CE/CME

October 5, 2018

7:30 a.m. – 3:30 p.m.

St. Vincent's Birmingham
Bruno Conference Center- Auditorium

Live Streamed http://www.stvhscme.com/
Register at (205) 838-3225

LEARNING OBJECTIVES:

Upon completion of this activity participants should be able to:

- The main goal of this activity is to increase the number of participants who understand how to assess and treat pain as well as how to identify patients at risk for misusing and abusing opioid medications.

Faculty/Course Director/Planners: STVHS has selected all faculty participating in this activity. It is the policy of STVHS that all CME/CE planning committees, faculty, authors, editors, and staff disclose relationships with commercial interests upon nomination or invitation of participation. Disclosure documents are reviewed for potential conflicts of interest and if relevant, they are resolved prior to confirmation of participation. Only those participants who have no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this activity.

Conflict of Interest: In accordance with the ACCME Standards for Commercial Support, it is the policy of St. Vincent's Health System to ensure balance, independence, objectivity and scientific rigor in all CME/CE activities. Full disclosure of conflicts and conflict resolution will be made in writing via handout materials or syllabus.

Target Audience:

This activity is designed for the inter-disciplinary audience.

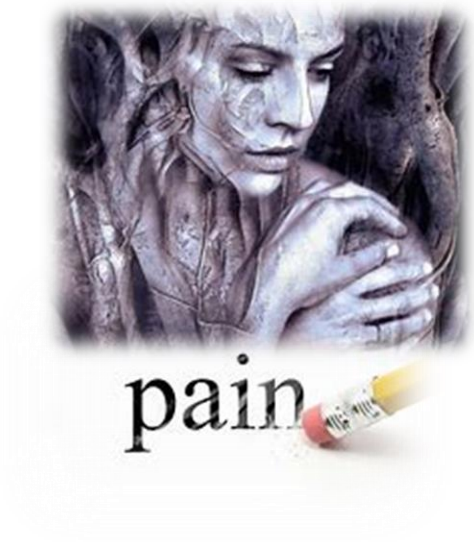
Gap in Knowledge:

*Lack of knowledge about the problem(s)
*Lack strategies to apply knowledge to practice (competence)

COMMERCIAL SUPPORT: No commercial support was received for this CME/CE activity.

Pain affects more lives than heart disease, cancer, and diabetes combined. The appropriate assessment and treatment of pain has a far-reaching impact on morbidity, mortality, quality of life, and economics – for individuals, communities, and across the healthcare systems.

The Ascension 2018 Pain Conference offers a unique forum for sharing advances and standards in pain management and treatment for colleagues in all disciplines of medicine, with exceptional content presented by leaders in pain medicine, patient safey, community health and the death and dying process.



Participants will explore various perspectives on pain, and by doing so, increase the knowledge base of practicing clinicians and will learn about evidence-based recommendations that include assessment tools. This Conference will provide opportunities to engage in discussions that stimulate critical thinking and develop new perspectives on caring for people with pain.

A renowned faculty will provide insightful assessment in addition to the didactic program; attendees will have opportunities to participate in a variety of education activities.

EVALUATION

The CE/CME Evaluation Form is included in your syllabus. Completed forms will be collected at the door at the end of this activity. We encourage you to complete the Evaluation Form in order to claim credit for attendance and to assess the degree to which the activity met its objectives. It will also guide the planning of future activities and inform decisions about improving the educational program

Gap in Knowledge:

- Lack of knowledge about the problem(s)
- Lack strategies to apply knowledge to practice (competence)

Learning Format:

Case-based, interactive live activity including assessment questions

Professional Competencies:

Patient Care

Medical Knowledge

Interpersonal & Communication Skills

TARGET AUDIENCE

This activity is designed for the interdisciplinary team and other interested health care professionals.

DISCLOSURE OF RELATIONSHIPS/CONTENT VALIDITY

It is the policy of Ascension CE Department to adhere to ACCME, ANCC and ACPE Criteria, Policies, and Standards for Commercial Support and content validation in order to ensure fair balance, independence, objectivity, and scientific rigor in all its sponsored activities. All speakers, Course Directors, Co-Course

Directors, planners, reviewers, and staff members participating in sponsored activities are expected to disclose relevant financial relationships pertaining to their contribution to the activity. Relationship information is analyzed to determine whether conflicts of interest exist. All conflicts of interest are resolved prior to participation in the planning or implementation of this activity. Presenters and authors are also expected to disclose any discussion of (1) off-label or investigational uses of FDA approved commercial products or devices or (2) products or devices not yet approved in the United States.

Ascension CE/CME activities are intended to be evidence-based and free of commercial bias. If you have any concerns, please call the Ascension CE Department at 205-838-3225 to anonymously express them.

Activity Director(s) & Independent Clinical Reviewer(s)

Shawn Morehead, M.D., David DeAtkine, Jr., M.D; Chris Moore, RN, MSN, MBA, Debbie Whisenhunt, RN, MSHA, CPHQ, Linda P. Adams, RPh, MBA; Leanne Phillips, Pharm.D, BCPS

- Have no relevant financial relationship to disclose.

Faculty, Planning Committee, Course Coordinator and CE Manager & Staff

Have no relevant financial relationship(s) to disclose

Ascension has selected all faculty appearing in this program. It is the policy of Ascension CE Department that all CE planning committees, faculty, authors, editors, and staff disclose relationships with commercial entities upon nomination or invitation of participation. Disclosure documents are reviewed for potential conflicts of interest and, if identified, they are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CE activity.

ACCREDITATION AND CREDIT DESIGNATION STATEMENTS

Credit Designation:

In support of improving patient care, Ascension/St. Vincent's Health] is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

IPCE CREDIT™

This activity was planned by and for the healthcare team, and learners will receive 7.5 IPCE credits for learning and change.

COMMERCIAL SUPPORT: No commercial support was received for this ICPE activity.

STVHS is accessible for individuals with disabilities or special needs. Participants with special needs are requested to contact the Ascension CE Department at 205-838-3225.

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INTERPROFESSIONAL CONTINUING EDUCATION

Agenda

October 5, 2018

Pain Conference 2018

7:30 a.m. Registration

8:00 a.m. – 9:00 a.m.
"Prescription Drug Misuse and Addiction – Recognizing the Signs"
Andrew Kaufman, M.D.
Professor of Anesthesiology
Director of the Comprehensive Pain Center
Rutgers, New Jersey Medical School
Auditorium

9:00 a.m. – 10:00 a.m.
"Legalized Marijuana and Opioids: Deadly Crossroads"
Andrew Kaufman, M.D.
Professor of Anesthesiology
Director of the Comprehensive Pain Center
Rutgers, New Jersey Medical School
Auditorium

10:00 a.m. – 11:00 a.m.
"Dying and Death Process & Pain Mgt."
Lyle S. Walton, M.D.
Assistant Professor of Geriatrics
Center for Palliative & Supportive Care
University of Alabama at Birmingham
Auditorium

11:00 a.m. – 12:00 p.m.
"Fentanyl Crisis – Overdose Epidemic"
Weifeng Song, M.D.
UAB
Auditorium

12:00 NOON – Lunch
Pick up in lobby of Conference Ctr.

12:00 p.m. – 12:30 p.m.
"Hospice Role in Coping with the Dying Process"
Christy Falligant, LGSW, ACHP-SW
St. Vincent's Hospice Social Worker

"Palliative Care"
Jenny Duke, RN, CHPN; Palliative Care Coordinator
Auditorium

12:30 p.m. – 1:30 p.m.
"A Review of Federal and State Responsibilities and Legal Issues Regarding the Opioid Crisis"
David Copenhaver, M.D. Director, UC Davis Cancer Pain Mgt. and Supportive Care
Assistant Professor of Anesthesiology & Pain Medicine Division, UC Davis School of Medicine
Auditorium

1:30 p.m. – 2:30 p.m.
"Chronic Pain Management & Medications"
Doris K. Cope, M.D.
Adjunct Professor of Anesthesiology
Johns Hopkins University School of Medicine
Auditorium

2:30 p.m. – 3:30 p.m.
"Interpretation of the Joint Commission Pain Guidelines for Use in Daily Practice"*Doris K. Cope, M.D.*
Adjunct Professor of Anesthesiology
Johns Hopkins University School of Medicine
Auditorium

3:30 p.m. Conclusion of Conference, Questions, & Evaluations

SPEAKER INFORMATION:

Andrew Kaufman, M.D.; Professor of Anesthesiology: Dr. Andrew Kaufman is an anesthesiologist in Newark, New Jersey and is currently the Associate Professor of Anesthesiology and Director of the Departent of Anesthesiology Comprehensivee Pain Center. He received his medical degree from University of Virginia School of Medicine and has been in practice for more than 20 years.

Lyle S. Walton, M.D.: Dr. Walton spent his formative years in Virginia and South Carolina. He received his undergraduate degree in English Literature from James Madison University and earned his medical degree from the University of South Carolina School of Medicine. Dr. Walton went on to complete Fellowships in Geriatric Medicine and Hospice and Palliative Medicine at the University of Michigan. While at the University of Michigan, he completed advanced studies in Health Management and Policy through the School of Public Health, earning an MHSA degree in August 2017. His research interests include Health and Aging Policy, Healthcare Resource Utilization and Palliative Medicine in the Post-Acute Care Setting. Dr. Walton is Board Certified in Family Medicine. He joined our clinical faculty in 2017 and currently provides inpatient consult services at UAB Hospital, UAB Highlands Hospital and the Birmingham VA Medical Center.

Weifeng Song, M.D.: Weifeng Song, MD is a practicing Anesthesiologist in Birmingham, AL. Dr. Song graduated from China Medical University in 1988 and has been in practice for 29 years. He completed a residency at Uab Hospital. He is affiliated with many hospitals including University Of Alabama Hospital. Dr. Weifeng Song also cooperates with other doctors and physicians in medical groups including University Of Alabama Health Services Foundation.

Christy Falligant, LGSW, ACHP-SW, STVHS Hospice Social Worker
Jenny Duke, RN, CHPN, Palliative Care Coordinator

David Copenhaver, M.D.: Dr David Copenhaver is a board certified anesthesiologist and pain medicine specialist and faculty in the Anesthesiology and Pain Medicine at UC Davis Health Center. Dr. Copenhaver is the director of Cancer Pain Management and Supportive Care Program in addition to the Pain Medicine Telehealth program at UC Davis.

Dr. Copenhaver has research interests in health services administration, pain medicine education, reesponsible opioid management, targeted drug delivery, and the applied use of stem cells in the setting of intervertebral disc disease. Copenhaver completed his undergraduate degrees in Neuroscience, Physiology and Behavior at UC Davis. He subsequently went on to UCLA to complete his medical school education and a master's degree in public health. Dr. Copenhaver completed his residency in Anesthesiology at Columbia Univeersity College of Physicians and Surgeons and his pain medicine fellowship at UC Davis.

Doris Cope, M.D.: Dr. Doris K. Cope, MS, MD serves as a Member of North American Medical Advisory Board at Best Doctors, Inc. Dr. Cope is double board certified in anesthesiology and pain medicine, a life member of the Academy of Anesthesiology and has been listed among the “Best Doctors in America” every year since 1998. She is one of the top pain doctors in the United States and has been featured on national television, radio and in numerous magazines and newspapers. She has written dozens of articles and abstracts on anesthesiology, chronic pain and pain medicine in top medical journals and has authored pain chapters and textbooks.

"Prescription Drug Misuse and Addiction – Recognizing the Signs"

8:00 a.m. – 9:00 a.m.

Andrew Kaufman, M.D.; Professor of Anesthesiology; Director of the Comprehensive Pain Center; Rutgers, New Jersey Medical School

- Dr. Andrew Kaufman has the following financial relationships to disclose
  Pindus Pharma

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) To understand the neuro-biology of addiction
2) To understand misuse and abuse
3) Recognition of addiction behavior
4) Review the proper screening of patients

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Prescription Drug Misuse and Addiction

Andrew G. Kaufman, M.D.
Professor of Anesthesiology
Rutgers-New Jersey Medical School

Disclaimers

Speakers Bureau

- Purdue Pharma

Consultant

- Purdue

OBJECTIVES

- To understand the neuro-biology of addiction
- To understand misuse and abuse
- Recognition of addiction behavior
- Proper Screening of patients

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ADDICTION: DEFINITION

Short Definition of Addiction:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

American Society of Addiction Medicine

ADDICTION: DEFINITION

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

American Society of Addiction Medicine

Origin of Drug Liking
Mesolimbic Reward System

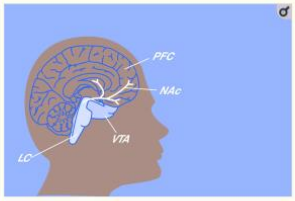
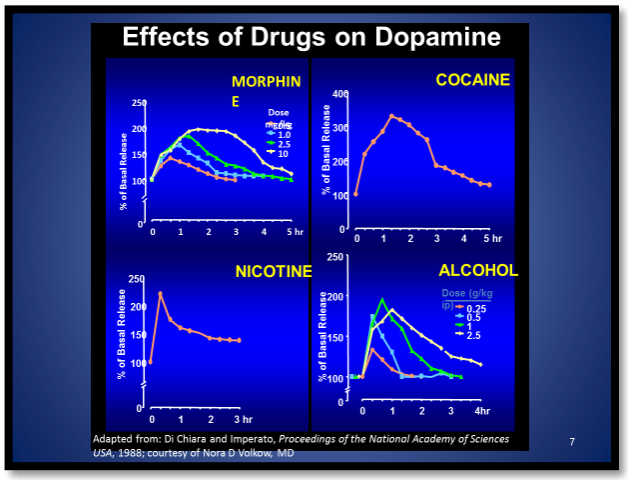
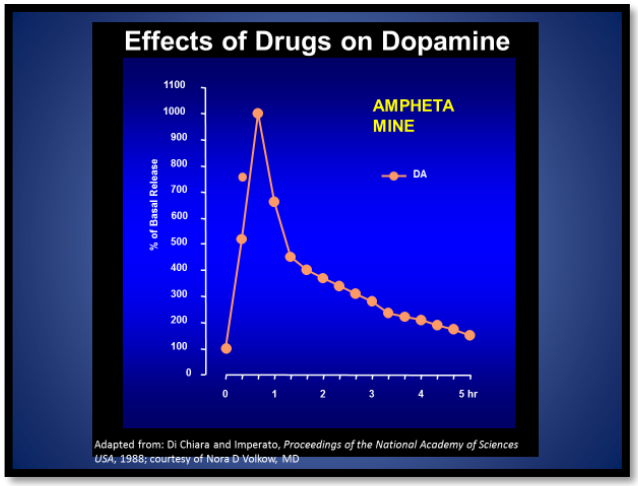


FIGURE 1
The Mesolimbic Reward System

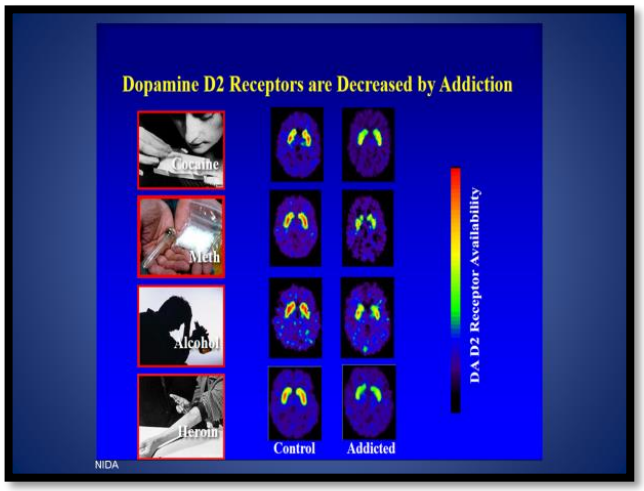
When drugs stimulate mu opioid receptors in the brain, cells in the ventral tegmental area (VTA) produce dopamine and release it into the nucleus accumbens (NAc), giving rise to feelings of pleasure. Feedback from the prefrontal cortex (PFC) to the VTA helps us overcome drives to obtain pleasure through actions that may be unsafe or unwise, but this feedback appears to be compromised in individuals who become addicted to drugs. The locus coeruleus (LC) is an area of the brain that plays an important role in drug dependence.





Origin of Drug Liking

- Particularly in the early stages of abuse, the opioid's stimulation of the brain's reward system is a primary reason that some people take drugs repeatedly. However, the compulsion to use opioids builds over time to extend beyond a simple drive for pleasure. This increased compulsion is related to tolerance and dependence.



Prevention of Withdrawal Symptoms

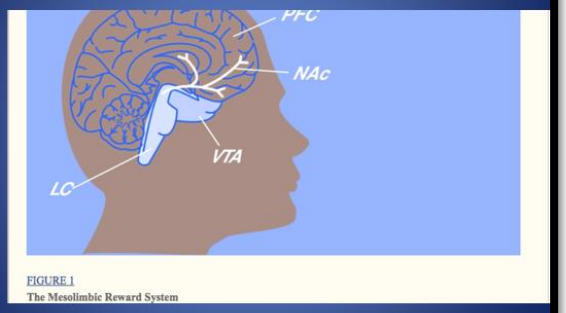


FIGURE 1
The Mesolimbic Reward System

Why do symptoms of withdrawal occur??

- Locus Cerulus
  - -provides noradrenaline (NA) to other parts of the brain, stimulates wakefulness, breathing, BP, general alertness
  - - opioids decrease release of NA
  - -with repeated exposure to opioids the LC adjust to increase levels of NA to compensate
  - -when opioids acutely withdrawn the LC is in compensation mode still so thus user feels anxiety, cramps, sweating, diarrhea
  - i.e. withdrawal symptoms

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Addiction
Multiple Models

- The cognitive deficits model proposes that PFC signaling to the mesolimbic reward system is compromised in individuals with addictive disorders, and as a result they have reduced ability to use judgment to restrain their impulses and are predisposed to compulsive drug-taking behaviors.

Addiction
Multiple Models

- The "changed set point" model of drug addiction has several variants based on the altered neurobiology of the DA neurons in the VTA and of the NA neurons of the LC during the early phases of withdrawal and abstinence. The basic idea is that drug abuse alters a biological or physiological setting or baseline.

Rates of Addiction

Vowles KE, et al. *Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis.* Pain 2015; 156(4): 565-759.

- Rates of addiction between 8% and 12%

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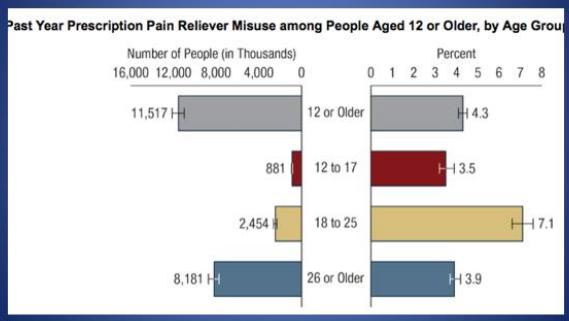
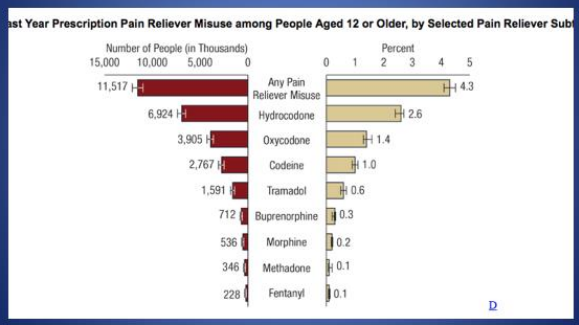
Rates of Addiction

- 2016 National Survey of Drug use and Health by SAMHSA
  (Substance Abuse and Mental Health Services Administration)

Rates of Addiction



What is the favorite to abuse?



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MISUSE

Use of a medication for non-medical use or for reasons other than prescribed.

Misuse can be willful or unintentional use of a substance in a manner not consistent with legal or medical guidelines, such as altering dosing or sharing medications, which has harmful or potentially harmful consequences.

ABUSE

- DSM IV: Misuse with consequences
- DSM-5: Combines the DSM IV categories of substance abuse and substance dependence into a single Substance use disorder, measured on a continuum from mild to severe.

ABUSE

- The use of a substance to modify or control mood or state of mind in a manner that is illegal or harmful to oneself or others.
- Potentially harmful consequences include accidents or injuries, blackouts, legal problems, and sexual behavior that increases the risk of HIV/Hepatitis

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ABUSE

Risk factors??

- Family history of EtOH/drug abuse
- Previous sexual abuse
- PTSD
- Psych history
- Socio-demographic factors
- Age less then 45

Recognizing the Problem from drugabuse.gov

Table: Recognizing Opioid Abuse and/or Addiction in Patients Taking Chronic Opioids

Components of Addiction *The 3- "C's"*	Possible expressions in patients on chronic opioids
Loss of Control	1. Reports lost/stolen medication 2. Calls for early refills 3. Seeks opioids from other sources 4. Withdrawal symptoms noted at appointments
Craving, preoccupation with use	1. Recurring requests for increases in opioids 2. Increasing pain despite lack of progression of disease 3. Dismissive of non-opioid treatments
Use despite negative Consequences	1. Over-sedation/somnolence 2. Decreases in activity, functioning and/or relationships

Adapted from:
Savage SR et al. NIDA. Addiction Science in Clinical Practice. Vol. 4, June 2008
Manchikanti L et. al. Pain Physician 2008; Opioids Special Issue I I:SI55-SI80

Recognizing the Problem Social

- Withdrawal from social and recreational activities
- Changes in behavior or mood
- Financial problems
- Making bad or reckless decisions
- Avoiding friends and family
- Missing school or work due to use
- Suspension from school or job loss due to a drug-related incident

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Recognizing the Problem Physical

Signs and symptoms of prescription drug abuse

Opioid painkillers	Sedatives and anti-anxiety medications	Stimulants
Constipation	Drowsiness	Reduced appetite
Nausea	Confusion	Agitation
Feeling high (euphoria)	Unsteady walking	High body temperature
Slowed breathing rate	Slurred speech	Insomnia
Drowsiness	Poor concentration	High blood pressure
Confusion	Dizziness	Irregular heartbeat
Poor coordination	Problems with memory	Anxiety
Increased pain with higher doses	Slowed breathing	Paranoia

I believe the patient would benefit from the use of an opioid.

what can I do to screen out potential issues??

Abuse Screening Tools

- S.O.A.P.
- O.R.T.
- D.I.R.E.

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ABUSE
Screening Tools

- S.O.A.P.P.

Screener and Opioid Assessment for Patients with Pain

Available in Several formats,
Either 4, 14 or 24 questions

SOAPP® Version 1.0

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you feel that your pain is "out of control?"	0 1 2 3 4
2. How often do you have mood swings?	0 1 2 3 4
3. How often do you do things that you later regret?	0 1 2 3 4
4. How often has your family been supportive and encouraging?	0 1 2 3 4
5. How often have others told you that you have a bad temper?	0 1 2 3 4
6. Compared with other people, how often have you been in a car accident?	0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain?	0 1 2 3 4
9. How often do you take more medication than you are supposed to?	0 1 2 3 4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4

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PainEDU

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

12. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
13. How often have you attended an AA or NA meeting?	0 1 2 3 4
14. How often have you had a problem getting along with the doctors who prescribed your medicines?	0 1 2 3 4
15. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
16. How often have you been seen by a psychiatrist or a mental health counselor?	0 1 2 3 4
17. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
18. How often have your medications been lost or stolen?	0 1 2 3 4
19. How often have others expressed concern over your use of medication?	0 1 2 3 4
20. How often have you felt a craving for medication?	0 1 2 3 4
21. How often has more than one doctor prescribed pain medication for you at the same time?	0 1 2 3 4
22. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
23. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
24. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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PainEDU

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Scoring Instructions for the SOAPP® version 1.0.

Of the 24 questions contained in the SOAPP® version 1.0, 16 have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP®, add the ratings of the following questions:

2, 7, 10, 11, 12, 13, 15, 17, 18, 19, 20, 22, 23, 24

A score of 7 or higher is considered positive.

Sum of Questions 2, 7, 10, 11, 12, 13, 15, 17, 18, 19, 20, 22, 23, and 24	SOAPP® Indication
> or = 7	+
< 7	-

ABUSE
Screening Tools

- How often do you have mood swings?
- How often do you smoke a cigarette within an hour after you wake up?
- How often have you taken medication other than the way that it was prescribed?
- How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?
- How often, in your lifetime, have you had legal problems or been arrested?

ABUSE
Screening Tools

SOAPP 24 Questions

- Passik et al – provides excellent discrimination between high risk and low risk patients
- Chou et al – high risk score correlates with an increased likelihood of drug abuse

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ABUSE
Screening Tools

- O.R.T.
  Opioid Risk Tool
- Passik et al – provides excellent discrimination between high risk and low risk patients
- Webster & Webster – exhibited a high degree of sensitivity and specificity for determining which individuals are at risk for opioid abuse

Date _____

Patient Name _____

OPIOID RISK TOOL

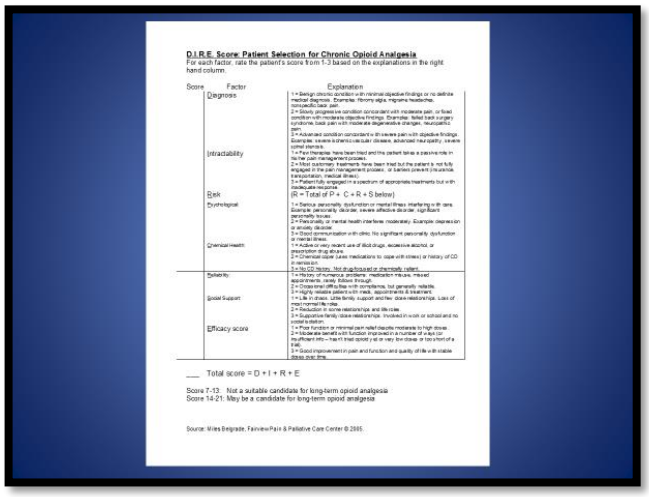
		Mark each box that applies	Item Score Female	Item Score Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	____	____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.

ABUSE
Screening Tools

- D.I.R.E.
  Diagnostic, Intractability, Risk, Efficacy
- Specifically designed for primary care use to assess candidates for long-term opioid therapy (a physician assessment tool, patients do not fill it out)
- Belgrade et al – Patient's DIRE score correlates well with patient compliance and efficacy of long term opioid therapy



D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headache, nonspecific back pain 2 = Slowly progressive condition consistent with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain 3 = Advanced condition consistent in 8h severe pain with objective findings. Examples: severe chronic cardiac disease, advanced neuropathy, severe spinal stenosis
	Intractability	1 = Pain therapies have been tried and the patient takes a passive role in pain management (pharmacotherapy) 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness) 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response
	Risk	(R = Total of P + C + R + S below)
	Psychological	1 = Serious personality dysfunction or mental illness interfering in life care. Example: personality disorder, severe affective disorder, significant psychosis 2 = Personality or mental health disorders moderately. Example: depression or anxiety disorder 3 = Good communication with clinic. No significant personality dysfunction or mental illness
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse 2 = Substance abuse (uses medications to cope with stress) or history of CD in remission 3 = No CD history. Not drug-focused or chemically reliant
	Relief to:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through 2 = Occasional difficulties with compliance, but generally reliable 3 = Highly reliable patient with meds, appointments & treatment
	Social Support	1 = Lack of family support and/or close relationships. Loss of meaningful life roles 2 = Reduction in some relationships and life roles 3 = Supportive family close relationships. Involved in work or school and no social isolation
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses 2 = Moderate benefit with function improved in a number of ways (or insufficient info – has not tried opioid yet or very low dose or too short of a trial) 3 = Good improvement in pain and function and quality of life with stable dose over time

___ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a candidate for long-term opioid analgesia

Source: Miles Belgrade, Fairview Pain & Palliative Care Center © 2005.

"Legalized Marijuana & Opioids: Deadly Crossroads"

9:00 a.m. – 10:00 a.m.

Andrew Kaufman, M.D.; Professor of Anesthesiology; Director of the Comprehensive Pain Center; Rutgers, New Jersey Medical School

- Dr. Andrew Kaufman has the following financial relationships to disclose Pindus Pharma

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) Understand the historical context of marijuana
2) Understand the evolution of marijuana laws in the U.S.
3) Interactions of opioids and marijuana

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Legalized Marijuana and Opioids: Deadly Crossroads

Andrew G. Kaufman, M.D.
Professor of Anesthesiology
Director, Division of Pain Management
Rutgers-New Jersey Medical School
Newark NJ

Speakers Bureau

- Purdue Pharma

Consultant

- Purdue Pharma

Objectives

- Understand the Historical context of Marijuana
- Understand the evolution of Marijuana laws in the U.S.
- Interactions of opioids and marijuana

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana
Historical Usage

- 2900 BC – First modern reference
  - Emperor Fu Hsi mentions it as a popular medicine due to it having yin (negative feminine)and yang (positive masculine)
- 1500 BC – Earliest written record in medicine
  - Listing in Chinese Pharmacopeia

Marijuana

- 70 AD – Roman medical text cited
  - Cannabis to treat ear ache and to suppress sexual longing
- 1850 – Cannabis added to the U.S. Pharmacopeia Standards
- 1889 – Published in *The Lancet*
  - Use in opioid withdrawal

Marijuana

THE USE OF INDIAN HEMP IN THE TREATMENT OF CHRONIC CHLORAL AND CHRONIC OPIUM POISONING.

Edward A. Birch, M.D., M.R.C.P. (HONORARY MEMBER OF THE CALCUTTA MEDICAL SOCIETY ; PHYSICIAN TO THE GENERAL HOSPITAL, CALCUTTA.)

Volume 133, Issue 3422, 30 March 1889

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana in the U.S.

- 1890s – Smoking of hashish becomes a fad in France and crosses over to the U.S.
- Only in the late 19th century did the use of Marijuana begin as a popular ingredient in many medical products sold openly in pharmacies
- 1906 – Pure Food Act requires labeling of any cannabis containing product over the counter

Marijuana in the U.S.

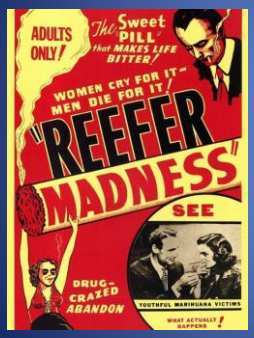
- 1900-1920
  - After the Mexican Revolution significant immigration with a culture of *recreational* usage
  - Marijuana began to be associated with Immigrants with fear/prejudice against both
  - Terrible crimes were being attributed to both Marijuana and the new Mexican population

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana in the U.S.

- 1929-1939 - The Great Depression
  - Outlawed in 24 states
  - "Research" showed Marijuana caused violent crimes and socially deviant behavior
  - Assumed to be caused by "racially inferior" or underclass communities



Marijuana in the U.S.

- 1937 Marijuana Tax Act
  - Campaign against "evil weed" act of congress
  - Statute effectively criminalized marijuana, restricting possession of the drug to individuals who paid an excise tax for certain authorized medical and industrial uses

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana in the U.S.

- NY Academy of Medicine
  The La Guardia Report 1944
  - An extensively researched report declaring that, contrary to earlier research and popular belief, use of marijuana did not induce violence, insanity or sex crimes, or lead to addiction or other drug use.

Marijuana in the U.S.

- 1972 – Shafer Commission
  - Bipartisan
  - Appointed by Nixon at direction of Congress
  - Recommended decriminalization of personal use of Marijuana

Nixon rejected the findings……..

Marijuana in the U.S.

- 1996 – Proposition 215
  - Passed in California
  - Legalized MEDICAL use of marijuana
- Currently 23 states and D.C. have legal MEDICAL use (Alabama does not)
- Alaska, California, Colorado,, Maine, Massachusetts, Nevada, Oregon, Vermont, Washington, and Washington D.C. have legalized recreational use

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INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

- Cannabinoids and Opioids both produce analgesic effects via G-protein coupled mechanism
- Activation of a G-protein decreases adenyl cyclase and decreases cAMP
- Causes inhibition of N-type Ca^{++} channels
- Stimulation of K^{+} efflux (hyperpolarizes)

Marijuana/Opioids

- Abrams, et al. *Cannabinoid-opioid interaction in chronic pain*
  Clin Pharmacol Ther 2011;90:844-51
- 21 patients with chronic pain due to arthritis, neuropathy, cancer, MS
- Patients using either Morphine ER 62mg q12 or oxycodone 53mg q12 (average doses)
- Vaporized cannabis x5 days

Marijuana/Opioids

Abrams, et al.

- Pain significantly decreased 27% (avg)
- No change in area under curve for morphine or oxycodone usage

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

Whiting PF, et al. *Cannabinoids for Medical Use: A Systemic Review and Meta-Analysis*. JAMA 2015;13(24):2456-73

- Moderate quality evidence to support use of cannabinoids for Tx of chronic pain spasticity due to MS
- Low quality evidence associated with improvement in:
  - Nausea/vomiting due to chemotx
  - weight gain in HIV pts
  - sleep disorders
  - Tourette's

Marijuana/Opioids

Degenhardt L, et al. *Experience of adjunctive cannabis use for chronic non-cancer pain: Findings from the Pain and Opioids IN Treatment (POINT) study*. Drug Alcohol Depend 2015; 147:144-50

- 1514 people in Australia who had Rx opioids for chronic non-cancer pain
- Data collected on:
  - cannabis use
  - ICD-10 cannabis use disorder (CUD)
  - cannabis use for pain

Marijuana/Opioids

- 16% use cannabis for pain
  - Tended to be Younger, and reported:
    - greater pain severity
    - greater interference from with ADL's
    - poorer coping with pain
  - Rx opioids:
    - longer, higher doses
    - more likely to be non-adherent with opioid use
- 12% fit ICD-10 for cannabis use disorder
- Almost 43% never used Marijuana to treat Pain

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

- Authors concluded that users report greater pain relief in combination with opioids than when opioids used alone.

Marijuana/Opioids

Reisfield GM, et al *The prevalence and significance of cannabis use in patients prescribed chronic opioid therapy: a review of the extant literature.* Pain Med 2009; 10(8):1434-41

- Review of literature
- Cannabis use is prevalent in patients Rx chronic opioid therapy and is associated with opioid misuse.

Marijuana/Opioids

Reisfield GM. *Medical cannabis and chronic opioid therapy.* J Pain Palliat Care Pharmacother 2010; 24(4):356-61

- Reported that a small high quality literature exists for medical cannabis for neuropathic pain
- Data from pain clinics reveals an unusually high prevalence of cannabis use in nearly all age groups and an associated use of cannabis and opioids and other substance misuse

ASCENSION

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INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

Reisfield

He Concluded

- In patients who use cannabis and are prescribed opioids, heightened vigilance for opioid and other substance related problems is warranted

Marijuana/Opioids

- Reisfield

  He Concluded
- It is appropriate to refrain from Rx opioids to individuals using medical cannabis if there is reasonable suspicion that the combination will pose a risk to patient or others

Marijuana/Opioids

Reisfield

He Concluded

- Concomitant use of cannabis and opioids is an absolute contraindication to operation of a motor vehicle

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

Perron BE, et al. *Use of prescription pain medications among medical cannabis patients.* J Stud on Alcohol Drugs 2015; 76(3):406-13

- Study looked at medical cannabis users who use or do not use Prescription Pain Medicine (PPM)
- N=273 patients
- PPM users tended to be older, reported higher levels of pain, lower functioning

Marijuana/Opioids

Perron, et al.

- PPM users and non-users did not exhibit any difference in either lifetime or past 3 month of other drugs, (cocaine, sedatives, street opioids or amphetamines)
- PPM users rated efficacy of cannabis higher than PPM for pain management

Marijuana/Opioids

Perron, et al.

He Concluded

- that use of PPM among medical cannabis users was not identified as a correlate for more serious forms of alcohol and other drug involvement.

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

- M. Olsen, M. Wall et al
  Cannabis Use and Risk of Prescription Opioid Disorder in the United States, American of Psychiatry, Sept. 2017

Author concluded that cannabis use appears to *Increase* rather then *Decrease* the risk of developing non medical prescription opioid use and opioid use disorder

Marijuana/Opioids

Bachhuber, et al. *Medical Cannabis Laws and Opioid Analgesic Overdose: Mortality in the United States, 1999-2010.* JAMA Intern Med 2014; 174(10): 1668-73

- Looked at Medical cannabis laws and opioid analgesic mortality 1999-2010
  - 1999 – 4,100 opioid induced deaths
  - 2010 – 16,235 opioid induced deaths

Marijuana/Opioids

Bachhuber, et al.

- On average, the 13 states that allowed medical marijuana had a 34.8% lower annual opioid overdose mortality rate after the laws were enacted than states without the laws.
- The relationship between lower opioid overdose deaths and medical marijuana laws strengthened over time:
  - 20% lower at year one
  - 33.7% lower after 5 yrs

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

Powell D, et al. Working paper,, National Bureau of Economic Research #21345 issued 7/15

- Found that states permitting medical marijuana dispensaries experience a relative decrease in both opioid addictions and opioid overdose deaths compared to states that do not

Marijuana/Opioids

Hefner K, et al. *Concomitant cannabis abuse/dependence in patients treated with opioids for non-cancer pain.* Am J Addict 2015; 24(6): 538-45

- Concomitant Cannabis abuse/dependence in pts treated with Opioids for non- cancer pain
- Looked at Cannabis use disorder (CUD) in a national sample of VA patients
- N= 1,316,464

Marijuana/Opioids

Hefner K, et al.

- Demonstrated that greater number of prescription opioid fills were associated with greater likelihood of CUD
- Increasing legalization of cannabis is likely to further increase use and abuse of cannabis in patients prescribed opioids

ASCENSION

JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

Bradford AC, Bradford WD
Medical Marijuana Laws Reduce Prescription Medication Use in Medicare Part D.
Health Affairs 2016 July 1;35(7):1230-6

- Used data on all prescriptions filled by Medicare Part D enrollees from 2010-2013

Marijuana/Opioids

Bradford & Bradford

- Found that the use of Rx drugs for which marijuana could serve as a clinical alternative fell significantly once a medical marijuana law was implemented

Marijuana/Opioids

Bradford & Bradford

- Overall reductions in spending were estimated to be 165.2 million per year in 2013.

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JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

Marijuana/Opioids

JAMA Intern Med. 2018 May 1;178(5):673-679. doi: 10.1001/jamainternmed.2018.1007.

Association of Medical and Adult-Use Marijuana Laws With Opioid Prescribing for Medicaid Enrollees.

Wen H[1], Hockenberry JM[2,3].

Author information

Abstract

IMPORTANCE: Overprescribing of opioids is considered a major driving force behind the opioid epidemic in the United States. Marijuana is one of the potential nonopioid alternatives that can relieve pain at a relatively lower risk of addiction and virtually no risk of overdose. Marijuana liberalization, including medical and adult-use marijuana laws, has made marijuana available to more Americans.

OBJECTIVE: To examine the association of state implementation of medical and adult-use marijuana laws with opioid prescribing rates and spending among Medicaid enrollees.

DESIGN, SETTING, AND PARTICIPANTS: This cross-sectional study used a quasi-experimental difference-in-differences design comparing opioid prescribing trends between states that started to implement medical and adult-use marijuana laws between 2011 and 2016 and the remaining states. This population-based study across the United States included all Medicaid fee-for-service and managed care enrollees, a high-risk population for chronic pain, opioid use disorder, and opioid overdose.

EXPOSURES: State implementation of medical and adult-use marijuana laws from 2011 to 2016.

MAIN OUTCOMES AND MEASURES: Opioid prescribing rate, measured as the number of opioid prescriptions covered by Medicaid on a quarterly, per-1000-Medicaid-enrollee basis.

RESULTS: State implementation of medical marijuana laws was associated with a 5.88% lower rate of opioid prescribing (95% CI, -11.55% to approximately -0.21%). Moreover, the implementation of adult-use marijuana laws, which all occurred in states with existing medical marijuana laws, was associated with a 6.38% lower rate of opioid prescribing (95% CI, -12.20% to approximately -0.56%).

CONCLUSIONS AND RELEVANCE: The potential of marijuana liberalization to reduce the use and consequences of prescription opioids among Medicaid enrollees deserves consideration during the policy discussions about marijuana reform and the opioid epidemic.

Marijuana/Opioids

- M. Olsen, M. Wall et al
  Cannabis Use and Risk of Prescription Opioid Disorder in the United States, American of Psychiatry, Sept. 2017

Author concluded that cannabis use appears to *Increase* rather then *Decrease* the risk of developing non medical prescription opioid use and opioid use disorder

Marijuana/Opioids

So what do I do??????

- Marijuana still ILLEGAL in NJ and Alabama
- NJ currently has medical marijuana approved usage:
  - Amyotrophic lateral sclerosis
  - Multiple sclerosis
  - Terminal cancer
  - Muscular dystrophy
  - Inflammatory bowel disease, including Crohn's disease
  - Terminal illness, if the physician has determined a prognosis of less than 12 months of life

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Marijuana/Opioids

- If all conventional therapy fails then these conditions are also approved:
  - Seizure disorder, including epilepsy
  - Intractable skeletal muscular spasticity
  - Glaucoma

  and just recently PTSD

Marijuana/Opioids

NOT IN A PROGRAM
- Positive test for Marijuana, speak to patient
- I tell them choose: Rx or Marijuana

IN A PROGRAM
- I do not accept them as new patients
- Existing patients: if they want to enroll I will begin to wean them down

RUTGERS
New Jersey Medical School

"Dying and Death Process & Pain Management"

10:00 a.m. – 11:00 a.m.

Lyle S. Walton, M.D.; Assistant Professor of Geriatrics; Center for Palliative & Supportive Care; University of Alabama at Birmingham

- Dr. Lyle S. Walton no financial relationships to disclose

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) Discuss the current status of end-of-life care in the United States
2) Defferentiate between palliative care and hospice care
3) Understand how to approach pain management during the active dying process
4) Explain the principles and ethical challenges of end-of-life care and hospice
5) Analyze various religious views of death and dying

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DYING AND DEATH PROCESS & PAIN MANAGEMENT

LYLE WALTON MD, MHSA

2018 PAIN CONFERENCE
ST. VINCENT HEALTH SYSTEM

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WE WILL ALL FACE DEATH SOMEDAY

- 15% die suddenly
- 85% die of prolonged illness
- “Terminal phase” or “Active dying phase” often has predictable features/course
- Understanding active dying is important
  - Important life event
  - Managing it well is important for patients, families, and healthcare workers

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INTERPROFESSIONAL CONTINUING EDUCATION

LEARNING OBJECTIVES

- Death
  - Discuss a patient-centered, quality-driven approach to death in medical practice
- Dying Process
  - Recognize and understand the dying process
  - Know how to care for patient's and families at end of life
- Pain Management at the End of Life
  - Be familiar with pain management issues and general pharmacologic approaches to pain management

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LEARNING OBJECTIVES

- Death
  - Discuss the approach to death in medical practice
- Dying Process
  - Recognize and understand the dying process
  - Know how to care for patient's and families at end of life
- Pain Management

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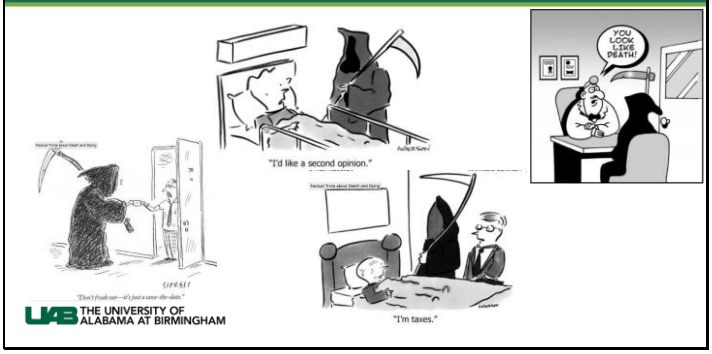
DEATH



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INTERPROFESSIONAL CONTINUING EDUCATION

CICELY

"Total pain" or "total suffering"

- Physical
- Psychological
- Social
- Spiritual

ST. CHRISTOPHER'S HOSPICE
SYNDENHAM (LONDON), UK

Dame Cicely Saunders

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THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE

The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians' failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.

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Cassell, E. NEJM *1982;306:639-45.*

"All illness…has…two dimensions: a physical deficit and a spiritual violation. And when there is no cure, the one thing we can offer is to really understand the story that is playing out, to aid and abet its satisfactory conclusion."

Verghese, A. The Physician as Storyteller, *Ann. Int. Med.* 2001; 135 (11): 1012-1017

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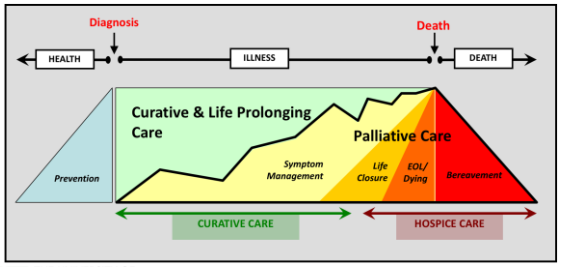
PALLIATIVE CARE IN THE CONTINUUM



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LEARNING OBJECTIVES

- Death
  - Discuss the approach to death in medical practice
- Dying Process
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- Pain Management

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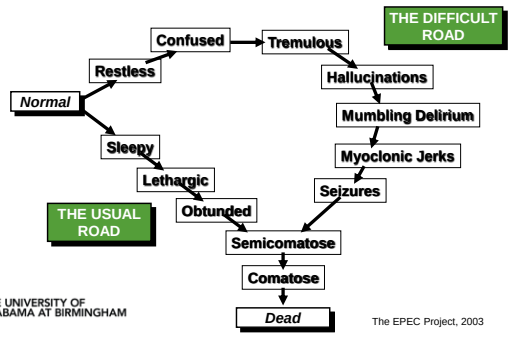
THE ROAD TO THE END



The EPEC Project, 2003

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INTERPROFESSIONAL CONTINUING EDUCATION

PHYSIOLOGIC CHANGES OF DYING

- **"Active Dying"** – a transition in the physical and cognitive status of a terminally ill patient which indicates probable survival measured in hours to days
- For cancer patients (and other advanced illnesses less consistently) usually reflected in a prior progressive decline in functional status
- Frequently goes unrecognized by healthcare providers who have not been trained to recognize the signs

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TIME COURSE OF ACTIVE DYING

- Once active dying begins, the time course is variable
  - Range: 24 hours to 10-14 days
- It is challenging to accurately predict the time course once dying begins
- "Lingering" can be distressing to families and care providers

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PHYSIOLOGIC CHANGES OF DYING

- Increasing weakness, fatigue
- Decreasing appetite and fluid intake
- Decreasing perfusion/circulation
- Neurologic dysfunction
- Pain
- Loss of ability to close eyes

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PHYSIOLOGIC CHANGES OF DYING

EARLY STAGE:

- Functional status declines: bed-bound and dependent for all activities of daily living (toileting, transfers, feeding, dressing, and bathing)
- Decreased desire for food or fluids; decreased urine output
- Increased sleep and/or a shift in sleep-wake cycle (altered circadian rhythm)
- Increased difficulty swallowing oral medications

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Weissman, D. Fast Fact and Concept #003

PHYSIOLOGIC CHANGES OF DYING

MIDDLE STAGE:

- Increased difficulty clearing oropharyngeal secretions, leading to noisy upper airway sounds (**"Death Rattle"**)
- Vivid dreams and "hallucinations" (often encounters with deceased relatives termed **"Near Death Awareness (NDA)")**
- In severe cachexia, may be unable to keep eyes closed during sleep because of loss of retro-orbital fat pad
- Further decline in mental status **("Terminal Delirium")**
  - May be more aware than appears: avoid referring to apparently comatose patients in the third person when in their presence

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Weissman, D. Fast Fact and Concept #003

PHYSIOLOGIC CHANGES OF DYING

LATE STAGE:

- Fecal and/or urinary incontinence
- Fever due to silent aspiration
- Changing respiratory pattern: fast, slow, periods of apnea or Cheyne-Stokes respiration
- Peripheral mottling and cooling of extremities (analogous to acrocyanosis in neonates)
- Coma

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SIGNS OF ACTIVE DYING (100 CANCER PATIENTS)

Signs	Mean (Median) time to death in hours
"Death rattle"	57 (23)
Respiration w/ mandibular movement	7.6 (2.5)
Cyanosis of extremities	5.1 (1.0)
Lack of radial pulse	2.6 (1.0)

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Morita et al, American Journal of Hospice and Palliative Care, 1998

LEARNING OBJECTIVES

- Death
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- Dying Process
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- Pain Management

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GENERAL CARE MEASURES

- Control the Environment
  - Quiet with minimal stimulation
  - Protect patient/family privacy – help them to have autonomy over space
  - Keep patient/climate comfortable with blankets, fans or etc. as needed
- Communicate Effectively with Patients
  - Be explicit: Don't be afraid to say "dying"
  - Prognosticate (with permission from the patient):
    - "hours to days, days to weeks, weeks to months, months to years"
  - "I wish" statements can be helpful when discussing things that are no longer possible

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JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

GENERAL CARE MEASURES

- Patient Care Basics
  - Oral care q 2 hrs to keep mouth clean, moist
    - Use swabs, ice chips, mouth moisturizer
  - Eye care: Artificial tears, Lacrilube
  - Review and simplify medications/routes of admin → anticipate needs
    - Consider adding or increasing opioid for dyspnea (occurs 75% at end of life)
    - Treat/anticipate anxiety and delirium
    - Add prn medications for respiratory secretions
- Education
  - Frequently update patient/family on care plan and hear their concerns

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COMMON FAMILY CONCERNS AT THE END OF LIFE

- Have we made the right decisions?
- Is he or she suffering?
- Can he or she hear me? What should I be saying?
- How will I know when death is close?
- What happens after the death? (not just a theological question)
- ***Regularly clarify and discuss the goals and plan of care with family.***
- ***Education, education, education.***

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FAMILY SUPPORT

- Active dying phase often as difficult for families as it is for patients
- Coach
  - Explain changes as they occur so family can adjust
  - Encourage nurturing of the patient
    - mouth swabs, ice chips, lip care, eye care
    - loss of senses: hearing, touch lost last
- Reframe
  - "He's starving to death" becomes "Fortunately, he's no longer feeling hungry or thirsty. "

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JOINT ACCREDITATION
INTERPROFESSIONAL CONTINUING EDUCATION

FAMILY SUPPORT

- Family members are grieving their own losses
  - Provide opportunities for them to nurture the patient and say goodbyes . . . Facilitate closure
- Give family permission to take a break from the vigil
- When death arrives, encourage family to take time, not rush to arrangements

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LEARNING OBJECTIVES

- Death
  - Discuss the approach to death in medical practice
- Dying Process
  - Recognize and understand the dying process
  - Know how to care for patient's and families at the end of life
- Pain Management

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MANAGING COMMON SYMPTOMS AT THE END OF LIFE

- Most common symptoms and signs in last week of life:
  - **pain**
  - respiratory changes with or without dyspnea
  - noisy breathing
  - fever
  - cognitive changes
- Dyspnea, **pain**, and agitated delirium are particularly distressing to patients/families and require urgent attention

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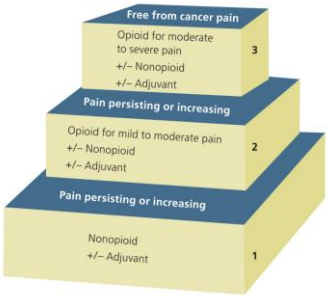
WHO "PAIN RELIEF" LADDER



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COMMON OPIOID ANALGESICS

MEDICATION	OME (mg)	ROUTE	NOTES
Tramadol	100	PO	• Good if elderly & don't want opioids
Tapentadol	75	PO	• $$$, diabetic neuropathy
Codeine	60	PO	• Cough suppression, not often used for pain
Hydrocodone	10	PO	• Usually with APAP
Morphine	10 (3:1, PO:IV)	PO,IV,IM,SQ,IT, topical	• Gold std, $ • Renal elimination • Histamine release → pruritus/dysphoria
Oxycodone	6.67	PO	• Less histamine release • ? Better for dyspnea up to 10mg
Oxymorphone	3.33	PO	• $$$, rarely used
Hydromorphone	2.5	PO,IV,IM,SQ	• Option in renal failure
Buprenorphine*	0.13	PO,IV	• $$$ • Mixed (bup + naloxone)
Fentanyl (TD/IV)*	~0.1	PO,IV,SQ,TD,buccal, intranasal	• ~18h to therapy effect • Metab in vessels (good for hepatic/renal failure)
Methadone*	1:4 (30-90 OME) 1:8 (90-300 OME) 1:12 (>300 OME)	PO,IV,SL	• Beware QTc prolong • Many DDI • Good in renal failure

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PAIN MANAGEMENT

- Opioids used to control pain before the phase of imminent death should be continued, even as patients gradually lose consciousness.
- Do not stop opioids abruptly, even if the patient becomes nonresponsive; sudden withdrawal can cause opioid withdrawal and severe distress.
- It may be appropriate to cautiously reduce the dose or frequency of dosing though.

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PAIN MANAGEMENT

- Lower renal clearance of opioids may result in greater potency or toxicity, especially myoclonus, which is an indication for dose reduction or rotation to a more appropriate analgesic
- Adequate dosing of opioid analgesics may require alternative route(s) of administration
- Severe pain crisis in the last days of life are rare, but when inadequately addressed, may cause great and lasting distress (complicated grief) for loved ones.

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PAIN MANAGEMENT

- A pain crisis requires frequent physician assessment and input for optimal management. When a parenteral opioid infusion is needed, use the SC route for patients who have no IV access.
- For severe pain that is difficult to manage at home, consider transferring the patient to an inpatient setting.
- Always, think of *Total Pain* – ask yourself "could this be psychological, social, or spiritual distress masquerading as a physical pain crisis?"

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SEDATION AT THE END OF LIFE

- Midazolam is the most popular agent internationally. Mean daily doses ranging from 21 to 61 mg/day used respectively in Israeli versus Spanish hospices. Clearly, goal of heavy sedation.
- Reasons for sedation: **Intractable pain**, nausea/vomiting, dyspnea, delirium, and existential distress.
- Alternatives:
  - Lorazepam + Antipsychotic
  - Barbituates (phenobarbital)

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Fainsinger, RL., et al. A multicentre international study of sedation for uncontrolled symptoms in terminally ill patients. *Palliat. Med.* 2000; 14: 257-265

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CONCLUSION

- Death is a part of life and will come to us all
  - Relief of suffering MUST NOT be neglected in the process of managing and treating disease
  - Strive to understand our patients and help them get as close to the outcome that they desire
- There are recognizable physiologic changes that occur with dying
- We have much to offer to dying patients and their families
- Dying people have many distressing symptoms, in particular pain, that require optimal management

"…engender hope by being present, giving information, and demonstrating caring" (Tulsky, 2002)

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THANK YOU

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"Fentanyl Crisis: Overdose Epidemic"

11:00 a.m. – 12:00 noon

Weifeng Song, M.D.

- Dr. Weifeng Song has no financial relationships to disclose

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) What are the current drug trends and what is causing the rise in opioid abuse
2) Understanding what are opioids, commonly abused drugs, and the difference between prescription and street drugs
3) Define Fentanyl and how it poses the greatest threat to opioid users
4) Recognize the importance of evidence-based protocols for potential misuse, abuse and diversion

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Fentanyl Crisis: Overdose Epidemic

Weifeng Song, MD PhD FCCM

Assistant Professor
Department of Anesthesiology and Perioperative Medicine
University of Alabama at Birmingham

Outline

- Presentation 40-45 min
- General Discussion 10-15 min

- No conflicts of interest

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Drug Overdoses in U.S.

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Let's First Talk about an OR Case

- A 36 yo WF without significant PMH underwent Lap Cholecystectomy with GETA. Procedure was ~ 110 mins long and uneventful. By the end of surgery she was not waking up or breathing spontaneously despite of a TOF=4 and a MAC monitor showed 0.0
- She received 3 mg Midazolam, 50 mcg Fentanyl and 120 mg Propofol for induction then another 200 mcg of Fentanyl by the resident during the case
- Your differentiations and treatment?

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Adverse Effects of Opioids

- Itching, nausea and vomiting
- Miotic pupils and dry mouth
- Constipation and decreased bowel sounds
- Bradycardia and hypotension
- Altered mental status: ranging from mild euphoria or lethargy to coma
- Hypoventilation to respiratory failure

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Uptodate: Diagnostic Evaluation of Opioid Overdoses

Diagnostic evaluation
Obtain rapid bedside serum glucose concentration, to exclude hypoglycemia as cause of coma.
Obtain creatine kinase (if history indicates prolonged immobilization).
Obtain chest radiograph (if physical examination suggests acute lung injury or aspiration).
Obtain serum acetaminophen concentration (if opioid was taken with intent of self-harm or in opioid/acetaminophen combination product).
Obtain electrocardiogram (if methadone or loperamide toxicity is suspected).

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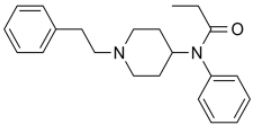
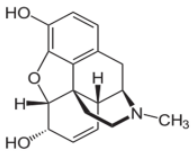
Fentanyl: A Potent Opioid

Fentanyl



Morphine



- Binding μ, κ, σ opioid receptors in the CNS
- Lipophilic vs Hydrophilic
- Protein binding: 80-85% vs 30-40%
- 50-100 x potent, lethal dose 2 mg vs 120 mg
- Fully synthetic vs natural opiates

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Surge of Fentanyl Overdose Deaths

Signs of Use
- Drowsiness or nodding
- Constricted or pinpoint pupils
- Agitation
- Depressed respiration
- Confusion
- Euphoria

Signs of Overdose
- Severe drowsiness and inability to be awaken
- Slow heartbeat
- Seizures
- Respiratory reduction
- Low blood pressure

Slang terms and texting phrases to be aware of
- Fading (slang for the high)
- Fet and Fetty
- Ice cream
- Chinese food
- White 80's
- Phantom 100
- A-215's

ILLICIT FENTANYL

Surge in Fentanyl Overdose Deaths - axialHealthcare

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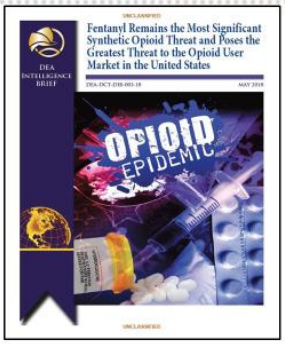
DEA Alerts The Danger of Fentanyl



Recreational use of illicitly obtained Fentanyl and other new psychoactive substances (NPS) has spread across the United States, with the DEA issuing nationwide health and public safety alerts in March 2015 and June 2016 about the dangers of Fentanyl

DEA Warning to Police and Public: Fentanyl Exposure Kills, June 10, 2016
DEA Issues Nationwide Alert on Fentanyl as Threat to Health and Public Safety, March 18, 2015

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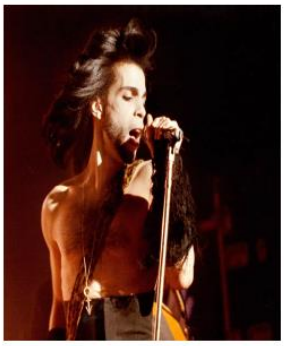
Death from Fentanyl Overdose



The New York Times

Prince, an Artist Who Defied Genre, Is Dead at 57

April 21, 2016

StarTribune

Prince died from accidental overdose of fentanyl

June 3, 2016

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Crisis from Fentanyl Overdose

CDC chief says fentanyl almost killed his son

At a conference in New Orleans (in July 12, 2018), Centers for Disease Control and Prevention Director Robert R. Redfield opened up about his family's experience with opioids, saying that one of his adult children nearly died of an overdose of cocaine mixed with fentanyl, a potent synthetic opioid that is 30 to 50 times stronger than heroin, according to the Associated Press.

Dr. Robert Redfield Jr. told the annual conference that the opioid epidemic will be his top priority after almost losing one of his children to it. (AP)

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Death from Fentanyl Overdose

'I was robbed of my daughter': SD news anchor reports on her own daughter's overdose death to raise awareness about opioid crisis

Angela Kennecke, an anchor at KELO-TV in Sioux Falls, lost her daughter Emily to a fentanyl overdose on May 16.

Angela Kennecke
@AngelaKennecke
I'm issuing a personal plea to end the stigma surrounding addiction and a call for action regarding the opioid crisis!
4:19 PM - 5 Sep 2018

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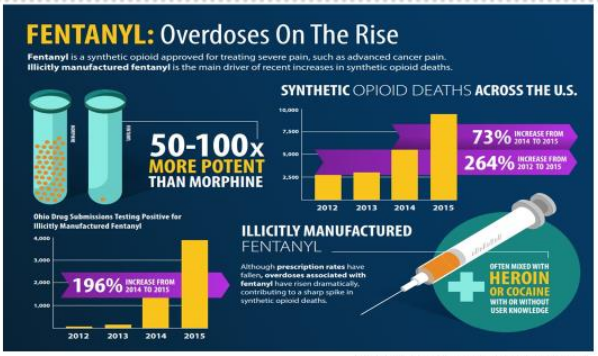
Fentanyl Overdoses On The Rise



CDC NPIPC and PBSS Issue Brief | July 2017

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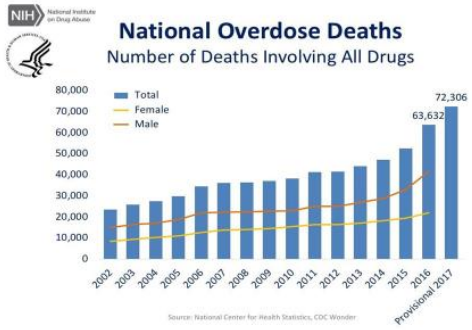
National Overdose Deaths



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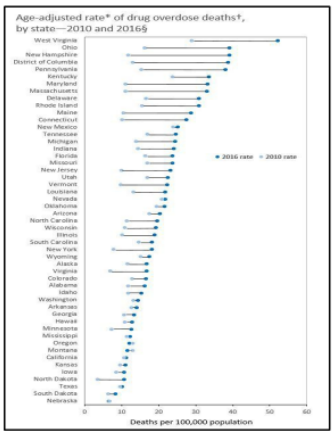

- In 2016, 63,632 drug overdose deaths occurred in the United States
- The age-adjusted rate of overdose deaths increased significantly by 21.5% from 2015 (16.3 (per 100,000) to 2016 (19.8 per 100,000)
- Opioids-prescription and illicit-are currently the main driver of drug overdose deaths
- Opioids were involved in 42,249 overdose deaths in 2016 (66.4% of all drug overdose deaths)

https://www.cdc.gov/drugoverdose/data/statedeaths.html

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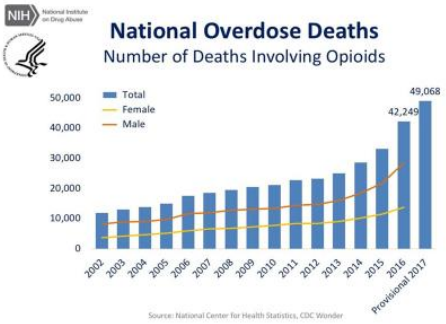
National Opioids Overdoses Deaths



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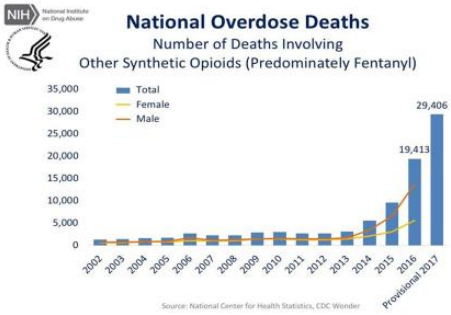
National Overdoses Deaths: Synthetic Opioids



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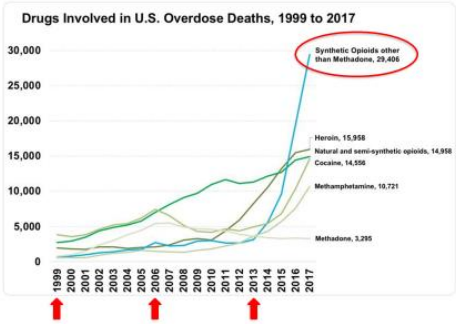
National Overdoses Deaths: Synthetic Opioids



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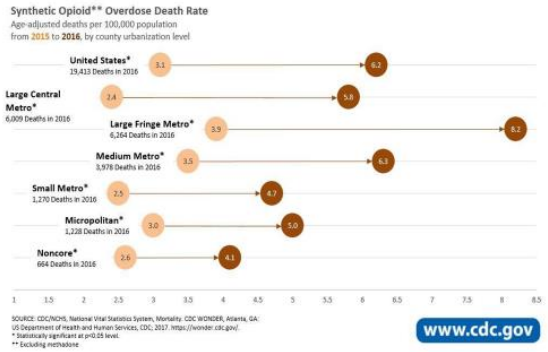
National Overdoses Deaths: Synthetic Opioids by Urbanization



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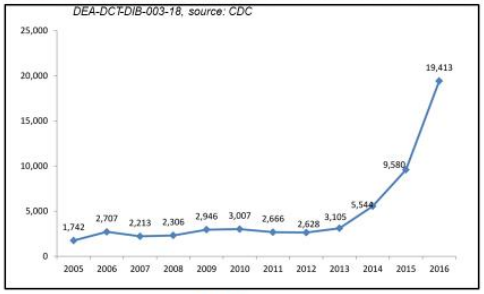
Synthetic Opioids Deaths 2005-2016



In 2016, there were over 14,000 overdose deaths involving natural and semi-synthetic opioids compared to the over 19,000 overdose deaths involving synthetic opioids

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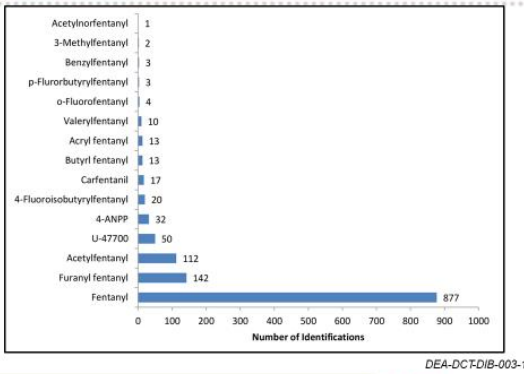
Synthetic Opioids Seized and Identified in 2016



DEA-DCT-DIB-003-18

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Synthetic Opioids Overdose Crisis

Based on 2015-2016 data from 31 states and Washington, D.C., CDC's analysis confirms that recent increases in drug overdose deaths are driven by continued sharp increases in deaths involving synthetic opioids other than methadone

- **Overall drug overdose death rates increased by 21.5%**
- **Across demographic categories, the largest increase in opioid overdose death rates was in males between the ages of 25-44**
- **The overdose death rate from synthetic opioids (other than methadone) more than doubled, likely driven by illicitly manufactured fentanyl (IMF), while the prescription opioid-related overdose death rate increased by 10.6%**
- **IMF is mixed into counterfeit opioid and benzodiazepine pills, heroin, and cocaine, likely contributing to increases in overdoses involving these other substances**

https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html

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The Sources of IMF

- The current Fentanyl crisis is multi-faceted and involves a global supply of Fentanyl and related materials
- Counterfeit pills containing Fentanyl are smuggled into the United States from Mexico and Canada
- Clandestine pill press operations also occur in the United States
- Traffickers usually purchase powdered Fentanyl and pill presses from China to create counterfeit pills to supply illicit U.S. drug markets

DEA-DCT-DIB-021-16

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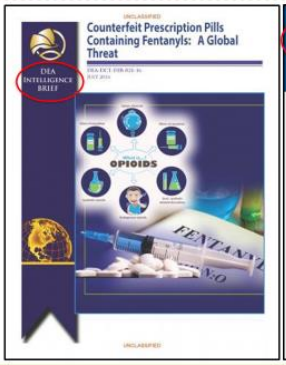
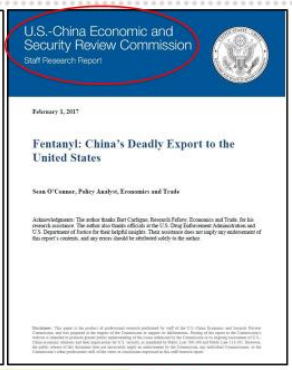
Fentanyl Crisis: A Global Threat





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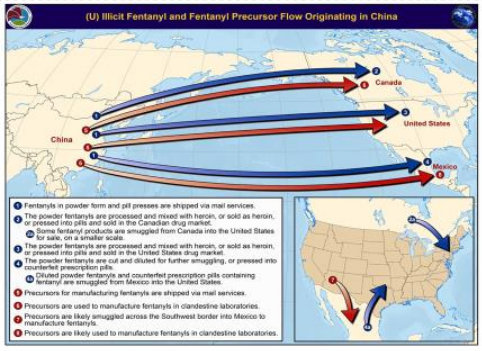
Fentanyl: Flows from China?



DEA-DCT-DIB-021-16

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Inefficient Regulations of Fentanyl Production and Export in China

- Various fentanyl products exported from China to the US
  - Raw fentanyl, fentanyl precursors, fentanyl analogues, fentanyl-laced counterfeit prescription drugs like oxycodone, pill presses and other machinery necessary for fentanyl production
- China's pharmaceutical market is the second largest in the world by revenue
- Chinese law enforcement and drug investigators are unable to effectively regulate the high volume of drugs and chemicals the country produces
- China's regulatory shortcomings are exacerbated by the fragmented and disorganized administrative system

https://www.uscc.gov/Research/fentanyl-china's-deadly-export-united-states

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Inefficient Chemicals Control in U.S.

- Chinese exporters circumvent U.S. chemical regulations
  - Online marketplace, mail forward chain, mislabeled shipment
- Manufacturers modify the chemicals to create new, unregulated substances
- The process for scheduling new chemicals remains time intensive, requiring coordination among several government entities and further adjustments
- Drugs trafficked into the United States from Mexico present an additional avenue to evade U.S. regulations

https://www.uscc.gov/Research/fentanyl-china's-deadly-export-united-states

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Tackling The Fentanyl Crisis: International Collaboration

- Long and close collaborations between DEA and NCB (Narcotics Control Bureau) of China
- Scheduling controls of 175 NPS (New Psychoactive Substances) in China since 2015
- Installation of 13,000 security check machines at shipping companies in China
- Tracking down importers of nuclear magnetic resonance (NMR) spectrometers used by underground drug laboratories in China

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Tackling The Fentanyl Crisis: Domestic Actions

- President Trump declared the opioid crisis in America a 'public health emergency.' - Oct 26, 2017
- Attorney General Sessions announces Opioid Fraud and Abuse Detection Unit - Aug 2, 2017
- Enforcement actions from The DEA Special Operations Division's (SOD)'s Heroin/Fentanyl Task Force (HFTF)
- Scheduling control by administrative rulemaking: temporarily Schedule I control on all 'fentanyl related substances' - Feb, 6 2018
- Creation of Heroin-Fentanyl Enforcement Teams and Fentanyl Signature Profiling Program (FSPP)

https://www.justice.gov/opa/pr/attorney-general-sessions-announces-opioid-fraud-and-abuse-detection-unit
https://www.justice.gov/sites/default/files/testimonies/witnesses/attachments/2018/09/11/09-06-2018_tackling_the_fentanyl_crisis_working_with_china.pdf

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Tackling The Fentanyl Crisis: Local Efforts

Alabama House approves fentanyl bill - Mar 23, 2018

"The bill makes distribution possession of one half to one gram of fentanyl a Class B felony, punishable by up to 20 years in prison. The bill also provides punishments ranging from three years to life in prison for selling or transporting a gram to eight grams of fentanyl."

https://www.wvtm13.com/article/alabama-house-approves-stiffer-penalties-for-fentanyl-trafficking-based-on-weight/19568187

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Tackling The Fentanyl Crisis: Improving Detection of Outbreaks

Public Health Departments
- Explore methods for more rapidly detecting drug overdose outbreaks,
- In critical areas, consider asking emergency departments to report fatal and nonfatal opioid overdose cases within 48 hours
- Identify and track decedent demographics and risk factors, along with geographic concentrations of cases

Medical Examiners/Coroners
- Screen specimens from fatal drug overdose deaths using an ELISA test with the capacity to detect fentanyl
- Implement standardized mechanisms for determining cause of death and methods of reporting to ensure death reports are complete and accurate

Law Enforcement
- Test drug samples seized or collected by law enforcement or found at the scene of death to detect fentanyl or fentanyl analogs
- Prioritize and expedite testing of drug samples taken from drug overdose scenes
- Share data on fentanyl and acetyl-fentanyl drug seizures with local health departments, coroners, and medical examiners

https://www.cdc.gov/drugoverdose/pdf/pbss/PBSS-Report-072017.pdf

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Tackling The Fentanyl Crisis: The Demand Side

- The more than 2 million Americans with opioid-use or heroin-use disorders (OUD) need help to quit
- People with OUD should have every opportunity to be brought into treatment
- OUD treatment should include opioid-based medications (Methadone, Buprenorphine and Suboxone etc.), along with behavior therapy
- Congress is considering bills to expand Medicaid and Medicare fund of medication-assisted therapy

https://www.bloomberg.com/view/articles/2018-09-10/fentanyl-america-s-opioid-epidemic-takes-a-darker-turn

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Tackling The Fentanyl Crisis: Preventing Overdoses with Naloxone

Health Care Providers
- Increase the amount of naloxone on hand for first responders such as law enforcement and EMS personnel
- Recognize and treat opioid overdose patients, with particular focus on how to respond to fentanyl and acetyl fentanyl overdose
- Understand that multiple doses of naloxone may need to be administered per fentanyl overdose event because of the drug's increased potency relative to other opioids

Harm Reduction Organizations
- Expand naloxone access to persons at risk for opioid-related overdose and their family members and train persons using drugs how to effectively administer naloxone
- Provide take-home naloxone kits and encourage people who use heroin and/or misuse opioid analgesics-or know people that do-to carry them

https://www.cdc.gov/drugoverdose/pdf/pbss/PBSS-Report-072017.pdf

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Uptodate: Opioid Overdose Treatment

Treatment
Ensure adequate ventilation. If respiratory rate is ≥12 breaths/minute and O2 saturation >90 percent on room air, observe the patient in a monitored setting and reassess frequently. **End-tidal CO2 monitoring** using capnography is an excellent means to monitor ventilation.
If the O2 saturation is <90 percent on room air but the patient is breathing spontaneously, administer supplemental oxygen followed by **intravenous naloxone, 0.05 mg**. In absence of IV access, naloxone can be given intramuscularly. Repeat until ventilation is adequate. The goal of treatment is adequate ventilation, **NOT** normal mental status. If the response is inadequate after 5 to 10 mg, reconsider the diagnosis.
If the patient is apneic, ventilate using a bag-valve mask attached to supplemental oxygen and administer naloxone in doses of **0.2 to 1 mg IV or IM**. If no response occurs after a total of 5 to 10 mg of naloxone, reconsider the diagnosis and perform tracheal intubation.
If hypoventilation recurs following the initial naloxone bolus, give **additional bolus doses** to restore adequate ventilation. When ventilation is adequate, a **naloxone infusion** can be instituted in lieu of frequent rebolusing. Begin the infusion rate at 2/3 of the total dose of naloxone needed to restore breathing, delivered every hour.
If the patient develops respiratory depression despite a naloxone infusion, administer a naloxone bolus (using half the original bolus dose) and repeat if necessary until adequate ventilation returns, then increase the infusion rate.
If the patient develops signs of opioid withdrawal, **stop the infusion**. If respiratory depression returns, start the infusion at half the original rate.
The patient is medically stable for transfer or discharge when their mental status and ventilation remain normal for **more than one hour after cessation of naloxone**.
Psychiatry consultation may be required to assess suicidality.

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Tackling The Fentanyl Crisis: Future Steps

Table. Research Plan for the NIH HEAL Initiative

Opportunities	Components
Improving Treatments for Opioid Misuse and Addiction	
New treatments for addiction	Identify new targets, develop new medications/immunotherapies; reformulate existing medicines
	Improve overdose reversal medicines
	Develop new therapies for opioid-induced respiratory depression
Optimization of effective treatments for addiction	Enhance NIDA Clinical Trials Network for opioid research
	Establish Justice Community Opioid Intervention Network
	Initiate HEALing Communities Study
NOWS	Expand ACT NOW pilot study; use results to conduct clinical trials to determine best practices for clinical care of NOWS
Enhancing Pain Management	
Better understanding of chronic pain	Establish Acute to Chronic Pain Signatures program
New nonaddictive pain treatments	Identify new targets for pain treatment
	Engineer preclinical testing platforms to profile potential nonaddictive treatments
Public-private HEAL Partnership to speed movement of nonaddictive treatments through clinical pipeline	Enhance data and asset sharing
	Validate biomarkers to inform neurotherapeutic and pain clinical research
	Establish clinical trials network to support and accelerate trials of nonaddictive pain therapies

Abbreviations: HEAL, Helping to End Addiction Long-term; NIDA, National Institute on Drug Abuse; NIH, National Institutes of Health; NOWS, neonatal opioid withdrawal syndrome.

JAMA. 2018;320(2):129-130. doi:10.1001/jama.2018.8826

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Conclusion

- Drug overdoses killed 63,632 Americans in 2016. Nearly two-thirds of these deaths (66%) involved a prescription or illicit opioid
- Overdose deaths increased in all categories of drugs examined for men and women, people ages 15 and older, all races and ethnicities, and across all levels of urbanization
- CDC's new analysis confirms that recent increases in drug overdose deaths are driven by continued sharp increases in deaths involving synthetic opioids other than methadone, such as illicitly manufactured fentanyl (IMF)
- All branches of the federal government are working together to reduce the availability of illicit drugs, prevent deaths from overdoses, treat people with substance-use disorders, and prevent people from starting using drugs in the first place

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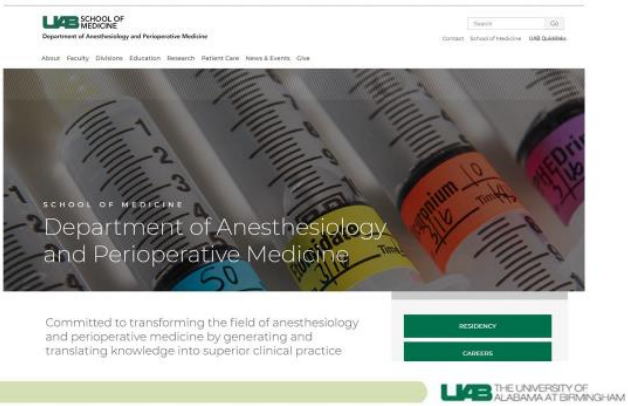
Questions and Discussion



"Breaking Bad News"

12:00 noon – 12:20 p.m.

Christy Falligant, LGSAW, ACHP-SW

- Christy Falligant has no financial relationships to disclose

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) What are the current drug trends and what is causing the rise in opioid abuse
2) Understanding what are opioids, commonly abused drugs, and the difference between prescription and street drugs
3) Define Fentanyl and how it poses the greatest threat to opioid users
4) Recognize the importance of evidence-based protocols for potential misuse, abuse and diversion

"Palliative Care"

12:20 noon – 12:30 p.m.

Jenny Duke, RN, CHPN, Palliative Care Coordinator

- Jenny Duke has no financial relationships to disclose

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Breaking Bad News

St.Vincent's HOME HEALTH & HOSPICE

Objectives:

At the conclusion of the program the participant will be able to:

- State the meaning of "bad news".
- Discuss why breaking "bad news" is so difficult.
- Demonstrate how "bad news" should be delivered.
- Recognize that Hospice does not mean giving up hope.

Bad News Defined

- Threat to person's mental or physical wellbeing
- Risk of upsetting an established lifestyle
- Limiting an individual's choices in his or her life

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Breaking Bad News Sucks

- Feeling responsible for patients' misfortune
- Perceptions of personal failure
- Unresolved personal feelings about death and dying
- Concern over patients' response to the news

Training in Breaking Bad News

- Formal training in breaking bad news is rare.
- Clinicians may think that clinical experience, ability to be sympathetic or empathic may give sufficient skill.

SPIKES Protocol for Breaking Bad News

- Setting
- Perception
- Invitation
- Knowledge
- Empathize
- Summary and strategy

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Setting

- Setting to establish patient rapport
- Privacy
- Patient or family comfort
- Uninterrupted time
- Sitting at eye level
- Inviting desired significant others
- Understand the family dynamics

Perception

- Elicit the patient (or family member's) perception of the problem

Invitation

- Obtain the patient (or family member's) invitation to disclose the details of the medical condition

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Knowledge

- Provide knowledge and information to patient or family member
- Small chunks
- Check for understanding frequently
- Avoid medical jargon

Empathize

- Empathize and explore emotions expressed by patient or family member
- Avoid closed-ended responses
- Avoid "I understand"
- Instead, "I appreciate how you are upset about this, what is most upsetting to you?"
- Or, "Tell me what you are feeling"

Summary and Strategy

- Provide a summary of what you said
- Negotiate a strategy for treatment or follow-up

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Counseling on Palliative Treatment Options

- Determine the patient's goals of care
- Often overlooked in traditional medicine
- SUPPORT study documented substantial deficiencies
- 47% of physicians were unaware of patients desire for no CPR

Goals of Care

- What is important to you at this point?
  - Relief of pain?
  - Cure or prolonged life?
  - Connection with family members?
- In what setting do you want to be treated?
  - Hospital
  - Home
  - Nursing home
  - Palliative inpatient unit

Goals of Care

- How much treatment burden are you willing to accept?
  - Surgery
  - Intensive care unit with monitors, ventilators
  - Dialysis
  - Sedation or other side effects of efforts

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Range of Decisions

- Not just about DNAR
- Artificial nutrition and hydration, ventilators, dialysis, sufficient analgesia to treat pain, palliative sedation…

Pitfalls

How do you proceed in patients with questionable decision-making capabilities?

Important Terms

Competency

- Reflects an individual's ability to understand the nature and consequences of decisions.
- A legal term, determined by a judge.
- A patient may be incompetent to make financial or business decisions, but still retain decision-making capacity in health care.
- Relatively permanent.

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Important Terms

Capacity

- Reflects a person's ability to understand relevant information and implications of various treatment choices
- Reflect on information in context of personal values and draw conclusions
- Make and communicate a choice to healthcare professionals

Determining Capacity

- Assess patient's mental status
- Consider conditions that can compromise capacity:
  - Delirium
  - Dementia
  - Metabolic imbalances
  - Severe pain
  - Life-threatening infections

Capacity May Fluctuate

- High doses of drugs to control symptoms
- Changes in level of consciousness due to advancing disease
- Psychological factors such as patient's denial of serious illness

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Assessing Decision Making Capacity

- As you understand it, what is your medical condition?
- How serious is your illness?
- What will happen if you do not seek aggressive treatment?

Substituted Judgment

Assuming lack of capacity, then…

- Families need to understand concept of substituted judgment
- Consider patient's values and wishes
- This helps to reduce guilt

Thoughts on Surrogates

- Surrogates often avoid using substituted judgment
- Instead they apply their own values and goals of care
- Force substituted judgment
- "Did she ever talk about her wishes"?
- "Fantasy time-travel" concept

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DNR should be DNAR or AND

- DNR implies one is avoiding a typically successful intervention.
- Do Not *Attempt* Resuscitation is a more accurate term.
- The chance of successful CPR in a terminally ill patient is virtually zero.
- Also consider "Allow Natural Death" -- AND

Discussing AND

- Inform patients and family members of the statistics surrounding and nature of CPR
- Teach them about the conditions for which CPR works
- Inform them that DNR ≠ Do Not Treat
- Reassure them of your commitment to care
- Never say "Nothing more can be done."

Hospice Doesn't Mean Giving Up Hope

- We often worry that choosing hospice means giving up hope.
- As health care professionals, our task is to show dignity and reverence to patients to support hope as *they* define it.
- The aim of the hospice discussion is to define the patient's goals and needs for care and present hospice as a way to meet those hopes and goals.

Be kind, for everyone you meet is involved in a great battle.

-Plato

"A Review of Federal and State Responsbilities & Legal Issues Regarding the Opioid Crisis"

12:30 p.m. – 1:30 p.m.

David Copenhaver, M.D.
Director, UC Davis Cancer Pain Mgt. and Supportive Care
Assistant Professor of Anesthesiology & Pain Medicine Division
UC Davis School of Medicine

- Dr. David Copenhaver has no financial relationships to disclose

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) Identify and improve documentation regaurding pain management and regulatory requirements
2) Specific knowledge regarding interpertutation of guidelines and understanding the current legal frame work and regulation

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THE LEGAL LANDSCAPE AND THE OPIOID CRISIS

DAVID COPENHAVER MD MPH
UC DAVIS

DISCLOSURE

- No disclosures
- I am not an attorney and opinions reflected must not be construed as legal advice. Such advice should be sought out by legal counsel.

OBJECTIVES

- In brief, describe the historical context of the opioid crisis.
  - Describe the current landscape: Where are we now ?
- Federal opioid regulatory efforts.
- State controlled substance regulations.
- The FDA and the Risk Evaluation and Mitigation Strategies (REMS) program.
- The CDC Guidelines.
- The Federation of State Medical Boards.
- What regulators expect in terms of assessment.
  - Case presentation

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HISTORICAL CONTEXT

- 1986 the WHO analgesic ladder for cancer pain (prior to the opioid crisis thereby not allowing for safety or surveillance). The lack of appropriate cancer pain care is seen as a global concern.
- 1995 Oxycontin approved by the FDA
- 1996 revision to the WHO ladder (prior to the opioid crisis thereby not allowing for for safety or surveillance).
- 1996 American Pain Society declares pain the fifth vital sign.
- 1998 Bergman versus Chin - landmark case for the "under treatment of pain" litigated under the elder abuse statute.
- 1998 Veterans Affairs starts comprehensive pain evaluation.
- 1998 Joint Commission declares pain the fifth vital sign.
- 2000 JCAHO pain initiative.

Doctor found reckless for not relieving pain / $1.5 million jury verdict for family of cancer patient who went home to Hayward to die

Matthew Yi, Chronicle Staff Writer Published 4:00 am PDT, Thursday, June 14, 2001

HISTORICAL CONTEXT

2007 Center for Disease Control begins to highlight opioid related deaths with substantial data.

2009 US consumes 99% of the worlds hydrocodone and 81% of the world's oxycodone.

2011 Institute of Medicine Report - Relieving Pain in America

2012 Physician in Los Angeles charged 30 years to life for opioid related deaths.

2016 CDC guidelines (exclude cancer pain patients from the discussion)

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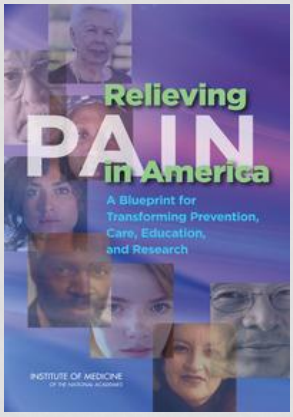

June of 2011

Doctor convicted of murder for patients' drug overdoses gets 30 years to life in prison

By MARISA GERBER FEB 05, 2016 | 5:30 PM

WHY DO WE USE SO MUCH OPIOID ?

- Extrapolation from the cancer pain experience.
- Over interpretation of weak data.
- Time
  - Much faster to give a prescription.
- Patient satisfaction
- Lack of education
- Pharmaceutical industry influence
- Some prescribers are unscrupulous
- Limited resources
  - Few available effective treatments
  - Poor reimbursement for non-medical procedure treatment
  - Covered benefit versus other helpful non covered therapies

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Forbes

315,976 views | Jan 2, 2013, 09:06am

Why Rating Your Doctor Is Bad For Your Health

Kai Falkenberg Contributor
Wall Street
I write about law and media.

WHY DO WE USE SO MUCH OPIOID ?

"I think doctors were trained – that pain is the fifth vital sign, so there was more liberal prescribing of these medications." Gottlieb said. "We now recognize that wasn't appropriate, so I think there needs to be some efforts to try and re-educate a generation of physicians."

Scott Gottleb MD FDA Commissioner
April 5th 2018

FDA

The NEW ENGLAND JOURNAL *of* MEDICINE

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies

Nora D. Volkow, M.D., and A. Thomas McLellan, Ph.D.

NIH
National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

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OPIOID ABUSE IN CHRONIC PAIN

- Although published estimates of iatrogenic addiction vary substantially from less than 1% to more than 26% of cases -
- Part of this variability is due to confusion in definition
- Rates of carefully diagnosed addiction have averaged less than 8% in published studies.
- Rates of misuse, abuse, and addiction related aberrant behaviors have ranged from 15-26%.
- A small (estimated at 4%) but growing percentage of persons who are addicted to prescription opioids transition to heroin.
  - Mainly because heroin is typically cheaper and in some instances easier to obtain than prescription opioids.

THE LATEST TRENDS IN UNDERSTANDING THE OPIOID EPIDEMIC.

Despite growing awareness of excessive opioid prescribing, unintended overdose deaths have continued to increase.

In 2015 opioid medications were involved in 12,700 deaths reflecting a 2.6% increase from the previous year.

Opioid prescriptions have decreased from 2012 to 2016 by approximately 12-18%.

Sadly, this has not translated to a reduction in deaths. The increased mortality is driven by prescription medications, synthetic fentanyl and illicit drugs.

FEDERAL OPIOID REGULATIONS

- Controlled Substances Act of 1970
- Methadone & Buprenorphine prescribing
- DATA 2000 amendment
- The “three day” rule.
- 2007 and REMS program
- Refills and sequential prescriptions of schedule II substances.

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STATE CONTROLLED SUBSTANCE REGULATIONS

- We will assess the state medical board opinion when describing the FSMB model policy.
- A brief mention of the - Supremacy Clause of Constitutional
  - marijuana

ALABAMA STATE MEDICAL BOARD

"PHYSICIANS SHOULD NOT FEAR DISCIPLINARY ACTION FROM THE BOARD OR OTHER STATE REGULATORY OR ENFORCEMENT AGENCY FOR PRESCRIBING, DISPENSING OR ADMINISTERING CONTROLLED SUBSTANCES, INCLUDING OPIOID ANALGESICS, FOR A LEGITIMATE MEDICAL PURPOSE AND IN THE USUAL COURSE OF PROFESSIONAL PRACTICE. THE BOARD WILL CONSIDER PRESCRIBING, ORDERING, ADMINISTERING OR DISPENSING CONTROLLED SUBSTANCES FOR PAIN TO BE FOR A LEGITIMATE MEDICAL PURPOSE IF BASED ON ACCEPTED MEDICAL KNOWLEDGE OF THE TREATMENT OF PAIN . ALL SUCH PRESCRIBING MUST BE BASED ON CLEAR DOCUMENTATION AND IN COMPLIANCE WITH APPLICABLE STATE OR FEDERAL LAW."

FDA (REMS)

- Risk Evaluation Mitigation Strategies
- Long Acting Opioid Therapy
- CME for responsible opioid prescribing mandated by the federal government to opioid manufacturers.

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2016 CDC GUIDELINES

- The CDC guidelines attempt to address:
  - Effectiveness of long term opioid therapy
  - Risks of opioids including misuse, addiction and overdose
  - Effectiveness of opioid dosing strategies
  - Accuracy of risk prediction and effectiveness of risk mitigation strategies.
  - Effects of long-term opioid use due to prescribing opioids for acute pain.
  - ***A discussion regarding risks associated with opioids and specifically dose.***

2016 CDC GUIDELINES

2013 FSMB

Federation of STATE MEDICAL BOARDS

- Understanding pain
- Patient evaluation and risk stratification
- Development of a treatment plan and goals
- Informed consent and treatment agreement
- Initiating an opioid trial
- Ongoing monitoring and adapting the treatment plan
- Periodic drug testing
- Consultation and referral
- Discontinuing opioid therapy
- Medical records
- Compliance with controlled substances laws and regulations

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2013 FSMB

Federation of STATE MEDICAL BOARDS

- The revised model policy makes it clear that the state medical board will consider inappropriate management of pain, particularly chronic pain, to be a departure from accepted best clinical practice, including, but not limited to the following:
- Inadequate attention to initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual in pain.
- Inadequate monitoring during the use of potentially abusable medications.
- Inadequate attention to patient education and informed consent.

2013 FSMB

Federation of STATE MEDICAL BOARDS

- Unjustified dose escalation without adequate attention to risks or alternative treatments.
- Excessive reliance on opioids, particularly high dose opioids for chronic pain management.
- Not making use of available tools for risk mitigation.

POLITICO

MAGAZINE THE AGENDA PRO

dancer
Support palliative care legislation (S.693).
LEARN MORE

HEALTH CARE

Tough reelection? Sponsor an opioid bill

Most of the bills sponsored by vulnerable lawmakers are not controversial, in part because they don't designate new spending.

By BRIANNA EHLEY and JENNIFER HABERKORN | 06/16/2018 06:37 AM EDT

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Some Congressional Republicans See Re-election Path in Opioid Bills

House Republicans delivered remarks after the passage of the Comprehensive Addiction and Recovery Act on Friday in Washington. Some party lawmaker are placing part of their re-election strategies in sponsoring and passing bills to help drug addicts.
Chip Somodevilla/Getty Images

NIDA

NIH National Institute on Drug Abuse

- "We must recognize that opioid analgesics, even at high doses and for long-term treatment, may be the appropriate strategy to mitigate chronic pain in some patients."

CASE

38 year old mother of two presents with chronic abdominal pain. The patient has a history of ulcerative colitis status post colectomy over 10 years ago. Further she is medicated with 100mcg fentanyl patch x 4 thus 400mcg of fentanyl patch. Additionally she is medicated with 4mg po q4 hours prn pain hydromorphone. Next the patient was also medicated with 10mg valium po q4. Patient arrives with her mother and two children (running about the exam room) all the while the patient was asleep.

What is the first step ?

What is the second move ?

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CONCLUSION

- Explained and reviewed the federal relationship to the CSA and the state regulations.
- Explained and reviewed the relationship between the state medical board, DEA and FDA.
- Explained the relationship between various stake holders in the circle of care most likely allowed for the CDC report of 2007 – elucidating many alarming concerns with opioids in America.
- The federation of state medical boards – what do regulators expect going forward.

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"Chronic Pain Management & Medications"

1:30 p.m. – 2:30 p.m.

"Medical-Legal Requirements for Federal, State (Alabama) and JCAHO"

2:30 p.m. – 3:30 p.m.

Doris K. Cope, M.D.
Adjunct Professor of Anesthesiology
Johns Hopkins University School of Medicine

- Dr. Doris Cope has no financial relationships to disclose

OBJECTIVES/DESIRED OUTCOMES

It is intended that this CME/CE activity will lead to improved patient care, including improvements in knowledge, competence, or performance. At the conclusion of this activity, participants should be able to:

1) Failure to treat pain as a serious health issue
2) Summarize how pain relievers are drugs of choice for abusers
3) Review tools and support for primary care physicians
4) Review new guidelines for prescribers

ASCENSION

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INTERPROFESSIONAL CONTINUING EDUCATION

Evaluating and Treating chronic and acute pain and regulatory issues in prescribing opioids

Doris K Cope MD
Medical Advisory Board, Best Doctors, Inc

St. Vincent's Health East
Birmingham Al

October 5, 2018

Part I

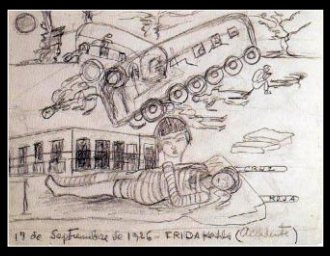
Evaluation and treatment of pain

Part II

Medical-legal requirements for
Federal, state (Alabama) and Jcaho

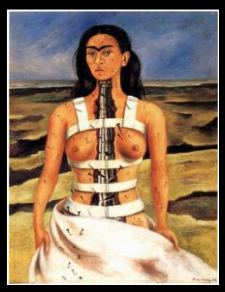
Today's Talk

- Failure to treat pain serious health issue
- Prescription pain relievers are drugs of choice for abusers
- Primary care physicians need tools and support
- New guidelines for prescribers

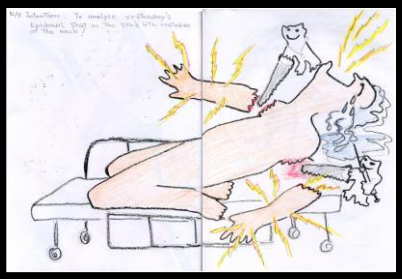


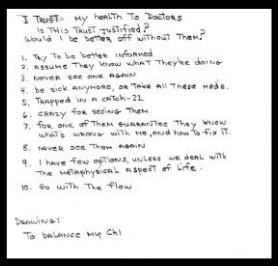
The Accident, 17 September 1926, by Frida Kahlo

Henry Ford Hospital, 1932, by Frida Kahlo



Self-Portrait, 1941, by Frida Kahlo

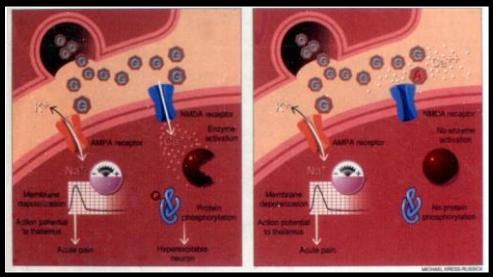


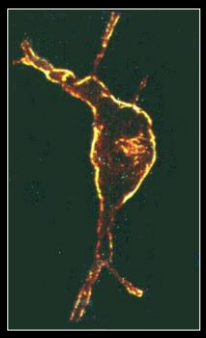


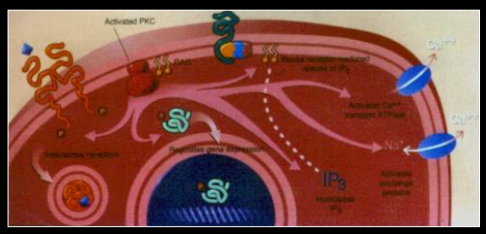
I Trust: My health To Doctors
Is This Trust justified?
Would I be better off without Them?

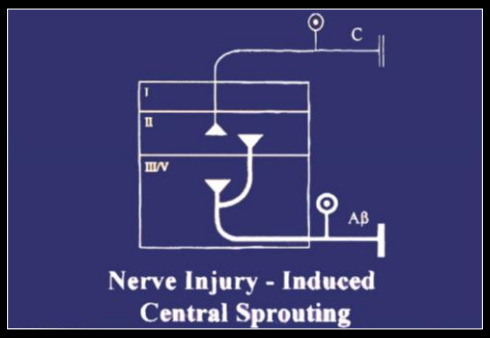
1. Try To be better informed
2. Assume They know what They're doing
3. never see one again
4. be sick anywhere, or Take all These meds.
5. Trapped in a catch-22.
6. crazy for seeing Them
7. For one of Them guarantee They know what's wrong with me, and how to fix it.
8. never see Them again
9. I have few options, unless we deal with The metaphysical aspect of Life.
10. Go with The flow

Drawing:
To balance my Chi


NMDA receptor
Enzyme activation
AMPA receptor
Protein phosphorylation
Acute pain
Hypersensitable neuron
NMDA receptor
No enzyme activation
AMPA receptor
No protein phosphorylation
Acute pain




Activated PKC
IP3



Hints for Prescribing Opioids

Acute vs. Chronic pain

Acute Pain

Goal:
Control pain as quickly as possible while healing occurs

- Limit number of days
- Physical dependence can begin at 2 weeks
- Discuss expected duration of therapy
- Encourage PRN use
- Short acting faster, easier to titrate

Case Study:
36 year old male undergoing
minor outpatient knee surgery

Chronic Non-Malignant Pain

Goal:
Control pain while restoring
physical or psychosocial function

ASCENSION

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Criteria for Opioids Use for Non-Cancer (Benign) Pain

1. Efficacy
2. Toxicity
3. Function
4. Drug-seeking behavior

Chronic Pain Syndromes

- Arthritis
- Migraine Headache
- Chronic Low Back Pain
- Myofascial Pain
- Neuropathic Pain
- Neck Pain
- Pelvic Pain
- Psychogenic Pain

What do you do with breakthrough pain or pain flares?

Definition:
A temporary exacerbation of pain that occurs on top of otherwise controlled chronic pain.

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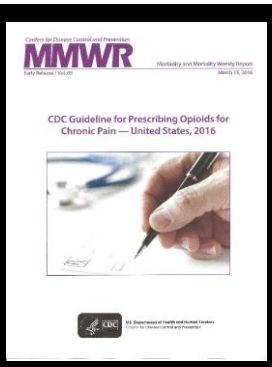
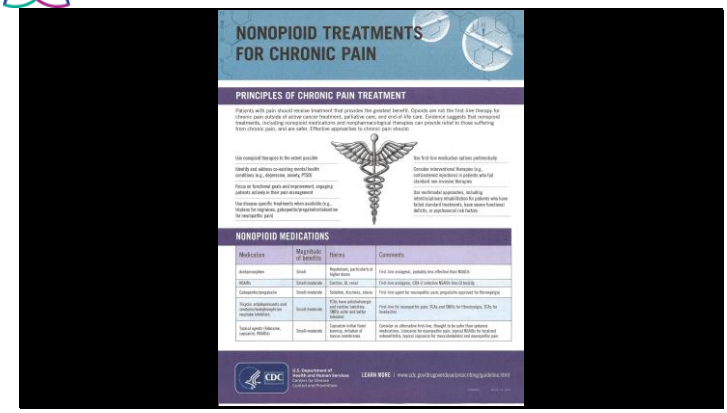
What Can We Do When Pain Control Is Inadequate?

- Titrate
- Adjuvants
- Alternative formulations

Discontinuing Opioid Therapy

- When
- How





NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

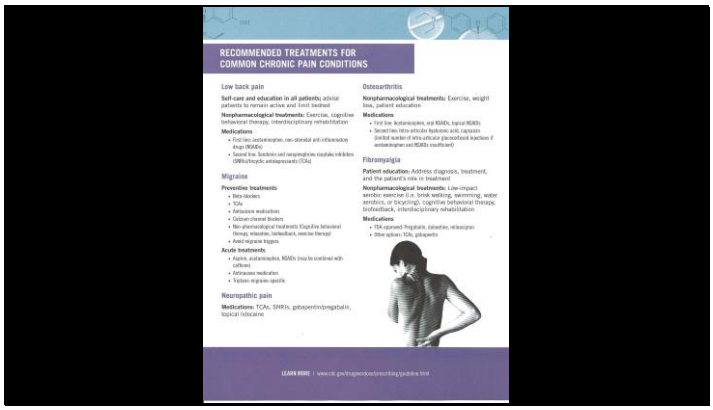
- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraine, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

Medication	Magnitude of benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First line agent for neuropathic pain, pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin-norepinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac side effects; SNRIs cause sexual dysfunction	First line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial burn/sting; irritation of lidocaine membranes	Consider as alternative first-line, thought to be safer than systemic medications; Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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

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



RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients: advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First line: acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs)
- Second line: Sumitrans and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Anticonvulsant medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First line: Acetaminophen, oral NSAIDs, topical NSAIDs
- Second line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

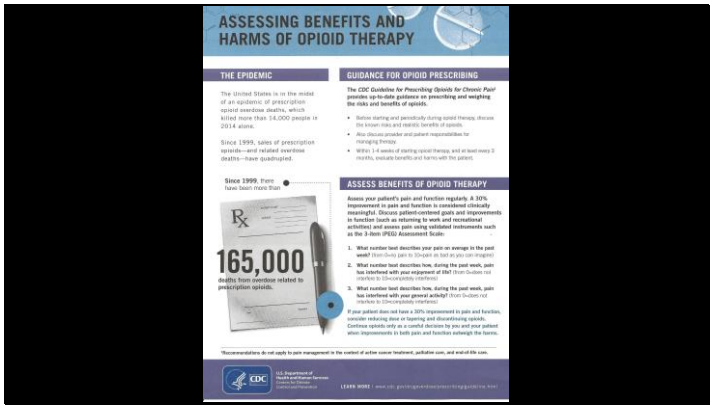
Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (i.e. brisk walking, swimming), water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin



ASSESSING BENEFITS AND HARMS OF OPIOID THERAPY

THE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdose deaths, which killed more than 14,000 people in 2014 alone.

Since 1999, sales of prescription opioids—and related overdose deaths—have quadrupled.

Since 1999, there have been more than

165,000

deaths from overdose related to prescription opioids.

GUIDANCE FOR OPIOID PRESCRIBING

The *CDC Guideline for Prescribing Opioids for Chronic Pain* provides up-to-date guidance on prescribing and weighing the risks and benefits of opioids.

- Before starting and periodically during opioid therapy, discuss the known risks and realistic benefits of opioids.
- Also discuss provider and patient responsibilities for managing therapy.
- Within 1-4 weeks of starting opioid therapy, and at least every 3 months, evaluate benefits and harms with the patient.

ASSESS BENEFITS OF OPIOID THERAPY

Assess your patient's pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and assess pain using validated instruments such as the 3-item (PEG) Assessment Scale:

1. **What number best describes your pain on average in the past week?** (from 0=no pain to 10=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?** (from 0=does not interfere to 10=completely interferes)
3. **What number best describes how, during the past week, pain has interfered with your general activity?** (from 0=does not interfere to 10=completely interferes)

If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids. Continue opioids only as a careful decision by you and your patient when improvements in both pain and function outweigh the harms.

*Recommendations do not apply to pain management in the context of active cancer treatment, palliative care, and end-of-life care.

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

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

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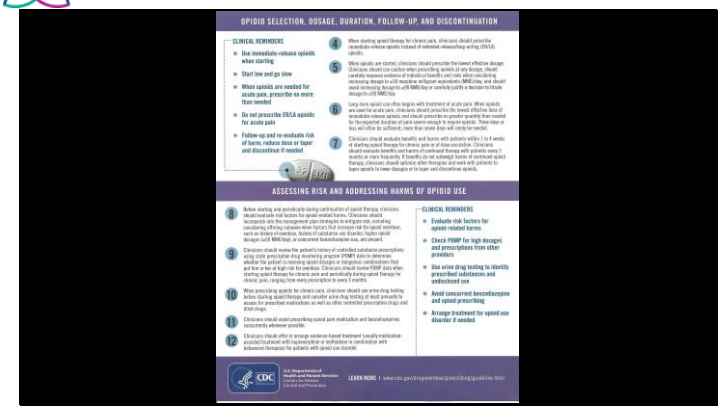


OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

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 assess evidence of individual benefit 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.

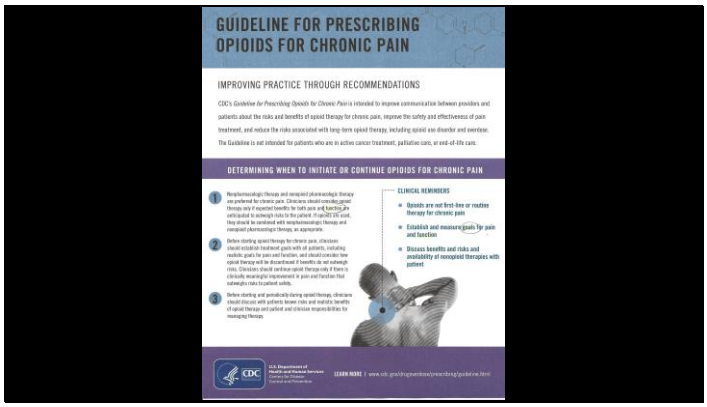
12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

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

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

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



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

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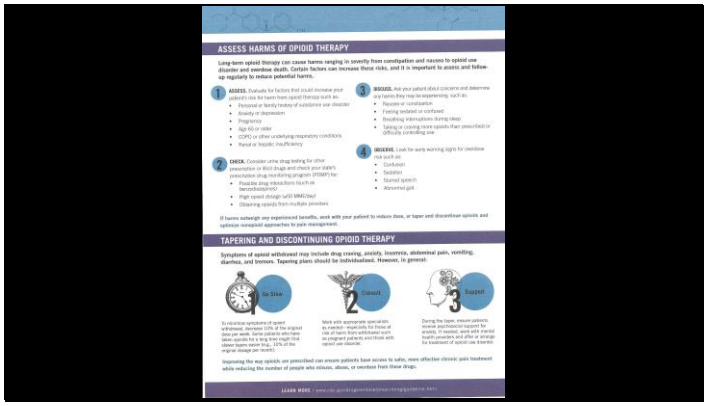

ASSESS HARMS OF OPIOID THERAPY

Long-term opioid therapy can cause harms ranging in severity from constipation and nausea to opioid use disorder and overdose death. Certain factors can increase these risks, and it is important to assess and follow-up regularly to reduce potential harms.

1 ASSESS. Evaluate for factors that could increase your patient's risk for harm from opioid therapy such as:

- Personal or family history of substance use disorder
- Anxiety or depression
- Pregnancy
- Age 65 or older
- COPD or other underlying respiratory conditions
- Renal or hepatic insufficiency

2 CHECK. Consider urine drug testing for other prescription or illicit drugs and check your state's prescription drug monitoring program (PDMP) for:

- Possible drug interactions (such as benzodiazepines)
- High opioid dosage (≥50 MME/day)
- Obtaining opioids from multiple providers

3 DISCUSS. Ask your patient about concerns and determine any harms they may be experiencing, such as:

- Nausea or constipation
- Feeling sedated or confused
- Breathing interruptions during sleep
- Taking or craving more opioids than prescribed or difficulty controlling use

4 OBSERVE. Look for early warning signs for overdose risk such as:

- Confusion
- Sedation
- Slurred speech
- Abnormal gait

If harms outweigh any experienced benefits, work with your patient to reduce dose, or taper and discontinue opioids and optimize nonopioid approaches to pain management.

TAPERING AND DISCONTINUING OPIOID THERAPY

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:

1 Go Slow

To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. For some patients who have been opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).

2 Consult

Work with appropriate specialists (e.g., addiction medicine) if there is risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.

3 Support

During the taper, ensure patients receive appropriate support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

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

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CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).

Dosages at or **above 50 MME/day** increase risks for overdose by at least

2x BMI

6x BMI

Dosages at or **above 100 MME/day**

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004-2009, **patients who died** of opioid overdose were prescribed on average of **55 MME/day**, while **other patients** were prescribed on average of **40 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone-sustained release 15 mg)
- 12 mg of methadone (~3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (2 tablets of hydrocodone/acetaminophen 7.5/500)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

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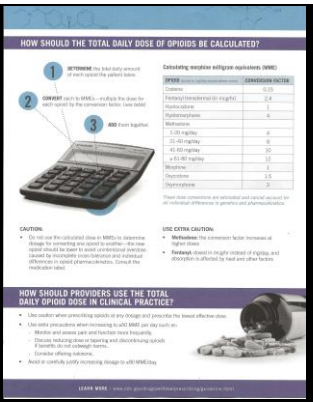


HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

1 **DETERMINE** the total daily amount of each opioid the patient takes.

2 **CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor (see table).

3 **ADD** them together.

Calculating morphine milligram equivalents (MME)

OPIOID (Adapted from Washington State Agency Medical Directors' Group)	CONVERSION FACTOR
Codeine	0.15
Fentanyl (transdermal) (in mg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are approximate and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for something one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

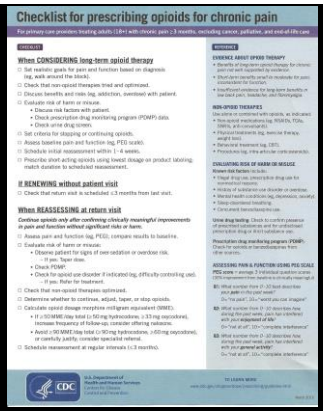
USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in micgrhr instead of mg/day, and absorption is affected by heat and other factors.

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.

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



Checklist for prescribing opioids for chronic pain

For primary-care providers treating adults (18+) with chronic pain (>3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled (≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG), compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine-milligram equivalent (MME):
  - If ≤50MME/day total (≤ 90 mg hydrocodone, ≤ 33 mg oxycodone), increase frequency of follow-up, consider offering naloxone.
  - Avoid ≥50 MME/day total (≥ 90 mg hydrocodone, ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits overall in moderate for pain; inconclusive for function.
- Risks of harm increase over time for long-term benefits in low back pain, headaches, and fibromyalgia.

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants)
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Procedures (eg, intra-articular corticosteroids)

EVALUATING RISK OF HARM OR MISUSE

Known risk factors (no b.b.b):

- Illegal drug use, concurrent other drug use for non-medical reasons
- History of substance use disorder or overdose
- Mental health conditions (eg, depression, anxiety)
- Sleep-disordered breathing
- Concurrent benzodiazepine use

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (10% improvement from baseline is clinically meaningful)

P: What number from 0–10 best describes your **pain** in the past week?
(0= "no pain", 10= "worst pain you can imagine"

E: What number from 0–10 describes how strongly the past week, pain has interfered with your **enjoyment of life**?
(0= "not at all", 10= "complete interference"

G: What number from 0–10 describes how strongly the past week, pain has interfered with your **general activity**?
(0= "not at all", 10= "complete interference"

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

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

Rev 2/13

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"Balanced" Opioid Therapy

- Appropriate vs inappropriate use
- Analgesia vs side effects
- Opioid vs nonopioid or nondrug strategies
- Pain relief, memory trace suppression vs tolerance, hyperalgesia
- Flexible prescribing vs regulatory constraints
- Patient-centered care vs defensive medicine (e.g., opioid agreements, drug testing…)
- Confidentiality vs provider access (PMP)
- Effects on patient vs effects on nonpatients (family members, friends, neonates)

How do you detect and address substance use problems and aberrant drug-related behavior?

Legal Considerations

- Federation of State Medical Boards model guidelines for the use of controlled substances for the treatment of pain

Model Guidelines: Controlled Substances for Pain Control

1. Evaluation of the patient
2. Treatment plan
3. Informed consent and agreement for treatment
4. Periodic review
5. Consultation
6. Medical records
7. Compliance with controlled substances laws and regulations

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Urine Drug Screens to Monitor Opioid Use for Managing Chronic Pain

SCHEDULE II DRUGS IN US

CODEINE
OPIUM
MORPHINE *
OXYCODONE *
OXYMORPHONE *
ALFENTINIL
CARFENTANIL
DIHYDROCODEINE
FENTANYL *
HYDROCODONE **
LEVOMETHROPHAN
LEVOPHANOL
METHADONE *
PENTHIDINE (MEPERIDINE)
REMIFENTANIL
SUFENTANIL TAPENTADOL
TAPENTADOL **
AMPHETAMINE SALES
METHAMPHETAMINE
METHYLPHENIDATE (RITALIN, CONCERTA)
LISDEXAMFETAMINE (VYVANASE)
AMOBARBITAL
PENTOBARBITAL
SECODBARBITAL

Hydrodocone (vicodin, norco) is now a Schedule II drug as is Tapentadol

These and all Schedule II drugs can NOT be
Eprescribed or called in.

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90 day refills of Schedule II drugs

Approved in established patients on stable doses

Write do not fill until (30 days after first dose)

EMERGENCY PRESCRIPTION OF SCHEDULE II DRUGS

In emergency pharmacist may dispense controlled substance receiving oral authorization of a prescribing individual practitioner if all of the following conditions are met:

1. Quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency

2. If the prescriber is not known to the pharmacist he/she shall make a reasonable effort to determine that the oral authorization came from a registered practitioner.

3. Within 7 days after authorizing emergency oral prescription the prescriber shall have written "Authorization for Emergency Dispensing and date of order. If delivered by mail the postmark must be within the 7 day period.

From A Requirement of Prescription-schedule II (21 CFR 1306.11)

http://www.dsd.state.md/us/com

When should I Query PDMP?

- Before a new course of therapy with opioids of Benzodiazepines
- When treatment extends > 90 days
- Must view at least last 4 months of data
- Delegate may pull data but prescriber must review and assess

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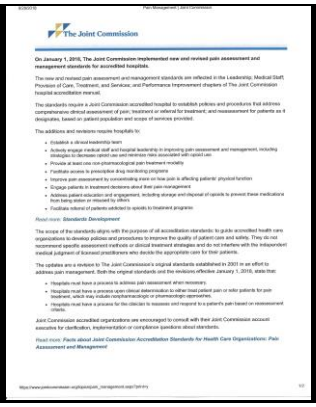
Exceptions to PDMP USE

Period of 3 days or less
Cancer treatment or cancer related pain
Diagnosed with terminal illness
Part of hospice, nursing home, long-term care, assisted living facility
To treat or prevent acute pain for < 14 days (surgical procedure, bone fracture, trauma, childbirth

Scenarios considered exempt

- When accessing PMP data results in delay of treatment which negatively impacts the medical condition of the patient
- When electronic access is not operational determined by Department of health
- In the event of temporary electrical or technological faiure



The Joint Commission

On January 1, 2016, The Joint Commission implemented new and revised pain assessment and management standards for accredited hospitals.

The new and revised pain assessment and management standards are reflected in the Leadership, Medical Staff, Provision of Care, Treatment, and Services; and Performance Improvement chapters of The Joint Commission hospital accreditation manual.

The standards require a Joint Commission accredited hospital to establish policies and procedures that address comprehensive clinical assessment of pain; treatment or referral for treatment; and reassessment for patients as it designates, based on patient population and scope of services provided.

The additions and revisions require hospitals to:

- Establish a clinical leadership team
- Actively engage medical staff and hospital leadership in improving pain assessment and management, including strategies to decrease opioid use and minimize risks associated with opioid use
- Provide at least one non-pharmacological pain treatment modality
- Facilitate access to prescription drug monitoring programs
- Improve pain assessment by consistently asking about how pain is affecting patients' physical function
- Engage patients in treatment decisions about their pain management
- Address patient education and engagement, including storage and disposal of opioids to prevent these medications from being stolen or misused by others
- Facilitate referral of patients addicted to opioids to treatment programs

Read more: Standards Development

The scope of the standards aligns with the purpose of all accreditation standards: to guide accredited health care organizations to develop policies and procedures to improve the quality of patient care and safety. They do not recommend specific assessment methods or clinical treatment strategies and do not interfere with the independent medical judgment of licensed practitioners who decide the appropriate care for their patients.

The updates are a revision to The Joint Commission's original standards established in 2001 in an effort to address pain management. Both the original standards and the revisions effective January 1, 2016, state that:

- Hospitals must have a process to address pain assessment when necessary.
- Hospitals must have a process upon clinical determination to either treat patient pain or refer patients for pain treatment, which may include nonpharmacologic or pharmacologic approaches.
- Hospitals must have a process for the clinician to reassess and respond to a patient's pain based on reassessment criteria.

Joint Commission accredited organizations are encouraged to consult with their Joint Commission account executive for clarification, implementation or compliance questions about standards.

Read more: Facts about Joint Commission Accreditation Standards for Health Care Organizations: Pain Assessment and Management

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JCAHO now requires hospitals to:

- Establish clinical leadership team
- Engage medical staff and hospital leadership to decrease opioid use and minimize risks of opioids
- Provide at least one non-pharmacological pain treatment modality
- Facilitate access to PDMP
- Improve pain assessment concentrating on function
- Engage patients in treatment deicisions
- Address patient education including storage and disposal of opioids
- Facilitate referral of patients addicted to opioids to treatment programs

Joint commission new standards for accredited hospitals for pain assessment and management January 1 2018

- Requires policy and procedures to establish comprehensive clinical assessment of pain, treatment or referral for treatment, reassessment based on patient population and scope of services provided

New January 1, 2018 from Original standards established in 2001

Hospital must have a process:

- To Address pain assessment when necessary
- To determine to either treat patient pain or refer patients for pain treatment which may include nonpharmacologic or pharmacologic approaches
- For the clinican to reassess and respond to a patient's pain based on reassessment criteria

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Joint Commission Report August 2017 on Opioid-Induced Ventilatory Impairment

- Annual cost 2011 study $2Billion
- Opioids most commonly prescribed medications for inpatients
- Opioids second highest class of medications associated with adverse effects
- Strategy 1 Assessment and mitigation of patient risk
- Strategy 2 Prescribing guidelines and standards e.g., ID which clinician will provide pain management, standardize handoffs and order sets, schedule pain medication, opioid de-escalation strategy in place

Opioid-induced ventilatory impairment - 2

- Strategy 3
- Patient assessment and monitoring standards such as pulse oximetry and capnography when needed with limitations such as alarm fatigue considered, monitor function and alertness, check PDMP and other data sources

- Strategy 4
- Engaging medical staff

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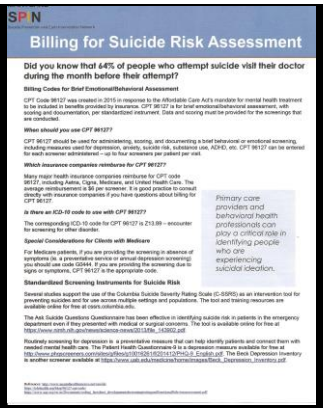
Evaluating risk for Obstructive Sleep Apnea >3 High Risk

- S snoring
- T tiredness daytime fatigue or sleepiness
- O observed stopping breathing while sleep
- P BP high BP present and/or treated
- B BMI>35 Kg/m2
- A age>50 years
- N neck circumference >40cm
- G gender- Male

AMA Opioid Task Force Report: the key to recovery is support and compassion

- Opioid-use disorder (OUD) is a medical illness vs. moral weakness or willful choice. Loaded language further stigmatizes patients seeking treatment
- Separation of treatment for OUD meant clinicians overlook other health issues
- Criminal justice system in conflict with medical judgment



SPN

Billing for Suicide Risk Assessment

Did you know that 64% of people who attempt suicide visit their doctor during the month before their attempt?

Billing Codes for Brief Emotional/Behavioral Assessment

CPT Code 96127 was created in 2015 in response to the Affordable Care Act's mandate for mental health treatment to be included in benefits provided by insurance. CPT 96127 is for brief emotional/behavioral assessment, with scoring and documentation, per standardized instrument. Data and scoring must be provided for the screenings that are conducted.

When should you use CPT 96127?

CPT 96127 should be used for administering, scoring, and documenting a brief behavioral or emotional screening, including measures used for depression, anxiety, suicide risk, substance use, ADHD, etc. CPT 96127 can be entered for each screener administered – up to four screeners per patient per visit.

Which insurance companies reimburse for CPT 96127?

Many major health insurance companies reimburse for CPT code 96127, including Aetna, Cigna, Medicare, and United Health Care. The average reimbursement is $8 per screener. It is good practice to consult directly with insurance companies if you have questions about billing for CPT 96127.

Is there an ICD-10 code to use with CPT 96127?

The corresponding ICD-10 code for CPT 96127 is Z13.89 – encounter for screening for other disorder.

Special Considerations for Clients with Medicare

For Medicare patients, if you are providing the screening in absence of symptoms (a. a preventative service or annual depression screening) you should use code G0444. If you are providing the screening due to signs or symptoms, CPT 96127 is the appropriate code.

Primary care providers and behavioral health professionals can play a critical role in identifying people who are experiencing suicidal ideation.

Standardized Screening Instruments for Suicide Risk

Several studies support the use of the Columbia Suicide Severity Rating Scale (C-SSRS) as an intervention tool for preventing suicides and for use across multiple settings and populations. The tool and training resources are available online for free at cssrs.columbia.edu.

The Ask Suicide Questions Questionnaire has been effective in identifying suicide risk in patients in the emergency department even if they presented with medical or surgical concerns. The tool is available online for free at https://www.nimh.nih.gov/news/science-news/2013/ms_143902.pdf

Routinely screening for depression is a preventative measure that can help identify patients and connect them with needed mental health care. The Patient Health Questionnaire-9 is a depression measure available for free at http://www.phqscreeners.com/sites/default/files/PHQ9B%20%1420%1420PHQ-9_English.pdf. The Beck Depression Inventory is another screener available at https://www.uab.edu/medicine/home/images/Beck_Depression_Inventory.pdf

References: http://www.asaphweb.org/home/ccs-tool
http://ultimatecare.org/Pdf/CCT-tool.pdf
http://www.ncqa.org/tabid/59/Default.aspx?Mode/PreviewDocument/DocumentID/5/Control/Ctl/ViewDocument.pdf

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Alabama state board of medical examiners rules and regulations (summary)

- Board recognizes that people of alabama must have access to appropriate and effective pain relief
- Inadequate pain control may result from lack of knowledge or fears of investigations or sanctions
- Board recognizes that controlled substances may be essential in acute and chronic pain whether due to cancer or non-cancer origins
- Board is obligated to protect public health and safety
- Physicians should not fear disciplinary action from the board or enforcement agencies for prescribing controlled substances for legitimate medical purpose

Alabama requirements for use of controlled substances for pain control

- Evaluation of patient
- Treatment plan
- Informed consent and agreement to include drug screening, refill policy, reason for d/c drug therapy, one physician/one pharmacy where possible
- Periodic review
- Consultation if needed especially patients high risk for abuse
- Complete medical records, maintained, accessible and readily available for review

Goal is to reduce pain and improve function

- References for Alabama state policies:
- Federation of state medical boards' model policy on the use of opioid analgesics in the treatment of chronic pain (July 2013) and as amended
- DEA administrative office of diversion control manual
- Narcotic treatment programs best practice guidelines as amended

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Thank you for your attendance if you have any question, comments or concerns please feel free to contact the Ascension CE Department.

If you would like information on any future CME/CE/CPE activity or be put on Ascension/St. Vincent's Health mailing list please email lisa.davis2@ascension.com

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