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

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Primary Care Physician

Learning Objectives

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

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
    (may be integrated within the primary practice)

- Minimal federal requirements: Waiver training, ability to refer to therapy, patient number limits
- State requirements for OBTs (Senate Enrolled Act 141)

CHANGES IN THE WAIVER REQUIREMENTS

- HHS posted their ***intent*** to remove requirement for waiver training
- Not in effect till posted in the Federal Register
- Proposed guidance
  - limited to 30 patients
  - physicians only
  - within a state
- Currently retracted pending legal reviews

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
- Provide naloxone rescue prescription

OFFICE BASED PRACTICE

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

- There are experts out there to do this
- Don’t have the time
- I don’t have the expertise
- The patients are manipulative
- It does not pay
- The DEA will be monitoring me
- Its not treatable anyway

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

Its not treatable

There is nothing more gratifying in medicine than being part of someone's recovery because it is a transformational event

WHAT MIGHT AN OFFICE BASED PRACTICE LOOK LIKE

- Initial visit would be an assessment (60 minutes)
  - Can be video or face to face or phone (currently)
- Focus on substance use history, mental health history, social history
- Motivational interviewing
- Obtain drug testing (POC or referral to lab)
- Consent process
- Induction and stabilization (maintenance)
- Once monthly for one year then less frequently if stable
- Therapy

Medical Management Alone

- 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

- multi drug
- unstable
- lacks insight

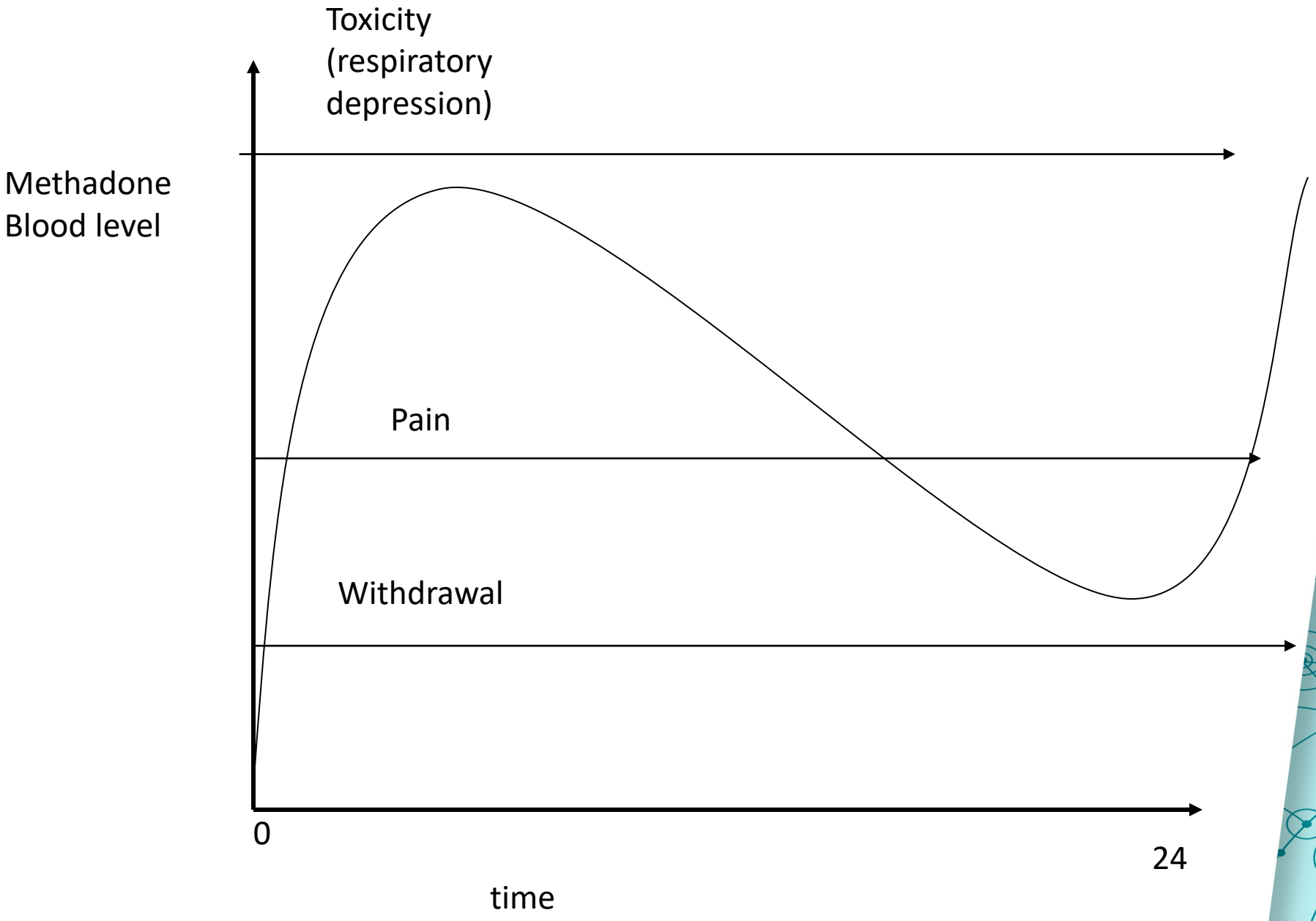
Medical Management Alone

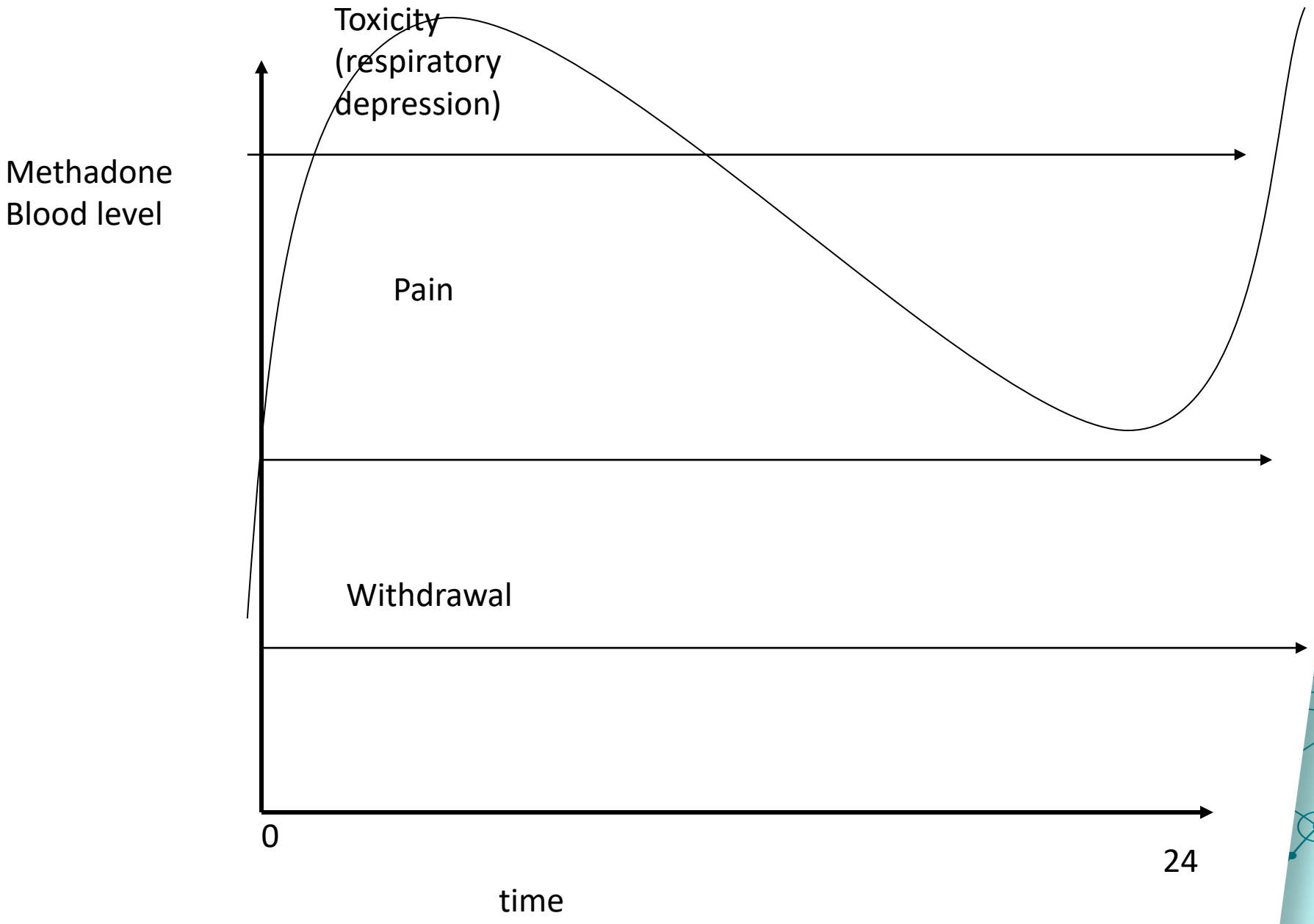
- Better candidates may include:

  - chronic pain patients with moderate use disorder symptoms
  - patients who are stable in most domains of their lives
  - prior history of doing well with minimal therapy
  - no significant psychiatric co-morbidity
  - fully engaged in outside recovery networks

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


Toxicity
(respiratory
depression)
Methadone
Blood level
Pain
Withdrawal
0
24
time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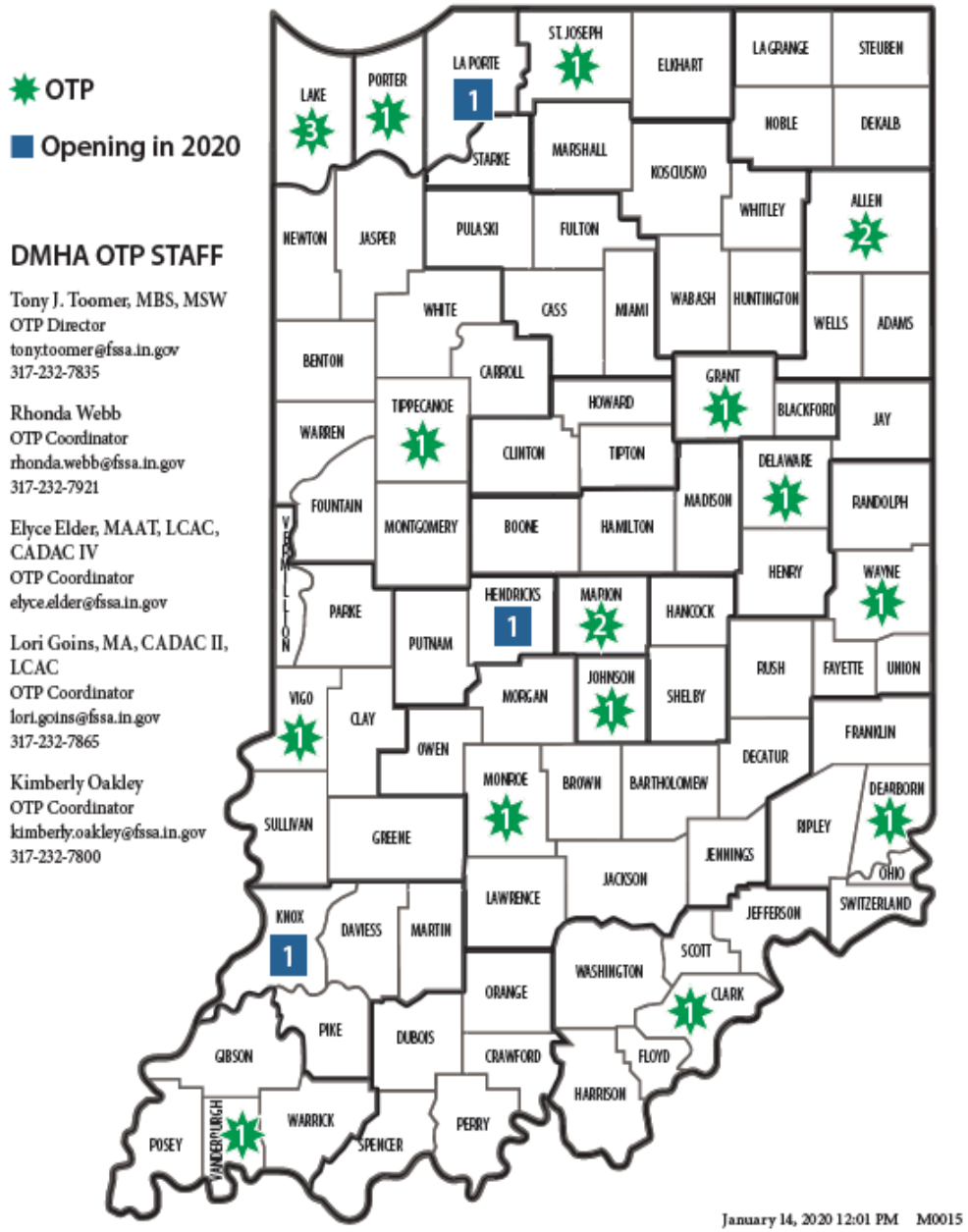
WHICH MAT ?

	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

Indiana Family & Social Services Administration

Division of Mental Health and Addiction

Opioid Treatment Programs



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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 required 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 to somewhere soon where they will not have access to MAT
- If their employment precludes it and they need to maintain that position (nurses, CDL License)
- Known allergy

WHEN SHOULD THE BUPRENORPHINE BE STARTED?

- 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

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

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

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

Precipitated opioid withdrawal

High dose fentanyl increases risk of precipitated withdrawal

Fentanyl is lipid soluble and may results in delayed withdrawal

Increasing reports of using microdosing to successfully transition the patient to buprenorphine without requiring patient to experience withdrawal

LINK TO STATE LAW 214

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