SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 36—MEDICATIONS FOR OPIOID USE DISORDER (MOUD)
PAUL BRASLER, LCSW, CAIP

MAY 24 & 26, 2022

Department of Medical Assistance Services
Welcome & Meeting Information

- WebEx participants are muted
- Please use the Q & A feature or the Chat feature if you have a question
- The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions
- We do not offer CEUs for this webinar series
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Naloxone Resources

• Get trained now on naloxone distribution
  ▪ REVIVE! Online training provided by DBHDS every Wednesday
  ▪ [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    • Register and enter your zip code to access free online training
• Medicaid provides naloxone to members at no cost and without prior authorization
• Call your pharmacy before you go to pick it up!
• Getting naloxone via mail
  ▪ Contact the Chris Atwood Foundation
  ▪ [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
  ▪ Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website
https://www.dmas.virginia.gov/#/artssupport
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven’t already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. https://redcap.vcu.edu/surveys/?s=C8HERT9N3P

• Your name and contact information will not be linked to your survey responses.
• Your decision to complete the survey is completely voluntary.
• When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
• You are able to complete one pre and post survey per each webinar topic you attend.
• Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Spring/Summer 2022 Webinars

• Medications for Opioid Use Disorder [NEW]
  • Tuesday, May 24, 2022: 10 – 11 AM & Thursday, May 26, 2022: 1 – 2 PM

• Urine Drug Screenings: Purpose & Practice
  • Tuesday, June 7, 2022: 10 – 11 AM & Thursday, June 9, 2022: 1 – 2 PM

• Medical vs. Mental Health Issues in Clients with OUD [NEW]
  • Tuesday, June 21, 2022: 10 – 11 AM & Thursday, June 23, 2022: 1 – 2 PM

• SUD Treatment for Adolescents
  • Tuesday, July 12, 2022: 10 – 11 AM & Thursday, July 14, 2022: 1 – 2 PM

• From Burnout to Resiliency [NEW]
  • Tuesday, July 26, 2022: 10 – 11 AM & Thursday, July 28, 2022: 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Paul also works in a ketamine-infusion practice where he provides psychedelic-assisted psychotherapy. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. He has also worked in community mental health, emergency departments, and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
Abbreviations

- MOUD: Medication for Opioid Use Disorder (formerly called Medication-Assisted Treatment)
- OBOT: Office-Based Opioid Treatment Program (prescribes buprenorphine or naltrexone)
- OTP: Opioid Treatment Program (formerly called Methadone Clinics—dispenses methadone, buprenorphine or naltrexone)
- OUD: Opioid Use Disorder (formerly Opioid Addiction, Opioid Misuse, Opioid Dependence)
- SUD: Substance Use Disorder (formerly Addiction, Abuse, Dependence)
Myths of Medically Treating Opioid Use Disorder

1. Medications like methadone and buprenorphine only replace one addiction with another
2. Clients should taper off of methadone and buprenorphine at some point
3. Dosages of methadone and buprenorphine should be limited
4. Clients prescribed buprenorphine or methadone must attend counseling
5. MOUD is incompatible with 12-step peer recovery programs
6. Clients should be terminated from MOUD programs if they use illicit substances
The Necessity of MOUD

• “Provisional data from CDC’s National Center for Health Statistics indicate there were an estimated 107,622 drug overdose deaths in the United States during 2021, an increase of nearly 15% from the 93,655 deaths estimated in 2020. The 2021 increase was half of what it was a year ago, when overdose deaths rose 30% from 2019 to 2020.” (Centers for Disease Control)

• Synthetic opioids (illicit fentanyl) were the cause of over 70,000 of overdose deaths in 2021

Heroin & Fentanyl
Opiate Abuse

Physical signs someone you know is abusing opiates.

Nodding
This is when a person temporarily falls asleep at an unusual time like during a conversation or while standing.

Constricted Pupils
Heroin or other opiates will cause the user to have constricted pupils which will appear as pinpoints or a small dot.

Covering their Arms
A person may wear long sleeve shirts, and keep their arms covered, even if it is hot outside.

Needle Marks
Also known as track marks, if someone is shooting the drugs, they may have needle marks on the arms, behind their knees, or ankles

Bad coordination
If someone is high on opiates, their balance may be off, and they might stumble and trip while walking.

Scratching
Another clue is that someone on opiates will usually itch and scratch frequently.

Are you concerned someone you love has an opiate addiction? Visit newroadstreatment.com and see what you can do to help.

• Sedation
• Nausea
• Constipation
• Pinpoint Pupils
• Slowed Breathing
• Coma & Death
Heroin

- “Dope, junk, smack, horse, shit, cheese...”
- One to four times the strength of morphine (metabolized into morphine in the body)
- First synthesized in 1874; marketed in 1898 by Bayer
- Crosses the blood-brain barrier quicker than morphine: Euphoria occurs 10 - 15 seconds after insufflation or smoking, 5 - 8 mins. after muscular injection and less than 20 seconds after intravenous injection
- Sold in **two** grades:
  - Lower grade (#3), “brown sugar;” “black tar” – usually injected (intravenous, intramuscular, or skin-popped)
  - Higher grade (#4 = up to 90% pure), “China White” – can be insufflated (snorted), smoked or injected
Heroin

• Injecting heroin (or any other injectable drug), increases the user’s potential of contracting HIV, Hepatitis B or C, and developing abscesses
  • Regular use causes the veins to narrow and harden
• Heroin, like all opioids, decreases respiration, which is the leading cause of overdose deaths
• Most heroin addicts use other drugs, particularly alcohol, nicotine, benzodiazepines and stimulants
  • Most fatal heroin overdoses are not the result of heroin alone, but heroin and another drug in combination, usually a depressant
Fentanyl

• The most powerful of all opioids, about 80 times more potent than morphine
• Used to treat chronic pain, acute pain, and in surgical procedures
• Most of the illicit fentanyl we see is manufactured in China; India is also emerging as a source (DEA, 2020)
• Fentanyl is being found in other drugs: Cocaine, methamphetamine, and illicitly-manufactured Alprazolam
  • This is likely due to cross-contamination as drugs are diluted and repackaged as they move down the supply chain
• Sometimes sold in gelatin capsules (“Beans”) to users who prefer fentanyl to heroin
• There are thousands of Fentanyl analogues, including: Acetyl Fentanyl, Sufentanil, and Carfentanil (100 times more potent than regular Fentanyl)
Fentanyl Analogues & Similar Chemicals

Fentanyl forms recently reported include:

- p-FBF: 4-Fluorobutyrfentanyl:
  - Created in the 1960’s, and found its way onto the Black Market in the 1980’s
  - Now a Schedule I drug
  - Sometimes sold in an intra-nasal spray formulary
- MAF: Methoxyacetylfentanyl
- U47700:
  - Created by Upjohn in the 1970’s; eight times more potent than morphine
  - Not a true Fentanyl analogue, but often taken with fentanyl
Opioid Withdrawal Symptoms

- Cravings
- Irritability, depression, anxiety
- Nausea, vomiting, stomach cramps, diarrhea
- Muscle (and possibly bone) aches and pains
- Lacrimation, Rhinorrhea, Piloerection

- Hot and cold flashes; uncontrolled sweating
- Yawning
- Anorexia
- Insomnia
- Fever
- Dilated pupils
Opioid Withdrawal Course

- Symptoms appear within 6 – 8 hours of last dose
- Symptoms peak on the 2\textsuperscript{nd} or 3\textsuperscript{rd} day
- Symptoms usually disappear within 7 – 10 days
- Duration is much longer with Methadone (about twice as long as heroin takes)
  - Methadone withdrawal can last at least three weeks after the last use if the patient was using a large amount of Methadone
- \textbf{Post-acute withdrawal symptoms continue for many months afterward}
Drugs & Neurochemistry
Neuroanatomy

• Neurotransmitters are chemicals that facilitate communication between brain cells

• A neurotransmitter binds only to a compatible receptor site
  • Each nerve cell produces only one type of neurotransmitter
  • But a nerve cell can have receptor sites for several neurotransmitters

• Once the neurotransmitter has “docked” with the site, channels on the neuron open to allow ions to enter the receiving cell, changing the polarization of that cell, causing it to “fire” electrically
Agonist and Antagonist

- **Agonist**: A drug or chemical that acts on a receptor to mimic the effects usually created by the naturally occurring neurotransmitter that “fits” that receptor
  - Examples include most opioids; Benzodiazepines act as agonists on the GABA receptor
- **Antagonist**: A substance or drug capable of blocking or reducing (at the receptor) the activity of an agonist without exerting any effect itself; there are competitive and noncompetitive agonists
  - Examples include most anti-psychotics (which block dopamine 2 receptors); naltrexone and naloxone (Narcan) which block opioid receptors
Pharmacotherapy (Medication-Assisted Therapy—now MOUD)

MAT has been shown to keep patients in treatment programs longer, increasing their chances of a long-term recovery.
Four Types of MOUD

- Methadone
- Buprenorphine
- Naltrexone
- Naloxone*
MOUD

- **Methadone** has the highest efficacy of any MOUD
- **Naltrexone** has the lowest efficacy of any MOUD, especially when it is used orally, but has greater efficacy (than oral naltrexone) when used in a depot injection
- **Buprenorphine** is slightly less effective than methadone as an MOUD
- **Naloxone** is used to reverse the effects of an opioid, and is often added to buprenorphine (Suboxone) to limit diversion. It is technically not considered a form of MOUD in its own right
MOUD

• Methadone and Buprenorphine are opioids—human-made chemicals that are like opiates (medicines made from opium)
• Methadone was approved for opioid use disorder treatment in the 1970’s and Buprenorphine in 2002
  • Used for opiate withdrawal management in inpatient settings and maintenance treatment in outpatient settings
  • Given by a licensed provider and administered in oral form (an injectable form of buprenorphine is available)
• Behavioral health treatment is an important part of MAT, but clients should not be forced to receive counseling to be able to receive pharmacotherapy
Methadone & Buprenorphine Therapies

• Methadone and Suboxone act as opioid agonists: They keep the client from experiencing opioid withdrawal symptoms (also called “dope sickness”) and block the euphoric effects should the client use heroin or another opioid, thus discouraging the client from continuing use
  • Neither of these chemicals, when used as prescribed, will get the client high
• However, methadone and buprenorphine are the most-regulated medicines in the U.S. when used for treating SUD
• Both chemicals allow the brain to heal from opioid use and provide opportunities for the client to address the underlying causes of their SUD
How OUD Medications Work in the Brain

- Methadone: Full agonist, generates effect
- Buprenorphine: Partial agonist, generates limited effect
- Naltrexone: Antagonist, blocks effect

Source: PCT, 2016
Methadone

“A Cochrane review of 5 randomized clinical trials with 788 participants found that, when provided at flexible doses on an outpatient basis, methadone retained patients in treatment longer than buprenorphine. That same review found that methadone and buprenorphine equally reduced illicit opioid use based on 8 studies with urine drug testing data from 1,027 participants and 4 studies with self-reported drug use from 501 participants.”

(SAMHSA, 2021, p. 3-11)
Methadone

• “Methadone has the strongest evidence base of any opioid addiction treatment” (Andraka-Christou, 2020, p. 52)
• Delivered in liquid or pill form in Opioid Treatment Programs (OTPs)
• Long-term effects: 24 – 36 hours
  • This allows the client to work, attend school, parent, and engage in pro-social activities as opposed to purchasing, using and recovering from illicit opioid use
  • Responsible for some opioid overdose deaths, since Methadone accumulates in tissues before binding to plasma proteins
  • Withdrawal develops slowly and is prolonged when compared to morphine or heroin
Methadone Doses

- “Higher methadone doses are associated with superior outcomes” (SAMHSA, 2021, p. 1-5)
- Methadone’s half-life is 8 – 59 hours
- Patients being methadone treatment should “start low and go slow”
- Federal guidelines limit the first dose to 30 Mg
- The goal is to eliminate cravings and block withdrawal symptoms without over-sedating the client
“Interviewees with methadone treatment experience argue that an appropriate methadone dose is critical to treatment success. Yet over 40 percent of U.S. methadone clinic patients receive too low a dosage, with nonwhite minorities particularly likely to receive insufficient doses. Significant evidence exists that methadone treatment programs should provide a minimum dose of 80 mg/day, as methadone dose is strongly related to treatment effectiveness.” (Andraka-Christou, 2020, p. 134)
Federal regulations based on patients’ time in treatment determine eligibility to be considered for receiving take-home doses of methadone (but buprenorphine is not bound by these limits):

- One earned dose/week (beyond a weekly clinic closure day or federal holiday, when clinics typically close) in the first 90 days of treatment
- Two doses during the 2nd 90 days
- Three doses during the 3rd 90 days
- Up to 6 doses during the last 90 days
- Up to 2 weeks of doses after 1 year
- Up to 1 month of doses after 2 years

(SAMHSA, 2021, p. 3-33)
Buprenorphine

• An opioid agonist in low doses and an antagonist in high doses, often combined with Naloxone: Suboxone®
  • In this formulation, should the patient try to inject or insufflate the drug (instead of taking it orally), they will go into withdrawal symptoms (but people have found ways around this) (Kavanaugh & McLean, 2020)
  • Suboxone is delivered in a buccal film or pill
  • Less respiratory depression than Methadone
• Has a "ceiling effect" (at 32 mg) which makes overdose less likely—except when mixed with alcohol
• In 2017, the Food and Drug Administration approved Sublocade®, an injectable form of buprenorphine
Buprenorphine Treatment

• “Buprenorphine has fewer clinically relevant drug interactions than methadone in general” (SAMHSA, 2021, p. 3-54)
• Treatment should last for as long as patients benefit from treatment
• Longer treatment length is associated with positive treatment outcomes
• Typical maintenance doses range from 4 mg/1 mg to 24 mg/6 mg per day. An effective dose is the lowest dose that can:
  • Eliminate withdrawal
  • Reduce or eliminate opioid cravings
  • Reduce or stop illicit opioid use’s desirable effects
  • Be well tolerated

(SAMHSA, 2021, p.3-68)
Buprenorphine (Andraka-Christou, 2020, p. 44)

• “Buprenorphine has greater affinity for the brain’s opioid receptors than other opioids, meaning it binds more tightly to the receptors, so it displaces other opioids already on the brain’s receptors, after which it blocks the effects of subsequent opioids”

• “Even though buprenorphine has greater affinity for the opioid receptor, it actually has weaker intrinsic activity [italics in original] at the opioid receptors relative to methadone, meaning it creates less cellular activity, so people with OUD taking buprenorphine as prescribed are less likely to feel euphoria than people taking methadone as prescribed”
Buprenorphine Side Effects

Buprenorphine’s side effects may be less intense than those of full agonists

- Oral hypoesthesia (oral numbness) (SAMHSA, 2021, p. 3-60)
- Constipation
- Glossodynia (tongue pain)
- Oral mucosal erythema [reddening]
- Vomiting
- Intoxication
- Disturbance in attention
- Palpitations
- Insomnia
- Opioid withdrawal syndrome
- Excessive sweating
- Blurred vision
Patient Limits with Buprenorphine

• “For the first year of waiver use, all providers can treat up to 30 patients at one time
  • However, providers who satisfy additional practice and reporting requirements, and physicians who are board certified in addiction psychiatry or addiction medicine, may request to treat up to 100 patients at a time in the 1st year of waiver
  • Practitioners in “qualified practice settings” as defined in title 42, section 8.615 of the Code of Federal Regulations, may request to treat up to 100 patients within the first year

• After the first year of waiver use, all providers may request to increase their patient limit to 100
  • Physicians who are board certified in addiction psychiatry or addiction medicine or who satisfy additional practice and reporting requirements may apply to increase their patient limit to 275 after a year at the 100-patient limit (SAMHSA, 2021, p. 3-93 to 3.94)
• Not enough providers prescribing medication
• Stigma
• Pharmacies refusing to fill prescriptions
• Concerns about diversion-related dangers (often unfounded)
• Rigid program requirements (Jakubowski & Fox, 2020):
  • Abstinence as a treatment goal/No positive UDS
  • Must attend counseling (either before starting medication or to continue medication)
  (ASAM highly recommends same-day treatment access)
  • Must attend outside/peer-support groups

Barriers in Buprenorphine Treatment
Naltrexone & Naloxone

These medications have antagonistic properties; they will cause an opioid user to go into withdrawal (Naloxone) if administered while the person is using opioids or will block the effects of opioids (Naltrexone)

- **Naltrexone** (Vivitrol®) is a deterrent, and is used to prevent relapse by limiting cravings
  - Also blocks the euphoric effects of opioids, cocaine, and alcohol
  - Time-release injectable versions and implant versions are available
- **Naloxone** (Narcan®) is injected or used intra-nasally to reverse an opiate overdose
Naltrexone

• “Oral naltrexone is not widely used to treat opioid use disorder (OUD) because of low rates of patient acceptance, difficulty in achieving abstinence for the necessary time before initiation of treatment, and high rates of medication nonadherence” (SAMHSA, 2021, p. 3-37)

• Depot injections of extended release naltrexone are more effective than oral naltrexone

• While naltrexone works to block opioid receptors, clients may consume large amounts of opioids to try and override naltrexone’s ability to block the receptor

- “Studies show that most patients with OUD who undergo medically supervised withdrawal will start using opioids again and won’t continue in recommended care”
- “Patients who complete medically supervised withdrawal are at risk of opioid overdose”
- “Medically supervised withdrawal is necessary for patients starting naltrexone, which requires at least 7 days without short-acting opioids and 10 to 14 days without long-acting opioids”
“The TIP expert panel [SAMHSA] recommends that providers not discharge patients from treatment solely because of continued illicit opioid use if the benefits of treatment continue to outweigh the risks”

(SAMHSA, 2021, p. 3-92)
What About Tapering?

- “Forcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate” (SAMHSA, 2021, p. 3-92)
- “In some circumstances, forced tapering or abrupt discontinuation may violate the Americans with Disabilities Act” (3-93)
Counseling & MOUD

“The counselor’s role with clients who take OUD medication is the same as it is with all clients who have SUDs: Help them achieve recovery by addressing addiction’s challenges and consequences”

(SAMHSA, 2021, p. 4-4)
“It would be inappropriate for a medical team to refuse radiation for cancer patients because the team believes chemotherapy is always needed, or to refuse chemotherapy because they believe that radiation is always needed, regardless of each patient’s diagnosis and condition. It would be just as inappropriate to refuse evidence-based treatment with medication for a patient with OUD, when that may be the most clinically appropriate course of treatment.”
(SAMHSA, 2021, p. 4-25)
Here is the link to the Post-Webinar Survey. It should take you less than 5 minutes to complete:

https://redcap.vcu.edu/surveys/?s=W4P4ANWYK7

- Your name and contact information will not be linked to your survey responses.
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References


• Centers for Disease Control. (2018, July). “CDC health alert network (HAN) health update: Rising numbers of deaths involving fentanyl and fentanyl analogs, including carfentanil, and increased usage and mixing with non-opioids.” CDC HAN-00413. coca@cdc.gov


References


