Prevención y Manejo del Uso de Opioides: Estrategias Psicológicas

5 de junio de 2020

urac ACCREDITED
Case Management
Expires 05/01/2023

urac ACCREDITED
Health Utilization Management
Expires 07/01/2023

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FULL

AGENDA

3:00pm	Bienvenida	Lcda. Awilda Broco-Rodríguez, Esq., CEO
3:05pm	Transición de Cuidado (TRC)	Luis Rivera, M.D.
3:20pm	Reconciliación de Medicamentos luego del Alta (MRP)	Brenda Medina Padró
3:25pm	Medidas HEDIS ▪ Iniciación y adherencia al tratamiento para el abuso y dependencia de alcohol u otras sustancias (IET)	César Ríos Cuevas, MS, LSSGB
3:40pm	Prevención y Manejo del Uso de Opioides: Estrategias Psicológicas	Dr. Luis Caraballo, PsyD

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Transitions of Care (TRC)

HEDIS 2020

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Description

The percentage of discharges for members 18 years of age and older who had each of the following:

- *Notification of Inpatient Admission*.
- *Receipt of Discharge Information.*
- *Patient Engagement After Inpatient Discharge*.
- *Medication Reconciliation Post-Discharge*.

Notification of Inpatient Admission

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day.

Receipt of Discharge Information

- Documentation of receipt of discharge information on the day of discharge or the following day.

Patient Engagement After Inpatient Discharge

- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

Medication Reconciliation Post-Discharge

- Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Our Initiatives

- Meetings and strengthen communication with psychiatric inpatient facilities.
- Update of providers contact information and sharing it with facilities.
- Involve clinical and pharmacy departments in the process to comply with different stages.
- Reevaluating technological tools with health plan to minimize barriers.
- Monitoring of preliminary results to identify areas of opportunity.

How Can I Contribute for Success

Psychologist, Social Workers, Counselors and other professionals:

- Educate your patients to save their psychiatrist name and to tell the hospital to contact him/her in case of a hospitalization.
- Ask your patient if they have had a recent Acute Psychiatric Hospitalization.
- If so, encourage them to assist to their psychiatrist appointment.
- If the patient doesn't have a psychiatric appointment, you could:

1) Make a direct referral to a psychiatrist,

2) Contact Us on behalf of the patient to coordinate a psychiatric visit,

3) Give our contact number to the patient and encourage them to get

an appointment

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How Can I Contribute for Success

Psychiatrists

- Educate your patients to save your name and to tell the hospital to contact you in case of a hospitalization.
- Send us your most updated contact information. Include your working days and hours, and your availability for new patients.
- Give us permission to share your email to the psychiatric facilities.
- Ask your patient if they have had a recent Acute Psychiatric Hospitalization.
- If so, complete a medication reconciliation and include the CPT of it in your claim.
- Keep in record every communication from the hospitals about admissions and discharges.

How Can I Contribute for Success

Hospitals and other Facilities

- Keep an updated directory of ambulatory psychiatrists.
- For every patient to be admitted, record the name and location of their psychiatrist. If they don’t have a psychiatrist, ask about their PCP.
- Notify ASAP the ambulatory psychiatrist by phone or email about the admission.
- Send ASAP the ambulatory psychiatrist the appropriate discharge summary.

Questions?

MRP, Facturación del Código 1111F y PMP Aware

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¿Qué es un MRP?

- **MRP-** "Medication Reconciliation Post-Discharge" por sus siglas en inglés.
  - Reconciliación de medicamentos luego del alta.

- **Comparación de medicamentos:**
  - Previos a la admisión en facilidad hospitalaria.
  - Medicamentos recetados durante/luego del alta.

- **Relevancia**
  - Pieza clave en la transición de cuidado.
  - Elemento importante en la seguridad del paciente.
    - Puede reducir los eventos de efectos adversos.

- **Código 1111F**
  - Efectivo el 1ro de enero de 2020, proveedores recibiran pago por servicio facturado.

Proceso de MRP para proveedor

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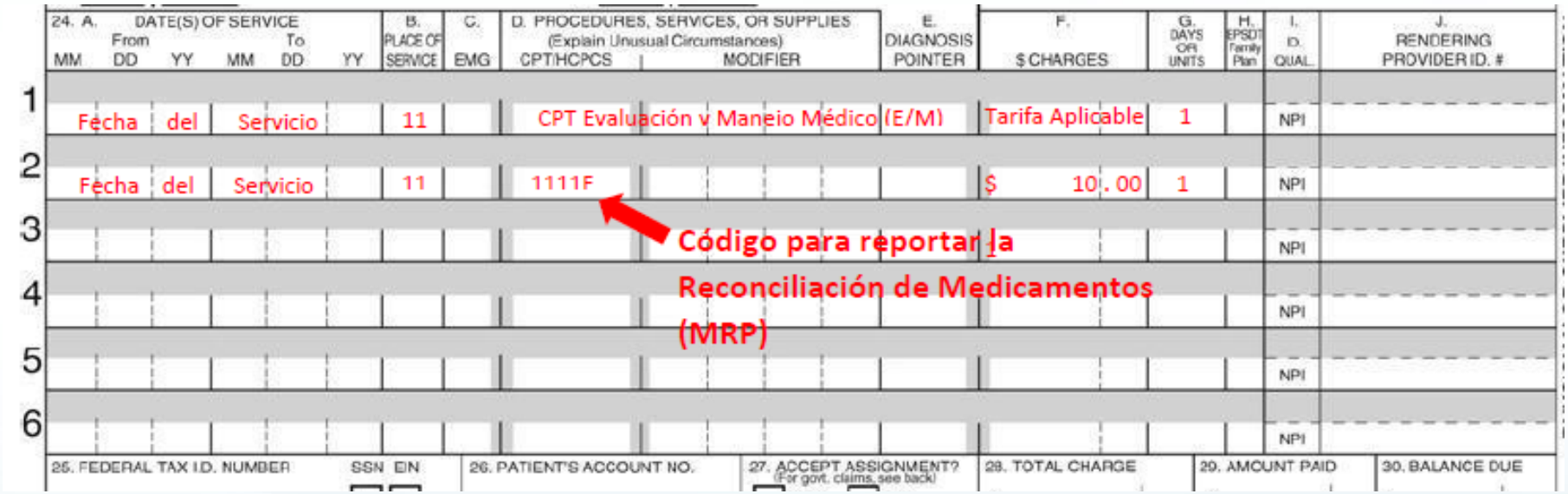
Facturación Código 1111F



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Para más información

- Teléfono FHC
  - (787) 622-9797
- Extensiones Departamento de Farmacia FHC
  - Enfermera del Departamento de Farmacia
    - Eirleen Merced
    - 2088
  - Coordinadora de Farmacia
    - Brenda Medina
    - 2178
  - Directora del Departamento de Farmacia
    - Dra. Selimar Ledesma Maldonado
    - 2064

PMP AWARE

- **¿Qué es PMP AWARE?**
  - Es una plataforma que presenta de forma actualizada el despacho a pacientes de medicamentos controlados. Cada farmacia reporta en esta plataforma los despachos de medicamentos controlados realizados. Esto permite que los proveedores y farmacéuticos puedan tomar decisiones mejor informadas según el perfil del paciente. La plataforma está actualmente activa en 42 estados y territorios de los Estados Unidos.

- **Beneficios**:
  - Con esta herramienta se puede monitorear el despacho de medicamentos controlados a través del plan médico y aquellos adquiridos sin el plan médico.
  - Permite al proveedor evaluar su historial de prescripciones de medicamentos controlados.
  - Ofrece al proveedor acceso al listado de medicamentos controlados despachados por otros proveedores.

- **¿Qué debo hacer para tener acceso a la plataforma?**
  - **Regístrese en: https://puertorico.pmpaware.net**

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PMP AWARE

- **PMP AWARxE**
  - Dirección: Carr. #2 Km 8.2 Bo. Juan Sánchez Bayamón, PR 00960
  - Teléfono: 1-833-276-0091

Referencia

- NCQA. 2018. Medication Reconciliation Post-Discharge (MRP). Se obtuvo de la página web: https://www.ncqa.org/hedis/measures/medication-reconciliation-post-discharge/. Accesado el 15 de marzo de 2019.

Referencia

- Appriss Health. 2019. PMPAWARxE. Se obtuvo de lapáginaweb: https://apprisshealth.com/solutions/pmp-awarxe/. Accesado el: 6 de mayo de 2019.
- Appriss Health. 2019. PMPAWARxE: User Registration Process Tutorial. Se obtuvo de la páginaweb: https://d1b1sdx6nwlphm.cloudfront.net/aware/default/updated_user_registration_tutorial.pdf. Accesado el: 6 de mayo de 2019.

Iniciación y Adherencia al tratamiento para el abuso y dependencia de alcohol u otras sustancias (IET)

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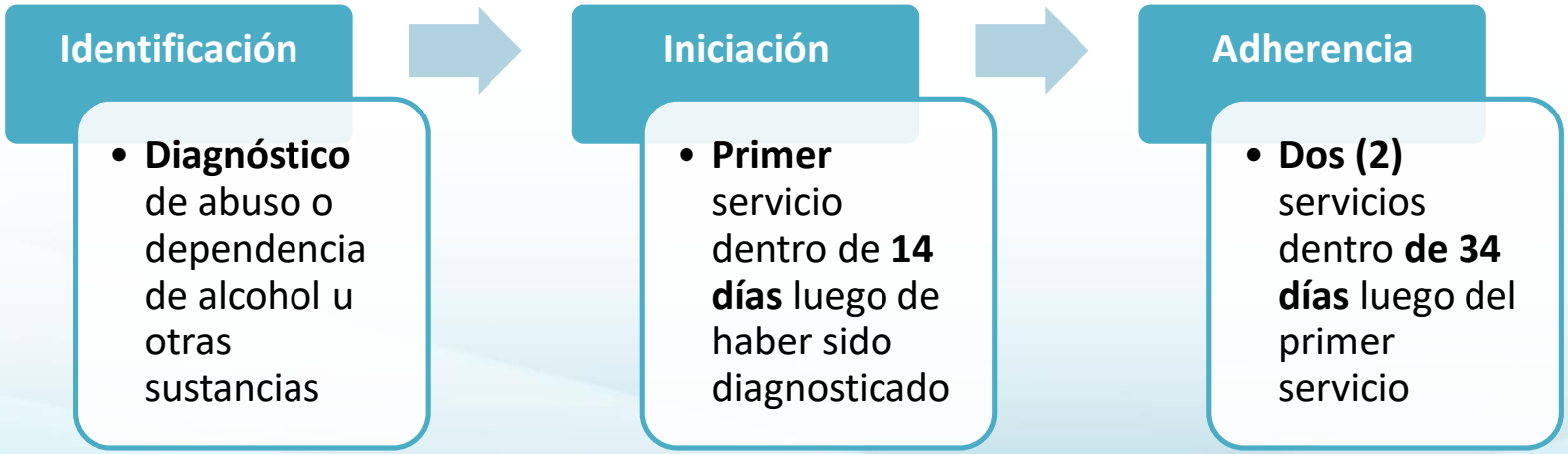
Encuesta relámpago

- Conozco sobre las especificaciones de la medida de Iniciación y Adherencia al tratamiento para el abuso o dependencia de alcohol u otras sustancias (IET, por sus siglas en inglés).

Iniciación y Adherencia al tratamiento para el abuso o dependencia de alcohol u otras sustancias (IET)

Descripción de la iniciativa:

El porcentaje de miembros con un nuevo episodio de abuso o dependencia de alcohol u otras sustancias que recibieron tratamiento a través de una **admisión hospitalaria**, **visita ambulatoria**, **ambulatorio intensivo**, **hospitalización parcial** o **telemedicina**.



Iniciación y Adherencia al tratamiento para el abuso o dependencia de alcohol u otras sustancias (IET)

- **Identificación** – Los diagnósticos son los siguientes:
  - Abuso o dependencia de **Alcohol**
  - Abuso o dependencia de **Opioídes**
  - Abuso o dependencia de **Otras drogas**
    - Canabis
    - Cocaína
    - Alucinógenos
    - Sedantes, hipnóticos, ansiolíticos

Iniciación y Adherencia al tratamiento para el abuso o dependencia de alcohol u otras sustancias (IET)

- **¿Por qué es importante?**
  - Menos del 20% de las personas diagnosticadas con trastornos por desórdenes de alcohol u otras sustancias reciben tratamiento.
  - En P.R., aproximadamente, 7 de cada 10 adultos (67.4%) que necesitan servicios para abuso de sustancias no reciben el tratamiento.
  - La iniciación de tratamiento y el compromiso con el mismo son puntos de referencia importantes en la recuperación de un trastorno por uso de sustancias.

Referencias:

- Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
- Garnick DW, Horgan CM, Lee MT, Panas L, Ritter GA, Davis S, Leeper T, Moore R, Reynolds M. Are Washington Circle performance measures associated with decreased criminal activity following treatment?.J Subst Abuse Treat. 2007 Dec; 33(4):341-52
- Godley SH, Hedges K, Hunter B. Gender and racial differences in treatment process and outcome among participants in the adolescent community reinforcement approach. Psychol Addict Behav. 2011 Mar; 25(1):143-54.
- Harris AH, Humphreys K, Bowe T, Tiet Q, Finney JW. Does meeting the HEDIS substance abuse treatment engagement criterion predict patient outcomes?. J Behav Health Serv Res. 2010 Jan; 37(1):25-39
- Canino et al. (2016)

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Resultados

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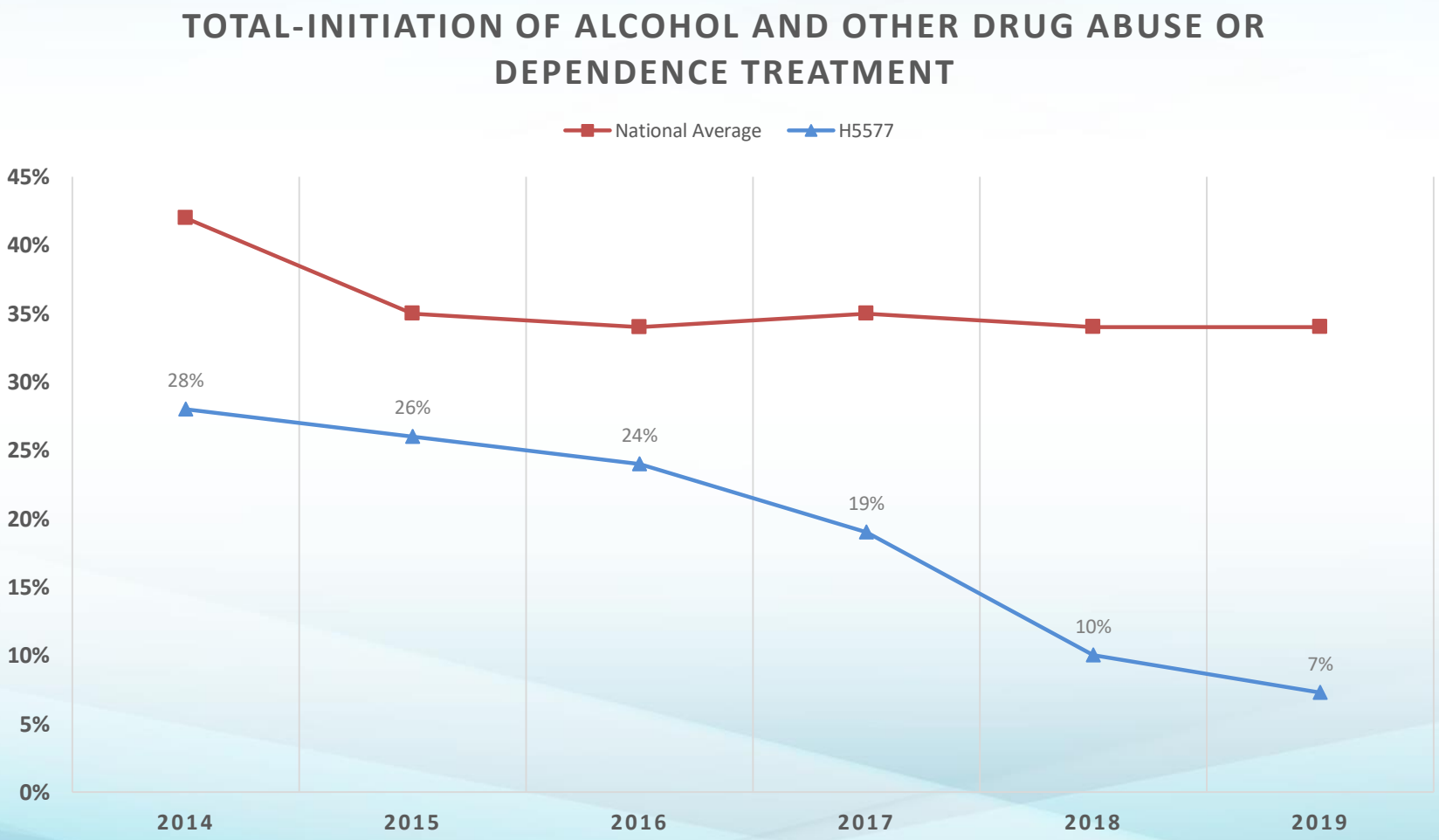
Iniciación y Adherencia al tratamiento para el abuso o dependencia de alcohol u otras sustancias (IET)



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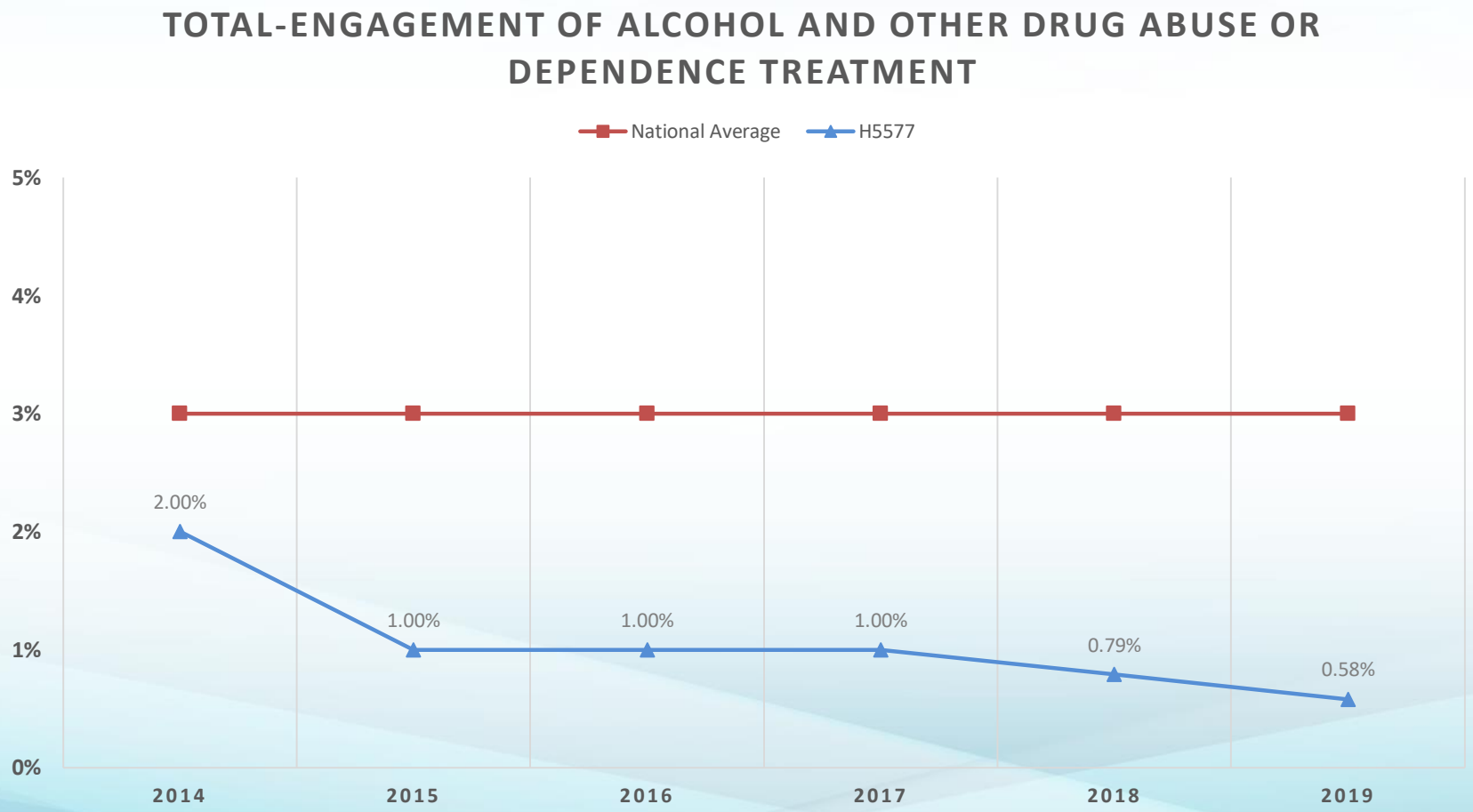
Iniciación y Adherencia al tratamiento para el abuso o dependencia de alcohol u otras sustancias (IET)



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Barreras

- **Proceso**
  - Falta de cernimiento apropiado (No diagnóstico)
  - Disponibilidad limitada de citas para seguimiento según frecuencia recomendada
  - Proceso de reclamación – No documentar diagnóstico en el expediente o en reclamación
  - Diagnóstico falso positivo (*overuse*)

- **Paciente**
  - Determinantes sociales
  - Falta de apoyo familiar
  - Factores psicológicos (motivación, estigma social, negación)

Queremos conocer su opinión

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Barreras

- **Proveedor**
  - Falta de colaboración entre los proveedores (facilidades, profesionales) en la red
  - Proveedores no proveen suficiente educación a los asegurados sobre el tratamiento para el abuso o dependencia de sustancias
  - Proveedores no conocen los profesionales o facilidades de la red disponibles para trabajar problemática de sustancias
- **Procedimiento escrito**
  - Falta de un procedimiento escrito para facturar el tratamiento de abuso de sustancias o alcohol

¿Qué opina?

¿Cómo se pueden mejorar los resultados?

- Luego de diagnosticar al paciente usted decide tratarlo, calendarice una cita de seguimiento dentro de 14 días luego del diagnóstico y, por lo menos, dos visitas adicionales dentro de 34 días.
  - **Importante**: Incluir el diagnóstico de abuso de sustancias en la reclamación
- Tenga discusiones continuas con el paciente sobre los tratamientos disponibles para que contribuya aumentar el compromiso y la voluntad en comenzar un tratamiento en 14 días.
- Si luego de diagnosticar al paciente y usted prefiere referirlo para tratamiento, comuníquese con el Programa de Manejo de Casos de FHC llamando al **1-800-760-5691** el mismo día o al día siguiente en que diagnostique al paciente o puede referirlo directamente a un proveedor de la red. El asegurado también puede ser referido a través de nuestra página web.
  - **Servicios de Programa de Intensivo Ambulatorio (IOP) no requieren pre-autorización**
- Utilice herramientas de cernimiento estandarizadas para facilitar el proceso de identificación de un posible diagnóstico. Estos cuestionarios pueden ser completadas por el paciente mientras espera por ser atendido.

Referido al Programa de Manejo de Casos

Visite: https://fhcsaludmental.com/

Escoja Beneficiarios

Programa de Manejo de Casos

Referido al Programa de Manejo de Casos - (fhcsaludmental.com/referido-de-programa-de-manejo-de-casos/)

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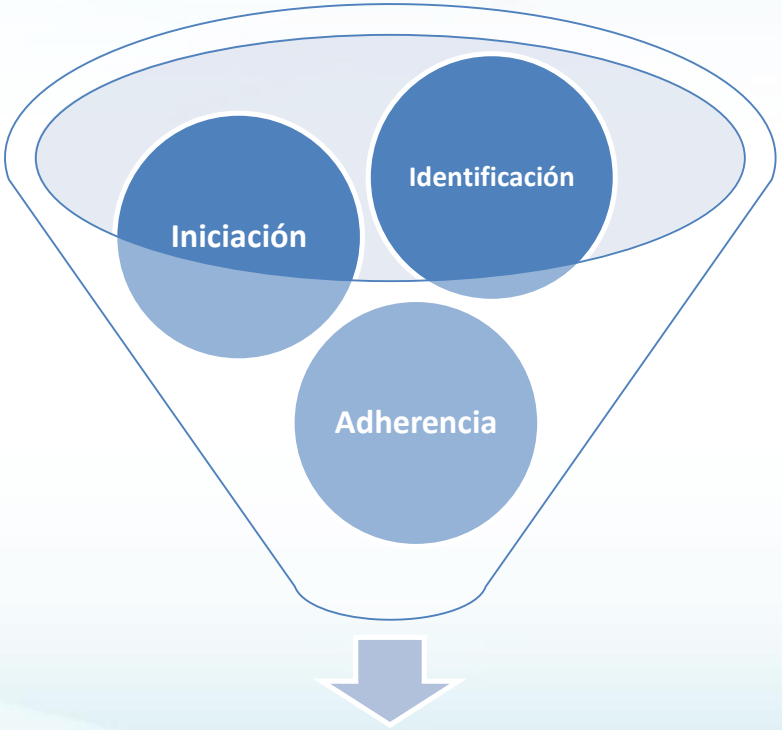
Resumen



Tratamiento efectivo

¡Contáctenos!

cesar.rios-cuevas@uhsinc.com

787-622-9797 ext. 2010 o 2096

Los proveedores puede dirigir sus preguntas sobre las iniciativas de calidad a través de email o llamando a nuestro departamento. Estaremos muy contentos de ayudarles.

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Prevention and Psychological Management of Patients with Opioid Use Disorder (OUD)

Luis Caraballo, PsyD, FPCP

Introduction

- Physicians, for many years, thought that solely medical treatment for SUD's would suffice, as they saw this disease merely as a physiological dependence for any given substance.
- Reality is that any substance that generates the multiplication of receptors in our brain, thusly, physiological tolerance, will generate physiological dependence upon said substance and subsequent withdrawal symptoms, but this disease is much more complex than the mere development of tolerance and physiological dependence.
- Due to the multifactorial etiology of this disease; the approach to treatment must also be multidisciplinary in nature and not just among health care and mental health professionals.
- SUD's are extremely complex diseases which can not be treated exclusively by just one professional.
- Due to the complexities and multifactorial etiology of this disease, a team approach, that is fully integrated and follows a Recovery Oriented System of Care philosophy is absolutely necessary
  - which takes into account not just the patient's intrinsic reality, but also his or her complete environmental reality (family, community, spirituality, education, legal status, etc., etc..)

Interesting Data

- Mental health co-morbidity as high as 70% in SUD patients
- 2016 NSDUH* data shows that nearly 0.5 million people in the US over the age of 12 were heroin users, which represents 0.2% of the population. (*National Survey on Drug Use and Health: SAMHSA).
  - This data shows an increase form 2013 NSDUH data that showed that 0.1 % of the population were regular heroin users.
- NSDUH 2016: 11.5 million opioid misuse in the US. (Most opioid misuse is not due to heroin, but rather to prescribed opioids, produced at our pharmaceutical companies.
  - 11.1 million misused pain relievers - 886,000 used heroin - 562,000 both misused pain relievers and heroin
- 2.1 million people had an opioid use disorder
  - 1.7 million people with a prescription pain reliever use disorder
  - 652,000 people with a heroin use disorder
  - 252,000 had both pain reliever and heroin use disorders
- 53.1% obtained the last pain reliever they misused from a friend or relative 36% from a prescription from a healthcare provider
- Main reasons……. for opioid misuse: Pain 62.6%

key Terms

- OUD is defined in the DSM-5 as a problematic pattern of opioid use leading to clinically significant impairment or distress.
  - OUD was previously classified as Opioid Abuse or Opioid Dependence in DSM-IV.
  - OUD has also been referred to as "opioid addiction.“
- Addiction: The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
  - Even individuals with severe and chronic SUDs can, with help, overcome their disorder and regain health and social function.
    - This is called remission.
  - When those positive changes and values become part of a voluntarily adopted lifestyle, that is called “being in recovery.”
  - Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature

Diagnosing OUD

- Diagnosing OUD requires a thorough evaluation, which may include obtaining the results of urine drug testing and prescription drug monitoring program (PDMP) reports, when OUD is suspected.
- It is also important to remember that OUD exists on a continuum of severity.
- As a result, a scale for assigning severity exists and is based upon the number of criteria that have been met (mild, moderate, severe).
  - This severity distinction has treatment implications.

Important Concepts in OUD

- **Opioids:**
  - Opioids are those alkaloids, natural or synthetic, that adhere to the opioid receptors and produce an agonist effect, similar to that of morphine.
- **Tolerance**
  - Tolerance is defined as either: 1) a need for markedly increased amounts of opioids to achieve intoxication or desired effect, or 2) a markedly diminished effect with continued use of the same amount of an opioid.
- **Withdrawal**
  - You can refer specifically to DSM-5 Criteria A and B for opioid withdrawal syndrome:
    - Either of the following: 1) Cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or 2) administration of an opioid antagonist after a period of opioid use
    - Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or sweating; diarrhea; yawning; fever; or insomnia

Assessing for OUD

- If you suspect OUD, you should not dismiss patients from care. Instead, use the opportunity to provide potentially lifesaving information and interventions.
- You should discuss your concern with your patient and provide an opportunity for him/her to disclose any related concerns or problems.
- You can use the DSM-5 criteria to assess for the presence of OUD or arrange for assessment with a substance use disorder specialist.
- You can perform urine drug testing (UDT) to obtain information about drug use that is not reported by the patient.

DSM-5 Diagnostic Criteria for OUD

- In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:
  - Opioids are often taken in larger amounts or over a longer period than was intended.
  - There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
  - A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
  - Craving, or a strong desire or urge to use opioids.
  - Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
  - Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
  - Important social, occupational, or recreational activities are given up or reduced because of opioid use.
  - Recurrent opioid use in situations in which it is physically hazardous.
  - 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.
  - Exhibits tolerance (discussed in the next section).
  - Exhibits withdrawal (discussed in the next section).

Talking with Patients About OUD

- Reviewing how you can talk to a patient if he or she meets the DSM-5 criteria for OUD. Use statements such as:
  - "Trouble controlling the use of opioid medication makes it unsafe, and long-term risk over time is substantial."
  - "The medicine has become a problem in itself. You have developed a known complication of therapy that we should not ignore."
  - "Continuing the current medication is not a reasonable option due to the risks, but there are options for treating what we call opioid use disorder, also known as OUD."
  - "It seems as if you are running out of your medication more quickly than anticipated."
  - "Sometimes people become too comfortable with the medications and start to take them for reasons other than pain."
  - "You meet the criteria for opioid use disorder, also known as OUD. It's helpful to put a name on it because it opens up a variety of approaches to help with your specific circumstance."
  - Now, let's review some specific strategies you can use to help patients understand their diagnosis of OUD.

Communication Strategies

- **Approach Patients with Compassion**
  - Use statements such as:
    - "Sometimes the medications cause problems that we cannot anticipate."
    - "All kinds of people have problems with opioids."
    - "You are not alone. All kinds of people can have problems with opioids.“
- **Use Relationship-Building Skills**
  - Relationship-building skills include reflective listening and empathetic statements to destigmatize OUD diagnosis and treatment. Use statements such as:
    - "I understand you have been struggling and know that discussing change can be distressing."
    - "My primary motivation is to provide care that leads to the healthiest version of 'you' in the long term."
    - "Getting help for this is like getting help for any other chronic medical problem."
    - "I want you to have the best possible care, and this difficult but productive conversation is a first step for us.“
- **Explain Treatment Methods**
  - Use statements such as:
    - "There are a number of treatment options. Let's explore them together."
    - "We will work together to find a treatment plan that works best for you."

Assessing the Need for Treatment

- An assessment should include:
  - A medical and MH history, a substance use history, and an evaluation of family and psychosocial supports
  - Frequency of opioid use and route of administration (e.g., oral, intravenous, intranasal) can help gauge likelihood of severe withdrawal or possible infections, which will influence further testing and the need for counseling
  - Prescription drug use history accessed through the state's PDMP (prescription drug monitoring program), where available, to detect unreported use of other controlled medications, such as benzodiazepines or other opioid medications, that may interact adversely with the treatment medications
  - Previous attempts to stop using opioids, type of treatment used, and response to treatment

Arranging Evidence-Based Treatment

- **Medication-assisted treatment (MAT) is considered the best treatment option for OUD as part of a comprehensive treatment plan.**
- MAT for OUD is defined as the use of one of three medications (buprenorphine, naltrexone, or methadone) in combination with psychosocial and/or behavioral therapy, through one of the following:
- Office-based provider for **buprenorphine** or **naltrexone**
  - Buprenorphine can be only be prescribed and dispensed by a certified provider who has a Drug Enforcement Agency license and has undergone training to qualify for a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver. You can apply for a waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management
  - Naltrexone is not a controlled substance, so it can be prescribed by any healthcare provider who is licensed to prescribe medications.
- Opioid treatment program (OTP) for methadone therapy
  - Methadone can only be dispensed through an OTP that is accredited by a SAMHSA-approved accrediting body and certified by SAMHSA.

Factors Influencing Selection of MAT

- Multiple factors may influence the selection of a specific type of MAT.
- General Considerations
  - Buprenorphine and naltrexone can block the effects of other opioids taken concurrently.
  - Methadone, naltrexone, and buprenorphine also reduce craving.
  - Naltrexone should not be used by pregnant women.

MAT Tx options

- **Buprenorphine**
  - Buprenorphine is likely to be safer than methadone for overdose risk, given its activity as a partial opioid agonist and lower potential for respiratory depression.
  - Unlike methadone, the lack of required daily visits to a treatment center can also be an advantage.
  - Another advantage of buprenorphine is the availability of long-acting injectable or implantable formulations that carry a low risk of diversion and can be managed as a monthly visit.
- **Methadone**
  - Methadone therapy for OUD requires frequent opioid treatment program visits (daily in early treatment) and may be inconvenient or feel stigmatizing for some patients.
- **Naltrexone**
  - Naltrexone is available in both an oral formulation, taken daily, and an extended-release intramuscular injection formulation, administered once monthly.
  - An advantage of naltrexone therapy is that there are no special regulatory requirements involved; any licensed clinician with the ability to prescribe medication can prescribe naltrexone. Also, naltrexone has no abuse potential.
  - However, despite these advantages, oral naltrexone is less frequently used to treat opioid use disorder (OUD); also, currently there is no clear evidence that predicts which patients are best treated with extended-release naltrexone versus other available medications to treat OUD.
  - Some experts recommend naltrexone primarily for highly motivated patients with a mild opioid use disorder and for patients whose occupations do not allow treatment with opioid agonists (methadone) or partial agonists (buprenorphine).

Additional Considerations When Initiating MAT

- **Initiating Naltrexone Treatment**
- As naltrexone is an opioid antagonist and will immediately precipitate withdrawal if taken while opioids remain in one's system, patients must remain abstinent from short-acting opioids (e.g. hydrocodone) for 7 to 10 days or from long-acting opioids (e.g. methadone, buprenorphine) for 10 to 14 days before receiving naltrexone.
- **Initiating Buprenorphine Treatment**
- Buprenorphine patients do not need to have all opioids out of their system but should be in mild to moderate opioid withdrawal when starting.
- When the patient is in mild to moderate withdrawal, buprenorphine's effects on the opioid receptors as a partial agonist are experienced as relief from withdrawal symptoms.
- However, if buprenorphine is started in a patient on full agonist opioids who is not in withdrawal, buprenorphine will displace the full agonist from opioid receptors, precipitating withdrawal symptoms.
- **Initiating Methadone Treatment**
- Patients for whom methadone therapy is being considered do not need to have all opioids out of their system, similar to buprenorphine, and should be in mild to moderate withdrawal. Because of the considerable variability among patients in methadone's bioavailability, clearance, and half-life, dosing should "start low and go slow." Patients starting methadone should be monitored very closely and be informed that the full effect of the initial dose might not be felt for 4 or more days, due to methadone's long half-life (24-36 hours) and time required to reach steady-state levels.

Managing Opioid Use Disorders and Chronic Pain

- Recognizing and treating opioid use disorders (OUDs) among patients with chronic pain on long-term opioid therapy is challenging.
- “Drug-seeking” behaviors for an active OUD can be very similar to those behaviors in a patient who has inadequately controlled severe pain.
- Determination of whether the benefits of continued opioid prescribing outweigh the harms in these patients is based on patient reports and subjective observations.

Biggest misconceptions among physicians regarding OUDs in patients with chronic pain?

- Certain aberrant behaviors in patients with chronic pain managed on opioids may be misinterpreted as signs of an OUD
- Those behaviors may be a result of poorly controlled severe pain and suffering. In some cases, the behaviors—unsuccessful attempts to try to cut down or cut back on opioids—may be caused by an OUD and/or inadequate pain control.
  - In fact, some of the 11 symptoms of an OUD in DSM-5 could apply to a patient who is in severe pain

Psychotherapeutic Models to Treat OUD's

Psychological Tx's

- In the past three decades, the addiction treatment field has focused on discovering and applying science-informed practices that help people with SUDs enhance their motivation to stop or reduce alcohol, drug, and nicotine use.
- As the addiction treatment field has matured, it has tried to integrate conflicting theories and approaches and to incorporate research findings into a comprehensive model.
- Historically the treatment field has focused on the deficits and limitations of clients. Today, greater emphasis is placed on identifying, enhancing, and using clients' strengths, abilities, and competencies.

Motivational interviewing (MI)

- Motivational interviewing (MI) is a respectful counseling style that focuses on helping clients resolve ambivalence about and enhance motivation to change health-risk behaviors, including substance misuse
- Motivation and Behavior Change Motivation is a critical element of behavior change (Flannery, 2017) that predicts client abstinence and reductions in substance use (DiClemente et al., 2017).
- You cannot give clients motivation, but you can help them identify their reasons and need for change and facilitate planning for change.
- Successful SUD treatment approaches acknowledge motivation as a multidimensional, fluid state during which people make difficult changes to health-risk behaviors, like substance misuse.

Motivational interviewing (MI)

- Motivation helps people resolve their ambivalence about making difficult lifestyle changes.
- Helping clients strengthen their own motivation increases the likelihood that they will commit to a specific behavioral change plan
- Motivation and readiness to change are consistently associated with increased help seeking, treatment adherence and completion, and positive SUD treatment outcomes

Elements of Effective MI Approaches

- Motivational counseling strategies have been used in a wide variety of settings and with diverse client populations to increase motivation to change substance use behaviors.
- The following elements are important parts of motivational counseling:
  - FRAMES approach
  - Decisional balancing
  - Developing discrepancy between personal goals and current behavior
  - Flexible pacing
  - Maintaining contact with client

FRAMES Approach

- Miller and Sanchez (1994) identified six common elements of effective motivational counseling, which are summarized by the acronym FRAMES:
  - **F**eedback on personal risk relative to population norms is given to clients after substance use assessment.
  - **R**esponsibility for change is placed with the client.
  - **A**dvice about changing the client's substance use is given by the counselor nonjudgmentally.
  - **M**enu of options and treatment alternatives is offered to the client.
  - **E**mpathetic counseling style (i.e., warmth, respect, an understanding) is demonstrated and emphasized by the counselor.
  - **S**elf-efficacy is supported by the counselor to encourage client change

CBT (Cognitive Behavioral Therapy)

- CBT is a form of psychological treatment that has been demonstrated to be effective for a range of problems
- CBT is based on several core principles, including:
  - Psychological problems are based, in part, on faulty or unhelpful ways of thinking.
  - Psychological problems are based, in part, on learned patterns of unhelpful behavior.
  - People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.
- Cognitive behavioral therapy (CBT) for substance use disorders has demonstrated efficacy as both a monotherapy and as part of combination treatment strategies.
- Types of interventions in CBT?:
  - functional analysis of behavior
  - promoting behavioral activation
  - identifying and coping with drug cravings
  - enhancing drug refusal skills
  - enhancing decision making around high –risk situations
  - improving problem solving skills

CBT-IC (CBT for Interoceptive Cues)

- An exposure-based focus on distress tolerance rather than distress amelioration
- Core of Treatment: 5-step drug use protocol
  - identification of external and internal cues for use
  - discussion of alternatives to drug use in response to these cues
  - in session induction of the relevant (primarily emotional) cue for use
  - practice of emotional labeling and acceptance of emotional states, and rehearsal of one or more non-drug response to the cues
  - home practice of exposure and alternative responses

Acceptance and Commitment Therapy

- Acceptance and Commitment Therapy (or ACT for short) is a form of behavioral therapy. It teaches individuals to *accept* without judgment – rather than resist and avoid – painful thoughts, feelings, and experiences that are a normal part of the human existence and *commit* to taking values-based actions that help create a fulfilling life.
  - Is "taking the view that trying to change difficult thoughts and feelings as a means of coping can be counter-productive, but new, powerful alternatives are available, including acceptance, mindfulness, cognitive diffusion, values, and committed action."
- 6 Core Processes of ACT
  - Acceptance
  - Cognitive Defusion
  - Being Present
  - Self as Context (The Observing Self)
  - Values
  - Committed Action

How ACT Helps with Addiction Recovery

- Several randomized controlled studies have shown that relatively short acceptance and commitment therapy (ACT) interventions have positive effects on mental health disorders
- The inability to cope with negative thoughts and feelings (both psychological and physical feelings) is often a driving factor in the development of substance abuse problems and addiction. By strengthening the psychological flexibility of individuals with a substance use disorder, ACT helps them learn to accept and handle discomfort and pain without turning to self-destructive coping mechanisms, such as getting high or intoxicated.
- Drugs can provide a quick and simple way to alleviate unwanted thoughts and feelings. But they inevitably cause more harm – and more unwanted thoughts and feelings along with new problems – as the individual continues to use them as a quick fix.
- ACT teaches strategies that enable individuals with a substance use disorder to tolerate unwanted feelings and experiences, including cravings and the urge to use.
- These strategies can assist individuals during their treatment program while also giving them the tools to avoid relapse and stay on the path of recovery once they leave treatment.

Prevention strategies for OUDs

- Reduce exposure to opioids and prevent opioid use disorder, such as:
  - Prescription drug monitoring programs.
  - State prescription drug laws.
  - Formulary management strategies in insurance programs, such as prior authorization, quantity limits, and drug utilization review.
- Patient education on the safe storage and disposal of prescription opioids
- Improve awareness and share resources about the risks of prescription opioids, and the cost of overdose on patients and families.
- Identify opportunities to expand first responder access to naloxone, a drug used to reverse overdose.

Questions??

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