Wisconsin Opioid Project ECHO
Agenda

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Zoom Meeting ID: 156 261 634

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Session Date: Friday April 19, 2019

Didactic Topic and Presenter:
Home Inductions by Randy Brown, MD UW DFMCH Addiction Medicine Program Director

Content Experts:
Ritu Bhatnagar, MD and Susan Mindock, CSAC; and Sheila Weix, MSN, RN, CARN

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Project Updates and Discussion
- 1:00 PM: Case #1 & discussion
  - Presenter: Paula Goldman, MD
- 1:15pm: Didactic Presentation
  - Presenter: Randy Brown, MD
- 1:30 PM End of Session

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2019 Universal Activity Number (UAN)
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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 4/19/2019

2-Presenter Name: Paula Goldman, MD

- Presenter Organization: University of Wisconsin Department of Family Medicine and Community Health – current third year resident

3-ECHO ID:

4-Have you presented this patient during this tele ECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

Chronic Pain or Opioid Use Disorder in Patient Started on Opioids as a Teen?

Demographic Information:

6-Age: 43

7-Gender: female

8-Education/Literacy: completed high school

9-Income source: has been receiving disability since age 18

10-Insurance: Badgercare

11- HPI:

She was started on opioids at age 14 for ankylosing spondylitis. She has been on daily long-acting Morphine as well as Oxycodone for breakthrough pain ever since. She arrived from California to establish care with me almost 2 years ago stating that her doctors in California didn't understand what she was going through and requesting an increase in her opioid dosing due to her pain being poorly controlled. I did not increase her opioids but did continue her chronic prescriptions and got her outside records, which confirmed that she had been on these medications long term and with escalating doses of Oxycodone.

Subsequently had 3 different episodes of requesting early pain medication refills because she used up her Oxycodone due to injury-related pain, examples being twisting wrong when walking down stairs and straining her neck while trying to do chair yoga. Each time I discussed with her that these are not injuries for which opioids are indicated.

She also had a variety of ED encounters as well as one admission for constipation with abdominal distention.

Then I got to know her more and she disclosed that she typically spends the majority of her day lying in bed, severely depressed, trying not to move to avoid pain and using her opioids to "dull the pain."

Which led to our first breakthrough conversation, the theme of which was "I'm worried that opioids are ruining your life." We discussed opioid hyperalgesia, constipation, lack of adaptive coping skills due to starting opioids so young, etc. She was surprisingly in agreement – although very scared of the pain she would experience with decreasing her dose – and we decided to start a very slow taper that day. Our goal at that time was not necessarily complete cessation of opioids, but we set the shared goal of not needing opioids every day. We set scheduled monthly visits, we got her into a Chronic Pain Group that focuses on developing coping skills, and I referred her to Pain Clinic as she had documentation of multiple unsuccessful trials of non-opioid pain medications from her time in California.

12-Social History:

She grew up in California with a mother who was on chronic opioids and who was abusive. She got married immediately after high school. She spent her time as a homemaker. She is divorced. She has two adult children who live out of state. They do not have a close relationship. She has a roommate. She cannot identify any social support outside of her roommate.

13-Housing:

Lives in an apartment near the clinic with a roommate. States that there is significant drug use and mental illness in her building.

14- **Substance Use History:**

Opioid use and tobacco use since adolescence

15- Consequences of Substance Use:

- Social/occupational/educational:
    - Strained relationship with her children: She is hesitant to go visit them because she might run out of opioids while traveling or have increased pain while traveling and need more opioids but be unable to obtain them. She also has significant guilt about feeling she was not fully present as a mother due to her pain.
    - Occupational dysfunction: She is on disability, has not had a job, volunteer position, or structured activity outside of the home for many years. She does not feel she can commit to any regular activity outside of the home because she can't predict when she will have "a bad day" with regard to her pain and does not feel she can be far from her supply of opioids.
- Physical (including evidence of tolerance/withdrawal):
    - She had a gradual up titration of her opioid requirements over many years, with escalating doses needed to control her pain.
    - After each acute injury for which she used more than her allotted opioids and requested an early refill, I requested she come into clinic to discuss the situation and she presented to clinic in crisis due to mild-moderate withdrawal

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HPI Part II:

The first few months of her slow opioid taper went extremely well. She felt better, she got out bed, she loved her Chronic Pain group and started to go out to lunch and exercise with the friends she met in that group, and her bowels started working again. We also talked about how tobacco abuse can worsen chronic pain and she quit and felt much better.

As we discussed her breakthrough symptoms with decreasing the dose of opioids, pain was nowhere on the list, it was increasing anxiety and cravings for opioids that came to light as her major struggles. We had an instance where she was extremely anxious about her daughter coming into to town and she took excessive doses of her opioids, feeling completely out of control of her use, and ran out of her opioids >1 week early.

Which led us to our second breakthrough conversation: You are using opioids to treat anxiety not pain.

16- <u>Behavioral Health Interventions that have been tried:</u>

- Weekly psychotherapy
- Volunteering at the library
- Exercise class
- Chronic Pain group

17-<u>Medications Tried for Relapse Prevention? (Specify):</u>
Gabapentin 100 mg scheduled at night, additional 100 mg twice daily as needed

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Oxycodone 5 mg twice daily (from 10 mg three times daily) Morphine 15 mg ER daily (from 30 mg ER daily) Gabapentin 100 mg nightly Capsaicin topical cream Nicotrol inhaler Fish Oil Vitamin B Complex Vitamin C	Major depressive disorder vs. Bipolar I Generalized anxiety disorder PTSD

*Now 30 Morphine equivalents, decreased from 75 Morphine equivalents

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19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
1. Motivated by desire to be part of her children's lives, be social, be active 2. Successfully quit smoking 3. Sees that her life has overall improved with decreasing opioids and tobacco cessation	1. Significant abuse by her mother 2. Mother with an opioid use disorder – treated all types of pain and illness with opioids 3. History of intimate partner violence 4. Undertreated mental health comorbidities with long list of failed attempts at pharmacologic management due to medication side effects 5. Limited social support

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.): N/A

HPI Part III:

For a period of time, after putting in place mental health supports and adding low-dose Gabapentin, she again did well. However, we have recently hit a major bump in the road in our partnership. One day she called me asking me to slow down the taper due to anxiety. I did and asked her to come in to discuss anxiety management. Her UDS was due that day and showed Clonazepam. She called me crying and apologizing BEFORE I got the result.

This required yet another difficult conversation about the fact that she had many times used increased opioids for acute injuries without my consent, requested many early refills, and now had Clonazepam in her urine. These are many breaches of our controlled substance agreement. We agreed that I would continue to prescribe her opioid taper with the understanding that we would pursue a set taper without early refills and would taper her off of opioids completely.

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

UDS 3 months ago: +opioids, +clonazepam

UDS 2 months ago: + opioids, +clonazepam

UDS <1 month ago: +opioids, +clonazepam

22-Prescription Monitoring Program Pertinent Findings:

Multiple early refills as described above

Now I am sticking to my principles of no early refills. I give her opioids in 2 week supply (her idea). Every 2 weeks, she runs out early and calls in withdrawal. She feels completely out of control of her use. Her mental health is worsening in the context of recurrent withdrawal. We are losing a lot of the ground gained in her life and in our partnership…

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23-Proposed Diagnoses:

Moderate opioid use disorder?

DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. **Taking the substance in larger amounts and for longer than intended**
2. **Wanting to cut down or quit but not being able to do it**
3. Spending a lot of time obtaining the substance
4. **Craving or a strong desire to use**
5. **Repeatedly unable to carry out major obligations at work, school, or home due to use**
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use **(?)**
7. **Stopping or reducing important social, occupational, or recreational activities due to opioid use**
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using **(?)**
10. *Tolerance as defined by either a **need for markedly increased amounts to achieve** intoxication or **desired effect** or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. ***Withdrawal** manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

24-Patient Goals for Treatment:

Would like to get off of opioids but having lots of difficulties getting there.

Would like to avoid going through withdrawal.

25- Proposed Treatment Plan:

The next time she runs out of opioids early and is in withdrawal, would she be better served by starting Suboxone instead of continuing the same cycle of treating her withdrawal symptoms and then resuming taper?

By initialing here PNG you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

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Buprenorphine OBOT: Home Inductions

Randall Brown MD, PhD, DFASAM

WI Opioid ECHO

April 19, 2019

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Overview

- Current OBOT recs & induction goals
- Observed vs. unobserved induction
  - Theoretical +'s and –'s
  - Research outcomes
  - Clinical considerations

Induction Goals

- Initiate effective BUP dosing
  - Reduce withdrawal
  - Reduce cravings
  - Stop non-rx opioid use
- Avoid adverse effects
- Establish care structure
  - Sets the tone regarding structure, follow-up, and monitoring
  - Helps establish patient rapport, develop therapeutic alliance

Can this be done with unsupervised inductions?

Guidance on Inductions

- Discuss typical w/d course, fears
  - Consider “abstinence challenge”
- Generally anticipate initial w/d
  - 12-16 hours after short-acting (heroin, oxy, fentanyl)
  - 17-24 for intermediate (oxy ER)
  - 30-48 hours for long (methadone)
- Await Clinical Opioid Withdrawal Scale > 11 (or 6, depending on who you believe)
- Initial 2-4mg SL dose
- Observe x 1 hr
- Up to 16mg total day 1

SAMHSA TIP 40: Clinical Guidelines for Use of Buprenorpine

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Wesson, D. R., & Ling, W. (2003). J Psychoactive Drugs

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Office Induction Allows for

- Ensuring pt knows how to take med
- Enhancement of therapeutic relationship
- Verification of opioid w/d
- Can use time between doses for pt self-assessment/trigger ID/goal setting
- Ensuring lack of sedation in pt w/ sedative-hypnotic use hx

Unobserved Inductions?

- Induction concerns
  - Travel
    - Driving discouraged after med
    - Driving impaired by w/d?
  - Challenge of office induction
    - Fears of precipitated withdrawal
    - 1-2 hr in office
  - Restrictions on office dispensing
  - Waiting area logistics/anonymity
- Potential advantages of unobserved
  - Less resource intensive
  - Pt comfort and preference
  - More in line with customary ambulatory prescribing

Unobserved Inductions

- Unobserved inductions done by 65% of DATA waived MDs in NY (Kermack et al 2017. J Subst Ab Treatment), 42% MA MDs (Walley et al 2008. JGIM.)
- Studies primarily observational
  - Cunningham 2011
    - 79 pts selected home v office (66 and 13 respectively)
    - No difference in opioid use; greater overall drug use reduction in home group
  - Lee 2008
    - 103 home inductions
    - No serious adverse events
      - w/d Sx > 24 hr in 2%
    - Tx retention 60% @ 12 wk
- One RCT (Gunderson 2010)
  - n = 20
  - No difference in adverse events, induction success, Tx retention, dose

Home Induction Protocol

- Assessment while actively using
  - H & P
  - Lab (LFT, UDT, ID serology/vax)
  - Pt selection(?)
- Preparatory office visit
  - Education
    - self-management of w/d
    - induction
    - Follow-up
  - Rx
    - Clonidine + adjuncts
    - limited supply buprenorphine/naloxone
      - 4mg Q 1-4 hr to max of 12mg day 1
- Telephone f/u
- Office f/u within 1 wk

Subjective Opioid Withdrawal Scale

Scale: 0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely

DATE						
TIME						
	SYMPTOM	SCORE	SCORE	SCORE	SCORE	SCORE
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are tearing					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
TOTAL						

Mild = 1–10
Moderate = 11–20
Severe = 21–30

SOWS ≥ 17
(Gunderson RCT)

Handelsman et al 1987. Am J Alc Abuse.

"Bottom Lines"

- Home induction is feasible and prevalent
- Evidence inadequate (low-moderate) to ascertain comparability of home v office inductions on treatment retention etc
- Guidelines (SAMHSA, ASAM) acknowledge home induction as option
- Precipitated w/d → reduced treatment retention
- Complicated/unsuccessful induction associated with
  - Methadone use
  - Recent BZ use
  - Lack of past pt experience w/ buprenorphine
  - Induction dose too low