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This menu allows you to **control**:

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- Access to the **Chat** box
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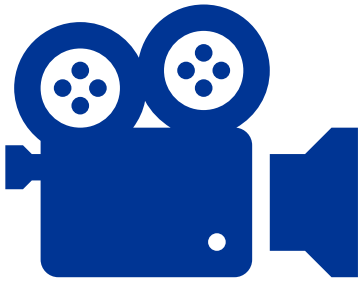

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Acknowledgements

- The COE project is a partnership of the University of Pittsburgh's Program Evaluation and Research Unit and the Pennsylvania Department of Human Services; and is funded by the Pennsylvania Department of Human Services, grant number 601747.

- COE vision: The Centers of Excellence will ensure care coordination, increase access to medication-assisted treatment and integrate physical and behavioral health for individuals with opioid use disorder.

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Program Evaluation and Research Unit

MOUD Prescriber Training

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By the end of this module, you will be able to do the following:

- Define key components of MOUD from research (e.g. importance of quick initiation, MOUD without therapy or other services works, dosing considerations)
- Discuss barriers/challenges for quick initiation of MOUD and potential solutions
- Discuss barriers/challenges for ongoing MOUD treatment and potential solutions
- Understand the importance of person-first language and reducing stigma
- Increase confidence in the safe and effective prescribing of MOUD

Treatment Terminology

Medication-Assisted Treatment (MAT)

- Use of medications in **combination with behavioral** therapies[1]
- **Medication as "assisting"** another form of treatment

Medications for Opioid Use Disorder (MOUD)

- Use of medications, with or without behavioral therapies[2]
- Medication is considered the **first-line** treatment for OUD

([1]SAMHSA, 2021; [2]NASEM, 2019)

MOUD - Medications

Methadone

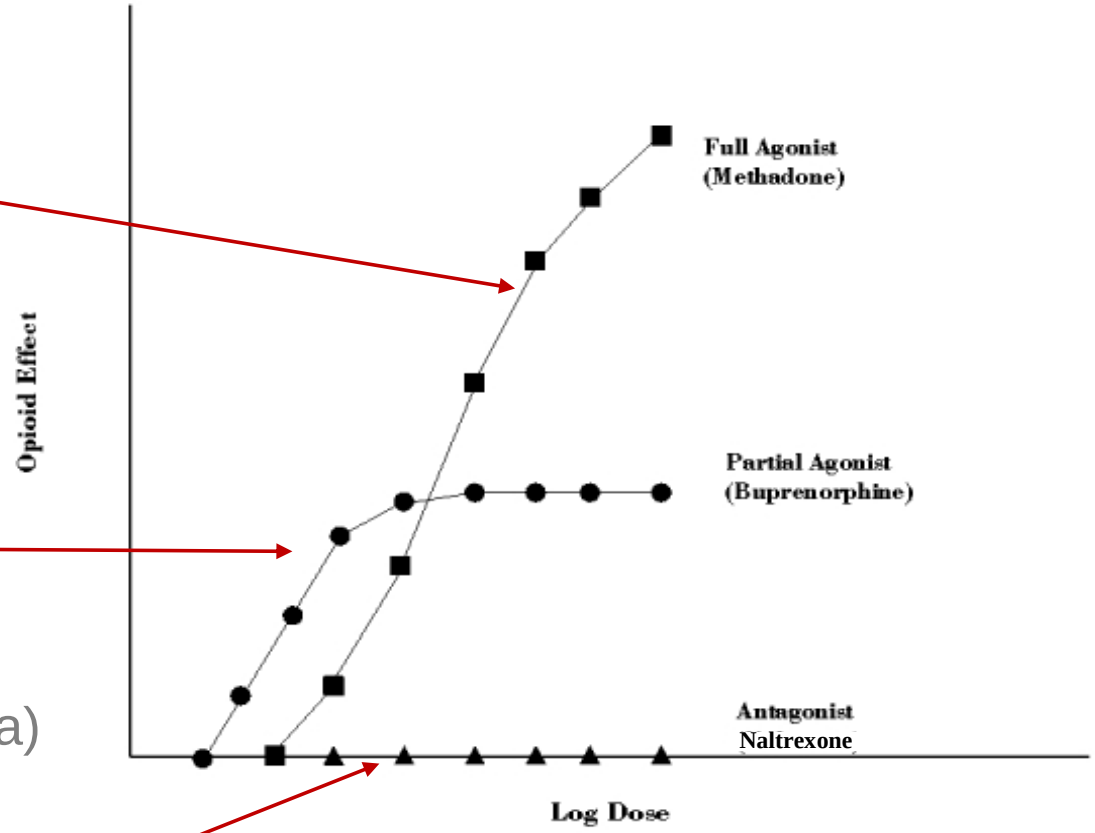
- Opioid receptor full agonist (no ceiling effect)
- Moderate receptor binding affinity
- Moderate to severe OUD

Buprenorphine

- Opioid receptor partial agonist (has ceiling effect)
- High receptor binding affinity
- Will displace full opioids agonists from the receptors (competitive antagonist)

Naltrexone

- Opioid receptor antagonist (no euphoria or analgesia)
- Very high receptor binding affinity
- Will displace partial and full opioid agonists from the receptors and blocks the effects



(SAMHSA, 2020; KCSAT, 2004; PCSS, n.d.; CSAT, 2000)

Medications for Opioid Use Disorder (MOUD)

The goals of MOUD treatment are to:

- **Stabilize** abnormal brain activity[1];
- **Reduce cravings** and **strengthen coping capacity**[2];
- **Increase periods of abstinence** and **self-efficacy**[2]; and
- **Improve clinical outcomes** for patients and reduce impact on family and loved ones.[2]

([1]SAMHSA, 2021; [2]CDC, 2017)

Potential Candidates: Methadone

Only available from licensed Opioid Treatment Programs (OTP)

Methadone treatment may be appropriate for the following types of patients:

- Need high level of monitoring
- Dependent on several substances
- History of diversion
- No insurance or limited means
- Meets criteria for OTP admission

Methadone (full agonist)

(SAMHSA, 2004; CSAT, 2004)

Potential Candidates: Buprenorphine

Buprenorphine/naloxone oral formulations (buccal or sublingual)

Monthly injectable formulation (Sublocade™).

Buprenorphine treatment may be appropriate for the following types of patients:

- Are currently physically dependent on opioids
- History of overdose
- Limited social supports
- Have insurance and means of payment
- Experience chronic pain and require chronic opioid treatment

(SAMHSA, 2004; CSAT, 2004)

Potential Candidates: Naltrexone

Daily oral formulation (ReVia®)

Monthly injectable formulation (Vivitrol®).

Naltrexone treatment may be appropriate for the following types of patients:

- Less severe OUD
- Have been abstinent from opioids for at least one week
- Do not want to take opioid agonists or are not able to receive them
- Unsuccessful agonist treatment (or want to transition to antagonist treatment)
- Have a co-occurring alcohol use disorder

(SAMHSA, 2004; CSAT, 2004)

Goals of MOUD

1

Stabilize abnormal brain activity[1]

2

Reduce cravings and **strengthen coping capacity**[2]

3

Increase periods of **abstinence** and **self-efficacy**[2]

4

Improve clinical outcomes for patients and reduce impact on family and loved ones[2]

([1]SAMHSA, 2021; [2]CDC, 2017)

Effectiveness of MOUD

- Randomized controlled trials (RCTs) are the **highest standard** used to demonstrate effectiveness in medicine.
- RCTs found methadone, buprenorphine and naltrexone (injectable) were each **more effective** at reducing opioid use than treatment not using medications.
- Methadone and buprenorphine treatment are associated with **decreased risk** of overdose death.

(Lee et al., 2016; Mattick et al., 2009; Mattick et al., 2014; Nielson et al., 2016)

Assess Patient Candidacy: Current Status

- Complete **level of care assessment** (COE requirement).
- Assess for **medical and psychiatric safety.**
- Assess for **withdrawal** and need for ambulatory **detoxification.**
- Review **recent substance** use (past 90 days).
- Assess patient's **treatment goals** and motivation for treatment.

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Assess Patient Candidacy: History

- **Determine severity of OUD** via patient's medical history of diagnosed substance use disorder(s) or completing a preliminary assessment of the DSM-5 OUD Criteria.
- **Complete a Prescription Drug Monitoring Program (PDMP) inquiry** to obtain additional history of controlled substance use and review use of contraindicated medications, if possible.
- Review substance use disorder **treatment history**.

Assess Patient Candidacy: Treatment Options

- Determine physical and psychiatric **health needs.**
- Discuss **barriers to accessing treatment**, for example, social or financial issues.
- **Review MOUD** and medications available.
- Discuss **treatment plan** and provide treatment schedule.

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Rapid MOUD Initiation

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Discussion Question

What is **“rapid”** initiation?

Considerations for Rapid MOUD Initiation

- Initiation of medication treatment should **not be delayed** while completing full assessment and intake[1]
- Medication therapy should **not be contingent upon participation** in behavioral therapy[1,2]
- Both **office-based and home buprenorphine induction** are safe and effective[1]
- Hospitalized patients started and maintained on buprenorphine **are 6x more likely** to engage in **ongoing treatment** with less illicit drug use 30 days after discharge[3]
- Patients seeking SUD treatment are **7 times more likely** to be engaged if they are seen on the **same day** compared to waiting 2+ days[4]

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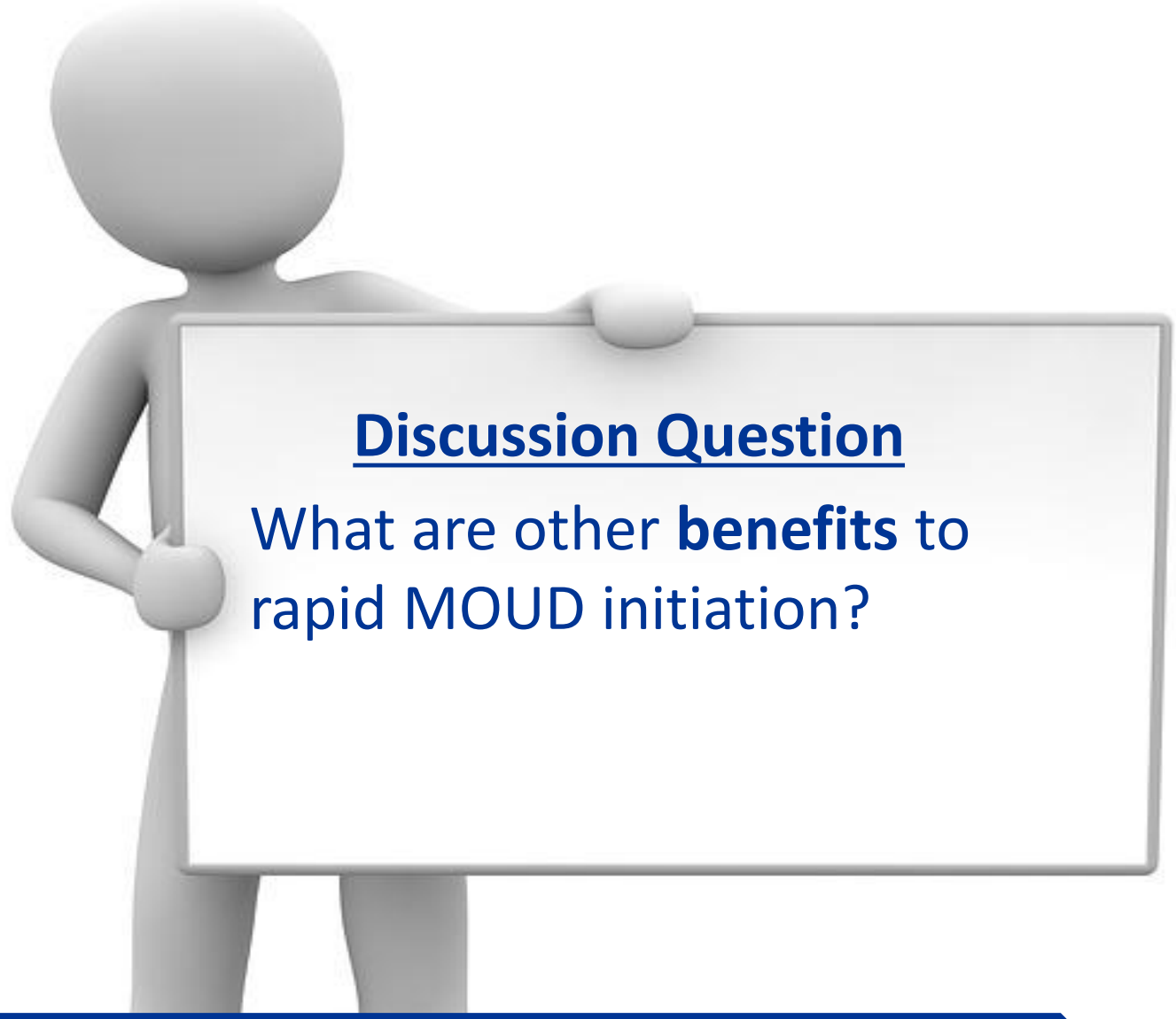
([1] ASAM, 2020; [2]National Academies of Sciences, Engineering, and Medicine 2019; [3]. Liebschutz et al, 2014.; [4] Roy et al., 2020)

Benefits of Rapid MOUD Initiation

- Improved Treatment **Retention**[1]
- Reduced **Overdose** Risk[2]
- Reduced Transmission of **Infectious Diseases**[2]
- Reduced **Criminal Activity**[2]
- **Cost-Efficiency**[2]

([1] Hadland et al., 2018; [2] Ahmed et al., 2021)



Discussion Question

What are other **benefits** to rapid MOUD initiation?

Qualtrics Results for Barriers to Rapid MOUD Initiation

- Client **fear of withdrawal**
- Client **not presenting** for treatment
- Length of the **intake process**
- Withdrawal **complicated** by fentanyl/ xylazine/ other adulterants
- Structural issues
  - **Negative UDS** requirement
  - Excessive **paperwork**
  - Missing **referral** information
  - Not designed for **immediate** prescriber **access**

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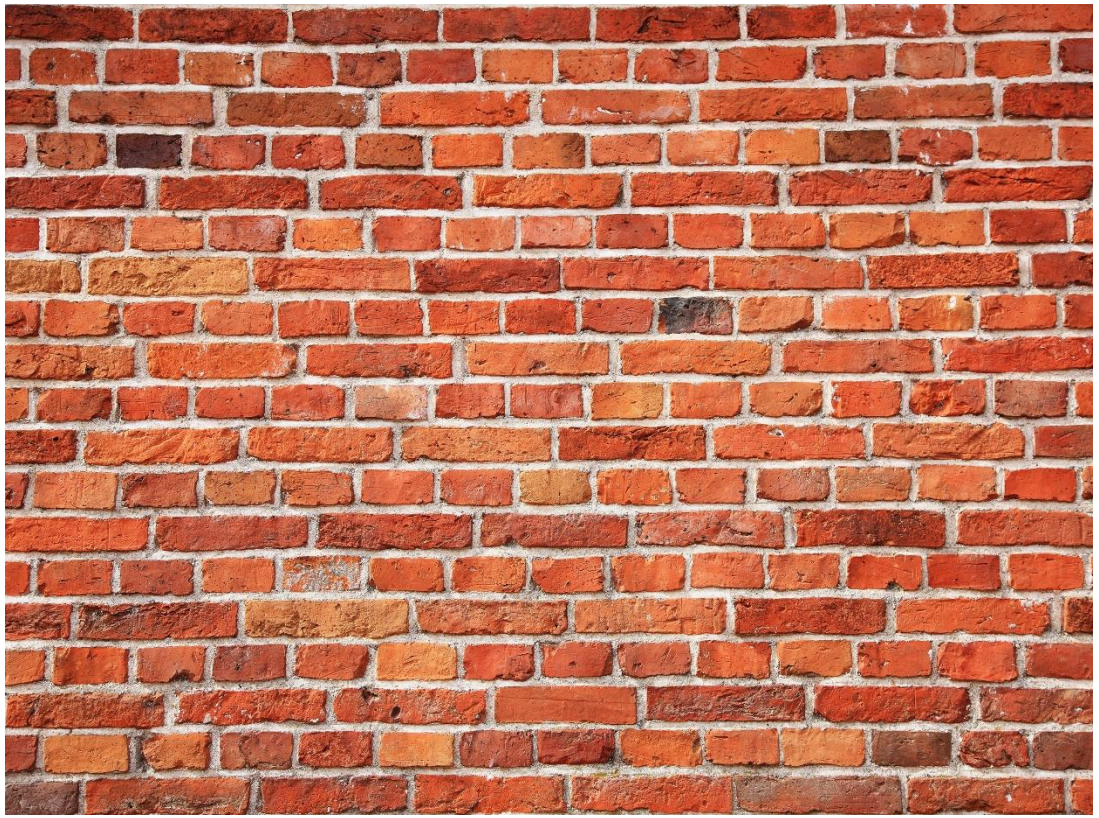
Other Identified Barriers to Rapid Initiation of MOUD



Lack of provider **confidence and training**[1]

Legal and **regulatory requirements**[2]

Fragmentation of services[2]

([1]Salter et al., 2020; [2] Manchester et al., 2019)

Dosing Considerations

Choosing an MOUD

- No clearly established criteria. Venue as important as Rx.
- Some things to consider
  - What is your patient's preference?
  - How stable is your patient?
  - Is the person pregnant?
  - What is their treatment history?
  - How severe is their use disorder?
  - Are there co-occurring disorders?
  - How strong is their support system?
  - What kind of and how much structure do they need?
  - Can the person stop using long enough for induction?

In Office Induction

- COWS score 12-15
- 1st dose 2-4 mg under observation in office or inpatient setting.
- Observe in office for at least 1 hr, document effect. Repeat dose to comfort.
- 1st day's dose may range from 2-16 mg. Lower doses required in those with lower level of physical dependence.
- If withdrawal occurs after patient leaves the office, request patient return to clinic. Avoid this complication by taking the time to assure moderate withdrawal discomfort prior to the first dose.
- Remain in contact with patient by phone during 1st 1-2 days; adjust dose as needed over next 5-7d
- Give sufficient medication only until the next visit, within 3-7 days

Home Induction

- Good candidate:
  - Pt who has had patient education
  - Previously treated patients known to be reliable
  - patients who demonstrate knowledge of the risks of unobserved induction, willing to come to the office in the event of problems.
- Suboptimal candidate:
  - patient has expressed significant fear of withdrawal
  - May starting buprenorphine too early and causing a precipitated withdrawal.
- Provide explicit written instructions and SOWS/COWS
- Maintain close telephone/office contact with patient during course of induction
- Have patient return within 2-7 days of starting buprenorphine.

Microdosing

- Methadone (MTD)
  - Works well for many, improved retention in treatment over bupe
  - requires no abstinence period
  - Limitations include daily dosing, geographic location, drug-drug interactions, careful titration to avoid side effects
- Buprenorphine (bupe)
  - Also works well for many; slightly less effective at retention in treatment vs MTD
  - Improved side effect profile, few drug-drug interactions
  - requires presence of withdrawal; can itself precipitate w/d if abstinence timing insufficient

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