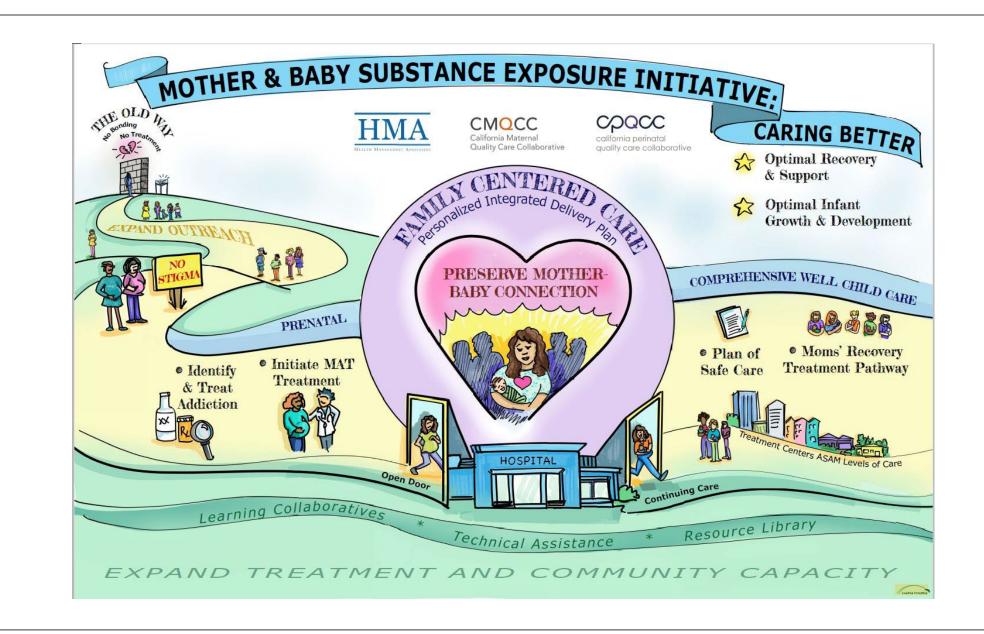
# EDUCATION REGARDING SUBSTANCE USE DISORDER

Presentation by Lorena Watson, FNP



### EDUCATE STAFF ABOUT OPIOID USE DISORDER

- Treatment of substance use disorder (SUD) is often eclipsed with misperception that SUD is a personal weakness or willful choice.
- Whether or not these misconceptions are consciously employed, they can have a dramatic impact on patient outcomes and adherence to treatment during recovery.

- Stigma can be experienced across several domains: self, social, and structural stigma.
- Stigma can come from all staff interactions at all contact points.
- It is not uncommon for health professionals to show unconscious bias whether or not they explicitly report negative attitudes.



### PERFORM LANGUAGE AUDITS

## Evaluate all materials distributed or posted regarding SUD to address stigma-perpetuating language

## **Diagnosis:**

Replace "abuse" "drug habit" "dependence"

with "Substance use disorder or opioid use disorder"

## Person-first language:

Replace "Abuse", "abuser", "addict" "druggie"

With "Person with SUD" or "person experiencing" or "person struggling with"

## Testing and Toxicology:

Replace "clean" and "dirty" urine toxicology screens

With "positive", "negative", "consistent with prescribed medications"

## Maternal and Newborn:

Avoid "crack baby", "drug-addicted baby"

With "neonatal abstinence syndrome (NAS)" and "in utero exposure to..."

## UNIVERSAL SCREENING

Physician:		Case	#:				
Patient Name	:		te:				
Date Of Birth		Race:	Age:				
Address:							
Dationt's Dhe	ne #:						Provide Tobacco
ratient's Filo	ne #				Provide Domestic Violence Assessment	Provide Substance Abuse Prevention/ Education	Intervention and/or Substance Abuse Assessment
<b>P</b> arents	Did either of you drugs or alcohol	r parents have any	problem with	Yes No			
Partner	Does your partner have any problem with drugs or alcohol?			No	Yes		
	ls your partner's temper ever a problem for you?			No	Yes		02
	Have you ever fe	lave you ever felt out of control or helpless?			Yes		- Carlotte
	Does your partn	er threaten to hurt	you or punish you?	No	Yes		a s
Past	Have you ever d	runk beer/wine(win	e cooler)/daiquiri/liquor	? No		Yes	
Pasi	Have you ever fe	elt down, depresse	d or hopeless?	No		Yes	
			t used to be fun to you?	No		Yes	
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•	am 2015. Sampl		stribution or reproduc	ction withou	t written co	onsent.	if Yes, co the follo questi
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## Educate patients about universal screening!!!

Let them know you ask every patient the same questions!

- We created a checklist to include this universal screening at first prenatal visit and once each trimester.
- A standard work flow reduces missed opportunities for screening.

## EDUCATE PATIENTS AND FAMILIES ABOUT OPIOID USE DISORDER

Addiction is a chronic, relapsing condition. Pregnancy can motivate women to discontinue drug abuse, but abrupt discontinuation of opioids during pregnancy can have negative effects for both mother and fetus.



Patients and their families may not be aware that medication assisted treatment (MAT) is the standard of care for opioid use disorder during pregnancy.

### **EDUCATION CONTINUED:**

- Patients need to be educated on different types of opioids to understand how they will affect their body.
- Understanding types of opioids opens a discussion about withdrawal symptoms, warning signs to look for, and when to obtain medical help for withdrawal.
- Patients and their families need to fully understand the nature of addiction, potential impact of continued use during pregnancy and recommended treatment for OUD during pregnancy and beyond.

## EDUCATE PATIENT ABOUT RESOURCES TO ASSIST WITH MAT

- Creating a list of contacts on one piece of paper for patient.
  - Including office address, phone numbers, behavioral health office, local resources.
  - This proved to be very helpful. We created folders and had all info ready to go (info on MAT, Naloxone, local resources to assist with special needs).

- Schedule extra prenatal appointments with patients.
  - Routine OB visits are every 4 weeks until 28 weeks. MAT patients are seen every 2-3 weeks (or weekly if needed).



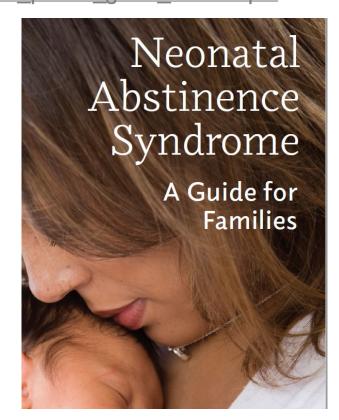
## CREATE A CHECKLIST INDIVIDUALIZED FOR THE PATIENT

- Include the patient in this checklist.
  - Includes overview of coordination of care between clinic and hospital.
  - Neonatal specific follow-up (withdrawal symptoms and ways to help prevent).
  - Postpartum follow-up such as contraception and close monitoring (visits every I-2 weeks postpartum).
  - Open conversations about risk of relapse after delivery.

- Include a detailed plan on hospital care:
  - Notify them that social worker may come and see patient. This is not a negative! Emphasize the positive of having someone else check on them and assess their needs in the hospital.
  - Notify them about pediatrician follow-up and extra appointments after birth.
  - Encourage patient to ask hospital staff if any part of the plan is unclear.

### EDUCATION ON NEONATAL ABSTINENCE SYNDROME

https://static1.squarespace.com/static/5e8f4e2a4eaf8154a7c9c939/t/5f8893c7c0207b1930f52e4b/1602786254066/
 opgc nas parent guide 092914.pdf



# What to Expect When Your Baby Leaves the Hospital

Parent and family support can make a big difference in how fast a baby with NAS gets better. Babies can continue to have mild symptoms of withdrawal for up to 6 months after leaving the hospital.

Once at home, your baby may continue to experience the following:

- Problems feeding
- Slow weight gain
- Crankiness
- Sleep problems
- Sneezing, stuffy nose, and trouble breathing

## Asking questions helps you help your baby

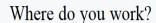
If you have any questions or concerns about your baby when you are at home, or if something just does not seem right, talk to your baby's doctor or nurse. It is important to feel comfortable taking care of your baby, and asking questions—any questions helps you help your baby.

## PATIENT EDUCATION OVERVIEWS:

- Emphasizing that universal screening for substance use is a standard practice.
- Educate all patients on risks SUD can have on their pregnancy and fetus.
- Educate on MAT. Start patients on MAT, get them established with resources and follow them closely.
- Educate patients on plan of care, in-office and in the hospital setting. No surprises!!
- Provide compassionate, culturally sensitive care.

## CMQCC MOTHER AND BABY SUBSTANCE EXPOSURE TOOLKIT

https://nastoolkit.org/



#### Outpatient

The Best Practices in this section apply to staff, administration, and providers who care for expecting and/or postpartum mothers, and newborns, in the outpatient

#### Labor and Delivery

The Best Practices in this section apply to staff, administration, and providers who provide inpatient care to women who are pregnant, in labor, or immediately postpartum.

#### Nursery/NICU

The Best Practices in this section apply to staff, administration, and providers who provide inpatient care to newborns in the newborn nursery and Neonatal Intensive Care Unit (NICU).

#### Click below to see the Best Practices for each topic area

### Screening Assessment and Level of Care Determination

Topic areas include: universal screening with a validated verbal screening tool, maternal urine toxicology and the role of explicit/implicit bias, selective newborn biological toxicology testing, and more

#### Transition of Care

Topic areas include: creating a dyad-centered Plan of Safe Care, implementing a discharge checklist, linking to home visitation programs and other resources, communication with the follow-up newborn provider, and more.

#### Treatment

Topic areas include: inpatient treatment protocols, pain management and anesthesia, minimizing opioid use, breastfeeding, pharmacologic and nonpharmacologic treatment of newborns with NAS, and more.

#### Education

Topic areas include: educating staff about opioid use disorder, Neonatal Abstinence Syndrome, stigma, Trauma-Informed Care, and more.

## https://cha.com/wp-content/uploads/2019/01/SHOUT-GUIDELINE-inpatient-buprenorphine-4-18-18.pdf

#### Quick Guide: Buprenorphine Starts in the Hospital Appendix B Check COWS on admission Can administer either buprenorphine or and discontinue all opioid buprenorphine-naloxone, films or tablets. Administer SL and allow to dissolve Patient needs to be in some withdrawa before starting buprenorphine. Pregnancy: only use buprenorphine monoproduct. unless > 5 days off of opioids As guidance, patient may need to wait for 12-24 hours of abstinence The following can be prescribed PRN for symptoms of · 24-48 hours for long acting opioids) · Acetaminophen 650 mg PO q 6 hours daily PRN COWS < 8 Patient has not had opioids Clonidine 0.1-0.3 mg PO q 6-8 hours PRN w/d or no objective withdrawa with objective signs of recently and is therefore not in assess every 2 hours while symptoms (NTE 1.2 mg/day, hold if BP < 100/70) withdrawal awake until COWS ≥ 8 (at least 5 days off opioids) Administer 4 mg of · Diphenhydramine 25-50 mg, PO q 8 hours PRN buprenorphine insomnia/anxiety Initiate buprenorphine at · Loperamide 4 mg PO initially, then 2 mg PRN each 2 mg SL x 1 additional loose stool (NTE 16 mg/24 hours) COWS < 8 · Ondansetron 4 mg PO g 6 hours PRN nausea Reassess q 6 hours. · Trazodone 50 mg PO qhs PRN insomnia Reassess in 2 hours. May assess COWS/redose · Melatonin 3 mg PO qhs PRN insomnia If cravings persist and not sooner May provide 4 mg of ssess COWS a 6 hours buprenorphine if COWS ≥ 8 or sooner if patient Add 2 mg SL x 1 Max dose 16 mg on Day 1. COWS < 8, Reassess q 6 hours or soo COWS > 8, administer 4 mg Repeat up to 16 mg total if patient endorses withdrawal. May give 4 mg of burpenorphir Reassess g 6 hours or sooner if patient endorses Max does 16 mg on Day 1. Total dose given becomes initial daily does for Day 2. Starting dose on Day 2 If COWS < 8. is total combined doses continue to reassess If COWS > 8 from Day 1 g 6 hours or sooner give another 4 mg of prenorphine and reassess patient endorses withdraw May give another 4 mg of q 6 hours for sooner patient endorses withdrawa COWS > 8 at any point Max dose 16 mg on Day 1. Max dose 16 mg on Day 1. Total dose given becomes otal dose given becomes i initial daily dose for Day 2. daily dose for Day 2.

#### Quick Guide: Buprenorphine Starts in the Hospital

#### Appendix B

#### Testing prior to first dose:

- Urine toxicology
- Liver function tests
- Urine pregnancy test
- (PRN childbearing potential)
- HIV, Hep B, Hep C as indicated
- DSM 5 criteria for opioid use disorder
- ☐ CURES report
- ☐ **Pregnancy:** non-stress test or fetal heart tones as indicated

#### **Contraindications/cautions:**

Call experts as needed, may still start with support

- Allergy to buprenorphine
- Medically unstable, unable to tolerate mild withdrawal
- Methadone in last week
- AST or ALT > 5x upper limit normal
- Surgery in next 48 hours
- Acute severe pain
- Binge alcohol or benzo use

#### Patients started in the ED:

- If given total dose of <16 mg in ED, continue to follow day 1 algorithm
- If given total dose 16 mg in ED, hold additional doses on day 1, then day 2 start 16 mg qday
- If given total dose > 16 mg in ED, hold additional dosing until return of cravings/withdrawal, then start 16 mg qday
- If patient is experiencing pain may split dose TID

#### **Day 2:**

- Administer total daily dose from day 1 as single dose in am, or if patient is experiencing pain may split total daily dose TID
- Repeat COWS in 6 hours, if ≥8 administer additional 4 mg

#### Subsequent days:

- Administer total daily dose from previous day as single dose in am – split TID if ongoing pain
- Increase dose prn cravings/withdrawal/pain
- Decrease dose prn sedation, insomnia, adverse effects
- Typical max dose 24 mg

#### Discharge prescriptions:

Buprenorphine may only be prescribed on discharge by X licensed provider. Prescribe dose required in hospital as daily dose on discharge.

#### Example:

- Buprenorphine/naloxone 8 mg/2 mg film, 2 films SL qday, #14, 0 refills
- Naloxone 4 mg/0.1 ml intranasal PRN opioid overdose. Spray 0.1 ml into one nostril, call 911, if no response in 2-3 minutes repeat with second device in additional nostril. #1 pack of 2, 3 refills
- Consider pre-exposure HIV prophylaxis

## **RESOURCES**

- Resources on Buprenorphine hospital quick start :
- https://cabridge.org/wp-content/uploads/CA-BRIDGE-Blueprint-for-Hospital-OUD-Treatment-September-2020.pdf
- Resources on screening tools, MAT prescribing and free clinical consultations:
- https://nccc.ucsf.edu/clinical-resources/substance-use-resources/
- California Maternal Quality Care Collaborative Mother Baby Substance Exposure Toolkit:
- https://www.cmqcc.org/resources-toolkits/toolkits/mother-baby-substance-exposure-initiative-toolkit
- 4 P's Screening Tool:
- https://www.ntiupstream.com/4psabout