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

Agenda

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

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Session Date: Friday December 20, 2019

Didactic Topic and Presenter:
Substance Use Issues in Older Adults
Randall Brown, MD, PhD, DFASAM - UW Project ECHO ACCEPT Project Director

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 Presentation & Discussion
  - Presenter: Sheila Weix, MSN, RN, CARN
- 1:15 PM: Didactic Presentation
  - Presenter: Randall Brown, MD, PhD, DFASAM
- 1:30 PM End of Session

Funding for this service was made possible by 435200-G-18-11448-285932-880 from Wisconsin Department of Health Services. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies 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 or the State of Wisconsin.

ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

2018-2020

Substance Use Issues in Older Adults

Friday December 20, 2019

Randall Brown, MD, PhD, DFASAM - UW Project ECHO ACCEPT Project Director

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 substance use disorders.
3. Seek, with greater frequency, overdose prevention education.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of substance use disorders.

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?
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Paul Hutson, Content Expert, Pharmacy	Consultant for Projections Research Inc.	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
Lindsey Peterson, MS, CRC, 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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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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Patient Case Presentation

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

1. Date: 12/20/2019
2. Presenter Name: Sheila Weix
3. Presenter Organization: MCHS-FHC
4. ECHO ID: 8126
5. Have you presented this patient during this teleECHO clinic before? No
6. PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Does anyone have alternative suggestions for the care of this patient?

Patient Demographic Information:

7. Age: 28
8. Sex: F
9. Education/Literacy: GED
10. Income source: Social support programs
11. 1Social Factors/History: SO & 2 minor children: strong family history of use

12. **Substance Use History:**

Entered MAT 2016 during pregnancy (OBOT) + reported counseling
Transitioned to SUD services with MAT 2017
Daily opioids and methamphetamine prior to starting tx
Injecting since age 21

13. **Consequences of Substance Use:**

- Social/occupational/educational: has lost placement of children in the past, regained placement
- Not employed; relationship stressed by use
- Physical (including evidence of tolerance/withdrawal): Hep C +; Injection sites on neck

14. Interventions that have been tried:

March 2016 45 day residential tx
Entered MAT 2016 during pregnancy (OBOT) + reported counseling
Transitioned to SUD services with MAT 2017
MAT with required counseling November 2016-October 2019 Entered MAT 2016 during pregnancy (OBOT) + reported counseling
Transitioned to SUD services with MAT 2017
Matrix ERS

15.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Suboxone taper • Sertraline • BuSpar • Olanzapine	• OUD severe • Amphetamine use disorder severe • PTSD • Hep C

16.

Patient Strengths/protective factors:	Risk factors:
• Relationship • Has had periods of increased stability (up to 3 months) followed by return to use	• Continued use with refusal of higher level of care • Very uneven involvement in services

17. Labs (as indicated), include summary of urine testing or last urine drug screen results:

Pt currently on MAT, findings:

(*) CONCERN - MAT positive but levels suggest potential INJECTION PROFILE (where either BUP > NORB or BUP is elevated for Hep C norm group). BUP Ratio Z-score elevated at +3.53 and BUP >>>> than NORB both suggesting injection. Pt reported last injection of "water" on xxxx but UDT suggests Suboxone Injection.

(*) CONCERN - POSITVE for METHAMPHETAMINE and related amphetamine suggesting CONFIRMED USE (due to history OR chiral analysis) with ratios of 5 and 2.7 respectively. Pt denied use but clearly has had some exposure.

18. Patient Goals/Motivations for Treatment:

Continued use in outpatient level of care; Refused needed residential care

19. Proposed Diagnoses:

20. Proposed Treatment Plan:

Naltrexone if she returns

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By initialing here __SW___ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

DSM 5 Criteria for Substance Use Disorder

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

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

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Department of Family Medicine and Community Health
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

PROTEA
Program for Research, Outreach, Therapeutics, & Education in the Addictions

Substance Misuse & Use Disorders in Older Adults

Randall Brown MD, PhD, DFASAM
UW Project ECHO: ACCEPT
December 18, 2019

Project ECHO University of Wisconsin

Introduction

- Geriatric U.S. population to reach ~72.1 million by 2030
- ↑↑ lifetime illicit drug use vs prior cohorts (47% vs 19%)
- Substance use disorders (SUDs) doubled [2.8 million in 2006 → 5.7 million in 2020 (17% of those over 65)]
- One of the fastest growing health problems in the U.S.
- Under-recognized (stigma, system/provider bias)
- Complicates wellness, function, and chronic illness mgmt

Overview

- Definitions & overarching concepts
- Epidemiology
- Medical management issues
  - Alcohol
  - Rx medications: Opioids & sedative-hypnotics

Risk Factors

- Family/personal history
- Male
- White or AA race
- Unmarried/divorced
- Bereavement or depression
- Chronic pain/illness
- Disability
- Loneliness/social isolation
- Being a caregiver
- Change in living situation/career
- Lack of spiritual community/practice

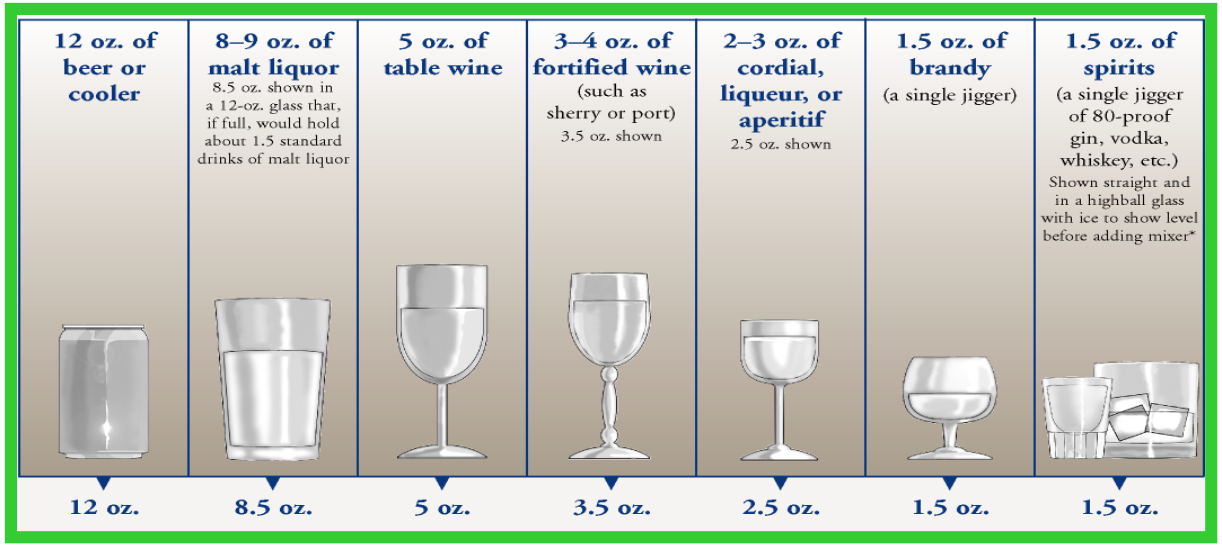
Indicators: At-Risk & Problem Use

Physical Sx/Indicators
Falls/injury
Impaired self-care/nutrition
Incontinence
Unusual med response/sensitivity
Idiopathic seizures
Dizziness
Blackouts

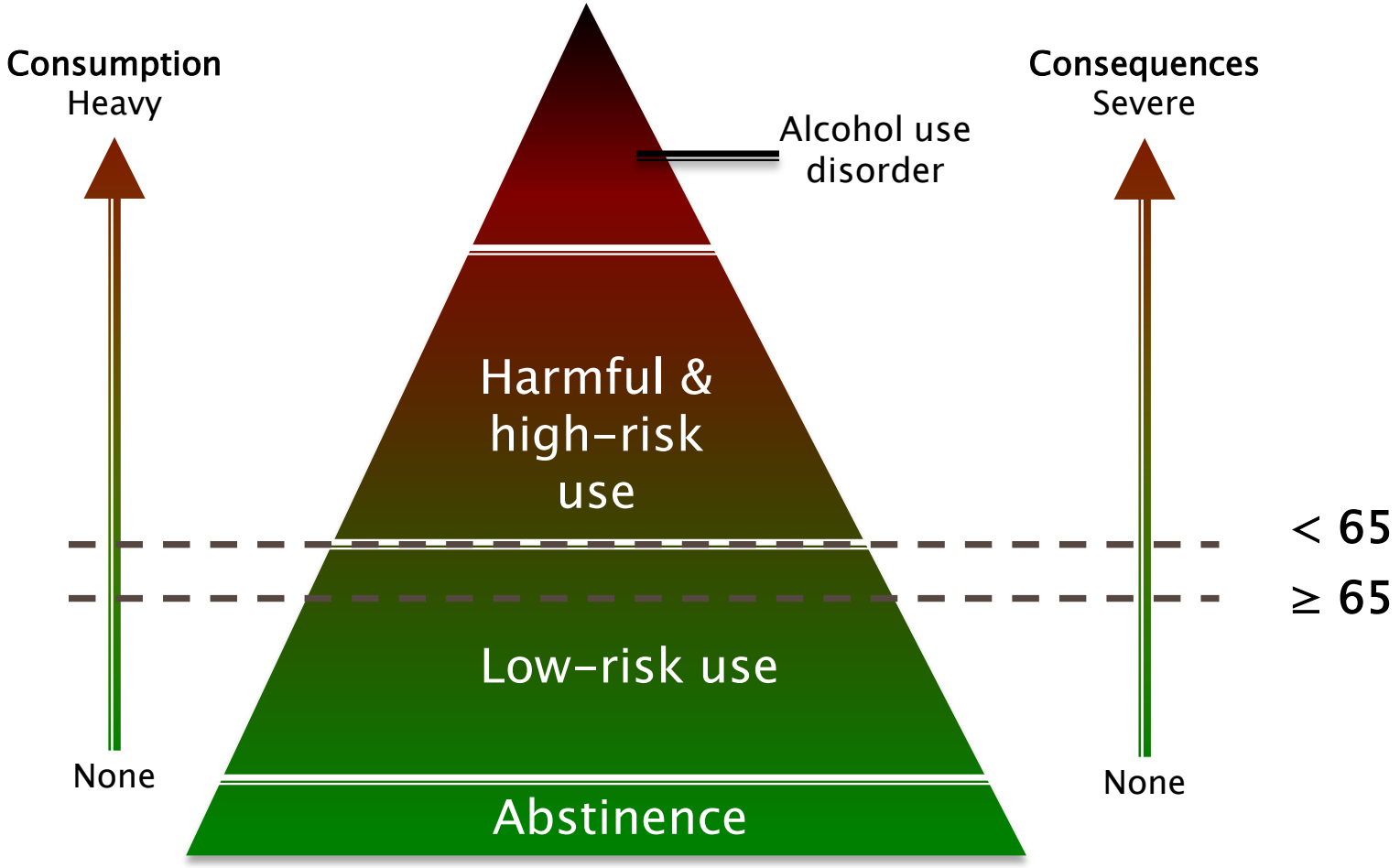
Cognitive/Psychiatric/Social
Disorientation
Memory impairment
Impaired decision-making
Anxiety/depression
Insomnia
Excessive mood swings
Isolation
Med over-use/borrowing
Family/financial problems

Alcohol

Recommended Limits



- For healthy **men up to age 65** — ≤ **4** in a **day** AND ≤ **14** in a **week**
- For healthy **women** (and healthy **men over age 65**)— ≤ **3** in a **day** AND ≤ **7** in a **week**


Consumption
Heavy
None
Consequences
Severe
None
Alcohol use disorder
Harmful & high-risk use
Low-risk use
Abstinence
< 65
≥ 65

Screening for Older Adults

	Sensitivity (%)	Specificity (%)
MI Alcohol Screening Test-Geriatric Version (MAST-G)	95	78
CAGE	65	40
Alcohol Use Disorders Identification Test (AUDIT/AUDIT-C)	83	91

"Binge" questions = most sensitive

AUDIT-C: 3 items on 0-4 Likert Scale

1. How often did you have alcohol in past yr?
   - Never - Monthly or less - 2-4x/mo - 2-3x/wk - 4+/wk

2. How many drinks did you have on a typical drinking day in past yr?
   - 1-2 - 3-4 - 5-6 - 7-9 - 10+

3. How often did you have ≥ 6 drinks on one occasion?
   - Never - < monthly - monthly - weekly - daily or almost daily

0-2 low risk 3-4 low-mod ("bibliotherapy") 5-7 mod/at-risk (BI) > 7 possible AUD

AUD Management

- Pharmacotherapy
  - Naltrexone
  - Acamprosate
  - Gabapentin (see w/d)
  - ~~Disulfiram~~
  - ~~Baclofen~~
  - ~~Topiramate~~

- Tx outcomes in older adults ≈ those in younger
- Access to elder-focused Tx programs is very limited

Rx Medications: Benzodiazepines & Opioids

Rx Drug Misuse Among Older Adults

- Older adults at greatest risk of misuse of Rx acquired from prescriber
  - More clinic contact
  - More pain-related visits
  - More benzodiazepine (BZ) Rx's
  - → Most misuse episodes & dependence are inadvertent
- More likely to cause memory and psychomotor abnormalities and functional impairment
  - ↑ Drug interactions (> 30% have 5+ Rx meds)
  - ↓ Volume of distribution & metabolism
  - ↑ Consequences: Falls, MVCs, ED utilization. . .

Screen Consideration

- Limited data/consensus
- Severity of Dependence Scale
  - Brief (5 items), each on 0-3 Likert Scale (worry, out of control)
  - Recent validation (Cheng 2019) in sample of older adults (n = 246)
  - ROC AUC 0.86
    - "Optimal" cut-off ≥ 6
    - Sensitivity 0.76, Specificity 0.86, PPV 0.76, NPV 0.85

Opioids

- Rx >> illicit
- As with other Rx substances, unintentional misuse/dependence more common
- Source more commonly = prescriber
  - If Rx'd, explore and counsel re: storage/environment
  - Majority of younger who misuse opioids obtain from family member/friend who obtained from single prescriber

Rx Opioid Considerations

- Can be considered for mod-severe pain impacting function, but:
  - Initiation w/ long-acting → ↑ overdose
  - Use lower dose than younger age groups
- Remember that tramadol/tapentadol are opioids!
  - Also associated w/ ↑ fall/fracture risk
  - ↑ delirium vs other opioids
- Consider use of buprenorphine preparation
  - Less sedation
  - Generally no ↑ in $t_{1/2}$ with aging
- Highly variable metabolism + cardiac risk (QT ↑) for methadone
  - Also a consideration for opioid use disorder pharmacotherapy

Tapering

- "CDC advises against misapplication of the guideline. . ."
  - Rapid taper associated with opioid w/d, pain, suicide
- Target < 50 MMED
- Go slow
  - 5-10% of max dose ↓ every 1-2 weeks
  - Be flexible to slow, without reversing, taper
- Consider adjunctive Rx's (e.g. clonidine/lofexedine, PRNs for Sx) during last ½ of taper

Benzodiazepines

- Most common psychiatric Rx med among all adults
  - 15-32% of adults over 65
  - Most common indications – insomnia, anxiety (poor quality evidence of long-term effectiveness, particularly in older adults)
- ↑ sensitivity in older adults
  - ↓ lean body mass ↑ fat → ↑↑ duration of action
    - Active metabolites and long half-life further increase risk of long-acting BZ's (diazepam, chlordiazepoxide) → relatively contraindicated for older adults
    - If indicated (short-term only), shorter half-life, less lipid soluble preparations are recommended (clonazepam, lorazepam)
- Physical dependence can develop w/ < 2 wk of continuous use

Benzodiazepines: Complications

- Dependence
- Falls/fractures
  - Disrupted balance, balance, visual impairment
  - 50% absolute ↑
  - Dose-dependent risk w/ detectable increase beginning at 0.3mg lorazepam equivalent daily
- Cognitive decline
  - Short-term: memory, learning, attention, and visuospatial ability
  - Longer-term: association w/ cognitive deficit, dementia
- Mortality (2-4x ↑)

Benzodiazepines: AGS Recommendations

- Generally to be avoided (strong rec; mod evidence)
- Specifically to be avoided in setting of
  - Fall history (strong rec; high quality evidence)
  - 2+ psychiatric medications (strong rec; high quality evidence)
- Non-BZ, BZ receptor agonists ("Z drugs") also viewed as contraindicated (change from 2012)

Tapering BZ's

- "The slower the better"
  - Anticipate several weeks if not months
  - Switch to long-acting NOT recommended
  - Be flexible about slowing rate

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1 and 2	Full	Full	Full	Full	Full	Half	Full
3 and 4	Full	Half	Full	Half	Full	Half	Full
5 and 6	Half	Half	Half	Half	Half	Half	Half
7 and 8	Half	Half	Half	Half	Half	Quarter	Half
9 and 10	Half	Quarter	Half	Quarter	Half	Quarter	Half
11 and 12	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter
13 and 14	Quarter	Quarter	Quarter	Quarter	Quarter	0	Quarter
15 and 16	Quarter	0	Quarter	0	Quarter	0	Quarter
17 and 18	Quarter	0	0	Quarter	0	0	Quarter
19	0	0	0	Quarter	0	0	0
20	0	0	0	0	0	Quarter	0
21	0	0	0	0	0	0	Quarter
22	0	0	0	0	0	0	0

Adapted from Markota et al 2016. Mayo Clin Proc, 91(11).

Tapering BZs

- Adjunctive Tx possibly helpful, but studies limited (or negative)
  - Insomnia
    - Doxepin ≤ 6mg*
    - Avoid BZ receptor agonists anti-cholinergics
  - Anxiety
    - Cognitive behavioral therapy*
    - TCA's risky and not effective
    - SSRI's
      - may ↑ fall risk & fx risk (↓ bone density)
      - Monitor Na
      - Avoid those with anti-ACH effects (e.g. paroxetine)
      - Avoid combination with other psychotropics

Recent Request for Advice

I am wondering if you can offer any tips/advice on how to safely cease prescribing controlled substances for a patient who has violated her contract multiple times?

I have inherited on my panel an 80 year old primary care patient on oxycodone and alprazolam who has had substance misuse issues in the past. She's on alprazolam 0.5 mg QID and oxycodone 10 mg, five times daily. The past 4 times she's come to our clinic, she's asked for more meds and the nurse practitioner who has been seeing her has reviewed her controlled substance contract each time and appropriately refused to offer additional controlled substances. She's also been inappropriate on the phone with our nursing staff, demanding early refills.

She went to an outside hospital ED over the weekend stating she'd run out of her alprazolam (early) and they gave her a week's supply.

So, our clinic is now interested in ceasing to prescribe for her due to clear contract violation. But I've actually never had to cut someone off, and wonder how to best do this as ethically/safely as possible? I'm worried about her benzo withdrawal (and also the risk that she'll proceed to find meds illegally if/when we cut her off).

Should I prescribe a clear-cut taper?

Conclusions

- Older adults are particularly vulnerable to complications of substance misuse
- SUDs are increasingly common, but under-recognized in older adults
- Rx misuse is most frequently inadvertent
  - Close monitoring
  - Appropriate counseling and support
- “Start low, go slow” when initiating OR tapering Rx

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Thank you!
Questions?
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