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GPTN Webinar Series

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Managing Patients On Opioids: An Addiction Medicine Perspective

Christopher Milburn, MD- Psychiatrist & Addiction Specialist
Kerianne Guth, MSW- Administrative Director
Iris Jones, LPC, LCADC- Behavioral Therapist

Christopher Milburn Milburn-Christopher@cooperhealth.edu

Dr. Milburn is a psychiatrist practicing addiction medicine. He completed his undergraduate medical education at Jefferson Medical College and his psychiatry residency at Thomas Jefferson University Hospital. He has always had a strong interest in addiction medicine and addiction treatment and after completing his residency worked as an attending at Jefferson in their methadone maintenance clinic. While at Jefferson, he was also the director of their psychiatric inpatient unit which worked closely with the OB/Gyn department to specialize in the treatment and management of pregnant patients with co-occurring substance use and mental health diagnoses. Following his work at Jefferson, he went to Christiana Medical Center, starting an outpatient buprenorphine/naloxone treatment program, focusing on the treatment of pregnant patients. Following his time at Christiana, he worked at Crozer hospital in their methadone maintenance program, expanding their outpatient Suboxone program, and assisting in the opening of a new inpatient detox and rehab unit. Dr. Milburn is now an attending at Cooper University Hospital where he treats patients with opioid and other addictive disorders, again focusing on the pregnant population.

Kerianne Guth, MSW Guth-Kerianne@cooperhealth.edu

Kerianne received her undergraduate degree in psychology from Illinois State University and her Master of Social Work degree from the University of Pennsylvania's School of Social Policy and Practice. She previously worked as a home visiting social worker in West Philadelphia for a federally funded maternal child health program. She is a founding team member of the Urban Health Institute at Cooper, a dedicated business unit transforming healthcare delivery for vulnerable and underserved patient populations. She served as a senior leader of the UHI for five years and contributed to the strategy, design and growth of UHI's signature programs: group medical visits, nurse led protocols, and complex care management. She's led diverse teams of clinical and administrative staff to achieve quality improvements, resulting in a 58% reduction in the business unit's deficit allowing the UHI innovation work to sustainably function without grant funding. Kerianne led the start-up of the Addiction Medicine program that includes hospital protocols, medication treatment for substance use disorders, behavioral health support, and health coaching.

Iris Jones, LPC, LCADC Jones-Iris@cooperhealth.edu

Iris earned her undergraduate degree in Psychology and Sociology from Albany State University and her graduate degree in Clinical Counseling from Eastern University. Her clinical internship was completed at Crozer-Chester Medical Center specializing in the treatment of addiction, trauma and co-occurring mental health disorders. She previously worked with complex populations in non-profit outpatient behavioral health as a co-occurring addictions counselor. Iris focused her energies on promoting the welfare of patients with substance use disorders involved with the New Jersey legal system, directing multiple outpatient sites to improve overall access and care for clinically complex patients.

In 2016 she began working in Cooper's Addiction Medicine department as a Behavioral Health Therapist, where she has worked to develop the perinatal addiction clinic, individual and group therapy, as well as hospital consults and protocols. Her credentials include Licensed Professional Counselor (LPC), a Licensed Clinical Alcohol and Drug Counselor (LCADC), and a Nationally Certified Counselor (NCC).

Agenda

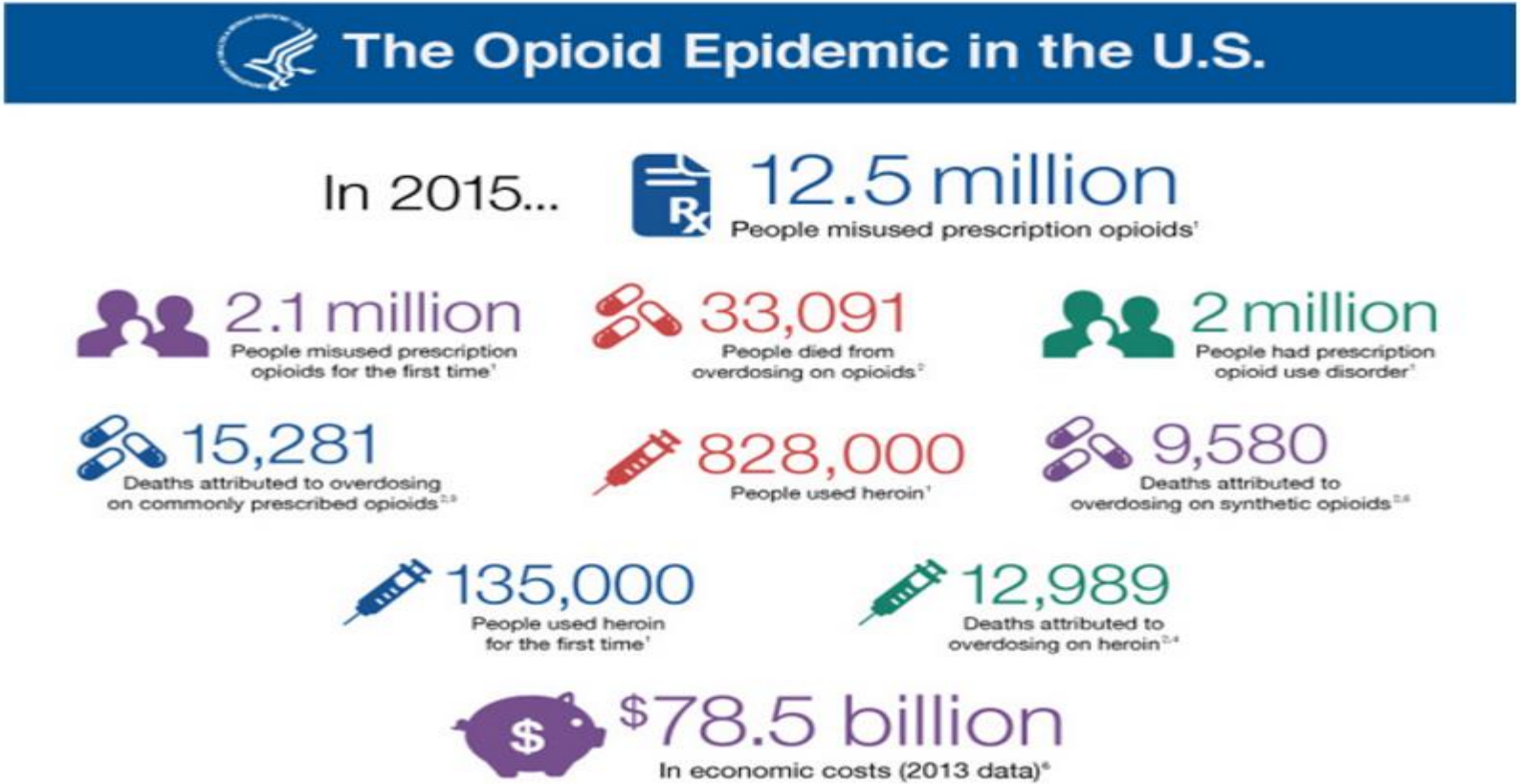
- **Introductions & Goals**
- **Opioid Use in the US**
  - **The Opioid Epidemic**
  - **Defining & Understanding Addiction**
  - **Responsible Prescribing**
- **Language, Stigma & Myths**
- **SBIRT**
  - Screening: Risk Factors and Early Signs
  - Brief Intervention
  - Referral to Treatment

Goals for Today's Presentation

- Recognize patient risk factors for developing a substance use disorder
- Identify tools for practice management that support evidence based care for those at risk of or already diagnosed with a use disorder.
- Locate resources in the community to support patients dealing with addiction

- Established in 2015
- Multidisciplinary approach to treating and understanding addiction
- Medical treatment, behavioral health support, education, training and culture change

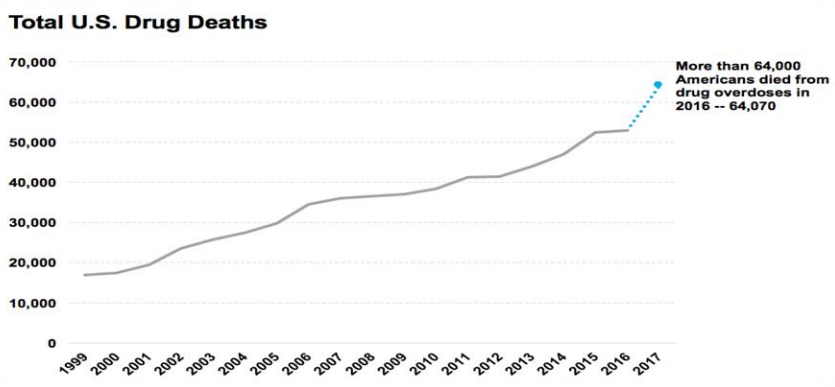
OPIOID USE IN THE US

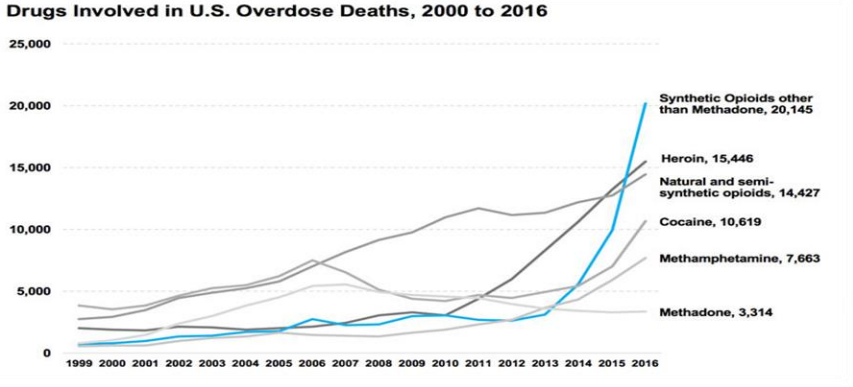

The Opioid Epidemic in the U.S.
In 2015...
12.5 million
People misused prescription opioids[1]
2.1 million
People misused prescription opioids for the first time[1]
33,091
People died from overdosing on opioids[2]
2 million
People had prescription opioid use disorder[1]
15,281
Deaths attributed to overdosing on commonly prescribed opioids[2,3]
828,000
People used heroin[1]
9,580
Deaths attributed to overdosing on synthetic opioids[2,4]
135,000
People used heroin for the first time[1]
12,989
Deaths attributed to overdosing on heroin[2,4]
$78.5 billion
In economic costs (2013 data)[5]

21.5 million Americans

2.5 million Americans

64076


Total U.S. Drug Deaths
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017
More than 64,000 Americans died from drug overdoses in 2016 -- 64,070


Drugs Involved in U.S. Overdose Deaths, 2000 to 2016
25,000
20,000
15,000
10,000
5,000
0
1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Synthetic Opioids other than Methadone, 20,145
Heroin, 15,446
Natural and semi-synthetic opioids, 14,427
Cocaine, 10,619
Methamphetamine, 7,663
Methadone, 3,314

4 out of 5

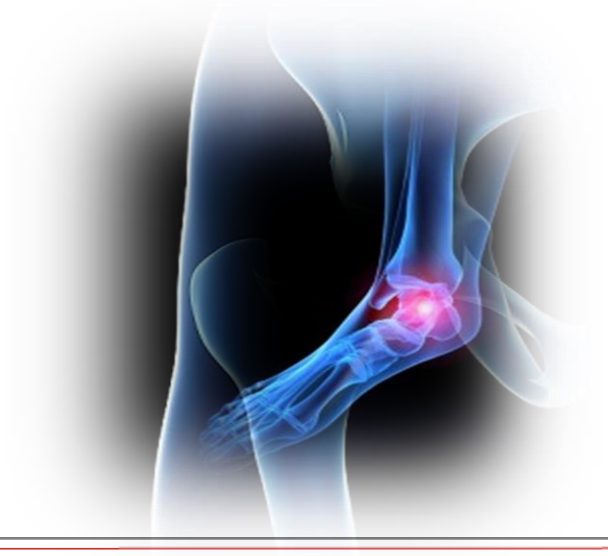
80 percent

5th vital sign

Lindenhovious

USA	Netherlands
77%	0%
85%	58%

Lindenhovious



USA	Netherlands
82%	6%
98%	64%

79.5 million


Rx Pharmacy
Rx:
TAKE 1-2 TABLETS BY MI
EVERY 4-6 HOURS AS
FOR PAIN
HYDROCODONE/AP
QTY:30
No Refills. Dr. Auth Required
Date Filled: 12-01-2016

Short Term


Rx Pharmacy
Rx:
TAKE 1-2 TABLETS BY MO
EVERY 4-6 HOURS AS N
FOR PAIN
HYDROCODONE/AP
QTY:30
No Refills. Dr. Auth Required
Date Filled: 12-01-2016

Primary Care

Risk factors for chronic use

- History of substance use disorder
- Family history
- Nicotine use
- Age < 45
- Psychiatric disorders
- Over-prescribing

Risk factors for chronic use

- History of substance abuse
- Family history
- Nicotine use
- Age < 45
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PMP

Expectations

Protocols

Consult

NSAIDs


Advil
CAPLETS
Adv
Relieves Headaches, Fever, Muscle and Joint Pain
ALEVE
New
TARGETS TOUGH PAIN FAST
Motrin
PLATINUM
ALEVE
comprimés de naproxène sodique
SOULAGEMENT JUSQU'À 12 HEURES

Acetaminophen

Gabapentenoids

Tricyclic Antidepressants

Managing Chronic Use

- Careful patient selection
- SOAPP
- Opioid Risk Tool
- Avoid benzodiazepines

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Managing Chronic Use

- Evidence limited for:
  - Low Back Pain
  - Headache
  - Fibromyalgia
- Function vs pain score
- Reassess every 3 months
- ≤ 90 morphine milligram equivalents

Developing concerning behavior

- Early refill requests
- Lost or stolen prescriptions
- Treatment non adherence
- Aggressive or threatening behaviour

LANGUAGE, STIGMA & MYTHS

ASAM Defining Addiction

American Society of Addiction Medicine Public Policy Statement on Addiction:

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Dependence vs Addiction

- Opioid Dependence: **physical dependence to opioids** where the body relies on a external source of opioids to prevent withdrawal. Physical dependence is predictable, easily managed with medication, and is ultimately resolved with a slow taper off of the opioid.

- Opioid Use Disorder: Problematic opioid use resulting in clinically significant impairment and characterized by tolerance, uncontrollable cravings, compulsive opioid use and **continued use despite hazards to self or others**.

Opioid dependence can occur *without* addiction.

Words to Avoid	Alternatives
Addict, abuser, junkie →	Person with active addiction, substance use disorder, substance exposed (newborns/infants)
Abuse →	Misuse, harmful use, hazardous use, active use
Clean & dirty →	Negative, Positive, & Substance Free
Drug habit or habit →	Alcohol /drug disease, misuse disorder
Replacement or substitution therapy →	Medication assisted treatment or medication treatment

"Words are important. If you want to care for something, you call it a 'flower'; if you want to kill something, you call it a 'weed'." ***~ Don Coyhis***

MYTH: Only addiction specialists can care for OUD

FALSE

- Addiction medicine should be part of all training, empathy is not a specialty
- Armed with empathy and an understanding of available resources, any physician can participate in the care of individuals with an opioid use disorder.

MYTH: These patients will overrun my family practice

FALSE

- These patients are already being seen in your practice.
- As a result of stigma, many patients in recovery do not disclose that they are in recovery or participating in MAT treatment.

MYTH: Substance misuse and addiction are actually the same thing

FALSE

- Fact: Though the terms “misuse”, “abuse” and “addiction” are often considered synonymous, they’re not the same.
- Substance misuse/abuse generally refers to the use of drugs or alcohol in unhealthy or even dangerous ways. Substance use disorder (SUD) is the diagnosis given to people who continually struggle with substance use, or who have **developed a dependence** on the substance. An individual who has a drug addiction has developed a physical, chemical and/or a psychological dependence on drugs or alcohol.
- People who engage in substance abuse without an active addiction are more likely to still experience the novel euphoric or depressive effects of the substance. Once addiction sets in, the individual develops a tolerance to the drug and will require more and more of the substance to achieve that original high, if it can be recreated at all.

Identifying Substance Use Disorders

- Screening
- Brief intervention
- Referral to treatment

- NIDA quick screen

Quick Screen Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- Universal Screening with Universal Reporting
  - Biological – Blood, urine, & hair
  - Questionnaires – CAGE-AID, NIDA Quick Screen, The Drug Abuse Screening Test (DAST) CRAFFT, SURP-P.
- Avoid targeted screening and reporting
- Consent for screening prior to testing.
- Should be good for mother & baby.

Evidence Based Care - Intervention

- Medication Assisted Treatment (MAT)
  - Methadone & Buprenorphine
  - MAT rather than controlled withdrawal because withdrawal has highest rates of relapse
  - MAT does not prevent NAS
  - Reduces harmful behaviors
- Comprehensive Care Including –
  - Evaluation and management of co-occurring psychiatric disorders, infectious diseases & social stressors.
  - Counseling regarding the importance of breastfeeding, contraception and neonatal abstinence syndrome.

Clin Obstet Gynecol. 2015 Jun; 58(2): 370–379.

- Full μ-opioid agonist

Buprenorphine/Naloxone

AKA suboxone

μ-opioid partial agonist

Buprenorphine only

- μ-opioid antagonist
- Oral naltrexone
- Vivitrol

Not satisfied with your options?

- Complete DEA X-Waiver training and prescribe Suboxone in your practice
- Call your local representatives and demand better treatment options for your community
- Explore partnerships with treatment centers

- Evidence Based Treatment

Evidence Based Care - Treatment

- Behavioral Therapy
- Cognitive-Behavioral Therapy (CBT)
- Contingency Management
- Rational Emotive Behavior Therapy (REBT)
- Motivational Interviewing
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Dialectical Behavior Therapy (DBT)
- Community Reinforcement and Family Training (CRAFT)
- Multidimensional Family Therapy
- Integrative Approach
- Person-Centered Therapy
- Matrix Model

Referrals to Treatment: Create a guide

- Known behavioral health care providers/systems
- Academic Medical Centers
- Methadone/ Buprenorphine “OTP” providers in your area
- Keep your guide current and up to date
- Keep it out in the open

Referrals to Treatment: Key Questions to Ask

- What insurance do you accept?
- Do you offer MAT (Methadone, Buprenorphine, Vivitrol)
- How long is the wait for a new patient appt?
- Do you provide any non-medical services? (ex. transportation, meals, child care)

- Questions?

Links to Resources

- NJ Division of Mental Health and Addiction Services (DMHAS) Addiction Services Treatment Directory https://njsams.rutgers.edu/dastxdirectory/txdirmain.htm
- The Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Facility Locator https://findtreatment.samhsa.gov/ SAMHSA's National Helpline – 1-800-662-HELP (4357)
- New Jersey Department of Health IME Addictions Access Center: 1-844-276-2777
- Reach NJ - New Jersey's Addiction Helpline is powered by NJ 2-1-1 (provides other community resources as well.

Additional Readings

- **A Primary Care Approach to Substance Misuse** BRAD SHAPIRO, MD; DIANA COFFA, MD; and ELINORE F. McCANCE-KATZ, MD, PhD*University of California, San Francisco, School of Medicine, San Francisco, California* https://www.aafp.org/afp/2013/0715/p113.pdf

- **Listing of current screening tools and their evidence:** https://www.opioidrisk.com/book/export/html/613

Join Us For Our Next Webinar

"The New Jersey Prescription Monitoring Program (NJPMP)"
Jeffrey D. Laszczyk, Jr., Administrator
Tuesday, July 10, 2018
12:00pm - 1:00pm EST

Objectives
Navigate the New Jersey Prescription Monitoring Program (NJPMP)
Identify patients with patterns of prescription drug abuse, misuse or diversion
Utilize NJPMP data to compliment treatment decisions.

Register at: www.njhcqi.org/PMP

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http://www.njhcqi.org/