Housekeeping – Facilities & Materials

- Training Folders
- Breaks
- Bathrooms
- Lunch
- Continuing Nursing Education
- Presentation Slides:
  https://waportal.org/what-we-do/expanding-role-nurses-whole-person-care
## AGENDA

<table>
<thead>
<tr>
<th>TIME</th>
<th>LOCATION</th>
<th>SESSION TITLE</th>
<th>PRESENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 – 8:30 AM</td>
<td>Grand Ballroom Foyer</td>
<td>Arrival and Registration</td>
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<tr>
<td>8:30 – 9:00 AM</td>
<td>Grand Ballroom Salons I-II</td>
<td>Welcome and Opening Remarks</td>
<td>Anne Shields MHA, RN Antwinett Lee EdD, MSN-CNS, RN</td>
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<tr>
<td>9:00 - 9:15 AM</td>
<td></td>
<td>Transition</td>
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<tr>
<td>9:15 – 10:45 AM</td>
<td>Shades Conf. Room</td>
<td>Introduction to Opioid Use Disorder Treatment and the Nurse Care Manager Role</td>
<td>Addy Adwell RN, BSN</td>
</tr>
<tr>
<td>10:45 - 11:00 AM</td>
<td></td>
<td>Break</td>
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</tr>
<tr>
<td>11:00 – 12:00 PM</td>
<td>Shades Conf. Room</td>
<td>Core Skills For Nurses Treating Opioid Use Disorder</td>
<td>Addy Adwell RN, BSN</td>
</tr>
<tr>
<td>12:00 - 1:00 PM</td>
<td></td>
<td>Lunch (On Your Own)</td>
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</tr>
<tr>
<td>1:00 - 2:30 PM</td>
<td>Shades Conf. Room</td>
<td>Polysubstance Use in the Treatment of Opioid Use Disorder with Buprenorphine</td>
<td>Mark Duncan MD</td>
</tr>
<tr>
<td>2:30 - 2:45 PM</td>
<td></td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>2:45 – 4:00 PM</td>
<td>Shades Conf. Room</td>
<td>Clinical Challenges and Comorbid Conditions</td>
<td>Mark Duncan MD</td>
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<tr>
<td>4:00 PM</td>
<td></td>
<td>Adjourn</td>
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Welcome & Introductions

Kelly Youngberg, MHA
- Senior Project Manager & Practice Coach, AIMS Center

Addy Adwell, RN, BSN
- Nurse Care Manager, HMC AMC
- RN Trainer, H&S OTNs

Mark Duncan, MD
- Assistant Professor, UW Psychiatry & Behavioral Sciences
- Provider Trainer, H&S OTNs

Paul Barry, LICSW
- Navigator Trainer, H&S OTNs, AIMS Center
Introductions

Prompt(s):
• Describe your experience in treating OUD?
• Describe your organization?
• What is your role?

Instructions:
1. In groups of 3-4, take turns discussing.
2. Choose 1 person to report out to the larger group.
INTRODUCTION TO OPIOID USE DISORDER TREATMENT AND THE NURSE CARE MANAGER ROLE

SESSION 1
LEARNING OBJECTIVES

- List the criteria to diagnose opioid use disorder
- List the medications used to treat opioid use disorder
- Describe rationale for buprenorphine as treatment for opioid use disorder
- Recognize pharmacology of buprenorphine
- Recognize the role of the nurse care manager in opioid use disorder treatment
More than 3 out of 5 drug overdose deaths involve an opioid (CDC).

91 Americans die from opioid overdose every day, nearly half involve prescription opioids (CDC, 2016).

In Washington, 57% of people currently using heroin were dependent on prescription opioids before they began using heroin. (UW Alcohol and Drug Abuse Institute)

Effective pharmacotherapy exists for people with opioid use disorders but fewer than 24% receive any medication for their addiction. (SAMHSA Center for Behavioral Health Statistics and Quality, 2014).
OPIOIDS

• Drug class that bind to opioid receptor

• Opioid: opiates or synthetic
  – Opiate: derived from opium, includes morphine, heroin
  – Synthetic: hydrocodone, fentanyl

• Chronic use can result in dependence and/or use disorder ("addiction")
OPIOID DEPENDENCE

Alford, Boston University, 2012
OPIOID USE DISORDER (OUD)

Two or more of the following criteria:

- Using larger amounts/longer than intended
- Much time spent using
- Activities given up in order to use
- Physical/psychological problems associated with use
- Social/interpersonal problems related to use
- Neglected major role in order to use
- Hazardous use
- Repeated attempts to quit/control use
- Withdrawal*
- Tolerance*
- Craving

<table>
<thead>
<tr>
<th>Severity</th>
<th>Score</th>
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<tbody>
<tr>
<td>OUD</td>
<td>Min. of 2</td>
</tr>
<tr>
<td>Moderate OUD</td>
<td>4 - 5</td>
</tr>
<tr>
<td>Severe OUD</td>
<td>6 - 7</td>
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</tbody>
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*Does not count if taken only as prescribed and is sole criteria

DSM 5, American Psychiatric Association
MEDICATION ASSISTED TREATMENT (MAT)

• **Methadone**
  – Full Agonist
  – Opioid treatment program (OTP) only

• **Buprenorphine/naloxone**
  – Partial Agonist
  – DATA-2000 waiver required, now includes NP & PA
  – Office-based setting or OTP
  – Few prescribers waived and few waived prescribe

• **Naltrexone Injection**
  – Full Antagonist
Efficacy: Full (Agonist Methadone), Partial Agonist (Buprenorphine), Antagonist (Naloxone)

All patients got counseling

Remaining in treatment (nr)

Treatment duration (days)

75% retention
75% UTS negative
20% mortality in placebo group

Control
Buprenorphine

RRies 2017
BUPRENORPHINE

- Poor oral bioavailability; given sublingually (subcutaneous implants: experimental; patch: for pain)
- Slow onset (Peak effects 3-6 hrs.)
- Long duration (24 - 48 hours)
- Slow offset from receptor
- Half life > 24 hours
PROPERTIES OF BUPRENORPHINE

- a µ-Opioid partial agonist
- *Ceiling effect* on respiratory depression
- *High affinity* for µ-opioid receptor
- *Slowly dissociates* from µ-opioid receptors
- Ameliorates withdrawal once underway
OPIOIDS: BUPRENORPHINE DOSE AND STABILITY

- **> 16mg**
  - Less illicit use
  - Increased retention in treatment
    - Hazard Ratio 3.09 for drop out at < 16mg of Buprenorphine

- **25% of Bup patients dropped out before 1 mo**
  - Early regular engagement/monitoring needed

**Best Practice:** Buprenorphine dosages ≥ 16mg, early engagement is key

• MA-CCM Background
• Developed at Boston Medical Center
• Integrates Addictions & Primary Care
• Multidisciplinary Team
• Nurse Care Manager (NCM)
  — provides office-based opioid treatment (OBOT) w/ buprenorphine
  — care to approximately 100 patients

Goal: increase access to OBOT in Primary Care

*Implemented at Harborview Medical Center in December 2015 through SAMHSA grant.*
Physicians have support structure to prescribe buprenorphine in Primary Care

Patients may prefer office setting for anonymity and convenience

Facilitates treatment of co-morbid conditions and preventive care

Possibility to engage non-treatment seeking patients screened in primary care

64% 12 month retention rates

(LaBelle et al., 2015)
**MASSACHUSETTS COLLABORATIVE CARE MODEL**

**Assessment**
- Program Manager
  - Initial Screening
- Nurse Care Manager
  - NCM Assessment
- Provider
  - Chart Review
  - Physical Exam
  - Dx & Treatment Decision

**Induction & Stabilization**
- Provider
  - Prescription
- Nurse Care Manager
  - Buprenorphine Induction Per Protocol
  - Patient Support & Titration

**Maintenance**
- Nurse Care Manager
  - Stabilization Monitoring
- Provider
  - Maintenance & Follow-up

**Goal:** increase access to OUD Tx by providing clinical support in a clinically effective & cost-effective manner

*Alford et al, 2011; LaBelle et al 2016*
FOUR TREATMENT STAGES

1. Screening and Intake
2. Medical Induction
3. Stabilization
4. Maintenance

DSM 5, American Psychiatric Association
SCREENING & INTAKE

- Opioid use history
- Use of other substances
  - Benzodiazepines
  - Alcohol
  - Stimulants
- Substance use treatment history
- Pain History
- Mental health history
  - PHQ9, GAD7, PCL5
- Social history
- Treatment agreement
- Medication teaching
- Prescription Monitoring Program check
- Patient’s Goals for Treatment
INDUCTION PLANNING

- Plan with patient for home or clinic induction
- Consider clinic induction when physiological withdrawal must be documented or based on patient preference
- Patient starts medication when in mild to moderate opioid withdrawal
- Follow up by phone same and next day
- Coach patient on what to expect - may feel mild intermittent symptoms of withdrawal for the first few days
• **Weekly appointments with NCM**
• **While stabilizing on medication**
  – Assess symptoms of withdrawal/cravings to use
  – Address lapses
  – Consider treatment supports
• **Appointment interval lengthens as treatment stabilizes**
  – After 4 to 6 consecutively appropriate UDT
  – Patients may eventually attend monthly
Weekly team meetings for challenging cases

Unstable patients
  - Add mental health care, recovery support
  - Consider dose increase

Can transfer care to directly observed at OTP
  - Return after 4 consecutive negative urine tests

Can transition to methadone maintenance
Prompt

1. Write down any big ideas from this session.