Introduction to Medication Assisted Treatment for Opioid Use Disorder in Primary Care

MICMT
Michigan Institute for Care Management & Transformation

Participation from learners

Video

Welcome!

- Host: Julie Geyer - MICMT Senior Project Manager
- Presenter: Nicole Rockey, PharmD, BCACP – MICMT Clinical Lead

Virtual Reminders

- We love to see your face! But not hear your dog ☺
  - Please try to keep your video ON. This will help with engagement, and mute yourself when “teaching” is going on
- Use Chat or Unmute anytime you have a question or want to speak
  - We will pause periodically to answer questions from chat/QA
- In the smaller breakouts, feel free to go Unmuted
- Try to stay present and avoid multitasking: we will do our best to keep you engaged and hear everyone’s voice

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Agenda

- Introduction
- Terminology used in OUD
- Who is affected
- Understanding addiction
- Approaches to treatment of OUD
- Medications for OUD
- Clinic workflow
- Stigma around OUD
- Talking with patients with OUD
- Summary and questions

What is Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)?

An evidence-based use of medications to help address issues related to opioid dependence, including withdrawal, cravings and relapse prevention. Three medications currently approved by FDA to treat OUD include:

- **Buprenorphine** (Requires DEA Waiver)
- **Methadone** (Specialty OTP clinic only)
- **Naltrexone**

Goal of MAT Initiative

Improve patient care and outcomes for patients with opioid use disorder (OUD) through the establishment of a team-based care support system for waivered primary care physicians in direct patient care across Michigan.

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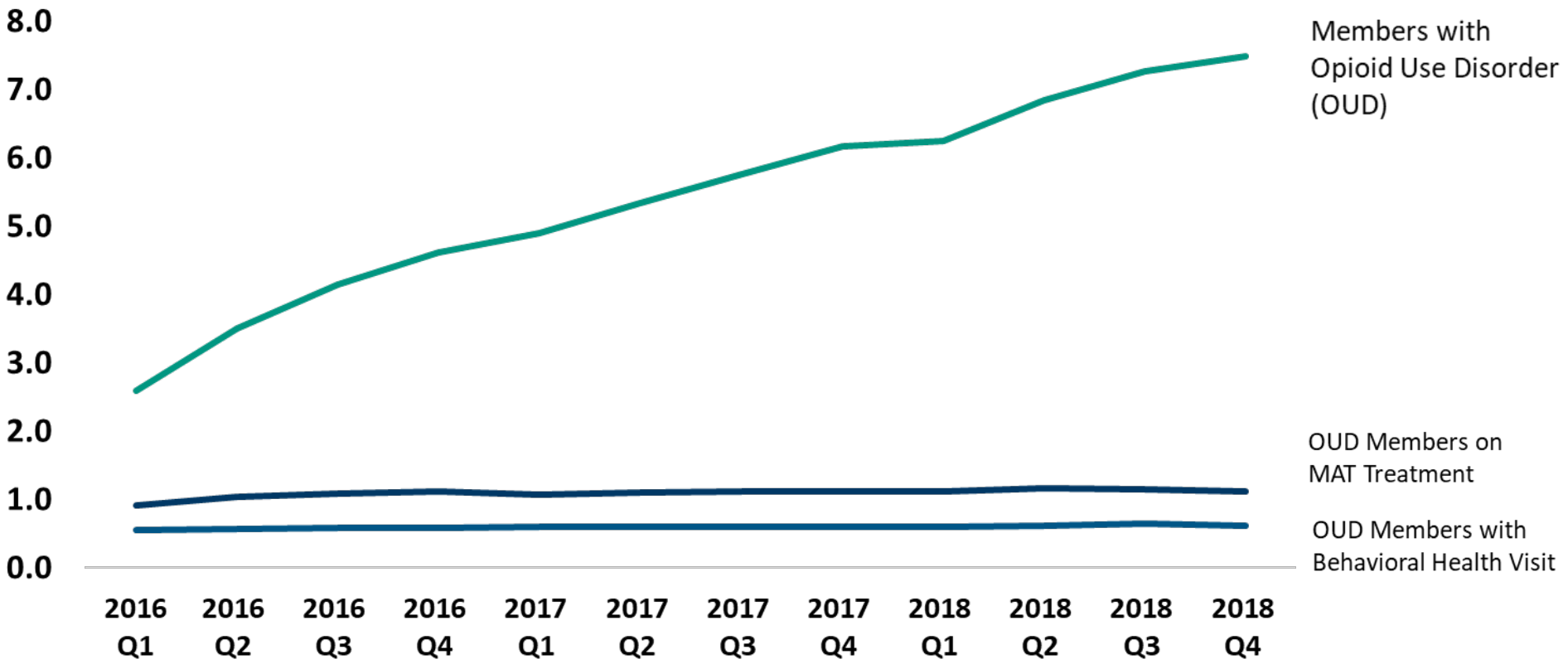
Why Are We Here?

BCBS Members with OUD Diagnoses and Treatment (per 1,000 members)



Objectives

- **Identify** the stigma faced by patients with OUD and how this can affect patient-staff relationships
- **Discuss** how opioids affect the brain.
- **Review** what does and does not work to treat opioid use disorder
- **Explore** effective ways to deliver MAT for OUD.

Monica’s Story

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Abbreviations/Definitions

OUD	Opioid Use Disorder
Diversion	Giving, selling, or trading of prescription drugs
Induction	Transfer from an illicit opioid to a dose of buprenorphine that provides relief from withdrawal and cravings; first step in decreasing/stopping illicit opioid use.
MAT	Medication for Addiction Treatment or Medication Assisted Treatment
MOUD	Medications for Opioid Use Disorder
Physical Dependence	Caused by repeated exposure to a substance leading to the body adjusting its functioning. Will result in a predictable set of withdrawal symptoms if the substance is abruptly withdrawn.
Relapse	Recurrence of symptoms of SUD (single or repeated episodes of substance use after a period of abstinence)
SUD	Substance Use Disorder
Tolerance	Reduced response to a substance due to repeated exposure

Stigmatizing Language	Preferred Language
Addict	Person with a substance use disorder
Addicted to X	Has a X use disorder
Addiction	Substance use disorder
Alcoholic	Person suffering from alcohol addiction
Clean	In recovery
Clean screen	Expected result; substance free
Dirty	Actively using
Dirty screen	Unexpected result; positive for…
Drug habit	Regular substance use
Drug abuser	Person who uses illicit substances
Reformed addict or alcoholic	Person in recovery
Opioid replacement	Medication for Addiction Treatment or Medication for Opioid Use Disorder

“Opiate” or “Opioid”?

Opiate:
Natural opioids (heroin, morphine and codeine), illicit or not

Opioid:
ALL substances that bind to the opioid receptors, including natural, synthetic (e.g. fentanyl, methadone) and semi-synthetic (e.g. oxycodone)

Narcotics:
Any substance that dulls senses/relieves pain. Technically refers only to opioids but often used to describe all illicit drugs (therefore not a preferred term due to confusion)

Opioid analgesics: (“Prescription Opioids”) Opioid medications used to treat moderate-severe pain (e.g. oxycodone, hydrocodone, morphine, fentanyl)

Methadone: Indicated for opioid addiction (in a specially licensed clinic only) OR pain

Buprenorphine: Indicated for opioid addiction (with a DATA2000 Waiver only) OR pain (with certain formulations only)

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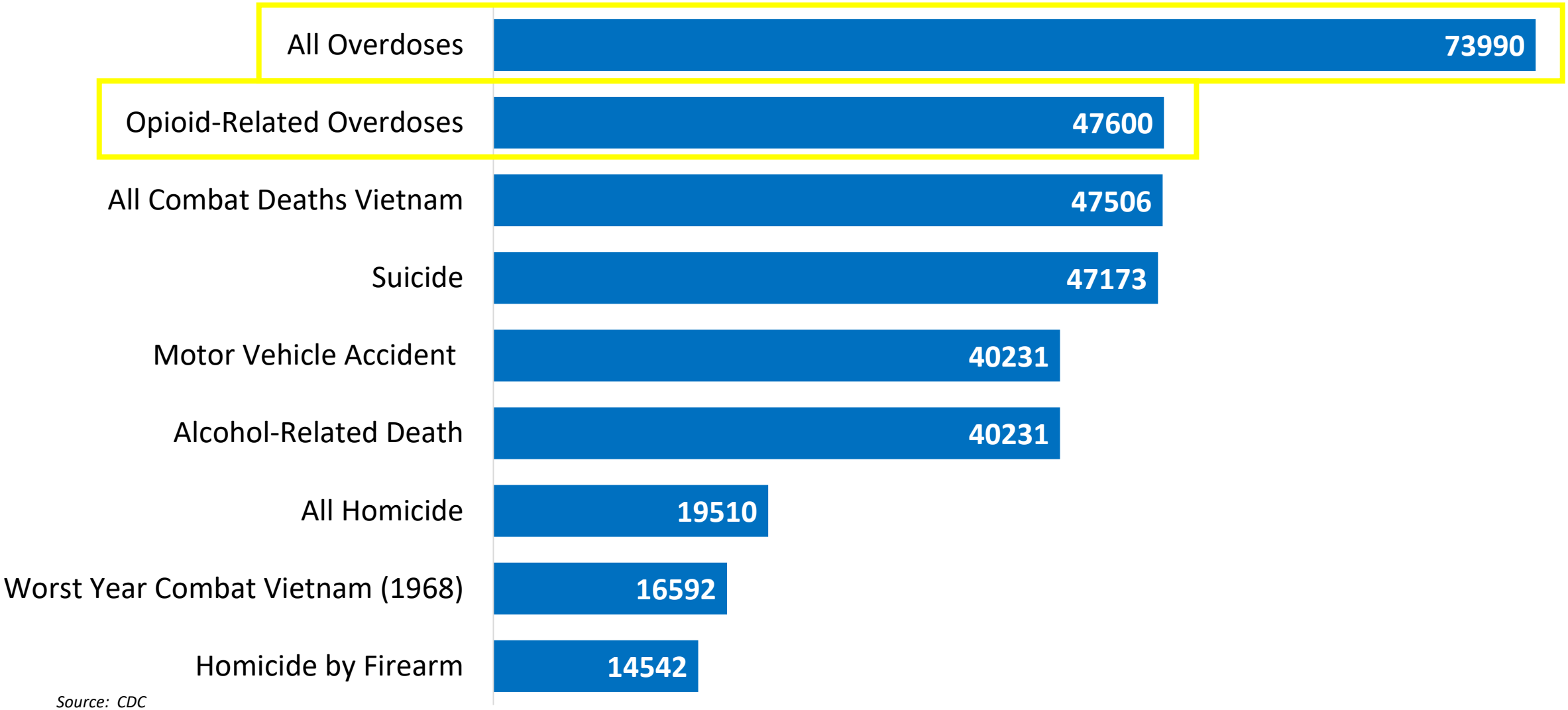
Participant Response

Have you, a family member, or a friend or co-worker been impacted by opioid use disorder?

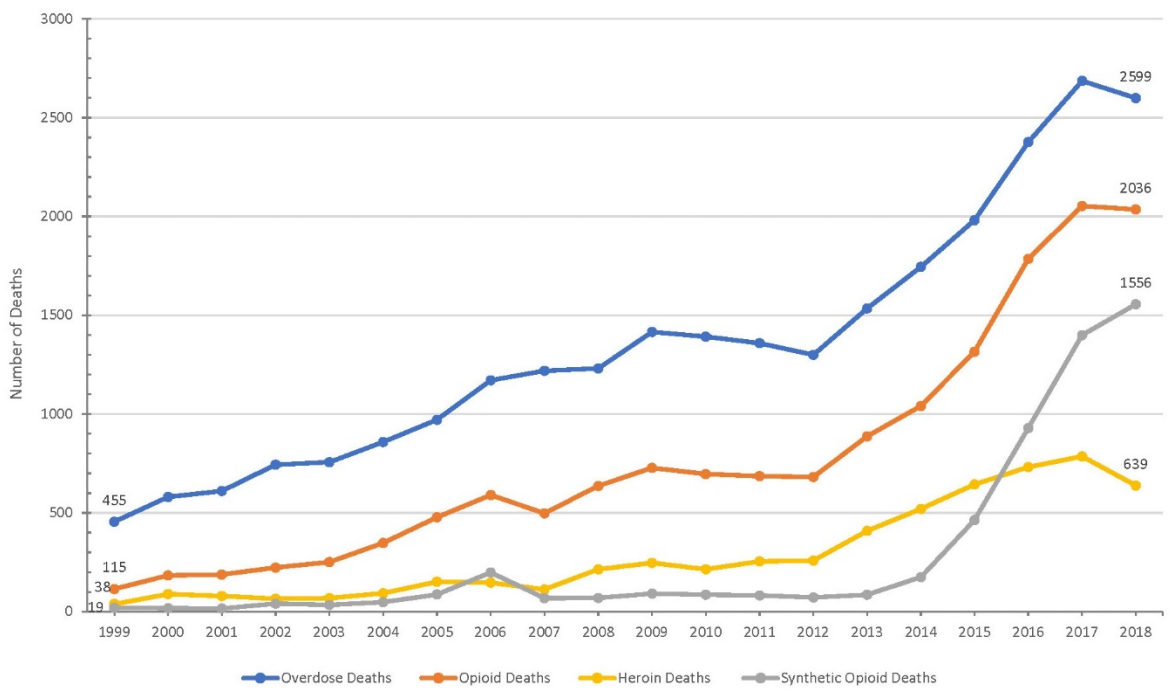
Number of Deaths in 2017 (US)



Source: CDC

Opioid Epidemic In Michigan (2018)

- Opioid Overdose Deaths: 2,036
- Rate increase in Opioid Overdose Death from 1999-2018: 18x
- Prescriptions for Opioids filled in 2018: 8.4 Million



Michigan.Gov (accessed 7/22/2020). https://www.michigan.gov/opioids/0,9238,7-377-88139---,00.html.

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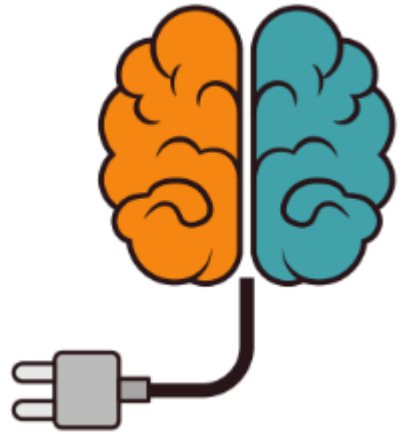


Discuss how opioids affect the brain

What is Addiction?

"Treatable, chronic medical disease involving complex interactions between brain circuits, genetics, the environment and an individual's life experiences." (ASAM)

“Treatable, chronic medical disease involving <u>complex interactions</u> between brain circuits, genetics, the environment and an individual’s life experiences.” (ASAM)

What are these interactions?

Involve disruptions in the circuits of reward, motivation, and memory.

Mesolimbic dopaminergic pathway

Organize behavior and learning around immediately rewarding or threatening situations.

For example, **could I do something quickly to improve my situation?** (obtain food or sex, escape danger, decrease pain)

The system will remember and encourage you to **try for the same effect again in the future**.

These are **not** behaviors that take a lot of pondering. They’re **“snap judgements”.**

If every time you opened Facebook…

Your phone periodically electrocuted you

Every article made you cry

Your spouse got mad at you

You got in trouble at work

You would (hopefully!) **STOP** using Facebook

Why doesn't this feedback system work with addiction?

Opioids significantly interfere with normal processing and feedback system, and cause the brain to…

Overestimate how good using will feel

"Over detect" situations where it would make sense to seek out drugs

Brain is flooded with signals to seek out drugs (whole world becomes a trigger)

No bandwidth to process negative consequences, especially long-term ones

All accelerator, no brakes!

Meanwhile…

Prolonged Use

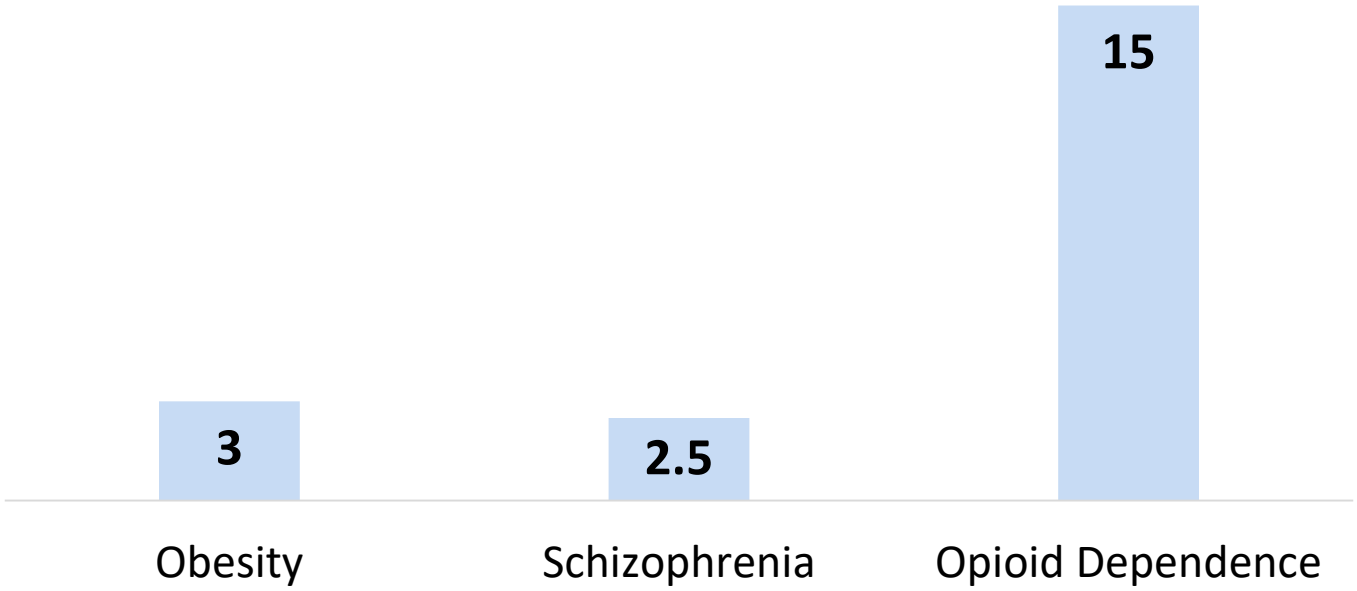
Increasingly painful tolerance/withdrawal

Any use produces abrupt relief of discomfort

Using becomes even more reinforcing (stopping pain is more powerful than creating pleasure)

Opioid Dependence Increases Mortality

If you are exposed as a young person, your risk of mortality compared to rest of population:



(Source: Degenhardt et al, 2010. Addiction, 106, 32–51.)

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Objective for this section

Explore effective ways to deliver MAT for OUD.

Medication Treatment (methadone or buprenorphine) is the gold standard treatment for OUD

Decrease use of opioids and OUD-related symptoms

Decrease mortality
(<1/3 of the risk expected in the absence of treatment)

Reduce risk of infectious disease transmission (Hep C, HIV)
(and more cost effective overall)

Reduce criminal behavior

Increase employment

Decrease opioid overdoses

Sordo et al. 2017. BMJ 357:j1550. Joseph et al. Mt Sinai J Med. 2000;67:347-364. Oesterle et al. 2019. Mayo Clinic Proceedings. 94.10.

Abstinence Only-Treatment

Data from decades of experience with MAT strongly support the conclusion that it is superior to abstinence-based approaches.

– Cleveland Clinic Journal of Medicine June 2013

- Swedish Randomized Controlled Trial included 40 adults seeking admission for medically assisted heroin withdrawal
- 2 Groups
  - Buprenorphine 16 mg sublingually x 12 months + Cognitive Behavioral Therapy
  - Buprenorphine tapered over 6 days followed by placebo + Cognitive Behavioral Therapy
- All received group therapy and weekly individual counselling sessions

Buprenorphine and Cognitive Behavioral Therapy:

75%

1 Year Retention in Treatment Comparison

Kakko et al. 2003. Lancet 361: 662-668.

Cognitive Behavioral Therapy:

0%

All dropped out by 4 months, 4 dead by 1 year

Tapering ("detoxing") is also usually ineffective

Gandhi et al. Study

123 Young OUD patients given outpatient Buprenorphine taper over 3 days.

- At 6 months, **88%** reported active use and had an opioid+ UDS.

(Gandhi et al. 2003. Addiction, 98, 453–462.)

POAT Study

Treatment of prescription opioid dependent patients with buprenorphine-naloxone for brief vs extended periods.

- Brief Treatment: 2 weeks of treatment, 2 week taper
  - 6.6% were successful 8 weeks later
  - Unsuccessful patients then underwent the extended treatment phase
- Extended Treatment: 12 weeks of treatment, 4 week taper
  - **49.2%** were successful at 12 weeks of treatment
  - **Only 8.6% were still successful 8 weeks after completing the taper**.

(Weiss et al. 2011. Arch Gen Psychiatry. 68(12):1238-1246.)

Overdose risk after abstinence-based treatment or a taper

- Risk of FATAL relapse in the period following a taper or discharge from abstinence-based treatment is higher than if the patient had stayed in active addiction
- Decreased opioid tolerance after period of abstinence
- Patient may resume use of illicit substance at prior doses when they had increased tolerance
- Education and naloxone!

(Binswanger et al. 2007. NEJM; 356:157-165; Ravndal et al. 2010. Drug and Alcohol Dependence 108: 65–69.)

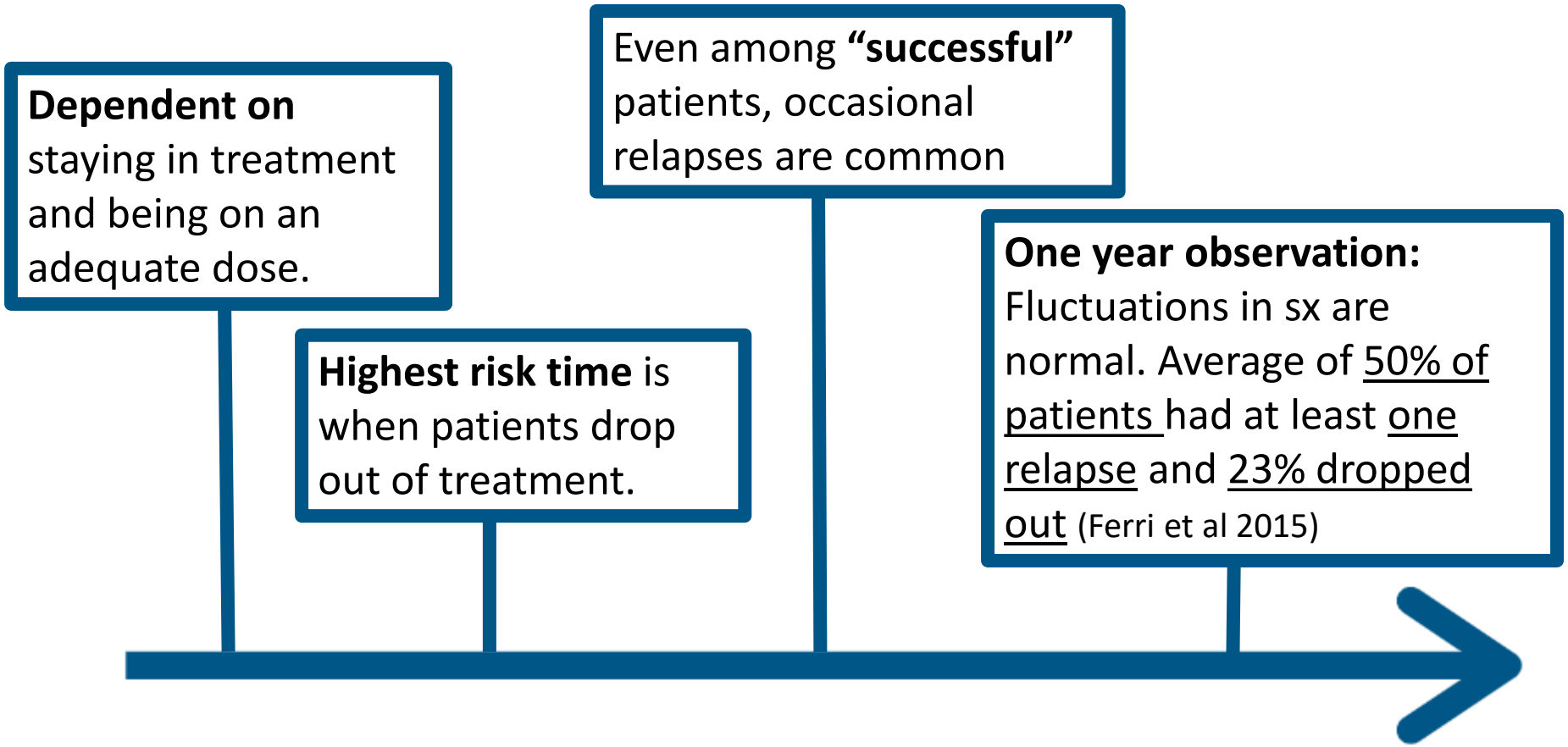
Best Practices for Opioid Treatment Include:

Medication

(First line are Buprenorphine and Methadone)

Long Term/ Indefinite Treatment

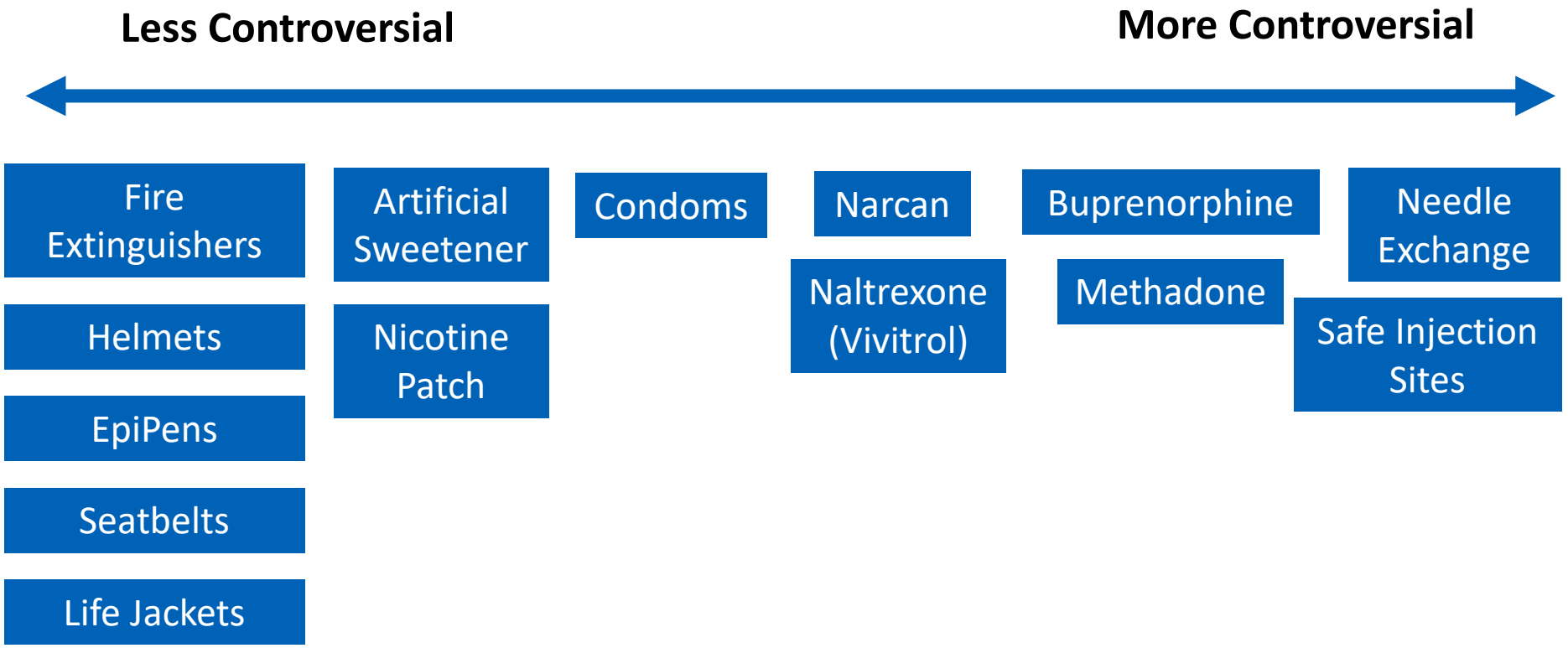
“Success” in Recovery



Characteristics of Harm Reduction Approaches

- **Being** realistic about what is happening.
- **Treating** others the way **they** want to be treated
- **Relying** on facilitation rather than coercion.
- **Meeting** people where they are and reducing barriers to change.
- **Encouraging** positive change. Celebrating small changes.
- **Interacting** in a non-judgmental, affirming and accepting way.
- **Focusing** on improving quality of individual and community life rather than JUST abstinence from illicit substances.

Harm Reduction Approaches



Break

5 minutes

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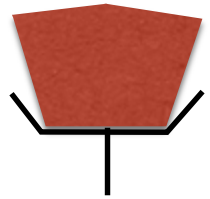
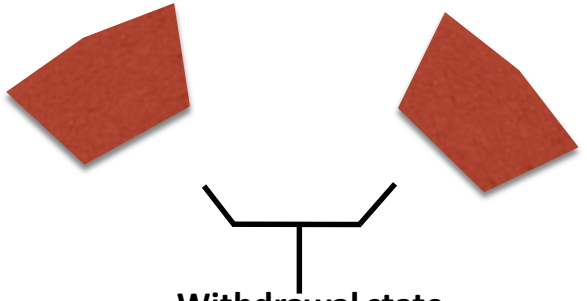
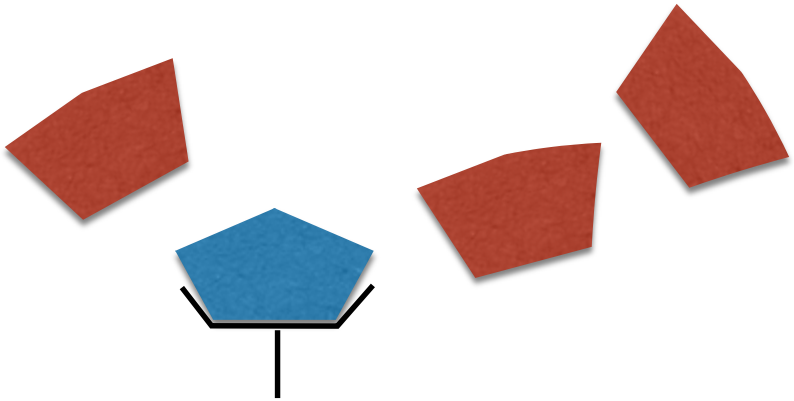
How do medications for opioid use disorder work?



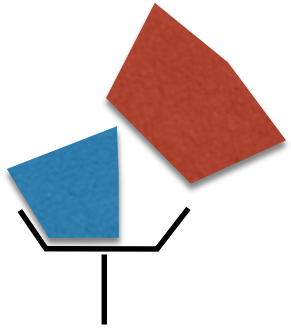
Full agonist (heroin, Oxy, etc.)
Full euphoric & analgesic effects



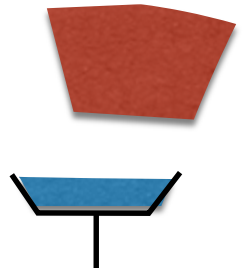
Withdrawal state
Triggers cascade of signals in the brain resulting in symptoms of withdrawal (restlessness, tremor, dilated pupils, chills or sweating, GI distress, etc.)



Full agonist
(methadone)
Analgesic effects, limited euphoric effects, no ceiling



Partial agonist
(buprenorphine)
Analgesic effects, limited euphoric effects, ceiling

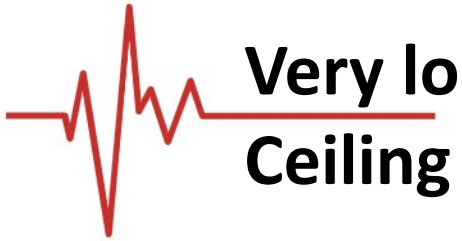


Antagonist
(naloxone, naltrexone, “Vivitrol”)
No opioid activity

Methadone	Buprenorphine	Naltrexone	Naloxone
Schedule II Controlled Substance – Highly regulated.	Schedule III Only waivered providers can prescribe bup for OUD.	Not a controlled substance. No special prescribing rules.	Not a controlled substance.
Full opioid agonist	Partial opioid agonist	Opioid antagonist	Opioid antagonist
Patients with OUD must go to a Methadone Clinic for this (cannot get it from PCP for OUD).	Limits for waivered physicians: 1st year: 30 patients After 1st year: 100 patients		Given alone for opioid OD (Narcan). Combined with bup to prevent diversion of the bup. Naloxone is not active if swallowed or used sublingually.

Pharmacologic differences between opioid agonist medications and other opioids

Substance	Time to Peak Effect	Mean Half-Life
Heroin	5 minutes	2-5 hours
Oxycodone	25 minutes	2-3 hours
Fentanyl	30-40 minutes	4 hours
Methadone	2-4 hours	24-36 hours
Buprenorphine	40 minutes	22-176 hours



Very long acting

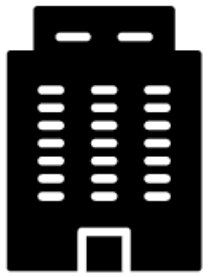
Ceiling effect of Buprenorphine - Little/no risk of overdose

Buprenorphine Induction Basics

Process used to start patients on buprenorphine that involves finding the right dose to relieve their withdrawal symptoms and prevent opioid cravings.

Office-Based Induction

- Ask patient to present to office in mild-moderate withdrawal (usually 12-24 hours after last use)
  - Important so that you don't precipitate opioid withdrawal by giving the bup too soon
- 1st dose of bup is given in office. Symptoms are observed and subsequent doses are given if withdrawal symptoms persist. Patient is monitored in clinic for up to 3 hours.
- May be necessary for frail or complicated pts



Home Induction

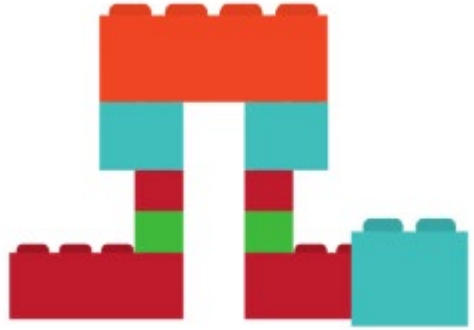
- Patients are educated and given clear instructions on how to dose bup at home based on withdrawal symptoms
  - Close telephone follow-up with clinic
- Helpful for transportation issues, mobility, etc.
- Safe, equal success rates
- Patient convenience

Maintenance Therapy

Finding the appropriate dose:

- It is the dose of medication that is sufficient to **BLOCK** all of the opioid receptors for a full 24 hours.
- If the person **DOES** use other opioids, they will not work because the receptors are literally blocked by the buprenorphine.

How to know if someone is at a blocking dose:



- Cessation of withdrawal symptoms ***including cravings*** for a full 24 hours
  - Patient report
  - Direct observation prior to next dose
- Opioid use will stop or decrease significantly
  - Drug screens negative (or more frequently negative)
  - Patient report of no/less drug use
- If use occurs, patient reports no euphoric effects of the opioid (the “high” or “rush”)

What kind of timeline are we looking at?

- Induction
- Cessation of acute withdrawal sx

→ Days to weeks

- Cessation of opioid use

→ Weeks to months

- Cessation of other drug use
- Stabilization of psychosocial issues

→ Months to years

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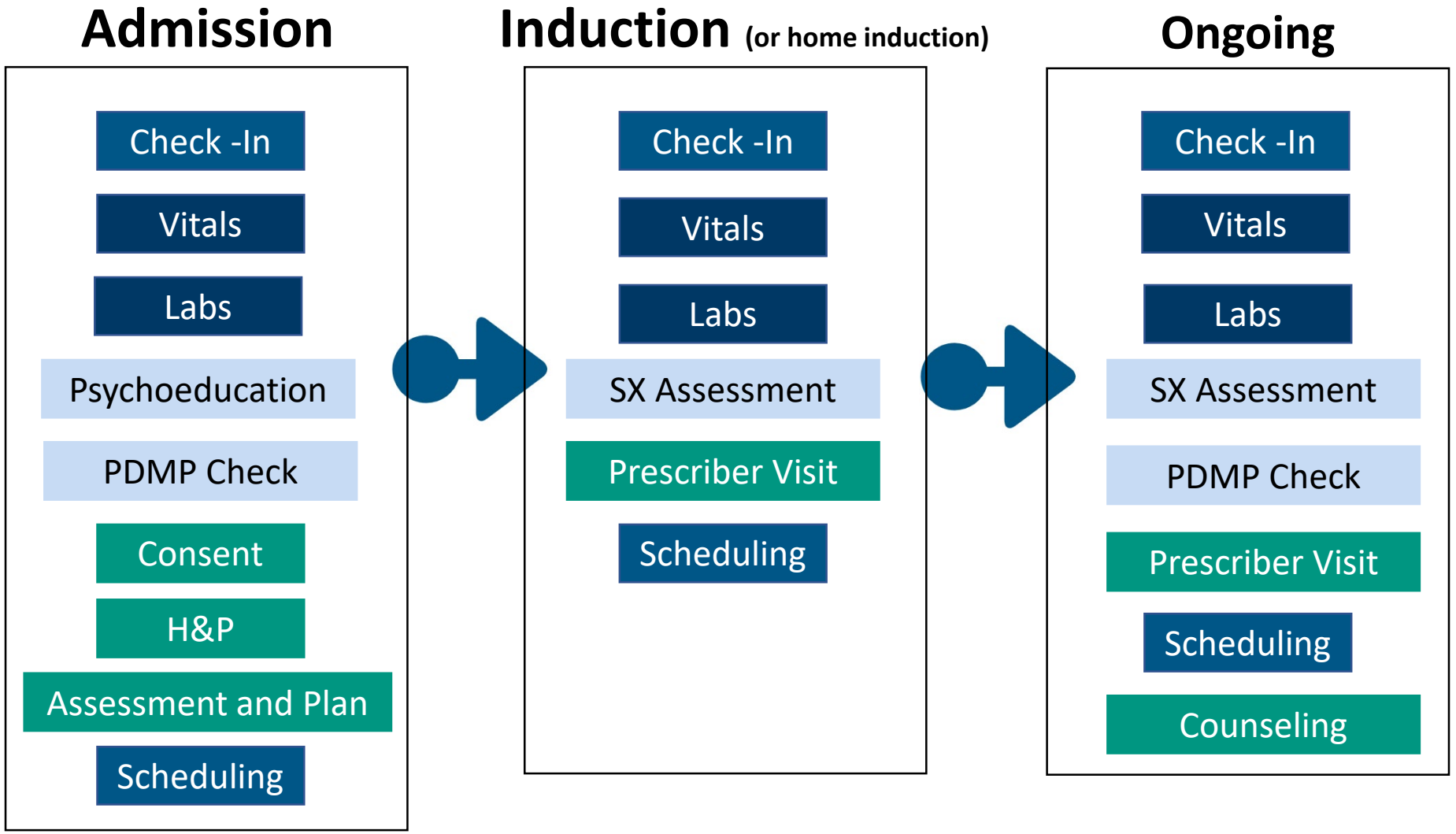
Overview of Flow



Roles/Interactions in the Clinic

Check-In/Scheduling (Clerical staff)	Waiting Room (Clerical staff)
Vitals, Labs (MA, lab tech)	Symptom Assessment (Prescriber or care manager)
Developing Care Plan and Prescribing (MD, PA, NP)	No-Show Calls (Care manager or front desk staff)
Follow-Up and Instructions (Care manager or prescriber)	Counseling (Behavioral health provider)
Check-Out (Clerical staff)	Dispensing Meds (Pharmacy staff)
Reminder Calls (Care manager)	Referrals (Prescriber)

Every role/interaction is an opportunity for engagement and an opportunity to reduce stigma.

Break-out Activity

- What is your name, your clinic, and your primary role in that clinic
- How do you think your role can best contribute to the care of this patient population?
- What challenges do you experience or imagine experiencing in your role?

15 min

Keeping Track

All waivered providers are subject to **periodic DEA audits**. If audited, the DEA will want to assess:

Compliance with the 30/100/275 patient limit

Medical record keeping

Security measures related to onsite drug storage if buprenorphine is dispensed from the office.

More information about How to Prepare for a DEA Office Inspection can be found on the American Society of Addiction Medicine website.
https://www.asam.org/advocacy/practice-resources/dea-office-inspection-tips

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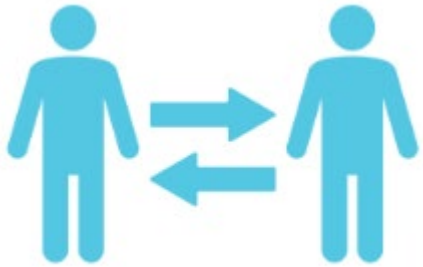


Identify the stigma faced by patients with OUD and how this can affect patient-staff relationships

Stigma

"A mark of disgrace associated with a particular circumstance, or quality of person that causes strong feelings of disapproval from most people in society." (Goffman)

Highly influenced by the perception that the situation is under the person's control ("their fault")

"Stigma becomes discrimination the moment it causes a negative action."
- Amanda LaMendola

Keeps patients from treatment

Discourages them from recovery

Decreases openness with providers about health issues

People are either “clean” or “dirty”

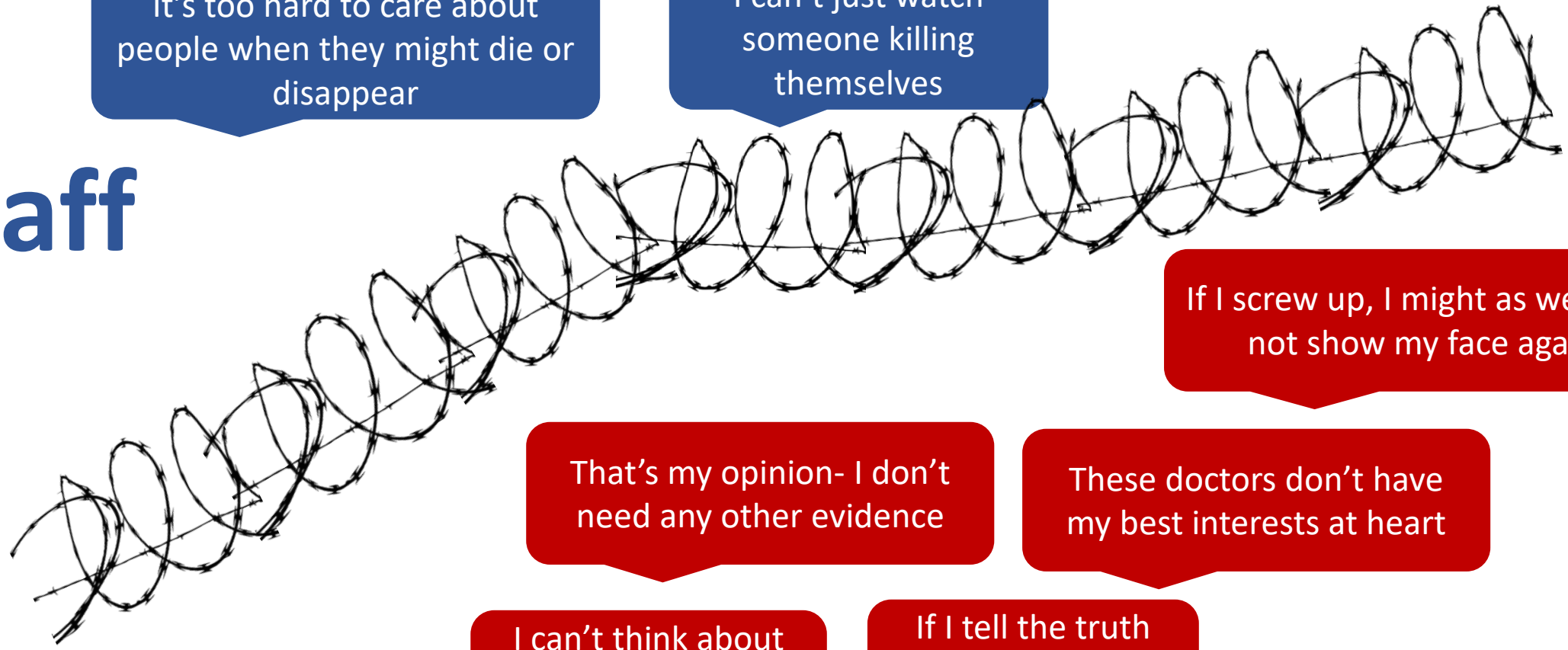
If you give these people an inch, they’ll take a mile

I feel so disappointed in him…I thought he would stay clean

It’s too hard to care about people when they might die or disappear

I can’t just watch someone killing themselves

Staff



If I screw up, I might as well just not show my face again

That’s my opinion- I don’t need any other evidence

These doctors don’t have my best interests at heart

I can’t think about anything further away than tomorrow

If I tell the truth I’ll be punished or kicked out

Patients

Vicious Cycle

Our expectations about patients can elicit the very behaviors we fear, and then those behaviors can pull for the exact reactions they hate.

"If I'm in a room with a cookie jar, you know everyone's going to assume I've already taken the cookies. And that ticks me off. If you're going to assume I ate them anyway, I may as well just eat them, because it doesn't matter either way."

Break-out Activity

- Can you recall a time when you observed stigma in the clinic setting OR a time when you judged someone unfairly or made assumptions about them that weren't true?

- What were the outcomes?

- What could you have done differently?

12 min

Vignettes

Patient who repeatedly misses appointments.

Patient who states s/he is going to stop taking buprenorphine ("I don't need it anymore").

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Communication Tactics

- Be **friendly**.
  - Notice and give **compliments.**
  - **Facilitate discussions** about issues that may increase motivation (family, finances, job, health, etc.)
  - Pass along behavioral observations to the appropriate provider.
- **Praise** people's efforts, not their "outcomes".
  - Reinforce extravagantly. Consider making use of certificates and other formal acknowledgements.
- **Ask what you would do/feel** if the situation were applied to a patient with diabetes.
- **Focus on engagement**
  - If you can keep people showing up, change will usually happen.
  - If people are missing, **follow up.**
- **Create a culture** where colleagues are comfortable confronting others when they see behaviors or hear language that perpetuates stigmas associated with OUD.

Stigmatizing Language	Preferred Language
Addict	Person with a substance use disorder
Addicted to X	Has a X use disorder
Addiction	Substance use disorder
Alcoholic	Person suffering from alcohol addiction
Clean	In recovery
Clean screen	Expected result; substance free
Dirty	Actively using
Dirty screen	Unexpected result; positive for…
Drug habit	Regular substance use
Drug abuser	Person who uses illicit substances
Reformed addict or alcoholic	Person in recovery
Opioid replacement	Medication for Addiction Treatment or Medication for Opioid Use Disorder

Social Determinants of Health

- SDoH screening is important for patients with OUD.
- **Identifying barriers** to treatment will help patients be more successful in recovery.
- The care team can play an important role in screening and **addressing barriers**.

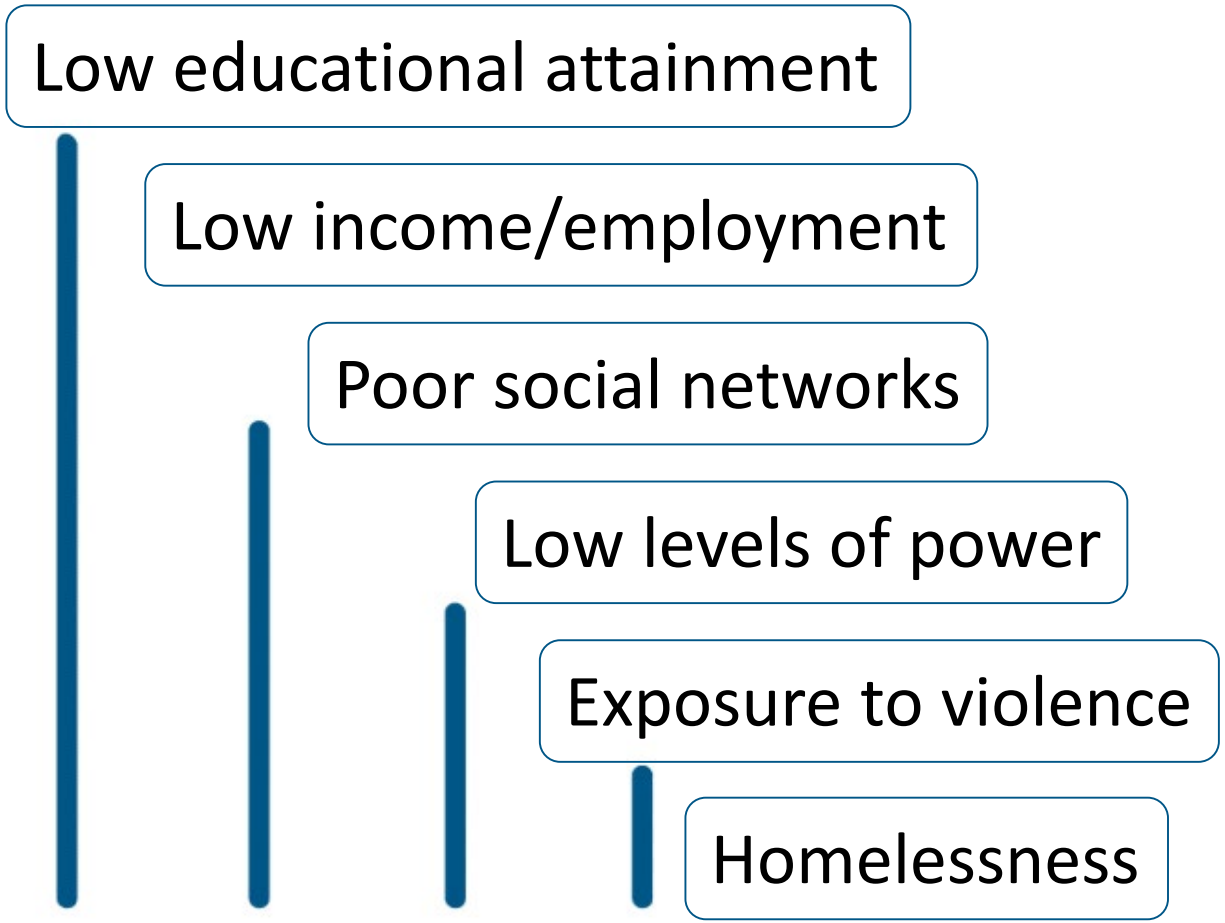
Financial

Safe housing

Transportation

Social support

Social Determinants Associated with Illicit Drug Use



Dasgupta et al, 2018. Barocas et al, 2019

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- Medications for OUD
- Clinic workflow
- Stigma around OUD
- Talking with patients with OUD
- Summary and questions

Final Activity

1. What are your key takeaways from this presentation?

2. What do you need in your clinic to be successful in this work?

Summary

- OUD is a treatable, chronic disease and **long-term** MAT is the gold standard for treatment.
- Buprenorphine is a Schedule III controlled substance that can be prescribed by a waivered provider for OUD.
- There is a significant need for improved access to MAT nationally and across Michigan- more access will decrease overdose deaths and improve long-term outcomes across a multitude of health and social measures
- People with OUD are often stigmatized. We have an opportunity to help them treat this chronic disease like we treat all other chronic diseases without stigma.
- Every person who interacts with OUD patients in your office from check-in to check-out has an opportunity to reduce stigma and make a major impact on these patients' care.
- This treatment can be the difference between life and death! Thank you for the work you are doing!

Where can I learn more?

- Michigan Institute for Care Management & Transformation (including MAT Reimbursement Opportunities Recorded Webinar) https://micmt-cares.org/resources
- Michigan Opioid Collaborative http://www.michiganopioidcollaborative.org/
- Providers Clinical Support System https://pcssnow.org/
- Substance Abuse and Mental Health Services Administration https://www.samhsa.gov/medication-assisted-treatment/treatment

Questions?