Beyond MAT

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Learning Objectives

- Understand the treatment needs for those w/ OUD
- List several treatment/program strategies for addressing varying needs for those w/ OUD
- Learn effective treatments for chronic pain.

MAT Settings

Opioid Treatment Programs (OTPs):

- Patients must attend specialized clinic daily and receive medication from a nurse
- Traditionally provided methadone, recently many programs include buprenorphine
- After periods of sobriety and demonstrated recovery, able to earn "take home" medications
- Take home med privileges increase as patient stabilizes
- Involves multi-disciplinary team of professionals including medical director, advanced practitioners, registered nurses, medical assistants, substance use disorder counselors & support staff

MAT setting continued

Office Based Treatment Programs (OBOTs or Data 2000):

- Medical doctor provides prescription for buprenorphine/naloxone out of office setting
- Prescription ranges from 1-4 weeks before return to appointment
- Highly recommended that patient participate in counseling
- Physicians and advanced practitioners can only have 30 patients their first year; can apply for 100 or 275
- These programs can also offer Naltrexone

The Importance of Maintenance in MAT[1]

- Adequate doses can help improve physical & psychological health when impaired by opiate use disorder.
- The steady state of functioning that MAT provides allows individuals to perform regular activities at work, school, or at home without the constant disruptions of drug seeking behaviors and the compulsion to use other opioids.
- Helps to reverse the reinforcement of addictive behaviors that often accompany opiate addictions.
- Reduces the risk of opiate abuse, overdose, and death
- Reduces the risk of IV use and needle sharing which can lead to diseases and infections.

MAT Treatment Duration

- Most people will be on it their entire life.
- The individual must make the decision to wean off.
- Forced withdrawal almost always leads to relapse.
- This applies to both methadone and buprenorphine.

Impact of Treatment Engagement / Stages of Change

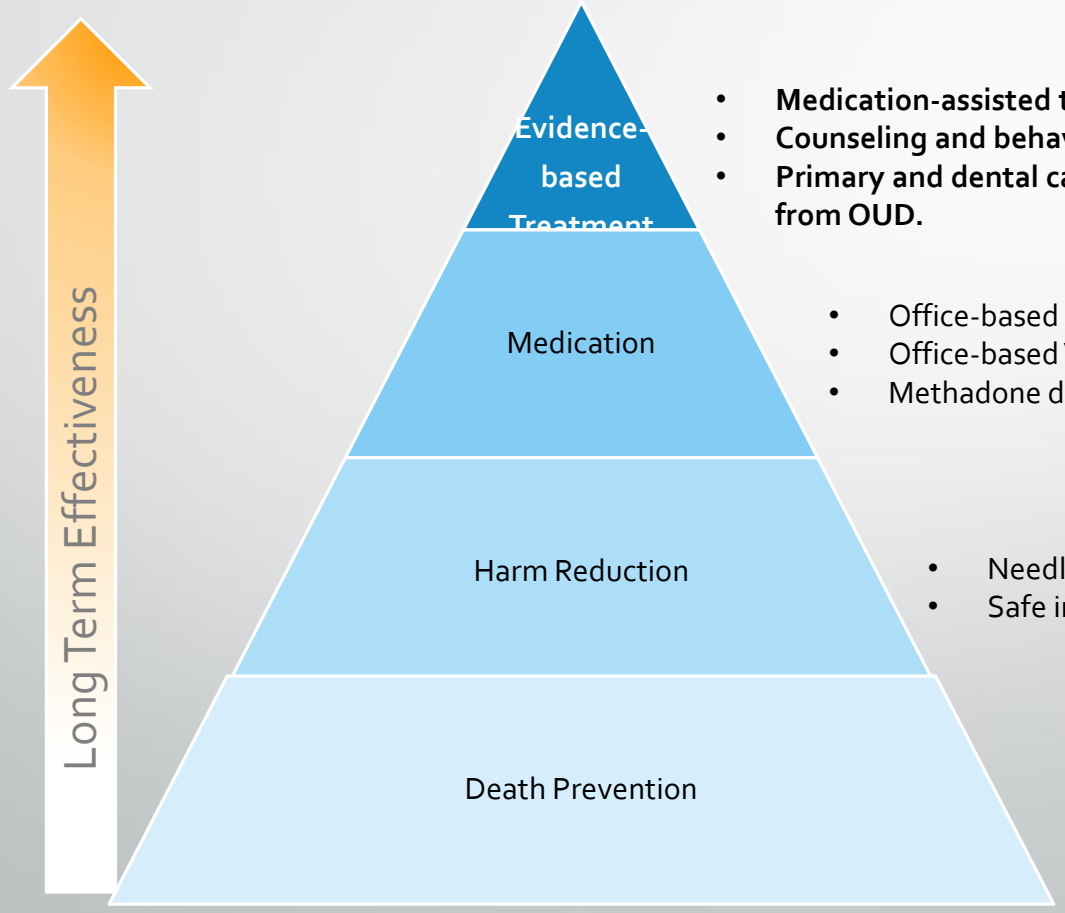
- As we assess and identify our clients treatment needs, it is important to know where they are in addressing those needs
- Someone can be in different stages of change across those treatment needs
- Meeting the individual where they are
- Are our clients in a different stage of change from where we are working?

Why Not Medication Only in Many Cases

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery – SAMHSA 2019

Is it ethical to offer medication for OUD, but not have resources in place to address the other complex needs?

HIERARCHY OF OPIOID USE DISORDER INTERVENTIONS



- **Medication-assisted treatment (MAT), <u>and</u>**
- **Counseling and behavioral therapy, <u>and</u>**
- **Primary and dental care for chronic pain and medical issues resulting from OUD.**

- Office-based Suboxone
- Office-based Vivitrol
- Methadone dose-and-go

- Needle exchange programs
- Safe injection sites

- Naloxone distribution
- ER intervention

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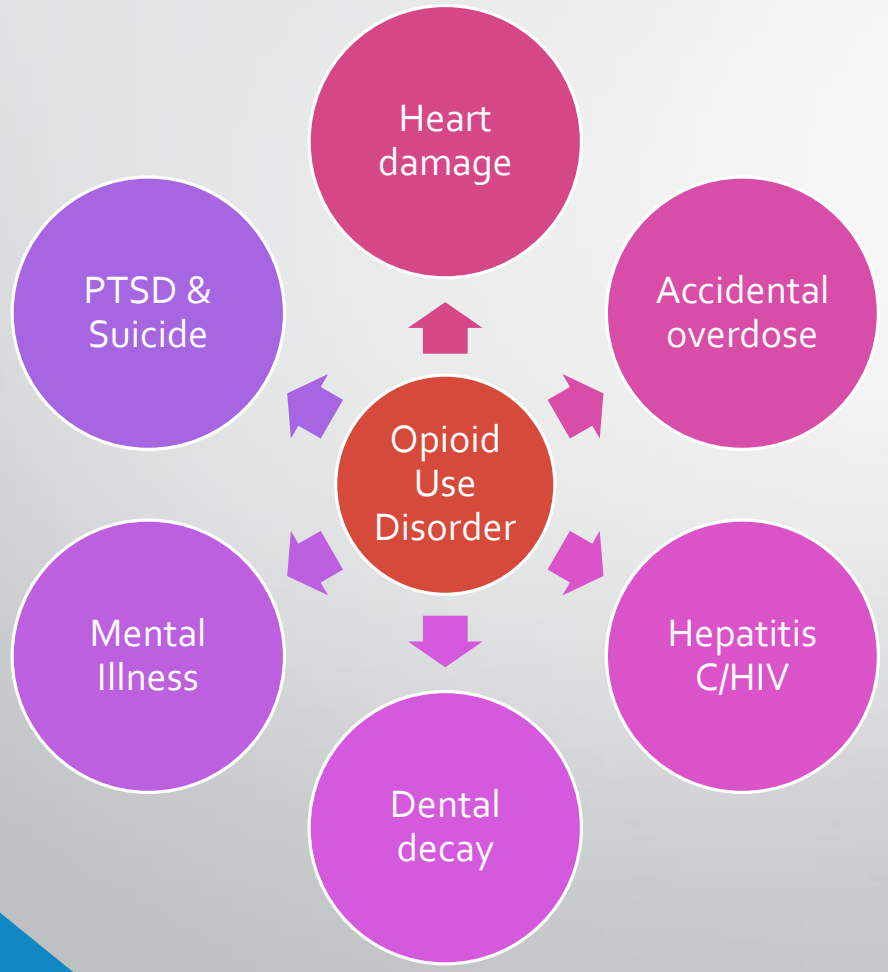
Opioid Use Disorder Causes High Morbidity and Mortality[2,3]

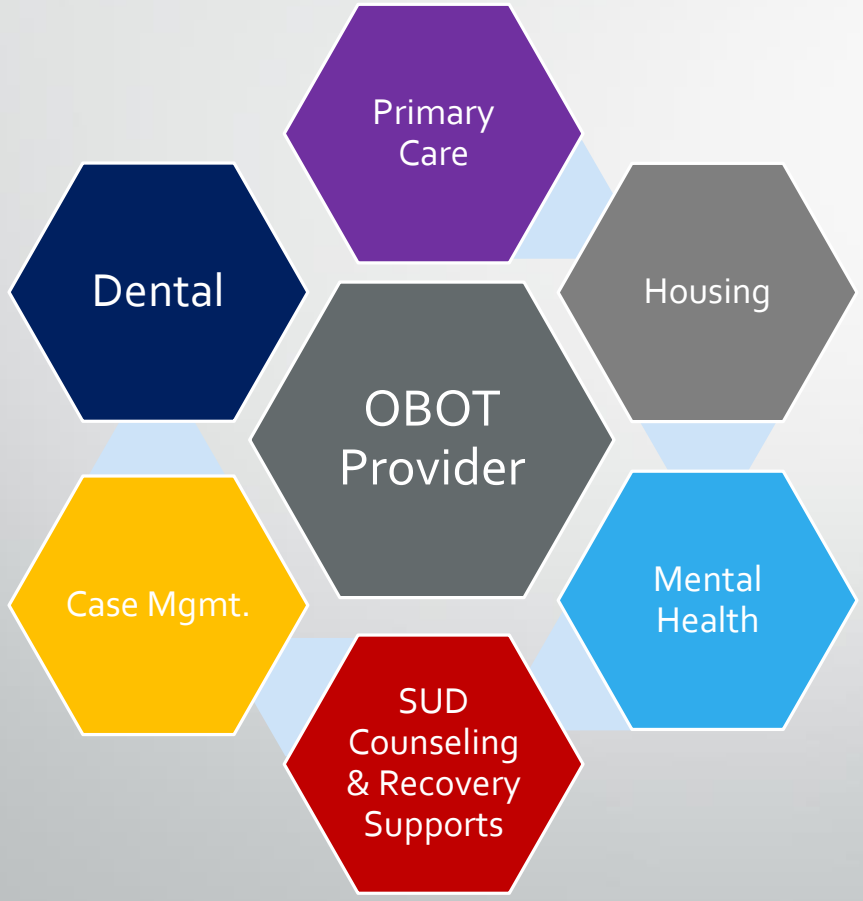


- Opioid use disorder is a chronic, relapsing medical condition.
- High mortality of OUD stems primarily from complications, such as accidental overdose, trauma, suicide, or infectious disease (e.g., Hepatitis C, HIV).
- There is no known cure. But OUD can be managed long-term with appropriate treatment.

Social Determinants of Health

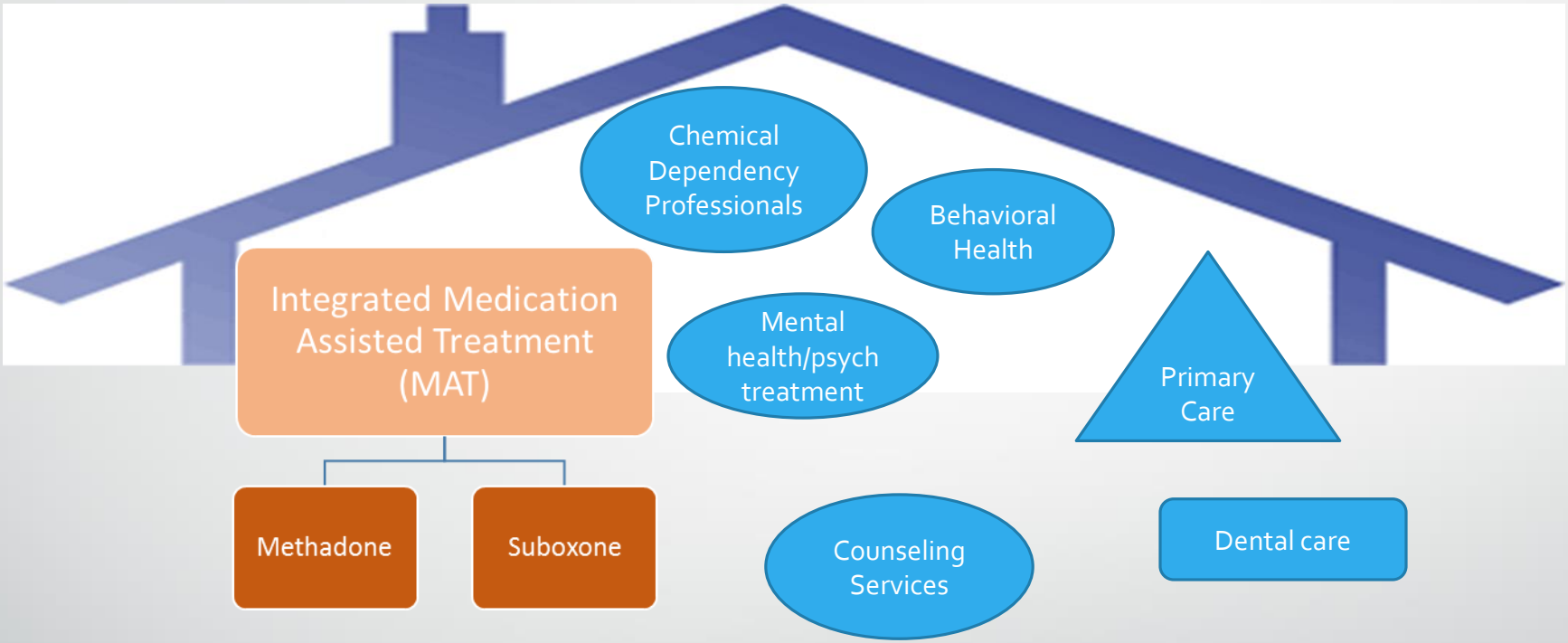
- Economic Stability
- Physical Environment
- Education
- Basic Nutrition
- Social Supports/Recovery Supports
- Health Care System
  - Physical Health
  - Behavioral Health

Ideal Model


Primary Care
Dental
Housing
OBOT Provider
Case Mgmt.
Mental Health
SUD Counseling & Recovery Supports


Bidirectional Continuum
OTP

Ideal Model Continued



MAT in Jail Program

REMOVAL OF BARRIERS TO CARE:
Transportation buses, on-site childcare, case management/social worker, parenting classes, life skills, assistance with housing

Transitional Housing

Barriers and Success

- Partnerships
- Capacity
- Legacy of Discrimination (Stigma)

Chronic Pain

Moving People from Hurt to Hope

Pain

and cognitive

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

International Association for the Study of Pain

Acute versus Chronic Pain

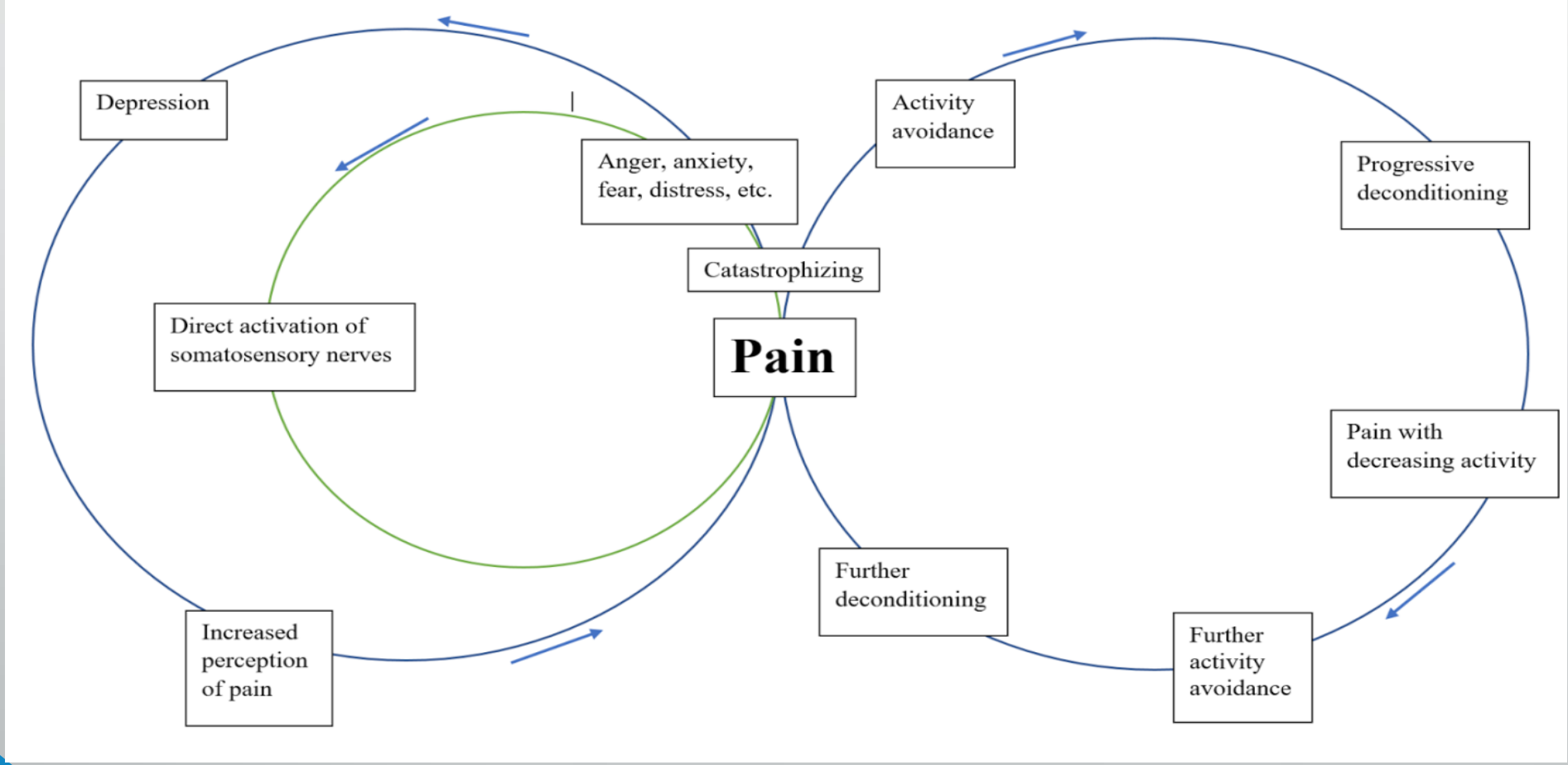
Acute Pain

- Less than 3 months
- Is a symptom
- Identified cause, body's response to injury
- Diminishes over time, responds to treatment

Chronic Pain

- More than 3 months
- Is a condition
- May develop after incident, known or unknown cause
- Persists beyond expected healing time and/or despite treatment

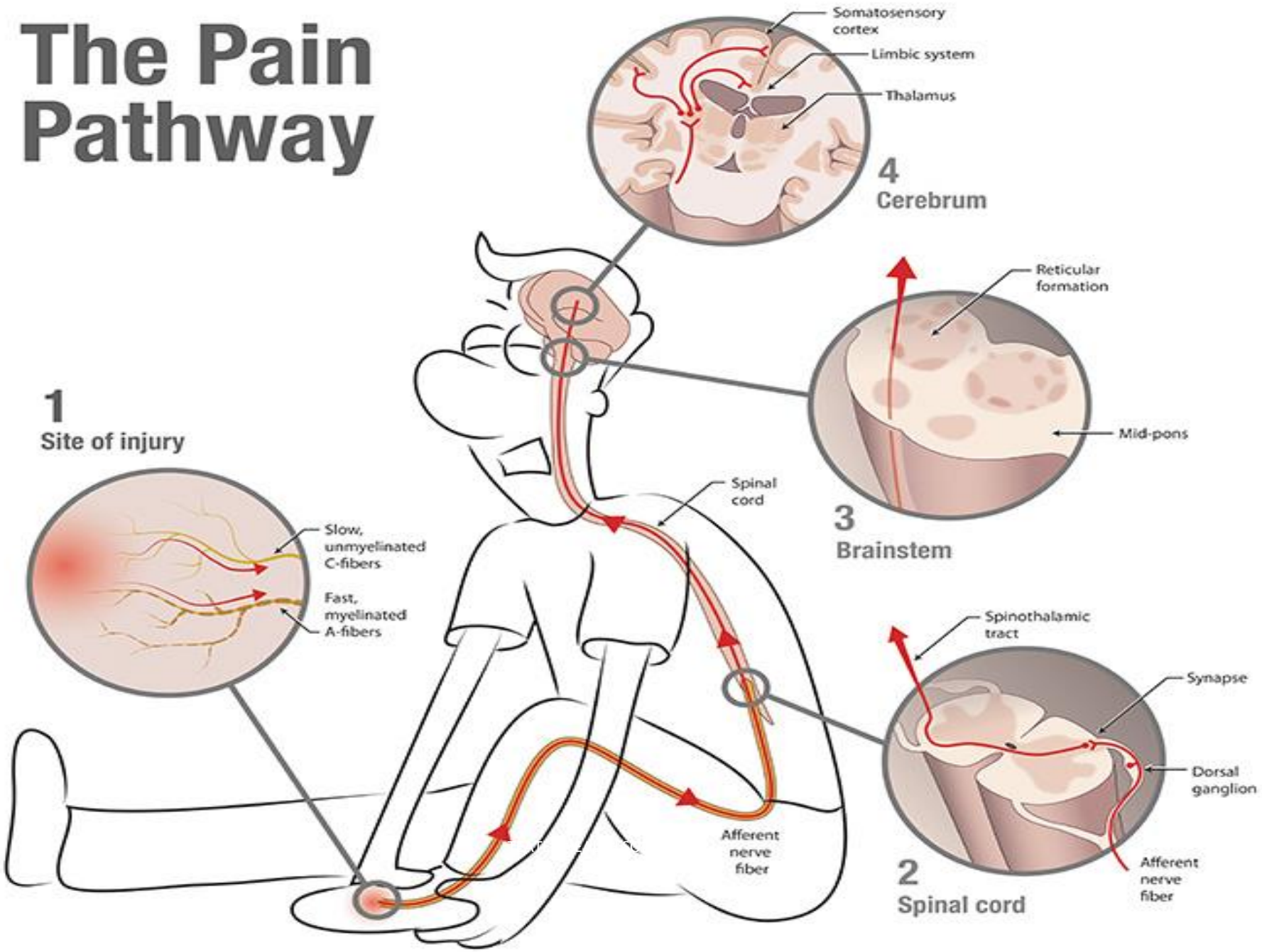
Chronic pain cycle



Psychological component

Physical component

The Pain Pathway



Pain pathways

Nociceptor

Spinothalamic nerve

Thalamus

Amygdala (fear)

Hippocampus (memory)

Somatosensory nerve (pain)

Limbic system (emotion)

Prefrontal cortex (rational thinking)

Central sensitization

Nociceptor

Spinothalamic nerve

Thalamus

Amygdala (fear)

Hippocampus (memory)

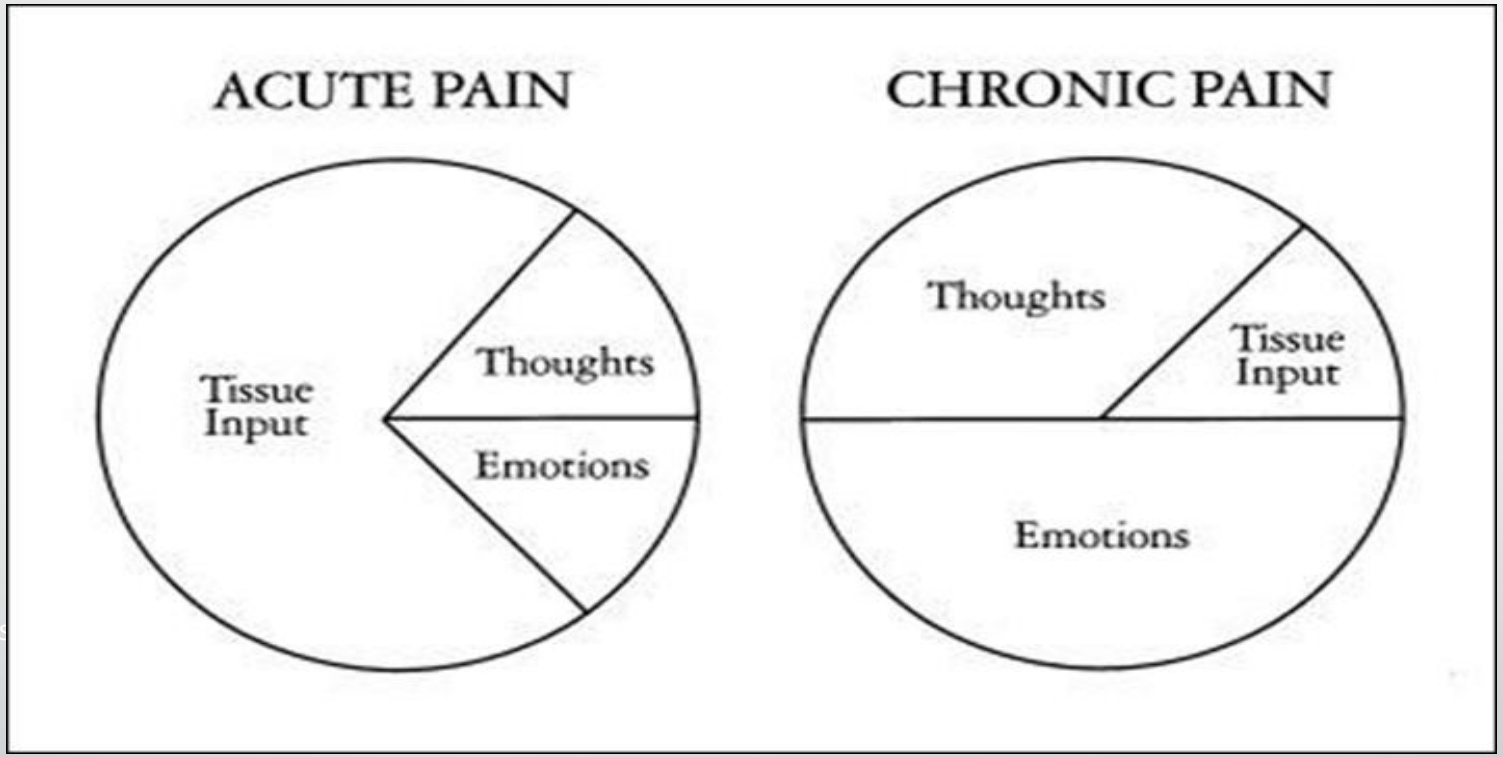
Somatosensory nerve (pain)

Limbic system (emotion)

Prefrontal cortex (rational thinking)

Central Sensitization Syndromes

- Fibromyalgia
- Chronic headaches
- Irritable bowel syndrome
- Chronic neck pain
- Chronic back pain
- Interstitial cystitis
- All chronic pain???


ACUTE PAIN
Tissue Input
Thoughts
Emotions
CHRONIC PAIN
Thoughts
Tissue Input
Emotions

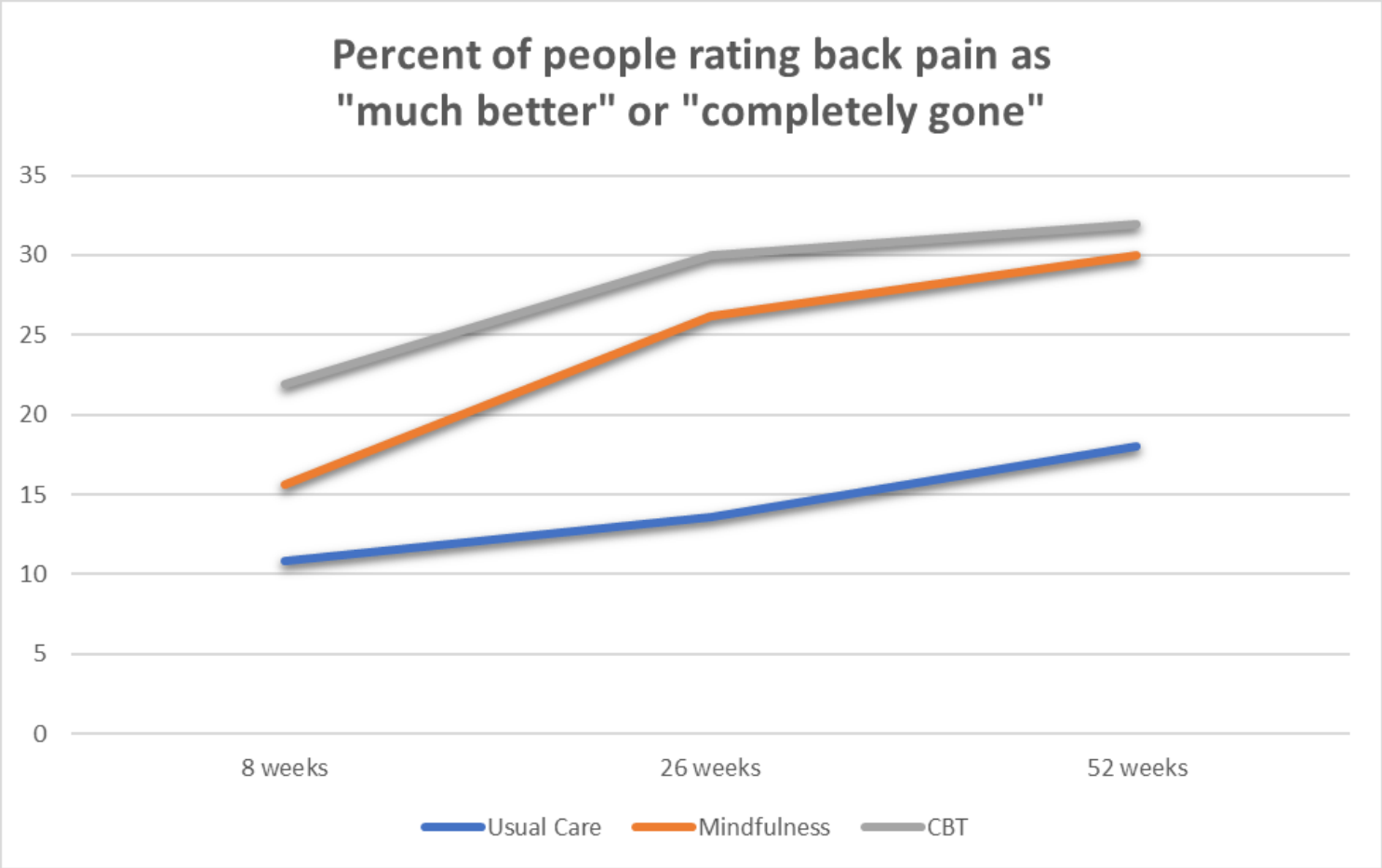
What we know

- No evidence that opioids are effective for long-term treatment of chronic pain.[4,5]
- Risks of chronic opioid therapy: *major depression, opioid induced hyperalgesia, diversion, addiction, overdose, death*
- Epidemiologic studies have shown that chronic pain patients on COT have a worse quality of life than those who are not on COT.[6]
- Evidence supports non-traditional approaches to treatment of chronic pain
- Evidence supports behavioral therapy

There are better treatments

- Behavioral therapy[7]
- Physical therapy
- Treatment of mood disorders
- Exercise
- Acupuncture
- Yoga and other alternative therapies
- Amitriptyline, duloxetine, gabapentin and similar drugs may help

Evidence in support of BH Interventions



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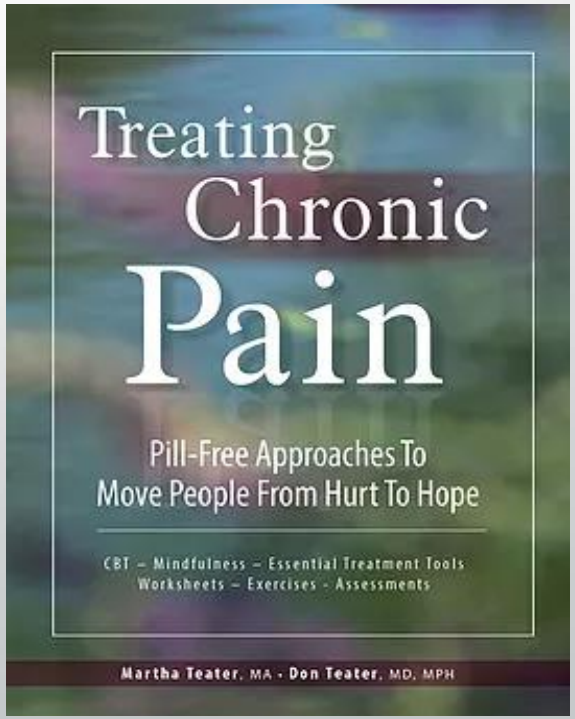
CDC Guidelines 2016

- CDC recommends behavioral therapy before any opioid for chronic pain
  - This means we have 100 million people who need behavioral interventions
  - Doctors need to be able to refer to trained providers

Chronic Pain and Integrated Care

- Behavioral therapy options for chronic pain:
  - Short-term brief individual and group counseling
  - Cognitive Behavioral Therapy
  - Mindfulness training
  - Decatastrophizing
- Models for care:
  - John Otis (11 sessions)
  - VA CBT for Chronic Pain (11 sessions)
  - Teater Health Solutions (10 sessions)



What about those with chronic pain & OUD?

Resources

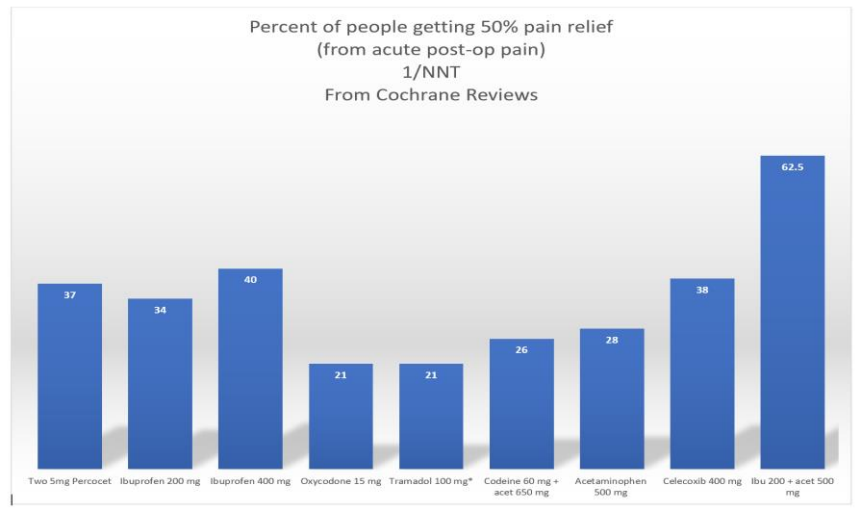
- Teater Health Solutions: https://www.teaterhs.com/
- Understanding Central Sensitization Youtube video: https://www.youtube.com/watch?v=n3VTk3TEZp8
- Screening Tools:
    - Opioid Risk Tool (ORT)
    - Pain, Enjoyment in Life, & General Activity (PEG)
    - Pain Catastrophizing Scale (PCS)
    - Central Sensitization Inventory (CSI)

Dear Doctor or Dentist,

Thank you for your care of our mutual patient who we are prescribing buprenorphine for treatment of their opioid use disorder.

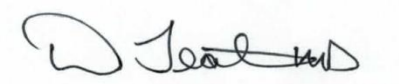
It is very important that our patient remain on buprenorphine and that they NOT receive opioids for outpatient treatment of their pain. Therefor, I recommend the following regimen for treatment of their postoperative pain:

1. Continue buprenorphine at the current dose. The morphine mg equivalent for buprenorphine is 30 to 1. So, if they are on 12 mg of bupe each day, that is the equivalent pain relief of 360 mg of morphine each day. However, the pain-relieving effects of buprenorphine only last 8 hours so their daily dose should be divided q 8 hours: i.e., if they are on 12 mg/day they should take 4 mg q 8 hours.
2. Add ibuprofen 200 mg + acetaminophen 500 mg q 6 hours prn in addition to the buprenorphine. As you can see from the graph below, this is more effective than most opioid options anyway. This information comes from a recent Cochrane review.[1]



Please let me know if you have any questions.

Sincerely Yours,



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Anesthesia care for patients on MAT:

Buprenorphine:

Scheduled surgery: options:

1. Take buprenorphine prior to surgery without change. May take on the morning of surgery.
    a. Following surgery, continue buprenorphine.
        i. Calculate total daily dose and divide by 3 and give sublingual q 8 hours (pain relief only lasts 8 hours). If needed, may increase dose up to 8 mg q 6 hrs. (This is the maximal effective dose.)
            1. MME conversion for bupe is 1mg bupe = 30 mg p.o. morphine = 10 mg parenteral morphine.
        ii. Also give IV ketorolac and acetaminophen until taking p.o.
        iii. When taking p.o., change to 200 mg celecoxib qd and 1000 mg acetaminophen q 8 hours p.o.
        iv. If necessary, hydromorphone or sufentanil may be used for pain that is uncontrolled. (Hydromorphone and sufentanil have mu opioid receptor binding affinity similar to buprenorphine and are likely more effective for pain relief than other opioids for people on bupe.)(Leighton & Crock, 2017)
        v. Also consider giving IV or IM buprenorphine (instead of hydromorphone or sufentanil) as there is some thought that there is no ceiling effect on the pain relieving properties of buprenorphine.
2. Take buprenorphine the day before surgery but none within 24 hours prior to surgery.
    a. Example: `If patient takes 8 mg tid and surgery is scheduled for 7 am, patient may take the total daily dose (24 mg) at 7 am on the day prior to surgery.
    b. Use opioids as needed but prioritize multimodal anesthesia postop to reduce opioid use.
    c. Discharge home on non-opioid pain medications with resumption of buprenorphine at the pre-op daily dose divided q 8 hours.
3. 2-3 days prior to surgery, reduce buprenorphine dose down to 12 mg qd. Continue 12 mg qd through the perioperative period. Use multimodal anesthesia. Use other opioids as needed. (Lembke, Ottestad, & Schmiesing, 2018)
4. For emergency surgery, use option #1 above.

Methadone:

- Take methadone prior to surgery without change. May take on the morning of surgery.
  - Following surgery, continue methadone.
    - Calculate total daily dose and divide by 3 and give p.o. q 8 hours (pain relief only lasts 8 hours).
      - If the patient is n.p.o., divide the dose in half and give parenterally divided q 8 hours. (Sen et al., 2016)
        - For example, if the patient is on 120 mg methadone q day and is n.p.o., divide the dose in half for parenteral equivalent (60 mg) and then divide q 8 hours (20 mg IM or IV q 8 hours)
    - Also give IV ketorolac and acetaminophen (IV or PR) until taking p.o.
    - When taking p.o., change to 200 mg celecoxib qd and 1000 mg acetaminophen q 8 hours p.o.
    - If necessary, supplement with other opioids (hydromorphone or sufentanil may be more effective than other opioids).
      - The patient may or may not have increased tolerance to other opioids.
      - If using supplemental opioids with methadone, the patient should have 24-hour pulse oximetry
    - Discharge home on previous dose of methadone and nonopioid medications.
  - Caution with any drugs that may cause drowsiness or have an interaction with methadone.
    - If the patient is on any QT prolonging drug in addition to methadone, they should be on telemetry.
    - If on any drug that cause additional drowsiness, continuous pulse ox monitoring should be utilized.

Responding to the Opioid Epidemic: Leveraging Care Integration in the Health Center Setting. Nov 15-16

Learn How To:

- Better treat pain
- Work with complex patients
- Use medication assisted treatment
  - Break-out tracts will include trauma informed practices & learning to facilitate behavioral interventions for chronic pain

In Addition:

- 14 hours CME/CEU credit & will meet Washington State CME guidelines for prescribing opioids
- More information here: www.nwrpca.org/event/opioidconference

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Questions?

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