Collaborative Response to the Opioid Overdose Epidemic: Prevention and Treatment

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Health Choice

Hope!
1. Connect People with Treatment
2. Support Providers

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CONNECT

COVID-19 PHE required DISTANCING…but…
2nd Epidemic: Mental Health and SUD Deaths

PHYSICAL DISTANCING

+

TELEHEALTH

=

SOCIAL CONNECTION

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CONNECT

Telehealth Increases Access

- Engaging people!
- Connection despite Digital Divide
- Groups via telehealth
- Tablets with data delivered to homes
- Reach out, telephonic if necessary.
- No More No Shows!

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MOUD is effective in reducing risk of overdose and death, BUT

- Barriers:
  - access to treatment: populations at elevated risk of death cannot easily access health care settings, appointment-based care, and, in turn, medications.
  - Induction issues

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MEDICATION FIRST

Modeled after Housing First, a homeless assistance program

1. Get persons with opioid use disorder onto MAT (meds) quickly

Persons with OUD should receive pharmacotherapy prior to undergoing lengthy assessment processes or treatment planning

2. THEN continually offer supportive services as needed

Individualized psychosocial treatment should be offered to patients, but not required as a condition of medications

3. Continue meds as long as they are helping.

Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits

4. Pharmacotherapy (meds) is discontinued only if it is worsening the person's condition.

MOUD Barrier: Induction

OPIOID USE DISORDERS:

-*__Buprenorphine Induction__ is a 2-3 day period where buprenorphine is cross-titrated with opioids based on withdrawal symptoms

-*__Methadone Induction__ is done in a SAMHSA certified Opioid Treatment Program (OTP)

-**Naltrexone Induction** requires detox and abstinence first, done anywhere (prison release)

*opioid, substitution therapy

Buprenorphine Induction: UNOBSERVED

Office-based induction: Observed all day in office

Home-based induction: Community Standard Care

- ASAM's National Practice Guideline Committee Consensus opinion supported the use of home-based induction (Kampman 2015). Good studies back to 2009=safe.
- Opiate Withdrawal is NOT dangerous to adults
- Biggest risk is precipitated withdrawal. Confirming of baseline withdrawal symptoms is the most difficult aspect of unobserved/home induction: Patient must be already in withdrawal before their first dose.
- Provide education on induction protocol
- Give prescription for initiation of buprenorphine, unobserved, at home

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If home, then… No Wrong Door!!

- Jail, Prison
- PCP office
- Release from Emergency Department
- Homeless, under the bridge
- Home-bound

FOCUS TWO: Prescriber Support Collaborative Care Committee

- DEA-Buprenorphine Data Waiver and XDEA number no longer required.
- Practitioners are intimidated
- Mentorship…see one, do one, teach one
- Train on evidenced based practices
- Advocacy on DEA, Telehealth

Mountain ECHO

- Goal: to expand specialty care through a multidisciplinary tele-mentoring program.
- Mountain ECHO Substance Use Disorders, a project ECHO replicate, began March 2018

- Our Mission:
  - Mountain ECHO's mission to increase access to treatment, reduce stigma, and promote coordination of care throughout the communities it spans by providing support through education and collaborative case consultations.
- Our objectives:
  - Engage in case-based clinical discussions.
  - Gain knowledge in evidence-based practices regarding prescribing guidelines, medications, co-occurring diagnoses, stigma and more.
  - Get to know fellow healthcare professionals from behavioral health, primary care, community partners, and more.
  - Share ideas and enhance overall collaboration efforts in Arizona.
- Each ECHO session consists of a lecture and a case presentation focused on SUD.
- To register for the current SUD program visit: https://www.healthchoiceaz.com/providers/mountain-echo/ or contact rose.kent@azblue.com

Resources

www.naabt.org/documents/TIP40.pdf

ASAM National Practice Guidelines

ncbi.nlm.nih.gov/pmc/articles/PMC4605275

https://pcssnow.org/education-training/sud-core-curriculum/

https://learning.pcssnow.org/p/BupandNaltrexoneInduction#tab-product_tab_contents__9

Buprenorphine Quick Start Guide-SAMSHA

https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

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Resources

SAMSHA Substance Abuse and Mental Health Services Administration: *Medications for Opioid Use Disorder.* Treatment Improvement Protocol (TIP) Series 63.

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002

www.samhsa.gov

https://www.samhsa.gov/medication-assisted-treatment

https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder

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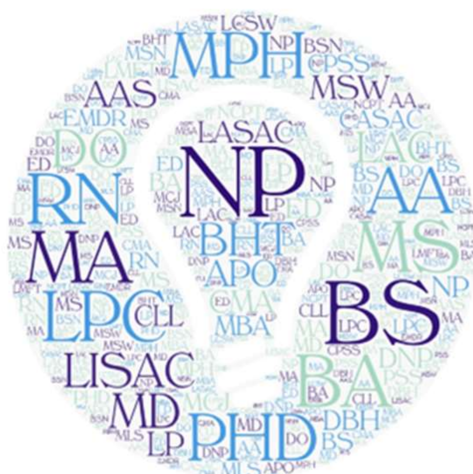
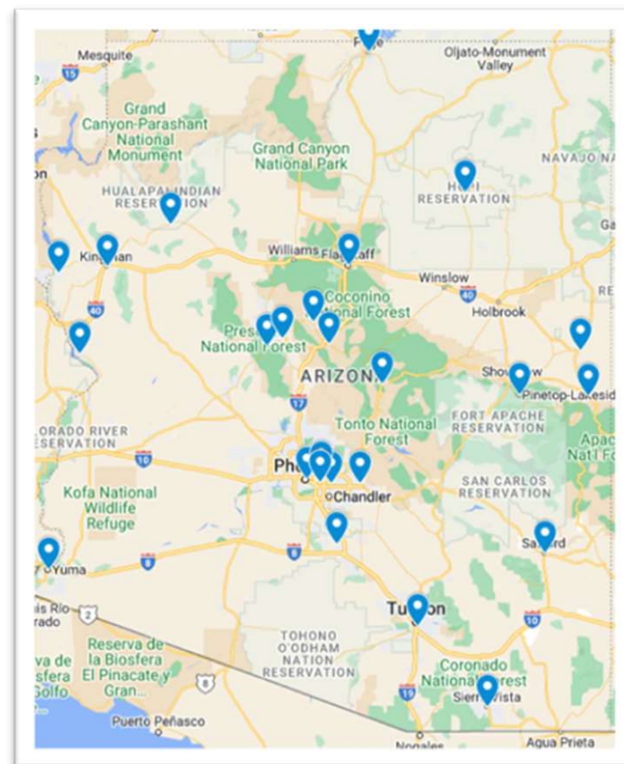
Mountain ECHO Overview

- Mountain ECHO SUD has 72 registered participants from across the state, representing 30 agencies.
- Our success is driven by a multidisciplinary approach, that allows all participants to be the students and the teachers.
- Lectures and case consultations are presented through a whole health and equity lens, focusing not just on SUD, but also housing, physical health, justice involvement, and other social determinants of health.





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What are people saying about Mountain ECHO?

"I learned several resources available in Northern AZ of which I was not aware. I also learned that this group of professionals is down to get into the nitty gritty, hard stuff like reconnecting Indigenous folks to their cultural roots & talking to patients about harm reduction in a more direct way. How refreshing!"

"It is wonderful to work with many different agencies that all have a common goal. This makes it feel most like a community to me."

"The session helped me think about alternate ways to engage clients in how to imagine a safe and healthy future that takes into account trauma and inequitable privilege."

"The group has consistent participants who openly discuss ways to better not only our patient population, but strengthen provider relationships by having created openness with one another."

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Medical Workup Prior to Induction

Buprenorphine absolute contraindications:

1. Severe bronchial asthma in unmonitored setting
2. Gastrointestinal obstruction
3. Severe respiratory depression
4. Allergy to buprenorphine

Buprenorphine to be avoided or used with caution in individuals with:

1. Severe liver disease (modify dosage)
2. Alcohol use (but BUP is less risky than alcohol+opioids)
3. Benzodiazepine use (but BUP is less risky than benzo+opioids)

-Laboratory testing should not delay treatment but should include liver function tests, pregnancy test, HIV, hepatitis and urine toxicology testing.

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Home Induction Patient Education

- Precipitated withdrawal
- How to take the medications prescribed
- Side effects
- Need to avoid other sedating substances and medications (especially alcohol and benzodiazepines)
- How to contact the clinic with questions
- SOWS: Subjective Opiate Withdrawal Scale
- Naloxone Education [for everyone!]
- Clinician contacts patient 1-2 days later, pt follow up in a week

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Medication for Induction

From Missouri Show-Me ECHO:

- BUPRENORPHINE/NALOXONE: 8/2mg #10-14, ½ tab q 2-4 H PRN withdrawal sx, not more than 1.5 tabs on day 1 and not more than 2 tabs/day thereafter.
- Adjunctive medications:

1. Clonidine 0.1 mg every six hours as needed
2. Hydroxyzine, trazodone, gabapentin (controversy) or mirtazapine for sleep and anxiety

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Induction Day

- Review informed consent
- Urine drug screen, vitals, pregnancy test
- Abstinence timing: Start when mild to moderate sx of opioid withdrawal. They may need to wait another day.

  Hours of abstinence since last full mu opioid use–
  12-16 short-acting: heroin, morphine, hydrocodone
  17-24 intermediate-acting, fentanyl, oxycodone
  30-48 methadone (taper down to 30mg prior)

- Administer COWS (clinical opiate withdrawal scale):
  - (COWS 12–16 is mild/moderate and appears sufficient to avoid precipitated withdrawal)
- Give patient SOWS scale to take home (subjective opiate withdrawal scale)

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MAT in Pregnant Women: URGENTLY ASSIST PRENATAL CARE

- Opioid Use Disorders:
  - Most urgent induction timing
  - Withdrawal most dangerous for baby, avoid precipitated withdrawal
  - At Birth: Biggest direct effect of opioid use is Neonatal Abstinence Syndrome which can be managed

- Alcohol Use Disorders:
  - Do not use MAT
  - Alcohol most dangerous for baby, no amount safe
  - Recommend Abstinence
  - May need inpatient detox

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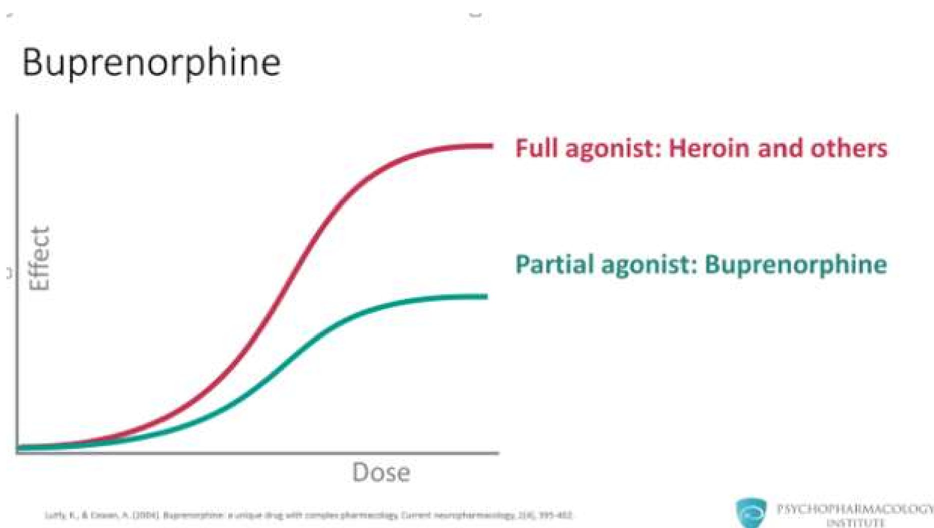
Buprenorphine=SAFER



Ceiling Effect: SAFER than full opioids

- Full agonists can cause death
- Less euphoria (means less drug seeking, abuse and dependency
- Less respiratory depression (means less fatal overdose; the only deaths from buprenorphine overdose were in combination with other sedatives: alcohol, sleeping pills, "benzos")

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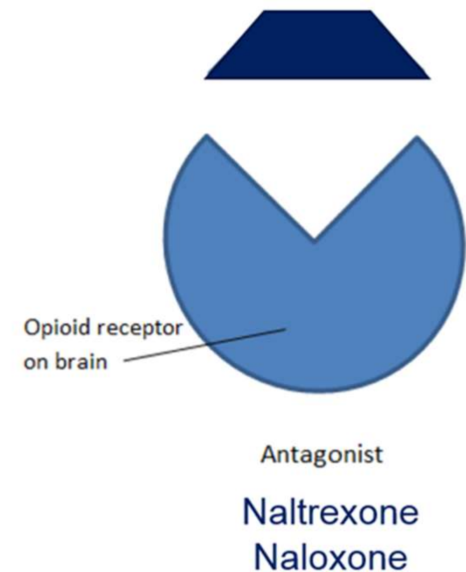
Buprenorphine + Naloxone = "Suboxone"

Naloxone is an opioid receptor **Antagonist**

Even Safer. Decreases Injection IV abuse

- Naloxone precipitates withdrawal from opioids (knocks opioids off the receptor). Also available for overdose situation as Narcan
- Naloxone blocks more opioids from attaching
- If swallowed or placed under the tongue, Naloxone is inactivated or doesn't absorb so it doesn't do anything.
- If injected or smoked, it causes immediate withdrawal off opioids and blocks more attachments (no high).



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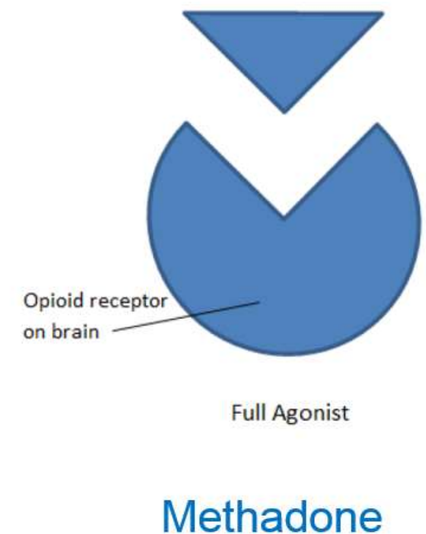
Methadone

- Full opioid
- Invented 1937, used in the U.S. since 1947 (80 + years!)
- Suppresses withdrawal and drug craving for 24–36 hours
- Is administered daily for opioid addiction treatment
- Is approved for use in pregnancy

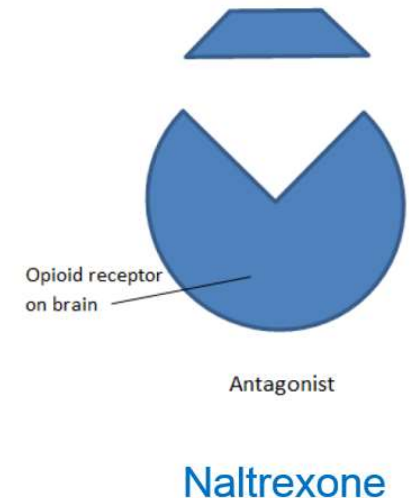


- Methadone can only be dispensed in a SAMHSA certified Opioid Treatment Program (OTP)
  - A significant barrier is access to OTPs, especially in rural areas or persons with transportation limitations

Naltrexone: Opioid Blocker

- Detox first…or risk Precipitated Withdrawal
  - Induction requires 7-14 days since last use (abstinence) first.
- Test dose of oral or IM first if in doubt

- Vivitrol=monthly injection
  - Excellent for incarceration release when risks are high



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