RN Care Manager Role Treating Opioid Use Disorder

Integrated Care and the Expanding Role of Nurses

Seattle Airport Marriott, SeaTac, WA
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The Healthier Washington Practice Transformation Support Hub

UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES
School of Medicine

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**

Booth BM et al, 2006; Sumnall HR et al, 2004; Patterson TL et al, 2005; John D et al, 2001; Bovasso G et al, 2001; Williamson A et al, 2015, Hser YI et al, 2016; Savant et al, 2013

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

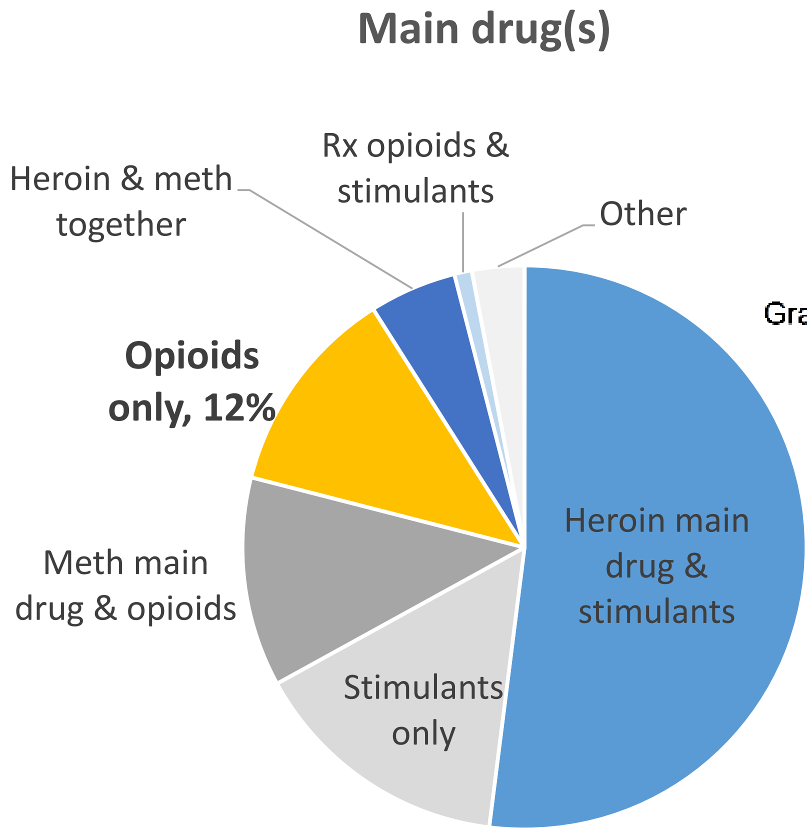
POLYSUBSTANCE USE IS COMMON

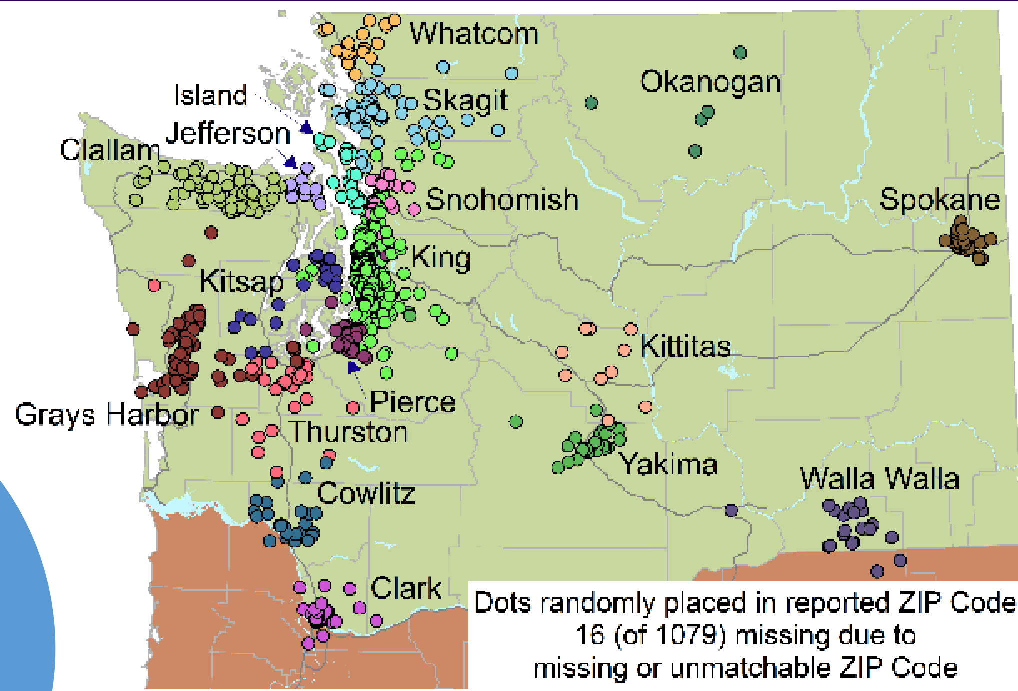
Common in Opioid Use Disorder patients:

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

Booth BM et al, 2006; Sumnall HR et al, 2004; Patterson TL et al, 2005; John D et al, 2001; Bovasso G et al, 2001; Williamson A et al, 2015, Hser YI et al, 2016; Savant et al, 2013

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.

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

- Cannabis
- Cocaine
- Benzodiazepines
- Alcohol
- Methamphetamine

CASE # 1: Scenario

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?

CASE #1

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

Opioid/Benzo Rx Status	12 month Mortality Rate	24 month Mortality Rate
Prescribed	4.3%	8.3%
Not Prescribed	3.1%	6.2%
% Change	29%	27%

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

Watkins, K, et al, 2017

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

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FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks

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This provides updated information to the **FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning** issued on August 31, 2016.

Safety Announcement

[9-20-2017] Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these

Implications

Concurrent CNS depressant use is not a contraindication to treating opioid use disorders with buprenorphine despite the increase risk of mortality

Source: https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm

THE BENZODIAZEPINE BIND

- 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

STUDY REVIEW

Drug Alcohol Depend. 2013 October 1; 132(3): 580–586. doi:10.1016/j.drugalcdep.2013.04.006.

Benzodiazepine use during buprenorphine treatment for opioid dependence: Clinical and safety outcomes

Zev Schuman-Olivier[a,b,*], **Bettina B. Hoeppner**[a,b], **Roger D. Weiss**[a,d], **Jacob Borodovsky**[c,e], **Howard J. Shaffer**[a,e], and **Mark J. Albanese**[a,e]

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?

U.S. FOOD AND DRUG ADMINISTRATION

- **Clinical Practice**
  - Limit home induction option
  - Increase frequency of contact
  - Administer a benzo taper
  - Treat co-occurring disorders

WHAT DO YOU DO?

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)

WHAT DO YOU DO? (CONT'D)

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

Kumari, S, e at 2016; Sullivan L. et al, 2010; Salehi M et al 2015

DISCUSSION

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."**

REDUCING POLYSUBSTANCE USE

- **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**

DISCUSSION

What Are The Benefits To Keeping Patients in Treatment With Ongoing Polysubstance Use?

- Keeps people engaged with treatment providers
- Treatment with MAT reduces mortality

DISCUSSION

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

DISCUSSION

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?

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