Pain Management in a Changing Regulatory Landscape

Eric J. Deppert, MD, FACP
Chief Medical Officer, Corpus Christi Medical Center
Disclosure Statement

I have nothing to disclose concerning possible financial or personal relationships with commercial entities (or their competitors) that may be referenced in this presentation.
Objectives

• Describe the need for legislation regarding controlled substances
• Distinguish between previous controlled substance prescribing and dispensing laws and the current law
• Recognize new requirements for controlled substance prescriptions, including the use of the Prescription Drug Monitoring Program Database (E-FORSCE)
• Explain the Joint Commission Standards regarding opioids including dosing guidelines, side effects, and drug-drug interactions.
• Apply the new laws and standards in practice and modify current practice to be in compliance
• Discuss available treatment resources for opioid dependence and substance use disorders.
I am able to confidently recommend adjunct and alternative therapies to opioids for pain management

a. Strongly agree
b. Agree
c. Disagree
d. Strongly disagree
Pain Management Guidelines & Recommendations

• CDC Chronic Pain Guidelines:
  • Opioids are neither first-line nor routine therapy for chronic pain
  • Discuss the benefits, risks, and availability of non-opioid therapies with patients

• Joint Commission Standard
  • Involve patients in decisions, set goals, and educate
  • Offer non-pharmacologic options for pain
  • Monitor high risk patients
  • Establish protocols

http://www.cdc.gov/drugoverdose
www.jointcommission.org
Pain Management Guidelines & Recommendations

• Acute Pain Management Guidelines
  • American College of Emergency Physicians’ Clinical Policy on Opioid Prescribing
  • Pain Management Dosing Guide – American Pain Society
  • American Dental Association Statement on the Use of Opioids in the Treatment of Dental Pain
CDC Recommendations for Chronic Pain

• Not applicable for cancer, palliative, or end-of-life care

• Opioids are not the first line therapy
  • Consider non-opioid and non-pharmacologic therapies

• Establish goals for pain and function that are patient specific and realistic

• Discuss risks and benefits of therapy

http://www.cdc.gov/drugoverdose
CDC Recommendations for Chronic Pain

• Use immediate release opioids first

• Use the lowest effective dose

  ≥ 50 morphine milligram equivalents (MME)/day – benefits and risks should be carefully considered

  ≥ 90 MME/day should be avoided without “careful justification”

• Evaluate frequently when starting or escalating therapy (every 1-4 weeks), then every 3 months

http://www.cdc.gov/drugoverdose
# Morphine Equivalency

<table>
<thead>
<tr>
<th>Opioid</th>
<th>IV (mg)</th>
<th>PO (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>---</td>
<td>30</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1</td>
<td>--- (12.5 mcg/hr patch)</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>0.3</td>
<td>0.4 (sublingual)</td>
</tr>
<tr>
<td>Codeine</td>
<td>100</td>
<td>200</td>
</tr>
<tr>
<td>Meperidine</td>
<td>100</td>
<td>300</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>---</td>
<td>75</td>
</tr>
<tr>
<td>Tramadol</td>
<td>---</td>
<td>300</td>
</tr>
</tbody>
</table>
CDC Recommendations for Chronic Pain

• Mitigate risk
  • Offer naloxone for patients
    • History of overdose
    • Substance use disorder
    • ≥ 50 MME/day
    • Concurrent benzodiazepine use
  • Review the PDMP
  • Use urine drug testing annually
  • Avoid concurrent benzodiazepines
    • Note: titration required
• Treat opioid use disorder
ACEP

• Review PDMP

• Acute Low Back Pain
  • Consider non-opioid and non-pharmacologic therapies
  • Opioids should be reserved for refractory pain
  • If opioids are required, a short duration should be used

• Acute Exacerbation of Chronic Pain
  • Consider non-opioids
Discussing Pain Management with Patients

Corpus Christi Medical Center is committed to providing excellent care for patients while hospitalized including keeping patients comfortable

• Avoiding all pain is not always possible or to be expected
• Minimizing pain and keeping it tolerable is the goal
Discussing Pain Management with Patients

• Pain can be treated in a variety of ways:
  • Non-medication (ice, heat, rest, elevation, physical therapy, massage)
  • Non-opioid medications
    • Acetaminophen (Tylenol®)
    • NSAIDs – ibuprofen, ketorolac
    • Topical analgesics (lidocaine patches)
    • Gabapentin, pregabalin (Lyrica®)
  • Opioids
    • CDC recommends to be used as second line agents for chronic pain
    • Use only when risks outweigh benefits
    • Use the lowest dose possible for the shortest course possible
    • Oral agents provide the same analgesia as IV agents
NL is a 36 y/o male with a history of nephrolithiasis 2 years ago. He presents to the ER with flank pain that he scores 10/10, dysuria, and nausea. His history is otherwise noncontributory. He endorses use of ibuprofen and acetaminophen within the past 2 hrs w/ minimal relief. NKA. The physician asks for a recommendation for this patient’s pain.
You recommend:

A. Ketorolac 30 mg IV + Acetaminophen 1,000 mg po x 1
B. NS 1000 mL + Lidocaine infusion
C. Hydromorphone 2 mg IV x 1 & NS 1000 mL bolus
Alternatives to Opioids
Pain Management and
Addiction Prevention Program

The Journey: Implementation Plan and Future Recommendations

Presented by
2006-2015 - 144% Increase in individuals treated and released from the ED for opioid-related care - prescriptions quadrupled.

2006-2015 - 64% Increase in individuals admitted to the hospital for opioid-related care.

**Opioid-Related Costs Taking Toll on Overall Economy**

- Estimated cost of opioids in lost economic productivity = **$55.6 Billion** (2016)
- Estimated total opioid-related costs to the American economy = **$1 Trillion** (2001-2017)
- Projected future opioid-related costs to the American economy = **$500 Billion** (2017-2020)

Yet....There was no overall increase in pain reported by Americans

Opioid Overview

A List of Common Opioids, in order of increasing strength:

- Codeine
- Hydrocodone
  - Vicodin®, Hycodan®, Norco®
- Morphine
  - MS Contin®, Kadian®
- Oxycodone
  - Oxycontin®, Percocet®
- Hydromorphone
  - Dilaudid®
- Fentanyl
  - Duragesic®

**Signs of an Opioid Overdose**

- Blue lips or nails
- Dizziness and confusion
- Can't be woken up
- Choking, gurgling or snoring sounds
- Slow, weak or no breathing
- Drowsiness or difficulty staying awake
Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted)

https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?activeTab=map&currentTimeframe=0&selectedDistributions=opioid-overdose-death-rate-age-adjusted&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

US Average = 14.9
Texas - Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted)

https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?activeTab=map&currentTimeframe=0&selectedDistributions=opioid-overdose-death-rate-age-adjusted&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Texas Opioid Deaths
(all intents, where opioids were involved)
Texas Opioid Deaths (accidental)
## Drug Overdose & Rx Mortality (top 12 counties)

<table>
<thead>
<tr>
<th>County</th>
<th>ER visits</th>
<th>Deaths per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris</td>
<td>1065</td>
<td>5.1</td>
</tr>
<tr>
<td>Dallas</td>
<td>965</td>
<td>6.8</td>
</tr>
<tr>
<td>Tarrant</td>
<td>834</td>
<td>4.9</td>
</tr>
<tr>
<td>Bexar</td>
<td>657</td>
<td>5.1</td>
</tr>
<tr>
<td>Travis</td>
<td>510</td>
<td>2.3</td>
</tr>
<tr>
<td>Denton</td>
<td>263</td>
<td>2.8</td>
</tr>
<tr>
<td>Collin</td>
<td>242</td>
<td>3.7</td>
</tr>
<tr>
<td>Montgomery</td>
<td>227</td>
<td>--Unreliable--</td>
</tr>
<tr>
<td>El Paso</td>
<td>224</td>
<td>3.2</td>
</tr>
<tr>
<td>Williamson</td>
<td>187</td>
<td>--Unreliable--</td>
</tr>
<tr>
<td>Galveston</td>
<td>179</td>
<td>--Unreliable--</td>
</tr>
<tr>
<td>Nueces</td>
<td>167</td>
<td>10.4</td>
</tr>
<tr>
<td><strong>STATEWIDE</strong></td>
<td><strong>9,147</strong></td>
<td><strong>4.3</strong></td>
</tr>
</tbody>
</table>

Sources: Texas Department of Health and Human Services and U.S. Centers for Disease Control and Prevention
Opioid-related deaths in TX, by age group

United States Drug Poisoning Deaths and Rates per 100,000 (2017 data)
All Races, Both Sexes, All Ages
ICD-10 Codes: X40-X44,X60-X64,X85,Y10-Y14

<table>
<thead>
<tr>
<th>County</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nueces</td>
<td>10.4</td>
</tr>
<tr>
<td>Dallas</td>
<td>6.8</td>
</tr>
<tr>
<td>Bexar</td>
<td>5.1</td>
</tr>
<tr>
<td>Harris</td>
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<tr>
<td>Tarrant</td>
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<td>Collin</td>
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<td>Denton</td>
<td>2.8</td>
</tr>
<tr>
<td>Travis</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Sources: Texas Department of Health and Human Services and U.S. Centers for Disease Control and Prevention
ER visits and deaths per 100,000 people in 2015

- Harris
- Dallas
- Tarrant
- Bexar
- Travis
- Denton
- Collin
- Montgomery
- El Paso
- Williamson
- Galveston
- Nueces

ER visits and Deaths per 100,000

- ER visits
- Deaths per 100,000

County
Understanding the Case for Alternatives to Opioids: The Facts

CDC Recommends:

• Opioids are not first-line or routine therapy for chronic pain.
• Discussion of benefits, risks, and availability of non-opioid therapies with patients.

CDC Guidelines for prescribing Opioids are underutilized

14% nationwide have taken a prescription pain medication without a prescription

1.5% admit to having injected an illegal drug

State Youth Risk Behavior Surveys, 2017
www.cdc.gov/healthyouth/data/yrgs/results.htm
CCMC’s ALTO Toolkit

- Charter
- Stakeholders
- Work Plan
- Communication Plan
- Community Information Sessions
- Data Management
- Patient Education Plan
- Tools for Success

- Pharmacists in the ER
- EMR alerts and notifications
- IP SWAT Team
- Post Hospitalization Support and Care Transitions
- Sustain and Maintain Program
- Recommendations

*Toolkit now available!*
Pain Management and Addiction Prevention Tool Kit

1. Charter
2. Stakeholders
3. Work plan
4. Communication Plan
5. Community Information Session with local facilities
6. Data Management
7. IP SWAT (Substance Withdrawal Action Team for patients with known addiction)
8. Patient Education Plan
9. Tools, Protocols for Success, Provider Education
   a) ECC
   b) Anesthesia
   c) PCP
   d) Specialists
10. Pharmacists in Emergency Care Center (ECC)
11. EMR Alerts/Push Notifications
12. Post Hospitalization support- Care Transitions
    a) Behavioral Health component
    b) Methadone Clinic
    c) Mental Health Counselors in Urgent Care Centers
13. Sustain and Maintain- Communication- internal and external
14. References
1. Charter

Opioid overdose deaths involving a prescription opioid are at 40\% \textsuperscript{1} Prescription pain reliever misuse occurs in 4.31 out of 100 people.\textsuperscript{2} 80\% of new heroin users began by misusing prescription pain medications.\textsuperscript{3} Up to 10\% of patients who are newly prescribed an opioid will become addicted.\textsuperscript{4} The Center for Disease Control recommends Opioids are not first-line or routine therapy for chronic pain.\textsuperscript{5} Most importantly, the discussion of benefits, risks, and availability of non-opioid therapies with patients must occur differently if a change in lifestyle and outcomes is to happen in your respective county. The main objectives for a hospital and community committee for consideration are as follows:

- Provide community with education, evidence based protocols, and support with pain management and addiction prevention. (hospitals, providers, payers, schools, faith based organizations)
- Develop enhanced Protocols, Medical Assisted Treatments (MAT), Pharmaceutical and Non-Pharmaceutical Interventions intra hospitalization and post hospitalization through collaboration and use of evidence based literature.
- Improve use of alternatives for opioids in your county.
2. Stakeholders

Identification of stakeholders across the continuum of care is essential for a successful program that meets the needs of the patient in the hospital and throughout the transitions of care. The hospital must take the initiative to develop a multidisciplinary team to manage prevention and treatment of opioid use disorder (OUD). This process begins with assessing awareness of the issues and developing a common level of understanding within the group of key stakeholders. A developed level of understanding identifies motivating factors of each stakeholder and advances the level of shared knowledge amongst its members to develop prevention and treatment needs. Key stakeholders may include:

- **Hospital stakeholders**
  - Hospital Administrators
  - Governing Bodies: Medical Committees, Board of Governors
  - Physicians: Emergency Medicine, Surgeons, Pain Management Specialists, Anesthesiologists, Internists, Psychiatrists, Neonatologists, Obstetricians
  - Nurse Leaders and Staff Nurses
  - Pharmacists
  - Social Workers and/or Case Managers
  - Physical Therapists
  - Department of Health Physician leadership
  - Marketing and Community Relations
  - Information System leaders

- **Community Stakeholders**
  - Primary Care Physicians
  - Pain Management Specialists
  - Free Standing Emergency Departments (FED)
  - Urgent Care Centers
  - Other Local Health Systems
  - Law Enforcement
  - Emergency Medical Services
  - Community Paramedicine Program
  - Drug Enforcement Agency
  - Community Institutions: Schools, Churches, Community Resource Centers
  - Behavioral Health and Rehabilitation Centers
  - Local Municipal and/or County, State, and Federal Legislators
  - Local and National Not-for Profit Organization
  - Peer to Peer Recovery Program
3. Work Plan

Work plans should be established with the aim to meet goals, provide methods for evaluation, and define stakeholders responsible for components of the plan. Work plans should include specific steps involved, a timeline for development and implementation of the steps, and accountability to the components of the plan.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Responsible Party</th>
<th>Action</th>
<th>Deliverable</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Workgroup or Committee</td>
<td></td>
<td>✔ Physician Champions - Emergency department, Surgery, Anesthesia, Pain Management, Internal Medicine ✔ Hospital Leadership – CEO, CNO, CMO ✔ Nurse Leaders ✔ Pharmacist ✔ Quality ✔ Community Liaisons ✔ EMS ✔ Information Technology</td>
<td>Timeline with interim goals</td>
<td></td>
</tr>
<tr>
<td>Create timeline for implementation</td>
<td></td>
<td>✔ ED: Target diagnoses ✔ Target Surgical Protocols ✔ Inpatient pain syndromes ✔ Transitions of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Define Scope</td>
<td>✔ ED: Target diagnoses ✔ Target Surgical Protocols ✔ Inpatient pain syndromes ✔ Transitions of Care</td>
<td>✔ Evaluate current state ✔ Electronic order sets and pathways ✔ Clinical decision support available and needed ✔ Design ideal build ✔ Test and Evaluate</td>
<td>IS workplan and gap analysis</td>
<td></td>
</tr>
<tr>
<td>Assess IS (Information Services aka- IT) infrastructure needed</td>
<td></td>
<td>✔ Evaluate current state ✔ Electronic order sets and pathways ✔ Clinical decision support available and needed ✔ Design ideal build ✔ Test and Evaluate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish policy and guidelines</td>
<td></td>
<td>✔ Workshops ✔ Primary Care ✔ Inpatient</td>
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<td></td>
</tr>
<tr>
<td>Education/Training</td>
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<td>✔ Workshops ✔ Primary Care ✔ Inpatient</td>
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<tr>
<td>Measuring and Monitoring</td>
<td>Define Key Performance Indicators</td>
<td></td>
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<td>--------------------------</td>
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<td></td>
<td></td>
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<tr>
<td>Regulatory Needs Assessment</td>
<td>Establish reporting structure</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Risk Screening/assessment and referral</td>
<td>SBIRT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk stratification (NIDA screening)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral procedure</td>
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</tr>
</tbody>
</table>

- providers
  - Internal Medicine and Family Residents
  - Nursing and Pharmacy Staff
  - hospitals/care networks
- Community education
  - Flyers
  - Workshops
  - Other media
4. Communication Plan

Programs should develop an internal and external communication plan for optimal success with opioid alternatives and overall pain management and addiction prevention initiatives. The first step is creating a sense of awareness at leadership and physician attended meetings. This includes but not limited to Board of Governors, Medical Executive Committees, Quality Committee of the Board, Senior Manager Meetings, Supervisor meetings, Pharmacy and Therapeutics, Surgical Services, and all other meetings involving decision makers within your program. The communication plan should describe the problem and a solid analysis of the problem in your respective area, current state, and problem analysis with use of a quality management performance improvement tool (Cause and Effect Diagram), Future state, Countermeasures, implementation plan, and sustainability plan with dashboard to track key performance improvement measures. External communication plan should involve the VP of Public Relations and Community Stakeholders, local media previously identified. Communication plans should be tailored to meet facility and community objectives and evolve as objectives are met and as timelines progress.
5. Community Information Sessions with Local Facilities

When a commitment to change has been agreed upon within your organization, it is imperative to host a community wide information session with guest speakers that can support your initiatives and back your current state and future state proposal. The goal of this session is to invite all community stakeholders and local facilities to develop a unified community wide action plan with goals and metrics to ensure a transparent and engaged community. Speakers can be from other counties in the state or other facilities in the country that have managed to achieve solid program outcomes. This session should be planned with senior hospital leaders, senior leaders from local hospitals in the community, local and state government officials, county or community task forces tackling drug free initiatives, behavioral health executives, local media, law enforcement, DEA representatives, and patients and families that have suffered through this addiction crisis. Develop a program with contact information from your facility, speaker biographies, and provide highlights of the initiative within the organization to support this program.
6. Data Management

Programs should establish key performance indicators (KPI) to evaluate the current state, establish a strategic plan, and measure success. KPI should evaluate each component of the plan. Leveraging data obtained from the Electronic Health Record (EHR) is an important component of the monitoring plan and should involve information technology specialists.

- Prevention
  - Initial opioid prescriptions per 1,000 patients or opioid prescription rate
    - Initial opioid prescribed in combination with benzodiazepine (rate)
    - Initial opioid is short acting
    - Initial opioid is for ≤ 50 MME (morphine milligram equivalents)/day
    - Initial prescription is ≤ 3 day supply
    - Rates of past or current substance use identified during screening
  - NSAID, acetaminophen, topical lidocaine, corticosteroid prescription rate
  - CDC guidelines for chronic pain followed
  - Rate of initial prescriptions that convert to chronic opioid use
  - Overdose rate

- Pain Management
  - Rate of ED visits for breakthrough surgical pain
  - Rate of ED visits for breakthrough chronic pain
  - PDMP (prescription drug monitoring program) use - ED and Inpatient

- Opioid Use Disorder Treatment
  - Referral to medication-assisted treatment (MAT) for patients with opioid overdose (OD) or identified opioid use disorder (OUD)
    - Compliance or retention rates in MAT
    - Evidence of naloxone fill among patients with OUD or OD

- Maternal, Infant, Child Health
  - Rate of infants with neonatal abstinence syndrome (NAS)

- Regulatory Compliance
  - Adherence to state prescription drug laws
  - Adherence to Joint Commission and CMS requirements for pain management
7. IP SWAT (Substance Withdrawal Action Team) for patients with known addiction

Programs that have matured are adding the Inpatient SWAT team concept to support patients suffering from opioid use disorder as a cause of admission or at high risk for developing opioid use disorder. The implementation of a validated risk screening tool is advised and should be incorporated into the electronic medical record, screening for opioid addiction or opioid addiction with co-occurring pain. Screening should be performed on all patient encounters including emergency care centers, urgent care centers, outpatient visits, and inpatient hospital stays. Positive screens should result in the use of a comprehensive assessment.

Teams should be focused on safe care of the patient while hospitalized including consideration of drug screening, camera observation of patient or assigned sitter, evaluation of visitors and belongings, psychiatry consult, pain management consult, spiritual care, nutritional support, and case management consult for discharge planning or ongoing treatment. Initiation of medication assisted treatment should also be considered as licensure permits.

APPENDIX D:

Referral algorithm using National Institute on Drug Abuse substance involvement screening:
Examples of patient screening tools:

- Screening, Brief Intervention and Referral to Treatment (SBIRT): https://www.samhsa.gov/sbirt/about
- Clinical Opiate Withdrawal Scale (COWS)
8. Community and Patient Education Plan

Community education should include prevention and awareness, pain management education, and recovery. This should include a comprehensive catalogue of community support available to high, medium, and low risk opioid use disorder patients. Community support may include support groups, peer to peer recovery support, withdrawal management, outpatient services and inpatient treatment services. All patient education materials should be available in Urgent Care Centers and Free Standing Emergency Rooms. Community partners should be engaged to assist with and coordinate community education plans.

Patient education should include resources to discuss opioid alternatives with patients, appropriate storage, disposal, and handling of prescriptions, and reinforcement of behaviors that promote reduced use or abstinence. For high risk patients, additional support and education should be offered. For patients who inject opioids, additional harm-reduction interventions to prevent unintentional overdose or communicable disease should be discussed.

Patient education and community awareness resources can be found:
https://www.cdc.gov/rxawareness/resources/socialmedia.html
https://www.cdc.gov/drugoverdose/patients/index.html
https://turnthetiderx.org/for-patients/
https://www.va.gov/PAINMANAGEMENT/docs/TakingOpioidsResponsibly20121017.pdf
http://www.lockyourmeds.org/
9. Tools, Protocols for Success: Provider and Internal Staff Education Plan

**Provider Education (Appendix E)**
Multimodal education approach is recommended
- Workgroups for protocol development with key physician stakeholders and champions
- Workshops/seminars
- Protocol distribution
  - Electronic notification boards
  - Physician newsletters
  - Computer screen savers
- Web based learning
  - [http://www.flhealthsource.gov/FloridaTakeControl](http://www.flhealthsource.gov/FloridaTakeControl)
  - [https://fl.cme.edu/](https://fl.cme.edu/)

Include key information
- Evidence behind protocols developed
- Implementation dates
- Clinical decision support and IS resources available
- Plans for monitoring

**Staff Education (Appendix F)**
Resident Education on Pain Management
SBIRT (Screening Brief Intervention and Referral for Treatment) Training Certification
Healthstream or other web-based education plan to include
- Protocols, timeline, clinical decision support, and monitoring plans
- Signs and symptoms of opioid intoxication and withdrawal
- Discharge Education from ECC and how to message patients (Pain Management Talking Points)
Discussing Pain Management with Patients

Manatee Memorial Hospital is committed to providing excellent care for patients while hospitalized including keeping patients comfortable

- Avoiding all pain is not always possible or to be expected
- Minimizing pain and keeping it tolerable is the goal

Pain can be treated in a variety of ways

- Non-medication (ice, heat, rest, elevation, physical therapy, massage)
- Behavioral (cognitive behavioral therapy, mindfulness)
- Non-opioid medications
  a. Acetaminophen (Tylenol®)
  b. NSAIDs—ibuprofen, ketorolac
  c. Topical analgesics (lidocaine patches)
  d. Gabapentin, pregabalin (Lyrica®)
- Opioids
  a. CDC recommends to be used as second line agents for chronic pain
  b. Use only when risks outweigh benefits
  c. Use the lowest dose possible for the shortest course possible
  d. Oral agents provide the same analgesia as IV agents
Protocol Development

Key Considerations:

1. Regulatory considerations related to the use of alternative agents such as ketamine and nitrous oxide
2. Training and credentialing considerations related to nerve blocks and trigger point injections, alternative medication administration
3. Medication access and distribution
4. Supply and equipment needs related to intranasal medication administration and nitrous oxide administration

Emergency Care Center

Consider key pain syndromes:

1. Musculoskeletal Pain: Sprains, strains, opioid-naïve lower back pain, acute neck, joint, soft tissue pain, rotator cuff tendonitis, arthritis of knee, etc.
2. Headache/Migraine
3. Renal Colic
4. Extremity Fracture or Joint Dislocation
5. Acute on chronic back pain
<table>
<thead>
<tr>
<th>Indication</th>
<th>Treatment Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal colic</td>
<td>Ketorolac 15mg IV&lt;br&gt;Acetaminophen 1,000 mg po&lt;br&gt;0.9% Sodium chloride 1,000 mL bolus&lt;br&gt;Lidocaine 200mg/100 mL infusion 1.5 mg/kg over 10 minutes (max 200 mg)</td>
</tr>
<tr>
<td>Musculoskeletal pain (sprains, strains, opiate naive lower back pain)</td>
<td>Acetaminophen 1,000 mg po&lt;br&gt;Ibuprofen 400mg po OR ketorolac 15 mg IV/IM&lt;br&gt;Muscle relaxant (Choose one)&lt;br&gt;Cyclobenzaprine 5 mg po (age &gt;65 yo or BW &lt;70 kg or concerns for somnolence) OR Cyclobenzaprine 10 mg po&lt;br&gt;Diazepam 5 mg po&lt;br&gt;Lidocaine patch –up to 3 patches to painful areas –remove after 12 hrs&lt;br&gt;Gabapentin 300 mg po (age &gt;65 yo or BW &lt;70 kg or concerns for somnolence/naive to med) OR gabapentin 600 mg po&lt;br&gt;Bupivacaine 0.5% OR lidocaine 1% 1-2 mL trigger point injection</td>
</tr>
<tr>
<td>Acute on Chronic Radicular Lower Back Pain (Opioid tolerant)</td>
<td>Acetaminophen 1,000 mg po&lt;br&gt;Ibuprofen 400mg po OR ketorolac 15 mg IV/IM&lt;br&gt;Muscle relaxant (Choose one)&lt;br&gt;Cyclobenzaprine 5 mg po (age &gt;65 yo or BW &lt;70 kg or concerns for somnolence) OR Cyclobenzaprine 10 mg po&lt;br&gt;Diazepam 5 mg po&lt;br&gt;Lidocaine patch –up to 3 patches to painful areas –remove after 12 hrs&lt;br&gt;Gabapentin 300 mg po (age &gt;65 yo or BW &lt;70 kg or concerns for somnolence/naive to med) OR gabapentin 600 mg po&lt;br&gt;Dexamethasone 8 mg IV&lt;br&gt;Bupivacaine 0.5% OR lidocaine 1% 1-2 mL trigger point injection&lt;br&gt;Ketamine 500 mg/250 mL: 0.3 mg/kg bolus over 10 minutes, then 1.7 mcg/kg/min infusion</td>
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</table>
| Headache/Migraine | Metoclopramide 10mg PO/IV  
0.9% Sodium chloride 1,000 mL bolus  
Acetaminophen 1,000 mg po  
Ibuprofen 400mg po OR ketorolac 15 mg IV/IM  
Bupivacaine 0.5% OR lidocaine 1% 1-2 mL cervical or trapezius trigger point injection  
Lidocaine 4% Intranasal 0.5 mL  
If <50% pain relief to above: Magnesium 1gm IV over 60 minutes  
Valproic acid 500mg IV over 20 minutes  
Dexamethasone 4-8 mg IV  
If <50% pain relief to above: Haloperidol 2.5-5 mg IV |
|----------------|--|
| Extremity Fracture or Joint Dislocation | Ketamine intranasal (50 mg/mL) 0.5 mg/kg (maximum 50 mg) x 1  
Acetaminophen 1,000 mg PO  
Ultrasound guided regional anesthesia peri-neural infiltration  
Lidocaine 0.5% (max 5 mg/kg) OR Ropivacaine 0.5% (max 3 mg/kg) |
Anesthesia
Standardize preoperative medications to include:
  Oral acetaminophen
  Gabapentin or pregabalin
Intra-procedural use of ketorolac injection and lidocaine and ketamine infusions to minimize 
opiod use

Primary Care Physicians
Acute pain protocols that mimic ECC pain protocols
Use of non-pharmacologic therapies
  Heat, ice, massage, early PT/OT evaluation and treatment, behavioral therapy
Screening for Opioid Use Disorder and activation of SWAT team
Utilize CDC guidelines for treatment of chronic pain

Specialists
Standardized post-operative pain management protocols and orders
Use of nerve blocks, scheduled acetaminophen and NSAIDS
Topical lidocaine at incision sites
Using opioids for breakthrough pain only
Pre-operative teaching and setting realistic pain management expectations and goals
10. Pharmacists in the Emergency Care Center

The American Society of Health Systems Pharmacist has defined roles for emergency medicine pharmacists. These pharmacists are important for advancing best practices in pain management and can be involved in collection of accurate pain management histories, allergy histories, providing patient specific pain management recommendations, avoiding medication interactions, identifying patients at high risk for OUD or OD, and patient education. Pharmacists are able to assist in creation of protocols, implementation, and monitoring of protocol compliance, and staff and provider education.
11. Electronic Medical Record (EMR) Alerts/Push Notifications/Defaults/Health Information Exchange (HIE)

Leverage local IS departments to establish evidence based order sets, screening tools, and decision support.

Evaluate current protocols and order sets to optimize pain management options and default to non-opioid options for first line therapy when appropriate. Ensure non-medication options are included in protocols and order sets.

Leverage local Health Information Exchange (HIE) and Prescription Drug Monitoring Programs (PDMP) to evaluate patient histories and prior treatments.

Consider establishing clinical decision support, alerts and notifications as follows:
   a. Patients with moderate or high risk substance involvement screening
      i. Consult SWAT team
      ii. Establish referrals
   b. Drug-drug and disease interaction warnings for opioids and alternative agents
   c. Maximum dose warnings for acetaminophen and NSAIDs
   d. Warnings/alerts for long acting opioids in opiate naïve patients
   e. Warnings/alerts for co-prescribed benzodiazepines and opioids
   f. Warnings/alerts for co-prescribed gabapentinoids and opioids
   g. Warnings/alerts for opioid orders and prescriptions for MME >50 mg/day
   h. Cascading order set options for treatment of acute pain in patients who are chronic opioid users
12. Post Hospital Support & Care Transitions

Facilities should utilize their established community support catalogue to refer patients for follow up and ensure appropriate care transitions. It is imperative that follow up and care transitions occur timely to avoid relapse soon after discharge. Patients are at highest risk of overdose following a period of abstinence such as a hospitalization. Some of these strategies may include:

a. Community paramedicine programs
b. Behavioral health referrals
c. Methadone clinic or other MAT clinic
d. Mental Health Counselors in Urgent Care Centers and FEDs
e. Peer to peer counseling programs
f. Primary care physicians engaged in treatment of OUD patients
g. Timely outpatient physical and occupational therapy referrals
h. Faith based organizations as appropriate
i. Naloxone distribution centers
j. Onsite behavioral health intake on same day of hospital discharge
k. Coordination of medical or pain treatment with treating psychiatrist of record
13. Maintenance, Sustainability, and Future Recommendations

**Sustainability** of the initiative requires continued engagement of all stakeholders. Providing regular feedback regarding key performance indicators and next steps in the plan is key for the success of the program. Additional broad support is also necessary for the success of these programs.

**Advocacy:** Engaging legislators at the local, state and national level to maintain focus and provide funding for programs is paramount for optimal benefit of this program.

**Research longitudinal studies:** Funding for research regarding long term success and strategies is needed. Advocacy for support of research is needed. Local research should focus on local strategies and patient outcomes from the program.

**Single integration and management of program:** Consider development of a Chief Pain Management or Pharmacy Officer to oversee and administer the program.

**Regional and state summits and integration of regional programs:** County, state, and national success is dependent on programs that are in alignment and seeking to meet similar goals and outcomes.
14. References


Authored by:
Stephanie Brown, Pharm D, Clinical Coordinator, Pharmacy, Manatee Memorial Hospital
Jody Rain, RN BSN CEN, Director, Emergency Care Center, Manatee Memorial Hospital
Candace S. Smith, PhD, RN, NEA-BC, Chief Nursing Officer, Manatee Memorial Hospital

Reviewed by:
Joshua T. Barnett, MHS, MA, ICCDP-D, Health Care Services Manager, Manatee County Government
Teresa Rawe, DO
Vernon DeSear
# Appendix A: Sample Work Plan - Opioid Stewardship

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Responsible Party</th>
<th>Action</th>
<th>Deliverable</th>
<th>Due Date</th>
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</thead>
</table>
| Establish Workgroup or Committee              |                                                                                  | ➢ Physician Champions-Emergency department, Surgery, Anesthesia, Pain Management, Internal Medicine | ➢ Team contact list & commitments  
➤ Meeting schedule               |                      |                                                                                             |                                                             |          |
|                                               |                                                                                  | ➢ Hospital Leadership – CEO, CNO, CMO                                                      |                                                                             |          |
|                                               |                                                                                  | ➢ Nurse Leaders                                                                           |                                                                             |          |
|                                               |                                                                                  | ➢ Pharmacist                                                                              |                                                                             |          |
|                                               |                                                                                  | ➢ Quality                                                                                 |                                                                             |          |
|                                               |                                                                                  | ➢ Community Liaisons                                                                       |                                                                             |          |
|                                               |                                                                                  | ➢ EMS                                                                                    |                                                                             |          |
|                                               |                                                                                  | ➢ Information Technology                                                                  |                                                                             |          |

Create timeline for implementation

 Define Scope

|                                               |                                                                                  | ➢ ED: Target diagnoses  
➤ Target Surgical Protocols  
➤ Inpatient pain syndromes  
➤ Transitions of Care | ➢ Timeline with interim goals  
➤ Establish subgroups to meet interim goals as needed |          |

Assess IS infrastructure needed

|                                               |                                                                                  | ➢ Evaluate current state  
➤ Electronic order sets and pathways  
➤ Clinical decision support available and needed  
➤ Design ideal build  
➤ Test and Evaluate | ➢ Charter  
➤ Define key Performance Indicators for measuring/monitoring  
➤ IS workplan  
➤ Gap analysis |          |

Establish policy and guidelines

|                                               |                                                                                  | ➢ Create policy based on scope of project  
➤ Create clinical pathways, guidelines, resources for implementation | ➢ Policy  
➤ Clinical pathways or references |          |
## Pain Management and Addiction Prevention Tool Kit

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<tr>
<th>Education/Training</th>
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<td>o Inpatient providers</td>
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<td>o Internal Medicine and Family Residents</td>
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<th>Measuring and Monitoring</th>
<th>Define Key Performance Indicators</th>
<th>Reporting tool (dashboard)</th>
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<td>Establish reporting structure</td>
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<th>Strategy for advocacy</th>
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<td>Pharmacist practice acts</td>
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<td>Payer methodology (CMS, commercial) - behavioral health</td>
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<td>Controlled substance regulations</td>
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<td>Public funding and support</td>
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<th>SBIRT</th>
<th>Screening and referral procedure</th>
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<td>Risk stratification (NIDA screening)</td>
<td>Education</td>
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<td></td>
<td>Referral procedure</td>
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### Appendix B: Opioid Alternative Protocol: Emergency Department

<table>
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<tr>
<th>Indication</th>
<th>Treatment Options</th>
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</table>
| **Renal colic**                                 | Ketorolac 15mg IV  
Acetaminophen 1,000 mg po  
0.9% Sodium chloride 1,000 mL bolus  
Lidocaine 200mg/100 mL infusion 1.5 mg/kg over 10 minutes (max 200 mg) |
| **Musculoskeletal pain**                        | Acetaminophen 1,000 mg po  
Ibuprofen 400mg po OR ketorolac 15 mg IV/IM  
Muscle relaxant (Choose one)  
Cyclobenzaprine 5 mg po (age >65 yo or BW <70 kg or concerns for somnolence) OR Cyclobenzaprine 10 mg po  
Diazepam 5 mg po  
Lidocaine patch –up to 3 patches to painful areas –remove after 12 hrs  
Gabapentin 300 mg po (age >65 yo or BW <70 kg or concerns for somnolence/naive to med) OR gabapentin 600 mg po  
Bupivacaine 0.5% OR lidocaine 1% 1-2 mL trigger point injection |
| **Acute on Chronic Radicular Lower Back Pain**   | Acetaminophen 1,000 mg po  
Ibuprofen 400mg po OR ketorolac 15 mg IV/IM  
Muscle relaxant (Choose one)  
Cyclobenzaprine 5 mg po (age >65 yo or BW <70 kg or concerns for somnolence) OR Cyclobenzaprine 10 mg po  
Diazepam 5 mg po  
Lidocaine patch –up to 3 patches to painful areas –remove after 12 hrs  
Gabapentin 300 mg po (age >65 yo or BW <70 kg or concerns for somnolence/naive to med) OR gabapentin 600 mg po  
Dexamethasone 8 mg IV  
Bupivacaine 0.5% OR lidocaine 1% 1-2 mL trigger point injection  
Ketamine 500 mg/250 mL: 0.3 mg/kg bolus over 10 minutes, then 1.7 mcg/kg/min infusion |
| **Headache/Migraine**                           | Metoclopramide 10mg PO/IV  
0.9% Sodium chloride 1,000 mL bolus  
Acetaminophen 1,000 mg po  
Ibuprofen 400mg po OR ketorolac 15 mg IV/IM  
Bupivacaine 0.5% OR lidocaine 1% 1-2 mL cervical or trapezius trigger point injection  
Lidocaine 4% Intranasal 0.5 mL  
If <50% pain relief to above:  
Magnesium 1gm IV over 60 minutes  
Valproic acid 500mg IV over 20 minutes  
Dexamethasone 4-8 mg IV  
If <50% pain relief to above:  
Haloperidol 2.5-5 mg IV |
| **Extremity Fracture or Joint Dislocation**     | Ketamine intranasal (50 mg/mL) 0.5 mg/kg (maximum 50 mg) x 1  
Acetaminophen 1,000 mg PO  
Ultrasound guided regional anesthesia peri-neural infiltration  
Lidocaine 0.5% (max 5 mg/kg) OR Ropivacaine 0.5% (max 3 mg/kg) |
Appendix C: Pain Management Orders: Surgery

Preoperative Orders (1 hr prior to surgery):
  Acetaminophen 1,000 mg po
  Gabapentin 300 mg po

Intraoperative Orders (at conclusion of surgery):
  Ketorolac 15-30 mg x 1

Postoperative Orders:
  Acetaminophen 1g PO q 8 hours
  Ketorolac 15-30 mg IV q 6-8 hours OR Ibuprofen 400 mg q 8 hours
  Lidocaine patch every 12 hours near incision site
  PRN:
  Tramadol 50 mg q 6 hours Prn for mild to moderate pain
  Oxycodone 5 mg PO q 4 hours PRN for moderate to severe pain
  Hydromorphone 0.5 mg IV q 2 hours PRN for breakthrough pain

Colorectal Surgery:
  In addition to above, consider intraoperative
  Ketamine 10-35 mg IV x 1, then 4-10 mg/hr
  Lidocaine 100 mg IV x 1, then 2-3 mg/min

*Drug allergies, contraindications, previous treatments, and drug-drug interactions must be considered prior to treatment*
## Appendix D: Opioid Screening Tools and Protocols for Withdrawal Management

NIDA Modified Scale – To be completed on admission

**Substance Involvement Screening (National Institute on Drug Abuse):**

**Screening Question:**

- In the past year, have you used illegal drugs or prescription drugs for non-medical reasons? (Screen in EMR)

- If YES, ask the questions below about each drug

In your **LIFETIME** have you ever used the following NOT PRESCRIBED BY YOUR DOCTOR?

<table>
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<tr>
<th>Circle responses – If A is no, move to next drug If A is yes, proceed across with questions</th>
<th>A: Ever used in lifetime?</th>
<th>Past 3 months used?</th>
<th>Past 3 months desire to use?</th>
<th>Past 3 months, use has led to health, social, legal, or financial problems?</th>
<th>Past 3 months, failed to do what was expected due to use?</th>
<th>Has a friend or relative expressed concern about use?</th>
<th>Have you ever tried and failed to control, cut down or stop using?</th>
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<tbody>
<tr>
<td>Cannabis (marijuana, pot, grass, hash)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>1-2 x 2</td>
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<td>Monthly 5</td>
<td>Monthly 6</td>
<td>Monthly 7</td>
<td>Monthly 8</td>
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<tr>
<td>Cocaine (coke, crack)</td>
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<td>No</td>
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<td>Monthly 5</td>
<td>Monthly 6</td>
<td>Monthly 7</td>
<td>Monthly 8</td>
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<tr>
<td>Prescription stimulants (Ritalin, Adderall, diet pills)</td>
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<td>Prescription opioids (fentanyl, oxycodone, methadone, buprenorphine)</td>
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<td>Other (Specify)</td>
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<td>8</td>
<td>Daily</td>
<td>6</td>
<td>Daily</td>
<td>6</td>
</tr>
</tbody>
</table>
| **Advise** about patient’s drug use: | • Recommend quitting  
| • Explain consequences of drug use |
| **Assess** readiness to quit | • Is the patient willing to engage in additional behavioral health therapies?  
  o Yes- requires outpatient MAT or inpatient treatment? **Arrange**  
  o Yes- does not require outpatient MAT or inpatient treatment? **Assist**  
  o No – offer best advice; revisit and offer additional therapies at each encounter |
| **Assist in making a change** | • Formulate a plan  
| • Offer Community Resources  
  o Manatee County Resources:  
    ▪ Centerstone: Inpatient and Outpatient Treatment (941-782-4617)  
    ▪ Operation PAR (MAT): 941-7453-0877 – walk in treatment M-F 0530-1000; Consultation fee $30, then $84 for initial treatment period. Time to treatment: 1-3 days  
    ▪ First Step: Medically supervised detoxification; inpatient and outpatient services (941-366-5333)  
    ▪ Peer to Peer recovery (free of charge): 941-444-7772 – referral can be made 24 hrs/day  
    ▪ Suncoast Behavioral Health:  
    ▪ AA/NA Meetings: https://yourlifemattersproject.org/aa-na-meetings/  
| • Consider necessary support for vocational training, housing, transportation, food, and legal support  
| • Schedule follow up (1-2 weeks) |
| **Arrange** specialty treatment | • Outpatient medication assisted treatment  
| • Inpatient treatment  
| • Referral Process |

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Clinical Opiate Withdrawal Scale

The Clinical Opiate Withdrawal Scale combines objective and subjective items and can be administered multiple times in a day.

For each item, write in the number that best describes the patient's signs or symptom. Rate each section on just the apparent relationship to opiate withdrawal, not a known medical diagnosis. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.
| Resting Pulse Rate (Beats per Minute) | 0=pulse rate 80 or below  
1=pulse rate 81-100  
2=pulse rate 101-120  
4=pulse rate greater than 120 | Score |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Sweating | 0=no report of chills or flushing  
1=subjective report of chills or flushing  
2=flushed or observable moistness on face  
3=beads of sweat on brow or face  
4=sweat streaming off face | Score |
| Over past ½ hour not accounted for by room temperature or patient activity | | |
| Restlessness | 0=able to sit still  
1=reports difficulty sitting still, but is able to do so  
3=frequent shifting or extraneous movements of legs/arms  
5=Unable to sit still for more than a few seconds | Score |
| Observation during assessment | | |
| Pupil size (Assessment) | 0=pupils pinned or normal size for room light  
1=pupils possibly larger than normal for room light  
2=pupils moderately dilated  
5=pupils so dilated that only the rim of the iris is visible | Score |
| 0=pupils pined or normal size for room light  
1=pupils possibly larger than normal for room light  
2=pupils moderately dilated  
5=pupils so dilated that only the rim of the iris is visible | | |
| Bone or Joint aches | 0=not present  
1=mild diffuse discomfort  
2=patient reports severe diffuse aching of joints/ muscles  
4=patient is rubbing joints or muscles and is unable to sit still because of discomfort | Score |
| If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored | | |
| Runny nose or tearing | 0=not present  
1=nasal stuffiness or unusually moist eyes  
2=nose running or tearing  
4=nose constantly running or tears streaming down cheeks | Score |
| Not accounted for by cold symptoms or allergies | | |
| GI Upset | 0=no GI symptoms  
1=stomach cramps  
2=nausea or loose stool  
3=vomiting or diarrhea x1  
5=2 or more episodes of diarrhea or vomiting | Score |
| Only score over last ½ hour | | |
Tremor
- Observation of outstretched hands
  0 = No tremor
  1 = tremor can be felt, but not observed
  2 = slight tremor observable
  3 = gross tremor
  4 = gross tremor or muscle twitching
  Score:

Yawning
- Observation during assessment
  0 = no yawning
  1 = yawning once or twice during assessment
  2 = yawning three or more times during assessment
  3 = yawning several times/minute
  Score:

Anxiety or Irritability
  0 = none
  1 = patient reports increasing irritability or anxiousness
  2 = patient obviously irritable or anxious
  3 = patient so irritable or anxious that participation in the assessment is difficult
  Score:

Gooseflesh skin
  0 = skin is smooth
  3 = piloerection of skin can be felt or hairs standing up on arms
  5 = prominent piloerection
  Score:

Total score (sum of all 11 items):

Scoring Scale:
- 5-12 = mild
- 13-24 = moderate
- 25-36 = moderately severe
- more than 36 = severe withdrawal

Management of mild opioid withdrawal
- Drink 2-3 liters of water per day during withdrawal to replace fluids lost through perspiration and diarrhea.
- Provide vitamin B and vitamin C supplements.
- Symptomatic treatment and supportive care are usually sufficient for management of mild opioid withdrawal.
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia</td>
<td>Zolpidem</td>
<td>5 mg</td>
<td>By mouth</td>
<td>As required, before going to bed</td>
<td></td>
</tr>
<tr>
<td>Nausea and Vomiting</td>
<td>Ondansetron</td>
<td>4-8mg</td>
<td>By mouth</td>
<td>Q6h PRN</td>
<td>QT prolongation</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide</td>
<td>4mg initially then 2mg</td>
<td>By mouth</td>
<td>4mg initially then 2mg after each unformed stool up to a maximum of 16mg per day</td>
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</tr>
<tr>
<td>Headache</td>
<td>Acetaminophen</td>
<td>650-1,000 mg</td>
<td>By mouth</td>
<td>4 times per day as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ibuprofen</td>
<td>400mg</td>
<td>By mouth</td>
<td>3 times per day as required</td>
<td>Gastric ulcer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Gastritis</td>
</tr>
<tr>
<td>Agitation, anxiety and restlessness</td>
<td>Lorazepam</td>
<td>0.5 mg</td>
<td>By mouth</td>
<td>2-3 times per day, reducing over 3-5 days</td>
<td>Benzodiazepine withdrawal</td>
</tr>
<tr>
<td>Abdominal cramping</td>
<td>Dicyclomine</td>
<td>10 mg</td>
<td>By mouth</td>
<td>Every 6 hours as needed</td>
<td>Caution with renal or hepatic impairment</td>
</tr>
</tbody>
</table>
Management of moderate to moderately severe opioid withdrawal

- Continue symptomatic management for mild withdrawal
- Consider addition of clonidine, lofexidine, or opioid medications such as buprenorphine or methadone.
  - Buprenorphine and methadone treatment require additional licensing
  - Clonidine or lefexidine may assist with lessening symptoms if abrupt discontinuation of opioid therapy is required
Management of Opioid withdrawal using clonidine:

Clonidine is an alpha-2 adrenergic agonist. It can provide relief to many of the physical symptoms of opioid withdrawal including sweating, diarrhea, vomiting, abdominal cramps, chills, anxiety, insomnia, and tremor. It can also cause drowsiness, dizziness and low blood pressure. It is recommended as adjunct therapy for patients with a clinical opioid withdrawal score of ≤24. Patients with higher scores will likely require opioids to assist with withdrawal.

1. At any time during clonidine treatment, blood pressure falls below 90/60 or HR 60 bpm, treatment may be interrupted and/or dose reduction required
2. Obtain baseline blood pressure (sitting and standing) and heart rate before administering clonidine. Do not begin clonidine treatment if blood pressure < 90/60mmHg or HR <60 bpm
3. Day 1: Administer test dose of clonidine 0.1 mg (0.2 mg for patients >90 kg)
   a. Recheck blood pressure & HR 45 minutes after test dose
   b. If blood pressure and HR within parameters, may continue treatment
   c. If clinical opioid withdrawal score remains >8 after test dose, may administer clonidine 0.1 mg every 45 minutes up to 4 doses
   d. Clonidine every 6 hours based on symptoms

<table>
<thead>
<tr>
<th>Clinical Opioid Withdrawal Score</th>
<th>Clonidine dose</th>
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</thead>
<tbody>
<tr>
<td>8-12</td>
<td>0.1 mg (0.2 mg if &gt;90 kg)</td>
</tr>
<tr>
<td>&gt;12</td>
<td>0.2 mg (0.3 mg if &gt;90 kg)</td>
</tr>
<tr>
<td>&gt;24</td>
<td>Consider additional therapy</td>
</tr>
<tr>
<td>Maximum total dose (Day 1)</td>
<td>0.8 mg (1.2 mg if &gt;90 kg)</td>
</tr>
</tbody>
</table>

4. Day 2: Add total clonidine administered day 1 and divide evenly between four doses on day 2
5. Day 4-5: Consider beginning clonidine taper as withdrawal symptoms improve – clonidine cannot be immediately discontinued due to risk of rebound hypertension
   a. Reduce dose by 0.1-0.2 mg/day
Follow-up care after Withdrawal Management:

Acute opioid withdrawal is followed by a protracted withdrawal phase that lasts for up to six months and is characterized by a general feeling of reduced well-being and strong cravings for opioids. This craving often leads to relapse to opioid use. To reduce the risk of relapse, patients should be engaged in psychosocial interventions such as described later in these guidelines. Patients who repeatedly relapse following withdrawal management are likely to benefit from mediation assisted treatment (MAT).

All opioid dependent patients who have withdrawn from opioids should be advised that they are at increased risk of overdose due to reduced opioid tolerance. Should they use opioids, they should take preventative precautions which include using a smaller amount than usual to reduce the risk of overdose, not use in isolation in the event of unintended overdose, or have access to overdose-reversal medication such as naloxone.

Polysubstance Withdrawal Management:

Assessment for polysubstance withdrawal should be completed based on risk from NIDA screening. Many symptoms overlap with those of opioid withdrawal. Supportive care should be given for patients experiencing cannabis withdrawal and stimulant withdrawal. Benzodiazepine withdrawal requires medical management.
**Benzodiazepine Withdrawal Management:**

Benzodiazepine withdrawal may result in anxiety, tremor, insomnia, nausea, vomiting, hallucinations, seizure, and delirium. Gradual tapering over a period of months is required to avoid adverse events. Converting patients to longer acting benzodiazepines may improve withdrawal symptoms.

**Benzodiazepine equivalencies:**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Half life</th>
<th>Onset of Action</th>
<th>Route of Administration</th>
<th>Equivalent Dosages (Lorazepam Equivalence)</th>
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<tr>
<td>lorazepam (Ativan)</td>
<td>12-14 hrs</td>
<td>2-3 minutes</td>
<td>Oral, IM, IV</td>
<td>1 mg</td>
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<tr>
<td>chlordiazepoxide</td>
<td>24-48 hrs</td>
<td>30 -60 min (time to peak)</td>
<td>Oral</td>
<td>25 mg</td>
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<td>(Librium)</td>
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<tr>
<td>oxazepam (Serax)</td>
<td>~8.2 hrs</td>
<td>180 min (time to peak)</td>
<td>Oral</td>
<td>30 mg</td>
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<tr>
<td>diazepam (Valium)</td>
<td>~30-40 hrs</td>
<td>4-5 minutes</td>
<td>Oral, IV, IM</td>
<td>5 mg</td>
</tr>
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Appendix E: Provider Education Presentations Available upon request to authors identified.
Appendix F: Patient Education on Discharge

Rx Pain Medications
Know the options • Get the facts

Treating Overdose with Naloxone

Naloxone is an antidote to opioid overdose and is available as an injection or pre-filled auto-injection or intranasal device. If you have been given a naloxone device, you should:

✓ Keep the device on you at all times in case of opioid overdose.
✓ Pay attention to the expiration date.
✓ Call your prescribing health care provider if you have a naloxone vial for injection and the liquid looks discolored or has particles.

Be sure family members/caregivers/other you are close to know the following. Learn more in the Opioid Overdose Prevention Toolkit.

✓ Know how to tell if you are experiencing an overdose.
✓ Know where you have the naloxone and how
✓ Call 9-1-1 in case of overdose and know what to do when waiting for emergency professionals.


Many states have expanded access to naloxone,4-6 making it available to people who may witness an overdose—including law enforcement, family members, and caregivers.6 Laws about naloxone use and administration vary from state to state.7,8 Please check your local state laws.

Signs of overdose, which often results in death if not treated, include:

• Extreme sleepiness, inability to wake verbally or upon sternal rub.
• Breathing problems that can range from slow to shallow breathing in a patient who cannot be awakened.
• Fingernails or lips turning blue or purple.
• Extremely small “pinpoint” pupils.
• Slow heartbeat and/or low blood pressure.


SMA-17-5053-13
Key Elements of the Plan:

1. Patient Education

- **Informing** patients of outcomes and procedures
- **Educating** on opioids and side effects
- **Demonstrating** how to counteract the outbursts

### Discussing Pain Management with Patients

- MMH is committed to providing excellent care for patients while hospitalized including keeping patients comfortable
  - Avoiding all pain is not always possible or to be expected
  - Minimizing pain and keeping it at a tolerable is the goal
- Pain can be treated in a variety of ways
  - Non-medications
    - Acetaminophen (Tylenol®)
    - NSAIDs – ibuprofen, ketorolac
    - Topical analgesics (lidocaine patches)
    - Gabapentin, pregabalin (Lyrica®)
  - Opioids
    - CDC recommends to be used as second line agents for chronic pain
    - Use only when risks outweigh benefits
    - Use the lowest dose possible for the shortest course possible
    - Oral agents provide the same analgesia as IV agents.
- It is important to ensure that patients receive appropriate education regarding pain control. Informing patients of shortages of opioids is not appropriate.
Key Elements of the Plan:

1. Hospital Prescriber Interventions

- Use of Alternative Agents
  - Focus on renal colic, low back pain, headache, muscle strain, fracture
- Limit discharge prescriptions to 3 days
- Use of Prescription Monitoring Program (PMP) system
- Enhanced patient education regarding prescriptions
- Use of Health Information Exchange (HIE)
3. Inpatient Substance Withdrawal Action Team (SWAT)

- Screenings done on presentation
- Patient admissions based on a consequence of their drug use are placed in program
- The implementation of a risk screening tool is advised and should be incorporated into the electronic medical record.
4. Post Hospitalization Support

- Community paramedicine program
- PeeCase management
- Transition to Peer Counseling

- Post Hospitalization support - Care Transitions
- Understand Behavioral Health component
- Methadone Clinic or other MAT clinic
- Mental Health Counselors in Urgent Care Centers and FEDs
The Florida Experience

Reduced Emergency Care Center Opioid Use by 40%
Reduced ECC Discharge Prescriptions by 64%

**MMH Opioid Stewardship**

**Monthly Summary 2018-2019**

**ECC Opioid Stewardship Initiative**

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<th>Nov</th>
<th>Dec</th>
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</thead>
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<td>899</td>
<td>741</td>
<td>670</td>
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<td>654</td>
<td>698</td>
<td>586</td>
<td>745</td>
<td>686</td>
<td>728</td>
<td>828</td>
<td>10,294</td>
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<tr>
<td>All Med Doses</td>
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<td>9,499</td>
<td>8,947</td>
<td>8,655</td>
<td>8,002</td>
<td>7,555</td>
<td>8,213</td>
<td>7,767</td>
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<td>9,404</td>
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<tr>
<td>Opioid %</td>
<td>11.32%</td>
<td>9.46%</td>
<td>8.28%</td>
<td>7.74%</td>
<td>8.62%</td>
<td>8.66%</td>
<td>8.50%</td>
<td>7.54%</td>
<td>8.22%</td>
<td>7.79%</td>
<td>7.74%</td>
<td>8.09%</td>
<td>8.72%</td>
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<tr>
<td>NSAID/APAP Doses</td>
<td>1,697</td>
<td>1,732</td>
<td>1,756</td>
<td>1,742</td>
<td>1,557</td>
<td>1,496</td>
<td>1,679</td>
<td>1,713</td>
<td>1,907</td>
<td>1,910</td>
<td>1,963</td>
<td>2,119</td>
<td>23,424</td>
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<tr>
<td>NSAID/APAP %</td>
<td>18.59%</td>
<td>18.23%</td>
<td>19.63%</td>
<td>20.13%</td>
<td>19.46%</td>
<td>19.83%</td>
<td>20.44%</td>
<td>22.05%</td>
<td>21.71%</td>
<td>21.68%</td>
<td>20.87%</td>
<td>20.70%</td>
<td>19.85%</td>
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<tr>
<td>Opioid dc Rx #</td>
<td>394</td>
<td>257</td>
<td>210</td>
<td>156</td>
<td>140</td>
<td>139</td>
<td>132</td>
<td>126</td>
<td>118</td>
<td>124</td>
<td>143</td>
<td>129</td>
<td>2068</td>
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<td>OP Patient Visits</td>
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<td>5,695</td>
<td>5,429</td>
<td>5,343</td>
<td>4,781</td>
<td>5,032</td>
<td>5,060</td>
<td>5,466</td>
<td>5,591</td>
<td>5,737</td>
<td>5,660</td>
<td>5,801</td>
<td>71,166</td>
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<tr>
<td>Opioid dc Rx %</td>
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<td>4.5%</td>
<td>3.9%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.6%</td>
<td>2.3%</td>
<td>2.1%</td>
<td>2.3%</td>
<td>2.5%</td>
<td>2.2%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total Visits</td>
<td>9,541</td>
<td>7,069</td>
<td>6,704</td>
<td>6,621</td>
<td>6,023</td>
<td>6,205</td>
<td>6,237</td>
<td>6,589</td>
<td>6,917</td>
<td>6,662</td>
<td>7,087</td>
<td>7,270</td>
<td>67,080</td>
</tr>
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</table>

**Inpatient Opioid Stewardship Initiative**

<table>
<thead>
<tr>
<th></th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan 2019</th>
<th>YTD</th>
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</thead>
<tbody>
<tr>
<td>Methadone MME/APD</td>
<td>0.88</td>
<td>6.36</td>
<td>8.87</td>
<td>8.36</td>
<td>0.95</td>
<td>4.9</td>
<td>7.46</td>
<td>7.03</td>
<td>2.64</td>
<td>6.3</td>
<td>2.36</td>
<td>0.92</td>
<td>5.38</td>
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<tr>
<td>Adjusted Pt days</td>
<td>10,834</td>
<td>11,723</td>
<td>11,253</td>
<td>11,338</td>
<td>10,864</td>
<td>9,901</td>
<td>10,170</td>
<td>9,745</td>
<td>10,664</td>
<td>10,483</td>
<td>11,122</td>
<td>11,667</td>
<td>129,854</td>
</tr>
<tr>
<td>All Providers; ED Orders Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Opioid Doses</td>
<td>1,167</td>
<td>1,040</td>
<td>867</td>
<td>740</td>
<td>787</td>
<td>714</td>
<td>778</td>
<td>713</td>
<td>845</td>
<td>770</td>
<td>807</td>
<td>992</td>
<td>11,555</td>
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<tr>
<td>All Med Doses</td>
<td>10,889</td>
<td>11,437</td>
<td>10,524</td>
<td>9,522</td>
<td>9,272</td>
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<td>9,047</td>
<td>9,170</td>
<td>9,951</td>
<td>9,707</td>
<td>10,311</td>
<td>11,876</td>
<td>132,705</td>
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<tr>
<td>Opioid %</td>
<td>10.72%</td>
<td>9.09%</td>
<td>8.24%</td>
<td>7.77%</td>
<td>8.49%</td>
<td>8.65%</td>
<td>8.60%</td>
<td>7.78%</td>
<td>8.48%</td>
<td>7.93%</td>
<td>7.83%</td>
<td>8.35%</td>
<td>8.71%</td>
</tr>
<tr>
<td>NSAID/APAP Doses</td>
<td>1,435</td>
<td>1,953</td>
<td>1,911</td>
<td>1,889</td>
<td>1,670</td>
<td>1,627</td>
<td>1,849</td>
<td>1,965</td>
<td>2,142</td>
<td>2,101</td>
<td>2,118</td>
<td>2,291</td>
<td>25,042</td>
</tr>
<tr>
<td>NSAID/APAP %</td>
<td>13.18%</td>
<td>17.08%</td>
<td>18.16%</td>
<td>19.84%</td>
<td>18.01%</td>
<td>19.71%</td>
<td>20.44%</td>
<td>21.43%</td>
<td>21.50%</td>
<td>21.64%</td>
<td>20.54%</td>
<td>19.29%</td>
<td>18.87%</td>
</tr>
<tr>
<td>Naloxone Use (doses)</td>
<td>37</td>
<td>66</td>
<td>33</td>
<td>39</td>
<td>38</td>
<td>30</td>
<td>33</td>
<td>21</td>
<td>28</td>
<td>44</td>
<td>34</td>
<td>18</td>
<td>421</td>
</tr>
</tbody>
</table>

Opioids include hydrocodone, hydromorphone, morphine, and oxycodone containing products. The focus is to review medications typically used for pain and not for procedural sedation (fentanyl).
Future Considerations

• **Incarcerated Individuals:**
  • Vivitrol + therapy available in jail for inmates with opioid-use disorder
  • Continuation of MAT inside jail
  • Firm coordination of continued treatment for inmates released to community care
  • Coordination to occur prior to release
• **Medication Assisted Treatment** (Methadone or Suboxone)
  • Outpatient Treatment
  • Ambulatory Detox Ensure providers are conducting therapy/counseling
• Develop a continuum of services that engage individuals in community settings – not all services that require those in need of treatment to “go to” office-based care (it doesn’t always work)
Future Considerations

- LCSW or LMHC (Social workers/Mental Health Counselors) available to support physicians prescribing Suboxone in offices
  - Support expansion of more patients to be served by Suboxone - $$ and Waiver
  - Suboxone is a prescription medication that combines buprenorphine and naloxone. It’s used to treat opioid addiction. (Heroin and narcotic painkillers are common opioid drugs.) Buprenorphine belongs to a class of drugs called opioid partial agonists, which help relieve symptoms of opiate withdrawal
  - Equip practitioners with access to an Addictions Certified Psychiatrist to round with physicians to safely titrate patients off narcotics (benzos and opioids)

- Peer Services
  - Hire AND certify Peer Recovery Workforce like Peer Coaches to be at ER or in high-drug use zones

- Naloxone –
  - Have naloxone in public spaces and trained to administer where First Aid kits are often found, and where folks may overdose

- Discuss Harm Reduction Approaches and De-Stigmatizing use
  - Foster understanding that although a person may not successfully complete one-type of treatment (i.e. Methadone, Suboxone, Vivitrol), they may need to try again with more counseling/therapy OR try a new medication (similar to blood pressure meds – they don’t all work equally for individuals).
  - This is IMPORTANT for folks to understand who are not SUD professionals.

- Partnership
  - Work with leaders in education, law enforcement, treatment, oversight (DCF), and funders to collaboratively develop strategies in partnerships
  - Host regional summits – multiagency approach to problem with legislative support
Clinical Evidence-Based Practices for Substance Use Disorder

- MAT in Jail
- MAT Detox or Induction
- Long-Term Treatment OPTIONS
- MAT Choices & Affordable
- Harm Reduction vs. Abstinence
- Take-Home Naloxone (Narcan)
- ALTO: CBT or Non-Opioid Rx
- Pain Management OR Integrated Care
- Peer Coach Services
- Voluntary vs. Marchman Act
- Pain, Depression & Anxiety

SUD

Pain, Depression & Anxiety

Voluntary vs. Marchman Act

Peer Coach Services

Take-Home Naloxone (Narcan)

Harm Reduction vs. Abstinence

MAT Choices & Affordable

MAT in Jail

MAT Detox or Induction

Long-Term Treatment OPTIONS

SUD
The Florida Experience

ATTORNEY GENERAL’S OPIOID WORKING GROUP

FLORIDA’S OPIOID EPIDEMIC: RECOMMENDATIONS & BEST PRACTICES

MARCH 1, 2019

Media Publication and Public Information Resource

January 2017
The Florida Experience

Opioid Use Disorder Prevention: A Community Based Approach

Date: Friday, March 22nd
Time: 1:00-4:00 PM
Location: Manatee Memorial Hospital
206 Second Street East, Bradenton FL 34208
Room: Manatee Auditorium
Capacity: 85

Panel discussions including, Law Enforcement, Healthcare Leadership, and County Administrators:

Topics included: ALTO Program, Peer to Peer, Grants, Taskforce, ED Physicians, Surgeons, Pharmacists, Nurses and Leaders sharing the Opioid Prevention Measures and Alternatives

Register online at: https://manatee-memorial-hospital.doodle.com/poll/qi8xxzmf7tcpk2e8
1. **Initiate** Task Force with all disciplines to develop recommendations for a coordinated statewide action plan to combat the crisis

2. **Expansion** of treatment availability including Medication-Assisted Treatment (MAT); increased funding to accomplish this goal

3. **Enhanced** penalties for drug trafficking of opioids

5. **Expanded** training for first responders, law enforcement, addiction treatment professionals, and health professionals in opioid prescribing, overdose prevention, and MAT

6. **Create** a bridge between patients treated in hospital emergency departments for overdoses and referrals for substance use disorder treatment

7. **Continue** Public awareness initiatives to inform public and reduce stigma

8. **Improve** reporting of data/utilization of data to guide state response, better target resources, and improve efficiency
This toolkit is designed to support your organization with the building blocks for a successful pain management and addiction prevention program.
Raise the Bar for Each County in Florida

- **Organize** multiagency taskforce
- **Implement** ALTO program using toolkit to kick start the program
- **Expand funding for** Peer to Peer program
- **Fund** Licensed Therapists in ED’s, UCC’s, FED’s
- **Host** Regional Summits with Panel discussion approach
- **Share** up to date data on number and types of prescriptions by prescriber from hospitals, ED’s, Dentist offices, UCC’s, FED’s, and Private Offices
ALTO℠

Alternatives to Opioids
ALTO<sup>SM</sup>
Alternatives to Opioids

Acute Pain Protocols: St. Joseph’s Hospital, New Jersey

- Renal Colic
- Musculoskeletal Pain
- Radiculopathy
- Migraine Headache
- Extremity Fracture/Dislocation

Decreased opioids by 57% in the first year

https://www.stjosephshealth.org/clinical-focuses/item/1861
ALTO – Renal Colic

- Ketorolac 15mg IV
- Acetaminophen 1,000 mg po
- 0.9% Sodium chloride 1,000 mL bolus
- Lidocaine 200mg/100 mL infusion 1.5 mg/kg over 10 minutes (max 200 mg)
Lidocaine IV

- Superior pain scores compared to morphine at 5, 10, 15, and 30 minutes post-administration
- No difference in adverse events
- Precautions:
  - Allergy to lidocaine or other amide anesthetics
  - Seizure
  - History of CAD, structural or valvular heart disease, arrhythmia
  - Cardiac monitoring

Solemanipour 2012
• Acetaminophen 1,000 mg po
• Ibuprofen 400mg po OR ketorolac 15 mg IV/IM
• Muscle relaxant
  • Cyclobenzaprine 5 mg po (age >65 yo or BW <70 kg or concerns for somnolence) OR Cyclobenzaprine 10 mg po
• Lidocaine patch – up to 3 patches to painful areas – remove after 12 hrs
• Gabapentin 300 mg po (age >65 yo or BW <70 kg or concerns for somnolence/naïve to med) OR gabapentin 600 mg po
• Bupivacaine 0.5% OR lidocaine 1% 1-2 mL trigger point injection
Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians *

Article, Author, and Disclosure Information
ALTO – Acute Back Pain

Non-Pharmacologic Treatment
Heat, massage

Pharmacologic Treatment
NSAID, muscle relaxants

Qaseem, 2017
ALTO – Radicular Back Pain

- Acetaminophen 1,000 mg po
- Ibuprofen 400 mg po OR ketorolac 15 mg IV/IM
- Muscle relaxant (Choose one)
  - Cyclobenzaprine 5 mg po (age >65 yo or BW <70 kg or concerns for somnolence) OR Cyclobenzaprine 10 mg po
  - Lidocaine patch – up to 3 patches to painful areas – remove after 12 hrs
- Gabapentin 300 mg po (age >65 yo or BW <70 kg or concerns for somnolence/naïve to med) OR gabapentin 600 mg po
- Dexamethasone 8 mg IV
- Bupivacaine 0.5% OR lidocaine 1% 1-2 mL trigger point injection
- Ketamine 500 mg/250 mL: 0.3 mg/kg bolus over 10 minutes, then 1.7 mcg/kg/min infusion
ALTO – Radicular Back Pain

- Corticosteroids-
  - Dexamethasone 8 mg IV x 1 vs Placebo
    - Improvement in mobility (leg raise angle 20.2° vs. 5.5°) and ED LOS (18.8 vs 3.5 hrs)
  - Adverse events
    - Hyperglycemia, facial flushing, infection, GI bleeding

Balakrishnamoorthy, 2015
Ketamine

- Endorsed by the American College of Emergency Physicians for a variety of pain syndromes
- Evidence supports effective pain control with reduction or elimination of opioid use
### 1.1.1 Ketamine vs Placebo

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Ketamine Mean</th>
<th>Ketamine SD</th>
<th>Ketamine Total</th>
<th>Ketamine Mean</th>
<th>Ketamine SD</th>
<th>Ketamine Total</th>
<th>Std. Mean Difference</th>
<th>IV. Random, 95% CI</th>
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<tbody>
<tr>
<td>Beaudoin, F.L. L 2014</td>
<td>-4.0</td>
<td>7.0442</td>
<td>20</td>
<td>-2</td>
<td>3.5221</td>
<td>20</td>
<td>37.9%</td>
<td>-0.35 [-0.98, 0.27]</td>
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<td>Galinski, M. 2007</td>
<td>34.1</td>
<td>23.9717</td>
<td>33</td>
<td>39.5</td>
<td>19.6928</td>
<td>32</td>
<td>62.1%</td>
<td>-0.24 [-0.73, 0.25]</td>
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</tbody>
</table>

Subtotal (95% CI) 53

Heterogeneity: Tau² = 0.00; Chi² = 0.07, df = 1 (P = 0.79); I² = 0%

Test for overall effect: Z = 1.45 (P = 0.15)

### 1.1.2 Ketamine vs Morphine

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Ketamine Mean</th>
<th>Ketamine SD</th>
<th>Ketamine Total</th>
<th>Ketamine Mean</th>
<th>Ketamine SD</th>
<th>Ketamine Total</th>
<th>Std. Mean Difference</th>
<th>IV. Random, 95% CI</th>
</tr>
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<tbody>
<tr>
<td>Jennings, P.A. 2012</td>
<td>-5.6</td>
<td>2.5163</td>
<td>70</td>
<td>-3.2</td>
<td>2.0179</td>
<td>65</td>
<td>34.9%</td>
<td>-1.04 [-1.40, -0.68]</td>
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<tr>
<td>Miller, J.P. 2014</td>
<td>-3.3</td>
<td>2.605</td>
<td>24</td>
<td>-3.2</td>
<td>2.4165</td>
<td>21</td>
<td>31.0%</td>
<td>-0.04 [-0.62, 0.55]</td>
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<td>Motov, S. 2015</td>
<td>4.1</td>
<td>3.2</td>
<td>45</td>
<td>3.9</td>
<td>3.1</td>
<td>45</td>
<td>34.1%</td>
<td>0.06 [-0.35, 0.48]</td>
</tr>
</tbody>
</table>

Subtotal (95% CI) 139

Heterogeneity: Tau² = 0.41; Chi² = 18.15, df = 2 (P = 0.0001); I² = 89%

Test for overall effect: Z = 0.90 (P = 0.37)

### 1.1.3 Ketamine vs Fentanyl

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Ketamine Mean</th>
<th>Ketamine SD</th>
<th>Ketamine Total</th>
<th>Ketamine Mean</th>
<th>Ketamine SD</th>
<th>Ketamine Total</th>
<th>Std. Mean Difference</th>
<th>IV. Random, 95% CI</th>
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<td>Messenger, D.W. 2008</td>
<td>2.1</td>
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<td>32</td>
<td>2.3</td>
<td>2</td>
<td>31</td>
<td>100.0%</td>
<td>-0.09 [-0.59, 0.40]</td>
</tr>
</tbody>
</table>

Subtotal (95% CI) 32

Heterogeneity: Not applicable

Test for overall effect: Z = 0.37 (P = 0.71)
Ketamine

• Single dose or infusion
  0.1-0.3 mg/kg over 10-20 minutes
  0.15-0.2 mg/kg/hr

• Do not use if patient with chest pain, facial trauma or eye injury, schizophrenia/bipolar history, < 3 months

• Caution if planned procedure that will stimulate posterior pharynx (bronchoscopy), history of ischemic heart disease, heart failure

ACEP 2017
• **Adverse Events**
  • Nystagmus
  • Blurred vision
  • Confusion
  • Hallucinations
  • Hypertension/tachycardia (more common)
  • Hypotension/bradycardia
  • Laryngospasm
  • Nausea/vomiting (give with ondansetron in pediatric patients)
  • Hypersalivation
Ketamine

- **Drug Interactions**
  - CNS depressants – monitor for enhanced effects
  - Substrate of CYP2B6, CYP2C9, CYP3A4
• Metoclopramide 10mg PO/IV
• 0.9% Sodium chloride 1,000 mL bolus
• Acetaminophen 1,000 mg po
• Ibuprofen 400mg po OR ketorolac 15 mg IV/IM
• Bupivacaine 0.5% OR lidocaine 1% 1-2 mL cervical or trapezius trigger point injection
• Lidocaine 4% Intranasal 0.5 mL

If <50% pain relief to above:
• Magnesium 1gm IV over 60 minutes
• Valproic acid 500mg IV over 20 minutes
• Dexamethasone 4-8 mg IV

If <50% pain relief to above:
• Haloperidol 2.5-5 mg IV
ALTO – Extremity Fracture

• Ketamine intranasal (50 mg/mL) 0.5 mg/kg (maximum 50 mg) x 1
• Acetaminophen 1,000 mg PO
• Ultrasound guided regional anesthesia peri-neural infiltration
  Lidocaine 0.5% (max 5 mg/kg) OR Ropivacaine 0.5% (max 3 mg/kg)
The Florida Experience Monitoring Outcomes

**35-40% Reduction in ECC Opioid Use Rate**

**60% Reduction in d/c Opioid Rx**

*Includes hydrocodone, hydromorphone, morphine, oxycodone
Baseline opioid use: 13%*
What if an opioid is needed?

- Appropriate stewardship and education are necessary
- Use the appropriate dose & duration of therapy
  - Evaluate side effects and drug interactions
- Don’t forget adjunct therapy
- Educate the patient
Pain medications should be safely stored and properly disposed.

**STORAGE:** Store pain medication safely and securely—away from people and pets. Avoid using common storage areas such as bathroom medicine chests, kitchen cabinets or bedroom night stands.

**DISPOSAL:** Always read and follow the disposal instructions on the drug label.

*Ask your provider about other options to treat your chronic pain.*

Be involved, keep your health care team updated on how your treatment is going.

*https://archive.epa.gov/region02/capp/web/pdf/ppcplyer.pdf

---

**Your prescribed medications must not be shared!**

**Common reasons why people share:***

- Failing to provide
drug information
- Sharing
- Taking
- Missing
- Endangering
- Not being about your medicine

**If your community does not offer a drug take-back program, follow these steps:**

1. Mix medicines with a substance that can't be eaten such as dirt, kitty litter or used coffee grounds—don't crush tablets or capsules.
2. Place the mixture in a plastic container or bag, and tightly seal.
3. Throw the container in your household trash.
4. Scratch out and make unreadable all personal information on the prescription label of your empty pill bottle or medicine packaging, and throw these items in your household trash.

---

# Patient Education

<table>
<thead>
<tr>
<th>Common side effects</th>
<th>Serious side effects of chronic opioid use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea/vomiting</td>
<td>Cardiac abnormalities, including prolonged QTc and torsades de pointes[^56]</td>
</tr>
<tr>
<td>Constipation</td>
<td>Sudden cardiac death with the concomitant use of benzodiazepines and methadone[^57]</td>
</tr>
<tr>
<td>Pruritus</td>
<td>Hormonal disruptions, including decreased testosterone in males[^58]</td>
</tr>
<tr>
<td>Euphoria</td>
<td>Decreased luteinizing hormone, follicle-stimulating hormone, and fertility in women[^59]</td>
</tr>
<tr>
<td>Respiratory depression, particularly with the simultaneous use of alcohol, benzodiazepines, antihistamines, muscle relaxants, or barbiturates</td>
<td>Musculoskeletal compromise, including an increased risk of osteoporosis[^60]</td>
</tr>
<tr>
<td>Lightheadedness</td>
<td>Immunosuppression[^61]</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>Inhibition of cellular immunity via delta and kappa receptors[^62]</td>
</tr>
</tbody>
</table>

[^56]: Cardiac abnormalities, including prolonged QTc and torsades de pointes[^56] |
[^57]: Sudden cardiac death with the concomitant use of benzodiazepines and methadone[^57] |
[^58]: Hormonal disruptions, including decreased testosterone in males[^58] |
[^59]: Decreased luteinizing hormone, follicle-stimulating hormone, and fertility in women[^59] |
[^60]: Musculoskeletal compromise, including an increased risk of osteoporosis[^60] |
[^61]: Immunosuppression[^61] |
[^62]: Inhibition of cellular immunity via delta and kappa receptors[^62] |
[^63]: Hyperalgesia (ie, upregulation of receptors and increased tolerance)[^63] |
[^64]: Sleep disturbances (eg, shortened deep sleep cycle)[^64] |
[^65]: Delayed or inhibited gastric emptying, increased sphincter tone, and blockade of peristalsis[^65]
I am able to confidently recommend adjunct and alternative therapies to opioids for pain management

a. Strongly agree
b. Agree
c. Disagree
d. Strongly disagree
Treatment Resources for Opioid Dependence and Substance Use Disorder

- Identify at-risk patients
  - PDMP Narx assessment
  - Inpatient Assessment
- Provide support for low to moderate risk patients
- Provide intervention for moderate to high risk patients
- Naloxone education and distribution
Opioids are often taken in larger amounts or over a longer period of time than intended.

There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.

Craving, or a strong desire to use opioids.

Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.

Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
Opioid Use Disorder DSM-5 Criteria

1 point for each score between 1-5

- Important social, occupational or recreational activities are given up or reduced because of opioid use.
  - Recurrent opioid use in situations in which it is physically hazardous
  - Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.

* Tolerance, as defined by either of the following:
  - (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect
  - (b) markedly diminished effect with continued use of the same amount of an opioid

* Withdrawal, as manifested by either of the following:
  - (a) the characteristic opioid withdrawal syndrome
  - (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms
Patient Identification: Inpatient Screening

- Screenings done on presentation
- Admits based on a consequence of their drug use trigger immediate referral
- The implementation of a risk screening tool is advised and should be incorporated into the electronic medical record.
Screening Tool

NIDA Drug Screening Tool
NIDA-Modified ASSIST (NM ASSIST)

Clinician's Screening Tool for Drug Use in General Medical Settings

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In the past year, how often have you used the following?

| Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day) |
|-----------------------------|-----------------|-----------------|-----------------|-----------------|
| Never                       | Once or Twice   | Monthly         | Weekly          | Daily or Almost Daily |

| Tobacco Products            |
|-----------------------------|-----------------|-----------------|-----------------|-----------------|
| Never                       | Once or Twice   | Monthly         | Weekly          | Daily or Almost Daily |

| Prescription Drugs for Non-Medical Reasons |
|-------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Never                                    | Once or Twice   | Monthly         | Weekly          | Daily or Almost Daily |

| Illegal Drugs                 |
|------------------------------|-----------------|-----------------|-----------------|-----------------|
| Never                        | Once or Twice   | Monthly         | Weekly          | Daily or Almost Daily |

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https://www.drugabuse.gov/nmassist/step/0
Screening Tool

In your **LIFETIME** have you ever used the following **NOT PRESCRIBED BY YOUR DOCTOR**? Circle responses — if A. is no, move to next drug

<table>
<thead>
<tr>
<th>A. Ever used?</th>
<th>Past 3 months used?</th>
<th>Past 3 months desire to use?</th>
<th>Past 3 months, use has led to health, social, legal, or financial problems?</th>
<th>Past 3 months, failed to do what was expected due to use?</th>
<th>Has a friend or relative expressed concern about use?</th>
<th>Have you ever tried and failed to control, cut down or stop using?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis (marijuana, pot, grass, hash)</td>
<td>Yes</td>
<td>No</td>
<td>1-2 x</td>
<td>3</td>
<td>1-2 x</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td>1-2 x</td>
<td>3</td>
<td>1-2 x</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>3</td>
<td>Monthly</td>
<td>4</td>
<td>Monthly</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>4</td>
<td>Weekly</td>
<td>5</td>
<td>Weekly</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Daily</td>
<td>6</td>
<td>Daily</td>
<td>6</td>
<td>Daily</td>
<td>7</td>
</tr>
</tbody>
</table>

*Screens cannabis, cocaine, stimulants, inhalants, sedatives, opioids, hallucinogens, and ‘other’*

https://www.drugabuse.gov/nmassist/step/0
Screening Tool

Screening Tool

• **Advise**: Provide medical advice about drug use
  • Recommend cessation; discuss health risks
• **Assess** readiness to quit
• **Assist** patient in making change
  • Set goals, refer if needed,
• **Arrange** specialty treatment

Screening Tool

Substance Involvement Screening

- Admission related to Opioid Use Disorder (Infection, Overdose)
  - Activate Inpatient OUD Team

- Low Risk (Score 0-3)
  - Reinforce abstinence
  - Provide positive feedback

- Moderate Risk (Score 4-26)
  - Notify Provider
  - Advise, Assess, Assist

- High Risk (Score ≥27)
  - Notify Provider
  - Arrange Referral
  - Activate Inpatient OUD Team
Opioid Use Disorder Resources

First Step Addiction and Recovery Programs  [www.fsos.org](http://www.fsos.org)
- MAT program
- Peer 2 Peer Recovery Coaching Services

PAR services [www.operationpar.org/manatee](http://www.operationpar.org/manatee)

Centerstone [www.centerstone.org/addictionsfl](http://www.centerstone.org/addictionsfl)
- Inpatient treatment
- Outpatient treatment
- Naloxone kits – free to public – no prescription needed

Drug Free Manatee [www.drugfreemanatee.org](http://www.drugfreemanatee.org)
- Community resources & referrals

Suncoast Behavioral Health [www.suncoastbhc.com](http://www.suncoastbhc.com)
- Inpatient and partial hospitalization programs
Post Hospitalization Support

- Community paramedicine program
- Case management
- Post Hospitalization support - Care Transitions
  - Behavioral health component
  - Methadone Clinic or other MAT clinic
  - Mental Health Counselors in Urgent Care Centers and FEDs
Medication Assisted Treatment

- Methadone
  - Requires registration with a certified opioid treatment program (OTP)
  - Limited distribution
  - Prolonged QTc interval; drug interactions; risk for abuse and misuse

- Buprenorphine (may be combined with naloxone to deter injection)
  - Can be used outside of an OTP with a waiver
  - Variety of dose forms (Tablet, film, patch, injection/implant)

SAMHSA 2017
Naltrexone

- Opioid antagonist
- Approved for both opioid and alcohol dependence
- No regulatory requirements
- Recommend 14 days abstinence prior to start
- Available as an implant or oral
Lucemyra (Lofexidine)

- Central α-2 agonist
- Facilitates abrupt opioid discontinuation in adults by mitigating opioid withdrawal symptoms
- 0.18 mg -3 tablets (0.54 mg) QID at 5-6 hour intervals for up to 14 days
- Dose reduction should occur for significant or symptomatic hypotension or bradycardia
- Tapering of dosing at the end of treatment is required
Lucemyra (Lofexidine)

- Renal adjustment required for eGFR <90 mL/min
- Adverse events
  - Orthostatic hypotension (29-42%), bradycardia (24-32%), hypotension (30%)
  - Insomnia (51-55%), dizziness (19-23%), sedation (12-13%)
  - Xerostomia (10%)
- Precautions
  - Will increase opioid sensitivity – education required
  - QT prolongation
Drug Interactions

- Other anti-hypertensive agents
- Beta blockers & other agents causing bradycardia
- CNS Depressants
- CYP2D6 Inhibitors (may increase lofexidine exposure)
- Methadone (QTc-prolongation) – noted that methadone was used concurrently in studies but with ECG monitoring
- Other QTc prolonging agents
- Tricyclic antidepressants
Clonidine vs. Lofexidine

- Cochrane review
  - 2 trials with comparative data
- Clonidine and lofexidine show similar withdrawal symptoms throughout the study period for all trials
- Similar use of lorazepam adjunct
- Similar refractory insomnia
- More hypotension in the clonidine group (93% vs 57%)
- Dose omission due to hypotension higher in clonidine group (8.9% vs. 4.1%)

Gowing, 2016
Overdose Risk

- Offer naloxone for patients
  - History of overdose
  - Substance use disorder
  - ≥ 50 MME/day
  - Concurrent benzodiazepine use
  - Narx score ≥ 450 from PDMP

http://prescribetoprevent.org/patient-education/materials/
References


Thank you!