Opioid Stewardship Series, Season 1, Episode 8:
Medication for Opioid Use Disorder (MOUD): Prescribing Buprenorphine

Speaker 1 (00:03):

And I'm going to introduce our two subject matter expert panelists today as we explore medication for OUD, otherwise known as MOUD, and initiating MOUD from the acute setting. So, we're honored to have Dr. Melody Glenn with us today, and who will be providing an overview of MOUD and specifically an introduction to buprenorphine induction. Dr. Glenn is a triple boarded, addiction emergency and emergency medical services physician. And she currently works clinically as an assistant professor at U of A College of Medicine in Tucson, Arizona. And we get two docs for one today. Isn't that awesome? So, thanks to their passion for MOUD. So, Dr. Alicia Gonzalez is gracing us today with her expertise in sharing how a hospital system actually implemented a network of MOUD bridge programs. And Dr. Gonzalez is a fellow of the American College of Emergency Physicians and the medical director of the emergency department at Marian Regional Medical Center in Santa Maria, California. So, we thank both of you so much for being with us today.

Speaker 2 (01:10):

Okay. We're talking about MOUD today, as mentioned. We'll go through some of our objectives. We'll be talking about opioid use disorder, evidence-based treatments we can use in various healthcare settings. The process of buprenorphine induction as well as the need for stabilization and maintenance will help you develop an action plan with identified resources for MOUD induction and referrals to ongoing care. We're going to understand the X-waiver training options, notice of intents that you can use to start prescribing immediately, almost immediately, and establish a workflow for induction and linkage to care. So, the main two forms of MOUD we'll be talking about today are methadone and buprenorphine. And probably all of you know about these, but just as a quick refresher, the main difference is their level of agonism. So, methadone is a full agonist, meaning the more you give, the more of an effect there is.

Speaker 2 (02:03):

Because of this, it's more heavily regulated. It is possible to overdose on methadone if people have too much, although it is very rare. A 1995 institute of medicine report said that the dangers of diversion and overdose were actually very overblown and that regulation is probably too much, while also talking about buprenorphine, which is a partial agonist with a really high affinity for the MU-opioid receptor. So, you can take more and more and more, but there may not be that much more of an effect. So, there's a ceiling to its effect, which you can see with this graph. So, a ceiling on the level of respiratory depression that someone might have, making it safer and less, less regulated. It's safer than many of the other opioids we prescribe regularly from our clinic environments. And questions about this come up in our hospital environment all the time.

Speaker 2 (02:47):

Can we start people on buprenorphine? Can we start people on methadone? Don't we need a special license for that? You don't, and this is where in the Federal Register it explains what we can do and we can't do. So, usually the people are correct. You have to prescribe methadone for a methadone clinic to use "bup," you have to have an X-waiver. But these are two exceptions to the Controlled Substance Act that allow us to start "bup" in the hospital or the emergency department. There's two little scenarios here. The first is colloquially known as the

"72 hour" or "Three Day Rule." So, we can start and titrate MOUD from the ED in the hospitals for patients who are in withdrawal and looking for treatment. So, if someone comes into the ED and says, Hey, I'm in withdrawal, I want to start treatment, we can do that right then and there.

Speaker 2 (03:35):

The second is, if we admit a patient for something else, if we're treating them for their cellulitis, if we are treating them for their COPD, we can start them, titrate them, maintain them on MOUD. The thing is that has to be listed as their admission diagnosis has to be something other than substance use disorder to a fit into this code of federal regulations. So, if you...I just wanted to show you that this exists. So, if you have any questions from your colleagues, here's where you find the answers. We're going to start with methadone. I know we're talking about "bup." "Bup" is the favorite golden child, I would say in the MOUD world, but I want to start with methadone just 'cuz it's actually easier to start with. And I think in our increasing world of illicit fentanyl, it's going to play a larger and larger role.

Speaker 2 (04:18):

I also find that some patients just want methadone. They prefer it for various reasons. They think it works better. They have traumatic memories experience with going through withdrawal and they want to avoid that. They like going to the clinic everyday. They feel like it gives 'em some accountability. Some people even like methadone because it doesn't, it feels a little bit more like what they're used to taking and they like that feeling. And some people like methadone because they still want to get high on the weekends and you can do that with methadone and in a harm reduction approach that's valid. We're looking for any positive change and methadone is safer than whatever illicit opioids they're using. So, if we can reduce that use of methadone, that's, you know, that's a game changer. So there's one little methadone sales pitch, how to do it.

Speaker 2 (05:01):

So, you can't give more than 40 milligrams on day one. And that's in the federal regulations. So, no one on day one can get more than 40 milligrams. I usually start people on 20 to 30 milligrams on their first day, 30 if they're in withdrawal, 20 if they're not, and then they get titrated. Once they get admitted, I usually go 10 milligrams a day. That's a little bit faster than most providers, but I like to get them up to a therapeutic dose quickly. And a therapeutic dose is 80 to a 100 milligrams. Some people need more though. People are still having withdrawal symptoms. If they're still having cravings, they need more. The methadone is actually very easy. It's something we don't do very often, but it's a great option especially for, you know, for patients who want to avoid withdrawal. There are microdosing with "bup" that you can avoid some of the withdrawal, but it's also easier to do with methadone.

Speaker 2 (05:53):

So, if you have a pregnant patient for example, who you really wanna avoid, withdrawal methadone might be easier. Okay, let's move on to "bup." So, "bup" is great for lots of reasons. One, it's safer. Uh, you can get it from any pharmacy, any doctor with an X waiver can prescribe it. So, it feels more like a medication that we use for anything else. Hypertension for diabetes. And the thing with "bup" is you have to be in some moderate amount of withdrawal when you first start it. And that's because it's a partial agonist. So, and it has a high affinity, so it's going to bind more tightly to that MU-receptor than any of the opiates that your patient is taking. So, it'll kick off those other opiates and because it has a ceiling effect, it will sort of drop them down and push them into withdrawal.

Speaker 2 (06:36):

If the patient's in withdrawal, that's not gonna be a problem. And there's also now microdosing protocols, which you could find in the California Bridge website that explain how to start "bup" without having to, without having to go through withdrawal. So, you can bypass that whole experience. But I'm going to be talking about the traditional way of starting "bup" in the emergency department. And this is, you have someone who comes in with withdrawal, I would say their COWS score should be at least an eight. And then you give them "bup" of eight. That's the easy way to remember it. COWS of eight, "bup" of eight. And then, if they feel the same or they feel better, give them more "bup." You wanna load them up in the emergency department or the hospital on that daily dose, which for most people is 16 to 24 milligrams a day.

Speaker 2 (07:21):

So, some emergency departments are giving 32 milligrams on day one 'cuz they want to really fill out those receptors, give them a little bit of time when they to get to their OTP or OBOT to keep getting their "bup." There's lots of ways of doing this. This is probably the simplest. So, you give them that test dose of eight. If it doesn't make them feel worse, you give them another eight to 16 milligrams. That's the most common. This just shows that second dose that you're giving. The point of the first dose is to make sure that you're not pushing them into precipitated withdrawal. The point of the second dose is to get them to therapeutic dosing. Moving on to maintenance. So, when your patients leaving and you want to prescribe them something, most patients are on this combination. Eight slash two milligrams, b.i.d. or t.i.d. I think I'm seeing more patients on t.i.d., now fentanyl.

Speaker 2 (08:11):

And you give them a week's worth. So, 14 to 24 tabs or strips and that should get them through for a week. So, they can set up care with an OBOT or OTP, some home start instructions that Dr. Jenny Wink, our addiction medicine fellow grad developed and I tinkered with a little bit. California Bridge also has Home Start instructions. So, let's say you have a patient who comes in with something completely unrelated to come in with a UTI and then you start talking to them and you realize that they have opioid use disorder and they're interested in stopping. You can just give them the prescription at, but to start at home, which is really great in line with trauma-informed care practices. They don't need to be suffering through withdrawal in the uncomfortable environment of the emergency department. They can be at home with people who care about them and support them and don't stigmatize them in their bed where they feel, you know, more comfortable.

Speaker 2 (09:00):

So, these are Home Start instructions. It's really very easy. You just tell 'em to wait until they're in withdrawal and they've been a certain number of hours since their last use, usually 12 for heroin or oxies. If you have a patient who's on methadone or longer acting, you might want to counsel addiction med first. But anyway, so they wait their time, they're in withdrawal, they're gonna cut their eight milligram fill in half. They'll take four milligrams as their test dose, see how they feel. Take the other half and there you go. There's their eight milligrams. They start doing that twice a day or three times a day. So, very easy. So, when you start someone on methadone or "bup," you want to link them to someone who can continue them. And especially with methadone, it's very important to put in your discharge instructions, the amount of methadone that they got while they were hospitalized, because then they can be counted as a methadone transfer at the OTP and not a new patient because there are federal regulations constraining how much a new patient gets. That's not the same for a transfer. So, as long as you just have in your discharge paperwork somewhere, hey, they were

admitted and they got up to 90 milligrams a day on methadone, put that in there so when they're transferred, they can start right at that 90. And thank you all for your time. That was a whirlwind.

Speaker 3 (10:08):

That was a whirlwind. But I I'm so impressed at how concisely you said all of that. That was amazing.

Speaker 2 (10:13):

It's that's so easy,

Speaker 3 (10:14):

<laugh>. It actually is, right? It is really easy. And so, I think what you want to talk about for the rest of this time is, what feels hard about it is, okay, well that all sounds very simple. How do I actually do this? Right? And so, I'm going to speak right now through the lens of how we did this, in this throughout the state of California with the Dignity Health sites, which is where I work. And so, this originally, if you, if you start, it came from the California Bridge model. We had the first wave of grant funding in the state and the California Bridge model talks about low-barrier treatment, right? Everything that Dr. Glenn just talked about it is, it is really easy, it is very simple. So, that part, we want to make gold standard care in every emergency department. But the other two pieces have to do with having an actual connection to care.

Speaker 3 (10:56):

How do we get patients from the acute care setting the hospital or the ER into the hands of a clinic that can continue to support their substance use treatment? And then finally building a culture of harm reduction, right? Getting rid of some of that stigma, learning how to talk to patients and doing these things successfully so they trust us and they'll come to us. The top five things we learned that you need to know to make this happen. First you have to have a few leaders in your system. Whether you're system is one hospital or whether you're system is 25, 20, 30, a hundred hospitals. There has to be somebody doing that coordination, staying accountable in our situation. That was myself and Dr. Fong. And so, we led that monthly meeting, but there's just got to be one person who rallies the troops. A lot of people are very willing to do the work and follow, but they need someone else to remind them and set up the meetings and send little emails that say, how's it going?

Speaker 3 (11:43):

So, there needs to be somebody, there has to be a champion. You also want a support network, right? So, for us, having multiple hospitals in our system was amazing. We could go through all the same barriers easier by saying, "Hey, this happened at my site, you know, let me tell you what we did to fix it. Or no, that's actually miseducation. Let me send you the real law about that." That's not illegal or whatever it is on those kinds of things. Having a support network, California Bridge can always be your support network. By the way, we have a lot of experts available to you. Feel free to go to our website. We have all those resources. We've done a lot of that. A lot of people have done a lot of that work for you already. You want to make sure you have a smooth patient referral process.

Speaker 3 (12:20):

So, every single place where you're starting buprenorphine in the acute care setting, you need to have a place where that person can go. That might be a telehealth option if you're in a more rural area that might be a brick

and mortar clinic down the street. But you want to make sure that you've reached out to what those options are and you know, their real phone number, not just the one that they post online where you wait three hours on hold or nobody ever answers the phone and there's no voicemail set up, right? You want a real phone number where one of our staff—we like to call 'em a patient navigator or substance use navigator—but it could be a charge nurse, it could be a social worker, it could be a case manager, it could be a random administrator in the care coordination office who comes in in the morning and reviews all the patients who got buprenorphine the day before and makes a couple phone calls to make sure they got linked to care.

Speaker 3 (13:02):

It doesn't matter who it is, but there needs to be somebody who helps navigate that process because understanding how to access care traditionally is not something that our patients with substance use disorder are very adept at because they haven't felt welcomed in our care system. So, they don't know how to navigate that system. They need a little bit of help with that. You probably needed an executive sponsor, right? Whether it's your chief medical officer, your chief nurse, somebody who, when you do have departments where you're struggling, maybe you're OB or your hospitalists are like, "This is ridiculous, I'm not doing that. You know, this is natural consequences." Well, I need somebody to back me up and say, actually our hospital or our system, we're doing this. And so, what do you need to get on board? Because sometimes your leader, your champion, doesn't have those teeth.

Speaker 3 (13:43):

So, you do need somebody to be able to back you up. And it really helps to measure and report things back. And this is just a little bit of nuance of what we were talking about with what a navigator is. It could be a dedicated substance use navigator or it could be anybody. But the goal is to have someone that can speak candidly at "normal person" language with a patient to help them navigate the system to get into ongoing care. We call it a warm handoff instead of a, "Here's a packet of 14 pages of many times copied over, difficult to read, non-verified phone numbers. Good luck to you." Quote the resources, right? We don't do that anymore. We need a real human to help them navigate that process for your first two action items. Build a referral process, right? So we have this education for you, teacher docs, how to do "bup," but make sure you have a referral process, and make sure that there's somebody designated to help do that warm handoff. Again, it can be so many iterations of what that looks like in your particular setting, but there's just got to be somebody who, who wraps around the care with those patients.

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