Wisconsin Opioid Project ECHO
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

For attendance purposes please text the following code: VOYYOB to 608-260-7097

Session Date: Friday August 17, 2018

Didactic Topic and Presenter: Counseling Strategies in Primary Care by Lindsey Peterson, MS, CRC

- 12:30 PM: Attendance text-in – Introductions

- 12:45 PM: Case #1 & discussion
  - Presenter: Dr. Philip Bain
  - Question: How to wean a patient with intractable headaches off of Fentanyl?

- 1:00 PM: Case #2 & discussion
  - Presenter: Dr. Randy Brown
  - Question: Suboxone/OUD management in setting of ongoing cocaine use

- 1:15 PM Didactic Presentation

- 1:30 PM: End of Mock Session

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

CONTINUING EUDCATION INFORMATION:

Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by the University of Wisconsin–Madison ICEP and the Wisconsin Department of Health Services, Division of Care and Treatment Services. The University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Designation Statements

Accreditation Council for Pharmacy Education (ACPE)

The University of Wisconsin-Madison ICEP designates this live activity for a maximum of 1 hour of knowledge-based CE credit. Credit can be earned by successfully completing this live activity. Pharmacists and Pharmacy Technicians should claim only the credit commensurate with the extent of their participation in the activity. CE credit information, based on verification of live attendance, will be provided to NABP within 60 days after the activity completion.

Pharmacists and Pharmacy Technicians must enter their NABP number in their profile in order to receive credit.

2018 Universal Activity Number (UAN)
JA0000358-9999-18-095-L04-P
JA0000358-9999-18-095-L04-T

American Medical Association (AMA)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Nurses Credentialing Center (ANCC)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.
The University of Wisconsin–Madison School of Nursing is Iowa Board of Nursing provider 350.

POLICY ON FACULTY AND SPONSOR DISCLOSURE

It is the policy of the University of Wisconsin–Madison ICEP, that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation(s).

Detailed disclosures will be available prior to the start of the activity.

WI Opioid Project ECHO 2018-2020

Counseling Strategies in Primary Care
Friday August 17, 2018
Lindsey Peterson, MS, CRC

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices
2. Participate in office-based management of opioid use disorders
3. Seek overdose prevention education with greater frequency.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD

Policy on Disclosure
It is the policy of the University of Wisconsin-Madison ICEP that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests* in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). For this educational activity, all conflicts of interest have been resolved and detailed disclosures are listed below.

** The University of Wisconsin-Madison ICEP defines a **commercial interest** as any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients The University of Wisconsin-Madison ICEP does not consider providers of clinical service directly to patients to be commercial interests.*

Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Lindsey Peterson, MS, CRC	No relevant financial relationships to disclose	No
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	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
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

Accreditation Statement

ıade possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed
s or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human
f trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

WISCONSIN DEPARTMENT of HEALTH SERVICES

WI Opioid Project ECHO 2018-2020

In support of improving patient care, this activity has been planned and implemented by the University of Wisconsin–Madison ICEP and the Wisconsin Department of Health Services, Division of Care and Treatment Services. The University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Designation Statements

Accreditation Council for Pharmacy Education (ACPE)

The University of Wisconsin-Madison ICEP designates this live activity for a maximum of 1 hour of knowledge-based CE credit. Credit can be earned by successfully completing this live activity. Pharmacists and Pharmacy Technicians should claim only the credit commensurate with the extent of their participation in the activity. CE credit information, based on verification of live attendance, will be provided to NABP within 60 days after the activity completion.

Pharmacists and Pharmacy Technicians must enter their NABP number in their profile in order to receive credit.

2018 Universal Activity Number (UAN)
JA0000358-9999-18-095-L04-P
JA0000358-9999-18-095-L04-T

American Medical Association (AMA)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Nurses Credentialing Center (ANCC)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.
The University of Wisconsin–Madison School of Nursing is Iowa Board of Nursing provider 350.

POLICY ON FACULTY AND SPONSOR DISCLOSURE

It is the policy of the University of Wisconsin–Madison ICEP, that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation(s).

Detailed disclosures will be available prior to the start of the activity.

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Program: #643618 COI for Ethos

Program Data
Program Credits
Program Categories
Delivery Types
Fee Types
Registration Charges
UWEX Registration Data
LMS Spaces

Relationships

Program Coordinators
Program Assistants
Local Coordinators
Presenters
Joint Sponsors
Direct Sponsors
Educational Reviewer
Organization Site
Grant Phases
Participants

Public Catalogs

Catalogs
Descriptions
Documents/Resources

Feedback

COI Information
Credit Letters

Actions

COI Cutoff Date 8/15/2018

Individual Name	Email	Individual Degree of Conflict (Relative to the Program's Start Date)	Unapproved Drugs?
BHATNAGAR, MD; RITU	ritu.bhatnagar@unitypoint.org	Low (0)	Yes
BROWN, MD, PHD; RANDALL T.	randy.brown@fammed.wisc.edu	Low (0)	Yes
COLLIER, ELIZABETH	elizabeth.collier@dhs.wisconsin.gov	Low (0)	No
HUTSON, PHARMD, MS; PAUL	paul.hutson@wisc.edu	Low (3)	No
KLEINFELDT, BRIANA	briana.kleinfeldt@fammed.wisc.edu	Low (0)	No
MINDOCK, SUSAN	smindock@uwhealth.org	Low (0)	No
NGO, MELISSA	mngo@uwhealth.org	Low (0)	No
NICHOLAS, CHRISTOPHER	psynich@gmail.com	Low (0)	Yes
PETERSON, LINDSEY	lindsey.peterson@fammed.wisc.edu	Low (0)	No
SPRECKER, PHD; KIMBERLY	sprecker@wisc.edu	Low (0)	No
WEIX, SHEILA	weix.sheila@marshfieldclinic.org	Low (0)	No

Conflict of Interest Summary:

Ritu Bhatnagar, MD: No Relevant Financial Relationships to Disclose
Randall T. Brown, MD, PHD: No Relevant Financial Relationships to Disclose
Elizabeth Collier: No Relevant Financial Relationships to Disclose
Paul Hutson, PHARMD, MS: Projections Research, Inc. (Consultant)
Briana Kleinfeldt: No Relevant Financial Relationships to Disclose
Susan Mindock: No Relevant Financial Relationships to Disclose
Melissa Ngo: No Relevant Financial Relationships to Disclose
Christopher Nicholas: No Relevant Financial Relationships to Disclose
Lindsey Peterson: No Relevant Financial Relationships to Disclose
Kimberly Sprecker, PHD: No Relevant Financial Relationships to Disclose
Sheila Weix: No Relevant Financial Relationships to Disclose

WELCOME

Wisconsin Opioid Project ECHO®

TeleECHO Clinic

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Please sign in by texting the following code:

VOYYOB to 608-260-7097

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written project materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Project ECHO
Wisconsin Department of Health Services

Accreditation Statement:

In support of improving patient care, this activity has been planned and implemented by the University of Wisconsin–Madison ICEP and the Wisconsin Department of Health Services, Division of Care and Treatment Services. The University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

POLICY ON FACULTY AND SPONSOR DISCLOSURE

It is the policy of the University of Wisconsin–Madison ICEP, that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation(s).

For this educational activity there are no reported conflicts of interest

Project ECHO®
Wisconsin Department of Health Services

For educational and quality improvement purposes, we will be recording this TeleECHO Clinic Session

By participating in this clinic you are consenting to be recorded – we appreciate and value your participation

Project ECHO®
Wisconsin Department of Health Services

Some helpful IT tips:

- Mute microphone when not speaking
- Position webcam effectively
- Test both audio & video
    - If joining by both video and phone combined, be sure to enter participant ID under audio options
- Communicate clearly during clinic:
    - Speak clearly
    - Use chat function
- If a “low bandwidth” message appears you may lose video access temporarily but should still hear audio. Your video will return when your internet improves.

Project ECHO®
Wisconsin Department of Health Services

To protect patient privacy, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.

Project ECHO®
Wisconsin Department of Health Services

Common Patient Identifier Slip-Ups:

1st – **Names**: Please do not refer to a patient's *first/middle/last name* or use any *initials*, etc. Instead please use the *ECHO ID*.

2nd – **Locations**: Please do not identify a patient's *county, city or town.* Instead please use only the patient's *state* if you must or the *ECHO ID*.

3rd – **Dates**: Please do not use any dates (like *birthdates*, etc.) that are linked to a patient. Instead please use only the patient's *age* (unless > 89)

4th – **Employment**: Please do not identify a patient's *employer*, work *location* or *occupation.* Instead please use the *ECHO ID*.

5th – **Other Common Identifiers:** Do not identify patient's *family* members, *friends*, *co-workers*, *numbers*, *e-mails*, etc.

Project ECHO
Wisconsin Department of Health Services

Project ECHO®
Wisconsin Department of Health Services

Counseling Strategies in Primary Care

Lindsey Peterson, MS, CRC

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Accreditation Statement:

In support of improving patient care, this activity has been planned and implemented by the University of Wisconsin–Madison ICEP and the Wisconsin Department of Health Services, Division of Care and Treatment Services. The University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

POLICY ON FACULTY AND SPONSOR DISCLOSURE:

It is the policy of the University of Wisconsin–Madison ICEP, that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation(s).

Overview

- Theories of Behavior
- What are “Helping Conversations”?
- Motivational Interviewing and Substance Use
- Five Principles of Motivational Interviewing
- Four Processes of Motivational Interviewing
- OARS Communication Skills

Overview

- Primary care clinicians may be the first resource for patients with substance or opioid use disorders
  - Co-morbid health issues often cause individuals to seek care
- Intervention by a primary care clinician may help motivate the patient to seek further treatment
- One counseling style called “Motivational Interviewing” has become an important tool for clinicians to engage with patients
  - Helps patients feel empowered to seek and maintain treatment

(Bates, 2013)

Theories of Behavior

- Ambivalence and the Righting Reflex
- Most people who need to make a change are ambivalent about doing so
  - They may see both reasons to change and reasons not to change
  - Normal part of the change process (DiClemente, 2003; Engle & Arkowitz, 2006)
- People who have a SUD/OUD are likely well aware of the downside of their behavior
- Ambivalence occurs when an individual wants two incompatible things (Miller & Rollnick, 2013)

Theories of Behavior

- Hear two kinds of "talk" mixed together
- Change talk
  - The person's own statements that favor change
- Sustain talk
  - The person's own arguments for not changing
- Both occur naturally, often within the same sentence
  - "I know I need to cut down on my heroin use, but I've tried everything and nothing has worked." (Miller & Rollnick, 2013)

Theories of Behavior

- Helpers want to help get clients on the road to health and wellness
- This may lead to the "Righting Reflex"
  - Desire to fix what seems wrong with people and set them promptly on a better course
- Ambivalent Client + Righting Reflex = ?
- When helper communicates the "good" side of the argument, a natural response is the client providing "sustain talk"
- "You have a serious heroin problem, and you need to quit."
  "No, I don't think it's that bad."
- Normal nature of ambivalence, not denial or opposition

(Miller & Rollnick, 2013)

Theories of Behavior

- Most people tend to trust their own opinions more than the opinions of others
- Causing someone to verbalize one side of an issue tends to move the person's opinion in that direction
- The client should be voicing the reasons for change

(Miller & Rollnick, 2013)

Helping Conversations

- Lie along a continuum
- Directing style
  - Helper is providing information, instruction, advice
  - Tells someone what to do and how to proceed
  - “I know what you should do, and here’s how to do it.”
  - Example: a physician explaining how to take a medication properly
- Following style
  - Helper is listening, seeking to understand, refrains from inserting their own material
  - “I will let you work this out in your own way.”
  - Example: Simply listening to a friend speak

(Miller & Rollnick, 2013)

Helping Conversations

- Guiding style
  - Listening and offering expertise where needed
  - Example: Traveling to another country and hiring a guide to help you
  - Motivational Interviewing lives in this middle ground, incorporating aspects of each (Miller & Rollnick, 2013)

Motivational Interviewing and Substance Use

- Motivational Interviewing (MI)
  - Treatment strategy developed to enhance motivation for change
  - Emerged in the context of addiction treatment
  - Strong empirical support in trials with a number of substance-using populations (Miller and Wilbourne, 2002, Dunn et al., 2001, Burke et al., 2003, McCambridge and Strang, 2004)
  - Broadly applied in a range of substance abuse treatment settings due to:
    - Empirical base
    - Short-term nature
    - Goal of improving client retention and treatment outcomes

(Carroll et al., 2006)

Motivational Interviewing and Substance Use

- Motivational Interviewing (MI) is:
  - Collaborative conversation style for strengthening a person's own motivation and commitment to change
  - Person-centered counseling style for addressing the common problem of ambivalence about change

(Miller & Rollnick, 2013)

Five Principles of Motivational Interviewing

- Express empathy through reflective listening
- Develop discrepancy between clients' goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- Support self-efficacy and optimism

(SAMHSA, 1999)

Four Processes of Motivational Interviewing

- Four central processes that form the flow of MI
- Engaging
  - *How comfortable is this person talking to me? How helpful and supportive am I being?*
- Focusing
  - *What goals for change does this person really have? Are we working together with a common purpose?*
- Evoking
  - *What are this person's own reasons for change? Am I steering too far or too fast in a particular direction?*
- Planning
  - *What would be a reasonable next step toward change? What would help this person move forward?*

(SAMHSA, 2007)

OARS Communication Skills

- Flexible and strategic core communication skills
- Used early and often throughout the MI approach
- **O**pen-ended questions
  - Elicit feelings about a given topic
  - Facilitates dialogue
  - *"What are the good things about using heroin and what are the not so good things about using it?"*
- **A**ffirmations
  - Support and promote self-efficacy
  - Validates client's experiences and feelings
  - *"You handled yourself really well in that situation."*

(SAMHSA, 1999)

OARS Communication Skills

- **R**eflective Listening
  - Demonstrating you have accurately heard and understand a client's communication
  - Checking rather than assuming
  - *"It sounds like you want to cut down on your heroin use, but you aren't sure how to start."*
- **S**ummarizing
  - Distilling the essence of what a client has expressed and communicating it back
  - Reinforce what has been said, show active listening, and prepare to move on
  - *"Here is what I have heard from you so far – tell me if I've missed anything."*

(SAMHSA, 1999)

Conclusions

- *"The expert approach is quite appropriate in acute medicine, but when the goal is personal or behavior change, this approach usually breaks down. Personal change requires the individual's active participation for the change process."*

(Miller & Rollnick, 2013)

Conclusions

- Resources
  - Wisconsin Motivational Interviewing Network of Trainers (https://motivationalinterviewing.org/)
  - Training Opportunities
    - Motivational Interviewing Certificate Program through UW-Madison Continuing Studies (https://continuingstudies.wisc.edu/certificates/motivational-interviewing/)
    - Motivational Interviewing Conference through UW-Eau Claire Continuing Education (https://ce.uwec.edu/programs/motivational-interviewing-practical-application-diverse-settings/)
    - Motivational Interviewing Development Workshops through UW-La Crosse (https://www.uwlax.edu/conted/mi/)
  - Reading Materials
    - Motivational Interviewing: Helping People Change (3rd Edition)
    - Motivational Interviewing in Health Care: Helping Patients Change Behavior (Rollnick, Miller, Butler & Aloia, 2009)
    - Strategies of Motivational Interviewing – OARS Worksheet (Miller & Rollnick, 2002)

References

Bates, H. (2013). *Motivational interviewing for primary care clinicians.* Massachusetts Behavioral Health Partnership. Retrieved from https://www.masspartnership.com/pdf/8_BHP_MotivationalInterviewingforPCCs.pdf

Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71(5),* 843-861.

Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., . . . Woody, G. E. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug Alcohol Dependence, 81(3),* 301-312.

DiClemente, C. C. (2003). *Addiction and change: How addictions develop and addicted people recover.* New York, NY: Guilford Press.

Dunn, C., Deroo, L., & Rivara, F. P. (2001). The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review. *Addiction, 96,* 1725-1742.

Engle, D. E., & Arkowitz, H. (2006). *Ambivalence in psychotherapy.* New York, NY: Guildford Press.

Enhancing Motivation for Change in Substance Use Treatment. Treatment Improvement Protocol (TIP) Series, No. 35. Center for Substance Abuse Treatment. Rockville, MD: Substance Abuse and Mental Health Services Administration (US); 1999. Report No.: (SMA) 99-3354.

McCambridge, J., & Strang, J. (2004). The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multi-site cluster randomized trial. *Addiction, 99(1)*, 39-52.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Miller, W. R., & Wilbourne, P. L. (2002). Mesa Grande: A methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction, 97,* 265-277.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (1999). *Enhancing motivation for change in substance use treatment. Treatment Improvement Protocol (TIP) Series, No. 35. Report No.: 99-3354.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2007). *Motivational interviewing: Open questions, affirmation, reflective listening, and summary reflection (OARS).* Retrieved from http://homelesshub.ca/resource/motivational-interviewing-open-questions-affirmation-reflective-listening-and-summary

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} **Physical Dependence ≠ Use Disorder**

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2–3 = mild
4–5 = moderate
≥ 6 = severe

Strategies of Motivational Interviewing – OARS

Strategies	Description	Examples
Open-Ended Questions	• Elicits descriptive information • Requires more of a response than a simple yes or no • Encourages student to do most of the talking • Helps us avoid premature judgments • Keeps communication moving forward	• Often start with words like "how" or "what" or "tell me about" or "describe." • What are you enjoying about college? • Tell me about your last major assignment or test. • What challenges you as a student? • How would you like things to be different? • What have you tried before to make a change?
Affirmations	• Must be done sincerely • Supports and promote self-efficacy • Acknowledges the difficulties the student has experienced • Validates the student's experience and feelings • Emphasizes past experiences that demonstrate strength and success to prevent discouragement	• I appreciate how hard it must have been for you to decide to come here. You took a big step. • I've enjoyed talking with you today, and getting to know you a bit. • I appreciate your honesty. • You handled yourself really well in that situation. • That's a good suggestion. • You are very courageous to be so revealing about this. • You've accomplished a lot in a short time.
Reflective Listening	• A way of checking rather than assuming that you *know* what is meant • Shows that you have an interest in and respect for what the student has to say • Demonstrates that you have accurately heard and understood the student • Encourages further exploration of problems and feelings	• It sounds like you... • You're wondering if... • So you feel... • Please say more... • Reflections are statements. Statements ending with downward inflection (as opposed to questions) tend to work better because students find it helpful to have some words to start a response. Statements are less likely than questions to evoke resistance. • Avoid "Do you mean..." and "What I hear you saying is that you...." (can appear patronizing).
Summarize	• Reinforces what has been said • Shows that you have been listening carefully • Prepares the student for transition • Allows you to be strategic in what to include to reinforce talk that is in the direction of change • Can underscore feelings of ambivalence and promote perception of discrepancy	• So, let me see if I got this right... • So, you've been saying... is that correct? • Let me see if I understand so far... • Here's what I've heard. Tell me if I've missed anything. • Let me make sure I understand exactly what you've been trying to tell me... • What you said is important. I value what you say. Here are the salient points. • We covered that well. Let's talk about...

(Miller & Rollinick, 2002)

Opioid & Addiction Treatment ECHO Patient Case Presentation

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

1-Date: 6/12/18

2-Presenter: Philip A. Bain MD

3-ECHO ID: TBD?

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

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: How can I wean this patient with intractable headaches off of fentanyl?

Demographic Information:

6-Age: 32

7-Gender: F

8-Education/Literacy: Degree in graphic design

9-Income source: unemployed due to chronic migraine/chronic daily HA

10-Insurance: DHP

11- HPI:

- 32 yr. old patient with long history of chronic headaches. Previously was seen in ER /UCC for treatment. We have tried all or nearly all common treatments for HA. The only thing that has allowed her to be functional is fentanyl patch 25 mcg Q 3 days. She is allowed to increase by 12.5 mcg when her schedule is more erratic as this is a significant ptt for worsening headaches.

12-Social History: Single. Unemployed. Good relationship with mother and father. Enjoys going to medieval reenactment fairs.

13-Housing: family home.

14- Substance Use History:

- clean- doesn't drink or use drugs currently.
- Has history of opioid overuse

15- Consequences of Substance Use:

- Social/occupational/educational: N/A

- Physical (including evidence of tolerance/withdrawal): N/A

16- <u>Behavioral Health Interventions that have been tried:</u>

- Sees therapist

17-<u>Medications Tried for Relapse Prevention? (Specify):</u>

- N/A

18-

Current Medications: (as of 6/12/2018)	Medical/Behavioral Health Diagnosis:
doxycycline (VIBRAMYCIN) 1 0 MG tablet estradiol (CLIMARA) 0.05 MG 24HR patch etonogestrel-ethinyl estradiol (NUVARING) 0.12-0.015 MG/24HR fentanyl (DURAGESIC) 12 MCG/HR patch Fluoxetine (PROZAC) 20 MG hydroxyzine hcl (ATARAX) 5 MG tablet metoclopramide (REGLAN) 10 MG tablet naloxone HCl (NARCAN) 4 M /0.1ML nasal spray naratriptan (AMERGE) 2.5 MG tablet ondansetron, disintegrating, ZOFRAN ODT) 8 MG tablet promethazine (PHENERGAN) 25 MG suppository promethazine (PHENERGAN) 5 MG tablet topiramate (TOPAMAX) 25 Md Patient has opioid pain medication agreement	Chronic daily headache Chronic migraine without aura Low serum progesterone Depressive disorder Neck pain Intractable migraine Vulvodynia Anxiety Abnormal ECG High cholesterol Hyperprolactinemia Opioid dependence in remission Insomnia

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Good family support Has been reliable in keeping appts No AODA issues	Long standing headaches Refractory to usual meds. I am esp concerned as I will have to hand off her care in 1/19 as I will be relocating.

20- <u>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.):</u>

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

- None

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

- UDS- always as expected (as long as I remember to order the specific assay for fentanyl)

22-Prescription Monitoring Program Pertinent Findings:

- Clean. I check it every time.

23-Proposed Diagnoses:

- Intractable headaches
- Chronic Daily Headache

24-Patient Goals for Treatment:

- Maintain function- ability to participate in Medieval fairs, do things with family and friends.

25- Proposed Treatment Plan:

- Continue status quo for now

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

By initialing here _____ 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)

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Opioid & Addiction Treatment ECHO Patient Case Presentation

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

1-Date: 8/17/18

2-Presenter: Randall Brown

3-ECHO ID: 1349

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

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Suboxone/OUD management in setting of ongoing cocaine use

Demographic Information:

6-Age: 26

7-Gender: male

8-Education/Literacy: HS grand

9-Income source: part time (auto parts)

10-Insurance: GHC MA

11- HPI: 5 yr. h/o injection heroin use. Arrested in setting of OD 3 mo. prior to intake. Started using cocaine in order to alleviate symptoms of heroin discontinuation. Suboxone initiated March 2018. Though urine testing is consistently reassuring vis a vis opioid use and adherence to Suboxone (16mg daily), cocaine positive persists now 3 mo. into treatment. He reports that use has decreased from multiple times daily to once each week or every 2 weeks. He has been adherent to follow-up with counseling (currently monthly), DOC programming, and with addiction medicine.

12-Social

- Living with mother and brother. Denies AODA issues in immediate family. Employed full time (auto parts). Mother is primary transportation due to DL loss subsequent to arrest.
- Significant stress due to mother's breast cancer dx and intolerance of chemotherapy. Prognosis uncertain.

14- Substance Use History:

- Low risk alcohol use
- Cannabis use on weekends
- Remote experimentation with psychedelics (psilocybin, MDMA) on ~15 occasions

15- Consequences of Substance Use:

- Social/occupational/educational: denies currently. Mother is unaware of ongoing use.
- Physical (including evidence of tolerance/withdrawal): h/o opioid w/d

16- Behavioral Health Interventions that have been tried:

- IOP followed by aftercare

17-Medications Tried for Relapse Prevention? (Specify):

- Suboxone currently

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Citalopram 20mg—initiated 6/2018	Depressive disorder

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Stable housing/employment	Legal involvement Mother's health Limited non-using social network outside family

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.):

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

Last 5 urine tests positive for cocaine metabolite, buprenorphine, norbuprenorphine and negative for other.

HIV and HCV negative

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

22-Prescription Monitoring Program Pertinent Findings:

- None

23-Proposed Diagnoses:

- Opioid use disorder in early remission
- Cocaine use disorder
- Major depression
- Psychosocial stressors
- Legal circumstances

24-Patient Goals for Treatment:

- Staying out of jail
- Discontinuation of cocaine

25- Proposed Treatment Plan:

By initialing here ___RB____ 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.

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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)

Funding for this project was made possible by grant 1H79T1080247-01 from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official polices of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.