Problem Solving + Overcoming Challenges with Addiction Screening and Treatment

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HealthRIGHT 360

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Poll – Who is in the room

What kind of clinical training do you have?

a. Physician (MD or DO)
b. Advanced Practice Clinician (NP or PA)
c. Nurse (RN or LVN)
d. Behavioral Health Provider
e. Other licensed health care provider
f. Unlicensed health care provider (e.g., medical assistant)
g. Health Educator
h. Non-clinician

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Poll – Practice Type

What kind of work do you do?

a. Primary care
b. Sexual and reproductive health
c. Addiction medicine
d. Behavioral health
e. Administration
f. Other [type in chat]

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Poll – Work Setting

What setting do you work in?

a. FQHC/Community clinic
b. Hospital based clinic
c. Multispecialty private practice
d. Single specialty private practice
e. Solo practice
f. Behavioral health setting
g. Other [type in chat]

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Disclosure

- Speaker and planners have no financial conflicts to disclose

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Learning Objectives

1. Identify 4 common objections to screening and treating people with addiction, including providing Medication in Addiction Treatment (MAT)
2. State evidence-based challenges to each of these objections
3. Identify one change that you will make to implement addiction screening or treatment in your practice

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My trajectory

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Why is this important?

- 69,419 drug overdose deaths in the 12 months ending November 2019[1]
- About 1 in 27 pregnant women reported binge drinking in the past 30 days and had 4.5 binge drinking episodes in that time period[2]
- Rates of infants born with fetal alcohol syndrome range from 0.2 to 1.5 infants for every 1,000 live births 0.3 out of 1,000 children from 7 to 9 years of age[3,4]
- Prenatal exposure to alcohol, drugs or tobacco is linked to psychological, cognitive and physical problems in children
- Children are impacted by parents' substance abuse – neglect and abuse

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Basic Assumptions

- Substance use disorders are chronic, relapsing diseases of the brain
- Recovery is possible
- FDA approved medications for alcohol use disorder (AUD) and opioid use disorder (OUD) are effective
- Medications are an important part of supporting a person in their recovery from a substance use disorder
- For patients with moderate to severe OUD, medications should be considered first-line treatment over other interventions (e.g., counseling, 12-step)
- Not every person with a substance use disorder is ready to start recovery

Why isn’t MAT widely available in primary care practices?

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Objection

Why bother?
Treatment doesn’t work

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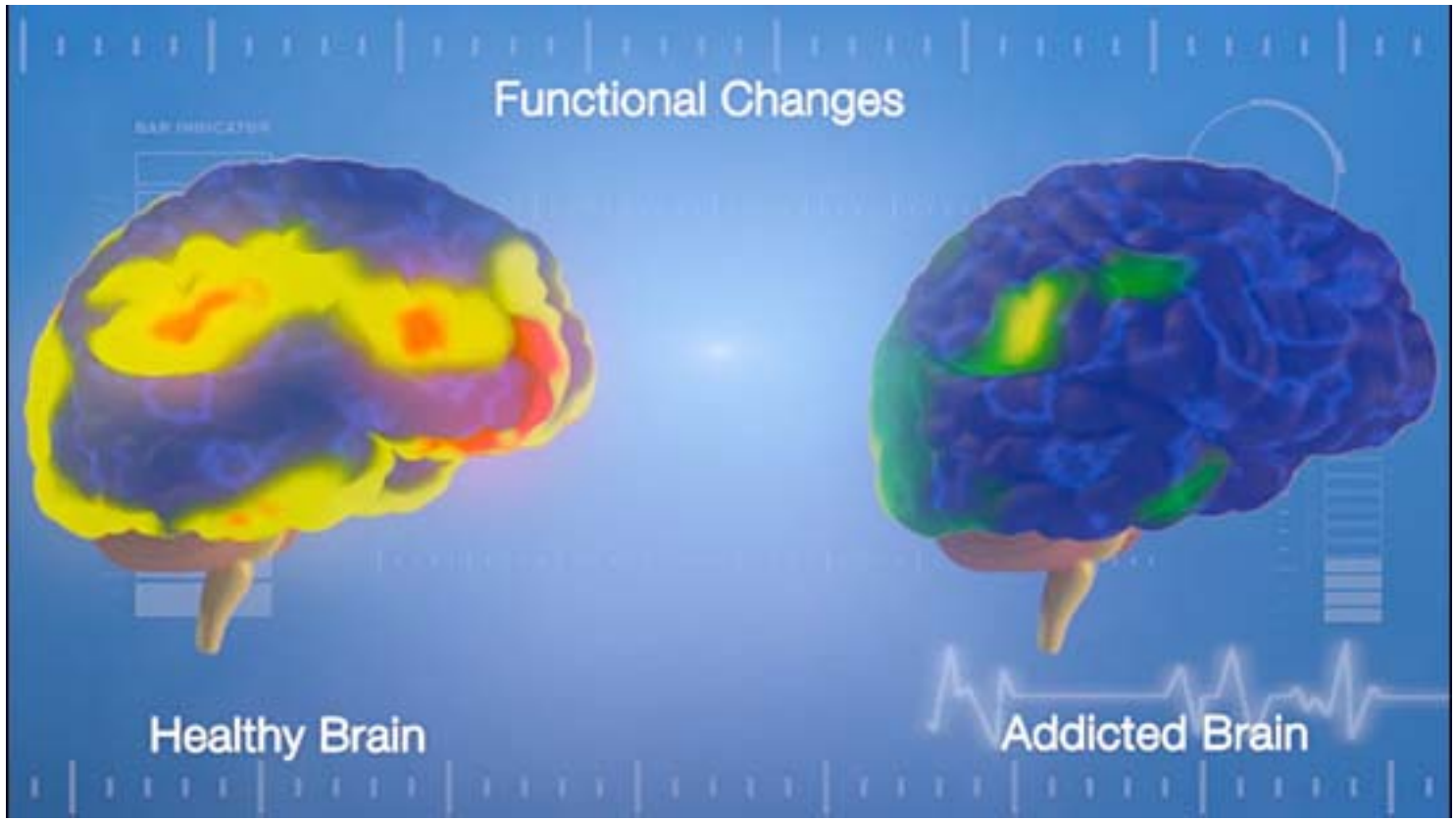
Basic Assumptions



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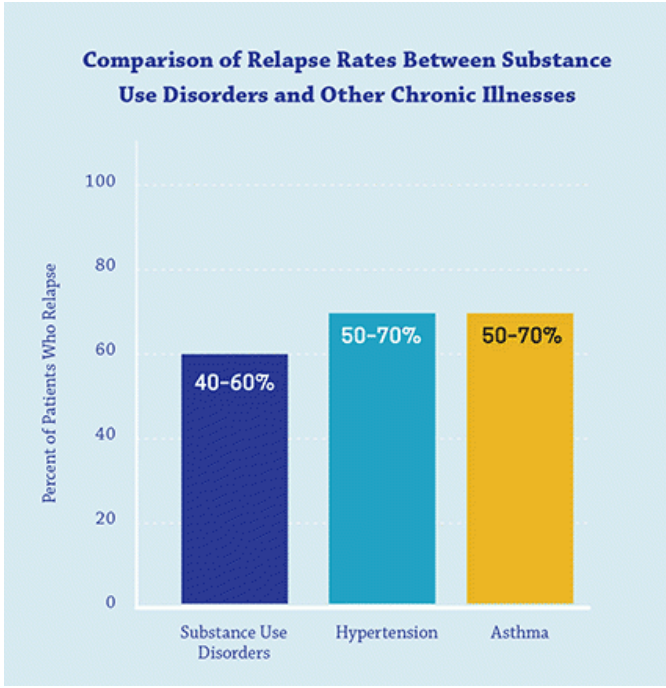
Chronic relapsing diseases

- Relapse rates for substance use disorders range from 40-80% [5,6]
- Smokers make an average of 30+ attempts to quit before quitting for good [7]
- Similar to other chronic illnesses



JAMA, 284:1689-1695, 2000

We shouldn't withhold effective medications for the treatment of any chronic disease

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Objection

You’re just trading one drug for another

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Abstinence-only vs MAT

- Cravings persist for years after last use [8,9]
- Relapses and deaths are common [10]
- The risk of opioid overdose death for people shortly after leaving prison is 129 times that of the general population [11]

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Abstinence-only vs MAT

- Overdose death rates were reduced by half through the use of MAT [12]
- Medication treatment decreased illicit drug use and HIV and hepatitis C transmission [13,14,15]
- Patients on MAT have lower health care costs compared to those on drug-free treatment [16]

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Length of treatment: buprenorphine

- Using medications for detoxification only result in high relapse [17,18] and death rates [19]
- People who stayed on medication for 15-18 months did better than those who stopped at 6-9 months in the 6 months after stopping [20]
  - Lower odds of having an emergency room visit (odds ratio 0.75)
  - Lower odds of being hospitalized (odds ratio 0.79)
  - Lower odds of filling an opioid prescription (odds ratio 0.67)
- Lifelong treatment is acceptable

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Objection

I didn’t learn this in school

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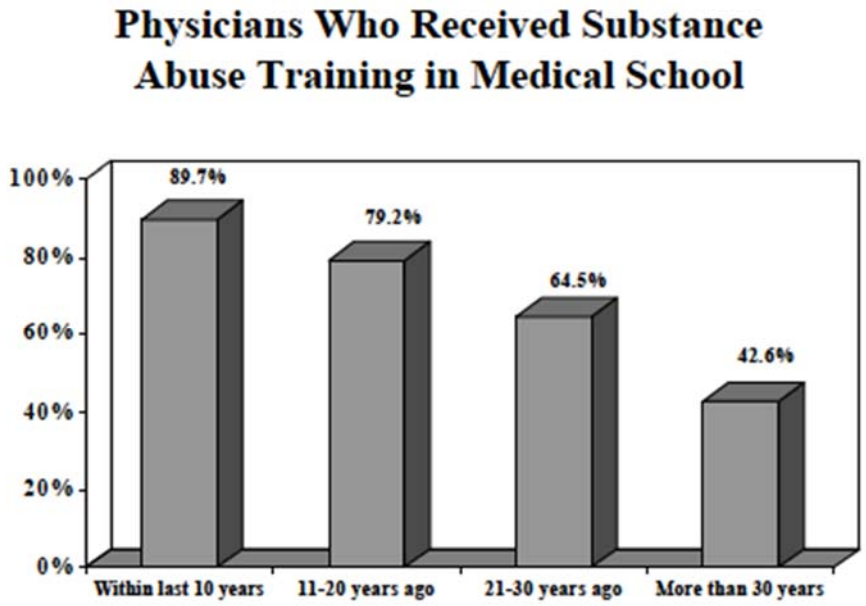
Lack of curriculum and training

- The longer a provider has been in practice, the less likely they have had training while in school [21]
- Only recently became a medical specialty through the American Board of Preventive Medicine



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Easy to learn

- Screening tools can be self-administered by patients in 5-8 min
  - TAPS (Tobacco, Alcohol, Prescription medications and other Substances)
  - DAST (Drug Abuse Screening Test)
  - SBIRT (Screening, Brief Intervention and Referral to Treatment)
  - Audit-C (Alcohol Use Disorders Identification Test)
- Limited number of medications
  - Naltrexone, Acamprosate, Disulfiram
  - Buprenorphine, Naltrexone
  - Varenicline, Bupropion, Nicotine replacement
- Buprenorphine requires special training – free and online
  - 8 hours for physician
  - 24 hours for advanced practice clinician

Resources and Supports

- Project ECHO: UC Davis offers mentoring and instruction for providers via teleconferencing
- California's Substance Use Line: UCSF supported 24/7 free consultation with addiction specialists (1-844-326-2626)
- Providers Clinical Support System: trainings and mentoring to help primary care providers treat opioid use disorders

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Objection

I can’t offer a robust treatment program

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Medication-first model

- Medication Assisted Treatment vs Medication for Addiction Treatment (MAT)
- No evidence that behavioral treatment improves outcomes in opioid users [22]
- Don’t punish patients for relapsing
- Develop robust referral networks and have local resources available (12-step programs and peer supports as well as paid supports

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Not time consuming

- Screening tools self-administered in 5-8 min
- Medications covered without prior authorization and dispensed at pharmacy
- All medications can be started at home
- Medical assistants and nurses can be trained to provide support and monitoring

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Objection

Naloxone encourages risky drug use

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Naloxone

- Antidote to opioid overdose that restarts breathing when someone is unconscious due to an overdose
- Increased access to naloxone reduces mortality and has not been shown to increase drug use [22]
- In communities with increased access to naloxone and overdose prevention education, there are fewer opioid-related deaths [23]
- Naloxone distribution is cost-effective [24]

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Naloxone and the Law

- CDC recommends co-prescribing naloxone when prescribing opioids
- It is legal in all states and the District of Columbia for pharmacists to dispense or distribute naloxone without a patient-specific prescription from another medical professional
- In 46 states and the District of Columbia, private citizens can administer the overdose-reversal medication without legal liability (good Samaritan laws)
- As of Sep 2019, 17 states have made it a legal requirement for providers to co-prescribe

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California AB 2760

- Prescribers must offer a prescription for naloxone and educate on overdose prevention under specified conditions
  - Prescription dosage for patient is 90 or more morphine milligram equivalents of an opioid medication per day
  - An opioid is prescribed concurrently with a benzodiazepine, even when prescriptions are not written concurrently
  - The patient has an increased risk of overdose, including those with a history of overdose, a history of a substance use disorder, or at risk for returning to a high dose opioid medication to which they are no longer tolerant
- Applicable even when you didn't write the prescription

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Objection

Addicts are a nuisance and a liability

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Institutionalized Stigma

- Patients lie [25]
- Addiction is a crime [26]
- Death certificate project

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Culture change

- Understand the science
- Chronic disease vs character flaw
- Treatment reduces the negative behaviors
  - Reduces chaos and patient vulnerability to arrest
  - Improves patient honesty and creates trust [27]
  - More likely to keep appointments
- Less risk in prescribing

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Treatment works

- After 6 months of treatment – 50% reduction in substance use [28]
  - Alcohol use disorders: 40-70% success rates
  - Cocaine use disorders: 50-60% success rates
  - Opioid use disorders: 50-80% success rates

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What you learned today

- 4 common objections to screening and treating people with addiction
- Evidence-based challenges to each of these objections
- At least one change you will make to improve the lives of people with substance use disorders

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Thank you

Questions?

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