Supporting Medication Management

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Land Acknowledgment

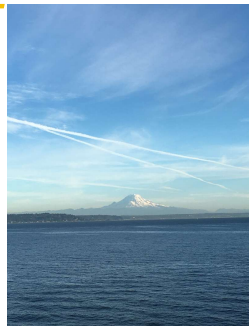

Photo Credit: Paul J Barry

The University of Washington acknowledges the Coast Salish people of this land, the land which touches the shared waters of all Tribes and bands within the Duwamish, Suquamish, Tulalip and Muckleshoot nations.

https://native-land.ca/

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• CHECK IN

- Approaching the end of the recruitment period- feelings?
- Medication management

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Discussion

On a scale of 1-5, what is your current comfort level talking to patients about psychiatric medications?

- 1 not comfortable
- 2 okay
- 3 very comfortable

How about Medications for Opioid Use disorder?

How about "adjunctive" medications (comfort meds for managing withdrawal) ?

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BHCM role in Medication Management

- Gathering medication history
- Psychoeducation
  - Rationale/how medications work
  - Familiarity with the reasons why medication trials fail
- Supporting treatment adherence
  - Barriers/concerns
  - Management of common benign side effects
  - Adherence is a big deal
    - Real-life medication adherence probably less than 50%!
- Monitoring response and communication with CoCM team

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Discussion

- How are these elements of the role different in supporting management of MOUD?
  - Medication history
  - Psychoeducation
  - Supporting adherence
  - Monitoring response

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Providing Education

- Managing misconceptions
- Ensure patient has information about medications-MOUD and Narcan (handouts, websites etc.)
- Ask for concerns about medications or plan
- Anticipate common challenges and questions
- Consult with CoCM team

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Helping to Manage Expectations

When will the medications work?
- "It can take several weeks before you stabilize on the right dose"

Realistic goals and timetables
- Encourage further recovery supports

What will getting better look like?
- Patient may be able to tell you, but PHQ9 GAD & OTRI can too!

What about side effects?
- Withdrawal concerns in particular

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Adjunctive Medications to Manage Withdrawal "Comfort Meds"

- Common effects of withdrawal
  - Fever, sweats, watery eyes, runny nose, shaking, yawning, itching, goose flesh, light sensitivity, nausea, and diarrhea
- Adjunctive/comfort meds
  - Offered to counter some of these effects of withdrawal.
    - Alpha-2 agonists (Clonidine-diarrhea, vomiting, cramps)
    - Analgesics (ibuprofen- pain fevers, chills)
    - Antihistamines (Zyrtec, Benadryl- itchiness, runny eyes and nose)
    - Anti nausea/anti diarrhea meds (Ondansetron, Immodium)
- More challenging side effects,
  - Insomnia, psychological issues- anxiety, cravings
    - Buprenorphine

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Discussion

- What are some common challenges to starting MOUD?
  - Let's talk about precipitated withdrawal

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Exploring Patient Concerns

- Questions to ask patients
  - How is this medication working for you? What has improved? Anything worse?
  - Any side effects? What, when, how much do these bother you?
  - Do you think this medication is helping you reach your goals?

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MOUD Treatment- Anticipating Challenges

- Are you taking the medication every day?
- Anything getting in the way of taking the medication?
- Are your family and friends supporting you in taking medication?
- How do you keep the meds safe?
- How are you managing side effects and cravings?

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Anticipate and Troubleshoot Specific MOUD Adherence Challenges

- Challenges at the Pharmacy
- MISSED PROVIDER APPTS
  - Treatment Agreement details
- Lost medications
- Lack of faith/hope, stigma

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Rates of successful Medication Initiation (Induction)

- Kurz study of 45,608 patients receiving *opioid agonist treatment* (MOUD) in British Columbia
- 220,474 total MOUD episodes 24.7 % on Buprenorphine/naloxone, 73.9 % with methadone
- 56.7% of all bup/naloxone episodes completed induction
- Only 48.2% of these successful ones reached " minimum effective dosage" 12mg/day

Assessing the determinants of completing OAT induction and long-term retention: A population-based study in British Columbia, Canada☆

Megan Kurz[a], Jeong Eun Min[b], Laura M. Dale[c], Bohdan Nosyk[b,d,e]

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Discussion

- What have you seen get in the way of patients' success with buprenorphine?
- How can we help with these issues?

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Kurz: Reasons for failed treatment

- Most common reason for discontinuing treatment: Conflict or challenge with program policies expectations or staff
- Dosing trajectory: those who started on a moderate dose and then shift to a high dose were 3 times less likely to drop out in first seven days
- Those with a higher chronic disease score and diagnosed mental health conditions had longer times to discontinuation- health care engagement

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"What If I Want To Stop My Medication?"

- Some good reasons to stop a medication:
  - Intolerable side effects/ lack of improvement
  - Dangerous interactions with necessary medications
    - *All of these are unlikely with Buprenorphine*
- Stigma is nearly always why patients want to stop MOUD
  - Direct patient to provider to discuss length of treatment
  - Help patient write down questions for their provider
  - Explore stigma towards meds by self, society/family/ support groups

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Encouraging On-going Adherence

- Reframe the on-going use of medications
  - A personal decision, but focus on staying well
  - Enhancing quality of life
  - Reinforce positive effects
  - "You can come back to us if you want to stop and we can make a plan"
  - "Some people may need to be on buprenorphine long term- that's not a bad thing. What are your concerns?"

You can be fully in recovery <u>and</u> taking a prescribed opioid

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Dr Edwin Salsitz - *counseling a patient who wants to stop taking buprenorphine* (11.39 mins)

Patient Wants To Stop Taking Buprenorphine

https://www.youtube.com/watch?v=WWqBgwREbrg

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Please Remember

- Calling to check in with patients after a medication visit is nearly always appreciated, even if not acknowledged
  - Offer assistance and support in voice mail, emphasize your role on team
- Missing just one dose of MOUD could have potentially life- threatening sequellae

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Questions & Discussion

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THANK YOU FOR JOINING US TODAY!

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