ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

Agenda

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Zoom Meeting ID: 156 261 634

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Session Date: Friday May 17, 2019

Didactic Topic and Presenter:
Addictions and Substance Use Disorders: Definitions and Concepts by Dean D. Krahn, MD, MS – Program Director, UW Addiction Psychiatry Fellowship Program

Content Experts:
Ritu Bhatnagar, MD and Susan Mindock, CSAC; and Sheila Weix, MSN, RN, CARN

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case #1 & discussion
  - Presenter: Kristen Fox, MD – MATS4MOMS program—Waukesha Family Medicine Residency ProHealth Care
- 1:15 PM: Didactic Presentation
  - Presenter: Dean Krahn, MD
- 1:30 PM End of Session

CONTINUING EUDCATION INFORMATION:

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Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

2018-2020

Addictions and Substance Use Disorders: Definitions and Concepts

Friday May 17, 2019

Dean D. Krahn, MD, MS

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.

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Kristen Fox, MD-Case Presenter	No relevant financial relationships to disclose	No
Elise Wessol, content expert	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	Yes
Paul Hutson, Content Expert, Pharmacy	No relevant financial relationships to disclose	Yes
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
Eun Ha Kim, Content Expert	No relevant financial relationships to disclose	No
Dean Krahn, Content Expert	No relevant financial relationships to disclose	Yes
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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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

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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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Patient Case Presentation

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

1. Date: 5/10/19
2. Presenter Name: Kristen Fox, MD,
3. Presenter Organization: MAT4MOMS program @ Waukesha Family Medicine Residency at ProHealth Care
4. ECHO ID: 1021
5. Have you presented this patient during this teleECHO clinic before? No

6. PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

   How do we determine when the right time to wean off Suboxone is? Looking for insight to help w/ shared decision making with the patient as well as practical tips on the weaning process

Patient Demographic Information:

7. Age: 32
8. Sex: F
9. Education/Literacy: College educated
10. Income source: Full time employed. Works as director of recruiting for a private school system
11. Social Factors/History: Married, 2 children (~ 4 years old and 9 mo.)

12. **Substance Use History:** Patient came to our clinic in the initial post-partum period after disclosing misuse of oxycodone to her labor nurse when the baby showed signs of withdrawal. The patient was afraid to disclose this to her OB provider prior to delivery. Ultimately she reported taking oxycodone up until a month prior to delivery and then used old Suboxone to self-medicate at a dose of 4-6 mg daily up until delivery in 8/2018.

    Timeline of Substance Use
    2011-Began using opioids as a legitimate prescription through pain management for chronic back pain. She started over-using oxycodone and then things “got out of control”. She eventually started obtaining prescriptions of the street using up to 120 mg Percocet daily. She reports only taking oxycodone orally, denies every snorting or injecting. No other opioid use, no other substance use. Does not smoke. Rare alcohol use.

2013- Completed an inpatient treatment program through Rogers Memorial. She then followed up through IOP and was initiated on Suboxone. She transitioned her Suboxone care to a "shady" cash only clinic where she felt like she had "no accountability". Eventually she started buying Suboxone off the street because it was cheaper.
2014-2015 Had a period of stability after self-weaning Suboxone. Occasional use of tramadol for LBP.

2016-Returned to old pain management physician who was now in private practice. She states she "justified" this to herself as a method to treat her pain but "knew" it was so she could get oxycodone again. It appears there was some degree of fraternization with this physician that may have contributed to less than appropriate prescribing.

Dec 2017-Found out she was pregnant and wanted to get off oxycodone but struggled to do so.

July 2018-Found old Suboxone films and decided to use these to wean off oxycodone as she thought it would be safer for the baby

August 2018-Delivered. Intake into MAT4Moms program while hospitalized after delivery.

Aug2018- patient has been doing very well on 8 mg total daily Suboxone. She is followed with monthly visits. All urine testing has been appropriate. She had 1 incident of missing strips when her toddler reportedly flushed strips down the toilet when she had them all out to cut them. Call back urine testing at this time was appropriate. She was given a lock box and there have been no further incidents. She has had no no-shows. Actively participates in behavioral health. CPS case closed. She continues to maintain full time employment. Infant is doing well.

The only "concern" throughout her treatment has been her continued self-directed dosing of Suboxone at 2 QID rather than the 4 BID. The concern arose because she report symptoms of anxiety and restlessness which raised the question of more of a behavioral need to take it so frequently rather than physiologic especially farther out post partum. Ultimately since the QID dose seemed to be effective for her we elected to continue. We also felt there would be some benefit for her underlying chronic pain.

4/2019- Patient began to ask about weaning off Suboxone. She is 8 months post partum. We discussed the "why" behind this and she stated she wants to get past the point where she needs a daily medication. She feels she has made many strides in her recovery and wants to be at the point where she can "do it on her own". She doesn't like the "constant reminder" of her past every time she takes a film.

We have several concerns about weaning off. First, she is still quite early in her treatment and in the 1st year post partum which we consider a high risk time for relapse. Second, she has returned to oxycodone use after Suboxone maintenance previously, albeit in a much less robust treatment setting. Third, she continues to have chronic pain and her preference to dose QID suggests she is getting some analgesic benefit from the Suboxone.

In terms strengths/reasons to wean she certainly has made huge strides into her insight into her OUD. When we first began working together she never really identified with the idea of having an addiction but mostly perseverated on her pain. She now understands how this evolved into OUD. She has a very stable social situation and support network. She is married with good support from her husband. She is employed in HR and has a stable position. Stable transportation and housing. She has a strong faith and is actively involved in her church.

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13. **Consequences of Substance Use:**
    - Social/occupational/educational: Continued use of illicit oxycodone while pregnant, significant strain on her marriage due to not disclosing use in pregnancy to her husband, financial strain/mistrust form diverting funds to purchase oxycodone and illicit Suboxone, intense feelings of guilt and shame

    - Physical (including evidence of tolerance/withdrawal): withdrawal symptoms agitation, anxiety, depression, irritability/labile mood, nausea, diaphoresis

14. **Interventions that have been tried: As above**

15.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Suboxone 4-1 BID (patient divides into 2-0.5 QID)	• OUD moderate in early remission on maintenance therapy • Some suspicion for underlying depression but does not meet criteria when on Suboxone so ? if this is more an issue of protracted withdrawal in the past

16.

Patient Strengths/protective factors:	Risk factors:
• Strong Social network • Employed • good insight	• Chronic pain • 1st year post partum • Prior relapse after stopping Suboxone

17. **Labs (as indicated), include summary of urine testing or last urine drug screen results:**
    All confirmatory urine testing has been consistent with treatment

18. **Patient Goals/Motivations for Treatment:**
    Patient would eventually like to be "off of everything"

19. **Proposed Diagnoses:**
    Opioid use disorder, moderate, in early remission on maintenance therapy

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20. Proposed Treatment Plan:

Would like to have a group discussion on addressing her desire to wean. We had a really good discussion on this during our last visit and she is coming to understand our concerns about weaning at this time as well. We are working on trying to change her perspective of what being "clean" is. We are emphasizing how well she is doing as the very reason why she should continue treatment.

That said, she has fair and reasonable questions about the next steps. She also feels frustrated about having to take medication every single day.

We brainstormed several options:

1. No change. Continue SL Suboxone and work with our BH to address her thoughts about "being clean" and the sense that Suboxone is a "constant reminder"

2. Consider transition to Sublocade. Currently not available in our system but it's in the works. Would be a nice option to address her concerns over taking something daily. Our concern however is the loss of the analgesic effect which could lead to a flare in pain which is what lead to relapsing on oxycodone in the past. We feel strongly that if we were to entertain this option we would need a comprehensive plan to address her pain including functional goals, non-opioid medications, therapies, etc. We have reached out to her PCP to assist with coordinating this but it is outside their comfort zone so we may need to involve PMR/PM again. (While we are family physicians and could certainly mange this we have elected to severe in a focused consulting role in this program so as to work well within our organization).

3. Transition to Vivitrol. As she is highly motivated and stable she could be a candidate but again the concerns over pain management arise.

By initialing here __KF__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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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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Addictions and Substance Use Disorders: Definitions and Concepts

DEAN D. KRAHN, MD, MS

DIRECTOR, UW ADDICTION PSYCHIATRY FELLOWSHIP

ADDICTION PSYCHIATRIST AND STAFF PSYCHIATRIST AT VA-MADISON, ROCKFORD CLINIC

- No financial disclosures

- One disclosure I do need to make is when people asked me to do this talk for the Fellowship or for the Echo program, I called Dr Kevin Sevarino who has led the AAAP annual review on addictions and their treatments and obtained his gracious permission to borrow from his talk on this topic

What will we cover today?

- Definitions
- Epidemiology/Impact

What is Addiction?

- The 3 (4) C's of Addiction:
  - Compulsion
  - Loss of Control
  - Consequences
  - (Craving)
- Inability to Control Use Despite Adverse Consequences

- Neither of these are formal definitions, but often used

DSM IV Drug Abuse

- Maladaptive substance use leading to clinically significant impairement or distress, as manifested by one (or more) of the following, occurring at any time in the same 12-month period
  - 1. Recurrent substance use leading to failure to meet work, school, or home obligations
  - 2. Recurrent substance use in situation that is physically hazardous
  - 3. Recurrent substance-related legal problems
  - 4. Substance use continues despite persistent or recurrent social or interpersonal problems caused by use
  - 5. Never met criteria for dependence

Drug Dependence (DSM IV)

- Maladaptive substance use leading to clinically significant impairment or distress, as manifested by 3+ of the following, occurring any time in same 12 month period:
- 1. tolerance
- 2. withdrawal
- 3. substance taken in larger amounts or over longer period than intended.
- 4. persistent desire or unsuccessful efforts to cut down or control substance use
- 5. a great deal of time spent in activities necessary to obtain substance or recover from its effects
- 6. important social, occupational, or recreational activities are given up or reduced because of substance use
- 7. substance use continues despite physical or psychological problems caused or exacerbated by substance

Why did DSM designers change from these two entities to SUD's?

- 1. physical dependence does not equal drug dependence
- 2. abuse doesn't necessarily precede or progress to dependence
- 3. substance use and misuse are arrayed along a continuum

DSM-5 Definition: Substance Use Disorder

- Maladaptive pattern of substance use leading to significant impairment or distress, as manifested by 2 (+) of the following within 12 month period:
- 1. substance taken in larger amount/longer period than intended
- 2. persistent desire or unsuccessful efforts to control substance use
- 3. craving or a strong desire or urge to use the substance
- 4. use continues despite knowledge of phys/psych problem
- 5. recurrent use in situations in which it is physically hazardous
- 1-5 indicative of lack of control
- 6. great deal of time spent to obtain, use or recover from effects
- 7. recurrent use resulting in failure to fulfill major role obligations
- 8. continued use despite recurrent social and interpersonal probs
- 9. important social/occup/recreational activities stopped/reduced
- 6-9 indicative of use despite adverse consequences
- 10. tolerance (not counted for prescribed meds)
- 11. withdrawal (not counted for prescribed meds)
- 10-11 Dependence///Mild SUD = 2-3; Mod SUD 4-5; Severe 6+

ASAM Definition

- Addiction is characterized by: (ABCDE)
- A. Inability to consistently **A**bstain (Control)
- B. Impairment in **B**ehavioral control
- C. **C**raving
- D. **D**iminished recognition of significant problems (Consequences)
- E. A dysfunctional **E**motional response (? compulsion

Addiction or Substance Dependence is :

- 1) A compulsion to seek or take a substance (craving)
- 2) Loss of control in limiting intake (binge)
- 3) Emergence of a negative emotional state when access denied (withdrawal and/or protracted withdrawal)
- Koob GF (2008) Textbook of SA Treatment

Behavioral Constructs of SUD Progression

- 1) Abuse---→Dependence
- 2) Impulse Control----→ Compulsive Disorder
- 3) Positive Reinforcement (reward)--→Negative Reinforcement