



## Opioid Abuse and Addiction Management Protocol

### All Team Members: Patient Self-Management Education and Support

Opioid abuse and addiction is a serious problem in the United States. Opioids are drugs with pain-relieving and sedative properties which contain opium or one or more of its natural or synthetic derivatives. The natural opioids (referred to as opiates) include opium and morphine. Heroin is synthesized from opium. Synthetic opioids (only made in laboratories) include methadone, codeine, OxyContin, Percocet, and most other prescription pain medications. In 2010, 2 million people reported using prescription pain medication nonmedically for the first time within the past year - nearly 5,500 every day.<sup>1</sup>

Coinciding with the increasing abuse of opioids is an increasing rise in overdose deaths. In 2010, New Mexico ranked 2nd in the nation for age-adjusted death rate from drug-induced causes with 24.3 deaths per 100,000, exceeded only by West Virginia (29.3).<sup>2</sup> The national drug-induced death rate was 12.9 per 100,000; Washington State was slightly higher than the overall national rate at 13.8 deaths per 100,000.<sup>3</sup> In 2007 in New Mexico, the number of deaths from prescription drugs exceeded the number of deaths from illicit drugs; in that same year, poisoning surpassed motor vehicle accidents as the #1 cause of unintentional injury death in New Mexico.<sup>4</sup>

### Opioid Screening - All Patients

<sup>1</sup> *Policy Impact: Prescription Painkiller Overdoses*, Centers for Disease Control and Prevention, December 2011.

<sup>2</sup> Murphy, SL, Xu, J, and Kochanek, KD. *Deaths: Final Data for 2010, National Vital Statistics Report*, Volume 61, Number 4, Centers for Disease Control and Prevention, May 8, 2013.

<sup>3</sup> Murphy, SL, Xu, J, and Kochanek, KD. *Deaths: Final Data for 2010, National Vital Statistics Report*, Volume 61, Number 4, Centers for Disease Control and Prevention, May 8, 2013.

<sup>4</sup> *The State of Health in New Mexico 2013*, NM Department of Health.



## ECHO Access Opioid Use Disorder Treatment Guideline CHW - Initial Screening

- assess any patients with high or moderate risk scores for opioid use on readiness to change using the Stages of Change Model (refer to ***Introduction to Stages of Change Model*** Power Point from ECHO Care face-to-face training)
- provide basic information about medication-assisted treatment (MAT) for opioid addiction for any patients with high or moderate risk scores for opioid use (see MAT section below)
- provide harm reduction education (including information on naloxone) to any patients with high or moderate risk scores for opioid use (refer to ***Harm Reduction for Alcohol and Other Drugs*** and ***Saving a Life: What to do in case of opioid overdose***)
- refer any patients with high or moderate risk scores for opioid use to NP for further assessment

### NP/PA - Patients with High or Moderate Risk Screening Scores: Initial Assessment

- assess for opioid dependence (using DSM-5 Opioid Substance Use Disorder criteria)
- assess for co-occurring substance use or psychiatric disorders and/or concurrent medical conditions → refer to counselor as needed
- assess for possible drug interactions with prescribed medications
- build on the readiness for change information and basic MAT education provided by the CHW at initial screening to further assess and educate the patient on treatment options
- offer HIV, Hepatitis B and C screening (especially if history of injection drug use)
- refer any patient testing positive for Hepatitis C to NP/PA for further assessment
- offer combined Hepatitis A/B vaccine (Twinrix)
- use the Stages of Change Model and Motivational Interviewing to assess and assist referred patients to develop a realistic action plan for change
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### Medication-assisted Treatment (MAT) for Opioid Addiction

Medication-assisted treatment (MAT) combines the use of prescription medications with counseling and behavioral therapies to treat addiction. *Using medications to reduce cravings, avoid relapse, or decrease the frequency and effects of drug or alcohol use can offer hope and reduce the emotional and social costs of substance abuse and addiction.*<sup>5</sup> MAT for opioid addiction provides:

- a medical model for the treatment of opioid dependence
- treatment for opioid dependence as a chronic, relapsing disease
- substitution of an opioid-like medication to prevent withdrawal and minimize cravings

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<sup>5</sup> Smith, JK, PhD, LCSW, *Drugs for Drugs - Medications to Treat Addictions*, Social Work Today, Vol. 7, No. 6, November/December 2007.



## ECHO Access Opioid Use Disorder Treatment Guideline

There are two (2) main medications used to treat opioid addiction - methadone and buprenorphine. They are long-acting opioids that are used to treat both withdrawal symptoms and drug cravings in people addicted to short-acting opioids. A third medication - naltrexone - is an opioid antagonist (see definitions below) and is used on a limited basis for the treatment of opioid addiction. All three (3) will be discussed after the definitions section.

It is important to emphasize to patients that while methadone, buprenorphine, and naltrexone can be important aids in treating opioid addiction, they are not meant to be stand-alone treatment. Counseling and/or participation in 12-step or other peer support groups are integral components of the holistic and successful treatment of opioid addiction.

### **Definitions<sup>6</sup>**

A few definitions are helpful to understand the differences between the two main medications used to treat opioid addiction - methadone and buprenorphine - and the medication used to treat opioid overdose - naloxone.

**Agonist** - a drug that activates receptors in the brain by binding to receptors and turning them on. Opioids bind with specific receptors, called mu opioid receptors, to produce their pain-relieving and sedative and high-inducing effects.

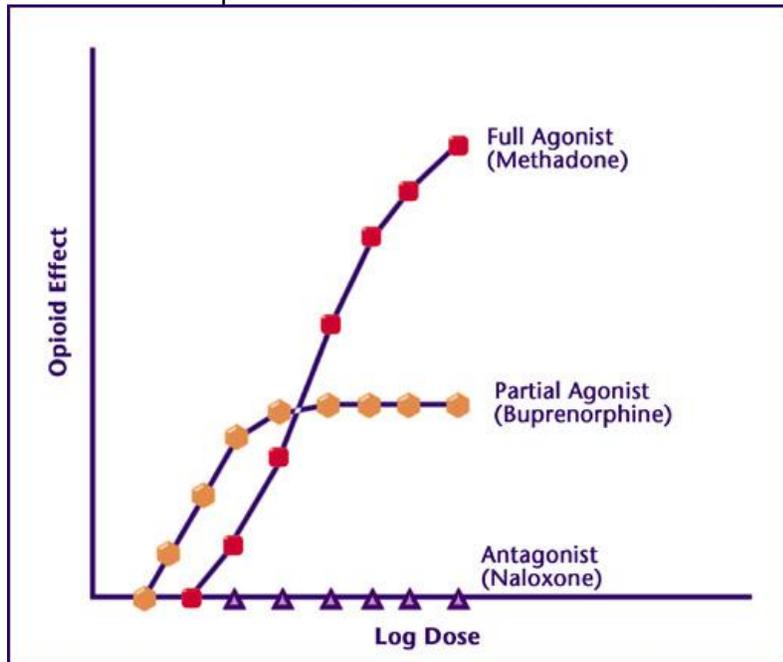
**Full Agonist** - a drug that produces increasing effects as more is used. Opioids that are full agonists have the highest abuse potential, and include heroin, methadone, morphine and oxycodone.

**Partial Agonist** - a drug that binds to receptors and activates them, but not to the same degree as a full agonist. At a certain point, partial agonists - such as buprenorphine - reach their maximum effect level, so that increasing doses do not produce increasing effects. This is called the "ceiling effect."

**Antagonist** - a drug that nullifies the effects of another drug without producing its own effect. Naloxone is an opioid antagonist that can reverse an opioid overdose by blocking the opioid's effect on the brain.

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<sup>6</sup> The National Alliance of Advocates for Buprenorphine Treatment, Glossary of Terms, <http://www.naabt.org/glossary.cfm#A>.



from *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*, Treatment Improvement Protocol (TIP) Series 40, DHHS Publication No. (SMA) 04-3939. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2004.

[http://www.naabt.org/links/TIP\\_40\\_PDF.pdf](http://www.naabt.org/links/TIP_40_PDF.pdf)

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**Methadone** was first synthesized in Germany during World War II and has been used for the treatment of opiate addiction for over 50 years. Although methadone may be prescribed as pain medication, methadone for the treatment of opioid addiction can only be prescribed in licensed methadone maintenance clinics which must comply with federal and state regulations. Some facts on the use of methadone for opioid addiction include:

- requires daily observed dispensing (six days a week) for first six months
- clients may eventually receive a 14-30 day supply to take at home
- best outcomes are achieved when patients are maintained for long periods of time (at least one year) on high doses (80 to 120 mg daily) of methadone. Strong data suggests that lifelong use of methadone is helpful for many patients
- a low dose of methadone will prevent withdrawal symptoms
- higher doses (80-120mg daily) are needed to minimize craving for opiates
- Methadone is a full-agonist, and although methadone for the treatment of opioid addiction is difficult to abuse because of observed dosing, other opioids can be used at other times during the day, potentially leading to opioid overdose. Patient education about this possibility is important
- Medicaid Salud insurance pays for methadone for treatment of opioid addiction

ECHO Access clients who are successfully being treated for opioid addiction with methadone should be supported and encouraged to continue this treatment.



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**Naltrexone** is an opioid antagonist that is used for the treatment of both alcohol and opioid addiction. It blocks opioid receptors so that other opioids cannot attach and cause a "high." It is not used extensively for the treatment of opioid addiction because it does not control drug cravings for most patients as well as either methadone or buprenorphine. Naltrexone in pill form is most commonly used to treat alcohol dependence. An extended-release injectable form, called **Vivitrol®**, was approved as a treatment for opioid addiction in 2010. Some facts about Vivitrol include:

- it is a once a month shot and is considerably more expensive than either methadone or buprenorphine
- it can only be started after detox from opioids. Patients generally need to stop taking any opioids 7-10 days prior to starting naltrexone
- it is an office-based treatment which can be prescribed by any clinician with prescribing authority, including nurse practitioners and physician assistants
- it may work well for patients highly motivated to stay abstinent
- cannot be used for patients who need to take opioids for pain control or who have advanced liver disease, including patients with Hepatitis C (common in patients with a history of injection drug use)
- not usually covered by Medicaid Salud insurance.

**Buprenorphine** was first synthesized for pain relief in England in 1969. Buprenorphine in pill form was approved by the FDA for the treatment of opioid addiction in 2002; a sublingual film was approved in 2010. Buprenorphine is a long-acting, partial agonist and the first office-based treatment for opioid addiction. Because of the "ceiling effect" of buprenorphine, it has less abuse potential than other opioids, produces less euphoria, and has a milder withdrawal profile.

The most commonly used forms of buprenorphine are **Suboxone®** and **Subutex®**. **These medications, and their generic counterparts, are available as tablets or film strips that dissolve under the tongue.** Suboxone combines buprenorphine with naloxone (an opioid antagonist) to reduce injecting it. When dissolved under the tongue, naloxone is not absorbed, so is not active to cause withdrawal. If someone tries to misuse Suboxone in order to become intoxicated, they will typically dissolve it and inject it or snort it; in this case it is likely to cause unpleasant withdrawal symptoms, which discourage misuse. Subutex is buprenorphine alone, and in the U.S., is mostly used for pregnant women. A new buprenorphine/naloxone combination called **Zubsolv®** was approved by the FDA in July 2013, and there are several other formulations of buprenorphine currently under review by the FDA for use as treatment for opioid addiction.

Buprenorphine can only be prescribed by physicians (not Nurse Practitioners or Physician Assistants) who have completed an approved 8-hour course and have received a DEA-license number specific to buprenorphine treatment. ECHO Teams will work in collaboration with a physician licensed to prescribe buprenorphine (if present at your clinical site), with NPs providing much of the patient medical oversight



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and monitoring. All ECHO Team members, including CHWs, will provide patient education, psychosocial support, and referrals as needed.

Project ECHO's Integrated Addictions and Psychiatry program offers free buprenorphine trainings for health care providers several times a year. All ECHO Access members are encouraged to attend one of these trainings.

Some facts on the use of buprenorphine for opioid addiction include:

- the usual daily dosage of buprenorphine is 16-24mg, which can be taken at one time in the morning or in divided doses during the day
- because buprenorphine at treatment dosage fills all the opioid receptors in the brain, the use of other opioids will have no effect (e.g., clients will not get "high" if they take other opioids)
- most street-use of buprenorphine is to help with withdrawal from opioids, not to get "high"
- opioid-naive people (not physically dependent or addicted) CAN get high from buprenorphine
- buprenorphine used in combination with benzodiazepines (anti-anxiety drugs such as Valium or Xanax) is very dangerous and can cause severe respiratory depression → death
- **Buprenorphine is extremely dangerous to infants and children** - even small amounts can cause respiratory suppression and death. It must be locked securely at all times
- Medicaid Salud insurance pays for buprenorphine, but requires prior authorization paperwork.

### **ECHO Team Member Duties and Responsibilities for Buprenorphine Treatment**

Following the steps outlined early in this protocol for initial screening of all patients, your patient fits the criteria for Opioid Substance Use Disorder, is within the Contemplation- Preparation-Action continuum of the Stages of Change Model, and has expressed an interest in starting buprenorphine treatment.

What happens next?

### **NP/PA - Initial Treatment Phase – When there is a suboxone-prescribing physician present in your clinical site**

- complete **history and physical exam**, including liver function testing (LFTs)
- order **urine drug screening** for presence of opioids, benzodiazepines and other illicit drugs (see *New Mexico Treatment Guidelines for Medical Providers who Treat Opioid Addiction Using Buprenorphine*, pages 55-58 and 134-138)
- check the **NM Prescription Monitoring Program** for any prescriptions for controlled substances [http://www.rld.state.nm.us/boards/Pharmacy\\_Prescription\\_Monitoring\\_Program.aspx](http://www.rld.state.nm.us/boards/Pharmacy_Prescription_Monitoring_Program.aspx)
- review and sign a **Treatment Agreement** with the patient (see *New Mexico Treatment Guidelines for Medical Providers who Treat Opioid Addiction Using Buprenorphine*, pages 37-38 and 120-121). (CHW may initially complete the Treatment Agreement with the patient - NP/PA and prescribing physician should review it). Key points of Treatment Agreements include:
  - no diversion (selling or sharing) of buprenorphine
  - no use of benzodiazepines, heavy alcohol, or carisoprodol (increases risk of overdose)



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- no "doctor shopping" - visiting multiple clinicians for multiple prescriptions
- cooperate with urine testing and/or other monitoring requested by clinicians
- participate in counseling or support groups
- educate patient and provide detailed instructions on **buprenorphine induction**, either in the office or at home (see *New Mexico Treatment Guidelines for Medical Providers who Treat Opioid Addiction Using Buprenorphine*, pages 43-49, 128-130, and 132-133) - **patient education may also be provided one-to-one or in a group setting by another member of the ECHO Team**
- ensure that patient has received harm reduction education and has access to naloxone
- referral to **collaborating physician** for buprenorphine prescription

### NP/PA - Monitoring Treatment/follow-up appointments

- order follow-up labs (e.g., LFTs) and urine drug testing as needed
- monitor patient for any medication-related problems (see *New Mexico Treatment Guidelines for Medical Providers who Treat Opioid Addiction Using Buprenorphine*, pages 49-52)
- continue to provide patient education and support as needed
- complete series of Hepatitis A/B vaccine (Twinrix) - 3 vaccinations over 6 months

### CHW - Initial and Ongoing Treatment

- act as "point of contact" for patients needing additional education and/or support
- provide ongoing psychosocial support and/or referrals for 12-step and/or other peer support programs (NA <http://riograndena.org/>, Smart Recovery [www.smartrecovery.org](http://www.smartrecovery.org), etc.)
- provide referrals for additional social services as needed, including programs for food, clothing, shelter, childcare, etc.

### CHW & NP - Initial and Ongoing Treatment

- provide crisis counseling and/or ongoing therapy as needed to support patients in treatment
- perform or refer for any indicated psychiatric tests
- facilitate ongoing support groups as indicated by patient interest and caseload
- provide referrals for psychiatric consults or in-patient treatment as needed
- collaborate with patient to develop a relapse-prevention plan
- provide education, support, and consultation for other members of OIT as needed

### Resources



## ECHO Access Opioid Use Disorder Treatment Guideline

- National Alliance of Advocates for Buprenorphine Treatment – includes education for patients and on-line support communities <http://www.naabt.org/#>
- Komaromy, M, Buser, R, Silver, H, Hayes, L, Bohan, J, Duhigg, D, Mount, B, Block, J, Weiss, J, and Cianciabella, S. *New Mexico Treatment Guidelines for Medical Providers who Treat Opioid Addiction Using Buprenorphine*, NM Behavioral Health Collaborative, 2012.
- Pharmacotherapy for Substance Use Disorders, SAMHSA website <http://www.dpt.samhsa.gov/medications/medsindex.aspx>
- SAMHSA buprenorphine guidelines: TIP 40, pub # 04-3939 <http://kap.samhsa.gov/products/manuals/index.htm>
- *Medication-Assisted Treatment for Opiate Addiction: Facts for Families and Friends*, SAMHSA Center for Substance Abuse Treatment, 2009. [http://centerforplainlanguage.org/downloads/clearmark2010/065\\_KAP\\_MAT.pdf](http://centerforplainlanguage.org/downloads/clearmark2010/065_KAP_MAT.pdf)