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 MAT 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

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.

WHICH MAT ?

	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

WHICH MAT ?

	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

State Prescription Monitoring Program (PDMP)

- 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

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

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

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

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

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?
- Upcoming presentation:
  - urine drug testing
  - what if the patient continues using other drugs
  - diversion issues
  - reasons to stop or wean buprenorphine

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 1:91217417730294. 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.

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OBOT Patient Agreement

Please review below and initial each line.

- I will keep and be on time to all my scheduled appointments with my doctor and nurse. I understand that a missed appointment may mean I don't get medication until the next scheduled visit.
- I will not sell, share or give any of my medication to another person. I understand that would result in immediate discharge from the program.
- I agree that the medication I receive is my responsibility and that I will keep it in a safe secure place. I agree that lost medication may not be replaced regardless of the reason.
- I agree to take my medication as prescribed, and notify my doctor or nurse if I am having difficulties with the medication.
- I agree not to take medications that are not prescribed to me.
- I agree that if I obtain medication from any doctors, pharmacies, or other sources or if I have an upcoming procedure, that I will inform my doctor or nurse.
- I will not tamper with urine screens and if I do so, I understand this may result in immediate discharge.
- I understand that mixing buprenorphine with alcohol or other medications, especially benzodiazepines such as Klonopin, Ativan, Valium, Xanax and other drugs can be dangerous.
- I agree to random urine drug screens and to bring in my remaining buprenorphine to each visit with my doctor or nurse when requested.
- I agree not to consume poppy seeds while in this treatment program. Poppy seed consumption will not be accepted as an excuse for a positive opiate screen.
- I understand that my treatment plan may change to random call back visits only and that I need to have a working telephone and updated contacts. When called for random call backs, I need to respond within 24 hours by telephone. Non-response to call backs will be considered the same as a positive urine.
- I understand that if I continue using opioids or other illicit substances, this issue will be addressed through changes in my treatment plan to help me. If I continue to struggle with ongoing drug use this may be grounds for transfer to other more intense treatment options.
- I understand that the DotHouse OBOT Program will not release the results of my urine drug screens to any other agency, program, or institution. The reason for this policy is that DotHouse does not have a chain of custody over the urines, the purpose of these tests are for my treatment at DotHouse only.

- If at any time I am discharged from this program I may be reconsidered at a future time to see if office based treatment may be an option for me.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education, substance abuse counseling and relapse prevention programs, to assist me in my treatment.
- I understand that my records, course of treatment, and medical care will be kept in an electronic medical record under a confidential filing system. These notes will be visible to any healthcare professional involved in my care.

My signature below indicates that I have read and understand this treatment agreement.

Patient: Printed Name	Signature	Date
Witness	Signature	Date

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We keep you well

Consent for Treatment with Buprenorphine

Buprenorphine is a Food and Drug Administration (FDA) approved medication for treatment of opioid use disorder. Only qualified physicians can prescribe this medication. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. We recommend for a minimum of six (6) months, but most patients will benefit from longer.

Buprenorphine treatment can result in physical dependence. Withdrawal from Buprenorphine is generally less intense than with heroin or methadone. If Buprenorphine is suddenly stopped, some patients have no withdrawal symptoms; others may have as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize this risk, Buprenorphine should be discontinued gradually over several weeks or more under medical supervision.

If you are physically dependent on an opioid, you should be in as much withdrawal as possible when you take the first dose of Buprenorphine. If you are intoxicated with opioids, Buprenorphine can cause severe opioid withdrawal.

It may take several days to get used to the transition from the opioid that you had been taking to Buprenorphine. During this time any use of other opioids may cause an increase in symptoms. After becoming stabilized on Buprenorphine, the use of other opioids will have less effect. Attempts to override the Buprenorphine by taking more opioids could result in an opioid overdose.

You should not take any other medications without first discussing with your health care provider.

Combining Buprenorphine with alcohol or other medications may be hazardous. Combining Buprenorphine with medications such as Klonopin, Valium, Haldol, Librium, Ativan, Xanax has resulted in deaths.

The form of Buprenorphine that you will be taking (Suboxone) is a combination of Buprenorphine with a short acting opioid blocker (Naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid, it would cause severe opioid withdrawal.

Buprenorphine tablets or film **must** be held under the tongue until they completely dissolve. Buprenorphine will not be absorbed from the stomach if it is swallowed.

Additional Comments: _____

_____

Patient: Print Name	Patient: Sign name	Date	Time
Physician: Print Name	Physician: Print Name	Date	Time

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