

## **Module 2**

### **Using Evidence-Based Practices to Overcome Barriers to OUD Treatment**

## **Module 2 Learning Objectives**

*At the end of Module 2, you will be able to:*

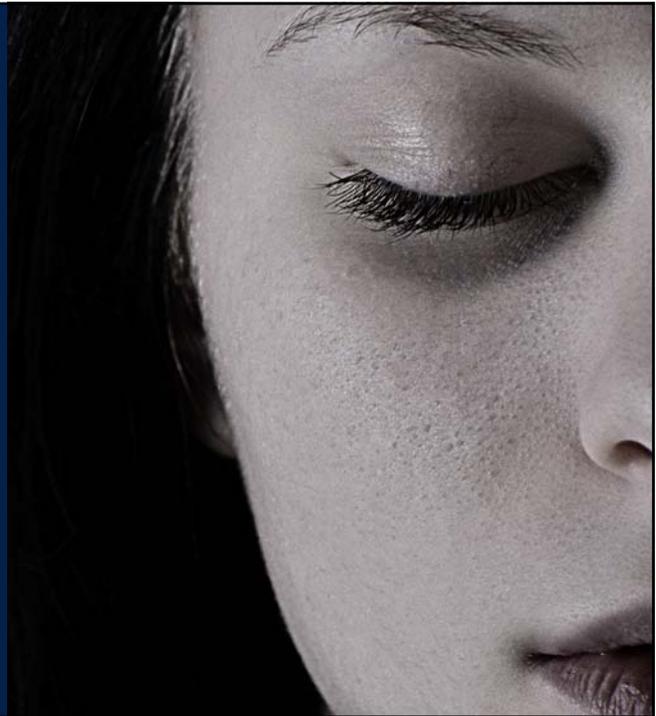
- Apply evidence-based practices to overcome obstacles to treatment of opioid use disorder (OUD).

# Kennedy

## Case Discussion

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Your colleague, a family physician, contacts you about a patient named Kennedy.



# Kennedy

## The Case

- Kennedy is a 22-year-old female who is currently using intranasal (IN) and intravenous (IV) heroin, about 10 bags daily, up from 3 bags last year. She is concerned because the patient has had another overdose.
- The FP had some prior knowledge about buprenorphine, but was never interested in obtaining an x-waiver to prescribe. She shamefully confided; “I didn’t think there were ‘addicts’ in my practice.

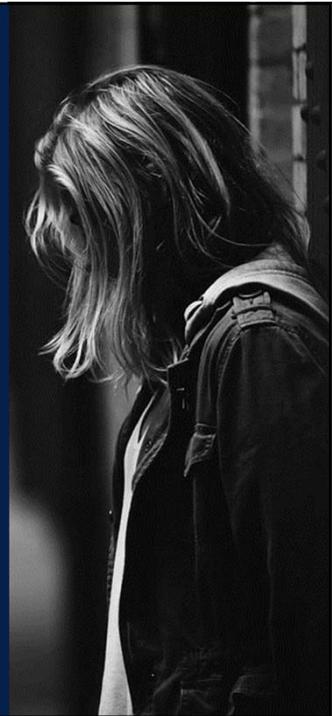
An appointment with you is scheduled for the next day.



## Kennedy

### The Case

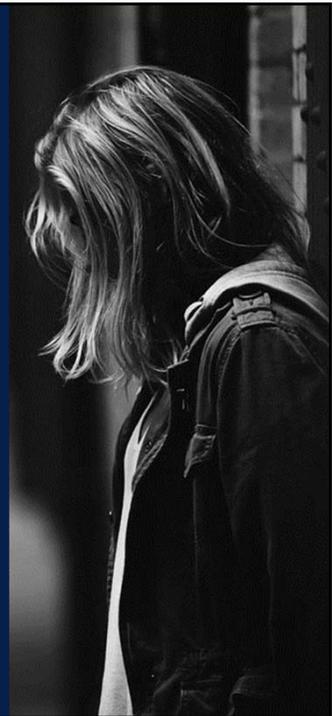
- Kennedy started binge drinking at parties on the weekends when she was 13. She is currently also smoking cannabis daily.
- Kennedy’s opioid use started in high school with non-prescribed oxycodone tablets, which her friends were crushing and snorting to get “high.” Her friends convinced her it was fun to do.
- At first, Kennedy did not like the feeling from the oxycodone—it made her nauseous and vomit. But after a few more tries, she found the oxycodone relaxing, and her anxiety “magically” disappeared.
- She felt like this was what her brain was “missing.”



## Kennedy

### The Case

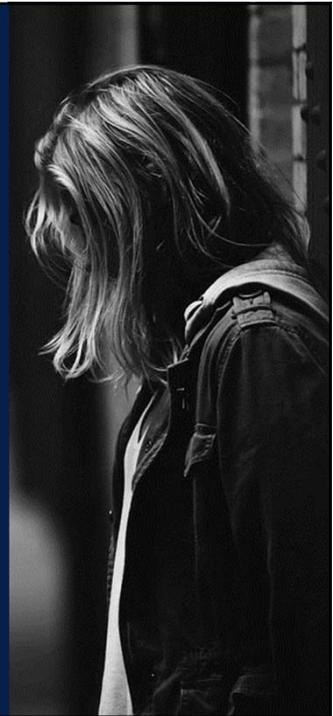
- Kennedy was sexually abused by an older male cousin when she was 9 years old. Kennedy is crying as she speaks of this traumatic event
- Kennedy had been evaluated by a psychiatrist as a teenager, and a diagnosis of PTSD was made. She was prescribed an SSRI, and started seeing a therapist.
- In her senior year, her oxycodone supplier was arrested, and a new boyfriend introduced her to heroin, which was more available and considerably cheaper. She was snorting the heroin to get high, and she subsequently stopped both the SSRI and the therapy.



## Kennedy

### The Case

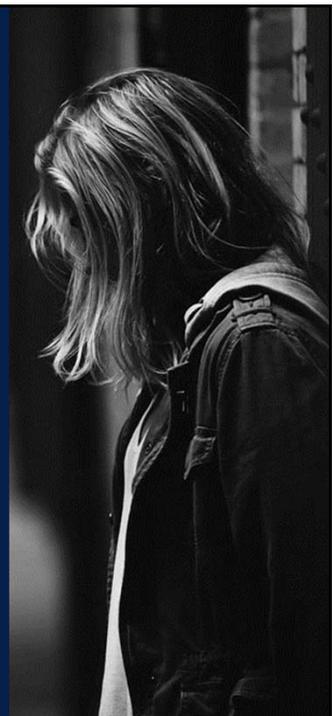
- She managed to graduate high school and enroll in her local community college. Due to her continued substance use, however, she was unable to continue her studies, and dropped out after one semester.
- Soon, she segued into injection drug use (IVU). She obtains sterile needs and syringes from a needle exchange. She admits to two unintentional overdoses, and was reversed with naloxone by her boyfriend both times. Fentanyl contamination was suspected in both cases, which she was unaware of.
- Currently, Kennedy smokes cannabis daily, a practice that also began in her teens.



## Kennedy

### The Case

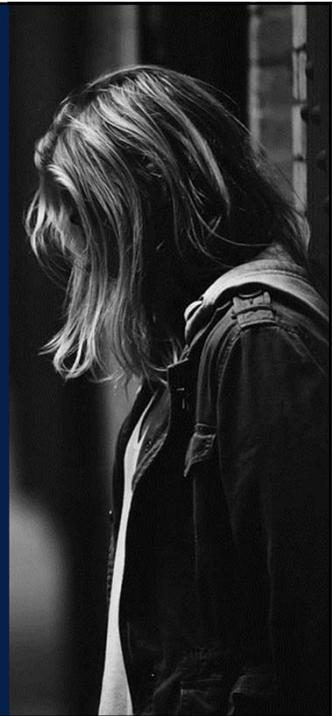
- Kennedy has entered medically-managed withdrawal three times (lasting from 3-5 days) and one 28-day rehab. She unfortunately relapsed in less than one week. She has attended a few NA meetings with her boyfriend. She thinks medications, such as methadone and buprenorphine, would just be trading one addiction for another. These medications have never been prescribed, there is no history of street use.
- At this point, it is unknown if MOUD has ever been offered.
- Currently, she lives with her boyfriend, who also uses IV heroin. He works part time in construction. She has reliable transportation, but is unemployed, and looking for work. She denies any legal ramifications related to her substance use.



# Kennedy

## The Case

- Her parents divorced when she was 12. She is estranged from her father, and claims her mother is supportive, but with minimal resources. She has a 28 yo brother with a history of alcohol use disorder (AUD) whose last use was 2 years ago. There is no other family history of SUD.
- PMH is noncontributory other than for PTSD; NKDA.
- She is currently on no prescribed medications, or OTC or herbal remedies.
- Kennedy has recently enrolled in the Medicaid program. She claims that her boyfriend is not eligible for Medicaid.



# Kennedy

## The Case

- Physical Exam: young, thin, disheveled female, sedated, with pinpoint pupils (miosis), and slurred speech. Bilateral upper extremities reveal fresh track marks on antecubital fossae, no abscess or streaking.
- COWS= 3
- Patient not aware of her HIV status or Hep C status.
- UDT(POC): + opiates, +THC, +fentanyl, and +cocaine.
- Kennedy states her last use of heroin was 2 hours ago. She admits to the use of cannabis, but denies the use of fentanyl and cocaine.



## Overcoming Provider Barriers



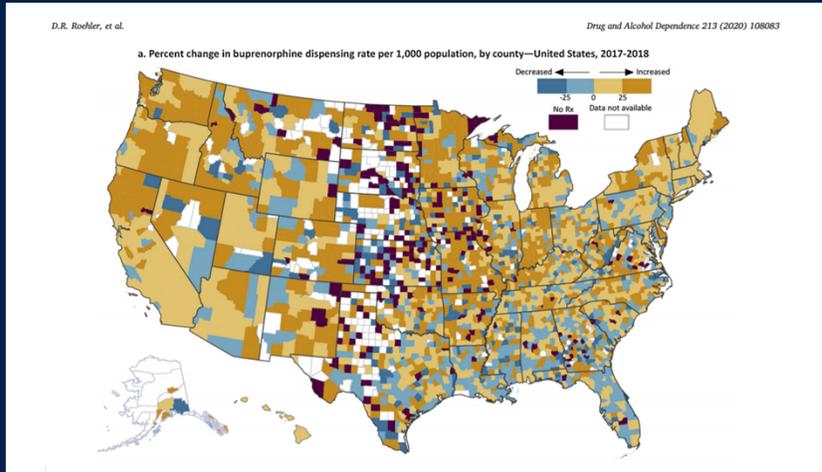
- Lack of Institutional Support for Buprenorphine
- Arbitrary Limits on Treatment Duration and Dose:
  - Time in Treatment
  - Dosing
- Misinformation/Lack of Recovery Support:
  - Counseling
  - Polysubstance Use
  - Drug Testing
- Fear of DEA
- Concern about Misuse/Diversion

## Overcoming Barriers Lack of Institutional Support for Buprenorphine Treatment



# The Treatment Gap

## The Need for Buprenorphine Treatment Providers



- Only 9.1% increase in buprenorphine prescriptions dispensed nationally (2017-18)
- Nurse practitioners and physician assistants account for 79.6% of total increase.
- Buprenorphine is underutilized.

Roehler DR, Guy GP, Jones CM. Buprenorphine prescription dispensing rates and characteristics following federal changes in prescribing policy, 2017-2018: A cross-sectional study. *Drug and Alcohol Dependence*. 2020;213:108083. doi:10.1016/j.drugalcdep.2020.108083

## Overcoming Barriers

# Time in Treatment



## How Long Should MOUD Continue?

- No known duration of treatment after which patients can stop medication and be certain not to return to illicit opioid use.
  - Patients should take medication as long as they benefit from it and wish to continue
  - Given the chronic nature of OUD and potentially fatal consequences of unintended opioid overdose and other associated mortality risk factors, it is critical to base length of time in treatment on patients individual needs

SAMHSA TIP 63 Medications for Opioid Use Disorders. 2018

## MOUD Discontinuation

### Important Considerations

- How has the patient responded to treatment so far?
- Why do they want to taper?
- What do they expect will be different after the taper?
- Do they understand the risks and benefits of continuing vs discontinuing treatment?
  - Many studies show high relapse rates with tapers and withdrawal from maintenance agonist treatment
  - Some studies show normalization of brain function with maintenance
  - Patients should be advised that even if they successfully taper and discontinue, they may always return to treatment
- Do they understand the risk of overdose associated with relapse?
  - Do they have a safety plan?
  - Prescribe naloxone to patients

## MOUD Discontinuation

### Important Considerations

- Patients should continue to be followed by provider after discontinuation.
- May continue drug toxicology testing.
- Psychosocial treatments should continue if applicable.
- Patients should be told they can resume buprenorphine treatment if cravings, lapses, or relapses occur.
- No correlation between duration of taper and relapse rates post-taper.
- Consider naltrexone.

## Michelle's Strategies

### Overcoming Discontinuation Barriers

- Clear understanding for reason(s) wanting to taper – may need to revisit as taper progresses
- Review details of treatment course (use big paper to map out major changes/accomplishments) so patient appreciates all their progress–goal then for patient to explain what they don't want to lose when tapering
- Ultra-slow flexible individualized tapers
- Educate on other med options – e.g., 6-month implants, future weekly and monthly injections with more dose options – e.g., if really wants to taper b/c dislikes way treated at pharmacy/ pressure to share medicine, wants to be done with a daily medication

## Debbie's Strategies

### Overcoming Discontinuation Barriers

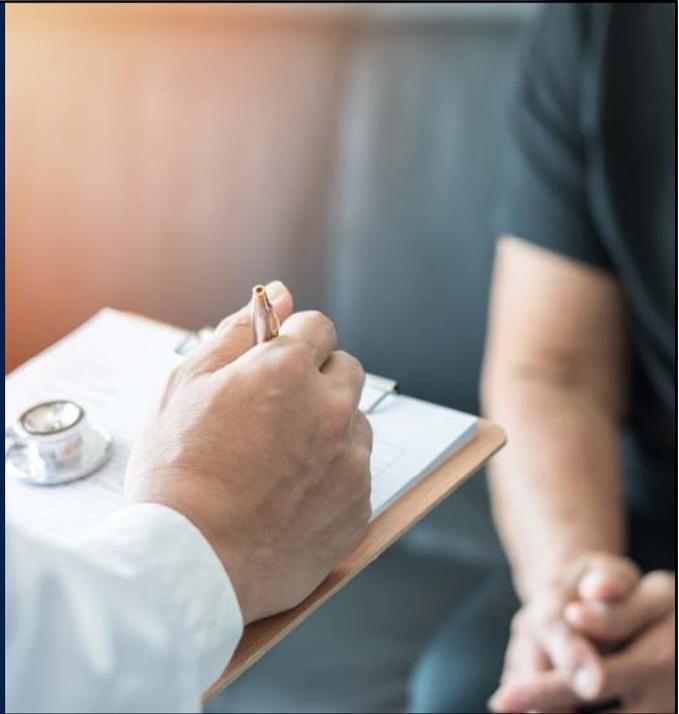
- Discuss depot formulations to keep them engaged
- Relate opioid use disorder to other chronic diseases for the purpose of stability
- Engage all partners

## Ed's Strategies

### Overcoming Discontinuation Barriers

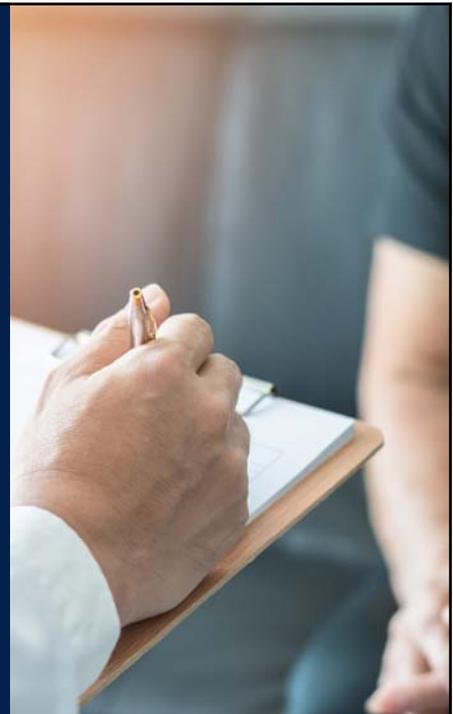
- Addiction 101 and an MOUD 101: Include Significant Others if possible
- Consider lowering dose to find lowest effective dose. Lower doses may be more palatable. Less adverse effects.
- Ask the patient how many times they have attempted to taper off opioids and relapsed? Share anonymously a patient who has relapsed multiple times and returned to treatment
- Be sure there is no misinformation driving discontinuation: e.g. Pregnancy
- If on OAT, offer Naltrexone as alternative.
- I can continue to monitor you and if you feel lapse or relapse has occurred we can restart medication
- Review the case, and be sure you are not putting obstacles in the treatment paradigm: e.g., Not giving refills to rock stable patients.

## Overcoming Barriers Dosing

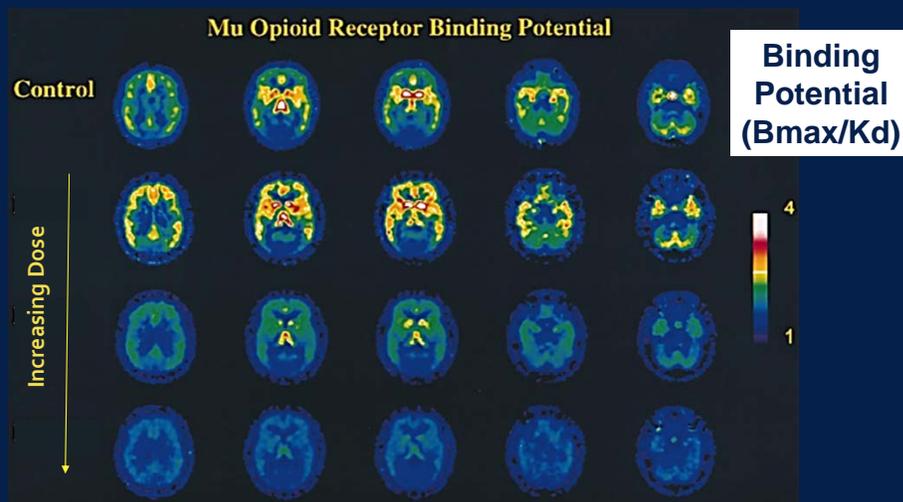


## Overcoming Barriers Dosing

- Dosing should be based on patient response and varies across patients
- Naltrexone should be administered ~4 weeks, but patients who metabolize more rapidly may benefit from dosing ~3 weeks or adding tablets during the 4<sup>th</sup> week
- Risk of precipitated withdrawal with buprenorphine can be reduced by using a lower initial dose of buprenorphine. An initial dose of 2–4 mg and observation of the patient for signs of precipitated withdrawal is recommended.



# Opioid Blockade



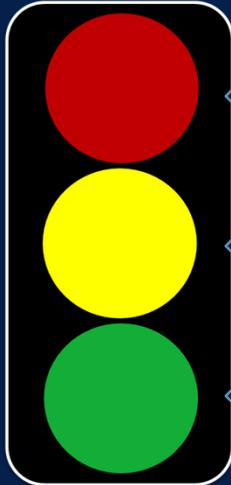
Zubieta et al. Neuropsychopharmacology 23:326–334, 2000

## Overview of Long-acting Buprenorphine Products

	6-month implants (Sixmo®/Probuphine®)	Monthly injection (Sublocade®)	Weekly and monthly injection (Buvidal®/Brixadi®)
Approval	EMA & USA	Australia & USA	Australia, EMA, USA*
Indications	Clinically stable adults with OUD, already on SL bup 8mg/day or less and already receiving medical, psychological and social support	Adults with moderate-severe OUD, tolerating SL bup at 8-24 mg/day for at least 7 days. Counseling and psychological support should be part of treatment plan.	Treatment OUD (age 16yrs +) within framework of medical, psychological and social treatment
Mean bup concentration at steady state (ng/mL)	~0.82	100 mg injection: 3.21 300 mg injection: 6.54	Variable depending on dose but >1
Minor surgical procedure required	Yes	No	No
Medication administration site	Upper arm - subdermal	Abdomen –subcutaneous (SC)	Abdomen, arm, leg, buttock (SC)
Refrigeration required?	No	Yes	No

Coe MA, Lofwall MR, Walsh SL. Buprenorphine Pharmacology Review: Update on Transmucosal and Long-acting Formulations. J Addict Med Volume 13, Number 2, March/April 2019. \*Not on US market due to Sublocade having exclusivity until 2020.

## Buprenorphine Dosing



> 24-32 mg/day (**Unusual:** Full Review of Medical/Behavioral Issues)

> 16–24 mg/day (**Possible:** Consider Patient Difference)

≤ 16 mg/day (**Typical**)

Zubieta et al., 2000; Greenwald et al. 2003; Product Information Suboxone 2005; personal communication RE Johnson, June, 2007

## Michelle's Strategies

### Overcoming Dosing Barriers

- Stay focused on objective behavior and outcomes, and stay focused on patient health.
- Don't make assumptions or jump to conclusions – be curious, ask hard questions framing questions and discussion always on how you are concerned about their health
- Don't hesitate to observe ingestion (you will be surprised to see what some patients do with med under their tongue)
- Buprenorphine doesn't work for everyone with OUD at all times.
- Always offer options/choices - frame options as benefits of each (not as punishments)

## Debbie's Strategies

### Overcoming Dosing Barriers

- Some of my patients never had a prescription for buprenorphine so their only experience with the medication was what was learned on the streets. Others may have been dosed in the (distant or sometimes not-so-distant past) with doses much higher with what I would have prescribed for this patient, and with increased frequency, say three to four times daily. Education is key.
- There have also been circumstances where even when patients have come to me being prescribed by three or four prescribers, they may have dosed improperly, stating they don't like the taste of the film, so they "down" it with their coffee in the morning. The power of the medication is in its ability to treat this disease--fill that opioid receptor so there are no cravings, no withdrawal symptom.
- Sometimes patients will take small pieces of the medication throughout the day, a practice referred to as "chemical coping" which should be addressed and discouraged, as it mimics the former pattern of substance use. Other patients will state they need higher doses of medication, and when queried about this, the response may be to address anxiety, sleep issues, depression, etc. which can be addressed non-pharmacologically or pharmacologically with other agents to assist with these symptoms.

## Ed's Strategies

### Overcoming Dosing Barriers

- Bup Pharmacology 101: More is not necessarily more, as with full mu agonists
- Importance of proper S.L. administration technique
- Although I understand that most diversion is used therapeutically by others, and ODs are decreased, still I don't want my prescribed bup to be diverted.
- Consider switching to S.C. formulation or intradermal implants
- Consider random call back to verify amount of bup in patient's possession
- Doses higher than 16mg daily may be required early in treatment, a so called "blocking dose." My own anecdotal clinical experience is that many patients, after stabilization and confidence that the medication works are able and willing to titrate to the lowest effective dose(LED), which treats "craving" and withdrawal
- Advantages of LED: ? Less constipation, less ↓ testosterone, etc
- Refer to OTP for continued bup or methadone

## Overcoming Barriers Counseling



## Overcoming Barriers Counseling

### ASAM National Practice Guideline:

- Opioid addiction is a chronic relapsing disease, therefore strategies directed at relapse prevention are an important part of comprehensive treatment and can include counseling and/or psychosocial treatments.
  - Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs.
  - *There may be instances when pharmacotherapy alone results in positive outcomes.*

The ASAM  
**NATIONAL  
PRACTICE  
GUIDELINE**  
For the Treatment of  
Opioid Use Disorder  
*2020 Focused Update*



## Overcoming Barriers Counseling

- Evidence does not indicate that adding psychosocial therapy improves the effectiveness in opiate prescribing programs.
  - This means that methadone maintenance treatment should be provided even if additional psychosocial therapies cannot be funded.
- There is little empirical evidence suggesting *which* psychosocial treatments work best in conjunction with medication for opioid use disorder (MOUD):
  - Few studies have compared the differential effectiveness of various psychosocial approaches for individuals receiving medications for the treatment of opioid addiction.

The ASAM  
**NATIONAL  
PRACTICE  
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*2020 Focused Update*



## Michelle's Strategies Overcoming Counseling Barriers

- Initial goals of treatment must be to **engage and retain** – don't get hung up on number of groups or counseling sessions attending.
- Sometimes acute treatment needs are more suited for a social work or nurse case manager/care coordinator [transportation, shelter and food insecurity, need for legal advocacy, help with getting an ID/DL/SSC, urgent medical follow-up]
- PCPs and non-therapists can establish therapeutic relationships and learn basic counseling techniques – part of every medication management visit
- Do comprehensive goals setting (worksheet in TIP 63)– what does patient see as a problem and feel like they want to work on – we focus on problems that provider and patient agree are a priority and something that will affect their ability to come back to the clinic.
- Oftentimes, patients are more willing to engage in counseling after some time in treatment.
- Vet your counselors and check-in on groups unannounced (do your own QA)

## Debbie's Strategies

### Overcoming Counseling Barriers

This may be impacted by work/life balance. There may be other options in the community for evening/weekend appointments if the patient is open to this. A patient who is stable over time may feel ready to discontinue the counseling piece while continuing treatment for OUD. Any interaction with a provider is a linkage to care and should be considered an opportunity to connect, listen, reflect, encourage, empower continued recovery and treatment success.

## Ed's Strategies

### Overcoming Counseling Barriers

- Individualize: Never Mandatory
- Must have permission to speak with counselor/therapist. Therapist may provide information which can clarify a clinical problem
- Consider non-Drug focused Psychotherapy
- Recognize that well done medical management visits are a form of "counseling." Patient knows you are "rooting" for them
- Modify counseling need as patient stabilizes.
- Counselor may provide follow-up if you are providing refills.

## Overcoming Barriers Polysubstance Use



## Overcoming Barriers Polysubstance Use

- Appropriately prescribed and monitored benzodiazepines should not be withheld from patients on MOUD.
- **Did you know?** One study result found daily cannabis use associated with ~21% greater odds of remaining in opioid treatment

Socias ME, Wood E, Lake S, et al. High-intensity cannabis use is associated with retention in opioid agonist treatment: a longitudinal analysis. *Addiction*. 2018;113(12):2250-2258. doi:10.1111/add.14398



## Overcoming Barriers

### Polysubstance Use: Don't Fire Your Patient

- When your patient tests positive for illicit or non-prescribed medications, respond therapeutically:
  - Document in patient chart
  - Evaluate current treatment plan
  - Consider all treatment options
- Educate patient on risks of using other substances: medical and legal (eg. unexpected fentanyl exposure).
- Continue/modify treatment (eg. more frequent visits, switch to depot formulation) or refer to a higher level of care.
- Discontinuing treatment should be last option—increases risk of overdose and death.

## Michelle's Strategies

### Overcoming Polysubstance Barriers

- Carefully assess, educate and make sure level of care matched to patient needs
- Responses may be tailored to each patient – e.g., response to chronic marijuana use may be different between Patient A and Patient B

## Debbie's Strategies

### Overcoming Polysubstance Barriers

- No MOUD for methamphetamine or several other substances to date
- Stay on top of clinical research for patient advantage: ASAM weekly, SAMHSA, NIDA, etc.
- If a patient is struggling with OUD and AUD, for example, consider the variety of medication options, self-help groups, always check labs!
- Make certain you are testing for the substances of concern in your community.

## Ed's Strategies

### Overcoming Polysubstance Barriers

- Ask the patient to explain the Drug toxicology report or other evidence of using illicit or non-prescribed drugs.
- Be sure you are properly evaluating the toxicology test. There are false positives and negatives. You need GC/MS back up for some cases.
- Assuming there is use of other drugs besides opioids, determine if the use meets criteria for a SUD, or is an occasional "use."
- Cannabis is difficult due to legalization and medicinal cannabis. However, as with alcohol which is legal, need to determine if there is a CUD.
- Need inpatient "detox" for sedative hypnotics.
- Refer to OTP for stabilization and then return to OBOT
- If MOUD exists for the substance, e.g., Alcohol, add to MOUD
- Naltrexone is FDA approved for opioid and alcohol use disorders
- Each provider will have a threshold for continuing OBOT—concerns about trading bup for cocaine as an example.

## Overcoming Barriers Drug Testing



## Overcoming Barriers Drug Toxicology Testing

- Testing is done for the patient, not to the patient
- Generally should be performed randomly
- Discontinuing MOUD should be the last option with an unexpected positive urine drug test
- Urine, saliva, and hair are appropriate matrices



## Michelle's Strategies

### Overcoming Drug Toxicology Barriers

- Part of monitoring treatment
- Ask what will test positive for before testing is done – always praised for honesty when test results match self-report, even if there was a slip
- Always confirm when a screening test is contested with a confirmatory test (GCMS or LCMSMS)
- Don't discharge from clinic due to a drug test result – give options that are matched to your assessment, aimed at protecting patient's health and document

## Debbie's Strategies

### Overcoming Drug Toxicology Barriers

UDT is a treatment tool such that a BP cuff and stethoscope are for hypertension, methods to track patient success. All clinicians should be well versed and educated on their utility and management--there are too many circumstances where point-of-care tests are misunderstood in daily practice and patients are "fired" for clinician error. An example of this is the opiate screen that will include all opiates and opioids; but on immunoassay, an opiate screen will not reliably detect oxycodone and fentanyl. UDT continues to be the most well accepted and studied medium for analyses of substance use. Negative results could mean a variety of things and engaging in thoughtful discussion without judgment does lead to treatment success over the long haul. The patient may have run out early, is using less than prescribed, or at a less frequent dosing interval. It is also important to understand what drugs trigger a false positive result. In some clinical settings, the choice may also be to test for both parent compounds and metabolites, and have an understanding of these results.

## Ed's Strategies

### Drug Toxicology Barriers

- Paradigm: Please tell me which drugs will be found in this urine. If you are truthful, there will not be any problems. If you are not truthful, and the test reveals a drug you did not disclose, this will erode the trust, which I want to have with you. I understand that lapses and relapses are part of the disease of addiction. The results are confidential. Routine part of care.
- "Shy Bladder." It can be real. Saliva matrix.
- POC versus send to lab: GC/MS for metabolite levels: Opiates/Opioids
- Substitution, Adulterated, Negative bup, Positive bup or Methadone with negative metabolites are a significant problem. Discuss with patient, increase monitoring, increase psychosocial, Depot bup, NTX, OTP
- Random Call back for Tox Screen.
- Observed Urine Collection rarely indicated.
- "Firing Patient" is generally to be avoided.

## Overcoming Provider Barriers Drug Enforcement Administration (DEA) Concerns



## Overcoming Provider Barriers

### Drug Enforcement Administration (DEA) Concerns

- Once you have obtained your waiver, you are subject to limits on the number of patients you can treat. You can find out more about your patient limit here: <https://www.asam.org/advocacy/practice-resources/buprenorphine-waiver-management>
- Certain state medical boards have implemented extremely prescriptive regulations governing use of buprenorphine containing products. These regulations include dosage limits, mandatory counseling, and mandatory consultations with addiction treatment specialists

## Michelle's Strategies

### DEA Concerns

- If you have a question, get it answered
- If storing controlled substances and have written SOPs and logs (will need these if using buprenorphine injection or implants), ensure they are compliant with DEA requirements
- If prescribing buprenorphine, abide by your limits, ensure you have a plan on how to demonstrate compliance with your waiver limit should DEA visit the address on your DEA license (e.g., many states' prescription medication monitoring programs can run a report on yourself)

## Debbie's Strategies

### DEA Concerns

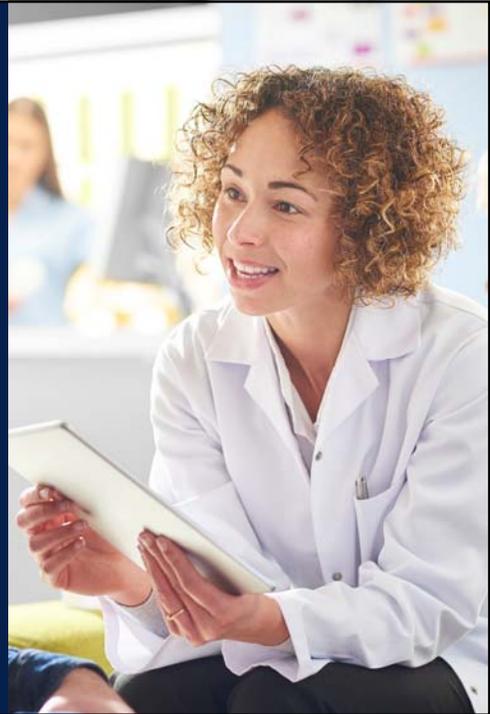
Be sure you understand your state guidelines not only with regard to prescribing buprenorphine but with all controlled substances. Any consultations with specialists, for example, if required, should be documented in your progress notes.

## Ed's Strategies

### DEA Concerns

- This one is easy. Follow the basic rules on patient caps, having a log of patients, knowing when they will run out of their medication.
- Record keeping up to date.
- The DEA is searching for the “bad apples” amongst us.
- If you are doing your work properly there is nothing to worry about.
- The inspections are like Grandma's teeth; “Few and Far Between.”
- Don't listen to “Old Timer's” Nightmare Audit Stories
- Easier not to purchase bup and store medication.
- SC formulations Consideration

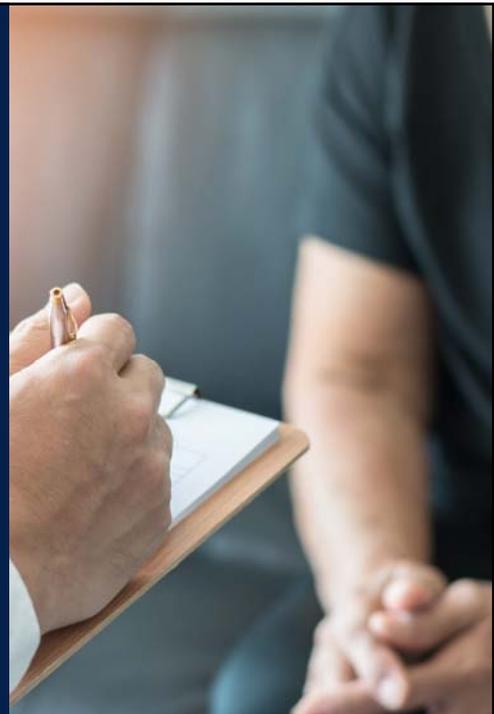
## Overcoming Barriers Misuse/Diversion



## Overcoming Barriers Misuse/Diversion

- The most frequently cited reasons for non-prescription use were consistent with therapeutic use.
- Study suggests that those who use diverted buprenorphine or methadone would prefer obtaining it through a valid prescription.

Cicero, T. Understanding the use of diverted buprenorphine. *Drug and Alc Depend.* 2018; 193: 117-123.



## Responding to Misuse/Diversion

- **Evaluate:** Reassess treatment plan and patient progress.
- **Intensify Treatment/Level of Care:** Consider alternate medications (depot formulations) or treatment settings.
- **Document and describe** the misuse/diversion incident, clinical thinking that supports the clinical response
  - should be aimed at **minimizing risk** of misuse/diversion and **treating the patient** at the level of care needed.

## Michelle's Strategies Overcoming Misuse/Diversion Barriers

- These are behavioral signs of non-adherence and active addictive illness. They include a wide array of different behaviors.
- Define these terms at outset of treatment with examples – and reasons why they may happen. This shows you/your team understand this illness (e.g., some people become addicted to injecting).
- Our nurse does a basic 101 on history of buprenorphine and how lucky patients are to have it as a prescription – literally took act of Congress, and talks about who may ask them for their medication, how they will store it, how we want to help them problem-solve.
- Want to find the underlying driver(s) of these behaviors and make plan to address those when they occur
- It may take time to find the underlying reason(s) – so in meantime, provide shorter prescriptions, observed dosing, consider consolidating dosing to M/W/F or change to an injectable, always focusing on concern on patient's health and status of illness – not punishing, and providing patient choices to help them to stay engaged.

## Debbie's Strategies

### Overcoming Misuse/Diversion Barriers

If you suspect diversion, consider pill/film counts (with COVID and virtual visits, consider accomplishing this through Zoom or Google Meets, etc.), metabolite testing, etc. Always check your state's PDMP/PMP. Recently I had a patient who had been receiving three 8/2 film along with two 12/3 film daily (total dose 48 mg daily) from the same MD for years. No UDS from that prescriber in more than 6-8 months. On our UDS, patient was positive for opiates, amphetamine, methamphetamine, and cocaine, but not for buprenorphine. You also may want to consider directly observed dosing.

## Ed's Strategies

### Overcoming Misuse/Diversion Barriers

- This issue overlaps to some extent with the dosing discussion we have had.
- The evidence is clear: Diverted bup can be understood as a harm reduction modality.
- Each provider will have to determine their level of concern and reaction to diversion.
- Depot formulations
- Although ODs on bup alone do not occur in adults—adding alcohol or benzos poses a threat of OD.
- Refer to OTP for stabilization
- Random call backs for medication count—only in serious cases, since relationship with patient will likely be affected
- There has always been a concern, that with increasing diversion of bup, the DEA might reschedule bup to a II, thereby eliminating OBOT

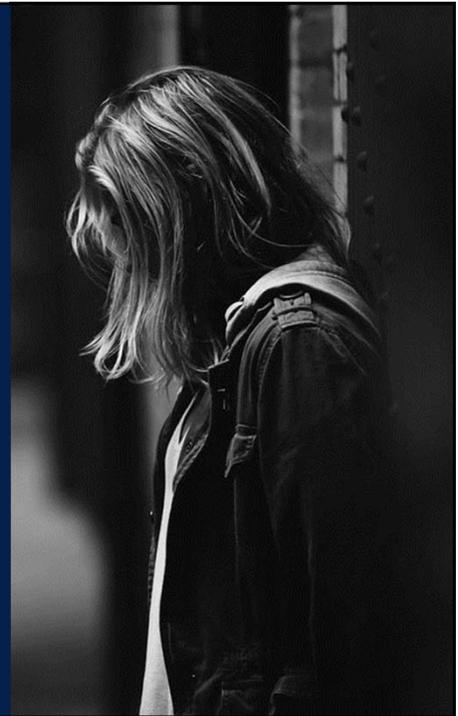
## Case Presentation: Kennedy

Task: Reflect on Kennedy's case further based on new information learned.

### Guiding Question:

Based on the case, what follow-up questions would you ask?

Time allocated: 5 minutes



**ASAM** American Society of  
Addiction Medicine

Break  
10 min

## Overcoming Patient Challenges



- Lack of Access to Care
- Lack of Belief in Agonist Tx
- Misinformation/Lack of Support for Patients using Medication
  - Prejudice and Bias in Healthcare Systems
- Complicated Patients
  - Psychiatric Comorbidities
  - Pregnancy
  - Managing Pain

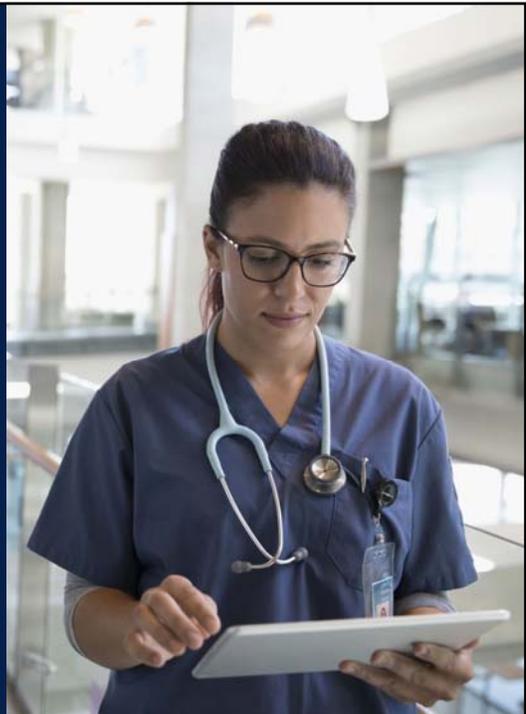
## Overcoming Patient Challenges Lack of Access to Care



## Overcoming Patient Challenges

### Lack of Access to Care

- An institutional/champion/role-model approach has been demonstrated to assist in prescribing (Gordon AJ et al 2011)
- Use nurse case managers to coordinate care and provide follow up (Deflavio J et al 2015; Barry DT et al 2009; Gordon AJ et al 2011)
- Utilize peer recovery/support specialists



## Michelle's Strategies

### Lack of Access to Care

- Know your local resources and link to them when possible
- Identify funding opportunities and support grant writers in your practice/organization
- Prepare to be a patient advocate and enjoy it—you are doing a great service

## Debbie's Strategies

### Lack of Access to Care

- Utilize IOP/detox/residential programs
- Engage sober family/friends for support
- Enlist local community partners
- Keep list of local, state, and national peer warm lines, crisis teams, and support lines.
- HARM REDUCTION!

## Ed's Strategies

### Lack of Access to Care

- Encourage OTPs to dispense bup alongside methadone
- Encourage all ED providers to become certified and start treatment in the ED with "warm" handoff to community providers.
- Encourage primary care providers in your institutions to become waived
- PAs, NPs, and other specialized nurses
- Eliminate waiver requirement
- Eliminate patient caps: universally or selectively

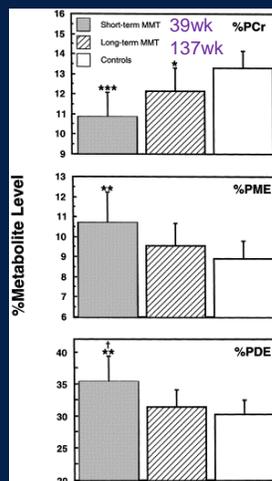
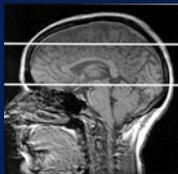
# Overcoming Patient Challenges

## Lack of Belief in Agonist Treatment

- There is clear evidence that agonist treatment works

## Methadone: Effectiveness/MOA

Cerebral phosphorus metabolite abnormalities in opiate-dependent polydrug users in methadone maintenance



### Phosphorous MR Spectroscopy

**Fig. 3. Metabolite levels in control subjects ( $n=16$ ) and in short- ( $n=7$ ) and long-term ( $n=8$ ) methadone maintenance treatment (MMT) subgroups. Shown are means  $\pm$  S.D. of percent metabolite measures.**

Psychiatry Research: Neuroimaging  
Volume 90, Issue 3, 30 June 1999, Pages  
143-152 Kaufman, M

## Methadone: Effectiveness/MOA

From these data, it is concluded that polydrug users in MMT have 31P-MRS results consistent with abnormal brain metabolism and phospholipid balance. **The nearly normal metabolite profile in long-term MMT subjects suggests that prolonged MMT may be associated with improved neurochemistry**

Psychiatry Research: Neuroimaging  
Volume 90, Issue 3, 30 June 1999, Pages 143-152

## Michelle's Strategies

### Lack of Belief in Agonist Treatment

- Do you believe in science?
- Methadone and buprenorphine are on the World Health Organizations list of essential medications
- Larochelle's big data in Massachusetts—real world—people on methadone and buprenorphine much less likely to die after a non-fatal opioid overdose than people not on these medications.
- Schwartz's real-world data in Baltimore City with rapid buprenorphine expansion and treatment on demand, there were fewer heroin overdose deaths.

1. Larochelle MR, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Mortality. *Ann Intern Med.* 2019;170(6):430-431. doi:10.7326/L18-0685 2. Schwartz RP, et al. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. *Am J Public Health.* 2013;103(5):917-922. doi:10.2105/AJPH.2012.301049

## Debbie's Strategies

### Lack of Belief in Agonist Treatment

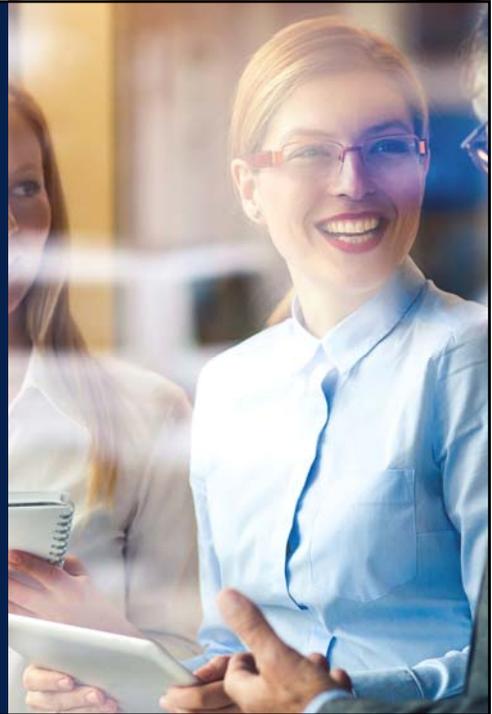
- What is heard from friends who have failed treatment for any one of a number of reasons; offer simple, straightforward education on the available FDA-approved products in a non-judgmental way, leaving time to answer questions, and revisiting at a future time.
- Offer patient education materials and consider employing a peer recovery specialist to your team. These tactics will often help to dispel any myths about these products.

## Ed's Strategies

### Lack of Belief in Agonist Treatment

- Review the overwhelming evidence base accumulated for 55 years on methadone's effectiveness, and 25 years on Buprenorphine's effectiveness. Although less robust, review Naltrexone's effectiveness.
- Contrast evidence based data with ideological biases.
- Acknowledge negative attitudes in Mutual Help groups which are not supported by data.
- Ask significant others to come in with patient to discuss (time consuming)
- Find a patient advocate to talk to patient and SOs.
- Dr. Dole, the father of methadone maintenance, was on the AA Board of Directors

Overcoming  
Patient Challenges  
**Prejudices and  
Bias in  
Healthcare  
Systems**



**Overcoming Patient Challenges**  
Prejudice and Biases in Healthcare System

- Replace stigmatizing language
- Utilize team-based care model
- Review articles on efficacy of medications for OUD with patients and significant others
- Advocacy opportunities—meet with policymakers on patient limits and legislation
- Utilize peer support

Non-stigmatizing Language	Stigmatizing Language
Person with a substance use disorder	Substance abuser or drug abuser Alcoholic Addict User Abuser Drunk Junkie
Babies born with an opioid dependency	Addicted babies/born addicted
Substance use disorder or addiction Use, misuse Risky, unhealthy, or heavy use	Drug habit Abuse Problem
Person in recovery Abstinent Not drinking or taking drugs	Clean
Treatment or medication for addiction Medication of opioid use disorder/alcohol use disorder Positive, negative (toxicology screen results)	Substitution or replacement therapy Medication-assisted treatment Clean, dirty

## Addiction Terminology Do's and Don't's

Grayken Center for Addiction.  
Boston Medical Center.

## Michelle's Strategies Prejudice and Biases in Healthcare System

- Develop a strong support network of like-minded colleagues
- Shed light on prejudice and biases
- Be willing to give talks and educate others who are willing to listen—across disciplines and even beyond health care (e.g., drug courts).

## Debbie's Strategies

### Prejudice and Biases in Healthcare System

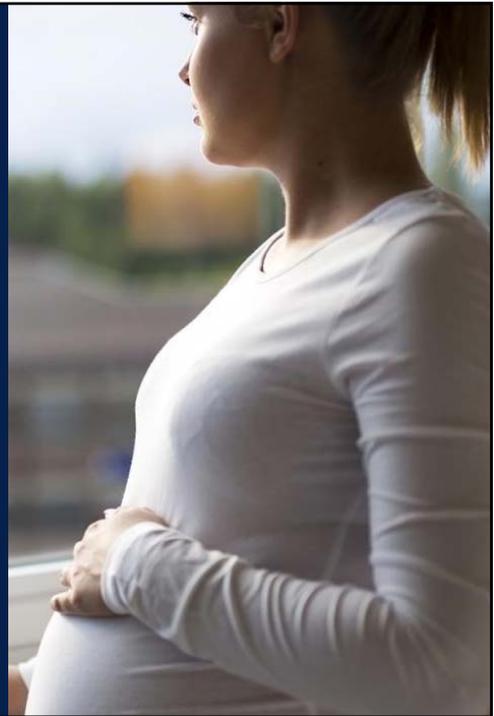
- Language is important, and colors/frames the tone of the patient encounter.
- The more we all make the change occur in all the places we live, the less often we will hear our patients calling themselves “addicts,” the results of their urines “dirty,” and they will feel more in control.

## Ed's Strategies

### Prejudice and Biases in Healthcare System

- Always use medical terminology
- Encourage the patient and SOs to use medical terminology
- Correct you peers when they speak about the “addict” they want to refer for treatment
- Volunteer for Grand Rounds presentations and other advocacy activities.
- Be active in your community: media, in-person presentations.

## Overcoming Patient Challenges **Complicated Patients**



## Overcoming Patient Challenges **Psychiatric Comorbidity**

- Patients should undergo an assessment of mental health status and possible psychiatric co-morbidity
  - Reassess after patient is stabilized on MOUD
- Psychiatric co-morbidity should not bar patients from OUD treatment
  - Use referrals when necessary

Kampman, K. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. 2020.



## Michelle's Strategies

### Psychiatric Comorbidity

- General mental health and suicide screening (C-SSRS) on all new patients
- Know who you can refer to for help to treat your patient's psych comorbidity when you are out of your lane
- Common diagnoses are affective and anxiety disorders – learn the basics about these so you are comfortable initiating some first-line medications like SSRI's and SNRI's (as long as not manic).
- Big paper to help differentiate independent vs. substance-induced
- Have an addiction psychiatrist in your network of colleagues

## Debbie's Strategies

### Psychiatric Comorbidity

Many of my patients live in rural, poor areas historically without access to treatment. Many treated their mental health conditions with drugs and alcohol—such as schizophrenia, bipolar disorder, schizoaffective disorder and more. Once their SUD are treated, and MH conditions stabilized, families come together, communities safer, patients safe and “whole.”

## Ed's Strategies

### Psychiatric Comorbidity

- Psychiatric co-morbidity is common among patients with SUDs
- Differentiate between substance induced symptoms versus independent.
- As a non-psychiatrist determine your comfort level diagnosing and treating psychiatric disorders; e.g. anxiety or depression versus Bi-Polar disorder.
- MOUD may improve some psychiatric co-morbid conditions.
- Psychosocial therapy to focus on underlying issues/vulnerabilities

## Overcoming Patient Challenges

### Pregnancy

- There are **safe and effective evidence-based** treatment options in pregnancy.
- Opioid agonist pharmacotherapy with **methadone** or **buprenorphine** is endorsed by the American College of Obstetricians and Gynecologists (ACOG) as the optimal treatment for OUD during pregnancy.
- Breastfeeding is safe and recommended.

Terplan M, et al. Obstetrics & Gynecology. 2018.

### CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS



## Michelle's Strategies

### Pregnancy

- Talk to all women about desire for pregnancy, birth control, and prevention of STDs.
- When pregnancy happens, don't freak out – actually a lot of data on safety of methadone and buprenorphine in pregnancy for both mom and baby. Want to deliver at a hospital with rooming in allowed.
- Refer to prenatal care, get ultrasound to document fetal viability, and know which OB's will treat pregnant patients with OUD and if you have a specialty addiction in pregnancy program near you
- Document and get consent for treatment while pregnant
- Proactively talk about labor plans – pain management, breastfeeding, any issues that may come up with child protective services (sometimes varies by state)

## Debbie's Strategies

### Pregnancy

I safely treat all pregnant patients with buprenorphine/naloxone, not the monoproduct.

## Ed's Strategies

### Pregnancy

- Sensitive to increased stigma in pregnant patients.
- The evidence is clear: Remaining on Opioid Agonist Therapy, or initiating Opioid Agonist Therapy is recommended for all pregnant patients with OUD.
- Patients encouraged to increase dose of methadone or buprenorphine if needed. May need to split the dose as well. Mother in W/D → Fetus in W/D
- Bup has more favorable profile in pregnancy than methadone
- The sooner the newborn can leave the hospital the better in terms of "Why is the Baby in the NICU?" Bup vs Methadone → ↓NAS → ↓LOS
- Inform patient that the dose of OAT is not related to the severity of the NAS.
- Be extraordinarily attentive to confidentiality. Some patients have not shared information with family members.
- ↓NAS → Breastfeeding and Tobacco Cessation
- Combo versus Mono SL, NTX in pregnancy, Depot. Evolving Issues.
- Many OBS are Waivered. Advocate for the patients.

## Overcoming Patient Challenges

### Managing Pain

- Buprenorphine, both on-label and off-label, could be prescribed instead of full mu-opioid receptor agonists for effective treatment of chronic pain
- For patients taking methadone or buprenorphine for the treatment of opioid use disorder, temporarily increasing the dose or dosing frequency (i.e. split dosing to maximize the analgesic properties of these medications) may be effective for managing pain.
- Short-acting full-agonist opioids may be added to the methadone or buprenorphine dose for acute pain (e.g. postoperative pain)
- Naltrexone presents unique clinical challenges

## Michelle's Strategies

### Managing Pain

- Pain = a symptom so want to complete individual assessment and plan—make sure nothing missed—often times our patients do not get the best medical/psychiatric work-ups.
- Very few randomized controlled trials on most effective way to treat pain
- Very easy to have very good pain control during delivery with epidural—and childbirth is painful (so there is hope)!
- A lot of acute pain can be managed with nerve blocks (more and more ED's using this)
- In general, do not stop MOUD treatment if there is a positive response to it

## Debbie's Strategies

### Managing Pain

- Discontinuing buprenorphine prior to a surgical procedure is incredibly risky and can lead to devastating consequences. I can offer the story of a patient with a complex ankle reconstruction where the surgeon did not return my call for almost one month to coordinate care and the outcome was potentially life threatening. He was lost to all of us—including every member of his family—for 6 months.
- It is much safer indeed to follow the guidelines to continue buprenorphine throughout the surgical period for continued patient safety, with explicit instructions on dosing all pain medications, with nursing calls to assure compliance.
- Buprenorphine in split dosing is very effective for many patients in the management of mild-moderate pain conditions, utilizing other modalities depending on diagnosis to achieve functional goals.

## Ed's Strategies

### Managing Pain

- Evolving clinical options. Current paradigm for anticipated acute pain while on OAT (e.g., post operative): Divide and continue dose of methadone or bup and add IR full opioid agonists. Similar for unanticipated acute pain; e.g., dental
- Unsettled paradigm among surgeons, anesthesiologists, and addiction medicine providers
- If a patient is fearful that there will be inadequate pain relief if bup is continued, consider "older" paradigm of taper prior to surgery.
- Naltrexone: Anticipated- D/C po, IM—at end of 4wks
- Non-Opioid Pharmacotherapy: Ketamine, Nerve Blocks, NSAIDS etc.
- There are 2 Buprenorphine formulations approved only for chronic pain: 7 day transdermal patch (Butrans®) and Buccal Mucosal Film (Belbuca®) No waiver is required and there are no patient caps
- Off-label use of SL formulations for pain do not require a waiver and there are no caps. Prior Auths can be a problem

## Activity 3: Barriers to Treating Kennedy

**Time Allotted**

5 minutes

### Case Exercise: Kennedy

**Task:** Explore Kennedy's case further based on new information.

#### Prompting Question

Which of the following do you consider barriers to treating Kennedy?

(Poll: Multiple Answers)

- dosing?
- polysubstance use?
- misuse/diversion (boyfriend with OUD)?
- Counseling?
- Time in Treatment
- Lack of Belief in Agonist Treatment?
- Psychiatric Comorbidities?

# Activity 4: The Elevator Pitch

## Case Exercise: Kennedy

**Task:** Identify strategies to overcome barriers to TOUD based on information provided in the case.

### Scenario:

You find yourself in the elevator with a staff member who thinks Kennedy should be off medication.

Using the evidence that was reviewed thus far, what would you say in a 30-second elevator pitch to counter this person's position?

### Time Allotted

15 minutes

**End of Module 2**  
**Overcoming Barriers**