



WHITE PAPER

MYTHS + MISCONCEPTIONS

That Impact Appropriate Treatment
for Opioid Use Disorder (OUD)

Abstract

Substance use disorder (SUD) is a pervasive, costly, and devastating health condition. Appropriate treatment can positively impact patient outcomes and health care costs; however, treatment decisions are often influenced by myths associated with treatment for SUD and opioid use disorder (OUD). The health care system, patients, payers, and providers benefit when patients are successful with OUD treatment. This article highlights five myths about treatment for OUD, provides context regarding current guidance, and offers suggestions for how managed care organizations (MCOs) can support care for patients with addiction through a chronic health model.

Introduction

Approximately 20 million adults have been diagnosed with substance use disorder (SUD).¹ According to the Center for Disease Control and Prevention (CDC) data, substances that drive the largest number of SUD-related deaths are synthetic opioids and psychostimulants with abuse potential (e.g., methamphetamines).² Alarming, deaths from these predominantly accidental overdoses are increasing, with an unprecedented 28.5% increase in fatal overdoses observed in 2020.³ According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019 National Survey on Drug Use and Health, over 80% of SUD patients go untreated annually, leading to excess hospital costs and making these some of the costliest health conditions.¹

As a sub-set of SUD, OUD patients have access to FDA-approved medications, which curb withdrawal and craving symptoms for opioids, reduce the stimulus for drug use, decrease accidental overdose risk, and lower associated costs. Driven by increased emergency department and inpatient resource utilization, patients with no medication treatment or low OUD medication adherence generate excess costs to the health care system compared to OUD treatment-adherent patients.⁴

Compounding this problem, dropout rates among patients in OUD treatment are high, ranging from 30% to 60% after two months, leading to more expensive untreated episodes.⁵ The road to recovery is difficult, with frequent relapses and costly OUD treatment cycles. Through holistically understanding patient challenges and supporting every effort for treatment retention, the health care system can limit patient exposure to the harms of opioids and limit costs related to accidental overdoses and expensive acute care services.⁶

Management of OUD is consistent with the chronic disease management model, where longitudinal care delivery incorporates patient and clinician education, community resources, self-management support, and other elements that address the needs of patients characterized by relapses.^{6, 7, 8} Patients in treatment for two to three years have better outcomes and lower costs than patients with shorter treatment durations.⁹

MCOs can provide access to lifesaving OUD treatments. Unfortunately, myths persist regarding the treatment of patients with OUD. This article highlights five myths about OUD treatment, provides context regarding current guidelines, and offers suggestions for how MCOs can support patients with addiction disorders through a chronic health care model.

MYTH
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1

Patients Taking Buprenorphine/Naloxone Must Be in Counseling

Perceptions exist that ongoing psychological counseling must accompany prescribed buprenorphine/naloxone.

Early buprenorphine/naloxone prescribing guidance set expectations that patients also engage in counseling. However, one study states, "...traditional counseling is not necessary for successful outcomes in buprenorphine treatment."¹⁰ A meta-analysis found psychosocial treatments were effective in patient outcomes. However, counseling is not necessary for therapeutic success with buprenorphine/naloxone.¹¹ This is echoed by recent studies and guidelines that advocate for combined medication use and psychological counseling therapy but suggest that buprenorphine/naloxone should not be withheld due to a lack of concurrent counseling, often unavailable due to a shortage of trained counselors.¹⁰ A randomized controlled trial comparing buprenorphine/naloxone to cognitive behavioral therapy also demonstrated that patients who were randomly assigned to opioid agonist treatment without additional psychosocial treatments reduced their opioid use as much as those receiving concomitant psychosocial treatment.¹¹

Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) 63 indicates that counseling should not be a requirement for receiving OUD medication.⁶ Proper assessment of patients with OUD and adherence to current guidelines can maximize the number of patients who can benefit from buprenorphine/naloxone.

MYTH
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2

Buprenorphine/Naloxone Should Only Be Used for Short-Term Therapy

Some health care professionals believe that buprenorphine/naloxone should only be used for short-term therapy. This may have manifested from initial guidance, which suggested buprenorphine might only be necessary for a few weeks or months.

However, a prospective cohort study found that when the average duration exceeded 12 months, opiate substitution treatment had a greater than 85% chance of reducing overall mortality. Furthermore, some patients benefited from indefinite maintenance, similar to thyroid replacement therapy.¹⁰ Clinicians and patients should be aware of the increased mortality risk at the start of opioid substitution treatment (e.g., one to four weeks) and immediately after stopping treatment.¹²

Longer-term therapy provides patients with the opportunity to make necessary life changes associated with long-term remission.⁶ Using buprenorphine/naloxone treatment benefits for a longer duration should be discussed with the patient prior to induction to help maximize remission success.

MYTH
3**Opioid Agonists Treatment (OAT) for OUD Keeps Patients Addicted**

Another misperception is that OAT keeps patients addicted and prevents remission.

OAT is available as full agonists (e.g., methadone) or partial agonists (e.g., buprenorphine). Full agonists have a dose/effect correlation: Increasing the dose increases the effect. Partial agonists have a ceiling effect: Increasing the dose beyond a certain point will not increase the effect. When given under appropriate supervision, both medications can diminish the effects of physical dependencies, such as withdrawal or cravings.

Patients taking buprenorphine/naloxone or methadone for treatment reset their physiologic dependence through the dopamine-reward system, not changing their state of mind for pleasure. Because their baseline dopamine is adjusted to higher levels, patients suffering from addiction require greater levels of dopamine to function. Resetting the dopamine level over time allows withdrawal symptoms to diminish and patients to focus on their health and wellness.

Addiction is a chronic medical condition, and patients with OUD should not be marginalized. They should be treated similarly to patients with other chronic conditions. For example, a health care provider should not treat patients with diabetes who use metformin daily differently than a patient using daily OUD medication treatment. If patients require medication to treat a condition, those patients should not be stigmatized because of their medical condition.

MYTH
4**It Is Expensive To Treat Patients With OUD**

Myths surrounding the cost/benefit of treatment for OUD can limit treatment access for patients.

The economic burden of untreated patients exceeds the burden of patients actively in treatment due to reduced health outcomes, such as increased overdoses, emergency department visits, inpatient stays, Intensive Care Unit (ICU) utilization, and end-organ damage that causes or perpetuates co-occurring chronic conditions.^{13, 14, 15, 16}

In 2008, a study showed that untreated patients cost almost twice as much as patients receiving counseling only or buprenorphine/naloxone plus counseling (\$31,035 vs. \$17,017 and \$13,578, annual costs respectively).¹⁶ Furthermore, a recent analysis of Medicaid claims data discovered that OUD treatment costs account for fewer than 10% of the total costs in this population and is increasing by 2.5% per year.¹⁷ Several studies demonstrate that OUD treatment is a lifesaving approach and a cost-saving approach.^{18, 19, 20}

continued

MYTH
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4

It Is Expensive To Treat Patients With OUD *(continued)*

Most accidental overdoses are non-fatal, resulting in excess emergency department visits and inpatient hospital stays due to opioid-related respiratory arrest, which can generate significant end-organ damage and additional long-term costs.²¹ Opioid overdoses cost the United States more than \$11 billion in hospital-related costs and close to \$90 billion in direct health care costs.^{14, 22}

When in OUD treatment, patients can benefit from medication, which minimize withdrawal symptoms and cravings for opioids, learn important skills to avoid substances, and mend interpersonal, vocational, and self-care-related aspects of their lives.⁶ Combined, these treatment modalities reduce exposure to opioids and decrease the probability of accidental overdose.

MYTH
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5

Patients With OUD Cannot Be Treated With Opioids for Pain

There are misconceptions that patients with OUD on OAT cannot be treated for acute pain with short-acting opioids.

Studies have shown that uncontrolled severe acute pain, when left untreated, may negatively impact relapse. When used for a short time in an acute pain condition, where the risks and benefits have been evaluated, patients can receive short-acting opioids while continuing treatment for OUD.

Opioids may be necessary in some scenarios for treating acute pain, and the smallest dose for the shortest duration is advised. Pain management in patients on OAT should be initiated with nonpharmacologic methods and with non-opioid medications for mild to moderate pain. For more severe pain, a short-acting opioid may be added to non-opioid treatments and the OAT.²³ After the acute pain subsides, the opioid should be tapered for discontinuation.

An additional misconception is that methadone and buprenorphine, when dosed once daily for the treatment of OUD, provide adequate pain relief. Formulations of buprenorphine and methadone are available and FDA-approved for pain control. They may provide some relief when used for pain. Tolerance may develop with chronic opioid use, and this may require patients to be treated with higher doses to adequately control pain.

Providers should conduct a thorough clinical assessment for all patients prescribed opioids while being treated for OUD. Important elements of successfully treating pain and OUD include engaging in risk/benefit conversations and developing short- and long-term treatment plans.

Opportunities for Managed Care Engagement

MCOs can combat myths that decrease patient access to appropriate medication treatment by acknowledging that OUD is a long-term, chronic medical condition. Effective treatment requires a quality-enhancing, total person strategy. Opportunities for MCOs to support patients with OUD and remove barriers to care are detailed in Table 1.

Table 1.

MYTH	OPPORTUNITIES FOR MANAGED CARE ENGAGEMENT
<p>1 Patients Taking Buprenorphine/ Naloxone Must Be in Counseling</p>	<ul style="list-style-type: none"> ■ Considering the clinical and economic value of accessible and comprehensive treatment for patients recovering from OUD. ■ Developing and disseminating education for providers on reducing stigma for patients with OUD. ■ Reviewing policies and procedures to remove unintended barriers to access for patients in need of medications to treat OUD. ■ Evaluating and making necessary adjustments to Utilization Management programs (UMs) and prior authorization requirements that allow for appropriate use of OUD treatments. ■ Developing reference resources for prescribers and pharmacists outlining treatment options (local and technology-enabled) for patients.
<p>2 Buprenorphine/ Naloxone Should Only Be Used for Short-Term Therapy</p>	
<p>3 Opioid Agonists Treatment (OAT) for OUD Keeps Patients Addicted</p>	
<p>4 It Is Expensive To Treat Patients With OUD</p>	
<p>5 Patients With OUD Cannot Be Treated With Opioids for Pain</p>	

Conclusion

OUD disrupts patients, families, and society. Providing increased access to comprehensive treatments and resources for patients with OUD is an evidence-based way to address this national health care crisis. The health care system, patients, payers, and providers benefit when patients are successful with OUD treatment. MCOs should be prepared to address misconceptions to improve appropriate access to OUD treatment and reduce the unprecedented number of patient deaths due to overdose.

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