Management of Substance Use Disorders in the TB clinic

Making the case for creating a context of concurrent care

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Hermione Hurley Disclosures

- I provide training courses to support clinicians prescribing buprenorphine through the Providers Clinical Support System Medications for Opioid Use Disorders (PCSS-MOUD) led by the American Academy of Addiction Psychiatry (AAAP)
- All relevant financial disclosures have been mitigated
- No other financial disclosures

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Overview

- Why concurrent treatment can improve outcomes
- Overview of treatment options for substance use
- How to create a context of concurrent care
- Five things you can do right now in your clinic

Case study

- 36-year male, arrived in USA from Nepal 1 year ago
- Pulmonary TB, smear positive, cavitary, no resistance
- Chef, busy shifts, drinks alcohol at home and work
- Wife concerned about alcohol use, he is ambivalent
- On DOT therapy for TB, often declines medications
- Team report that he can be intoxicated or nauseous
- Missing >2 days per week multiple times in first months of Rx

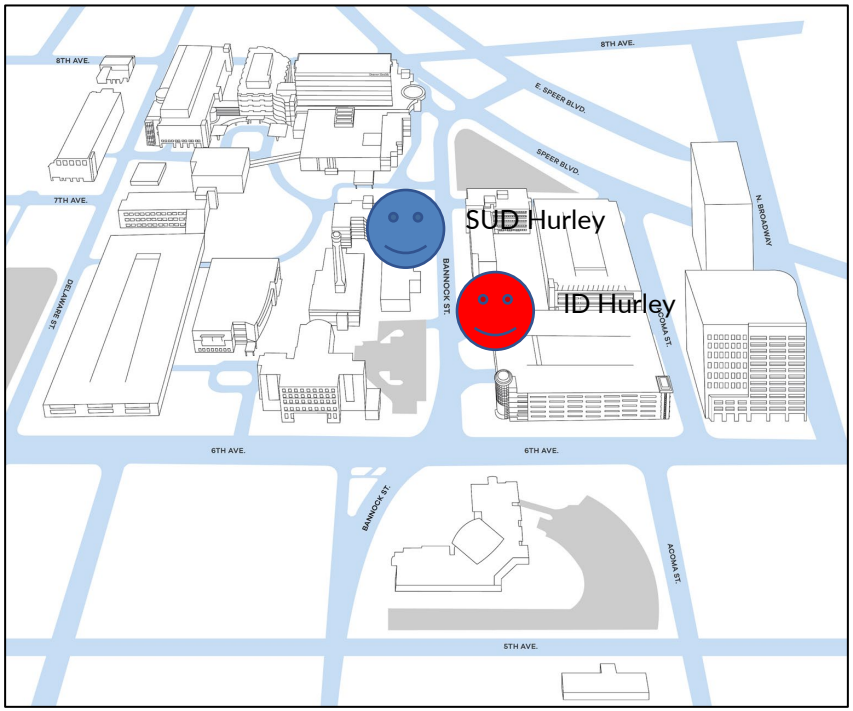
Why treat infections and substance use together?

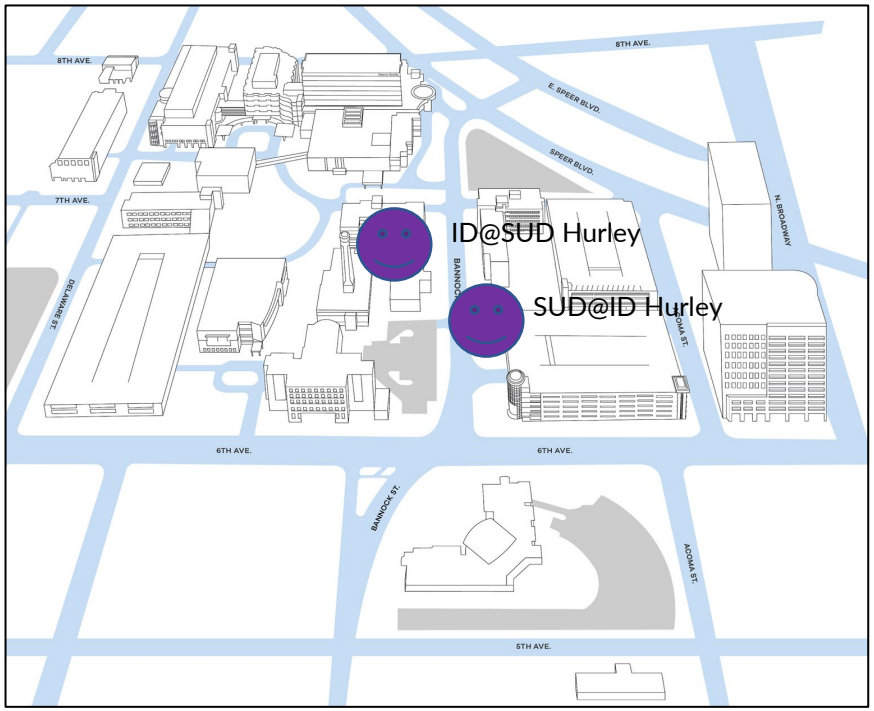
- Conditions are treatable, people recover and improve
- Concurrent treatment lowers many barriers
- Strong evidence-based medications for TB and SUD
- Stigma on stigma decreases engagement
- It’s fun, it’s real, it works, patients like it, I like it

Where do you expand the ID/SUD context of care?

Answer everywhere, all the time, all at once

Mix it up. ID@SUD, SUD@ID, EVYTHG@RRL, ID@OTP, ID@Parole, ID@Jail, ID@Prison, ID@Syringe Services, ID@Dentist, ID@Street





The phenomenon of the 1000-mile parking lot, it's hard to get people to another clinic

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Treating SUD at Denver Health Ryan White HIV clinic

Public Health Use Disorder (PHUD) clinic

PHUD has treated 119 individuals over 4 years (8% HIV clinic)

32 declined referral for PHUD evaluation

35% stimulant use disorder

45% alcohol use disorder

20% opioid use disorder

95% PHUD patients are HIV virally suppressed

70% PHUD patients also use tobacco

Most were HIV undetectable at the time of PHUD appointment. Attendance for SUD counseling improved after PHUD referral.

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How do I start treating TB and SUD?

"An approach that attempts to move an individual away from a state of indecision or uncertainty and towards finding motivation to making positive decisions and accomplishing established goals." *

- Allows individual to use **change talk**
- Can disagree, but **roll with resistance**
- Less conflict, **less expressed sustain talk**
- Stepwise progress, **evolution not revolution**

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Naloxone saves lives - give it to everyone

(including people who use stimulants, lots of fentanyl in methamphetamine)

Non-responsive?
Administer naloxone
Call 911
Recovery position
Rescue breathing
Repeat in 5 minutes

Come visit Vendy at Denver Health to get your free naloxone kit 24/7

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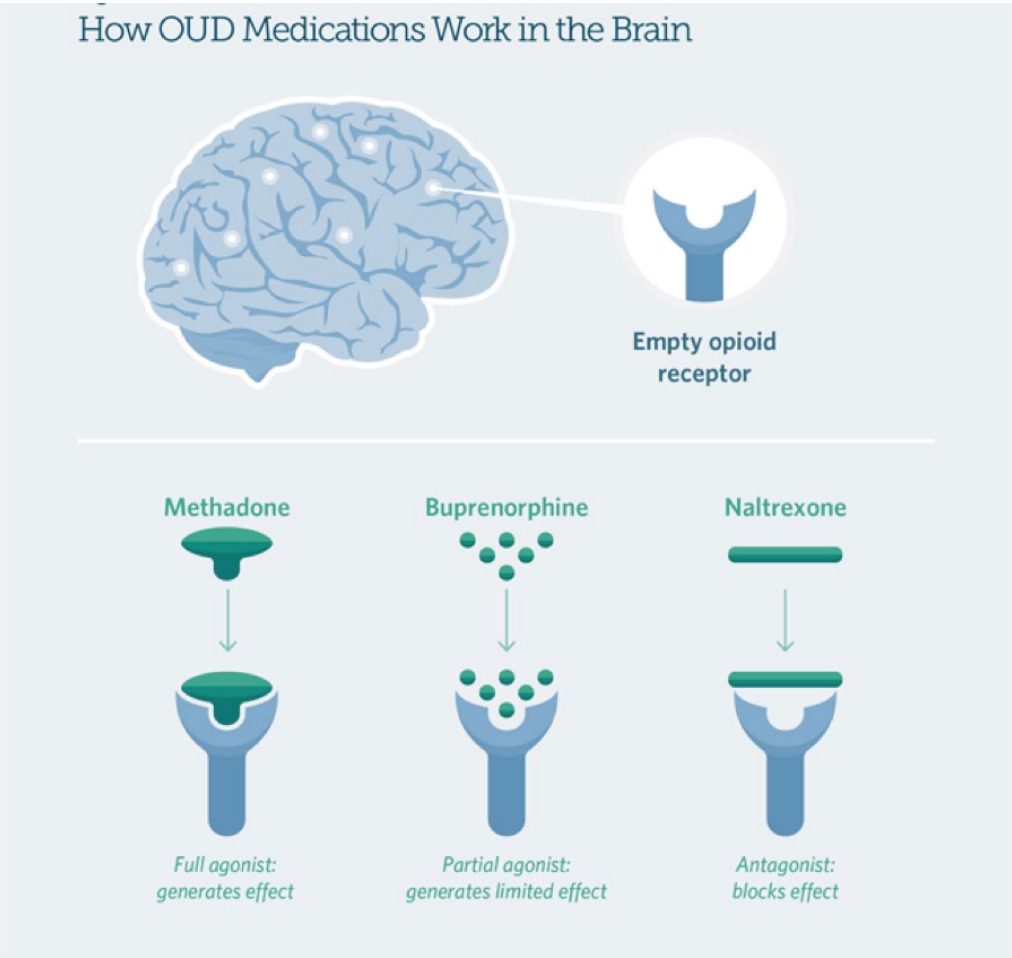
Start evidence-based medications for SUD



- Methadone – full agonist (activates)
  - Needs to be dispensed from an opioid treatment program
- Buprenorphine – partial agonist (partially activates)
  - Can be prescribed from clinic
- Naltrexone – antagonist (blocker)
  - Suitable opioid use in remission
  - First line alcohol use disorder
  - Oral or injection formulation
- Supportive medications
  - For nausea or withdrawal
  - For sleep or chronic conditions
  - For anxiety and depression
  - For tobacco cessation

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Drug – drug interactions and QTc prolongation

- Rifampin is a potent inducer of CYP3A4
  - Opioids including methadone, antidepressants, sedatives
  - Get a ROI, titrate the other med, communicate cessation
- Risk of serotonin syndrome when treating with linezolid and medication for opioid use disorder (moud)
  - 2017 review article 494 encounters with linezolid and either methadone or buprenorphine, 2 cases possible, 0 definitive
- QTc prolongation common, look at the tracing
  - Beware the “smushy” T wave and rapid electrolyte shifts

Edward C Traver, Emily L Heil, Sarah A Schmalzle, A Cross-sectional Analysis of Linezolid in Combination with Methadone or Buprenorphine as a Cause of Serotonin Toxicity, *Open Forum Infectious Diseases*, Volume 9, Issue 7, July 2022, ofac331, https://doi.org/10.1093/ofid/ofac331

Treat the whole person, not just substance use

- Hungry, Angry, Lonely, Tired – HALT triggers
- Vaccinate influenza, COVID, Hep A/B, Tdap pneumococcal, meningococcal, MPOX, HPV
- Tobacco, nicotine replacement and meds
- Harm reduction, test strips, methods of use
- Certified Addiction Counselor, Social Worker
- Onion method of care, keep peeling layers

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Use person first language, increase return visits

Words matter - for newcomers, for TB, for SUD

~~Abuse, dependence, clean, dirty~~

~~Injection drug user, addict, you are addicted~~

Sobriety, recovery, harm reduction

Person with substance use disorder

Person who injects drugs (PWID)

Person in early or sustained recovery

Memorandum Office of National Drug Control Policy. Changing Federal Terminology Regarding Substance Use and Substance Use Disorders. Jan 9th 2017

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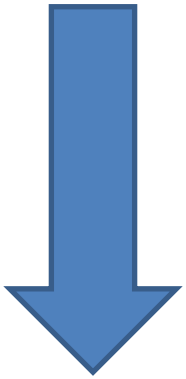
TB treatment teams are already very good at this

Stigma and Shame



Trust and Hope

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Top tips to treating substance use in outpatient TB or primary care clinics

- Use protocols to reflex labs and minimize visits for procedures
- Embedded care navigators increase treatment
- Insurance or lack thereof can complicate medications
- Find the window of opportunity to treat, stay open to change
- Encourage providers to include SUD treatment as part of holistic care
- Consider taking TB and supportive SUD medications to home

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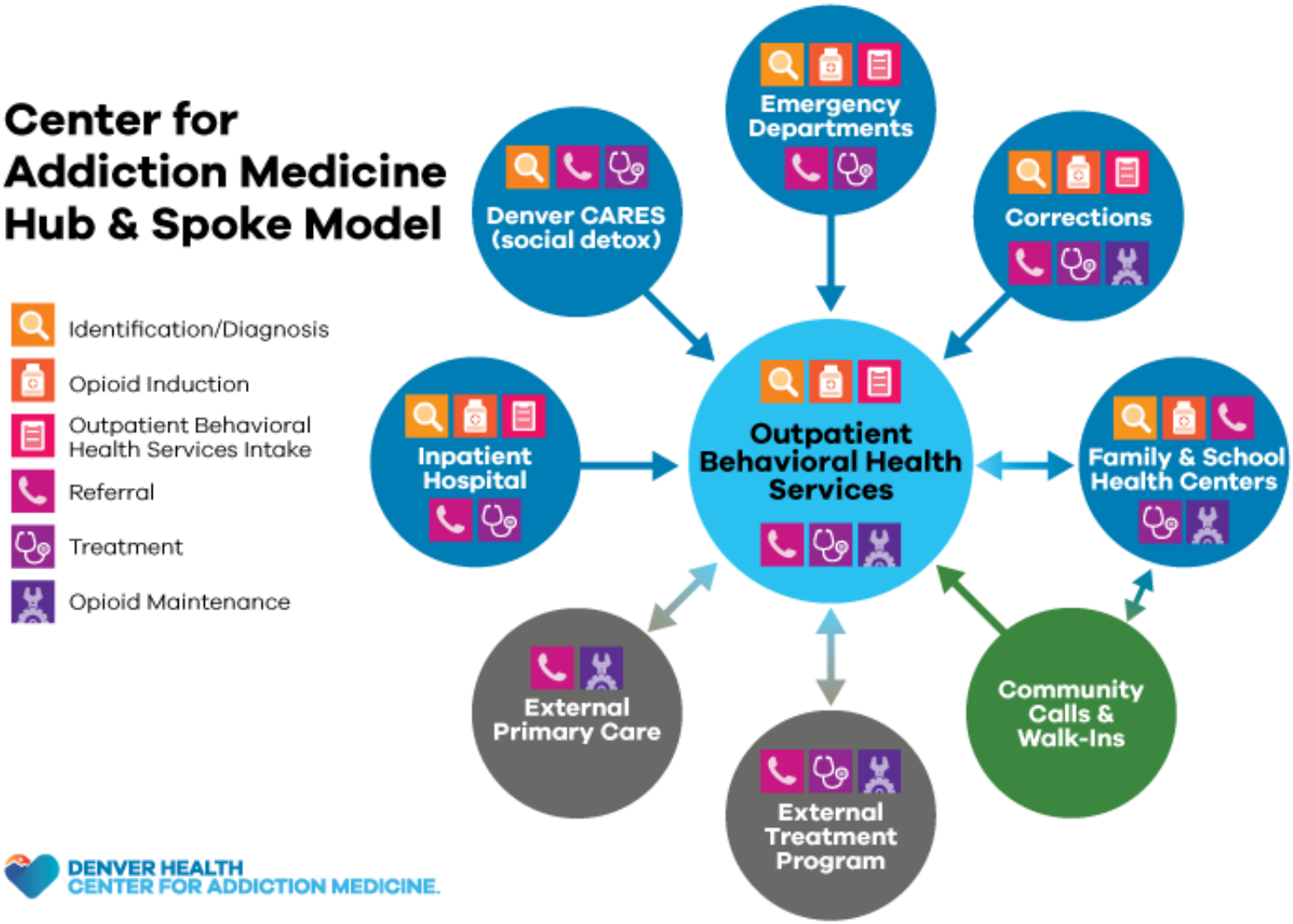
Barriers to treating substance use in outpatient Tb or primary care clinics

- Most people are not ready if still in active withdrawal
- The quality of your team rapport is critical, TB does this well
- TB is managed by medicine, not psychiatry, but we can do it
- Be careful to decouple offerings, need non punitive approach
- Likely to be significant history of trauma in your patients
- Don’t forget tobacco, they may survive TB but die of COPD

Case study – what happened with treatment

- Variable progress, good weeks and difficult weeks
- Required some hospital admissions for withdrawal
- Sometimes team took him ED, sometime by himself
- Came to clinic to discuss alcohol directly with me
- OK conversation but he was reluctant for meds
- More comfortable with the TB team declined referral
- Finished his course of TB treatment, drinking less

You are not alone, there are supports in systems
Substance Treatment Line – 720 912 4567



Summary - five things to do in clinic now

Use motivational interviewing

Make naloxone and test strips available

Start treatment for substance use disorders

Treat the whole person

Destigmatize with person first language and care

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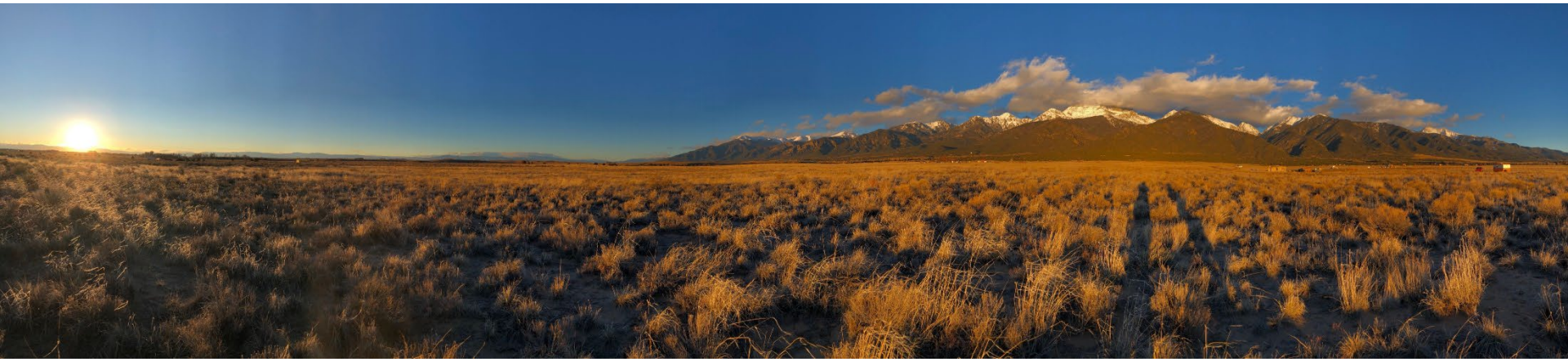

Thank you