NAS ICM
Prevention and Opiate Impact on Newborns
Ann Negri, MD, FAPA, DFAPA
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Objectives

• Identify high risk and vulnerable parent/child constellation for mothers with dual diagnoses and substance use.

• Support the mother's adherence to treatment prenatally and after delivery.

• Provide NAS education and treatment options including MAT for opiate use disorder.

• Talk with members addicted to opioids about a management plan and how prescribing of opioids will be handled during the pregnancy.

• Reduce neonatal intensive care unit (NICU) admissions and hospital stays from NAS complications.
Neonatal Abstinence Syndrome (NAS)

1,903 cases during 2008-2014

235% increase in NAS Rates from 2008 to 2014

US rate is 5.8 for 2012*


*Source: AZ HDD 2008-2014*
<table>
<thead>
<tr>
<th>Year</th>
<th>NAS</th>
<th>Narcotics</th>
<th>Cocaine</th>
<th>Hallucinogens</th>
<th>Alcohol</th>
<th>Other Drugs of Addiction</th>
<th># of Hospital Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>145</td>
<td>234</td>
<td>161</td>
<td>35</td>
<td>22</td>
<td>95,420</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>154</td>
<td>410</td>
<td>99</td>
<td>51</td>
<td>25</td>
<td>89,115</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>223</td>
<td>414</td>
<td>79</td>
<td>46</td>
<td>15</td>
<td>84,069</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>300</td>
<td>424</td>
<td>68</td>
<td>46</td>
<td>30</td>
<td>81,988</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>304</td>
<td>531</td>
<td>59</td>
<td>47</td>
<td>27</td>
<td>82,905</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>339</td>
<td>646</td>
<td>55</td>
<td>68</td>
<td>20</td>
<td>82,338</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>438</td>
<td>650</td>
<td>34</td>
<td>93</td>
<td>33</td>
<td>83,427</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>470</td>
<td>462</td>
<td>37</td>
<td>73</td>
<td>33</td>
<td>299</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,373</strong></td>
<td><strong>3,771</strong></td>
<td><strong>592</strong></td>
<td><strong>459</strong></td>
<td><strong>205</strong></td>
<td><strong>299</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Arizona Department of Health Services, Public Health Vital Statistics, Hospital Discharge Data
NAS Rate (NAS Births per 1,000 births)

source: Arizona Department of Health

Neonatal Abstinence Rates per 1,000 live births Arizona, 2008-2015

2015
470 infants
dx with NAS

Proprietary and Confidential
Illicit drug use and associated lifestyle risks

Pregnant women who use illicit drugs aren’t just putting their baby at risk – they’re also putting themselves at risk. They have an increase likelihood of getting involved with or facing:

• Prostitution
• Theft
• Violence (becoming victims of violence)
• Sexually transmitted infections
• Loss of child custody
• Criminal proceedings
• Incarceration
• Victims of sex trafficking
Complications from drug, alcohol use during pregnancy

Possible complications from drug and alcohol use during pregnancy can lead to many health problems in the baby besides NAS. These may include:

- Birth defects, smaller head circumference
- Premature birth
- Sudden Infant Death Syndrome (SIDS)
- Risk for developmental problems, such as cerebral palsy, seizure disorder and intellectual disabilities
Provider collaboration for treating pregnant women using substances/opioids

Who is talking to women about substance use, prescription opioid use and NAS before they become pregnant?

Who is asking pregnant women about substance use/prescription opioid use during pregnancy?
Goals of the pregnancy ICM program

- Reducing the high volume of NICU babies with NAS
- Education and outreach of member who are identified as high risk in pregnancy due to substance use
- Education and outreach to OB providers to utilize CSPMP to identify and refer to CM
- Education and outreach of methadone clinics to encourage pregnant members to enroll in CM
- Early identification through pharmacy reports for first fill MAT and opioid Rx to identify pregnant members and to identify and monitor opioid use
- Increase CM engagement and care coordination with OB and pain management providers
NAS CM Process Flow

1. Referral received and triaged
2. Member visit
3. Assigned to NAS CM
4. Education & referrals
5. Member outreach and engagement
6. Coordination of care
7. Mbr specific care planning begins
8. Mbr remains in CM 6-8 wks PP
9. Infant remains in CM until 1 yr. of age
NAS resources and care coordination

- Parent and infant monitoring 0-5 programs
- Special programs/home visiting programs
- Resources and services for mother
- AzEIP, WIC, BH/develop mental services
- Behavioral Health and Addiction services
- PCP and medical specialists

Member and Child
Mercy Care data on at-risk pregnancies: SMI population

Mercy Maricopa preliminary at-risk pregnancies
Type of substance use 2015-2017 (422 of 615 births)

Identified Substance Use: Opioid Abuse, Opioid Treatment, CNS Stimulants, CNS Depressants, Cannabinoids, Alcohol, Tobacco

68.6% identified with prenatal substance use

CNS Stimulants: Meth/Amphetamines, Cocaine, Adderall. CNS Depressants: Benzodiazepines.
Opioid Abuse: Rx Opiates, Heroin; Opioid Treatment: Methadone, Subutex
Mercy Care data at-risk pregnancies for SMI population

Mercy Maricopa preliminary at-risk pregnancies
Type of opioid use 2015-2017 (211 of 615 births)

34.3% identified with prenatal Opioid use
NAS babies enrolled in CM July 2015-July 2019

- (July-Dec)2015: 19
- (Jan-Dec)2016: 136
- (Jan-Dec)2017: 170
- (Jan-Dec)2018: 162
- (Jan-July)2019: 55
Mercy Care data on at-risk pregnancies for SMI population

NICU admissions by type of opioid use

- Opioid Abuse: Rx Opiates, Heroin
- Opioid Treatment: Methadone, Subutex

<table>
<thead>
<tr>
<th>Type of Opioid Use</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Abuse</td>
<td>35</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Opioid Treatment</td>
<td>10</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Opioid Abuse and Treatment</td>
<td>9</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>
NAS Program Outcomes

• Substantial increase in referrals to NAS case management since implementing the enhanced processes
  • Greater number of referrals for use of prescription opioids
  • Primary Dx related to prescription opioids: back pain

• Implementation of case management for mother and baby together

• Outreach materials
  • NAS parent/guardian brochure, Pregnancy newsletter
  • Provider notification

• Community education: Presentations/symposiums

• Mercy Care representation on advisory teams and task forces

• Collaboration with state agencies, and community partners

Proprietary and Confidential
Challenges for early identification

- Pregnant women are reluctant to self-report opioid use because of social or legal consequences
- Not receiving prenatal care of late care in second or third trimester
- Multiple prescribers
- Under reporting of illicit and/or prescribed substance use in pregnancy by OB and pain specialists
- Methadone clinics not referring members to health plan ICM
- Lack of universal drug screening
- 42 CFR Part 2 restrictions on sharing of SUD information
Challenges

• Limited number of OB providers willing to manage opioids during pregnancy
• Provider coordination (OB/BH/pain management)
• Variation in utilization of newborn NAS screening and treatment protocols
• Inability to simultaneously case manage all mothers/babies together due to change in insurance/health plan coverage
• Difficulty contacting members/engagement
• Pregnant members concerned about stigma and possible DCS involvement
• Challenges in case management re: DCS involvement
How to refer to NAS Intensive care management plan team

- Title XIX Mercy Care Members: complete the referral form on the web site and fax to mailto:OBfaxes@aetna.com
  https://www.mercycareaz.org/assets/pdf/acc-providers/forms/Perinatal%20Referral%20Form%20UA.pdf

- SOR grant is available to increase access to Opioid Use Disorder treatment for uninsured/under-insured pregnant women. MC Care Management Team: RN: Anita Delley RN 480 486-4950 Tracey Abrego, Comm. Health Worker: 480 327-7448
Resource referral for uninsured and Non-title members

- Contact information and more information on SABG can be found at: [https://www.mercycareaz.org/wellness/sabg](https://www.mercycareaz.org/wellness/sabg)
- Non-Title OUD Pregnant women from the SOR Grant the referral process. Provider can call Mercy Care Perinatal Care Management team services include:
  - In home/community or phone support
  - Connections to resources OUD treatment; counseling; OB services; housing; benefits; transportation
  - Patient Education Topics include:
    - Opioid Use in Pregnancy
    - Nutrition
    - Pregnancy and Birth
    - Managing a newborn
    - Diabetes management
    - well-baby needs
    - NAS baby needs
    - life skills
Resource referral for uninsured and Non-title members

- Funding targets the following populations:
  - Pregnant women/teenagers who use drugs by injection
  - Pregnant women/teenagers who use substances
  - Other individuals who use drugs by injection

Substance using women/teenagers with dependent children and their families, including women who are attempting to regain custody of their children

As funding is available - all other individuals with a SUD, regardless of gender or route of use.

You can call Mercy Care Member Services at 602-586-1841, toll free at 1-800-564-5465 or TTY/TDD: 711 to get connected to care. Representative are available 24 hours a day, 7 days a week.
Additional Resources

http://pediatrics.aappublications.org/content/129/2/e540.full.html

Neonatal Abstinence Syndrome State of the Art Review Article
http://pediatrics.aappublications.org/content/pediatrics/134/2/e547.full.pdf

Reasons for Rehospitalization in Children Who Had Neonatal Abstinence Syndrome
http://pediatrics.aappublications.org/content/136/4/e811

Prescription Opioids Epidemic and Infant Outcomes
http://pediatrics.aappublications.org/content/pediatrics/early/2015/04/08/peds.2014-3299.full.pdf


Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care
http://www.astho.org/Prevention/NAS-Neonatal-Abstinence-Report

March of Dimes NAS information
Thank You
Substance Use Disorder in Pregnant and Parenting Women

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Professor, Department of Obstetrics and Gynecology
University of Arizona College of Medicine Phoenix
2019
Conflict of interest

No financial conflict to disclose
Objectives

Describe the Obstetric Care for Women with Opioid Use Disorder Patient Safety Bundle

- List components of Readiness presented
- List 3 Recognition & Prevention practices that all providers should include in their care
- List 4 Response actions that providers should include in the care
- Describe the Reporting & Systems Learning that are required in Arizona

Discuss Practical Care for Opioid Dependence in Pregnancy

- Describe required components in managing patients on OBOT (Office Based Opioid Agonist Treatment)
Neonatal Abstinence Syndrome

39% of mothers of NAS cases were being medically supervised while taking opioids while pregnant.

Percentage of mothers that were being medically supervised while taking opioids while pregnant.

Medical supervision includes Medication Assisted Treatment (MAT), pain management, & treatment with certain psychiatric medications.
Resources: Patient Education

Neonatal Abstinence Syndrome

"Too often we underestimate the power of touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring. All of which have the potential to turn a life around."

-- Leo F. Buscaglia

Sources: Catholic Health WomenCare
National Perinatal Association

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018
Council on Patient Safety in Women’s Health Care


- Maternal Mental Health: Depression and Anxiety
- Maternal Venous Thromboembolism
- Obstetric Care for Women with Opioid Use Disorder
- Obstetric Hemorrhage
- Postpartum Care Basics for Maternal Safety: From Birth to the Comprehensive Postpartum Visit
- Reduction of Peripartum Racial/Ethnic Disparities
- Safe Reduction of Primary Cesarean Birth
- Severe Maternal Morbidity Review
- Support After a Severe Maternal Event
Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine

Jeffrey Ecker, MD; Alfred Abuhamad, MD; Washington Hill, MD; Jennifer Bailit, MD; Brian T. Bateman, MD; Vincenzo Berghella, MD; Tiffany Blake-Lamb, MD; Constance Guille, MD; Ruth Landau, MD; Howard Minkoff, MD; Malavika Prabhu, MD; Emily Rosenthal, MD; Mishka Terplan, MD; Tricia E. Wright, MD; Kimberly A. Yonkers, MD

The American College of Obstetricians and Gynecologists supports the value of this clinical document as an educational tool, March 2019.
Epidemiology of opioid use in pregnancy

21.6% of pregnant women enrolled in Medicaid receive a prescription for opioids

From 2000-2009 antepartum maternal opioid use increase from 1.19% to 5.63%

4.7% of pregnant women reported using illicit substances in past month

1 in 300 women will become dependent on opioids after a cesarean section

NOW / NAS treatment cost ~$1.5 billion in 2015

Substance use in pregnancy-associated deaths in TX, MD, AK were 17%, 15% and 22% respectively
Case presentation

24yo G2P0101 Hispanic female present in first trimester. Your medical assistant has prescreened patient and she admits to using heroin, cannabis and nicotine. She denies ETOH use. When you see her, she reports having a preterm delivery 18 months ago, the child is in care of the FOB’s mother. Pt states this is an unintended pregnancy but desired.
## Social History

<table>
<thead>
<tr>
<th>Alcohol Use:</th>
<th>Yes</th>
<th>No</th>
<th>Deferr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinks/Week:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses of wine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cans of beer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shots of liquor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Weed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td>occasional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexuality Active:</th>
<th>Yes</th>
<th>No</th>
<th>Not Currently</th>
<th>Deferr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Control / Protection:</td>
<td>Abstinence</td>
<td>Condom</td>
<td>Intrauterine Device (IUD)</td>
<td>Implant</td>
</tr>
<tr>
<td>Partners:</td>
<td>Female</td>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Use:</th>
<th>Yes</th>
<th>No</th>
<th>Deferr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types:</td>
<td>Amphetamines</td>
<td>Amyl nitrate</td>
<td>Anabolic Steroids</td>
</tr>
<tr>
<td></td>
<td>Barbiturates</td>
<td>Bath salts</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td></td>
<td>&quot;Crack&quot; Cocaine</td>
<td>Cocaine</td>
<td>Codeine</td>
</tr>
<tr>
<td></td>
<td>Flunitrazepam</td>
<td>GHB</td>
<td>Hashish</td>
</tr>
<tr>
<td></td>
<td>Hydrocodone</td>
<td>Hydromorphone</td>
<td>Ketamine</td>
</tr>
<tr>
<td></td>
<td>LSD</td>
<td>Marijuana</td>
<td>MDMA (Ecstasy)</td>
</tr>
<tr>
<td></td>
<td>Methamphetamine</td>
<td>Methaqualone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylphenidate</td>
<td>Morphine</td>
<td>Nitrous Oxide</td>
</tr>
<tr>
<td></td>
<td>Opium</td>
<td>Oxycodone</td>
<td>PCP</td>
</tr>
<tr>
<td></td>
<td>Solvent Inhales</td>
<td>Spice</td>
<td>Other comments on drugs</td>
</tr>
<tr>
<td>Per Week:</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NIDA Quick Screen & 4Ps Plus/5Ps

https://www.drugabuse.gov/nmassist/

Parents
Peers
Partner
Past
Pregnancy
Sensitively, Specificity, PPV, NPV
What labs do you need?

Serum electrolytes
BUN and creatinine
CBC with differential and platelet count
Liver function test (GGT, AST, ALT, PT, albumin)
Lipid profile
Urinalysis
Urine drug screen
HIV antibody test
Hepatitis B virus and hepatitis C virus screens
Serology for syphilis
PPD or QFT
# Signs of Intoxication and Withdrawal

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Physical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid intoxication</td>
<td>Conscious, Sedated, drowsy, Slurred speech, “Nodding” or intermittently dozing, Memory impairment, Mood normal to euphoric, Pupillary constriction</td>
</tr>
<tr>
<td>Opioid overdose</td>
<td>Unconscious, Pinpoint pupils, Slow, shallow respirations (respirations below 10 per minute), Pulse rate below 40 per minute, Overdose triad: apnea, coma, pinpoint pupils (with terminal anoxia: fixed and dilated pupils)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage of Withdrawal</th>
<th>Grade</th>
<th>Physical Signs/Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early withdrawal</td>
<td>1</td>
<td>Lacrimation and/or rhinorrhea, Diaphoresis, Yawning, Restlessness, Insomnia</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Dilated pupils, Piloerection, Muscle twitching, Myalgia, Arthralgia, Abdominal pain</td>
</tr>
<tr>
<td>Fully developed</td>
<td>3</td>
<td>Tachycardia, Hypertension, Tachypnea, Fever, Anorexia or nausea, Extreme restlessness</td>
</tr>
<tr>
<td>withdrawal</td>
<td>4</td>
<td>Diarrhea and/or vomiting, Dehydration, Hyperglycemia, Hypotension, Curled-up position</td>
</tr>
</tbody>
</table>
# COWS
Clinical Opiate Withdrawal Scale

<table>
<thead>
<tr>
<th>Resting Pulse Rate:</th>
<th>GI Upset: over last 1/2 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beating/min</td>
<td></td>
</tr>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over last 1/2 hour not accounted for by room temperature or patient activity.</th>
<th>Tremor observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No report of chills or flushing</td>
</tr>
<tr>
<td>1</td>
<td>Subjective report of chills or flushing</td>
</tr>
<tr>
<td>2</td>
<td>Flushed or observable moistness on face</td>
</tr>
<tr>
<td>3</td>
<td>Beads of sweat on brow or face</td>
</tr>
<tr>
<td>4</td>
<td>Sweat streaming off face</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness Observation during assessment</th>
<th>Yawning Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to sit still</td>
</tr>
<tr>
<td>1</td>
<td>Reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>3</td>
<td>Frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>5</td>
<td>Unable to sit still for more than few seconds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil size</th>
<th>Anxiety or irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Pupils pinned or normal size for room light</td>
</tr>
<tr>
<td>1</td>
<td>Pupils possibly larger than normal for room light</td>
</tr>
<tr>
<td>2</td>
<td>Pupils moderately dilated</td>
</tr>
<tr>
<td>5</td>
<td>Pupils so dilated that only rim of the iris is visible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint Aches</th>
<th>Gooseflesh skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</td>
<td>Skin is smooth</td>
</tr>
<tr>
<td>0</td>
<td>Not present</td>
</tr>
<tr>
<td>1</td>
<td>Mild diffuse discomfort</td>
</tr>
<tr>
<td>2</td>
<td>Patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>4</td>
<td>Patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny nose or tearing</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not accounted for by cold symptoms or allergies</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>0</td>
<td>Not present</td>
</tr>
<tr>
<td>1</td>
<td>Nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2</td>
<td>Nose running or tearing</td>
</tr>
<tr>
<td>4</td>
<td>Nose constantly running or tears streaming down cheeks</td>
</tr>
</tbody>
</table>

**Score:** 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

**Initials of person completing Assessment:**
<table>
<thead>
<tr>
<th>Opioid</th>
<th>Half-Life (Adults)</th>
<th>Onset of Withdrawal Symptoms After Exposure</th>
<th>Onset of Withdrawal Symptoms After Prenatal Exposure</th>
<th>Typical Duration of Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>2-6 min(^{a})</td>
<td>6 h</td>
<td>24-48 h</td>
<td>8-10 days</td>
</tr>
<tr>
<td>Methadone</td>
<td>8-150 h (mean 35 h)</td>
<td>24-96 h</td>
<td>48-72 h</td>
<td>10-14 days, secondary withdrawal as long as 6 mo</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Mean 37 h</td>
<td>6-24 h</td>
<td>36-60 h</td>
<td>Milder withdrawal than other opioids. Usually resolves within 7 days, but may be prolonged in neonates</td>
</tr>
<tr>
<td>Morphine</td>
<td>1.5-7 h</td>
<td>8-12 h</td>
<td>ND</td>
<td>7-10 days</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>3-5 h</td>
<td>6-12 h</td>
<td>36-72 h</td>
<td>7-14 days, secondary withdrawal as long as 6 mo</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>7-9 h</td>
<td>8-12 h</td>
<td>24-96 h</td>
<td>5-14 days, secondary withdrawal as long as 6 mo</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>11-36 h (mean 21 h)</td>
<td>3-5 h</td>
<td>ND</td>
<td>4-5 days</td>
</tr>
</tbody>
</table>

\(^{a}\) Heroin is metabolized to morphine-6-glucuronide and morphine.  
min: minute; ND: no data available.  
Source: References 4, 5, 11, 12, 14, 16, 18, 25.
Management in Pregnancy

Induction / Transition to MAT maintenance agonist therapy
  • Methadone
  • Buprenorphine

Dose adjustment and monitoring

Counseling regarding NAS and breastfeeding

Counseling regarding pain management in labor

Counseling on postpartum birth control
NIDA for Medical and Health Professionals

https://youtu.be/H0vWVLuXTW0
Response actions

Get waived

Buprenorphine induction

Medications to assist with withdrawal symptoms

- Dicyclomine for abdominal cramps
- Hydroxyzine for agitation
- Loperamide for diarrhea
- Ibuprofen for muscle aches
- Clonidine for withdrawal symptoms
- Trazadone for insomnia
Providers’ Clinical Support System

For Medication Assisted Treatment

What We Do

PCSS-MAT is a national training and clinical mentoring project developed in response to the opioid use disorder crisis. The overarching goal of PCSS-MAT is to provide the most effective evidenced-based clinical practices in the prevention, identification, and treatment of opioid use disorders. These are available to all health professionals at no cost and include:

- Online modules
- Webinars
- Small Group Discussions with experts
- 8 hour MAT waiver training course

https://pcssmat.org/
Case Presentation

24yo G2P0101 Hispanic female presents at 38w3day with fetal growth at 8%tile in labor. SVE 5cm/100/0 station. After 2 hours she has a Category III FHR tracing secondary to persistent late decelerations refractory to uterine resuscitative measures.
Pain Management

Consider full agonist opioid

Offer regional analgesia

Vaginal delivery
  • Routine postpartum orders with prn opioid analgesia x24 hours. Resume/continue buprenorphine

Cesarean section
  • 1st 24 hours: anticipate increase needs PCA
  • After 24 hours: increased potency short acting
    o hydromorphone with 50-70% increased dose (4-6mg PO every 4-6 hours)
Team Coordination

Provide referrals to providers (e.g. social workers, psychiatry, and infectious disease) for identified co-morbid conditions.

Identify a lead provider responsible for care coordination, specify the duration of coordination and assure a “warm handoff” with any change in the lead provider.

Develop a communication strategy to facilitate coordination among the obstetric provider, OUD treatment provider, health system clinical staff (i.e. inpatient maternity staff, social services) and child welfare services.
Reporting requirements in AZ

A.R.S 13-3620 a health care professional, who reasonably believes that a newborn infant may be affected by the presence of alcohol or a drug, to immediately report this information

SB1283 was signed into law late 2017, this requires doctors in AZ to check the CSPM (Controlled Substance Prescription Monitoring) System before prescribing certain controlled substances to a patient

HB 2355 was signed into law, allows pharmacist to dispense Naloxone without a prescription to a person at risk of experiencing an opioid-related overdose.
The FACTS about street FENTANYL

There is no such thing as a safe street drug. Know the risks.

Fentanyl is often added to other illegal drugs without people knowing.

Fentanyl has been used illegally in various forms including:
- Pills
- Pure powder
- Powder mixed with other drugs
- Patches

50 - 100 times more potent than Heroin • Oxycodone • Morphine

Fentanyl [fen-tuh-nil] An opioid narcotic, a prescription drug used for cancer patients in severe pain.

Overdose Signs
- Trouble walking or talking
- Pinpoint pupils
- Seizures
- Slow heartbeat
- Shallow breathing
- Bluish or cold/clammy skin

Slang Terms
- Fake oxy
- Greenies
- Green beans
- Green apples
- Apples
- Eighties
- Shady eighties

You can't See it, Smell it, or Taste it.

“Above all, Do No Harm”
You're Invited!

Expanding Capacity for Health Outcomes in Pregnant and Parenting Women (PPW) with Substance Use Disorder (SUD)

Join us in standardizing care for PPW with SUD by attending tele-mentoring sessions led by addiction medicine experts. The tele-mentoring sessions will begin with a small teaching segment, followed by case reviews, discussion and recommendations.

This publication was made possible by grant number H/S108020 from SAMHSA. The views, opinions and content of this publication are those of the author and do not necessarily reflect the views, opinions or policies of SAMHSA or HHS.
Thank You!

Addiction Medicine Clinic
Banner University Women’s Institute
1441 N 12th St.
Phoenix, AZ 85006
Phone 602-521-5700

Substance Use Disorder Clinic
MIHS CHC Women’s Care Clinic
2525 E Roosevelt Street
Phoenix, Arizona 85004
Phone 602-344-5407
Prescription for Change Opioid Conference
August 24, 2019

Resource Table Break
Return to your seats by 10:20 am
Changing the Conversation
The Myth of the Magic Pill

Elisa Segal, MD, DABFM
What if everything you thought you knew about treating pain is wrong?
Disclosure

• I have no financial relationships to disclose
No formal pain management training

Why should I change? What’s in it for me?

Expectation of zero pain

Alternative treatments not covered by insurance

Time constraints

Patient satisfaction surveys tied to bonuses
Proprietary

Perception that opioids are the most effective treatment for "real" pain

Expectation of zero pain

Don't question the provider

Insurance coverage or lack thereof for MAT---the drug is the cheaper option

Already dependent/addicted

Stigma attached to seeking treatment
Rapid Tone
Burn Fat Quicker
Without Dieting or Exercise

Rapid Tone Benefits
- Fat Blocker - Helps Prevent Fat From Building Up
- Appetite Suppression - Control Food Cravings
- Serotonin Increase - Improve Overall Mood
- Feel Better, Comfortable, and Energized

CLAIM YOUR FREE BOTTLE TODAY!
Try Rapid Tone Absolutely Risk Free for 30 Days!!!
The “Dirty Little Secret”- A conspiracy of silence?

Little to no evidence from high quality clinical trials that opioids work well for pain.

SPACE Study¹ - Chronic pain
 Bronx EDs² - Acute pain
 Portland VA³- Longterm opioids
 Fifty three unique trials- Compared with placebo

¹“Opioids not better than non-opioid medication,” Strategies for Prescribing Analgesics Comparative Effectiveness Trial (SPACE), U.S. Department of Veterans Affairs, 16 May 2017
³Sterling McPherson, Crystal Lederhos Smith, Steven K. Dobscha, Benjamin J. Morasco, Michael I. Demidenko, Thomas H. A. Meath, Travis I. Lovejoy. Changes In Pain Intensity Following Discontinuation of Long-Term Opioid Therapy for Chronic Non-Cancer Pain. PAIN, 2018; 1 DOI:
Non-narcotics work BETTER for acute pain
Shhh...

Percent of people with 50% pain relief

If You Don’t Believe Studies...

My dentist!
“They kept giving me 10 mg of Vicodin every four hours, because (they said) that’s what the doctor authorized. I asked. At one point, they asked if I wanted morphine, and I said I would like 800 mg of ibuprofen. I knew that worked well because that’s what (I was given) when I broke my arm (and) it was the only thing that relieved the pain.

They would not give it to me. Vicodin and morphine were the only things they would give...”
First Fill Limits

Risk of continued opioid use increases at 4-5 days

Likelihood of continuing to use opioids

1 year

3 years

5 days=20 pills!

It may only take one

Source: Centers for Disease Control and Prevention
Credit: Sarah Frostenson
In Guilty Plea, OxyContin Maker to Pay $600 Million

By BARRY MEIER   MAY 10, 2007

Origins of an Epidemic: Purdue Pharma Knew Its Opioids Were Widely Abused

A confidential Justice Department report found the company was aware early on that OxyContin was being crushed and snorted for its powerful narcotic, but continued to promote it as less addictive.

Congressional report: Purdue Pharma influenced World Health Organization’s opioid guidelines

But according to federal officials, Purdue sales representatives falsely told doctors that the statement, rather than simply being a theory, meant that OxyContin had a lower potential for addiction or abuse than drugs like Percocet. Among other things, company sales officials were allowed to draw their own fake scientific charts, which they then distributed to doctors, to support that misleading abuse-related claim, federal officials said.

American Pain Society Goes Belly Up

— Opioid lawsuit costs prompt membership to approve bankruptcy filing

by Cheryl Clark, Contributing Writer, MedPage Today

June 28, 2019
Primary Prevention/Provider Education

If At First You Don't Prescribe
Educate the consumer!
The public doesn’t read medical journals...and shouldn’t have to...

Scare tactics/ “not me”

Pain News Network Article, June, 2016:
“...at a time when people are under siege, AMA has made it clear they are hard-hearted toward suffering...”

ASSIST providers / video campaign saturation
People share, read and generally engage more with any type of content when it’s surfaced through friends & people they know and trust.

MALORIE LUCICH
FACEBOOK SPOKESPERSON
The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire.

― Malcolm Gladwell ―

#changingtheconversation #tellyourfriends #letsendthis
segale@aetna.com
SAMHSA’s National Helpline
1-800-662-HELP (4357)
is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.

Also visit the online treatment locators.
A Prescription for Change - State of the State Opioid Panel

August 14, 2019

The project described was supported by Funding Opportunity Number CMS-331463-04-00 from the U.S. Department of Health & Human services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the Practice Innovation Institute and do not necessarily represent the official views of HHS or any of its agencies.
THE OPIOID EPIDEMIC BY THE NUMBERS

130+ People died every day from opioid-related drug overdoses (estimated)

47,600 People died from overdosing on opioids

81,000 People used heroin for the first time

28,466 Deaths attributed to overdosing on synthetic opioids other than methadone

11.4 m People misused prescription opioids

2.1 million People had an opioid use disorder

886,000 People used heroin

2 million People misused prescription opioids for the first time

15,482 Deaths attributed to overdosing on heroin

SOURCES
2. NCHS Data Brief No. 293, December 2017
From January to July 2017, 205 million opioid pills were prescribed in Arizona.....enough for every resident in AZ to have a 30-day supply

Enough pain relievers were dispensed last year in Arizona to medicate every adult in AZ for 2 weeks around the clock - 348 million opioid pills (GOYFF)

Estimates indicate that nearly 4 Arizonans die each day from opioid-related overdose

Approximately 39% of individuals with suspected opioid overdoses received prescription opioids from 10 or more prescribers in that past year
From June, 2017 through May 2018, ADHS and partners worked tirelessly to answer Governor Ducey’s call to address the continuing increase in opioid-related deaths across Arizona.

**June 2017**
- 2016 Arizona Opioid Report released
- Opioid Emergency declared
- Enhanced Surveillance Reporting implemented
- Implementation of Emergency Opioid Prescribing and Treatment Rules for Healthcare Institutions

**April 2017**
Executive Order for 7 day fill limit

**September 2017**
Opioid Action Plan issued

**October 2017**
PDMP Mandate in effect

**March 2018**
OAR Line launches

**April 2018**
Arizona Opioid Epidemic Act takes effect

**May 2018**
Governor Ducey terminates Declaration of Opioid Emergency

**January 2018**
Arizona Opioid Epidemic Act is passed
Arizona Opioid Surveillance

- 3,516 suspect opioid deaths
- 25,115 suspect opioid overdoses
- 1,536 neonatal abstinence syndrome
- 56,315 naloxone doses dispensed
- 15,925 naloxone doses administered

- 19,070 naloxone kits ordered for 116 law enforcement agencies (June 2017 - present)
- 36.4% of individuals with suspected opioid overdoses in prior month receiving prescription opioids from 10 or more prescribers in past year
- 238,732 opioid prescriptions dispensed last month in Arizona

- 45.1 average Morphine Milligram Equivalent (MME) daily dosage prescribed for all people receiving an opioid prescription in Arizona
- 46.2% of prescribers who prescribed opioids or benzodiazepines have “lookups” in the Controlled Substances Prescription Monitoring Program

Updates posted at www.azhealth.gov/opioid
Opioid Induced Deaths

Opioid Induced Deaths, Arizona 2008-2018

Note: 2018 data is preliminary data from Vital Records
8 Key Areas Discovered During Recent Planning Summit

- Improve referrals to treatment
- Improve access to MAT services
- Improve access to Naloxone
- Improve work with priority populations ie: pregnant and parenting
- Improving trauma-informed care
- Improve diversion programs
- Reduce stigma
- Address illicit drug use/trafficking ie: increase inspections

Medication-Assisted Treatment
Myths, Misconceptions and Stigma

• MAT is just replacing one drug with another.
• MAT is too expensive.
• MAT doesn’t work.
• MAT isn’t true ‘abstinence.’
• My patient/client is abstinent, so they don’t need MAT.
• Patients/clients get ‘high’ on these medications.
• People become ‘addicted’ to these medications.
• Psychotherapeutic practices alone are just as effective as MAT.
• MAT is ok for short-term use, but should not be used long-term.
• Methadone will result in overdose.
Statewide Provider Survey

Data collected from May 9, 2018 through June 20, 2018

A total of 333 responses were collected

Survey distributed through provider community; results collected anonymously and electronically

Most common profession of providers was Nurse Practitioner, followed by Physician.

Most common primary employment setting was Clinic or Health System, followed by Private Practice.
Top 3 reasons for not prescribing:

1) Not within my scope of practice
2) Do not feel prepared to treat OUD
3) A lack of behavioral health services in my practice area
Prepare to treat OUD

- Take a training from CABHP on Motivational Interviewing, SBIRT, or buprenorphine waivers. See the training opportunities at: https://cabhp.asu.edu/professional-development
- Participate in PCSS, a peer-to-peer mentoring program for new MAT prescribers at: https://pcssnow.org/mentoring/
- Call the OAR line! A free 24/7 hotline that assist providers with complex patients with pain and opioid use disorders. Call at: 1-888-688-4222

Locate behavioral health supports and resources

- Use the SAMHSA OTP locator at: https://dpt2.samhsa.gov/treatment/
- Governor’s Office of Youth, Faith, and Family Substance Abuse Treatment locator at: http://substanceabuse.az.gov/

Know OUD is within every providers’ scope of practice

- According to the recent studies, as many as 4-6 million Americans meet the criteria for an Opioid Use Disorder
- According to the American Society of Addiction Medicine, general practice providers are often the first line of medical care for OUD
Medication-Assisted Treatment (MAT) combines behavioral therapy and medication to treat substance use disorders for the purposes of promoting and maintaining recovery.

The Evidence Research on MAT shows:
- Half of patients participating in treatment with behavioral therapies alone will be lost to follow-up.
- Treatment that combines medication with behavioral therapies has been shown to be more effective than treatment with behavioral therapies alone.
- MAT has been found to improve treatment retention, reduce illicit opioid use, decrease cravings, and improve occupational functioning.
- MAT has demonstrated a 75% reduction in mortality and premature death.
- MAT has been found to reduce healthcare costs, primarily in the form of fewer and shorter inpatient admissions. When considering the costs of drug-related crime, criminal justice costs, and total healthcare expenses, every dollar invested in addiction treatment programs yields twelve-fold savings.

Overdose Reversal All patients with an opioid use disorder should be co-prescribed naloxone.

Consider prescribing naloxone for patients prescribed an opioid medication, particularly those patients at high risk for respiratory depression. Per Arizona Revised Statutes 32-2348, patients must be co-prescribed naloxone when prescribed more than 90 morphine milligram equivalents (MME) per day. As a patient experiencing an overdose cannot self-administer naloxone, friends and family members of those with opioid use disorders should have naloxone readily available and be trained to administer the medication. For more information on obtaining and administering naloxone, opioid users and friends/family of opioid users can visit getnaloxonenow.org.

Medications: naloxone (Narcan®, Evzio®)

Administration: Intravenous, subcutaneous, intramuscular, or intranasal spray

Mechanism: Reverses opioid overdose by removing opioids from receptor. Only effective at reversing overdose for 20-90 minutes. Patients should be taken for medical attention after naloxone is administered.

Frequently Asked Questions

How long should my patient remain on MAT?
MAT, like other forms of pharmacological treatment, is individualized. Some patients may utilize MAT to stabilize in their recovery for a period of time, while others may remain on these medications for their lifetime. Research suggests brief courses of MAT may not be sufficient and a minimum of 12-month courses or longer may be optimal.

My patient is currently abstaining from opioids, do they really need MAT?
Patients who are currently abstinent, but at risk for relapse, may be good candidates for MAT. Patients are most at risk for overdose when they have a reduced tolerance for opioids, which may occur after a period of abstinence, incarceration, or detoxification services. This may be a critical time to consider medication-assisted treatment.

Aren’t methadone overdoses common?

Would I be putting my patient at risk?
A federal panel of national experts, through an extensive review of the research literature and national data, determined the majority of methadone overdoses occur when methadone is used as an analgesic, not when methadone is dispersed in Opioid Treatment Programs (OTPs). Methadone and other forms of MAT are some of the most heavily regulated and monitored forms of medication in the healthcare system.

Is one form of medication better than another?
The best medication is the one that works for the patient. A patient’s response to a medication is primarily based on genetic markers, though the patient’s history and the treatment setting are also factors that can be used in deciding the most appropriate medication.

I work with pregnant women, what are the standards of care for this population?

Due to the risk of miscarriage with untreated opioid withdrawal, the American College of Obstetricians and Gynecologists endorses methadone and buprenorphine (mono-product), accompanied by behavioral therapy, as the standard of care for pregnant women with opioid use disorders and dependence.

Arizona Opioid Assistance & Referral Line
This free 24/7 hotline gives providers information about safe prescribing limits, potentially dangerous drug combinations, chronic pain treatment options, and caring for patients who are suffering from opioid use disorder.
1-888-688-4222

Patients at Risk for Overdose:
- Individuals receiving rotating opioid medication regimens
- Individuals who inject opioids
- Individuals with reduced tolerance who have:
  - Recently been released from incarceration and are a past user of opioids
  - Recently been released from emergency medical care following opiate ingestion or poisoning
  - Compliant opioid detoxification or have been abstinent for a period of time
MAT ‘Plug n Play’ Curricula

MAT
Medication-Assisted Treatment for Opioid Use Disorder
Facilitator Manual

https://cabhp.asu.edu/request-mat-curricula
C. Luke Peterson, DO
Addiction Medicine Physician & Professor, University of Arizona
Buprenorphine Waiver Training & Ongoing Technical Assistance

Arizona Society of Addiction Medicine, Inc.

The Arizona Chapter of ASAM

Center for Applied Behavioral Health Policy

Arizona State University

AHCCCS
Arizona Health Care Cost Containment System

HonorHealth

MobilizeAZ
Opioid Replacement Therapy

- No significant withdrawals
- No other opioid use
- Improved function
- Blockage of the euphoric effects of other opioids

- Opioid Use
- Anti-Social Behavior
- Desperation
- Withdrawal
- Physical Dependence
Withdrawals & Cravings Timeline

Start
Take your last dose

72 Hours
Physical symptoms at peak
Chills, fever, body aches, diarrhea, insomnia, muscle pain, nausea, dilated pupils

1 Week
Physical symptoms start to lessen
Tiredness, sweating, body aches, anxiety, irritability, nausea

2 Week
Psychological and emotional symptoms
Depression, anxiety, irritability, restlessness, trouble sleeping

1 Month
Cravings and depression
Symptoms can linger for weeks or months

Source: National Institute on Drug Abuse
Partial Recovery of Brain Dopamine Transporters in Methamphetamine (METH) Abuser After Protracted Abstinence

Source: Volkow, ND et al., Journal of Neuroscience 21, 9414-9418, 2001
How Medications Work in The Brain

- Methadone: Full agonist; generates effect
- Buprenorphine: Partial agonist; generates limited effect
- Naltrexone: Antagonist; blocks effect
Massachusetts Study (Medicaid Patients-2018)

**Conclusion:**

- Research confirms that more people respond to methadone than buprenorphine and more people respond to buprenorphine than to naltrexone.

- But the best medication is the one that works for the patients. Thus, no one medication is best for all people.
Impact of Current Treatment Trends

OUD Cascade of Care in USA

1. OUD diagnosed
2. Engaged in Care
3. MAT initiation
4. Retained 6+ months
5. Continuous abstinence

Williams AR, Nunes E, Olfson M. Health Affairs Blog, 2017.
China Conducted 12 month surveys on it’s first 8 OTP in the country

**Results:**

- Rates of injection drug use: Down from 69.1% to 8.8%
- Frequency of injection in the past month: Down from 90 times per month to 2 times per month
- Employment rate: Increase from 22.9 to 40.6%,
- Self-reported criminal behaviors: From 20.7 to 3.8%
- Harmonious relationship with families: Increased from 46.8% to 65.8%
McKinsey’s Analysis: The Crisis is Likely to Worsen

1. The crisis is drastically understated

2. Greater focus on prevention will cause those receiving pain management medications to turn to illicit opioids

3. The 3\textsuperscript{rd} & 4\textsuperscript{th} order effects (strains on other social systems) have not yet been seen

4. Even a mild recession could compound the problem.
Harm Reduction Implementation In Arizona

Presenter: Maria Jagles
Sonoran Prevention Works
END OVERDOSE DEATHS
CARRY NALOXONE
Call for a free kit 480-442-7086

SONORAN PREVENTION WORKS
SPWAZ.ORG

Practice Innovation Institute
Mission:
Centering harm reduction in Arizona through participant-driven advocacy, education, and outreach

- Overdose Prevention
- Advocacy & Policy
- Kingman Harm Reduction Program
- Harm Reduction Outreach Workers
- Capacity Building & Training
Jan. 2017 - May 2019

233,192 Doses of Naloxone

7,251 Overdose Reversals
<table>
<thead>
<tr>
<th>Drug use &amp; recovery exist along a continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Complex and multifaceted</td>
</tr>
<tr>
<td>- Abstinence is one of many possible goals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug-related harm cannot be assumed</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Drugs meet important needs</td>
</tr>
<tr>
<td>- Not an attempt to minimize or ignore real harms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People who use drugs are more than their drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Centers people who use drugs as the experts on their own care</td>
</tr>
</tbody>
</table>
Harm Reduction Solutions

- Reality-based Education
- Trauma-informed Care
- Criminal Justice Diversion
- Syringe Service Programs
- Naloxone
Harm Reduction Outcomes: Supporting ANY Positive Change

- Reduced Transmission of HIV & HCV
- Not Use Alone
- Sterile Syringes
- Move to Safer Ingestion

- Reduced Amount/Volume of Drug Use
- Safer sex – Using Condoms/Lube
- Reduced Involvement with Criminal Justice
- Carry Naloxone
Example Services

Staying Safe and Healthy
- Fentanyl Test Strips
- Overdose Prevention Kits
- Quitting one drug while managing the use of another
- Wound care education

Getting Basic Needs Met
- Food, water, and shelter
- Rides to appointments or job interviews
- HIV/Hepatitis C Screening
- Counseling or group therapy

Know Your Rights
- Rights restoration
- Court proceedings
- Probation
- DCS cases

We utilize a **person-centered, harm reduction-informed perspective** to help our participants **achieve the positive changes they desire.**
Sonoran Prevention Works
Harm Reduction Outreach Worker Program

We utilize a **person-centered, harm reduction-informed perspective** to help our participants **achieve the positive changes they desire.**

**Contact**

**Yavapai County**
(928) 514-1845

**Southern AZ**
520-461-2418
928-514-7660
520-402-7352

**Maricopa County**
602-802-3795
602-668-0234
480-907-8902

**Gila County**
928-955-9149

**Mohave County**
928-514-7487
Now Go Forth and Save LIVES!

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The AzCRH Mission is “to improve the health & wellness of rural and vulnerable populations.”

http://crh.arizona.edu
Life Jackets & Seatbelts are Good!
Naloxone & harm reduction...
also Good!

WE SHOULD BAN LIFE JACKETS & OTHER FLATION DEVICES

THEY ONLY ENCOURAGE RISKY BEHAVIOR. THE ONLY 100% EFFECTIVE WAY TO PREVENT DROWNING IS TOTAL ABSTINENCE FROM GOING IN THE WATER.
AZ Opioid Epidemic Act 3 hours CME Requirement:
Qualifies as opioid, substance use disorder or addiction-related CME.

https://crh.arizona.edu/programs/prescription-drug-misuse-abuse-initiative
ARIZONA OPIOID PRESCRIBER EDUCATION
Resources • Response • Recovery
Free CME for All Providers at www.AzRxEd.org

Understanding the Opioid Prescribing Laws and Regulations

2018 Opioid Prescribing Guidelines

Medication Assisted Treatment for Opioid Use Disorder
Search Treatment by Zip Code: 85541

Caring Connections for Special Needs, LLC - Payson
600 E Hwy 260
Suites 4 & 5
Payson
Arizona
85541
(520) 364-3162

Horizon Health and Wellness - Payson
600 E Hwy 260
Suite 8
Payson
Arizona
“If you don't like something, change it. If you can't change it, change your attitude.”

-Maya Angelou

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Arizona Center for Rural Health
Special Projects Coordinator
alydilla@email.arizona.edu
520-626-4439
crh.arizona.edu

Photo by Jill Bullock
Questions ?
Answers

Prescription for Change
Prescription for Change Opioid Panel

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