Low-Barrier Medications for Opioid Use Disorder (MOUD): A Focus on Buprenorphine

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DISCLOSURES

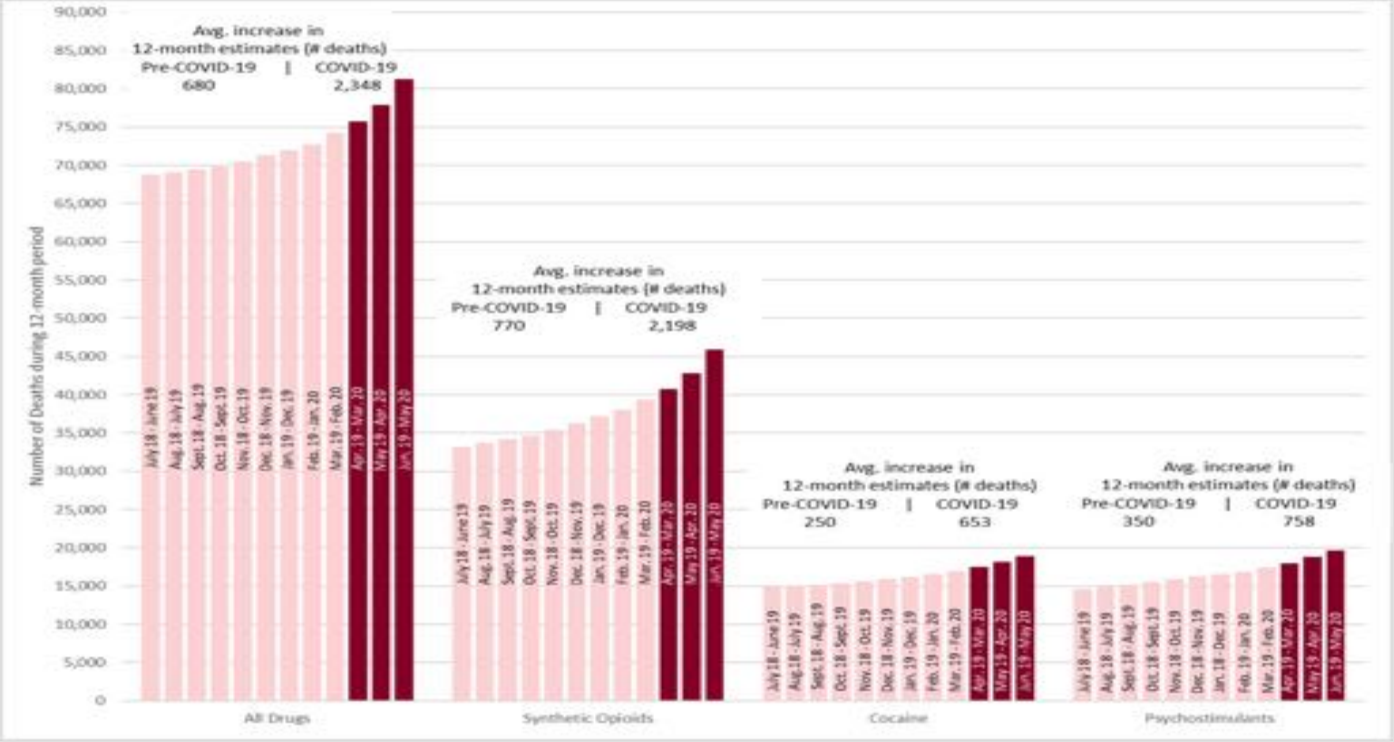
- **I have no relevant financial disclosures.**

OBJECTIVES

- At the conclusion of this roundtable, participants will be able to:
  - Define low barrier MOUD
  - Identify the barriers to a low-threshold approach to MOUD
  - Understand the seven principles of low barrier MOUD
  - Utilize an evidence-based approach to buprenorphine

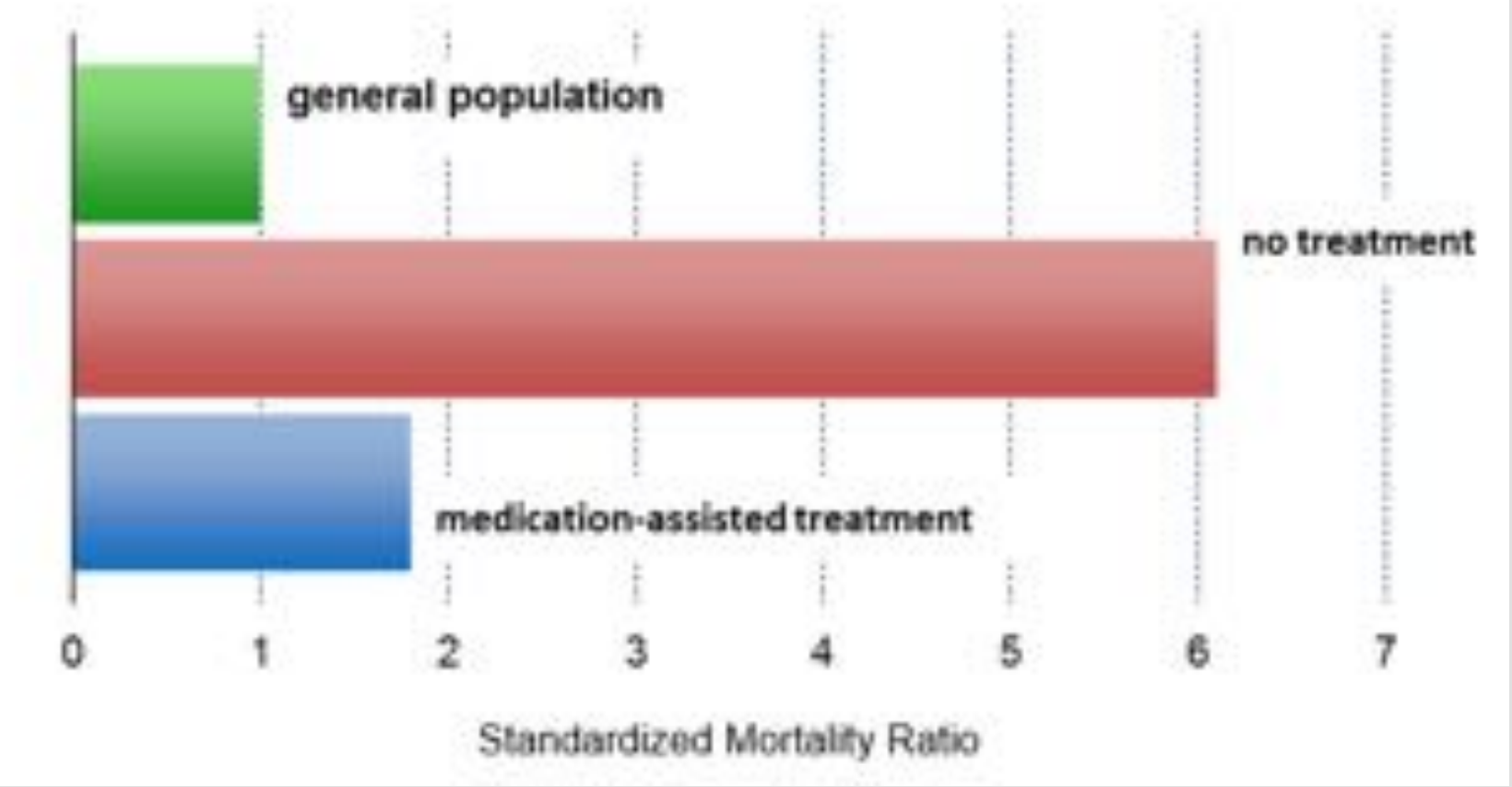
DRUG OVERDOSE DEATHS

- 81,230 overdose deaths from June 2019 – May 2020
  - 18.2% increase and largest number of overdoses in 12-month period recorded



1) J Katz: Drug Deaths in America Are Rising Faster than Ever, NYT 6.5.17
2) CDC: Provisional Drug Overdose Death Counts. Accessed from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed on: October 27, 2020.
3) CDC: Increase in Fatal Drug Overdoses Across the U.S> Driven by Synthetic Opioids Before and During the COVID-19 Pandemic. Accessed from: https://emergency.cdc.gov/han/2020/han00438.asp

BENEFITS OF MOUD: DECREASED MORTALITY



Sordo, et al. *BMJ.* 2017 Apr 26;357:j1550.
Liebschutz JM, et al. *JAMA Intern Med.* 2014 Aug;174(8):1369-76.
D'Onofrio G, et al. *JAMA* Apr 28;313(16):1636-44.

BARRIERS TO ACCESS TO MOUD

- Non-evidence based program requirements
  - Abstinence goal
  - No other substance use
  - Several visits before initiation of therapy
  - Mandatory psychosocial counseling
  - Mandatory attendance at support groups (i.e., Narcotics Anonymous)
  - Frequent visits beyond regular office visits
- Demand for care >>> Supply
  - Waivered providers prescribing far below limits
- Stigma
- Concerns about diversion

Jakubowski A, et al. *J Addict Med.* Mar/Apr 2020;14(20:95-98.
Duncan A, et al. *JAMA Netw Open.* 2020;3(8):e2014045.

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MONTHLY PATIENT VOLUMES FOR BUP-WAIVERED CLINICIANS

Table. Monthly Patient Census Among Active Clinicians Prescribing Buprenorphine for Opioid Use Disorder From April 2017 to January 2019

Patient limit	Waivered clinicians, No.	Active clinicians, No. (%)	Monthly patient census, median	Monthly patient census, percentile		
				10th	25th	75th
30	42 508	16 525 (38.9)	3.4	1.0	1.3	9.6
100	8923	7504 (84.1)	23.9	2.0	7.2	55.4
275	4507	4419 (98.0)	101.5	16.1	48.3	171.5
Total clinicians	55 938	28 448 (50.9)	8.3	1.0	2.1	35.9

Duncan A, et al. *JAMA Netw Open.* 2020;3(8):e2014045.

WHAT IS "LOW BARRIER" MOUD?

- Access to MOUD that provides consistent and easy access to care regardless of current stage of change, race, socioeconomic status, ability to pay, and other social determinants of health
  - Basically: "Meet patients where they are at"

- Ultimate Goal: Reduce overdose deaths and save lives

J Katz: Drug Deaths in America Are Rising Faster than Ever, NYT 6.5.17
CDC: Provisional Drug Overdose Death Counts. Accessed from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed on: October 27, 2020.

SEVEN PRINCIPLES OF LOW BARRIER MOUD

1. Every person's SUD is unique and every recovery trajectory is different

2. Individuals should receive MOUD as quickly as possible, prior to lengthy assessments or treatment planning sessions

3. Maintenance medication is delivered without arbitrary tapering or time limits

SUD = substance use disorder
OUD = opioid use disorder

Colangelo B and Bascelli L. Camden's Medication First Model.

SEVEN PRINCIPLES OF LOW BARRIER MOUD, CONT.

4. Individual psychosocial services are continually offered but not required as a condition of receiving MOUD

5. Medication is provided regardless of insurance or income

6. Medication is available regardless of age, race, gender, sexual orientation, spirituality, criminal history, mental health condition, or medical condition

7. Medication is discontinued only if it is worsening the person's condition

SUD = substance use disorder
OUD = opioid use disorder

Colangelo B and Bascelli L. Camden's Medication First Model.

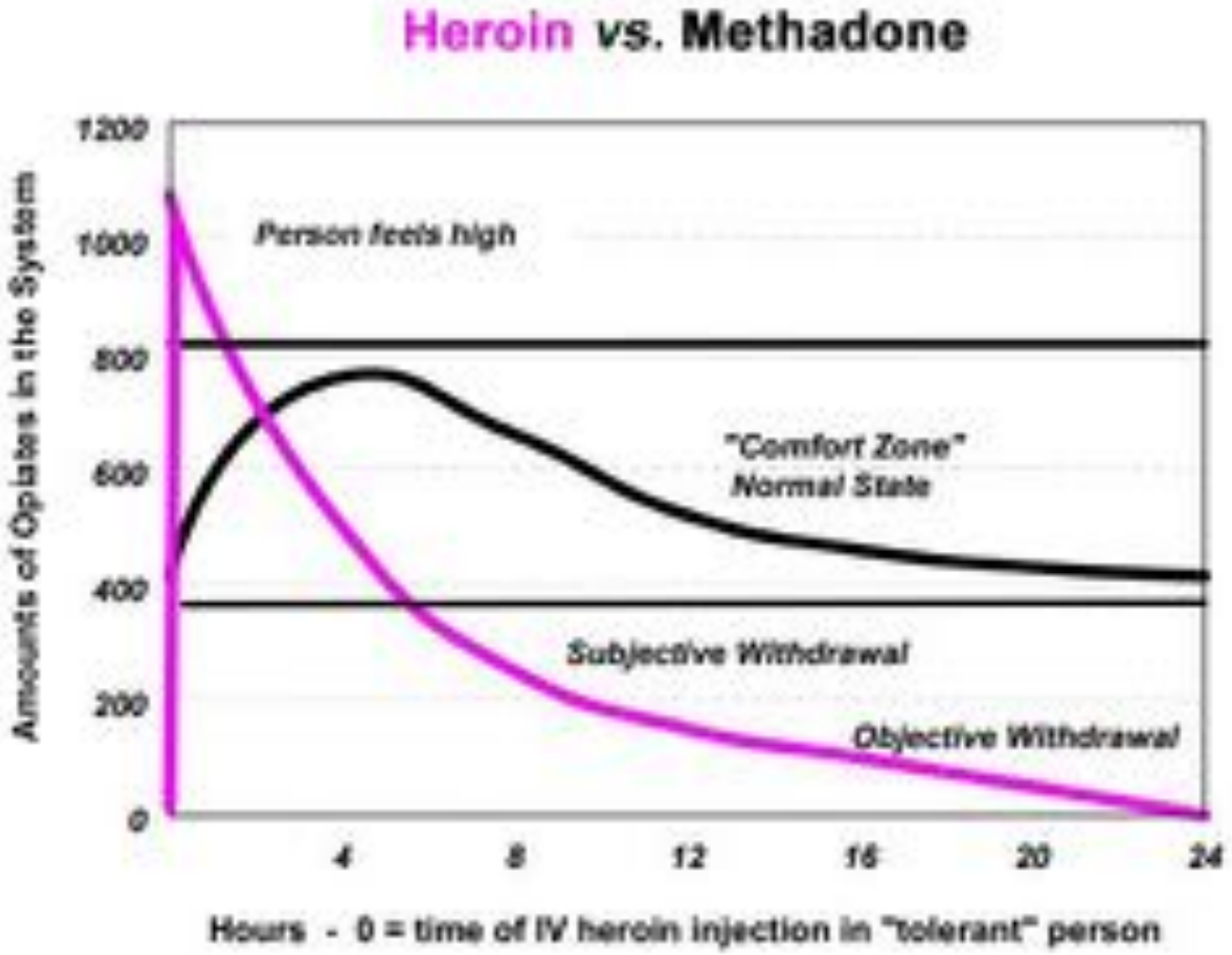
SUPPORT FOR A LOW BARRIER APPROACH C

- Improve patient quality of life
- Reduce overdose deaths
- Keep patients retained in care
- Reduce HIV and hepatitis C incidence
- Reduce criminal activity
- **Allow neurobiological recovery**

Image from: https://www.recoveryanswers.org/resource/drug-and-alcohol-harm-reduction/

D'Onofrio G, et al. *JAMA.* 2015 Apr 28;313(16):1636-44.
Jackubowski A, et al. *J Subst Abuse Treat.* 2020 Dec;119:108140.
Carter J, et al. *Addict Sci Clin Pract.* 2019 May 6;14(1):20.
Duncan L, et al. *J Addict Med Ther Sci.* 2015;1(2):31-36.

WHY DOES MOUD WORK?



RECENT LITERATURE ON OFFICE VISITS

Jakubowski et al:

Retrospective cohort study of 237 patients initiated on buprenorphine at an urban FQHC

- **Objective:** Same-day vs. delayed buprenorphine Rx and association with 30-day retention in treatment
- **Findings:** 30-day buprenorphine treatment retention was high even when patients received prescriptions at their initial encounter
- **Conclusion:** Same-day prescribing not associated with worse retention, suggesting that allowing for same-day treatment should become the standard of care

Jakubowski A, et al. *J Subst Abuse Treat.* 2020 Dec;119:108140.

RECENT LITERATURE ON BUP DIVERSION

- Silverstein et al:
  - Qualitative interview of 65 individuals within the Dayton, Ohio metropolitan area
  - **Objective:** Understand motivations of people who have OUD and are using non-prescribed buprenorphine (NPB)

Silverstein SM, et al. *Drug Alcohol Depend.* 2020 May 1;210:107958.

SILVERSTEIN ET AL, CONT.

- Key Motivators for using NPB:
  - Avoid the "burden" of intensive program requirements (i.e., IOP)
  - The "geographic cure" + self-tapered NPB
  - Self-initiate treatment while waiting for formal services
  - Bolster a sense of self-determination prior to entering formal treatment: "On my own terms"

Silverstein SM, et al. *Drug Alcohol Depend.* 2020 May 1;210:107958.

METHODS TO INCREASE LOW BARRIER MOUD

- Increase the initiation of MOUD in the emergency department setting
- Prescribe MOUD in harm reduction centers (i.e, syringe access programs)
- Implement mobile treatment sites
- Utilize telehealth as allowed by current regulations
- Offer walk-in services
- Don't discharge for non-compliance; see the patient more frequently instead

Mobile treatment unit in Colo

Jakubowski A, et al. *J Addict Med.* Mar/Apr 2020;14(20:95-98.
Rhee, TG, et al. *JAMA Netw Open.* 2020 Oct 1;3(10):e2021209.
Jakubowski A, et al. *J Subst Abuse Treat.* 2020 Dec;119:108140.

SPECIFICALLY FOR BUPRENORPHINE…

Table. Buprenorphine Care: Previous Approaches Compared With New Findings and Recommendations

Previous Approach	New Findings and Recommendations
A medical setting is needed for induction.	Home induction is also safe and effective (6).
Benzodiazepine and buprenorphine coprescription is toxic.	Buprenorphine should not be withheld from patients taking benzodiazepines (5).
Relapse indicates that the patient is unfit for buprenorphine-based treatment.	Relapse indicates the need for additional support and resources rather than cessation of buprenorphine treatment (43).
Counseling or participation in a 12-step program is mandatory.	Behavioral treatments and support are provided as desired by the patient (6).
Drug testing is a tool to discharge patients from buprenorphine treatment or compel more intensive settings.	Drug testing is a tool to better support recovery and address relapse (56).
Use of other substances is a sign of treatment failure and grounds for dismissal from buprenorphine treatment.	Buprenorphine treatment does not directly affect other substance use, and such use should be addressed in this context (43).
Buprenorphine is a short-term treatment, prescribed with tapered dosages or for weeks to months.	Buprenorphine is prescribed as long as it continues to benefit the patient (6).

Martin, et al. *Ann Intern Med.* 2018 Nov 6;169(9):628-35.

ASAM NATIONAL PRACTICE GUIDELINE – 2020 OPIOID USE DISORDER UPDATE

- Start patients on evidence-based medication immediately:
  - Buprenorphine
  - Methadone
  - Naltrexone ER

MAJOR REVISION Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management.

NEW Comprehensive assessment of the patient is critical for treatment planning. However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder. If not completed before initiating treatment, assessments should be completed soon thereafter.

J Addict Med. Mar/Apr 2020;14(2S Suppl 1):1-91.

ASAM NATIONAL PRACTICE GUIDELINE – 2020 OPIOID USE DISORDER UPDATE

- Optimal dose to prevent all of the below:
  - Opioid withdrawal
  - Opioid **cravings**
  - Overcoming the mu-receptor blockade

MAJOR REVISION Following initiation, buprenorphine dose should be titrated to alleviate symptoms. To be effective, buprenorphine dose should be sufficient to enable patients to discontinue illicit opioid use. Evidence suggests that 16 mg per day or more may be more effective than lower doses.

J Addict Med. Mar/Apr 2020;14(2S Suppl 1):1-91.

POLICY CHANGE

SUBSTANCE ABUSE, 2018
VOL. 39, NO. 3, 263–265
https://doi.org/10.1080/08897077.2018.1543382

EDITORIAL

No end to the crisis without an end to the waiver

Joseph W. Frank, MD, MPH[a,b], Sarah E. Wakeman, MD[c,d], and Adam J. Gordon, MD, MPH[e,f]

SUMMARY

- Opioid overdose mortality is much lower when patients are on MOUD.
- Utilize a treatment plan driven by the patient and acceptable to you as the provider.
- Remember that the guiding principles of a low barrier approach = harm reduction.

Sordo L, et al. *BMJ.* 2017 Apr 26;357:j1550.

THE TRANSFORMATION OF RECOVERY

Source: https://www.the-sun.com/news/106584/before-and-after-photos-show-face-of-americas-addiction-crisis-as-drug-and-alcohol-users-are-transformed-after-quitting/

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