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: BUHFOP to 608-260-7097

Session Date: Friday March 15, 2019

Didactic Topic and Presenter:
Buprenorphine and Managing Diversion Risk by Elise Wessol, DO Addiction Medicine Fellow

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case #1 & discussion
  - Presenter: Sreevalli Atluru, MD
- 1:00 PM: Case #2 & discussion
  - Presenter: Sheila Weix, MSN, RN, CARN
- 1:15 PM Didactic Presentation
- 1:30 PM: End of Session

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WI Opioid Project ECHO 2018-2020

Buprenorphine and Managing Diversion Risk
Friday March 15, 2019
Elise Wessol, 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?
Elise Wessol Presenter	No relevant financial relationships to disclose	No
Sree Atluru, Presenter	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:

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.

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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.

2019 Universal Activity Number (UAN)
JA0000358-9999-19-002-L04-P
JA0000358-9999-19-002-L04-T

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

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Interprofessional Continuing Education Partnership
WISCONSIN DEPARTMENT of HEALTH SERVICES

Opioid & Addiction Treatment ECHO Patient Case Presentation

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

1-Date: 3/15/2019

2-Presenter Name: Sreevalli Atluru MD

- Presenter Organization: University of Wisconsin School of Medicine and Public Health/UW Health

3-ECHO ID:

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

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

- How and which medications to trial with managing her mood disorder and ADHD in setting of substance use disorder?

Demographic Information:

6-Age: 25

7-Gender: F

8-Education/Literacy: 11th grade. No GED

9-Income source: Unemployed

10-Insurance: Medicaid

11- HPI: 25 yo G1P1001 with opioid use disorder(DSM V severe), IV methamphetamine use disorder, tobacco use disorder, mood disorder NOS(concern for bipolar II based on Columbia screening), anxiety, ADHD-mixed hyperactive and inattentive, hepatitis C with elevated LFTs with frequent anger outbursts/mood swings and anxiety with sleeplessness.

12-Social History:

- Transfer of care from Green Bay WI in pregnancy to Madison. Will return to living in Manitowoc area in next 2 weeks with partner and FOB
- Smoking cigarettes <1 ppd

13-Housing:

- Lives in corrections housing at this time then will transfer back home to live at home on probation

14- Substance Use History:

Opioids: first use at age 20-21, first started using morphine, smoking Percocet due to pain/other people using; it has become regular since 2014 when starting to use heroin; the patient describes it as problematic. Never overdosed previously. Never tried suboxone. Tried vivitrol in March 2018. Was in intensive outpatient treatment March 2018.

Sedative medications: none

Stimulants: used methamphetamine in 2017; it has become regular since 2017-2018; the patient describes it as problematic; treatment: yes intensive outpatient in March 2018.

Hallucinogens: none

Inhalants: none

Ecstasy: none

Alcohol: first drink at age 14-15; drinking has become regular since 16-18; the patient describes it as problemati and got intoxicated everyday; the patient does not have history of advanced alcohol withdrawal; the patient reports no treatment:

Tobacco: has smoked since age 10, on average 2-3 cigarettes per day, for 15 years

15- <u>Consequences of Substance Use:</u>

- Social/occupational/educational: Not able to work or employed for significant periods of time though got part time jobs here and there working for companies in her home area. Partner is also in/out of jail and prison due to their substance use history. Infant is currently in her custody so long as she completes the treatment program as mandated by her probation officer and court system
- Physical (including evidence of tolerance/withdrawal): Reported she developed chills, nausea, diarrhea, increased anxiety/mood swings when not using. No known history of overdose.

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

- Intensive outpatient treatment through ARC
- Behavioral health counseling at PCP clinic: insurance limits options

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

- Suboxone: patient purchased from dealer/friend in Manitowoc, WI. Declined subutex during pregnancy. Interested in IM vivitrol.

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Wellbutrin XL 150 mg once daily Gabapentin 400mg 1 cap BID Ibuprofen 600mg 1 tablet every 6 hours as needed Abilify 2.5mg once daily(wean from 5mg to discontinue in 4 days) (trial lead to significant RLS/tardive sx and masked facies) Trial of lamictal lead to rash	ADHD OUD/MUD – severe by DSM V ?Mood disorder NOS (concern for bipolar II disorder)

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19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
- Son and keeping custody - Partner in recovery and desiring her to remain in recovery	- No MAT in her area nor connections/PCP upon return back home - History of verbal abuse(no physical abuse) in her past

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>

- None that she's reported to me

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

- UDS: Negative
- LFT: ALT 145, AST 60 (positive hepatitis C with type 3a genotype)

22-<u>Prescription Monitoring Program Pertinent Findings:</u>

- None

23-<u>Proposed Diagnoses:</u>

- Mood disorder NOS (bipolar II)
- ADHD
- SUD

24-<u>Patient Goals for Treatment:</u>

- Control mood swings, episodes where she feels "she can do anything" and sleepless nights
- Assist with treating opioid use disorder as she is concerned she will lose custody of her child if she does not maintain her recovery

25- <u>Proposed Treatment Plan:</u>

- Consideration of vivitrol IM once LFT stabilize and her hepatitis C is treated
- Other medication trials prior to her returning home?

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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: 3/15/2019

2-Presenter Name: Sheila Weix

- Presenter Organization: FHC A&DRC

3-ECHO ID:

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

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Any thoughts on additional interventions that may be helpful?

Demographic Information:

6-Age: 35

7-Gender: Female

8-Education/Literacy: GED/HSED

9-Income source: Unemployed x 3 years d/t medical issues; Relies on family for financial resources

10-Insurance: Forward Health

11- HPI: Abdominal pain, chronic, generalized

Anxiety

Depression

Diabetes mellitus

Dyslipidemia

Gastroparesis

Hypothyroidism

Iron deficiency anemia

Lactose intolerance

Migraines

Opioid Misuse.

Fibromyalgia.

Chronic Back Pain.

12-Social History: Divorced x1. Currently in relationship. Has teen-aged child

13-Housing: Lives with SO and child

14- Substance Use History:

Opioids since age 25

Marijuana since age 27

15- Consequences of Substance Use:

- Social/occupational/educational: Yes

- Physical (including evidence of tolerance/withdrawal): Yes

16- Behavioral Health Interventions that have been tried:

Several psychiatric consults while hospitalized; some involvement in counseling over the years, but limited engagement

Current meds: Cymbalta (duloxetine), Seroquel (quetiapine), gabapentin, hydroxyzine, Pamelor (nortiptyline), buspirone

Using Marijuana to treat nausea and lack of appetite – vapes and uses edibles

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

Has most recently been on fentanyl patches with episodes of uncontrolled pain leading to hospitalization;
Receives IV morphine, in addition to po tramadol and transdermal fentanyl when hospitalized
Outpatient: has been tried on several different oral opioid pain meds, most recently tramadol

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Psych meds above atorvastatin buprenorphine-naloxone film 2 mg-0.5 mg, 2 EA, Sublingual, BID calcium carbonate ferrous gluconate insulin aspart, insulin detemir levothyroxine, 150 mcg= 1 tab(s), Oral, DAILY nortriptyline, 20 mg=	Complex medical situation with 17 hospitalizations related to uncontrolled abdominal pain see Dx by HPI Major Depressive Disorder with anxious distress Personality Disorder in Adult

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19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Relationship Willingness to try alternative to current POC	Childhood sexual abuse, other trauma + family history for SUD Long term chronic health issues

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.):

Perhaps the belief that the answer lies in taking something

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

UDT: + for prescribed fentanyl & tramadol, and ongoing marijuana use

22-Prescription Monitoring Program Pertinent Findings:

Consistent with information above

23-Proposed Diagnoses:

Opioid use disorder – severe

Cannabis use disorder – mild (?)

24-Patient Goals for Treatment:

"To become pain-free"

"To be able to live a life with my family and be more active"

25- Proposed Treatment Plan:

Suboxone induction initiated 2/20 immediately following hospital discharge; Currently at 4/1 TID

3/4 – 3/6 Hospitalization

3/12 Hospitalization

Is attending individual counseling sessions in between hospitalizations. Will begin group as soon as out of hospital long enough to do so

**Note, on review of symptom onset (early morning abdominal pain in conjunction with uncontrolled vomiting) and factors that alleviate (hot showers and rehydration with IV anti-nausea medication), we are considering cannabinoid hyperemesis syndrome as potential additional diagnosis

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Buprenorphine and Managing Diversion Risk

3/15/2019

Elise Wessol, DO
Addiction Medicine Fellow
UW Madison DFMCH

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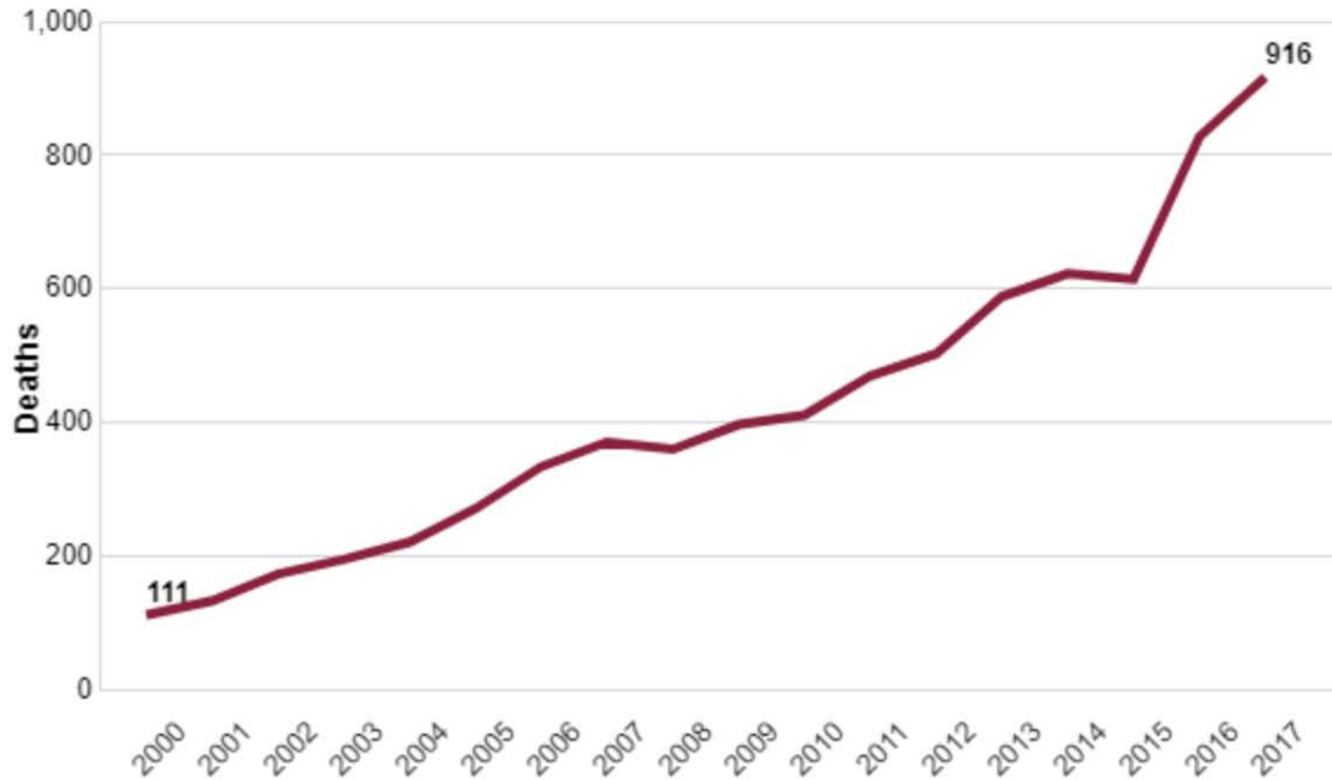
Overview

- Why MAT MATters: the benefit of prescribing Suboxone
- “Red Flags”
- Managing diversion



Opioid overdose deaths have been increasing. There were over eight times as many deaths in 2017 as in 2000.

Last Revised: December 18, 2018

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- Some providers erroneously believe that prescribing buprenorphine is contrary to a standard of care when patients continue to use other opioids or other classes of drugs. Buprenorphine helps patients reduce or cease use of other opioids. Reduced opioid use is not only an acceptable outcome, it is a desirable one. There have been concerns about prescribing buprenorphine to patients who use or misuse benzodiazepines or alcohol, as the risk of adverse reactions may be higher when either of these is combined with buprenorphine. In 2017, however, the Food and Drug Administration issued a Drug Safety Communication stating that buprenorphine should not be withheld from these patients as "the harm caused by untreated opioid addiction can outweigh these risks." [iv] Concomitant use of other opioids, cocaine, cannabis and amphetamines does not pose elevated risk in the patients taking buprenorphine and should not be a basis for terminating care.

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- Maintenance with buprenorphine can reduce morbidity and mortality even when drugs other than opioids are being used and in the presence of relapse to opioid use.

Carroll JJ1, Rich JD, Green TC. The More Things Change: Buprenorphine/naloxone Diversion Continues While Treatment Remains Inaccessible. J Addict Med. 2018; Nov/Dec;12(6):459-465

- “RED FLAGS”
  - early refills
  - lost or stolen films
  - tampered urine
  - high levels bup and naloxone without norbup

- Strategies for addressing medication non-adherence and diversion
- Asking patients to bring their unused medication into the office for counting.
- Checking urine for buprenorphine and its metabolites.
- Avoiding doses over 24mg(save in rare cases).
- Talking with family members or significant others(with appropriate consent).
- Writing prescriptions for shorter duration.

- Transition to higher level of care
  - If care is to be terminated for any reason, the prescriber should offer the patient a transfer to an alternative prescriber allowing the patient to continue medication without interruption.

Conclusions

- Treatment of buprenorphine should be continued as long as the patient is benefitting. Risk of return to illicit opioid use is high when MAT is stopped.
- Concomitant use of other opioids, cocaine, cannabis and amphetamines does not pose elevated risk in the patients taking buprenorphine and should not be a basis for terminating care.
- Buprenorphine prescribers have an important role in bringing greater access to life-saving medication to patients and to do so in a way that promotes enduring, positive outcomes.
- Practice open communication and transparency.