PROVIDING COMPASSIONATE CARE

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Medication Assisted Treatment, Opioid Use Disorder and Stigma

Chapa-De Medication Assisted Treatment – one program, two sites

- **Our Team**
  - **Annie Mascorro – RN Case Manager *Auburn***
  - **Katie Bell - RN Case Manager *Grass Valley***
  - **Holly Castro CAADC I – Substance Use Counselor *Auburn***
  - **Donita King – LMFT MAT *Grass Valley***
  - **John Bachman PhD –**
    - **Interim Behavioral Health Director/MAT team supervisor**
  - **Alinea Stevens MD – *Auburn - Medical Dir.***
    - **MAT Lead Provider**
  - **Michael Quion MD – *Grass Valley***
  - **Dr. Julie Garchow MD – *Auburn***
  - **Sarah Bland FNP-C - *Grass Valley***

Our Program

- RN Case manager model of MAT care
  - Evidence based care
- Focus on stabilization and whole person care
- Harm-reduction and abstinent directed
- Refill/Stabilization Group every week
- Phased program
  - Phase 1 – weekly groups, UDS and 7 day suboxone scripts, BH intake, outside treatment commitments
  - Phase 2 – progress to 14 day Rx, group visits and UDS
  - Phase 3 – progress to monthly visits, UDS and Rx refills

Pathway of Care

- **Trauma-informed care is essential with opioid use disorder**
- Education and Support
- Level of Care per ASAM criteria
- Case Management – refers based on LOC
  - Referrals to outside Recovery Providers
  - Referrals to community resources
- Clear expectations
- Phases of Care
- **Refill/Stabilization Groups**

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The Opioid Epidemic
Key Factors

Promotion of opioid pain management medications with inadequate research and slick, convincing marketing.

The VA and the Joint Commission developed and promoted assessing pain as the The 5th vital sign.

Patient Satisfaction Surveys focusing on pain management designed and promoted by Pharmaceutical companies.

Oxycontin - 1996 quickly became drug of abuse. Oxycodone – offers more euphoria than hydrocodone

Unethical prescribing and distribution

Powerful heroin distribution system to all parts of the country.

Multiple economic factors such as 2008 Recession, increased poverty, Iraq and Afghanistan wars.

Opioid Dependence + Behaviors = Opioid Use Disorder

Opioid Dependence is Physiologic – tolerance causes need to increase quantity to sustain effect; withdrawal symptoms when opioid is stopped.

Addictive Behaviors involve misuse such as taking more than prescribed or continued, compulsive use in the face of increasing consequences to health and wellness, diversion and relapse driven by craving and triggers.

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Addiction or Substance Use Disorder?

- ***Addiction is a chronic, progressive, relapsing disease.*** **We use this term in Medicine – American Society of Addiction Medicine, Addictions RN, Addictionologist.**
- **Substance Use Disorder – in Behavioral Health (DSM-5) measured on a continuum of mild to moderate to severe. Opioid Use Disorder, Stimulant Use Disorder, Alcohol Use Disorder, etc.**

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A Guide to Acronyms and Terms

- **MAT – Medication-Assisted Treatment or Medications for Opioid Use Disorder (MOUD)**
- **OUD – Opioid Use Disorder**
- **Stigma – barrier to care communicated by language, judgmental attitude and because of this judgment, decrease in quality of care.**
- **Diversion – trading, sharing, stealing, selling, buying illegal or prescribed controlled medications and substances.**
- **Misuse – replaces the word abuse. Taking more than prescribed, using non-prescribed opioids including IV heroin.**

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Common terms

Harm-reduction – The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs. Ex. Needle exchange, Opioid Replacement Therapy.

Abstinence – directed – SUD treatment which is focused on abstinence from all drugs and alcohol. "Clean and Sober". Does not include tobacco or caffeine.

Level of Care (LOC) – using American Society of Addiction Medicine criteria for assessing whole person needs and best LOC for stabilization.

Stigma – in our thinking, attitude and our language

- Stigma is shaped by our thinking – a bias and perception that substance users are "bad" and immoral rather than ill with a chronic condition requiring care and treatment. Often there is more than one chronic condition such as mental health disorders which also require care.
- Stigma is communicated by tone, interpersonal attitude, body language.
- Stigma is communicated by words.
- Stigma becomes internalized by the person seeking help. The person views themselves as bad, as dirty, as weak which fuels the shame of stigma.

Stigmatizing language no longer used

"Abuse" as in Substance Abuse. Was identified as the only diagnosis which had the word abuse. "Misuse" or "Use".

"Addict" – rather, *person with substance use disorder* or *people who inject drugs* or *opioid users*. Still used in 12 Step culture as a part of the recovery process.

"Drug-seeking" – can be re-framed as "relief-seeking". Focus on the person rather than the behavior.

"Nodding Out" – a street term that is used to describe sedation caused by too many opioids or combining opioids with other sedating drugs.

Stigma is a secondary injury of substance use and can require treatment

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The Stigma Injury – how to treat

- Begin with acknowledgement of the injury caused by stigma
  - Symptoms can be fear of Emergency Departments, distrust of medical providers; feelings of shame and dishonesty.
  - If not treated, the person internalizes the shame and low-self worth caused by stigma

OFFER HIGH DOSES OF:

- Dignity
- Empathy/ Compassion
- Kindness
- Respect
- Listening

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Urine Drug Screens - Labs

- **In medicine, we do not refer to lab results as “clean” or “dirty”, we use medical language at all times to support the dignity of our patients.**
- **We say positive or negative. Consistent or Inconsistent.**

The Human Suffering
Craving

- **"We need three things to survive (besides oxygen): food, water and dopamine. If you deprive study subjects of water for three days, then put them in a functional MRI and place water on their lips, the relative size of the craving is like a baseball. Do the same with food, and it is like a basketball. …Then, take someone with an addiction to opioids, *up to one year after their last use*, and talk about OxyContin while they are in a functional MRI, and the relative size of that craving is the size of a baseball field." (Corey Waller MD, 2016)**

Craving

Human Suffering
Opioid Withdrawal

- 11 primary symptoms - Clinical Opiate Withdrawal Scale (COWS)
  - Elevated heart rate
  - Pupil dilation
  - Hot and Cold Sweats
  - Intense over-all body aches, especially in back and legs
  - Runny nose and tearing eyes
- Intense intestinal distress – cramping and diarrhea
- Severe anxiety and agitation
- Severe restlessness
- Tremors
- Yawning
- Gooseflesh

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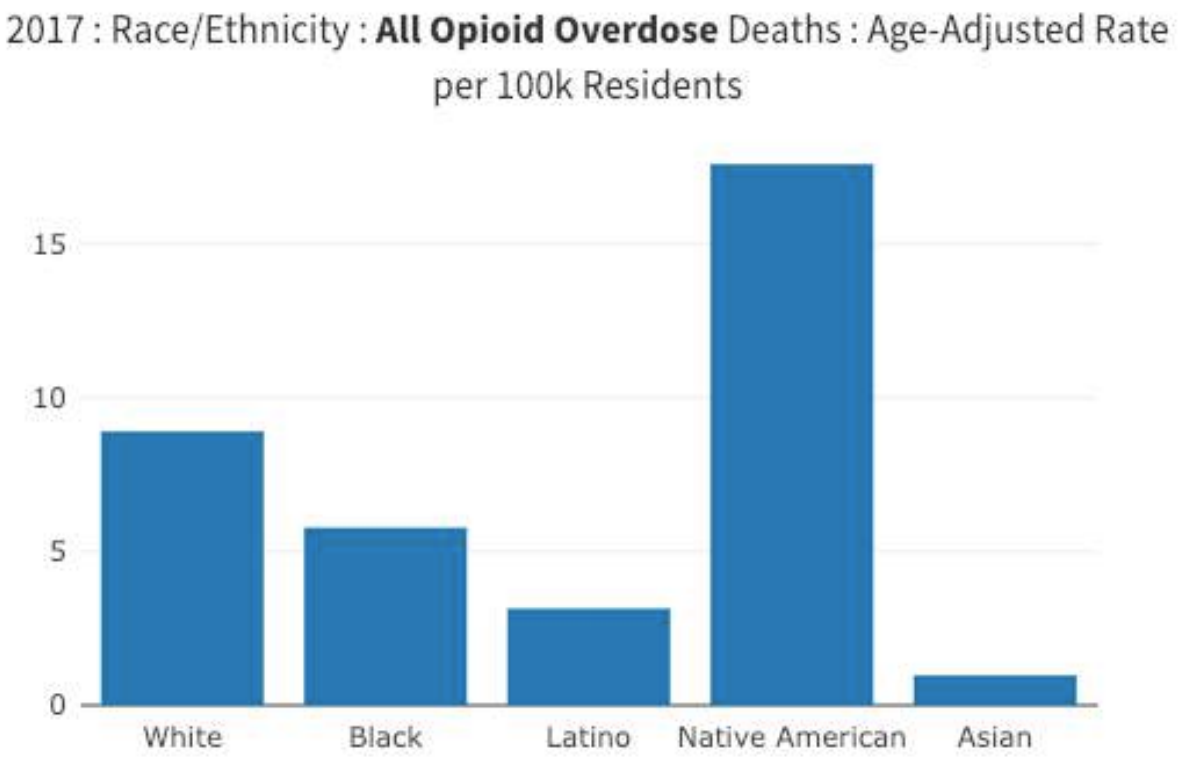
Human Suffering *Losses*

- **Overdose deaths – 114 every day**
- **Orphaned children**
- **Grandparents raising families**
- **Babies born with opioid dependence**
- **Children in Foster Care**
- **Overwhelmed agencies such as Law Enforcement, CPS and Emergency Services**
- **Heart broken families and communities**
- **Incarceration**
- **Felonies**
- **Medical challenges – HCV, HIV, Endocarditis, abscesses and cellulitis**

Consider the injustice of this epidemic



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The Solution – Access to care Addiction Treatment Starts Here

- **To increase access to care – Open doors to treating Opioid Use Disorder**
  - **Develop a Medication-Assisted Treatment program**
  - **Community Outreach and Education**
  - **No Wrong Door – have an effective referral system**
  - **Keep barriers to a minimum**

The Solution – Medications of MAT

- **Buprenorphine - Suboxone, Sublocade** – partial agonist opioid, high affinity for receptors, low activating, long-acting 37 hour half-life. No Cravings, No withdrawal, No euphoria. Normalizes the brain. Combined with naloxone is brand name Suboxone. Taken through skin – sublingual or transdermal. Also Subcutaneous injectable and implants.
- **Naloxone – Narcan** – Opioid antagonist. Opioid overdose reversal treatment.
- **Naltrexone** – monthly injection of long-acting opioid antagonist. Vivitrol. Blocks effects of opioids. Minimal relief of opioid cravings but effectively saves lives. This medication useful treating OUD with co-occurring Alcohol Use Disorder.

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Suboxone, Narcan, Vivitrol

Sublocade™
(buprenorphine extended-release) injection for subcutaneous use
100mg·300mg

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The Solution: Recovery and Wellness

Culture and Tradition

White Bison /Red Road to Wellbriety

- **Restoration of wellness**
- **12 Step support**
  - **Healers and Artists**
  - **Culture and Identity**
  - **Behavioral Health**
  - **Life Directions**
  - **Restored Relationships**

What about Pain and Opioids?

- **Patients must be carefully assessed for co-morbidity and safety. When a change in medication is recommended, patient will need additional support, monitoring and choices along the way. This often requires more *frequent visits*. When managing these changes, go slowly, partner with and reassure patient: use the phrase "safely and comfortably".**
- **Consider *Buprenorphine for Pain Program***

Assessing Pain Patients Consider:

- Is pain med regimen safe?
- Is pain well-managed?
  - Opioid Induced Hyperalgesia?
  - Buprenorphine for Pain Management?
- Is there a co-occurring Opioid Use Disorder? Mild – Moderate - Severe
- Is there co-occurring substance use disorders? Increased alcohol use to manage pain as opioids decreased?
- Re-evaluate benzodiazepine Rx – Generalized Anxiety Disorder tied to low-grade opioid withdrawal acquired from long term short-acting opioid therapy for pain.

Building a Medication-Assisted Treatment Program in a busy Primary Care Setting

- Waivered providers
- Nursing support
- BH therapists
- Substance Use Counselors
- Policies & Procedures
- Treatment Agreement

- Sustainability – billing and coding
- Nuts & Bolts
  - EHR templates
  - Provider schedules
  - Patient handouts/ materials

Pathway of Care our OUD patients

Focus on stabilization with medication, monitoring and recovery tools

- **Screening and referral**
- **Importance of assessment**
- **Begin with medical stabilization**
- **Starting Buprenorphine (induction)**
- **Right dose of medication**
- **Hand off to Behavioral Health and SUD team**
- **Treatment Agreement with Treatment Plan**
- **Education and Support**

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Phases of Care Phase 1

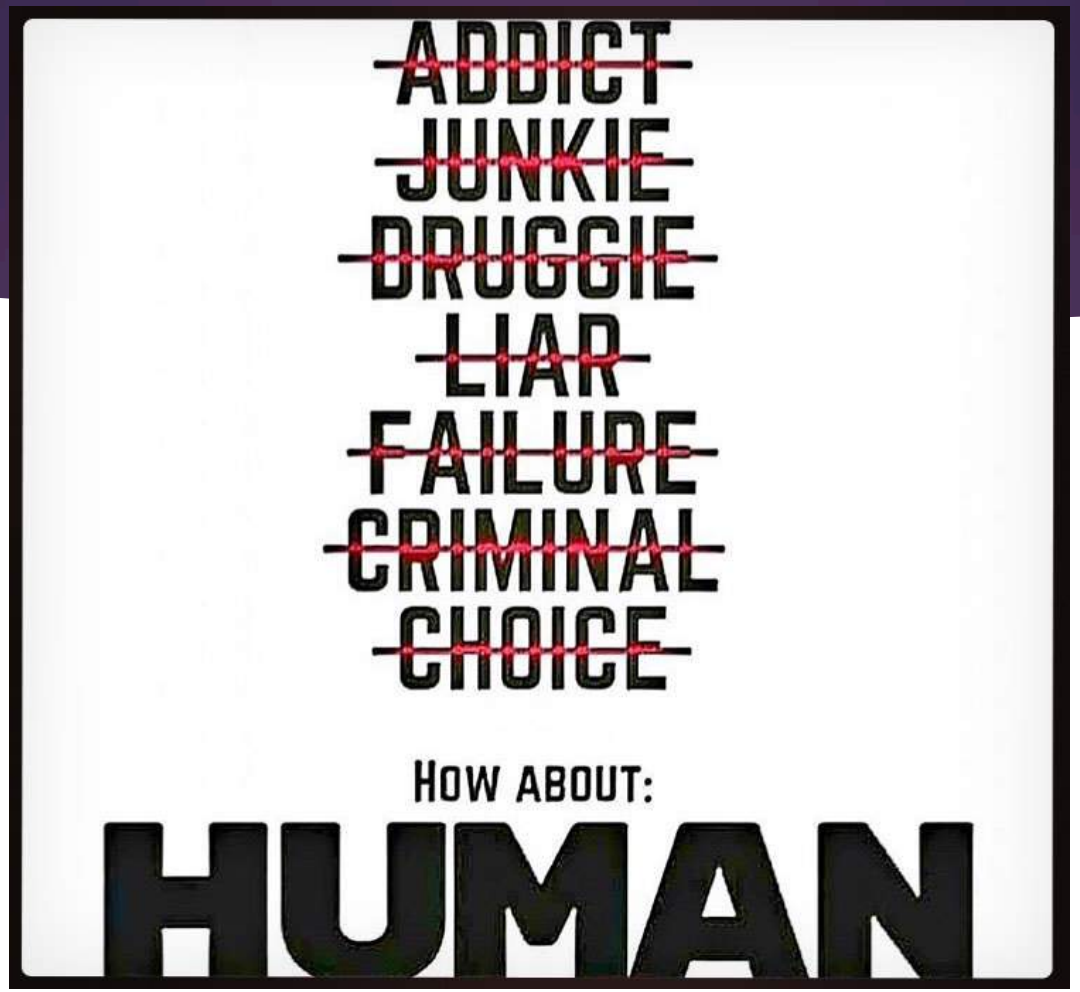
- **Harm Reduction and Abstinence-Directed**
- **Weekly MAT group (also known as refill/ stabilization groups)**
- **7 day suboxone Rx (with refills, if appropriate and for clinic convenience**
- **Weekly Point of Care Urine Drug Screens**
- **Behavioral Health Biopsychosocial assessment with appropriate referrals for therapy and psychiatry *within 30 days. Patients with immediate needs for continued medications and referral to psychiatry will be identified in Nursing Assessment And Medical Admission appointment.***

Phases of Care Phase 2

- Patient-centered decision made by the MAT Team
- Patient has adhered to all requirements of their Phase 1 Treatment Plan
- Meet with patient to update Treatment Agreement and Phase 2 expectations
- 14 day Suboxone Rx
- 14 day Urine Drug Screen
- Bi-weekly attendance at MAT Refill/ Stabilization Group

Phases of Care Phase 3

- 30 day Rx (or 28 day to keep pick-up days consistent throughout Phases)
- One required Counseling visit – individual or group
- Monthly UDS
- MD visit every 90 days minimally, some patients prefer monthly visits
- If relapse then increase care, patient returns to Phase 1 or Phase 2 per MAT team decision for more care and stabilization.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HOW ABOUT:
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