Wisconsin Opioid Project ECHO
Agenda

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

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Zoom Meeting ID: 156 261 634

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

Session Date: Friday December 21, 2018

Didactic Topic and Presenter: Management of Opioid Use Disorders in Pregnancy by Sreevalli Atluru, MD

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

- 12:45 PM: Case #1 & discussion
  - Presenter: Sheila Weix, MSN, RN, CARN
  - Question: How to integrate behavioral health/MAT in the treatment of OUD?

- 1:00 PM: Case #2 & discussion
  - Presenter: Alison Miller, MD
  - Question: Can a urine drug screen show low dose of buprepnorphine?

- 1:15 PM Didactic Presentation

- 1:30 PM: End of Session

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WI Opioid Project ECHO 2018-2020

Management of Opioid Use Disorders in Pregnancy
Friday December 21, 2018
Sreevalli Atluru, MD

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
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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Sreevalli Atluru, MD	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
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

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CONTINUING EUDCATION INFORMATION:

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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

American Medical Association (AMA)

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The University of Wisconsin–Madison School of Nursing is Iowa Board of Nursing provider 350.

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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: 12/21/2018

2-Presenter: Sheila Weix MSN RN, CARN

3-ECHO ID: 6692

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

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: This case is being presented as a brief case study of behavioral health/MAT provider integration in the treatment of OUD

Demographic Information:

6-Age: 60

7-Gender: Male

8-Education/Literacy: High School and technical college. Worked briefly as an MA

9-Income source: Spouse has full-time employment.

10-Insurance: Private through spouse's employment

11- HPI: Degenerative joint disease.

Hypertension.

Kidney cancer s/p resection at 50

Right eye cataract

12-Social History:

From therapist's note:

FAMILY/SOCIAL/PEER HISTORY (including trauma history)

- Family history and family members with substance use disorders? Pt reports to writer no history of alcohol or drug use and or abuse in his family. Pt reports his use began in high school and in his words, "I was out of control and thought I could just stop, years later I still use pain meds".
- Social support: Pt reports spouse supportive with and adult son (22) who resides with them.
- Noted trauma, past or current: Pt reports the loss of all of his immediate family due to cancer. Reports when his 12-year-old sister died of brain cancer he feels he never dealt with her loss and nor did his family. He was 10 when she passed away. Pt reports his mother, father, brother and sister passed away all of kidney cancer. He reports he was also diagnosed with kidney cancer 9 years ago and is now cancer free.
- Strengths of client and family identified: He reports strong family support to assist him in his treatment and recovery.

13-Housing: lives with wife and son

14- **Substance Use History:**

9/6/2018 ALCOHOL/DRUG HISTORY AND SUMMARY

Pt reports his drug use began around age 18 and has continued for most part of his life. He reports he believes at one time in his life he was able to control it when prescribed pain medication and then has now come to believe he has an addiction to opioids.

Pt has scored 11/11 on the SUDDS 5. Prior to entering into treatment he reports he was using opioids daily. "I was no longer getting the same feeling from it, I knew it was a problem and my wife said you need to get help".

PHQ-9 = 25

15- Consequences of Substance Use:

- Social/occupational/educational:
  - Was unable to work or assist in home tasks due to continued use and "back pain"
  - Marital relationship stressed
  - Currently buying drugs on the street
- Physical (including evidence of tolerance/withdrawal):
  - multiple hospitalizations for pain

16- Behavioral Health Interventions that have been tried:

TREATMENT HISTORY: MD OBOT and an OBOT clinic for last 13 months. Proud that he has always passed his urine screens, but left those services over a combination of insurance and clinic rule compliance.
On initial presentation, was insisting that he be dosed at 16 mg daily. Initial induction dose was 8 mg film and he was provided with additional explanation of dosing decisions, process and options. Staff followed protocol including COWS for dosing decisions.

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

Suboxone 16 mg daily prior to our clinic.
From Clinic Alert:
Pt has hx of a broken opioid agreement (2013) due to narcotic self-escalation and of impersonating a MC physician in attempt to obtain controlled substances and requesting pain meds from multiple providers and on behalf of family members. Controlled substances advised ONLY for clear and compelling clinical indication.
Also has the Financial Alert as well.

****Course of Treatment to Date****

Level 1: 2x/week clinic contact and Rx dispensing for a minimum of 8 weeks

9/6/18 Initial diagnostic evaluation with therapist and initiation of induction
9/10/18 Co-appointment with therapist and induction team to address patient's concerns and need for alternative coping. Pt strongly believes he needs 16 mg dose. Focus on medication versus recovery work identified and explored. Pt stated he didn't need to do any of that when he "had enough Suboxone". Agreeable to journaling. Pt also established with PCP
9/17/18 Contact with PCP to discuss treatment plan and explain rationale. PCP supportive of plan.
9/20/18 Therapy: Pt focus on medication dosing. CBT with mindfulness and relaxation techniques practice

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9/24/18 Therapy: Pt attempted focus on dosing. Boundary set that this appointment is not for discussion of his medication but rather to explore other elements of his current situation and the positive steps he is taking to improve his life. Pt initially angry. Challenged therapist and then began to talk about other things including past trauma.
10/1/18 Therapy: Arrives early. More open. Admits to feeling a bit better. Planning for cataract surgery
10/9/18 Therapy: Admits to feeling better a good portion of the day. Has begun doing tasks at home.
10/11/18 UDT appropriate
10/16/18 Therapy: Working through harder part of the day. Doing more. "I feel that I am contributing."
10/18/18 **ED: Fall on street with rib contusions and fractured wrist. **Informs ED that he does not want any narcotic pain medication.**
10/23/18 Therapy: Review of progress to date with recognition of patient's efforts and strengths
10/25/18 Patient moves to Level 2 with 1x/week clinic contact on basis of Stability Tool score.
10/29/18 Cataract surgery
11/6/18 Initiation of group therapy (1x/week)
11/7/18 Therapy: Pt identifies both his previous behaviors in seeking medication and his strong negativity. He also shares his current feelings of happiness and relaxation, particularly following group. Pt is visibly different from when he presented to the clinic.
11/13/18 UDT appropriate
12/10/18 Therapy: Pt states he feels good on current dose of medication. Is able to identify coping strategies he is using routinely. Has become a leader in group and holds others accountable. Is planning to seek employment after the beginning of the year. PHQ-9=5

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Acetaminophen Amoxicillin (preprocedure) Buprenorphine/naloxone 8-2 once a day Lisinopril Narcan NO mood altering medications, muscle relaxers or sleep aids. Significant change	

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Once he processed that his body didn't need 16 mg a day: Dedication to program Holds others accountable Family is supportive Desire to work again Goals: Cataract and teeth repaired. He took care of his eye now after beginning of year he is making appointments for his teeth.	Above

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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.):

Strong work ethic in an individual who was not currently working or taking care of home-related tasks due to physical complaints. Presented as angry and dismissive of female staff. Later work indicates a level of self-loathing due to failure to work and fulfill his self-expectations as a man

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

ALL UDTs appropriate. 3 so far. 4th specimen in process and if appropriate then will go to twice a month dispensing.

22-Prescription Monitoring Program Pertinent Findings:

No controlled substances prescribed. Had been seeking street source prior to starting with this service

23-Proposed Diagnoses:

Opioid Use disorder- Severe

24-Patient Goals for Treatment:

See above for earlier goals. Currently, seeking employment; addressing dental issues;

25- Proposed Treatment Plan:

Move to Level 3 with 1x/month dispensing and continuation of group treatment.

Long-term goal to taper off medication.

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.

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Opioid & Addiction Treatment ECHO Patient Case Presentation

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1-Date: 12/21/18

2-Presenter: Alison Miller

3-ECHO ID: 5874

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

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: My clinical question is can a urine drug screen show low dose of bup?

Demographic Information:

6-Age: 40

7-Gender: Male

8-Education/Literacy:

9-Income source: works fulltime at subzero

10-Insurance: Quartz

11- HPI:

12-Social History: Married with 2 children

13-Housing: lives in Janesville rents

14- Substance Use History:

Hz of Opioid addiction. Started using oxycodone after an achilles tendon rupture in high school over 20 yrs. ago. Initially was getting a prescription. Over the years after about a week he would run through his prescription and need to buy more oxycodone on the street. No hz of IVDA. Eventually he could not find the oxycodone and did not want to use Heroin so got help.

Was put on Suboxone 15 yrs. ago and was started initially started on 32 mg. He has been weaning himself down over the years, but has never been able to completely wean off. Has been stable on 2 mg a day for 4 yrs. He is a new patient to me and I have been seeing him and now prescribing his Suboxone, but his urine drug screens have all been negative for Suboxone x 3. My clinical question is does a urine drug screen show that low of a dose of bup?

15- Consequences of Substance Use:

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

16- Behavioral Health Interventions that have been tried:

N/A

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

N/A

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Suboxone	

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events

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

- Urines negative 3x

22-Prescription Monitoring Program Pertinent Findings:

- No issues found

23-Proposed Diagnoses:

- Opioid Use Disorder in remission

24-Patient Goals for Treatment:

25- Proposed Treatment Plan:

Discussed case with provider on call for provider Hotline Service. They recommended calling our lab that does that testing to see if there are spikes in the urine for buprenorphine. The lab has a cut off and it won't be considered positive. I did call the lab and indeed there were spikes for bup and norbup.

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Management of Opioid Use Disorders in Pregnancy

Sreevalli Atluru MD
Assistant Professor
University of Wisconsin Madison School of Medicine and Public Health
Department of Family Medicine and Community Health

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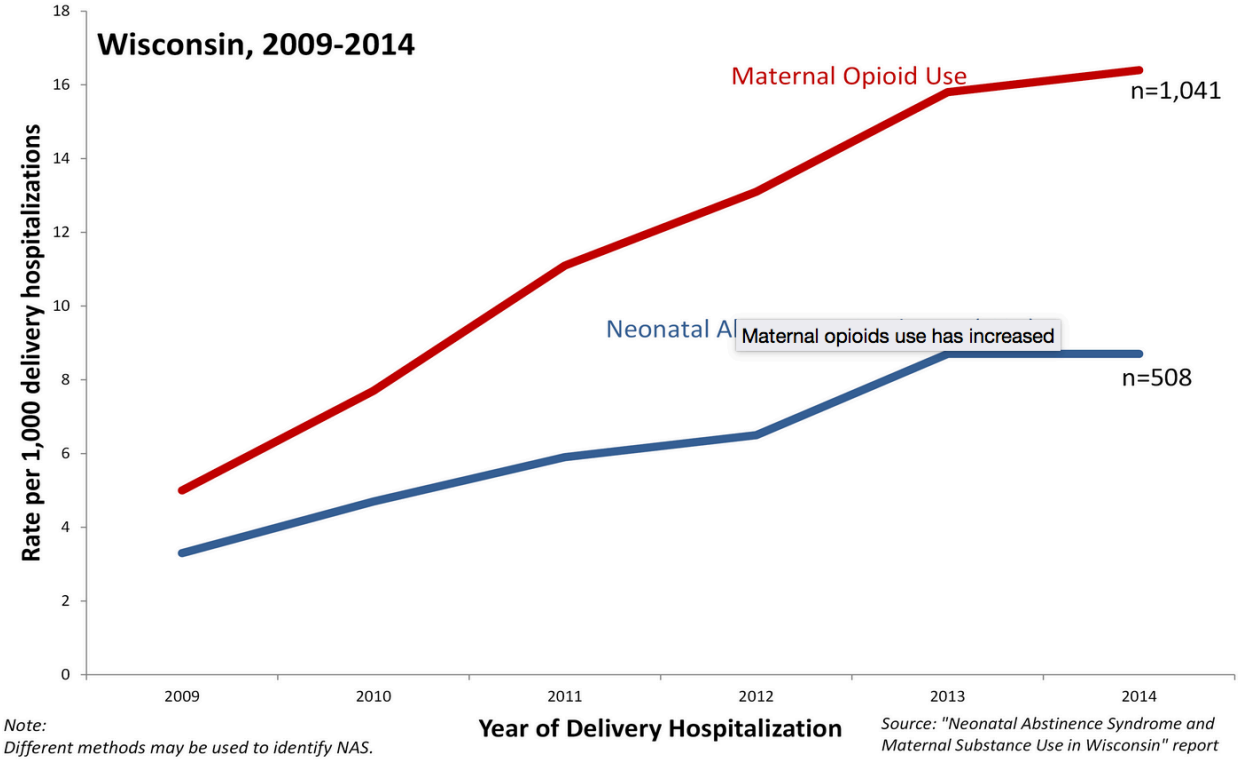
Overview

- To identify women of child bearing age at risk of opioid use disorder
- To assist providers to provide medication assisted treatment for women with opioid use disorder in pregnancy
- To ensure adequate follow up and referrals for concurrent mental health and medical comorbidities

Epidemiology

As Opioid Use Identified at the Time of Delivery Increased Among Mothers, the Rate of Neonatal Abstinence Syndrome also Increased.

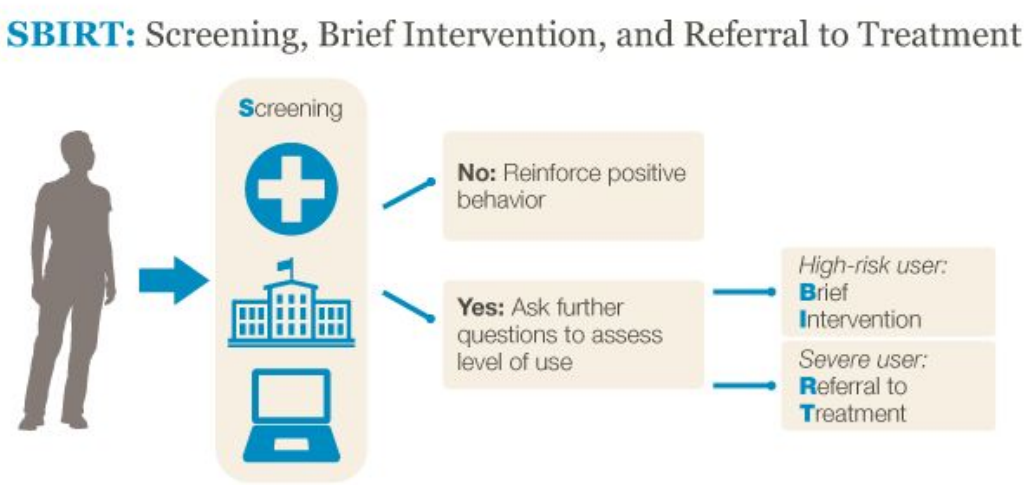


Note:
Different methods may be used to identify NAS.

Source: "Neonatal Abstinence Syndrome and Maternal Substance Use in Wisconsin" report

Project ECHO®
Wisconsin Department of Health Services

Screening


SBIRT: Screening, Brief Intervention, and Referral to Treatment
Screening
No: Reinforce positive behavior
Yes: Ask further questions to assess level of use
High-risk user: Brief Intervention
Severe user: Referral to Treatment

Treatment

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711, August 2017 *(Replaces Committee Opinion Number 524, May 2012)*

Opioid Use and Opioid Use Disorder in Pregnancy

For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes. More research is needed to assess the safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal.

Methadone

- Most evidence in pregnancy
- Daily observed dosing
- No diversion potential
- No ceiling effect
- Slightly higher rates of NAS
- Difficult to access in rural areas

Buprenorphine(Subutex)

- Office based therapy
- Diversion potential
- Need to be in withdrawal
- Ceiling effect
- Less NAS

Conclusions

- Maintenance therapy recommended
- Dosing may need to be split or increased as pregnancy progresses
- No relationship between methadone/buprenorphine dose and NAS
- Postpartum contraception talk as soon as possible
- Subutex NOT suboxone
- Growth ultrasounds: controversy
- Infectious screening every trimester/on admission

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