Office-Based Management of Opioid USE Disorder (OUD):

Christopher Suelzer, MD.

Primary Care Physician

Learning Objectives

1. Which MAT for which patient?
2. What Office based practice might look like
3. Induction process and options

WHAT DO WE MEAN BY MAT (Medication –Assisted Treatment)

- Use of medications in the treatment of opioid use disorders
- Medication directly treats cravings, withdrawal, blocking use
  -promote long term recovery
- Methadone / Naltrexone / Buprenorphine
- Strong evidence based medicine to support their use
- Standard of care , superior to abstinence based models
- Like all treatments, must be tailored to the patient's needs

MAT OPTIONS

- METHADONE
  - pure opioid agonist (replacement, full mu agonist)
  - reduces or eliminates cravings
  - blocks other opioids (dose dependent)
- BUPRENORPHINE
  - partial agonist (replacement without all the mu properties)
  - reduces or eliminates cravings
  - blocks other opioids (dose dependent)
- NALTREXONE
  - full antagonist (blocks)
  - reduces cravings +/-

MAT SETTINGS AND REQUIREMENTS

- METHADONE
  - first MAT developed in 60s
  - restricted to DEA approved Opioid Treatment Programs
  - physician must be registered with the DEA
  - long list of federal and state requirements
  - highly structured

MAT SETTINGS AND REQUIREMENTS

- NALTREXONE
  - developed in 70s
  - approved for heroin addiction as oral version in 1984
  - injectable formulation approved for alcohol use disorder 2006
  - injectable formulation approved for opioid use disorder 2010
  - Office based,
  - No restrictions or special requirements to prescribe

MAT SETTINGS AND REQUIREMENTS

BUPRENORPHINE/NALOXONE

- approved in 2002 (Drug Abuse Treatment Act 2000)
  OFFICE BASED TREATMENT
  - setting of a substance use disorder clinic
    (concurrent therapy, offer higher level of cares)
  - setting of a medical clinic -Office Based Treatment)
    (may be integrated within the primary practice)

- Minimal federal requirements: waiver requirement removed, special DEA number, patient number limits
- State requirements for OBTs (Public Law 213-2019)

WHICH MAT ?

	METHADONE	BUPRENORPHINE/NALOXONE	IM NALTREXONE
EFFICACY	Most proven, higher retention	Close if not equal to methadone	Less but mostly due to dropouts during induction (25%)
SIDE EFFECTS	Prolonged QT Constipation Low testosterone Respiratory depression Sweating Pituitary suppression	Constipation Low testosterone(less) Nausea, LE edema, HA Insomnia Sweating Blistering in mouth	Nausea Liver function tests Dizziness, drowsiness Injection site tenderness
RISK OF OVERDOSE	+++ if dose is too high or patient mixes with sedatives (6x OD risk)	Very low, possible when mixed with sedatives but low	None
PAIN CONTROL	Yes (caveat)	Yes	No

WHICH MAT ?

	METHADONE	BUPRENORPHINE/NALOXONE	NALTREXONE
MEDICATION INTERACTIONS	Yes (anticonvulsants, HIV meds, antidepressants…)	Few	Opioids
REGULATION	VERY High	Moderate	Minimal
CONVENIENCE	Daily visits for at least 3 months (Covid changes) Limited number of clinics-19	Monthly visits	Monthly visits
COSTS	Medicaid/? Insurance	Medicaid/Insurance	Medicaid/Insurance
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	Initially > methadone but less dangerous when diverted	None

Buprenorphine vs Methadone vs XR-Naltrexone vs Abstinence

- Prior experience of patient (or friends) with MAT often drives the decision
- Many patients will not tolerate the withdrawal period for naltrexone
- 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 but typically something needs to be adjusted

Who shouldn't be placed on MAT for opioid use disorder?

- There is no opioid use disorder (? Chronic pain patients)
- They already are getting MAT from someone else
- If they are clearly intoxicated at time of starting
- They are transitioning somewhere soon where they will not have access to MAT
- Short term "detoxes"
- If their employment precludes it and they need to maintain that position (nurses, CDL License)
- Known allergy or adverse reaction

OFFICE BASED PRACTICE

WHY WOULD I WANT TO TAKE ON TREATING PATIENTS WITH OPIOID USE DISORDER ??

- There are experts out there to do this (not enough)
- Don’t have the time (once stabilized about 30 min./month)
- I don’t have the expertise (it is easily learned)
- The patients are manipulative (its not personal, good people)
- It does not pay (reimbursable)
- The DEA will be monitoring me (DEA audits infrequent)
- Its not treatable anyway (It is one of the most gratifying treatments we can offer)

OBT STATE REQUIREMENTS

- INSPECT on induction and 4 times/yr
- Initial assessment including mental health assessment
- Treatment agreement
- Some level of counseling
- Regular follow up visits with documentation of progress
- Drug testing as part of their follow up and documentation of plan when positive or no buprenorphine in urine
- Provide naloxone rescue prescription

FIRST PATIENT VISIT

- Initial drug use history
- Mental health history
- Medical history
- Drug Screen (buprenorphine/methadone)
- Labs (HIV, liver functions, communicable diseases)
- Review INSPECT
- Informed consent (documented)

HISTORY

- Age on onset
- Drug use patterns
- Overdose assessment (history of overdoses)
- Social history (family issues, drivers license, legal)
- History of abuse/neglect
- Negative consequences of use (motivational interviewing)
- Prior treatments
- Longest sobriety and what led to that
- Patient goals

Should buprenorphine be started on the first visit?

- Must weigh the risk of overdose vs the need to engage more fully in their treatment
- Develop a sense of commitment to recovery by the patient
- Don’t give one months supply the first visit (close fu the first week)

Medical Management Alone vs Therapy linked

- 4 studies that suggest no additional benefit of behavioral intervention with buprenorphine but…

- Regular medical management that included weekly appointments for early phase
- Regular urine monitoring
- Physician counseling on addiction that stressed importance of abstinence, outside meetings.

THERAPY

Minimal

Intense

- prescription
- stable in most domains
- high level of motivation
- engaged in outside groups

- multi drug
- unstable
- lacks insight

Office Based Induction

- educate the patient on proper way to take the medication
- visual verification of opioid withdrawal (COWS)
- 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

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)
- Phone contact next day or two
- Titration instructions
- Follow up visit within 2-7 days
- How much for the first prescription?
- Do not try with methadone conversions

Precipitated opioid withdrawal

1- Administration of naloxone or buprenorphine while pure mu agonist are present

2- It is more severe than typical opioid withdrawal (naltrexone > buprenorphine)

3- Unlike withdrawals from stopping these withdrawals can manifest with
- delirium
- autonomic hyperactivity (severe hypertension)
- require supportive management in ER or hospital

4- If not severe can be managed with clonidine, Imodium,

5- Overriding with pure mu agonists not recommended (risk of rebound respiratory depression)

6- If in doubt consider Naloxone (0.1mg SQ/IV) challenge first to avoid precipitated withdrawal

LINK TO STATE LAW 214

https://services.statescape.com/ssVersions/2479000/2479076/u_20190509.pdf

Download your PDF of **Ind. Code § 12-23-20-2**