EAST TENNESSEE
OPIOID CONFERENCE

Schedule of Events

8:30 - 9:00	Registration
9:00 - 9:15	Welcome: Eric Penniman, DO - Summit Medical Group
9:15 - 9:45	Presentation: Adolescent Neurological Development and the Impact of ACEs *Keith Bailey, PhD - Harmony Family Center*
9:45 - 10:15	Presentation: “Innovations in Pain Treatment” *James Choo, MD - Pain Consultants of East Tennessee*
10:15 - 10:25	Break
10:25 - 11:10	Presentation: “Case Studies in Treating Chronic Pain” *Darren McCoy, FNP - Pain Consultants of East Tennessee*
11:10 - 11:40	Presentation: “Medications Used to Treat Substance Use Disorder” *Stephen Loyd, MD - Cedar Recovery*
11:40 - 12:15	Lunch Presentation: “Update on SARS-CoV-2 Community Impact” *Lauren Havrilla, DO - Assistant Chief Medical Examiner for Knox and Anderson Counties*
12:15 - 1:15	Community Panel: “Law Enforcement Update on East Tennessee Substance Use Trends” Christopher A. Kresnak, DEA; Heather Reyda, KCSO; Tommy Farmer, TBI; Director David Rausch, TBI; Josh Shaffer KPD

EAST TENNESSEE
OPIOID CONFERENCE

Schedule of Events Continued...

1:15 - 1:45 Presentation: "Recovery Coaching Model"
Jason Goodman, CPRS - Metro Drug Coalition

1:45 - 1:55 Break

1:55 - 2:25 Presentation: "SBIRT/Motivational Interviewing"
Brian Winbigler, PharmD – University of Tennessee

2:25 - 3:25 Presentation: "Methamphetamine Treatment and Recovery"
Jerome Cohan, APRN - Catalyst Health Solutions
Erika Slemp, LCSW - Catalyst Health Solutions

Wifi Password: BananaNutBread

Access Full Length Speaker and Presenter Bios: bit.ly/ETOC22

IMPORTANT CME INFORMATION

Please complete and leave your evaluation sheet (blue) on your table at the end of today's conference.

This event is partially funded by an unrestricted educational grant from Cigna.

Cigna®

This program is brought to you in collaboration with the following community partners:

SUMMIT MEDICAL GROUP
MDC metro drug coalition
Pain Consultants OF EAST TENNESSEE
KAM KNOXVILLE ACADEMY OF MEDICINE
Cherokee HEALTH SYSTEMS

Surviving Methamphetamine

February 17th, 2022

Speakers

Jerome J. Cohan, NP
Erika Slemp, LCSM

1. **Methamphetamine overview**
   a. What it is.
   b. What it does. Dopamine levels. **(Slide 1)**
   c. Initial effects on the body and mind.
   d. Continued effects on the body, brain, and mind
   e. Legal: Scheduling, therapeutic dose vs illicit use **(Slide 2)**

2. **Treament Initial Concerns**
   a. Physical Exam: Skin (track marks, skin picking tattoos), Heart (a-fib etc), Nose (snorting, inflamed ulcerated), mouth (poor dentation and infections)
   b. Telehealth visits are least effective. (Everyone is doing great!)
   SLIDE SET Three: Track Marks and Tats
   c. MUST HAVE WITNESSED UDS AS MAIN OBJECTIVE DATA TO PROMOTE ACCOUNTABILITY
   SLIDE SET Four: Devices
   d. Labs: CBC, CMP, TSH, Free T4, Vitamin D and B12, Testosterone, Hepatitis Panel, HIV
   e. Withdrawal Medications 1st considerations:
      1. Buproprion (depression)
      2. Mirtazapine and trazodone (sleep)
      3. Lamotrigine, cariprazine (mood stabilizer)
      4. Buspirone and hydroxyzine (anxiety)
      5. Hypertension, standard protocols, ACE inhibitors, CCBs, etc.
   f. Family meeting. Sober support. Educate.
   g. Delete social media (Especially Facebook)

3. **Treatment, 5 Stages of Meth Recovery**
    a. *Withdrawal 0-15 Days* (consider inpt care, changing the environment)
    b. Honeymoon Stage 16-45 Days (cognitive behavioral therapy and increased face to face visits. Consider treatment locations, BLR, moving away, partial hospitalization, sober living)
    c. *The Wall 46-120 Days* (prepare pt, family and treatment team for this. Strong counseling support and relationship)
    d. *Adjustment Stage 121-189 Days* (enhancing relapse prevention and trigger management with counseling and cognitive behavioral therapy)
    e. *Resolution Stage 181- Open* (vigilance towards triggers and solidifying people, place, and things to prevent relapse. (Recovery is not a destination it's a cultural shift hallmarked by healthier behaviors involving people places and things.

4. **Focus and considerations**
    a. Contingency Management, practical issues.
    b. Cognitive behavioral therapy
        1. CBT is a form of "talk therapy" based on principles of social learning theory.
        2. Used to teach, encourage, and support individuals in reducing or stopping their harmful drug use.
        3. Provides skills aimed at sustaining abstinence.
        4. Addresses negative thought patterns and helps to develop coping strategies to prevent relapse.
    c. Community reinforcement
        1. Behavioral skills training
        2. Social and recreational counseling
        3. Marital therapy
        4. Motivational enhancement
        5. Job skills counseling
    d. Polysubstance abuse and Buprenorphine use.
    e. Stimulant use disorder should be included as a standalone diagnosis for treatment resources in the OBOT/IOP setting. OBOT should be OBAT?

5. **Protection of Children**
   Erika Slemp, LCSW Head of the Social Work Dept at CHS.
   Licensed Clinical Social Worker. Focus: DCS, childcare, and domestic violence.

6. **Survivor Stories.**
   a. James Smithey
   b. Tamika Bennett
   c. Hanna Tester-Smith
   d. Charlie Smith

Jerome Cohan, ANP
Cell 423-268-6600
JJCohan@Catalysthealth.org

Erika Slemp, LCSW
EFugere@Catalysthealth.org

Catalyst Health Solutions
926 West Oakland Ave
Johnson City TN, 37604
423-282-3379

References

Brown, H. D., & DeFulio, A. (2020). Contingency management for the treatment of methamphetamine use disorder: A systematic review. *Drug and Alcohol Dependence*, *216*, 108307. https://doi.org/10.1016/j.drugalcdep.2020.108307

Herbeck, D. M., Brecht, M.-L., Christou, D., & Lovinger, K. (2014). A qualitative study of methamphetamine users' perspectives on barriers and facilitators of drug abstinence. *Journal of Psychoactive Drugs*, *46*(3), 215–225. https://doi.org/10.1080/02791072.2014.914611

Knox, J., Marinelli-Casey, P., McCann, M., Obert, J., Pharnichyakul, S., & Rawson, R. (2018). *A Clinician's Guide to Methamphetamine* (2nd ed.). Hazeden Publishing.

Rawson, R., PhD. (2021, February 24). *Psychostimulants - New Risks, New Treatments Webinar Resources* [Webinar]. The Rural Communities Opioid Response Program- Technical Assistence. https://www.rcorp-ta.org/resources/psychostimulants-new-risks-new-treatments-webinar-resources

Science Direct. (n.d.). *Contingency management for the treatment of methamphetamine use disorder: A systematic review*. https://www.sciencedirect.com/science/article/abs. https://www.sciencedirect.com/science/article/abs/pii/S0376871620304725?via=ihub

The Hazelden Betty Ford Foundation. (n.d.). *Addiction treatment center*. Hazelden Betty Ford Foundation. https://www.hazelden.org

Weisheit, R., & White, W. (2009). *Methamphetamine: Its history, pharmacology, and treatment* (1st ed.). Hazelden Publishing.

metro drug coalition

Born Drug-Free Tennessee
Medical Partnership Agreement

The goal of Born Drug-Free Tennessee is to connect pregnant women who are struggling with a substance use disorder to locate an evidence-based substance use treatment provider and enter prenatal care as early in pregnancy as possible. BDFTN also educates women of childbearing age about the dangers of using substances while pregnant. With this goal in mind, it will take a collaborative effort among multiple community stakeholders, with medical practices being a key partner in this venture.

This agreement between *Metro Drug Coalition* and _____ shall be from _____ until terminated by a mutual accord. This agreement will be re-evaluated on a yearly basis.

The Born Drug-Free Tennessee Partner, _____ will be held responsible for:

ALL Women of Childbearing Age

1. The prescriber shall annually assess the patient's risk for misuse, abuse, diversion and addiction using a validated risk assessment tool prior to initiating opioid therapy. (*Please refer to SAMHSA http://bit.ly/2vFlhqx)*
2. Clinicians should review the patient's history of controlled substance prescriptions using the Controlled Substance Monitoring Database (CSMD) to determine whether the patients are currently receiving opioid prescriptions or potentially dangerous combinations, such as opioids and benzodiazepines.
3. Check the Controlled Substance Monitoring Database (CSMD) on **all** patients **prior** to prescribing an opioid or benzodiazepine medication, *including those used for Medication Assisted Treatment (MAT).*
    a. *This is required by law. The statute governing the operation of the CSMD is found under T.C.A. § 53-10 Part 3 and the supporting rules are 1140-11.*
    b. *Methadone used to treat a substance use disorder is **not** reported to the CSMD. Please be advised to discuss methadone use with patient.*
4. Appropriate documentation of CSMD query should be included in the patient's medical record.
5. Pregnancy test every woman of childbearing age **prior** to prescribing an opioid or benzodiazepine medication, *including those used for Medication Assisted Treatment (MAT).*
6. Women who are on long-term opioid/benzodiazepine therapy or medications used to treat substance use disorders should be pregnancy tested **monthly** during the course of treatment.
7. Inform women of childbearing age of the risks of Neonatal Abstinence Syndrome (NAS) **prior** to prescribing an opioid or benzodiazepine medication, *including those used for Medication Assisted Treatment (MAT).*
8. The provider shall advise every woman of childbearing age on the full range of methods available to prevent unintended pregnancy, specifically considering Voluntary Reversible Long Acting Contraceptive (VRLAC) methods.
9. The treatment agreement shall include an expectation that a female patient will tell the provider if she becomes pregnant or plans to become pregnant.
10. If patient plans to become or becomes pregnant she shall be referred to an obstetrician.
11. Provide Born Drug-Free TN patient brochures to all women of childbearing age.
12. Provide Born Drug-Free TN materials in lobby and patient rooms for all patients/patrons.

Pregnant Women

1. The Obstetric and medical treatment physician should work together to encourage compliance with both chronic pain management or medical replacement therapy plan, and prenatal care.
2. A UDT should be performed at intake to prenatal care. If positive, the mother should be referred to appropriate chronic pain management or replacement therapy specialists. The risks of Intra-Uterine Drug Exposure should be discussed, and documented, and random UDT should be performed throughout the prenatal period.
3. If a woman is pregnant and currently using substances, the clinician should provide all options of treatment (*subutex, methadone or medically supervised weaning)* so she can make an informed medical decision for her health and her baby's health.
    a. *Appropriate discontinuation has been shown to be safe for fetus during pregnancy. However, unintended consequences from tapering may outweigh benefits. (Bell J, Towers CV, Hennessy MD, et al. Detoxification from opiate drugs during pregnancy.Am J Obstet Gynecol 2016)*
4. If a woman has a positive UDT on initial prenatal visit, A UDT should be performed upon admission for delivery to help identify the infant at risk for NAS or other harms from drug exposure.

We strongly encourage all partners to refer to the Tennessee Chronic Pain Guidelines and the Tennessee Buprenorphine Guidelines for further guidance on the management of pregnant women.

Metro Drug Coalition will be responsible for:

1. Providing Born Drug-Free TN materials to office(s)/medical practice(s)
2. Providing office(s)/medical practice(s) with Born Drug-Free TN partner window cling
3. Listing name of participating practice(s) on the Born Drug-Free TN website (borndrugfreetn.com)
4. Providing SBIRT consultation as needed for office/medical practice
5. Providing lapel pins for medical practitioners

By signing, your practice agrees to adhere to all the components of this agreement.

_____	_____
MDC Representative Name	***BDFTN Practice Name***
_____	_____
Title	***Practice Address***
	_____
	Practice Representative's Name
_____	_____
MDC Representative Signature	***Practice Representative's Title***
	_____
	Practice Representative's Phone
	_____
	Practice Representative's Email
Date: _____	_____
	BDFTN Partner Signature
	Date: _____

If operating medical practices in multiple site locations, please contact Miria Galyon at mgalyon@metrodrug.org with a full list of locations.

All offices will receive the information on page 2.
An MDC representative will be in contact with your office to deliver materials .

Please return ONLY this sheet of the partnership agreement to Metro Drug Coalition by email at mgalyon@metrodrug.org or by fax at 865-588-0891.