SHOUT TEXAS

Shared Decision Making and MOUD Transitions Guide

This document is intended to be a guide for hospital-based clinicians and their patients to select the appropriate medication for opioid use disorder (MOUD) and transition between buprenorphine and methadone. More information on hospital-based treatment of OUD can be found in the SHOUT Texas Toolkit and at SHOUTx.org.

Medications for OUD are the cornerstone of treatment. Both methadone and buprenorphine reduce risk of mortality.

Shared Decision Making:

MOUD decisions must be individualized according to patient preference, available medications, funding, and exposure to full agonist opioids, and should respect patient agency. Review the following with your patient:

🔹 *True for both methadone and buprenorphine*

	Methadone	Buprenorphine
Pros	- Eliminates withdrawal, reduces cravings, and blocks effects from opioids 🔹 - Better allows for continued full opioid agonist use compared to buprenorphine - Most studied and considered to be the most effective medication at therapeutic dose, typically 80mg-120mg daily - Will not precipitate withdrawal - Safe for long-term, continuous use 🔹	- Eliminates withdrawal, reduces cravings, blocks effects from opioids 🔹 - Produces a less sedating effect - Ceiling effect lowers risk of overdose - Office-based and can be taken at home - Long-acting injectable formulations are available - Can be prescribed at hospital/ED discharge - Safe for long-term, continuous use 🔹
Cons	- Stopping abruptly will likely cause withdrawal 🔹 - Overdose can occur if mixed with large amounts of sedatives or alcohol 🔹 - Requires daily dosing in outpatient setting - May take longer to get to a comfortable dose - Many medication interactions and potential risk of abnormal heart rhythms (QTc prolongation) - Cannot be prescribed at discharge	- Stopping abruptly will likely cause withdrawal 🔹 - Overdose can occur if mixed with large amounts of sedatives or alcohol 🔹, although this risk is generally lower compared to methadone - Can precipitate withdrawal symptoms if started too soon - Patients must be experiencing withdrawal symptoms before starting with standard protocols
Best Suited For	- Can be more effective for patients with severe opioid dependence - Patients who can attend daily dosing visits (transportation, time commitment, etc.)	- Patients who do not prefer or cannot complete structured daily visits, as required for methadone - Patients with significant medical complexity
Notes or Considerations	- Patients may be started during inpatient hospitalization or emergency department visit by any hospital clinician without additional training, certification, or licensure 🔹 - Outpatient dosing experience poses many barriers. See details about coordinating outpatient care in the Methadone Quick Start Guide	- Patients may be started during inpatient hospitalization or emergency department visit by any hospital clinician without additional training, certification, or licensure 🔹 - Can be prescribed on discharge and longitudinally by any provider with Schedule III DEA prescribing authority (X-waiver removed January 2023)

How to Use the Shared Decision Making Guide

Discussing options with your patient can help you build a trusting relationship

1. Involve your patient and their family (if desired by patient) or caregivers in the conversation/decision
    a. Use plain language as free as possible of jargon and medical terminology
    b. Prompt for input and demonstrate the value in your patient's voice
2. Summarize the healthcare concern(s) you and your patient have in relation to using drugs or otherwise (e.g., infection, heart disease, liver disease, etc.)
3. Ask your patient to identify their goal(s) for treatment
4. Identify any Social Determinants of Health (SDoH) barriers your patient experiences
5. Ask your patient if they have tried methadone, buprenorphine, or naltrexone before
    a. If yes, what was their experience? What worked? What didn't work?
6. Review the medications in the table above with your patient
    a. Allow time and space for questions and clarifications
    b. Map back to SDoH barriers to identify facilitators and obstacles
7. Identify your patient's preference(s)
    a. Call out any important issues, concerns, or considerations with this preference
8. Provide your patient with additional information, tools, resources, or time to decide
9. When ready, reach a decision with your patient

NOTE: Some patients may not be interested or ready to participate in a shared decision making process. The active decision not to participate in the decision making process, or to delegate the decision to the provider or a caregiver, should be respected.

Adapted and more details and guiding questions available from the Agency for Healthcare Research and Quality

Transitioning between MOUD Options

Transitioning between MOUD options can be difficult and risks discomfort, destabilization, and self-directed discharge. Opioid agonists and adjunctive medications can and should be used as needed in all transition strategies to maximize patient comfort, pain management, and acute care treatment completion.

Full agonist opioids (e.g., morphine, hydromorphone, or oxycodone) are appropriate to treat co-occurring pain and withdrawal symptoms when tapering or discontinuing methadone or buprenorphine in the hospital.

Adjunctive medications can/should be used during variable washout periods or to treat breakthrough withdrawal symptoms before completing transition and reaching a therapeutic dose.

Methadone to Buprenorphine Transition Details

- Standard methadone to buprenorphine transition (example protocol on next page)
    - Preferred for patients on lower methadone doses (up to 50mg)
    - Patients should be experiencing mild to moderate withdrawal prior to buprenorphine start (up to 24-96 hours after the last dose of methadone). A COWS score of 11-12+ is a general indicator of sufficient withdrawal to allow for smooth transition to buprenorphine.
- Crossover methadone to buprenorphine transition (example protocol on next page)
    - Preferred for patients on methadone doses of 50-120mg
    - Seek expert opinion if a patient is on >120mg of methadone
- Increase buprenorphine dose as needed to manage withdrawal symptoms after methadone is stopped. High doses (24-32mg daily) are often needed, especially for the first week.
- More information on crossover, low-dose, and high-dose buprenorphine administration is available in the Alternative Administration Guide.

Example Standard Methadone to Buprenorphine Transition Protocol												
	Variable	**Day 1**								**Day 2**		**Day 3+**	
Total Daily Bup Dose	0mg	8-32mg QD								8-32mg QD		8-32mg QD	
Dosing Time	Washout Period *Length varies (generally 24-72 hours), use COWS to identify visible withdrawal before initiating treatment*	**Every 2 hours**								AM	PRN	AM	PRN
mg Bup Dose		2 mg	2 mg	2 mg	2 mg	8 mg	8 mg	8 mg	8 mg	Day 1 Total Dose	+ 4-8mg	Day 2 Total Dose	+ 4-8mg
Methadone Dosing	**STOP**	**STOP**								**STOP**		**STOP**	

Example Crossover Methadone to Buprenorphine Transition Protocol													
	Day 1		**Day 2**		**Day 3**		**Day 4**		**Day 5**		**Day 6**		**Day 7+**
Daily Bup Dose	.5mg		.5mg BID		1mg BID		2mg BID		4mg BID		8mg BID		Refer to Buprenorphine Quick Start Guide to find maintenance dose after initial transition
Dosing Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
mg Bup Dose	.5	.5	.5	.5	1	1	2	2	4	4	8	8	
Methadone Dosing	Continue		Continue		Continue		Continue		Continue		**STOP**		

Note: If the patient is discharged prior to completing the transition, prescribe buprenorphine and advise patient to return to ED or OTP for daily methadone step-down dosing until transition is complete. Provide patient with documentation.

Buprenorphine to Methadone Transition Details

- Transitioning from a partial agonist to a full agonist does not pose a risk for precipitated withdrawal.
- No time delay is required in transitioning a patient from buprenorphine to methadone, however, persistent buprenorphine levels can limit methadone effect on day 1.
- If the patient was on a low buprenorphine dose (<8mg QD), reduce methadone daily dosage by 10mg and follow protocol as provided in the Methadone Quick Start Guide.

Example Buprenorphine to Methadone Transition Protocol				
	Day 1	**Day 2**	**Day 3**	**Day 4+**
Methadone Daily Dose	30mg QD	40mg QD	50mg QD	Refer to Methadone Quick Start Guide to find maintenance dose after initial transition is managed
Reassess at	2-6 hours			
PRN Dose	Add 10mg to daily methadone dose to manage withdrawal and cravings			
Buprenorphine Dosing	**STOP**	**STOP**	**STOP**	