WEBINAR VIDEO TRANSCRIPT

Opioid Addiction Treatment ECHO

Office-based management of OUD Part 1_Evaluation and management of new patients

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LECTURER: Get rolling with treatment of opioid use disorder in your office. It does have some focus on medications, but it's also -- there's a little bit about behavioral health integration as well. So I have... nothing to disclose.

The goal of this talk is to provide you with some sort of foundational tools for treating opioid use disorder. Every program is different, has different team members, resources, scheduling, and so you'll probably need to think about what applies to your setting and what doesn't. A lot of what we're talking about applies to office-based treatment with naltrexone, but the talk was focused on treatment with buprenorphine, and when we speak of buprenorphine in this training, or use the term bupe, we're really referring to buprenorphine, naloxone, because monotherapy's generally reserved for people who are pregnant.

So... we'll talk about tools that are useful, screening of patients for their appropriateness for medication treatment, and looking at different options for how to do the induction. Certainly... treatment of opioid use disorder is highly effective, but studies have been published showing that office-based treatment in federally-qualified health centers has similar results to other settings, with retention rates that are between 50 and 60 percent in the six- to twelve-month marker. So that means that a lot of people will drop out, and it's important from the get-go to recognize that that would happen no matter how much experience you had, how much expertise you had, that's just part of the nature of the disease, and so not to take it personally.

This is not a solo sport, when we're treating opioid use disorder, it's really important to take a team-based approach, and I think in my experience, when I've seen medical providers take this on and then fail, they said that they can't do it, it's usually because they either haven't had a team, or haven't engaged the team. So your team might be made up of a prescriber and a nurse, and ideally also include counselors, community health workers, medical assistants, and a pharmacist, so bringing everyone together to tackle this problem is really, really helpful. It makes it more fun, and brings in a lot of needed additional expertise.

It's important to recognize that, as medical providers, we should really be addressing addiction as a disease and not a character flaw, in spite of a lot of social norms that persist around blaming people who have substance use disorders, and a lot of stigmatizing attitudes, medical science is really clear that addiction is a brain disease, and we're most effective if we treat it like other chronic diseases. Part of that is thinking about the language that we use, and the attitude that we bring to the table. So if a urine sample shows a drug that you weren't expecting, it's tempting to think that the patient lied to me, but if

you can take a moment and reframe your thinking to something like, This patient's disease is uncontrolled, that can help to sustain your efforts and help to keep your team focused on the treatment of this devastating and really lethal disease.

Another part of that is thinking about the language that you use with the patient, but also with your team, when you're talking about the patient. Terms like addict or dirty urine are stigmatizing and are non-clinical terms, so instead, talking about a person who has an opioid use disorder, and a positive or abnormal urine drug screen, can really help to frame things in a different and more clinically appropriate way.

This doesn't happen overnight, we all bring a lot of ... acknowledged, and sometimes attitudes that are hidden even to us, and it takes time to unearth those and really become aware of them, and particularly to change them, so it's an ongoing effort that you can engage in as a team. It could be helpful to have some materials available to use when you are introducing treatment to a patient. Having some kind of informed consent form or patient agreement is very useful, and required in many settings. It's also really important to recognize that even though we're treating addiction, overdose can still happen, and so overdose education information is very important and ideally, to provide patients with training on how to use naloxone right then and there is particularly helpful.

Patients are often frightened of the induction process, the process of starting the buprenorphine, and so having a handout about that, and particularly a handout about inductions that a patient's going to manage at home is very useful. You could consider a wallet card that would tell a first responder that a patient is being treated with buprenorphene, because it can have implications for pain management in an emergency situation. And then finally, you'll probably wanna have information about local recovery resources, such as 12-step meetings, SMART Recovery meetings, maybe even detox or rehab facilities in the area, church-based recovery groups, et cetera, so that people have those resources readily available.

So who is appropriate to treat with medication treatment for opioid use disorder? The patient should meet criteria for OUD, and we've reviewed that in the past and in these talks, but just to briefly... summarize it, people who have opioid use disorder generally have poor control over their urgings and cravings to use opioids, they use in spite of significant adverse consequences to their health, to their relationships, to their ability to carry out their goals, and... they... typically... have made efforts to quit or cut back and been unsuccessful. So in addition to meeting those criteria, you need to ascertain whether the patient is at least willing to commit to adhering to clinic visits. That may be a dicey preposition for some patients when they don't have transportation, or if, as with many of our patients, they have very chaotic lives, but at least being willing to plan to attend clinic visits regularly scheduled can be -- is important.

Some clinics do require an agreement to stay on treatment for a particular minimum time period, you can think about whether that's something that you wanna do, and in general, treating patients who are using benzodiazepines should be done with caution, if they're prescribed, it may be wise to help the patient to wean down to lower doses. If they're used on the street, I would be particularly careful, because of the risk of high-dose benzodiazepine use and opioid use together, quitting buprenorphine use, setting them up for overdose. And finally, if the patient's on methadone at the time that they're

wanting to start buprenorphine treatment, thinking about why they wanna do that, and then helping them to taper down to a low dose of methadone to make the transfer easier could be helpful.

Labs, prior to starting buprenorphine treatment, everybody's gonna have a slightly different approach to this, but it's reasonable to check for HIV, Hepatitis, how the liver's functioning, and a pregnancy test for women of childbearing age, and if indicated, perhaps that TB screen. Urine drug screening would also be part of your initial evaluation, and you wanna use a screen that captures a lot of important substances, so particularly opiates, synthetic opiates like Oxycodone, Methadone and Fentanyl, if you're in an area where a bunch of Fentanyl's being seen, benzodiazepines, cocaine, amphetamine, methamphetamine, and barbiturates. Can take this down for a minute. So, what are your thoughts about what you might be looking for in an initial urine drug screen?