Wisconsin Opioid Project ECHO
Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

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Zoom Meeting ID: 156 261 634

For attendance purposes please text the following code: SUCHUF to 608-260-7097

Session Date: Friday October 19, 2018

Didactic Topic and Presenter: Transition from Methadone to Buprenorphine by Ritu Bhatnagar, MD, MPH

- 12:30 PM: Attendance text-in – Introductions

- 12:45 PM: Case #1 & discussion
  - Presenter: Allison Miller, MD
  - Question: Patient has been buying Buprenorphine off the street and is now seeking prescription, prescribe or not?

- 1:00 PM: Case #2 & discussion
  - Presenter: Eun Ha Kim, MD
  - Question: How to transition from Methadone to Buprenorphine?

- 1:15 PM Didactic Presentation

- 1:30 PM: End of Session

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WI Opioid Project ECHO 2018-2020

Transition from Methadone to Buprenorphine

Friday October 19, 2018

Ritu Bhatnagar, MD, MPH

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:

As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices
2. Participate in office-based management of opioid use disorders
3. Seek overdose prevention education with greater frequency.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD

Policy on Disclosure

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Chris Nicholas, Content Expert, Psychology-SUD/Mental Health Counselor	No relevant financial relationships to disclose	No
Elizabeth Collier, Content Expert, Social Worker	No relevant financial relationships to disclose	No
Paul Hutson, Content Expert, Pharmacy	No relevant financial relationships to disclose	No
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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2018 Universal Activity Number (UAN)
JA0000358-9999-18-095-L04-P

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 10/19/19

2-Presenter: Alison Miller

3-ECHO ID: 3034

4-Have you presented this patient during this teleECHO clinic before? NO

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:
Patient has been buying buprenorphine and adderall off street for 1 year and now would like me to prescribe.

Demographic Information:

6-Age: 45

7-Gender: F

8-Education/Literacy: Finished H.S.

9-Income source: childcare

10-Insurance: BC/BS

11- HPI: 45 y/o ♀ with long term Hx of OUD started after C-section of 1st child with oral oxycodone. Was getting it from health care provider for years and then got cut off. Was buying it on street. Used Heroin for 1-2 weeks and did not like it and went into inpatient treatment program where she was put on buprenorphine 3yrs ago. Lost insurance 1yr ago and that is when she started buying it on street.

12-Social History:
(+) smoking
(-) alcohol

13-Housing:
Yes; lives 45 miles NO of Madison

14- **Substance Use History:**

15- **Consequences of Substance Use:**

- Social/occupational/educational:
- Physical (including evidence of tolerance/withdrawal):

16- Behavioral Health Interventions that have been tried:

Was in intensive inpatient → outpatient program (crossroads in Sunpraire) but lost insurance & therapy in one year - Has been occasionally going to NJA

17-Medications Tried for Relapse Prevention? (Specify):

Bought Buprenorphine on street

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Omeprazole 20mg	

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):

Ø

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

Lab - (+) amphetamine (+) Buprenorphine & norbuprenine

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22-Prescription Monitoring Program Pertinent Findings:

Ø

23-Proposed Diagnoses:

(1) Opioid Use Disorder
(2) ADD

24-Patient Goals for Treatment:

(1) Return to therapy.
(2) ~~N/A~~ Narcotic Anonymous
(3) Appropriate urine drug screen

25- Proposed Treatment Plan:

My question is do I prescribe? Does she need induction? How do I start?
Would you prescribe ADD meds?

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DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 10/19/18

2-Presenter: Eun Ha Kim, MD

3-ECHO ID: 5718

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

How to transition from high dose of methadone to Suboxone.

Demographic Information:

6-Age: 48

7-Gender: M

8-Education/Literacy: not accessed

9-Income source: self- employed.

10-Insurance: none. Applied for Badgercare MA during hospital staying

11- HPI:

- Patient is 48-year-old male with history of opioid use disorder, on methadone maintenance therapy who was hospitalized for Legionella pneumonia. He has been on methadone 90mg for 3 months, last dose was morning of admission. The night of admission, he had an episode of unresponsiveness, acute respiratory distress. He was given a dose of Narcan, he improved rapidly. Methadone was on hold due to concerns of possible contribution to acute hypoxic and hypercarbic respiratory failure, and recurrent hypercarbia. Oxycodone 5mg q6h prn ordered to prevent withdrawal symptoms. He maintained with minimal withdrawal symptoms on 1-2 dose of oxycodone 5mg.
- Patient started use opioid about 3 years ago for pain from heavy work, became recreational, quickly progress to daily use, getting pills from others, using IV heroin, oxycontin. He wanted to cut down, and he realized it had gotten out of control. He brought himself to methadone clinic 5-6 months ago. He is living in New Glarus, getting methadone in Madison, with self-pay because he has no health insurance. 12-Social History:

12. Social History

- He is self-employed, works with plaster, only one other co-worker who has no substance use problem.

13-Housing:

- Living with girlfriend, 3-year-old son, and 10-year-old girlfriend's daughter from previous relationship.

14- Substance Use History:

- Patient has history of heavy alcohol use disorder, in 90s. he reported transition to crack cocaine use from alcohol before he started using opioid. He Started taking opioids about 3 years ago recreationally, for pain, which was a consequence of heavy work. He got it from his friends, and felt that it helped him with his energy and made him feel good. He escalated to daily use fairly quickly, and was using IV heroin, OxyContin for a year. He changed to snorting these for a year, as he wanted to cut down, and knew it had gotten out of control.
- Nicotine: 2 packs per day for 20 years

15- Consequences of Substance Use:

- Social/occupational/educational:
  - OWI
  - Felony charge; Possession of narcotic drugs twice

- Physical (including evidence of tolerance/withdrawal):

16- Behavioral Health Interventions that have been tried:

- Newstart IOP twice once in 90s and in 2006

17-Medications Tried for Relapse Prevention? (Specify):

- Methadone is firsts and only trial.

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Methadone 90mg (on hold upon admission) Oxycodone 5mg q6h prn Clindamycin Guaifenesin Ipratropium-albuterol nebulizer Levofloxacn Naloxone PRN Prednisone	Legionella pneumonia COPD Opioid use disorder Tobacco use disorder

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Motivation for treatment Self-employed Supportive family Safe living environment No psychiatric co-morbidity	

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20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

- Positive for oxycodone and methadone, negative all other tested panel. sample collected hospital day #2.

22-Prescription Monitoring Program Pertinent Findings:

23-Proposed Diagnoses:

- Opioid use disorder
- Tobacco use disorder
- Alcohol use disorder in remission
- Cocaine use disorder in remission

24-Patient Goals for Treatment:

- "get my life back"

25- Proposed Treatment Plan:

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From Methadone to Buprenorphine: Watch Your Step!

Dr. Ritu Bhatnagar, M.D., M.P.H.
Medical Co-Director, Addiction Psychiatrist
UnityPoint Health- Meriter/ NewStart
October 19, 2018

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- No financial disclosures for Dr. Bhatnagar
- Some off-label uses of medications may be discussed in this presentation

Overview

- Reasons for transfer
- How to transfer safely
  - old and new methods

Evaluate reasons for transfer carefully.

- If stable on methadone, usually not advisable to transfer.
- Easier to transfer from buprenorphine to methadone than methadone to buprenorphine.
- Pharmacology review:
  - partial vs. full mu agonist.
  - buprenorphine high affinity for mu receptor, slow association/ dissociation kinetics

Some benefits of transfer to buprenorphine:

- lower risk of overdose
- lower risk of respiratory suppression, QT prolongation
- fewer medication interactions
- less severe withdrawal if dose is missed

Lifestyle factors:

- medication available at a local pharmacy vs. OTP
- treatment in outpatient setting

Patient factors may include:

- perceived stigma of daily dosing program
- distance to OTP
- desire to travel, or for work
- unhappiness with structure of program
- ongoing use of other substances

Always get records from OTP to help coordinate care, verify dose and treatment history.

In the past, recommended process (Tip #40):

- Taper methadone to 30 mg per day for at least 1 week.
- Hold methadone and all other opioids for 36-72 hours (as long as possible).
- Once COWS > 13, can start buprenorphine, 2-4 mg, and continue with usual induction process.
- Can require higher doses of buprenorphine, up to 32 mg, initially.
- Dose based on patient comfort in the first 3-5 days.

Tapering is NOT straightforward for the patient's body.

- Can use clonidine, dicyclomine, NSAIDs, hydroxyzine, tizanidine, ropinirole to assist with withdrawal symptoms.

Risk of relapse during methadone taper, even when done in coordination with OTP, is high.

- Deterioration in mental health possible.
- Support patient with more frequent phone/ counseling contact.

New data (Lintzeris) suggests:

- Reduce methadone dose until mild to moderate withdrawal between doses- with coordination, as outpt.
- Inpt process if pt is at high methadone dose (> 70 mg), has significant health co-morbidities, or unstable socially.
- Once > 24 hours after last methadone dose and COWS >12, can start buprenorphine at 2 mg.
- Monitor COWS hourly, and give 6 mg after 1 hr.
- Give 4 mg prn COWS > 12, keep dosing until pt comfortable.
- Usual adjunctive medications for comfort.

Conclusions

There is no single “right” choice- methadone or buprenorphine.

- Dependent on pt preference and characteristics

Transfer from methadone to buprenorphine is possible, and can be successful.

- Needs coordination with OTP
- Pt needs to be informed of usual course, comfort medications and additional available support

References:

Casadonte, P. “PCSS Guidance: Transfer from methadone to buprenorphine.” 2006. Online at http://www.naabt.org/documents/PCSS_Meth-bupe-transfer.pdf

Lintzeris N et al. “Transferring Patients From Methadone to Buprenorphine: The Feasibility and Evaluation of Practice Guidelines.” J Addict Med, 2018; 12: 234-40. Online at https://journals.lww.com/journaladdictionmedicine/Fulltext/2018/06000/Transferring_Patients_From_Methadone_to.10.aspx

Mannelli P et al. “Buprenorphine-mediated transition from opioid agonist to antagonist treatment: state of the art and new perspectives.” Curr Drug Abuse Rev 2012;5:52–63. Online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3496559/

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2- 3 = mild
4- 5 = moderate
≥ 6 = severe