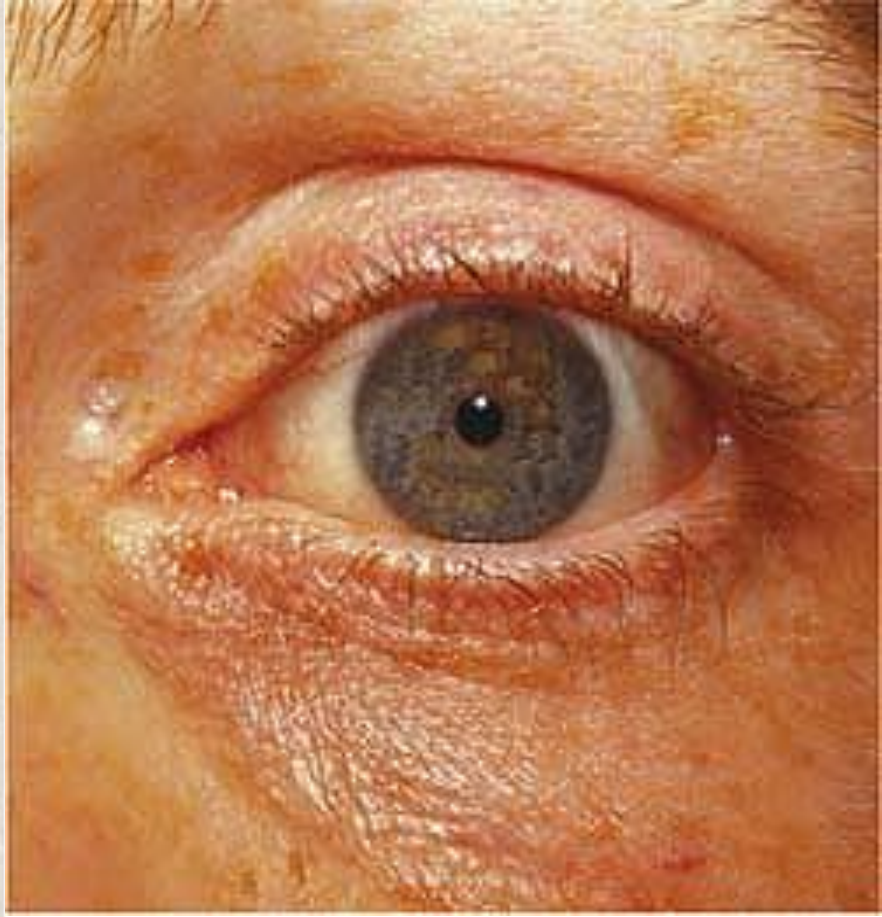
INTER-PROFESSIONAL EFFORTS TO CURB OPIOID DEPENDENCE

Paul Brasler, L.C.S.W.

Daily Planet Health Services

Richmond, Virginia



- Sedation
- Nausea
- Constipation
- Pinpoint Pupils
- Slowed Breathing
- Coma & Death

3

SCOPE OF THE PROBLEM

VIRGINIA DEPARTMENT OF HEALTH

FATAL DRUG OVERDOSE REPORT
FIRST QUARTER 2018

VDH REPORT: MAIN TAKEAWAYS

- Fatal drug overdose has been the leading method of unnatural death in Virginia since 2013
- Opioids have been the driving force behind the large increases in fatal overdoses since 2013
- In 2015 statewide, the number of illicit opioids deaths surpassed prescription opioid deaths. This trend continued at a greater magnitude in 2016 and 2017 (an average of 4 deaths per day)
- There has not been a significant increase or decrease in fatal prescription opioid overdoses over the 10 year time span (2007-2016)
- Fentanyl (prescription, illicit, and analogs) caused or contributed to death in over 50% of fatal overdoses in 2017

VDH REPORT: MAIN TAKEAWAYS

- Rural areas of Virginia have the highest mortality rates due to prescription opioids while urban areas have the highest mortality rates due to illicit opioids
- Virginia experienced the largest increase (38.9%) in the number of fatal overdoses on record in 2016 compared to 2015. Although 2017 numbers surpassed those of 2016, the rate of change (7.6% increase) was not as significant as that seen in 2016 compared to 2015
- Preliminary statistics calculated to predict 2018 final totals suggest that the total number of all fatal overdoses may actually decrease compared to 2017

TRADITIONAL PATHS TO DEPENDENCE

"Denny"

- Upper-middle class background
- Raised by two parents
- No history of family violence
- Both grandfathers were alcoholics
- Started drinking as a teen, progressed to heroin by 19
- Numerous opportunities and attempts at treatment
- Family remains supportive and concerned throughout
- Died of a heroin overdose at age 23

"Ashley"

- Low socio-economic background
- Raised by a single mother; father not identified
- Extreme family violence
- Molested at age 7, first rape at age 11 by uncle
- Started smoking marijuana by 12, progressed to heroin by age 20
- Jailed for prostitution and drug possession, no offers of treatment
- Stuck in a sexually-abusive situation for housing and money for drugs

A NEWER PATH TO DEPENDENCE

"Shirley"

- No history of any substance of abuse
- Work-related back injury in 2007
- Prescribed OxyContin by Primary Care Provider for pain
- Tolerance develops, so dosage is increased
- Medical provider becomes concerned about possible dependence, so dosage is decreased
- Shirley starts running out of medication early and starts to purchase illicitly (~$1.00 per mg on the street); loses housing
- She soon realizes that heroin is cheaper, and stronger, so she starts to purchase it instead

9

MAT AT DAILY PLANET HEALTH SERVICES

OUR PREFERRED MAT/OBOT

- Our MAT utilizes buprenorphine/naloxone as an opioid substitute
  - Our medication is prescribed electronically and distributed via commercial pharmacies off-site
- "Aren't you just replacing one drug for another?"
  - In a word: Yes
  - The difference is that one is produced per federal guidelines while the illicit option could be anything (heroin, fentanyl, cornstarch, aspirin, etc.)
  - Our medication keeps people from getting sick, providing them with the opportunity to stop using heroin without getting sick
  - Buprenorphine is safe when taken as directed
  - Clients can remain on the medication as long as they choose

OUR PREFERRED MAT/OBOT

- We operate 8 MAT "clinics" per week (each client is assigned to a specific clinic—no more than 10 clients per clinic)
- Each clinic involves the client doing the following:
  - Vital signs are checked by a Medical Assistant
  - Client provides a Urine Drug Screen (which may be sent to a lab for further validation)
  - Prescription-Monitoring Program (PMP) reports are checked for each client
  - Client attends a psychotherapy group
  - Client meets individually with prescriber (if needed)
- Clients can also attend additional groups and/or individual therapy during the week
- Clients meet with the case-manager as needed

OUR MAT TREATMENT PHASES

	Phase 1	Phase 2	Phase 3	Phase 4
Prescriber	Weekly	Bi-Weekly	Monthly	Monthly
Group Therapy	Weekly	Weekly	Bi-Weekly	Monthly
PMP & UDS	Weekly	Bi-Weekly	Monthly	Monthly
Minimal Length of time	4 Weeks	8 Weeks	13 Weeks	None

OUR MAT CLINIC

- Medical, oral health and behavioral health services are closely aligned—clients can enter MAT through another services
- Once in the MAT clinic, clients can also access other services in our agency, including oral health
- It is not unusual for our MAT to receive referrals from our dental office
- We utilize in-service trainings to educate all staff on emerging drug trends, changes to our programs, etc.

CARE COORDINATION BEST PRACTICES

- Walk-in and call-in scheduling are a must—clients should have access to treatment when they are ready
- We have found that contact with a clinician early in the registration process is key. Speaking with someone who understands substance dependence and treatment appears to relax the client. Initial data suggests that this also improves adherence to beginning treatment
- We try to personally introduce clients to the staff they will have direct contact with as quickly as possible
- We also try to determine what the clients' needs are as quickly as possible to mobilize whatever services we have available to help the client
- This includes screening for Medicaid GAP

We really do have a solution to the opioid epidemic — and one state is showing it works

Virginia shows how Medicaid can help end the opioid crisis.

By German Lopez for Vox

REFERENCES

- Bourgois, P. & Schonberg, J. (2009). Righteous Dopefiend. Berkley: University of California Press.
- Comptom, W.M., Jones, C.M., & Baldwin, G.T. (2016) "Relationship between Nonmedical Prescription-Opioid Use and Heroin Use." The New England Journal of Medicine 374(2). 154 – 163.
- Darke, S. (2011). The Life of the Heroin User: Typical Beginnings, Trajectories and Outcomes. New York: Cambridge University Press.
- Inaba, D.S. & Cohen, W.E. (2014). Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs, Eighth Edition. Medford, OR: CNS Productions, Inc.
- Li, X., Shorter, D., & Kosten, T.R. (2016). "Buprenorphine Prescribing: To Expand or Not to Expand." Journal of Psychiatric Practice, Volume 22(3). 183 – 192.