# Module 2

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

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# Module 2 Learning Objectives

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

# Case Discussion: *Kennedy*

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

# Kennedy's Case

## *Case Information:*

- 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 family physician (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.***

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# Kennedy’s Case

*Case Information:*

- 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.
- She eventually felt like this was what her brain was “missing.”

# Kennedy's Case

*Case Information:*

- Kennedy was sexually abused by an older male cousin when she was 9 years old. Kennedy cries 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.
- 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's Case

*Case Information:*

- She managed to graduate high school and enroll in her local community college. She was unable to continue college due to her continued substance use.
- Soon, she segued into injection drug use (IVU). She obtains sterile needles 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.

# Kennedy's Case

*Case Information:*

- Kennedy has entered medically-managed withdrawal three times and one 28-day rehab. She, unfortunately, relapsed in less than one week. She has attended a few Narcotics Anonymous (NA) meetings with her boyfriend. She thinks medications, such as methadone and buprenorphine, would just be trading one addiction for another. There is no history of street use.
- At this point, it is unknown if Medications for Opioid Use Disorder (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's Case

*Case Information:*

- Her parents divorced when she was 12. She is estranged from her father, her mother is supportive, and she has a 28-year-old brother with a history of alcohol use disorder (AUD) .
- Past medical history: Post-Traumatic Stress Disorder (PTSD)
- No current medications, no known drug allergies (NKDA)
- Kennedy has recently enrolled in the Medicaid program. She claims that her boyfriend is not eligible for Medicaid.

# Kennedy's Case

*Case Information:*

- Physical Exam: Drowsy, young, thin, disheveled female, with pinpoint pupils (miosis), and slurred speech. Bilateral upper extremities reveal fresh track marks on antecubital fossae, no abscess or streaking.
- COWS= 3
- Unaware of HIV status or Hep C status.
- Urine drug test (point of care):
  - + opiates, +THC, +fentanyl, and +cocaine
- Kennedy states her last use of heroin was two hours ago. She admits to the use of cannabis but denies the use of fentanyl and cocaine.

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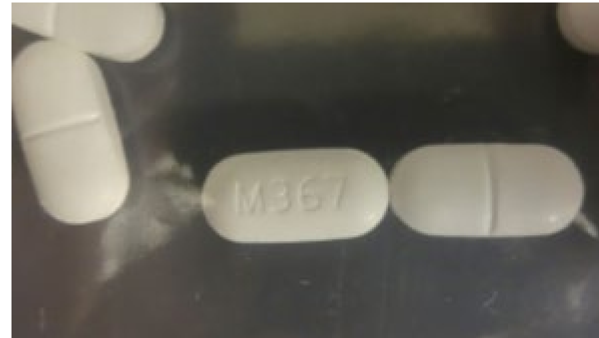
# "Death Pill"–

Fentanyl disguised as other drugs linked to spike in US overdoses.

**_Fentanyl Laced Cocaine_**

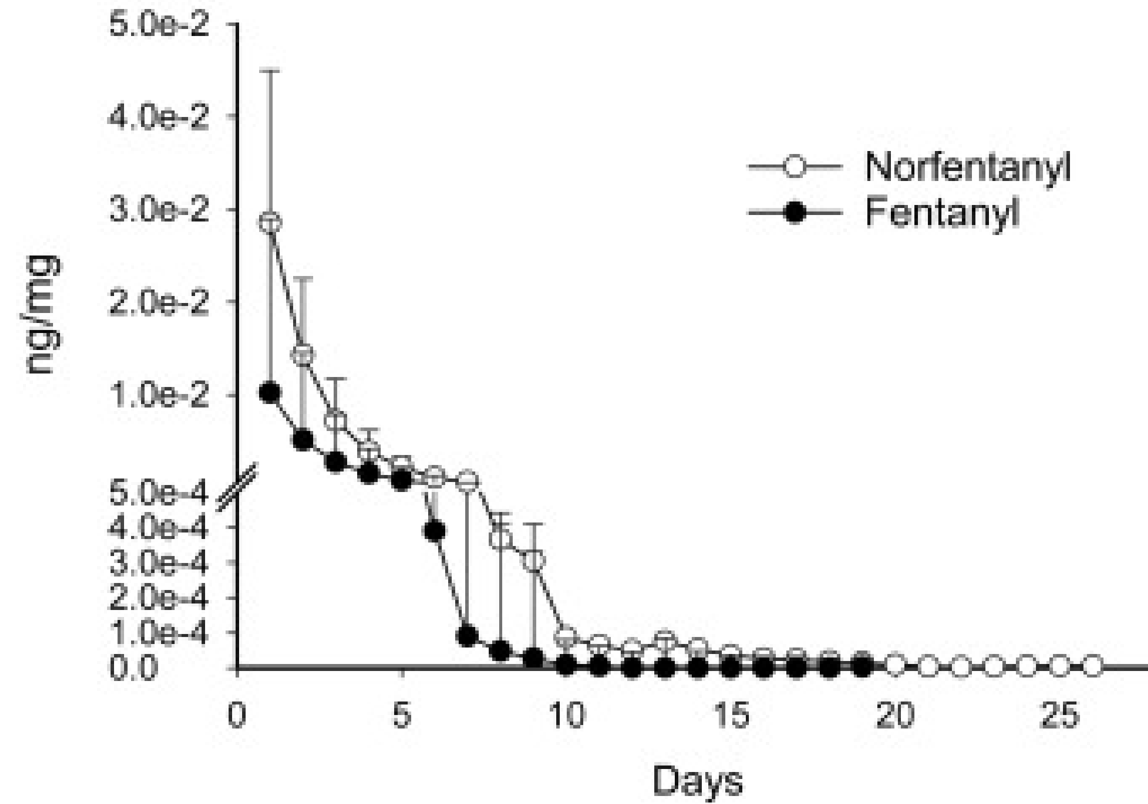



**_Fentanyl Laced Hydrocodone_**

**_Fentanyl Laced Xanax_**

Image sources: NIDA, SF Public Health

# Fentanyl and Norfentanyl Elimination




Huhn, AS, et al. Protracted renal clearance of fentanyl in person with opioid use disorder. Drug and Alcohol Dependence. 2020; 214: 1-4

# Acute Skeletal Muscle Rigidity: "Wooden Chest"

- First reported in 1953 in anesthesia literature
- *Skeletal muscle rigidity*: chest wall is the most common
- Known to occur with synthetic lipophilic opioids—like fentanyl and its congeners
- More common with rapid IV admin than other routes (ex: transdermal)
- Not clearly dose-related and can occur with low or absent norfentanyl concentrations
- Mechanism believed to be activation of the coerulospinal noradrenergic pathway, following mu-receptor activation in LC.
- Reversed with rapid naloxone administration (typically IV route in literature)
- May need neuromuscular blockade with intubation and ventilatory support

Burns, G et al  Clinical Toxicology, Vol. 54, No 5, 420-23, 2016

# Impact on Addiction Treatment

- Fentanyl—not detected as an “opiate” on Enzyme Linked Immunosorbent Assay (ELISA) or POCT unless in the panel as a synthetic.
- Some patients and providers report buprenorphine-precipitated withdrawal with home and in-office inductions. Pharmacologically thought to be related to lipophilicity of fentanyl and depositing.
- In treatment, providers can avoid precipitating withdrawal by:
  - Requiring higher Clinical Opiate Withdrawal Scale (COWS), smaller buprenorphine doses, “micro-dosing," or potential "macro-dosing"

# Overcoming Provider Barriers

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

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# Overcoming Barriers

*Lack of Institutional Support for Buprenorphine Treatment*

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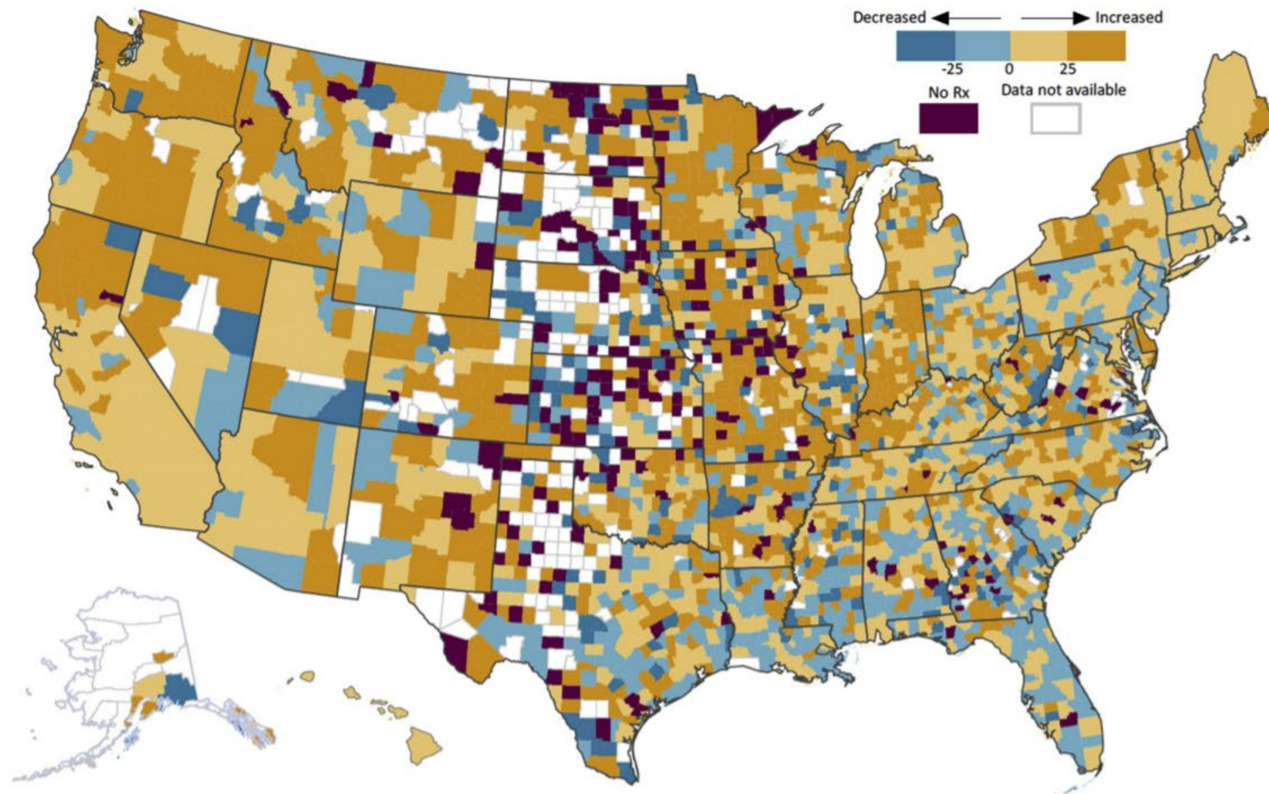
# The Treatment Gap
## *The Need for Buprenorphine Treatment Providers*




- 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? Does someone else want them 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

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# 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.

# Overcoming Discontinuation Barriers

## Dan's Strategies

- Discuss the "whys"
- Family, significant others, sponsor, home group, self-stigma, pregnancy and stigma, DFS concerns, misconceptions around NOWS.
- Opportunity for education and changing attitudes.
- Address stability across multiple domains.
- Address poor outcomes with early tapers and educate regarding risks.
- Pregnancy concern, welfare of baby, DFS concerns, fear of loss of child. Safe-harbor laws?
- After informed consent, support taper, go slow, support in returning to maintenance if needed or requested without shaming. Return to use as part of chronic brain disease, mistakes versus failure. Use as a learning opportunity. Keep engaged after taper completed.
- Don't forget naloxone rescue!

## Barb's Strategies

- Studies in adults have found that patients continued to improve over the course of the first 6 years of treatment
- Warm hand-off after pregnancy
- Medicaid coverage for full year post partum
- Review research studies showing better outcomes with MOUD during pregnancy and post partum

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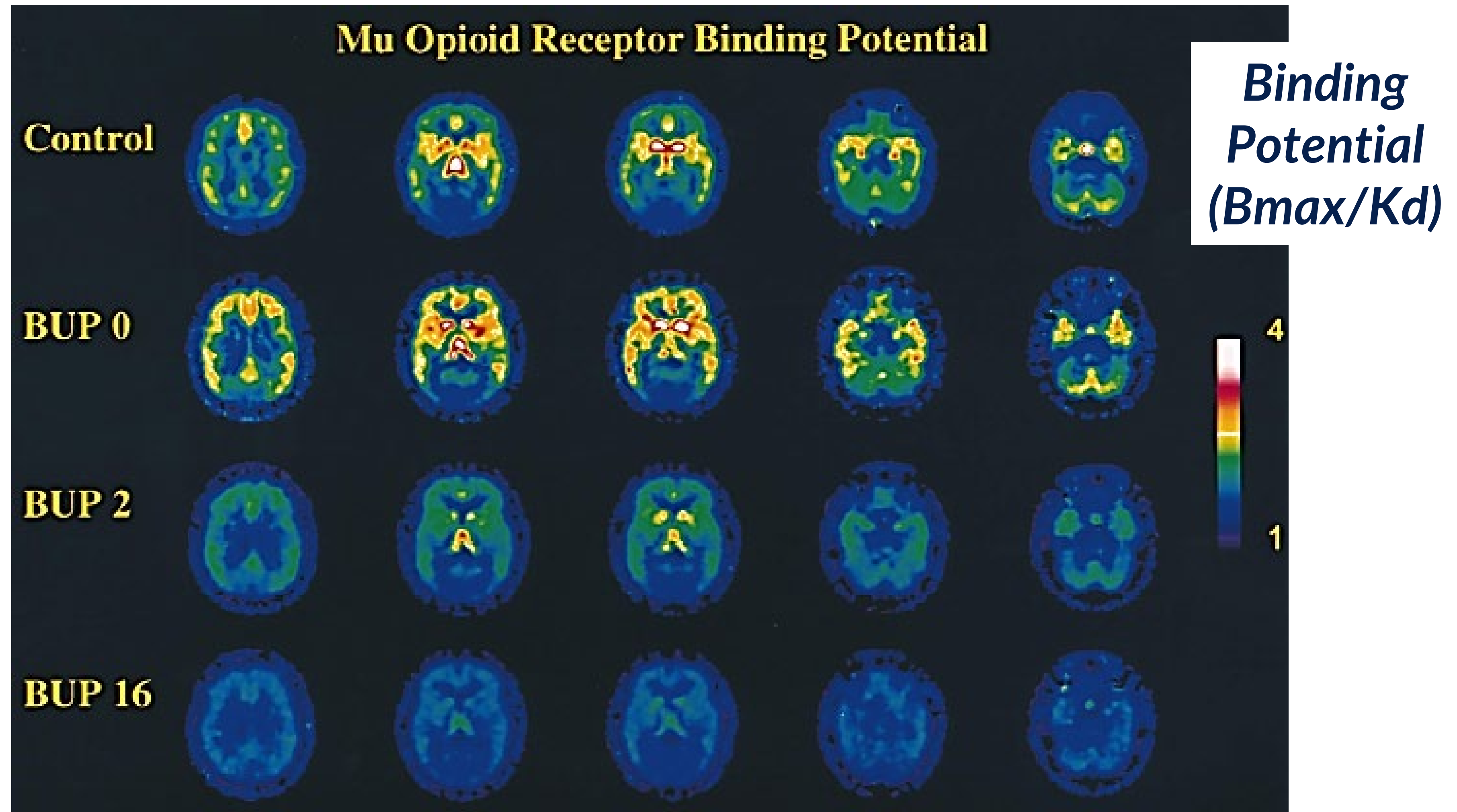
# Overcoming Barriers

*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 4th 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. Potential added complexity with fentanyl—could require micro-dosing or macro-dosing.

# Opioid Blockade




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

# Overview of Long-acting Buprenorphine Products

| | Monthly injection (Sublocade®) | Weekly and monthly injection (Buvidal®/Brixadi®) |
|---|---|---|
| Approval | Australia, Canada & USA | Australia, Canada, EMA, USA* |
| Indications | 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) | 100 mg injection: 3.21<br>300 mg injection: 6.54 | Variable depending on dose but >1 |
| Minor surgical procedure required | No | No |
| Medication administration site | Abdomen –subcutaneous (SC) | Abdomen, arm, leg, buttock (SC) |
| Refrigeration required? | 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

- Based on the unique patient situation (opioid used) dosing will vary from 0.5 mg on day 1 to perhaps 4-8 mg on day 1. This is based on patient history, presentation, drug of choice, etc.
- Most patients do well on doses ranging from 2 mg to 16 mg daily. There are cases where some patients will need higher doses, but more than 24 mg is not recommended.

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# Overcoming Dosing Barriers

## Dan’s Strategies

- Individualize, as “one size does not fit all”.
- Increasing prevalence of high potency synthetics.
- Comorbid chronic pain.
- Value of depot formulations.

## Barb’s Strategies

- 2-4 mg dosing initially, higher COWS score
- Fentanyl strips, micro dosing
- Pregnant women have definitively been shown to need increased doses of buprenorphine and more frequent dosing intervals
- Pregnancy dosing does not seem to affect NAS/NOWS rates

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# Overcoming Barriers

*Counseling*

# Overcoming Barriers
*Counseling*

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

ASAM American Society of Addiction Medicine

## 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.*

# Overcoming Barriers

*Counseling*

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

ASAM American Society of Addiction Medicine

- **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 MOUD:**
  - Few studies have compared the differential effectiveness of various psychosocial approaches for individuals receiving medications for the treatment of opioid addiction.

# Overcoming Counseling Barriers

## Dan's Strategies

- Identify psychosocial or behavioral health problems and readiness to change, motivational enhancement key.
- Always address safety. Collaborate on safety plan.
- Address the potential for the emergence of symptoms related to past trauma. Explore previous traumatic counseling experience. Use warm hand-offs.
- If not ready to address problem(s) ask permission to monitor, establish trust and continue to explore readiness. Explore logistic impediments.

## Barb's Strategies

- Most important to start MOUD
- Know your psycho social resources in the area
- Introduce yourself/develop a relationship

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# 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

Socías 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 (e.g., unexpected fentanyl exposure).
- Continue/modify treatment (e.g., 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.

# Overcoming Polysubstance Barriers

## Dan's Strategies

- Is other use at problematic, functional level?
- Express concern and inform regarding potential risks.
- Ask permission to monitor and re-assess readiness.
- Do not discharge with return to use, or continuation of other substance use.

## Barb's Strategies

- Treat what you can- MOUD
- Slow taper of other substances, i.e. benzos
- Psycho social support

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# Overcoming Barriers

*Drug Testing*

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# Overcoming Barriers

## *Drug Toxicology Testing*

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

# *Overcoming Drug Toxicology Barriers*

## Dan's Strategies

**Point of Care vs Definitive LC/GC/MS**

- Emphasis is on therapeutic benefit not punitive
- Assessment initially and for change in function, random, role in contingency management.
- No solid evidence that UDTs change outcomes
- Key question: *Will positive test change treatment plan*?
- Understand limitations of POCT. What does panel detect? What are the thresholds? Too high and false positives and negatives?
- Definitive high cost but accurate and can measure unique substances, maybe do fewer test but higher quality
- Don't provide CJ testing, violates provider patient relationship.

## Barb's Strategies

- Used to monitor patient's progress
- Not punitive

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# Overcoming Barriers

*Drug Enforcement Administration (DEA) Concerns*

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# 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.

# DEA Concerns

## Dan's Strategies

- Myths and the reality that audits are infrequent.
- Are your active patients within your limit—30, 100, 275?
- Log
- PDR
- Quality documentation, function is key.

## Barb's Strategies

- Exempt physicians from waiver requirement
- Contributes to prejudice and bias by labeling addiction treatment as outside of mainstream medicine

# 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.
- Encourage/invite person using diverted medication to access treatment.

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# *Overcoming Misuse/Diversion Barriers*

## Dan's Strategies

- Misuse? Is it a dosing issue? Explore other options, like, depot formulation, methadone.
- Reassess for other substance use and missed or un-addressed behavioral health problems.
- Diversion? Compassionate and cultural factors. Poverty. Welcome those using diverted medication in for assessment.
- Harm reduction.
- Medication control.
- Increased frequency of visits, decreased prescription interval, OTP referral. Peer support involvement.

## Barb's Strategies

- Initial contract "lost meds will not be replaced"
- Does she need a higher maintenance dose?
- More frequent visits
- Consider higher level of care
- Increase psycho social support

# Overcoming Barriers

*Stigma*

# Avoiding Stigmatizing Language

| *The language we choose shapes the way we treat our patients…* | |
|---|---|
| **Instead of:** | **You can say….** |
| addict, junkie, substance abuser | Person with a substance use disorder |
| Addicted baby | Baby experiencing substance withdrawal |
| Alcoholic | Person with alcohol use disorder |
| Dirty vs clean urine | Positive or negative, detected or not detected |
| Binge | Heavy drinking episode |
| Detoxification | Withdrawal management, withdrawal |
| Relapse | Use, return to use, recurrence of symptoms or disorder |
| substance abuse | Use (or specify low-risk or unhealthy substance use) |
| Substitution, replacement, Medication assisted treatment | Opioid agonist treatment, medication treatment |

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# Stigma

- Stigmatizing language can create barriers affecting many aspects of life for the person struggling with a SUD—such as health care, employment, and insurance coverage.
- Efforts must be made to normalize destigmatized language not only when referring to substance use, but to people struggling with the disease.
- Stigmatized people do not seek help, they do not access care, and this reduces the quality of care provided.

Snodgrass S: The Power of Words: Changing the Language of Addiction, 2020.

# Overcoming Barriers

*Stigma*

- Self-stigma occurs when individuals internalize and accept negative stereotypes. Then the “whole person is “broken” with little or no self-esteem.
- Stigma keeps people in the shadows.
- Stigma keeps people from coming forward and asking for help.
- Stigma keeps families from admitting there is a problem.

Stigma, Goffman, Erving 1963; Shatterproof.org , Stigma Summit, University of Texas at Austin, Shatterproof, National Academy of Medicine, June 2021.

# Overcoming Barriers

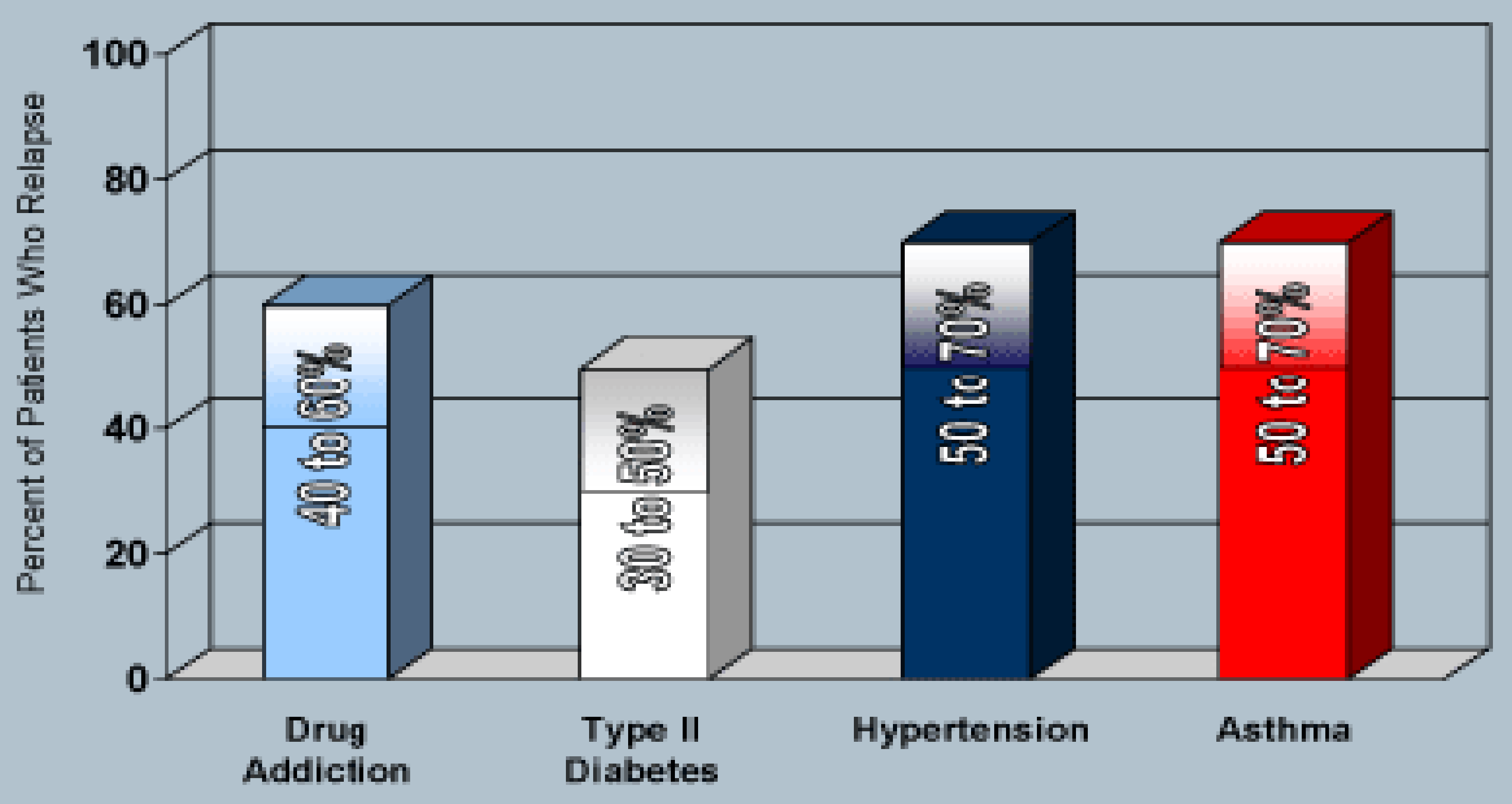
*Eliminating Stigma in OUD Treatment*

Best practices to eliminate stigma:

1. Use gender/sexuality-inclusive language.
2. Be mindful of gender use in language, specifically during anecdotes and question responses. Avoid assumptions.
3. Use "they," "one," and "who" as opposed to "he" or "she."
4. Avoid jokes at the expense of patients and stigmatizing/offensive language.

Stigma, Goffman, Erving 1963; Shatterproof.org , Stigma Summit, University of Texas at Austin, Shatterproof, National Academy of Medicine, June 2021.

# Relapse Rates Are Similar for Addiction and Other Chronic Illnesses



# Stigma

## Barb's Strategies

- Chronic medical disease with same rates of relapse as T2 Diabetes, HTN, Asthma. Need provider, nursing, and staff education on OUD.
- Systems failure, not patient failure
  - Patient admitted to the hospital with a heart attack…
  - Told it's her fault because of her diet, high stress job, and history of tobacco use
  - Advised to call a list of cardiologists/cath labs
  - Told she can't get aspirin or cholesterol lowering drugs unless she sees a nutritionist first
  - Sent home with a stern reminder to not have another heart attack
  - Engage Moms in the care of their newborn as they are part of the solution, "Eat, sleep, console."

## Dan's Strategies

- 3 levels:
  - systemic, institutional, and structural
  - Interpersonal and personally mediated
  - Internalized
- ACEP video, Shatterproof.org
- Commitment to motivational enhancement, listening skills, "your life matters" and "if you are judging, you are not listening"
- Harm reduction/outcome directed care is part of continuum of patient centered care
- Successes are usually not heard, encourage and support the telling of recovery stories
- Educate on basic neurobiology, the influence of genetics, SDOH, and ACEs especially with pregnant women
- Promote team-based care with inherent support for each other!

Harvard Medical School Global Academy, 2017. SUD, stigma, bias: why we should care and what we should do, understanding Addiction.
Flanigan, RN, MA, et al, JAMA, Aug 17, 2021.

# 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

THE
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**Moving Beyond the Barriers**
of Treating Opioid Use Disorder

Break
10 min

# Overcoming Patient Barriers

- 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, e.g. stigma
- Complicated Patients
  - Psychiatric Comorbidities
  - Pregnancy
  - Managing Pain

# Overcoming Barriers

## *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.

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# *Lack of Access to Care*

## Dan's Strategies

- Shortage of providers, wait lists. Minority of residential treatment programs provide MOUD.
- Lack of funding resource.
- Logistics such as transportation, childcare, limited flexibility of employment and provider availability.
- Fear of practice becoming overwhelmed with OUD patients.
- Telehealth? Will decreased restrictions follow the end of the Covid pandemic?
- No OTP within a reasonable distance.
- Limited education of providers.

## Barb's Strategies

- Telemedicine
- Social service support: transportation, child care

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# Overcoming Patient Challenges

*Lack of Belief in Agonist Treatment*

There is clear evidence that agonist treatment works.

# Buprenorphine Outcomes

- Less craving
- Greater retention in treatment
- Greater percentage of drug free urines
- Decreased mortality
- Improved psychosocial outcomes
- Improved occupational stability

Fudala et al. Office-based Treatment of Opiate Addiction with a Sublingual-Tablet Formulation of Buprenorphine and Naloxone. NEJM. 2003;349(10):949-958.
Kakko et al. 1-year Retention and Social Function in Buprenorphine-assisted Relapse Prevention Treatment for Heroin Dependence in Sweden: a Randomised, Placebo-controlled Trial. Lancet. 2003;361(9358):662-668.
Mattick et al. Buprenorphine Maintenance versus Placebo or Methadone Maintenance for Opioid Dependence (Review). Cochrane Database of Systematic Reviews. 2014;Issue 2. Art. No.:CD00207.
Ma et al. Effects of Medication-Assisted Treatment on Mortality among Opioid Users: A Systematic Review and Meta-analysis. Mol Psych. 2019;24:1868-1883.

# Methadone Outcomes

- Decreased mortality
- Improved fetal outcomes
- Decreased in HIV sero-conversion rate
- Decrease in hepatitis sero-conversion rates
- 79% reduction in crime
- Increased retention in treatment
- Improved psychosocial adjustment

Joseph et al. Methadone Maintenance Treatment: A Review of Historical and Clinical Issues. Mt Sinai J Med. 2000;67:347-364.

# Lack of Belief in Agonist Treatment

## Dan's Strategies

- Larochelle, Marc, et al, Annals, 2018.
- Poor outcomes of non-MOUD TAU.
- Natural history of OUD.
- Adverse influence in support groups of the minority that have succeeded without MOUD—"not real recovery".
- Hazelden experience.

## Barb's Strategies

- Review research studies with patient
- Evidence for decrease in fatal overdoses by 50%
- Stabilizes the brain
- Highs and lows of illicit drug use most damaging

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# Overcoming Patient Challenges

## *Prejudices and Bias in Healthcare Systems*

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# 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.

# Addiction Terminology Do's and Don'ts

*Grayken Center for Addiction*
*Boston Medical Center*

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

# *Prejudice and Biases in Healthcare System*

## Dan's Strategies

- Long term strategies needed with community education re: OUD as a chronic disease. This could include simplified neurobiology, and an understanding of the SDOH and influences of ACE scores on substance use as well as other chronic diseases.
- Talk about the effect of trauma within our systems whether that be health care, criminal justice settings, and in behavioral health.
- Use champions to educate with patients and their families, providers, and peer support specialists.
- Treatment works with decreased medical utilization, decreased deaths with decreased loss of productivity, decreased crime, and improved SDOH.

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# Prejudice and Biases in Healthcare System

## Dan's Strategies

- Address deficiencies in our medical education.
- Treat not punish. Expand safe harbor legislation.
- Require documentation of training in pain management and OUD treatment linked to renewal of DEA registration.
- Use recovering persons to diminish the inherent fear of SUDs and enhance compassion
- Harm reduction is a part of the continuum of care not something separate. We all benefit.
- Tirelessly address stigmatizing language and judgmental attitudes.

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# *Prejudice and Biases in Healthcare System*

## Barb's Strategies

- Words matter
- Be kind
- Meet people where they are
- Education of staff
- SUD is a chronic and relapsing brain disease like any other medical condition

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# 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, or delay treatment.
  - Use referrals when necessary.

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

# *Psychiatric Comorbidity*

## Dan's Strategies

- Do symptoms of behavioral health issues antedate SUD/OUD or occur within windows of abstinence?
- Or are these symptoms prevalent during use?
- Does acuity or safety require immediate attention?
- Can one safely monitor with initiation of MOUD?
- Buprenorphine is antagonist at kappa receptor and may dramatically improve mood and decrease anxiety.

## Barb's Strategies

- Treat SUD
- Screen for depression EPDS
- Utilize mood disorder questionnaire to rule out bipolar
- OB physicians in general comfortable initiating SSRIs for depression
- Know your resources for referral

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# 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.

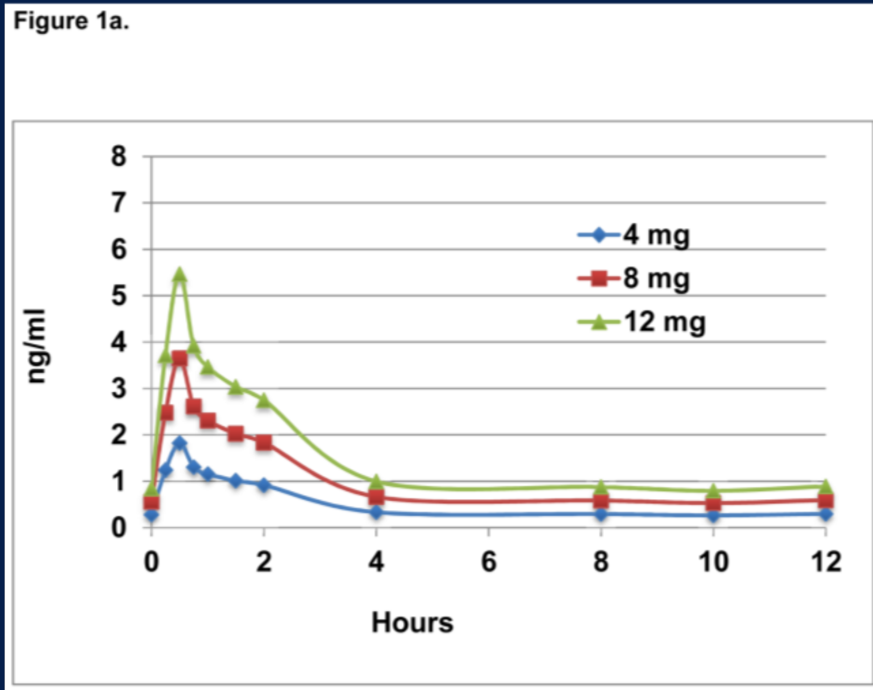
Terplan M, et al. Obstetrics & Gynecology. 2018.

*Pregnancy*

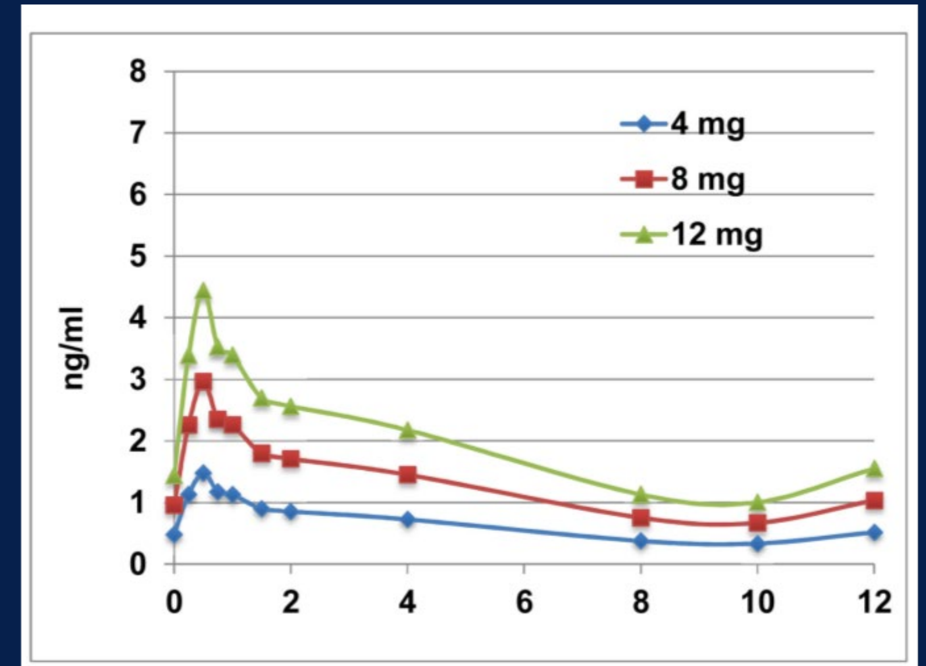
# Dan’s Strategies

- Stigma from patient, family, significant others, healthcare system and family service
- Safe harbor laws help.
- Lack of understanding of the detrimental effects of fluctuating opioid levels on fetus, labor, and to mother.
- Lack of understanding of NOWS/NWS and its treatment.
- Babies are born passively dependent not “addicted”. Media doesn’t help!

# Pregnant Women Need Split Dosing




Concentration per dose 2nd trimester




Concentration per dose 3rd trimester

Caritis et al 2017

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# Opioids, Obstetrics, and Opportunities

- Screen for OUD with a validated screening tool
- MOUD- Buprenorphine, Methadone, Naltrexone
- Screen for comorbidities (mental health, infectious diseases)
- Serial growth scans
- Consult with neonatology for NAS counseling, ESC
- Intrapartum- continue MOUD
- Prioritize regional anesthesia
- Consider alternative therapies (NSAIDS, acetaminophen), multimodal
- Avoid mixed antagonists (butorphanol, nalbuphine, pentazocine)
- Encourage breastfeeding, contraception- LARC
- Opioids are prescribed in excess post cesarean delivery ; set expectations, check PMP
- 4th trimester; continue MOUD, warm hand off

*Reddy UM, Davis JM, Ren Z, Greene MF; Opioid Use in Pregnancy, Neonatal Abstinence Syndrome, and Childhood Outcomes: Executive Summary of a joint workshop. Obstet Gynecol. 2017;130(2):e81-e94.*

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# 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.

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# Managing Pain

## Dan's Strategies

- Communication challenges working with emergency physicians, OBs, surgeons and anesthesiologists in providing  rational pain management
- Educate with up-to-date clinical evidence
- Med/surg/ob staff training; challenging stigma
- Warm-handoffs key and also benefit from hospitalists being waived and understanding the continuum of care.

## Barb's Strategies

- Keep buprenorphine dose stable through peri-partum period
- We've had good luck with scheduled NSAIDs, APAP, and TAP blocks for C-section
- Full agonist opioids (usually oxycodone) as needed

# Poll

*Barriers to Treating Kennedy*

## *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?

## *Time Allocated:*

5 minutes

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# Activity

*Strategies to Treating Kennedy*

## *Case Exercise: Kennedy*

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

## *Prompting Question*

What do you find to be the most effective way to deal with a patient like Kennedy?

### *Time Allocated:*

10 minutes

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# End of Module 2

*Overcoming Barriers*