Empowering Recovery from Opioid Use Disorder:
Transforming Lives and Enhancing Professional Fulfillment
Transcript

**Daniel Alford, MD:** Hello. And welcome to our program entitled Empowering Recovery from Opioid Use Disorder: Transforming Lives and Enhancing Professional Fulfillment. I'm Dr. Daniel Alford. I'm a professor of medicine at Boston University and a general internist and addiction medicine specialist at Boston Medical Center. My areas of interest include incorporating opioid use disorder treatment into primary care, and co-managing patients with pain and addiction.

I'm happy to be joined by two of my colleagues, Dr. Hallie Rozansky, who's an assistant professor of medicine at Boston University, and also a primary care physician and addiction medicine specialist at Boston Medical Center. Her clinical interests include low barrier addiction treatment, the integration of addiction treatment into primary care, and pre-exposure prophylaxis for HIV.

And Kristin Wason, who's a nurse practitioner at Boston Medical Center, and an assistant professor at Boston University. Kristin currently works on the inpatient setting, caring for patients with addiction and mental health conditions, and has practiced within Boston Medical Center's adult primary care and office-based addiction treatment settings. Kristin specializes in addiction medicine and serves as the Director of the Grayken Addiction Nursing Fellowship at Boston Medical Center, the first program of its kind in the United States.

So the outline for this presentation is that we'll be talking about opioid use disorder and its treatment. We'll talk specifically about patient care, including co-morbidities, and putting it all into practice. We'll present some case vignettes that are quite common in clinical practice. We'll have interspersed testimonials. And we'll talk about state and federal resources.

**Meagan, Patient:** I started using unprescribed opiates when I was 15 years old. And my addiction just slowly grew from there. I kept it under control for a little while. Then I moved to heroin shortly after that. I lost custody of my two children. I was suicidal. I just didn't want to live anymore. But a couple years before that, my mother, she had my—my two older kids. And

she had told me—And this is—it sticks with me all the time. She was like, "I never want to tell your kids you're dead because of drugs."

And after those four overdoses, like that just kept playing in my head. That's when I decided to get treatment. And that was actually the first time I was introduced to buprenorphine (suboxone). That saved my life. It's really changed who I am, and where I'm going. It's allowed me to be a mother. It's allowed me to give back to a community that means so much to me. It's allowed me to pursue an education to keep giving back to this community. Without buprenorphine, I probably wouldn't be alive right now. And I probably wouldn't be able to do the things that I'm doing. And that's why this is so important to me, because it really does save lives. And it changes lives. And it allows us to keep going, to help others.

**DA:** So let's start with kind of an overview of opioid use disorder and its treatment. So first, let's start with the problem. Medications for opioid use disorder, or MOUD, are highly effective. And they're easy to use. But they're not available for many of our patients in need. Greater than half of rural counties in the United States, patients don't have access to MOUD. In a recent survey, 78 percent of primary care providers believed that buprenorphine was an effective treatment. But only 20 percent were interested in treating patients with OUD.

What are some of the barriers to offering MOUD? Well, they include belief that treating OUD is not a primary care issue, concerns about potential disruptive behaviors of patients with OUD in their waiting room, lack of adequate training, lack of clinical support, and lack of psychosocial services, or clinical supports for patients with OUD.

So let's take a moment to listen to some actual clinicians talk about their own personal hesitancy or reluctance to treat patients with OUD in their primary care practices.

**Blake Fagan, MD:** So prior to about 2011, I—I didn't even know buprenorphine existed. And if somebody would have asked me to write it, I was in that ballpark of, "Hey, you're just substituting one addiction for another. I'm really not going to do that."

**Audrey Provenzano, MD:** The idea of trying to learn some new medication that I wasn't comfortable with using or familiar with using, I didn't think I have the skills to be able to do it.

**Matthew Bair, MD:** One of my concerns was how I would incorporate it into the workflow of my—my typical, you know, practice. I had a notion that it was very complicated, and that it was going to, I don't know, be disruptive to my typical workflow.

**Annie Potter, NP:** I had this thought process that patients who were experiencing OUD would be ones that had protective behaviors that would be problematic for people in the waiting room, for other staff, and certainly myself. There was some apprehension that I didn't want, quote, "those people" in the waiting room, and having friction and confrontational visits in the middle of a very busy workday, where I was seeing up to 24 patients a day.

**Carlos Dostal, MD:** Initially, I would say that my personal concerns were really just rooted in stigma. My perception might have been that maybe I was going to be starting a practice where I was dealing exclusively with difficult patients. And, in fact, that's—that's been the furthest from truth.

**DA:** So now, let me present an overview of some national data from the National Survey on Drug Use and Health, looking at opioid use disorder and opioid overdoses. From that National Survey, it's estimated that 0.2 percent of US adults have a heroin use disorder. That's over 500,000 people. Whereas, 1.9 percent, or 5.3 million adults, had a prescription opioid use disorder. Percentages did not differ significantly among racial and ethnic groups.

What about opioid overdoses? Well, from 1999 to 2022, nearly 720,000 individuals in this country died from an opioid overdose. In 2022, 76 percent of opioid overdose deaths, or over 100,000, involved synthetic opioids. That is, illicitly manufactured fentanyl analogues. Since 2016, more than 2,000 Massachusetts residents die annually from opioid overdoses.

So let's talk a little bit about the neurobiology of why opioid addiction or opioid use disorder occurs. Well, we know that opioids that are used act on the reward pathway, which is the mid-

brain, involves the ventral tegmental area, and the nucleus accumbens. And it's a dopaminergic system. And the reward pathway is there for a reason. It rewards life-sustaining and species-sustaining activities. That is, when you eat, which is life-sustaining, it's triggered, and we feel reward, and we continue to eat throughout our lives to survive. The same thing with having sex. That is, species-sustaining.

Turns out, with drugs that are causing problems for patients, like opioids, it triggers that reward pathway three, four, five, even tenfold, what our natural triggers do. So that's why patients run into problems with opioids. It triggers the reward pathway. And I would say, if that's the end of the story, many of us would be using opioids to feel good. What's the problem with feeling good?

But the problem is, that that is not the end of the story, because we know that, over time, the receptors change in individuals who are using these medications or these substances chronically. There is a derangement of the endogenous opioid receptor system resulting in what's considered a hypo, or lower, dopaminergic state. And what we see clinically, our patients complain of malaise, fatigue, insomnia, poor tolerance of stress and pain, craving of opioids. And, when they see something that reminds them of that opioid use, it causes people to think about it and sometimes use again, or triggers. And when they do use once, it sometimes causes a priming effect, where they start to use over and over again, even though they had been in recovery.

So now I want to transition to thinking about treatment of opioid use disorders. But before I do that, I want to talk, just in general terms, about how do we assess treatment for addiction? Or, in this case, opioid use disorder? So let's first think about hypertension treatment. And if I ran a pharmaceutical company, and I created a medication, and I wanted to have you invest in it. And I said, "You know, it works. This medication works." And you say, "Prove it to me."

And I'd say, "Okay, fine. We'll take a group of people who have high blood pressure. I'll give them this new medication. And look, their blood pressure came down." And you would say, "Yeah, but maybe they started exercising, or dieting, because they knew they had a problem. Prove to me." And I said, "Fine. We'll take away the medication. And, lo and behold, their blood

pressure came up again." And you would say, "Okay, well maybe it is related to the medication." And we would say, that treatment works.

Now let's transition to, how do we think about addiction treatment? So we have a group of people who are actively addicted, using substances. We start treatment, and they get better. We take away the treatment, and they relapse. And you say, "That treatment didn't work. It's failure." And I would say, "No. The problem was, we took away the treatment. The treatment needs to continue, like with any other chronic disorder."

So let's move onto, well, how does this pan out in clinical care? Well opioid detoxification outcomes are poor. That is, people don't stay in treatment. There are high rates of relapse after detox. Less than 50 percent are abstinent at six months. Less than 15 percent are abstinent at 12 months, because of what I just told you. That is, this is a chronic problem. And people need to stay on treatment. And detox is the start of treatment. It is not treatment—treatment in and of itself.

The other problem with detox is, people, during detox, have lost their tolerance to the substance that they're using. And here a case, namely opioids. And when they relapse, they're at very high risk of overdosing, including overdose deaths. So what is the gold standard of treatment for opioid use disorders? It's pharmacotherapy. The goals of pharmacotherapy include suppressing, opioid withdrawal, creating something called mu opioid receptor blockade—that is, the medication sits on the receptor. And if somebody slips or relapses, they don't get that reward. They don't get that euphoric effect, because the medication is blocking that. So there's no reinforcement. It also blocks craving. That is, they don't have an urge to use. And we've known, from some imaging studies, that there is a normalization of the brain changes that have occurred, that cause that hypodopaminergic state.

So what medications are we talking about? Well, we've got a toolbox. We include naltrexone, which is a full antagonist, and two opioid agonist therapies, or OAT: methadone, a full opioid agonist, and buprenorphine, a partial opioid agonist.

So I'm just going to talk briefly about each one. And then you're going to start hearing about, how do you use these medications? And then, how do you set your practice up to use these medications in an effective way? So let's just talk a little bit about each medication. Naltrexone. I mentioned it's a pure opioid antagonist. And because it is, the patient needs to be completely opioid-free for seven to ten days beforehand. Because, if you give them naltrexone too early, you can cause the person to go into opioid withdrawal if they have opioids onboard. So this is already a bit challenging to get a patient in a state where they can abstain from an opioid for seven to ten days in an outpatient setting.

But if they're able to, or if they're coming from a detox, and they're already abstaining from the opioid, and you can start naltrexone right away, it comes in a different—a few different formulations. There is the oral naltrexone, which you would take daily. It's well tolerated. It's safe. Its duration of action is a day to two days. But, as you can imagine, there's poor retention in treatment, because people can just stop taking the naltrexone. They don't suffer any withdrawal. So people just stop taking it, unfortunately.

Well, one way to address that lack of adherence, or lack of retention, is to use injectable or long-acting naltrexone, which is a monthly injection. This injection needs to be done in the office setting. It's been shown to increase abstinence. But unfortunately, again, there's poor retention in treatment. That is, people don't show up necessarily for their second or third or fourth injection.

As I had mentioned before, after a detox, well the same thing with naltrexone, people have lost their tolerance to the opioids. And if they do relapse, there is a risk of overdose. Because they start to use the same amount of opioid that they used before. And they just don't have the tolerance.

Now I'm going to transition to methadone, the full opioid agonist, with a duration of action of 24 to 36 hours. How do you dose methadone? Well, it's dosed 20 to 50 milligrams on day one for acute withdrawal. And over time, many patients require milligrams of 80 or higher to prevent craving, and to achieve that opioid blockade. And we are seeing the need for higher doses in the

fentanyl era, where people are using fentanyl, which has a high affinity to the opioid receptor, and has a very long half life.

Keep in mind that methadone, for the treatment of OUD, is only available in licensed opioid treatment programs. You can absolutely use methadone on the inpatient service. And, as you'll hear later, there is the opportunity to dispense methadone in an emergency room, or in a bridge clinic, or some other outpatient setting, for 72 hours. But you'll hear more about that. But for the most part, methadone treatment is available in licensed opioid treatment programs, which are highly structured, and offer—actually require, initially, observed dosing. That is, every single day, the person needs to come in and be observed while they're taking their medication. However, over time, as people start to recover, and are in remission, they can achieve take-home doses, where they get bottles of methadone to take home, and take it not at the clinic.

The benefits and limitations of methadone. Well the benefits: increased treatment retention, decreased illicit opioid use, decreases of hepatitis and HIV seroconversion. We've seen improved psychosocial outcomes, improved birth outcomes in those that are pregnant, decreases both opioid-related and all cause mortality.

But there are limitations. As I had mentioned, that methadone, for the treatment of OUD, is only available in federally regulated treatment programs. There is limited access. It can be inconvenient and highly punitive. That is, if you're on take-homes, and then you relapse, you could lose your take-homes, even though you have a fulltime job. So it's, it can be challenging with some people. It mixes stable and unstable patients. Lack of privacy. Many times, people are waiting in line, and they could be waiting in line with people that they know and don't want them to know that they have an opioid use disorder. And, if you're really doing well on methadone, and you need to stay on it long-term, there's no ability to graduate from methadone treatment to, like, a primary care setting, unless you convert to a medication like buprenorphine. And, as you know, there's a lot of stigma associated with methadone treatment.

And then finally, buprenorphine, which is a mu opioid receptor partial agonist, has this ceiling effect property on sedation and respiratory depression. So it's safer, from an overdose

perspective. It also has this added benefit of being a kappa-opioid receptor antagonist. And what does that mean? It means it has some antidepressant and anxiolytic effects.

The formulations it comes in are sublingual tablets and film, with or without combined naloxone. But it can also be given weekly and monthly with subcutaneous injections. But again, these need to be administered by a healthcare provider. The good news is, you don't need a waiver anymore to prescribe buprenorphine. You could start prescribing it tomorrow. All you need is a DEA number, which many of you already have. And, there's no limits on the number of patients you can prescribe to. So that's an improvement as well. It's also a schedule three, as opposed to many of the opioids that we use, which means that patients can get up to five refills when they're stable in treatment.

The benefits of buprenorphine include treatment retention, decrease in illicit opioid use, again, decreases in hepatitis and HIV seroconversion, again, improved psychosocial outcomes, improved birth outcomes. And it, like methadone, also decreases both opioid-related and all-cause mortality. The additional benefit is that we can do this in primary care. Again, starting today, prescription refills can be done at community pharmacies, which is where they usually get their other medications as well. So it really normalizes the treatment of opioid use disorder.

I just want to talk very briefly about nonpharmacological treatment. Behavioral therapies, when delivered alone, have very limited efficacy, compared to medications alone. Turns out that psychosocial treatments, including individual or group counseling, can help some patients with OUD, but often need to be combined with medication. So, you know, the combination of medications plus behavioral treatments is really the way to go for many patients.

So before Hallie tells us about how to use these medications in practice, let's hear from some clinicians about their concerns about the complexities of these treatments.

**Rachel Kon, MD:** In the end, I don't think it's the buprenorphine that's complicated. I think it's our patients' lives that are complicated.

**MB:** I think there's a lot of similarities in treating patients with other chronic conditions, as there is with treating patients with OUD. I mean the necessity for—for continuity of care, and follow-up, and checking on—on symptoms, checking on how their response to therapy. And I think that's very similar between OUD and chronic diseases like hypertension, hyperlipidemia, and diabetes. You could say it's less complex. I mean, you could make that argument, I think. I mean, there's, you know, the complexity of sort of co-morbidities that are often involved might complicate treatment. But I've found it simple, and rewarding, and not nearly as complex as I expected it to be.

**Hallie Rozansky, MD:** Okay. So let's talk a little bit about how to put this into practice, in terms of patient care. So first off, let's talk about how to diagnose opioid use disorder. So diagnosing any substance use disorder relies on the use of the DSM-5. The DSM-5 has 11 criteria, which include tolerance, withdrawal, three criteria that look at loss of control over the substance, and then five criteria looking at continued use, despite negative consequences, as well as craving. Some people refer to this colloquially as the three C's, so craving, loss of control, and consequences. That's one way to remember it. But in general, to meet DSM criteria for substance use disorder, someone has to have at least two of these.

So how do you talk with a patient about what MOUD type might be right for them? I would say, first off, a lot of this is just conversation with the patient about what works best. As Dan mentioned, methadone can be much more restrictive. But it's also a full agonist, which means that, for some people, it can feel like a better fit. And we can go into that.

But, so I typically approach a discussion by looking at the patient's medical history first, just to think about, are there any contraindications that would make a medication not a good choice for them? So, for example, if someone has severe liver disease or QTc prolongation, methadone may not be a safe option. I talk with the patient about what has and hasn't worked, to think about whether there are dose adjustments, or whether a medication just wasn't a particularly good fit. And then, run through sort of pros and cons of different options.

So how does one start buprenorphine in a patient? So buprenorphine inductions used to be much simpler in the era of oxycodone use and heroin use. Illicitly manufactured fentanyl has been more complicated. And I'm going to walk through a couple ways that we can approach that.

So, because buprenorphine is a partial agonist that binds the mu opioid receptor more avidly than any other opioids, essentially, it displaces the rest of them, causing this very sudden and intense withdrawal phenomenon known as precipitated opioid withdrawal. This is the same thing that would happen if someone took naltrexone too soon, for example, as a full antagonist. It just boots the other opioids out of the system, and causes an acute withdrawal.

Illicitly manufactured fentanyl, what many of our patients are using these days, has fairly unpredictable pharmacokinetics. And so even when a patient notes subjective opioid withdrawal, so might be feeling sweats, anxiety, chills, restlessness, there may still be enough fentanyl in their body that buprenorphine can still cause withdrawal when they take the medication. And so, because of this, we think a lot more about time since last use when initiating buprenorphine, rather than just a patient's COW score, or clinical opioid withdrawal score.

Methadone, because it's a full opioid agonist, and has a lower binding affinity, does not cause precipitated opioid withdrawal, particularly because, when someone takes methadone, it just fully agonizes the receptor, as opposed to buprenorphine, which only gives that partial agonist effect.

So buprenorphine can still be started via traditional induction. But that would primarily be for patients who are using oxycodone or opioid pills with predictable pharmacokinetics. Just for what it's worth, many oxycodone pills that patients are taking actually are what are known as pressed pills. So they're actually made with fentanyl in them. And so, if folks tell me they're using oxycodone, I typically would still get a urine toxicology test, to make sure that they're not actually using fentanyl. If the person is very confident that it's oxycodone purchased, for example, from a friend or family member, and you know, they saw it in the bottle, you can also trust them that it really is oxycodone.

For folks taking non-fentanyl opioids, a traditional buprenorphine induction works, where you have the patient wait about six or 12 hours after their last use, and would also use the COW score, wait until it's greater than 12. And then the patient can take buprenorphine, sort of according to these instructions below. So taking two to four milligrams about every two hours, until symptoms are resolved. And there are multiple algorithms for this online. But it's pretty straightforward. You can reference the SAMHSA Guide if you're interested.

For folks using illicitly manufactured fentanyl, this is where it gets a little more complicated. And so low-dose buprenorphine inductions are one method that's become very popular to avoid precipitated opioid withdrawal. So the way that these work is a patient takes progressively increasing doses of buprenorphine, starting in a very low dose, overlapping with a full opioid agonist, to get up to a therapeutic dose of buprenorphine without causing that withdrawal.

And so the thinking behind this is that, when patients take these very, very low doses of buprenorphine, so 0.25 milligrams, 0.5 milligrams, it's still likely displacing some fentanyl from the receptor, but is doing so in such a small volume, that the patient doesn't really appreciably feel it. At the same time, because it's such a low dose of buprenorphine, it's not going to provide significant withdrawal relief for the patient, right. 0.25 milligrams isn't actually going to make the patient feel much better in that moment. And so, the patient has to continue using a full opioid agonist to mitigate those withdrawal symptoms.

So, in many cases, what this practically means, is that a patient is continuing to use fentanyl throughout this process, with a goal of trying to decrease their use as the buprenorphine dose gets higher. But that's just something we do acknowledge with patients, is that we understand that they likely will be using fentanyl during this early part, because we know the doses of buprenorphine we're giving them are not going to treat their withdrawal symptoms.

There are many different low dose inductions. This is just one example here. Some clinics are also doing these with a buprenorphine patch. So that's transdermal delivery of low dose buprenorphine. And again, this is a little dependent on just sort of individual clinic protocol,

insurance coverage. But that is another way to get very low dose, progressively increasing doses of buprenorphine, into a patient's body, while they sort of taper their other opioid.

Another approach to starting buprenorphine in the era of fentanyl is a high dose induction. And so the idea here is essentially taking the complete opposite approach of the low dose induction, and saying, "We are probably not going to be able to have somebody wait long enough from their last dose of fentanyl, that they're able to do a traditional induction." And low dose inductions can be challenging. They take multiple days. They sometimes rely on patients cutting the buprenorphine films on their own. You can see, I'm referencing the last slide, that the doses are low enough that they're require patients to actually cut the films.

And so, the approach here is folks say, "Okay, we're just going to give a really high dose, and try to fully saturate the new opioid receptor," to the point where the patient will experience withdrawal. But ideally, it is sort of rapid and fast. And then the buprenorphine displaces the fentanyl, such that the patient is feeling the effects of the buprenorphine instead, and is feeling better.

I would say some words of caution with this. So high dose inductions typically rely on doses about 16 to 24 milligrams, given as a single dose, sometimes up to 32 milligrams. There are some references here, if anyone is interested in looking into specific protocols. The caveat is that some of the published data on this do not show high rates of precipitated withdrawal. Others do show some precipitated withdrawal, which makes sense, right. You're giving someone a large dose of buprenorphine. So that can cause sudden precipitated opioid withdrawal.

And so, for folks who are trying this, I would recommend substantially counseling the patient about the risk of precipitated withdrawal. And often doing it, truthfully, in a bridge-type setting, where there may be other medications on hand, to mitigate these withdrawal symptoms if they occur. This is also a good method for the emergency department for that reason. So maybe less applicable to primary care. But we do want to mention it, because it's an important emerging area that may become more popular in the coming years.

In terms of high dose vs low dose, there is no conclusive evidence about which is better at this time.

So let's talk a little bit about the longer acting formulations of buprenorphine as well. So once somebody is on buprenorphine, they can stay on the sublingual films for, really, as long as they would like. There's no impetus to switch to a longer-acting form. But for some folks, the longer acting formulations are preferable, (a) because of ease of use. They just come into the clinic once a week, once a month, get their injection, can go back home, and not need to worry about taking films every day. And also, for some folks who may have some more instability around their opioid use, it may be easier to just get their injection and not need to worry, sort of, about that intentional choice, to take a buprenorphine film every day. And that intentional choice not to use, they know that they have buprenorphine in their body. If they get the long acting formulation, it can suppress cravings in a longer acting way, and also prevent against overdose.

And so, our long acting formulation options, there are two formulations. I'm going to use the brand names, because at this time, that's the best way to distinguish between them. So there's Brixadi, which comes in both weekly and monthly formulations. And then there's Sublocade, which is just a monthly formulation.

Sublocade has been around longer. And so for that reason, it may be easier to get insurance coverage for it. Brixadi is newer, and can be a little more challenging. Sublocade does leave a residual pellet. So the way it works, is it's essentially an injection that then forms a small pellet that dissolves over time, and releases buprenorphine slowly. Brixadi, on the other hand, does not have a pellet. So some patients prefer it for that reason.

And then, in terms of how do you actually get these medications into your clinic, if you go to the pharmaceutical websites, there are links for specialty pharmacies, where you can figure out where to order this, to how it would be picked up, et cetera. And then, in terms of initiation, ideally, someone would tolerate one equivalent dose of sublingual buprenorphine before starting. Some folks would start this without a sublingual lead-in. I think, again, just going back to what we talked about before, you'd want to make sure that a patient both can tolerate buprenorphine,

so that it wouldn't be too sedating. They've tolerated previous doses. And, that it won't put a patient into precipitative withdrawal. So a patient is far enough out from their last fentanyl use.

And I don't believe I said this explicitly before. In terms of how far out from fentanyl use is appropriate to start buprenorphine, it really varies by patient. I would say, at a minimum, 24 hours out from last fentanyl use. Realistically, we're seeing more like 48 to 72 hours is safer for avoiding precipitated opioid withdrawal. And then some patients, in truth, will still say they get precipitated withdrawal even five days out. So it's just very, very tough to know, patient to patient. And I would honestly encourage asking your patients, because a lot of them have tried to start buprenorphine before. And they have a sense of what is a good time for them.

Okay. So what about methadone? So as Dan mentioned earlier, methadone for opioid use disorder is only available at federally licensed opioid treatment programs. And so, you yourself cannot prescribe methadone in the office for the treatment of opioid use disorder. Methadone is a fabulous medication. It's a full opioid agonist. As Dan mentioned, it has really, really excellent outcomes. But it can be challenging to get.

So getting to a methadone clinic, the wait time, after someone sort of submits their name and requests an appointment, can still be 30 days or longer. Some data has also demonstrated that, because of where the clinics are located, travel time one way to a methadone clinic could be at least 45 minutes, and perhaps even longer, in more rural settings. So this may not be a good fit for everyone, because of this.

And we know that one of the tricky things about this is that patients who have same or next-day addiction medicine appointments are more likely to attend them, right. Patients may feel ready for change at a particular moment. And then, being told they have to wait a month to get into a clinic may be really, really tough for them. So these are just things to think about when you evaluate whether or not methadone is a good fit for your patient.

A couple other things to know about methadone. I think of my role with patients on methadone as basically coaching them around methadone-related expectations, and helping them figure out

how they can use their own internal resilience to succeed in that setting. So I remind them methadone clinics open and close on time. If folks show up even a couple minutes late, they likely cannot get dosed. So reminding patients to show up early and on time.

Clinics can do random urine toxicology testing. And so, if someone has an unexpected substance in their urine, that could be cause for a dose decrease or a dose—dose cut, as they're called. And then, if folks miss days or seem sedated, the dose is often typically decreased for that as well. And so, again, I just want patients to know this, so this doesn't feel like a surprise if this does happen.

I also counsel patients that, if they're doing well in the clinic, they will likely get take-homes over time, meaning they won't have to show up every day. And they could even show up once a month at some point. And then, just reminding patients that they have overcome a lot of challenges on their own already, and that they have the internal strength and resilience and the ability to succeed in this kind of setting.

So I'm going to briefly mention the 72-hour rule, which Dan alluded to earlier. This is a DEA exception that allows for methadone to be dosed at a setting other than a federally licensed OTP. So this is the rule by which emergency departments provide missed doses of methadone. So, if a patient shows up to an ER, and says, "I missed my dose. Can I get dosed today?" this is the rule that the—that the ERs operate under.

But it can also apply to non-emergency settings. So bridge clinics, for example, can also provide methadone under this rule. A couple things to know about this. So this DEA exception allows for dispensing and administering of methadone. It does not mean that you can prescribe methadone to somebody's outpatient CVS. So I would not recommend that. And it also, as the rule implies, is only good for up to 72 hours.

So some care settings are using this as essentially a bridge to get a patient into an OTP. So if a care setting, like a bridge clinic, establishes a relationship with local OTPs, and I would also advise working with the legal team, to make sure that everything checks out, they could start

dosing a patient in this bridge clinic setting, dose them for three days, and then directly link them to the OTP. And so talking about some of the challenges with getting into methadone clinics, and how the wait time can be up to a month, this can be one way to establish really strong partnerships and help patients get into methadone clinics a little more easily.

So what about naltrexone? So Dan mentioned this earlier. But because naltrexone is a full opioid antagonist, and has the risk of causing that same precipitated opioid withdrawal, folks need to be abstinent from opioids for at least seven days prior to starting this. The intramuscular formulation does not require an oral lead-in. So folks can go straight to the IM formulation if they're interested. But just practically, it's really hard for patients who are using opioids, and are experiencing withdrawal when they stop use, to remain opioid-free for seven days. So absolutely an option for some patients. For some patients, this is a really good fit. It's just practically more challenging to initiate.

One thing I do counsel folks about, though, is this loss of opioid tolerance. So if someone is interested in naltrexone, I just remind them that, if they do stop it, the oral formulation, or if they miss a dose of the IM formulation, that if they go back to using the same amount they were using previously, they are at higher risk of overdose. And so, if they are going to use again, I would counsel them to start with a very small amount, to assess their tolerance, before moving forward.

Okay. So how do you engage with your patients once they are on MOUD? I always talk with patients about relapse prevention. And I let patients know, relapse is often part of the process on the way to remission, on the way to recovery, right. We often don't succeed at something the first time we try. And that's okay. And just counseling them that relapses are an opportunity for learning, for growth, and for planning together for what the future is going to look like, and how we're going to troubleshoot for next time.

I talk with patients when I see them about cravings and withdrawal, and thinking about whether there are any dose adjustments we need to make to their medication, or whether there are other things we can do to support them. And talk a lot around potential triggers. So I like this mnemonic HALT, which is thinking about being hungry, angry, lonely, tired, or bored. And

thinking about when those feelings come up, what can patients do to troubleshoot, rather than turn back to what might be familiar, which might be a substance, to address these feelings? And also, thinking a little bit about queuing. Mutual support organizations like AA often say people, places, and things. So you may hear that lingo from your patients. But, so thinking with them about, if you come across a people—sorry, a person, a place, or a thing that feels triggering, how can we troubleshoot? How can we think about other healthy coping skills that are not reliant on a substance?

I talk with patients about overdose safety. And this is huge. So I make sure that I offer and recommend naloxone to all of my patients. And I always tell them, "Even if you don't plan to use again, this isn't for you, necessarily. You can't use naloxone on yourself. Carry this so you can save someone else's life." And I also do encourage them to coach people who are their loved ones, who are around them, whether that's a partner, a family member, a friend, to make sure that everyone knows how to use naloxone. So that, if there is a relapse, someone is able to save them.

I also talk with folks about overdose prevention hotlines. So Safe Spot is one such hotline. Where, if someone plans to use alone, they can call an operator, and have someone sit with them on the phone, and just do check-ins, to make sure that the patient is still breathing, and able to respond. And if not, the operator on the hotline will send out EMS to rescue the patient. And then, I also like to talk with my patients about using clean supplies and works, to prevent risk of infection.

And, so what about toxicology testing? So this has become more and more controversial over time. It used to be a very standard part of monitoring for all patients with SUD. More and more, now, it's still being recommended as part of a toolkit. But when an unexpected toxicology result arises, we are encouraged to talk with our patients about it, and partner with them around the result, and approach it from a point of curiosity, rather than as something punitive or catching them in something that they didn't share with us.

So managing a patient who relapses. So as I said, relapse is a very common part of the road to recovery. And so, I like to think about how I'm going to talk with the patient about it, if they do have a relapse. So just definitionally, lapse vs relapse. A lapse is what we think of when someone uses a substance maybe a handful of times, maybe once. But thinking back to our DSM-5, does not experience those negative consequences of use like loss of control, legal consequences, personal consequences, et cetera.

A relapse is really more of a return to uncontrolled use, where someone is then experiencing all of those negative consequences of their use again. I mentioned this. But I think of a relapse or a lapse as a learning opportunity for you and the patient. Talk with the patient about what the trigger was. Think about other ways to brainstorm for how you could potentially troubleshoot in the future, and how you can inform future planning.

It's also an opportunity to increase support for your patient. So thinking about untreated or under-treated psychiatric disease, and whether there are opportunities to bolster that. Thinking about behavioral therapies and peer support, like recovery coaching. And then, again, reviewing strategies for avoidance of cues.

If a patient is on MOUD, and they have a relapse, that may mean that you want to adjust the dose. It also could mean they started a new drug that's interacting with their MOUD. So making sure there's nothing that's changing the effect they're feeling. And then, if they're not on MOUD, this may be an opportunity to say, "Look. We tried this. I'm worried about you. Maybe it's a good time, now, to try MOUD, and just give this a whirl."

And then, just remembering always using motivational interviewing principles that we're really partnering with our patients around change and recovery.

Okay. So I'm now going to talk about a couple sub-populations just briefly, who we do see with OUD in our clinics. So the first is older adults. And so, how do we approach them? I would say, in general, very similarly to our younger adults, except for using the geriatric principle of start low and go slow. So for older adults, they do have physiologic changes, where they have

decreased metabolism of drugs and other substances. They may be on a number of different medications and experiencing polypharmacy, some of which may be sedating. And they also may have other co-morbidities, like liver disease, frailty, et cetera.

Because of all of this, buprenorphine may be a preferred medication, because it's a partial agonist, and it has that ceiling effect on respiratory and CNS depression. It's less sedating. It also has less QTc prolongation than methadone. And, for older adults who may have challenges traveling or mobilizing, it's easier, because they can take it at home, rather than traveling to an OTP.

That said, whatever MOUD is right for the patient is right for the patient. If the patient prefers methadone or naltrexone, those can be used as well. Again, just making sure with methadone, to start low and go slow.

What about adolescents and young adults? So this is a traditionally understudied population when it comes to MOUD. Buprenorphine is approved for youths who are greater than or equal to 16 years old. It can be used off-label in younger adolescents, but does not have approval for that. Methadone, on the other hand, is available for folks who are younger than 18 years old, but requires written consent of a parent, a legal guardian, or another responsible adult, which may be a very large barrier for some youths who are not sharing with their family or with their caretakers, about their substance use. And then, naltrexone is only approved for upwards of 18 years old. Similarly—Similarly to buprenorphine, it can be used off-label in younger patients.

For adolescents and young adults, buprenorphine is often preferred, just due to ease of administration. And, compared to naltrexone, due to the longer lasting overdose protection. But again, any of these are reasonable choices.

So, as I mentioned, MOUD is under-studied in adolescents. And it's also under-prescribed. So a study from 2023 noted that only one in four US facilities serving adolescents offered buprenorphine. And the average parent or caregiver would have to call nine facilities on the SAMHSA treatment locator, to find one that offered buprenorphine for their adolescent. A study

in 2017 also showed that, for adolescents, only 27 percent of those with OUD were on MOUD. And younger, female, Black, and Hispanic adolescents were less likely to receive medications for OUD.

And so, what about our pregnant patients with OUD? So opioid agonist therapy, which is either methadone or buprenorphine, are endorsed by ACOG as appropriate treatment for OUD during pregnancy. Either is a safe and appropriate option. One thing to note about buprenorphine, both the buprenorphine monoproduct and co-formulated buprenorphine naloxone, are safe and effective during pregnancy. Buprenorphine monoproduct is slightly preferred, just because, in general, we're minimizing medications in pregnancy that the pregnant patient does not need. And the naloxone is really co-formulated with the buprenorphine, just as a missed use deterrent, so that folks cannot inject or take the buprenorphine-naloxone other than sublingually. And so, in the case of pregnancy, just in an effort to minimize other medications, we would typically prefer the monoproduct. But again, either is safe and acceptable.

And so, just a reminder, that our folks who use opioids are often using other substances, other drugs as well. And so, while today we are focusing on talking about OUD, it's really important to ask your patients about other drugs they use, how they may use them in relationship to their opioids. Do they use them before, after, during? And thinking about treating those other substance use disorders as well.

Over 25 percent of folks with OUD also have at least two other substance use disorders. And over 90 percent of folks with OUD have used over two other substances within the past year. So this is very common. And then, I do just want to note, there's increasing co-use of stimulants. So thinking about cocaine and methamphetamines. And we have seen an increase in overdose deaths that are related to stimulant use with opioid use together. So this is really important to talk with your patients about, and counsel them around.

**DA:** Thanks Hallie. Along with polysubstance use being common, many of our patients also have other co-morbidities. And so let me address some of those and how you might manage them. And I'm going to focus on basically psychiatric co-morbidities, and OUD and pain.

In terms of psychiatric co-morbidities, they often precede opioid use and persist after abstinence. And these are kind of independent chronic conditions, compared to individuals who have no history of psychiatric illness, but it only presents itself when they're actively using substances. And that would be substance-induced psychiatric conditions that, when the person is in remission, those should get better.

We know that 38 percent of treatment-seeking patients with OUD have a current co-morbid psychiatric diagnosis. And usually, we're talking about major depression, anxiety, bipolar, and PTSD. We know that people with psychiatric co-morbidities often have worse treatment outcomes, when we're treating their OUD, such as higher risk for return to opioid use, non-adherence with pharmacotherapy, and just poorer psychosocial and physical health status, and lower quality of life.

So it is recommended that, whenever we see a patient with OUD, and consider them for treatment, that we also assess them for mental health issues, and treat them concurrently, or refer them to psychiatric care, if it's more complex than we can manage independently.

So moving on to pain. What about OUD and pain? Well first, it's important to recognize that, through experimental studies, it's been shown that patients with OUD have less pain tolerance than those match controls. Even when someone with OUD is on a medication like methadone or buprenorphine, they still seem to have less pain tolerance, or they're more sensitive to pain.

Also, it's important to remember that these individuals must be maintained on their methadone or buprenorphine, which is their daily equivalence, before they can achieve any analgesic effect of an additional opioid for their pain. And oftentimes, they need a higher opioid analgesic dose, due to that increased pain sensitivity. But also, due to some opioid cross-tolerance that may require dosing more frequently than you normally would.

It's important to recognize that the addition of an opioid analgesic for, let's say, acute pain, will absolutely not compromise recovery. And we know that untreated or under-treated pain can be a

trigger for use. Also, it's completely unlikely that someone who's on buprenorphine or methadone will actually get CNS or respiratory depression due to the cross-tolerance from their chronic opioid administration.

So moving on to methadone. What about methadone maintenance and pain? Well, we know that methadone's analgesic properties only last six to eight hours. And remember, that patients on methadone for their OUD are being dosed daily. So they're really not going to feel analgesia beyond the six to eight hours. And since methadone maintenance programs or OTPs only dose or dispense methadone once daily, patients may require additional short-acting opioid analgesics for pain if opioids are required to treat their severe pain. Obviously, we're going to be trying non-opioids first. But if an opioid is required, we'll need to add an additional short-acting opioid.

What about buprenorphine? Well, similar to methadone, buprenorphine confers analgesia for just six to eight hours. However, unlike methadone, which is being dispensed in an opioid treatment program, buprenorphine can be prescribed and taken multiple times a day, at home. Studies have demonstrated the efficacy of chronic pain management with buprenorphine that's comparable to other full opioid agonists.You can maximize the analgesic effect in both acute and chronic pain, by prescribing the same or higher dose of buprenorphine than someone who's already on buprenorphine, and maybe increase the frequency of dosing, if they have an acute pain issue. If other opioids are needed, you may need higher doses, due to cross-tolerance and the avidity of buprenorphine to the opioid receptor.

What about naltrexone and pain? Well remember that naltrexone is an opioid antagonist, has no analgesic effect at the doses that we're using to treat OUD. And that orally, naltrexone can last 72 hours. And the intramuscular long-acting naltrexone can last for 25 days. So if someone comes in with acute pain, and they require an opioid to treat that acute pain, we need to stop the naltrexone. And really, we should be considering non-opioids and regional anesthesia. Again, because of the opioid blocking effects of naltrexone, we may need to consult anesthesia. And we may need to use medications like ketamine as an opioid-sparing medication. And if opioids are needed, we really need to require high doses and close monitoring for respiratory depression.

So now, let's hear personal stories from providers about how they overcame their own hesitancies and got started incorporating the treatment of OUD into their practice.

**AP:** What changed my mind about all of it is that I was, you know, practicing primary care in my clinic. I saw a patient of mine who I'd been taking care of for, at that point, about two years, I think. In her chart, you know, it said opioid use disorder. But she was in recovery for many years, steady recovery, and being very honest, like had never come up. Until one day she asked me if I could prescribe buprenorphine for her. I didn't really know how to use the medication. I referred her to my colleague in the clinic, who did the OBOT clinic. But she left that day without a prescription.

Sometime later, she died of an overdose. And so for me, it was just a very horrible experience, to be in a position where I had this opportunity to treat a patient with a very safe, very effective medication. And I didn't.

**BF:** I had a patient of mine who, at the time, had a six and an eight year old. And she rolled into the ER dead from an overdose. And it just changed my life, changed my professional life. I remember talking to the ER doc and saying, "What happened?" And he looked at me and said, "Well, duh, we're in an opioid crisis. Where have you been?" And I don't know where I had been. But from that, I read a lot about buprenorphine, and then I really came to that conclusion that, yes, we need to help stabilize people's brains, so that they can do life. And I—I think that—that experience moved me on the continuum of change and wanting to be someone that was not only writing buprenorphine for patients, but teaching others.

**RK:** My early experiences prescribing buprenorphine was actually a patient of one of my residents, who came in, who had been using fentanyl. In the past, he had had a brief inpatient rehab, where they had put him on buprenorphine. And then, actually, came down very quickly on it, and sent him out on nothing. And he did well for a few months, and then relapsed. And he came to us soon after the relapse for help. We had this very wonderful conversation about keeping him safe. And he was very, you know, grateful that we were able to offer the buprenorphine in the primary care clinic on the day he came in for help. And then, he is—I got to

see him in follow-up several times, where he actually used the phrase, “I feel like I have my life back. I was able to sit with my five and six year old daughter, and watch a whole movie without having withdrawal symptoms. And I haven't done that in several years.”

**AP:** One person particularly comes to mind, is a woman I was treating for hepatitis C. and she had been in recovery for about 15 to 20 years, and still did not feel deserved or worthy of evidence-based treatment. And I could only think how she must come down and beat herself up about other things in life. And so, with that, it opened up an opportunity to talk about some of the hesitations that she had, the thoughts of self-stigma and shame that she carried with her. And that really changed my mind of, I could see where she was coming from. And I thought, if this is some people that we don’t see from the public health messaging of stigma and shame, then we’re missing so many people who are really deserving of treatment for their OUD.

**MB:** Listening to colleagues that were treating the OUD in primary care, and—and their positive stories and anecdotes, that was helpful. And then, I finally just overcame some inertia and said, “I need to go for it and try this, and gain some experience.” And so, once I did that, that was actually the most helpful, to just—just to actually try it, and incorporate it in my practice, and see—see how it went.

**DA:** So we’ve talked a lot about what these medications are, and how you would prescribe them. But I think it’s time, now, to shift. And Kristin, can you talk to us about how a practice could incorporate this into their workflow?

I would love to. And so, as we’ve discussed, medications for opioid use disorder can be started in primary care settings. There are many models for delivery of MOUD in primary care. Successful models typically include four components. So that would be the medication, the provider and the care team, integration of OUD alongside other medical needs, as well as psychosocial services.

We've talked a lot about the pharmacotherapy. Over the next few slides, I’m going to be talking about the provider and the care team, how to integrate this work alongside your other primary care needs that you’re providing to patients, as well as those psychosocial services.

Surveys have shown that a majority of patients would feel comfortable receiving MOUD in a primary care setting, which makes sense. Primary cares are convenient. Patients are going frequently. It's a non-stigmatizing healthcare touchpoint. And yet, we know that millions of Americans have an opioid use disorder in the US. And there are only several thousand prescribers who are addiction specialists. And so, we really do need primary care providers to step into this role, to help combat the epidemic that we are experiencing.

As you are doing this work, and setting up your program, it's important to think, like, who is going to be on the team with you? Because, just like primary care, you could be a prescriber doing all of the work on your own. But certainly, you are going to have a better experience, and your patients are going to have better outcomes, if you have a care team. Addiction treatment, in many ways, is a team sport.

And so, when we look at the prescriber, this must be a person who is a licensed physician or advanced practice provider, such as a nurse practitioner, physician assistant, clinical nurse specialist, certified registered nurse anesthetist, or a certified nurse midwife. Prescribers, in addition to writing the prescriptions for the medications, they are establishing a diagnosis of the substance use disorder. They're creating and implementing treatment plans, often in collaboration with additional care team members. And they are coordinating care with external providers when there's specialty care that's needed.

For instance, you may have a patient who's going to be needing a surgery. You want to be able to reach out to the surgical teams to make sure that there's not an inappropriate lapse in the patient's MOUD.

Another person that you may have on your care team, or another role that you may have, is a nurse or nurse care manager. Nurses, working at their full scope of their license in office-based addiction treatment programs, are really able to care for patients across the spectrum from their other substance use disorder, from active use through long-term recovery. Nurses are able to do initial assessments, which can include like an intake visit, in which nurses are providing

education about the person's opioid use disorder. They could be providing education about the medication, talking about how your clinical program works, laying out the expectations for what the clinic expects from the patient, but also what the patient can expect from your care team.

After the prescription is written, nurses can also partner with the prescriber and the patient to support that initiation process, helping patients get through that time, where they would have to do that expected spontaneous withdrawal, maybe talking with the patients about how to assess withdrawal symptoms, using a COW scale, maybe supporting medications to help mitigate some of those withdrawal symptoms, so that the patient can successfully start medication. And then, during the stabilization phase, nurses can also help make recommendations about dose adjustments, again, alongside the prescriber.

The maintenance phase of treatment, as somebody who was a nurse in the OBAT program, this was one of my favorite phases of treatment to treat patients with, because you really got to enjoy that longitudinal relationship with patients, and have almost like a recovery check-up, where you'd be saying, "Are you feeling safe and supported in your recovery? Are there any threats to your recovery?" And then, really working together to ensure that we're addressing those issues as they arise.

Nurses are trained in chronic disease management and clinical case management. They're able to provide more close follow-up, and to address acute medical needs as they arise. Again, these are patients that we will be following long-term, ideally. And so patients, you know, they can experience pregnancies. There can be urgent care issues that arise. They might have pain, or maybe they're developing hypertension. You can really—This really helps make it so that we're integrating the addiction care alongside that other primary care. And patients get that extra education and support.

Nurses are also able to address lab results. They can provide brief counseling and motivational interviewing, to help identify those patients' goals for recovery. And then, develop strategies to keep them motivated, and working towards those goals. Because recovery can be tough. They can provide logistic support, like prescriptions, help with prior authorizations, working with

pharmacies. And really helping with insurance, too, if there's any sort of barriers and lapses that happen with insurance.

I was a nurse within the Massachusetts Model, which is a model of care that really empowers nurses to take on a pretty autonomous role, in which you're able to serve as a primary point of contact for the patient. As a nurse practitioner, doing primary care for persons with opioid use disorder, I also really liked this model, because I had a large caseload of patients, many of which who had an opioid use disorder, and were on buprenorphine or naltrexone. And I could really have—Really, I was able to rely on the nurses to help with those close follow-ups. And actually, our patients had a direct line to our nurses. So, if there were any prescription issues, or acute issues that were arising, the patients could call and go straight to our nurse, rather than getting triaged through the—the typical primary care process.

If you want to learn more about the Massachusetts model, and have access to clinical care or collaborative guidelines, please do visit the Grayken Center for Addiction Training and Technical Assistance team at Boston Medical. They have a number of resources here that can help you in implementing such a model of care.

You will also have folks at your practice who might become clinical champions, who could be medical assistants, or a pharmacist. Medical assistants can provide administrative support, like tracking data, observing work—workflows, helping with phone calls, and filing forms. They can also provide clinical support, like completion of vital signs or specimen collection. They can help with screening questionnaires that you may have in your practice.

Even if you don't have a pharmacist on your onsite team, I do recommend that, if you have a pharmacy in your area, where you know that a lot of your patients will be filling their buprenorphine prescriptions, it's nice to build a relationship with them. So that way, you can, in a more expedited fashion, assist with any sort of like symptom management, prior auth issues. You can help optimize medications by working together and provide that patient education, that sometimes needs to happen outside the clinic setting as well. And many states do have the ability

to engage in a collaborative practice with a clinical pharmacy, or a clinical pharmacist. But please know that clinical pharmacists do not diagnose.

Peers and navigators are also potential care team members, not someone that you necessarily must have on your team, but certainly can help support the work and the patients. A care coordinator or a support navigator is someone who can assist with those concrete services and supports to address social determinants of health. So maybe the patient needs help with transportation to the clinic, or they need help with an insurance update, or maybe a housing application. These persons should have knowledge of their organization and healthcare system, as well as community resources. And they can really be huge assets in scheduling and coordinating care in a way that works for the patient and the care team.

I want to talk a little bit, too, about peer support specialists, or recovery specialists, or recovery coaches. This is a relatively new role in the workforce. And who these are, are really people who have lived experience that are helping to guide patients through recovery. And they're doing that through offering hope, optimism, encouragement, and emphasizing the patient's voice. We need to recognize that this is—is really like a marginalized group of people that are caring for another marginalized group of people, and navigating a really complex healthcare system at times.

And so, as with, really, all members of our care team, we want to be offering support and opportunities for professional development. But I think, even more so with peers, who are so willing to share their expertise and their experience, we really do need to recognize the high risk nature of the role, and make sure that our—our colleagues are not just doing their job well, but they're well at doing their job. And certification for a recovery coach really does vary state to state.

Looking at the psychosocial supports of your program, you may have mental health specialists on site. Or these may be folks in your community that you can partner with, to help ensure that your patients are getting talk therapy, or group therapy, to help support their recovery process and build insight into their addiction. These may include alcohol or drug counselors, which really vary quite a bit state to state, with their role sort of defining. Their licensures and certifications

do vary quite a bit. But essentially, what these folks do, is they're assessing clinical needs, and creating individualized treatment plans, and doing a lot of service coordination for patients.

You may have access to a social worker or a mental health counselor on your team. And these are folks who can do assessments using validated screening tools and psychotherapy. They can provide case management, connecting people with community resources and supports. And they can provide follow-up services to help ensure success with a treatment plan.

And finally, you may have a psychologist, which is a person with a graduate degree, who would really do a lot of higher level psychotherapy, with an emphasis on cognitive, emotional, social behaviors. And they may have specific trainings in things like cognitive behavioral therapy, or DBT, or group sessions.

And we can't forget our support staff. Really, we must just keep in mind that everyone who is patient-facing, in some way, is a member of our care team and can really influence the patient's ability to engage in care or remain engaged in care. A substance use disorder is such a stigmatizing condition, and patients really can internalize that. And so we want to have staff that is welcoming and making patients feel safe in our space.

Our front desk staff is often the first point of contact. They are vital for patient engagement. And it's helpful if they understand workflows of the department. Public safety and security may also be the first person that a patient encounters. Really, we want to make sure that we're collaborating with public safety and security to decrease any negative encounters, and to actually encourage engagement. These folks can be an asset or a barrier to care. Many of our patients may have some adverse experiences with the criminal legal system. And so, this can really be very healing for folks, if we can get these folks to partner with our patients.

Now looking at accessing care, we want to reduce as many barriers to care as possible. The data shows that if we have programs that can be flexible and innovative, and using these collaborative care models, we are really able to meet patients on the full spectrum of their substance use

disorder, from active use through long term recovery. This really does improve engagement and care and helps with retention.

**DA:** So now let's hear from providers about how they brought their teams onboard, and how they've incorporated team-based care in treating OUD in their primary care practices.

**RK:** There is actually a lot of reluctance in my practice. I think, in primary care specifically, I work in a very, very large safety net clinic. And the feeling that we already are trying to do so many things for our patients, we only have finite resources. And at my—the other faculty in my clinic honestly felt like it was just not something we could take on. And so it took a lot of me convincing them that it actually wasn't as complex as they thought.

One fascinating thing I found was how many of my colleagues felt, "Oh, we don't actually have that many patients with opioid use disorder in our practice." And I was like, "I promise you, I think we have enough that this will be used." And it has been utilized quite frequently. So they are all realizing that patients don't come out and say, "This is what I need," when they don't think that there's an option for treatment there.

**BF:** And from the day I said to my administration, "Hey, I think we should write this medicine," it took us 18 months to write the first prescription. I found out we have a risk department here, and that people were really worried. Things I heard were like, "Hey, people are going to be throwing up in the waiting room. What are we going to do with all the needles in the parking lot?" And so I had to have a lot of meetings with people and say, like, "Hey, these are already our patients. They—They just haven't disclosed they have a use disorder yet. And when they do, we should be ready to take care of this chronic disease. Hey, we're good at taking care of chronic diseases like diabetes, COPD, asthma. And we can take care of this one as well."

**AP:** I was also getting pushback from some support staff and some administration, and saying, "We just can't handle that kind of complexity in our patient cases. I don't know how we would find time to open up your practice so that you could see people with substance use disorders."

And so there was some pushback. And I just thought, you know, we wouldn't say this about somebody who is coming in post-stroke, saying, "It's just going to take a little longer. So I don't think we should open up your practice to seeing people who are afflicted by that."

**BF:** What we learned, and then what we've been teaching to other clinics as well, is that you have to have a guiding coalition. And who are those people? Well, if you have a clinical pharmacist, it's super helpful. If you're in a residency program, having a resident that is a lead on this, is going to be very helpful as well. But you also have to have someone from the clinical staff that's onboard with this. So we—we got our—our RN clinical lead, and we—we made this guiding coalition of folks that wanted to do this. And that group is still together to this day, more than ten years later. We meet once a month to talk about how things are going.

**Kristin Wason, NP:** So those practice-based barriers that you just heard are not at all uncommon. And so, let's talk through these a little bit. We can sort of define barriers to care as either organizational or as patient level. When we look at organizational barriers to care, we need to be thinking, what is the access like to our addiction care team members? Like how full are these schedules? It doesn't help if you have one person or 27 people on your team, if everyone is booking three months out in advance.

So, what would happen in my practice is that we would often have spots that would be essentially frozen, meaning that no one could book into them within about 24 to 48 hours, and then those appointments would thaw. And so, it became about the day before my clinic, we could have patients that then could be accommodated for a walk-in or more urgent care visits. So that's one thing that you might want to be able to think about, in terms of, like, access.

Also think about like the hours that you're available to patients. Are you available only during normal business hours? Or is there any way you can expand the time that you could be able to interact with patients? And do you have an on-call provider for after-hours care, so that any emergencies arise at, like, a pharmacy, for instance, with a patient unable to fill their prescription?

Organizational policies are important, too. Like, can patients be seen if they arrive late? How will you be contacted if a patient calls in crisis? That was part of the reason why I did love that our patients had direct line access to our nurses in our OBAT program. It really helped put out a lot of those fires that can happen at times.

When we look at patient level barriers to care, really, a lot of patients might have limited insight into their own substance use disorder, which is why screening is so helpful. There can be a lack of knowledge about treatment availability and structure. There still is a lot of misinformation and even stigma about addiction treatment. I've had patients say, "You know, I'm using illicit substances, but I can't go away to detox." And it's like, "Well, well, we could actually treat you for your opioid use disorder right here in this clinic right now." And that can be really eye-opening and reassuring to a lot of patients.

There can be privacy concerns, which is part of the reason why primary care is such the perfect place to do this work. It can be a very discreet setting. Patients don't know why another person's in my office. It could be due to hypertensive treatment, or it could be due to get treatment for their opioid use disorder.

And then finally, social determinants of health are both risk factors for developing a substance use disorder, as well as barriers to engaging and care for that substance use disorder. And so, that's why being able to help with things like transportation, and really, that whole Maslow's hierarchy of, like, shelter, food, that can make a big difference. Because then someone is able to take less focus off of those immediate stressors, and then be able to care for their—their self and their recovery.

One way to reduce a barrier to care is by implementing visits that can be done through telemedicine. During the COVID pandemic, SAMHSA did permit buprenorphine initiation via telemed. You can do this through audio only, so it doesn't even need to be like—like a visual. That has—That permission has continued to this day, which is excellent, because we do know that significantly more individuals received opioid use disorder-related telehealth services after

the start of the pandemic. And that increase in telehealth services has really shown to increase the odds of MOUD retention, improved treatment access, and rejection of barriers to care.

Another way to help reduce a barrier to care is to help identify and partner with a bridge clinic. So these are low barrier transitional SUD care settings that offer urgent care appointments. Patients can typically be seen on, like, a walk-in or a same day, or even next day basis. There are multiple models for bridge clinics. You might have a model that is within an outpatient hospital-based, or an emergency department-based, or a virtual setting.

What these programs really do is offer low barrier MOUD often alongside harm reduction services. For initiation methods, like with low dose buprenorphine, a lot of times, people are continuing to use fentanyl, and so it's much better—the patient's going to continue to use fentanyl, that they have harm reduction supplies, and naloxone, and safer use equipment. Many bridge clinics have also recently leveraged that 72-hour rule to provide short term methadone, while connecting patients to an OTP.

Acute care settings can also provide reachable moments for starting MOUD. We really do want to be able to have more touchpoints with patients. Anywhere they enter our hospital or health care system, they really should be able to identify someone that can help connect them to evidence-based care. Engaging patients wherever and however they present has positive outcomes.

In emergency departments, there are many programs that do ED-initiated buprenorphine. That has been shown to increase engagement for opioid use disorder treatment, and reduces self-reported opioid use. Short course prescriptions are typically offered, maybe for one, two, or three days in their EDs. And this—And then, after having that short prescription, patients are then able to help receive assistance with transitioning to an office-based addiction treatment setting for ongoing care.

You may also have patients that begin their MOUD within an inpatient setting, like within their hospital admission. What has been shown, that regardless of the reason why patients are admitted

to the hospital, they're not always going in to get treatment for their substance use disorder, certainly. But what we see in the data, is that really, when patients are initiated on MOUD during that inpatient setting, we see improvements in engagement, again, less self-reported opioid use. So patients are using less. And they also have reductions in their length of stay, readmissions, and self-directed discharges.

Once patients start on the medication, engagement is key. We want to keep patients coming back. I know that our clinics are a safe space. I often, when I'm meeting patients, I say, "I love to see you on a good day. I want to be able to see you on a bad day as well." And really make sure patients know that—that you care about them. It sounds like an arbitrary or silly thing at times, I know. But this work is so rewarding, and patients really do open up with you, if they feel like you care about them, you can help them and you're not going to judge them. So build that rapport. It's essential. Get to know your patients. That's what also makes this work so rewarding.

And we always have our goals and our agenda when we're meeting with patients. But just recognize that, like, a history collection can be done over time. We don't need to have these hour-long intakes, where someone is coming in, having recently used a substance, or getting into more progressive withdrawal during our visit. So really, during those first visits, prioritize that data collection. Focus on recent news. What are we most concerned about, in terms of like causing precipitated withdrawal or spontaneous withdrawal those first few days in recovery?

If you can engage your patient and keep them coming back, you will have time to learn more about them and implement more components of the treatment plan. Ask permission, and choose your words thoughtfully. We want to make sure that we're using language that is non-judgmental, and person-first, and not stigmatizing. There's a QR code here for the Words Matter Pledge. I encourage you to scan that and take a look at those words that can be helpful in supporting a therapeutic relationship.

When we're talking to patients, too, we want to make sure that we're assessing those safety risks, and using a standardized assessment for overdose and HIV. And make sure patients know that we're asking these sensitive questions not to punish them, but so that way, we can implement

therapeutic interventions. And be sure to explain that rationale when you are asking. And again, we don't need to always ask about, like, inter-partner violence on that very first visit. I don't even know you yet and you don't know me. But maybe early in treatment, or as we start to build a rapport and trust, we can then sort of talk about intimate—intimate partner violence, transactional sex, criminal justice involvement, which can help inform our interventions and decrease further risks.

Also, be sure to assess protective factors. Our patients do have a lot going for them, too. So what are those strengths? Who are those support persons? What is your longest time in recovery? And really emphasize those successes. Sometimes, when I ask about their recovery time, I have patients that will say, "My longest time in recovery is three years." And I'll say, "That's amazing. What were you doing during that time? Let's try to replicate some of that."

Sometimes they'll say, "I've had three days." And I'll say, "That's amazing. What were you doing in that time? Let's try to figure out how we can build on that." And really trying to like, build people up. They're often told so often what they're doing wrong. We want to show them what they're doing right.

And be aware of power dynamics, and recognize that adversity. We are in a position of power over our patients. We're controlling their medication and their treatments, which can influence their recovery and quality of life. And so we really do want to make sure our patients know that we are here to support them. That is how you're going to build that relationship.

Integration of addiction care can include many things. We're not just prescribing medications, right. During those initial phases, patients may also benefit from withdrawal management. So maybe your stomach is a really problematic withdrawal symptom for you. Maybe I can prescribe a medication like dicyclomine to support you during those initial phases of treatment.
We can provide support and treatment for co-occurring substance use disorders, behavioral health conditions. We can implement peer support. We can talk to patients about safer use, education, and supplies, as well as overdose prevention and access to naloxone.

And really, we can provide a lot of preventative and proactive treatment as well, such as HIV prevention, family planning services, sexually transmitted infection screening, cancer screenings, immunizations. These are really all practical components of primary care that can really benefit all of our patients.

Also, wound care, particularly for patients who inject substances. Something I like to ask patients is, you know, "Is there anywhere that you inject, that you're concerned about, or you want me to take a look at?" that can sort of be less—less stigmatizing way to ask patients about if they're having any abscesses or skin and soft tissue infections. And really, we should be working to mitigate stigma.

When we're addressing use of other substances, just remember that buprenorphine and methadone are only FDA approved to treat opioid use disorder. Naltrexone is FDA approved to treat both alcohol and opioid use disorder. But our patients might be using other substances, like cocaine, or methamphetamine, or benzodiazepines. And so just remember, is it safer for my patient to be using buprenorphine or cocaine, or fentanyl and cocaine?

And so really, we want to try to keep patients engaged in treatment and on the medication that's working to treat their opioid use disorder. If patient is using other substances, we can still adjust our treatment plan. We can offer more intensive follow-up plans, with an increased frequency of visits, shorter duration prescriptions. Maybe we can do a handoff to other care members, like our psychosocial colleagues, or a peer recovery specialist.

And just recall, too, I think a lot of times, when patients are struggling, we used to always say they needed this higher level of care. But sometimes, what they really need is just like another level of care. Not all of our patients' goals are to stop using illicit substances forever. And so for these folks, they might actually benefit from like a harm reduction program connection.

If a person is using stimulants, know that contingency management is really seen as the gold standard of care. And in many ways, these are things that we can implement within our primary care practice as well.

And there is a full spectrum of recovery in resources, from a detox like clinical stabilization, recovery, sort of residences, like a halfway house or sober living facility. We're providing outpatient care. But there's also intensive outpatient programming that's done in a lot of different communities, which can include things like counseling visits, where patients are going nearly daily for those first two to four weeks. Sometimes that's something that patients, say, can like jumpstart their recovery.

So when you're meeting with patients and doing this work, you don't need to have a huge Rolodex right at the beginning of places to go. But as you're talking with patients, and you hear about a great program, make a note of that, you know, and identify those resources in your community. Reach out to better partner with those people in organizations. And that's really how you're going to build relationships and have more folks on your care team, even if they're not under your roof.

**DA:** So now I'd like to apply what we've talked about to a common scenario. So the title of this case is, "This treatment isn't working I want to get off." And the case I'm presenting is a 26 year old female with a history of severe OUD and asthma. Her OUD history began when she was 18, with oxycodone and intranasal heroin, and later followed by injection use of her heroin, and fentanyl.

She's had two prior overdoses, reversed with naloxone, five detoxes, two residential treatment program stays. And she began buprenorphine, the combination buprenorphine-naloxone, 16 milligrams, three months ago. Hepatitis C positive. She was treated. Has minimal liver fibrosis and HIV negative. Her recent urine drug tests, however, have been consistent with intermittent fentanyl use.

She works full time in a hardware store, lives with her long-term boyfriend, who also has a history of opioid. Is in remission, and goes to NA meetings. Is not on any medication. And she's now presenting, demanding to be taken off buprenorphine, because, quote unquote, "It isn't working." And she's tired of all the clinic rules, including urine drug testing.

So the question is, how would you manage this patient who's asking to come off MOUD, even though there's still evidence of continued substance use?

**KW:** I'll start.

**DA:** Okay.

**KW:** I would say, the first question that I would ask her is, "What do you mean by the treatment isn't working? Do you mean that you're still having ongoing cravings, and that when you use fentanyl, that you are experiencing the effects of those opioids. And that's reinforcing. And therefore, maybe we need a dose adjustment, or some other adjustment to the treatment plan? Or do you mean that it's all the rules and regulations of the clinic that are maybe interfering with your life, and maybe getting to work? You know, what do we need to adjust to make the treatment plan work for you?"

**HR:** Yeah. I think I would want to understand what she is looking for with treatment. Which gets a little bit to what Kristin said about, "Why isn't this working?" but what are her goals? Are her goals to be able to go to work safely, and not need to use while she's at work?
Is she looking for total abstinence? Just sort of what would a good treatment look like to her, so that I can understand the direction that we're trying to head in.

**DA:** Yeah. So I think you both have addressed kind of internal motivation, internal influences. And I wonder about the external influences too. Sometimes somebody's significant other could have misconceptions about the role of medications. And I feel like, you know, her boyfriend, who is in recovery, but is in recovery without medications, might also be playing a role in her wanting to get off medication. So I think sometimes exploring those issues as well.

**HR:** I think one thing I'll just point out that I love about this case, is that she's coming to you saying, "I want to get off this." If she was completely disengaged with care, she could have just stopped the buprenorphine and left. And she's coming to you to ask for help with this. And so

there's a real opportunity here to partner and work with her, even if she'' not exactly happy with the treatment she's getting right now.

**DA:** Yeah. So in my experience, and I'm sure in yours too, this is a common scenario, especially the piece about, "I can't deal with all the rules and all the monitoring and stuff."
So how do you guys deal with that aspect of it all?

**KW:** Yeah, I mean, I think we do need to look at how—how we are building our treatment programs, too. You know, this is a young woman who's working, who is starting her life out. She has a partner. She has other priorities. And so we want to make sure that treatment should always help someone function better. We don't want to be a barrier to her moving forward in her life.

So I think we really do need to look at our programs too. You know, what are—Can we sort of adjust her visit frequency to make this work for her? Are there other ways we can keep her safe? Maybe we could do some telemedicine visits to reduce the burden of coming into the clinic all the time. And so, you know, really trying to partner with her, to build a treatment plan that's going to work for her, and not one that's just sort of like the provider focus.

**DA:** Yeah. I'm glad you mentioned safety, because she's still using intermittently. And I want to make sure that she and her boyfriend have naloxone, in case something happens, like an overdose. I'm just wondering. So, say, even with the education, we figure out she just is not willing or interested in continuing this form of treatment. Is there anything else that you would recommend?

**HR:** I mean, I would talk with her about whether something like methadone or naltrexone might be a better option for her. I would be somewhat worried about naltrexone and the overdose risk, given that she's still using, as we discussed. Methadone will have more rigidity than buprenorphine, which may not be helpful if she's really struggling with frequency of tox testing and things like that.

But some patients also just prefer methadone. It just feels like it helps with their cravings, with their withdrawal, better than buprenorphine, as a partial agonist does. So I would ask her about that. And if she's not—if she's genuinely not interested in any MOUD at this time, I think, Dan, like you said, focusing a lot on safety, harm reduction, safe supplies, test strips if—if able to get them, and then thinking about really bolstering non-pharmacological therapy. So psychiatric support, peer recovery coaching, things like that, to make sure that she's still engaged and knows that we're supporting her, whatever her choice is.

**KW:** One other thing I would mention, too, is that maybe another form of buprenorphine might be a good fit. So she might be a good candidate for a subcutaneous or the long-acting injectable formulation of the medication, that would offer her overdose prevention, and might help stabilize and reduce some of her cravings and withdrawal that she may be experiencing, and really improve her quality of life by not needing to remember to take her medication every day. Maybe she's feeling like she needs to take it to work to administer it, because she's working long hours. So injectable formulation might be a good fit too.

**DA:** Right. So let me tell you what happened. So when I talked to her, her—her boyfriend was actually very supportive. And that wasn't the issue. The issue was, she was still craving. And when she would use, she would still feel the effects. And she was on 16 milligrams, and we ended up boosting up her dose to 24, and she felt much better. And she's been consistently doing well since that time. So I think, you know, all the things that were mentioned are ways that we should approach a patient like this. But sometimes it's not overly complicated, once you take the history and figure out why she's still using.

Great. So I'd like to present a second case, another case that's common in my practice. And the title of this case is, "I'm not using cocaine. The test must be wrong." And so this is a 47 year old male with a history of severe OUD, in long term remission. Has hypertension and hyperlipidemia. And his OUD history, started using oxycodone at age 22, followed by intranasal heroin use. Never injected drugs. Has been in long term remission on buprenorphine, initially sublingual, and now he's on monthly injections. Hepatitis C and HIV negative.

However, his recent urine drug test surprised you, not because it was positive buprenorphine, but because it was positive also for cocaine. He initially did not disclose his cocaine use. But when asked about it, he confirmed that, yes, he uses cocaine occasionally with friends, but doesn't think it's a problem.

He works full time as a city building inspector, and lives with his wife and three young children. So the question is, how would you manage this patient who has this unexpected urine result, namely cocaine positive, and someone who is doing very, very well on buprenorphine for their OUD? Hallie, why don't we start with you?

**HR:** Sure. So when I get unexpected urine toxicology results, (a) I want to make sure it is a valid, appropriate test. Cocaine positive is typically a true positive. And then, I just ask the patient what's going on. So I typically would say, "Hey, I saw this result. This was unexpected. Was this unexpected to you as well? Or what do you think about this?" And, more often than not, the patient then discloses they're using cocaine.

And then in terms of counseling around that, I think one of my—my big questions and thoughts around stimulants is just thinking about safety. So, so many stimulants in our drug supply have fentanyl in them, have other substances in them. So really, counseling a patient about ways to test their supply, getting fentanyl test strips, namely, sometimes Xylazine test strips as well, to make sure they actually know what they're using.

And then sometimes, folks are not aware of health risks associated with even intermittent use of other substances. And so asking their permission to share a little bit, and then talking with them a little bit about my concerns, from a health and safety standpoint, non-judgmentally about their use of the substance.

**DA:** Yeah. Kristin, what do you think?

**KW:** Yeah, I agree with everything that was just said. And I would just add, too, that I know that some folks might be thinking, "This is a patient that didn't endorse use right away.

They sort of were caught, and then they fessed up to it." But I would just really want us to recognize that being in long term recovery is a big part of who someone is, that people are appropriately very proud of that. And a return to use can be devastating in a lot of ways. There's a lot of stigma with using substances.

And so the fact that you're having the conversation with the patient, they're sitting in front of you, is great. And so, I would try to reassure the patient that you are here to care for them, whether they're doing well or they're struggling. And in many ways, you want to see them even more when they're having a hard time.

And so, in terms of talking to them about their return to use, it would be helpful to understand, like, how they're using cocaine. Like how frequently is not very much, because that varies tremendously from patient to patient. The settings that they're using cocaine would be helpful as well. And really trying to understand, like, is there something that caused you to drive to want to use another illicit substance again? Like maybe we can go back and fix that. Like maybe there's some underlying depression, or there's something happening that really was the trigger for a return to use, that we can talk about, and make a therapeutic intervention for.

**DA:** Great. Thanks. Yeah, I mean, I have, when I've taught this to other colleagues, and sometimes they do get overly fixated on, "Well, the patient didn't disclose it. They lied to you." And I'm reminded about patients who lie to me about other things, like, do they really floss every single day? Do they really exercise and diet like they say they are? And I never take that personally. So I'm not going to take it personally that somebody who used a substance didn't tell me initially.

In fact, especially with people with substance use disorders, oftentimes they don't tell the truth to themselves. They don't tell the truth to their families. And they certainly can tell me things that aren't true as well. I don't take it personally. So I think it's really important to get into a conversation. We're not judging. We're not penalizing. This is not punitive. We're trying to help somebody. And we have found a new problem. And, as we know with urine drug testing, a urine

drug test positive for cocaine means they used once, at least. Doesn't mean they have a cocaine use disorder.

But in this case, it turns out that he was using more often than he was initially disclosing. And we talked about the pros and cons for him, or the likes and dislikes of it. And—And there were a lot of dislikes, in terms of what it did, in terms of racing his heart, the cost, and his worries about the legal issues. And, we'll see.

I mean, I don't know where this is going to lead, because this is a pretty recent case. But all of the things that you had mentioned were things that I found important, clinically, to address this new issue.

**KW:** Yeah. And it sounds like that was a great approach to take with him, too. Because I think we have to recognize, too, that a lot of treatment programs, historically, were very punitive when there was a return to use. People, I think still, when they use cocaine, are afraid that their prescriber is going to try to taper them off of buprenorphine. And really, what we need to do instead, is like lean in and provide more services. And so, that is something that we really need to be reassuring with patients for, too. We need to build trust both ways.

**DA:** Thanks for that great discussion of these pretty common cases in primary care, when you're treating patients with MOUD. Now I just want to focus on a few Massachusetts-specific, as well as some national resources, that can help you manage your patients with OUD.

So firstly, in Massachusetts, we're fortunate that we have a substance use helpline. This is funded by the Department of Public Health. It really helps our patients connect with harm reduction services, treatment, and other recovery services. And it's free and confidential.

What do they do when your patient calls? Well, they assess the person's needs and provide referrals. They provide information, answer questions about substance use disorders, treatment and recovery. And they even follow up after the first call, just to check in. And it's available 24 hours a day, seven days a week, 365 days a year, including holidays. And it's a 1-800 number.

And as I said, it's free and confidential. So really, you should have this available so that you can refer your patients to this helpline.

Now there's a resource for us, for clinicians. And this is called the Massachusetts Consultation Service for the Treatment of Addiction and Pain, or MCSTAP. And it's funded through the Mass. Executive Office of Health and Human Services. And it's also free. And what is it for? It's to support clinicians and to increase 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.

And this service offers real time phone curbside consultation around safer prescribing and managing care of patients with OUD and chronic pain. You can request consultations over the phone. You can do it online. They have experienced physician consultant experts who are ready to take your call.

Also a resource in Massachusetts is MassPAT, which is the Massachusetts Prescription Drug Monitoring Program. And they just put out this alert for potential interruption in MOUD. What does that mean? Well, MassPAT will inform you if your patient is missing some of their doses. They're just not picking them up on a regular basis at the pharmacy. They are very clear that this service is not intended to be used as grounds to stop prescribing MOUD, or to dismiss a patient from your practice. It really is supposed to help you care for your patients more effectively. Again, it's a notification. It will be sent by email only to prescribers or to the people you've delegated authorization, to check the PDMP on your behalf, for patients who have experienced a medication lapse. That is, they haven't picked up their medication as expected. The specific medications that are captured under this will be buprenorphine products. It does not monitor for methadone or naltrexone.

Also, the Boston Medical Center Grayken Center for Addiction has a training and technical assistance program. I know that Kristin mentioned this program as well. But I just want to put it out there, that it provides free education, support, and capacity-building to community health centers, and other health care settings, and social service providers. And it's really quite an

amazing resource in Massachusetts. It's funded by the Mass. Bureau of Substance Addiction Services or BSAS. And you can request training and technical support through this website.

And finally, there are a lot of national resources, whether it be the FDA, the Provider Clinical Support System that is funded through SAMHSA, or the Substance Abuse and Mental Health Services Administration. It has lots of resources, lots of training, lots of guidelines. SAMHSA, again, has a Buprenorphine Quick Guide that you could print out if you need, as well as they have a much longer guide around treating opioid use disorder with medication. So there are a lot of free resources out there in the national space, that you can use to incorporate this into your practice.

To access any of the resources just discussed in this program, click on the resources tab in the website.

**Jen, Patient:** I was fortunate enough to know somebody who was on buprenorphine, and who had a lot of success with it. She actually had six years clean when she had suggested that I try the same thing. I reached out to my primary care doctor that a friend of mine also was seeing at the time. I asked about it, and it was suggested as also would be a good idea. It was agreed upon that it would be a good idea for me to try it.

When I first started buprenorphine, I don't think I was necessarily ready at the beginning. It did take me a few times. You know, a few relapses, before it—it really worked for me. But I—It did work for me. It helped me. It helped control my cravings. It actually helped me manage my pain, too. I have rheumatoid arthritis and a lot of residual pain from a cervical neck fracture, some nerve damage. And it helped ease that pain. So that was another benefit that happened to work for me.

Having that personal connection with my primary care doctor, knowing my primary care cared enough to call me if I missed an appointment, to make sure I was okay, who cared about my well-being, who continued to have faith in me, in wanting me to do the right thing, kept me coming back.

It's important to me to be able to get this from my primary care doctor. It's one less appointment I have to go do. Being able to talk about my addiction and my medical issues, get all my medications in one convenient appointment, has made things so much easier for me.

**DA:** Here are some final thoughts from our providers, on how easy and rewarding it is to incorporate the treatment of OUD into primary care.

**MB:** I think my message to primary care clinicians that might be hesitant is, you know, to do it. Just, you know, the Nike slogan, just do it. And, I think once you have an experience or two under your belt, you feel much more comfortable and confident. And I think you will realize that it's not nearly as complicated as you think it might be.

**CD:** And the need is astronomical. And—And it is—it is rewarding. You will have to educate your staff. There is going to be stigma. The stigma is going to come from both, you know, from both patients and from the community members, and from the staff. And so there is a constant reeducation. I think that you'll find that it's incredibly rewarding. I think that if we can do this in, you know, in Southeast Texas, that you can do this anywhere in the United States.

**RK:** What I would say to those who are still hesitant, is that it has been one of the more gratifying things, personally, to talk to patients who have become stabilized on treatment for their opioid use disorder, and the impact the treatment has on getting them back to functioning well in their lives.

**AP:** This is a chronic relapsing medical condition. And so it did take several years. But I think down the line, people start to make progress. And I, firsthand, don't hear it. But I'll have colleagues say, "Oh, I saw so-and-so. And they really say how you made a significant mark on their life. And they wouldn't be where they are today."

**AP:** I find it endlessly gratifying. I think that it's one of the most important medications that we can prescribe in primary care, in terms of reducing morbidity and mortality, and also just helping people live the lives that they want to live.

**BF:** It is life changing and life saving. I've seen patients that get jobs. I've seen patients come back into my office. They're in tears. They got their kids out of foster care. This can really change that family unit. And you'll notice, over time then, that that's just one of their chronic diseases. And you're taking care of them and doing their pap smear, setting them up for their colonoscopy, taking care of their high blood pressure, et cetera. And then, oh yeah. About once a month or so, you're—you're seeing them, and this is their buprenorphine visit. And you're refilling that medication. But you really can incorporate this into your practice. And you can do it well. And the patients are very appreciative.

**DA:** We want to thank the primary care clinicians who spoke to us about their experiences. We also would like to thank the patients who joined us today. To receive CME, CNE, or AAPA credit, please proceed to the post-test by clicking on it in the navigation bar.

You'll receive credit with a score of 70% or greater. After you've passed the post-test and completed an evaluation, you'll be able to download your certificate. Thanks so much for joining us.

END

# Empowering Recovery from Opioid Use Disorder: Transforming Lives and Enhancing Professional Fulfillment
Transcript

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