UNC ECHO

FOR MEDICATION ASSISTED TREATMENT

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

The UNC Extension for Community Healthcare Outcomes for Rural Primary Care Medication-Assisted Treatment (UNC ECHO for MAT)
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Project ECHO®

The University of North Carolina at Chapel Hill

Opioid Addiction Treatment ECHO

For Providers and Primary Care Teams

at UNC

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Office-based management of OUD: Addressing challenges with MAT

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Learning Objectives

1. Be able to interpret urine drug screen results, while understanding the limitations

2. Review strategies to recognize a relapse and adapt treatment plan

Urine drug screens

- Familiarize yourself with what is available through your lab and toxicologist
- Have a way to confirm unexpected results
- Do not base treatment decisions solely on urine drug screen results
- Ask patients what you will find
- No need to “catch” patient in a lie – be upfront about results

Common urine drug screens

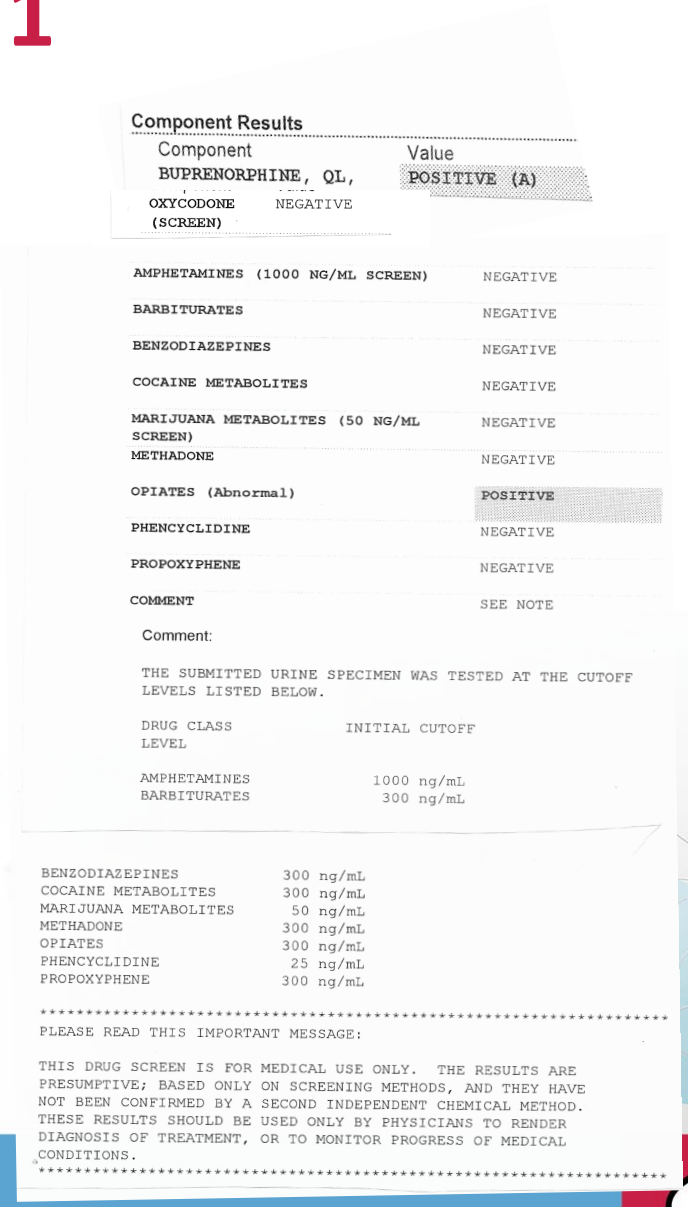
- Opiates – will include heroin, morphine, hydrocodone
  - Will NOT include oxycodone, methadone, fentanyl, buprenorphine
- Cocaine – false positives are unusual
- Benzodiazepines
- Marijuana – may stay positive for 28 days in frequent user
- Amphetamines/Barbiturates – false positives more common

- Alcohol urine screen can also be added

Case 1

A patient stable on buprenorphine for months has the following urine drug screen result. He reports doing well on treatment and has no concerns.

Urine drug screen result: Bupe + Opiates + otherwise negative



Component Results

Component	Value
BUPRENORPHINE, QL,	POSITIVE (A)
OXYCODONE (SCREEN)	NEGATIVE
AMPHETAMINES (1000 NG/ML SCREEN)	NEGATIVE
BARBITURATES	NEGATIVE
BENZODIAZEPINES	NEGATIVE
COCAINE METABOLITES	NEGATIVE
MARIJUANA METABOLITES (50 NG/ML SCREEN)	NEGATIVE
METHADONE	NEGATIVE
OPIATES (Abnormal)	POSITIVE
PHENCYCLIDINE	NEGATIVE
PROPOXYPHENE	NEGATIVE
COMMENT	SEE NOTE

Comment:

THE SUBMITTED URINE SPECIMEN WAS TESTED AT THE CUTOFF LEVELS LISTED BELOW.

DRUG CLASS	INITIAL CUTOFF LEVEL
AMPHETAMINES	1000 ng/mL
BARBITURATES	300 ng/mL
BENZODIAZEPINES	300 ng/mL
COCAINE METABOLITES	300 ng/mL
MARIJUANA METABOLITES	50 ng/mL
METHADONE	300 ng/mL
OPIATES	300 ng/mL
PHENCYCLIDINE	25 ng/mL
PROPOXYPHENE	300 ng/mL

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PLEASE READ THIS IMPORTANT MESSAGE:

THIS DRUG SCREEN IS FOR MEDICAL USE ONLY. THE RESULTS ARE PRESUMPTIVE; BASED ONLY ON SCREENING METHODS, AND THEY HAVE NOT BEEN CONFIRMED BY A SECOND INDEPENDENT CHEMICAL METHOD. THESE RESULTS SHOULD BE USED ONLY BY PHYSICIANS TO RENDER DIAGNOSIS OF TREATMENT, OR TO MONITOR PROGRESS OF MEDICAL CONDITIONS.

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Possible scenarios

1. Patient relapsed with an opioid such as heroin

2. Patient was prescribed opioids for a medical reason, such as cough syrup with codeine

3. Patient has false positive from poppy seed ingestion or technical error

Addressing relapse

- Relapses are expected and will vary in severity
- Do not “fire” a patient for positive urine
- Intensify treatment plan through more frequent visits, urine drug screens, and psychosocial supports
- Have a guide for when you will refer for higher level of care (i.e. methadone or detox)

How to approach patient-UDS mismatch

- Consider confirmatory testing with quantitative levels
- Do not focus on patient characteristics “you relapsed” but focus on result “the urine was positive for cocaine”
- If patient reluctant to intensify treatment, present this as standard care and not a personal decision

Back to Case… Next steps

- Tell patient “urine showed opioids”
- Confirm with patient any prescriptions or recent medical procedures

Patient denies relapse -->

- Ask lab to confirm results
- Check NCCSRS
- Inquire about recent triggers
- Intensify treatment by increasing visit frequency, BH support

Case 2

A patient has been struggling since engaging in treatment. She has had intermittent relapses with heroin and benzos. She continues to smoke MJ daily. She is at risk of losing custody of her child. She struggles with anxiety and insomnia. Today she presents as sedated and guarded, and denies any recent drug use.

Urine drug screen result:

Bupe + otherwise negative

Possible scenarios

1. Patient is taking bupe and sedation is due to non-drug effect
2. Patient is taking bupe and sedation is due to use of drug not tested for on urine drug screen (such as alcohol or fentanyl)
3. Patient tampered with urine, since it would be unusual for a daily MJ user to have a urine negative for MJ

Polysubstance use

- Research shows mixed results about effect of other drug use on retention in bupe treatment
- Alcohol and benzos are the riskiest because of overdose risk
- Determine if habitual use or if meets criteria for SUD
- Maximize psychosocial supports
- Decide how your program will approach ongoing use of other substances

Back to Case… Next steps

- Express concern about patient's mental status and aim to build rapport
- Intensify treatment with frequent clinic visits, BH support, and possible SSRI to treat *anxiety-consider referral to one of NC's Perinatal, Maternal CASAWORKs residential programs*
- If concern for tampering, ask for repeat urine or consider other testing (such as oral swab, urine temperature/creatinine)

Resources

Email: paula_bell@unc.edu

Help with Urine Drug Screen Interpretation - http://mytopcare.org/udt-calculator/interpret-opiates-test-result/

The North Carolina Perinatal and Maternal Substance Abuse and CASAWORKS for Families Initiatives https://alcoholdrughelp.org/getting-help/womens-services/

Case 3

A patient is stabilizing on buprenorphine, has been adherent with recommended treatment, and you have no concerns.

Urine drug screen result:

Negative for all substances

Possible scenarios

1. Patient is diverting bupe
2. Patient has run out early of bupe
3. Patient is fast metabolizer or has dilute urine
4. Patient has tampered with urine to hide relapse

Detecting diversion

- Urine drug screens must include buprenorphine testing
- Consider occasional specific metabolite testing (norbuprenorphine)
- Do random visits with pill counts for stable patients
- Routine PDMP checks

Addressing diversion

- Use of non-prescribed bupe is often to self-treat withdrawal *
- Risk of diversion may increase as patients stabilize and choose to self-taper the medication
- Educate patients up front about importance of not diverting
- Must stop prescribing if strong evidence of diversion

* Allen B J Subst Abuse Treat. 2016 Nov

Back to Case… Next steps

- Ask lab to run quantitative testing
- Consider checking urine creatinine/specific gravity
- Call patient back for random pill count
- Disclose result with patient “the urine did not show any bupe”
- Confirm they are taking bupe as prescribed
- If patient no-shows to random call back, high suspicion for diversion