Opioid Use Disorder and Medication Assisted Recovery: Caring For Our Communities

Speaker: Elisabeth Fowlie Mock, MD

Tuesday, November 27, 2018
12 – 1 PM

Audio is available through your computer speakers.

Mission

Maine Quality Counts is a nonprofit located in Manchester, Maine.

We are working to improve the health of all Maine people (and beyond) by transforming the way healthcare is delivered.

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Priorities

QC Brings Together the People Who Give, Get and Pay for Healthcare to Address Shared Priorities:

- Improve the alignment of healthcare systems to transform health for all Maine people
- Provide quality improvement assistance to practices
- Engage consumers in healthcare
- Promote the integration of physical and behavioral health

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mainequalitycounts.org

Engage and be social

Important Webinar Notes

- You are in listen-only mode. Please use the Q&A function to ask questions or make comments.
- Video screen size and location is adjustable.
- Tomorrow you'll receive an email with links to slides and recordings.

CME

- **Disclosure: Today's speaker does not have any relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.**
- **CME** will be available for participants who have signed into the live webinar. If there are multiple people at one computer, please type their names and email addresses into the chat box for our attendance records.
- We do not have separate nursing CEUs- but you can get a CME certificate.
- A CME evaluation survey will be will be sent after the webinar via email the day following the webinar.
- Please complete the survey via Survey Monkey within 2 weeks.
- New CME Documentation Procedure: You are now able to access your CME document immediately by clicking the link at the very end of the survey.

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Caring for ME

This activity has been planned and implemented in accordance with the Essentials and Standards of the Maine Medical Association Committee on Continuing Medical Education and Accreditation through the partnership of Maine Medical Education Trust and the Maine Independent Clinical Information Service (MICIS). The Maine Medical Education Trust is accredited by the Maine Medical Association to provide Continuing Medical Education (CME) activities for physicians.

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Today's Speaker

Speaker: Elisabeth Fowlie Mock, MD, MPH, FAAFP

Elisabeth is a Family Physician living in Holden, ME, and practicing part-time as an Adult Hospitalist (or "Nocturnist") at Eastern Maine Medical Center in Bangor. She does consulting work and teaches for the Maine Medical Association's Academic Detailing Program, MICIS. She attended Colby College and Emory University and received her MD from Vanderbilt University School of Medicine. After a residency in rural Family Medicine, she received her MPH in Health Policy and Administration from UNC-Chapel Hill. She is a Past President of the Maine Academy of Family Physicians and an Alternate Delegate to the American Academy of Family Physicians. Elisabeth very recently took her addiction medicine boards.

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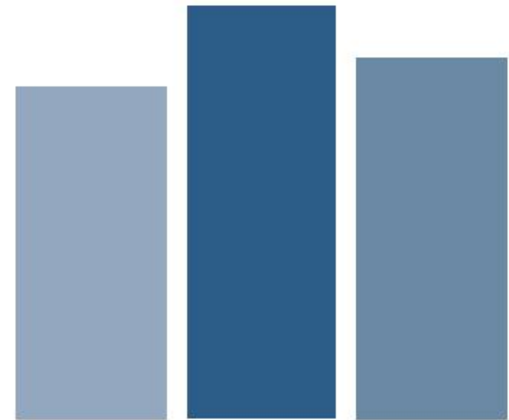

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Maine Medical Association

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor

Ricker Hamilton, Commissioner

OUD & MAR:

Caring for Our Communities

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Brenda's story

"How can I be addicted to these? I get them from my doctor. It kills your soul and makes you feel worthless."

Disclosures

- MICIS does not accept any money from pharmaceutical companies
- This presentation may include "off label use" of medications

Objectives

At the conclusion of the MICIS learning session, the learner will have the ability to:

1. Appropriately recognize, diagnose and language opioid use disorder (OUD)
2. Compare pharmacologic treatments used in Medication Assisted Recovery (MAR)
3. Develop a strategy for treating acute pain for patients with OUD
4. Constantly consider harm reduction

Additional Materials Include

- "un-ad" one page handout
- How to Use Naloxone (pt brochure)
- Summary of training options
- Evidence document (20 pages)
- References

Opioid Use Disorder is a Chronic Disease

typically, a chronic, relapsing, yet treatable illness; associated with significantly increased rates of morbidity and mortality

(Strain, 2018)

LIKE MANY CHRONIC DISEASES, OUD HAS ITS ORIGINS IN ADOLESCENCE

Use in Adolescence

- 9 of 10 people with addiction started smoking, drinking or using drugs before age 18
- The earlier the substance use, the greater the likelihood of addiction
- Average age of first use 13-14 years

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(Essentials of Addiction Medicine, 2015)

High School Students—EtOH, Tobacco & Drugs

- 75% have used 1 or > substances
- ~50% are current users
- 12.5% meet diagnostic criteria for addiction

(Essentials of Addiction Medicine, 2015)

Reframing social norms:

YOUTH SUBSTANCE USE IS A HEALTH THREAT RATHER THAN A NORMAL RITE OF PASSAGE

Reducing Risk

- Delay all substance use for as long as possible
- Be vigilant for signs of risk
- Intervene appropriately

Substance use is changing our demographics

U.S. life expectancy declined for 2 years in a row (2014-2016), largely because of unintentional injuries (includes unintentional OD).

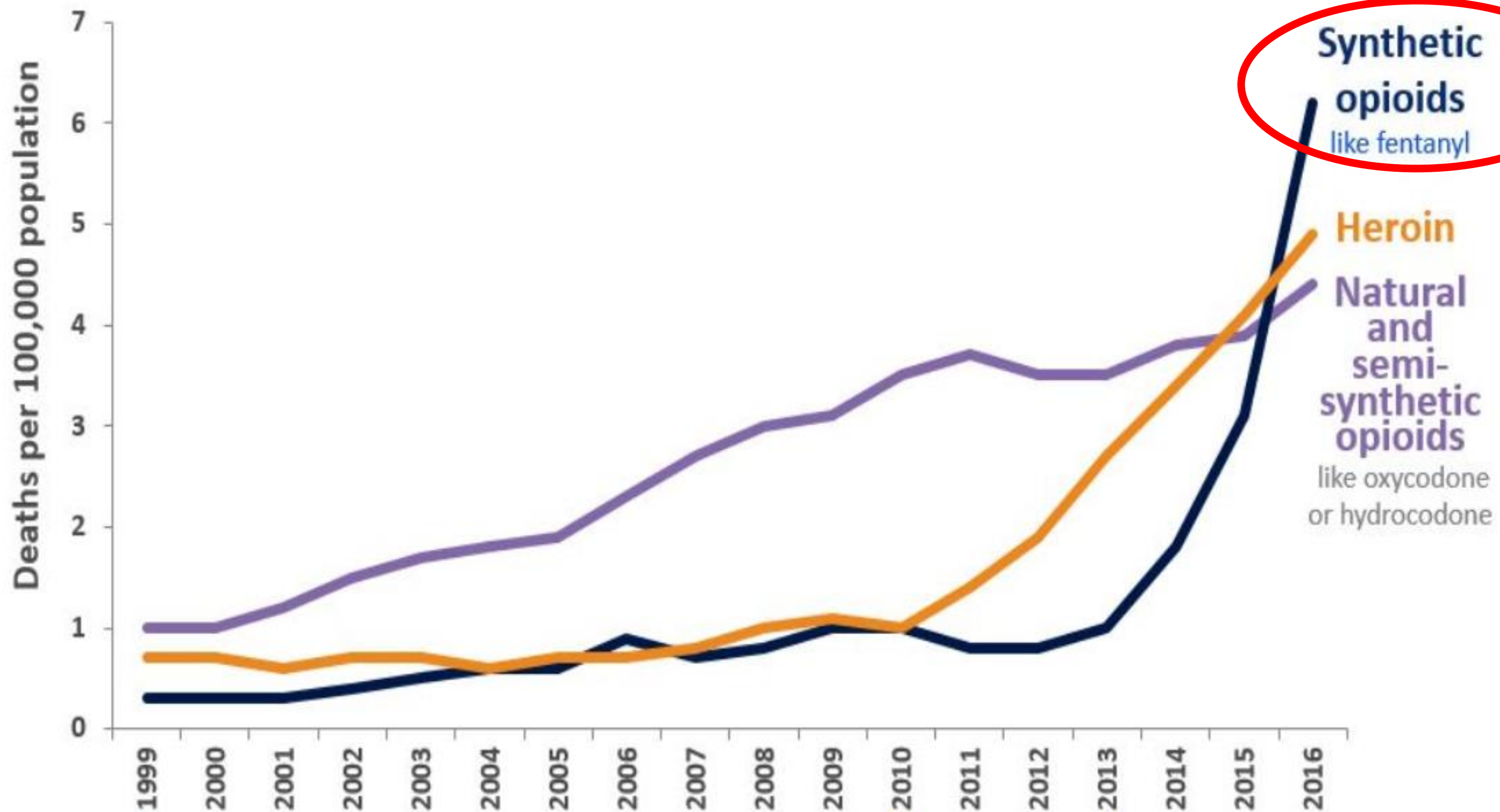
(NCHS Data Brief No. 293, 2016)

Opioid-related ED Visits July 2016 – Sept 2017

- Increase of 34% in Maine
- Massachusetts, New Hampshire, Rhode Island had 'nonsignificant' decreases (<10%)
- Maine noted to be one of 16 states with high prevalence of overdose mortality

(Vivolo-Kantor, 2018)

3 Waves of the Rise in Opioid Overdose Deaths



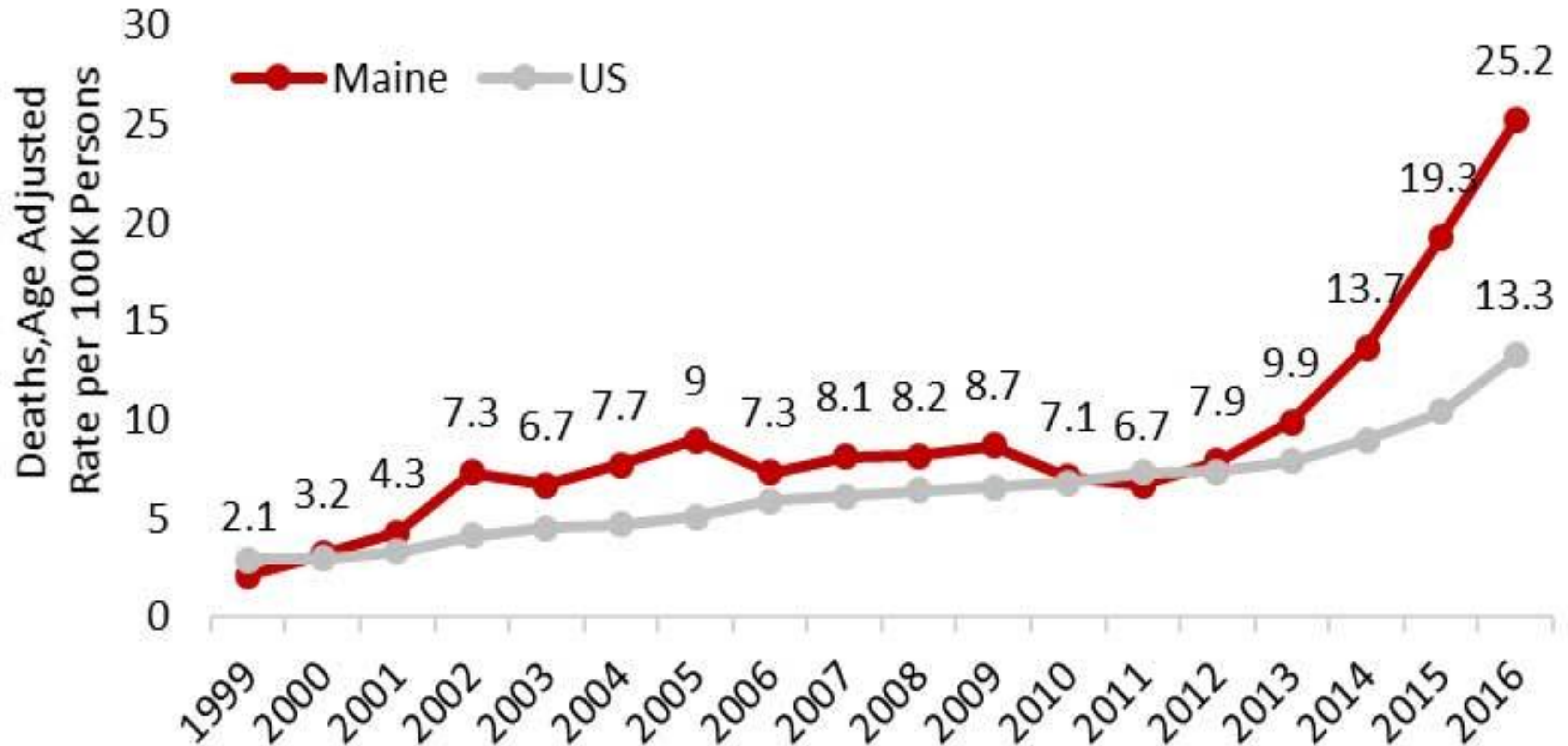
Wave 1: Rise in Prescription Opioid Overdose Deaths

Wave 2: Rise in Heroin Overdose Deaths

Wave 3: Rise in Synthetic Opioid Overdose Deaths

SOURCE: National Vital Statistics System Mortality File.

Maine Overdose Deaths



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We Need to Be Prepared to Recognize and Treat OUD

And how we talk about it MATTERS

The words you use to describe OUD and an individual with OUD are powerful. Providers should adopt terminology that will not reinforce prejudice, negative attitudes, or discrimination.

- Omar Manejwala, MD, Addiction Specialist

There are several studies that demonstrate the negative impact of using demeaning, pejorative, or stigmatizing language — such language doesn’t just hurt feelings — the research shows that when such language is used people are less likely to get the medical care they so desperately need.

- Omar Manejwala, MD, Addiction Specialist

DSM-5 Criteria for Opioid Use Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- Mild: 2-3 criteria
- Moderate: 4-5 criteria
- Severe: >=6 criteria

DSM-5 Criteria for Opioid Use Disorder

- Opioids are often taken in **larger amounts** or over a **longer period** than was intended.
- There is a persistent **desire** or unsuccessful efforts **to cut down** or control opioid use.
- A great deal of **time is spent** in activities necessary to **obtain** the opioid, **use** the opioid, or **recover** from its effects.
- **Craving**, or a strong desire or urge to use opioids.

DSM-5 Criteria for Opioid Use Disorder

- Recurrent opioid use resulting in a **failure to fulfill** major **role obligations** at work, school, or home.
- Continued opioid use despite having **persistent or recurrent social or interpersonal problems** caused or exacerbated by the effects of opioids.
- **Important** social, occupational, or recreational **activities** are **given up** or reduced because of opioid use.
- Recurrent opioid **use** in situations in which it is **physically hazardous.**

DSM-5 Criteria for Opioid Use Disorder

- Continued opioid use despite knowledge of having a **persistent or recurrent physical or psychological problem** that is likely to have been caused or exacerbated by the substance.
- **Tolerance,*** need for markedly increased amounts of opioids to achieve intoxication/desired effect or markedly diminished effect with continued use of the same amount of an opioid.
- **Withdrawal,*** characteristic opioid withdrawal syndrome or opioids are taken to relieve or avoid withdrawal symptoms.

*Criteria are not applied to individuals taking opioids by prescription as most on chronic, higher doses have tolerance and withdrawal.

RECOVERY

Guiding Principles of Recovery

- a process of change
- improving health and wellness
- living a self-directed life
- striving to reach full potential
- no “one size fits all” approach

(SAMSHA, 2012)

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Four Dimensions that Support a Life in Recovery

- Health
- Home
- Purpose
- Community

(SAMSHA website)

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Recovery Occurs via Many Pathways

- one year recovery rates:
  - – 50% with medication-assistance,
  - – 10% without medication

(multiple sources cited in references)

MAR: Effective, Cost-effective, and Cost-beneficial

Medications:

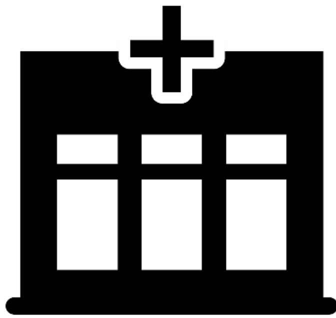
- reduce illicit opioid use
- retain people in treatment
- reduce risk of opioid overdose death
- better than treatment with placebo or no medication

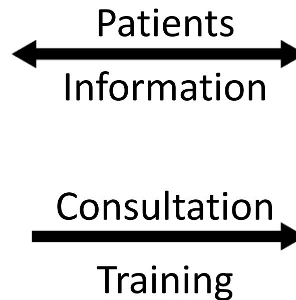
Who Can Prescribe?

- Buprenorphine
- Methadone
- Emergency methadone or buprenorphine (72h)**
- Naltrexone

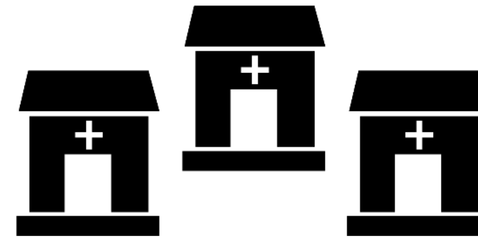
Hub & Spokes Collaborate

Hubs





Spokes



High intensity MAT

Methadone, buprenorphine, naltrexone

Regional locations

All staff specialize in addictions treatment

Maintenance MAT

Buprenorphine, naltrexone

Community locations

Lead provider + nurse and LADC/MA counselor

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Which Patients Are Best Suited for tx in Primary Care Settings?

- stable/controlled medical comorbidities
- stable/controlled psychiatric comorbidities
- safe, substance-free living environment

Which Patients Are Best Suited for tx in "HUBS"?

- continued opioid use despite bup tx
- poor response to bup
- previous misuse or diversion of bup
- poorly controlled psychiatric illness
- co-morbid SUD (especially severe BZDP/EtOH use)

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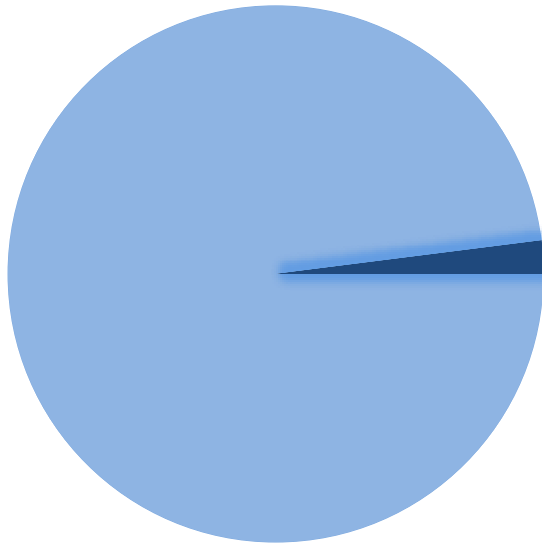
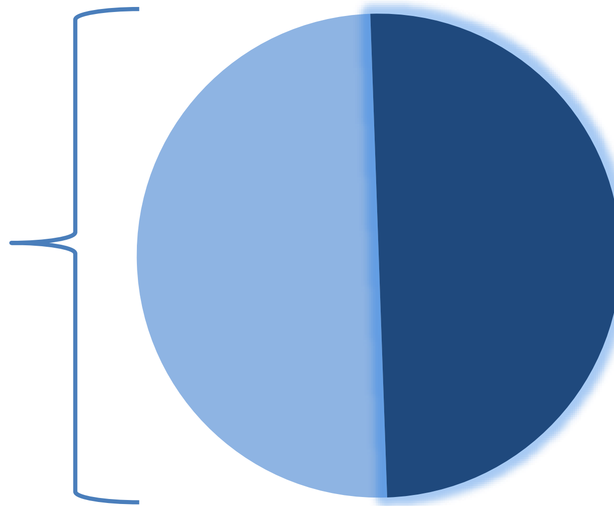
National Buprenorphine Data

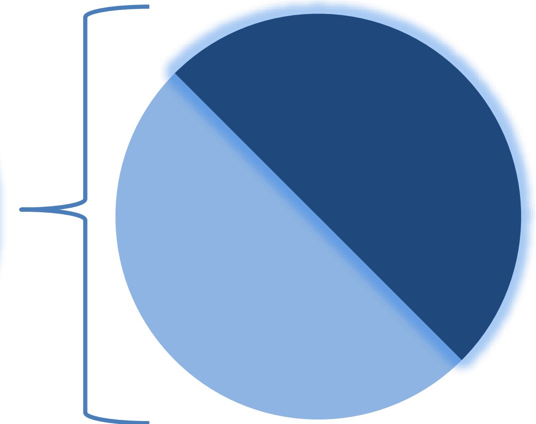
2% of all prescribers have an x-waiver



~50% of those ever prescribe



~50% of those prescribe 1-4 patients



(SAMSHA)

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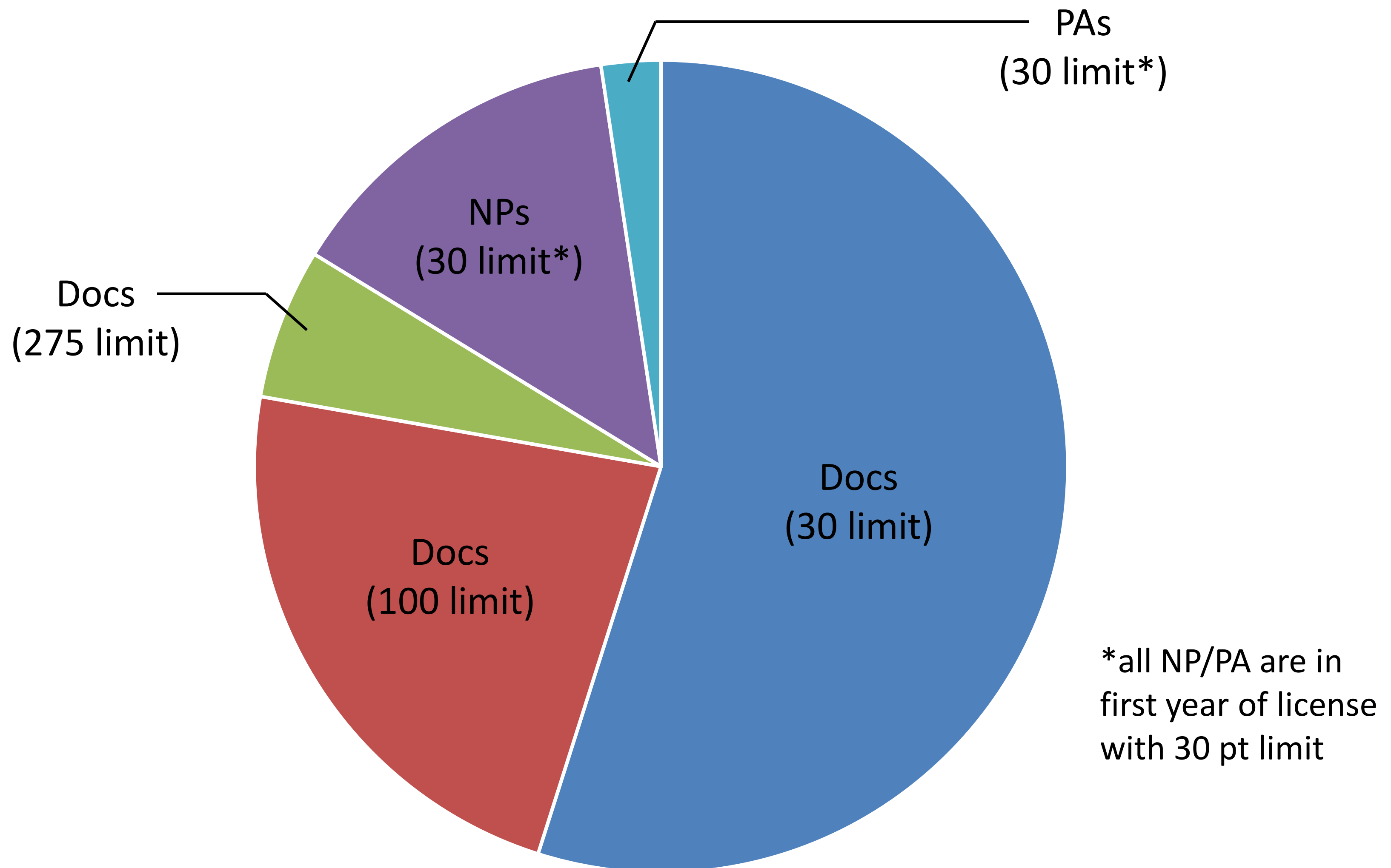
Maine Buprenorphine Prescribers



*all NP/PA are in first year of license with 30 pt limit

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Data: SAMSHA, January 2018, Abstracted by Lisa Letourneau, MD, MPH

How long to treat?

Some patients:

- may slowly taper and wean after 1-2 years of stability
- remain on low dose therapy long-term
- may go on and off treatment

Acute Pain in Patients with OUD

Baseline opioid maintenance therapies are not adequate for pain control in patients with acute, moderate to severe injuries and surgeries beyond minor procedures.

In Patients on Methadone and Buprenorphine:

- verify the dose
- maximize nonopioid pain treatments *(pharmacologic and nonpharmacologic)*
- **consider increasing or splitting dose**
- add higher dose short-acting opioids for 3-5d

Actively using heroin/other opioid:

- try to get a history of ‘dose’
- maximize non-opioid modalities
- consider tramadol
- always try to use oral medications in preference over IV
- consider increased doses post-operatively
- avoid take-home prescriptions in most cases

In Patients on Naltrexone:

- try to delay elective interventions
- maximize nonopioid pain treatments
  (pharmacologic and nonpharmacologic)
- if emergency may need higher than usual doses of opioids to overcome—high risk of respiratory depression

Contact recovery medication prescriber proactively (or as soon as possible in unscheduled/emergent situations)
to discuss acute pain needs, taper schedule, and who will handle prescribing

Hardwire HARM REDUCTION Strategies in All Medical Practices

SAVE LIVES FIRST

Harm Reduction

Social Determinants of Health Contribute to the Opioid Epidemic

Homeless persons were **9x** more likely to die from OD than persons stably housed.

A “housing first” approach to recovery increases likelihood of success.

(Baggett, 2013)

Social Determinants of Health Contribute to the Opioid Epidemic

Persons who are released from incarceration

are at a 12*x risk of overdose.*

Jails/prisons in Maine do not provide MAR **yet.**

Harm Reduction

- Prescribe opioids using conservative management strategies
- Limit supplies to 3-5 days for acute pain
- Avoid co-prescribing with BZDP
- Exhaust nonopioid and nonpharmacologic treatment strategies (for acute or chronic)
- Document informed consent

Consider Naloxone Prescriptions for:

- all patients on chronic opioids, especially at doses over 50 MME
- any patient co-prescribed benzodiazepines/sedatives or actively using alcohol
- friends or family members who might witness overdose
- patients with OUD being released from incarceration or treatment programs
- patients with history of overdose
- patients with underlying respiratory disease, especially sleep apnea
- all patients in MAR

In Summary…

- The words you use to describe OUD and an individual with OUD are powerful.
- Recovery is possible and more likely when using medications combined with counselling
- OUD medications reduce illicit opioid use, reduce overdose deaths, decrease crime and retain people in treatment/counselling
- Treat acute pain with multiple modalities for all patients, including those in recovery
- Recommend naloxone prescriptions for all patients in recovery

QC MAR Resources

- https://mainequalitycounts.org/what-we-do/population-health/naloxone-and-mat-resources/

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Peter Leighton video updates

- Filmed early 2017
- OD numbers are 2016
- Our understanding of the types of counselling and peer support most effective for achieving recovery continues to evolve
- As of 4/17: NPs & PAs can get independent buprenorphine waivers (24 hour course)

references: MICISMaine.org

Video Resources

- Diversion Alert/recoveryinme video
  - www.youtube.com/watch?v=q1lSmWWwM40
- CDC Videos
  - www.cdc.gov/rxawareness/resources/video.html

RX Awareness Campaign Trailer (1:53) & Brenda's Rx Awareness Story (0:30)

- Leighton MAT
  - www.youtube.com/watch?v=WjtYp_pMUqI (trailer)
  - www.youtube.com/watch?v=3pT_BJtsraA&feature=youtu.be (full length)

Bias may be a Barrier

Emergency physicians at Hopkins had lower regard for pts with SUDs than other medical conditions with behavioral components.

54% at least "somewhat agree" that they prefer not to work pts with SUD who have pain

(Mendiola, 2018)

Words are important. If you want to care for something, you call it a 'flower'; if you want to kill something, you call it a 'weed'.

- Don Coyhis, Native American Recovery coach

"Use of marijuana, stimulants, or other addictive drugs should not be a reason to suspend OUD tx. However, evidence demonstrates pts actively using substances during OUD tx have a poorer prognosis. The use of EtOH, bzdp and other sedative hypnotics may be a reason to suspend agonist tx—safety concerns related to respiratory depression."

(ASAM Guideline, 2015)

Contact Information

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QC Website: https://mainequalitycounts.org/

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Caring for ME

Upcoming Webinars!

1. **Tuesday, December 11, 2018**: 12:00 PM - 1:00 PM EST **Registration** MICIS: Co-Prescribing Benzodiazepines and Opioids: The Black Box of Increased Overdose Risk: Elisabeth Fowlie Mock

2. **Thursday, December 20, 2018 12:00 pm – 1:00 PM**
   MICIS; Alternative Treatments to Chronic Pain **Registration**
   Speaker: Elisabeth Fowlie Mock