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Chronic Opioid Use, Addiction and Heroin – A Care Team Approach:

Suboxone Therapy in a Rural Primary Care Setting

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Learning Objectives:

1. Review Controlled Substance Care Team and Opioid program.
2. Importance of a care team (Medical Home)
3. Suboxone as treatment for opioid addicted/dependent patients
4. Screening, documentation and record keeping for Suboxone Patients
5. Basics of Suboxone induction in a clinic/ED setting
6. Long-term monitoring and longevity of Suboxone patients
7. Hot Topics – Things to consider…..

Controlled Substance Care Team

- Medical Home's comprehensive care team to include: MD's RN Navigator (care coordinator), Social Worker, Pharmacy, administration, other support staff

- Weekly meetings
  - Care team conference – review patients, make recommendations
  - Misc. program review

- Patient monitoring – pill counts, UDAS

MD Recommendations

CSCT REVIEW

Dr._____, Date: _____

The CSCT has reviewed the following patient:

Patient Name: _____ DOB: _____ MRN: _____

Diagnosis: _____

Medication Agreement/Care plan signed: Y/N, Date: _____

Anxiety: Y/N, Depression: Y/N, Mental Health issues: Y/N, _____

Mental Health Provider/Therapist: _____

Current Medications of Concern:

- _____
- _____
- _____
- _____

Images Reviewed: Y/N _____

Other Modalities attempted: _____

_____

UDAS in past year: Y/N, Date of most recent UDAS: _____

UDAS Findings:

- _____
- _____
- _____

Pill Counts: _____

PMP Reviewed: Y/N, Findings: _____

Social History: _____

Social Needs identified: _____

Recommendations: _____

_____

_____

_____

Scanned in EMR: Y/N

Signed: _____

Potential Recommendations

- Mental Health referral
- PT/OT
- Pharmacy: med review, interaction, recommendations
- Pain clinic/injections
- Surgical
- Adjust dose for chronic pain meds (morphine equivalents)
- Taper
- Taper
- Taper
- STOP

Morphine Equivalents MME

- CDC: Recommends daily “MME” < 90/day (we target 120)
- Common morphine equivalents (oral)
  - Morphine -> Oxycodone: 1.5:1
  - Morphine-> Hydromorphone: 5:1
  - Morphine ->

Morphine Equivalents

Opioid (mg/day except where noted)	Conversion Factor	Example Conversion to Morphine
Codeine	0.15	200 mg codeine x 0.15 = 30 mg morphine
Fentanyl transdermal (mcg/hr)	2.4	12 mcg/hr fentanyl x 2.4 = 30 mg morphine
Hydrocodone	1	30 mg hydrocodone x 1 = 30 mg morphine
Hydromorphone	4	7.5 mg hydromorphone x 4 = 30 mg morphine
Methadone		
1-20 mg/day	4	20 mg methadone x 4 = 80 mg morphine
21-40 mg/day	8	40 mg methadone x 8 = 320 mg morphine
41-60 mg/day	10	60 mg methadone x 10 = 600 mg morphine
≥61-80 mg/day	12	80 mg methadone x 12 = 960 mg morphine
Morphine	1	
Oxycodone	1.5	20 mg oxycodone x 1.5 = 30 mg morphine
Oxymorphone	3	10 mg oxymorphone x 3 = 30 mg morphine

Dose conversions are estimates that do not account for differences in genetics or pharmacokinetics.

When switching from one opioid to another, remember to consider incomplete cross-tolerance. Decreasing the dose of the new opioid can help avoid unintentional overdose.

Reference
Calculating Total daily Dose of Opioids for Safer Dosage. Centers for Disease Control and Prevention. Available at **https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. Accessed 21 February 2017.**

Results:
Controlled Substance Care Team

- 225 Total Tapered Patients (narcotics, stimulants & Benzo.)
- **127 Opioid Tapers**
  - Average decrease = 8792 units/month no longer prescribed
  - Approx $7/pill = $738,528 per year
- Reasons for Tapers:
  - Dose too high
  - Diverting
  - No Diagnosis/Reason for medications
  - “other” – Urine drug screen results, self medicating, etc.
- Patient Needs/Support Referrals
  - 2016: 146
  - 2017: 50

Our Story – (MN Physicians Magazine)

Our Story: MN Commissioner's Circle of Excellence

Our Story: MN Commissioner's Circle Of Excellence (Cont)

Community Parnterships

Why the effort?

- National Prescription Drug and Heroin Summit
- Heroin is a real problem – persons dying every 20 min
- Law enforcement concerns
- No MAT (Medication Assisted Therapy) in our area
- Over-dose in our community

DSM 5 Opioid Use Disorder Checklist - Yes/No

Mild: 2-3 Moderate: 4-5 Severe: 6+

1. Opioids are often taken in larger amounts or over longer period of time than intended.
2. There is a persistent desire or unsuccessful effort to cut down or control opioid use.
3. A great deal of time is spent in activities to obtain the opioid, use the opioid or recover from its effects.
4. Craving or a strong desire to use opioids
5. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
10. Tolerance, as defined by: (a) remarkably increased amount of opioids to achieve effect (b) Markedly diminished effect with continued use of the same amount of opioid.
11. Withdrawal , as manifested by: (a) characteristic opioid withdrawal syndrome (b) the same (or related) substance are taken to relieve or avoid withdrawal symptoms.

SUBOXONE:

What is it?

- Buprenorphine/naloxone
- Agonist/antagonist
- Pills or films form

Vs Methadone

- Agonist only
- Ability to get high

Diversion differences

Physician Training/Preparation:

8 hour course
www.buppractice.com
SAMHSA

- www.samhsa.gov

XDEA

Prescribing Limits - XDEA

- First Year = 30
- 2nd Year = 100
- Thereafter = 200-275
- Requirements
  - Documentation
  - Accessibility
  - Audits

Our Suboxone Program:

1) Phone Intake- Screening Criteria

1. Where do you live?
2. What is the drug or medication abused?
3. Have you been prescribed Suboxone in the past or currently?
   - If so, dose? And why changing providers?
4. Who is your doctor now? If none, who in the past?
5. Have You had any previous treatment?
6. Are you currently in counseling?
7. What medications are you currently taking? (Including herbals/OTC).
8. Review Substance Use

Our Suboxone Program
2) Intake Day

- Roomed with UDAS
- Review intake form and drug history
- Family History
- Social History – Who they live with, etc.
- Referrals: Mental Health/Rule 25/social services
- Drug History
- Treatment History

Our Suboxone Program (Cont)

2) Intake Day cont.

Care Team Members meet with patient (Nurse/Social worker)

- Set up referrals
- Set up Rule 25
- Complete forms:
  - consents, care plan

Our Suboxone Program
3) Medications

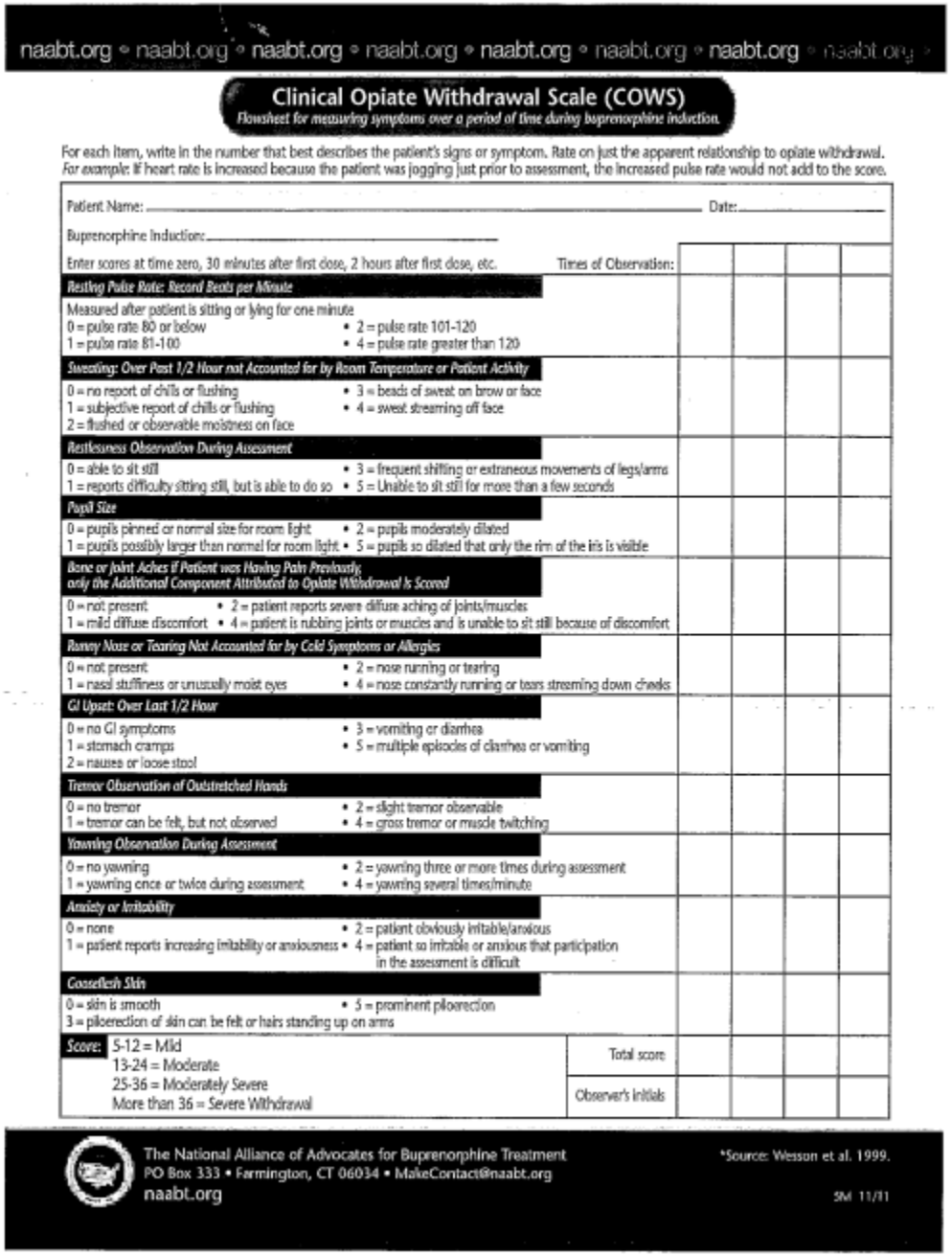
Prior Authorization for Prescriptions:

* South Country Health Alliance partnership (Brad Johnson)
* Minimal # Of private insurance patients thus far.

- **Induction: -** COWS form

Our Suboxone Program (

C.O.W.S.



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Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

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 increased pulse rate would not add to the score.

Patient Name: _____ Date: _____

Buprenorphine Induction: _____

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Times of Observation:			
Resting Pulse Rate: Record Beats per Minute Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below • 2 = pulse rate 101-120 1 = pulse rate 81-100 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity 0 = no report of chills or flushing • 3 = beads of sweat on brow or face 1 = subjective report of chills or flushing • 4 = sweat streaming off face 2 = flushed or observable moistness on face				
Restlessness Observation During Assessment 0 = able to sit still • 3 = frequent shifting or extraneous movements of legs/arms 1 = reports difficulty sitting still, but is able to do so • 5 = Unable to sit still for more than a few seconds				
Pupil Size 0 = pupils pinned or normal size for room light • 2 = pupils moderately dilated 1 = pupils possibly larger than normal for room light • 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 Opiate Withdrawal is Scored 0 = not present • 2 = patient reports severe diffuse aching of joints/muscles 1 = mild diffuse discomfort • 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 • 2 = nose running or tearing 1 = nasal stuffiness or unusually moist eyes • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour 0 = no GI symptoms • 3 = vomiting or diarrhea 1 = stomach cramps • 5 = multiple episodes of diarrhea or vomiting 2 = nausea or loose stool				
Tremor Observation of Outstretched Hands 0 = no tremor • 2 = slight tremor observable 1 = tremor can be felt, but not observed • 4 = gross tremor or muscle twitching				
Yawning Observation During Assessment 0 = no yawning • 2 = yawning three or more times during assessment 1 = yawning once or twice during assessment • 4 = yawning several times/minute				
Anxiety or Irritability 0 = none • 2 = patient obviously irritable/anxious 1 = patient reports increasing irritability or anxiousness • 4 = patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh Skin 0 = skin is smooth • 5 = prominent piloerection 3 = piloerection of skin can be felt or hairs standing up on arms				
Score: 5-12 = Mild 13-24 = Moderate 25-36 = Moderately Severe More than 36 = Severe Withdrawal	Total score			
	Observer's Initials			

The National Alliance of Advocates for Buprenorphine Treatment
PO Box 333 • Farmington, CT 06034 • MakeContact@naabt.org
naabt.org

*Source: Wesson et al. 1999.

SM 11/11

Suboxone Program:
3) Induction (Continued)

- Dosed (2mg) and monitored: q1 hr COWS scores
- Max dose 1st day = 12mg
  - 2mg "saved" for evening/overnight dose
- Follow up in clinic day 2
  - Split to BID Dosing
- Pitfalls:
  - Withdrawal
  - Side effects

HEROIN vs. SUBOXONE DOSING:
Heroin: 6-8mg BID
Pills: ~4mg BID Dosing

Suboxone Program

4) Monitoring/Follow Up

- Weekly Follow Up after the first few days.
- Occasionally more frequent in the first few weeks IF waiting on rehab and/or higher risk patient (IV heroin)
- Then 2 weeks – monthly
  - Progression to monthly typically about 8 weeks
- If a “lapse” shorter, more frequent follow up
- **How Long continue to take Suboxone**?
  - If a patient stops sooner than 4 years ~ 86% chance of relapse
  - Prior To this, patients do get tapered to lower doses
  - Some stay on long term- “forever”

Suboxone Program

5) Program Requirements:

- Frequency of visits
- IP/OP treatment – rule 25 determination
- Med counts/UDAS
- Lapses/relapses
- Release of records for continuity of care:
  - Past medical records
  - Mental health
  - Probation
  - Drug court
- **Deal Breakers:**
  - Selling
  - Benzo's
  - No suboxone in urine-"soft deal breaker"
  - Repeated no shows – "soft deal breaker"

Suboxone Program: (Cont)

6) Follow Up Visits:

- RN:
  - Urine (witnessed)
  - PDMP
- Care Coordinator
  - Social Worker assessment
  - Meetings (AA, NA)
  - Support
  - Cravings/triggers
- Side effects
- Exam:
  - Arms, pupils, weigh, tremors

Suboxone Program:
How to Spot the Difference in Urine?

Component Results

Component	Value	Ref Range & Units	Status
UR CANNABINOID	PRESUMPTIVE POSITIVE (A)	NEG	Final
UR PHENCYCLIDINE	NEGATIVE	NEG	Final
UR COCAINE	NEGATIVE	NEG	Final
UR METHAMPHETAMINE	PRESUMPTIVE POSITIVE (A)	NEG	Final
UR OPIATE	PRESUMPTIVE POSITIVE (A)	NEG	Final
UR AMPHETAMINES	PRESUMPTIVE POSITIVE (A)	NEG	Final
UR BENZODIAZEPINE	NEGATIVE	NEG	Final
UR TRICYCLIC ANTIDEP	NEGATIVE	NEG	Final
UR METHADONE	NEGATIVE	NEG	Final
UR BARBITURATE	NEGATIVE	NEG	Final
URINE OXYCODONE	NEGATIVE	NEG	Final
UR PROPOXYPHENE	NEGATIVE	NEG	Final
UR BUPRENORPHINE	PRESUMPTIVE POSITIVE (A)	NEG	Final

Component Results

Component	Value	Ref Range & Units	Status
UR CANNABINOID	NEGATIVE	NEG	Final
UR PHENCYCLIDINE	NEGATIVE	NEG	Final
UR COCAINE	NEGATIVE	NEG	Final
UR METHAMPHETAMINE	NEGATIVE	NEG	Final
UR OPIATE	NEGATIVE	NEG	Final
UR AMPHETAMINES	NEGATIVE	NEG	Final
UR BENZODIAZEPINE	NEGATIVE	NEG	Final
UR TRICYCLIC ANTIDEP	NEGATIVE	NEG	Final
UR METHADONE	NEGATIVE	NEG	Final
UR BARBITURATE	NEGATIVE	NEG	Final
URINE OXYCODONE	NEGATIVE	NEG	Final
UR PROPOXYPHENE	NEGATIVE	NEG	Final
UR BUPRENORPHINE	PRESUMPTIVE POSITIVE (A)	NEG	Final

Suboxone Program:
Why witness/observe a UDAS?

Suboxone Program: (Cont)

Hints:

- Law enforcement
- “rat on each other”
- Witnessed Urine
- MA requirements
- PMP
  - Has not been useful for suboxone
  - Need to check and document regardless
- 2 Providers
- Benzo’s
- How to prescribe
- Jail
- DHS

Suboxone Program (Cont)

Success Thus Far:

- Total considered for program = 37
- Total Enrolled = 32
- Currently Active =24
- Inactive = 8

THANK YOU!

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