Best Practices in Detecting Opioid Misuse and Managing CDC Guidelines

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Disclosures

- Medical Director, Dannemiller, Inc., A Healthcare Education Company
- Standard of Care Case Reviewer, Texas Medical Board

Objectives

- List the “CDC Guidelines for Prescribing Opioids for Chronic Pain”
- Interpret the usefulness of the CDC Guidelines
- Use evidence-based interventions to attempt to detect opioid misuse

Caveat

Summary

This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

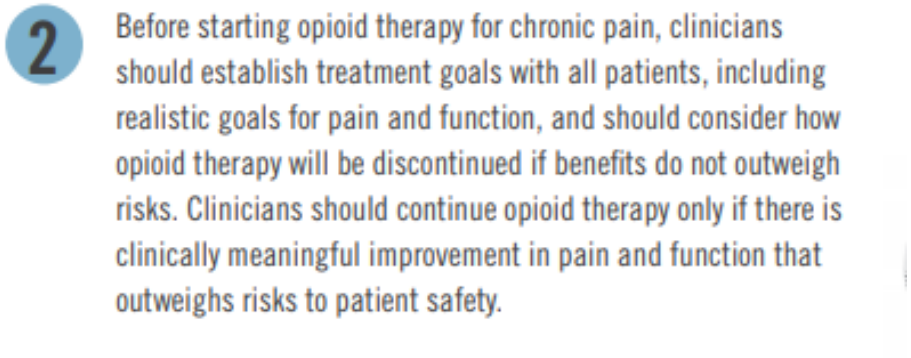
- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

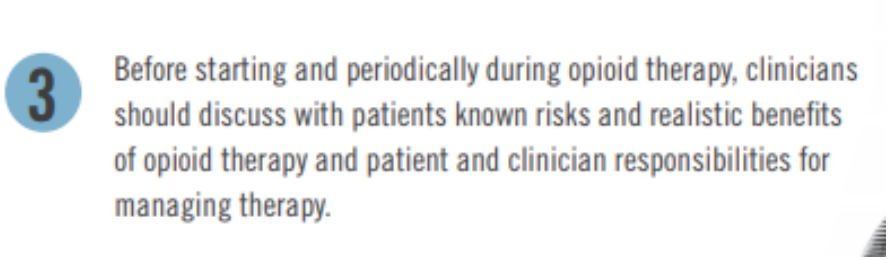
Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

- Non-pharmacologic therapies include cognitive behavioral therapy, biofeedback, mindfulness, and physical therapy.

- Non-opioid therapy includes anticonvulsants (i.e. gabapentin, pregabalin, topiramate), SNRIs (duloxetine, milnacipran), NSAIDs, muscle relaxants, acetaminophen, etc.



- Goals for pain and function can be as simple as chores or as meaningful as objective use of scales (modified Oswetry disability index, short-form 36, Roland Morris disability questionnaire, etc.)



- What are the known risks?

- Sedation
- Constipation

- Hypothalamic pituitary adrenal axis suppression
- Development of osteoporosis
- Worsening of depression, anxiety
- Increasing angiogenesis in tumors?

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

- This is specific to initiation of therapy
- Abuse-deterrent technologies don't seem to work
- "ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least 1 week."
- Methadone should not be first choice
  - Only prescribe if you are very comfortable with its use

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

- Dosages of 50-100 MME/day associated with 1.9-4.6x increased risk in overdose compared to 1-20 MME/day.

- "Most experts agreed that, in general, increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function and that clinicians should carefully reassess evidence of individual benefits and risks when considering increasing opioid dosages to ≥50 MME/day. Most experts also agreed that opioid dosages should not be increased to ≥90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks."

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

- Many insurance carriers and even pharmacies are limiting prescription of opioids to 7 days for certain conditions

- There is not a single published manuscript that recommends anything greater than a 14 day prescription of opioids for the treatment of **acute** pain

- Some experts think that 7 days is **too long**

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

- Regarding tapering:
  - Weekly reduction of 10-50% (10%/week best tolerated as compared to rapid taper)
  - Rapid taper over 2-3 weeks in cases of overdose
  - Opioid withdrawal during pregnancy associated with spontaneous abortion and pre-term labor
  - Can be stopped when taken less frequently than once per day
  - Supplement with non-opioid pain management, appropriate specialty referrals

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

- Two points here:

- 1. Pre-therapy risk assessment
- 2. Ongoing strategies/**treatments** to mitigate risk **during** therapy

NOT assessment for active misuse/abuse during ongoing therapy – this comes later

Pre-Therapy Risk Assessment

- Historical data:
- sleep apnea,
- pregnancy,
- hepatic/renal insufficiency,
- geriatric age group,
- mental health (specifically anxiety, depression),
- substance use disorder,
- prior overdose

Pre-Therapy Risk Assessment

- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)
- Brief Risk Interview
- Not mentioned in CDC Guidelines: Diagnosis, Intractability, Risk, Efficacy (DIRE) and Screening Instrument for Substance Abuse Potential (SISAP)

Ongoing Treatment Strategies To Mitigate Risk

- Naloxone + education
- Continuous Opioid Misuse Measure (COMM)
- Patient Health Questionnaire-9 or -4 (PHQ) – Depression?
- Generalized Anxiety Disorder-7 (GAD) – Anxiety?
- Education
- Education
- Education

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

- "Dangerous combinations" – CDC Guidelines only specifically mention benzodiazepines here (will discuss later), but…

FDA Black Box Warning on opioids **and** benzos:

- "Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol."

List of Benzodiazepines and Other CNS Depressants*

Generic Name	Brand Name(s)
Benzodiazepines	
alprazolam	Xanax, Xanax XR
chlordiazepoxide	Librium, Librax
clobazam	Onfi
clonazepam	Klonopin
clorazepate	Gen-Xene, Tranxene
diazepam	Diastat, Diastat Acudial, Valium
estazolam	No brand name currently marketed
flurazepam	No brand name currently marketed
lorazepam	Ativan
oxazepam	No brand name currently marketed
quazepam	Doral
temazepam	Restoril
triazolam	Halcion
Other Sleep Drugs and Tranquilizers	
butabarbital sodium	Butisol
eszopiclone	Lunesta
pentobarbital	Nembutal
ramelteon	Rozerem
secobarbital sodium	Seconal sodium
suvorexant	Belsomra
zaleplon	Sonata
zolpidem	Ambien, Ambien CR, Edluar, Intermezzo, Zolpimist

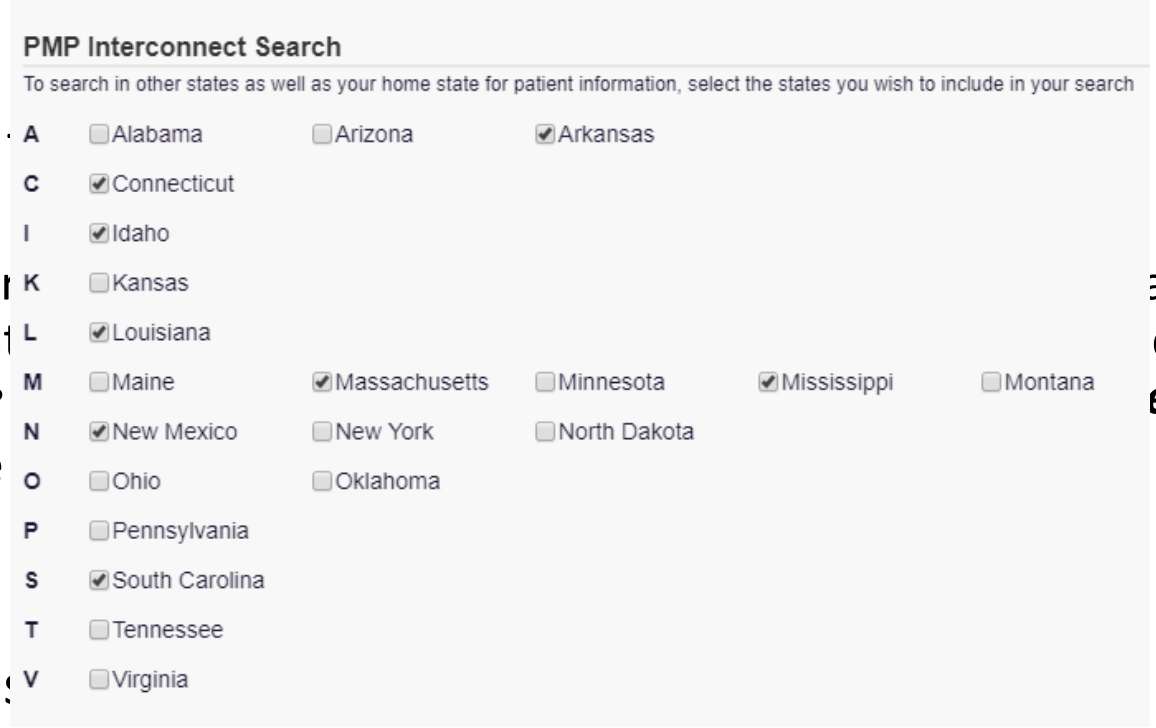
Muscle Relaxants	
baclofen	Gablofen, Lioresal
carisoprodol	Soma, Soma Compound, Soma Compound w/ codeine
chlorzoxazone	No brand name currently marketed
cyclobenzaprine	Amrix
dantrolene	Dantrium, Revonto, Ryanodex
metaxalone	Skelaxin
methocarbamol	Robaxin, Robaxin-750
orphenadrine	No brand name currently marketed
tizanidine	Zanaflex
Antipsychotics	
aripiprazole	Abilify, Abilify Maintena, Aristada
asenapine	Saphris
cariprazine	Vraylar
chlorpromazine	No brand name currently marketed
clozapine	Clozaril, Fazaclo ODT, Versacloz
fluphenazine	No brand name currently marketed
haloperidol	Haldol
iloperidone	Fanapt
loxapine	Adasuve
lurasidone	Latuda
molindone	No brand name currently marketed
olanzapine	Symbyax, Zyprexa, Zyprexa Relprevv, Zyprexa Zydis
paliperidone	Invega, Invega Sustenna, Invega Trinza

perphenazine	No brand name currently marketed
pimavanserin	Nuplazid
quetiapine	Seroquel, Seroquel XR
risperidone	Risperdal, Risperdal Consta
thioridazine	No brand name currently marketed
thiothixene	Navane
trifluoperazine	No brand name currently marketed
ziprasidone	Geodon

*This is not a comprehensive list.

PDMP

- Missouri is … a functional PDMP
  - A Missour… an) vehement… quote: ***"If they overdose… ene pool."***
  - Has since…
- Many states…



What To Look For

- Multiple prescribers
- Prescription of other CNS depressants
- Errors in database

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

- "The clinical evidence review did not find studies evaluating the effectiveness of urine drug screening for risk mitigation during opioid prescribing for pain"
- "Although random drug testing also might destigmatize urine drug testing, experts thought that truly random testing was not feasible in clinical practice."
- Dissention regarding whether UDS prior to initiation of therapy is necessary
- Immunoassay panel vs. confirmatory testing
- Should assess for presence of non-prescribed medications/drugs **and** absence of prescribed medications

Pain Physician 2012; 15:ES119-ES133 • ISSN 2150-1149

Current Opinion

Urine Drug Testing: Current Recommendations and Best Practices

Graves T. Owen, MD[1], Allen W. Burton, MD[2], Cristy M. Schade, MD, PhD[3], and Steve Passik, PhD[4]

Table 4. *UDT recommendations based on risk stratification. Modified from Official Disability Guidelines for UDT (25) and Sundwall et al (26).*

Risk	Number of Urine Drug Tests per Year
Low	1 or 2
Moderate	3 or 4
High	4 or every month, office visit, or every drug refill

- “Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety, potentially including the patient obtaining opioids from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.”

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

- " In addition, given that other central nervous system depressants (e.g., muscle relaxants, hypnotics) can potentiate central nervous system depression associated with opioids, clinicians should consider whether benefits outweigh risks of concurrent use of these drugs."

- "Because of greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and because tapering opioids can be associated with anxiety, when patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first."

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

- Another option: naltrexone

- "Physicians not already certified to provide buprenorphine in an office-based setting can undergo training to receive a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) that allows them to prescribe buprenorphine to treat patients with opioid use disorder. Physicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder should strongly consider obtaining this waiver."

DSM-V Opioid Use Disorder Critera

Opioid Use Disorder
Diagnostic Criteria

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of an opioid.

    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
    b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Take Home Points

- The CDC Guidelines are **guidelines** – not laws, rules, or regulations
- CDC Guidelines are specifically designed to assist PCPs in the management of acute and – mainly – chronic pain
- Not every patient fits in a box
- Arm yourself with knowledge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- Questions?

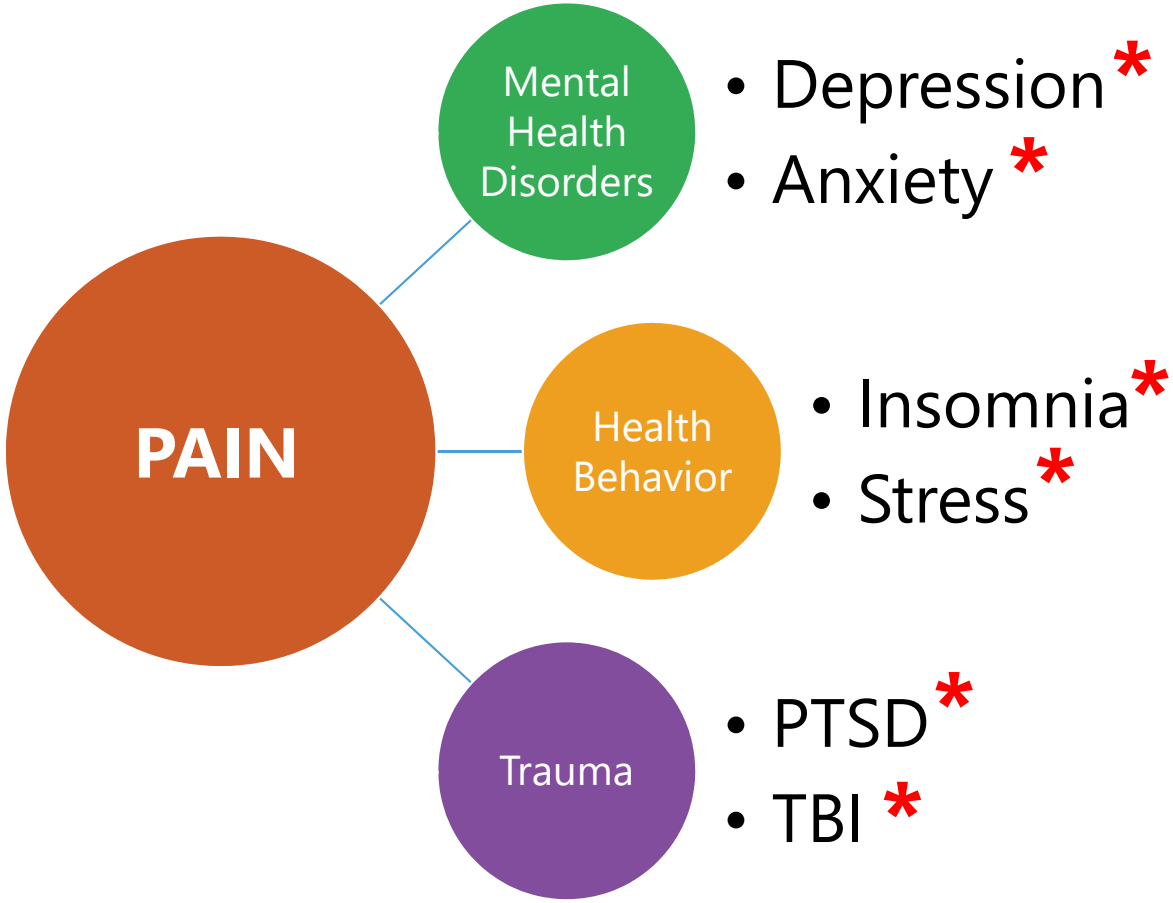
VA Best Practices in Non-Opioid Pain Management

Don McGeary, PhD, ABPP
Associate Professor, Department of Psychiatry
UT Health San Antonio

Disclaimer

The ideas and opinions expressed by the presenter **do not** represent the opinions and policies of the South Texas Veterans Health Care System or the Department of Veterans Affairs. Nor do the opinions or views expressed represent those of the Military Health System or the Department of Defense.

Chronic Pain in Active Duty Service Members and Veterans



Chronic Pain in the VA

Polymorbidity + Depression
(additive pain risk, especially in mTBI, Seal et al., 2017)

TBI and Chronic Pain
(increased risk of receiving opioid therapy, Seal et al., 2018)

Older Veterans with Pain
(pain variability, Dobscha et al., 2015; Less Improvement with Opioids + Mental Health, Dobscha et al., 2016)

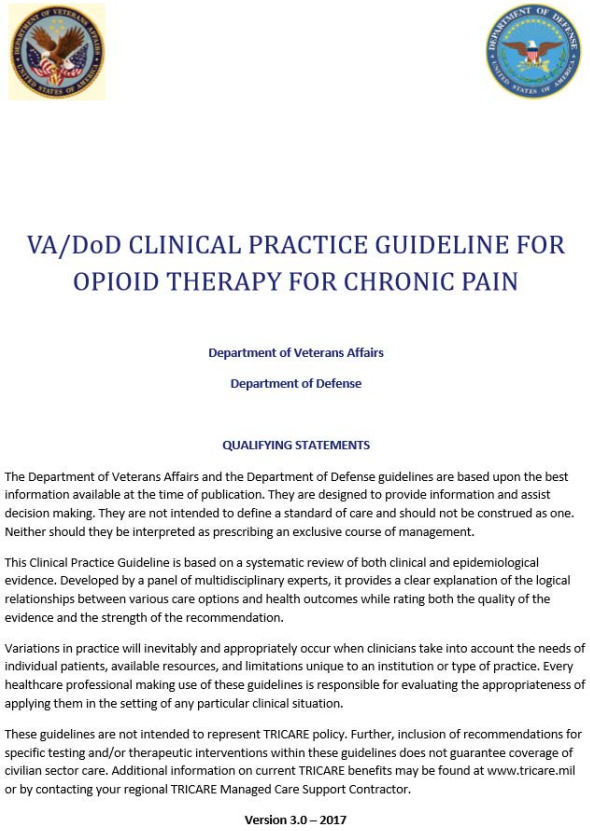
Suicide and Violence
(increased risk in polytrauma, Blakey et al., 2018)

Non-pharmacological Pain Management in the VA

Acceptability
(over half of Veterans with pain use NPM, Edmond et al., 2018)

Preference
(Psychosocial vs. Exercise vs. Manual, Edmond et al., 2018)

VA/DoD CPG for Opioid Therapy for Chronic Pain



VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

Department of Veterans Affairs

Department of Defense

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 3.0 – 2017

- 2010 - President's National Drug Control Strategy
- 2010 – Affordable Care Act (Interagency Pain Research Coordinating Committee
- 2013 – Opioid Safety Initiative
- 2014 – VA policy for standardized education and signature informed consent for LOT
- 2015 – Presidential memorandum on preventing prescription drug abuse
- 2016 – CDC Guideline for Prescribing Opioids for Chronic Pain
- 2016 – Comprehensive Addiction and Recovery Act

VA/DoD CPG for Opioid Therapy for Chronic Pain

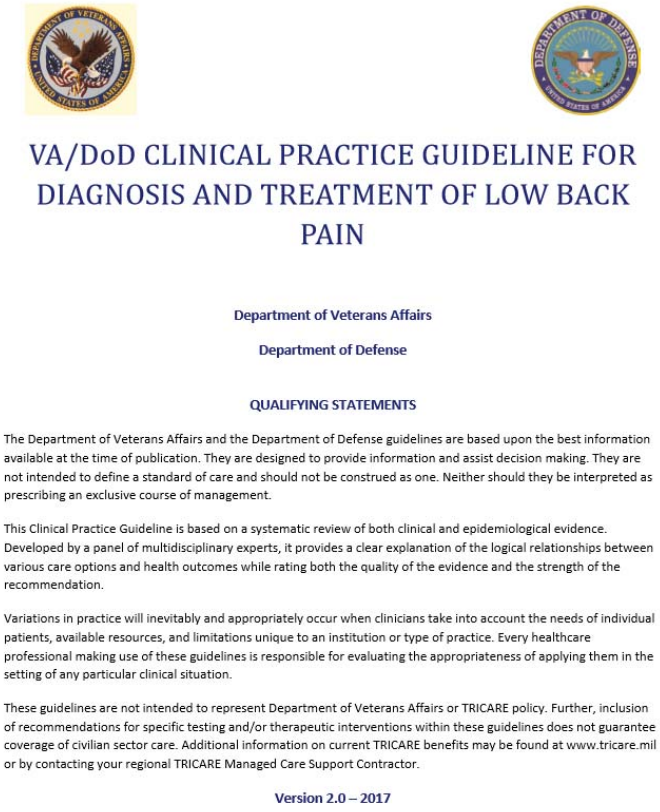
Key Recommendations

Strong Recommendation **against** LOT for chronic pain

Strong Recommendation **for** self-management and NPM

Strong Recommendation **for** using non-opioid meds

VA/DoD CPG for Diagnosis and Treatment of LBP



VA/DoD CLINICAL PRACTICE GUIDELINE FOR DIAGNOSIS AND TREATMENT OF LOW BACK PAIN

Department of Veterans Affairs

Department of Defense

QUALIFYING STATEMENTS

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Version 2.0 – 2017

- 2007 Clinical Practice Guidelines
- 2016 Guideline Clinical Champions Workgroup
- 2016 Guideline Workgroup Assembled
- 2016 Evidence Review by Multiple Consultants
- 2017 Update of 2007 CPG through Peer Review
- 2017 Graded Recommendations for LBP Treatment

VA/DoD CPG for Opioid Therapy for Chronic Pain

Key Recommendations

Strong Recommendation **for** patient-centered, evidence-based care

Strong Recommendation **for** cognitive and behavioral therapies

Weak Recommendation **for** CIH, exercise, TENS

Brief Cognitive Behavioral Therapy for Chronic Pain

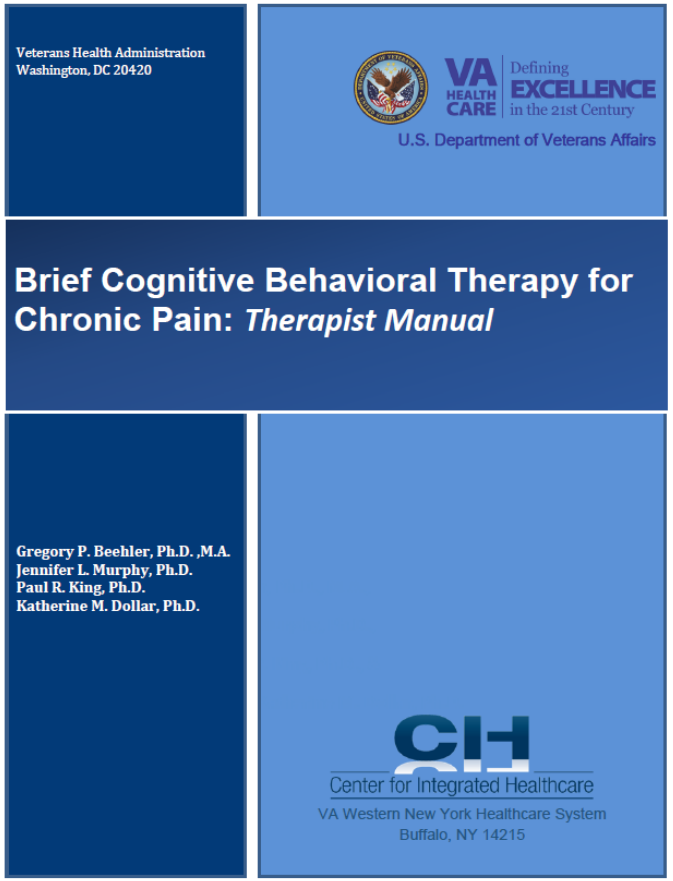


Table 3: BRIEF CBT-CP MODULES

Brief CBT-CP Modules	
Module	**Content**
1	**Education and Goal Identification:** Pain education and development of treatment goals
2	**Activities and Pacing:** Importance of engagement in activities using a thoughtful approach
3	**Relaxation Training:** Relaxation benefits and techniques
4	**Cognitive Coping 1:** Recognize unhelpful thoughts that negatively impact the pain experience
5	**Cognitive Coping 2:** Modify thoughts that are unhelpful when managing pain
6	**The Pain Action Plan:** Plan for independent implementation of CBT-CP skills and identify additional follow-up needs

79% completion rate

Decreased pain catastrophizing

Decreased pain interference

Improved QoL

Good therapeutic alliance

Stewart et al., 2015; Connolly et al., 2018

Chronic Pain Rehabilitation Programs

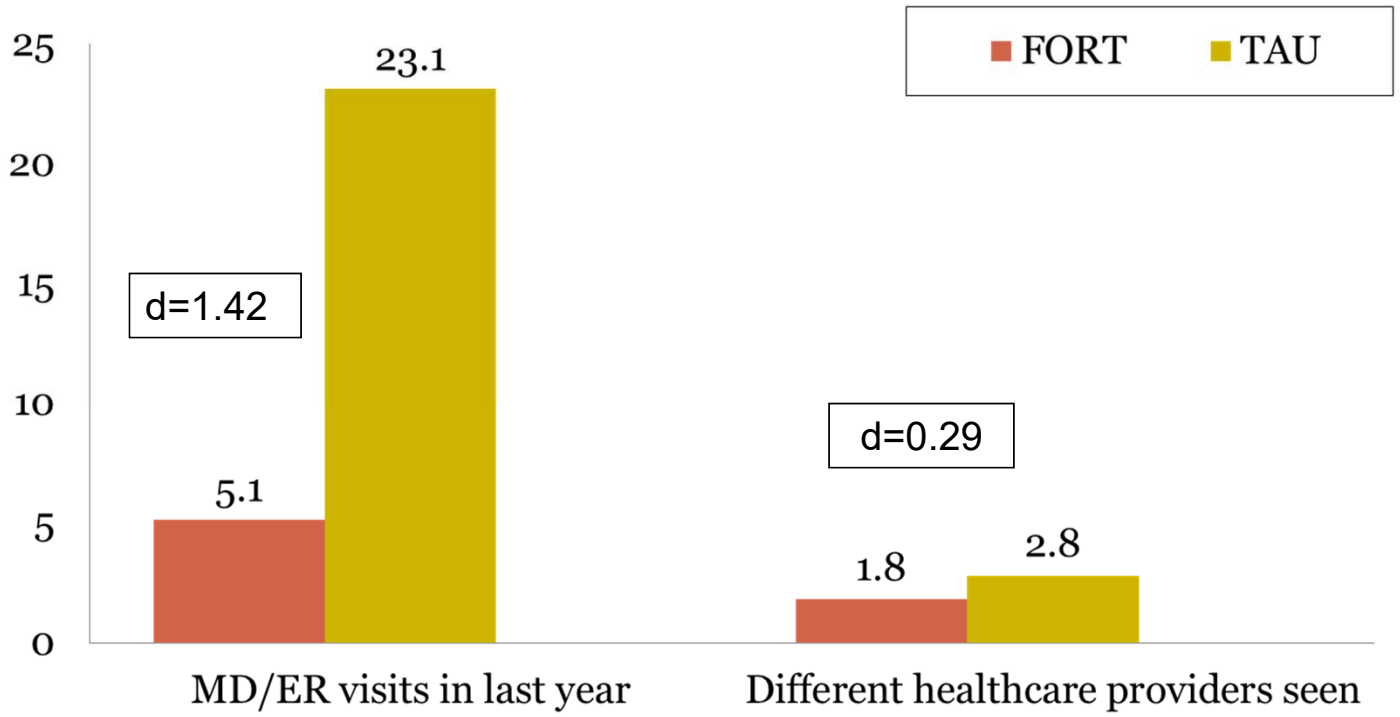
Intensive	Interdisciplinary	Functional
• 3-4 weeks • Daily • Up to 8 hours a day	• Psychology • Physical Therapy • Occupational Therapy	• Objective function • Subjective function • Coping

One-Year Socioeconomic Outcomes

Variable	FORT (% Yes) n=34	TAU (% Yes) n=33	Fisher's † p-value (1-sided)	RR	phi‡
Pain Treatment Visits	91%	100%	.125	.912	.213
NSAID Use	71%	52%	.088	.443	.196
Opioid Use	50%	82%	.006	4.500	-.335
Surgery for Pain	0%	12%	.053	1.138	.256
Medical Board	0%	27%	.001	1.375	.400
Psych Treatment	35%	39%	.462	1.192	.042
ER Visits for Pain	0%	24%	.002	1.32	.374

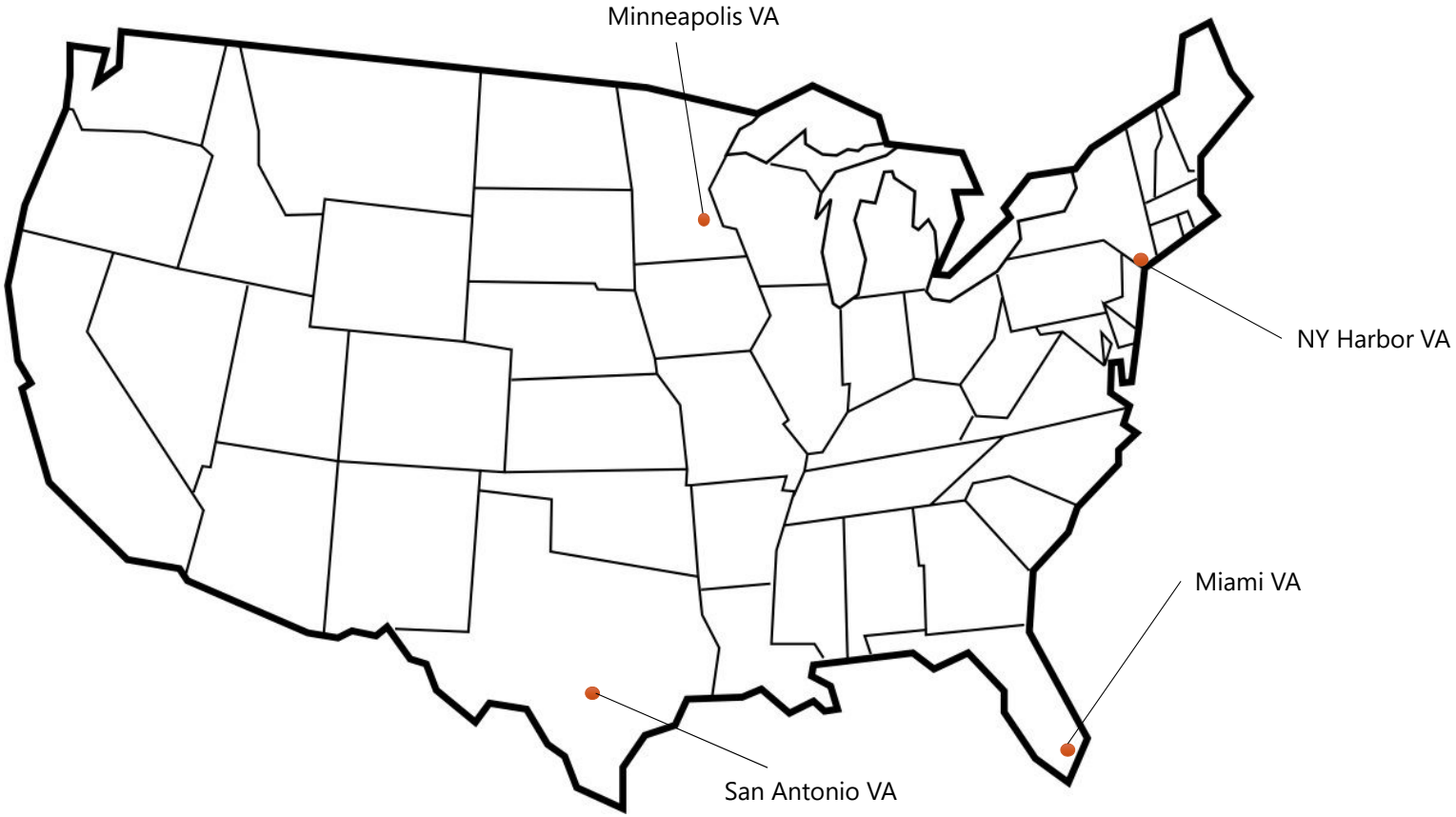
† Fisher's Exact test was used because there are some variables for which frequency is less than 5 in one group (a condition under which X-square fails to be robust).
‡ Phi values were included as a rough measure of effect size (comparable to r-square values), though max values can fall short of 1.00 or -1.00, so these are hard to interpret (Morgan et al., 2007).

One-Year Socioeconomic Outcomes

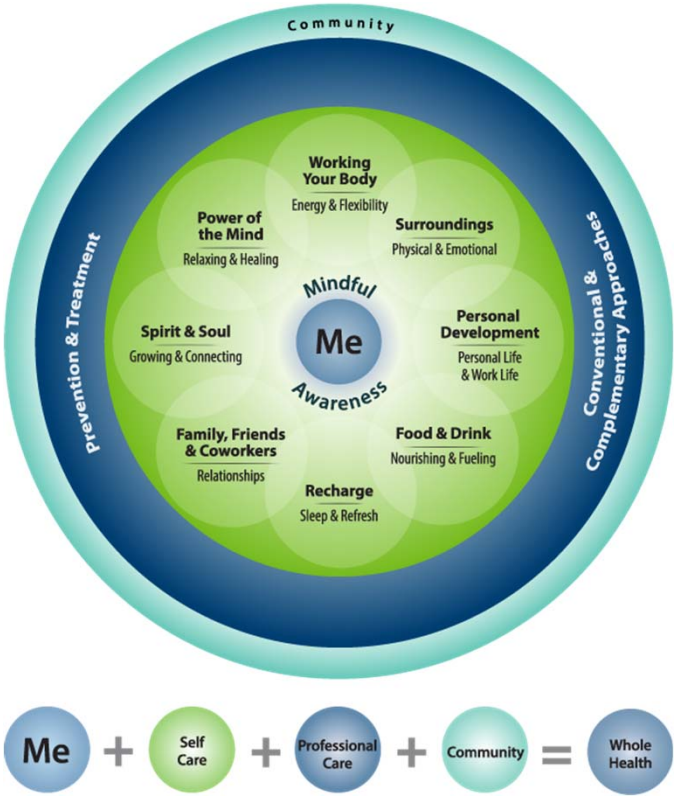


Both results were statistically significant; Gatchel et al., 2009

Chronic Pain Rehabilitation Programs



CIH for Pain – The Whole Health Initiative



Taken from: https://www.va.gov/PATIENTCENTEREDCARE/explore/about-whole-health/look-at-the-big-picture.asp

Veterans show high interest in CIH services for pain, but are low utilizers because these services were not widely available in the VA (Fletcher et al., 2016)

General Goals:

* Patient-centered care
* Focus on health and well-being
* Holistic care for chronic illness
* Community of care

Pain-Specific Goals:

* Improved function & coping
* Decrease opioid use

https://www.va.gov/PATIENTCENTEREDCARE/features/CIH_Programs_Effective_To_Reduce_Opioid_Use.asp

References

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Connolly KS, Vanderploeg PS, Kerns RD, Grant C, Sellinger J, Godleski L. Nationwide Implementation and Outcomes of Cognitive Behavioral Therapy for Chronic Pain Over Clinical Video Teleconferencing. Journal of Technology in Behavioral Science. 2018 Mar 1;3(1):26-31.

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Fletcher CE, Mitchinson AR, Trumble EL, Hinshaw DB, Dusek JA. Perceptions of other integrative health therapies by Veterans with pain who are receiving massage. Journal of rehabilitation research and development. 2016;53(1):117.

Gatchel RJ, McGeary DD, Peterson A, Moore M, LeRoy K, Isler WC, Hryshko-Mullen AS, Edell T. Preliminary findings of a randomized controlled trial of an interdisciplinary military pain program. Military Medicine. 2009 Mar 1;174(3):270-7.

Seal KH, Bertenthal D, Barnes DE, Byers AL, Gibson CJ, Yaffe K. Traumatic brain injury and receipt of prescription opioid therapy for chronic pain in Iraq and Afghanistan veterans: Do clinical practice guidelines matter? The Journal of Pain. 2018; doi: 10.1016/j.jpain.2018.03.005.

Seal KH, Bertenthal D, Barnes DE, Byers AL, Strigo I, Yaffe K. Association of traumatic brain injury with chronic pain in Iraq and Afghanistan veterans: Effect of comorbid mental health conditions. Archives of Physical Medicine and Rehabilitation. 2017;98:1636-45.

Stewart MO, Karlin BE, Murphy JL, Raffa SD, Miller SA, McKellar J, Kerns RD. National dissemination of cognitive-behavioral therapy for chronic pain in veterans: Therapist and patient-level outcomes. The Clinical journal of pain. 2015 Aug 1;31(8):722-9.

Helpful Websites

https://www.va.gov/PAINMANAGEMENT/For_Providers.asp

https://www.ptsd.va.gov/professional/co-occurring/chronic-pain-ptsd-providers.asp

https://www.va.gov/PAINMANAGEMENT/Research.asp

https://www.va.gov/painmanagement/

What's next for Prescription Monitoring Programs

Allison Vordenbaumen Benz, R.Ph., M.S.
Executive Director

San Antonio Substance Use Symposium
April 20, 2018

TEXAS STATE BOARD OF PHARMACY

Texas Prescription Monitoring Program

- In 2015, the 84th Texas Legislature voted to transfer the PMP from DPS to the Texas State Board of Pharmacy.
- Senate Bill 195 moved the Prescription Monitoring Program from the Department of Public Safety (DPS) to the Board of Pharmacy; and
- Eliminated the Texas Controlled Substance Registration program.

Log In

Texas Prescription Monitoring Program

Powered by PMP Awarxe™

Support: 844-4TX-4PMP (844-489-4767)

Log In

Email

Password

Reset Password

Log In

Create an Account

Need Help?

Browsers Supported  (8+)

My Dashboard

Patient Alerts

PATIENT ALERTS

No patient alerts received.

Recent Requests

RECENT REQUESTS

No Requests found.

View Requests History

My Favorites

RxSearch - Patient Request

PMP Announcements

NEW **Improper use of the Prescription Monitoring Program (PMP)** 11/06/2017

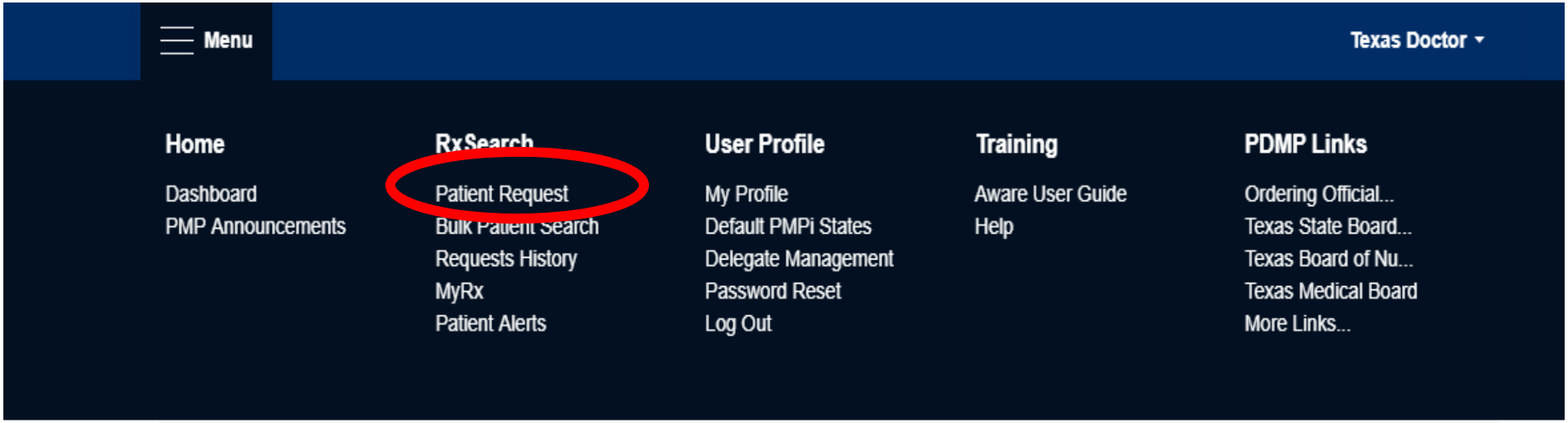
Improper use of the Prescription Monitoring Program (PMP) is a serious offense subject to sanctions under federal and state law...

more

View all Announcements

Quick Links

Ordering Official CII Prescription Forms
Texas State Board of Pharmacy
Texas Board of Nursing
Texas Medical Board
Texas State Board of Dental Examiners
Drug Enforcement Administration
Texas Optometry Board
Texas State Board of Podiatric Medical Examiners
Texas Board of Veterinary Medical Examiners
Texas Administrative Code
Texas Health and Safety Code
Texas Prescription Monitoring Program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Bulk Patient Search
Requests History
MyRx
Patient Alerts
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My Profile
Default PMPi States
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Password Reset
Log Out
Training
Aware User Guide
Help
PDMP Links
Ordering Official...
Texas State Board...
Texas Board of Nu...
Texas Medical Board
More Links...

Menu

Texas Doctor

RxSearch > Patient Request

Texas Prescription Monitoring Program

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Support: 844-4TX-4PMP (844-489-4767)

Patient Request

Patient Rx Request Tutorial

Can't view the file? Get Adobe Acrobat Reader

* Indicates Required Field

Patient Info

First Name*

Partial Spelling

Last Name*

Partial Spelling

Date of Birth*

MM/DD/YYYY

Phone Number

Prescription Fill Dates

No earlier than 3 years from today

From* 12/18/2016

To* 12/18/2017

Patient Location

Search accuracy can be improved by including the address

Street Address

City

State/Province Select State

Zip Code

PMP Interconnect Search

To search in other states as well as your home state for patient information, select the states you wish to include in your search

Street Address

City | State/Province | Zip Code

State/Province: Select State

PMP Interconnect Search

To search in other states as well as your home state for patient information, select the states you wish to include in your search

A	Alabama	Arizona	Arkansas	
C	Connecticut			
I	Idaho			
K	Kansas			
L	Louisiana			
M	Massachusetts	Minnesota	Mississippi	Montana
N	New Mexico	New York	North Dakota	
O	Oklahoma			
P	Pennsylvania			
S	South Carolina			
T	Tennessee			

I agree to the terms of the acknowledgement.

Search

Powered By

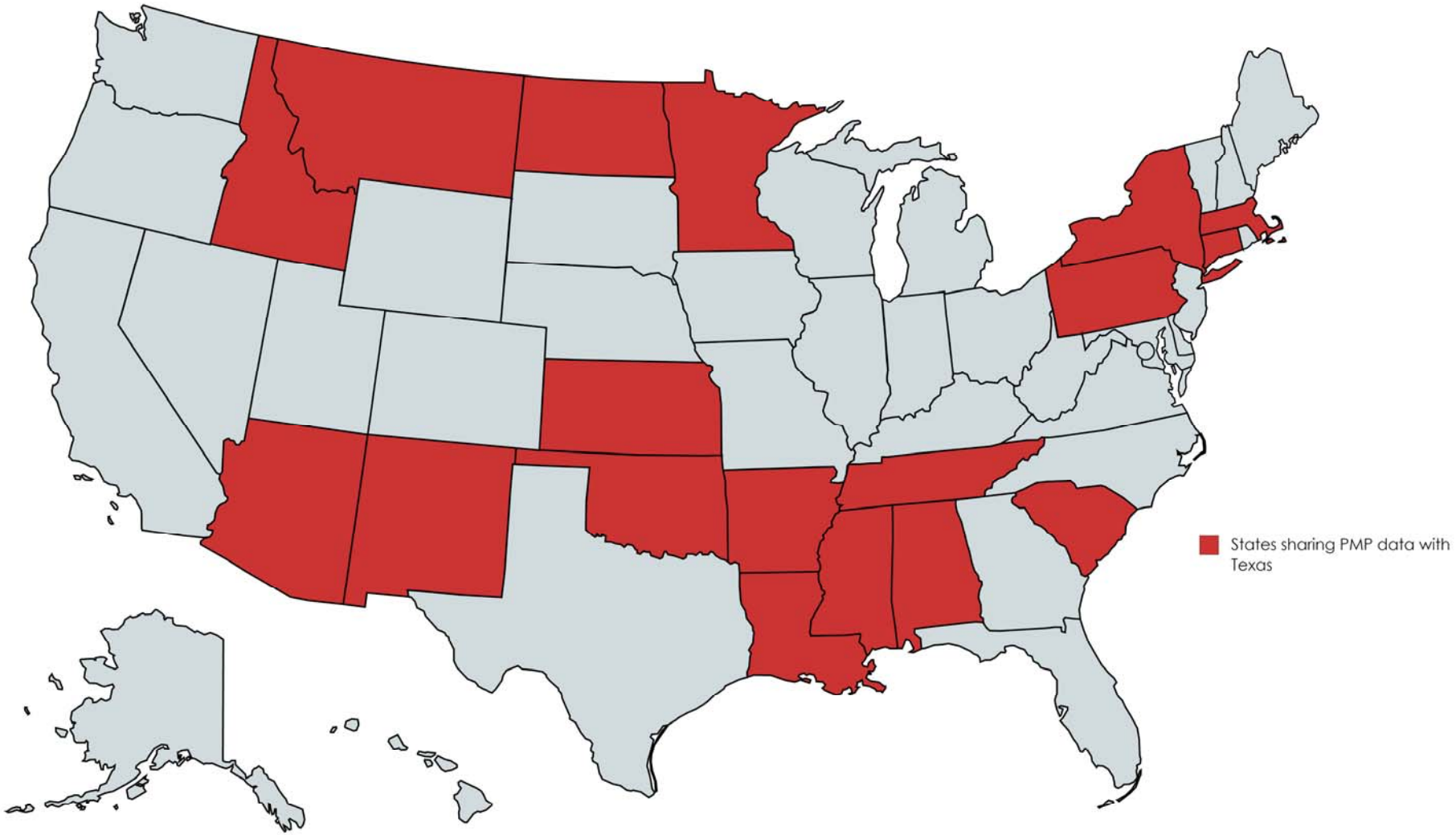
APPRISS HEALTH

TEXAS PMP AWARE

For assistance using this application, please contact

Austin, TX

844-4TX-4PMP (844-489-4767)



Street Address

City | State/Province | Zip Code

State/Province: Select State

PMP Interconnect Search

To search in other states as well as your home state for patient information, select the states you wish to include in your search

A	Alabama	Arizona	Arkansas	
C	Connecticut			
I	Idaho			
K	Kansas			
L	Louisiana			
M	Massachusetts	Minnesota	Mississippi	Montana
N	New Mexico	New York	North Dakota	
O	Oklahoma			
P	Pennsylvania			
S	South Carolina			
T	Tennessee			

I agree to the terms of the acknowledgement

Search

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844-4TX-4PMP (844-489-4767)

Pharmacists Busted for Prying into Prince's Medical Records

Three pharmacists were caught trying to access the deceased star's records just days after his death.

Las Vegas Strip shooter prescribed anti-anxiety drug in June

Menu

Texas Doctor

RxSearch > Patient Request

Back

Texas Prescription Monitoring Program

Powered by Awarxe

Support: 844-4TX-4PMP (844-489-4767)

Patient Report

Refine Search

Report Prepared: 12/18/2017
Date Range: 12/18/2016 – 12/18/2017

Download PDF Download CSV

Test Patient

Summary

Prescriptions:	5
Prescribers:	4
Pharmacies:	3
Private Pay:	0
Active Daily MME:	18.487

Prescriptions

Filled	ID	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy *	Refills	MME/D	Pymt Type	PMP
07/25/2017	1	07/17/2017	MODAFINIL 200 MG TABLET	186.0	233	Al Tes	UerqlR	Beatt (1119)	0		Military/VA	TX
07/24/2017	2	07/16/2017	LORAZEPAM 2 MG/ML VIAL	911.0	923	Al Tes	o6AH92yl82TW4hd	Hartm (1119)	0		Medicare	TX
07/24/2017	2	07/13/2017	DULOXETINE HCL DR 60 MG CAP	439.0	484	Ja Tes	671YhUE3	Hoppe (4563)	0		Other	TX
07/22/2017	2	07/17/2017	OXYCODON-ACETAMINOPHEN 7.5-325	585.0	356	An Tes	lwkJS7HUBLVkgyAsmgQQrxcz	Beatt (1119)	0	18.487	Medicaid	TX
07/21/2017	2	07/14/2017	LORAZEPAM 2 MG/ML VIAL	877.0	810	Ja Tes	wBhqqfaEQ4c2DDHPg	Hoppe (4563)	0		Medicaid	TX

*Pharmacy is created using a combination of pharmacy name and the last four digits of the pharmacy license number.

Per CDC guidance, the conversion factors and associated daily morphine milligram equivalents for drugs prescribed as part of medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain.

Prescribers

Name	Address	City	State	Zip	Phone
TestDoc, Alexandrea R					3341410806
TestMD, Alice C			TX		
TestPA, Jany M					7465940035
TestPrescriber, Andre P					9739317396

Dispensers

Pharmacy	Address	City	State	Zip	Phone
Hoppe-Stiedemann Mailorder (4563)	100 TANGLEWOOD DR	CARTERSVILLE	GA	30120	2301155244
Hartmann and Sons Test Pharmacy (1119)	8770 SOUTHAMPTON ROAD	RICHARDSON	TX	75080	
Beatty, Cronin and Becker Test Pharmacy (1119)	68 ANDOVER RD	FORNEY	TX	75126	

Physician (MD, DO) Disclaimer:
I understand that I must treat the information in the PMP system as confidential healthcare information in accordance with federal and state laws. I understand that inappropriate access or disclosure of PMP information is a violation of federal and state law, and may result in disciplinary action, revocation of PMP database access, civil penalties, and/or criminal action. I understand the PMP administrator will conduct auditing activities to monitor for unusual or potentially unauthorized use of the system. The information in the PMP database and reports generated from the information may contain errors resulting from the information submitted by dispensers. The Texas State Board of Pharmacy recommends independent verification of the patient prescription information with pharmacies and prescribers when prudent or necessary. The data available from other state Prescription Monitoring Programs is based on the data submitted by the dispensers in the specific state in accordance with their state's reporting requirements.

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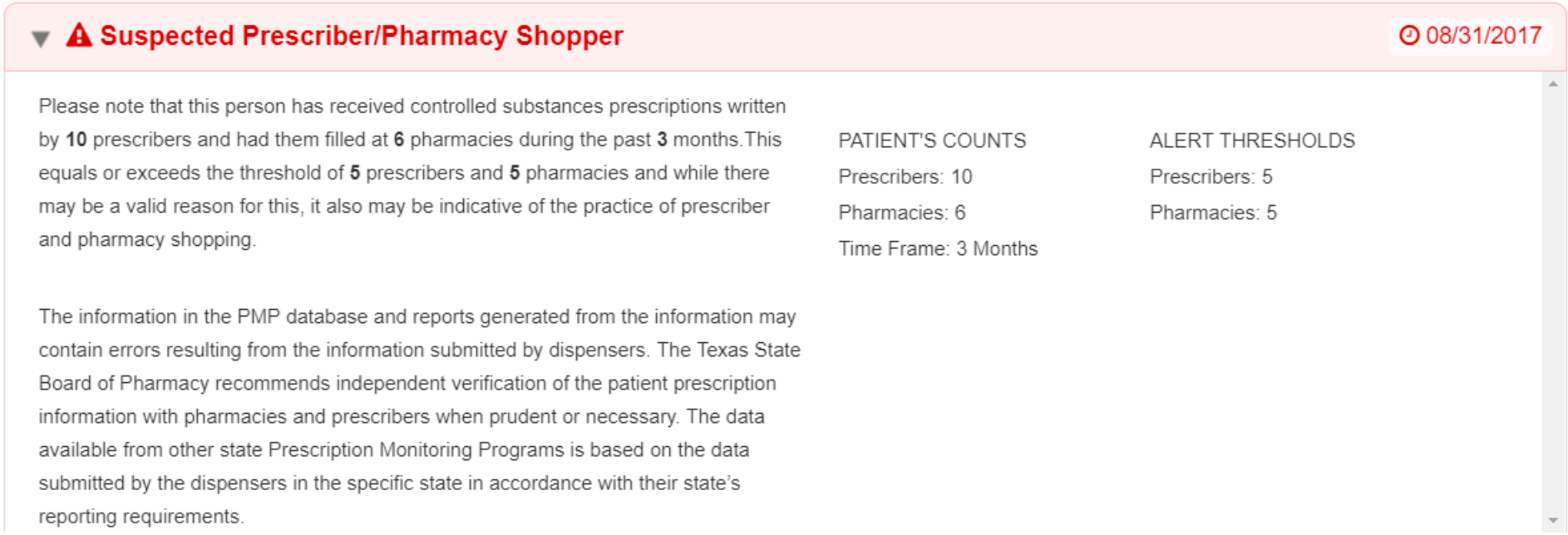
Austin, TX
844-4TX-4PMP (844-489-4767)

Threshold Alerts



Effective September 1, 2017, HB 2561 amended the Texas Controlled Substances Act

The bill:

- requires pharmacies to send all required information for Schedule II – V prescriptions to the PMP not later than the next business day after the date the prescription is completely filled;
- specifies that after 9/1/2019, a pharmacist or prescriber authorized to access the PMP, other than a veterinarian, shall access the PMP for the patient before prescribing or dispensing:
  - Opioids;
  - Benzodiazepines;
  - Barbiturates; or
  - Carisoprodol;

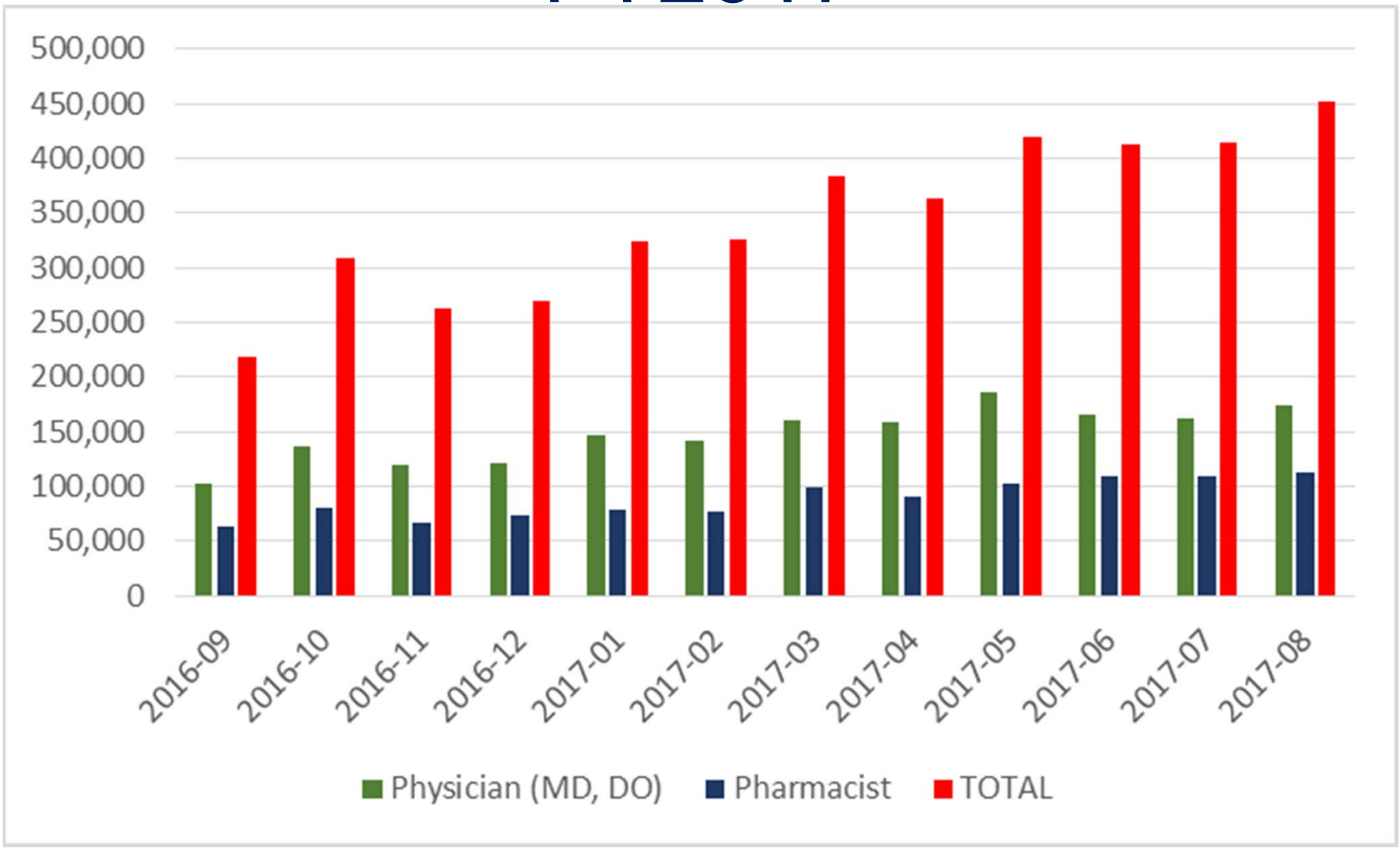
HB 2561 (cont.)

- specifies that a regulatory agency that issues a license to a prescriber or dispenser shall provide TSBP with any necessary information, including contact information to register the prescriber or dispenser with the PMP; and
- adds a new Sec. 481.0764 to require wholesalers to report to TSBP the sale of controlled substances made by the distributor to a person in this state.

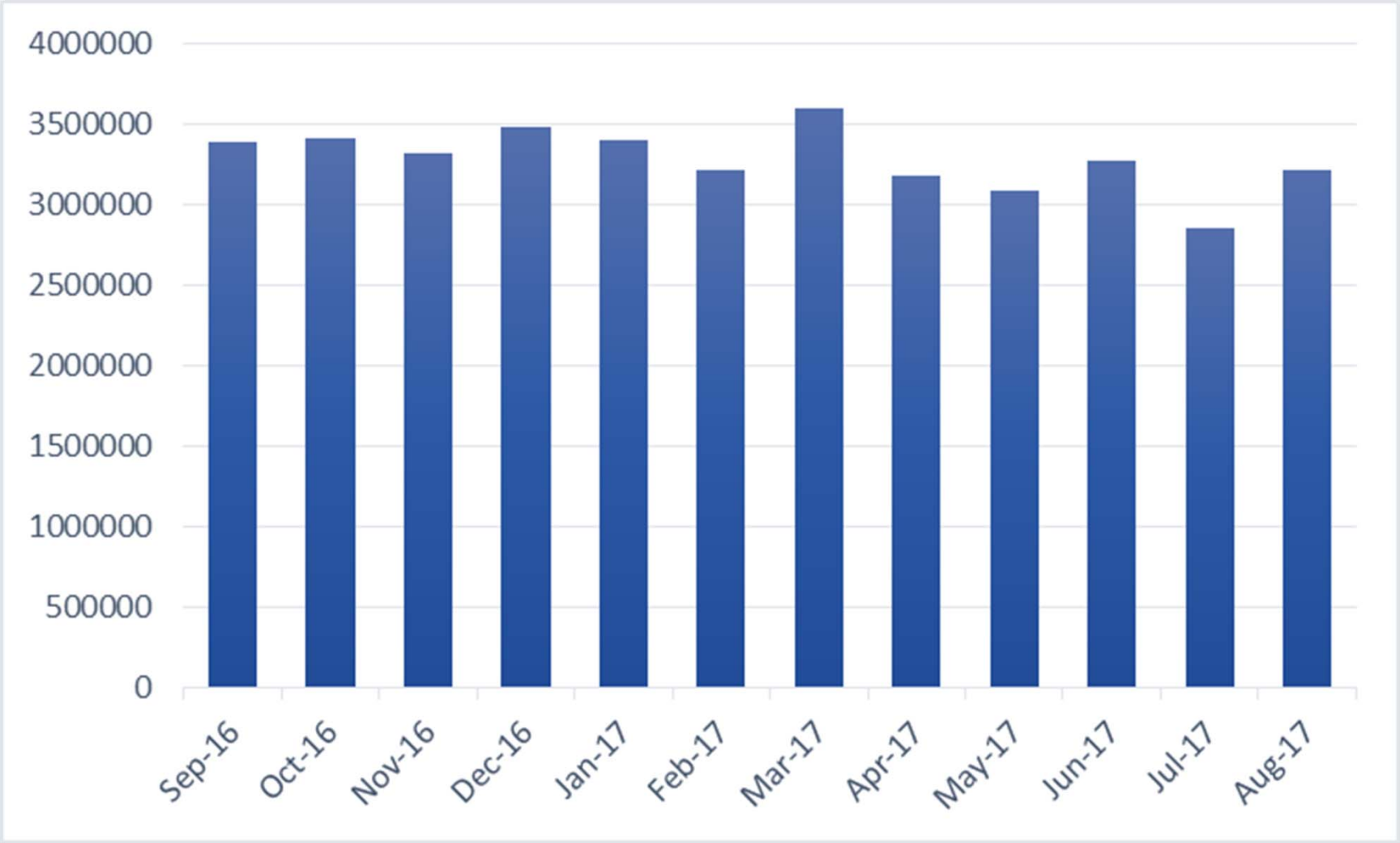
Registered Users
FY2017

License	Number of Registered Users
Dentist	3,291
Medical Resident with Prescriptive Authority	191
Advanced Practice Registered Nurse	6,786
Optometrist	16
Pharmacist	18,460
Pharmacist Delegate (Pharmacy Technician)	918
Physician (MD, DO)	22,737
Physician Assistant	2,989
Podiatrist	221
Prescriber Delegate	1,642
Other Prescriber	86
Veterinarian	109
Other	138
TOTAL	**57,584**

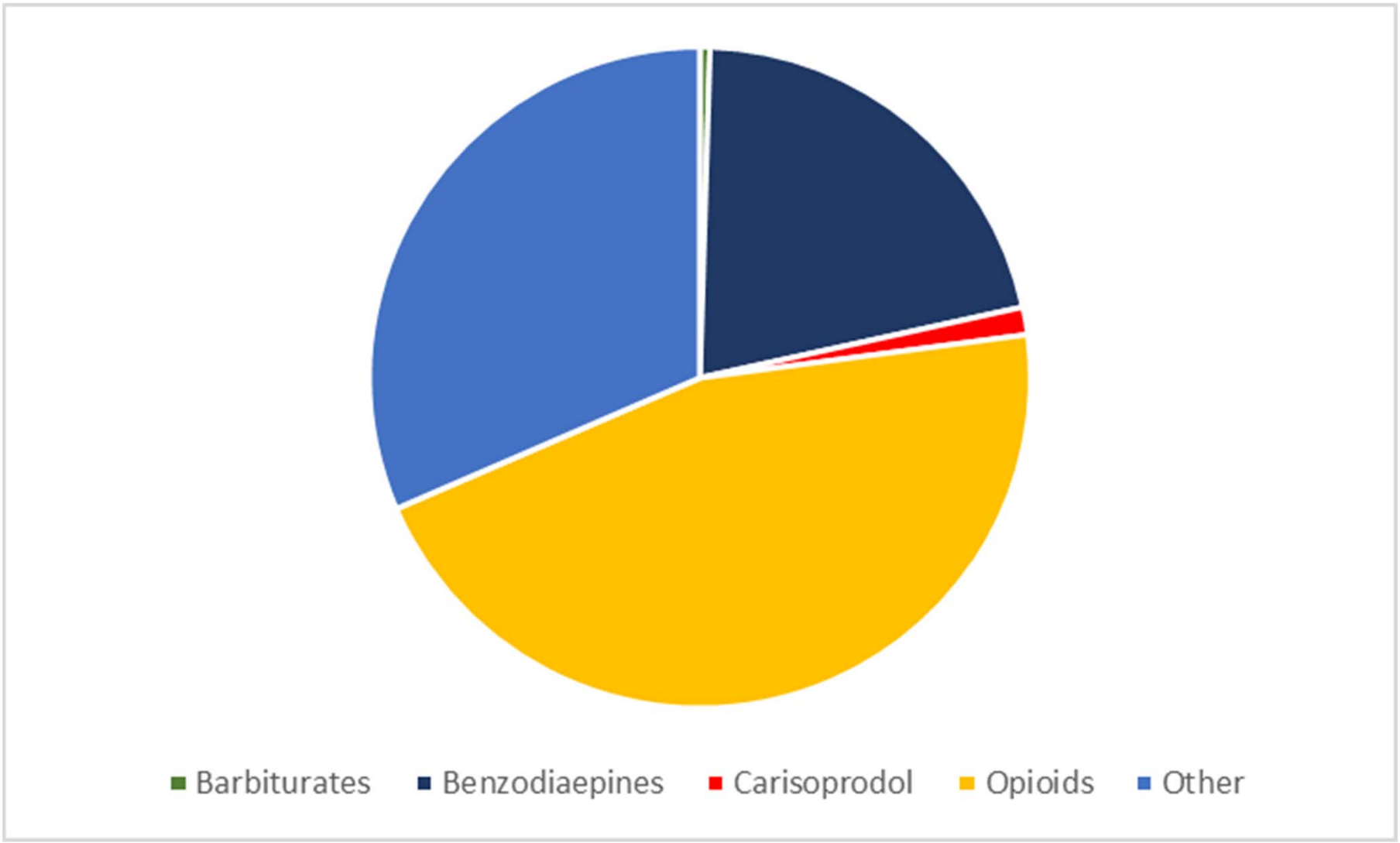
Number of Searches FY2017



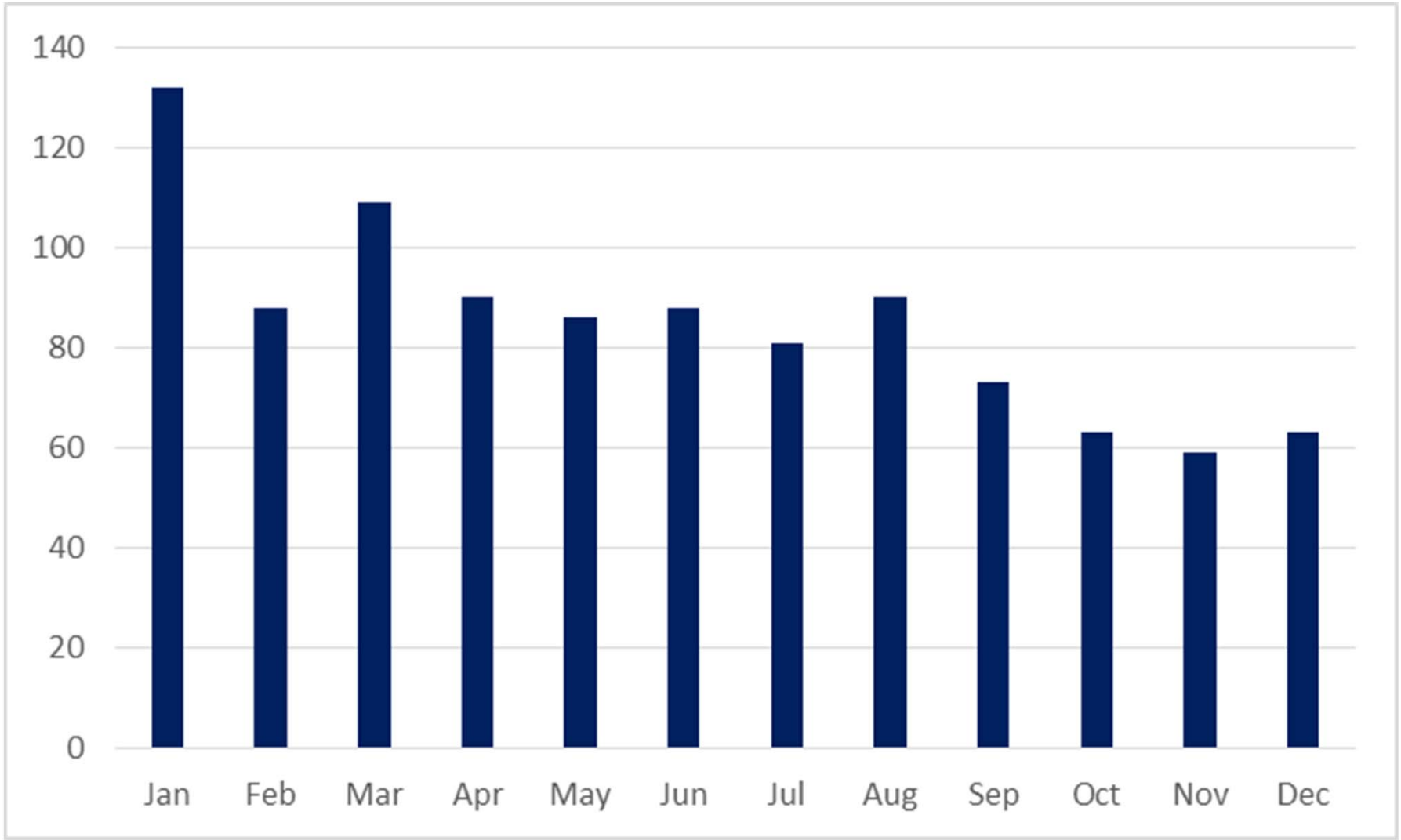
Total Controlled Substances Dispensed FY2017



Controlled Substances Dispensed by Type



Push Notifications



Wholesaler Reporting

- 185 wholesalers reporting
- Over 600,000 records

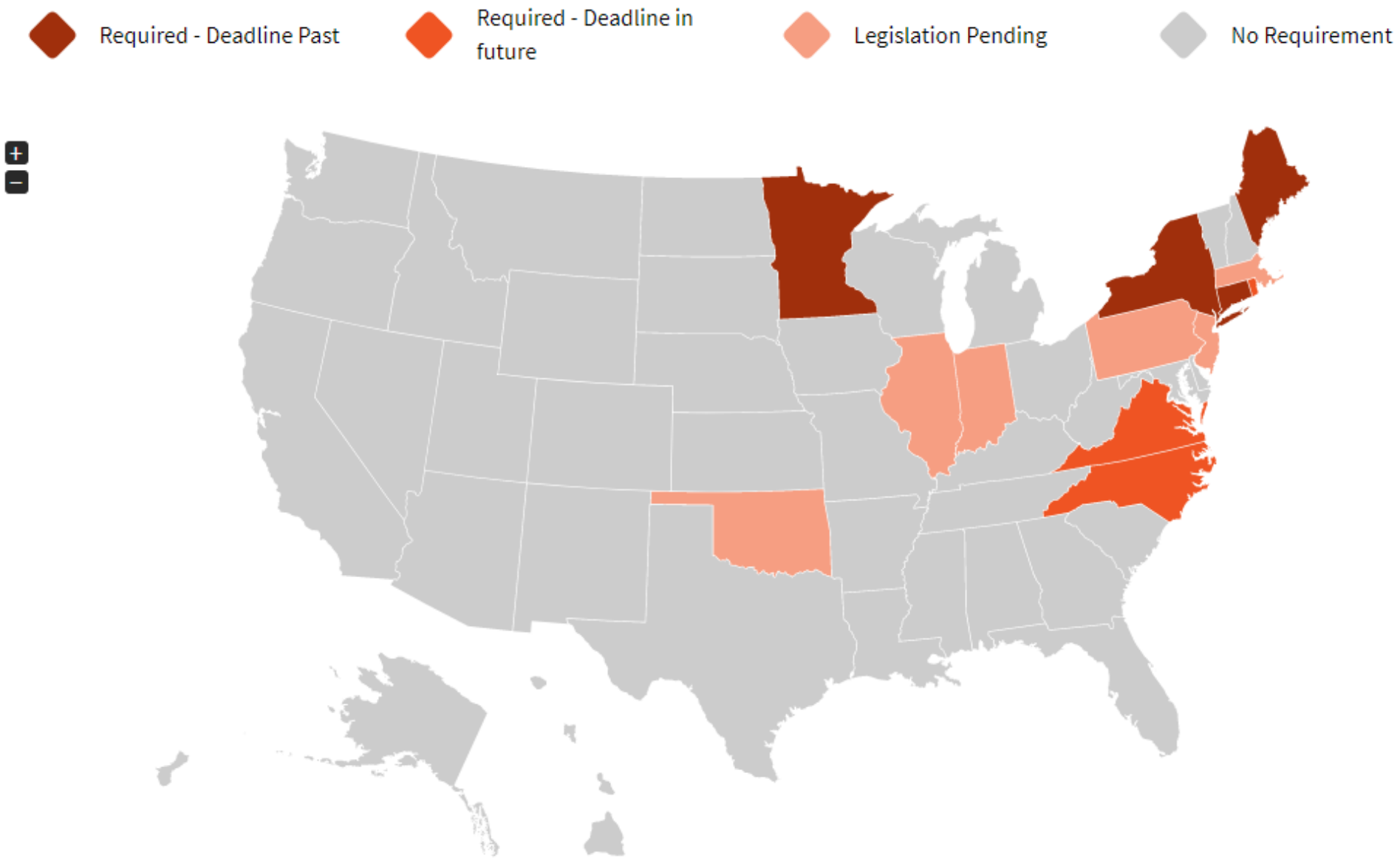
Enhancing the Prescription Monitoring Program

- E-prescribing
- Clinical Alerts
- NarxCare
- System Integration

Benefits of E-Prescribing

- Adds safety and security
- Improves patient care and outcome
- Reduces errors

E-Prescribing map

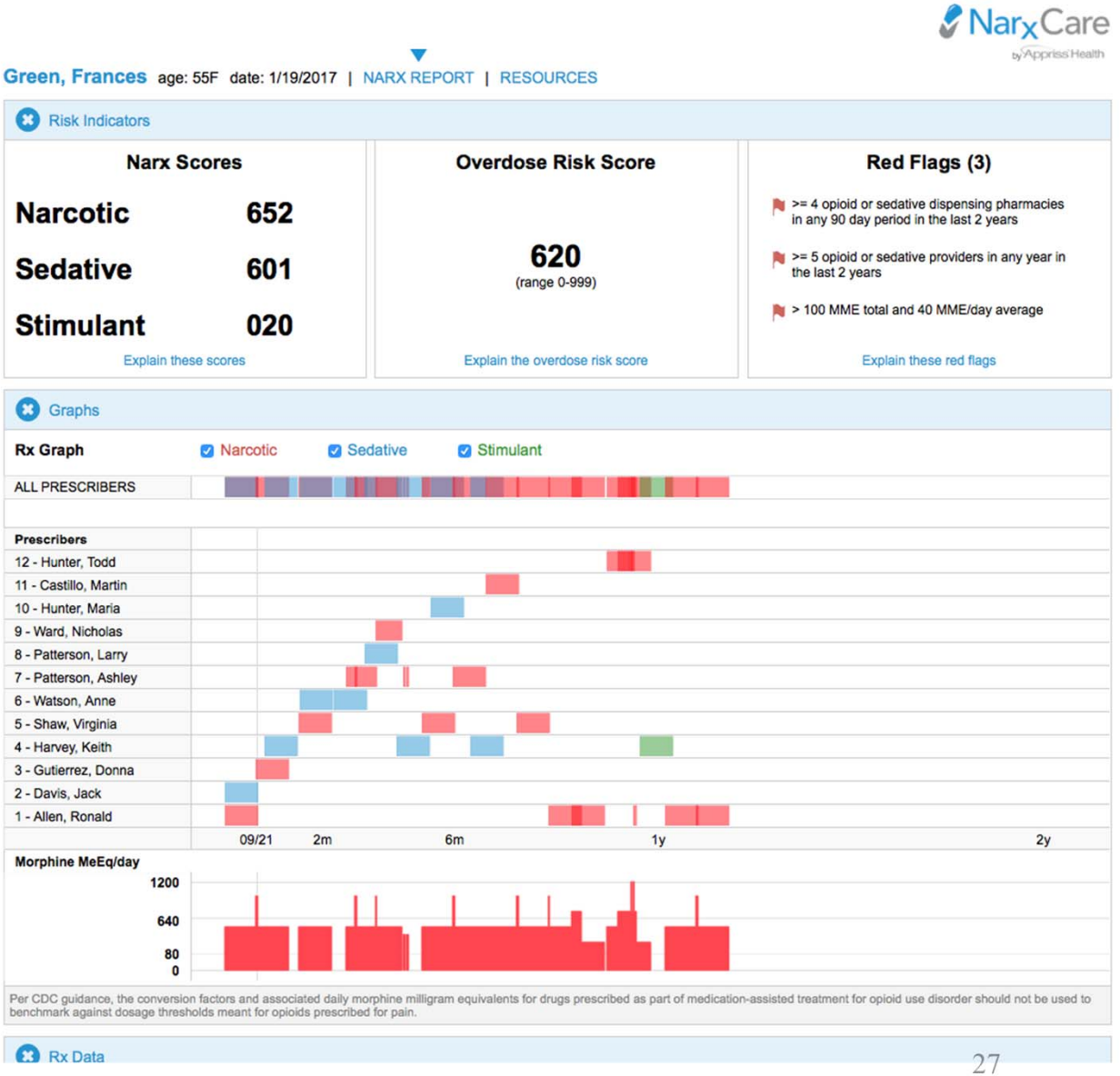


Clinical Alerts

- Prescriber and Dispenser Thresholds
- Opioid and Benzodiazepine Threshold
- Opioid Consecutive Days Threshold
- Daily Active MME Threshold
- Daily Active Methadone Threshold

NarxCare is also available within PMP AWARE

- Provides full access to state of the art tools and assessments regardless of integration status
- Sets the stage for incremental data addition (determined by the State)
  - i.e. non-fatal overdose, drug court participation, naloxone administration data



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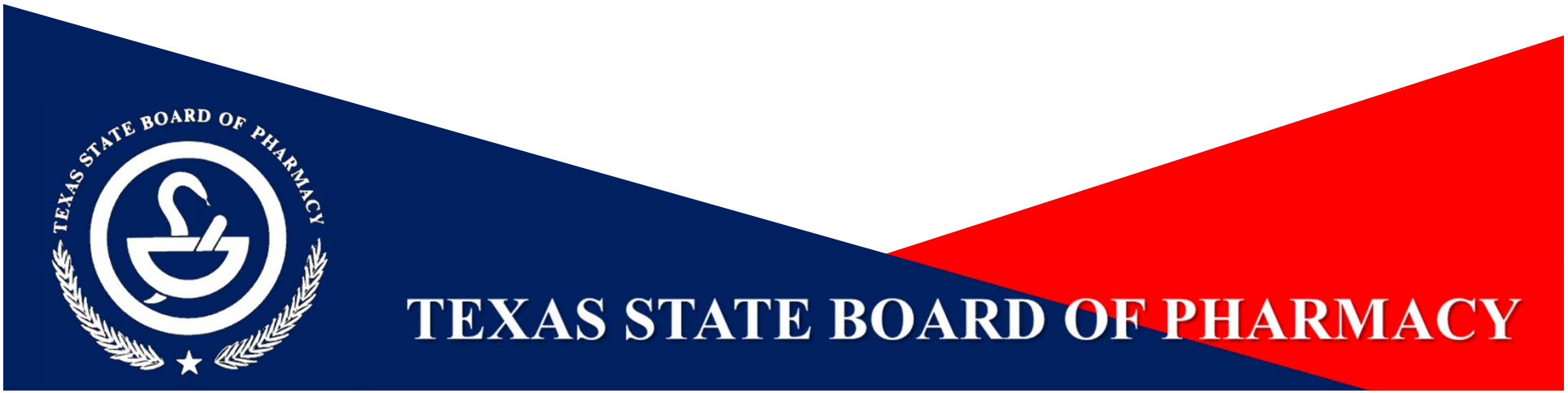

TEXAS STATE BOARD OF PHARMACY
TEXAS STATE BOARD OF PHARMACY

Rethinking the Care of Mothers and Infants Impacted by Opioid Use: A Coordinated County and State Response

Lisa M. Cleveland PhD, RN, CPNP, IBCLC

UT Health, School of Nursing

Moderator

UT Health San Antonio

Objectives

1) Discuss the impact of opioid use on Texas and Bexar County families.

2) Describe innovative, coordinated, local and state initiatives to address the opioid crisis at the Bexar County level.

3) Discuss how you can become involved.

UT Health San Antonio

Background

- **1/3 the cases of neonatal abstinence syndrome (NAS) in TX occur in Bexar County**
  - ***NAS is a withdrawal syndrome occurring in infants prenatally exposed to opioids***
  - ***Approx. 300-400 infants born with NAS annually in San Antonio***
- **Overdose death is the leading cause of injury death**
  - ***A leading cause of maternal mortality in TX***

UT Health San Antonio

Kangaroo Mother Care Study

- Impact of KMC on stress reactivity and attachment
  - *Completed; data analysis and dissemination in progress*
- Findings:
- *High attachment scores*
- *Parental role alteration was the most stressful*
- separation from the infant, not being the primary caregiver, not having alone time
- *Significant reduction in within dyad heart rate*
  - *Reduction in NAS symptoms while in KMC*
  - *Maternal engagement*

Written consent obtained for use of photos

Funded by the Texas Health & Human Services Commission

Maternal Opioid Mortality Study (MOMS)

- Purpose is to explore circumstances surrounding maternal opioid use, relapse, and overdose
  - Currently enrolling throughout TX
- Qualitative interviews and focus groups
  - Women and family members
  - Relapse, overdose, or "near miss"
- Quantitative survey data
- Goal of developing a predictive screener for administration at well child visits

Funded by the Texas Health & Human Services Commission

Preliminary Findings

- Stressful Life Events Questionnaire
- Participants experienced high rates of exposure to multiple stressful and traumatic life events beginning early in life and extending into adulthood
- Of 13 individual stressful/traumatic event items, women indicated having experienced an average of 5.4 (SD = 2.91) stressful/traumatic events in their lifetime
- 80% of women indicating 4 or more items

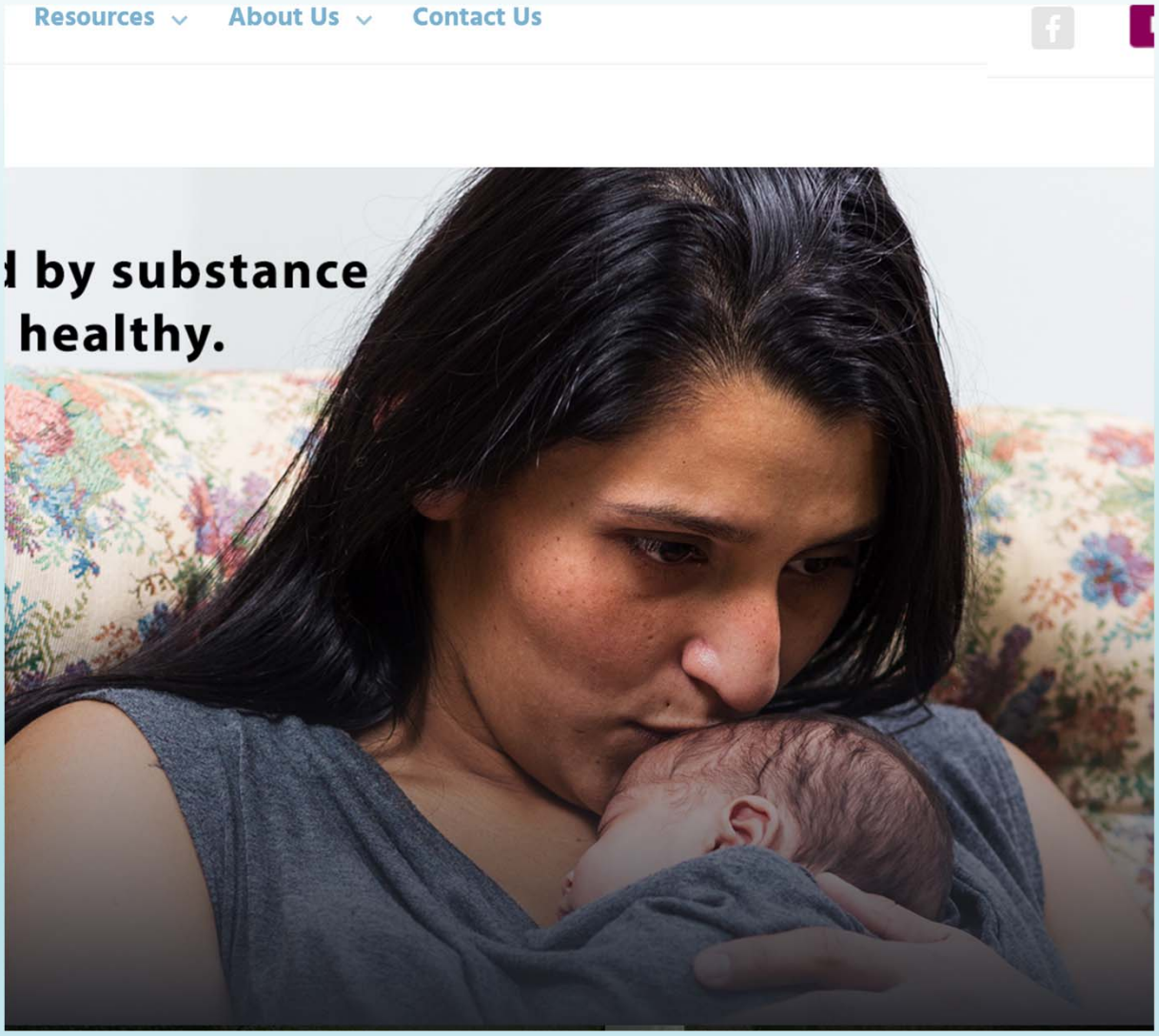
UT Health San Antonio

Preliminary Findings

Stressful Life Event Question	% of women impacted
Has an immediate family member, romantic partner, or very close friend died because of an accident, homicide, or suicide?	80.0%
Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you or told you you were no good?	80.0%
At any time, has anyone (parent, other family member, romantic partner, stranger or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated?	70.0%
As an adult, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, family member, stranger or someone else?	60.0%

Preliminary Themes

- Losing my children/escaping the pain
- Need for support
- Trauma
- Mental health symptoms
- *Lack of options*



The Bexar County NAS Collaborative (BCNC)

Keepingfamiliestogether.org

Funded by the Patient Centered Outcomes Research Institute

Introduction of Panel Members

- **John Isaac MD: Medical Director of Baptist Medical Center-Downtown Neonatal Intensive Care Unit, *_VON designated NAS Center of Excellence_***
- **Suzie Aldous MBA, BSN, RN: NICU & NAS Program Director, Baptist Medical Center- Downtown**
- **Yolanda Aldana: Lead Family Partner-Bexar County NAS Collaborative**
- **Lisa Ramirez MA, LCDC: Texas Health & Human Services Commission, Substance Use Disorder Unit, Behavioral Health Services Section, Project Director-Texas Targeted Opioid Response**
- **Dianna Mitchell BS: Alpha Home, Family First Director**

Questions?

Lisa Cleveland
210-567-3844
clevelandl@uthscsa.edu

UT Health San Antonio

The influence of co-occurring conditions on pain and opioid use

Donald McGeary, PhD, APBB
Cindy McGeary, PhD, APBB
Tabatha Blount, PhD

San Antonio Substance Use Symposium
April 20, 2018

UT Health
San Antonio

Objectives

1. Provide a general overview of comorbidities common to pain and OUD
2. Examine the impact of co-occurring conditions (including mental health problems, relationship problems, and trauma) on pain and OUD
3. Discuss putative mechanisms underlying these co- and polymorbidities
4. Review treatment implications in these complex patients

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Chronic Pain is Prevalent and Costly…

- Chronic pain affects approx. 100 million Americans

- Impacts our service members and veterans:
  - e.g., Prevalence rates for chronic pain within the VA Polytrauma Rehabilitation Centers is over 80%

IOM, 2011; Lew et al., 2009

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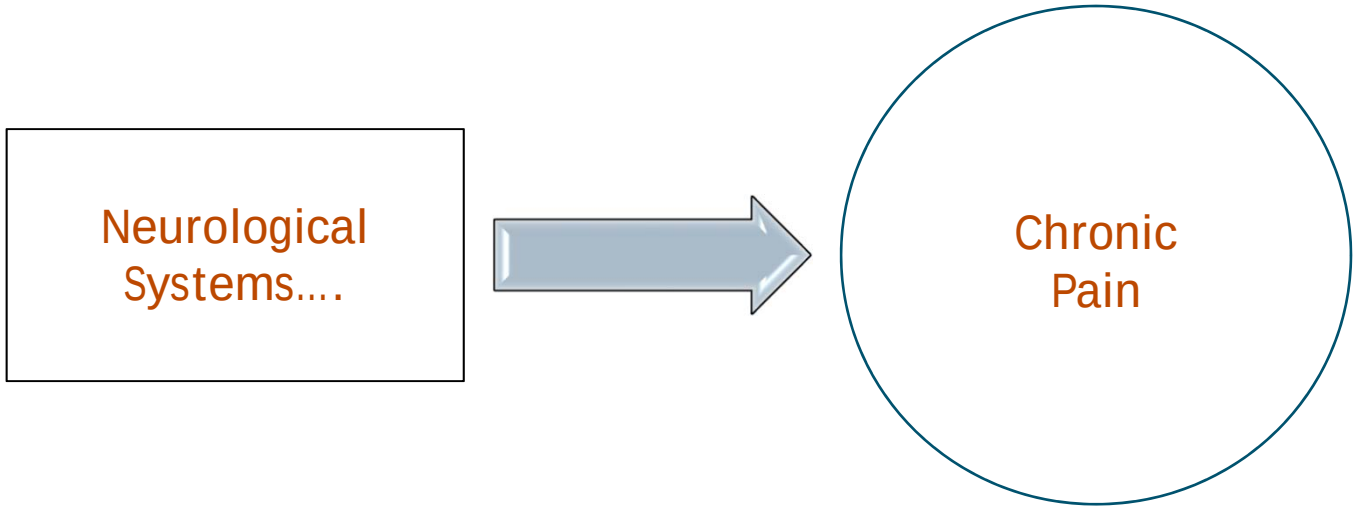
Biomedical View of Chronic Pain….



Limits Treatment Options:

- Medications (e.g., Opioid Prescriptions)
- Surgery
- Steroid Injections

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Socioeconomic

$600 billion direct and indirect costs annually

- Healthcare visits
- Missed work days
- Medications
- Disability

Accounts for 45% of $1.5 billion per year that the DoD pays in disability

Psychological

Comorbidity:

- Depression
- Sleep disorders
- PTSD
- Substance abuse

Interpersonal

Families report:

- Caregiver Burden
- ↓ Relationship Quality/Satisfaction
- ↓ Physical Health
- Depression
- Anxiety

POLYMORBIDITY

Gaskin & Richard, 2012; US General Accounting Office, 2006; Maloney & McIntosh, 2001; Chapman, Lehman, Elliot, & Clark, 2006; Trost, Vangonsveld, Linton, Quartana, & Sullivan, 2012; Goebel et al., 2011; Martire, Lustig, Schulz, Miller, and Helgeson, 2004; Leonard & Cano, 2006

UT Health San Antonio

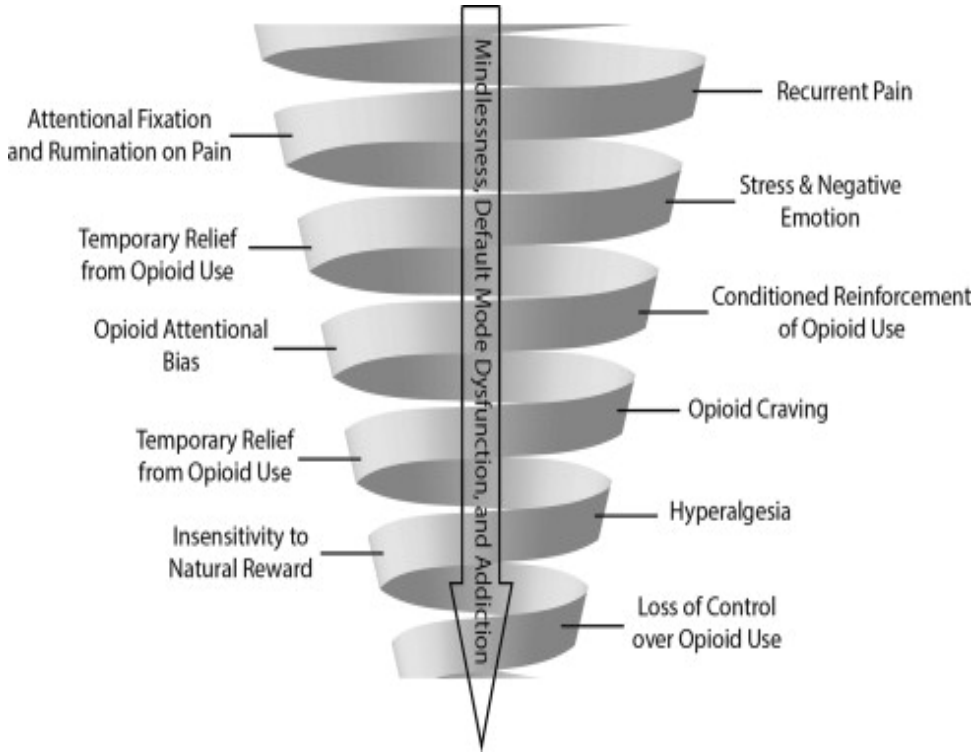
Summary of the Extant Research

Discussion Point	Citation
Polymorbidity is complex with multiple concerns	Malchow & Black, 2008 Lew et al., 2009 Stratton et al., 2014 Finley et al., 2015
Polymorbidity is less responsive to tx	Clark et al., 2009
Polymorbidity is disabling	Gironda et al., 2009 Gross & Amsler, 2011 McGeary et al., 2011
Comprehensive assessment is required	Attenberger et al., 2012
Multicomponent intervention recommended	Malchow & Black, 2008 Clark et al., 2009 Gironda et al., 2009 Gatchel et al., 2011
Simplistic interventions (e.g., opioid meds) are not helpful	Clark et al., 2009 McGeary et al., 2011 Gatchel et al., 2014

Contemporary Model of Pain & Addiction

The relationship between chronic pain management and addiction is complex:

- Pain coping
- Negative affect
- Hypervigilance to pain cues
- Hypervigilance to drug cues
- Cognitive control
- Reward pathways
- Stress pathways

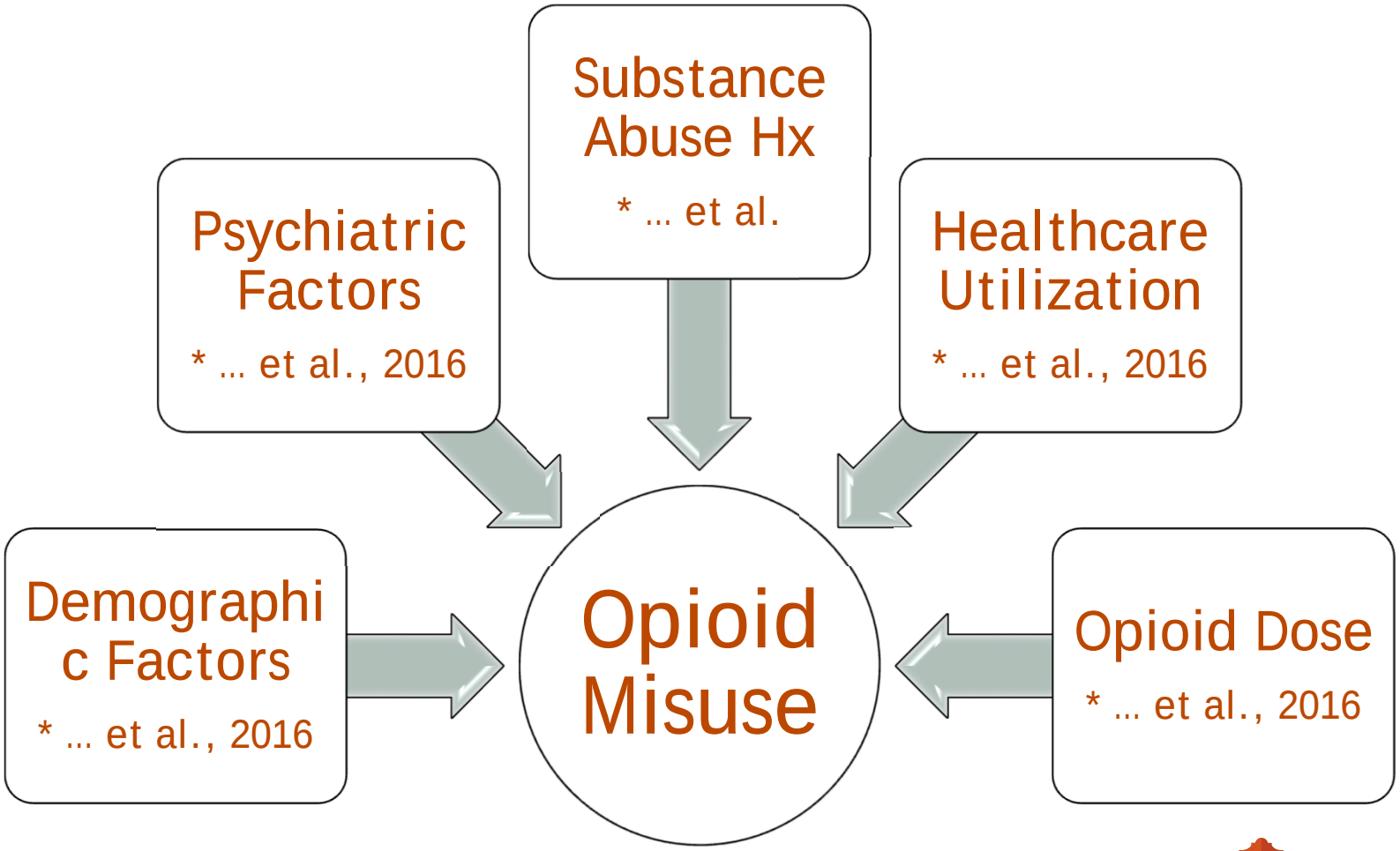


Reprinted from Garland et al., 2013

UT Health San Antonio

MCA2

Mechanisms of Opioid Misuse



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Slide 8

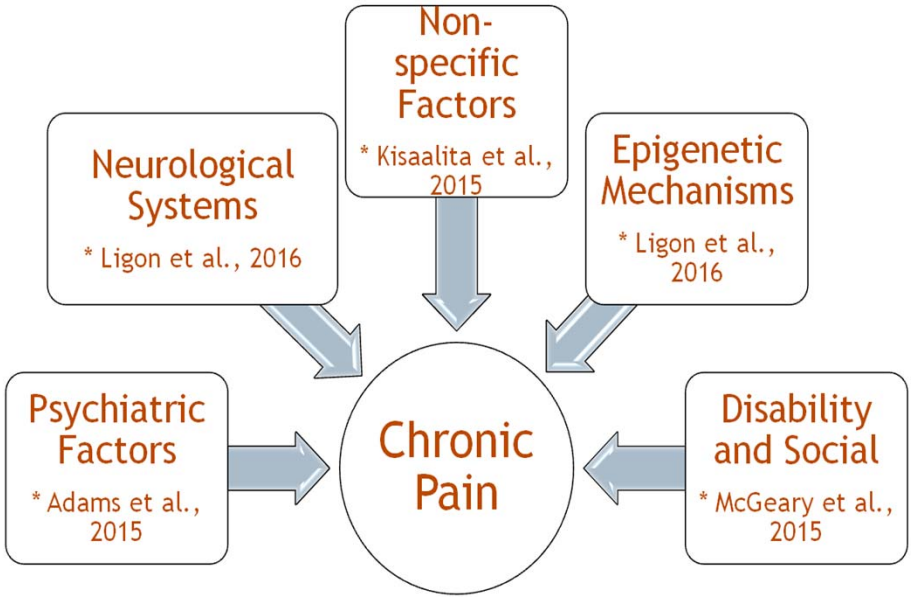
MCA2 Need actual references here - asterisks are not researchers
McGeary, Cindy A, 4/19/2018

Overlapping Mechanisms

Non-opioid pain pathways
Zeidan et al., 2016

Non-pharmacologic interventions are recommended but not often used
Poor reimbursement rates
Not well-disseminated
Gatchel, McGeary, McGeary, & Lippe, 2014

Chronic pain **and** opioid misuse are complex phenomena with overlapping factors



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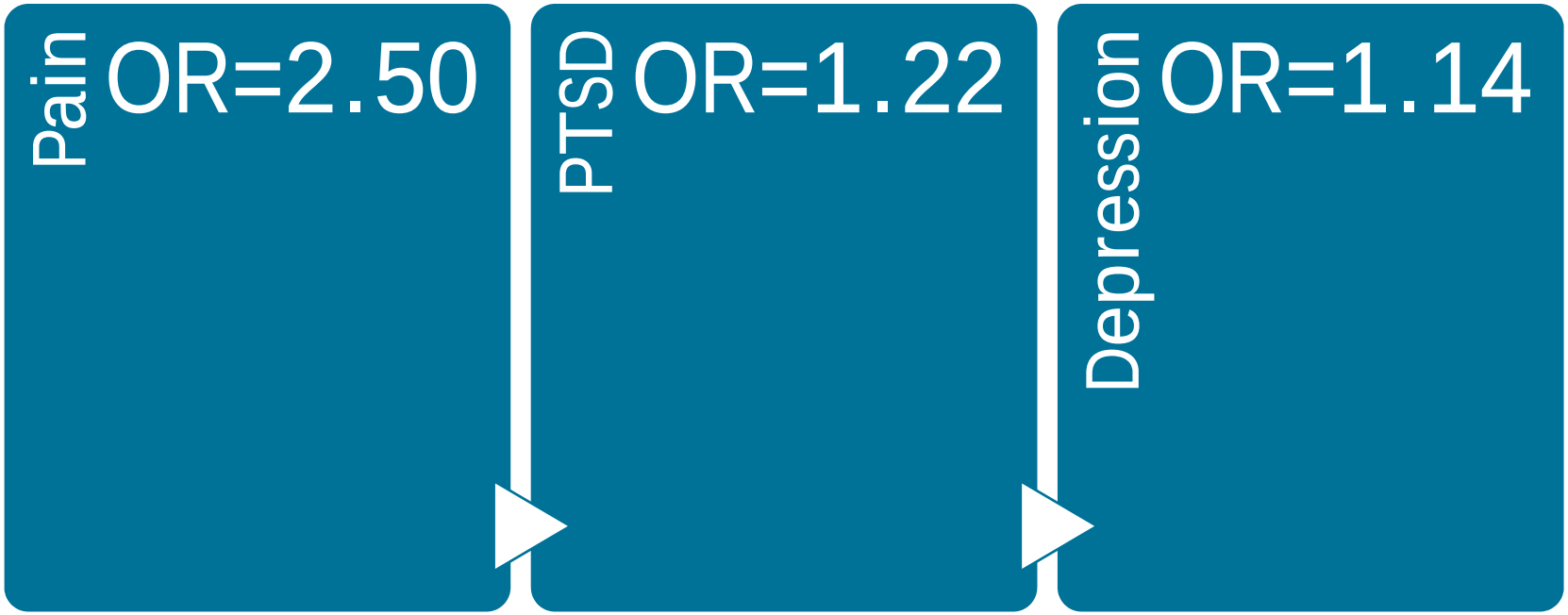
Pain polymorbidity matters when it comes to long-term opioid use

Contribution of pain, depression and PTSD to odds of “chronic” opioid use in the VA



Hudson et al., 2017

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If pain influences the comorbidities, then maybe better pain management is the answer…

Does non-pharmacologic intervention affect patterns of opioid use?

Extant data are inconclusive

Opioid naïve patients exposed to opioid meds during rehab risk persistent use (Furlan et al., 2016)

Some persistent users discontinue opioid medication within 1 year after treatment (Gatchel et al., 2009)

Effective non-pharmacologic intervention may reduce opioid misuse (Wilson et al., 2015; McGeary et al., 2016)

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Overlapping mechanisms

Perception of efficacy

- Time spent thinking about opioids decreases with effective non-pharmacologic treatment (Wilson et al., 2015)

- Some patients may not believe that there is another way

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Overlapping mechanisms

Emotional distress

Distress may be linked to hyperalgesia, which could erode benefit of opioid meds

(Edwards et al., 2016)

High levels of negative affect (i.e., depression, anxiety) lead to 5 times greater rate of opioid misuse compared to low negative affect

(Wasan et al., 2015)

Persistent opioid use may directly contribute to depression

(Fitzgerald & Edell, unpublished)

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Overlapping mechanisms

Changes in healthcare utilization

Decreases in healthcare utilization for pain may be linked to decreased opioid misuse

(Cheatle, 2016)

Stated goal of increased function and decreased medication use can be helpful

(Gatchel et al., 2009)

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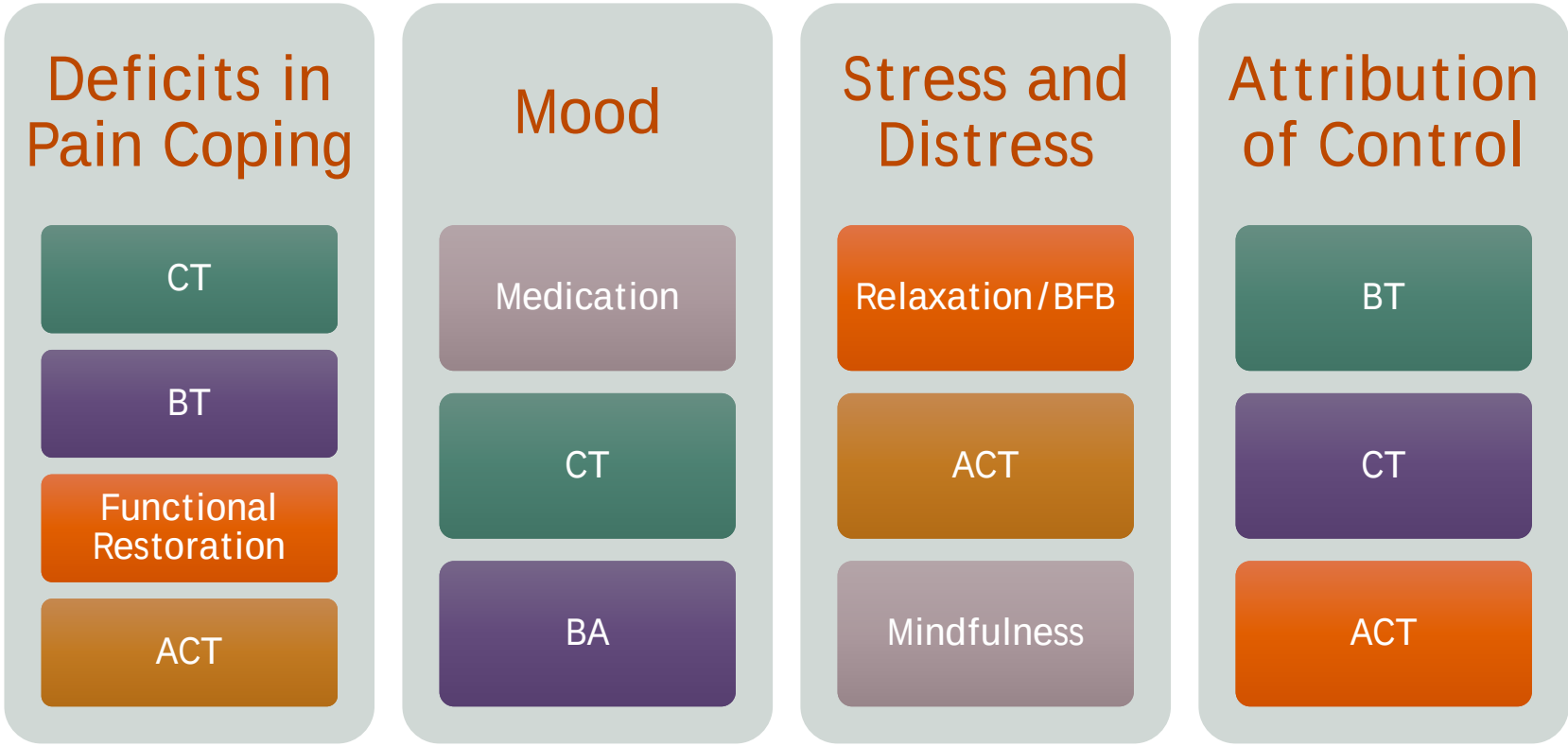
Intervention – Strategies (what we do now)



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Chronic Pain and PTSD/Depression

A case for an integrated approach to treating comorbid pain and emotional distress

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Pain and PTSD

	General Population	Low Back Pain	Headache and Facial Pain	Veterans	MVA Pain	Misc Pain
% with PTSD	9.8	1.0	25.3	50.1	46.7	39.7

Fishbain et al., 2017

- The relationship between chronic pain and PTSD is complicated
- PTSD prevalence varies based on "type" of pain
- There are at least 8 active theories for why these co-occur

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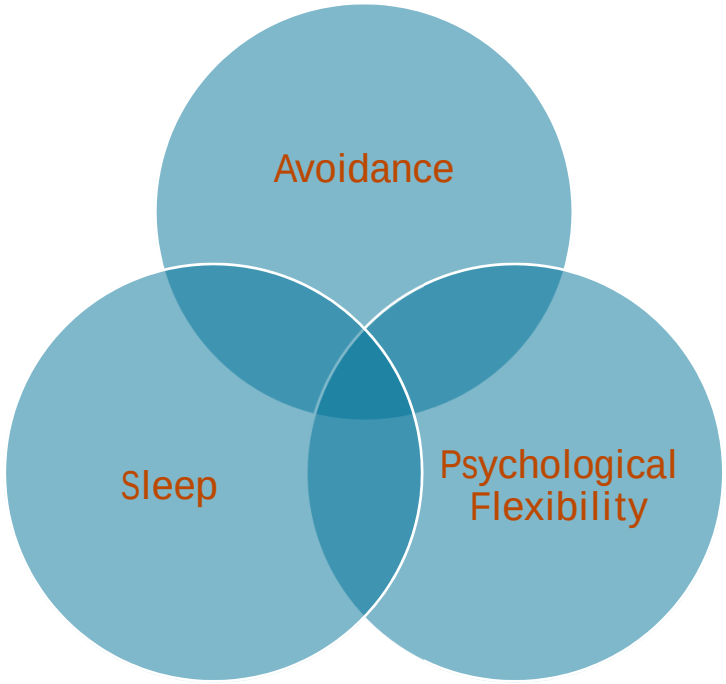
Pain and PTSD Overlap in a Number of Ways



Lies et al., 2017; Noel et al., 2018; Vaegter et al., 2018; Pare et al., 2018
Akerblom et al., 2017; Langford et al., 2018

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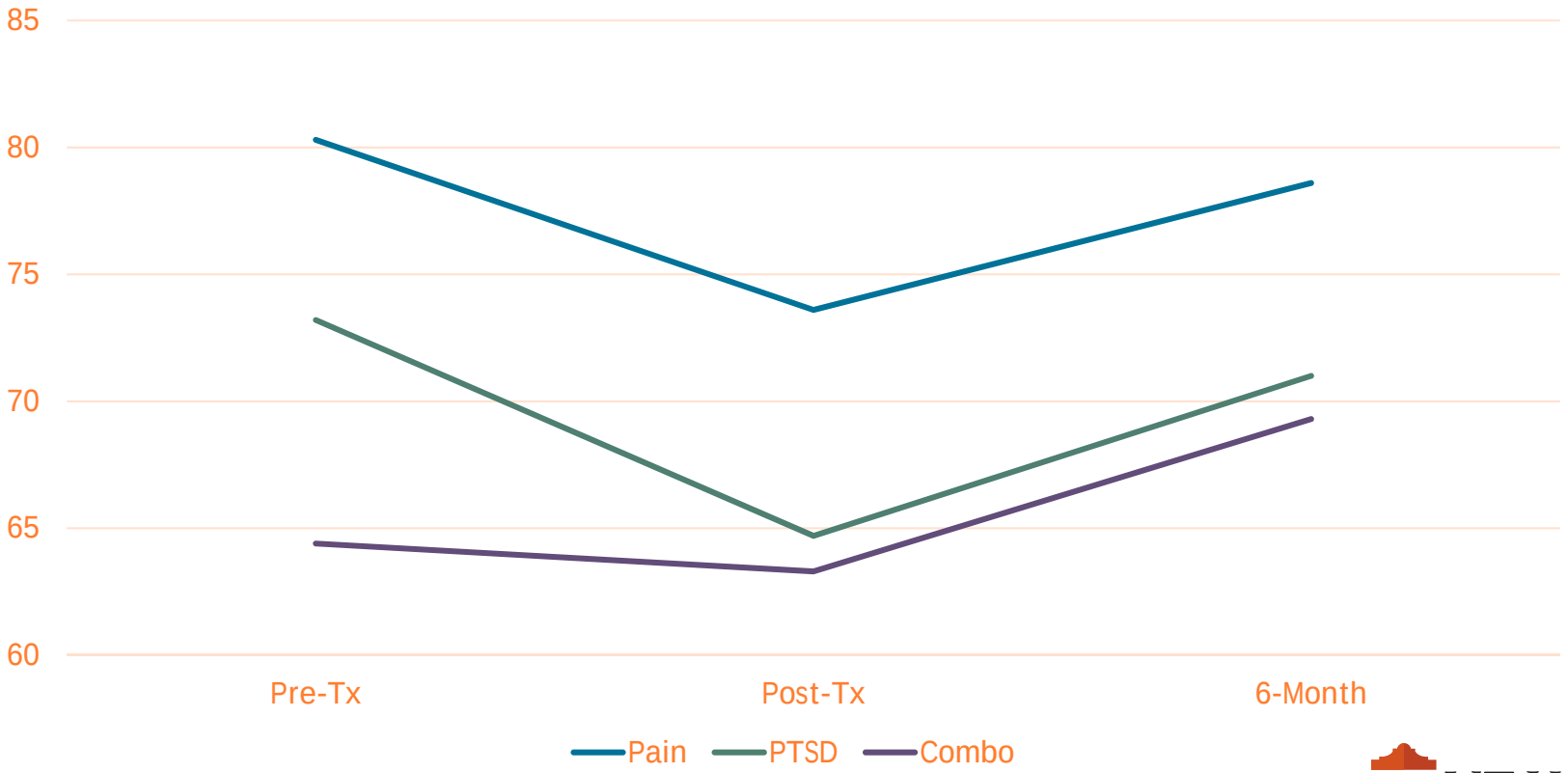
Pain and PTSD Treatment Outcomes

Individual versus Combined Treatment (PDQ)



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Pain and Depression

	General Population	Low Back Pain	Headache and Facial Pain	Veterans	Dental	Inpatient
% with Depression	5-9	30-54	33-50	16-63	85	18

Britton et al., 2017; Sondergard et al., 2017; Feingold et al., 2018; Bair et al., 2003; Outcalt et al., 2015; Sellinger et al., 2016

- Patients with pain **and** depression have 4 times greater odds of opioid misuse than those without depression
- Veterans taking opioids are more likely to take antidepressants as well (whether they have depression [14%] or not [34%]) and # of antidepressant prescriptions increase with opioid prescriptions
- The presence of major depression in pain patients is associated with increased frequency of both short- and long-term (>90 days) opioid therapy

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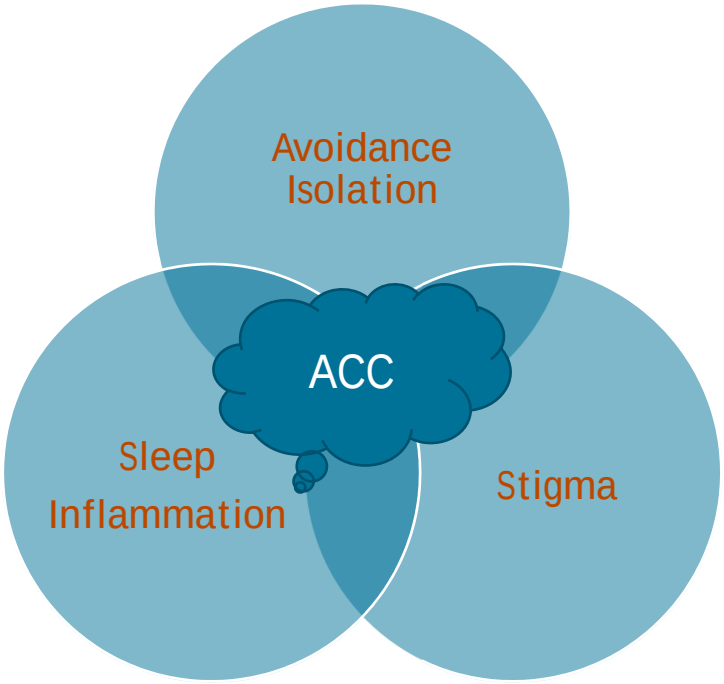
Pain and Depression Overlap in a Number of Ways



Naushad et al., 2018; Barthas et al., 2015

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Pain and Depression Treatment Outcomes

Individual versus Combined Treatment

Treat Depression

- Positive but small effect on pain
  - Teh et al., 2011; Lin et al., 2003

Treat Pain

- Positive but small effect on depression
  - Dixon et al., 2007

Combined Depression and Pain

- ?????????

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Treating Comorbid PTSD and Substance Use

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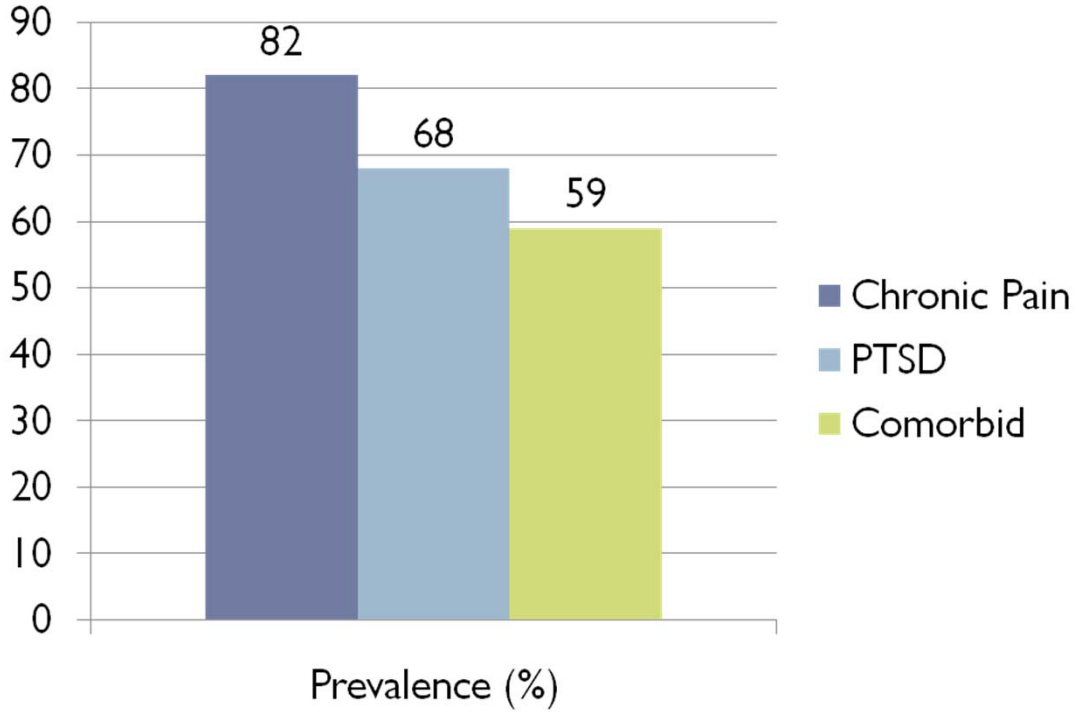
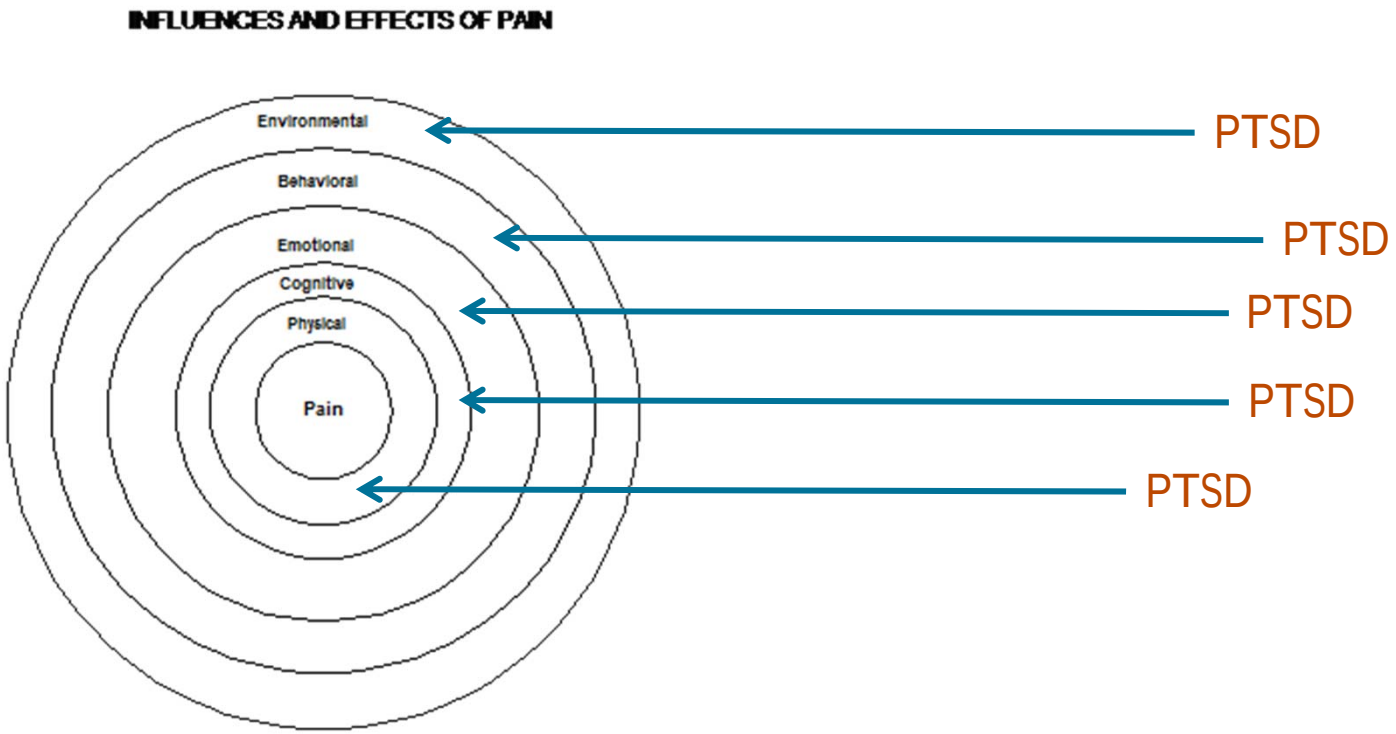
Strong connection between Pain and PTSD

A recent review of OIF/OEF deployers found high rates of chronic pain and PTSD with a 59% comorbidity rate.

Lew et al., 2009



PTSD and Pain…hit on same domains



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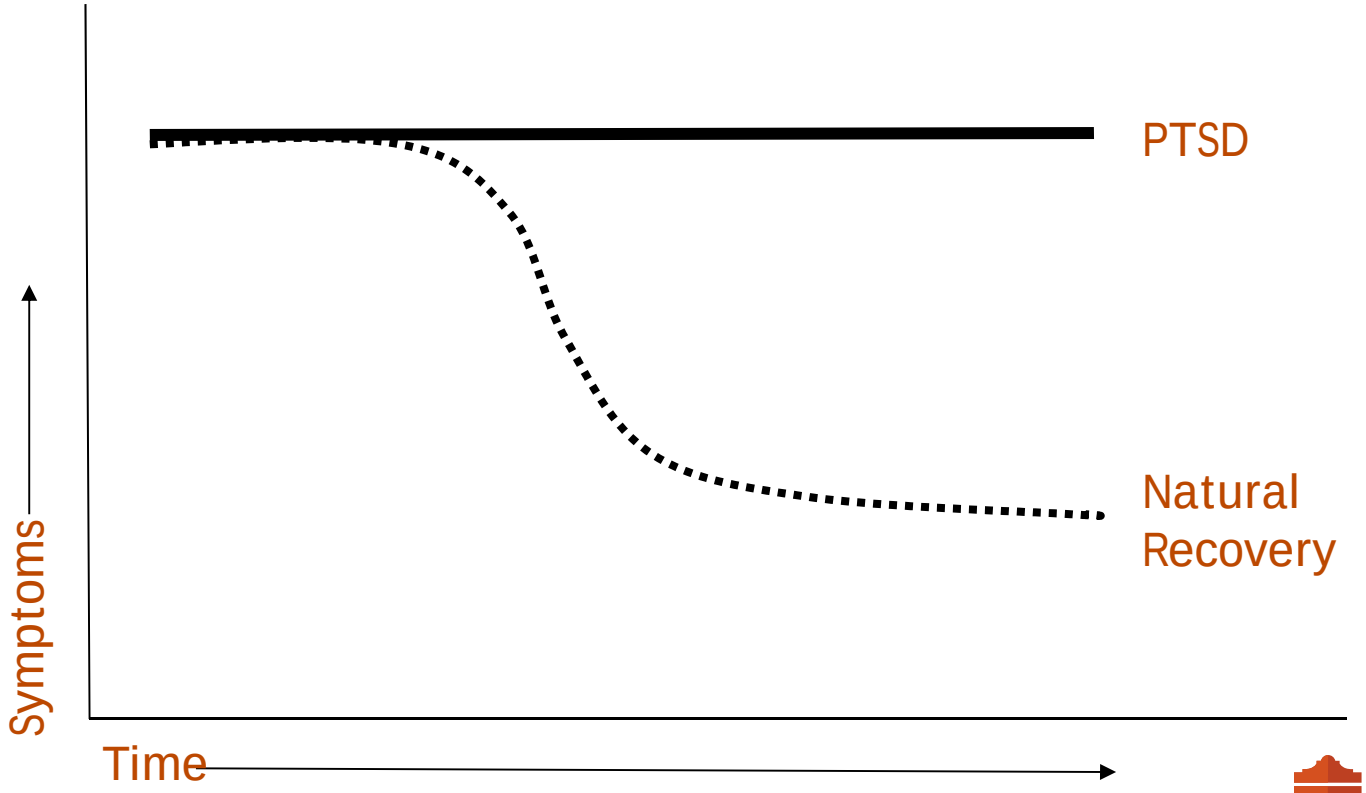
How We Make Sense of PTSD

PTSD is a disorder of the Recovery Process



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How We Make Sense of PTSD

Factors that Maintain PTSD:

- Avoidance
  - Behavioral: places, people, situations.
  - Cognitive: thinking about the trauma
  - Emotion: avoiding certain emotions
- Changes in Thoughts
  - Negative Views of Self: incompetent, damaged
  - Negative Views of World and Others: 100% dangerous, unsafe, mean.

Also contribute to poor pain management and substance use.

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Available Treatment Options

- Doing Nothing
- Medication Management
- Talk Therapies
  - Prolonged Exposure for PTSD
  - Cognitive Processing Therapy for PTSD
  - Cognitive Behavioral Conjoint Therapy for PTSD
  - Written Exposure Therapy for PTSD
  - Eye Movement Desensitization &Reprocessing
  - Present Centered Therapy for PTSD
  - **COPE**

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Concurrent Treatment of PTSD and Substance Use Disorders using Prolonged Exposure (COPE)

Recognizes high comorbidity of PTSD and SUD

- 52% of men and 28% of women diagnosed with PTSD also meet lifetime diagnostic criteria for AUD
- 25-42% of patients seeking txt for SUD have PTSD

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COPE for Dual Diagnosis PTSD/SUD

Recognizes comorbidity increases problems

- More severe clinical presentation
- Higher relapse rates
- Poorer physical & psychological health
- More interpersonal problems
- Poorer compliance with aftercare

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COPE for Dual Diagnosis PTSD/SUD

- Twelve 90-minute sessions

- Concurrently treats PTSD and SUD
  - Prolonged Exposure
  - Craving awareness and management
  - Planning for Emergencies
  - Awareness/Management of High-Risk Thoughts
  - Refusal Skills
  - Anger Awareness and Management

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Evidence for COPE

- Pilot Study: 22 women, PTSD, depression, alcohol use, cravings, and dependence severity were significantly reduced (Persson et al., 2017)

- RCT: 103 civilians; significant reduction in PTSD and substance; more effective at treating PTSD than treatment as usual comparison (Mills et al., 2012)

- Effective for individuals with traumatic brain injuries (Gros, et al., 2017)

- Case study supports telehealth COPE (Jaconis et al., 2017)

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Conjoint Therapy for Pain Management (CTPM)

Treating Comorbid Pain within the context of relationships

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Why Include Partners….

Family members of chronic pain sufferers report:

- Greater caregiver burden
- Lower relationship quality and satisfaction
- Decreased physical and psychological health

Link between chronic pain, partners' maladjustment, and pain management

- Partners with depression or anxiety are less effective helping partner with chronic pain
- Relationship distress increases additional stress for patient coping with pain.

Individual Behavioral Interventions

- Enhance Pain Management
- Increase Physical Functioning
- Decrease Disability
- ***Do not alter maladaptive pain-related interpersonal interactions*** *(McGeary et al., 2016)*

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Caregivers and Chronic Pain

Chronic pain affects caregivers and caregivers affect chronic pain

- Caregivers experience significant exhaustion
  - Kindt et al., 2016

- Caregivers become increasingly attentive to pain stimuli
  - Mohammadi et al., 2015

- Alarming cognitions related to pain can impact pain intensity
  - Mohammadi et al., 2017

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Rationale for CTPM

May benefit both partners

Successful application of conjoint framework with other disorders

Expands upon the Biopsychosocial model

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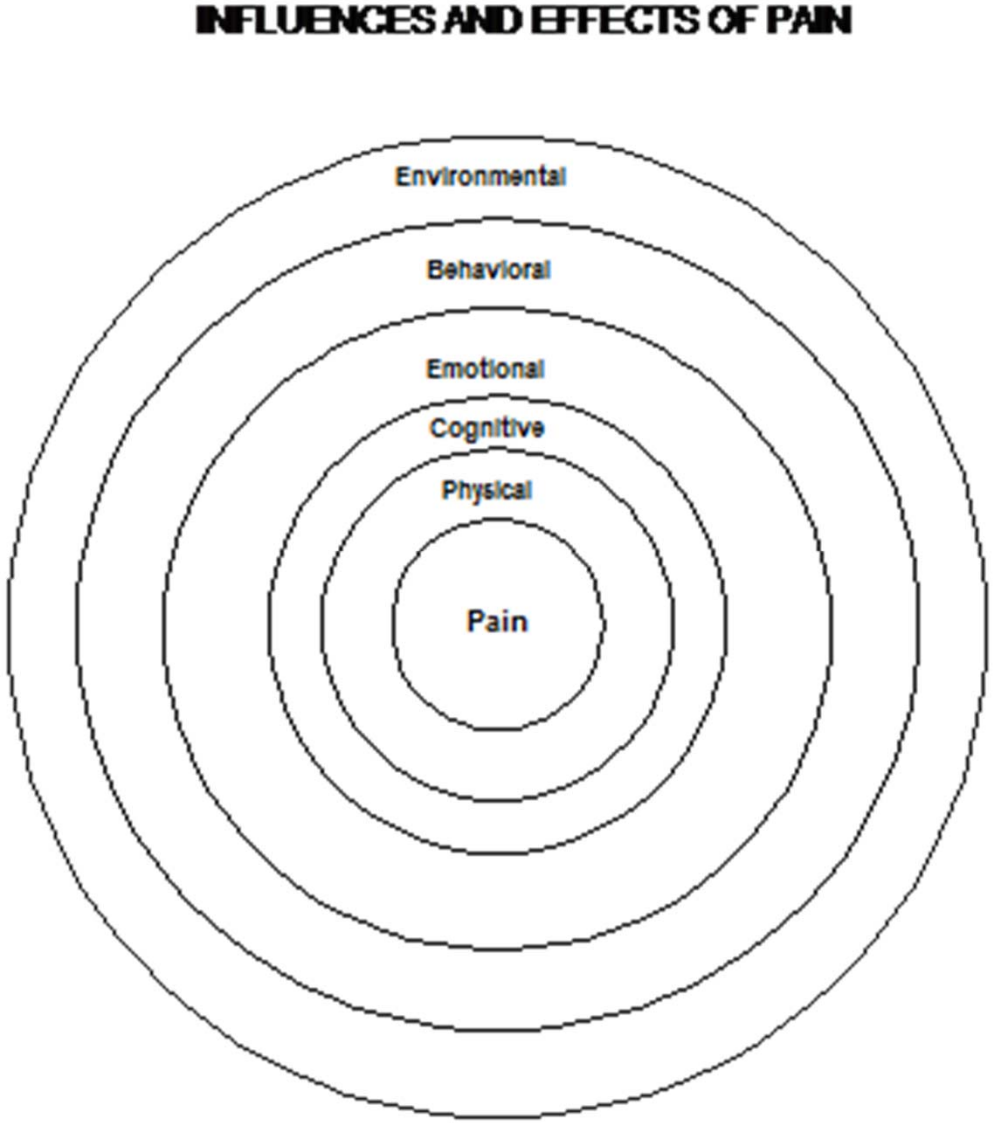
Biopsychosocial Model of Chronic Pain



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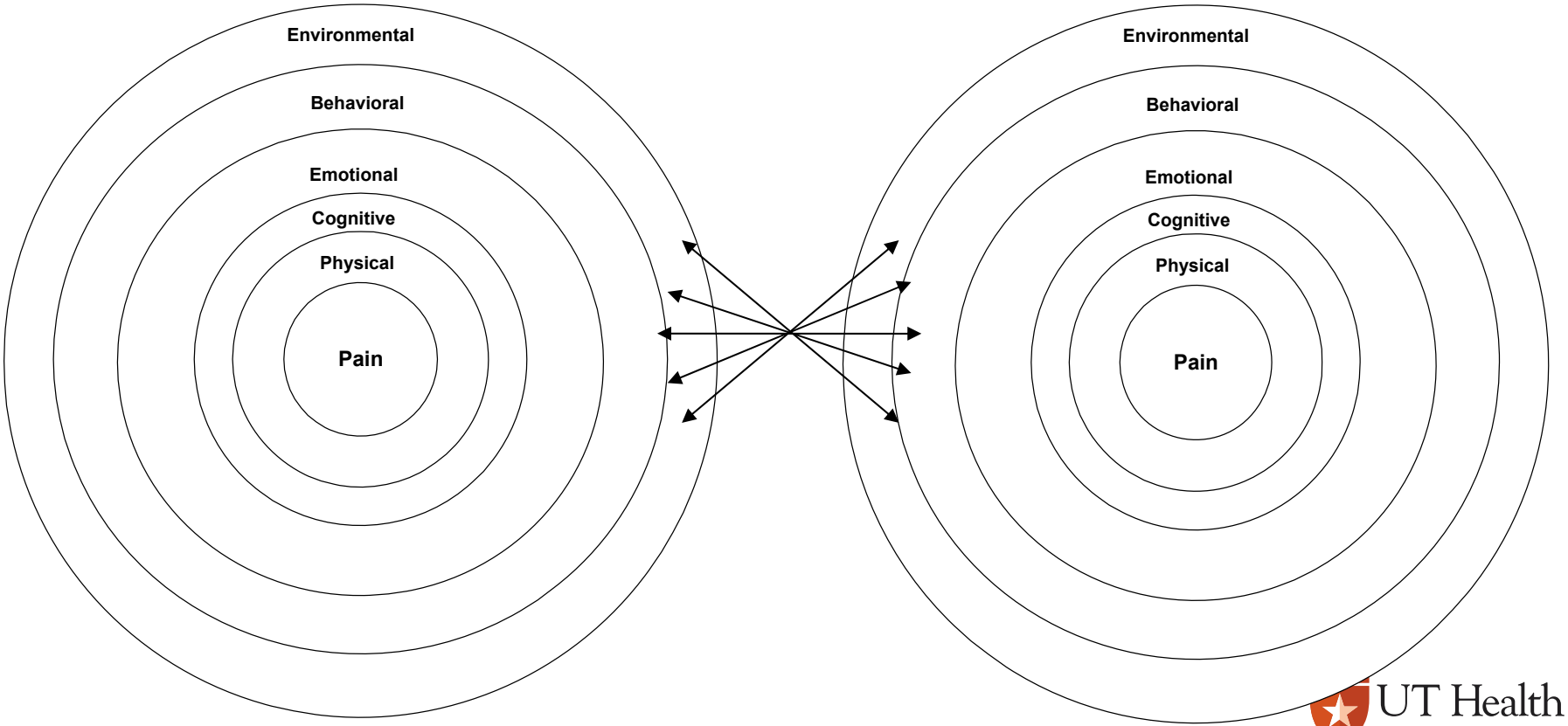
The Influences of Chronic Pain on the Relationship

Partner 1

INFLUENCES AND EFFECTS OF PAIN

Partner 2

INFLUENCES AND EFFECTS OF PAIN



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CTPM Treatment Overview

Combines elements from two effective treatment modalities:

Functional Restoration

- Psychoeducation
- Cognitive Behavioral Techniques
- Acceptance and Mindfulness Techniques
- Behavioral Activation

Cognitive-Behavioral Treatment for PTSD

Three Treatment Phases:

1. Treatment Rationale, Psychoeducation, Safety Building
2. Relationship Enhancement and Undermining Avoidance
3. Cognitive Interventions for Maladaptive Thought Processes

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Pilot Study

CTPM obtained funding from the University of Texas Health San Antonio Clinical Investigator Kickstart Pilot Grant to collect pilot data

Phase I: Needs Assessment

- Target Enrollment:
  - 5-10 Pain Clinic Providers
  - 3-5 Couples

Phase II: Treatment

- Target Enrollment:
  - 10 Couples

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CTPM Outcomes

Conjoint Therapy for Chronic Pain Management is a feasible and acceptable treatment

Small decreases in reported pain

Patients report decreases in pain catastrophizing

Perceptions of Distracting Responses increase over the course of treatment

Little change in couple satisfaction

Treatment improves depression in both partners

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1. Chronic pain and opioid misuse are complex problems requiring a complex solution.

2. Interdisciplinary models of intervention offer the most promise in addressing pain and related comorbidities.

3. Ongoing research on CIH approaches (including interdisciplinary pain management) will offer valuable guidance for the future of VA pain management.

Lessons Learned

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Questions

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Engaging Young People in Recovery

Objectives

- Review history of gaps and supports for young people in recovery
- Assess the usefulness of youth peer recovery support and empowerment in connection to the adolescent addicted brain
- Identify youth appropriate modalities and resources in your community

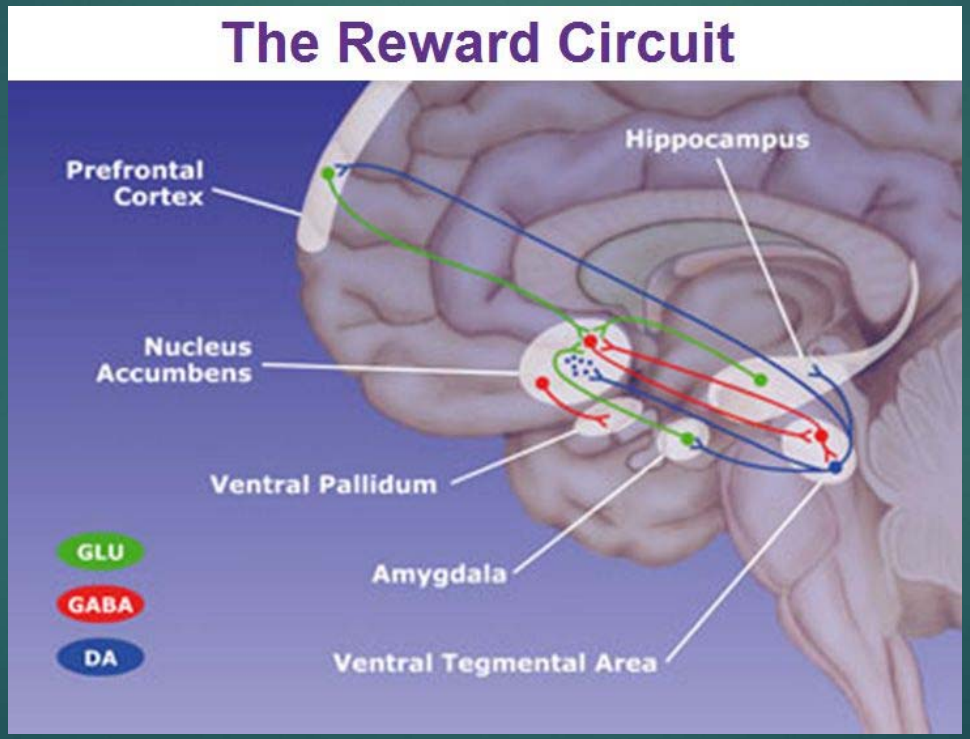
Most evil “disease” would..

- Wouldn’t look like a disease at all
- Genetic, but with variable penetrance
- Repulsive symptoms easily confused with “willful badness”
- Self deception as a clinical feature
- Chronic and relapsing condition
- Culturally and politically divisive
- Weird solutions of peer support, accountability, spiritual growth

Desires/Appetites

- We were created with natural appetites. These allow us to know what we like – in order for us to do them to live.
- The desire for food
- The desire for drink
- The desire for sleep
- The desire for sex
- The desire for connection/community?

Designed for



Inherent Desires

- We also have the capability to *learn* what we desire. For example, everyone in here probably has a favorite coffee or steak house or type of food or music.
- Please be thinking about this as we move forward with how young people become addicted

What is addiction

- Hi-jacking of the brain which leads to habitual acts done even when harmful?
- A genetic predisposition to seeking pleasure or relief to the point of a habitual act?
- Love of something more than is good or useful which causes problems?
- Doing something over and over again expecting different results?
- All these may have some usefulness to them. In short, there are many different ways people define or perceive addiction. How about for our purpose we use this one…

Addiction defined for our use today

- Persistent habitual use of a substance known by the user to be harmful.
- Repeatedly satisfying a natural appetite and desire with a temporary pleasure until you become a servant of the temporary pleasure rather than its master.

- Okay so how do these persistent habits come to be formed?

- Let's look at what dominates a young person

Insecure

- Who am I?
- Am I normal?
- What is happening to my body?
- Do I look okay?
- What do people think about me?
- Do I have friends?
- What am I going to do with my life?
- Will I be a success or a failure?
- What is right and what is wrong?
- Who should I listen to for advice?
- Is God real?

Rebellion

- The desire to be…..
- An individual
- to think for oneself
- for freedom
- to try new things
- to test the boundaries

- For control
- To make one's own decisions
- To be different
- To fit in
- To be accepted

These serve as opportunities for us to counsel youth about respecting authority, sowing and reaping, truth and falsehood, wisdom and foolishness, taking responsibility, forgiveness and our natural desires

Fear and Pride

- Our young people can be dominated by feelings of fear and pride. They can be concerned primarily with what others think about them and they can be full of fear they are not going to get what they want (validation, friendship, success) or that something they love will be taken away (sense of worth, idols, feeling good)

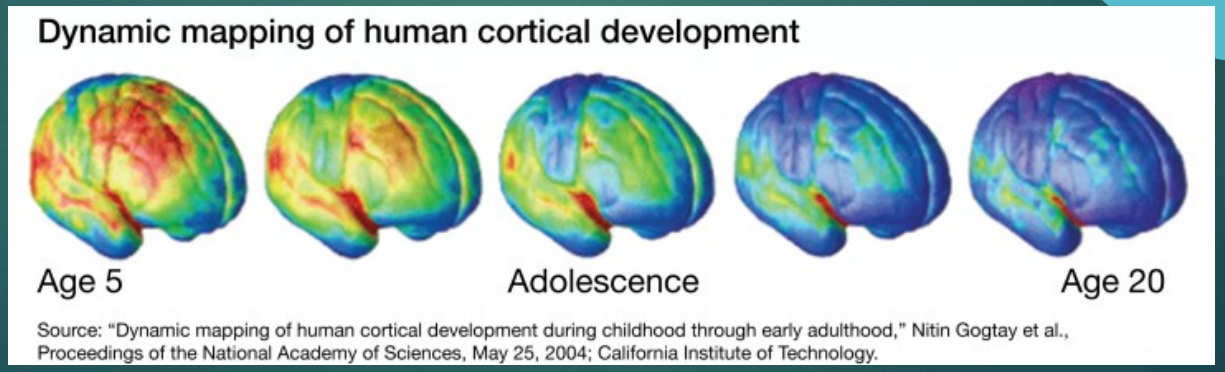
- ***Really – our young people are no different than us they just have not learned from experience how to prioritize these things. We can struggle with the same things.***

General teenager struggles

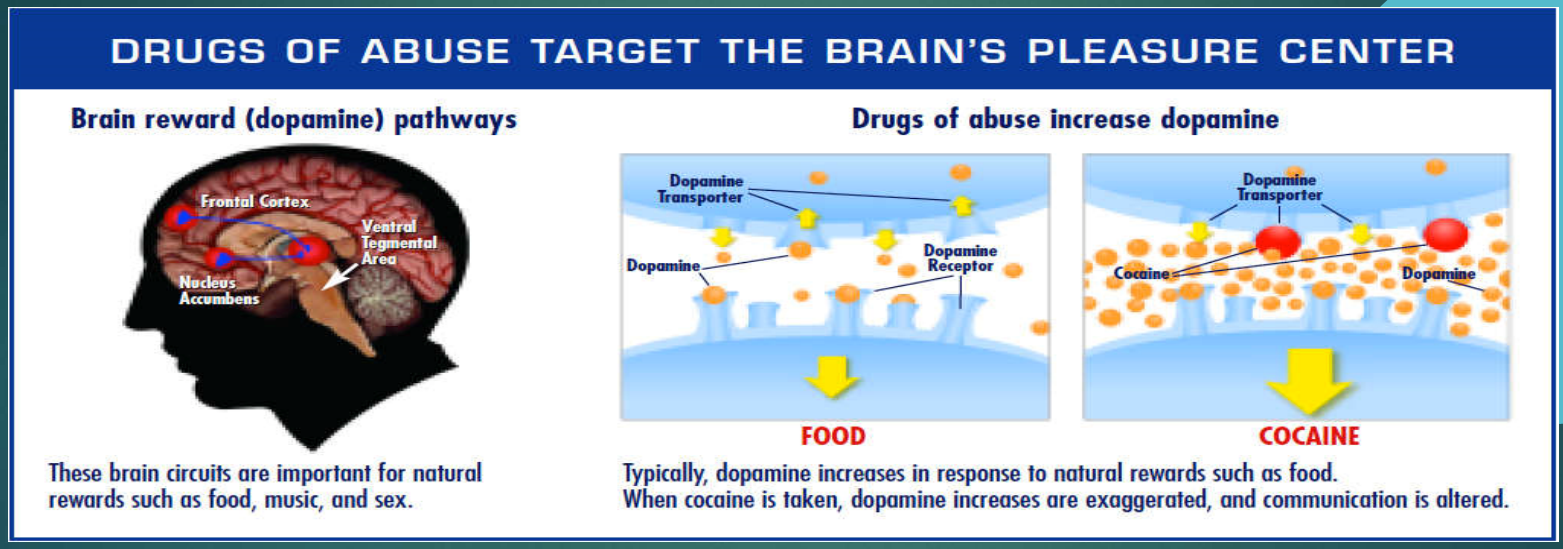
- Belief the good stuff is out there
- No hunger for wisdom and correction
- Particularly susceptible to sexual temptation
- Lack the long view perspective
- Tend to lack heart awareness
- *Dr. Paul Tripp – Heart of Parenting*

Adolescents biologically uniquely vulnerable

- Prefrontal cortex not fully developed
- Poor judgement weighing risks vs. rewards
- Difficulty holding back emotions



Enter Drugs into the equation



What we're really dealing with

What's the solution? Give us some hope!

- Thankfully – there is a solution
- Almost none of liked **the self-searching, the leveling of pride**, the **confession of shortcomings** which the process requires for its successful consummation. **But we saw** that it really worked in others, and we had come to **believe in the hopelessness and futility** of life as we had been living it. When, therefore, we were **approached by those in whom the problem had been solved**, there was nothing left for us but to pick up the simple kit of **spiritual tools** laid at our feet. Alcoholics Anonymous, pg. 25 (emphasis mine)

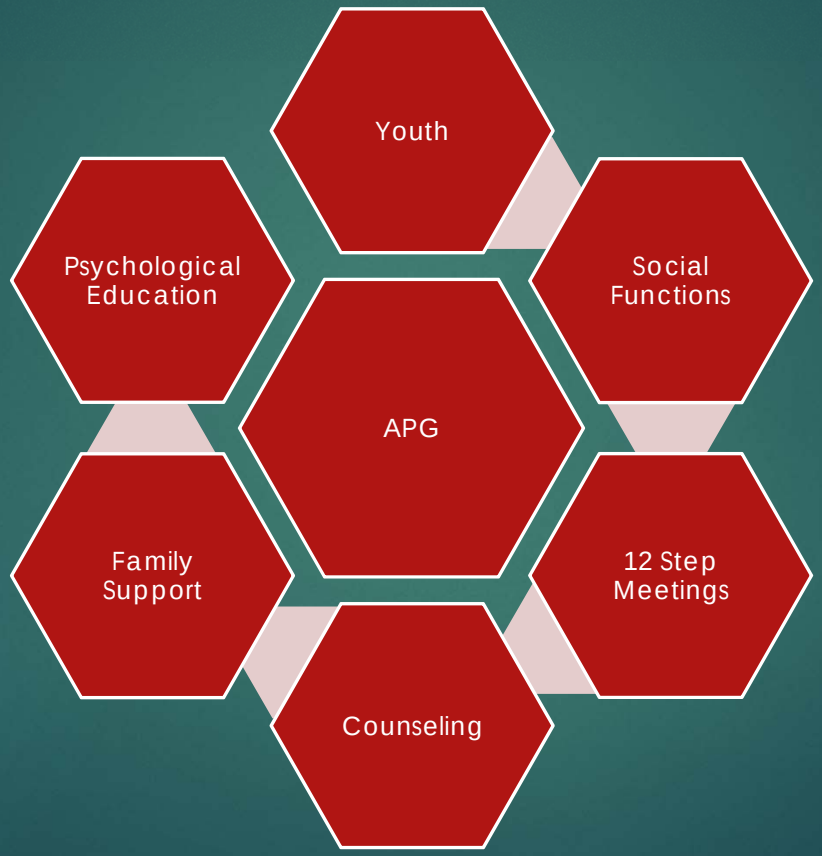
Help them with the solution

- Help them to “self-seek and level their pride”
- Help them to “confess their shortcomings”
- Help them to SEE the “hopelessness and futility of life as they are living it”
- Help them to SEE the “problem solved in others”
- AND
- Give them access to “spiritual tools”

History of supports

- 1964-1975 – Insurance industry begins to reimburse the treatment of alcoholism on par with treatment for other illnesses. This leads to dramatic expansion in private and hospital-based inpatient treatment programs
- 1971 – Reverend Charles Wyatt Brown establishes Palmer Drug Abuse Program out of Palmer Memorial Episcopal Church in Houston, TX. This serves as first outpatient model of youth support for addiction treatment. The Alternative Peer Group model quickly spread throughout Texas and across the country.
- 2013 – UT Board of Regents unanimously vote to expand Collegiate Recovery Programs to all UT institutions.
- 2014 – State of Texas allocates seed funding for Youth Recovery Community Centers – Rise Recovery being one out of eight. Youth supports offered by youth

The APG Model



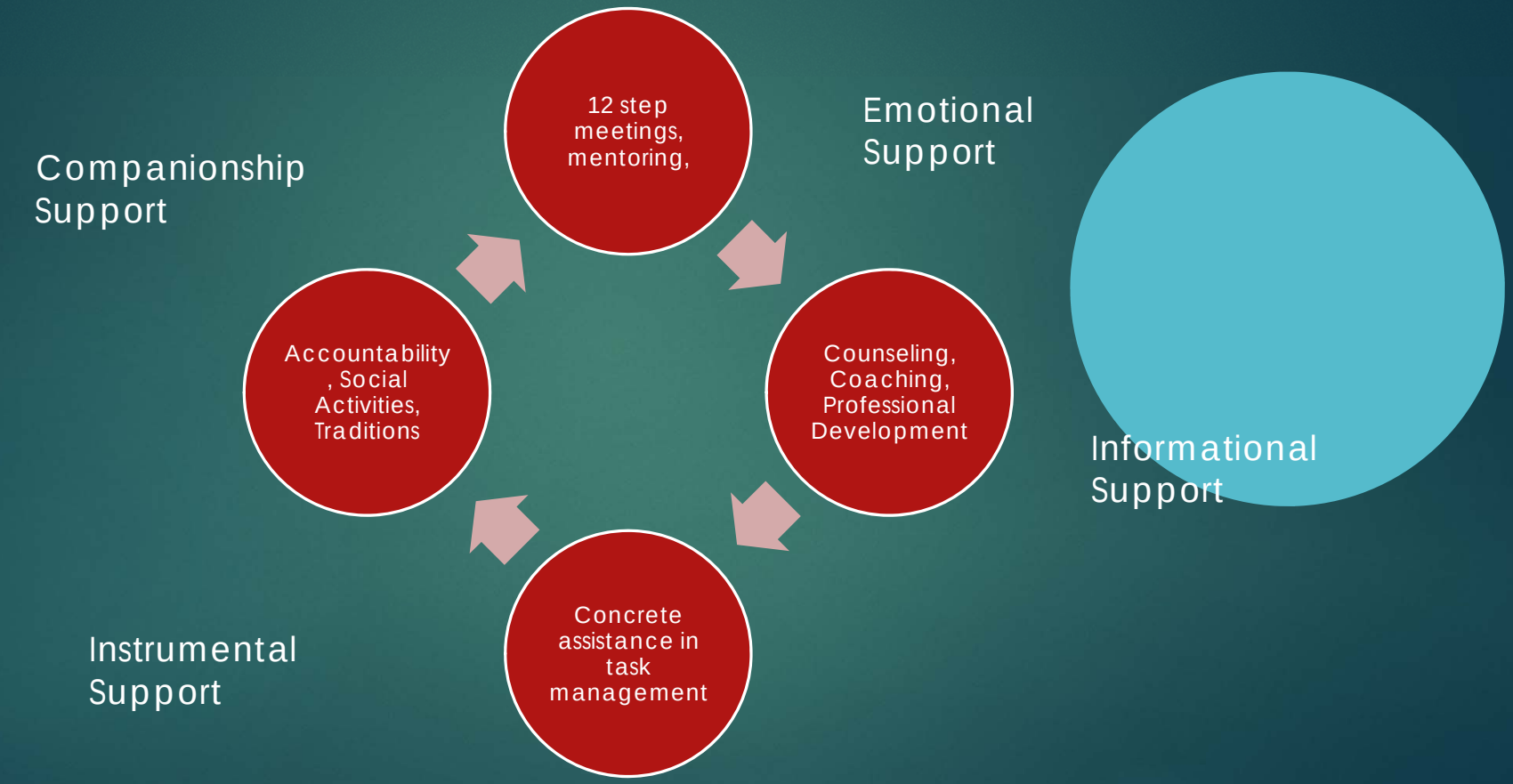
The APG Model

- AN APG offers an adolescent a new group of friends that provide alternative attitudes, values, judgements, processes, and behavior that support change necessary to recover from substance abuse disorders (Binarium Productions, 2011)
- Problem with this model can be who the new group of friends come to be and what they have to offer

Effective Youth Programs

- Longer lengths of stay, parental involvement, aftercare participation and positive social support within a climate of trust (Brannigan et. Al, 2004)
- Benefit of positive social influence (Kelly et. Al, 2005)
- Holistic in that they treat the Mind, Body and Spirit
- Offer assistance in areas of high need due to delayed development (education, housing, employment, leadership)

Rise Recovery CRP



Research on Faith in Recovery

- Neuroanatomical correlates of religiosity and spirituality. (Lisa Miller, et al)
- Neuroscientific studies of spiritual practices (Andrew Newberg)
- Religion or spirituality confers a neuroanatomical resilience in those predisposed to developing depressive illness. (American Journal of psychiatry, Miller et al) (2012)
- 74 percent of graduates reported no use in the six months prior to follow-up. 62 percent of graduates reported no relapses since graduation nor use in the past 6 months. Among youth graduates, abstinence rates are lower with 64 percent of youth reporting no use in the prior six months and 47 percent reporting no relapses since graduating Teen Challenge. Minnesota teen challenge follow up study – Wilder Research (2011)

Effective Youth Recovery

- Belief – programs and services which challenge teen's current belief system, explore areas of unmanageability, values and purpose
- Mind – Putting to practice new ways of thinking about life, getting what one wants, what is healthy, how to show respect and gratitude and be a friend, how to function in society
- Behavior – Changing one's peers, participating in 12 step meetings/groups, going to counseling, getting involved in school, youth group or an extra curricular activity, going to church and praying

Q & A

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The Treatment Gap:
Policy, Politics, and Patient Care

SASUS
San Antonio, TX
April 19th, 2018

Leo Beletsky, JD, MPH

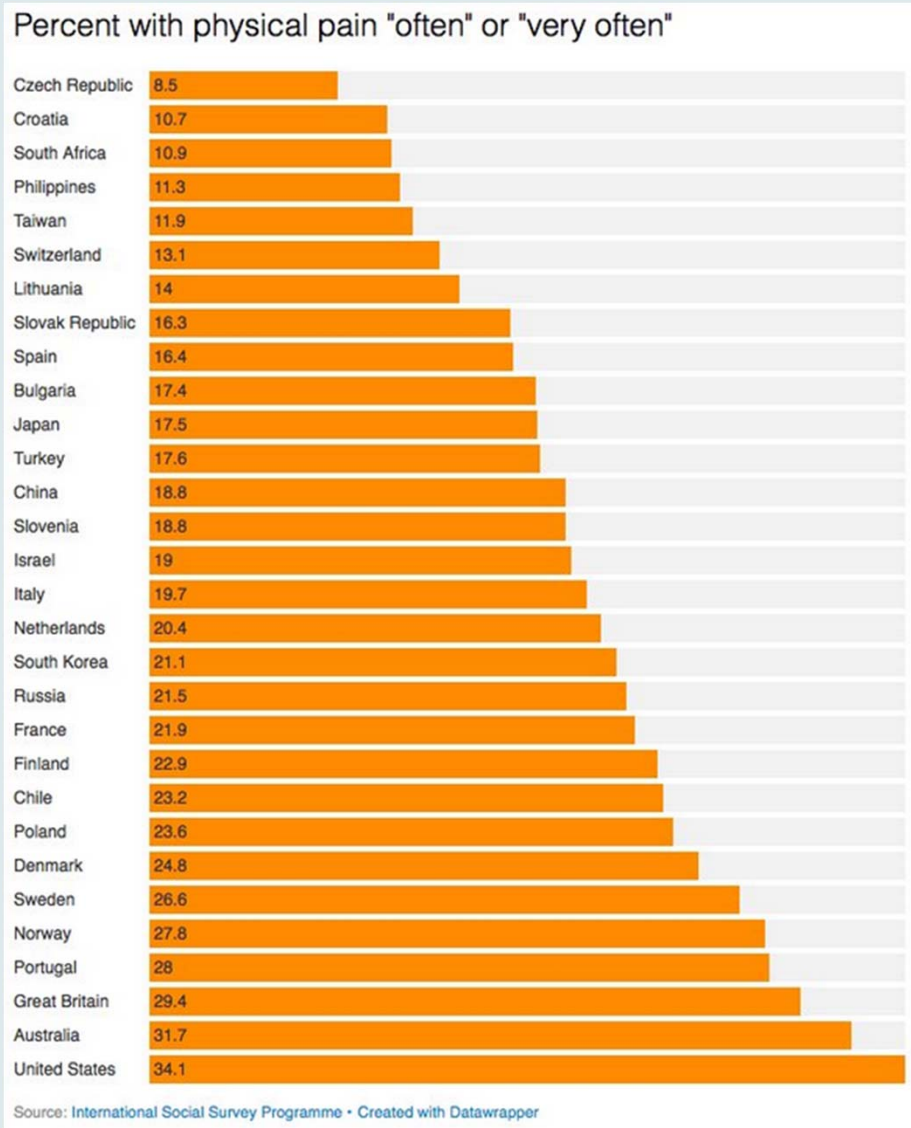
Northeastern University
School of Law and
Bouvé College of Health Sciences

UC San Diego School of Medicine

Overview

1. The Treatment Gap
2. The Role of Law in Treatment Access
3. Recent Case Studies
4. Implications and Future Opportunities

American Suffering

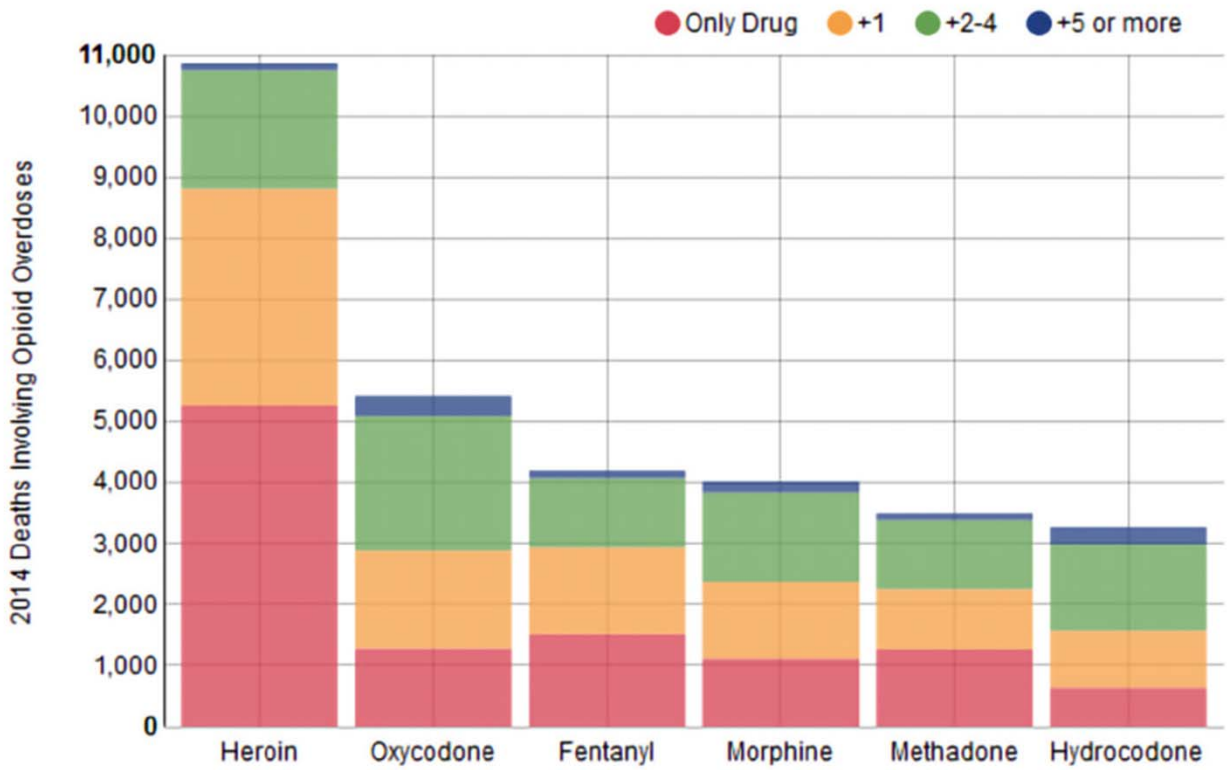


Structural Determinants:

- Occupational injury
- Protracted military conflict
- Overweight and obesity
- Lifestyle
- Built environment
- Diet
- Environmental/metabolic
- Cultural attitudes/stigma
- Etc.

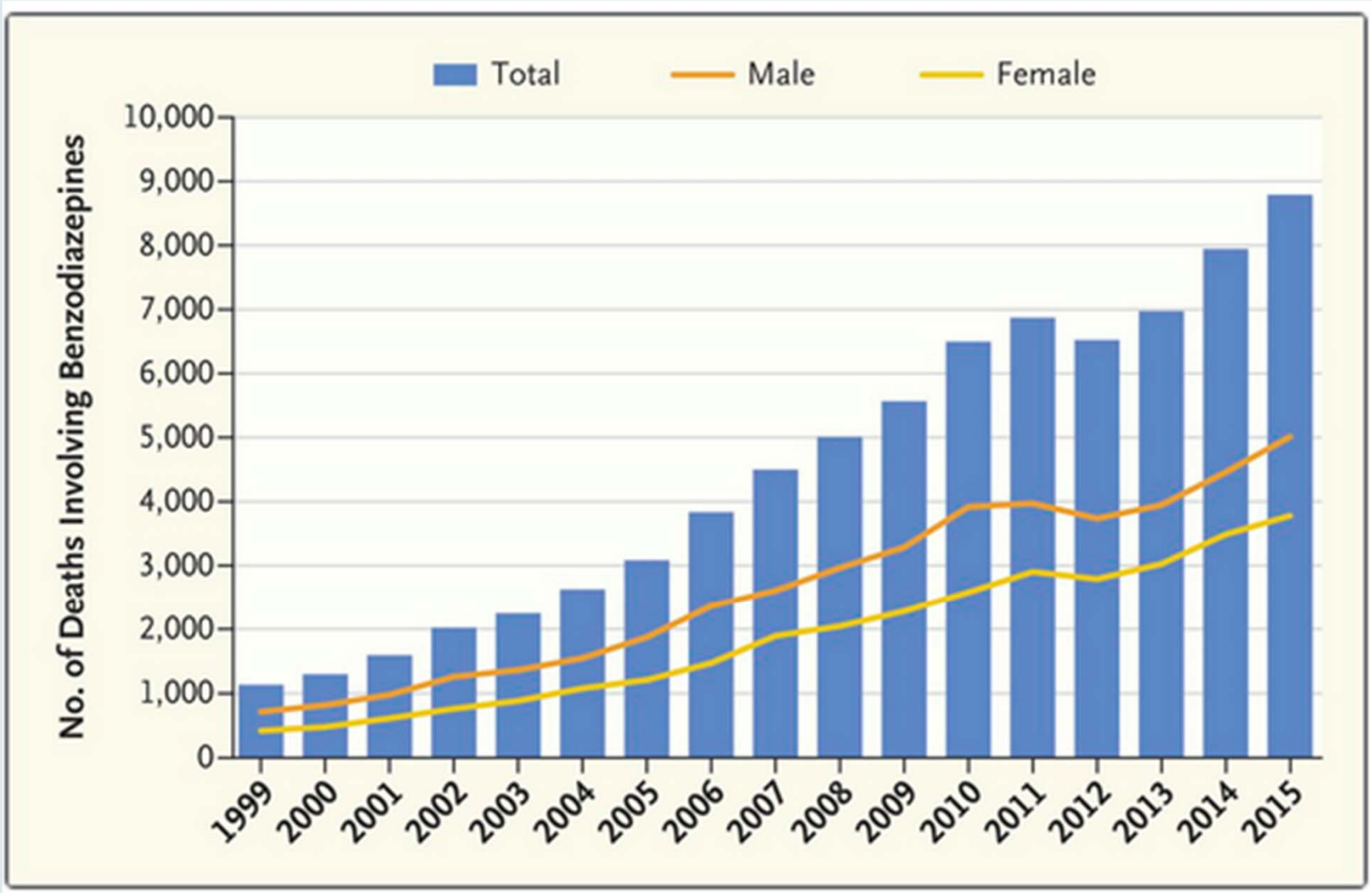
Defining the Problem

Figure 9. Opioid Overdose Deaths by Number of Drugs Involved, 2014

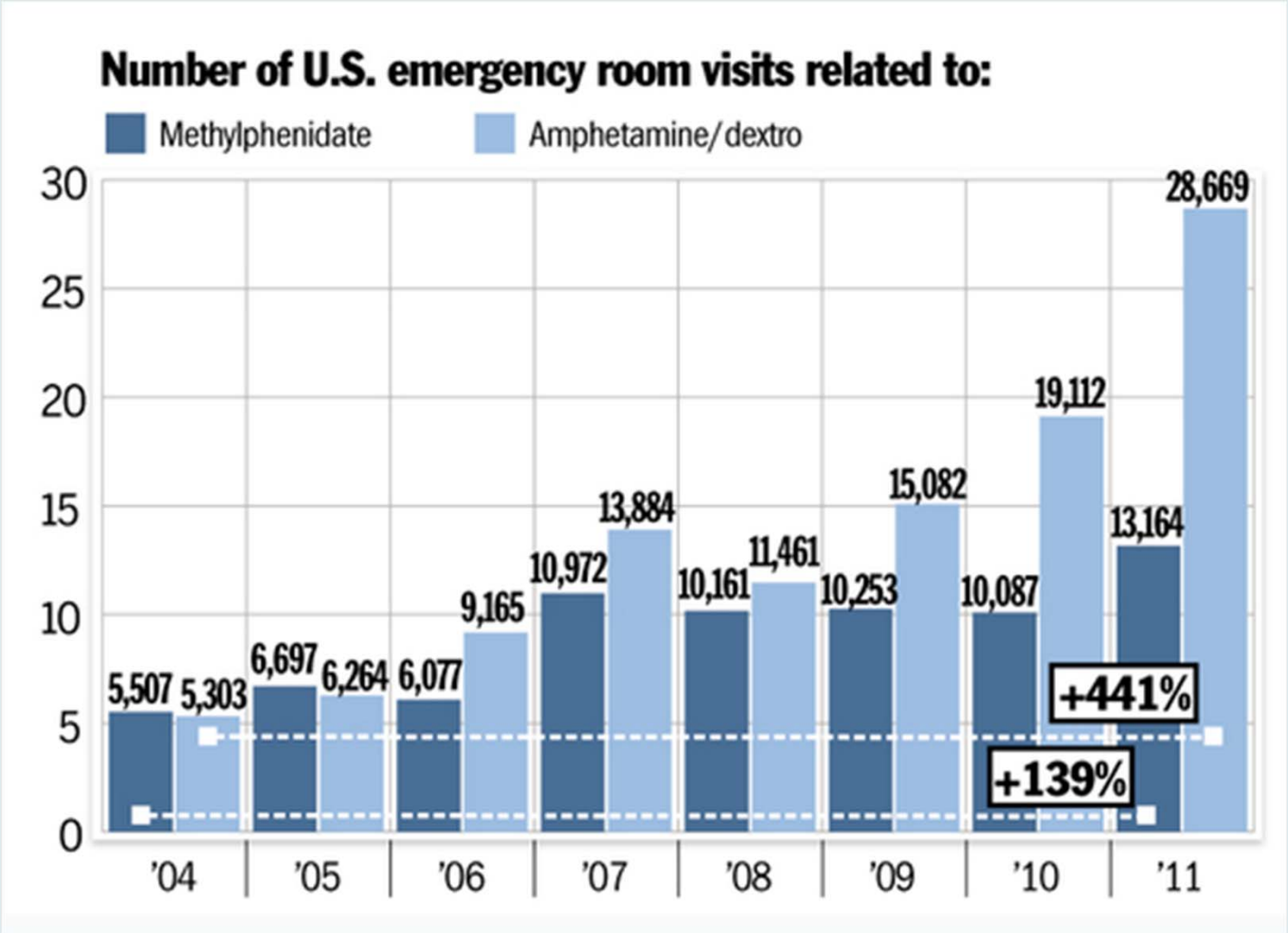


Source: CDC, National Vital Statistics Reports, Vol. 65, No. 10, December 20, 2016, Table 5 (https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_10.pdf). Includes all deaths, unintended or otherwise.

Defining the Problem



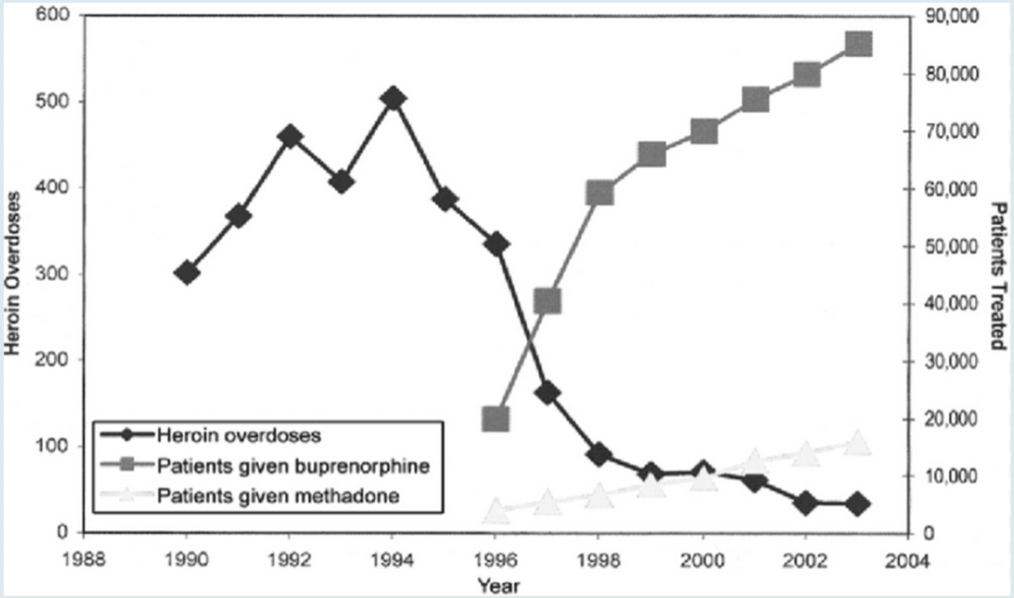
Defining the Problem



The Treatment Gap

Defining "treatment"

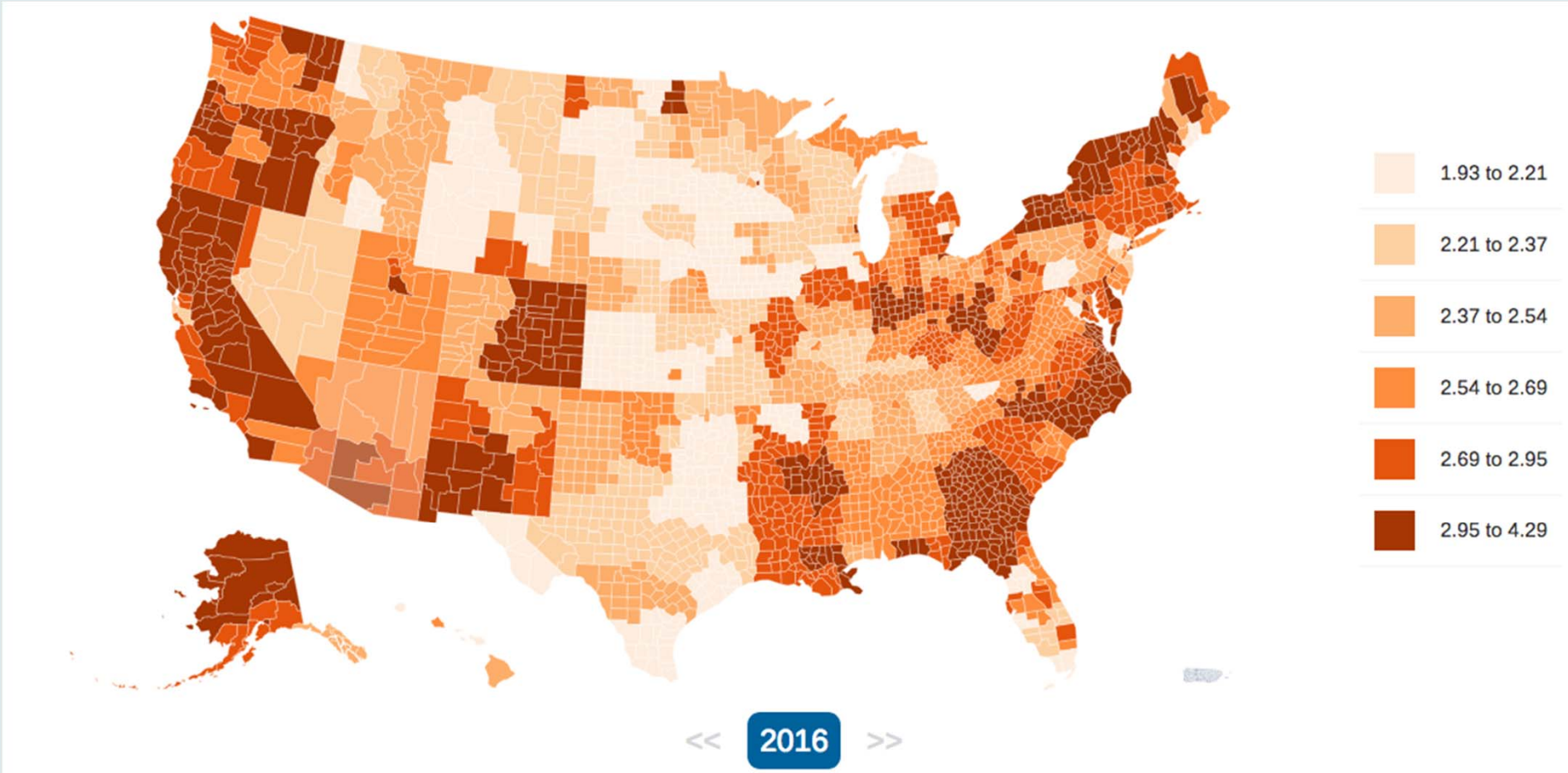
- Medication-Assisted Treatment/Therapy (MAT)
- Opioid Agonist Treatment/Therapy (OAT)



Source: Lavignasse et al (2012)

The Treatment Gap: Access

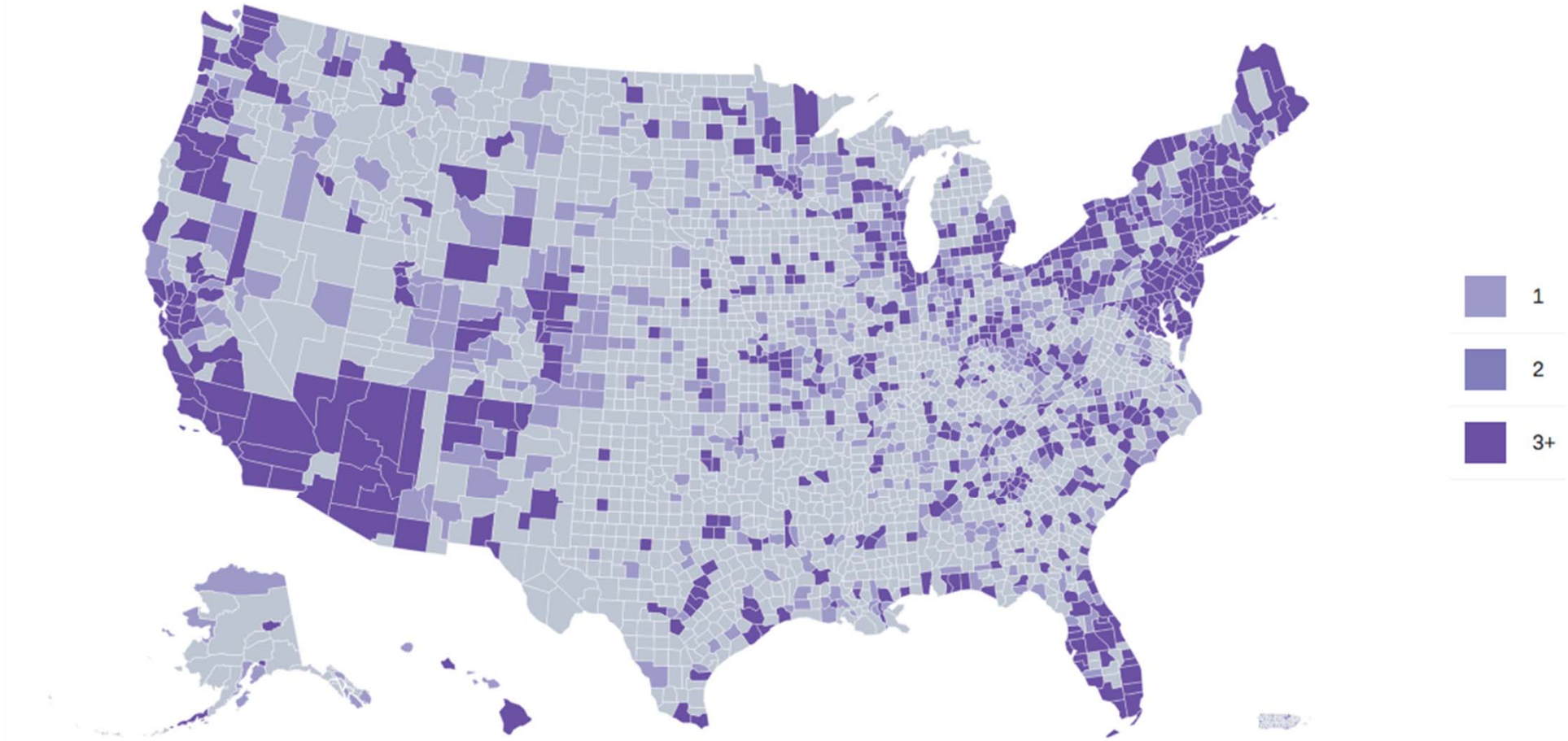
Percent of Population 12+ Diagnosable w SUD



Source: amFar.org (2018)

The Treatment Gap: Access

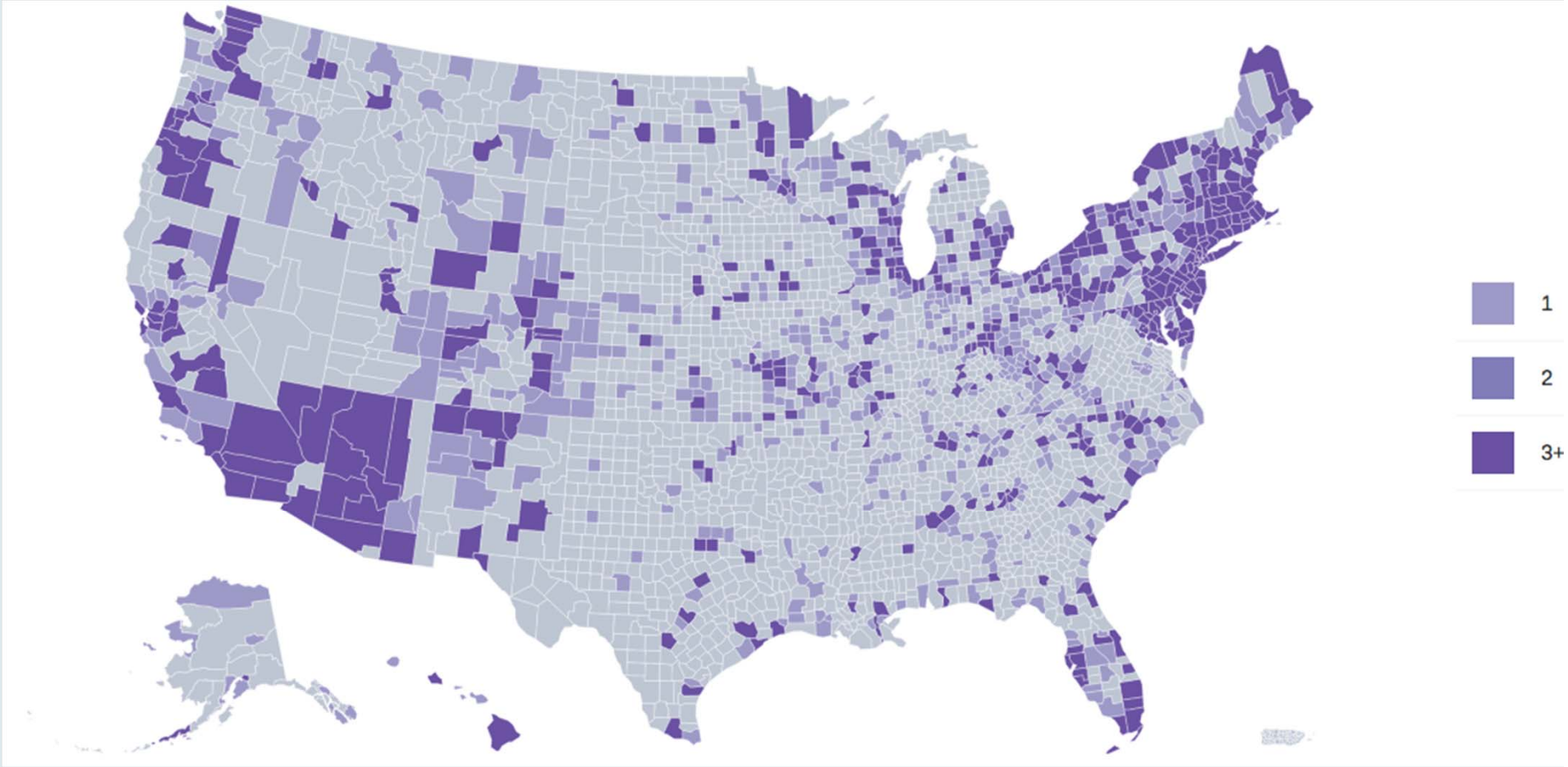
Treatment Providers with **Any** MAT



Source: amFar.org (2018)

The Treatment Gap: Access

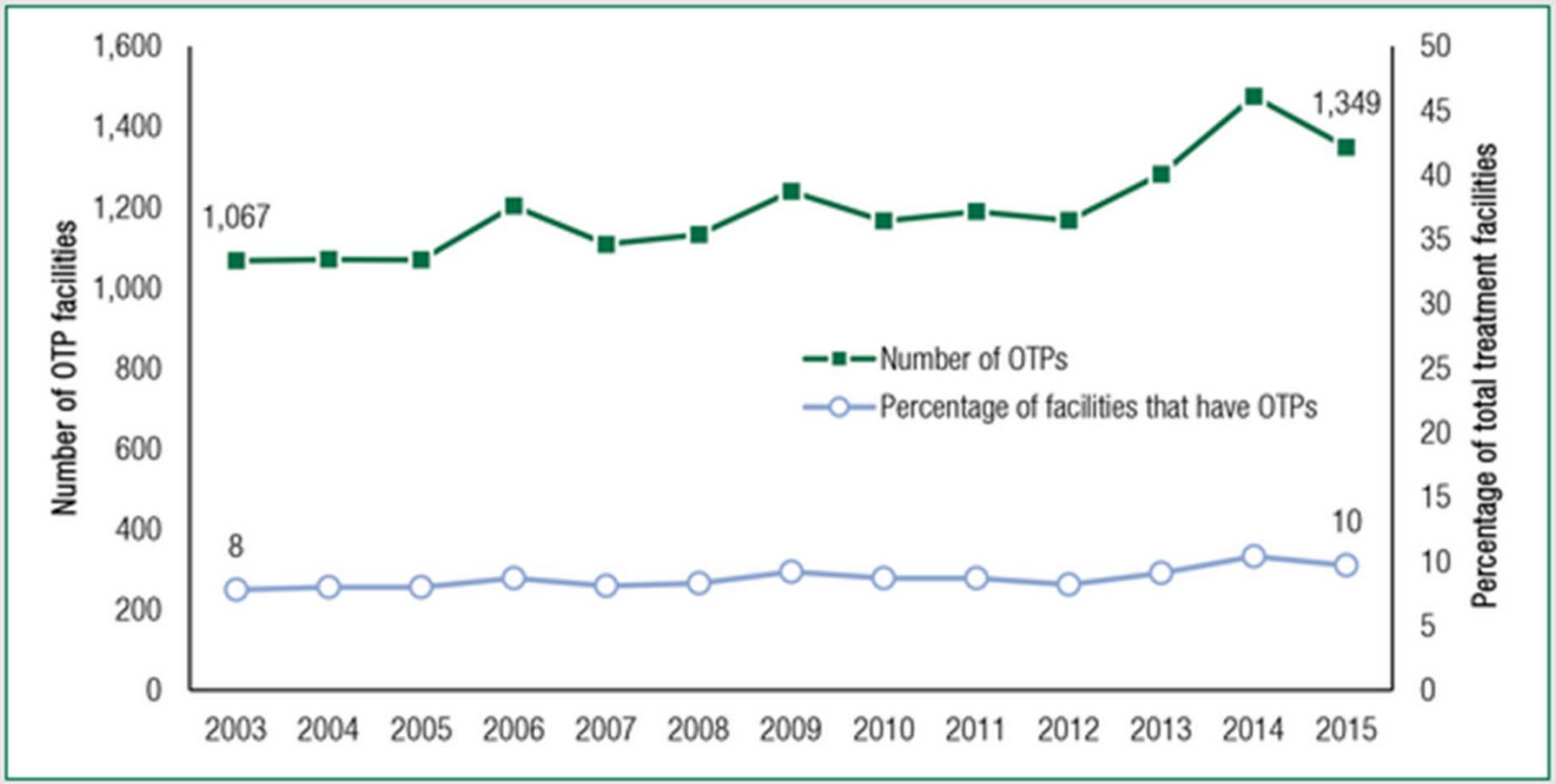
Treatment Providers w/any MAT Accepting **Medicaid**



Source: amFar.org (2018)

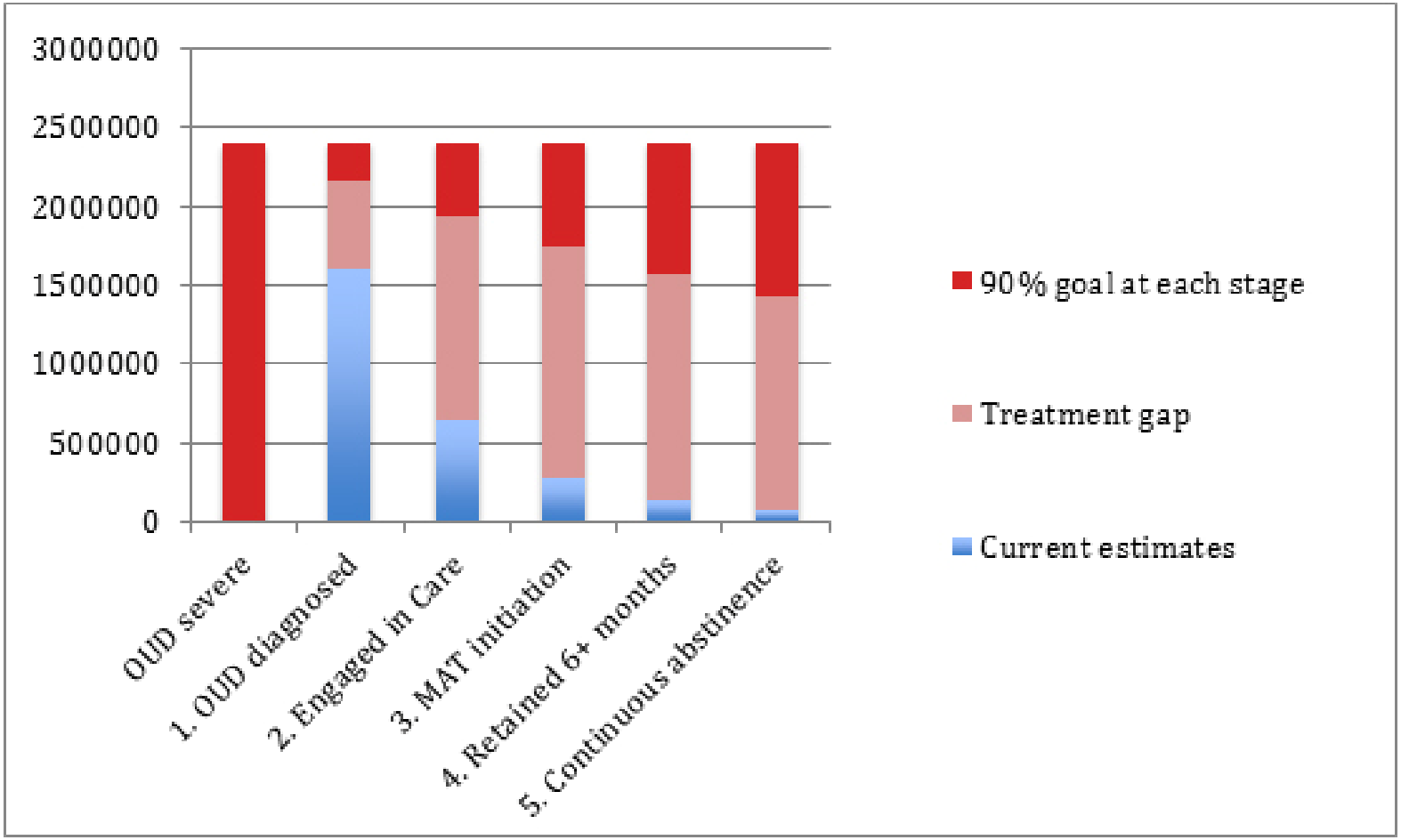
The Treatment Gap: Access

Figure 1. Number of Opioid Treatment Programs (OTPs) and Percentage of Total Substance Abuse Treatment Facilities that Provided Them: 2003 to 2015



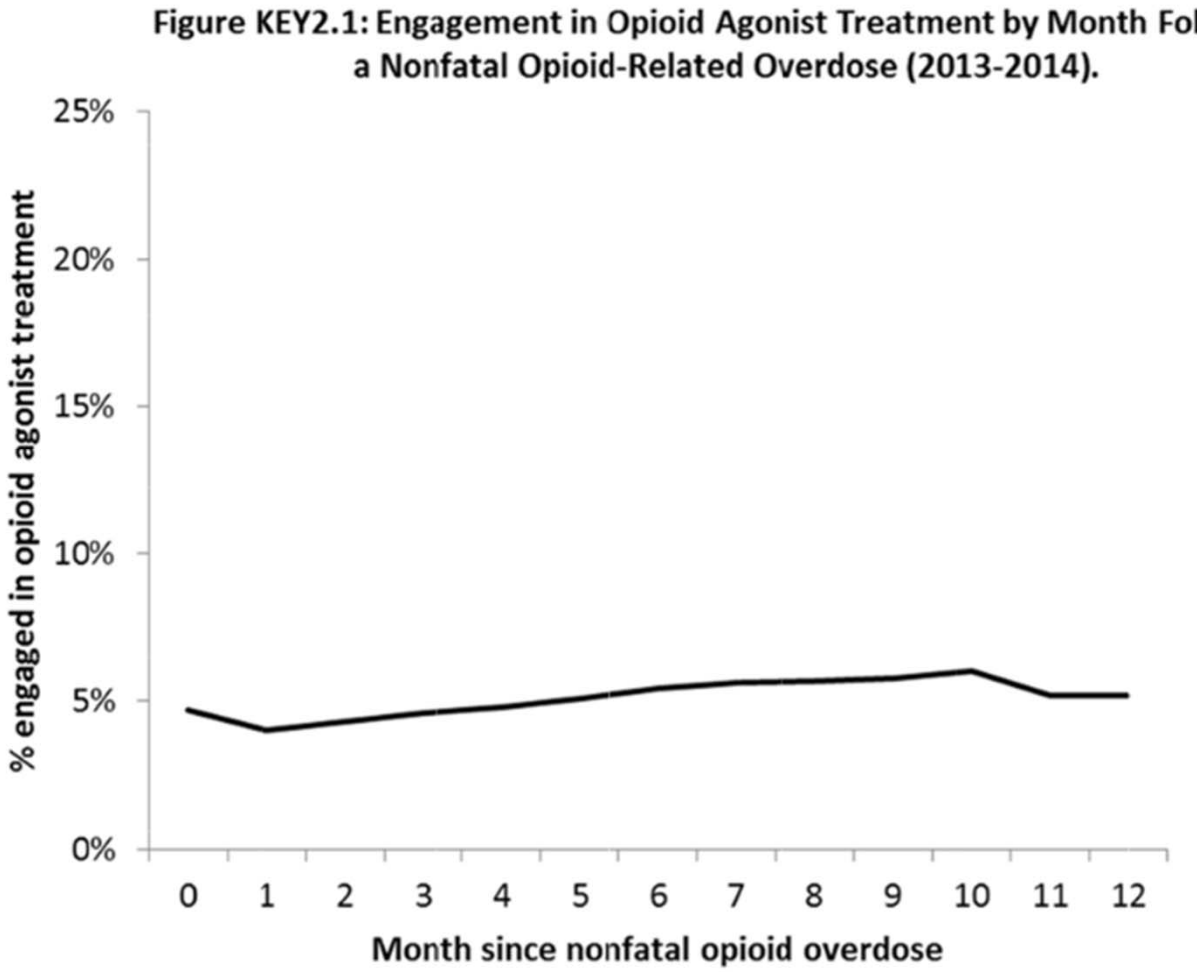
Source: SAMHSA National Survey of Substance Abuse Treatment Facilities (N-SSATS), 2003 to 2015

The Treatment Gap



Source: Williams et al, To Battle The Opioid Overdose Epidemic, Deploy the 'Cascade of Care Model' *Health Affairs Blog* (2017)

The Treatment Gap



Mass. Dept of Public Health (2016)

The Treatment Gap

- Opioid blockade mechanism
- Favored in criminal justice settings because of stigma
- Inferior outcomes along numerous metrics

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

REVIEW

doi:10.1111/add.14180

Extended-release injectable naltrexone for opioid use disorder: a systematic review

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ABSTRACT

Aims To review systematically the published literature on extended-release naltrexone (XR-NTX, Vivitrol®), marketed as a once-per-month injection product to treat opioid use disorder. We addressed the following questions: (1) how successful is induction on XR-NTX; (2) what are adherence rates to XR-NTX; and (3) does XR-NTX decrease opioid use? Factors associated with these outcomes as well as overdose rates were examined. **Methods** We searched PubMed and used Google Scholar for forward citation searches of peer-reviewed papers from January 2006 to June 2017. Studies that included individuals seeking treatment for opioid use disorder who were offered XR-NTX were included. **Results** We identified and included 34 studies. Pooled estimates showed that XR-NTX induction success was lower in studies that included individuals that required opioid detoxification [62.6%, 95% confidence interval (CI) = 54.5–70.0%] compared with studies that included individuals already detoxified from opioids (85.0%, 95% CI = 78.0–90.1%); 44.2% (95% CI = 33.1–55.9%) of individuals took all scheduled injections of XR-NTX, which were usually six or fewer. Adherence was higher in prospective investigational studies (i.e. studies conducted in a research context according to a study protocol) compared to retrospective studies of medical records taken from routine care (6-month rates: 46.7%, 95% CI = 34.5–59.2% versus 10.5%, 95% CI = 4.6–22.4%, respectively). Compared with referral to treatment, XR-NTX reduced opioid use in adults under criminal domization occurred prior to detoxification. **Conclusions** Many individuals intending to start extended-release naltrexone (XR-NTX) do not and most who do start XR-NTX discontinue treatment prematurely, two factors that limit its clinical utility significantly. XR-NTX appears to decrease opioid use but there are few experimental demonstrations of this effect.

The Treatment Gap

Comparative Effectiveness and Cost-Effectiveness

Exhibit 2

Benefit-Cost Results for Medication-Assisted Treatment for Alcohol and Opioid Use Disorders

Program name	Benefits				Costs	Summary		
	Total benefits[1]	Taxpayer benefits	Non-taxpayer benefits	Deadweight cost of the program	Program costs	Benefits minus costs (net present value)	Benefit to cost ratio	Chance benefits will exceed costs
Methadone maintenance for opioid users	$8,280	$1,153	$8,962	($1,835)	($3,727)	**$4,554**	$2.22	**89%**
Buprenorphine/buprenorphine-naloxone	$8,054	$1,174	$8,996	($2,116)	($4,579)	**$3,475**	$1.76	**86%**
Injectable naltrexone for opioids for persons in the criminal justice system	($305)	$1,331	$6,555	($8,192)	($16,359)	**($16,665)**	($0.02)	**0%**
Injectable naltrexone for opioids	($948)	$823	$6,448	($8,218)	($16,349)	**($17,297)**	($0.06)	**0%**
Injectable naltrexone for alcohol	($7,188)	$269	$654	($8,111)	($16,375)	**($23,563)**	($0.44)	**0%**

Notes:

These results are current as of December 2016. More recent results may be available on WSIPP's website http://www.wsipp.wa.gov/BenefitCost?topicId=7

[1] The total benefits include the monetary benefits of reduced substance use disorders but also include the deadweight cost of taxation. See the detailed tables in Appendix II of the report for more information.

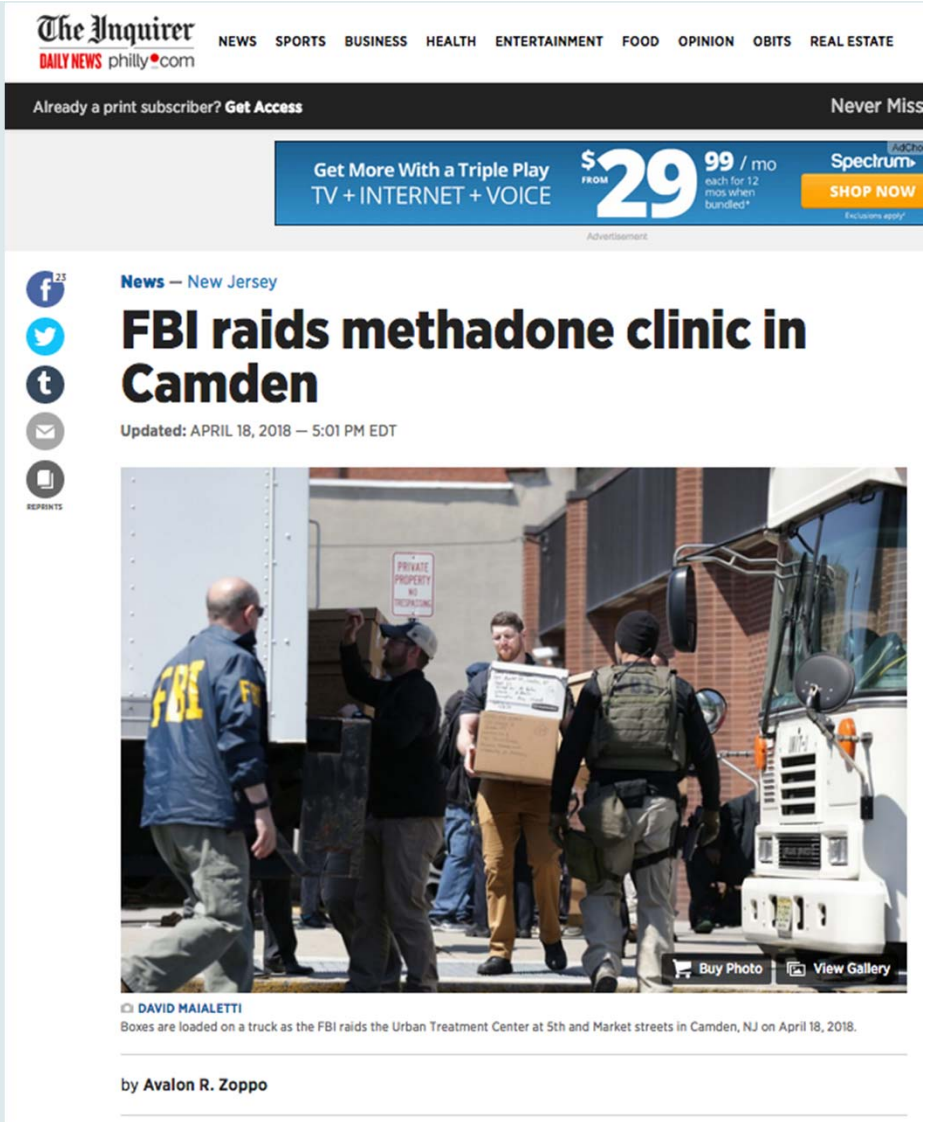
Source: WA Institute of Public Policy (2016)

Policies as "Structural Determinants"

- Laws, their enforcement determine MAT access (and OD risk)
  - Medication approval and regulation
  - Regulation of prescription and dispensation
  - Parity laws
  - Anti-discrimination laws
  - Zoning, health and safety regulations
  - Enforcement practices and monitoring
  - Access to health care, health insurance, housing, wrap-around services
  - Structural drivers of health and problematic substance use

Methadone Access: Role of Law

- OTP: special setting
  - Directly-observed therapy
  - Separate infrastructure
  - Tight federal regulations
  - Counseling req. (SAMHSA)
  - Siting and zoning challenges
  - Disproportionately minority clientele
- Induction possible in other settings



Methadone Access: Role of Law

Source: amFar.org (2018)

Buprenorphine Access: Role of Law

- Office-based settings
  - "Waiver" required
  - Can be integrated with other services
  - Insurance coverage more permissive
  - Tapering often required
  - Multiple barriers for prescribers (e.g. prior authorization)
  - Result: low penetration

CHALLENGING THE MYTHS ABOUT MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER (OUD)

MAT JUST TRADES ONE ADDICTION FOR ANOTHER: MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery. (10)

MAT IS ONLY FOR THE SHORT TERM: Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT. (11)

MY PATIENT'S CONDITION IS NOT SEVERE ENOUGH TO REQUIRE MAT: MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient (2).

MAT INCREASES THE RISK FOR OVERDOSE IN PATIENTS: MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (14)

PROVIDING MAT WILL ONLY DISRUPT AND HINDER A PATIENT'S RECOVERY PROCESS: MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.

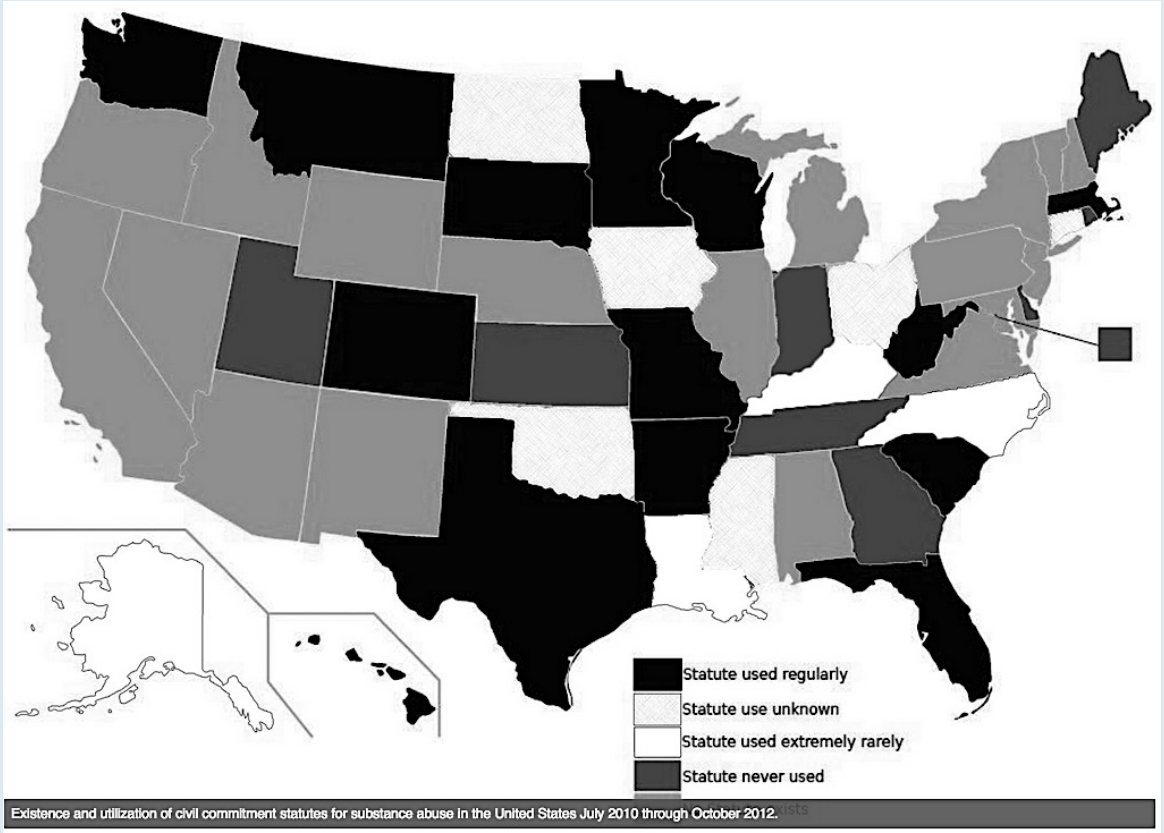
THERE ISN'T ANY PROOF THAT MAT IS BETTER THAN ABSTINENCE: MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment. (8)

MOST INSURANCE PLANS DON'T COVER MAT: As of May 2013, 31 state Medicaid FPS programs covered methadone maintenance treatment provided in outpatient programs (4). State Medicaid agencies vary as to whether buprenorphine is listed on the Preferred Drug List (PDL), and whether prior authorization is required (a distinction often made based on the specific buprenorphine medication type). Extended-release naltrexone is listed on the Medicaid PDL in over 60 percent of states. (5)

FOR MORE INFORMATION,
PLEASE CONTACT NICK SZUBIAK, DIRECTOR, CLINICAL EXCELLENCE IN ADDICTIONS, AT NICKS@THENATIONALCOUNCIL.ORG

Case Study: Commitment for Substance Use

- Allows family members, police, others to petition a court to civilly commit an individual with substance use disorder
- Rationale: posing danger to themselves or others
- 38 sates, some for 100 years
- Heterogeneity in procedure, legal authority, and utilization
- **Emerging emphasis in opioid crisis response**

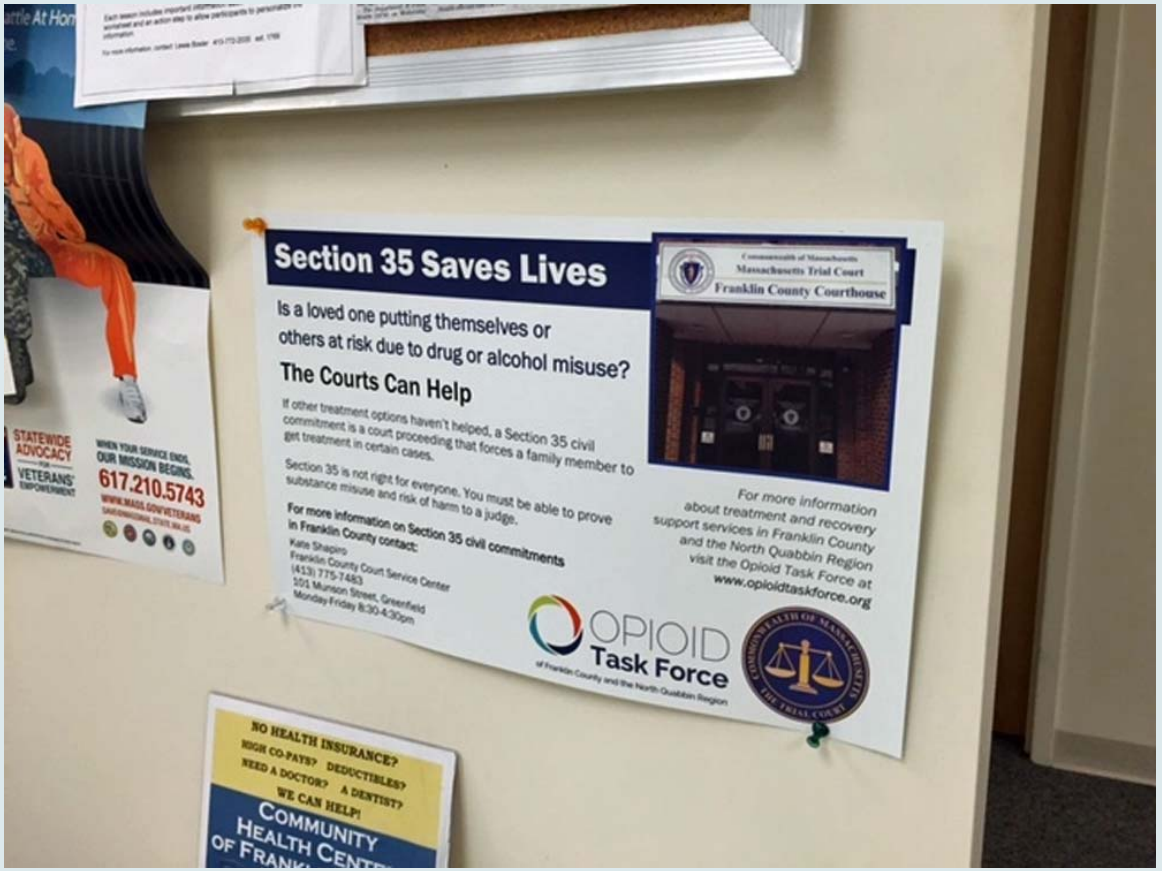


Existence and utilization of civil commitment statutes for substance abuse in the United States July 2010 through October 2012.

Christopher, Pinals, Stayton, et al., (2015)

Case Study: Involuntary Commitment

- Popularized by parent support groups, police, politicians
- State policymakers see it as a key tool
  - Proposed 72 hour holds
  - Proposed expansion in scope of petitioners
  - Standing order model
  - Expansion of physical restraints



Source: WBUR Morning Edition (2016)

Case Study: Involuntary Commitment

Nine briefly escape from state substance abuse facility amid move to Plymouth

MarshfieldFair.org
AUGUST 18-27

MAS

THE LATEST NEWS FROM A

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Residents Rais
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By Michael Rosenfield

Worse than jail: Addicts civilly committed say DOC abused them and ...

Eleven men — all civilly committed to receive substance abuse treatment — are suing the state for placing them at the Massachusetts Treatment Cent...

bostonglobe.com

Focus: Health Outcomes

Based on admissions during the study period, 67% of clients with a history of involuntary treatment had at least one opioid-related admission, 83% reported prior mental health treatment, and 44% reported a prior overdose. For clients with only a voluntary treatment history, 46% had at least one opioid-related admission, 58% reported prior mental health treatment, and 18% reported a prior overdose. Clients who received involuntary treatment were 2.2 times as likely to die of opioid-related overdoses and 1.9 times as likely to die of any cause compared to those with a history of voluntary treatment only.

Table A4: Risk of Opioid-Related Overdose Death (2013-2014) by Treatment Status (2011-2014)

Treatment Type and Risk of Fatal Opioid Overdose	Voluntary Treatment	Involuntary Treatment
Fatal Overdoses	892	134
Total Individuals	139,887	9,464
Percent Fatal Overdoses	0.63%	1.4%

MA Department of Public Health (2016)

Case Study: MAT-Based Discrimination

U.S. Attorney Investigating Mass. Prison Officials' Tre Inmates With Addic

March 29, 2018 | By Deborah Becker

The Massachusetts U.S. attorney is investigating whether sta are violating federal law by forcing inmates to stop taking th medication when behind bars.

U.S. Department of Justice

Andrew E. Lelling
United States Attorney
District of Massachusetts

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HEALTH

Nursing homes routinely refuse people on addiction treatment — which some experts say is illegal

By ALLISON BOND / APRIL 17, 2018

Role of Criminal Law, Enforcement

1. Criminalization = stigmatization
2. Criminal justice institutions and actors often make treatment decisions
    1. Correctional settings
    2. Probation and parole
    3. Drug courts
    4. Child welfare and other systems
3. Law enforcement programs: facilitators or structural barriers to help-seeking, adherence

Ethical and Legal Considerations

- How to calibrate regulation to maximize patient care benefit?
- Is it appropriate to use coercion to provide treatment ?
- What are definitions and metrics of success, in clinical practice and in law?
- What is the role of care providers in shaping policy?

Implications

1. Opportunity to scale up OAT access
2. Implementation has major gaps
3. Role of criminal justice systems, actors needs to be re-examined
4. Use "choice architecture" to design regulation
5. Focus on a more comprehensive response

Future Directions

Never let a crisis go to waste

1. Improve patient care, focus on health measures
2. Reform architecture for drug regulation and their enforcement
   - MAT regulations
   - ADA current use exception
   - Centrality of criminal justice system, e.g. inmate exception
3. Align criminal justice with health imperatives
4. Address structural determinants of health

Questions?

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