Humboldt Opioid Summit
AGENDA

Friday, April 26, 2019
Fortuna River Lodge
1800 Riverwalk Dr, Fortuna, CA 95540

WIFI NETWORK: City of Fortuna Guest

MATERIALS CAN BE VIEWED AT http://www.rxsafehumboldt.org/ | 2019 Humboldt Opioid Summit

8:00 to 8:30 am	Registration and Breakfast

8:30 to 9:00 am	Welcome & Mindfulness Activity.....2-12
9:00 to 10:15 am	**Keynote Address: Opioids In Our Backyard** **Dr. Matthew Polacheck, PsyD, MA** 13-30
10:15 to 10:30 am	Break
10:30 to 11:45 am	Complementary Therapies for Management of Pain Panel ❖ Mindfulness for Patients (Heidi Bourne).....31-32 ❖ Cannabis for Pain (Diane Dickinson, MD).....33-35 ❖ Tai Chi for Pain (Candice Brunlinger).....36-37 ❖ Integrative Services (Connie Earl, DO, ABIHM) 38-39
11:45 to 12:15 pm	Break: Get Lunch
12:15 to 1:15 pm	Complex Pain Management (Dr. Corey Waller, Health Management Associates).....40-50 ❖ Tapering ❖ Handling Multi-high risk prescriptions ❖ Rx Management
1:15 to 2:50 pm	Treating Pain and Addiction: Remembering the Patient ❖ Hub-Spoke Model: Tale of a Small Health Center (Mandi Battles, PA, Redwoods Rural Health Center) .....51-54 ❖ Integrated Suboxone Program (Willard Hunter, MD, Open Door Community Health Centers) ❖ Perinatal Substance Use Treatment (Candy Stockton, MD, Humboldt IPA) .....55 ❖ California Bridge-ER/Inpatient MAT (Andrew Herring, MD, ED Bridge) 56-59
2:50 to 3:00 pm	Closing and Evaluations

CME/CEU: Application is being submitted. Determination of credit is pending.

This event was supported by the California AHEC with HRSA grant number U77HP23071 and the California Hub and Spoke System MAT Expansion Project.

Humboldt IPA | NORTH COAST CLINICS NETWORK | AHEC | AEGIS

SAFE HUMBOLDT

Safer Care and Better Outcomes

Est. 2013

SAFE HUMBOLDT

Safer Care and Better Outcomes

Develop and implement community standards and supporting infrastructure for diagnosis and treatment for chronic pain

- Provide patients with optimum care consistent with the risks of treatment
- Support diagnosis and treatment for acute pain recognizing the risks of treatment, across providers and settings prescribing opioids
- Develop strategies for minimizing misuse and diversion of prescription pain medications

Strategies for Getting to Zero Overdose Deaths in CA

Prevent
addiction and harm

- Fewer new starts on long-term opioid use
- Opioids used for fewer diagnoses, shorter durations, and lower doses
- Upstream prevention and education

Manage
chronic pain safely

- Alternative pain therapies
- Slowly tapering high dosages to safer dosages
- Limiting opioids + sedatives

Treat
addiction

- Medications for addiction treatment (MAT)
- Reduce stigma

Stop
overdose deaths

- Naloxone
- Needle exchanges
- Supervised injection sites

Coalition Partners

- Humboldt Independent Practice Assoc.
- North Coast Health Improvement and Information Network
- Open Door Community Health Centers
- North Coast Clinics Network
- Partnership Healthplan of California
- Mad River Community Hospital
- Humboldt County Sheriff's Department
- Humboldt County Department of Health and Human Services
- Humboldt County Public Health Department
- St. Joseph Health, Humboldt County
- Humboldt Area Center for Harm Reduction
- Cloney's Pharmacy
- Aegis Treatment Centers
- Community members

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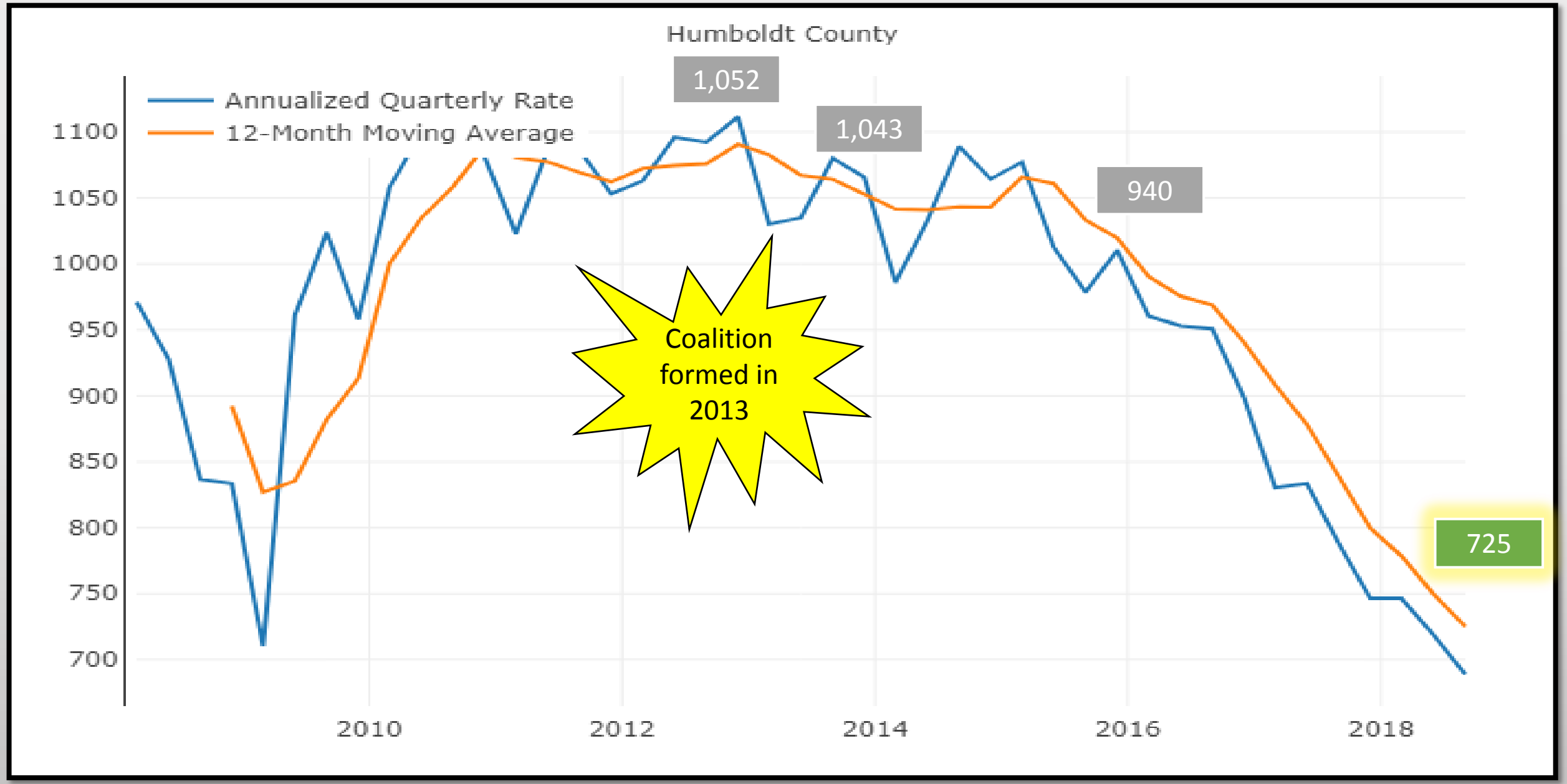
Safer Care and Better Outcomes

Coalition Accomplishments

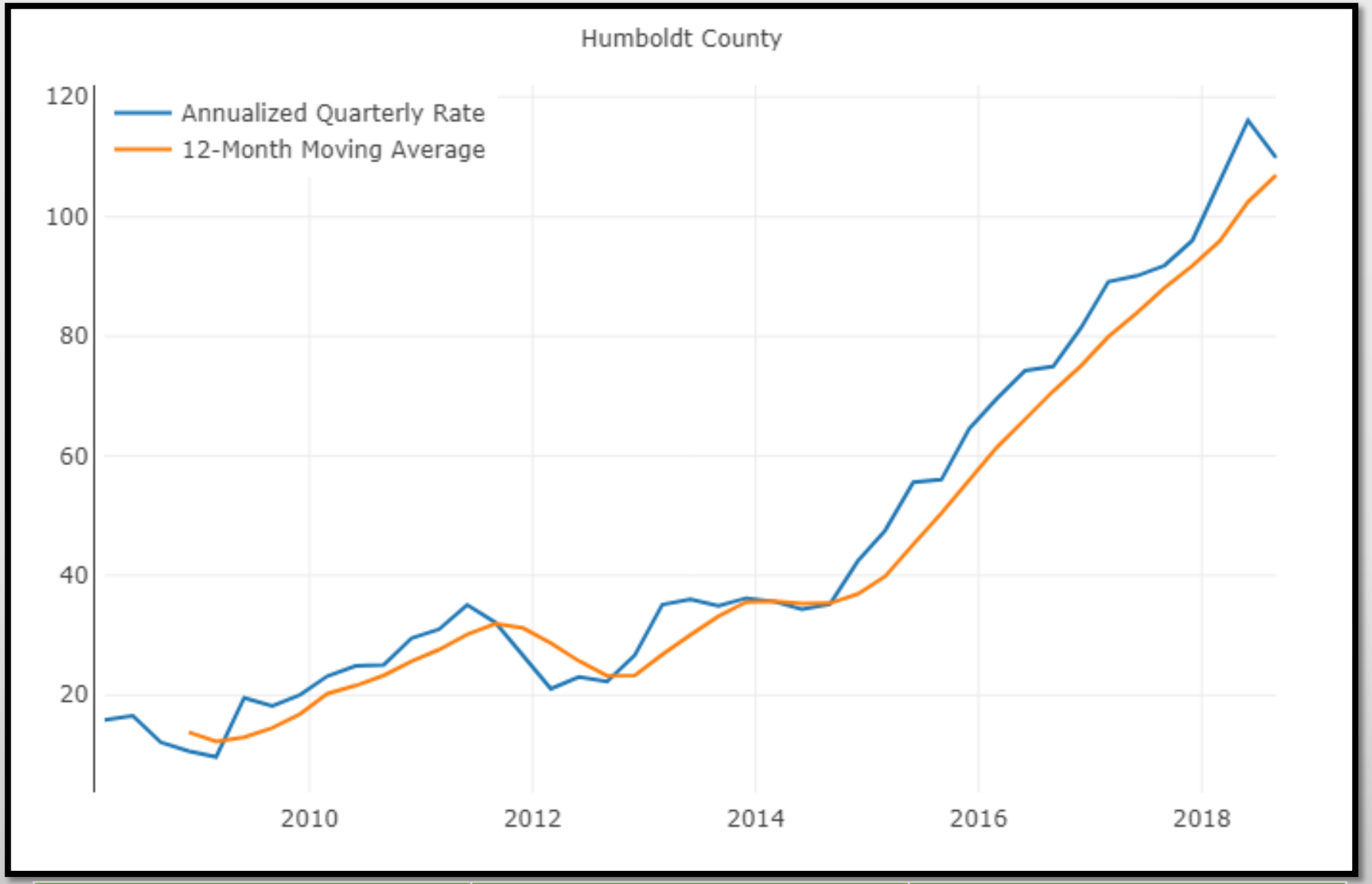
- 12 Medication Disposal Bins located across Humboldt County
- Over 5,000 lbs. of unwanted prescriptions disposed of in the last 3 years

- Naloxone kits distributed by the Humboldt Area Center for Harm Reduction and the County Public Health Department.
- Several hundred over dose reversals reported each year.



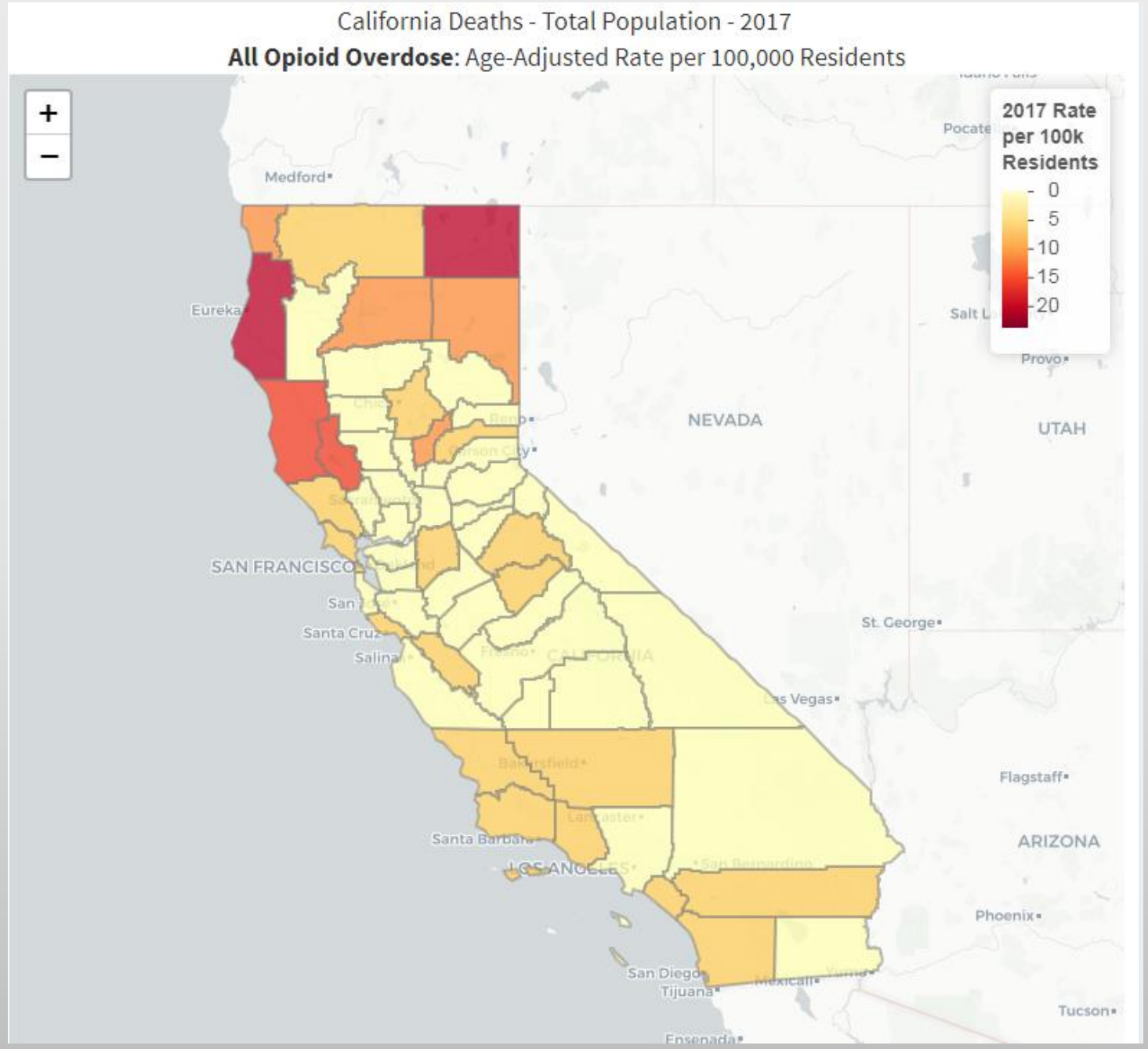
Opioid prescriptions (excl. bup) by prescriber location, age adjusted per 1,000 12 month moving avg. CDPH Opioid Dashboard

Buprenorphine Average Prescribing Rates per 1,000



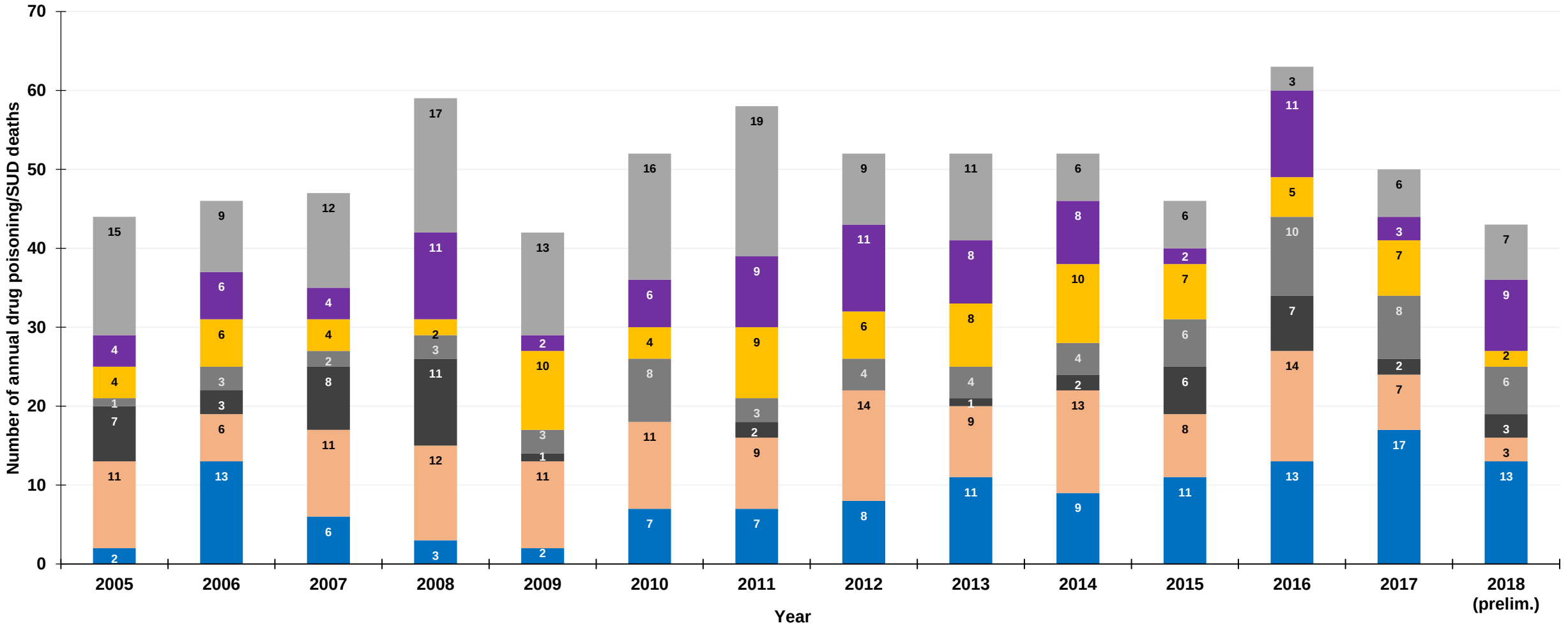
	2013	2018 Q3
Humboldt County	**35.58**	**106.96**
California	11.18	14.29

12 Month moving average by patient location - CDPH Opioid Dashboard



County	Rates	Counts
Modoc	23.58	3
Humboldt	**21.03**	**28**
Mendocino	19.34	17
Lake	17.02	13
Shasta	14.06	24
Lassen	13.91	5
Yuba	13.15	9
Del Norte	12.56	4
Siskiyou	9.97	4
Ventura	9.8	85
San Francisco	9.62	99
California	**5.23**	**2,196**

Humboldt County drug poisoning and substance use disorder deaths by drug type/category, 2005-2018



Source: County of Humboldt Vital Statistics

Rx Safe Humboldt Coalition Meeting

The 4th Friday of every month at 8:30am

Hospice of Humboldt Conference Room

For more information

www.RxSafeHumboldt.org

www.StopOverdoseHumboldt.org

A Public Health Paradox

Many of our most common and intractable public health problems are unconsciously attempted solutions to personal problems dating back to childhood, buried in time, and concealed by shame, by secrecy, and by social taboos against certain topics.

Vincent Felitti

Opioids In Our Backyard

Dr. Matthew Polacheck

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Part of the Hazelden Betty Ford Foundation

Learning Objectives

- Understand the risk factors for addiction in youth
- Formulate a systematic intervention plan for youth in the recovery process
- Analyze how key components of the brain and central nervous system are effected by opioid use disorder

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How we got here

- 1. Dark web- TOR project, eliminates IP address
- 2. Cryptocurrency - bitcoin
- 3. Cheaper more access

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Focus on prevention and early education:

- 1. 2 kids example (acute model)
  2. Focus on people not drugs
  3. Call for perspective change (developmental disorder , adolescent to mid 20's development)
  4. Less daunted from consequences (marshmallow, 10 dollars , did it hurt anyone)
  5. Trouble with hardwire (rationalization)
  6. Harder to delay gratification
  7. Consequential decision makers

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Environmental and social factors

- 1. Nature vs nature
  2. Using friends
  3. Shared attitudes
  4. Popularity (debunk peer pressure)
  5. Problem with continuation school
  6. Adversity and trauma : ACE

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Important takeaways :

1. Cohort isn't about drugs
2. Development of SUD is about risk and reward
3. Risk continues even after sober (look at opioid withdrawal and PAWS).

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Transmissible liability index TLI

Familial risk factors

- 1. Genetics
- 2. Parent behavior
- 3. Parenting tactics
- 4. Parent / child relationship

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Drug and Alcohol Dependence
Author Manuscript HHS Public Access

Index of the Transmissible Common Liability to Addiction: Heritability and Prospective Associations with Substance Abuse and Related Outcomes

Brian M. Hicks, William G. Iacono, and Matt McGue

So what are the risk factors?

- Individual
  - Early initiation
  - Behavior problems
  - Poor emotional regulation
  - Poor grades
  - Too much work
  - Attitudes
  - ADHD?

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Prevention tactics

- 1. Focus on specific population -10 percent of Americans compose of over 50 percent of SUA
- 2. Think differently about behavioral problems
- 3. Assess “family risk “
- 4. Pro social prevention focus
- 5. Don’t wait for substance use to occur

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Traps clinicians fall in

- 1. Ranking one drug vs . Another (adolescents who smoke cigarettes 2x more likely to drop out of school)
- 2. Dismissing early use as a phase
- 3. Assuming use is due to something else
- 4. Waiting for full addiction to come

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Opiates and Adolescents:

- 1. Understand the Why?
- 2. Unique challenge of Chronic Brain Disease in particular opioids?
- 3. Stigma and Treatment
- 4. How have we responded and what can we do?

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Why

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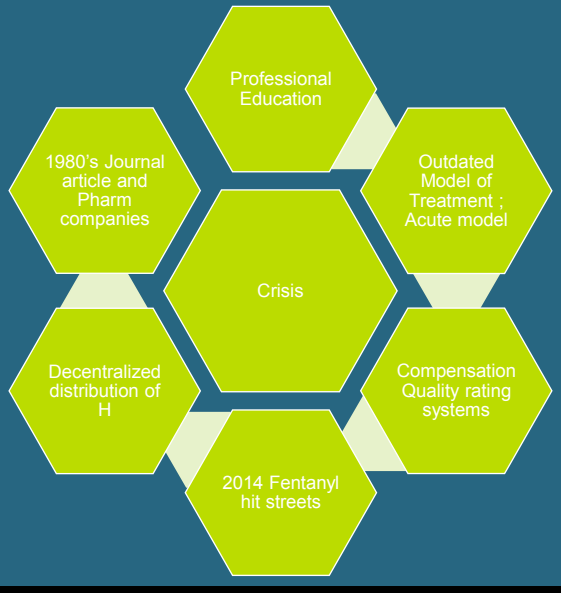

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Exercise #1

- Mental Image: Close your eyes and think of the words "Breast Cancer". What images come to mind.

Example: Pink bracelet

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Impact of Language

- **From SAMHSA 2017**

- Language frames what public thinks about substance use
- It controls what the individual of themselves
- It effects ability to change
- Reoccurrence vs. relapse

- Language should:
- 1."people first language"- respect worth and dignity of all people
- 2. focus on medical nature
- 3. promote recovery process, avoid perpetuating negative stereotypes

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Understand Stigma

- People with substance use disorder are 50 percent less likely to be offered help than people with mental health illness or physical disability.
- Even stigma within stigma, alcohol is legal and looked at differently than “drug addict”
- Terms like “Junkie” “ Crackhead” is dehumanizing, we need to focus on the whole person not the behavior .

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Chronic Disease

Stigma

Treatment

Risk/Trajectory

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Chronic Brain Disease Model

*Spect scans: understanding brain activity effected by opioids
*Stimulus and Response (S-CR)
*Chronic vs. Acute

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Nervous System

How is it activated? Symptoms?
Para vs. Sympathetic systems
Brain Scan functioning
Relaxation vs. Regulation
Clinical application and implementation

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What can we do? Prevention to post prevention!

- Clinical Response
- Managed Care response
- Doctor's response
- Communities response

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Treatment; What is comprehensive treatment?

- MAT Debate
- Unique challenges of 30,60,90, 360 etc.
- Motivational Interviewing
- Change old AA way, meet where they are at?

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Therapist's
; What can they do?

- **Cognitive behavioral therapy (CBT)** is a type of therapy in which patients learn to identify and manage negative thought and behavior patterns that can contribute to their drug use disorder. CBT helps patients identify negative thinking, change inaccurate beliefs, change unhelpful behaviors, and interact with others in more positive ways.
- **Motivational interviewing** is a type of therapy in which psychologists use nonjudgmental, no confrontational interviews with patients to help them feel comfortable discussing their drug use behaviors and inspire them to want to change.
- **Mindfulness-based stress reduction (MBSR)** is a therapeutic intervention that teaches people the principles of mindfulness, the ability to tune into the body's thoughts, feelings and behaviors in the present moment. The goal of mindfulness and MBSR is to create greater awareness of the ways that unconscious thoughts and behaviors might be affecting the body and undermining emotional and physical health.

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Too late…..Solutions after prevention

Medical Providers

- CURES; (2019) all new patients for medical providers

Therapists

- Narcan

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95% of people that qualify for treatment don't get it!!!!

Why and how do we fix?

- Over 20 million Americans are not getting the treatment they need. Reasons : Fear, Denial, Hope problem will resolve in its own, or given up and want to die
- Reasons they explained in survey (National Survey on drug use, 2016). They didn't want to stop using , negative effect on job, not knowing how to get treatment, or could not access it .
- Solutions: 3 Interventions
- 1. Screening
- 2. Brief Interventions
- 3. Appropriate referrals : SBIRT

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Communities and the public

- Policies:
- Good Samaritan law – to the person effected and person reporting
- Allowing pharmacies to dispense Naloxone (25 states so far)

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Takeaways

- This is not an opiate problem it is an addiction problem (McDonalds/obesity)
- Recovery is possible; Hope (20 million)
- This isn't about pointing fingers?
- What are you going to do about it; personal responsibility

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What can Insurance Companies do?

- **Modifying or rejecting a prescription at the point of sale.** Pharmacy "edits" are computer alerts that flag possible problems, including drug misuse and abuse. For example, a quantity edit alerts a pharmacist that more pills than recommended by the Food and Drug Administration were prescribed.
- **Flagging potential opioid misuse.** Some insurers review claims for signs of opioid abuse. An insurer then typically contacts the member, pharmacist and any prescribing doctors involved in a potential abuse case, and they create a plan to lower use. If the patient and doctor can't reduce the amount or dosage of opioids, the insurer might eventually stop paying for the prescription or send the case to its investigation team.
- **Changes in "prior authorization."** Doctors use this process to get an insurer's approval to prescribe medication that will be billed to the plan. Insurers have typically required prior authorization for opioid-withdrawal drugs — creating a delay for addiction treatment — but not for opioid prescriptions. Now some insurers are reversing those restrictions.

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And the results…….

	Mod or rej	Flagging	Prior Auth
Aetna	Yes	No	No
Anthem	Yes	Yes	No
Cigna	Yes	Yes	No
Humana	Yes	No	Yes
Kaiser Permanente	Yes	Varies by plan	Varies by plan
UnitedHealth Group	Yes	Yes	No

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Substance Use Disorder Treatment Task Force

- Aetna,AmeriHealth Caritas Family of Companies, Anthem, Inc., Beacon Health Options, Blue Cross Blue Shield of Massachusetts, CareOregonCareSource, Centene Corporation, Cigna,

Commonwealth Care Alliance, Envolve Health, Horizon Blue Cross Blue Shield of New Jersey, Magellan Health, UnitedHealth Group,UPMC Insurance Division, WellCare.

This group includes six of the largest payers in the United States, covers over 248 million patient lives, and has provided letters of commitment and signed a memorandum of understanding to advance the following eight “National Principles of Care”

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1st Qtr 2nd Qtr 3rd Qtr 4th Qtr

Universal screening for substance use disorders across medical care settings
Personalized diagnosis, assessment, and treatment planning
Rapid access to appropriate Substance Use Disorder care
Engagement in continuing long-term outpatient care with monitoring and adjustments to treatment
Concurrent, coordinated care for physical and mental illness
Access to fully trained and accredited behavioral health professionals
Access to Food And Drug Administration (FDA)-approved medications
Access to non-medical recovery support services

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Managed Care

- Cigna-to reduce the number of opioid overdoses by 25 percent among its commercial customers in these communities by December 2021.
- **Aetna** wants to reduce members' opioid prescriptions by 50% by 2022, says Dr. Mark Friedlander, the insurer's chief medical officer for behavioral health.
- **Anthem** started lock-in program in April 2016, because its internal research shows that many consumers who abuse prescriptions use more than one pharmacy, says Tracy Harrell, the insurer's director for clinical pharmacy strategies.
- **Kaiser Permanente** employs its own doctors and pharmacists, allowing it to take more direct action against opioid misuse.
- United Health Group-In 2015, UnitedHealth says it reduced the number of opioid prescriptions written to its members by 41% and reduced the number of doctors prescribing opioids by 45%.

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Pharmacies: What can they do?

Pharmacists can help by providing education, serving on interdisciplinary teams, assisting with prescription drug monitoring and urine drug screening, and most of all, serving as advocate for patients.

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Additional areas pharmacies can step up

- **Adopting New Protocols**
- **Using PDMP**
- Lock in program
- Expand Access and education around Naloxone

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Pharmacies

- Walgreens -which has 8,200 stores, from 2012-2015 enacted 3 pronged approach ; provide safe medication destruction kiosks, expand national access to naloxone, provide education on opioid misuse and overdose.
- CVS Health- expanded two of their signature opioid abuse prevention programs: safe medication disposal program and Pharmacists Teach.

- Other pharmacy interventions have included: has strengthened counseling for patients filling a first-time opioid prescription. Limit supply of prescription to 7 days

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Mindfulness Meditation
Pacific Mindfulness

Promising Practice Overview:	Introducing the Therapy:
Mindfulness is the present moment balanced awareness of whatever is happening within us - in our minds, hearts and bodies for the purpose of cultivating compassionate, skillful response in all aspects of our lives. It is awareness free of judgement and reactivity, and supported by an expanding capacity for discerning responsiveness. Mindfulness Meditation is the gradual steadying of the mind by intentionally focusing on the breath, sounds, or sensations in the body and training ourselves to see what's there.	Impulse Control: Noticing thoughts and emotions and how they inform actions. Making a Choice: Noticing stress, anxiety and/or pain and how it manifests in the body and mind. Learning to pause. Cultivating Awareness: Breath and body meditation Self-compassion Increasing Capacity & Resilience: Bringing mindful awareness to the present experience and responding skillfully increases the capacity to make wise choices and the sense of overall well-being

Aim/Goal:

- **What is the aim or goal of the therapy?**
  Manage impulses that lead to harmful choices and deliberately choose alternative actions that decrease stress and anxiety and support well-being.
- **Who is the "ideal" individual to recommend for these therapies? How do you evaluate what therapy is best for a patient?**
  Anyone wishing to make a change and manage stress, anxiety, pain and discomfort.

Workflow: (The basic steps)

What does a typical course of therapy look like?

- Individual daily meditation of at least 10 minutes, including practices of breath, body and self-compassion.
- Meeting with a weekly mindfulness group has an enormous impact on the success of developing an individual meditation practice.

Results to Date:

Please share data or results (successes) to date with the work that you do. What are the advantages or benefits of this therapy?

Most people report an overall decrease in stress, anxiety and reactivity and an increase in balance, awareness and compassion for self and others.

Challenges:	Lessons Learned/Advice to Others:
What are some challenges that you have heard from patients about these therapies? It is very hard to develop a meditation practice without the regular support of a group and/or teacher.	**How do you approach management of pain in relation to the challenges? What advice would you give to providers?** There are specific meditations helpful for pain that are most effective when guided by a teacher or available on a recording or app. It is strongly recommended that one work with a teacher in person first, before using an app if possible.
Referral Criteria:	**Images/Additional Information:**
Contact Name: Heidi Bourne, Pacific Mindfulness **Contact Phone:** 707/498-5562 **Contact Email:** Heidi@pacificmindfulness.com **Website (if applicable):** pacificmindfulness.com **What documentation and/or tests/labs/images are needed for an effective referral?** None **Do you accept patient self-referrals or do you require a referral from a provider?** I accept patient self-referrals and referrals from providers. **What payor types do you accept (insurance company names, MediCal, Medicare, cash/check/credit)?** Self Pay - cash/check/credit **What tends to be the average wait time for an appointment?** 1 week	 Heidi Bourne, RN, CMF Certified Mindfulness Facilitator Pacific Mindfulness

Cannabis for Pain
Diane Dickinson, M.D.

Promising Practice Overview:	Introducing the Therapy:
To provide consultations for patients regarding use of medical cannabis in a caring and professional setting while providing education regarding the use of medical cannabis.	When I see patients initially, I spend as much time as needed (usually 1 hour) to teach them about the chemistry and science behind why this plant can be so effective, and for so many conditions. I review the discovery of the endocannabinoid system in our bodies, which was in 1988. I also review the most useful websites, which I use daily, and send folks home with multiple handouts including a list of websites.

Aim/Goal:

There is no one goal for medical cannabis therapy. We all have receptors virtually throughout our body which is why one very complex plant can help with such varied conditions, including: Chronic and acute pain, depression/anxiety, migraines, cancer treatment and to help with the side effects of chemo/radiation, and SO many more conditions.

Regarding cannabis use for pain:
The National Academies of Sciences, Engineering, and Medicine published a report in 2017: **The Health Effects of Cannabis and Cannabinoids**, a 468-page book. This is the third publication of this organization has produced after careful review of all available research, each 17 years apart. 16 internationally recognized experts, with varied backgrounds, reviewed 24,000 publications. They focused on 10,700 of those reports, editorials, commentaries, or conference abstracts.

They determined for each of 11 categories of conditions whether or not there was Conclusive, Substantial, Moderate, Limited or No evidence of therapeutic effects. The number 1 finding under CONCLUSIVE EVIDENCE was: "for treatment of CHRONIC PAIN IN ADULTS".

Workflow: (The basic steps)

To evaluate what type of cannabis therapy may be best for any patient depends on many factors: especially their goal, then their experience with cannabis (in past or currently), their age, diagnoses, and disabilities. Tolerance is importance to evaluate. Tolerance is very useful when using cannabis as medicine – in occurs primarily when our body down regulates CB1 receptors on nerve cell membranes. CB1 receptors can attract and hold onto THC, the potentially (depending on the dose) intoxicating cannabinoid. When CB1 receptors are exposed to THC, many of these retreat inside the cells and are not available to be stimulated. This useful so that patients can effectively treat their pain or depression, etc., but not feel intoxicated. (Although I do have one 95-year-old patient who said to me, "There is no harm in a little giggling…").

ADDITIONALLY, REGARDING PAIN:
Two important factors, documented in studies, but also observed in primary care providers:

IF, patients use cannabis WITH EACH DOSE of an opioid, 1 and 1 does not equal 2 in pain control. Pain control doubles to 4 or 5 in most people. Secondly, most folks do NOT develop the usual tolerance to opioids when combined with cannabis.

I use the "Dosing Programs" frequently on **healer.com** with many patients. Especially if they are new to cannabis or have not used it in a long time (hence no tolerance). The Programs on this website were developed by Dustin Sulak, D.O., who is a doctor in Maine. The programs include: **"Introduction to Cannabis"** which is a 4-day program with a handout to write on and 3 videos a day for 4 days of initial use.

Another is an 8-page handout: **"How to Use Cannabis to Reduce and Replace Opioids"** which is excellent.

The ideal medical cannabis patient is anyone with an open enough mind to consider plan therapy. Many of my patients use an oil based tincture 3 or more times a day with both CBD and THC in it. They do work best together. Studies have demonstrated that with neuropathic pain, a 1:1 (CBD:THC) preparation works best for many folks. This not the dose I would start a new patient on, however. And, many folks use tiny doses of THC at bedtime to help with sleep (THC, not CBD helps people sleep). They can purchase products that have 1mg to 2.5mg of THC in an edible form and titrate this to achieve good sleep without feeling groggy in the am.

Results to Date:

BENEFITS: I have many patients managing their chronic pain with cannabis alone and many using a combination of cannabis and pharmaceuticals and/or other modalities. I also have many patients using cannabis as harm reduction to avoid use of many substances, including prescription opioids, heroin, meth, alcohol and tobacco.

Challenges:	**Lessons Learned/Advice to Others:**
Primarily, per patients: Cost. And patients are used to having prescriptions with clear directions. Use of medical cannabis requires patience while determining one's effective dose. I see this as an advantage (a patient is in control of their own meds and health), but not every patient agrees. For Providers working with interested patients: Direct them toward programs at healer.com. The main advice is always to start with tiny doses and increase very slowly.	Safety: No one will die from a cannabis overdose. Cannabinoid receptors are not in the brainstem like opioid receptors are, so an overdose of cannabis does not shut down breathing. (An overdose can be miserable though and best to avoid: can cause vomiting, anxiety, paranoia, disequilibrium, etc.) Very few drug interactions: with children on medications to prevent seizures that start cannabis, the doses of anti-seizure meds need to be carefully decreased over time. Most medication simply work more effectively when that endocannabinoid system is also involved.

Referral Criteria:

Contact Name: Diane Dickinson, M.D.
Contact Phone: 707-826-1165
For Cannabis Consultation information: northcoast-medical.com
For Primary Care for adults: dianedickinsonmd.com

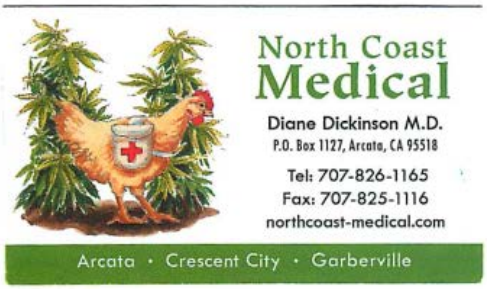
What documentation and/or tests/labs/images are needed for an effective referral?
N/A

Do you accept patient self-referrals or do you require a referral from a provider?
Self-referral is fine for both.

What payor types do you accept (insurance company names, MediCal, Medicare, cash/check/credit)?

No insurance will pay for cannabis related consultations at North Coast Medical at this point in time. At my primary care office, I do not bill insurance. For those with insurance that allows this (Medicare and MediCal do not), I give them a "superbill" at the end of the appointment to send to their insurance for partial reimbursement. This allows me to spend 2 hours with new patients and do "slow medicine".

What tends to be the average wait time for an appointment?
There is very little wait time for either appointment, usually within a week if desired.



Humboldt Tai Chi
Candice Brunlinger

Promising Practice Overview:	Introducing the Therapy:
In tai chi and qigong, we use gentle movement meditation with breath and visualization to connect to and integrate the body, mind, emotions and energy systems to support physical, mental and emotional health. Regular practice is known to support stress and pain management, mental health, balance, endurance, enhance the mind-body connection, feel-good hormones and more. When I work one on one with clients, I also address lifestyle and diet and how our emotions and life experiences affect the way we handle our stress and hold onto our pain. I help my clients create self-care routines and show them quick exercises to reverse their stress response while enhancing the flow of energy and blood circulation, and the production of feel good neurotransmitters.	❖ Focus on breath and body with every movement ❖ Listen to your body and modify any movement to meet your individual needs and range of motion, accommodating your injuries and discomfort. ❖ Overtime, range of motion and comfort increases with practice. ❖ Be compassionate for yourself and everything you have experienced in life. ❖ We carry our emotions, stress and traumas in our physical body and can release it with tai chi and qigong practice. ❖ Release and let go….surrender to the journey of the human experience. Life is tough but we don't need to hold onto the stress and we can learn how to not react to the stressor and traumas in our life causing pain, discomfort and addictions. This is easier said than done but tai chi and qigong supports this process.

Aim/Goal:

- The aim of tai chi and qigong is to enhance balance, strength, endurance and overall health and wellness. As we bring balance to the body, increase strength, and learn to manage our stress and pain, we are less likely to rely on addictive substances to get us through life and tend to make healthier choices.
- *Tai chi is beneficial for EVERYONE and can be modified to meet anyone's limitations. It is especially beneficial for those with chronic stress, tension, anxiety & pain.*

Workflow: (The basic steps)

- Attend a beginner's Tai Chi or Energy Healing and Qigong class 1-2 times a week. If possible, also incorporate a 5-10 minute practice daily between classes.
- Stay open minded and give it time. Most generally feel the relaxing benefits instantly but it can sometimes take a few weeks or more for beginners to notice those subtle shifts in the energy systems and physical body for the deeper healing.
- Find moments all throughout the day, even if it is for a minute, to tune in with your breath, emotions and physical body.
- Use the quick exercises and visualizations to support your stress, pain and addictive behaviors. The more often you integrate those quick exercises and reduce the stress response, the more you retrain your body and energy systems to heal and re-program the hippocampus of the brain to support emotional attachments and addictive behaviors.

Results to Date:

There are endless benefits and advantages. I have consistent positive feedback, especially from those who are diligent about maintaining a consistent practice. I often hear from my students and clients that the more they practice, the more exponential the benefits. Sometimes folks struggle with having enough patience and slowing down to learn the details of the movement and to enjoy the activity but that is one of the most important lessons they eventually learn….how to enjoy slowing down so they can learn to listen and pay attention to what they need to do to support their health and wellness, prioritizing their self-care and stress management practices. Overtime, I notice my students and clients gradually having better posture, increasing their range of motion, having brighter eyes, more energy, clarity, focus, improved balance and coordination, and less stress and pain overall.

Folks in a lot of pain and discomfort can often struggle at first as they learn how to gently move their body and increase their range of motion…especially because they are having to address the emotional component of pain and need to feel safe doing so.

Challenges:

- Slowing down
- Breathing
- Having compassion for their experiences and hardships
- Quieting the mind chatter
- Memorizing the movements if they do not practice between classes

Lessons Learned/Advice to Others:

People need to feel safe enough to address the emotional component of their pain, even if it is injury related. The body's ability to heal and recover from pain is inhibited by chronic stress, so I always address stress management and emotional holding patterns when supporting a client with pain and addictions.

Referral Criteria:

Contact Name: Candice Brunlinger
Contact Phone: 707-630-5025
Contact Email: candicebrunlinger@gmail.com
Website (if applicable):
www.humboldttaichi.com
www.herballivingandhealing.com

What documentation and/or tests/labs/images are needed for an effective referral?
N/A

Do you accept patient self-referrals or do you require a referral from a provider?
No referral needed

What payor types do you accept (insurance company names, MediCal, Medicare, cash/check/credit)?
Cash/local check

What tends to be the average wait time for an appointment?
2-4 weeks for appointment
No wait for class drop-ins
Full tai chi terms offered seasonally

Additional Information:

I also work with herbal support, diet and lifestyle to support stress management, self-care, pain, addictions and general healing.

I have mainly found that when we focus on stress management, the shift for healing begins.

Managing stress and learning how to connect with our breath throughout the day is always my underlying approach to working with folks. As they manage their stress response, it allows them to slow down and take better care of themselves to support their pain.

When we are not stressed, we are more likely to make healthier choices and not rely as much on addictive behaviors. As we practice this, we can reprogram the brain to not rely on addictions.

Integrative Services for Chronic Pain
Connie Earl, DO, ABIHM

Promising Practice Overview:	Introducing the Therapy:
I am the medical director of Forestville Wellness Center, a stand-alone clinic within West County Health Centers (WCHC), a multi-site Federally Qualified Health Center (FQHC) in West Sonoma County. We offer only integrative medicine services and group visits, and serve only WCHC primary care patients. We offer visits with clinical herbalists, Ayurvedic practitioners, HeartMath (a form of biofeedback), a naturopathic doctor, nutritionists, acupuncturists, integrative health and osteopathic manipulative medicine practitioners. Our groups include support for patients with chronic illness, as well as wellness focused groups like nutrition and cooking education, qigong, narrative medicine, and movement groups.	We are integrated into primary care and consider the therapies at the Wellness Center to be part of how we treat chronic pain.

Aim/Goal:

- The goal of integrative services is improved function, decreased pain, decreased suffering, community and decreased isolation.
- Any patient can be appropriate, but the context is important. Ideal is always self-motivated and engaged, but part of what we do is to facilitate conversation about their goals and engage them where they are. Some therapies are more effective with patients taking opioids than others.

Workflow: (The basic steps)

The workflow depends on the therapy. We aim to practice "public health integrative medicine", with one of our main goals being access to care, so we do limit the number of visits to avoid impacted services, and we aim to have patients feel more able to self-manage after a series of visits. They often go home with exercises or regular practices to maintain, with the goal of not needing long term regular visits with us.

Results to Date:

Our myriad groups have shown to lead to a decrease in isolation and loneliness and improvement in quality of life scores for those who regularly attend. Various biomarkers like blood pressure, hemoglobin A1c, and others have shown improvement with the groups and services. Our qualitative data has consistently demonstrated increased patient involvement in their care and a sense of belongingness and feeling supported.

We are currently working on the analysis of several years of data for our groups with new software to extract the collected data from our EMR.

Challenges:

Mainly managing patient expectations: if patients think their pain is going to be cured, they will often be disappointed, but if they understand that there are many goals to the treatment, and if they are clear on their goals, we can think through how to plan for the attainment of their goals.

Concrete challenges are transportation and time, and being able to track appointment times and participate in self-management in a systemically disempowered patient population.

Lessons Learned/Advice to Others:

Engage in active conversation about the patient's goals. We start with working toward a realistic functional goal, and aim to form a treatment plan around it. By engaging the patient in the goal setting, they are better able to track their progress and remain involved in the process.

Referral Criteria (if applicable):

Forestville Wellness Center
Website:
https://www.wchealth.org/location/forestville-wellness-center

What documentation and/or tests/labs/images are needed for an effective referral?
Just documentation for the reason for the referral

Do you accept patient self-referrals or do you require a referral from a provider?
We accept self-referrals for nearly all our services

What payor types do you accept (insurance company names, MediCal, Medicare, cash/check/credit)? All of the above

What tends to be the average wait time for an appointment? Depends on the service, but we are able to get patients in for urgent appointments who are working on tapering or weaning off controlled medications.

Images/Additional Information:

Contact Name: Connie Earl, DO, ABIHM
Contact Email: connie.earl@gmail.com

Complex Pain Management and Rewinding the Clock

R. Corey Waller MD, MS
Principal – Health Management Associates

2019 Disclosure: Corey Waller, MD

With respect to the following presentation, I have no actual or potential conflict of interest in relation to this program/presentation and no relevant (direct or indirect) financial relationships to disclose.

Objectives

- The learner will understand the neuroscience of pain
- The learner will know when to wean opioids
- The learner will be able to wean most classes of pain medications

Pain vs Suffering

> *"If you are distressed by anything external, the pain is not due to the thing itself, but to your estimate of it; and this you have the power to revoke at any moment."*
>
> — Marcus Aurelius, Meditations

Confounding Issues

- Early Life Trauma
- Superimposed Mental Illness
- Social Instability
- Familial Predisposition
- The Current Health Care System

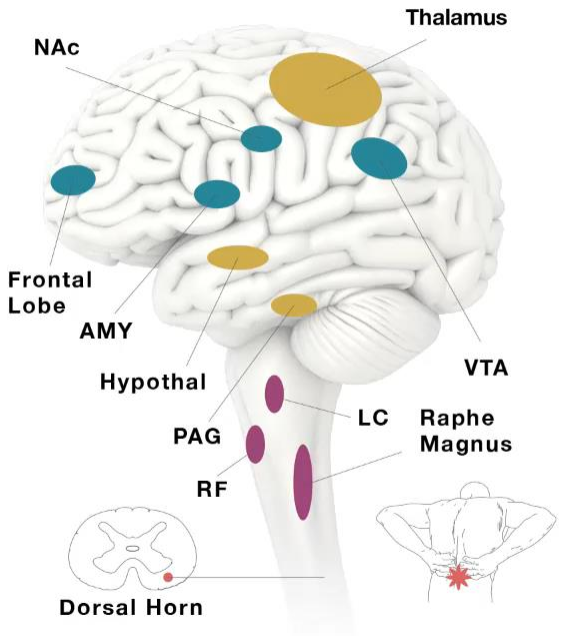
What is Our Goal?

- Get rid of all your pain?
- Make you forget you have pain?
- Decrease your pain and improve your function!

Neuroscience of Pain

Ascending Tracts

- Spinothalamic/Cervicothalamic (localization)
- Spinoreticular (arousal, sleep/wake cycles)
- Spinomesencephalic (PAG, emotional context of pain)
- Spinohypothalamic (endocrine response)

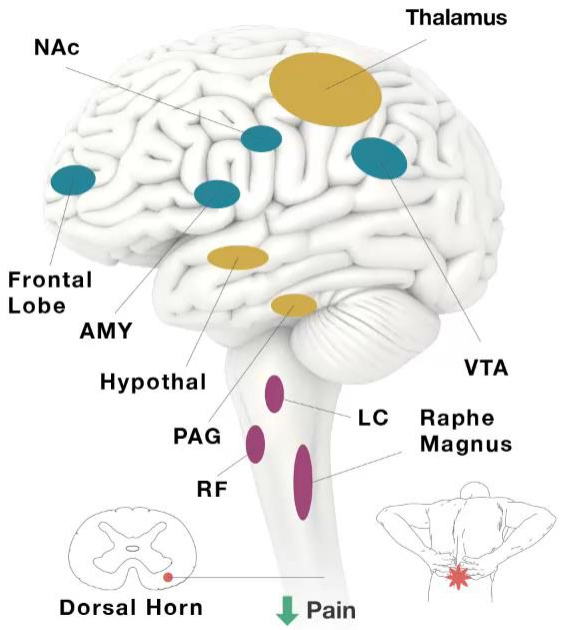


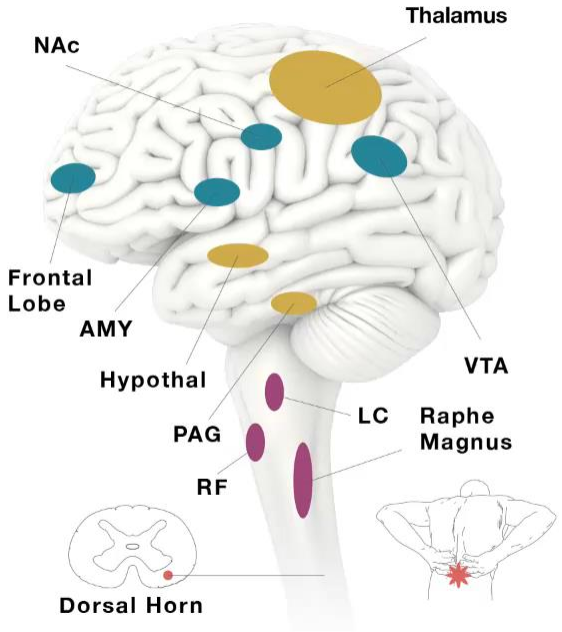
Neuroscience of Pain

Descending tracts (GABA inhibits)

PAG → Locus Coeruleus (NE)→ Dorsal horn (can increase pain)

PAG → Raphe Magnus (5HT, Enk) → Dorsal horn (will decrease pain)





Who Cares and Why Does it Matter?

- Opioids (PAG, Ventral Medulla, Dorsal Horn)
- Serotonin (amygdala, Raphe Magnus)
- Norepinephrine (Locus Coeruleus)
- Why GABA matters
  - Enk inhibits GABA thus allowing release of the above
  - With benzos or EtOH descending pathways are inhibited

Normal Response with “High/Average Pain Tolerance”

- Acute on chronic pain (twisting a chronically painful back)
- Emotionally asses and if all good then,
- Increase descending inhibition
- Thus decreasing the ascending pain signal
- All happening while we produce our own endorphins from the dorsal horn and the periaqueductal grey (PAG)

This equals less pain and greater function

Normal Response with “Low Pain Tolerance”

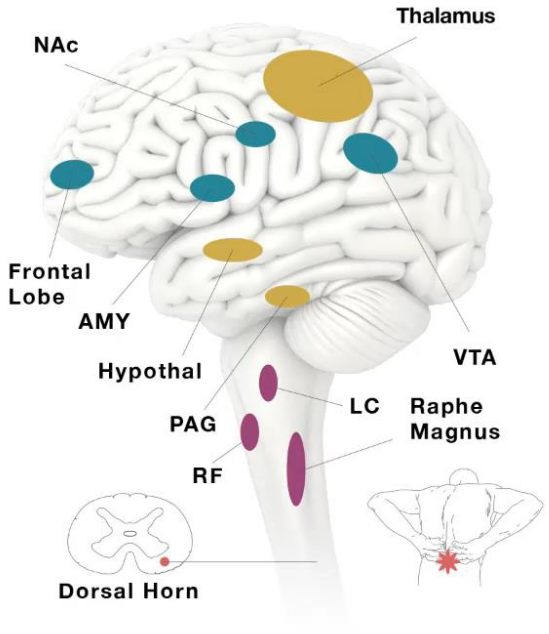
- Acute on chronic pain (twisting a chronically painful back)
- Emotionally assess and not all good
- Increase in descending excitatory pathway
- Decrease in inhibitory pathway
- Increase in perceived pain followed by hysteria and tachypnea
- This changes the pH in the serum and thus increases the amount of endorphin released in response from PAG and Zone II and III of the dorsal horn
- Then after the panic like state, pain normalizes

When Opioids are Added

- Decreased production of endogenous opioids
- Body "ramps up" pain signal frequency
- Thus greater signal from Ascending tracks (spinothalamic, Spinoreticular and Spinomesencephalic)
- More pain in widened area
- Decreased endorphin production from PAG and Dorsal Horn
- Worsened sleep patterns
- More emotional lability from opioid effects in limbic system

So…

- Emotionally assess and all good or not all good?
- Increase in descending excitatory pathway to overcome outside opioids
- Decrease in inhibitory pathway given presence of opioid
- Increase in perceived pain followed by hysteria (tachypnea blocked by opioids)
- So no change in the pH in the serum and thus no increase in the amount of endorphin released from PAG and Zone II and III of the dorsal horn
- Then after the panic like state, pain continues and in many cases widens in area and intensity from increased c-fiber signal



What to do with opioids

- Reasons to wean
  - Addiction
  - Risky use
  - No increase in function
  - Worsening pain

How to wean

- Opioids
- Benzo’s
- Gabapentinoids
- SNRIs

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Redwoods Rural Health Center
Medication Assisted Treatment Program
Mandi Battles PA-C

Promising Practice Overview:	Actions Taken:
Redwoods Rural Health Center obtained a California Hub & Spoke grant that allowed the health center to collaborate with a local rehabilitation facility for counseling services. The actual program began a year ago in March with two prescribing providers, one PA and one FNP. Each provider had several hours in the afternoon of one day each week designated to Suboxone treatment. Groups are offered twice a week.	• Obtained a buprenorphine waiver • Created a team to support program • Educated staff regarding expectations and goals of program • Identified space to support groups • Worked with AEGIS on grant reporting • Worked with a pharmacy delivery program

Aim/Goal:

To support the Opioid Use Disorder needs specifically for the Southern Humboldt community.

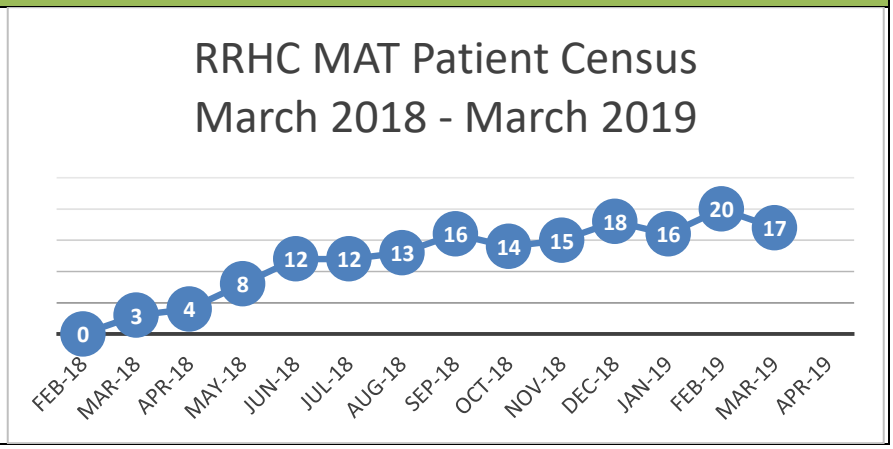
Workflow: (The basic steps)

- Patients call and speak with the scheduler for the Suboxone program.
- The patient's first appointment is made with the intake provider/counselor and Suboxone prescriber.
- Suboxone inductions are done usually same day as the first appointment for best patient compliance.
- A follow-up appointment is made for the next day.
- Patients in the program have weekly visits in group or personal counseling and with the prescriber for 3 months. A urinalysis is done every visit.
- Patients then graduate to every two week visits for 3 months if consistent in the program and with favorable urinalysis results.
- If progress continues, the patient is then seen every month after that.
- Meds are delivered to RRHC from Cloney's in McKinleyville every week.

Results to Date:

We have had both some great success stories, as well as others who have relapsed and returned to the program. We've also had others who "disappear", dismissing themselves from the program.

This chart shows the number of patients that were active RRHC's MAT program each month since starting the program in March 2018.



Redwoods Rural HEALTH CENTER
Family Health Care

Challenges:	Lessons Learned/Advice to Others:
❖ Staff education, including prescribing providers ❖ Commitment from patients ❖ Medication management ❖ Hub & Spoke grant reporting.	❖ Communicate your goals for the program clearly; try to all be on the same page ❖ Be supportive- don't discriminate. ❖ Have a good team to help with making sure medications are delivered on time, or keep meds on site if possible ❖ Work closely with AEGIS

Referral Criteria:

Contact Name: Mandi Battles
Contact Phone: 707-923-2783
Contact Email: mbattles@rrhc.org
Website (if applicable):
www.rrhc.org

What documentation and/or tests/labs/images are needed for an effective referral?
Preferably most recent records from either Primary Care Provider (PCP) explaining need or previous Suboxone program.

Do you accept patient self-referrals or do you require a referral from a provider?
We are accepting both at this time.

What payor types do you accept (insurance company names, MediCal, Medicare, cash/check/credit)?
We accept all payors and also have the AEGIS grant to help with copays, and med coverage.

What tends to be the average wait time for an appointment?
1-2 days, no more than a week.

Images/Additional Information:

Redwoods Rural Leadership Team

Tina Tvedt, MHA, Executive Director
Jamie Walling, CFO
Dr. Scheel, Medical Director
Mandi Battles, Co-Medical Director
Chris Hansen, HIT Technician
Stephen Paytash, QI
Terri Klemetson, Facilities Manager
Amber Wallan, Back Office Supervisor
Barb Taylor, Dental Operations Manager
Katy Allen, MFT
Tawnya Carr, Front Desk Supervisor

Hub & Spoke System Grantee Profile:

STR-51 Aegis Treatment Centers (Humboldt)

The California Hub & Spoke System (CA H&SS) is a component of the California Medication Assisted Treatment (MAT) Expansion Project, and is being implemented as a way to improve, expand, and increase access to MAT services across the state. Each CA H&SS consists of a "Hub" that serves as the addiction center of expertise, and multiple "Spokes" that act as clinical service providers.

About the future Hub:

Aegis Treatment Centers is a state and federally licensed Narcotic Treatment Program (NTP) offering Medication Assisted Treatment (MAT) in combination with evidence-based behavioral therapy to give our patients the skills and confidence to lead a drug-free life. Aegis offers individual and group counseling, case management, crisis intervention, and physician services and focuses on treating the whole person. Aegis serves over 10,000 patients in California with 31 clinics and 2 medication units to improve access in rural areas. 80% of Aegis patients are illicit opiate free after 90 days in treatment.

- Waterfront Recovery Services
  - 2413 Second Street Eureka, CA 95501
- Full Circle Center for Integrative Medicine
  - 4641 Valley E Blvd, Arcata, CA 95521

Spokes:

- Redwoods Rural Health Center
  - 101 West Coast Road, Redway, CA
- K'ima:w Medical Center
  - 535 Airport Rd., Hoopa, CA 95546
- Open Door Community Health Centers
  - 550 East Washington Blvd., Crescent City, CA 95531
  - 770 Tenth St., Arcata, CA 95521
  - 785 18th St., Arcata, CA 95521
  - 2200 Tydd St., Eureka, CA 95501
  - 2426 Buhne St., Eureka, CA 95501
  - 38883 Highway 299, Willow Creek, CA 95573
  - 3750 Rohnerville Rd., Fortuna, CA 95540

AT THIS HUB & SPOKE SYSTEM:

Treatment Available for MAT Expansion Project Patients:

- Individual & Group Counseling
- Case Management
- Medical, Social Work, and Mental Health Services
- Peer Mentoring
- Assessment
- HIV and HCV testing
- Transportation Assistance

Counties Served:

Humboldt, Del Norte

(Continued on Back)

Hub & Spoke System Grantee Profile:

STR-51 Aegis Treatment Centers (Humboldt)

(Continued from Front)

Aegis Treatment Centers (Humboldt)

Contact Information:

Sarah Vogel
sarah.vogel@aegistreatmentcenters.com
(707) 599-1596 or
Judson Lea
jlea@aegistreatmentcenters.com
(530) 774-8451

Hub Websites:

https://aegistreatmentcenters.com
https://www.facebook.com/AegisEureka

INNOVATIONS

Increasing Access to MAT in Rural Counties

- Aegis Treatment Centers is increasing access to MAT in the rural counties of Del Norte and Humboldt where overdose rates are among the highest in the state.

Community Outreach

- Aegis Treatment Centers' community outreach efforts include promoting education and stigma reduction about Medication Assisted Treatment. Additionally, outreach for spokes and the future hub include promoting activities through local media outlets (e.g. newspapers, free papers, radio stations, movie theaters (pre-show slides), and free public access TV channels. Community advertisement will be utilized to engage and inform communities of opioid epidemic and services available in their community.

Coalition Support

- Aegis Treatment Centers actively participates in and supports local SafeRx, Drug Free, and Opioid Coalitions such as; Rx Safe Humboldt, Rx Safe Del Norte and the Hoopa Community Coalition.

Electronic Medical Records (EMR) System (PHASE)

- Aegis is building upon its PHASE EMR system and is in the initial stages of developing a mobile app (AegisConnect) that will assist in better connecting patients with clinical and medical staff. The mobile app is expected to additionally improve communications between providers and patients in remote Hub or Spoke locations.
- The AegisConnect patient application is expected to provide patients with the following capabilities:
  - Join a video counseling session with their caseload manager or with a medical provider
  - Patient registration and authentication
  - View upcoming appointments list
  - View lab results history
  - Send messages to caseload manager and receive appointment reminders
  - Journal and provide daily reports on their withdrawal symptoms and other indicators
  - Send an SOS alerts, which trigger immediate callbacks from support staff
  - Low-bandwidth mode for those in areas where mobile data connections are not fully feasible, including SMS based check-ins and reminders, as well as counseling via telephone.

RESOURCES

bit.ly/MATexpansion
FOR MORE INFO AND/OR TO BECOME A PRESCRIBER

www.uclaisap.org/ca-hubandspoke/
TO PARTICIPATE IN TRAININGS

Humboldt IPA

Humboldt Independent Practice Association

Perinatal Substance Use Disorder
Humboldt IPA

Promising Practice Overview:	Actions Taken:
86% of pregnancies in women with Opioid Use Disorder (OUD) are unplanned. Contraception is a critical component of OUD treatment for all women of child-bearing age. Increasing access to Medication Assisted Treatment for women with OUD who are pregnant is critical, but to get ahead of the problem, we need to increase access to effective contraception for women who have OUD prior to the development of an unplanned pregnancy.	Implementation of regular pregnancy testing in treatment programs. Improved access to contraception integrated into treatment programs.

Aim/Goal:

To ensure that all women with SUDs (substance use disorders) have easy access to effective contraception to decrease the rates of unplanned pregnancies in this population.

Workflow: (The basic steps)

1. Pregnancy testing on all women at intake to treatment.
2. Quarterly testing of all women who are not on Long Acting Reversible Contraception (LARC).
3. Access to Depo-Provera injections and Oral Contraceptive Pill (OCP) Rx's as part of treatment.
4. Streamlined referral for Long Acting Reversible Contraception options, such as IUDs or Nexplanon when appropriate.

Challenges:	Lessons Learned/Advice to Others:
1. Many women with OUDs don't seek treatment until they are already pregnant. 2. Shortage of providers able to provide Long Acting Reversible Contraception.	1. OCPs are not terribly effective in this population and you should continue screening for pregnancy in women using OCPs as contraception. 2. Offering Depo injections with Medication Assisted Treatment (MAT) can be effective, especially for women in the early stages of treatment who have frequent office visits. 3. Having in-program capacity to place IUD/implantable hormonal contraception, or a warm hand off process to another provider who can, increases the likelihood women will pick this option and follow through. Because many women in treatment for OUD will phase in and out of treatment, this is the ideal method of contraception for this population.

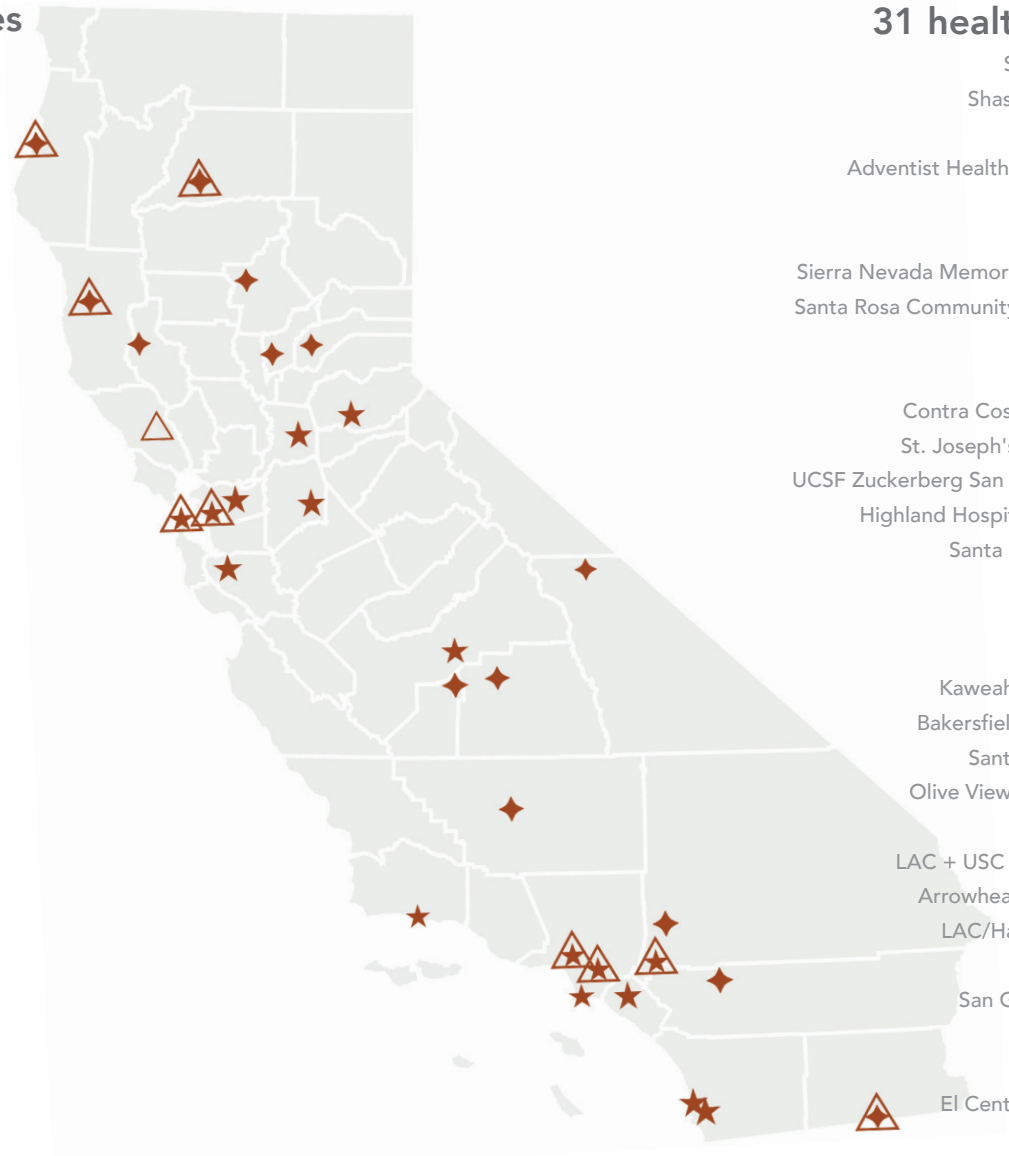
CA BRIDGE
TREATMENT STARTS HERE

Evidence-based treatment starts in every community
24 hours a day – 7 days a week – 365 days a year

Substance use disorder is a high-risk chronic illness. These patients routinely present to emergency rooms and acute care hospitals in need of medical care. **Treatment can start here.**

27 counties

Alameda
Butte
Contra Costa
El Dorado
Fresno
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Los Angeles
Mendocino
Nevada
Orange
Riverside
Sacramento
San Bernardino
San Diego
San Francisco
San Joaquin
Santa Barbara
Santa Clara
Shasta
Sonoma
Tulare
Yuba



31 health care facilities

St. Joseph Hospital (Eureka)
Shasta Regional Medical Center
Enloe Medical Center
Adventist Health Howard Memorial Hospital
Sutter Lakeside
Adventist Health Rideout
Sierra Nevada Memorial Hospital-Miners Hospital
Santa Rosa Community Health Center - Brookside
UC Davis
Marshall Medical Center
Contra Costa Regional Medical Center
St. Joseph's Medical Center (Stockton)
UCSF Zuckerberg San Francisco General Hospital
Highland Hospital, Alameda Health System
Santa Clara Valley Medical Center
Northern Inyo Hospital
UCSF Fresno
Adventist Health Hanford
Kaweah Delta Hospital Foundation
Bakersfield Memorial Medical Center
Santa Barbara Cottage Hospital
Olive View LAC+ USC Medical Center
St. Mary's Medical Center
LAC + USC Medical Center Foundation
Arrowhead Regional Medical Center
LAC/Harbor UCLA Medical Center
UC Irvine
San Gorgonio Memorial Hospital
UC San Diego
Scripps Mercy Hospital
El Centro Regional Medical Center

★ Star sites will become regional 'centers of excellence' for initiating treatment for substance use disorders from the inpatient, ED, or prenatal setting and work with other hospitals to spread best practices.

✦ Rural Bridge sites will provide new access points for evidence-based treatment for substance use disorders, primarily in the emergency department.

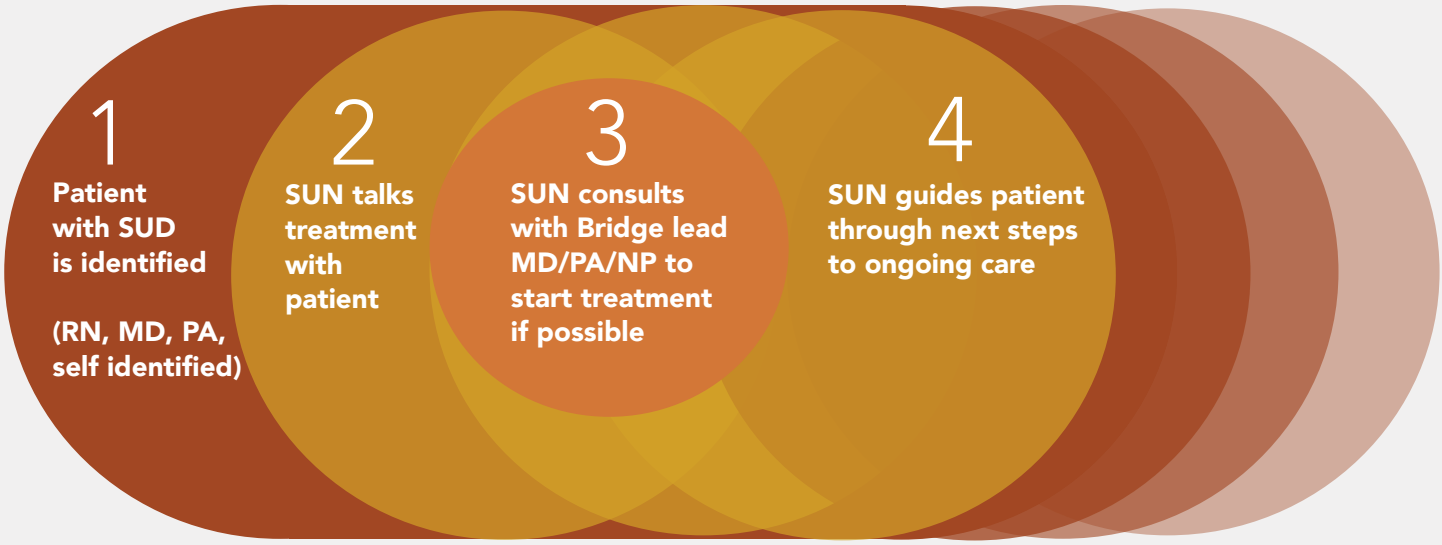
△ Bridge clinics will offer 'low-threshold' follow-up for patients started on treatment in the acute care setting, assisting patients with overcoming barriers to continued long term outpatient treatment in the community.

BRIDGE
TREATMENT STARTS HERE

Bridge provides training and technical assistance to support and enhance evidence-based treatment for substance use disorders within an acute care setting in every community.

bridgetotreatment.org

Substance Use Navigators (SUNs) in all Bridge sites will assist the identification and treatment for patients in need of care



WHAT IS A SUN?

A substance use navigator (SUN) is a care coordinator and an integral team member that improves access to Medication for Opioid Use Disorder (MOUD). A SUN is embedded within either an emergency department (ED) or an inpatient setting to assist patients to begin and remain in addiction treatment via motivation, resources, and encouragement. An essential link to the community, SUNs outreach to treatment partners and facilitate transitions from the acute care setting to outpatient treatment. They also provide a direct link to organizations and individuals seeking treatment.

A SUN is sometimes known as Treatment Navigator, Treatment Coordinator, Medication for Opioid Use Disorder Navigator, MOUD Navigator, Patient Navigator, Linkage Coordinator, or Care Coordinator.

WHAT DO SUNS DO?

SUNs conduct initial brief assessments, introduce patients to MOUD programs and services, expedite appointments at MOUD-capable clinics, serve as the primary coach for their clients, and maintain ongoing contact with their panel. They also assist with access to other services such as financial counseling, primary care, mental health services, social services, and residential treatment facilities.

SUN TRAINING SERIES

The California Bridge Program will provide extenseive and ongoing training and technical assistance to SUNs that includes education on the scientitfic model of addiction treatment, motivational interviewing, trauma informed care, harm reduction, site-specific community outreach, and much more.

Bridge, a program of the Public Health Institute, is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis Grant to the California Department of Health Care Services (DHCS).

BRIDGE
TREATMENT STARTS HERE

PUBLIC HEALTH INSTITUTE

ED BRIDGE
Emergency Buprenorphine Treatment

HOW TO START A BUPRENORPHINE PROGRAM IN THE ED

1. **Talk with your pharmacy director to be sure that buprenorphine is on the hospital formulary.**
2. **Develop a connection and with an outpatient facility who can receive patients referred from the ED.**
3. **Train nurses and doctors how to assess opioid withdrawal severity and how to dose buprenorphine.**
4. **Create or adapt a simple guide for providers for use in the clinical areas for real-time consultation.**
5. **If possible, bring in a patient care navigator to help patients transition to outpatient care.**
6. **Obtain patient education materials from outpatient partners that describe how to access their buprenorphine treatment services.**

Will treatment with buprenorphine reduce mortality among patients with opioid addiction?

In a recent study of over 150,000 National Health Service patients treated for opioid dependence, followed for a total of 442,950 patient years, treatment of opioid dependence with buprenorphine was found to reduce risk for opioid overdose death by one half versus patients with no treatment or psychosocial treatment only.[1]

In a study of 33,923 Medicaid patients diagnosed with opioid dependence in Massachusetts, mortality during the four-year study period (2003-2007) was double among patients receiving no treatment versus patients treated with buprenorphine. Additionally, patients treated with buprenorphine experienced a 75% reduced mortality versus patients treated with psychosocial interventions alone.[2]

Among the highest risk patients who inject heroin, treatment with methadone or buprenorphine for at least 5 cumulative years, is associated with a reduction in mortality from 25% at 25 years to 6%. The association between treatment and improved survival is likely multifactorial and mediated through reduced risk of HIV infection, improved social functioning, reduced criminality, and establishing long-term contact with health professionals.[3,4,5,6,7,8,9,10] Importantly, survival benefit is not affected by cessation of injection drug use.[3]

[1] Pierce M, Bird SM, Hickman M, Marsden J, Dunn G, Jones A, and Millar T. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction.* 2016;111(2):298-308. doi:10.1111/add.13193.

[2] Clark RE, Samnaliev M, Baxter JD, and Leung GY. The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine. *Health Aff (Millwood).* 2011;30(8):1425-33. doi:10.1377/hlthaff.2010.0532.

[3] Kimber J, Copeland L, Hickman M, Macleod J, McKenzie J, De Angelis D, and Robertson JR. Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. BMJ. 2010;341(jul01 1):c3172-c3172. doi:10.1136/bmj.c3172.

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[7] Gowing L, Farrell M, Bornemann R, and Ali R. Substitution treatment of injecting opioid users for prevention of HIV infection. The Cochrane Library. 2004.

[8] Amato L, Davoli M, Perucci CA, Ferri M, Faggiano F, and Mattick RP. An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research. J Subst Abuse Treat. 2005;28(4):321-9. doi:10.1016/j.jsat.2005.02.007.

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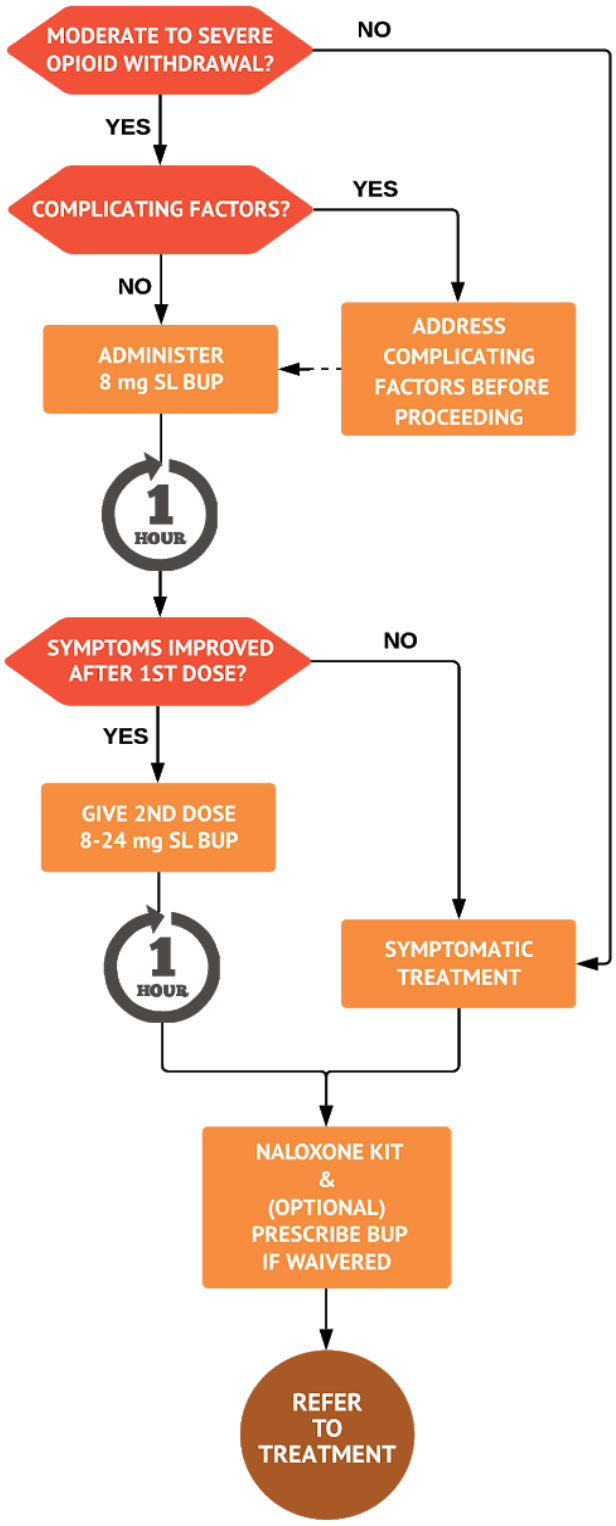
[10] Ward J, Hall W, and Mattick RP. Role of maintenance treatment in opioid dependence. Lancet. 1999;353(9148):221-6. doi:10.1016/S0140-6736(98)05356-2.

BUPRENORPHINE (BUP) ALGORITHM

AUGUST 2018



MODERATE TO SEVERE OPIOID WITHDRAWAL

- Use clinical judgement to determine moderate to severe withdrawal.
- If uncertain, use the Clinical Opioid Withdrawal Scale (COWS)
- If using COWS, the score should be ≥ 8 or ≥ 6 with at least one objective sign of withdrawal
- Document: which opioid used, time of last use

COMPLICATING FACTORS

Identify and manage complicating factors prior to proceeding.
The only absolute contraindication is allergy to buprenorphine.

Refer to Buprenorphine Guide before dosing buprenorphine for:

- Clinical suspicion of acute liver failure
- ≥ 20 weeks pregnant
- Intoxicated or altered
- Withdrawal precipitated by naloxone
- Taking methadone or long acting opioid
- Chronic pain patients taking prescribed opioids
- Withdrawal symptoms are inconsistent or borderline (COWS of 6-8), or opioid use within 12 hours; consider beginning with a low dose (2-4 mg SL) and titrating every 1-2 hours

PARENTERAL DOSING

- Use if unable to take sublingual (SL)
- Start with 0.3 mg IV/IM buprenorphine; may repeat as needed; switch to SL when tolerated

PRECIPITATED WITHDRAWAL

- Buprenorphine can cause precipitated withdrawal if too large a dose is given too soon after the last opioid use
- The longer the time since last opioid use (> 24 hours) and the more severe the withdrawal symptoms (COWS ≥ 13) the better the response to initial dosing
- Only patients with objective improvement in withdrawal after the 1st dose should receive subsequent dosing
- Worsening after buprenorphine is likely precipitated withdrawal; no further buprenorphine should be administered in the ED; switch to symptomatic treatment

SYMPTOMATIC TREATMENT

- Supportive medications such as clonidine, gabapentin, metoclopramide, low-dose ketamine, acetaminophen, NSAIDs

LOWER TOTAL DOSE OPTION (16 mg)

- Possible lower risk of sedation or precipitated withdrawal
- Some patients will go back into withdrawal in less than 12 hours increasing risk of early dropout.
- Buprenorphine prescription or next day follow-up should be available

HIGHER TOTAL DOSE OPTION (24-32 mg)

- Increased magnitude and duration of opioid blockade
- More complete treatment of withdrawal in heavy users
- May suppress craving and protect against overdose (opioid blockade) for 2 days or more
- Use with caution in medically complex patients, older patients, and patients using other sedatives such as alcohol or benzodiazepines

RE-EVALUATION TIME INTERVALS

- The time to SL buprenorphine onset is typically 15 minutes and peak clinical effect is typically within 1 hour
- Re-evaluate patient 1 hour after buprenorphine doses
- Observe for 1 hour after the final dose before discharge

DEA 72 HOUR RULE

- Patients may return to the ED for up to 3 days in a row for repeat doses
- At each visit administer 16 mg SL buprenorphine

FOLLOW-UP

- Goal: follow-up treatment available within 3 days

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

ED BRIDGE
Emergency Buprenorphine Treatment