Sharing the Wealth

Disseminating Addiction Skills Across Clinical Settings

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META:PHI

September 20,2019

Contention:

RAAM clinicians are perfectly positioned to impact our colleagues' knowledge, skills and attitudes with respect to patients with substance use disorders

Strategies:

- Lectures/workshops/rounds
- Journal clubs
- Observerships
- Mentorship
- Consultations

Ken Lee - Disclosures

- Grants/Research Support: ARTIC META:PHI
- Speakers Honoraria: Indivior, Knight, Merck, Gilead, Specialty RX
- Consulting: CPSO, NIHB, MOHLTC, VAC/DND, CEP, OCFP
- Patents: none

Jennifer Wyman- Disclosures

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- Consulting Fees: none
- Patents: none
- Other: Salary support from Ministry of Health and Long-Term Care for leading the Opioids Clinical Primer

Lori Regenstreif - Disclosures

Relationships with financial sponsors:

- Grants/Research Support: none
- Speakers Bureau/Honoraria: Indivior Information evening on RAAM Clinics, Ontario College of Family Physicians
- Consulting Fees: none
- Patents: none

Knowledge-sharing opportunities for Primary Care

Sharing the Wealth

Dr. Ken Lee, London RAAM Clinic

Canadian Mental Health Association
Mental health for all

Thames Valley Family Health Team

Buprenorphine/Naloxone Microdosing: The Bernese Method

A Brief Summary for Primary Care Clinicians

Disclaimer:

Microdosing principles are currently not included in any clinical practice guidelines for the management of Opioid Use Disorder, rather it is an off-label practice that has been included in clinical practice amongst addiction specialists. It is therefore important to obtain informed consent prior to initiating it with a patient. Microdosing is frequently used at the London Rapid Access and Addictions Medicine (RAAM) Clinic with good results.

What is Microdosing?

The Bernese Method uses the principle of Microdosing to initiate a patient onto buprenorphine/naloxone (bup/nlx) maintenance therapy. The theoretical background of this method is based on the following hypotheses:

1) Repetitive administration of very small buprenorphine doses with sufficient dosing intervals (e.g. 12 hours) should not precipitate opioid withdrawal
2) Because of the long receptor binding time, buprenorphine will accumulate at the opioid receptor
3) Over time, an increasing amount of a full μ-agonist will be replaced by buprenorphine at the opioid receptor

Therefore, overlapping induction of buprenorphine with ongoing use of opioids, from the unregulated drug market or prescription, including maintenance doses of a full μ-agonist (e.g. methadone or sustained release oral morphine), should be possible without precipitating severe opioid withdrawal. Mild withdrawal symptoms may be experienced during the induction.

Although dosing schedules vary, principles of the Microdsoing method include:

1) Prescriber starts with a low dose of buprenorphine, overlapping with other opioid use
2) Small daily buprenorphine dose increases
3) Abrupt cessation of opioid use at sufficient dose of buprenorphine

Why use it, and who is a good candidate?

Microdosing may have considerable advantages despite taking longer for the overall induction than the traditional protocol. It may be useful for <u>most</u> patients. In more detail:

- It may be helpful for patients fearing withdrawal or experiencing severe symptoms during conventional induction, or who have failed conventional induction due to inability to tolerate withdrawal symptoms

May 2019

Dr Ken Lee London RAAM Clinic

Who was involved?

- RAAM Clinic Physician
- RAAM Clinic Nurse Practitioner
- Centre for Effective Practice (Academic Detailer)
- Thames Valley FHT (Pharmacists)

How was it done?

- Teaching tool was adapted from Vancouver Coastal Health
- Met with Dr. Robert Hammig in Bern, Switzerland
- London RAAM Clinic Nurse Practitioner (Katie Dunham) was the lead writer
- Thames Valley FHT Pharmacist (Payal Patel) was the assistant writer
- Ken Lee provided moral support

RAAM Clinic Preceptorships

- Centre for Effective Practice Academic Detailer (Pharmacist Nicole Seymour)
- Family Health Team Pharmacists
- Interested Family Physicians & NP's (find someone who's interested in taking up the cause for their practice group)

Other participants:

- Residents (Family Medicine, Pain Fellows, Internal Medicine, Emergency Medicine, Addiction Medicine, Psychiatry, Clinical Pharmacology Fellows)
- Community Pharmacists
- Hospital Pharmacists
- Social Workers & Addiction Counselors

Ongoing Support

- Telephone Consults
- Email Consults
- Text Consults
- OCFP MMAP
- OTN e-Consults
- METAPHI online discussion group
- Addiction Medicine Journal Club

Addiction Medicine Journal Club

- Unrestricted Educational Grant to “Master Clinician”
- “Master Clinician” applies to CFPC for MainPro + study credits (approved for 2.0 hrs per monthly session for one year)
- “Master Clinician” sends out the invites, collects RSVP’s, collates the evaluations forms, prints the Study Credit certificates
- “Master Clinician “ uses the monies to have take out food delivered to the meeting

- No speaker fees
- Food encourages participation
- Brief presentation followed by lots of discussion

New Expertise

London:

Springbank Family Medical Centre (Dr Jeff Spence)

Thompson Medical Centre (Dr Brenna Velker)

Westmount Medical Centre (Dr Dawid Martyniak)

St Joseph's Family Medical Centre (Dr Laura Lyons)

St Thomas:

Windermere Medical Clinic (Dr Joe Mai)

Woodstock:

Oxford CHC (Dr Kevin Dueck, Sonya Scholarchos NP)

Lessons Learned

The key to spreading the word is networking by developing relationships and personal contacts

“People are more likely to help you if they know you and like you”
Lori Lee, RN

ken.lee@sjhc.london.on.ca

Knowledge-sharing opportunities for Primary Care

Dr. Ken Lee, London RAAM Clinic

Knowledge-sharing through Consult Letters and Communications with Colleagues

Sharing the Wealth

Jennifer Wyman, RAAM Clinic, Women's College Hospital, Toronto

Consult letters = Opportunity for Education

Useful tips and pointers

Guidance around follow-up

Links to resources and references

Common pitfalls

LU codes

Safer prescribing strategies

- Don’t dispense more than 30 days of opioids/BZDs/gabapentinoids, even to stable patients; consider more frequent dispensing if concerns are present
- Co-prescribing of benzodiazepines and opioids should be avoided in all patients whenever possible
- Store medications out of sight and out of reach; suggest locked boxes for storage of all opioids.
- Unused medications should be returned to a community pharmacy.
- All patch formulations (fentanyl and buprenorphine) should be managed with a **patch exchange** policy

What to do if you recognize that a patient has an opioid use disorder

Do NOT stop opioids suddenly:

Sudden and intense withdrawal symptoms can lead patients to engage in risky and illegal activities to secure opioids;

Loss of tolerance can lead to overdose if patients use their previous amounts

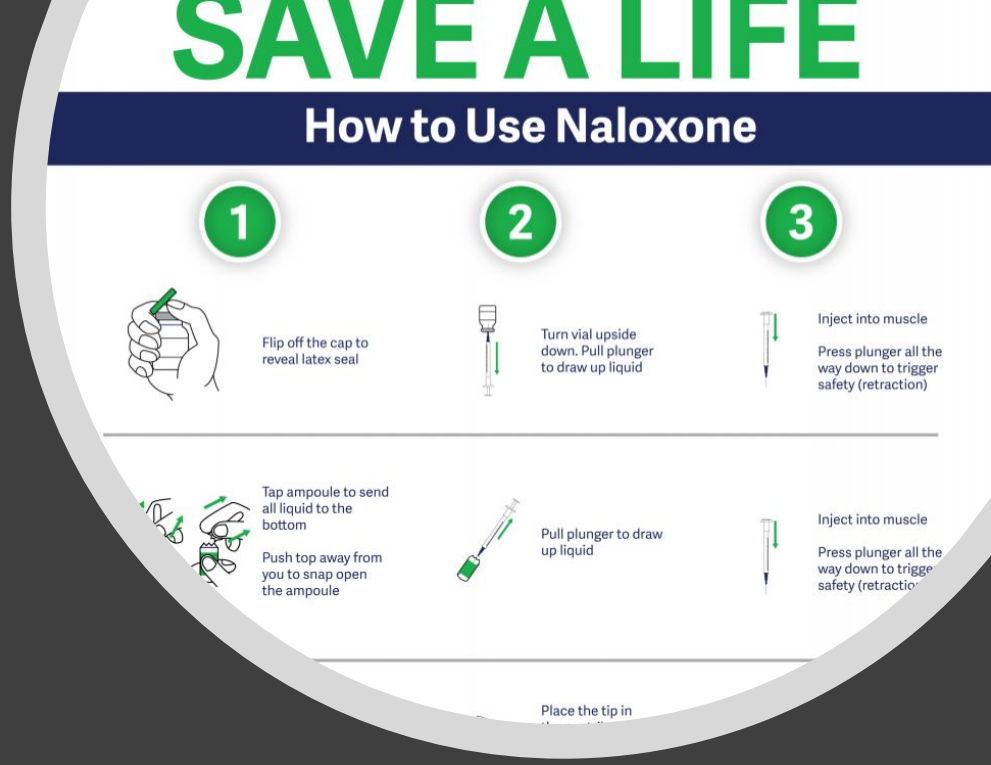
DO continue prescribing in tightly controlled quantities until there is a plan in place, e.g. dispensed twice weekly or even dosed daily at the pharmacy

DO recommend a naloxone kit; available free from pharmacies and Harm Reduction Agencies

Naloxone Kits

Should be offered to:

- Every patient on higher dose opioids
- Every patient who uses street opioids
- Patients who may have an opioid use disorder
- Family members or friends of those with opioid/illicit drug use and those who take prescription opioids
- Free from the pharmacy: adding a notation to the prescription asking the pharmacist to dispense a kit increases the likelihood that a patient will actually receive one



Overlap between mental health and substance use disorders

Depression, anxiety and trauma are all associated with higher risks of both chronic pain and substance use disorders

Offer info about ACEs: https://www.cdc.gov/violenceprevention/acestudy/about.html

Patients do better when both their substance use and mental health disorders are treated concurrently; treatment of the SUD typically starts first, but treatment of the mood/anxiety disorder does not require and should not wait for abstinence

Nonpharmacologic strategies and supports are important tools for developing healthier coping mechanisms. symptom management and coping skills. Consider mentioning tools like:

Big White Wall

Bounce Back Ontario

Anxiety Canada

Apps: Mindshift, SoberTool

More about BZDs

- Comment on risks with opioids
- Avoid long term BZDs in people with anxiety, especially those on opioids or with co-existing SUDs
- Consider deprescribing BZDs with guidance from the following tools:
  - deprescribing.org
  - The Ashton Manual
  - CEP Benzodiazepine Tool

- Similar risks with high dose gabapentin/pregabalin

Alcohol Strategies

- Withdrawal - avoid ongoing prescriptions for BZDs
- Treat for 4-5 days max, caution with prescribing criteria
- Consider gabapentin as an alternative
- Studies have shown that anti-craving medications such as acamprosate and naltrexone are effective in the treatment of alcohol use disorders
- Anti-craving medications should be continued for at least 6 months

LU codes: Naltrexone LU 532
Acamprosate LU 531

Using anti-craving medications for AUD

- Both naltrexone and acamprosate can be safely used long-term, with the following precautions:
- Naltrexone is an opioid blocker and should not be used in patients on opioids
- Patients on naltrexone should have their liver enzymes checked every 3-6 months; medication should be held if liver enzymes rise more than 3-fold
- Acamprosate should not be used with significant renal disease

Naltrexone

- Naltrexone can be easily restarted patients whose drinking has begun to escalate afer a period of stability, or who notice an increase in cravings
- Start at 25mg OD x 3 days to avoid GI side effect then increase ot 50mg/day
- It is not necessary to abstain from alcohol before starting naltrexone, whereas it is advisable to be abstinent from alcohol for 2-3 days before starting acamprosate
- It is worth retrying whichever medication has worked in the past but switching medications if the desired response is not achieved

Additional Supports

- OCFP Mentorship Programs https://ocfp.on.ca/cpd/collaborative-networks/mmap
- RAAM Clinics/META:PHI http://www.metaphi.ca/raam-clinics/
- HQO Ontario Pain Management Resources
- Centre for Effective Practice https://cep.health
- Opioids Clinical Primer machealth.ca

Opioids Clinical Primer

This six-part program provides an overview of key concepts and skills for clinicians facing common challenges in the management of patients with chronic pain, including reducing the risks of opioids and addressing opioid use disorder.

Welcome to the Opioids Clinical Primer. The six courses in this program are organized into two streams, Managing Opioid Use Disorder and Managing Chronic Pain. Each is comprised of three courses. Get started by exploring the individual courses and associated resources including the Buprenorphine Reference Guide.

Managing Opioid Use Disorder

Managing Chronic Pain

Featured Resources

Buprenorphine Reference Guide

This guide has been developed to complement the Opioids Clinical Primer CPD series and includes an overview of buprenorphine/naloxone pharmacology; guidance for initiation, dosing, managing and writing buprenorphine/naloxone prescriptions; and the role of urine drug testing. Click for more information.

Brought to you by:

Ontario · University of Toronto · McMaster University · Lakehead/Laurentian Medicine · Northern Ontario School of Medicine · uOttawa · Western University · Queen's University

Courses

- Managing Chronic Pain
- Managing Opioid Use Disorder

Resource Categories

- Course Handouts
- Patient-Oriented Resources
- Clinical Tools
- Buprenorphine Reference Guide
- Continuing Professional Development Opportunities
- Additional Supports and Services
- Evidence, Guidelines and Recommendations

More

- About
- Promote
- Acknowledgements

Want to receive updates for new tools and resources? Sign up for alerts using the button below!

Receive course a

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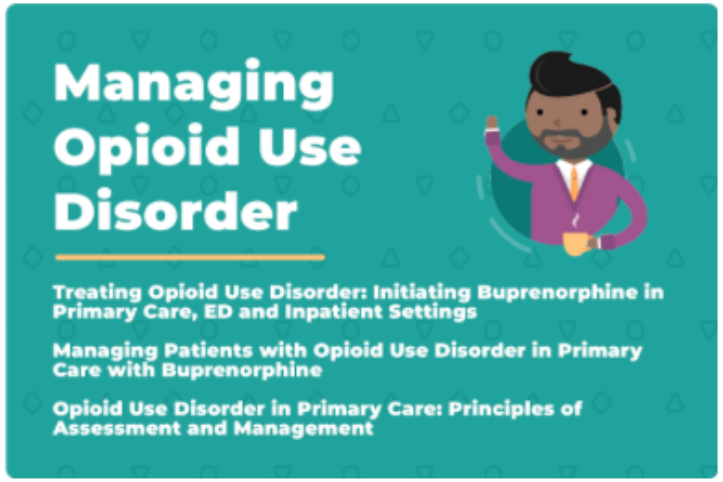
Managing Opioid Use Disorder



Managing Chronic Pain

Featured Resources

Buprenorphine Reference Guide

This guide has been developed to complement the Opioids Clinical Primer CPD series and includes an overview of buprenorphine/naloxone pharmacology;

Courses

Managing Chronic Pain

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More

About

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Knowledge-sharing opportunities for in-patient addiction care

Sharing the Wealth

Lori Regenstreif, St. Joseph's Healthcare Hamilton RAAM Clinic

Hamilton Hospital Opioid Treatment Team

- Five MDs – cover 2 inner city hospitals
- RAAM located at one of the hospitals
- At RAAM we see about 75% AUD:25% OUD
- Hospital team – we see only OUD patients
- AUD referrals can be seen by addiction workers and referred to RAAM on out-patient basis

- Majority of in-patient MD care and knowledge-sharing is around OUD, IV drug use and harm reduction

Who partakes in this knowledge exchange?

- Nurses
- Social workers
- Pharmacists
- Nurse-practitioners
- ER staff
- Hospitalists
- Specialist staff – medical, surgical, obstetrics, pediatrics
- Residents
- Medical and nursing students
- Patients
- Us

What do we have to share that is most valuable?

- **Knowledge and Experience about:**
  - The DRUGS
  - The DISEASE
  - The PATIENT

THE DRUGS

The DRUGS:

1. Methadone – drug-drug interactions, cardiac issues (ECG, ♥ hx), managing acute pain and W/D with short-acting opioids during titration, missed doses,
2. Suboxone – how to avoid precipitating withdrawal, sublingual route – not mixing pill in with other meds in cups
3. Kadian – long-acting morphine, once daily, sprinkle onto apple sauce or yoghurt
4. Naloxone kits - turn into routine
5. Naltrexone – cannot be given with opioids; LFTs
6. Acamprosate – availability?

*Get them onto the hospital formulary

*Link with pharmacy for mutual coaching

LB

Pt in ED. Frequent admissions past year, infections – TVIE, abscesses, MRSA bacteremia

Most recently left AMA after TVR 2 weeks ago. On Suboxone 16 mg when he left

Febrile, septic, SOB, in W/D, used fentanyl early in the morning

Given Suboxone 16 mg……collapses…cardiac arrest, intubated, resuscitated, 4 days in ICU. Now refusing suboxone

On Kadian 100 mg daily plus high-dose IV HM Q1-2H PRN. Afraid to restart Suboxone

The following week – rapid microdosing is re-started, after much coaxing

Refused (micro)doses x 2 days , then Day 3 accepted 2mg

Pt given full 2 mg on Day 3.
But…PO

THE DISEASE

MB

23F G6P3 24wks GA, admitted through ER for vag bleeding. Dx: placenta previa

No PN care; unplanned pregnancy, sex trade, street involved, homeless, using IV fentanyl.

Consult: “please start the patient on methadone”. Day 2 gets methadone 30 mg

Day 3 – discharged. “Not engaging in care” and “we have nothing to offer her"

No ID*; no OHIP card*; no fixed address*

3 days after D/C, OB calls to report VDRL+ syphilis and needs to be treated.

10 weeks later, pt delivers at 35 wks – neonatal syphilis, prolonged infant admission

The Culture

"How to talk so patients will listen and listen so patients will talk"

Sick, homeless, pre-contemplative

- Harm reduction strategies – HCPs unfamiliar or put off by patient realities
- Provide sharps container at bedside, “cleans”
- If patient leaves to drink or use drugs, adjust sedating meds but don’t change treatment plan or course of admission
- Advise prolonging a "routine" admission
- Find a shelter bed and pay for a taxi when they do leave, even AMA
- Talk about trauma and ACE scores to learners
- Acknowledge and address the frustrations of the work (who better to understand than us?)

Aim to increase future health care-seeking

Ask: What goals do you share with the patient?

- Comfort and pain relief
- Acceptance of treatment (“compliance”)
- Reducing chance of future admission
- Harmony
- A shift in thinking

  -the patient: “maybe something good *can* happen when I seek help”

  -the staff: “maybe these patients *do* need my help”

  -the addiction team: “humans are too complicated; I’m going home”

Most hospital encounters are teachable moments

Inform	Patient's nurse, NP, social worker, MRP/SMR and explain tx and discharge plans.
Encourage	Encourage questions and communication between and within teams
Offer	Offer rounds through pharmacy, nursing, medical teams to discuss Inclusion in case conferencing
Facilitate	"Detailing" for pharmacists Communication between hcp's

↑ morphine — currently 8mg PRN
∴ ↑ morphine 12mg Q4H
+ morphine 4-6mg q1-2H PRN

1.

* Suboxone at doses of 12-16mg may interfere with pain control by short-acting opioids.

2. Split dosing of Suboxone may helps with pain control

3. Higher doses of opioids will be needed in the short term

PubMed.gov
US National Library of Medicin
National Institutes of Health
PubMed
Advanced
Format: Abstract
Send to

Can J Anaesth. 2019 Feb;66(2):201-217. doi: 10.1007/s12630-018-1255-3. Epub 2018 Nov 27.

The perioperative patient on buprenorphine: a systematic review of perioperative management strategies and patient outcomes.

Goel A[1,2], Azargive S[3], Lamba W[4], Bordman J[4], Englesakis M[5], Srikandarajah S[6], Ladha K[1,7], Di Renna T[1], Shanthanna H[8], Duggan S[3], Peng P[1], Hanlon J[1], Clarke H[9,10].

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SHARE THE WEALTH AND LIGHTEN THE LOAD

- The more successful we are at sharing the knowledge and collaborating, the lighter the load and the better the care.

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Knowledge-sharing opportunities for in-patient addiction care