IT MATTTRs Colorado

Implementing Technology and
Medication Assisted Treatment and Team Training
in Rural Colorado

Primary Care Practice Training

[Faculty name, credentials]

No disclosures to report

Whole Practice Training Modules

4 modules (1 hour each) + SBIRT Training

1. Opioids, Receptors, Colorado, and You
2. The Patient: *What is your role in helping a patient?*
3. The Practice: *What does a practice need to support a patient getting MAT or provide MAT?*
4. **Special Populations**
5. SBIRT: Screening, Brief Intervention, and Referral to Treatment

Special Populations

Module IV: Special Populations

- Pregnancy, Neonatal Abstinence, Breastfeeding
- Adolescents and Young Adults
- Medical Co-Morbidities:
- Psychiatric Co-Morbidities [i.e., psychiatric Assessment, Major Depression, Anxiety Disorders, Trauma and Stressor-related Disorders (PTSD), Personality Disorder]
- Acute and Chronic Pain
  - Pain and addiction
  - Use of opioid analgesics
    - Buprenorphine Maintenance

Lauren

30 y.o. female with prior history of prescription opioid use disorder. Has been doing well on buprenorphine/naloxone for 8 months with improvements in function and quality of life. Returns for routine follow up appointment and mentions that her last period was 6 weeks ago. Doubts she could be pregnant as she and her husband practice the rhythm method. Her urine pregnancy test comes back positive. She wants to know if she should stop her buprenorphine/naloxone immediately, like her husband is telling her to do.

Pregnancy
Neonatal Abstinence
Breastfeeding

Pregnancy

- Know if specialized treatment services are available in the community for pregnant, opioid-dependent patients.
- Recommend consultation with addiction specialist who works with pregnant females or high-risk obstetrics.
- Buprenorphine dose may need to be increased.

Should women undergo detoxification in pregnancy?

- Initial studies from 1970s demonstrated fetal distress and 5 fold increase in still birth rates with antepartum detoxification. (Zuspan et al. 1975; Rementeria et al. 1973)

- More recent data shows 2nd trimester detoxification can be safe for the fetus; however, maternal relapse rates prior to delivery range from 70-98%. (Luty et al. 2003; Maas et al. 1990; Dashe et al. 1998)

- Maintenance therapy in pregnancy has been shown to increase retention in prenatal care, addiction recovery and in-hospital deliveries. (Jones et al. 2008.)

Pregnancy:
Benefits of buprenorphine treatment

Maternal Benefits

- 70% reduction in overdose related deaths
- Decrease in risk of HIV, Hep B, and Hep C
- Increased engagement in prenatal care and recovery treatment

Fetal Benefits

- Reduces fluctuations in maternal opioid levels, reducing fetal stress
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery

Pregnancy: Maintenance Therapy Remains the Standard of Care

- Methadone and buprenorphine (both category C) are safe and effective treatment options in pregnancy.
- The decision of which therapy to start should be individualized for each woman.
  - Based on available options, patient preference, patients' previous treatment experiences, disease severity, social supports, and intensity of treatment needed.

Management of Buprenorphine Patient: Newly Pregnant

For women stable on buprenorphine/naloxone who become pregnant:

- Current standard of care is to switch to **buprenorphine monotherapy at the same dose.**
- Combination therapy avoided due to the unknown exposure risk of naloxone in pregnancy and concern for misuse.

Maintenance Therapy in Pregnancy: Neonatal Abstinence Syndrome (NAS)

- Generalized disorder with dysfunction of the autonomic nervous system, GI tract and respiratory system.
- Occurs in 60-80% of infants with intrauterine exposure to opioids. This includes buprenorphine.
- Onset: majority present within 72 hours after delivery.
- Duration: up to 4 weeks (prolonged if exposed in-utero to more than one substance associated with NAS).

Maintenance Therapy in Pregnancy: Neonatal Abstinence Syndrome (NAS)

The good news is…

- Infants of buprenorphine-treated moms do better than infants of methadone-treated moms
- Meta-analysis of 12 studies from 1996-2012 showed buprenorphine exposed neonates (515) compared to methadone exposed (855) had shorter mean length of hospital stay (-7.23 days, 95% CI: -10.64, -3.83 – statistically significant)

Brogly et al. 2014

Opioid Use Disorder and Breastfeeding

- Buprenorphine has poor oral bioavailability and is also compatible with breastfeeding.
- The amount of buprenorphine in human milk is small and unlikely to have negative effects on the infant.
- Both are considered Category L3 (probably compatible benefits of breastfeeding for newborns with NAS
  - 30% decrease the development of NAS
  - 50% decrease in neonatal hospital stay
  - Improved mother-infant bonding
  - Positive reinforcement for maternal recovery

JJ 2000; Begg EJ 2001; Jansson LM 2007 & 2008;
Hale 2008; Grimm 2005; Lindemalm 2008; Ilett 2012.

Pritham UA et al. *J Obstet Gynecol Neonatal Nurs.* 2012.
Welle-Strand GK et al. *Acta Paediatr.* 2013.
Wachman EM et al. *JAMA.* 2013.
Abdel-Latif ME et al. *Pediatrics*. 2006.

Adolescents and Young Adults

Pharmacologic Treatment with Adolescents

- Pharmacologic therapy is recommended for adolescents with severe opioid use disorder.
- Buprenorphine is considered first line treatment. Most methadone clinics cannot admit patients under 18 years old.
- The optimal length of time for medication treatment is not known.
- Buprenorphine does not put adolescents at a higher risk for suicide than adults.

Confidentiality

Teens Presenting <u>with</u> Parents

- In many cases, adolescents will present for treatment with the knowledge, and often with the support, of parents.
- In these cases, managing confidentiality is a clinical decision of what information to share with parents in the context of parents already being aware of the “big picture.”

Confidentiality

Teens Presenting without Parents

- Teens may present for treatment without the knowledge or consent of their parents
- In most states, adolescents above a certain age may consent for treatment for an SUD without their parents. (CO = 15 yrs)
- Regarding insurance…if child is on parents' insurance, it's difficult to keep treatment from them.

Confidentiality

Managing Teens that Refuse to involve Parents

- Ask adolescent their reasons for excluding parents. Many teens could benefit from the support of parents, but are too embarrassed to discuss the problem.
- In these cases, offer to treat confidentially and leave the decision of how to proceed up to the teen.
- Ask what would happen if a parent learned about a drug problem by accident.
- Offer to help “break the news” to parents.
- Emphasize that teens who enter treatment should be proud of their decision to get help.

Confidentiality

Tips on "Breaking News" to Parents

- If an adolescent asks for help in disclosing a SUD:
  - Choose words that are acceptable to the teen and convey the message accurately. "Pain meds" may be preferable to "narcotics."
  - Share diagnosis and treatment plan; avoid details from the history.
  - Support self-efficacy by congratulating the teen on recognizing his/her problem and seeking help.

- Support parents who may be shocked and disappointed:
  - Focus on the positive: treatment-seeking behavior.
  - Reassure that you can help.
  - Redirect if a parent becomes very angry or invasive.
  - Offer education about opioid use disorder and medication assisted treatment

Medical Co-Morbidities

Nothing New Here

- Chronic Care Management 101
- Persons with opioid use disorders frequently have or at risk of other comorbid medical conditions.
- Office-based buprenorphine treatment provides an opportunity to combine substance use treatment with medical care.

Hepatitis C virus infection

The silent epidemic

- Most common blood-borne infection in U.S., 3.2 million people.
  - 70-90% of people who inject drugs have Hep C
  - ~30% are <30 years old
- 40-60% of chronic liver disease cases.
  - Leading indication for liver transplantation.
- Hep C-related deaths outnumber deaths due to HIV.

Psychiatric Co-Morbidities

Induced vs Independent Disorder

Distinguish between substance-induced disorders versus independent psychiatric disorders.

- Substance-induced: Disorders related to the use of psychoactive substance; typically resolve with sustained abstinence.

- Independent: Disorders which arise during times of abstinence; use of psychoactive substances not the etiology.

Substance Induced Psychiatric Disorders

- Patient's history suggests symptoms occur only when he/she is actively using substances.
- Symptoms are related to intoxication, withdrawal, or ongoing neurobiologic perturbation from substances.
- Onset and/or offset of symptoms are preceded by increases or decreases in substance use.
- Goal should be sustained abstinence followed by re-evaluation of symptoms.

Substance Independent Psychiatric Disorders

- Earliest psychiatric symptoms often precede onset of substance use disorder.
- Patient's history suggests symptoms occur during periods when not using psychoactive substances.
- May also find a family history of the disorder.
- Goal of substance use disorder treatment should still be cessation of substance use, but treatment must also address psychiatric symptoms simultaneously.

General Treatment Principles

- Patients with opioid use disorder and independent depressive, anxiety, or stress disorders (PTSD) can respond to medication (typically antidepressants) and/or psychotherapy
- Generally avoid use of benzodiazepines
  - Risk of misuse
  - Possibility of interactions with buprenorphine

- Buprenorphine can be a good replacement treatment for benzos

Chronic Pain - Buprenorphine Maintenance Treatment

- Systematic review (no randomized control trials, rather observational).
- All studies reported effectiveness in treating chronic pain.
- Current evidence reported some effectiveness of SL buprenorphine for treatment of chronic pain.
    - Requires more frequent dosing (2-4x a day vs 1x daily OR 4, 4, 4, 4, vs 16)
- Use of buprenorphine for chronic pain treatment is increasing.

Module IV Wrap-up

- Adolescents and pregnant females with OUDs can be managed successfully with buprenorphine.
- Buprenorphine is an excellent analgesic, although it is ideally dosed as often as 4x/day for pain.
- OUD is a chronic condition that can co-occur with other medical and psychiatric problems.

IT MATTTRs Colorado Wrap-up

What we've covered:

- Neurobiology of addiction
- Efficacy of MAT
- Creating a successful multidisciplinary team
- Patient Assessment
- Induction, Stabilization, and Maintenance
- Appropriate monitoring and OpiSafe
- Management of special populations

IT MATTTRs Colorado Wrap-up

- The opioid epidemic is an unprecedented public health problem.
- As unintentional contributors to the problem, primary care practices must be part of the solution.
- These trainings aim to allow your practices to feel empowered and equipped to:
  - identify and diagnose patients in need of treatment
  - monitor patients (with OpiSafe)
  - understand what their treatment experience will include
  - continue providing care for co-morbidities in context of MAT
  - implement buprenorphine-based treatment of OUD

What's Next

- Practice Facilitation
- MATerials Toolkit
- What do you need?
- When are you going to evaluate and schedule your first induction?
- Optional SBIRT Training – Module 5
- We'll be around (ITMATTTRsColorado@ucdenver.edu)

Thank you!

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HIGHPLAINS RESEARCH NETWORK

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