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

The Healthier Washington Practice Transformation Support Hub

QUALIS HEALTH Washington State Department of Health Healthier WASHINGTON

UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES
School of Medicine

Clinical Challenges & Co-occurring Conditions

SESSION 3

OBJECTIVES

- ❑ Identify psychosocial factors that impact OUD treatment
- ❑ Develop strategies to address impactful psychosocial factors
- ❑ Identify co-occurring medical conditions that impact OUD treatment (pain, mental health diagnosis)
- ❑ Develop strategies to address impactful co-occurring conditions

WHAT IS YOUR MOST *CHALLENGING* "COMPLICATION" OF TREATING PATIENTS WITH BUPRENORPHINE-NALOXONE FOR OPIOID USE DISORDER?

- On-going illicit use of opioids
- Other illicit drug use
- Co-occurring psych disorders
- Chronic pain
- Social chaos
- No-shows/early refills
- Diversion
- Others?

CASE # 3: SCENARIO

20-year-old male presents for treatment of his opioid use disorder. He has been diagnosed with **Bipolar II** and is currently in college. He is living with friends. Drug of choice is **heroin**.

- **Urine drug screen:** + opioids, cannabis
- **Meds:** Quetiapine 600mg qhs, Gabapentin 600mg tid
- **PMH:** Bipolar II

Is this a high risk patient for drop-out? Why?

Should he be started on Bup-Nal for OUD? Why?

CASE #3:
POSSIBLE TREATMENT OPTIONS

- Refer for evaluation of his bipolar disorder before treatment to make sure he is stable
- Refer this patient to a higher level of care because he is not going to succeed in clinic- based treatment
- Wait for this patient's urine to be free of cannabis
- Start induction when he is ready

FACTORS THAT CAN IMPACT RETENTION IN BUPRENORPHINE MAT

- **Early Treatment**
  - Polysubstance use
  - Access (lack of access can also promote diversion)
- **Ongoing Treatment**
  - Male gender (?)
  - Employment(?)
  - Race (Black and Hispanic) (?)
  - Age (18-25)
  - Family support (?)
  - Psychiatric problems (?)

Simon CB, et al, 2017; Weinstein ZM, et al, 2017; Hui D, et al, 2017; March et al, 2005

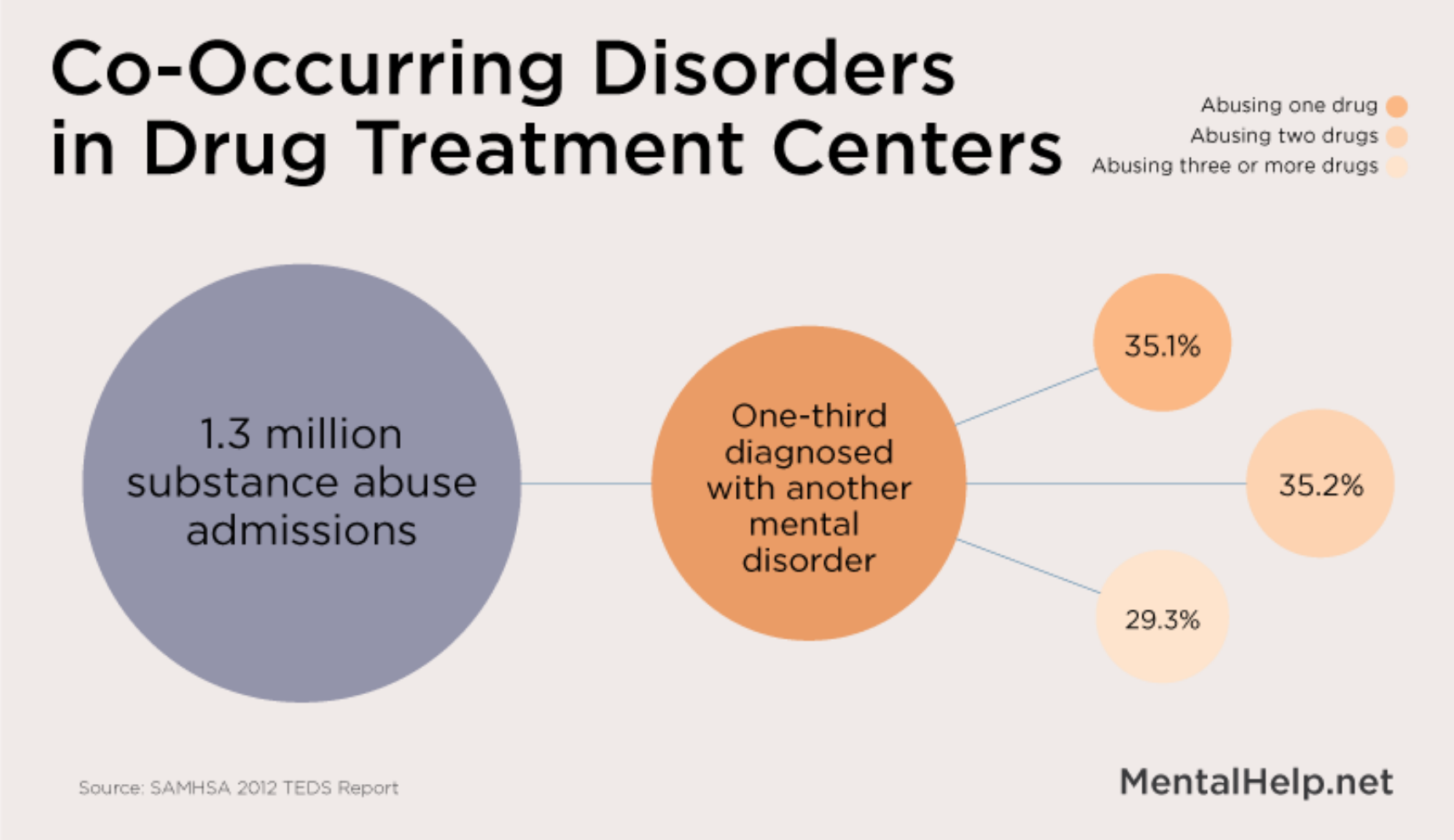
DISCUSSION

What Are Some Tools You Use To Improve Engagement For Patients at Risk Of Dropping Out?

POTENTIAL TOOLS TO IMPROVE ENGAGEMENT

- Medication dose adjustment
- Frequency of visits
- Change psychosocial intervention
- Treatment change
- Increase flexibility in treatment demands
- Involve family sooner
- Consider residential treatment first

CO-OCCURRING PSYCH DISORDERS



CASE # 4: SCENARIO

40-year-old female with OUD and difficulties keeping a job.

HPI: The patient has been in on **Bup-Nal** for **four months, and** continues to have **positive drug screens for methamphetamine**. She states that she uses it to help her with her job as a waitress because she has had long-standing problems with concentration and focus. She has **not used opioids for the past 3 months.**

CASE # 4:
POSSIBLE TREATMENT OPTIONS

- Refer this patient to an IOP
- Have her come for weekly check-ins
- Reduce the dose, to let her know she needs to stop and you are taking this seriously
- Screen her for a psychiatric disorder

CO-OCCURRING PSYCH DISORDERS

- **These are common**
  - Lifetime rate of 47%
  - Current rates from 39-70%
  - Depression, anxiety, personality disorders

- **They *will* impact treatment success**

Savant et al, 2013; Brooner et al, 1997; Rounsaville et al, 1982

NEXT STEPS

- **Screen for psychiatric disorders**
  - Depression: PHQ-9
  - Anxiety: GAD-7
  - PTSD: PC-PTSD
  - ADHD: ASRS

- **Treat their psychiatric disorder**
  - Continue to treat opioid use disorder (will help mood)
  - Psychopharm (wait a week after induction?)
  - Therapy
  - Enroll in collaborative care

Savant et al, 2013; Prins et al, 2003

TREATING ADHD IN SUDS

- **ADHD should be treated**
- **Treatment Options**
  - CBT for ADHD
  - Pharmacotherapy
    - Bupropion (if you are not 100% sure of dx)
    - Atomoxetine
    - Long-acting methylphenidate preparations
    - Vyvanse

ACUTE AND CHRONIC PAIN

CASE # 5: SCENARIO

CC: 30-year-old male on 16-8mg of Bup-Nal for OUD

HPI: Patient calls your clinic because he is at home after accidentally getting the tips of his 3rd and 4th digit caught in the timing belt of his car, resulting in losing the tips of his fingers. He is **post-op** and back at home and this **nerve block is wearing off**. He is asking for some help for **pain relief**.

What can you suggest to help treat his pain?

CASE # 5:
POSSIBLE TREATMENT OPTIONS

- Send him to the ED, because he must be in a monitored bed to have his pain appropriately treated
- Call him in for a nerve block
- Recommend he use a combination of Acetaminophen and an NSAID
- Prescribe him Tramadol to take PRN
- Increase his dose of buprenorphine-naloxone

ACUTE PAIN TREATMENT ON BUPRENORPHINE

- **Treatment options**
  - Use non-opioid pain medications
    - Acetaminophen
    - NSAIDs
  - Temporarily increase the dose
    - Split the dose?
  - In the hospital?
    - Switch to full agonist

CASE # 6: SCENARIO

CC: 57-year-old male with chronic abdominal pain.

HPI: About **2 months ago**, he was started on **buprenorphine-naloxone** for an OUD, after he was found to be running out of his oxycodone early and buying more illicitly from a friend. He was successfully transferred **onto Bup-Nal 16-6mg qd**. He describes his pain as persisting which causes his anxiety to get worse. He is requesting **lorazepam.**

CASE # 6:
POSSIBLE TREATMENT OPTIONS

- Refer him to physical therapy
- Start Clonazepam for his anxiety, which should help his pain indirectly
- Screen him for PTSD
- Increase his dose of Bup-Nal

CHRONIC PAIN & PSYCH DISORDERS ARE COMMON

- **59-75% have at least one co-occurring psychiatric disorder**
- **Most common psychiatric diagnoses**
  - Depression: 50%-67%
  - Anxiety: 36%
  - Somatoform disorder: 20.4%
  - Substance Use disorder: 16.6%
- **Sleep disorders are common (50-90%)**

Annagur, MD, et al, 2014; Boakye, PA, et al, 2015; Arnow, BA, et al, 2006

THE PAIN & DEPRESSION CONNECTION

- **Common pathways**
  - Atrophy of the hippocampus, activation of limbic area
  - Disruption of HPA axis →Inc cortisol
  - Decreased Brain-derived neurotrophic factor
  - Pro-inflammatory cytokines
- **Implications**
  - Worse quality of life and greater somatic symptom severity
  - Less likely to have complete remission of symptoms
  - Sleep disruption

Arnow, BA, et al, 2006; Boakye, PA, et al, 2015

PAIN AND PTSD: HIGHLY CO-OCCURRING

- **Up to 2/3 in some US Veteran study populations**
- **Shared pathways**
  - Mutual maintenance model
  - Shared vulnerability
  - PTSD associated changes in HPA axis affecting
  - Sympatho-adrenal medullary axis
- **Pain mediates relations between re-experiencing, avoidance, and arousal symptoms**
  - Both worsen each other

Gros et al, 2015

USE SCREENERS TO HELP IDENTIFY CO-OCCURRING PSYCHIATRIC CONDITIONS

Chronic pain and psychiatric conditions are common

- Depression: PHQ-9
- Anxiety: GAD-7
- PTSD: the PCL (PTSD checklist "PCL-C" is for civilians)

PAIN AND SUBSTANCE USE DISORDERS

- **3-48% overall prevalence of SUD in chronic non-cancer pain patients (CNCP)**
  - Highest rates: those visiting EDs for opioid refills
    - 74% lifetime
  - Patient medically compromised
    - 48% of inpts with severe pain

- **CNCP and SUD patient characteristics vs CNCP patients**
  - May see more prescription med misuse
  - Will be prescribed opioids more often & at higher doses
  - Higher alcohol/drug craving
  - Higher the pain → increase risk of relapse
  - SUD treatment response is similar to CNCP pts without SUD

Morasco, BJ, et al, 2011; Witkiewitz, K, et al, 2015

PTSD AND SUBSTANCE USE DISORDERS

Relations Between Pain, PTSD Symptoms, and Substance Use in Veterans

Daniel F. Gros, Derek D. Szafranski, Kathleen T. Brady, and Sudie E. Back

- **N=136 treatment seeking pts with both PTSD & Substance Use Disorders**
  - Avg age 41; Male: 89.6%
- **Results**
  - 80% diagnosed with PTSD with severe symptoms
  - 82.2% diagnosed with alcohol dependence
    - 39.2% endorsed current substance dependence
  - Higher pain symptoms → higher PTSD symptoms
  - No relationship found between pain on substance use

PAIN AND OPIOID USE DISORDERS TX

- **CNCP prevalence in medication-assisted treatments : 31-67%**
- **Chronic pain and medicated-assisted treatment outcomes**
  - CNCP NOT associated with prescription drug misuse or illicit drug misuse
  - CNCP associated with depression/anxiety at follow-up (OR 1.721)

Stevenson, BJ, et al, 2015

KEY POINTS

Chronic pain & mental disorder & addiction are often co-occurring

Addiction will often complicate pain issues

Medication assisted treatment for opioid use disorders in chronic pain needs to be considered

CASE #6:
57 YO MALE WITH ABD PAIN, OUD, & ANXIETY

- **What if?**
  - "Doc, I would like to try medical marijuana."

- **Or, more likely.**
  - "Doc, I am trying medical marijuana."

CANNABIS AND CHRONIC PAIN

- **Strongest evidence for use of cannabis:**
  - N/V associated with chemotherapy
  - Appetite stimulation in wasting illnesses
  - Chronic pain, neuropathic pain, & spasticity due to MS
- **No evidence for use in any psychiatric disorder and can worsen the course of some**
- **No significant evidence it is helpful in SUDs**
- **Need to be aware of the risks of use**

Hill, KP, 2015

ADVERSE EFFECTS OF SHORT-TERM USE AND LONG-TERM OR HEAVY USE OF MARIJUANA

Table 1. Adverse Effects of Short-Term Use and Long-Term or Heavy Use of Marijuana.

Effects of short-term use
Impaired short-term memory, making it difficult to learn and to retain information
Impaired motor coordination, interfering with driving skills and increasing the risk of injuries
Altered judgment, increasing the risk of sexual behaviors that facilitate the transmission of sexually transmitted diseases
In high doses, paranoia and psychosis
Effects of long-term or heavy use
Addiction (in about 9% of users overall, 17% of those who begin use in adolescence, and 25 to 50% of those who are daily users)*
Altered brain development*
Poor educational outcome, with increased likelihood of dropping out of school*
Cognitive impairment, with lower IQ among those who were frequent users during adolescence*
Diminished life satisfaction and achievement (determined on the basis of subjective and objective measures as compared with such ratings in the general population)*
Symptoms of chronic bronchitis
Increased risk of chronic psychosis disorders (including schizophrenia) in persons with a predisposition to such disorders

* The effect is strongly associated with initial marijuana use early in adolescence.

Volkow ND et al. N Engl J Med 2014;370:2219-2227

CASE # 6:
57 YO MALE WITH ABD PAIN, OUD, & ANXIETY

- **What if?**
  - You would like to start an antidepressant for his anxiety, is it safe?

Increased risk of SI

- Addiction
- Chronic Pain
- Depression

Will this antidepressant make it worse?

RESEARCH

IASP

PAIN® 155 (2014) 2471–2475

PAIN®

www.elsevier.com/locate/pain

Topical review

Suicidal ideation and behavior associated with antidepressant medications: Implications for the treatment of chronic pain

Anthony Pereira [a], Yeates Conwell [b], Michael J. Gitlin [c], Robert H. Dworkin [a,*]

- No clear evidence for increased risk, but data is scarce
- Monitor young adult 18-25, as is typically indicated
- All classes of antidepressants are equal in this area
- Watch for med interactions due to polypharmacy

KEY TAKEAWAYS

- **Cannabis can have a role in chronic pain, but not in patients with addiction and active psychiatric conditions.**
- **Monitoring for SI with SSRIs is warranted when starting in patients with these issues.**

ANTIDEPRESSANTS AND CHRONIC PAIN

- **Tricyclics**
  - Most evidence vs SNRI for chronic pain
  - Can be used for depression and anxiety
  - Titrate to effect slowly, may need higher doses for pain as well
  - Side effects are bothersome, especially in patients over 65YO
    - Desipramine and Nortriptyline are safer for those patients
    - Caution in ischemic cardiac disease or conduction problems

ANTIDEPRESSANTS AND CHRONIC PAIN

- **SNRIs**
  - Venlafaxine-evidence for peripheral neuropathy
  - Duloxetine-neuropathy, fibromyalgia, low back pain, and osteoarthritis
  - May increase blood pressure

KEY TAKEAWAYS

- **Consider medications for treatment of co-occurring conditions.**
- **Patients with addiction, chronic pain, and psychiatric conditions need a broader psychosocial approach**

BUPRENORPHINE AND PAIN

- **Buprenorphine can provide an analgesic effect**
  - All poor quality studies
  - Bup vs Tramadol: similar pain reductions
  - Bup vs Fentanyl: similar pain reduction
  - Bup vs morphine: morphine has more pain reduction
- **No evidence that doses > 24mg are more helpful**

ENCOURAGING ENGAGEMENT/ALLIANCE

- **Work on engaging**
  - Elicit story
  - Elicit hopes and dreams
  - Feedback
  - Address barriers
- **Focus on patient's goals**
  - Housing
  - Personal life
  - Work
- **Listen to what the patient might need → increase flexibility?**
- **Use as a form of measurement-based care**

Ling et al, 2012; Mitchell et al, 2011

UW PACC

UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

Psychiatry and Addictions Case Conference (UW PACC)

Thursday, September 29, 12:00 PM - 1:30 PM PST

Alcohol Use Disorders and Harm Reduction

Speaker: **Susan E. Collins, PhD**
Panelists: **Mark Duncan, MD**, **Richard Ries, MD**

Session Agenda

Save to My Outlook Calendar

UW PACC is sponsored by the UW Integrated Care Program (ICTP), funded and supported by the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout the State of Washington.

Schedule of Upcoming Presentations

STRENGTH OF MODEL: CLINICAL SUPPORT

DISCUSSION

How do you know what kind of clinical challenges you are having and what kind of impact they are having at your clinic?

POPULATION-BASED CARE

Registry Requirements

Tracks progress at individual level and at caseload level	Tracks population-based care	Facilitates efficient systematic case review	Prompts treatment to target

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

ADDICTION REGISTRY

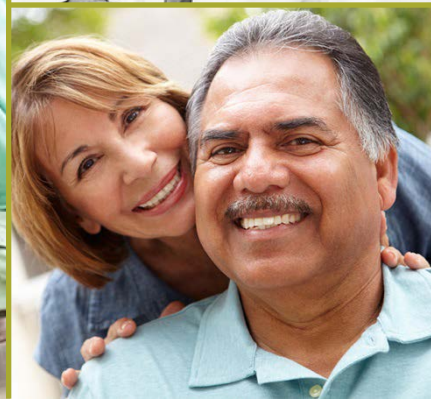
Name	Treatment Status				Urine Drug Screens		Brief Addiction Monitor						MAT	Last PMP accessed	Addiction Consult
	Initial Assessment	Most Recent	# Sessions	Weeks in Tx	First	Last	First			Last			Med and dose		
							Use	Risk	Protection	Use	Risk	Protection			
Joe	8/25/17	9/21/17	2	4	Opioids, THC, Cocaine	THC	75	172	8	17	39	124	Bup-Nal 16mg	9/21/17	9/1/2017
Sally	6/21/17	8/1/17	3	5	Alcohol, THC	None	50	126	29	45	90	29	Naltrexone 50mg	8/21/17	8/3/2017

ACCOUNTABLE CARE

- **The registry**
- **Tracks patients individually and the population as a whole**
- **Start to see trends**
  - What is my retention rate as a clinic?
  - Is my clinic doing as well as other clinics?
  - Are people getting regular follow-up?
  - Are people as a whole getting better?
- **Plan → Do → Study → Act**

SUMMARY

- **Think through potential psychosocial issues to augment in treatment**
- **Treat co-occurring psych disorder**
- **Address ongoing pain issue**
- **Don’t discontinue treatment**
- **Work with patient’s on life goals**
- **Shared decision making**
- **Not a good fit?**
  - Help with transfer to new treatment center
- **Get ongoing support**



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.