



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

LOGISTICS

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



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>



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!!!**

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.

LET'S GET STARTED

Let's get started . . .



LET'S GET STARTED

ENJOY THE
FORUM!



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



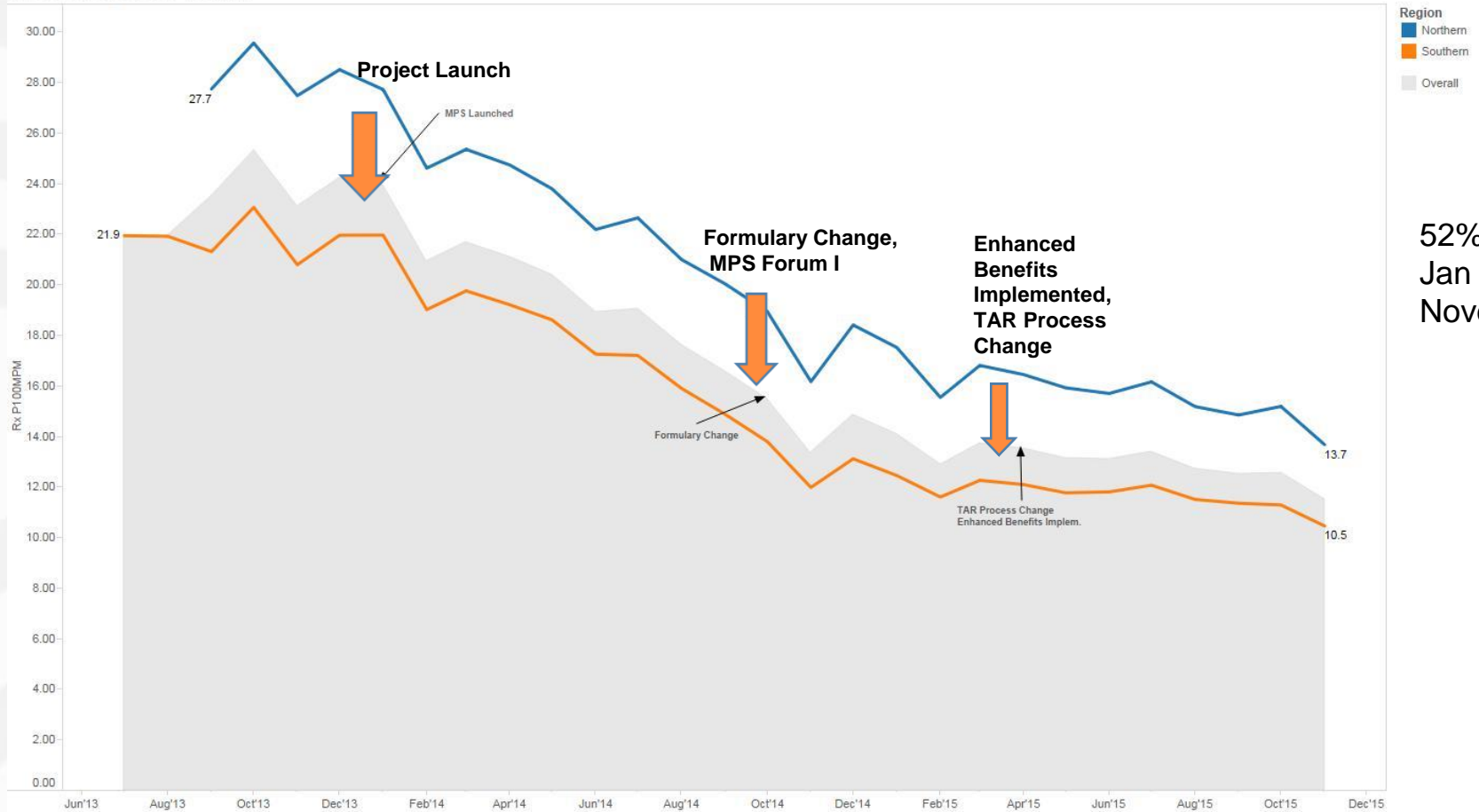


Accomplishments:

Review of PHC Opioid
Prescription Data

MPS Data – Total Prescriptions

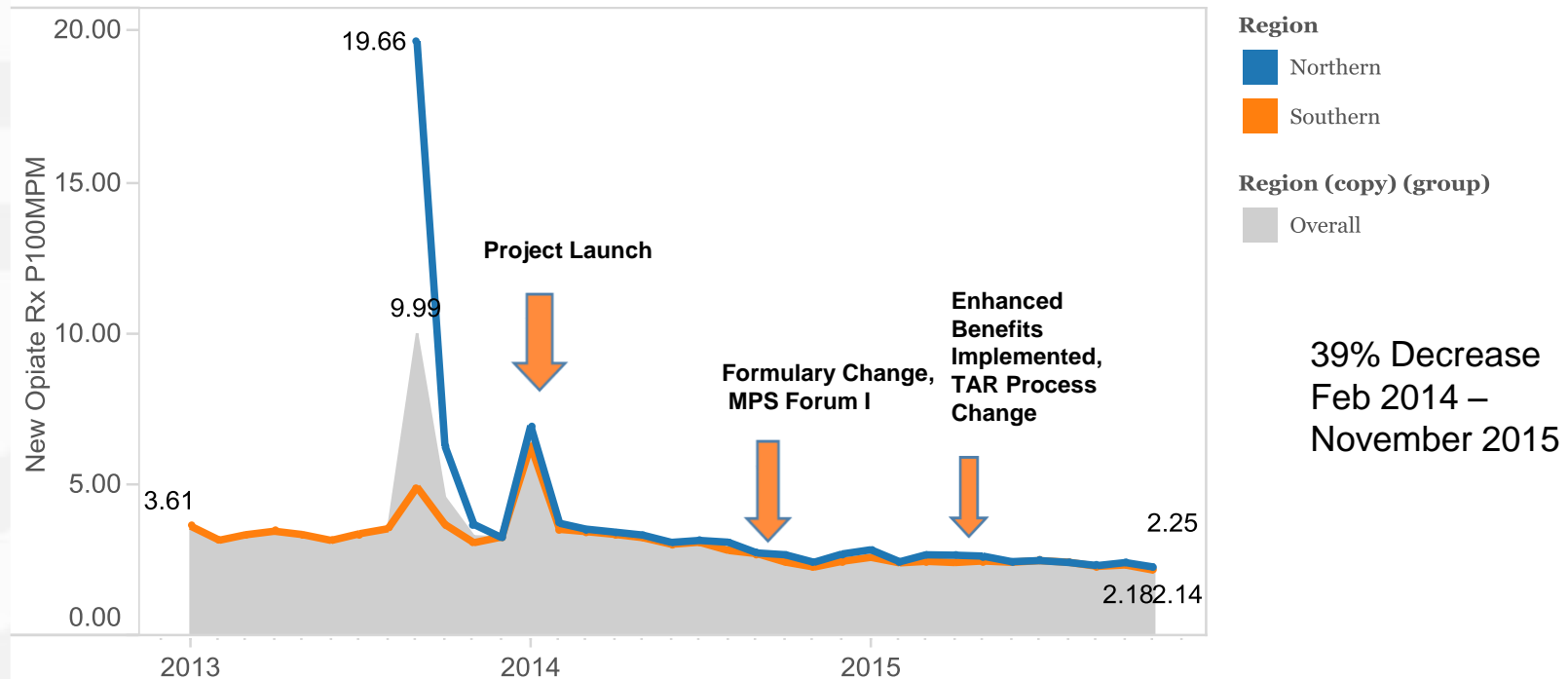
Opioid Prescriptions P100MPM



52% Decrease
Jan 2014 –
November 2015

MPS Data – Initial Prescriptions

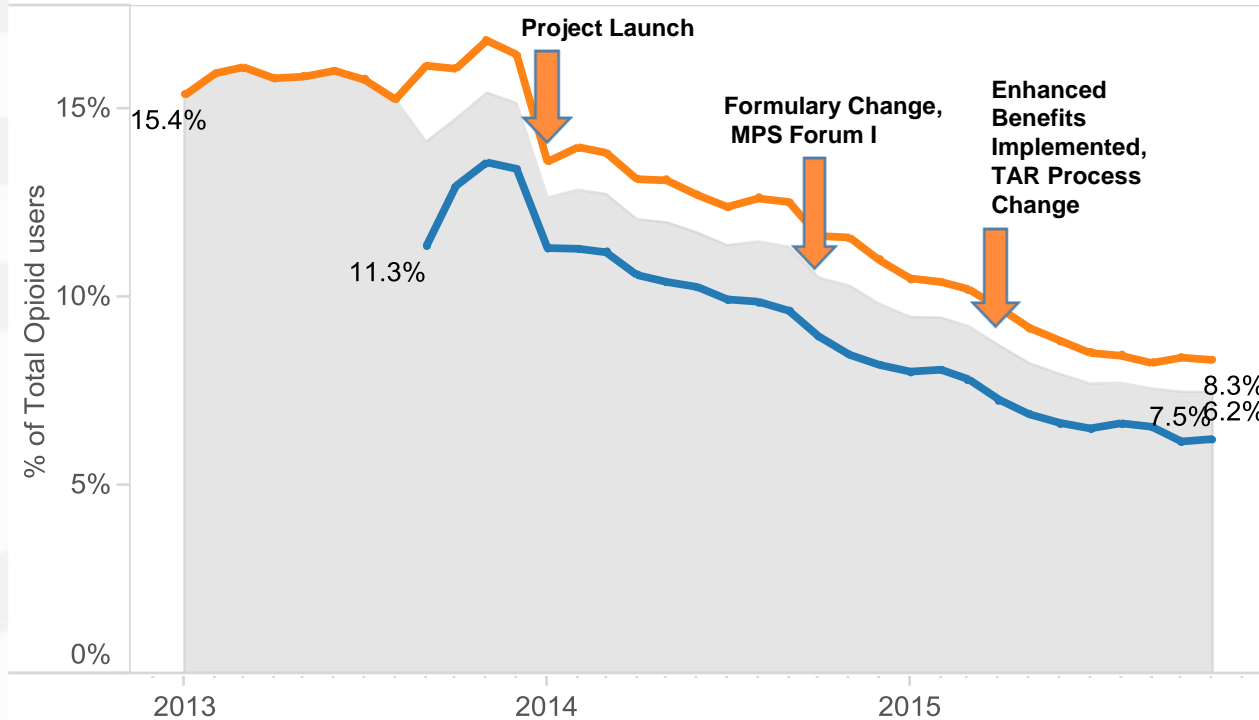
Initial Opiate Fills P100MPM



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

MPS Data – Unsafe Dose

% Opioid Users on Unsafe Dose (>120 MED)



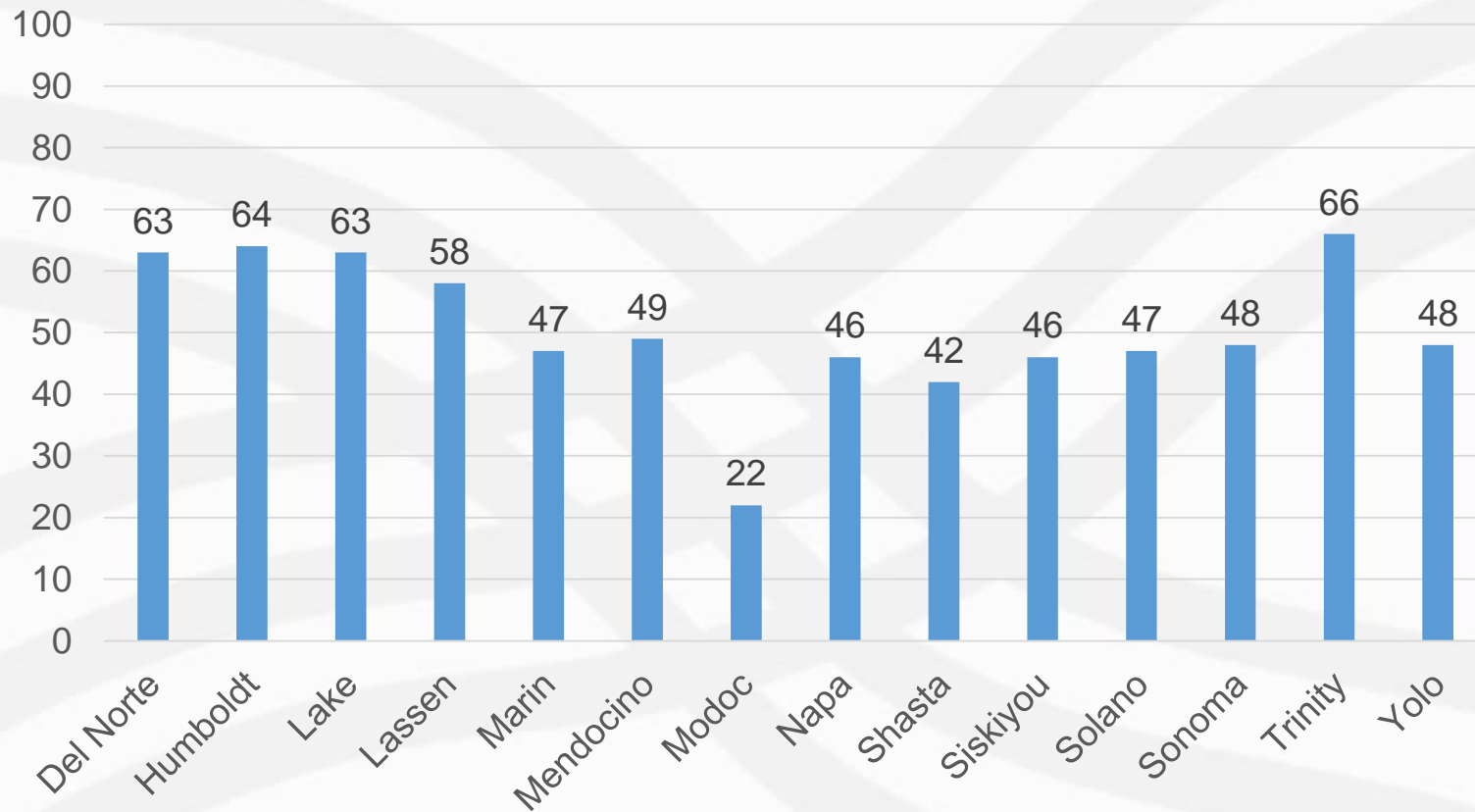
■ Northern
■ Southern
Region (copy) (group)
 Overall

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.

Percent Decrease of Unsafe Dose

% Decrease Unsafe Dose
December 2013-November 2015





Accomplishments:

Health Plan Activities

MPS Workgroups

MPS Technical Support

Data Management

Pharmacy

Provider Network

Care Coordination/Utilization Management/ Member Services

Legislative Policy/Regulation/Communication

Community Support

MPS Steering Committee

Interventions

Education

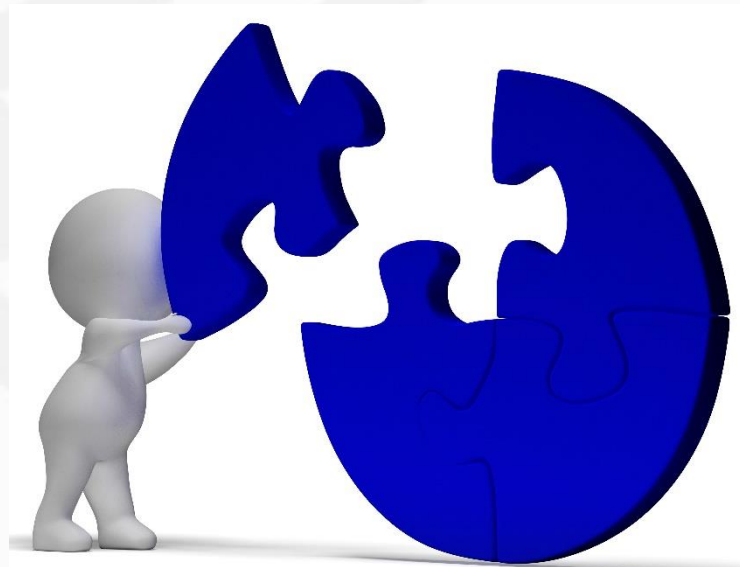
Health plan pharmacy prior authorization changes

Additional options for treating pain

Community activation

Aligned incentives

Additional resources

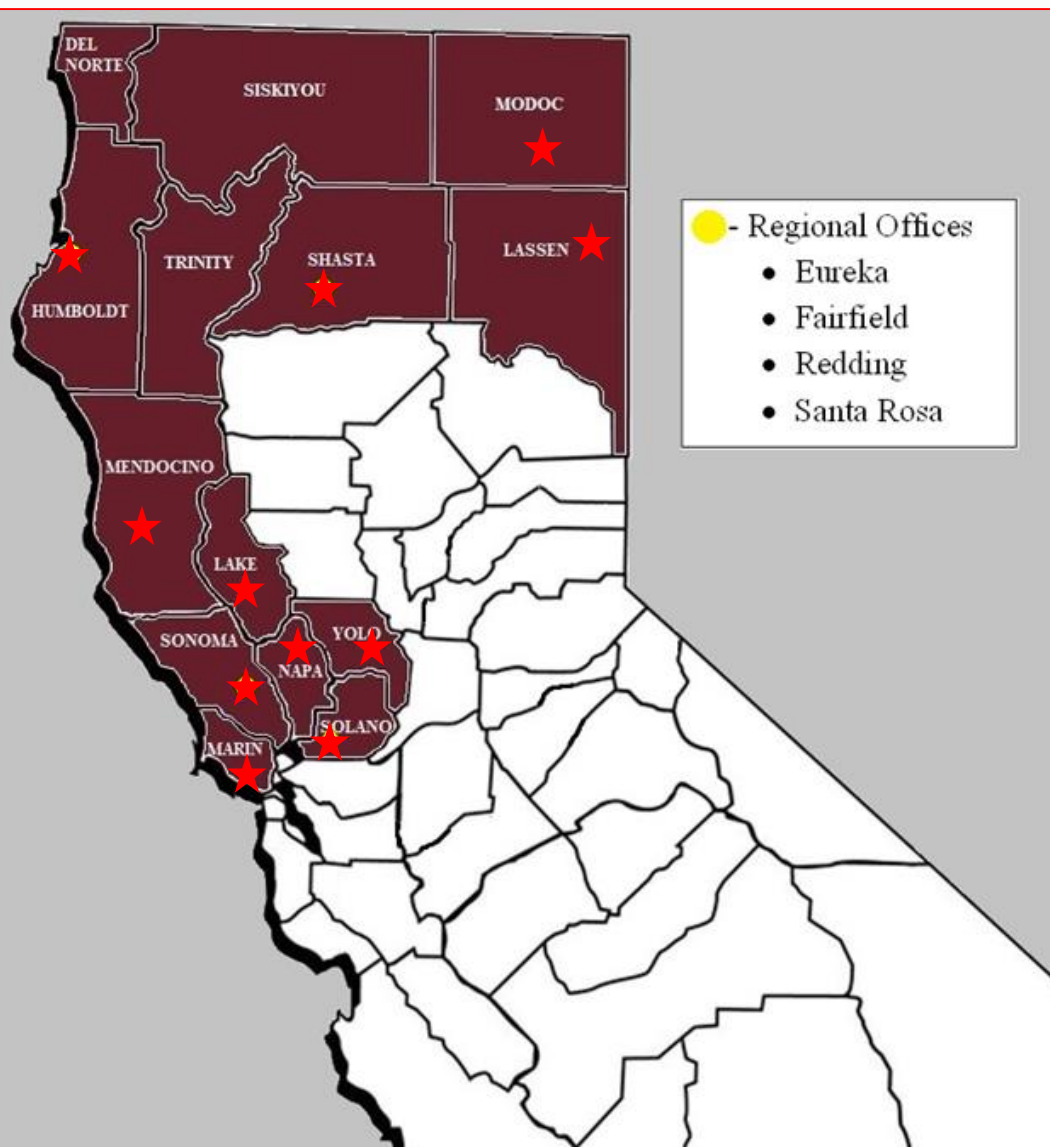




Accomplishments:

Community Coalitions

PHC Counties Participating in CHCF Regional Opioid Safety Coalition Grant Program

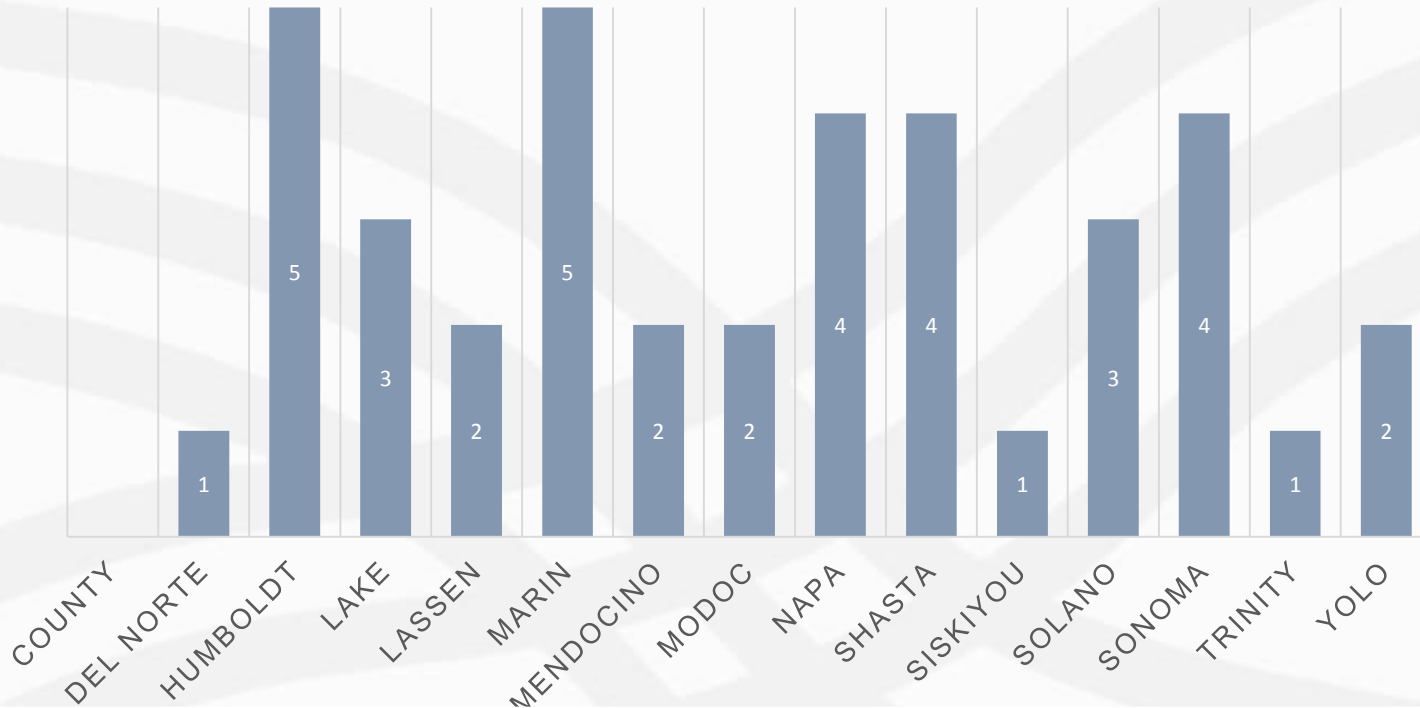


10 PHC Counties are participating in CHCF's Regional Opioid Safety Coalition Grant Program

★ CHCF Opioid Safety Coalition County

Community Coalition Status

PHC COUNTY 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 |



Accomplishments:

Primary Care Providers

Interventions

Opioid Oversight Committees

Setting up Health Center-wide policies

Tapering

Integrated Behavioral Health

Talking to patients, one by one.



PARTNERSHIP



HEALTHPLAN
of CALIFORNIA



Progress Towards Goal

Managing Pain Safely – Aim Statement

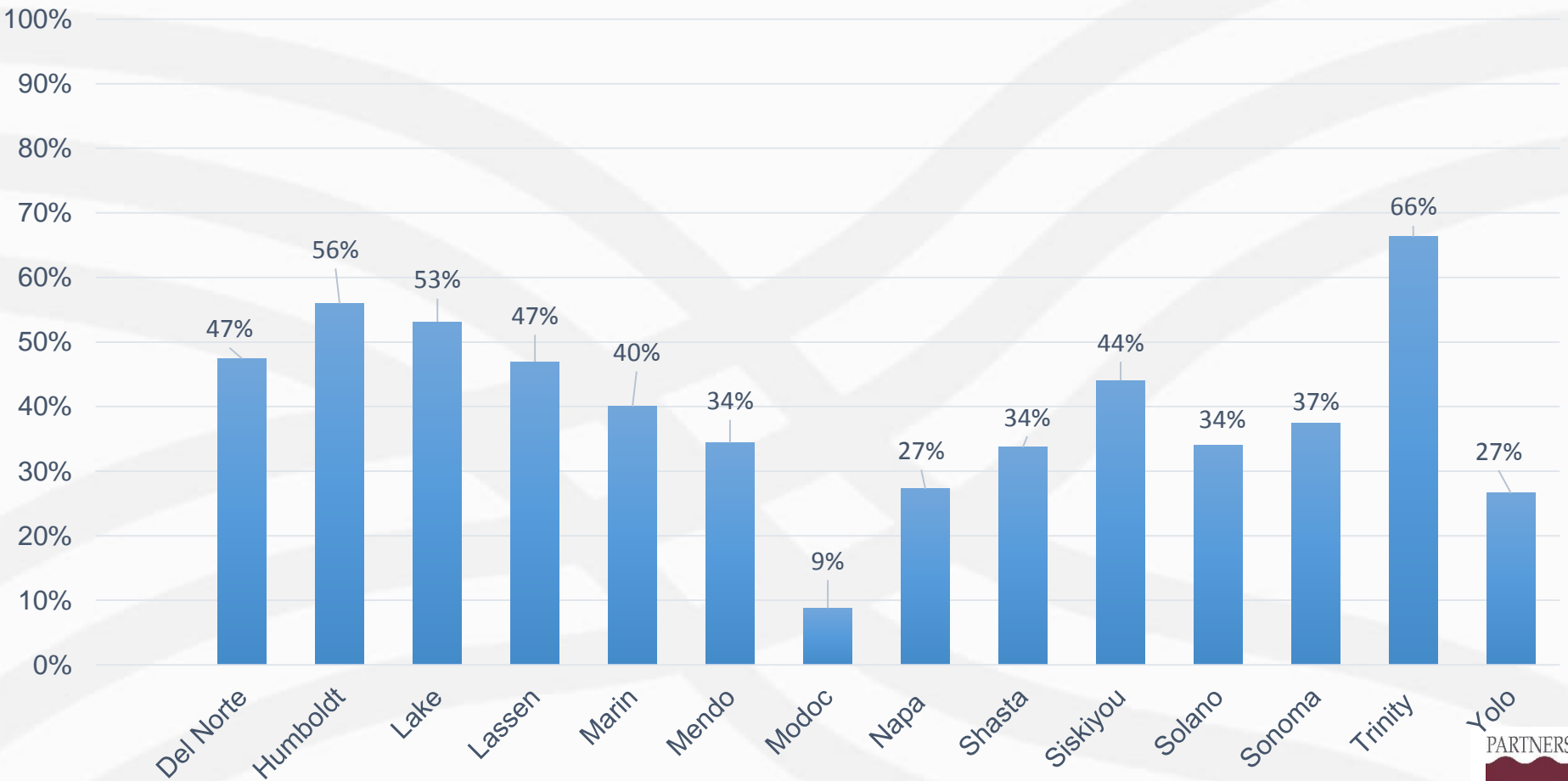
By December 31, 2016, we will improve the health of PHC members by ensuring that prescribed opioids are for appropriate indications, at safe doses, and in conjunction with other treatment modalities as measured by a:

- 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%

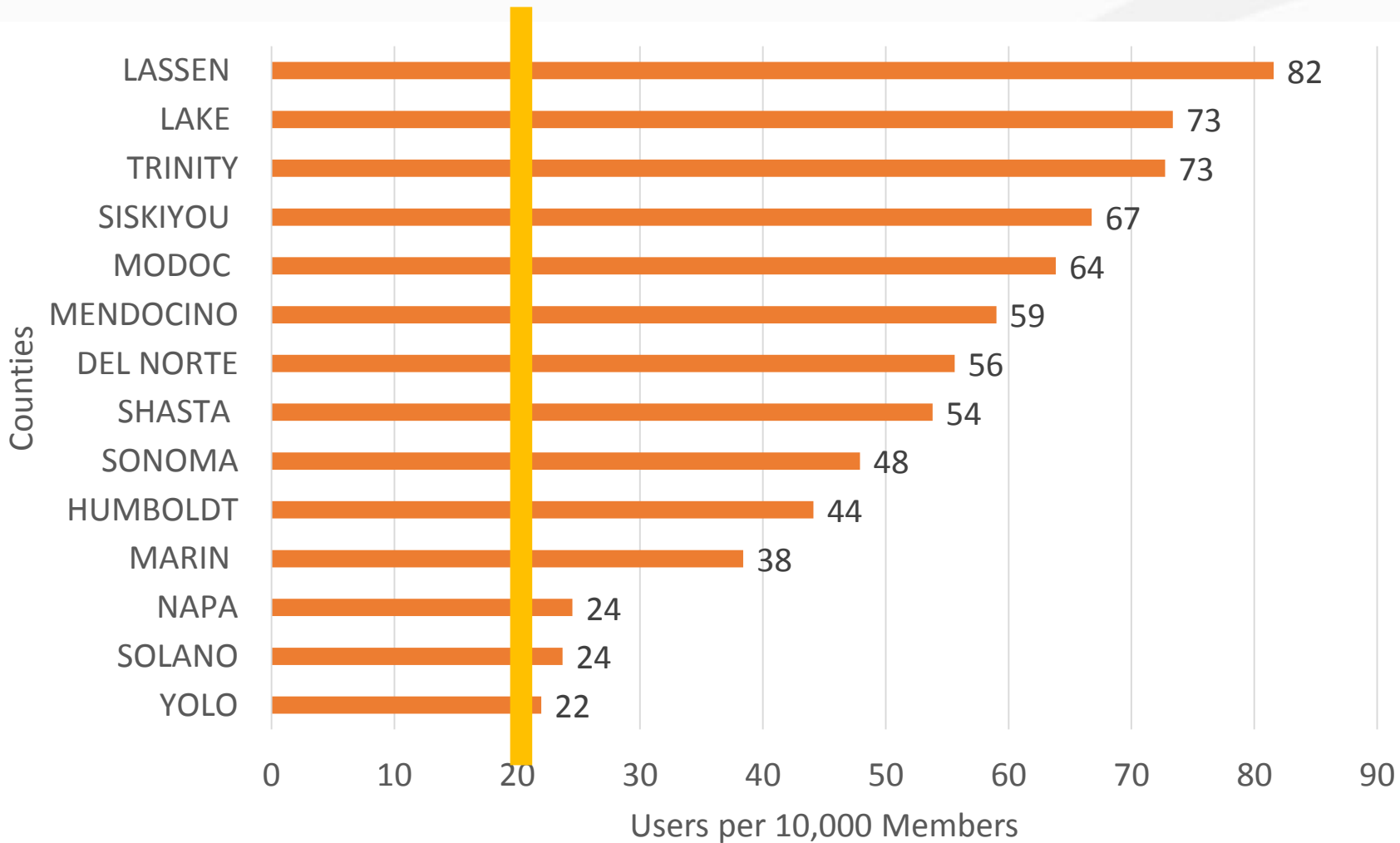
*Defined as greater than 120 mg. MED

Percent Decrease of Unsafe Dose

% Decrease Unsafe Dose January 2014-October 2015



Rate of High Opioid Users: End of 2015





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



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.

Thank You!!!

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





Cory Waller, Medical Director Center for
Integrated Medicine

Spectrum Health Medical Group



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 ...

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.

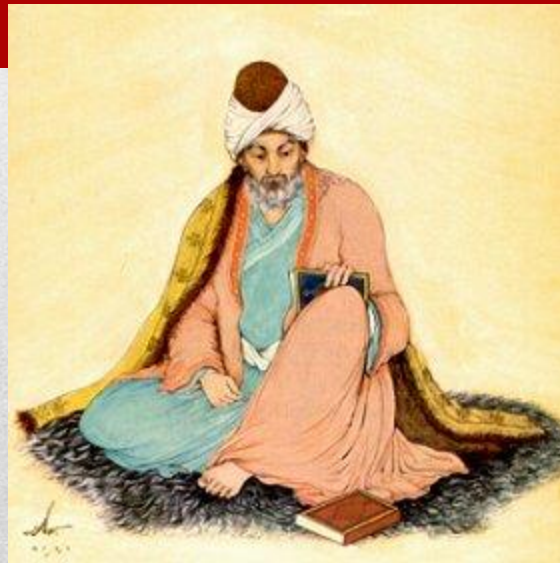
Reverse

Summarizing

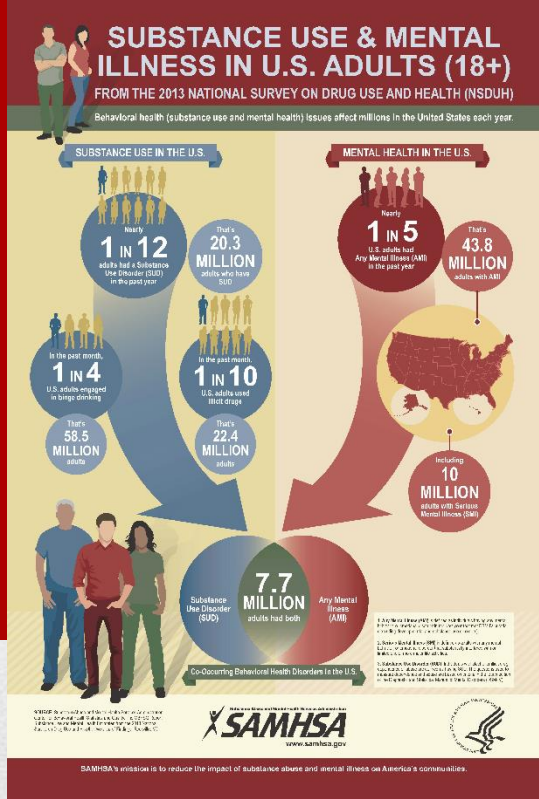
Empathy Exercise



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

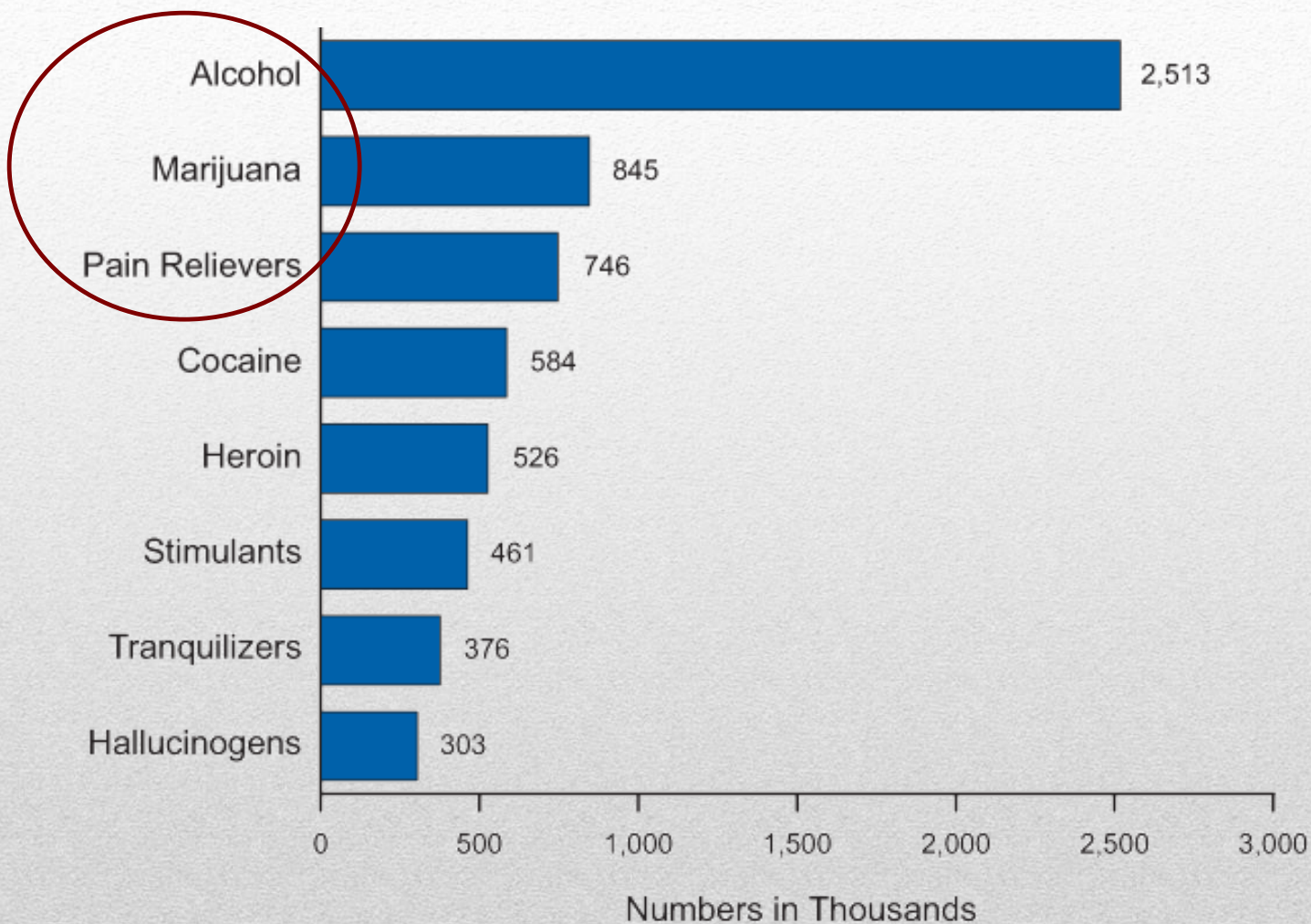


Rumi

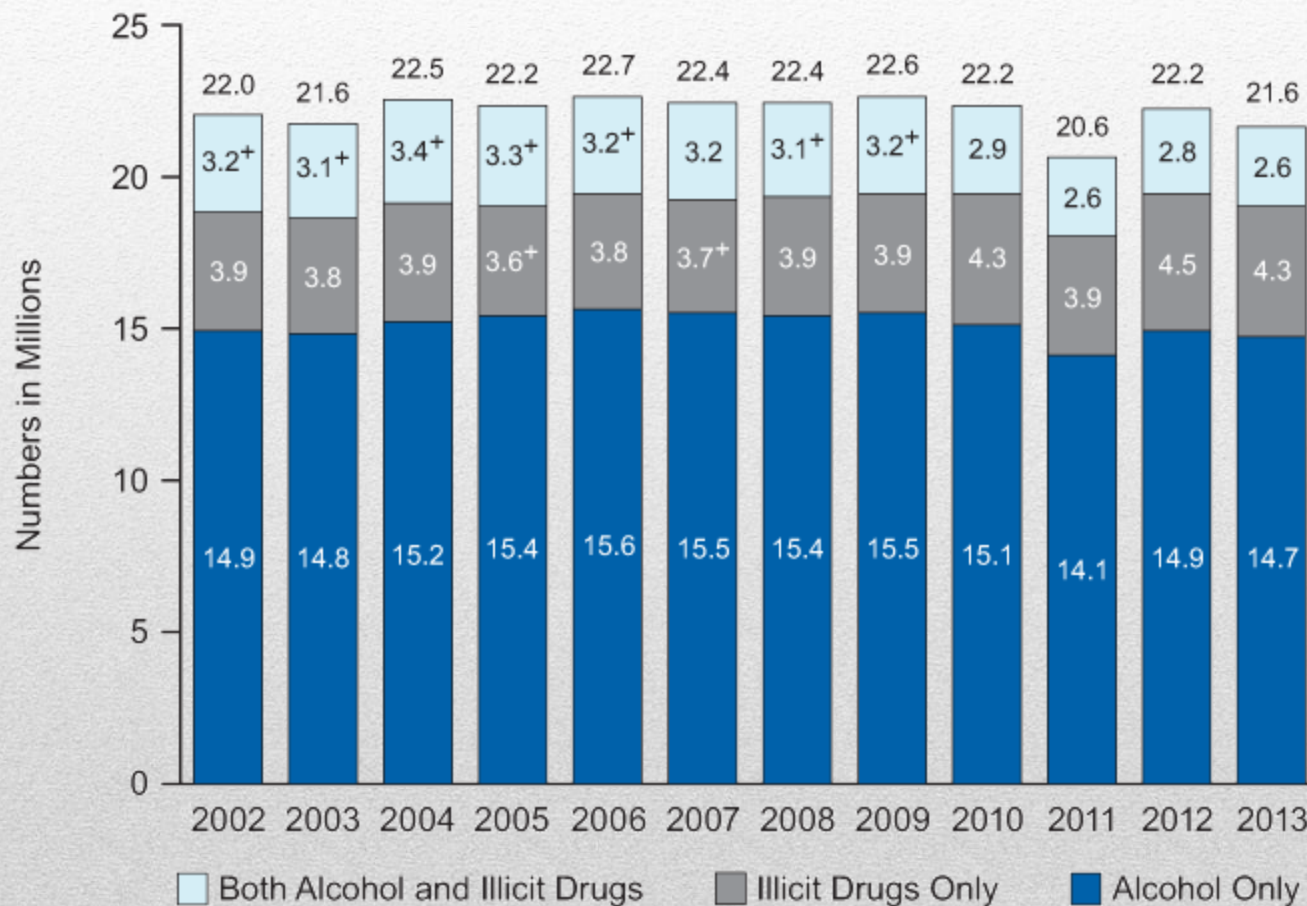


EPIDEMIOLOGY

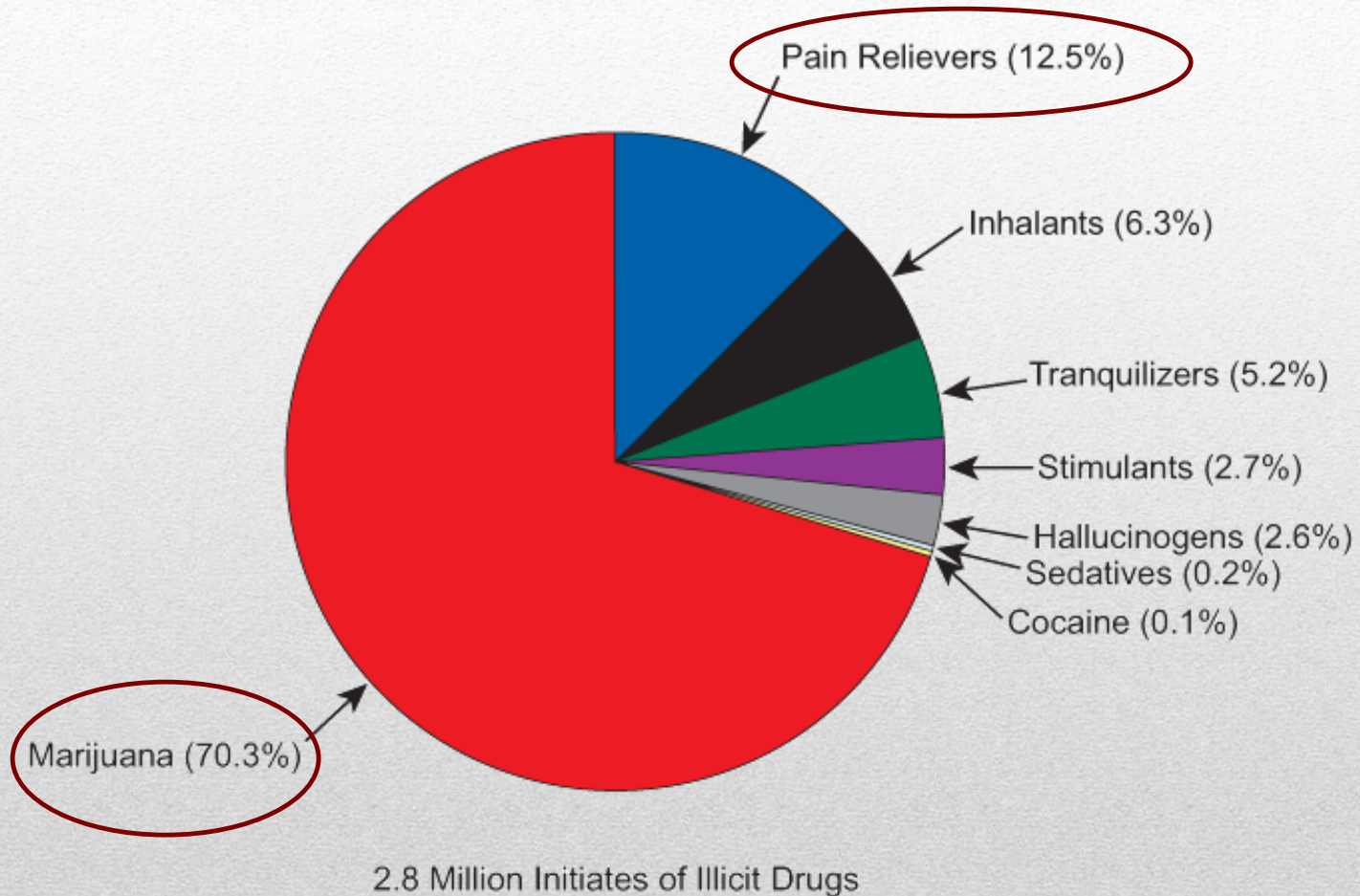
Substances for Which Most Recent Treatment Was Received in the Past Year among Persons Aged 12 or Older: 2013



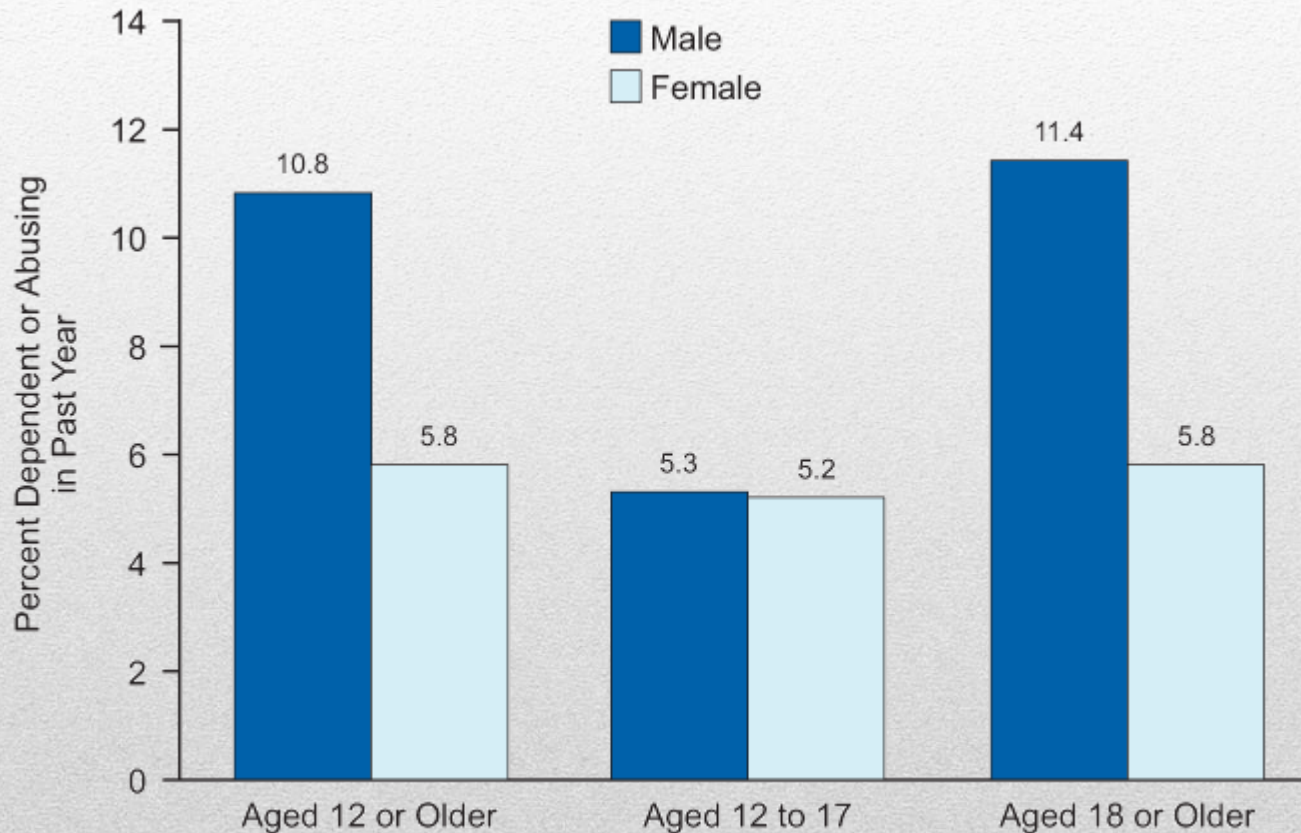
Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2013



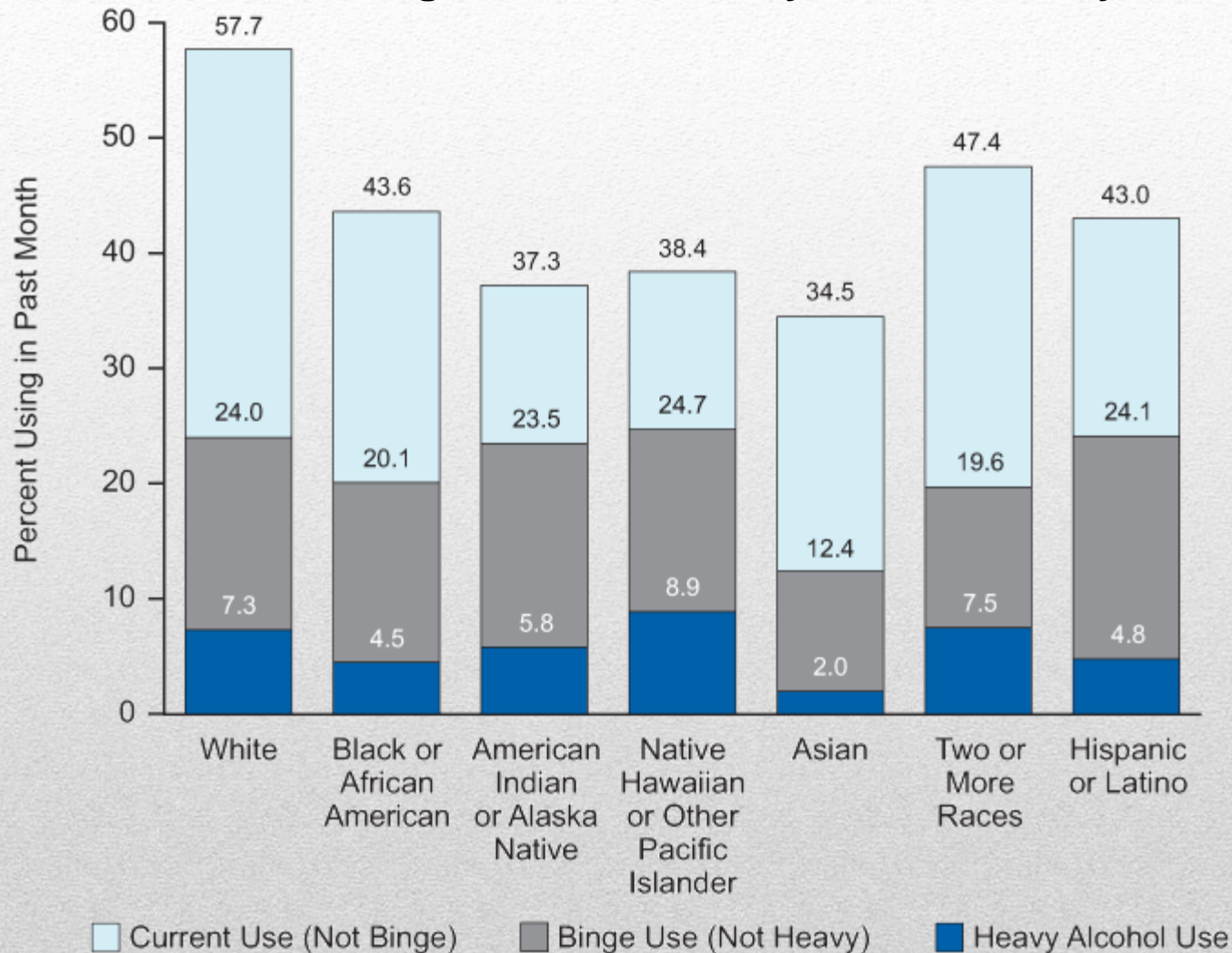
First Specific Drug Associated with Initiation of Illicit Drug Use among Past Year Illicit Drug Initiates Aged 12 or Older: 2013



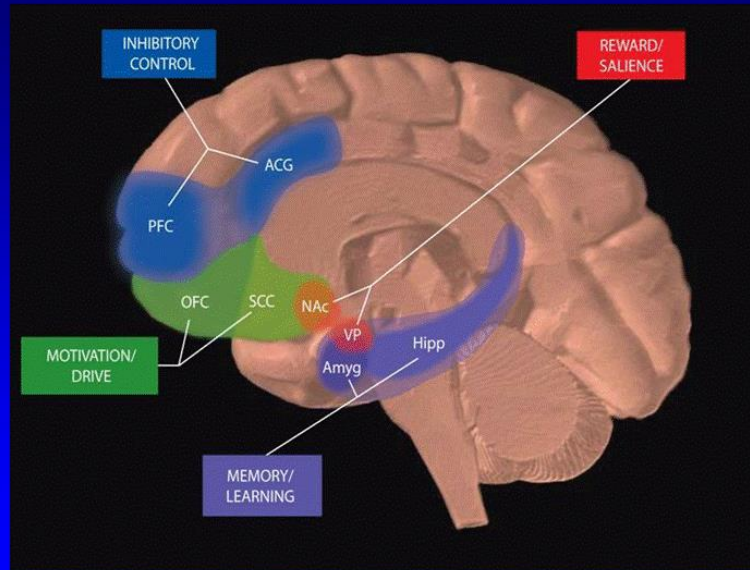
Substance Dependence or Abuse in the Past Year, by Age and Gender: 2013



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



Circuits Involved In Drug Abuse and Addiction



All of these brain regions must be considered in developing strategies to effectively treat addiction

NIDA

THE BRAIN & ADDICTION

SUDs as a Chronic Brain-Based Disease



Epigenetics & SUDs



Adverse Childhood Events (ACE)

CDC & Kaiser San Diego Study

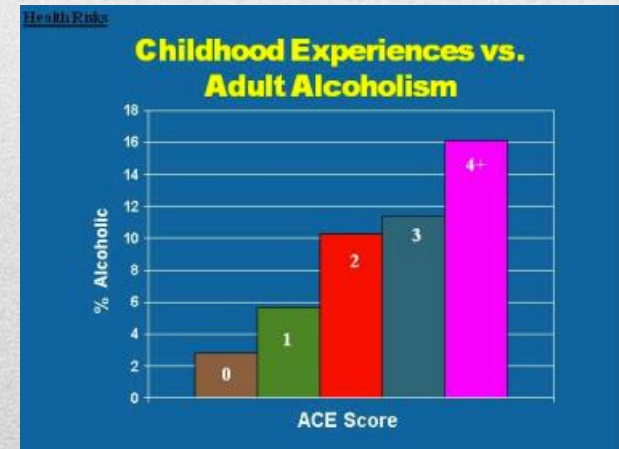
<http://www.cdc.gov/violenceprevention/acestudy/>

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?”

Drug and stress innate immune gene induction
creates the neurobiology of addiction

Disrupts frontal cortical
behavioral control
mechanisms.

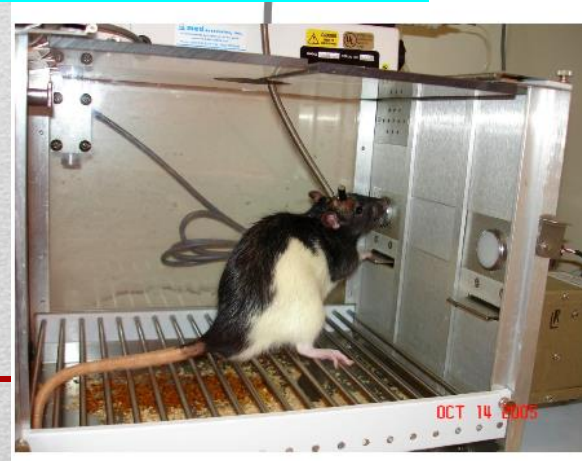
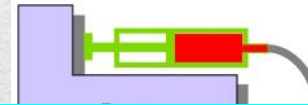
Increases limbic
negative affect,
craving and anxiety.

Frontal Cortex
Goal setting
Motivation
Planning
Impulse Inhibition

Amygdala
Hippocampus
Anxiety, Urgency
Negative Affect
Craving
Impulsiveness

Adapted from Crews and Boettger

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



SEX DRUGS & ROCK 'N ROLL

Dopamine

Sex, food, drugs, social connections
VTA (mesolimbic)

Pleasure, reward, socializing

Addiction *

Psychosis *

Pain processing
PNS & CNS pain system

Chronic pain *

Movement
Substantia Niagra

Parkinson's disease

Executive Function
PFC

ADHD *

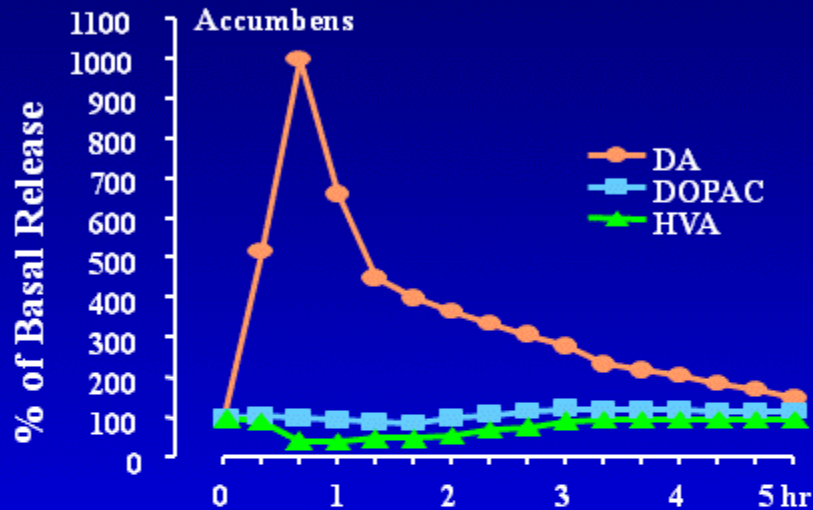
Inhibits PRL
hypothalamus

Stop lactating

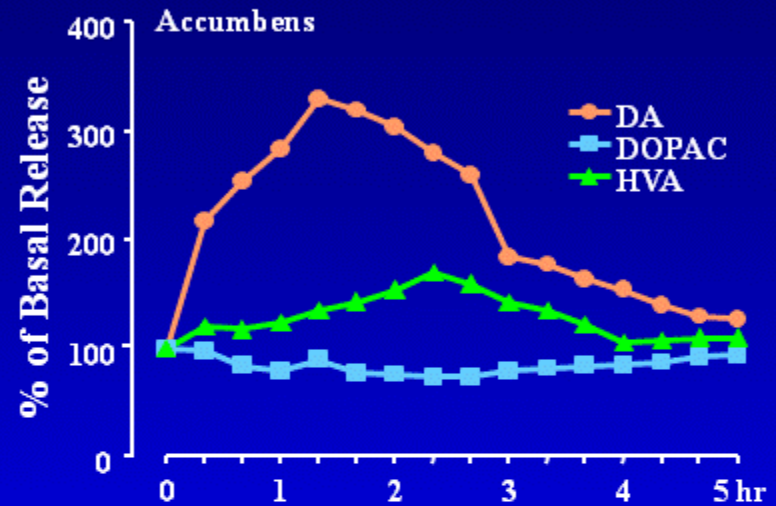


Effects of Drugs on Dopamine Release

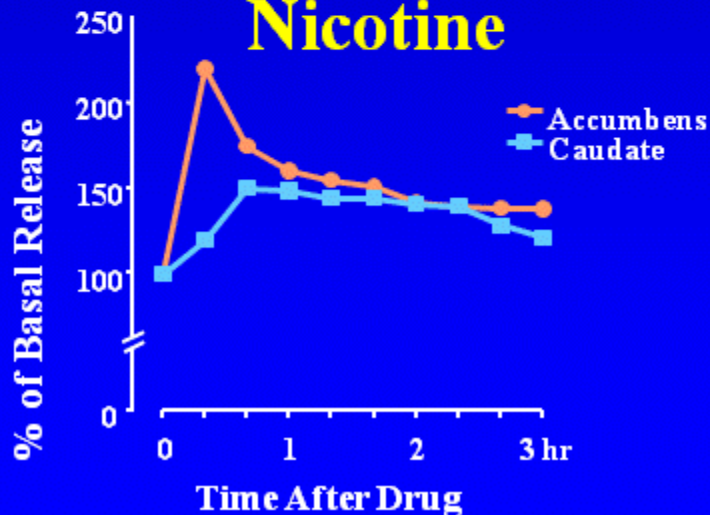
Amphetamine



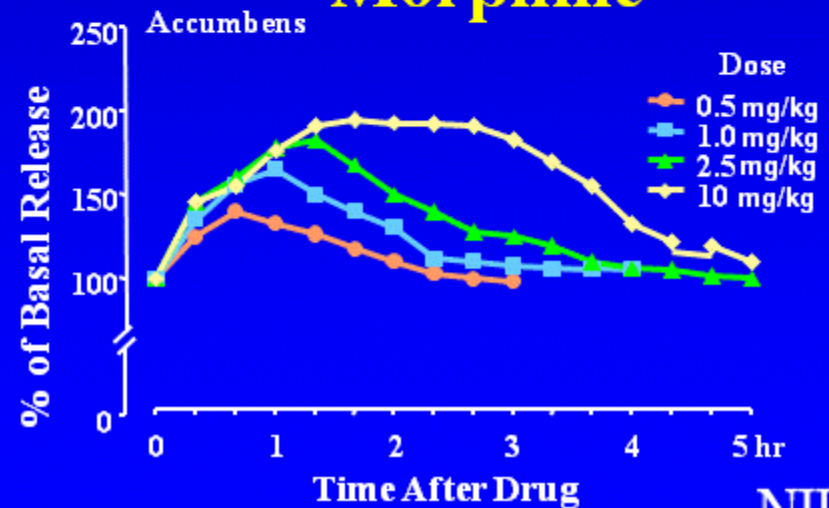
Cocaine



Nicotine



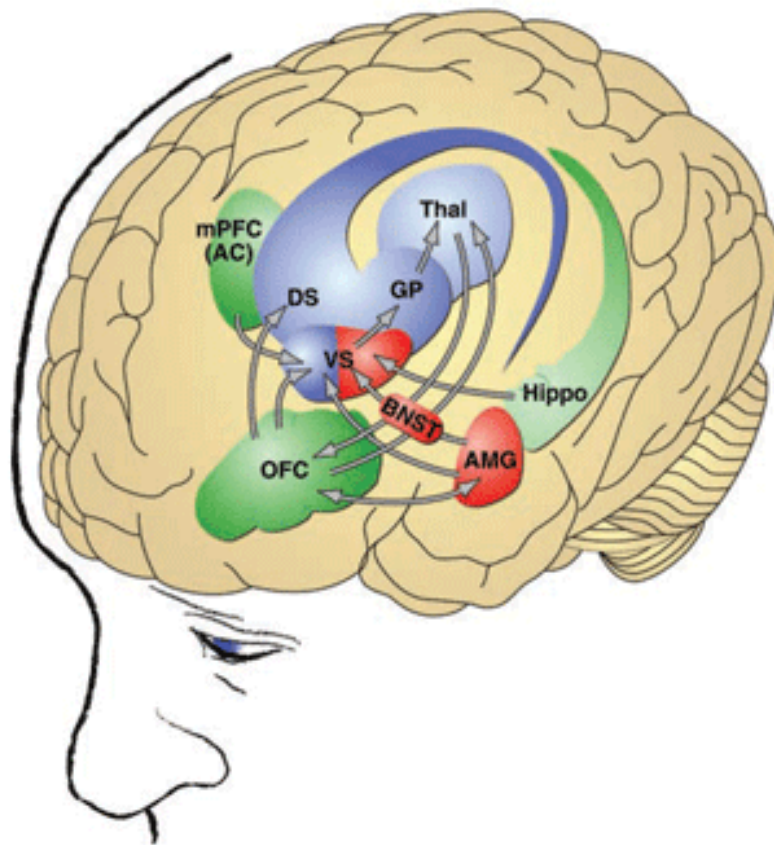
Morphine



Dr. Nora Volkow on Addiction: A
Disease of Free Will, July 2015
[www.youtube.com/watch?
v=X1AEvkWxbLE](http://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
- globus 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



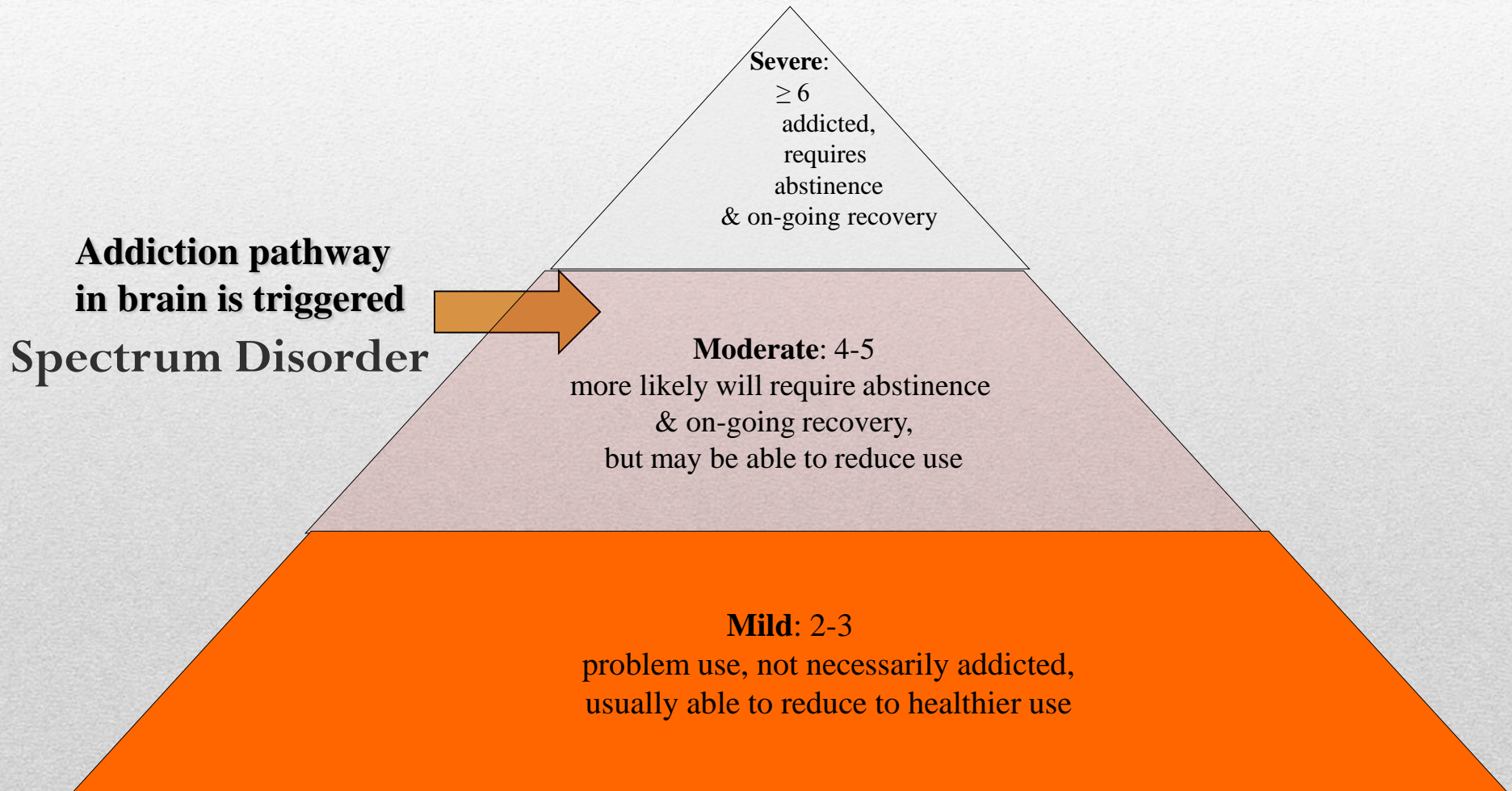
DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FIFTH EDITION
DSM-5

AMERICAN PSYCHIATRIC ASSOCIATION

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

THE UNITED STATES

We account for:



OF THE GLOBAL
POPULATION

&



OF THE GLOBAL PRESCRIPTION
OPIATE CONSUMPTION

PRESCRIPTION OPIATE SUD

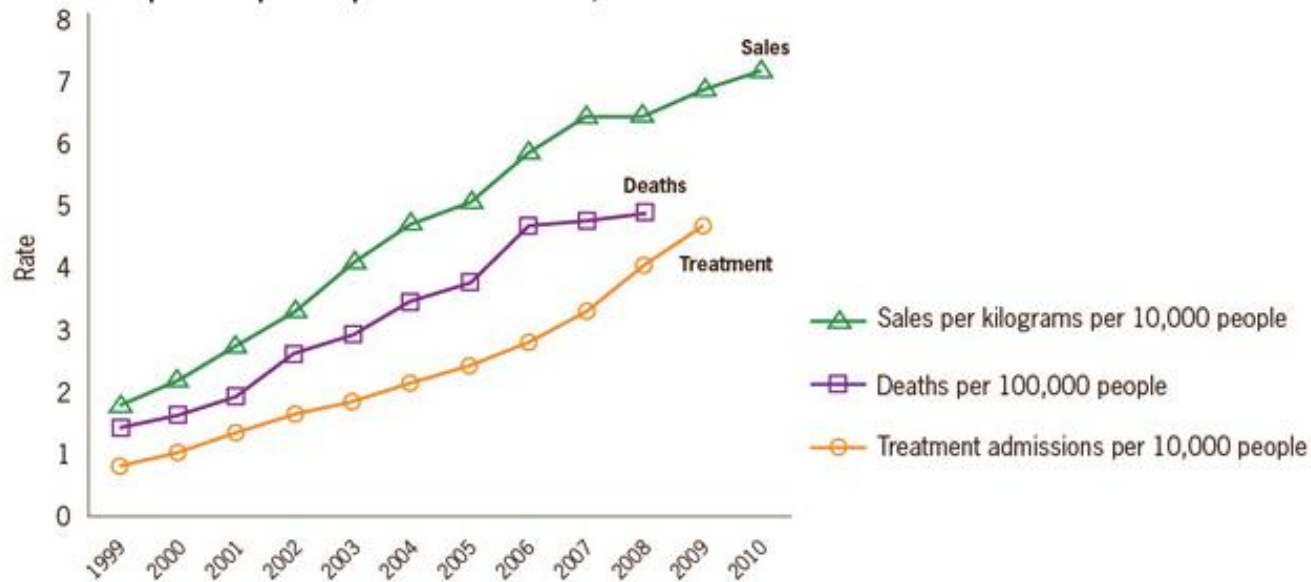
#3 most abused substance in the U.S.



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)

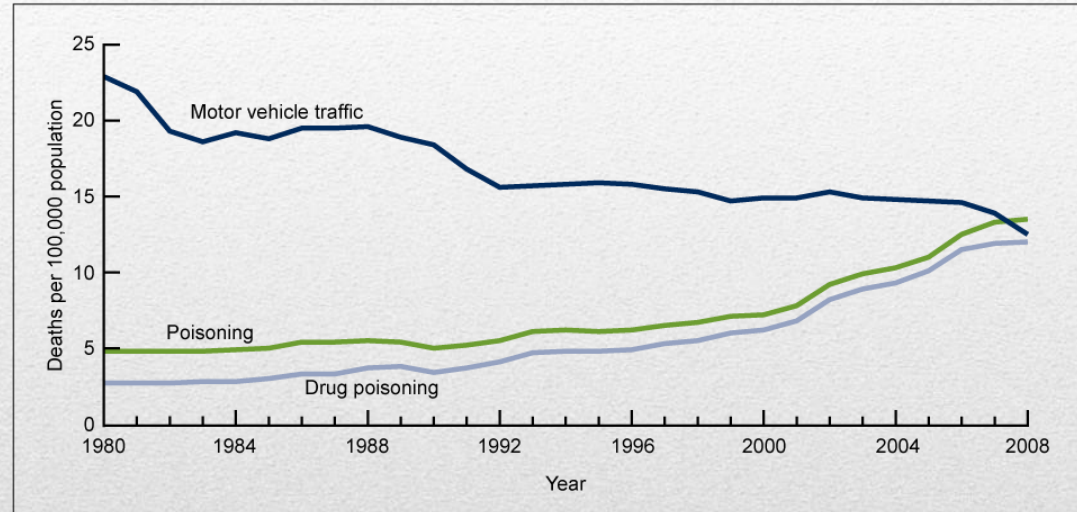


SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

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>.

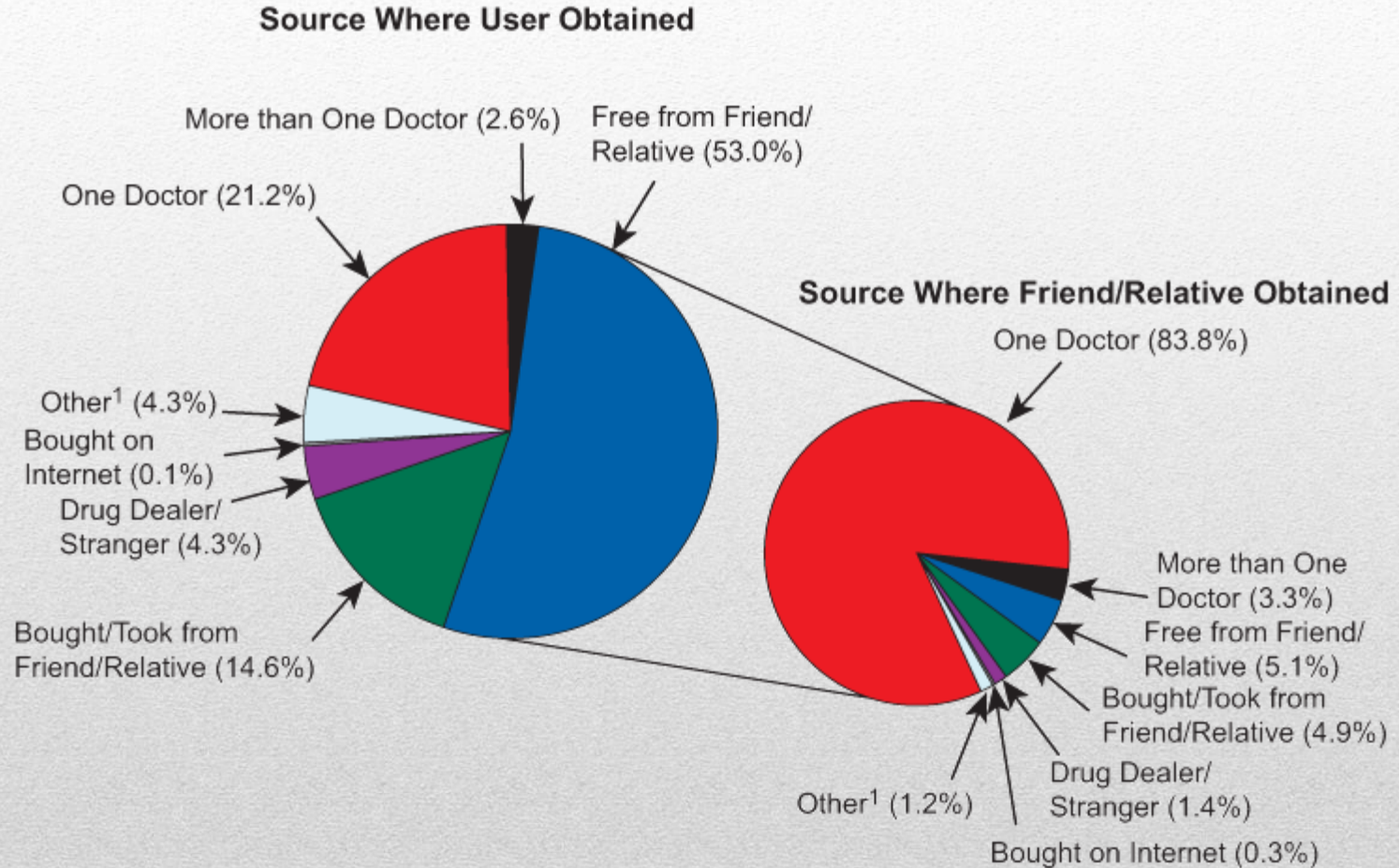
Figure 1. Motor vehicle traffic, poisoning, and drug poisoning death rates: United States, 1980–2008



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



She gets her hair
from her mom.

Her eyes from her dad.

And her drugs
from her grandma's
medicine cabinet.

70% of children who abuse prescription drugs get them from family or friends. Prevent your children from abusing your own medication by securing your meds in places your child cannot access.

BE AWARE. DON'T SHARE.

For more information, go to www.lockyourmeds.org.



**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

Addiction:
Substance Use Disorder

Prescription Drug Misuse

Aberrant Medication-Taking Behaviors
A spectrum of patient behaviors
that *may* reflect misuse

Total Chronic Pain Population

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 | • 3 = beads of sweat on brow or face | | |
| 1 = subjective report of chills or flushing | • 4 = sweat streaming off face | | |
| 2 = flushed or observable moistness on face | | | |
| Restlessness Observation During Assessment | | | |
| 0 = able to sit still | • 3 = frequent shifting or extraneous movements of legs/arms | | |
| 1 = reports difficulty sitting still, but is able to do so | • 5 = Unable to sit still for more than a few seconds | | |
| Pupil Size | | | |
| 0 = pupils pinned or normal size for room light | • 2 = pupils moderately dilated | | |
| 1 = pupils possibly larger than normal for room light | • 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 | • 2 = patient reports severe diffuse aching of joints/muscles | | |
| 1 = mild diffuse discomfort | • 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 | • 2 = nose running or tearing | | |
| 1 = nasal stuffiness or unusually moist eyes | • 4 = nose constantly running or tears streaming down cheeks | | |
| GI Upset: Over Last 1/2 Hour | | | |
| 0 = no GI symptoms | • 3 = vomiting or diarrhea | | |
| 1 = stomach cramps | • 5 = multiple episodes of diarrhea or vomiting | | |
| 2 = nausea or loose stool | | | |

COWS Clinical Opioid withdrawal scale

- 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

Tolerance and Withdrawal (W/D)

- 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

Hyperalgesia:

Opioids May Worsen Pain

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 | <input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal Drugs <input type="checkbox"/> Prescription Drugs | | 1 2 4 | 3 3 4 |
| 2. Personal History of Substance Abuse | <input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal Drugs <input type="checkbox"/> Prescription Drugs | | 3 4 5 | 3 4 5 |
| 3. Age (Mark Box if 16-45 years) | | | 1 | 1 |
| 4. History of Preadolescence Sexual Abuse | | | 3 | 0 |
| 5. Psychological Disease | <input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder; <input type="checkbox"/> Obsessive Compulsive Disorder; <input type="checkbox"/> Bipolar Disorder; <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Depression | | 2 1 | 2 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.

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

**Approach to monitoring
depends on risk level**

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
-

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)

Behaviors Highly consistent with SUD

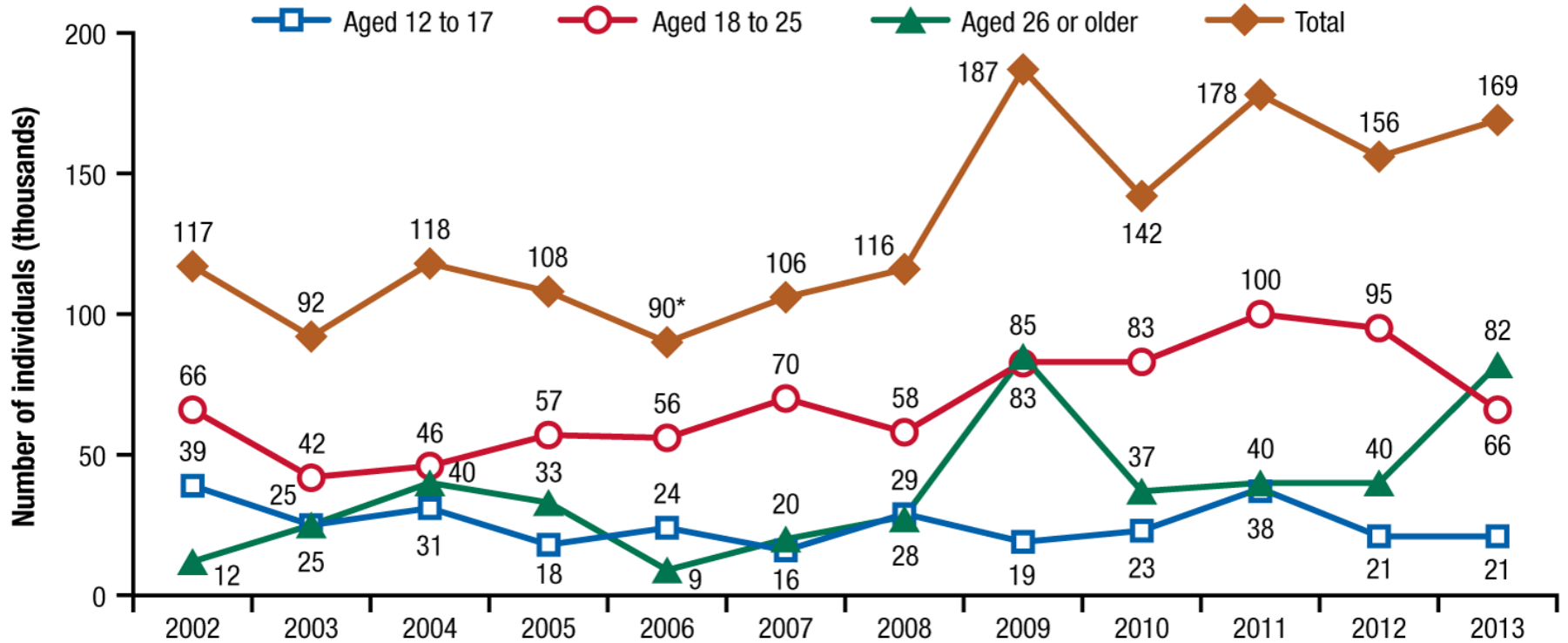
- Opiate Replacement Therapy (ORT)
 - Suboxone
 - Methadone
- Help families and pts to understand this
 - Compare to thyroid replacement therapy
- Why?
 - Likely chronic endogenous opioid deficiency
 - Need chronic opioid receptor occupation (other opiates don't do this)
 - Acute WD can be managed
 -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

Best Evidence-Based Treatment for Opioid SUD

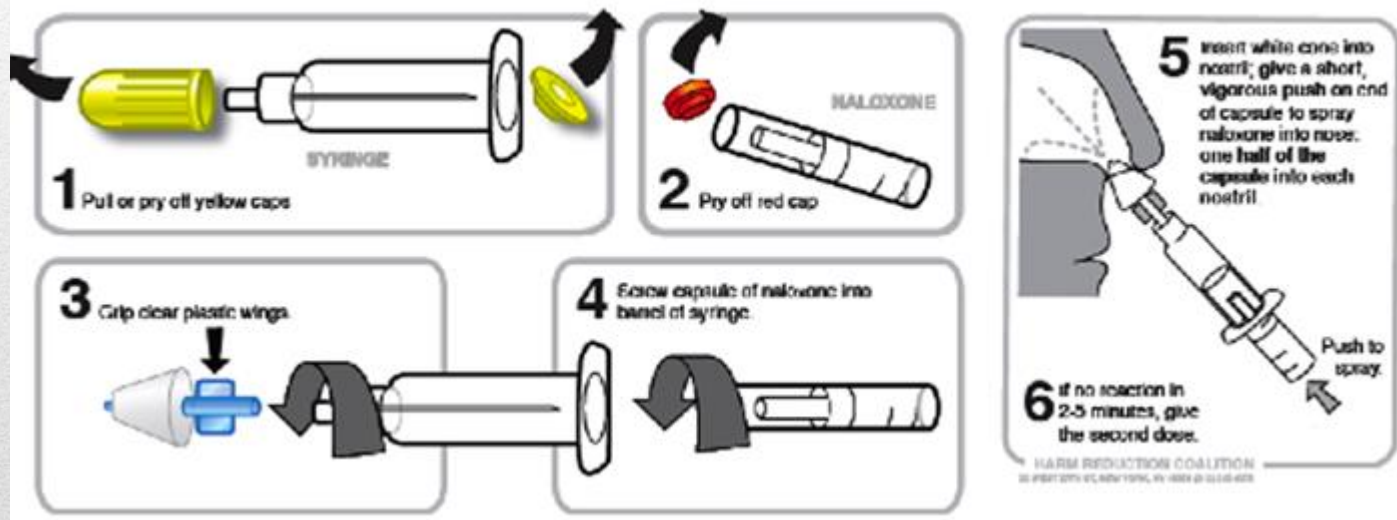
- Anxiety/Depression
- Sleep disturbances
- Fatigue
- Dysphoria/Irritability
- Decreased ability to focus on a task
- Deficits in executive control
- **Can mimic:**
 - **Mood disorder**
 - **Sleep disorder**
 - **ADHD**

Post Acute WD Syndrome (PAWS):
Opioids


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



HOW TO GIVE NASAL SPRAY NARCAN



Naloxone Saves Lives

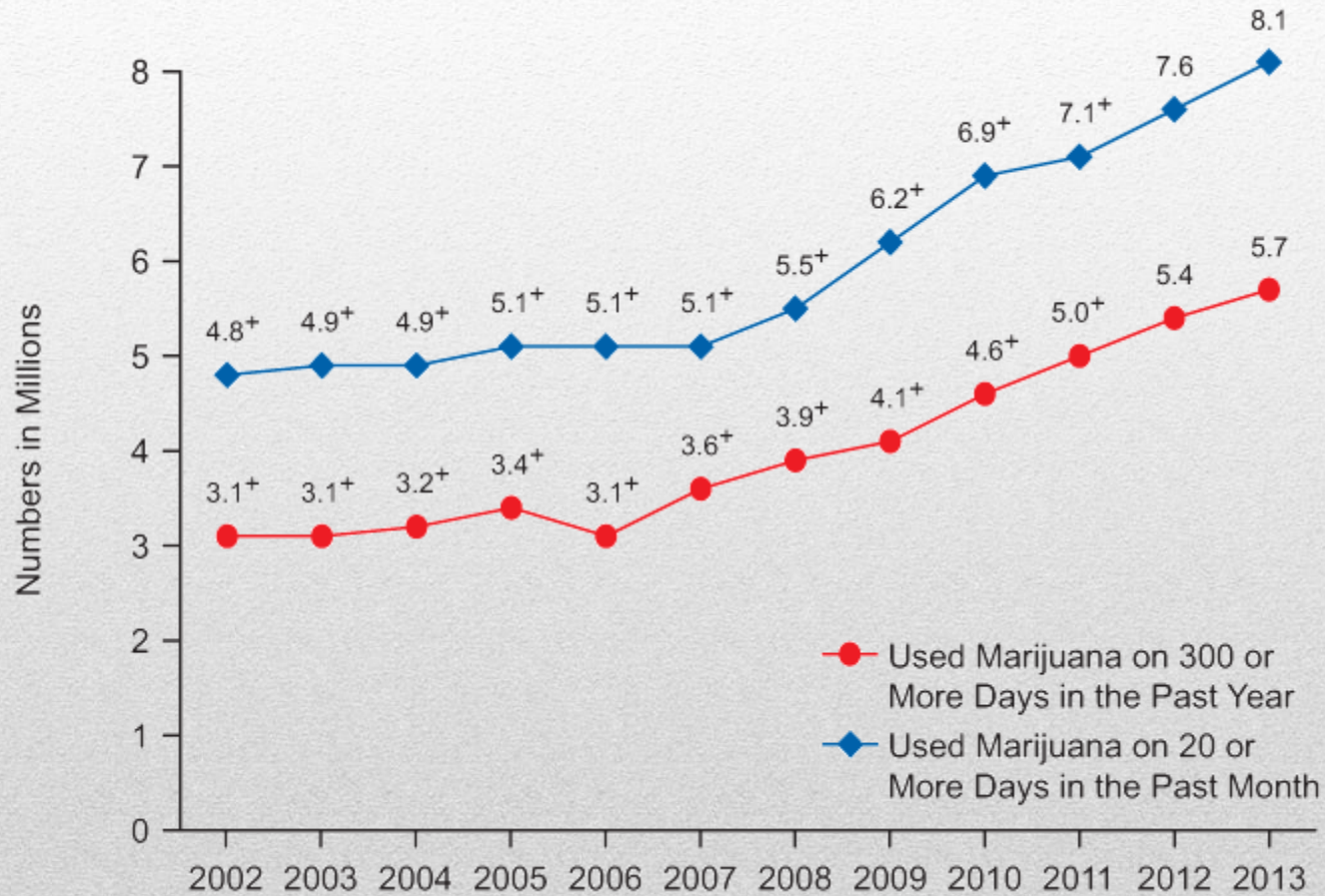


"Emerald Triangle" by O'Dea -
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Commons -
[https://commons.wikimedia.org/
wiki/](https://commons.wikimedia.org/wiki/)

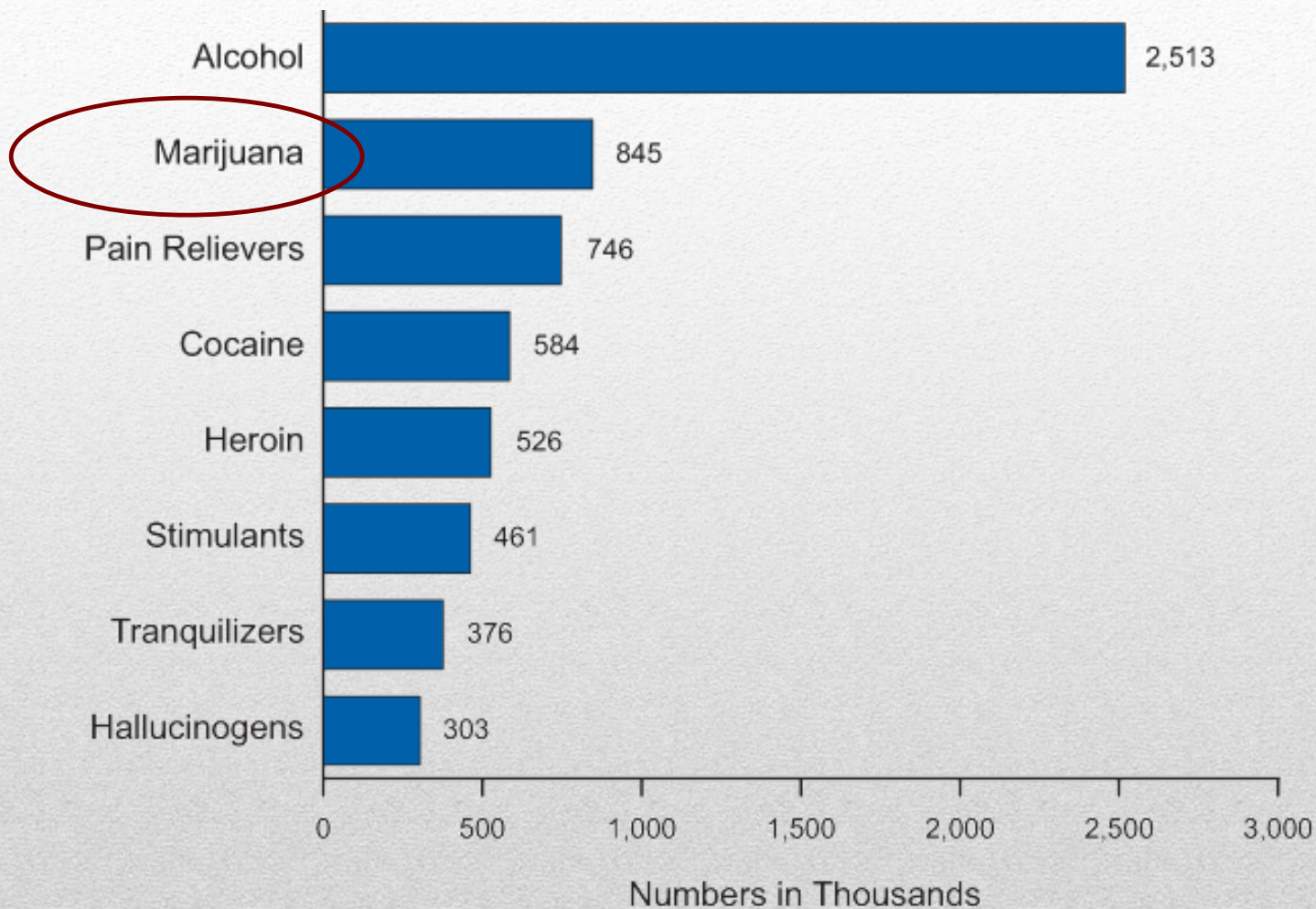
MARIJUANA

#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



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



Endocannabinoids

neuromodulators scattered throughout the brain and spinal cord

CB1: in brain & spinal cord

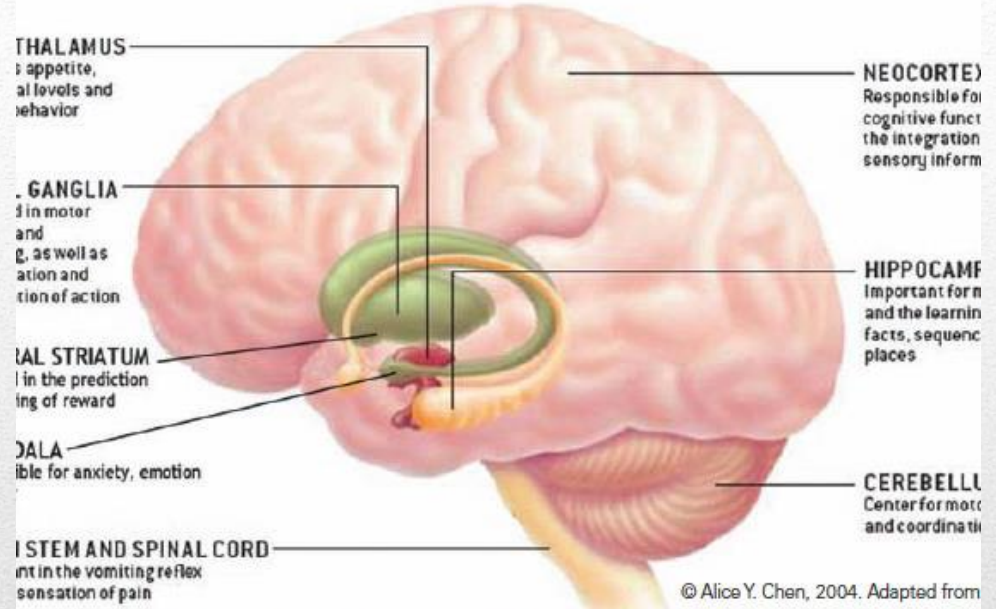
CB2: in immune system

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

Marijuana's Effects on the Brain



When marijuana is smoked, its active ingredient, THC, travels throughout the body, including the brain, to produce its effects. It attaches to sites called cannabinoid receptors on nerve cells in the brain, affecting the way those cells function. These receptors are abundant in parts of the brain that regulate movement, coordination, learning and memory, as well as functions such as judgment, and pleasure.

NIDA website

Why we like 'weed' & not hay?

- 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
-

•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

Cannabis Use Disorder Identification Test

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 0 | Monthly or less 1 | 2-4 times a month 2 | 2-3 times a week 3 | 4 or more times a week 4 |
| 2. | How many hours were you “stoned” on a typical day when you had been using cannabis? | Less than 1 0 | 1 or 2 1 | 3 or 4 2 | 5 or 6 3 | 7 or more 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 0 | Less than monthly 1 | Monthly 2 | Weekly 3 | Daily or almost daily 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 0 | Less than monthly 1 | Monthly 2 | Weekly 3 | Daily or almost daily 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 0 | Less than monthly 1 | Monthly 2 | Weekly 3 | Daily or almost daily 4 |
| 6. | How often in the past 6 months have you had a problem with your memory or concentration after using cannabis? | Never 0 | Less than monthly 1 | Monthly 2 | Weekly 3 | Daily or almost daily 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 0 | Less than monthly 1 | Monthly 2 | Weekly 3 | Daily or almost daily 4 |
| 8. | Have you ever thought about cutting down, or stopping, your use of cannabis? | Never 0 | Yes, but not in the past 6 months 2 | | Yes, during the past 6 months 4 | |

This scale is in the public domain and is free to use with appropriate citation:

Mood:

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

Physical Symptoms:

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

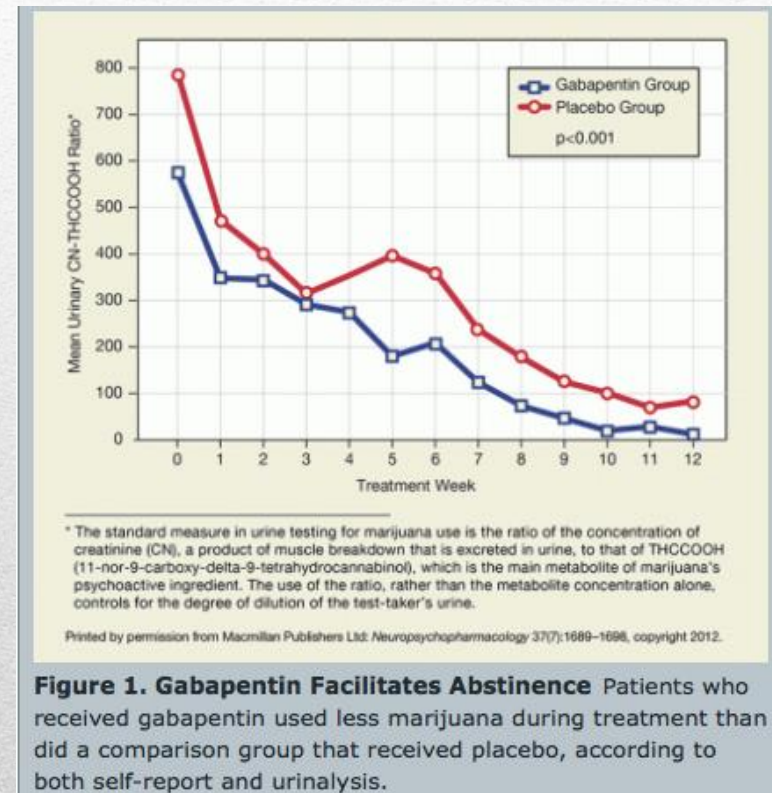
- NIDA

Marijuana Withdrawal Symptoms

Gabapentin Treatment for CUD

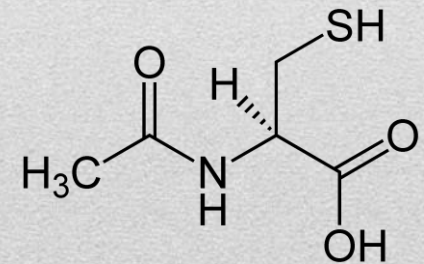
Treated with gabapentin in a pilot RCT DBP x 12 wks, tapered up to 300/300/600:

- 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



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



NAC Treatment for CUD

- 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 ?





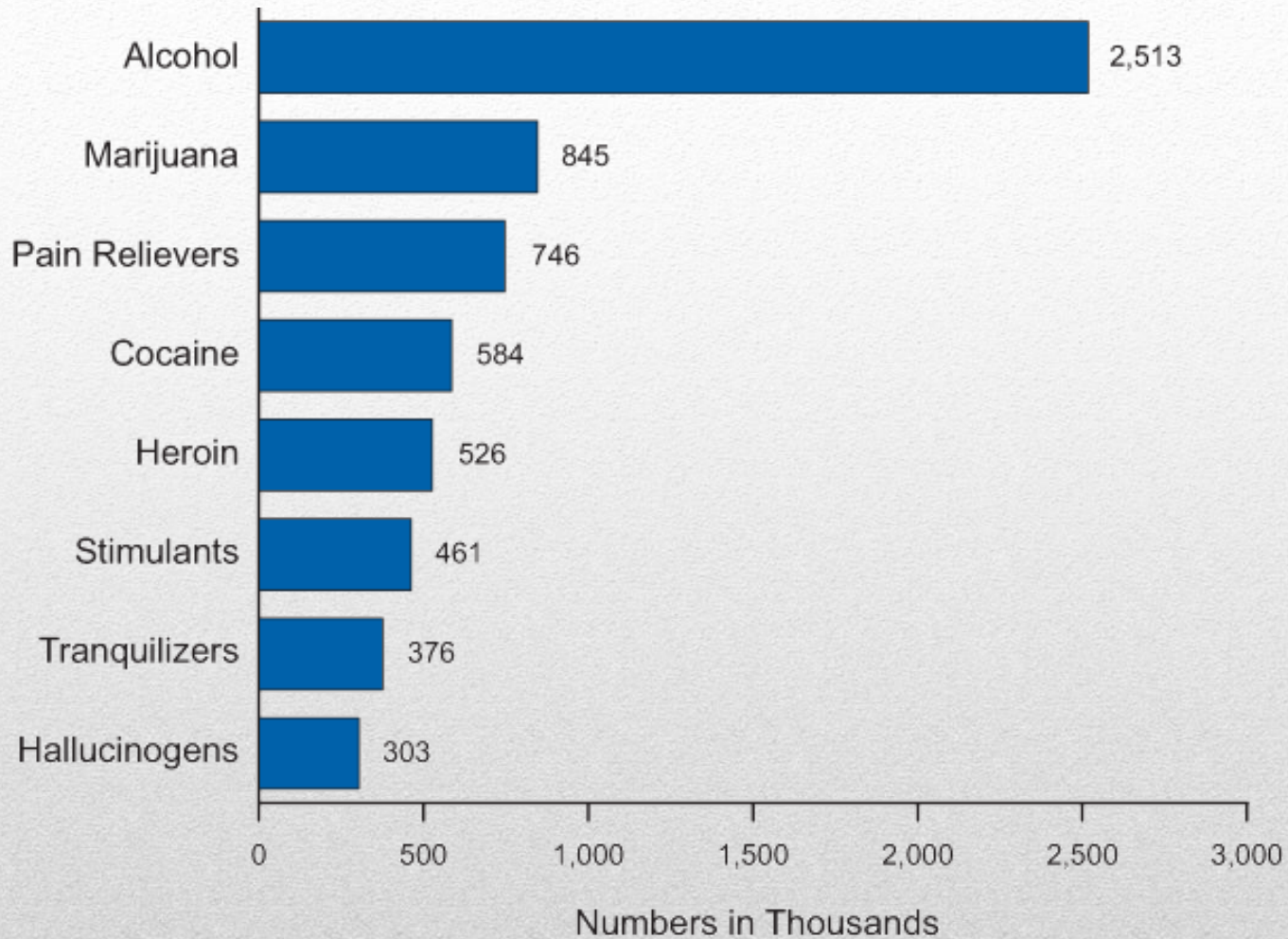
BREAK

15 minutes



ALCOHOL

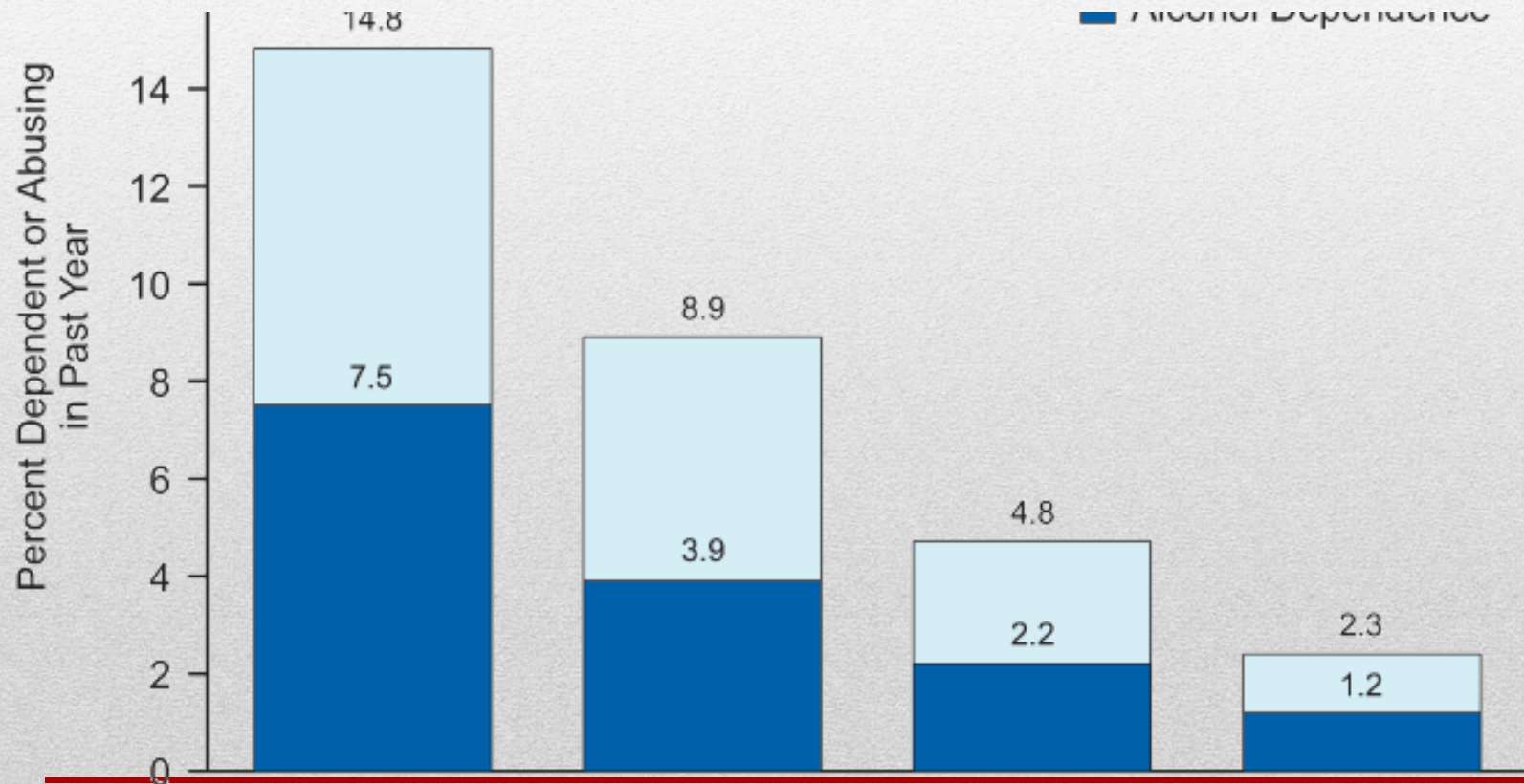
#1 most abused substance in the U.S.

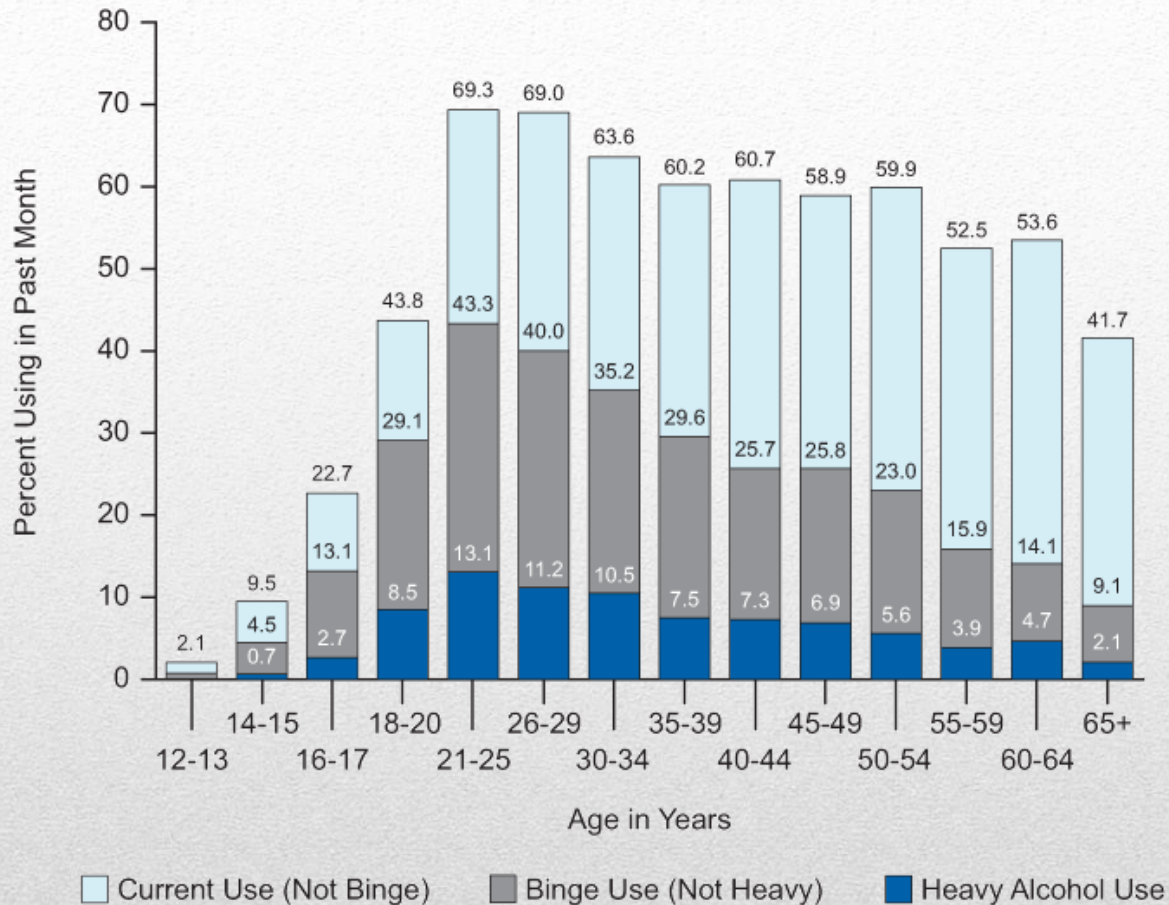


Substances for Which Most Recent Treatment Was Received in the Past Year: 2013

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
-

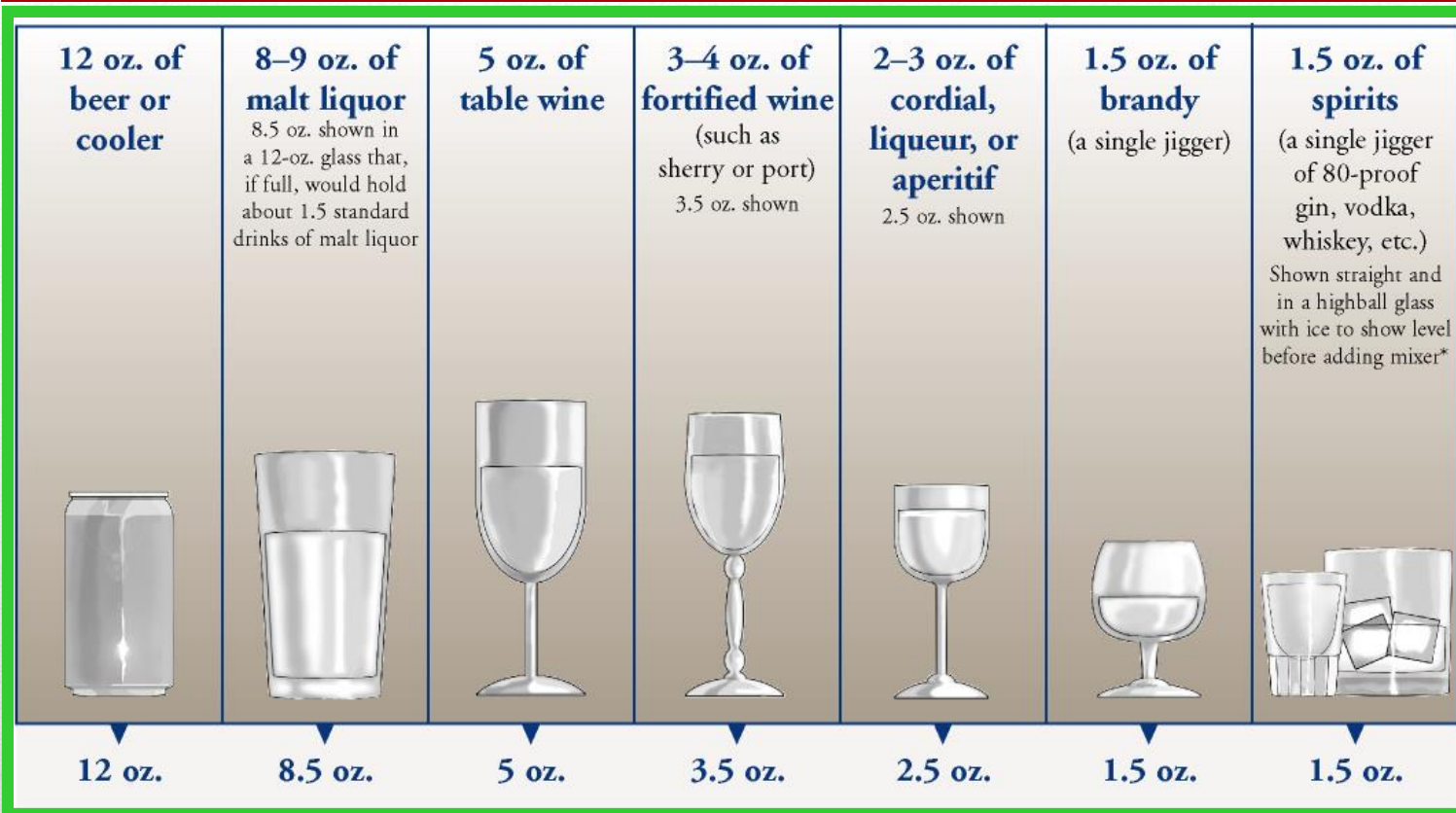


Alcohol Screening, Brief Intervention,
and Referral to Treatment

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!



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

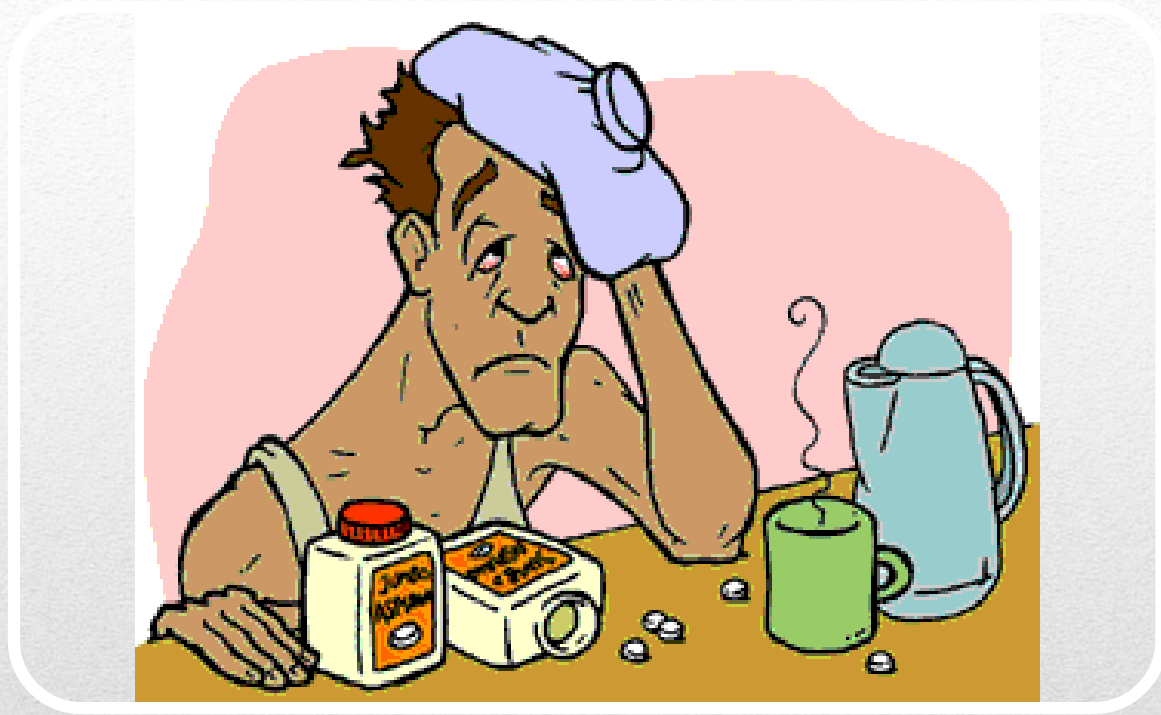
(and healthy men over age 65)—

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

Maximum ‘Healthy’ Drinking Limits

- “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.

1-Item Saitz question (recommended by the NIAAA)



Alcohol Medication Treatment

- 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

Outpatient Alcohol Withdrawal

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 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 |

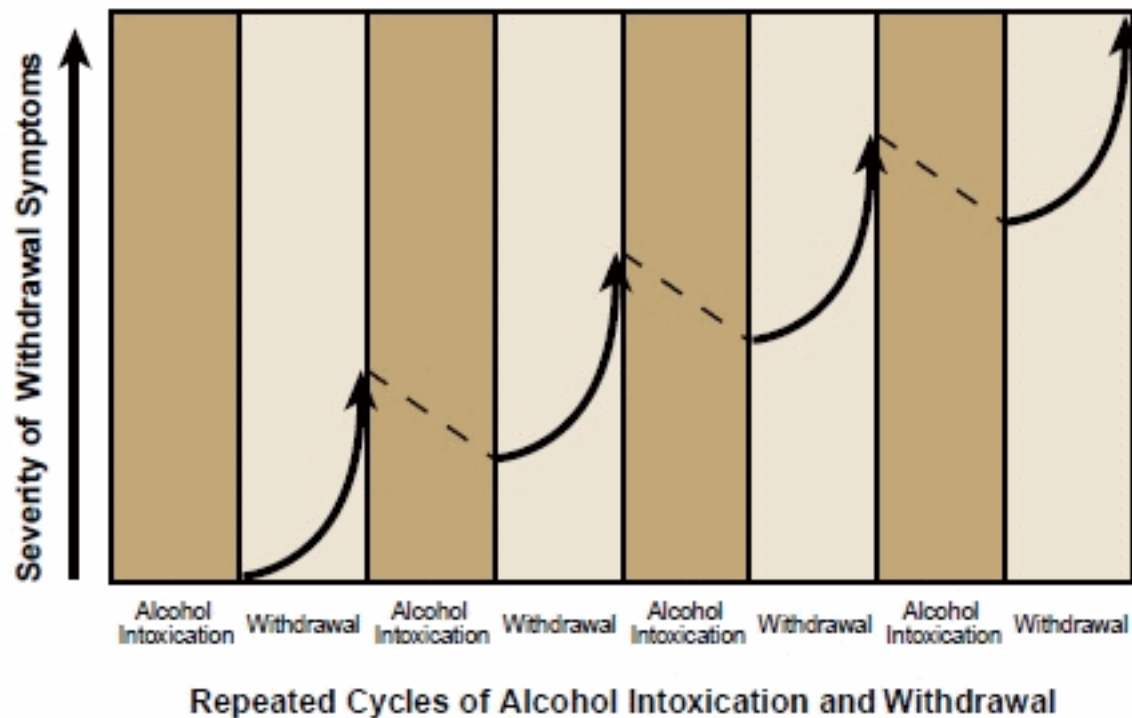


Figure 1 Graphic representation of the kindling concept during alcohol withdrawal. The term "kindling" refers to the phenomenon that people undergoing repeated cycles of intoxication followed by abstinence and withdrawal will experience increasingly severe withdrawal symptoms with each successive cycle.

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*
-

- 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.

Results of the COMBINE Study

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
-

- Gabapentin
 - 300-600 bid to tid prn
- Topiramate
 - GABAergic anticonvulsant
 - May improve depressive, anxiety, PTSD and obsessive-compulsive drinking symptoms
 - Positive dbprc 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

Others ... (not FDA approved)

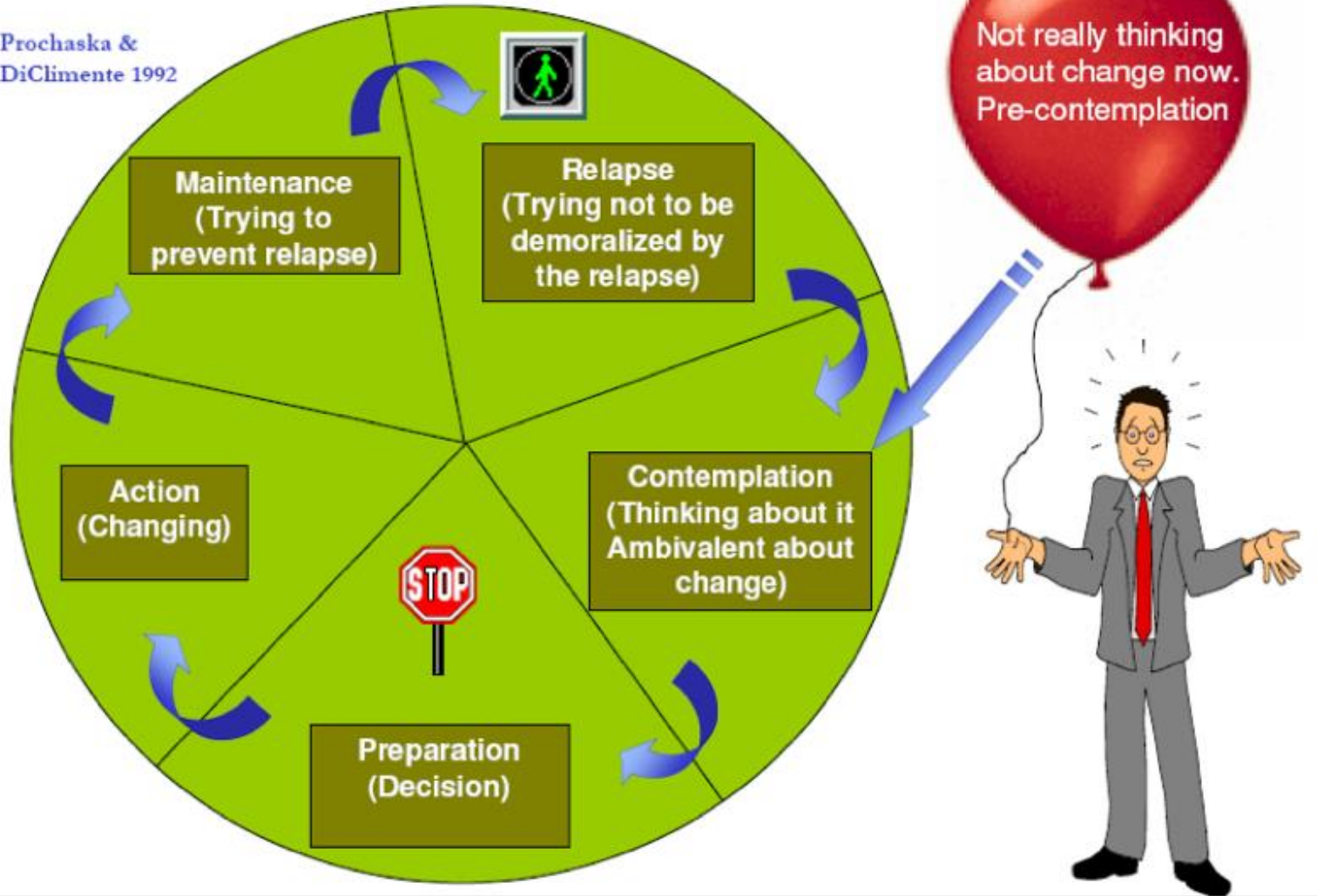


Counseling Approaches

Assess Stage Of Change

“Where are you at with your drinking?”

Prochaska &
DiClemente 1992

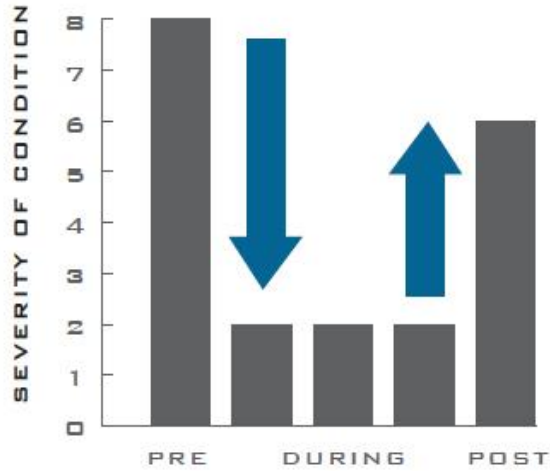


WHY IS ADDICTION TREATMENT EVALUATED DIFFERENTLY?

BOTH REQUIRE ONGOING CARE

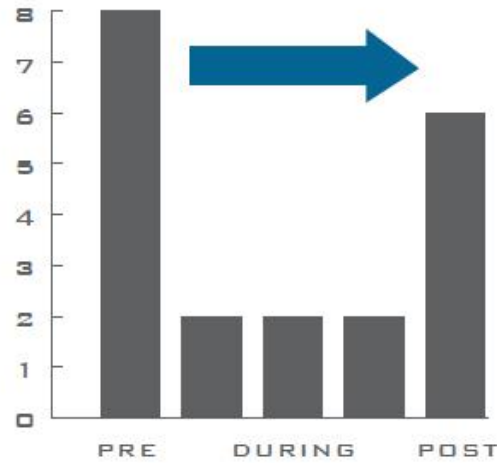
YES!!!

Hypertension Treatment



NO???

Addiction Treatment



STAGE OF TREATMENT

Percentage of Patients Who Relapse

TYPE I DIABETES



DRUG ADDICTION



HYPERTENSION



ASTHMA



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?
-

- CBT
 - ETOH, MJ, Cocaine, Meth, Nicotine
- Contingency management/motivational incentives
 - ETOH, stimulants, opioids, MJ, nicotine
- 12-step facilitation
 - ETOH, stimul, 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.

Evidence Based Treatments

NIDA

- 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 (criteria 1, 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

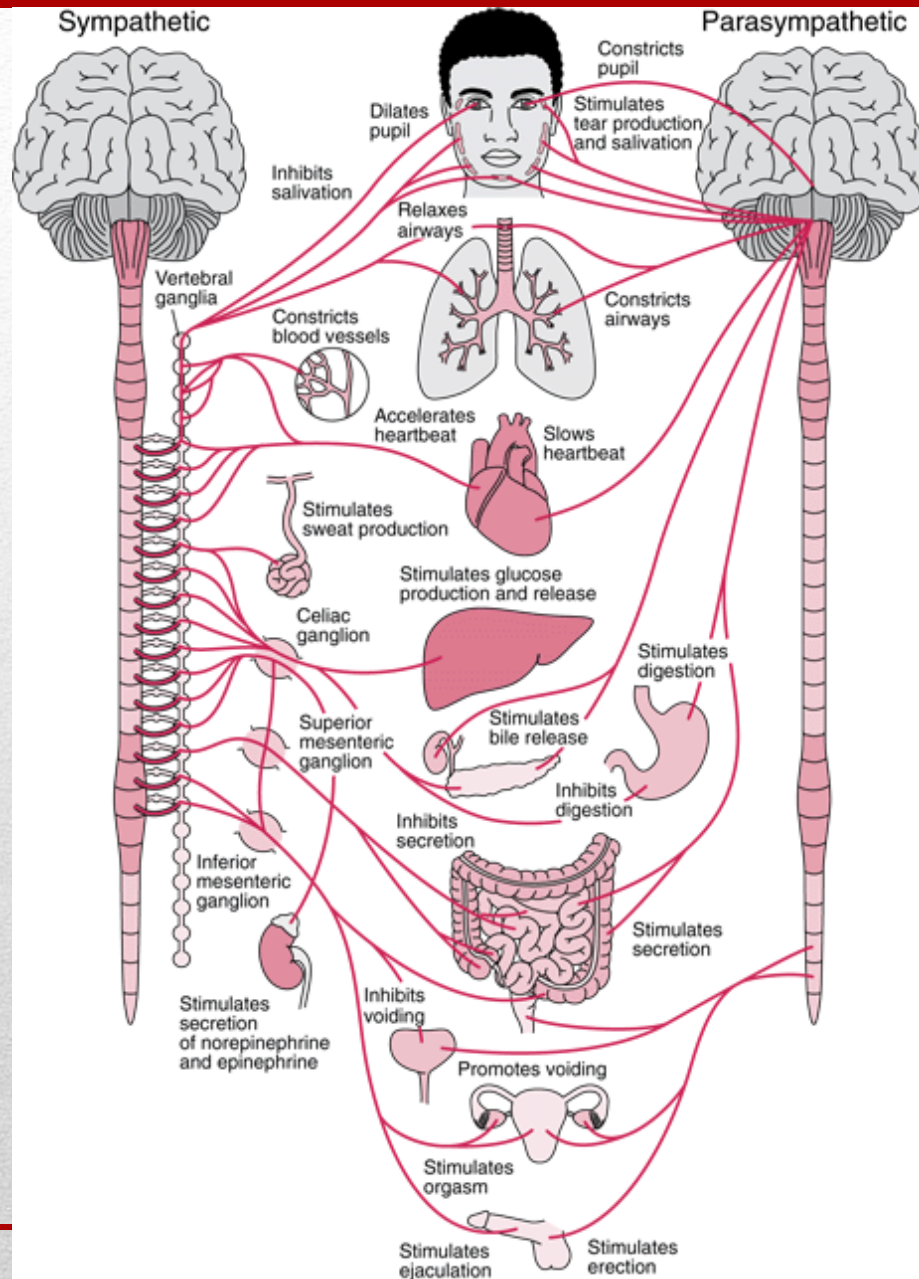


- What are your concerns?
 - Can someone go with you to a first meeting?
 - You don't have to talk. Just watch.
 - Try a few meetings to find one where you feel socially comfortable
 - Home meeting
 - Action plan to commit to go to one meeting
 - Keep eye out for a “temporary” sponsor
 - Look at it like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

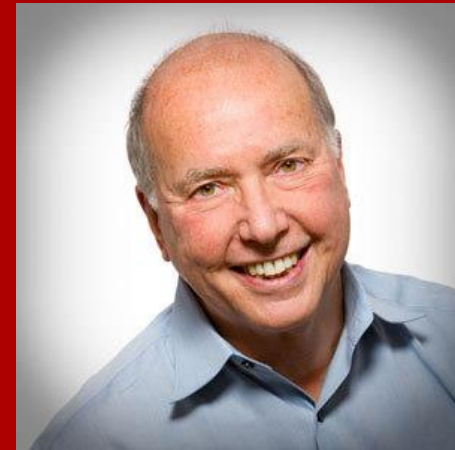
AUD Integrative Approaches

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 hygiene
 - Nutrition and supplements
 - B complex & thiamine
 - Vitamin D
 - Fish Oil: 2000 mg EPA
 - Magnesium
 - MVI
 - NAC
-



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



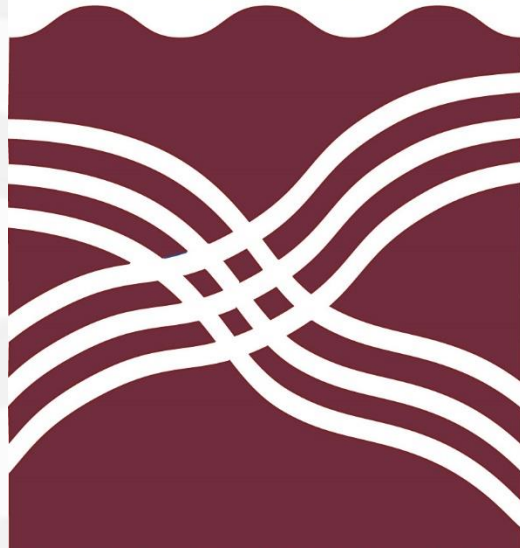
SOFT BELLY BREATHING EXERCISE (A BACK POCKET RELAXATION TOOL)



QUESTIONS

15 minutes

PARTNERSHIP



HEALTHPLAN
of CALIFORNIA

Lunch

12:00-12:45pm



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

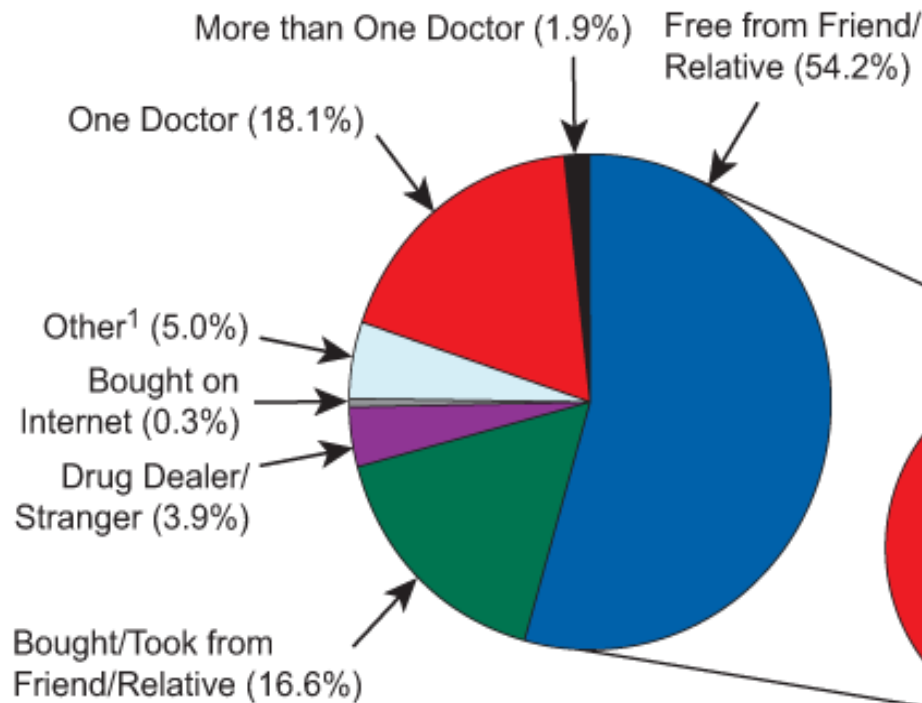
- Have you ever stopped prescribing?
- What were some of the warning signs to make you stop prescribing?
 - What type of diversion were you suspicious of?
- What would have helped you navigate this encounter?

How are drugs diverted?

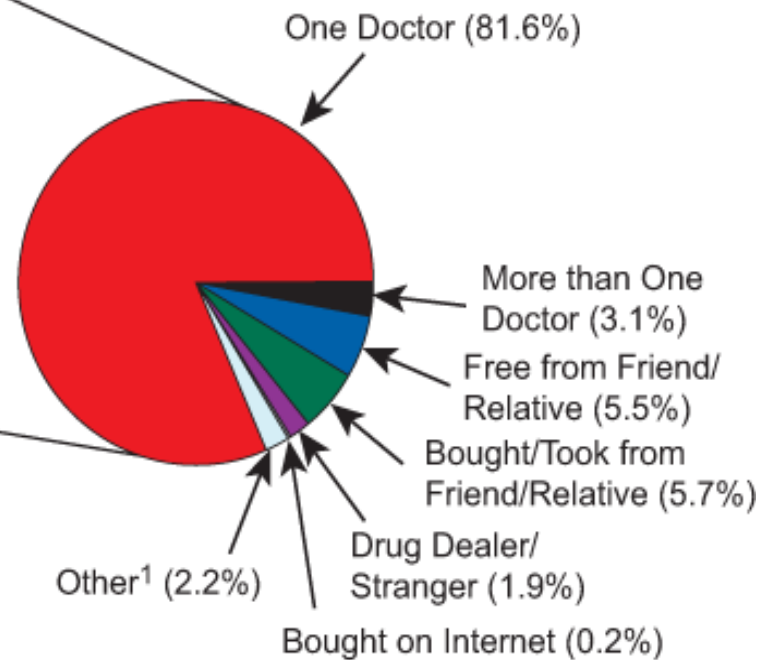
- All stages in the “life of the pill” are controlled under law
 - Manufacture, transport, storage, prescription, dispensing, use, disposal
 - All persons with access are specially entrusted
- Diversion can occur at any stage
- Sold, stolen, traded, given away

SOURCES FOR NONMEDICAL USE OF PAIN RELIEVERS

Source Where User Obtained



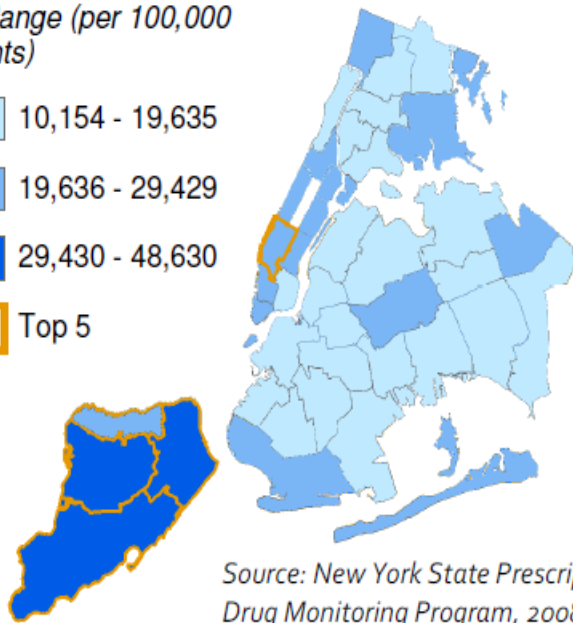
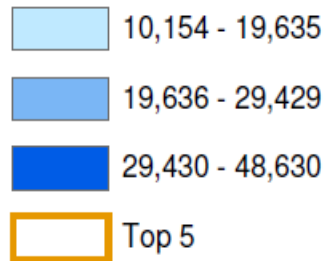
Source Where Friend/Relative Obtained



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 neighborhood⁵

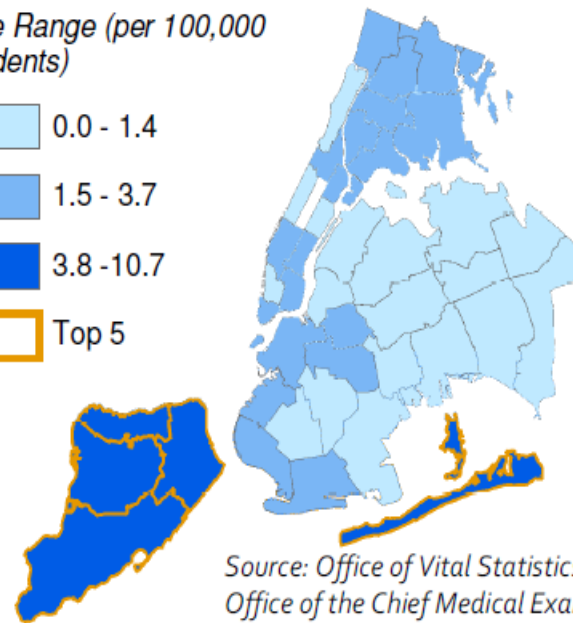
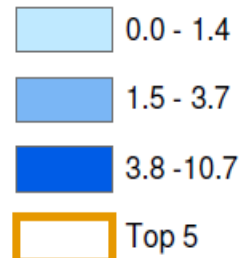
Rate Range (per 100,000 residents)



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

Rates of unintentional opioid analgesic poisoning (overdose) deaths by NYC neighborhood⁴

Rate Range (per 100,000 residents)



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.

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?

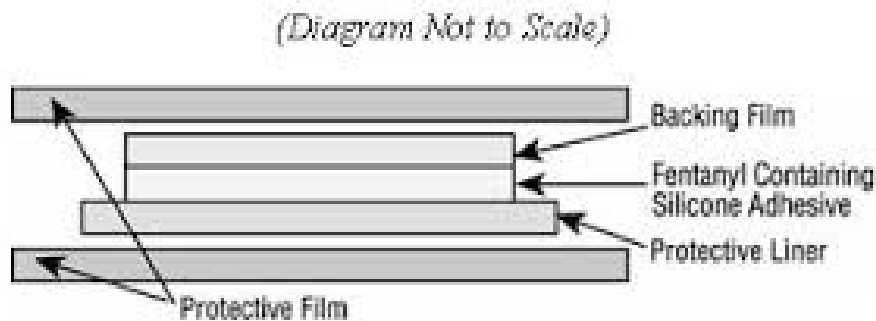
A: \$1 per mg

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

New CDC Opioid Prescribing Guidelines

**Improving the Way Opioids are Prescribed
for Safer Chronic Pain Treatment**



The problem:

Existing guidelines vary in recommendations, and primary care providers say they receive insufficient training in prescribing opioid pain relievers. It is important that patients receive appropriate pain treatment, and that the benefits and risks of treatment options are carefully considered.



259 million

In 2012, health care providers wrote 259 million prescriptions for opioid pain relievers – enough for every American adult to have a bottle of pills.¹



300% increase

Prescription opioid sales in the United States have increased by 300% since 1999², but there has not been an overall change in the amount of pain Americans report^{3,4}.



2 million

Almost 2 million Americans, age 12 or older, either abused or were dependent on opioid pain relievers in 2013.⁵



16 thousand

In 2013, more than 16,000 people died in the United States from overdose related to opioid pain relievers, four times the number in 1999.⁶

Improving practice:

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these powerful drugs.

Marin County Prescribers Survey, 2015

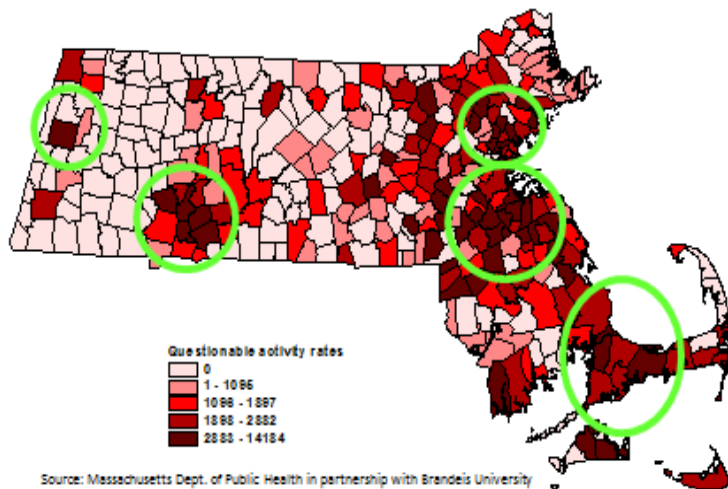
- Providers who self-report as operating under opioid prescribing guidelines were:
 - **8** times more likely to perform urine drug screening
 - **12** times more likely to use a medication agreement
 - **17** times more likely to utilize CURES

An Argument for Using CURES When Prescribing

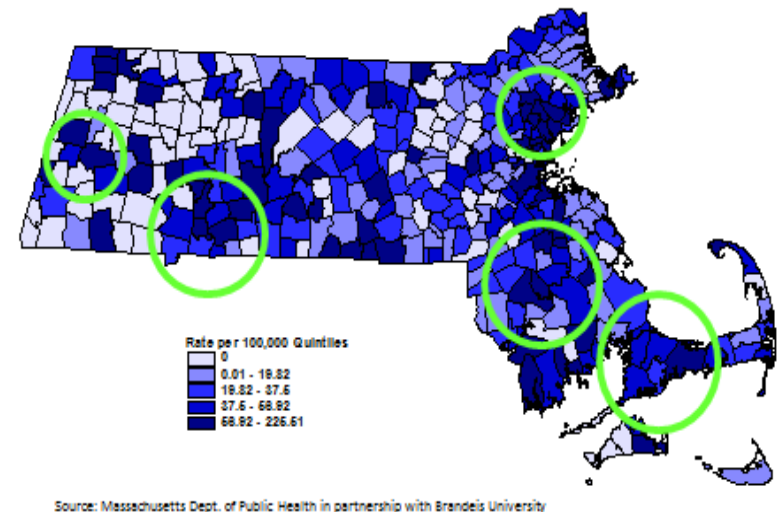
“Shopping” as a portion of all prescriptions

Opioid Overdoses

2005 Prescriptions Associated with Questionable Activity
(Rates per 100,000 Prescriptions) by Pharmacy Town



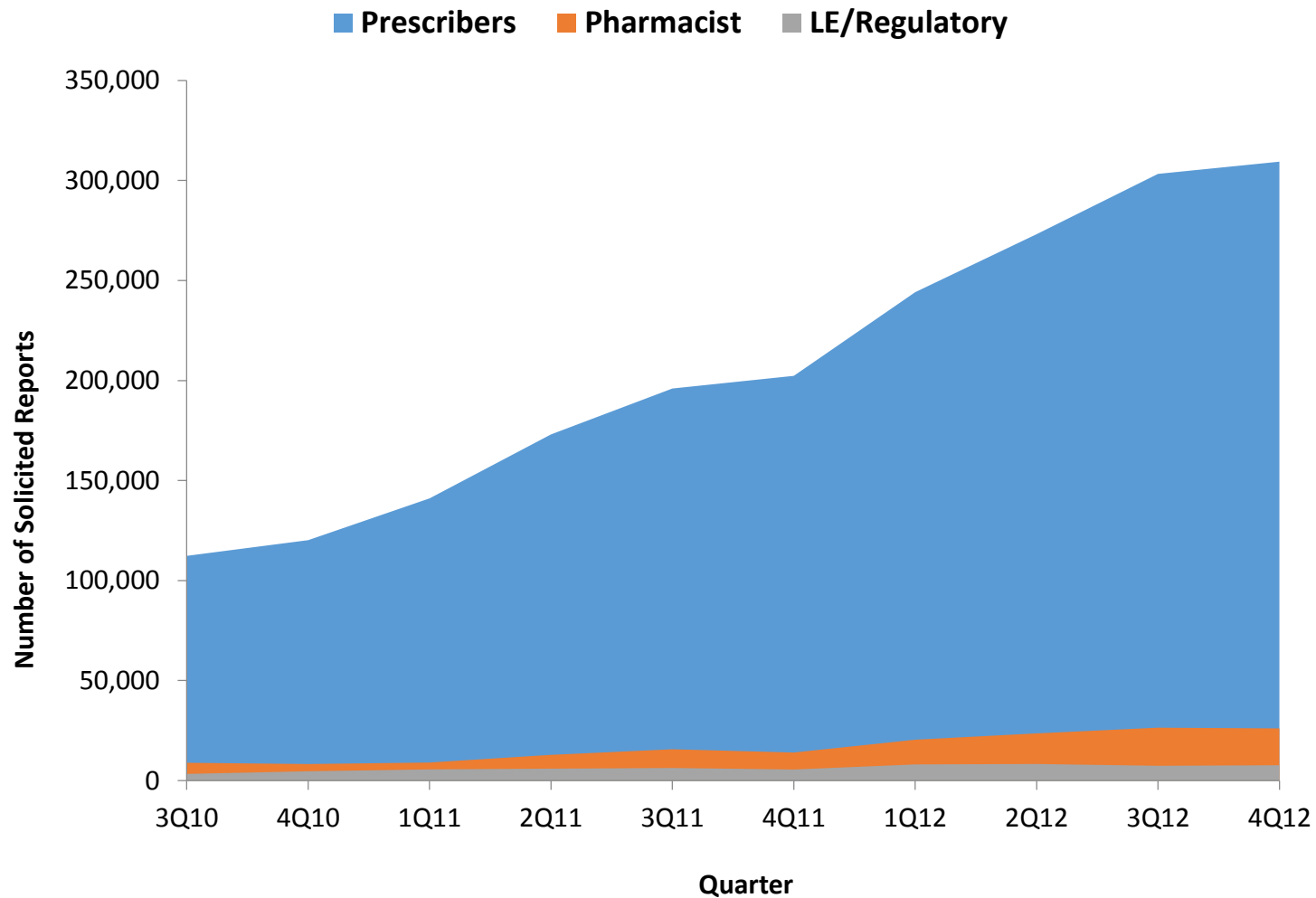
2005 Opioid-related Overdoses
Rate per 100,000 by Town



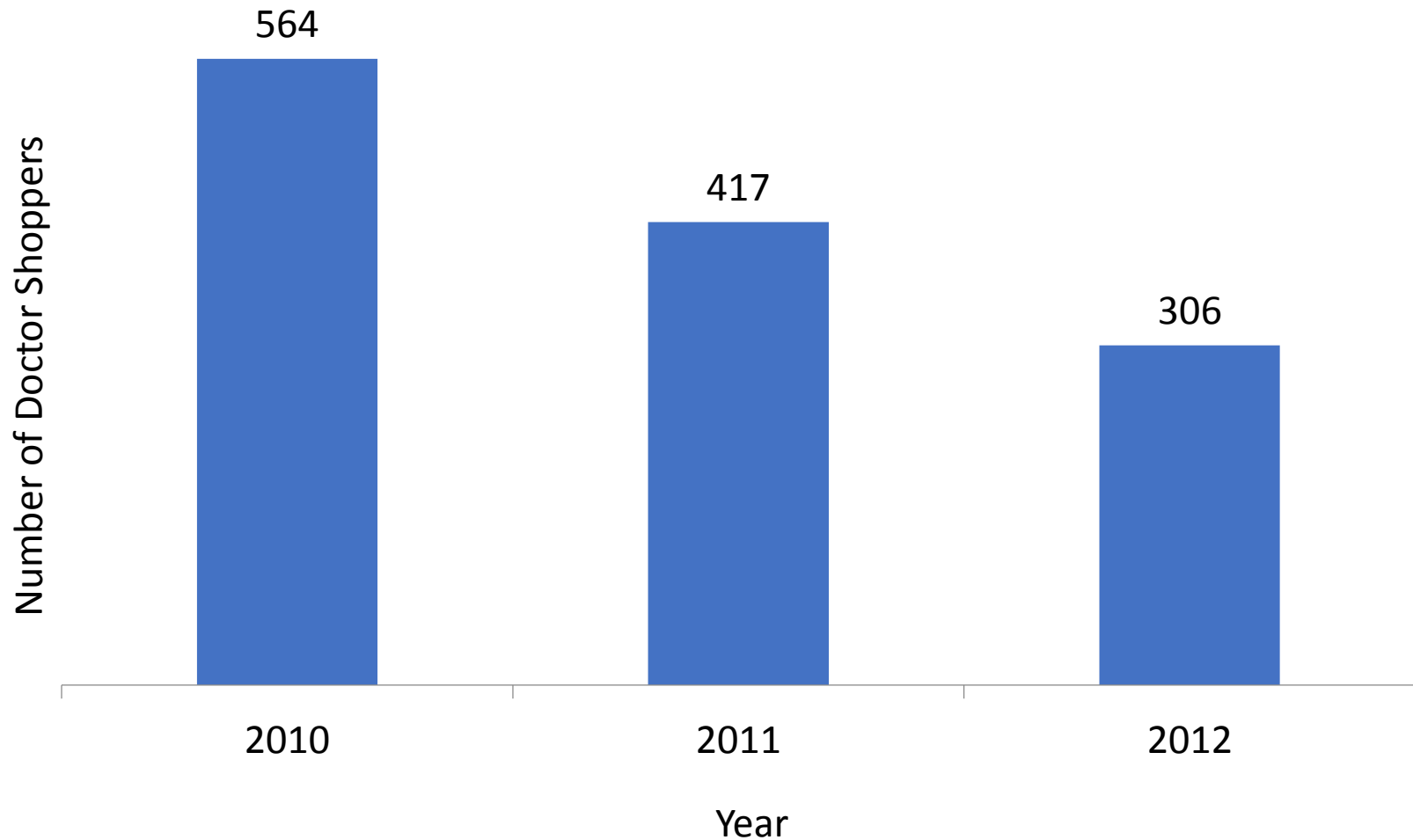
Slide provided courtesy of Peter Kreiner, PMP Center of Excellence at Brandeis. Doctor shopping= 4+ prescribers and 4+ pharmacies for CS in six months.

CHANGES CAN BE MADE:

SOLICITED PDMP REPORTS, OKLAHOMA, 2010-2012



CHANGES CAN BE MADE: AS PDMP USAGE INCREASED, DOCTOR SHOPPING DECREASED IN OKLAHOMA



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
X

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 | Clonazepam 1 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 | Clonazepam, 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”

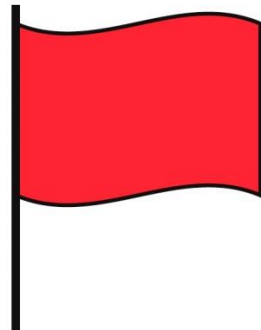
23 Scripts
10 Providers

| | |
|-------------------------|--|
| 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

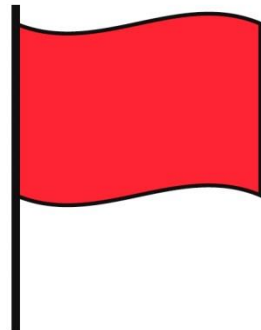
Flags

- 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



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!

WARNING!!!

www.chronic-illness.org

Things **NOT** to say to someone with a disabling chronic illness:

- ...but you don't look sick
- ...everybody gets tired
- ...you're just having a bad day
- ...it must be nice not having to go to work
- ...I wish I had time to take a nap
- ...if you'd get out more
- ...you're just getting older
- ...if you'd get more exercise
- ...it can't be that bad
- ...it's all in your head
- ...you're just depressed
- ...there are people worse off than you
- ...you'll just have to tough it out
- ...you just need a more positive attitude
- ...this, too, shall pass

(I wouldn't wish what I have on anyone, but unless you get it, you just don't get it.)

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

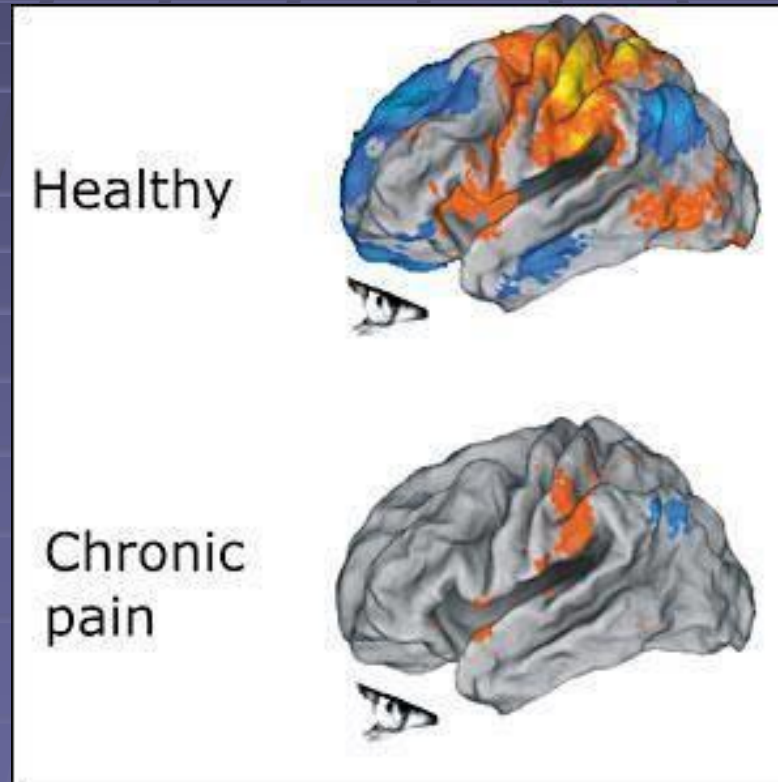
Children or grandchildren

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

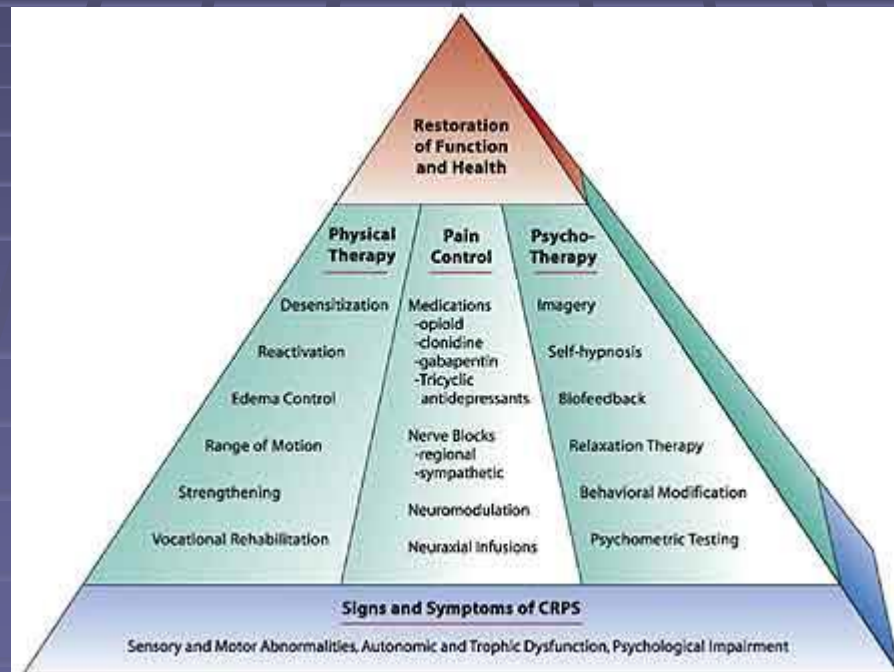
At Evaluation

- 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

Successful Surgery

Medications

Good Diet

Movement

Pacing (activity/rest)

Positive outlook

Hopefulness

Managing the pain

Pleasant events

Open

Surgery/broken bones

Drug and ETOH overuse

Poor Diet/Nicotine

Deconditioning

Worry about Hurt vs Harm

Negative outlook

Hopelessness

Focusing on the pain

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

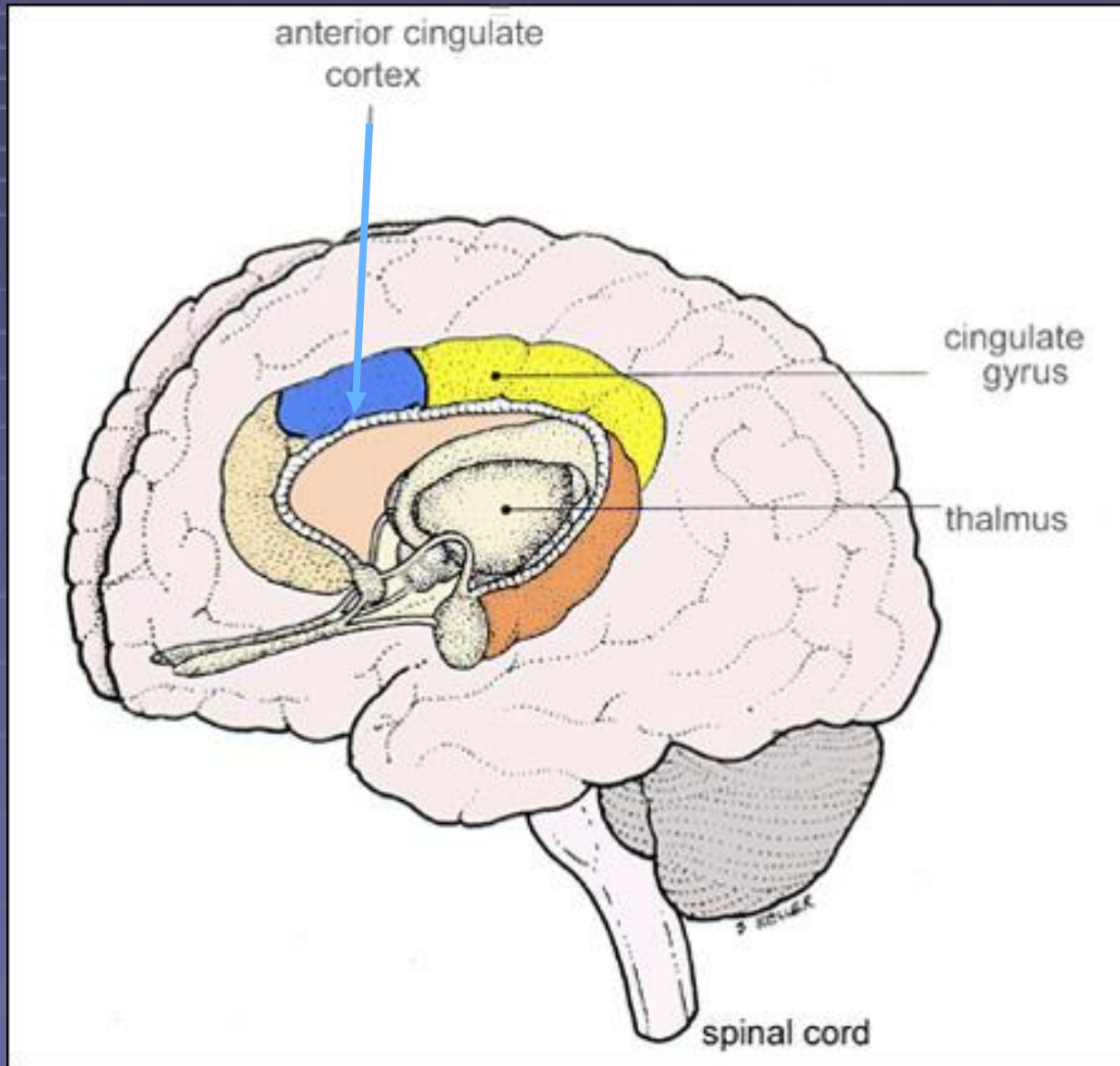


Changing the Brain

- 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. Christopher 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

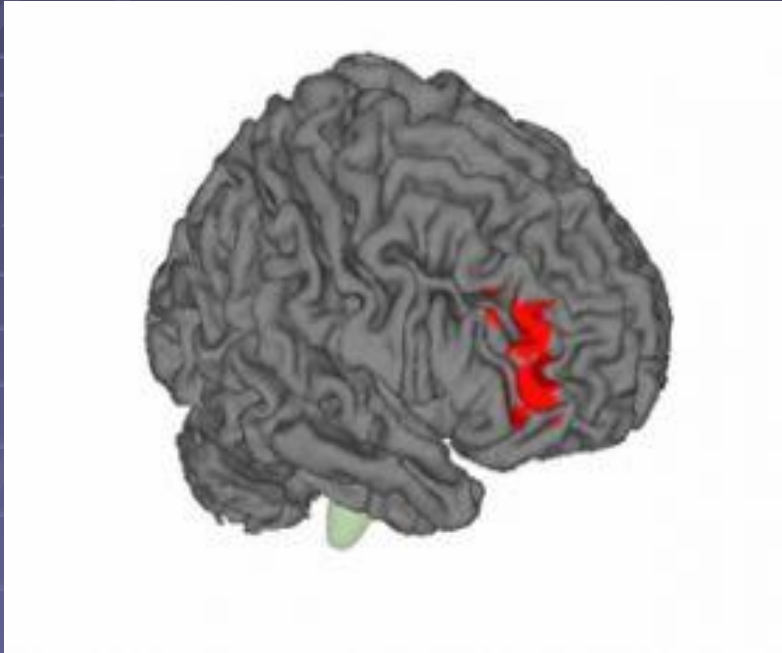
Cortical Re-Organization

- 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 Biofeedback 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, P.J., 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





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

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

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.

MPS Data Sharing Webinars

MANAGING PAIN SAFELY DATA SHARING WEBINARS



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:
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Thank You!

