OPIOID SAFE-PREScribing TRAINING IMMERSION (OSTI)

Case 105- Prep Materials

University of Massachusetts Medical School
Opioid Conscious Curriculum  March 2018
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 substance 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
5. Evaluate history and risk of psychiatric comorbidity and suicidality
6. Ensure that the patient and partner can identify signs of opioid overdose and dependency
7. Demonstrate use of a naloxone atomizer (intranasal naloxone) and explain when and how to use it to patient and partner
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
Figure 2. Clinical Findings in Opioid Analgesic Intoxication.

The sine qua non of opioid intoxication is respiratory depression, but miosis and stupor are often observed in poisoned patients. Hypoxemia or ingestion of drugs that are coformulated with acetaminophen can cause hepatic injury; acute renal failure can result from hypoxemia or precipitation of myoglobin due to rhabdomyolysis. Opioid analgesics decrease intestinal peristalsis by binding to opioid receptors in the gut. Patients with stupor who are motionless often have compressed fascia-bounded muscle groups, culminating in the compartment syndrome; they may also have hypothermia as a result of environmental exposure or misguided attempts at reversing intoxication. Since fentanyl can be a source of overdose, patients should be examined for the presence of fentanyl patches.
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
**Figure 4. Decision Tree for Managing Opioid Analgesic Overdose in Adults.**

Because of the long duration of action of many opioid analgesic formulations, the brief effectiveness of naloxone, and the potential lethality of an opioid analgesic overdose, there should be a low threshold for admitting intoxicated patients to a hospital unit that provides close monitoring, such as an intensive care unit. Published guidelines for the management of opioid intoxication were developed on the basis of data from patients with heroin overdose and should not be applied to patients with opioid analgesic overdose.
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.
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](https://www.samhsa.gov)).
  - 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](https://www.youtube.com/watch?v=example) on using SBIRT for drug use.
- Consider using an [SBIRT app](https://www.example.com).
- 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)

• 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

1. How important to you is your physical health?
   ‘The Readiness Ruler’

<table>
<thead>
<tr>
<th>Not important at all</th>
<th>Extremely important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2  3  4  5  6  7</td>
<td>8  9  10</td>
</tr>
</tbody>
</table>

2. How confident are you about changing?
   ‘The Confidence Ruler’

3. Not confident at all | Extremely confident
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2  3  4  5  6  7</td>
<td>8  9  10</td>
</tr>
</tbody>
</table>

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?
Components of Comprehensive Drug Abuse Treatment

- Child Care Services
- Vocational Services
- Family Services
- Intake Processing/Assessment
- Behavioral Therapy and Counseling
- Treatment Plan
- Substance Use Monitoring
- Clinical and Case Management
- Pharmacotherapy
- Self-Help/Peer Support Groups
- Continuing Care
- Medical Services
- Educational Services
- Housing/Transportation Services
- Financial Services
- Legal Services
- HIV/AIDS Services

The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.
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.
Matching patient substance use disorder treatment needs to levels care using ASAM criteria

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 a behavioral health specialist.
- **Alcoholics Anonymous/Narcotic Anonymous**: 12-step model (See below).
- **Sponsor**: An individual in recovery 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.


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.
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.”

Key Concepts for Case 105

- Naloxone can fail for multiple reasons including: fentanyl co-ingestion or not using the medication due to concern about being ‘caught’ (this is also a reason some people do not call 911);
- Classic triad of opiate overdose: pinpoint pupils, unconsciousness, respiratory depression.
- 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 misuse disorder is a chronic disease. Patients should be counseled to seek support to maintain behavioral change, identify triggers that may 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.
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.