Office-Based Management of Opioid USE Disorder (OUD): Evaluation of New Patients for Opioid Agonist Treatment (OAT)

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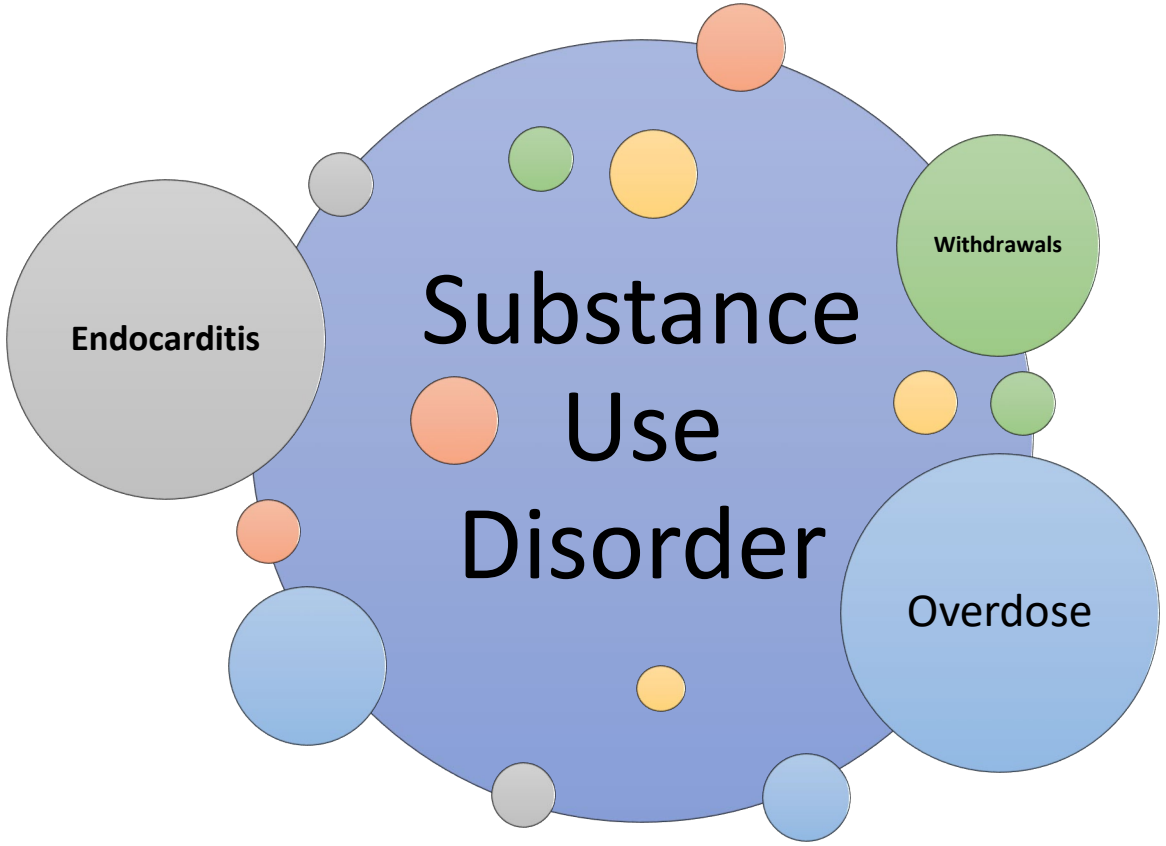
Learning Objectives

1. Discuss selection of patients for MOUD using buprenorphine
2. What are the essentials of starting someone on buprenorphine
3. Elements of Consent
4. Induction process
5. Management of precipitated withdrawal
6. Transferring patients from methadone to buprenorphine

Goals of MOUD

- Keep patient alive and healthy
- Reduce/Eliminate Withdrawals
- Blunting the effects of illicit opioids
- Reducing or eliminating cravings
- Keep patients engaged in treatment

- Treating Withdrawals/Overdose is not the same as treating the Primary Disorder; which in this case is one or more Substance Use disorders!!


Substance Use Disorder
Endocarditis
Withdrawals
Overdose

Patient Characteristics

1. Must meet criteria (Diagnostic and Statistical Manual, DSM-V) for opioid use Disorder (OUD)
2. Able to adhere to clinic visits and willing to comply with expectations of prescriber's practice.

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Clinical Interview

- HPI: Narrative of intertwined development of addiction and Mental illness
- ROS (Pertaining):pain, insomnia, current medication, Side Effects
- Past Psychiatric HX: mood/psychosis/trauma/hospitalizations, SI/A, meds, competency of past care
- Past SUD Hx: Drug by Drug timeline (STIMs (AMP/COC), ETOH, MJ, OP, BZDs, boutiques). Sources, amounts, economy

- Past Treatment experience
- Social History: legal, education, relationships, personal and family economy, social network supporting addiction
- Medical Hx: (injuries/organ damage due to Addiction?)
- Addiction Psychiatry Mental Status Exam: Craving/ preference/triggers/stage of change

Evaluation of OUD- severity

Impaired Control

Social Problems

Physical Dependence

Risky Use

Complications of Substance Use Disorder that may need to be addressed

Accidental	Infection	Pharmacologic	Neuropsychiatric
• Falls • Assaults • Accidents • Neglect • Abuse	• Hepatitis C • Hepatitis B • Endocarditis • HIV • Cellulitis • Osteomyelitis	• Constipation • Respiratory depression	• Depression • Anxiety • PTSD • Psychosis

State Prescription Monitoring Program (PDMP)- INSPECT

- PDMP is a state-specific database which collects data on controlled substances dispensed in the state
- Check prior to induction for evidence of prior treatment or ongoing benzodiazepine prescriptions
- Limitations: May not connect to other states, does not include methadone maintenance or inpatient treatment.
- Check your state guidelines about legislative requirements for PDMP checks

Clinical Opiate Withdrawal Scale (COWS)

Resting Pulse Rate: _____beats/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 rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 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	**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
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	**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/minute
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	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates 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	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
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	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Urine Drug Test

- To Improve Patient Care and Safety
  - Facilitate doctor-patient communication
  - Provide objective information
  - Confirm use of prescribed medication: Adherence testing
  - Confirm lack of use of non-prescribed medications or illicit drugs
- Part of treatment agreement discussion)

– “This is our routine practice for patient safety and treatment.”

MOUD

- Medications should be considered for all patients with OUD.
- Patients with OUD should be informed of the risks and benefits of medications to treat OUD, treatment without medication, and no treatment.
- Patients should be advised on where and how to get treatment with OUD medication
- Discuss safe storage of medications with patients

WHICH MOUD ?

	METHADONE	BUPRENORPHINE	NALTREXONE
EFFICACY	Most proven	Close if not equal to methadone	Less but mostly due to dropouts during induction
SIDE EFFECTS	Prolonged QT Constipation Low testosterone	Less cardiac Constipation Low testosterone Nausea, edema, HA, local	Nausea LFTs
RISK OF OVERDOSE	+++ if dose is too high or patient mixes with sedatives	Very low, possible when mixed with sedatives	None
PAIN CONTROL	Yes	Yes	No

	METHADONE	BUPRENORPHINE	NALTREXONE
MEDICATION INTERACTIONS	Yes (anticonvulsants, HIV meds, antidepressants…)	Yes (less severe)	Opioids
REGULATION	VERY High	Moderate	Minimal
CONVENIENCE	Very structured	Much less	Least restrictive
COSTS	Covered	Covered	Covered
WORK / MILITARY STATUS	Prohibited in certain job situations (CDL)	Less restrictive but often prohibited in CLD	None
DIVERSION RISK	Very low for 1st three months but higher after take homes are granted	Intially > methadone but less dangerous when diverted	None
EASIEST TO WEAN FROM	Difficult	Less difficult but still difficult	Minimal

Buprenorphine vs Methadone vs XR-Naltrexone vs Abstinence

- Prior experience of patient (or friends) with MAT often drives the decision
- Prior use of diverted buprenorphine does not preclude OUD treatment with buprenorphine
- Opioid agonist therapy should not be denied to patients solely because they take benzodiazepines or other drugs
- Prior failure should not preclude another attempt

Patient Materials to Consider

- Informed consent / patient agreement
- Overdose education information
- Handout about induction
- Handout on how to take the medication
- Wallet card
- Information about local recovery resources, including AA/NA meetings

Treatment Agreements Elements

- *goals of treatment*
- *consent to drug monitoring testing*
- *prescriber's prescribing policies including*
  - *a) a requirement that the patient take the medication as prescribed*
  - *b) prohibition of sharing or selling the medication*
  - *c) requirement patient inform about other controlled substances, other medications, alcohol consumed*
- *permission for random pill counts*
- *reasons why the OBT treatment may be changed or discontinued*

Treatment Agreements Elements

- *risk/benefit and discussion of other treatment options*
- *safe storage provision*
- *keep appointments*
- *single provider*
- *no early refills*
- *expectations for behavior in the clinic*
- *random urine drug testing*
- *pill counts*
- *intoxication*
- *risk of death from concurrent alcohol/benzo*
- *agree to addressing all recovery needs*

Screening Checklist Example

- ❑ Labs
- ❑ Urine Drug Screen
- ❑ Urine pregnancy test
- ❑ PDMP check
- ❑ Pt signed informed consent
- ❑ BH treatment plan
- ❑ Naloxone Rescue Kit

Goals of Induction

- Reduce withdrawal and cravings
- Eliminate opioid use
- Establish care structure to patient
- Develop therapeutic alliance
- Maximize retention
- Link the patient to full recovery treatment as needed

Office Based Induction

- educate the patient on proper way to take the medication
- visual verification of opioid withdrawal
- ensure the lack of over sedation
- enhance therapeutic relationship
- advise pt to abstain from tobacco before dosing (vasoconstriction)
- no need to use buprenorphine without naloxone as induction medication
- pt returns next day for dose titration
- can patient drive after induction?

Office Based Induction

- Educate about precipitated withdrawal; timing varies
  - Advise to abstain for roughly: 6-8 hrs for short-acting opioids, 24 hrs for long-acting opioids, and 48-72 hrs for methadone
- Patient should be in mild to moderate withdrawal
- Initial dose can be 2-4mg with repeat of 4mg first day, max 8-12mg on day 1
- Wait 2 hours before repeating dose
- Goal of induction is to reach stable dose that reduces or eliminated cravings and withdrawal
- Office-based vs home inductions are likely equivalent *

* Sohler NL J Subst Abuse Treat. 2010 Mar

Concept of precipitated withdrawal

- Partial or full agonist displaces full agonist if present, stronger affinity for mu receptor, difficult to displace- it is not the naloxone

- Best avoided by good education and trust

- COWs of 8-12 (mild/moderate) is usually enough to avoid precipitated withdrawal

- Do not need to be severe withdrawal
- Do not have to have a negative urine drug screen

Home Based Induction

- Experienced clinicians (and patients) probably better suited for unobserved approach
- Patient needs to understand withdrawal and when to take first dose (written instructions- teach back)
- Still requires initial face to face contact for evaluation and diagnosis
- Phone contact next day or two
- Titrations instructions
- Follow up visit within 2-7 days
- How much for the first prescription?
- Do not try with methadone conversions

A Guide for Patients Beginning Buprenorphine Treatment at Home

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

It should be at least . . .

- **12 hours** since you used heroin/fentanyl
- **12 hours** since 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:
8-12mg of buprenorphine

Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

Step 1.

Take the first dose

4mg

Wait 45 minutes

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

4mg

Wait 6 hours

6 hours

Most people feel better after two doses = 8mg

Step 3.

Still uncomfortable? Take last dose

4mg

Stop

Stop

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

DAY 2:
16mg of buprenorphine

Take one 16mg dose

Most people feel better with a 16mg dose

16mg

Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

Management of Precipitated Withdrawal

2 strategies

- symptomatic withdrawal treatment: clonidine, agents for diarrhea, nausea, anxiety and return later
- provide symptomatic treatment and repeat low doses of buprenorphine (2mg-4mg) 4 hours later

Transferring from Methadone to Buprenorphine

- Reasons patients may want to convert to buprenorphine:

  - believe it is easier to come off buprenorphine
  - side effects of methadone
  - methadone “not holding”
  - want more flexibility in their dosing
  - toxicity: prolonged QT, constipation
  - discharged from a methadone program

Transferring from Methadone to Buprenorphine

- Clarify why patient is transferring
- Methadone is especially long-acting opioid; risk of precipitated withdrawal is higher and dose dependent
- Confirm patient is in withdrawal prior to induction – the timeline will vary amongst patients (24-36 hours typically)
- Ideally patient should be stable around 30-35mg for one week, success has been shown for pts up to 100 mg, higher conversions seek expertise and probably hospitalization
- Use small test dose , ie 2 mg, repeat, but if no PW then escalate dose the 1st day
- Patients need lots of support – ok to go back to methadone if buprenorphine fails
- Microdosing of buprenorphine (Bernese method) , patient continues full agonist with slowly increasing micro doses of buprenorphine?

Stabilization Phase

- Most patients stabilize on 16mg/4 mg dose or lower

- What is the right dose?

Resources

SAMHSA publications TIP 63: Medications for Opioid Use Disorder- Introduction to Medications for Opioid Use Disorder Treatment
https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Introduction-to-Medications-for-Opioid-Use-Disorder-Treatment-Part-1-of-5-/BackInStock/SMA18-5063PT1

COWS for opioid withdrawal:

http://www.mdcalc.com/cows-score-opiate-withdrawal/

- Robohm JS. Training to reduce behavioral health disparities: How do we optimally prepare family medicine residents for practice in rural communities? Int J Psychiatry Med. 2017 Jan 1:912174177302 94. doi: 10.1177/0091217417730294.
- Wakeman SE. Medications For Addiction Treatment: Changing Language to Improve Care. J Addict Med. 2017 Jan/Feb;11(1):1-2. doi: 10.1097/ADM.0000000000000275
- Livingston JD, et al. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction 2011. 107:39-50.