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Maine Medical Association

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

OUD & MAR:

Caring for Our Communities

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Speaker:
Elisabeth Fowlie Mock, MD, MPH

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Disclosures

- MICIS does not accept any money from pharmaceutical companies
- Speakers and planners have no significant or relevant financial relationships to disclose
- This presentation includes “off label use” of medications

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Objectives

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

1. Appropriately recognize, diagnose and talk about 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

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Handout Materials May Include

- “un-ad” or one page handout
- How to Use Naloxone (pt brochure)
- Evidence & Resource document at MICISMAINE.org

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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)

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LIKE MANY CHRONIC DISEASES, OUD HAS ITS ORIGINS IN ADOLESCENCE

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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

(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

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Reframing social norms:

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

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Reducing Risk

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

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Substance use is changing our demographics

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U.S. life expectancy declined for 3 years in a row (2014-2017), largely because of unintentional injuries (includes unintentional OD).

(NCHS Data Brief No. 293, 2016; NCHS Data Brief No. 328, 2018)

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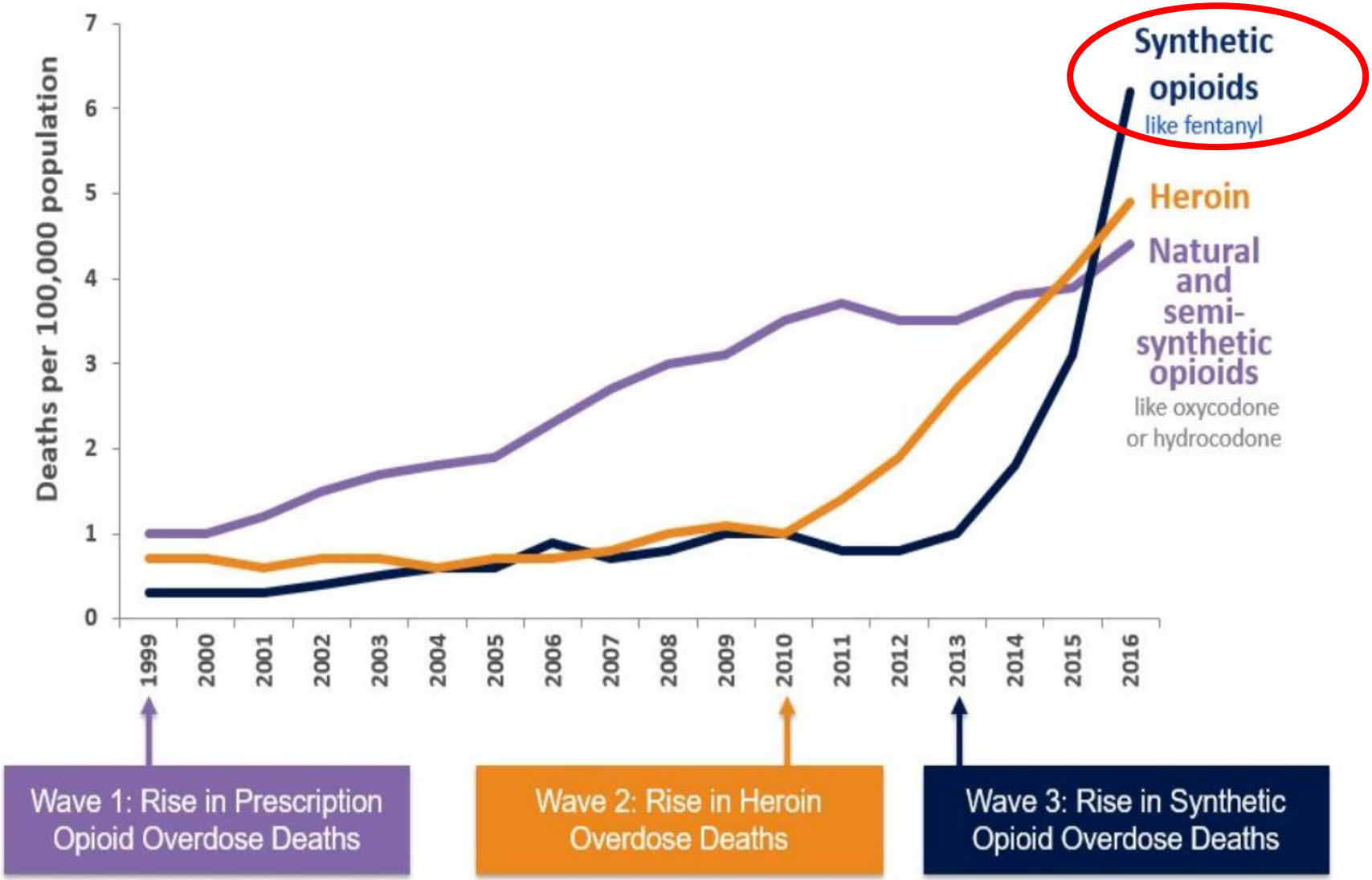
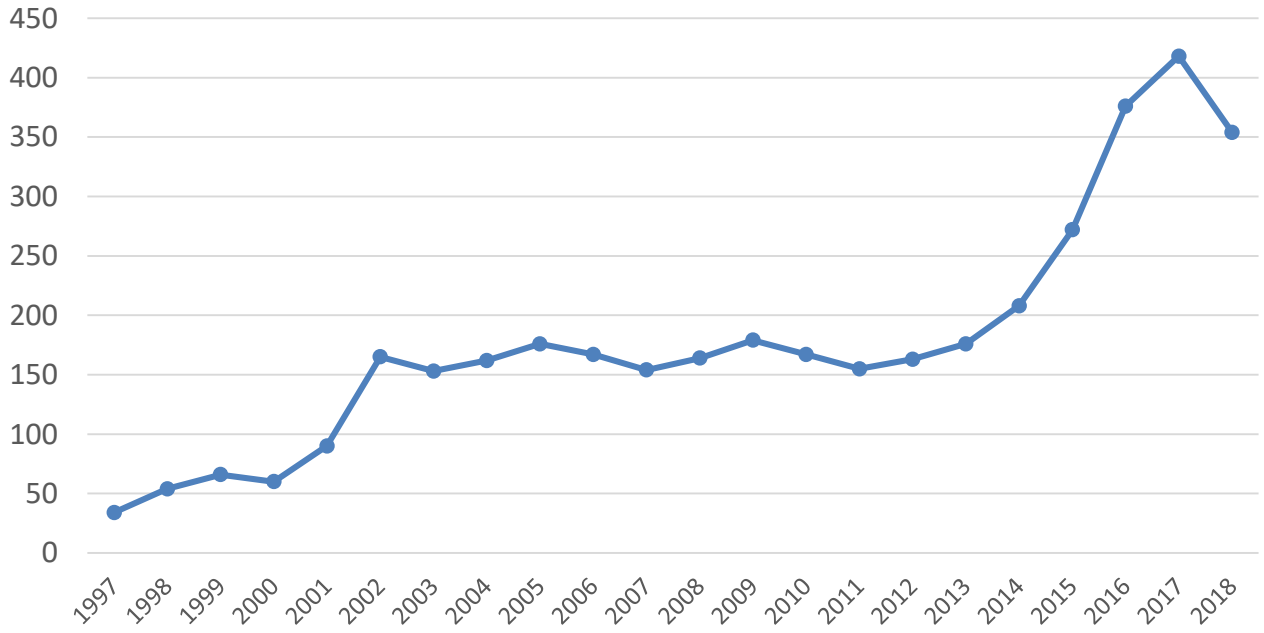
3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

Maine Overdose Deaths



2018 overdoses involving opioids: **80%**

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2018 OD Deaths by County

- Waiting for final report from Atty General's office

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Opioid-related ED Visits
July 2016 – Sept 2017

- Increase of 34% in Maine
- Massachusetts, New Hampshire, Rhode Island had 'nonsignificant' decreases (<10%)

(Vivolo-Kantor, 2018)

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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

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OUD/MAR Debate

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We Need to Be Prepared to Recognize and Treat OUD

And how we talk about it MATTERS

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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

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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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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 or Dispense?

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

Newer Buprenorphine Formulations

- subdermal implant (6 months)
- injection (monthly)

Naltrexone

- Initiation of naltrexone must be preceded by withdrawal from opioids (preferably medically supervised);
- oral naltrexone has higher dropout rates than injectable.

Recovery Occurs via Many Pathways

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

(multiple sources cited in references)

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

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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

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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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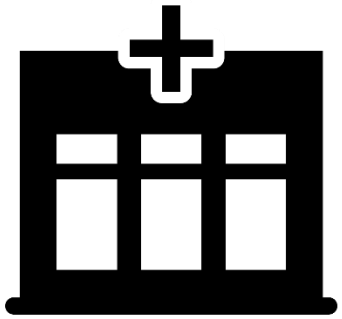
Hub & Spokes Collaborate

Hubs



High intensity MAT

Methadone, buprenorphine, naltrexone

Regional locations

All staff specialize in addictions treatment

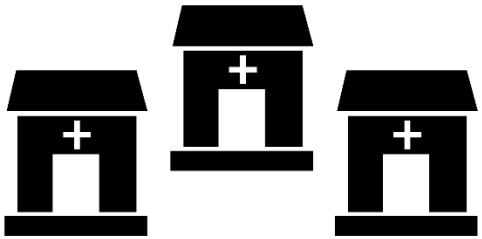
Patients

Information

Consultation

Training

Spokes



Maintenance MAT

Buprenorphine, naltrexone

Community locations

Lead provider + nurse and LADC/MA counselor

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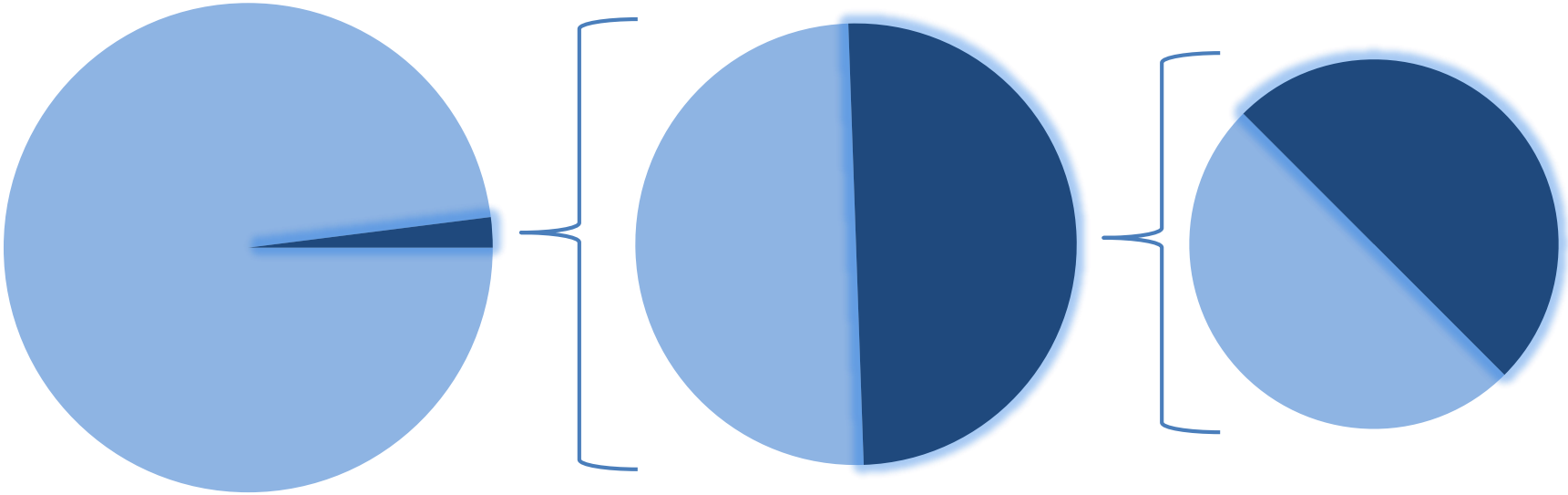
National Buprenorphine Data

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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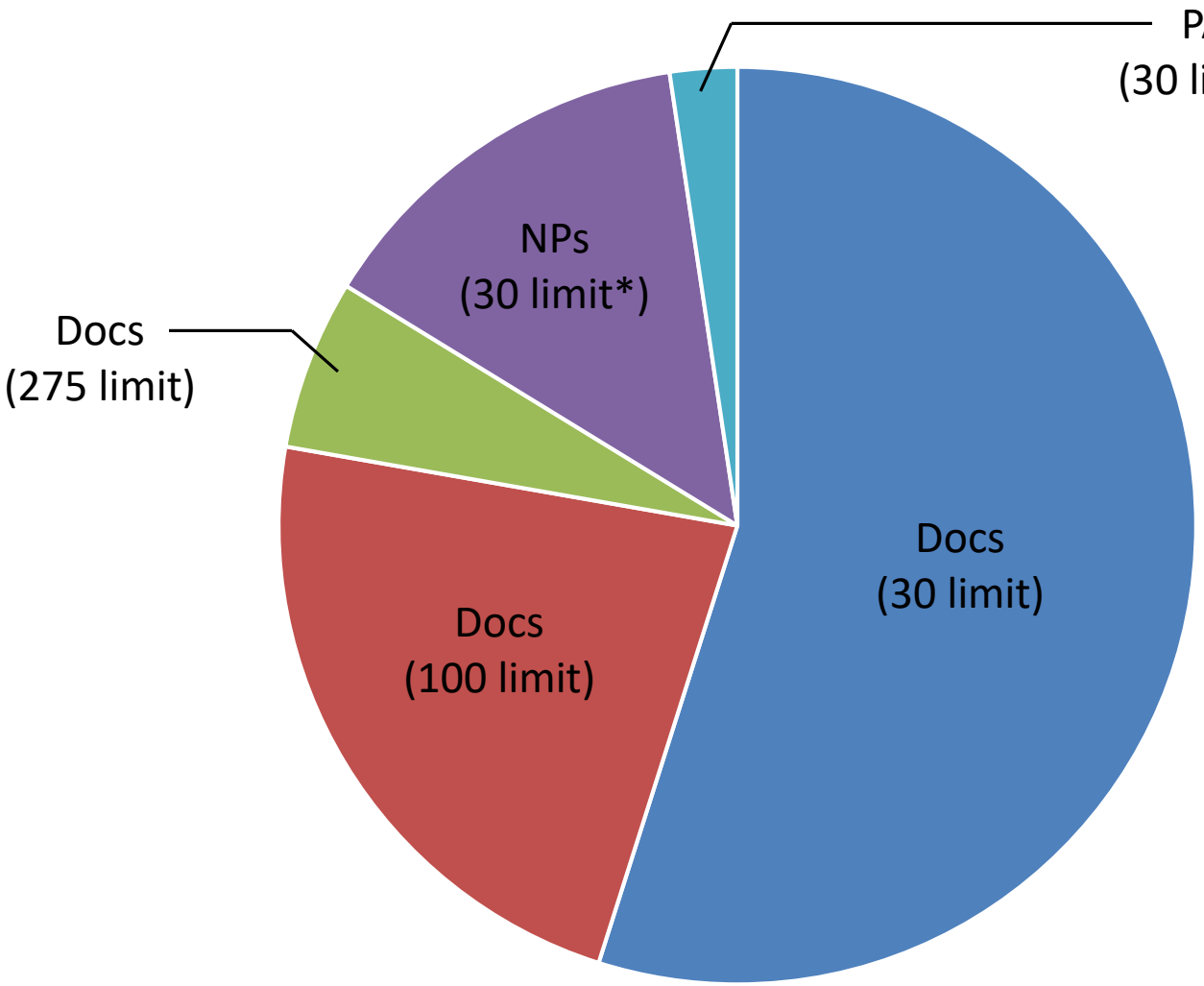
Maine Buprenorphine Prescribers



*all NP/PA were 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?

Indefinite. No evidence base. Patients:

- may stay on medium doses (~8-16)
- may slowly taper and wean after a few years of stability
- remain on low dose therapy long-term
- may go on and off treatment

Acute Pain in Patients with OUD

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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

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Hardwire Harm Reduction Strategies in All Medical Practices

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SAVE LIVES FIRST

(Harm Reduction)

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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.

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(Baggett, 2013)

Social Determinants of Health Contribute to the Opioid Epidemic

Persons who are released from incarceration

are at a 12x risk of overdose.

Jails/prisons in Maine

will provide MAR soon.

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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

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"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~~ adjust agonist tx—safety concerns related to respiratory depression."

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(ASAM Guideline, 2015)

In Summary...

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- 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

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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)

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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)

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

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MICISTravels on facebook

references: MICISMaine.org

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Balanced Data About Medications

SLIDE PARKING LOT

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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

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Counselors help clients by…

addressing the challenges & consequences of OUD

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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

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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

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(Mendiola, 2018)