



# Opioid Stewardship Program (OSP) | Session 9

## Medication for OUD (MOUD): Prescribing Buprenorphine

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Thursday, April 14, 2022

# Medication for Opioid Use Disorder (MOUD): Prescribing Buprenorphine

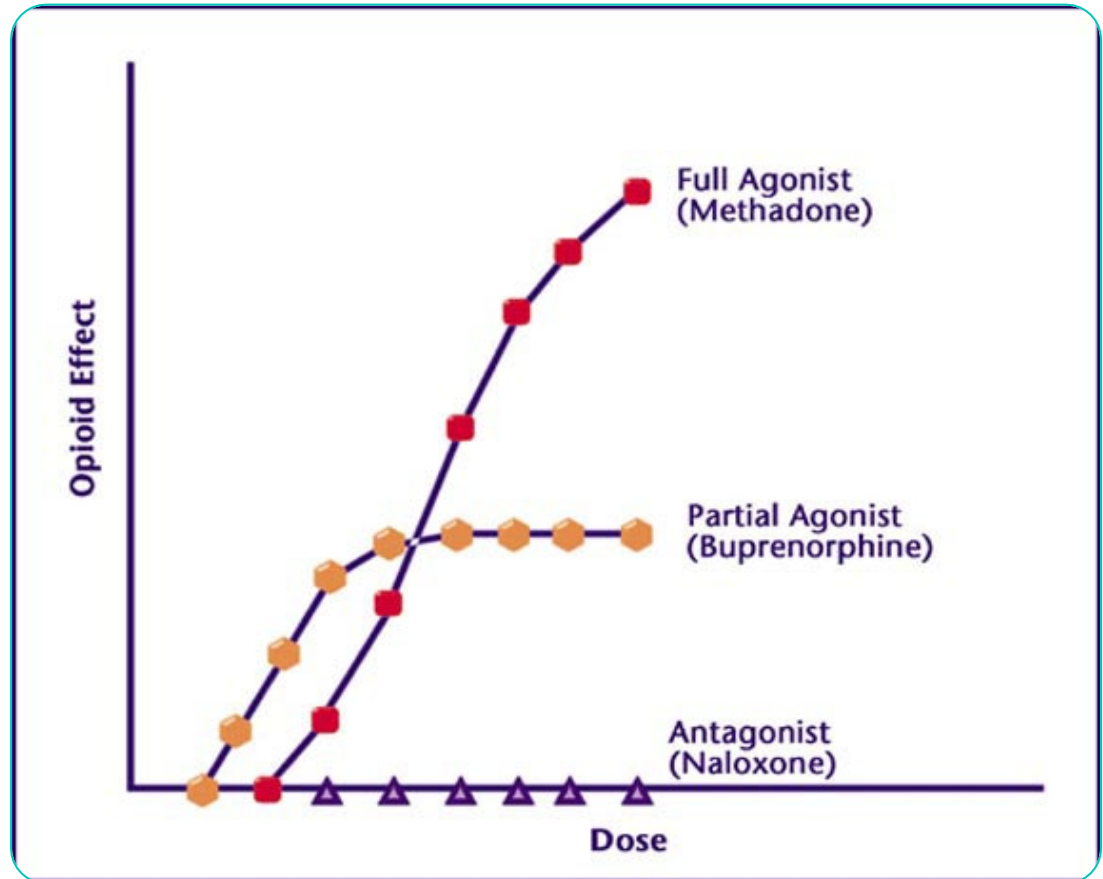
Melody Glenn, MD MFA

Alicia Mikolajcik Gonzalez, MD

# Objectives

- Identify opioid use disorder evidence-based treatments to provide in various healthcare settings
- Explain the process of buprenorphine induction as well as the need for stabilization and maintenance
- Develop an action plan with identified resources for MOUD induction and referrals to ongoing care
- Understand x-waiver training options and the alternative type of notice of intent in order to waive training requirements
- Establish a workflow for induction and linkage to MOUD for patients with OUD

# MOUD



# Title 21 of the Federal Regulations, Part 1306.07

- Narcotic drugs may be administered or dispensed to patients at methadone clinics registered with the DEA
- However, there are two sections of this regulation that apply to patients in emergency and hospital settings and allow for specific exceptions:
  - 1306.07 (b) Nothing in this section shall prohibit a physician who is not specifically registered to conduct a narcotic treatment program from administering (but not prescribing) narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended. [This is often referred to as the 3-day rule]
  - 1306.07 (c) This section is not intended to impose any limitations on a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction, or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none has been found after reasonable efforts





# Resources

[Problem](#)[Solution](#)[Impact](#)[Tools](#)[Training](#)[About](#)[Join Us](#) [HOME](#) > [TOOLS](#) > [RESOURCES](#)

Our resources have been developed by an interdisciplinary team based on published evidence and expert opinion.

However, they should never be used as a substitute for clinical judgement. Providers are responsible for assessing the unique circumstances and needs of each case. Adherence to these guidelines will not ensure successful treatment in every situation.

### A Patient-Centered, Rapid Access Approach to Substance Use Disorder

GUIDE: Prioritize timely medication access, improve care effectiveness, and expand on a 'low-threshold' model



### Acute Care Treatment of Alcohol Use Disorder

GUIDE: Guidance incorporating treatment for alcohol use disorder into emergency department and inpatient settings



### Acute Pain Management in Emergency Department and Critical Care

PROTOCOL: Clinical acute pain management guide for EDs patients undergoing buprenorphine treatment for opioid use disorder



### Toolkit Quick Links:

- Blueprint for Hospital Opioid Use Disorder Treatment
- MAT Toolkit for Nurses
- Substance Use Navigation Toolkit

### FILTER BY AUDIENCE

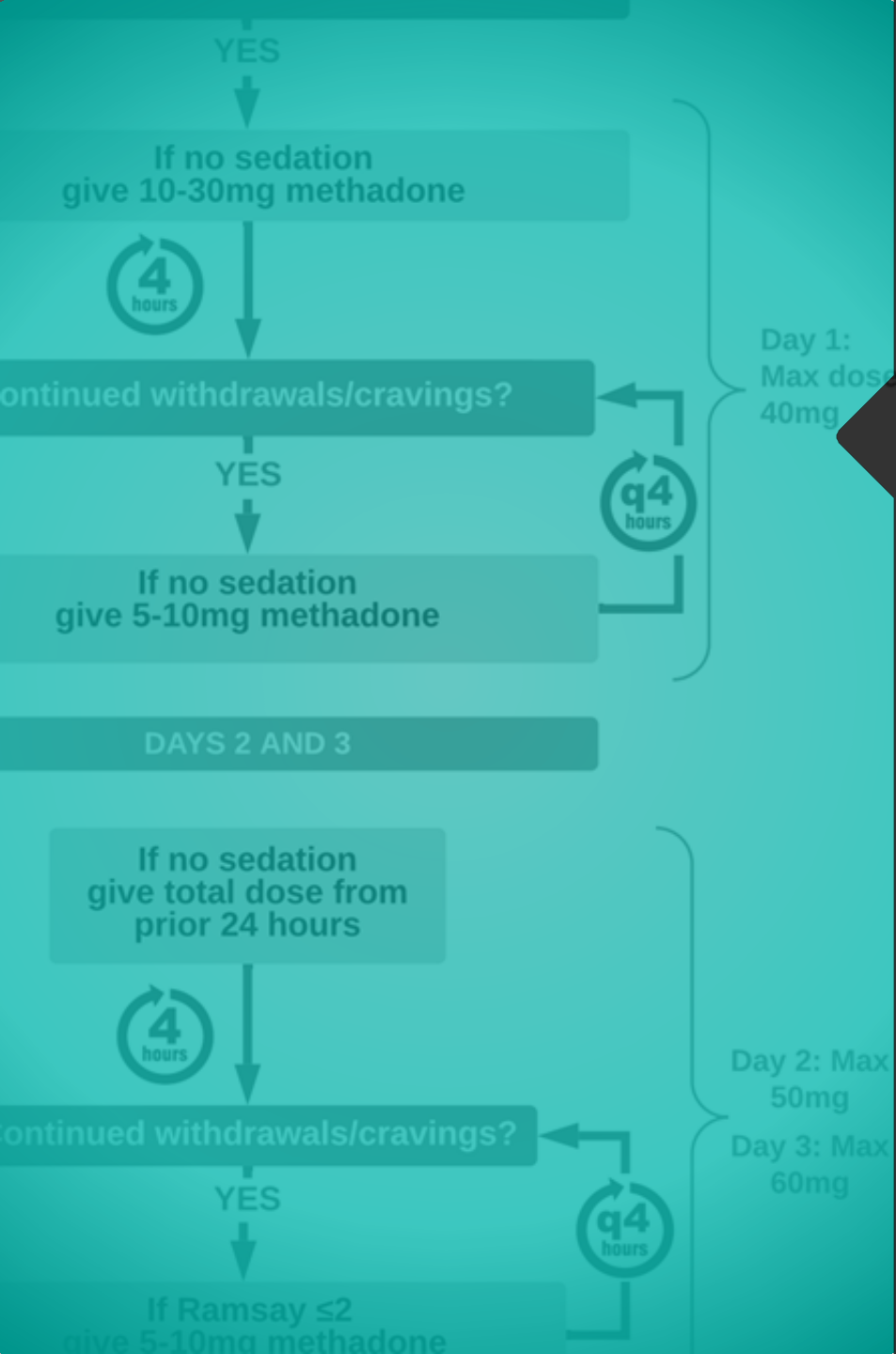
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### FILTER BY TOPIC

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### SEARCH BY TITLE





# Methadone

- Confirm maintenance dose, give maintenance dose.
- If unable to confirm dose, give methadone 30-40mg and increase to full dose when dose is confirmed. OK to uptitrate per protocol until dose confirmed.
- If patient missed outpatient dosing, strongly recommended to discuss dosing changes with methadone clinic provider.
- If patient missed dose and dose is confirmed by clinic but clinic unable to confirm by patient
  - If 1-2 days are missed, give patient's regular dose
  - If 3-4 days are missed, give half patient's regular dose
  - If ≥5 days are missed, treat as a new start.

Initial dose: Usually 20-30 mg

Hospitalist can titrate upwards 5-10 mg q day

Most patients stabilize at doses from 80-120 mg /daily

## Complicating Factors

- Allergy to methadone
- Respiratory depression
- Ramsay sedation scale ≥3

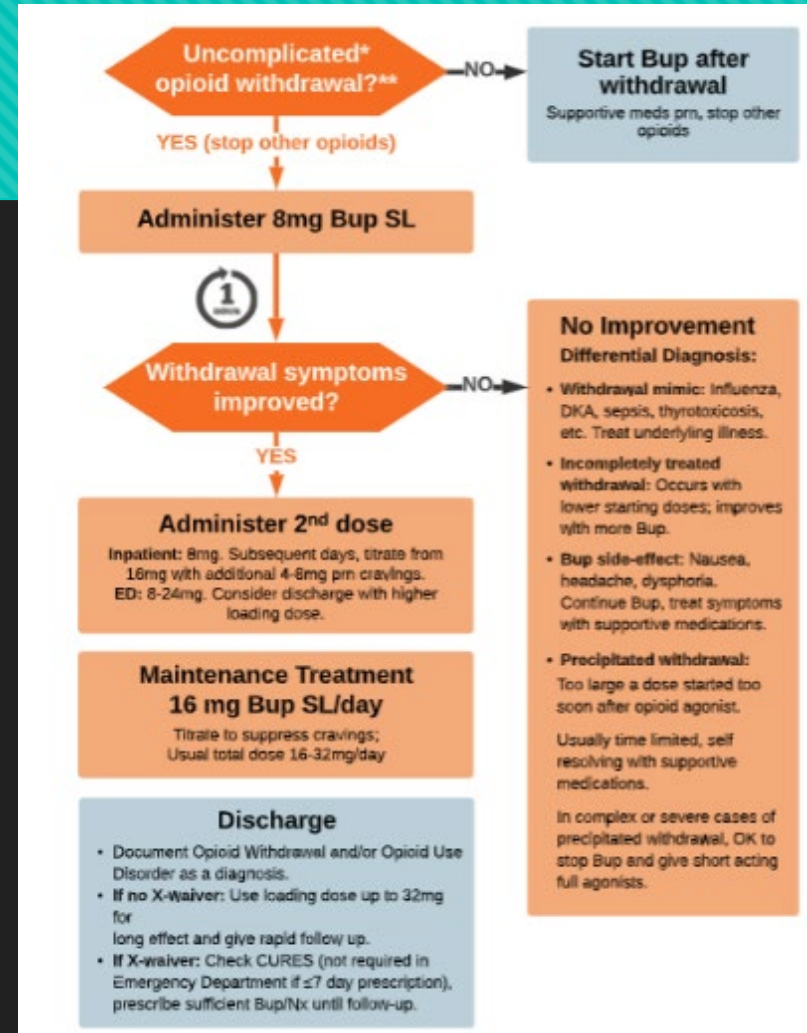
# Starting Bupe



COWS  
8+



Bupe  
8





# Time for monitoring dosage of buprenorphine



12 – 24 mg

# X-waiver

- Physicians no longer need 8 hours of specialized training
- As long as you maintain less than 30 patients at any one time on bupe
- Fill out a form at the following link:
  - <https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php>

The screenshot shows the SAMHSA Buprenorphine Waiver Notification form. The header includes the SAMHSA logo and the title "Buprenorphine Waiver Notification", with a "View Practitioner Profile" link on the right. The main content area is titled "New Applicant Eligible For Waiver Level 30 or 100". Below this, a paragraph states: "Based on the credentials entered, you appear to be a new applicant. If this is not the case and you have previously submitted a waiver application, please recheck your data and resubmit so that we can link your new activity to your existing account. If you need further assistance, please contact our help desk at 866-BUP-CSAT (866-287-2728). You can also email us at infobuprenorphine@samhsa.hhs.gov." The form then presents two options for starting at the 100-patient level, each with "No" and "Yes" radio buttons. Option 1: "I am board certified in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology." Option 2: "I provide medication-assisted treatment with covered medications (as such terms are defined under 42 C.F.R. § 8.2) in a qualified practice setting as described under 42 C.F.R. § 8.615." Below these, there are checkboxes for "I wish to apply for the 30-patient level with training." and "I wish to apply for the 30-patient level with exemption (no training required)." The "exemption" checkbox is selected. A message states: "You are applying for the 30-patient level at this time. Press the Next button to begin your application." A "Next" button is located at the bottom right of the form area. At the bottom of the page, there is a section titled "Select your practitioner type:" with radio buttons for "MD/DO" (selected), "APRN (NP/CNS/CRNA/CNM)", and "PA".

**SAMHSA Buprenorphine Waiver Notification** [View Practitioner Profile](#)

### New Applicant Eligible For Waiver Level 30 or 100

Based on the credentials entered, you appear to be a new applicant. If this is not the case and you have previously submitted a waiver application, please recheck your data and resubmit so that we can link your new activity to your existing account. If you need further assistance, please contact our help desk at 866-BUP-CSAT (866-287-2728). You can also email us at infobuprenorphine@samhsa.hhs.gov.

**Starting at the 100-Patient Level**  
New legislation makes it possible for practitioners to apply for a waiver at the 100-patient level if they meet the following condition(s):

☒ **No** ☐ **Yes** I am board certified in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology.  
OR  
☒ **No** ☐ **Yes** I provide medication-assisted treatment with covered medications (as such terms are defined under 42 C.F.R. § 8.2) in a qualified practice setting as described under 42 C.F.R. § 8.615.

☐ I wish to apply for the 30-patient level with training.

☒ I wish to apply for the 30-patient level with exemption (no training required).

You are applying for the 30-patient level at this time. Press the Next button to begin your application.

[Next](#)

Select your practitioner type:  
☒ MD/DO ☐ APRN (NP/CNS/CRNA/CNM) ☐ PA

# Maintenance

Buprenorphine/Naloxone  
8/2 mg BID x 7 days, #14

# Home Start Instructions

## Starting Buprenorphine at Home

### When to start:

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

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

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

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

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

### When you start:

- Put **4 mg (1/2 tablet/film) under the tongue**. Do not swallow the buprenorphine. It is best absorbed under the tongue. It takes 20-45 minutes for the medicine to have an effect. Usually you will feel a little better, or at least no worse. If you feel worse, it means you started taking it too soon.
- **1 hour or more after the first dose see how you feel.**
  - If you have worsening symptoms of withdrawal, stop. Wait several more hours (~6) until you try again.
  - If you feel the same or better, take another 4 mg.
    - In 12 hours, you can begin to take your regular dose of 8 mg every 12 hours.

### Cautions:

- Don't take buprenorphine when you are high.
- Don't use buprenorphine with alcohol.
- Don't use buprenorphine with benzodiazepines like alprazolam (Xanax®), clonazepam (Klonopin®), diazepam (Valium®), or lorazepam (Ativan®).
- Don't use buprenorphine if you are taking other medicine for pain until you talk to your doctor.
- Don't use buprenorphine if you are taking more than 60 mg of methadone.
- Don't lose your buprenorphine. It cannot be refilled early.
- Don't swallow or suck on the buprenorphine.

# Linkage to Care

- Extremely important to share methadone dosing info with the OTP



How do we  
*make it happen?!*

# CA Bridge Model

Revolutionizing The System Of Care



Low-Barrier Treatment

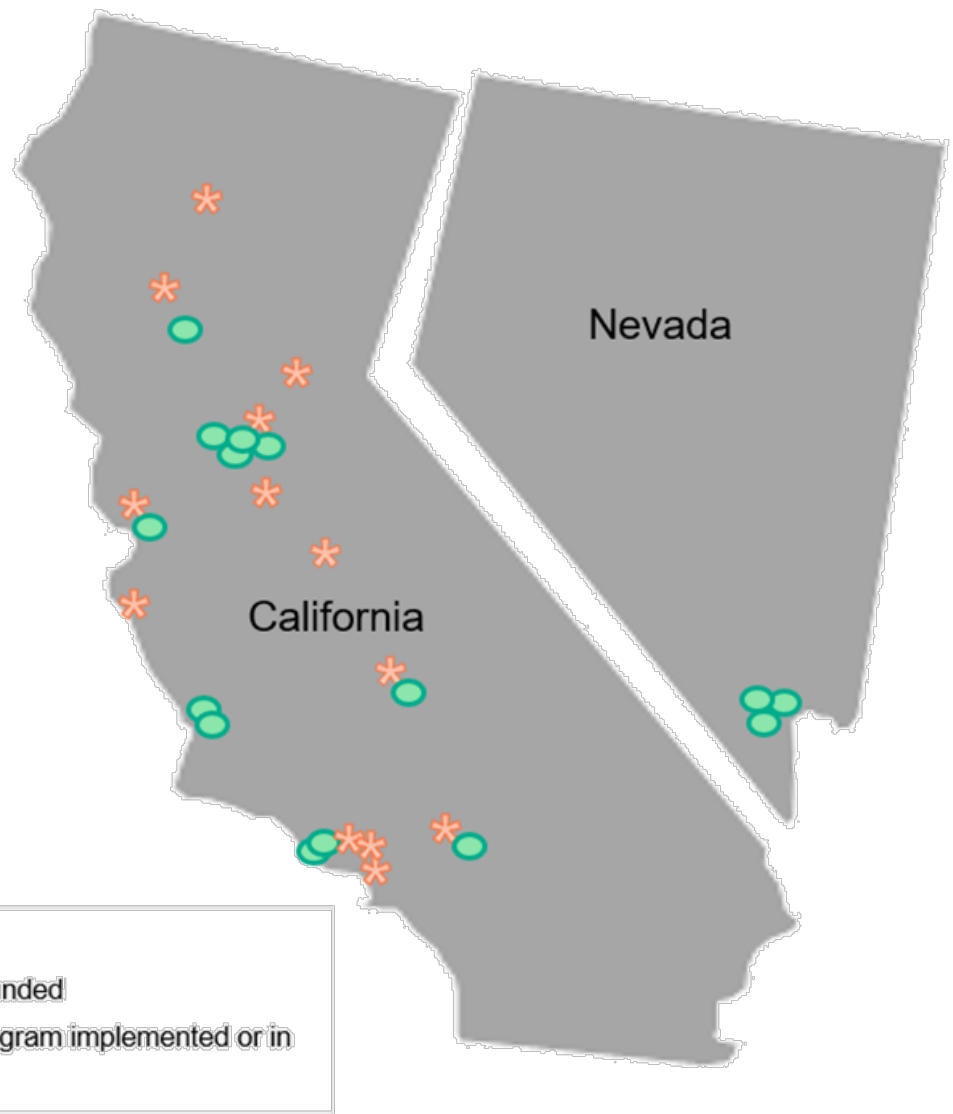


Connection to Care and  
Community



Culture  
of Harm Reduction

**Starting out 2019: 28 sites**





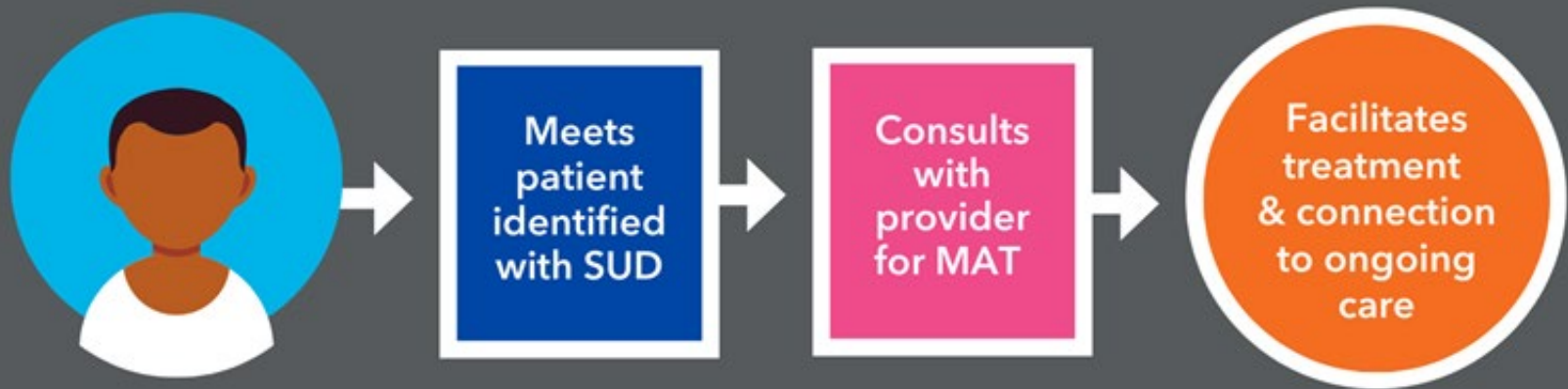
# Pro Tips to Make it Happen:

1. Establish Leaders.
2. Build a support network
3. Create a smooth patient referral process
4. Secure Executive Support
5. Measure & report back



# The Substance Use Navigator

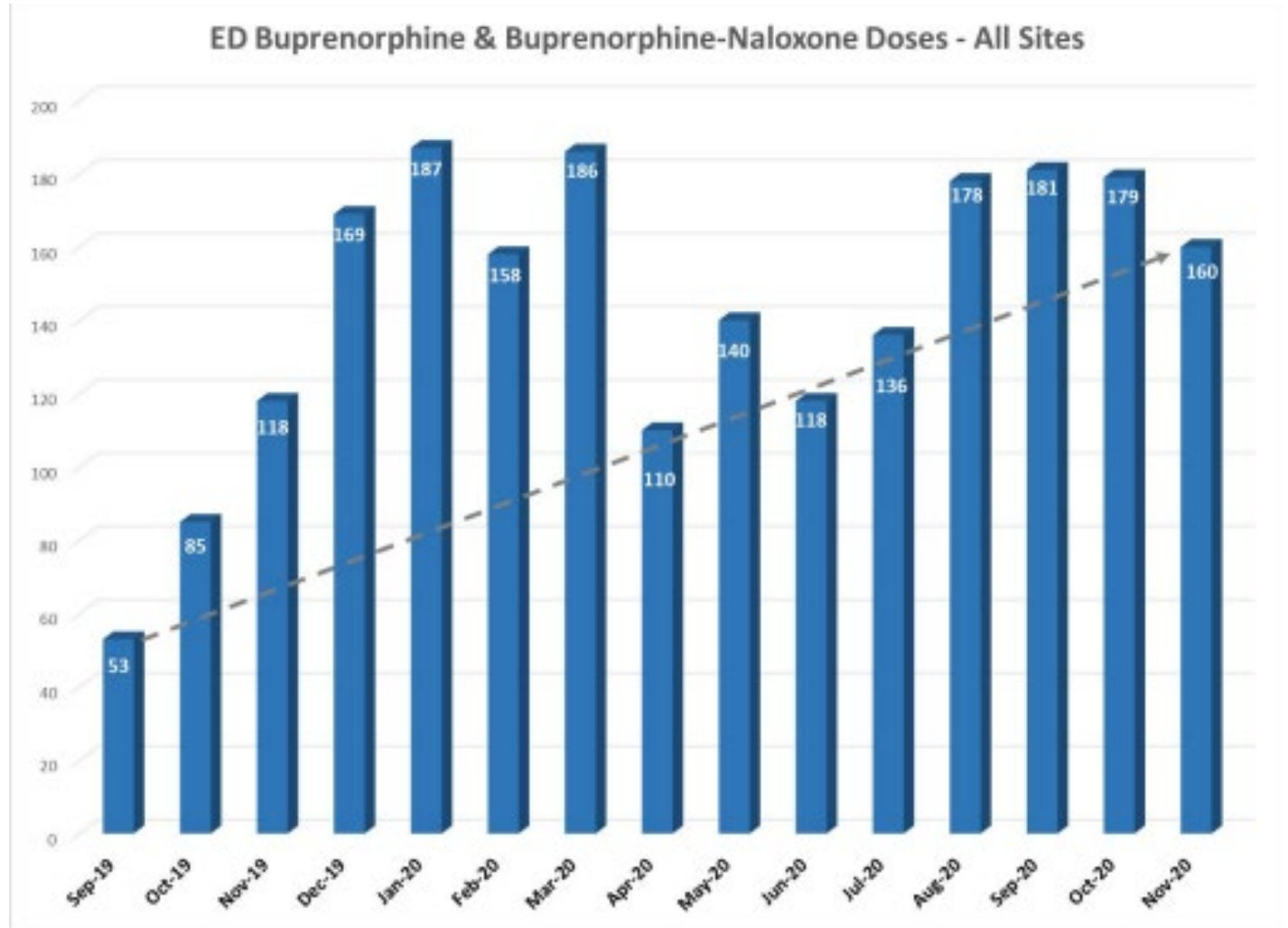
guides patients with acute substance use disorder (SUD) through the emergency department and beyond.



# Initial Action Items

3. Establish a **referral process with** at least one MAT clinic, & one Telehealth provider.
4. Designate a person responsible for the **“warm handoff”** / ***linkage to care*** – Substance Use Navigator, Social Worker, charge RN, etc.

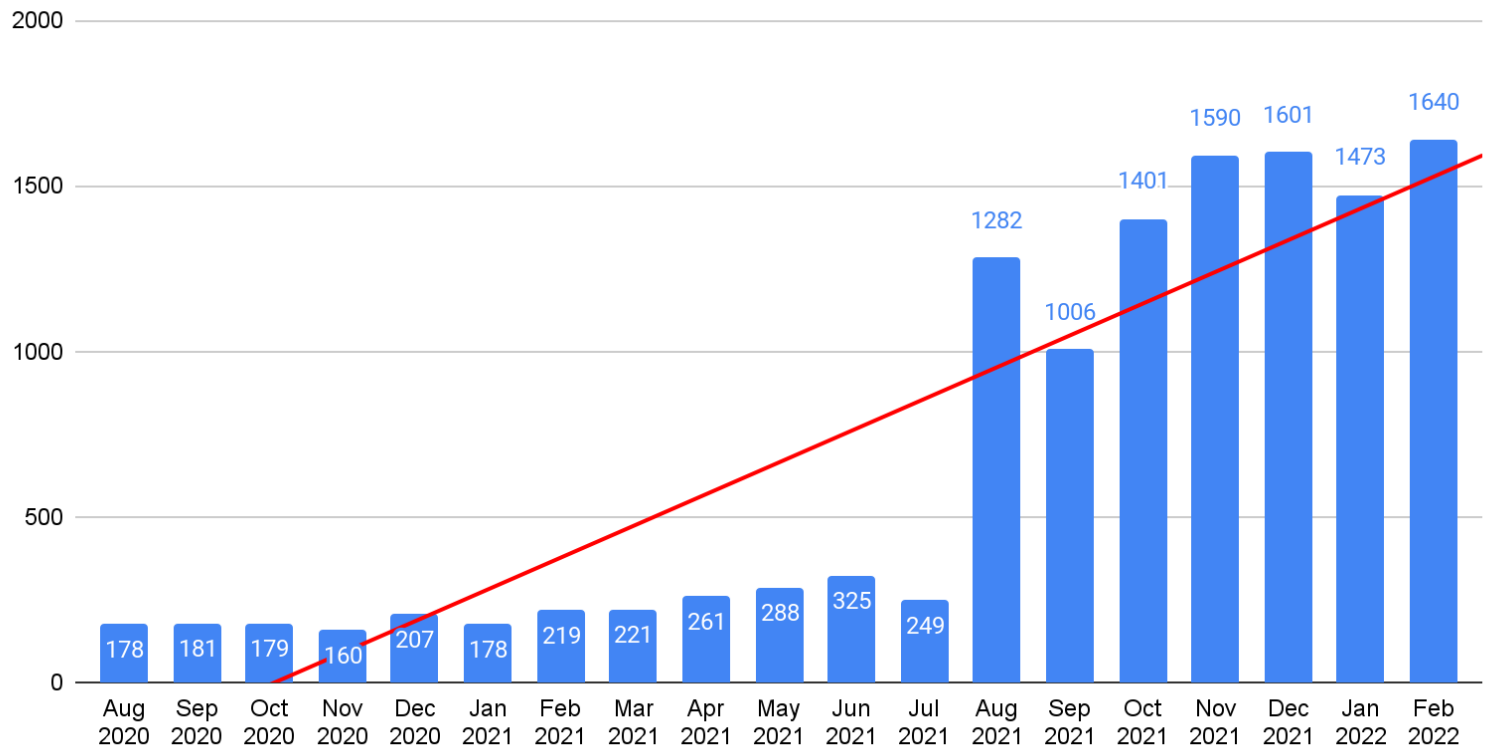
# MAT: Our First Year



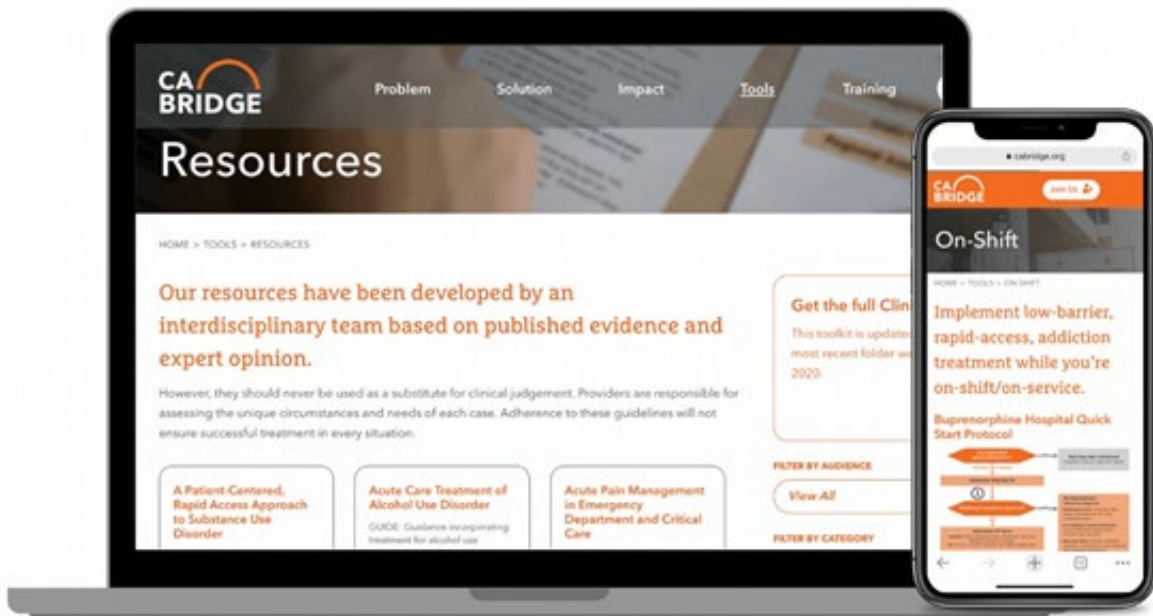
**MAT:**  
**Year #2!**

## ED Buprenorphine & Buprenorphine-Naloxone Doses by Month

Aug 2020 - Feb 2022



# CABridge.org Resources









# Questions?

# Opioid Stewardship Resource Site

<https://www.hsag.com/osp-resources>



**Quality Improvement Organizations**  
Sharing Knowledge. Improving Health Care.  
CENTERS FOR MEDICARE & MEDICAID SERVICES



**HSAG** HEALTH SERVICES ADVISORY GROUP

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You are here: Home ▶ Medicare Quality Improvement (QIO) ▶ Hospitals Task Areas ▶ Opioid Stewardship

## Opioid Stewardship



### ED Treatment of Opioid Withdrawal

- AHA—Stem the Tide: Addressing the Opioid Epidemic
- Clinical Opiate Withdrawal Scale (COWS)
- CDC—Creating a Culture of Safety for Opioid Prescribing: A Handbook for Healthcare Executives
- Buprenorphine: An Overview for Clinicians
- Management of Opioid Use Disorder in the Emergency Department: A White Paper Prepared for the American Academy of Emergency Medicine (pp. 5–7)
- Support for Hospital Opioid Use Treatment (SHOUT) Webinar 6: Discharge Planning and ED Buprenorphine Induction
- CA Bridge Guide—Treatment of Substance Use Disorders in Association with COVID-19
- CA Bridge Guide—Acute Pain Management in Patients on Buprenorphine in ED and Critical Care
- HHS—Pain Management Best Practices (pp. 26, 65)
- Recommendations from the ERAS® Society for standards for the development of enhanced recovery after surgery guidelines
- Basics of Enhanced Recovery
- HSAG—Enhanced Recovery After Surgery (ERAS) and Managing the Difficult Patient

### Referring for Ongoing MAT/SUD Treatment

- Bridge Program—Buprenorphine-Naloxone: What You Need to Know
- CA Bridge—MAT Options for Ongoing Treatment After Hospital Starts
- CDC—Creating a Culture of Safety for Opioid Prescribing: A Handbook for Healthcare Executives (pp. 14–15)
- CDC—Vital Signs: Opioid Overdoses Treated in Emergency Departments—Identify opportunities for action
- SAMHSA Treatment Locator
- AHCCCS Treatment Locator
- A Health System-Wide Initiative to Decrease Opioid-Related Morbidity and Mortality (p. 4)


### SNF

- The Care of Residents with Opioid and Stimulant Use Disorders in Long-Term Care Settings


#### Opioid Stewardship Assessments

Download PDF versions:

- Emergency Department OSP Assessment
- Acute Care Provider OSP Assessment
- Skilled Nursing Facility (SNF) Pain Assessment and Management Program



#### Opioid Stewardship Quickinars & Assessments



#### Medicare Quality Improvement (QIO)

COVID-19 Events

QIO Events

# Action Items by Next Quickinar (5/12/2022)

1. Complete your OSP Assessment in the HSAG QIIP.  
If you have difficulty, email it to Claudia at [ckinsella@hsag.com](mailto:ckinsella@hsag.com).

2. Identify your Bridge MOUD leaders and establish a workflow for initial treatment and referral to MAT clinic.



# OSP “Quickinar” Schedule: Mark Your Calendars

<b>OSP Quickinar Kickoff: Introduction to Opioid Stewardship and Quickinar Format</b> Thursday, October 21, 2021   10:30–11:00 a.m. PT ✓	<b>Partnering with Pharmacists for ongoing Medication Management</b> Thursday, February 10, 2022   10:30–11:00 a.m. PT ✓
<b>OSP Assessment Overview</b> Thursday, October 28, 2021   10:30–11:00 a.m. PT ✓	<b>Double Trouble: Benzos and Opioids   Harm Reduction with Naloxone</b> Thursday, March 10, 2022   10:30–11:00 a.m. PT ✓
<b>Interpreting the OSP Assessment Results/Developing an Action Plan</b> Thursday, November 18, 2021   10:30–11:00 a.m. PT ✓	<b>Medication for OUD (MOUD): Prescribing Buprenorphine</b> Thursday, April 14, 2022   10:30–11:00 a.m. PT ✓
<b>Developing a Dashboard</b> Thursday, December 9, 2021   10:30–11:00 a.m. PT ✓	<b>Getting Patient Buy-in through Education</b> Thursday, May 12, 2022   10:30–11:00 a.m. PT
<b>Screening Patients for OUD Risk and Opioid Withdrawal</b> Thursday, January 13, 2022   10:30–11:00 a.m. PT ✓	<b>Reevaluating Your Program and Celebrating Success</b> Thursday, May 26, 2022   10:30–11:00 a.m. PT
<b>A Good Discharge Plan for Pain Management with Opioids</b> Thursday, January 27, 2022   10:30–11:00 a.m. PT ✓	

**Register for the entire OSP “Quickinar” series today!**  
[bit.ly/OpioidStewardshipProgramQuickinars](https://bit.ly/OpioidStewardshipProgramQuickinars)



# Please Take 5 Seconds and Let Us Know



We want this call to be meaningful to you, so we need your input.

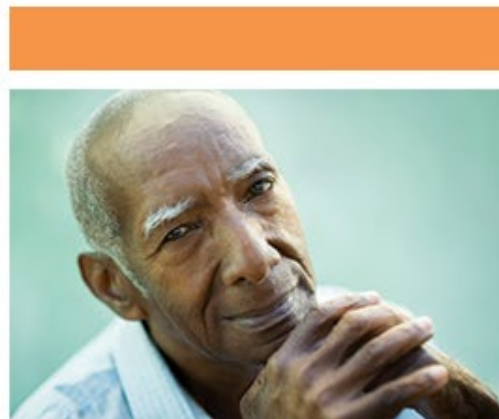
At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing opioid stewardship practices.

## Thank you!

Claudia Kinsella: [ckinsella@hsag.com](mailto:ckinsella@hsag.com)

Jeff Francis: [jfrancis@hsag.com](mailto:jfrancis@hsag.com)





## CMS Disclaimer

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