Addressing Opioid Use Disorder in Primary Care

John Nusser, MD MS
Faculty Physician, Family Medicine SW Washington
Medical Director for Testing (WA), Cascade AIDS Project
Faculty, Oregon AETC

Andrew Seaman, MD
Physician, Old Town Clinic at Central City Concern
Assistant Professor of Medicine,
Oregon Health & Science University

Last Updated: March 2021

Oregon Health Authority

END HIV

AETC AIDS Education & Training Center
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Land Acknowledgment

The Oregon AETC would like to take a moment to recognize the unceded ancestral lands of the first people. We pay respects to their elders, past and present. Please take a moment to consider the many legacies of violence, displacement, migration, and settlement that bring us together here today.

Infectious diseases do not discriminate. As part of our response to the HIV epidemic, we must elevate those groups who have been historically marginalized in our communities. It is our responsibility to listen, recognize, and bring their experiences to the forefront.

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Your Zoom Hosts

Send a private chat to these folks for any technical issues

- Abby Welter
- Rachel Greim
- Ashley Allison
- Dayna Morrison

This presentation is being recorded

- In order to have this presentation as a resource, we are recording this session and will provide the video following the event.
- All chats (private or public) will be automatically downloaded.
- Please participate and enrich our presentation.

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Disclosures

No conflicts of interest or relationships to disclose.

Content Acknowledgement

The Oregon AETC and OR-HOPE would like to thank the following team of people who helped inform this curricula:

Todd Korthuis, MD, MPH
John Nusser, MD, MS
Jude Leahy, MPH
Dayna Morrison, MPH
Jim Winkle, MPH
Susan Collins, PhD
Andy Seaman MD
Rae Wright, MD
HIV Alliance Staff
Peers

Oregon – HOPE partners

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Objectives

- Understand opioid use disorder (OUD) trends in Oregon
- Describe why primary care is well-suited for treating opioid use disorders
- Articulate steps to integrate buprenorphine into your practice

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Zoom polling question

On a scale of 1 – 5, how expert do you feel on knowing medication for opioid use disorder (MOUD)?

1) Novice
2) Advanced beginner
3) Competent
4) Proficient
5) Expert

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Zoom polling question

For clinicians, are you:

a) Not waivered and not interested

b) Interested, but not waivered

c) Waivered, but not prescribing

d) Waivered and prescribing a little

e) Waivered and prescribing with some confidence

f) Waivered and prescribing like crazy

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For clinic folks: What's holding you back?

OPIOID USE DISORDER TRENDS IN OREGON

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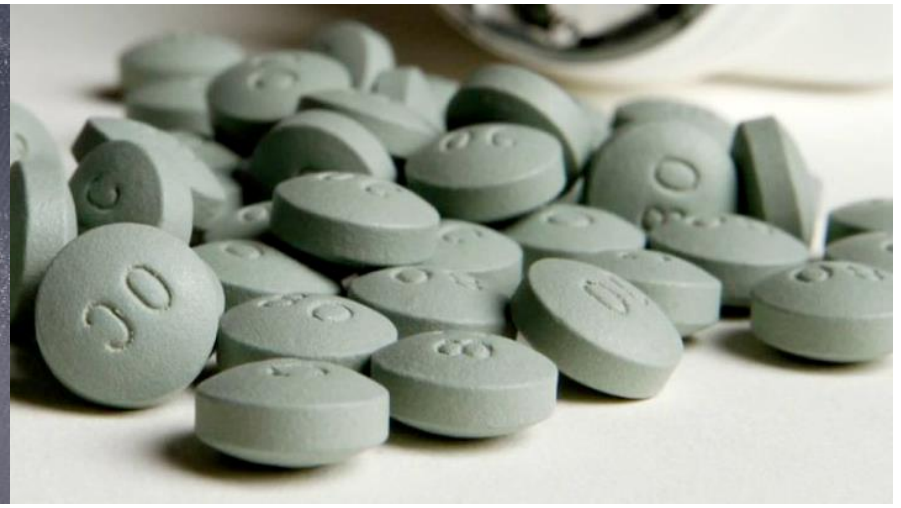
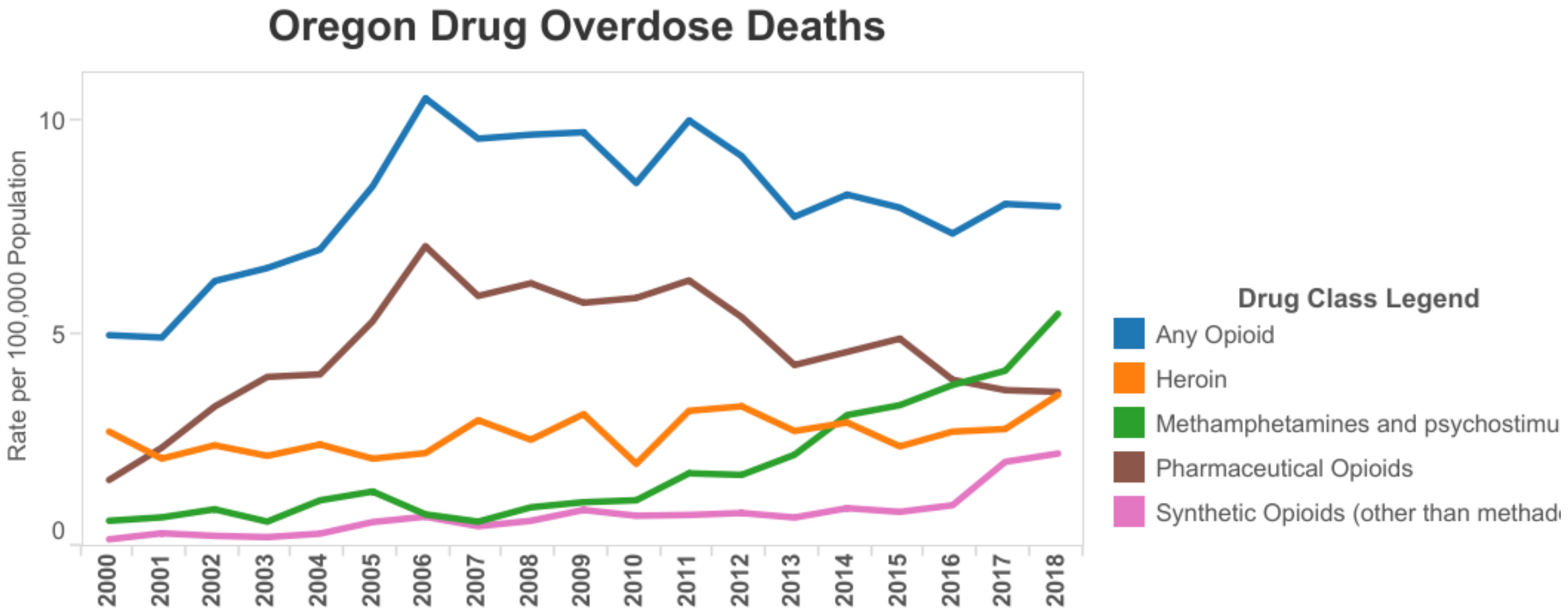
Why?

- Overdose: The leading cause of injury death in US
- Opioids are associated with 80% of these deaths
- Every 12 minutes, a person in the US ODs & dies



Overdose Deaths by Drug



Source: Oregon Health Authority

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Impact of COVID-19

- Following U.S. trend, Oregon saw a nearly **40% increase** in overdose deaths over 2019 and during first half of 2020
  - Total of 580 deaths over the 12-month period
- Linked to COVID-19 pandemic disruptions
- Contributing factors include:
  - Food insecurity
  - Lack of access to safe housing and mental health services
  - Stress from social isolation, job losses, and school
- Illicit fentanyl and methamphetamines have been troubling contributors

Source: Oregon Health Authority

CD Summary
July 2019 | Volume 68, Number 6
Contact: 971-673-1111 | cd.summary@state.or.us | www.healthoregon.org/cdsummary

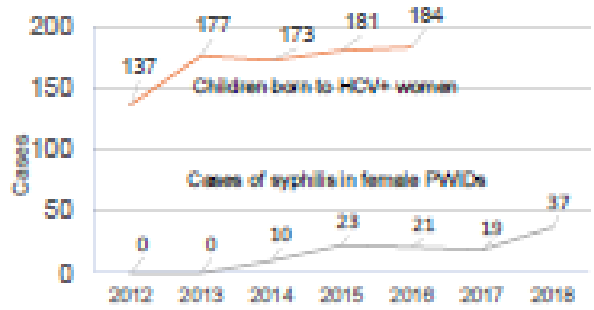
SEX, DRUGS, AND INFECTIOUS DISEASES — THE NEW SYNDEMIC

While prescription opioid overdose deaths have been declining in Oregon since 2011, deaths due to other drugs, including illicit pills, heroin, methamphetamine and illicit fentanyl have been increasing. Concurrently, Oregon has been experiencing increases in substance use disorder diagnoses (SUD), injection drug use, as well as infectious diseases related to injection drug use. We refer to this as a "syndemic", meaning two or more epidemics occurring simultaneously that interact and exacerbate the burden of disease.

The roots of the substance use and infectious disease syndemic are complex, involving poverty, homelessness, trauma and toxic stress. The response has been hindered by lack of health

cent occurring in persons who inject drugs (PWID) use tripled. The sharp increase in early syphilis** cases in Oregon has also been fueled by injection drug use, primarily of methamphetamine. Use of methamphetamine and other stimulants is associated with behaviors that increase risk of sexually transmitted infections, including sex with multiple partners, condomless sex, and transactional sex.[1] Although the increase in cases in acute HCV in PWID is less dramatic, injection drug use accounts for most cases in Oregon, and we suspect that many more cases go unreported, given that most patients are asymptomatic. Lastly, despite stable numbers of invasive GAS infections since we implemented surveillance in 2004, we have seen a

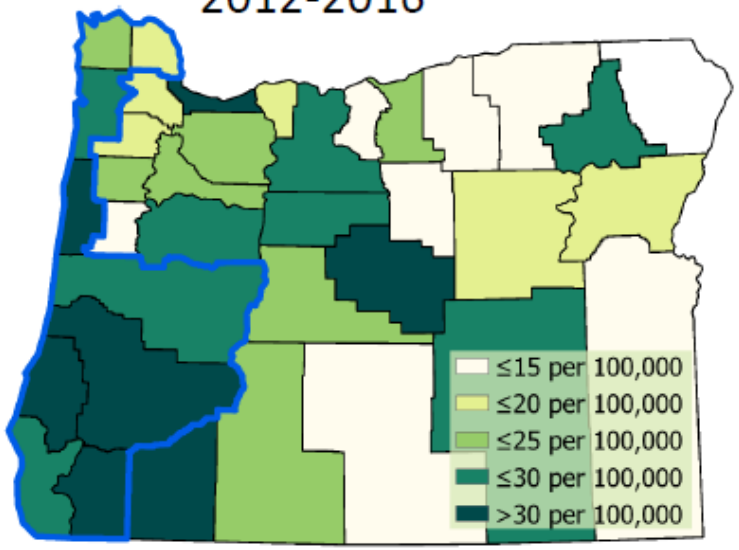
Figure 1. Impact of opioid epidemic and injection drug use on women and infants, Oregon, 2012–2018



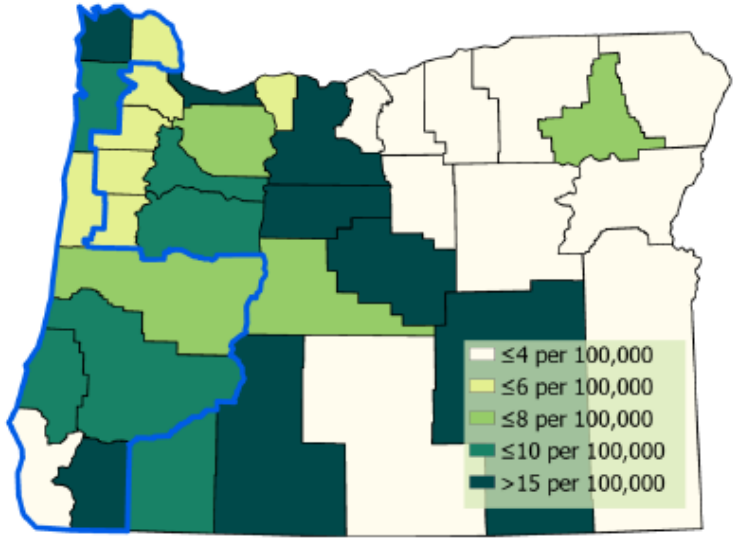
on data from Oregon birth certificates† (Figure 1). In addition, comparing birth certificates from 2015 with cases of HCV reported in Oregon women from 2001 through 2015,[2] we identified an additional 113 HCV-positive women who

Overdose Hospitalizations

Opioid Overdose Hospitalizations, 2012-2016



Methamphetamine/Psychostimulant Hospitalizations, 2012-2016



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WHY ADDRESS SUBSTANCE USE DISORDERS IN PRIMARY CARE?

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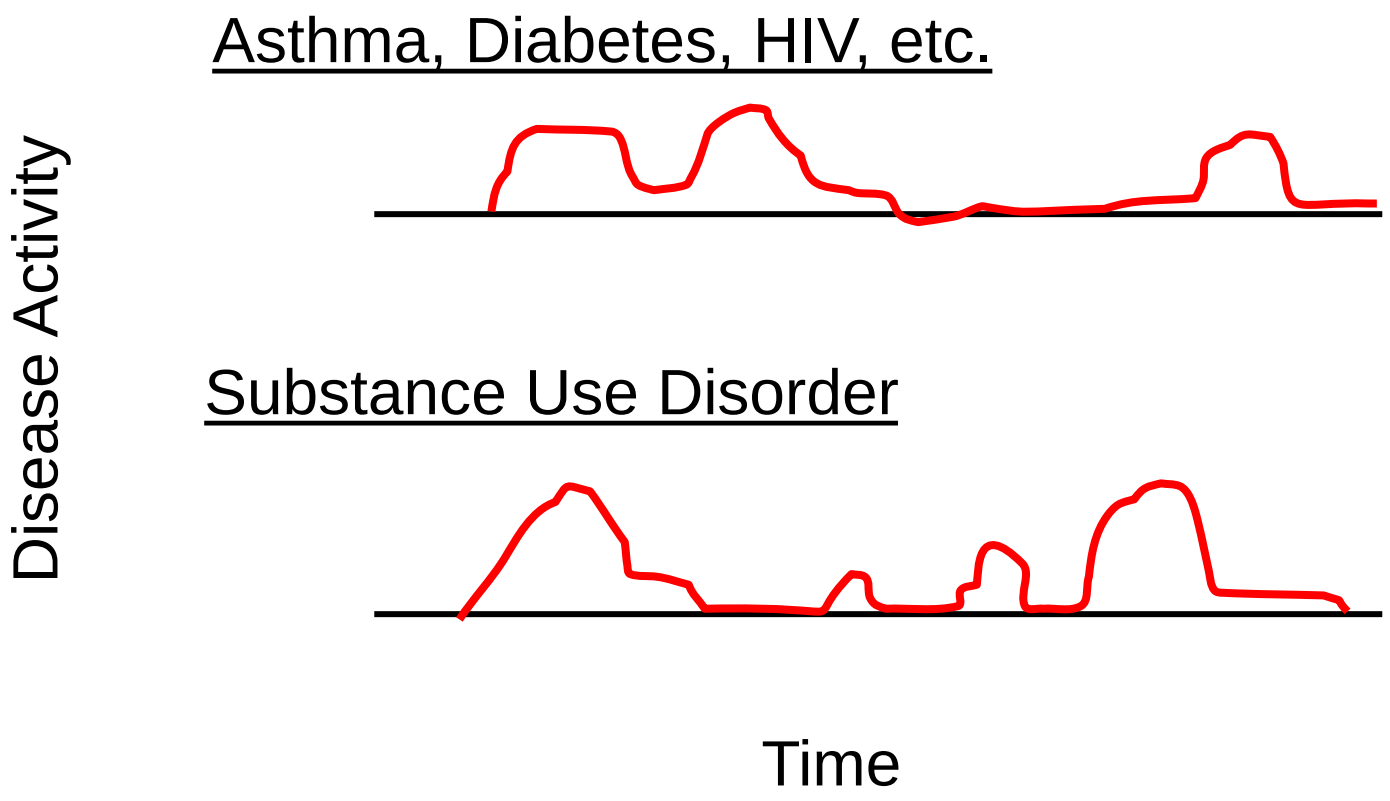
Substance Use Disorder: A Chronic Illness



O'Connor, JAMA 1998; Lucas, JAIDS 2005

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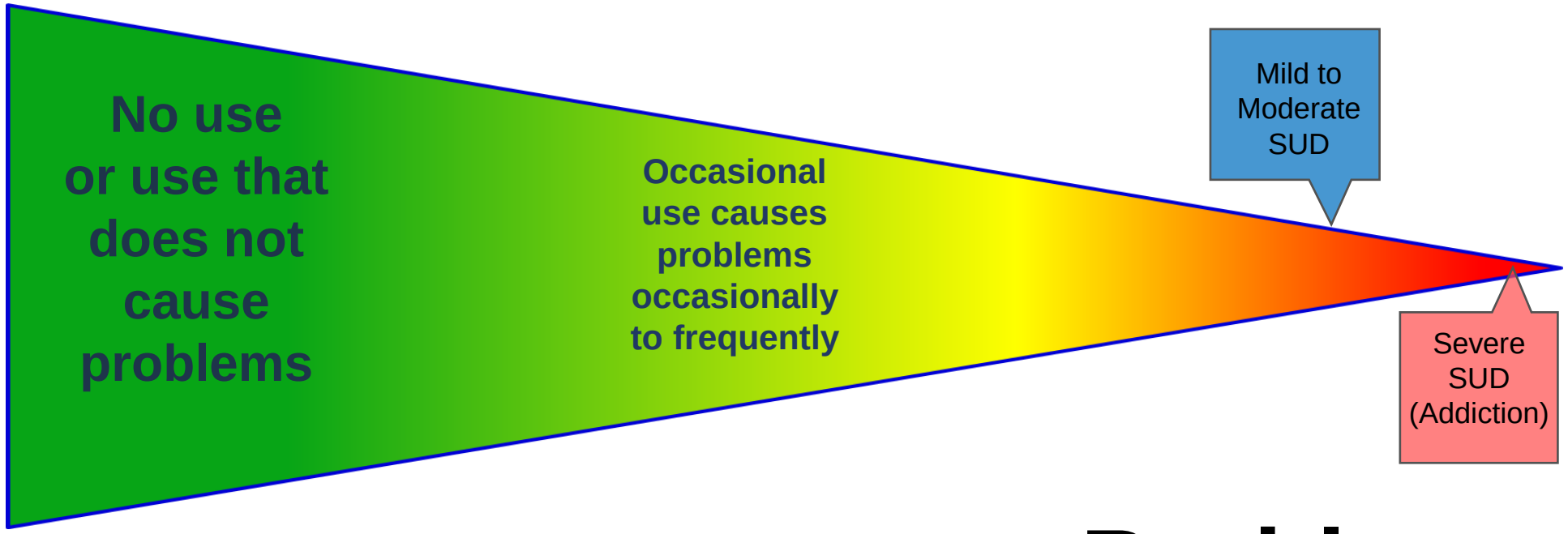
Definitions of a Spectrum: Drug Use to Drug Use Disorder, Mild to Moderate to Severe



Fun → Fun with Problems → Problems

DSM-5 Definition: Opioid Use Disorder

Maladaptive pattern of use, *clinically significant impairment or distress* and 2+ of the following in the same 12-month period:

1. Tolerance
2. Withdrawal
3. Used for longer periods than intended
4. Can't cut down or quit
5. Time spent getting, using or recovering
6. Give up social, work or fun activities
7. Craving or a strong desire or urge to use a substance
8. Continued use despite knowledge of negative consequences
9. Failure to fulfill major role obligations
10. Use in physically hazardous situations
11. Continued use despite social and interpersonal problems

Mild = 2-3 criteria; Moderate = 4-5 criteria; Severe = 6+ criteria


HOPE

Think, Pair, Share

- Share a story of how working with someone who has struggled with substance use has inspired you.
- Think about a recent positive encounter you had with someone who has struggled with substance use.
- What did you do that made that encounter go well?

MEDS FOR OPIOID USE DISORDER (MOUD)

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Meds for Opioid Use Disorder (MOUD)

- Formerly known as Medication-Assisted Treatment

- Naloxone
- Naltrexone
- Methadone
- Buprenorphine

Saitz R. et al. 2021. Recommended Use of Terminology in Addiction Medicine. J Addict Med 2021 15(1) 3-7.
Available here

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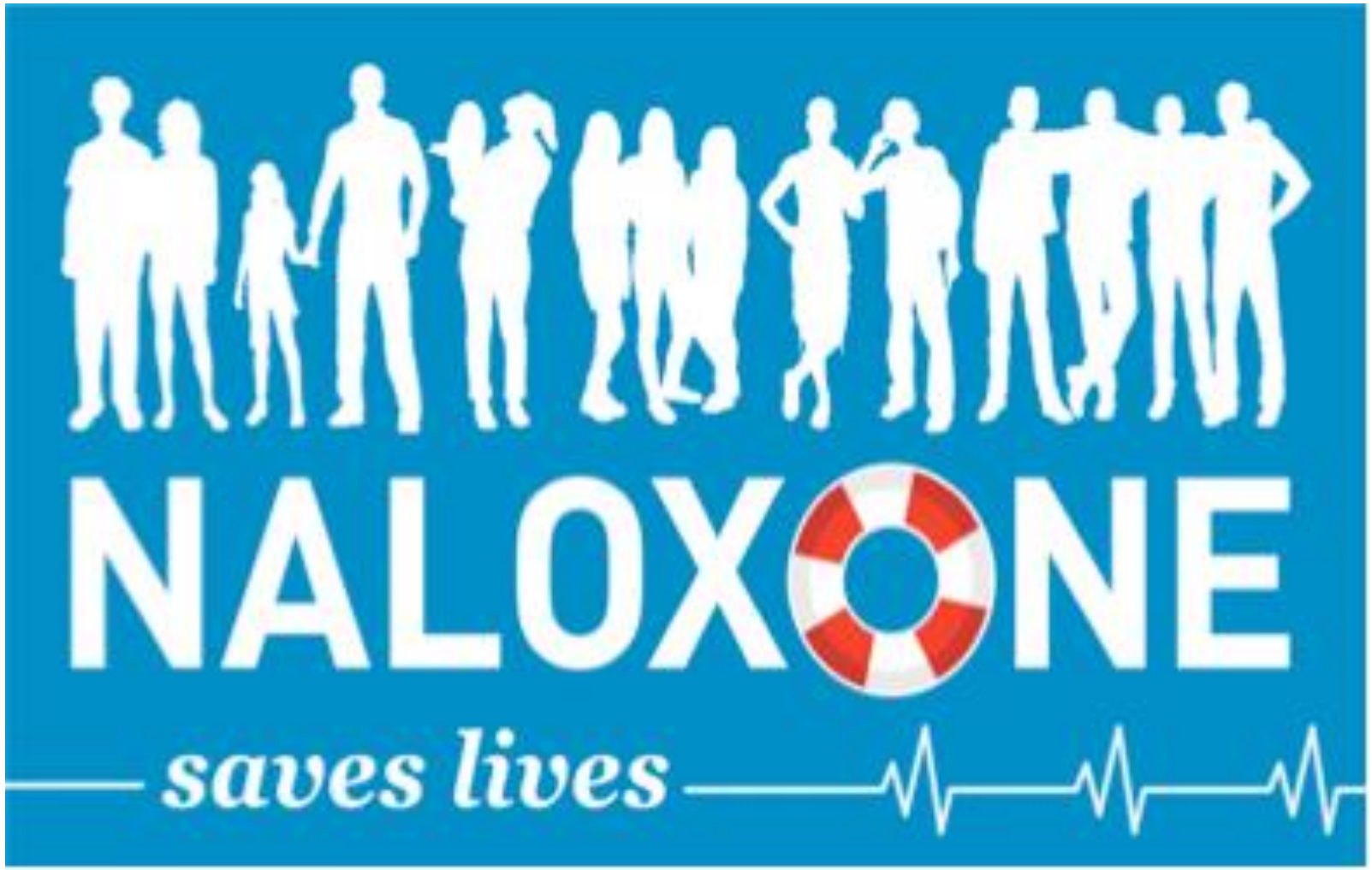
Naloxone reverses overdoses



My ask of clinicians

Recommend naloxone for:

all your patients

taking chronic opioids,

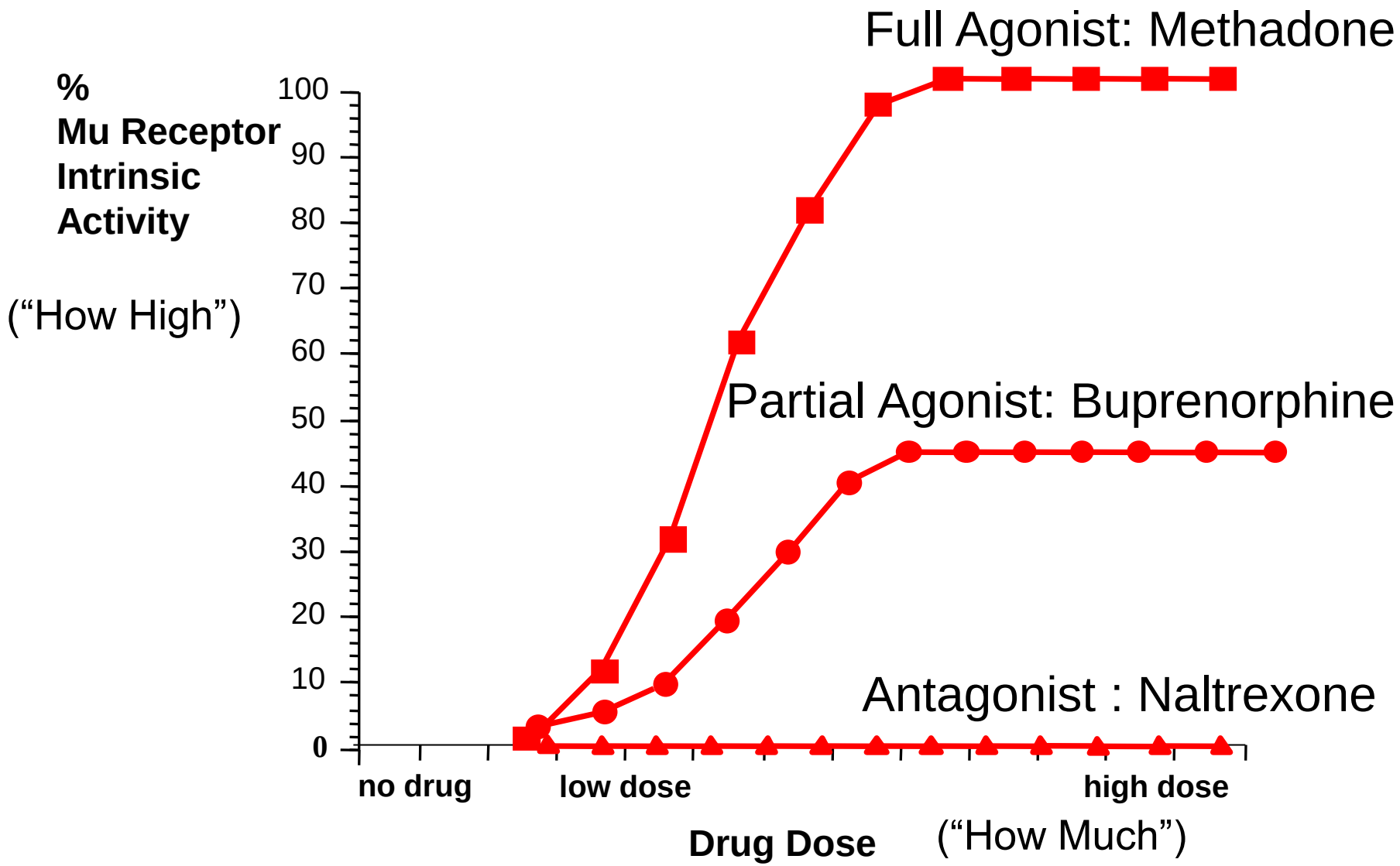
buprenorphine,

or IV drugs.

How?

- Naloxone 4mg/nasal spray. May repeat in 2 min #2, Refill 1
- Not as effective with fentanyl
- Many insurances have no co-pay
- Cash price $30-$50.
- Free at many syringe exchanges
- No Rx is needed,
- Clinicians: Please prescribe it early and often

Medications for Opioid Use Disorder



Naltrexone for Opioid Use Disorder

- Opioid antagonist
  - Blocks opioid μ, κ, and δ receptors
- Oral formulation 50mg once daily
- Effective for treatment retention & opioid abstinence[1]
- Few drug-drug interactions[2]
  - No CYP 450 metabolism

[1] Minozzi Cochrane 2011
[2] McCance-Katz 2001

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Integrating Naltrexone into clinical practice
XR-NTX induction

- Helps to have staff help with prior auth
- Advise patients regarding potential for precipitated withdrawal if they have recently taken opioids

To safely initiate XR-NTX

- Avoid precipitated withdrawal
- Avoid opioid relapse prior to XR-NTX dosing

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Naltrexone clinical pearls

- IM formulation can be given upon discharge from jails
- Must be opioid free for 3 days (short-acting), 7 days (bup or methadone)
- If in doubt, consider naloxone challenge test
- Oral formulation is less effective than IM
- Oral appears less effective than methadone or bup
- Excellent for patients with concurrent alcohol use disorder
- Generally well-tolerated, 33% report some nausea
- Patient coming off naltrexone are at risk of overdose & death

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Methadone

- Full opioid agonist
- >50 years data support[1,2]
  - Safety
  - Sustained abstinence
  - Reduced IDU risks
- But…
  - Requires careful monitoring
  - Prolongs QTc
    - 23% of patients by 16 weeks[3]
  - Many drug-drug interactions[4]

[1] Kreek Addict Dis 2010 [2] Mattick Cochrane Rev 2008 [3] Wedam Arch Intern Med 2007 [4] McCance-Katz Am J Addict 2009

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Buprenorphine/naloxone
(4:1 combination)

Partial opioid agonist

- Decreased overdose risk

Naloxone inactive unless injected –then precipitates withdrawal

- Decreased abuse risk

Sublingual, once daily

- Safe for flexible dosing

2mg/0.5mg

8mg/2mg

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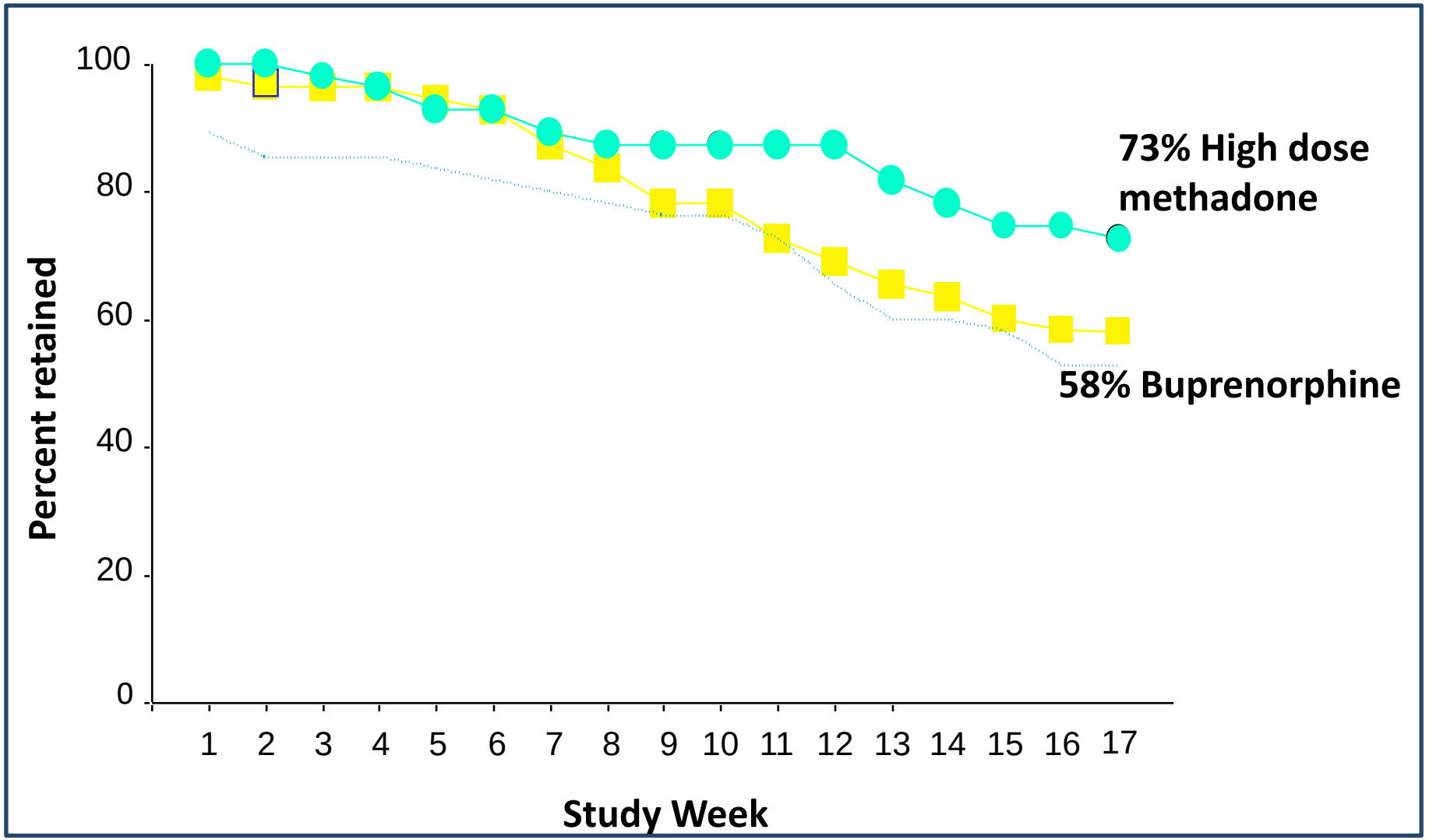
What defines treatment success?

Buprenorphine vs. Methadone treatment retention



Johnson NEJM 2000

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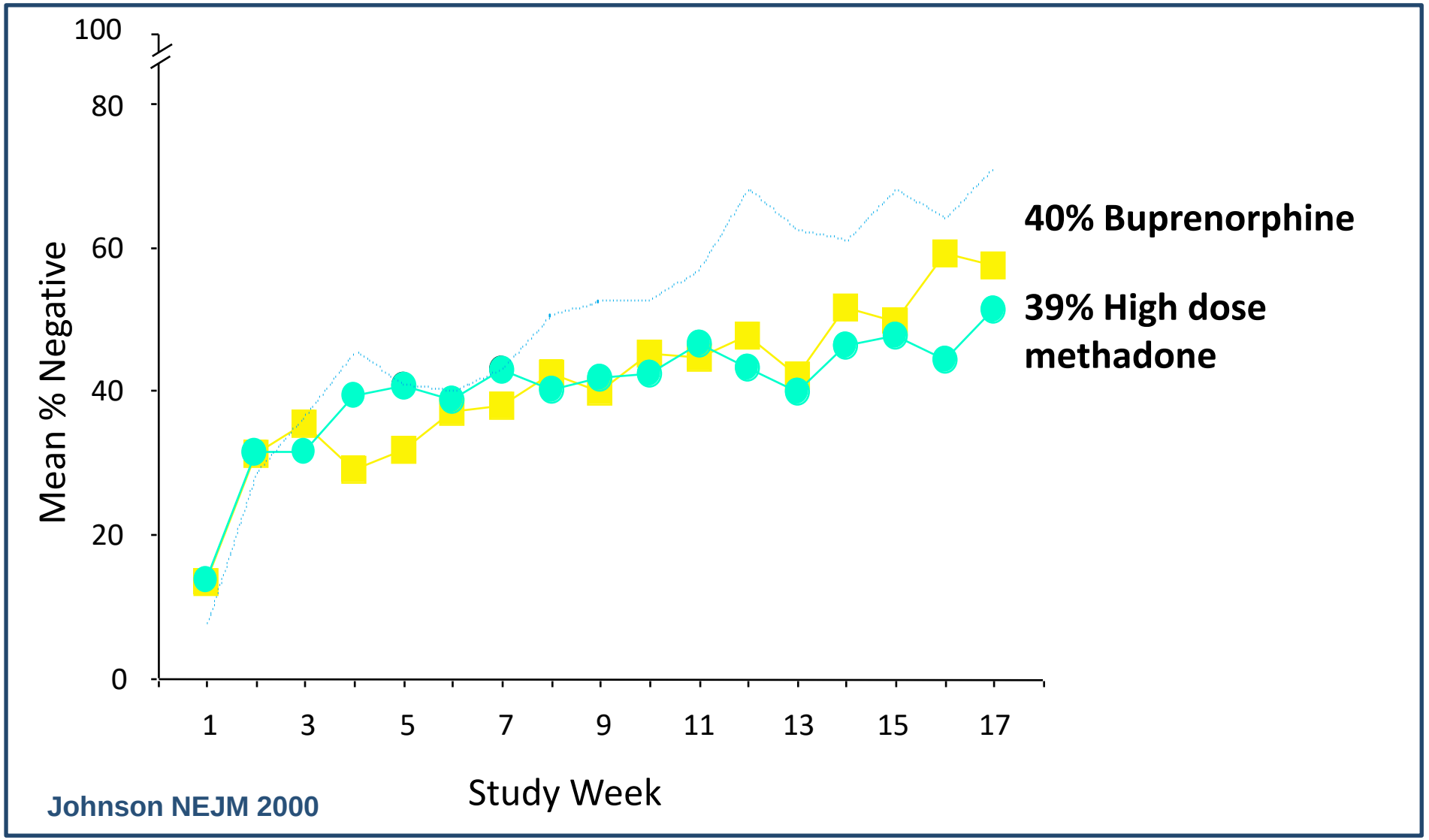
Buprenorphine vs. Methadone

Opioid Urine Results



Johnson NEJM 2000

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Bup versus methadone

- Methadone must be dispensed at a methadone clinic.
- While daily to <daily dispensing of methadone likely provides support to clients, it also is not very convenient.
- The therapeutic window for methadone is lower, so

  doses of methadone must be titrated up slowly.
- Both can be given in pregnancy.
- Some patients who have “failed” bup, may have tried it without sufficient guidance
- Both can be highly effective; see what the patient desires.

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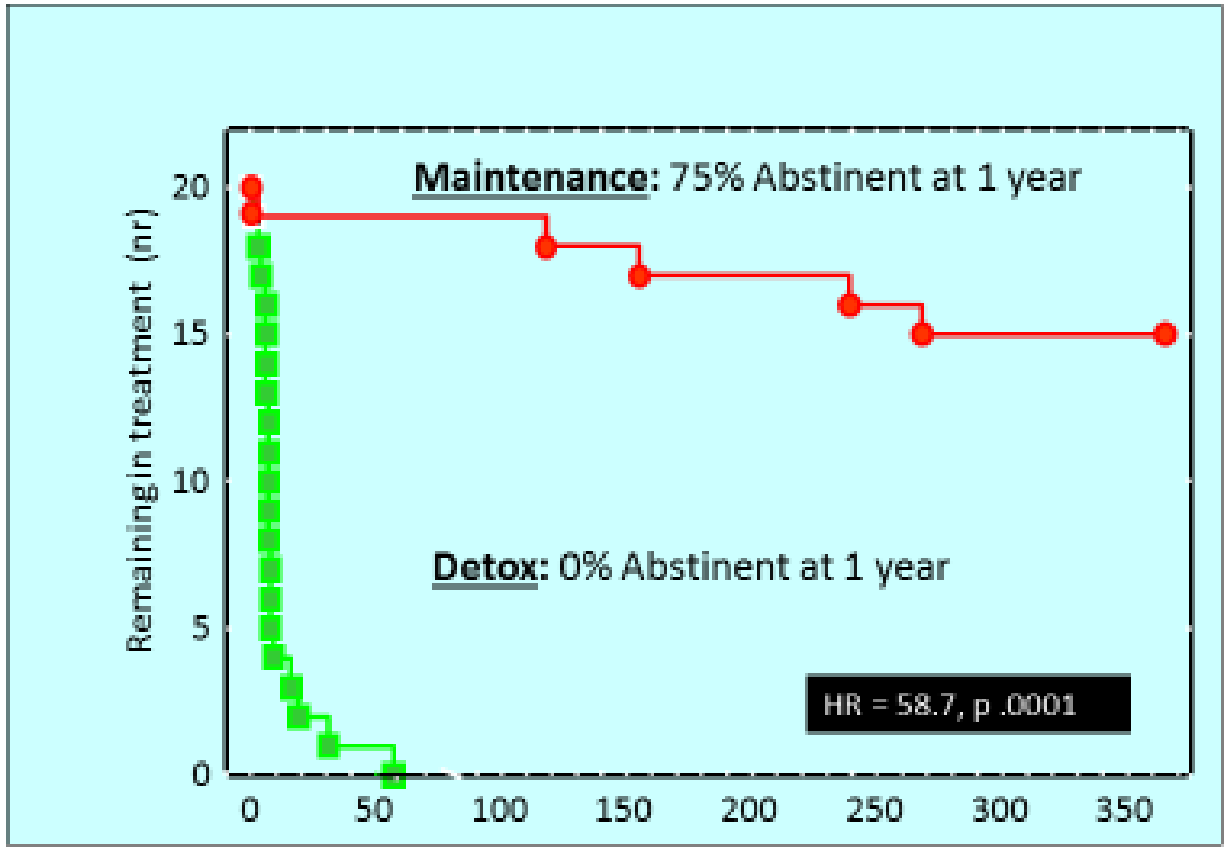
Buprenorphine Maintenance is Effective… Detox Is Not

Treatment Retention: Buprenorphine Detox vs. Maintenance



Deaths:

0% Maintenance

20% Detox

Kakko, Lancet 2003

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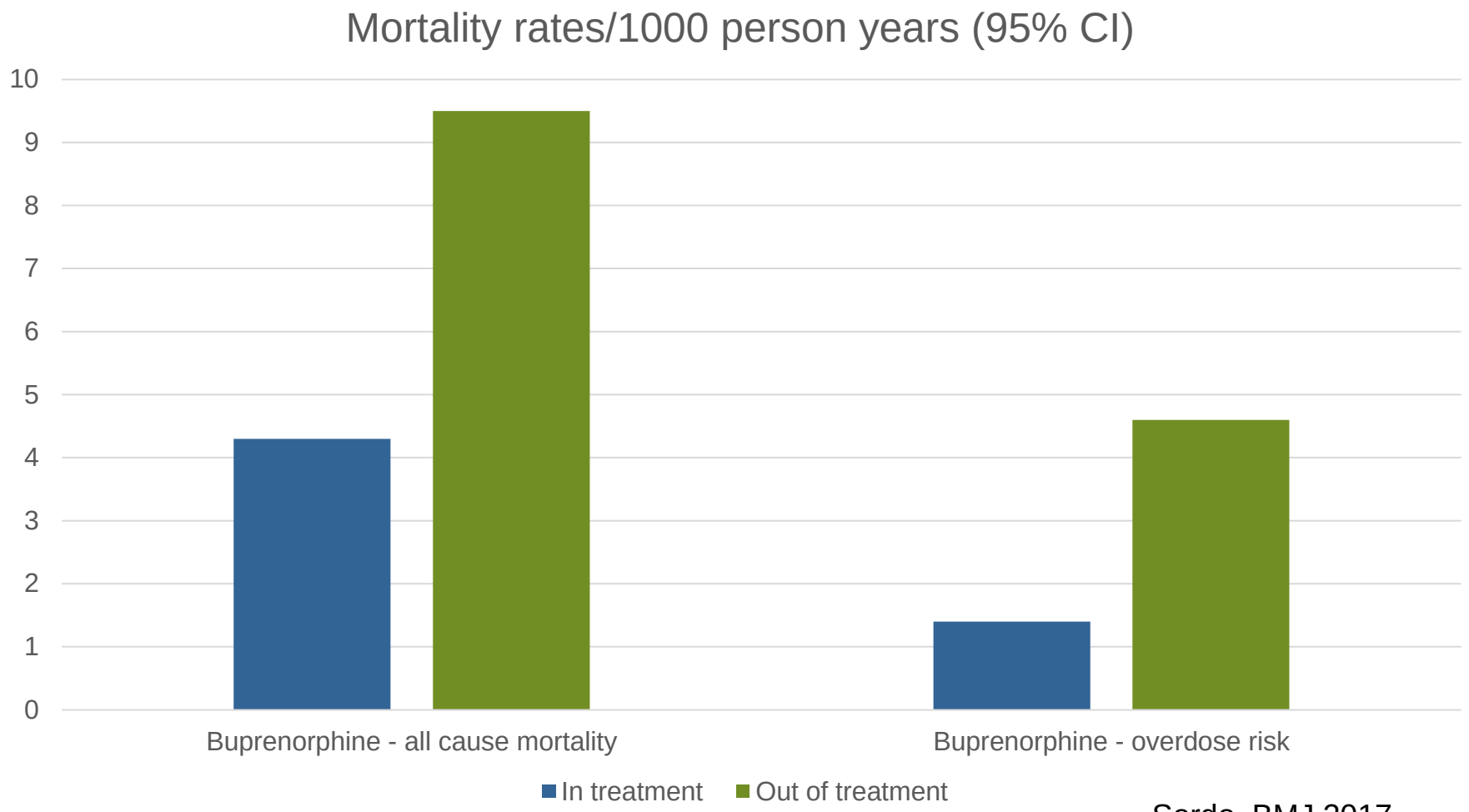
Mortality Risk During and After Buprenorphine Treatment



Sordo, BMJ 2017

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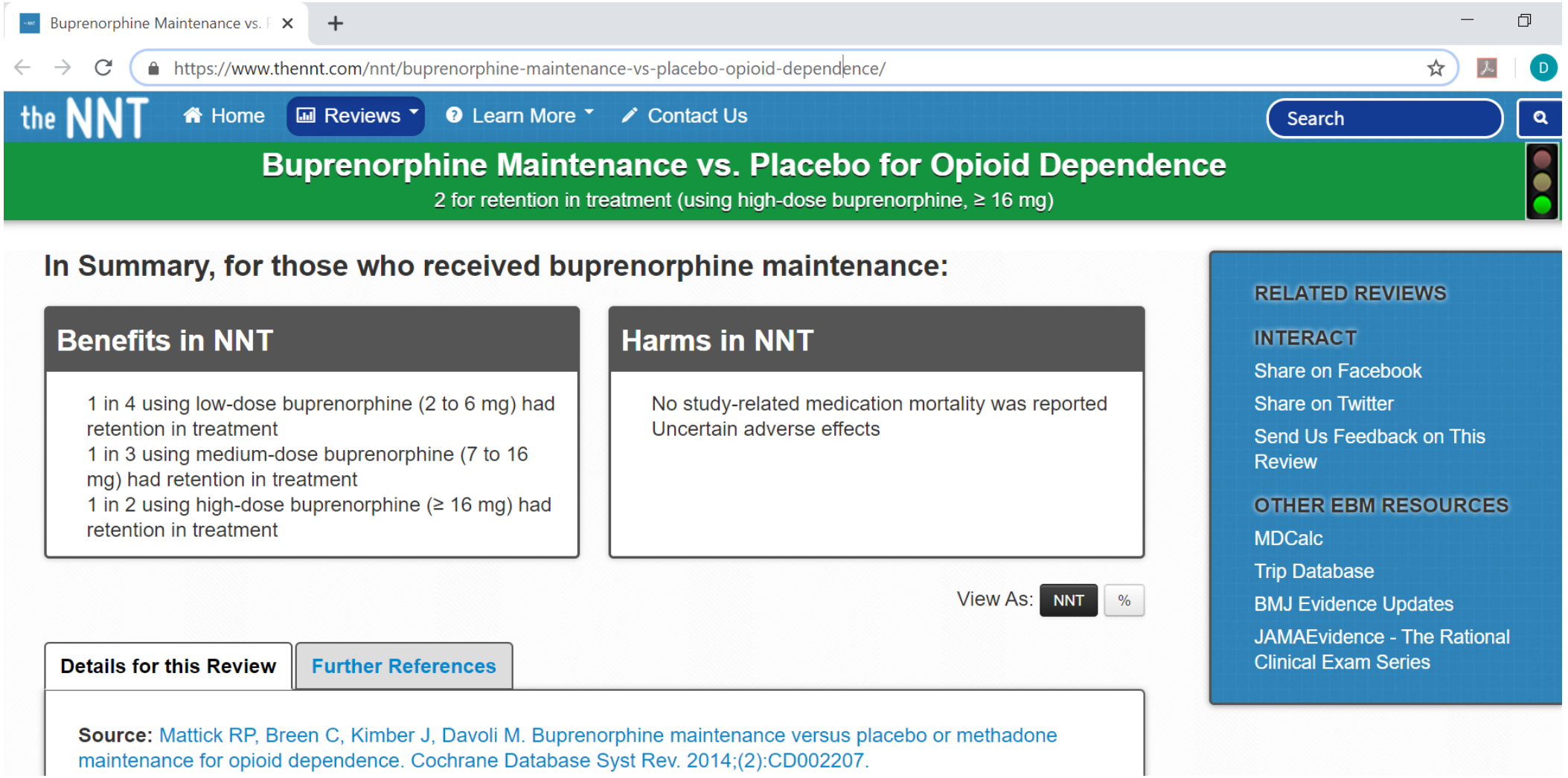
Number Needed to Treat (NNT) = 2-3!



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TOOLS FOR IMPLEMENTING BUPRENORPHINE IN CLINICAL PRACTICE

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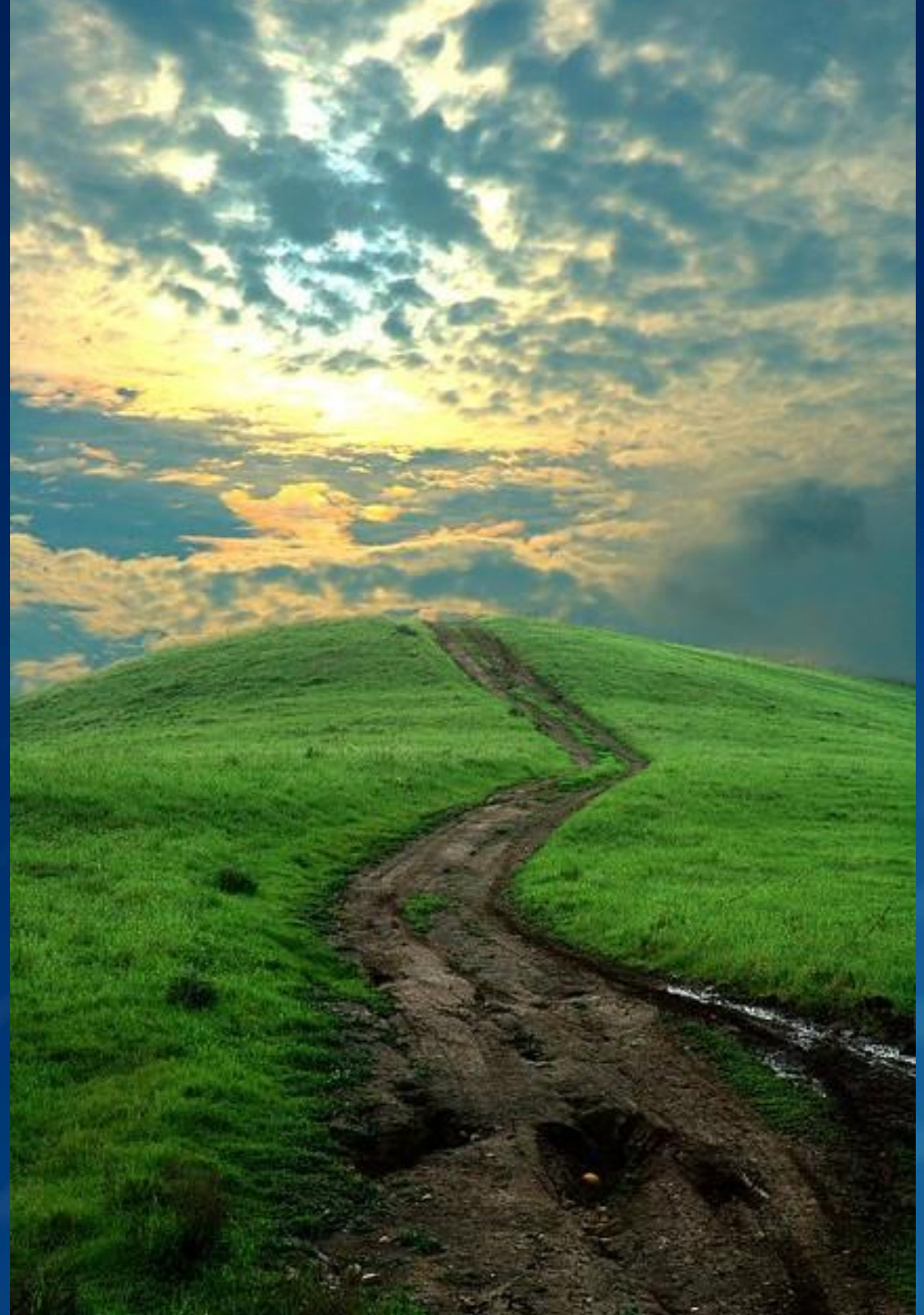

Updated OUD Treatment Guidelines

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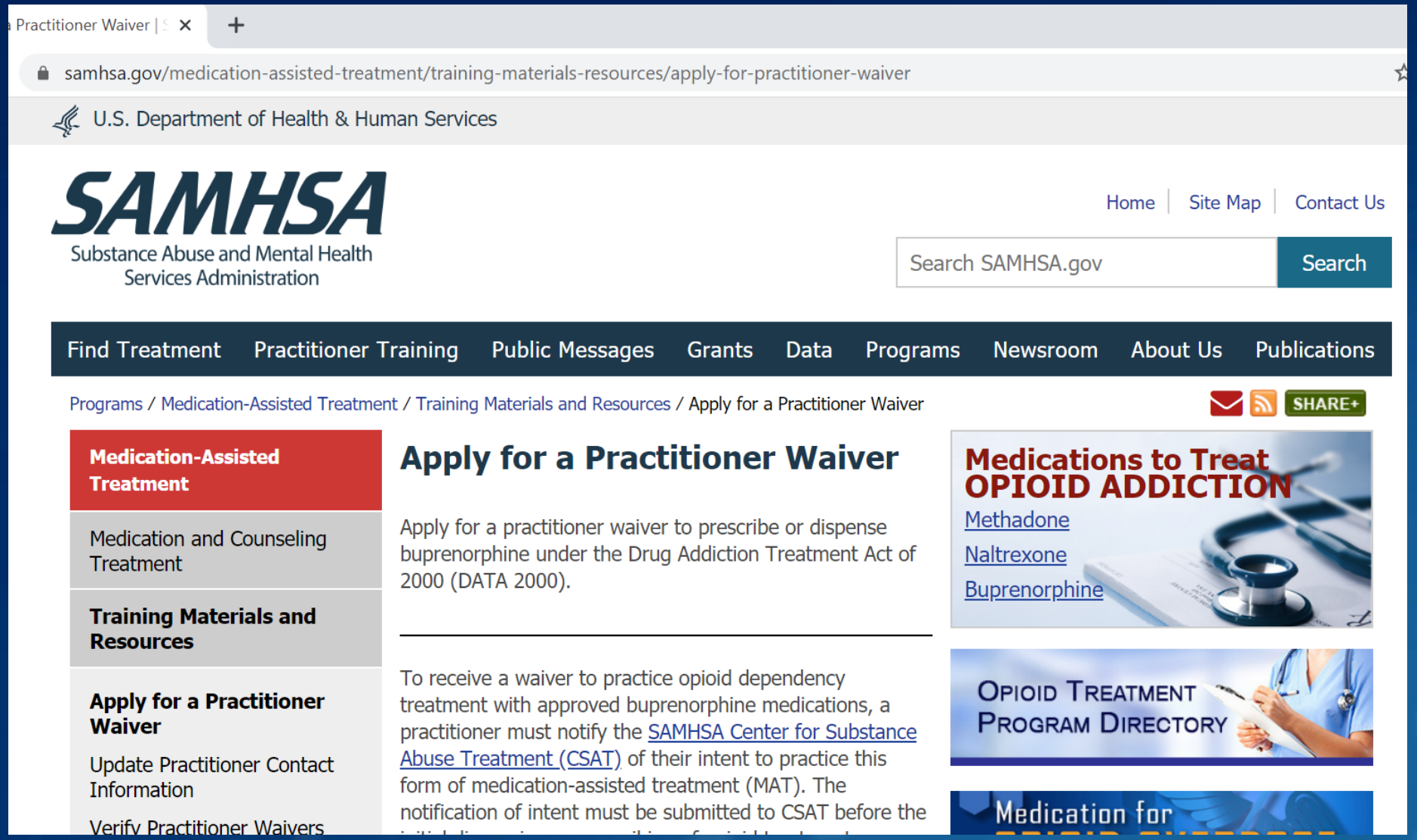
How to get Waiver Trained in Oregon



March 11, 2021
Volume XI, Number 70

THE NATIONAL LAW REVIEW

80
NEW ARTICLES

X-Waiver Changes Axed: Federal Government Backtracks on Previously Announced Rescission of Waiver Requirements

Monday, February 8, 2021

ARTICLE BY

Daniel S. Zinsmaster
Christopher B. Begin

Dinsmore & Shohl LLP

https://www.natlawreview.com/article/x-waiver-changes-axed-federal-government-backtracks-previously-announced-rescission

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What's In It For Me? (WIFM)

- It is mentally easy.
- Documentation is super-easy.

- The visits are fun and meaningful.
- You get to connect deeply with patients

- Your patients need your help to be healthy.
- Your community needs you & your colleagues.
- You can clearly feel that you are making a difference.

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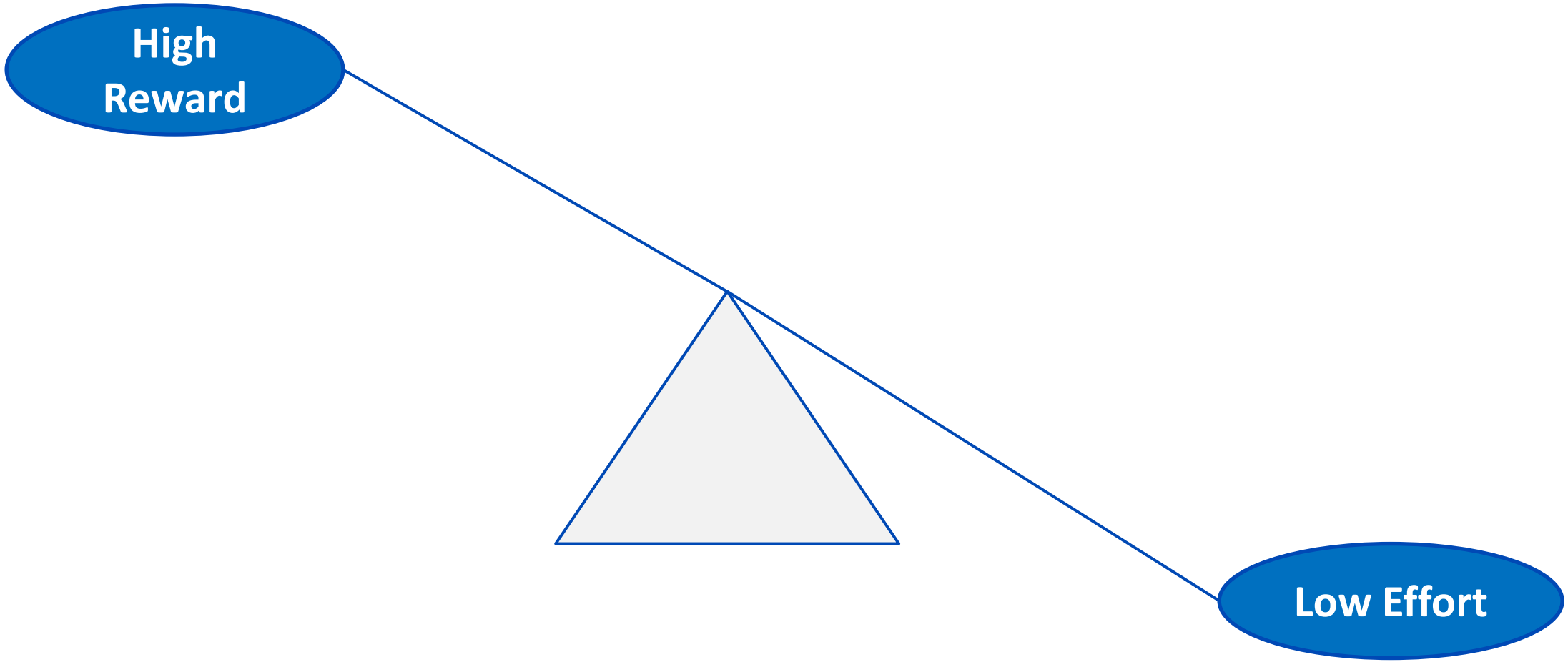
Prescribing Buprenorphine:



Integrating Buprenorphine into Clinical Practice

- Preparing the Whole Team
  - Front desk/phone room staff
  - MAs, Nurses
  - Clinicians
  - Counselors (if available)
  - Clinic leadership

- Designate a coordinator (“the glue person”)

- **Start small and go slow -- just start!**

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Essential Treatment Team Training

Goal: Develop Shared Philosophy and Scope

- Recognizing withdrawal symptoms (vs. “acting out”)
- Importance of timely buprenorphine refills
  - (vs. “we’ll let the provider know…”)
- Embrace substance use disorder as medical condition (vs. moral failure)
- Urine toxicology screening as medical safety, (vs. policing activity)
- Relapse is common and does not equal failure
  - Goal is to limit duration and build on success
- Timing of buprenorphine induction

Who Does What?

- Front desk/phone room staff
  - Scheduling, face/voice of practice
- Medical assistant or Nurse
  - Measure COWS during induction; collect/run UDS; PDMP checks
- Primary care provider
  - Confirm DSM-5 diagnosis, assess comorbidites, monitor progress
- Counselor (if available)
  - Behavioral counseling, monitoring
- Clinic medical director
  - Ensure protocols in place & appropriate billing

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THE CENTRAL CITY CONCERN EXPERIENCE

Mary

Mary is a 25 y.o. patient of yours who is using heroin and occasionally meth. She usually uses IV, but she is getting low on access to good veins. She's used some suboxone from a friend, and she wants to get some from you.

1. What else do you want to know?
2. Do you prescribe her suboxone (or find someone who can)?
3. What labs do you recommend?
4. When and where should she take it?
5. What dose?

Prior to Induction

- Counsel patient on
  - Alternatives
  - Induction timing
  - Precipitated withdrawal
  - Recommendation for behavioral treatment
- Get treatment agreement signed
- Order labs:
  - UDS, HCG *(highly recommended labs)*
  - HIV, HCV, HepA total Ab, Hep BsAb, Hep BsAg, and HepBcAb , treponemal Ab *(best practice given IV drug use)*
- Write prescription

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Clinical Opioid Withdrawal Scale (COWS)

Rates 11 Withdrawal Symptoms:

- Resting pulse rate
- Sweating
- Restlessness
- Pupil size
- Bone or joint aches
- Runny nose
- GI upset
- Tremor
- Yawning
- Anxiety or irritability
- Goose bumps

- Guides timing of first dose of buprenorphine
- Typically safe to give 1st dose when COWS > 8

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Timing of Buprenorphine Induction

- Plan induction soon after intake visit
- Must be in at least mild-to-moderate opioid withdrawal in order to begin induction
  - The more severe the withdrawal, the greater the relief
- Withdrawal symptoms typically begin
  - 12-24 hours after last dose of a short-acting opioids like heroin
  - 2-4 days after last dose of long acting opioids like methadone

SAMHSA, *Medications for Opioid Use Disorder.* Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC

Management of Precipitated Withdrawal

- If a participant develops signs or symptoms of opioid withdrawal after dosing with buprenorphine, the clinician can:
  - Administer non-narcotic medications that provide symptomatic relief
  - Increase the dose of buprenorphine to overcome withdrawal symptoms

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Induction & Stabilization Dosing Schedule

Tailor to Patient

	Suggested Dosing*	Maximum Dose*
Day 1	2-4mg (wait 45 min) + 4mg if needed	8-12mg
Day 2	Day 1 dose + 4mg if needed (single dose)	12-16mg
Day 3	Day 2 dose + 4mg if needed (single dose)	16mg
Day 3-28	May increase dose 4mg per week, if needed (single dose)	24mg

*Suboxone equivalents dose: 8mg Suboxone = 5.7mg Zubsolv, 4.2mg Bunavail

SAMHSA, *Medications for Opioid Use Disorder.* Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC

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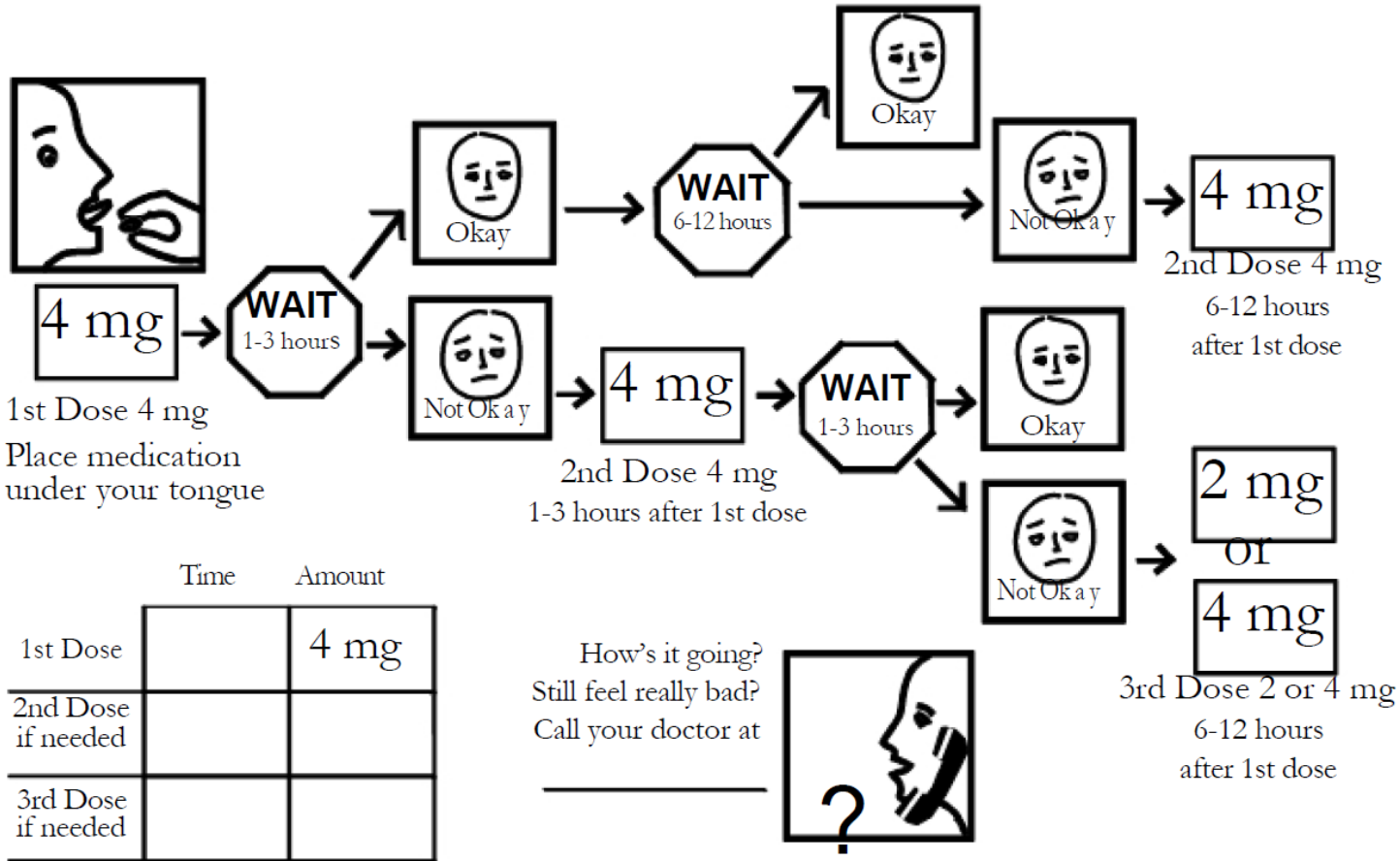
Home Induction Hand-Out

Day One Summary: 4 mg under your tongue, wait 1-3 hours. If still feel sick, take 4 mg again. Wait 1-3 hours. If still sick, take 2-4 mg again. Do not take more than 12 mg on Day 1.



	Time	Amount
1st Dose		4 mg
2nd Dose if needed		
3rd Dose if needed		

= Total mg taken on Day One

Lee, J. D., Vocci, F., & Fiellin, D. A. (2014). *Journal of Addiction Medicine, 8*(5), 299–308.

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Mary – Day 2

As planned, Mary waited until she was in mild withdrawal and then she started the bup/naloxone on Monday. You call her Tuesday morning. You find she took 4mg initially and then took another 4mg Monday evening. She took 8 mg this morning. She complains of significant nausea, diarrhea & sleeping poorly. She has slight cravings as well.

- What do you do with your buprenorphine dose?
- How do you manage her withdrawal symptoms?

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Supportive meds during opioid withdrawal

- Autonomic symptoms (sweating, shakiness, agitation, muscle cramps):

  tizanidine 4mg tid prn (also for myalgias) or clonidine 0.1 mg q6 prn
- **Anxiety, rhinorrhea: hydroxyzine 25-50 mg po q4 prn**
- **Nausea/vomiting: ondansetron 4mg po q8 prn**
- **Diarrhea: loperamide 4mg x 1, then 2mg qid prn**
- Abdominal cramps: dicyclomine 20mg q6 prn
- Myalgias: Ibuprofin 600mh q6 prn and acetaminophen 1000mg q6-8 prn
- Insomnia: trazodone 25-100 mg qhs prn

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Mary

- Mary is delighted with the buprenorphine you gave her. She finds the daily dose of 16mg (8,4,4) works well. She is not craving nor using heroin at all.
- However, she still uses meth every few days and her POCT UDS is positive for bup and meth.

- Do you continue the buprenorphine?
- How do you address her meth use?

When Patients Misuse or Divert

- Stress willingness to continue working together, and…
- Consider higher level of care
  - Increase visit frequency?
  - Referral for dispensary-based buprenorphine/methadone?
  - Referral for residential treatment?

    (but…make sure “higher level of care” ≠ “no care”)

Oregon HOPE Study

HIV, Hepatitis, Overdose Prevention and Engagement

Drug preference split between heroin and meth. People who use heroin also use meth.
(*N* = 144)

Drug of choice:

44% heroin
49% meth
7% other

30 **Past 30 day use:**

78% used an opioid

↓

Of these, **96% also used meth** in past 30 days

Oregon Health Authority

Methamphetamines-specific options:

- **Contingency management: most effective.**
- **Motivational interviewing (MI): also effective**
- **Meds: mirtazapine (remeron):**

  NNT = 3! (based on 60 MSMs on 30mg for 12 weeks)
- **Bupropion** helpful in subgroup analysis (men used less frequently)
- Naltrexone may be helpful based on small trials. More data is needed.
- None are FDA-approved

Colfax GN et al. 2011. Arch Gen Psychiatry.68(11): 1168–1175
Elkashef AM et al. 2008. Neuropsychopharmacology. 33:1162-70

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Microdose Buprenorphine Induction

- Removes the need for patients to be in any degree of withdrawal when starting SL bup/nlx.
- Allows opioid pain medications to be administered simultaneously with induction.
- Lower risk for precipitating withdrawal.
- Excellent choice if patient is on methadone. Can also be used if patient is on fentanyl (with a dependent supply).

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Standard vs. Microdose

COWS OF 12	REMAIN ON FULL AGONISTS
4 mg + 4 mg	1 mg + 1 mg
8 mg + 4 mg + 4 mg	2 mg + 2 mg
	4 mg + 4 mg
	6 mg + 6 mg

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How frequently do you see patients for bup?

- 1 week: 1st month of tx; recent relapse
- 2 weeks: 2nd month of tx; high risk pt but in monitored program (drug court, etc)
- 1 month: often 1st 6 months of tx; chronic, stable patients on 16mg or more
- 2-3 months: Low risk & low dose (<16mg)

- Our group is OK with telehealth for up to 4 months, for patients on monthly schedule. Other groups do more telehealth.

Bup pearls

- Dividing dose is often helpful esp. for chronic pain (tid common)
- Bup should be placed under tongue to dissolve fully (5 min)
- Many have tried bup already, so they have a sense of their ideal dose
- 16 mg is a typical dose, 24 mg is max FDA dose
- Some patients with chronic pain do fine on 8mg or less
- Templates make care quite easy.

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What is Microdosing?

(No, it does not involve psychedelics.)

Microdose buprenorphine induction remains loosely defined as there are not yet widely validated standardized protocols.

Essentially, it is an approach to starting buprenorphine that introduces the medication onto the receptors so slowly that no withdrawal of any kind is involved in the process.

Slides thanks to Jenny Hartley

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Microdose Buprenorphine Induction

- Removes the need for patients to be in any degree of withdrawal when starting SL bup/nlx.
- Allows opioid pain medications to be administered simultaneously with induction.
- Lower risk for precipitating withdrawal.

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Standard vs. Microdose

COWS OF 12	REMAIN ON FULL AGONISTS
4 mg + 4 mg	1 mg + 1 mg
8 mg + 4 mg + 4 mg	2 mg + 2 mg
	4 mg + 4 mg
	6 mg + 6 mg

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Multiple Protocols

- Multiple protocols involving buprenorphine strips, tabs, or strips/tabs plus transdermal buprenorphine
- No comparative effectiveness studies

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3. Rozylo et al. Case report: Successful induction of buprenorphine/naloxone using a microdosing schedule and assertive outreach. Addict Sci Clin Pract (2020) 15:2 https://doi.org/10.1186/s13722-020-0177-x
4. Terasaki D, Smith C, Calcaterra SL. Transitioning Hospitalized Patients with Opioid Use Disorder from Methadone to Buprenorphine without a Period of Opioid Abstinence Using a Microdosing Protocol. ACCP: Pharmacotherapy. (26 July 2019) https://doi.org/10.1002/phar.2313
5. Lembke A, Raheemullah A. Initiating Opioid Agonist Treatment for Opioid Use Disorder in the Inpatient Setting: A Teachable Moment. JAMA Internal Medicine (March 2019) 179:3 10.1001/jamainternmed.2018.6749

CCC Microdosing Protocol for Short-acting Opioids

DAY	Daily Dose	Sig	Full opioid agonist
1	0.5 mg	0.5 mg qday	Continue
2	2 mg	1 mg BID	Continue
3	4 mg	2 mg BID	Continue
4	6 mg	2 mg TID	Continue
5	8 mg	4 mg BID	Taper or Continue
6	12 mg	4 mg TID	Taper or Continue
7	16 mg	8 mg BID	Discontinue

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CCC Microdosing Protocol for Long-acting Opioids

DAY	Daily Dose	Sig	Full opioid agonist
1	0.5 mg	0.5 mg qday	Continue
2	0.5 mg	0.5 mg qday	Continue
3	2 mg	1mg BID	Continue
4	4 mg	2 mg BID	Continue
5	6 mg	2 mg TID	Continue
6	8 mg	4 mg BID	Continue
7	12 mg	4 mg TID	Continue
8	16 mg	8 mg BID	Discontinue

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Objectives

- Understand opioid use disorder (OUD) trends in Oregon
- Describe why primary care is well-suited for treating opioid use disorders
- Articulate steps to integrate buprenorphine into your practice

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Acknowledgment

The Mountain West AIDS Education and Training (MWAETC) program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,803,298 with 0% financed with non-governmental sources.

AETC AIDS Education & Training Center Program Mountain West

Let’s end HIV in Oregon.

We can make it happen.

The time is now.

Additional Resources

- USCF Substance Use Consultation “Warm Line”
  - (855) 300-3595; Mon-Fri, Get any question kindly answered.
- Provider Clinical Support System (PCSS): Get waivered!
  - https://pcssnow.org/
- ECHO – For ongoing prescriber mentoring
  - https://echo.unm.edu/opioid-focused-echo-programs/
- STR-Technical Assistance – Get mentoring for your clinic!
  - https://www.getstr-ta.org/
- SAMHSA, *Medications for Opioid Use Disorder.* Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC

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Additional Resources – Buprenorphine Microinduction

Linked Resources:

- Outpatient Microinduction Schedule
- Buprenorphine Telehealth Visit
- Buprenorphine Pre-Treatment Questionnaire
- Buprenorphine Induction
- Protocol for the Use of Transdermal Buprenorphine in Treating OUD
- Buprenorphine Clinic Template
- Buprenorphine Prescribing Guidelines
- JAMA – Inpatient MAT Initiation (2019)
- Supportive Care Medications during Opioid Withdrawal
- Buprenorphine Patch Guidelines

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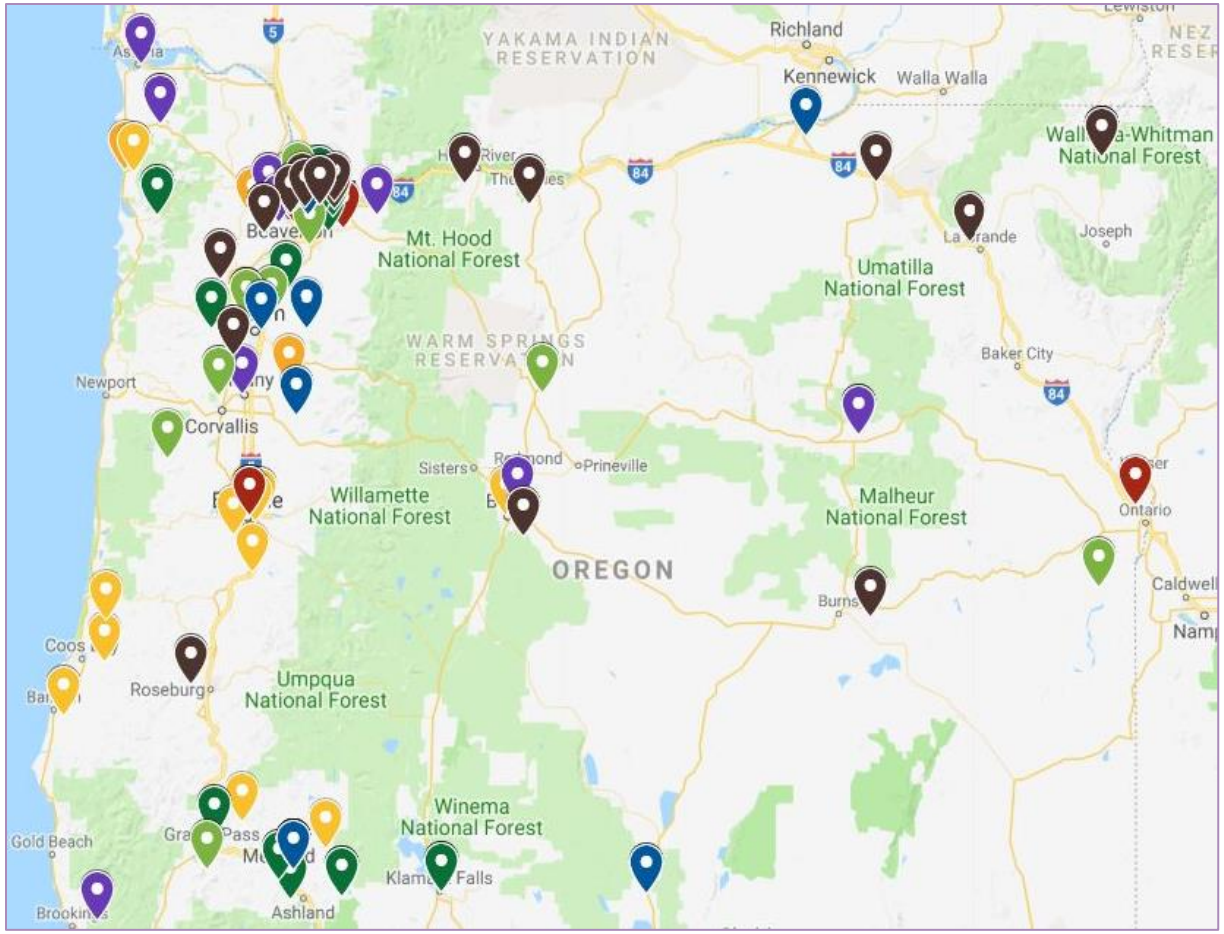
Project ECHO

Telehealth Support for Primary Care Providers

- Weekly telehealth CME conference
  - Case presentations
  - Panel discussion
  - Brief Didactic
- Inter-professional panel
  - Counselor
  - Recovery Peer
  - Psychologist
  - Addiction physician
- Oregon ECHO
  - https://www.oregonechonetwork.org/



ORN: Opioid Response Network

- ORN provides local consultants for free education & training
- ORN & this presentation are funded by SAMHSA
- For more support, go to www.OpioidResponseNetwork.org
- Examples of support:
  - Substance Use Prevention
  - Waiver Training & Webinars
  - Assistance with creating a strategic plan
  - Assistance with creating peer support programs

- Link to brochure:
  - https://opioidresponsenetwork.org/documents/OpioidResponseNetwork_TrifoldBrochure_FINAL.3.2019.pdf

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