioid use</td>
</tr>
<tr>
<td>Risky use</td>
<td>Opioid use in physically hazardous situations</td>
</tr>
<tr>
<td></td>
<td>Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use</td>
</tr>
<tr>
<td>Pharmacological properties</td>
<td>Taking or demonstrating signs or symptoms of opioid withdrawal syndrome</td>
</tr>
<tr>
<td></td>
<td>Opioids listed to relieve or ward off withdrawal</td>
</tr>
</tbody>
</table>

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*Remember the drug screen is not meant to be punitive.*
Point of Care Testing

- Cocaine
- Opiates
- Methamphetamines
- THC
- Amphetamines
- PCP
- Benzodiazepines
- Barbiturates
- Methadone
- Oxycodone

Send out to Lab

- UDM
  - Amphetamines
  - Barbiturates
  - Benzodiazepines
  - Cocaine
  - Methadone
  - Marijuana
  - Opiates
  - Propoxyphene

- UDM Pain
  - Amphetamines
  - Barbiturates
  - Benzodiazepines
  - Cocaine
  - Demerol
  - Fentanyl
  - Methadone
  - Opiates
  - Oxycodone
  - PCP
  - Propoxyphene
  - Soma
  - THC
  - Tramadol
  - Tricyclics
  - Zolpidem

Length of time specific drugs are detected in urine

<table>
<thead>
<tr>
<th>Drug</th>
<th>Time of detection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>7 – 12 hours</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>48 hours</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Short: 24 – 48 hours, Long: up to 3 weeks</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Short: 3 days, Long: up to 30 days</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2 – 4 days</td>
</tr>
<tr>
<td>Marijuana</td>
<td>3 – 30 days</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>3 – 5 days</td>
</tr>
<tr>
<td>MDMA</td>
<td>48 hours</td>
</tr>
<tr>
<td>Opioids</td>
<td>Depends on drug/metabolite</td>
</tr>
<tr>
<td>PCP</td>
<td>8 days</td>
</tr>
</tbody>
</table>
**Intake**
- Bloodwork is recommended prior to starting Bup/Nx treatment
- Ascertain other medical conditions
  - Anemia, HIV, Hepatitis C
  - Establish baseline liver function
- Physical exam is recommended

**Jane’s story**
- Began using pain pills as a teenager. Used at parties, but then started using more frequently
- She transitioned to smoking heroin with her friends at the age of 18 because it was cheaper. Soon she was using daily
- She started using IV at the age of 23. She says she has used daily since that time
- She uses about “two bags” daily
- She gets sick if she doesn’t use after about 8 hours
- She has never sought treatment before but tried bup/nx from a friend when she couldn’t get heroin

**More history**
- PMH: otherwise negative
- Psychiatric Hx: she endorses anxiety and depression but does not have a formal psychiatric diagnosis
- PSH: no surgeries, but has had I&D of several abscess in the ED
- FH: negative
- Soc Hx: lives in town with her boyfriend, she works part-time as a cashier. + tobacco use daily, 1ppd. No alcohol use. She has used cocaine and methamphetamine in the past, but not regularly. Daily heroin use
- Labs: normal, negative HIV, HCV
Next step…

- The patient meets criteria for office-based treatment for opioid dependence
- You determine to begin the treatment
- Initiate treatment agreement
- Initial Rx
  - How many doses
  - Minimal quantity is recommended on first Rx
  - Most Medicaid, Medicare, and insurance coverage will allow a 14-day supply without prior authorization

Treatment Agreement

- It is required that you have a treatment contract for the patients on buprenorphine
- Similar to a controlled substance contract
- May want to include clause about
  - Counseling
  - Avoiding potentially harmful substances (benzos, alcohol, sedatives)
  - Pregnancy

Induction

- Office-based induction
  - Recommended
  - Not always feasible
  - Good for patients who have never tried Bup/Nx
  - Patient needs to be instructed to arrive in mild-moderate withdrawal
- Home induction
  - Becoming more popular in practice
  - Easier for patients
  - Easier for the providers with very busy schedules
  - Patient needs to be given clear dosing instructions and a contact number for any problems, questions or concerns
  - Close office or phone contact recommended
**Induction dosing**

- Assess for adequate withdrawal
- Start with 4mg dose
- Leave until completely dissolved then spit or swallow the saliva
- Monitor for worsening symptoms of withdrawal
- May dose an additional half tablet if symptoms persist
- Maximum dose for first 24 hours is 16mg buprenorphine/naloxone
- Some patients may need 20mg for comfort of severe symptoms
- Day 2: begin with full dose from prior day

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**Short Opiate Withdrawal Scale**

Please put a check mark in the appropriate box for each of the following conditions in the last 24 hours:

<table>
<thead>
<tr>
<th>Description</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling Sick</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Stomach Cramps</td>
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<td></td>
<td></td>
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<tr>
<td>Muscle Spasms/Twitching</td>
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<td></td>
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<tr>
<td>Feelings of Coldness</td>
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<tr>
<td>Heart Pounding</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Muscular Tension</td>
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</tr>
</tbody>
</table>
Jane is determined a good candidate
- After discussion, Jane wants to try office based treatment
- You determine she can probably do a home induction because she has tried Bup/Nx on the streets before
- You give her a 7 day supply of medication and home dosing instructions

Stabilization
- Induction is completed when the patient experiences no withdrawal symptoms
- Stabilization is the “fine-tuning” of the Bup/Nx dose
- Goal is to find the minimum dose necessary to hold the patient in treatment, suppress opioid withdrawal and suppress other opioid use

Stabilization
- Most patients stabilize on 16mg buprenorphine per day (range 4mg to 24mg)
- Dose adjustments should occur every 3 to 7 days to allow for steady-state levels
Jane comes in for follow up

- Overall feeling well
- Has found that 16mg is keeping her withdrawal symptoms under control
- She is still struggling with cravings but did not use
  - What can you do with this?
    - Increase her dose of medication
    - Utilize counseling
    - Explore triggers

Stabilization

- Very fragile time for the patients
- Great time to begin psychosocial counseling
  - Individual counseling
  - Group therapy
  - NA or AA
  - SMART recovery
  - Here to Help

Counseling

- Thoughts for your clinic
  - Who can you refer to for counseling?
  - How will you verify the patient has attended?
    - Trust the patient
    - Signature sheet
    - Verify appointments attended in your system
  - Do you need a release of information to discuss the patient’s care with the counselor?
Maintenance

- Prevent opioid withdrawal symptoms
- Suppress opioid cravings
- Prevent use of self-administered opioids
- Duration of the maintenance phase depends on the individual needs of the patient
  - May be weeks to years
  - Continue regular office visits
  - Frequency may decrease with time

Medically supervised withdrawal

- Not recommended in most patients
- Some patients will progress from stabilization to medically supervised withdrawal
- The Bup/Nx dose should be slowly tapered at a rate that both physician and patient consider acceptable
- Patients should be prepared for mild, transitory withdrawal symptoms
  - Fatigue, anorexia, irritability, insomnia, anxiety

DEA requirements

- Any provider who prescribes buprenorphine must apply for a waiver per DATA 2000. Usually part of your training
- You will receive an “X” number that must be written on all buprenorphine prescriptions
- Documentation of opioid dependence must be in the medical record
DEA requirements

- Records on buprenorphine
  - May need to be kept separate from primary care records
  - If not, then a consent for the buprenorphine records to be part of the medical record should be obtained. May be part of the consent for treatment or buprenorphine contract

DEA requirements

- A log of active Bup/Nx patients must be upkeeped
  - Patient identifier
  - Date of prescription
  - Number of tablets prescribed
  - Spreadsheet, paper, card file, EHR patient list

  The attending "X" number will be the legal prescription writer. Residents should keep a log of their patients, but each attending will need the log of patients at all times

DEA Audits

- The DEA may come to the clinic for an audit
- Unannounced visit
- Will ask to see log of active patients
- Will review charts of active patients to assure proper prescribing of buprenorphine
How to get trained!

Questions or Comments?