Treating Opioid Use Disorder in Rural Communities

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Disclaimer/Disclosures

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**Presenter Disclosures:** No disclosures
Goals for Today

• History of OUD treatment
• Addiction as disease
• Harm Reduction/Stigma
• Opioid Education and Naloxone Distribution
• Medications for OUD (MOUD)
Poll questions

- What is your role (social worker, behavioral health, prescriber (APP or MD/DO)?)
- What is your practice environment (ED, primary care, hospitalist, other?)
- Are you prescribing buprenorphine in your practice?
My background
Attention, ED’s

Paradigm SHIFT

Treat opioid overdose as any other emergency.
Attention, PCP’s

Paradigm SHIFT

Treat opioid use disorder as any other health condition that you Tx in primary care.
MOUD are just like any other med
History of OUD Treatment

1914 Harrison Anti-Narcotic Act

Image from La Crosse Public Library:
https://archives.lacrosselibrary.org/blog/la-crosses-drug-problem/
1918: Supreme Court, Webb v. US

Image from the Supreme Court Historical Society:
https://supremecourthistory.org/timeline_court_white.html
The Farm and Dr. Nyswander
Methadone

Vincent P. Dole, MD - Marie Nyswander, MD - Mary Jeanne Kreek, MD
Implications Today

- Requirement for 8-hour DATA Waiver training
- Consents for buprenorphine
- Favoring of in-office inductions
- Terminology
  - MAT
  - Induction
- Perceived need for mandatory counseling
- Idea that patients with OUD are best treated at an OTP
Today: Treating OUD

Reducing Morbidity & Mortality for Opioid Use Disorder

- Access to Care
- Treatment
- Legal (Good Samaritan Laws)
- Community Partnerships
- Harm reduction (Naloxone Distribution)
- Prevention (Safe prescribing)
What is Harm Reduction?

Harm Reduction

• Meet patients where they are
• Practical strategies
• Reduce negative consequences a/w drug use

https://harmreduction.org/about-us/principles-of-harm-reduction/
Harm Reduction

• Drug use & recovery exist along a complex continuum
• Drug-related harm cannot be assumed
• Harm reduction does not aim to minimize real harm related to substance use
• People who use drugs are more than their drug use

Source: Sonoran Prevention Works Naloxone Training by Christopher Thomas
Harm Reduction as Empowerment

Empower people to make decisions about their health

- Give people options
- Acknowledge difference in experience
- Take a realistic approach
- Utilize low-barrier services
- Understand that individuals are experts on their own lives

Source: Sonoran Prevention Works Naloxone Training by Christopher Thomas
Examples

- Buddy system
- Syringe exchanges
- Take-home naloxone
- Fentanyl testing strips
- Low barrier MAT
- Wound care
- Supervised consumption sites

Source: Sonoran Prevention Works Naloxone Training by Christopher Thomas
What is Stigma?

- Stereotype: a negative belief about a group (dangerousness, laziness, moral weakness)
- Prejudice: Agreement with belief + negative emotional reaction (fear, anger)
- Discrimination: Behavior response to prejudice (avoidance, withhold access to basic needs/help)

Stigma permeates every aspect of a marginalized person’s life – relationships, health care, housing, employment, and education.

Corrigan and Watson. Understanding the impact of stigma on people with mental illness, 2002
Stigma

Source: Sonoran Prevention Works Naloxone Training by Christopher Thomas
Opioid Education & Narcan Distribution
Support increased Naloxone access

- World Health Organization
- American Medical Association
- American Public Health Association
- National Association of Boards of Pharmacy
Role for Layperson Naloxone

1999 survey of heroin users: 89% said they would have used naloxone at the last OD they witnessed if they’d had it available

2010: nearly 200 community-based naloxone distribution programs were in operation.
  • 50,000+ lay people were trained
  • Participants reported reversing more than 10,000 OD’s

In Canada, take-home Naloxone kits are available at most pharmacies without a prescription and many provinces offer it for free.

Is the training enough?

- A single training session increases knowledge of appropriate OD response\(^1\)
- Even a very brief education session is likely sufficient\(^2\)
- Even those without formal training are probably fine\(^3\)
  - No sig diff in rescue behaviors or reversal rates between naloxone administered by people who had received formal training vs those who had not

Medical risks a/w naloxone administration are low

• Most common AE is withdrawal (Buajordet, Naess, Jacobson, & Brors, 2004; Kelly et al., 2005). Pulmonary edema is extremely rare

• It appears that individuals who receive naloxone but do not receive additional medical care are not at increased risk of negative outcomes
  • A 2003 study of 5 years of data in San Diego found no deaths in the 12 hours after patients who were administered naloxone by EMS refused transport to the hospital (n=998) (Vilke, Sloane, Smith, & Chan, 2003).
  • A 2005 study from Finland found no life-threatening events in the 12 hours after overdose patients (n=84) were treated prehospital and refused further treatment, which lead the authors to conclude that permitting “presumed heroin overdose patients to sign out after pre-hospital care with naloxone is safe” (Boyd et al., 2006)
  • A 2011 retroactive study of 20 months of data from San Antonio found no evidence that any patients who had been administered naloxone and refused transport died in the next 48 hours (n=542) (Wampler et al., 2011).
Even expired/heated naloxone works

• Took samples of naloxone carried by EMS or Law enforcement with expiration dates ranging from 1990 -2018
  • Most tested samples contained more than 90% of labeled naloxone
    • Including those stored for nearly 30 years
• Naloxone exhibits no changes in drug concentration following exposure to heat or freeze-thaw cycles for up to 28 days

Does not appear to increase drug use or risky behavior:

• SF study – heroin users who received OEND reported a statistically significant decrease in heroin injection 6 mo after intervention (Seal et al, 2005)

• LA study – A majority of individuals trained in OD prevention reported that their drug use decreased after the training (wagner 2010)

• MA – OEND did not lead opioid users to increase their overall opioid use (Doe-Simkins et al, 2014)
Likely reduce OD-related morbidity and Mortality

• MA study – Communities with higher access to naloxone and OD training had significantly lower opioid overdose death rates than those did not (Walley et al 2013)

• NC – Striking decrease in OD deaths after a comprehensive prevention program was initiated (Albert et al, 2011)

• Chicago – Reduction in heroin deaths may be partly attributable to a naloxone distribution program in that city (Maxwell et al 2006)

• UK – The distribution of take-harm naloxone decreased OD deaths by around 6.6% (Langham et al)
In a 2013 study, the provision of naloxone kits to heroin users was found to be robustly cost-effective even under extremely conservative assumptions (Coffin & Sullivan, 2013).

A separate study noted that the cost of treating people who had overdosed in Rhode Island hospitals could have paid for more than 61,000 naloxone kits at the then-current cost of $15 (Yokell et al., 2011).
Some prescribers worried that prescribing naloxone may increase their risk of civil liability (Beletsky et al., 2007; Burris et al., 2009)

- Burris et al’s Legal review:
  - Every tort claimant must establish that he or she suffered an injury actually caused by the negligence of the defendant health-care provider.
    - Negligence?
      - Naloxone has long been the standard of care for reversing opiate overdose.
      - It would be virtually impossible for a plaintiff to get a claim that it was not to a jury, let alone to prevail.
    - Harm?
      - No – naloxone is extremely safe, and can’t blame prescriber for pt’s decision to use
Will the needles be diverted for substance use?
And even if they were...

- Syringe Access programs (SAP’s) do not cause an increase in drug use (Institute of Medicine)
  - Some studies have show that SAP’s decrease drug use (WHO and Hou et al)
- SAP’s reduce needle-stick injuries to LE in CT (Groseclose)
- Neighborhoods in Baltimore with SAP’s have a decrease in crime (CIPP)
Arizona has a Standing Order for Naloxone

Naloxone HCl (LUER-JET)
(2)* 2mg/2mL

Narcan® (Naloxone HCl)
(2)* 4mg/0.1mL

Evzio® (Naloxone HCl)
(2)* 0.4mg/0.4mL

(2) Nasal Atomizer included
FDA DRUG INFO
Who can we leave Naloxone with?

• Patients who:
  • Overdosed on opioids
  • Are at risk of overdosing on opioids

• Bystanders who are in close contact with persons at risk of opioid overdose
Patients at risk for OD:

• Mixing drugs (eg, benzo’s and oxycodone)
• Reduced tolerance
  • Rehab/detox/jail/prison/hospitalization
    • Death most likely in first 28 days after leaving inpt tx
• Increased dependence
• New/different supply
• New route (IV instead of pills)
• Using alone or injection by partner
When giving someone a kit:

- Give them the kit
  - Naloxone IM
  - Naloxone IM educational sheet
  - Local resources for treatment
- Provide bystander training
- Explain various options for treatment
Bystander training

• Identify opioid OD
• Assess scene safety
• Verbal/Tactile simulation
• Administer naloxone/call 911
• Recovery position/CPR if no improvement
• Stay with the patient until EMS/Police arrive
  • Good Samaritan laws protect you
• Learn about treatment options and ways to reduce risk (harm reduction)
Example of bystander pamphlet

- Peel back the package to remove the device. Hold the device with your thumb on the bottom of the red plunger and two fingers on the nozzle.
- Place and hold the tip of the nozzle in either nostril until your fingers touch the bottom of the patient’s nose.
- Press the red plunger firmly to release the dose into the patient’s nose.
- After you administer the dose, call 911 and perform rescue breathing
- If your friend wakes up, they may feel very sick. Don’t let them use again, even if they want to, otherwise they may overdose again. They may be at risk of overdosing after the naloxone wears off.
Good Samaritan Law

Dont run...
Call 911

You cannot be charged for possession if you call 911 for an overdose, and neither can the overdose victim.

The most commonly cited reason for not calling for help is fear of arrest or punishment by law enforcement.

In early 2018, Arizona Revised Statute (ARS) 13-3423 was amended.

In any drug-related overdose in which no drug was taken, anyone who is at risk for overdose or anyone who cares about someone who could overdose, both parties can no longer be charged for the possession or use of a controlled substance or paraphernalia.

If someone is experiencing a drug-related overdose or someone calls 911 in a drug-related overdose, both parties can no longer be charged for the possession or use of a controlled substance or paraphernalia.

WHO DOES IT HELP?
Anyone who is at risk for overdose or anyone who cares about someone who could overdose.

You can still be charged with intent to sell if there are greater than these amounts in your possession:
HEROIN: 1 gram
Medications for OUD (MOUD)
Bupe’s Ceiling Effect

- Full Agonist (Methadone)
- Partial Agonist (Buprenorphine)
- Antagonist (Naloxone)
Buprenorphine
Benefits of MOUD

- Reduction in drug-related overdose deaths
- Reduction in disease and violent crimes
- Improved treatment outcomes
- Helping reduce cravings and withdrawal symptoms
MOUD decreases mortality

- Meta-analysis of 19 cohorts
- Followed:
  - 122,885 people treated with methadone over 1.3-13.9 years
  - 15,831 people treated with buprenorphine over 1.1-4.5 years.
- Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk for all cause and overdose mortality in people dependent on opioids

Overdose deaths during expansion of methadone and buprenorphine in France, 1996–2003

Emmanuelli, Addiction, 2005
Heroin overdose deaths during expansion of methadone and buprenorphine in Baltimore, 1995-2009

Schwartz, AJPH, 2013

MOUD reduces (some) risky behaviors

• Thirty-eight studies, involving some 12,400 participants, were included
• Majority were descriptive studies
• MAT reduces:
  • Illicit opioid use
  • Injecting use
  • Sharing of injecting equipment
  • Number of sexual partners
  • Exchange of sex for drugs/money

Replacing one drug for another?

• Addiction is more than just dependence

• Bupe and Methadone are legal and regulated
  • We know what is in them = safer
  • Don’t have to illicitly obtain them = safer
  • Have a team supporting the patient = safer
What about abstinence?

“Compared with use of α2-adrenergic agonists or psychosocial treatment alone, opioid agonist treatment with buprenorphine–naloxone or methadone has proven superior in terms of retention in treatment, sustained abstinence from illicit opioid use, and reduced risk of morbidity and death.”

2018: Management of opioid use disorders: a national clinical practice guideline
Do people stay on MOUD for life?
As a comparison….

• After six to 12 months of treatment with buprenorphine, 50 percent to 80 percent of patients no longer use opioids.

• By comparison, after the same length of time in treatment, 40 percent to 70 percent of patients have type 1 diabetes under control, and less than half are adhering to their medication regime.

• Twenty percent to 50 percent of patients with hypertension achieve good control of their condition during the same period, and less than 30 percent adhere to medical therapy.

Aleksandra Zgierska, M.D., Ph.D., a family physician from the University of Wisconsin School of Medicine and Public Health
ED settings
Why focus on the ED?
Because that’s where the patients are

Or the inpatient service, or primary care?

- Overdose
- Treatment Seeking
- Screening
If your patient is ready, be there!
Q3. Should patients with opioid withdrawal be treated with opioid agonist therapies or non-agonist therapies?

Opioid agonist therapy (OAT) should be the first line treatment for patients with OWS in the ED. OAT, as compared to therapies that do not utilize opioid agonists, treats the underlying etiology of the OWS, manages the symptoms of OWS much more quickly and effectively, and can be continued long term, which allows the immediate transition from withdrawal to sustainable addiction treatment.

In some settings, OAT may not be available or a patient may not be amenable to OAT. In these cases, OWS should be treated with medications that are not opioid agonists.

Q4. How is OWS treated with agonists and/or non-agonists?

Agonist treatment of OWS is best initiated in the ED using buprenorphine or methadone. Buprenorphine is preferred for most patients given its safety benefits compared to methadone (Q8). Treatment of OWS with buprenorphine in the ED is equivalent to initiation of buprenorphine as a treatment for OUD (Q19). Methadone should be used to treat OWS if
ED Bridge Model

Key ED-BRIDGE partners include:

- DHCS
- SAMHSA
- California Hub and Spoke System
- CSAM
- California Poison Control System
- UCLA
- California Health Care Foundation
- SHOUT
- Clinician Consultation Center
- California ACEP
72-hour rule

Title 21, Code of Federal Regulations, Part 1306.07(b)

Allows to administer (but not prescribe) narcotic drugs for the purpose of relieving acute withdrawal symptoms while arranging for the patient's referral for treatment

- Not more than 1-day's medication may be administered or given to a patient at one time
- Patient must return to ED each day for no more than 72 hours
- This 72-hour period cannot be renewed or extended.
3 interventions:  
(100+ pts in each arm)

- Referral (37%)

- Brief intervention + referral (45%)

- Brief intervention + bup + referral (78%)

Primary outcome: receiving addiction treatment in 30d
CA Bridge

bridgetotreatment.org/resources

Clinical Protocols:
• Hospital Quick Start Algorithm
• Buprenorphine After Overdose
• Acute Pain and Buprenorphine
• Methadone Quick Start
• Home-Starts
**Uncomplicated* opioid withdrawal?**

- NO: 
  - Start Bup after withdrawal
  - Supportive meds prn, stop other opioids

- YES (stop other opioids)

**Administer 8mg Bup SL**

**Withdrawal symptoms improved?**

- NO: 
  - No Improvement
  - Differential Diagnosis:
    - Withdrawal mimic: Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlying illness.
    - Incompletely treated withdrawal: Occurs with lower starting doses; improves with more Bup.
    - Bup side-effect: Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
    - Precipitated withdrawal: Too large a dose started too soon after opioid agonist. Usually time limited, self resolving with supportive medications.

- YES: 
  - Administer 2nd dose
    - Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
    - ED: 8-24mg. Consider discharge with higher loading dose.

**Maintenance Treatment**

- 16 mg Bup SL/day
  - Titrate to suppress cravings; Usual total dose 16-32mg/day

**Discharge**

- Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
- If no X-waiver: Use loading dose up to 32mg for long effect and give rapid follow up.
- If X-waiver: Check CURES (not required in Emergency Department if ≤7 day prescription), prescribe sufficient Bup/Nx until follow-up.

**Overdose Education Naloxone Kit**

- Naloxone 4mg/0.1ml intranasal spray

**Buprenorphine Dosing**

- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days
- May dose qday or if co-existing chronic pain split dosing TID/QID.

**Complicating Factors**

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness
- Recent methadone use

**Diagnosing Opioid Withdrawal**

**Subjective symptoms AND one objective sign**

**Subjective:** Patient reports feeling “bad” due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)

**Objective:** [at least one] restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor

**Typical withdrawal onset:**
- ≥ 12 hrs after short acting opioid
- ≥ 24 hrs after long acting opioid
- ≥ 48 hrs after methadone (can be >72 hrs)

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.

If Completed Withdrawal:
Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

**Opioid Analgesics**

- Pause opioid pain relievers when starting Bup.
- OK to introduce opioid pain relievers after Bup is started for breakthrough pain. Do not use methadone with Bup.

**Supportive Medications**

- Can be used as needed while waiting for withdrawal or during induction process.

**Pregnancy**

- Bup monoprod or Bup/Nx OK in pregnancy.
- Consider referencing buprenorphine in pregnancy guide.
COWS (Clinical Opiate Withdrawal Scale)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resting pulse rate</td>
<td>0-4</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>0-4</td>
</tr>
<tr>
<td>Restlessness</td>
<td>0-5</td>
</tr>
<tr>
<td>Pupil size</td>
<td>0-5</td>
</tr>
<tr>
<td>Bone or joint aches</td>
<td>0-4</td>
</tr>
<tr>
<td>Runny nose or tearing</td>
<td>0-4</td>
</tr>
<tr>
<td>GI upset (n/v/d)</td>
<td>0-5</td>
</tr>
<tr>
<td>Tremor (outstretched hands)</td>
<td>0-4</td>
</tr>
<tr>
<td>Yawning</td>
<td>0-4</td>
</tr>
<tr>
<td>Anxiety/irritability</td>
<td>0-4</td>
</tr>
<tr>
<td>Gooseflesh skin</td>
<td>0-5</td>
</tr>
</tbody>
</table>

5-12: Mild
13-24: Moderate
25-36: Severe
CA-BRIDGE Initial dose

COWS 8+ Sublingual BUP
2nd Dose

1 HOUR ➔ 8 – 24 mg
D/C with Naloxone
What if they’re not reliable to f/u?
Buprenorphine exhibits a higher binding affinity at the μ-opioid receptor than full μ-opioid receptor agonists. A low $K_i$ value corresponds to greater binding affinity but does not necessarily translate to greater receptor activity [18].

Can we prescribe without guaranteed counseling?

- Reviews 3 prominent reviews and 27 recent studies
- Wide range of psychosocial methods used, but most seemed to enhance clinical outcomes
- Most of the studies looked at methadone, and not bupe
- Benefit of concurrent psychosocial interventions with bupe was less robust
  - Some studies show no difference

“Providers should not link the initiation of MAT to the immediate availability of or patient willingness to participate in counseling.”

Primary Care Setting
Potential Flow

- Identify the patient as having OUD
- Rule out complicating factors
- Obtain a UDS
- Review PMP
- Write for a week’s supply
- Instruct on how to take the first few doses
- Give naloxone kit
- See in a week
DSM V Diagnostic criteria - OUD

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms

Complicating factors

• Uncompensated psychiatric disease
• Methadone
• Severe liver disease
• High dose benzodiazepenes
• Altered mental status, delirium, intoxication
Urine drug Screen

Multi-Drug Screen Test

ID/DATE

[Image of a multi-drug screen test kit with results indicated as negative, positive, and invalid.]
PMP (Prescription Monitoring Program)

• How often to check?
• What are we looking for?
When to start:

- Have at least 5 of these symptoms before starting. If you don’t have at least 5, wait a bit longer. The worse you feel, the more you will be satisfied with the experience.

- It varies but should be at least 12 hours since you last used heroin or opiate/narcotic pills and at least 24 hours since you used methadone.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Do I have this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel like yawning</td>
<td>€ Yes</td>
</tr>
<tr>
<td>My nose is running</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I have goose bumps</td>
<td>€ Yes</td>
</tr>
<tr>
<td>My muscles twitch</td>
<td>€ Yes</td>
</tr>
<tr>
<td>My bones &amp; muscles ache</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I have hot flashes</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I’m sweating</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I feel unable to sit still</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I am shaking</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I feel nauseous</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I feel like vomiting</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I have cramps in my stomach</td>
<td>€ Yes</td>
</tr>
<tr>
<td>I feel like using</td>
<td>€ Yes</td>
</tr>
</tbody>
</table>

- Before taking the buprenorphine drink some water. Buprenorphine is absorbed under the tongue. Don’t eat or drink anything until the medicine has dissolved completely.

- Avoid using tobacco products before taking dose of buprenorphine. Nicotine causes constriction of blood vessels, and this may decrease absorption of buprenorphine.

- You may be receiving a prescription for 8 mg tablets or films. Cut these in half to get 4 mg.

- Bring your buprenorphine to each appointment.

- Please call our clinic at (520) XXX-XXXX with questions or problems.
Day 1:
- Put **4 mg (1/2 tablet/film) under the tongue**. Do not swallow the buprenorphine. It is best absorbed under the tongue. It takes 20-45 minutes for the medicine to have an effect. Usually you will feel a little better, or at least no worse. If you feel worse, it means you started taking it too soon.
  - **1 hour or more after the first dose see how you feel.**
    - If you feel fine, don’t take any more.
    - If you have symptoms of withdrawal take another 4 mg dose.
  - **1 hour or more after the second dose see how you feel.**
    - If you feel fine, don’t take any more.
    - If you have symptoms of withdrawal take another 4 mg dose.
  - **1 hour or more after your third dose see how you feel.**
    - If you feel fine don’t take any more.
    - If you have symptoms of withdrawal take another 4 mg dose.
  - **Keep track of your doses and the times you take them:**

<table>
<thead>
<tr>
<th></th>
<th>Time Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} dose (4 mg)</td>
<td></td>
</tr>
<tr>
<td>2\textsuperscript{nd} dose (4 mg) – if needed</td>
<td></td>
</tr>
<tr>
<td>3\textsuperscript{rd} dose (4 mg) – if needed</td>
<td></td>
</tr>
<tr>
<td>4\textsuperscript{th} dose (4 mg) – if needed</td>
<td></td>
</tr>
</tbody>
</table>

Record your total daily dose here: __________________________________________

Day 2:
Take the **total dose** you recorded from day 1 at once in the morning. Come to your follow up appointment. Bring this form with you.

Record your morning dose here: __________________________________________
Diversion?

• Lack of treatment access is a major risk factor for diversion
• Diverted buprenorphine is often used by people who cannot access treatment to manage their withdrawal symptoms

Behavioral Health?

Benefits¹:

• Improve adherence to medications; Address issues related to the disorder that medications do not

Types of evidence-based behavioral treatments²:

• Motivational Enhancement Therapy (MET)
• Cognitive Behavioral Therapy (CBT)
• Contingency Management (CM)
• Family-Based

But...

- Data
- Access
ASAM statement

“In areas where such services are not available, such as areas where there are no OTPs, pharmacological treatment alone with support of the treating clinician results in improved outcomes for some patients.”

Document provision of or referral for additional psychosocial treatment

Higher level of care?
Liability?

• 2002-2013: 464 deaths with bupe in the US
  • Unsure how many also on benzodiazepenes
  vs

• 2008: 14,800 deaths d/t prescription opioids

• Morbidity and mortality among people with OUD that is untreated is much higher

Risk Evaluation and Mitigation Strategies | REMS

- Meets OUD diagnostic criteria?
- Counseled on risk and safe storage?
- Complete the Appropriate Use Checklist
  - Checked PMP
  - Reviewed all other meds
  - Induction doses
  - Limited amount of meds
  - Provided or referred to counseling/support
  - Scheduled next visit
Interested in Provider-to-Provider Collaboration?

The Arizona Center for Rural Health has developed a **collaborative consultation model** to pair experienced MAT providers with new MAT providers for the purpose of increasing capacity for providing evidence-based treatments.

Check out the [website](https://crh.arizona.edu/mentor) and [interest form](https://crh.arizona.edu/mentor):
Need a DATA Waiver?

ACEP/PCSS training:
https://www.acep.org/education/ed-x-waiver-training-corps/

Provider Clinical Support System (PCSS) at
http://pcssnow.org/medications-for-addiction-treatment/

Arizona State University Medication-Assisted Treatment for Opioid Use Disorder at https://cabhp.asu.edu/medication-assisted-treatment
Community Resources in Arizona

1. Go to [211arizona.org](http://211arizona.org) (call Arizona 2-1-1) or Arizona Opioid Assistance & Referral Line at 1-888-688-4222

2. Find local Rx Drug Drop-Off Locations: [Dumpthedrugsaz.org](http://dumpthedrugsaz.org)

3. Find Local treatment Services: [findtreatment.samhsa.gov](http://findtreatment.samhsa.gov)

4. Find Naloxone: [spwaz.org/arizonanaloxone/](http://spwaz.org/arizonanaloxone/)
Download the slides

- https://cpac.arizona.edu/23-c
There are two surveys we are inviting you to complete. The first is for grant purposes and the second is for you to receive CMEs. Please complete the one below for our grant purposes.

https://redcap.uahs.arizona.edu/surveys/?s=W4JF8TMAEF

You will receive an email for the second evaluation from CAAHEC, which is tied to your CMEs.