1

Disclosures

Grant Support

- -National Institute on Drug Abuse
- -Doris Duke Foundation
- -SCDHHS/21st Century Cures (website and Project ECHO)

Committees

- -BCBS Pharmacy & Therapeutics Committee

Clinical work

- -Work in MUSCs Pain Rehabilitation Program
- -**No financial conflicts of interest**
- -Will not discuss non-FDA indicated use of medications

MUSC Health
Medical University of South Carolina
Changing What's Possible | MUSChealth.org

2

This lecture addresses the “prescribing and monitoring of controlled substances”

This lecture will review:

-monitoring procedures (including clinical signs/symptoms and validated scales) to identify opioid use disorder in patients on prescription opioids

-prescribing of buprenorphine and naltrexone for the treatment of opioid use disorder

3

Outline

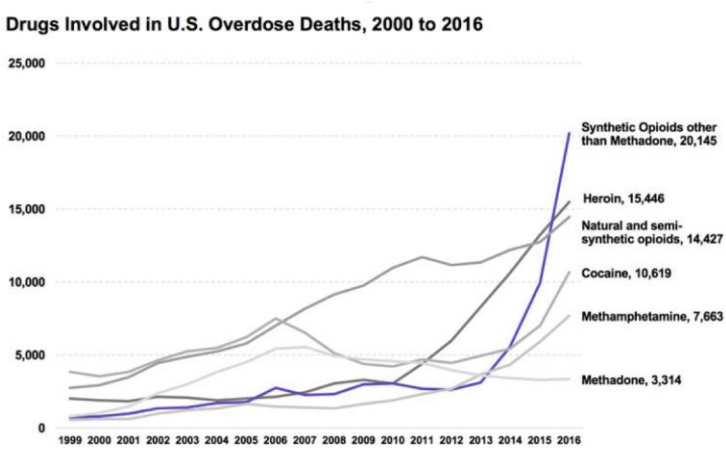
I. Identify signs, symptoms, and challenges in identifying Opioid Use Disorder (OUD) in medical settings

II. Discuss Medication-Assisted Treatment (MAT) for OUD, and challenges and opportunities utilizing MAT in medical settings

III. Review pilot initiatives that address barriers to utilizing MAT in medical settings and future directions of such initiatives

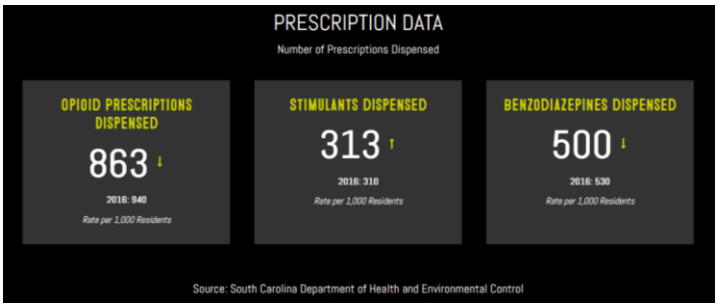
4

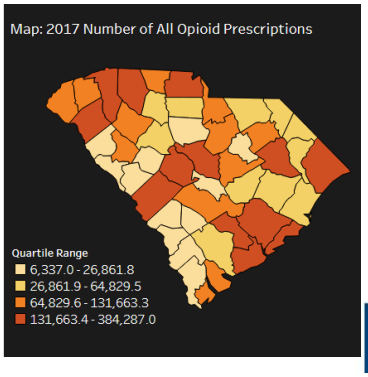
Nationwide Opioid Crisis….Continued



CDC, 2016

5

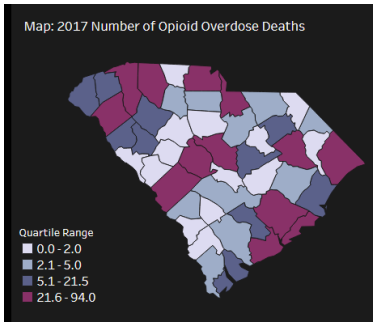




Despite decreasing opioid prescriptions…

www.justplainkillers.com

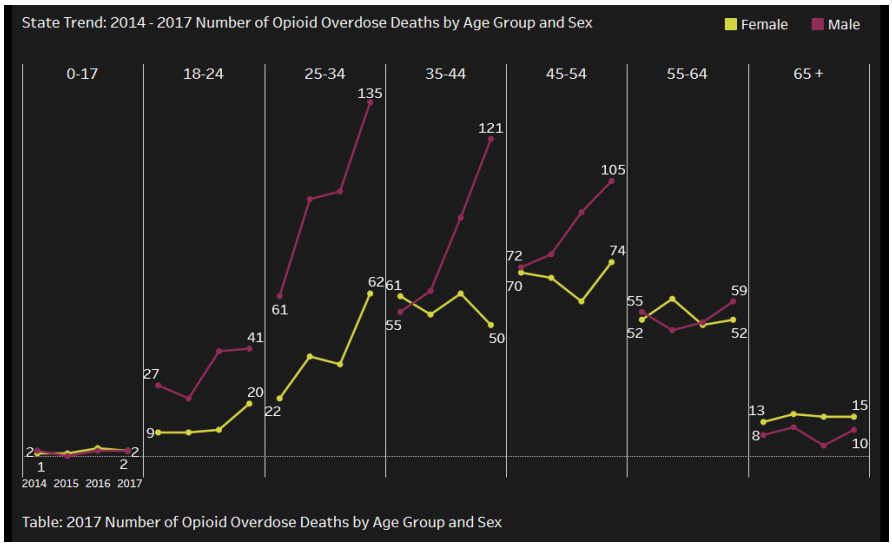
6



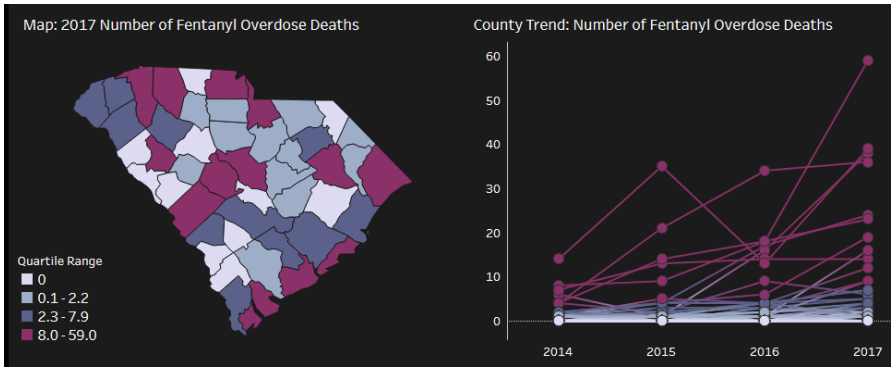
SC Drug Overdose Mortality Data

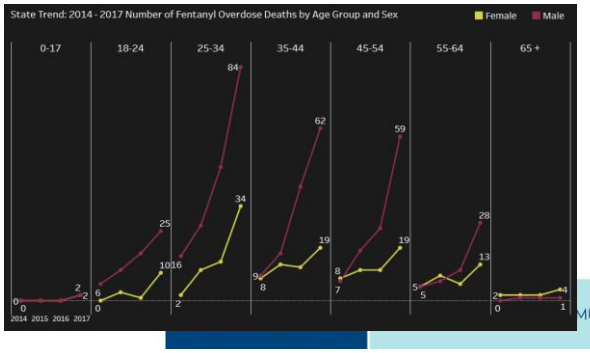
7

SC Opioid Overdose Mortality Data



8

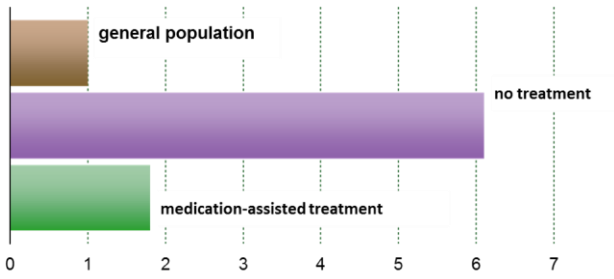




9

Why Identify and Treat OUD?
To Decrease Mortality

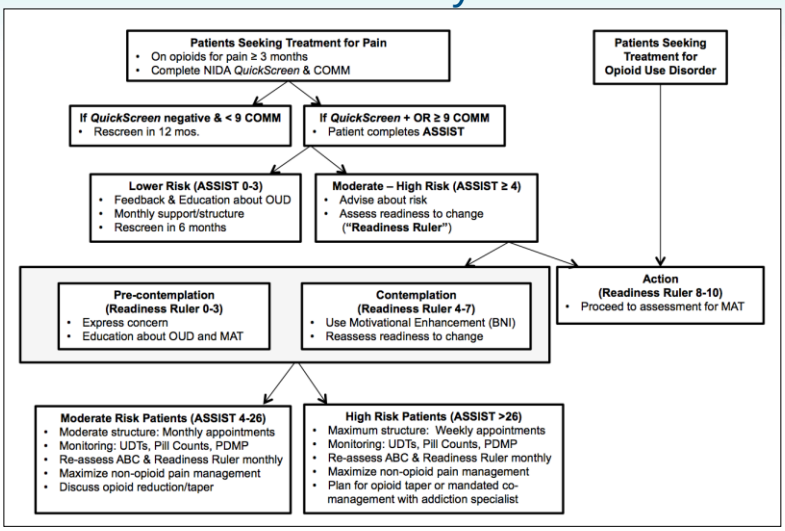
Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

10

Diagnosing OUD in Medical Settings is Not Easy



11

How to Identify OUD in Medical Settings

Clinical Assessment

Poor Functioning
- Emotional
  - Depression/Anxiety
- Physical
  - Sedation/in bed/ED
- Social
  - Pt or family concern

Aberrant Behaviors
- Running out early
- Rx from another provider
- Use of illicits

Screening scales

NIDA Quick Screen
COMM
DAST
SOAPP-R
ORT

12

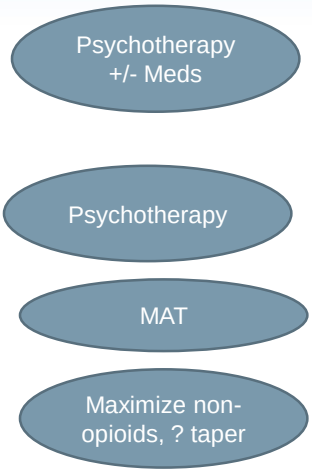
DDX for a Poorly-Functioning Pain Patient

Psychiatric co-morbidity
- Depression
- Anxiety, esp early-life trauma

Psychologic co-morbidity
- "Chemical coping"
- Personality disorders

Opioid Use Disorder (OUD)

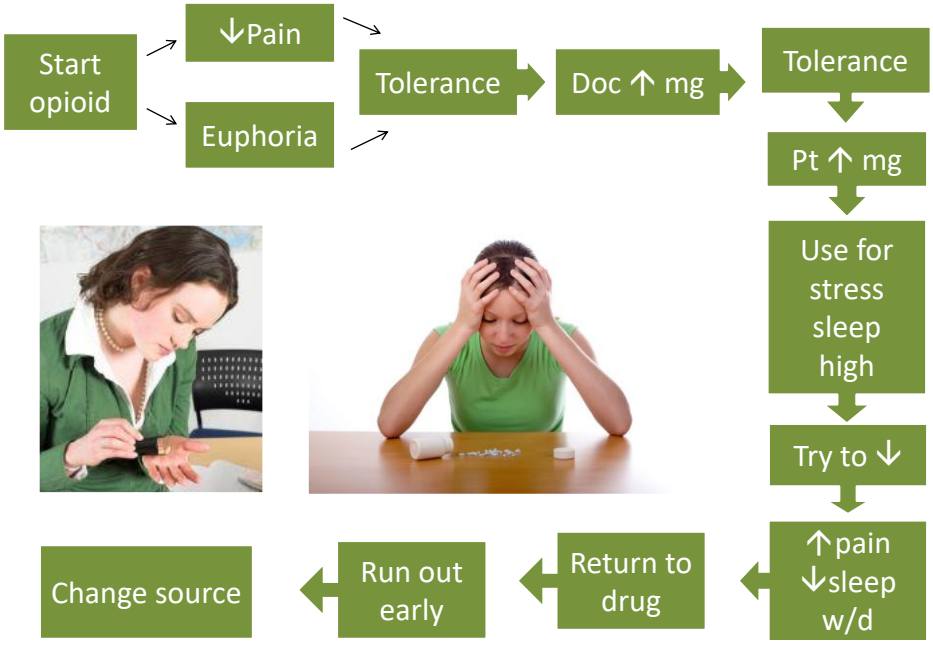
Pseudoaddiction
Tolerance/Withdrawal/OIH?



13

When does a poorly-functioning patient with pain "cross the line" to addiction?

14



15

RECOGNIZING OUD
Aberrant Behaviors

More clear	Less clear
Forging	Request ↑ mg
Steal/borrowing	Hoarding
IV use	Asking specific Rx
Obtained on street	"Doc shopping"*
Abuse other drugs	1-2 dose ↑
Multiple dose ↑	Rx another sx
Recurrent Rx loss	Psychic effects

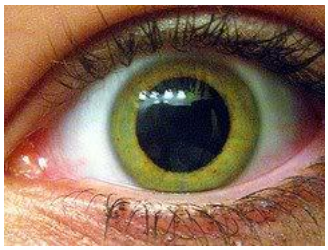
(Passik & Portenoy 1998)

16

RECOGNIZING OUD

Signs

Intoxication	Withdrawal
Euphoria	Pain/Distress
Constricted pupils	Dilated pupils
Slurred speech	GI upset/diarrhea
The “nods”	Goosebumps



17

Risk Factors for Inadvertent Prescription Opioid Overdose

- Higher doses of opioids
  - 100mg morphine equivalent or higher
- Using with sedatives or alcohol
- Co-morbid mental health or medical issues
- Recent abstinence (recent hospital detox)
- Other substance abuse
- Aberrant behavior (running out early)
- Using alone

Bohnert, et al. JAMA. 2011;305(13):1315-1321

18

Screening Tools (all validated)

NIDA Single-Question Screener:

"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" (where a response of ≥1 is considered positive).

Quick, direct, effective, good for universal screening

19

Opioid Risk Tool (ORT)

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Good at baseline for pts on opioids; most factors unchangeable; differentiates gender

20

Screen & Opioid Assessment For Patients With Pain—Revised (SOAPP®-R)

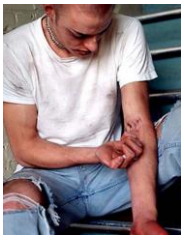
Current Opioid Misuse Measure - COMM

- Longer scales (SOAPP=24, COMM=16 items)
- Ask some common themes, indirect
  - Concern/worry about meds
  - Use pain meds for other symptoms
  - Go to ER/friend for meds
  - Arguments/social discord
  - Other drug/alcohol problems
- Better for a group with some risk and for repeated measures

21

DSM-V Opioid Use Disorder

Maladaptive pattern of use



leading to impairment or distress

22

- Failure to fulfi
- Importa

Decline in functioning

are given up

- Tolerance (not with prescribed medications)
- Withdrawal (not with prescribed medications)

- Taken in lar
- Persistent

Loss of control

s intended
ntrol use

- Great deal o

e substance

- Craving or a strong desire or urge to use a specific substance

- Continued
- Use despi
the substa

Continued use despite consequences

xacerbated by

- Recurrent use in si

y hazardous

23

- Failu
- I

Decline in functioning

ctivities are given up

- Tolerance (not with prescribed medications)
- Withdrawal (not with prescribed medications)

- Tal
- P
- Grea

Loss of control

than wa
wn or
from th

PAIN

- Craving or a strong desire or urge to use a specific substance

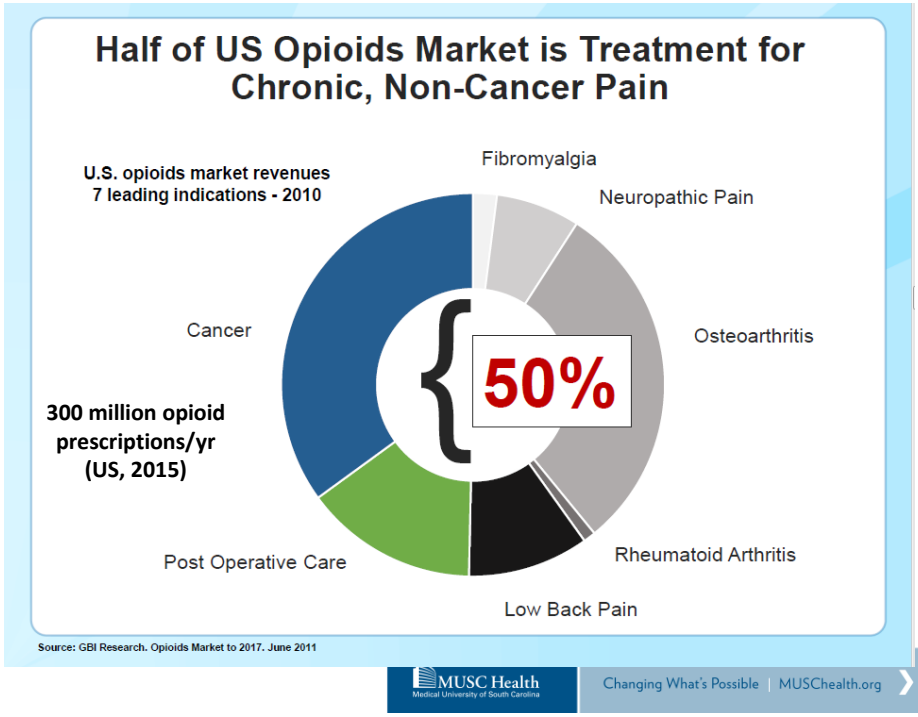
- Co
- U
the
- Recurrent u

Continued use despite consequences

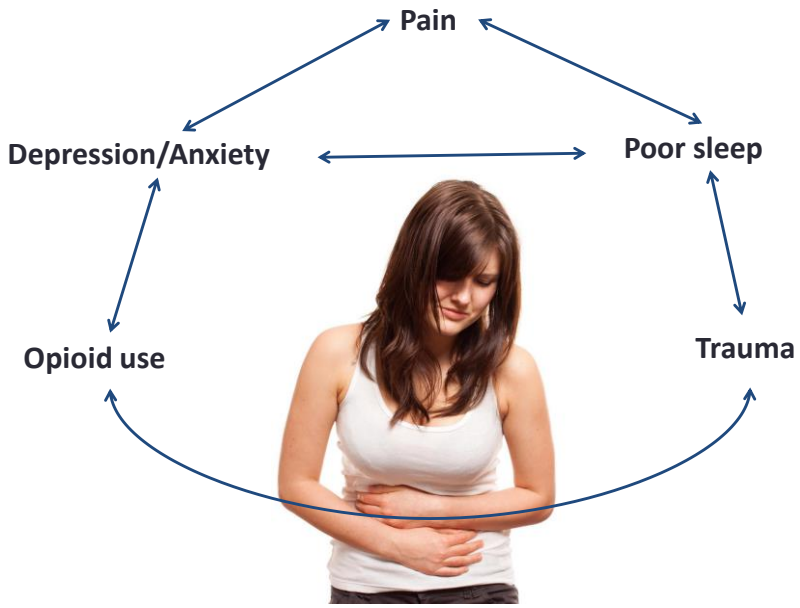
oblem exacerbated by

physically hazardous

24


Half of US Opioids Market is Treatment for Chronic, Non-Cancer Pain
U.S. opioids market revenues
7 leading indications - 2010
Fibromyalgia
Neuropathic Pain
Osteoarthritis
Rheumatoid Arthritis
Low Back Pain
Post Operative Care
Cancer
50%
300 million opioid prescriptions/yr (US, 2015)
Source: GBI Research. Opioids Market to 2017. June 2011
MUSC Health
Medical University of South Carolina
Changing What's Possible | MUSChealth.org

25


Pain
Depression/Anxiety
Poor sleep
Opioid use
Trauma

26

Dual Problem in Medical Settings:

27

Pain, Opioids, and Gender

- Women = 80% of chronic pain populations
  (Croft P, 2002; Fillingim et al., 2009; Gerdle et al., 2008)
- Opioids (+ other pain medications) recommended for women > men
  (Wandner et al., 2010; Hirsh et al., 2009, Fillingim 2009)
- Women have > rates of co-occurring mood & anxiety disorders
  (Grella et al., 2009)
- Women (with OUD) report greater use of opioids to cope with negative emotion and pain
  (McHugh et al., 2013)
- Women are more likely to receive benzodiazepine co-prescription with opioids
  (Hwang et al., 2016)

28

SC females outpace males with opioid prescriptions received

Table: 2017 Number of All Opioid by Age Group and Sex

		0-17	18-24	25-34	35-44	45-54	55-64	65+	All Ages
South Carolina	Female	40,226	75,343	239,371	321,506	468,127	572,895	726,853	2,444,321
	Male	38,500	46,125	154,954	236,045	358,419	471,170	498,829	1,804,042
	All	99,059	123,649	400,626	566,363	839,363	1,059,501	1,245,208	4,333,770

www.justplainkillers.com

29

Dual Problem:

Women are more likely to start opioid use in medical settings.

Women are less likely to enter traditional substance use treatment programs.

30

Outline

I. Identify signs, symptoms, and challenges in identifying Opioid Use Disorder (OUD) in medical settings

-Men more likely to have OUD and OD but women more likely to present in medical setting

-Major challenge is PAIN, pts treatment-seeking for pain are more likely to attribute symptoms to pain vs OUD, esp among women

II. Discuss Medication-Assisted Treatment (MAT) for OUD

-challenges and opportunities utilizing MAT in medical settings (focusing on primary care, ED and inpatient)

II. Review pilot initiatives that address barriers to utilizing MAT in medical settings and future directions of such initiatives

31

CHALLENGE # 1: HAVING THE CONVERSATION WITH A PATIENT WITH SUSPECTED OUD

Empathy (pt is suffering)

Focus = safety & functioning

Professionally set boundary

Lifesaving tx available!

32

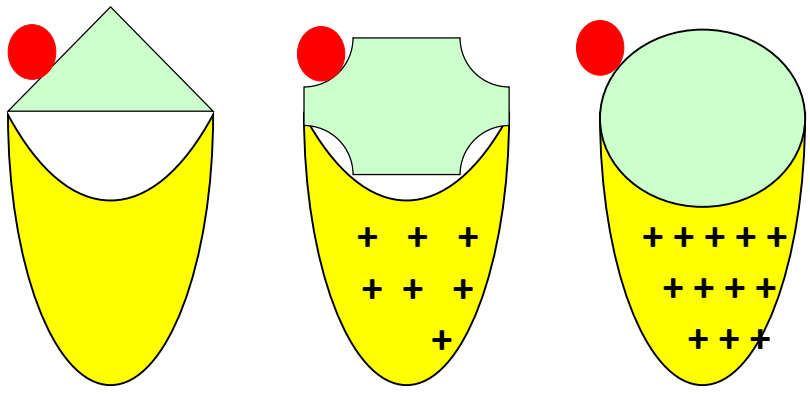
Approach to the Patient With Addiction + Pain

- Express Concern + Provide Feedback
  - "I am concerned about your health and safety."
  - "This is the 3rd time you have run out of pain medications early."
  - "You have been to the ED 6 times in the past 3 months."
  - "I am concerned that you are showing several signs of addiction."
- Validate Pain + Set Boundary
  - "I believe you are suffering/in pain. I can Rx non-opioid pain meds."
  - "I cannot safely prescribe you opioids at this time."
- Provide Education + Support
  - "I want you to know that there is excellent medication for opioid addiction that can help with pain and prevent withdrawal. We can try this."
  - "I hope we can continue to work together to get you feeling better."

33

LIFESAVING TREATMENTS

Naltrexone	**Buprenorphine**	**Methadone**
Antagonist	Partial Agonist	Agonist



34

Medications for the treatment of opioid use disorder (MAT)

	Naltrexone (Vivitrol®, ReVia®)	Buprenorphine/ Naloxone (Suboxone®)	Methadone
Mechanism	Opioid antagonist	Opioid partial agonist/partial antagonist	Opioid agonist
Availability	Extended-release injection, tablet	Sublingual, Buccal, Implant, Injection	For treatment of OUD in a methadone clinic, usually in syrup form
Prescribing Restrictions	None – any prescriber can prescribe	Must receive a waiver to prescribe (MD/DO/NP/PA); 8-24 hours of training	Patients must obtain from a methadone clinic
Initiation	Must wait to initiate until patient has been free of opioids for 7 to 10 days	Must wait to initiate until after withdrawal symptoms have started to appear	May initiate immediately to avoid withdrawal
Abuse Potential	No abuse potential	Less likely than methadone: only a partial agonist; dissolution and injection may induce withdrawal	Low compared to other opiates Very low within methadone clinic
Patient Population/ Other	–Concomitant alcohol dependence –Highly motivated pts –Patients with mandated use (medical boards, etc)	–Improving insurance coverage –Can requires pre-authorization –Decreases mortality in heroin users	–Not yet covered by insurance in SC (~$15/day) –Decreases mortality in heroin users

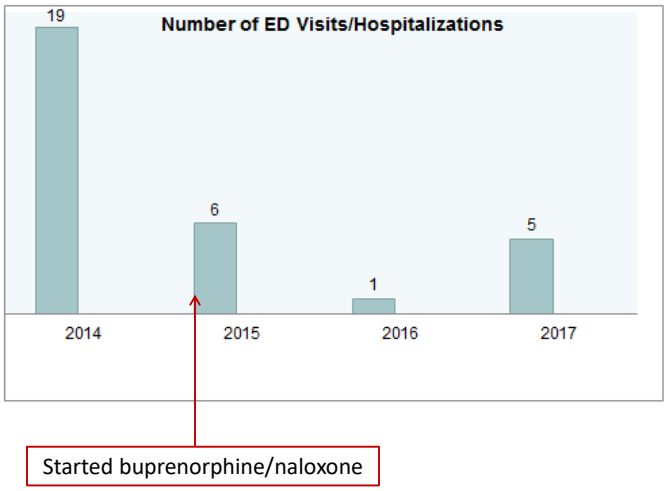
35

How can identification and treatment look in medical settings?

- 54 yo F with PTSD & ETOH dependence in long-standing remission, very involved with AA
- S/P total pancreatectomy with auto-islet cell transplant for non-alcoholic pancreatitis, 2009
- Poor pain control, slowly escalating opioids (MEQ 320)
  - -Oxycodone ER 80 MG q 12h #60
  - -Oxycodone 10 mg 1-2 tabs q4 prn #180
  - -COMM=high, poorly-controlled pain
- High medical utilizer, poorly-functioning:
  - -2014: 19 ED/hospital admissions (DKA, pain)
  - -1/21/15: took #115 oxycodone 10mg in 6 days after a break-up; went to ER in pain, received dilaudid
  - -Started buprenorphine/naloxone the following week

36

ED/Inpatient Utilization



37

Challenge # 2: Access to Care

- Mortality rate of those with OUD in a large university health system:
  - crude mortality rate: 48.6 per 1000 person-years
  - standardized mortality ratio: 10.3
- Effective, life-saving treatments for OUD exist
- Treatment capacity is lacking
  - Nearly 80% of Americans with OUD don't receive treatment[1]
  - There are just > 3000 addiction specialists (ASAM)
  - Only 16% of 52,000 active psychiatrists had a waiver for buprenorphine in 2015
  - 60% of U.S. counties have no psychiatrists[3]
  - Most methadone treatment programs are already operating at 80% of capacity or greater[4]
- Training enough addiction medicine or psychiatric specialists would take years
- "To have any hope of stemming the overdose tide, we have to make it easier to obtain buprenorphine and naltrexone than to get heroin and fentanyl."[2]

38

Options for improving access to care for OUD

- Emergency Departments
  - High rate of opioid-related ED encounters :178/100k visits[1], 5 million/yr
  - ED is often the first point of health care contact for pts with OUD
  - Over 8k discharged from SC EDs/year without immediate access to treatment
- Inpatient Hospitals
  - Higher rate of inpatient opioid-related hospitalizations: 225/100k stays
  - Rates have doubled in past decade; estimated annual cost of $700 million[1-3]
    - related to ↑ opioid OD, opioid-related infectious endocarditis, skin/soft tissue infections, viral hepatitis[4]
- Primary Care Practices
  - More than 320,000 PCPs (Kaiser, 2017)
  - Plus a broad workforce of primary care NPs and PAs
  - "Mobilizing the PCP workforce to offer office-based buprenorphine treatment is a plausible, practical, and scalable intervention that could be implemented immediately."[2]

39

Published in final edited form as:
JAMA. 2015 April 28; 313(16): 1636–1644. doi:10.1001/jama.2015.3474.

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence:

A Randomized Clinical Trial

Gail D'Onofrio, MD, MS,
Department of Emergency Medicine, Yale School of Medicine, New Haven, Connecticut

- 329 OUD pts in ED (mostly heroin)
- 1:1:1: RCT with primary outcome 30d treatment retention
  - Screening + treatment referral (SRT): 38/102 (37%)
  - SBIRT: 50/111 (45%)
  - SBIT with bup/nlx and "fast track" follow-up: 89/114 (78%)
    - P<.0001

40

Barriers to MAT use in Emergency Department
MUSC ED Focus Groups (n=9)

- Most commonly reported barrier to using MAT in ED:
  - Lack of hospital/institution endorsement
    - Addressed during pilot
  - Fears of being "flooded" with patients
    - Addressed before pilot with Grand Rounds + champion
- Most frequently cited facilitators to using MAT:
  - Receiving paid time off for training
    - Unnecessary for one-time dosing
  - Having availability of outpatient follow-up
    - Addressed during pilot – established "fast track providers"
    - Also, peer navigator is key player for follow-up

41

	Total since 12/17	Pilot Goals
# ED patients screened for substance abuse/misuse	4314	500
# ED patients screened positive for substance abuse/misuse	1444 (33%)	
# ED patients screened positive for OUD	476 (11%)	
# ED patients provided with naloxone kits	103	150
# ED patients determined eligible for buprenorphine	329	150
# ED patients inducted on buprenorphine	150	100
# (%) ED patients inducted that arrived to first appointment	121 (81%)	
# retained at thirty-day mark	65/106 (61%)	

ED MAT Project: Treatment & Retention Outcomes for 3 SC EDs

TIDELANDS HEALTH

Grand Strand Health
Live your healthy

42

Original Investigation

August 2014

Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients

A Randomized Clinical Trial

Jane M. Liebschutz, MD, MPH[1,2]; Denise Crooks, MPH[1]; Debra Herman, PhD[3,4]; et al

Author Affiliations | Article Information

JAMA Intern Med. 2014;174(8):1369-1376. doi:10.1001/jamainternmed.2014.2556

- Patients with opioid-related hospitalizations rarely receive effective OUD treatment
- Similar barriers to ED initiation (need for follow-up care)
- Delayed OUD treatment in acute medical settings:
  - AMA discharges
  - Behavioral issues requiring added staff support and monitoring
  - Incomplete medical treatments
  - Increased risk for 30-day hospital readmission (50% more likely)
- Hospitalization represents a reachable moment for patients with OUD

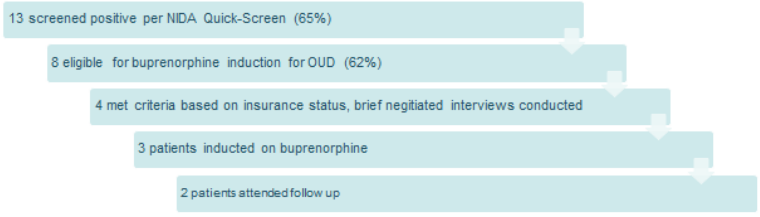
43

Inpatient Buprenorphine Induction for Medically Hospitalized Patients with Opioid Use Disorder

Sarah Oros, $MD_{1,2}$, Skip Schumann, MD_1, Rachel Perkins, MSW, Kelly Smith, MSW, Caitlin Kratz, MSW, LISW-CP_3, Kerri Holmes-Maybank, MD_1, Carolyn Bogdon, FNP_2 and Kelly Barth, $DO_{1,2}$

1. Department of Internal Medicine 2. Department of Psychiatry and Behavioral Sciences 3. Charleston County Department of Alcohol and Other Drug Abuse Services

- Brief 2-month pilot evaluation
  - Gen Med Service, funded pts
- 3 inducted on buprenorphine: 2 heroin, 2 Rx opioids
  - 2 followed-up (66%)
- Reasons for admission: Suicide attempt /bacteremia, Acute respiratory failure, Endocarditis, Intractable N/V/D



44

Opportunities for Inpatient OUD Treatment

- Established relationship with patient
  - If the inpatient provider is waivered, do not need next day follow-up, can write a bridging prescription
  - We already have a number of waivered inpatient providers
- Opportunity for detox + naltrexone induction for pts with length of stay 7+ days
- Also opportunity for quick induction for patients on high MEQ who destabilize while undergoing taper
- Need resources for unfunded patients
- These are high risk and expensive hospitalizations
  - If prevent one endocarditis readmission, can have huge impact
- Multiple opportunities as a site for upcoming RCTs

45

Medscape Medical News > Conference News

Buprenorphine 'Underused' in Primary Care as Opioid Abuse Soars

Nancy A. Melville

May 20, 2016

81 comments Print

EDITORS' RECOMMENDATIONS

Buprenorphine May Beat Opioids for Triad of Pain, PTSD, SUDs

CDC Opioid Guideline Lands, Controversy Continues

Pain Management News & Perspectives

RELATED DRUGS & DISEASES

AUSTIN, Texas — Despite being at the front lines in the nation's battle against opioid addiction as the first to treat chronic pain, and opioid overuse, few primary care and family physicians use the one drug available to them to treat addiction, buprenorphine, experts say.

"Sublingual buprenorphine is the only treatment for opioid addiction that can be provided by primary care providers [PCPs], yet it's rarely used by them and the demand for it is enormous," said Lucinda Grande, MD, from the University of Washington's Department of Family Medicine, in Seattle.

"Primary care is an ideal place for this drug to be used, with PCPs being the ones treating most of the chronic pain out

46

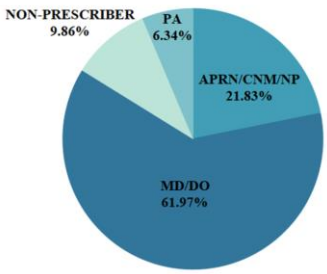
Barriers to MAT use in Primary Care
MUSC PCP Focus Groups (n=46)

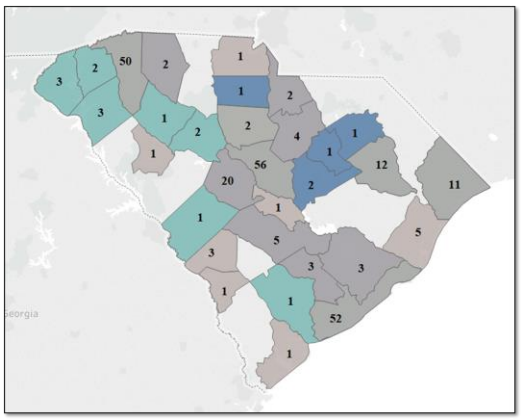
- Need for education and training
  - "I'm trying to understand how these are prescribed. What's the 8-hour training? Why does it take 8 hours? How involved is it? It sounds risky itself. Naltrexone sounded like it wasn't as risky. Is it a shot a month?"
- Need for specialty support
  - "So where is that specialist? Where are those systems to support us?"
- Emotional challenge
  - "…the vast majority of patients we're treating have chronic pain and that's why they are on opioids anyway, this conversation introduces an emotionally charged element that can halt your entire day and be very disruptive to practice as well. So just getting into that conversation there can be barriers there too."

47

Provide Training for Primary Care

- In the past year, we've provided the official 8-hour training course to prescribe buprenorphine to 227 providers in SC
  - Free of charge
  - 8 hours CME



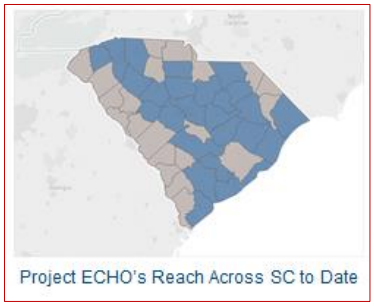


48

Addressing Need for Specialty Support & Emotional Challenge

Project ECHO Opioid Use Disorder in South Carolina: Amplifying Capacity for Evidence-Based Treatment

Rachel Grater, MFA, MA[1], Caitlin Kratz, MSW, LISW-CP[2], Carolyn Bogdon, MSN, FNP-BC[1], Suzanne Lane, MSHI[1], Kelly Barth, DO[1,3]
[1] Department of Psychiatry & Behavioral Sciences, [2]Charleston County Department of Alcohol & Other Drug Abuse Services, [3] Department of Internal Medicine



Project ECHO's Reach Across SC to Date

- 20 sessions to date
- 436 participants
- Average 22 participants/session
- One hour over lunch
- CME provided
- Website support

49

What about Chronic Pain?

Seeking Treatment for Addiction

70% Male

Life-saving treatment is available!

Connect patient to addiction treatment (MAT)

2 million

Seeking Treatment for Pain

65-80% Female

SBIRT +

SBIRT -

?????

7 million chronic opioid users with no exit plan

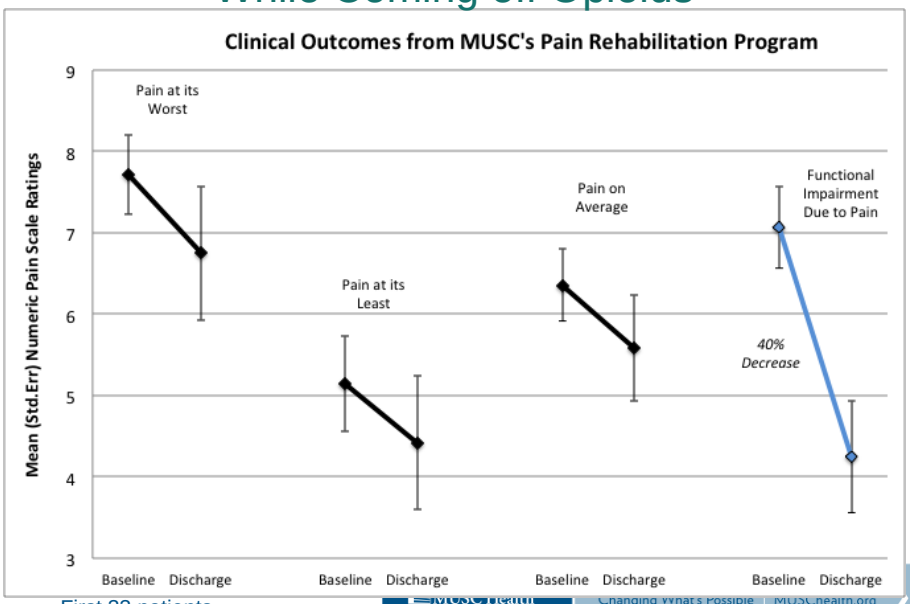
50

MUSC Outcomes – Pain Rehabilitation

- Operationalization
  - Funded through Duke Endowment
  - Ribbon cutting March 5, 2018
- Our Model
  - 3 week intensive outpatient program, group setting
  - Incorporates PT, OT, medical management, psychotherapy
  - Psychotherapy is Acceptance-based
  - Opioid discontinuation is mandatory
  - Childcare & travel scholarships available
  - Epic Referral
- Feasibility of Recruitment/Demonstration of Need
  - 154 referrals (no formal advertising)
    - 76% female
    - Averaging 22 referrals/month
    - 17 counties
    - Payor mix: BCBS, Medicaid, Medicare – Now Covered by BCBS

51

Decrease in Pain and Disability While Coming off Opioids



First 33 patients

52

Gender differences in Pain Rehab Outcomes

Table 3
Benefit from the pain management for the total sample and for each sex.

	Benefit	SD	d	T	*df*	*P*
PDI						
Total sample	−7.64	11.58	.570			
Men	−5.89	10.30	.436	3.330	494	.001
Women	−9.32	12.48	.684			
NRS minimum				*U*	Z	*P*
Total sample	−.95	2.09	.410			
Men	−.76	1.83	.359	27,027	−2.348	.019
Women	−1.14	2.30	.451			
NRS average						
Total sample	−1.54	1.96	.911			
Men	−1.23	1.74	.758	25,873	−3.083	.002
Women	−1.83	2.12	1.045			
NRS maximum						
Total sample	−.87	1.73	.642			
Men	−.74	1.55	.549	28,421	−1.475	.140
Women	−.99	1.87	.741			

NRS = Numeric Rating Scale; PDI = Pain Disability Index; U = Mann-Whitney *U* test; Z = z statistic; T = paired *t* test; *df* = degrees of freedom; M = mean; SD = standard deviation; n = set of numbers; *P* = *P* value (2-tailed); d = Cohen d.

Pieh et al., 2012

Pharmacologic Therapies Chronic Low Back Pain

Drug	Pain		Function	
	Magnitude of Effect	Strength of Evidence	Magnitude of Effect	Strength of Evidence
NSAIDs	Small-Moderate*	Moderate	None-Small	Low
Opioids (full)	Small*	Moderate	Small	Moderate
Buprenorphine	Small*	Low	Unable to estimate	Insuf
Tramadol	Moderate*	Moderate	Small	Moderate
Duloxetine	Small*	Moderate	Small	Moderate
Pain Rehab	Moderate-Large	Low-Mod	Moderate-Large#	Low-Mod

- *Mean effect = 1 point or less on 0-10 pain scale across medications
- #Clinically meaningful (for women)

Chou et al., 2017
Pieh et al., 2012

Summary

- The opioid crisis is ongoing and evolving – and affecting SC
- Treating OUD decreases overdose mortality
- Medications for OUD include both opioid and non-opioid treatments
- Identifying and treating OUD with MAT is the most evidence-based intervention for those with chronic pain (most common presentation in medical settings)
- Addressing the evolving crisis requires multiple adaptable approaches, including addressing barriers and improving access to OUD care
- Mobilizing the ED, hospital and PCP workforce to treat OUD effectively is a plausible, practical, and scalable intervention that can be implemented immediately
- Providing training/education + support through tele-mentoring/ECHO are approaches that can be implemented now and be fluid/adaptable as the crisis evolves
- There are multiple SC initiatives to improve access to OUD care for patients in medical settings
- Free training and support is available for SC providers to treat OUD
- Pain rehabilitation is a highly effective treatment for poorly-functional patients with chronic pain, especially effective in females

55

Acknowledgments

Charleston Center
A division of Charleston County Government
Renewing Hope, Strengthening Lives

South Carolina DAODAS
Department of Alcohol and Other Drug Abuse Services

MUSC
Medical University of South Carolina

FACES & VOICES OF RECOVERY

MUSC Health
eHEALTH INNOVATIONS
Center for Telehealth

56

www.scmataccess.org

Upcoming topics for Project ECHO Opioid Use Disorder

Proposed ECHO schedule Sept-Dec 2018 (1st & 3rd Fridays 12:30-1:30)

Date	Topic	Presenter
9/21	Co-morbidities: Personality Disorders	Dr. Kelly Barth
10/5	Treatment of Perinatal Opioid Disorder	Dr. Constance Guille
10/19	Medication Update: Alpha agonists (clonidine, lofexidine) for opioid withdrawal	Dr. Dan McGraw
11/2	Methadone Maintenance Treatment	Caitlyn Kratz, MSW, LISW-CP, CAC-I
11/16	Urine Drug Testing	Dr. Kelly Barth
11/30	Counseling Techniques for Primary Care: Motivational Enhancement	Dr. Joe Schacht
12/14	Brain Stimulation Techniques for Pain and Opioid Use	Dr. Colleen Hanlon

For more information and/or to register, contact:

Rachel Grater, Program Coordinator
at grater@musc.edu

57

Questions?

Slides, scales, and other practice tools are available on our website:

www.scmataccess.org

Kelly Barth, DO
stephen@musc.edu
(843) 792-5380

58