Dealing With Bumps in the Road

Positive Drug Screens

- Do not shame the patient. Most of the time, the patient is already quite ashamed of using, and many are very worried about disappointing us. Encourage the patient to be truthful. Relapses happen in addiction just like relapses happen in other chronic diseases like heart failure or cancer.
- Focus on problems with the treatment plan and how we can make it better.
- Ask questions about what happened to the patient using. Determine if it was a one-time use or ongoing.
- Find out the circumstances of use.
- Ask if they need more support, such as counseling or other support.
- Because of shame, many patients will not acknowledge use. Many patients are also worried that their buprenorphine will be discontinued.
    - It can be frustrating to us as clinicians when patients lie.
    - Continued use is often a sign that withdrawal symptoms or cravings are not controlled.
        - Every clinician is allowed to determine their own level of comfort with this.
    - In general, it is recommended to try to cultivate a relationship where the patient feels comfortable talking about use.
        - Helpful to understand that most patients with substance use disorders have been lying about their use (to others and themselves) for a long time, as an ongoing coping mechanism.
- It can take a while for patients to become comfortable disclosing their substance use.
    - An occasional lie is not uncommon, both in our substance use disorder populations and in our general population. It can be helpful to remind ourselves of this.

Drug Screens with Abnormal Buprenorphine Metabolites

- This is obviously concerning for diversion.
- Many providers will discontinue buprenorphine automatically at this time because they assume that they patient is not taking it. However, there are often other explanations. It is recommended that the clinician discuss this with the patient first and find out what it going on.
- There are some patients for whom it is a one-time mistake, and it may be reasonable to continue the buprenorphine with the understanding that it can't happen again.
- Discuss what the results showed.
    - If the patient acknowledges that they put a pill in the urine, discuss the circumstances, and why it happened.
    - If the patient doesn't acknowledge it, make it clear what the results showed and that it can't happen again.
- Recurrent urine drug screens that are negative for buprenorphine should be a cause for discontinuation.
    - Prior to discontinuation, alternative care should be done. This includes helping the patient find a higher level of care such as an inpatient treatment program or addiction clinic.
- However, prior to discontinuation of treatment, the clinician can make changes in care. These can include injectable buprenorphine, witnessed urine samples (by same gender staff), more frequent visits, shorter prescriptions, etc.

Pain

- Maximize non-opioid treatments:
  - NSAID's
  - Acetaminophen
  - Gabapentin/pregabalin
  - Duloxetine/venlafaxine/milnacipran
  - Physical therapy
  - Acupuncture
  - Therapeutic injections
  - Mindfulness
- If the pain is not relieved by the above measures, try increasing the dose of buprenorphine to 24 mg daily and splitting the dose to have the patient take it every 4 hours.
- If the pain is ACUTE and not relieved by the above measures, may prescribe opioids on top of the buprenorphine. Make it clear it is a short-term measure only.
- If the pain is chronic and not improved by the above measures, consider referring the patient to a methadone clinic. However, be aware that methadone in a methadone clinic is not dosed to provide good pain relief, as it is almost always dosed once daily. There may also be a delay in being started on methadone and in getting to a therapeutic dose.
- Under no circumstances should a clinician put a patient they have been treating with buprenorphine on methadone, as this may be viewed as a violation of federal law.

Need for Procedures/Operations

- Maximize non-opioid treatments:
  - NSAID's
  - Acetaminophen
  - Gabapentin/pregabalin
  - Duloxetine/venlafaxine/milnacipran
  - Physical therapy
  - Acupuncture
  - Therapeutic injections
- If the pain is not relieved by the above measures, try increasing the dose of buprenorphine to 24 mg daily and splitting the dose to have the patient take it every 4 hours.
- If the pain is not relieved by the above measures, the prescriber may prescribe opioids on top of the buprenorphine. Make it clear it is a short-term measure only.
- If the patient has a condition that will likely require opioids for an extended period, the provider can discuss with the patient whether to continue buprenorphine and prescribe opioids on top of the buprenorphine or stopping the buprenorphine for a period of time. If the buprenorphine is stopped, there should be a plan to resume buprenorphine in the future.

Pregnancy

- DO NOT STOP BUPRENORPHINE.
- If you are not comfortable with management, arrange for transfer to a prescriber who is comfortable. Write a script for buprenorphine without naloxone to last until they have an appointment.
- Send in a prescription for prenatal vitamins.
- Make a referral for prenatal care if you will not be providing it yourself.

Early Refills

- Ask the patient why they need an early refill.
- If they are overtaking, find out if their dose is too low and adjust if needed. This is the most common reason.
- If they have lost the prescription or had it stolen, make sure that they have taken steps to prevent it from happening again.
    - Consider doing a refill if this happens once. If it happens recurrently, the patient needs to take steps to prevent it from happening.
    - Patient may need more frequent visits, with shorter prescriptions.

Missed Appointments

- If it is a one-time occurrence, send in a script for a few days and reschedule the appointment.
- If it is recurrent, determine why and work with patient on fixing the problem:
    - Lack of transportation. See if they are eligible for transportation through their insurance. (Medicaid will provide non-emergency transport to appointments with 72-hour notice.)
    - Poor executive function with disorganization – this is common in patients with substance use disorder. Counseling can often help with this.
    - Shame/embarrassment about having relapsed and fear of being scolded if they come in. Try to be compassionate with patients who have relapsed. Work on not shaming them.
    - Fear of medical appointments/history of medical trauma. Refer for counseling.
    - Lack of commitment to treatment. While this can occur, it is important to rule out the above causes before assuming this is the reason they are not showing up for appointments. The fact that patients are showing up is a huge step in wanting help.
- Some clinics allow patients to be able to walk in for their appointment for buprenorphine. This will not work in all clinical settings.