Empowering Recovery from Opioid Use Disorder

Transforming Lives and Enhancing Professional Fulfillment

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Outline

- Opioid Use Disorder and Its Treatment
- Patient Care
- Co-Morbidities
- Putting it into Practice
- Testimonials
- Case Vignettes
- Resources

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Opioid Use Disorder and Its Treatment

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The Problem

Medications for OUD (MOUD) are **highly effective**, **easy to use** but are **not available** for many patients in need

- Over 50% of rural counties in the US patients do not have access to MOUD

78% of PCPs believe that buprenorphine is an effective treatment but only 20% are interested in treating patients with OUD

Barriers to offering MOUD include

- Belief that treating OUD is not a primary care issue
- Concerns about potential disruptive behaviors of patients with OUD
- Lack of adequate training of clinicians and their teams to treat OUD
- Lack of clinical support for the clinicians treating patients with MOUD
- Lack of psychosocial services or clinical supports for patients

Harder VS et al. *Prev Med.* 2021; Patel K et al. *Cureus*. 2021;
Andrilla CHA et al. *J Rural Heal*. 2022; McGinty EE et al. *Ann Intern Med*. 2020

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Provider Stories

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Opioid Use Disorder (OUD) and Overdose Death

Opioid use disorder (OUD)

- 0.2% (or 587,000 people) had a heroin use disorder
- 1.9% (or 5.3 million people) had a prescription opioid use disorder
- Percentages did not differ significantly among racial or ethnic groups

Opioid overdose deaths

- 1999-2022, nearly 720,000 opioid overdose deaths
- 2022, 76% of opioid OD deaths (108,000) involved synthetic opioids (i.e., illicit fentanyl)
- **Since 2016, more than 2,000 MA residents die annually from opioid overdoses**

SAMSHA. (2024). 2023 National Survey on Drug Use and Health;
CDC/NCHS National Vital Statistics, Mortality. 2024; www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2022/

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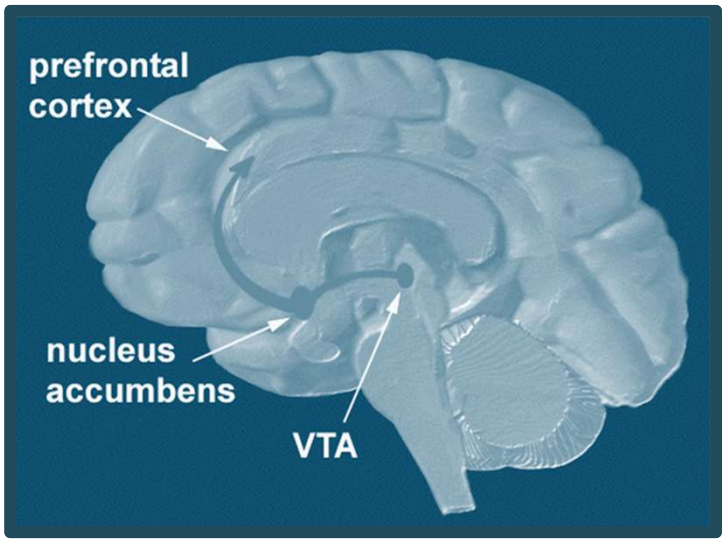
The Reward Pathway



Reward and reinforcement is in part controlled by **mu-opioid receptors** in the **Reward Pathway**

Dopaminergic system

Ventral Tegmental Area (VTA)

Nucleus Accumbens with projections to **Prefrontal Cortex**

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Changes to the Reward Pathway

Derangement of endogenous opioid receptor system resulting in a **hypo-dopaminergic state**

Symptoms include

- Malaise, fatigue, insomnia
- Poor tolerance to stress and pain
- Opioid craving
- Conditioned cues (triggers)
- Priming w/ small dose of drug

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Volkow et al., *Neuro Learn Mem* 2002

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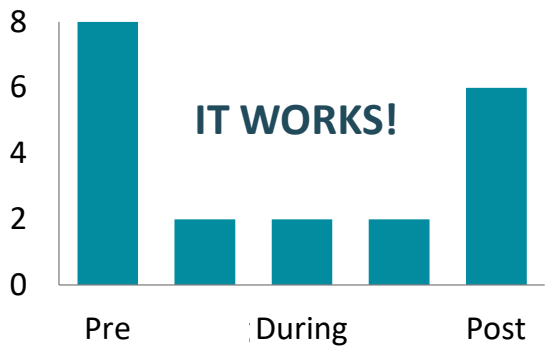
Assessing Treatment Effectiveness

Hypertension Treatment



Addiction Treatment

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McLellan AT et al. *JAMA* 2000

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Opioid Detoxification Outcomes

Low rates of retention in treatment

High rates of relapse post-treatment

- < 50% abstinent at 6 months
- < 15% abstinent at 12 months

Increased rates of overdose due to decreased tolerance

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O'Connor PG *JAMA* 2005; Mattick RP, Hall WD. *Lancet* 1996; Stimmel B et al. *JAMA* 1977

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Pharmacotherapy is the Gold Standard

Goals

- Suppress opioid withdrawal*
- Mu opioid receptor blockade "opioid blocking"
- Alleviate craving
- Normalize brain changes

Medications for OUD (MOUD)

- **Naltrexone** (full antagonist)
- **Opioid Agonist Therapy (OAT)**
  - **Methadone** (full agonist)
  - **Buprenorphine** (partial agonist)

*Only methadone and buprenorphine suppress opioid withdrawal.

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Peterkin A et al. *Med Clin N Am*. 2022

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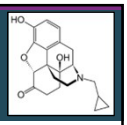
Naltrexone



Pure opioid antagonist (must be opioid-free for 7-10 days beforehand)

Oral naltrexone (daily)

- Well-tolerated, safe, duration of action 24-48 hours
- Poor retention in treatment

Injectable IM XR naltrexone (monthly)

- In-office injection
- Increased abstinence
- Poor retention in treatment (40% at 3 months, <10% at 6 months)

Risk: Loss of tolerance to opioids and risk of overdose if patient returns to opioid use at previous level

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Cousins SJ et al. *J Sub Abuse Treat* 2016

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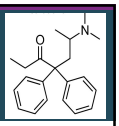
Methadone



Full opioid agonist

- Duration of action 24-36 hours to treat OUD
- Dosing for OUD
- 20-50 mg on day 1 for acute withdrawal
  - > 80 mg for craving, “opioid blockade”
  - Higher doses in fentanyl era

Only available outpatient in Opioid Treatment Programs (OTPs)

- Highly structured
- Observed daily → “Take homes”

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Methadone Benefits & Limitations

Benefits

- Increases treatment retention
- Decreases illicit opioid use
- Decreases hepatitis and HIV seroconversion
- Improved psychosocial outcomes
- Improves birth outcomes
- **Decreases both opioid-related and all cause mortality**

Limitations

- Federal regs prohibit use methadone to treat OUD outside federally regulated OTPs
- Limited access
- Inconvenient and highly punitive
- Mixes stable and unstable patients
- Lack of privacy
- No ability to “graduate” from program
- **Stigma**

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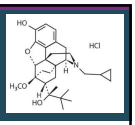
Buprenorphine



Mu-opioid receptor partial agonist

- Ceiling effect on CNS and respiratory depression

Kappa-opioid receptor antagonist

- Antidepressant and anxiolytic effects

Formulations

- Sublingual tab or film (+/- naloxone)
- Weekly & monthly SQ injections (administered by healthcare provider)

Waiver no longer required; just need a DEA #

No limits on # of patients a prescriber may treat

Schedule III – up to 5 refills

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Buprenorphine Benefits

Increases treatment retention

Decreases illicit opioid use

Decreases hepatitis and HIV seroconversion

Improved psychosocial outcomes

Improves birth outcomes

Decreases both opioid-related and all cause mortality

Additional benefits

- Available in general practice
- Prescription filled a community pharmacy

Buresh M et al. *BMJ.* 2021

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Nonpharmacologic Treatment

Behavioral therapies when delivered alone have very limited efficacy compared to MOUD alone

Psychosocial treatments including individual or group counseling can help some with OUD but often need to be combined with MOUD

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Buresh M et al. *BMJ.* 2021

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Provider Stories

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Patient Care

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Diagnosing Opioid Use Disorder: DSM-5

Mild OUD: 2-3 Criteria	**Moderate** OUD: 4-5 Criteria	**Severe** OUD: ≥6 Criteria

Loss of Control

1. **Tolerance**
2. **Withdrawal**
3. Larger amounts and/or longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using or recovering

Continued Use Despite Negative Consequences

6. **Craving/ Compulsion**
7. Role failure: work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm

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APA. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.)

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Counseling a Patient on Choosing MOUD

- Review PMH for relative contraindications (e.g. severe liver disease, QTc prolongation)
- Assess what has/has not worked in the past
- Discuss pros/cons of different options
- IF patient is using fentanyl, buprenorphine initiation can be more challenging – *more to come*

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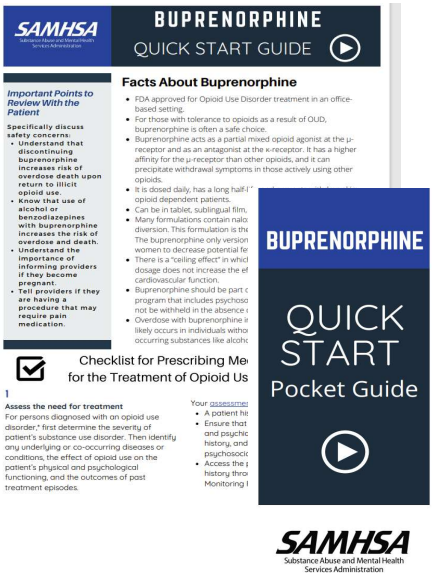
Prescribing Buprenorphine

Waiver no longer required to prescribe buprenorphine to patients with OUD; just need a DEA #

No limits on # of patients

New training requirement **for all providers** - 8 hours of SUD training



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Starting Buprenorphine

Illicitly-manufactured fentanyl has complicated "traditional" buprenorphine inductions

Buprenorphine is a partial agonist that binds avidly to the mu opioid receptor → displaces other opioids causing sudden and intense withdrawal, aka "precipitated opioid withdrawal" (POW)

Illicitly manufactured fentanyl has unpredictable pharmacokinetics – lasts much longer than the effects are felt

Thus, starting buprenorphine even when patient is experiencing clinical opioid withdrawal can **still** cause POW

Methadone, as a full opioid agonist with lower binding affinity, does not cause POW

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Varshneya et al. *J Addict Med* 2022; Thakrar et al. *JAMA Netw Open* 2024.; Volpe et al. *Reg Tox Pharm* 2011.

23

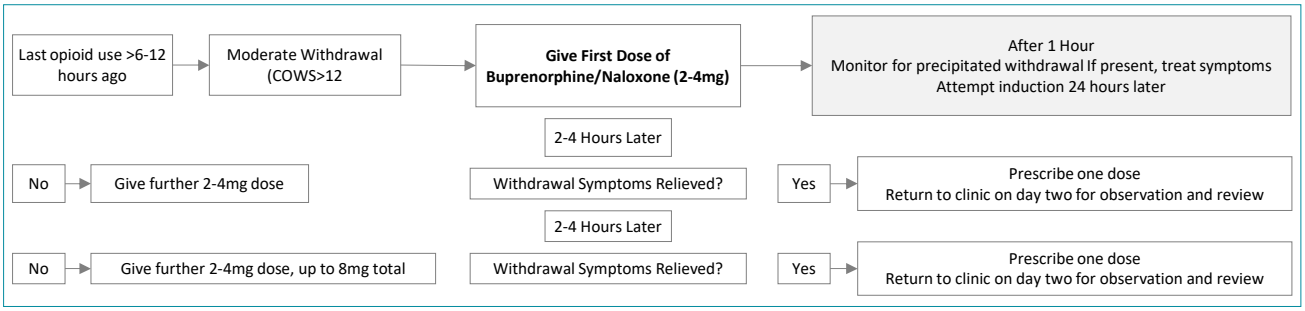
Starting Buprenorphine: Traditional Induction

For patients using **non-fentanyl opioids**, can do a "traditional" buprenorphine induction

- Many "oxycodone" pills are pressed, aka actually fentanyl or other substances – if not sure, confirm with toxicology testing

For induction

- Wait at least 6-12 hours after last use AND until COWS (Clinical Opioid Withdrawal Score) is >12
- Take 2-4 mg buprenorphine, repeat every ~2 hours until symptoms resolved



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SAMHSA. Buprenorphine Quick Start Guide.

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Starting Buprenorphine: Low-Dose Induction

- In patients using **illicitly manufactured fentanyl**, to avoid POW, "low-dose induction" has become popular
- **Progressively increasing doses of buprenorphine** overlapping with **full agonist** opioid (progressively decreasing or stable)
- Multiple approaches; one example here

Day	Total daily buprenorphine dose	Buprenorphine-naloxone film strength	Instructions	Full opioid agonist
1	0.5 mg	2-0.5 mg films	Take 0.25 mg (1/8 film) twice daily	Continue
2	1 mg		Take 0.5mg (1/4 film) twice daily	Continue
3	2 mg		Take 1 mg (1/2 film) twice daily	Continue
4	4 mg		Take 2 mg (1 film) twice daily	Continue
5	8 mg	8-2 mg films	Take 4 mg (1/2 film) twice daily	Continue
6	16 mg		Take 8 mg (1 film) twice daily	none

Spreen et al. *Pharmacotherapy* 2022; Hammig et al. *Subst Abuse Rehab* 2016; Randhawa et al. *CMAJ* 2020; Brar et al. *Drug Alcohol Rev* 2021; Shalapour et al. *JAM* 2024.

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Starting Buprenorphine: High-Dose Induction

"High-dose" induction is another strategy developed in response to challenges with buprenorphine initiation in era of fentanyl

Start with higher doses of buprenorphine

≥16 mg as a single dose, often up to 24 – 32 mg Day 1

May increase risk of precipitated withdrawal; other studies suggest only limited risk

No conclusive evidence re: high-dose vs low-dose initiations

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Herring AA et al. *JAMA Netw Open* 2021. ; Snyder H. *JAMA Netw Open* 2023. Wong S et al. *JAM* 2024.

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Buprenorphine: Long-Acting Formulations

Two SQ formulations

Brand names Brixadi® (weekly or monthly) and Sublocade® (monthly)

- Sublocade® approved 2017
- Brixadi® approved 2023

Logistics

- Ordered through specialty pharmacy
- Should be able to tolerate one equivalent dose of SL buprenorphine
- Sublocade® may be easier to get insurance approval; leaves a residual pellet
- Brixadi® does not leave a residual pellet, wider dosing range

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Sublocade.com. Brixadi.com.

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Starting Methadone

Methadone for OUD only at federally licensed OTPs

Methadone clinic wait times can be upwards of 30 days

Can be tough to get to

- Average one-way travel time 46 minutes
- Longer in rural settings

Access to treatment impacts linkage: patients more likely to attend same- or next-day addiction appointments

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Starting Methadone

Your role:
Coaching and supporting patients around expectations

- Must show up on time
- May have random urine toxicology testing
- If they miss days or appear sedated, dose will typically be decreased
- Can get take-homes over time
- Clinics can be strict; encourage patients that they have resilience and ability to succeed

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72-Hour Rule and Methadone

"72-hour rule" (21 CFR 1306.07(b)) allows non-OTP facilities to administer opioids (inclusive of methadone) for emergency withdrawal management for ≤ 72 hours

Emergency departments utilize this when providing missed doses

Non-emergency department settings **can also** provide methadone under this rule

Updated in 2022 – can dispense, in addition to directly administering

Clinics could consider this as a "bridge" to local OTPs after building connections and discussing with legal teams

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Code of Federal Regulations. 21 CFR 1306.07(b); Laks et al. *Addict Scien Clin Pract* 2021; Taylor et al. *Drug Alc Rep* 2022.

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Starting Naltrexone

Intramuscular formulation does not require oral lead-in

Full opioid **antagonist** requires at least 7 days of abstinence from opioid agonists (including buprenorphine, methadone, fentanyl) prior to initiation to avoid POW

Practically – often challenging for patients to be opioid-free for 7 days

While taking naltrexone, patients lose opioid tolerance; counsel patients on increased overdose risk when they stop the medication

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Ongoing Engagement with Patients

Discuss relapse prevention – typically part of the process

- Assess cravings and withdrawal
- Review identification of early signs
- Motivational interviewing around self-efficacy and change talk
- Brainstorm triggers and how to anticipate, avoid, or cope
  - Emotional (**H**ungry, **A**ngry, **L**onely, **T**ired (HALT) or bored)
  - Craving/cueing (people, places, and things)

Discuss overdose and overall safety

- Review overdose prevention hotlines (e.g., Safe Spot https://safe-spot.me), clean needles / works, access to naloxone

Toxicology testing

- Utility debated; recommended as part of toolkit but becoming less routine

McEvoy et al. *Addiction Behaviors Reports* 2025; McEachern et al. *Int J Drug Policy* 2019; McDonell et al. *JAM* 2016; Bharat et al. Addiction 2023.

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Managing a Patient Who Relapses




"Lapse" vs "relapse"

- **Lapse** is brief resumption, **relapse** is continued uncontrolled/ continued use
- Learning process: Opportunity to grow and inform future planning

Increase support

- Treat comorbid psychiatric disease
- Enhance behavioral therapies, peer support
- Review strategies for avoidance of triggers

Adjust medications

- If not on MOUD, consider starting
- If on MOUD, review adherence and drug-drug interactions, consider dose change

Counseling

- work together to develop next steps
- Motivational interviewing

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Older Adults with OUD


Unique features

- Physiologic changes with decreased metabolism and increased elimination time
- Polypharmacy
- Co-morbidities including cognitive decline, pain, renal and liver impairment, frailty

Treatment

- **Buprenorphine may be preferred** - less sedating, less QTc prolongation, ease of administration
- Start low and go slow with dosing

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Adolescents & Young Adults with OUD

Buprenorphine **approved for ≥ 16 years old**; often used off-label in younger adolescents

As of 2024, methadone **available for <18 years old with written consent** of parent, legal guardian, or responsible adult

Naltrexone FDA-approved for **≥ 18 years old**

Buprenorphine typically preferred due to ease of administration

Sanchez-Samper X, Levy S. Office-Based Buprenorphine Treatment of Opioid Use Disorders. 2nd ed. 2018.; SAMHSA Federal Guidelines for Opioid Treatment Programs 2024.

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MOUD for Adolescents

2023 study

- Only 1 in 4 US facilities offered buprenorphine
- Average parent would need to call 9 facilities on SAMHSA Treatment Locator list to find one that offered buprenorphine

2017 study

- **Only 27% on MOUD** within 6 m of dx (89% buprenorphine, 11% naltrexone)
- Younger, female, Black, Hispanic youth less likely to receive medications

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Hadland SE, et al. *JAMA Pediatr*, 2017; King C et al, *JAMA*, 2023.

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Pregnancy and OUD

Opioid agonist pharmacotherapy (either **methadone or buprenorphine**) is endorsed by the American College of Obstetricians and Gynecologists (ACOG) as optimal treatment for OUD during pregnancy

Methadone and buprenorphine are both safe and effective

Buprenorphine monoproduct preferred to co-formulated buprenorphine/naloxone though either is safe and acceptable

37

Jones HE et al. *Addiction* 2012; Suarez EA et al. *N Engl J Med* 2022

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Polysubstance Use

90% of persons with OUD used >2 other substances within past year

>25% of persons with OUD have at least two other SUDs

Increasing co-use of stimulants; many other substances as well

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Compton et al. *Mol Psychiatry*. 2020.

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Co-Morbidities

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Psychiatric Co-morbidities

Psychiatric conditions that precede opioid use or persist after abstinence are chronic conditions compared to substance-induced psychiatric conditions that manifest with active drug use

38% of treatment-seeking patients with OUD have a current comorbid psychiatric diagnosis including major depression, anxiety, bipolar disorder and PTSD

Psychiatric comorbidity associated with worse treatment outcomes including relapse, nonadherence, poorer psychosocial or physical health status, and lower quality of life

Recommended that mental health assessment and treatment be provided in conjunction with MOUD

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Zhu Y, et al. *Drug Alc Depend* 2021

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OUD and Pain

Patients with an OUD including those on opioid agonist treatment

- Have **less pain tolerance and increased pain sensitivity** than matched controls
- Must be maintained on baseline daily opioid equivalence before any analgesic effect of additional opioids
- Often have **higher opioid analgesic requirements** due to increased pain sensitivity and opioid cross tolerance – may also require dosing at more frequent intervals

Addition of opioid analgesics for pain will not compromise recovery; untreated or undertreated pain, however, can be a trigger for use

- Also unlikely to cause excessive CNS or respiratory depression due to cross-tolerance

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Alford DP, et al. *Ann Intern Med* 2006

41

Methadone Maintenance and Pain

Methadone confers analgesia for ~6-8 hours; patients on daily dosing will not feel analgesic effect beyond this

Since methadone maintenance programs only dose (dispense) methadone once daily, patients may require addition of short-acting opioid analgesics for pain

Note: It is illegal to prescribe at-home methadone for the treatment of OUD whether or not the patient has concurrent pain (Harrison Narcotics Act of 1914)

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Alford DP, et al. *Ann Intern Med* 2006

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Buprenorphine Maintenance and Pain

Like methadone, buprenorphine confers analgesia for ~6-8 hours
- Unlike methadone, buprenorphine can be prescribed to be taken multiple times per day

Studies have demonstrated efficacy for chronic pain comparable to that of morphine, oxycodone, and fentanyl

Can **maximize analgesic effect** in both acute and chronic pain by prescribing same or higher dose of buprenorphine in **more frequently divided doses**

If other opioids are needed, may need higher doses due to cross-tolerance and avidity of buprenorphine for opioid receptor

Note: Buprenorphine/naloxone coformulation not FDA-approved for pain; off-label use

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Naltrexone Maintenance and Pain

Opioid antagonist effect of oral naltrexone lasts up to 72 hours; IM naltrexone lasts at least 25 days

For acute pain management
- STOP naltrexone (no taper required)
- Multimodal: Consider nonopioids and regional anesthesia
- May need to consult anesthesia
  - Use of agents like ketamine
  - If opioids needed, will require high doses with close monitoring of respiratory status

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Edinoff AN, et al. *Curr Pain Headache Rep*. 2023

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Provider Stories

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Putting it into Practice

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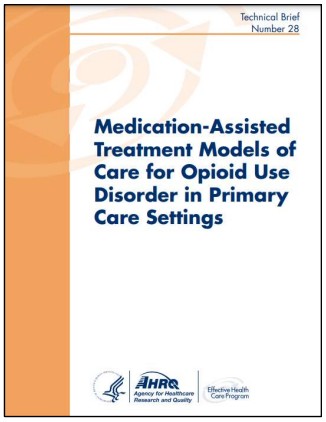
MOUD Can Be Started in Primary Care

Multiple models - successful models typically involve
- Pharmacotherapy
- Provider and Care Team
- Integration of OUD treatment with other medical care
- Psychosocial services

Majority of patients would feel comfortable receiving MOUD via primary care

Millions with OUD but only several thousand MOUD prescribers

Elimination of the DATA-Waiver intended to broaden reach of MOUD



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Korthius et al. *Ann Intern Med* 2017; Del Pozo et al. *JAMA Network Open* 2024; Agency for Healthcare Research and Quality (2016)

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Prescribers

Must be a licensed physician, nurse practitioner, physician assistant, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife

Active DEA license
- Medication Access and Training Expansion Act requires 8 hours of training on managing patients with substance use disorders

Establishes diagnosis of OUD

Creates and implements treatment plans, in collaboration with additional care team members

Coordinates with external providers for specialty care

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Nurse, Nurse Care Manager (NCM)

- Office Based Addiction Treatment (OBAT): Assessment, initiation, stabilization, maintenance
- Clinical case management with close follow-up
- Chronic disease management and address acute medical needs
- May address laboratory results
- Brief counseling/motivational interviewing
- Logistical support
  (prescriptions, prior authorizations, pharmacy issues, insurance)

Grayken Center for Addiction Training & Technical Assistance
Boston Medical Center

"Massachusetts Model": NCMs serves as the primary point of contact for the patient, working with the prescriber to deliver comprehensive outpatient addiction treatment

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Clinical Care

Medical Assistant

- Administrative support – tracking data, observing workflows, phone calls, filing forms
- Clinical support– vital signs, specimen collection, demographic questionnaires, screening questions

Pharmacist

- Off-site community pharmacist or internal pharmacist
- Assists in medication reconciliation, symptom management, prior authorizations, patient education, optimize medication management
- Most states include the ability to engage in a collaborative practice with a clinical pharmacist.
- Do not diagnose

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Peers and Navigators

Care Coordinator, Patient Navigator, Recovery Support Navigator

- Assists with concrete service supports and addresses social determinants of health
- Knowledge of organization, healthcare system, community resources
- Scheduling and coordination of care

Peer Support, Recovery Coach, Recovery Specialist

- Person with lived experience to help guide patients through recovery
- Offer hope, optimism, and encouragement, emphasizing the patients voice
- Ensure support for professional growth for peers due to the high-risk nature of the role and relatively new role in workforce
- Certification varies by state

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Mental Health

Alcohol and Drug Counselor

- Several different licensures and certifications that vary by state
- Assesses for clinical needs and creates individualized treatment plans

Social Worker/Mental Health Counselor

- Assessment with validated screening tools and psychotherapy
- Case management: Connecting people with the community and support services.
- Provide follow-up services to help ensure succuss with treatment plan

Psychologist

- Assessment and psychotherapy
- Emphasis on cognitive, emotional and social behaviors and may have training in specific treatment modalities (e.g. CBT, DBT, group)

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Support Staff

Front Desk/Administrative Staff

- Often the first point of contact
- Important for patient engagement
- Understands workflows of department

Public Safety, Security

- May also be the first staff that patients encounter due to institution stationing
- Must understand policies of organization
- May be an asset or barrier to care
- Collaborative efforts decrease negative encounters and encourage engagement

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Accessing Care

Decreasing barriers is important for patient engagement and retention
Access to substance use care through a variety of entry points

Low-Barrier Care

- Collaborative, multidisciplinary approach
- Flexibility
- Innovation
- Meeting patients on full SUD spectrum from active use through long-term recovery

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Provider Stories

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Identify Potential Barriers to Care

Organizational

- Access to addiction care team members. How full are the schedules?
- Limited Hours –Normal business hours only? On-call provider for after-hours care?
- Organization policies – Can patients be seen if they arrive late? How will you be contacted if a patient calls in crisis?

Patient level

- Limited insight into one's own SUD. Screening helps.
- Lack of knowledge about treatment availability and structure
- Privacy concerns
- Social Determinants of Health

Ask patients about treatment barriers and strategies to improve care

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MOUD via Telemed or in Person

During COVID pandemic, SAMHSA permitted buprenorphine initiation via telemed → continued to present day

Significantly more individuals received OUD-related telehealth services (20% vs 0.6%) and MOUD (13% vs 11%) during the pandemic

Receipt of OUD-related telehealth services is associated with increased odds of MOUD retention, improved treatment access, reduced barriers to care

- 33% lower odds of overdose in one study of COVID-era telehealth

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Jones CM et al. *JAMA Psychiatry*. 2022. Telehealth. HHS.gov.

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"Bridge Clinics" to MOUD Initiation

Low barrier, transitional SUD care offer urgent care (same or next day) appointments

- Often accommodate walk-ins

Multiple models – outpatient hospital-based, emergency department-based, virtual

- Typically offer MOUD as well as harm reduction services
- More recently some have leveraged 72-hour rule to provide short-term methadone while connecting to OTP

Patients enjoy flexibility of appointments and dedicated nonjudgmental setting

Taylor JL, et al. *Addict Science Clin Pract* 2023. Serdarevic et al. *Ann Emerg Med* 2023. Lynch et al. *Drug Alc Depend Rep* 2024. Taylor et al. *Drug Alc Depend* 2022.

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Acute Care Settings "Reachable Moments" to Start MOUD

Engaging with patients wherever / however they present has positive outcomes

Emergency Departments

- ED-initiated buprenorphine increases OUD treatment engagement and opioid use
- Short-course prescriptions with hand-off to transitional care or OBAT

Inpatient setting

- Starting MOUD while inpatient (even in patients not seeking addiction treatment) leads to more engagement with addiction care and less self-reported opioid use
- Also reduces LOS, readmissions, and self-directed discharges

D'Onofrio et al. *JAMA* 2015.; Herring et al. *JAMA Network Open* 2024.; O'Rourke et al. *Drug Alc Depend* 2022.; Martin and Krawczyk. *JAMA Network Open* 2024.

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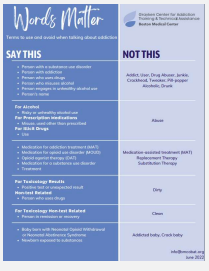
Engagement is Key

Building rapport is essential. Get to know your patient.

- **History obtained over time**. Prioritize data collected, focus on recent use.
- **Ask permission and choose your words thoughtfully.** Non-judgmental person-first language
- **Assess Safety Risks.** Utilize standardized assessment for overdose and HIV risk.
- **Reassure that you are asking to improve care**, not to punish.
- **Additional screening** for intimate partner violence, transactional sex, and criminal justice involvement can help inform interventions to decrease risks
- **Assess protective factors**. Support persons, strengths, longest recovery time, etc., emphasize successes
- **Be aware of Power Dynamics** and recognize adversity.

Take the Words Matter Pledge



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Taylor et al. *J Gen Intern Med* 2021

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Integration of Care is Key

Treatment components may include

- Medications for Addiction Treatment
- Withdrawal Management
- Support for Co-occurring Substance Use Disorders
- Behavioral Health Interventions
- Peer Support
- Safer Use Education and Supplies
- Overdose Prevention Education and Naloxone
- Preventative and Proactive Treatment: HIV Prevention, Family Planning, Sexually Transmitted Infection Screening, Cancer Screening, Immunizations
- Stigma mitigation

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Addressing Other Substance Use

Buprenorphine and methadone only FDA-approved to treat OUD. Naltrexone FDA-approved for AUD and OUD.

Offer treatment options including

- More intensive follow-up plans:
  - Increase frequency of visits
  - Shorter duration prescriptions
  - Warm-handoff to additional care team members or community-based resources
    - May be more or less structured: IOP/residential vs harm reduction program

Behavioral health interventions for stimulant use disorder (StUD) such as contingency management

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Taylor et al. *J Gen Intern Med.* 2021

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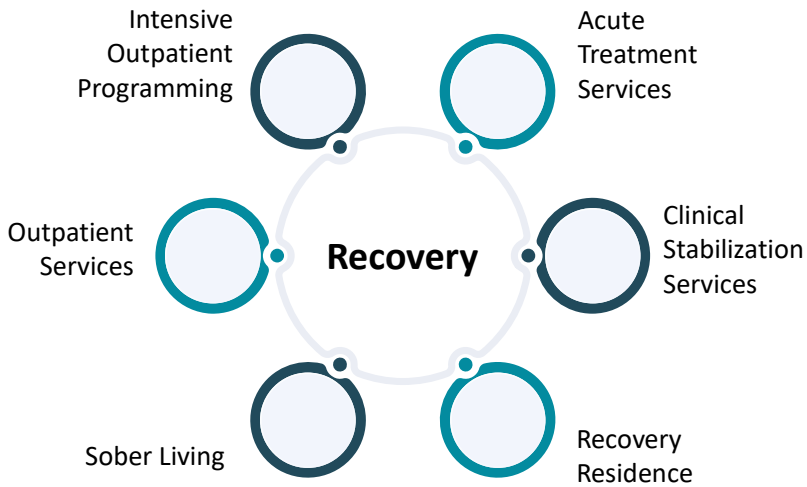
Spectrum of Recovery and Resources



- Ask Questions!
- Identify resources in your community
- Reach out to better partner with those people and organizations

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Case Vignettes

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Case: **"This treatment isn't working; I want to get off"**

- 26 yo female with h/o severe OUD, and asthma
- OUD history began at age 18 with oxycodone then intranasal heroin 6 months later followed by injection heroin and fentanyl
  - 2 prior opioid overdoses reversed with naloxone administered by her boyfriend
  - 5 detoxes, 2 residential programs
  - Began buprenorphine/naloxone 16 mg daily 3 months ago
  - Hepatitis C positive (s/p treatment, minimal liver fibrosis) and HIV negative
  - Recent urine drug tests consistent with intermittent fentanyl use

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Case: **"This treatment isn't working; I want to get off"**

- Works fulltime in a hardware store and lives with her long-term boyfriend who has a history of OUD and is in remission through attending NA meetings
- She now demands to be taken off the buprenorphine because "it isn't working" and she is tired of all the clinic rules including urine drug testing

Clinical question:
How would you manage this patient's request to discontinue MOUD?

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Case: "I'm not using cocaine; the test is wrong"

- 47 yo male with h/o severe OUD in long-term remission, hypertension and hyperlipidemia
- OUD history started using oxycodone at age 22 followed by intranasal heroin
  - Never injected drugs
  - Has been in long-term remission on buprenorphine, initially SL and now monthly injection
  - Hepatitis C and HIV negative

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Case: "I'm not using cocaine; the test is wrong"

- Recent urine drug test was positive for buprenorphine and cocaine
- He initially did not disclose his cocaine use but when asked about it after the urine test was confirmed he stated that he uses cocaine occasionally with friends and does not think that it is a problem
- Works fulltime as city building inspector, lives with wife and 3 young children

Clinical question:
How would you manage this patient's cocaine use?

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Resources

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Massachusetts Substance Use Helpline

The Helpline is funded by the Bureau of Substance Addiction Services of the Massachusetts Department of Public Health

Help to connect individuals with harm reduction, treatment, and recovery services free and confidential including

- Assess an individual's needs, provide referrals
- Provide information and answer questions about substance use disorders, treatment, and recovery
- Follow up after the first call to check in

Available 24 hours a day, 7 days a week, and 365 days a year, including all holidays by calling 800.327.5050, texting 800327, or chat online

The Massachusetts Substance Use HELPLINE

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Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP)

To support clinicians in increasing their capacity for and comfort in using evidence-based practices to screen for, diagnose, treat, and manage the care of patients with Chronic Pain, Substance Use Disorders, or both

Real-time, phone **"Curbside Consultation"** for clinicians on safer prescribing and managing care for Massachusetts adults with **Chronic Pain (CP)** and/or **Substance Use Disorder (SUD)**

Call for FREE Consultations for patients at **1-833-PAIN-SUD** (1-833-724-6783), Monday - Friday from 9:00am - 5:00pm (insurance agnostic)

Request Online: mcstap.com/providers/request consultation.aspx

Staff: Experienced physician-consultants expert in treating addiction and pain

Funding: Mass. Executive Office of Health & Human Services

Massachusetts Consultation Service MCSTAP for Treatment of Addiction and Pain
Call for a Consult, Care with Confidence

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MassPAT Alert of Interruption in MOUD

- The Massachusetts prescription awareness tool (MassPAT) has added an "MOUD Alert" feature
- Will inform buprenorphine prescribers to identify patients potentially at risk for non-adherence to their MOUD treatment
- Not intended to be used as grounds to stop prescribing MOUD or to dismiss a patient from your practice
- The alert notification will be sent via email only to the prescribers (and their authorized delegates) of those patients who have experienced a medication lapse
- The specific medication that will be captured will be buprenorphine products but not Methadone or Naltrexone

Massachusetts Department of Public Health

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BMC Grayken Center for Addiction Training and Technical Assistance

Provides education, support and capacity building to community health centers and other health care and social service providers on best practices caring for patients with substance use disorders

Funded in part by the MA Bureau of Substance Addiction Services (BSAS)

Request training and/or technical support
https://www.addictiontraining.org/training/request/

Grayken Center for Addiction Training & Technical Assistance
Boston Medical Center

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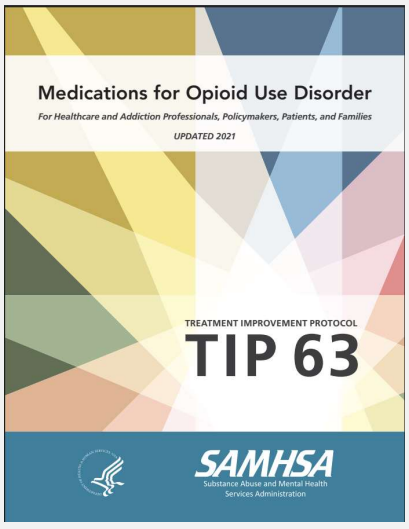
National Resources



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Patient Stories

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Provider Stories

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Thank you!

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