

ECHO IDAHO



Boise VAMC • Saint Alphonsus • St. Luke's



ECHO Idaho: Opioid Addiction and Treatment

What's MAT got to do with it? Common Myths and Misconceptions

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Learning Objectives

- Review common myths and misconceptions
- Discuss best practices for office-based treatment of opioid use disorder with buprenorphine/naloxone

Common Myths & Misperceptions

1. I don't want "those patients" in my waiting room.
2. Induction is too time consuming & difficult.
3. I don't have behavioral health in my clinic, so I can't start prescribing bupe.
4. Continued polysubstance use is a sign of treatment failure.
5. The goal should be the lowest possible dose, for the shortest possible time.

“Those Patients”



**WE ARE
LIVING PROOF
THAT
BUPE WORKS.**

For help, call
888-545-2600

“Those Patients” → 

Stigma decreases access to **care**

Meth-head User Dirty
Crack-head Addict Clean
Abuser Junkie
Druggie
Alcoholic Abuse



ASAM

American Society of
Addiction Medicine

“Those Patients” → 

Changing the Language of Addiction

ASAM
American Society of
Addiction Medicine

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists, and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

Terms Not to Use

- addict, abuser, user, junkie, druggie
- alcoholic, drunk
- oxy-addict, meth-head
- ex-addict, former alcoholic
- clean/dirty (drug test)
- addictions, addictive disorders

Terms to Use

- person with a substance use disorder
- person with an alcohol use disorder
- person with an opioid use disorder
- person in recovery
- negative/positive result(s)
- addiction, substance use disorder

Inductions too difficult



try HOME inductions

Inductions too difficult →



STARTING BUPRENORPHINE ("Bupe" or "Suboxone") Congratulations on starting treatment!

WHAT TO START WITH?

- ✓ 4 Buprenorphine (Bupe) pills or films (8 mg)
(*There are many different brand names and generic forms of Bupe. Some are shown below.)



- ❑ 6 Ibuprofen pills (200 mg) – for body pain, take 1-2 pills every 8 hours as needed
- ❑ 6 Clonidine pills (0.1 mg) – for anxiety, take 1 pill every 8 hours as needed
- ❑ 6 Imodium pills (2.0 mg) – for diarrhea, take 1 pill after each episode of diarrhea. Max 6 pills per day

WHEN AM I READY TO START BUPE?

- ✓ Use the list of symptoms below to see when you are ready to start Bupe.
- ✓ Wait until you have at least 5 symptoms to start Bupe. If you don't have 5 symptoms, wait a bit longer and review the symptoms again. It is very important that you wait until you feel at least 5 symptoms before starting Bupe! To be sure that you are ready to start, it's best to have at least 1 of the 5 symptoms in the grey shaded area.

Symptoms	Do I have this?
I feel like yawning	<input type="checkbox"/> Yes
My nose is running	<input type="checkbox"/> Yes
I have goose bumps	<input type="checkbox"/> Yes
My muscles twitch	<input type="checkbox"/> Yes
My bones & muscles ache	<input type="checkbox"/> Yes
I have hot flashes	<input type="checkbox"/> Yes
I'm sweating	<input type="checkbox"/> Yes
I feel unable to sit still	<input type="checkbox"/> Yes
I am shaking	<input type="checkbox"/> Yes
I feel nauseous	<input type="checkbox"/> Yes
I feel like vomiting	<input type="checkbox"/> Yes
I have cramps in my stomach	<input type="checkbox"/> Yes
I feel like using	<input type="checkbox"/> Yes

THINGS NOT TO DO WITH BUPE

- * DON'T use Bupe when you are high—it will make you dope sick!
- * DON'T use Bupe with alcohol –this combination is not safe.
- * DON'T use Bupe with benzos (like Xanax ("sticks"), Klonopin, Valium, Ativan) unless prescribed by a doctor who knows you are taking Bupe.
- * DON'T use Bupe if you are taking pain killers until you talk to your doctor.
- * DON'T use Bupe if you are taking more than 60 mg of methadone.
- * DON'T swallow Bupe – it gets into your body by melting under your tongue.
- * DON'T lose your Bupe – it can't be refilled early.

HOW TO TAKE BUPE



- ✓ Before taking Bupe, drink some water.
- ✓ Put Bupe under your tongue.
- ✓ Don't eat or drink anything until the Bupe has dissolved completely.

PLAN

- Use your last heroin / methadone / pain pill: _____
- When you have at least 5 symptoms from the list, then you are ready to start.
- Start with _____ pill or film under your tongue.
- Wait _____ minutes.
- If you feel the same or just a little better, then take another _____ pill or film
- Wait 2 hours – if you still feel sick or uncomfortable, take another _____ pill or film.

PROBLEMS? QUESTIONS?

- Call _____ at _____.
- Call _____ if you still feel sick after taking a total of _____ pills or film (____ mg).

NEXT STEPS

- Appointment with _____ at _____.
- Appointment with Dr. _____ at _____.

WHAT I TOOK

	Time	Amount of pills or films
Day 1	_____ am / pm	_____
	_____ am / pm	_____
	_____ am / pm	_____
	_____ am / pm	_____
Day 2	_____ am / pm	_____
	_____ am / pm	_____
	_____ am / pm	_____
	_____ am / pm	_____
Day 3	_____ am / pm	_____
	_____ am / pm	_____
	_____ am / pm	_____
	_____ am / pm	_____

Inductions too difficult →

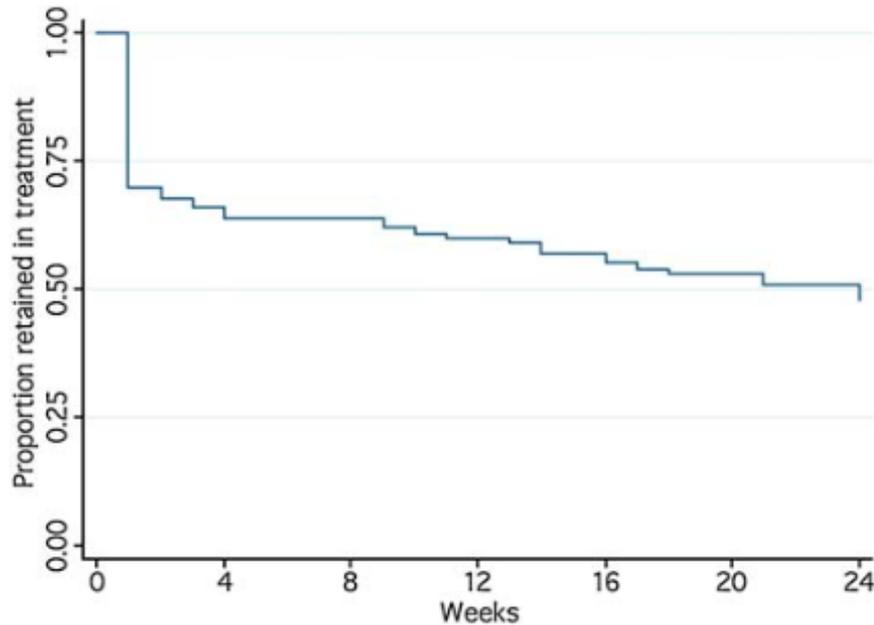
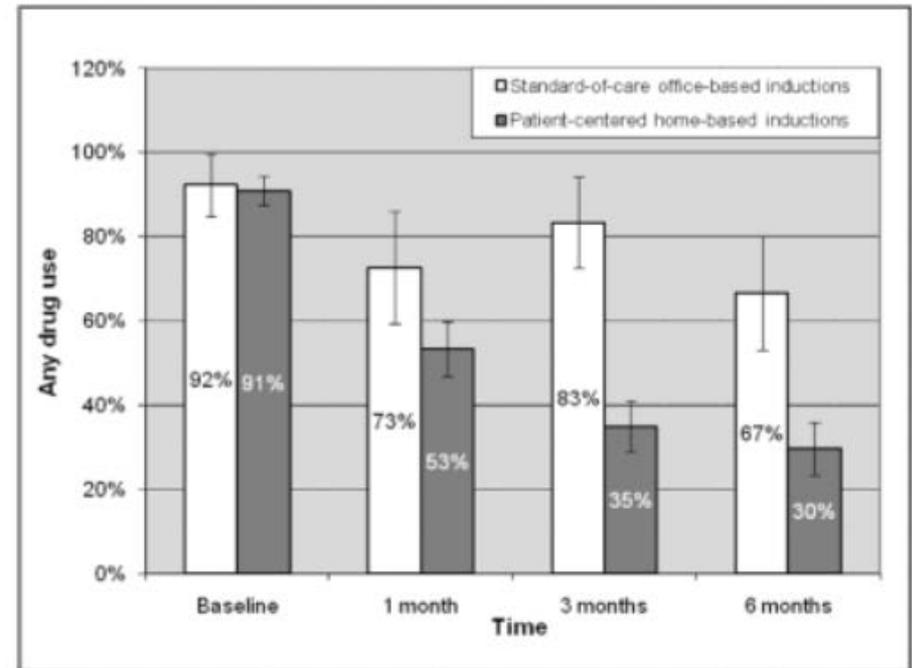


Figure 1. Treatment retention following home buprenorphine induction (N=103).



Don't have behavioral health

- DATA Waiver requires the *ability* to refer
- Not all patients need behavioral health
- Many patients do well with medications alone



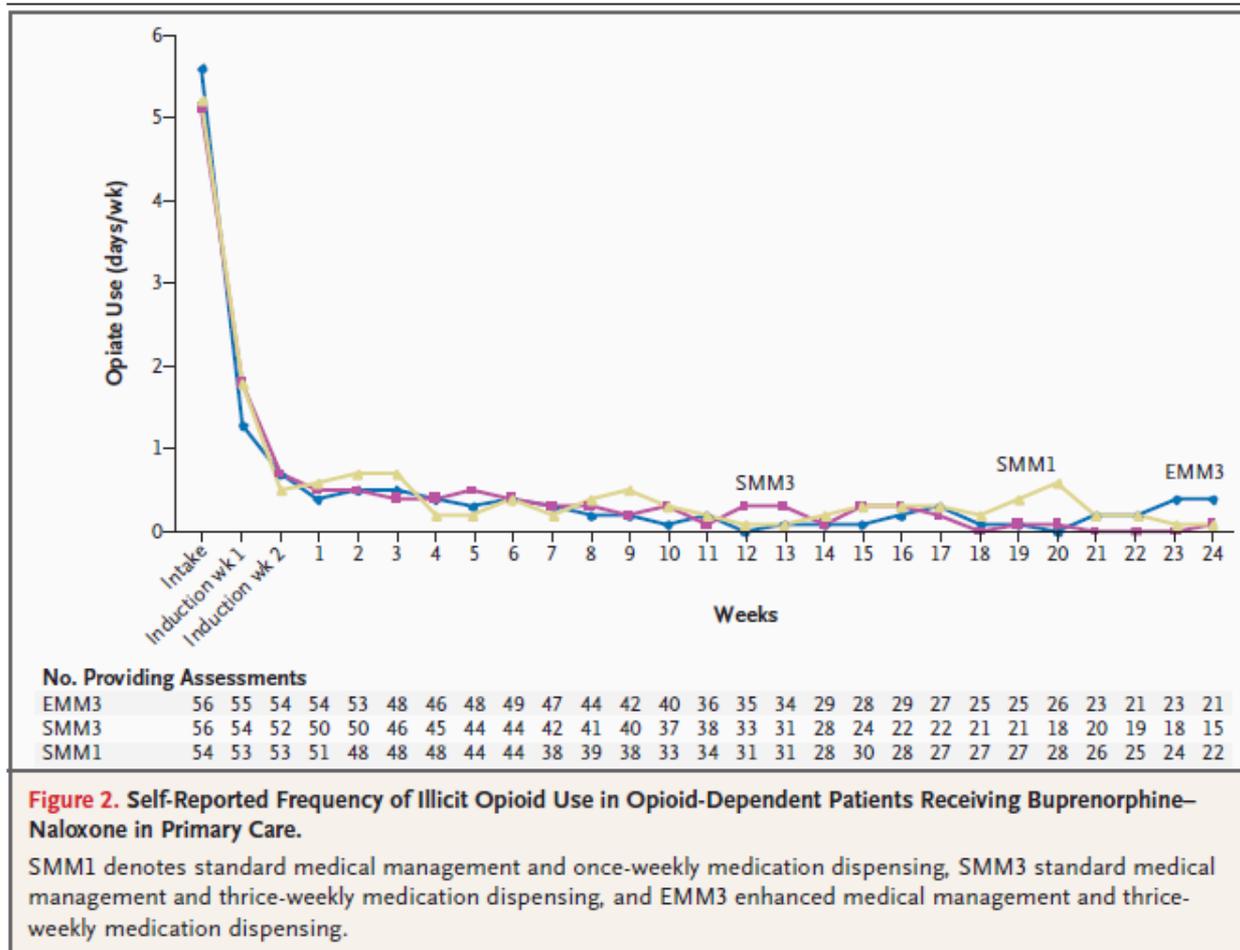
Don't have behavioral health →



- Treatment plan needs to be tailored to the individual – and patients find behavioral support in many ways, as they do for other chronic diseases



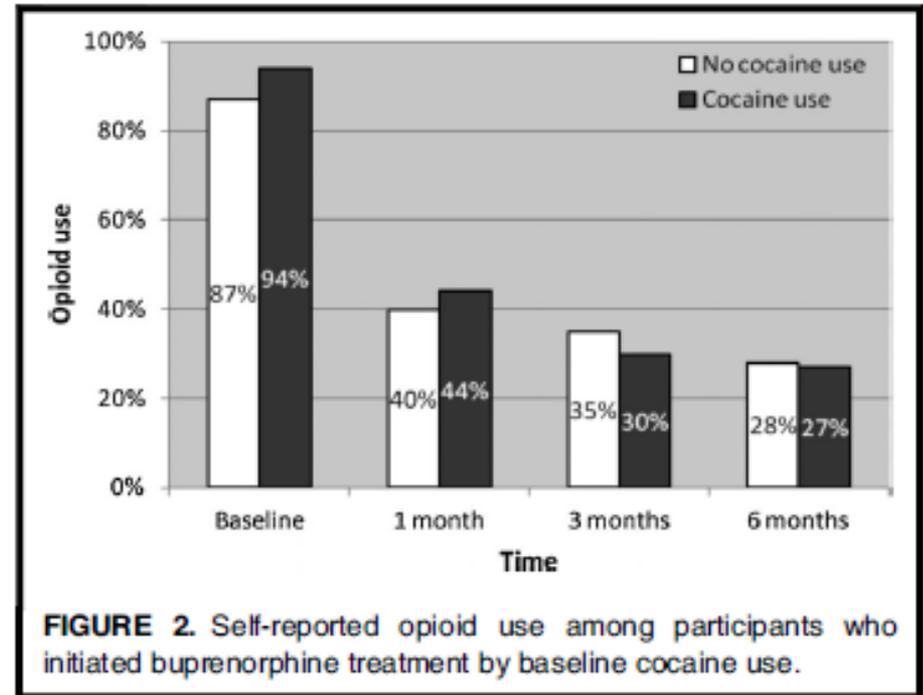
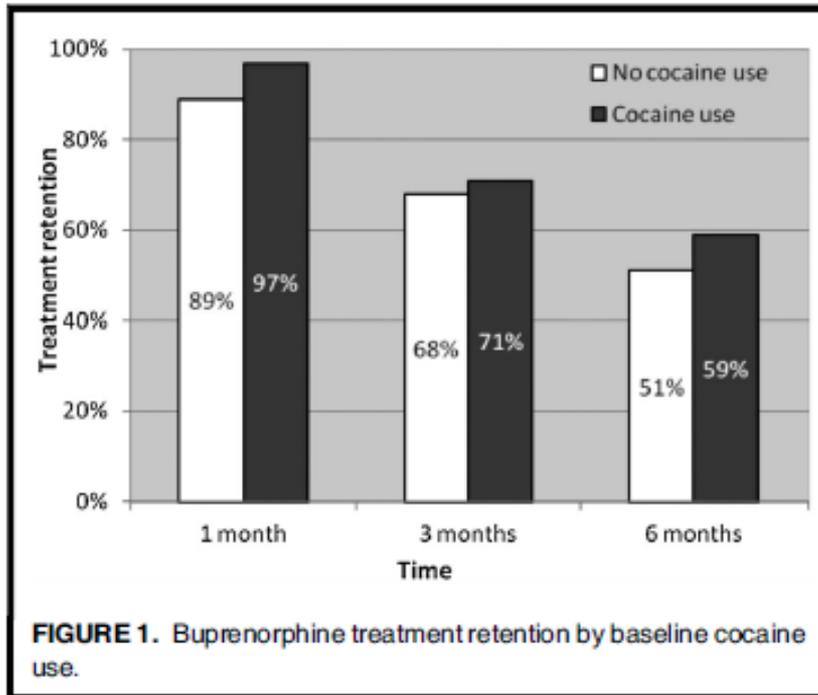
Don't have behavioral health →



Polysubstance use a failure?

- Continued polysubstance use often related to underdosing of buprenorphine
- Buprenorphine treats OUD, but not other SUD – patients can be successful in their treatment of OUD while continuing to use other substances
- ASAM National Practice Guideline recommends AGAINST suspending MAT because of polysubstance use

Polysubstance use a failure? →



Polysubstance use a failure? →

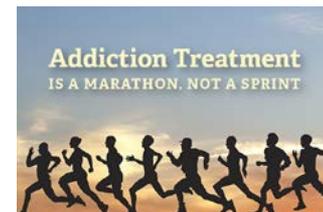
diabetes COPD
IBD dermatitis obesity bipolar hypertension
anxiety
depression
hyperlipidemia

The screenshot shows the FDA website's 'Drugs' section. The main heading is 'FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks'. Below the heading are social media sharing options (SHARE, TWEET, LINKEDIN, PIN IT, EMAIL, PRINT). A light blue box contains a summary: 'This provides updated information to the FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning issued on August 31, 2016.' Below this is a 'Safety Announcement' section with the text: '[9-20-2017] Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these

Lowest possible dose, shortest possible time?

- Buprenorphine is always going to be safer
- Goal dose where withdrawals and cravings controlled – for most patients around 16mg/day (FDA approved to 24mg/day)

Lowest dose, shortest time? →



- Most patients will need long-term (life-long?) buprenorphine
- High failure rates with early discontinuation
- Increase in mortality off buprenorphine
- Most cessation related to discharge
- SAMHSA Tip 63: “The best results occur when a patient receives medication for as long as it provides a benefit.”

Common Myths & Misperceptions

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Best Practices

1.  Embrace opioid use disorder like any other chronic disease and take it on in primary care!
2.  Let patients do their own inductions in the comfort of their own home, on their own time.
3.  Behavioral supports should be patient-centered and depend on their desires & needs.
4.  Patients often struggle with multiple chronic diseases; they may not be ready to tackle all of them simultaneously.
5.  Less is not more, both in terms of dose and duration! For many this will be a lifelong treatment.

Recommended Reading

SPECIAL ARTICLE

Annals of Internal Medicine

The Next Stage of Buprenorphine Care for Opioid Use Disorder

Stephen A. Martin, MD, EdM; Lisa M. Chiodo, PhD; Jordon D. Bosse, MS, RN; and Amanda Wilson, MD

Buprenorphine has been used internationally for the treatment of opioid use disorder (OUD) since the 1990s and has been available in the United States for more than a decade. Initial practice recommendations were intentionally conservative, were based on expert opinion, and were influenced by methadone regulations. Since 2003, the American crisis of OUD has dramatically worsened, and much related empirical research has been undertaken. The findings in several important areas conflict with initial clinical practice that is still prevalent. This article reviews research findings in the following 7 areas: location of buprenorphine induction, combining buprenorphine with a benzodiaz-

epine, relapse during buprenorphine treatment, requirements for counseling, uses of drug testing, use of other substances during buprenorphine treatment, and duration of buprenorphine treatment. For each area, evidence for needed updates and modifications in practice is provided. These modifications will facilitate more successful, evidence-based treatment and care for patients with OUD.

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Annals.org

For author affiliations, see end of text.

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Buprenorphine received approval from the U.S. Food and Drug Administration (FDA) in 2002 for

“The consensus panel recommends that physicians administer initial induction doses as observed treatment”

Acknowledgment

- Chinazo Cunningham MD MS, Associate Chief of Division of General Internal Medicine, Professor of Medicine, Albert Einstein College of Medicine/Montefiore Medical Center

References

- Amato et al. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment. Cochrane 2011.
- Barr et al. The availability of ancillary counseling in the practices of physicians prescribing buprenorphine. *J Addict Med*; 10(5):352-6.
- Bentzley et al. Discontinuation of buprenorphine maintenance therapy: perspectives and outcomes. *J Subst Abuse Treat* 2015; 52: 48-57.
- Bentzley et al. Patient perspectives associated with intended duration of buprenorphine maintenance therapy. *J Subst Abuse Treat* 2015; 56: 48-53.
- Carroll & Weiss. The role of behavioral interventions in buprenorphine maintenance treatment: a review. *Am J Psychiatry* 2017; 174(8): 738-747.
- Cornish et al. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Database. *BMJ* 2010; 341:c475.rug
- Cunningham et al. A comparison of buprenorphine induction strategies: patient-centered home-based inductions versus standard-of-care office-based inductions. *J Subst Abuse Treat* 2011; 40(4): 349-56.
- Cunningham et al. Buprenorphine treatment outcomes among opioid-dependent cocaine users and non-users. *Am J Addict* 2013; 22(4): 352-357.
- Fiellin et al. A Randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *Am J Med* 2013; 126 (74): e11-17.
- Fiellin et al. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *NEJM* 2006; 355: 365-74.
- Gryczynski et al. Leaving buprenorphine treatment: patients' reasons for cessation of care. *J Subst Abuse Treat* 2014; 46(3): 356-61.
- Heikman et al. Polydrug abuse among opioid maintenance treatment patients is related to inadequate dose of maintenance treatment medicine. *BMC Psychiatry* 2017; 17: 245.
- Lee et al. Home buprenorphine/naloxone induction in primary care. *JGIM* 2008; 24(2): 226-32.
- Martin et al. The Next Stage of Buprenorphine Care for Opioid Use Disorder. *Ann Intern Med* 2018; 169: 28-635.
- Ruetsch et al. The Effect of telephonic patient support on treatment for opioid dependence: outcomes at one year follow-up. *Addictive Behaviors* 2012; 37: 686-9.
- Sordo et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ* 2017; 357: j1550.
- Tetrault et al. Brief versus extended counseling along with buprenorphine/naloxone for HIV-infected opioid dependent patients. *J Subst Abuse Treat* 2012; 43: 433-439.
- SAMHSA. TIP 63: Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families. HHS 2018.
- Weiss et al. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence. *Arch Gen Psychiatry* 2011; 68(12): 1238-46.