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February 24, 2021

Best Practices for Long-Term Maintenance with Medications for Patients with Opioid Use Disorder (OUD)

New York State Office of Addiction Services and Supports (OASAS) Medical Advisory Panel (MAP)

In the United States, unintentional overdose deaths, mostly involving opioids, now eclipse all other causes of death for individuals under 50 years of age[1]. Additionally, approximately 2.4-5 million individuals nationwide have an addiction to heroin or other opioids, including painkillers as well as high-potency synthetic opioids like fentanyl and its analogues[2]. Medications for OUD (MOUD) are widely recognized as the standard of care for OUD. Approved MOUD include buprenorphine, methadone, and long-acting injectable naltrexone (XR-naltrexone). In addition to many other demonstrated benefits, MOUD can reduce overdose death risk by 66-80% while patients are receiving treatment[3] but remains greatly underutilized[4]. While all three available MOUD confer benefits, it should be noted that buprenorphine and methadone currently have more robust evidence bases for treating OUD than XR-naltrexone, especially for preventing overdose death. Early dropout remains a major challenge in treating OUD. For instance, more than a quarter of patients receiving methadone do not complete their first year in treatment, roughly half of patients on buprenorphine leave treatment within 3-6 months, and many patients receiving XR-naltrexone only receive one or two monthly injections before stopping the medication[5]. Following MOUD discontinuation, the great majority of patients eventually experience a recurrence of regular opioid use and face the risk of overdose and death.

The National Quality Forum (NQF) recently endorsed a quality measure of the percentage of patients initiated on MOUD who are continuously retained in treatment for a minimum of 6 months, underscoring the critical importance of long-term maintenance treatment[6]. This continuity of pharmacotherapy measure has now been recommended to the Center for Medicare and Medicaid Services (CMS) to be included in the Core Measure Set guiding insurance plan design. However, this measure is based on expert consensus, as empiric data regarding the minimal duration of MOUD treatment is lacking. More recent longitudinal studies involving buprenorphine have shown that treatment durations of even 18 months remain insufficient for conferring long-term protection from overdose and relapse after medication discontinuation for many patients with OUD[7].

To improve rates of long-term maintenance on MOUD and enhance outcomes, the OASAS MAP issues the following recommendations to treatment providers:

- Patients should remain on MOUD for as long as they are benefiting from it and want to continue medication treatment.
- Providers should use shared decision-making to develop individualized treatment plans that include length of MOUD use and may include discussions of lifelong maintenance for patients who are benefitting from MOUD and wish to continue medication treatment.
- Treatment plans should be updated as patients' goals evolve, while ensuring that patients understand accurate information about the benefits of continued MOUD and the risks of discontinuation, including possible overdose and death.

- All care settings treating patients with OUD should ensure their treatment approach recognizes long-term maintenance with MOUD as a critically important treatment approach for patients.
    - This emphasis should inform scheduling and intake procedures, initial evaluations, and all subsequent follow-up care in both individual and group settings.
- All clinical settings should employ assertive efforts – spanning individual and group treatment as well as administrative policies and protocols—to confront stigma and bias against the long-term use of maintenance MOUD.
- Providers should frequently reassess the dose of buprenorphine or methadone early in care, as underdosing and restrictive prescribing practices often undermine successful maintenance treatment, leading to discontinuation of MOUD and disengagement from treatment.[8]
- Programs should help patients address stigmatizing attitudes against long-term use of maintenance MOUD from family members and other community supports.
- Providers should be aware that additional comprehensive services, such as care coordination and integrated treatment for mental health and physical health conditions (e.g., hepatitis C and HIV services), often improve rates of adherence with long-term MOUD maintenance.
- Continued opioid or other substance use should not lead to withholding or discontinuing MOUD aside from acute safety concerns.
- Providers should understand that intermittent drug testing to confirm medication adherence as well as to assess for substance use can improve treatment outcomes when conducted in a person-centered manner.
- While individual and group counseling can help patients with recovery goals, they should not be required as a condition for MOUD initiation or continuation.
- Patients receiving MOUD cannot be excluded from any OASAS licensed residential or outpatient program and should not be excluded from other settings (e.g., skilled nursing facilities, long term care facilities), simply because of their MOUD use.

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