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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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Speaker:
Elisabeth Fowlie Mock, MD, MPH

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Video Resources

- Diversion Alert/recoveryinme video
  https://www.youtube.com/watch?v=q1lSmWWwM40
- CDC Videos

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

"How can I be addicted to these? I get them from my doctor. It kills your soul and makes you feel worthless." https://www.cdc.gov/rxawareness/resources/video.html

- Leighton MAT trailer https://www.youtube.com/watch?v=WjtYp_pMUqI

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Disclosures

- MICIS does not accept any money from pharmaceutical companies
- 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 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

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Materials May Include

- “un-ad” one page handout for each topic
- How to Use Naloxone (pt brochure)
- ME Law slides/Chapter 21 rules
- DHHS prescription guide
- National/state numbers
- 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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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)

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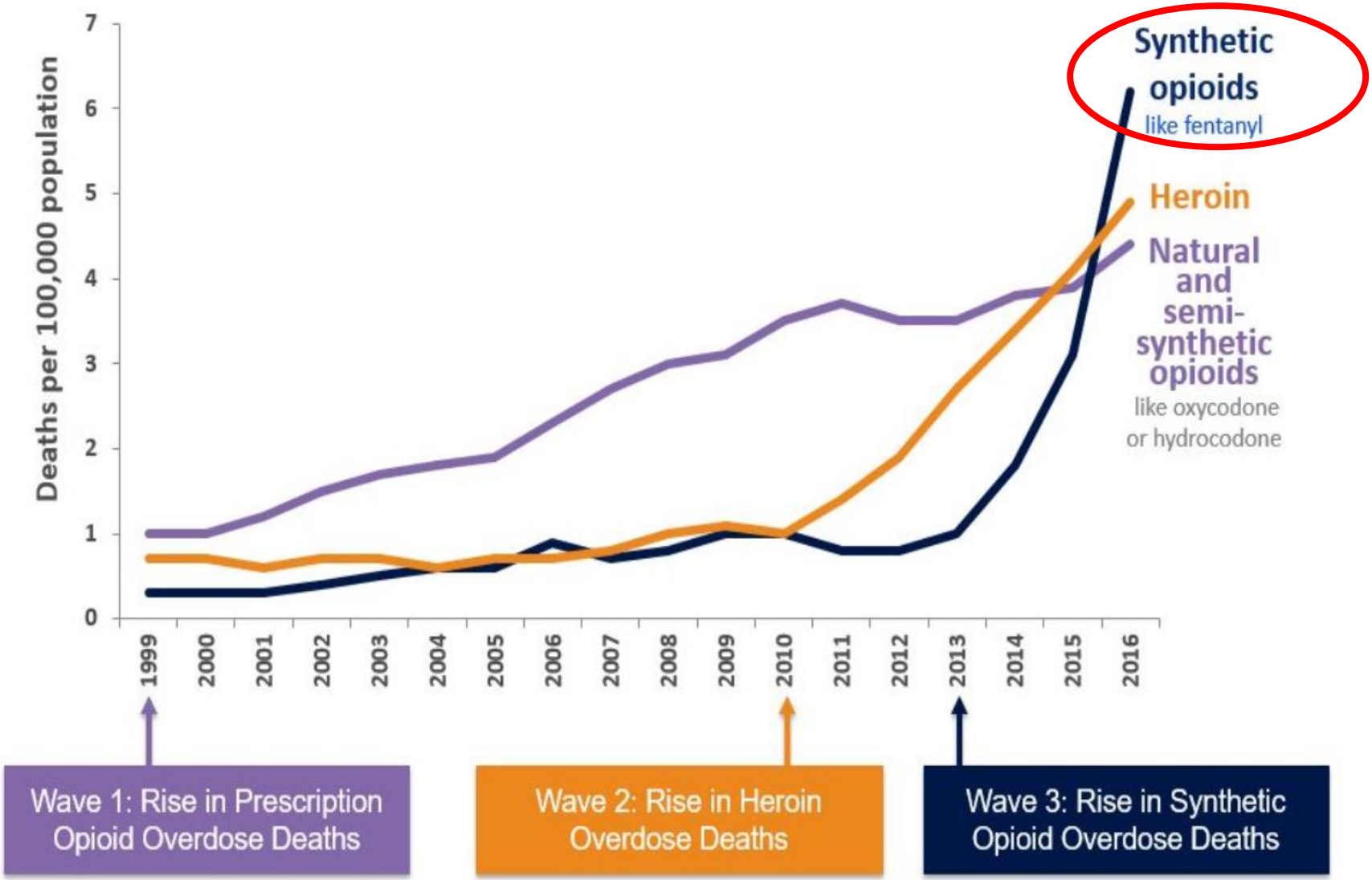
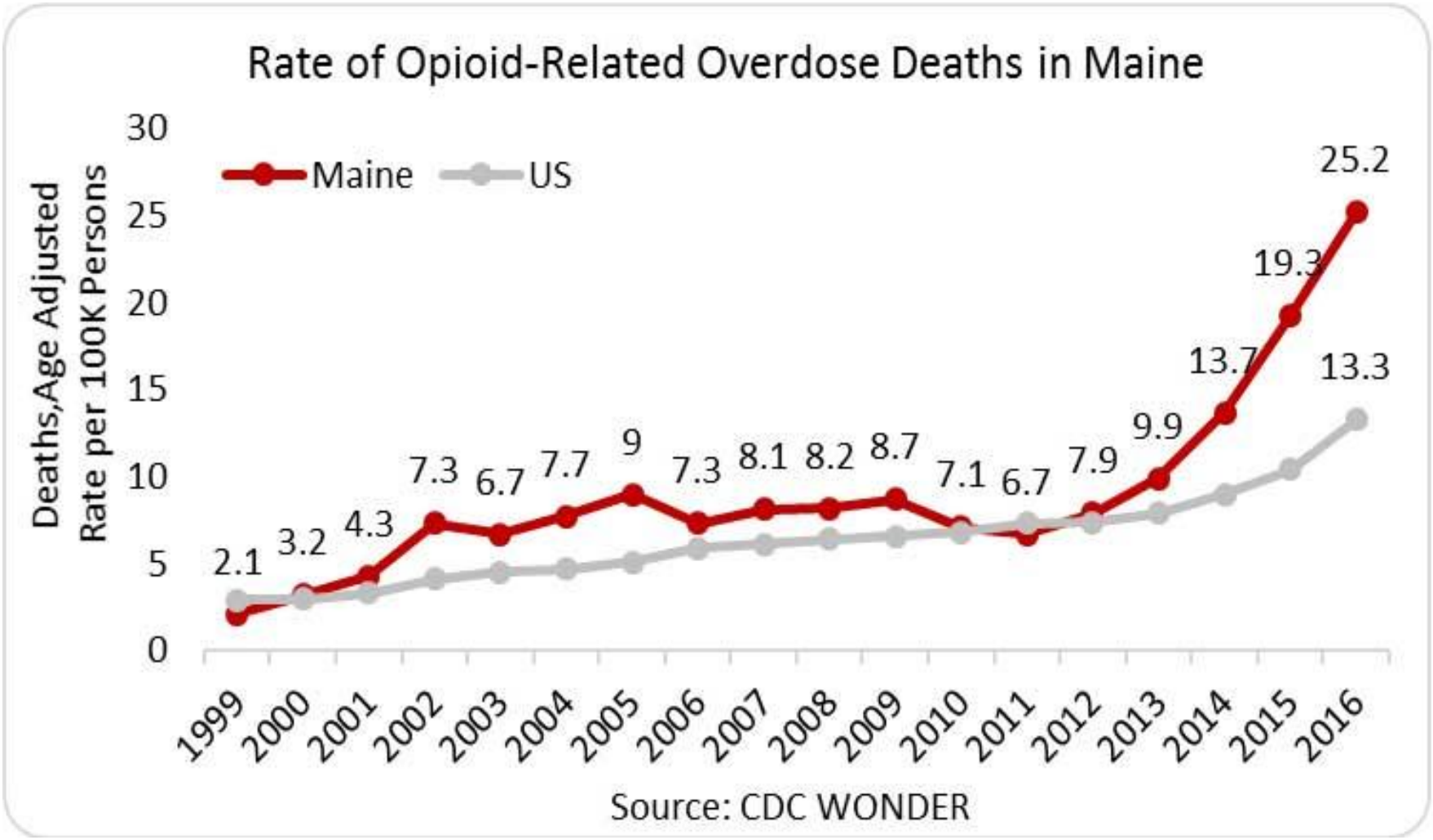
3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

Maine Overdose Deaths



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Challenge Question

Name the four counties in Maine
that had OD deaths higher than proportion
to population size
(from Attorney General OD report,
2017 statistics)

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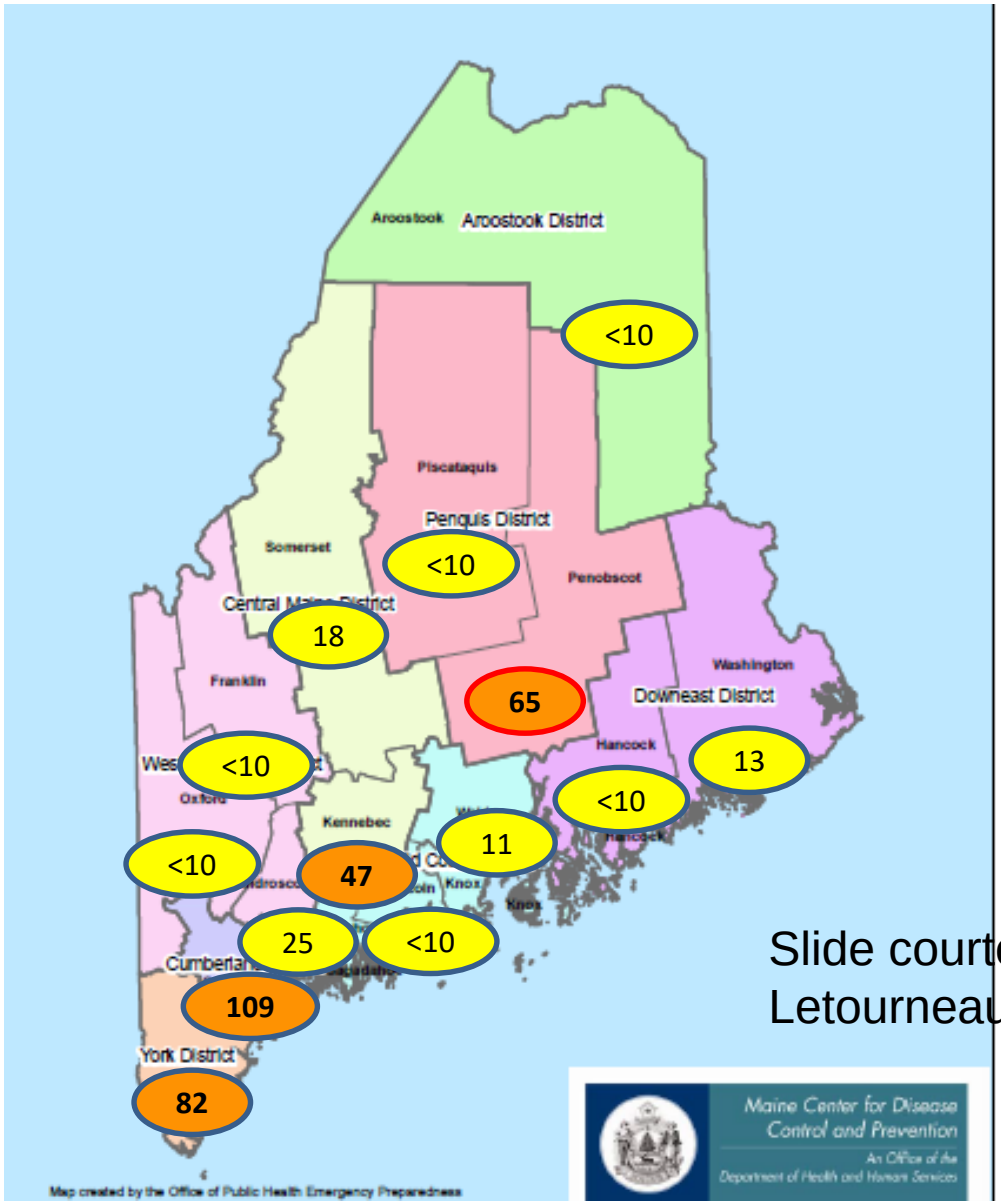
2017 Overdose Deaths by County



Deaths higher than proportion to population size

Deaths proportional to population size

[2017 Drug Deaths Report](#) – ME Attny Genl's Office

Slide courtesy of Lisa Letourneau/ME Quality Counts

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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%)
- Maine noted to be one of 16 states with high prevalence of overdose mortality

(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 Myths Exercise

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We Need to Be Prepared to Recognize and Treat OUD

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Review/fill-in the diagnostic criteria for OUD

- Two
- Larger
- Desire
- Time
- Craving
- Failure
- Despite
- Given up
- Hazardous
- Caused

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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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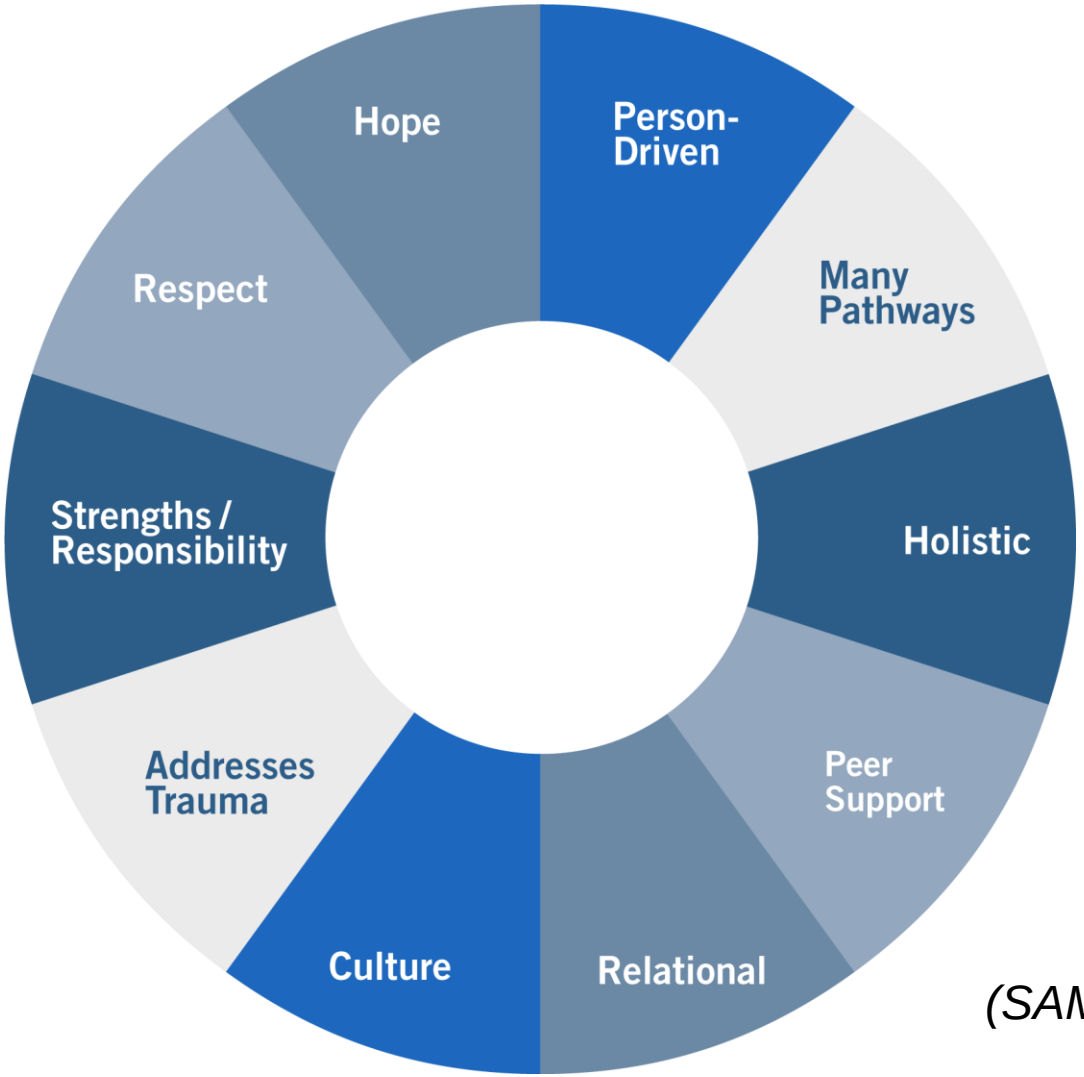
10 Guiding Principles of Recovery



(SAMSHA, 2012)

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Four Dimensions that Support a Life in Recovery

- Health
- Home
- Purpose
- Community

(SAMSHA website)

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

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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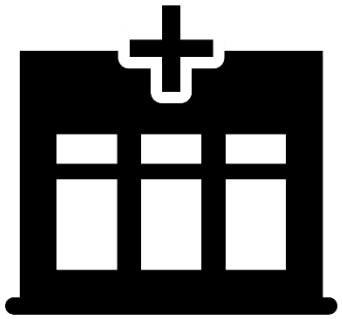
Hub & Spokes Collaborate

Hubs



High intensity MAT

Methadone, buprenorphine, naltrexone

Regional locations

All staff specialize in addictions treatment

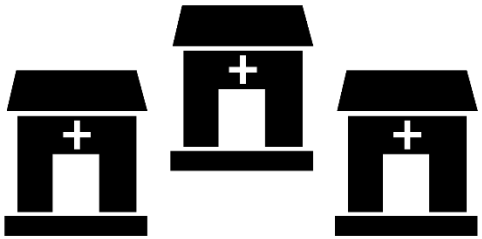
Patients

Information

Consultation

Training

Spokes



Maintenance MAT

Buprenorphine, naltrexone

Community locations

Lead provider + nurse and LADC/MA counselor

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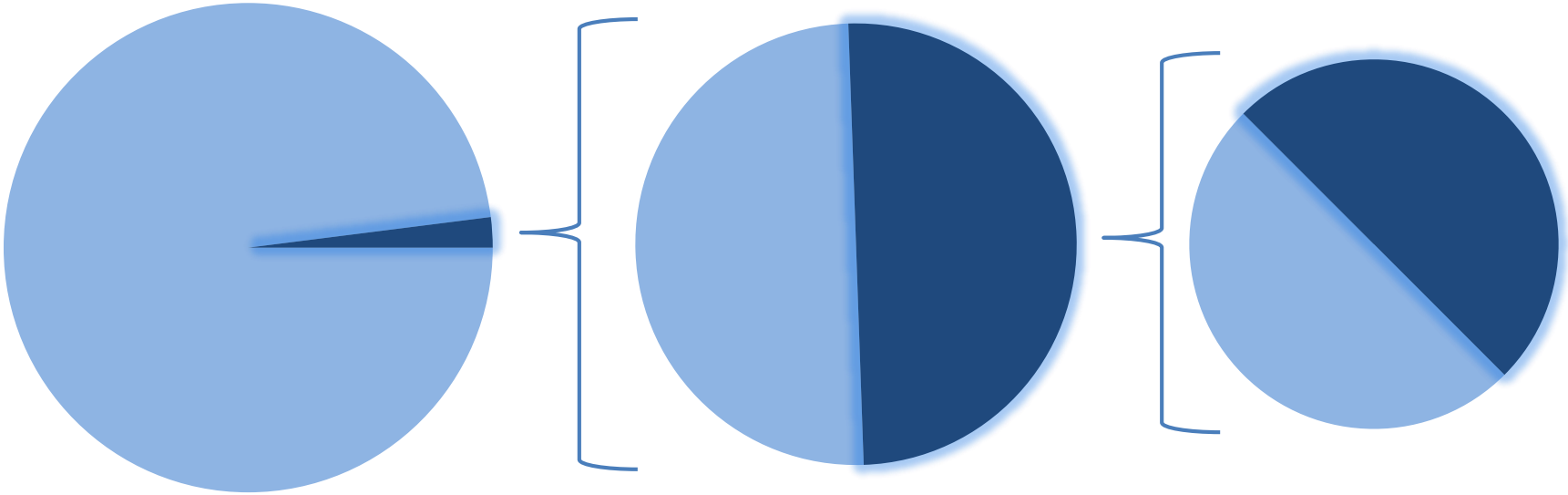
National Buprenorphine Data

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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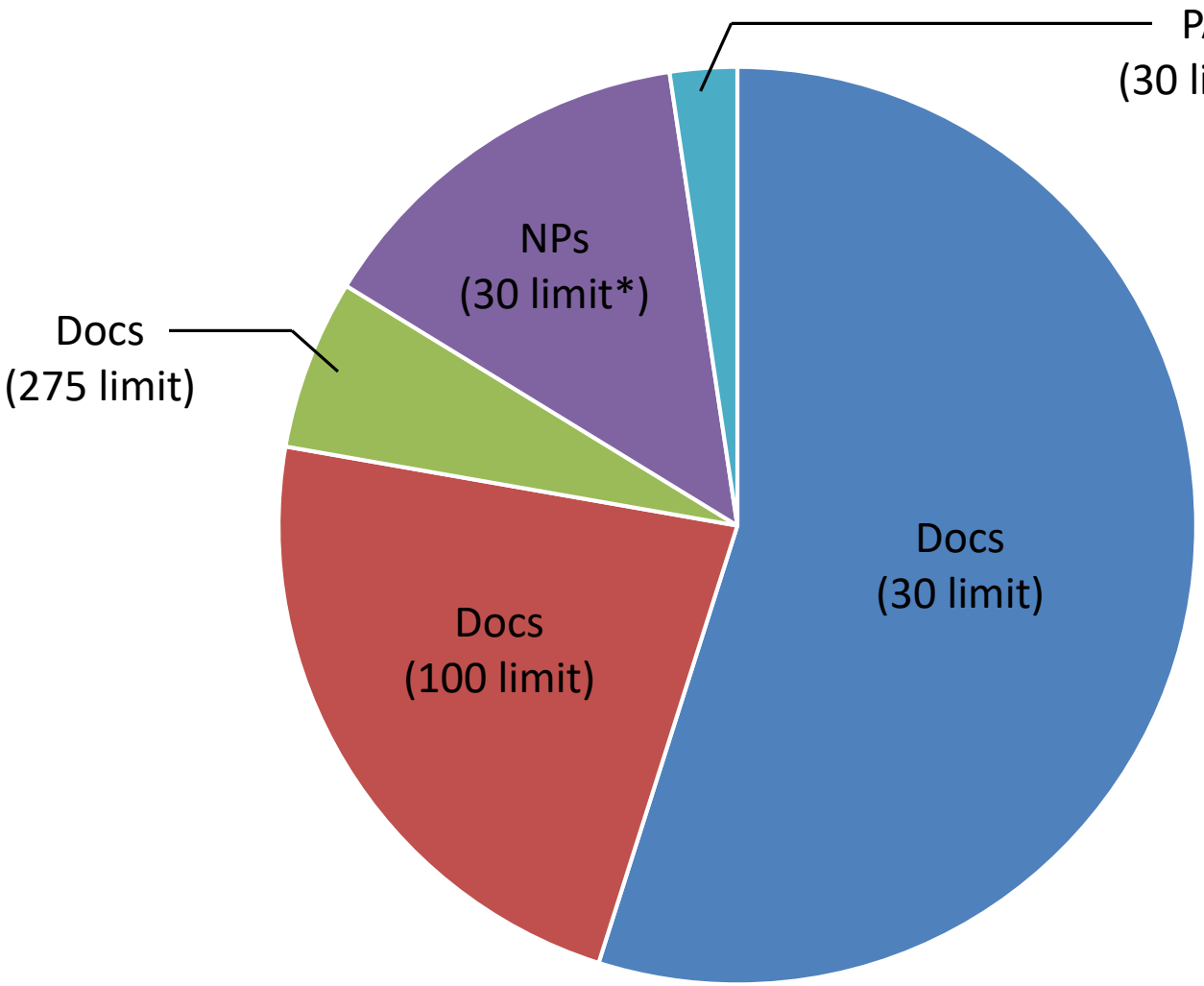
Maine Buprenorphine Prescribers



*all NP/PA 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?

Indefinite.

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

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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

(Mendiola, 2018)

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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.

(Baggett, 2013)

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Social Determinants of Health Contribute to the Opioid Epidemic

Persons who are released from incarceration

are at a 12x risk of overdose.

Most jails/prisons do not provide MAR.

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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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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

MICISTravels on facebook

references: MICISMaine.org

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Balanced Data About Medications

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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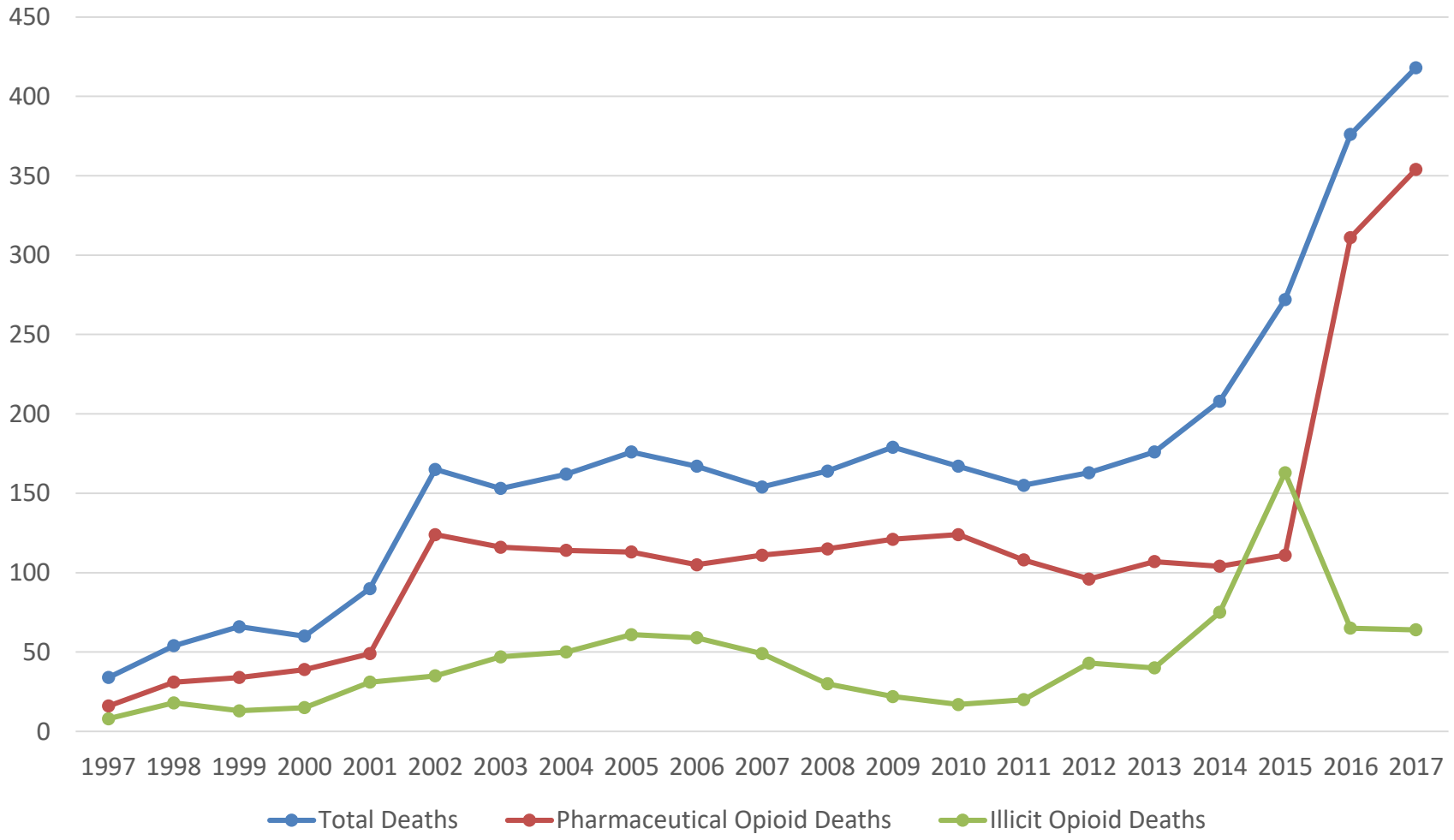
Maine Overdose Deaths



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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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"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)

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