Hello everyone and welcome to the fourth annual session of the Opioid Safety and COVID workshop. Thank you for joining. We would like to welcome you all and will be featured by Dr. Robeck. This session is being recorded. We ask everyone to make sure your phones are silenced or muted. You will be able to find the workshop agenda, presentations and a full bio of Dr. Robeck which can be found in the files pod. You may download everything in the bottom left corner. We also have a Q&A throughout and you can ask questions in the chat box, as well as raise your hands depending on what you would like. You are welcome to join into the conversation. We welcome the participation.

We also have a few other things. The training survey evaluation to receive CME and tonight can be found in the files pod. You will download those files. For CME you return to Troy, myself and for the CEU you will return to Carla. Also, if you have trouble viewing the slide presentation you can exit out and come back in and download the presentation from the files pod. Also, if you would like to follow along you may do the same thing. I would like to turn it over to Dr. Robeck.

Thank you all for joining us. I want to do a sound check. I have my phone on speaker. We tried it with headphones. Does this sound okay? Or do I need to go back to handheld? Let me know.

You are good.

Thank you for joining us. One of the things I wanted to do today was to intersect our growing understanding of opioids, opioid tissues disorder and opioid dependence. And, the importance of understand that opioid safety is part of your medical policies and plans during the COVID epidemic. There are a lot of reasons why this epidemic is going to increase risks related to opioids that we will talk about. Frequently, when I do a presentation that involves any disorder program I go to a number of different websites. I go to the American society website, among others. Frequently, there is a lot of up-to-date information. In my inquiries I found that many of the concerns I have had during the past few months have been very well addressed by ASAM. I will combine this visitation with a lot of information that is updated from the ASAM website. This will be critical for you in terms of keeping in touch with the evolving literature related to treating substance tissues disorder or dependents in 2020. Also, I would like you very much make this interactive. If you want to put your questions or comments into chat, I will try to incorporate that into this presentation. This is going to be 45 minutes long, followed by a 15-minute break. Then, we will do the same format for everything else.

Let's just talk about this. What we want to start out with is discussing chronic pain, opioids and opioid safety in general. Even separate from discussing opioid use disorder. But, in disjunction with that. There is a lot of new current guidelines that we will review. We want to keep in mind this case, which will be an ongoing case throughout our discussion. A 35-year-old male requests telehealth visit due to worsening back pain. He is currently on oxycodone and has non-opioid therapies and they have not been given him acceptable pain care in the past. He is now concerned as his current dose is now 30 milligrams every six hours as needed, and

it is no longer helping him. He had been down to taking 10 milligrams but has increased his dose in March when his pain started to flow. He would now like a higher dose. Think about this during a presentation. What other questions do you need answered? And how would you proceed at this time?

I really want to bring up to everybody that ASAM has completely redone their OU D guidelines. As part of that there is a very nice discussion of opioids and people with pain. I want to really review that right now. Here is what they said. For all patients with pain, it is important that the correct diagnosis is made, and that pain is addressed. Whether that patient has a documented opioid use disorder or documented substance tissues order or other health problems, what is going on in terms of the diagnosis of pain, which you can then add other morbidities that may be exacerbating the pain.

Alternative treatments including non-opioid medications with pain modulating properties, behavioral approaches, physical therapy, and residual approaches should be considered before prescribing opioid medications for pain. Unfortunately, by 2020 we have patients that have already been exposed to opioids. For that patient population, we need to remember what opioids they may be taking, and what opioids they may have taken in the past and may still have lying around. If a pharmacological treatment is considered, non-opioid analgesics, such as acetaminophen and

NSAODs be tried first. For patients with pain who have an active opioid use disorder but are not in treatment, and this will treat the patient's opioid disorder and pain should be stabilized and managed concurrently.

I hear a dog somewhere.

I will explain my bias to you whenever possible. Some medications are easier to be used because it can be used in different clinic settings. It can split the dose. It can also be incorporated into patients with complex medical regiments with less risk for drug interactions.

Let's remember, separate from opioid use disorder and opioid dependence and overdose, the list of side effects of opioids for anybody, taking them especially long-term is large. We see endocrine apathy is, sleep apnea, constipation, cognitive problems, immunosuppression, respiratory depression, worsening postoperative outcomes, etc. So, we also see worsening problems related to mental health concerns, depression, PTSD, anxiety, etc. We are seeing that people on opioids for long-term actually decline in functional improvement. The increased risk of falls, accidents, dry mouth with increased risk of dental disease, osteoporosis. And, we are actually saying there is an amazingly high incident of opioid use disorder. In one study this was over 40%. And sometimes it can be even higher than that we also worried quite a bit about the issue of over-sedation and respiratory depression.

Early on, and prescribing opioids there was a myth that patients took opioids as prescribed, they would not have a problem. But, now we find many years later that there are actually comorbidities that increase risks so that some patients taking opioids as prescribed will actually

overdose and have a significant risk of respiratory depression if they have sleep disorder, morbid obesity, snoring, older age. With people over age 70 having 5.4 times the risk of respiratory depression. If you stop opioids and go back onto them post-surgery, especially if there is upper abdominal thoracic surgery, increasing dose and other sedating drugs, etc. We see incidents of nicotine dependence in smoking. We also see that long acting opioids most double the risk of and cause mortality, even if people did not overdose.

This increased mortality was related to infection, cardiovascular disease, suicide and cancer, as well as overdose. And this was data obtained prior to COVID. Recent data in the COVID era is that patients on opioids who get COVID are at increased risk of complications. We also see that prescription opioid duration longer than 30 days was tied to an increased risk of new onset depression. And that family members who were living with people who had opioids prescribed were also at increased risk of overdose. We have known over the past years that fentanyl has now inserted itself into the illicit opioid availability and that illicit opioids are substantially more available than they had been 10 years ago. And, that a fatal dose of fentanyl is quite small. It is 500 times more potent than morphine. 25-50 times more potent than heroin.

Car fentanyl is 10,000 times more stronger than morphine and overdose with fentanyl may occur in seconds or minutes in response to usual locks and doses may be inadequate. We have also seen, unfortunately that it being admitted to a hospital with an overdose did not necessarily mean that patients-opioids were changed. In one study, 91% of patients prescribed were re-prescribed opioids after a nonfatal overdose. At two years after that, the cumulative incidence of repeat overdose was 17%. Especially, for patients receiving high doses, 15% for those receiving moderate dosages and 9% for those receiving low doses. Because of the untreated opioid use disorder that has been present in many of these patients who overdose, even when discharged home and not on opioids, but not on treatment for Opioid Use Disorder there was an 8% risk of repeat overdose.

We also saw increased death rates due to cardiovascular disease, infection, cancer, suicide, as well as overdose. When patients were discharged on medications used to address opioid dependence, the death rate dramatically decreased. We always wonder with Opioid Use Disorder, and once again this very briefly defined his continued use of opioids despite the fact that it has become clearly harmful to the individual. Taking more or for longer than intended. Spending a lot of time obtaining, using or recovering from use. Giving it up or reducing important social, occupational or recreational activities. Persistent desire for or being able to cut down, craving, failure to fulfill major obligations, continued to use despite social or interpersonal problems, continued to use and physically hazardous situations, continued to use despite knowledge or even withdrawal.

Tolerance and withdrawal do have consequences, even if prescribed opioids. Whether you include that were not in your criteria for diagnosing Opioid Use Disorder, the implication of tolerance and withdrawal cannot be overlooked. Many people have looked at whether this

complex dependence, the inability to stop opioids despite knowing they are harmful, even if prescribed has led to something that people sometimes call a distinction without a difference. Because, having patients who are dependent on opioids stop opioids, even when we explain to them how harmful they are is not as easy as people once thought.

So, whether or not you call it an addiction, dependence, or serious consequence of long-term pain treatment requires consideration when deciding whether to embark on long-term opioid therapy. This is really an issue that needs to be addressed because we know there are brain changes when the brain is exposed to long-term opioids. Whether they are prescribed or illicit. These brain changes occur after a fairly brief period of time and can occur after weeks or months. They can occur in over 40% of patients. They can occur even after acute use, especially in vulnerable populations. And those vulnerable populations may have everything to do with things the patient has no way to change. Patients under 30, patients with a family history of substance use disorder, as well as a personal history. Family or personal history of mental health problems. And totality is extremely high with untreated OUD.

Once again, untreated OUD doesn't justly do mortality due to overdose. It can also lead to mortality do to cardiovascular disease, cancer, infectious diseases, and this is the COVID information. I think a colleague for use of this light. When you cease using opioids and you are dependent upon it, it leads to a long series of symptoms, including worsening pain and depression and emotional dysregulation that makes pain care more difficult. Mental health care is more difficult. And treating opioid use is very difficult when we have tried to taper and discontinue opioids to people who have become dependent upon them.

Just a few years ago there was actually the first controlled study looking at patients given opioids for back pain versus patients who were treated without opioid for back pain. Opioid therapy with non-opioid medications did not result in better pain related function over 12 months. It actually resulted in worsening pain intensity. And farmer medication related adverse symptoms occurred then non-opioid medications. While opioids may have provided us with some help when used acutely for a brief period of time, while other modalities are being added long-term efficacy for many of the chronic problems we see has not been demonstrated, and in fact they have been demonstrated to make symptoms worse. Even over short-term, we are starting to see that. Postoperatively many people are experiencing better pain control without excessive use of opioids and even for acute pain care. We are not seeing worsening pain outcomes when we minimize or avoid opioid altogether.

We also know that 21st-century life is not really good for many of our chronic pain problems. In the COVID area it will be worse with sitting long periods a day in front of computers hunched over without adequate exercise. So, some of those lifestyle changes are going to need to be incorporated into every single patient we see with chronic pain, whatever that pain is due to. But especially those with back pain.

Thinking about pain care, Einstein was right. If you always do what you always did, you will always get what you always got. Our decades of using

opioids have come to an end and we have much better options right now that we need to be thinking about. Everything should be made as simple as possible, but not simpler. This is a quip I use with patients, effective pain care equals MC squared. It equals movement options and cognitive approaches. It includes our behavioral cognitive approaches. The others are the cognitive approaches that help in terms of brain neural plasticity. Which, we are learning more and more about. Add TLC to that, treating comorbidities and lifestyle counseling and we see that we have a combination that makes a big difference when we treat every patient with pain. Even when we use other medications and procedures. If the medicines and procedures are adjunct to care and not our cognitive and movement approaches to pain.

What about when patients are on opioids? This comes from an article about opioid tapering. What happens when a decision is made that the risk exceed the benefit of opioids and patients are already on opioids, further prescribed or taken from a previous stash, whether borrowed from a friend or family member, or taken illicitly? The first thing is to identify the social, emotional and health factors that will impact patients tapering. If you are going to taper opioids, this is a more complex situation than just taper. Identify the roadblocks you will have to taper.

Patients are fearful of tapering. Frequently, they have tried to do so and have been unsuccessful. What are those fears? Acknowledge them and address them and make sure that you also address the fear of abandonment. Only propose tapering when you believe it is in the patient's best interest. Tell people what to expect when tapering. And help them identify right up front the strategies to manage this. Because there is going to have to be an upfront admission that there are going to be bumps in the road. That is just what life is about and what tapering is about. But, they are manageable. And individual tapering plans with provisions for making adjustments based on patient responses. And assess for development of opioid use disorder a dependence that may make tapering risky, and a switch to Buprenorphine, 21 or Naltrexone your first choice.

We also see that there are common protracted withdrawal symptoms common in patients with pain. We know that withdrawal symptoms from opioid tapering don't just occur during the taper but can last for months following the taper. This is called protracted withdrawal. Anxiety, sleeping difficulties, problems with short-term memory, persistent fatigue, difficulty concentrating and making decisions. People finding this quite frustrating. This is probably the thing people complain to me the most about. They have other drug cravings and alcohol being more available. We will see switches to alcohol. There is impaired executive control. Just the ability to get through the day. People have difficulty focusing on tasks. There is depression and irritability, which doesn't make life easy if you are quarantined or with limited outside activity with others. There will be unexplained physical complaints, reduced interest in sex, etc.

We have realized that especially with Opioid Use Disorder these medications we use treating Opioid Use Disorder are not what used to be called medication-assisted treatments. These medications for Opioid Use

Disorder are actually really primary. We will talk more about that today. We call them medication for addiction treatment. MAT is the acronym. Over the long haul this saves everybody money and reduces cravings and withdrawal and stabilize and improves function. It improves treatment and has outcomes for not just Opioid Use Disorder, but medical, mental health and substance abuse problems. It decreases emergency room visits, hospitalizations, risks of suicide and overdose, as well.

When we talk about MAT we will talk about methadone. I will talk less about that than other modalities. Methadone is really only to be prescribed in opioid treatment programs. These are federally regulated, and they usually dispense daily in the clinic. There is a higher risk then Naltrexone or Buprenorphine. It has multiple drug interactions and can have an impact on heart rhythm. The dose is best split. However, in the clinic especially early on in treatment is usually dosed once daily. And some people it has been associated with an increased symptom due to hyperalgesia. Naltrexone injected once monthly can be prescribed in any clinical setting. But patients must be opioid free for at least one week for oral and more often than that, it should be a month. I would recommend more a month than a week.

Buprenorphine/Naloxone can be more helpful here, in that it is available in a lot of different options. It can be given sublingually as well as a monthly injection. It has a much better side effect profile over methadone. There is an analgesic impact that can be substantial when the dose is split 2-3 times a day. When taken sublingually,

Naloxone is used to prevent abuse by intravenous injections. Medical management of Buprenorphine/Naloxone, meaning medication with brief, patient centered counseling in primary care, these outcomes are similar to or better than in addiction settings for patients dependent on prescription opioids and unable to taper off. And, for those with mild to moderate disease. It is important for us to understand that frequently for patients with pain this may be our first choice if we had decided the patient has Opioid Use Disorder, or complex dependence and unable to taper.

There are a lot of myths and realities about MAT. Let's talk about them. Especially related to Buprenorphine. There is a myth that Buprenorphine is more dangerous than other chronic disease management. That is actually not the case. Buprenorphine is infinitely simpler than many other routine treatments in primary care, such as titrating insulin or starting anticoagulation's. I can tell you it is infinitely easier than managing diabetes. Another mess, use of Buprenorphine is simply a replacement addiction. Addiction is defined as compulsively using a drug despite harm. Taking a prescribed medication to manage chronic illness does not meet that definition. Myth, detoxification for opioid use disorder is affected. We have found it is not effective. There is no data showing detox alone is helpful. Actually, these interventions may increase the likelihood of overdose by eliminating tolerance. Then, when the patient goes back to taking what they thought was a safe dose their ability to tolerate that has markedly diminished. Myth, prescribing Buprenorphine is time-consuming and burdensome. And treating patients with stabilize can be rewarding and is actually not time-consuming. It allows you time to

deal with other problems in the clinic setting. We even have an office in the options and intensive behavior therapy. They are not necessarily needed for effective treatment, however. We have combinations of at-home induction or initiation in the clinic then, follow-up at home. It really is quite efficient. Myth, reducing opioid prescribing along will reduce overdose deaths. That has not happened. Despite decreasing opioid prescribing, overdose mortality had still increased as of a few years ago. Patients may shift to drug markets where the risk of overdose is higher.

There are a lot of advantages of adding MAT for patients with OUD and pain. It decreases overdose. It addresses these protracted withdrawal symptoms we have been discussing. It disgraces treatment retention for all problems and is cost-effective. It decreases the total cost of care even with name brand products. Tapering these with Opioid Use Disorder can result in destabilization, unless dependence is addressed. It can read else in a relapse of approximately 90% of the time. Even with intensive, positive approaches when it occurs without medication.

For patients taking Buprenorphine/Naloxone for treatment of Opioid Use Disorder, the doses frequency and the analgesic properties of these medications may be effective for managing pain. There are options available for pain management acutely while addressing the opioid management. For chronic pain, stabilizing Buprenorphine and splitting the dose can be helpful and the cognitive approach or use of pain. Patients taking methadone for treatment of Opioid Use Disorder require additional [Indiscernible] adding the short acting agonist opioid analgesic can be considered to manage acute pain but it also increases the risk and the locks and will be critical in that setting. The anticipation is high as the analgesic in individuals but once again the increase, even though possible, make sure patients have naloxone and maximize the non-opioid doses for pain.

For those receiving Buprenorphine for opioid abuse disorder may require additional [Indiscernible] and benefit as needed the doses of opioid and morphine over time. If you split the dose and it is inadequate you may be able to increase that dose to a slightly higher dose. It is safely easy up to 20 formulas of milligrams a day during that acute period of time. Once again maximizing the non-opioid options for pain. It used to be felt that you had to stop the Buprenorphine but this is been found not to be the case and infinitely safe to continue Buprenorphine even during the acute pain flare. You can add a short acting coagulant in a supervised setting of the hospitalization especially. It is anticipated to be high for analgesic due to a lack of evidence.

The committee that put these guidelines together was unable to come up to a consensus whether it could be safely prescribed in the ambulatory setting. It's mostly used to address in a setting where not splitting the dose for a higher dose of Dr. Robeck or -- Buprenorphine or adding a non-opioid option that is proven effective. It is not a one thought mandatory requirement and the high potency inconvenience with it turns out it's much more difficult to continue the medication in the perioperative late and analgesia and finding a way to treat the pain with opioid use disorder is possible and effective. It is adjusting the dose of

Buprenorphine made on an individual basis by the team and treatment provider whenever possible. If it is decided that the Buprenorphine should be discontinued, it may occur the day before the day of surgery. Higher potency can be used perioperative late and when the need for opioid analgesia has resolved with consideration for postoperative pain management and the initial dose and try Titration -- Titration should typically be determined by the prescriber. In general, it can be resumed if help for less than two or three days. The patients on L tracks on may not respond in the usual manner so it is recommended that mild pain be treated with not opioid uses and moderate with treatment on a short-term basis and discontinued 24 hours before surgery on Naltrexone and for extended use after surgery. In these incidents, patient should be closely monitored in an emergency or hospital setting.

How does a patient or their support system manage overdose risk? Do you train loved ones on the locks own administration and absolutely. There is a time period after dosing for Naloxone for pain and must be aware that the over dough -- overdose risk is higher. I view Naloxone is what I call my trifecta. Whenever I prescribed Naloxone it is opportunity to reinforce to the patient the risk associated with opioid and overdose. When you say your patient, your risk at overdose and you do nothing about it, that has a very different level of meeting than when you say to a patient that you are at risk of overdose. I feel so strongly about that even though we are continuing opioids for now, I am going to give you an antidote for that and you need to let everybody that you have close contact with know about this. That is the first trifecta.

The number two on part of the trifecta is that you have now given the patient something that may save their life. Number three, every single time, 100% of the time I encourage the patient to have their friends and family members understand about this. With the loosening up of telehealth, this is actually easier than it used to be. A number of years ago those people had to come into the clinic in order to demonstrate. But now we can do that on telehealth demonstration for anybody that the patient feels is important to have one. That is 100% of the time this is really going to be very, very important. I find that even when you have patience in treatment, what happens is unpredictable. Even in treatment I make sure that the patient has active Naloxone and have the family and friends know how to use it. Low-dose Naltrexone is another presentation that we should be doing and upcoming presentations. There is ongoing data about low-dosage Naltrexone and for fibromyalgia and acute pain situations. That data is becoming more impressive and worth certainly another presentation. We will talk to Chris about getting that as part of the upcoming pain calls.

So, Naloxone should be administered in the effective use against overdose and can be used for pregnant women in the case where it is used to save the mother's life and overdose. It can be used in leaving incarceration and family members and significant others to be given prescriptions for Naloxone and should be trained in the use of Naloxone and overdose. If you go to Google map and type in on Google map, when naloxone is available it will show you where it is available in the pharmacies. The last I looked it was available without prescription in 46 states.

Concerns related to opioid safety may be heightened during the COVID pandemic. There are added risks related to increased stressors, risk of patients on opioids developing COVID in a risk of disruption of medication. For patients with pain who are on opioids, have used opioids in the past, and at risk of utilizing illicit opioids, opioids needs to be a part of the pain care.

Let's go back to our case. We have another 10 minutes or so before we take our break. At this period of time we are open for all questions, all statements, all comments as well as the session in our case.

A 35-year-old male requests a telehealth visit due to worsening back pain. He is currently on oxycodone and not opioid therapies, have not given him pain care in the past, and concerned because his doses escalated with 30 milligrams every six hours. 120 milligrams daily of oxycodone, 120+60 is a 180 morphine equivalent. He has now taken 10 milligrams every six hours increasing in March when his pain started to flare. He now wants a higher dose. What other questions would you need answered and how do you proceed at this time?

We are now open for comments, questions or anything talking about this case. Are there any thoughts? I see that some people are typing.

While we are waiting for everyone to type, I can make a couple of comments about this case. What we are seeing is that with much of what is going on, the increased computer use, increased stressors, and were also seeing increases in pain, especially back pain and other problems. Asking about pain, is really an important part of our day-to-day care.

Use assessments in care point to understand risk, absolutely. And that is a risk of opioid overdose. And I think what we want to do is to be able to use these things and there are other things, especially, that the VA has and the DOD has in terms of other workups, but these are tools to help you understand. I use the universal precaution approach and assume every patient on opioid is at risk. I assume that every patient on opioids may or may not be taking the dose that I think they are taking. I always approach every patient that I see on opioids with precaution. I find we can use these tools as a way to better educate patients. I also think that in this day and age in 2020 when we know all of the opioid risk, that anyone that remains on long-term opioids for a high dose, than short-term opioid therapy should get overdose education in naloxone. I think these are hugely important tools, especially in terms of patient education. In my mind they should not be used solely as a determinate of risk. If there is a high risk there, it helps, but if patients at low risk also over this. We want to evaluate the back pain. What is causing that back pain? What has been going on with this patient?

Now we find out that the patient, starting in March, and given up their previous exercise regimen. They stopped going to the occasional PT and stop doing their PT. They spend more time at the computer, and in a much more stressful situation related to many of the things they used to do to de-stress. They have not actively put back on their agenda. Evaluating back pain is important but does not necessarily mean that we need to actually immediately get an x-ray. If we don't have symptoms of localized

pain, the patient has more diffused pain, and also does not have any red flags such as fever or any loss of function. We can do that a valuation with good questioning and even a better virtual exam for we ask the patient certain maneuvers, and able to walk, watching the patient walk and see if they can show us where they have tenderness. That is why we are waiting for the patient to feel comfortable in order to be able to come back into the clinical setting.

In addition, when we start to see the escalating dose of opioids, is it due to the opioid use disorder, opioid dependent or hyperalgesia. We see a combination of a situation here where the patient had a regimen that was working better than the current regimen but right now it has -- its plans and what he was previously doing had been abandoned in the middle of the pandemic. That was with the perception he did not have time for them and lack of understanding about prolonged sitting at a computer does for back pain here perhaps a little bit of eating with some people gaining weight. Ask about weight changes during the pandemic. Also, how the rest of his family's doing. What are the other stressors going on in his family? He has a wife, to make children at home, older parents that he is concerned about. All of these things put together in order to be able to explain the exacerbation of his pain and we want to make sure that while we are going to try to do this virtually at the patient request, and we can do it virtually, but we will let the patient know about the red flags. We want to know about this and will want to bring that patient back into the clinic for an evaluation face-to-face.

We will potentially comment that occurs, into up with the situation in which we have a hybrid approach of really carefully picking our face-to-face visits and then doing a lot of our follow-up by virtual visit. Are there any other comments or questions before we go to the break? We will be seeing this patient again during the rest of this presentation. We will have plenty more chances to be able to talk about this patient in the second and third hour as well. Think about any of your thoughts that you want related to this patient.

For now, we are going to get a 15-minute break. I'm going to start precisely at 2:00. Be back immediately on time, and we will see you then.

[The event is on a recess. The session will reconvene at 2:00. Captioner on standby]

We are waiting for people to join us. Make a couple of comments about virtual care during a large portion of my career with the VA. I saw many patients virtually and found that when thinking a little outside of the box there are many things we can do virtually that are really very helpful in terms of evaluating that patient. In that it is possible to really pick and choose the times we truly need to see that patient face-to-face.

There's a lot you can do in terms of looking by history, in terms of assessing back pain. As I said, in terms of looking for localized features and other red flags. Also, in terms of having that patient stand up and being able to move from side to side and look at what happens if they been down or other activities that worsen the back pain. So, it's

really, why we feel more comfortable with the face-to-face visit, frequently there's a lot we can do virtually. For many patients having the option for a virtual visit will decrease the time from the onset of symptoms to when they are willing to see you.

Lastly, keep in mind that many patients have a lot of obligations right now. They have limited childcare and other obligations at home. They have a lot of commitments. You want to see people when you need to see them face-to-face, but you want to make sure to keep the bridge to care open. You want to maximize your face-to-face visits in terms of what you can get accomplished each visit. But also maximize the amount of time you can spend virtually. Because you will find that patients find this extremely helpful. You also get a chance to see what their environment is like, how they are sitting at the computer, how they are functioning in their house. Do they work from home or do they have the space to work from home? What is the noise level? You get a chance to meet with family members in a way that you cannot easily do in the office environment.

I do think it is important for us to look at some of the advantages of some of these virtual visits that are not actually there and available to us in between. That is in a face-to-face visit.

So, do you do face-to-face quarterly and virtual visits in between? I'm not sure you could make a statement as to exactly what you will do weigh-in and I think it all needs to be individualized depending on the patient and the situation of the patient.

I want to do a sound check before our 2:00, and can you hear me? Sound check, can someone let me know?

We got it, okay. All right. We have one more minute. I think the concept of individualizing your visit is really important. You may find that for some patients they are going to need to be seen face-to-face, no way around it. With other patient you can do more virtually than with face-to-face I think you need to make decisions based upon your situation, the patient situation, and at what crossroads you find yourself at with each of your visits.

It is now 2:00. We will get started.

Coming up with a well done task force on addressing addiction and substance abuse disorder with ASAM during the pandemic and I think this is a good time to talk about this. Let's go back to our patient. This is where we talk about this at the end. It is attempts to taper the patient with naloxone unsuccessful despite mortality and you are considering naloxone therapy, what do you need to take into account and how is it perceived? Let's talk about this because this is very important for patients with Buprenorphine, for patients that are opioid dependent and unable to taper, develop Opioid Use Disorder or have a history of Opioid Use Disorder and show up with declining function. It is a life-sustaining medication an important in terms of being life-sustaining and cannot be over emphasized.

Abrupt discontinuation can lead to relapse and overdose death and also continuation of opioids in the opioid dependent patient. We also need to remember that anxiety and stress with COVID has been unprecedented. The differences in opinion in the societal response is added to the stress. We don't want to talk about right or wrong approaches but just understand we have many differences of opinion. That can exacerbate symptoms of Opioid Use Disorder. In addition, while stay-at-home orders are declining, they still have restrictions on how people can get out of the house. The restrictions on border crossings could reduce the drug supply and need for treatment and also the request for treatment. Someone that thought they were sustaining themselves with their usual non-pharmaceutical stash may find that their sources for that are declining. It could be opportunity for help, with treatment. Every effort should be made to ensure the patient currently taking Buprenorphine have timely access to refills of the medication and that any new patient in need of treatment for opioid use disorder can initiate treatment in a timely manner.

This is a fabulous time to take online training if you're not already there. It's easy to do and to provide you with the way to make sure that your patient has access to the life-sustaining medication. Once again, a lot of this presentation at this time is going to come from the ASAM guidelines and they are fabulous. I want to serve this as a vehicle for reviewing these guidelines right now. What happens upon reopening your clinic and reopening in general?

This pandemic is not over. We see different ways in different parts of the country within places that did not have high into these before. We see some areas that have been decreasing but persisting cases. So, we want to make sure that we make sure that we are available to patients that have been on opioids. You really also need to keep strong policies, procedures and precautions related to COVID in your clinic. Do not assume that if you're good now in terms of COVID that you will be good tomorrow, the next day, or next week. We have a lot of variables in terms of what to expect within your community. The universal precaution approach to COVID is going to be very important. Programs and providers need to maintain or implement an incident command structure to prepare for and address any issues that arise due to COVID in your clinic. Review current infection control processes and assess what worked well and your initial response and where there may be room for improvement, updating related policies and procedures as needed.

This is a fluid, ongoing process. Can you provide online training information for us to complete the training? I don't know if you mean this training, but if you are talking about the training for getting the X waiver, I would recommend the website pcssnow.org. They have completely online trainings to enable you to get X flavored and they have virtual training to allow you to get X flavors as well. You want to assess your program and practices, potential needs related to your own need for PPE and other supplies needed to control and mitigate the spread. How about staff training and staff support, what technology do you need to support telehealth. The addressing of the faces of the epidemic and how to prepare for the next stages within your community. Telemedicine or

telephonic visits to be used whenever possible and appropriate to provide Buprenorphine treatment to patients and it could mean the entire Buprenorphine is virtual or the initial is face-to-face with the rest being virtual or intermittent face-to-face with intermittent virtual. Once again, this is very much a case-by-case individualized treatment.

Typically, prescriptions for controlled substance must be predicated on in-person medical evaluation, but a lot of that has been relaxed. There are policymakers that enabled exceptions. This is been going on for the past few months. As of March 15, sanctions and penalties have been temporarily waived for health care providers that do not comply with certain provisions with the HIPAA privacy rule which may enable the use of non-HIPAA compliant telemedicine applications that are widely available such as face time and Skype. This is changing all the time so you have to keep in touch. What are the rules and regulations? And not only federally but also in your state. Telemedicine communication conducted using an audiovisual real-time two-way interactive communication system is preferred. But if you don't have all the time telephone-based visits may also be considered. Some patients may not have the technical capabilities available for video visits, especially those in rural areas or those that don't have the money for the updated smartphones, tablets or computers.

Disabled patients, the risk of in-person visits likely to outweigh the benefit of in-person visits. And especially if COVID is spiking in your area. Patients who are unstable or do not have reliable access to a telephone may still benefit from in-person visits. Providers and programs should consider infection mitigation strategies for all inpatient visits and in-person visits.

What if you decide that you're going to use the buprenorphine induction at home? It's not meant to be a Bible, by any means, but more to demonstrate for everybody that there are guidelines for home use induction going on for years now.

I advise you to keep an eye on them. They are available on the ASAM website and available in many different resources, and resources are constantly being updated, and change, and improve over time. If you're thinking of inducing a patient you want to, before the first dose, make sure the patient is in withdrawal and they need at least three of the following; restlessness, twitching, tremors, shaking, enlarged pupils, bad Childers wedding, heavy yawning, joint and bone aches, running nose, tears in your eyes, gooseflesh or goose bumps, cramps, nausea, vomiting or diarrhea. You want to give them a handout. Let's say you decided to induce. Once again, this is not meant to be your Bible. It is meant to show you a possible induction schedule on day one, take 4 milligrams of buprenorphine. Patients on multiple medications or morbidity or those with a complex dependent despite lower opioid doses may not need to start at 4 but may do better him lower doses which we have found to be the case. While many patients if not most started at 4, some may need to start at 2. Put the pillow under your tongue and wait one hour. If you feel fine, you're good at that point but if not and you continue with withdrawal symptoms take a second dose under your tongue. Once again,

it's important to understand that this is more of a reminder that these protocols exist and can be individualized for patients.

The X waiver is a onetime training, and it gives you information on getting your ex waiver. Call your provider and office staff to check in and wait one or two hours if you feel fine and do not take more medicine if you continue to have withdrawals, take the third dose under your tongue. Call your provider office staff and check in. Wait one or two hours and do not take any more medication if you feel fine. You can continue with your diet -- withdrawal dose and take the full dose on day one. For example, if your daily dose on day one is 8 milligrams and if you feel fine, take 8 milligrams and that two. If you feel strong withdrawal symptoms start with 12 milligrams in the morning and later in the day see how you feel. If you feel okay don't take more but if you feel the withdrawal take another number four milligrams. This is based on how the patient feels. If you feel good at end of day two, repeat the dose on day two back in if more than eight milligrams but the dose on a morning and afternoon dose, especially for patients that have chronic pain problems.

If you feel too tired, groggy or over sedated take a lower dose on day three. While we want to make sure that we don't over medicate the patients, there is a safety here that by monitoring the fatigue and grogginess we don't get in the same risk as we do with respiratory difficulty with [Indiscernible]. If you still feel withdrawal and that two, you can take that same daily dosage on day 2+ another number four milligram dose and see how you feel is the day goes on. If you have withdrawal symptoms you can take another dose but most patients will stabilize by day three. But it demonstrates the quality related to this that can be individualized. Once you have the patient stabilized, what about prescriptions and refills?

Providing refills without requiring in-person visits is another strategy for risking exposure of COVID-19 and give the safe dosage of buprenorphine. The benefit of providing refills is greater given the risk of severe other offense like fatal overdoses which are uncommon for this recommendation. The CDC recommends that individuals maintain a two would supply of a helpful plan of action in case of illness in the house so, disruption of daily activities, and also distancing including limiting exposure to groups of people larger than 10 is key to reducing the spread of COVID-19. We want to make sure we intertwine with our treatment that we also remind patients that the importance of wearing the mask, importance in social distancing, and importance for washing hands and avoiding crowds.

There is released guidance from SAMHSA to facilitate week prescribing controlled substances including buprenorphine without an in-person medical evacuation during this medical health emergency. There is a separate registration requirement across state lines by the DEA so be careful about what is an active rule and regulation in the patient population that you're working with. And the exception applies to prescription of controlled substances be a telehealth medicine and the temporary exception with DA that says you may prescribe controlled substances to patients via telemedicine and states in which they are not

registered with the DEA but you need to check with the facility that you're working in, the organization you're working for, as well as your state and federal laws to understand what you can and cannot do.

Buprenorphine prescribers typically provide one to four-week prescription for sublingual buprenorphine/naloxone formulations for the patient with Opioid Use Disorder. As prescribers respond to recommendations for decreased in-person, face-to-face visits and other CDC COVID-19 guidance and ASAM recommends a thoughtful approach to changing buprenorphine and prescribing to ensure three goals. Make sure they let you know if they run out of medicine. Even if they took more than prescribed because you have to figure out why they take more than is prescribed. Are they diverting? Which takes you into one direction or under dosing? Which would take you in another direction. You want to protect the safety of the patient as well as their families. Minimize unintended exposure to buprenorphine, especially with children and pets. Provide buprenorphine refills to stable patients without requiring in-person visits or urine toxicology testing.

It does not mean if your antenna and red flags are up that you don't do a drug screen. It means for patients that are otherwise doing well you will have to individualize what your requirements are to continue buprenorphine. The benefit of buprenorphine for fairly stable, the approach is very high, so we want to make it as easy as possible during that period of crisis. While diversion of buprenorphine happens, the use of buprenorphine is often lower and often occurs with people self-treating with the drug and it does not mean that we want to abandon all attempts of understanding whether there is diversion and act on it but it means that there is a little bit of leeway here as we treat patients during the current period of time where we have this unpredictable relaxing and waning of COVID cases.

What about buprenorphine and Opioid Use Disorder?

Ask the following questions, does the patient belong to a high-risk group with severe COVID-19 illness and due to age or underlying health conditions as outlined by the CDC? That would mean you would bend over even further to accommodate virtual care. Is the patient under quarantine or isolation, either due to symptoms or concerning confirmed positive? Once again, those are the patients that you will bend over backward for virtual care. What capability does the patient have to safely and securely store different quantities of buprenorphine/naloxone without access to safe storage? Less medication may be preferable. What about the following: who has potential access to medications in the home, including children, heads of household, and neighbors?

While buprenorphine is associated with relatively less respiratory depression risk compared with methadone, opioid naive individuals like children who can be harmed from unexpected exposure. You really want to make sure that you hammer home the point that this medication, while safer than co-agonist that it needs to be stored safely. You never know at what point the patient may be tempted or start to use opioids even though on buprenorphine. We know the data says they will do better on buprenorphine that there will be patients, especially during these

stressful times and whom they may go back to the opioid. You want to make sure they have the overdose education with naloxone and a warning not to do that as well.

How stable is the patient Opioid Use Disorder and/or other substance use disorders if present?

Less medication or more frequent monitoring by telehealth or audio only check and may be preferable for patients at high risk of overdose due to co-occurring alcohol or sedative hypnotic misuse. It was preferable to prescribed things but unfortunately you may end up with the situation with the patient at high risk for COVID that is also at high risk related to their Substance Use Disorder.

I really also want everybody to understand the issues related to cycle social treatment. And the best of all worlds we would love psychosocial treatment for patients. But the patient reluctant or resistant to psychosocial treatment or inability to deliver psychosocial treatment early on should not dissuade from medication therapy.

We are going to be talking with more and more detail about the recent release national practice guidelines with ASAM. That is the treatment of Opioid Use Disorder but I want to emphasize here that the statement that a patient decision to decline psychosocial treatment or in the absence of available psychosocial treatment should not preclude or delay pharmaceutical therapy with appropriate medication management.

We would not preclude the use of insulin in a diabetic, and not ready or able to follow the diet or exercise program. We would continue to work with that patient for behavior modification, diet and exercise program while we give them a life-saving medication. Likewise, we want to give buprenorphine/naloxone to patients with Opioid Use Disorder and overtime their ability to function with psychosocial treatment will improve.

This guidance is even more applicable right now in patients that need to self-quarantine or have other risk factors that lead them to want to minimize external interaction. While some patients are likely to benefit from psychosocial counseling depending on their specific conditions and scenarios, we've actually had multiple randomized trials that found enhanced psychosocial counseling provided no additional benefit than typical medical management that occurs during routine office-based visits for many patients. So, it's important to understand that we no longer are calling it medication-assisted treatment. This is medication for addiction treatment.

For some, maintaining access to a place of treatment during times of anxiety and stress may be important for preventing substance use and minimizing patient mental health risk. We want to make sure it is always offered and offered in an individualized way to the patients. Offered in a way that makes sense for them. That's even if we don't require it. Individual therapy when needed may be continued through telehealth when possible, by the group therapy with a licensed therapist. We can create seeking safety programs, and a variety of ways in which we can awful -- also utilize virtual support groups with virtual support programs and

other virtual support groups that offer support during this period of time.

Consider what therapies are possible to convert to virtual platform and limit physical in-person groups to no more than 10 individuals. Preferably it's in a large room where social distancing of six feet between individuals is possible. Consider longer duration prescriptions as safe and appropriate to minimize community exposure retrieving prescriptions from pharmacies. Consider appropriateness of prescriptions-by-mail. We now need to make sure we allow time for any possible delay.

Consider assigning a staff member to routinely follow up with patients to ensure they are able to obtain their refills on time. Case management is becoming increasingly important in this situation. Frequently it can provide a probable insight into the patient needs. I found that when I had a case manager during virtual case management work that frequently the patient was more than willing to disclose things to that case manager, that they were less likely to disclosed to me. Case management can be lifesaving. Again, the stress, it cannot be underestimated or overestimated. We want to ask about anxiety and stress associated with this pandemic, and we want to be able to normalize it, and also view that it is manageable and provide stress-related alternatives to patients rather than medication only alternatives.

Ensure patients access to naloxone and make sure they get education on naloxone and make sure it's updated and always ask if it has been used. Patients may have difficulty accepting or opioid time due to quarantine status as individuals and they have been relying on opioids from many sources. We may find them to be less tolerant than they thought they were. Highlight the importance of having naloxone on hand and also re-warned them that first responders now have other responsibilities that are far greater than existed at the beginning or before the pandemic.

They cannot rely on first responders getting there the way that they did a year ago. So, the naloxone becomes even more important. Also, keep in mind the growing list of comorbidities associated with increased risk of COVID. That's at risk of changing on the CDC website and other websites that has this list actively growing. That's the Mayo Clinic, Johns Hopkins and the CDC, they all have increasing levels of concern related to age, people 65 and older. Heart problems, lung disease, immunity compromise, obesity, and also women that are pregnant need to be monitored very carefully. We will talk a little bit about pregnant women because they actually have a far increased risk of needing hospitalization than women not pregnant.

High risk patient should continue to have access to appropriate addiction treatment. It is going to have to be a mixed bag of face-to-face and telehealth. Consider risk further and ability to access telehealth services and risk, history of telehealth services and consider prescriptions beyond the usual practice to allow for fewer person-to-person encounters. This cannot be discussed often enough. You're going to have to individualize what happens in terms of prescriptions. But you can actually increase your ability to interact with patients by increasing phone calls, increased case management, increased-telehealth visits.

That is compared to what we used to have with just face-to-face visits alone.

Telehealth can benefit us in many ways. It promotes the practices social distancing to reduce spread, shifting visits and initial patient evaluation to a modality that does not require in-person or face-to-face visits. It allows monitoring of patients to identify potential and confirmed cases and enables quarantine clinicians to safely treat patients.

What if you have been exposed and can no longer come to the clinic but you are perfectly capable of working?

Then you can participate in these virtual visits. Once again, I've seen that virtual visits enable us to know the patients better, follow-up more frequently, and also get access to patients that may live in rural areas. It reduces the risk of spreading high-volume traffic areas such as waiting rooms, emergency rooms, and enables clinicians to continue patient engagement while reducing potential for exposure. It reduces the likelihood of patients participating in activities to risk exposure like public transportation to attend an appointment here……

It creates the family support structure for you and the patient. And allows you to look at the surroundings. Patients may be more comfortable and better able to carry on difficult conversations at home. It allows you to see the patient even if they are filling you for any reason.

Let's go back to our case discussion. We now have about 15 minutes for any further comments, questions. What do we want to do about this case?

Remember, this is our 35-year-old patient who has escalated use of opioids and is now on 160 milligram equivalent of morphine every day. Attempts to taper the patient's oxycodone are unsuccessful. You have concerns he has developed OUD and are considering Buprenorphine/Naloxone therapy. What considerations do you need to take into account now? And how would you proceed?

Any comments that people want to make? Any questions or discussion about this case? Since it is quite obvious today, you will have to listen to me for another 15 minutes. Otherwise, I am happy to hear from you.

This patient shows many concerns related to the development of 11. He has escalated his dose and is unable to decrease his dose even though it is not really helping him very much. So, in our conversations with this patient it is easy for us to show the patient it is not working. As we attempt to taper the patient our conversations will revolve around some of the symptoms related to why he is unable to taper.

So, this patient is unable to taper because when he tries to lower the dose, even by 5% he develops symptoms related to difficulty sleeping, irritability, intermittent worsening pain and fogginess. This patient works and has been able to work mostly virtually but, he is responsible for a lot of computer related activities. He just can't focus. He just feels like if given a simple task as he is trying to taper his opioids,

things don't work. He feels he is in quicksand and can't really think through a problem. This is a very, very common symptom with this kind of dependence.

He is unable to function with a lower opioid dose. He does agree it is not really helping and he doesn't think a higher dose will help for very long. But, he is unable to function. You also find out that the reason he is up to 30 milligrams four times a day when he has only been prescribed 10 milligrams four times a day is that he has kept a stash of oxycodone over the years for fear that he would not have oxycodone should he want it or need it. After careful questioning, there is not a lot of evidence this is being diverted. It is all being utilized by him. Also, you wonder what is going on in the family.

Here is a fabulous opportunity to engage the family. So, if you ask the patient's permission to talk to his wife. His wife is more than happy to agree and comes onto the call with you. She says that even on the higher dose oxycodone he is not functioning at all. He is not sleeping well. He is extremely irritable. The children are afraid to interact with him for fear of what he will say and what he will do. He is a person with a very short fuse and living in the house has become unbearable. They have no idea whether or not he is going to even show up to a male even though he lives in the house. The unpredictability of his personality has become worrisome to her. She is extremely happy that he is getting help. She is very concerned that he has developed Opioid Use Disorder. She has been reading about it and feels like he has lost control. That is where we are now.

Any other questions or comments people want to make about this particular case, or anything else that I have presented during this segment of the discussion?

Is he seeking any psychiatric care?

That is a great question. No, he is not. He says I have never had any problems with my mood before I went on opioids. I have no family history of problems. I just know that right now I feel like all of this is related to my difficulty on this medication. So, he is not seeking any psychiatric care. He is actually resisting psychiatric care.

Is he willing to speak with a psychologist or a family counselor?

He hesitates and his wife jumps in and says, please, I hope we can get a family counselor or psychologist. If he is unwilling to talk to a family therapist or counselor, I would certainly like to. I am at my wits end. The patient then says, yes, I am willing to talk to somebody now. I can see how this has impacted my family more than I thought.

So, by having this virtual interaction with that three-way conversation between you, the patient, his wife, it is an aha moment for that patient and he basically now says, I had no idea this was impacting my family the way it was. I now feel even more so that I need to do something about this. Frequently, what happens when patients have developed an Opioid Use Disorder there is a clouding of the cognition.

So, there is a minimization of the impact of what is going on related to other people. That is what has happened in this situation. If we had to do a face-to-face visit and that wife could not come in, this realization would not have been as forthcoming. You now have in this visit the wife being able to communicate how bad things have become within the household. This is the first time he has really got this. This is the first time he has really understood that this is not just impacting him. It just impacting his wife. And the wife also let you know it is really impacting the kids, as well. So, this gives you a way to start the conversation about trying to get some of this cognitive care.

In my mind, this cognitive care is going to need to occur related to medication. To me, this is the time to start that conversation.
I see other people typing, so I want to be able to address what they are putting into the chat.

Here is what I would standardly say and do at this juncture. Once again, this is all related to motivational interviewing techniques and stating what is without judgment. So, the first thing you want to do is to make sure that as you are going through the process of getting everything together that you need that the patient has an updated naloxone prescription.

The first thing we will do is to make sure we address this patient's problem. We will say, I understand you are having back pain and I don't want to ignore that, but what is clear, is escalating the opioid dose is not a solution to that. Therefore, while I may not taper your opioid right now, and we will talk about other alternatives, we are going to add non-opioid options for your pain. Let's talk about what has worked in the past.

So, what he tells you is that in the past he was walking daily. He was practicing mindful meditation exercises, and he had an app for that. He was eating better. He had been placed on an anti-inflammatory diet, which he has abandoned during this epidemic. And he can recall things that were working for him. Medication wise he found that he did fairly well with nonmedical options. Different relaxation techniques. He did well with the physical therapy program and on an anti-inflammatory diet. He now realizes that he needs to get back on track with that. He did well with intermittent heat. He actually had a unit that worked for him on-and-off. There are things that did work in the past and he had abandoned them. He is willing to go back to them.

Do we know if any other abuse substances are in use?

This is a really good question. These are fabulous questions, and I am glad we are getting them. The answer to that is, no he never used other substances before being placed on opioids. He didn't even use nicotine. But someone had given him an opioid in the past and it seemed to work. That sort of took over at that time. The opioid has been started and here is something really critical, this isn’t his first experience with opioids. It was when he was in his 20s. That seemed to start to cause problems for him.

Why is that critical here?

This guy has no other risk factors except opioids were started in his 20s. Now, we know that early initiation of opioid therapy in teens or 20s increases the risk for developing problems down the road. I want to talk about the other substance to ask about. It is nicotine. People that are nicotine dependent are more likely to develop worsening pain problems and problems related to Opioid Use Disorder. So, you want to always ask about nicotine because some people are going back to use of nicotine. We also know that nicotine and vaping also creates problems. You want to make sure you ask that question. It is great to make sure we don't have any other issues related to substitutes. And his wife corroborates that. He said, he is actually not using those substances. This has just been a problem with the opioids. In fact, it has been off and on since he has been in his 20s. It was under better control being able to utilize lower doses earlier. It has just gotten worse this year.

Has he ever been on stimulants for ADD or ADHD?

No, he has not. That is another thing to keep in mind. We really want to look at these past problems that may have been there that need to be addressed. In this particular situation, we have a gentleman whose opioid use disorder has developed and seems to be his big risk factor that it started early in his 20s. It has led to other problems down the road and has exacerbated during this stressful time right now.

Once again, since we are going to be talking to this patient quite regularly now, we have a way to call him and do virtual visits with him. We have his wife being an active participant in our call. We also have the ability in all of our treatment settings for secure messaging. We can really keep tabs on what is going to happen with this patient. Now, it is a great opportunity to be able to say, we understand that when people develop dependence on opioids, and they are unable to taper that there are medications we can use that are safer to help in that process.

When we go through our checklist related to opioid use disorder, we find this patient meets criteria for use of that medication. And asked the patient to consider this as an option as we institute everything. There are many handouts we can give the patient and the family about the use of Buprenorphine/Naloxone. There are handouts for academic detailing. There are handouts available through SAMSHA and ASAM that we may want to print out and get to the patient and the family to think about getting Buprenorphine. We are also considering a home induction. This is a low-risk patient with a lot of family support. He is a good candidate for a home induction. In order to do a home induction, we need to look at the different mechanisms for how he might be getting his Buprenorphine.

Is he going to get it from a local pharmacy? Do we need to arrange for mail? What do we need to do or consider for a home induction? What are we going to do in the interim between now and the time the medication arrives?

This is to be continued. Time for our 15-minute break. We will see you back here exactly at 3:00.

Symposium is on a 15-minute break. It will resume promptly at 3:00 EST.]
[Captioner Standing By]

I just put some key websites in and went to this presentation for many of those websites. I would highly recommend going to those websites and marking them. The ASAM website is being updated related to all substance abuse disorders. This is where you can go to get training, as well as a large number of opioid-related safety presentations and other resources. We have a couple of minutes before everybody checks back in. Any other questions or comments or anything people want addressed in our last hour and 15 minutes?

We are going to get started with the last time stretch. Remember, this is our case discussion. This is what happened. The patient agreed to the Buprenorphine/Naloxone therapy. You are able to arrange for a home induction and able to get medications mailed to him. He successfully underwent home induction and currently states he is no longer taking the oxycodone. He does have oxycodone left in the house and you have highly advised him to find the appropriate place to dispose of it if available in his community and make sure it is away from children in the household.

He is now stabilized at eight milligrams of Buprenorphine twice a day. He is better but continues to have flares managed by non-opioid modalities. He does not really have time for the CBT options for pain or opioid dependence. What are your options at this time? We will talk more about that.

In my research for this presentation I came across fully updated 2020 set of opioid use disorder guidelines. I felt they were so well done and so well updated, I thought it was important for this group to see them. These are key excerpts from the guidelines. The guidelines are available for everybody on the ASAM website. It is www.asam.org. I have created this PowerPoint in such a way that you can download it and have those key points available to you. I will tell you these are just straight from the ASAM guidelines. I thought that was going to be very, very important for people to understand. Assessment and diagnosis of opioid use disorder. It is important for a continuation of what we were talking about before.

The first clinical priority should be given to identifying and making appropriate referrals for any urgent or emergent medical or psychiatric problems. Within our situation with that patient we made sure he had naloxone and naloxone education, overdose education. We made sure his wife had overdose education. Everybody was at their wits end and things were not going well. In fact, they were quite relieved to know there was a solution to the problem. Comprehensive assessment of the patient is critical for treatment planning. Completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder. We would all feel more comfortable getting everybody in and giving a full psychiatric evaluation. Having a full drug screen. All of our bloodwork and a full exam. We would feel so much better, but we don't necessarily have that. It doesn't mean we are not going to get it in bits and pieces over time. It does mean we are going to start treatment once we are

comfortable understanding what we are treating. Then, come up with a safety plan for how we are going to get the assessments we need and the assessments we want.

We also want to know the difference. What is the difference between the assessment we need and the assessment we want? And focus on what we need. Completion of the patient's medical history should include screening for con commitment medical conditions, including psychiatric disorders, which we can do telehealth. We need to look for infectious diseases, acute trauma and pregnancy. For some of this, we may need some lab work. Even if we physically do not see that patient it may be easier to arrange for a close by lab, which has covert precautions to get that lab work for us. And we need to broach this issue with the patient. There will be labs we want to do and figure out the best way to do it.

We should do some research to the closest place you are able to get labs in a COVID safe lab. We would love to do a physical exam, but once again this exam is going to be done in a way in which it is for the patient. It is important for us to put in at some point but won't be necessarily critical early on. There are ways we can do exams virtually and ways we can see if there is tenderness or any findings that can help us as we wait for a more hands-on approach. The current recommendations if you are going to get bloodwork is a CBC, liver enzymes, a test for TB may be a little more difficult. Bloodwork for hepatitis B and HIV. Sexually transmitted infections should be asked about. Once again, once we get to see this patient, we want to make sure they are up to date with vaccinations.

Women of childbearing potential should be tested for pregnancy and all women of childbearing potential should be queried regarding methods of contraception. Patient being evaluated for Opioid Use Disorder and or for possible medication use in the treatment of Opioid Use Disorder should undergo or have completed an assessment of mental health status and possible psychiatric disorders. This does not mean you necessarily need a psychiatrist in a lower risk patient. It means you want to make sure all mental health issues are addressed and you have done present screening, anxiety stream screening, and have a safety plan for the patient. We want to make sure there are no Opioid Use Disorder. In some states use of cannabis is not viewed as a substance that is a problem. Whereas we do want to know about that related to opioids. There are problems associated with cannabis use and opioids. So, stimulants, alcohol and other addictive drugs should be a reason to withhold treatment. There was a time when we thought that was the case. We now know that is not the case and that treatment for other substances may or may not be adequate with treating Opioid Use Disorder alone. However, treating Opioid Use Disorder needs to be a primary goal here. Then, we need to see what comorbidities need to be treated in addition to that. You may see that other substance use may be stabilized once the Opioid Use Disorder is treated. It also used to be felt that use of some drugs was a contraindication to some conditions. While there is no doubt that common use of these drugs is riskier than in a patient without sensitive to the pains. The use of Buprenorphine may be a marker to you, but this patient may require that face-to-face this is required to be. That patient may require further screening prior to initiation of Buprenorphine as much as possible. You

may decide that is a patient you are not going to have a home induction with, but you will still be able to follow up with that patient virtually. And it is not a contraindication to Buprenorphine use.

Nicotine is a very important. We understand that nicotine makes pain worse, increases your risk of having developed Opioid Use Disorder. Also, it has been seen that increasing use of vaping has increased risks. Education and assessment is going to be important. You do not suspend or discharge patients for positive use of Buprenorphine. It is not currently felt that benzodiazepines is a contraindication to Buprenorphine treatment. It is very important. This is an important change in how policies and procedures and understanding about this has occurred. Why did this happen?

It happened because the risk of death or severe morbidity and mortality related to ongoing use of some drugs in patients was so high without the use of Buprenorphine that the risks of not treating were felt to be far greater than the risks of treating and simultaneously addressing benzodiazepines use.

Brenda, thank you that is a great question for clarification. This is a definite change over five years ago. Exactly where we are going. The lethality of Opioid Use Disorder and the current age is so high that we want to make sure it gets treated.

What about patients who are diverting some of the supply?

You want to address the diversion. And addressing the diversion is going to be part and parcel of what to do. The biggest challenge in terms of addressing the diversion is going to be proving versus suspecting diversion. In the situation of Opioid Use Disorder, went you prove the patient is diverting the Buprenorphine that will have to be addressed in a very serious way. You do not want to just completely stop Buprenorphine for a non-proven suspicion. You want to follow up on it and keep an eye on it.

As part of comprehensive care, the patient should receive a multidimensional assessment including emotional and social factors. Addiction is a complex social illness in which the use of medication is only one component of comprehensive treatment. In this setting, our ability to interact with the family improves that ability. Right now, I don't know of any specialty in healthcare that does not offer you options for virtual follow-up and a virtual evaluation, as well. All of us are going to be coordinating and integrating care with virtual care, as well as very selective face-to-face care.

Other clinicians may diagnose opioid use disorder, but confirmation of the diagnosis must be obtained by the prescriber. So, in your own mind you need to be able to document Opioid Use Disorder. We talked about this issue of, what about opioid dependence? When you look at the criteria, if someone knows they are at risk and unable to taper they almost always meet the criteria for Opioid Use Disorder. I think there are myths about needing to be taking medication not as prescribed. You need to be taking illicit medicine to qualify for that diagnosis. Go back and look at the

criteria. If you continue to use opioids despite the fact that it is harmful and it has been explained that it is harmful and you cannot taper, you will meet that criteria. There is also a large number of people who believe that opioid use disorder has a bit of a difficult term to it. We won't get involved in those nuances right now. Although, we can discuss them further towards the end.

That diagnosis was made on the basis of history. Validated clinical scales that measure withdrawal symptoms may be used to assist in the evaluation of patients with Opioid Use Disorder. Direct testing is recommended. We need to look at ways we can get that done during the COVID era. Also, keep in mind when we do drug testing, it does not always include what we need for alcohol or other alcohol tests. Drinking and opioids is a very high-risk factor for overdose risks. We want to be able to look for illicit controlled substances that are not being prescribed. The frequency of that testing after initial tests depends upon the risks of the patient. Also, the behavior of the patient.

We have talked a little bit about medications and are treatment options with using Buprenorphine/Naloxone. That is what most of us will be primarily using. Methadone must be prescribed in a federally approved opioid treatment program and cannot be prescribed in a primary care setting. Or a pin cleaning setting for treating opioid use disorder. Now, Naltrexone injectable can be used for Opioid Use Disorder. It is a bit of a challenge for patients who have Opioid Use Disorder and chronic pain. There is no recommended time later limit for pharmacological treatments. I have seen a lot of patients get into trouble because somebody has decided treatment should be for three months or six months or one year. For many patients, this treatment is going to be lifelong.

A decision to taper opioid use disorder treatment medication should be done individually and carefully and slowly. Some patients may never be able to taper but will be able to do well on a lower dose. That is a whole other topic of conversation, which we will be able to talk about at the end. Do not rush to taper. Remember, there are a large variety of psychosocial needs that we can include and continue to offer. The patient's ability to offer this help and take advantage of this help will improve over time. So, it is important for us to keep in mind that the offer for psychosocial help may be declined, but it should not interfere with treatment. It should continue to be reoffered at every visit if thought to be helpful or important.

Obviously, the venue is going to be dependent upon what medication you are going to use and what is available to you and what the comorbidities are of the patient. We have already covered the issue of methadone and Naltrexone. Patients with active co-occurring alcohol use or substance use disorders may not be your best patients to treat along in primary care or, in that only virtual visit. Here is where the team-based approach may be very important. It may very well be that even if patients are treated in a Opioid Use Disorder setting, that primary care provider may be critical in keeping that patient engaged and involved. There should be a team-based approach to treatment and monitoring. We absolutely understand that, especially for patients not on benzodiazepines initially, we do not want to have them start

benzodiazepines. However, as a patient is already on benzodiazepines and understanding the risk, we are going to carefully monitor them and enlist greater help in terms of our mental health, medical and psychosocial support.

Briefly, I am going to gloss over methadone. That is really something more that we are using when Buprenorphine/Naloxone is not appropriate. Even in opioid treatment program clinics there is a Buprenorphine/Naloxone arm because it is much needed for medication. Opioid dosing guidelines developed for chronic pain, expressed in morphing equivalents are not applicable to medications for the treatment of Opioid Use Disorder. Oral Naltrexone is really not widely used for Opioid Use Disorder. It has been used for alcohol use disorder. But extended release Naltrexone is considered a must more effective treatment for patients who are going to use Naltrexone for Opioid Use Disorder. The prescription drug monitoring program must be checked regularly. This is a huge benefit and most prescription drug monitoring programs now offer you the ability to check other states. I would highly recommend that, especially neighboring states. We talked also about the importance of using Naloxone.

What about treating opioid withdrawal?

It is important to understand that treating opioid withdrawal without treating Opioid Use Disorder has not been shown to be effective. So, you can use methadone or Buprenorphine but, we want to make that more part of a full treatment program using medications rather than a treatment for withdrawal. Opioid withdrawal management on its own without ongoing treatment for Opioid Use Disorder has been shown to actually be ineffective and potentially increase the risk of overdose because patients will not understand that their tolerance after a few weeks off is going to be lower. Since the relapse rate off medication is 90%, 90% of patients will go back to using an opioid. If they go back to the previous dose, the risk of overdose is actually higher after detox then prior to detox. So, you of course want to do a thorough history and physical when you can. And you want to really be able to address opioid withdrawal. When you use Buprenorphine, and that is the main medication we will continue to talk about.

That patient should be in withdrawal at the time you begin to give Buprenorphine. The one caveat I will also mention here is there are multiple low dose Buprenorphine regiments for induction that you will be hearing more and more about. Either placing the patient on a Buprenorphine patch or using very low dose micro dosing of Buprenorphine that people are using and that will enable you to start medication and low doses as part of the induction. We are not going to go through the details of that now. There are multiple induction regiment using micro dose Buprenorphine. But it is important for you to know those options do exist and are starting to evolve in terms of a myriad number of protocols for patients at risk, if they wind up going into withdrawal.

What if the patient says, I am absolutely not going to go into treatment and you don't have an option of using Buprenorphine. There are other products. There is actually alpha-2 that is FDA approved. There are other

drugs safe and effective for managing opioid withdrawal. Even though methadone and Buprenorphine are more effective, they really do need to be used in a setting of treatment. Clonidine is tried and true. We have used that for many, many decades. It is effective. But, once again this issue of detox without treatment is really to be avoided whenever possible. Ultra-rapid opioid detoxification, there used to be a lot of ads for this on the Internet. It is not recommended due to high risk of adverse events.

Now, Naloxone facilitated opioid withdrawal management can be safe and effective but, should be only used clinicians experienced with clinical method, and in cases in which anesthesia or conscious sedation are not employed. This is a sophisticated process. Advise patients that any ultra-rapid opioid detoxification is not beneficial.

Reporter: Let's talk about Buprenorphine in more detail. We talked about how we initiate Buprenorphine and how we do a home induction. And the way you make decisions individualized about those things. Once again, more and more we are seeing the use of home induction being very safe and effective. We do have a number of formulations for many of the substance use disorder clinics once people are stabilized. They do have more prolonged utilization of Buprenorphine in induction form. Initially, most people are not utilizing them. They are utilizing the ability to use sublingual Buprenorphine tablets in order to be able to get that patient stabilized. We are still looking at what patients may be able to look at a more prolonged product.

Let's address this issue of diversion. Conditions should take steps to reduce the chance of diversion. Recommended strategies may include frequent office visits. It may very well be that for people you are suspecting of diversion, those may be the people that you need to bring in because you are going to be looking at their urine more often and looking at the Buprenorphine metabolism more often. If you can't bring them in, more frequent drug testing, better understanding of their environment, combinations of in person and virtual visits are recommended. If necessary, we call visits medication counts.

Drug testing should be used to monitor patients for adherence and use of illicit controlled substances. In this era of COVID, that is going to be modified based on the safety of the patient and what is available in their community and what you think that patients risks are. If they are a very high-risk patient that is going to require more monitoring, then a lower risk patient in whom you watch behavior is much as drug screens.

Patient should be seen frequently at the beginning of treatment until they are determined to be stable. Once again, being seen does not meet face-to-face requirements. A provider should note that 7-14 days should elapse between the last dose of Buprenorphine and the start of Naltrexone. When considering a transition from Buprenorphine/Naloxone methadone, there is no required time delay because the transition does not result in an adverse reaction. It cannot be over emphasized, do not place limits on treatment. This is very important. If a decision is made to taper Buprenorphine, it should be done as a very slow process. With

the ability for the patient to easily change their mind if things are not going well without judgment.

Close monitoring that should be done over several months. It should remain in some type of cognitive treatment program past the point of discontinuation. Extended release injectable is more helpful for preventing relapse for patients who are no longer physically dependent. The one caveat about extended release injectable Naloxone is that there is a subset of patients in whom this only lasts for three weeks. If you start to see people who have craving after three weeks, that is going to be very important because that is a Sub Pop chelation that will need an injection more often than every four weeks. It is very important also, because patients who understand that it is not necessarily lasting for more than three weeks may find that in that 3-4 week they are at risk of overdose.

Be very careful of the monitoring for any kind of craving symptoms between that three and four week mark. Once again, it is important to assess psychosocial needs, but don't let that interfere with treatment. Transitioning from Naltrexone to methadone or Buprenorphine should be planned, considered and monitored. It will generate less complications then transitioning from a full or partial antagonist because there is no physical dependency associated with antagonist treatment. And there is no possibility of withdrawal. Transition will not have an induction but will start a low dosage and monitor symptoms of craving. Patient should not be transitioned until a significant amount of naltrexone is no longer in their system. Allow about one day for oral Naltrexone or 28 days for extended release Naltrexone. Patients who discontinue the treatment should be made aware of the increased risks associated with opioid overdose. It is very important for them to understand that if they are going to discontinue Naltrexone.

The first time this is a problem they need to understand that other treatment options are available, including Buprenorphine and methadone. Don't wait until that craving gets to the point where they go out and use an illicit opioid or borrow some from friends and family and are a great risk of overdose.

Reporter: Let's talk a little bit about psychosocial treatments. As much as we want to initiate treatment even prior to or even if the patient denies the need for psychosocial treatment, understanding all the psychosocial treatment needs of the patient are going to be important. Having your team psychosocial support available is going to be very important. This may include psychologists, psychiatrists and the ability to offer help with support groups and unmarried support groups available for treating Opioid Use Disorder. Social work, vocational training, and the full list needs to be available. Also, the ability to use cognitive behavioral therapy approaches for pain. They frequently go hand in hand with treating Opioid Use Disorder.

Let's talk a little bit about special populations like pregnant women. The first priority in evaluating pregnant women for Opioid Use Disorder should be to identify emergent urgent medical conditions that require immediate referral for clinical evaluation. Treatment with methadone or

Buprenorphine is recommended and should be initiated as early as possible. This is not a time that you would detox. More and more we are using Buprenorphine as a medication. It used to be methadone was the primary medication used. However, Buprenorphine is better tolerated, and the babies seem to undergo a much less severe neonatal abstinence syndrome. You do not want to use withdrawal management in pregnant women. That is a much larger risk for the baby in utero. Also, there is a very high relapse rate.

We talked about the need for a medical examination psychosocial assessment. It may very well be that for pregnant women outpatient approach initially may not be as important as a face-to-face visit in pregnant women. Pregnant women are seen regularly in the clinic related to their pregnancy. So, it would be important to help coordinate your face-to-face visits whenever possible with the OB/GYN caring for that patient. This is really a team approach related to determining what that patient may need. Frequently, pregnancy is a wonderful time for motivational interviewing for many women. They will think about doing things for their unborn baby that they would not necessarily do for themselves. Once again, testing and frequently the testing we would do for treating Opioid Use Disorder in pregnancy is part and parcel of what is being done related to their pregnant see. So, coordination of care with the OB/GYN when his important. We would also want to test for drug and alcohol. Especially, alcohol testing because of fetal alcohol syndrome. We want to make sure that the patient understands the risks of using all of these substances during their pregnancy.

The integration in management of care is critical. These patients may require an observational stay for induction. They certainly are going to require a much more careful monitoring then non-pregnant women or a lower risk mail in terms of their induction. Dosing of methadone is going to be important and important to understand that during the pregnancy dosing may change. If a woman becomes pregnant while she is receiving Naltrexone, it may be appropriate to discontinue the medication if the patient and clinician agree that the risk of relapse is low. Or, you can consider a switch to Buprenorphine or methadone. A patient and her clinician should include a discussion of the insufficiency of research on Naltrexone. Treatment with methadone and Buprenorphine should be considered in this patient. You have that much period of time where extra support will be needed before you can initiate either methadone or Buprenorphine during that pregnancy.

Use of naloxone challenge to test for opioid dependence and risk of persistent dictated withdrawal is not recommended for pregnant women with Opioid Use Disorder. Unless otherwise contraindicated, mothers receiving methadone or Buprenorphine should be encouraged to breast-feed. Once again, we don't have a pregnant woman, but I want to make sure people had that understanding about those guidelines. For the last 10 minutes here, patients are now stabilized in eight milligrams of Buprenorphine and naloxone twice a day. This is our patient with chronic pain. Pain is much better and he continues to have some players that are managed by non-opioid modalities. He does not really have time for CBT options for pain or opioid dependency. What are your options at this time? Any discussion

about this? What are your experiences for patients like this who feel they don't have time?

Let's talk a little bit about this. I will start the conversation. But please jump in at any time. This patient does have a track record of having done well before. Frequently, that is forgotten about in the midst of the opioid dependence. We want to slowly, but surely reintroduce some of the things that of worked for him. The other thing that we have more and more of our apps. The VA and DOD have a plethora of apps. We want to be able to help this patient with something that he can do in his own time and place. So, frequently those apps can be standalone. Sometimes, they can be sort of a way of increasing treatment options. Here are a couple I like to use. The VA has a fabulous app. I would highly recommend it. It is called the mindfulness coach. It gets patients back on track related to their mindfulness options, which really don't take that long during the course of the day. Also, it gets the patient to understand it does not a matter of the time critical in most of these situations, but they feel the need to pick out their own time and space for them.

Jennifer said, he had a positive response prior and there are multiple sites that offer services. There are also community resources available after hours.

That is fabulous. A lot of the times, there is this resistance and feeling overwhelmed and that you can't put anything more into their day. They need their own time and space in order to be able to do this. So, introducing these apps and community resources and online resources is extremely helpful. It frequently breaks down some of the resistance. Another app I like is, DVT I. Problems with sleeping are really important. It is important for us to remind patients that, if they are not sleeping these cognitive behavioral approaches to insomnia have been far superior to medications. And, to introduce the patient to this. There is another app called breve to relax. It is, once again for those periods of the day when you just feel like things are getting away from you, creating ability to have a simple breathing program for the biggest stressors of the day.

As Jennifer points out, he has done very well with things before. Pull out those old physical therapy sheets. Get a walking program together. A walking program is safe during COVID, for the most part. It is also very good for pain and extremely good for addiction problems. It raises endorphins and decreases pain levels. It is actually something that can be done as a family. We see more and more families out walking together during COVID. In addition, it may very well be helpful to also offer some of those apps to the family. To his wife. The mindfulness coach at is appropriate for family members. Breathe to relax, see PTI at can be helpful. Pulling the family into the recovery process is so much easier during these virtual visits. And offering that to the family to make a big difference. Those are the things that we can offer him.

The other thing is what I call my open-door policy. You can easily say to this patient, I understand that right now things are overwhelming. But it is important for you to understand that what I have available is going to be available to you tomorrow, next week, next month. If you change your

mind, it is as simple as an email to me, a phone call. We can get the case manager to ask questions. If you change your mind, all we need is a communication back and we will get things set up. So, is there a particular CBT I at? There is a VA app called CBT -I and it is available and helpful for everybody. That is an extremely helpful app. We are seeing more and more that during COVID people are having greater problems with sleep. So, it is another entrée into, you are not alone if you are having sleeping problems. Feel free to use this app whenever you need it. It also sets up some sleep hygiene that people need to look at. Once again, it helps the family.

Free is better also.

These are all free.

Lopez are becoming an issue with patients. They are seeing the resources and fearful of limited finances. Also too, whatever we can offer without a co-pay is very, very important. Also, how stressful are financial issues? If we do have options to help with financial issues, I know in the VA there is availability of counseling related to jobs and job-related issues. It is not as much of an issue in the DOD, because everybody has a job in the DOD. They are in the Department of Defense. Also, really important to be respectful of some financial problems that people may be having. Many people, even if they do have a job have been dependent on two incomes, and now they only have one income. Either somebody has lost a job or somebody needs to be home with the homeschooling.

It is important for us to leave an open door to be able to discuss where finances play related to being able to participate in the treatment options available. There is also virtual physical therapy. Once again, this patient has some old physical therapy sheets that he can pull out. Or, we can produce some for him. Or, we can say, if you are unwilling to participate in ongoing physical therapy, I have a physical therapist that will see you and give you an outline for what to do. So, it is not such a huge time commitment in terms of us determining when you will do it. It is a matter of you determining when you are going to follow up. Also, that is a great way to look at the importance of balance in life. If you are working 16-hour day, your back pain is never going to get better. Let's have a conversation about balance. Is it that you don't have the time? Or, that you cannot commit to a specific time of the day? Have that conversation because that will be very important.

Bernadette is typing. It is time for our break. I will take one last break and then I want to meet at 4:00 and we will tie up loose ends for however long it takes. Here is your 15-minute break one more time. Let's meet again at 4:00 and finish this up. Please, any questions you have, comments or questions, discussions about this case, or even about your own patients bring that to the 4:00 time slot. The 4:00 time slot for me is for you to bring in all of the patient issues that you have concerns about that we can try to do some problem solving with. See you all back here at 4:00.

[Symposium is on a 15-minute break. It will resume promptly at 4:00 EST.]

[Captioner Standing By]

Please feel free to enter anything into the chat box that you would like to discuss or comment on. We can use it to finish up the last part of this dialogue. Once again, as everybody comes back to join us for the last part of this discussion please type in anything that you want to add. Any problems that you have with patients that you want us to address. Any questions or additions or any further comments at all. These are questions that are really good. We will get started on them exactly at 4:00. We will get started in just one more minute. These are great questions. Please keep them coming. I really want to make sure this is more interactive, and everybody has a chance to ask questions and make comments or be able to share some of the clinical situations that they want addressed. Let's go. We are at the home stretch here.

How are you integrating the requirement to review PMP reports prior to prescribing into your practice (do you look up/designate surrogate)? Julie says,

That depends on the state you live in. Most states allow you to designate a surrogate. Frequently, it is a team-based decision on how that gets done. If you are working from home frequently, it is more difficult to create that team-based approach unless you have already decided ahead of time and there is a note in the record. If you have a team decision and your state allows it, then by all means you can have a team-based approach with different people being assigned a PMP check. If not, you would have to do it yourself. I do know that at some point there were state that have different requirements about who could and couldn't check. Know what the rules are in your state. The main thing is to make sure it gets checked.

Also, the other thing I found incredibly helpful is to check the states that are close to you and those in which the patients had previously had prescriptions. It is very eye-opening. Frank says, a patient I have been treating for about six months came to me on 400 milligrams of extended release Ultram daily is doing pretty well by putting her down to 150 milligrams of short acting. She is now recently pregnant with twins. Referral to OB, yet no plans from their end on the Ultram. Anything on next steps is much appreciated. This clearly needs to be a coordination with the OB.

Ultram is not recommended in pregnancy. However, Ultram does not necessarily create criteria for your patient to qualify for being treated with Buprenorphine/Naloxone. As we know, transcend the six times. The big thing really is how is she doing with the titration? You have to be very careful and be in touch with the OB about what their priorities are for her. Also, find out is there lurking other substance use disorders in the mix? The use of Ultram is associated with other Opioid Use Disorder's. I would be very careful about what other substances she may be using. Is she using opioids or nicotine? Is she using alcohol? There may be more lurking under the surface then just the Ultram. And, coordinating to figure it out would be really, really important.

Bernadette says, service member being separated pretty quickly who is on Vivitrol for AUD but has a history of OUD. Should I switch him to oral Naltrexone because I can get him a three-month supply, or is there a free or low-cost option to refer him to continue injections? He will likely relocate to Maryland. My recommendation would be to not change anything during his relocation process. If at all possible, get a hold of the local VA. They may be able to quickly get him involved in local treatment options whether it be on a VA site or through the use of community care. Switching anything out at a time of turmoil is difficult. I think if you can get a hold of the VA and find out what treatment options are available for him in the community that would be your best bet. If you can't do that, then it is possible to switch him to a three-month supply. But, I would highly recommend that if you have another option to do so. There are a lot of options available on the SAMSHA website in terms of looking for treatment facilities that you can work with.

Also, on the VA website there are treatment options. Everything in our system has substance use disorder program. Also, see if you have any case managers who can help create some type of dialogue during that transition time. Jennifer is thinking the same as me. Coordinate with your VA. Once again, that VA will not only be able to see the patient, but there may be the ability to arrange for urgent care. I would wonder about just giving him the VA numbers, as opposed to trying to get somebody to make a call to the VA. It would be better to have a warm hand off. Everyone is saying the same thing. Is there a V-8 liaison at your base?

We certainly have done this many, many times with transitioning service members in the VA. There should be a way to set up that warm hand off. What is the timing of his injection? Is there a way to time the injection so he gets an injection just before separating? That gives you a month to be able to get him an appointment. The other thing that is possible here is that although he needs to shop face-to-face for the injection, he may not be needing to show up face-to-face for the liaison appointment. He may have a virtual appointment and then make arrangements for the injection. I am glad we could create this community we have with VA and DOD. If he is leaving without benefits, he may qualify for a bridge program in the community. There are ways we can possibly see what is available wherever he is moving. Either in the VA facility or in the community.

Any other comments or questions? This is a great opportunity for people to share ideas.

Anything at all?

I see Bernadette is typing. I don't see anything else going on.

She said, he got a follow-up next week. The last injection is 3 September. Usually, the injections can be given every 3-4 weeks. That is a bit of a challenge. I don't know if there is any way that you can make arrangements for him to get an injection at a point in which you can buy yourself some time. I would hope there would be somebody within the facility that can get you a way to bridge him over. In fact, I may send a

quick email to someone to see if we can find out what happens in those situations from a logistical standpoint of somebody being discharged just before he is due for an injection.

Anything else? Any other comments or questions? Any other solutions to these problems? Any other experience? Any last-minute ideas or thoughts before we and for the afternoon?

Seeing none, I will let everybody get out early. Thank you all for attending. I hope that this gives you a sense of how we are starting to think outside of the box. How we need to think of ways to creatively, even into the future come up with hybrid ways that we are seeing patients.

Some of them will be seen more often virtually and less often face to face. The more challenging patients may require more face-to-face visits. Also, you may get a benefit from those virtual visits that include the family, even for your more challenging patients. Be on the lookout for all sorts of innovative ways we can care for patients more effectively using the newer approaches that we have related to virtual consulting that are extremely helpful and beneficial. And the patients love them.

Okay, thank you all very much. I have enjoyed being here with you for the afternoon. If you have any questions, please email to the team and they will get them to me.

[Event Concluded]