Opioid Stewardship Series, Season 1, Episode 4: Screening Patients for OUD Risk and Opioid Withdrawal

Speaker 1 (00:03):

I am honored to present to you Dr. Sandra Springer. She's an associate professor of medicine in the Department of Internal Medicine section of an infectious disease at Yale School of Medicine. And she's board certified in internal medicine, infectious disease, as well as addiction medicine. So, upon graduating from Harvard University, she later received her medical degree from University of Massachusetts medical school and did her internal medical residency and infectious disease fellowship at Yale School of Medicine. So yeah, she's currently the director of her clinical research lab in Stride, which stands for integrating substance use treatment research with infectious disease.

Speaker 2 (00:40):

So, the purpose of this talk, and kind of what I do as well is, is trying to identify those who are at risk, right? So the expert system screening and brief intervention and initiation referral of medication treatment. So, this is, you know, a well known process across all forms of substance use disorder, including alcohol. Um, and in particular where I've worked at the setting of justice settings as well as hospital settings that we need to improve screening. So, there's definitely data in harm reduction programs, um, as well as, justice settings and then of course, emergency room and hospital settings. But if we can identify individuals, so screen them, we can improve the likelihood of rapidly including them into treatment. So, that whole expert continuation. So, if we think about it, we can't really do a "DSM" kind of psychiatric diagnostic measure for everybody.

Speaker 2 (01:41):

So, that's why screening is important. And then trying to find a tool that could maybe help somebody, even a non-clinician diagnose more quickly for any screening, uh, situation. Basically, single screening questions we know are the most effective, especially in busy emergency rooms, primary care settings, prisons, or jails in particular. Um, court settings. So, something you can remember easy. So, the NIAAA, the National Institute Alcohol Abuse and Alcoholism. Um, what the best screening question is for alcohol use or hazardous drinking is: have you ever had four or more drinks in one day? And that then stimulates, if anyone says "yes," to go on and ask an alcohol use disorder, um, questionnaire. We need something like that for opioid use and, and other, um, substance use, uh, disorders. So those single screening questions for opioid use disorder are, can be validated, and have been validated in primary medical care settings, including emergency rooms.

Speaker 2 (02:45):

And I'll show you one that, um, that how we've then taken this and validated a tool for, uh, actually not just screening, but diagnosis of opioid use disorder. So, one is, if you look at this question: how many times in the past year have you used an illegal drug, which I don't like the term illegal, but this is the quote from the NIDA, assist. But have you ever used an illegal drug or used a prescription medication for non-medical reasons? So that was just one question. That question if answered "yes," as a high sensitivity and specificity for the likelihood of having, um, in this case a substance use disorder with an opioid or, um, stimulant. If you look at standardized screening tools, um, again, the best are those that you could, you could potentially build into your, um, EHR, your, your medical record system, like we have Epic here.

Speaker 2 (03:44):

Um, and it can be an automatic score that automatically scored and then, uh, lead to the rest of that, um, expert protocol that. So, you did your screening, you have a positive result, then, you know, moving on to what would be your intervention. So, you know, as a whole part of the continuum of care as opposed to just doing your screening saying, okay, well that's it. Um, this could be built into your medical record and the next and be continued on. So, um, whether you're in the emergency room or in a jail, et cetera. So this is just a summary of some of the validated standardized screening instruments for substance use disorder. And some people use these for opioid use disorder, the DAST, um, the assists are probably the ones I hear that are used the most. Um, and you can see other characteristics that tells you that the type, the number of items.

Speaker 2 (04:39):

Um, and then, uh, like the audit on the bottom is, is well known to be used for alcohol use disorders. But I'm going to talk in the next slide about one that we've developed. You know, it's not just me that, that thinks this is important. This, um, article that I have referenced down here, uh, measurement-based care, you think the DSM-5 criteria for opioid use disorder, can we make opioid medication treatment more effective? This is a good article to read. Nora Voca, the director of NIDA and colleagues have really commented on how important it is to be able to take a rapidly validated tool that you can screen and diagnose that can lead to treatment of opioid use disorder, just like I was had been saying. So, you know, if you look at some of those other screeners, they're not specific to opioid use disorder.

Speaker 2 (05:28):

So, you could identify somebody has used what, what the term was, illegal substances, which I, again, I don't like, but substances that one, you know could put one at risk for opioid use disorder, opioid, uh, overdose. Um, but it doesn't give you that diagnosis that you need to say. I want to start you on buprenorphine, um, which, you know, as always said, we do need to know in order to safely start someone on a medication. So, um, in my work, if you, uh, on the bottom it says we're doing research to start buprenorphine screener was born and, um, the rapid opioid dependency screen. So a while ago, um, and if you look on the, the next click, uh, we had an error just because, uh, the scoring of the, it was missing the, um, equal sign. But, um, I'll talk to you about that in a minute.

Speaker 2 (06:23):

Um, this is the rapid opioid dependency screen. It's free. I created this because way back when, when buprenorphine was just FDA approved in 2002, a couple years after that, I wanted to evaluate could I start buprenorphine in people who were being released from prison and jail to reduce their likelihood of craving and use, and could I also do that in individuals who also had HIV and improved their likelihood of improving viral suppression? And I realized there was no quick opioid at that call at that time. It was called opioid dependence screener. So, I created one, but then also did, um, a DSM-5 tool at the same time to ensure that when they were released that they really had opioid dependency. And then later we validated it, and that was those articles. And so, what it was as it takes, it was eight questions.

Speaker 2 (07:21):

Um, non-clinicians used it, so individuals who go in in the prison, the jail, um, and, uh, we would identify those who had, uh, pre-incarceration opioid dependence based on this, a score of three or greater indicated they had opioid dependence. And then, we could initiate medication treatment immediately at the time of release. So

that was, um, with sublingual buprenorphine. And then, we later did trials using extended release naltrexone or Vivitrol, and now we use it to start injectable buprenorphine sublocade, um, for people in hospital settings and people in, um, substance use treatment programs and people in prisons and jails as well. So this is just kind of a quick way to think about this. So you screen, you could use that NIDA quick first, uh, screen in the first little box, and they say, "yes," in the last year, you know, they have used some illicit drugs or could have said "yes," just specifically, "I did use opioids," that would then move you to the rapid opioid dependency screen.

Speaker 2 (08:24):

Do they have a score of three or greater? And then, then you could move down the trail and ask, would you be interested in treatment with medication treatment for opioid use disorder? Again, it's very quick. We put it on, um, tablets. We, you can also have a paper form, you could ask over the phone. Um, and again, it's, um, anyone can ask it. It doesn't have to be used by a clinician. So that next step of, well, are they ready for medications? That brief intervention, you really need to assess readiness. And some people just aren't ready for treatment. And, but part of it is informing the individual. They may not know they have an opioid use disorder. So that can give them some by giving them this, this feedback that can be helpful. And then, you know, we have to also include education.

Speaker 2 (09:17):

So, what is available for them? Are they interested? Are they, um, do they need help in stopping use? Do they understand the importance of change for them? Are they motivated to change? Do they need assistance? I think it's just critical. As I mentioned, it's not just identifying those who have opioid use disorder, but the other issue is, is direct. We need to be able to recognize those who might have be undergoing or at risk for opioids withdrawal. So, they're actively using, they might be coming to the emergency room, they might come be, um, arrested in jail, uh, or they could be in the hospital setting or their supervised setting and then being and undergo withdrawal without access to opioids. And we need to be able to recognize that quickly: 1) to treat it right away; and help them, but, 2) allow that as a way to, um, lead them towards maintenance treatment, so that if they are released back to the community or discharged, that instead of returning back to opioid use, and increasing the risk of death from overdose, that they could be maintained on treatment, decrease their craving, decrease use.

Speaker 2 (10:29):

So, this is the, the clinical opioid withdrawal scale. The COWS, it's free. You, uh, I keep, uh, you just look it up on your phone or whatever. It comes up for free. Um, it can be built into your medical record and it actually gives you a score: a very quick, any score of five or more indicates, um, withdrawal. And you can start, um, medication treatment to immediately help relieve withdrawal. It's one of the most rewarding things I've ever done. You can actually see people improve right in front of your eyes and feel better with buprenorphine methadone to start start treatment. You can go to the SAMHSA website, you can go to the American Society of Addiction Medicine website. There's multiple free ways to show how you can treat withdrawal. Um, this is just a slower way of doing it.

Speaker 2 (11:23):

I'll just tell you with those, um, who are who are addicted to fentanyl, that you will not wait three days to start somebody to get some up to 24 milligrams of buprenorphine. You probably are going to do it all, um, within the first day because the withdrawal is so severe. So, um, that, uh, there's a lot of folks who can help. Um, and, and

the training is also, um, very easy to do. And then methadone is similar, but you start slower, 10 to 20 milligrams. And then, um, typically though, within 20 minutes, you should start seeing some improvement in symptoms. So I, I'm just going to end here, but I just wanted to just to reiterate that if we want to improve or reduce these numbers, reduce the likelihood of an individual dying from overdose. If we need to improve the likelihood of finding people, making it, um, easy for them to talk to you by just offering routine screening and routine diagnosis, just like we do with other, um, uh, chronic medical diseases.

Speaker 2 (12:38):

And then not only screen and diagnose, but think about can you quickly initiate or offer treatment, um, and across the board from wherever you are in emergency room all the way through admission, prior to discharge, a justice setting or whatever, it can be integrated in specialty settings like, um, infectious disease or liver patients who see, um, hepatitis C, other, other conditions. And then not only that, but be able to recognize withdrawal. Know that you can treat it. Um, also don't forget to be able to recognize overdose, uh, and have Naloxone, and other harm reduction services for them. And I think the key part is, you know, being able to meet people wherever they are, um, and, and just understand that some people might not be ready for treatment, but if you continue to offer a non-punitive open, um, dialogue and understand, and that they understand that you're there to help them, you're more likely to have success maybe someday in the future. And or in that moment, depending on where they're at and helping them, um, move forward and, and hopefully saving their lives.

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