Buprenorphrine

Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

DISSEMINATION OF

EVIDENCE-INFORMED

INTERVENTIONS

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INTRODUCTION

PURPOSE AND BACKGROUND

The intersection of opioid use and HIV, particularly via injection, is well documented. In the United States, contracting HIV through injection drug use, either directly or via sexual contact with a person who injects drugs, accounts for approximately 23% of diagnosed cases since the beginning of the AIDS epidemic,[1] and more than 6% of diagnosed new HIV infections.[2] In addition, people living wth HIV (PLWH) are more likely to have chronic pain, receive opioid analgesic treatment, receive higher doses of opioids, and have substance use disorders and mental illness compared with the general population, putting them at increased risk for opioid use disorder.[3]

Untreated opioid use disorder is problematic, particularly as injecting behavior is associated with increased risk of HIV transmission, as it interferes with antiretroviral treatment (ART) adherence[4,5,6,7,8,9,10] and impedes HIV viral suppression.[11,12,13,14] The devastating outbreak of more than 180 HIV infections diagnosed in 2015 among persons injecting oxymorphone in rural southeastern Indiana is an example of the way in which injection drug use can be the primary driver of localized epidemics.[15]

In recent years, dramatic increases in opioid-related fatal overdoses and acute hepatitis C infections[16,17] underscore the urgent need to identify and treat opioid use disorder in both PLWH and people at risk of HIV infection. In January 2016, the CDC reported that since 2000, there has been a 200% increase in the rate of overdose deaths involving opioids.[18]

[1]Centers for Disease Control and Prevention (CDC). HIV Surveillance Report, 2016; vol. 28, Table 2b. www.cdc.gov/hiv/library/reports/hiv-surveillance.html. November 2017. [2]CDC. HIV Surveillance Report, 2016; vol. 28, Table 1b. www.cdc.gov/hiv/library/reports/hiv-surveillance.html. November 2017. [3]Cunningham CO. Opioids and HIV infection: From pain management to addiction treatment. Top Antivir Med. 2018; 25(4): 143-6. [4]Cheever LW, Kresina TF, Cajina A, et al. A model Federal collaborative to increase patient access to buprenorphine treatment in HIV primary care. JAIDS (Suppl). 2011; 56(S1):S3–S6. [5]Ingersoll K. The impact of psychiatric symptoms, drug use, and medication regimen on nonadherence to HIV treatment. AIDS Care. 2004;16(2):199– 211. [6]Hinkin CH, Barclay TR, Castellon SA, et al. Drug use and medication adherence among HIV-1 infected individuals. AIDS Behav. 2007;11(2):185– 94. [7]Arnsten JH, Demas PA, Grant RW, et al. Impact of active drug use on antiretroviral therapy adherence and viral suppression in HIV-infected drug users. J Gen Intern Med. 2002;17(5):377– 81. [8]Chander G, Lau B, Moore RD. Hazardous alcohol use: a risk factor for non-adherence and lack of suppression in HIV infection. JAIDS. 2006;43(4):411– 381. [9]Braithwaite RS, McGinnis KA, Conigliaro J, et al. A temporal and dose-response association between alcohol consumption and medication adherence among veterans in care. Alcohol Clin Exp Res. 2005;29(7):1190– 97. [10]Berg KM, Demas PA, Howard AA, et al. Gender differences in factors associated with adherence to antiretroviral therapy. J Gen Intern Med. 2004;19(11):1111– 17. [11]Chander G, Lau B, Moore RD. Hazardous alcohol use: a risk factor for non-adherence and lack of suppression in HIV infection. JAIDS. 2006;43(4):411– 381. [12]Palepu A, Tyndall MW, Li K, et al. Alcohol use and incarceration adversely affect HIV-1 RNA suppression among injection drug users starting antiretroviral therapy. J Urban Health. 2003;80(4):667– 75. [13]Conigliaro J, Gordon AJ, McGinnis KA, et al. How harmful is hazardous alcohol use and abuse in HIV infection: do health care providers know who is at risk? JAIDS. 2003;33(4):521– 25. [14]Lucas GM, Gebo KA, Chaisson RE, et al. Longitudinal assessment of the effects of drug and alcohol abuse on HIV-1 treatment outcomes in an urban clinic. AIDS. 2002;16(5):767– 74.[15]CDC. QuickStats: Use of Prescription Opioid Analgesics* in the Preceding 30 Days Among Adults Aged ≥20 Years, by Poverty Level† and Sex — National Health and Nutrition Examination Survey, United States, 2007– 2012. MMWR. April 24, 2015. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm6415a10.htm?s_cid=mm6415a10_w [16]Zibbell JE, Iqbal K, Patel RC, et al. Increases in hepatitis C virus infection related to injection drug use among persons aged </=30 years - Kentucky, Tennessee, Virginia, and West Virginia, 2006-2012. MMWR. 2015,64:453-8. [17]Suryaprasad AG, White JZ, Xu F, et al. Emerging epidemic of hepatitis C virus infections among young nonurban persons who inject drugs in the United States, 2006– 2012. Clin Infect Dis. 2014; 59:1411– 9 [18]CDC. Increases in drug and opioid overdose deaths – United States, 2000-2014. MMWR. January 1, 2016. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w

Opioid use disorder is treatable with U.S. Food and Drug Administration (FDA)-approved pharmacotherapies. Buprenorphine is one such treatment option, which can be delivered in the primary care office setting. For PLWH, office-based buprenorphine treatment delivered in HIV clinics is associated with decreased opioid use, increased ART use, higher quality of HIV care, and improved quality of life.[19,20,21,22]

TARGET AUDIENCES

This intervention is intended for providers interested in learning more about buprenorphine treatment for opioid use disorder and how they can integrate this treatment into existing clinic and prescribing practices.

TRAINING DESIGN AND INSTRUCTIONAL APPROACH

The curriculum is broken into training modules. Each module tackles a key critical topic area related to the intervention. At the beginning of each module is a lesson plan that provides an overview. Modules include a PowerPoint training slide presentation, as well as a script, learning activities, and additional explanations.

Where possible, trainings encourage learning through interaction rather than lecture alone in order to familiarize participants more fully with the intervention. As such, there are a number of hands-on activities.

Where participants may need more information to reference or as a key takeaway, handouts are included in the appendix as well as reference material for further learning.

ADDITIONAL RESOURCES

Additional resources from this project include an intervention summary, implementation manual, and technical assistance (TA) agenda, all of which can be found at: https://nextlevel.targethiv.org/

A NOTE ON LANGUAGE

Participant refers to someone in this training.

Client refers to a person who is receiving services through the buprenorphine intervention or who otherwise suffer from opioid use disorder.

Facilitator refers to the person(s) providing this training.

[19]Fiellin DA, Weiss L, Botsko M, et al. Drug treatment outcomes among HIV-infected opioid dependent patients receiving buprenorphine/naloxone. J Acquir Immune Defic Syndr (Suppl). 2011;56 (S1): S33-8. [20]Altice FL, Bruce RD, Lucas GM, et al. HIV treatment outcomes among HIV-infected, opioid dependent patients receiving buprenorphine/naloxone treatment within HIV clinical care settings: results from a multisite study. J Acquir Immune Defic Syndr (Suppl). 2011;56 (S1): S22-32. [21]Korthuis PT, Fiellin DA, Fu R, et al. Improving adherence to HIV quality of care indicators in persons with opioid dependence: the role of buprenorphine. J Acquir Immune Defic Syndr (Suppl). 2011;56 (S1): S83-90. [22]Korthuis PT, Tozzi MJ, Nandi V, et al. Improved quality of life for opioid-dependent patients receiving buprenorphine treatment in HIV clinics. J Acquir Immune Defic Syndr (Suppl). 2011;56 (S1): S39-45.

MATERIALS AND EQUIPMENT

Trainers will need the following items:

- A computer or flat screen/ projector that can play each of the PowerPoint presentations
- A screen, television, or blank wall on which to project each training
- A printer and/or copier to produce the handout materials being reviewed in the training (or send electronically to participants if they are able to review in real-time online (e.g., on a laptop).

MANUAL FORMAT

Each training module begins on a new page and section and is identified by a section title and module number. Throughout the manual are explanations of slides, talking points, and activities. Below are the symbols used throughout the trainings:


THE APPROXIMATE LENGTH OF TIME THE SESSION WILL TAKE.


POWERPOINT SLIDE


HANDOUTS


TRAINER'S NOTE


FLIP CHART SHEETS


REFERENCE MATERIALS


ACTIVITY MATERIALS

MODULE 1:
Introductions and Intervention Overview

Topics Covered: Training overview, using local data to identify trends and community needs, opioid overdose trends, and heroin use by demographics.

OBJECTIVES

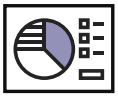
By the end of this module, participants will be able to:

- Identify program goals.
- Assess and formulate critical community partnerships and relationships addressing the opioid epidemic.
- Define trends and strategies in response to the opioid crisis in local settings/jurisdictions and nationally.

Method(s) of Instruction

- Lecture
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

– Note: Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

PROCESS

- Facilitators will welcome participants and lead introductions.
- Facilitators will briefly summarize the content of the training.
- Facilitators will review national data relating to the opioid epidemic.
- Facilitators will provide an example of how a local jurisdiction experiences the opioid epidemic. They will explain that local data is helpful identifying community needs and structuring medication assisted treatment (MAT) programs to meet those needs.

ACTIVITIES

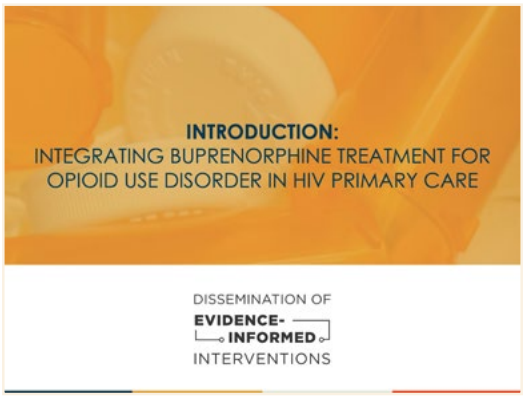
Ask participants to participate in basic introductions: include name, background, as well as description of experience in HIV and addictions medical care.

Key Words and Phrases

- *Introductions*
- *Overview*
- *Opioid Epidemic*
- *Overdose*

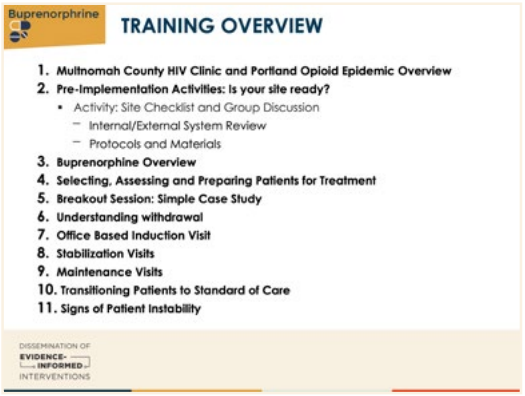
The approximate length of time the session will take.

Total: 20 minutes



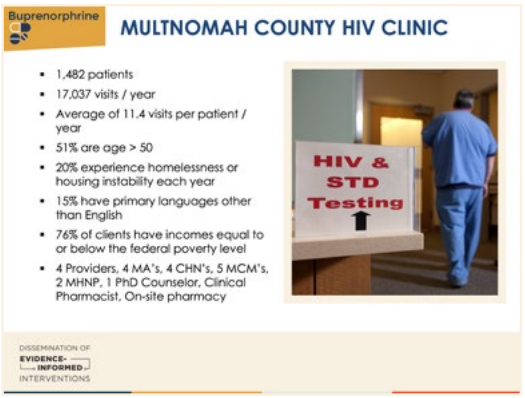
SLIDE 1:

Welcome participants to the training. Ask participants to participate in basic introductions: include name, background, as well as description of experience in HIV and addictions medical care.



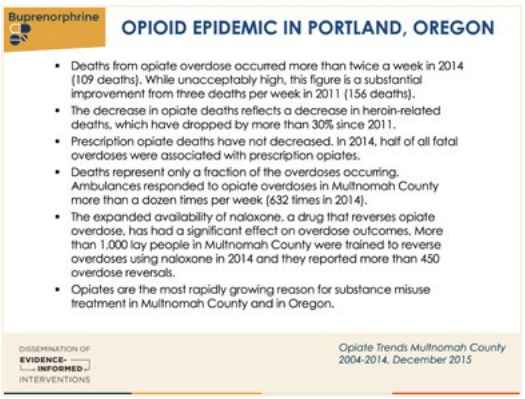
SLIDE 2:

This is an introductory training to the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual intervention. Our training will cover these 11 topic areas.



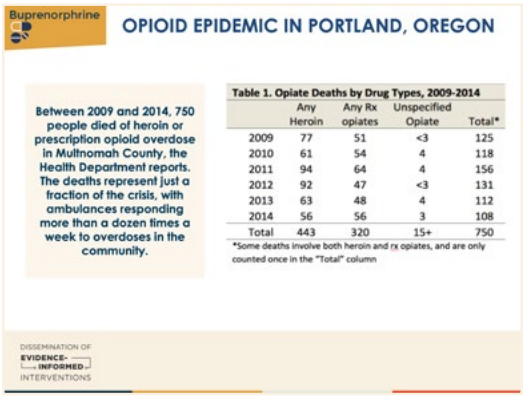
SLIDE 3:

Description of Multnomah County Health Department's HIV Health Services Center (HHSC), a Ryan White HIV/AIDS Program-funded clinic receiving Part A, C, and D support as well as an AIDS Education and Training Center. The trainers who originally presented this model were part of a medical team at the Multnomah County HHSC. The following slides present data about the clinic, as well as the opioid and HIV epidemics in the city of Portland as an example of how future implementation sites should collect and assess local trends.



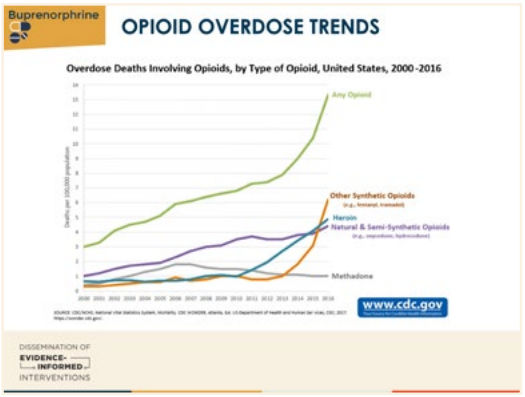
SLIDE 4:

Every geographic area experiences the opioid epidemic. Local data is helpful in understanding your trends and identifying your community's needs. The above data shows this information in Portland, Oregon for the noted time period.



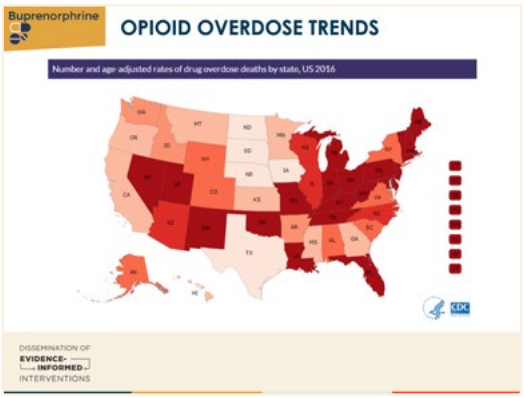
SLIDE 5:

Each locale may have specific drug-use patterns reflected in their overdose data. In many locations, prescription opiates are overtaking heroin in terms of use and overdose. Any site that is going to initiate medication-assisted treatment (MAT) needs an assessment of their local data as this information will help structure your program.



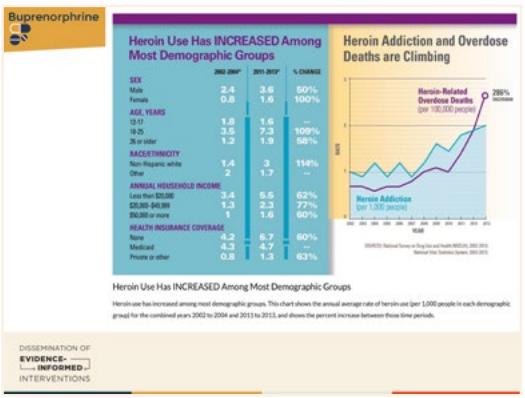
SLIDE 6:

Overdose by any opioid is trending upwards in the national data, as shown here.



SLIDE 7:

Drug overdose deaths vary by geographic locations and even local trends can be markedly different. Nonetheless, this map of the U.S. shows distinctly higher rates of overdose in specific locations.



SLIDE 8:

The rate of heroin use has increased in almost all demographic categories in the time frame shown. This rise correlates with increasing overdose deaths. The rate of heroin use and the percent change is distinctly higher in ages 18-25 and in non-Hispanic whites. Overall use rates are higher in men, the uninsured, and those in lower-income households.

CLOSING:

Next, each participant will complete a site-specific checklist. This check list will guide implementation for an office-based buprenorphine study, with attention to the local epidemic and system in which implementation will occur. Sites will be able to use completed check lists to develop protocols and procedures that are specific to the needs of their system.

MODULE 2:
Pre-Implementation Activities: A Systems Review

Topics Covered: Pre-implementation activities and checklist

OBJECTIVES

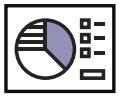
By the end of this module, participants will be able to:

- Complete a self-assessment checklist focused on an internal and external systems review.
- Compare and contrast each other's system for future reference and potential learning points.
- Develop protocols and procedures to support implementation plan as informed by the self-assessment checklist.

Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Activity

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Self-Assessment Checklist

FLIP CHART SHEETS

PROCESS

ACTIVITIES

Participants will complete the self-assessment checklist (one checklist for each organization).

Participants will share their completed checklist with trainers or participants from other organizations, as applicable.

FACILITATED DISCUSSION:

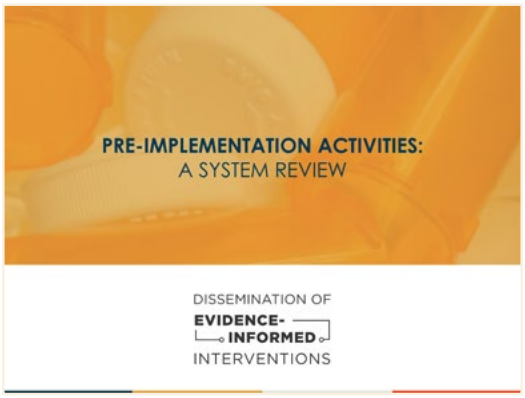
If individuals from multiple sites are participating in the training, a facilitated discussion will occur to compare and contrast systems. This will enable participants to learn about and from each other's systems. Facilitators will also share a self-assessment of their system and examples of how participants can use the assessments to develop their own specific guidelines.

Key Words and Phrases

- *Pre-Implementation*
- *Systems Assessment*

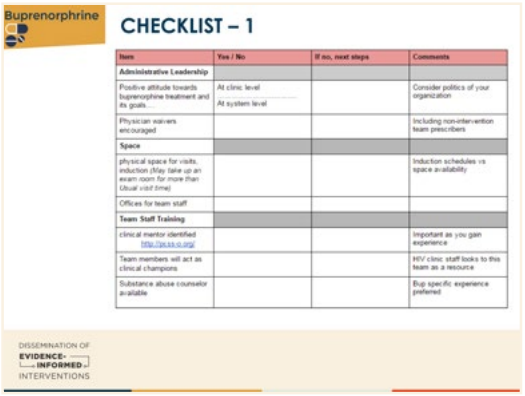
The approximate length of time the session will take.

Total: 30 minutes



SLIDE 1:

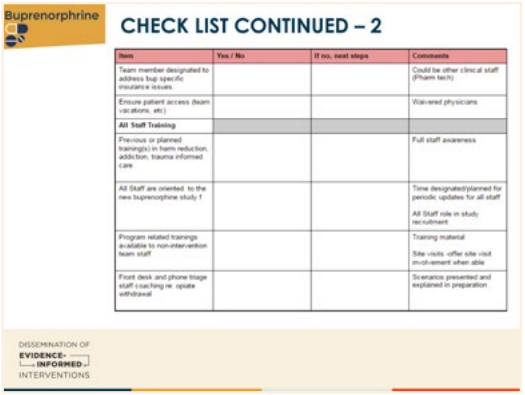
In this module, we will be covering pre-implementation activities.



SLIDE 2:

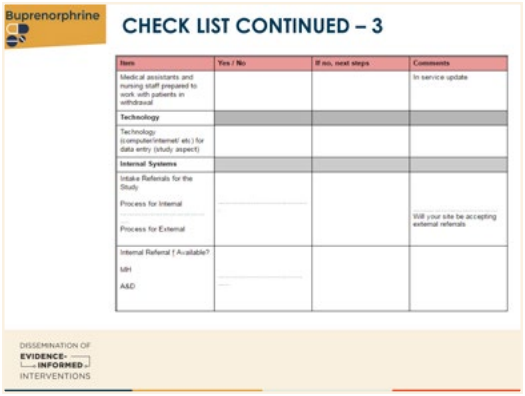
This checklist (slides 2-6) is a site-specific guide for initiating implementation of an office-based buprenorphine program. Any program can use this checklist as a framework. However, the checklist speaks directly to the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual intervention protocol. If your clinic is adopting this protocol, the checklist can also be adopted to fit the needs of your specific program. Completion of the checklist will allow your program to assess internal and external systems, and build protocols that are specific to the needs and structure of your local setting.

The checklist begins with leadership support, physical space, and required staff training for team members who are directly managing clients with an opioid use disorder.



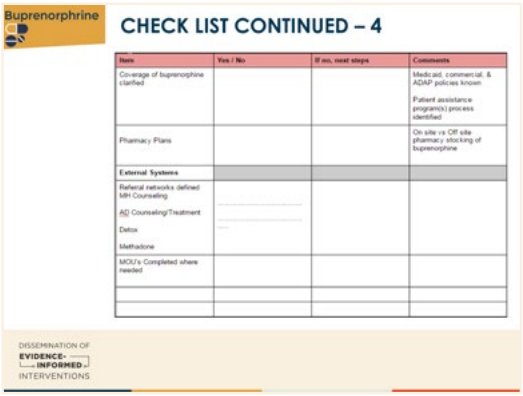
SLIDE 3:

This section of the checklist continues the focus on staff training needs and then adds additional training topics for all clinic staff.



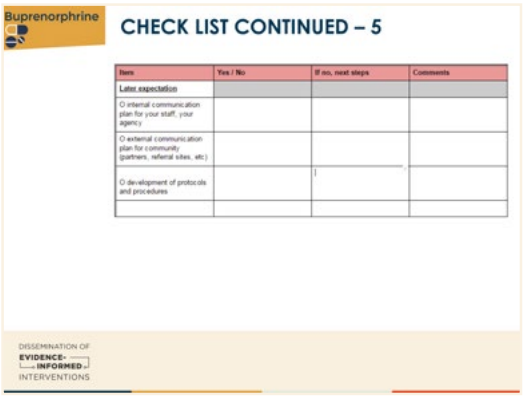
SLIDE 4:

This section of the checklist continues the focus on all staff training for substance use disorder. Technology needs and internal system workflows are then highlighted.



SLIDE 5:

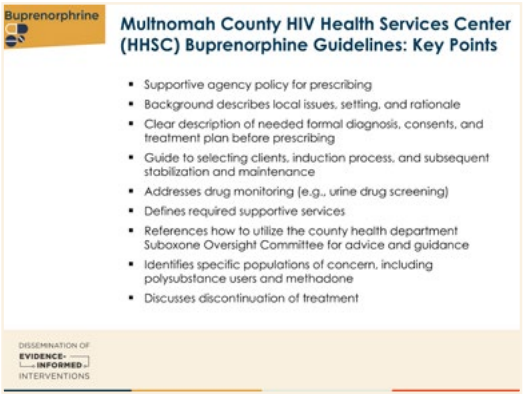
This section of the checklist continues the internal systems workflow and identifies external system services that can support your clients.



SLIDE 6:

This section of the checklist points out the need for clear communication processes both internally and externally. Now you will complete the checklist. Please break up into organization-specific groups and spend the next 15 minutes completing the checklist for your clinic.

Note: Facilitators will handout copies of the checklist and assist participants into breaking up into small groups.



SLIDE 7:

Now that you have completed your checklist, the next step is to use the information compiled to develop policies and procedures to support implementation of the buprenorphine intervention within your clinic. This slide summarizes key points that should be addressed in the development of guidelines for treatment of opioid use disorder with buprenorphine, based on the experience of Multnomah County HIV Health Services Center (HHSC). for treatment of opioid use disorder with buprenorphine. Facilitators will lead a discussion so that all participants can learn about each other's systems and brainstorm next steps to develop policies and procedures, utilizing the checklist as a guide. Discussion questions can include:

- What guidelines already exist?
- Which need to be created?
- How can the existing strengths and anticipated challenges of integrating buprenorphine treatment into your system inform the development of new or adaptation of existing guidelines?
- What are tangible next steps if challenges are identified?

Treatment Improvement Protocol (currently TIP 63): Medications for Opioid Use Disorder can also be leveraged to develop local protocols and guidelines. TIP 63 can be accessed here: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

CLOSING

Now that we have a better understanding of your systems, we will discuss in depth the specific protocols and material that are necessary to have in place prior to implementation.

MODULE 3:
Pre-Implementation Activities: Protocols & Materials

Topics Covered: Pre-implementation, record keeping, inclusion and exclusion criteria, site-specific issues, trauma-informed responses, buprenorphine overview, and opioid activity levels

OBJECTIVES

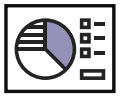
By the end of this module, participants will be able to:

- Describe federal record keeping requirements.
- Recognize the importance of internal protocols that ensure timely client care and referrals.
- Assess site-specific issues that will impact protocol development, implementation, and the intervention's inclusion/exclusion criteria.
- Understand the basics of buprenorphine treatment, including how it works and formulations available.

Method(s) of Instruction

- Lecture
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Trauma-Informed Assessment Checklist: www.integration.samhsa.gov/about-us/TIC_Environmental_Scan.pdf
- Checklist Assessment Tool, completed in Module 2

FLIP CHART SHEETS

PROCESS

Review federal record keeping requirements, as well as inclusion/exclusion requirements for enrollment. Then, facilitators will complete a brief buprenorphine 101 lecture. The lecture is a refresher for participants who already received a waiver and a summary for participants who have not received a waiver (e.g., behavioral health professionals, counselors, social workers). The lecture is not a substitute for the Drug Addiction Treatment Act Data Act of 2000 (DATA 2000) waiver training, which is the eight-hour training for physicians to qualify for a waiver to prescribe and dispense buprenorphine.

FACILITATED DISCUSSION:

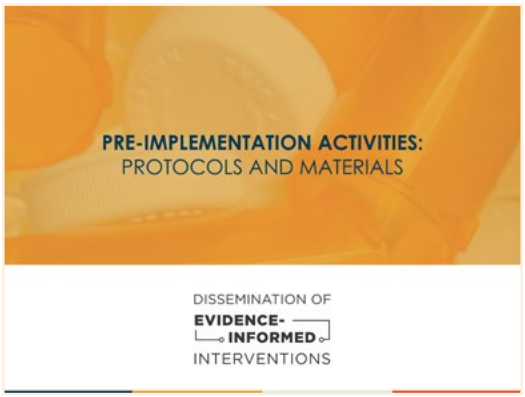
Engage participants in a more in-depth discussion around how their site will receive referrals of potentially eligible clients, how back up will be provided for key staff, and how they will refer clients to a higher level of care, if necessary. If applicable, facilitators will share examples of how these components are handled in their setting.

Key Words and Phrases

- *Inclusion-Exclusion Criteria*
- *Buprenorphine 101*
- *Trauma-Informed Care*
- *Federal Record Keeping Requirements*

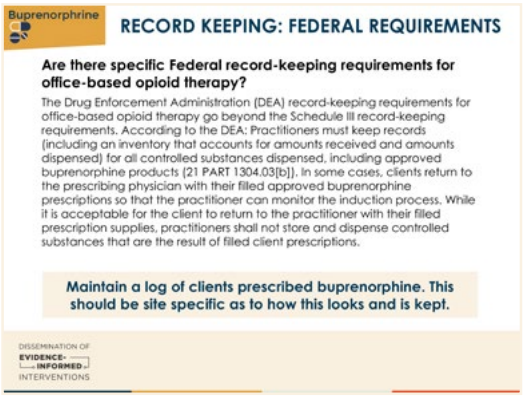
The approximate length of time the session will take.

Total: 30 Minutes



SLIDE 1:

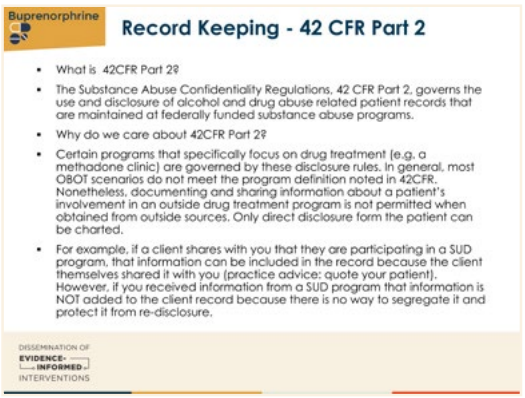
In this module, we will be covering pre-implementation activities.



SLIDE 2:

Federal requirements for office-based opioid therapy are specific and regulated. It is critical that practitioners and clinics understand these requirements, particularly being able to identify patients receiving buprenorphine.

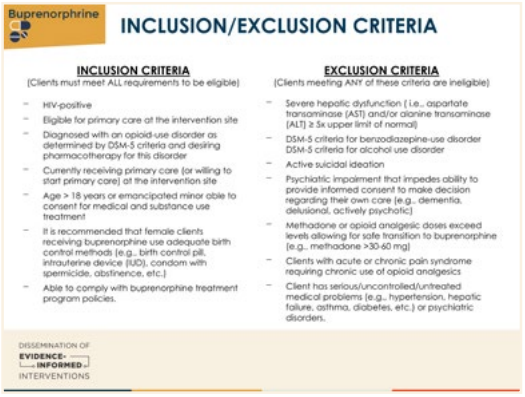
(**Note:** Storing and dispensing these medications by practitioners is specifically prohibited. Induction with filled prescription supplies is allowed).



SLIDE 3:

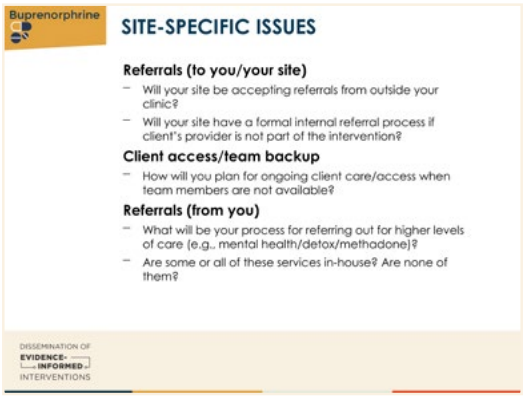
This slide is to provide a brief overview of 42 CFR Part 2 and how a program providing OBOT might encounter 42 CFR Part 2 information and recommendations on how to document this information to avoid redisclosure of this information. Speaker will advise that each program that provides OBOT is uniquely different and will recommend that staff work with their specific clinic staff to review best practices for that site on managing 42 CFR Part 2 information.

Speaker will note that in May 2018, the Overdose Prevention and Patient Safety Act (HR 3545) would amend 42 CFR Part 2, which is intended to protect the confidentiality of people who seek SUD treatment, to expand healthcare provider access to SUD patient records while maintaining privacy protections under HIPAA.



SLIDE 4:

All clinics providing buprenorphine should have clearly defined criteria for selecting clients. This slide represents specific criteria utilized in the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual intervention, as part of the Dissemination of Evidence-Informed Interventions initiative. The specific criteria should reflect up-to-date medical literature, local and federal laws, and your own clinic system policies. Updated medical literature includes a more lenient approach to alcohol and benzodiazepine use in buprenorphine treatment. See: Martin, S., Chiodo, L., Bosse, J., et al. The Next Stage of Buprenorphine Care for Opioid Use Disorder. Ann Intern Med. 2018: 169: 628-635.



SLIDE 5:

While we began discussing these issues during the self-assessment activities, these three issues are key to preparing your clinic and system for implementation of buprenorphine prescribing. Specific issues include planning for how clients will engage with your prescribers and other buprenorphine skilled staff, what staff back-up looks like, and how you refer clients for higher levels of care. How you address these questions is specific to your clinic/location, but having a plan in place prior to implementation will help services run smoothly.

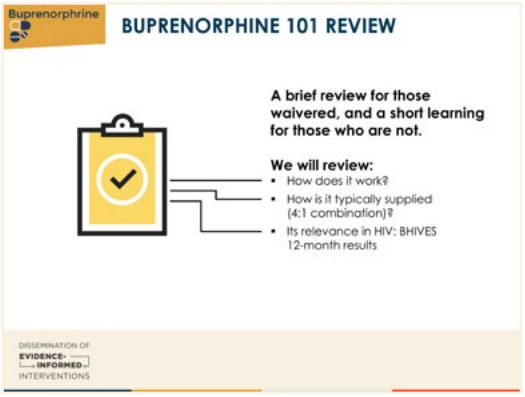
Activity (Discussion):
How do you think you will address these issues in your setting?

SLIDE 6:

Using a trauma-informed lens when developing office-based policies and procedures is recommended. On this slide are national and Oregon-specific resources. SAMHSA's Six Key Principles of a Trauma-Informed Approach are:

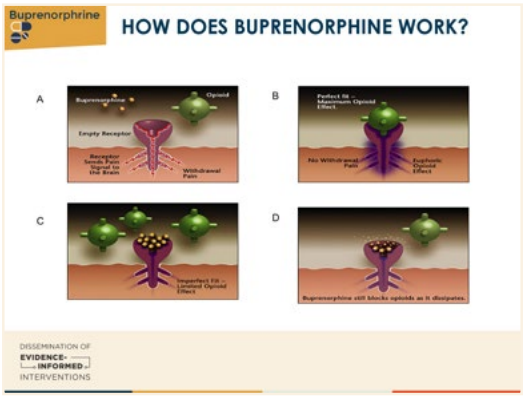
1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

Activity (Discussion):
Do your policies and procedures incorporate these principles? What do these principles look like in practice? How could incorporating these principles be challenging?



SLIDE 7:

A DATA-2000 waiver from the DEA is required for buprenorphine prescribing (by MDs, DOs, NPs, and PAs). The next slides provide a brief buprenorphine 101 refresher for participants who are already waivered and a summary for participants who are not waivered (e.g., behavioral health professionals, counselors, social workers).



SLIDE 8:

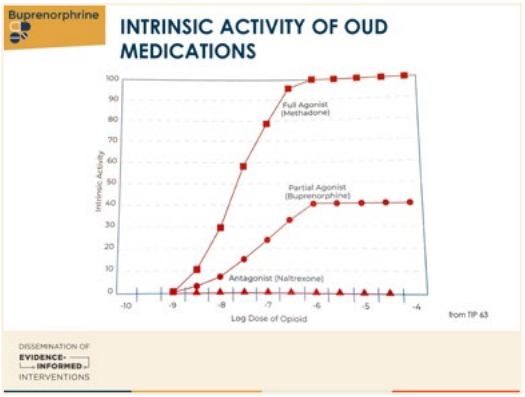
A. Empty opioid receptor, a tolerant/using client would experience discomfort/withdrawal.

B. Receptor filled with full agonist (e.g., heroin, prescription opioids), a client would experience euphoria and pain relief.

C. Buprenorphine binding, high affinity (strong binding ability) partial agonist, can displace other opioids from the receptor. A client would experience withdrawal if on opioids but prevent withdrawal on chronic buprenorphine with limited opioid effects.

D. Buprenorphine has a long half-life and continues to block other opioids and prevents rapid withdrawal.

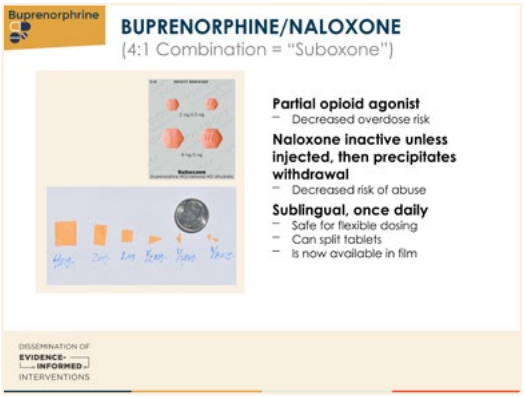
Citation: National Alliance of Advocates for Buprenorphine Treatment. Available at: www.naabt.org/education/literature.cfm



SLIDE 9:

A comparison of the three FDA-approved medications to treat OUD and their intrinsic activity. This slide helps to demonstrate buprenorphine's unique partial agonist intrinsic value, creating an overall ceiling effect even if/when dose increases. This reduces the likelihood of overdose in comparison to full agonist such as methadone.

Citation:
SAMHSA. Treatment Improvement Protocol (TIP) Series, No. 63, Chapter 3A. "Overview of Pharmacotherapy for Opioid Use Disorder."



SLIDE 10:

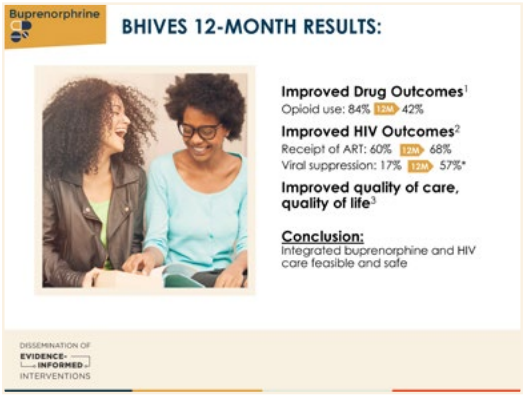
- Buprenorphine is commonly manufactured with naloxone as seen in this slide.
- The partial agonist ceiling effect of buprenorphine provides some safety in terms of lower overdose risk and naloxone is added to decrease the risk of intravenous abuse, due to its antagonist activity (i.e., induces withdrawal).
- Oral preparations of this combination allow for flexible dosing in either the tablet or the film.
  - There are reports of injection drug use (IDU) abuse despite naloxone component, particularly with the film (it melts).

SLIDE 11:

This subcutaneous form of buprenorphine is another MAT option, though it requires thoughtful client selection and timing of treatment initiation. It requires specific training to place the implant, which has a six-month duration of effect. This was FDA approved in May 2016.

SLIDE 12:

A visual image of sublocade, an intramuscular (IM) version of buprenorphine to treat OUD. This was FDA approved in late 2017. This medication is administered intramuscularly every month. The purpose of this slide is to familiarize the trainees of the different forms of buprenorphine available to treat OUD. The treatment team can use this information to determine best treatment options for their clients whom are being treated for OUD.



SLIDE 13:

The Buprenorphine-HIV Evaluation and Support (BHIVES) study funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance showed the value of providing buprenorphine therapy to HIV-infected, opioid-dependent clients living with HIV and an opioid use disorder in their primary care setting. Benefits included a reduction in opioid abuse, improved HIV measures (including antiretroviral therapy adherence and higher rates of HIV suppression), and improved quality of life.

Citation:

Korthuis PT, Tozzi MJ, Nandi V, et al. Improved quality of life for opioid-dependent patients receiving buprenorphine treatment in HIV clinics. J Acquir Immune Defic Syndr. 2011 Mar 1;56 Suppl 1:S39-45.

CLOSING

Now that we have discussed factors that should be considered prior to implementation, we will review the protocols for selecting, assessing, and preparing patients for treatment. Case examples will be used to illustrate how procedures work in practice.

MODULE 4:
Addiction 101

Topics Covered: Addiction 101

OBJECTIVES

By the end of this module, participants will be able to:

- Identify how addiction affects the brain, through a neurobiology review of the neural circuitry and reward centers.

MATERIALS NEEDED

POWERPOINT

– **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

REFERENCE MATERIALS

– Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual https://nextlevel.targethiv.org/deii/buprenorphine

Method(s) of Instruction

- Lecture

PROCESS

Facilitators will engage in a brief lecture describing how addiction impacts the brain. Attention will be paid to simplify the complex training concepts for trainees who may be less familiar with brain chemistry, anatomy, and physiology.

Facilitators will describe how drugs directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Facilitators will provide examples of how specific drugs effect the brain's reward circuitry.

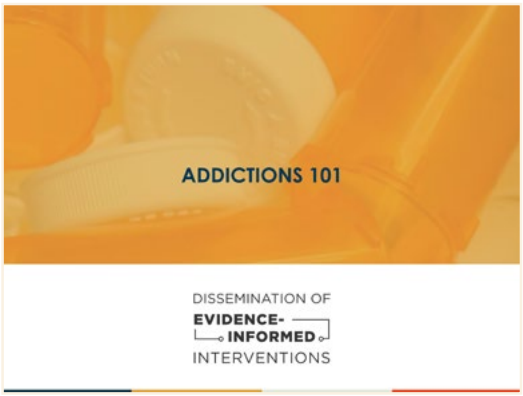
Facilitators will identify different areas of the brain and define their functions and roles in the reward circuitry.

Key Words and Phrases

- *Neurobiology of Addiction*
- *Reward Circuitry*
- *Dopamine*

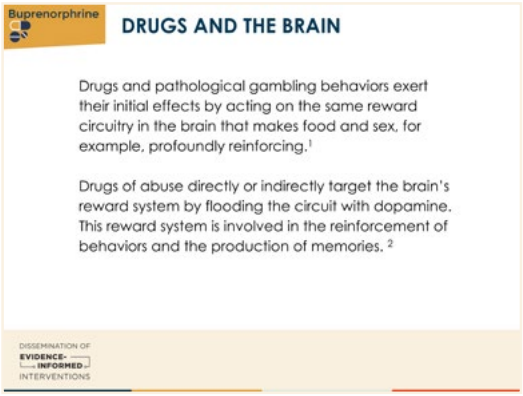
The approximate length of time the session will take.

Total: 15 minutes



SLIDE 1:

In this module we will explore how addiction works and how particular substances affect the brain.

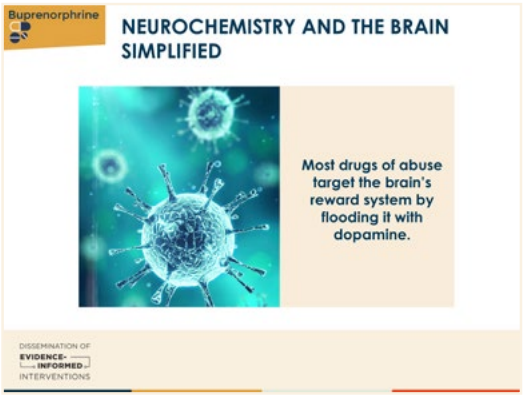


SLIDE 2:

In "reward circuitry," essentially certain areas of the brain are involved in pleasure perception, and these areas form a self-reinforcing "loop" fueled by neurotransmitters, especially dopamine.

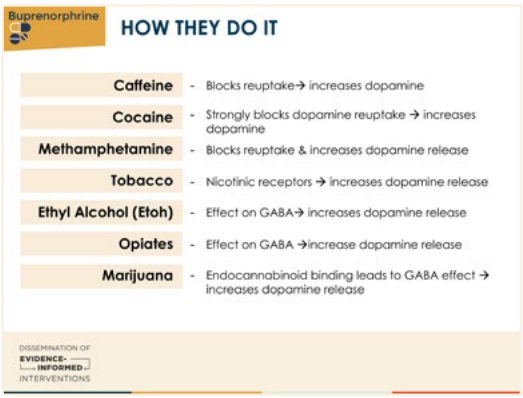
Citations: American Society of Addiction Medicine. Public Policy Statement: Definition of Addiction. Available at: www.asam.org/quality-practice/definition-of-addiction

National Institutes of Health, National Institute on Drug Abuse. Drugs, Brains, and Behavior: The Science of Addiction. July 2018. Available at: www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain



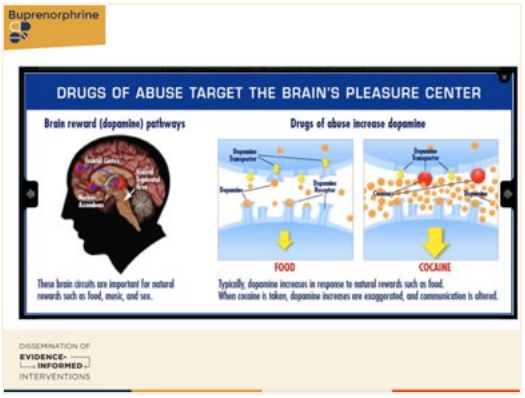
SLIDE 3:

On a very simplified level, dopamine has a key role in substance use disorders.



SLIDE 4:

As the slide explains, multiple drugs have a common pathway of dopamine effects in the brain of people who use substances.

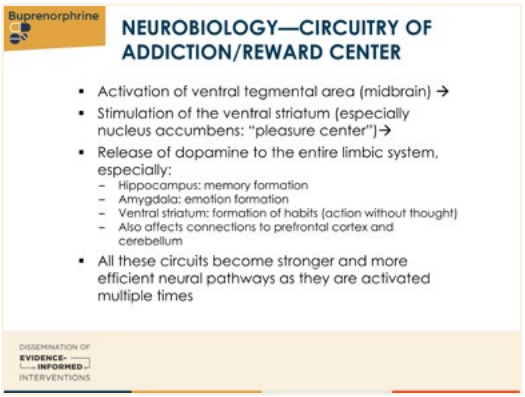


SLIDE 5:

This slide provides a more visual understanding of both the locations in the brain of the reward circuitry, as well as comparative effects of two pleasurable stimuli (food vs. cocaine).

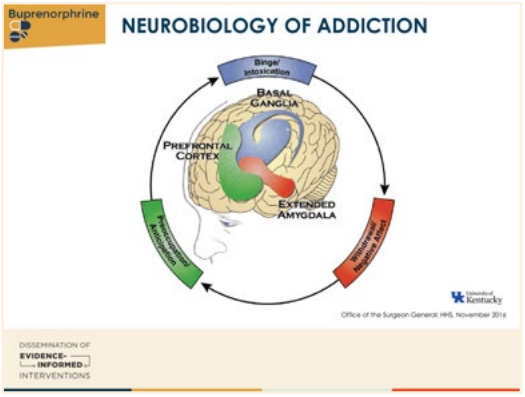
SLIDE 6:

A straightforward anatomic brain image with important reward circuitry areas are identified on the slide. Our next slide will discuss functional details.



SLIDE 7:

This slide provides specifics about areas of the brain and their functions and roles in the reward circuitry.



SLIDE 8:

This slide offers another visual view of how the brain areas involved in addictions influence a person's mood and perceptions with use, in withdrawal, and their preoccupation with maintaining use.

CLOSING

With this understanding of the neurobiology of addiction, we will discuss treatment approaches that create a relapse-sensitive environment and support retention in care.

MODULE 5:
Selecting, Assessing, and Preparing Clients for Treatment

Topics Covered: Client assessments and preparation, case studies, provider assessments, and drug interactions

OBJECTIVES

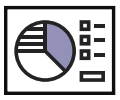
By the end of this module, participants will be able to:

- Practice appropriate client selection based on protocol criteria and internal referral processes.
- Describe the specific documentation, the timeframe, and steps involved in preparation for treatment for each role in the multidisciplinary team.
- Recognize when client sedative abuse requires referral services.

Method(s) of Instruction

- Lecture
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Case Examples in Slides
- Buprenorphine Assessment Smart Phrase
- Client Educational Materials:
  - What is Buprenorphine Treatment Like?: www.naabt.org/education/what_bt_like.cfm
  - The Facts about Buprenorphine for Treatment of Opioid Addiction: https://store.samhsa.gov/product/The-Facts-about-Buprenorphine-for-Treatment-of-Opioid-Addiction/SMA15-4442
  - Home Induction Instructions: Starting Buprenorphine

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

Utilizing a case example, facilitators will review the logistics of finalizing client's clinical eligibility for buprenorphine treatment.

The steps taken by the medical provider to assess clients and document interactions in electronic medical records will be covered, including:

- Tentative DSM-5 diagnosis
- Identification of comorbid factors and communicable disease concerns
- Referrals for clients who need medically supervised withdrawal management
- Addressing chronic pain
- Assessing potential drug interactions
- Assessing client's current use and withdrawal potential
- Reviewing client labs
- Reviewing and ensuring understanding of client's medical history
- Obtaining urine drug screen
- Beginning education about buprenorphine and the use of naltrexone for overdose prevention
- Initiating "kick-packs"

The steps taken by the clinical coordinator to assess clients and document interactions in the electronic medical record will be covered, including:

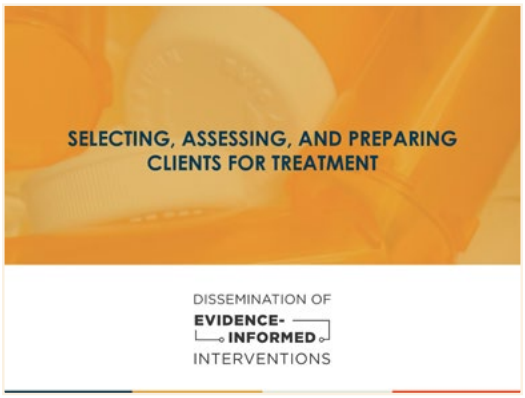
- Finalization and documentation of DSM-5 diagnosis
- Completion of a mini-assessment, covering current client use, other drugs of use, and withdrawal potential
- Providing basis for treatment plan
- Educating clients about buprenorphine treatment and the use of naltrexone for overdose prevention
- Creation of a plan for withdrawal and induction
- Completion of a treatment agreement, communication with other providers in client's circle
- Completion of prior authorization paperwork and other insurance reviews, if needed
- Coordination of clients obtaining "kick-packs"

Key Words and Phrases

- *Patient Assessment*
- *Preparing Clients for Treatment*
- *Diagnostic and Statistical Manual of Mental Disorders (DSM) Diagnosis*

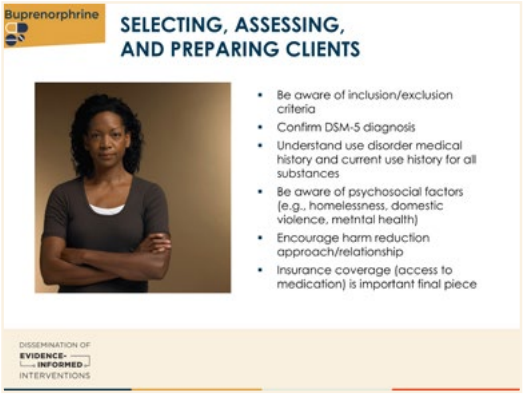
The approximate length of time the session will take.

Total: 50 Minutes



SLIDE 1:

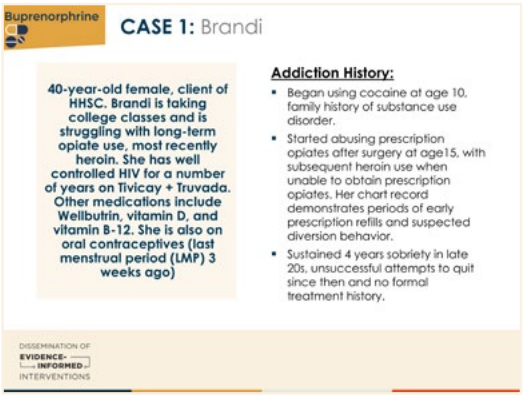
In this module, we will review the processes to select, assess, and prepare clients for treatment. Case studies will be used to illustrate how these processes are implemented in real world settings.



SLIDE 2:

- Criteria matter, whether implementing this intervention protocol or specific organizational guidelines.
- Diagnostic criteria and details of substance use history are critical factors in knowing your clients and choosing best treatment options.
- Psychosocial factors impact care at all levels, as well as interactions with staff.
- Client safety and support are encouraged through harm reduction practices.
- Understand your local treatment access limitations.

(See Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual page 5).



SLIDE 3:

Cases provide a real world backdrop for learning the process of buprenorphine treatment.

Important highlights from the case example outlined in the slide include:

- Facts pertinent to the history of a client living with HIV and a opioid use disorder.
- Age, gender, current medications, pregnancy status.
- Details of current and past substance use.

SLIDE 4:

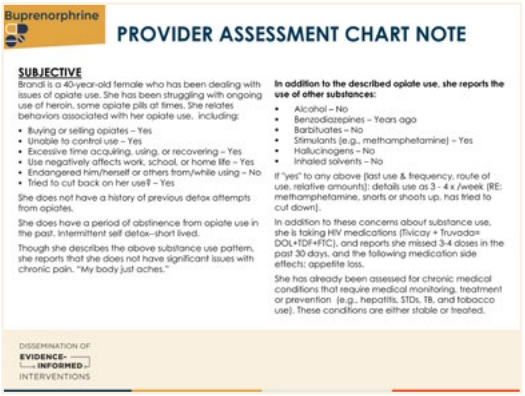
Given this information about Brandi, discuss:

- How to determine—and who determines—DSM-5 opioid use disorder (OUD) diagnosis?
- Though most providers would give a **tentative** opioid-use disorder (OUD) diagnosis, further detail and preferably other team member(s) input, helps to clarify the picture.

SLIDE 5:

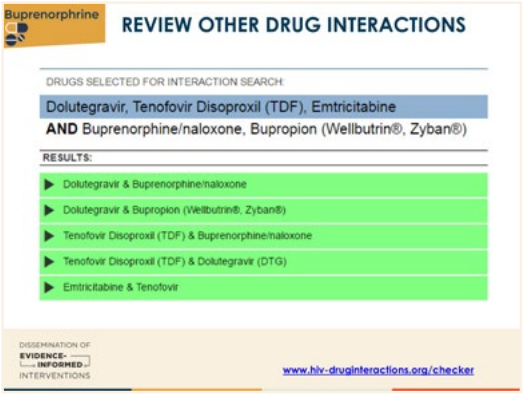
Considerations for providers:

- Clarify HIV status and any other acute conditions that need treatment.
- Significant alcohol or benzodiazepine abuse may require a detox facility and raises concern for buprenorphine treatment appropriateness (likely too high risk).
- Undisclosed controlled prescriptions raises red flags. PDMP programs are further explained in Module 14, Slide 16.
- Need to know what drugs are being used in order to plan and prepare for induction timeframe.
- Assess labs, in particular renal and liver abnormalities.



SLIDE 6:

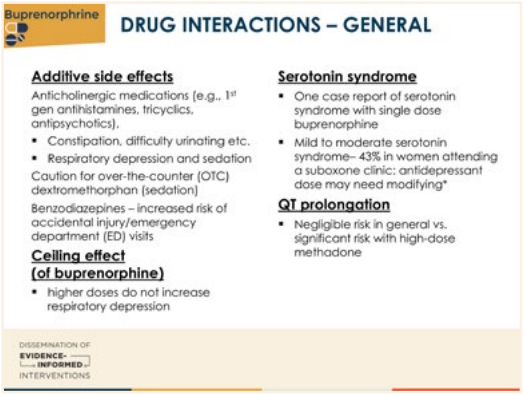
Here is the subjective section of provider chart notes that specifically addresses the DSM-5 criteria, current medications, and concerns regarding comorbid conditions. In the electronic health record system, developing a template can be a helpful tool for both providers and staff to guide the documentation of your assessment. The Smart Phrase handout included in the appendix is an example of such a template. The template chart note was designed using the Epic electronic health record (EHR), and may be incorporated as a SmartPhrase. The "@" phrases are links to data elsewhere in the medical record, and will populate automatically in the document. Users will need to make adjustments for their own systems.



SLIDE 7:

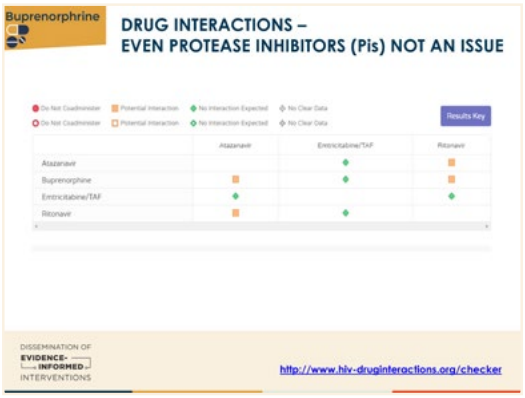
The website listed on the slide is one resource for confirming safety of buprenorphine prescribing in the setting of other chronic medications.

Citation: University of Liverpool. HIV Drug Interactions. November 8, 2018. Available at: www.hiv-druginteractions.org/checker



SLIDE 8:

General themes for drug interactions are mostly focused on additive side effects as noted in the slide.



SLIDE 9:

In the setting of HIV care, even protease inhibitors (PIs) are not associated with significant interaction issues with buprenorphine.

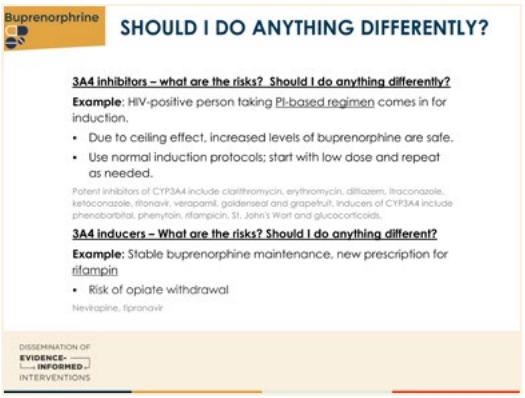
Affinity vs. activation. Buprenorphine has higher affinity (i.e., binding capability to the receptor) than morphine/methadone/oxycodone. It has a much lower activation point than these. Binding strength is not the same as affinity (key in lock example).

Citation: University of Liverpool. HIV Drug Interactions. November 8, 2018. Available at: www.hiv-druginteractions.org/checker

SLIDE 10:

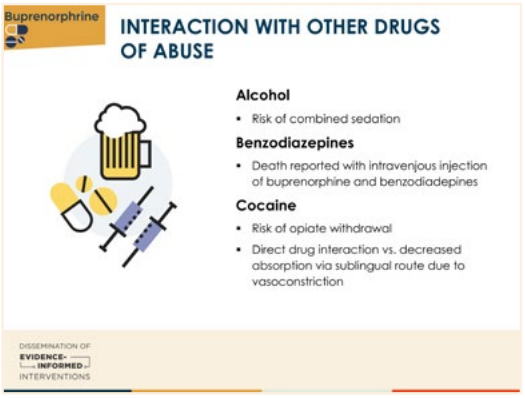
Even when potential interactions are called out, there have been only rare case reports and the pharmacokinetic data are not alarming, as detailed on slide.

Citation: University of Liverpool. HIV Drug Interactions. November 8, 2018. Available at: www.hiv-druginteractions.org/checker



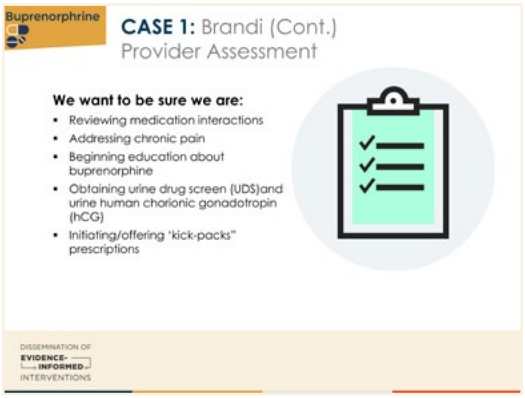
SLIDE 11:

The major potential concern for drug interactions relates to the liver P450 3A4 system. Both inhibitors and inducers present theoretical concerns, but at a practical level require simple attentiveness by the prescriber to the situations as described above.



SLIDE 12:

Concern exists for potential overdose due to the combined effects of respiratory depression from other drugs of abuse. The highest risk is with benzodiazepines and alcohol. However, the only reported death involved intravenous injection use of buprenorphine in the setting of benzodiazepine use. Hence, provider discretion and ongoing monitoring are important factors in determining continued buprenorphine prescribing. Cocaine is a theoretic concern for withdrawal (versus overdose).



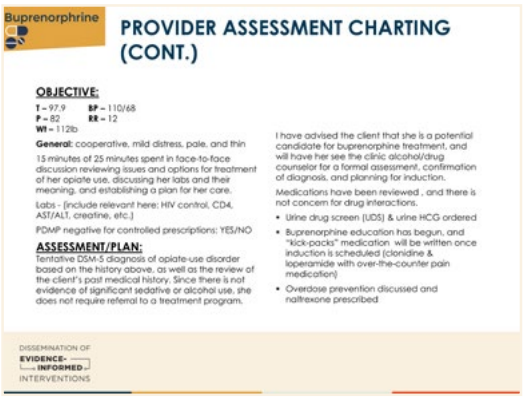
SLIDE 13:

Cases provide a real world back drop for learning the process of buprenorphine treatment.

Important highlights from this slide includes:

- Chronic pain can be an issue and needs to be addressed regarding a non-opioid plan.
- Start buprenorphine education once you view it as an option.
- Know pregnancy status.
- Use the urine drug screen to enhance your knowledge of the client's reported use.
- "Kick packs" are medications to reduce symptoms of withdrawal that can be offered in anticipation of an induction for buprenorphine.

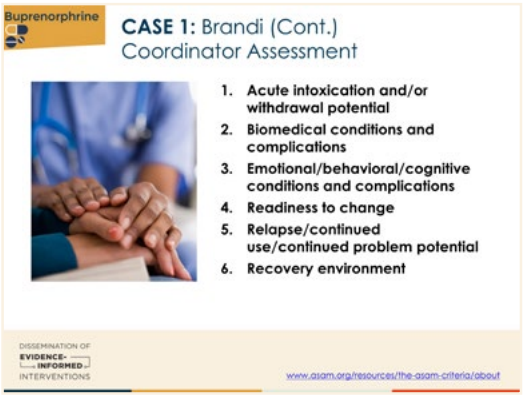
(See also Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual page 5).



SLIDE 14:

The charting in the slide is continued from previous prescriber note example for "Brandi," our case that was first introduced on slide 3.

Provider notes should represent the assessment as described in previous slides. In electronic health record systems, developing a template can be a helpful tool for both providers and staff to guide the documentation of your assessment. See: Buprenorphine Assessment Smart Phrase Handout.

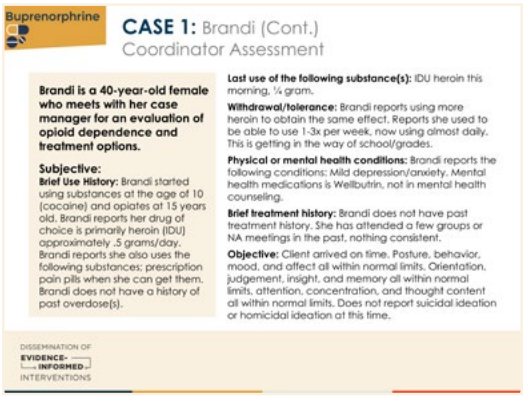


SLIDE 15:

Some clinic settings may involve an additional assessment by a social worker or trained addiction specialist. This process provides a more systematic overview to determine the client's service needs and overall stability to help create a support plan, in addition to likely MAT.

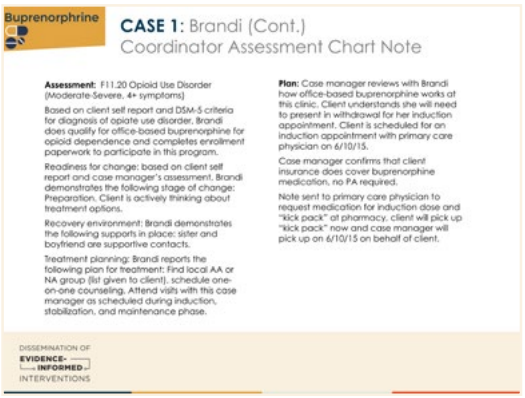
These six elements are part of the American Society of Addiction Medicine (ASAM) placement criteria:

1. Any past history of serious life-threatening withdrawal and any current use history that indicates need for detox?
2. Any current severe health problems?
3. Suicidal/homicidal ideation imminent? Unable to complete activities of daily living?
4. Readiness for treatment: Is the client ambivalent? Has treatment been mandated?
5. Is substance use active or ongoing?
6. Are there immediate threats to safety? Is the clients' social environment unstable?



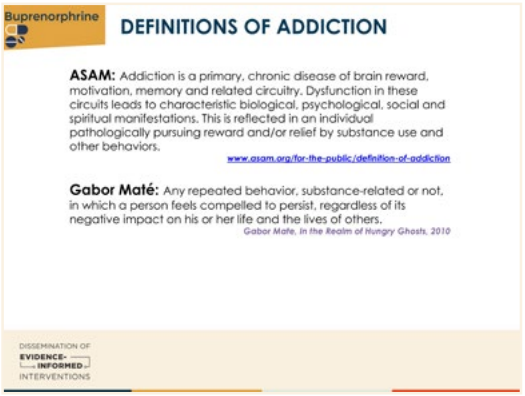
SLIDE 16:

This slide and the following slide show the documentation by the coordinator that specifically addresses the ASAM criteria and associated assessment. These notes accompany the provider assessment documented in previous slides.



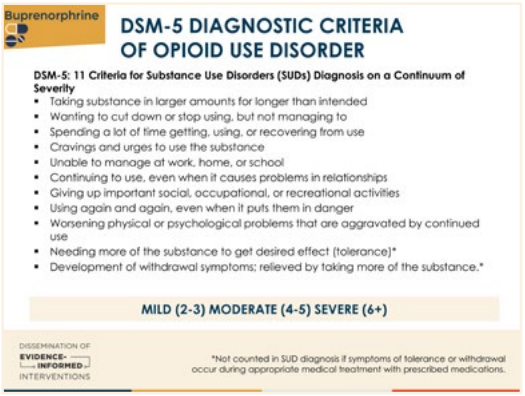
SLIDE 17:

This slide is a continuation of the case example on Brandi and further addresses ASAM criteria and associated assessment.



SLIDE 18:

ASAM provides the framework for a clinical diagnosis of substance use disorder, additional definitions of addiction are helpful in understanding your clients' behavior.



SLIDE 19:

The specifics of OUD are laid out in the DSM-5 in addition to criteria for severity. The diagnosis of OUD must be made before initiation of treatment.

Citation: Bucholz K, Budney A, Compton WM, et al. DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale. Am J Psychiatry. 2013;170(8):834-51. Available at: https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2013.12060782

SLIDE 20:

After confirmation of diagnosis, the details of treatment need to be reviewed, the client needs to be educated on buprenorphine and the treatment process, any required paperwork needs to be completed (study or organizational policies), insurance coverage must be reviewed, and scheduling of any follow-up should be completed.

CLOSING

Now it is your turn. In the next module you will have the opportunity to work through the logistics of a client assessment, enrollment, and induction plan using the provided case examples.

MODULE 6:
Practice Activity

Topics Covered: Selecting, assessing, and preparing clients for treatment

OBJECTIVES

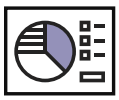
By the end of this module, participants will be able to:

- Implement the logistics of a patient assessment, enrollment, and induction plan using provided case study.
- Analyze a patient case to identify potential problems and strategize solutions.

Method(s) of Instruction

- Activity
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

- Note: Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Case Examples (in slides)
- Education pamphlets (links to examples provided in Module 4)

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine
  - Worksheet for DSM-5 Criteria: Diagnosis of Opiate Use Disorder, p. 31
  - DSM-5 Criteria for Substance Use Disorder, p. 32-33
  - Treatment Agreement Example, p. 34-36

PROCESS

ACTIVITIES

Utilizing a provided example, site teams will discuss logistics, problems, and solutions, with specific attention to American Society of Addiction Medicine (ASAM) guidelines and DSM-5 criteria.

Teams will be asked to:

- Assess this client for opioid use disorder.
- Review current medications and medical comorbidities.
- Understand the overall social supports/scenario.
- Develop a tentative plan for induction.

FACILITATED DISCUSSION

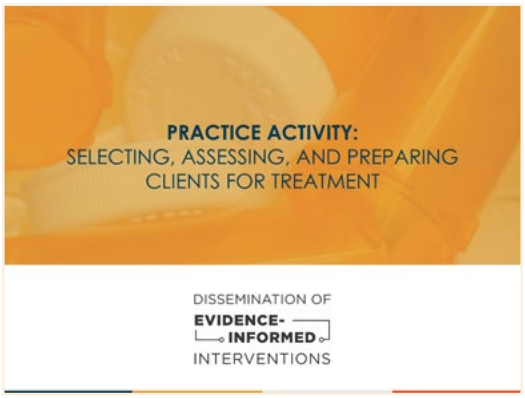
After teams work together to formulate a plan, the facilitator will lead a discussion of the final assessment and plan. Facilitators should be prepared to offer a response to all questions and lead the discussion, based on their own clinical experience and up-to-date clinical guidelines. The following modules will describe the plan that was actually pursued for Raul (the case example introduced in this module).

Key Words and Phrases

- *Case Study*
- *Patient Assessment*

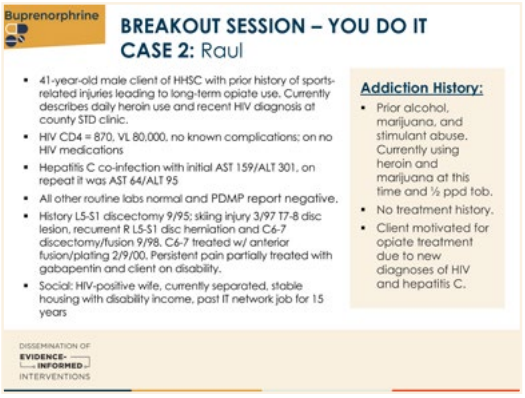
The approximate length of time the session will take.

Total: 30 Minutes



SLIDE 1:

In this module we will conduct a practice activity and engage in a discussion to build your comfort level with the protocols for selecting, assessing, and preparing clients for treatment.



SLIDE 2:

This slide is intended to assist trainees to utilize the ASAM guidelines and DSM-5 criteria. Organization specific teams should huddle and complete the following activities. Teams should use the handouts in the linked Implementation Manual (DSM-5 Criteria, Worksheet for DSM-5 Criteria, and Treatment Plan Agreement).

- Assess the client for opioid use disorder,
- Review current medications and medical comorbidities,
- Understand the overall social supports/scenario, and
- Develop a tentative plan for induction.

Activity **(Discussion):**

Once teams can discuss the case, the facilitators will lead discussion of final assessment and plan. Potential guiding questions include:

- What is the diagnosis/does the client meet the DSM-5 criteria for opioid dependence?
- What are the treatment options for this client?
- Is this client a candidate for treatment with buprenorphine?
- What are treatment goals?
- What is the initial treatment plan?
- Is there any additional information you want to know about this client? If so, how will you obtain it (e.g., coordinate with the multidisciplinary care team)?

CLOSING

Now that you have practiced assessing and preparing a client for treatment, we will review the processes to initialize, stabilize, and maintain clients on treatment.

MODULE 7:
Initializing, Stabilizing, and Maintaining Clients

Topics Covered: Initializing, stabilizing, and maintaining clients

OBJECTIVES

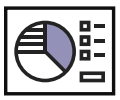
By the end of this module, participants will be able to:

- Conduct an assessment to determine stage of opioid withdrawal.
- Analyze urine drug screen (UDS) results to assess appropriateness of treatment induction.
- Initiate induction, if appropriate.

Method(s) of Instruction

- Lecture
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Case Examples (in slides)
- Opioid Metabolization Chart
- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine
  - Clinical Opioid Withdrawal Scale (COWS), p. 38-39
  - Buprenorphine Assessment Smart Phrase

FLIP CHART SHEETS

PROCESS

ACTIVITIES

The training will begin with two YouTube videos to ground participants in their clients' experiences with withdrawal and potential prior buprenorphine use.

FACILITATED DISCUSSION

A facilitated discussion will occur, utilizing a client case example (slide 4), so that participants can practice assessing a client for opioid use disorder, reviewing current medications and medical comorbidities, understanding a client's overall social supports, and developing a tentative plan for induction.

Once a facilitated discussion occurs, facilitator will review provider notes, summarizing the client's presentation on induction day and the subsequent provider assessment. Throughout the lecture, facilitators should engage participants with questions, such as: What would you do if a client presents on induction day and is not in withdrawal?

Facilitators will also highlight key concerns, such as avoiding and managing precipitated withdrawal, as well as coordinating and communicating a clear follow-up plan with the client and the multidisciplinary care team.

Key Words and Phrases

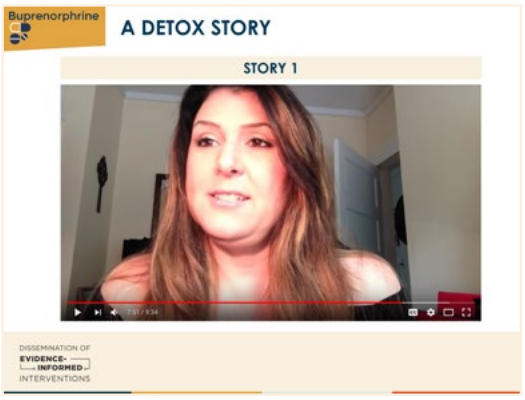
- *Induction*
- *Precipitated Withdrawal*
- *Office Based Induction Assessment*
- *Clinical Opiate Withdrawal Scale (COWS)*
- *Opioid Metabolism*

The approximate length of time the session will take.

Total: 50 minutes

SLIDE 1:

In this module we will cover initializing, stabilizing, and maintaining clients.

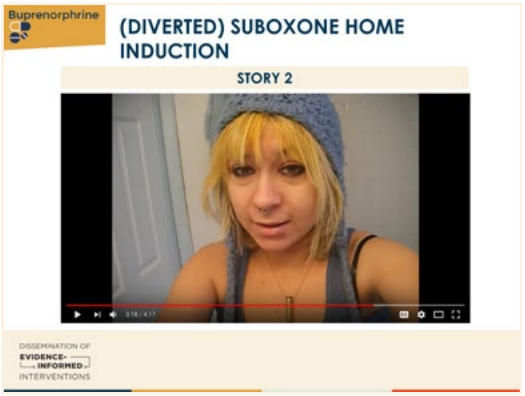


SLIDE 2:

This is a publicly posted personal YouTube video of a woman detoxing off of oxycodone (cold turkey). This is a demonstration of untreated withdrawal. It is important to understand clients' previous experiences and/or fears based on stories they have heard from others.

Play video here: www.youtube.com/watch?v=JHJ-6pQmEdo

Citation: BindMercyandTruth. "I Detox Off 60 mg/day Opiates in 3 Days! Shows Start to Finish." June 11, 2014. Available at: www.youtube.com/watch?v=JHJ-6pQmEdo

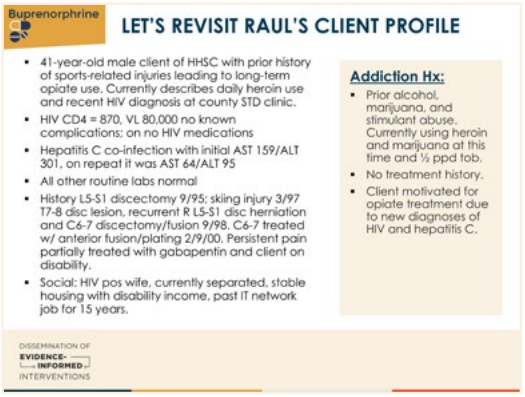


SLIDE 3:

This is a publicly posted personal YouTube video of a woman who is using diverted Suboxone to treat her heroin withdrawal.

Play video here: www.youtube.com/watch?v=ARY_pjP-Z08

Citation: Sicnixi. "Introduction (Kickin' Day One)." February 6, 2010. Available at: www.youtube.com/watch?v=ARY_pjP-Z08

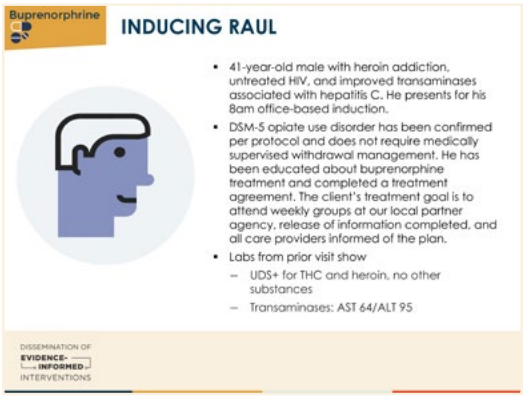


SLIDE 4:

This slide is intended to assist participants to utilize the ASAM guidelines and DSM-5 criteria:

- Assess this client for opioid use disorder,
- Review current medications and medical comorbidities,
- Understand the overall social supports/scenario, and
- Develop a tentative plan for induction.

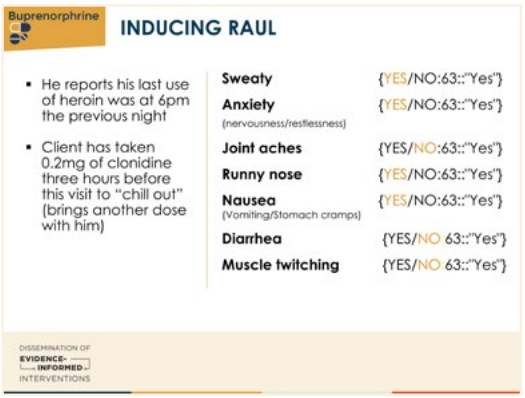
The facilitators should lead a discussion of the final assesment and plan. Subsequent slides will review the induction plan pursued for Raul.



SLIDE 5:

The following slides walk participants through a typical presentation and assessment on an induction day.

Facilitators remind participants of Buprenorphine Assessment Smart Phrase handout, introduced in Module 4, that can be useful for setting a template in EHRs for documentation.



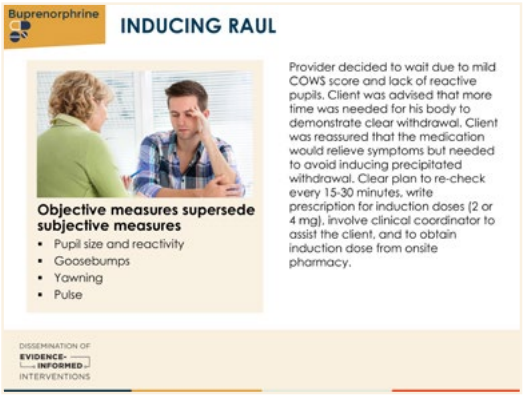
SLIDE 6:

Client's opioid withdrawal symptoms should be assessed: cravings, anxiety, discomfort, pain, nausea, hot or cold flushes. Based on physical exam, document the client's signs of withdrawal, including autonomic excitation (elevated BP, increased HR), mydriasis, tremors, agitation/restlessness. Also note the presence or absence of yawning, rhinorrhea, piloerection, hot and cold flushes, diaphoresis, lacrimation, vomiting, and muscle fasciculations. Use the Clinical Opiate Withdrawal Scale (COWS) to score the client's opioid withdrawal as mild, moderate, or severe.

SLIDE 7:

These are the provider's objective findings upon Raul's presentation in the clinic. His COWS scores were observably mild.

Activity (Discussion):
Ask participants: What would you do?

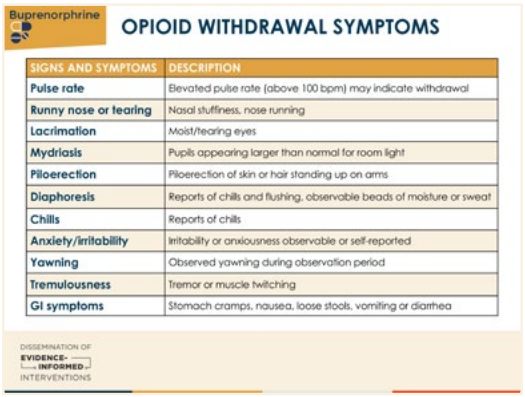


SLIDE 8:

Clients should exhibit signs of at least mild withdrawal (COWS > 5) prior to receiving their first dose of buprenorphine.

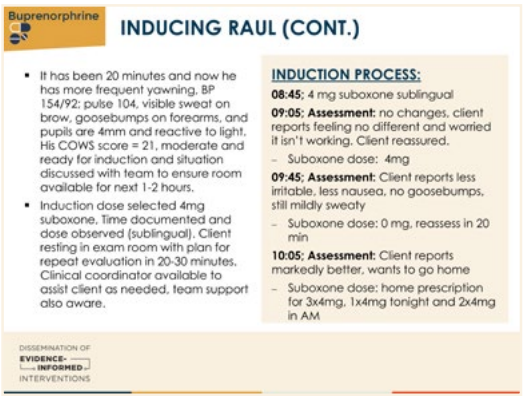
This slide demonstrates the providers action:

- Waiting for client to demonstrate clear withdrawal. (Facilitators should highlight the importance of objective measures if there is any question of the client's severity in withdrawal).



SLIDE 9:

This slide is a reminder of withdrawal symptoms to assist in Clinical Opiate Withdrawal Scale (COWS) scoring. (See COWS handout provided).

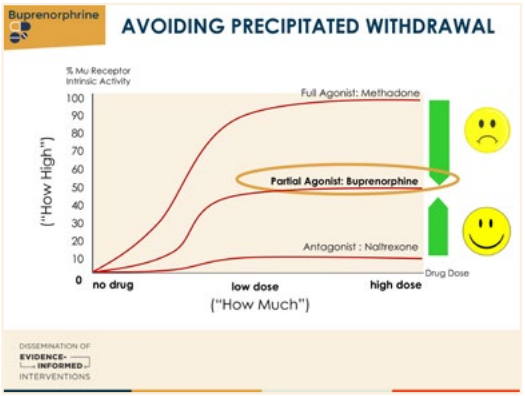


SLIDE 10:

This slide demonstrates a typical suboxone induction and client response.

Clients who are determined to be in at least mild opioid withdrawal (COWS >5) and who do not have signs of intoxication of other substances should receive their initial doses of buprenorphine. For clients exhibiting mild withdrawal, give buprenorphine 2 mg sublingual. For clients exhibiting moderate to severe withdrawal, give buprenorphine 4 mg sublingual. The sublingual tablet or film must dissolve completely under a moist tongue, which may take 5-10 minutes. Most clients experience relief of withdrawal symptoms or reduction in cravings within the first 15-20 minutes after taking the tablet or film. Depending on the specific formulation prescribed, the initial doses of buprenorphine may be portions of a tablet or film, or the entire tablet or film. Because of possible authorization issues required by many insurance companies, prescribing the 8 mg tab or film may be the most feasible. In this case, clients may need to take ¼ or ½ of the tablet or film as the initial dose.

Re-evaluate client after 20-30 minutes. If there is no change in symptoms (no worsening), or symptoms are somewhat improved, an additional dose of buprenorphine 2 to 4 mg sublingual may be given. Reassess the client again in 20- 30 minutes for symptom relief. This process of providing an additional dose and reassessment may occur again, or the client may be provided with two additional 4 mg take-home doses should withdrawal or marked craving recur in the evening. The total amount of buprenorphine that is typically provided on the first day of dosing is 8-12 mg.



SLIDE 11:

As a partial agonist and with high mu receptor affinity, buprenorphine can induce precipitated withdrawal in clients with significant opioids on board. Conversely, buprenorphine can reverse withdrawal, which is the goal of induction. This is why clients should not be induced on buprenorphine if they have opioids in their system.

SLIDE 12:

Clients should return to clinic in the next 1-2 days for re-evaluation and upward dose titration.

Clear planning for the client after the induction is critical.

- Coordinate between the primary care provider and support staff to ensure timely follow-up as needed.
- Typical dosing does not exceed 16 mg per day.
- The client's chart should document appropriate diagnosis and a clear follow-up plan.

SLIDE 13:

See details in the Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual regarding symptom management:

- Clonidine 0.1 PO q 6 hours PRN lacrimation, diaphoresis, rhinorrhea, piloerection
- Loperamide (Immodium) 4 mg PO x I PRN diarrhea, then 2 mg PO PRN each loose stool or diarrhea thereafter, not to exceed 16 mg/24 hrs
- Ibuprofen 600 mg q 8 hrs, or naproxen 500 mg q 12 hrs PRN myalgias or arthralgias

Management of precipitated withdrawal with increasing buprenorphine has been described, but requires dedicated time and room in the clinic setting.

CLOSURE:

Now that you have learned to initiate a client on buprenorphine treatment, we will discuss the process to stabilize clients on treatment in greater depth.

MODULE 8:
Stabilization Visits

Topics Covered: Stabilization visits

OBJECTIVES

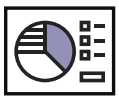
By the end of this module, participants will be able to:

- Recognize the importance of timely assessment for stabilization with MAT target dosing.
- Differentiate key objectives for stabilization medical visits post MAT induction.
- Distinguish the roles between clinical coordinator and provider visits.

Method(s) of Instruction

- Lecture
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Case Examples (in slides)

FLIP CHART SHEETS

PROCESS

Facilitators will utilize case examples to guide discussion and demonstrate a client experience and provider response as indicated in both the first and second medical visits post-induction.

Facilitators will elicit participant perspectives on key questions throughout the presentation (as noted in slides).

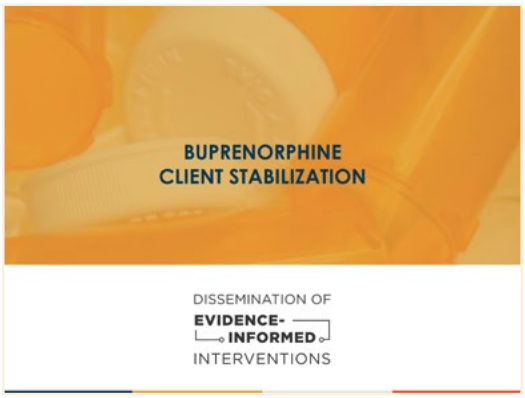
Facilitators will review logistical concerns associated with buprenorphine prescriptions and location/relationship with pharmacies.

Key Words and Phrases

- *Stabilization Visits*
- *Target Dose*
- *MAT Clinical Coordinator*

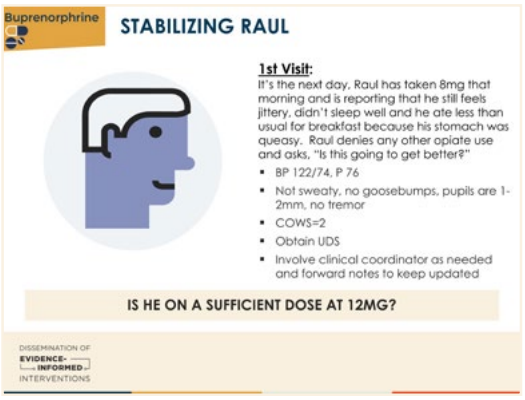
The approximate length of time the session will take.

Total: 15 Minutes



SLIDE 1:

In this Module we will explore buprenophrine client stabilization.

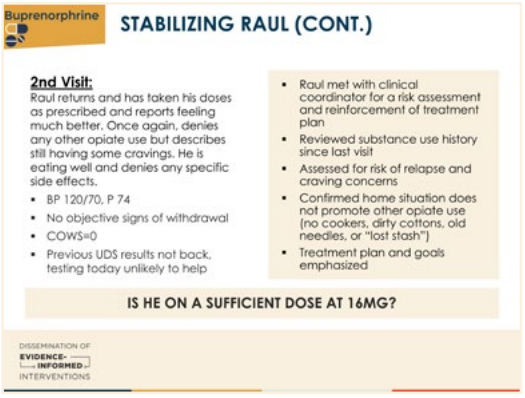


SLIDE 2:

The following slides focus on stabilization of the case previously introduced and the themes that arise.

At a stabilization visit, the treatment team will: assess opioid withdrawal using the COWS worksheet and review use of any adjunct medications for symptom management; order a urine sample for toxicology; give total daily dose administered on the previous day. The treatment team will add an additional 2 to 4 mg as needed (up to 16 mgs) based on severity of withdrawal symptoms (i.e., add 2 mg for mild withdrawal or 4 mg for moderate to severe withdrawal). A typical dose at the first stabilization visit is 16 mg, with a typical range between 8-24 mg.

Activity **(Discussion):**
Engage participants feedback on the following question: Is Raul's dose sufficient? No evidence of other opioid use but persistent subjective symptoms are sufficient reasons to cautiously increase the buprenorphine dose with close follow-up planned. In this case, the treatment team decided to increase dose by 4 mg. Raul is sent home with a total of 16 mg/day (8 mg bid) and a return appointment for the next day.



SLIDE 3:

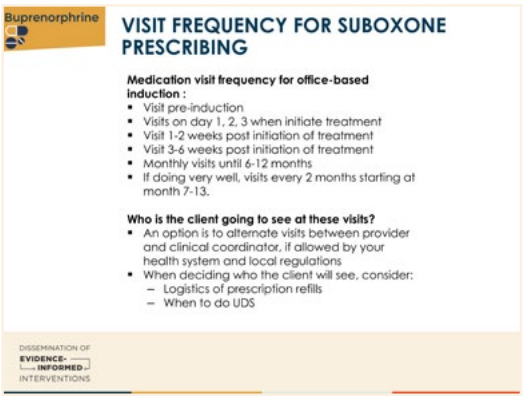
Important highlights here, include the following:

- In addition to subjective and objective withdrawal findings, a continued focus on the recovery environment cannot be ignored. It is important for the provider and clinical coordinator to work together to assess and provide a supportive recovery environment.
- Facilitators should engage participants in a discussion on if Raul's dose is sufficient.
  - Raul's treatment team decided he should remain at 16 mg. After the client visit summarized above, the client was sent home with a total of 16 mg/day (8 mg bid) and return appointment for one week.
- Dosing higher than 16 mg-a-day should illicit concern and caution.

SLIDE 4:

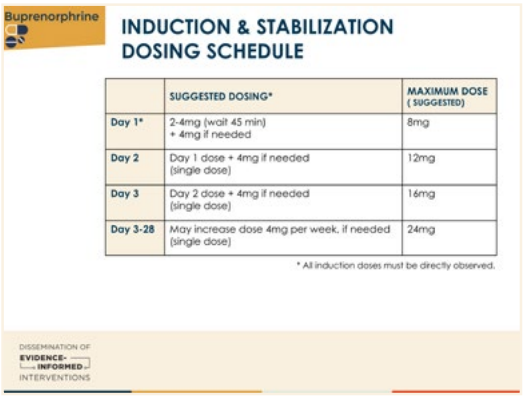
The location and provider relationship with the pharmacy from a system perspective could be helpful, especially focused on the process involving multiple visits and frequent prescribing.

It is critically important that prescription wording is precise for appropriate dosing and clear planning for subsequent visits.



SLIDE 5:

- The above schedule of visits represents the ideal client who is doing well.
- If problems develop, visit frequency and monitoring should be increased.
- Develop a plan for when the client sees each provider (PCP/RN/clinical coordinator) on the treatment team.
- System guidelines are invaluable regarding the frequency of UDS testing are helpful.
  - General UDS frequency guidelines: Week 1-4: Once weekly during initiation and stabilization. Month 2-12: Weekly to monthly depending upon clinical stability.



SLIDE 6:

This slide provides an overview of a typical dosing schedule.

CLOSING

Now that you understand the stabilization process, we will discuss the logistics of maintaining a client on buprenorphine treatment.

MODULE 9:
Maintenance Visits

Topics Covered: Maintenance

OBJECTIVES

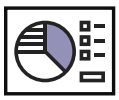
By the end of this module, participants will be able to:

- Assess the variability of client presentations with medical visit needs.
- Utilize multi-faceted strategies to support client success on MAT.
- Interpret client and system level issues that impact client maintenance on treatment, relapse, diversion, and chronic pain management.
- Ensure safety regarding overdose and relapse is revisited and naltrexone is prescribed.

Method(s) of Instruction

- Lecture
- Facilitated Discussion

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Case Examples (in slides)
- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual
  - Maintenance Visit Protocol

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

Facilitators will utilize a case study to illustrate concerns, strategies, and next steps for clients during the maintenance phase of treatment.

Facilitators will utilize scenarios related to relapse and chronic pain management to engage participants in a discussion around how they would handle client and systems level issues.

Facilitators will utilize examples throughout training to illustrate use of motivational interviewing, multidisciplinary team structure, and harm reduction techniques.

Key Words and Phrases

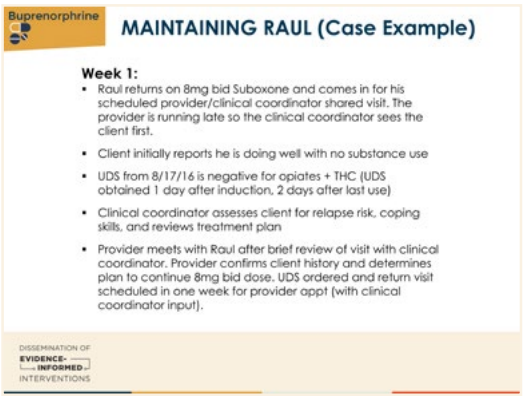
- *Maintenance Visits*
- *Relapse*
- *Chronic Pain Management*
- *Motivational Interviewing*

The approximate length of time the session will take.

Total: 50 minutes

SLIDE 1:

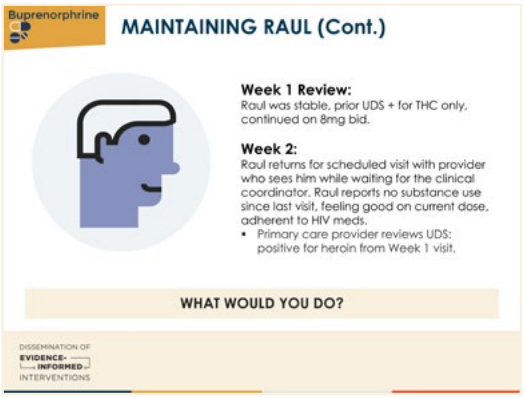
In this module we will cover maintenance visits.



SLIDE 2:

The following slides focus on maintenance of the case example of Raul, first introduced in Module 5, and the themes that arose. Maintenance visits consist of counseling, functional assessments, medication visits, and urine drug screen testing.

This slide represents the need for teamwork and flexibility within the team. At week one, this client appears to be stable and on an appropriate dose of buprenorphine.



SLIDE 3:

This case example above highlights two key points in early buprenorphine treatment:

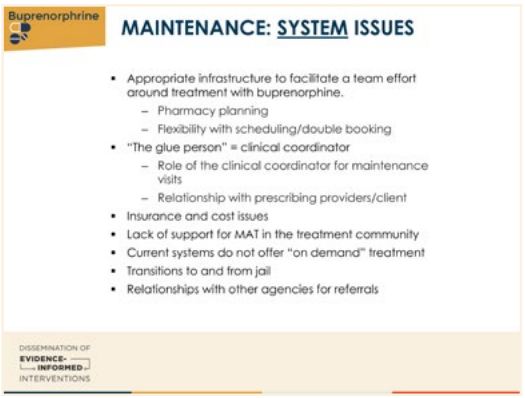
- Early relapse episodes are common.
- It's important to maintain a relapse-sensitive environment to maintain engagement.

Facilitators should engage feedback from participants on what they would do. Raul's treatment plan included:

- Eliciting client response and discuss reason for heroin relapse: Was relapse due to dose issue? Was relapse due to other reasons ("challenge" medication effectiveness)?
- Offer clinical coordinator presence to discuss further (client comfort/ preference).
- Discussion of THC use, group meetings, and/or treatment plans.
- Emphasize support for ongoing buprenorphine prescribing in the face of expected relapse, with a focus on safety.
- Decide on dosing plan.

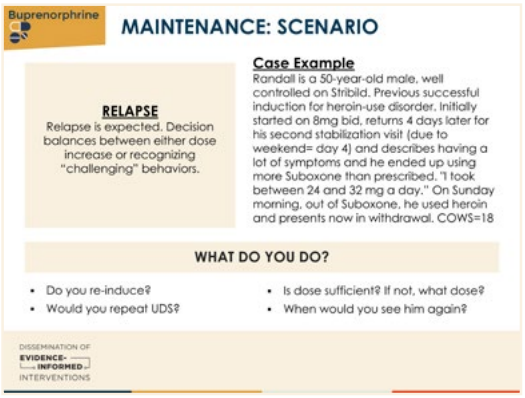
SLIDE 4:

For any given clients maintained on long-term buprenorphine, you can expect to face at least a few of these issues. Do not ignore early signs of client instability or diversion. It is important to address early on and directly, if they arise.



SLIDE 5:

Each locale will present a number of system issues that can complicate maintaining buprenorphine therapy. Having a plan in place for how to discuss these issues will help you to be prepared.



SLIDE 6:

Reference slide summarizing client issues (slide 3) for assistance in discussing this scenario.

Activity (Discussion):

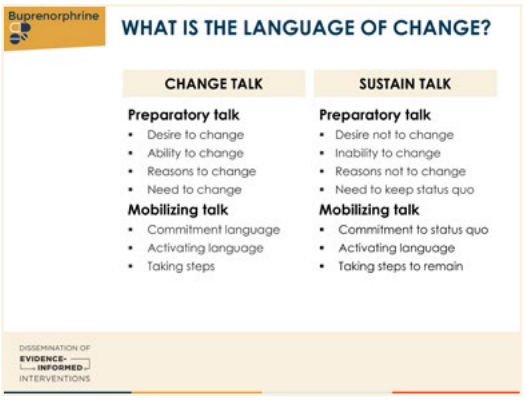
- Ask participants to consider and discuss the questions detailed on this slide.

Facilitator recommendations include:

- Obtain UDS to inform subsequent decisions.
- Re-induction given obvious withdrawal and need.
- Increase to 20-24 mg per day.
- Close follow-up due to initial instability (1-2 days) and involve your multidisciplinary team for additional perspectives.
- Review UDS and discuss with client.

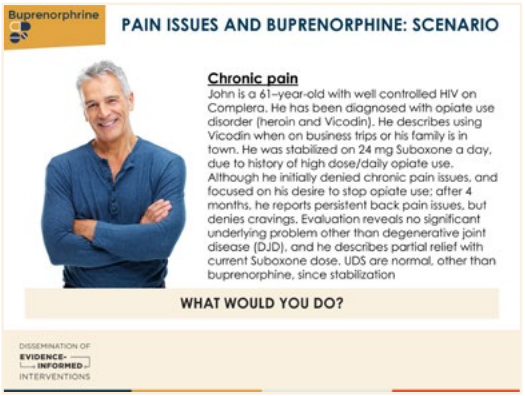
SLIDE 7:

- What are your clients' prevention and coping skills? Involve behavioral health staff to assist clients.
- Be mindful of each client's stage of change.
- Be watchful for polydrug use or other instability. "Trust but verify." Ask the client: "Tell me what you used?" but verify with UDS. Discuss any discrepancies directly with the client. Remember that opioid agonist therapy is not an effective treatment for substance use disorders other than opioid use disorder.



SLIDE 8:

The language of change is often used in the Motivational Interviewing counseling method. Learning to elicit change talk is the goal for any provider working with a client around their substance use.



SLIDE 9:

Chronic pain in the setting of buprenorphine treatment is common. Prescribers new to buprenorphine should realize the need to develop skills for managing pain with non-opiates in these clients.

Activity (Discussion):
Elicit from participants what they would do if treating a client like John.

Facilitator recommendations regarding client care in this scenario include:

- Per protocol and, in general, MAT is not directed at pain, dose would not be increased.
- Focus on maintaining current dosing and non-opiate treatment modalities.
- Involve clinical coordinator to continue to work with client on treatment plan and relapse prevention.
- Consider if you would change frequency of UDS and office visits.

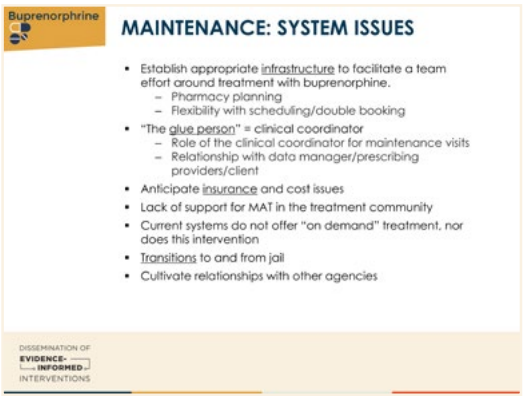
Consider the following client-level issues:

- Pain management
- Surgery/emergencies/acute pain
- Stolen and lost medications/travel
- Mental illness

Remind participants to be flexible and patient with the stages of change process.

SLIDE 10:

Acute pain management in clients on buprenorphine is an evolving field. Options as noted in the slide have been utilized, though current practice guidelines are in flux and include maintaining buprenorphine with inpatient opiate treatment and close monitoring for major surgery. Module 17 reviews issues around pain management in further detail.



SLIDE 11:

This slide may look familiar. As client issues arise, remember to expect, plan, and prepare for system issues.

CLOSING

Clients can be maintained on buprenorphine treatment long-term. However, we will also discuss clinical and logistical concerns associated with ceasing treatment, whether due to provider judgment or client request.

MODULE 10:
Transitioning Clients to Standard of Care

Topics Covered: Transitioning clients to standard of care

OBJECTIVES

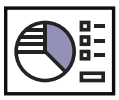
By the end of this module, participants will be able to:

- Complete individualized client treatment plans that assess continuation or cessation of MAT.
- Assess clinical and logistical concerns associated with treatment cessation.

Method(s) of Instruction

- Lecture

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

Facilitators will review key reasons why a provider may taper a client off treatment, rather than maintaining a client on treatment.

Facilitators will review how to taper a client off treatment, including reviewing a sample dosing schedule and logistical items to be considered by the multidisciplinary team.

Facilitators will review data indicating that clients can be maintained on buprenorphine long-term, if clinically appropriate and desired by client. This includes data regarding buprenorphine abuse, misuse, and diversion.

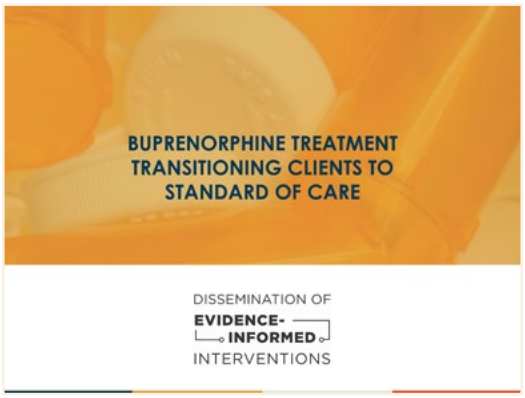
Facilitators will review concerns related to treating clients who return to care after missing buprenorphine doses.

Key Words and Phrases

- *Taper off Buprenorphine*
- *Transition to the Standard of Care*

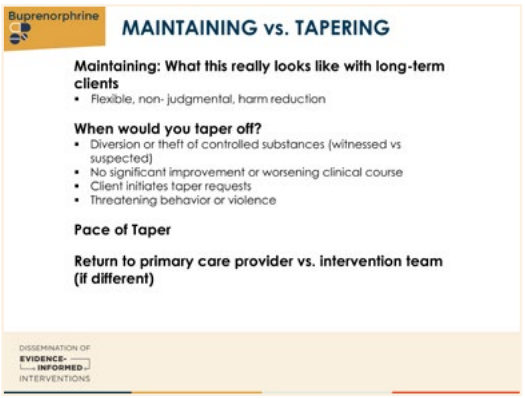
The approximate length of time the session will take.

Total: 30 minutes



SLIDE 1:

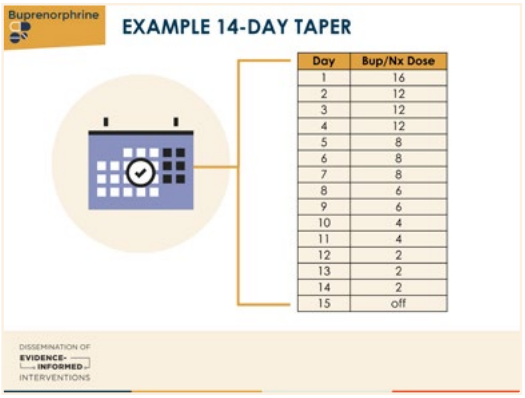
In this module we will discuss buprenophrine treatment, particularly as it relates to transitioning clients to standard of care.



SLIDE 2:

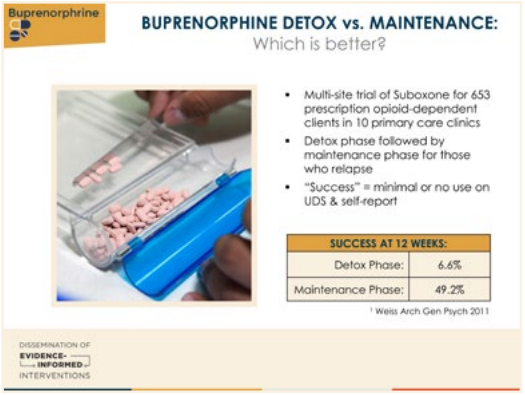
Long-term buprenorphine is often time a stabilizing factor in clients' lives, but sometimes tapering down is required or requested.

Buprenorphine-maintained clients who were clinically stable and wanted to discontinue treatment are tapered slowly. Slow tapers have been shown to be more successful than rapid tapers. The pace of a voluntary taper is determined by the client and can be halted or reversed at the client's request.



SLIDE 3:

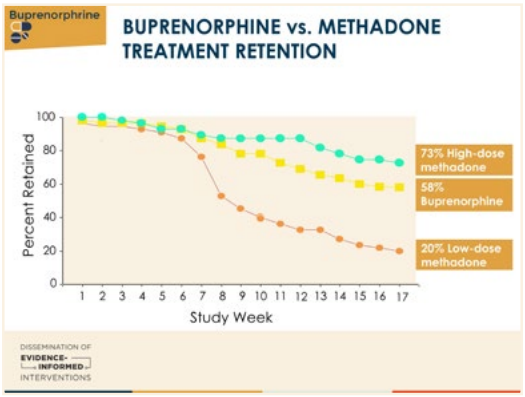
This is an example of a 14-day taper and demonstrates a mid-range duration for taper.



SLIDE 4:

While cessation of buprenorphine treatment is requested by clients or required at times, data supports maintaining clients on long-term buprenorphine treatment.

Citation: Weiss RD, Potter JS, Fiellin DA, et al. Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2-Phase Randomized Controlled Trial. Archives of General Psychiatry. 2011; 68(12): 1238–46.



SLIDE 5:

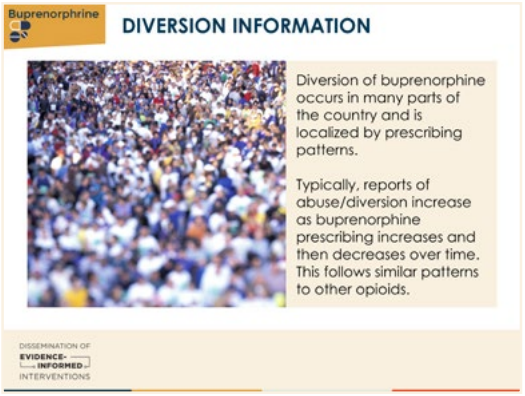
Treatment retention is comparable between buprenorphine and methadone (at 18 weeks).

Citation: Johnson RE, Chutuape MA, Strain EC, et al. A Comparison of Levomethadyl Acetate, Buprenorphine, and Methadone for Opioid Dependence. New Engl J Med. 2000; 343(18): 1290-7.

SLIDE 6:

These charts demonstrate the information explained in the following two slides—basically that buprenorphine abuse, misuse, and diversion follows a predictable pattern similar to other opiate prescribing patterns. A key difference is the overall safety of buprenorphine in the community at large.

Citation: Dasgupta, N. RADARS® System Subutex & Suboxone: How Much is Prescribed vs. Abuse/Diversion Reports [PowerPoint]. 2008. Accessed at: www.radars.org/system/publications/2008_Dasgupta_CSAT.pdf



SLIDE 7:

Diversion of buprenorphine occurs in many parts of the country and is localized by prescribing patterns.

Typically, reports of abuse/diversion increase as buprenorphine prescribing increases and then decreases over time. This follows similar patterns to other opioids.

Citation: Dasgupta, N. RADARS® System Subutex & Suboxone: How Much is Prescribed vs. Abuse/Diversion Reports [PowerPoint]. 2008. Accessed at: www.radars.org/system/publications/2008_Dasgupta_CSAT.pdf

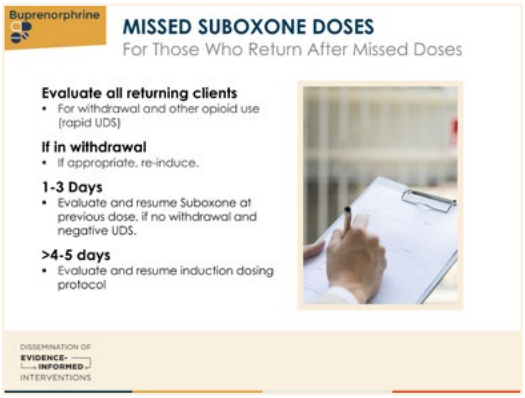
SLIDE 8:

While buprenorphine diversion should be monitored and directly addressed, if suspected, characteristics of buprenorphine do lower its potential for diversion.

Citations: Yokell MA, Zaller ND, Green TC, et al. Buprenorphine and Buprenorphine/Naloxone Diversion, Misuse, and Illicit Use: An International Review. Current Drug Abuse Reviews. 2011; 4(1), 28–41.

Bazazi AR, Yokell M, Fu JJ, et al. Illicit Use of Buprenorphine/Naloxone Among Injecting and Noninjecting Opioid Users. Journal of Addiction Medicine. 2011; 5(3), 175–180. http://doi.org/10.1097/ADM.0b013e3182034e31

Larance B, Degenhardt L, Lintzeris N, et al. Post-marketing Surveillance of Buprenorphine-Naloxone in Australia: Diversion, Injection and Adherence with Supervised Dosing. Drug & Alcohol Dependence. 2011; 118(2-3), 265-73.



SLIDE 9:

Clients returning for care after missing doses are not uncommon. Be prepared to stabilize them medically and consider if they need more intensive visits or contact.

CLOSING

This bring us to the end of our introductory training. We will review some next steps or provide supplemental resources.

MODULE 11:
Introductions and Overview Presentation

Topics Covered: Re-introduction, overview of the opioid epidemic

NOTE

Modules 1-10 stand as an introductory session to integrate buprenorphine into HIV primary care. Modules 11-16 can stand as a second level training, intended for practitioners who already have some experience with the intervention. Or, individual modules can be integrated into the introductory training, based on the trainer's judgment and the needs of trainees.

OBJECTIVES

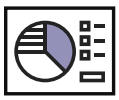
By the end of this module, participants will be able to:

- Identify trends and data regarding the opioid epidemic in the United States.
- Share experience with the Integrating Buprenorphine into HIV Primary Care Settings intervention.

Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Trainee Presentations

MATERIALS NEEDED



POWERPOINT

– **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

– Preparation for Presentation: Buprenorphine Intervention Updates

FLIP CHART SHEETS

REFERENCE MATERIALS

– Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

If this module will serve as the introduction to a second level training, begin by asking participants to participate in basic introductions; include name, background, as well as description of experience in HIV and addictions. Trainers will also briefly introduce themselves and summarize the content of the training and the agenda.

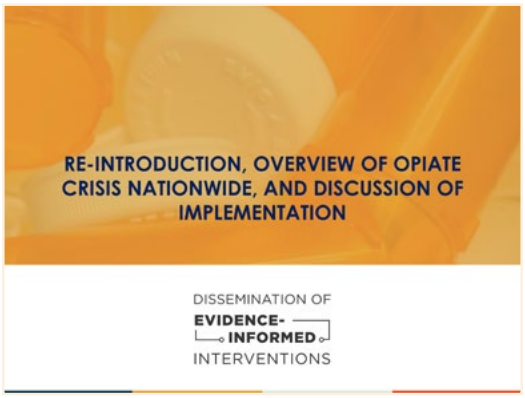
Review national data relating to the opioid epidemic. Engage trainees in presenting their experience implementing buprenorphine treatment in HIV primary care settings, utilizing the preparation for presentation handout as a guide.

Key Words and Phrases

- *Introductions*
- *Overview*
- *Opioid Epidemic*
- *Overdose*

The approximate length of time the session will take.

Total: 30 minutes

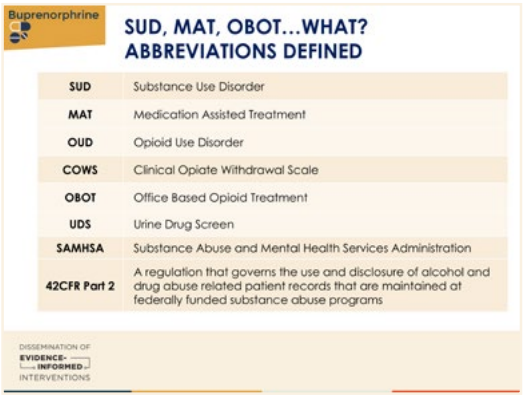


SLIDE 1:

If modules 11-16 will be used as a second-level training, ask participants and facilitators to introduce themselves. Include name, background, as well as description of experience in HIV and addictions.

SLIDE 2:

If modules 11-16 will be used as a second-level training, provide participants with a high-level schedule for training, using this slide as a guide.

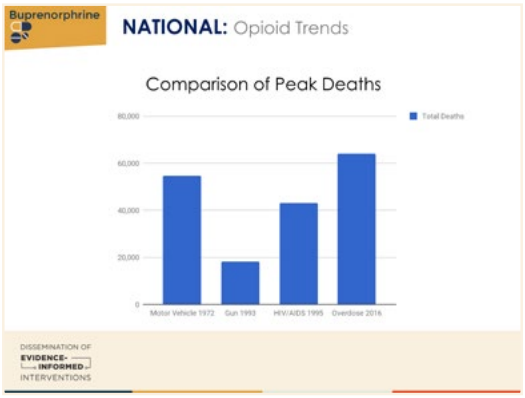


SLIDE 3:

This slide is a brief overview of common abbreviations used during this training. The abbreviations are terms that are frequently used for those who are providing office-based opioid treatment.

SLIDE 4:

There is overlap between OUD and HIV populations and the associated treatment trends. The following slides will provide further details and statistics.



SLIDE 5:

This chart is a visual comparison of peak death rates for other major epidemics that have impacted U.S. citizens on a large scale. The chart demonstrates death rates at their peak of each epidemic for motor vehicle accidents, guns, and HIV/AIDS, as well as for current overdose deaths that hit their peak in 2016 at approximately 64,000 deaths. When comparing these 4 epidemics, it becomes clear that the magnitude and scale of overdose death rates are significant and will require significant efforts on both local and national levels to combat this epidemic. Before we begin to see a downward trend in death rates.

1972 peak car crash deaths=54,589

1993 peak gun deaths=18,253

1995 peak HIV deaths= 43,000

2016 peak OD deaths=64,000

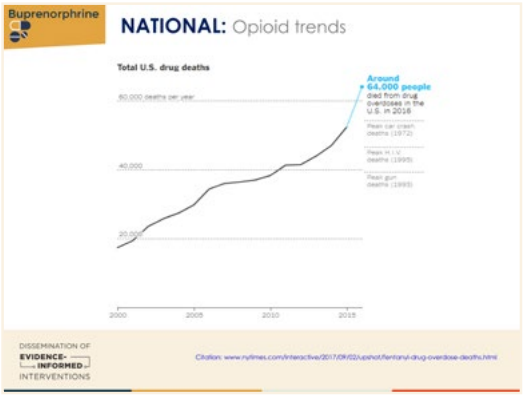
SLIDE 6:

(The facilitators should emphasize the comparison between HIV and overdose deaths noted by the U.S. Centers for Disease Control and Prevention (CDC) official in a New York Times article).

Robert Anderson, the CDC chief of mortality statistics stated the following "...H.I.V. deaths rose in a shorter time frame, but their peak in 1995 is similar to the high point of deaths from drug overdoses reached in 2014, Mr. Anderson said. H.I.V., however, was mainly an urban problem. Drug overdoses cut across rural-urban boundaries…"

As of 2017, the number of opioid overdose deaths continue to rise each year.

Citation: Park H, Bloch M. "How the Epidemic of Drug of Drug Overdose Deaths Rippled Across America." The New York Times. January 19, 2016. Available at: www.nytimes.com/interactive/2016/01/07/us/drug-overdose-deaths-in-the-us.html



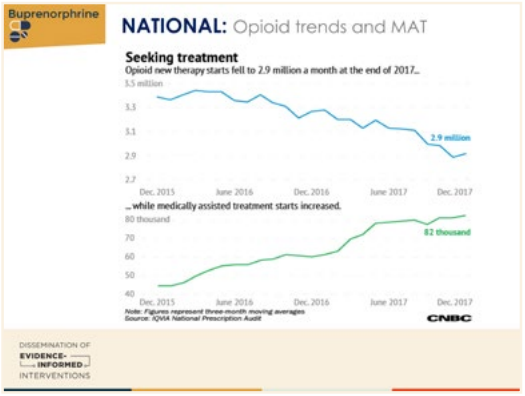
SLIDE 7:

This chart exhibits the total U.S. drug overdose deaths from 2000-2015. An estimated total of 64,000 deaths from drug overdoses have been calculated for 2016. The purpose of this chart is to demonstrate a compelling upward trend in the overall overdose rate with a marked spike in the past 5 years. Understanding the fast trajectory in overdose deaths will allow those who are providing office-based opioid treatment to understand how critical office-based opioid treatment is to help combat these overdose deaths.

Addendum: 2017 OD deaths was approximately 72,000.

SLIDE 8:

A significant number of people have been affected by opioid misuse or deaths related to opioid use in the United States. The numbers shown are as of early 2018. Emphasis should be placed on the significant numbers of people receiving prescription opioids in this country, the U.S. consumption of worldwide opioids, the remarkable percentage of worldwide hydrocodone prescribed in the U.S., the link between prescription opioid prescription use and abuse, and the connection between heroin use and prescription drug access. Also note the dramatic rise in heroin overdoses in the timeframe indicated.



SLIDE 9:

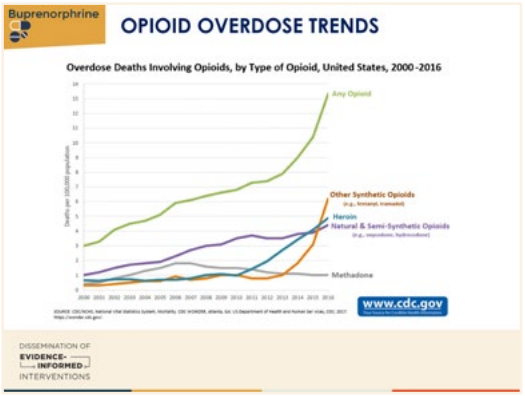
The purpose of this chart is to show the recent national trend of a decrease in new opioid prescriptions and the growing trend to start MAT to combat the opioid epidemic. This chart is from a CNBC article that looked at U.S. opioid prescribing.

They noted that the number of opioid pills prescribed peaked in 2011 and has since declined.

The top chart shows how in a two-year period, opioid new therapy starts fell to 2.9 million at the end of 2017.

The bottom chart demonstrates during a two year period that medically assisted treatments starts have increased to 82,000 in 2017.

This is significant for those who are currently providing office based opioid therapy to understand how the trends are shifting towards more medication assisted treatment to combat the opioid epidemic.

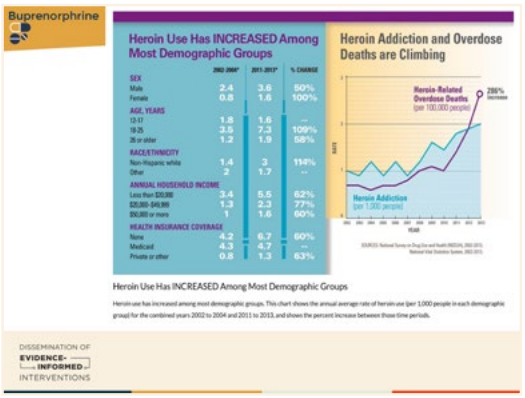


SLIDE 10:

Look at the data presented in the slide and note the national trend of increasing overdose by any opioid.

SLIDE 11:

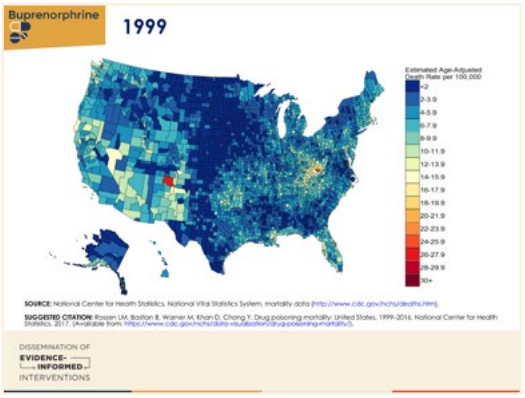
Notice the data that is circled in red, which demonstrates prescription opioids as primary OD risk as well as overall rising trends.



SLIDE 12:

The rate of heroin use has increased in almost all demographic categories in the timeframe shown. This rise correlates with increasing overdose deaths. The rate of heroin use and the percent change is distinctly higher in ages 18-25 and non-Hispanic whites. Overall use rates are higher in men, the uninsured, and those in lower income households.

Citation: CDC. Today's Heroin Epidemic: More People at Risk, Multiple Drugs Abused. July 7, 2015. Available at: www.cdc.gov/vitalsigns/heroin/index.html

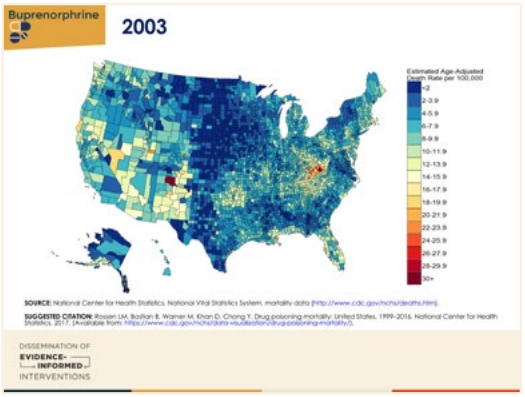


SLIDE 13:

As you will see in the following slides, age-adjusted death rates for drug poisoning began steadily increasing in 1999.

Note: The facilitator should utilize these slides (13 - 17) as a demonstration of trends, including increases in age-adjusted death rates for drug poisoning beginning in 1999 through 2016 as well as demographic trends. If internet is available, use the website in the citation below for demonstration of how to obtain these various slide sets and data visualizations can be very helpful.

Citation: Rossen LM, Bastian B, Warner M, et al. "Drug Poisoning Mortality: United States, 1999-2016. National Center for Health Statistics, Centers for Disease Control and Prevention.2017. Available at: www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/

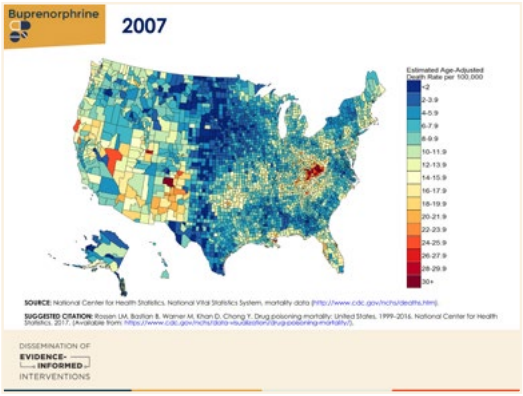


SLIDE 14:

This slide indicates the age adjusted death rates for drug poisoning in 2003.

Note: The facilitator should utilize these slides (13 - 17) as a demonstration of trends, including increases in age-adjusted death rates for drug poisoning beginning in 1999 through 2016 as well as demographic trends. If internet is available, use the website in the citation below for demonstration of how to obtain these various slide sets and data visualizations.

Citation: Rossen LM, Bastian B, Warner M, et al. "Drug Poisoning Mortality: United States, 1999-2016. National Center for Health Statistics, Centers for Disease Control and Prevention.2017. Available at: www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/

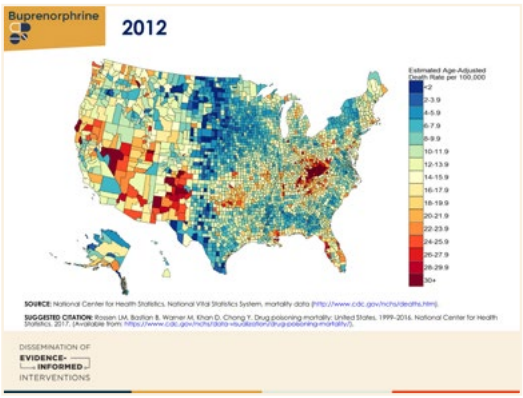


SLIDE 15:

This slide indicates the age adjusted death rates for drug poisoning in 2007.

Note: The facilitator should utilize these slides (13 - 17) as a demonstration of trends, including increases in age-adjusted death rates for drug poisoning beginning in 1999 through 2016 as well as demographic trends. If internet is available, use the website in the citation below for demonstration of how to obtain these various slide sets and data visualizations.

Citation: Rossen LM, Bastian B, Warner M, et al. "Drug Poisoning Mortality: United States, 1999-2016. National Center for Health Statistics, Centers for Disease Control and Prevention.2017. Available at: www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/

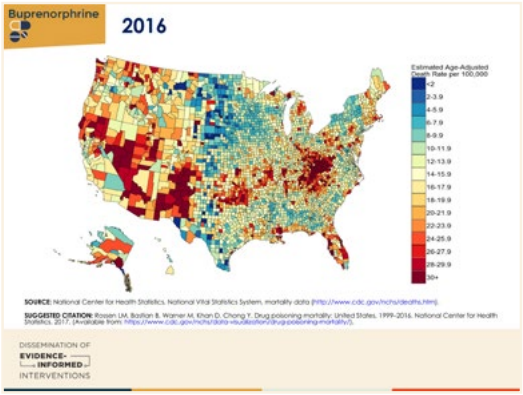


SLIDE 16:

This slide indicates the age adjusted death rates for drug poisoning in 2012.

Note: The facilitator should utilize these slides (13 - 17) as a demonstration of trends, including increases in age-adjusted death rates for drug poisoning beginning in 1999 through 2016 as well as demographic trends. If internet is available, use the website in the citation below for demonstration of how to obtain these various slide sets and data visualizations.

Citation: Rossen LM, Bastian B, Warner M, et al. "Drug Poisoning Mortality: United States, 1999-2016. National Center for Health Statistics, Centers for Disease Control and Prevention.2017. Available at: www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/

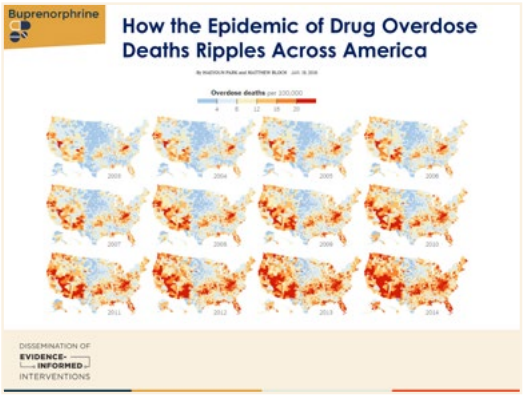


SLIDE 17:

This slide indicates the age adjusted death rates for drug poisoning in 2016.

Note: The facilitator should utilize these slides (13 - 17) as a demonstration of trends, including increases in age-adjusted death rates for drug poisoning beginning in 1999 through 2016 as well as demographic trends. If internet is available, use the website in the citation below for demonstration of how to obtain these various slide sets and data visualizations.

Citation: Rossen LM, Bastian B, Warner M, et al. "Drug Poisoning Mortality: United States, 1999-2016. National Center for Health Statistics, Centers for Disease Control and Prevention.2017. Available at: www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/



SLIDE 18:

This slide is a summary of the sequential individual slides 13-17.

Citation: Rossen LM, Bastian B, Warner M, et al. "Drug Poisoning Mortality: United States, 1999-2016. National Center for Health Statistics, Centers for Disease Control and Prevention.2017. Available at: www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/

SLIDE 19:

Activity:

If participants have previously implemented the Integrating Buprenorphine into HIV Primary Care Settings intervention and/or this training is being used as a second-level course, ask each participant group to present on their experience to date. Use the "Presentation Preparation: Buprenorphine Intervention Updates Handout" to guide conversations. Participants and presenters can also use these presentation as context to discuss emerging trends and reflections on the opiate crisis, described in the preceding slides.

CLOSING

Next, we will discuss the intersection of the HIV and opioid epidemics, with a focus on stigma.

MODULE 12:
Stigma, Shame, and the Power of Language

Topics Covered: Stigma, shame, power of language

OBJECTIVES

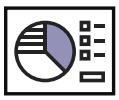
By the end of this module, participants will be able to:

- Identify the role of shame and stigma in opioid use disorder (OUD) and how this impacts treatment in office based opioid treatment (OBOT) settings.
- Apply person-first language in working with clients in treatment to decrease stigma and shame.

Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Videos

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

HANDOUTS

- Language of Recovery: http://attcnetwork.org/home/Language%20of%20Recovery%20071416.pdf

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual

PROCESS

Facilitators will describe the intersection between the HIV and opioid epidemics. This will demonstrate the applicability of a treatment cascade for people living with substance use disorders.

Facilitators will define stigma and share examples of progress in addressing HIV-related stigma. Facilitators will also focus on the impact of stigma as it relates to treatment for substance use disorders, including the prevalence of stigma, common myths about substance use disorders, and strategies to address stigma.

Facilitators will define shame and its relation to internalized stigma.

ACTIVITIES

Facilitators will use a video to demonstrate this point, as well as examples of stigmatizing language. Person-first language will be introduced to replace stigmatizing language.

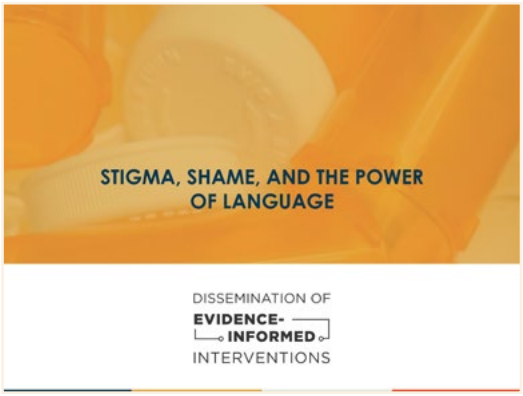
Participants can be engaged throughout the session, by sharing examples of how stigma or shame has impacted clients and their engagement in treatment.

Key Words and Phrases

- *Stigma*
- *Shame*
- *Treatment Cascade*
- *Stigmatizing Language*
- *Person-first Language*

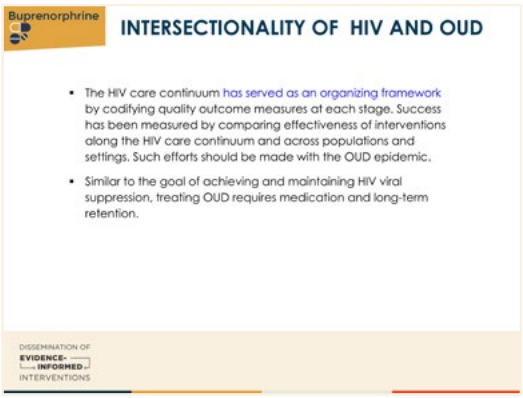
The approximate length of time the session will take.

Total: 25 minutes



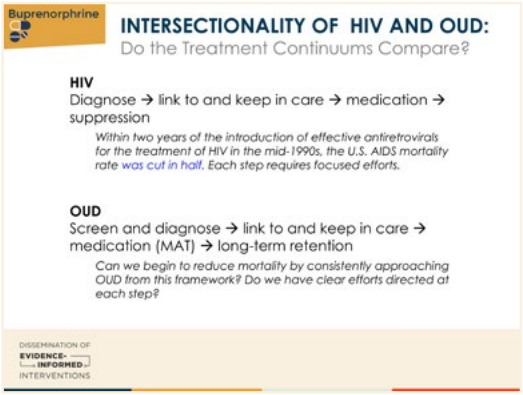
SLIDE 1:

In this module we will be discussing stigma, shame, and the power of language.



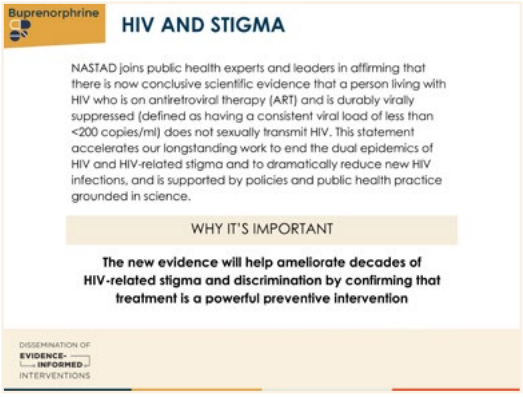
SLIDE 2:

The HIV Cascade of Care has served as an organizing framework by codifying quality outcome measures at each stage along the cascade. The idea of a treatment cascade is also applicable in the treatment of opioid use disorder.



SLIDE 3:

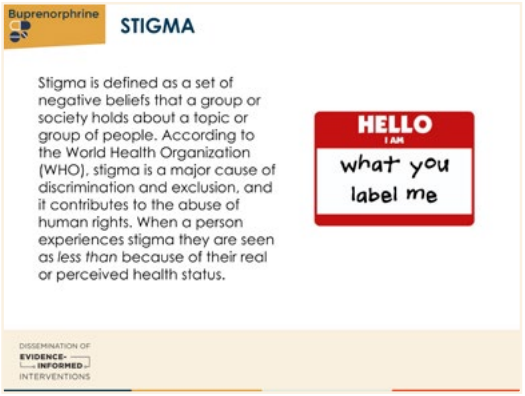
HIV treatment is successful when all HIV care continuum stages are addressed. Similar efforts need to be directed at the OUD population. HIV treaters are primed to replicate their HIV successes.



SLIDE 4:

The National Alliance of State and Territorial AIDS Directors, now simply known as NASTAD, issued this statement in Februrary 2017: there is now conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy (ART) and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV.

This evidence helps to address HIV-related stigma and discrimination by confirming that treatment is a powerful preventive intervention. What if we think of substance-use disorder treatment in a similar way? If we treat it, we begin to reduce overall prevalence of disease and how it impacts health.



SLIDE 5:

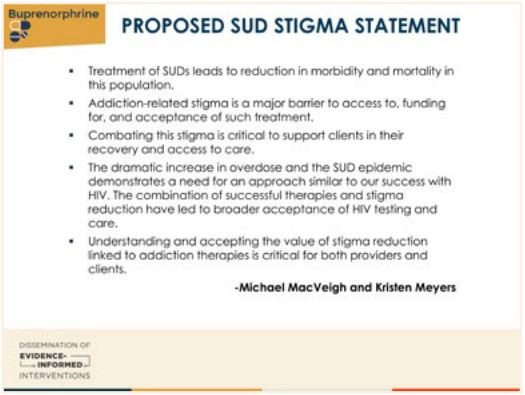
According to the World Health Organization, stigma causes discrimination and exclusion. Stigma has a significant impact on health outcomes.

Citation: Salsitz EA. Stigma in Methadone and Buprenorphine Maintenance Treatment. PCSS-MAT Modules.

SLIDE 6:

This slide demonstrates how several countries' beliefs about addiction are often stigmatized as something "bad" and at times, worse than criminal behavior.

Citation: JF Kelly, R Saitz, S Wakeman. Language, substance use disorders, and policy: the need to reach consensus on an "addiction-ary". Alcoholism Treatment Quarterly. 2016.



SLIDE 7:

Stigma has had a significant impact on how people living with HIV are treated. HIV providers have worked to de-stigmatize HIV to support people living with HIV in accessing treatment. This statement calls on providers to approach treatment of SUD with MAT with the same lens.

Examples of stigmatizing terms related to HIV, include: "bug free," "clean."

SLIDE 8:

Activity:

Play the video "LIVES Challenge: Leveraging Impactful Videos to End Stigma" (3 MIN) https://vimeo.com/153845422

The associated video with this slide is part of Recovery Brands LIVES (Leveraging Impactful Videos to End Stigma) campaign to combat stigma and addiction. The video portrays random people being interviewed about what they think about addiction. It demonstrates the broad concepts that are part of the stigmatized dialogue we continue to hear about addiction. This includes thoughts that addiction is a choice, the person is seen as lesser than and is at fault for their addiction. The video also interviews recovering addicts and family members telling their stories to help demonstrate how addiction can impact anyone and that recovery from this disease requires a cultural shift in how we perceive and treat those who are experiencing addiction.

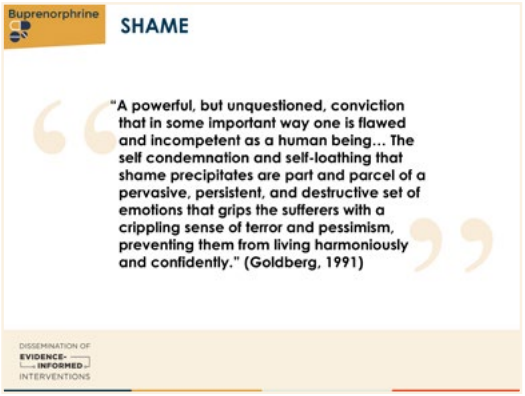
Hearing these stories can help us start to understand the role stigma plays in the lack of treatment for substance use disorders.

SLIDE 9:

Activity (Discussion):

Review the slide with participants. Now ask the group to think of others myths. Remind participants that addiction still seen as a "choice," even though we know that half the risk for addiction is conferred by genetics. In 1972 methadone treatment regulation was enforced and no other treatment was and still is that regulated. Dr. Salitz said in 1997, "A methadone patient is monitored more closely than a paroled murderer." This level of regulation has set the stage for stigma.

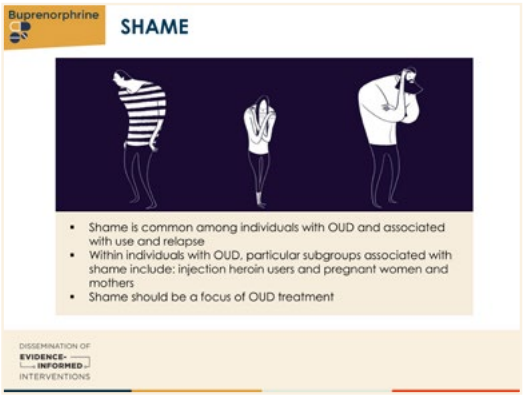
Citation: Salsitz EA. Stigma in Methadone and Buprenorphine Maintenance Treatment. PCSS-MAT Modules.



SLIDE 10:

Stigma leads to a sense of internalized shame. The clients we treat for SUD will often being grappling with their own internalized shame. This sense of shame will be demonstrated in ways that clinicians often deem as wrongful behavior (e.g., lying, omitting information, not showing for appointments, defensiveness). When providing SUD treatment, providers need to be aware of the shame that their clients might bring to the visits and that they can help to build and foster a relationship that is trauma-informed to ensure the client is treated in a way that helps to reduce further stigma that results in internalized shame.

Citation: Braun-Gabelman A. "The Role of Shame in Opioid Use Disorders." PCSS-O Modules.



SLIDE 11:

In order for a client to build shame resilience, OBOT services should practice empathy, encourage self-compassion, and allow vulnerability through non-judgment. OBOT services must be a safe space where the client is offered acceptance and empathy. Then, the client can begin to internalize new experiences and begin to revise their beliefs about themselves.

Citation: Braun-Gabelman A. "The Role of Shame in Opioid Use Disorders." PCSS-O Modules.

SLIDE 12:

The quote and the video demonstrate the importance of being aware of how stigma and shame impact those who are seeking SUD treatment services. It is also a reminder that the words we use to describe treatment services must be reflective of non stigmatizing and shaming language.

White Bison=culturally specific treatment center for Native Americans

Activity:
Play video "LIVES Challenge: Judge's Choice Award" (1 min)

https://vimeo.com/185592929

SLIDE 13:

This slide represents the importance of using person-first language when discussing a person's SUD and the treatment of it.

500 doctoral-level MH and A&D providers given two vignettes. First vignette described has a substance abuser and 2nd vignette as having SUD. Otherwise, scenarios were identical. Clinicians exposed at random to the substance abuser term were significantly more likely to judge the person as deserving of blame/punishment.

Activity:
Review "Language of Recovery handout" as a good reference/resource.

CLOSING

We will now transition to a brief lecture. This will serve as a general, Addictions 101 training.

MODULE 13:

Key Approaches—Relapse Sensitive Environments, Strategies to Support Retention in Care, Methods to Reduce Diversion, and Compliance Monitoring

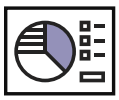
Topics Covered: Relapse sensitive environments, strategies to support retention in care, methods to reduce diversion, and compliance monitoring

OBJECTIVES

By the end of this module, participants will be able to:

- Define a relapse sensitive environment and the best practices to support people through the treatment process.
- Assess their own OBOT program to ensure that services provided are relapse sensitive.
- Compare MAT industry standard and OBOT methods.
- Assess the suitability of clients for a standard treatment environment (more structure) or an OBOT setting (less structure).
- Utilize prescription drug monitoring programs as a helpful tool for providers to determine if a client is being prescribed contraindicated medications.
- Utilize urine drug screening and other testing (creatinine levels) as a tool to help guide treatment planning for clients and the OBOT team.

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

FACILITATED DISCUSSION

Facilitators will start by defining a relapse sensitive environment, why it can have an impact in OBOT, and key principles. Participants can be engaged in a discussion around key principles and how they might look in practice.

Facilitators will transition to a discussion regarding retention in care and the individualized approaches to treatment that often support retention.

Facilitators will briefly discuss methods that can be used by a provider to prevent buprenorphine diversion.

Facilitators will then discuss approaches that can be used to guide treatment planning, including urine drug screens and prescription drug monitoring programs. Participants will be engaged in a discussion regarding their experiences with these tools and strategies to date.

Key Words and Phrases

- *Relapse*
- *Relapse Sensitive environment*
- *Retention in Care*
- *Stages of Change*
- *Diversion*
- *Urine Drug Screens*
- *Prescription Drug Monitoring Programs (PDMPs)*

Method(s) of Instruction

- Lecture
- Facilitated Discussion

The approximate length of time the session will take.

Total: 30 minutes

SLIDE 1:

In this module we will discuss relapse sensitive environments and retention strategies.

SLIDE 2:

This quote introduces the concept of creating a relapse-sensitive environment in OBOT. Relapse sensitive environments are aware that relapse is part of the process and use empathy and non-judgemental practices rather than punitive practices if/when a relapse occurs.

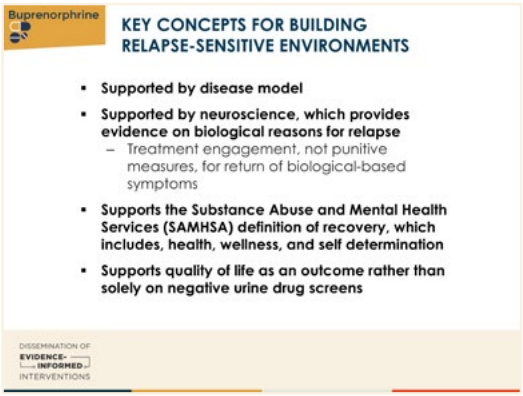
Citation: White, W. Slaying the Dragon: The History of Addiction Treatment and Recovery in America. 2998. Bloomington IL: Chestnut Health Systems.

SLIDE 3:

Defining a relapse sensitive environment focuses on how the OBOT team reacts to and manages a client's relapse. Utilizing a relapse-sensitive framework is critical to successful client treatment outcomes.

The long-term goal is to maintain people in treatment to enhance the potential for sustained recovery.

Citation: Conroy SC. Relapse Sensitive Care: Changing Systems of Addiction Treatment. PCSS-MAT Online Modules. Available at: http://pcssnow.org/wp-content/uploads/2016/03/Conroy.-PCSSMAT-AMERSA-Conroy-Relapse-Sensitive-Care-Module-II.pdf



SLIDE 4:

Overarching treatment system leaders, such as SAMHSA, are supportive of a relapse-sensitive approach. There is evidence-based research (neuroscience models) that have demonstrated the efficacy of building a relapse sensitive OBOT program.

Citation: Conroy SC. Relapse Sensitive Care: Changing Systems of Addiction Treatment. PCSS-MAT Online Modules. Available at: http://pcssnow.org/wp-content/uploads/2016/03/Conroy.-PCSSMAT-AMERSA-Conroy-Relapse-Sensitive-Care-Module-II.pdf

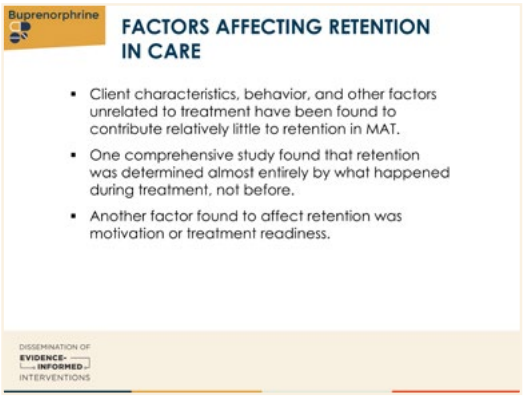
SLIDE 5:

These are examples of relapse-sensitive responses that are action-focused and take into consideration that substance use is a learned behavior that serves a range of functions for an individual (e.g., coping and socializing).

Citation: Conroy SC. Relapse Sensitive Care: Changing Systems of Addiction Treatment. PCSS-MAT Online Modules. Available at: http://pcssnow.org/wp-content/uploads/2016/03/Conroy.-PCSSMAT-AMERSA-Conroy-Relapse-Sensitive-Care-Module-II.pdf

SLIDE 6:

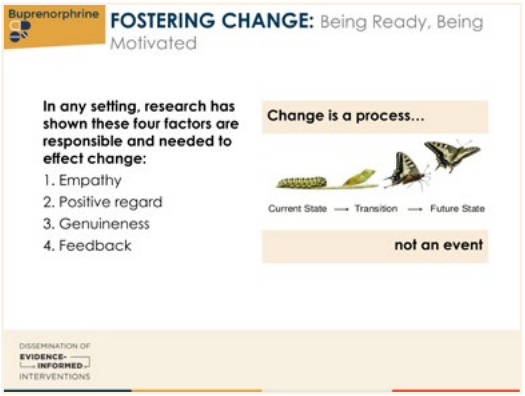
To retain a client in OBOT care, treatment must be individualized and the treatment team should be mindful that one type of treatment approach may not work for each individual.



SLIDE 7:

Studies referenced have demonstrated that the key components to retention in care were related to what occurred during the treatment process and the client's own motivation and treatment readiness.

Citation: SAMHSA. Treatment Improvement Protocol (TIP) Series, No. 43, Chapter 8. "Approaches to Providing Comprehensive Care and Maximizing Patient Retention."



SLIDE 8:

To enhance a client's motivation and readiness for treatment, the treatment team can utilize motivational interviewing skills to help move a client through the stages of change.

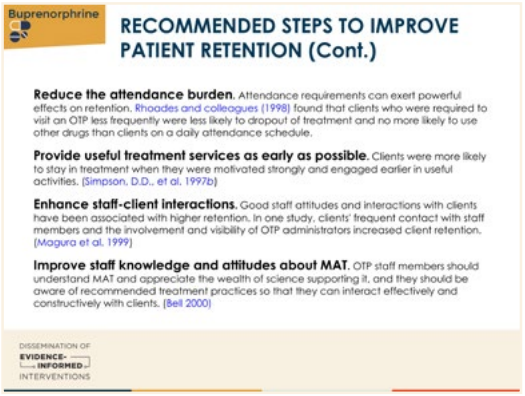
Some examples of the four factors listed in the slide and that can be utilized when working with a client, include:

- Emphasizing a strength (to support self efficacy)
- Noticing and appreciating a positive action
- Being genuine
- Expressing positive regard and care
- Strengthening the collaborative relationship

SLIDE 9:

This slide demonstrates concrete steps that a treatment team can utilize to foster client retention in OBOT.

Citation: SAMHSA. Treatment Improvement Protocol (TIP) Series, No. 43, Chapter 8. "Approaches to Providing Comprehensive Care and Maximizing Patient Retention."

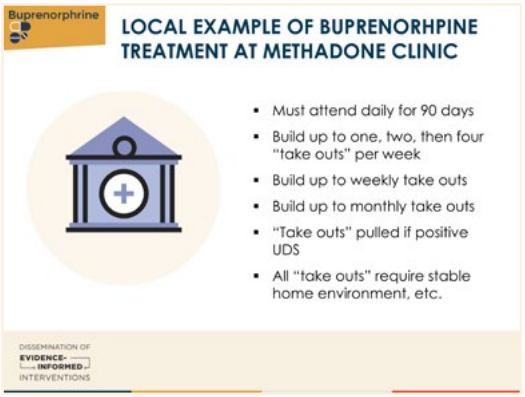


SLIDE 10:

As a reminder, the overall process of addiction and recovery includes the following:

- Ambivalence is common in SUD.
- It takes 30 days for the average person to move one stage of change.
- SUD is a disorder of memory, motivation, and reward.
- Avoid the "righting reflex" (it's not your job to "fix" the client's problem); assess for quality of life rather than your own ideas of what a person needs.

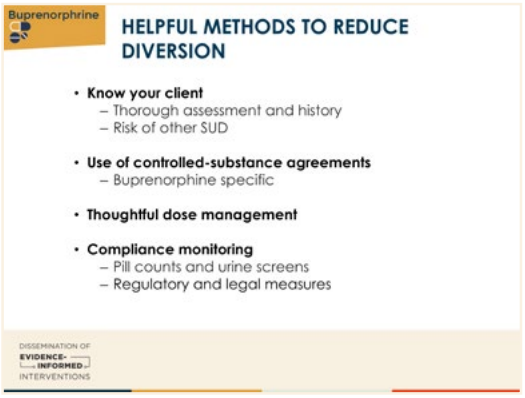
Citation: SAMHSA. Treatment Improvement Protocol (TIP) Series, No. 43, Chapter 8. "Approaches to Providing Comprehensive Care and Maximizing Patient Retention."



SLIDE 11:

This slide demonstrates what buprenorphine treatment looks like at a local methadone clinic in Portland, OR. The purpose of this slide is to demonstrate the more rigid, step-therapy based treatment that is offered at a methadone clinic versus an OBOT program, which has the flexibility to incorporate client factors to develop the right treatment plan for each individual.

Some individuals may have better treatment outcomes if they are receiving their buprenorphine treatment within the structured environment of a methadone clinic.



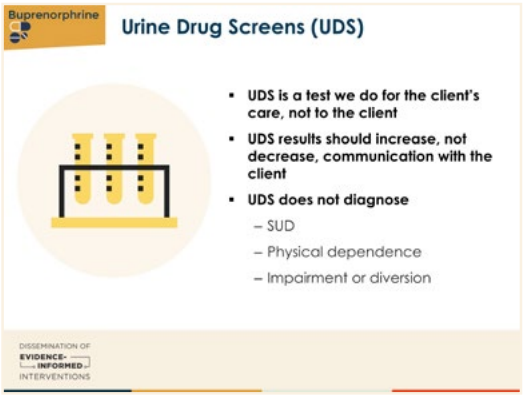
SLIDE 12:

To help reduce diversion, providers should utilize a certain amount of caution when prescribing.

The following points can help guide new (and experienced) prescribers:

- Use lowest dose that works: no specific test, but average dose 12-16 mg, anything over 24 mg/day would be suspicious.
- Prescription Drug Monitoring Program (PDMP) queries - be sure you are aware of your state/territory's program.
- Long-acting preparations may provide less frequent visit frequency in stable clients
  - buprenorphine implants (Probuphine)
  - XR-buprenorphine (Sublocade)
  - (non bup) XR-naltrexone (Vivitrol)

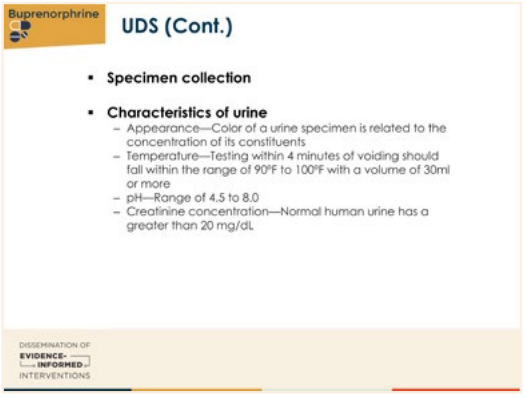
Citation: Argoff CE. Managing Aberrant Drug-Related Behavior in Primary Care: A Systematic Review.



SLIDE 13:

Drug screen tests are helpful to add knowledge and inform discussions with our clients, not to specifically penalize. Providers should discuss with clients the use of urine drug screen tests up front, and clients should be aware of the focus on their safety as well as legal responsibilities of the provider.

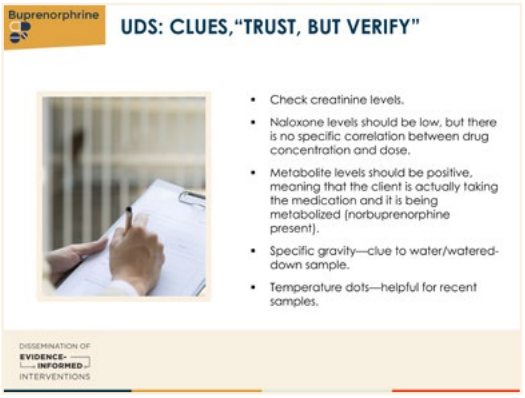
Citation: Heit HA. Patient-Centered Urine Drug Testing: Facts You Should Know! PCSS-MAT Module 4.



SLIDE 14:

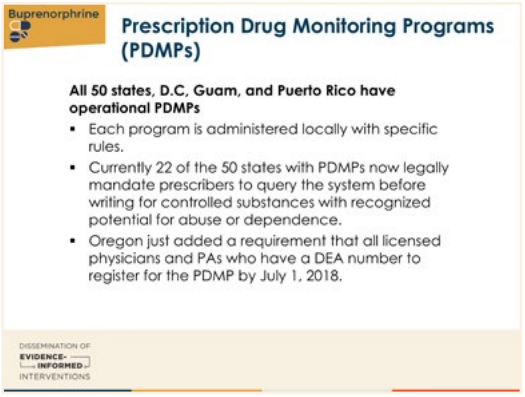
Most primary care sites do not have the skills or staff to do monitored collection, but findings consistent with altered samples should be discussed with the client to explore the cause of such behavior. Trainers should review the specifics that alert a provider to possible altered samples. (Note: See next slide for further information).

Citation: Heit HA. Patient-Centered Urine Drug Testing: Facts You Should Know! PCSS-MAT Module 4.



SLIDE 15:

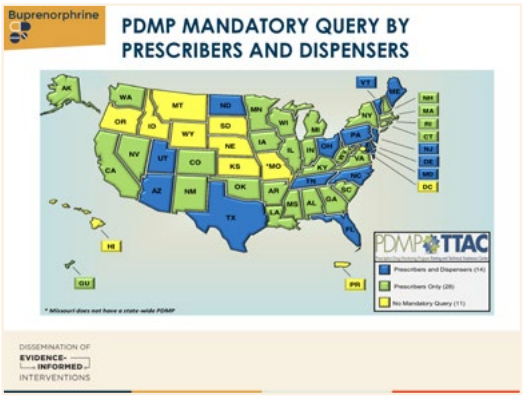
Activity (Discussion):
Facilitators should use the slide's helpful pointers to guide a discussion with participants about the meaning of specific UDS findings.



SLIDE 16:

Prescription Drug Monitoring Programs (PMDPs) now exist in all 50 states (MO started theirs in January 2018) as well as the territories and DC (as noted in the slide). These programs allow prescribers to check on what controlled substances have been filled by clients at a pharmacy in the jurisdiction queried. However, providers typically have to register in order to make (online) queries. Each program has its own specific rules. For example, in OR, once registered, a provider may assign delegates (CMA, RN, etc). to make queries under their (provider's) name and registration; this function facilitates ease of use when seeing/preparing clients in SUD treatment. Other states (like those mentioned on the next slide) require the PDMP be consulted before any controlled substance is prescribed in any setting.

Citation: Haffajee RL, Jena AB, Weiner SG. Mandatory Use of Prescription Drug Monitoring Programs. JAMA. 2015. 313(9): 891-2. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4465450/



SLIDE 17:

A handful of states currently require use of PDMP when prescribing opioids.

Activity (Discussion):
Elicit feedback from any participants from states that require use of PDMP when prescribing opioids as well as describe your own experience: How does the PDMP work in your state? Have you been able to easily integrate checking the PDMP into your clinical practice? Has information gleaned from the PDMP changed your prescribing?

CLOSING

Now, we will discuss higher levels of care that may be utilized when it appears that OBOT treatment is no longer the best option for sustained treatment outcomes.

MODULE 14:

Referrals to Higher Levels of Care, Other Treatment Options, and Tapering Off Buprenorphine

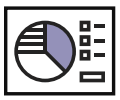
Topics Covered: Referrals to higher levels of care, other treatment options, tapering off buprenorphine

OBJECTIVES

By the end of this module, participants will be able to:

- Refer clients to higher levels of care for OUD and assist clients with the referral to these programs, including the advocacy to continue MAT while in the program.
- Describe other MAT options used to treat OUD.
- Discuss case examples and client reports on transitions from buprenorphine to naltrexone or methadone.
- Implement a process to re-start a client back on OBOT with buprenorphine after a lapse in treatment.
- Apply common buprenorphine taper protocols and guidelines.

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

HANDOUTS

- Case Examples (in slides)

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

Facilitators will first discuss processes to refer clients to a higher level of care (i.e., residential treatment, methadone) when it appears that OBOT treatment is no longer the best option for sustained treatment outcomes. Two case studies will be utilized to review recommendations, challenges, and treatment plans in scenarios where a client is:

1. Currently in OBOT and referred to an outpatient treatment program (OTP).
2. Referred to inpatient treatment for further stabilization and the OBOT treatment team facilitates continued buprenorphine treatment while in the residential setting.

Facilitators will then review data around alternative forms of medication-assisted treatment if buprenorphine is no longer the best option for sustained treatment outcomes.

Lastly, facilitators will discuss guiding principles, timelines, and withdrawal symptoms that may be experienced after implementing a planned or unplanned taper from buprenorphine.

FACILITATED DISCUSSION

Facilitators should be prepared to discuss the course of action they would pursue for the cases as outlined and engage participants in discussion around cases. Trainers can also incorporate their own cases that touch on similar themes.

Discussion will include data around retention in care and misuse patterns for several treatment modalities, as well as provider guidelines and client perspectives around switching from buprenorphine to naltrexone, or vice versa.

Key Words and Phrases

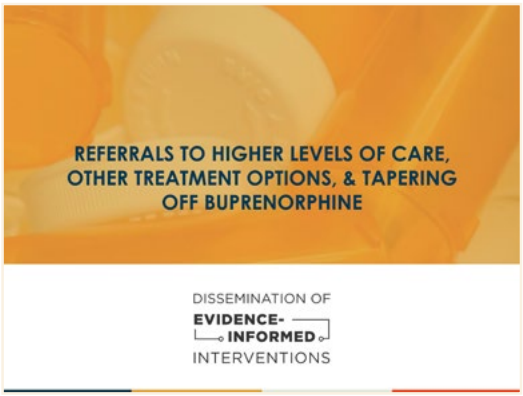
- *Outpatient Treatment Program*
- *Inpatient Treatment Program*
- *Methadone*
- *Naltrexone*
- *Taper*
- *Withdrawal*

Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Case Discussion

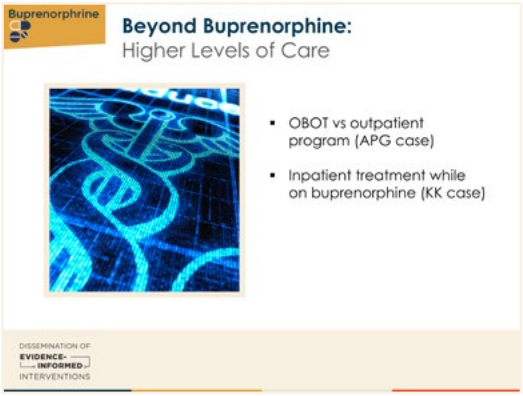
The approximate length of time the session will take.

Total: 30 minutes



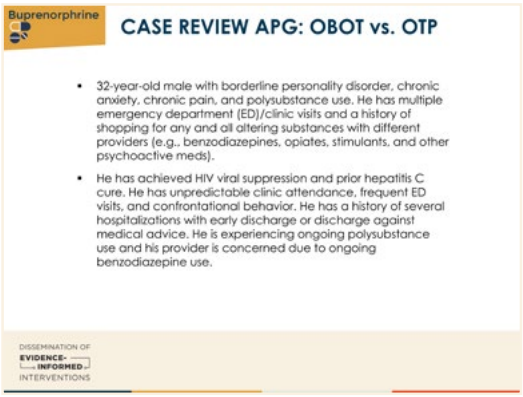
SLIDE 1:

In this module we will discuss referrals, other treatment options, and tapering.



SLIDE 2:

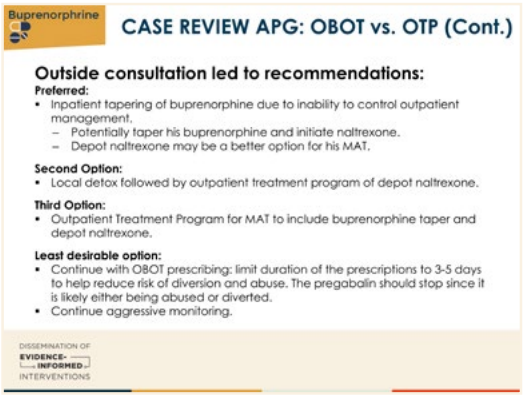
This slide introduces the topic of referring clients to a higher level of care (e.g., residential treatment, methadone) when it appears that OBOT treatment is no longer the best option for sustained treatment outcomes. Two specific cases will be utilized. The first case is a client (that we'll refer to as APG); this client is currently in OBOT and will be referred to an outpatient treatment program (OTP) to manage his care. The second case is a client (that we'll refer to as KK) who is being referred to inpatient treatment for further stabilization. The OBOT treatment team facilitates continued buprenorphine treatment while in the residential setting.



SLIDE 3:

Review the key information regarding this client's (APG) treatment history in the OBOT setting as outlined on the slide. This case represents a complex OBOT client where the team has determined that there are concerns about continued buprenorphine treatment in the OBOT setting.

With this information, what is your preferred course of treatment for this client?



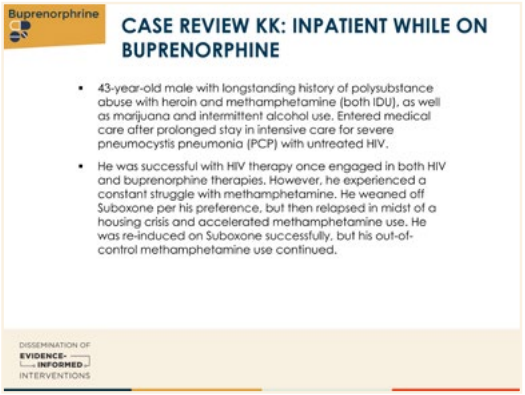
SLIDE 4:

This slides demonstrates how an OBOT team utilized a Project ECHO (Extension for Community Healthcare Outcomes) mentorship to seek advice on treatment planning for a complex client.

The advice was given by providers who participated as experts in Project ECHO.

As exemplified in the slide, the mentor offered several options for a treatment plan. Before facilitators share treatment plan pursued for APG, ask participants: What would you do, based on these recommendations? Based on the resources available in your community, which recommendations would be actionable for you?

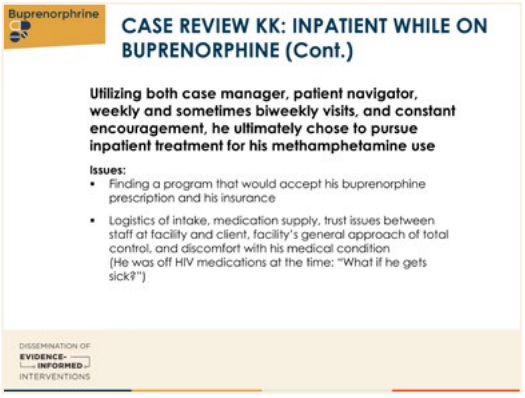
Ultimately, OBOT team decided to refer this client to a six month residential treatment program and buprenorphine treatment was stopped. The client left residential treatment against medical advice (AMA) and was lost to follow up for over a year.



SLIDE 5:

Let's review the key information regarding this client (who we'll call KK) and his treatment history in the OBOT setting. This case represents another complex OBOT client where the team struggled (as did the client) with his ongoing methamphetamine use while on buprenorphine. Though he felt stable regarding his opiate recovery, his chaotic life associated with methamphetamine use binges led to homelessness and mental health issues.

With this information, what is your preferred course of treatment for this client?

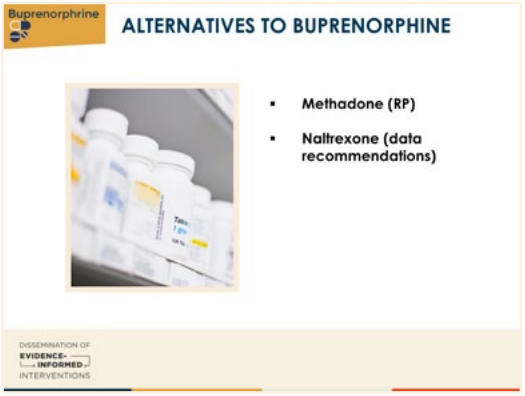


SLIDE 6:

Important points to note include:

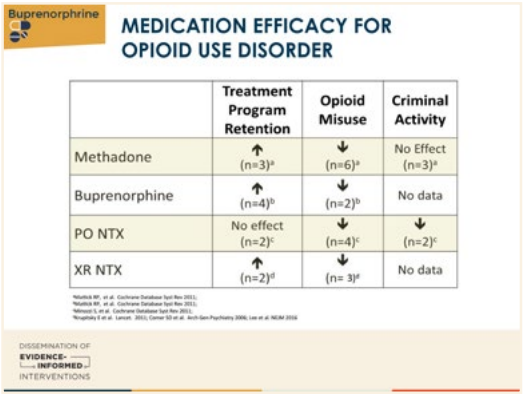
- The frequency of visits to maintain his ongoing OBOT: a combined effort by his medical team, his case manager, and his patient navigator (a service fairly new to the clinic and focused on patients with significant housing, substance use and/or mental health issues).
- Clinical team had significant issues coordinating with the care system. The inpatient program was concerned about his medical status regarding his advanced HIV medical status.

Have you faced some of these issues in your setting? How would you address these issue?



SLIDE 7:

It is also important to consider that buprenorphine may not be the best treatment modality for all clients. Methadone and naltrexone are the two major alternatives.



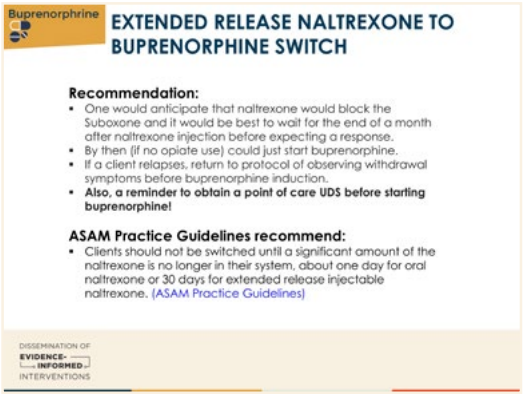
SLIDE 8:

These data (though small numbers) suggest that all these modalities decrease opioid use, but oral naltrexone unlike the other options (e.g., long acting naltrexone, methadone program, and buprenorphine) had poor retention.

SLIDE 9:

Given that some clients may prefer one treatment over another, or need to switch for a variety of specific client related reasons (e.g., coverage, incarceration, tolerance, preference, etc)., general guidelines do exist for the timing of each switch. Here the guidelines around switching from buprenorphine to naltrexone are described.

Citation: Mannelli P, Peindl KS, Lee T, et al. Buprenorphine-Medicated Transition from Opioid Agonist to Antagonist Treatment: State of the Mind and New Perspectives. Curr Drug Abuse Rev. 2012 Mar: 5(1): 52-63.



SLIDE 10:

The treatment team will need to take extra steps to plan and monitor a client who is switching from naltrexone to buprenorphine. Switching from an antagonist such as naltrexone to a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist because there is no physical dependence associated with antagonist treatment and thus no possibility of precipitated withdrawal. Clients being switched from naltrexone to buprenorphine will not have physical dependence on opioids so the initial induction dose should be low.

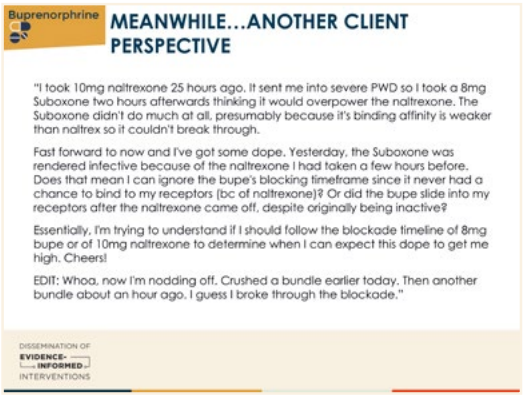
SLIDE 11:

This slide shows a post on an online drug forum.

In the above example, this person posts their experience using MAT for their daily heroin use. This person was given an XR-naltrexone and it caused this person to experience precipitated withdrawal. They then describe using buprenorphine one day after the naltrexone to stop their precipitated withdrawal.

Note: The facilitator should note that this timeframe of medication switch is not a recommended treatment protocol (XR-naltrexone to buprenorphine switch). This person's post highlights the low risk involved in replacing an antagonist with a partial agonist.

Citation: Drugs Forum. Available at: https://drugs-forum.com/forum/showthread.php?t=255209

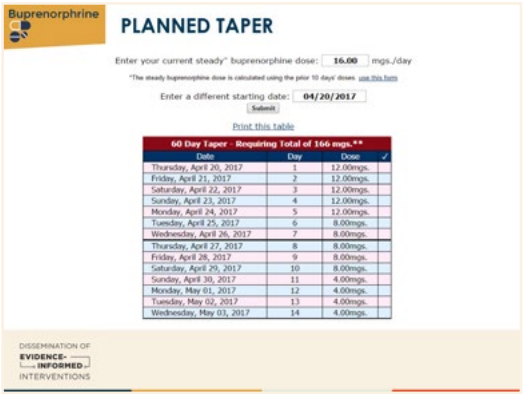


SLIDE 12:

This is another post from an online drug forum. It highlights the high level of knowledge most clients have in regards to managing their own withdrawal (or attempts to get high). It also highlights the unique efforts made by the client to determine binding affinity of an antagonist (oral naltrexone) vs. a partial agonist (buprenorphine) vs. a full agonist (heroin).

SLIDE 13:

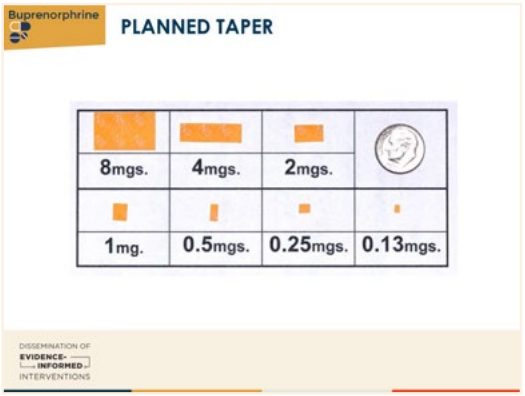
Tapers should generally be gradual and individualized. When client's request taper, providers should initiate a risk-benefit discussion.



SLIDE 14:

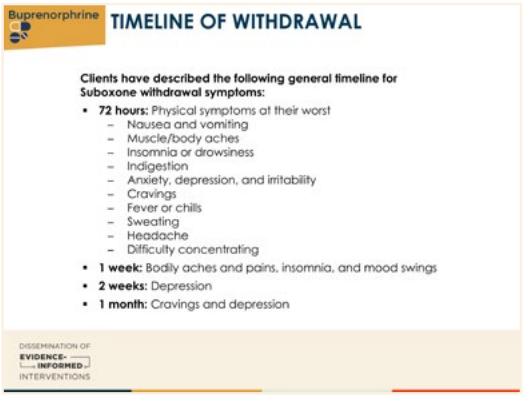
Providers can use a schedule when clients plan to taper off buprenorphine. This website can be used to develop a taper plan:

www.helpmegetoffdrugs.com/taper



SLIDE 15:

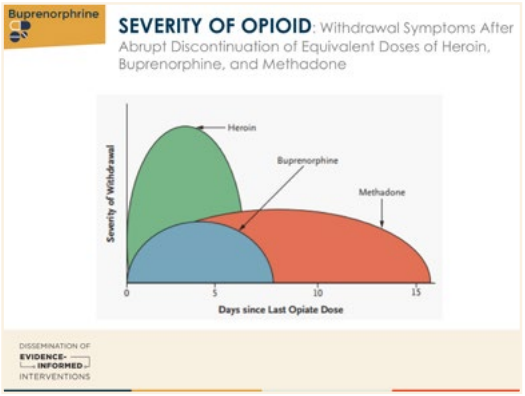
A client (using sublingual film strips) can cut the strip down into smaller and smaller dose amounts as a part of their taper plan.



SLIDE 16:

Clients have described the following withdrawal symptoms within 72 hours-1 month after tapering off buprenorphine. However, psychological symptoms and intense cravings may last for years after the acute withdrawal phase.

Citation: Recovery.org. Suboxone Withdrawal. August 17, 2018. Available at: https://www.recovery.org/topics/suboxone/



SLIDE 17:

Though buprenorphine does have a withdrawal pattern, it is less intense than either heroin or methadone.

Citation: Kosten TR, O'Connor PG. Management of Drug and Alcohol Withdrawal. New Engl J Med. 2003; 348(18): 1786-95.

CLOSING

The final component of our training is to discuss co-morbid mental health disorders and pain.

MODULE 15:
Mental Health and Substance Use Disorders

Topics Covered: Mental health, substance use disorders

OBJECTIVES

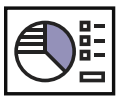
By the end of this module, participants will be able to:

- Identify existing data, including the lack of evidence, for the treatment of mental health disorders in the presence of opioid use disorder.
- Analyze existing expert opinion to create treatment plans for clients with co-occurring mental health and substance use disorders.

Method(s) of Instruction

- Lecture

MATERIALS NEEDED



POWERPOINT

- **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

REFERENCE MATERIALS

- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

PROCESS

Facilitators will briefly discuss the absence of evidence to guide treatment for clients with co-occurring mental health and substance use disorders. Facilitators will offer some key principles to guide practice.

Then, facilitators will review both pharmacotherapy and psychotherapy-based evidence available for the treatment of depression, post-traumatic stress disorder (PTSD), attention-deficit/hyperactivity disorder (ADHD), and anxiety disorders in the presence of substance use disorders. Facilitators will note when specific data regarding the treatment of these mental health conditions in the presence of opioid use disorder is available.

Key Words and Phrases

- *Pharmacotherapy*
- *Psychotherapy*
- *Depression*
- *Post-traumatic stress disorder (PTSD)*
- *Attention-deficit/ hyperactivity disorder (ADHD)*
- *Anxiety*

The approximate length of time the session will take.

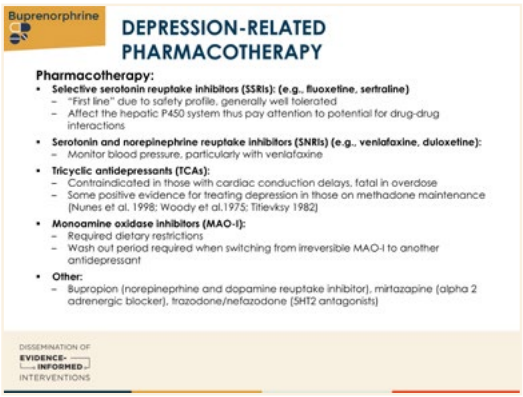
Total: 15 minutes

SLIDE 1:

In this module we will discuss the intersection and treatment considerations for clients who are dually diagnosed with mental health and substance use disorder.

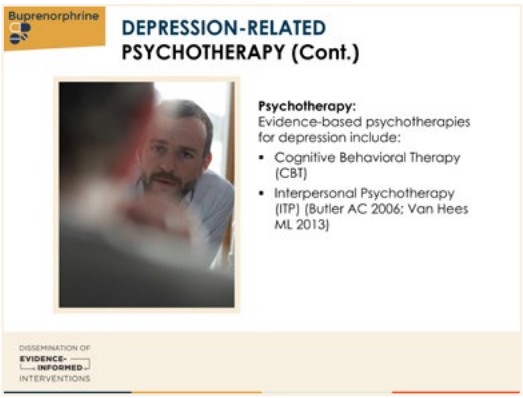
SLIDE 2:

There is a lack of clarity regarding best treatment choices for specific mental health diagnoses in the setting of SUD, and specifically for clients on buprenorphine. An important thread to follow is the need to be cautious with any medications with sedative qualities due to drug interactions. Benzodiazepines would be of the greatest concern, but other medications should be individually checked for interactions and monitored appropriately.



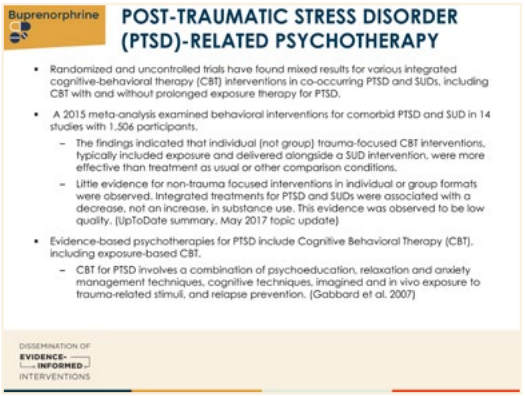
SLIDE 3:

There are no well established guidelines for the treatment of depression in the specific circumstance of a comorbid OUD (or SUD) diagnosis. General guidelines and experience of the prescriber should focus on the value of therapy, the need to check for drug interactions of any chosen drug, and the prior client experience and response to medications.



SLIDE 4:

In addition to pharmacotherapy for depression, therapeutic approaches, including cognitive behavioral therapy (CBT) and interpersonal psychotherapy (ITP) may also be effective treatments.

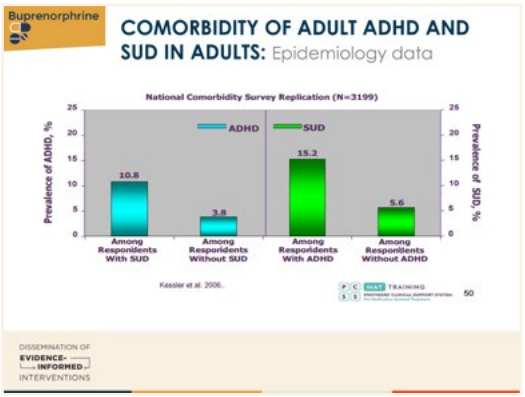


SLIDE 5:

As it relates to PTSD and psychotherapy, a variety of studies large and small indicate potential benefits of individual trauma-focused CBT in combination with SUD therapy. Most of the studies did not clarify the specific substance use issue.

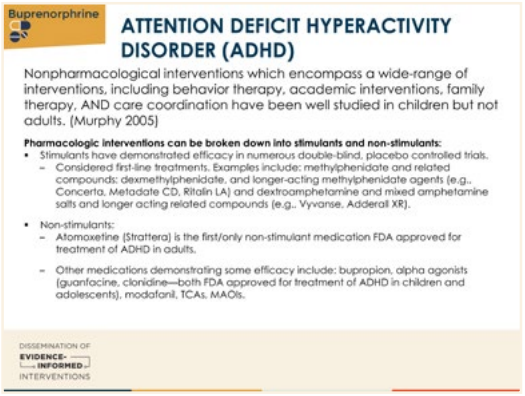
SLIDE 6:

The take-home message is the difficulty in treating PTSD in settings without SUD, and that treatment with SUD has less data, and none specific to OUD. Nonetheless, medication guidelines, like those in the previous slide and in this slide, can help with a clear eye to avoid significant sedative treatment with buprenorphine clients.



SLIDE 7:

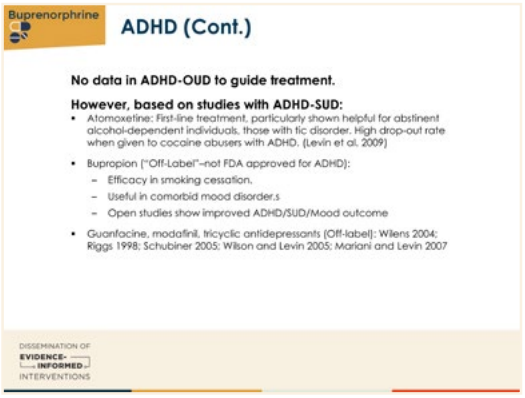
National data demonstrate the significant overlap between SUD and ADHD.



SLIDE 8:

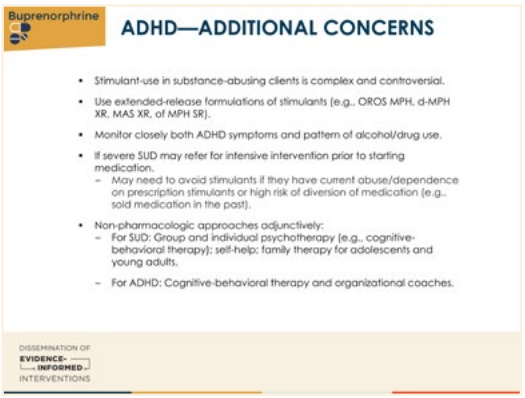
This slide covers the standard options available to treat ADHD. However, in the presence of comorbid SUD, additional factors come into play and are discussed in the subsequent slides.

Citation: Psychiatric Comorbidities Diagnosis and Treatment of Comorbid Psychiatric Disorders and Opioid Use Disorders Frances R. Levin, MD Kennedy-Leavy Professor of Psychiatry Columbia University Medical Center/ New York State Psychiatric Institute Elizabeth A. Evans, MD Fellow, Division on Substance Abuse Department of Psychiatry New York State Psychiatric Institute/Columbia University Medical Center.



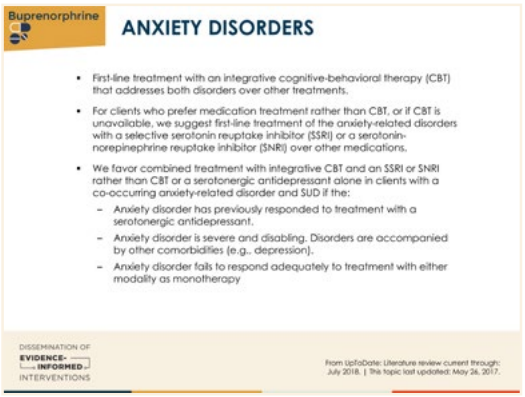
SLIDE 9:

ADHD needs to be carefully diagnosed. As is often the case, guidelines recommend treatment of the SUD first, then with stabilization, making a diagnosis and beginning ADHD treatment. Real-life situations may not be so clean-cut. However, avoidance of stimulant based pharmacotherapy is considered first line of treatment in general for people with SUD.



SLIDE 10:

In clients without a history of stimulant, cocaine, or club-drug abuse, a long-acting stimulant can be used with regular monitoring for signs of abuse, addiction, or diversion.



SLIDE 11:

Anxiety treatment presents a particular concern due to patterns of community practice that often rely on benzodiazepines, which would be inappropriate in the setting of buprenorphine treatment. (Note: The guidelines outlined on the slide should be emphasized by the facilitators, as they represent what little evidence is available, and help maintain a safe practice).

CLOSING

Our last module will review best practices to treat chronic and acute pain in the buprenorphine treatment setting.

MODULE 16:
Pain and Substance Use Disorder

Topics Covered: Pain and Substance Use Disorder

OBJECTIVES

By the end of this module, participants will be able to:

- Discuss differing approaches to chronic versus acute pain in the setting of buprenorphine treatment.
- Reference current, evolving practices for acute pain management.
- Evaluate treatment options for chronic and acute pain.

MATERIALS NEEDED

POWERPOINT

– **Note:** Computer displaying PowerPoint should have the ability to connect to Internet and project to the class.

FLIP CHART SHEETS

REFERENCE MATERIALS

– Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual: https://nextlevel.targethiv.org/deii/buprenorphine

Method(s) of Instruction

- Lecture
- Question and Answer

Key Words and Phrases

- *Chronic Pain*
- *Acute Pain*
- *Analgesic*

PROCESS

Facilitators will start by discussing the different approaches involved in treating chronic and acute pain (such as trauma or major surgery) for clients on buprenorphine for opioid use disorder (OUD).

Facilitators will discuss theoretical concerns as well as the existing evidence surrounding buprenorphine in chronic and acute pain management.

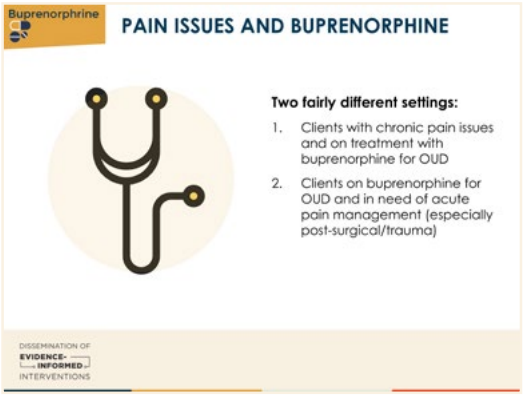
Facilitators will provide current guidance for managing minor, moderate, and severe acute pain in clients on buprenorphine. Facilitators will also describe how treatment guidelines are evolving and advise providers to contact their local hospital systems to understand their policies and procedures for peri-surgical management.

The approximate length of time the session will take.

Total: 15 minutes

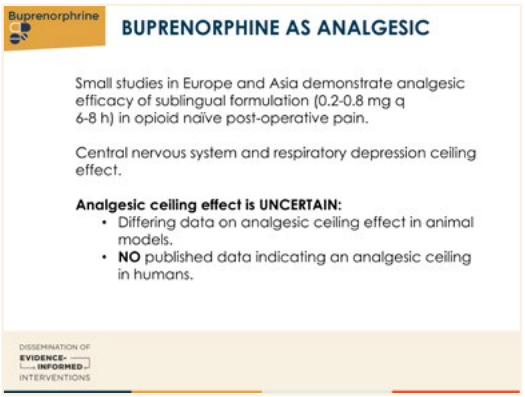
SLIDE 1:

In this module we will discuss pain and substance use disorder.



SLIDE 2:

Chronic pain and acute pain are approached very differently in the setting of buprenorphine prescribing. The issues of chronic pain should already have been considered before prescribing a client buprenorphine for OUD.

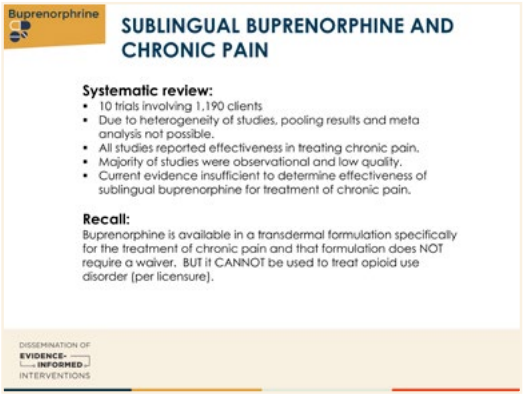


SLIDE 3:

For clients with minor-to-moderate chronic pain, they may get notable benefit from their buprenorphine treatment, and consideration should be given to advising split (q 8 or 12 hr) dosing.

Citations:

WG Edge, GM Cooper, M Morgan. Analgesic effects of sublingual burenorphine. Anaesthesia. May 1979. Vol 34, 463-467.
G. Moa, H. Zetterström. Sublingual buprenophine as postoperative analgesic: a double-blind comparison with pethidine. Acta Anaesthesiol Scand. Jan 1990.



SLIDE 4:

There are reasons—physiologic and clinical studies—to expect some pain response to buprenorphine.

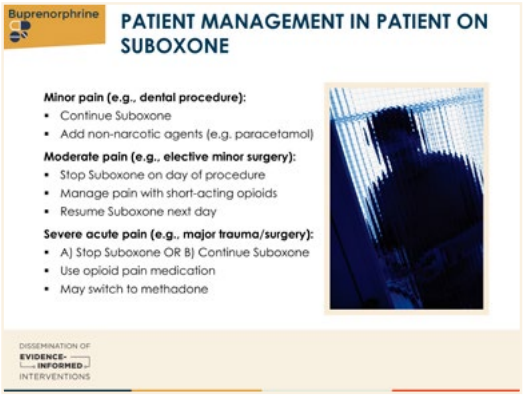
Citation: J Cote, L Montgomery. Sublingual Buprenorphine as an Analgesic in Chronic Pain: A Systematic Review. Pain Medicine. July 2014. Vol 15, Issue 7, 1171-1178.

SLIDE 5:

There are theoretical reasons why opioids would not be effective in the presence of buprenorphine, but the animal models are not consistent.

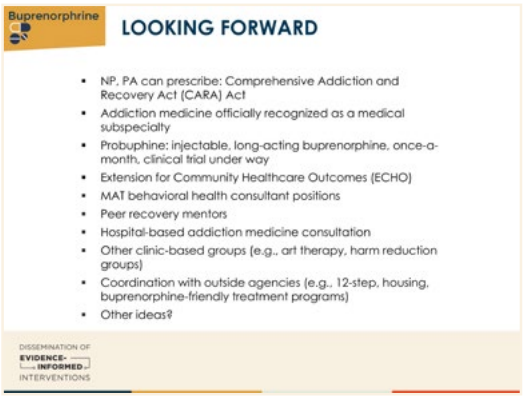
Citations:

T Christoph, B Kögel, K Schiene, et al. Broad analgesic profile of buprenorphine in rodent models of acute and chronic pain. European Journal of Pharmacology. Jan 2005. Vol 507, Issue 1-3, 87-98.
W Englberger, B Kögel, E Friderichs, et al. Reversibility of opioid receptor occupancy of buprenorphine in vivo. European Journal of Pharmacology. Mar 2006. 534 (1-3): 95-102.



SLIDE 6:

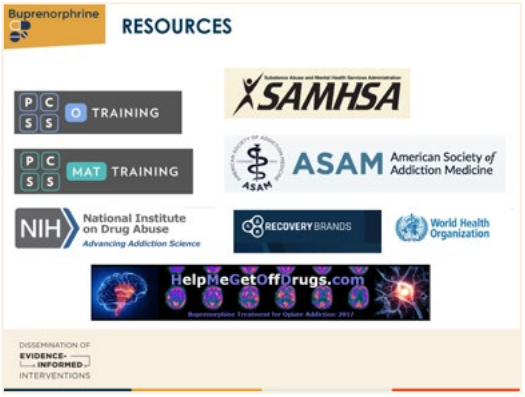
Acute pain management in clients on buprenorphine is an evolving field. Options as noted above have been utilized, though current practice guidelines are in flux and include maintaining buprenorphine with inpatient opiate treatment and close monitoring for major surgery. Large hospital systems have developed guidelines for peri-surgical management of clients receiving buprenorphine. Contacting your local hospitals to understand their policies would be beneficial.



SLIDE 7:

That ends our training. As we wrap up, consider the trends outlined in the slide. These are some topics to watch that are developing in the field of MAT and OBOT.

(**Note:** Facilitators should consider updating these trends with any additional up-to-date information at the time of future trainings).



SLIDE 8:

If additional support is needed, this slide contains a list of sites that are frequently used for MAT/OBOT treatment reference and resources.

CLOSING

This concludes our training. We can now discuss any participant questions.

APPENDICES

Appendix 1:
Checklist for Site Preparation

CheckList for Site Preparation

Item	Yes / No	If no, next steps	Comments
Administrative Leadership			
Positive attitude towards buprenorphine treatment and its goals….	At clinic level …… ……. At system level		Consider politics of your organization
Physician waivers encouraged			Including non-intervention team prescribers
Space			
physical space for visits, induction *(May take up an exam room for more than Usual visit time)*			Induction schedules vs space availability
Offices for team staff			
Team Staff Training			
clinical mentor identified https://pcssnow.org/mentoring/			Important as you gain experience
Team members will act as clinical champions			HIV clinic staff looks to this team as a resource
Substance abuse counselor available			Bup specific experience preferred

Appendix
Checklist for Site Preparation (cont).

Item	Yes / No	If no, next steps	Comments
Team member designated to address bup specific insurance issues.			Could be other clinical staff (Pharm tech)
Ensure patient access (team vacations, etc)			Waivered physicians
All Staff Training			
Previous or planned training(s) in harm reduction, addiction, trauma informed care			Full staff awareness
All Staff are oriented to the new buprenorphine program			Time designated/planned for periodic updates for all staff All Staff role in patient engagement
Program related trainings available to non-intervention team staff			Training material Site visits -offer site visit involvement when able
Front desk and phone triage staff coaching re: opiate withdrawal			Scenarios presented and explained in preparation

Appendix
Checklist for Site Preparation (cont).

Item	Yes / No	If no, next steps	Comments
Medical assistants and nursing staff prepared to work with patients in withdrawal			Offer additional training and support to those staff
Technology			
Technology (computer/internet/ etc) for data entry (grant purposes)			
Internal Systems			
Process for Internal Referrals for Buprenorphine ……. Process for External Intake/Referrals for Buprenorphine	……		…… … Will your site be accepting external referrals
Internal Referral Available? MH A&D	……		

Appendix
Checklist for Site Preparation (cont).

Item	Yes / No	If no, next steps	Comments
Insurance/payment coverage of buprenorphine clarified			Medicaid, commercial, & ADAP policies known Patient assistance program(s) process identified
Pharmacy Plans			On site vs Off site pharmacy stocking of buprenorphine
External Systems			
Referral networks defined MH Counseling SUD Counseling/Treatment Detox Methadone	…… ……		
MOU's Completed where needed			
Item	**Yes / No**	**If no, next steps**	**Comments**
<u>Later expectations</u>			
internal communication plan for your staff, your agency			
external communication plan for community (partners, referral sites, etc)			
development of protocols and procedures			

Appendix 2:
Trauma-Informed Assessment Checklist

Name of Agency: _____

Reviewers: _____

Date of Assessment: _____

Organizational Assessment

Positive Trauma Informed Care Environment

	YES	NO	DID NOT OBSERVE
Welcome Sign Posted	☐	☐	☐
Initial greeting at agency was welcoming	☐	☐	☐
Staff is friendly/respectful/caring/welcoming/calm	☐	☐	☐
Staff offices are welcoming/engaging	☐	☐	☐
Comfort/Healing/Meditation room(s) or comfort, privacy, quiet areas	☐	☐	☐
Space to make private phone calls	☐	☐	☐
Manipulatives and/or soothing kits (play dough, crayons, washcloths, heated blankets, etc.) are available	☐	☐	☐
Age appropriate toys and materials available	☐	☐	☐
Fish tanks	☐	☐	☐
Pet therapy option/opportunity to have pet interaction	☐	☐	☐
Waterfall/fountains	☐	☐	☐
Plants	☐	☐	☐
Comforting music	☐	☐	☐
Soothing smells	☐	☐	☐
Paint colors soothing/calming	☐	☐	☐
Carpet/flooring - safe & non-institutional	☐	☐	☐

Reproduced from: SAMHSA-HRSA Center for Integrated Health Solutions, Adopting Trauma-Informed Approaches in Health Care Settings Innovation Community, 2018. https://www.integration.samhsa.gov/about-us/TIC_Environmental_Scan.pdf

	YES	NO	DID NOT OBSERVE
Lighting is soothing/calming (non-institutional/not fluorescent lighting)	☐	☐	☐
Natural lighting	☐	☐	☐
Operating hours are consumer-friendly	☐	☐	☐
Artwork is:			
Empowering, hopeful, recovery-focused	☐	☐	☐
Culturally diverse	☐	☐	☐
Done by consumers	☐	☐	☐
Soothing/calming	☐	☐	☐
Consumer accomplishments posted/celebrated	☐	☐	☐
Clear, concise, positive signage			
Spanish signage	☐	☐	☐
Consumers screened/assessed for trauma	☐	☐	☐
Consumer referred to trauma services/referral	☐	☐	☐
"Consumer Rights" (includes 'Trauma Rights) are posted several places, clearly visible and consumers are informed of their rights	☐	☐	☐
Consumers/Families are educated about treatment and diagnosis	☐	☐	☐
Consumers are kept informed about any changes in the day's agenda	☐	☐	☐
Trauma/Stress Reduction/Wellness/Recovery materials available	☐	☐	☐
English/Spanish reading materials available in reception area	☐	☐	☐
Veteran Program materials in reception area	☐	☐	☐
Gender specific reading materials are available	☐	☐	☐
Conference rooms/offices are sound proof for confidentiality	☐	☐	☐

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	YES	NO	DID NOT OBSERVE
Assistance to complete paperwork and/or surveys is provided if needed (reading level, audio tapes)	☐	☐	☐
Consumers are encouraged to provide feedback (or surveys) on services/experiences, Grievance Policy is explained	☐	☐	☐
Consumers are encouraged to provide immediate feedback	☐	☐	☐
Seating allows for personal space	☐	☐	☐
Opportunity for consumers to complete forms ahead of appointment/forms available on-line	☐	☐	☐
If there is a smoking area, it is safe and 15- 20 feet away from the building	☐	☐	☐
Non-caffeine drinks or water offered to consumers	☐	☐	☐
Physical environment shows evidence of on-going attention to safe practices	☐	☐	☐
Designated/adequate consumer parking	☐	☐	☐
Parking lot is safe with lights	☐	☐	☐
Bike racks available	☐	☐	☐
Office location is safe	☐	☐	☐
Agency Employed Peer Support and Wellness Specialist	☐	☐	☐
Age appropriate recreational games, crafts, sports equipment, leisure activities available	☐	☐	☐
On-going staff Trauma Informed Care training is offered (including re-traumatization)	☐	☐	☐

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Non-Trauma Informed Care Environment ("No's" are a positive observation)

	YES	NO	DID NOT OBSERVE
Staff using first/last names to identify consumers	☐	☐	☐
Staff dress (uniforms, identification)	☐	☐	☐
Staff not welcoming/friendly	☐	☐	☐
Security guards and procedures	☐	☐	☐
Special staff parking	☐	☐	☐
Staff talk with consumers behind a desk and/or completing paperwork on computer without facing consumers	☐	☐	☐
Consumers kept waiting	☐	☐	☐
Signage (list of do's, don'ts, no's, rules, language of oppression, we/they language)	☐	☐	☐
Glass bubble/wall/glass separating consumers from registration/admission area	☐	☐	☐
Uncomfortable furniture	☐	☐	☐
Chairs or couches that don't allow for personal space (group rooms are crowded)	☐	☐	☐
Chairs with arms only	☐	☐	☐
Paneled wood	☐	☐	☐
Separate bathrooms for staff and consumers	☐	☐	☐
Smoking area located right outside the entrance door	☐	☐	☐
Noisy/chaotic environment	☐	☐	☐
Damaged walls	☐	☐	☐
Dirty facility	☐	☐	☐
Slamming doors	☐	☐	☐
Loud intercom systems	☐	☐	☐
Offices are not inviting/closed doors	☐	☐	☐
Cubicles	☐	☐	☐

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	YES	NO	DID NOT OBSERVE
Religious materials available in reception area	☐	☐	☐
Religious themes in offices	☐	☐	☐

Other:_____

_____

Overall Comments:

What you liked about the environment?

_____

_____

What you didn't like about the environment?

_____

_____

Date: _____ Exit interview completed with _____
(Agency Staff)

Please provide Agency Staff with a copy of the Trauma Informed Environmental Scan.

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Residential Settings (Please also complete this portion if facility is a Residential Setting)

	YES	NO	DID NOT OBSERVE
Staff and consumers are interactive (not separated)	☐	☐	☐
Space available for staff and consumers to talk privately	☐	☐	☐
Staff/consumer name tags are similar	☐	☐	☐
Consumers are welcoming and friendly	☐	☐	☐
Rules are rigid and not age appropriate	☐	☐	☐
Accessibility for privacy	☐	☐	☐
Seclusion and restraint practices	☐	☐	☐
Clear boundaries between men and women (if mixed gender program)	☐	☐	☐
Ability to move bed where it feels safe	☐	☐	☐
Consumers can personalize their rooms (photographs of loved ones)	☐	☐	☐
Consumers are given considerations to feel safe, (e.g. CD player for calming music, reading light after lights out, etc.)	☐	☐	☐
If smoke free campus - (smoking cessation, patches offered)	☐	☐	☐
Outside seating available	☐	☐	☐
Accessibility to nature (green spaces, flower/vegetable garden, trees, birdbath, bird feeders, fish pond)	☐	☐	☐
Medication given privately	☐	☐	☐
Dining areas are comfortable (not cafeteria style)	☐	☐	☐
Consumers are actively involved in menu planning	☐	☐	☐
Options available for healthy meals and snacks	☐	☐	☐
Snacks, coffee, drinks accessible to consumers and visitors	☐	☐	☐
Age appropriate leisure activities, arts, entertainment, etc.	☐	☐	☐

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	YES	NO	DID NOT OBSERVE
Exercise room/equipment available	☐	☐	☐
Labyrinth	☐	☐	☐
Spaces for family visits	☐	☐	☐

Other:_____

_____

_____

Follow-up items needed from Environmental Scan:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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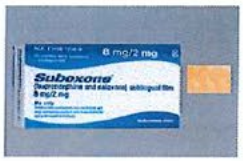
Appendix 3:
Home Induction Instructions: Starting Buprenorphine

STARTING BUPRENORPHINE ("BUPE")
Congratulations on starting treatment!

WHAT IS IN THIS PACKET?

- ✓ 4 Buprenorphine (Bupe) pills or films (8 mg)
  (**There are many different brand names and generic forms of Bupe. Some are shown below.)





- ✓ 6 Ibuprofen pills (200 mg) – for body pain, take 1-2 pills every 8 hours as needed
- ✓ 6 Clonidine pills (0.1 mg) – for anxiety, take 1 pill every 8 hours as needed
- ✓ 6 Immodium pills (2.0 mg) – for diarrhea, take 1 pill after each episode of diarrhea. Max 6 pills per day

WHEN AM I READY TO START BUPE?

- ✓ Use the list of symptoms below to see when you are ready to start Bupe.
- ✓ Wait until you have **at least 5 symptoms** to start Bupe. If you don't have 5 symptoms, wait a bit longer and review the symptoms again. It is very important that you wait until you feel at least 5 symptoms before starting Bupe!

Symptoms	Do I have this?
I feel like yawning	☐ Yes
I'm sweating	☐ Yes
My nose is running	☐ Yes
I have goose bumps	☐ Yes
I am shaking	☐ Yes
I have hot flashes	☐ Yes
My bones & muscles ache	☐ Yes
I feel unable to sit still	☐ Yes
I feel nauseous	☐ Yes
I feel like vomiting	☐ Yes
My muscles twitch	☐ Yes
I have cramps in my stomach	☐ Yes
I feel like using	☐ Yes

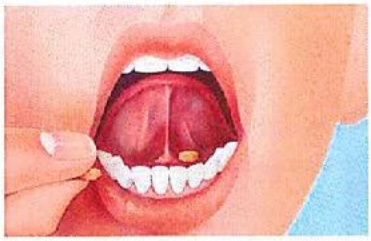
Reproduced from: Dissemination of Evidence-Informed Interventions Initiative. Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual-DRAFT. https://nextlevel.targethiv.org/sites/default/files/file-upload/interventions/Integrating.-Buprenorphine-Manual.pdf

Appendix
Home Induction Instructions: Starting Buprenorphine (cont).

THINGS *NOT TO DO* WITH BUPE

- DON'T use Bupe when you are high—it will make you dope sick!
- DON'T use Bupe with alcohol –this combination is **not safe**.
- DON'T use Bupe with benzos (like Xanax ("sticks"), Klonopin, Valium, Ativan) unless prescribed by a doctor who knows you are taking Bupe.
- DON'T use Bupe if you are taking pain killers until you talk to your doctor.
- DON'T use Bupe if you are taking more then 60 mg of methadone.
- DON'T swallow Bupe – it gets into your body by melting under your tongue.
- DON'T lose your Bupe – it can't be refilled early.

HOW TO TAKE BUPE



- ✓ **Before** taking Bupe, drink some water.
- ✓ Put Bupe under your tongue.
- ✓ **Don't** eat or drink anything until the Bupe has dissolved **completely**.

PLAN

- Use your last heroin / methadone / pain pill: _____
- When you have at least 5 symptoms from the list, then you are ready to start.
- Start with _____ pill or film under your tongue.
- Wait _____ minutes.
- If you feel the same or just a little better, then take another_____ pill or film
- Wait 2 hours – if you still feel sick or uncomfortable, take another _____ pill or film.

PROBLEMS? QUESTIONS?

- Call _____ at _____.
- Call _____ if you still feel sick after taking a total of _____ pills or film (____ mg).

NEXT STEPS

- Appointment with _____ at _____
- Appointment with Dr. _____ at _____

Reproduced from: Dissemination of Evidence-Informed Interventions Initiative. Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual-DRAFT. https://nextlevel.targethiv.org/sites/default/files/file-upload/interventions/Integrating.-Buprenorphine-Manual.pdf

Appendix
Home Induction Instructions: Starting Buprenorphine (cont).

WHAT I TOOK

	Time	Amount of pills or films
Day 1	_____am / pm _____am / pm _____am / pm _____am / pm	_____ _____ _____ _____
Day 2	_____am / pm _____am / pm _____am / pm _____am / pm	_____ _____ _____ _____
Day 3	_____am / pm _____am / pm _____am / pm	_____ _____ _____

Reproduced from: Dissemination of Evidence-Informed Interventions Initiative. Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care Implementation Manual-DRAFT. https://nextlevel.targethiv.org/sites/default/files/file-upload/interventions/Integrating.-Buprenorphine-Manual.pdf

Appendix 4:
Buprenorphine Assessment Smart Phrase

BUP Assessment = MSMBUPASSESS

SUBJECTIVE

@NAME@ is a @AGE@ @SEX@ who has been dealing with issues of opiate use. @HE@ has been struggling with ongoing use of *** . @HE@ relates behaviors associated with @HIS@ opiate use, including:

Buying or selling opiates	{YES/NO:63::"Yes"}
Unable to control use	{YES/NO:63::"Yes"}
Excessive time acquiring, using or recovering	{YES/NO:63::"Yes"}
Use negatively affects work, school or home life	{YES/NO:63::"Yes"}
Endangered him/herselfor others from /while using	{YES/NO:63::"Yes"}
Tried to cut back on @HIS@ use?	{YES/NO:63::"Yes"}

@HE@ {DOES/DOES NOT:10028} have a history of previous detox attempts from opiates
@HE@ {DOES/DOES NOT:10028} have a period of abstinence from opiate use in the past. ***
In addition to the described opiate use, @HE@ reports the use of other substances:

Alcohol	{YES/NO:63::"Yes"}
Benzodiazepines	{YES/NO:63::"Yes"}
Barbituates	{YES/NO:63::"Yes"}
Stimulants (amphetamines,cocaine, crack,meth, etc).	{YES/NO:63::"Yes"}
Hallucinogens	{YES/NO:63::"Yes"}
Inhaled solvents	{YES/NO:63::"Yes"}

If "yes" to any above: details *** (last use & frequency, route of use, relative amounts)

Though @HE@ describes the above substance use pattern, @HE@ reports that @HE@ {DOES/DOES NOT:10028} have significant issues with chronic pain. ***

In addition to these concerns about substance use, @HE@ {IS/IS NOT:9024} taking HIV medications, and reports @HE@ missed *** doses in the past *** days, and the following medication side effects: {SIDE EFFECTS:10359}.

@HE@ has already been assessed for chronic medical conditions that require medical monitoring, treatment or prevention (hepatitis, STD's, TB, and tobacco use). These conditions are either stable or treated .

Appendix
Buprenorphine Assessment Smart Phrase (cont).

OBJECTIVE:
@VS@

General: {GEN APP:50::"alert, no apparent distress"}

15 min of 25 min spent in face to face discussion reviewing issues & options for treatment of @HIS@ opiate use, discussing @HIS@ labs and their meaning, and establishing a plan for @HIS@ care

ASSESSMENT /PLAN:
Tentative DSM 5 diagnosis of Opiate Use Disorder

Based on the history above, as well as the review of the client's past medical history, @HE@ appears to meet criteria for opiate use disorder. Since there {IS/IS NOT:9024} evidence of significant sedative or alcohol use, @HE@ {DOES/DOES NOT:10028} require referral to a treatment program.

I have advised the client that @HE@ is a potential candidate for buprenorphine treatment, and will have @HIM@ see the clinic alcohol/drug counselor for a formal assessment, confirmation of diagnosis, and planning for induction.

Medications have been reviewed, and there {IS/IS NOT:9024} concern for drug interactions.
PDMP reviewed and {IS/IS NOT:9024} of concern.

- UDS ordered
- Buprenorphine education begun, and 'kick-packs" prescription will be written once induction scheduled (clonidine & loperamide with over the counter pain medication)
- Overdose prevention discussed and naltrexone prescribed.

@DIAG@

Appendix 5:
Opioid Metabolization Chart

URINE DRUG TESTING
A Reference Guide for Clinicians

In this guide:

When to order UDT

Two types of tests

Interpreting UDT results

Discussing UDT with patients

Ordering Urine Drug Tests

When should I order urine drug tests?

1. Before prescribing controlled substances
2. Regularly throughout treatment
   - For all patients, at least every 6 months
   - More frequently for higher risk patients

     Risk factors include: personal or family history of substance abuse, tobacco dependence, mental health disorders, young age (<45), caucasian race, and previous red flag behaviors like requesting early refills, losing prescriptions, obtaining opioids from other sources, or unexpected UDT results

Which type of test should I order?

-or-

SCREENING TEST	CONFIRMATORY TEST
Method: Enzyme-based immunoassay (EIA)	Method: Gas chromotography/ mass spectrometry (GC/MS) or Liquid chromotography & tandem MS
Logistics: Inexpensive Fast Widely available	Logistics: More expensive Takes longer Often sent-out
Results: Susceptible to false positive & false negative results (see table) Opiate screen not sensitive for semi-synthetic (e.g., oxycodone) or synthetic opioids (e.g., fentanyl)	Results: Highly sensitive Highly specific Specifies drugs within class Reports concentration even if low (no cut-off)

Reproduced from: Joanna L. Starrels, MD, MS and Bryan Wu, MS. Albert Einstein College of Medicine & Montefiore Medical Center. Bronx, NY. Supported by the National Institute on Drug Abuse (5K23DA027719). Updated May 2013.

Appendix
Opioid Metabolization Chart (cont).

Table: Quick Guide to Urine Drug Testing

RESULTS

⊕ Should be +
\+ Might be +
F Potential false +

DRUGS TAKEN		Screening Test Results (EIA)										Confirmatory Test Results (GCMS)										Common Detection Time
		Amphetamines	Barbiturates	Benzodiazepines	Buprenorphine	Cocaine	Methadone	Opiates	Oxycodone	PCP	Cannabis	Buprenorphine, norbup.	Codeine, norcodeine	Fentanyl	Hydrocodone	Hydromorphone	Meperidine, normep.	Methadone	Morphine	Oxycodone	Oxymorphone	Heroin (6-MAM)	
Prescription Opioids	Buprenorphine				⊕							⊕											1-6 days
	Codeine							⊕					⊕		+				+				1-3 days
	Fentanyl													⊕									24 hours
	Hydrocodone							⊕[1]							⊕	+							1-3 days
	Hydromorphone							+[1]								⊕							1-3 days
	Meperidine																⊕						2-3 days
	Methadone						⊕											⊕					1-3 days[2]
	Morphine							⊕								+			⊕				1-3 days[2]
	Oxycodone							+[1]	⊕											⊕	+		24 hours
	Oxymorphone								⊕												⊕		24 hours[2]
Illicit Drugs	Amphetamines	⊕																					1-3 days
	Barbiturates		⊕																				24 hours[2]
	Benzodiazepines			+[3]																			3 days[2]
	Cocaine					⊕																	1-4 days[2]
	Heroin							⊕					+						⊕			+	1-3 days[2]
	PCP									⊕													1-3 days[2]
	Cannabis										⊕												1-3 days[2]
Other	Poppy seeds[4]							F					F						F				
	Other medications[5]	F	F	F	F		F	F	F	F	F												

1. Sensitivity of opiate screen to semi-synthetic opioids varies by lab. Generally, hydrocodone > hydromorphone > oxycodone. Higher dose is more likely to yield a + opiate screen. Consider confirmatory test, especially to confirm negative for rx'd drug.
2. Chronic use may result in longer detection times. 6-MAM is pathognomonic for heroin use, detection time is 12-24 hours.
3. Benzodiazepine screen likely positive if alprazolam or diazepam taken, likely negative if clonazepam, lorazepam. Varies by lab.
4. Heavy poppy seed ingestion (3+ bagels) may test positive for opiates-- repeat off poppy seeds.
5. Some commonly used medications reported to cause false + results on screening assays are below-- order confirmatory test.
   Amphetamine: buproprion, SSRIs, chlorpromazine, mexilitene, pseudoephedrine, decongestants, ranitidine, trazodone, labetalol
   Barbiturate: ibuprofen, naproxyn, phenytoin. Benzodiazepine: sertraline, oxaprozin.
   Buprenorphine: tramadol, other opioids. Cocaine: none confirmed. Coca leaves or dental use cause rare true +.
   Methadone: diphenhydramine, doxylamine, clomipramine, chlorpromazine, quetiapine, thioridazine, tramadol, verapamil.
   Opiate: dextromethorphan, diphenhydramine, fluoroquinolones, quinine, rifampin.
   Oxycodone: naloxone, see list for "opiates." PCP: dextromethorphan, diphenhydramine, ibuprofen, tramadol, venlafaxine.
   Cannabis: dronabinol, PPIs. Note that ibuprofen does NOT cause false + using modern tests (previously did).

Appendix
Opioid Metabolization Chart (cont).

Interpreting UDT Results

What if result is positive for a non-prescribed drug?

Possibilities are:

1. False positive (on screen) -- order confirmatory test
2. Substance detected is a metabolite of a prescribed drug (see metabolic pathways)
3. Patient ingested the drug, or drug that metabolizes to it (see Opioid Metabolic Pathways)
4. Lab error or contamination

**Consider all the possibilities before acting on UDT results*

What if result is negative for the prescribed drug?

Possibilities are:

1. Urine drug screen won't reliably detect the prescribed drug (see Table) -- order confirmatory test
2. Drug present but concentration is below the cutoff for a positive result (on screen) -- order confirmatory test
3. Urine is diluted (physiologic or tampering)
4. Patient is a fast-metabolizer
5. Patient has not taken drug recently
6. Patient is diverting medication
7. Urine is adulterated or substituted

**Consider all the possibilities before acting on UDT results*

Is the specimen valid?

A valid urine sample has the following:

- Temperature 90-100 F (within 4 minutes of voiding)
- pH 4.5 to 8.5
- Creatinine >20mg/dl
    - <20mg/dl is dilute
    - <5 is not consistent with human urine

Discussing UDT

Before requesting urine, always ask:

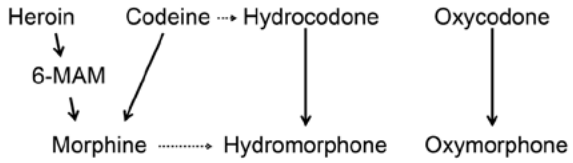
- When did you take your last dose? How much?
- In the past week, have you taken any other pain medicine?
- In the past week, have you used any drugs?

**Documentation of this is crucial for interpreting UDT results*

Language for introducing drug testing

- "As part of treating [pain] with medications like [X], I order urine tests to get more information about how safe they are for patients."
- "The test measures a number of medications and drugs that could interfere with your treatment."
- "This is something I do with ALL patients on these medications."
- "If I find something unexpected, we'll talk about it and work together to address it."

Opioid Metabolic Pathways



Created by Joanna L. Starrels, MD, MS and Bryan Wu, MS. Albert Einstein College of Medicine & Montefiore Medical Center. Bronx, NY. Supported by the National Institute on Drug Abuse (5K23DA027719). Updated May 2013.

Email: jostarre@montefiore.org

Appendix 6:
Preparation for Presentation: Buprenorphine Intervention Updates

BUPRENORPHINE INTERVENTION UPDATES

Please fill out this form and bring the completed form with you to the training. The form will guide a presentation you will deliver.

1. # of clients total enrolled in the intervention: _____
2. # of clients active of those enrolled in the intervention:_____
3. # of clients no longer in care: _____

If not in care, list reasons for not in care (i.e., lost to f/up, transition to higher level of care)

4. **Inductions:** Please briefly summarize your experience with inductions to date.

5. **Referrals:** Please list referrals you frequently provide to clients for other services in the community.

6. **Naloxone:** What is the availability of naloxone kits in your community?

7. **Insurance:** Have you experienced any insurance challenges, including concerns with prior authorizations, dose amount, or brands.

8. **Staffing:** Have you experienced any staffing changes? What was the effect of the change?

9. **Notes:** Have you experienced any challenges with charting? Have you implemented any tools like smartphrases with Epic-based systems?

10. Any other updates you would like to share?