# Managing Pain Safely Forum II

Partnership HealthPlan of California

January 15, 2016

# OBJECTIVES

- To understand the neuroscience of prolonged opioid use
- To understand the similarities and differences with addiction
- To understand approaches to working with patients affected by chronic pain
- To participate in interactive breakout sessions

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# LOGISTICS

- Folders
  - Agenda
  - Presenter Biographies
  - PHC Contact List
  - Evaluation
  - PHC Website
  - NoRxAbuse Flyer
  - MPS County Webinar Flyer
- CME Logistics
- Q&A Process

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# HOUSEKEEPING

- Restroom Locations
- Electronic Devices
- WIFI Name: Red Lion Guest
- WIFI Code: Harley
- Presentation Materials Online

http://www.partnershiphp.org/Providers/HealthServices/Pages/MPSUpcomingEvents.aspx

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# GROUND RULES

- Begin and end on time
- Be open-minded – respect all ideas and opinions
- Use technology sparingly and place on silent
  - If you must take a call, please step out of the room
- Be engaged – participate
- Have fun!!!

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# Conflict of Interest

- All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.

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# Let's get started . . .

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# LET'S GET STARTED

# ENJOY THE FORUM!

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# Managing Pain Safely: Progress on Reducing Opioid Overuse in the PHC Service Area

Robert Moore, MD, MPH

Medical Director, Partnership HealthPlan of California

January 15, 2016

# Managing Pain Safely – 2016 Update

Accomplishments

Progress towards goal

How we will achieve goal


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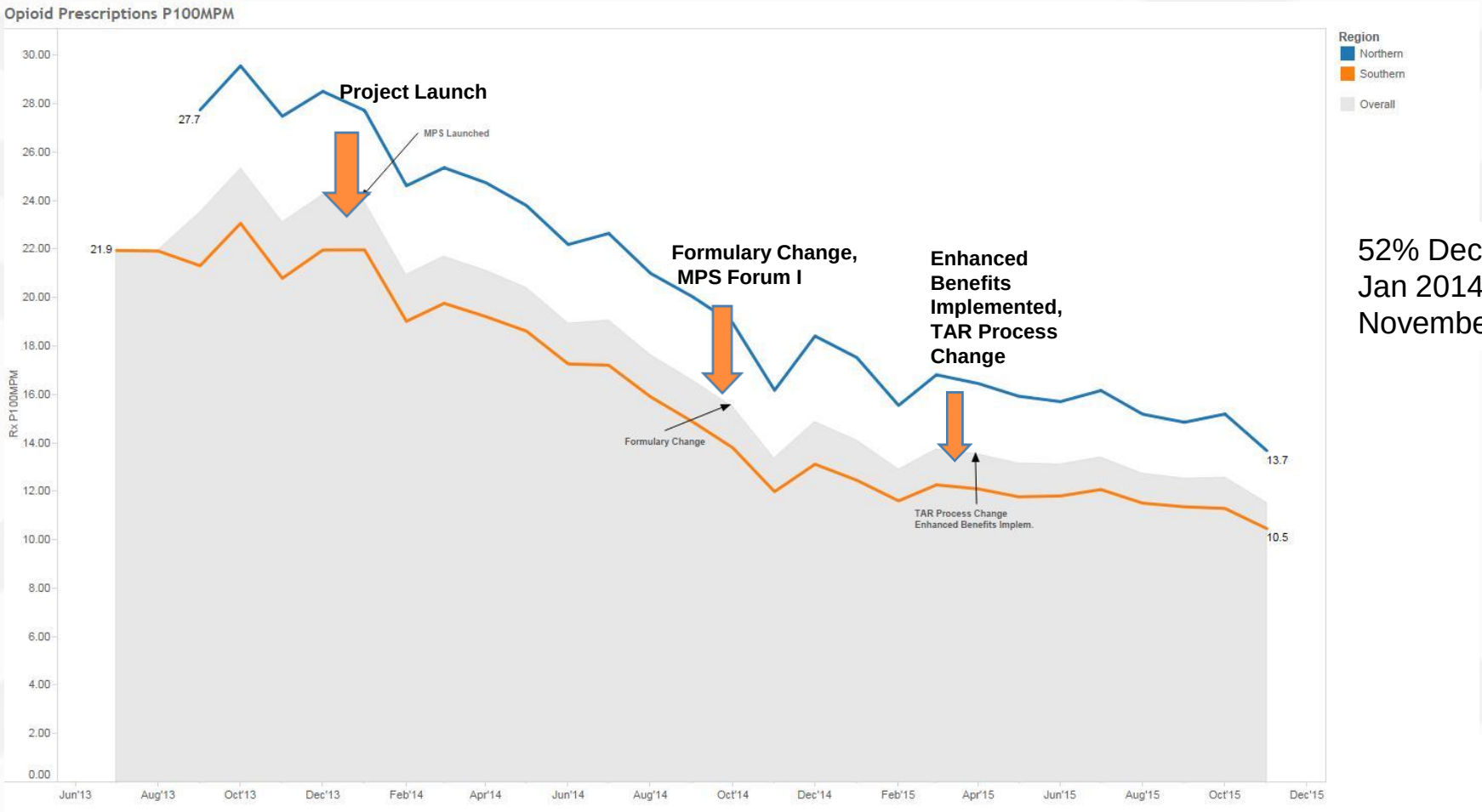
# Accomplishments:

Review of PHC Opioid Prescription Data

# MPS Data – Total Prescriptions




52% Decrease Jan 2014 – November 2015

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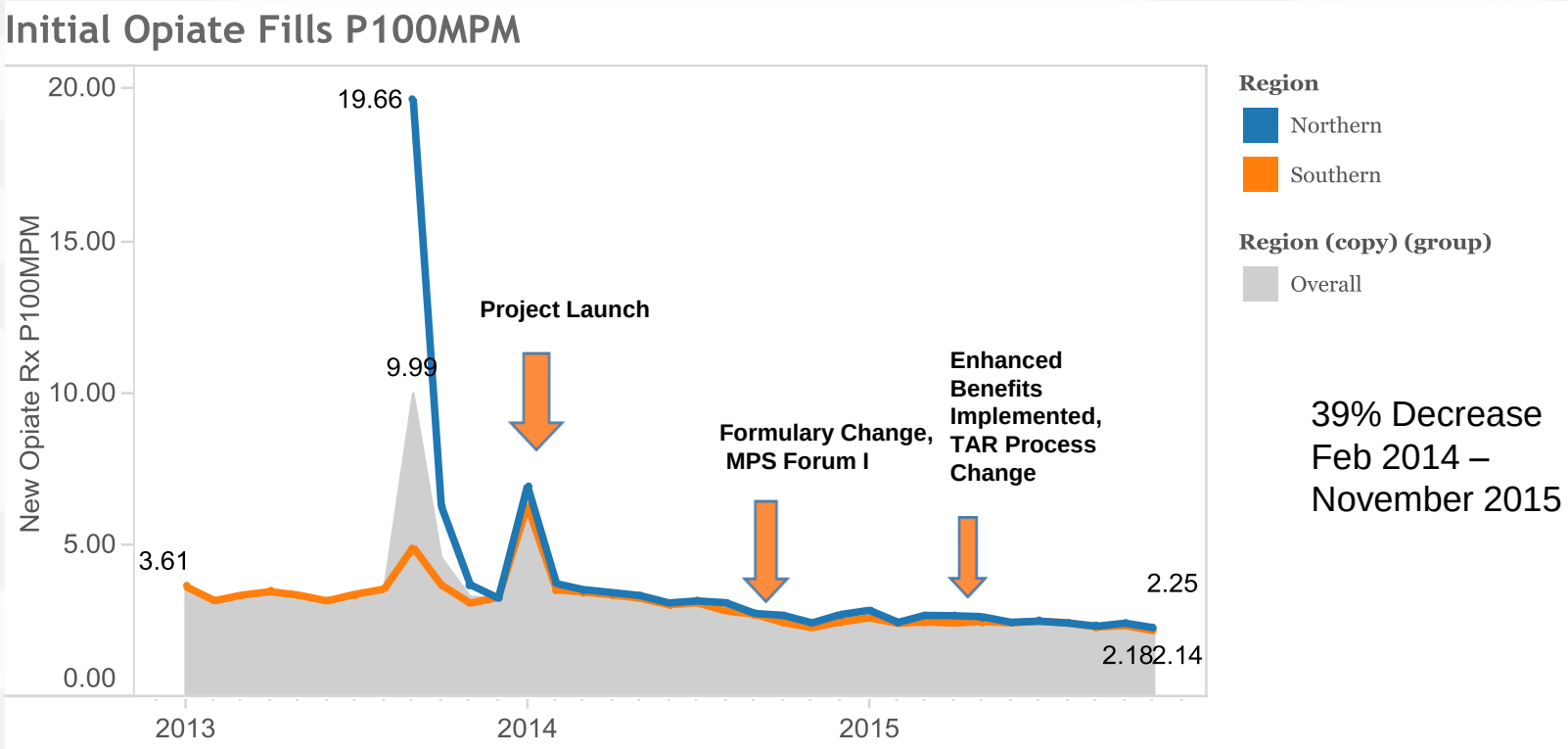
# MPS Data – Initial Prescriptions




39% Decrease Feb 2014 – November 2015

The trends of Initial Rx P100MPM and Initial Rx P100MPM for fill_dt Month. The marks are labeled by Initial Rx P100MPM. For pane Initial Rx P100MPM: Color shows details about Region (copy) (group). For pane Initial Rx P100MPM (2): Color shows details about Region. The data is filtered on Initial and Date Filter. The Initial filter keeps Y. The Date Filter

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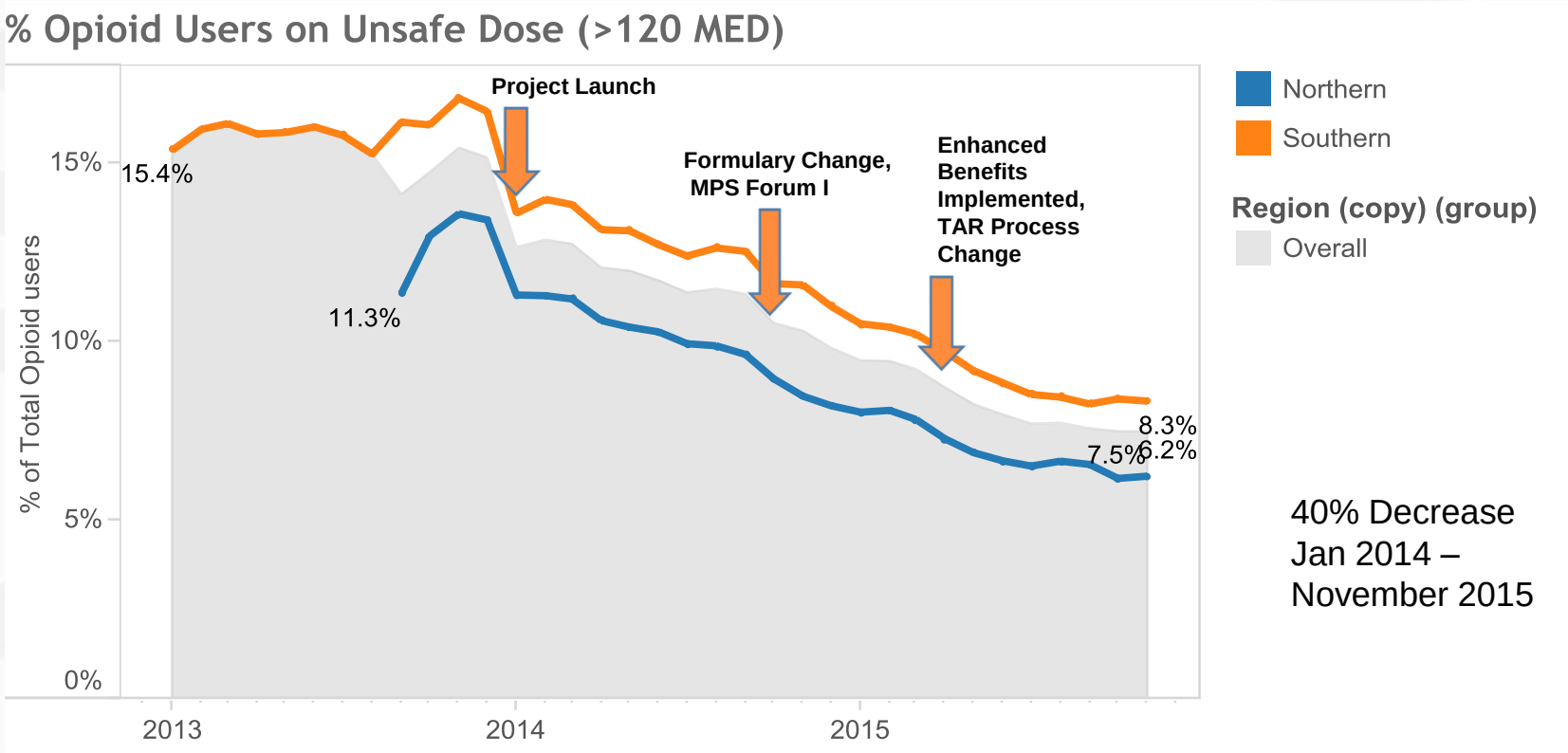
# MPS Data – Unsafe Dose




40% Decrease Jan 2014 – November 2015

The trends of % of Total Opioid users and % of Total Opioid users for Latest Fill Month broken down by User type. For pane % of Total Opioid users (2): Color shows details about Region. For pane % of Total Opioid users: Color shows details about Region (copy) (group). The data is filtered on Date Filter and Latest Fill. The Date Filter filter keeps True.

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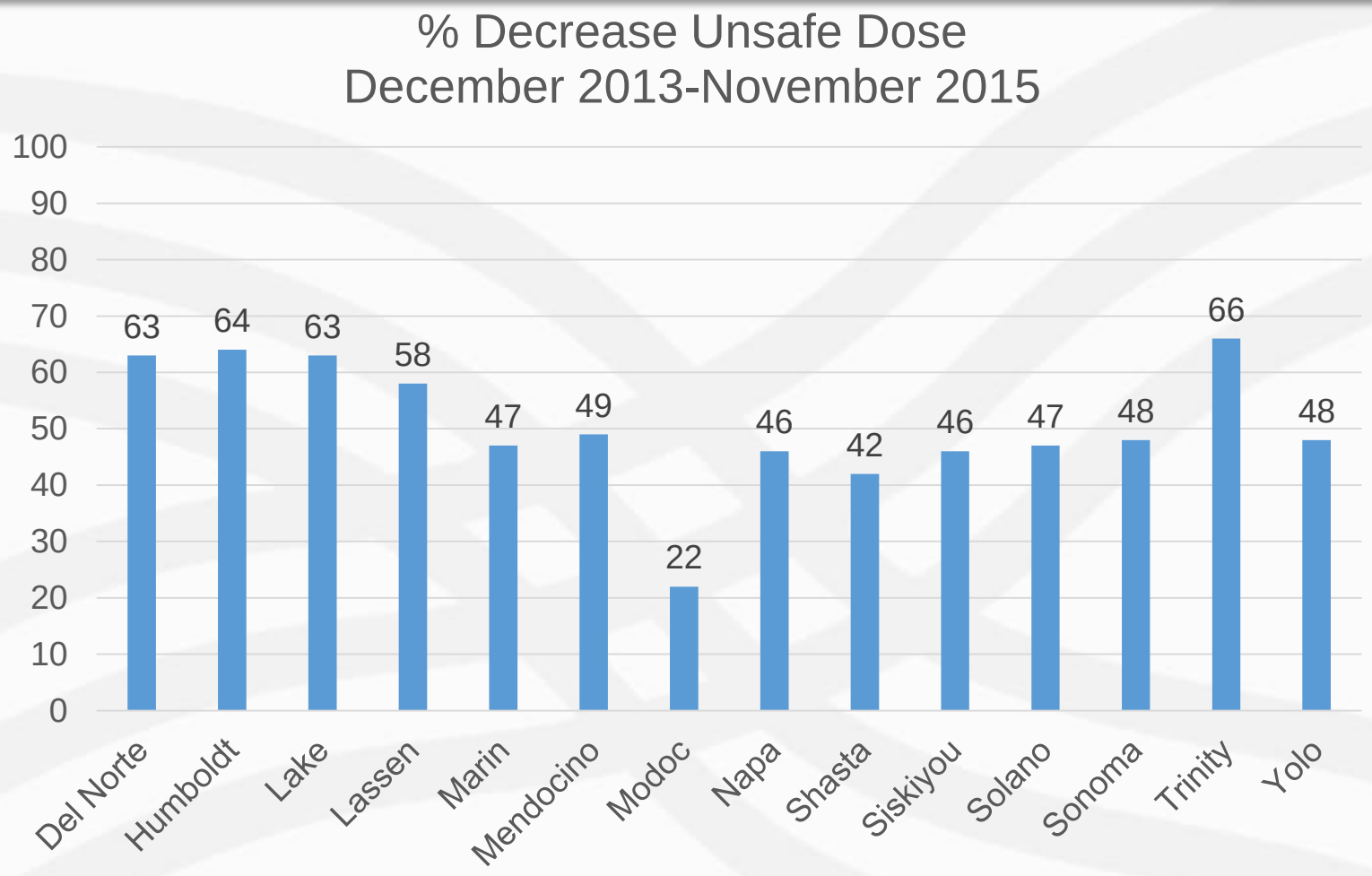
# Percent Decrease of Unsafe Dose

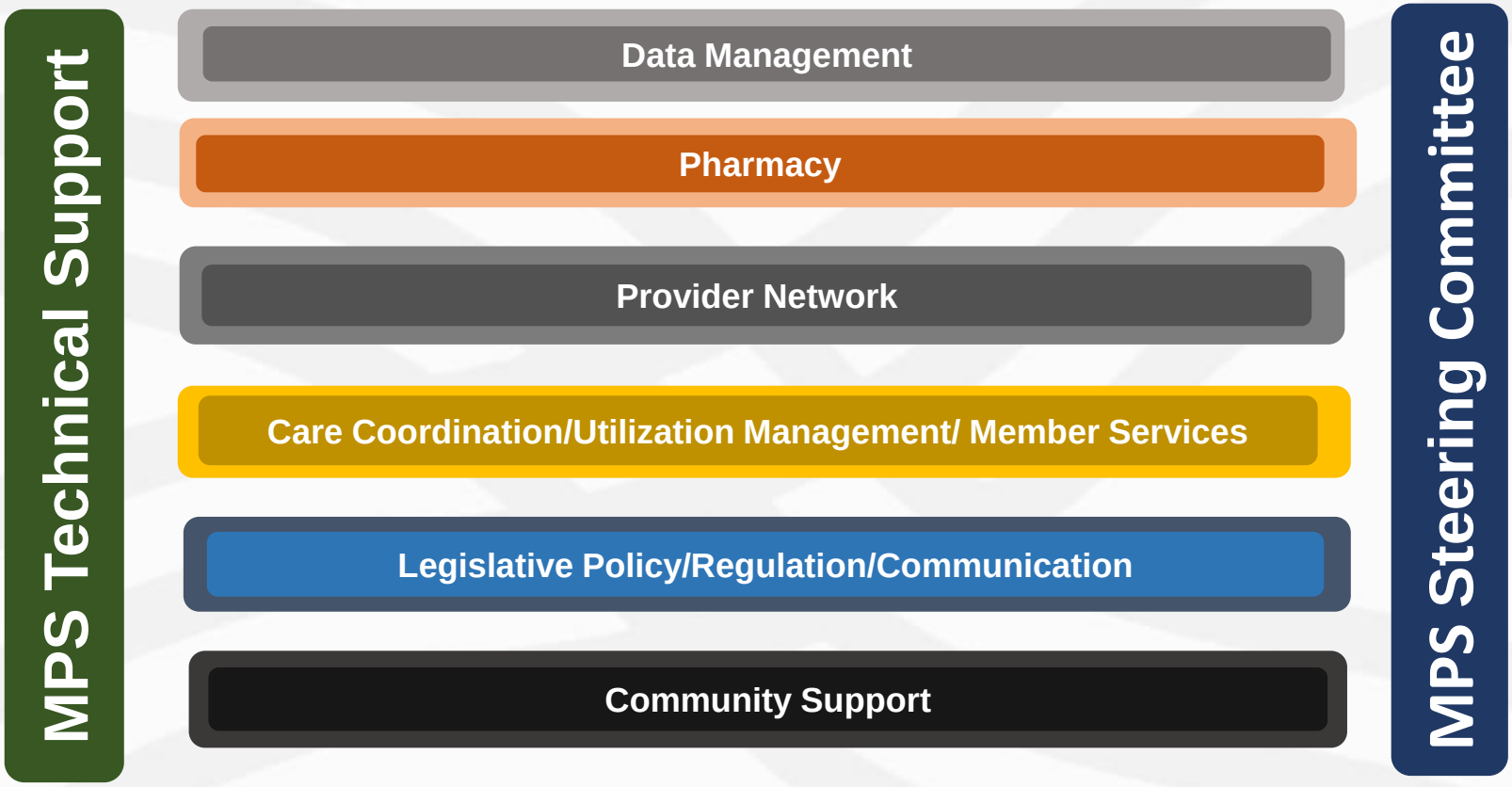



Moore R. CMO Report on Quality. Dec. 2015

# Accomplishments:

## Health Plan Activities

# MPS Workgroups

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# Interventions

Education

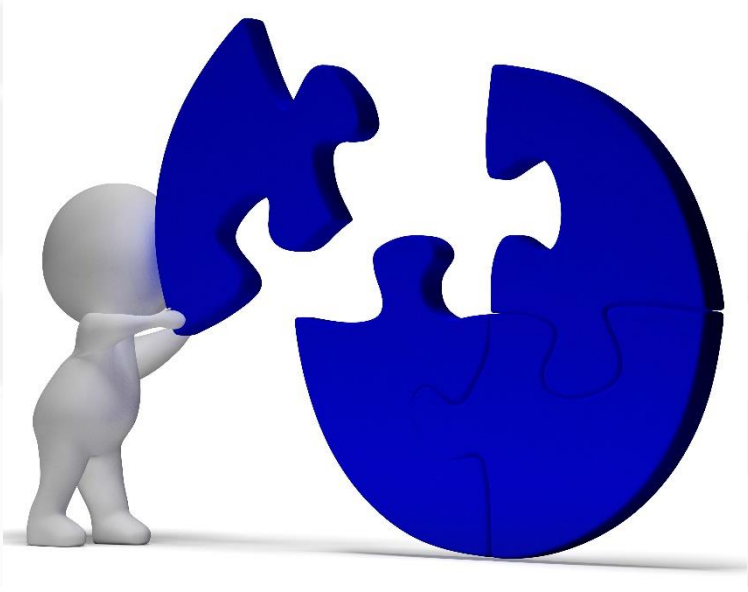
Health plan pharmacy prior authorization changes

Additional options for treating pain

Community activation

Aligned incentives

Additional resources



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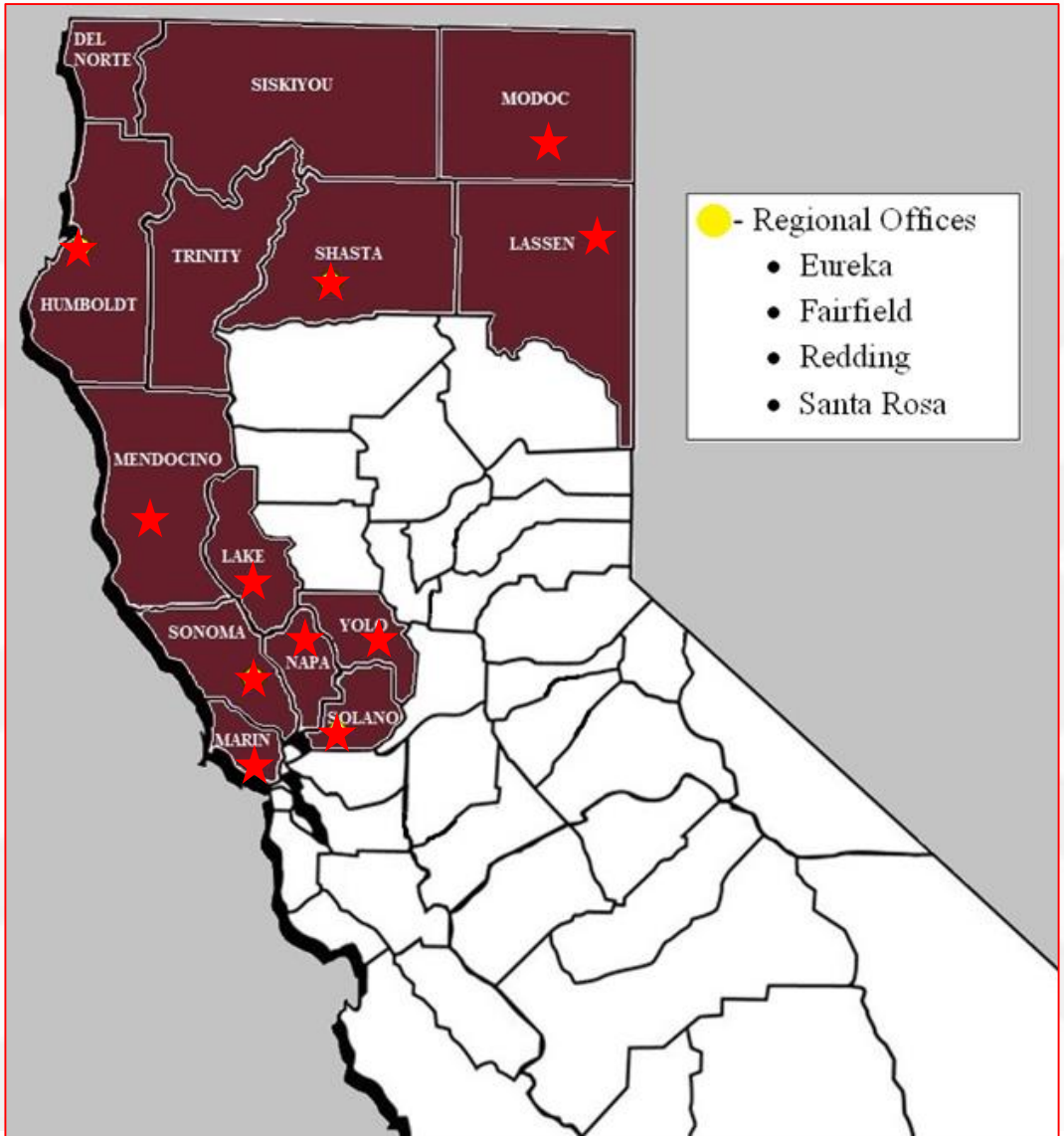
# Accomplishments:

## Community Coalitions

# PHC Counties Participating in CHCF Regional Opioid Safety Coalition Grant Program




10 PHC Counties are participating in CHCF's Regional Opioid Safety Coalition Grant Program

★ CHCF Opioid Safety Coalition County

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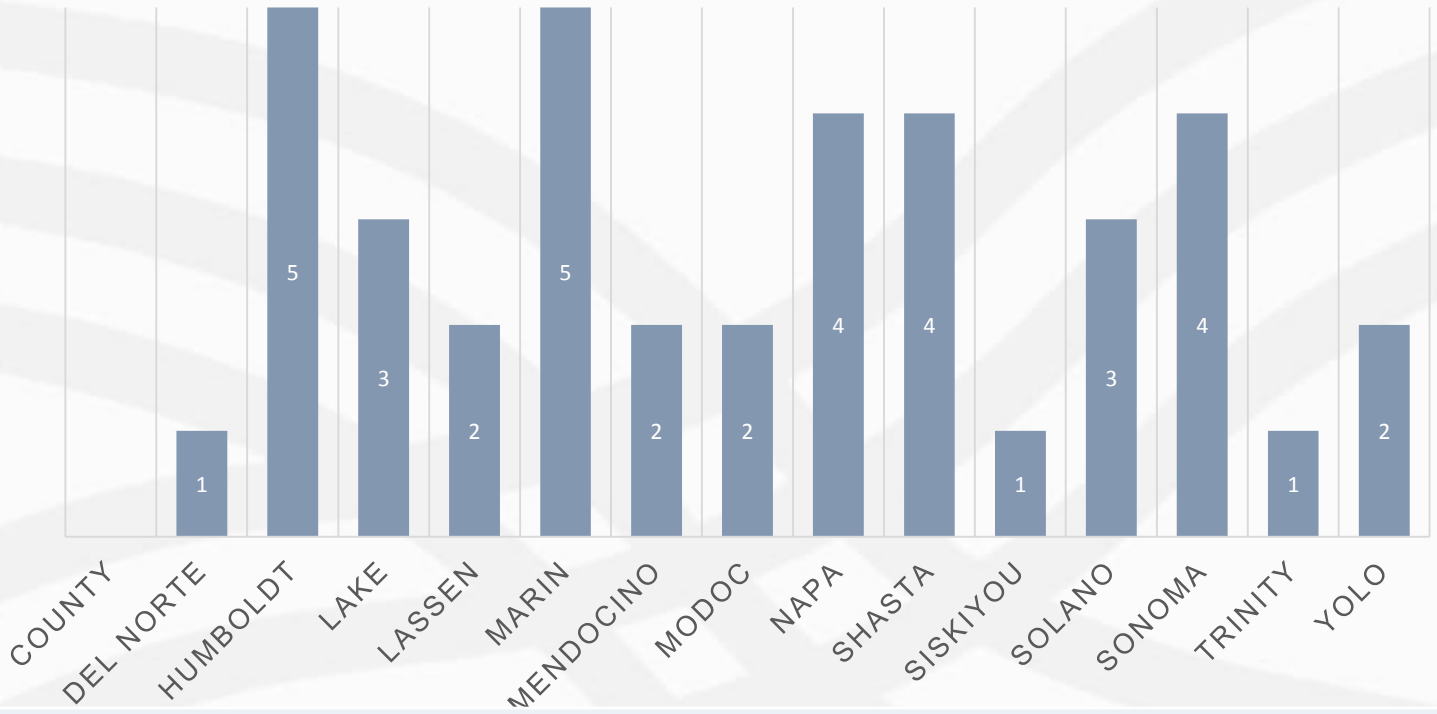
# Community Coalition Status




| Key | |
|---|---|
| 1 | Little or No Effort (Yet) |
| 2 | Initial Meetings, Beginning of Framework Formation |
| 3 | Framework Formation, Action Teams Initiating |
| 4 | Strong Effort- Framework Implemented, Regular Meetings, Active Action Teams, Working towards Milestones |
| 5 | Robust Effort- Active Action Teams, Accomplishing Milestones, Measurable Results |

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# Accomplishments:

## Primary Care Providers

# Interventions

Opioid Oversight Committees

Setting up Health Center-wide policies

Tapering

Integrated Behavioral Health

Talking to patients, one by one.

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# Progress Towards Goal

# Managing Pain Safely – Aim Statement

By December 31, 2016, we will improve the health of PHC members by ensuring that prescribed opioids are for appropriate indications, at safe doses, and in conjunction with other treatment modalities as measured by a:

- Decrease in total number of initial prescriptions by 75%
- Decrease in total number of prescription escalations by 90%
- Decrease in total number of patients on high-dose opioids* by 75%

*Defined as greater than 120 mg. MED

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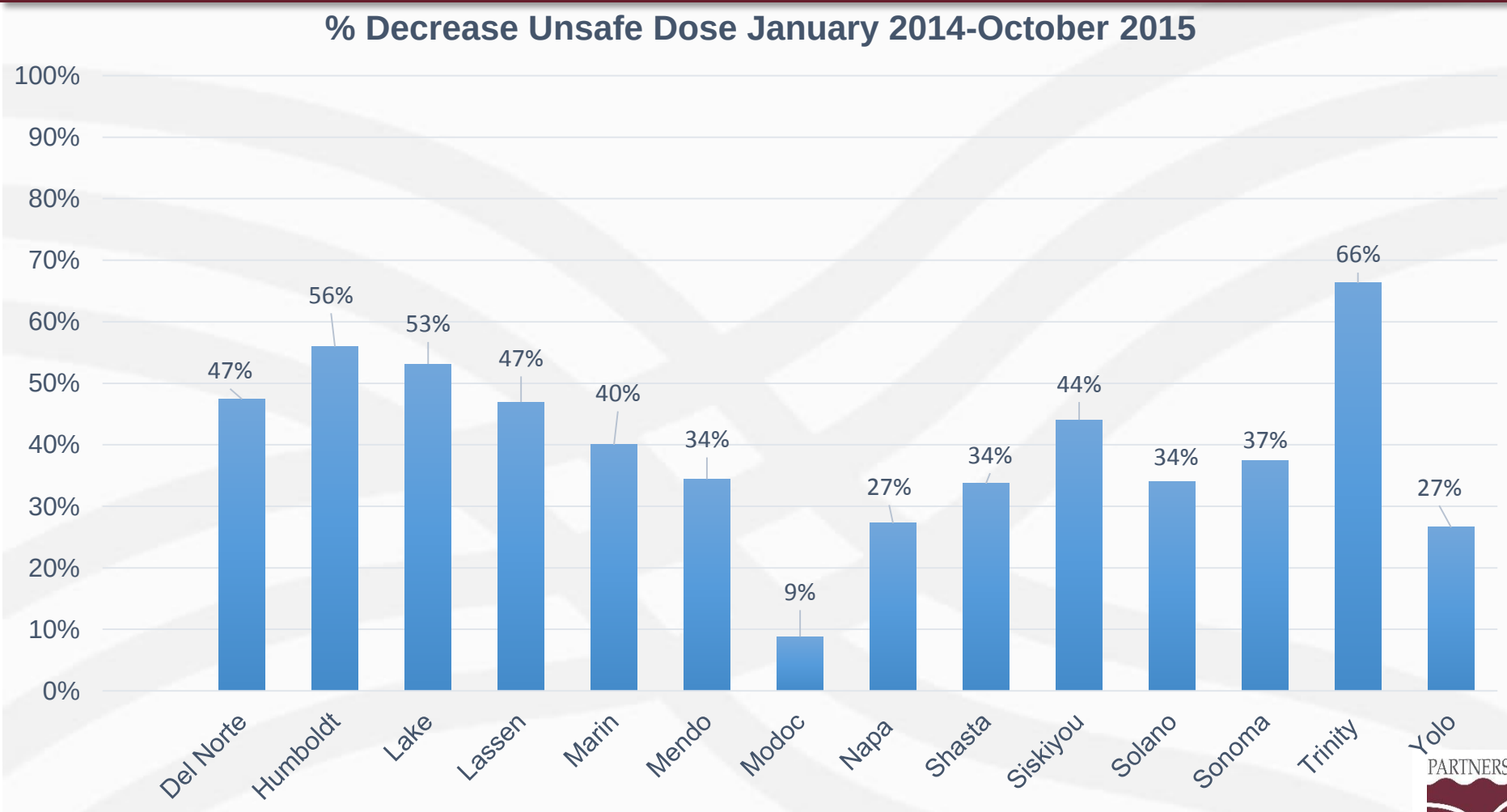
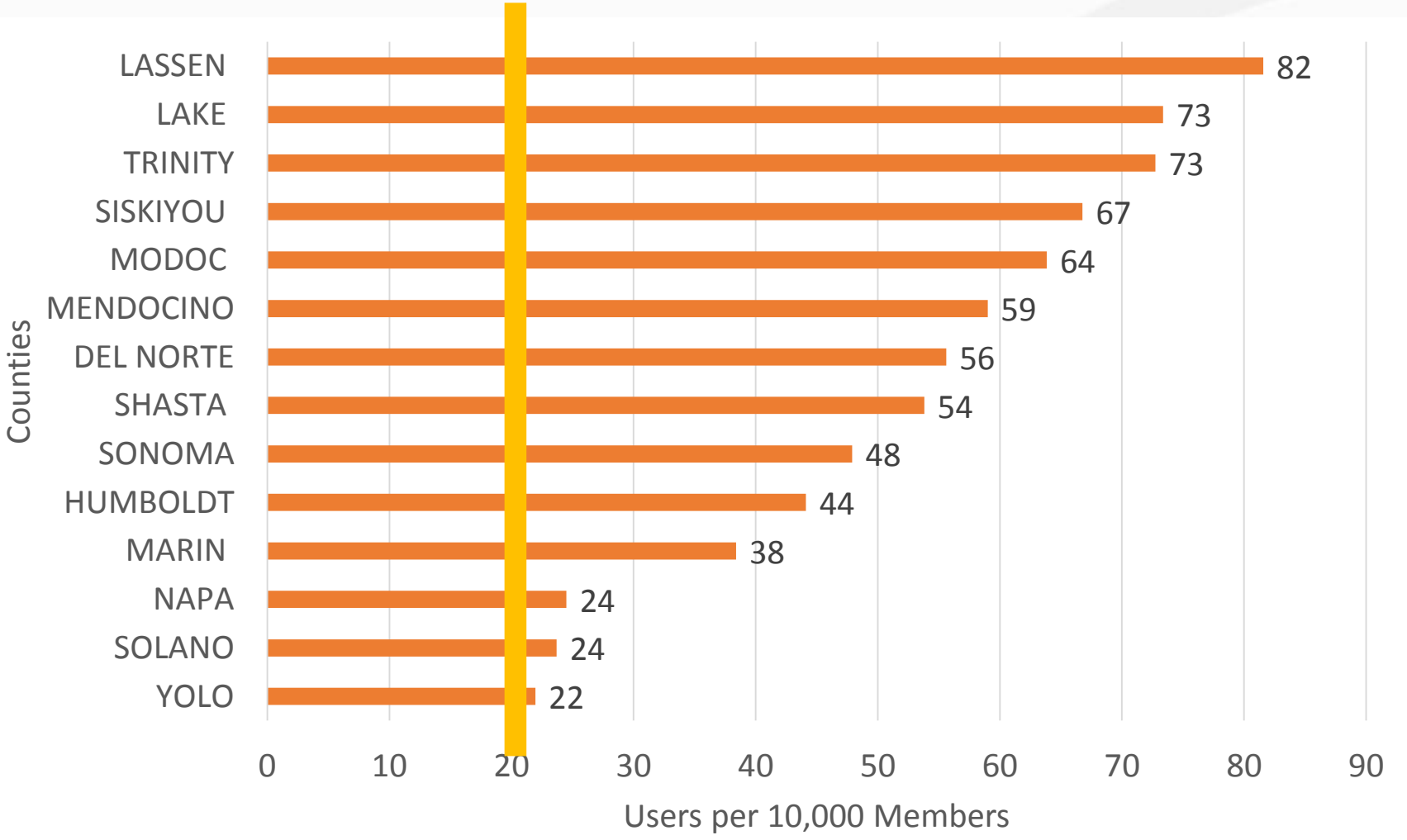
# Percent Decrease of Unsafe Dose




Moore R. CMO Report on Quality. Dec. 2015

# Rate of High Opioid Users: End of 2015

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# Achieving Our Goal: I

## Health Plan Activities for 2016

# Looking Ahead in 2016: Health Plan Activities

- Provision of tele-consult services for complex patients on high-dose opioids
- Education and coordination around addiction screening and treatment
- Partner with CHCF for continued support in developing and sustaining local efforts targeted at reducing improper use of opioids
- Planning process for creating integrated clinics for high utilizers
- Pharmacy academic detailing
- MPS provider level data sharing
- Tapering guide/ toolkit
- Naloxone Pilot

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# Achieving Our Goal: II

## State Wide Activities

# Looking Ahead in 2016: State Wide Activities

- Support for Community Coalitions
- Planning for Integrated Approach to Patients on High Doses of Chronic Opioids
- CDC Guidelines
- CURES 2.0

# Achieving Our Goal: III

## Prescriber Activities

# Looking Ahead in 2016: Prescriber Activities

- Sign up for tele-consult services for complex patients on high-dose opioids
- Make local opioid oversight committees more robust
- Participate in regional coalitions
- Give feedback on draft plan for integrating chronic pain treatment with Medication Assisted Therapy
- Ask your PHC Regional Medical Director to meet with you and/or your clinicians to review their individual PHC opioid data and to review MPS
- Tapering guide/ toolkit
- Distribute Naloxone and educate patients/families on how to use it.

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# Thank You!!!

Robert Moore, MD, MPH, Medical Director,
Partnership HealthPlan of California


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complex
.care

Cory Waller, Medical Director Center for Integrated Medicine

*Spectrum Health Medical Group*

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# An Overview Of Substance Use Disorders

## Partnership Health Plan

Sharone Abramowitz M.D.

Psychiatrist & Addiction Medicine Board Certified

Behavioral & Addiction Medicine Director, Primary Care Medicine Residency, Highland Hospital, Alameda Health System

Executive Council, Calif Society of Addiction Medicine

Motivational Interviewing Network of Trainers

Integrative Psychiatry Private Practice, Oakland & San Francisco

**www.Abramowitz-Psychiatry.com**

- Epidemiology
- Brain & Addiction
- DSM V
- Opiates
- Marijuana
- Alcohol
- Screening & Counseling

# What we will cover ...

# Summarizing

## Empathy Exercise

**Pair off**

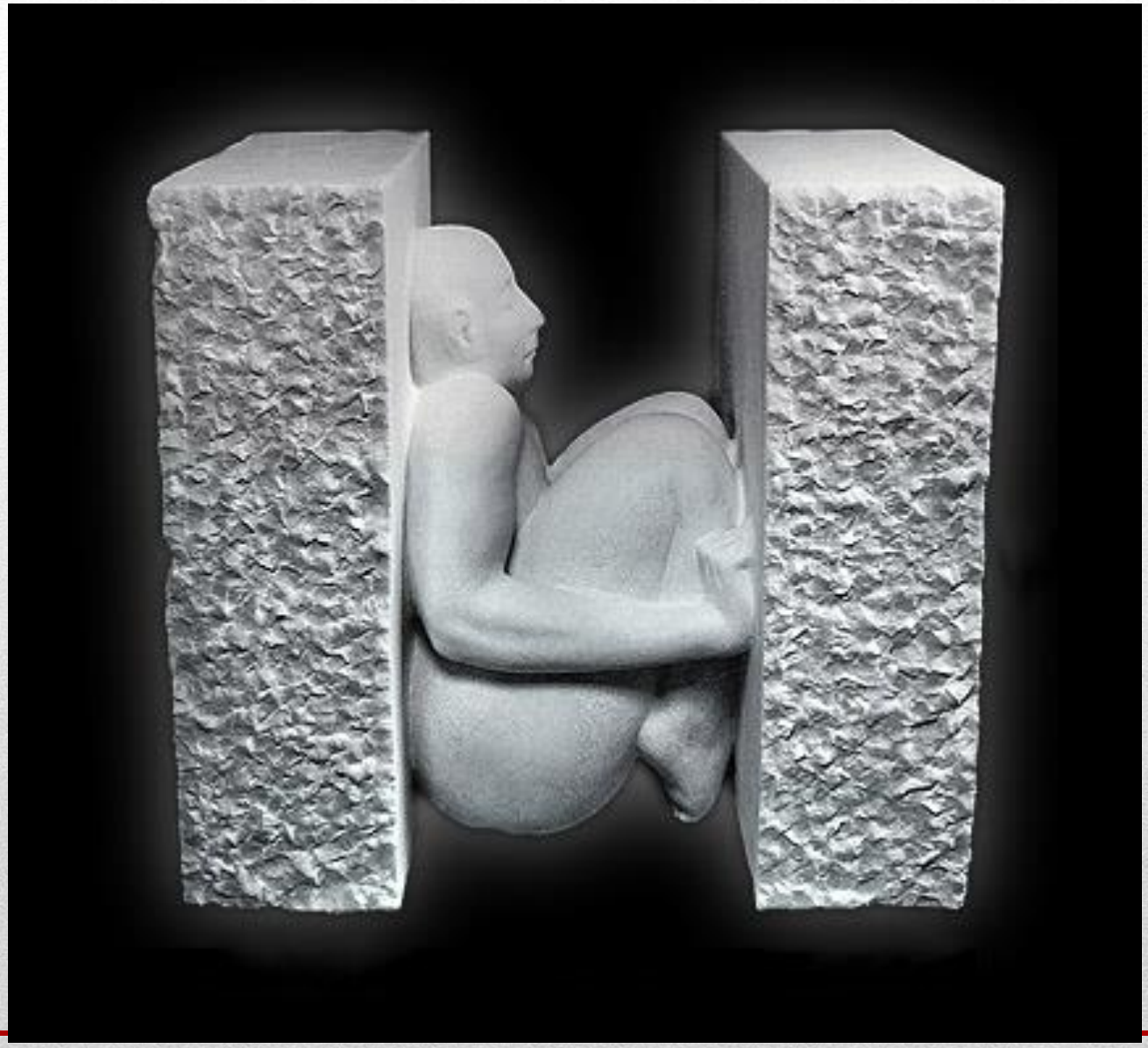
**Speakers**

- Think of an impactful interaction you've had with one of your addiction pts (positive or negative)
  - Emotional impact, what did you learn?, what you need to learn?
- Speak for 90 seconds

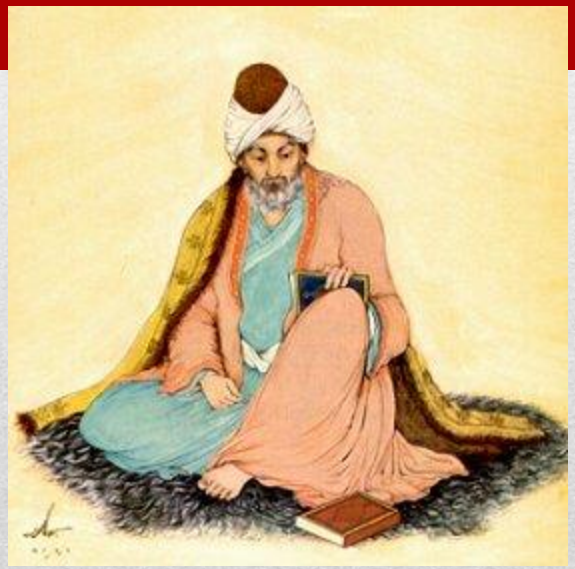
**Listeners**

- Listen without speaking
- Your face will show natural responsiveness
- After time is called, you have 60 seconds to summarize in your own words the story you just heard.

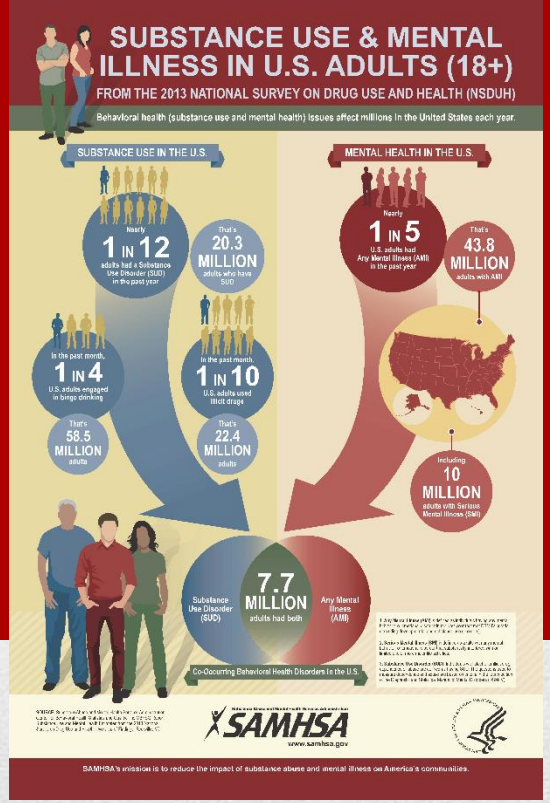
**Reverse**



*“The wound is the place where*
*the light enters you.”*

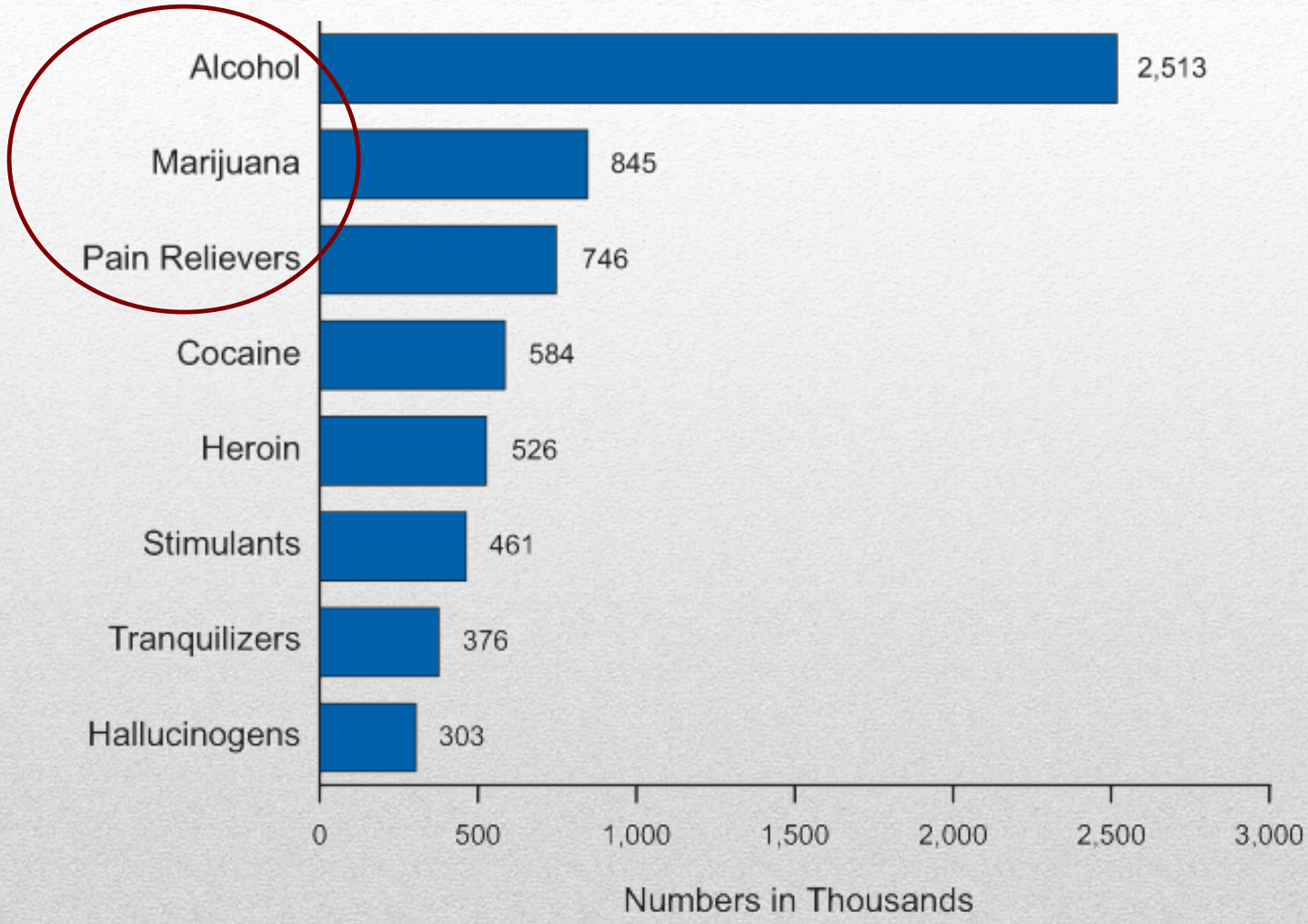


**Rumi**



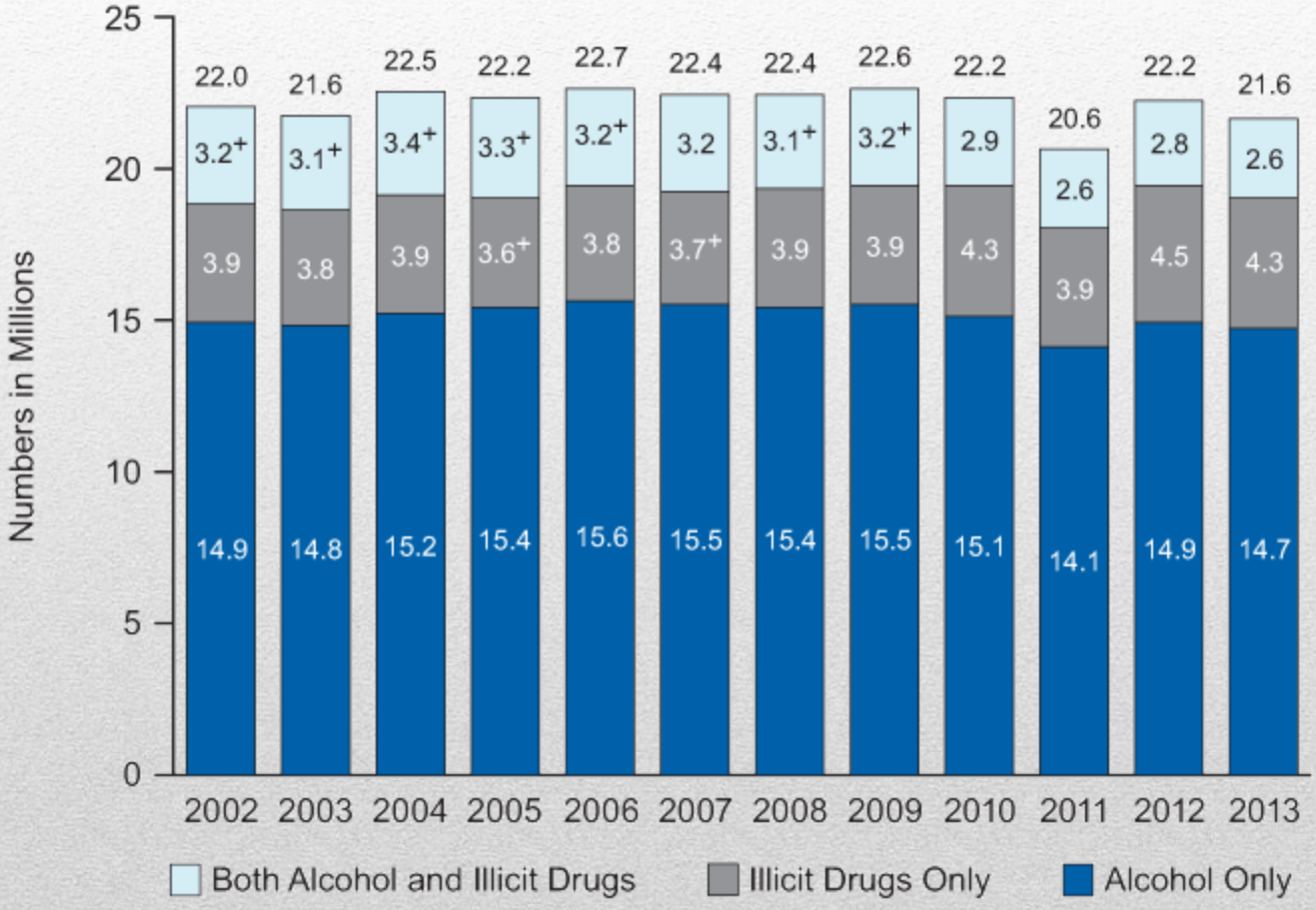

# EPIDEMIOLOGY

## Substances for Which Most Recent Treatment Was Received in the Past Year among Persons Aged 12 or Older: 2013



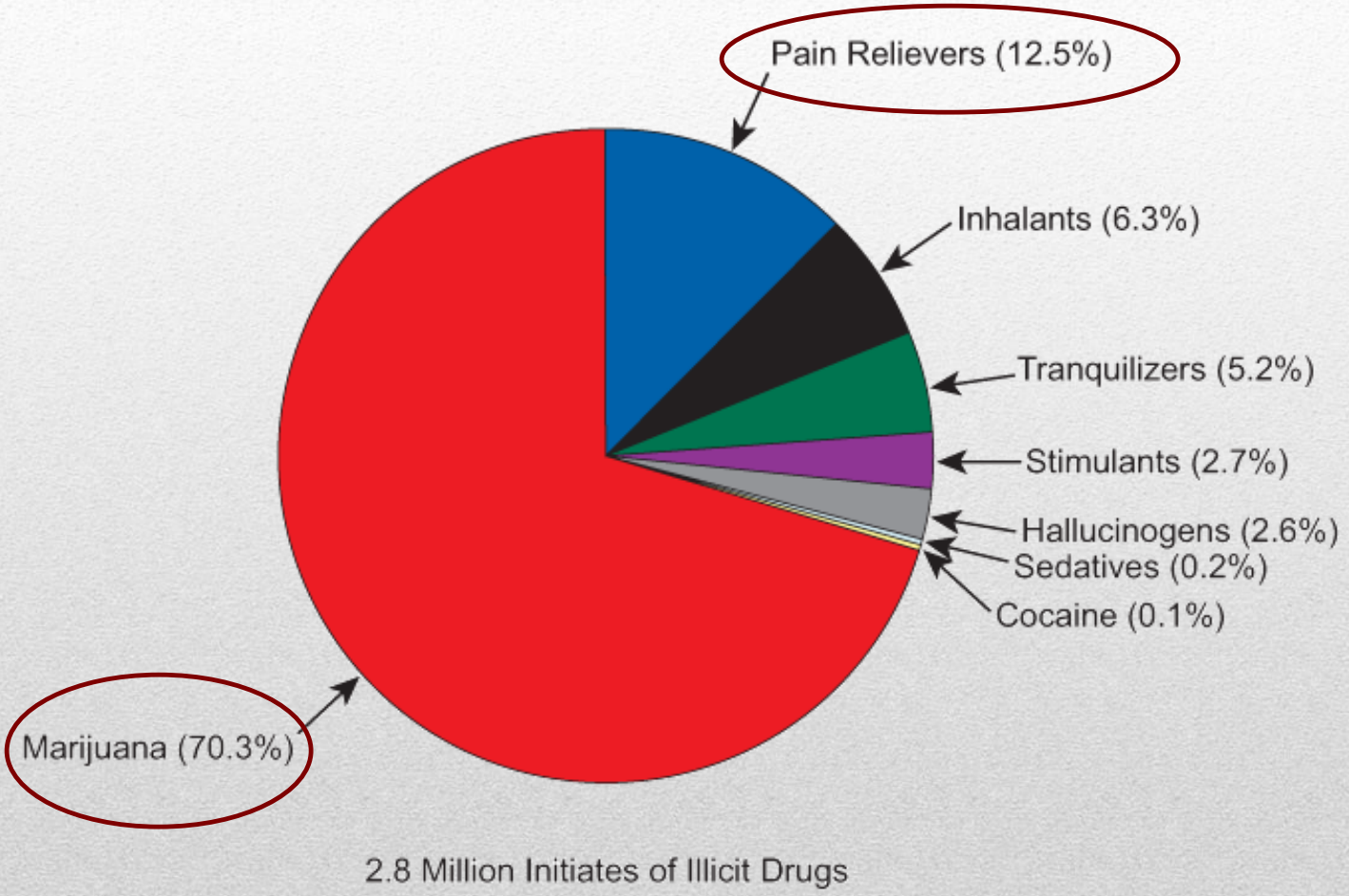

NSDUH 2013

## Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2013




NSDUH 2013

**First Specific Drug Associated with Initiation of Illicit Drug Use among Past Year Illicit Drug Initiates Aged 12 or Older: 2013**

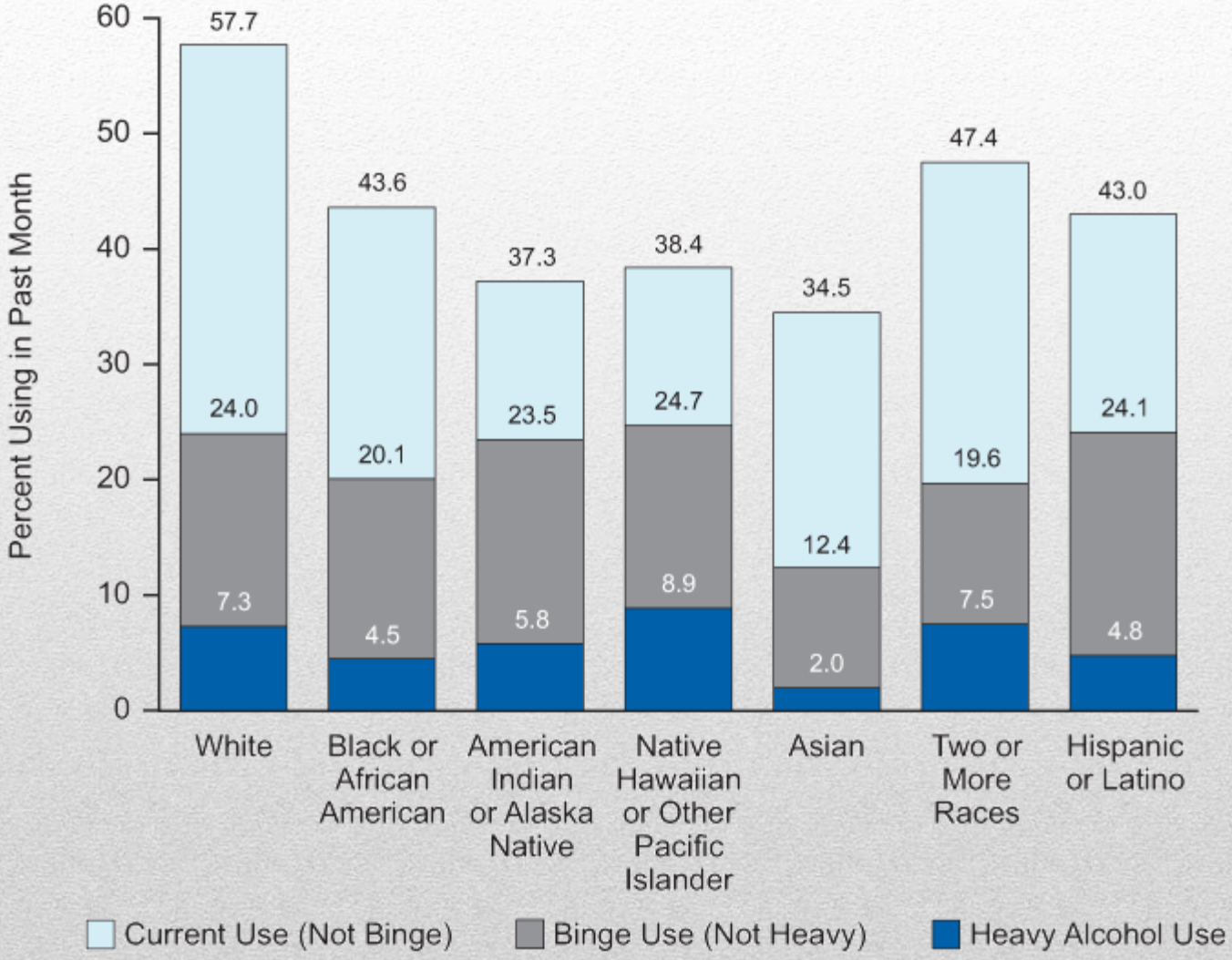



NSDUH 2013

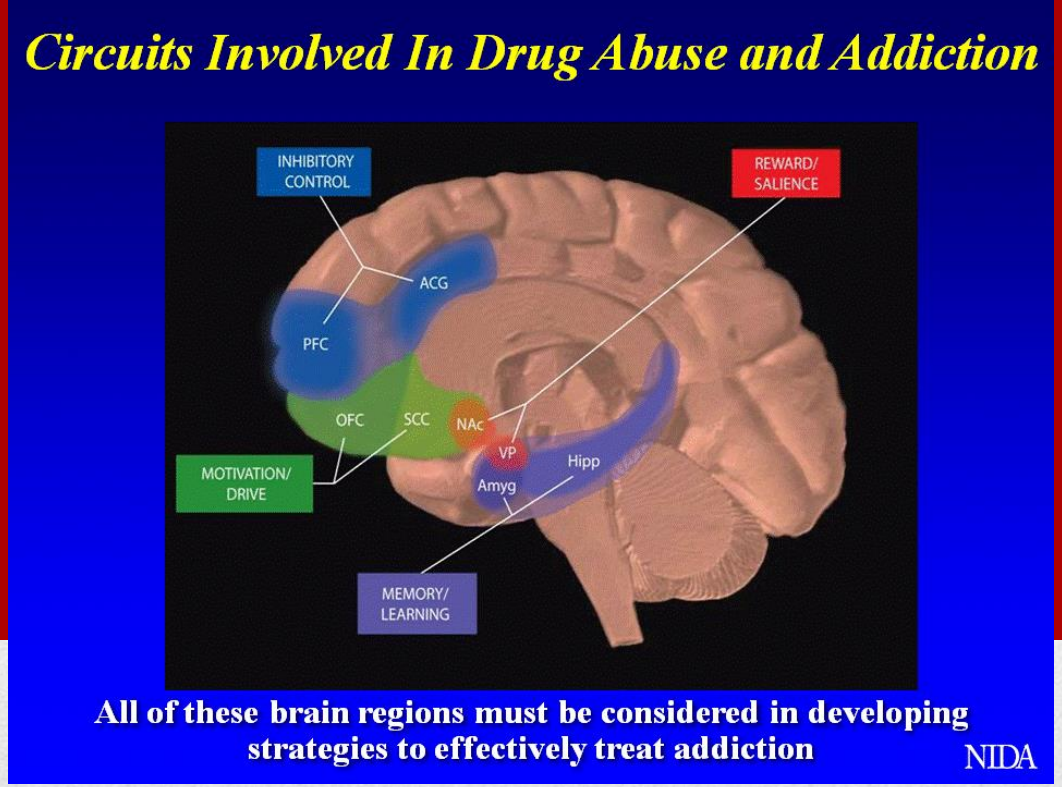
**Substance Dependence or Abuse in the Past Year, by Age and Gender: 2013**


NSDUH 2013

## Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Race/Ethnicity: 2013




NSDUH 2013




# THE BRAIN & ADDICTION

**SUDs as a Chronic Brain-Based Disease**

# Epigenetics & SUDs


# Adverse Childhood Events (ACE)

## CDC & Kaiser San Diego Study

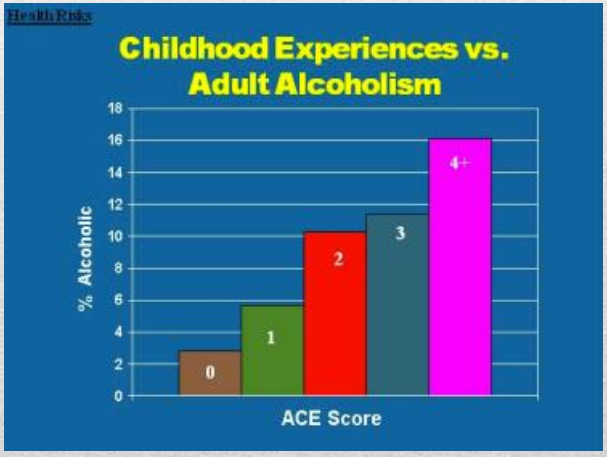
http://www.cdc.gov/violenceprevention/acestudy/

**4 or more categories of ACEs, compared to those w/ none**:

- 4-12-fold risks for alcoholism, drug abuse, depression, and suicide attempt
- 2- 4-fold increase in smoking, poor self-rated health
- 1.4- 1.6-fold increase in physical inactivity and severe obesity

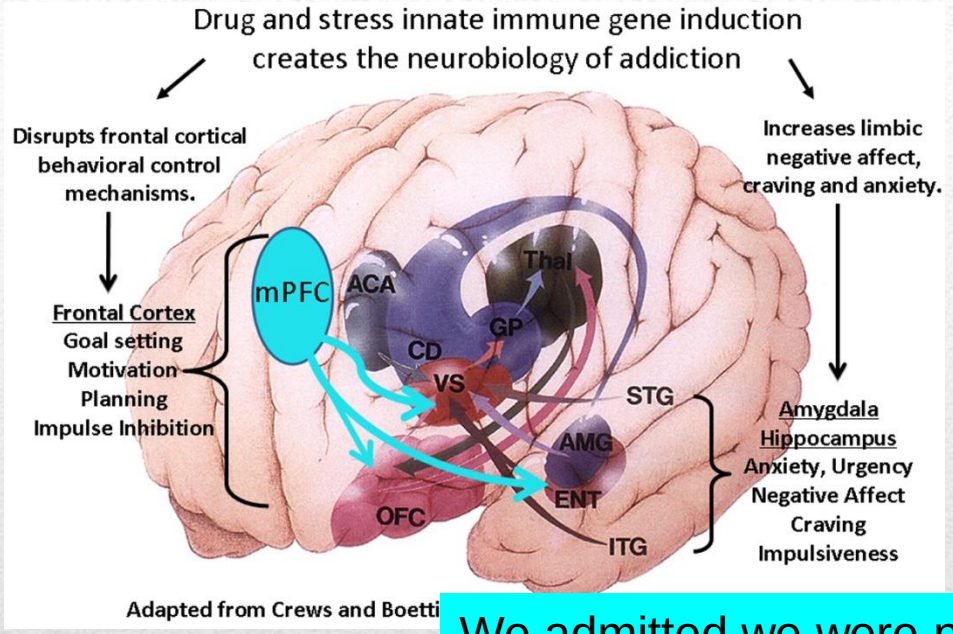
- **# of ACEs showed a graded relationship to the presence of adult diseases including**: ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

Am J Preventive Med 1998

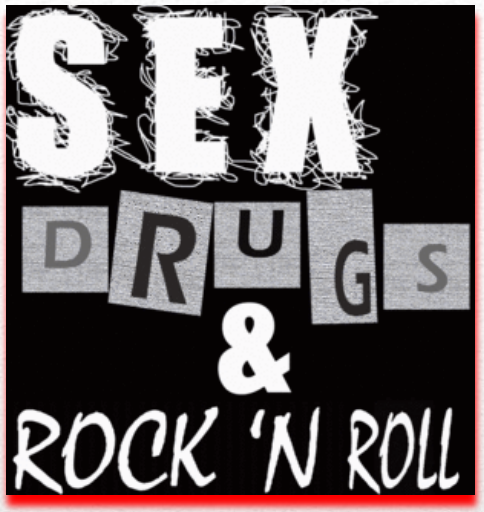



Useful to ask all pts:

"Have you ever been harmed physically, sexually, emotionally as a child or an adult?"




We admitted we were powerless over drugs – that our lives had become unmanageable.

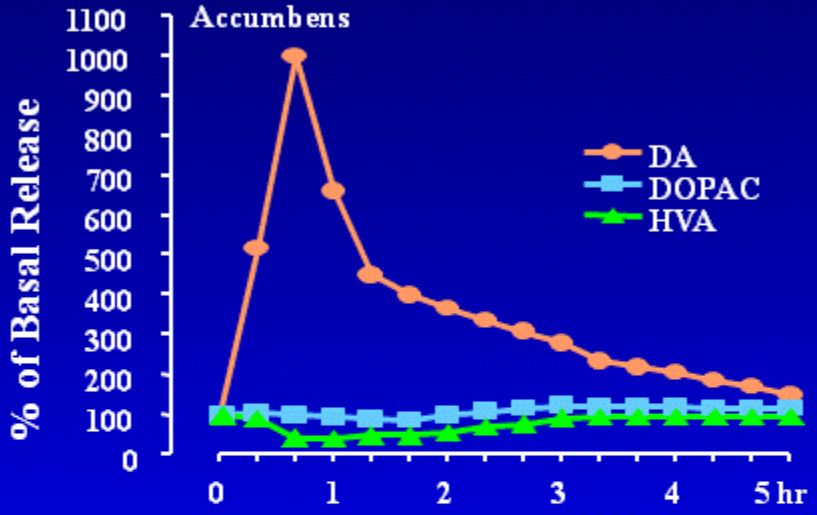



Dopamine

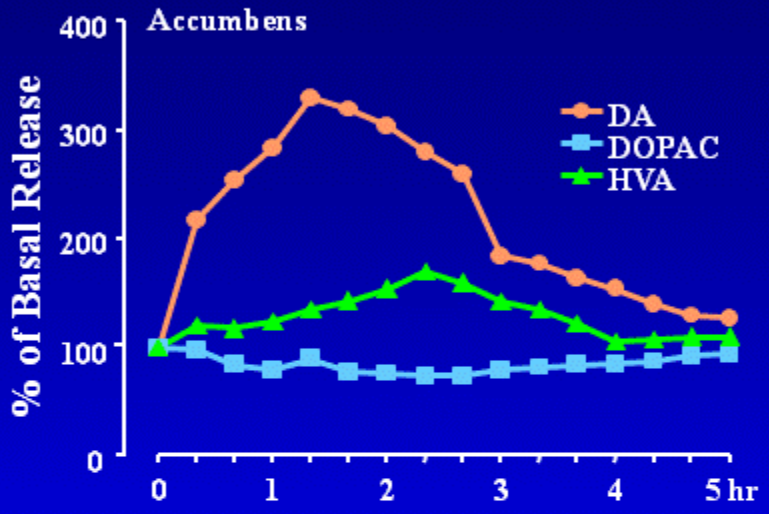
- Sex, food, drugs, soci connections VTA (mesolimbic)
  - Pleasure, reward, socializing
  - Addiction *
  - Psychosis *
- Pain processing PNS & CNS pain systen
  - Chronic pain *
- Movement Substantia Niagra
  - Parkinson's disease
- Executive Function PFC
  - ADHD *
- Inhibits PRL hypothalamus
  - Stop lactating

# *Effects of Drugs on Dopamine Release*

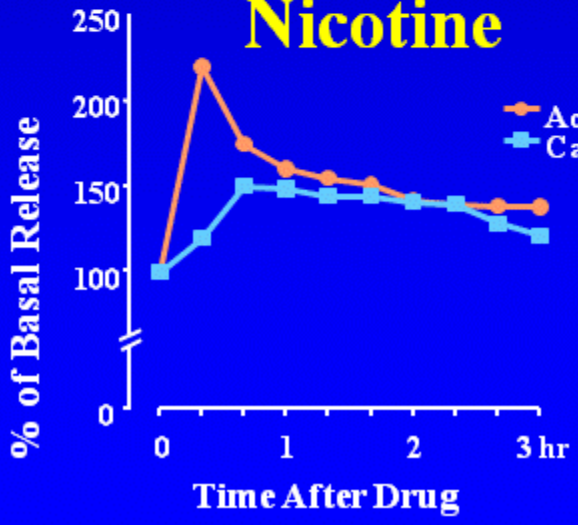
## Amphetamine



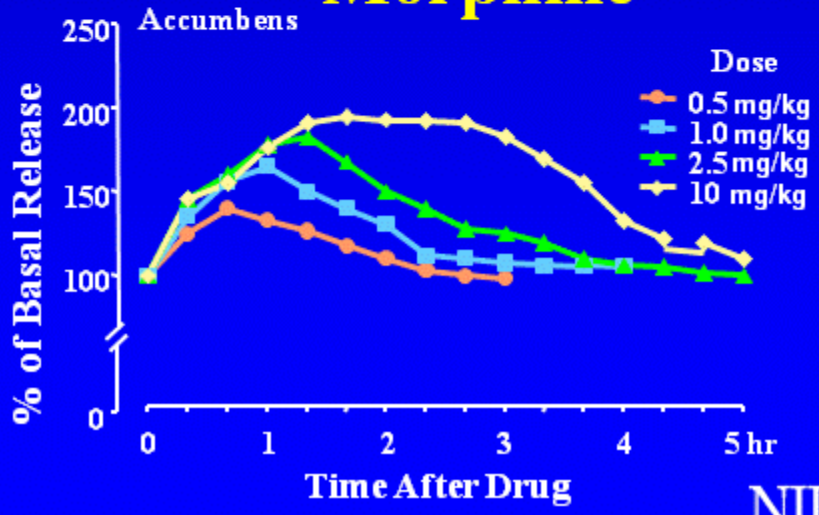

## Cocaine




## Nicotine




## Morphine




*Di Chiara and Imperato, PNAS, 1988*

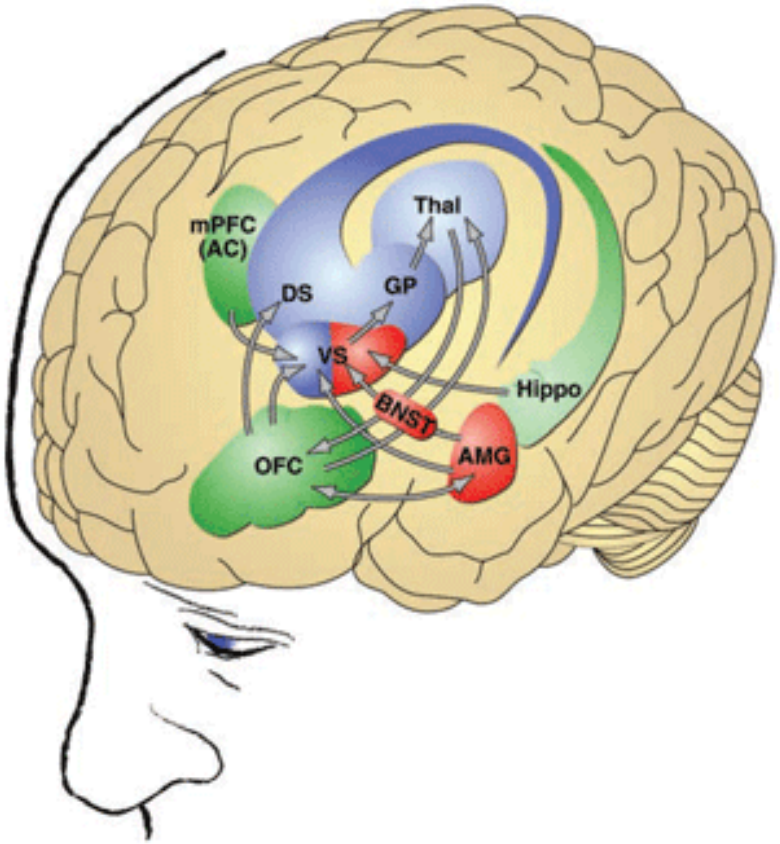
NIDA

Dr. Nora Volkow on Addiction: A Disease of Free Will, July 2015

**www.youtube.com/watch?v=X1AEvkWxbLE**

# Dr. Nora Volkow

## NIDA Director




**Binge/intoxication**

- ventral striatum (VS), including nucleus accumbens
  euphoria, reward
- dorsal striatum (DS)
  habits, perseveration
- global pallidus (GP)
  habits, perseveration
- thalamus (Thal)
  habits, perseveration

**Withdrawal/negative affect**

- amygdala (AMG), bed nucleus of the stria terminalis (BNST), together also known as the "extended amygdala"
  malaise, dysphoria, negative emotional states
- ventral striatum (VS)
  decreased reward

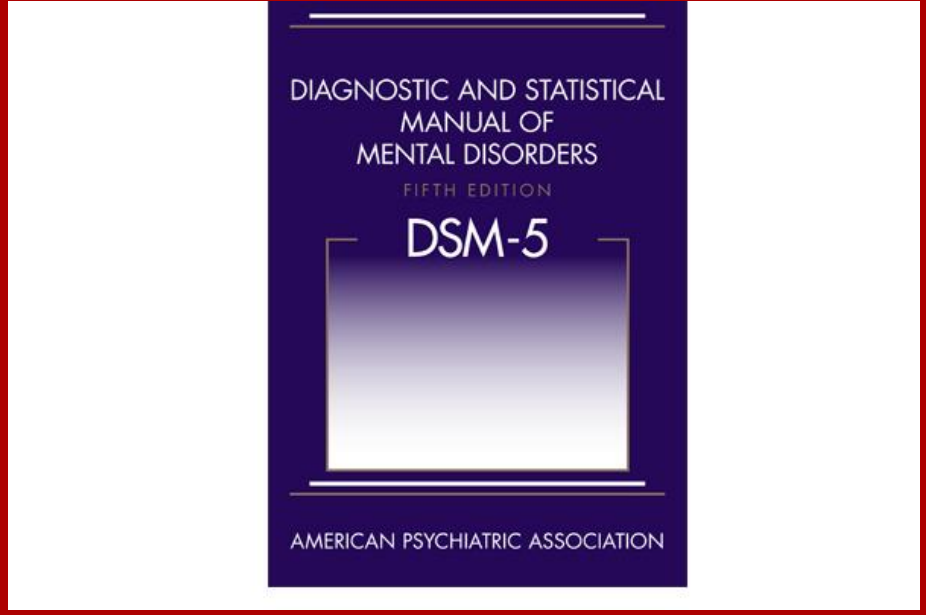
**Preoccupation/anticipation**

- anterior cingulate (AC)
- prefrontal cortex (mPFC), orbitofrontal cortex (OFC)
  subjective effects of craving, executive function
- basolateral nucleus of the amygdala
  conditioned cues
- hippocampus (Hippo)
  conditioned contextual cues

# 3 Stages of the Addiction Cycle

G. Koob, The Potential of Neuroscience to Inform Treatment, NIAAA

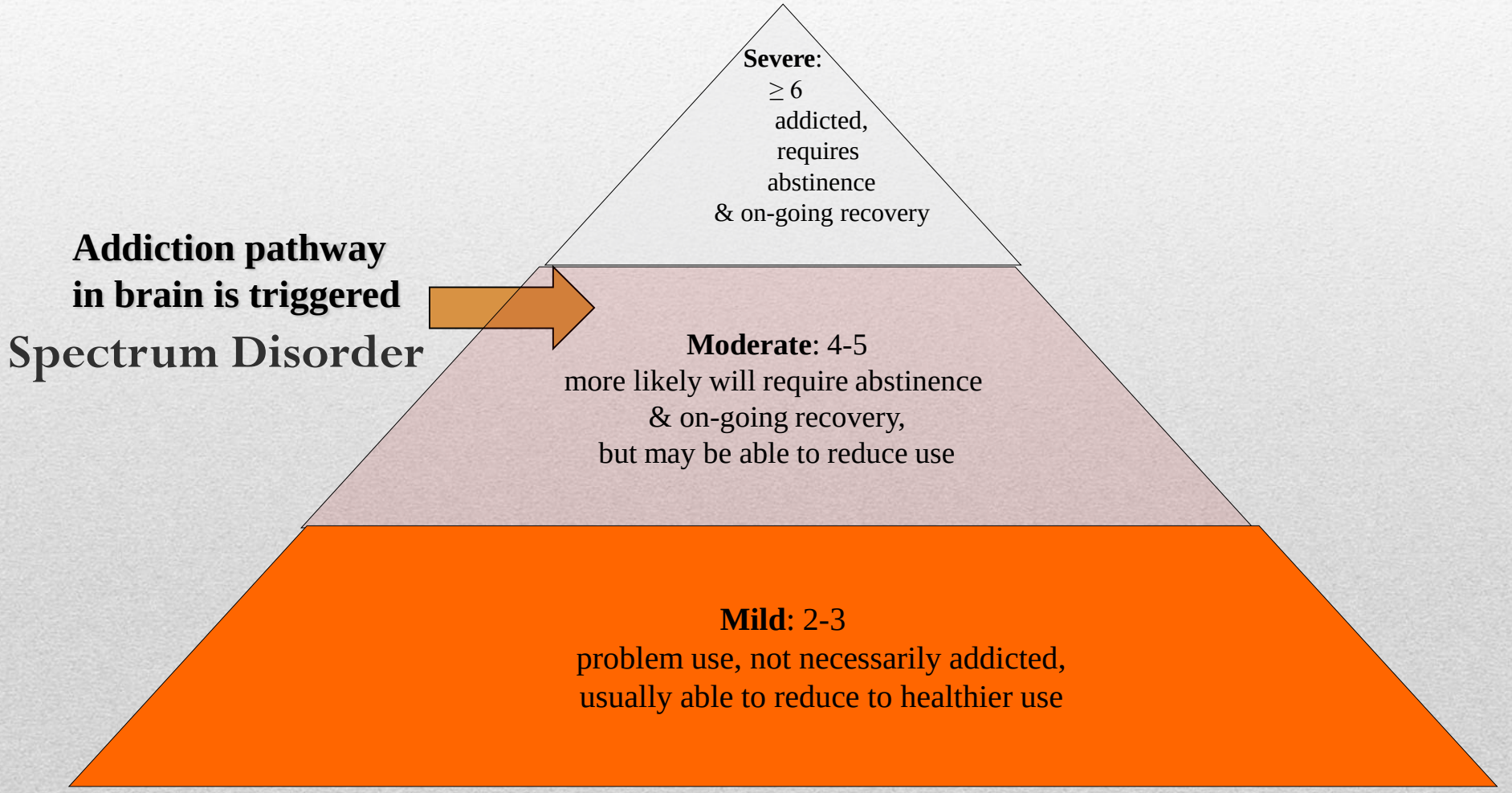

Stop
Go




# DSM 5 CRITERIA

## Alcohol Use Disorder

# DSM 5: Alcohol/Drug Use Disorder



Impaired Control
(1-4)

Social Impairment
(5-7)

Risky Use
(8-9)

Pharmacological Criteria
(10-11)

11 dsm 5 criteria

# DSM 5: Alcohol Use Disorder Criteria

Within a 12-month period:

- Took more than intended
- Unsuccessful efforts to cut down
- Lots of time spent obtaining, using, or recovering
- Craving
- Failures to fulfill obligations at work, school, home
- Use despite social or interpersonal problems
- Giving up activities because of opioids
- Use when physically hazardous
- Use despite negative psych or physical impact
- Tolerance (not a criteria for opioids)
- Withdrawal (not a criteria for opioids)

- MILD: 2-3
- MODERATE: 4-5
- SEVERE: 6 or more

# What are the 4 C's of Addiction?

- Loss of **C**ontrol
- **C**ompulsive use
- **C**ontinued use despite harm
- **C**raving

- In the last year:
  - Have you ever drunk or used drugs, including prescription drugs, more than you meant to?
  - Have you felt you wanted or needed to cut down on your drinking or drug use, including prescription drugs?
  - 1 pos answer: 80% sensitivity/specificity
    - Brown, et al. J Am Board Fam Pract 2001.

# Two Item Conjoint Screen: TICS

used in *Screening Brief Intervention & Referral to Treatment (SBIRT)*

**Single Question Screen**
**(National Institute on Alcohol Abuse and Alcoholism, Variations Exist)**

*Question:* How many times in the past year have you had X or more drinks in a day? (X is 5 for men, 4 for women.)

*Scoring:* One or more is considered a positive screen for alcohol misuse.

| *Score* | *Sensitivity (95% CI)* | *Specificity (95% CI)* | *+LR* | *−LR* |
|---|---|---|---|---|
| ≥1 | 82% (73%–89%) | 79% (73%–84%) | 3.9 | 0.2 |

**AUDIT-C**

| *Question* | *Points* | | | | |
|---|---|---|---|---|---|
| | *0* | *1* | *2* | *3* | *4* |
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2–4 times a month | 2–3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7–9 | 10 or more |
| 3. How often do you have 6 or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

*Scoring:* Points from the 3 questions are summed for a total 0 to 12. A positive screen for alcohol misuse is usually considered ≥4 for men and ≥3 for women but may be adjusted for increased sensitivity or specificity. If patients answer *never* for the first question, scores of 0 can be entered for questions 2 and 3.

| *Score* | *Sensitivity* | *Specificity* | *+LR (95% CI)* | *−LR (95% CI)* |
|---|---|---|---|---|
| Men ≥4 | 0.86 | 0.89 | 7.8 (5.5–11.1) | 0.16 (0.1–0.2) |
| Women ≥3 | 0.73 | 0.91 | 7.9 (6.2–10) | 0.29 (0.2–0.4) |

The full AUDIT questions can be found at the World Health Organization. AUDIT, the alcohol use disorders identification test: guidelines for use in primary care. 2nd ed. Geneva, Switzerland: World Health Organization, Department of Mental Health and Substance Dependence; 2001.

| ***The DAST-10 survey: These questions refer to the past 12 months. One point is awarded for each "Yes" answer.*** | |
|---|---|
| 1. Have you used drugs other than those required for medical reasons? | Yes / No |
| 2. Do you abuse more than one drug at a time? | Yes / No |
| 3. Are you unable to stop using drugs when you want to? | Yes / No |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | Yes / No |
| 5. Do you ever feel bad or guilty about your drug use? | Yes / No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes / No |
| 7. Have you neglected your family because of your use of drugs? | Yes / No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | Yes / No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes / No |
| 10. Have you ever had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | Yes / No |

## Treatment Effectiveness Assessment (TEA)

The TEA asks you to express the extent of changes for the better from your involvement in the program to this point (or how things are if it's your first TEA or baseline) in four areas: substance use, health, lifestyle, and community. For each area, think about how things have become better and circle the results on the scale below: the more you have improved, the higher the number – from 1 (not better at all) to 10 (very much better). In each area write down the one or two changes most important to you in the Remarks section. Feel free to use the back of this page to add details, explain remarks, and make comments.

**Substance use**: How much better are you with drug and alcohol use? Consider the frequency and amount of use, money spent on drugs, amount of drug craving, time spent being loaded, being sick, in trouble and in other drug-using activities, etc.

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

**Health**: Has your health improved? In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

**Lifestyle**: How much better are you in taking care of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

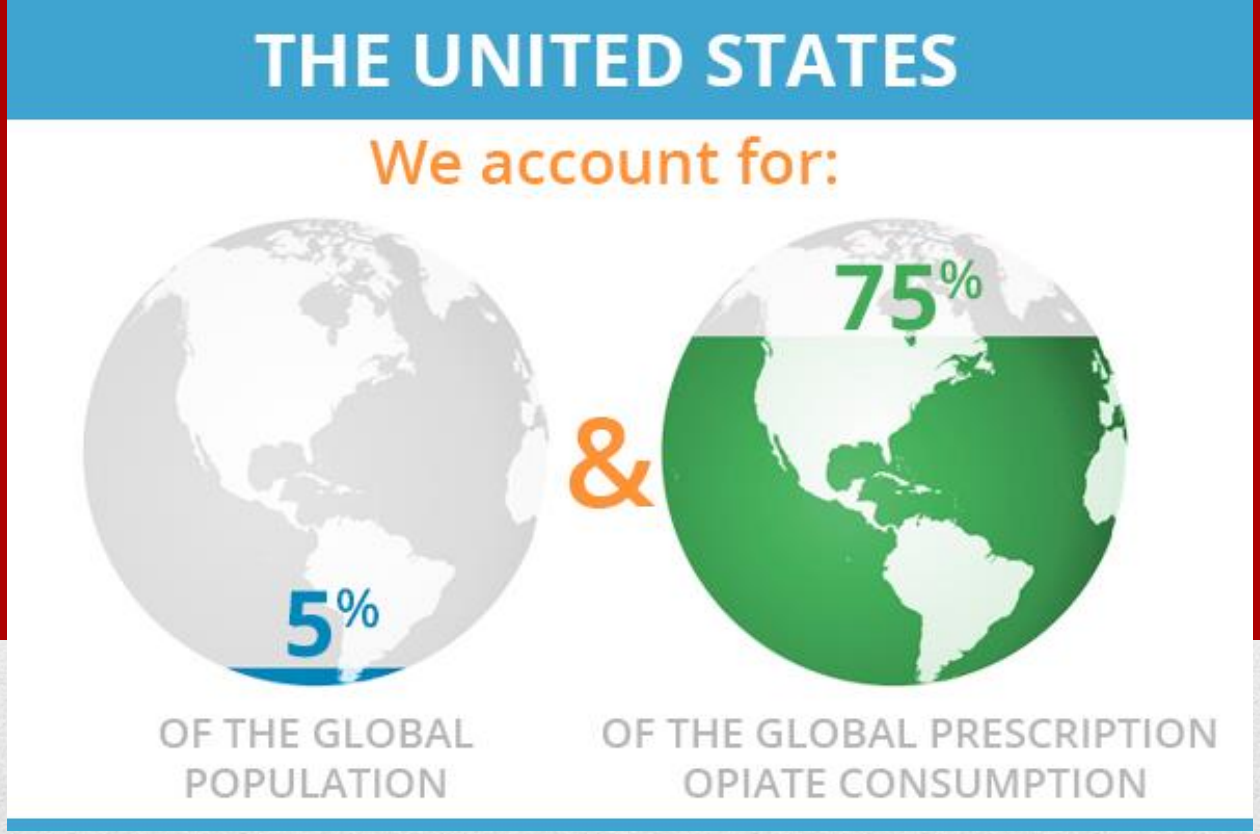
**Community**: Are you a better member of the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

No or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

# Brief Addiction Monitor



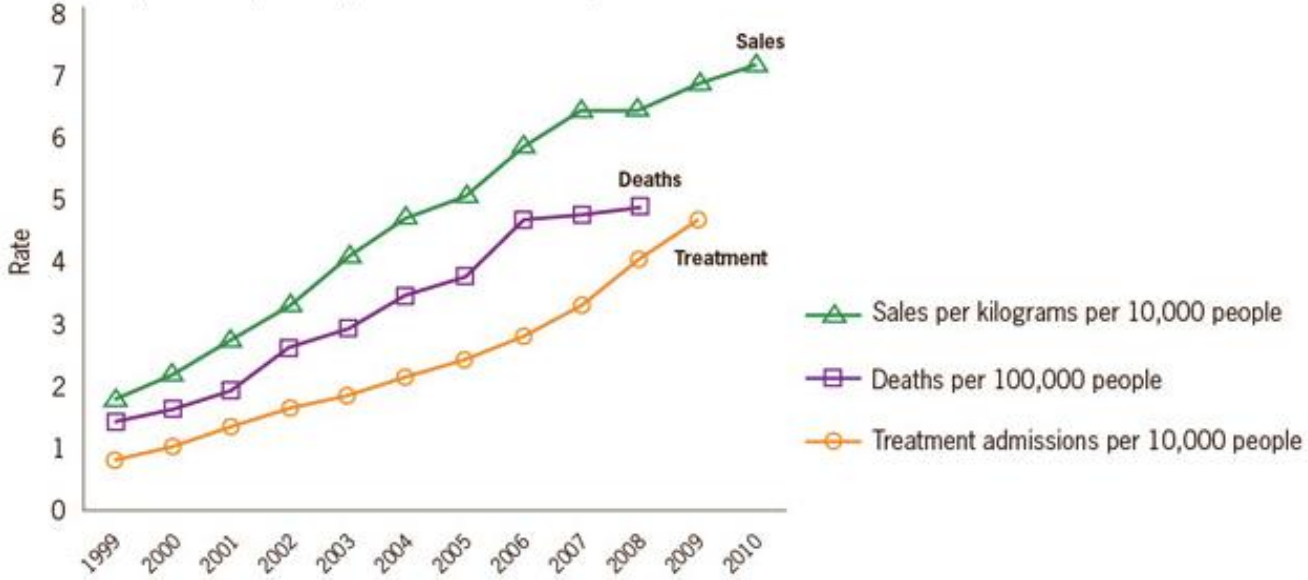

# PRESCRIPTION OPIATE SUD

**#3 most abused substance in the U.S.**

**1 Month**

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)

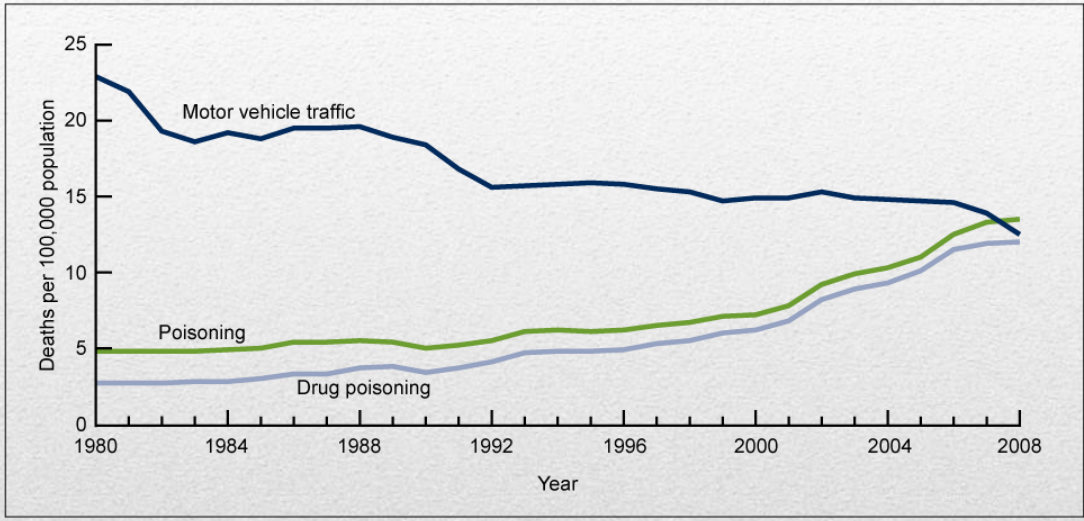



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Drug overdose was the leading cause of injury & death in 2012 for 25-64 yo. Drug overdose caused more deaths than motor vehicle traffic crashes.

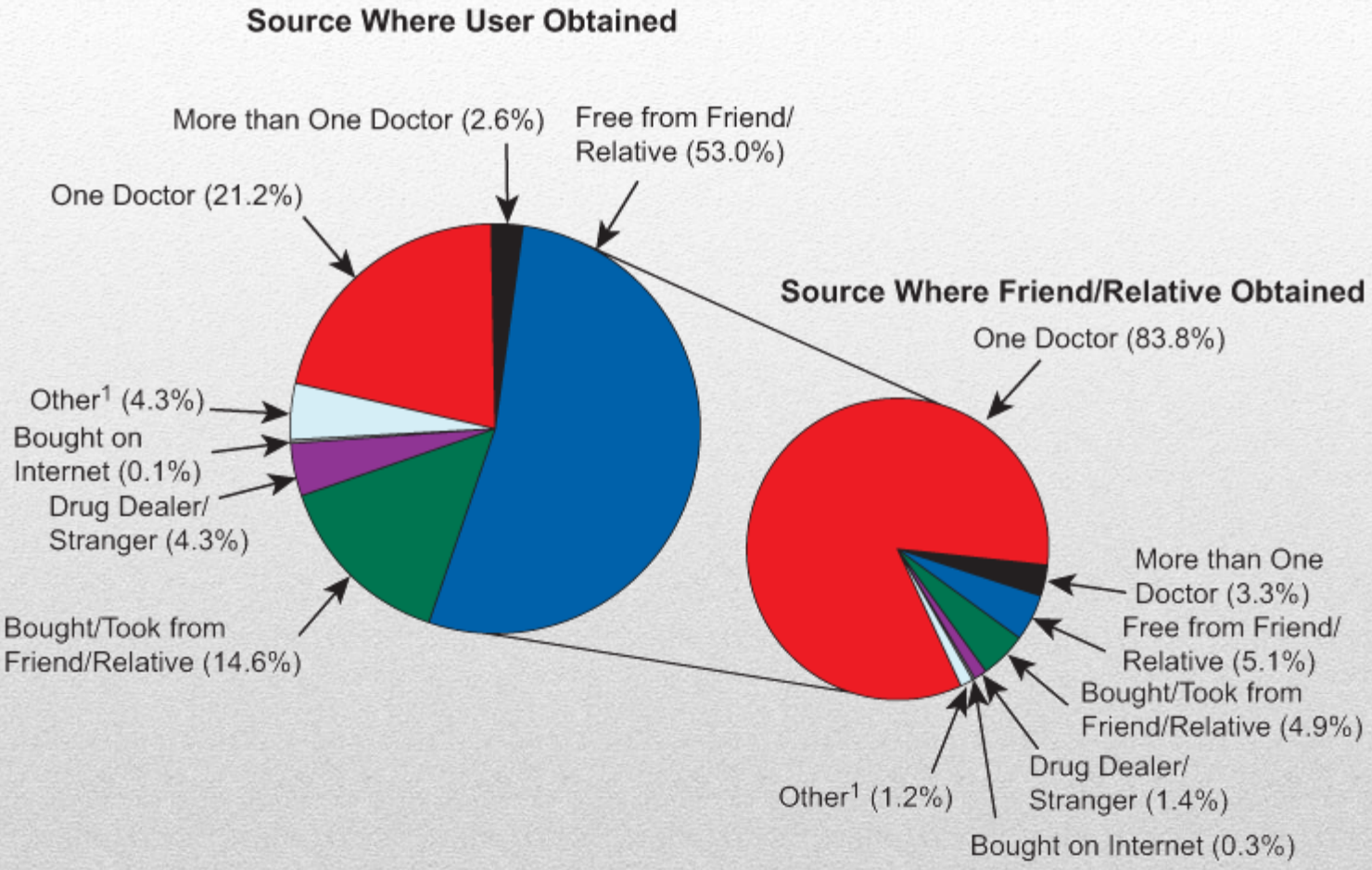
Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2014) Available from URL: http://www.cdc.gov/injury/wisqars/fatal.html.

Figure 1. Motor vehicle traffic, poisoning, and drug poisoning death rates: United States, 1980–2008




NOTE: In 1999, the *International Classification of Diseases, Tenth Revision (ICD–10)* replaced the previous revision of the ICD (ICD–9). This resulted in approximately 5% fewer deaths being classified as motor-vehicle traffic–related deaths and 2% more deaths being classified as poisoning-related deaths. Therefore, death rates for 1998 and earlier are not directly comparable with those computed after 1998. Access data table for Figure 1 at http://www.cdc.gov/nchs/data/databriefs/db81_tables.pdf#1.
SOURCE: CDC/NCHS, National Vital Statistics System.

# Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012-2013




NSDUH 2013


# Tell pts w/ abusable prescription meds to lock them up !

35% of primary care pts have chronic non-cancer pain (CNCP)

opioids are the most commonly prescribed treatment

Morasco J Pain 2011 March, Fleming J Pain 2007 July

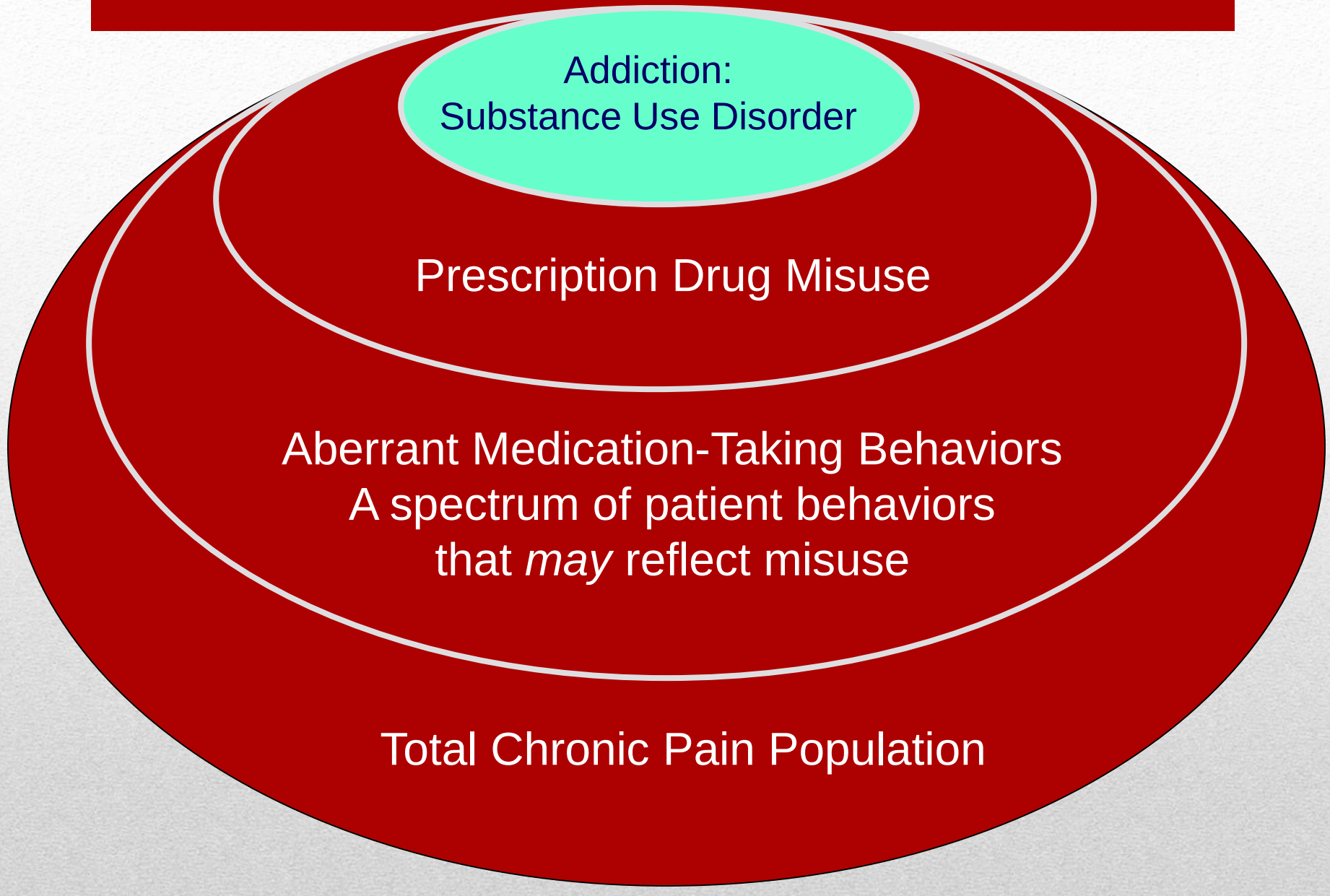
# Are opioids the optimal treatment for CNCP ?

- Weak evidence that pts w/ CNCP who continued on opioids long-term (> 6 months) experienced significant pain relief
  - But not clear if function or quality of life was improved
- Some evidence short-term efficacy (for both pain and function) of opioids to treat CLBP compared to placebo
- No placb-RCTs supporting the effectiveness and safety of long-term opioid therapy for treatment of CLBP

.

**NO**

Cochrane Reviews 2010 & 2013




Adapted from Steve Passik. APS Resident Course, 2007

Chronic opioid therapy (COT) may worsen pain experience:

1. Tolerance
2. Intermittent withdrawal
3. Hyperalgesia

| | | | | |
|---|---|---|---|---|
| ***Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity*** | | | | |
| 0 = no report of chills or flushing<br>1 = subjective report of chills or flushing<br>2 = flushed or observable moistness on face | • 3 = beads of sweat on brow or face<br>• 4 = sweat streaming off face | | | |
| ***Restlessness Observation During Assessment*** | | | | |
| 0 = able to sit still<br>1 = reports difficulty sitting still, but is able to do so | • 3 = frequent shifting or extraneous movements of legs/arms<br>• 5 = Unable to sit still for more than a few seconds | | | |
| ***Pupil Size*** | | | | |
| 0 = pupils pinned or normal size for room light<br>1 = pupils possibly larger than normal for room light | • 2 = pupils moderately dilated<br>• 5 = pupils so dilated that only the rim of the iris is visible | | | |
| ***Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored*** | | | | |
| 0 = not present<br>1 = mild diffuse discomfort | • 2 = patient reports severe diffuse aching of joints/muscles<br>• 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort | | | |
| ***Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies*** | | | | |
| 0 = not present<br>1 = nasal stuffiness or unusually moist eyes | • 2 = nose running or tearing<br>• 4 = nose constantly running or tears streaming down cheeks | | | |
| ***GI Upset: Over Last 1/2 Hour*** | | | | |
| 0 = no GI symptoms<br>1 = stomach cramps<br>2 = nausea or loose stool | • 3 = vomiting or diarrhea<br>• 5 = multiple episodes of diarrhea or vomiting | | | |

**COWS Clinical Opioid withdrawal scale**

# Tolerance and Withdrawal (W/D)

- Normal for opiates, benzodiazepines, barbituates, others
- Reduction in response to a given dose after repeated administration
- Brain neuroadapts to incoming drugs to maintain homeostasis
- Results in need for increasing doses to maintain equipotent analgesic effects
  - Koob, Le Moal Annu Rev Psychol 2008

# Hyperalgesia: Opioids May Worsen Pain

- Tolerance may paradoxically activate a pro-nociceptive mechanism that counteracts opioid analgesia
  - Pain scores reported higher in COT pts than in matched pts without opioid treatment
  - Pain sensitivity is increased in opioid SUDs and with methadone maintenance treatment
    - Mao J, Psych Annals, 2006, Curr Pain Headach Rep. 2006, Am J of Psych, 2006

# Other Opioid Side Effects

- Acetaminophen toxicity with combo
- Nausea and constipation
- Psychomotor compromise w/ increase risk of falls
- Methadone QT prolongation
- Increased sleep disturbances
- Mood impairment
- Decreased testosterone, estrogen, cortisol, others
- Hyposexuality
- Immuno-compromise due to NK cell impairment, etc.
- Drug interactions: ex. inhibit opioid metabolism
    - Pain Physician 2008

# Opioid Risk Tool (ORT): method to risk-stratify and deliver appropriate care

| | | Mark Each Box That Applies | Score if Female | Score if male |
|---|---|---|---|---|
| 1. Family History of Substance Abuse | ☐ Alcohol<br>☐ Illegal Drugs<br>☐ Prescription Drugs | | 1<br>2<br>4 | 3<br>3<br>4 |
| 2. Personal History of Substance Abuse | ☐ Alcohol<br>☐ Illegal Drugs<br>☐ Prescription Drugs | | 3<br>4<br>5 | 3<br>4<br>5 |
| 3. Age (Mark Box if 16-45 years) | | | 1 | 1 |
| 4. History of Preadolescence Sexual Abuse | | | 3 | 0 |
| 5. Psychological Disease | ☐ Attention-Deficit/Hyperactivity Disorder;<br>☐ Obsessive Compulsive Disorder;<br>☐ Bipolar Disorder;<br>☐ Schizophrenia<br>☐ Depression | | 2<br>1 | 2<br>1 |

**Total Score _____Risk Category_____**

**Low Risk 0-3: 6% chance of developing problematic behaviors**
**Moderate Risk 4-7: 28% chance …**
**High Risk >7: >90% chance …**

**Webster & Webster, Pain Med. 2005.**

# Approach to monitoring depends on risk level

**Low Risk:** follow up every 3 months, managed by PCP, routine CURES, urine drug screen, annual review of pain agreement

**Medium Risk:** Past history of SUD, but not actively addicted; PCP with consultant or review committee support, monthly visits, more frequent monitoring including pill counts

**High Risk:** Patient actively addicted/abusing; unstable major psychiatric disorder; should be in narcotic treatment program, or managed by PCP with buprenorphine and behavioral health treatment

- Adapted from Gourlay,et al 2005, 2009

# What are the risk factors for prescription opioid induced SUD?

a. Personal hx of substance abuse
b. Hx of sexual abuse
c. Age less than 45
d. Hx of psychiatric illness
e. All of the above

## Compared to CNCP pts without SUDs, CNCP pts with SUDs are:

a. Less likely to be treated with opioids
b. More likely to be treated with opioids
c. More likely to have restricted early refills
d. A & C
e. B & C

40.3% vs 26.2%

## Behaviors May or May Not Be consistent with SUD?

R/o opioid misuse due to opioid adaptation or pain under treatment

- Express desperation over current sxs
  - Aggressively asks providers to provide more opiates
  - Repeated requests for early refills
  - Doctor shopping
- Uses more meds than prescribed
  - Hoards meds
  - Taken someone else's meds
- Use MJ, smokes cigs, drinks to help with pain
- Resistant to integrated pain care
- Some adverse consequences related to use (family, work, health)
- Ever used opioids to treat other symptoms: rule out other psychiatric diagnoses

# Behaviors Highly consistent with SUD

**Loss of control of use and much adverse consequences related to use**

- Frequent "lost prescriptions"
- Shows no concern about opioid side-effects or interest in integrative care approaches
- Preoccupation with obtaining prescription opioids for other than analgesia
  - R/o self-tx for untreated dual diagnosis
- Seen multiple providers w/o disclosure
  - Check CURES Physician Drug Monitoring Program (PDMP)
- Injecting oral medication
  - Check for skin signs
- Associated with illegal activities
  - Prescription theft and forgery
  - Stole drugs from other
  - Illegal buying
  - Prostitution to get drugs or money to buy drugs
  - Theft to get money to buy drugs

- Fishman, Responsible Opioid Prescribing,Federation of State Medical Boards, Miotto, et al. Psychiatr Clin N Am 35 (2012)

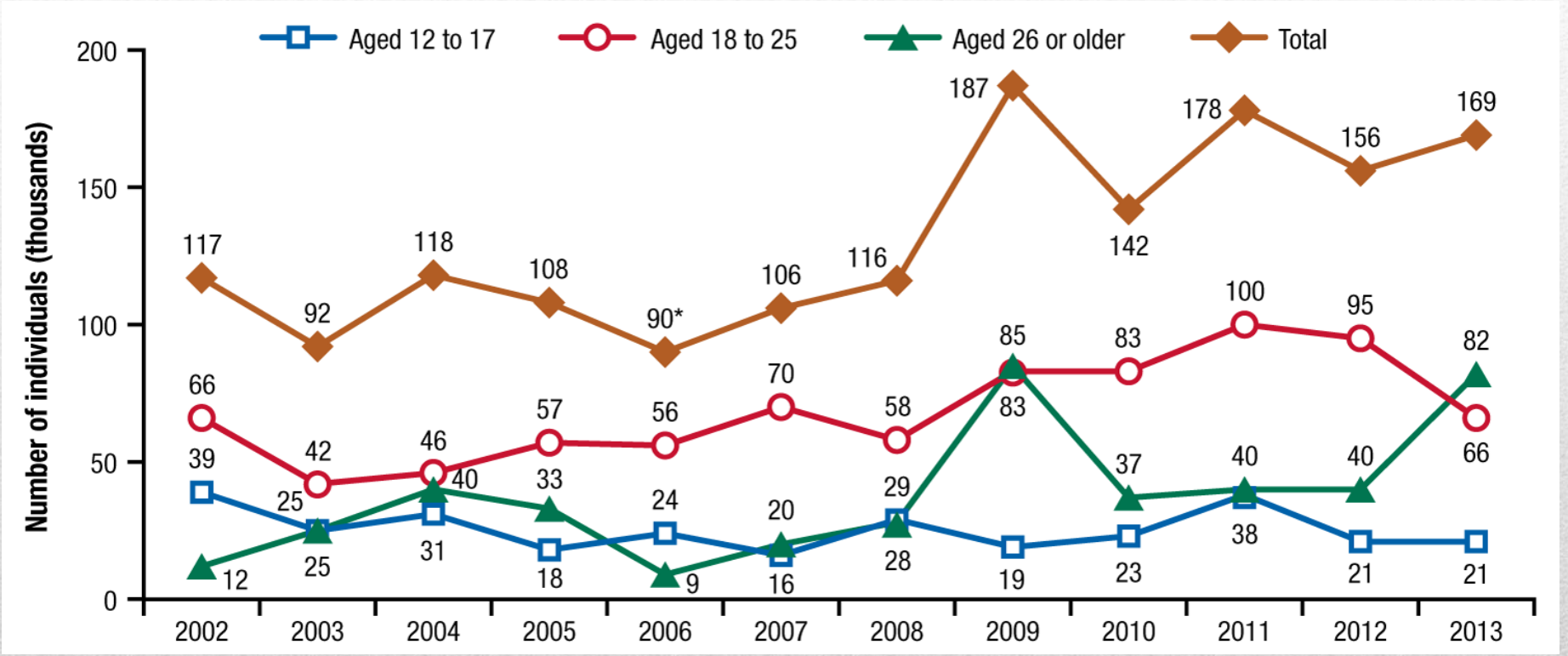
# Best Evidence-Based Treatment for Opioid SUD

- Opiate Replacement Therapy (ORT)
  - Suboxone
  - Methadone
- Help families and pts to understand this
  - Compare to thyroid replacement therapy
- Why?
  - Likely chronic endogenous opioid deficiency
    - Need chronic opioid receptor occupation (other opiates don't do this)
  - Acute WD can be managed
  - PAWS drives relapse

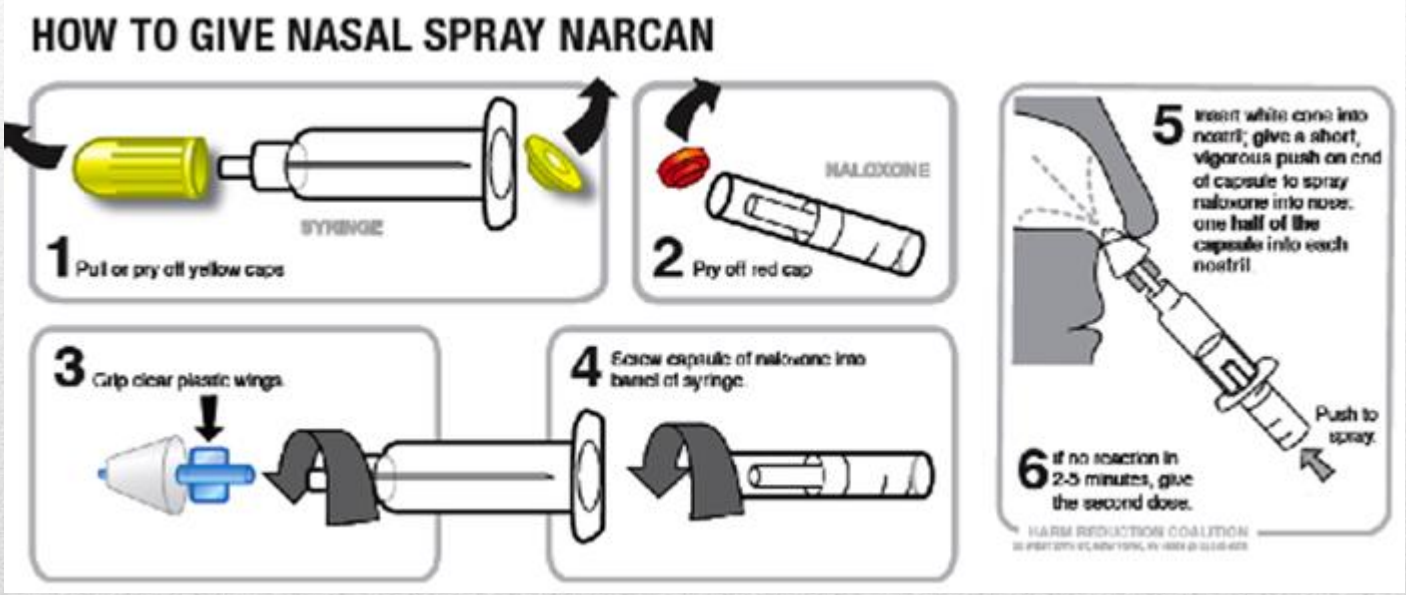
# Post Acute WD Syndrome (PAWS): Opioids

- Anxiety/Depression
- Sleep disturbances
- Fatigue
- Dysphoria/Irritability
- Decreased ability to focus on a task
- Deficits in executive control
- **Can mimic:**
  - **Mood disorder**
  - **Sleep disorder**
  - **ADHD**

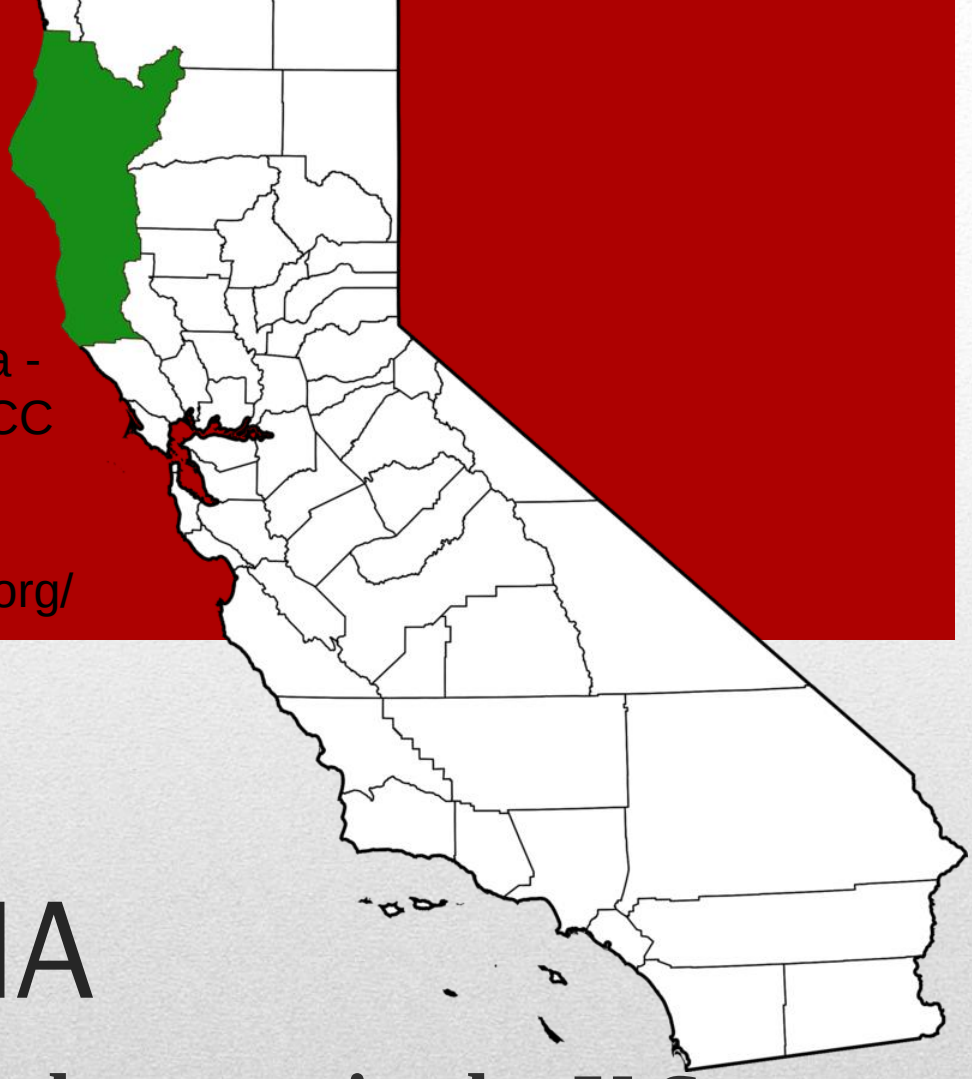
**Past year initiation of heroin among individuals aged 12 or older, by age group: 2002 to 2013**




NSDUH 2013




# Naloxone Saves Lives

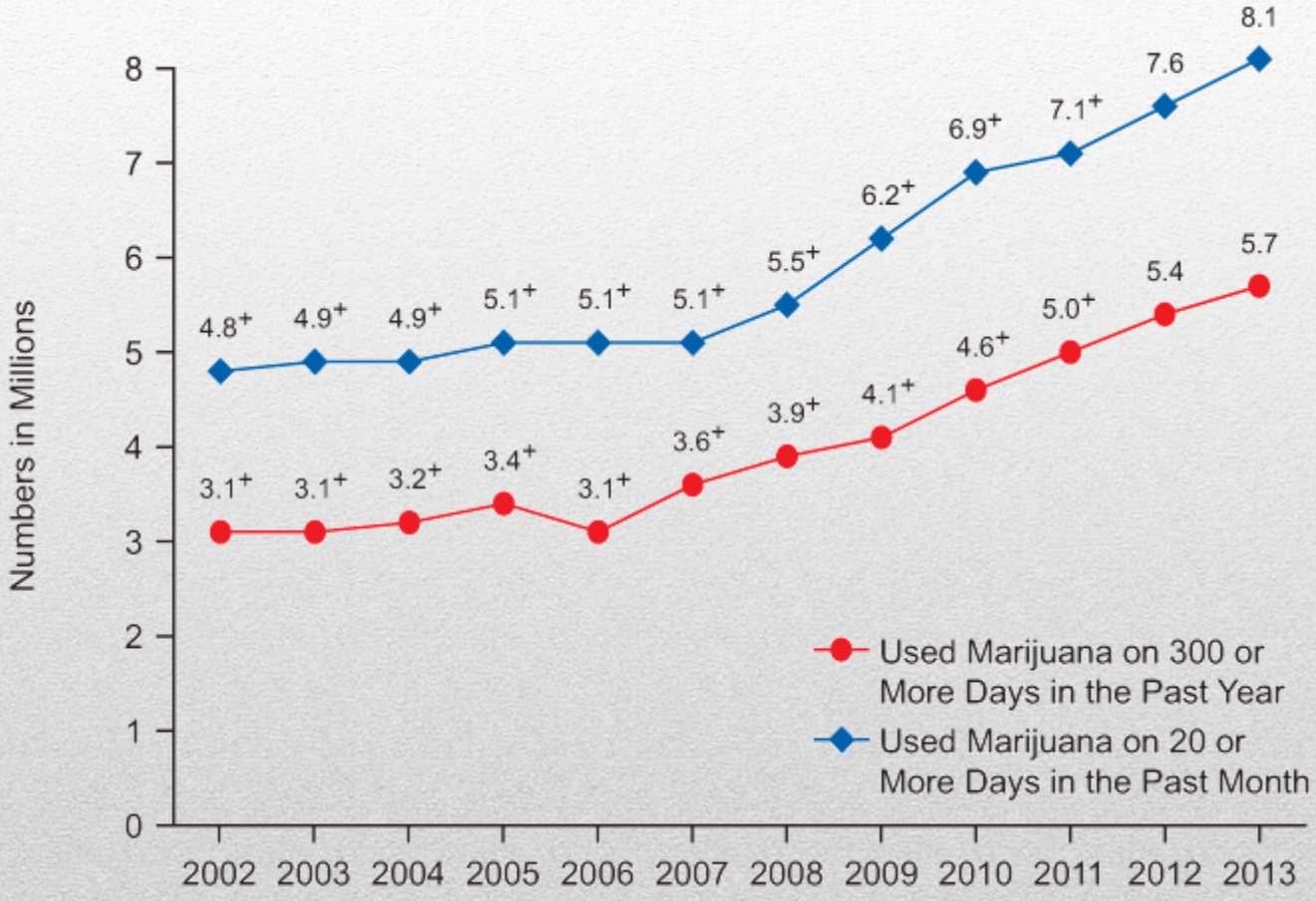




# MARIJUANA

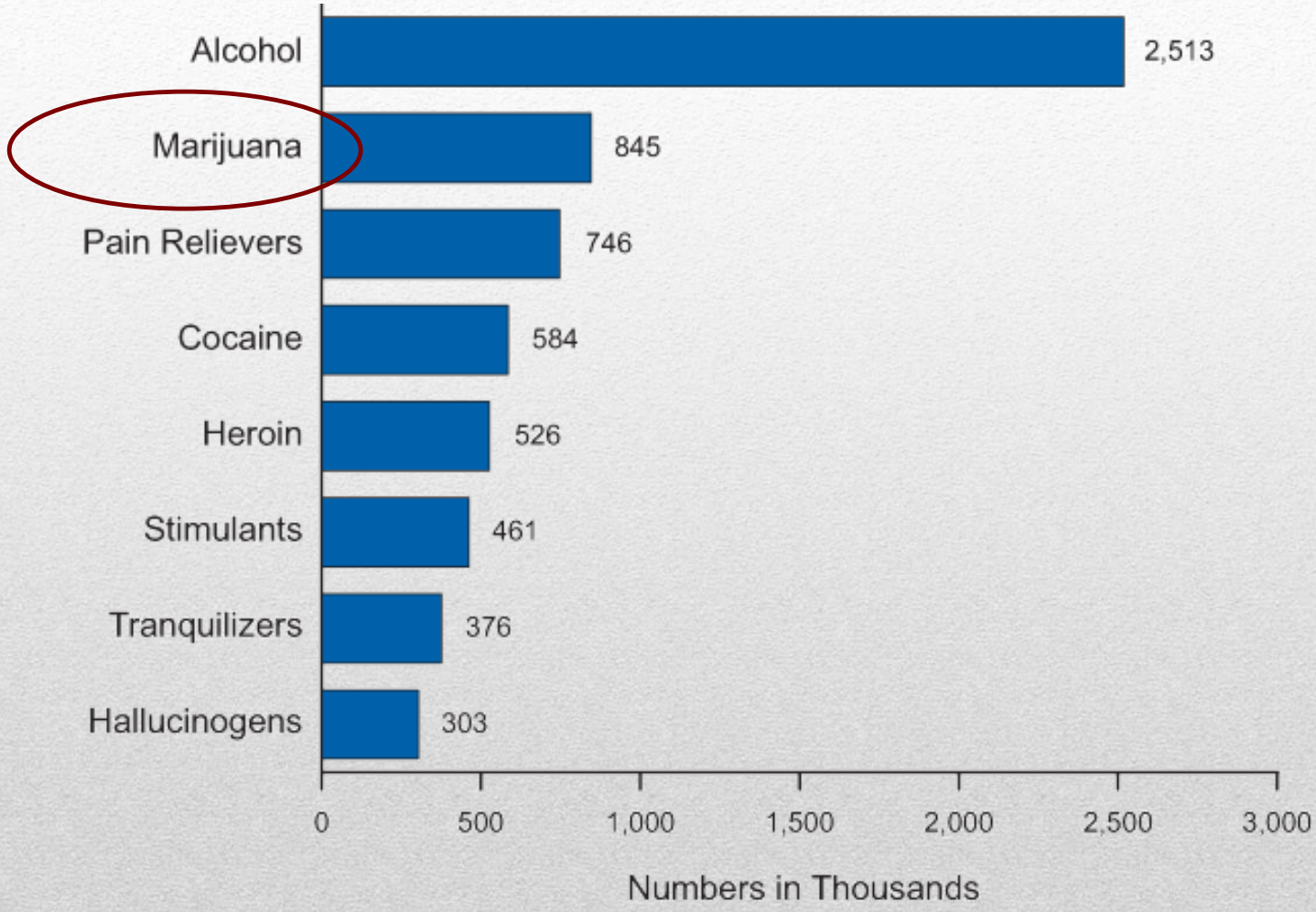
**#2 most abused substance in the U.S.**

**Daily or Almost Daily Marijuana Use in the Past Year and Past Month among Persons Aged 12 or Older: 2002-2013**




NSDUH 2013

## Substances for Which Most Recent Treatment Was Received in the Past Year among Persons Aged 12 or Older: 2013




NSDUH 2013

# Why we like ‘weed’ & not hay?

**Endocannabinoids**

neuromodulators scattered throughout the brain and spinal cord

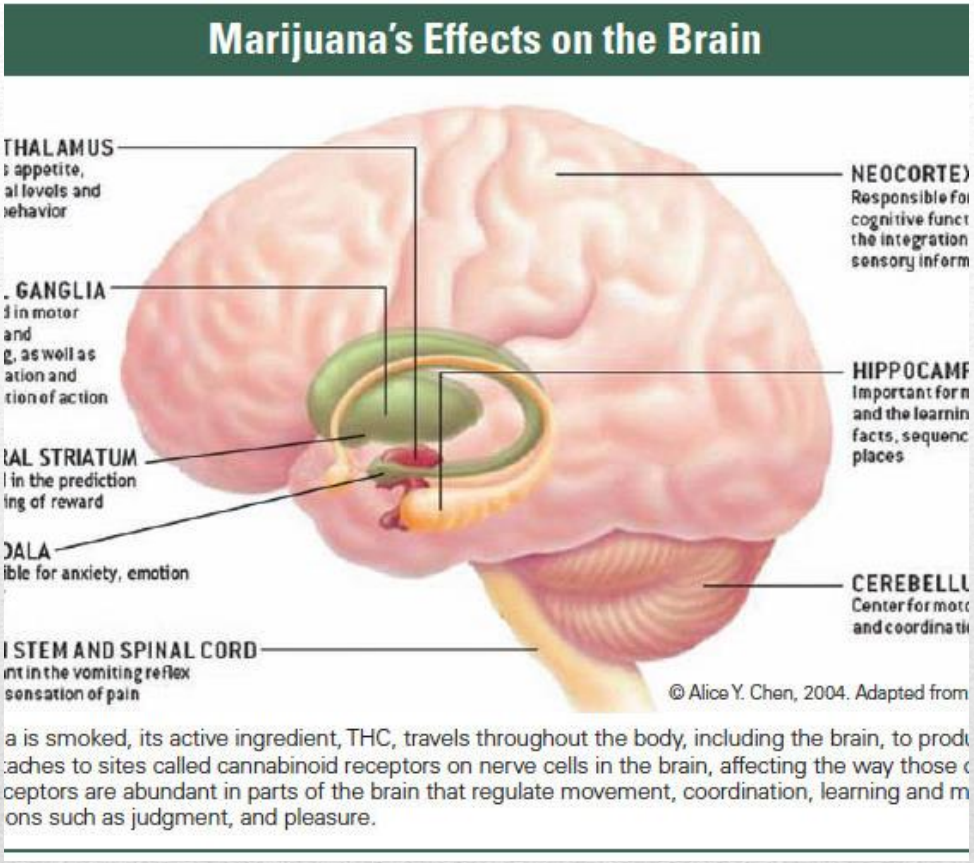
**CB1**: in brain & spinal cord

**CB2**: in immune system

**Intoxication Symptoms**:

Euphoria, psychosis, impaired memory & cognition, reduced locomotor function, increased appetite, antiemetic, antispasticity, sleep-promoting, anti-anxiety, pain-relieving

Koppel, et al, Neurology 2014




NIDA website

- MJ contains > 60 pharmacologically active cannabinoids
  - Primary cannabinoids in MJ
    - THC (tetrahydrocannabinol)
      - Euphoria
      - Psychosis
    - Cannabidiol
      - Not psychoactive
      - Possible anti-anxiety & anti-psychotic
    - THC:Cannabidiol ratio engineered to achieve desired effects
      - Pertwee, Br J Pharmacology 2006
      - Hill, JAMA 2015

# Weed is Not Oregano

# Neurotoxic Effect of MJ on Youth

- Dunedin prospective study: n=1037. Neuropsych testing done at 13 yo (before cannabis initiation) and again at age 38 yo (after persistent cannabis use, at least 4d/wk).
  - 8 point drop in IQ, even if quit in adulthood
  - Persistent use was associated with neuropsych decline broadly across domains of functioning, even after controlling for years of education
  - Persistent use interfered with everyday cognitive functioning
  - Among adolescent former persistent users, impairment was still evident after cessation of use for 1 y or more
  - Suggest a neurotoxic effect of cannabis on the adolescent brain and highlight the importance of prevention and policy efforts targeting adolescents
    - Meier et al, Proc Natl Acad Sci U S A. 2012

# Cannabis Use Disorder Identification Test

- CUDIT-R
  - Scores of ≥13 identify DSM-5 moderate and severe CUD
  - ≥13 demonstrated significantly greater psychological distress and poorer physical and mental health functioning

    - NIDA: Screening for DSM-5 cannabis dependence using the Cannabis Use Identification Test–Revised
    - CUDIT-R: Adamson et al. Drug and Alcohol Dependence 2010

**Have you used any cannabis over the past six months?** **YES / NO**

**If YES**, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*

1. How often do you use cannabis?

| Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

2. How many hours were you "stoned" on a typical day when you had been using cannabis?

| Less than 1 | 1 or 2 | 3 or 4 | 5 or 6 | 7 or more |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

8. Have you ever thought about cutting down, or stopping, your use of cannabis?

| Never | Yes, but not in the past 6 months | Yes, during the past 6 months |
|---|---|---|
| 0 | 2 | 4 |

# Marijuana Withdrawal Symptoms

Mood:

- Irritability
- Anxious or worried
- Depressed
- Restless
- Insomnia and fatigue
- Low appetite or losing weight

Physical Symptoms:

- Stomach pain
- Sweatiness
- Shakiness
- Fever
- Chills
- Headache

- NIDA

# Gabapentin Treatment for CUD

Treated with gabapentin in a pilot RCT DBP x 12 wks, tapered up to 300/300/600:

- Reduced use more
- Reported fewer symptoms of drug withdrawal
- Showed sig greater improvement in overall performance on tests of executive function
  - Mason et al. Neuropsychopharm 2012

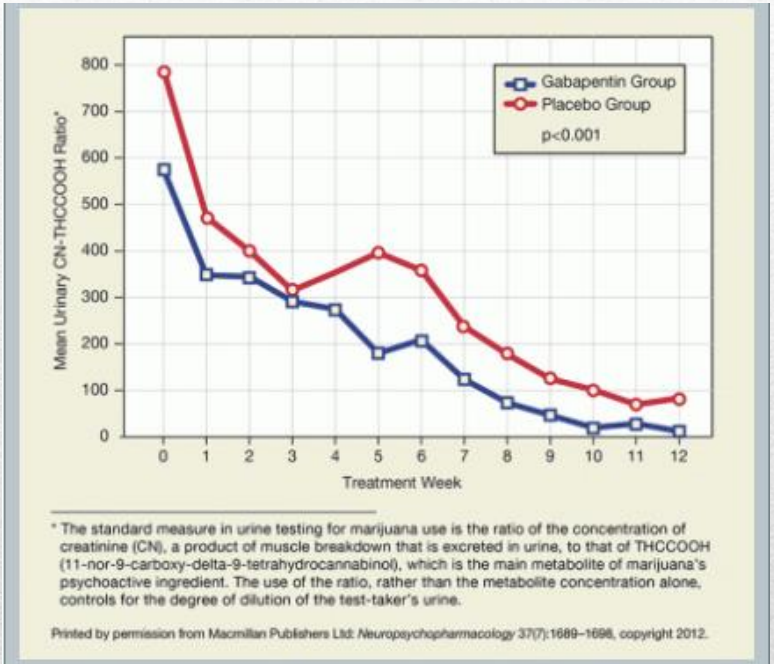
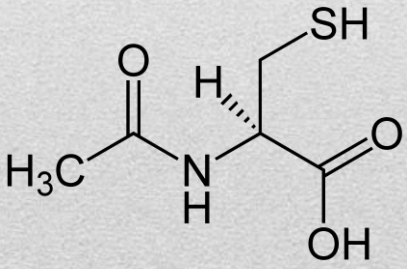



**Figure 1. Gabapentin Facilitates Abstinence** Patients who received gabapentin used less marijuana during treatment than did a comparison group that received placebo, according to both self-report and urinalysis.

# NAC Treatment for CUD

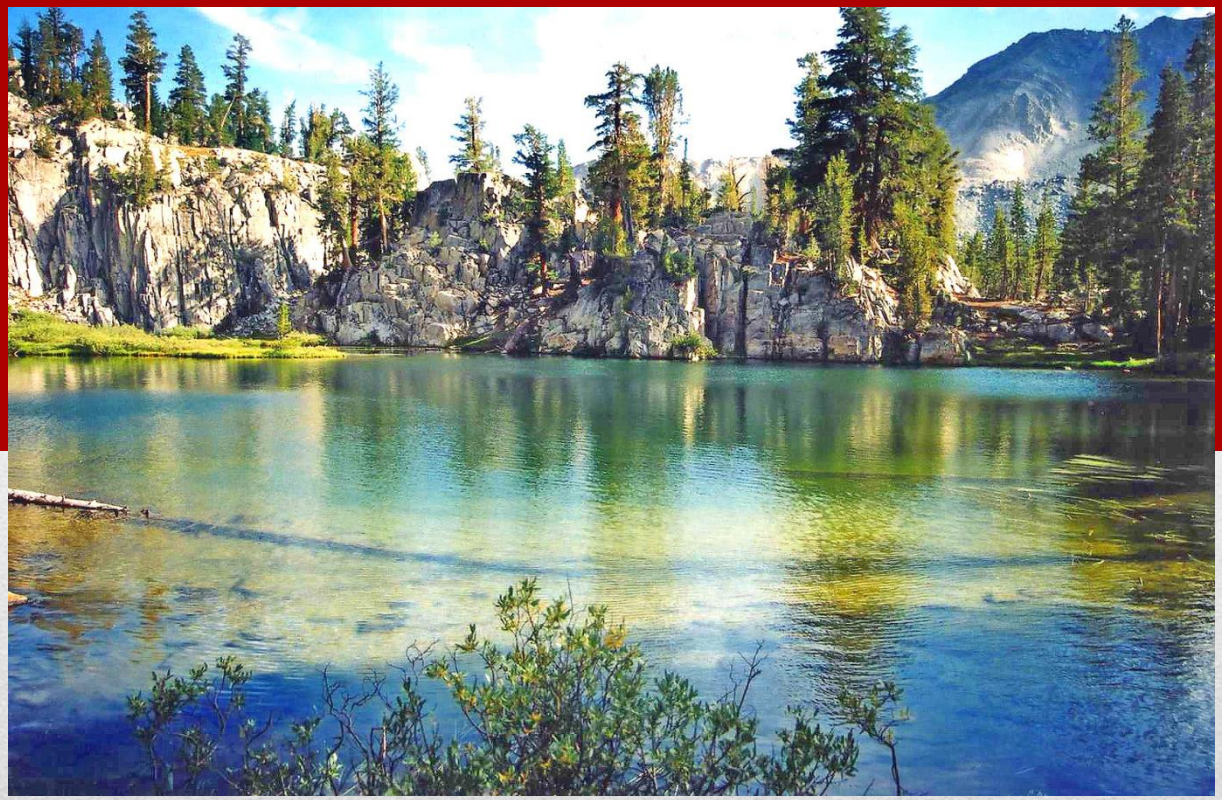
OTC supplement *N*-acetylcysteine works via glutamate modulation in the nucleus accumbens

- RCT DBP x 8 wks CUD adolescents (ages 15-21 years; N=116) received NAC (1200 mg bid)
  - Included contingency rewards & brief counseling
- Participants receiving NAC had more than twice the odds, compared with those receiving placebo, of having negative urine cannabinoid test results during treatment
- NAC was well tolerated, with minimal adverse events



- References:
  - Hill, JAMA 2015
  - American Academy of Neurology, Neurology 2014
- FDA approved:
  - Dronabinol & nabilone
    - N/V due to cancer chemotherapy
    - Appetite stimulation in wasting illness
  - Best RCT evidence for:
    - MS spasticity
    - Chronic pain
    - Neuropathic pain


# MJ Medical Uses ?

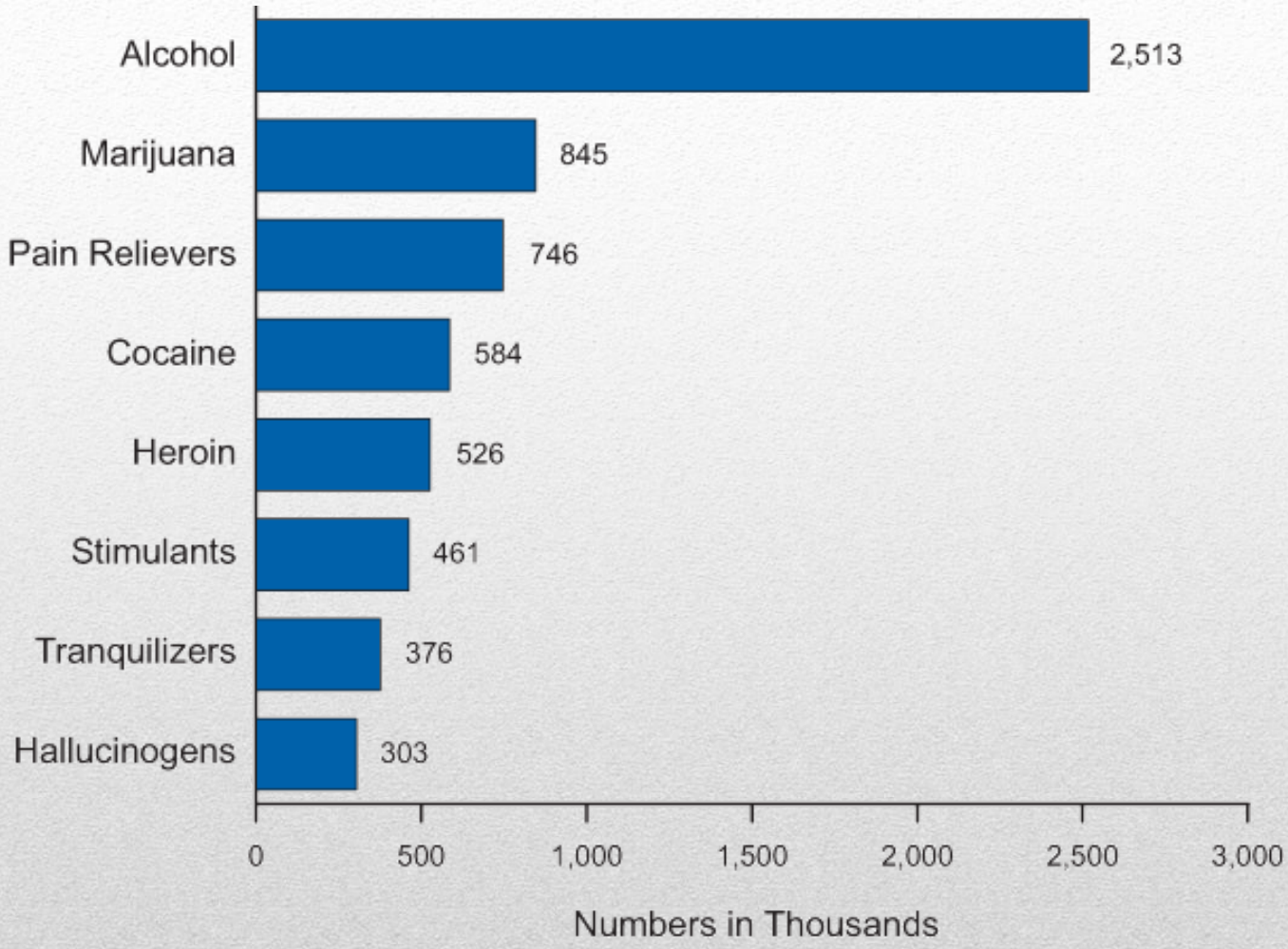


# BREAK

15 minutes

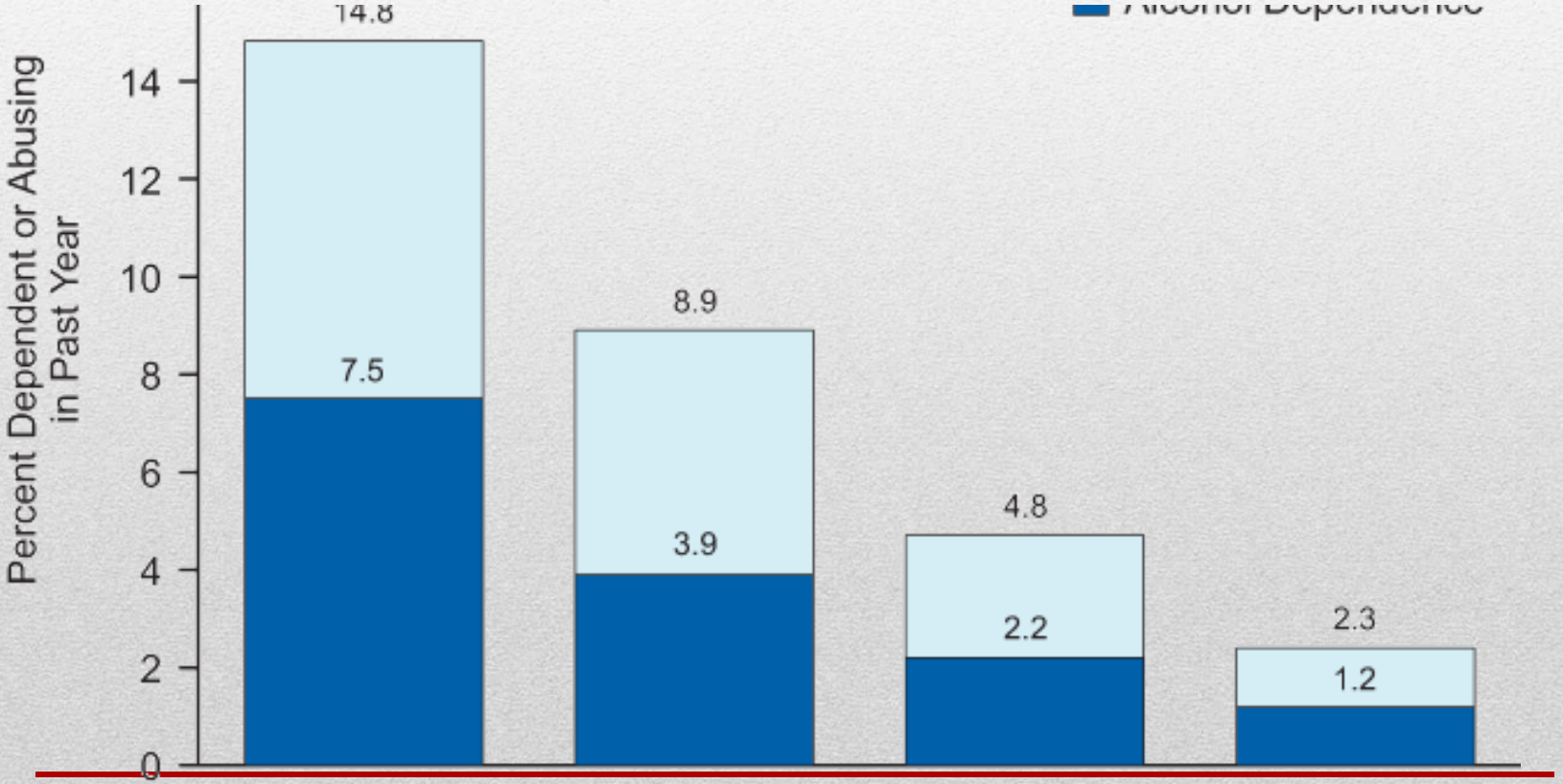
# ALCOHOL

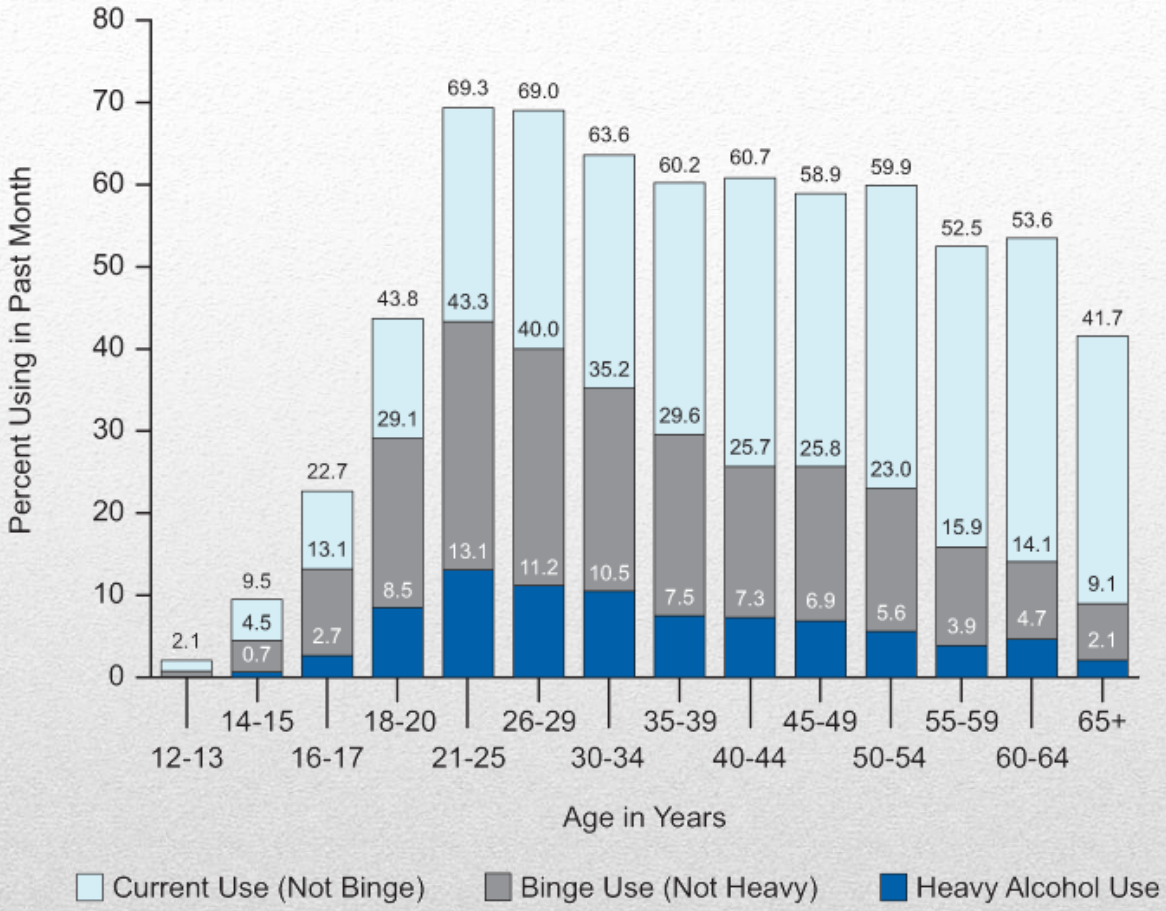
**#1 most abused substance in the U.S.**




Substances for Which Most Recent Treatment Was Received in the Past Year: 2013

# Alcohol Dependence or Abuse in the Past Year among Adults Aged 21 or Older, by Age at First Use of Alcohol: 2013 NSDUH 2013, SAMHSA






# Current, Binge, and Heavy Alcohol Use: 2013

# ETOH & Brain Reward Circuits

- Dopamine system
  - Indirectly increases DA in mesocorticolimbic system
    - Positively reinforces & rewards ETOH's effects
    - Makes ETOH addictive
- Opioid system
  - Indirectly activates the opioid system
    - Reinforces the effects of mu-receptors
    - Creates a 'buzz' high
- GABA system
  - Increases GABA + inhibits glutamate: inhibitory system
    - Decreases anxiety, increases sedation

# ETOH Biomarkers

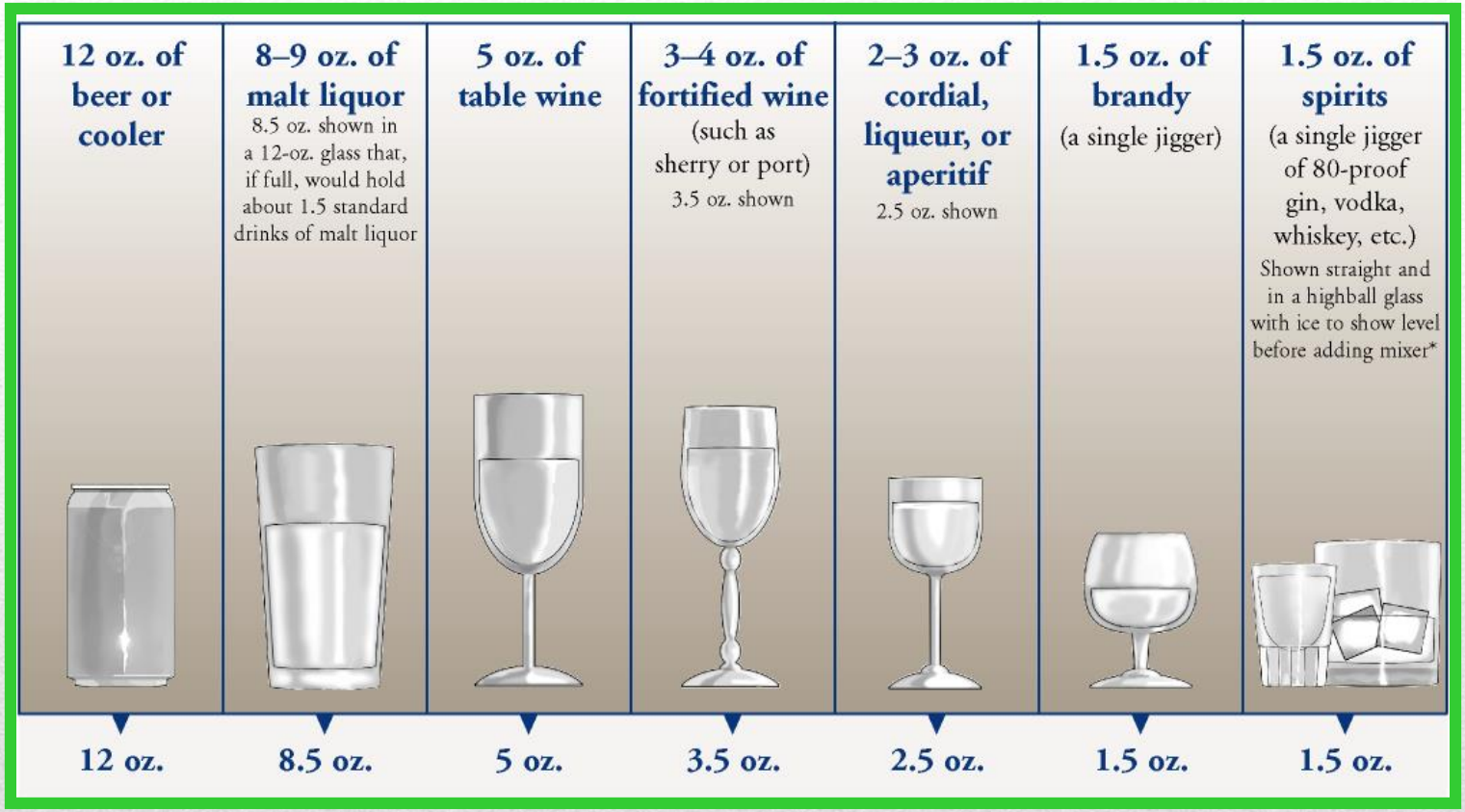
## R/O Denial

- Elevated MCV + GGT: 95% sensitive for abuse
  - GGT elevated 24 hrs to 2 wks after heavy ETOH use
    - Nml = 0-45 females, 0-53 males
  - Returns to nml within 2-6 wks of abstinence
  - Detects binge drinking
- AST:ALT ratio >2:1 = 90% chance of ALD
- Elevated GGT + AST:ALT >2:1 = 95% sensitive for abuse


# SBIRT Screening

# SBIRT Treatment Outcomes

- At risk drinkers
  - Identified
  - Given education and Brief MI
  - Reduce drinking by 25% over following year
- Dependent drinkers (similar across studies & treatment modalities)
  - 1/3 remission x 1 yr
    - Abstinence or non-abstinence remission
  - 1/3 will show substantial improvement, but have some heavy drinking episodes
  - 1/3 will show no effect
  - Relapse occurs in most over ensuing 5-10 yrs




## What's a Standard Drink?

In the U.S., a standard drink is any drink that contains about 14 grams of pure alcohol


I KNEW I COULD CUT DOWN TO ONE DRINK A DAY!

# Maximum ‘Healthy’ Drinking Limits

**For healthy men up to age 65—**

- no more than 4 drinks in a day AND
- no more than 14 drinks in a week

**For healthy women**

**(and healthy men over age 65)—**

- no more than 3 drinks in a day AND
- no more than 7 drinks in a week

# 1-Item Saitz question (recommended by the NIAAA)

- "How many times in the past year have you had X or more drinks in a day?"
  - X is 5 for men and 4 for women, and a response of >1 is considered positive
    - 81.8% sensitive and 79.3% specific for the detection of unhealthy alcohol use
    - 87.9% sensitive and 66.8% specific for the detection of a current AUD
      - Smith, et al. J Gen Intern Med. 2009 July; 24(7): 783–788.

# Alcohol Medication Treatment

# Outpatient Alcohol Withdrawal

- Ask about past WD sxs
- Use a CIWA-Ar (www.pcbehavioralhealth.com)
  - 0-8 No medication is necessary
  - 9-14 Medication is optional
  - A score of 15 or over requires meds
    - Consider hospitalization

Patient: _____ Date: _____ Time: _____:_____

Pulse or heart rate, taken for one minute: _____ Blood pressure: _____/_____

**Nausea and vomiting.** Ask "Do you feel sick to your stomach? Have you vomited?"

Observation:

0—No nausea and no vomiting
1—Mild nausea with no vomiting
2—
3—
4—Intermittent nausea with dry heaves
5—
6—
7—Constant nausea, frequent dry heaves, and vomiting

**Tremor.** Ask patient to extend arms and spread fingers apart.

Observation:

0—No tremor
1—Tremor not visible but can be felt, fingertip to fingertip
2—
3—
4—Moderate tremor with arms extended
5—
6—
7—Severe tremor, even with arms not extended

**Paroxysmal sweats**

Observation:

0—No sweat visible
1—Barely perceptible sweating; palms moist
2—
3—
4—Beads of sweat obvious on forehead
5—
6—
7—Drenching sweats

**Anxiety.** Ask "Do you feel nervous?"

Observation:

0—No anxiety (at ease)
1—Mildly anxious
2—
3—
4—Moderately anxious or guarded, so anxiety is inferred
5—
6—
7—Equivalent to acute panic states as occur in severe delirium or acute schizophrenic reactions

**Agitation**

Observation:

0—Normal activity
1—Somewhat more than normal activity
2—
3—
4—Moderately fidgety and restless
5—
6—
7—Paces back and forth during most of the interview or constantly thrashes about

**Tactile disturbances.** Ask "Do you have you any itching, pins-and-needles sensations, burning, or numbness, or do you feel like bugs are crawling on or under your skin?"

Observation:

0—None
1—Very mild itching, pins-and-needles sensation, burning, or numbness
2—Mild itching, pins-and-needles sensation, burning, or numbness
3—Moderate itching, pins-and-needles sensation, burning, or numbness
4—Moderately severe hallucinations
5—Severe hallucinations
6—Extremely severe hallucinations
7—Continuous hallucinations

**Auditory disturbances.** Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"

Observation:

0—Not present
1—Very mild harshness or ability to frighten
2—Mild harshness or ability to frighten
3—Moderate harshness or ability to frighten
4—Moderately severe hallucinations
5—Severe hallucinations
6—Extremely severe hallucinations
7—Continuous hallucinations

**Visual disturbances.** Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"

Observation:

0—Not present
1—Very mild sensitivity
2—Mild sensitivity
3—Moderate sensitivity
4—Moderately severe hallucinations
5—Severe hallucinations
6—Extremely severe hallucinations
7—Continuous hallucinations

**Headache, fullness in head.** Ask "Does your head feel different? Does it feel like there is a band around your head?"

Do not rate for dizziness or lightheadness; otherwise, rate severity.

0—Not present
1—Very mild
2—Mild
3—Moderate
4—Moderately severe
5—Severe
6—Very severe
7—Extremely severe

**Orientation and clouding of sensorium.** Ask "What day is this? Where are you? Who am I?"

Observation:

0—Orientated and can do serial additions
1—Cannot do serial additions or is uncertain about date
2—Date disorientation by no more than two calendar days
3—Date disorientation by more than two calendar days
4—Disorientated for place and/or person

Total score: _____ (maximum = 67) Rater's initials _____

## Timing of Alcohol Withdrawal Syndromes

| Syndrome | Clinical findings | Onset after last drink |
|---|---|---|
| Minor withdrawal | Tremulousness, mild anxiety, headache, diaphoresis, palpitations, anorexia, GI upset | 6 to 36 hours |
| Seizures | Generalized, tonic-clonic seizures, status epilepticus (rare) | 6 to 48 hours |
| Alcoholic hallucinosis | Visual (occasionally auditory or tactile) hallucinations | 12 to 48 hours |
| Delirium tremens | Delirium, tachycardia, hypertension, agitation, fever, diaphoresis | 48 to 96 hours |

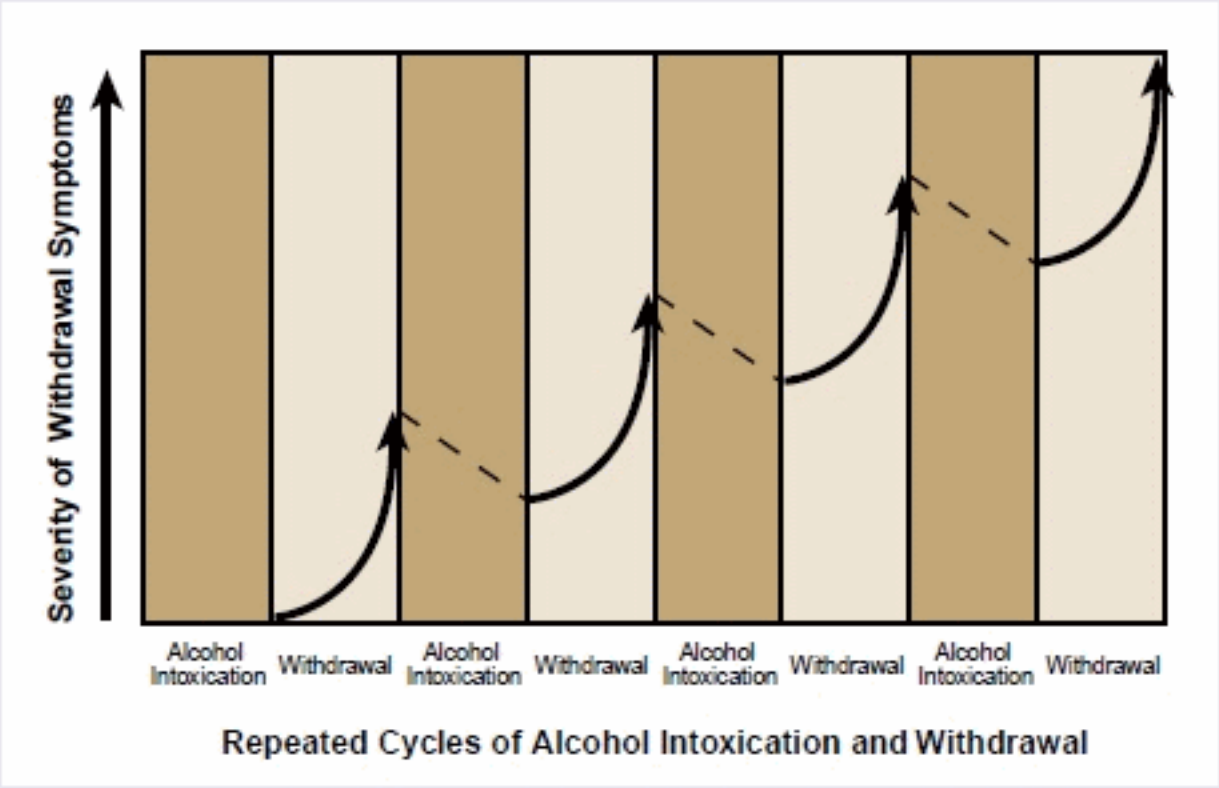



**Figure 1** Graphic representation of the kindling concept during alcohol withdrawal. The term "kindling" refers to the phenomenon that people undergoing repeated cycles of intoxication followed by abstinence and withdrawal will experience increasingly severe withdrawal symptoms with each successive cycle.

Alcoholism: Clinical and Experimental Research Vol. 33, No. 9 2009

**Double-Blind Trial of Gabapentin vs Lorazepam in the Tx of Alcohol Withdrawal**

**Methods**: 100 individuals seeking opt tx of alcohol withdrawal randomized to double-blind treatment with 2 doses of gabapentin (900 mg tapering to 600 mg or 1200 tapering to 800 mg) or lorazepam (6 mg tapering to 4 mg) for 4 days.

**Results**: CIWA-Ar scores decreased over time in all groups; **high-dose gabapentin was statistically superior but clinically similar to lorazepam.** During treatment, lorazepam- treated participants had higher probabilities of drinking on the first day of dose decrease (day 2) and the second day off medication (day 6) compared to gabapentin-treated participants. Post-treatment, gabapentin-treated had less probability of drinking during the follow-up post-treatment period ($p = 0.2$ for 900 mg and $p = 0.3$ for 1200 mg) compared to the lorazepam-treated participants ($p = 0.55$)**. The gabapentin groups also had less craving, anxiety, and sedation compared to lorazepam**.

**Conclusions**: Gabapentin was well tolerated and effectively diminished the symptoms of alcohol withdrawal in our population especially at the higher target dose (1200 mg) used in this study. Gabapentin reduced the probability of drinking during alcohol withdrawal and in the immediate postwithdrawal week compared to lorazepam.

# The COMBINE Study

## largest alcohol treatment to date

- **RCT: 2001- 2004, 1383 recently alcohol-abstinent volunteers (median age, 44 years) with primary alcohol dependence.**
- **Interventions: 8 groups received management with 16 weeks of naltrexone (100 mg/d) or acamprosate (3 g/d), both, and/or both placebos, with or without a combined behavioral intervention (CBI). A ninth group received CBI only (no pills). Patients were also evaluated for up to 1 year after treatment.**
- **Main Outcome Measures: Percent days abstinent from alcohol and time to first heavy drinking day.**
  - *JAMA. 2006;295*

# Results of the COMBINE Study

- All 9 groups had a substantial reduction in days of drinking
- The patient groups who demonstrated the best drinking outcomes after 16 weeks received:
  - Naltrexone with medical management (MM) counseling alone (no specialty CBI)
  - Or received specialty CBI with placebo pills and MM counseling
  - No advantage found for adding acamprosate either to MM or CBI
- This acamprosate result is puzzling, given the many European studies that have reported an acamprosate effect (over placebo) for maintaining abstinence from alcohol.

# Naltrexone

- Mechanism: opioid antagonist
  - Blocks ETOH's euphoric effect
  - Limits heavy drinking relapse
  - Limits craving
- Clinical use
  - Check LFTs
    - May give if mildly elevated
    - Consistent effect is to overall lower LFTs
  - Start after acute ETOH withdrawal
  - Best to start when beginning psychosocial treatment
  - 25 mg and increase after 7d to 50 mg
    - Initial transient S/E's: nausea, HA, dizziness, weakness

# Acamprosate

- Mechanism: GABA agonist and NMDA modulator
  - Not metabolized by liver
  - May help maintain abstinence, reduces heavy drinking
    - Prevents relapse, reduced drinking in those who do
  - US COMBINE Study no advantage over placebo
  - European meta-analyses conclusions
    - Modest effect over placebo
    - Effects increased as tx duration increased (3-12 months)

- Clinical use
  - Check RFTs before use in elderly or renal disease
  - Start after acute ETOH withdrawal
  - Best to start when beginning psychosocial treatment
  - 1998 mg/day (2- 333 mg tabs TID)
    - S/Es: transient diarrhea, bloating, pruritis

# Disulfiram (Antabuse)

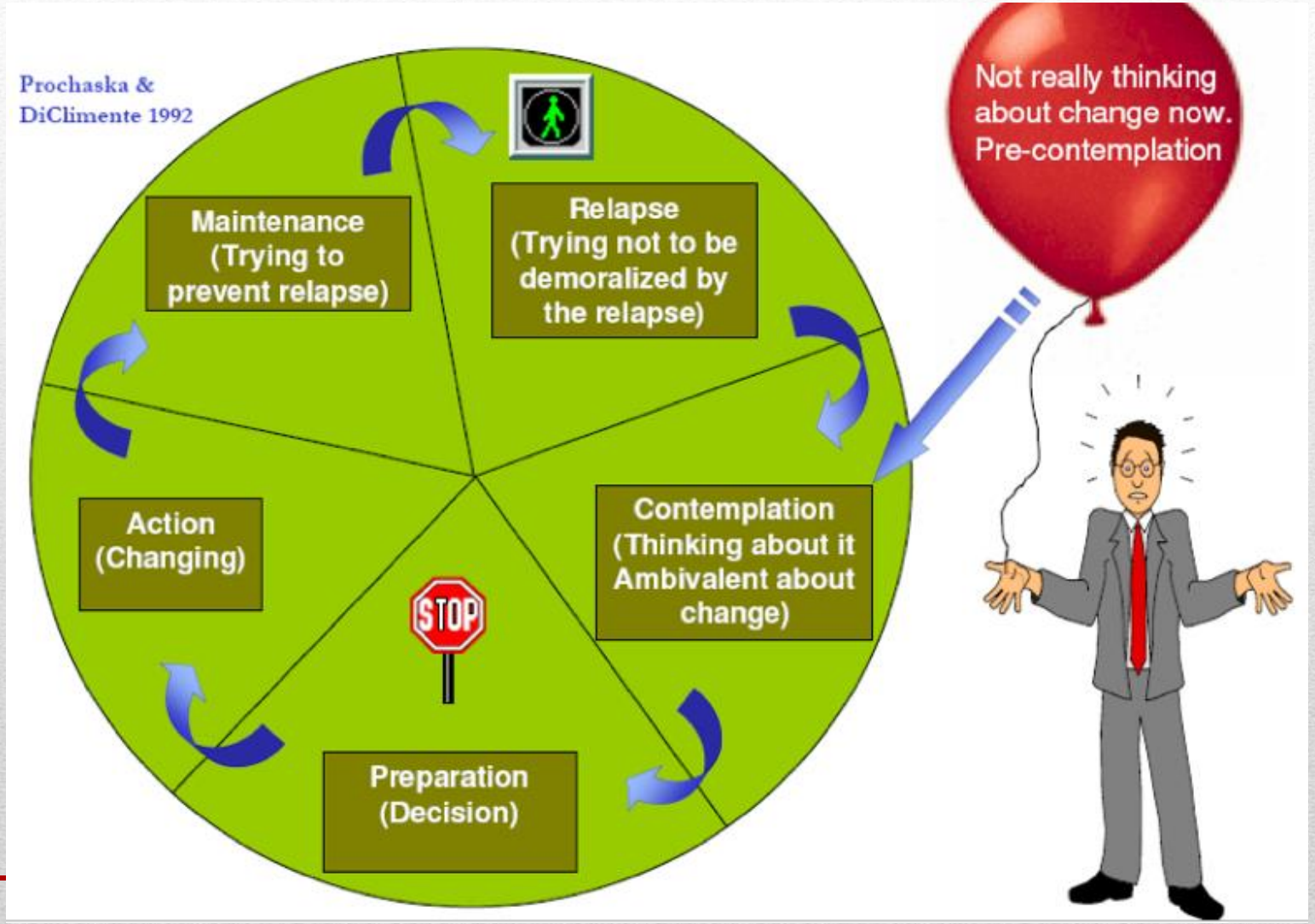
- Mechanism: Inhibits aldehyde dehydrogenase
  - DER: ingesting ETOH increases acetaldehyde
    - Flushing, palpitations, decreased BP
    - N/V, SOB, dizziness, blurred vision, confusion
    - Severe: hypotension, tachy/bradycardia, death
      - >500 mg + >2oz ETOH
      - Reported to occur rarely w/ smaller doses + 1 drink
- For those highly committed to sobriety
  - Take 250 mg, carry ID
  - Avoid OTC & foods with ETOH
  - Wait 2 wks after d/c for ETOH exposure
- Side-effects: Hepatotoxicity: monitor LFTs closely. Optic neuritis: watch for visual changes. Peripheral neuropathy

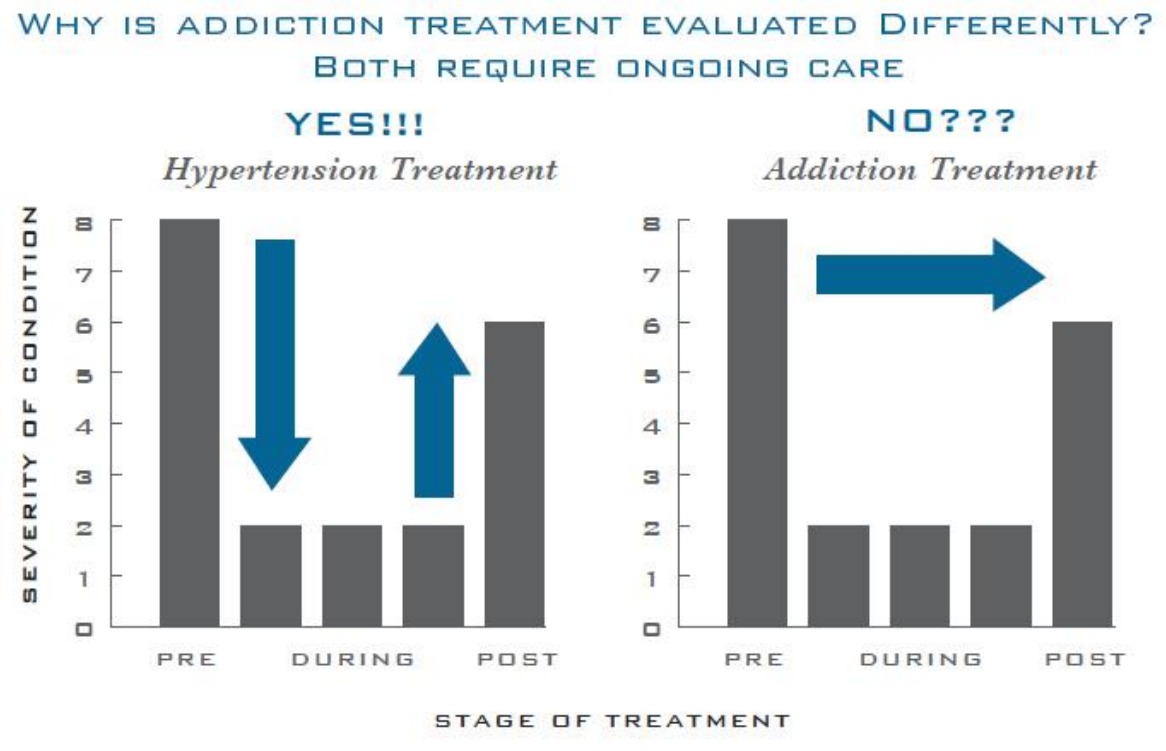
# Others … (not FDA approved)

- Gabapentin
  - 300-600 bid to tid prn
- Topiramate
  - GABAergic anticonvulsant
  - May improve depressive, anxiety, PTSD and obsessive-compulsive drinking symptoms
  - Positive dbrpc study, may get away with 75 mg qhs (taper up slowly)
    - Topiramate for treating alcohol dependence. *JAMA;* 2007;298(14):1641–1651.
    - Treatment of alcohol dependence with low-dose topiramate: an open-label controlled study. *BMC psychiatry*. 2011;11(1):41.
- SSRIs
  - Especially effective if also meet MDD criteria
  - Start with citalopram, taper up to 20 mg
  - Study showed when trazadone stopped for early recovery insomnia, worsened relapse

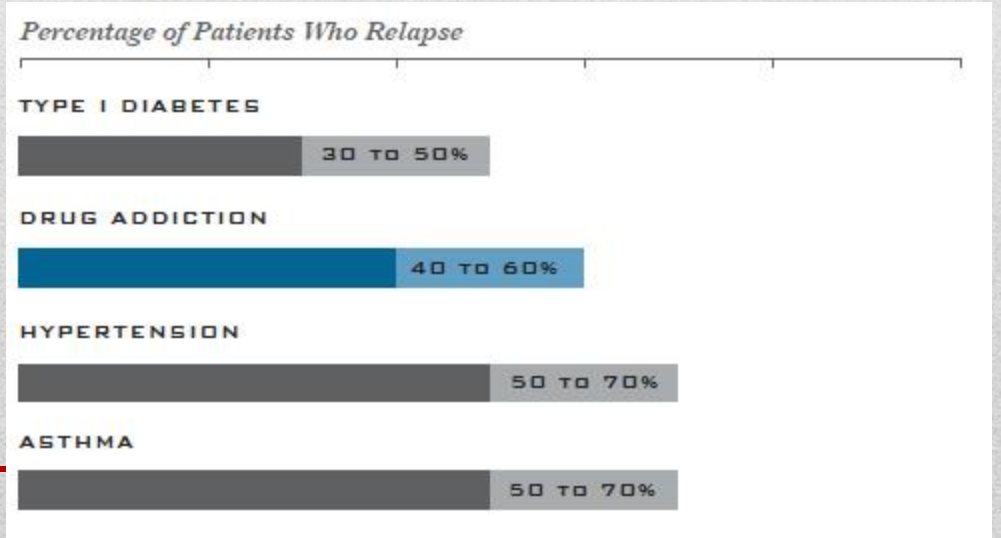
# Counseling Approaches

# Assess Stage Of Change
# "Where are you at with your drinking?"






NIDA: Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)



## *Brief MI Strategy*

# Pros & Cons

***SBIRT screened positive:***

**Pros first**: "What works for you about…?"

- Repeat using a reflective statement

**Cons second**: "What's less useful for you about…?"

- Repeat using a reflective statement
- Brings out change talk

**Anything else?**

- End with a summarizing statement
- May move pt away from denial

## *Brief MI Strategy*

# Ask-Tell-Ask

Collaborative way to provide medical feedback and education:

- ***Ask***: How much do you know about…
- ***Tell***: Would you mind if I tell you some further info? Or, What happens to some people is that…?
- ***Ask***: How does that fit with your own sense of things? What is your reaction to this information? Where does this leave you?

# Evidence Based Treatments

NIDA

- CBT
  - ETOH, MJ, Cocaine, Meth, Nicotine
- Contingency management/motivational incentives
  - ETOH, stimulants, opioids, MJ, nicotine
- 12-step facilitation
  - ETOH, stimuls, opiates
- Family Behavioral Therapy
- MI
  - ETOH, MJ, nicotine
- Matrix Model
  - Stimulants
  - Learn about issues critical to addiction/relapse, direction & support from a therapist, and become familiar with self-help programs. monitored through urine testing.

- 6 criterion required for establishing causation: (1) magnitude of effect; (2) dose response effect; (3) consistent effect; (4) temporally accurate effects; (5) specific effects; (6) plausibility.
- Evidence for criteria 1, 2, 3, 4 and 6 is very strong
  - Rates of abstinence are about twice as high among those who attend AA (criteria1, magnitude)
  - Higher levels of attendance are related to higher rates of abstinence (criteria 2, dose response);
  - Prior AA attendance is predictive of subsequent abstinence (criteria 4, temporal)
  - Mechanisms of action predicted by theories of behavior change are present in AA (criteria 6, plausibility)

# Alcoholics Anonymous Effectiveness: Faith Meets Science Kaskutas, J Addict Dis 2009

# Positive AUD/SUD

**and pt is at preparation stage of change …**

"Others have found these 3 alternatives helpful, which would work best for you?"

- 12-step alone
- 12-step plus intensive outpatient treatment
- 12-step plus residential treatment
- Other programs in your community

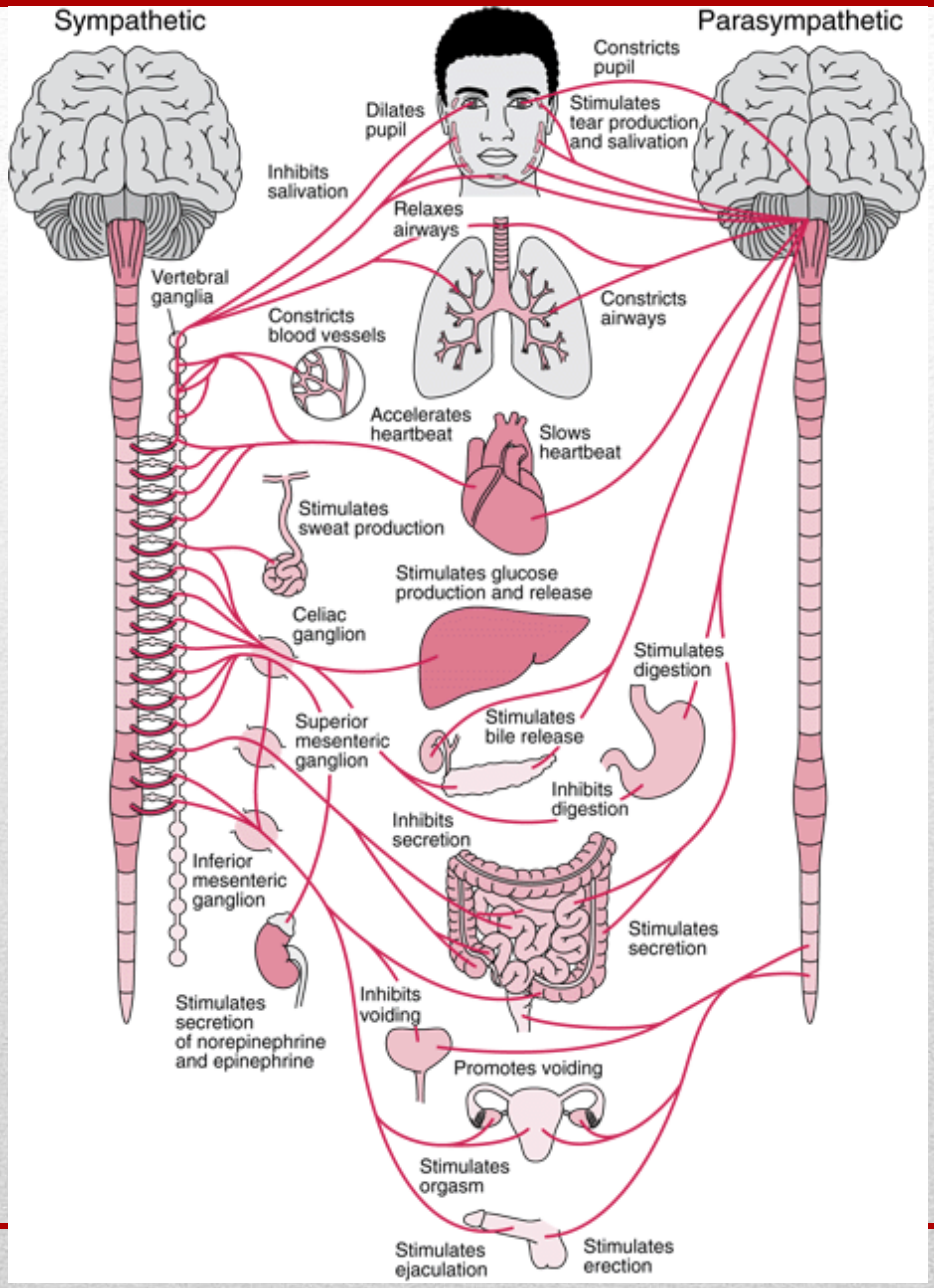
# 12 Step Preparation


- What are your concerns?
- Can someone go with you to a first meeting?
  - You don't have to talk. Just watch.
- Try a few meetings to find one where you feel socially comfortable
  - Home meeting
  - Action plan to commit to go to one meeting
- Keep eye out for a "temporary" sponsor
- Look at it like rehab after a knee replacement
  - Not easy, hard work, but necessary to walk again

# AUD Integrative Approaches

**www.pcbehavioralhealth.com**

- Smart Recovery and Life Ring
- Other 12-Step
  - Adult Children of Alcoholics , Alanon & Alateen
- Mindfulness-based
  - Refuge Recovery
  - Meditation Centers
- Auricular acupuncture for cravings
- Exercise
- Sleep hygeine
- Nutrition and supplements
  - B complex & thiamine
  - Vitamin D
  - Fish Oil: 2000 mg EPA
  - Magnesium
  - MVI
  - NAC




Merck Manual

Thanks to James Gordon MD
Center for Mind-Body Medicine
(he credits Stephen Levine for idea)

# SOFT BELLY BREATHING EXERCISE (A BACK POCKET RELAXATION TOOL)

# QUESTIONS

15 minutes


# Lunch

12:00-12:45pm

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Diversion Breakout Session

# Preventing Prescription Drug Diversion

Managing Pain Safely Forum
January 15, 2016
Matt Willis, MD MPH

# What is drug diversion?

**Drug diversion:** The transfer of any prescribed controlled substance from the individual for whom it was prescribed to another person.

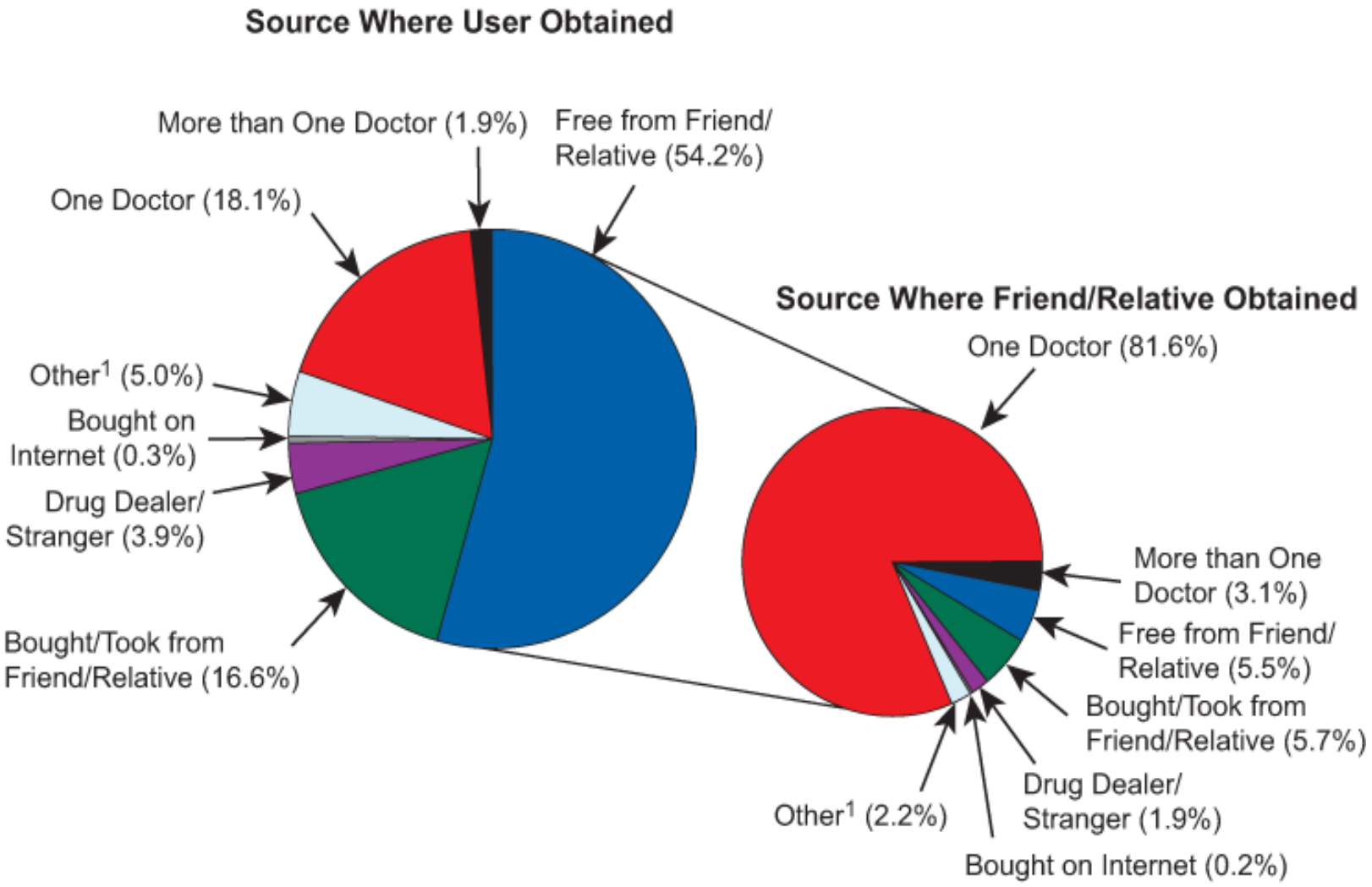
# Your Experiences

- Have you ever stopped prescribing?
- What were some of the warning signs to  make you stop prescribing?
  - What type of diversion were you suspicious of?
- What would have helped you navigate this encounter?

# How are drugs diverted?

- All stages in the “life of the pill” are controlled under law
  - Manufacture, transport, storage, prescription, dispensing, use, disposal
  - All persons with access are specially entrusted
- Diversion can occur at any stage
- Sold, stolen, traded, given away

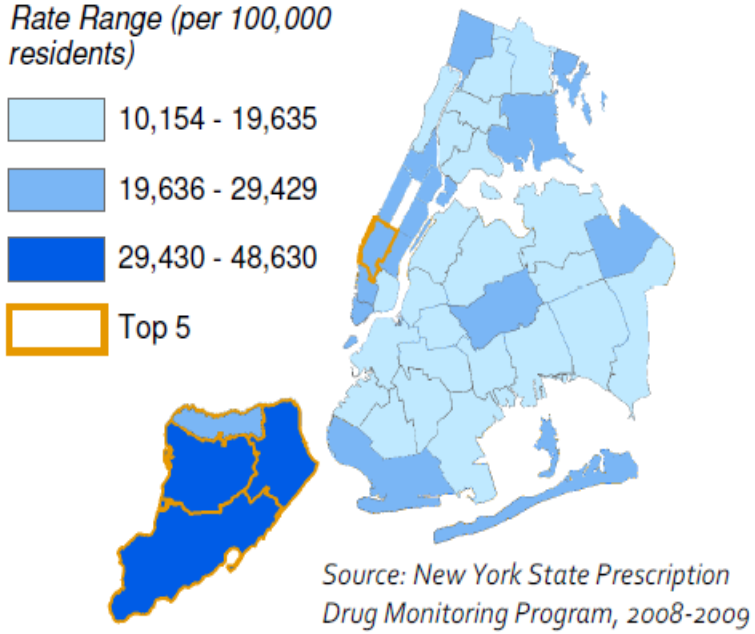
# Sources for Nonmedical Use of Pain Relievers




SAMHSA, 2011 NSDUH National Findings Report

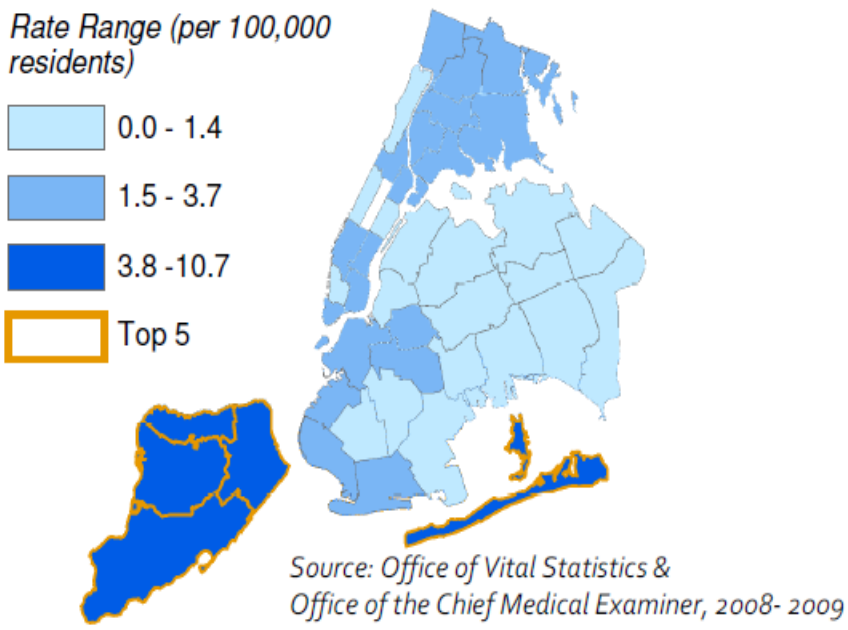
# Neighborhoods with Highest Rates of Opioid Prescriptions Also Have the Highest Rates of Overdose Deaths

**Rates of hydrocodone and/or oxycodone prescriptions filled by NYC neighborhood[5]**




*Source: New York State Prescription Drug Monitoring Program, 2008-2009*

**Rates of unintentional opioid analgesic poisoning (overdose) deaths by NYC neighborhood[4]**




*Source: Office of Vital Statistics & Office of the Chief Medical Examiner, 2008- 2009*

**Definitions:** The United Hospital Fund (UHF) classifies NYC into 42 neighborhoods, comprised of contiguous zip codes. Income is defined by the percent of households below 200% of the federal poverty level (Census 2000) and separated into three groups: low-income (43%-70%), medium-income (30%-43%) and high-income (13%-30%). To ensure rate stability, two years of prescription and death data were combined for neighborhood analyses.

Source: http://www.nyc.gov/html/doh/downloads/pdf/epi/epi-data-brief.pdf

Q: What is the approximate street value of an 8 ounce bottle of Promethazine with codeine?

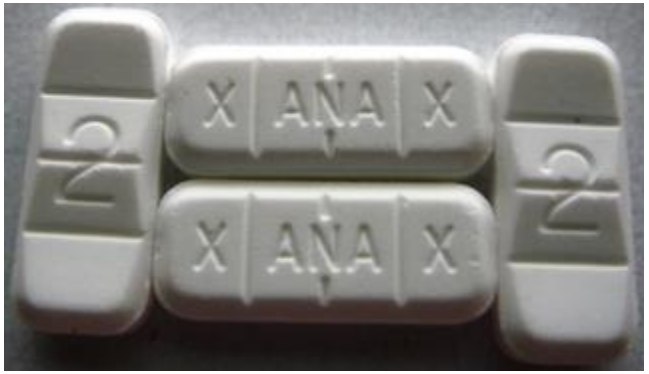
A: +/- $300

Q: What are some names for cocktails made with promethazine w/ codeine?

A: Purple drank, purple sizzurp

Q: What is a Xanny Bar?

A: Xanax (Alprazolam) 2mg



Q: What is the most popular strength of Oxycodone on the street?

A: 30mg tabs

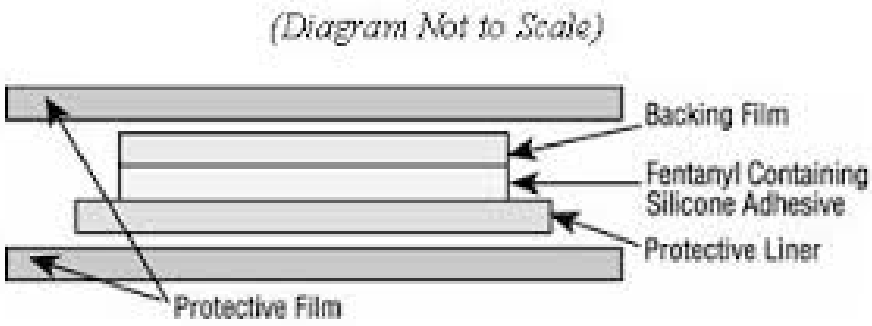
Q: What is the approximate street value for Oxycodone?

A: $1 per mg

A quick math exercise—
Oxycodone 30mg x $1/mg x 180 tablets =
**$5400**

Q: How are people abusing the Fentanyl patch

A: They are scraping the patch, drawing it up, and injecting it




# How to Prevent Diversion

# Established Guidelines

PHP and CDC Opioid prescribing guidelines include:

- PDMP (CURES)
- Toxicology screens
- Medication agreements
- Safe storage
- Safe disposal

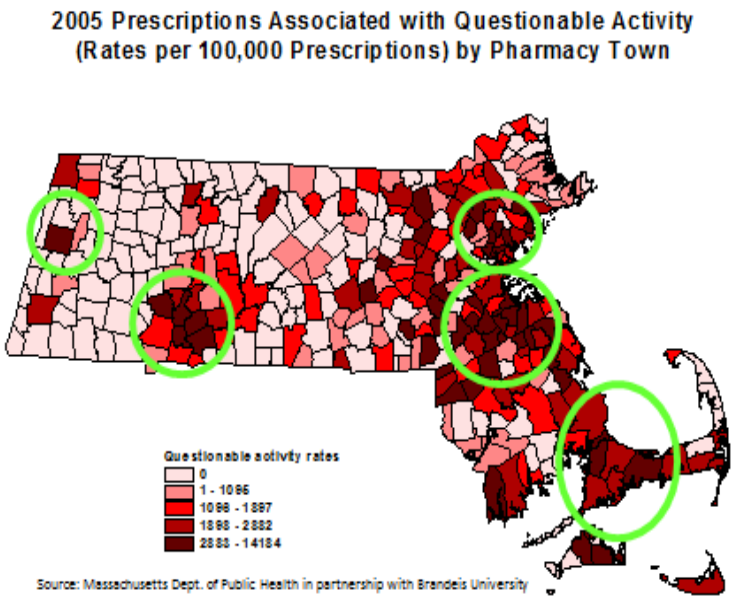

Source: http://www.cdc.gov/drugoverdose/prescribing/guideline.html

# Marin County Prescribers Survey, 2015

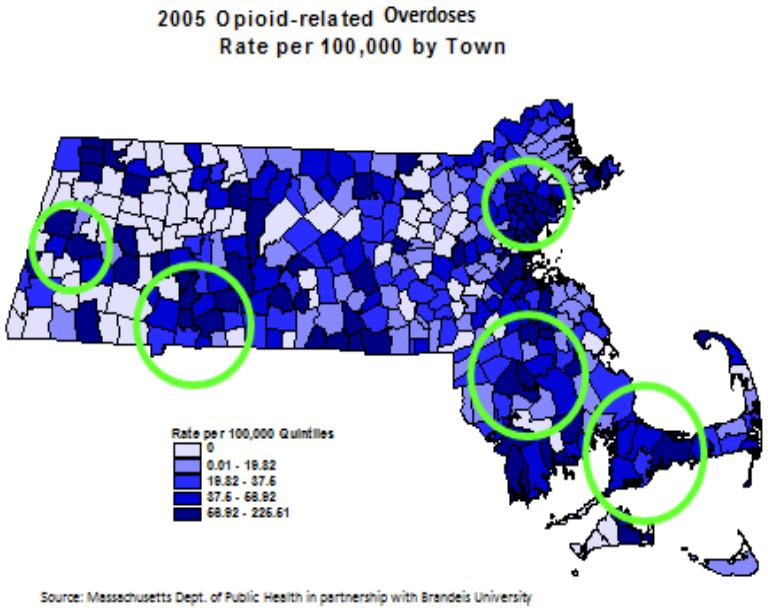
- Providers who self–report as operating under opioid prescribing guidelines were:
  - **8** times more likely to perform urine drug screening
  - **12** times more likely to use a medication agreement
  - **17** times more likely to utilize CURES

# An Argument for Using CURES When Prescribing

"Shopping" as a portion of all prescriptions



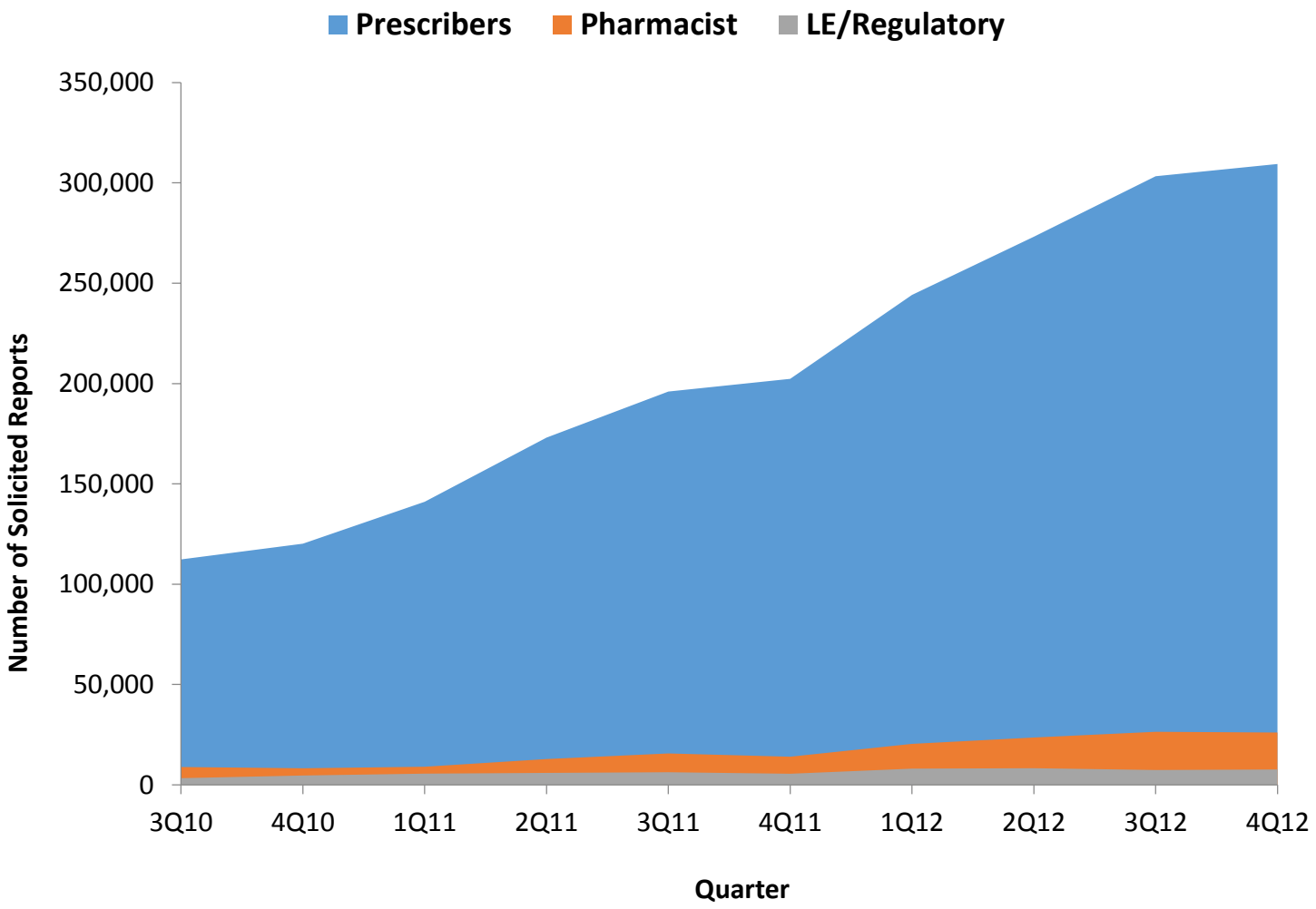

Opioid Overdoses




Slide provided courtesy of Peter Kreiner, PMP Center of Excellence at Brandeis. Doctor shopping= 4+ prescriber s and 4+ pharmacies for CS in six months.

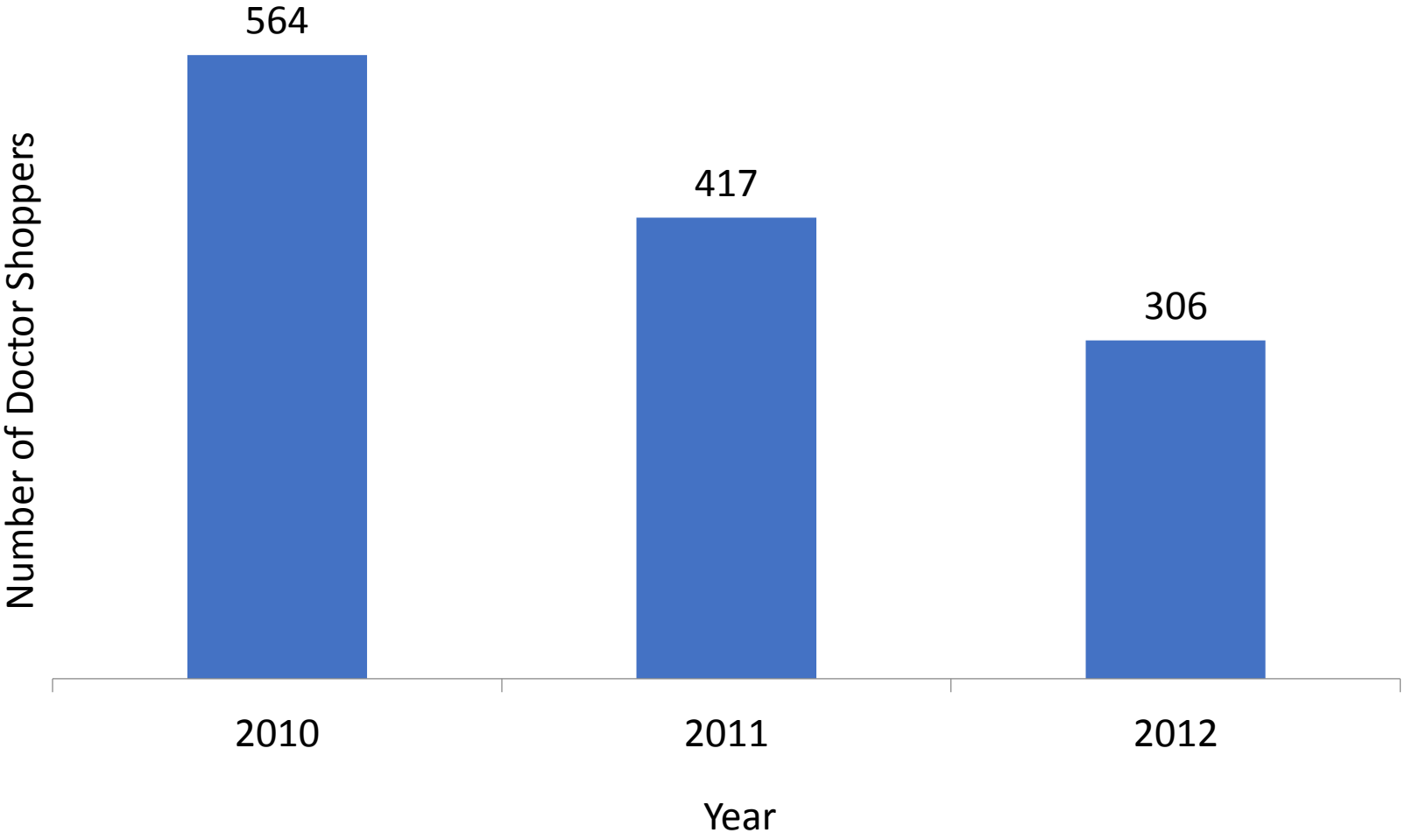
# Changes Can Be Made:

# Solicited PDMP Reports, Oklahoma, 2010-2012




Information provided by Don Vogt, OK Bureau of Narcotics PMP, 2013.

# Changes Can Be Made: As PDMP Usage Increased, Doctor Shopping Decreased in Oklahoma




Information provided by Don Vogt, OK Bureau of Narcotics PMP, 2013.

# CURES 2.0 User Features

- Delegation Authority
  - Multiple designees can run report
- Peer-to-Peer Communication
  - Messaging between prescribers and with pharmacists
- Patient Safety Alerts/Messaging

# CURES 2.0 Patient Safety Alerts

- Prescriber's Rx Recipients being Prescribed More than 100 MME/Day

- **Prescriber's Rx Recipients being Prescribed More than 40 mg Methadone /Day**

- Prescriber's Rx Recipients Who Have Obtained Prescriptions from 6 or More Prescribers, or 6 or More Pharmacies During Last 12 Months

# CURES 2.0 Patient Safety Alerts

- Prescriber's Rx Recipients Who Are Currently Prescribed Opioids More Than 90 Consecutive Days

- Prescriber's Rx Recipients Who Are Currently Prescribed Both Benzodiazepines and Opioids

# CURES Access is Mandatory

On Sept. 27, 2013, Senate Bill 809 passed requiring prescribers and pharmacists to *apply* for CURES access.

*H&S Code section 11165.1 (a)(1)(A)(i)*
A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances…shall, before July 1, 2016, or upon receipt of a federal DEA registration, whichever occurs later, submit an application to obtain approval to access CURES.

*H&S Code section 11165.1 (a)(1)(A)(ii)*
A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application to obtain approval to access CURES.

Use of the PDMP by prescribers and dispensers for prescription abuse prevention/intervention is *voluntarily*.

# Law Enforcement: Example of Marin County DA Communication


OFFICE OF THE DISTRICT ATTORNEY
MARIN COUNTY, CALIFORNIA

*Prevention ★ Prosecution ★ Protection*

*Edward S. Berberian*
**District Attorney**

*Barry G. Borden*
CHIEF DEPUTY DISTRICT ATTORNEY

*Robert R. Guidi*
CHIEF INSPECTOR

*Peggy M. Toth*
CHIEF, FINANCE AND ADMINISTRATION

(Date)

*
*
*

Re: Defendant's name; Marin County Superior Court Case No. *A

Dear Physician's Name:

It has come to our attention that * is currently, or was recently a patient of yours.

On *, 2014, a criminal complaint was filed against *, alleging violations of Section * of the * Code, occurring on *. A copy of the Complaint is attached hereto for your reference.

This information is being provided as the result of a partnership between the Marin County District Attorney's Office, Marin Health & Human Services, and Partnership HealthPlan of California. The goal of this partnership is to share information with physicians regarding unlawful prescription drug diversion and misuse, enabling physicians to make informed treatment decisions.

Please do not hesitate to contact our office if you have any questions.

Very truly yours,

EDWARD S. BERBERIAN
DISTRICT ATTORNEY

*
Deputy District Attorney

"The goal of this partnership is to share information regarding diversion… enabling physicians to make informed treatment decisions."

# Death Diary: 49 year old female "Compliant"

12 Rx – 1 Psychiatrist – 1 Pharmacy

| | |
|---|---|
| September | Clonazepam 1mg #45 , 45 |
| October | Clonazepam 1mg - #30, 45, 90 |
| November | Clonazepam 1mg - #90 |
| December | Clonazepam 1 mg - #15,90 |
| January | Clonzepam1 mg - #120 |
| February | Clonazepam - #120 |
| March | Clonazepam - #30, 120 |

Autopsy: Oxycodone

# Death Diary: 59 year old male "Holy Trinity"

75 Rx – 1 Psychiatrist – 3 Primary Care – 1 Pain

| | |
|---|---|
| September | Hydrocodone, Soma Hydromorphone, Ambien |
| October | Clonazpam, Soma, Hydromorphone, Ambien, Hydrocodone, Soma, Clonazepam |
| November | Hydromorphone, Hydrocodone, Soma, Clonazepam, Hydromorphone |
| December | Hydrocodone, Hydrocodone, Soma, Clonazepam, Hydromorphone, Ambien |
| January | Hydrocodone, Soma, Clonazepam, Hydromorphone 4 mg, Ambien |
| ..... | |
| August | Hydrocodone, Soma, Clonazepam, Morphine 60 mg , Ambien |

Autopsy: Morphine, Ambien, Sertraline, Hydroxyzine

# Death Diary: 56 Year Old Female "Start on methadone, End on Methadone"

23 Scripts
10 Providers

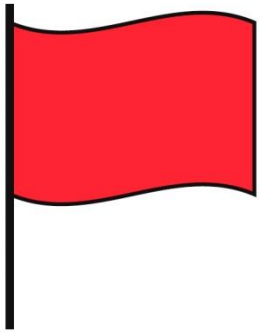
| | |
|---|---|
| February, March | No Meds |
| April | ER#1: Hydrocodone #10 |
| | Dr. R: Codeine#40, Lorazepam #42 |
| May | Dr. P: Hydrocodone #15, Lorazepam #20 |
| June | ER#2: Hydrocodone #20, Lorazepam #20 |
| August | ER#3: Oxycodone #20, Lorazepam #21 |
| | ER#4: Oxycodone #21, Lorazepam #20 |
| September | ER#5: Oxycodone #20, Lorazepam #6 |
| | Dr. L: Methadone #120 |
| October | Dr. L: Methadone #120 |
| | ER #6: Hydrocodone #15 |
| | Dr. W: Lorazepam #8 |
| November | ER #3: Oxycodone #5, Lorazepam #4 |
| | Dr. L: Methadone #120 |
| December | Dr. L: Methadone #120 |
| January | ER #7: Lorazepam #4 |
| February 1, 2013 | Dr. L: Methadone #30 |

Death: February 7, 2013

Methadone, Clonazepam, Phenytoin, Carbamazepine, Gabapentin

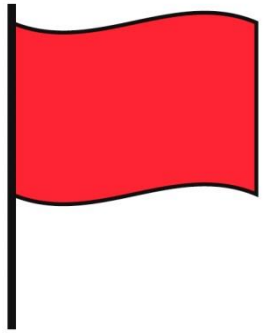
# Flags

- Combinations or “cocktails” of frequently abused controlled substances
- New clients with limited documentation and specific regimen requests
- Multiple prescribers in CURES
- Discrepancy between self report and CURES findings
- Discrepancy between self report and UDS
- Travel long distance to visit
- Strong preference for specific medication or brand



# Flags

- Reluctance to allow examination or to provide urine for UDS
- Discussion of analgesic dominant issue of visit
- UDS +ve for illicit drugs or –ve for prescribed drugs
- Lack of interest in self management strategies
- Failure to attend appointments e.g. physiotherapy
- Hostile / aggressive (sudden change if not satisfied)
- Refusal to sign treatment agreement



*Thank You*

SAFE Rx MARIN
MARIN COUNTY PRESCRIPTION DRUG MISUSE AND ABUSE INITIATIVE


# Behavioral Health for Chronic Pain Patients Breakout Session

# Chronic Pain: Skills for Patients and Practitioners


***Presented by:***

**Pat Dwyer, Ph.D.**

**Psychologist**

**Kaiser Permanente**

**Chronic Pain Program**

**pat.j.dwyer@kp.org**

**(707) 651-4451**

# What NOT to Say!

# At Our First Contact We Want Our Patients To Know

- Goals functional improvement, not zero pain along with keeping our patients safe
- You have real pain and it's as bad as you say
- Meds aren't enough
- Skills and Pills will help more
- Use movement and exercise for improvement
- Stage of Change-we'll be working on what's hardest to change

# Like an iceberg PAIN is more than what we see

# Assessment

- Mood evaluation and assessment for risk for harm to self or others
- Risk Factors and Protective Factors
- I put in every note--Patient does not appear to present an imminent risk for suicide

# Risk Factors

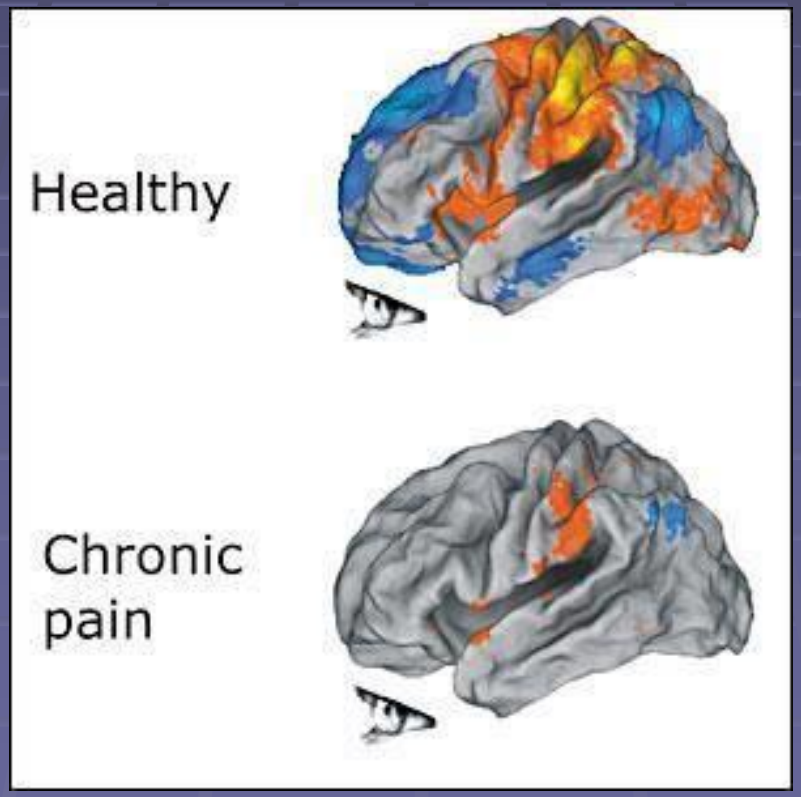
Passive thoughts would be better off dead
Insomnia vs Global Insomnia
Impulsivity
Psychic anxiety/agitation
Severe Hopelessness
Severe Anhedonia
Medication Overdose, recent or remote
ED visits for suicidal ideation
Recent suicide attempt or serious gesture
Specific plan, intent and means
Intoxication
Mood congruent delusions of doom
Severe Ruminations
Guns -who is holding them, safety locks, bullets

# Protective Factors

- Hopeful
- Seeking help
- Seeking better pain control
- Problem solving
- Social support
- Future goals
- Religious
- Children or grandchildren
- Family member holds meds
- Patient is followed in PSY

Aware of PSY crisis resources including going to the ED and dialing 911 if needed

# The Brains of a Healthy vs Chronic Pain Person



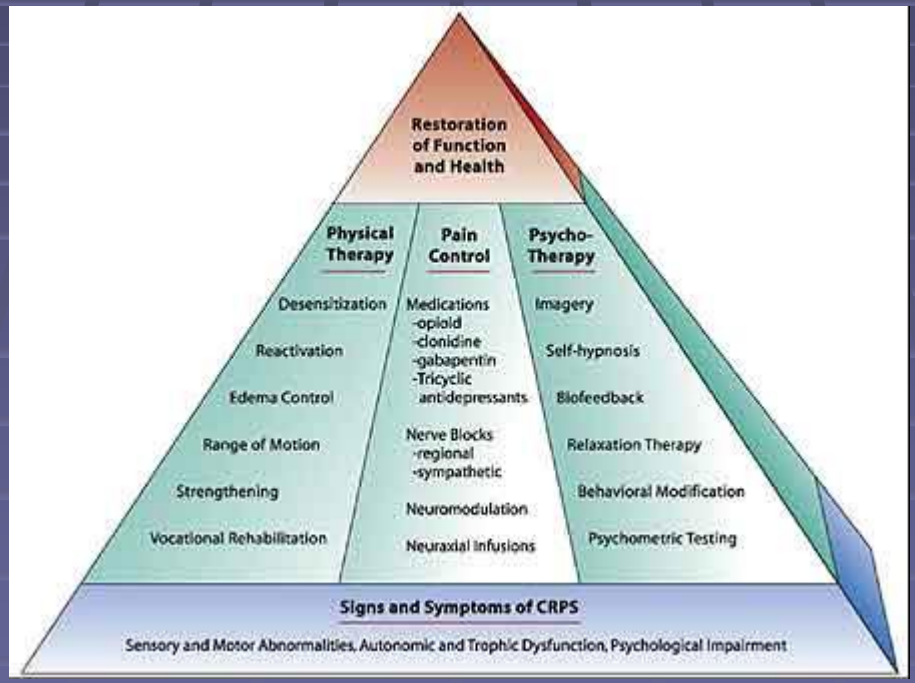

Northwestern University fMRI scan

# At Evaluation

- Try to give the patient something to leave with, some hope
- Ask about their occupation use that with your skills metaphors
- Reinforce their resilience
- Ask them about something that is positive
- See if they notice their mind/body response and the shift in their comfort level and reduction in their pain level
- Sign release to coordinate care

# Ways to help our patients manage

# Complexity of Improved Function



# Pain Pathways and the Mind-Body Connections

- Gate Control Theory (1965, 1982) and Melzak (2001) the matrix
- Biopsychosocial Factors that Open or Close the Gate
- Mind-Body Connections
- Using Mindfulness techniques
- Psychoneuroimmunology (PNI)

# Melzak & Wall (1965, 1982) Factors that Open and Close the Gate

| Close | Open |
| --- | --- |
| Successful Surgery | Surgery/broken bones |
| Medications | Drug and ETOH overuse |
| Good Diet | Poor Diet/Nicotine |
| Movement | Deconditioning |
| Pacing (activity/rest) | Worry about Hurt vs Harm |
| Positive outlook | Negative outlook |
| Hopefulness | Hopelessness |
| Managing the pain | Focusing on the pain |
| Pleasant events | Depression/Anger |

# Pain Management Tools

- Goal Setting
- Behavior Change -*Premack Principle*
- Predicting "*The good the bad and the ugly*"
- Automatic Thought Records
- Pleasant Events for mood improvement "Left brain shift"
- Pacing activity/rest cycle vs "Just do it"
- Relaxation- "small, medium and large"
- Communication use the cell phone and say NO
- Sleep- try a fan, turn the clock, nap

# The Mind-Body Connection

- The brain is not a passive recipient of pain signals
- Thoughts and feelings can “rewire” the brain and increase experience of pain

# Relaxation Practice Time at the Beach
# Small, Medium, Large

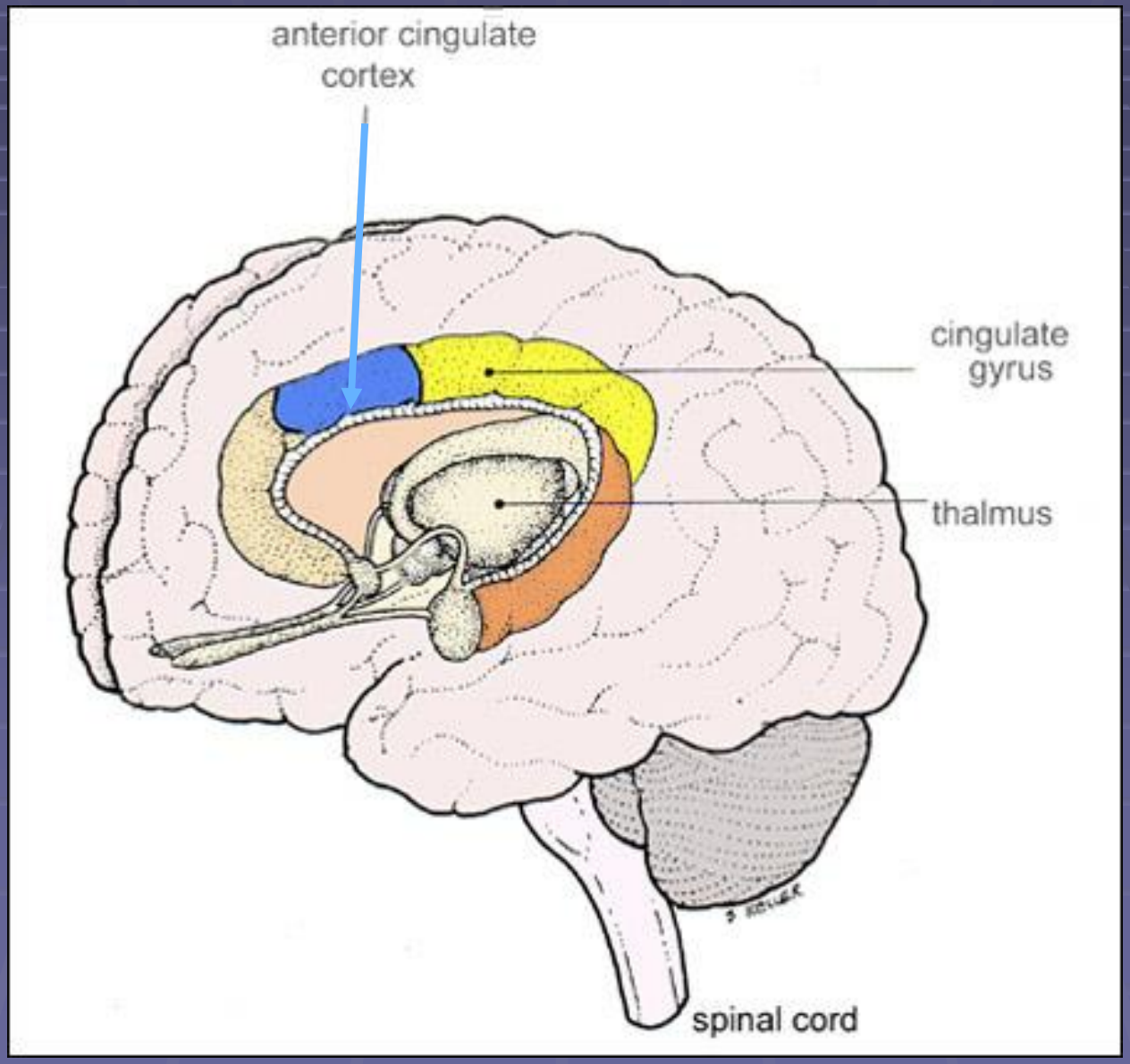
# Changing the Brain

- Patients can gain control over specific brain regions with training

- Rostral Anterior Cingulate Cortex (rACC) leads to control over pain perception even severe, chronic pain

deCharms, R. Chistopher et al. (2005) Proc. Natl. Acad Sci. USA 102, 18626-18631.

# Anterior Cingulate Cortex



# Hod Carrier
# Cologne, Germany 1929
# August Sanders Photographer

Learning to let go

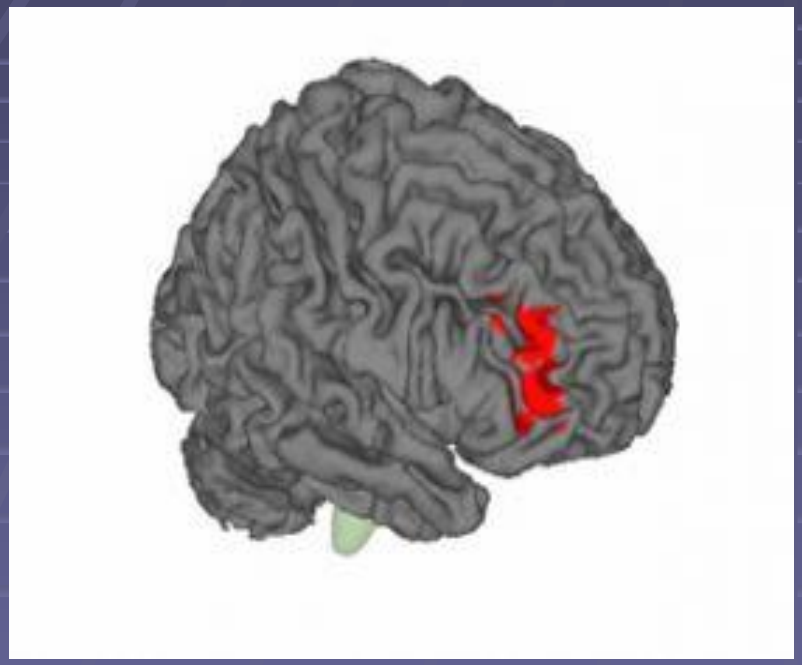
of what we don’t need

# Cortical Re-Organization

- Cortical plasticity related to chronic pain can be modified by behavioral interventions that provide feedback to the brain areas that were altered by somatosensory pain memories

Flor,H. Appl Psychophysiol Biofeeback 2002 Sep, 27(3) 215-27.
Flor, H. Jour Rehab Med 2003. May 41, (Suppl) 66-72

# Where Placebo Effect Works in the Brain



- Using PET scans found that when treated with placebo the brain released more opioids to relieve pain

The research team of Tor Wager, Columbia University

# Pain and Positive Expectation

- Positive expectations (i.e. decreased pain) produce a reduction in perceived pain by 28.4% and compares to a dose of morphine with an expected 25% reduction in pain

- Data provide a neural mechanism that can modulate pain by positive expectations and has implications for use of CT skills

Koyama, T. McHaffie, J.G., Laurienti, PJ., Coghill, R.C.. Proc Natl Acad Sci USA. 2005; 102:12950-12955.

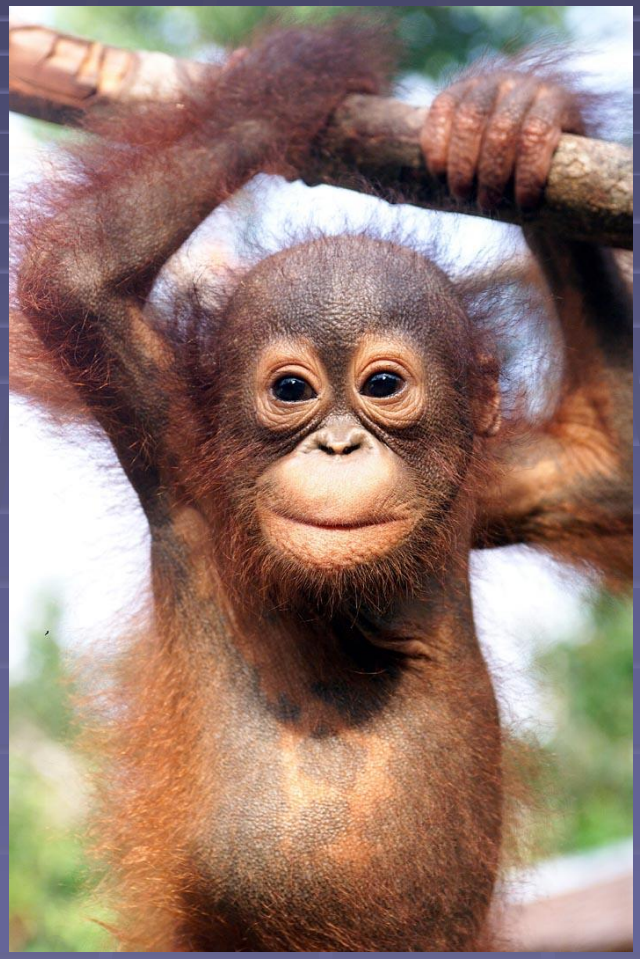
# Humor and Psychological Well-Being

Relationships between sense of humor and reports of physical well-being are supported in the literature.

# At Termination

- ✓ Document treatment is ended
- ✓ Ways to continue to use skills
- ✓ Patient can return in the future

# You too must have something that makes you smile



PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Buprenorphine Induction Breakout Session


# Buprenorphine MAT

R. Corey Waller MD, MS, FACEP, FASAM
President, Michigan Society of Addiction Medicine
Director, Center for Integrative Medicine
Medical Staff Chief, Division of Pain Management

# Objectives

- How to Choose the right patients
- Special needs for pregnant patients
- Workflow
- Documentation
- Long Term Planning
- Regulatory Requirements

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# Who is appropriate for buprenorphine?

- Positive DSM 5 with a score of 2 or greater
- Positive DAST (6 or greater)for opioids
- Per the SAMHSA guidelines, a patient should have a 1 year history of opioid use disorder prior to use of methadone. (however, many caveats)
- No guidance on Buprenorphine

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# Before the first dose

- Informed consent should be obtained
- Physical exam
- Toxicological evaluation

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# Dose Equivalents Buprenorphine/naloxone

| Suboxone (SL-film) | Zubsolv (ODT) | Bunavail (B-Film) |
|---|---|---|
| 2 mg / 0.5 mg | 1.4 mg / 0.36 mg | --- |
| 4 mg / 1 mg | 2.9 mg / 0.71 mg | 2.1 mg / 0.3 mg |
| 8 mg / 2 mg | 5.7 mg / 1.4 mg | 4.2 mg / 0.7 mg |
| 12 mg / 3 mg | 8.6 mg / 2.1 mg | 6.3 mg / 1 mg |
| ---- | 11.4 mg / 2.9 mg | ---- |

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# First dose when flipping from full agonist opioids

In general the patient should either be completely negative for opioids in the urine or in mild to moderate withdrawal based on the clinical opioid withdrawal scale (COWS)

Patients who are negative for opioids can be given up to 8 mg

Patients who are positive for opioids, but in moderate withdrawal should receive 2-4 mg.

If the withdrawal worsens then can give up to 24 mg to abate withdrawal

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# Partial agonist/agonist-antagonist

**Nubaine:**

- Nalbuphine belongs to the agonist-antagonist group. This exerts its analgesic actions by agonistic activity at opioid kappa (“κ”) receptors. It possess opioid mu (“μ”) receptor antagonistic activity leading to less abuse potential (and unwanted withdrawal).

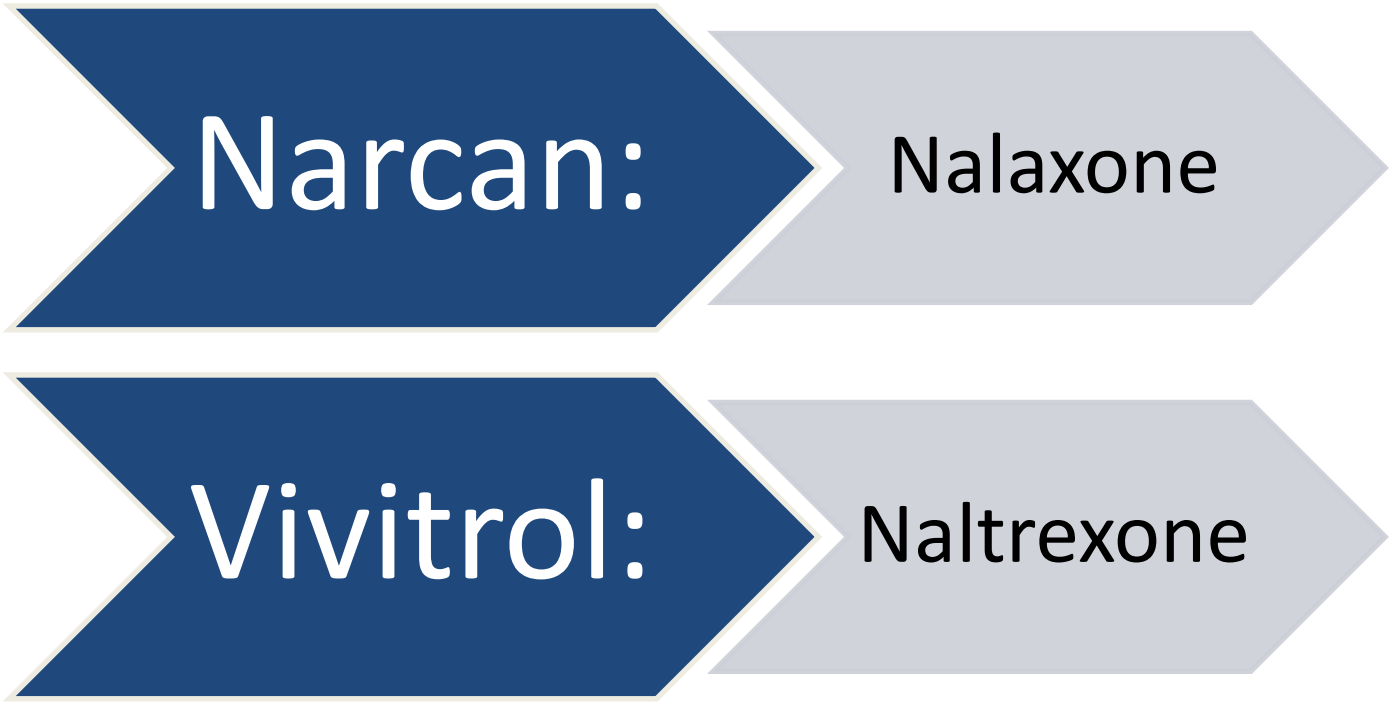
**Stadol:**

- Butorphanol exhibits partial agonist and antagonist activity at the μ opioid receptor, as well as competitive antagonist activity and partial agonist activity at the k opioid receptor.

**Buprenorphine:**

- Buprenorphine is considered a partial μ-opioid agonist displaying high affinity for and slow dissociation from the μ-opioid receptor.

# Antagonist

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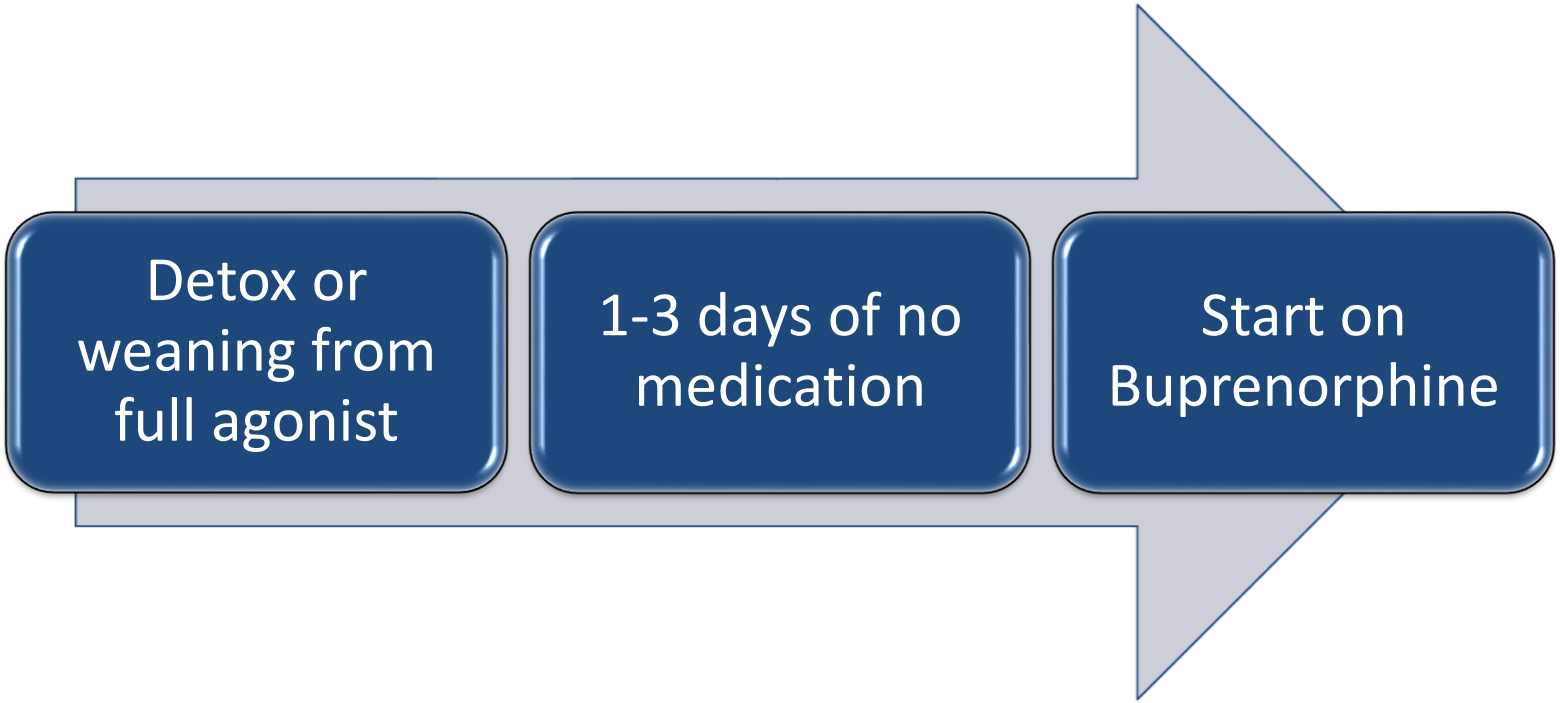
# Typical opioid “flip”

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# Other types of induction

**Butrans-** Place transdermal buprenorphine patch on skin. It takes 36 hours to peak. After 36-48 hours remove the patch and give 1st SL buprenorphine dose of 4-8 mg

**Fentanyl Bridge-** For patients on opioids place morphine equivalent patch on skin. Have patient return in 72 hours. Give 2 mg of buprenorphine, remove the patch and have patient take next SL dose of Bup when they start to experience withdrawal

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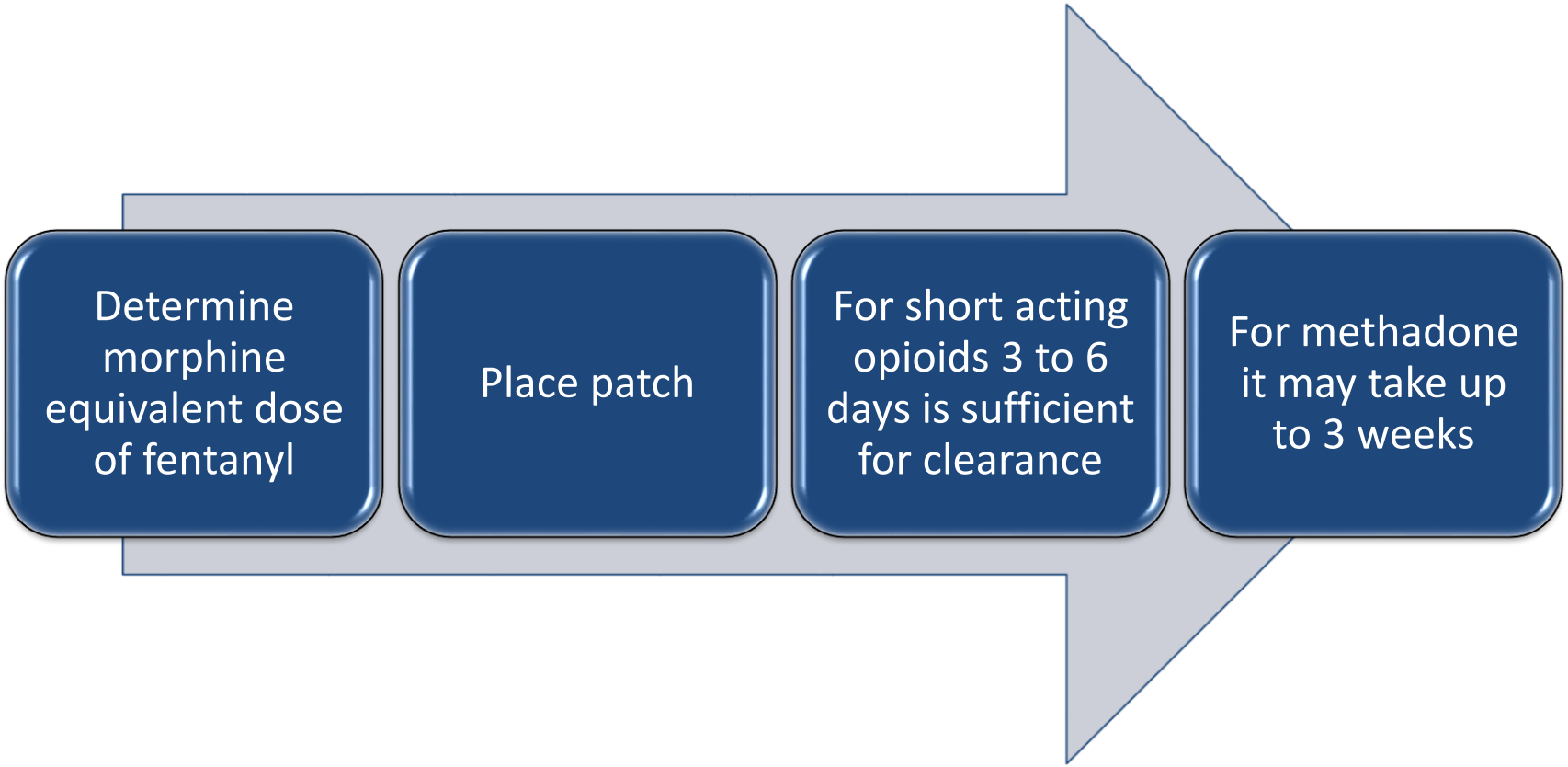
# Fentanyl Bridge

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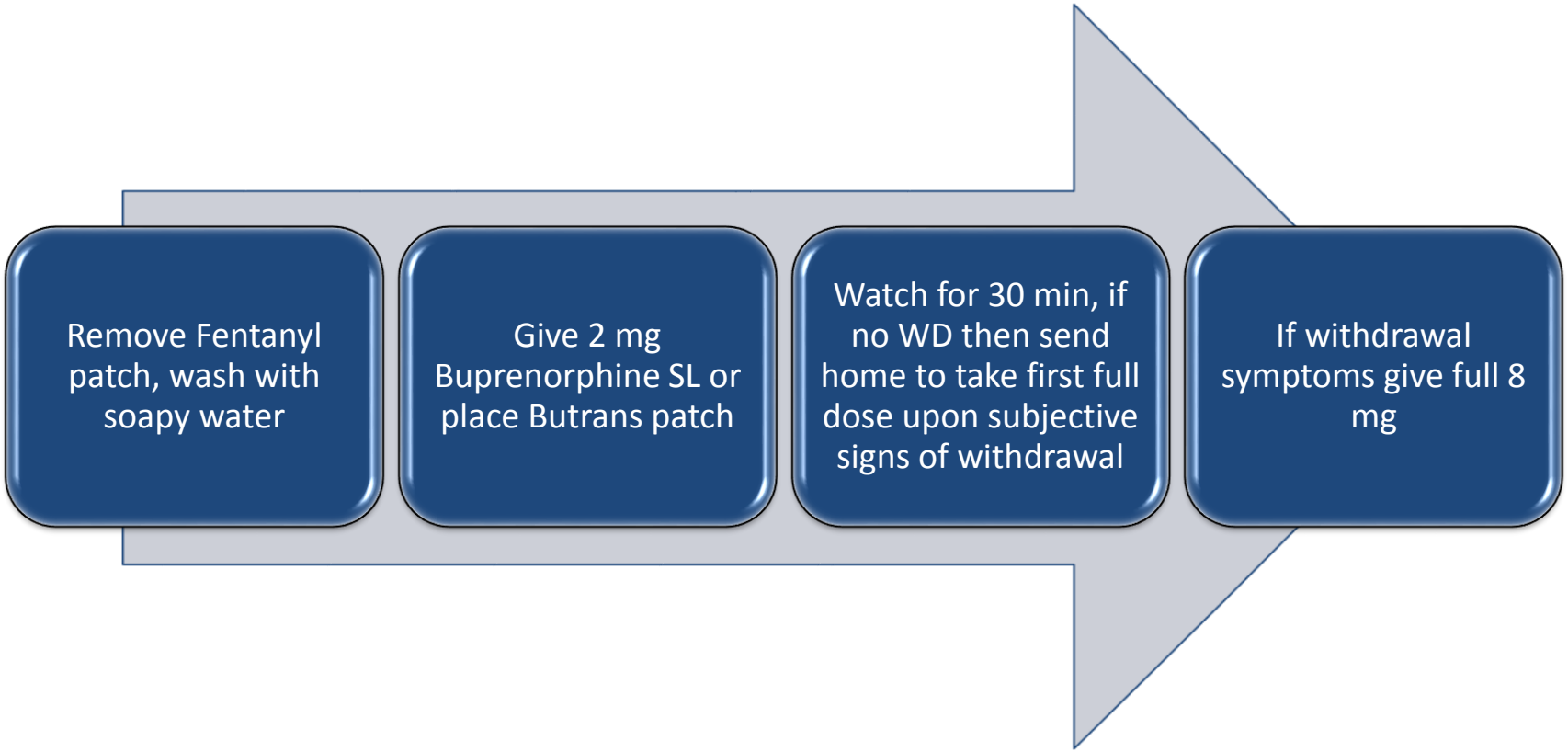
# Induction

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# Fentanyl Bridge Data

Of the 54 inductions attempted for short acting opioids all completed, however patients with greater than 90 mg of methadone have had mixed results

We now use it as a “standard” option along with Butrans

Works great for patients in the hospital

- Can discharge on fentanyl and start Buprenorphine on first out patient visit

We now use it for pregnant patients as well

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# Risks

**Not considered standard of care**

- Patients should be apprized of the risks, benefits and alternatives
- Close monitoring is required

**Fentanyl has abuse potential**

- If patients previous drug of choice then not a great med
- If patient is an injector then use Mylan brand patch
- If patient is an oral abuser then the liquid brands are preferred
- Write for 1-2 patches at a time

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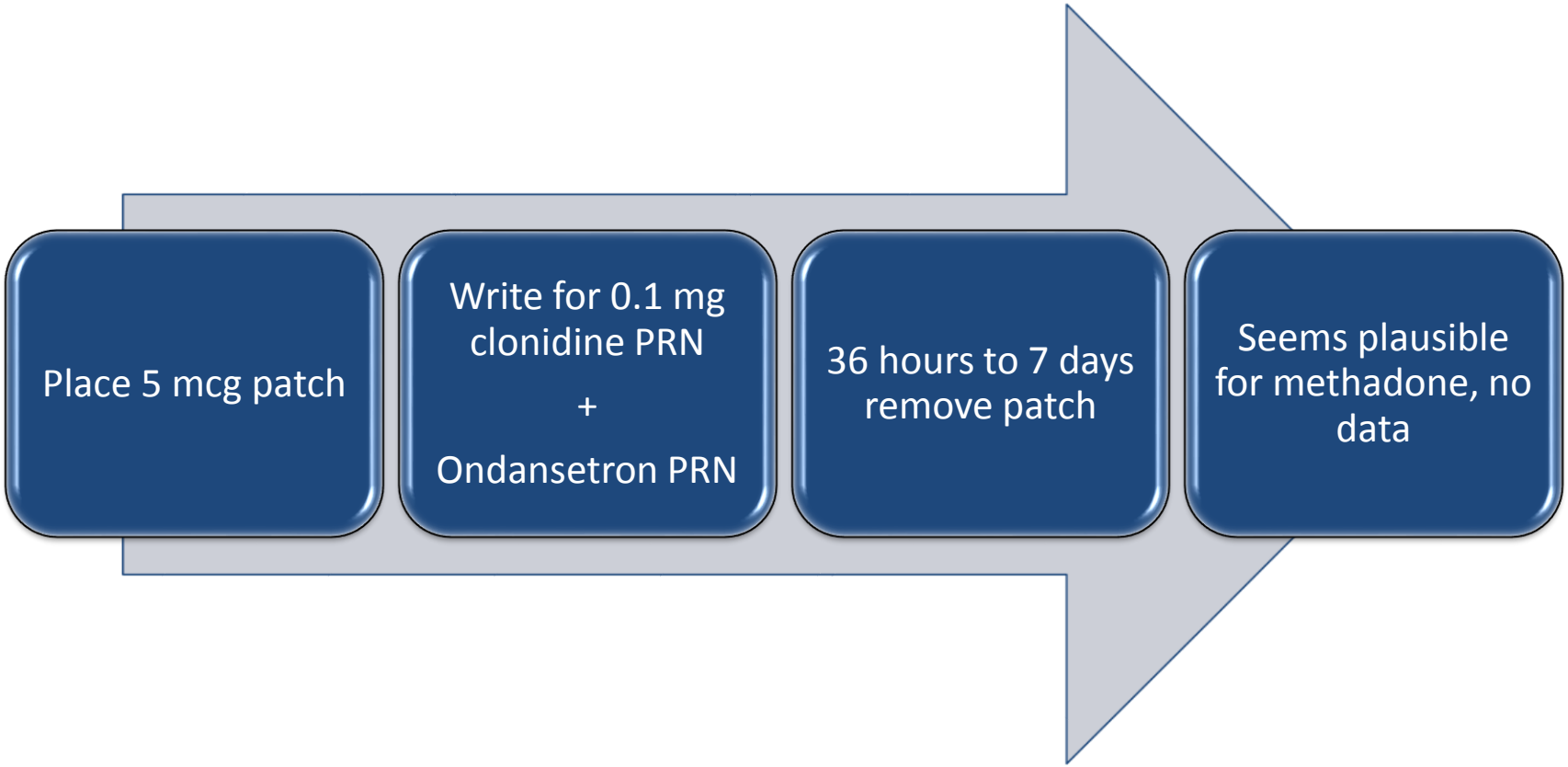
# Butrans Bridge

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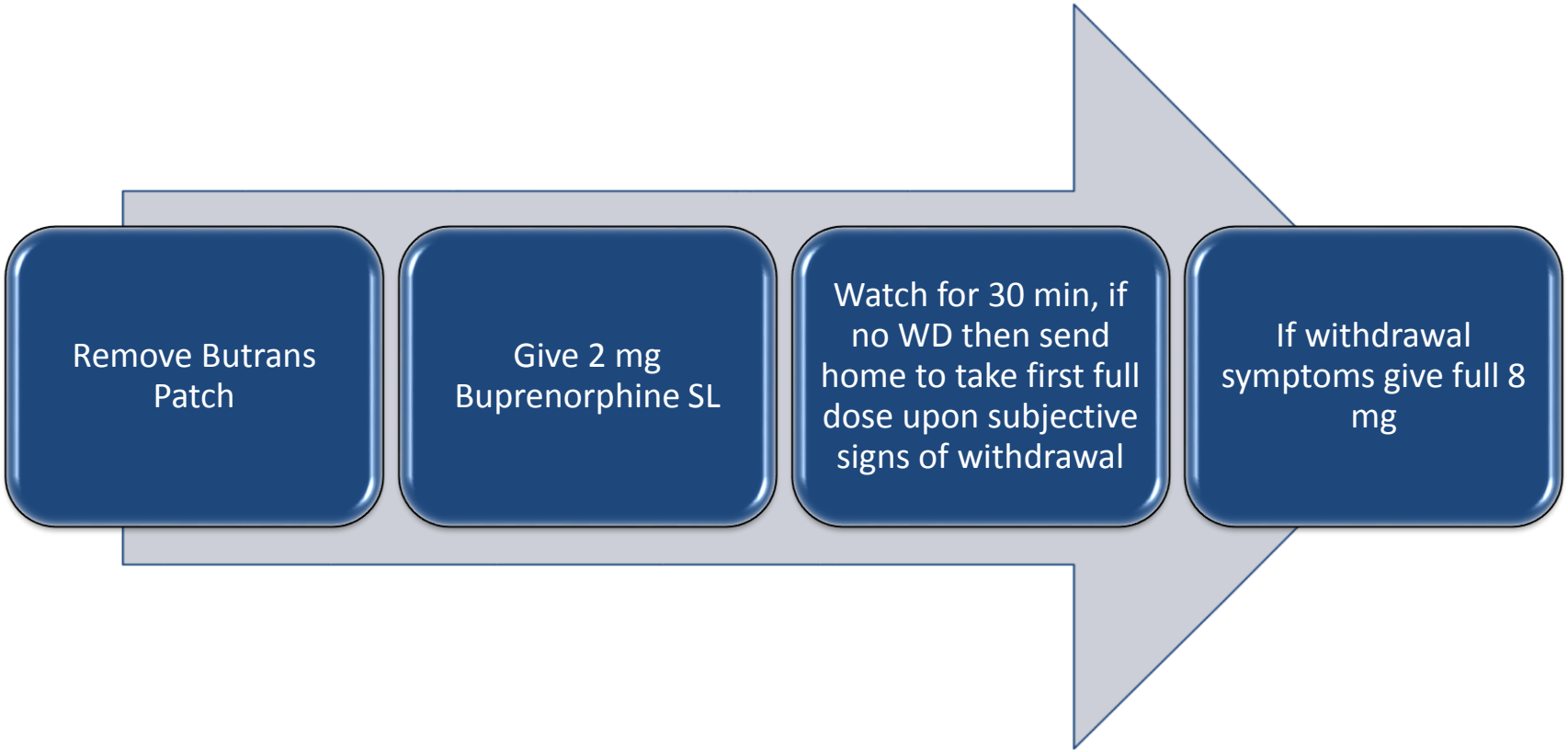
# Induction

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# Data

Kornfeld et al, Transdermal Buprenorphine, Opioid Rotation to Sublingual Buprenorphine, and Avoidance of Precipitated Withdrawal: A Review of the Literature and Demonstration in Three Chronic Pain Patients Treated with Butrtans

We have used on 16 patients with same positive results.

We now use it for pregnant patients as well

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# Pregnant Patients

- Main risk is unabated withdrawal leading to preterm labor and/or precipitous delivery
- Higher in 1st and 3rd trimester
- Probably overstated risk if monitored appropriately.
- Same pre-eval requirements as non-pregnant patients

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# Pregnant Patients

For first few, OK to do in OB triage or in collaboration with OB and/or fetal monitoring.

My first 5 were inpatient and no anomalies were found to justify the need for inpatient monitoring

Induction should always be done in person and watched for 1 hour after 1$^{st}$ dose

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# MOTHER Study

Addiction. 2012 Nov;107 Suppl 1:28-35. doi: 10.1111/j.1360-0443.2012.04036.x.

- Maternal Opioid Treatment: Human Experimental Research (MOTHER)--approach, issues and lessons learned.
- Jones HE1, Fischer G, Heil SH, Kaltenbach K, Martin PR, Coyle MG, Selby P, Stine SM, O'Grady KE, Arria AM.

The Maternal Opioid Treatment: Human Experimental Research (MOTHER) project, an eight-site randomized, double-blind, double-dummy, flexible-dosing, parallel-group clinical trial is described. This study is the most current--and single most comprehensive--research effort to investigate the safety and efficacy of maternal and prenatal exposure to methadone and buprenorphine.

At least seven important lessons have been learned from the MOTHER study: (i) an interdisciplinary focus improves the design and methods of a randomized clinical trial; (ii) multiple sites in a clinical trial present continuing challenges to the investigative team due to variations in recruitment, patient populations and hospital practices that, in turn, differentially impact recruitment rates, treatment compliance and attrition; (iii) study design and protocols must be flexible in order to meet the unforeseen demands of both research and clinical management; (iv) staff turnover needs to be addressed with a proactive focus on both hiring and training; (v) the implementation of a protocol for the treatment of a particular disorder may identify important ancillary clinical issues worthy of investigation; (vi) timely tracking of data in a multi-site trial is both demanding and unforgiving; and (vii) complex multi-site trials pose unanticipated challenges that complicate the choice of statistical methods, thereby placing added demands on investigators to effectively communicate their results

# Birth Plan

**Patient example: 23 y/o on 8mg of buprenorphine-naloxone 2 times per day (BID)**

## Spontaneous vaginal delivery:

- Decrease Buprenorphine to 8 mg daily
- May use epidural but would use fentanyl as opioid
- Add Ketorolac 15-30mg IV every 6-8 hours or Ibuprofen 800mg every 8 hours
- After 36 hours return to 8mg of Buprenorphine-naloxone BID
- Discharge on same dose with no further opioid prescriptions

## C-section Delivery:

- Decrease buprenorphine to 8mg daily
- Spinal analgesia using fentanyl as the opioid
- Add Ketorolac 15-30mg IV every 6-8 hours or Ibuprofen 800mg every 8 hours
- If still painful would use Patient Controlled Analgesia (PCA) at 150 mcg/4 hours with no basal rate for 36-48 hours
- May add 1 gram of IV acetaminophen Q 6 hours
- Increase buprenorphine-naloxone to 8 mg 3 times per day and call provider to obtain insight and provide appropriate care transition

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# Early Monitoring

Patient should be monitored closely for diversion, and ingestion of other sedatives such as Alcohol and/or Benzo's

Generally patient should be seen weekly for 6 weeks, bi-weekly for 8 weeks and the monthly there after.

This is only if the urine toxicology is positive for buprenorphine and negative for other elicit substances. If they are negative for bup or positive for other substances then they should continue weekly until stable

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# Long Term Planning

- Need 18 months to 2 years for neuronal Stabilization
- Patient centered wean
- Early High intensity BH with long term recovery program (groups etc)
- Hope is for long term abstinence (70-80%)

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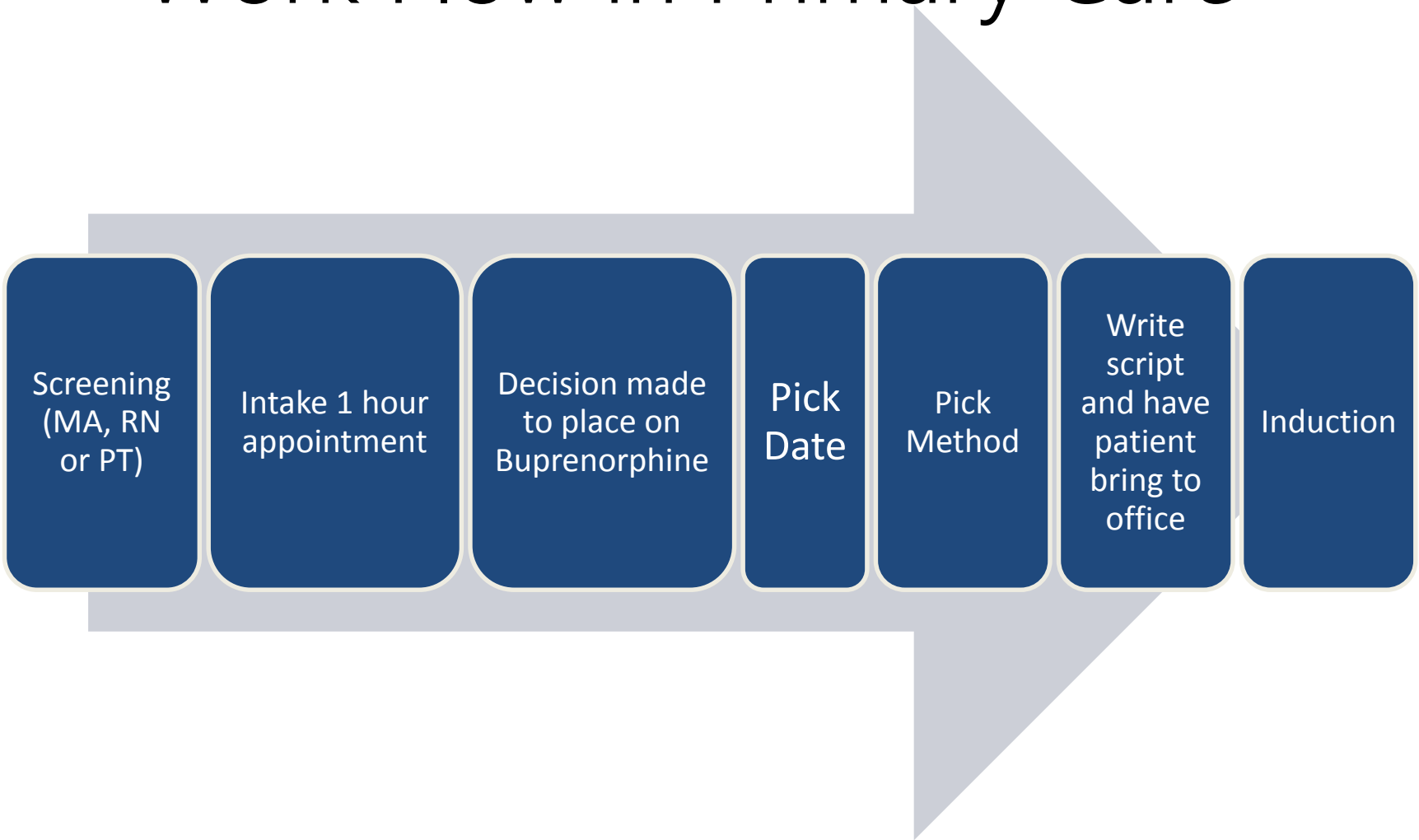
# Work Flow in Primary Care

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# Patient Documentation

## HPI

- Drug use from age of 12 to current
- DSM 5 Criteria met
- DAST Criteria met
- Co-Occuring evaluation
- PE
  - Focused on Mental Status
  - Sequela of drug abuse (injection marks, superficial skin infections, Murmurs)

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# Documentation

## Labs

- Hep C, HIV, STDs, CMP, CBC, UDS

## Diagnosis

- Use DSM 5 Designation

## Plan

- Include medication dose and frequency
- Include BH referral and basic plan (i.e. CBT, DBT, 12 step, Contingency Management)
- Other drug use and plan of action (Benzo, MJ, etc.)

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# Office based Documentation

Keep an active list of all current patients (seen within the last 30 days)

Keep a list of all past patients and why they are no longer patients

Call your regional DEA agent and ask for a preemptive visit and evaluation.

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# Regulatory Requirements

DATA 2000

- Must have X license
- 30 patients year 1
- Can apply for 100 patients year 2

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# FAQ's

- With a DATA 2000 waiver, can I *prescribe* approved buprenorphine products for opioid addiction in more than one practice location? Can I *dispense* approved buprenorphine products from more than one location?
  - Physicians with DATA 2000 waivers may prescribe approved buprenorphine products for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice (e.g., office, hospital). However, they may store and dispense approved buprenorphine products (or any other controlled substances) only at the practice address(es) that they have registered with the DEA. Only one DATA-waiver unique identification number will be issued for each DATA-waived physician, no matter how many practice locations or DEA registrations a physician may have.

# FAQ's

- I've heard this new model for the treatment of opioid addiction referred to as "office-based opioid therapy." Does that mean that physicians with DATA 2000 waivers can use approved buprenorphine products to treat opioid addiction only in the office-based setting?
  - No. Treatment of opioid addiction under the authority of a DATA 2000 waiver is not confined to the office-based setting. Physicians with DATA 2000 waivers may treat opioid addiction with approved buprenorphine products in any practice settings in which they are otherwise credentialed to practice and in which such treatment would be medically appropriate (e.g., office, community hospital, health department).

# FAQ's

- Can physicians and other authorized hospital staff administer buprenorphine to a patient who is addicted to opioids but who is admitted to a hospital for a condition other than opioid addiction?
  - Neither the Controlled Substances Act (as amended by the Drug Addiction Treatment Act of 2000) nor DEA implementing regulations (21 CFR 1306.07(c)) impose any limitations on a physician or other authorized hospital staff to maintain or detoxify a person with an opioid treatment drug like buprenorphine as an incidental adjunct to medical or surgical conditions other than opioid addiction.
  - Thus, a patient with opioid addiction who is admitted to a hospital for a primary medical problem other than opioid addiction, e.g., myocardial infarction, may be administered opioid agonist medications (e.g., methadone, buprenorphine) to prevent opioid withdrawal that would complicate the primary medical problem. A DATA 2000 waiver is not required for practitioners in order to administer or dispense buprenorphine (or methadone) in this circumstance. It is good practice for the admitting physician to consult with the patient's addiction treatment provider, when possible, to obtain treatment history

- May physicians in residency training programs obtain DATA waivers?
  - The DATA legislation does not specify that a physician in a residency training program who otherwise meets the qualifications for a DATA waiver is ineligible to apply for and obtain a waiver. Therefore, SAMHSA has granted DATA waivers to physicians in residency training who have unrestricted licenses and the appropriate DEA registration. Individual States may have laws with more restrictive rules regarding who may prescribe or dispense Schedule III narcotic drugs for detoxification or maintenance treatment.

# FAQ's

- **Are there specific Federal record keeping requirements for office-based opioid therapy?**
  - DEA record keeping requirements for office-based opioid therapy go beyond the Schedule III record keeping requirements. According to DEA: Practitioners must keep records (including an inventory that accounts for amounts received and amounts dispensed) for all controlled substances dispensed, including approved buprenorphine products (21 PART 1304.03[b]). In some cases, patients return to the prescribing physician with their filled approved buprenorphine products prescriptions so that the practitioner can monitor the induction process. While it is acceptable for the patient to return to the practitioner with their filled prescription supplies, practitioners shall not store and dispense controlled substances that are the result of filled patient prescriptions.

# Refrences


- Kranzler, Ciraulo and Zindel, Clinical Manual of Addiction Psychopharmacology (2nd addition) American Psychiatric Publishing. 2014
- The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use. 2015
- The State of Michigan MAT Treatment Guidelines For Opioid Use Disorder, R. Corey Waller. 2014


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# Question 1

- Which of the following is correct?

  A. You can safely start buprenorphine while a patient is still taking a full agonist

  B. The first dose can be up to 24 mg if patient is in withdrawal

  C. Patients must be completely free of other opioids

  D. Patients should be given a 30 day prescription on day 1

  Answer: **B**

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# Closing and Evaluation

# Summary of Day

- Integrated Clinics to treat substance use disorder
- The neuroscience behind SUD
- Screening for SUD
- Behavioral health techniques when working with chronic pain patients/ patients with SUD
- Red flags and warning signs for diversion
- Medication assisted treatment

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Looking Ahead in 2016: Health Plan Activities

- Provision of tele-consult services for complex patients on high-dose opioids
- Education and coordination around addiction screening and treatment
- Partner with CHCF for continued support in developing and sustaining local efforts targeted at reducing improper use of opioids
- Planning process for creating integrated clinics for high utilizers
- Pharmacy academic detailing
- MPS provider level data sharing
- Tapering guide/ toolkit
- Naloxone Pilot

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Looking Ahead in 2016: Prescriber Activities

- Sign up for tele-consult services for complex patients on high-dose opioids
- Make local opioid oversight committees more robust
- Participate in regional coalitions
- Give feedback on draft plan for integrating chronic pain treatment with Medication Assisted Therapy
- Ask your PHC Regional Medical Director to meet with you and/or your clinicians to review their individual PHC opioid data and to review MPS
- Tapering guide/ toolkit
- Distribute Naloxone and educate patients/families on

how to use it.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# MPS Data Sharing Webinars

## MANAGING PAIN SAFELY
## DATA SHARING WEBINARS

PARTNERSHIP HEALTHPLAN of CALIFORNIA

This February, we will be hosting four county-focused webinars highlighting the data collected through our Managing Pain Safely program. The webinar will include a discussion of aggregate county-level data for specific measures and include a real-life example of provider-level data (all provider identifiable information will be omitted). This will be an opportunity for PHC providers to view the data collected, ask questions, and learn how to request additional data.

Visit the MPS webpage to register for one of the following webinars.

### Northern Region

**February 9:** Humboldt and Del Norte Counties

**February 10:** Shasta, Siskiyou, Trinity, Modoc, and Lassen Counties

### Southern Region

**February 11:** Mendocino, Lake, Sonoma, and Marin Counties

**February 22:** Yolo, Napa, and Solano Counties

### Contact Us

- For additional information for Northern Region webinars contact:
  Marya Choudhry at (530) 999-6903 or mchoudhry@partnershiphp.org

- For additional information for Southern Region webinars contact:
  Danielle Niculescu at (707) 420-7617 or DNiculescu@partnershiphp.org

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# Thank You!


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