University of Idaho
WWAMI Medical Education

Project ECHO®

ECHO IDAHO: OPIOID ADDICTION AND TREATMENT

Stigma and MAT: Common Myths and Misconceptions

9/24/20

Magni Hamso, MD MPH FACP
Medical Director, Idaho Medicaid
Staff Physician, Boise VA

The University of Idaho, WWAMI Medical Education Program is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The University of Idaho, WWAMI Medical Education Program designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learning Objectives

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

Common Myths & Misconceptions

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.
6. If it's an opioid blocker, it must be better.

University of Idaho
WWAMI Medical Education
Project ECHO

“Those Patients”

University of Idaho
WWAMI Medical Education

Project ECHO®

“Those Patients” →

University of Idaho
WWAMI Medical Education
Project ECHO

"Those Patients" → STIGMA

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	Terms to Use
• addict, abuser, user, junkie, druggie	• person with a substance use disorder
• alcoholic, drunk	• person with an alcohol use disorder
• oxy-addict, meth-head	• person with an opioid use disorder
• ex-addict, former alcoholic	• person in recovery
• clean/dirty (drug test)	• negative/positive result(s)
• addictions, addictive disorders	• addiction, substance use disorder

University of Idaho
WWAMI Medical Education

Project ECHO®

Inductions too difficult

try HOME inductions

Cunningham et al. J Subst Abuse Treat 2011; Lee et al. JGIM 2008; Martin et al. Annals 2018; SAMHSA Tip 63.

University of Idaho
WWAMI Medical Education

Project ECHO®

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?

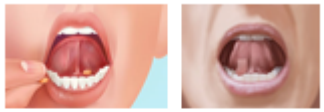
- ✓ Use the list of symptoms below to see when you are ready to start Bupe.
- ✓ Wait until you have **at least 5 symptoms** to start Bupe. If you don't have 5 symptoms, wait a bit longer and review the symptoms again. It is very important that you wait until you feel at least 5 symptoms before starting 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	☐ Yes
My nose is running	☐ Yes
I have goose bumps	☐ Yes
My muscles twitch	☐ Yes
My bones & muscles ache	☐ Yes
I have hot flashes	☐ Yes
I'm sweating	☐ Yes
I feel unable to sit still	☐ Yes
I am shaking	☐ Yes
I feel nauseous	☐ Yes
I feel like vomiting	☐ Yes
I have cramps in my stomach	☐ Yes
I feel like using	☐ 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	_____

Unpublished protocol, Cunningham et al, Montefiore Medical Center, Bronx, NY 2018

University of Idaho
WWAMI Medical Education

Project ECHO®

Don't have behavioral health

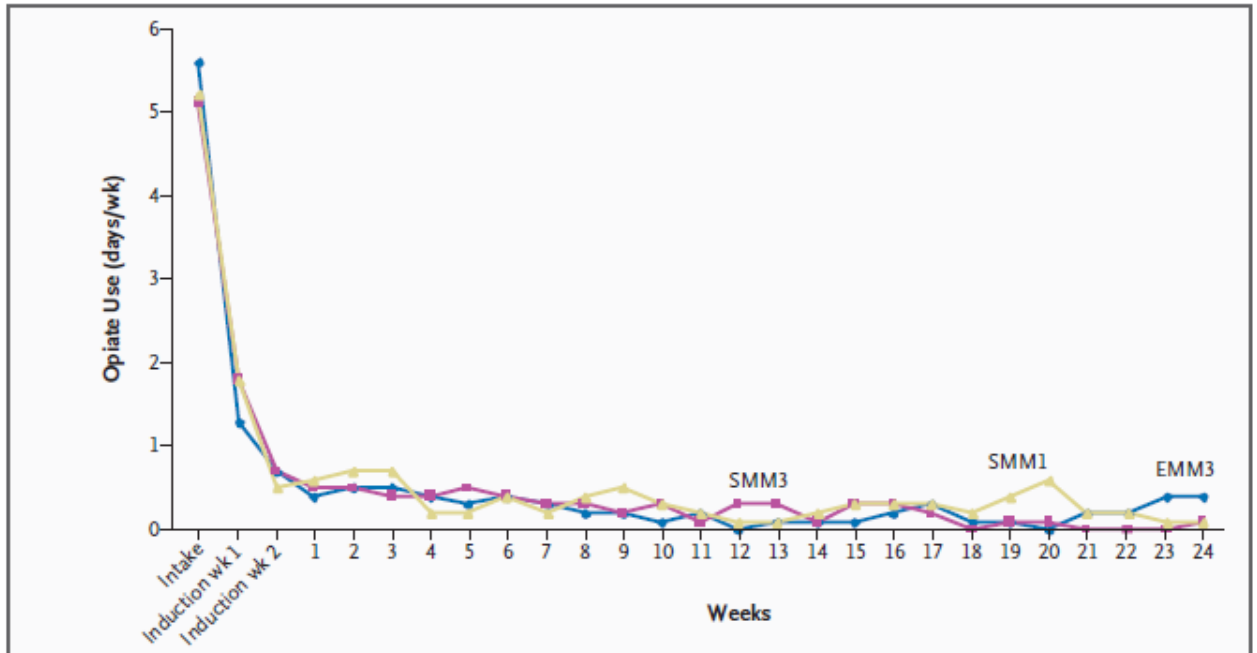
- DATA Waiver requires the *ability* to refer
- Not all patients need behavioral health
- Many patients do well with medications alone
- Patient-centered approach
- Should not tie life-saving medication to counseling requirements

Fiellin et al. NEJM 2006; Amato et al. Cochrane 2011; Martin et al. Annals 2018; Tetrault et al. J Subst Abuse Treat 2012; Wakeman et al. JAMA Open Network 2020

University of Idaho
WWAMI Medical Education

Project ECHO®

Don't have behavioral health →



No. Providing Assessments

EMM3	56	55	54	54	53	48	46	48	49	47	44	42	40	36	35	34	29	28	29	27	25	25	26	23	21	23	21
SMM3	56	54	52	50	50	46	45	44	44	42	41	40	37	38	33	31	28	24	22	22	21	21	18	20	19	18	15
SMM1	54	53	53	51	48	48	48	44	44	38	39	38	33	34	31	31	28	30	28	27	27	27	28	26	25	24	22

Figure 2. Self-Reported Frequency of Illicit Opioid Use in Opioid-Dependent Patients Receiving Buprenorphine–Naloxone in Primary Care.

SMM1 denotes standard medical management and once-weekly medication dispensing, SMM3 standard medical management and thrice-weekly medication dispensing, and EMM3 enhanced medical management and thrice-weekly medication dispensing.

Fiellin et al. NEJM 2006.

University of Idaho
WWAMI Medical Education

Project ECHO®

Polysubstance use a failure?

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

Cunningham et al. Am J Addict 2013; Heikman et al BMC Psych 2017; Martin et al. Annals 2018; Park et al. Addiction 2020; ASAM National Practice Guideline 2015.

Polysubstance use a failure? →

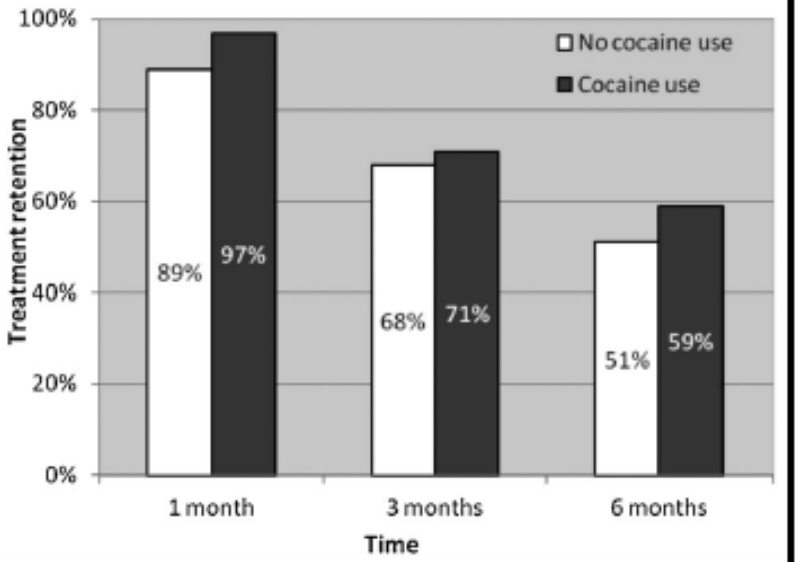


FIGURE 1. Buprenorphine treatment retention by baseline cocaine use.

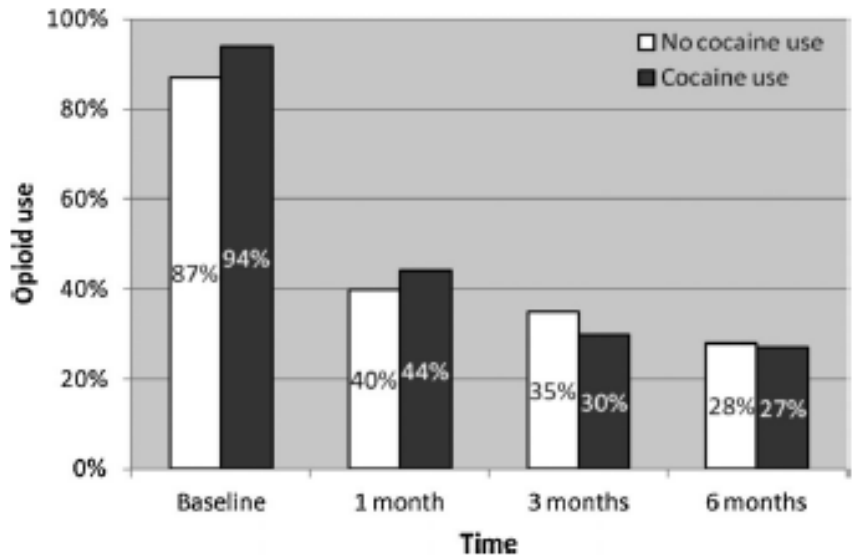


FIGURE 2. Self-reported opioid use among participants who initiated buprenorphine treatment by baseline cocaine use.

Cunningham et al. Am J Addict 2013.

University of Idaho
WWAMI Medical Education

Project ECHO®

Polysubstance use a failure? →

U.S. Department of Health and Human Services

FDA U.S. FOOD & DRUG ADMINISTRATION

A to Z Index | Follow FDA | En Español

Search FDA

Home | Food | Drugs | Medical Devices | Radiation-Emitting Products | Vaccines, Blood & Biologics | Animal & Veterinary | Cosmetics | Tobacco Products

Drugs

Home > Drugs > Drug Safety and Availability

- Drug Safety and Availability
- Drug Alerts and Statements
- Medication Guides
- Drug Safety Communications
- Drug Shortages
- Postmarket Drug Safety Information for Patients and Providers
- Information by Drug Class
- Medication Errors
- Drug Safety Podcasts
- Safe Use Initiative
- Drug Recalls

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

SHARE | TWEET | LINKEDIN | PIN IT | EMAIL | PRINT

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.

Safety Announcement

[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

University of Idaho
WWAMI Medical Education

Project ECHO®

Lowest possible dose, shortest possible time?

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

Fiellin et al. JAMA Intern Med 2014; Martin et al. Annals 2018;

University of Idaho
WWAMI Medical Education
Project ECHO

Lowest dose, shortest time? →

- Most patients will need long-term (life-long?) buprenorphine
- High failure rates with early discontinuation
- Increase in mortality off buprernorphine
- 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."

Cornish et al. BMJ 2010; Bentzley et al. J Subs Abuse Treat 2015; Fiellin et al. JAMA Intern Med 2014; Gryczynski et al. J Subs Abuse Treat 2014; Martin et al. Annals 2018; Sordo et al. BMJ 2017; SAMHSA TIP 63

University of Idaho
WWAMI Medical Education

Project ECHO®

If it's an opioid blocker, it must be better?

- Data limited & study quality poor
  - Most RCTs compared to placebo
  - RCTs against buprenorphine flawed
- Observational studies suggest increased risk of death from overdose
- Mortality benefit from methadone and buprenorphine, not from ER naltrexone
- Should only be used in unique situations

Binswanger & Glanz Drug Safety 2018; Darke et al. Addiction 2019; Lee et al. NEJM 2016; Lee et al. Lancet 2018; Morgan et al. Drug & Alc Depend 2019; Tanum et al. JAMA Psych 2017; Wakeman et al. JAMA Network Open 2020.

An opioid blocker better? →

FDA issues warning letter for not including the most serious risks in advertisement for medication-assisted treatment drug

Share | Tweet | Linkedin | Email | Print

think twice before prescribing ER naltrexone for OUD
*****do prescribe naloxone*****

Massachusetts, for misbranding the drug Vivitrol (an extended-release injection
formulation ssociated
with the dru on of
relapse to o t of a
comprehen wn as
medication- tion with
counseling disorder
(OUD) and sued in
relation to a contains
claims and municate
important v lnerability
to opioid ov

University of Idaho
WWAMI Medical Education

Project ECHO®

Common Myths & Misconceptions

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.

6. Think twice before choosing opioid antagonist over opioid agonist therapy

University of Idaho
WWAMI Medical Education
Project ECHO

Key Points

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.

6. Focus on access to opioid agonist therapy (bupe or methadone) for OUD.

University of Idaho
WWAMI Medical Education
Project ECHO

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 benzodiazepine, 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.

Ann Intern Med. 2018;169:628-635. doi:10.7326/M18-1652 **Annals.org**
For author affiliations, see end of text.
This article was published at Annals.org on 23 October 2018.

University of Idaho
WWAMI Medical Education

Project ECHO®

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.
- Darke et al. Circumstances of death of opioid users being treated with naltrexone. Addiction 2019; 114: 2000-2007.
- 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. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicenter, open-label, randomized controlled trial. Lancet 2018; 391 (10118): 309-318.
- Lee et al. Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. NEJM 2016; 374: 1232-42.
- 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.
- Morgan et al. Overdose following initiation of naltrexone and buprenorphine medication treatment for opioid use disorder in a United States commercially insured cohort. Drug & Alc Depend 2019; 200: 34-39.
- Park et al. Associations between prescribed benzodiazepines, overdose death and buprenorphine discontinuation among people receiving buprenorphine. Addiction 2020; 115(5): 924-932.
- 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.
- Tanum et al. Effectiveness of injectable extended-release naltrexone vs daily buprenorphine-naloxone for opioid dependence: a randomized clinical noninferiority trial. JAMA Psych 2017; 74(12): 1197-1205.
- 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.
- Wakeman et al. Comparative effectiveness of different treatment pathways for opioid use disorder. JAMA Open Network 2020; 3(2): e1920622.
- Weiss et al. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence. Arch Gen Psychiatry 2011; 68(12): 1238-46.

University of Idaho
WWAMI Medical Education

Project ECHO®

ECHO Idaho: Opioid Addiction and Treatment

JOIN US FOR OUR NEXT SESSION!

For information, please visit uidaho.edu/echo

University of Idaho
WWAMI Medical Education

Project ECHO®

Ongoing Resource List

RESOURCES FROM TODAY'S SESSION AND PAST SESSIONS CAN BE FOUND IN OUR ONGOING RESOURCE LIST.

https://iecho.unm.edu/sites/uidaho/download.hns?i=51

University of Idaho
WWAMI Medical Education

Project ECHO®