WISAM Newsletter: April 27, 2017 Teleconference

Attendees: Dr. Aleksandra Zgierska (President), Dr. Matthew Felgus (President-Elect), Dr. Brian Lochen (Treasurer), Dr. David Galbis-Reig (Secretary), Dr. Gayl Hamilton, Dr. Selahutin Kurter, Dr. Bill Gaertner, Dr. Subhadeep Barman, Dr. John Ewing, Dr. Ritu Bhatnagar, Dr. Blaise Vitale, Dr. Bruce Weiss.

Main topics addressed at tonight's teleconference

1) **WISAM's election of new officers and board members**
    a. Voting period ends on May 13, 2017.
    b. Please vote – follow the link sent in the email from Badger Bay, the WISAM's new, professional management group. We're very happy to have Badger Bay's support for our operations!

2) **Update from National and State Level:**

    a. Dr. Zgierska provided an update on the new proposal by Gov. Walker's administration (Wisconsin's 1115 Waiver) regarding mandatory screening toward drug use disorders (specifically mandatory drug testing) for Medicaid recipients (https://www.washingtonpost.com/powerpost/want-medicaid-coverage-a-drug-test-should-come-first-wisconsin-governor-says/2017/04/02/190068f0-160c-11e7-ada0-1489b735b3a3_story.html?utm_term=.968c491f2d8a)
        i. While it is agreed that screening for substance use disorders should be part of a regular comprehensive medical care, it is felt that drug misuse assessment / testing in isolation, outside of clinical setting is not useful, and can have negative consequences. It is unclear how the State plans to obtain and then utilize the information from these screening tests.
        ii. Excluding someone from Medicaid eligibility due to refusal of a drug test is not acceptable. (Current rule will prohibit such an individual from reapplying for Medicaid for six months.)
            1. These individuals will continue to require care and Hospital's will be on the hook.
            2. Performing coercive drug testing in the absence of clinical justification is not acceptable.
            3. Talking Points for those interested in making comments during the Open Comment period are included as a separate attachment ("Wisconsin Waiver Talking Points").

4. Dr. Kurter volunteered and then attended the public hearing on this law in Milwaukee on Monday, May 1st, 2017.

b. Here is the link to the DHS' site that describes the details and allows comments (open comment period ends on May 19) **– please consider commenting on this proposed law**! https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm

c. Results from the ongoing mandatory testing in Wisconsin of those on welfare (http://www.ncsl.org/research/human-services/drug-testing-and-public-assistance.aspx) showed that among 1,305 people assessed, only 10 screened positive… (http://knowledgecenter.csg.org/kc/content/results-coming-states-drug-testing-welfare-recipients). Is this really a cost-effective use of limited resources?

3) Check-in on the ePDMP

a. Teleconference participants expressed concern that medications prescribed (specifically buprenorphine) was not showing up in the ePDMP and asked what could be done about this. In addition, there is often a lag between when the medication was dispensed versus when this info appears in the ePDMP.
   i. The Legal Requirement as of April 1, 2017 is that dispensed medications be reported to the ePDMP within 24 hours (business day).
   ii. Several participants in the teleconference noted that prescriptions for buprenorphine have not appeared for over one week and a few reported that their prescriptions were not recorded at all.
   iii. The discussion pointed to the approach it might be best to first call the involved pharmacy and work with them individually, in a collegial manner, to make sure they are reporting the data to the ePDMP. In case a pharmacy continues to be / repeatedly is non-compliant with the law and prescriptions continue to not be recorded in the ePDMP, consider contacting the Controlled Substances Board or ePDMP so that they can work with the pharmacy to ensure that timely transmittal is occurring.
   iv. It was again noted that the VA Medical Centers and the federally-licensed opioid agonist maintenance programs are not required by law to report the data to the ePDMP. The VA pharmacies can do it on a voluntary basis, and some of them are doing it.

b. A question was asked regarding how to report a suspected case of "double dipping" to the ePDMP to create an Alert in the data base.
   i. It is not clear that there is currently a method for prescribers to create "alerts" in the ePDMP database to communicate such concerns with other providers; the understanding is though this type of functionality will be made available in the future.
   ii. At the present time, alerts are being populated by algorithms (co-prescribing, high dose opioid, etc.) or by law enforcement or pharmacy creating an alert (overdose, stolen prescription pads, etc.). If the alert entered by law enforcement is incorrect (ie, was entered for a non-

controlled substance), one can notify the ePDMP so that they can reach out to the officer and educate.

4) **Accepting new patients who are already established on Medication Assisted Treatment (specifically buprenorphine).**

   a. TIPS for Accepting new patients switching care from another provider.
      i. Check ePDMP
      ii. Obtain prior medical records for review
      iii. Talk with previous provider (after signing a release of information form) to ensure a smooth and safe transition and transfer of the Medication Assisted Treatment.
      iv. Sign treatment agreement when deciding to continue this therapy (ie, after checking on appropriateness of continuation of this therapy).
      v. Obtain a urine drug test at the initial visit.
      vi. Most providers see patients more frequently (every 1-2 weeks) initially, even if the patient reports to be "established" in recovery, to both establish rapport and ensure that the patient is doing well. Once rapport and trust are established, and appropriateness of a less-frequent follow-up is confirmed, a patient may be seen less frequently.

   b. Patients who come in on stimulants and buprenorphine, or are requesting stimulants for (presumed) ADHD while on buprenorphine.
      i. There was agreement that ADHD treatment is not an urgent issue and use of non-stimulant options (guanfacine, atomoxetine, bupropion) is a reasonable first line approach for the treatment of ADHD in patients on buprenorphine.
      ii. Prior to prescribing a stimulant, assess the patient carefully toward ADHD either by referring for a consult to mental health providers or by using validated assessment instruments. A link to the Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist, reported to be free, was provided by Dr. Bhatnagar: https://add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf
      iii. If patient's truly have ADHD, and would benefit from stimulants, consider using the extended release formulations that seem to be more resistant to misuse.
      iv. Carefully document everything.

   c. Patients who come in on benzodiazepines and buprenorphine, or are requesting benzodiazepines for (presumed) anxiety or sleep problems, while on buprenorphine.
      i. There was agreement that benzodiazepines and buprenorphine should not be prescribed. Those coming to establish care and are on this combination of medications, can be offered a continued buprenorphine treatment if they agree to a benzodiazepine taper (or vice versa) so that both medications are not continued together long-term. Taper off

benzodiazepines is usually a longer, gradual process – unless patient or societal safety are compromised, in which case a gradual taper may not be appropriate.

ii. Carefully document everything.

Meeting adjourned at 8:04 PM.

The next WISAM Teleconference will occur on Thursday, Apr 27, 2017, 7-8 PM.

Please let Cindy Burzinski, WISAM's Executive Administrator, know if you have suggestions for topics to discuss at the upcoming teleconference or if there are any errors in the current document: Cindy.Burzinski@fammed.wisc.edu

IMPORTANT REMINDERS

Please remember to **renew your ASAM / WISAM membership** or consider becoming a member (open to all clinicians). More details can be found at: http://www.asam.org/membership

Please mark your calendars for the **WISAM 2017 Annual Conference** on September 14-16, 2017 at the Pyle Center, Madison, WI
(Thu and Fri: educational topics and workshops; Sat: buprenorphine / Probuphine® training).

RESOURCES
TO ENHANCE CLINICAL CARE RELATED TO ADDICTION MEDICINE

FREE CSAM Webinars
These live webinars are FREE for all clinicians (4th Fri of the month, 12-1 PM PST). Current series of 12 monthly webinars is designed to support the implementation of Medication Assisted Treatment (MAT) in primary care. In general, CSAM (California Society of Addiction Medicine) offers great resources, available at: http://cme.csam-asam.org/content/buprenorphine-resources#overlay-context=courses

FREE Provider's Clinical Support System (PCSS) for Medication-Assisted Treatments (PCSS-MAT: http://pcssmat.org) and Opioid Prescribing (PCSS-O: http://pcss-o.org): excellent free resource, funded by a grant from SAMHSA; it offers free webinars available "real-time" or via the archived library. One can sign up for regular news emails from them.

FREE David Mee-Lee's monthly Tips and Topics, sent via email (one needs to sign-up to it), it is an excellent resource:
dmeelee@changecompanies.net
http://www.changecompanies.net

FREE Join Together Daily News is a news service from the Partnership for Drug-Free Kids that provides daily or breaking news on the top substance abuse and addiction news that impacts our work, life and community. It also provides original reporting and/or commentary features published every Wednesday by influential thought leaders in the addiction field or staff.
http://www.drugfree.org/join-together/

PAID The Carlat Report: Addiction Medicine (however, it appears to be a paid resource, ~$109/year); a link to the copy of the recent report is attached so that you can get a flavor of what it is: http://carlataddictiontreatment.com/sites/default/files/CATR_May2016.pdf

The National Academy of Sciences (IOM) Recent Report on Cannabis

"*The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*" was published in Jan 2017; free copy is available for a limited time at the following web site:
https://www.nap.edu/login.php?record_id=24625&page=https%3A%2F%2Fwww.nap.edu%2Fdownload%2F24625.

a. The report's tone is generally favorable toward use of cannabis as medicine despite not-so-convincing evidence on some of the recommendations.
b. The report is surprisingly sparse on discussing potential adverse effects of cannabis and cannabinoids (in general).
c. The report makes recommendations regarding the need for more research.
d. Provides should familiarize themselves with the report as patients (and other professionals) are likely to ask questions about this issue.
e. It's worth remembering that marijuana use is illegal in Wisconsin; professional societies, including the ASAM/WISAM, overall do not endorse its use (as a plant) for medicinal purposes due to lack of convincing evidence for effectiveness, while, at the same time, presence of evidence for harms, including addiction (as outlined in a recent ASAM's white paper on this topic); cannabis produces sedating effects, which can potentiate sedating effects of other substances, eg, opioids.