

Addiction Treatment Starts Here: Primary Care Learning Collaborative

Addiction as a Chronic Disease

May 19, 2021

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Rename



3

Add your name, pronouns and organization's name



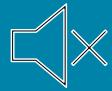
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Housekeeping Reminders



Mute

Please mute when not speaking. Please don't put put the call on hold!



Chat Box

Use the chat box to introduce yourself and questions



Slides + Recording

Slides and recoding will be posted to the ATSH Online Home



Tech Issues

Private chat Briana or Meaghan for assistance

Today's Presenters



Joe Sepulveda, MD, FAPA, FASAM **Chief of Psychiatry**

Family Health Centers of San Diego



Kenneth Pettersen, MD **Primary Care Physician**

Olive View – UCLA Medical Center



Addiction = Chronic Disease

Joe Sepulveda, M.D., FAPA, FASAM

Chief of Psychiatry, Family Health Centers of San Diego Medical Director, Substance Use Disorder Services Medication-Assisted Treatment (MAT) Program Psychiatric Nurse Practitioner Program Voluntary Assistant Clinical Professor, UCSD Health Sciences—Dept. of Psychiatry Diplomate of the American Board of Psychiatry and Neurology Diplomate of the American Board of Preventive Medicine—Addiction Medicine Fellow of the American Psychiatric Association Fellow of the American Society of Addiction Medicine



Agenda

- Stigma vs. Health
- Genetics role in addiction
- Neurobiology of addiction
- Addiction = Chronic Brain Disease
- Stigma associated with treatment
- Addiction is treatable
- Access to treatment... YOU ARE IMPORTANT!!!



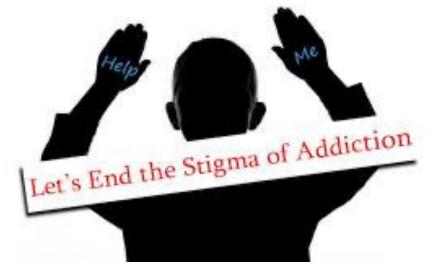
What are some things you offer to patients with chronic diseases such as diabetes, asthma, or COPD to help them manage their conditions? And why isn't this offered to individuals who have addiction?



The Stigma of Addiction

"Addiction is primarily a social problem, not a health problem."

Reality... Addiction is a Medical Disease





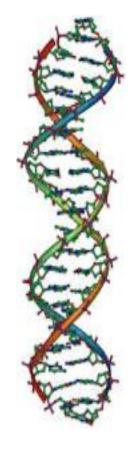
Genetic Heritability

Twin and adoption studies confirm a genetic role

Account for between ½ and ¾ of the risk for addiction.

Twins (Monozygotic)>Dizygotic

Genetic factors appear to be stronger drivers than environmental factors for initiation of substance use at an early age.





Genetic Heritability

"Traditional" Medical Diseases

- HTN \rightarrow 0.25-0.5
- **Diabetes Type 1** → 0.30 to 0.55
- Diabetes Type $2 \rightarrow 0.80$
- Adult-onset Asthma → 0.36-0.70

Substance Use Disorders

- **Heroin** → 0.34
- **Marijuana** → 0.52
- **Alcohol** → 0.52
- Cigarette → 0.61

Monozygotic > Dizygotic



^{** 1.0 =} genetics are the only factor



^{*0.0 =} genetics are not a contributing factor at all

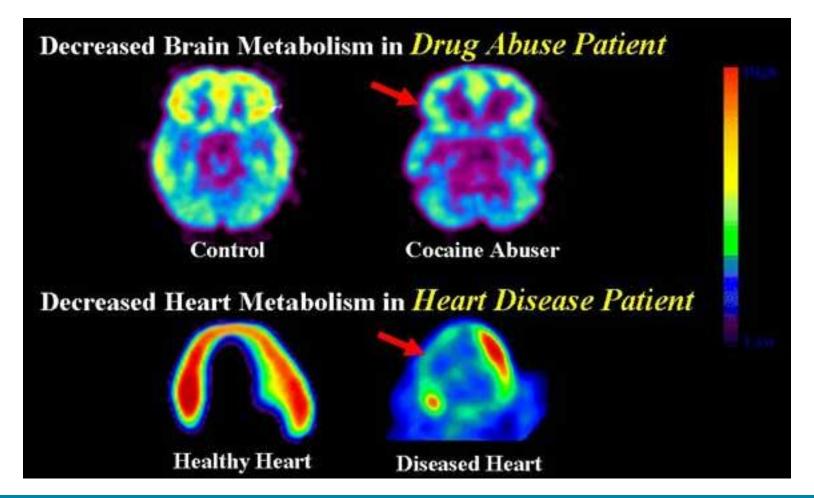
Addiction = Chronic Brain Disease

- 1. Brain diseases → some form of behavioral expression
 - Alzheimer's = memory loss
 - Schizophrenia = unusual perceptions of reality and mood changes
 - Opioid addiction = cravings which lead to uncontrollable compulsion

2. Precipitated by fundamental, long-term, changes to the biological structures and functioning of this organ

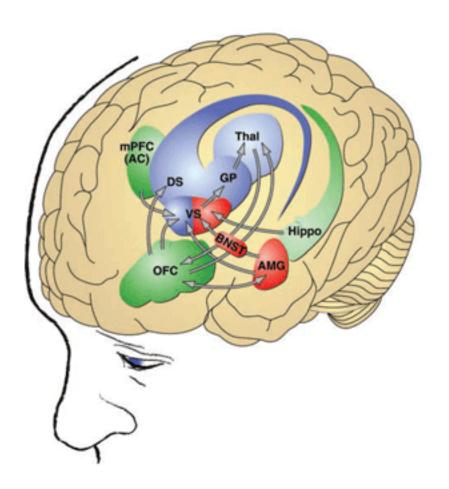


Addiction and Changes to biological structures





Neurobiology of Addiction



Binge/intoxication

- · ventral striatum (VS), including nucleus accumbens euphoria, reward
- · dorsal striatum (DS) habits, perseveration
- global pallidus (GP) habits, perseveration
- · thalamus (Thal) habits, perseveration

Withdrawal/negative affect

- . amygdala (AMG), bed nucleus of the stria terminalis (BNST), together also known as the "extended amygdala" malaise, dysphoria, negative emotional states
- · ventral striatum (VS) decreased reward

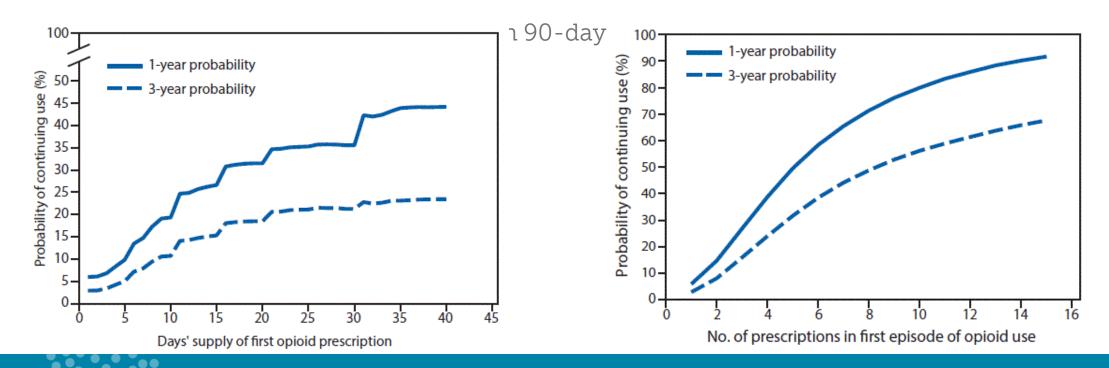
Preoccupation/anticipation

- anterior cingulate (AC)
- · prefrontal cortex (mPFC), orbitofrontal cortex (OFC) subjective effects of craving, executive function
- · basolateral nucleus of the amygdala conditioned cues
- · hippocampus (Hippo) conditioned contextual cues



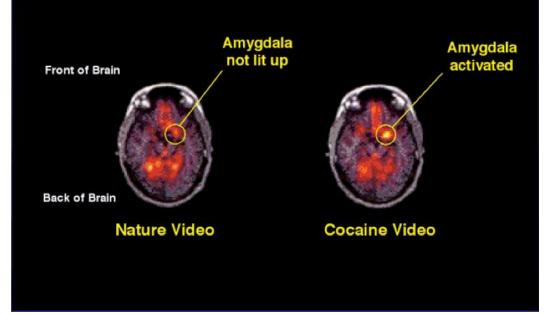
Addiction can happen to anyone

- 1. The longer you are prescribed an opioid the greater likelihood you'll develop addiction.
 - Prevalence rates as high as 50% for an opioid use disorder on chronic opioid therapy
 - Opioid therapy >90 days at >120 MME = 100x's as likely to develop OUD



Wait a minute... addiction was a choice

- 2. ...they chose to try it for the first time = their fault
 - Initial voluntary misuse does NOT make their condition any less the result of disease
 - Addiction = INVOLUNTARY COMPULSIVE USE, cravings CANNOT be controlled
 - = Chronic Condition





What cravings and involuntary compulsive use feels like... a patient experience...

- Shaking her head and trying to hold back tears...
- "It's like God tells you that if you take another breath, your children will die."
- "You do everything you can not to take a breath. But eventually you do. That's what it's like. Your brain just screams at you."

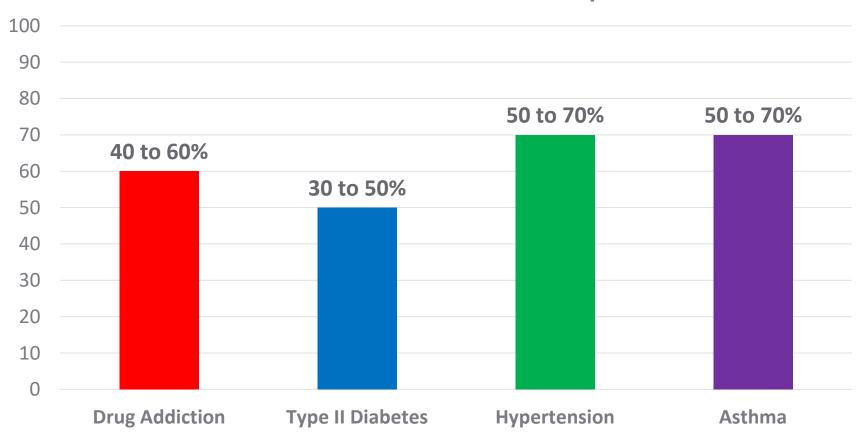




https://www.usatoday.com/story/news/health/2019/11/02/meth-use-surges-stronger-cheaper-drugs-imported-

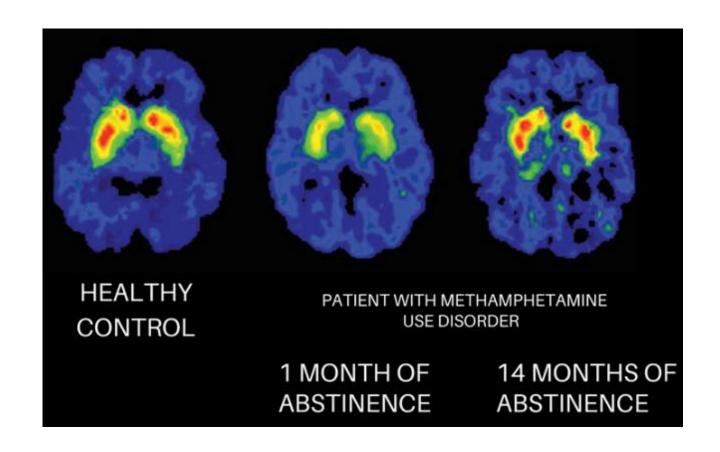
You relapsed = You're not serious or committed

Percent of Patients Who Relapse





It takes time for your brain to recover





Selective forgiveness and understanding

3. What other choices lead to chronic disease

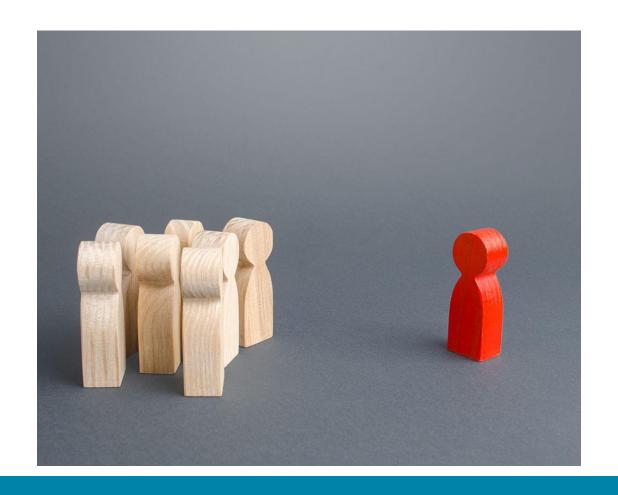
■ Diet and Exercise → Diabetes, Hypertension and Congestive Heart Failure to

name a few.



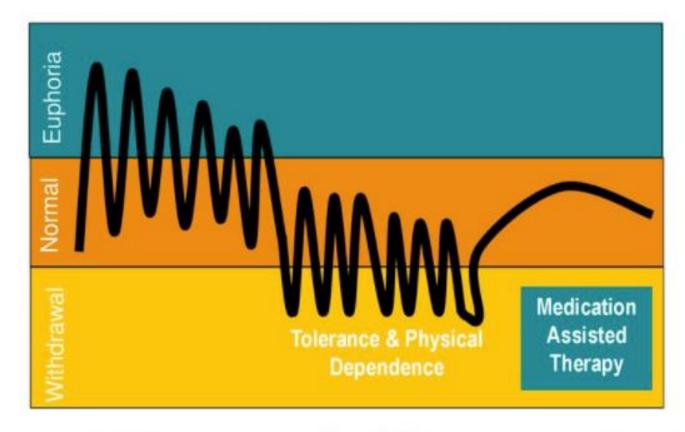
MOUD and stigma







MOUD ≠ substituting one drug for another



Acute Use

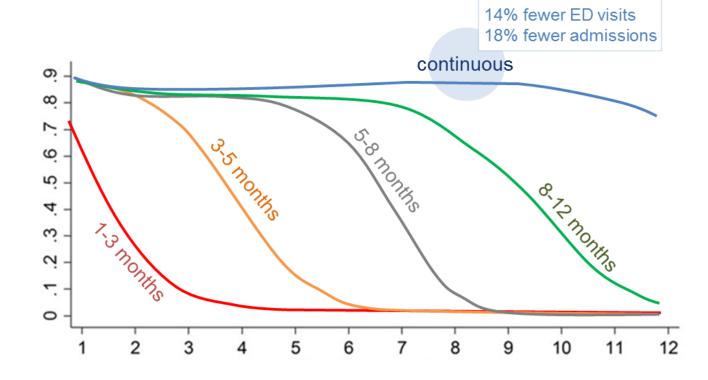
Chronic Use

Alford, Boston University, 2012



You've been on MOUD long enough... you should think about stopping

proportion of days when buprenorphine was taken



months since starting treatment

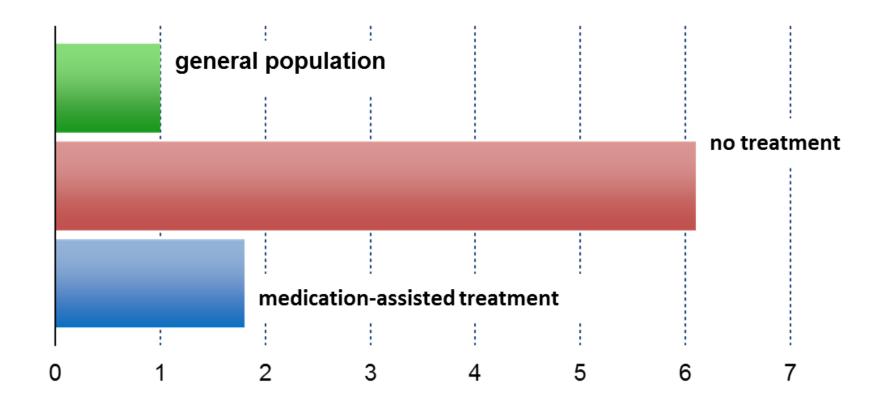
Addiction is a treatable condition



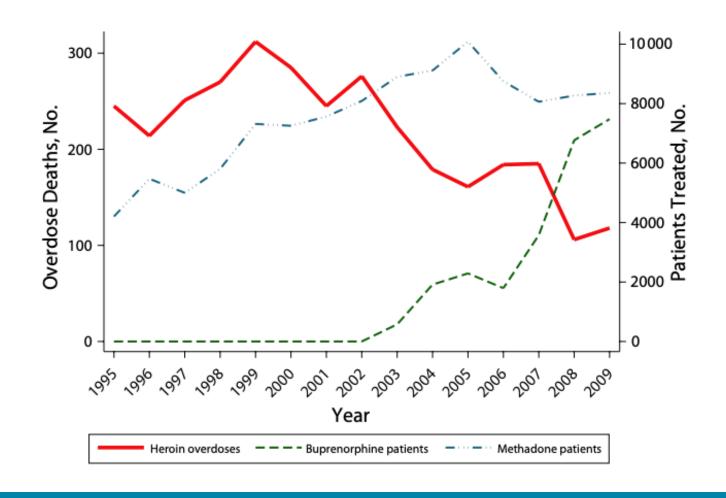


Benefits of MOUD: Decreased Mortality

Death rates:

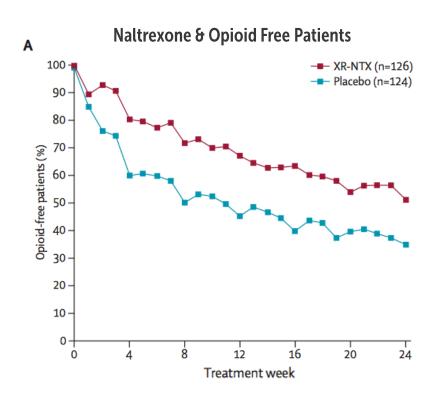


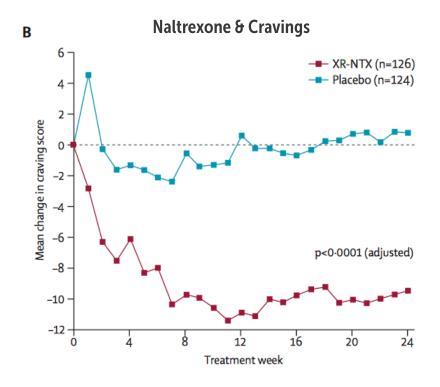
Overdoses decreased with buprenorphine availability





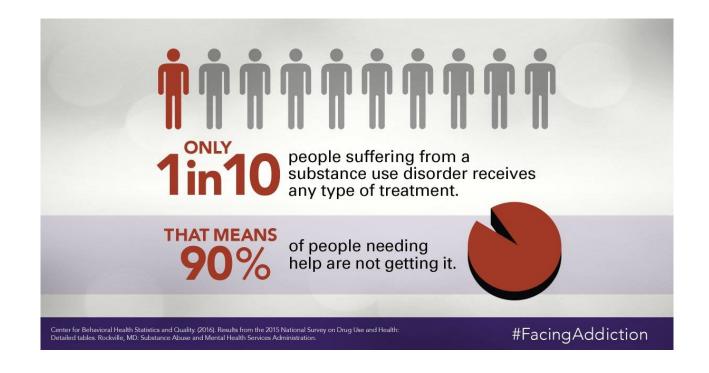
Addiction is a treatable disease—Naltrexone





THM: Naltrexone added to standard federal probation lead to 70% less opioid use and 50% less incarceration

Access to treatment is critical



THM: Few receive anything that approximates evidence-based care

THM: In contrast, 70%-80% of people with diseases such as HTN and DM receive care



You are making a big difference

Published in final edited form as:

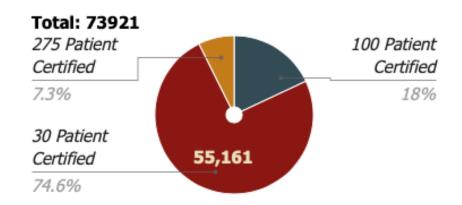
J Subst Abuse Treat. 2017 July; 78: 1-7. doi:10.1016/j.jsat.2017.04.005.

Why Aren't Physicians Prescribing More Buprenorphine?

Andrew S. Huhn, Ph.D.1 and Kelly E. Dunn, Ph.D.1

¹Behavioral Pharmacology Research Unit, Johns Hopkins University School of Medicine, Baltimore MD

Practitioner and Program Data



THM: Approx. 48% of X-waivered physicians prescribe on average 5 patients per provider



Questions?



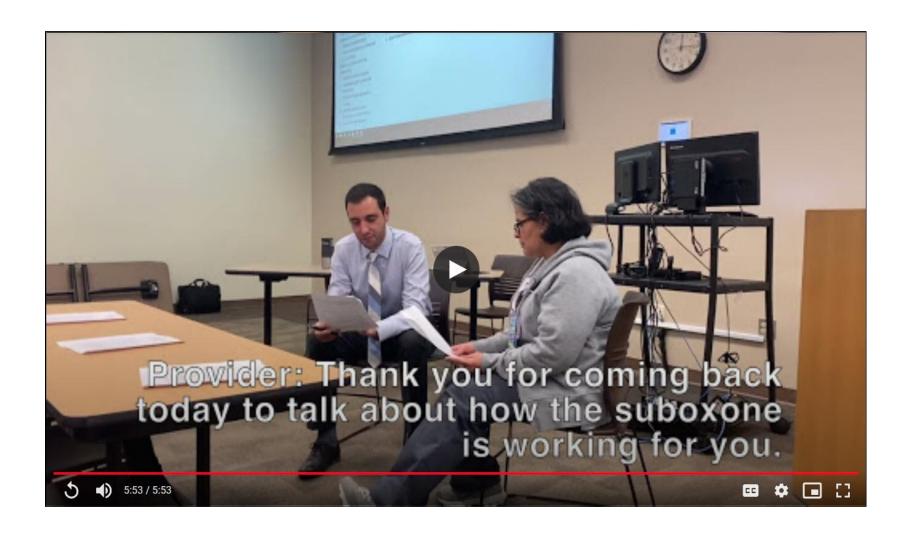
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Group Discussion

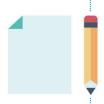
- What is one insight you will bring back to your organization?
- Share your responses in the chat box!





Poll Questions

1. On a scale of 1 - 5, please select the number that best represents your experience with today's session



- 5 Strongly Agree
- 4 Agree
- 3 Neutral
- 2 Disagree
- 1 Strongly Disagree

2. Please select the number that best represents your response to the statement: Today's session was a valuable use of my time.



- 5 Strongly Agree
- 4 Agree
- 3 Neutral
- 2 Disagree
- 1 Strongly Disagree

References

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- 9 Krupitsky E, et al., Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicenter randomized trial. Lancet. 2011 Apr 30;377(9776):1506-13.
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- 13. Krawczk N., et al., "Opioid agonist treatment and fatal overdose risk in a state-wide US population receiving opioid use disorder services." Additction 2020 Feb 24.
- Additional citations can be found on the PPT slides



Thank you!

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