Speaker 4
Introduction

Our last speaker, is Dr. Joseph Liberto oh. Dr. Liberto oh, will discuss our very recent published clinical practice guidelines for substance use disorder, from the VA, and the DoD, we have chosen this topic. About this time last year. We were kind of a little bit on pins and needles, because we weren't sure if it would be done in time, but lo and behold, it was published I think about two weeks ago, and it's then it just felt right into place. A VA mental health director, for Substance Use Disorder, in the prevention, of veterans prepares and includes leadership positions, and in areas of mental health Substance Use Disorder, and he has been a very participant , working as a principal counselor, within the VA. He is in the American medical opioid task force I have had the pleasure of working with Dr. Liberto, and other initiatives we are currently working on together, in terms of joint education program, and the VA, and the health system, with that I will turn it over to you. >>

I think you need to press star pound to unmute.
[Audio Issue]

Okay that is okay.

Thank you for the introduction thank you for having me today I look forward to talking to you today about the VA, clinical practice guidelines for the management of substance use disorders. Hopefully let me first say, I have no disclosures. And my presentation doesn't speak about official policy, from the Veterans Administration, or any other government agency. What I would like to do is really to set the stage briefly. Why at this point in time, the update and guidelines is critically important, and talking about a little bit in background, what is happening in the United States, and how that is impacting veterans as well. Then we will talk to you about a little really quickly about the process that has taken and the way we have taken to put guidelines together, Chris has alluded to that, which was introduction, and the process that was starting in 2020, and just recently we have gotten approved for those guidelines. And then really I would like to spend the majority of my time today, and talk about evidence-based clinical based connections, that can walk you through the algorithm, and which is also part of the guideline in terms of substance use disorders, and a time at the end for discussions. In terms of background, I don't think it comes to any surprise for anyone attending today, that we are in the midst of an epidemic. We have clearly seen overdoses rise dramatically, over the last few years. There was a little bit of a slight word downward trend in 2018. And pre-pandemic, we have seen why in fatalities, and wide overdoses, and in the pandemic as I will show you in a second, things have really escalated. As you are probably aware, most of the others are related to the opioid overdoses, and most of those are related to the non-synthetic opioid such as fentanyl. I think it is important to point out, as we talk about the guideline. We also even pre-pandemic, we are seeing a continual lysed stimulant overdose fatalities. Stimulants I think are really an emergent threat, and one that we are going to need to

be careful with, in terms of the treatment disorder. During the pandemic, from the CDC, if you look at the 12 months prior to January 2021. And compare that to the previous year. There has been almost 31% increase in the number of those fatalities. We have hit historical highs in that same time period of 95,000 Americans dying of an overdose. If you go back to 2015, more than doubled in overdose fatalities compared to 2015. So we have a lot of fatalities, a lot of death related to substance use and the context I think that can be behind the scenes. We also have seen of course during the pandemic, increases in alcohol use, among patients, and other substance use. The increase of negative, that goes along with that maybe a variety of reasons during the isolation particularly in the early part of the pandemic. And all in all, we have seen an escalation in substance use disorder, and with problems.

This is always in the backdrop, we have a lot of veterans who are not engaging in treatment. SAMHSA puts out annual national household survey. In 2019, they estimated that less than 15% of veterans with a Substance Use disorder, were not getting treatment anywhere, and those who had acute morbid , those numbers were you seeing here they were worse, getting a handle, and having an impact on the epidemic as well as the quality of life for veterans

some of these trends we are seeing, the upper blue line is the number of veterans with trend 19, we are seeing within DHA in the number of years, and we see this downward trend, the thing I want to point out, among the drug use and these disorders, you want to keep in mind, alcohol use disorder, clearly, is a driver of more ability , and the morbidity , not all with specialty care, and about 550,000, 2019, these patients with Substance Use Disorder , about 5000 have alcohol use disorder, as one of their substances. Alcohol is remaining a critical initiative, and

among these disorders, some of the parts of the slide didn't come up when I moved this transition to the DoD slide deck, I will walk you through, the top line, here these are the trends in substance use disorder, and these top lines, we are seeing a lot more cannabis use, I think probably that make sense in the state, since they have increasingly relaxed on legal consequences for recreational use, and medical use of cannabis. We are also seeing if you look at the green line the second line from the bottom. Increase over the last few years in and phentermine, amphetamines, and these disorders, part of this is really to methamphetamine, and the related to. If you look at the line in the middle, the modest increases, one represents cocaine, one opioid use disorder, and the bottom are all other disorders.

What about the clinical practice guideline? The last clinical practice guideline was published in 2015, and as Chris noted, it was updated just recently as part of the update, we have looked at published data through June 2020, and anything that came out after 2020 it was not considered looking at several key areas, including Substance Use Disorder, issues related to stabilization, and management, help in telehealth, and I will go through these in a little more detail. I did want to point out, we had a lot of people involved in the guidelines, more than a knowledge today, but I want to particularly acknowledge there were VA and the Department of Defense, leaderships , members of CPG committee.

Indeed champions of the committee included the Department of Defense, and Dr. Christopher Perry, and of course Chris was on the committee has a number of us were. A leadership for clinically focused committees, including the Department of Defense, and the leadership there. A long process. If any of you have been through guideline development. In just trying to walk you through very quickly, a lot of effort of front, in March 2020, just to begin to understand what are the important topics, that was based on the critical review of the last clinical practice guidelines, and trying to think through what data may be out there for updated guidelines. And then the development of these with patients, to help inform decisions as well as the development of key questions. These key questions focus on issues to pharmacologic, and non-pharmacologic treatment, a variety of substance use disorders, and increase signals of Substance Use Disorder like how to miss here for example, and these questions and comparative between these treatments and pharmacologic therapy . There were many iterations of the guidelines reviewed internally by the committee, eventually the guideline did go out for external review. To the VA, DoD, and subject matter experts, in the community.

It is come to fruition in the last couple weeks, to a published document. I did want to point out. Unlike 2015, all of the guidelines that went before, there was a much more robust and focused attention to evidence-based. The bar was set much higher than it had been in 2015 for example, in terms of what was expected in order to make strong recommendations. One of the things as you think about interpreting and understanding recommendations and guidelines that you notice. You may notice, some recommendations that maybe had stronger evidence, or at least come I should say stronger statement. In previous guidelines, they didn't necessarily have a strong of statements, because as we looked critically as the evidence here we see randomized control trials, and stronger regulations, and some of these have to do with the strength. Indeed like all recommendations, they received one of five different categories, and a strong way for robust evidence, and in which we still recommend, and the evidence was not quite as strong, for nor against, whether sufficient evidence, and strong again depending on the practice.

The goals of the guidelines really to assess the patient's condition, and to live with the idea of collaborating with patients, as well as a family and other caregivers where appropriate, and really just a strong emphasis on patient centered care, using individual risk factors in history, to help guide decision-making. And to aim at reducing harm, to minimize complications, and morbidity, and improve quality of life. The guideline guidance, where the VA providers. Targeted empire, and the primary care, for all providers who are providing treatment with patients with substance use disorders, and the population include service members, over 18 years old. Now let's go now, getting into the recommendations. The recommendations are divided into different sections.

I will go through each section primarily each recommendation, I will add a little more detail where it will add sense in detail. Robust evidence base, or a strong evidence base for screening for alcohol use disorders, and such as primary care settings. Utilizing either the alcohol use

disorder identification test, in a single item, called SASQ , there is value in screening, in part, this value comes from the fact there is evidence not quite as robust, if the screen positive for unhealthy alcohol use, then providing a very focused brief intervention. Really where there is a focus on advising the patient to abstain, and having impact, this is a recommendation.

I will also say, we look at the same data for screening for substance use disorders, and out of the level of data and research, as robust, you can certainly screen for patients, with substance use disorder, increasing the likelihood of identifying patients with higher risk, though studies didn't show whether that improved the -- Improve the engagement which we would like to achieve we land on neither for nor recommendation against, in screening for these disorders.

One question of treatment we did look at different studies looking at a patient placement criteria, and this criteria and other criteria not sufficient evidence to suggest the criteria necessarily increased improved outcomes. Again we landed neither for nor against recommendation.

In terms of stabilization and withdrawal. I will go through each of these substances in particular. For Alcohol Use Disorder, there was a strong recommendation if you have moderate to severe alcohol withdrawal you should be using benzodiazepines, for monitoring. With risk of these and outweighing benefits, for example detox, and concerns of diversions or use of bins AP means -- benzodiazepines , And as this here, you could see an alternative.

In terms of opioid use disorder, you probably know, patients who are detoxed off of opioids, or much higher risk for morbidity and mortality, high risk of overdose potential, and for that reason. There is a strong against management, against pharmacotherapy, with the use, lots of data showing detox generally is not very effective, and increases more ability here and mortality. With management as indicated. Perhaps patients who are setting the stage for an extended pharmacotherapy. Preparations as well as these which data suggests these would probably be the ones to start with. And for patients for whom here it is indicated, and we were willing to have data that suggests the effects of these also decreasing the sympathetic symptoms that were also associated with withdrawals. Since a few here, they are not life threatening, there are medications that certainly can help to make it a less more painful process for patients as they go through the withdrawal process. In terms of hypnotic withdrawals. Strong evidence suggesting the management and particularly with these benzodiazepines, gradually tapering, and there was no evidence with these and could be helpful in this withdrawal. Moving down on treatment, alcohol use disorder, these patients with moderate or severe use disorder, there is a robust amount of evidence to suggest naltrexone, or in the oral form has benefit for improving treatment outcome, not FDA approved, but Topiramate , appears to have effect. There's data to suggest but not quite robust in Topiramate , but a second line [Indiscernible - low volume] in terms of psychotherapy or psychosocial interventions, clearly there are improved outcomes, data

suggest just behavioral outcomes and then these outcomes, not sure what happened here -- Let me try to get back to that quickly.

>> Here the enhancement therapies and the twelve-step facilitation's. Opioid use disorder.

Strongest amount of data that we have. Here suggested that benzodiazepine, or methadone, these are the treatment of choice for opioid use disorder. There is not as robust data in part, there's not as much data out there, under these randomized control trials, and for the extended release, clearly no locks on, even though we didn't see approving these and benzodiazepine superior to others and ailment some of these long acting interjections. In addition for this disorder, there was not evidence really to clearly support the oral of compliance issues, and for opioid use disorder, there was this which any interventions true for patients that were on these aggregates, you could see and 21, for patients who did not use this therapy, pharmacotherapy, and there is no weaker strong support for psychosocial interventions, for the treatment of opioid use disorder, primary treatment is pharmacotherapy.

Increase in cannabis use disorder, we look at data to see if there was pharmacologic intervention, and that was emerging as possible, the signals of some medication, and some benefit really the group really looked at the data to see any evidence , and with cannabis use disorder treatment, psychosocial, through this therapy, and combined therapy approach. Also interest in this brief intervention, for cannabis use disorder, and thinking along the lines of these interventions, and shown benefits, and in fact no benefit was seen and we decided on the brief interventions for the treatment of cannabis use disorder, I mentioned this stimulant disorder is emerging threats. Overdose is rising over the last few years, and these related to the stimulant overdose, and what treatments are effective? We don't see any pharmacotherapy, and nothing emerging as in medication, that we can say has sufficient evidence, for or against evidence for the use for stimulant use, or cocaine use, for cocaine use disorder, you have a body of literature very strong, on psychosocial treatments therapy, recovery focus, and contingency knowledge meant for this benefit, and unique for patients that have methamphetamine disorders, this that suggests the use of contingency management for the use of these disorders, very important. This is a treatment with efficacy for the use of the time were stimulant use was rising, and these mortalities were increasing. We look at group involvement, and we saw these with the support and for the group for support was very helpful strong for this recommendation. And mainly for drug use disorders in particular, they did show some benefit, but we look at the first time for this mindfulness-based therapy, and since we are utilized more and more in the context of whole health, and this point clearly for efficacy, and we landed neither for nor against this approach.

We also spent a considerable amount of time looking at data on telehealth, and honestly we think we will look to see more come out of telehealth in the next coming years as we work through the pandemic and develop strategies moving forward, after the pandemic ends, and certainly there was data to suggest automated text voice messaging. In a few different apps and programs. They did have some efficacy. And for the

recommendation for this disorder, and not so much for Substance Use Disorder, or any of these other disorders. And the telephone-based care, as a JEM2 care as usual. Otherwise there was not a lot of data shown efficacy, for automated text, or drug use disorder in general, so alcohol use disorder is mentioned, and nothing mentioned for or against the use of telemedicine, for substance use disorders.

Now going through briefly the algorithm, talking a little bit about some of the advice and recommendations. Some of the consensus that came down with algorithms. Basically, there are two algorithms in the document. One is the screening treatment algorithm, the second is stabilization and withdrawal, and patients come into a variety of settings, within VA and the DoD, are they psychiatrically stable, if not , referring to psychiatry units and medical units. If there is an acute mental health problem. Then we look to ascertain are there any time Substance Use Disorder, or those that have evidence involving a disorder, or may be involved, and I will go through that assessment in a few minutes. If not then we perform here the audit, which has the strong evidence base as we talked about, here you see positive, then we will do confirmation assessment, just to see how much the patient has been drinking. Whether they been drinking at levels, whatever the recommendation levels are and I'll show you those in a minute. Looking to make a recommendation doses, if they screen negative, then you can see them at the follow-up visits. If you look at this coming down here. You have done this screening, it is positive, and you made a brief intervention to try to get patients focused on decreasing the alcohol use, and following up in future events. If they are willing to accept treatment, then you would have them evaluated through specialty care setting. And if not then you would continue to see them in the frequency of where you see them, and to try to remember to follow up with them around alcohol use. If you have a specialty care setting, and seeing these come down, patients with probably who have a Substance Use Disorder, if the patient is willing to get treated, then recommending like a social assessment, and a variety of things that could happen, including if the patient as a use disorder, and it puts them at a very high risk for potential overdose, and fatalities, then we would provide the necessary interventions psychotherapy interventions, pharmacotherapy interventions, and manage any occurring conditions. Ultimately assessing the response to treatment, if treatment is needed to continue. And whether patients can then be followed through the same course of that care. The algorithm, the second one I mentioned, is a stabilization, and the withdrawal algorithm care patients come in. They may require stabilization, and you will get history if there is a need for emergent care, for medical or psychiatric conditions, then they would go to the appropriate setting. Potentially the psychiatric or the medical unit, if there is not, then you would assess the severity of withdrawals utilizing the clinical Institute assessment , for alcohol, or for the CALS , for opioid withdrawal assess whether they need management. If they're not needing that, returning to the treatment options, then to be treated. If they are willing to have withdrawals managed. With that is the first major question. One you will get out, in the patient, they are requiring and making the decision at this point I will go through the criteria in a minute, will they go ambulatory, inpatient? Then put them into the appropriate setting to

manage their care. And then assessing at the end, it is a withdrawal management, was it successful? And if it was whether they accept ongoing treatment, and if the answer to that is yes, then they would go to the treatment algorithm that we discussed. There were a number of sidebars that were included in the algorithms as we are going through. I will just go quickly through the sidebars again. And then I will open things up to questions. Now utilizing data from NI AAA, and alcohol consumption, and for 65 and below, these on average, where they are less than or equal to four drinks per day, less than 14 drinks per me -- Per week, and less than one standard drink per day, less than three drinks, or less than seven drinks in a week. The main components of a brief intervention, and to express concern and to advise, and largely focusing on whether you're abstaining or decreasing the alcohol use, providing feedback, showing good thing they have functioning abnormalities, and they may be contributed to these functions, and for a referral , if they have that which is appropriate, or any other problems related, those that can be addressed. In terms of pharmacotherapy, I've gone over opioid use disorder, and this primary recommendation, opioid use disorder, and one thing I will mention, I'm sure you probably are aware, unlike benzodiazepine which can be treated, in an office space practice, anyone providing care, or perforating here, or prescribing, cannot be treated except

in a regulated certified treatment program , treatment programs that have gone through accreditation process by one of several different accrediting bodies including joint commission, and in addition to that the program has to be certified by the substance use administration, and the only time you will use this, the provider in these very highly regulated opioid treatment programs. In terms of the component of medical management, and primary care provider, and certainly among these treatments and the adverse effects, and educated in these health consequences and treatments, and encouraging to abstain, particularly when it is related to substances, and with alcohol perhaps, it is to recommend at least decreasing below, and via the cut off limits we talked about before. Encouraged to attend and referral to community supports for recovery. And also encourage to make lifestyle changes that support recovery. This guideline I will say, does not speak to the co-management of the conditions, with Substance Use Disorder , and this patient has depression , we do have obviously a number of other practice guidelines, for the management of those disorders, and we highlight them and note them in the algorithm.

Treatment settings for alcohol withdrawals. Inpatient treatment, medically supervised alcohol withdrawal treatment, usually were talking about a score that is high, here we say greater than 20. Or a history of particular withdrawals of withdrawal seizures, and patience

have the ability to tolerate medical conditions, and posing serious risk for control management, risk of withdrawal from other substances, and if you have patients who maybe are withdrawing from Alco, then suddenly you have other patients with hospitalization, and maybe those that wanting monitored alcohol withdrawals, within the following, unsuccessfully, maybe likelihood with the patient, they will comply with the talks, and having a lot of severe Como bid 50 psychosis, or severe cognitive impairment. In terms of treatment we've gone over this.

These per management of alcohol withdrawals, and primarily if you have less severe withdrawals, and considering these here, and in terms of opioid withdrawal, again benzodiazepine, and methadone, even in these controlled patient settings, and patient has to be with a certified treatment program as we talked about. As some we have contraindication, do be treated with the use of these with some of the withdrawal symptoms and tapering strategies, going down the road, these tapering schedules, which have medications, that treat as appropriate, and the approach of the system here, monitoring patients giving patients only with [Indiscernible - low volume], using a structured table, for this is preferred. We have little over five minutes on this I'm happy to entertain any questions, or happy to take questions if you want to send them directly to me on the email, my email is Joseph lLiberto .

Absolutely a fantastic summary, and a significant heavy list you have in this clinical practice guideline up and going. I think much appreciated by all, and one of the things that I did want to mention to you. We include sections on suggestive future research. And for all of the people that are letting researchers out there, and budding researchers out there thinking about it, it is awesome for people to look at not only our recommendations, but also having spent a lot of time with the literature, and sing where these gaps are. Looking at that, and sing how that works. I will start off with the quick question. I know it's something that we are always as you are looking at within the system. This implementation, and the kind of I don't want to say monitoring, that is not the right word, but the implementation of this clinical guidelines and what you are doing to get these guidelines out there, a lot of new people that come into the VA, as we do all the time. Everywhere from medical school nurse practitioner, physician assistants, and everyone in the healthcare teams. And then how are you looking at how it's being used, and just those questions. I think we are trying to communicate those guidelines, much as we are at this conference. To the treatment community.

Obviously what I have mainly is the Substance Use Disorder cut in that community, and invited to speak with primary care, and other communities of practice within the VA, and with this program, I can certainly get high points for them as well.

Generally speaking, in the VA guidelines, they are monitored if you will, in terms of implementations, and what are key metrics. Those that we would look at. And we have in fact since the update , we can focus on what these metrics and what these are going to be, we have some of these following, like how many patients with opioid use disorder, have evidence-based pharmacotherapy ? For those patients who have disorders, and that really is the treatment of choice. How many we plan with stimulant use disorder, or launching in January, of 2022, a stimulant safety initiative. Part of which will be related to appropriate prescribing stimulants in the context. And also looking at evidence-based use disorder and obviously we do not have pharmacotherapy, and that the VA, we will be seeing what percentage of patients have stimulant use disorder, and who are receiving cognitive disorder behaviors, and those that we are putting most emphasis on providing the most training for. Working at those outcome parameters, and those we

look at, we breakdown those metrics by facilities, and by integrated service networks, and we can be serving those , back to the field, and some have greater accordance depending on the integrated service network, the metrics and those that they are being held accountable for. Trying to use those metrics in a way that focuses and we always see these highest priorities.

Fantastic.

Final question before I think we've run out of time. And that Clark Brown asks, we have a shortage of prescribers for medical assisted therapy, what are your thoughts on primary care being trained to provide MOU D? Can you tell us a little bit about the great initiative you have to do that in the VA?

Absolutely. Since 2018, we have had pushed out a program called scalp program you may have heard about Train The Trainer Program focused largely on moving treatment of opioid use disorder beyond SU do specialty care, and primary care and pain management clinics, we had a lot in the clinics, and this program actually , beyond the integrated service networks right now, we have two programs in each VA integrated service network. That is part of the pilot for this, and part of the program where it gets active facilitation by experts in the field. The management of patients, and opioid use disorder. We really push the idea of people getting a waiver prescribed, and in these settings, beyond just the physician but the number of different providers who are eligible to be practitioners to prescribe people in morphine and. -- In the pilot clinic, to get back to the first set, most data here, we see a little bit less than the increase in the number of providers, who have these waivers, to prescribe, and somewhere in the neighborhood of 180% or so increase in the number of patients that are treated for this disorder, and we are continuing to push this out. I think we have a long ways to go let's say. Patients within the VA who have a diagnosis located here a disorder over 45% right now, and FDA approved medication for opioid use disorder, and that number is not really going to be driving it up high, I think it represents how well we are trying to send the message on patients that are high risk, if they are this high risk, and they have this decrease of life, then we would get these people on medications decrease mortality and increase on the other side.

Thank you we appreciate that, thank you to the speakers and to the audience, we look forward to seeing you at 1300, in your workshops. Again check your emails with the links to the workshop that you have signed up for. Thank you all for a really fantastic morning. Grab some lunch and we will see you at 1300 goodbye.

For those of you I will leave the room open for a few minutes download the CME sign in sheet and the CEU sheets, make sure that the CEU sheets get can go to Karla, and the other sheets go to Troy Spencer, and we will see you at 1300 thank you. >>
[Event Concluded]