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Primary Care Addiction Medicine

Implementation Guide

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THE WACO GUIDE

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Table Of Contents [3]

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Background

Substance use disorders (SUDs) are common, occurring in up to 17% of the population in a given year; however, only a fraction of people with an SUD receive treatment.[1] As a result, the United States now faces a crisis of overdose deaths; 105,000 people died from a drug overdose in 2023.[2] Adolescent deaths from opioid use have markedly increased, now making drug overdose/poisoning the third leading cause of pediatric death following firearm injuries and motor vehicle collisions.[3]

Primary care clinicians (PCPs) often build therapeutic relationships centered in compassion and cost-effective, shared decision making that is well congruent to the care required in substance use treatment.[4] Moreover, the United States Department of Health and Human Services advocates for a primary care–forward approach to addiction treatment as the most effective means to improve population level access to treatment.[5] However, PCPs report several barriers to substance use care delivery: (1) structural or system-level barriers; (2) difficulty engaging with patients; (3) limited proficiency in prescribing medications for substance use treatment; and (4) varying attitudes on primary care's role in addiction medicine services.[6]

The primary care system, being the de facto system for mental health in the United States, has the incredible opportunity to provide essential and meaningful addiction treatment services for millions of affected individuals. The Primary Care for Addiction Medicine (PCAM) model detailed in this implementation guide improves the way we approach care for addiction in the primary care context using a multimodal service delivery. This model addresses many of the reported barriers to effective implementation highlighted above by consolidating resources into a hub-and-spoke model that leverages extant resources.

Our intent with this implementation guide is to provide a starting point for other primary care systems looking to institute similar addiction medicine programs. While this implementation guide is not comprehensive, we hope that most of the tools in it will catalyze innovation and transform care at a population level.

References

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03 Friedman J, Hadland SE. The overdose crisis among US adolescents. N Engl J Med. 2024;390(2):97-100. doi:10.1056/NEJMp2312084.

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05 US Dept. of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Best practices and barriers to engaging people with substance use disorders in treatment. 2019.

06 Austin EJ, Chen J, Briggs ES, et al. Integrating opioid use disorder treatment into primary care settings. JAMA Netw Open. 2023;6(8):e2328627.

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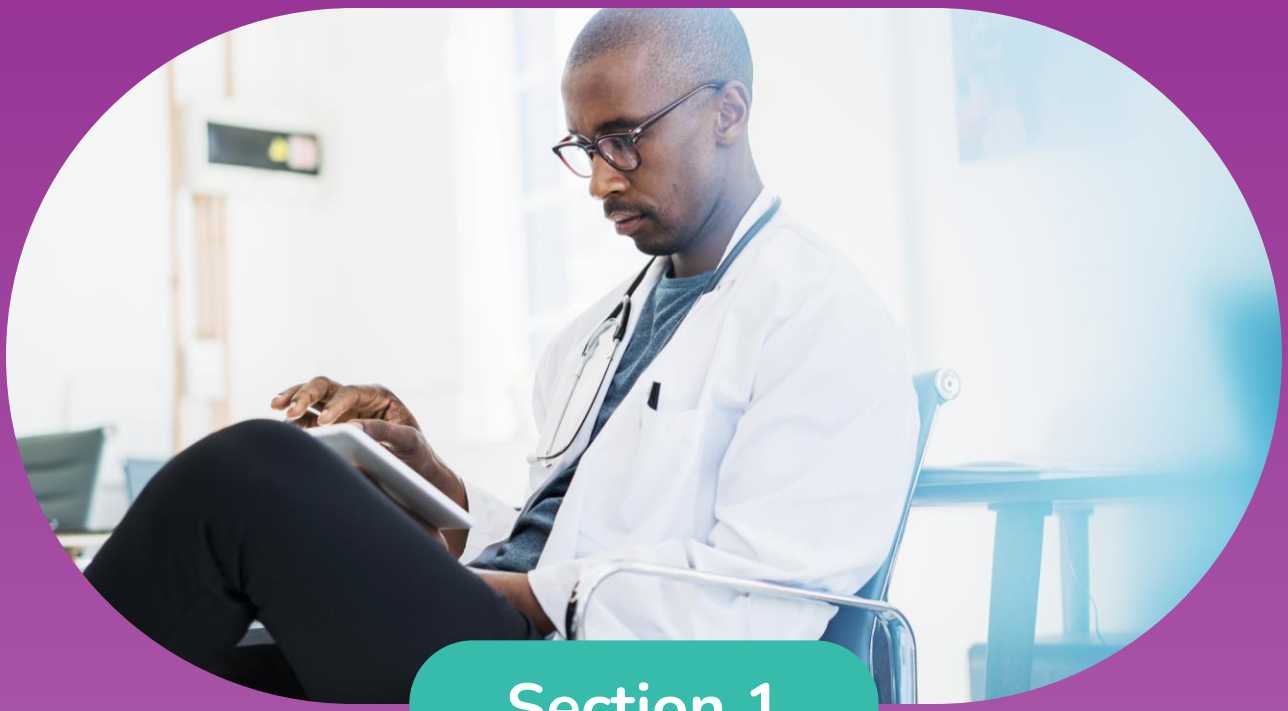

Section 1

Implementation Resources

PCAM Implementation Checklist

Clinician Champion(s)

- At least one clinician, but more likely a group of champions to lead the innovation
- Prescribing proficiency can be enhanced through use of clinical decision support tools, which are included in this implementation guide
- Lead the organization and direction of the team as a whole

Nursing and Ancillary Staff

- Staff should be patient and flexible, able to adapt to new situations, and have excellent problem-solving skills

Behavioral Health Providers

- Importantly, this is not a required portion of treatment for any patient

Clinical Instruments and Patient Education Material

- Included in this implementation guide

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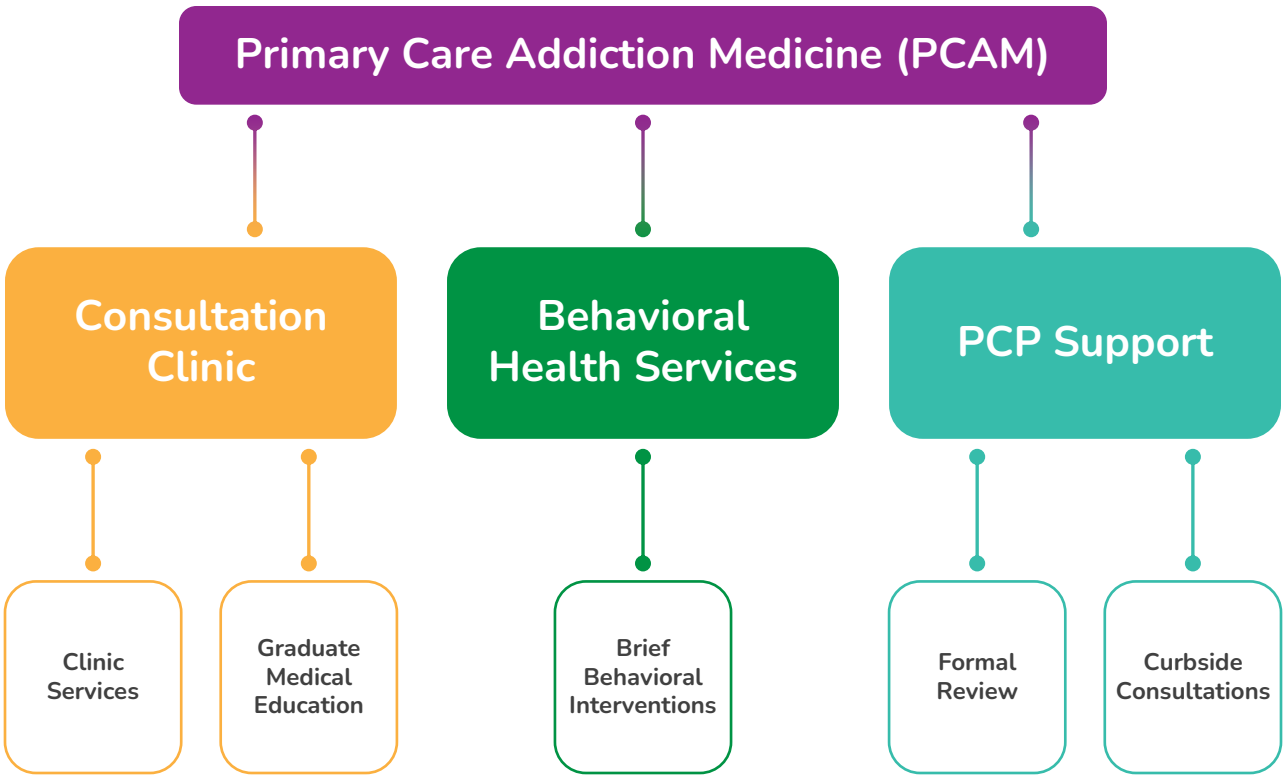
PCAM Concept Map

Primary Care Addiction Medicine (PCAM) represents a clinical model to support addiction medicine treatment access within an existing primary care healthcare system. The PCAM concept is built on the hub-and-spoke model for health service delivery. Patients access clinical services directly through a consultation clinic, which serves as the hub. Additionally, patients in other portions of the health system may receive addiction care through their PCPs, who are the spokes of the model.

The hub supports this care through chart reviews and curbside consultations as needed. The hub-and-spoke structure allows a health system to consolidate resources and expertise into a centralized structure for efficiency. This centralization, in turn, helps support the broader population health aims of the clinic. Thus, the PCAM model represents an effective means for health systems to "mainstream" addiction medicine into existing clinic service structures.



Consultation Clinic

- Functions as the home base for PCAM operations
- Centralizes expertise for greater efficiency
- Serves as a platform for graduate medical education

Behavioral Health Services

- Brief behavioral interventions to complement medical treatment of addiction
- Extends the principles of integrated behavioral health to addiction medicine

PCP Support

- Provides support to the entire health system
- Leverages the centralized expertise of the consultation clinic (the hub) to strengthen the preparedness of other clinicians to treat addiction (the spokes)
- PCPs interact with addiction medicine hub through formal chart reviews or through curbside consultations
- Chart reviews: PCPs send records to the clinicians in the consultation clinic who review the case and provide recommendations related to addiction treatment back to the PCP
- Curbside consultations: Clinicians in the consultation clinic are available for as-needed clinical questions

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Nursing Procedures Best Practices

Tips for Success

- Having a single point of contact is extremely important, as this helps to develop a trusting relationship with patients.
- Flexibility and problem-solving are crucial qualities in nursing and other ancillary staff.

For New Patient Appointments (Intakes)

- Maintain a direct referral process to prioritize same-week or next-week access.
- Day before intake appointment:
  - Chart review for screening needs (hepatitis, HIV, IPV) or paperwork needs.
  - Call or text a reminder to the patient regarding upcoming appointments.
- Day of the appointment:
  - Schedule follow-up before departure and provide direct contact information.

For Follow-Up Appointments

- Maintain a list/registry for tracking follow-up and refill needs.
- Schedule follow-up before refill needs.
- Establish what modalities for visits work best for your patients (e.g., phone visits after missed in-person appointment).

PCAM Behavioral Health Integration

Brief Behavioral Interventions	
Motivational Interviewing (MI)	✓ Used to elicit and enhance patients' motivations for making behavior change ✓ Important to recognize dynamic stages of behavior change
Solution-Focused Brief Therapy (SFBT)	✓ Goal-directed approach to help patients construct solutions to barriers to treatment engagement and retention ✓ Patients identify coping mechanisms that have been helpful in the past, and problem solve around how to incorporate them again
Cognitive Behavioral Therapy (CBT)	✓ Helps patients change unhelpful or negative thoughts and behaviors ✓ Typically structured, goal-oriented, and time-limited sessions focusing on current thoughts and behaviors impacting treatment
CBT for Insomnia (CBT-I)	✓ Specifically for patients with chronic insomnia ✓ Useful for both onset and maintenance insomnia ✓ Typical structure includes psycho- and sleep hygiene education, stimulus control, sleep restriction, and cognitive therapy focused on negative thoughts regarding insomnia
Acceptance and Commitment Therapy (ACT)	✓ Aims to increase patients' psychological flexibility ✓ Six main tenets include: acceptance, attention to the present moment, values, committed action, self as context, and defusion

Integration of Brief Behavioral Interventions	
Hallway Handoff	✓ Medical practitioner and behavioral health provider (BHP) meet outside of the exam room to discuss care for an identified patient ✓ BHP meets with the patient without the medical practitioner present, typically after the medical practitioner has seen the patient ✓ Most helpful and practical for existing BHP and patient relationships, but not exclusively
Warm Handoff	✓ As in the hallway handoff, the clinician typically brings BHP into the exam room to introduce the BHP to the patient ✓ Most helpful for establishing BHP-patient relationship using the medical practitioner–patient relationship
Reverse Warm Handoff	✓ The BHP identifies a patient that could benefit from a behavioral intervention and sees the patient before the medical practitioner ✓ The BHP then briefs the clinician, who sees the patient for further clinical management ✓ Most helpful when the BHP and the patient have an existing relationship with an existing behavioral intervention plan on which the BHP can follow up
Co-visit	✓ The clinician and BHP see the patient together ✓ Helps establish the team mentality approach to treatment by bringing all parties into the exam room ✓ Most helpful when the patient's treatment needs are primarily behavioral ✓ Also helpful when room turnover time is tight, as this method is often the most time efficient

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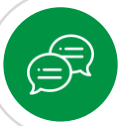
Motivational Interviewing Principles

OARS (open-ended questions, affirmations, reflections, summaries)

- OARS are key microskills of MI that help elicit change talk
- Motivational interviewing supports patients in exploring ambivalence by collaboratively identifying intrinsic motivations for change prior to addressing strategies for implementation
- Communication style that focuses much more on statements than questions
- Open-ended questions
  - Goal is to open the door to further communication rather than fact finding
  - "Can you tell me about what brings you here today?"
  - "Can you tell me more about how this began?"
- Affirmations
  - Offer positive observations of patient strengths, acknowledge their efforts
  - "It takes a lot of courage to discuss something so personal with us today."
  - "I am so glad you came into the clinic today. It isn't always easy the first time."
  - "I appreciate your willingness to meet with me today."
- Reflections
  - Bread and butter of MI
  - Statements, not questions, in response to what a patient says
  - Focus on listening rather than questioning, providing space for clarification, expressing empathy, and building trust instead of interrogating
  - Beware of the righting reflect—the urge to give the answer to a difficult scenario or question
  - "It seems like . . ."
  - "It sounds like . . ."
- Summaries
  - Paraphrased statements that highlight key points, helping to transition and bring closure to the conversation
  - Sometimes lead to a plan, but not always
  - The clinician's goal is to summarize the patient's change talk and the steps they're taking toward behavior change while also guiding the conversation toward planning next steps
  - "If it's OK, I'd like to review what we've discussed so far . . ."



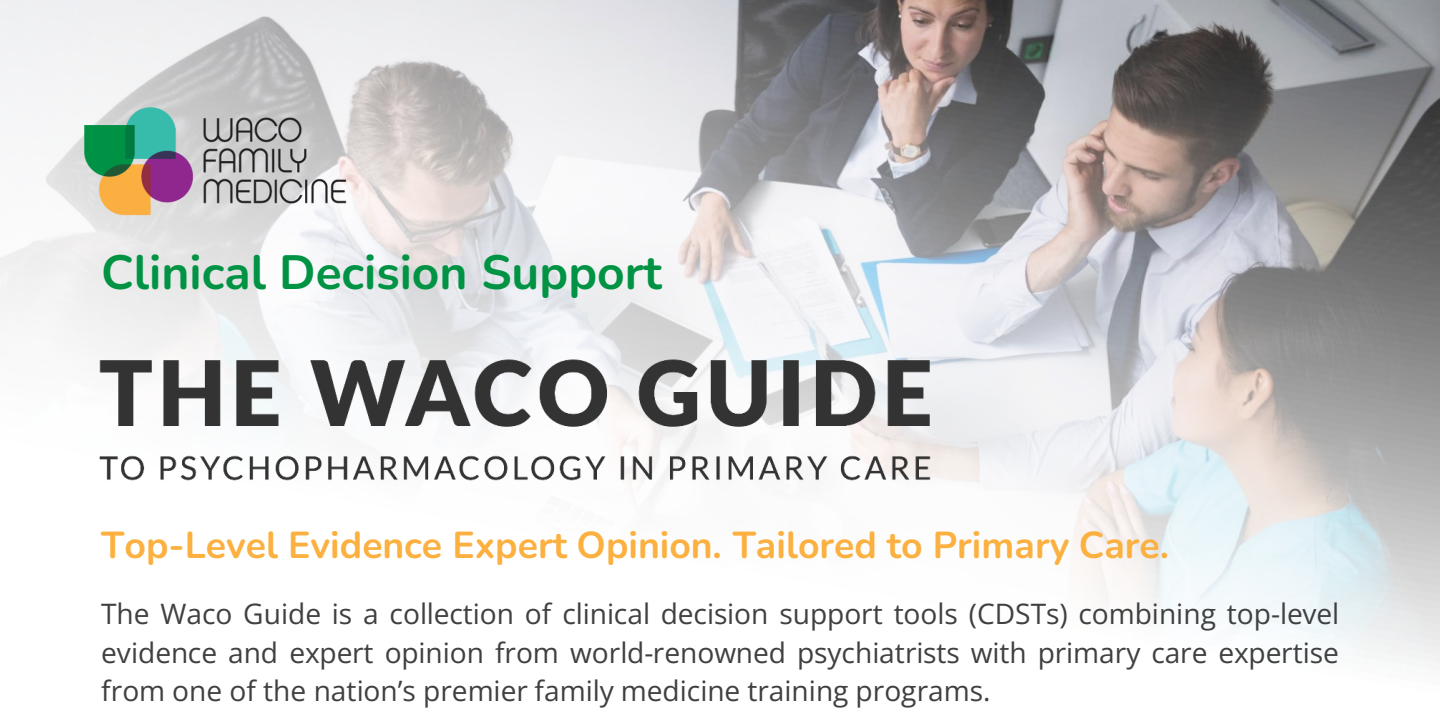
Change/Sustain Talk

- Goal is to move patients with ambivalence from sustain talk to change talk
- Sustain talk is the patient's own motivations and verbalizations favoring the status quo
- Change talk is any self-expressed language that is an argument for change

- Studies show that as change talk increases, the likelihood of behavior change also increases
- Goal is to evoke and reinforce change talk and limit evocation of sustain talk
- Clinicians influence change/sustain talk
  - If you reflect/ask a question about sustain talk, you will tend to hear back sustain talk
  - If you reflect/ask a question about change talk, you will tend to hear back change talk
- Strategies for responding to sustain talk
  - Amplified reflection: intensify to what you've just heard
  - Double-sided reflection
    - Recognize sustain talk and relate it to change talk
    - Use "and," not "but"
    - "You think it's going to be a real challenge to change the way you cook and eat, and you also shared how important it is to keep your blood sugar level regulated."
  - Emphasize autonomy
    - Emphasize their own right to choose next step (be careful to avoid sarcasm)
    - "I wonder what you'll decide to do."
  - Reframing
    - Offer a different meaning or take on what the patient is experiencing
    - Agreeing with a twist
  - Running head start
    - Summarize the patient's stated reasons for not changing, then ask about downsides of not changing

Change Planning

- Timing
  - Use your clinical intuition and engagement with patient to ensure they're ready to plan
  - Research suggests that requiring a change plan at the end of every visit may not be helpful and could even be counterproductive
- Ask a KEY question (if ready for change)
  - "Given all you have said, where should we go from here?"
  - "It sounds like you are ready to address this issue. What now?"
- SMART planning
  - Specific: "What will you do?"
  - Measurable: "How long? How much? How many?"
  - Achievable/Realistic: "What have you done before that's worked?"
  - Timely: "When will you start?"



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Clinical Decision Support

THE WACO GUIDE

TO PSYCHOPHARMACOLOGY IN PRIMARY CARE

Top-Level Evidence Expert Opinion. Tailored to Primary Care.

The Waco Guide is a collection of clinical decision support tools (CDSTs) combining top-level evidence and expert opinion from world-renowned psychiatrists with primary care expertise from one of the nation's premier family medicine training programs.

The Waco Guide features several CDSTs on evaluating and treating substance use disorders—including alcohol use, stimulant use, opioid use, and nicotine use, among others—for adult, adolescent, and perinatal populations.

This resource is free to all clinicians, accessible either through the website or as an iOS or Android app download. Additionally, for easy reference, the CDSTs for substance use disorder treatment are included in this implementation toolkit.

The Waco Guide has been featured by the American Medical Association and the American College of Physicians.

AMA

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

The Waco Guide was developed by faculty of the Waco Family Medicine Residency in consultation with faculty of Massachusetts General Hospital Visiting.

MGH VISITING

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SCAN

Scan the QR code to access the full Waco Guide library of decision support tools and other resources

Team-Based Care Roles and Responsibilities

	Front Office	CNA	MA	Care Manager	BH Provider	Peer Support	Clinician	Other
Identifying and Engaging Patients								
Handles referrals into clinic								
Schedules patients for assessment and follow-up								
Monitors schedule utilization								
In-Office and Telehealth Appointments								
Rooms patients and completes vitals								
Administers standardized assessments (e.g., intake forms, PHQ-9, etc.)								
Provides BH assessment and diagnosis								
Provides brief behavioral interventions (e.g., SFBT)								
Prescribes medications								
Maximizes treatment of comorbid conditions (e.g., depression)								
Educates patients and support people on medication and treatment plan								
Facilitates internal and/or external referrals as needed to support treatment								
Schedules patients for follow-up appointments								
Asynchronous Treatment Support								
Engages patients as needed during early treatment								
Tracks follow-up appointments and proactively reaches out to reschedule as needed								
Coordinates internal and external referrals								
Repeats validated instruments, if needed, to support treatment (e.g., PHQ-9 repeat assessment)								
Arranges team conferences to report on treatment plans								
Adjusts treatments as needed								
Additional Activities								
Coordinates regular team huddles								
Champions QI initiatives								
Reports on utilization metrics and QI initiatives								

Adapted from the AIMS Center, University of Washington Department of Psychiatry and Behavioral Sciences

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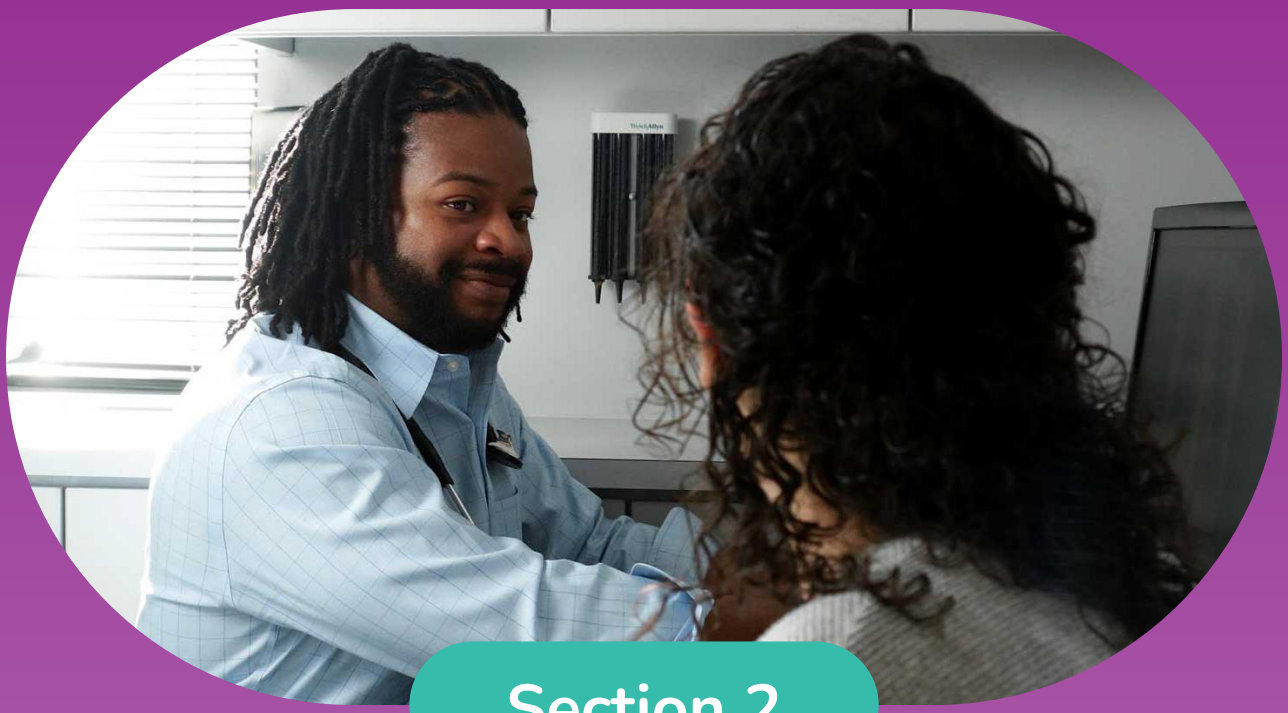


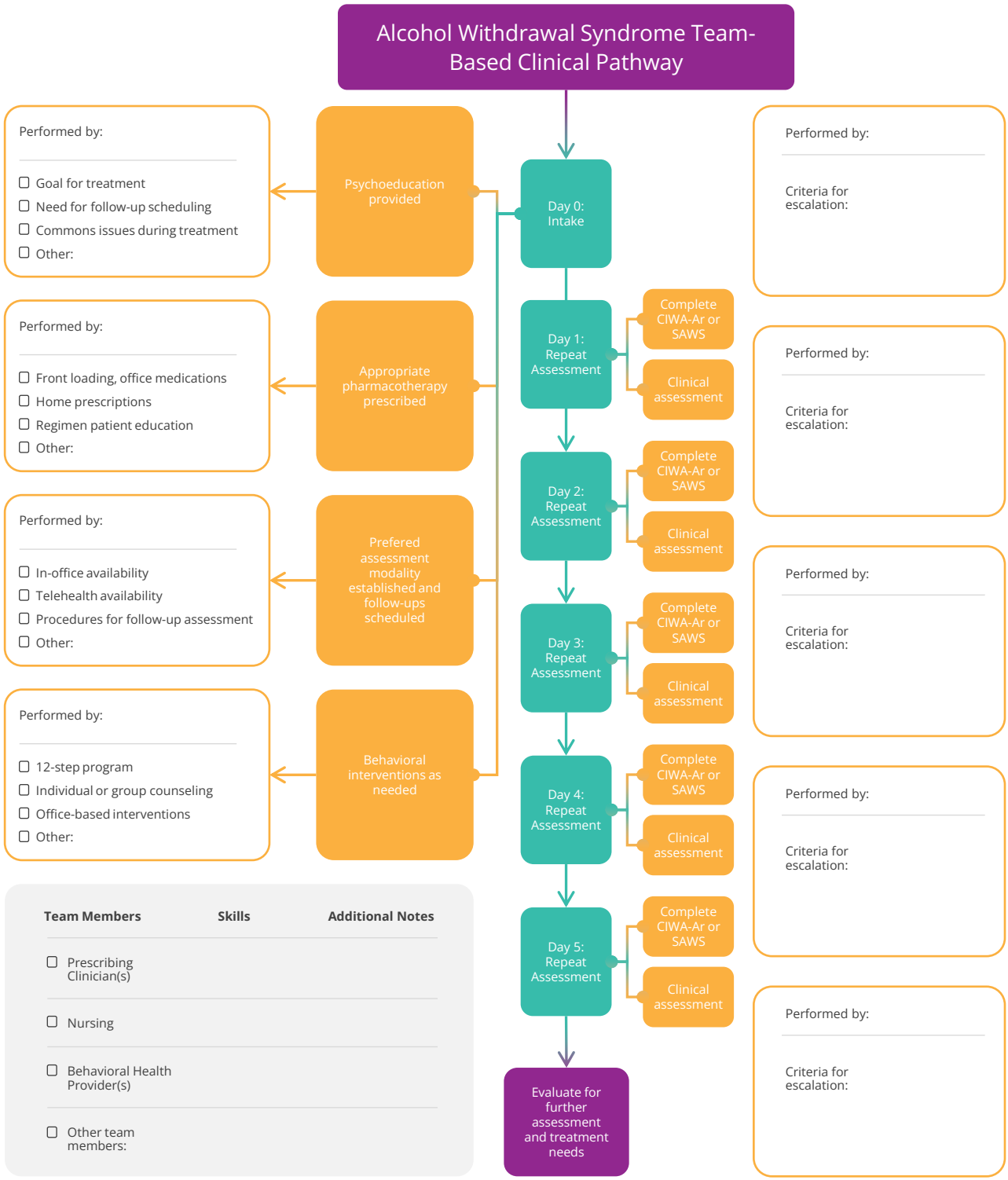
Section 2

Clinical and Patient Resources

Alcohol Use Disorder Resources

The following resources include common instruments to assist in the evaluation of alcohol use disorder. Alcohol withdrawal treatment is an essential aspect of care. Therefore, the first resource in this implementation guide is a clinical pathway that is customizable based on clinical team members and/or resources.

Team-Based Clinical Care Pathway



Drink Diary - English

Date: _____

Week#: _____

GOAL:

Max # of drinks/day: _____

Max # of drinks/week: _____

Reason for Drinking:

C = for Coping

P = Pleasure

H = for Habit

Day of the Week	# of drinks in the morning	# of drinks in the afternoon	# of drinks in the dvening	# of total drinks for the day	Reasons for drinking today	Did your drinking cause you any problems? Yes or No	What thoughts or feelings were you experiencing?
Monday Date:							
Tuesday Date:							
Wednesday Date:							
Thursday Date:							
Friday Date:							
Saturday Date:							
Sunday Date:							

Total # of drinks this week: _____ Most common reason(s) for drinking this week: _____

Time(s) of day when most of your drinking occurred: _____

Additional notes related to your use or urges to drink alcohol: _____

Drink Diary - Spanish

Objectivo:

Fecha: _____ Total de bebidas en un día: _____

Semana #: _____ Total de bebidas en una semana _____

Razón para Beber:

C = Afrontar
P = Placer
H = Hábito

Registro Diario	# bebidas en la mañana	# bebidas en la tarde	# bebidas en la noche	# total de bebidas en el día	Razones para beber hoy	¿Tu consumo de alcohol te causó algún problema? Sí o No	¿Qué pensamientos o sentimientos estabas experimentando?
Lunes Fecha:							
Martes Fecha:							
Miércoles Fecha:							
Jueves Fecha:							
Viernes Fecha:							
Sábado Fecha:							
Domingo Fecha:							

Total de bebidas esta semana: _____ Razón(es) más común(es) para beber esta semana: _____

Hora(s) del día en la(s) que más bebiste: _____

Notas adicionales relacionadas con tu consumo o impulsos de beber alcohol: _____

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____ Blood pressure: _____

NAUSEA AND VOMITING: Ask "Do you feel sick to your stomach? Have you vomited?" Observation. 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	TACTILE DISTURBANCES: Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation. 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
TREMOR: Arms extended and fingers spread apart. Observation. 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended	AUDITORY DISTURBANCES: Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation. 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
PAROXYSMAL SWEATS: Observation. 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	VISUAL DISTURBANCES: Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation. 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
ANXIETY: Ask "Do you feel nervous?" Observation. 0 no anxiety, at ease 1 mild anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	HEADACHE, FULLNESS IN HEAD: Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe
AGITATION: Observation. 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about	ORIENTATION AND CLOUDING OF SENSORIUM: Ask "What day is this? Where are you? Who am I?" 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place/or person

Total CIWA-Ar Score _____ Rater's Initials _____ Maximum Possible Score 67

 This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, and Sellers EM. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). British Journal of Addiction 1989;84:1353-1357, 1989.

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Short Alcohol Withdrawal Scale (SAWS)

Score each symptom based on the following scale:

None = 0 Mild = 1 Moderate = 2 Severe = 3

Symptom	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Anxious					
Feeling Confused					
Restless					
Miserable					
Problems With Memory					
Tremor (Shakes)					
Nausea					
Heart Pounding					
Sleep Disturbance					
Sweating					
Total					

Alcohol Withdrawal Treatment Plan

Name: _____ DOB: _____

Clinic Contact: _____

My Treatment Goals:

Day 1 Date: _____

Medication	
Behavioral Support	
Appointment Time	

Day 2 Date: _____

Medication	
Behavioral Support	
Appointment Time	

Day 3 Date: _____

Medication	
Behavioral Support	
Appointment Time	

Day 4 Date: _____

Medication	
Behavioral Support	
Appointment Time	

Day 5 Date: _____

Medication	
Behavioral Support	
Appointment Time	

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Opioid Use Disorder Resources

Opioid use disorder is especially amenable to a primary care–forward approach to treatment. The following resources empower clinicians and staff to provide high-quality care for this disorder.

Patient Information:
Buprenorphine for Opioid Use Disorder

Buprenorphine is used to treat opioid use disorder (OUD) to help people cut back on or quit their use of heroin or other opiates, such as pain relievers like morphine. Buprenorphine is safe and effective.

Buprenorphine may be used along with counseling or participation in social support programs to help treat OUD. However, these programs are not required to receive buprenorphine in the clinic.

Buprenorphine Safety

Buprenorphine is very safe. It works differently and does not cause the same level of breathing trouble that can happen with heroin or other opioids.

Do not take other medications without first consulting your doctor. At your first visit in the clinic, your doctor will go over all your medications with you. You should also have a primary care doctor check in with you regularly to monitor your overall health.

Constipation with Buprenorphine

Some people may have constipation or problems having bowel movements when taking buprenorphine. Be sure to drink plenty of water and eat lots of fiber when taking buprenorphine. If you do get constipated, you can try taking a laxative medication like senna-docusate or MiraLAX, which are over the counter at most pharmacies and grocery stores. If your constipation doesn't improve with this, talk to your doctor about other medication options to treat the constipation.

Dental Problems with Buprenorphine

Some people have reported getting cavities (dental caries) as a result of using this medication. Your doctor recommends that you see a dentist regularly for checkups. You also can prevent cavities by rinsing your mouth out with water after the medication dissolves (usually takes up to 10 minutes). It is also important to brush and floss daily, but you need to wait one hour at least after taking the medication before brushing your teeth. This will help prevent damage to your teeth from the medication (FDA Advisory 2022).

How Buprenorphine Works

Buprenorphine helps people who use opioids feel better from feeling "dopesick" when they stop taking opioids. It also stops cravings for opioids and blocks the effects of other opioids to keep you safe from overdosing. Buprenorphine works like other opioids but without the same risk of overdose. There is also less of a chance for having breathing problems from taking too much buprenorphine compared to other drugs like heroin.

Buprenorphine Misuse Potential

Buprenorphine can be misused, particularly by people who do not normally take opioids. Naloxone is added to buprenorphine to prevent this from happening. When the tablets are dissolved in the mouth, the naloxone does not affect the body at all. If the tablets are crushed and injected or snorted, the naloxone blocks any effects the medicine may have.

Treatment with Buprenorphine

Buprenorphine treatment happens in three phases:

01 **The Induction Phase**: The medication is started, usually at home, and requires you to be in some withdrawal first. You will be seen in the office within a week after starting your medication to check in with your doctor.

02 **The Stabilization Phase**: This phase involves seeing your doctor in clinic regularly. The buprenorphine dose may need to be adjusted during this phase to get rid of any withdrawal or craving you may still have. You will usually see the doctor every 1-2 weeks until your withdrawal and cravings are gone.

03 **The Maintenance Phase**: In maintenance, you are doing well without regular cravings. The length of time of the maintenance phase is tailored to each patient and could be indefinite. You will usually see the doctor every 3 months during maintenance, but it could be more often if needed.

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Información para el Paciente:
Buprenorfina para el Trastorno por Uso de Opioides

La buprenorfina se utiliza para tratar el trastorno por uso de opioides (OUD) para ayudar a las personas a reducir o dejar su uso de heroína u otros opiáceos, como analgésicos como la morfina. La buprenorfina es **segura** y **efectiva**.

La buprenorfina puede usarse junto con el asesoramiento o la participación en programas de apoyo social para ayudar a tratar el OUD. Sin embargo, estos programas no son necesarios para recibir buprenorfina en la clínica.

Seguridad de la buprenorfina

La buprenorfina es **muy segura**. Funciona de manera diferente y no causa el mismo nivel de problemas respiratorios que pueden ocurrir con la heroína u otros opioides. No tome otros medicamentos sin antes consultar a su médico. En su primera visita a la clínica, su médico revisará todos sus medicamentos con usted. También debe tener un médico de atención primaria regular que se comunique con usted regularmente para monitorear su salud general.

Estreñimiento con Buprenorfina

Algunas personas pueden tener estreñimiento o problemas para evacuar cuando toman buprenorfina. Asegúrese de beber mucha agua y comer mucha fibra cuando tome buprenorfina. Si se estriñe, puede intentar tomar un medicamento laxante como senna-docusate o MiraLAX, que están disponibles sin receta en la mayoría de las farmacias y supermercados. Si su estreñimiento no mejora con esto, hable con su médico sobre otras opciones de medicamentos para tratar el estreñimiento.

Problemas dentales con la buprenorfina

Algunas personas han informado de la aparición de caries (caries dentales) como resultado del uso de este medicamento. Su médico recomienda que visite regularmente a un dentista para chequeos. También puede prevenir las caries enjuagando su boca con agua después de que el medicamento se disuelva (generalmente toma hasta 10 minutos). También es importante cepillarse y usar hilo dental diariamente, pero necesita esperar al menos una hora después de tomar el medicamento antes de cepillarse los dientes. Esto ayudará a prevenir daños en sus dientes por el medicamento (Advertencia de la FDA 2022).

Cómo funciona la buprenorfina

La buprenorfina ayuda a las personas que usan opioides a sentirse mejor al evitar sentirse "dopesick" cuando dejan de tomar opioides. También detiene los antojos por los opioides y bloquea los efectos de otros opioides para mantenerte a salvo de una sobredosis. La buprenorfina funciona como otros opioides pero sin el mismo riesgo de sobredosis. También hay menos posibilidades de tener problemas respiratorios por tomar demasiada buprenorfina en comparación con otras drogas como la heroína.

Potencial de mal uso de la buprenorfina

La buprenorfina puede ser mal utilizada, particularmente por personas que normalmente no toman opioides. Se agrega naloxona a la buprenorfina para evitar que esto suceda. Cuando las tabletas se disuelven en la boca, la naloxona no afecta al cuerpo en absoluto. Si las tabletas se trituran e inyectan o se inhalan, la naloxona bloquea cualquier efecto que el medicamento pueda tener.

Tratamiento con buprenorfina

El tratamiento con buprenorfina ocurre en tres fases:

01 **La Fase de Inducción:** El medicamento se inicia, generalmente en casa, y requiere que esté en algo de abstinencia primero. Será visto en la oficina dentro de una semana después de comenzar su medicamento para consultar con su médico.

02 **La Fase de Estabilización:** Esta fase implica ver a su médico en la clínica regularmente. La dosis de buprenorfina puede necesitar ajustarse durante esta fase para deshacerse de cualquier abstinencia o antojo que aún pueda tener. Generalmente verá al médico cada 1-2 semanas hasta que su abstinencia y antojos hayan desaparecido.

03 **La Fase de Mantenimiento:** En el mantenimiento, usted está bien sin antojos regulares. La duración de la fase de mantenimiento se adapta a cada paciente y podría ser indefinida. Generalmente verá al médico cada 3 meses durante el mantenimiento, pero podría ser más a menudo, si es necesario.

A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin, you want to feel sick from your withdrawal symptoms

It should be at least . . .

- 12 hours since you used heroin
- 12 hours since you snorted pain pills (Oxycontin)
- 16 hours since you swallowed pain pills
- 48-72 hours since you used methadone

You should feel at least three of these symptoms . . .

- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose
- Body aches
- Tremors/twitching
- Chills or sweating
- Anxious or irritable
- Goose pimples
- Stomach cramps, nausea,
- vomiting, or diarrhea

Once you are ready, follow these instructions to start the medication

DAY 1

Step 1

Take the first dose

4 mg

Wait 45 minutes

- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

Step 2

Still feel sick? Take next dose

4 mg

Wait 6 hours

Most people feel better after two doses = 8 mg

Step 3

Still uncomfortable? Take last dose

4 mg

Stop

Stop

- Stop after this dose
- Do not exceed 12 mg on Day 1

DAY 2

Take 8 mg in the morning and 8 mg in the evening

8 mg

am

8 mg

pm

Repeat this dose until your next follow-up appointment

If you have any problems starting the medication, call (254) 313-4200 and ask to speak to Melissa with the PCAM Clinic.

Un Guía para Pacientes que Incian Tratamiento con Buprenorfina en Casa

Antes de comenzar, desea sentirse enfermo por los síntomas de abstinencia

Debería ser al menos...

- 12 horas desde que consumo heroína
- 12 horas desde que esnifó analgésico
- 16 horas desde que tragó analgésicos
- 48-72 horas desde que uso metadona

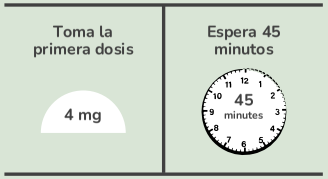
Debería sentir al menos de 3 de estos síntomas...

- Inquietud
- Bostezo profundo
- Pupilas angrandadas
- Rinorrea
- Dolor de cuerpo
- Temblores/contracciones
- Escalorfríos o sudoración
- Anciedad o irritabilidad
- Piel de gallina
- Dolor de estomago,
- náusea, vómito, diarrea

Que esté listo, siga estas instrucciones para comenzar a tomar el medicamiento

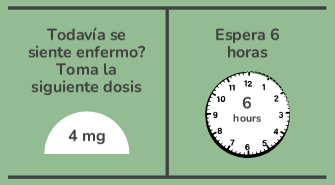
Día 1

Paso 1



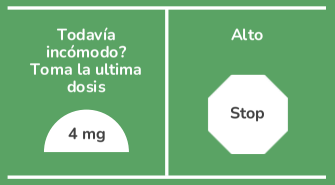
- Coloque la tableta o tira debajo de la lengua
- Manténgalo allí hasta que esté completamente disuelto
- No debe comer ni beber en este tiempo
- No debe tragar el medicamento

Paso 2



La mayoría de personas se sienten mejor después de la segunda dosis = (8 mg)

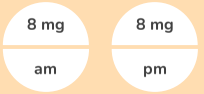
Paso 3



- Detener después de esta dosis
- No exceda los 12 mg en día 1

Día 2

Toma 8 mg en la mañana y 8 mgen la tarde



Continúe esta dosis hasta su cita de seguimiento

Si tiene algún problema para comenzar a tomar el medicamento, llame (254) 313-4200 y pregunta a hablar con Melissa con la clínica de MAAP (medicina de adicciónes de atención primaria)

Low Dose Start For Buprenorphine At Home

What is it?

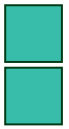
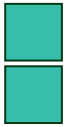
Low dose initiation is a way to start buprenorphine while remaining on full agonist opioids (methadone, heroin, fentanyl, etc.) by gradually increasing the dose of buprenorphine over 1 week.

How it works

Imagine full agonist opioids are like a car speeding along at 120 mph. Buprenorphine (a partial agonist) is like the car going 60 mph.

If you start buprenorphine with full agonists still in the gas tank, all of the sudden the car slows from 120 mph ► 60 mph. That sudden sensation of stopping is what causes PRECIPITATED WITHDRAWAL.

With low dose initiation, our car slows down over days from 100 mph ► 90 mph ► 80 mph ► 70 mph 60 mph ► 50 mph. There is no sudden feeling of stopping, so there's no precipitated withdrawal.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Buprenorphine Dose	0.5 mg daily	0.5 mg BID	1 mg BID	2 mg BID	4 mg TID	4 mg TID	8 mg BID
Film Size	2 mg	2 mg	2 mg	2 mg	2 mg	2 mg	8 mg
Morning Dose							
Afternoon Dose							
Night Dose							
Full Agonist	Continue	Continue	Continue	Continue	Continue	Continue	STOP

If you have any problems starting the medication, call (254) 313-4200 and ask to speak to Melissa with the PCAM Clinic.

Inicio de Dosis Bajas Para Buprenorfina en Casa

¿Qué es?

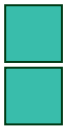
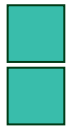
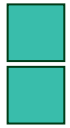
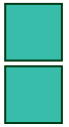
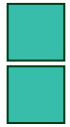
El inicio de dosis baja es una manera de comenzar la buprenorfina mientras se continúa con opioides agonistas completos (metadona, heroína, fentanilo...) aumentando gradualmente la dosis de buprenorfina durante 1 semana.

Cómo funciona

Imagina que los opioides agonistas completos son como un coche acelerando a 120 mph, la buprenorfina (un agonis-ta parcial) es como el coche yendo a 60 mph.

Si comienzas buprenorfina con agonistas completos aún en el tanque de gasolina, de repente el coche reduce de 120mph ►60 mph. Esa sensación repentina de parar es lo que causa el RETIRO PRECIPITADO.

Con la iniciación de dosis baja, nuestro coche reduce la velocidad gradualmente durante días de 100 mph 90 mph ►80 mph ►70 mph ►60 mph► 50 mph. Sin sensación repentina de parar, así que no hay retiro precipitado.

	DÍA 1	DÍA 2	DÍA 3	DÍA 4	DÍA 5	DÍA 6	DÍA 7
Dosis de Buprenorfina	0.5 mg daily	0.5 mg BID	1 mg BID	2 mg BID	4 mg TID	4 mg TID	8 mg BID
Tamaño de la Película	2 mg	2 mg	2 mg	2 mg	2 mg	2 mg	8 mg
Dosis Matutina							
Dosis Vespertina							
Dosis Nocturna							
Agonista Completo	Continuar	Continuar	Continuar	Continuar	Continuar	Continuar	ALTO

Si tiene algún problema para comenzar a tomar el medicamento, llame (254) 313-4200 y pregunta a hablar con Melissa con la clínica de MAAP (medicina de adicciónes de atención primaria).

Clinical Opiate Withdrawal Scale (COWS)

Flow sheet for measuring symptoms for opiate withdrawal over a period of time

For each item, write in the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient's Name: _____ Date: _____

Times:	Now	30 min. after first dose	2 hr. after first dose	Etc.
Resting pulse rate: (record beats per minute) Measured after patient is sitting or lying for one minute 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rates great than 120				
Sweating: Over past ½ hour; not accounted for by room temperature or patient activity 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness: Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds				
Pupil size: 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or joint aches: If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort.				
Runny nose or tearing: Not accounted for by cold symptoms or allergies 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				
GI upset: Over last ½ hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting				
Tremor: Observation of outstretched hands 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning observation during assessment: 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/times				
Anxiety or irritability: 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin: 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection				
Total Score **Observer's Initials**				

Score: 5-12 = Mild 13-24 = Moderate 25-36 = Moderately Severe More than 36 = Severe Withdrawal

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Subjective Opiate Withdrawal Scale (SOWS)

Name:_____ DOB:_____

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale 0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely

Date					
Time					

Symptom:		**Score**	**Score**	**Score**	**Score**	**Score**
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are tearing					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
TOTAL						

Mild withdrawal = score of 1–10 Moderate withdrawal = 11–20 Severe withdrawal = 21–30

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc. For use outside of IT MATTTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu

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Primary Care Addiction Medicine (PCAM)

Induction Appointment Intake Form

Your answers to the following questions will not have any negative impact on your ability to continue in the program but will be used by your clinician to assist in your treatment plan. All answers are kept confidential. We may ask for a urine sample at each visit.

Alcohol And Drug History

Substance (check if ever used)	Never Used	Last 3 Months	Used in Past Week	Frequency (Day/Week)
Tobacco/Nicotine	☐	☐	☐	
Alcohol *One standard drink is about 1 small glass of wine (5 oz.), 1 beer (12 oz.), or 1 single shot of liquor*	☐	☐	☐	
Marijuana (hash, weed)	☐	☐	☐	
Heroin	☐	☐	☐	
Cocaine, Crack, or Methamphetamine (crystal meth)	☐	☐	☐	
Inhalants (paint, gas, glue, aerosols)	☐	☐	☐	
Recreational Drug (ecstasy/molly, GHB, PSP, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana "spice")	☐	☐	☐	
Anxiety/Sleep Medication (Xanax, Ativan, or Klonopin) Not as prescribed or not prescribed to you	☐	☐	☐	
Opiate Pain Reliever (Percocet, Vicoden) Not as prescribed or not prescribed to you	☐	☐	☐	
ADHD Medication (Adderall, Ritalin) Not as prescribed or not prescribed to you	☐	☐	☐	
Other: _____	☐	☐	☐	

01 What is/was your substance of choice? Route? (injecting, pills, smoking, etc.) How often in a given week? Last day of use?

02 What triggers do you know of that may put you in danger of relapse? Have you developed any coping methods to help with these triggers? If yes, what?

03 Do you have any disabilities that may make it hard for you to read labels or count pills?

04 Do you have family or significant other that will be supportive during your treatment? If yes, who?

05 Why are you interested in treatment? What are your plans for the upcoming year? (home, work, or otherwise)

Medicina de adicción de atención primaria (PCAM)

Formulario de admisión de cita de inducción

Sus respuestas a las siguientes preguntas no tendrán ningún impacto negativo en su capacidad para continuar en el programa, pero su médico las utilizará para ayudarlo en su plan de tratamiento. Todas las respuestas se mantienen confidenciales. Es posible que le pidamos una muestra de orina en cada visita.

Historial de Alcohol Y Drogas

Sustancia (marque si alguna vez se usó)	Nunca Usado	últimos 3 Meses	Usado en la semana pasada	Frecuencia (día/semana)
Tabaco/Nicotina	☐	☐	☐	
Alcohol *Una bebida estándar es aproximadamente 1 vaso pequeño de vino (5 oz), 1 cerveza (12 oz) o 1 trago de licor*	☐	☐	☐	
Marihuana (hachís, hierba)	☐	☐	☐	
Héroe	☐	☐	☐	
Cocaína, crack o metanfetamina (crystal meth)	☐	☐	☐	
Inhalantes (pintura, gas, pegamento, aerosoles)	☐	☐	☐	
Droga recreativa (éxtasis/molly, GHB, PSP, poppers, LSD, champiñones, K especial, sales de baño, marihuana sintética "spice")	☐	☐	☐	
Medicamentos para la ansiedad/el sueño (Xanax, Ativan o Klonopin) No según lo prescrito o no prescrito para usted	☐	☐	☐	
Analgésico opiáceo (Percocet, Vicoden) No según lo prescrito o no prescrito para usted	☐	☐	☐	
Medicamentos para el TDAH(Adderall, Ritalin) No según lo prescrito o no prescrito para usted	☐	☐	☐	
Otro: _____	☐	☐	☐	

01 ¿Cuál es/era su sustancia de elección? ¿Ruta? (inyectarse, pastillas, fumar, etc.) ¿Con qué frecuencia en una semana determinada? ¿Último día de uso?

02 ¿Qué factores desencadenantes conoce que pueden ponerlo en peligro de recaída? ¿Ha desarrollado algún método de afrontamiento para ayudar con estos factores desencadenantes? Si es así, ¿qué?

03 ¿Tiene alguna discapacidad que le dificulte leer las etiquetas o contar las pastillas?

04 ¿Tiene familiares o personas importantes que lo apoyen durante su tratamiento? Si es así, ¿quién?

05 ¿Por qué te interesa el tratamiento? ¿Cuáles son tus planes para el próximo año? (hogar, trabajo u otros)

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Keeping Yourself Safe While Using Drugs

General Safety Tips

- **Don't share equipment**. Always use your own supplies.
- **Test a small amount first**. The drug supply can be unpredictable; you may not be getting what you think you are.`
- **Take care of your body**. Stay hydrated, keep up with vaccines, and get regular health checks.
- **Carry Narcan® (naloxone)**. It's a medicine that can reverse an opioid overdose. This is important even if you're not using opioids because they may be mixed in with your drug.
- **Try snorting or smoking instead of injecting**. Injecting carries the highest risk for overdose, so snorting or smoking may help reduce risk. A person can still overdose by smoking or snorting, so start slow.
- **Space out doses**. Take time between doses because fentanyl acts fast and is different for everyone, depending on dose and tolerance.
- **Use with others**. Try to have someone you know check on you if you must use alone so they can intervene in the event of an overdose, and if you do use with others, stagger your use. Make sure someone is always alert and that at least one person has naloxone on them.

Safe Injection Tips

- **Use new supplies each time**. Never reuse needles or equipment.
- **Wash your hands and clean the skin**. Use an alcohol pad on the area before injecting.
- **Find a good vein**. Apply a tourniquet to locate a vein, then remove it before injecting.
- **Cook the substance when possible**. This helps kill germs and prevent infections.
- **Insert the needle correctly**. Keep the needle's hole facing up, and always point it toward the heart.
- **Apply antibiotic ointment afterward**. This helps the area heal.

Safe Snorting Tips

- **Switch nostrils**. This gives your nose time to recover.
- **Clear out your nose afterward**. Rinse with sterile saline or distilled water if possible.
- **Crush the substance into a fine powder**. This reduces harm to your nose.
- **Use a clean surface**. Avoid using parts of your body or dirty surfaces to snort from.

Safe Smoking Tips

- **Use safe equipment**. Discard any broken pipes that could hurt you.
- **Use a mouthpiece**. It can prevent burns and cuts.
- **Be cautious with flames**. Keep your hair and clothing away from open flames.

Safe Rectal/Vaginal Use Tips

- **An alternative option**: Use the bathroom first, and fully dissolve the substance before insertion.
- **Be aware of risks**. This method can increase the chance of HIV if you share equipment.
- **Use a needle-less syringe and lube**. Insert carefully while lying on your side.
- **Allow time for absorption**. Wait before doing other activities.

Cómo protegerse cuando use drogas

Consejos generales de seguridad

- **No comparta el equipo**. Utilice siempre sus propios suministros.
- **Pruebe primero con una pequeña cantidad**. El suministro de la droga puede ser impredecible y es posible que no obtenga lo que cree.
- **Cuide su cuerpo**. Manténgase hidratado, póngase al día con sus vacunas y hágase controles de salud periódicos.
- **Lleve consigo Narcan® (naloxona)**. Es un medicamento que puede revertir una sobredosis de opioides. Esto es importante incluso si no está usando opioides porque pueden estar mezclados con su droga.
- **Pruebe a inhalar o fumar en vez de inyectarse**. La inyección conlleva el mayor riesgo de sobredosis, por lo que inhalar o fumar puede ayudar a reducir el riesgo. Una persona también puede sufrir una sobredosis al fumar o inhalar, por lo que debe comenzar lentamente.
- **Espacie las dosis**. Tómese un tiempo entre dosis porque el fentanilo actúa rápido y es diferente para cada persona, según la dosis y la tolerancia.
- **Consuma la droga con otras personas**. Si debe consumirla solo, intente que alguien que conozca lo observe para que pueda intervenir en caso de una sobredosis y, si la consume con otras personas, espacie el uso. Asegúrese de que siempre haya alguien alerta y de que al menos una persona tenga naloxona a mano.

Consejos para una inyección segura

- **Utilice suministros nuevos cada vez.** Nunca reutilice las agujas o el equipo.
- **Lávese las manos y limpie la piel.** Utilice una gasa con alcohol en la zona antes de inyectar.
- **Busque una vena sana**. Aplique un torniquete para localizarla y luego retírelo antes de inyectar.
- **Cocine la sustancia siempre que sea posible**. Esto ayuda a matar los gérmenes y prevenir infecciones.
- **Inserte la aguja correctamente**. Mantenga el orificio de la aguja hacia arriba y apunte siempre hacia el corazón.
- **Aplique ungüento antibiótico después**. Esto ayuda a que la zona sane.

Consejos para inhalar de forma segura

- **Cambie de fosa nasal.** Esto le dará tiempo a su nariz para recuperarse.
- **Después, límpiese la nariz.** Si es posible, enjuáguese con solución salina estéril o agua destilada.
- **Triturar la sustancia hasta convertirla en polvo fino.** Esto reduce el daño a la nariz.
- **Utilice una superficie limpia.** Evite utilizar partes del cuerpo o superficies sucias para inhalar.

Consejos para fumar de forma segura

- **Utilice equipos seguros**. Deseche cualquier pipa rota que pueda causarle daño.
- **Utilice una boquilla**. Puede evitar quemaduras y cortaduras.

Consejos para el uso seguro por vía rectal o vaginal

- **Una opción alternativa**: Use primero el baño y disuelva completamente la sustancia antes de la inserción.
- **Tenga en cuenta los riesgos**. Este método puede aumentar las probabilidades de contraer el VIH si comparte el equipo.
- **Utilice una jeringa sin aguja y lubricante**. Introdúzcala con cuidado mientras está recostado de lado.
- **Dé tiempo para que se absorba**. Espere antes de realizar otras actividades.

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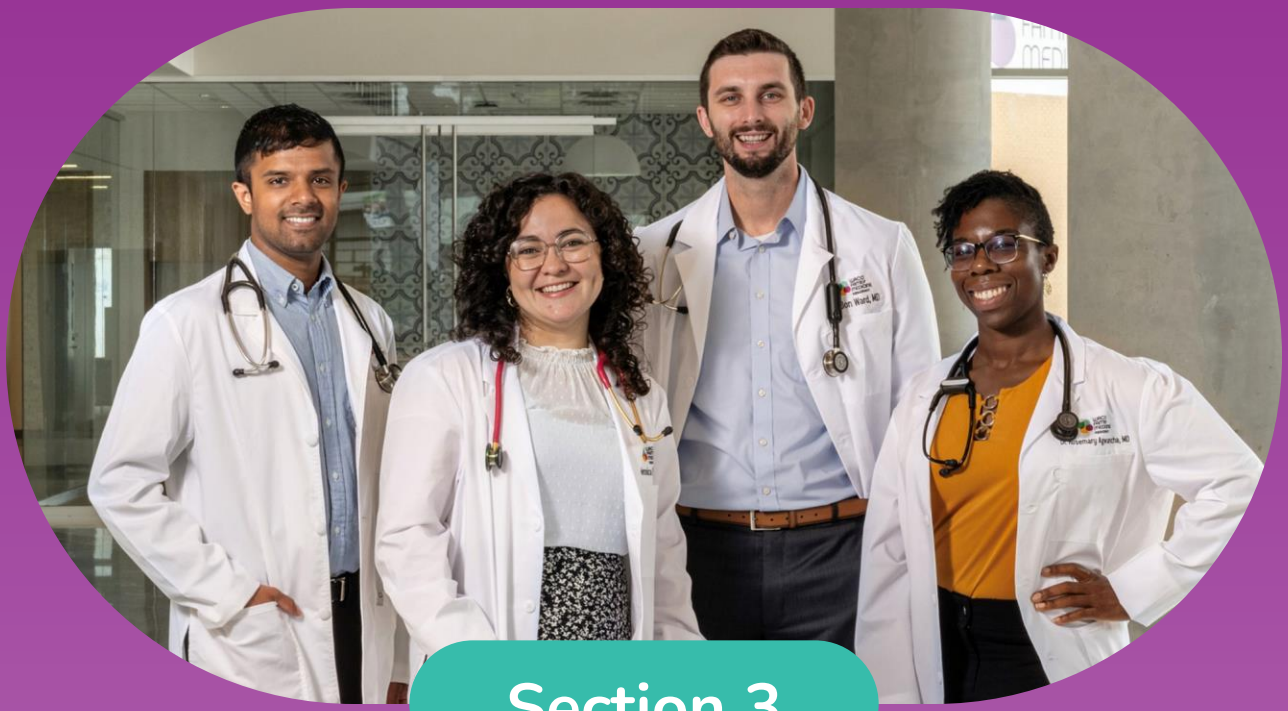

Section 3

Other Resources

Primary Care Addiction Medicine GME Curriculum

Description

The primary care system, being the de facto system for mental health in the United States, is well positioned to provide essential and meaningful addiction treatment services for millions of affected individuals. This Primary Care for Addiction Medicine (PCAM) residency curriculum improves how we approach training family medicine trainees to provide these services. The scope of the curriculum includes education and clinical training for substance use disorders and for risky drug use of licit and illicit substances for adults, adolescents, and women who are pregnant or intend to become pregnant.

Goals	Objectives
Understand the scope of substance use disorders, from population health needs to individual diagnosis.	✓ Describe the current opioid epidemic, the implications this has for public health, and primary care's role in providing services to combat this issue. ✓ Rate as important the need to provide addiction medicine services to patients in future practice. ✓ Recall the diagnostic criteria for substance use disorder and then apply this in the clinical setting to correctly identify patients that may benefit from treatment.
Apply best practice principles to unhealthy substance use screening and intervention.	✓ Understand the basic concepts of unhealthy substance use. ✓ Demonstrate basic proficiency in validated screening for unhealthy substance use with the Single Item Screening Questionnaire (SISQ). ✓ Utilize a validated approach to screening for and evaluation of SUD exemplar of AUD and the CAGE-AID and DSM-5-TR. ✓ Utilize the Brief Negotiated Interview (BNI) to explore and negotiate treatment readiness.
Learn the central clinical management principles of office-based addiction medicine treatment.	✓ Explain which patients may be candidates for addiction medicine treatment. ✓ Demonstrate proficiency in taking a substance use–focused history and physical exam. ✓ Construct treatment plans independently for patients, including nonpharmacological and pharmacological interventions as appropriate and indicated, with sufficient faculty guidance and oversight. ✓ Recommend evidence-based psychotherapy and/or social support programs for patients with substance use disorders. ✓ Describe the indications for pharmacotherapy for substance use disorders. ✓ Describe the basic protocol and necessary steps for initiation, stabilization, and maintenance of patients using buprenorphine products for the treatment of opioid use disorder. ✓ Utilize evidence-based pharmacology for the treatment of alcohol withdrawal and maintenance.
Understand how comorbid behavioral, mental, and other substance use disorders affect treatment plans.	✓ Appreciate how comorbid behavioral, mental, and other substance use disorders inform addiction medicine treatment. ✓ Apply best evidence treatment for common cooccurring behavioral health disorders in the context of substance use.

Educational Resources

Readings

- Coffa D, Snyder H. Opioid use disorder: medical treatment options. Am Fam Physician. 2019;100(7):416-425.
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- Fairbanks J, Umbreit A, Kolla BP, Karpyak VM, Schneekloth TD, Loukianova LL, Sinha S. Evidence-based pharmacotherapies for alcohol use disorder: clinical pearls. Mayo Clinic Proceedings. 2020;95(9):1964-1977.
- Selby P, Zawertailo L. Tobacco addiction. N Engl J Med. 2022;387(4):345-354.

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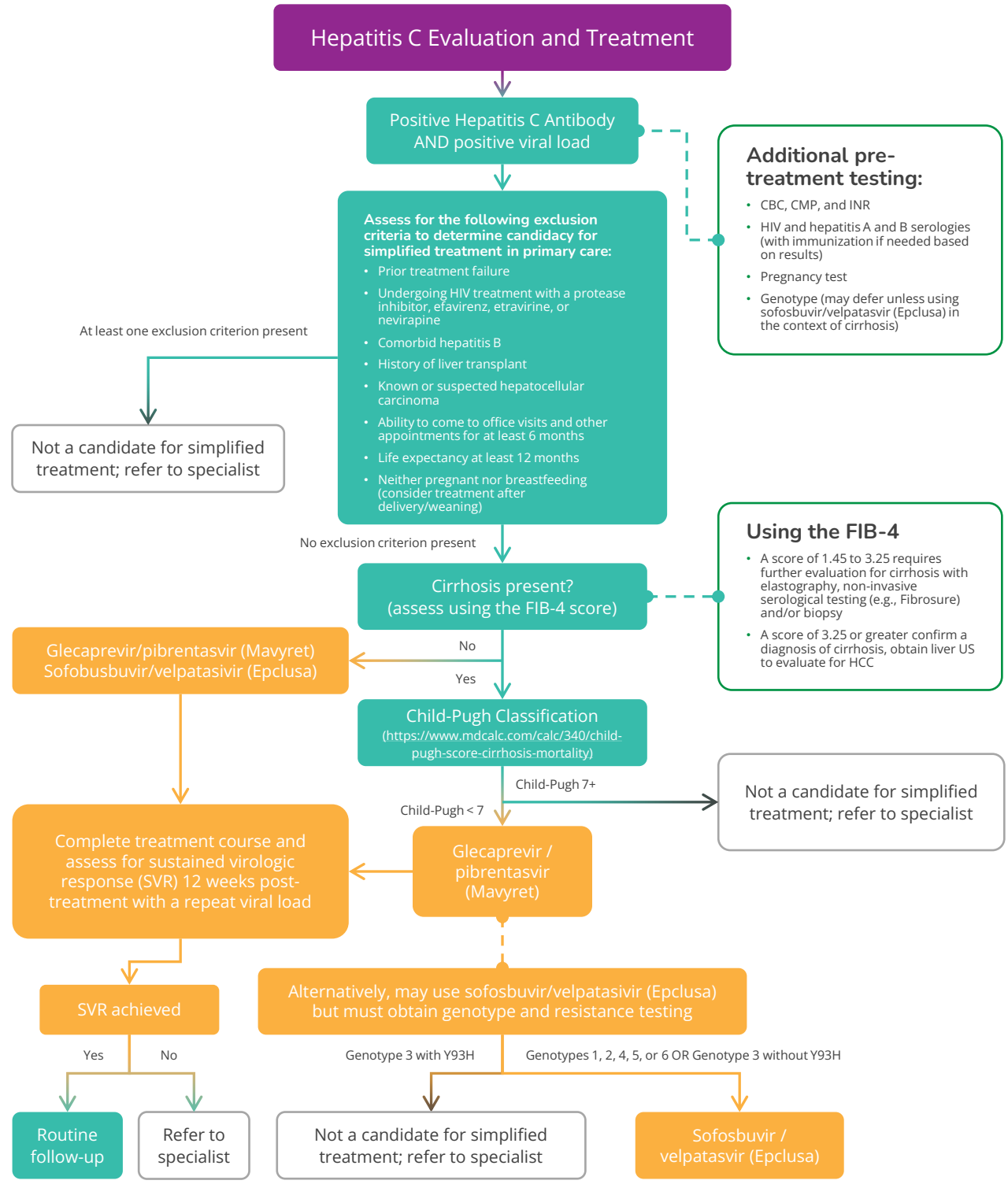
Infectious Disease Prevention in Addiction Medicine

Addiction medicine clinical services like PCAM provide an incredible opportunity to integrate hepatitis C (HCV) evaluation and treatment and pre-exposure prophylaxis (PrEP) for HIV prescribing. Patients with substance use disorders, especially those persons who inject drugs, are at increased risk for HCV and HIV, yet these conditions often go undiagnosed and untreated, while PrEP utilization in persons who inject drugs remains very low. The following clinical decision support tools aim to streamline integration of these crucial services into the fabric of addiction care.


Hepatitis C Evaluation and Treatment
Positive Hepatitis C Antibody AND positive viral load
Additional pre-treatment testing:
CBC, CMP, and INR
HIV and hepatitis A and B serologies (with immunization if needed based on results)
Pregnancy test
Genotype (may defer unless using sofosbuvir/velpatasvir (Epclusa) in the context of cirrhosis)
Assess for the following exclusion criteria to determine candidacy for simplified treatment in primary care:
Prior treatment failure
Undergoing HIV treatment with a protease inhibitor, efavirenz, etravirine, or nevirapine
Comorbid hepatitis B
History of liver transplant
Known or suspected hepatocellular carcinoma
Ability to come to office visits and other appointments for at least 6 months
Life expectancy at least 12 months
Neither pregnant nor breastfeeding (consider treatment after delivery/weaning)
At least one exclusion criterion present
Not a candidate for simplified treatment; refer to specialist
No exclusion criterion present
Cirrhosis present? (assess using the FIB-4 score)
Using the FIB-4
A score of 1.45 to 3.25 requires further evaluation for cirrhosis with elastography, non-invasive serological testing (e.g., Fibrosure) and/or biopsy
A score of 3.25 or greater confirm a diagnosis of cirrhosis, obtain liver US to evaluate for HCC
No
Yes
Glecaprevir/pibrentasvir (Mavyret) Sofobusbuvir/velpatasivir (Epclusa)
Child-Pugh Classification (https://www.mdcalc.com/calc/340/child-pugh-score-cirrhosis-mortality)
Child-Pugh 7+
Not a candidate for simplified treatment; refer to specialist
Child-Pugh < 7
Glecaprevir / pibrentasvir (Mavyret)
Complete treatment course and assess for sustained virologic response (SVR) 12 weeks post-treatment with a repeat viral load
Alternatively, may use sofosbuvir/velpatasvir (Epclusa) but must obtain genotype and resistance testing
SVR achieved
Yes
No
Routine follow-up
Refer to specialist
Genotype 3 with Y93H
Genotypes 1, 2, 4, 5, or 6 OR Genotype 3 without Y93H
Not a candidate for simplified treatment; refer to specialist
Sofosbuvir / velpatasvir (Epclusa)

Hepatitis C Simplified Treatment Regimens Dosing Guide

Trade Name	Generic Name	Dosing	Side Effects	Additional Info
MAVYRET	Glecaprevir / pibrentasvir	100-40 mg 3 tablets daily	• (Less serious) Fatigue, nausea, skin rash and pruritus, GI upset • (More serious) Increased serum bilirubin, angioedema, hepatic failure, reactivation of hepatitis B, drug-drug interactions	• Avoid administration of antacids during treatment • Stop the following medications during treatment, if possible: statins and estrogen containing OCPs. • Significant interactions occur with anticonvulsant medications. • For a complete list of possible drug-drug interactions, refer to www.hcvguidelines.org or use the Liverpool drug-drug interaction tool available at https://hep-druginteractions.org/checker • For missed doses during treatment: Refer to www.hcvguidelines.org for recommendations on approach to restarting treatment
EPCLUSA	Sofobuvir / velpatasvir	400-100 mg 1 tablet daily	• (Less serious) Fatigue, headache, skin rash, nausea, insomnia, irritability, asthenia, depressed mood • (More serious) Increased serum creatinine kinase, increased serum lipase, reactivation of hepatitis B including fulminant hepatic failure, drug-drug Interactions	• Avoid administration of antacids during treatment • Stop the following medications during treatment, if possible: statins and estrogen containing OCPs. • Significant interactions occur with anticonvulsant medications. • For a complete list of possible drug-drug interactions, refer to www.hcvguidelines.org or use the Liverpool drug-drug interaction tool available at https://hep-druginteractions.org/checker • For missed doses during treatment: Refer to www.hcvguidelines.org for recommendations on approach to restarting treatment

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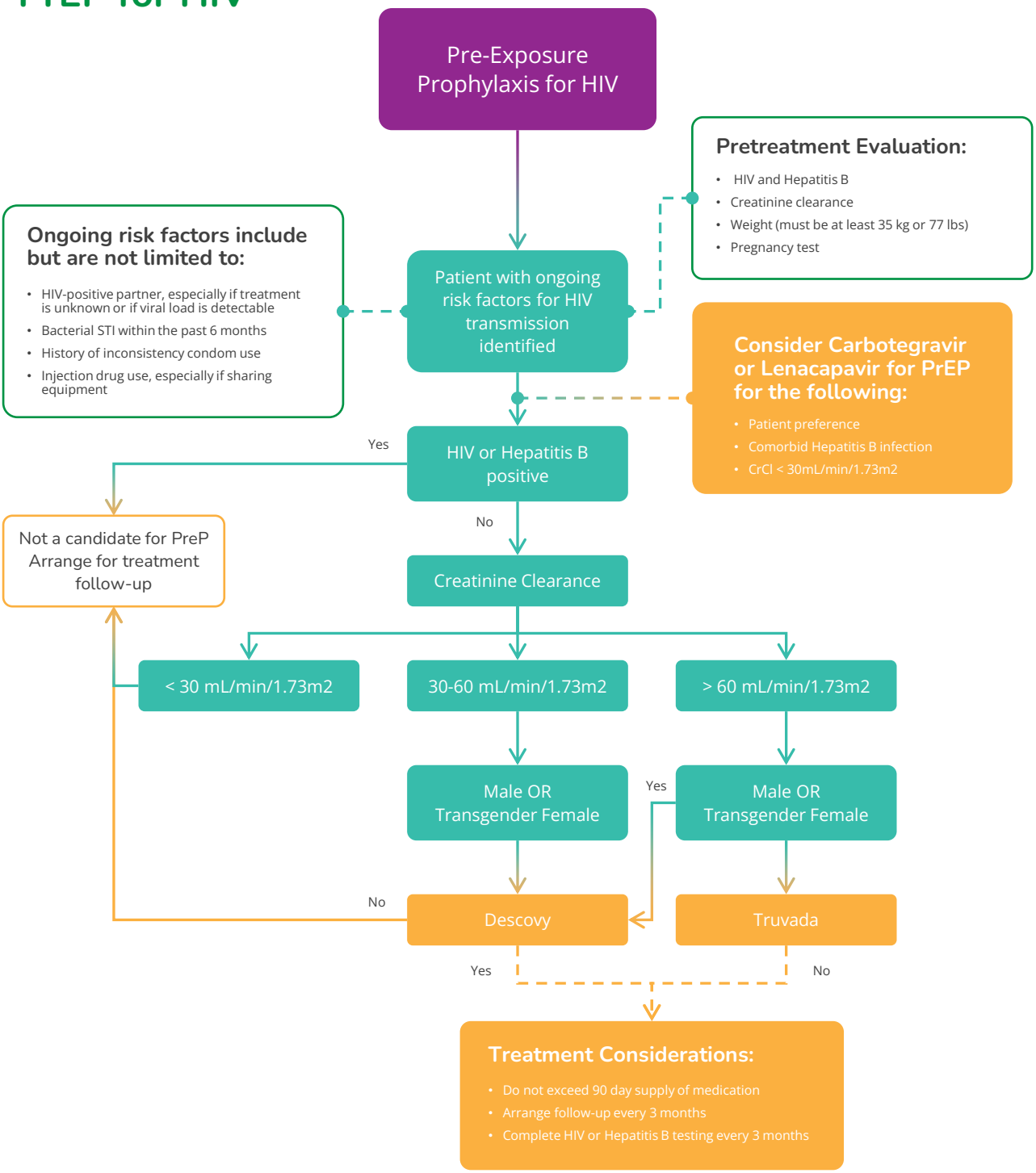
PrEP for HIV



PrEP Dosing Guide

Trade Name	Generic Name	Dosing	Side Effects	Additional Info
DESCOVY	Emtricitabine/ Tenofovir Alafenamide	200-25 mg daily	• (Less serious) abdominal pain, diarrhea, nausea, fatigue, headache • (More serious) Decreased bone mineral density with prolonged use (less compared to Truvada)	CrCl must be at least 30 at treatment initiation; discontinue if CrCl falls below 30 during treatment
TRUVADA	Emtricitabine/ Tenofovir Disoproxil Fumarate	200-300 mg daily	• (Less serious) abdominal pain, headache, hypophosphatemia, weight loss • (More serious) Decreased bone mineral density with prolonged use	• CrCl must be at least 60 at initiation; discontinue if CrCl falls below 60 during treatment • On demand dosing (2-1-1) not recommended for most patients; encourage daily use in most circumstances)
CARBOTEGRAVIR	Cabotegravir	• Oral lead-in therapy: 30 mg daily for 28 days followed by 600 mg IM every 2 months within 3 days of last oral dose. • IM Initiation: 600 mg IM monthly for two doses followed by 600 mg IM every 2 months.	• (Less serious) injection site reaction, GI distress, headache • (More serious) elevated creatinine kinase levels, elevated liver chemistries, elevated serum creatinine	• May initiate with oral-lead therapy or start directly with IM injection • Maintenance injections may be administered up to 7 days before or after the injection due date

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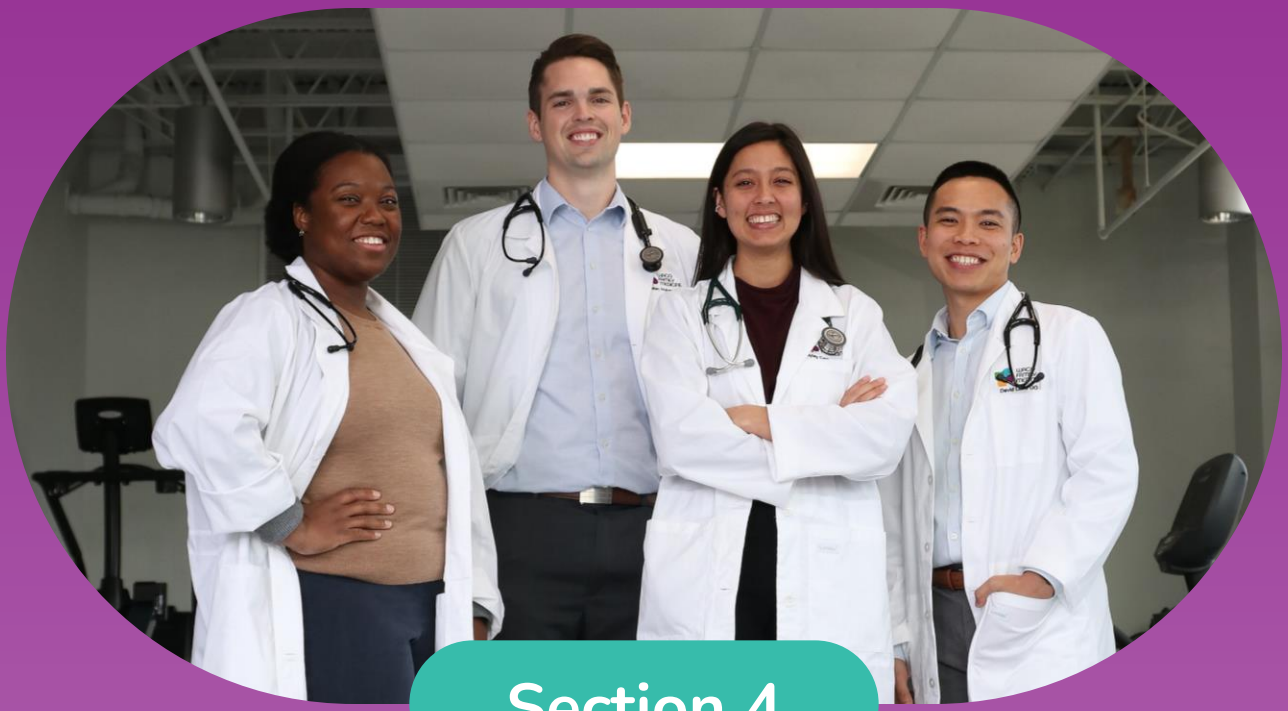

Section 4

About

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About

Ryan Laschober, MD, FAAFP, Family Medicine

Ryan Laschober, MD, FAAFP is the editor in chief of The Waco Guide and an associate program director for Waco Family Medicine Residency. Dr. Laschober received a BS in biochemistry from Baylor University and an MD from University of Arkansas for Medical Sciences. He completed his family medicine residency at Waco Family Medicine–Residency, during which time he served as chief resident. Dr. Laschober is invested in full-spectrum family medicine, with special interests in global health, mental health care, and care for the underserved. In addition to medicine, he is involved with his local church, foster care, and adoption community. He resides with his wife and five children blocks away from the federally qualified health center residency clinic where he practices.

Lance Kelley, PhD, Clinical Psychology

Lance Kelley, PhD is a clinical psychologist, associate editor of The Waco Guide, and chief behavioral health officer at Waco Family Medicine. Dr. Kelley pioneered the federally qualified health center's integrated behavioral health program and oversees the behavioral health training for Waco Family Medicine–Residency. Dr. Kelley has published articles on PTSD, health anxiety, obesity, pediatric disruptive behavior, and the science of psychology, and regularly presents at state and national conferences on primary care behavioral health and residency training. He also serves on the editorial board for Psychological Services, the board of directors for the Heart of Texas Behavioral Health Network, and the clinical committee for the Texas Association of Community Health Centers.

About

Zachary Sartor, MD, Family Medicine

Zachary Sartor, MD, FAAFP is associate editor of The Waco Guide and a family medicine faculty physician with Waco Family Medicine–Residency, serving as associate program director for curriculum and evaluation and director for primary care addiction medicine. He received a BS in chemistry from Baylor University and MD from Texas Tech University School of Medicine Health Science Center School of Medicine. Dr. Sartor also completed family medicine residency training at Waco Family Medicine and an academic development fellowship at the University of North Texas Health Science Center. His primary interests are medical education, including curriculum design and evaluation; primary care behavioral health, specifically involving system-level innovations targeted at improving the preparedness of primary care clinicians to address the behavioral health needs of communities; addiction medication in primary care; and health disparities and the impact of leveraging unique care models to improve health outcomes in communities. Dr. Sartor is a Bloomberg American Health Initiative scholar in the addiction and overdose focus area at the Johns Hopkins University Bloomberg School of Public Health.

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Disclaimer

The names of patients used in the testimonials within this document have been changed to protect patient privacy. The testimonials provided are based on the experiences of individuals who have consented to share their feedback and have been anonymized to safeguard patient identity.


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Waco Family Medicine Residency is one of the nation's premier family medicine training programs. Our unique culture cultivates compassionate care to the underserved, and our uncompromising rigor forms exemplary family physicians. We boast the highest board exam pass rate in the state of Texas and an award-winning integrated behavioral health program. Waco Family Medicine graduates practice both nationally and globally in diverse settings, with a high proportion of physician graduates serving in health professional shortage areas.

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