Substance Use Disorder Diagnosis, Management, Understanding, Caring

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POMA DISTRICT #4 MID-WINTER SYMPOSIUM

Disclosure

We have no actual or potential conflict of interest in relation to this program/presentation.

Addiction and the Brain
Overview of OUD Treatment & Outcomes

POMA District #4 Mid-Winter Symposium

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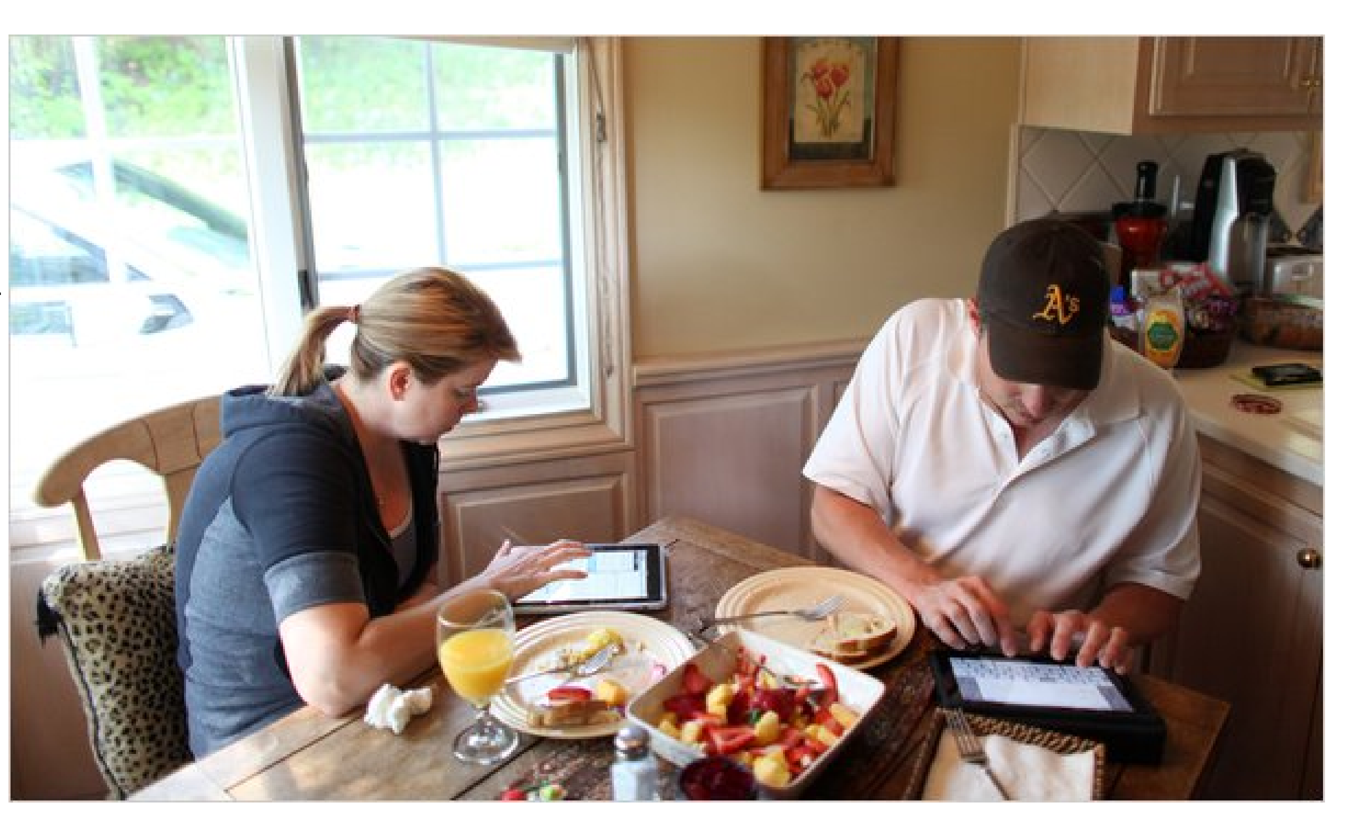
Substance-Related and Addictive Disorders

- ✓ Alcohol
- ✓ Caffeine
- ✓ Cannabis
- ✓ Hallucinogen
- ✓ Inhalant
- ✓ Opioid
- ✓ Sedative
- ✓ Stimulant
- ✓ Tobacco
- ✓ Gambling Disorder



THE BEHAVIORAL ADDICTIONS

1. Exercise
2. Food
3. Gambling
4. Internet Gaming
5. Internet Surfing
6. Kleptomania
7. Love
8. Sex
9. Shopping
10. Tanning
11. Texting & Emailing
12. Work

Ascher and Levounis, *The Behavioral Addictions,* APA Publishing, 2015.

Neurobiology of Addiction

The Fundamental Model

Biological

Psychological

Social

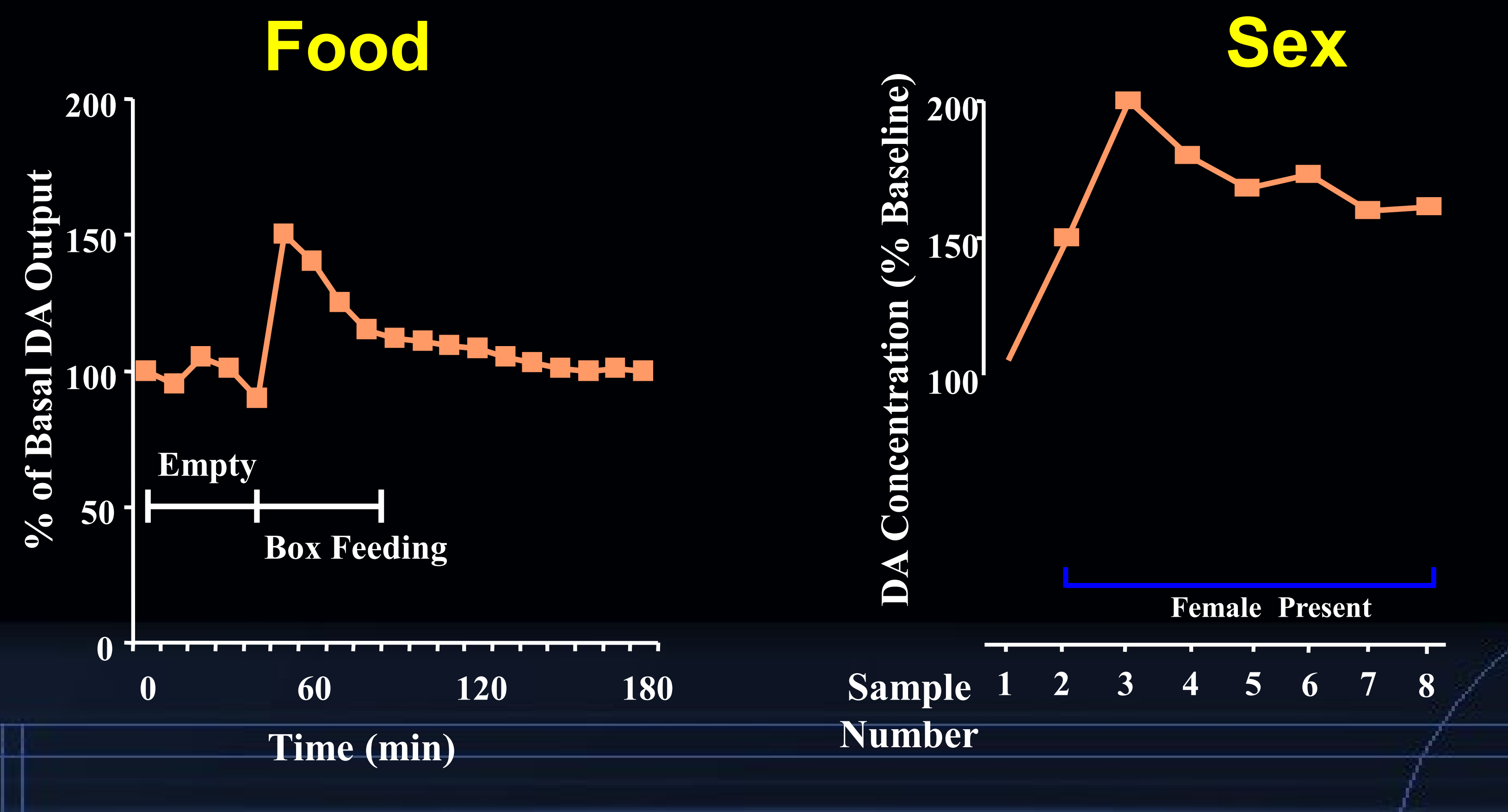
Use

Brain Switch

Addiction

Olsen and Levounis, *Sober Siblings*, 2008.

Natural Rewards and Dopamine Levels



Adapted from: Di Chiara, *Neuroscience*, 1999; Fiorino and Phillips, *J Neuroscience*, 1997.

Effects of Drugs on Dopamine Levels

MORPHINE

% of Basal Release

0, 100, 150, 200, 250

0, 1, 2, 3, 4, 5 hr

Dose mg/kg
0.5
1.0
2.5
10

COCAINE

% of Basal Release

0, 100, 200, 300, 400

0, 1, 2, 3, 4, 5 hr

NICOTINE

% of Basal Release

0, 100, 150, 200, 250

0, 1, 2, 3 hr

ETHANOL

% of Basal Release

0, 100, 150, 200, 250

0, 1, 2, 3, 4hr

Dose (g/kg ip)
0.25
0.5
1
2.5

Adapted from: Di Chiara and Imperato, *Proceedings of the National Academy of Sciences USA*, 1988; courtesy of Nora D Volkow, MD.

The Special Case of the Amphetamines

AMPHETAMINE

DA

% of Basal Release

1100
1000
900
800
700
600
500
400
300
200
100
0

0
1
2
3
4
5 hr

Adapted from: Di Chiara and Imperato, *Proceedings of the National Academy of Sciences USA*, 1988; courtesy of Nora D Volkow, MD.

Pleasure-Reward Pathways

movement
sensations
vision
judgement
reward
memory
coordination
NIDA
www.drugabuse.gov

National Institute on Drug Abuse, DrugAbuse.gov.

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Dopamine Pathways

Serotonin Pathways

Frontal cortex

Striatum

Substantia nigra

Functions
- Reward (motivation)
- Pleasure, euphoria
- Motor function (fine-tuning)
- Compulsion
- Perseveration

VTA

Nucleus accumbens

Hippocampus

Raphe nucleus

- Functions
- Mood
- Memory processing
- Sleep
- Cognition

NIDA

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The DSM-5

	PHYSIOLOGY
The	**Tolerance**
Wise	**Withdrawal**
	THE CORE PROBLEM OF SUBSTANCE USE
Know:	**Knowledge** of adverse consequences, yet continued use
	INTERNAL PREOCCUPATION
Decline	**Desire** to cut down
Tender	**Time**—a great deal of time—spent using
Loving	**Larger** amounts or longer periods of use than intended
Care,	**Craving**
	EXTERNAL CONSEQUENCES
And	**Activities** given up
Respect	**Role** obligations neglected
Silver	**Social** or interpersonal problems
Hair.	**Hazardous** use

Levounis, *Academic Psychiatry*, 2015.

Assessment of individuals with an OUD

- **In Short Use:**
  - **DSM 5**
  - **The 6 Tips**
  - **Lab Studies**

SIX TIPS FOR RECOGNIZING ADDICTION

1. Moody
2. Changes in Sleep
3. Changes in Appearance
4. Work Performance
5. Financial Difficulties
6. Abusive Behavior

Treatment of Addiction

Opioid Use Disorder (OUD) Issues

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Psychiatric Issues and Co-occurring Disorders

- What are the integrated medical, mental health, and social needs of a patient?
  - Mental Health Needs often include depression, chronic anxiety, panic disorder, Bipolar Disorder and trauma of all types including PTSD. For those with OUD, OCD is common as is suicidal ideation and risk. ADHD is often claimed
  - Please avoid treating these disorders with Rx approach that leads to cross addiction (e.g. benzodiazepines or stimulants)
- Social Needs
  - ***Homelessness***

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Common Concerns

- Use/Abuse of Benzodiazepines
- Distinguishing anxiety from withdrawal
  - Withdrawal, though time limited (unlike anxiety) can easily last 30 days at a lesser level. It's more likely to elevate vital signs.
  - It's possible to have both anxiety and withdrawal symptoms
- What types of therapies vs Rx need be initiated?
- Is everybody with OUD/SUD invariably anxious?
- Too many patients present on combination of Buprenorphine (Suboxone), alprazolam (Xanax) and mixed amphetamine salts (Adderall)

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Medication Assisted Treatment (MAT)

- Medication Assisted Treatment
  - Buprenorphine (Suboxone™)
  - Methadone
  - Naltrexone (Vivitrol™)

- Adherence to MAT (methadone or buprenorphine) is associated with:
  - Reduction in nonmedical opioid use[2]
  - Reduced incidence of HIV and Hepatitis C[1,3,4]
  - Mortality reduction of up to 50%[4]
  - Reduction in crime and improved social functioning[4]
  - Correction of neurobiological dysfunction that leads to relapse[1]
  - 42% overall annual reduction in healthcare costs[5]

Adjusted post-period means.

	Buprenorphine Non-Adherent		Buprenorphine Adherent		p^1
	$n = 309$		$n = 146$		
	Mean	Std. Err.	Mean	Std. Err.	
Service Utilization					
Prescription Fills	25.8	1.0	32.8	1.4	<0.001
Outpatient Visits	30.1	1.8	27.3	2.3	0.264
Inpatient Hospital Admissions	1.41	0.20	0.52	0.26	<0.001
Inpatient Days	10.0	0.8	3.7	1.1	<0.001
ER Visits	1.61	0.17	0.78	0.22	<0.001
Charges					
Pharmacy Charges	$3,581	$205	$6,156	$269	<0.001
Outpatient Charges	$14,570	$1,430	$9,288	$1,871	0.011
Inpatient Hospital Charges	$26,470	$3,163	$10,982	$4,142	<0.001
ER Charges	$4,439	$547	$1,891	$717	<0.001
Total Medical Charges	$45,381	$4,047	$22,409	$5,298	<0.001
Total Healthcare Charges	$49,051	$4,108	$28,458	$5,376	0.001

Covariates appearing in model include gender, region of residence, age, Charlson Comorbidity index, and the pre-period value.

[1] Analysis of covariance was used to assess significant group differences.

Disparity in Access to Medication Treatment

- Nationwide, 56% of rural counties lack a buprenorphine provider[1]
- 30% of rural Americans live in a county without a buprenorphine provider[1]
- <40% of patients with OUD receive medication treatment[2]
- <4% of physicians have an x-waiver[2]
  – Most are not treating at capacity[3]

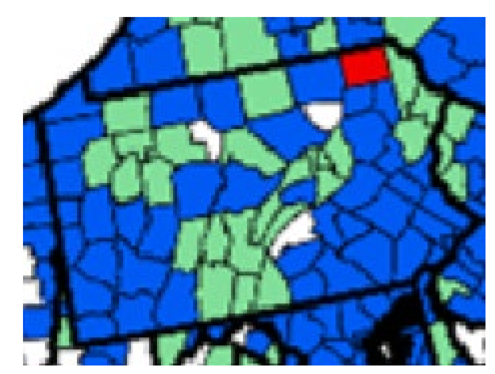
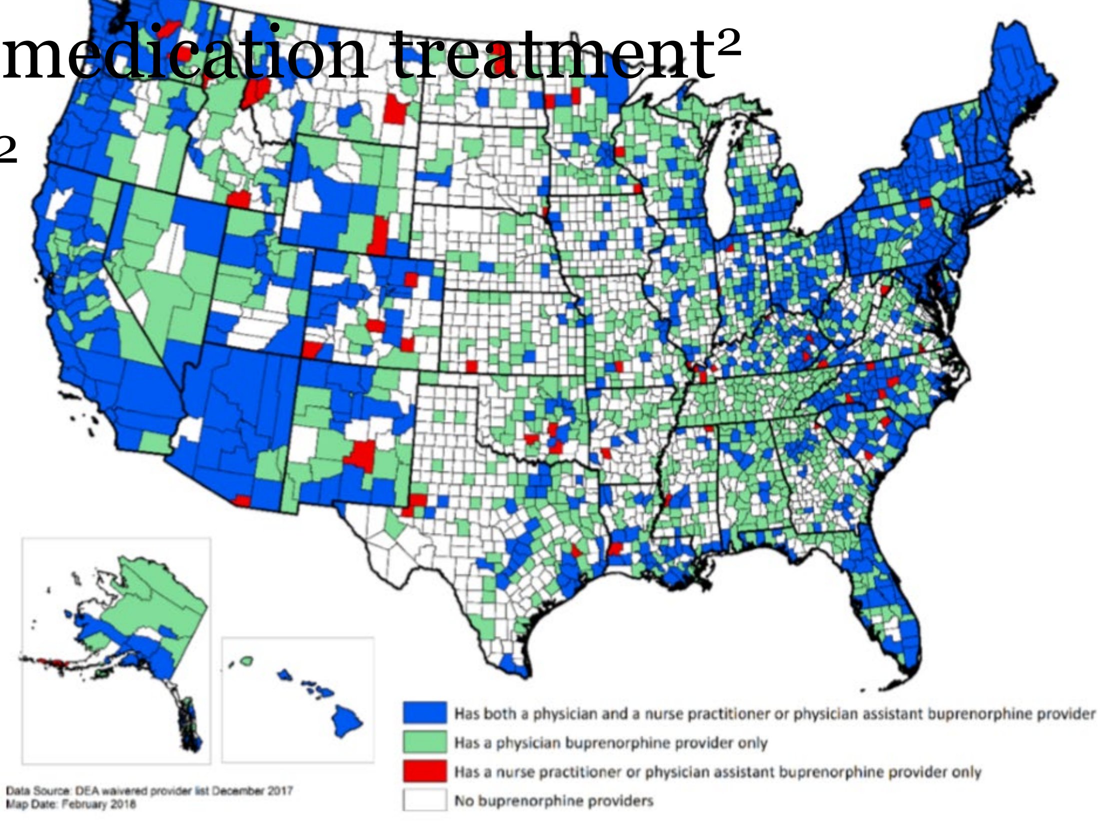


Figure 1 US Counties With Providers With a DEA Waiver to Prescribe Buprenorphine.



Recommendations for Initiation of Medication Assisted Treatment for Individuals with an Opioid Use Disorder (OUD)

interrelated elements for treating individuals with an OUD:

1. Assessment 2. Medication triage 3. Stepped or level of care.

Three Versions of MAT for OUD

Methadone	• Opioid Agonist Therapy • Most effective of the 3
Buprenorphine	• Opioid Agonist Therapy • Safer with its ceiling effect • Ease of office-based model
Extended release naltrexone	• Opioid Antagonist Therapy • Used in relapse prevention & cannot be used with Methadone or buprenorphine

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Medication Triage - Decision Tree

Treatment consideration	Methadone	Buprenorphine	Intra-muscular naltrexone
Duration of OUD	>5 years	> 2 years	< 2 years
Form of Opioids used	I V heroin, crushing & combining medications in a needle, or extensive exposure to fentanyl	IV heroin or prescription medications	Mostly prescription medications taken orally and at lower doses
Overdose history	Multiple overdoses	Recent overdose or multiple overdoses	No history of overdose
Ability to abstain for brief periods in outpatient setting	Rapid relapse; no ability to abstain in OP setting	Rapid relapse; minimal ability to abstain in OP setting for more than a few days	Able to abstain in OP setting for 7 to 10 days – abstaining in residential tx or jail should not be counted
Prior abstinence-based treatment	Multiple episodes of residential & detoxification treatments	One or more treatment episodes	No history of treatment or first treatment episode
Prior MAT treatment	Failed on buprenorphine or naltrexone	Failed on naltrexone, cannot access an OTP, or successfully managed on methadone for 24 months (step down)	No history of MAT or successfully managed on buprenorphine for 24 months (step down)
Social supports & recovery capital	Inadequate psychosocial or recovery supports, unemployed	Employed, moderately good social supports	Strong social support & recovery capital
Chronic pain	High levels of pain	High levels of pain	Low levels of pain
Co-occurring mental illness	Multiple diagnoses and active symptoms	Multiple diagnoses and active symptoms	no co-occurring MI conditions or stabilized
Diversion risk	High risk – increase counseling, eliminate take home privileges, and use weekly UA testing	High risk – offer sublocade or daily dosing, provide weekly UA testing	NA – no diversion risk associated with IM naltrexone

Medication management

Medication	Day 1	Days 2 to 6	Days 7 to 10	Days 11 & beyond
Extended release naltrexone – IM injection for 28 days	Injection can be given within 7 to 10 days of the person's last use of opioids; a low dose of oral naltrexone can be initiated sooner or as an adjunct to the IM injection			
Buprenorphine – oral formulations (for patients in withdrawal)	Initiate with 2 mgs; provide 2nd 2 mg in two hours – can provide an additional 2 to 4 mg for take home – maximum 8 mgs daily dosage	2 mg to 8 mg on 2nd day – maximum dose is 16 mg by 2nd day	An additional 2 to 4mg can be added over the next two weeks, though clinical effective dosages for non-pregnant patients will be between 8 and 20 mg, based on the type of formulation used	
Buprenorphine – oral formulations (for patients without opioids in their bloodstream)	1 mg on first day	1 mg increase in first week	Increase by 1mg every week to achieve a 4mg daily dosage – can increase by 1 mg overtime, if urges to use persist to a daily dose of 6mg	
Buprenorphine – IM injection for 30 days	Initiate oral buprenorphine protocol for 3 to 5 days – injection can be provided once tolerance for buprenorphine is determined		Dosage levels do not changed over time – repeat IM injection every 30 days, though monitor for urges to use	
Methadone (for patients in withdrawal)	Initiate between 10 to 30 mg on first day, at do not exceed 30 mg in first day	Maintain or increase daily dose to 30 mg for first 2 to 5 days, add 5 mg for severe withdrawal symptoms	Increase by 5 mg every 3 to 5 days, to reduce withdrawal symptoms, while avoiding sedation – goal is between 60 and 120 mgs daily dosage	
Methadone (for patients without opioids in their bloodstream)	Initiate 5 mgs on first day	Increase dosage by 5 mgs every week, to reduce withdrawal symptoms, while avoiding sedation		

MAT vs Traditional D&A Treatment

- The following slide highlights the challenges of treating individuals with an OUD based on SAMHSA national TEDS data set (2015)

  - ✓ Individuals with an OUD are less likely to complete any level of treatment, including detoxification, residential (short & long-term) or outpatient treatments compared to all other SUDs, and

  - ✓ Individuals with OUD tend to withdraw from treatment at higher rates than those with all other SUDs. This increases mortality rates

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Completion Rates from D&A Treatment

completion rates by primary drug

60%
50%
40%
30%
20%
10%
0%

alcohol stimulants marijuana cocaine opiates

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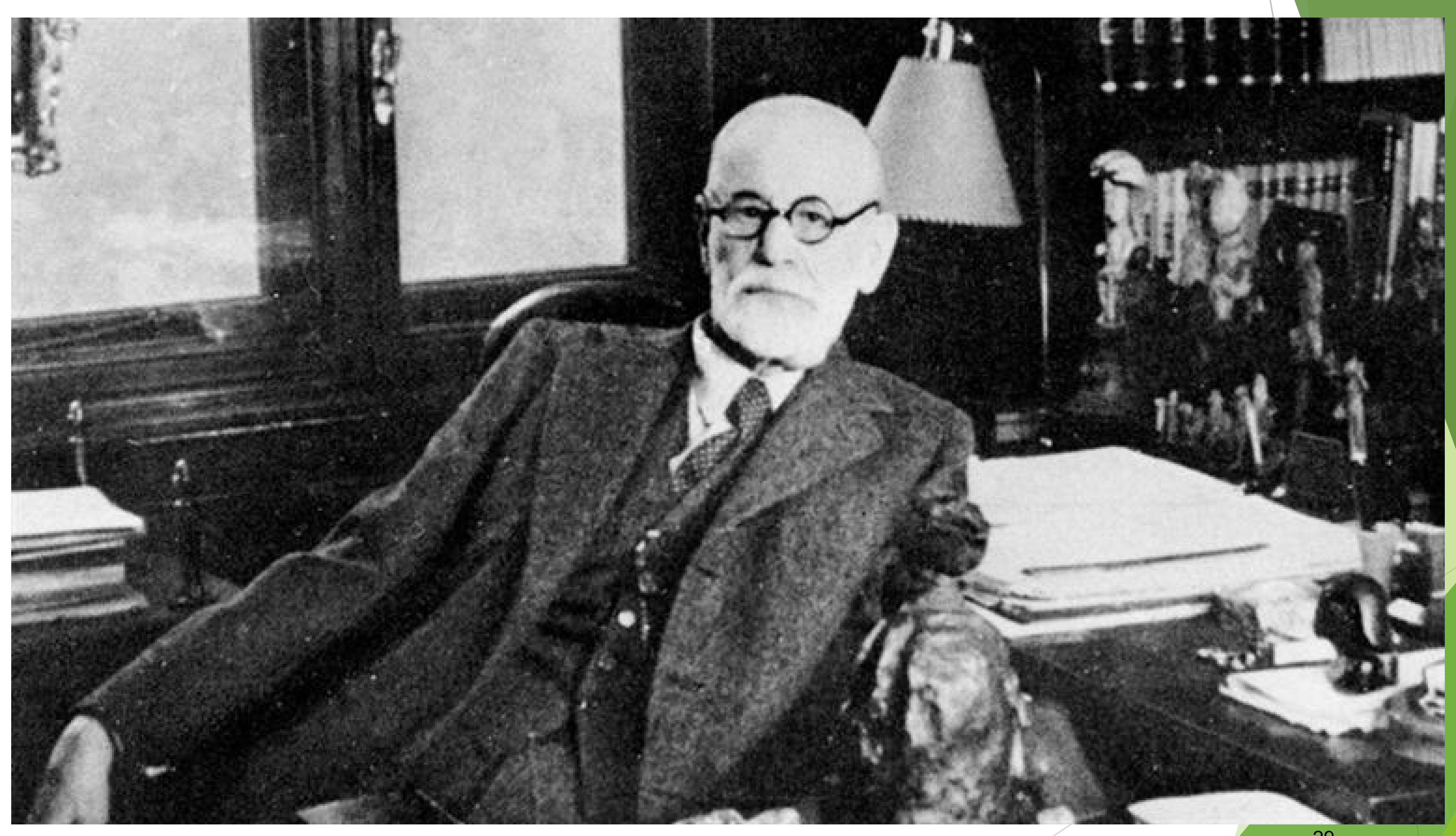
Structure & oversight (S&O).

- 1. frequency of dosing for the agonist medications
- 2. frequency of urine analyses that are collected from the individual
- 3. frequency of checks with the PDMP
- 4. Level of take-home privileges
- 5. The frequency of anti-diversion procedures for monitoring the risk of storing, selling or sharing agonist

Psychosocial Treatments

The Old Wave: Psychoanalysis



Levounis, *Journal of Medical Toxicology*, 2016.

The Current Approach

1. Mutual Help Groups (12 -step/SmartRecovery.Org)
2. Psychotherapy (CBT, MI and Mindfulness)
3. Medications (MAT)
4. Family Therapy
5. Primary Care Services
6. Mental Health Services
7. ROSC – during all levels of care and Aftercare

Engagement – My Views

- Engagement is similar to Therapeutic Alliance
- It’s easy to burn out or have compassion fatigue when we see the same patient 5+ times have relapses or need Narcan
  - This can be related to addiction’s (as a disease) intensity
  - This can be an outcome of ineffective treatment, e.g. MAT wasn’t utilized or utilized in a timely manner (instead of blaming it on the patient’s bad character)
- Try to remember addiction affects our families and our neighbors
- Our Words Matter!

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Misperceptions and misused language of addiction

- Dr. Richard Saitz, Boston University of Public Health

Words that matter--Summary

Use
- Alcohol, drug use disorder
  - Addiction
  - Person with/who...
- (Agonist) treatment
- Positive/negative (test)
- Unhealthy
- At-risk, risky, hazardous
- Heavy use, episode
- (Return to) use
- Low risk

Avoid
- Abuse, abuser, user, addict, alcoholic
- Substitution, replacement
- Clean, dirty
- Misuse*
- Relapse
- Binge*
- Dependence*
- Problem
- Inappropriate

*define to avoid confusion. Misuse may be ok for Rx drug...
Taking a birth control pill to relieve a headache is misuse
"medication" vs. "drug"

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The language we use

- Contributes to stigma
  - Affects policy
  - Affects care
- Substance use disorders are health conditions
  - There is a spectrum of use and consequences and the distinctions matter
- Consensus is emerging around accurate non-stigmatizing terminology
  - Botticelli MP, Koh HK. Changing the Language of Addiction. *JAMA*. 2016;316(13):1361–1362. doi:10.1001/jama.2016.11874Calver KE,
  - Saitz R. Substance Use Terminology. *JAMA*. 2017;317(7):768–769. doi:10.1001/jama.2016.20469

Suggested terms

Journal of Addiction Medicine

- Person-first language
  - Not addict, alcoholic, drunk but person with…
- Avoid "abuse," "abuser"
  - usually "use" is more accurate (unless referring to DSM dx)
- The disease: substance use disorder (DSM), addiction, other diagnostic terms (ICD dependence, harmful)
- Drug versus medication
- Generally avoid misuse (when disorder is meant; except for prescription?), problem, binge, inappropriate, moderate
  - Use low risk, at risk, risky, hazardous, unhealthy (spectrum)

http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2014/08/01/terminology-related-to-the-spectrum-of-unhealthy-substance-use

Saitz R. Things that Work, Things that Don't Work, and Things that Matter—Including Words J Addict Med 2015;9:429-30.

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Summary or Take Home Messages

- Opioid Dependency treatment is most effective when combined with MAT
- Benzodiazepines need to be replaced with non-addictive anxiety reducing approaches
- For best outcomes for SUD, MAT needs to be part of counseling, supports and integrated care
- Stigma can stop treatment being initiated or being effective.

Thank You

PDMP and SBRT

KAREN E. ARSCOTT, D.O., M.SC.

Prescription Drug Monitoring Program

- https://data.pa.gov/stories/s/9q45-nckt/

Opioid Command Center Update

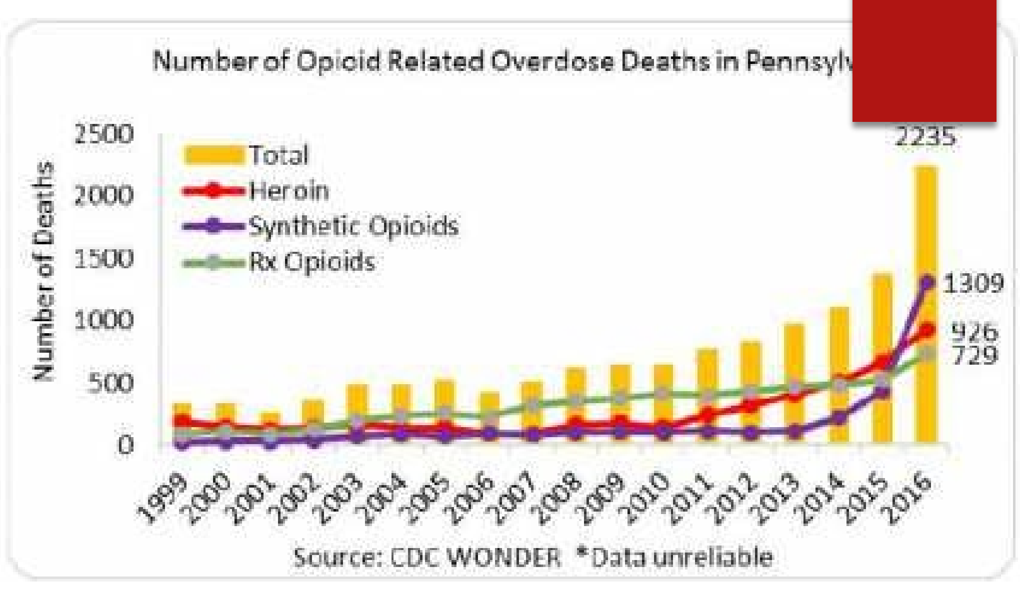
neonatal abstinence syndrome births
Jan. 10-Nov. 24: **1,803** *cases reported*
(86 percent of birth facilities reporting)

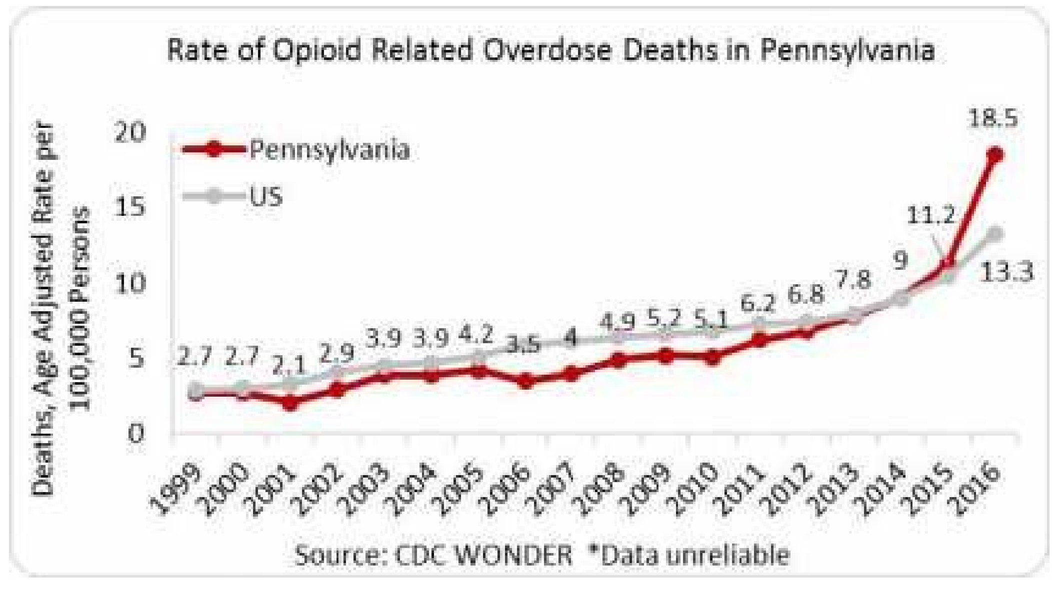
Get Help Now hotline
Jan. 10-Nov. 24: **14,973** *hotline calls*

naloxone doses administered by ems
Jan. 1-Nov. 24: **11,954** *doses provided*

Death rates

- In 2016, there were more than 63,600 drug overdose deaths in the U.S. Pennsylvania is amongst the top four states
- In 2016, approximately 13 people died of drug-related overdose each day in Pa.
- These people are our patients and members of our community.





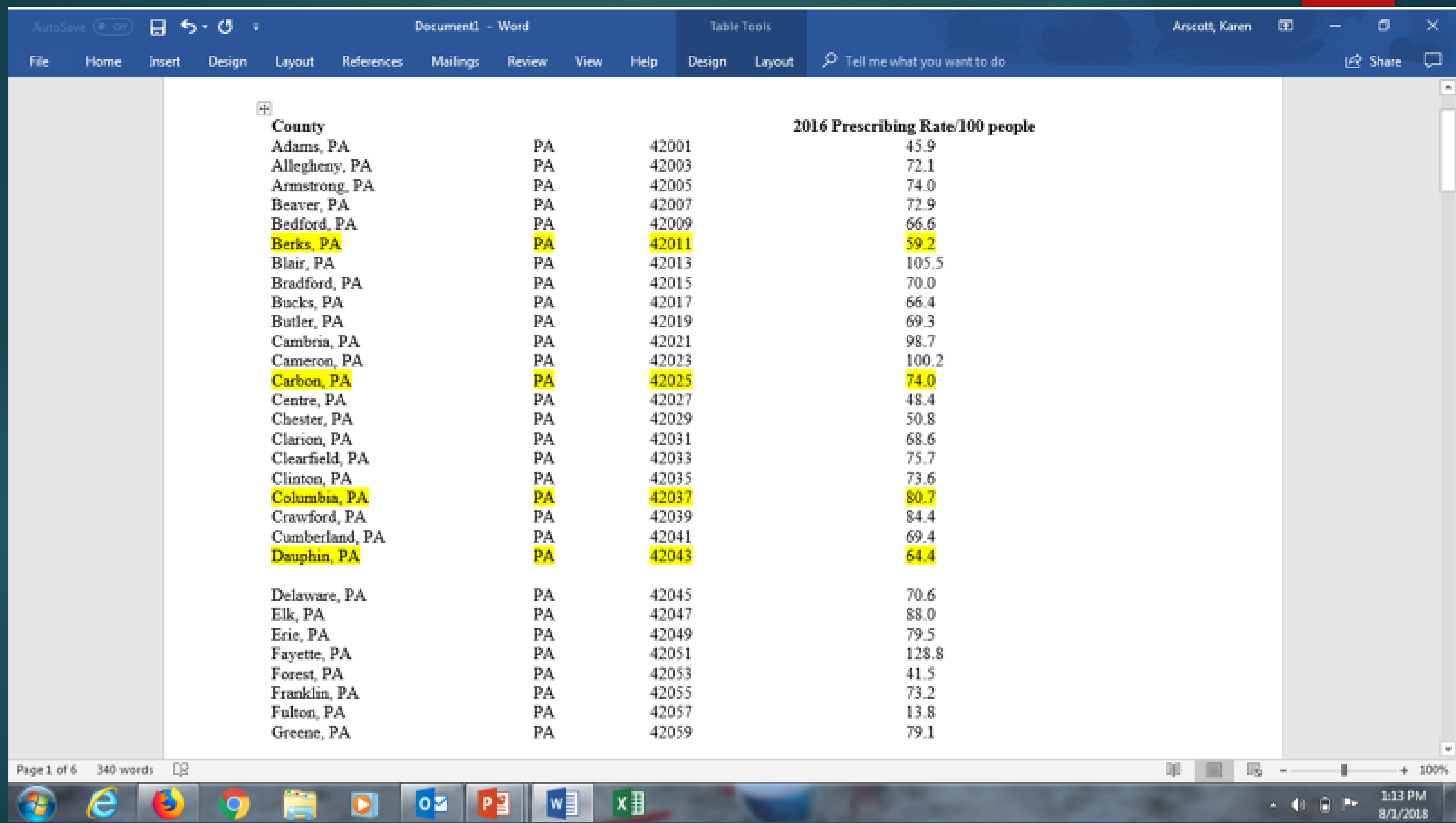
U.S. County Prescribing Rates, 2016

‹ U.S. County Prescribing Rates, 2015

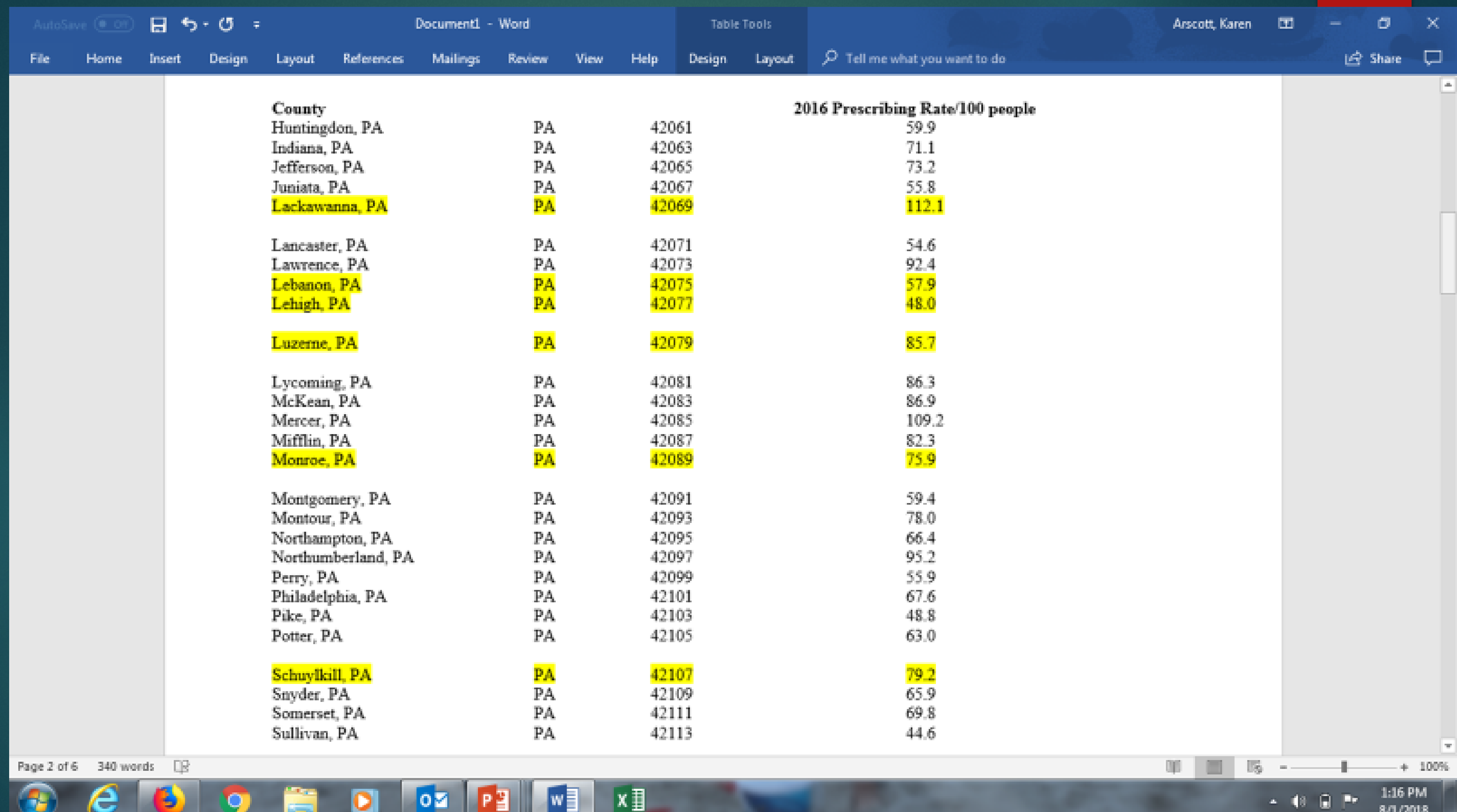
U.S. Prescribing Rate Maps

+
−

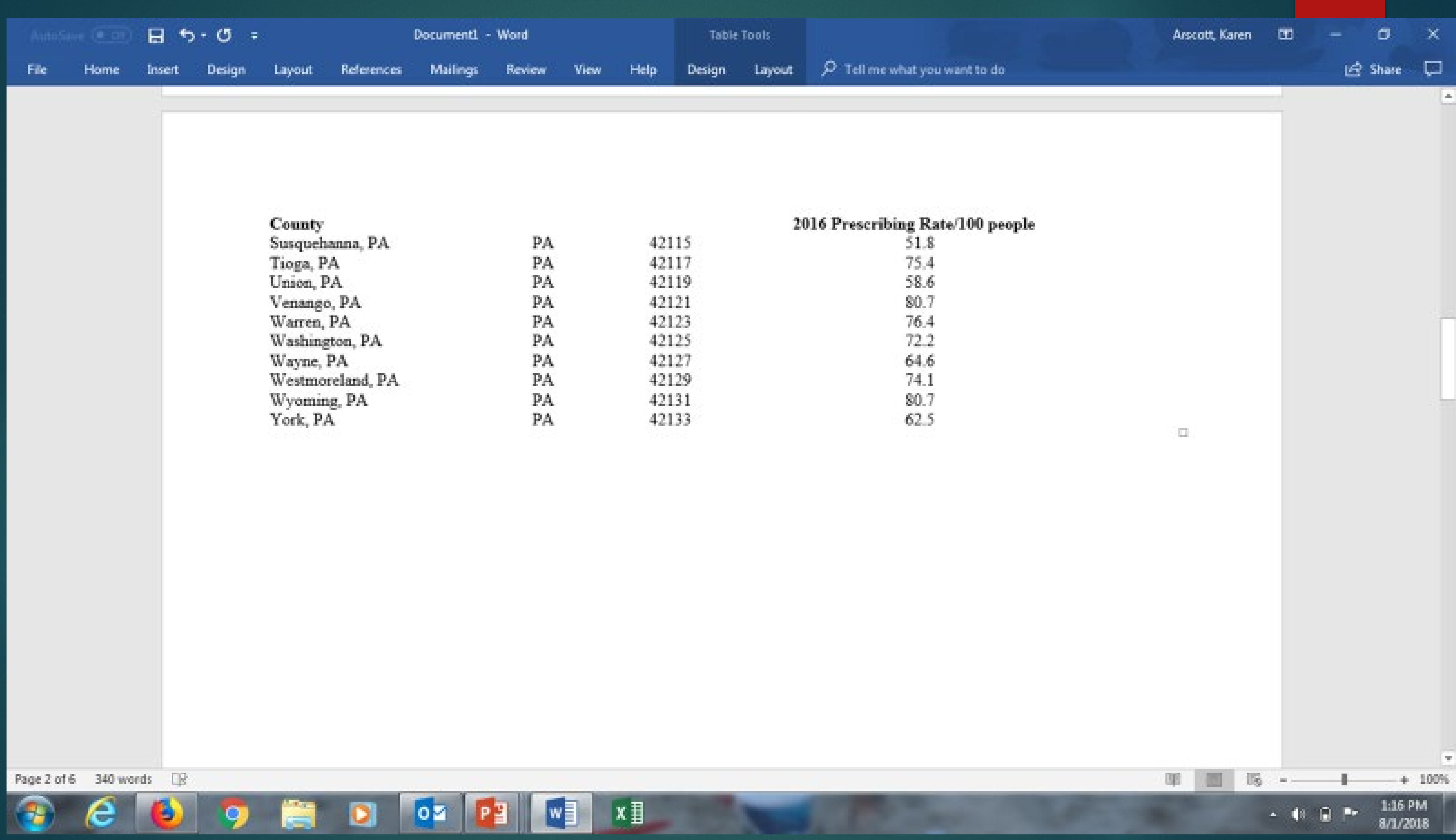
Cities
2016 Rate per 100 persons
< 57.2
57.2 - 82.3
82.4 - 112.5
> 112.5
Missing Data
States
Inset boxes



County			2016 Prescribing Rate/100 people
Adams, PA	PA	42001	45.9
Allegheny, PA	PA	42003	72.1
Armstrong, PA	PA	42005	74.0
Beaver, PA	PA	42007	72.9
Bedford, PA	PA	42009	66.6
Berks, PA	PA	42011	59.2
Blair, PA	PA	42013	105.5
Bradford, PA	PA	42015	70.0
Bucks, PA	PA	42017	66.4
Butler, PA	PA	42019	69.3
Cambria, PA	PA	42021	98.7
Cameron, PA	PA	42023	100.2
Carbon, PA	PA	42025	74.0
Centre, PA	PA	42027	48.4
Chester, PA	PA	42029	50.8
Clarion, PA	PA	42031	68.6
Clearfield, PA	PA	42033	75.7
Clinton, PA	PA	42035	73.6
Columbia, PA	PA	42037	80.7
Crawford, PA	PA	42039	84.4
Cumberland, PA	PA	42041	69.4
Dauphin, PA	PA	42043	64.4
Delaware, PA	PA	42045	70.6
Elk, PA	PA	42047	88.0
Erie, PA	PA	42049	79.5
Fayette, PA	PA	42051	128.8
Forest, PA	PA	42053	41.5
Franklin, PA	PA	42055	73.2
Fulton, PA	PA	42057	13.8
Greene, PA	PA	42059	79.1



County			2016 Prescribing Rate/100 people
Huntingdon, PA	PA	42061	59.9
Indiana, PA	PA	42063	71.1
Jefferson, PA	PA	42065	73.2
Juniata, PA	PA	42067	55.8
Lackawanna, PA	PA	42069	112.1
Lancaster, PA	PA	42071	54.6
Lawrence, PA	PA	42073	92.4
Lebanon, PA	PA	42075	57.9
Lehigh, PA	PA	42077	48.0
Luzerne, PA	PA	42079	85.7
Lycoming, PA	PA	42081	86.3
McKean, PA	PA	42083	86.9
Mercer, PA	PA	42085	109.2
Mifflin, PA	PA	42087	82.3
Monroe, PA	PA	42089	75.9
Montgomery, PA	PA	42091	59.4
Montour, PA	PA	42093	78.0
Northampton, PA	PA	42095	66.4
Northumberland, PA	PA	42097	95.2
Perry, PA	PA	42099	55.9
Philadelphia, PA	PA	42101	67.6
Pike, PA	PA	42103	48.8
Potter, PA	PA	42105	63.0
Schuylkill, PA	PA	42107	79.2
Snyder, PA	PA	42109	65.9
Somerset, PA	PA	42111	69.8
Sullivan, PA	PA	42113	44.6



County			2016 Prescribing Rate/100 people
Susquehanna, PA	PA	42115	51.8
Tioga, PA	PA	42117	75.4
Union, PA	PA	42119	58.6
Venango, PA	PA	42121	80.7
Warren, PA	PA	42123	76.4
Washington, PA	PA	42125	72.2
Wayne, PA	PA	42127	64.6
Westmoreland, PA	PA	42129	74.1
Wyoming, PA	PA	42131	80.7
York, PA	PA	42133	62.5

How can the PDMP Help?

- To be used as a tool to increase the quality of patient care by giving prescribers and dispensers access to a patient's controlled substance prescription medication history, which will alert medical professionals to potential dangers for purposes of making treatment determinations; and
- To aid regulatory and law enforcement agencies in the detection and prevention of fraud, drug abuse and the criminal diversion of controlled substances.

Evidence that it WORKS!

- Kentucky – reduced multiple provider episodes by 50%
- In 2016 a review of 24 states resulted in 30% reduction in rate of schedule II opioid prescriptions
- In 2010 Ohio demonstrated a decrease in prescriptions or no prescription in 61% of queries
- Florida saw a 24% decline in oxycodone prescriptions
- Analysis of 10 states showed overall reduction in opioid volumes prescribed
- PDMP query results in increased referral for management
- Reduced overdose deaths

What Exactly is the PDMP?

- As of Jan 1, 2017 all licensed individuals who are lawfully authorized to prescribe, distribute, dispense or administer a controlled substance in PA are ***REQUIRED*** to register with the program.
- Prescribers can delegate authority to individuals in their employment or under their supervision
- Delegates need to have their own account
- Prescribers are ***REQUIRED*** to query the PDMP in 3 clinical situations:
  - The first time the patient is prescribed a controlled substance
  - Each time the patient is prescribed an opioid or benzodiazepine
  - If a prescriber believes or has reason to believe that a patient is misusing or diverting drugs

Pharmacists and the PDMP

- Pharmacists are also required to register with the PDMP
- Also may designate a delegate
- Dispensers MUST query the PDMP before dispensing an opioid or benzodiazepine when a patient:
  - Is new to the pharmacist
  - Has insurance but chooses to pay for prescriptions with cash
  - Requests an early refill
  - Has opioid and/or benzodiazepine prescriptions from more that one prescriber

How to Register.....

- https://www.health.pa.gov/topics/programs/PDMP/Pages/Register.aspx

SBIRT

- Screening
- Brief intervention
- Referral to Treatment

Screening

- **PDMP may be first screening tool !!!**
- Screening Tools for Adult Patients
  - The Alcohol, Smoking, and Substance Involvement Screening Test – 8 questions
    - https://www.who.int/substance_abuse/activities/assist/en/
  - The CAGE Questions Adapted to Include Drugs Tool – Cut down, Annoyed, Guilty, and Eye-opener

CAGE Screening

- CAGE Questions for alcohol
- 1.Have you ever felt you should ***cut*** down on your drinking?
- 2.Have people ***annoyed*** you by criticizing your drinking?
- 3.Have you ever felt bad or ***guilty*** about your drinking?
- 4.Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (***eye-opener***)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

- 1. Have you ever felt you ought to cut down on your drinking or drug use?
- 2. people annoyed you by criticizing your drinking or drug use?
- 3. Have you felt bad or guilty about your drinking or drug use?
- 4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Screening

- Screening Tool for Pregnant Patient
  - The institute for Health and Recovery Integrated Screening Tool: 5 P's Screening Tool – Parents, Peers, Partner, Past and Present

Screening for Pregnant Patients

- Advise the client responses are confidential.
- A single "YES" to any of these questions indicates further assessment is needed.
- 1. Did any of your Parents have problems with alcohol or drug use?___ No ___Yes
- 2. Do any of your friends (Peers) have problems with alcohol or drug use?___ No ___Yes
- 3. Does your Partner have a problem with alcohol or drug use?___ No ___Yes
- 4. Before you were pregnant did you have problems with alcohol or drug use? (Past)___ No ___Yes
- 5. In the past month, did you drink beer, wine or liquor, or use other drugs? (Pregnancy)___ No ___Yes

Screening

- Screening Tool for Adolescents
  - The CRAFT Screening Tool – Car, Relax, Alone, Forget, Friends, Trouble

CRAFT Screening Tool – Part A

- During the PAST 12 MONTHS, did you: (No or Yes)
- 1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)
- 2. Smoke any marijuana or hashish?
- 3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")

CRAFT Part B

- 1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- 2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
- 3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
- 4. Do you ever FORGET things you did while using alcohol or drugs?
- 5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
- 6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

Brief Intervention

- Beginning – Middle – End
- Three Basic Components of Motivational Interviewing
  - Spirit: Collaboration, Acceptance, Evocation, Compassion
  - Skills: Open-ended questions, affirmations, reflections, summaries
  - Strategy: Engaging, focusing, evoking planning

Brief Intervention – for patient with suspected Substance Use Disorder

- **1. Build Rapport and Raise the subject: Ask permission to discuss his/her drug use. Use open-ended questions.**
  - "Thank you for answering the screening questions. Can we discuss them together?"
  - "Describe a typical day in your life. How does your drug use fit into your routine?"
  - "What are some things you enjoy about your drug use? What are some of the things that you do not enjoy about your drug use?"

Brief Intervention

- **2. Provide Feedback: Ask permission to relay information and discuss results of screening. Discuss connections between substance use and behaviors and known consequences to those behaviors.**
  - "In order to prevent new health problems from forming or prevent current problems from getting worse. I recommend all my patients drink less than the low-risk limits and abstain from using drugs."
  - "Many patients who score this highly are at an elevated risk of social or legal problems, as well as illness and injury. Can I talk to you about some of these risks?"
  - "There are many different reasons you could be feeling this way. Can I ask you some questions so we can figure this out?"

Brief Intervention

- **3. Build Readiness to Change: Use readiness ruler.**
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
  - "On a scale of 1 -10, with 0 being not ready at all and 10 being extremely ready, how ready and confident are you that you can change your behavior?"
  - "It's okay if you do not feel ready to make this change. Would you like to discuss some other options?"
  - "So you feel you are at a 6 in terms of readiness to address your use of prescription opioid medications. Can you tell me your thoughts behind that answer? Why didn't you choose a lower number?"

Brief Intervention

- 4. Negotiate a Plan for Change: include a plan for reducing use to low-risk levels and an agreement to follow-up with specialty treatment services (Warm Hand-off coming up).
  - "What steps do you think you can take that will help you reach your goal of reducing your drug use to low-risk levels?"
  - "Those are great ideas! Can we write down you plan so that you can refer to it in the future?"
  - "Can we schedule a follow-up appointment to see how you are doing?"
  - "It's really great that you came in and talked to me about this. Let's review what we discussed."

Referral to Treatment

- "Warm Handoff"
- Directly contact a substance use disorder treatment provider and solidify an appointment with patient present.
  - Be careful who you refer to – there are many different "practitioners" out there
- Stay positive and nonconfrontational
- Expect resistance – don't allow it to upset you – express concern

References

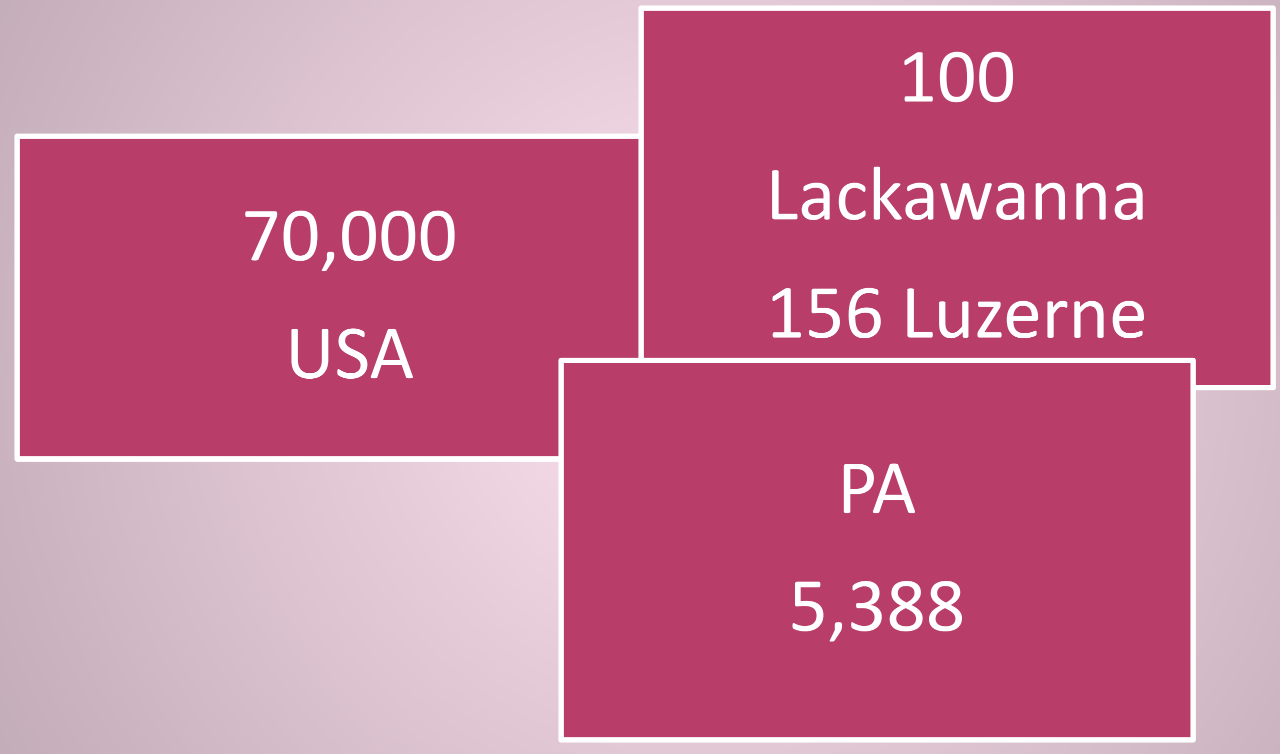
- https://data.pa.gov/stories/s/9q45-nckt/
- https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
- https://pennsylvania.pmpaware.net/login
- https://www.health.pa.gov/topics/programs/PDMP/Pages/PDMP.aspx
- https://www.integration.samhsa.gov/clinical-practice/sbirt
- https://www.who.int/substance_abuse/activities/assist/en/
- https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/CAGE%20Substance%20Screening%20Tool.pdf
- http://www.ilpqc.org/docs/toolkits/MNO-OB/5Ps-Screening-Tool-and-Follow-Up-Questions.pdf
- https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf

THANK YOU

Cold Turkey Kills

Donna Eget, DO

Overdose Statistics



3 Waves (CDC)

- 1990sRx opioids
- 2010 Heroin
- 2017 Fentanyl (IMF)

From the CDC

PAST MISUSE

of Rx opioids is the biggest risk factor for heroine use

From the DEA

- **85%** of heroin addicts across the US used prescription opioids as their first opioid

- **97%** of MAT patients in my practice began with prescription opioids

Reasons People Switch to Heroin

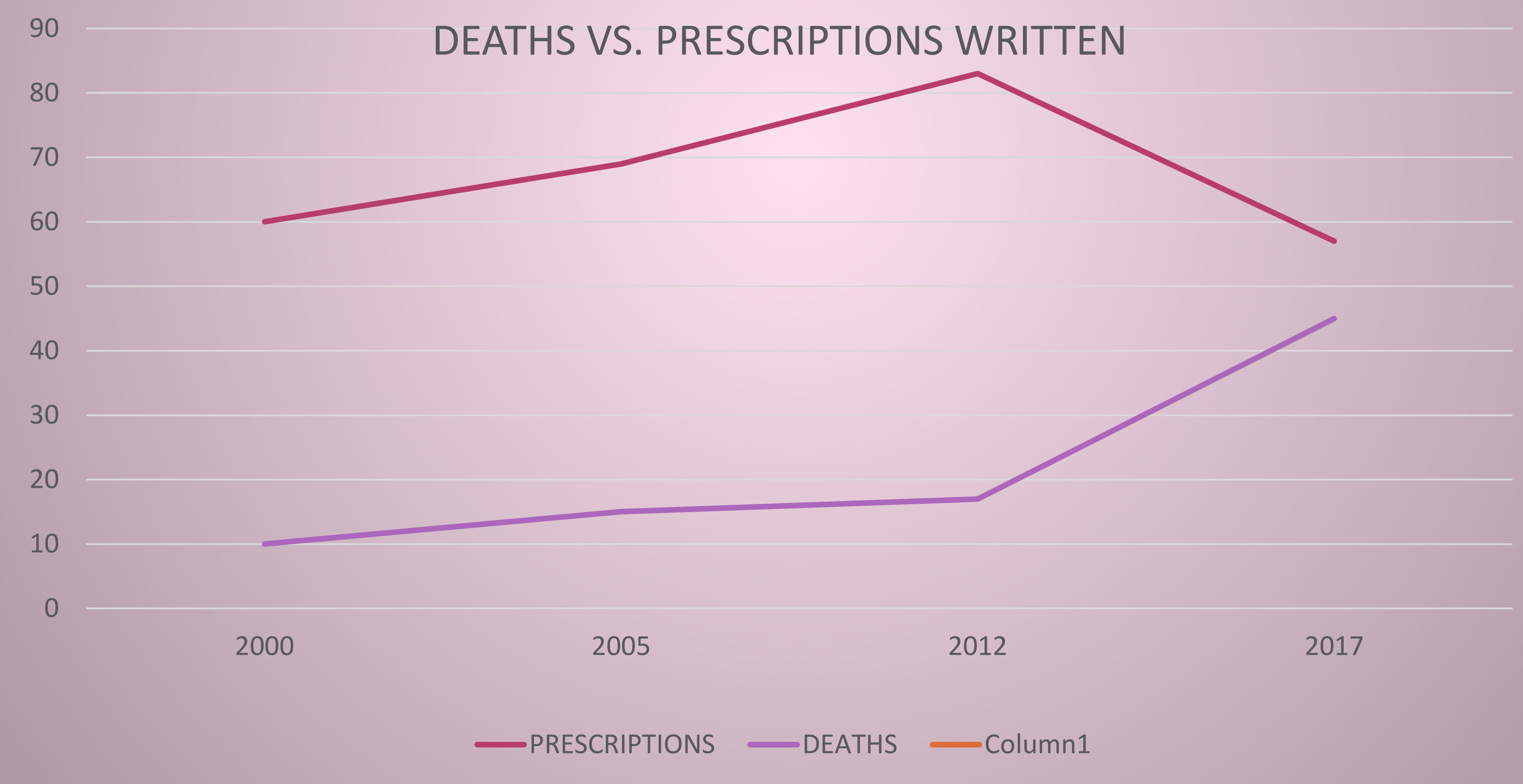
- It's ***cheaper*** than prescription drugs
- It gives them a ***better high***
- Prescription drugs are ***not as easily accessible***

Data from Florida

- 2011: the state cracked down on PILL MILLS
- 2012: prescription numbers fell
- 2013: heroin overdoses skyrocketed, up 39%

Data from PA

- 2012-2019: prescription numbers fell
- 2013-2019: heroin and synthetic overdose deaths rise



Drugs Implicated (NIDA)

	2000	2006	2012	2016
Synthetics:	0	50	50	2235
Rx:	100	250	400	729
Heroin	200	100	450	926
Prescriptions	60	69	83	69

– Per 100 pop

Conclusion:

If we stop prescribing opioids, people will turn to other sources!

Opioid Withdrawal

anxiety	GI: N/V/D	Muscle aches
sweating	Runny nose	gooseflesh
Rapid pulse	Dilated pupils	Exhaustion

Physician Culpability

The Bottom Line:

As prescribers, we gave people opioids.

Physician Responsibility

We need to work with our patients to treat their underlying disease as well as their opioid dependency!

Patient Culpability

Patients

- had pain (2/3 of local MAT patients)
- requested relief
- abused their medications
- diverted their prescriptions (25%)

Patients Are Now in Real Trouble

Dependence on Meds

Damaged Relationships with Providers

Cautious/Uncertain Providers

>70% Pyschiatric Comorbidity

Prescribing Habits (CDC)

2006

Lackawanna:

108.77

rx per 100 persons

Luzerne

92.44

2017

- 97.3
- 70.8

Solutions:

Cold Turkey Kills…Warm Handoffs Save Lives

Solutions

Identify the Issue

Discuss Options for the Patient

Solutions: Identify the Issue

Identify the Issue:

-Discussion with patients and family

-PDMP

Solutions: Discuss Options

If pain is no longer an issue, weaning is appropriate…

Go slowly!

Solutions: Weaning

Understand: this is a difficult endeavor

Solutions: Weaning

Understand: this may be an impossible feat for some people

Brain changes

Solutions: Discuss Options

If the patient has persistant pain:

Maintain Dose if Appropriate but refrain from increasing

Solutions: Discuss Options

Consider MAT

The brain changes, pain levels, comorbidities (mental illness, social situations) may make weaning impossible

MAT

Buprenorphine

Suboxone Products

Long Acting Opiods

Satisfies Biochemical Need

Partial Agonist with low overdose potential

MAT

Methadone

Long Acting

Satisfies Biochemical Need

Full Agonist with overdose potential

MAT

Vivitrol

Antagonist which decreases cravings

Prevents use of opioids and alcohol

Lackawanna County Warm Hand-off

CMC + Scranton Counselling Center

24 hour access to a certified recovery specialist in the ER

Establish a treatment plan

Interim Plan

Have a plan!

Refer!

Utilize Resources: Medical Society, Opioid Coalitions, County D&A agencies

Summary

Many patients cannot tolerate withdrawal symptoms and will turn to other sources if we abandon them.

Summary

first,

do no harm

???????????

Warm Hand-off

Barbara Durkin, M.A.

Lackawanna/Susquehanna Office of Drug and Alcohol Programs(SCA)

What is an SCA?

- The Pennsylvania Department of Drug and Alcohol Programs (DDAP) transfers the responsibilities of carrying out the drug and alcohol provisions under the State Plan to the local level through the SCA structure.
- The SCA (Single County Authority) is the local entity charged with the assessment, design, and implementation of a full array of drug and alcohol services across the continuum of care for the local residents of their county.
- There are 67 Counties in the State of Pennsylvania, however there are 47 SCA's. Some SCA's, referred to as Joinders, care for more than one County.
- Each SCA in unique due to geographic, socio-economic, political, funding, and operating differences. Hence, processes may differ from one SCA to another.

Single County Authority Administrators Contact Information

SCA Name	SCA Phone	First Name	Last Name	Email
Allegheny	(412) 350-3328	Latika	Davis-Jones	Latika.Davis-Jones@AlleghenyCounty.us
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Up To Date Resources

DDAP (Pennsylvania Department of Drug and Alcohol Programs

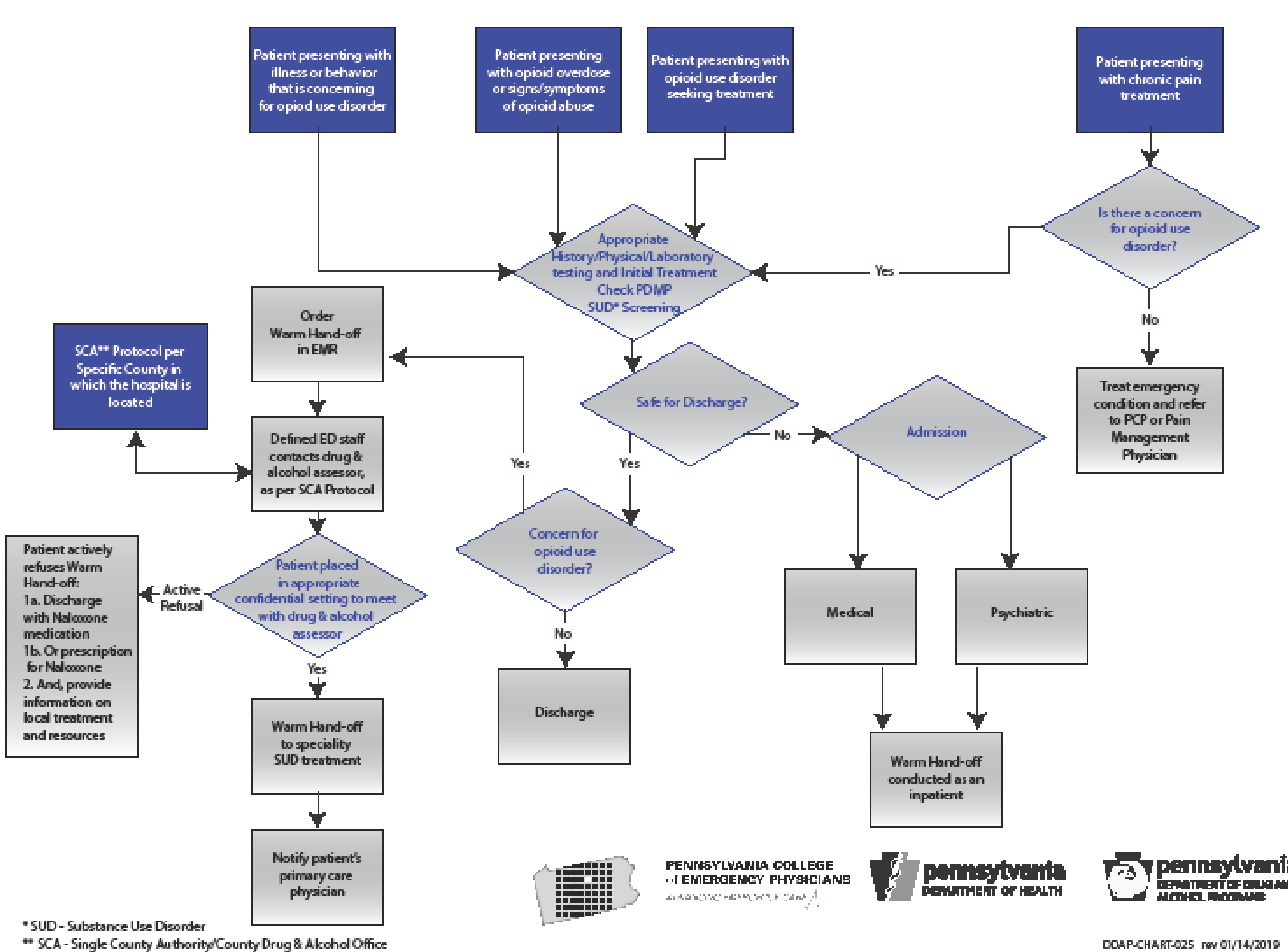
www.ddap.pa.gov

PACDAA (Pennsylvania Association of County Drug and Alcohol Administrators)

www.pacdaa.org

What is a Warm Hand-off?

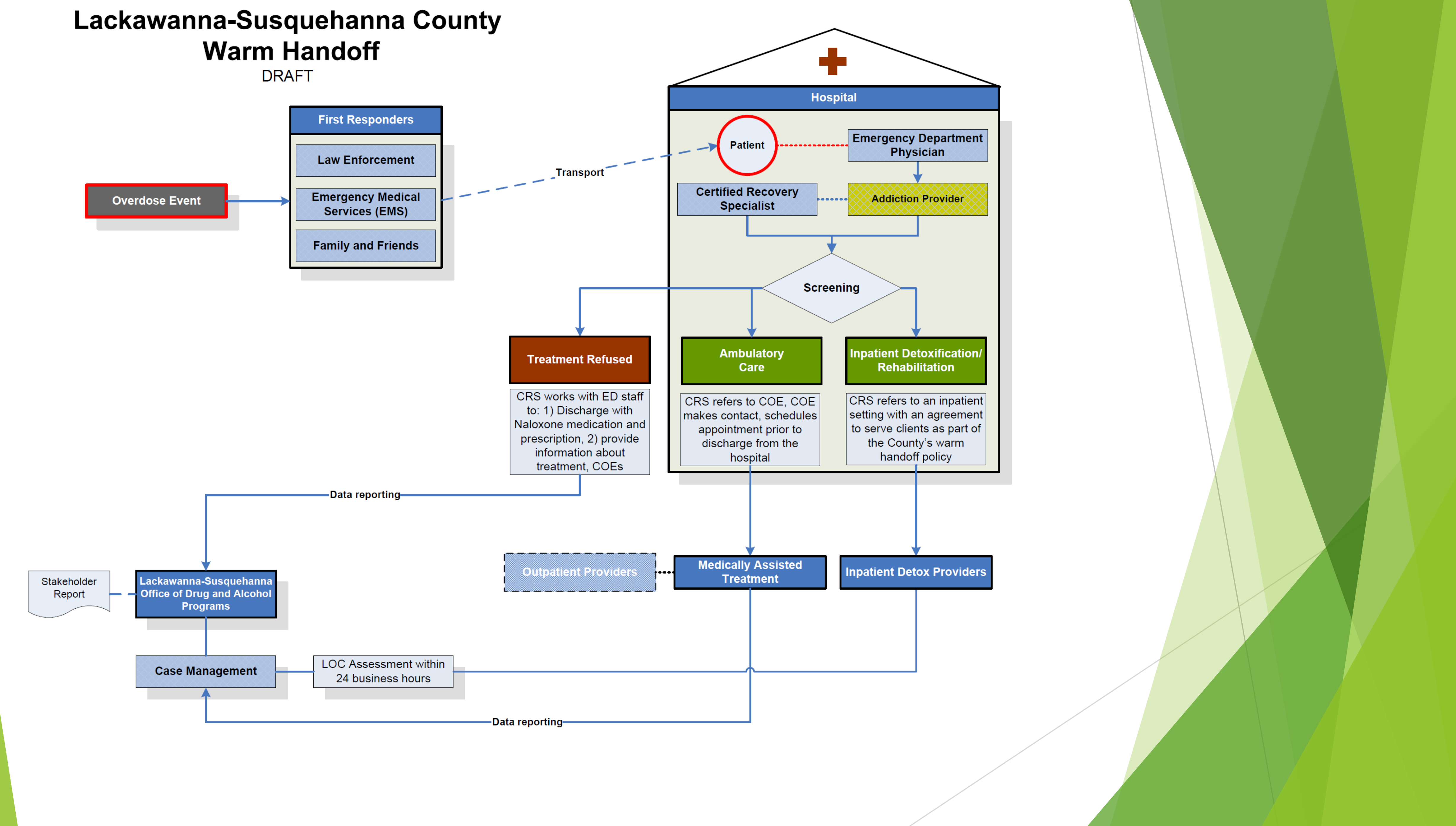
- Beginning in 2016, DDAP (Pennsylvania Department of Drug and Alcohol Programs) incorporated contractual changes to the 2015-2020 SCA Grant Agreement that establishes the overdose survivor as a priority population and requires the SCA to create a Warm Hand-off policy.
- The Warm Hand-off policy must ensure that a process exists by which an overdose survivor will be offered a 24/7 direct referral from the Emergency Department to treatment.
- While SCA's individual Warm Hand-off processes may differ, the overarching goal of offering a direct referral to treatment will exist.



Warm Hand-Off Care Map
Patient presenting with illness or behavior that is concerning for opioid use disorder
Patient presenting with opioid overdose or signs/symptoms of opioid abuse
Patient presenting with opioid use disorder seeking treatment
Patient presenting with chronic pain treatment
Is there a concern for opioid use disorder?
Yes
No
Treat emergency condition and refer to PCP or Pain Management Physician
Appropriate History/Physical/Laboratory testing and Initial Treatment Check PDMP SUD* Screening
Safe for Discharge?
No
Admission
Medical
Psychiatric
Warm Hand-off conducted as an inpatient
Yes
Yes
Concern for opioid use disorder?
No
Discharge
Order Warm Hand-off in EMR
SCA** Protocol per Specific County in which the hospital is located
Defined ED staff contacts drug & alcohol assessor, as per SCA Protocol
Patient placed in appropriate confidential setting to meet with drug & alcohol assessor
Active Refusal
Patient actively refuses Warm Hand-off: 1a. Discharge with Naloxone medication 1b. Or prescription for Naloxone 2. And, provide information on local treatment and resources
Yes
Warm Hand-off to speciality SUD treatment
Notify patient's primary care physician
* SUD - Substance Use Disorder
** SCA - Single County Authority/County Drug & Alcohol Office
PENNSYLVANIA COLLEGE OF EMERGENCY PHYSICIANS
pennsylvania DEPARTMENT OF HEALTH
pennsylvania DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS
DDAP-CHART-025 rev 01/14/2019

Lackawanna/Susquehanna Warm Hand-off Policy

- There are multiple ways for individuals struggling with a substance use disorder (SUD) to access services 24/7 in Lackawanna and Susquehanna counties. For instance:
  - Individuals or families struggling with an SUD including opioid use disorder (OUD) can connect to a case manager 24/7 by calling (570) 840-8475 for Lackawanna County residents or (570) 767-9411 for Susquehanna County residents. Commonwealth Moses Taylor and Regional staff can use these numbers to assist patients needing services.
  - Individuals can connect to services at Geisinger Community Medical Center 24/7 by connecting with a Certified Recovery Specialist (CRS) connected to the Crisis system in the Emergency Room. Individuals can connect to a CRS at Barnes Kasson or Endless Mountain Health System in Susquehanna County. Individuals seen in the hospital can be immediately connected to treatment services, including medication assisted Treatment, right from the Emergency Department.



Lackawanna-Susquehanna County
Warm Handoff
DRAFT
Overdose Event
First Responders
Law Enforcement
Emergency Medical Services (EMS)
Family and Friends
Transport
Hospital
Patient
Emergency Department Physician
Certified Recovery Specialist
Addiction Provider
Screening
Treatment Refused
Ambulatory Care
Inpatient Detoxification/ Rehabilitation
CRS works with ED staff to: 1) Discharge with Naloxone medication and prescription, 2) provide information about treatment, COEs
CRS refers to COE, COE makes contact, schedules appointment prior to discharge from the hospital
CRS refers to an inpatient setting with an agreement to serve clients as part of the County's warm handoff policy
Data reporting
Outpatient Providers
Medically Assisted Treatment
Inpatient Detox Providers
Stakeholder Report
Lackawanna-Susquehanna Office of Drug and Alcohol Programs
Case Management
LOC Assessment within 24 business hours
Data reporting

The Journey of the WHO process

- Collaboration between the SCA, hospitals, Emergency room physicians and staff, substance use providers and payors
- Yearlong planning including meetings with hospital staff, ER doctors, and other pertinent staff and individuals
- What about the Non-Opioid patient?
- Barriers experienced with the client:
  - Client in active withdrawal
  - Unreceptive to treatment
  - Unreceptive to Level of Care needed
- Barriers experienced with the ER:
  - Miscommunication
  - Staff Turnover
  - STIGMA
  - Disconnect between Physical Health and Behavioral Health

The Journey of the WHO Process (continued)

- Applied and received a grant to implement a hospital-based WHO program.
- Worked through the Lackawanna Recovery Coalition to identify a champion at the hospital.
- Identified a provider to help implement the 24/7 WHO model at GCMC.
- Worked with the provider, Scranton Counseling Center, to hire Certified Recovery Specialists (CRS), people with lived experience, to work in the ER.
- Rolled program out in September 2018.

A Year in Review

- Started at GCMC on September 24, 2018
- 424 individuals seen by the WHO Program at GCMC since start. On average, 35 individuals seen per month. Monthly totals have increased over last couple months.
- Residents from Lackawanna, Wayne, Monroe, Philadelphia, Susquehanna and Luzerne Counties as well as New York, Maryland and Florida.
- Approximately 70 percent of clients are referred to treatment directly from ED. Many clients are referred to an inpatient drug and alcohol facility. Many clients are referred and/or agreeable to outpatient treatment, including outpatient MAT. All cases offered MAT if appropriate. All follow up with inpatient providers includes discussion on MAT. Induction in ED on MAT is not happening frequently.
- Alcohol use disorder remains primary substance of choice. More males seen than females in ED.
- Lackawanna/Susquehanna Case Management staff follow up on all clients referred to CRS, regardless of insurance or treatment status. Of those agreeing to a connection to treatment, approximately 85 percent were engaged in treatment 30 days post ED. Case management staff also attempt to follow up with clients 60 and 90 days post treatment but call back from client is rare.

What’s Next?

- Expansion of program to other hospitals in the county—Commonwealth Moses Taylor and Regional
- Improving treatment retention—expansion of case management support
- Continued networking and collaboration
- MAT (Medication Assisted Treatment) inductions in the ER
- What is happening to the Opioid use disorder client…expansion of program to EMS.