RN Care Manager Role Treating Opioid Use Disorder

Integrated Care and the Expanding Role of Nurses

Seattle Airport Marriott, SeaTac, WA
Tuesday, January 9, 2018
POLYSUBSTANCE USE IN THE TREATMENT OF OPIOID USE DISORDERS WITH BUPRENORPHINE

SESSION 2
WHY WORRY ABOUT POLYSUBSTANCE USE IN PATIENTS BEING TREATED FOR OUD WITH BUPRENORPHINE?

- Associated with greater psychopathology
- Increased levels of risky behaviors
- Poor treatment engagement
- Death

OBJECTIVES

- Understand benefits and risks of treating OUD in context of polysubstance use
- Understand interventions available for alcohol, benzodiazepine, and stimulant use disorder
- Discuss programmatic approaches to ongoing polysubstance use
POLYSUBSTANCE USE IS COMMON

Common in Opioid Use Disorder patients:

– Up to 70% lifetime
– Cocaine (6-68%)
– Alcohol (25-49%)
– Cannabis (8-41%)

Background: 2017 WA State Syringe Exchange Survey

Note: Your local syringe exchange has been provided their specific data. State report to be released in December 2017.
WHY WORRY ABOUT POLYSUBSTANCE USE IN PATIENTS BEING TREATED FOR OUD WITH BUPRENOPHRINE?

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WHICH OF THESE SUBSTANCES HAS BEEN ASSOCIATED WITH OVERDOSE DEATHS IN PATIENTS ON BUPRENORPHINE?

- Cannabis
- Cocaine
- Benzodiazepines
- Alcohol
- Methamphetamine
35 year old female on Bup-Nal 12-6mg qd for OUD-severe (heroin). She has been in treatment for three months and is doing fairly well. She is housed and working part-time in retail.

At the time of enrollment she was taking illicit benzodiazepines and agreed to stop using them. However, she has continued to use them and every urine drug screen is positive. She reports having too much social anxiety without them.

What would be your next few steps?
35 year old female on Bup-Nal 12-6mg qd for OUD-severe (heroin), with persistent benzo use for social anxiety.

What would be your next few steps?

A. Cut Bup dose in half to reduce toxicity potential
B. Taper and discharge from the program
C. Send to residential treatment
D. Continue prescribing Bup and refer to mental health
E. Ask her for her dose and start prescribing both benzodiazepines and buprenorphine-naloxone yourself
OPIOIDS: PRESCRIBING OPIOIDS AND BENZODIAZEPINES IN PATIENTS WITH OUDS

Sample

— All Veterans (N=32,422) in 2007 with an Opioid Use Disorder (OUD) Diagnosis

<table>
<thead>
<tr>
<th>Opioid/Benzo Rx Status</th>
<th>12 month Mortality Rate</th>
<th>24 month Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed</td>
<td>4.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Not Prescribed</td>
<td>3.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>% Change</td>
<td>29%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Best practice: Avoid prescribing opioids and benzodiazepines to patients with Opioid Use Disorders

OPIOIDS: Z-DRUGS AND PREGABALIN

Sample

– Swedish nation-wide register-based open cohort from 2005-2012, N=4501
– OUD Dx and at least one Rx for methadone or buprenorphine

Results

– Overdose deaths
  • Z-drugs HR 1.98 (CI 1.38-2.84)
  • Pregabalin HR 3.22 (CL 2.13-4.86)

Best practice: Avoid prescribing z-drugs and pregabalin to patients with OUDs

Abrahamsson, T, et al 2017
A HISTORY OF BUP-BENZO RELATED DEATHS

• **1998 French case series**
  – Six overdose deaths related to bup + benzo’s
  – IV buprenorphine (Not Bup-Nal)

• **Can occur at therapeutic doses of Buprenorphine in the following contexts:**
  – Related supra-therapeutic doses of benzodiazepines
    • Removes ceiling effect
  – IV injection of benzos at therapeutic doses
  – Combined with sedatives

Reynaud M et al, 1998; Schuman-Olivier Z et al, 2013
Implications

Concurrent CNS depressant use is not a contraindication to treating opioid use disorders with buprenorphine despite the increase risk of mortality.
• If patients are admin discharged or not enrolled for Benzos, then they will now likely be doing heroin + Benzo

• Out of treatment → Not able to help

• Increase risk for IV use, infections, OD, and death
N=386, Primary Care-Nurse Care Manager Program

- Benzodiazepine use
  - Prescribed, illicit, misuse, not misused
- No impact on treatment retention
- No impact on illicit opioid or cocaine use
- Those prescribed benzos had more ED visits
  - OR 3.75 due to accidental injury
- Prescribed benzos were continued
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What would be your next few steps? Why?
• **Clinical Practice**
  
  – Limit home induction option
  – Increase frequency of contact
  – Administer a benzo taper
  – Treat co-occurring disorders
There are several options, none are EBP, but are practice-based evidence:

1. Cut bup dose in half each + Benzo tox
   • This balances risk with intervention to “get attention” to issue

2. In patients with panic or social anxiety disorders, ensure a trial of high dose SSRI and focused CBT anxiety Rx (if available)
3. If motivated but can’t stop, send to residential addiction treatment, continue Bup/Nx, make sure of anxiety dx or not and use Rx for that if present while in residential Rx

4. If supermotivated and stable, consider outpatient taper, but this rarely works
ALCOHOL AND BUPRENORPHINE

• Has been associated with increased risk for death when combined with buprenorphine

• How do you identify it?
  – Use AUDIT or AUDIT-C to screen for risky use and use disorder at initial visit and yearly
  – Ask about use at every visit
  – Monitor with urine drug screens
STIMULANTS AND BUPRENORPHINE

• **Notable in opioid treatment: cocaine**
  – Higher opioid use at baseline
  – Higher relapse rates
  – Worse adherence to Buprenorphine

• **How do you identify it?**
  – Ask about it at every visit
  – Urine drug screens

• **Methamphetamines**
  – Buprenorphine can reduce methamphetamine cravings

Is Substitution Treatment for Stimulant Use Disorders Effective?
IS SUBSTITUTION TREATMENT FOR STIMULANT USE DISORDERS EFFECTIVE?

• What does the evidence say are (modestly) effective medications for methamphetamine?
  – Bupropion
  – Mirtazapine
  – Stimulants? → ADHD

• What makes medications effective for substitution?
CANNABIS AND OPIOID MAT

- Common: 39-66%
- Impact on treatment outcomes are mixed
- Associated with non-medical opioid/heroin use
  - No impact, form of self-regulating
- Cannabis is addictive
- Case reports of cannabis + Bup vasospasm?
- Use CUDIT-R to screen for cannabis use disorder

Wasserman et al, 1998; Balhara et al, 2014; Roux et al, 2011
NEXT STEPS

• Evaluation ➔ Why are they using it?
  – Psychiatric condition?
  – Another substance use disorder?
  – Opioid use disorder not adequately treated?

• “I am treating her opioid use disorder and she is doing well with that.”
• Continue treating with buprenorphine
  – Dose change
  – Pill counts
• Increase frequency of visits, urine drug screens
• Screen for mental illness and treat
• If continued, use consider higher level of care
  – Maximize psychosocial supports
• Consider prescribing of all controlled substances
What Are The Benefits To Keeping Patients in Treatment With Ongoing Polysubstance Use?

– Keeps people engaged with treatment providers
– Treatment with MAT reduces mortality
What Are The Harms Of Keeping Patients In Treatment With Ongoing Polysubstance Use?

– Are you just enabling patients?
– Other patients will find it disruptive
– Clinic hassle
– Risk of overdose
ADDITIONAL TREATMENT OPTIONS

• Alcohol MAT options while on buprenorphine-naloxone
  – Acamprosate
  – Disulfiram
  – Topiramate

• Stimulants
  – Bupropion
  – Mirtazapine
How does your clinic handle polysubstance use?

- Are you checking for it and how?
- If a person is found to be using other substances, what do you do next?
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Funding for ‘RN Care Manager Role Treating Opioid Use Disorder (OUD)’ track was made possible in part by Grant TI080249 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.