OTP Session 11 Transcript

Gretchen Shoemaker:

All right. Well, it is 2 p.m., so why don't we get started? Hope you all are in the right place here. We're going to be chatting about building provider confidence in modern methadone treatment. This is one of two breakout sessions right now. And then I'll go ahead and introduce our fantastic presenters. We have Doctor Heidi Ginter here today.

Doctor Ginter is a family doctor and addiction medicine specialist. She has worked in OTPs in Massachusetts, Connecticut, New Hampshire and Maine for a variety of different organizations Right now, she is currently the medical director for addiction services at Signature Health Care in Brockton, and she believes that methadone is truly the best medication ever developed. I'm sure you will leave this session knowing that that is one of her true sentiments.

We've also got Amy Thomas here today who has provided substance use disorder care professionally and within the community for the past 21 years. She transitioned nine years ago to the outpatient Mat, including the Massachusetts Department of Corrections and various opioid treatment programs. Amy enjoys helping to educate, reduce stigma and provide support for all affected by the disease. We are so happy to have them here today.

Briefly, I'll just go over our session objectives. We are hoping that you will leave this session being able to: 1) list the number of take-home methadone doses a person-served can receive based on their time in treatment. 2) Describe 3 strategies for safely achieving a daily methadone dose of 100mg within the first week of treatment 3) Explain ways that the perception of risk in methadone treatment can differ between persons-served and providers. And with that, I'll pass it over to Doctor Ginter.

Dr. Heidi Ginter:

All right. Thank you so much. And welcome to everyone who's joining us. Amy and I are incredibly passionate about this topic and are looking forward to having a lot of interaction from our audience. So feel free to raise your hand or type something in the chat, and either we'll get to it in the moment or will wait until the end. But one of the things that I want to just start with is by saying, there are some things that we'll probably

say that sound bananas. If you haven't started to make these major shifts in how things are working at your OTP.

And there may be some things that you feel like, oh my gosh, can you even do that? Or you may be sitting back, you know, styling your nails, feeling like, no, I got this. I don't need to change anything. So wherever you are on the stages of change, we hope that you will take at least some little nugget of information home with you, no pun intended. Take home. Get it? So anyway, what I'm going to do is get started. And the thing I want to introduce you to is that 20 years went by before any changes to the federal regulations were made, and then all of a sudden last year, changes to part eight of CFR 42. And what they call that is the quote unquote, unquote final rule.

Overall, what that did is it actually brought OTPs from the 20th century into the 21st century, like one fell swoop. And so instead of doing incremental changes over the past two decades, it just all happened. And one of the beautiful things about this is that we took today's knowledge and didn't have to iterate on it. It just went like literally closing the door on the past, opening the door to the future. And what that looks like is removing stigma, removing barriers, increasing flexibility, and really focusing care on a patient centered approach, truly shared decision making, and completely modernizing the way that people received methadone treatment for the disease of opioid use disorder. A lot of the things that we were talking about over the course of the two days of this convening, but specifically with the patients with lived experience, is literally as if they could have written the regulations themselves.

And finally, the regulations have caught up. And so with that in mind, what we're going to do is I'm going to turn it over to Amy to talk about some of the specific changes around take homes so that you can be very clear on what is acceptable within the federal changes to SAMHSa that happen, 42 CFR part eight. And then what business our state regulatory body agreed on, which is essentially spoiler alert, the same. So whatever SAMHSa said be said to. And so we're in a really great place where it's easy to interpret what to do, because both federal and state are in lockstep. So, Amy, take homes, take it away, and I will be your person.

Amy Thomas, NP:

So just tell me when to switch. All right. Thank you so much. I think, one of the biggest things was that they removed cannabis from the guidelines because a lot of patients met the criteria for take homes, but we couldn't give them because cannabis, even when they said, you know, I have a medical card, we're like, well, we can't give it to you.

The data does show improved outcomes. It is a much more personalized approach, I believe. Here in our clinic, we may have different guidelines than what's put out there. The guidelines are that they could have take-homes immediately based on their eligibility, length of time they've been in treatment. What? Their urine, their toxins, what their protective factors are now.

And that's a new term for me. In the past couple of years, they've also taken out mandatory counseling groups, things like that. We still encourage it here. So, what we do, we're not quite up to like, immediate take homes, but what we do is we'd like the patient to be 30 days in treatment, 14 if they're in a residential facility they have to complete orientation, which is either zoom or in person. It's an hour-long orientation. We will give them after the 30 days or the 14 days. We have to have two negative urine, a urine and a swab. And then we start with four. So these are all earned for take-homes. And after two weeks we can increase to six 1320, 27. We don't go right to 27 from 14 because there's, you know, there's been some difficulties or patients maybe have a setback. So we try to do it incrementally. The other thing that we do, which I, I'm not sure if other locations do it, but I think that, we call it an IU intermittent urine. And that's really kind of an incentive. So if the patient's urine is positive, and we see a reduction in what they're using, we will give them one take home.

And then, you know, if it stays the same or changes again less substances we give them another. So it's kind of an incentive where we're saying, you know, we're here to help you. We want to help you reduce here. So we're going to give you a take home. We also are closed Sundays and have known a lot of locations are closed. So that counts as a take-home but not really. And what we do right when they come in during admission, we talk to them about getting take homes that we want to help you get take-homes. So you don't have to come in every single day because that's a lot for a lot of patients. They work, they have responsibilities, kids, transportation. So the sooner we can help them get to a dose, it's fairly stable. Stop to use. We want to help them get to take homes and they're really, really happy about this. I think that these changes, you know, again, it's a partnership. We're not saying, well, you have to do this and you have to do that. You know, we've reduced some of the guidelines for earning them. We have a lot of patients here that are on take-homes and more since Covid. We're a pretty small clinic and we have about 320, and 70% of our patients are getting 27 take-homes. So that's pretty good. You know, the numbers are eight, four, six, 13, but I'd say at least half of all the patients here are getting take-homes, which helps with their care, I think. And they're much happier about it. Also like the infractions say they're getting take-homes and then they have a positive tox screen. We've taken it. We've suspended them for 14 days instead of 30, which again, it's not as punitive as it was. You made a mistake. Now we're going to take them all away completely.

It's really a case by case, you know, process. If people are traveling, we can give them extras, depending on how they're doing. It's all very patient, specific how we look at the criteria as how many we give. You know, it. I think that our patients are very happy. The guidelines have changed and they want to get take-homes. They don't want to have to come in every single day and get, you know, treatment. This is for now.

Dr. Heidi Ginter:

Oops sorry little trigger finger here with the mouse. Thank you so much, Amy. One of the things that I think is really valuable about Amy's presentation is that from the position where she is working at one methadone, one OTP company is how they have interpreted the regulations to meet the needs of their patient population, but also be within a space that they feel confident and comfortable, that they are doing good by the patients and also not increasing the harm and the risk to the providers and to the organization. And so, as you can see, as I was as Amy was talking, I was sort of going through some of the changes, from a regulatory perspective. And you can see that her organization has not gone all the way to the limit of what is permitted with the current regulatory changes. So to contrast with that, the way that things actually could be is even more dramatic changes than what Amy presented.

And so I want to highlight a couple of things. One is that the reason we know we have some confidence around the ability to do this safely is because a ton of stakeholders were given during the pandemic and the risk related to diversion and overdose, and complications from having more methadone out in the community was studied and did not differ substantially in any way to prior, when we had very restrictive take home regulations. And this idea that you can individualize care, liberate methadone and still keep the environment of treatment safe is phenomenal. I will say that, interestingly, some companies still do use the concept of earned privileges, and I have that in quotes because there are other companies that have now determined that take homes are actually not a privilege that you earn, but a fundamental right as a person to engage in treatment for a potentially life threatening disease, while also doing recovery based activities that could not be attended to.

If you had to come in to dose as regularly as we used to require. And so the idea of an earned privilege versus a fundamental right is very much a tension that I think each company needs to struggle with. I think the other piece of the struggle is, how do you create an environment where you can be very patient centered, provide more access to more take homes, but also recognize that screening a patient from treatment such that they can do recovery based on their own values and needs, but also receive treatment based on the fact that the substance use that you're seeing is not consistent with their

goals, is potentially harmful to them, their families, the community, and that you want to have interface and interaction so that you can make those changes using motivational interviewing and moving along the stages of change to help people get to a place of whether it's reduced use or abstinence. And so how do you balance that tension? And then this idea of really balancing the fundamental piece of is a person coming into treatment, coming to receive care from you as somebody who's going to partner with them or are you in this adverse aerial role where you're trying to sort of gotcha them versus them trying to better their lives in the only way that's acceptable within the current legal framework.

And so it used to be that there were these eight point criteria. Now it's six points. And the piece that Amy was talking about really beautifully and eloquently is this number one, absence of active substance use disorder or other physical behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose or ability to function safely. That is, I think, the hardest part of these new guidelines to interpret, because you do want to give people the opportunity to make changes in their behavior, to allow them to expand the flexibility that they have with take-homes. At the same time, how do you define an active substance use disorder? Is it truly just chaotic use where somebody just cannot put together a cogent plan for life that is somewhat distant from the needs to get the substance, use it, recover from its use, and then get the substance use to recover from it.

So as somebody reduces their use, is that still an active substance use disorder or at what point do they no longer meet criteria? Or do you think it's in their best interest, even with an active substance use disorder, that the benefit is really going to be outweighed by the risk. And so you are going to reduce the regularity of their attendance for supervised medication. So this is really, really interesting and does require a lot of discussion and multidisciplinary input. I think these other ones are a little bit more straightforward, but that number one is really hard to interpret. And then the other thing that Amy again said beautifully is even though the regulations allow us to give up to seven days of unsupervised doses on day one of treatment, there are very few places that are going to feel confident doing that. And the truth is that there is this shared decision making, like a patient could say, hey, I've been on 50 before, but just put me on 50 and you know, I'll come back in a week and I'll be good and you can go up then, okay. Like, is that my right to listen to you, to give you the right to make a choice?

Or is the fundamental right, the one of me to keep the licensure that I have and the safety around my understanding of my obligation, compared to your right to be an independent person with a life saving medication, engaging in what you need to do to become, you know, to find the recovery that you define. So really interesting stuff.

And I'm so I'd be very curious to see sort of how people think through this and talk through it. But yeah, super, super, super important stuff. So induction and titration, one of the things, and Amy and I will talk about this as you sort of side by side as well, we have these actually, before I move on. Let me stop there and see. Are there specific questions related to take homes that people want to sort of like throw out there before we move on to induction and titration? And Amy, what else do you want to say, too? Because I, well, I think that, you know, the old way was that one. Right.

Amy Thomas, NP:

And then they could get to and then they could get three. I mean, it was such a prolonged procedure, whereas now you can increase them more quickly where we also haven't jumped up to take homes right away. We're moving very slowly because again, you know, we're all used to operating the old way, being concerned about taking less. But we have noticed much better compliance. You know, we move about four and then six and then in two weeks 14 you know, you quickly get maybe not in a month, but you could be getting 27 take homes much quicker now than in the old days. And again the patients are much happier with that. You know, we all have some patients who still want to come in, right? Oh I don't want 27. I can have them but I don't want them, I want 13. And then when we do increase the dose, we still bring them in for a few days to live dose just to make sure that they're okay because you don't want to give someone 27 and have them be overly sedated.

Dr. Heidi Ginter:

Oh, I love that because that's sort of the like fading into the next section. Sheila, you had a question.

Sheila:

I do, I was just wondering, the time in treatment versus the take-home dose eligibility. Does that include drug activity or not at all?

Dr. Heidi Ginter:

So you always have to take into account the six criteria. And if somebody is meeting these six point criteria for take-homes then time in treatment is okay. Does that clarify that?

Sheila:

Yes. Okay. Yes. I just changes in that. But there's no changes in that okay. Thank you okay. Absolutely.

Amy Thomas, NP:

Yeah. We reduced it. They reduced it from the 8 to 6. So that's a little more helpful for the patients. All right let's move on to induction and titration. And then the quick before we move on we've got one more question and yeah thoughts about significant and benzo slash use.

Dr. Heidi Ginter:

All right let's move on to induction and titration.

Gretchen Shoemaker:

And then the quick before we move on we've got one more question and yeah thoughts about significant and benzo slash use.

Dr. Heidi Ginter:

We're actually going to come to that later. Thank you, Gretchen, for pointing it out. I meant to type a little message to Hiroko and say, that's actually part of our presentation. So thank you for foreshadowing what's going to come next. That is very exciting stuff and really controversial, but important to talk about. So one of the other things that changed about the final rule is related to how we can do induction dosing. It used to be back in the day that 30mg was the largest single dose that you could give on day one, but you could give a secondary dose of ten milligrams for a total of 40 on that single first day. In the modern world, we can start at a single dose of 55 zero. And if you believe that the patient needs more, you can document that and give more. So we went from maximum 30 plus 1040 to no maximum. Now that's profound. Being able to dose at this rate within the era of sentinel use has been a total game changer.

In the past, it also used to be that titrations were ‘start low go slow’, so sometimes you'd increase by five milligrams every 3 to 4 days. Now it is more common again in the Sentinel era for people with high tolerance that you'll see orders to increase by five, ten,

15, or sometimes 20mg a day to get to a stable dose quickly so that somebody stops using fentanyl. The therapeutic dose used to be achieved within the first couple of months, which is tricky because you have people who are actively continuing to use, because they know they're not getting their dose changed. And so we often talk to people now about the possibility of us getting to a stable dose, which is going to be your therapeutic dose, plus or minus a little bit within the first 1 to 2 weeks.

That is completely game changing. And I will say that there are some systems that feel very anxious about these changes and are not being as aggressive as some other systems, but this is the reality of what's permitted within the current, regulatory changes. So what we want to do a little bit is talk about how you would walk through this in a case situation. So a 36 year old cisgender man comes in for a same day admission. He is reporting using three grams of I.V. Sentinel daily. And this has been going on for the past five months, over the period of time that he's been using in his adult life, he's had five unintentional overdoses, the most recent one was last week. He had been on methadone in the past and had really excellent success.

Two years of no opioid use when he was on a stable methadone dose. At this point, he is not reporting any other drug or alcohol use, and he is not on any prescription medicines, nor does anything come up when we review mass pat on the prescription drug monitoring program. His toxicology is on the dip positive for cocaine Sentinel and THC. He has a full time job and does not want to miss work and doesn't want to know that anybody else in his world is going to find out that he's at the clinic. So he wants to get in and out of here and on a stable dose fast. And he's one of the people who is trying not to have his car seen when it's in the parking lot of the OTP.

So the question is, and, Amy, I'll let you take this one. And we can sort of go back and forth on how would people start this? What would you think about in terms of his starting dose and either what you are currently doing or what you would be, a, a fan of doing. So, Amy, how would you guys approach this patient and then we'll ask for input from the audience?

Amy Thomas, NP:

Well, we haven't come up to speed with those guidelines yet. I think typically we start at 40 after two doses, go up by ten, up to 80, and then put it back to every three days. When I write the orders, I just put that order in up to 120 and then we meet with them. So it would probably be 2 or 3 weeks maybe.

But again, everybody's different. You know, I don't know what dose is going to be good for him. And a lot of patients will say, well, you know I might still use and my response is

always, I know that like, you're probably going to keep using we all know that. Just be careful, you know, and just come over.

Please come every day. Let us know how you're feeling. Only you know how you feel. Obviously impersonated you. Let us know. I know the doctor here. When I said, oh, we could start at 50, we were both a little like, oh, I don't know. But I think the more experienced, perhaps we do it more rapidly, we'll get comfortable with it.

Dr. Heidi Ginter:

Yeah. And so there are, I did put a couple of, thank you so much for that, Amy, because it's so honest and, I so for those of you, I should have pointed out something about my relationship with Amy. So she and I worked together, many years ago, in an OTP, with, with CRC, that became Bay Mark. And so I know and trust Amy and very much respect the idea that different people are going to interpret not only how they interact with the regulations and how it interacts with their practice of medicine, and how that then impacts the patient differently. And even though Amy and I have very different ways of currently practicing based on where we practice and our style of practice, I want you to see that both are okay and correct and acceptable within the guidelines. And so I'm very curious to see what other people would do. So I'll tell you what I would do with this patient. I'd start him at 60, ask if he could stay for four hours so I could look at him at the peak of the dose, 3 to 4 hours later, if he was still sick, I might give him another 10 or 20mg.

I would also ask him, hey, when you were on methadone before, what was your dose? Because if he tells me I was on a split dose of 200 twice a day, that's different from someone telling me I stabilized at 65mg. So I may very well use a little bit of his past history as well as his current tolerance to make a decision. So he tells me that he was stable at 120mg. That's great. I may get him up to 15, possibly 70 on day one. And then what I would do is increase him by ten milligrams a day, possibly 15mg a day, depending on what he continues to use and what he looks like when he comes in in the morning.

One of the things I tell patients is, if our goal is to get you to 120. I can do it really fast, but you got to be careful and you got to work with me here because if you are sick in the morning, I would like to see you sick rather than you using right before you come in. Because if you look a little sedated, I can't go up on your dose as fast. But if you come in looking sick, I know you're sick. We're going to go up on your dose faster. So I sometimes attempt to do a little negotiation, but I could get him up to 120 within the first ten days.

And I will say I'll be very transparent about this. It is a risk that I'm taking, because what I'm saying is that I understand how the metabolism of methadone works. It's going to take his body about 3 to 7 days to fully reach a steady state for each dose change that we've made. So it is very possible that I got him to 120 and then by week three, he can't keep his eyes open. And so now I've got to back off. However, the likelihood of that happening with the current use that he's reporting and his past history of success with a dose around 120 is unlikely that we're going to have that issue. But this is a special case with a lot of caveats that I wanted to make it simple, to provide evidence of where we can go and how quickly.

There also is an article at the end that I've cited for rapid titration in inpatient settings that demonstrates the safety and efficacy of doing a very rapid titration, like I just described in an inpatient setting where somebody has 24 hour monitoring, I will say that I would do this outpatient as well. So I'd love to hear about other places. Who, if anyone's on here and wants to share what you think would happen, at your OTP and if there are areas that would be helpful from the perspective of us understanding barriers to care that currently happen or things that are working great about how your OTP is practicing.

Gretchen Shoemaker:

Cindy, I see you have your hand raised. Do you want to come off mute?

Cindy Beaupre:

All righty. Hi doctor Ginter, Cindy Beaupre, and I had to laugh when you showed the slide of what the current thought process is. And the old thought process is with every three days and that and whatnot. I come from an even older school that everybody came in. They started at 40. They went up 5 or 10 every day. As long as your pulse was over 90 and you had a symptom, you went up and people were at, you know, 100mg. After six days. And that was pretty standard back in the early 2000. And then it faded off and we got into this very slow titration process that was actually even slower than what you were describing. One of the organizations I worked for, it was, you know, nobody ever got a ten milligram increase. So nowadays it's like, yeah, like, let's meet, you know, get the dose up. But I still see there's a lot of hesitancy, so to speak, in that because, you know, we're sending the patients out with the increased doses and bouncing them up so quickly.

And how are they tolerating that? Because what I'm seeing is a lot of folks, even if you're bouncing them up, they're still not stopping the use. So it's like how how far do you go. And having done this for as long as I have, I'm seeing now a rebound to much higher doses than we did ten years ago. 20 years ago. Way higher doses.

Dr. Heidi Ginter:

Yeah. Cindy, thank you so much for that perspective. As a nurse who's been working in this field for so long and really seen so many different styles of care and so many different ways in which a standard of care can change based on not only the organization that you work for, but also the specific medical director at the OTP where you're working. It's really striking that even within one organization, you can be on one side of town and get one interpretation and be on the other side of town in the same company and get a totally different interpretation, because the medical directors have a different style of practice. And so the multi-disciplinary team really does provide a place where people should be able to come together and share what's comfortable, what's not, what they've seen in other places, and, and try to meet the needs of the patients within the bounds of everyone's practice. And yeah, there's so many nuances here. And thank you for that. Does anyone else want to share before we go on, the concept of sort of. Oh, actually, we didn't even talk about the take- homes. We can get to that, too. But any other things that you want to share before we move on to risk?

Amy Thomas, NP:

One of my other concerns is the Zylazine that's in everything, which, you know, the patients are saying, I don't even get hired. I just go out. Like, the sooner we can get them stable and reduce and then stop the use, the better. That is for them, too, in terms of risk.

Dr. Heidi Ginter:

Yeah, I love that perspective. And yes, Zylazine. It's like, yeah. All right. Amy, do you want to take this one?

Amy Thomas, NP:

Sure. So again, as we've discussed, a lot of us are we're in the thinking of caution. Go slow. You know the risk again. It depends where you are. I'm in Boston, but I'm not downtown. I'm kind of over in Brighton, so we don't have as many people, you know, unhoused out on the streets. What community? Right, are you in mass n cass? Are you here or are you out in the Western Mass? You know what type of treatment they want to be on methadone? Do they want to be on Suboxone? Do they want to start the methadone? Come off as quickly as possible? There's so much different variation in the patients as a provider. Of course, you know, that's my concern.

I really don't think that I'm going to kill them with the dose of methadone. I'm going to give them. That's always been my perception. Because you know what? They're using work and wear off quickly, whereas methadone is going to get them to a steady state. The morbidity, you know, so many of the patients have other multiple diseases respiratory, cardiac cirrhosis diversion. Again there's always going to be that risk of diversion. But I really think for the patients that have to take homes that are doing well, they don't want to lose those chemicals. I don't think they're going to go out and share their doses or give it to someone else. I mean, they might, but again, it's all the people in the population.

Where are they living? Do they have stable housing? Lots of the DEA. Again, I, I don't know if my thinking is crazy, but I mean, I'm here to help them achieve their goal. I would not go up so quickly as to put them at risk. And again, that's why I'm a little bit slower and more cautious if they get to very high doses. We have some patients here that are around 165 twice a day, like those doses. I would defer to the doctor. You know, we discuss it all, but most of them have chronic pain. Most of them have take-homes and they're doing very well. So again, the goal is you know what dose is comfortable for the patient. That's really the bottom line. And then how can we prevent increasing their risk.

Dr. Heidi Ginter:

I love that you said that Amy. And I totally agree. I think one of the challenges in thinking from a provider's mindset, which of course, is our mindset, is what I'm doing causing harm. And my goal is not to cause harm. My goal is to reduce suffering and to practice safe medicine. And one of the challenges, I think, is, is trying to judge, like, where's that line? And one of the important things for providers is really documenting what you're thinking and why you're doing what you're doing, so that it's clear what your thought process is. And it's in the medical record. Simultaneously documenting the shared

decision making with the patient that you both were on the same page and that this is what you thought.

Here's the risks, here's the benefits. This is what the patient presented to me. We discussed risks and benefits, and through shared decision making came to this plan for the following reasons. And so in the event that something negative occurs, everyone is on the same page about the risk we're taking and why, and that we actually think we're going to get a positive outcome.

And in the unlikely event that we get a negative one, we have a paper trail to describe that. We weren't making the decision alone, that everyone had their eyes open and was trying to do the right thing based on the information they had. I think one of the challenges that sometimes patients experience, and we certainly heard that this morning or earlier this afternoon, is the things that patients are thinking about are so different, really different.

And so I want to just sort of post this up here as just a whole list of things that people will say. And I've heard and you guys have probably heard these things and maybe even more like you're keeping my dose low, what do you think is going to happen? Like, how is this impacting me? You're all worried about your license. You're all worried about this, but who's asking me what I'm worried about? And these are some of the things that I hear. Amy, what are your thoughts?

Amy Thomas, NP:

Most patients, well, you know, new patients, they have a lot to learn. They don't know anything. So we really need to guide them and educate them and help them become stable patients. That have been on methadone, switch to Suboxone, come back, have had good experiences. They kind of know and like you said earlier, I usually ask them what was the max dose you want before? Were you able to become absent or not? Or some patients come in like, I only want to go to 100 and I always stress to them, please don't limit yourself because you might have been unhappy. Then maybe you'll be on 200, maybe be on 60. You know, just don't have it set in your mind where you want to stop that. I think the biggest thing is the patients come to us wanting to stop using. So how can we help them? You know, that's and we can only advise, you know, they do the work like they'll say thank you so much for you. You made me sober. I didn't do that. You did that. We're just here to support you. And I always say, the patients, please just let us know how you're feeling. Do you need to go up to one to go up five? Do you want to go up ten again? I do go more than ten, but they have to tell us because we don't know otherwise.

Dr. Heidi Ginter:

Yeah, I love that because it really is. It's again the shared decision making and listening to what the patient's saying. And also sometimes it's like listening to what they don't say. I found, and I'd be interested to see what other people think about this. Sometimes when you're sitting in the room with a patient who is experienced in the OTP world and has been in situations where they know what they need to say to get their needs met, and it's like, hold on, hold on. What if we do a thought experiment here where you don't have to tell me a story that I'm actually just going to believe you? So what if you could be honest with me? And based on what you say, we can have a discussion and get your needs met. So how about if we drop all the things that you feel like you need to do to help me understand? And what have I actually just understood? I think there's a lot of value in meeting people where they are and letting them know that what used to happen is different now that you don't have to do the thing that you used to have to do to get the thing that we're wiser now. We're better. I think the other thing that comes from this, and I want to get to some of the questions that have come up, is what's the right number to take home? What is the right dose? Is there such a thing as a too high methadone dose? Is there such a thing as a too low methadone dose? For sure. But what happens when people get on doses that feel high to us or feel high to the patient? Like, is there something that becomes unsafe or inappropriately high? And then how do you manage take-homes? What if the person has a full-time job and they're trying to get back to work? So this is another sort of thought experiment that I'd love to have people weigh in on. And I think, you know, question number one, patient’s on 160mg and methadone as prescribed, Klonopin, one milligram, three times a day for anxiety. So think about what your answer- like how many take- homes should they have.

What are the questions you want to ask? But then change it to say? Also, how would you feel differently if the patient's on 160mg of methadone and their talk screens are positive for benzos, but they are not prescribed benzos and think about that person and then think about the person who's on 160mg of methadone, not prescribed benzos positive for benzos in their tox screen and presenting with zero impairment, zero sedation, and explaining that their prescription was cut off because their doctor is no longer in practice. They couldn't find someone else to prescribe. They've been stable on this dose for many years, but haven't been able to get it. They now get it on the street. They buy it from somebody whose prescription bottle they literally have. They test it, they take it as needed. Like cannot get a prescription because no one will prescribe and has a full time job parenting. Three kids just regained custody, no longer have legal obligations, can't come in every day. And so like thoughts and I'll stop and see what people say. And Amy, please weigh in with how you guys would manage this.

Amy Thomas, NP:

I'd like to see what other people think. We still, if they are on prescribed benzos, we only limit it to 13. I like what you just said and maybe that would be a discussion. We would have, you know, if they're stable, but they're taking illicitly once in a while. I guess it would depend once in a while, you know, even when they're prescribed, sometimes it doesn't show up on the tox screen. So you don't know if they're taking it as prescribed or not. But again, I think looking at a person who's very stable maybe was prescribed cant get them, maybe give them 60, you know, and see how they do.

Dr. Heidi Ginter:

The other two cases here, is this idea about a person with chronic pain and opioid use disorder on a split dose of methadone, 250mg in the morning, 150 in the evening, and is abstinent, doing well, able to actually manage life. Whereas before they were almost housebound and bedridden. How many take homes should that person have or what would be the right number? And then this final case is somebody who continues to use cocaine on the weekends, but really has been abstinent from opioids for a very long time on a methadone dose. That hasn't changed in a while. What would you do for take-homes there? So I'd love to hear what people think and how they think through the idea of take-homes in these such situations based on now what you know about the regulations and what flexibilities we have versus, you know, risk and benefit. And if you want to type in the chat instead of come off mute or put your hand up, but anyway, you want to talk, feel free.

Amy Thomas, NP:

We have a lot of patients on doses up to that and they get take-homes. They can get 27. I mean, that's a lot of bottles, and again, the patients say, oh, 120 is a high dose. And my response is there really is no high dose anymore because everybody's dose is different. And the chronic pain people really do find relief and can have a life if they're on split doses.

Dr. Heidi Ginter:

Amy, how do you guys design methadone from the perspective of a dose being too high, what would you say? How would you assess a dose that's really inappropriately high versus a dose that is therapeutic and high?

Amy Thomas, NP:

Well, I know like a split dose is like the patient 165 165 we do an EKG typically every six months. We do our peak level just to see if they're total doses in a toxic range. That's probably every six months, you know. And so many of them are doing well I don't know. I mean, I don't really know what a high dose is anymore because, you know, people have different needs. So it's I guess, I would say yes, 400 also is elevated, but I would never say to a patient, wow, that's a really high dose. You know, that's what they need.

Dr. Heidi Ginter:

I love that because I think there's in some ways this is a trick question. It's like, you know, what's a high dose? It's who knows. But who knows. What is too high is when you have somebody who's sedated, impaired, is not using anything else except methadone, and is unable to manage to keep their eyes open, their head up and their breathing regulated as a result of excess methadone. Methadone is an opioid. It is a pure mu agonist, full and sole mu agonist. And so you can have too much of that and can have opioid overdose from too much methadone. The other thing that would define a dose that is too high is one that has caused prolonged QT. And so oh yeah, it changes. And so, you know, those are two areas to consider. Methadone that's too high. Another area that Amy alluded to was if you are drawing levels is the level in toxic range at the peak of the dose or at the trough of the dose. And so you may define too high as being outside of those ranges. So I think to answer that question, those are some ways to think about it. But to get back to actually, how do you take these three cases and use the regulations that we just talked about to interpret what you could do? Although there are many right answers, patient 160mg and prescribed Klonopin, this individual is eligible for the full 27 take homes monthly, depending on whether they meet the six point criteria and their time in treatment.

So the point of this question was to say that in the regulations, being on a benzodiazepine prescription is not one of the factors that determines appropriateness for the number of care homes. However, there are many companies that have used sedating medications as a gate to a certain limit in their take homes. So for example, there are companies that will say if you're on a prescribed benzo, you can get no more than a total of five take homes in a week and A23 split, or you cannot exceed 13. Take-homes. So there are gates that companies will put in place, but the clarity piece here is that that is not based on state or federal regulation. Similarly, in patient number two, just because you are on a large dose of Macedon, that feels large to us because this is

outside of two standard deviations when you take all comers into treatment and it's split again, the regulations do not state that this person is limited in the number of take homes that they can have.

So based on the six point criteria and time and treatment, this individual could also have a total of 27 take homes, which is 27 times two bottles. A take home is defined as both doses that are required within a 24 hour period. And then this patient number three is really interesting. So I want to spend some time talking about this because it gets back to how do you interpret the six point criteria. So patient's been absent from opioids on a dose of methadone 135mg daily. So right there that sentence tells us that opioid use disorder is in remission. So that disorder is not active. So based on the first part of the sentence, this patient meets number one of the six point criteria- continues to use cocaine on weekends. So is that an active substance use disorder. So I'm curious what do people think? She says provocatively, waiting to see if anyone will come into a trap. This is a trick question as well.

Jennifer:

Like I'll take a stab at it. Yes. I think that, you know, if the patient is consistently meeting with their counselor and, and is open and honest, like, yeah, you know, I have a stressful job. I'm a pipefitter and I just, you know, cut loose a little bit on the weekends. I don't let it get out of control because I have to take care of my kids, you know, so you're balancing the different, different points, within this, within these six factors. So, if there's no history of diversion, if they're, you know, candid about their use and trying to work with the counselor on, on, decreasing their, their cocaine use, if that is part of their goal. And then, you know, you would consider the additional factors in, in your decision making or we would.

Dr. Heidi Ginter:

Thank you so much. So I'm actually going to if any of you get nauseous if people do slides to close your eyes for a second, because I want to go back and I want to just spend a couple seconds, okay? I stopped driving fast. You can open your eyes. So this slide, this number one absence of active studies, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose or the ability to function safely. So think about a diagnosis of an Sud. You need the 11 criteria in the DSM five, and in order to meet it for an SUD, you have to have a minimum of three, because that would be a mild cocaine use disorder.

So when you're thinking about those 11 criteria in the DSM five, does this patient need these. So we don't know. We have to ask more questions. But let's say they don't. Let's actually say that they don't meet criteria. When you go through every 11 they only have two. So it's not a substance use disorder. It's just cocaine use, not cocaine use disorder.

Okay. So now we say it's not an active substance use disorder. Are there physical or behavioral health conditions to increase the risk for patient harm as relates to overdose. So yes, cocaine is not a regulated substance. You have to get it on the street. But Jennifer's patient comes in and says, I have the same dealer I've been using for the past 20 years. I use fentanyl test strips religiously. I always use nasally. I always use it with somebody else. I have the number four safe spot with me every time I use it. I only use it with friends on weekends. I use it on Saturday nights only. I have never had blah blah blah blah blah. So is this person actually at increased risk for harm and overdose? Sure. Compared to somebody who doesn't use drugs at all. But this person just described to you a pristine harm reduction plan I'm going to go with. This person meets criteria for 27 take- homes that might drop. Now you might think, I don't ever want to go to an OTP where that woman is the medical director. And that's okay. But I do want you to just get uncomfortable for a minute thinking about is this within the realm of possibility?

And it feels icky, but it actually, if you take it from the patient's perspective, if there somebody in this audience who's on methadone uses cocaine on the weekends, you might be giving me a high five in the air right now because I'm speaking your language. You're somebody who's functioning with substance use that is not a substance use disorder. And if I were to limit your ability to maintain your opioid recovery that required methadone based on drug use, that isn't a use disorder and isn't causing you increased harm. Regulatory you are meeting the criteria. And if I document all of this and we are in touch and we've got shared decision making, I actually can sleep at night and I want you to. I'm going to drive fast again. So if you need to close your eyes, I want you to just, like, sit in that for a minute, because one of the purposes of this interaction that we're having with me and Amy and you is obviously I am somebody who's way out there, and I want to be way out there so that you can think. And maybe I stretch you a little bit. But I also wanted Amy to co-present with me, because I want you to also know that we're both right. And it's okay to go slow, to be deliberate, to engage with additional patient centered care that doesn't go all the way, but keep that thought. Like if you're pre contemplative about some of this stuff, start doing a little contemplation.

Start doing a little bit more movement in your own thought process and your personal take home for today. Again, I'm riffing on that little, take home thing is consider what would it be if tech homes were right, not a privilege? Think about what rapid titration to

therapeutic dose look like? If you feel like you're getting feedback from your current patients that you may be going too slowly, and how do you share risk in a shared decision making situation and truly individualized care is clearly the only right answer. But there's not one answer. It is like it is the magic answer. We have like eight more minutes and I don't want to be the one to end. I definitely want Amy to be the one who ends and then sort of manages the conversation, because I know that my voice is often heard and I don't need to be heard anymore. So I'm going to turn my voice off. And, Amy, to have you, manage the, the moderate, the end of conversation.

Amy Thomas, NP:

Well, again, I think a lot of this is new. It's scary for many people because we're not used to being more aggressive. But as you said, if we let the patients also have to want to, like, check in with us and talk to us, and they don't always want to do that, they just want to get their dose and leave. But if we could explain it, you know, we're trying to help you get stopped using quicker, get more stable, be able to have take homes, not have to come all the time. I just feel I'm okay with changing. But I think I'd want to go slow because hey, don't you know you've been trained to not go quickly? And if they're using something, don't give them take-homes. It's like alcohol use. Do they use once in a while? Who defines if they're if they're actively drinking? I mean there are criteria but that's the new thinking. Also if you're in recovery from alcohol can you drink? And who decides that? I'm sure that everybody here does things a little bit differently. That was kind of our, our hope, you know, that people would join in and tell us how they're doing.

Dr. Heidi Ginter:

Was, like, able to stop the sharing. I was clicking so many buttons. So Hiroko had asked the question earlier about alcohol use. Amy, say more about that, because I do think that's a topic that we probably don't spend enough time talking about. And we have like a minute or so.

Amy Thomas, NP:

But there's been a lot of discussion about the alcohol, right? If you're, you're in recovery, but you go out and have a drink or two. I mean, am I going to say you're an alcoholic again? Am I going to say you have a problem? It's like with the cocaine, if you drink 1 or 2 drinks and you're not intoxicated, is it bad? Is it good? My opinion is again, the person would decide that obviously if they drink and they can't stop drinking, you know, they

shouldn't be. But that's kind of the old way of thinking. You have to be absent from everything to be considered sober. Right. And that's changed.

Dr. Heidi Ginter:

One of the things that is listed is Jim, some clients have the perception that using cocaine with fentanyl prevents overdose. Yeah. So, Amy, do you have any experience with that, or are you hearing, patients?

Amy Thomas, NP:

I don't know. My concern is to make sense that they don't know about if they could get silencing test strips, you know, because as animals, scenes and everything, so are they at even more risk using the cocaine and the fentanyl and the zylazine and the methadone?

Dr. Heidi Ginter:

And I love how you describe it as mixins, because I think I can picture going to the place where you can say what you want in your ice cream. Those kinds of mix-ins, good, fentanyl mix-ins bad. And so like really being cognizant of the supply. And any time somebody switches towns or even dealers or is with a new partner, like all of a sudden the supply is different and they have no idea. And so underlying all of this, it is, I think, crucial for us and I. I violated my own rule, which is never end a presentation without a picture of test strips. Safe works. The pictures of nasal naloxone. And also, information about safe spot. So, make sure that we are talking to patients about never using alone. You can have a thousand doses of Narcan around, but if you use alone, you're going to die surrounded by a thousand doses of Narcan. So never use alone is super, super critical. And we have our own, safe spot here in Massachusetts that is outlined, amazing, and incredible work there. I know we're getting close to needing to switch. Oh, thank you for sharing. Safe spot. Yeah. And then Katie says, are you guys providing I was in touch strips? Amy.

Amy Thomas, NP:

No, we had them. But then I was told they're pretty expensive to get. I had a patient, though, actually. So here I don't know if you can see this. So that's a picture of one. The

patient brought it in and I think she's maybe she gets it from a safe spot or she gets it down at Mass and Cass.

Dr. Heidi Ginter:

Yeah. You know Ramsey out in Brockton has and I think tapestry out west had so. Yeah, you know, this is an area for us to give us some collective data about where to obtain harm reduction supplies for our patients, including test strips. I know we've got two minutes left, and we should probably, I don't know where. Let's see. Oh, you know, they were on the clearinghouse. It's a great question. I haven't been on there in a while. Maybe that's something we can add in our follow up materials. That's great. We can check in with BSAS. Yeah. With the saying. Yeah, they're not in the clearinghouse. Okay. Yeah, we'll figure out. We'll get this to you guys. So incredible. I'm so grateful for all their participation, and I. Gretchen, is there a link for us to go back? Oh, no. I just popped it in the chat. So we are all in the same room for this next session on telehealth, so we will see you all back there. Thank you so much. And thank you Amy. Love presenting with you. See you all in a few minutes.