Wisconsin Opioid Project ECHO
Session Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

Joining by phone ONLY: +1 646 558 8656 or +1 669 900 6833 (US Toll)
Zoom Meeting ID: 156 261 634

Session Date: 5/18/18

Today's Didactic Topic and Presenter:
Opioid Prescription Limits: A Dentistry Illustration by Paul Hutson, PharmD, BCOP

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case #1 & discussion
- 1:00 PM: Case #2 & discussion
- 1:15PM Didactic Presentation
- 1:30 PM: End of Session

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Wisconsin Opioid Project ECHO

May 2018 – June 2018
Live Webinar

Session Date: 5/18/18
Presenter: Paul Hutson, PharmD, BCOP

Provided by the:
Wisconsin Department of Health Services
University of Wisconsin Department of Family Medicine and Community Health
University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience and Scope of Practice:
Physicians, advance practice nurses, physician assistants, nurses, pharmacists, and social workers. The audience includes both UW and non-UW clinicians and staff.

Statement of Need and Purpose:
Opioid-related complications are at crisis levels with no signs of abatement. Rural patients and providers experience particular management challenges due to a lack of resources and expert knowledge.

Elements of Competence:
In addition to knowledge, this activity has been designed to change learner competence and performance.

Learning Objectives:
As a result of this educational regularly scheduled series, it is expected that participants will:

- Understand the potential risks and benefits of chronic opioid prescribing
- Review appropriate opioid prescribing and monitoring practices
- Discuss evidence-based practices related to opioid withdrawal management
- Develop skills in the management and care coordination for patients with opioid use disorders
- Review opioid overdose prevention and intervention strategies
- Discuss the management of OUD in pregnancy
- Understand the effectiveness and logistics of office-based opioid treatment with buprenorphine and treatment services
- Understand the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD
- Discuss the management of OUD in pregnancy

Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair, Program Director	No relevant financial relationships to disclose	Yes
Maireni Cruz, Content Expert, Addiction Medicine Physician	No relevant financial relationships to disclose	No
Chris Nicholas, Content Expert, Psychology-SUD/Mental Health Counselor	No relevant financial relationships to disclose	No
Elizabeth Collier, Content Expert, Social Worker	No relevant financial relationships to disclose	No

Paul Hutson, Content Expert, Pharmacy	No relevant financial relationships to disclose	No
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
David O'Donnell, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse Practitioner	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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Project Funding:

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 5-18-18

2-Presenter: Director Sheila Weix, MSN, CARN

3-ECHO ID: 1648

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: What should we do next (in terms of MAT or other interventions) to assist this person in managing his SUDs?

Demographic Information:

6-Age: 60

7-Gender: Male

8-Education/Literacy: High School graduate with some technical school degree

9-Income source: He is on disability for a combination of his back, HIV status, dyslexia, and history of depression. He received disability in 1995.

10-Insurance: Forward Health and Medicare

11- HPI: Opioid addiction- current drug of choice is injecting suboxone. Started initially with our system in pain clinic as early as 2001-2002, returned 2012-16, and now again in 2018 at FHC. Many years ago was involved with a methadone clinic in Arizona. Per patient report he was drug free from early 1990s until 2007/08.

Medically complex:

Lumbar spine foraminal stenosis with chronic low back pain.

Type 2 diabetes; dx'd approx. 2005.

Spinal stenosis; cervical spine.

HIV infection; on suppressive med Rx.

Hepatitis C infection; resolved after treatment.

Hypertension.

Insomnia, chronic.

Depression.

Tobacco use disorder.

Opioid use disorder.

Alcohol use disorder; resolved.

Injection drug use.

Necrotizing fasciitis Right forearm; complication of injection drug use.

S/P surgical debridement and skin grafting Right forearm.

COPD.
S/P full mouth dental extraction.
S/P ORIF mandibular fracture.

12-Social History: Worked as a machinist prior to disability. Divorced when his children were 1 and 2 years old. Ex-wife kidnapped his children and lived in hiding for 13 years. Son came back to live with him as a teenager. His children are now in their 30 and his son has fairly frequent contact with him despite living a distance away. Has some family ties. Does report a close friend network. Likes to fly remote control planes.

13-Housing: He lives in a house but is 3 months or more behind in his bills.

14- **Substance Use History:** As of March 2018: Currently the patient is using Suboxone, heroin, other opiates such as Dilaudid, cocaine and crack. He started using these 4 drugs around the age of 33. He uses all 4 drugs, injecting them, except for the Suboxone medication. Patient stated he used heroin about 3 weeks ago and he uses $60.00 worth at a time with the other opiates such as Dilaudid and whatever else he can get his hands on with the Suboxone. He goes through $300-$500 worth a month and he uses those IV. With the crack cocaine, it is $300-$500 a month and it is usually a couple times a week and he injects those drugs. His last use of Suboxone was this morning. Patient switches from 1 drug to the other to kind of avoid withdrawal symptoms. He did state that he likes the uppers versus the other types of medications.

15- Consequences of Substance Use:

- Social/occupational/educational:

Disabled
Divorced
Behind in his bills

- Physical (including evidence of tolerance/withdrawal):

HIV positive from IV drug use
Hep C positive
Recent welfare check d/t call to clinic about overusing his sleeping medication and wanting to die. EMS transport to ER.
Detox at inpatient unit, 4/2018

16- Behavioral Health Interventions that have been tried:

Patient attended a medication assisted treatment program years ago when he was out in Arizona. It was roughly a year that he was there. He was on methadone at that time and that was in the late 1980s. Then he moved back to Wisconsin in the early 1990s, was clean and free from drug use until roughly 2007-2008 and he relapsed and has been using ever since.

Patient identified that he has been diagnosed with depression. He thinks that he is on medication for his depression but he could not remember for sure.

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17-Medications Tried for Relapse Prevention? (Specify): Methadone in the past, Suboxone, Vivitrol

18-

Current Medications:	**Medical/Behavioral Health Diagnosis:**
Acetaminophen 650mg Tablet Sustained Release Sig: 1 Tablet(s) (650 mg) by mouth four times daily for 1-2 weeks then as needed	Pain
Albuterol Sulfate (Ventolin HFA®) Inhalation 90mcg/Actuation HFA Aerosol Sig: 1 or 2 Puff(s) by mouth every 4 to 6 hours as needed for pneumonia and wheezing	COPD
Alum-Mag Hydroxide-Simeth (Maalox®) 200-200-20mg/5 mL Suspension Sig: 30 Milliliter(s) by mouth every four hours as needed	GERD
Aspirin 325mg Tablet, Delayed Release (E.C.) Sig: 1 Tablet(s) (325 mg) by mouth once daily	CAD
Atorvastatin 10mg Tablet Sig: 1 Tablet(s) (10 mg) by mouth once daily	Hyperlipidemia
Blood Sugar Diagnostic (Accu-Chek Aviva Plus Test Strip®) Miscell. (Med.Supl.;Non-Drugs) Strip Sig: 1 Strip(s) up to four times daily and as needed	DM
Cholecalciferol (Vitamin D3) 50,000unit Capsule Sig: 1 Capsule(s) (50,000 unit) by mouth once weekly for 6 weeks for Vitamin D deficiency.	Vit D deficiency
DULoxetine (Cymbalta®) 60mg Capsule, Delayed Release(E.C.) Sig: 1 Capsule(s) (60 mg) by mouth once daily	Depression and pain
Efavirenz-Emtricitabin-Tenofov (ATRIPLA®) 600-200-300mg Tablet Sig: 1 Tablet(s) by mouth once daily at bedtime	HIV
Famotidine 20mg Tablet Sig: 1 Tablet(s) (20 mg) by mouth twice daily as needed	GERD
Fluticasone-Salmeterol (Advair Diskus®) Inhalation 250-50mcg/dose Disk with Device Sig: 1 Inhalation by mouth twice daily	COPD
Gabapentin (Neurontin®) 800mg Tablet Sig: 2 Tablet(s) (1,600 mg) by mouth twice daily per Jennifer	Pain
Glucose (BD Glucose®) 5gram Tablet, Chewable Sig: 1 Tablet(s) (5 gram) by mouth as needed	Hypoglycemia
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100unit/mL Insulin Pen	DM

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Sig: 8 Unit(s) subcutaneously three times daily at meals plus sliding scale. Insulin Glargine (Lantus Solostar®) Subcutaneous 100 unit/mL(3 mL) Insulin Pen Sig: 58 Unit(s) subcutaneously daily at bedtime Insulin Needles (Novofine 32®) Miscell. (Med.Supl.;Non-Drugs) 32 gaugex 1/4" Needle Sig: 1 Needle(s) four times daily Insulin Syringe-Needle U-100 Miscell. (Med.Supl.;Non-Drugs) 1/2 mL31 x 5/16" Syringe Sig: 1 Syringe(s) subcutaneously as directed Dispose of syringe in a Sharps container. Ketoconazole (Nizoral®) Topical 2% Shampoo Sig: Shampoo as directed topically three times weekly Meloxicam 7.5mg Tablet Sig: 1 Tablet(s) (7.5 mg) by mouth once daily Naloxone (Narcan®) Nasal 4mg/actuation Spray, Non-Aerosol Sig: 1 Spray(s) alternating nostril every 2 to 3 minutes as needed If the first dose wears off may repeat dose in alternate nostril every 2 to 3 minutes. Call 911 emergency medical care. Use for narcotic overdose.	DM DM DM Fungal infection Pain Opioid reversal

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Identifies family support: sisters, aunt and son Self-initiated referral Has continued to engage in services	Continues to inject Suboxone Multiple chronic disease states with poor self-care

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.): None identified

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

1-22-18 HIV1 Load Not DetectedHIV1 Log Not Detected

1-22-18 HgbA1c 8.0

3-1-18- Intake UDT- positive for non-prescribed buprenorphine

5-1-18 (ER visit for welfare check): barbiturates only.

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22-Prescription Monitoring Program Pertinent Findings:

Ambien 10 mg #30 with one refill on 4/27/18 (not our prescriber)

Prior to that Suboxone 4 mg bid (3/23/18-4/9/18)

23-Proposed Diagnoses:

Cocaine Use Disorder - Severe - 304.20 (F14.20) Patient met 11 out of 11 criteria.

Stimulant Use Disorder - Severe - 304.40 (F15.20) Patient met 11 out of 11 criteria.

Opioid Use Disorder - Severe - 304.00 (F11.20) Patient met 11 out of 11 criteria.

Sedative Use Disorder - Severe - 304.10 (F13.20) Patient met 11 out of 11 criteria.

Depression

Multiple chronic medical conditions

24-Patient Goals for Treatment:

What are your top 3 goals for treatment?

1. To quit other drugs
2. To quit shooting drugs
3. Better my health

25- Proposed Treatment Plan:

Patient was started on Suboxone, Day 1 induction on 3/27/18, but by 4/3/18 he was found to be injecting his films. "He did report to Dr. X that he had injected his Suboxone on Saturday and Sunday. He cut a small piece off the 4mg and let it dissolve in 15 cc of distilled water and he does agree that it's the injecting and the needle that is the hook for him. He

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reports that sometimes he just injects distilled water. He is wanting to work with us and he is not taking any other substances other than the Suboxone. He is willing to do the Vivitrol if that is recommended."

From 4/3/18 to 4/16/18, he was maintained on daily Suboxone administered at the clinic Monday-Friday with take-home doses only on Saturday and Sunday.

Entered inpatient detox on 4/16/18 with discharge on 4/25/18 to facilitate initiation of Vivitrol.

5/1/18 was date of welfare check.

Currently, he is concerned that he is reacting to Vivitrol with complaints of nausea, diarrhea, chills, h/a, RLS, and difficulty sleeping. He is continuing to report that he does not want the Vivitrol injection. Second injection is due: 5/21/18.

He is scheduled for weekly counseling sessions.

By initialing here SMW 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.

DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

Date: 5/18/18

Presenter: Randy Brown

ECHO ID: 1820

Have you presented this patient during this teleECHO clinic before? ☐ Yes ☑ No

PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

Management of acute pain in setting of OUD on Suboxone.
Briefly, patient with recent episode of chest pain. Underwent cardiac catheterization which demonstrated severe multi-vessel coronary disease. Seen by CT surgery and recommended for surgical revascularization. Being admitted for CABG.

Demographic Information:

Age: 32

Housing: stable w/ mother

Gender: ☐ Male ☑ Female ☐ Transgender

Education/Literacy: HS grad

Income source: home care (mother)

Insurance: MA

Social History: She was homeless for a time last year, but now living with sister and mother in a stable, supportive environment. She has a car, but needs license plates, currently relying on family for transportation. Not working currently, on disability after MVA in 4/2015. Plans to start work at Burger King in Sun Prairie when ok to go back to work. Denies h/o physical/sexual abuse. ACE = 0.

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Family support Stable housing	ACE = 0 Unstable employment Co-morbid depression Co-morbid medical (DM, CAD, LBP)

Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc):

none

Substance Use History:

Started smoking MJ at age 14->cocaine-->crack-->opioid pills-->heroin. Was using IV heroin 2/10th of a gram daily x 2 years. Started Suboxone in 2015. Pattern of adherence and urine drug testing have been reassuring. Graduated IOP.

Behavioral Health Interventions that have been tried:

As above + behavioral health check-in at clinic visits.

Medications Tried for Relapse Prevention? (Specify):

Suboxone max 16mg. Currently 8mg.

Labs (as indicated): Include summary of urine testing or last urine drug screen result

Reassuring UDT (negative for controlled substances other than buprenorphine and metabolite)

Consequences of Substance Use:

Social/occupational/educational:

Physical (including evidence of tolerance/withdrawal):

Current Medications:	**Medical/Behavioral Health Diagnosis:**
Fluoxetine Gabapentin DM Rx's	Depression DDD

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Prescription Monitoring Program Pertinent Findings:

Reassuring

Proposed Diagnoses:

Patient Goals for Treatment:

Proposed Treatment Plan:

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1. **Taking the substance in larger amounts and for longer than intended**
2. **Wanting to cut down or quit but not being able to do it**
3. **Spending a lot of time obtaining the substance**
4. **Craving or a strong desire to use**
5. **Repeatedly unable to carry out major obligations at work, school, or home due to use**
6. **Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use**
7. **Stopping or reducing important social, occupational, or recreational activities due to opioid use**
8. **Recurrent use in physically hazardous situations**
9. **Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using**
10. ***Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)**
11. ***Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)**

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Opioid Prescription Limits: A Dentistry Illustration

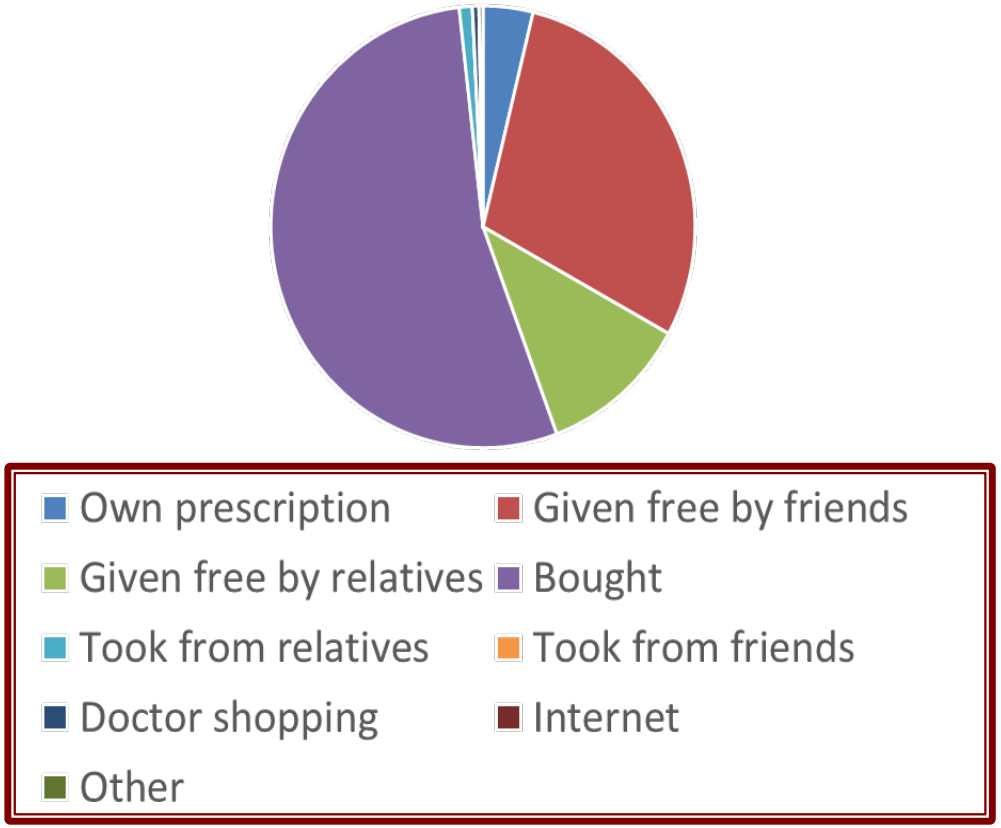
Paul Hutson, PharmD, BCOP
Professor (CHS)
University of Wisconsin School of Pharmacy

Why Dentistry?

- Dental extractions are a model of acute, procedural pain
- In 1998, dentists were the leading prescribers of immediate-release opioids
  - !5.5% of all IR opioids
  - Decreased to 6.4% by 2012
- Extractions are a major reason for prescribing opioids to adolescents

Safer Opioids at Home

- The safest opioid with regard to abuse potential is the one that isn't there.
- Most abused prescription opioids were obtained from a friend or family member that had more doses than were needed for the treatment of the prescribed indication.



J Psychoactive Drugs. 2014 Jul-Aug; 46(3): 198–207

Project ECHO
Wisconsin Department of Health Services

Safer Opioids at Home

- Re-evaluate need for and risks of opioids frequently
  - Addition of benzodiazepines or other interacting medications
  - New diagnosis of sleep apnea, other conditions
- Limit number of doses prescribed and dispensed at any time
- Counsel on using medication exactly as prescribed, and getting rid of expired or leftover medication
  - Provide information on drug return locations

Risks to children in the home

- United States 2007-2011
  - Accidental opioid ingestion by child under the age of 6 accounted for highest number of emergency hospitalizations
  - Most common source: unsecured meds within child's environment
  - Most commonly ingested drug: buprenorphine
  - Occasionally malicious exposure by caregiver – statistics not available
  - Exposures to illicit drugs tend to be fatal

Lovegrove MC, Mathew J, Hampp C, et al. *Pediatrics* 2014; 134:e1009.
Budnitz DS, Lovegrove MC, Sapiano MR, et al. *MMWR Morb Mortal Wkly Rep* 2016; 65:1148.
Nielssen OB, Large MM, Westmore BD, Lackersteen SM. *Med J Aust* 2009; 190:7.
Perez A, Scribano PV, Perry H. *Pediatr Emerg Care* 2004; 20:769.

Unused Opioids after Outpatient Extraction

	Control	Intervention	P-value
Participants	39	40	-
Caucasian (%)	16 (41%)	18 (45%)	0.72
Female (%)	25 (64%)	23 (58%)	0.58
Mean age in years (SD)	29.6 (9.2)	27 (10.1)	0.27
Mean number of teeth extracted (SD)	3.2 (1.4)	3.1 (1)	0.5
Filled opioid prescription (%)	36 (92%)	36 (90%)	0.72
Received NSAID prescription (%)	33 (85%)	32 (80%)	0.56
Received antibiotic prescription (%)	31 (79%)	31 (78%)	0.91

Maughan BC, et al. Drug Alcohol Dep 2016; 168: 328-34

Unused Opioids after Outpatient Extraction

	Without dry socket	With dry socket
Patients (N)	67	5
Mean opioid analgesic pills prescribed (SD)	28 (6)	36 (11)
Mean opioid analgesic pills consumed (SD)	13 (10)	18 (9)
Patients with opioid analgesics remaining at day 21 (% of total)	61 (91%)	4 (80%)
Total opioid analgesic pills prescribed	1870	181
Total opioid analgesic pills remaining at day 21 (% of total)	1010 (54%)	92 (50%)

Maughan BC, et al. Drug Alcohol Dep 2016; 168: 328-34

Dentist vs Other Opioid Prescribers

- Prescribing of IR Opioids for acute oral pain in Medicaid recipients was conservative when compared to others:

Prescriber	Odds Ratio (95%CI)
Emergency Department	**4.66** (4.59 – 4.74) (relative to DDS)
Medical Specialist	**1.98** (1.94 – 2.01) (relative to DDS)
Nurse Practitioner	**2.64** (2.57 – 2.70) (relative to DDS)
Race/Ethnicity	
African American	**3.29** (3.18 – 3.40) (relative to Hispanic)
Non-Hispanic White	**3.29** (3.18 – 3.40) (relative to Hispanic)

Janakiram c, et al. JADA 2018; 149: 246-55

New ADA Guidelines (March 2018)

- Consistent with CMS recommendations:
  - Limit initial prescription of immediate release opioid to no more than a “7 day supply”
  - Monitor Prescription Monitoring Database
  - Prescribe/recommend opioid-sparing pharmacotherapy
    - Ibuprofen 400mg / Acetaminphen 1,000 mg more effective than Acetaminophen / Oxycodone (650/10mg)

Moore PA, et al. JADA 2018; 149: 256-68.

What is a “7 day Supply”?

- Is it 1-2 Vicodin tablets (5/325 mg) every 4-6 hours, PRN?
  - If so, that would be 2 tablets x 6/day x 7 days = 84 tablets

- Should it reflect likely need?
  - 12 tablets as mean of Maughan study?

- Should a double-prescription be offered, with the second post-dated?
- Other examples of acute pain:
  - Bunionectomy
  - Long Bone Fracture

Summary

- Dental pain is often used to seek IR opioids from various prescribers and pharmacies
- Dental extractions provide a model for gauging the benefit of various pain treatment (and prevention) modalities
- Large data sets suggest that specialists (DDS) are more likely to be conservative in their opioid prescribing than ED or others
- Specialist knowledge can inform generalists (eg, family medicine) of likely opioid needs
  - Orthopedics and other surgery