



**UW PACC**

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

# STARTING SUBOXONE IN PRIMARY CARE

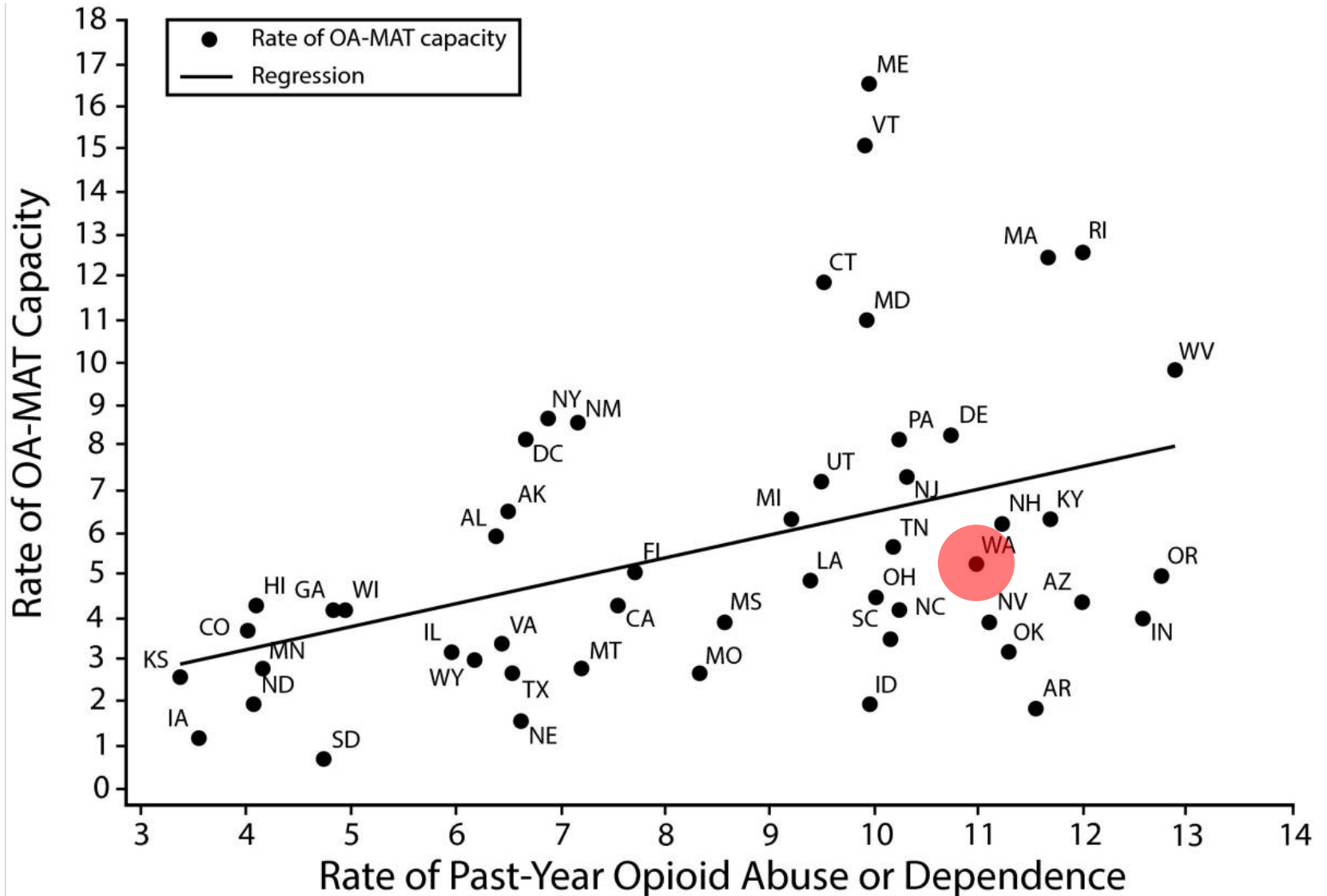
MARK DUNCAN MD

UNIVERSITY OF WASHINGTON



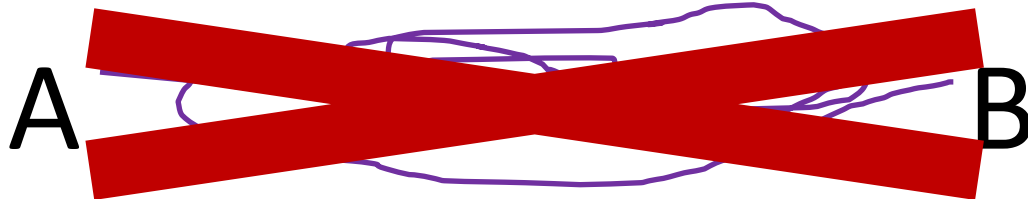
# OBJECTIVES

1. Review evidence of how to use Suboxone in Primary Care
2. Discuss considerations for a Suboxone workflow
3. Develop understanding on ways to handle Suboxone issues



- 12<sup>th</sup> highest rate of past-year opioid abuse or dependence
- 22<sup>nd</sup> highest rate of OA-MAT capacity

# BUPRENORPHINE IN PRIMARY CARE



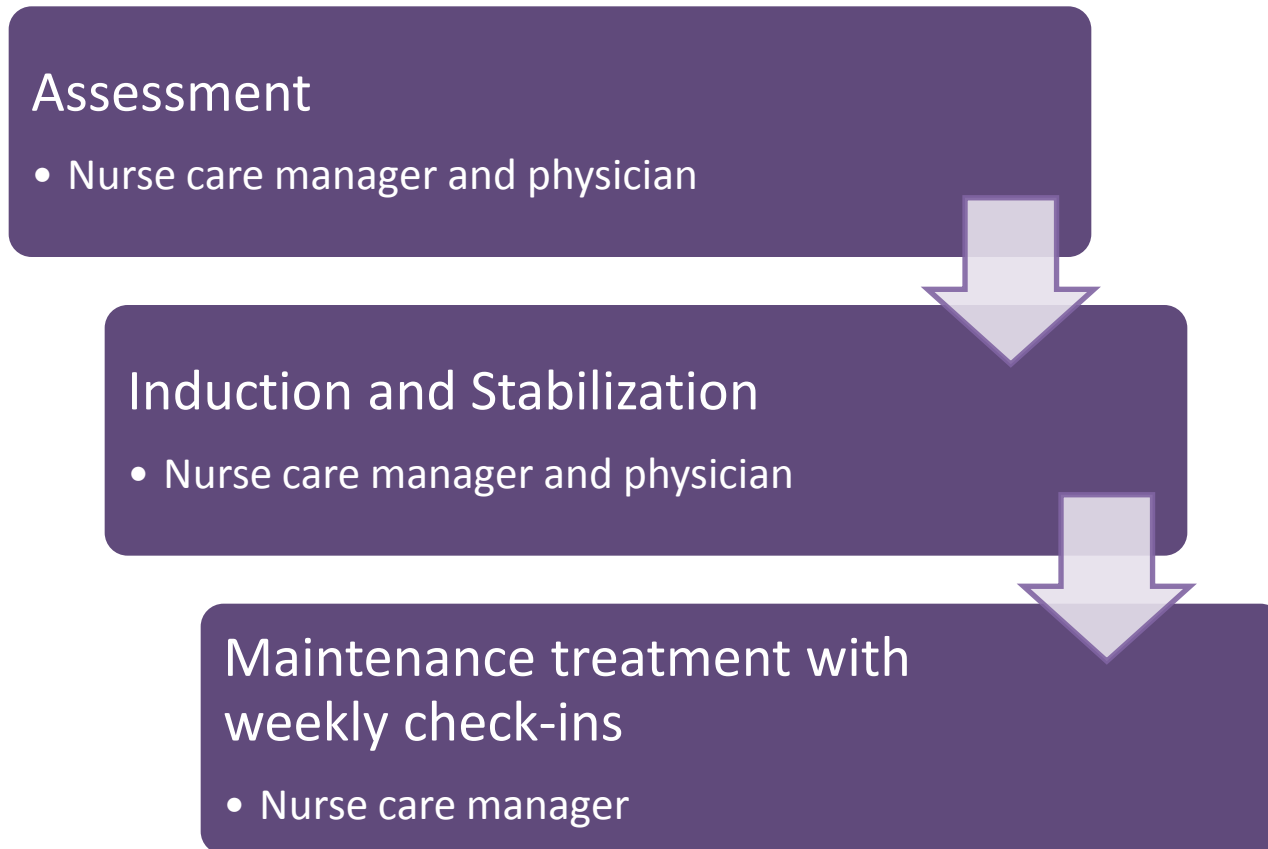
Keep it simple



- Medication management is enough for some
- People do better with long-term treatment

# MASSACHUSETTS CC MODEL

## 3 STAGES



### Purpose:

- provide clinical support, increase access, leverage provider efforts

# MASSACHUSETTS MODEL

- Outcomes
  - Success: treatment retention or Bup taper after treatment adherence and sober x 6 months
    - 51% at 12 months
  - Unsuccessful: loss to f/u, involuntary discharge due to continued drug use, non-adherence, disruptive behavior
    - 42% at 12 months
  - Methadone transfer
    - 6%
  - Illicit Drug Use: q3 months
    - Of those remaining in study, 93% had negative tests

# SUBOXONE MEDICATION GROUPS: AN EMERGING TREATMENT MODALITY

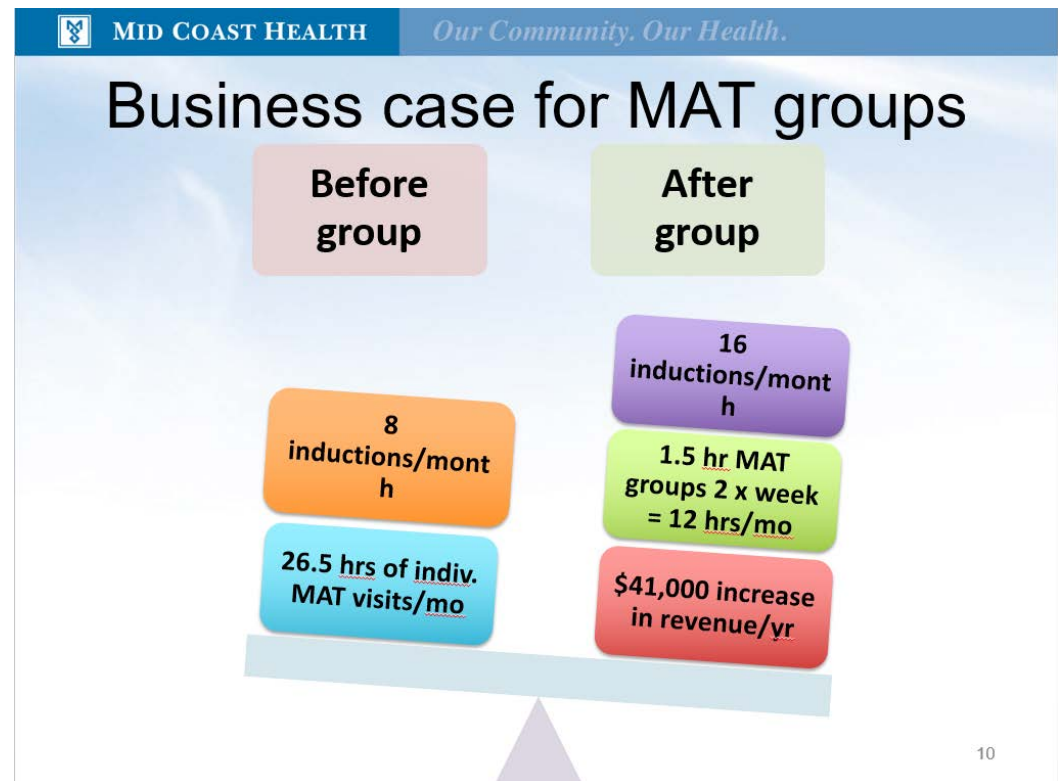
- Shared Medical Appointment
- 60min-90min
- Weekly→Monthly
- 8-10 participants
- Individual time and Peer support time
- Used in maintenance phase
- Patients like them

## The answer to?

Lack of access

Lack of milieu in primary care

Cost



Leah Bauer MD

# DATA 2000 WAIVER

- DATA 2000 Waiver NEEDED
- Providers' Clinical Support System
  - PCSSMAT.org webinar for waiver



- ASAM

- <http://www.asam.org/education/live-online-cme/buprenorphine-course>



**ASAM** American Society of  
Addiction Medicine



# THE GROUND RULES

- Initial limits: 30 patient
  - 100
    - May request increase after 1 year
  - 275
    - Need waiver treating 100 patients x 1 year
    - 1 or 2 qualifications
      - Additional credential i.e. board certified ASAM, ABAM, ABMS
      - Qualified practice setting

[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/medication\\_assisted/understanding-patient-limit275.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/understanding-patient-limit275.pdf)

# CFR 42, PART 2 & PC CLINICS

- Requires a higher level of confidentiality when treating patients with addiction
- Does not apply if a program is a general medical care facility and does not “hold itself out” as an addiction tx
- Have patients sign release allowing for disclosure
  
- SAMSHA FAQ
  - <http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>

**WHAT ARE YOUR BARRIERS TO  
USING SUBOXONE?**

# UW PACC

- Number of Participants with waiver: 21
- Reasons for not using Suboxone for Opioid Use disorders
  1. Lack of access for additional supportive treatment (9)
  2. Never trained in residency (8)
  3. Other (7)
  4. Clinic not supportive (6)
  5. Patients are hard to deal with (6)

# THINGS TO CONSIDER

- Who do you want to treat
- How many patients
- How to induce
- Refills?
- Coverage while away
- Use of urine drug screens
- Monitoring the PMP
- Use of treatment agreement
- Support and referral

# PATIENTS FOR SUBOXONE IN PC

- First time in treatment
- People transferring care
- Heroin vs Prescription opioids?
- Homeless?
- Polysubstance use?
- Cannabis?
- Pregnancy
- Screen for psych/substance disorders
- Screen for possible infections

# HOME INDUCTIONS-DO THEM

## Buprenorphine - Beginning Treatment

Day One: Before taking a buprenorphine tablet you want to feel lousy from your withdrawal symptoms. Very lousy. It should be at least 12 hours since you used heroin or pain pills (oxycontin, vicodin, etc.) and at least 24 hours since you used methadone.

Wait it out as long as you can. The worse you feel when you begin the medication, the better it will make you feel and the more satisfied you will be with the whole experience.

You should have a least 3 of the following feelings:

- twitching, tremors or shaking
- joint and bone aches
- bad chills or sweating
- anxious or irritable
- goose pimples



• very restless, can't sit still



• heavy yawning



• enlarged pupils



• runny nose, tears in eyes

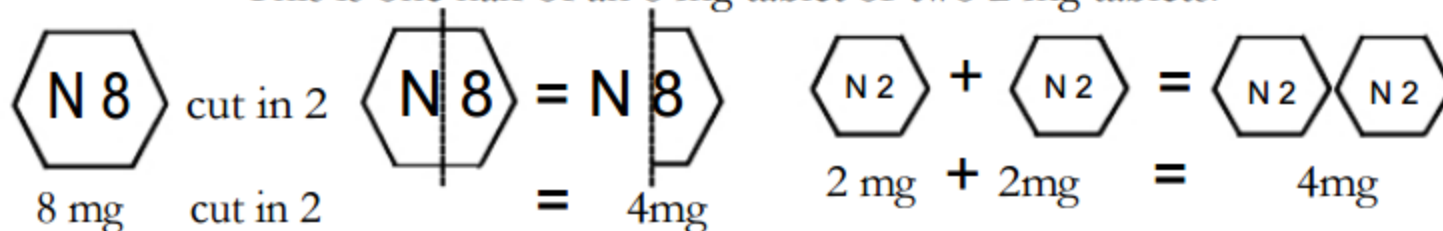


• stomach cramps, nausea, vomiting, or diarrhea

---

First Dose: 4 mg of Buprenorphine (Bup) under the tongue.

This is one half of an 8 mg tablet or two 2 mg tablets:



[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628995/bin/11606\\_2008\\_866\\_MOESM1\\_ESM.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628995/bin/11606_2008_866_MOESM1_ESM.pdf)

# TREATMENT AGREEMENTS?

- Can be helpful in the following ways
  - Good to help review consent
  - Helps establish refill request limitations
  - Help disclose progression of care
    - When a higher level of care is needed
- I don't threaten to stop treatment



# MONITORING TREATMENT

- Weekly visits at the start
- Regular review of the PMP
- Urine Drug Screens
  - Diversion monitoring
  - Other drugs
  - No set approach
- Pill counts



# MEDICATION MANAGEMENT VISIT

- Elements
  - Review substance use since the last visit
  - Review adherence
  - Advises abstinence
  - Addresses non-abstinence to treatment if indicated
  - Asks about NA or other self-help group and lifestyle issues
  - Asks about pain
  - Makes referrals and asks about previous referrals if indicated
  - Dispenses Buprenorphine

<http://ctndisseminationslibrary.org/protocols/0030.pdf>

# BUPRENORPHINE & PAIN PATIENTS

- Concerning behavior
  - Runs out early
  - Increasing use
  - Needing prns
  - PMP irregularities
  - Intoxicated presentation
  - Expresses worry about addiction
  - Strong preference for med
  - Concern about future availability
  - Opioids are the only option
- Difficult to engage around addiction issues
- Consider split dosing
- May help with patients on high dose opioids
- Not a panacea, but...

# A CHRONIC DISEASE

- There will be relapses
- Provider clinical support
- Are they on an adequate dose
- Co-occurring issues?
- When to stop?

# NEXT STEPS

1. Get waiver
2. Think through work flow
  1. Induction
  2. Return visits
  3. Treatment monitoring
  4. Psychosocial support
  5. Partner prescriber
3. Develop consent
4. Start seeing patients
5. Stay in touch with UW PACC for support

# RESOURCES

- Treatment Improvement Protocol 40
  - Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction
    - <http://www.store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>
- ASAM Practice Guidelines
  - <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>
- VA/DOD Treatment Guidelines
  - <http://www.healthquality.va.gov/guidelines/MH/sud/>