PainWeek®

Pain Management at Ground Zero

Mark Garofoli, PharmD, MBA, BCGP, CPE

Faculty

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  - Coordinator, WV Pain Management Expert Panel (SEMP Guidelines)
  - WV PDMP Advisory Panel Member
  - CDC Grant Reviewer

Disclosures

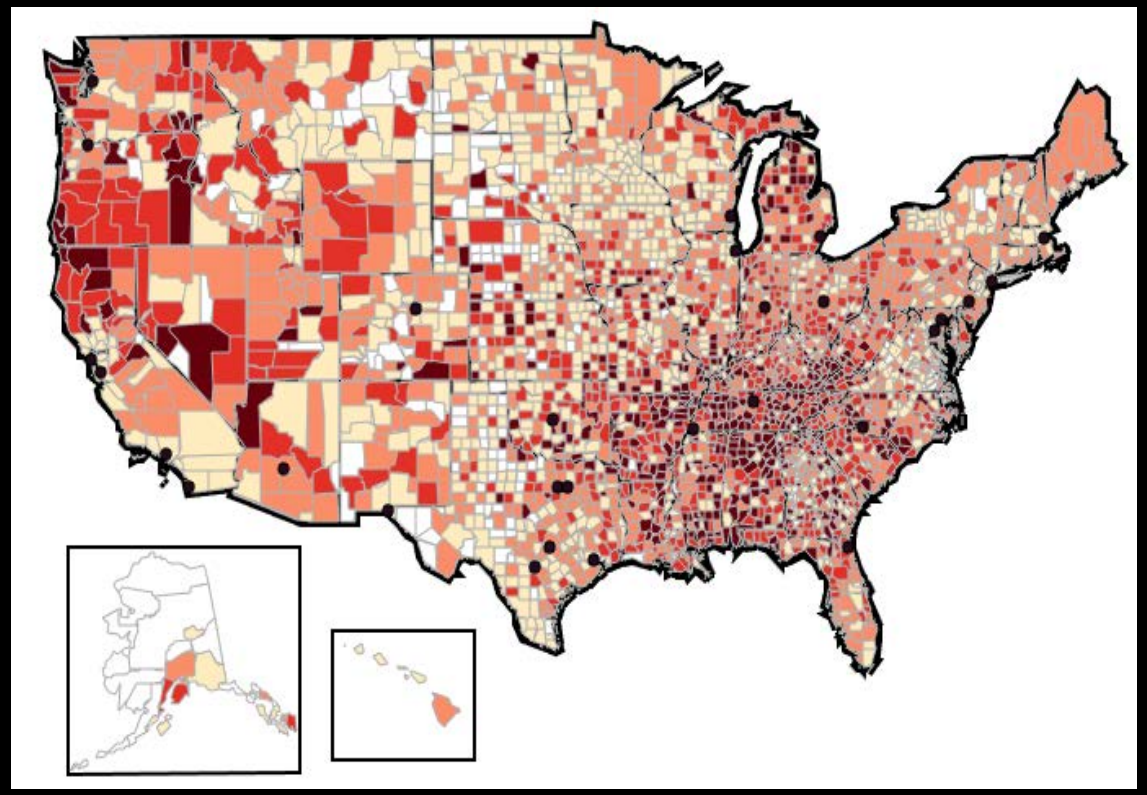
- Consultant/Independent Contractor: Daiichi Sankyo, Clinical Pharmacists Advisory Panel, Member

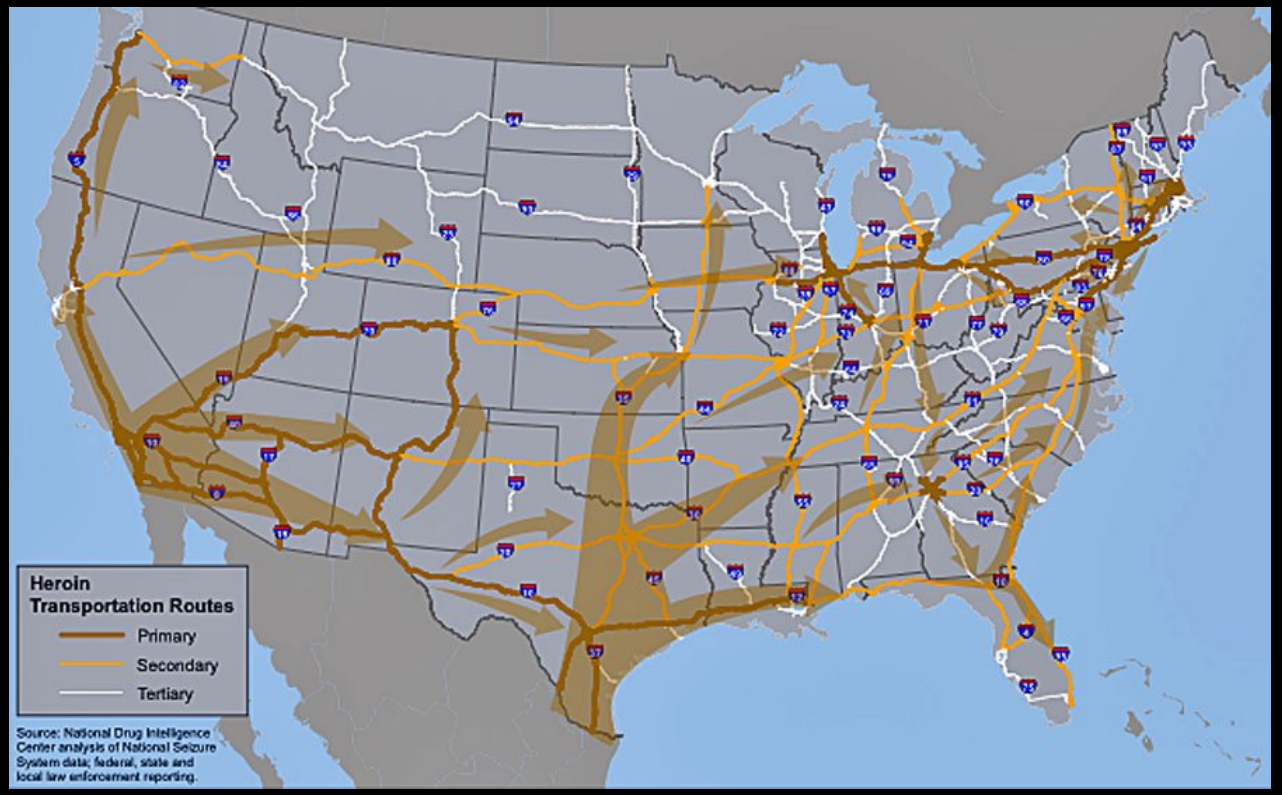
This presentation was not a part of the presenter's official duties at the WVU and does not represent the opinion of WVU

Learning Objectives

- Discuss the 2016 CDC Chronic Pain Opioid Guidelines directly into clinical practice.
- Describe the best practices within pain management with particular attention to risk reduction strategies.
- Recall multi-modal pain management treatment plan options.

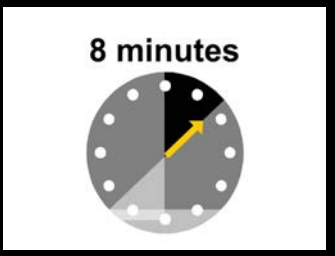
US Opioid Prescribing & Heroin Distribution

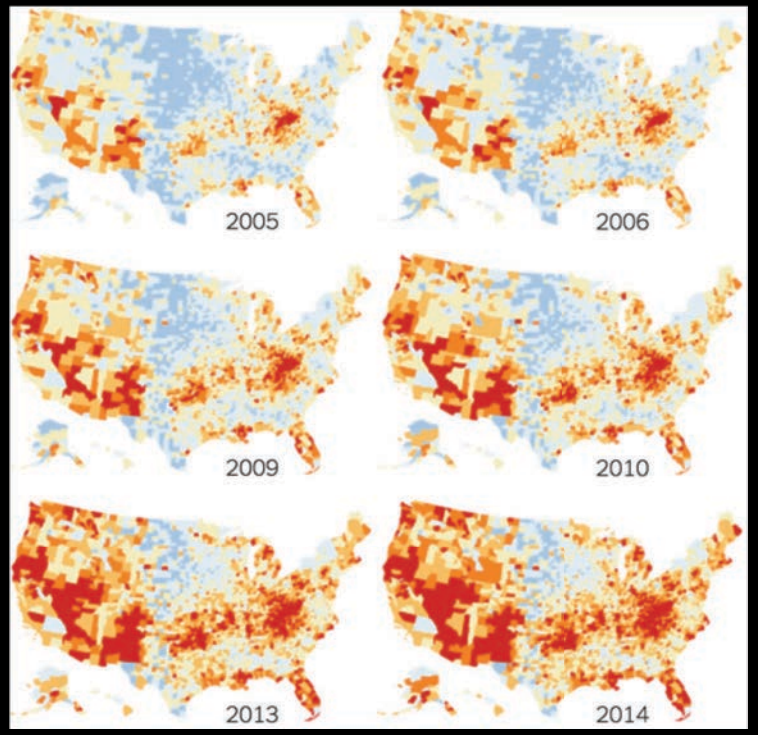


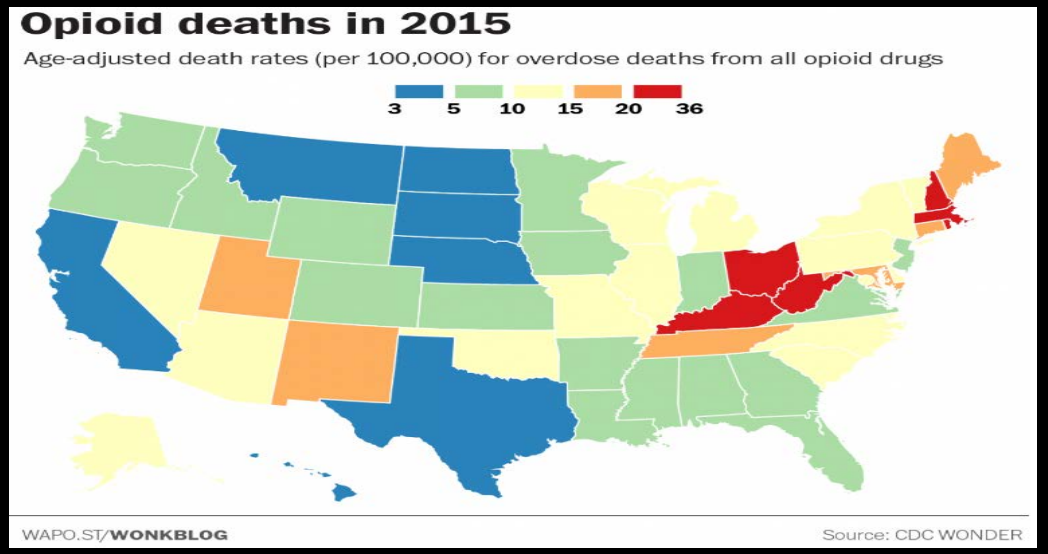


https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html
https://dabrownstein.com/2015/04/27/alternative-metrics-of-americas-divided-economy-3/

US Drug Overdose Deaths







https://www.healthnutnews.com/wp-content/uploads/2016/08/drug-overdose-deaths-in-the-us-1453224385472-master495-v2.png
http://www.wral.com/states-with-the-biggest-drug-overdose-problem/15391563/
Holly H, et al. Drug Overdose Deaths in the United States, 1999–2016. NCHS Data Brief No. 294, December 2017.

Ground Zero Transcending to the Entire Nation…

HEALTH INC.

Drug Distributors Penalized For Turning Blind Eye In Opioid Epidemic

January 27, 2017 · 5:00 AM ET

CHARLES ORNSTEIN

FROM ProPublica

Charleston Gazette-Mail

A Pulitzer Prize-Winning Newspaper

A Few Clouds 88.0 °F

HOME NEWS BUSINESS OPINION SPORTS LIFE A&E OUTDOORS BLOGS OBITUARIES MULTIMEDIA WEATHER

WV Supreme Court says addicts can sue doctors and pharmacists

Kate White, Staff Writer

May 15, 2015

2016 Murder Conviction

Dr. Hsiu-Ying ”Lisa” Tseng guilty of second-degree murder (30 years to life)

First time a doctor had been convicted of murder in the United States for overprescribing drugs

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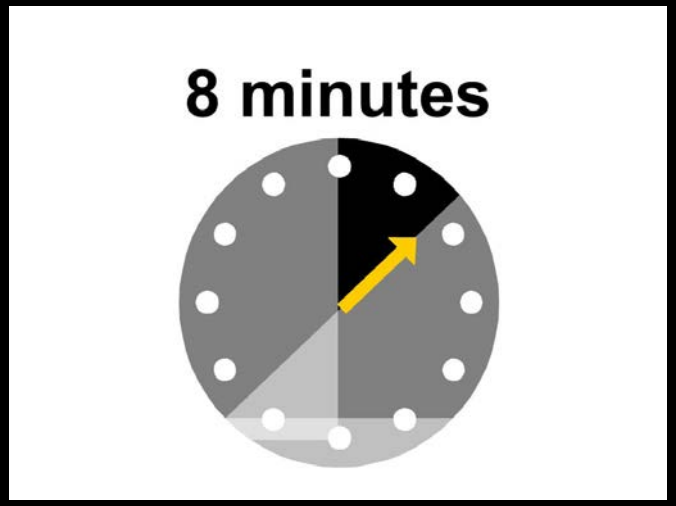
http://www.latimes.com/local/lanow/la-me-ln-doctor-murder-overdose-drugs-sentencing-20160205-story.html

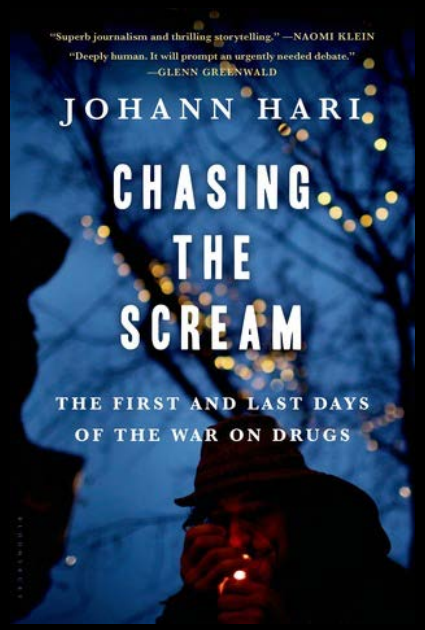
63,400 US Drug Overdose Deaths (2016)

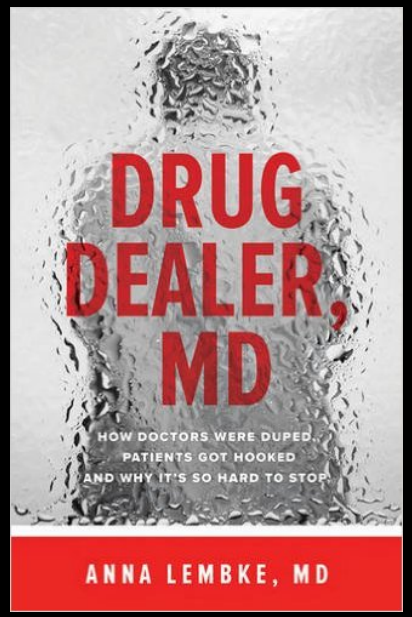


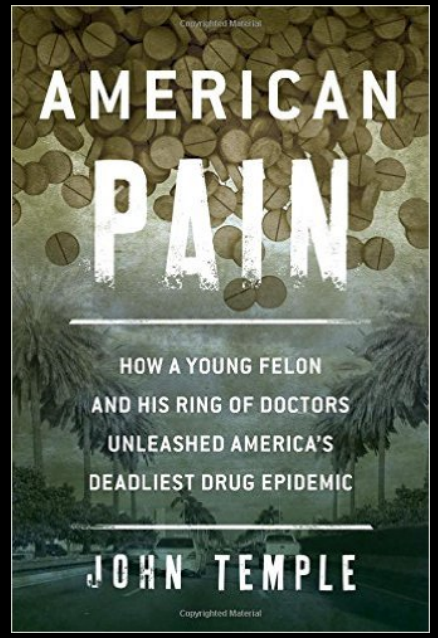
Age-adjusted Drug Overdose Death Rates (per 100K)	
West Virginia	52
New Hampshire, Ohio, & D.C.	39
Pennsylvania	38

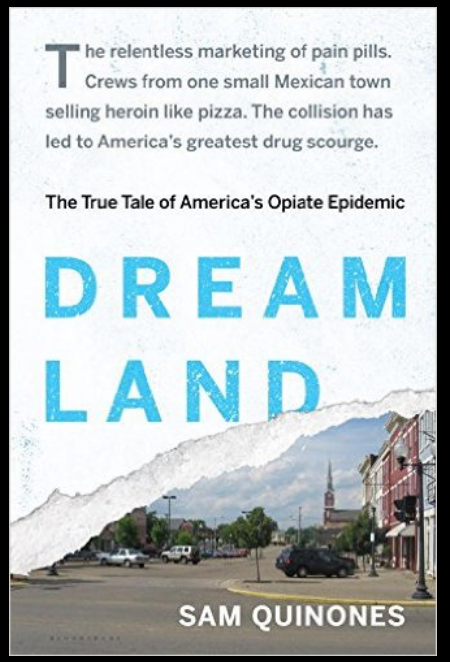
Holly H, et al. Drug Overdose Deaths in the United States, 1999–2016. NCHS Data Brief No. 294, December 2017.

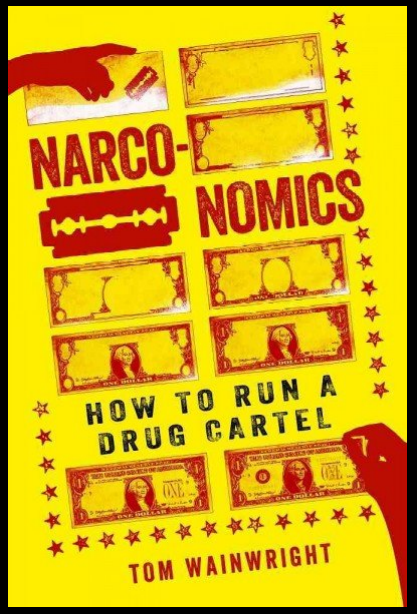
“Opioid Epidemic” Literature











2016 CDC Chronic Pain Opioid Guidelines

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

CDC Chronic Pain ***Opioid*** Guidelines

Opioid Use Decision

1. Non-Pharm, Non-Opioid, then Opioid
2. Treatment Goals
3. Risk Assessments & Side Effects

Type/Amount/Time of Opioid

4. IR not ER
5. MME >/= 50/day: Use caution
   MME >/= 90 avoid unless justified
6. Acute pain: Short duration
7. Re-evaluate 1 month, then every 3 months.

Risk/Harms of Opioid Use

8. Higher risk → naloxone
9. PDMP initially + every 1-3 months
10. UDT initially + annually
11. Avoid combining opioids & benzos
12. Opioid Use Disorder: Offer MAT

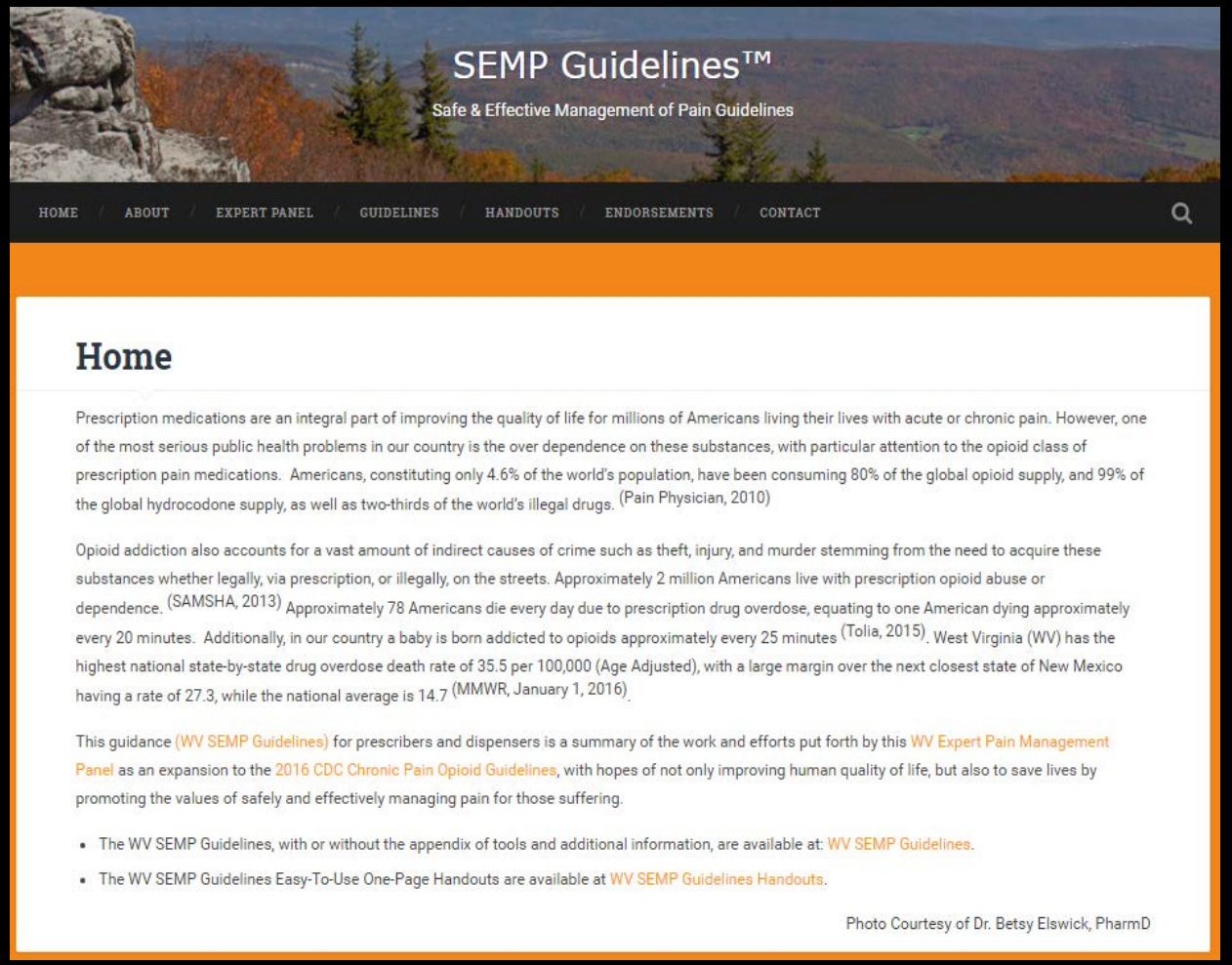
Adapted from: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

2016 West Virginia
Safe & Effective Management of Pain (SEMP) Guidelines

West Virginia
Expert Pain Management Panel

Panel Member	Organization/Title
Mark Garofoli, PharmD, MBA, BCGP, CPE (Coordinator)	Pharmacist
Timothy Deer, MD (Chairperson)	Medical Doctor
Richard Vaglienti, MD (Vice Chairperson)	Medical Doctor
Ahmet Ozturk, MD	Medical Doctor
Denzil Hawkinberry, MD	Medical Doctor
Bradley Hall, MD	Medical Doctor
Matt Cupp, MD	Medical Doctor
Rahul Gupta, MD	Medical Doctor (Public Health)
Michael Mills, DO	Osteopathic Doctor
Jimmy Adams, DO	Osteopathic Doctor
Richard Gross, PhD	Psychologist
Jason Roush, DDS	Dentist
Stacey Wyatt, RN	Registered Nurse
Vicki Cunningham, RPh	Pharmacist (Insurance)
Felice Joseph, RPh	Pharmacist (Insurance)
Stephen Small, RPh, MS	Pharmacist
Patty Johnston, RPh	Pharmacist
Charles Ponte, PharmD, CPE	Pharmacist
James Jeffries, MS	Health & Human Resources
Michael Goff	Retired State Policeman & PDMP Administrator

2016 West Virginia
Safe & Effective Management of Pain (**SEMP**) Guidelines



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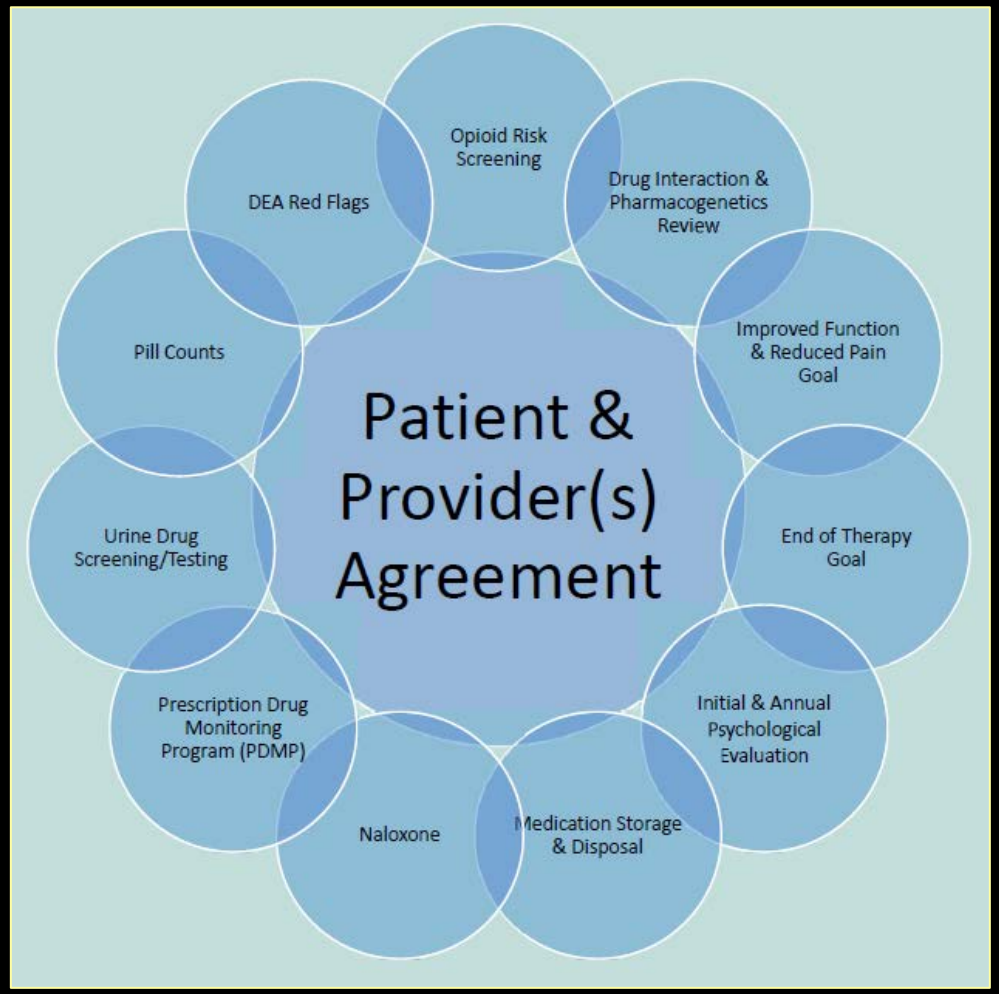
www.sempguidelines.org

www.sempguidelines.org



	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1st Line	Non-Pharmacological (Active & Passive) APAP then +/-NSAID* Topical Agent (NSAID, Lidocaine, Capsaicin)	Non-Pharmacological (Active & Passive) Acute Trial of NSAID*/APAP Add on Topical Agent (NSAID, Lidocaine, Capsaicin) Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA)	Non-Pharmacological (Active & Passive) Acute Trial of NSAID*/APAP Topical Agent (NSAID, Lidocaine, Capsaicin)
2nd Line	Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**	Anti-Epileptic Drugs (AEDs) Controlled Substance Class IV **Consider Referral to Specialist**	Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**
3rd Line	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer*** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer*** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**
4th Line	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Botox Injection**** Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Consider Clinical Trial

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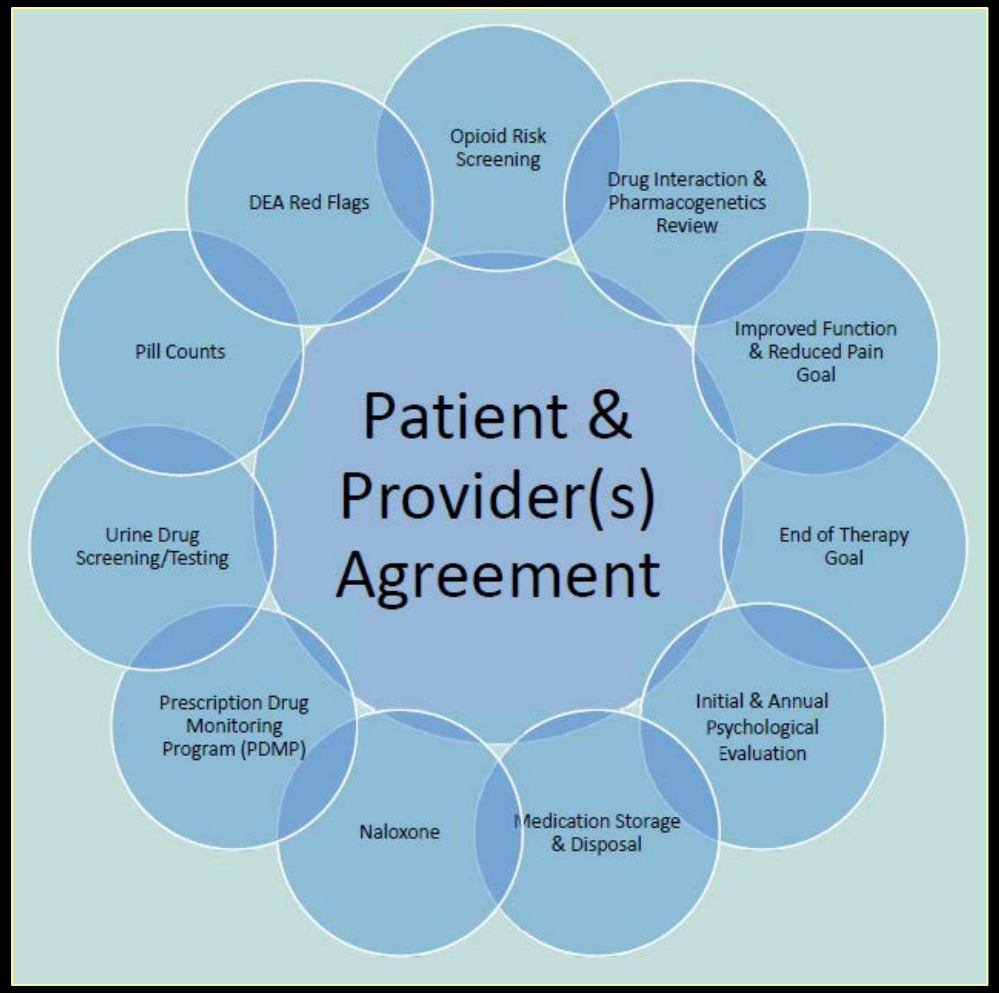
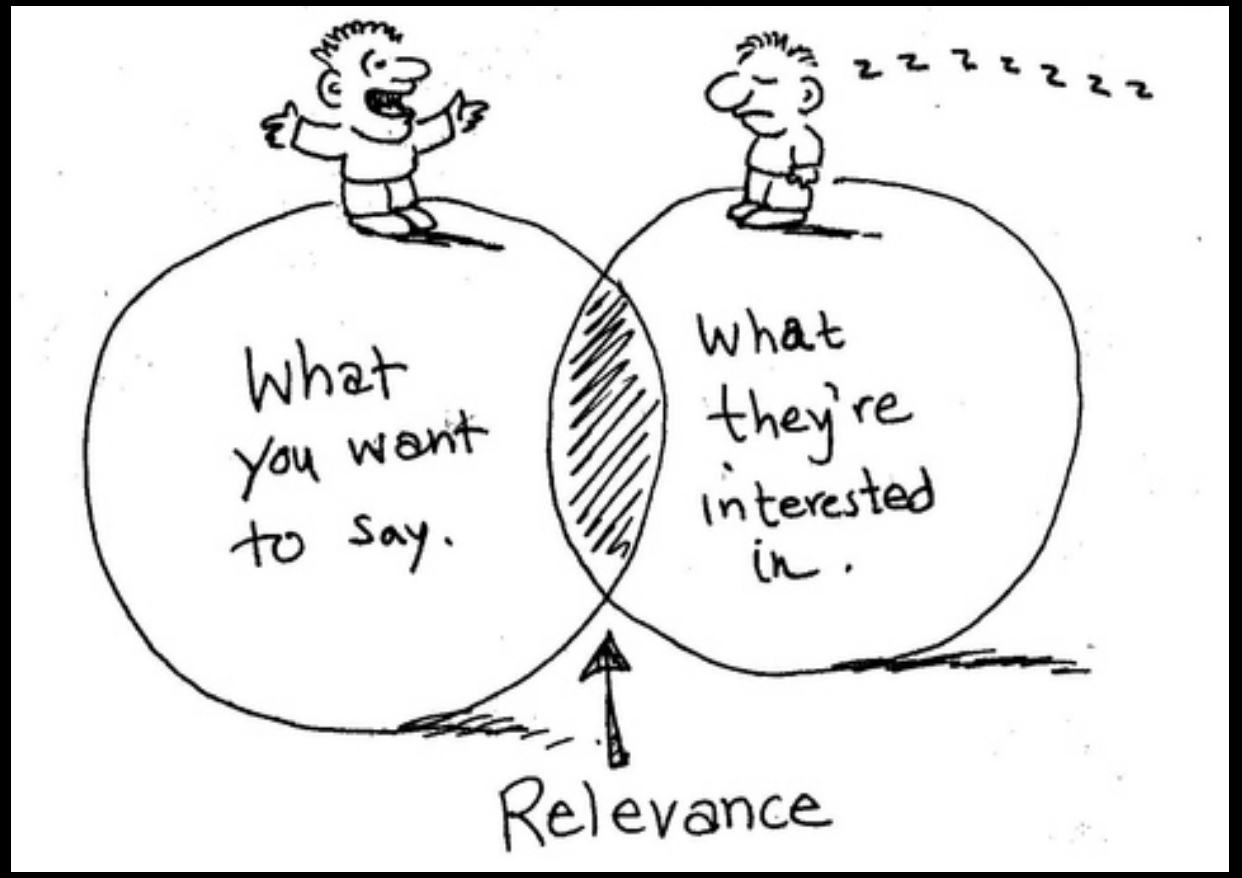
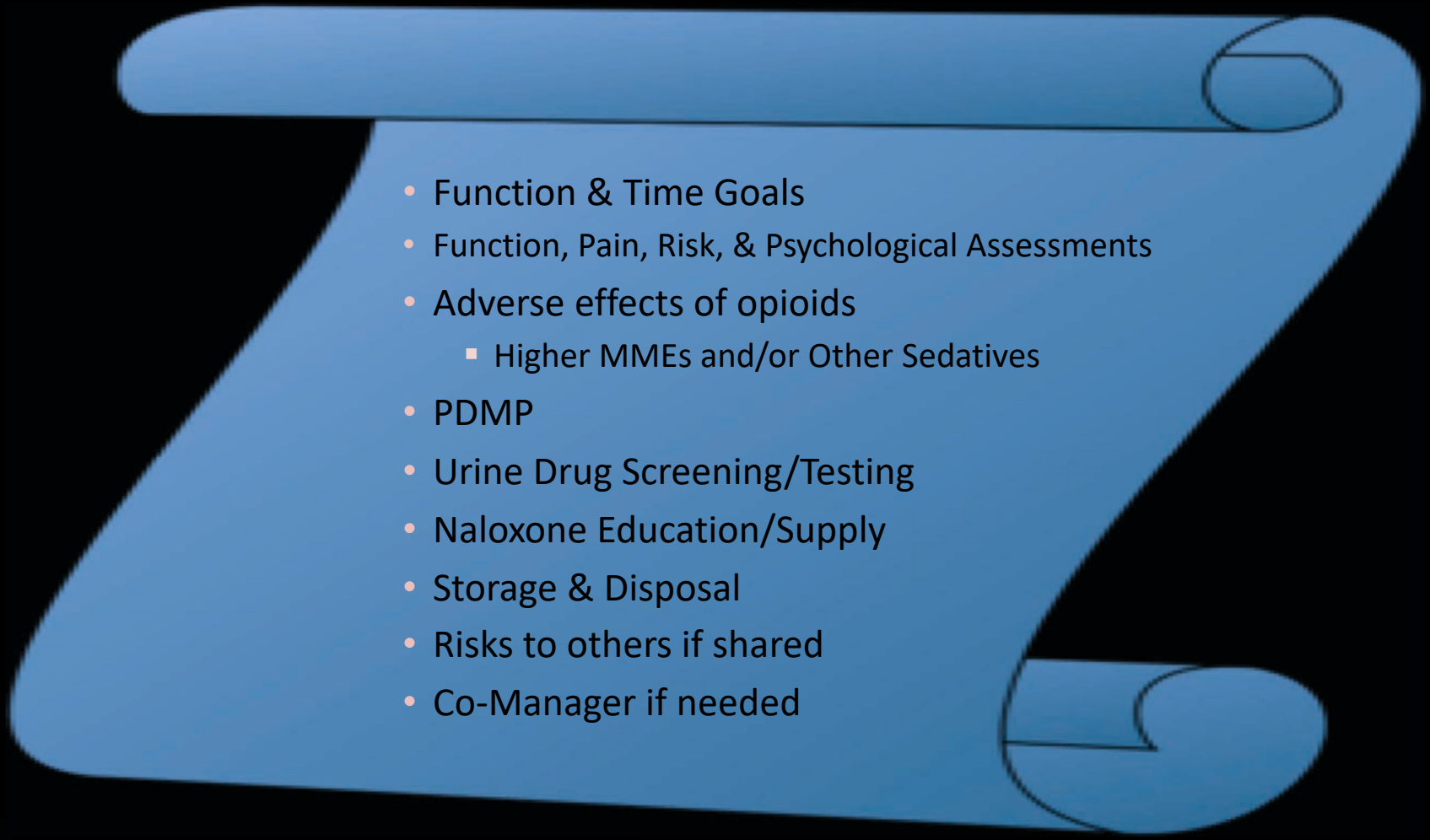
Risk Reduction Strategy



Risk Reduction Strategy



Patient & Provider Agreement Items



- Function & Time Goals
- Function, Pain, Risk, & Psychological Assessments
- Adverse effects of opioids
  - Higher MMEs and/or Other Sedatives
- PDMP
- Urine Drug Screening/Testing
- Naloxone Education/Supply
- Storage & Disposal
- Risks to others if shared
- Co-Manager if needed

Pain Reduction & Function Improvement Goal

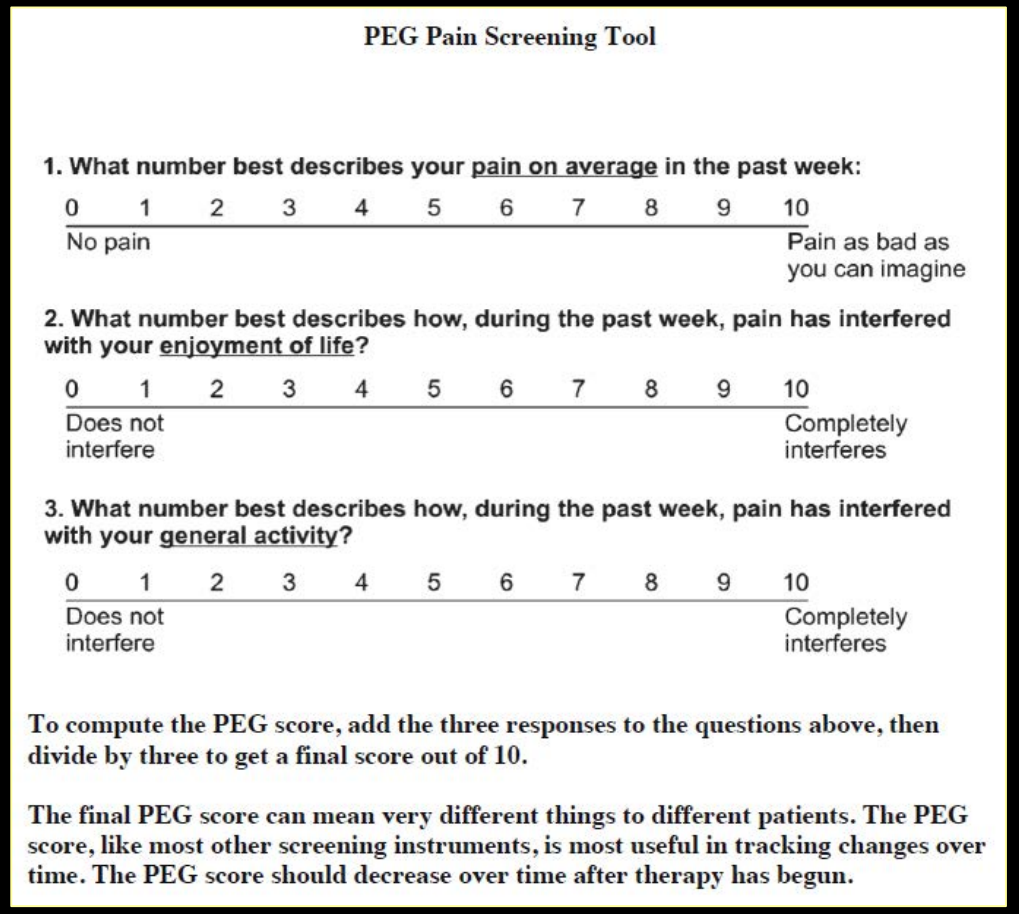
Pain = 5th Vital Sign ???

Analgesic ???

The goal is NOT necessarily to eliminate pain

- The goal is to Improve Function & Reduce Pain

PEG Scale



PEG Pain Screening Tool

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.

PEG Scale

Pain intensity (P)
Interference with Enjoyment of life (E)
Interference with General activity (G)

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Krebs E, et al. Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. J Gen Intern Med 24(6):733–8.

Graded Chronic Pain Scale

Graded chronic pain scale: a two-item tool to assess pain intensity and pain interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain										**Pain as bad as could be**
0	1	2	3	4	5	6	7	8	9	10

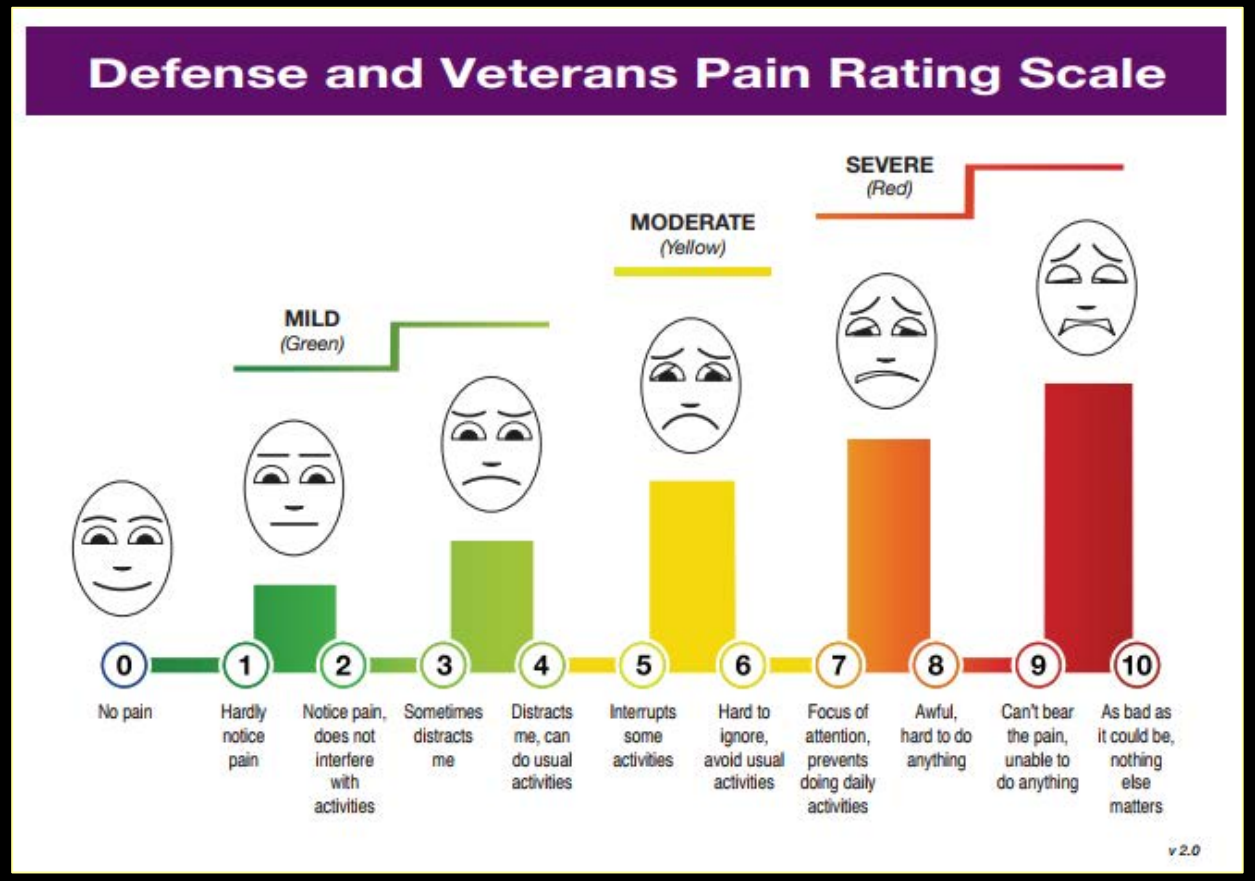
In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."

No interference										**Unable to carry on any activities**
0	1	2	3	4	5	6	7	8	9	10

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

http://www.agencymeddirectors.wa.gov/Files/AssessmentTools/4-Two%20Item%20Graded%20Chronic%20Pain%20Scale.pdf

DVPRS



DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute — Contributes a great deal

*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.

v 2.0

https://www.va.gov/PAINMANAGEMENT/docs/DVPRS_2slides_and_references.pdf

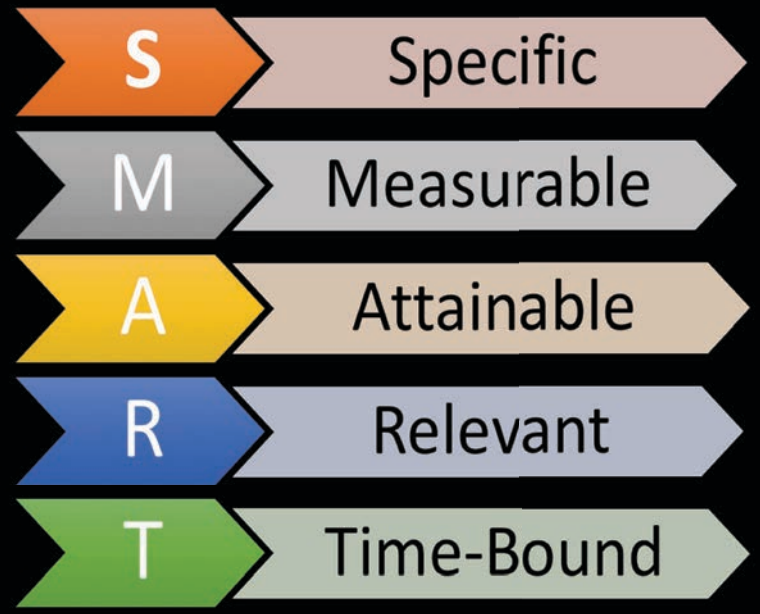
End of Therapy Goal

Acute Goal

- Expected time frame of healing

Chronic Goal

- Resolution of the syndrome is not always expected
- Prevent long term medication issues (possibly d/c)
  - Adverse effects, dependency, etc.



Proper Medication Storage

Bathroom Medicine Cabinets → NO

- Humidity
- Unsecure
- Typically accessed at “groggy” times of day (AM/PM)

Lockable Safe Boxes → YES

- Away from children and pets
- Secure
- Still must incorporate into daily routine

Proper Medication Disposal

EPA

1st Choice

Drug Take-Back Event

2ND CHOICE: HOUSEHOLD DISPOSAL STEPS*

1. Take your prescription drugs out of their original containers.

2. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds.

3. Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a sealable bag.

4. Conceal or remove any personal information, including Rx number, on the empty containers by covering it with permanent marker or duct tape, or by scratching it off.

5. The sealed container with the drug mixture, and the empty drug containers, can now be placed in the trash.

* Drug Disposal Guidelines, Office of National Drug Control Policy, October 2009

https://www.epa.gov/sites/production/files/2015-06/documents/how-to-dispose-medicines.pdf

Proper Medication Disposal

FDA

1. DEA Sponsored Take-Back Programs (*Same as EPA*)
2. Household Trash (*Same as EPA*)
3. DEA Authorized Collector
   - Pharmacies can Register
   - https://apps.deadiversion.usdoj.gov/webforms2/spring/disposalLogin?execution=e2s1
4. Flushing a list of ~40 CIIs
   - Drugs enter water systems through human excretion
   - No sign of environmental damage from flushing drugs yet

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https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm#steps
https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm576167.htm

Psychological Evaluation

PHQ-2 & PHQ-9

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ-2 Score >/= 3 → Take PHQ-9

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	_____ +	_____ +	_____	
Add Totals Together	_____			

PHQ-9 Score >/15 → Psychotherapy +/- Antidepressant

PHQ-2: http://www.cqaimh.org/pdf/tool_phq2.pdf
PHQ-9: https://www.mdcalc.com/phq-9-patient-health-questionnaire-9

Opioid Risk Screenings

Opioid-Naïve

Patients Being Considered for Opioid Therapy

- Opioid Risk Tool (ORT)
- Drug Abuse Screening Test (DAST)
- Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)

Opioid Experienced

Patients Already Receiving Opioid Therapy

- Current Opioid Misuse Measure (COMM)
- Pain Medication Questionnaire (PMQ)
- Prescription Drug Use Questionnaire (PDUQ)
- Others

Opioid Risk Screenings

Opioid Naïve

Self Reported

- Drug Abuse Screening Test (DAST)
- Screener & Opioid Assessment for Patients with Pain (SOAPP)

Provider Reported

- Opioid Risk Tool (ORT)
- Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)

Opioid Experienced

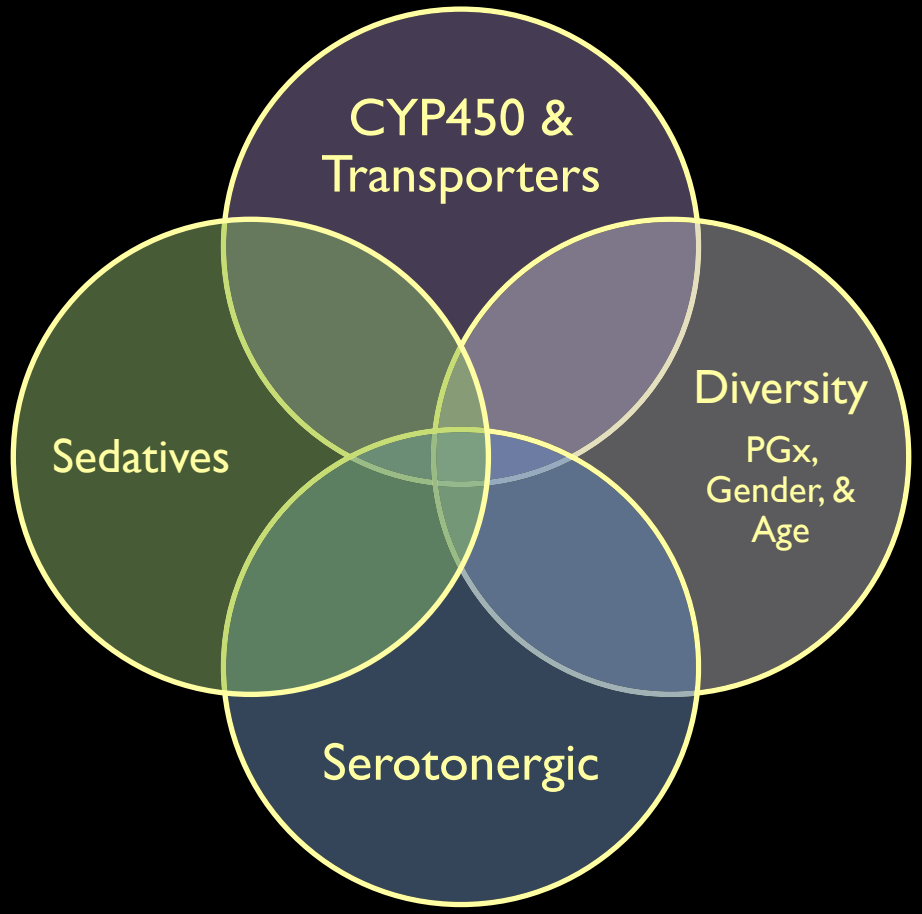
Self Reported

- Current Opioid Misuse Measure (COMM)
- Pain Medication Questionnaire (PMQ)
- Prescription Drug Use Questionnaire, Patient (PDUQp)

Provider Reported

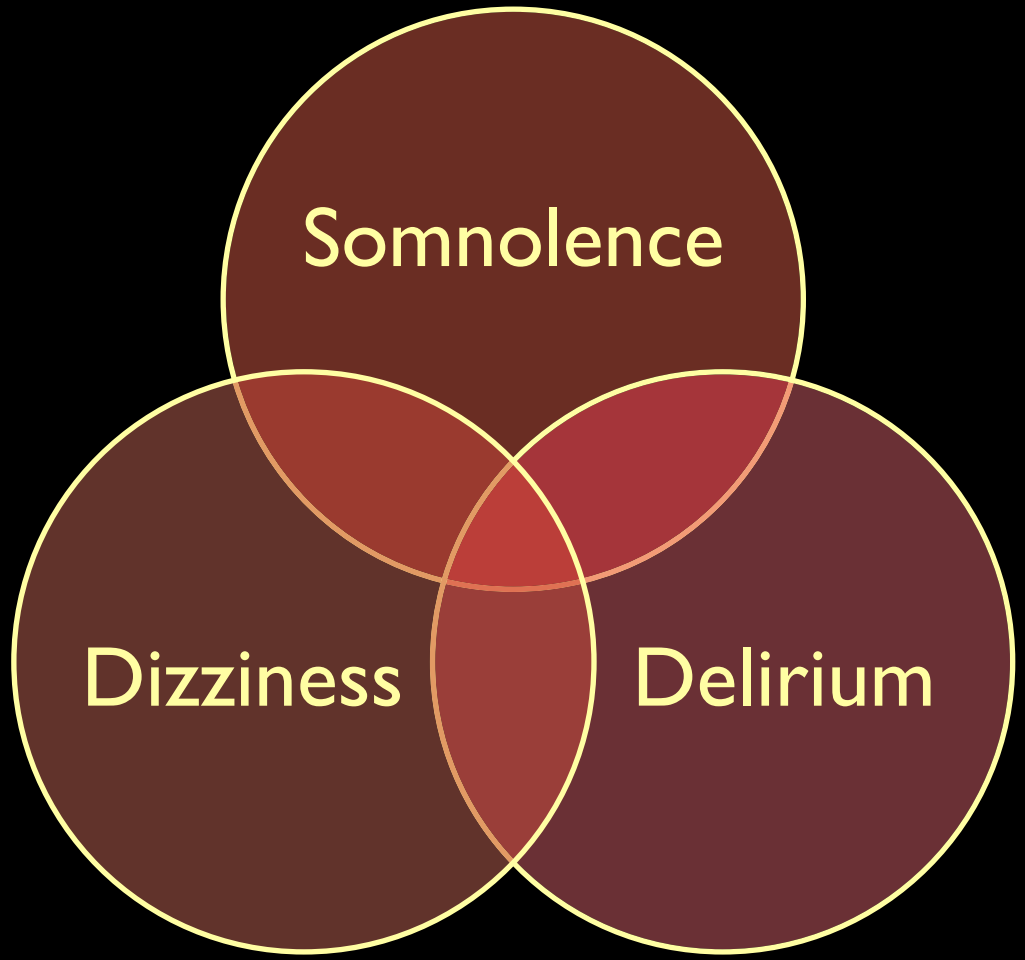
- Prescription Drug Use Questionnaire (PDUQ)

Opioid Medication Interactions



Opioids, Benzos, “Relaxants”, & Hypnotics

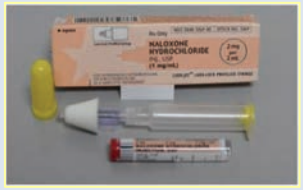
Overlapping Sedative Side Effects…



Opioid-Sedative Interactions
"Name Game"

Drug-Drug Interaction	Proposed Name
Opioid + Benzodiazepine Sedative	"Bozo"
Opioid + "Muscle Relaxant" Sedative	"Relaxoid"
Opioid + Sedative Hypnotic	"Hypoid"
Opioid + One Other Sedative	"Deadly Duo"
Opioid + Two Other Sedatives	"Unholy Trinity"
Opioid + Three Other Sedatives	"Quattro Killer"
Benzodiazepine & Sedative Hypnotic	"Hypzo"
Benzodiazepine & "Muscle Relaxant" Sedative	"Relaxzo"

Naloxone Products

Product	Generic Injectable	Generic Intranasal	Narcan® Nasal Spray	Evzio® Auto-Injector
Dose	0.4mg IM	1mg in each nostril	4mg in one nostril	0.4mg/2mg IM/SQ
Dosing	Inject 1mL in shoulder/thigh, may repeat in 2-3min Use 3mL 23G syringe &1" needle	Spray 1mL (half of syringe) in each nostril with atomizer, may repeat in 2-3 min	Spray 0.1mL into one nostril; may repeat in 2-3 min with 2nd device in alternate nostril	Press black side firmly onto outer thigh through clothing, hold 5 seconds, may repeat in 2-3 min
Availability	0.4mg/mL 4mg/10mL	2mL prefilled Luer-Jet syringe + Atomizer (Item # MAD-301)	0.4mg/0.1mL	0.4mg/0.4mL 2mg/0.4mL
Manufacturer	Pfizer, West-Ward, & Mylan	IMS/Amphastar	Adapt	Kaleo
Cost	$	$$	$$	$$$$$
NDC	00409-1215-01 00409-1219-01 67457-0292-01 00641-6132-25	76329-3369-01	69547-0353-02	60842-0030-01 60842-0051-01
Picture				

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Adapted from: Toderika Y, Williams S. Naloxone for Opioid Overdose and the Role of the Pharmacist. Consult Pharm. 2018 Feb 1;33(2):98-104.

Naloxone Candidates

- Any patient receiving >/=50mg MME
- Opioid Rotation
- Recent Opioid Overdose
- Opioid Use Disorder
- Personal/ Family History Substance Abuse
- Respiratory Condition
  - COPD/Asthma
  - Sleep Apnea
  - Smoking of Anything
- Heavy Alcohol Use
- Benzodiazepine or Other Sedatives
- Difficult Access to EMT (Rural)
- Voluntary Request (Patient/Caregiver)

https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone

Opioid Overdose Symptoms

Death Rattle
Gargled, Slow, Absent Breathing

Unconscious and Unarousable

Pinpoint Pupils

Pale Clammy Skin

Hypoxia
Blue Lips & Nails

Hypotension

Slow or No Heartbeat

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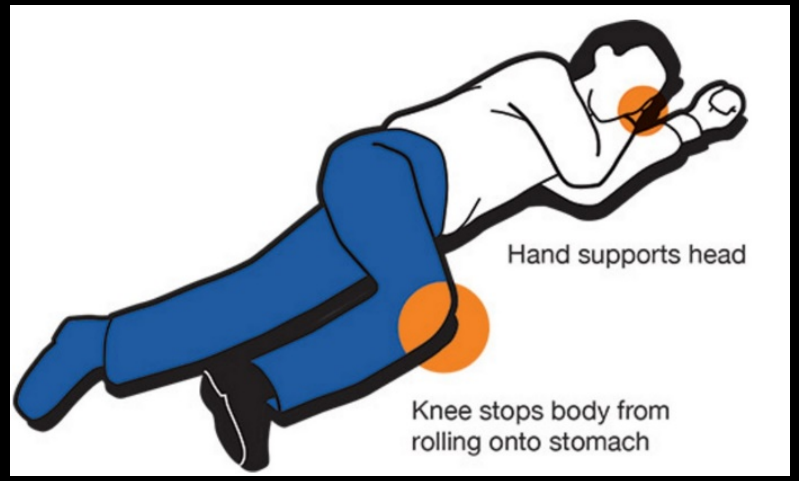
https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone

Naloxone Administration

SAMHSA Guidelines



1. Check for signs of opioid overdose
2. Call EMS to access immediate medical attention*
3. Administer naloxone (rescue position)*
4. Rescue breathe if patient not breathing*
5. Stay with the person and monitor their response until emergency medical assistance arrives. After 2-5 minutes, repeat the naloxone dose if person is not awakening or breathing well enough (10 or more breaths per minute)

*Order depending on the source of guidance

https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone

Pill Counts

- Randomized or Scheduled
- Goals
  - Improve proper medication adherence
  - Prevent and/or detect medication diversion
- Recommend not to have support staff perform
- Use a counting tray

➢ Realize Pills can be rented/borrowed (online/street)

Viscomi CM, et al. Pill counts and pill rental: unintended entrepreneurial opportunities. The Clinical Journal of Pain. 29(7):623–624, JUL 2013

Urine Drug Screening/Testing

- Randomized or Scheduled
- Goals
  - Improve proper medication adherence
  - Prevent and/or detect medication diversion
- Witnessed or private

➢ Realize Urine can be purchased online or shared
  - www.thewhizzinator.com

Urine Drug Screening/Testing

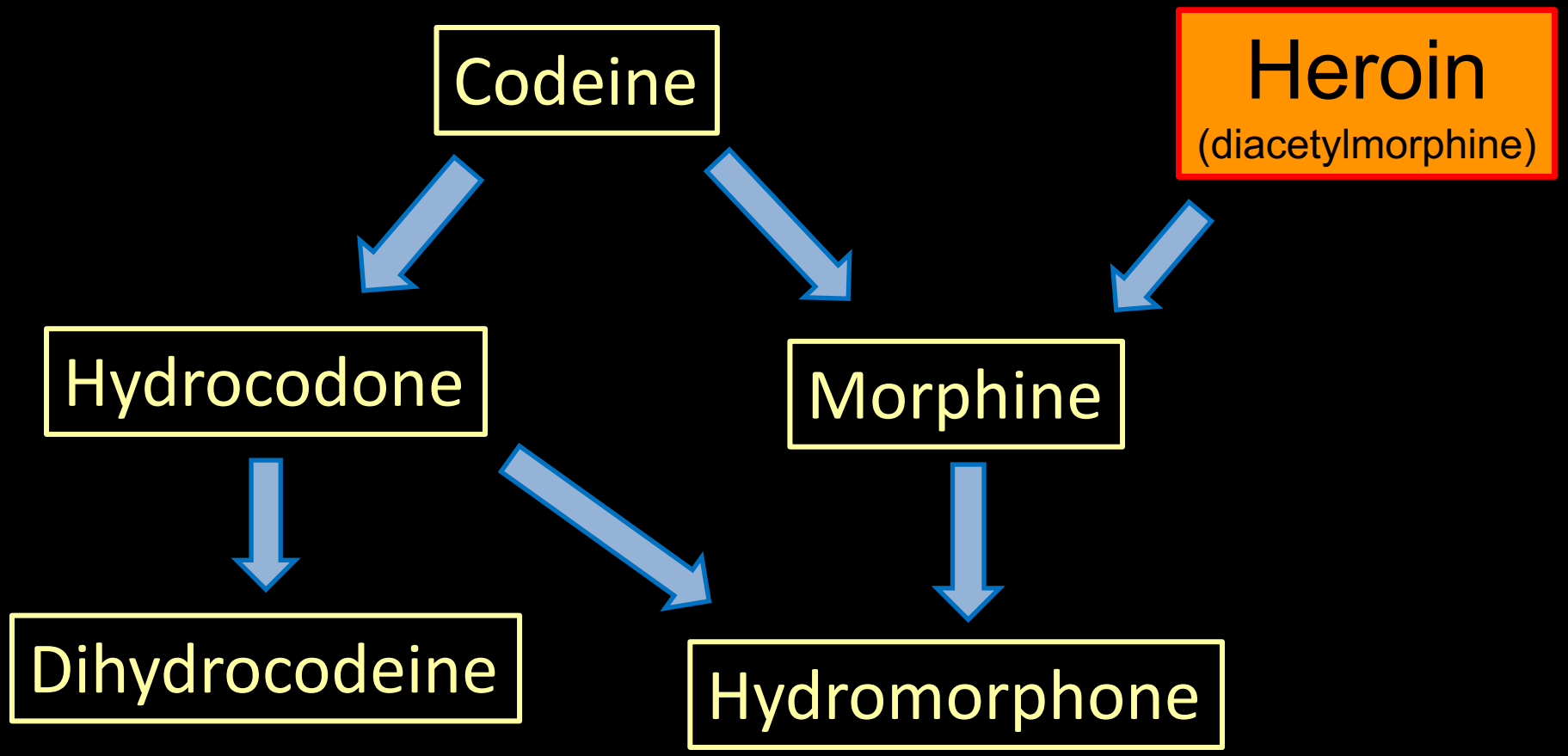
Urine Drug Screening versus Testing

 **Urine Drug Screening (UDS)**	**Urine Drug Testing (UDT)** 
Immunoassay screen (i.e. Cup)	GC-MS or LC-MS/MS
In-office, point-of-care, or lab-based	Laboratory, highly specific & sensitive
Results within minutes	Results in hours or days
Detects a few legal & illicit medications by structural class	Measures concentrations of all drugs & metabolites
Guidance for preliminary treatment decisions	Definitive identification & analysis
Cross-reactivity common: more false positives	False-positive results are rare
Higher cutoff levels: more false negatives	False-negative results are rare
$	$$$

Adapted from the WV SEMP Guidelines. www.sempguidelines.org

Opioid Metabolism

Active Metabolites



Adapted from the WV SEMP Guidelines. www.sempguidelines.org

Urine Drug Screening Panels

<table>
<tr><th colspan="5">Urine Drug Screening Panels</th></tr>
<tr><td>7 Panel</td><td rowspan="4">Marijuana (THC)
Cocaine
Opiates/Derivatives
PCP
Amphetamines
Benzodiazepines
Barbiturates</td><td colspan="3"></td></tr>
<tr><td>10 Panel</td><td rowspan="3">Methadone
Propoxyphene
Quaaludes</td><td colspan="2"></td></tr>
<tr><td>12 Panel</td><td rowspan="2">Ecstasy &
Oxycodone</td><td></td></tr>
<tr><td>Pain 13 Panel</td><td>Fentanyl & Meperidine</td></tr>
</table>

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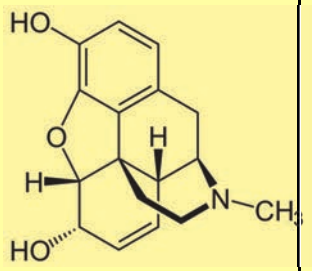
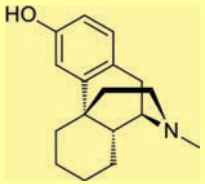
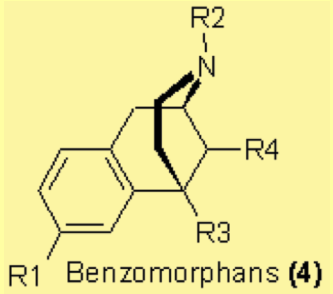
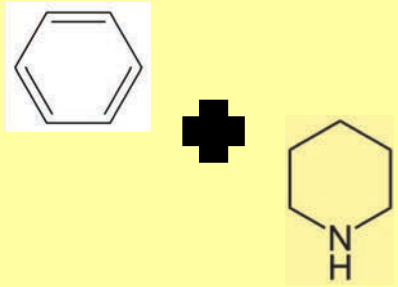
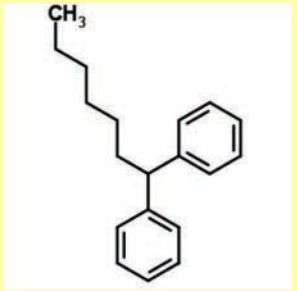
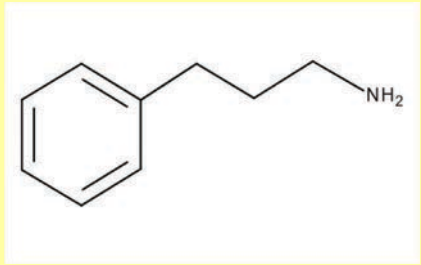
http://www.mobilehealth.net/screening/drug-screening/5-panel/the-different-drug-panels/

Opioid Structural Classes

Phenanthrenes		Benzomorphans	Phenylpiperidines	Dipheylheptanes	Phenylpropylamines
5 Rings	4 Rings	3 Rings	2 Rings	2 Rings	2 Rings
					
Buprenorphine Codeine Diacetylmorphine Hydrocodone Morphine Naloxone Oxycodone Oxymorphone	Butorphanol Levorphanol	Diphenoxylate Loperamide Pentazocine	Fentanyl Meperidine	Methadone Propoxyphene	Tapentadol Tramadol

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Adapted from Volkow ND, McLellan AT. NEJM 2016; 374:1253-1263.

Urine Drug Screening

Cross-Reactants

Chemical	Cross-Reactant
Cannabinoids	NSAIDs, dronabinol, promethazine, & pantoprazole
Opioids	poppy seeds, chlorpromazine, rifampin, dextromethorphan, quinolones, diphenhydramine, & quinine
Amphetamines	methylphenidate, trazodone, bupropion, amantadine, propranolol, labetalol, ranitidine, & menthol
PCP	ibuprofen, tramadol, chlorpromazine, venlafaxine, thioridazine, meperidine, dextromethorphan, diphenhydramine, & doxylamine
Benzodiazepines	oxaprozin, sertraline, & some herbals
Alcohol	asthma inhalers
Methadone	quetiapine

Adapted from WV SEMPP Guidelines. www.sempguidelines.org

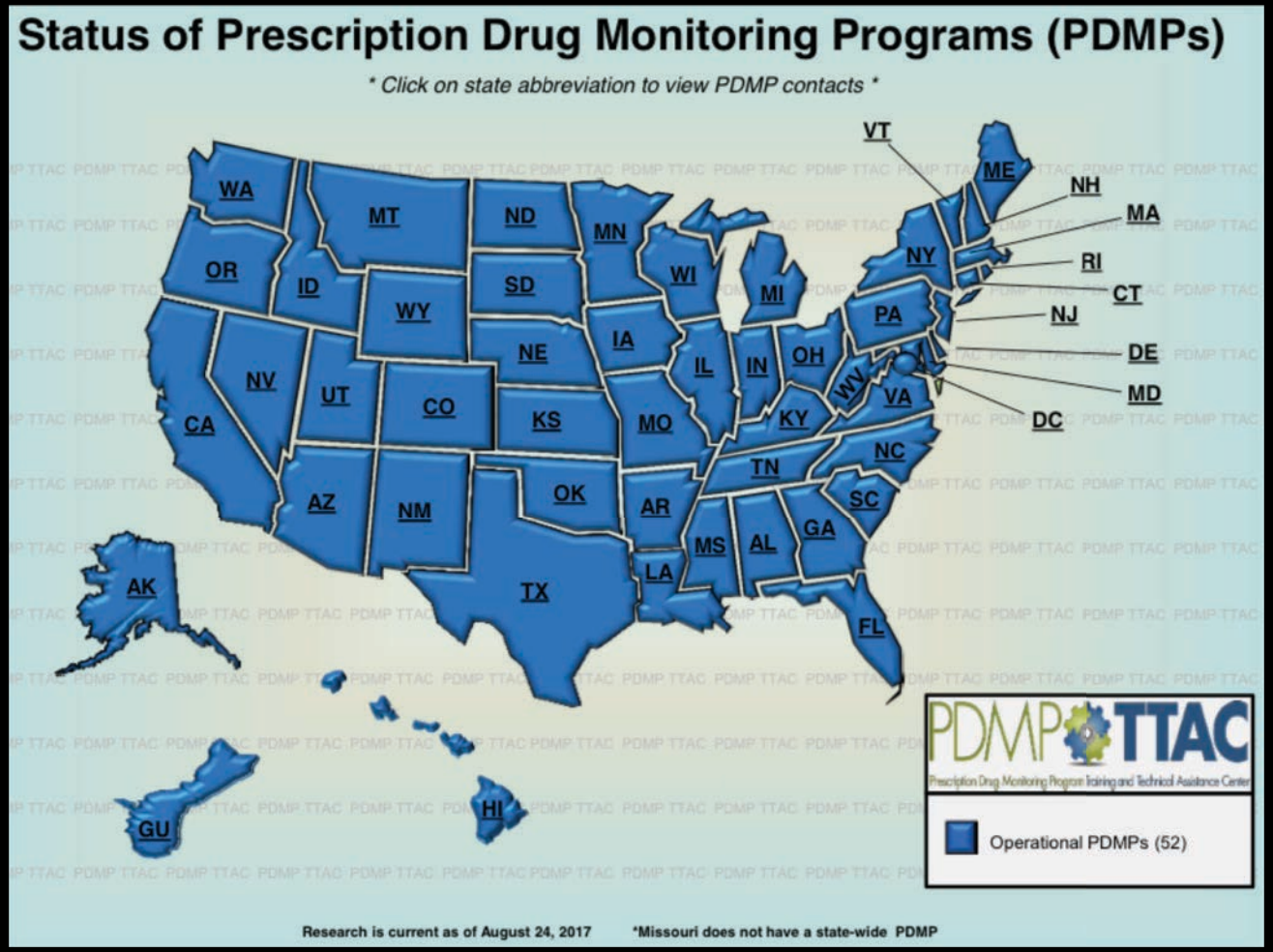
Urine Drug Screening/Testing

Conversation Starters

Conversation Leaders

Prescription Drug Monitoring Programs

PDMPs



State	PDMP Legislation	PDMP Operational
California	1939	1939
Hawaii	1943	1943
Idaho	1967	1967
Illinois	1961	1968
New York	1972	1973
Pennsylvania	1972	1973
Rhode Island	1978	1979
Texas	1981	1982
Michigan	1988	1989
Oklahoma	1990	1991
Massachusetts	1992	1994
West Virginia	1995	1995
Utah	1995	1996
Nevada	1995	1997
Indiana	1997	1998
Kentucky	1998	1999
Virginia	2002	2003
Maine	2003	2004
Wyoming	2004	2004
New Mexico	2004	2005
Mississippi	2005	2005
Ohio	2005	2006
Alabama	2004	2006
Tennessee	2003	2006
Colorado	2005	2007
North Dakota	2005	2007

State	PDMP Legislation	PDMP Operational
North Carolina	2005	2007
Connecticut	2006	2008
Arizona	2007	2008
Louisiana	2006	2008
South Carolina	2006	2008
Vermont	2006	2009
Iowa	2006	2009
Minnesota	2007	2010
New Jersey	2008	2011
Alaska	2008	2011
Oregon	2009	2011
Washington	2007	2011
Kansas	2008	2011
South Dakota	2010	2011
Florida	2009	2011
Nebraska	2011	2011
Delaware	2010	2012
Montana	2011	2012
Guam	1998	2013
Wisconsin	2010	2013
Arkansas	2011	2013
Georgia	2011	2013
Maryland	2011	2013
New Hampshire	2012	2014
District of Columbia	2014	2016
Missouri	2016	2017

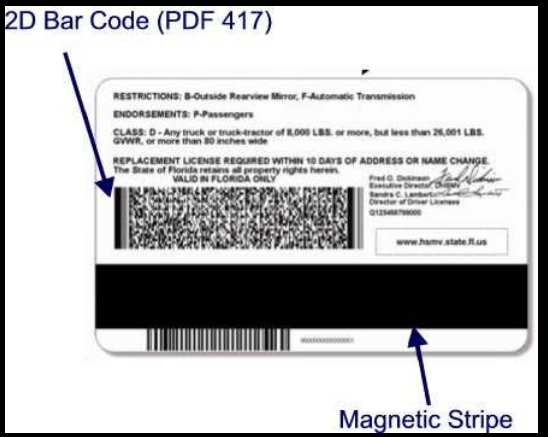
Verifying Identification Cards
Magnetic Strip Swipe

- States with Magnetic Stripes

  AL, AZ, AR, CA, CO, FL, KS, LA, MI, MN,
  MS, NH, NM, OH, PA, SC, TX, & VT

- Fast Scanning: 1 second for response

- ~$500 Device Cost



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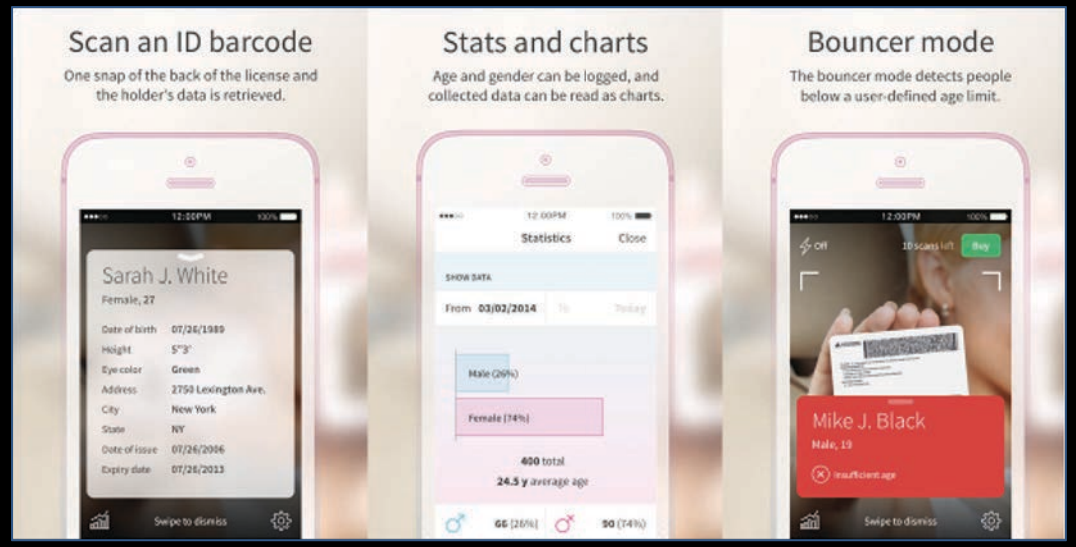
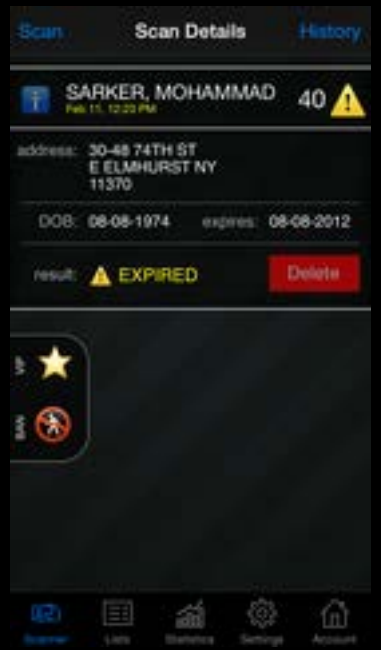
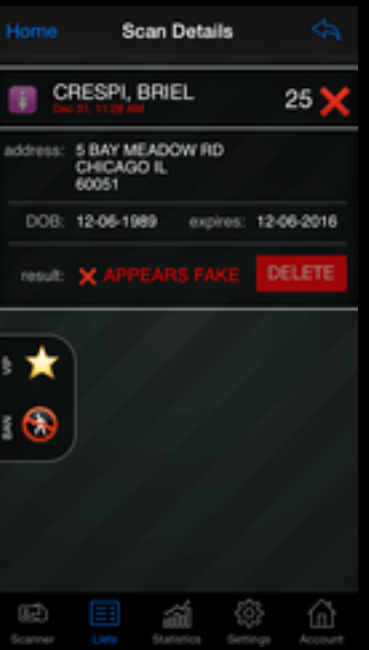
http://www.idscanner.com/products/magnetic-stripe-id-swiper/

Verifying Identification Cards
Barcode Reader

- Process via smartphones/pads
- Link directly to state ID databases







PaiNweek

https://www.barandclubstats.com/collections/id-scanner
http://www.netocratic.com/scannr-app-infinum-photopay-3140

DEA Red Flags

Prescribers

- Cash only patients and/or no acceptance of worker's compensation or insurance
- Prescribing of the same combination of highly-abused drugs
- Prescribing the same (high) quantities of pain drugs to most/every patient
- High number of prescriptions issued per day
- Out-of-area patient population

➢NABP "Red Flags" Video (https://nabp.pharmacy/initiatives/awarxe/pharmacist-resources/)

https://nabp.pharmacy/initiatives/awarxe/pharmacist-resources/

DEA Red Flags

Dispensers

- Dispensing a high percentage controlled to non-controlled drugs
- Dispensing high volumes of controlled substances generally
- Dispensing the same drugs & quantities prescribed by the same prescriber
- Dispensing to out-of area or out-of-state patients
- Dispensing to multiple patients with the same last name or address
- Sequential prescription #s for highly diverted drugs from the same prescriber
- Dispensing for patients of controlled substances from multiple practitioners
- Dispensing for patients seeking early prescription fills

➢NABP ”Red Flags” Video (https://nabp.pharmacy/initiatives/awarxe/pharmacist-resources/)

When Drug Seeking or Diversion is Suspected

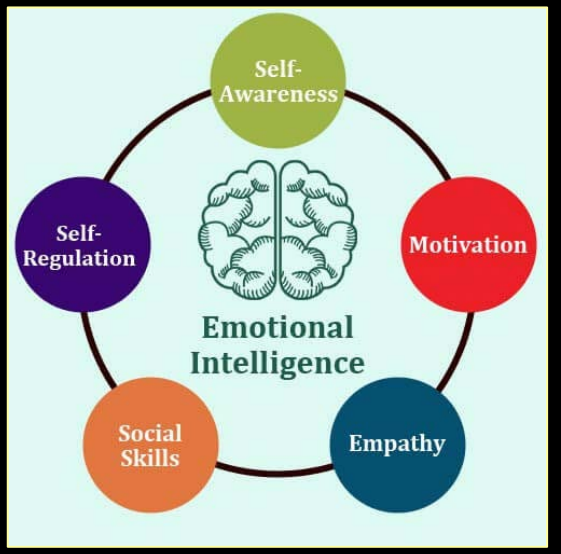
- Eliminate personal or judgmental biases

- Calm, collected, knowledgeable, and well researched approach
  - "Never pick up a phone until you've completed research"

- Conversation with other respective healthcare professionals
  - May not even be aware of the use of his/her name

- Conversation with respective patient
  - "There's two sides to every coin"
  - "False positives"

??? Responsibility ???



??? Comfort Level ???

Once Drug Seeking or Diversion is Confirmed

- Refer to a substance-use disorder (addiction) specialist/program
- Contact law enforcement if concern for the safety of the patient or others exists
- Treatment can continue with alternative therapies (e.g. non-controlled substances)
- Reference the patient and provider agreement/contract
  - Avoid patient abandonment concerns (e.g. provide 30 days of additional treatment)
- Respect all involved while complying with federal and state laws

Reporting to the DEA


U.S. DEPARTMENT OF JUSTICE ★ DRUG ENFORCEMENT ADMINISTRATION

DIVERSION CONTROL DIVISION

RX Abuse Online Reporting: Report Incident

Complaint Type* :
- Select One -

Person Making the Report

Your First Name

Your Last Name

Your Zip Code*

Phone Numbers:

Cell:

Home:

Other:

Location of Incident

Location is same as person making the report:

Zip Code*

State*
- Select State -

City*

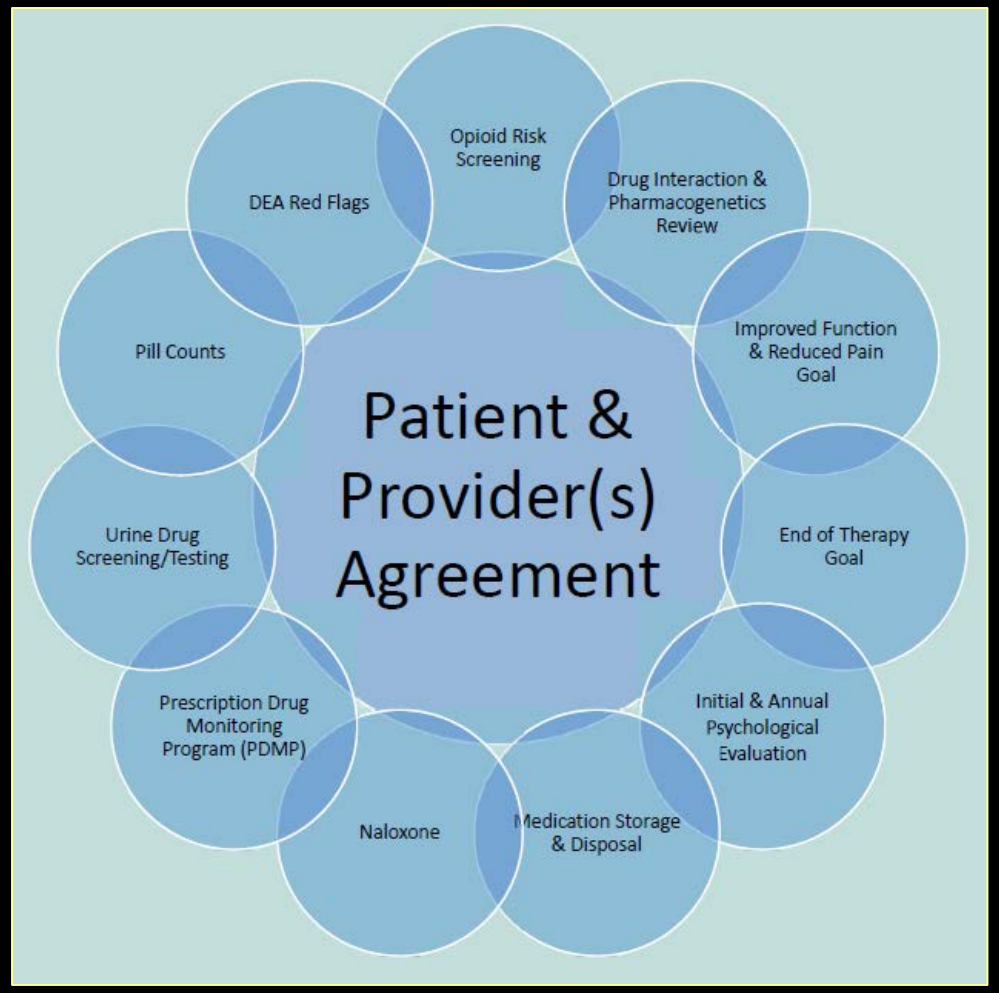
Description

Briefly describe situation being reported - who, what, where and when. 1200 Characters Maximum *

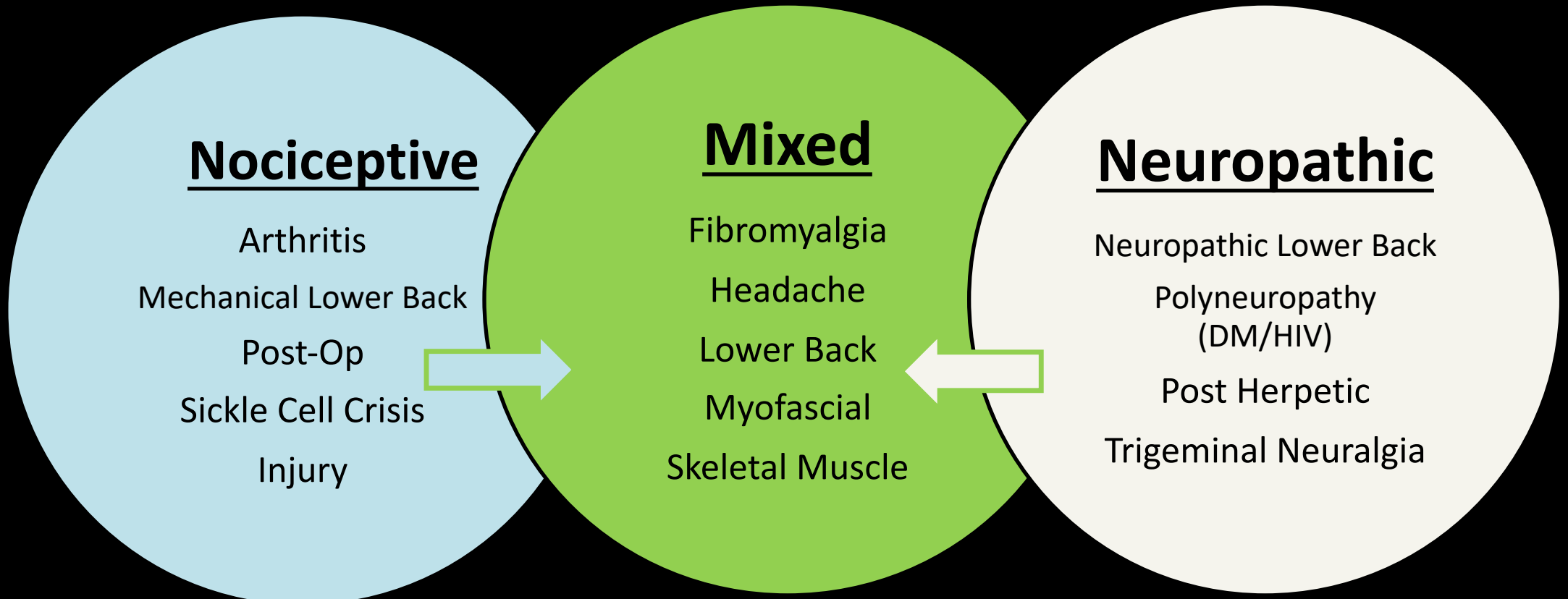
https://apps.deadiversion.usdoj.gov/rxaor/spring/main?execution=e1s1

1-877-RX-Abuse (1-877-792-2873)

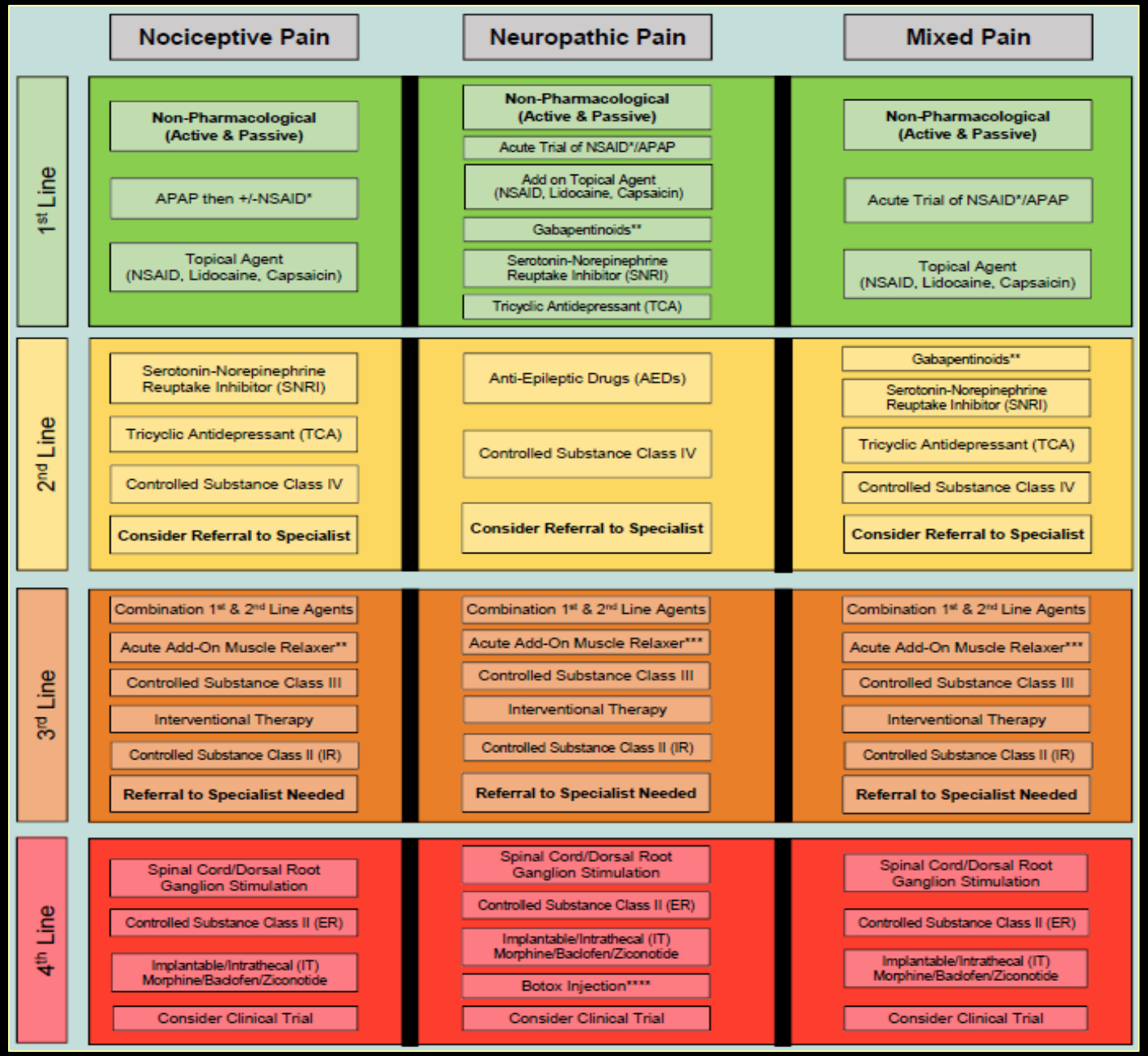
Risk Reduction Strategy



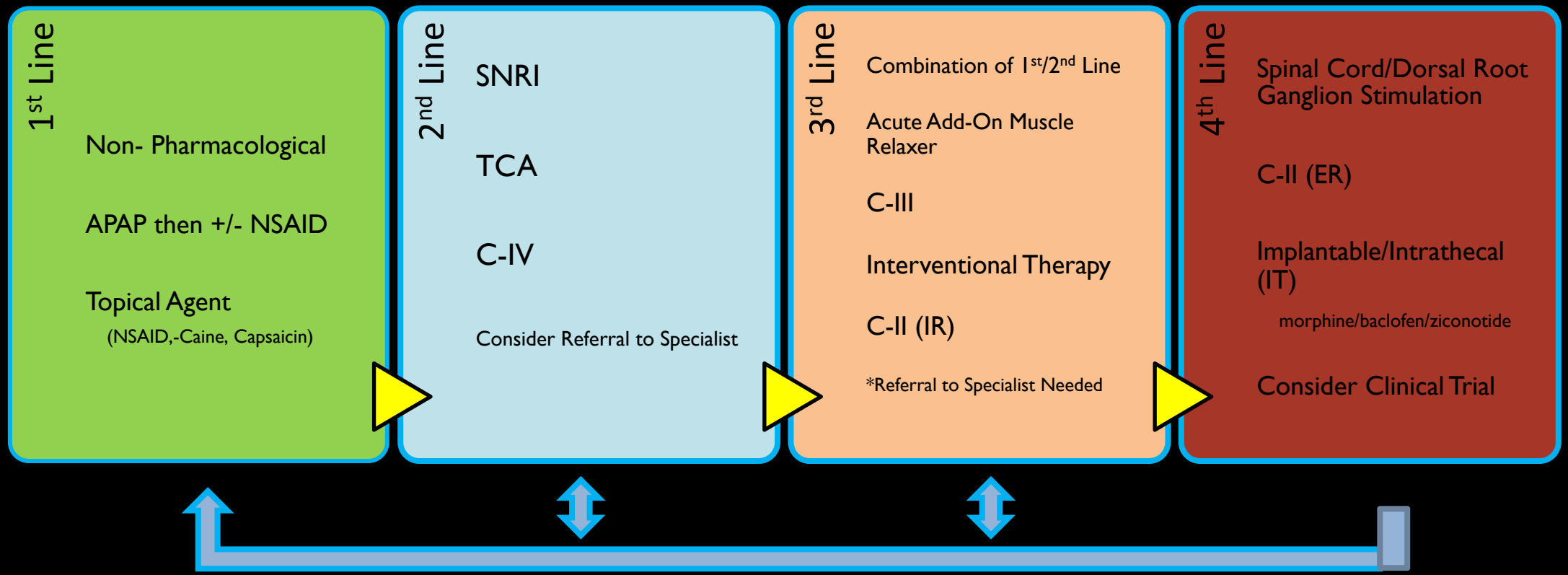
3 Main Types of Pain



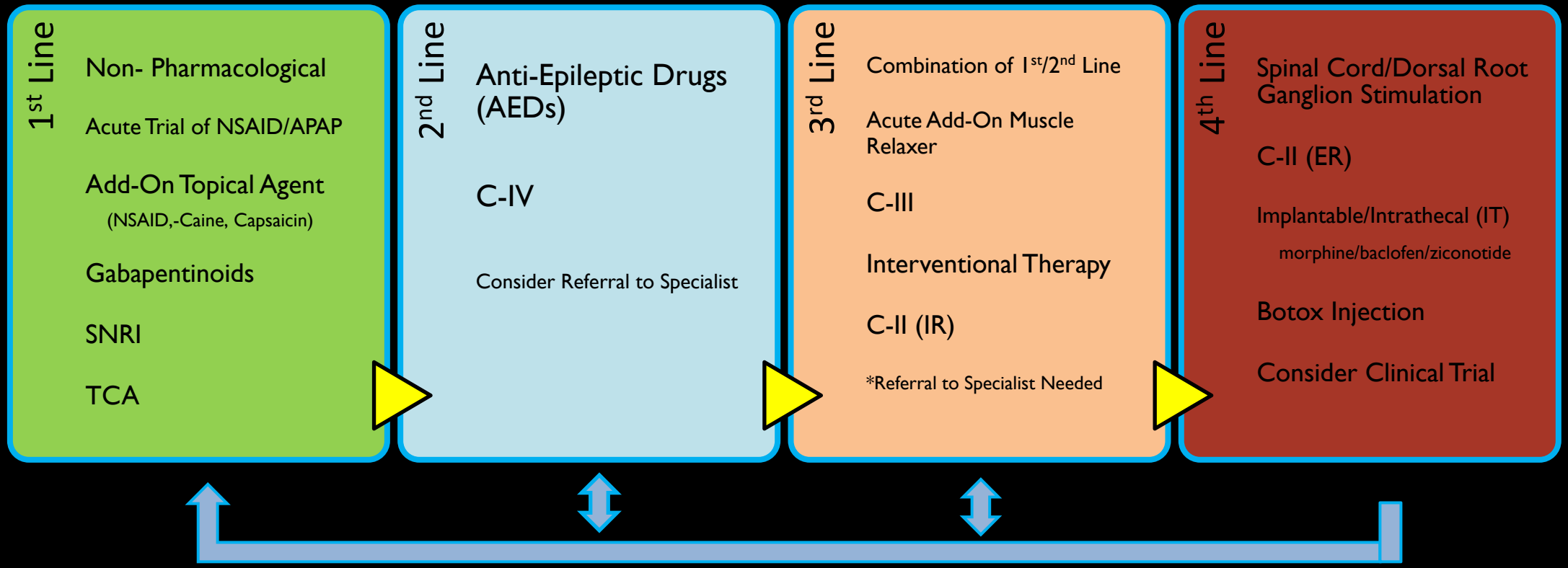
Clinical Treatment Algorithms



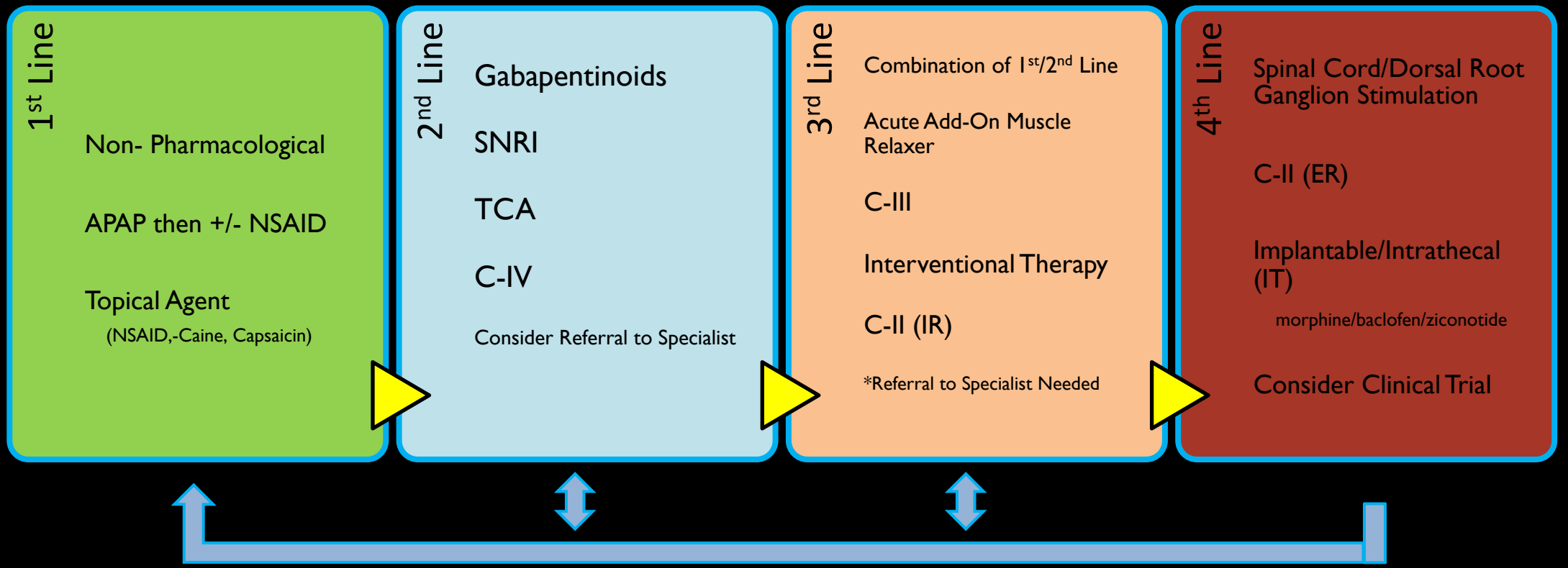
Nociceptive Pain
Clinical Treatment Algorithm



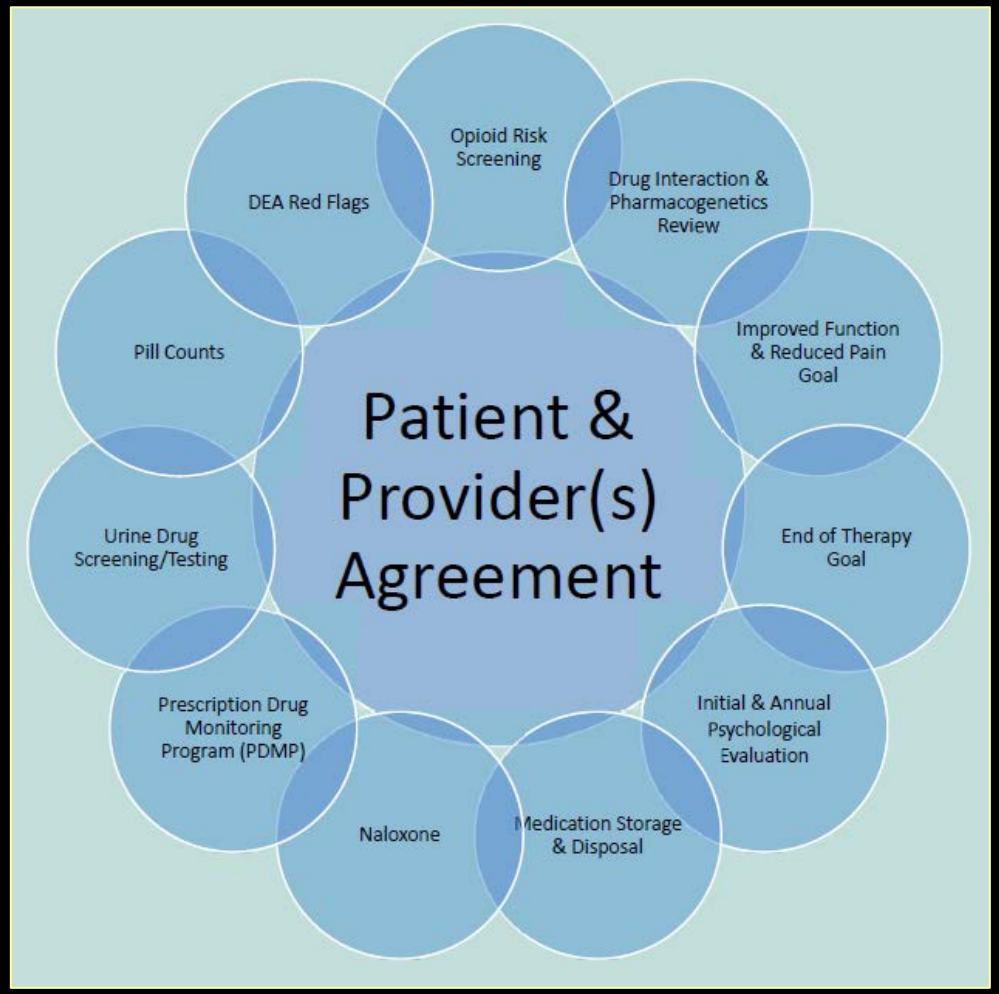
Neuropathic Pain
Clinical Treatment Algorithm



Mixed
Pain Algorithm



www.sempguidelines.org



	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1st Line	Non-Pharmacological (Active & Passive) APAP then +/-NSAID* Topical Agent (NSAID, Lidocaine, Capsaicin)	Non-Pharmacological (Active & Passive) Acute Trial of NSAID*/APAP Add on Topical Agent (NSAID, Lidocaine, Capsaicin) Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA)	Non-Pharmacological (Active & Passive) Acute Trial of NSAID*/APAP Topical Agent (NSAID, Lidocaine, Capsaicin)
2nd Line	Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**	Anti-Epileptic Drugs (AEDs) Controlled Substance Class IV **Consider Referral to Specialist**	Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**
3rd Line	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer*** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer*** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**
4th Line	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Botox Injection**** Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Consider Clinical Trial

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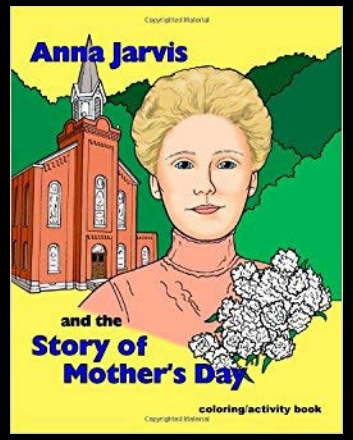
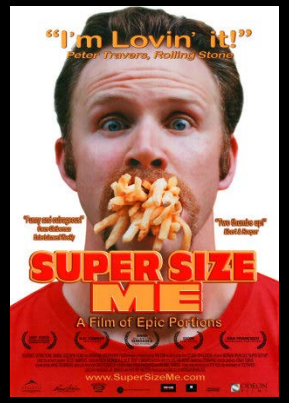
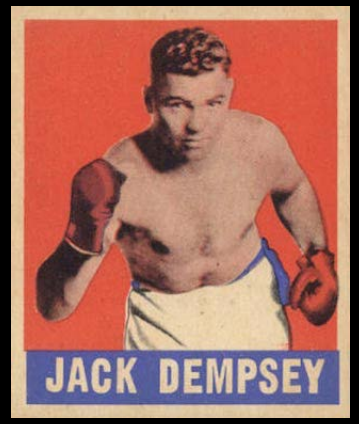
The West Virginia Way

Almost Heaven…







PAINWEEK

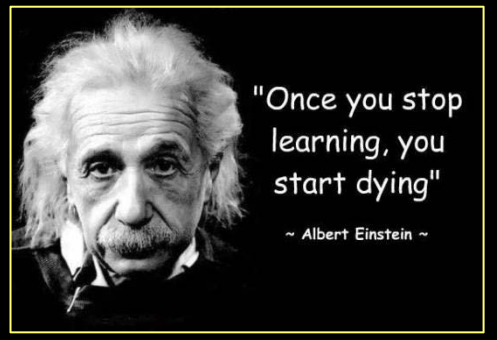
Pain Management Best Practices

People Respect What You Inspect, Not What You Expect

An Ounce of Prevention, is Worth a Pound of Treatment

Never Stop Learning

Hippocratic Oath: Do No Harm



Audience Question #1

After reading headline after headline regarding our nation's opioid crisis, Dr. Payne has decided to begin to mandate patient and provider agreements for all of his patients being prescribed opioid medications. Which of the following would NOT be recommended to include in the patient and provider agreement for his office?

a) Review of the Prescription Drug Monitoring Program (PDMP)
b) Random Urine Drug Screening and/or Testing
c) Mandatory cash payments for office visits
d) Review of the negative effects of utilized medications

Audience Question #1 (ANSWER)

After reading headline after headline regarding our nation's opioid crisis, Dr. Payne has decided to begin to mandate patient and provider agreements for all of his patients being prescribed opioid medications. Which of the following would NOT be recommended to include in the patient and provider agreement for his office?

a) Review of the Prescription Drug Monitoring Program (PDMP)
b) Random Urine Drug Screening and/or Testing
c) MANDATORY CASH PAYMENTS FOR OFFICE VISITS
d) Review of the negative effects of utilized medications

Audience Question #2

Ms. Fay Kinet was recently diagnosed with diabetic peripheral neuropathy, a very common form of neuropathic pain. According to the West Virginia Safe & Effective Management of Pain (SEMP) Guidelines, which of the following medications would be an appropriate first line treatment?

a) Muscle Relaxant
b) TCA or SNRI Antidepressant
c) Mixed Action Opioid
d) Botox Injection

Audience Question #2 (ANSWER)

Ms. Fay Kinet was recently diagnosed with diabetic peripheral neuropathy, a very common form of neuropathic pain. According to the West Virginia Safe & Effective Management of Pain (SEMP) Guidelines, which of the following medications would be an appropriate first line treatment?

a) Muscle Relaxant Medication
b) TCA OR SNRI ANTIDEPRESSANT
c) Mixed Action Opioid Medication
d) Botox Injection

Audience Question #3

While at a loud club on Las Vegas Boulevard (i.e. The Strip), your friend is sitting in a VIP area 20 yards away and looks like he may have had too much to drink since he is practically asleep. What you do not know is that he inadvertently added laced Heroin to his beverage when he thought he added a sweetener. What symptom could you notice form afar that would indicate an opioid (Heroin) overdose?

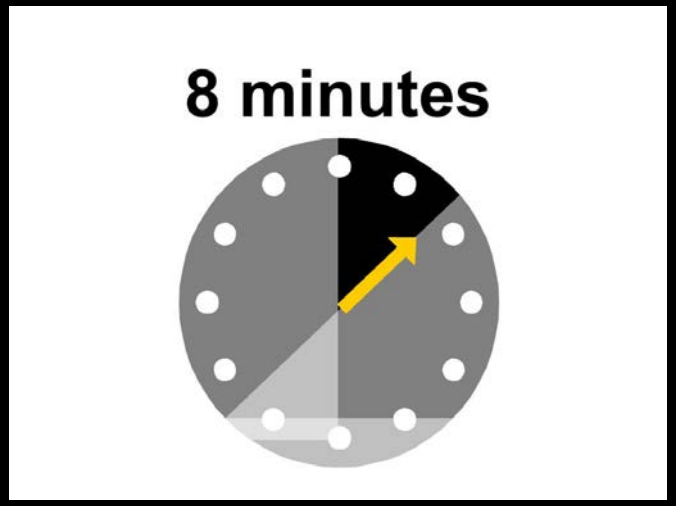
a) Slow Heart Rate
b) Pin Point Pupils
c) The Death Rattle
d) Hypoxia

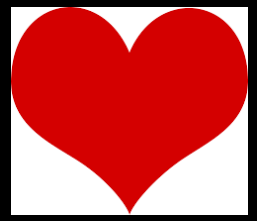
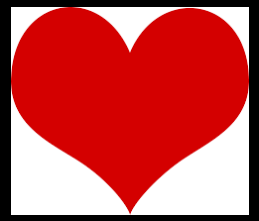
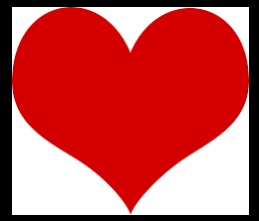
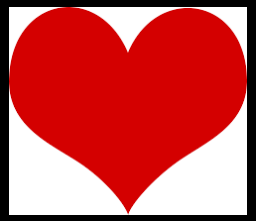
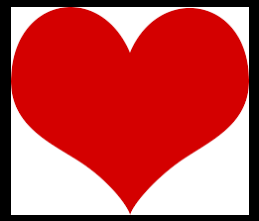
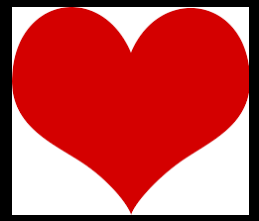
Audience Question #3 (ANSWER)

While at a loud club on Las Vegas Boulevard (i.e. The Strip), your friend is sitting in a VIP area 20 yards away and looks like he may have had too much to drink since he is practically asleep. What you do not know is that he inadvertently added laced Heroin to his beverage when he thought he added a sweetener. What symptom could you notice form afar that would indicate an opioid (Heroin) overdose?

a) Slow Heart Rate
b) Pin Point Pupils
c) The Death Rattle
d) HYPOXIA

63,400 US Drug Overdose Deaths (2016)



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Holly H, et al. Drug Overdose Deaths in the United States, 1999–2016. NCHS Data Brief No. 294, December 2017.

Discussion

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