HEALTH MANAGEMENT ASSOCIATES

DHCS
California Department of HealthCareServices

ASAM Clinical Guidelines for Opioid Use Disorder 2020 Updates

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TODAY'S PRESENTER

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Disclosures:

Dr. Robinson discloses that they are employees of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

At the end of presentation participants will be able to discuss:

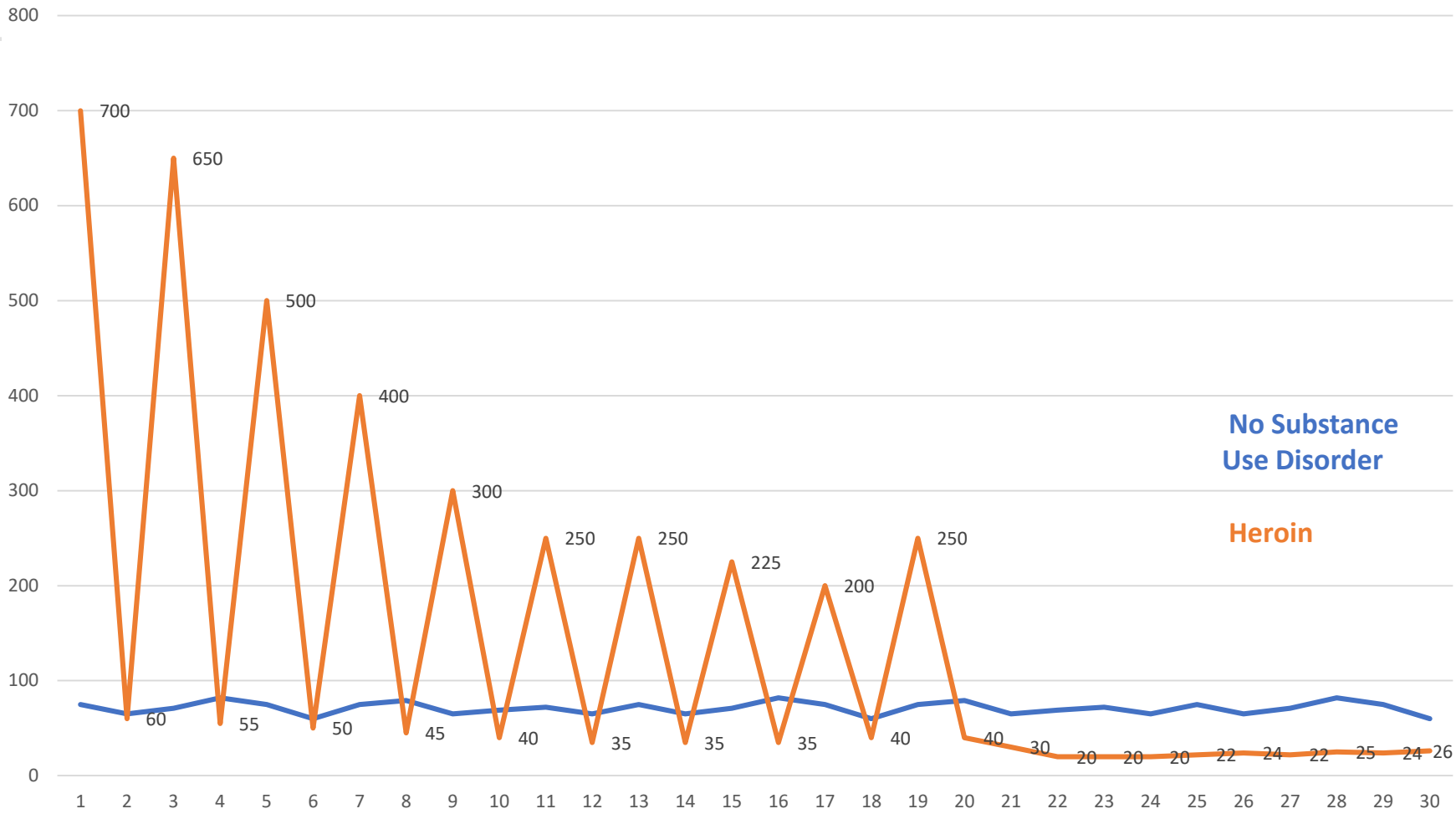
+ 2020 ASAM Updates:
  National Practice Guidelines for the Treatment of
  Opioid Use Disorder (OUD)

+ Standards for treatment of people OUD who are incarcerated

AGENDA

- Introduction
- ASAM Updates on opioid withdrawal
- ASAM Updates on treatment of OUD
- Questions

INTRODUCTION



Dopamine levels vs. Episodes of heroin use

Source: Volkow (2015) Cell, 162 (4), 712-25.

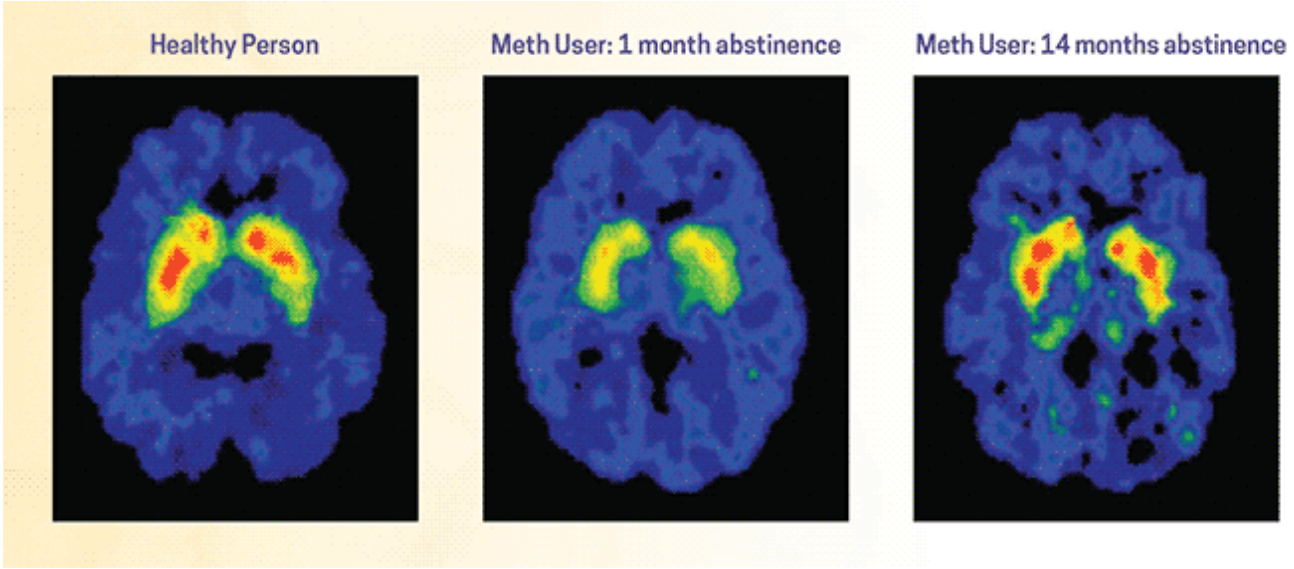
INTRODUCTION

RECOVERY TAKES TIME

- Prolonged drug use changes the brain in long-lasting ways
- And evidence shows that these changes are both functional and structural
- Return to normal takes over 1 year

These images showing the density of dopamine transporters in the brain illustrate the brain's remarkable ability to recover, at least in part, after a long abstinence from drugs—in this case, methamphetamine. [51]

Source: The Journal of Neuroscience, 21(23):9414-9418. 2001



https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

WHY USE MAT?

Treat opioid withdrawal (7days)

- Methadone or buprenorphine is recommended over abrupt cessation due to risk of relapse, OD & death
- Methadone or buprenorphine is more effective than alpha agonists
- Withdrawal management without ongoing treatment is NOT recommended
- Avoid deaths
- Avoid litigation
- Methadone
- Buprenorphine

Address dopamine depletion (>year)

- Reward/motivation pathway
- Persists for months after people stop using

- Methadone
- Buprenorphine

Treat OUD and achieve desired outcomes

- Patients more agreeable
- Patients less disruptive
- Decreased healthcare demand
- Retention in treatment
- Decreased opioid use
- Decreased overdoses
- Decreased ED send outs
- Decreases HIV & HCV
- Decreased criminal behaviors & recidivism
- Decreased death
- Avoid litigation
- Methadone
- Buprenorphine
- Naltrexone

PEOPLE DIE FROM WITHDRAWAL BECAUSE

+ Failure to recognize withdrawal, because of other conditions
+ Failure to take withdrawal seriously
+ Failure to use opioid agonists to treat withdrawal
+ Failure to monitor withdrawal
+ Masking of underlying life-threatening conditions by withdrawal

Opioid Withdrawal

- Fever

- Muscle aches
- Rhinorrhea
- Insomnia
- Nausea & Vomiting
- Diarrhea
- Tachycardia
- Tachypnea
- Anxiety

- Lacrimation
- Dysphoria

COVID-19

- Fever
- Cough
- Shortness of breath
- Muscle aches
- Rhinorrhea
- Insomnia
- Nausea & Vomiting
- Diarrhea
- Tachycardia
- Tachypnea
- Anxiety

Source: Fiscella, 2020 Drug & Alcohol Associated Deaths in US Jails. Journal of Correctional HealthCare 26 (2): 183-93

ASAM 2020 OUD UPDATES: SPECIAL POPULATIONS- CRIMINAL JUSTICE

NEW — Forced opioid withdrawal should NOT occur

NEW — All FDA approved medications should be available

Major Revision — Pts should not be forced to transition to antagonists

Major Revision — Pts with OUD not already in treatment should be assessed and offered individualized pharmacotherapy

Major Revision — If OTP is not available, then an experienced provider can transition from methadone to buprenorphine

ASAM 2020 OUD UPDATES: SPECIAL POPULATIONS- CRIMINAL JUSTICE

Major Revision

Decision to decline, or absence of, psychosocial tx should not preclude or delay pharmacotherapy

NEW

Naloxone kits should be available prior to release with individuals AND families being trained

Major Revision

Coordinate continuity of care to the community

ASAM NEW OR MAJOR UPDATES: OPIOID WITHDRAWAL

Using opioid agonists is recommended over abrupt cessation

Initiate buprenorphine after objective evidence of withdrawal

Provide adequate buprenorphine to suppress withdrawal symptoms

Alpha 2 adrenergic agonists are less effective than methadone and buprenorphine

Withdrawal management is NOT a treatment for OUD

Treatment of withdrawal does not count for buprenorphine limit

ASAM NEW OR MAJOR UPDATES: ASSESSMENT AND DIAGNOSIS

Completion of assessment should not delay or preclude pharmacotherapy

ASAM NEW OR MAJOR UPDATES: TREATMENT OPTIONS

All FDA approved medications should be available to all patients

Pts decision to decline or absence of psychosocial treatment for SUD should not preclude or delay pharmacotherapy

Use of other substances (including benzodiazepines) are NOT contraindications to pharmacotherapy

There is no recommended time limit for pharmacological treatment

Offer or refer to appropriate level of care with qualified Behavioral Health provider

Psychosocial treatment for SUD is NOT the same as treatment for criminogenic thinking

ASAM NEW OR MAJOR UPDATES: BUPRENORPHINE

- Buprenorphine is a recommended treatment for OUD
- Office based and home-based induction are safe
- Start with 2-4mg and increase in 2-8mg increments
- >16mg may be more effective than lower doses
- Buprenorphine discontinuation is a slow process accomplished over several months
- Be mindful of emerging evidence as it becomes available with new formulations*

ASAM NEW OR MAJOR UPDATES: METHADONE

Initial dose ranges from 10mg to 30mg

Typical daily dose of methadone ranges from 60-120mg

Pts should be on ≤30-40mg methadone before being transitioned to buprenorphine

Methadone is recommended for pts who are unsuccessful with buprenorphine for OUD

Methadone is recommended for pts who may benefit from daily dosing

ASAM NEW OR MAJOR UPDATES: EXTENDED-RELEASE NALTREXONE

- A recommended treatment for preventing relapse to opioid use disorder
- Administer in the gluteus q 3-4 weeks
- Oral naltrexone is not recommended except in highly motivated patients, unable to take XR, observed dosing
- Transition to agonist can successfully occur after 1 day for oral and 28 days for injectable
- Increased risk of death if return to illicit drug use, due to loss of tolerance

ASAM NEW OR MAJOR UPDATES: SPECIAL POPULATION-CO-OCCURRING

Do not exclude people with psychiatric disorders from MAT

Offer or refer to appropriate level of care with qualified BH provider; address any life- threatening issues

Completion of all assessments should not delay or preclude pharmacotherapy

ASAM NEW OR MAJOR UPDATES: SPECIAL POPULATION PREGNANT WOMEN

- Assess for urgent medical conditions requiring immediate referral
- Agonist treatment for pregnant women who are physiologically dependent
- Informed consent for toxicology includes reviewing adverse legal and social consequences
- Twice daily dosing is more effective & has fewer side effects
- Agonist recommended for pregnant women with OUD; if already on naltrexone, then weigh risks & benefits of naltrexone compared to alternatives

ASAM NEW OR MAJOR UPDATES: SPECIAL POPULATIONS- PAIN

- Make an accurate diagnosis
- Utilize nonopioid meds, behavioral therapy, physical therapy and procedural approaches
- For pts with pain AND an active OUD, consider methadone or buprenorphine
- For pts on methadone or buprenorphine increase dose or dose frequency
- For pts with OUD who have pain, medication requirements will be higher than those without OUD
- Pts on buprenorphine can be administered as needed doses of buprenorphine
- Short acting (high potency) agonists can be effective when pts are on methadone or buprenorphine
- Discontinuation before surgery is NOT required; if discontinued, then resume when need for agonists resolved
- Naltrexone should be discontinued 3 days (oral)/ 30 days (injectable) before planned surgery
- Naltrexone can be overcome by use of high potency full agonist

ASAM NEW OR MAJOR UPDATES: SPECIAL POPULATIONS- ADOLESCENTS

Utilize your full range of treatment options, including 3 FDA approved pharmacotherapy, when indicated

Specialized treatment programs may be beneficial

Absence of or declining psychosocial treatment should not preclude or delay pharmacotherapy

Risk reduction interventions are recommended: safer injection practices & safer sex practices

ASAM NEW OR MAJOR UPDATES: NALOXONE

Should be administered in suspected overdose

Should be administered to pregnant women in case of overdose

Patients and families should be trained on administration

First responders should be authorized to carry and administer

Naloxone should be available to everyone with OUD

In CA it's the LAW

AB 2760

1-1-2019

DASHBOARD QUESTION: ARE ALL DETAINEES WITH OUD PROVIDED WITH NALOXONE AT RELEASE?

- **POLLING QUESTIONS:**
  - **DO DETAINEES LEAVE WITH NALOXONE IN HAND?**
    - Yes
    - No
  - **POLLING QUESTION # 2: IF NOT, THEN DO DETAINEES LEAVE WITH A PRESCRIPTION FOR NALOXONE?**
    - Yes
    - No
    - NA
  - **POLLING QUESTION # 2: IF NOT, THEN DO DETAINEES LEAVE WITH INFORMATION ON WHERE TO OBTAIN NALOXONE IN YOUR COUNTY?**
    - Yes
    - No
    - NA

ASAM AND THE STANDARDS OF CARE: MEDICATION FIRST

2003: Initiation and continuation of MAT was contingent upon	Outcomes: Continued use of opioids & possible death	2020: Medication is	Outcomes: Buprenorphine blocks opioid receptor & prevents OD & death
being face to face in clinic to look for evidence of IVDU and withdrawal symptoms	☹	Not contingent	☺
completion of a biopsychosocial assessment	☹	Not contingent	☺
completion of lab work	☹	Not contingent	☺
use of no other substances and no relapses	☹	Not contingent	☺
attending therapy	☹	Not contingent	☺

BARRIER TO TREATMENT: CONTINUITY OF CARE

- At first dose of in-custody buprenorphine, provide every detainee with information card on how to access buprenorphine if jail release is precipitous
- Work with county Public Health, Opioid Coalition, harm reduction folks, probation, courts, advocates to assure that detainees on MAT are a priority population at release
  - Assessments done in jail accepted by community providers
  - Immediate access to counselling and MAT upon release
  - Track engagement in community treatment, recidivism, overdoses

POLLING QUESTION

You are completing Mr. Johnson's SUD assessment. Mr. Johnson, agreed to start on buprenorphine when he saw the prescriber. Along with the medication, you refer the patient for counselling. But Mr. Johnson does not want to attend any counselling sessions. He said he's tried this before and feels it's a waste of time. What is the best next step?

1. Tell Mr. Johnson all patients must agree to counselling in order to receive MAT.
2. Tell Mr. Johnson to just say he's going to therapy so that he can get the medication.
3. Let Mr. Johnson know that counselling is optional and its up to him.
4. Let Mr. Johnson know that counselling can be a helpful part of recovery, and you respect his desire to not attend counseling right now.

QUESTIONS

NEXT STEPS

- Please look for a follow-up email with:
  - A poll with a brief evaluation - We appreciate your feedback!
  - A link to the recording of today's webinar and the slides for reference: Feel free to forward to others on your team.

- Save the dates for the next webinars in the series – invites coming soon!
  - October 7 Stimulant Use Disorder
  - October 13 Injectable Buprenorphine
  - November 11 Methadone
  - December 3 Opioid Withdrawal Management- COWS Training

- For more information, please contact your HMA Coach
  - Donna Strugar-Fritsch: dstrugarfritsch@healthmanagement.com
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  - Bren Manaugh: bmanaugh@@healthmanagement.com
  - Shannon Robinson: srobinson@healthmanagement.com

Thank you and stay safe!

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- https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications
- Ling W et al. (2013) Comparison of behavioral treatment conditions in buprenorphine maintenance. Addiction 108(10)
- http://www.NoMoDeaths.org/medication-first-implementation
- https://www.mbc.ca.gov/Download/Documents/AB2760FAQs.pdf (naloxone prescribing FAQs)

Evaluation for today's webinar

1. Overall, today's webinar was:
   - A. Very useful
   - B. Somewhat useful
   - C. Not very useful
   - D. Not useful at all

2. The material presented today was:
   - A. At the right level
   - B. Too basic
   - C. Too detailed