OPIOID SAFE-PRESCRIBING TRAINING IMMERSION (OSTI)

Case 105- Prep Materials

University of Massachusetts Medical School
Opioid Conscious Curriculum Jan 2019

Learner Prep Objectives

- The purpose of this prep material is to prepare you for the Opioid Safe-Prescribing Training Immersion (OSTI) Curriculum
- The following slides provide an introduction to some of the key tools that you should be familiar with before participating in the OSTI.
  - Note that additional information and resources are in the notes section of these slides
- By the end of this prep, you should be familiar with the following tools and concepts:
  - Referring treatment resources including early discussion of medication assisted therapy (MAT)
  - Administering and using the readiness to change/confidence in change tool
  - Recognition and early management of a patient who has overdosed
  - Discussing Naloxone use
  - Using the SBIRT tool – Screening, Brief Intervention, Referral for Treatment
  - Reading an EMS run sheet

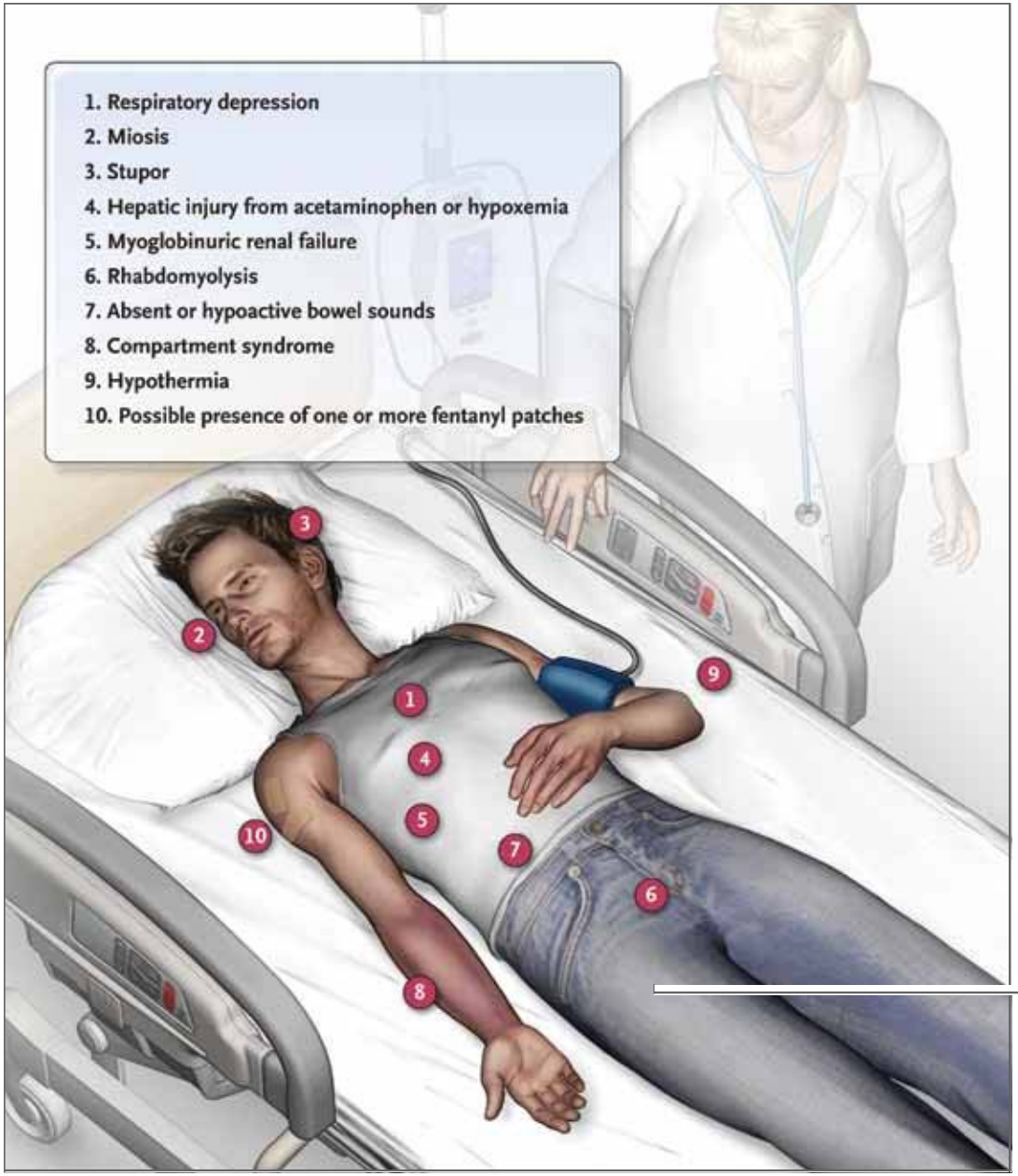
Case 105- Learner Tasks

1. Take a focused opioid use history
2. Utilize SBIRT to develop a plan with the patient, including assessment of readiness and confidence in change
3. Talk to the patient about substance use treatment history, what has worked well previously, and options for future treatment
4. Counsel patient regarding the nature of substance use disorder as a chronic disease, with MAT options and empathy
5. Evaluate the presence of depressed mood and risk of self-harm
6. Ensure patient and partner understand chronicity of OUD and risk of relapse.
7. Discuss diagnosis and treatment options including MAT in the ED, bridging programs and barriers to follow up care
8. Describe appropriate buprenorphine administration
9. Ensure patient has access to and can use naloxone

Recognition of Opioid Overdose

Classic triad:

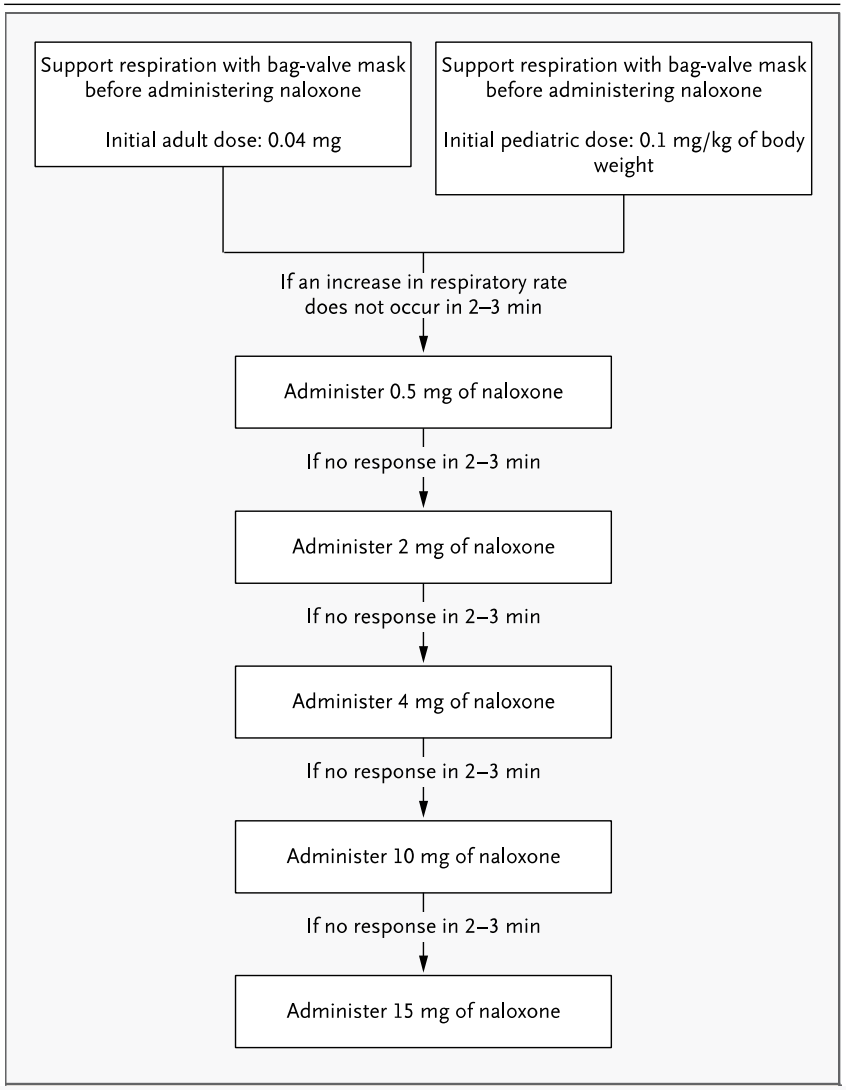
- Coma (depressed mental status)
- Pinpoint pupils
- Respiratory depression (<12 breaths/min in adults)
- All three may not be present


1. Respiratory depression
2. Miosis
3. Stupor
4. Hepatic injury from acetaminophen or hypoxemia
5. Myoglobinuric renal failure
6. Rhabdomyolysis
7. Absent or hypoactive bowel sounds
8. Compartment syndrome
9. Hypothermia
10. Possible presence of one or more fentanyl patches
1
2
3
4
5
6
7
8
9
10

Management of Opioid Overdose

In medical setting:

- Restoration of oxygenation and ventilation are the first priorities
  - Ventilation with BVM, supplemental oxygen administration
- Reversal of naloxone with escalating doses (dose titrated to restoration of respiration; excessive dosing may precipitate withdrawal)
- Naloxone dosing per table on following page


Support respiration with bag-valve mask before administering naloxone
Initial adult dose: 0.04 mg
Support respiration with bag-valve mask before administering naloxone
Initial pediatric dose: 0.1 mg/kg of body weight
If an increase in respiratory rate does not occur in 2–3 min
Administer 0.5 mg of naloxone
If no response in 2–3 min
Administer 2 mg of naloxone
If no response in 2–3 min
Administer 4 mg of naloxone
If no response in 2–3 min
Administer 10 mg of naloxone
If no response in 2–3 min
Administer 15 mg of naloxone

Naloxone and opiate overdose

- Death generally occurs within 1-3 hours of overdose (Kin, 2009)
- Bystander Naloxone use is associated with increased odds of recovery (Giglio, 2015)
- Discuss Naloxone with all patients who have an opiate use disorder
- Explain signs and symptoms of overdose (handouts and videos may help)

Prescribe to Prevent Video

Watch this 3-minute video describing response to a patient who has overdosed including using nasal Naloxone here

Prescribe to Prevent
Patient Handout

Detach for patient

How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
- Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose

Are they breathing? → Call 911 for help

Signs of an overdose:

- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)

All you have to say:
"Someone is unresponsive and not breathing."
Give clear address and location.

Airway → Rescue breathing

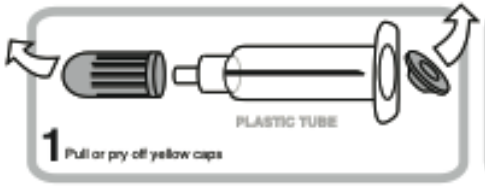
Make sure nothing is inside the person's mouth.

Oxygen saves lives. Breathe for them.
One hand on chin, tilt head back, pinch nose closed.
Make a seal over mouth & breathe in
1 breath every 5 seconds
Chest should rise, not stomach

Prepare Naloxone

Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?

PrescribeToPrevent.org



Source: HarmReduction.org

Evaluate + support

- Continue rescue breathing
- Give another 2 sprays of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

POISON Help 1-800-222-1222 AAPCC

v02.12.11

NOTE: Administering Naloxone to someone who has NOT used opiates does NO harm.

Screening, Brief Intervention, Referral to Treatment (SBIRT)

- Consists of
  - Screening: assess the level of use, reasons for use, and other important factors (there are many specific tools and additional SBIRT information on the SAMHSA website)
  - Brief intervention: engage the patient in conversation, consider using ‘ruler’ to assess interest/willingness to change
  - Referral to Treatment: based on availability and the patient’s specific needs, interest, insurance.
- Watch this 7 minute video on using SBIRT for drug use
- Consider using an SBIRT app
- Can be used in multiple settings including the office, emergency room or urgent care.

Readiness/Confidence to Change

- Provides a framework for allowing the patient to address the motivation to change through importance, readiness, and confidence
- Asks patients to use a 10-point ‘ruler’ (mostly validated in tobacco and Alcohol behavioral change)
  - – Miller 1991, Rollnick 1997, Boudreaux 2012, Zimmerman 2000
- The patient is asked to score each of these items for the habit being addressed (e.g., heroin use)
- Providers then ask questions about their scoring
  - “Why not lower?” can provide insight into their motivation
  - “Why not higher?” can identify perceived obstacles
- An example ruler follows

Readiness/Confidence to Change

Readiness/ Confidence to change rulers

1. How important to you is your physical health?

'The Readiness Ruler'

Not important at all									***Extremely important***
1	2	3	4	5	6	7	8	9	10

2. How confident are you about changing?

'The Confidence Ruler'

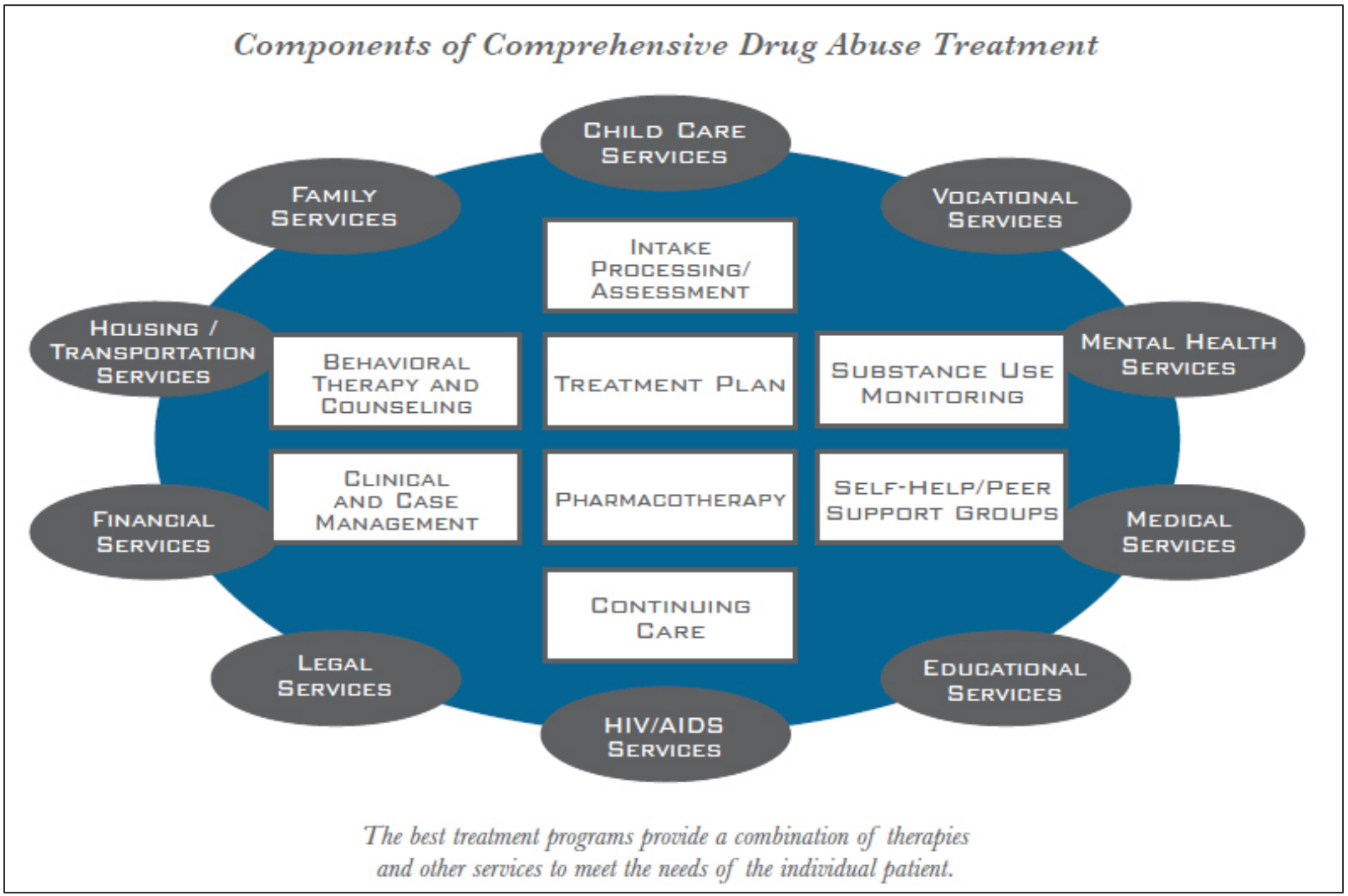
3. ***Not confident at all***									***Extremely confident***
1	2	3	4	5	6	7	8	9	10

4. Why did you score yourself so high/ low?

5. What would help to move you higher on the scale?

6. How high on the scale would you need to be to change?

Substance Use Disorder Treatment



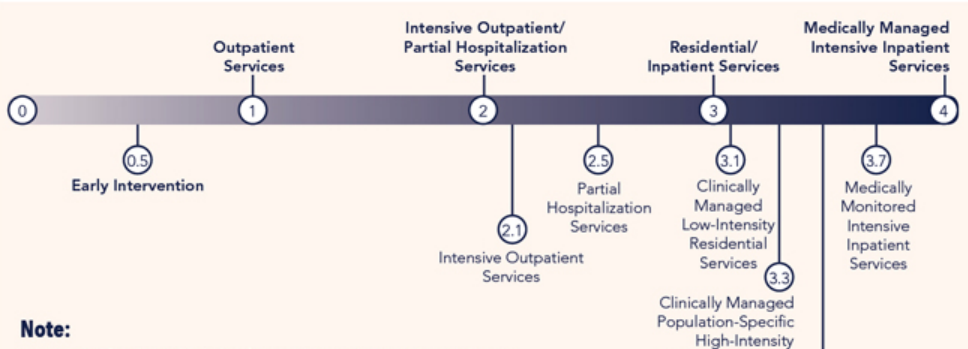
AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3	DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
5	DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things

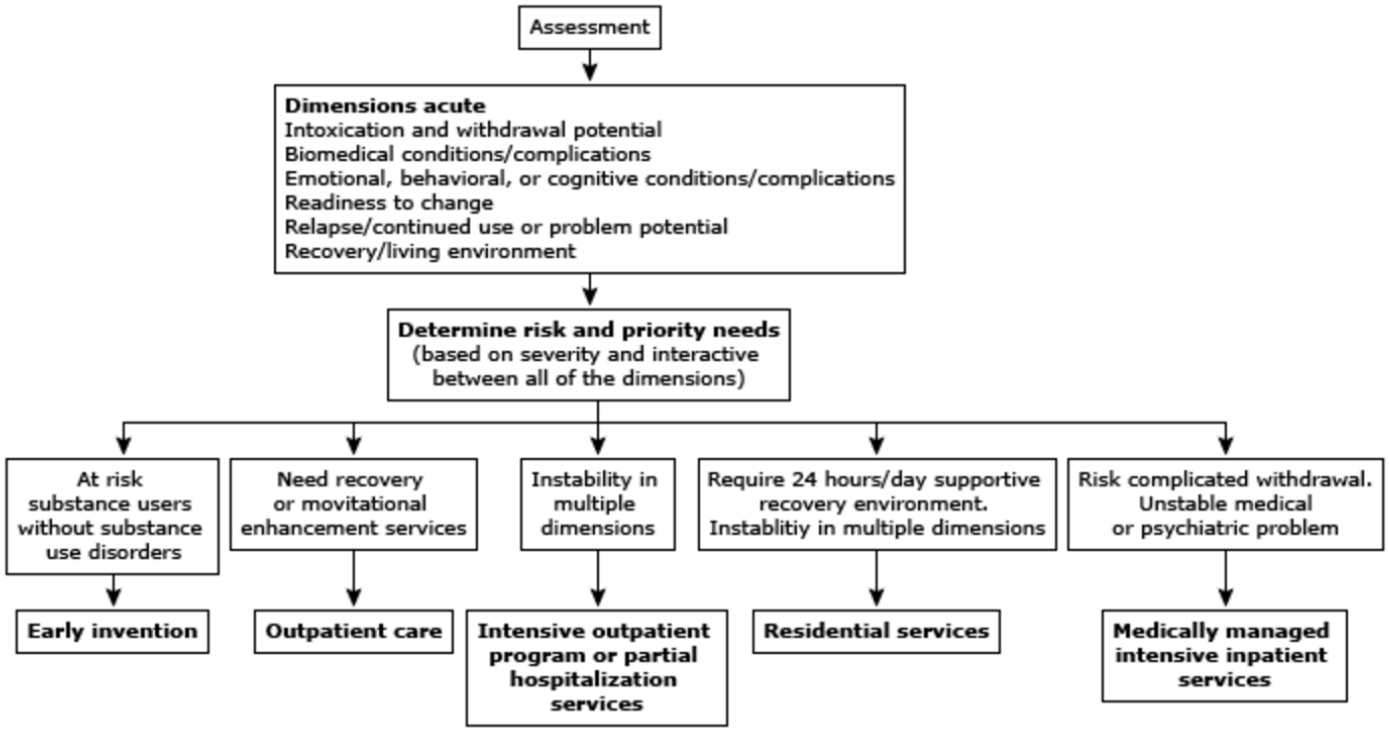
- Substance Use Disorder Treatment is a continuum
- A given patient may need some or all of these levels of care at some point in their addiction; however, not all do

REFLECTING A CONTINUUM OF CARE



Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

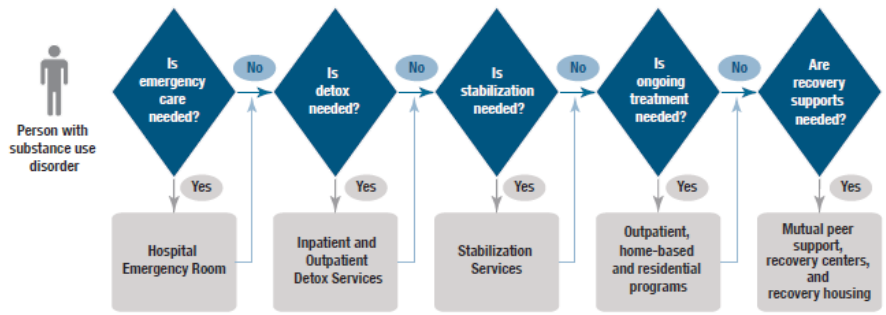
Matching patient substance use disorder treatment needs to levels care using ASAM criteria



Adapted from: The American Society of Addiction Medicine Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed., Mee-Lee D, Shulman GD, Fishman MJ, et al. (Eds), The Change Company, Carson City, NV 2013.

Access to SUD Treatment Services

Depicting the different levels of care based on need.



Vocabulary for the SUD Inpatient Treatment

- **Inpatient Detoxification Program** (“Detox”): 4-6 days of inpatient medical monitoring of withdrawal symptoms
  - Usually includes some counseling services, but focus is on medical management of symptoms
- **Clinical Stabilization Services** (CSS): Intensive, short-term (up to 30 days) inpatient residential program
  - Focus on skills for early recovery
- **Transitional Support Service** (TSS): Inpatient treatment (counseling, skills building) step-down in transition to next step in care (often longer-term residential)
  - Sometimes referred to as “holding”
  - Will hold patients up to 28 days, but usually shorter
- **Short-Term Residential Treatment**: 24 hours a day care, generally in non-hospital settings, often in therapeutic community model with varied lengths of stay of between 30 days-6months
- **Long Term Residential Treatment**: Residential treatment between 6 and 12 months
  - Sometimes referred to as “rehab”; however, “rehab” may refer to any treatment level
- **Alcohol and Drug-Free Housing AKA “Sober Home”:** Typically unstructured community of individuals in recovery from addiction, often requires drug monitoring
  - Definition is not regulated, MA has a voluntary certification process; Quality and intensity of housing varies
  - Many private companies, not licensed or regulated by state or local governments
  - **Half-way House:** May refer to a Sober Home with more intensive treatment engagement requirements
    - “Half-way” between residential treatment and independent sober living
    - Also not regulated
  - **Three-quarter House:** May refer to Sober Home with fewer requirements than a half-way house, but more than minimum sober home requirements

Vocabulary for SUD Outpatient Treatment

- **Partial Hospitalization Program**: Intensive outpatient treatment usually 5 days/week all day group counseling and skills workshops
- **Intensive Outpatient Program** (IOP): Usually half-day 3-4 days/week group counseling and skills workshops
- **Group counseling**: Often once or twice weekly for 1-2 hours. Type of group is determined by the therapist and can include support groups, skills development and psychoeducational
- **Individual counseling**: One-on-one counseling sessions with behavioral health specialist
- **Alcoholics Anonymous/Narcotic Anonymous**: 12-step model (See below)
- **Sponsor**: An individual in recovery addict who is willing to share their knowledge with those who are less experienced in the program
  - Resource for information about recovery
  - Someone who is available to listen, guide
  - Role model

Medication Assisted Treatment (MAT)

To date, there is strong evidence to support the use of MAT (usually methadone, buprenorphine or naltrexone) in opioid addiction. Yet, there remains a stigma of “replacing one drug with another” and 25% of publicly funded treatment programs offer FDA approved MAT.

MAT:

- Decreases withdrawal in the early phases of recovery
- Decreases cravings
- Decreases risky activities associated with obtaining medications or drugs
- The POATS study found that approximately 61% of patients taking buprenorphine-naloxone as MAT with standard medical management remained abstinent from opioids at 3 ½ years.

Knudsen H, Abraham A, Roman P, “Adoption and Implementation of Medications in Addiction Treatment Programs,” Jrnl Addiction Med 5, no1 (2011):21-7.
Weiss R, Potter J et al, Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug and Alcohol Dependence, March 6, 2015.

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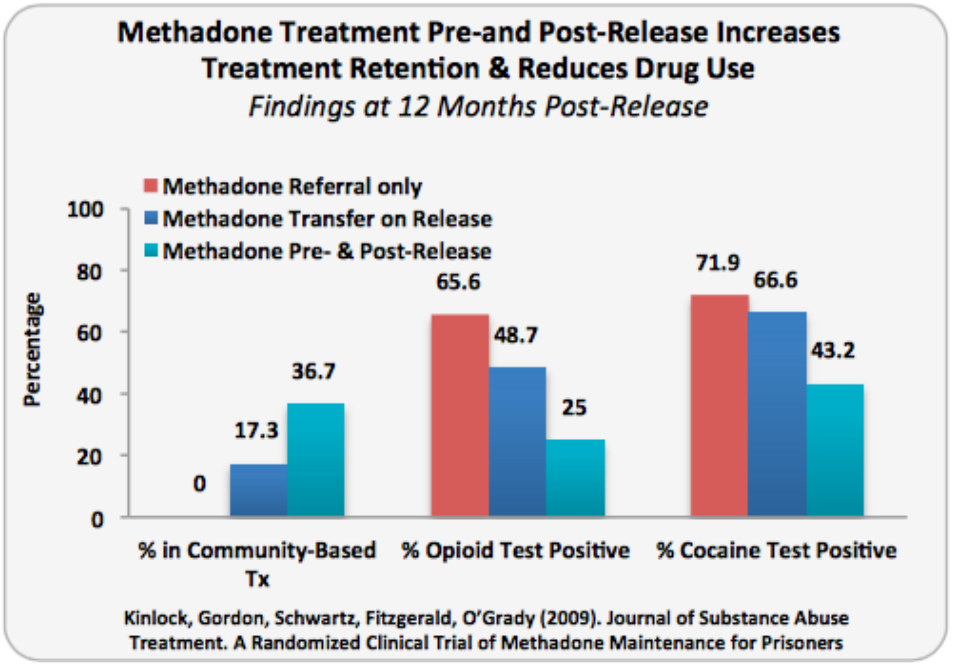
MAT

Benefits of Medication-Assisted Treatment – Beyond Reducing Drug Use

Scientific research has established that medication-assisted treatment of opioid addiction increases patient retention and decreases drug use, infectious disease transmission, and criminal activity. For example, studies among criminal offenders, many of whom enter the prison system with drug abuse problems, showed that methadone treatment begun in prison and continued in the community upon release extended the time parolees remained in treatment, reduced further drug use, and produced a three-fold reduction in criminal activity.

Investment in medication-assisted treatment of opioid addiction also makes good economic sense. For methadone, every dollar invested in treatment generates an estimated $4–5 return.



https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf

Narcotics Anonymous

Mutual aid groups like AA and NA have frequent meetings, and require no financial resources or insurance to participate

- 12-step programs
- Focus tends to be on drug-free living, sometimes to the exclusion of MAT
- Your patient may have a sponsor through AA or NA, that serves as additional support

"NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem. We … meet regularly to help each other stay clean. … We are not interested in what or how much you used … but only in what you want to do about your problem and how we can help."

http://www.na.org/admin/include/spaw2/uploads/pdf/PR/Information_about_NA.pdf

Clinical Opiate Withdrawal scale (COWS)

- 11 items
- Used to assess and follow signs and symptoms of opiate withdrawal and assess physical dependence on opioids
- Validated against the clinical institute narcotic assessment (CINA)
- Can be used to determine patients appropriate for initiation of MAT such as buprenorphine in the ED setting

- Wesson, DR & Ling W (2003). The Clinical Opiate Withdrawal Scale. J Psychoactive Drugs, 35(2), 253-9.

Key Points for Case 105

- Medication Assisted Treatments (MAT) for OUD include buprenorphine, methadone and naltrexone, however ED initiation often uses buprenorphine due to its practicality and safety profile
- Effective treatments for opioid dependence exist. MAT may help approximately 60% of patients in recovery abstain from opiate misuse, but only 25% of publicly funded treatment programs offer FDA approved MAT, and as few as 10% of patients receive it (WHO information sheet 2014: http://www.who.int/substance_abuse/information-sheet/en/).
- Opiate use disorder is a chronic disease. Patients should be counseled to seek support to maintain behavioral change, identify triggers that my promote relapse and set proactive plans should these arise.
- Patients in recovery can be prescribed opiates when benefit outweighs risk (such as major surgery, trauma), but there must be careful planning, open discussion, safe dispensing and close monitoring.
- MAT with agents such as methadone, buprenorphine and naltrexone can act as abridge or long-term therapy to assist patients in overcoming OUD.

Key Concepts for OSTI

- Opioid use disorder is and should be treated as a chronic illness.
- The opiate epidemic has impacted communities of color for years. The current national focus suggests bias in the healthcare system, policy-makers and media.
- Safe-prescribing does not mean NO prescribing, even for patients in recovery.
- The prescription monitoring program (PMP or MassPAT) provides accurate, up-to-date prescribing information and must be accessed before prescribing
- Co-prescribing naloxone should be considered for any patient on chronic opiates.
- Best practices include risk assessment (including for diversion), informed consent, monitoring, safe storage and disposal counseling.
- Medication assisted treatment with agents such as methadone, buprenorphine or naltrexone can act as a bridge or long-term therapy to assist patients in overcoming opioid use disorders.