Virginia Opioid Addiction ECHO* Clinic

November 16th, 2018

*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders

- Rename your ZOOM screen: Please rename your screen with your full name
  - For attendance, please type your full name and organization into the chat box

- All participants are Muted during the call, Please Unmute yourself before speaking. If you have a question, use the 'hand-raised' future in ZOOM or type your question in the Chat box.

- Speak to the Camera, avoid distractions and for ZOOM issues (such as echoing, audio level etc.), use the chat function to speak with the clinic IT team (Vlad)

VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in substance use disorder
- Website Link: www.vcuhealth.org/echo

VCU

Hub Introductions

VCU Team	
Clinical Director	Mishka Terplan, MD, MPH, FACOG, FASAM
Administrative Medical Director ECHO Hub and Principal Investigator	Vimal Mishra, MD, MMCi
Clinical Expert Program Manager Practice Administrator IT Support	Thokozeni Lipato, MD Lori Keyser-Marcus, PhD Bhakti Dave, MPH David Collins, MHA Vladimir Lavrentyev, MBA

Just for fun: What food are you most looking forward to on Thanksgiving?

Spoke(Participant) Introductions

- Name
- Organization
- Just for fun:
  - Which food are you most looking forward to on thanksgiving?

What to Expect

I. Didactic Presentation
    I. Dr. Lipato

II. Case presentations
    I. Case 1
        I. Case summary
        II. Clarifying questions
        III. Recommendations

    II. Case 2
        I. Case summary
        II. Clarifying questions
        III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Chronic Opioid Therapy in Patients with Substance Use Disorders

Thokozeni Lipato, MD
Assistant Professor, Internal Medicine
Virginia Commonwealth University School of Medicine

Disclosure Statement

I have no financial interest or affiliation concerning material discussed in this presentation

Objectives

- Identify criteria for Diagnosis of Opioid Use Disorder
- Name risk factors for addiction
- Develop strategies for treating chronic pain in SUD patients receiving COT

DSM – 5 Criteria for Diagnosis of Opioid Use Disorder

- ❑ Opioids often taken in larger amounts or for longer than intended
- ❑ Persistent desire or unsuccessful efforts to cut down or control opioid use
- ❑ Great deal of time spent obtaining, or using opioids, or recovering from its effects
- ❑ Craving, or a strong desire to use opioids
- ❑ Recurrent use results in failure to fulfill major role oblige
- ❑ Continued opioid use despite having persistent or recurrent social or interpersonal problems at work, school or home
- ❑ Important social, occupational or recreational activities are given up or reduced
- ❑ Recurrent opioid use in situations in which it is physically hazardous
- ❑ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids
- ❑ *Tolerance
- ❑ *Withdrawal (OWS or take medication to treat OWS

* These criteria [illegible] opioids solely under [illegible]

Prevalence of SUDs in chronic pain patients

- 21,685 enrollees in commercial insurance plans and 10,159 in Arkansas Medicaid
  - Possible misuse at 24% of COT recipients in the commercially insured sample and 20% in the Medicaid sample[1]

- A random sample of 705 chronic pain patients receiving COT in primary care and specialty pain treatment
  - 26% of those reported a current opioid use disorder and 36% had a life-time[2]

Syndrome of pain facilitation[4]

- Acute pain seems to decrease the euphorogenic (pleasurable) qualities of opioids

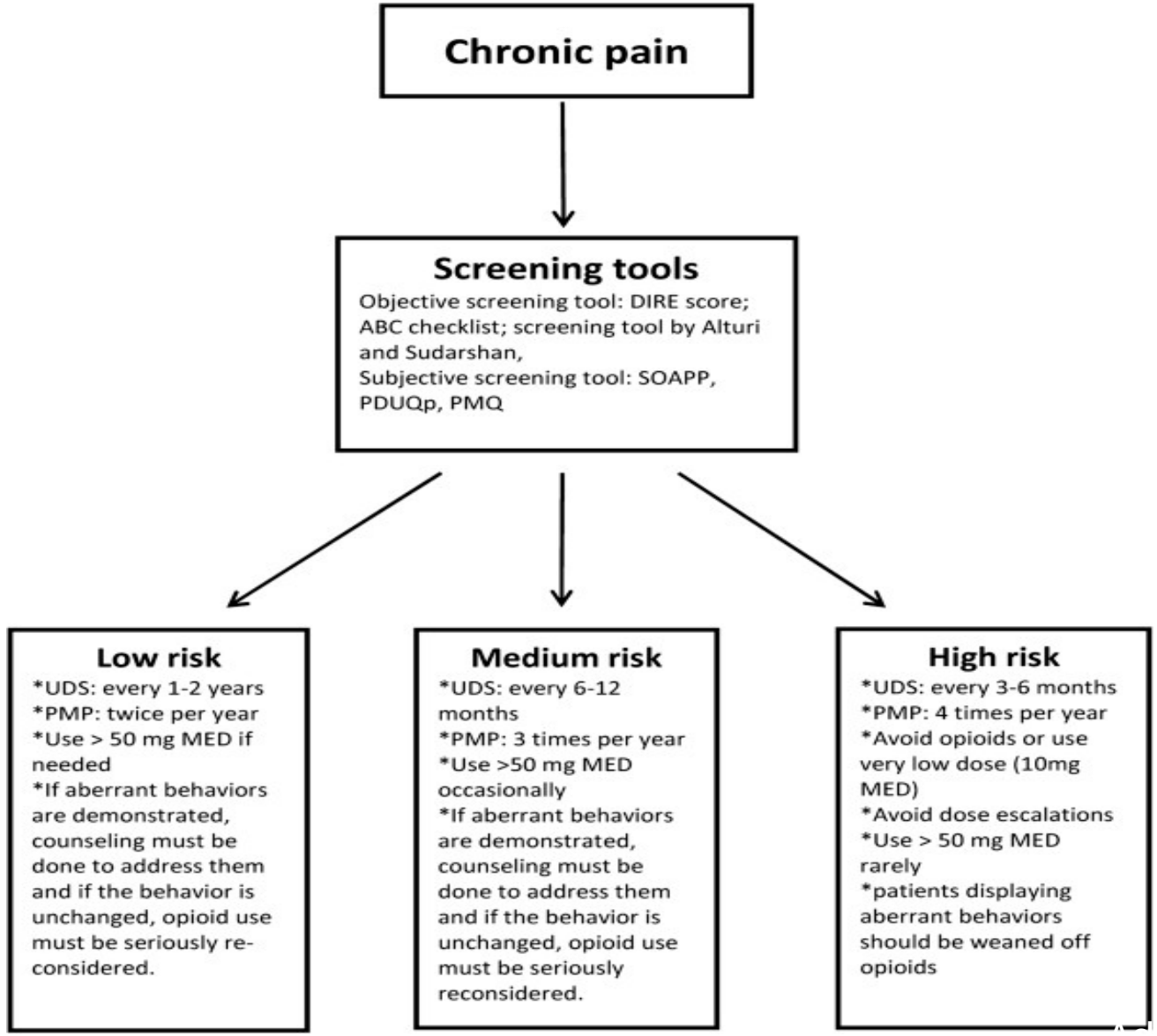
- Persons with addiction and pain have a “syndrome of pain facilitation”
  - Pain experience is worsened by consequences of addition
    - Withdrawal syndromes
    - Intoxication
    - Withdrawal-related sympathetic nervous system arousal
    - Sleep disturbances
    - Affective changes

Risk factors

- Prior history of opioid abuse
- Pain-related functional limitations/impairments (including sleep disturbances)
- Current cigarette smoking
- A family history of substance abuse
- A history of a mood disorder (e.g. post-traumatic disorder or depression)
- History of child sexual abuse or child neglect
- Involvement in the legal system
- Significant psychosocial stressors

Risk stratification and monitoring strategies

	SUBJECTIVE (Patient)	OBJECTIVE (Provider)
RISK ASSESSMENT TOOL (Opioid naïve)	1. Screener and Opioid Assessment for Patients with Pain (SOAPP) 2. SOAPP-Revised	1. Diagnosis, Intractability, Risk, Efficacy (DIRE) 2. Opioid Risk Tool (ORT)
ONGOING ASSESSMENT & MONITORING TOOLS	1. Pain Medication Questionnaire (PMQ) 2. Prescription Drug Use Questionnaire Self-Report (PDUQp)	1. Addiction Behaviors Checklist (ABC) 2. Current Opioid Misuse Measure (COMM) 3. Prescription Drug Use Questionnaire Self-Report (PDUQ)



Chang, Y. P., & Compton, P. (2013). Management of chronic pain with chronic opioid therapy in patients with substance use disorders. *Addiction science & clinical practice*, *8*(1), 21.

10 Steps of Universal Precautions[5]

1. Make a diagnosis with appropriate differential
   - Treat cause of pain
   - Treat comorbid conditions (substance abuse; mental illness)
2. Psychological assessment, including risk of addictive disorders
   - Personal & family history
   - UDS
3. Informed consent
   - Discuss proposed treatment plan, anticipated benefits and foreseeable risks
   - Patient education: dependency, tolerance, addiction

10 Steps of Universal Precautions[5]

4. Treatment agreement
    - Expectations and obligations of both the patient & practitioner
    - Adjuvant therapies (PT, psychology)

Informed consent & treatment agreement forms the basis of the therapeutic trial

- Explain the therapeutic trial
- Begin developing a treatment goal
    - Plan to titrate up if needed
    - What success is (duration of trial); what failure is
    - Reasons not to titrate, or to decrease/wean off (strategically)

10 Steps of Universal Precautions[5]

5. Pre- or post intervention assessment of pain level and function
   - The essence of Therapeutic Trial
   - PRE: Develop a goal (e.g. functional) >> TREAT >> POST: Was goal meet?
   - RAND 36 Item Health Survey
   - Quick Dash Questionnaire
   - Modified Oswestry Low Back Pain Disability Questionnaire
6. Appropriate trial of opioid therapy +/- adjunctive medication
7. Regular reassessment of pain score & level of function
   - Every 3-4 months

10 Steps of Universal Precautions[5]

8. Regularly assess the "4 A's"
    - Analgesia, activity, adverse effects, and **aberrant behaviors**
    - Taking an opioid n a manner that is not prescribed
        - Lack of understanding
        - External pressures
        - Chemical coping - use of opioids to cope with emotional distress
        - Pseudoaddiction (see below)
            - Physical tolerance
            - Opioid-resistant pain
            - Opioid-induced hyperalgesia
            - Progression of their pain generator or disease
        - Addiction
        - Diversion

10 Steps of Universal Precautions[5]

9. Periodically review pain diagnosis and comorbid conditions, including addiction
10. Documentation
    - Important for provider & patient
    - Reduce medicolegal exposure & risk of regulatory sanction

VA Regulations Governing Prescribing of Opioids

- A medical history & PE, to include a mental status examination, shall be performed and documented…
- Carefully consider and document reasons to exceed 50 MME/day
- Prior to exceeding 120 MME/day, the practitioner shall document reasonable justification for such doses.
- Document the rationale to continue opioid therapy every three months

VA Regulations Governing Prescribing of Opioids

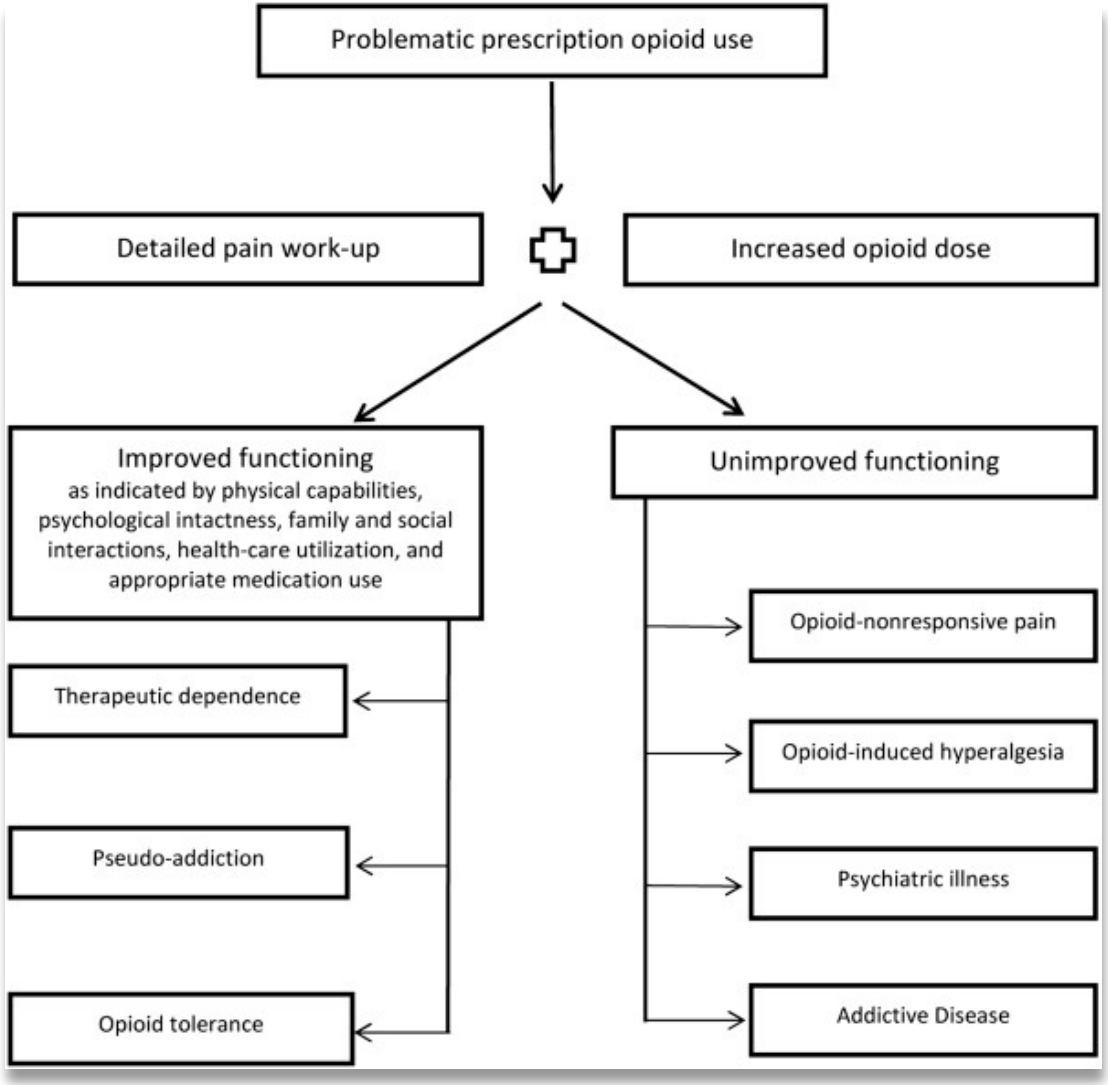
- The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities.
- The prescriber shall document the presence or absence of any indicators for medication misuse, abuse, or diversion and shall take appropriate action.
- The practitioner shall document informed consent, to include risks, benefits, and alternative approaches, prior to the initiation of opioids for chronic pain.

VA Regulations Governing Prescribing of Opioids

- Expected outcomes shall be documented… including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented…
- Continuation of treatment with opioids shall be supported by documentation of continued benefit from such prescribing

Identification of addiction in the chronic pain patient receiving COT

Decision tree for interpreting aberrant prescription opioid use behavior



Chang, Y. P., & Compton, P. (2013). Management of chronic pain with chronic opioid therapy in patients with substance use disorders. *Addiction science & clinical practice*, *8*(1), 21.

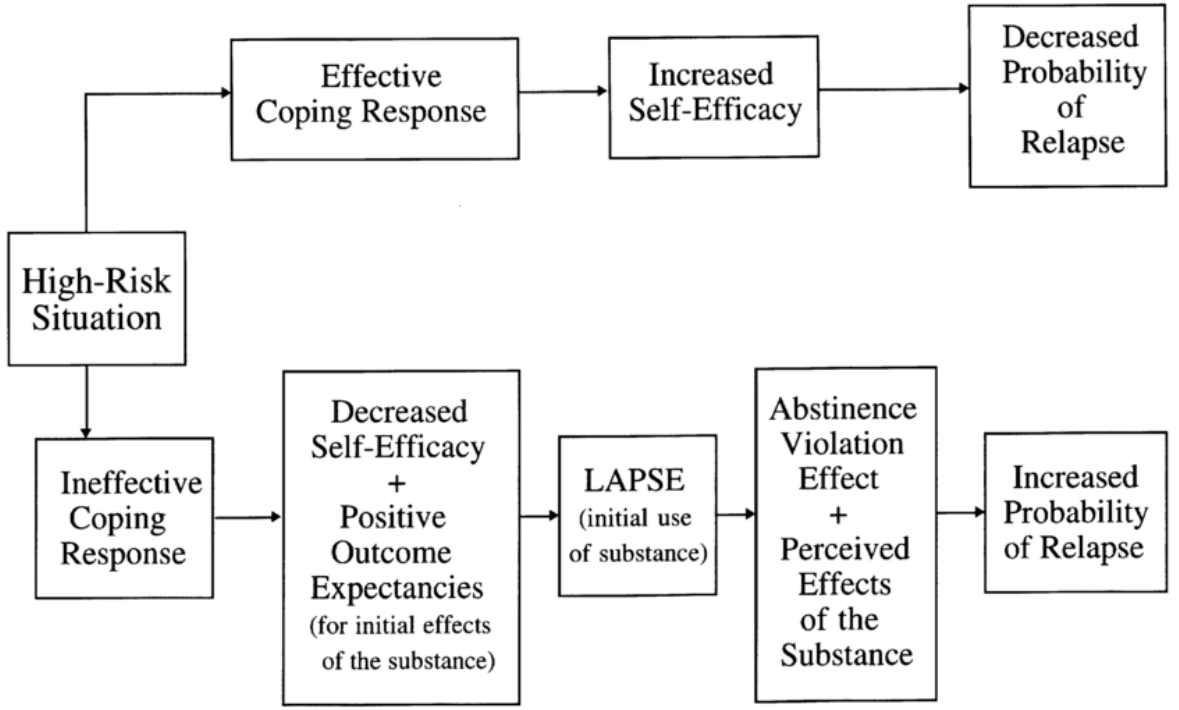
Treating chronic pain in SUD patients receiving COT

- Patients with chronic pain and active addiction are not candidates for COT
- Patients with addiction in remission: focus on relapse prevention

The cognitive – behavioral model of the relapse process

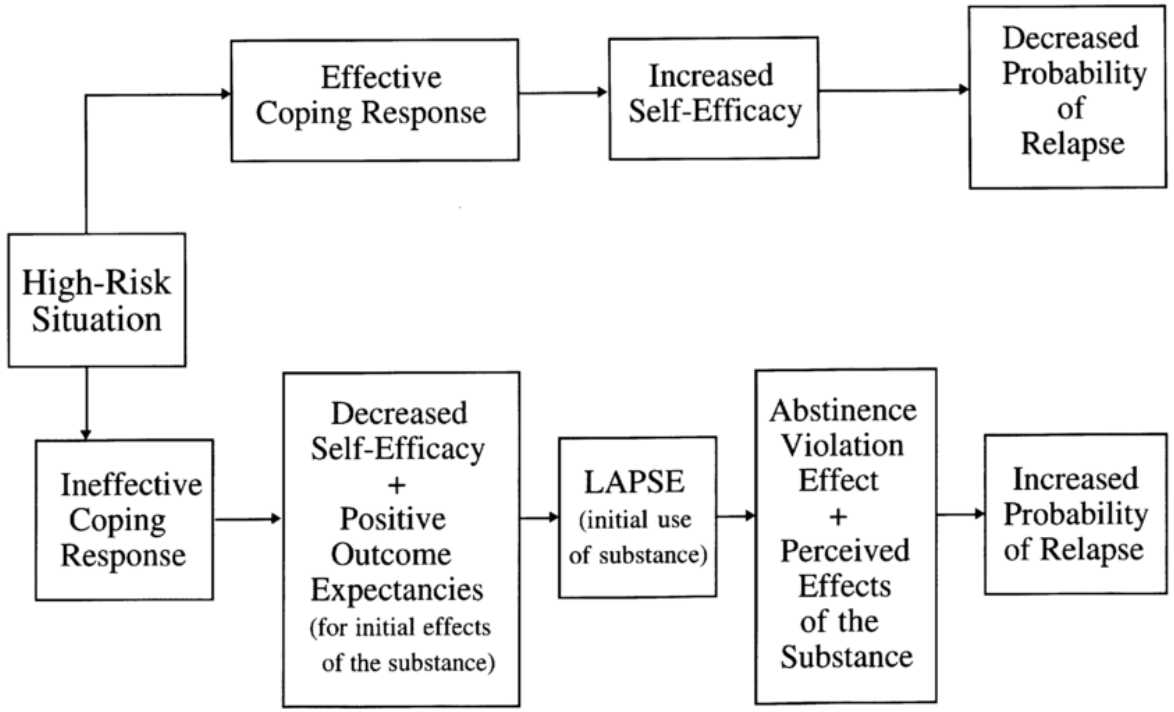
Management of chronic pain with chronic opioid therapy in patients with substance use disorders Addiction Science and Clinical Practice 2013; 8(1): 2

Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.



Coping response – response to high-risk situation

Self-efficacy – personal perception of the level of mastery over the specific high-risk situation



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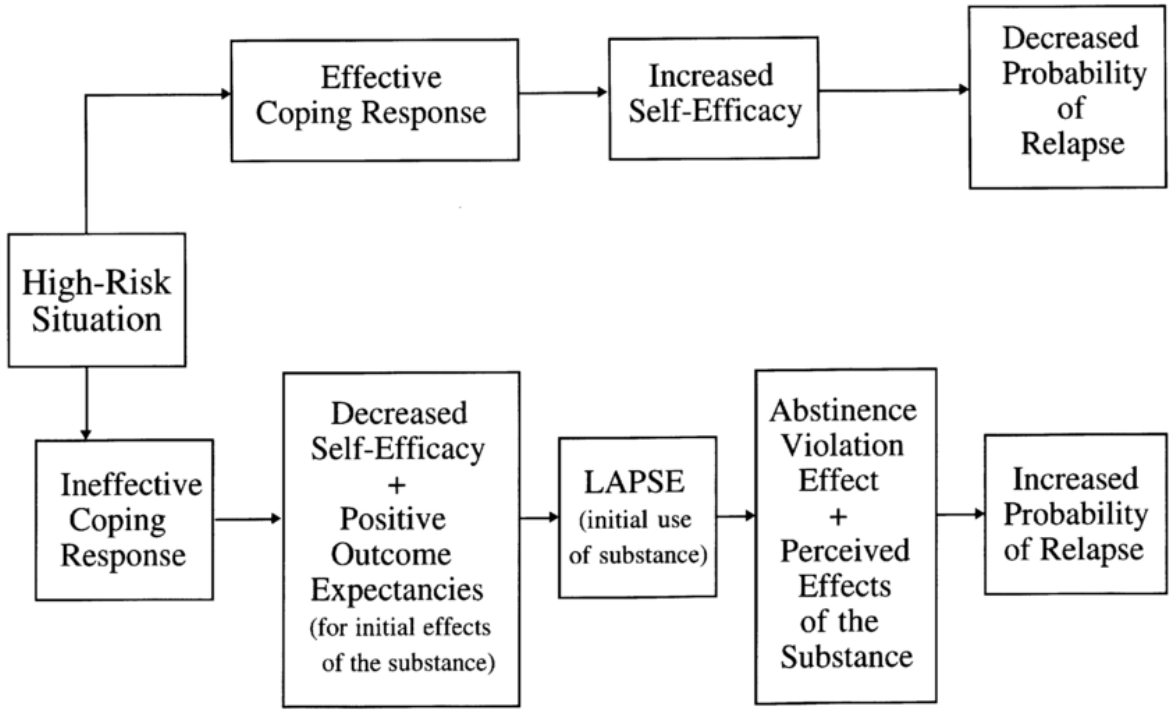
Positive outcome expectancies – anticipate only the immediate + effects of use



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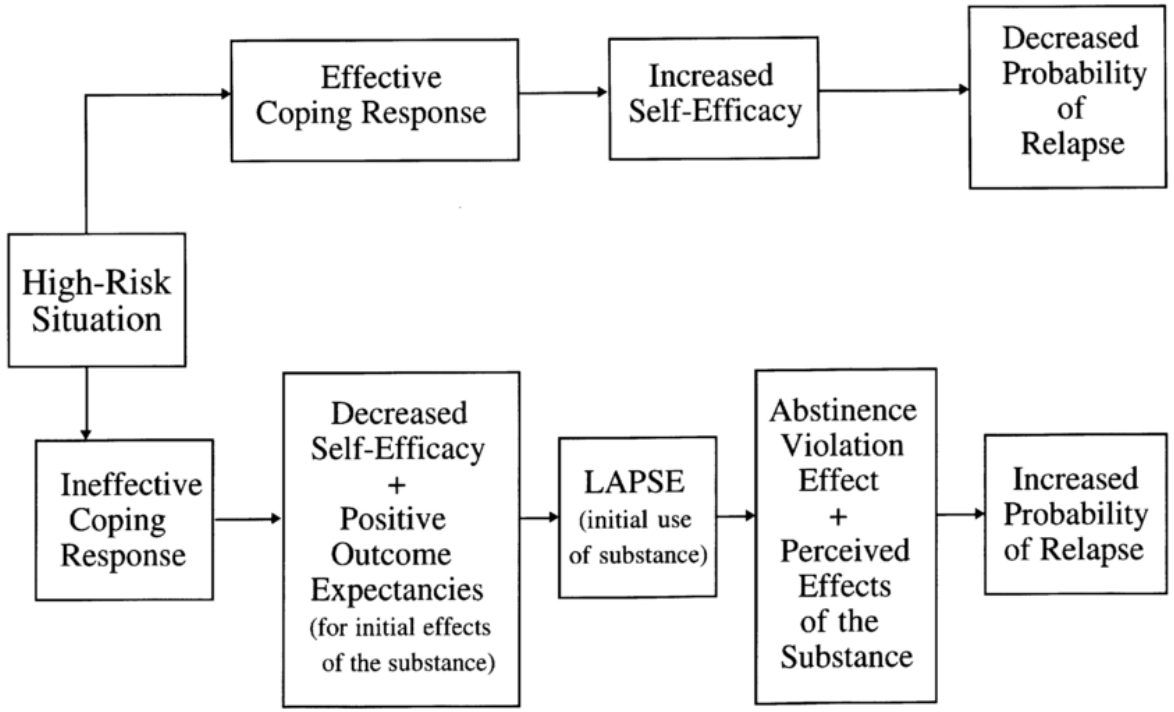
Abstinence violation reaction -

Focuses on emotions (guilt; failure)

Lack of willpower vs poor coping response



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Successful relapse prevention

1. Specific intervention techniques: enhance self-efficacy
   - Talk openly about relapse
   - Improve coping response – IDENTIFY HIGH-RISK SITUATIONS
   - Decrease positive outcome expectancy
   - Educate patient about Abstinence Violation Effect.

2. Global self-control approaches designed to reduce relapse risk by promoting positive lifestyle changes
   - Stress-reduction activities into their daily life, such as exercise or meditation

Management of lapse/relapse

- Informed consent & treatment plan
- Lapse vs relapse (7)
  - Lapse: a brief episode of opioid use
  - Relapse: the resumption of more extended and excessive opioid use involving the return of symptoms meeting diagnostic criteria for a substance use disorder
- Addiction: continuum marked by 3 broad zones of action & experience
  - 1) A stage of excessive, compulsive, and problematic opioid use
  - 2) A stage of recovery stability, and
  - 3) A transitional stage in which people pass back and forth between addiction and recovery

Management of lapse/relapse

- Following a lapse, a careful review of the lapse episode can be helpful
- Simply discharging patient from treatment is problematic
- VA regulations: The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated
- Maintain high levels of controls over opioid access
- Opioid detoxification should be gradual
- Initiate SUD treatment, or refer out

Management of lapse/relapse

- Informed consent & treatment plan
- Lapse vs relapse (7)
  - Lapse: a brief episode of opioid use
  - Relapse: the resumption of more extended and excessive opioid use involving the return of symptoms meeting diagnostic criteria for a substance use disorder
- Discharging the patient from pain treatment without providing addiction intervention is premature and is not patient-centered.
- VA regulations:The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated.
- Maintain high levels of controls over opioid access
- Opioid detoxification should be gradual

References

1. Risks for Possible and Probable Opioid Misuse Among Recipients of Chronic Opioid Therapy in Commercial and Medicaid Insurance Plans: the TROUP Study. Pain. 2010 Aug; 150 (2): 332 -9
2. Risk factors for drug dependence among out-patients on opioid therapy in a large US health-care system. Addiction. 2010 Oct; 105 (10): 1776 - 82
3. Management of chronic pain with chronic opioid therapy in patients with substance use disorders. Addition Science & Clinical Practice. 2013; 8(1): 21
4. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. Annals of Internal Medicine. 2006 Jan 17; 144 (2): 127 – 134.
5. Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain. Pain Medicine 2005. 6(2). 2005.
6. Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Research & Health. 1999; 23(2): 151 – 60.
7. Lapse and relapse: Is it time for a new language. www.facesandvoicesofrecovery.org.

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Questions?

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Case Presentation #1

- 12:35pm-12:55pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Case Presentation #1

Presenter: Dr. Van Zee

Requesting assistance with (check all that apply):

☒ Other

If Other please explain:

case example of buprenorphine in pain treatment

Please state your MAIN QUESTION for this patient case:

this case is presented to illustrate that buprenorphine, in selective clinical situations, can be an effective & compassionate tool for patients with history of opioid use disorder now living with severe chronic pain

Patient Case - Demographic Information

Age:

48

Sex:

⊗ Male

Current Living Situation

lives with family

Case Presentation #1

Presenter: Dr. Van Zee

Employed

⊗ Yes

Education/Literacy:

⊗ High School Degree/GED

Does patient have social support or any significant social history?

⊗ Yes

If Yes please explain:

has immediate family plus girl friend

Patient Strengths/Protective Factors

has prior history of opioid use disorder, IVDA, HCV, morbid obesity, DM-type II, and lumbar radiculopathy.---had disabling severe pain related to his lumbar radiculopathy. gabapentin helped his leg pain to modest extent, but continued severe disabling back pain. he adamantly did not want any pain pill exposure as he knew he would relapse.

Potential Barriers to Treatment

financial barriers. was initially not working when he came into treatment.---was able to get the Gap Medicaid insurance.

Any cultural factors that may have an impact on this patient's situation?

⊗ Yes

If Yes please explain:

---lives in region of widespread prescription opioid misuse

Case Presentation #1

Presenter: Dr. Van Zee

Any Substance Use history?

⊗ Yes

If Yes please explain:

Opioid use disorder, remote Hx IVDA, + HCV

Have any Behavioral Interventions been tried?

⊗ Yes

If Yes please explain:

relapse prevention & management of chronic pain discussion

Medication History

--initially tried on Suboxone films->> severe nausea & vomiting. changed to bup/naloxone tablets--->> severe N/V
--given in office trial of Bunavail-->> nausea, but not severe, no vomiting, and able to tolerate
---has been maintained on Bunavail 4.2/0.7--2 films daily since that time with good analgesic response,, with pain level decreasing from 8-9 level to a 1-2 level if sedentary, a 4-5 level if active. --multiple UDS before & after start of Bunavail---negative for illicit drug use

Any comorbidities?

⊗ Yes

If Yes please explain:

--as above, morbid obesity (419#, BMI =55.6), DM, type II, + HCV, hypertension

Any Medications Tried for Relapse Prevention?

⊗ Yes

If Yes please explain (Specify):

Bunavail

Case Presentation #1

Presenter: Dr. Van Zee

Any Labs (including urine) ?

⊗ Yes

If Yes please explain (as indicated):

negative for illicit drug use. A1C much better control. HCV + RNA

Is the patient involved in any Prescription Monitoring Program?

⊗ Yes

If Yes please explain pertinent findings:

Virginia PMP

Proposed Diagnoses

#1--opioid use disorder #2--Lumbar radiculopathy with severe chronic pain #3--Hx IVDA #4--Hep C
#5--DM, type II #6--Hypertension #7--Morbid obesity

Any Substance Abuse Treatment history?

⊗ Yes

If Yes please explain:

as above

Case Presentation #1

Presenter: Dr. Van Zee

Does the patient have goals for treatment?

⊗ Yes

If Yes please explain:

(1) attain adequate analgesia so he can have better functioning and continue to work (he was able to go to work driving a coal truck after Bunavail started and had better pain control)

Proposed Treatment Plan

(1) maintain Bunavail for treatment of severe chronic pain & opioid use disorder
(2) complete treatment for Hepatitis C---started through the UVA Telemed treatment project

REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.

By signing below, you have acknowledged that Project ECHO case consultations DO NOT create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

Case Presentation #2

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Case Presentation #2

Presenter: Dr. Lipato

Requesting assistance with (check all that apply):

☒ Other

If Other please explain:

Management of significant opioid dependency

Please state your MAIN QUESTION for this patient case:

Is there is a safe way to manage this patient with sickle cell disease and chronic pain secondary to avascular necrosis on opioids?

Patient has a diagnosis (sickle cell disease and avascular necrosis) for which opioids are an integral part of the treatment. He has been on HIGH dose chronic opioid therapy for many years (more than 7; total daily MME of 660). Over the years his UDS has been negative for opioids, making use concerned for diversion; however we now suspect overuse of his chronic opioids after taking him and his wife. Both admit to him running out early; over-sedation; and even what appear to be apneic episodes at night.

Patient Case - Demographic Information

Age:

44

Sex:

⊗ Male

Current Living Situation

Lives with wife

Case Presentation #2

Presenter: Dr. Lipato

Employed

⊗ Yes

Education/Literacy:

⊗ High School Degree/GED

Does patient have social support or any significant social history?

⊗ Yes

If Yes please explain:

He is married

Patient Strengths/Protective Factors

He is married and his wife is very supportive. She tries to manage his opioids but holding them for him.

Any cultural factors that may have an impact on this patient's situation?

⊗ No

Current Substance Use

Intermittent cocaine use
Smokes tobacco

Any Substance Use history?

⊗ Yes

If Yes please explain:

intermittent use of cocaine (7/2011; 9/2011; 12/2014; 03/2015; 10/2018)
one documented used of heroin (3/2015)

Case Presentation #2

Presenter: Dr. Lipato

Have any Behavioral Interventions been tried?

⊗ No

Medication History

1.Oxycodone 30mg, 240 tabs / day
2. Methadone 10mg, 300 tabs/ day. This is a decrease from 360 tabs/ day that he used to get dating back to 2011.
3. Used to be on a benzodiazepine. Not anymore.
4. Allergy to Gabapentin
5. Stopped using Tylenol and NSAIDS years ago.

Any comorbidities?

⊗ Yes

If Yes please explain:

Sickle cell disease; Hb SC disease

Avascular necrosis in hips and shoulder, s/p bilateral hip replacement and a unilateral shoulder replacement

Any Medications Tried for Relapse Prevention?

⊗ No

Any Labs (including urine) ?

⊗ Yes

If Yes please explain (as indicated):

UDS positive for cocaine -7/2011; 9/2011; 12/2014; 03/2015; 10/2018
UDS positive for heroin - 3/2015
Over the past years UDS has been negative and positive for oxycodone and methadone.

Case Presentation #2

Presenter: Dr. Lipato

Is the patient involved in any Prescription Monitoring Program?

⊗ Yes

If Yes please explain pertinent findings:

No recent history of multiple providers.

Proposed Diagnoses

1. Opioid dependency
2. Chronic pain from AVN
3. Opioid use disorder vs pseudoaddiction
4. Cocaine abuse

Any Substance Abuse Treatment history?

⊗ No

Does the patient have goals for treatment?

⊗ Yes

If Yes please explain:

1.Decrease pain so he can be more functional, but functional goals not set yet.
2. Has enough opioids so he won't has withdrawal.

Proposed Treatment Plan

1. Have him formally evaluated for an opioid use disorder.
2. Engage is some form of behavioral therapy, such as CBT for chronic pain, but also to address his cocaine use.
3. More frequent visit (every 2 weeks), more frequent UDS
4. Develop specific functional goals.

Not being proposed, but maybe should - wean off opioids and treat with an opioid replacement therapy (daily dose of methadone; suboxone)

REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.

Case Studies and Feedback

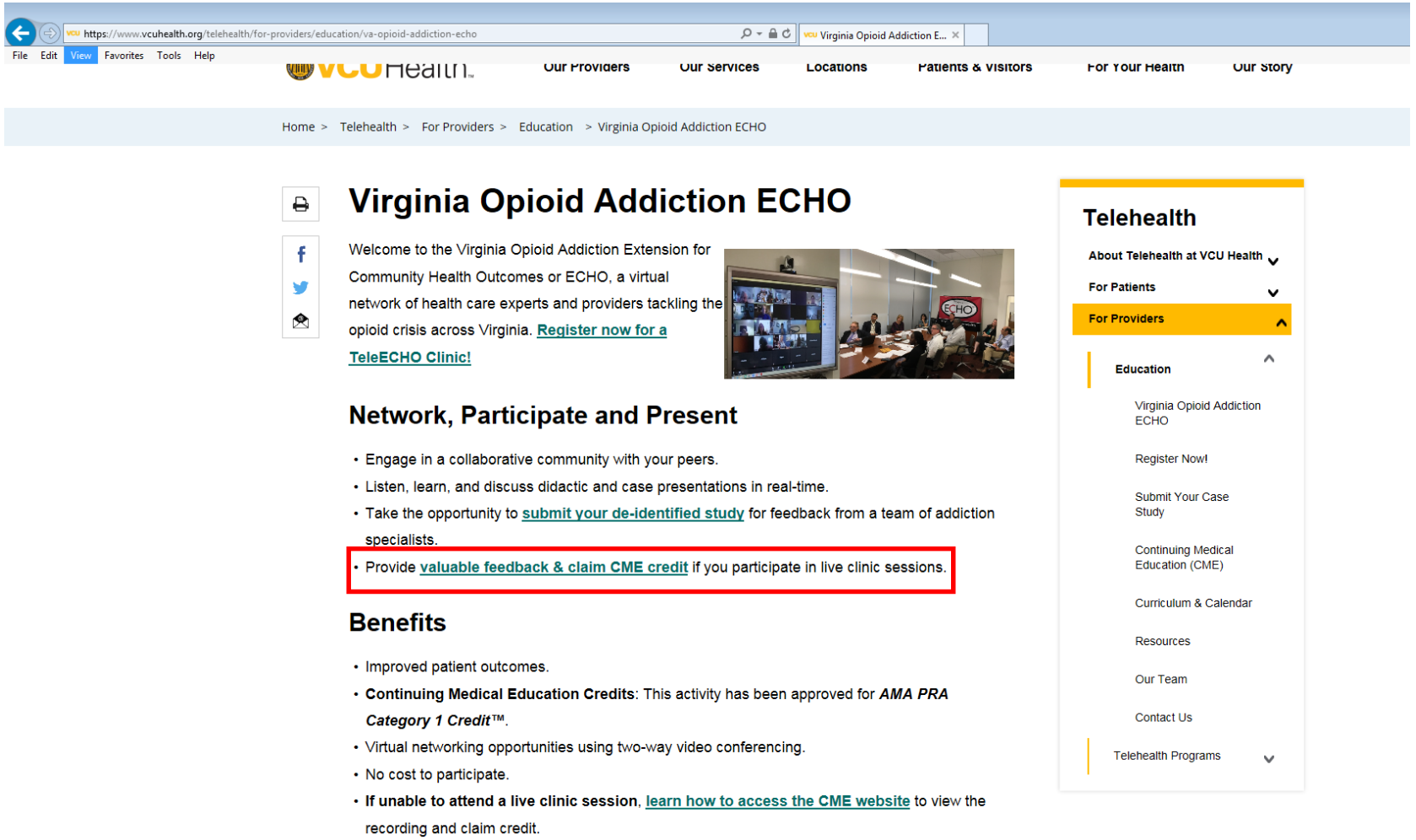
- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
- Opportunity to formally submit feedback
  - Survey: www.vcuhealth.org/echo
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo

  - To claim CME credit for today's session

Access Your Evaluation and Claim Your CME



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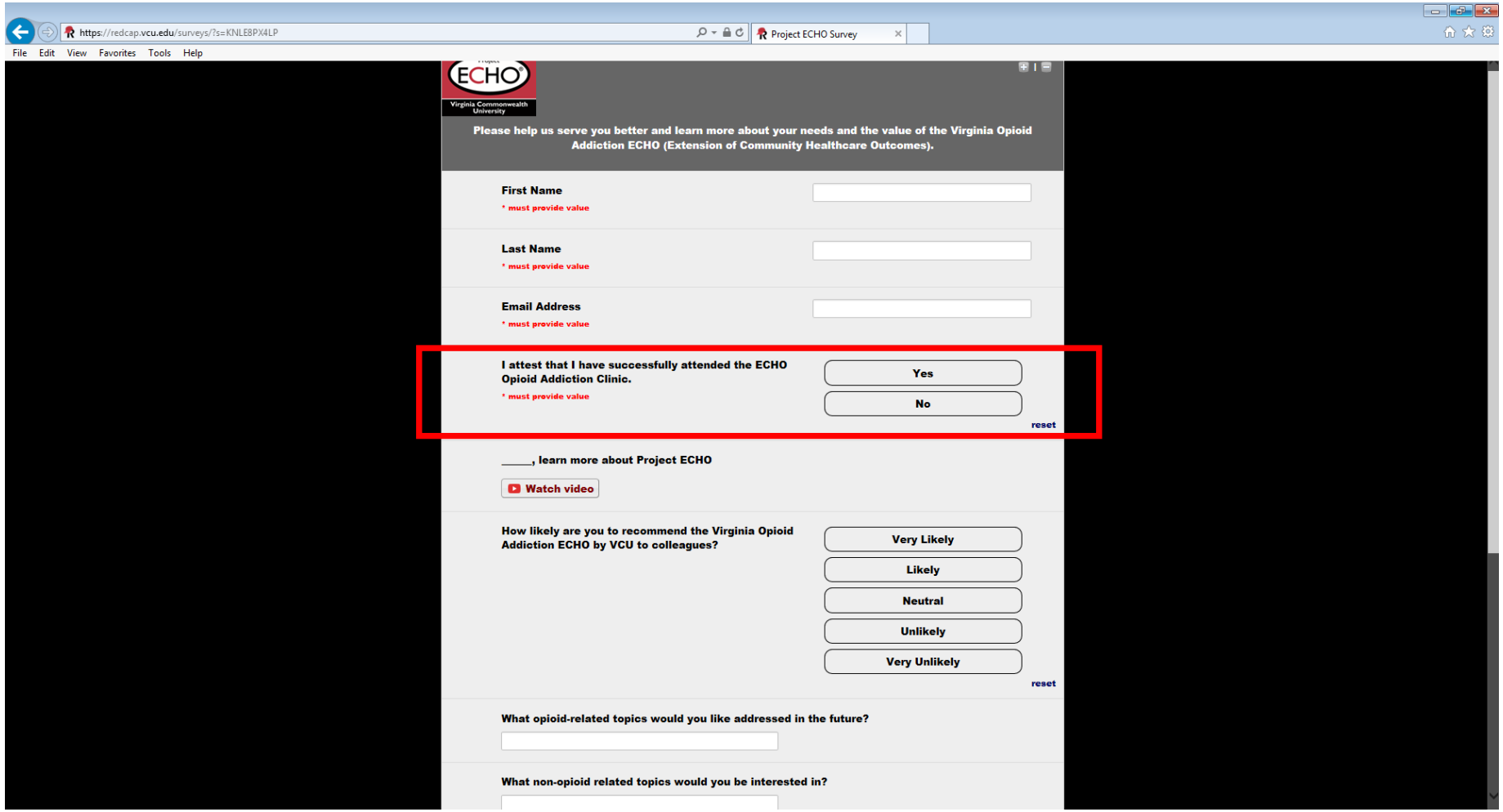
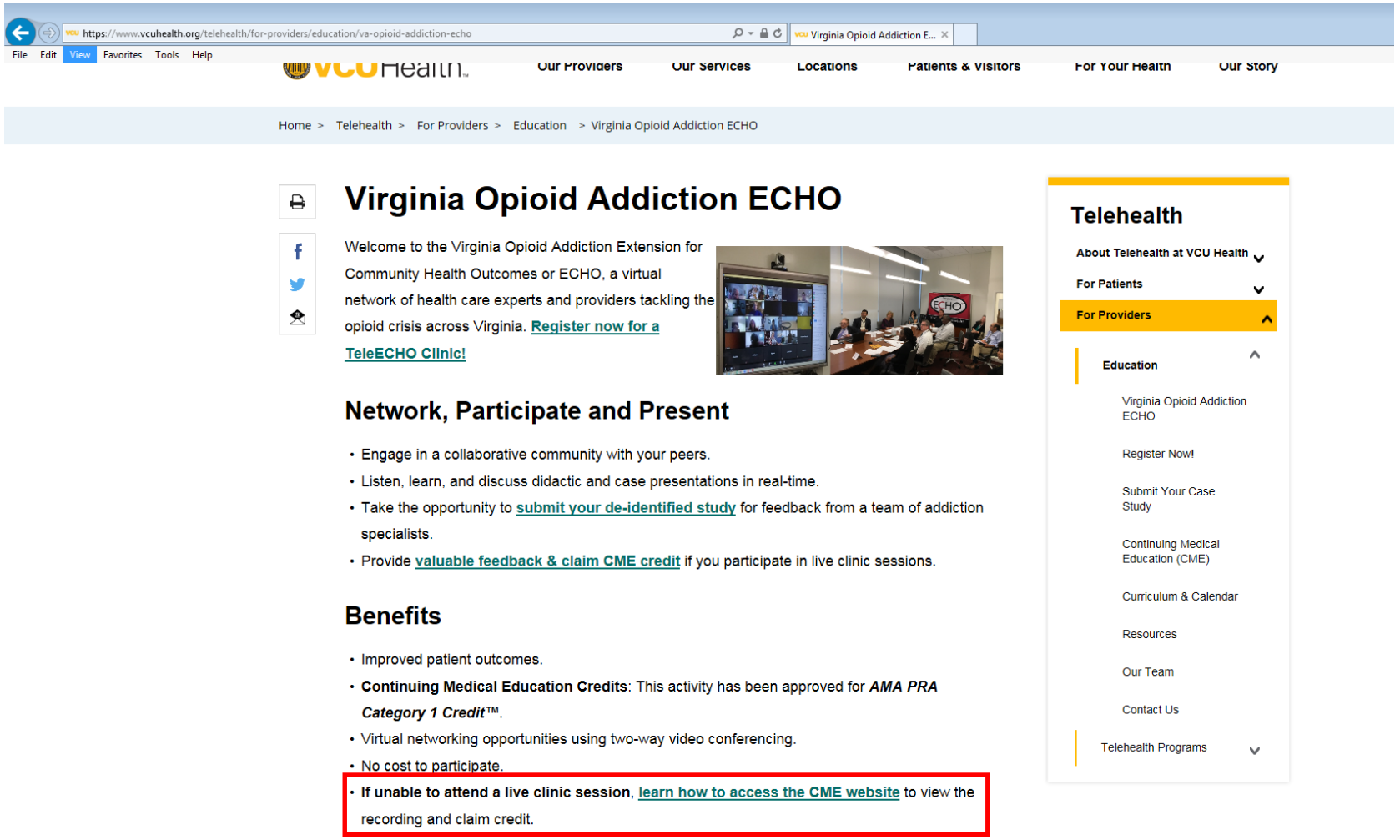


Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME



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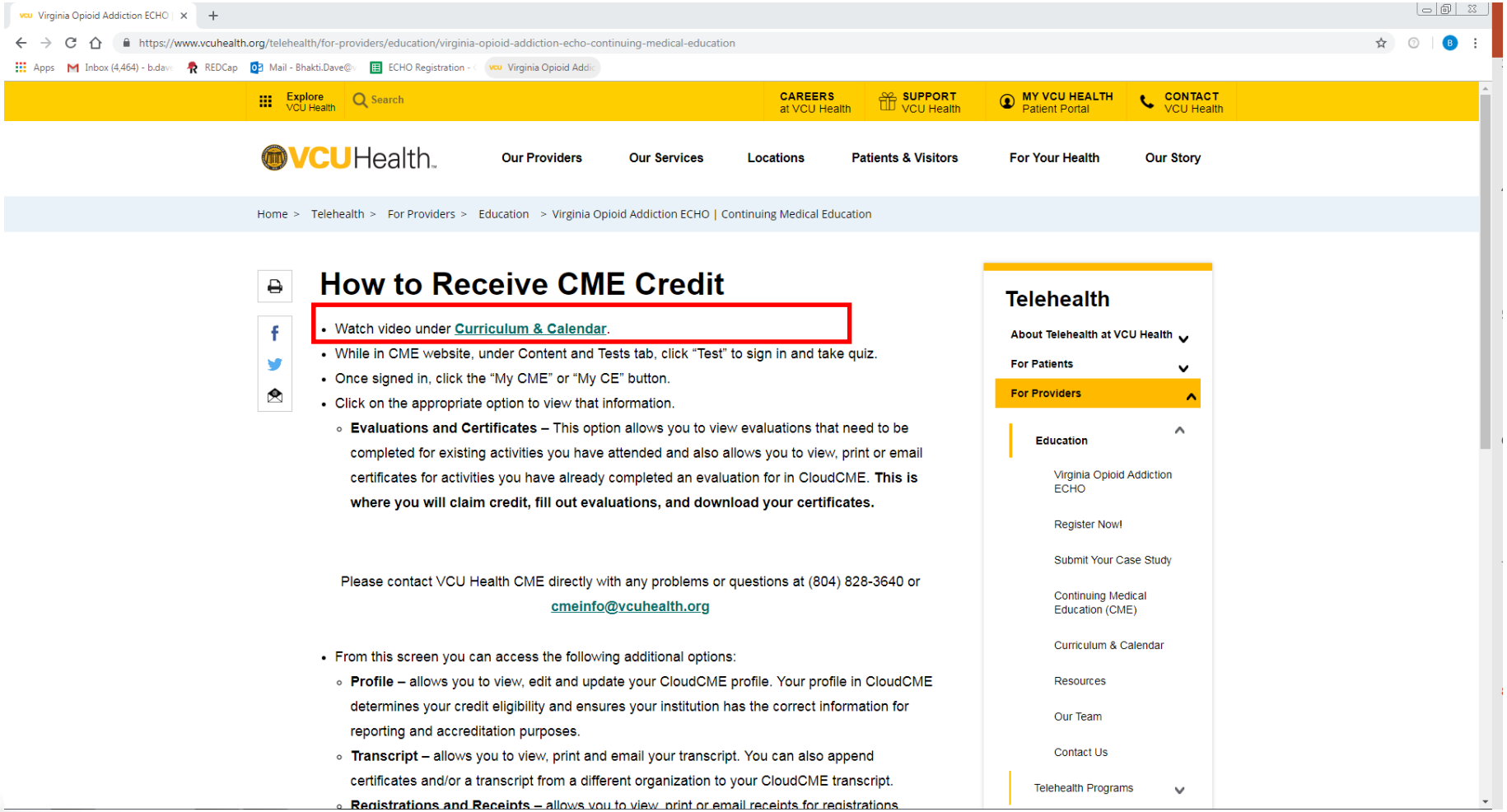

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

11/30	Office Based Opioid Treatment using the DMAS model	Ke'Shawn Harper, MIS
12/07	Pharmacotherapy for AUD	Megan Lemay, MD
01/04	Trauma Informed Care and Treating Those Experiencing Opioid Addiction	Courtney Holmes, PhD
01/18	Syringe Exchange	Mishka Terplan, MD

Please refer and register at vcuhealth.org/echo

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THANK YOU!

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Case Study #1 – Recommendations

Presented by Al Van Zee, MD

48 YO Male
Relapse prevention and management of chronic pain

- History of substance abuse
- Chronic back pain, occupation as truck driver
- Tried antiflammatory medication
- Has seen orthopedic
- Wants pain management, but reluctant to use traditional opioids
- Treated with Bunavail (combo of Buprenorphine and Naloxone), not traditional, but gave enough pain relief so that he could be functional

Spoke recommendations:

- None stated

Hub recommendations:

- Bunavail is not a traditional pain medication, but they do have analgesic effect
- Embeda which is morphine sulfate and naltrexone is a new morphine formulation that is FDA approved with an "abuse deterrent labeling". According to the manufacturer's literature the naltrexone is designed to reduce abuse via oral and intranasal routes when crushed; however, reduction abuse by IV route has not been proven yet; additional post-marketing data is pending.
- Important for patients to understand the medication
- Important for patients that it is provided for 2 reasons: To treat pain, and for relapse prevention

---

Case Study #2 – Recommendations

Presented by Thoko Lipato, MD

44 YO Male
Sickle cell patient

- Never formally diagnosed with SUD
    - High dose opioids, exhibiting aberrant behavior
    - However, has had several documented uses of cocaine and heroine
    - Intermittently positive and negative on opioid
        - Concern that patient might be diverting medications
- Is there a safe way to manage this patient with sickle cell disease, chronic pain, and significant opioid dependency
- Does he have OUD? Or pseudo-addiction?

Spoke recommendations:

- Most still consider diversion; also consider the possibility that medication is being used a family member (wife).
- Failure of opioid therapy?
    - Consider genetic testing to see if an ineffective opioid is being used.
- Change opioid regimen
    - Consider a pain pump
    - Change opioid rotation
- Tighter monitoring
    - Put on regimen of weekly toxicology screens
- Adjuvant therapy
    - Consider any psychiatric conditions not being addressed
- Other
    - Consider having spouse control medicines; however, this is not ideal.
    - Any role for an anti-depressant
    - Consider giving patient a purpose, and have him serve in his role as barber, to provide some emotional fulfillment

Hub recommendations:

- Regarding genetic testing, pharmacogenetics is not currently used in our clinic for pain management because we are not familiar with how to test, interpret, or apply this technology in our clinical practice; however, we should learn more about pharmacogenetics and see if we can use it clinically. Here is a recent article that is a good place to start learning from-
    - D. Agarwal, MA Udoji, A Trescot. Genetic Testing for Opioid Pain Management: A Primer. Pain Ther. 2017 Jun; 6(1): 93–105.