35th Annual JOSE I. RICARD, MD

FAMILY MEDICINE & SPORTS MEDICINE CONFERENCE

November 12-14, 2021

DoubleTree by Hilton
Huntington, West Virginia

In person or virtually,

Welcome!

Drug Diversion Training and Best Practice Prescribing of Controlled Substances

Tracy Hendershot, DC, MD, FAAFP

For the

Family Medicine Foundation of West Virginia

Huntington, WV

November 5, 2020

Credentials

Dr. Hendershot, MD, DC, FAAFP is a past Paul Ambrose Health Policy Fellow. He trained at Marshall University's Joan C. Edwards School of Medicine with completion of a family practice residency at the same.

He's worked in private practice as a chiropractor from 1996-2004, observing the WV opioid crisis develop from the vantage point of a non-prescribing provider. Since becoming an MD he's worked at the Ebenezer Clinic- a free clinic blocks from Huntington, WV's initial opioid epicenter. He's been CMO of a rural FQHC and Past Chair of the WV PCA CMO committee. He's now employed in the WVU Medicine Health System. At each location he's been handed his share of chronic opioid patients. He manages < 30 chronic opioid patients in the outpatient setting.

Finally, Dr. Hendershot has served as Past President of the WVAFP, currently serving as WVAFP Delegate to the AAFP Congress of Delegates. He also serves as chair of the WVAFP Legislative Committee.

Disclaimers

Dr. Hendershot has **no** conflicts of interest or disclaimers to announce.

The use of brand specific names are not meant as an endorsement,
But to ensure familiarity of the prescriber with the common opioid products.

I receive no renumeration from any manufacturer.

Objectives

1. Review the climate and trends in WV that contribute to opioid overdose deaths.
2. Review best practice prescribing of controlled substances.
3. Review drug diversion concerns and best practices.
4. Encourage the appropriate use of Naloxone and MAT.

Agenda

The First 30 min.

Why We Are here

The current situation

The Next hour:

Starting Patients on Opioids

Assessment of Need

Assessment of Risk

BOP

Contracts

The Hour after that..

Prescribing Opioids

Opioid equivalents

Testing:
Urine
Pill counts

Stopping Opioids

The Last 30 min.

The latest opioid bill

How to help the Heroin users

Why We Are Here...its required

Mandatory Controlled Substance CME for all Licensees

(SB 437 passed 2012)

"Physicians who have prescribed, administered, or dispensed any controlled substance in any jurisdiction in the two year license cycle preceding renewal, are required to complete three hours of Board-approved CME in drug diversion and best practices prescribing of controlled substances **during each reporting period. This is not a one-time only requirement.**

A physician who has **not prescribed any controlled substances whatsoever during the reporting period may seek a waiver** of this requirement by attesting on the renewal application that he or she has not prescribed, administered or dispensed any controlled substances whatsoever since July 1, 2016."

Why We Are Here…its a state objective

https://dhhr.wv.gov/office-of-drug-control-policy/news/Pages/Reports-and-Data.aspx

WV .gov

Health Hu

About

WVDHHR > Off

Reports a

Reports

Goal 2: Monitor opioid prescriptions and distribution.

Strategy 1	E k m
KPI 1	B fc in m a
Strategy 2	C W C (C e w
KPI 1	In (i. P
KPI 2	B re M p m

Not secure | sempguidelines.org/guidelines/

HOME / ABOUT

Guideli

Please click the l

WV Pain Manag

Complete PD

Expert Pain Management Panel Members

Panel Member	Or
Mark Garofoli, PharmD, MBA (Coordinator)	West Virginia University (
Timothy Deer, MD (Chairperson)	Centers for Pain R
Richard Vaglienti, MD (Vice Chairperson)	WVU P
Rahul Gupta, MD	West Virginia DHHR, Publ
Ahmet Ozturk, MD	Marshall Unive
Denzil Hawkinberry, MD	Community Ca
Bradley Hall, MD	WV Medical Professionals
Matt Cupp, MD	Board Certifi
Michael Mills, DO	West Virginia Office
Jimmy Adams, DO	Active Phy
Richard Gross, PhD	WVU Pai
Jason Roush, DDS	West Vi
Stacey Wyatt, RN	St. Franc
Vicki Cunningham, RPh	WV Bureau of Medic
Felice Joseph, RPh	PE
Stephen Small, RPh, MS	Rational Dr
Patty Johnston, RPh	Colony Drug & Wel
Charles Ponte, PharmD, CPE	WVU Sch
James Jeffries, MS	WV DHHR, Division of
Michael Goff	West Virginia Prescriptio

West Virginia Expert Pain Management Panel

Safe & Effective Management of Pain Guidelines

2016

1

http://sempguidelines.org/wp-content/uploads/2016/09/W

WVBM and WVBOM Approved Courses:

The Boards of Medicine maintain a list of all three-hour courses that have been approved..

WV Board of Osteopathic Medicine

Legislative Rules Calendar News About IMLCC Contact

Licensing Options

OSTEOPATHIC PHYSICIANS

Application

Emergency Temporary Permit

Application Status

Renewal

Print Licensure Card

CSL Application

CSL Renewal

CSL Print Licensure Card

West Virginia Board of Medicine

LOOK UP A DOCTOR OR PA · LICENSURE · LAWS & RESOURCES · COMPLAINT PROCESS · PUBLIC

Licensure

Continuing Education

FAQs

Interstate Telehealth Registration

Initial Licensing Fee Waiver

Medical Doctors

Educational Permits

Controlled Substance Dispensing Registration

Physician Assistants

Podiatric Physicians

Medical Corporations

Forms

Verification of Licensure to Another State Board

2022 Renewal CME Courses

List of Board-approved CME courses which satisfy the 3-hour Drug Diversion Training and Best Practice Prescribing of Controlled Substances Training requirement for medical doctors whose last names begin with the letters A through L, and who will be renewing on or before June 30, 2022.

Course Name	Sponsor	Location / Date
Pain & Addiction, Best Practices & Proper Prescribing: Changing a Culture by Changing the Culture of Medicine	WVU School of Medicine and WV Medical Professionals Health Program	ONLINE COURSE Expires 01/01/2022
From Prescription Drug Abuse to Street Heroin...The Tale of West Virginia's Drug Abuse Epidemic	CAMC Health Education and Research Institute	ONLINE COURSE
Prescribing Opioids, Providing Naloxone, and Preventing Drug Diversion: The West Virginia Requirement, #91601 or #91602	NetCe	ONLINE COURSE Expires 03/19/2022

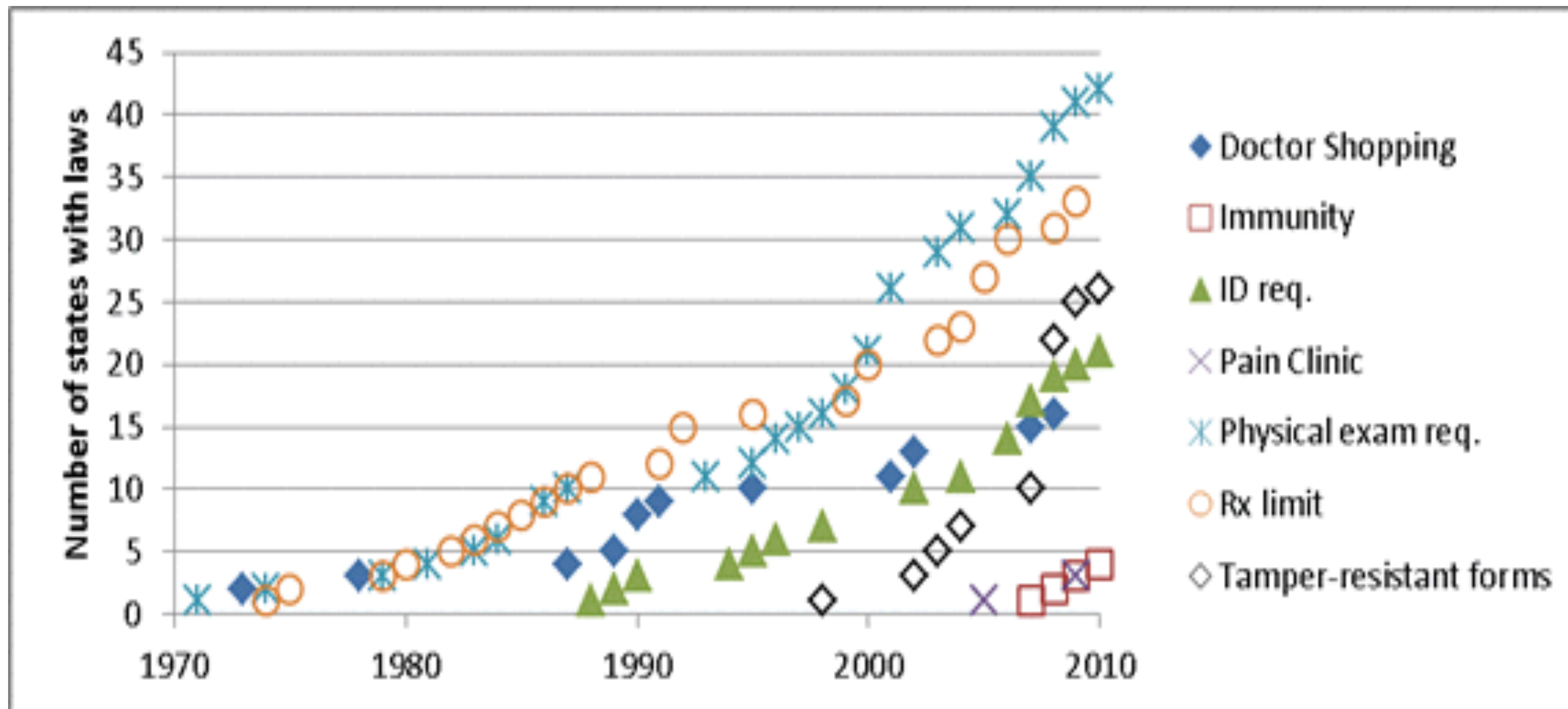
-Thank you for attending **this** lecture

https://wvbom.wv.gov/Cont_Med_Education.asp

https://www.wvbdosteo.org/article.asp?action2=showArticle&id=14&ty=CTTS

Opioid Regulation is Not New:

Narcotic Regulation, slow steady



Cumulative number of states authorizing prescription drug abuse-related laws by type of law, United States, 1970-2010 http://www.cdc.gov/homeandrecreationalsafety/Poisoning/laws/index.html

Harrison Anti-Narcotics Act of 1914

Current Politics:

Recent Appalachian Region Prescription Opioid Strike force Takedown:

In April, 2020, 53 medical professionals, were charged for unlawfully distributing opioids and other controlled substances:

Local, specific cases included Physician(s) in:

Saint Clairsville, OH, was charged with health care fraud, etc., for an alleged scheme to cause submissions for unperformed health care services, and to prescribe controlled substances (CS) while he was out of the state or country.

Saint Clairsville, OH, for alleged participation in the unlawful prescription of CS outside of the course of professional practice and without a legitimate medical purpose, and health care fraud for the submission of claims for services which were medically unnecessary and/or performed below medically-accepted standards.

Vienna, Ona, and multiple physicians in Charleston, WV were charged with allegedly unlawfully distributing CS without a legitimate medical purpose.

Current Politics:

Recent Appalachian Region Prescription Opioid Strike force Takedown:

Local, specific cases included Physician(s) in:

Wheeling, WV, was charged with diversion of CS for alleged participation in the unlawful prescription of CS outside of the course of professional practice and without a legitimate medical purpose.

Huntington, WV, pleaded guilty to illegal drug distribution including dextroamphetamine, methylphenidate and amphetamine salt to a patient who did not have a medical need for the drugs. The physician did not perform examinations **of any kind** prior to dispensing the narcotics even though the patient had a history of abusing narcotics.

Charleston, WV, pleaded guilty to illegal distribution of CS without legitimate medical purposes, including methadone pills.

https://www.justice.gov/opa/pr/second-appalachian-region-prescription-opioid-strikeforce-takedown-results-charges-against-13

Current Politics:

U.S. Attorney Mike Stuart
of the
Southern District of West Virginia:

"We have taken a very tough stance against those that fuel the opiate crisis at every level including **pill writers**, pill fillers, and drug dealers,"

"The unlawful distribution of controlled substances ..is **one of our highest priorities for prosecution** as we continue with our efforts to protect the public and the people of West Virginia.

https://www.justice.gov/opa/pr/second-appalachian-region-prescription-opioid-strikeforce-takedown-results-charges-against-13

Current Politics:

Assistant Attorney General Brian A. Benczkowski

of the

Justice Department's Criminal Division.

"To the doctors, pharmacists, and other medical professionals engaged in this egregious criminal behavior across Appalachia.. **the data in our possession allows us to see you and see you clearly**, no matter where you are,"

"Medical professionals who violate their solemn oaths and peddle opioids for profit should know that **we will find you and ensure that the justice system treats you like the drug dealer you are."**

https://wvmetronews.com/2019/09/24/federal-charges-filed-against-13-individuals-in-appalachian-opioid-sting/

Common Perception of Opioid Users:

https://www.spineuniverse.com/conditions/fibromyalgia

http://we-fix-u.com/back-pain/

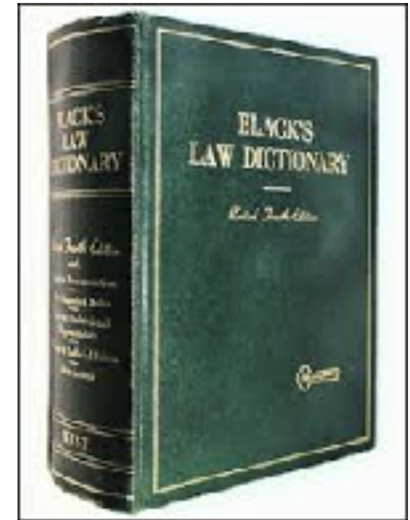
Opioid Overdoses:

https://www.featureshoot.com/2012/09/photographing-a-heroin-addict-through-despair-horror-and-hope/

https://www.pri.org/stories/2016-04-27/photos-getting-know-person-behind-heroin-addiction
Aaron Goodman

Common Terms:

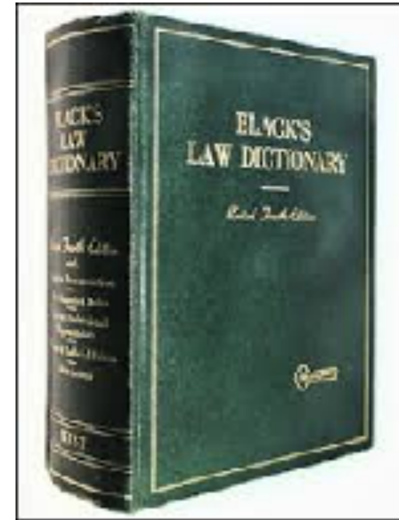
- **Opiates:** refer to natural opioids such as heroin, morphine, and codeine.
- **Opioids:** refers to all natural, semisynthetic (hydrocodone, oxycodone, hydromorphone..) , and synthetic opioids (excludes methadone, includes tramadol and fentanyl)
- **MAT:** Medication assisted treatment for opioid use disorder when combined with counseling and behavioral therapies.
- **MME:** Morphine milligram equivalents, accounts for different drug types and strengths.



cdc.gov/drugoverdose/opioids/terms.html

Common Terms:

- **Illicit drugs:** drugs prohibited by law or illicitly manufactured drugs, i.e. fentanyl, ecstasy.
- **Drug Misuse:** The use of drugs in a manner other than prescribed by a doctor.
- **Tolerance:** Reduced response to a drug with repeated use.
- **Dependence**: adaption to a drug that produces symptoms of withdrawal when drug is stopped.
- **Drug addiction**: Preferred term is Substance Use Disorder, a problematic pattern of opioid use that causes significant impairment or distress.
  - Unsuccessful efforts to reduce.
  - Use resulting in personal, social, and/or work problems



https://www.google.com/url?sa=i&url=https%3A%2F%2Fwww.legalgenealogist.com%2F2017%2F03%2F24%2Fdont-buy-that book%2F&psig=AOvVaw0THAzloUqGPxH7vXfhUEzU&ust=1603140274387000&source=images&cd=vfe&ved=2ahUKEwivvvSFgb_sAhVFR6wKHfrkDtkQr4kDegUIARDoAg

The Current Threat:

The Press Herald, January 24, 2018

Man arrested in Boston had more than 5 kilos of fentanyl, authorities say.

Prosecutors say the 26-year-old Guatemalan was scheduled to deliver the drug to a witness cooperating with the U.S. Drug Enforcement Administration..

https://www.pressherald.com/2018/01/24/man-arrested-in-boston-had-more-than-5-kilos-of-fentanyl-federal-authorities-say/

https://www.statnews.com/2016/04/05/fentanyl-traced-to-china/

Current National Trends?

The overall national opioid **prescribing rate** has declined from 2012 to 2018.

2018 prescribing rate had fallen to **51.4 prescriptions per 100 persons**

However, the prescribing rates continued to remain high in certain areas across the country.

In 11% of U.S. counties the rate is still 100:100

Some counties' rates were **6X higher** than that.

https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html#:~:text=The%20overall%20national%20opioid%20prescribing%20rate%20declined%20from%202012%20to,168%20million%20total%20opioid%20prescriptions).

WV Trends?

In 2018, West Virginia providers wrote:

69.3 opioid prescriptions for every 100 persons,

(Still among **the top ten rates in the U.S**. that year)

Positive news?

This was the lowest WV rate since data became available in 2006

https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/west-virginia-opioid-involved-deaths-related-harms

Current National Trends?

The age-adjusted rate of overdose deaths decreased.

In 2018, 67,367 drug overdose deaths occurred in the USA.

A 4.6% drop from 2017 (21.7 per 100,000) to 2018 (20.7 per 100,000).

Synthetic opioids (other than methadone)—remain the main driver of drug overdose deaths.

67.0% of opioid-involved overdose deaths involve synthetic opioids.

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

Current National Trends?

In 2018, states with **the highest rates of drug overdose deaths** were :

West Virginia (51.5 per 100,000),

Delaware (43.8 per 100,000),

Maryland (37.2 per 100,000),

Pennsylvania (36.1 per 100,000),

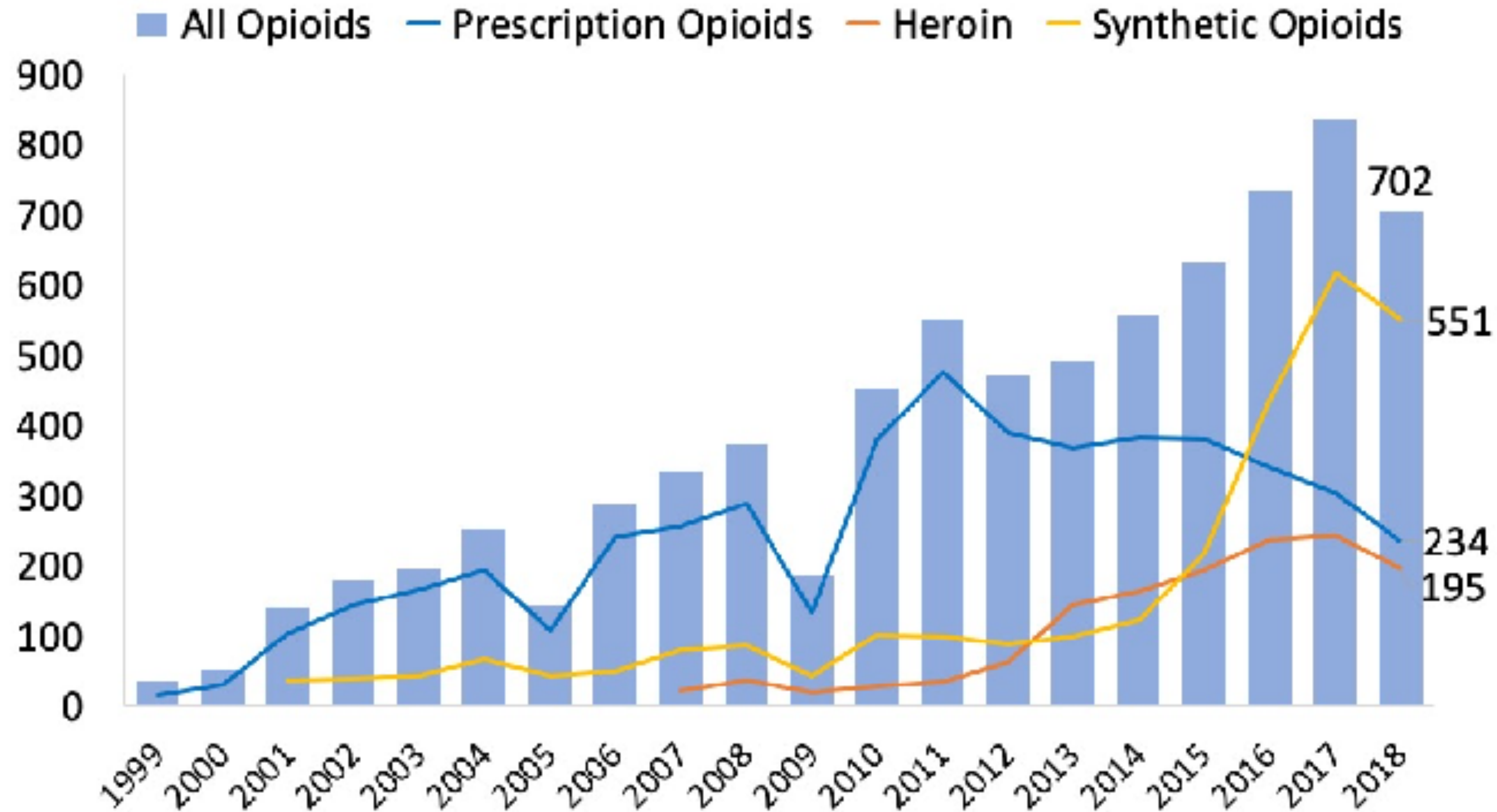
Ohio (35.9 per 100,000), and

New Hampshire (35.8 per 100,000).

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

WV Trends?

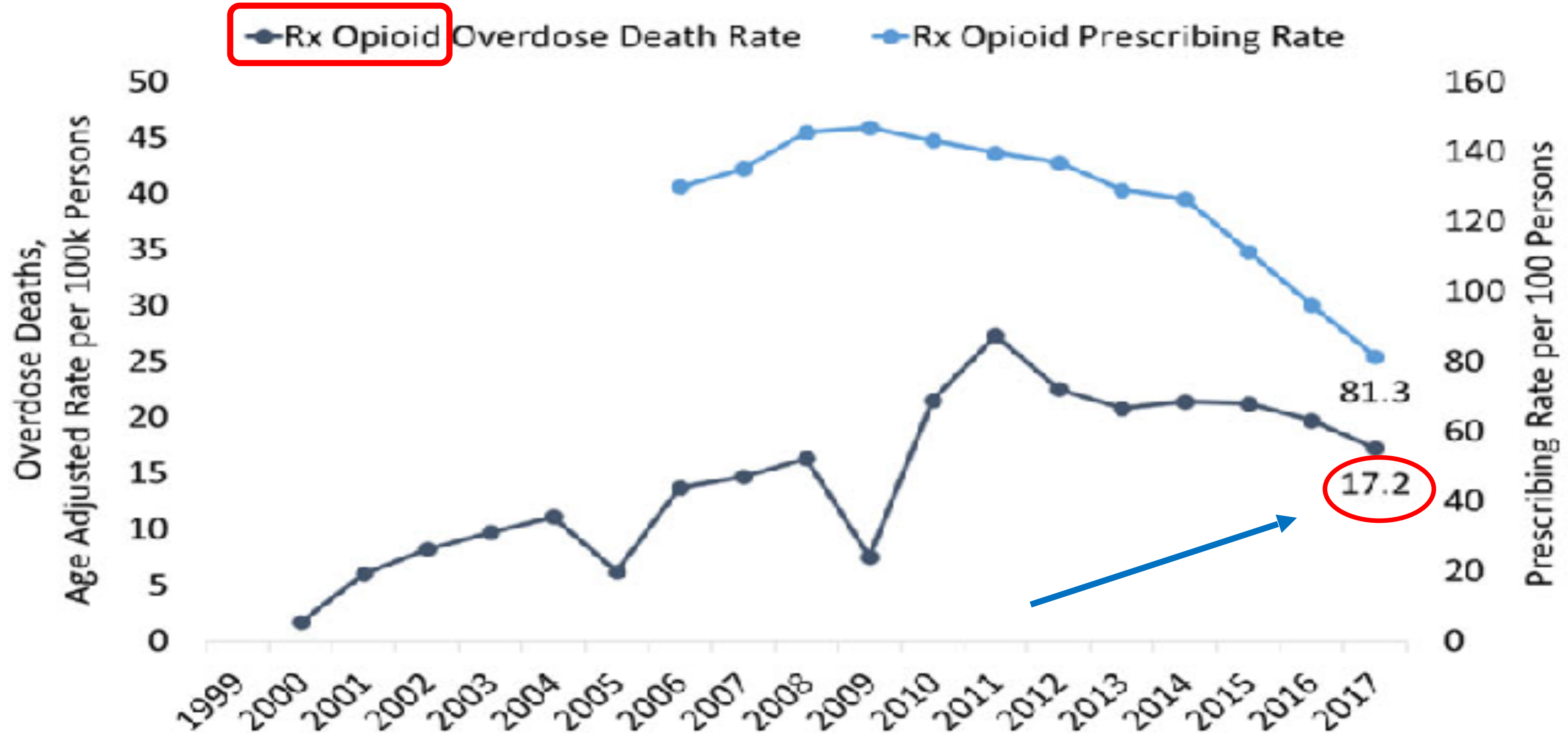
WV Opioid Overdose Deaths



..WV follows national picture.

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

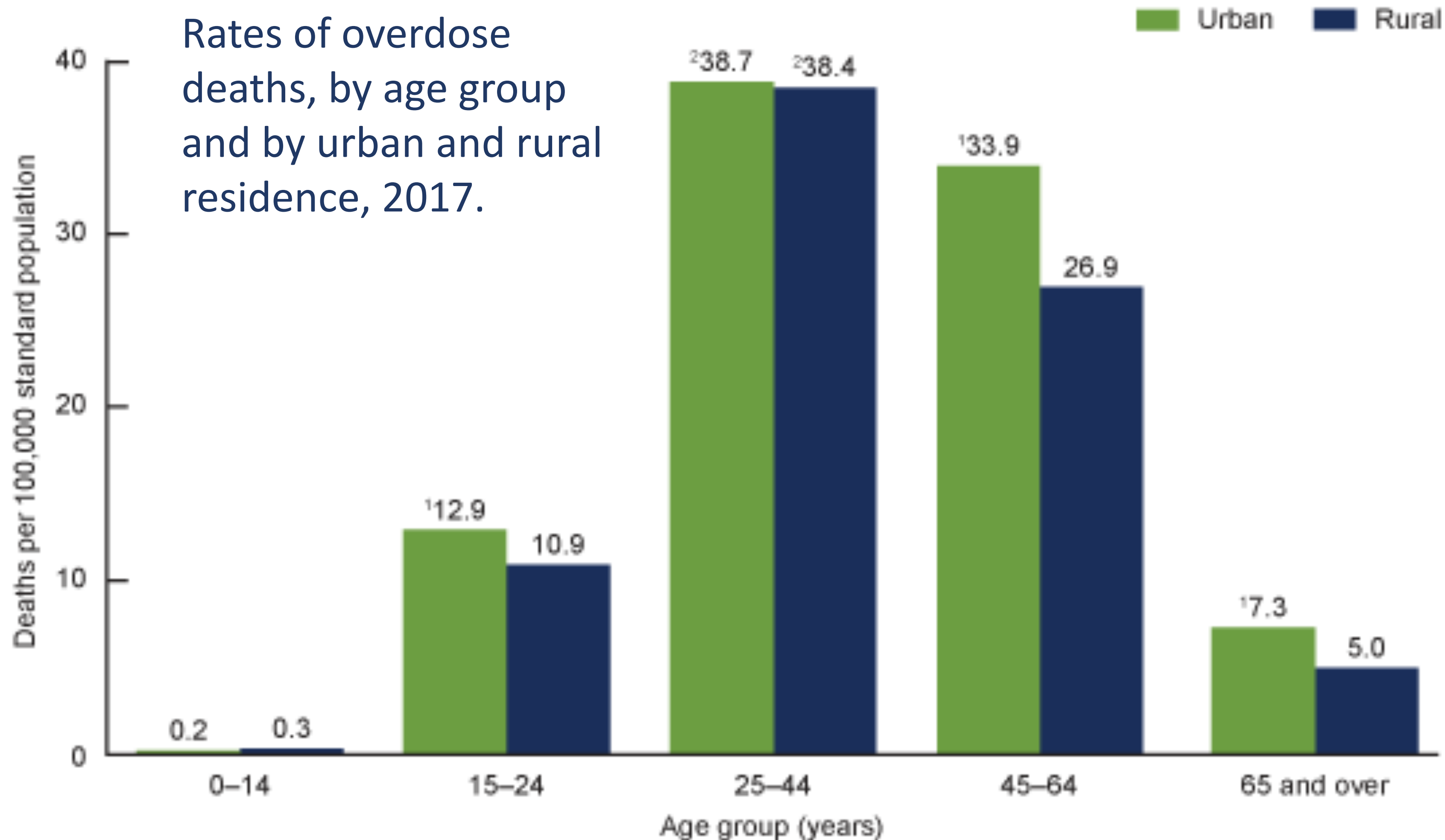
Current WV Trends?:



https://www.drugabuse.gov/opioid-summaries-by-state/west-virginia-opioid-summary. Source: CDC and CDC WONDER.

Current Demographics:

Rates of overdose deaths, by age group and by urban and rural residence, 2017.

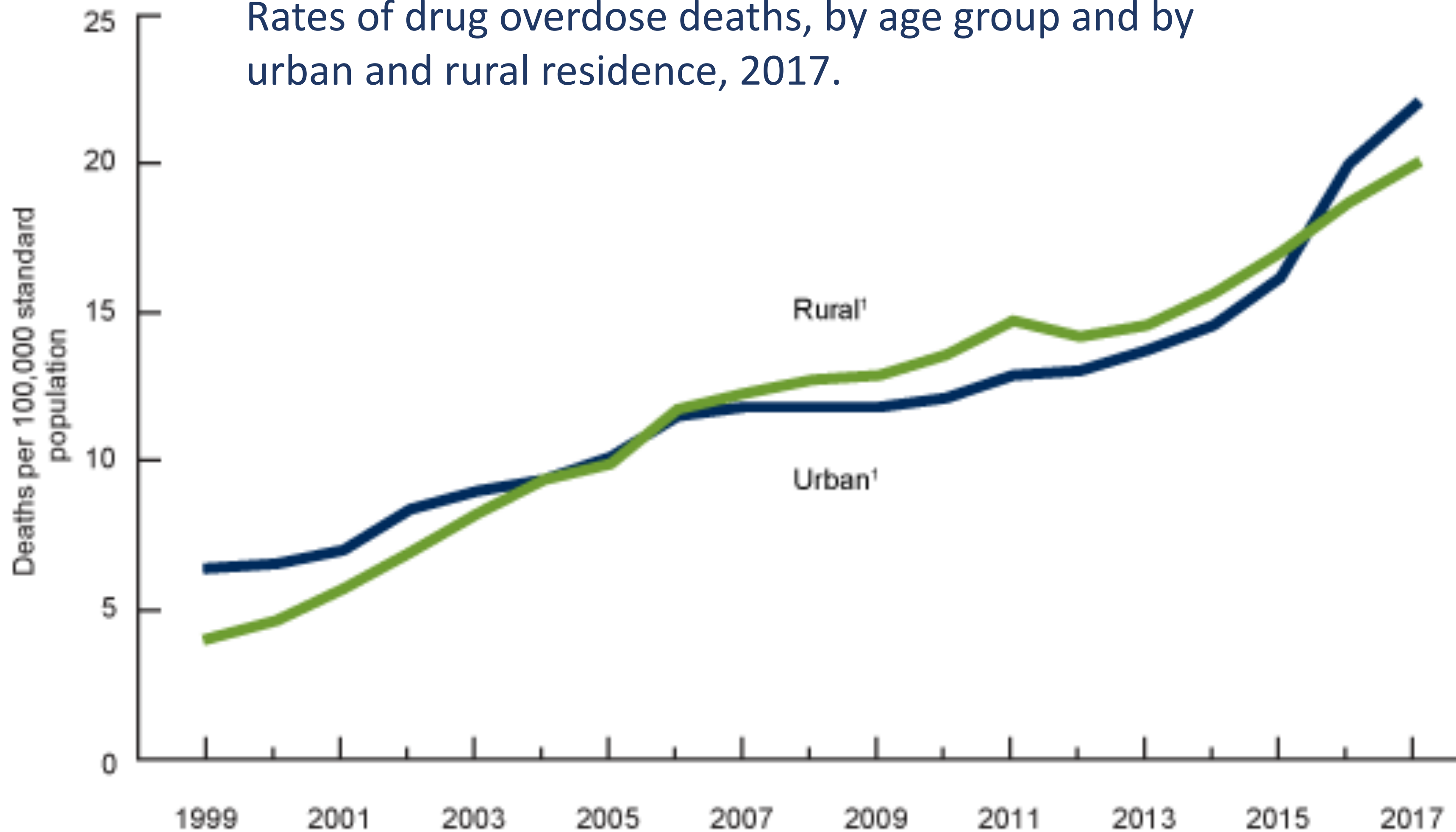


Age group has become younger:

25-44 YOA

SOURCE: NCHS, National Vital Statistics System, Mortality. 2019

Current Demographics:

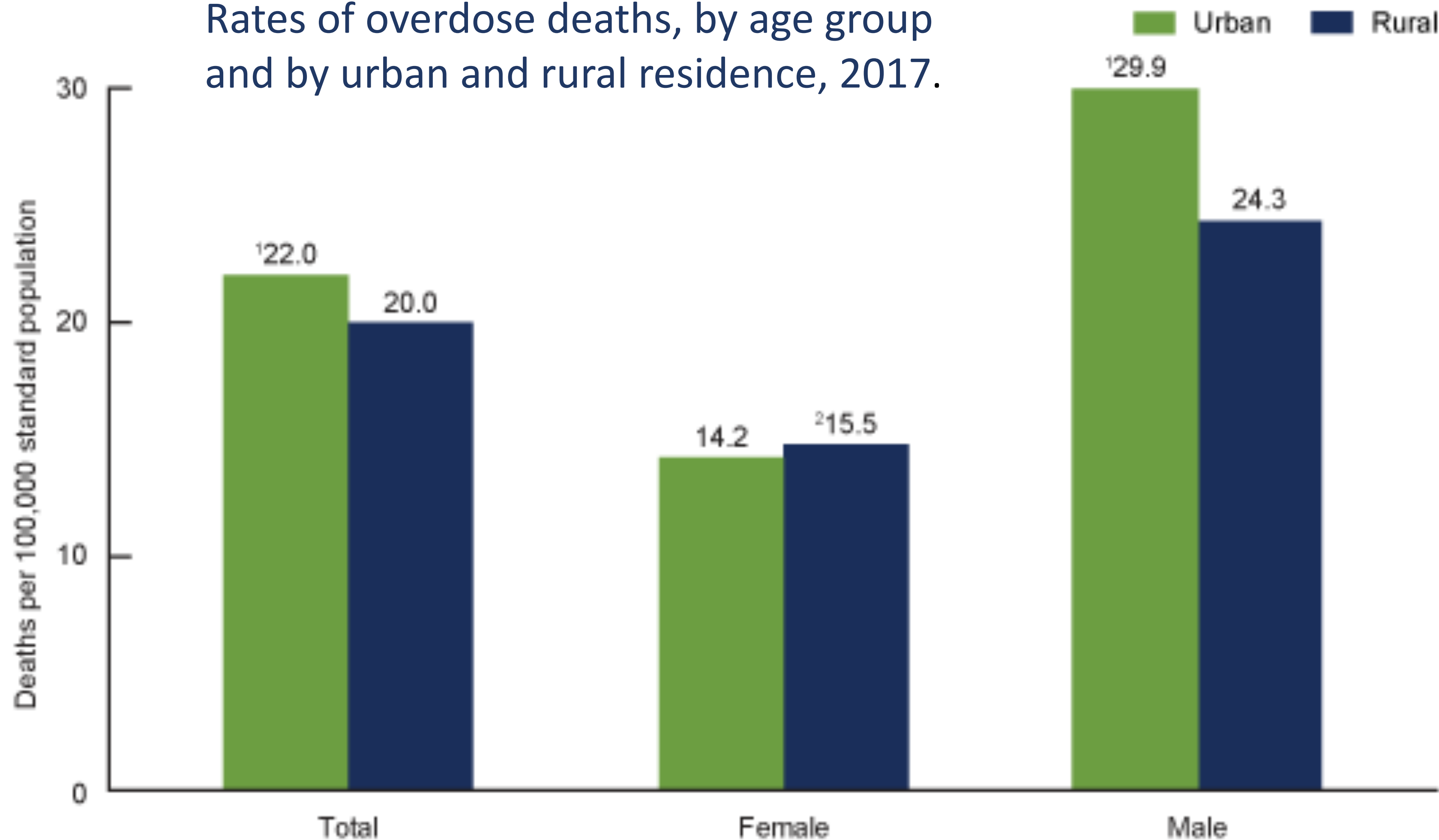


Since 2016

Urban more than rural

SOURCE: NCHS, National Vital Statistics System, Mortality. 2019

Current Demographics:



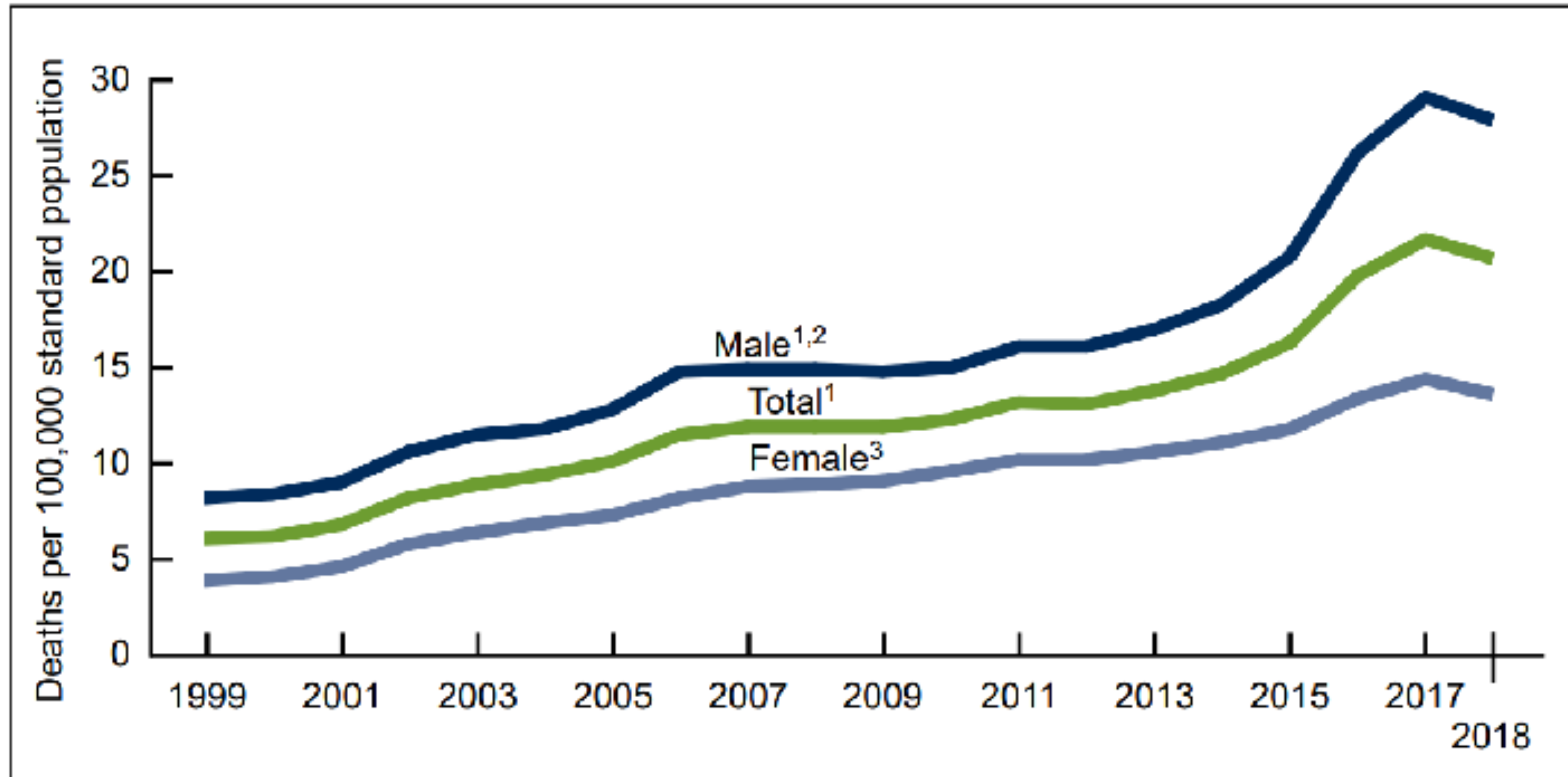
Males,
more than
Females.

More
urban males.

Slightly more
rural female.

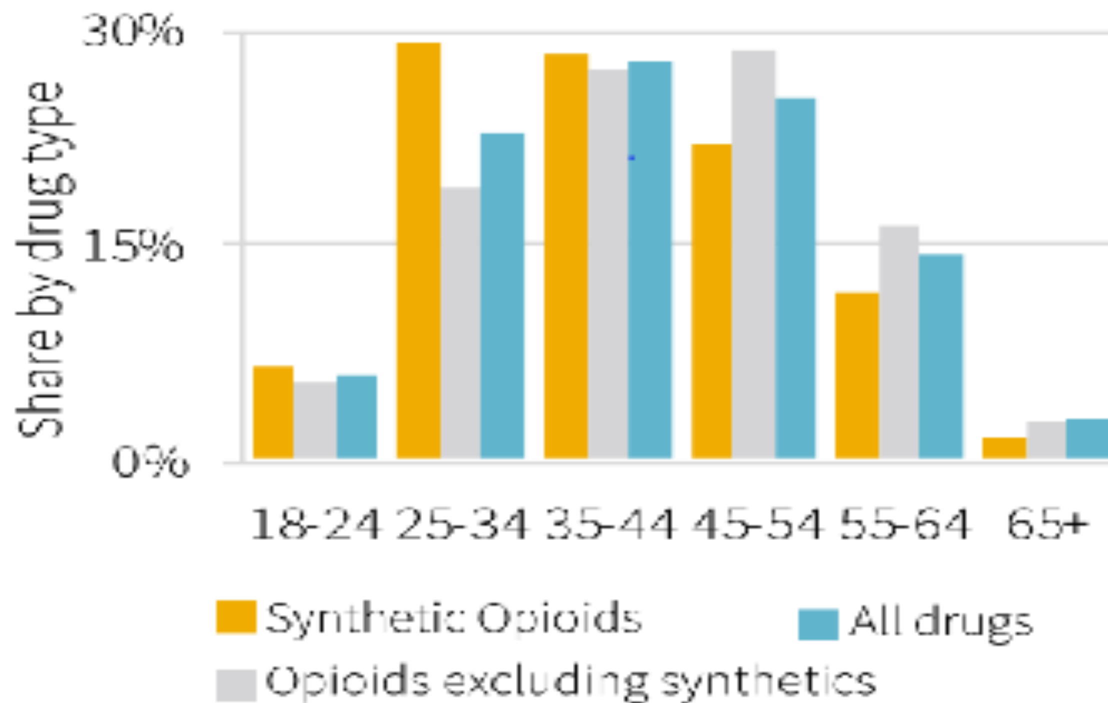
SOURCE: NCHS, National Vital Statistics System, Mortality. 2019

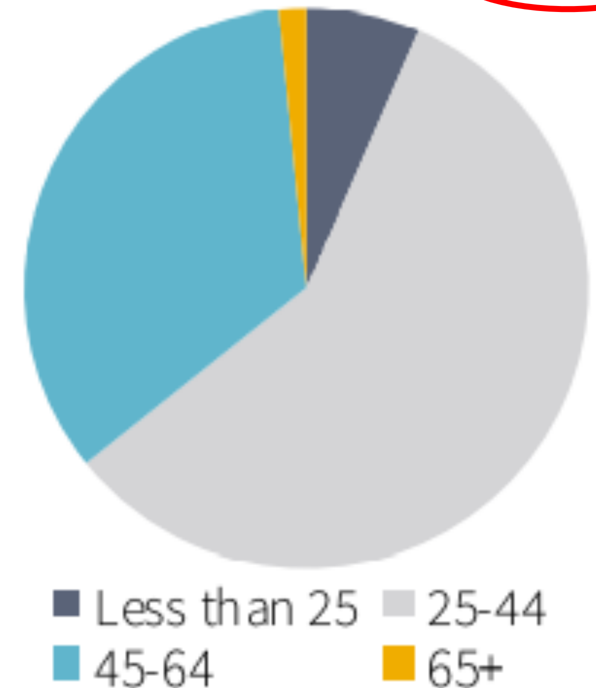
Current Demographics:



SOURCE: NCHS, National Vital Statistics System, Mortality. 2020

Current WV Demographics:

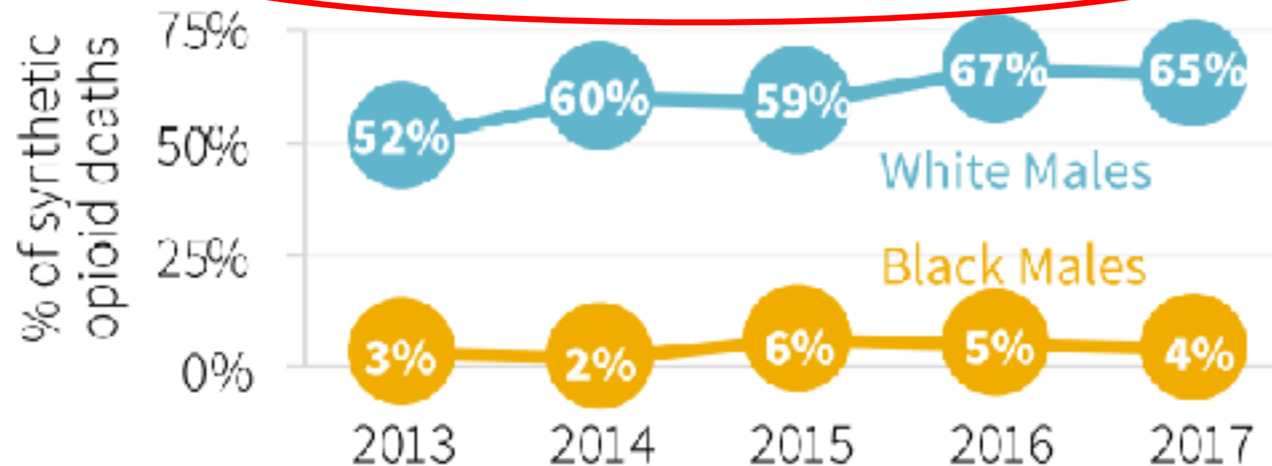




Current WV Demographics:

34.8 fatal synthetic opioid deaths per 100,000 residents in West Virginia in 2017

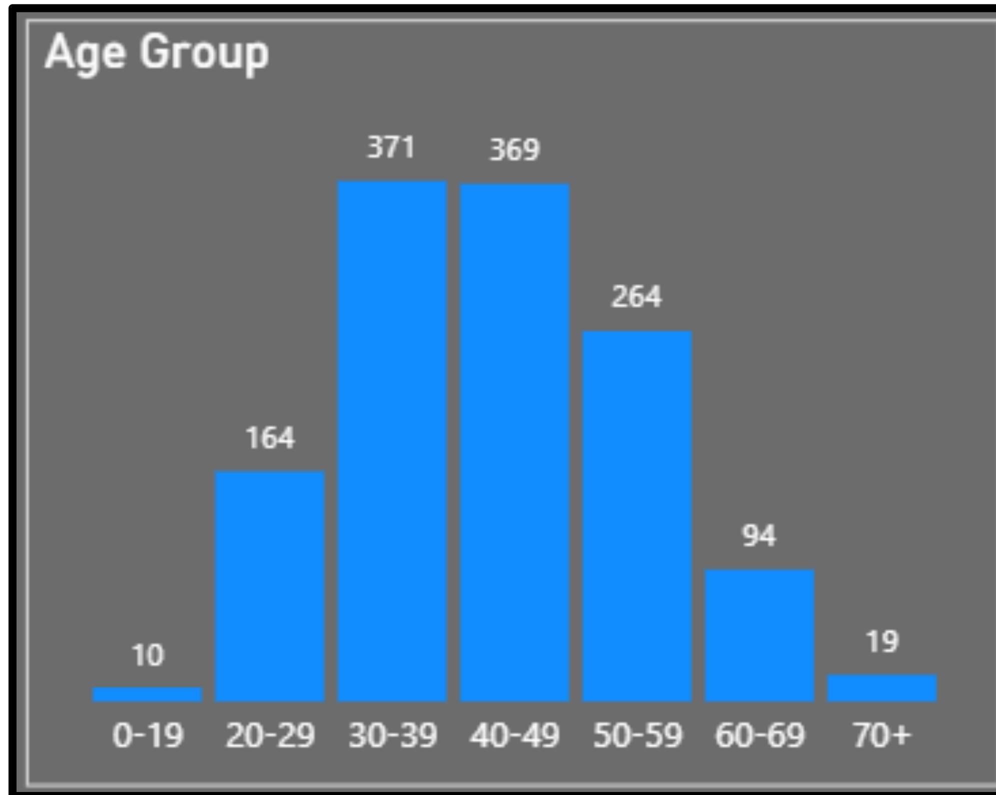
The share of fatal synthetic opioid-related overdoses among males has increased.

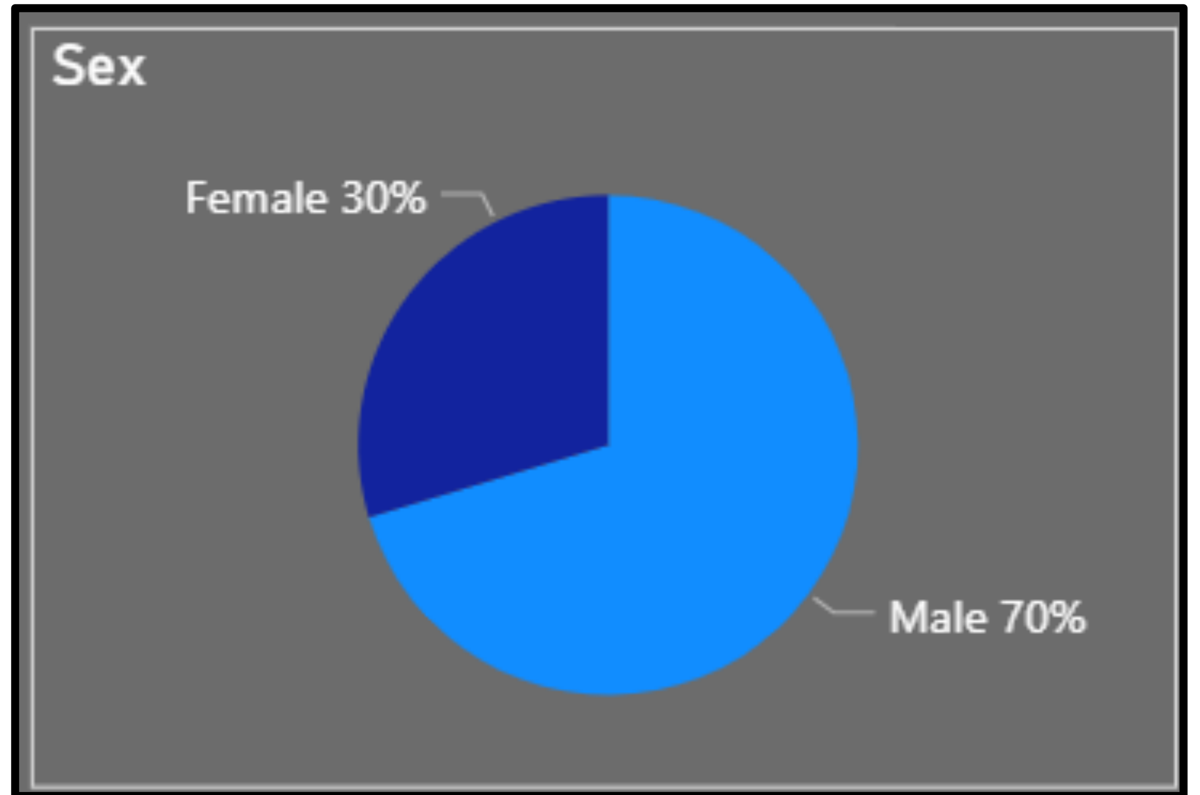


http://www.wvdhhr.org/bph/hsc/pubs/other/SyntheticOpioidFastStats/Synthetic_Opioid_Fast_Stats.pdf

WV Demographics 2020

WV Fatal Overdoses by age and sex





https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx 9/17/21

WV Overdose Death Rates

The following slides show the **rise in death WV death rates since 2014**

The slides report WV death rates per 100,000 population and total deaths, i.e. 35 and 627

West Virginia

35.5	627

Number and age-adjusted rates of drug overdose deaths by state, US 2014

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

Number and age-adjusted rates of drug overdose deaths by state, US 2015

West Virginia

41.5 725

WA MT ND MN ME OR ID SD WI MI NY MA WY IA NV NE PA UT CO IL IN OH CA KS MO KY WV VA TN NC AZ NM OK AR SC MS AL GA TX LA FL AK HI

CT DC DE MD NH NJ RI VT

West Virginia

52.0	884

Number and age adjusted rates of drug overdose deaths by state, US 2016

WA MT ND MN ME
OR ID SD WI MI NY MA
WY IA PA
NV UT NE IL IN OH
CA CO KS MO KY WV VA
AZ NM OK AR TN NC SC
MS AL GA
TX LA FL
AK HI

CT
DC
DE
MD
NH
NJ
RI
VT

West Virginia

57.8 974

Number and age-adjusted rates of drug overdose deaths by state, US 2017

Cities DC

Number and age-adjusted rates of drug overdose deaths by state, US 2018

West Virginia

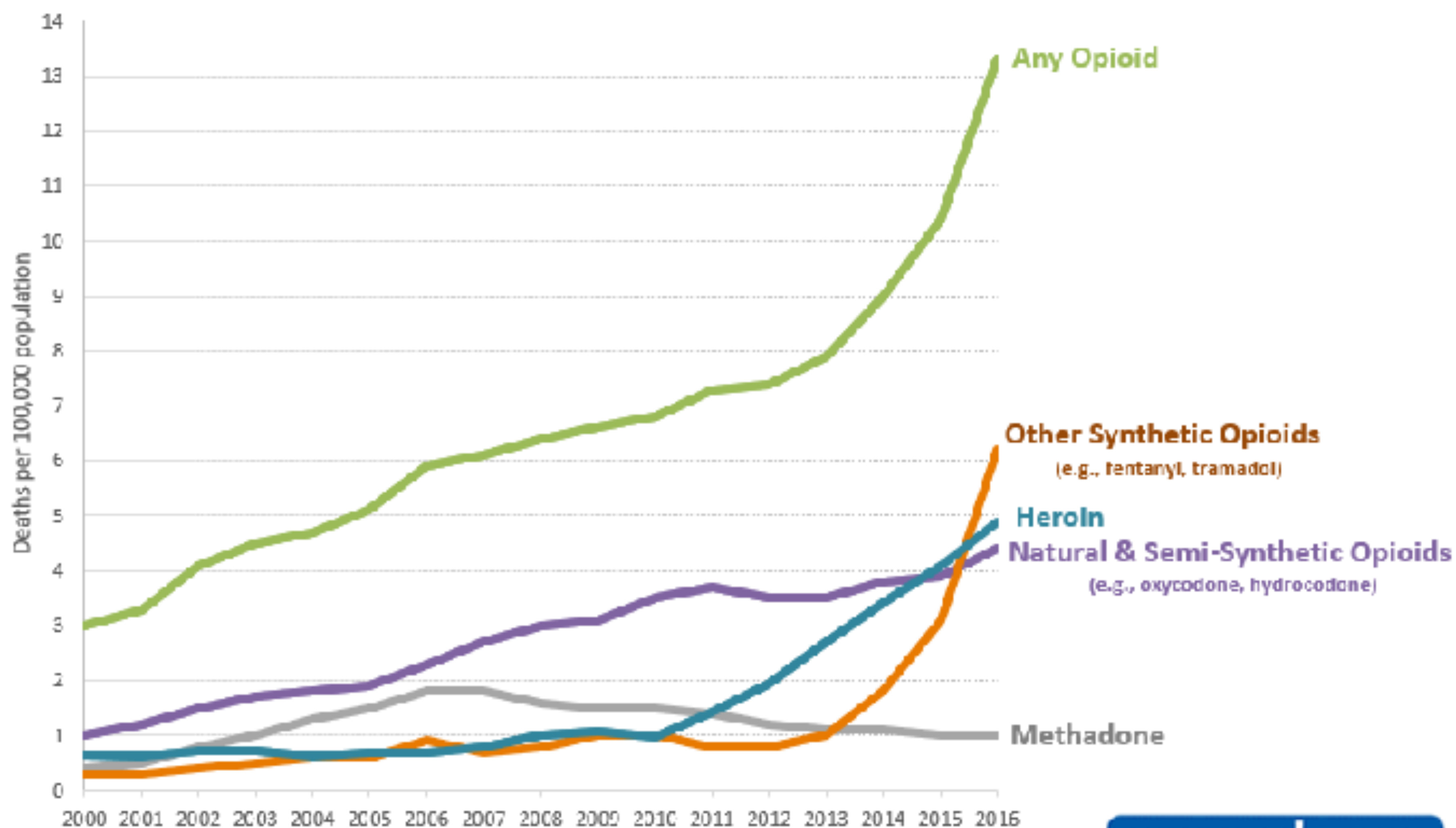
51.5 856

Fentanyl is Leading Opioid Deaths

It continues to be illegal opioid deaths, **not prescription opioids**, that drive the current national epidemic.

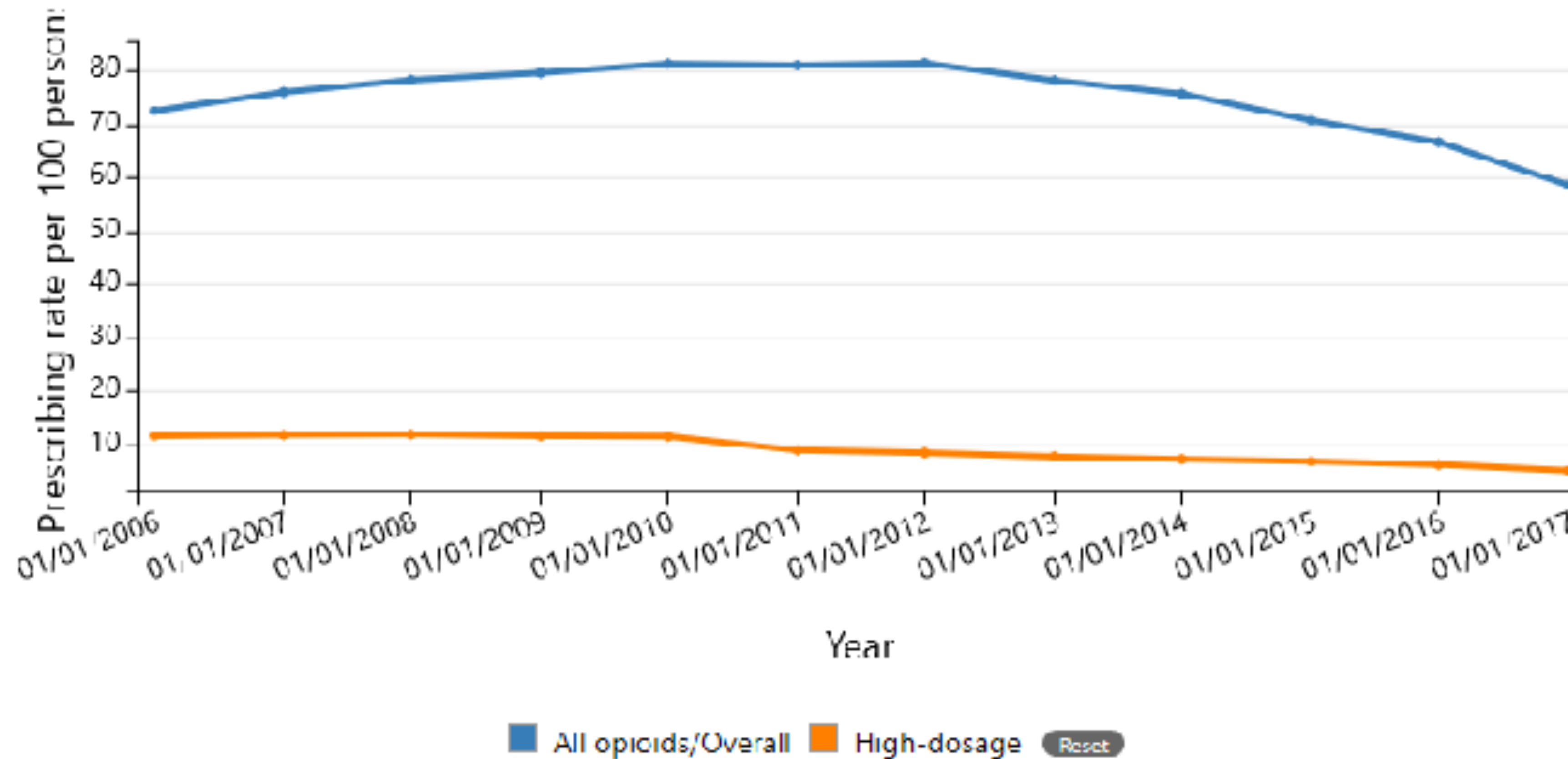
Please Note : as methadone decreased in use, opioid deaths have increased.

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2017. https://wonder.cdc.gov/.

Trends in Annual Opioid Prescribing Rates by Overall and High-Dosage Prescriptions



80/100 is benchmark

https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html

Source: IQVIA® Transactional Data Warehouse

WV Opioid Rx Rates Have Declined Since 2009

The **physicians in WV began changing Rx habits by 2009**, before many current legislative efforts began.

The physician community has supported the legislative efforts at stopping the deaths resulting from this epidemic.

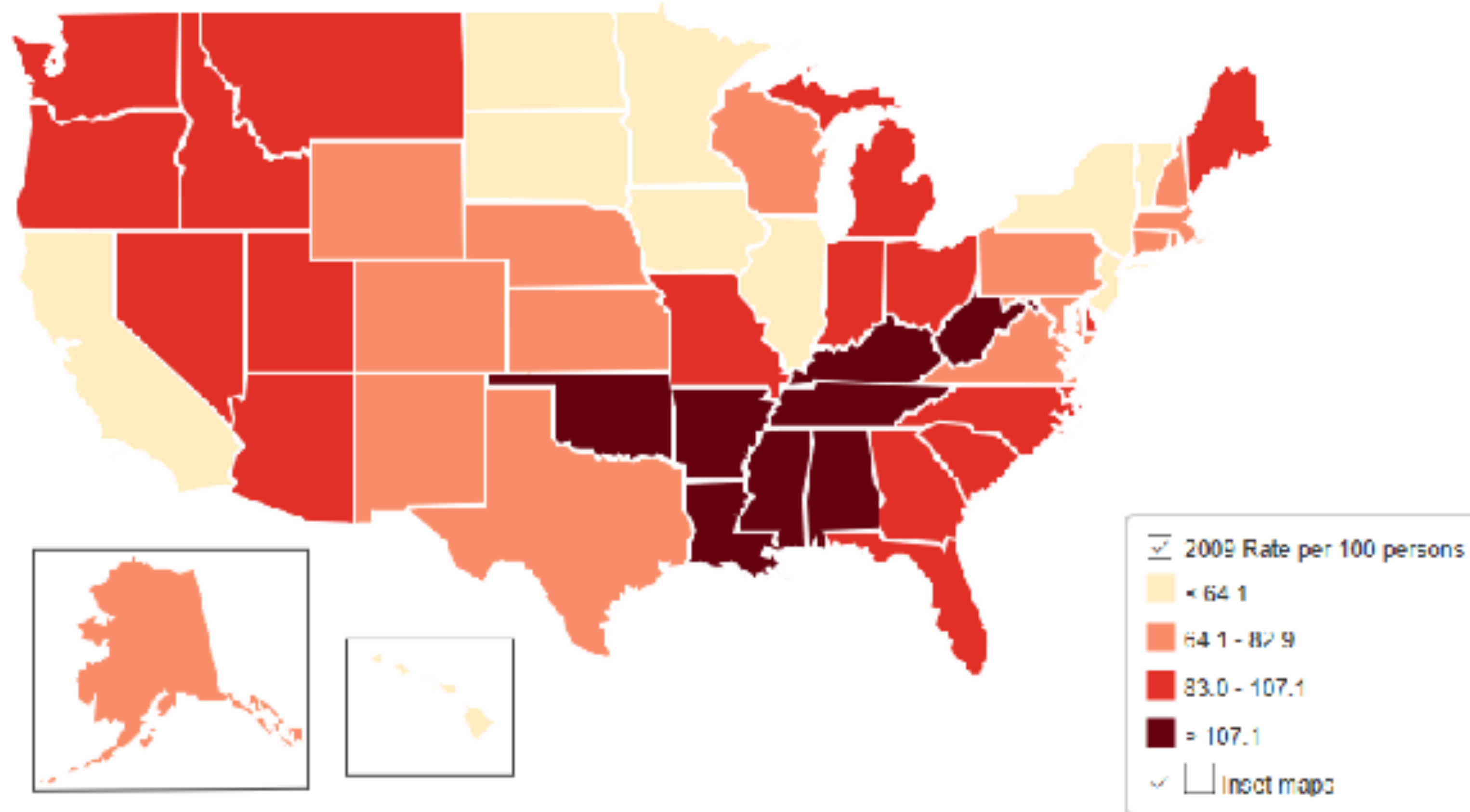
The following slides show WV opioid Rxs per 100 persons, i.e. 146 in 2009.

Please Note: The national physician community has reacted similarly.

U.S. State Prescribing Rates, 2009

West Virginia

146.9

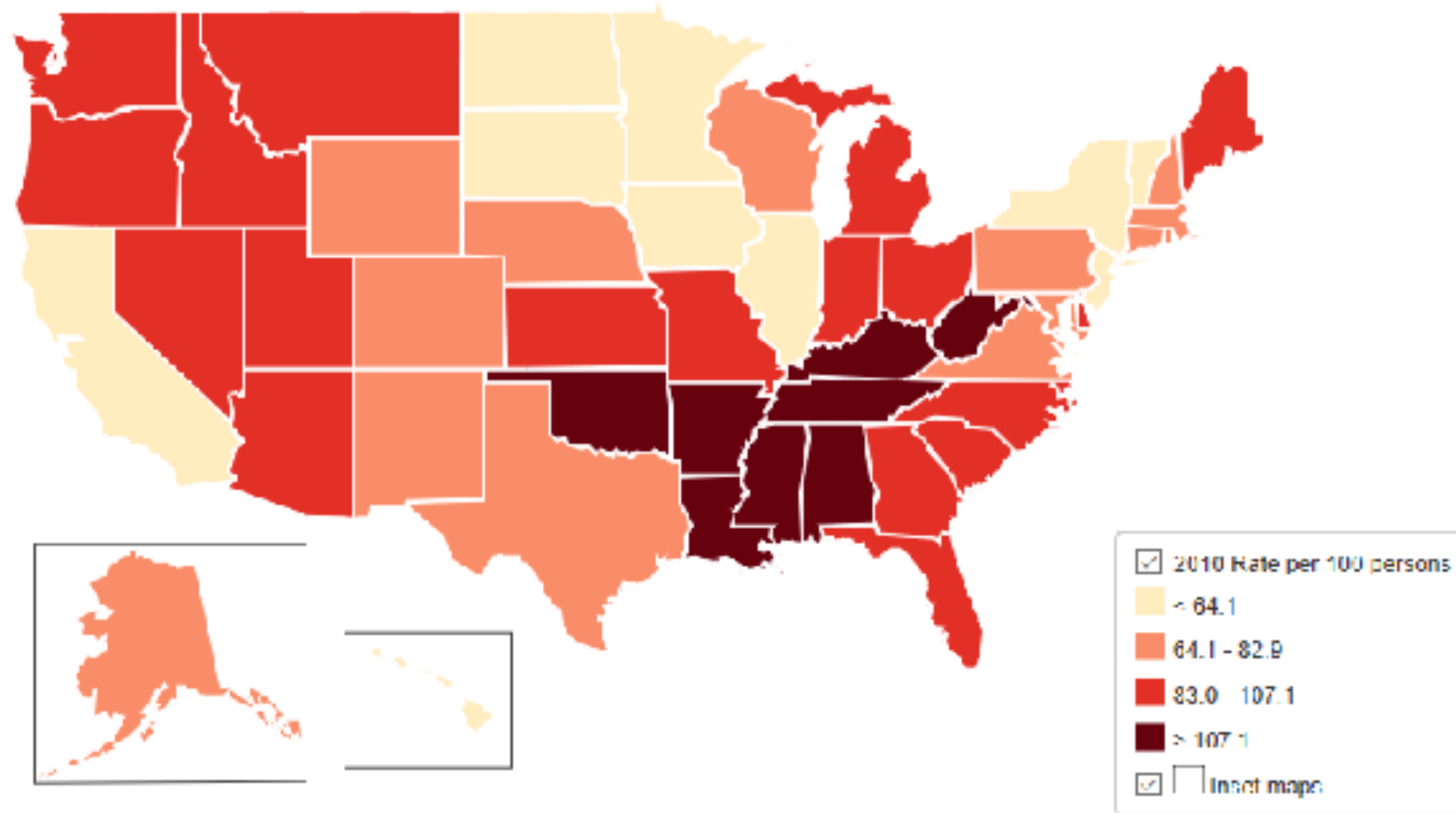


https://www.cdc.gov/drugoverdose/maps/rxstate2009.html

U.S. State Prescribing Rates, 2010

West Virginia

143.1

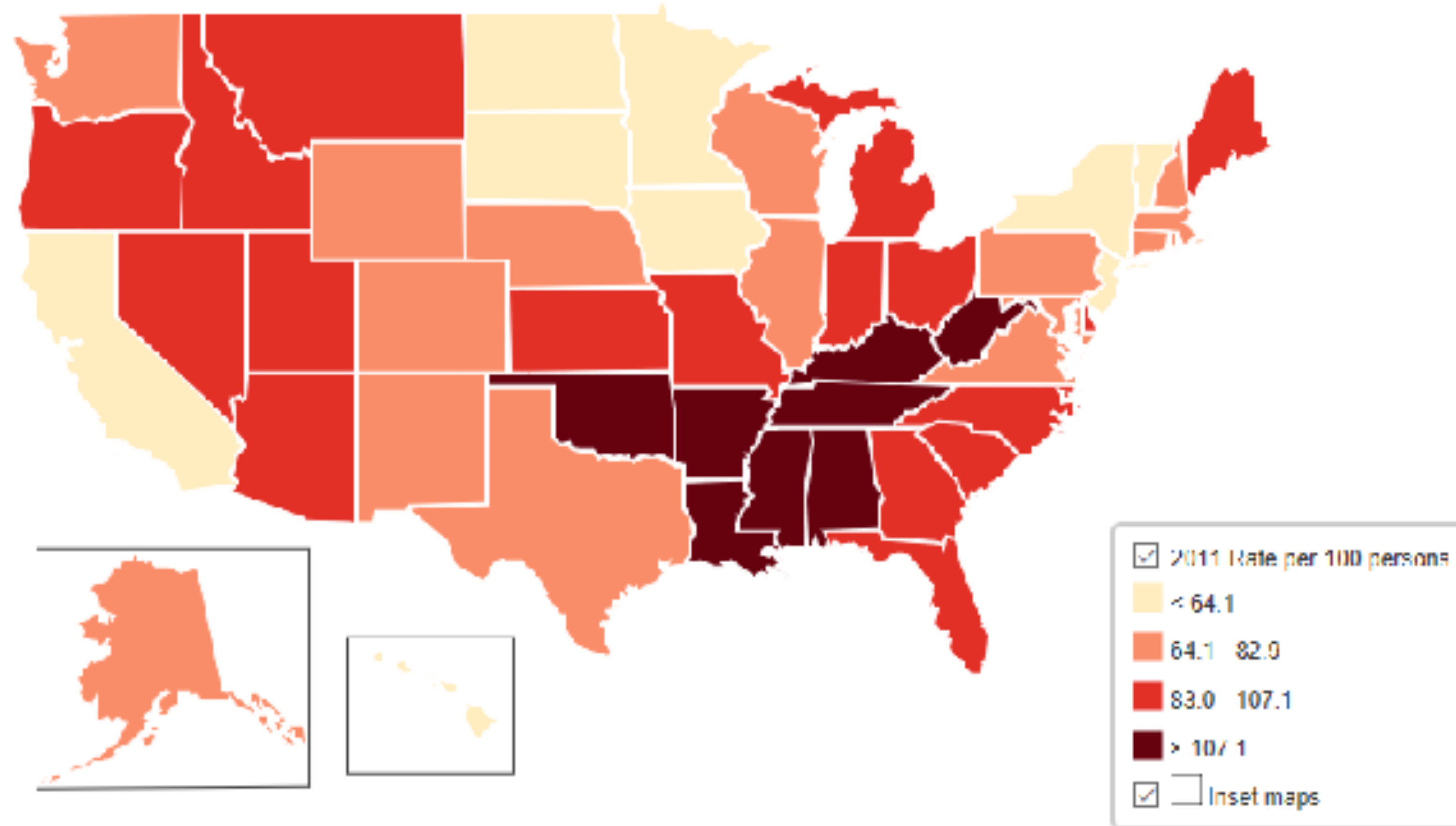


https://www.cdc.gov/drugoverdose/maps/rxstate2010.html

U.S. State Prescribing Rates, 2011

West Virginia

139.6

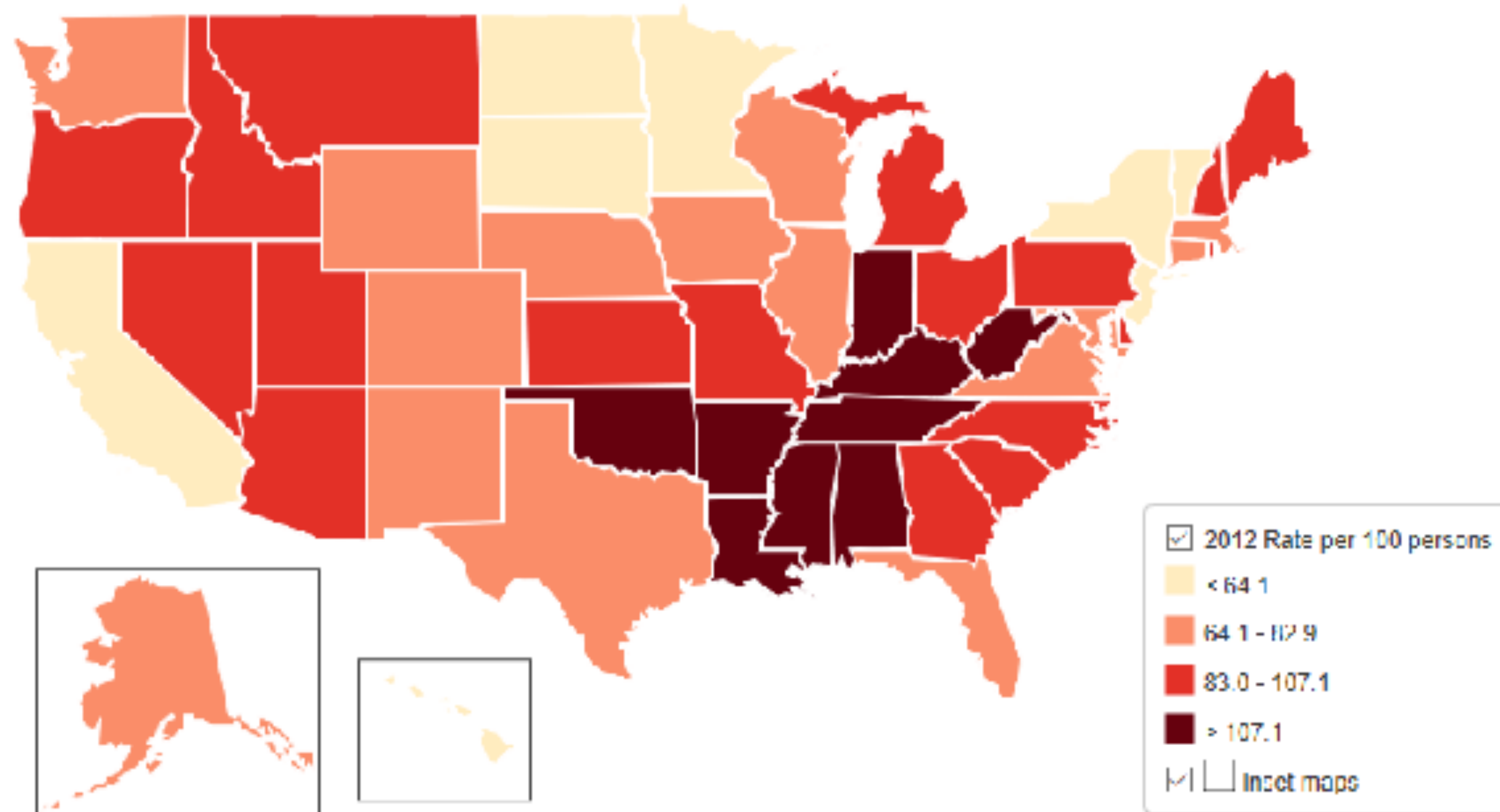


https://www.cdc.gov/drugoverdose/maps/rxstate2011.html

U.S. State Prescribing Rates, 2012

West Virginia

136.9

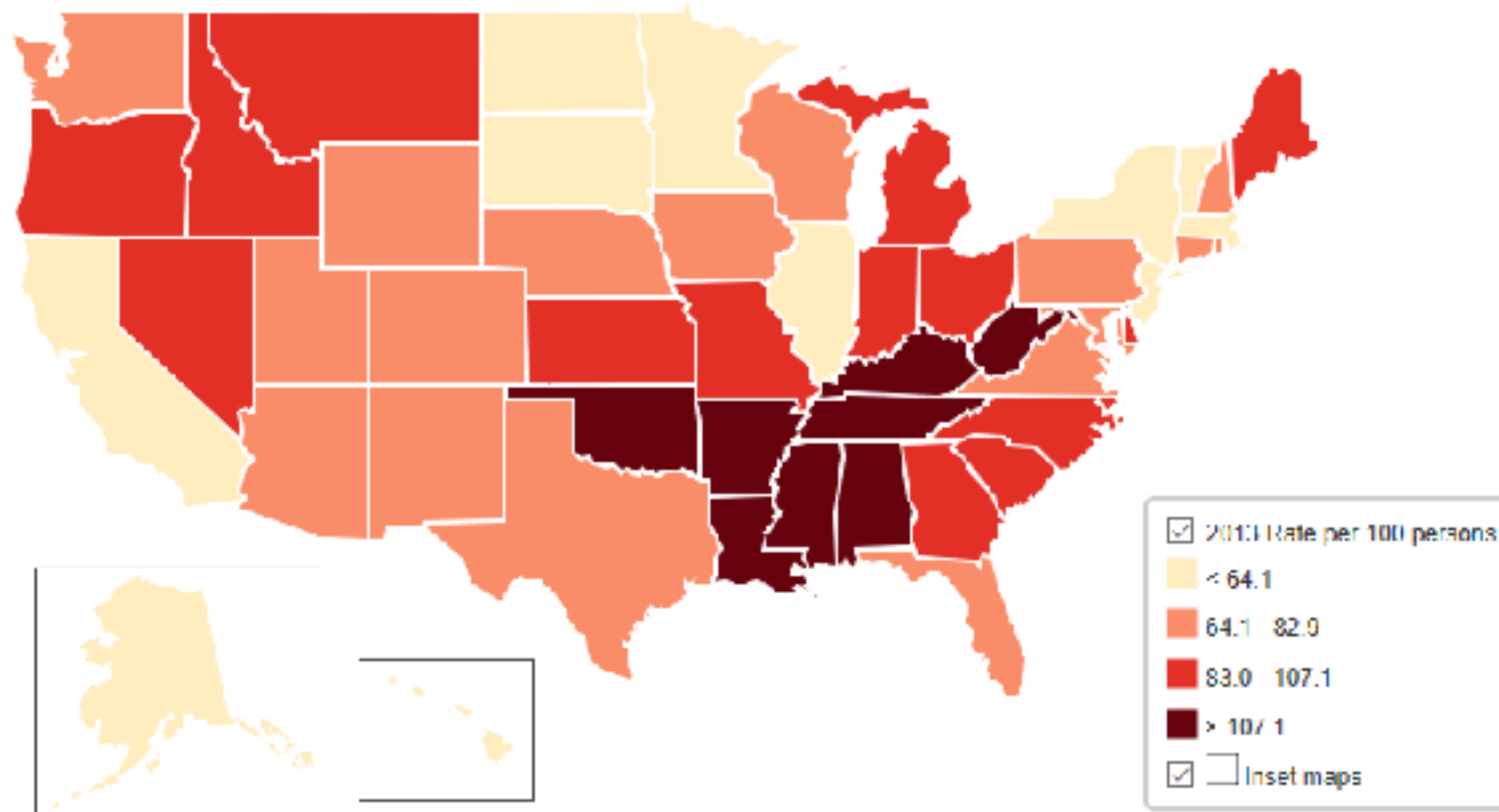


https://www.cdc.gov/drugoverdose/maps/rxstate2012.html

U.S. State Prescribing Rates, 2013

West Virginia

129

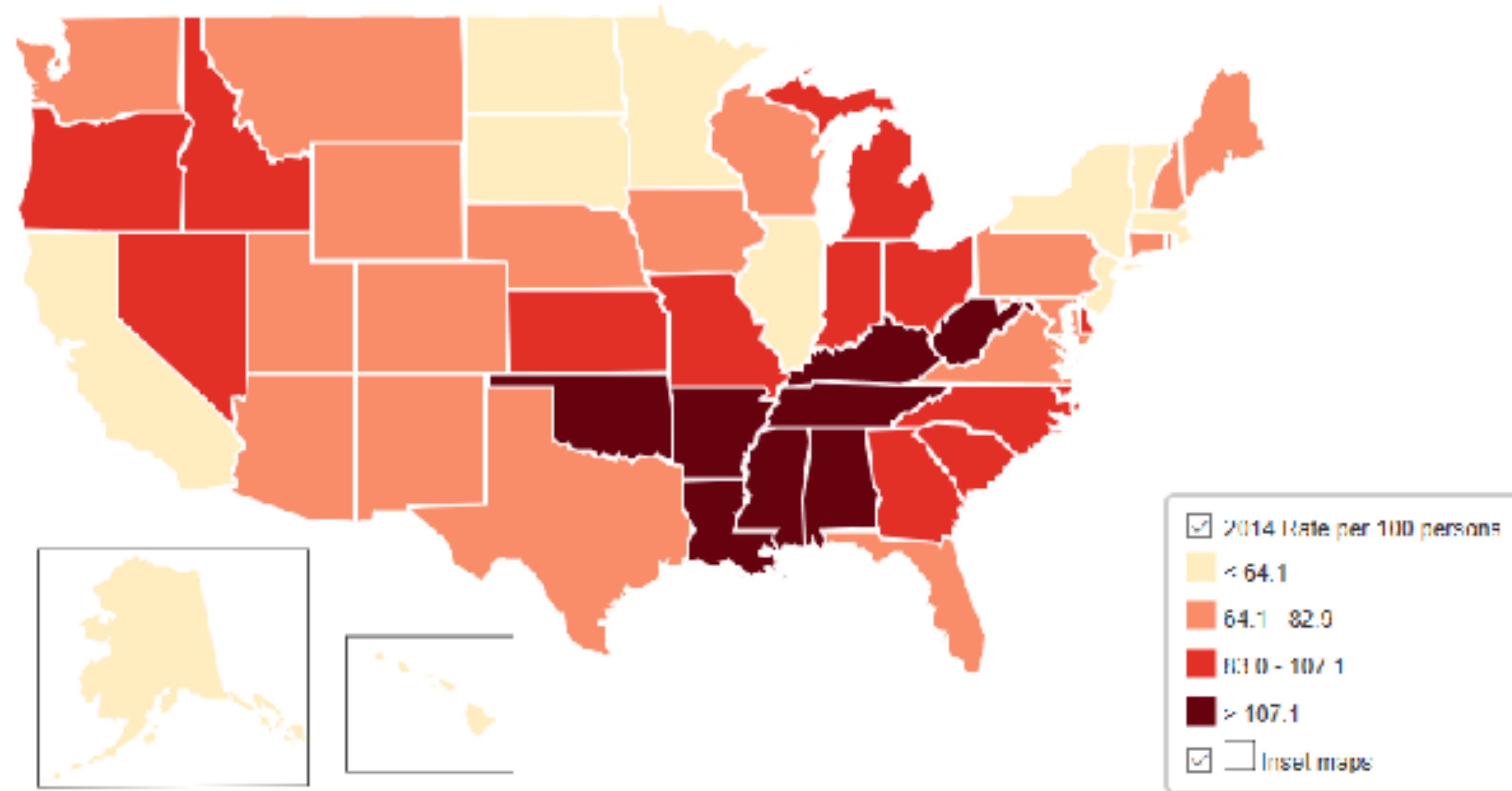


https://www.cdc.gov/drugoverdose/maps/rxstate2013.html

U.S. State Prescribing Rates, 2014

West Virginia

126.4

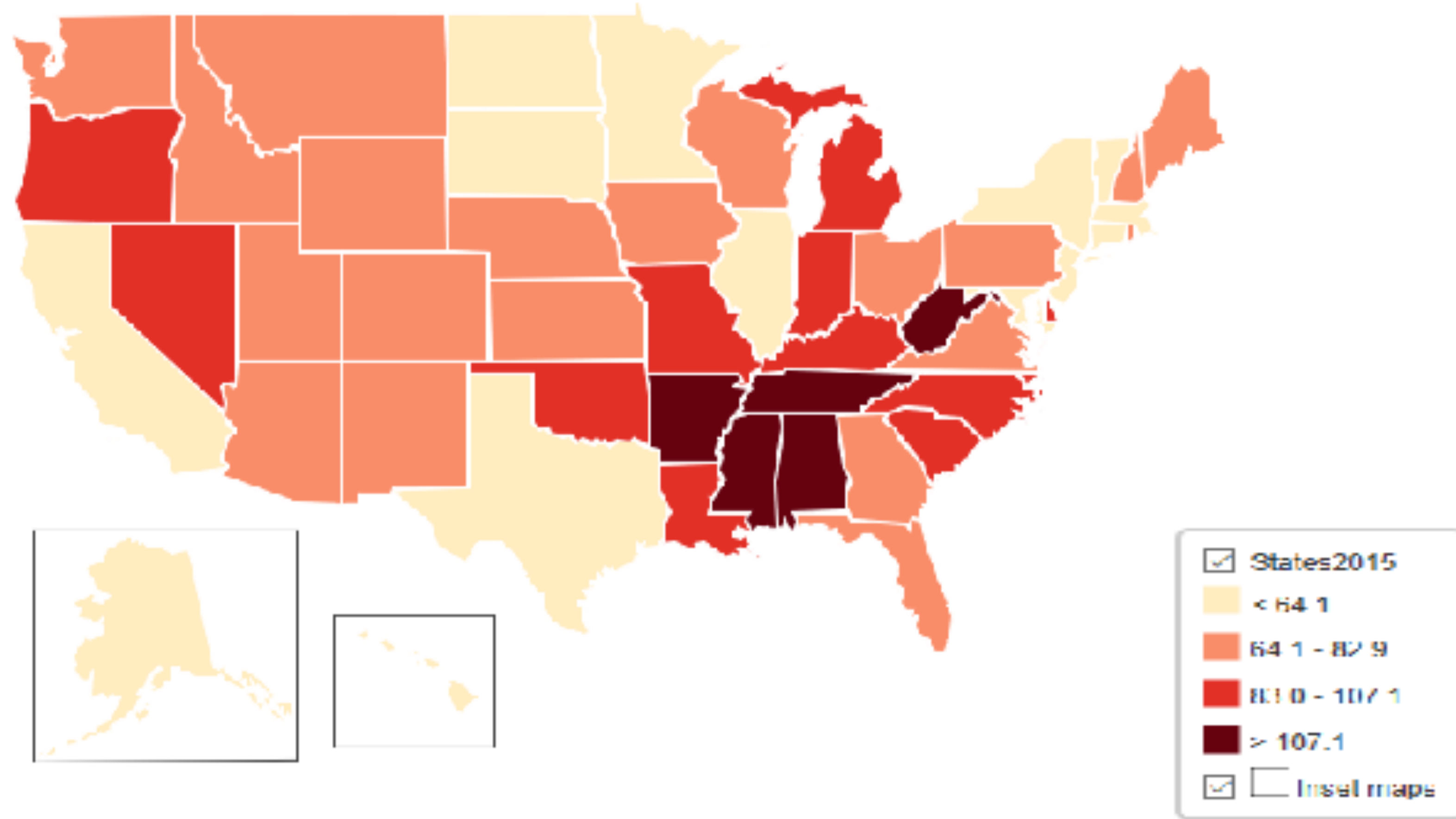


https://www.cdc.gov/drugoverdose/maps/rxstate2014.html

U.S. State Prescribing Rates, 2015

West Virginia

111.3

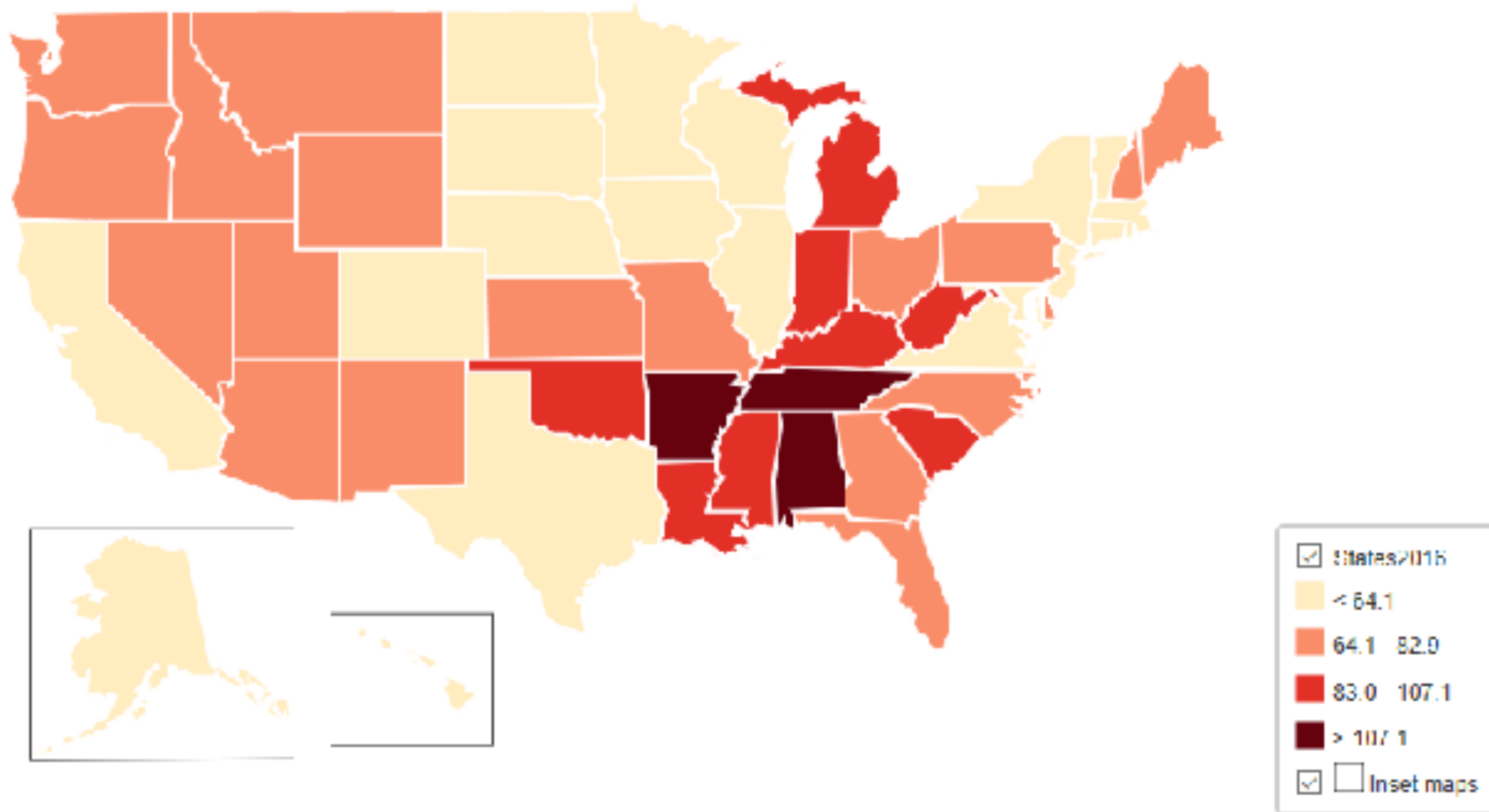


https://www.cdc.gov/drugoverdose/maps/rxstate2015.html

U.S. State Prescribing Rates, 2016

West Virginia

96

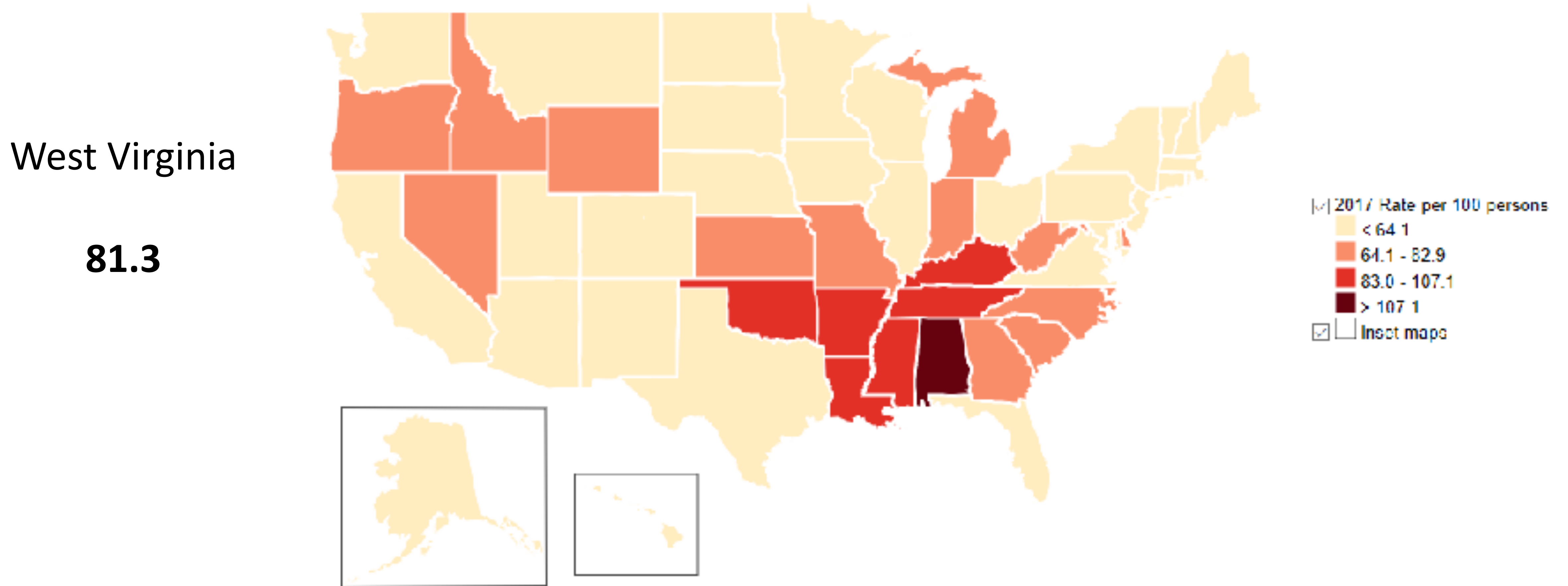


https://www.cdc.gov/drugoverdose/maps/rxstate2016.html

U.S. State Prescribing Rates, 2017

West Virginia

81.3

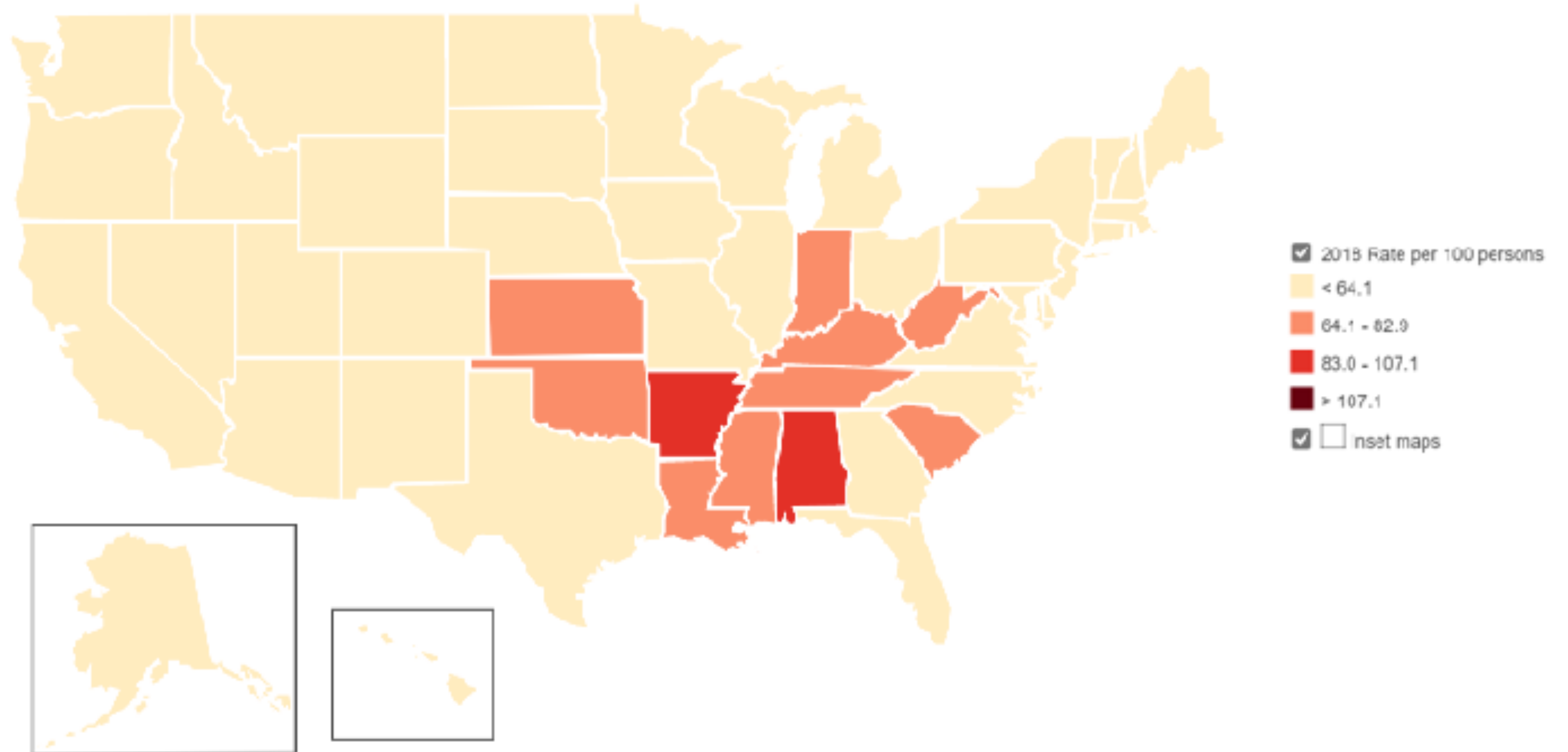


In 2017, however, there were still almost 58 opioid prescriptions written for every 100 Americans

U.S. State Prescribing Rates, 2018

West Virginia

69.3



https://www.cdc.gov/drugoverdose/maps/rxstate2018.html

WV County Rx Data

By 2009 individual WV county physicians began to respond to the crisis.

At that time, **Mingo county** lead the state in Rx rates-With **nearly triple** the rate of other high prescribing counties.

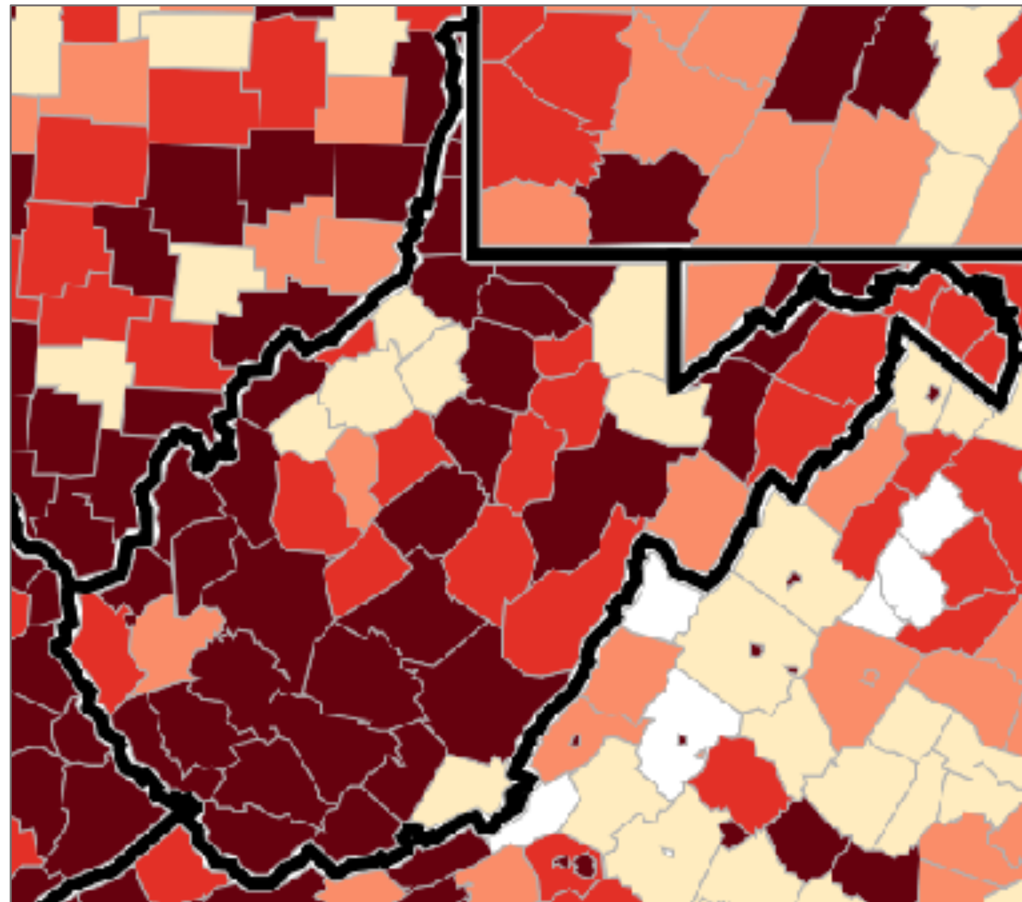
This abruptly stopped by 2010 and **Logan county** alone has driven WV outlier status.

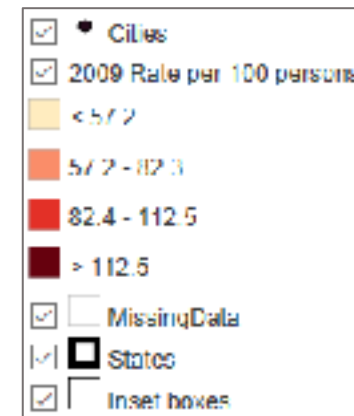
This because it has a larger population than other outliers and because its rate is triple the other outliers. (36,000 pop and 15th in WV)

U.S. County Prescribing Rates, 2009

Mingo, WV

437.2



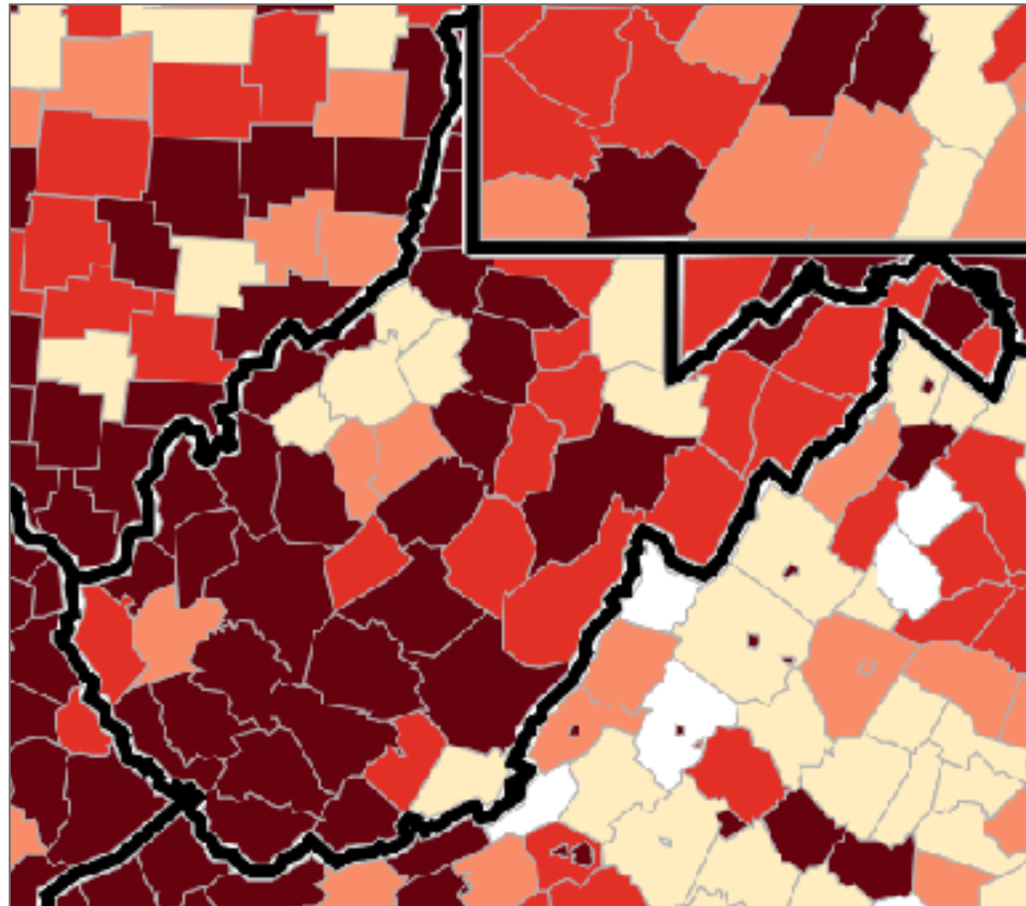


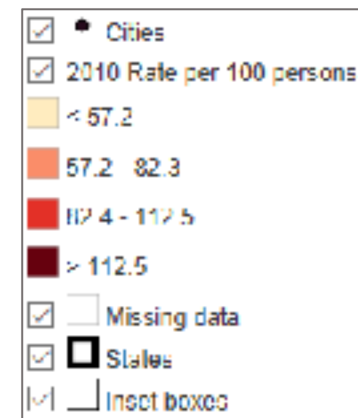
https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html

U.S. County Prescribing Rates, 2010

Logan, WV

287.4



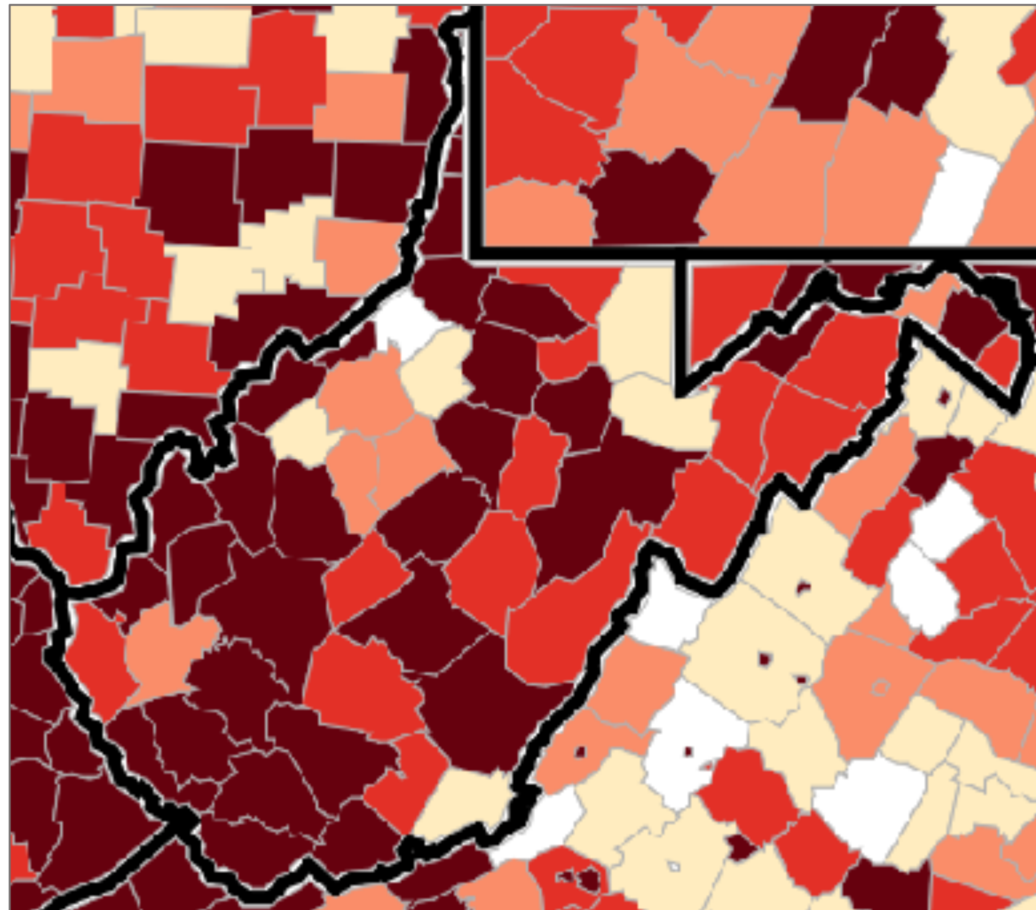


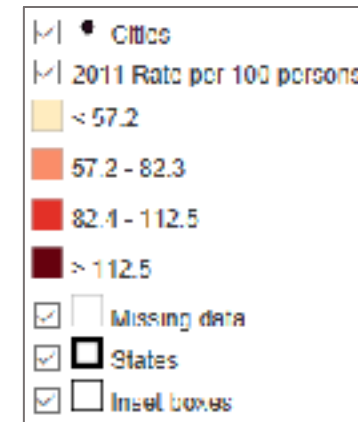
https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html

U.S. County Prescribing Rates, 2011

Logan, WV

291



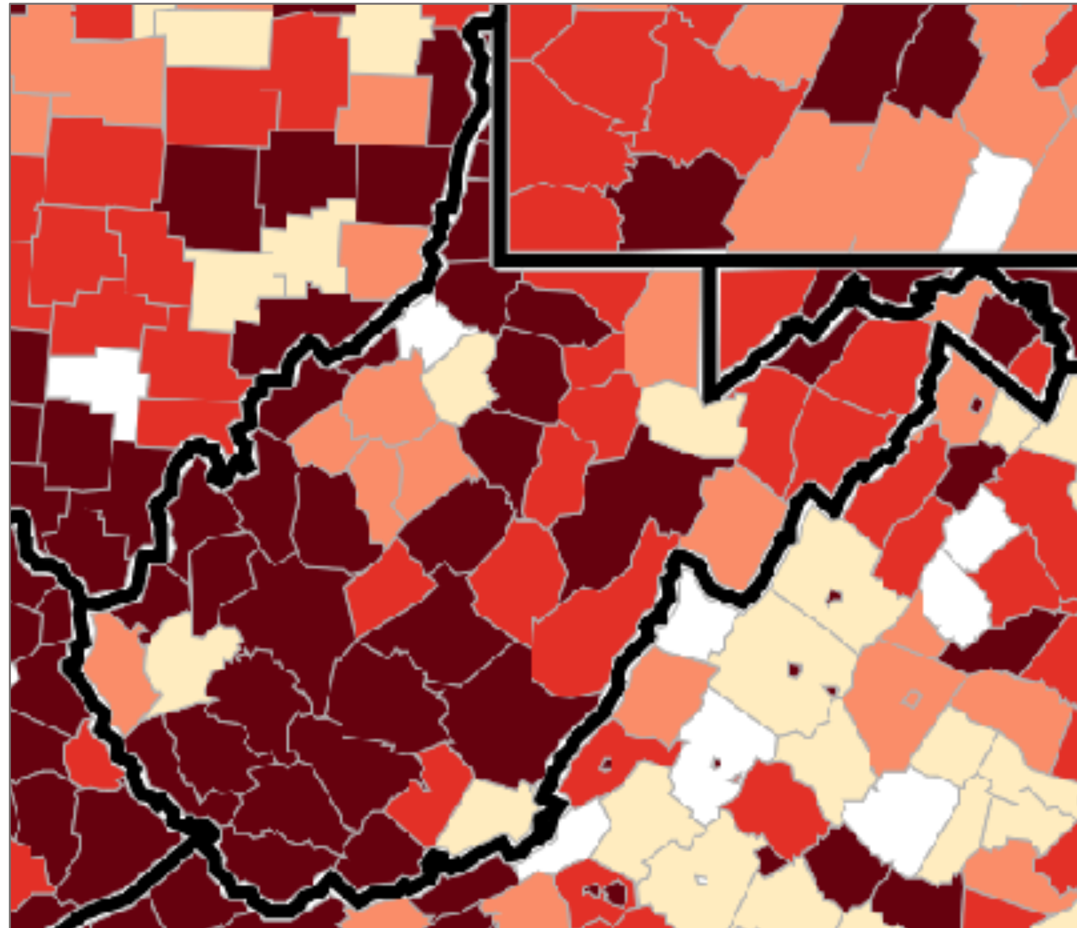


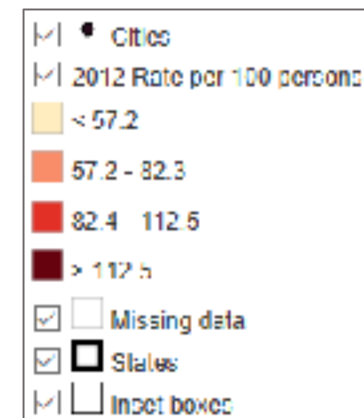
https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html

U.S. County Prescribing Rates, 2012

Logan, WV

300.1



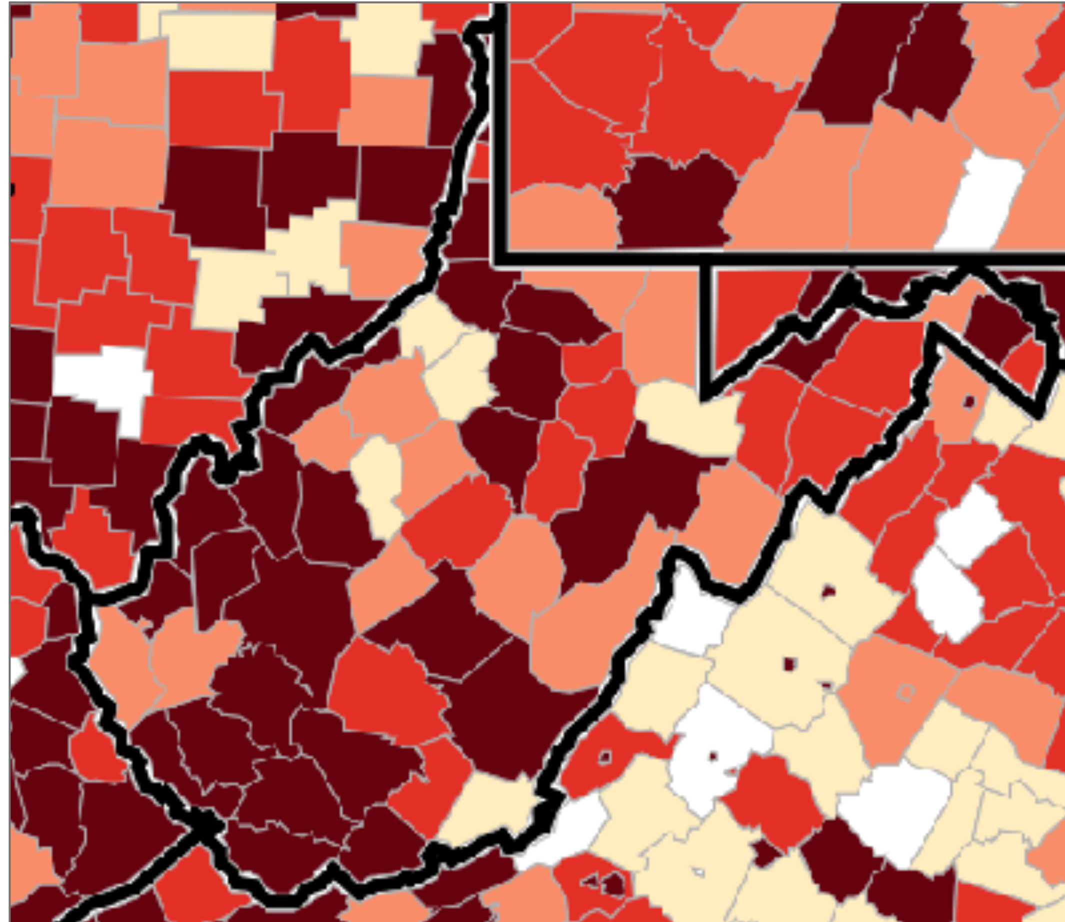


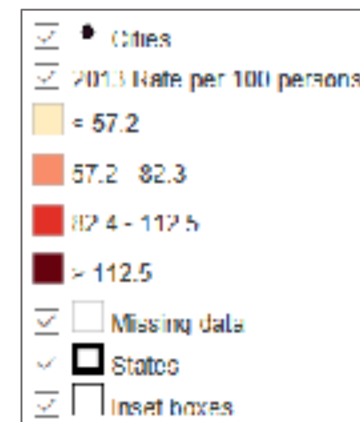
https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html

U.S. County Prescribing Rates, 2013

Logan, WV

272.4



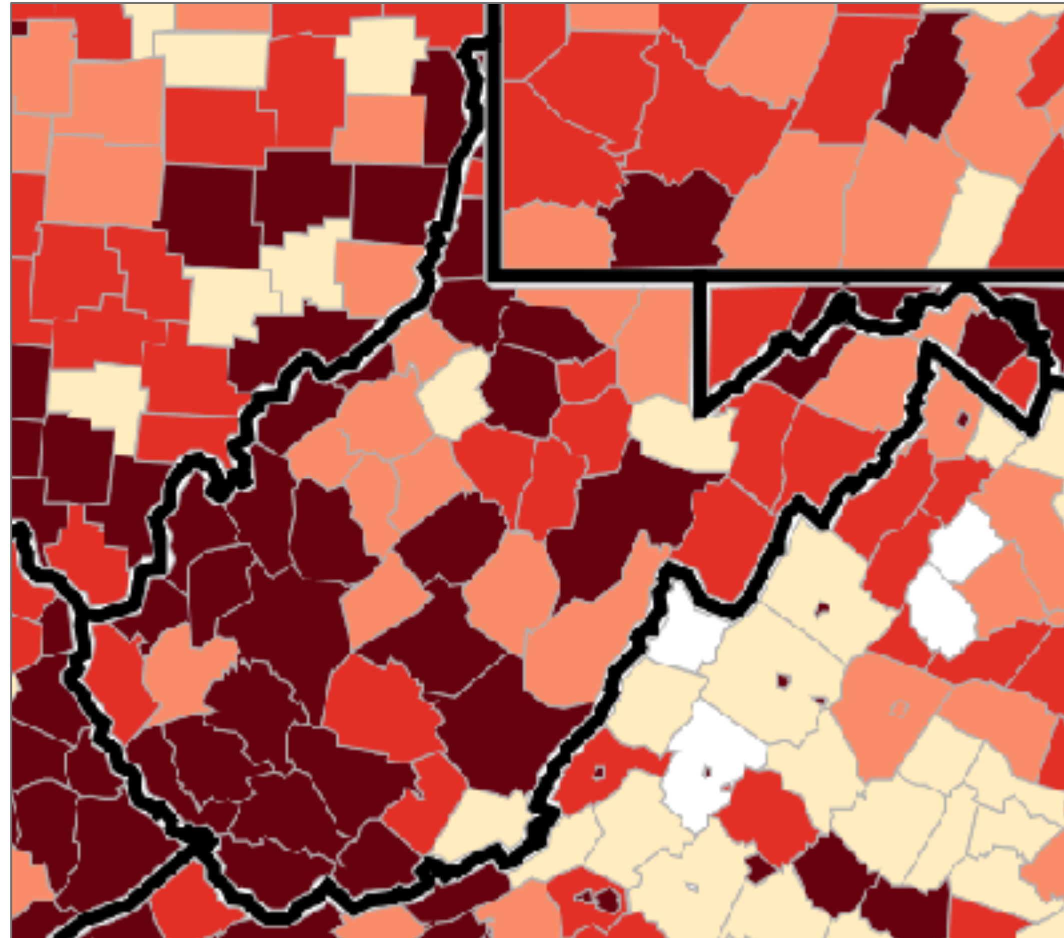


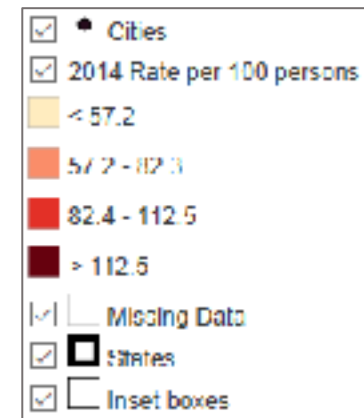
https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html

U.S. County Prescribing Rates, 2014

Logan, WV

263



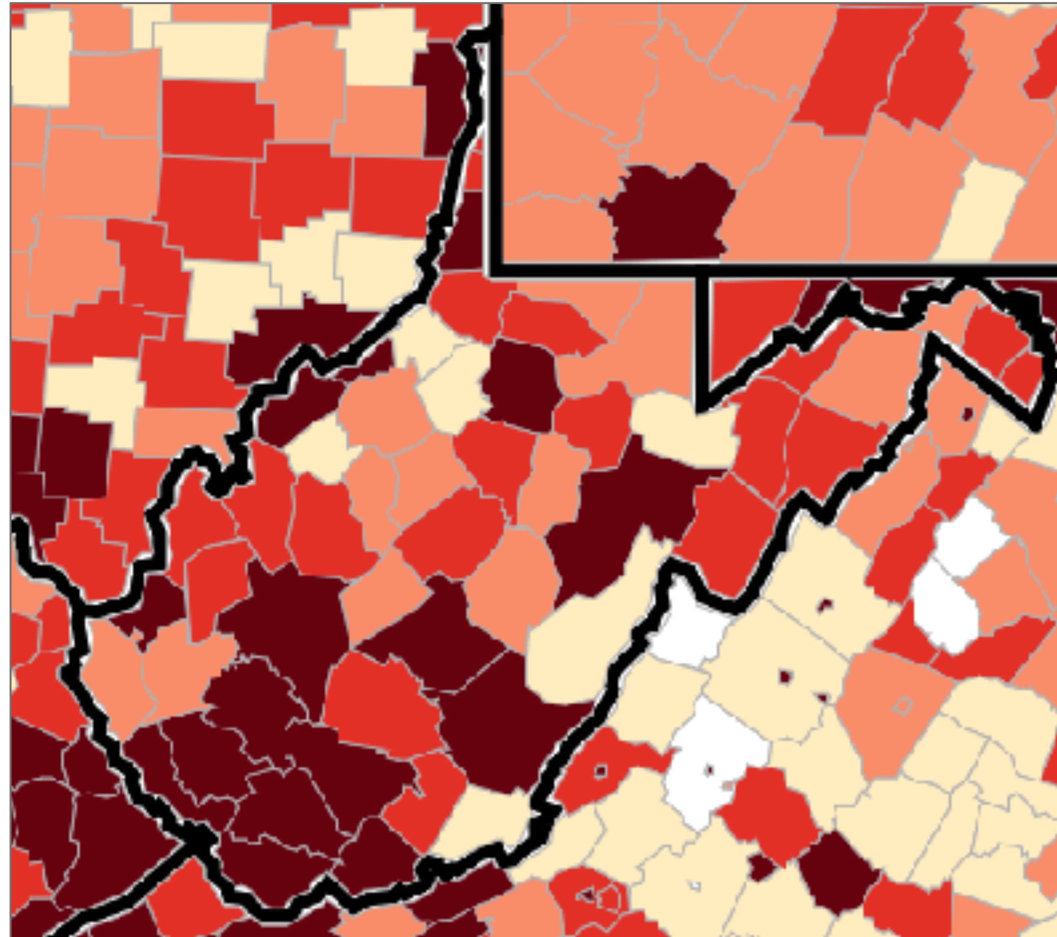


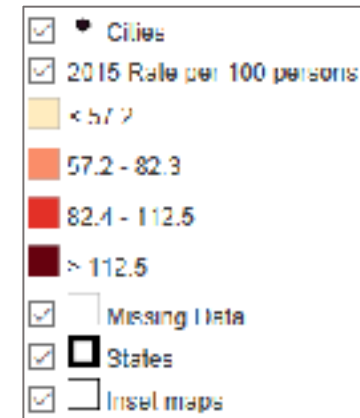
https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html

U.S. County Prescribing Rates, 2015

Logan, WV

206.6



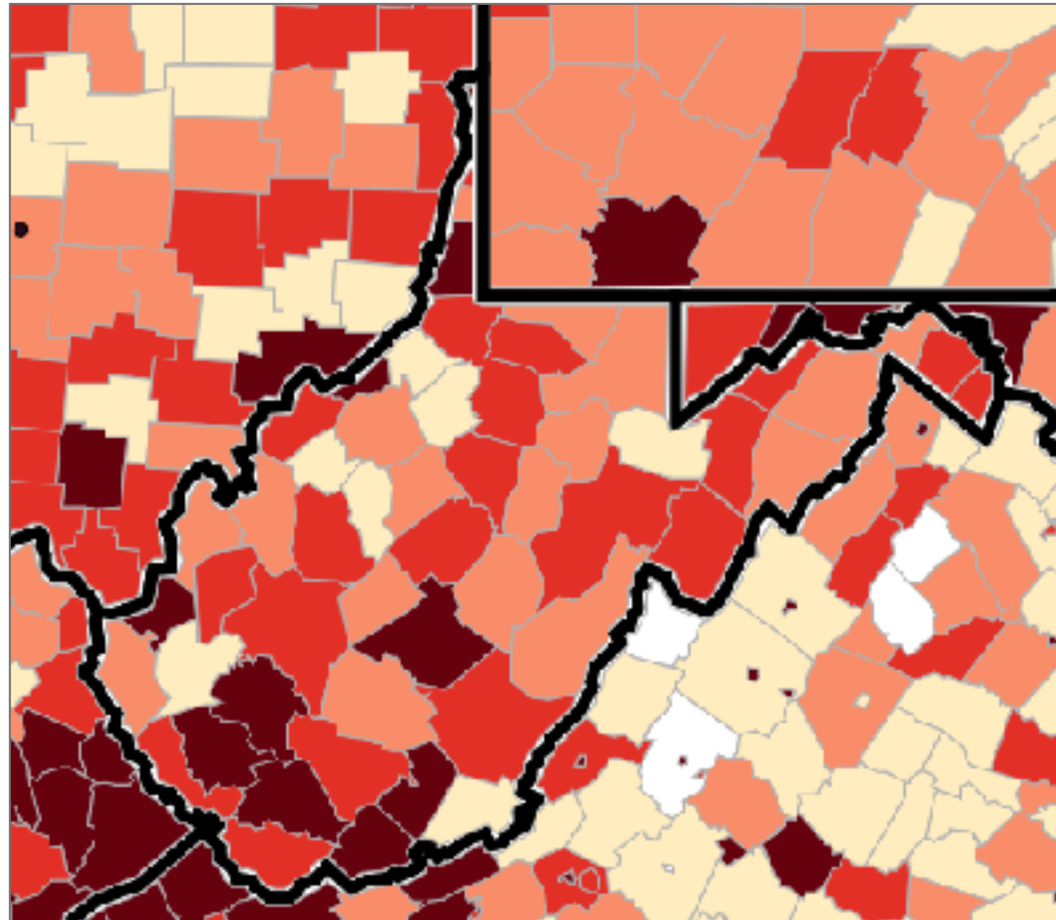


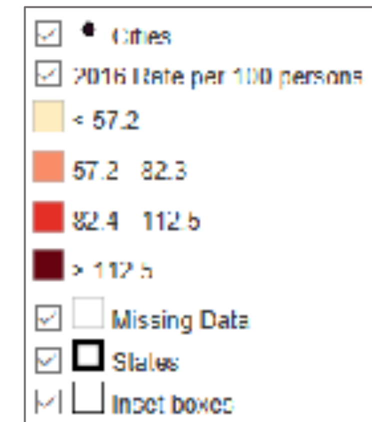
https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html

U.S. County Prescribing Rates, 2016

Logan, WV

194.3



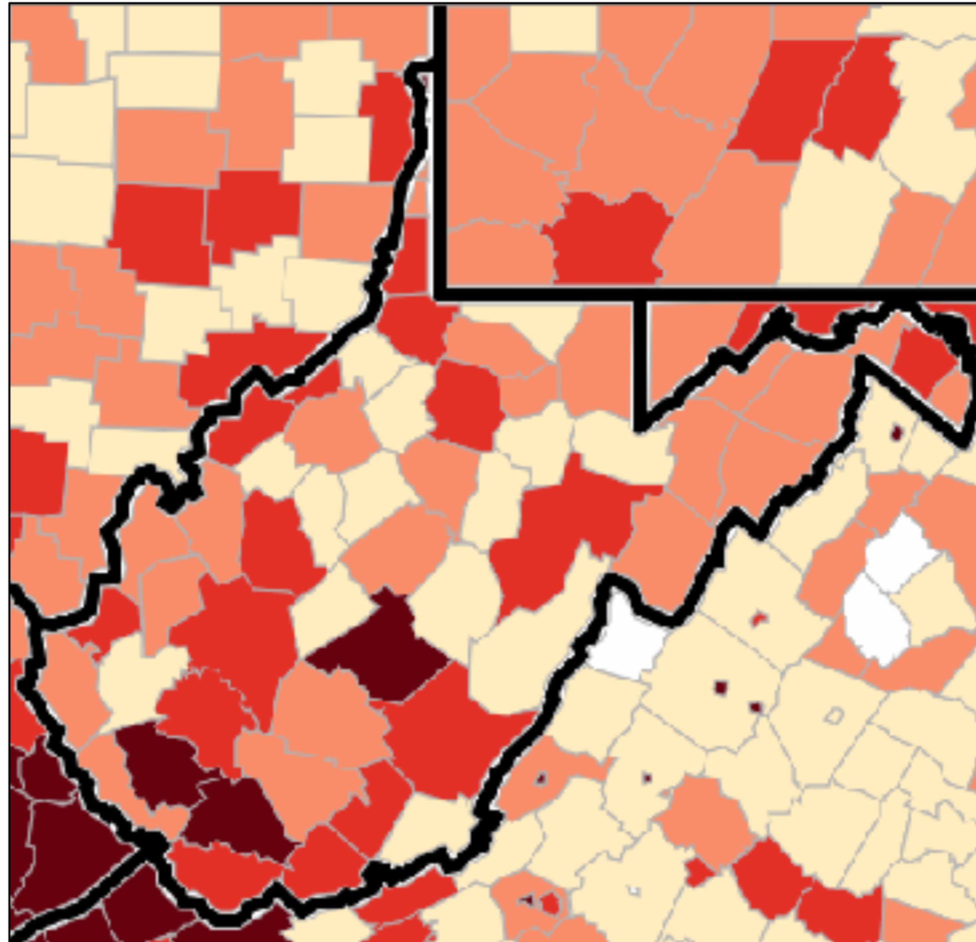


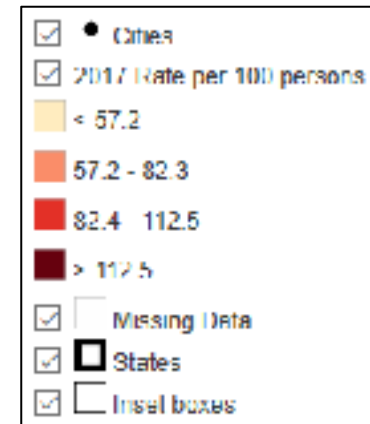
https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html

U.S. County Prescribing Rates, 2017

Logan, WV

170.7

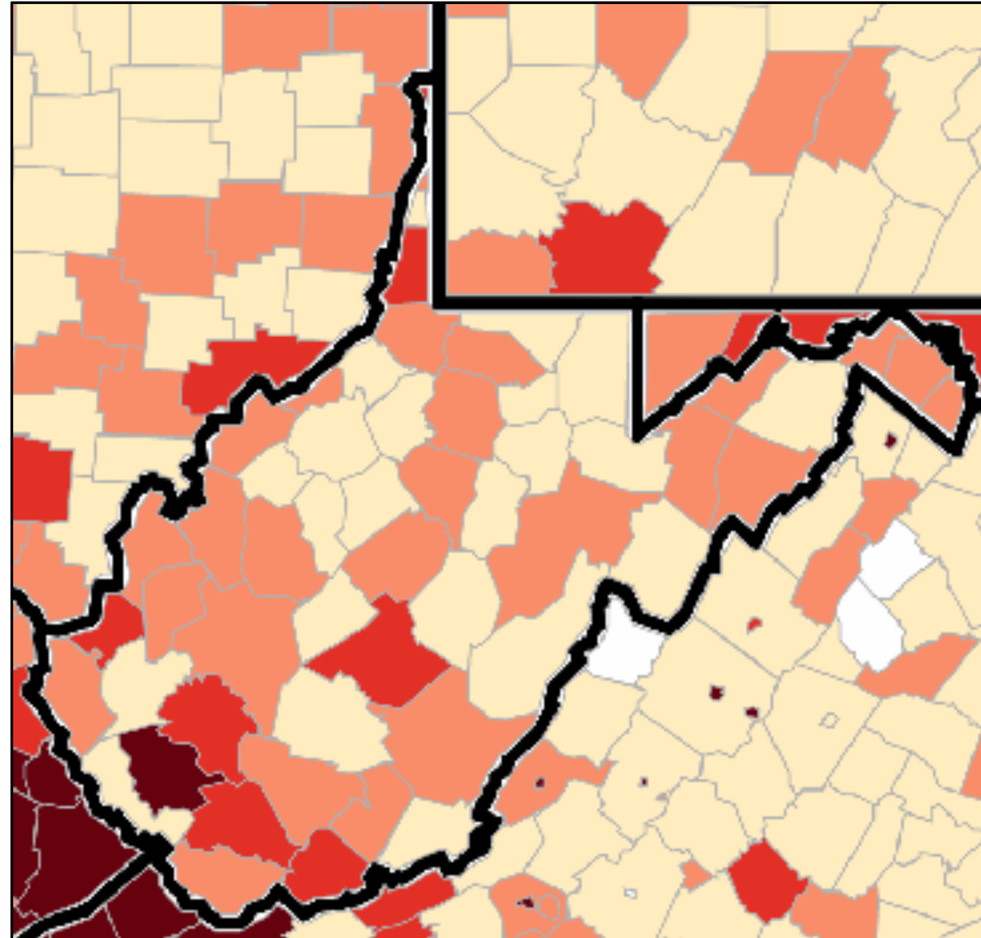


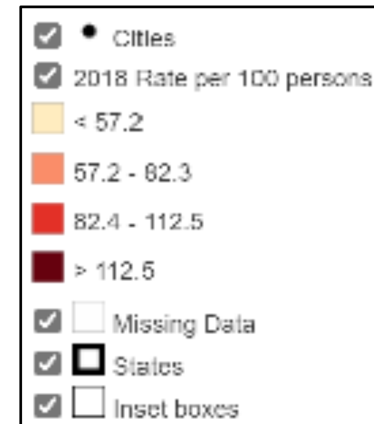


U.S. County Prescribing Rates, 2018

Logan, WV

146.43





Population: 54045

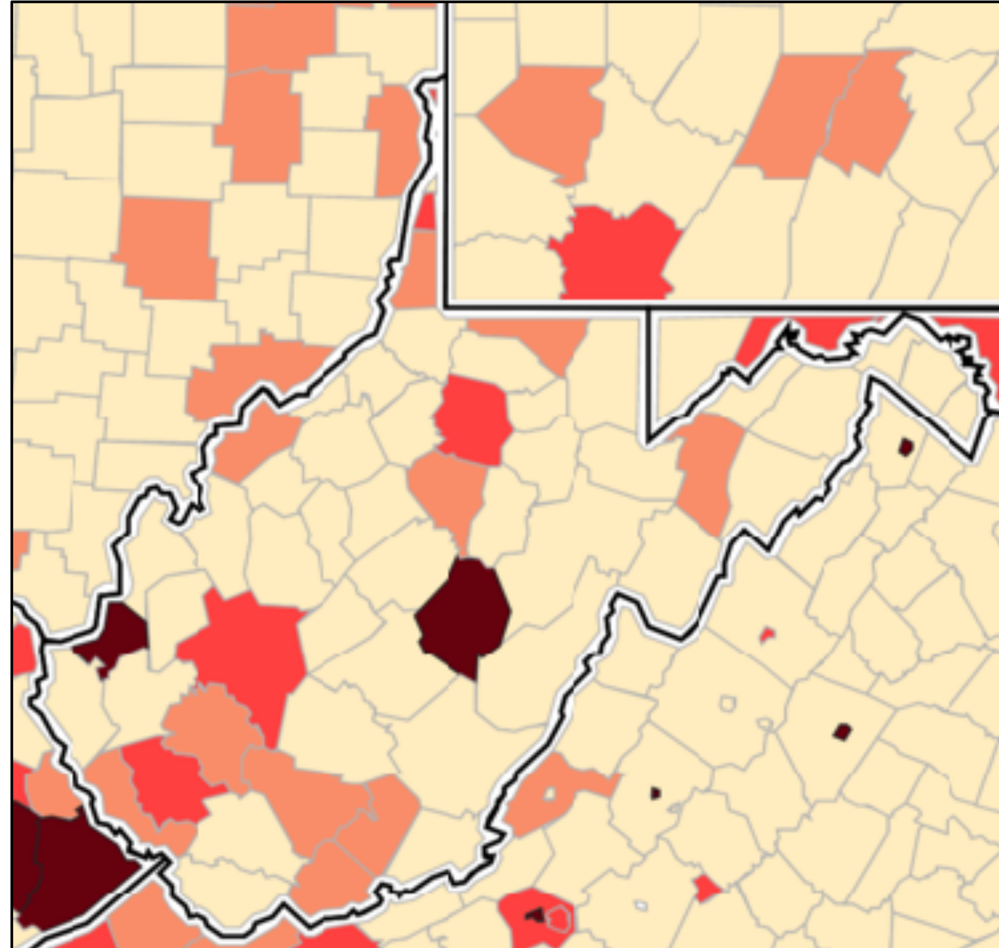
U.S. County Prescribing Rates, 2019

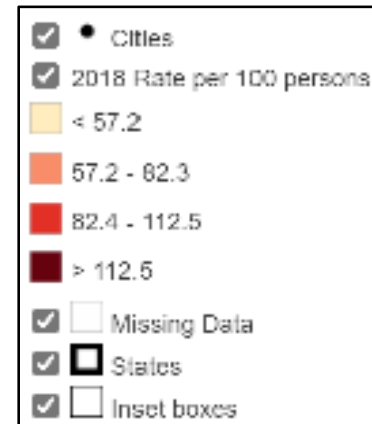
Logan, WV

93.7

WEBSTER, WV

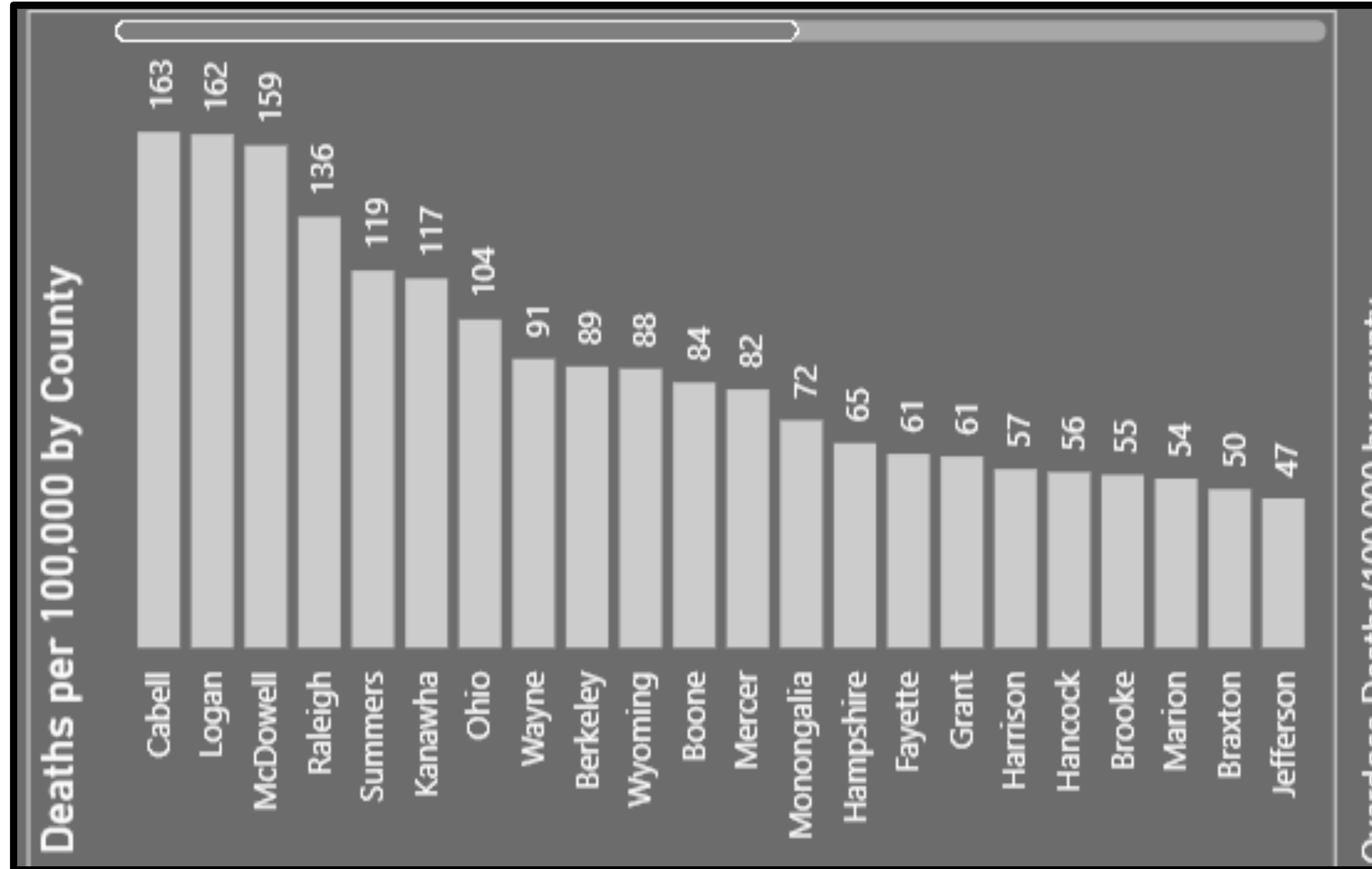
Opioid Rx Rate:
124.8





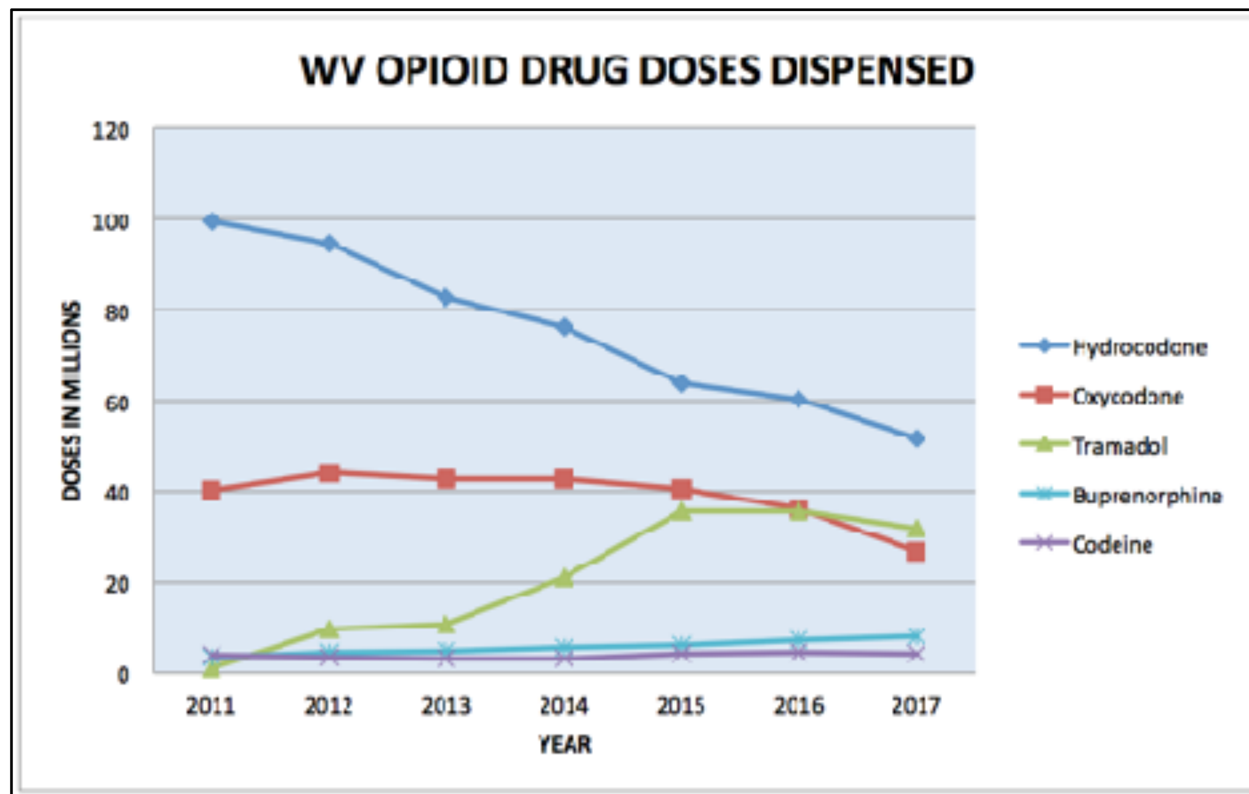
Population: 54045

WV Overdose Fatalities 2020



https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx 9/17/21

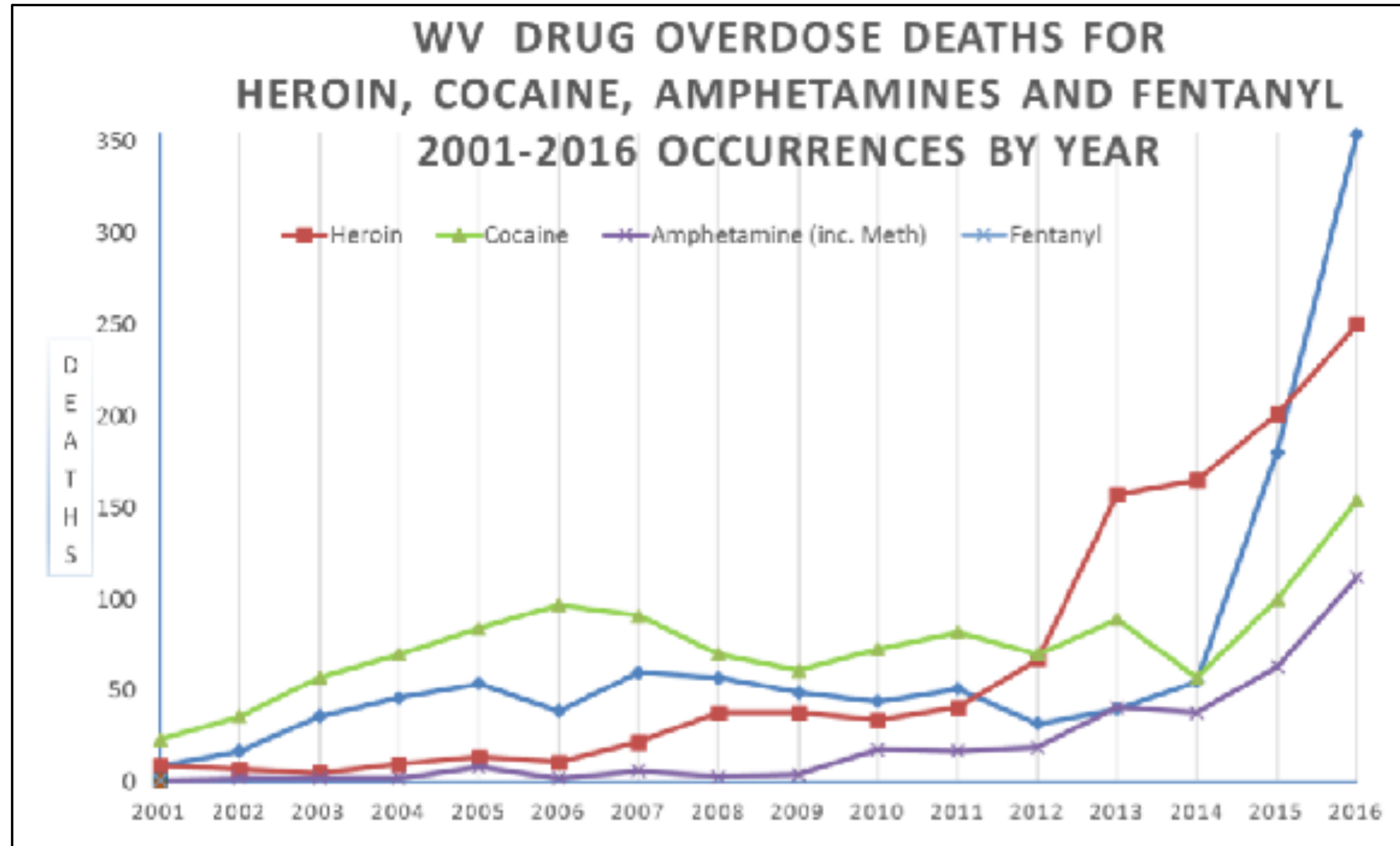
WV Opioid Reduction Not Tied to Fewer Deaths



In 2017, the number of doses of prescribed controlled substances — dispensed in West Virginia **fell by 31.3 million compared with 2016**.

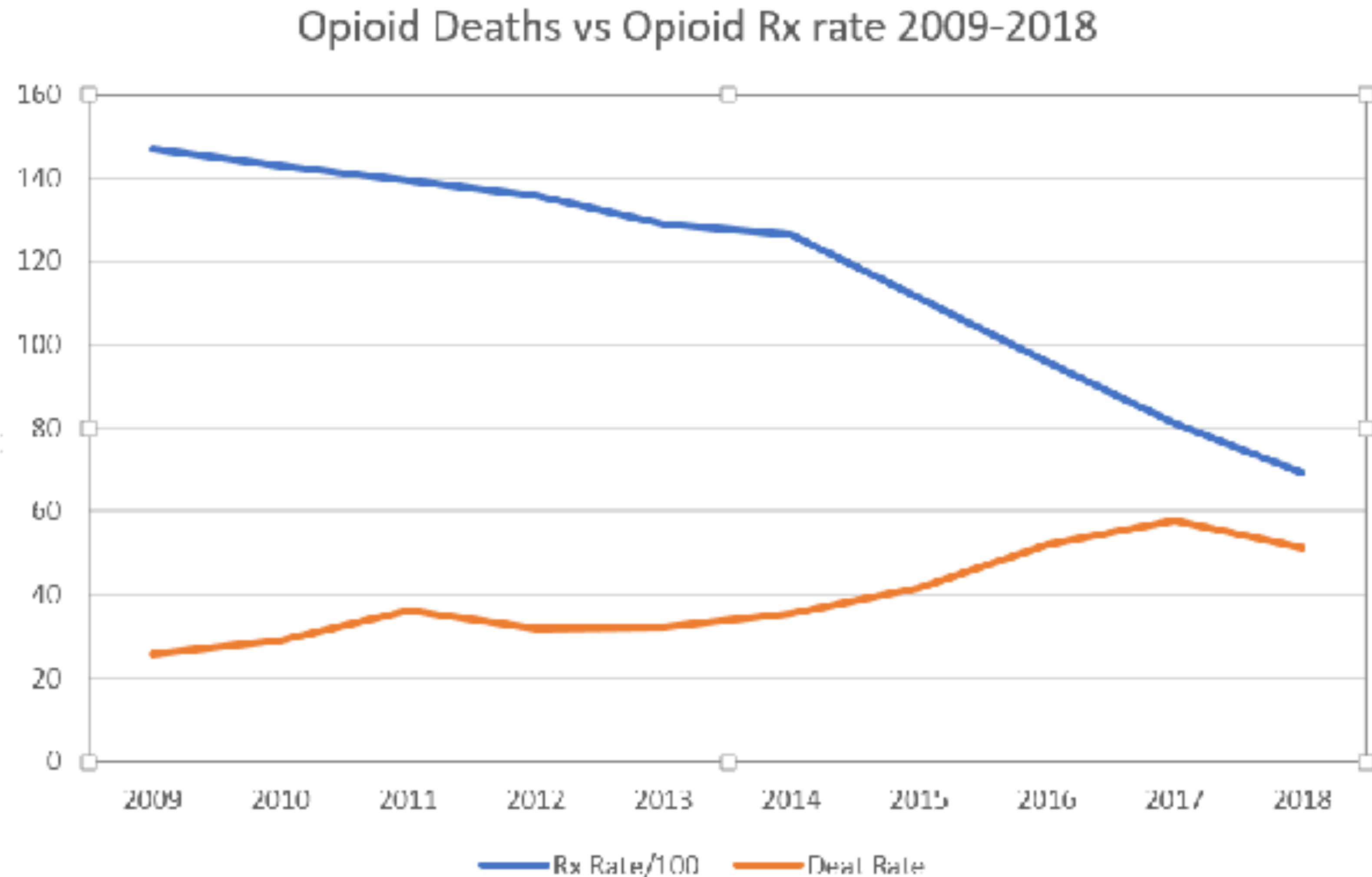
https://www.cnbc.com/2018/01/22/west-virginia-saw-drop-in-opioid-painkillers-prescribed deaths-rose.html

WV Rx Reduction Not Tied to Fewer Deaths

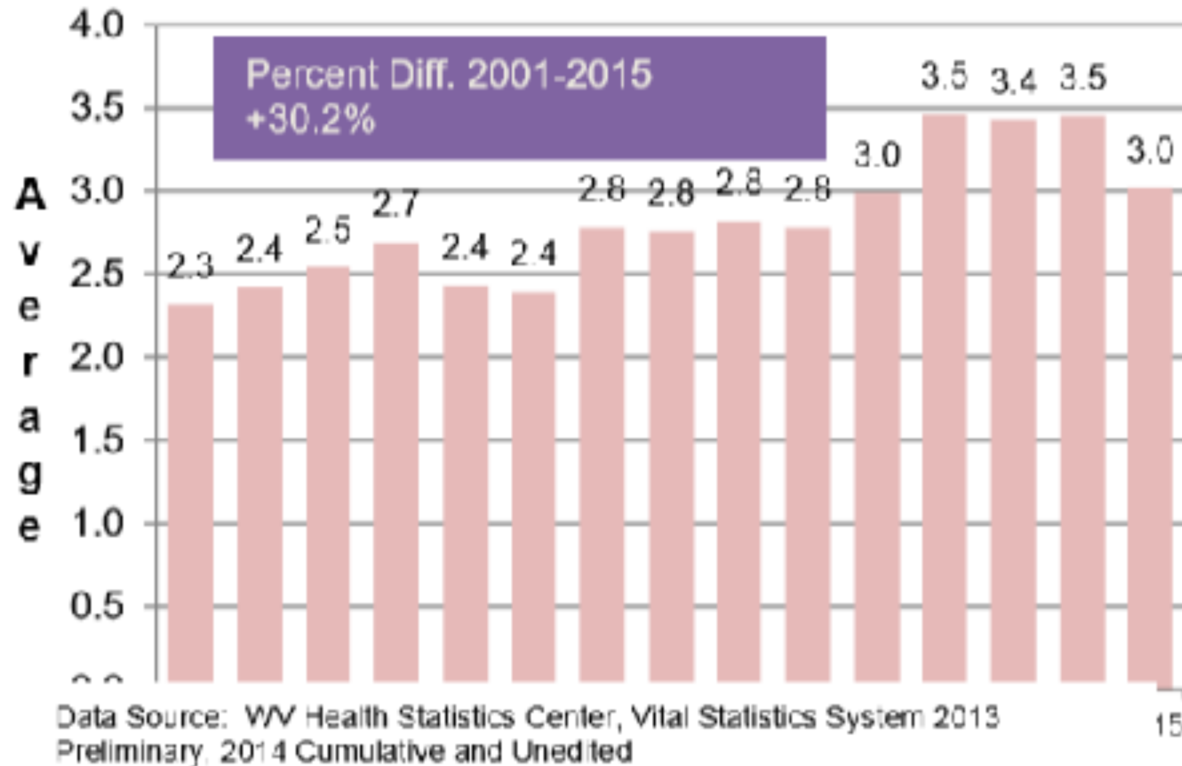


https://www.cnbc.com/2018/01/22/west-virginia-saw-drop-in-opioid-painkillers-prescribed-deaths-rose.html

WV Opioid Reduction Not Tied to Less Deaths



Heroin and Rx Opioids Often Mixed:



This is a primary rational for appropriate, ongoing, prescribing education as opposed to ongoing education regarding Addiction Treatment.

The Role of WV Prescribers

The above slides show **WV physician opioid prescribing continues to decline**.

Outlier counties continue to reduce usage, including the lead outlier, Logan county.

We are just now beginning to see fewer opioid related deaths.

Break

Agenda

The First 30 min.

Why We Are here

The current situation

The Next hour:

Starting Patients on Opioids

Assessment of Need

Assessment of Risk

BOP

Contracts

The Hour after that..

Prescribing Opioids

Opioid equivalents

Testing:
Urine
Pill counts

Stopping Opioids

The Last 30 min.

The latest opioid bill

How to help the Heroin users

Starting a Patient on Opioids

Reminder:

"Prescription opioid use is highly associated with risk of opioid-related death, with 1 of every 550 chronic opioid users dying within approximately 2.5 years of their first opioid prescription. "

Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W. **Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-control study.** PLoS Med. 2017 Oct 3;14(10).

Starting a Patient on Opioids

Clinical Practice Guideline
Opioid Prescribing for Chronic Pain
Affirmation of Value, April 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
Recommendations and Reports / March 18, 2016 / 65(1);1–49

Starting a Patient on Opioids

Best Practices: from the Choose Wisely Campaign

Do Not Prescribe Opioids as first line medication for Non-Cancer Pain.

American Society of anesthesiologist

Do Not prescribe Opioids as long term therapy for non-cancer pain until the risks are considered and discussed with the patient.

American Society of anesthesiologist

Do not prescribe Opioids for Acute or long-term therapy for patients in safety sensitive jobs, such as driving or operating heavy equipment.

American College of Occupational and environmental medicine.

https://www.aafp.org/afp/2016/0615/p982.html

Starting a Patient on Opioids

The CDC guidelines are written for FPs and Internist

-Together they Rx ½ of all Opioids.

They inform the Physician regarding the Prescribing of Opioids

-Chronically and not acutely.

The guideline defines chronic pain as:

"-pain conditions that typically last >3 months or past the time of normal tissue healing.. in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care"

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

Starting a Patient on Opioids

The Guidelines assume the physician is starting a patient on opioids for the first time, not continuing or extending the care initiated previously.

The guidelines have been converted into a **Checklist** on the CDC website.

The **Checklist** is outlined in the following slides:

Checklist for prescribing opioids for chronic pain

Starting a Patient on Opioids AAFP Guidelines

The Checklist

- ❑ **Nonopioid pharmacologic therapies are preferred for chronic pain.** Consider opioids when benefits for both pain and function outweigh risks. Opioids should be combined with nonopioid pharmacologic therapy as appropriate.

- ❑ **Assess Baseline Functional status** (PEG)

- ❑ **Establish realistic treatment goals** for pain and function before initiating opioid therapy. Stop opioid treatment if there is no meaningful improvement in pain and function.

Starting a Patient on Opioids AAFP Guidelines

The Checklist

- ❑ For chronic pain, **the lowest effective dose of immediate-release opioids should be prescribed** instead of long-active (LA) opioids.

- ❑ Reassess benefits and risks when increasing dosages to ≥50 morphine milligram equivalents (MME)/day. **Dosages ≥90 MME/day should be carefully justified or avoided** if possible.

Starting a Patient on Opioids

The Checklist

- ❑ **Evaluate risk factors** for opioid-related harms prior to initiation and periodically during treatment. Develop strategies to mitigate risk including offering naloxone to those at increased risk for overdose.

- ❑ **Use a prescription drug monitoring program** (PDMP) to review past opioid history when starting opioid therapy and periodically during treatment.

- ❑ **Use urine drug testing** (UDS) prior to initiating opioid therapy and periodically during treatment to assess compliance or illegal drug use.

Starting a Patient on Opioids:

The Checklist

- ❑ **Discuss benefits and risks** (eg, addiction, overdose) with patient.
- ❑ **Set criteria for stopping** or continuing opioids.
- ❑ Execute an **informed consent** or Opioid Contract.

file:///C:/Users/thendershot/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/cdc_38025_DS1%20(1).pdf

Starting a Patient on Opioids

The Checklist

- ❑ For acute severe pain, **the lowest effective dose in the smallest quantity** of immediate-release opioids should be prescribed.
- ❑ **Re-evaluate benefits and harms within 1 to 4 weeks of initiating** or escalating opioids for chronic pain and at least every 3 months thereafter.
- ❑ If benefits do not outweigh the harms, **start a plan to taper opioids** and optimize other therapies.

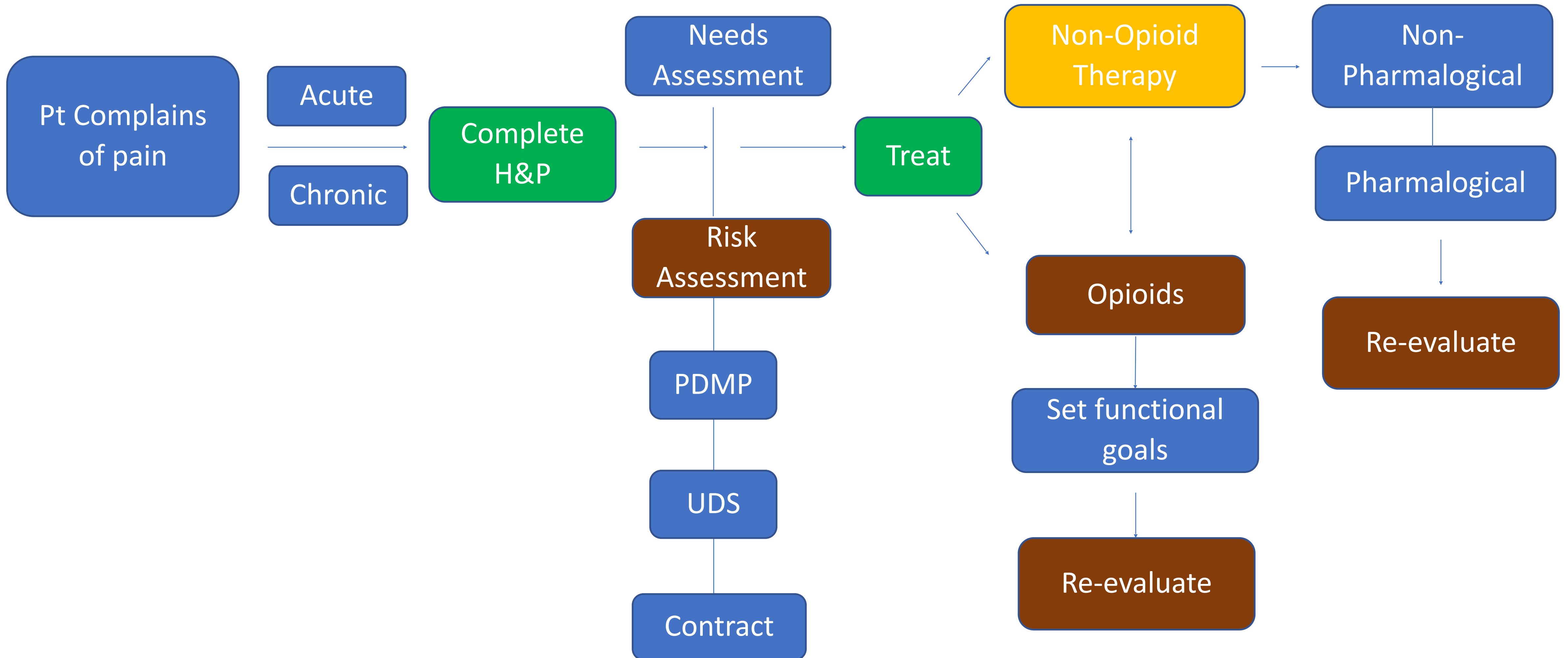
Starting a Patient on Opioids

The Checklist

- ❑ **Avoid co-prescription of opioids and benzodiazepines** whenever possible.

- ❑ **Evidence-based treatment** including medication-assisted treatment (MAT) with buprenorphine or methadone and behavioral therapies **should be offered to patients with opioid use disorder.**

Opioid Prescribing Flow:



Assessment of Need

My experience is that there are three categories of need:

1) **Accepted Causes**: Cancer, End stage disease, Hospice, palliative care, hospital level care (CP, air hunger, interoperative, post-op)
2) **Acute Pain**: trauma, worrisome infection, organ stress/death (pancreatitis, biliary obstruction, Nephrolithiasis, etc.)
3) **Chronic Pain:**
   a) Progressive and considering new start: rare in last 10 years
   b) Continuation of Prescriptions: previous provider retiring/deceased/ incarcerated

Assessment of Need

Chronic somatic or neuropathic pain e.g., musculoskeletal pain, peripheral neuropathy, postherpetic neuralgia is at least partially responsive to opioids.

Chronic visceral or central pain syndromes e.g., abdominal or pelvic pain, fibromyalgia, headaches, are less responsive or nonresponsive.

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician.* 2012 Aug 1;86(3):252-258

Assessment of Need-The PEG

Baseline Functional Tool

PEG score = average 3 individual question scores

What number, from 0 – 10 best:

Q1: Describes your

Pain in the past week?

Q2: Describes how, during the past week, pain has interfered with your **Enjoyment** of life?

Q3: Describes how, during the past week, pain has interfered with your

General activity?

Assessment of Risk

Does Risk Assessment Matter?

One open label, multi-primary care center study evaluated:

Potential for and incidence of aberrant drug-related behaviors among patients with..

Chronic, moderate-to-severe pain

To determine **investigator compliance** with a Universal Precautions (UP) approach to pain management.

Brown J, Setnik B, Lee K, Wase L, Roland CL, Cleveland JM, Siegel S, Katz N. Assessment, stratification, and monitoring of the risk for prescription opioid misuse and abuse in the primary care setting. J Opioid Manag. 2011 Nov-Dec;7(6):467-83.

Assessment of Risk

Does Risk Assessment Matter?

The UP approach included:

- Treatment agreements,
- **S**creener and **O**pioid **A**ssessment for **P**atients with Pain-Revised questionnaire,
- Pill counts,
- Pain-patient follow-up tool,
- Investigator assessment/plan, and
- Urine drug screens (UDS).

https://www.compliancesigns.com/OWE-8540.shtml

Brown J, Setnik B, Lee K, Wase L, Roland CL, Cleveland JM, Siegel S, Katz N. Assessment, stratification, and monitoring of the risk for prescription opioid misuse and abuse in the primary care setting. J Opioid Manag. 2011 Nov-Dec;7(6):467-83.

Assessment of Risk

Does Risk Assessment Matter?

At baseline:

47% were considered low risk for opioid misuse/abuse,
52 % moderate, and
1% **high.**

UDSs were + for nonprescribed drugs in some patients throughout the study.

Brown J, Setnik B, Lee K, Wase L, Roland CL, Cleveland JM, Siegel S, Katz N. Assessment, stratification, and monitoring of the risk for prescription opioid misuse and abuse in the primary care setting. J Opioid Manag. 2011 Nov-Dec;7(6):467-83.

Assessment of Risk

Does Risk Assessment Matter?

Study Results:

64% of investigators were compliant with major components of UP approach in greater than or = 75% of their patients.

But there was a tendency for investigators to assign lower risk levels than those that were protocol-specified.

Brown J, Setnik B, Lee K, Wase L, Roland CL, Cleveland JM, Siegel S, Katz N. Assessment, stratification, and monitoring of the risk for prescription opioid misuse and abuse in the primary care setting. J Opioid Manag. 2011 Nov-Dec;7(6):467-83. PubMed PMID: 22320029.

Assessment of Risk

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

https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html

Assessment of Risk

Measure risk using one of several partially validated measures:

The **Screener and Opioid Assessment for Patients with Pain** (SOAPP),

The **Diagnosis, Intractability, Risk, and Efficacy inventory** (DIRE),

The **Opioid Risk Tool** (ORT).

One small study predicting discontinuance for aberrant drug-related behavior found **the highest sensitivity for the clinical interview** (0.77) and the SOAPP (0.72), followed by the **ORT** (0.45) and the **DIRE** (0.17). Combining the clinical interview with the SOAPP increased sensitivity to 0.90.

Moore TM, Jones T, Browder JH, Daffron S, Passik SD. A comparison of common screening methods for predicting aberrant drug-related behavior among patients receiving opioids for chronic pain management. Pain Med. 2009 Nov;10(8):1426-33.

Assessment of Risk-ORT

Indicates the **probability of opioid-related aberrant behaviors**

In a study, 158 consecutive new patients treated in a pain clinic took the Opioid Risk Tool (ORT). It measured valid risk factors associated with substance abuse. All patients were monitored for aberrant behaviors for 12 months after their initial visits.

The ORT displayed **excellent discrimination** for both the male (c = 0.82) and the female (c = 0.85) prognostic models.

Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005 Nov-Dec;6(6):432-42.

Assessment of Risk-ORT

Those Scored as..

- **Low Risk: scores of 0-3**, 17 out of 18 (94.4%) did not display an aberrant behavior.
- **Moderate risk: Score of 4-7**
- **High Risk: Score of > or = to 8**, 40 out of 44 (90.9%) did display an aberrant behavior.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005 Nov-Dec;6(6):432-42.

Assessment of Risk-SOAAP

The **Screener and Opioid Assessment for Patients with Pain** (SOAPP)® helps determine how much monitoring a patient on long-term opioid therapy might require. It comes as a short and a standard form.

SOAPP endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The SOAPP is less good at identifying who is not at-risk.

The SOAPP is scored as > than 4 or less than 4.

Assessment of Risk-SOAAP

The tool asks interesting risk factors:

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 had legal problems or been arrested?

SOAPP Version	SOAPP Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ratio
Short Form	Score 4 or above	.86	.67	.69	.85	2.59	.20
Standard	Score 7 or above	.91	.69	.71	.90	2.94	.13

SOAPP® Version 1.0 - SF

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 have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
5. 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.

Assessment of Risk

What to do with the results?

Low risk: Treat the patient in-house.

Moderate risk: Either in-house or refer. If in-house, check more frequently and tighten up encounters, i.e. more frequently, only one script at a time, drug testing quarterly, etc.

High risk: Most refer.

https://www.noisyplanet.nidcd.nih.gov/have-you-heard/hospital-green-light-noise-awareness

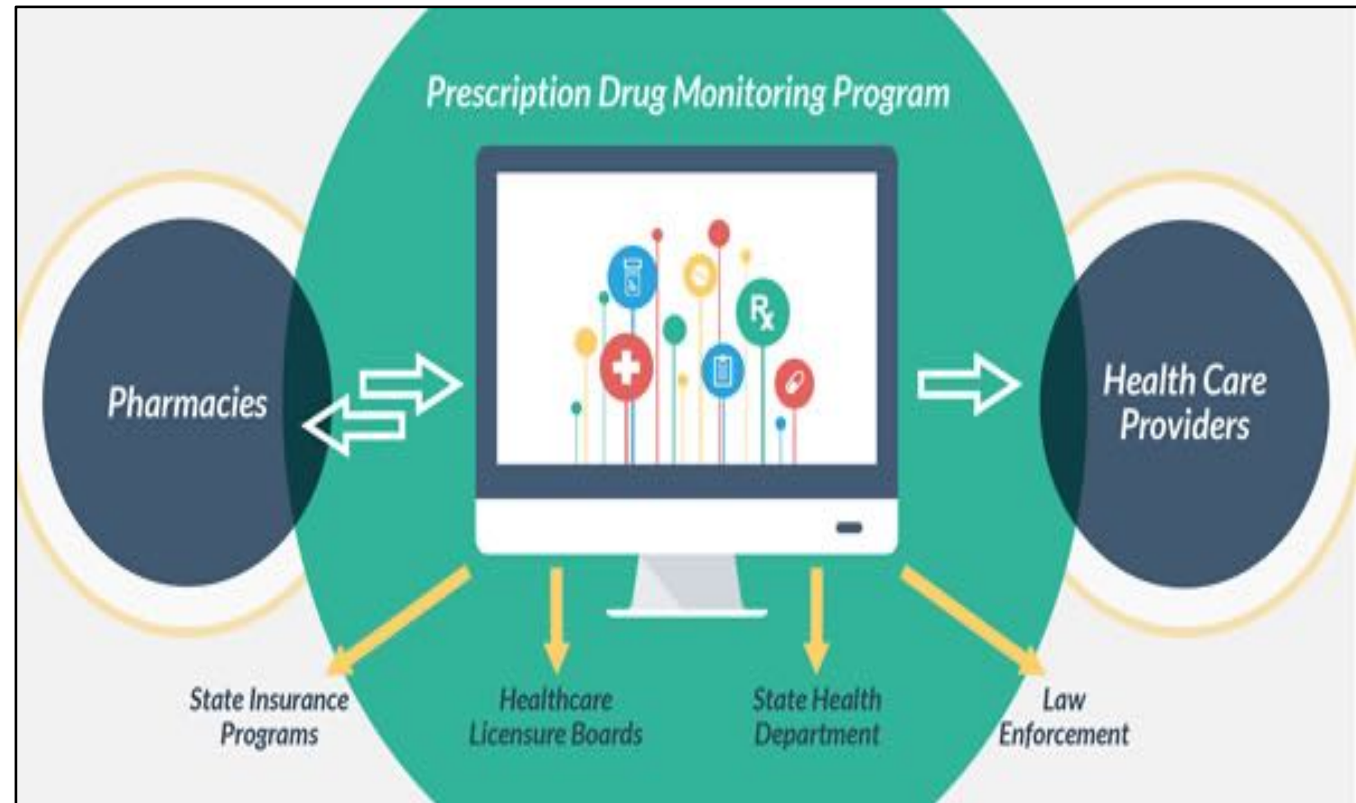
BOP

Evaluating for Misuse

Prescription Drug Monitoring Programs (PDMPs) collect data from pharmacies on dispensed controlled substance prescriptions and make those data available to authorized users through a secure, electronic database. Currently, all states have operating PDMPs. More than 20 have joined a shared database.

Some EMRs can pull PDMP data.

Making a query more convenient.



https://www.aafp.org/afp/2016/0615/p982.html#sec-1. https://www.cdc.gov/drugoverdose/pdmp/states.html. Missouri.

BOP

Warning Signs for Opioid Misuse

- Early refills
- The same or similar prescriptions from multiple physicians simultaneously (doctor-shopping)
- Dangerous drug-drug interactions (opioids and benzodiazepines)
- Total morphine milligram equivalents exceeding 120 mg per day

BOP

False Signs of Opioid Misuse

- Patients who are receiving care in a group/academic practice, where doctors cover for each other, should not be confused with patients who are doctor-shopping.
- Patients who are receiving prescriptions for limited quantities (e.g., a two-week prescription as part of an opioid taper) may not be getting early refills.

Contracts

In order to receive controlled medications, patients often sign a:

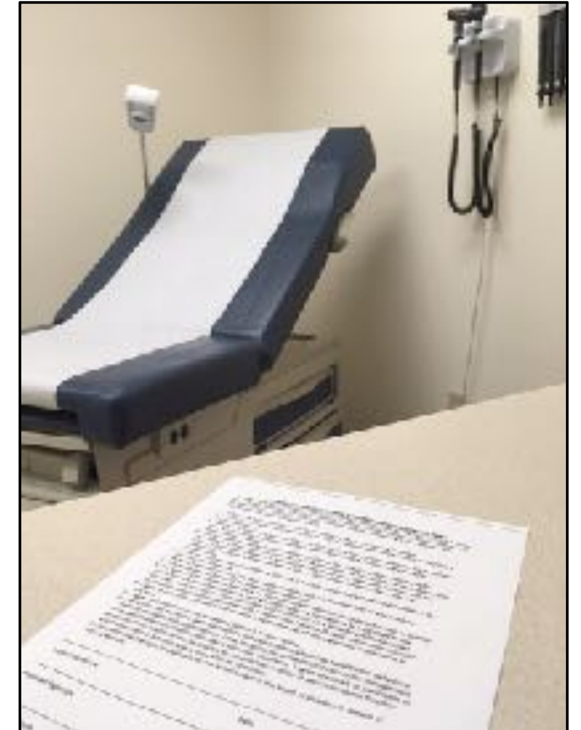
“**Pain Contract**,” or

“**Treatment Consent Form**,” or

“**Narcotic Contract**, " or

“**Opioid Treatment Agreement**" (OTA),

There is some criticism that OSAs are ethically suspect, if not unethical, and should be used with extreme care.



Rager JB, Schwartz PH. *Defending Opioid Treatment Agreements: Disclosure, Not Promises.* Hastings Cent Rep. 2017 May;47(3):24-33. doi: 10.1002/hast.702.

Contracts

Use an agreement that defines the terms and expectations of therapy

It should outline:

- Appropriate intervals for follow-up,
- Refill policies,
- Participation in any indicated multimodal management plan (e.g., physical therapy, psychological treatment),
- Use of only one prescriber and one pharmacy for all controlled medications, and prohibition of illicit substance use or prescription diversion.
- Should be part of an ongoing treatment plan for all patients receiving chronic opioid therapy, thereby avoiding reliance on physician judgment, suspicion, or bias.

https://www.aafp.org/afp/2016/0615/p982.html#sec-1

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician*. 2012 Aug 1;86(3):252-258

Contracts

Controlled Substance Agreements (CSAs)

One retrospective cohort study evaluated the opioid dosing for 1066 patients with CSAs in a primary care practice.

Patients were prescribed :

- an average of 40.8 MME/day,
- 21.5% of patients were receiving ≥50 MME/day and
- 9.7% were receiving ≥90 MME/day.

The Authors' Conclusions?

CSAs present an opportunity to engage patients taking higher doses of opioids in discussions about opioid safety, appropriate dosing and tapering.

Philpot LM, Ramar P, Elrashidi MY, Mwangi R, North F, Ebbert JO. Controlled Substance Agreements for Opioids in a Primary Care Practice. J Pharm Policy Pract. 2017 Sep 12;10:29.

Breaks

Agenda

The First 30 min.

Why We Are here

The current situation

The Next hour:

Starting Patients on Opioids

Assessment of Need

Assessment of Risk

BOP

Contracts

The Hour after that..

Prescribing Opioids

Opioid equivalents

Testing:
Urine
Pill counts

Stopping Opioids

The Last 30 min.

The latest opioid bill

How to help the Heroin users

Initial Dosing

Controlled Substances Act, (1970)

WV Code: Chapter 60A

Schedule	Definition	Examples	WV Rx Authority
1	Drugs with potentially severe physiological and psychological dependence. Considered to have no acceptable medicinal qualities.	Heroin, **Marijuana,** MDMA (ecstasy), Lysergic acid diethylamide (LSD), GHB (date rape drug), Mescaline, Cathinone (used in bath salts), Peyote, Psilocybin and psilocin (mushrooms)	**(For Details check w/ Licensing Boards)**
2	Commonly abused and causing dependency. They have a legitimate medical use. Must be prescribed to a patient by their provider and received from a pharmacist	Cocaine, OxyContin, Dilaudid, Methadone, Fentanyl, Vicodin, Methamphetamine, Dexedrine, Adderall, Ritalin	**MD/DO**
3	Drugs with a moderate to low potential for dependence and have accepted medicinal qualities. Only legally obtained with a provider's prescription.	Ketamine, **Tylenol with codeine**, **Buprenorphine** (Suboxone, Subutex), Anabolic steroid, Testosterone,	MD/DO. PA: Prescribe. NP Prescribe, Dispense, Administer
4	Less chance of addiction or abuse. Providers allowed to include 5 refills in a 6 month period without additional consultation.	**Xanax,** Valium, Klonopin, **Ambien**, Sonata, Lunesta, Phenobarbital (long acting barbiturate), Modafinil (Stimulant-like drug), lomotil	**MD/DO. PA: Prescribe. NP Prescribe, Dispense, Administer**
5	Lowest likelihood for abuse, don't require a prescription and may be refilled.	**Robitussin AC**, Pyrovalerone (for chronic fatigue/ appetite suppressant), Some anticonvulsants (Lyrica, gabapentin)	**MD/DO. PA: Prescribe. NP Prescribe, Dispense, Administer**

https://www.dea.gov/drug-scheduling https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf

Initial Dosing

Non-opioids

Seldom should pain be treated w/ opioids alone.

There is **A level evidence** that TCA or SSNRIs should be included in patients with **chronic** nonterminal pain with a neuropathic component.

https://www.vivehealth.com/blogs/resources/best-ice-pack-for-knee

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician*. 2012 Aug 1;86(3):252-258

Initial Dosing

Opioids should be initiated as a trial,

Continue IF:

Progress is documented toward functional goals, **and**

There is no evidence of complications, including misuse or diversion.

C level evidence

http://www.kmzu.com/sodomy-case-proceeds-pettis-county/istock_generic-scales-of-justice/

Initial Dosing

Expect Adverse Effects:

Most Common - Constipation

Greatest Mortality - **Respiratory Depression**

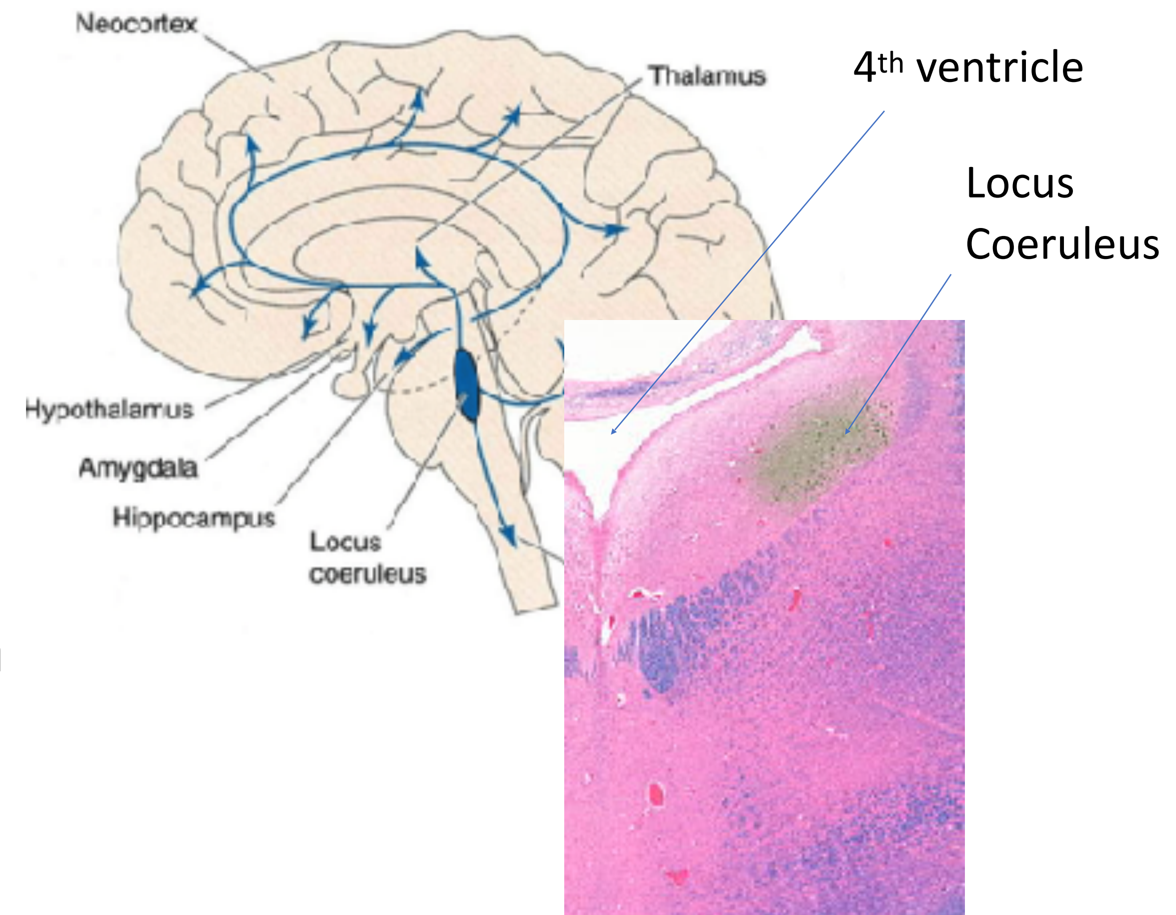
Other serious Mortality - Dependence, Hyperalgesia, Addiction

Other concerns: Sedation, Falls, Hypogonadism, Sweating, Miosis, Urinary Retention.

Initial Dosing

Why Respiratory Depression?

When opioid receptors in the **locus coeruleus** (brainstem) are activated they **prevent the release of noradrenaline** – decreasing alertness and blood pressure, increasing drowsiness, slow respiration (breathing), and induce analgesic (pain relieving) effects.

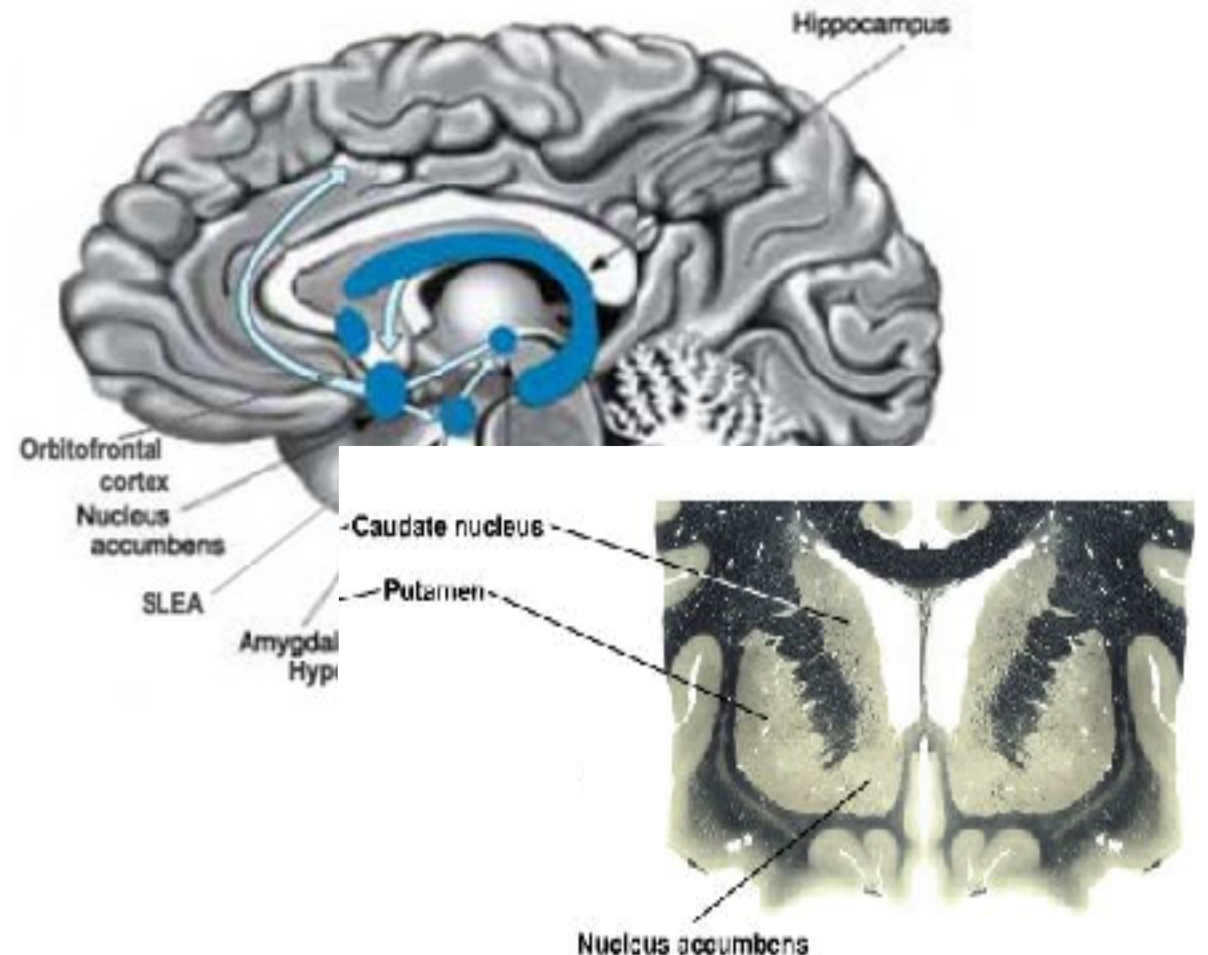


https://www.workithealth.com/blog/science-of-suboxone. https://en.wikipedia.org/wiki/Locus_coeruleus.

Initial Dosing

Why Respiratory Depression?

Opioid receptor activation in the **nucleus accumbens releases dopamine**, stimulating feelings of pleasure.



https://www.basisonline.org/2003/08/the-wager-833-.html

Initial Dosing

Expect Adverse Effects:

Identify Risk of Respiratory Depression

- Elderly, Debilitated
- Co-administered with other Resp Depressants
- Opioid Naive patients
- **Contraindicated** in those with Respiratory Suppression risks (COPD?)

http://oxygenadvantage.co.za/2017/02/15/simulate-high-altitude-training-acclimatization/

Initial Dosing

Expect Adverse Effects:

Greatest Mortality-Respiratory Depression

- Discuss risk with patient
- Explain how hypercapnia exacerbates the sedating effect of opioids
- Urge supervision during initial use
- Encourage immediate use of 911 if respiratory depression suspected
- Offer Opioid Antagonists-**Naloxone**

Initial Dosing

Low, Slow, and Steady

Stabilize patient with one opioid.

Limit continuous use of short-acting opioids for breakthrough therapy- especially when transitioning to LA therapy.

Avoid polypharmacy with multiple opioids or co-treatment with benzodiazepines.

Initial Dosing

Sustained-release preparations..

Offer more consistent drug levels.

Use caution when a patient demands only short-acting medication.

High potential for abuse or diversion:

fentanyl (Duragesic) patches

oxycodone (Roxicodone)

methadone (but easily monitored)

Lower risk, and has less abuse potential:

sublingual or transdermal buprenorphine

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician*. 2012 Aug 1;86(3):252-258

Initial Dosing

Black Box Warnings:

All opioid agonist-

- Addiction, abuse, misuse.
- Respiratory Depression.
- Accidental Ingestion.
- Neonatal withdrawal syndrome.
- CYP450 3A4 interactions.
- Risk of Concomitant use w/ Benzo./ CNS Depressants.

Acetaminophen warning-for acute liver failure.

MOA: Opioid Receptor Agonist.

Initial Dosing

Safety and Monitoring

Renal Dosing: Cr at baseline, then if severe renal disease or >65YOA check periodically.

Hepatic Dosing: if acetaminophen check LFTs, esp if severe hepatic disease.

Pregnancy/Lactation: may result in androgen deficiency-limited studies. Weigh risk/benefit if prolonged use. Risk of NAS. The risk of fetal harm is low. Acetaminophen is analgesic drug of choice while breast feeding.

Initial Dosing

Simplify Dosing

Consolidate any other opioid therapy into one medication using an **equianalgesic calculator** (narculator.com).

When exceeding a **morphine equivalent of 100 mg per day**:

-Use extra caution.

-Consider referral to a pain management team.

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician.* 2012 Aug 1;86(3):252-258

Initial Dosing

Low, Slow, and Steady

Morphine: should be the 1st choice for chronic potent opioid therapy.
Morphine doses are the units on which opioid equianalgesic calculations are based.

Side Effects: constipation, nausea, pruritus, and drowsiness, all of which are more common than morphine allergy.

Use with caution in patients with renal failure.

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician*. 2012 Aug 1;86(3):252-258

Initial Dosing

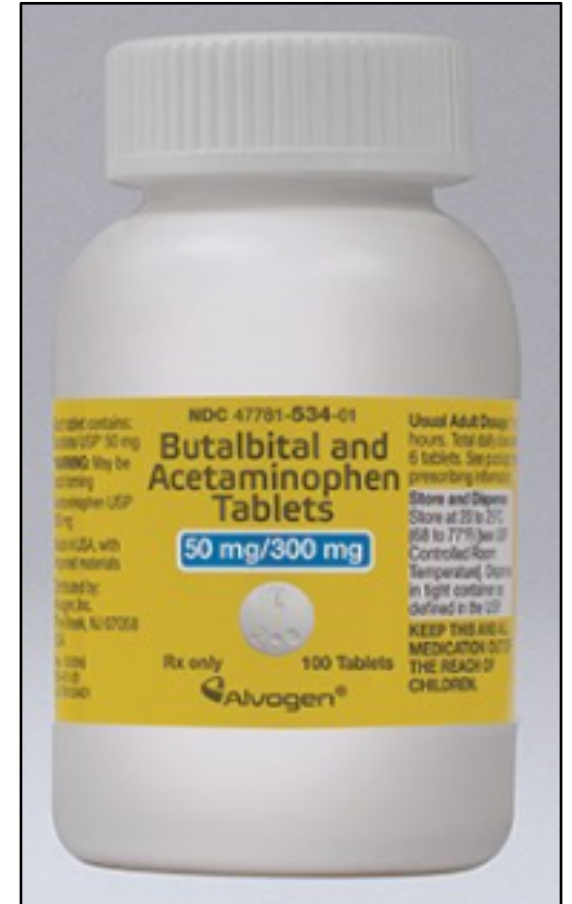
Butalbital/Acetaminophen

Brand Name: Bupap, Allzital

DEA Schedule II-V, status by state laws

MOA: Butalbital produces sedation/Selective COX-2 inhibitor. **Half-life 35 hours.**

Tension HA: 1-2 tabs PO q 4h prn. Limit to <300mg/day butalbital, 1g/4hrs and 4 g/day acetaminophen



http://alvogenus.com/products/product/butalbital-and-acetaminophen

Initial Dosing

Butalbital/Acetaminophen/Caffeine/Codeine

Brand Name: Fioricet with Codeine, 50/300/40/30

DEA Schedule III status by state laws

MOA: Butalbital produces sedation/Selective COX-2 inhibitor/binds to opioid receptors.

Tension HA: 1-2 caps PO q 4hrs prn. **Max 6 caps a day.** Limit to <300mg/day butalbital, 1g/4hrs and 4 g/day acetaminophen, 360 mg/day codeine.

Taper: 25-50% q 2-4 days

http://buynembutal.com/shop/fiorinal-codeine-side-effects/

Initial Dosing

Acetaminophen/Codeine

Brand Name: Tylenol No. 3 (300/30mg)

DEA Schedule III with Black Box warnings

MOA: Selective COX-2 inhibitor /Binds to Opioid receptors

Mild to Mod pain:15-60mg of codeine PO q 4-6hrs PRN, >60mg not more effective.

http://canacopegdl.com/keyword/tylenol-bottle-3.html

Initial Dosing

Tramadol

Brand Name: Ultram (50mg, ER 100, 200,300mg)

DEA schedule IV, Black Box warnings

Half-life: 6-8 hours, **Renal Dosing** CrCl < 30.

MOA: Binds to MU Opioid receptors (Central opioid agonist) and inhibits Norepinephrine/serotonin reuptake.

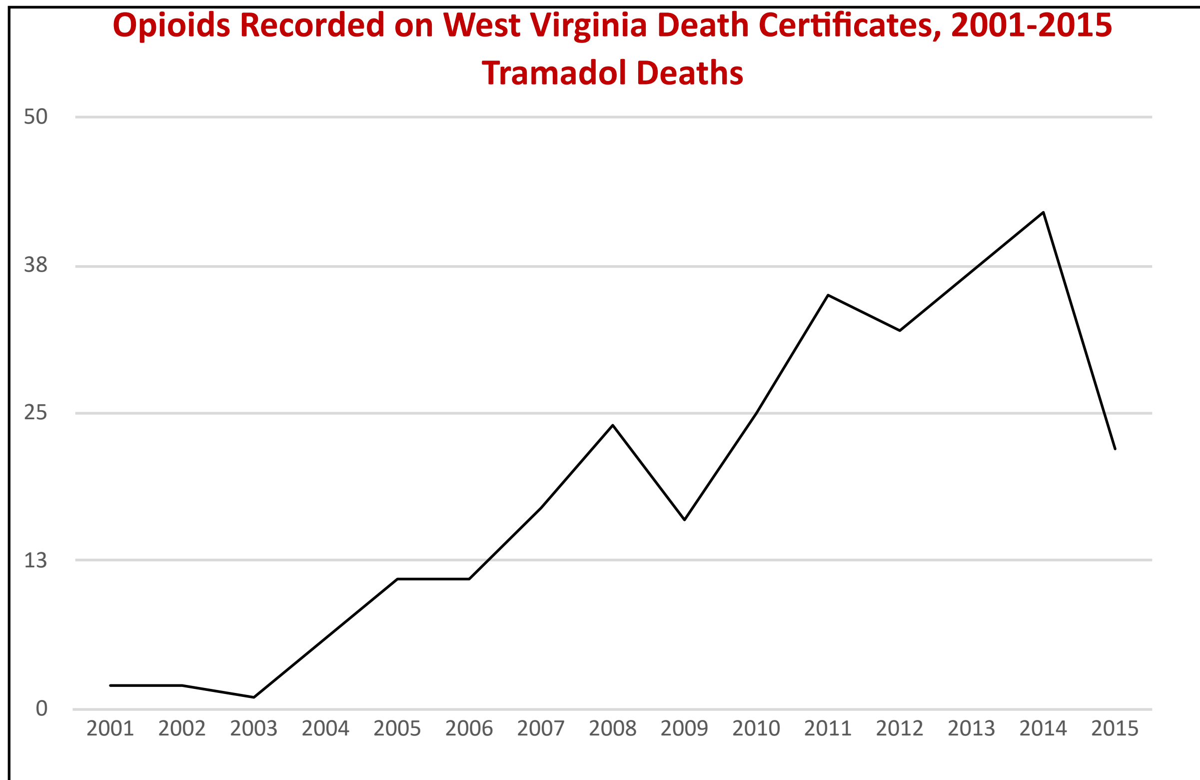
Mod-severe pain: Start 25 mg PO q AM. Increase 25 mg Q 3 days. Titrate to Q 4 hrs., Max 400mg. PRN, >60mg not more effective.

Chronic, Mod-severe Pain: ER PO Q day increase by 100 mg/day q 5 days, Max of 300 Q day. Conversion from IR 1:1

https://drugsdetails.com/wp-content/uploads/2016/03/tramadol-50mg-100ct-3.jpg

Initial Dosing

Tramadol-Associated Deaths



The opioid painkiller Tramadol has increased from less than **1 million pills in 2011 to 35.7 million last year..**

"It's way less potential for abuse, way less diversion," (Mike) Goff said.

- Eric Eyre WV Gazette. Jan 21, 2017

https://www.wvgazettemail.com/news/health/opioid-alternative-linked-to-spike-in-wv-overdose-deaths/article Eric Eyre Jan 21,2017
WV Drug Overdose Deaths Historical Overview 2001-2015. Jim Justice, Bill Couch, Rahaul Gupta, MD. August 17, 2017.

Initial Dosing

Hydrocodone/Acetaminophen

Brand Name: Norco, Vicoden, Lortab, etc.

DEA Schedule II

Pain, Moderate-Moderate Severe

2.5-10mg hydrocodone PO q**4**-6hrs PRN. DO NOT Exceed 1g/4hr or 4 g/day of acetaminophen from all sources

Hydrocodone/Acetaminophen Tablets
Watson Pharmaceuticals

http://www.opiateaddictionresource.com/media/images/hydrocodone_acetaminophen

Initial Dosing

Oxycodone/Acetaminophen

Brand Name- Percocet. An alternative for patients with morphine intolerance or allergy.

DEA Schedule II.

Pain, Moderate-Moderate Severe 2.5-10mg oxycodone **PO 6hrs PRN**. May use Q 4 four hours for uncontrolled pain/tolerance.

http://www.empr.com/percocet/drug/8161/

Initial Dosing

Oxycodone

An alternative for patients with morphine intolerance or allergy.

Has a higher risk of abuse use with caution in patients with higher risk scores.

Long-acting oxycodone: **not** recommended for patients with chronic pain because it is not truly long-acting, is expensive, and has a high street value.

https://www.aliem.com/2012/08/trick-of-trade-oral-naloxone-for-opioid/oxycodone/

Initial Dosing

Oxycodone

Brand Names: Roxicodone, Oxycontin

DEA Schedule II

Pain, Mod-Severe: 5-15mg PO q 4-6hrs, PRN, Titrate slowly in elderly, (renal). Taper dose 25-50% q 2-4 days.

Pain Severe, Chronic: Start 10 mg ER PO q 12 increase 25-50% q1-2 days. Titrate slowly in elderly. Reduce dose 50% in debilitated pt > 65YOA. >40mg ER for use in opioid tolerant patients only.

https://www.aliem.com/2012/08/trick-of-trade-oral-naloxone-for-opioid/oxycodone/

Initial Dosing

Transdermal Fentanyl

More steady, may be a better alternative, it is expensive and can produce tolerance relatively quickly. DO NOT use on opioid naive patients.

DEA/FDA schedule II

Fentanyl is lipophilic, and absorption is affected in patients with little subcutaneous fat and in those prone to edema at application sites

https://www.ctvnews.ca/health/fentanyl-patch-return-program-saves-lives-ontario-politician-says-1.2536908

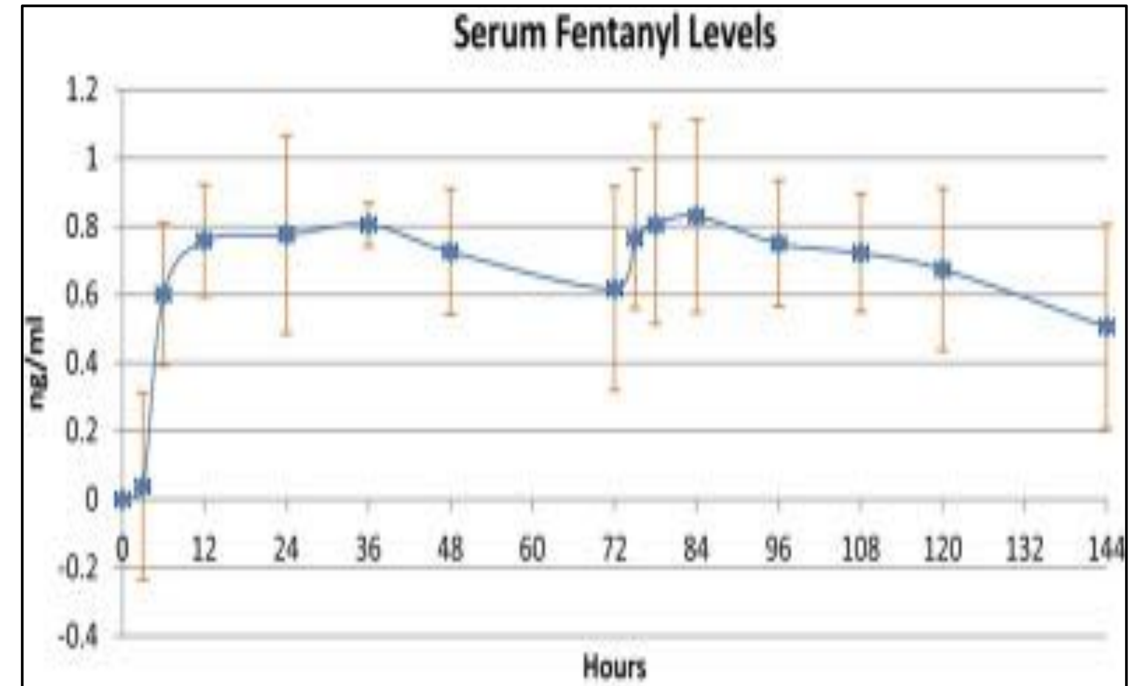
Initial Dosing

Transdermal Fentanyl

The pkg insert has conversion tables. Adjust dose after three days, then no more frequently than Q 6 days. Do not cut patch.

Start lower dose in the elderly. Renal/Hepatic dosing-moderate impairment, start dose at 50%.

To discontinue: Taper dose 50% q 6days.



Chris Christou, Rema A Oliver, John Rawlinson, William R. Walsh Transdermal fentanyl and its use in ovine surgery. Research in Veterinary Science. Volume 100, June 2015, Pages 252-256

Initial Dosing

Methadone

Effective for many patients, may produce less tolerance than other opioids.

DEA/FDA schedule II,

It is inexpensive, long-acting, and has a combination of opioid and *N*-methyl-D-aspartate receptor activity that may make it **a good choice for patients with mixed somatic and neuropathic pain.**

However, **physicians who prescribe methadone must be familiar with its use.**

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician.* 2012 Aug 1;86(3):252-258

Initial Dosing

Methadone

Unique pharmacokinetics!

Very **long elimination half-life**(12 hrs.), and its MME conversion ratio increases as dosages increase.

Starting dosages in opioid-naive patients are 2.5 to 5 mg q 8-12 hours.

https://www.saukvalley.com/2018/04/24/lawmakers-push-to-have-medicare-cover-methadone-treatment-to-combat-opioid-addiction/aiwdh6z/

Initial Dosing

Methadone

Brand Name: Methadose, 40mg dispersible tab

Can be used for treatment of **opioid dependence**

Start: 15-30 mg PO X1 then 5-10 mg PO q 2-4 hours PRN.

Max: 40 mg on day 1, stabilize dose Q 2-3 days, **then decrease dose** by up to 20% q 24-48 hours. Document if using > 40 mg.

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician.* 2012 Aug 1;86(3):252-258

Initial Dosing

Methadone

After initial control of symptoms, dosages should be titrated slowly and no more than once per week.

Side Effects: Methadone can prolong the QT interval, avoid co-use with other QT-prolonging medications. Serum drug levels can be used for monitoring.

Methadone does not interfere with urine testing for other opioids.

http://onlinepillsstore.net/?product=buy-methadone-online

Initial Dosing

Methadone

Onset of Action-0.5-1 hour.

Peak effect: 1-7.5 hours.

Steady state w/ continuous dosing: 3-5 days

Methadone can prolong the QT interval, avoid co-use with other QT-prolonging medications. Serum drug levels can be used for monitoring.

Initial Dosing

Methadone:

Elimination of methadone is **by hepatic metabolism** , followed by renal and fecal excretion.

Transformed to :

2-ethylidene-1,5-dimethyl-3,3-diphenlypyrroline **(EDDP)** and 9 other metabolites.

Metabolized by CYP 3A4

So plasma concentrations are **increased** by:

Macrolides, fluoroquinolones, SSRIS, TCAs (decrease dose by 25%), and

Decreased by:

Antiepileptics, Antipsychotics, antiretrovirals. (encourage rescue medications)

https://www.painweek.org/assets/PAINWeekEnd%20Slides/2018/Dallas/Saturday_06_IV%20Methadone%20(Aljassem).pdf

Chin B. Eap, et. Al, Interindividual Variability of the Clinical Pharmacokinetics of Methadone. Implications for the Treatment of Opioid Dependence. Clin Pharmacokinetics 2002: 41(14) 1153-1193

Initial Dosing

Buprenorphine Transdermal

Brand Names: Butrans

DEA/FDA schedule III

Dosed by Equivalents:

Opioid Naïve: 5 mcg patch Q 7 days.

<30 MME mg/day: Start 5 mcg patch, increase q 72 hours. Max is 20 mcg.

30-80 MME mg/day: Start 10mcg patch, increase q 72 hours. Max is 20 mcg.

Half Life: **26 hours. Watch Resp Depression onset-24-72 hours**

http://www.newbridgerecovery.com/spotlight-buprenorphine-patches

Initial Dosing

Buprenorphine

DEA/FDA schedule III partial opioid agonist that is less likely to produce tolerance.

It is effective for treatment of pain, has lower abuse potential, and is easily monitored.

It is expensive, and its use requires special prescriber training (**except for the transdermal patch**).

May use while breast feeding.

https://www.blvdcenters.org/opiate-rehab-treatment-centers/need-know-guide-buprenorphine

Initial Dosing

Buprenorphine

Sublingual Form

Used for **opioid dependence. NOT** for Maintenance therapy.

Begin: 8-12 hrs. after last opioid use or per symptoms

Start: 2-8 mg SL Q day X 1 day,

Then: 8-16 mg Q day X 1-2 days,

Consider 50% reduction for Hepatic impairment.

http://fortune.com/2016/07/06/obama-admin-opioids-buprenorphine/

Initial Dosing

Buprenorphine

Brand Name: Buprenex

Max IV dose 300 mCg q6-8 hrs.

May repeat 300 mcg after 30-60 min.

Max IM dose 600 mcg Q 6-8 hrs.

Decrease dose 50% if Resp Dz or elderly, debilitated. EKG if QT interval is concern. Taper gradually if long term use.

http://fortune.com/2016/07/06/obama-admin-opioids-buprenorphine/

Initial Dosing

Buprenorphine/Naloxone

Suboxone

Used for **opioid dependence.**

MOA:

Buprenorphine: agonist at Delta receptors, Partial Agonism at MU Receptors, and antagonistic at Kappa receptors. (opioid agonist-antagonist)

Naloxone: opioid antagonist

Consider 50% reduction for Hepatic impairment.

http://fortune.com/2016/07/06/obama-admin-opioids-buprenorphine/

Initial Dosing

Buprenorphine/Naloxone

Brand Name: Suboxone

Used for **opioid dependence.** **NOT** for Maintenance therapy.

Begin: 8-12 hrs. after last opioid use or per symptoms

Start: 2-8 mg SL Q day X 1 day,

Then: 8-16 mg Q day X 1-2 days,

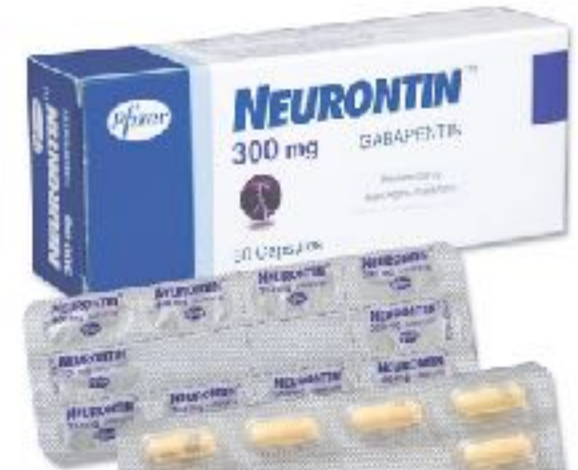
Consider 50% reduction for Hepatic impairment.

http://fortune.com/2016/07/06/obama-admin-opioids-buprenorphine/

Initial Dosing

Gabapentin

Brand Name: Neurontin



Scheduled-IV. States regulate for association with overdoses.

MOA: blocks voltage dependent calcium channel

Post Herpetic Neuralgia: Start 300 mg PO Q Day X 1 day, then 300 mg PO BID, then 300 Mg TID, Max 1800 mg. Taper dose over 7 days to D/C.

https://www.painnewsnetwork.org/stories/2016/1/30/lyrica-and-neurontin-face-uk-restrictions

Initial Dosing

Gabapentin

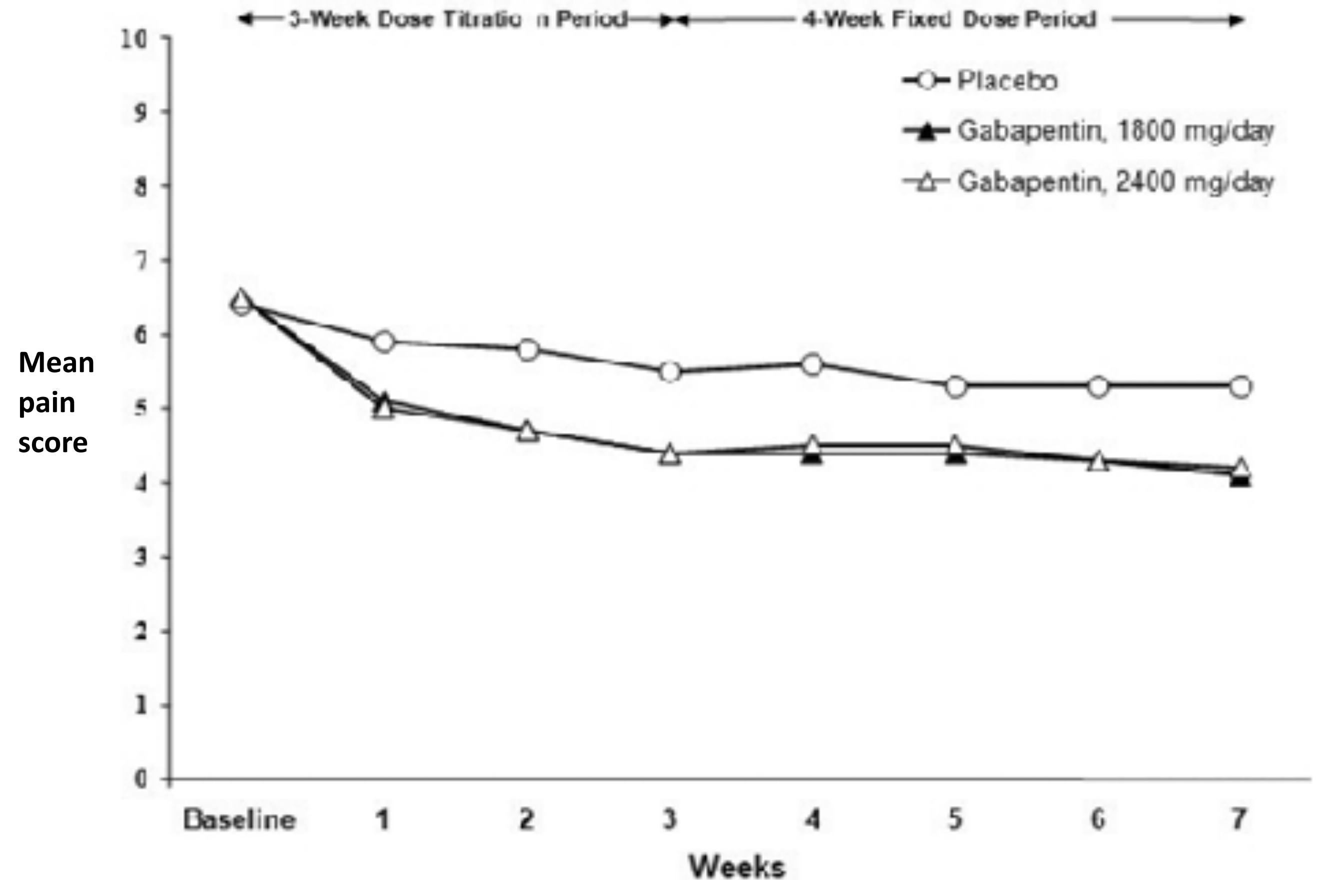
Neuropathic Pain:

Start 300 mg PO Q Day X 1 day,

Then 300 mg PO BID,

Then 300 mg TID. **Max 3600 mg**.

Taper dose over 7 days to D/C.



https://www.rxlist.com/neurontin-drug.htm

Initial Dosing

Neurontin Associated w/ Opioid Overdose?

A **population-based nested case-control study** among opioid users who were residents of Ontario, Canada, between August 1, 1997, and December 31, 2013 was published in 2017.

Cases, defined as **opioid users who died of an opioid-related cause,** were matched with up to 4 controls.

Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W. **Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-control study.** PLoS Med. 2017 Oct 3;14(10).

Initial Dosing

Neurontin Associated w/ Opioid Overdose?

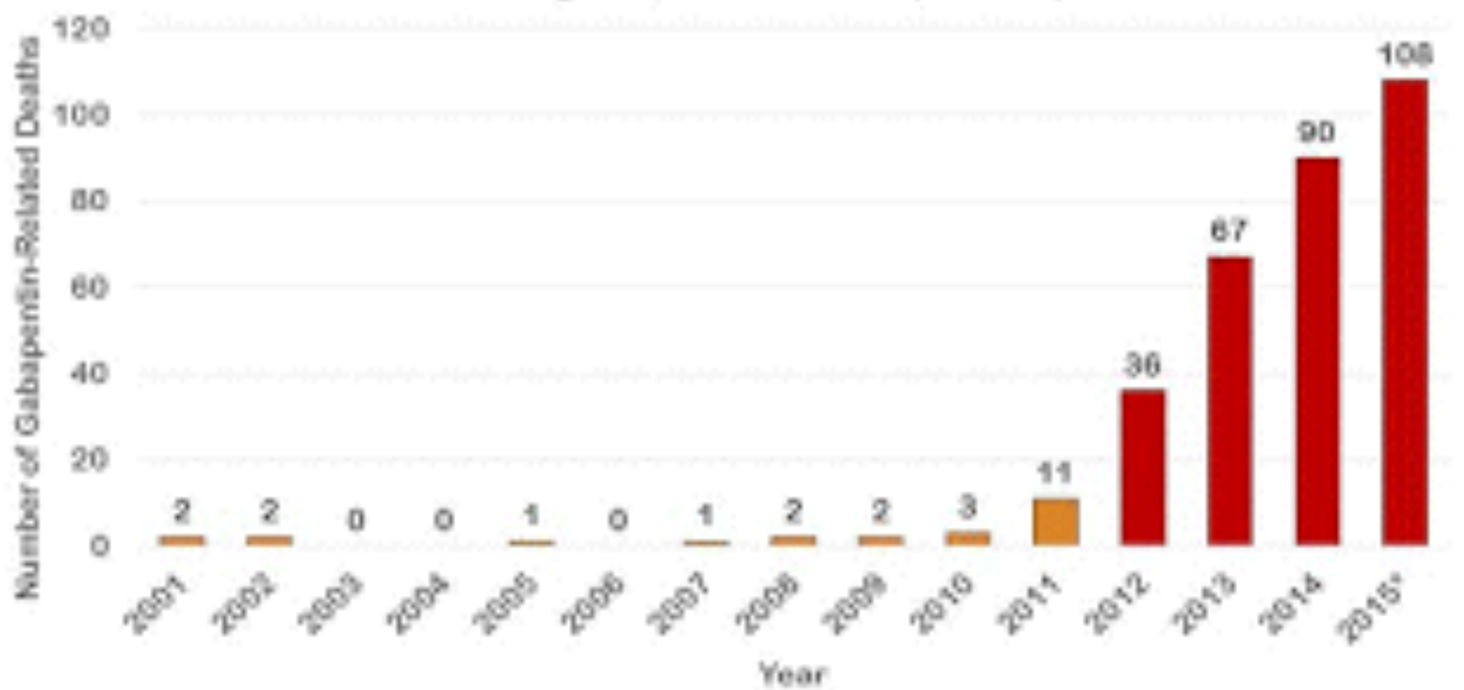
After multivariable adjustment, gabapentin use was associated with a nearly **60% increase in the odds of opioid-related death** relative to no concomitant gabapentin use.

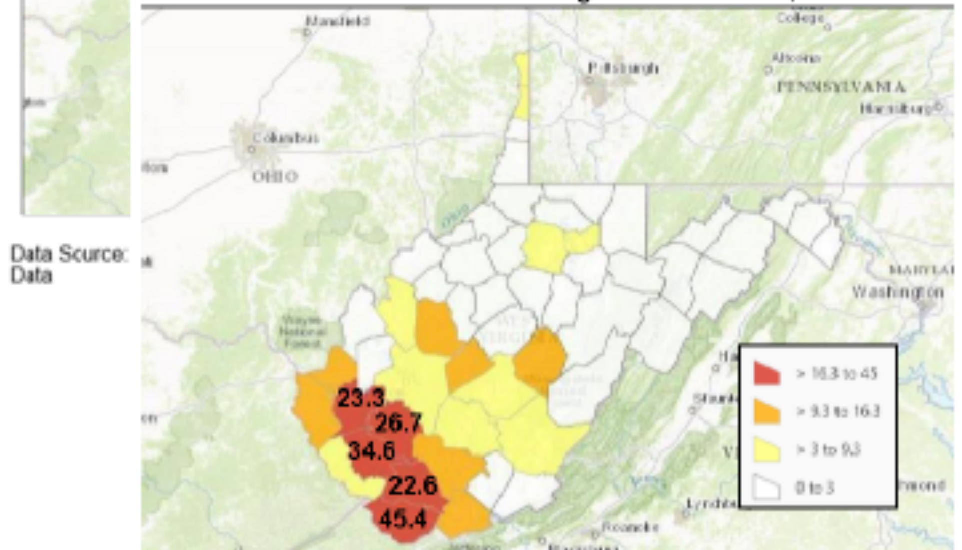
What about in WV..?

Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W. **Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-control study.** PLoS Med. 2017 Oct 3;14(10).

Initial Dosing

WV Gabapentin Associated Deaths





Data Source: WV Health Statistics Center, Vital Statistics System 2015 Preliminary Data

https://dhhr.wv.gov/oeps/disease/ob/documents/opioid/wv-drug-overdoses-2001_2015.pdf

Initial Dosing

Pregabalin

Brand Name: Lyrica

DEA Scheduled V. States may regulate for association with overdoses.

MOA: Binds Alpha2-Delta subunit of voltage dependent calcium channel reducing neurotransmitter release

Diabetic Neuropathic Pain Start 50 mg PO TID X 1 week, then 100 mg PO TID if needed. Taper dose over 7 days to D/C.

Post Herpetic Neuralgia or Other Neuropathic Pain Start 75 mg PO BID X 1 week, then 150 mg PO BID X 2 week, then 300 mg BID if needed. Taper dose over 7 days to D/C.

Initial Dosing

Recent Lyrica Concerns

A 2018 study describe **Australian patterns of pregabalin use** and intentional poisoning and identify people potentially at high risk of misuse.

Pregabalin dispensing **increased by between 2013 and 2016** and there were 88 pregabalin-associated deaths, a 57.8% yearly increase per year of intentional pregabalin poisonings.

Cairns R, Schaffer AL, Ryan N, Pearson SA, Buckley NA. **Rising pregabalin use and misuse in Australia: trends in utilisation and intentional poisonings.** Addiction. 2018 Aug 11.

Initial Dosing

Recent Lyrica Concerns

Patients overdosing on pregabalin commonly co-ingested opioids, benzodiazepines, and illicit drugs, and had high rates of psychiatric and substance use comorbidities.

http://prescriptionassistance123.com/blog/lyrica-prescription-assistance-programs/

14.7% of pregabalin users were at high-risk of misuse.

Cairns R, Schaffer AL, Ryan N, Pearson SA, Buckley NA. **Rising pregabalin use and misuse in Australia: trends in utilisation and intentional poisonings.** Addiction. 2018 Aug 11.

Initial Dosing

Recent Lyrica Concerns

Those at high-risk of misuse were more likely to be:

- Younger
- Male
- Co-prescribed benzodiazepines or opioids
- Have more individual prescribers, and
- Have higher pregabalin strengths dispensed

Cairns R, Schaffer AL, Ryan N, Pearson SA, Buckley NA. **Rising pregabalin use and misuse in Australia: trends in utilisation and intentional poisonings.** Addiction. 2018 Aug 11.

Initial Dosing

Naloxone

Routes: Pre-filled syringe, Vial, intranasal routes

MOA: opioid antagonist, blocks opioids. ½ life is 60-90 minutes.

Opioid Overdose (child or adult):

Narcan Nasal Spray: 4 mg dose sprayed into one nostril

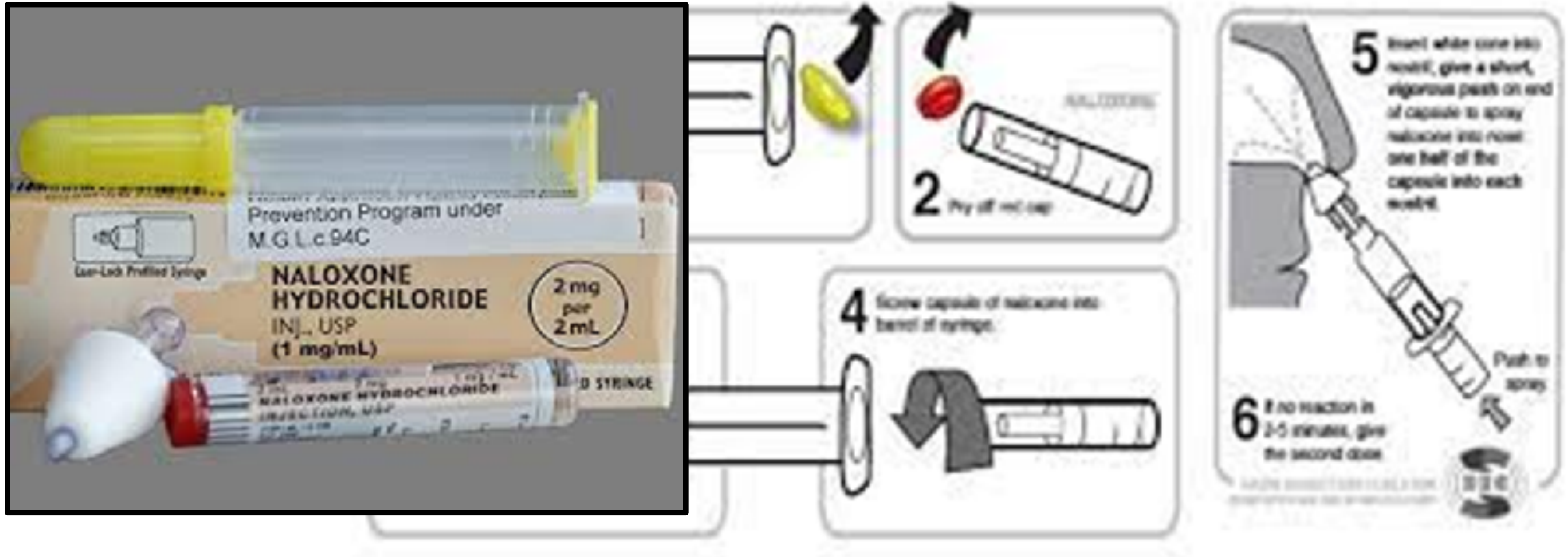
Naloxone Nasal via Atomizer: 2 mg dose sprayed into the nostrils (half in each nostril)

Evzio Auto-injector: 2 mg dose of naloxone injected into the outer thigh

Call 911, Repeat after 4 min if symptoms reoccur.

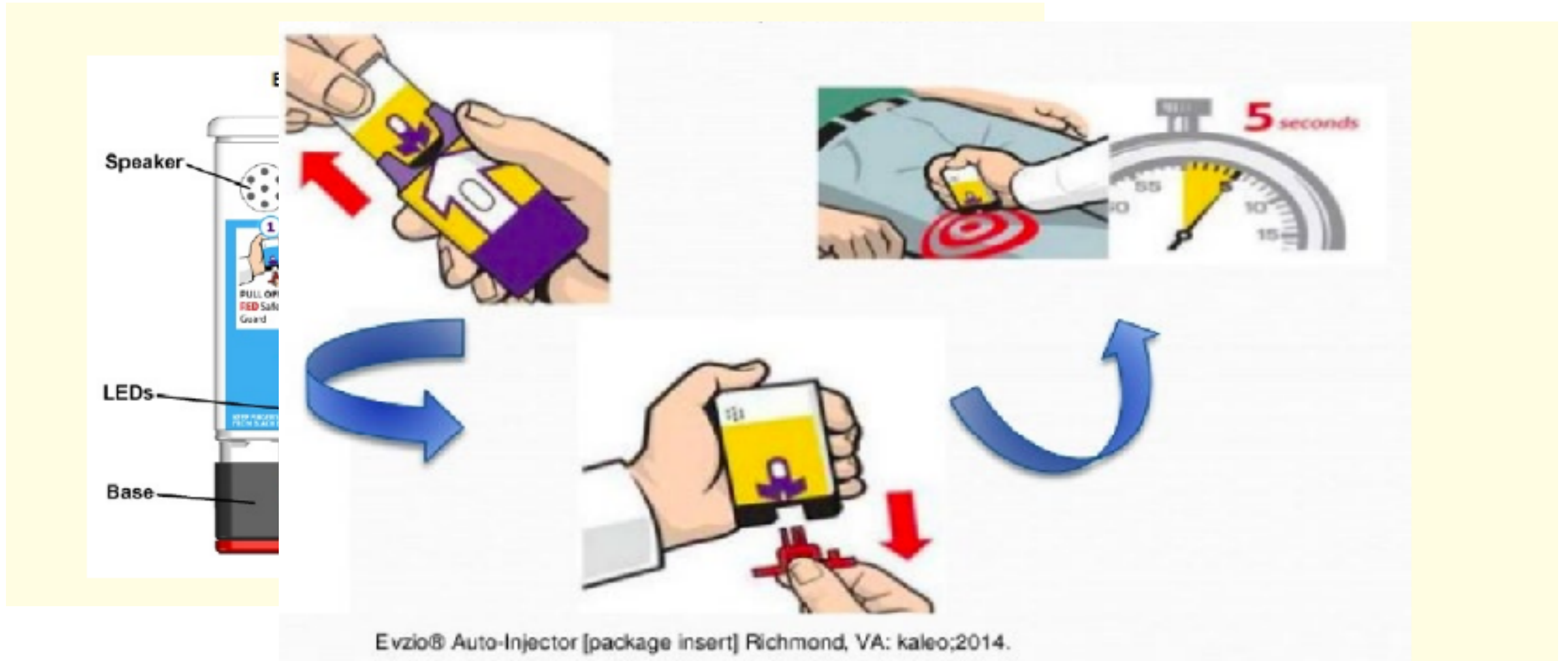
https://dhhr.wv.gov/office-of-drug-control-policy/Documents/Naloxone%20Video%20End%20User%20approved%2011-2019.pdf

Initial Dosing-Naloxone



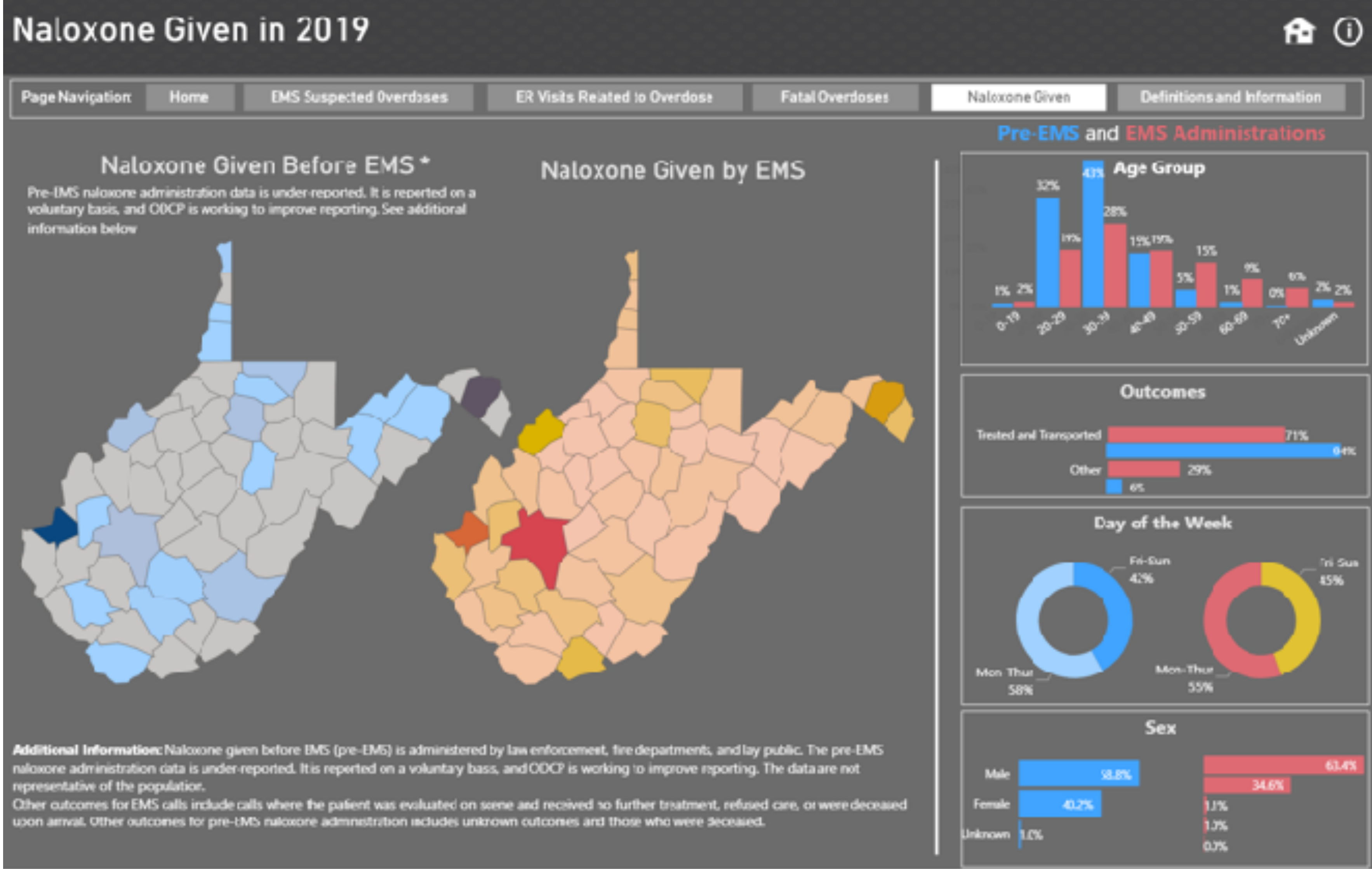
https://dhhr.wv.gov/office-of-drug-control-policy/Documents/Naloxone%20Video%20End%20User%20approved%2011-2019.pdf

Initial Dosing-Naloxone



https://dhhr.wv.gov/office-of-drug-control-policy/Documents/Naloxone%20Video%20End%20User%20approved%2011-2019.pdf

Initial Dosing



Kanawha: 1905

Cabell: 1608

Berkeley: 1154

https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx 9/17/21

Break

Agenda

The First 30 min.

Why We Are here

The current situation

The Next hour:

Starting Patients on Opioids

Assessment of Need

Assessment of Risk

BOP

Contracts

The Hour after that..

Prescribing Opioids

Opioid equivalents

Testing:
Urine
Pill counts

Stopping Opioids

The Last 30 min.

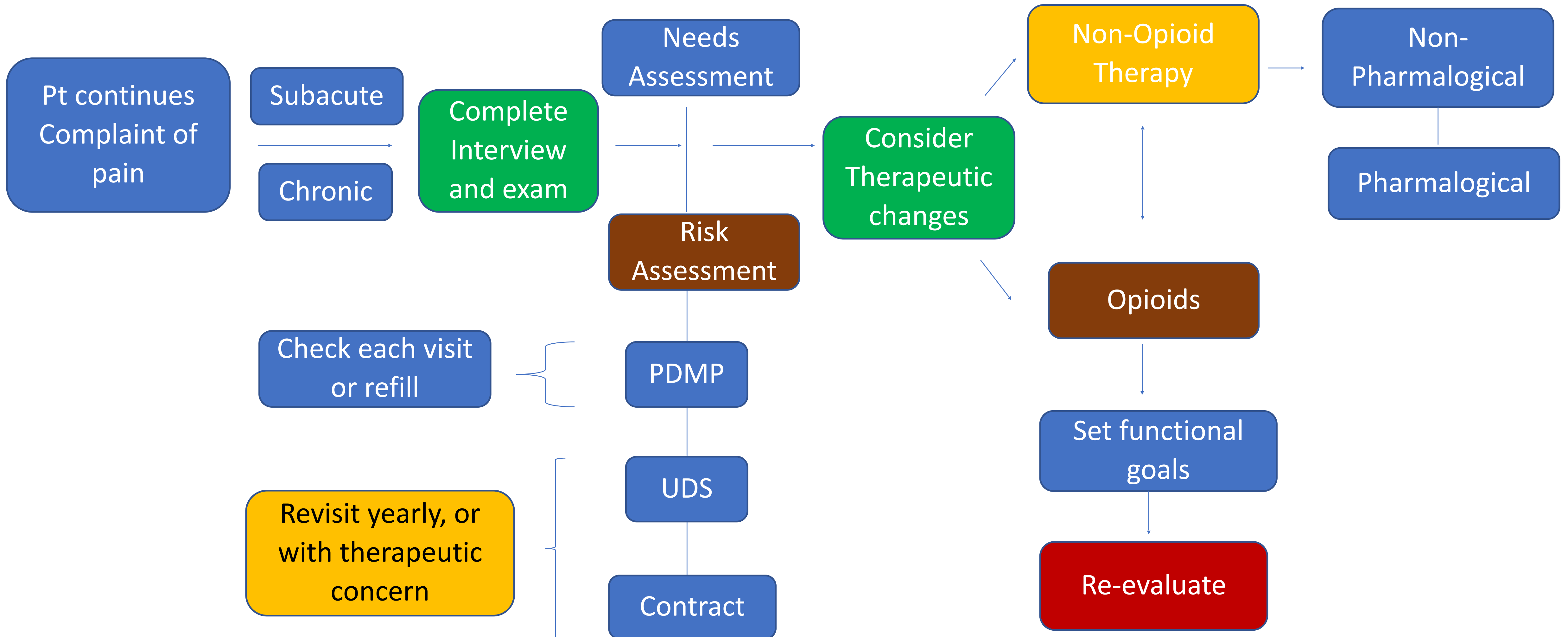
The latest opioid bill

How to help the Heroin users

Keeping Patients on Opioids

https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

Continuing Opioid Prescriptions:



Keeping Patients on Opioids

CDC Checklist

If renewing opioids without patient visit check that a return visit is scheduled ≤ 3 months from last visit

Checklist for prescribing opioids for chronic pain

https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

Keeping Patients on Opioids

Reassessing at Return Visit:

- Assess pain and function (e.g., 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.

https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

Keeping Patients on Opioids

Reassessing at Return Visit:

- **Check** that non-opioid therapies optimized.
- **Determine** whether to continue, adjust, taper, or stop opioids.
- **Calculate** opioid dosage morphine milligram equivalent (MME).

If ≥ 50 MME /day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; **consider offering naloxone**.

Avoid ≥ 90 MME /day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; **consider specialist referral**. Schedule reassessment at regular intervals (≤ 3 months).

https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

Keeping Patients on Opioids-The PEG

Checking for Functional Improvement

What number, from 0 – 10 best:

Q1: Describes your Pain in the past week?

Q2: Describes how, during the past week, pain has interfered with your **Enjoyment** of life?

Q3: Describes how, during the past week, pain has interfered with your **General activity**?

PEG score = **30% improvement from baseline is clinically meaningful.**

Keeping Patients on Opioids

Therapeutic Changes

As with any medication, consider increasing or decreasing dosage, or even drug switching to reach therapeutic goals.

If medication not resulting in improved function, can begin to taper off medication.

If medication is helping, consider a lower or more sustainable dose.

Keeping Patients on Opioids

Therapeutic Changes

Why Change from Short Acting to Long Acting?

- Reduce numbers of Pills.
- Improve control-consistent blood levels, Longer control.
- Sleep disruption caused by pain and by opioid withdrawal.
- Improved adherence.

Opioid Equivalents

Caution: 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).

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Opioid Equivalents

Caution: Higher Dosage, Higher Risk

In a national sample of **Veterans Health Administration** patients with chronic pain receiving opioids from 2004–2009.. patients who died of opioid overdose were prescribed an average of **98 MME/day**, while other patients were prescribed an average of 48 MME/day.

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Opioid Equivalents

Determine the total daily amount of each opioid the patient takes.

Convert each to MMEs—multiply the dose for each opioid by the conversion factor.

Add them together.

Warning: Do not use the calculated dose in MMEs to determine dosage for converting 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.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/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 estimated and cannot account for all individual differences in genetics and pharmacokinetics.

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Opioid Equivalents

50 MME/day:

50mg Hydrocodone: 10 tablets of hydrocodone/ acetaminophen 5/300

33mg of oxycodone: 2 tablets of oxycodone sustained-release 15 mg

12mg of methadone: <3 tablets of methadone 5 mg

90 MME/day:

90mg Hydrocodone: 9 tablets of hydrocodone/ acetaminophen 10/300

60 mg of oxycodone: 2 tablets of oxycodone sustained-release 30 mg

20 mg of methadone: 4 tablets of methadone 5 mg

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Case Study:

Your employer has recently lost three long established family physicians and management has informed you that, as a physician, you will have to assume the care of their patients on controlled medications. Your area has lost it's only non-interventionist pain specialist to a recent drug sweep.

On Monday, after this conference, the first patient presents. He's a 56 years of age former timber worker on disability for the last 22 years after being crushed by a tree and suffering a flailed chest and multiple vertebral fractures. He smokes, has COPD, his A1C is 9.8% and his LDL is 140.

He's on Metformin, Pro-air, and hydrocodone 5 mg TID. He's been on these meds for the last 6 years. He has refused preventative efforts and your EMR informs you of multiple care gaps including colonoscopy and immunizations.

Case Study:

Preparing for the 15 minute visit (he's established in the system) you prioritize your efforts.

Which of the following is the most worrisome health concern?

A) His socioeconomic status
B) His lack of preventative care
C) His uncontrolled diabetes
D) His chronic opioid use

Rx Opioid Overdose 17.2 per 100,000
Diabetes mellitus 47.6 per 100,000
Diseases of heart 267.0
Malignant neoplasms 256.3
Chronic lower respiratory diseases 92.6
Cerebrovascular diseases 58.3

https://www.cdc.gov/nchs/nvss/mortality/lcwk5_hr.htm

Case Study:

You decide to focus on his diabetes during todays visit, but recognize you must address his opioid use as well.

You decide to make an effort to reduce his opioid use by limiting his number of pills but not his total MMEs.

What is his current MME use:

A) 50 MME

B) 30.5 MME

C) 15 MME

D) 5 MME

Case Study:

What choice or choices offer an equivalent MME?

A) Oxycodone 7.5mg BID

B) Hydrocodone 7.5 mg BID

C) Oxycodone 10mg QHS

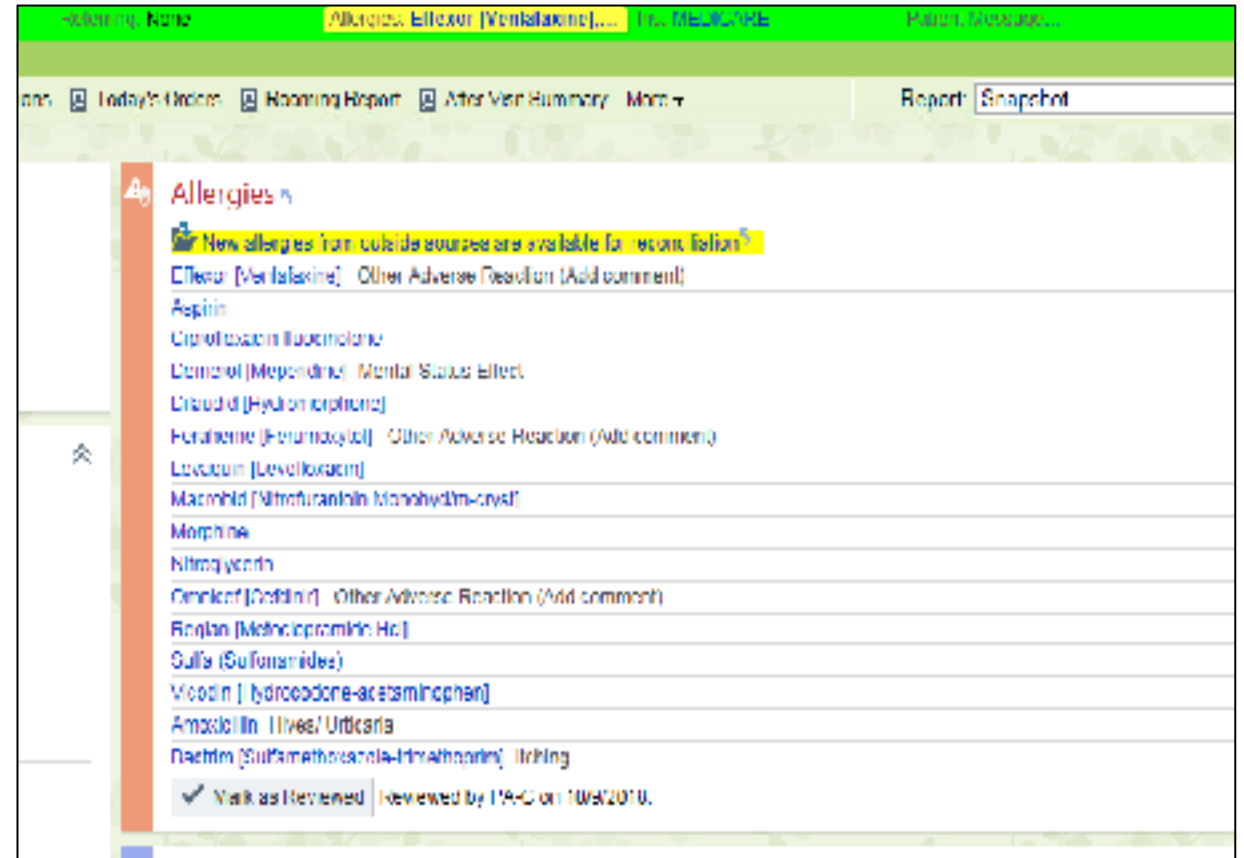
D) Hydrocodone 10mg Q AM

Behaviors Suspicious for Misuse or Dependency

- Taking a controlled substance for a long period of time (new patients)
- Refusing to grant permission to obtain old records or communicate with previous physicians
- Demonstrating reluctance to undergo a comprehensive history, physical examination, or diagnostic testing (especially urine drug screening)

Behaviors Suspicious for Misuse or Dependency

- Requesting a specific drug (often because of the higher resale value of a brand name)
- Professing multiple allergies to recommended medications
- Resisting other treatment options



Behaviors Suspicious for Misuse or Dependency

Other aberrant behavior

- Issuing threats or displaying anger
- Targeting appointments at the end of the day or during off hours (nights or weekends)
- Giving excessive flattery

https://lane.stanford.edu/about/donations.html

Behaviors Suspicious for Misuse or Dependency

- Calling and visiting a physician's associates
- Repeatedly losing a prescription
- Requesting a dose escalation
- Demonstrating noncompliance with prescription instructions
- Demonstrating other evidence of alcohol or illicit drug misuse

Testing:

Schedule patients additional time:

For example, writing a new prescription for a controlled substance would require evaluating the patient for a history of abuse or addiction, and may include screening.

https://uk.rs-online.com/web/p/stopwatches/0329727/

Testing:

Schedule Patients Additional Time:

A history of substance misuse **does not preclude** opioid analgesia;

however, patients in recovery may require boundary setting, clear delineation of the rules, and participation in an active recovery program.

Urine drug screening is also useful before increasing patients' dosages of analgesics or referring patients to a pain or addiction specialist.

Testing:

Schedule Patients Additional Time:

A **negative urine drug screening** result **does not exclude** occasional or even daily drug use.

Infrequent drug use is difficult to detect regardless of testing frequency, **the benefits of frequent drug testing are greatest in patients who engage in moderate drug use.**

Testing:

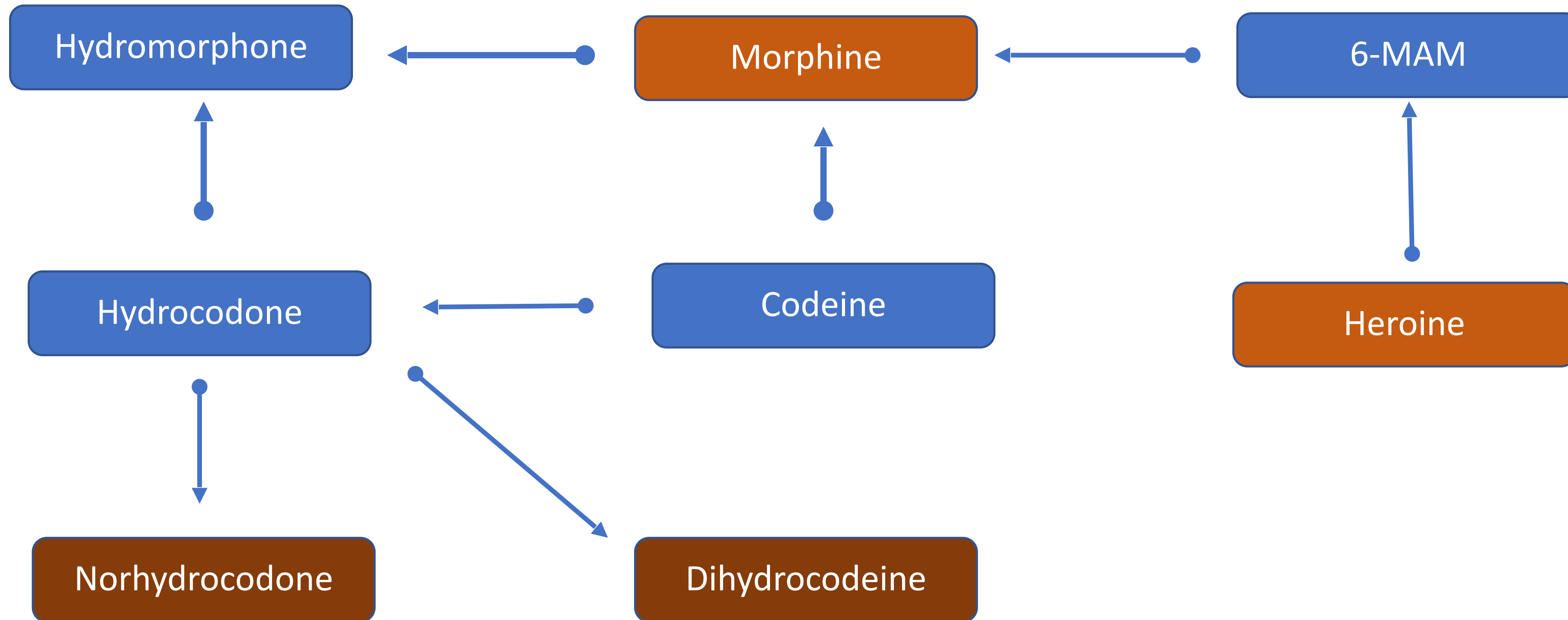
There are two main types of Urine Drug Screening:

- **immunoassay testing,** and
- **chromatography** (i.e., gas chromatography/mass spectrometry [GC/MS] or high-performance liquid chromatography

- **Immunoassay tests are the preferred initial test for screening.** They use antibodies to detect the presence of drugs. These tests can be processed rapidly, are inexpensive.

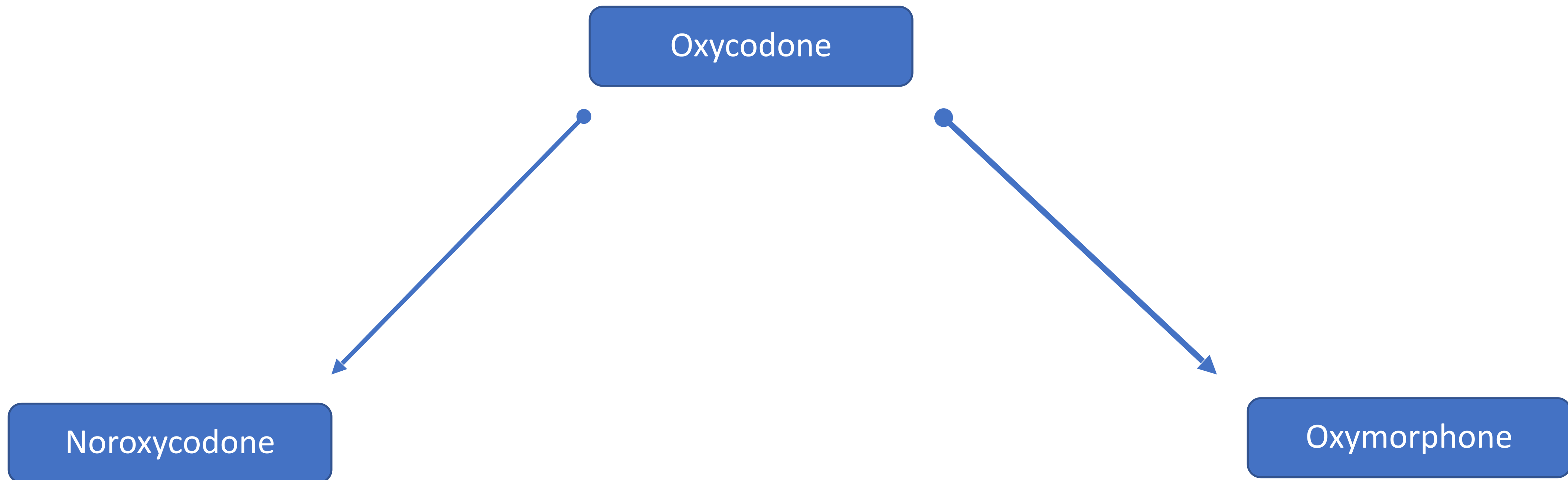
JOHN B. STANDRIDGE, MD; STEPHEN M. ADAMS, MD; and ALEXANDER P. ZOTOS, MD, Urine Drug Screening: A Valuable Office Procedure. *Am Fam Physician.* 2010 Mar 1;81(5):635-640.

Opioids Metabolism



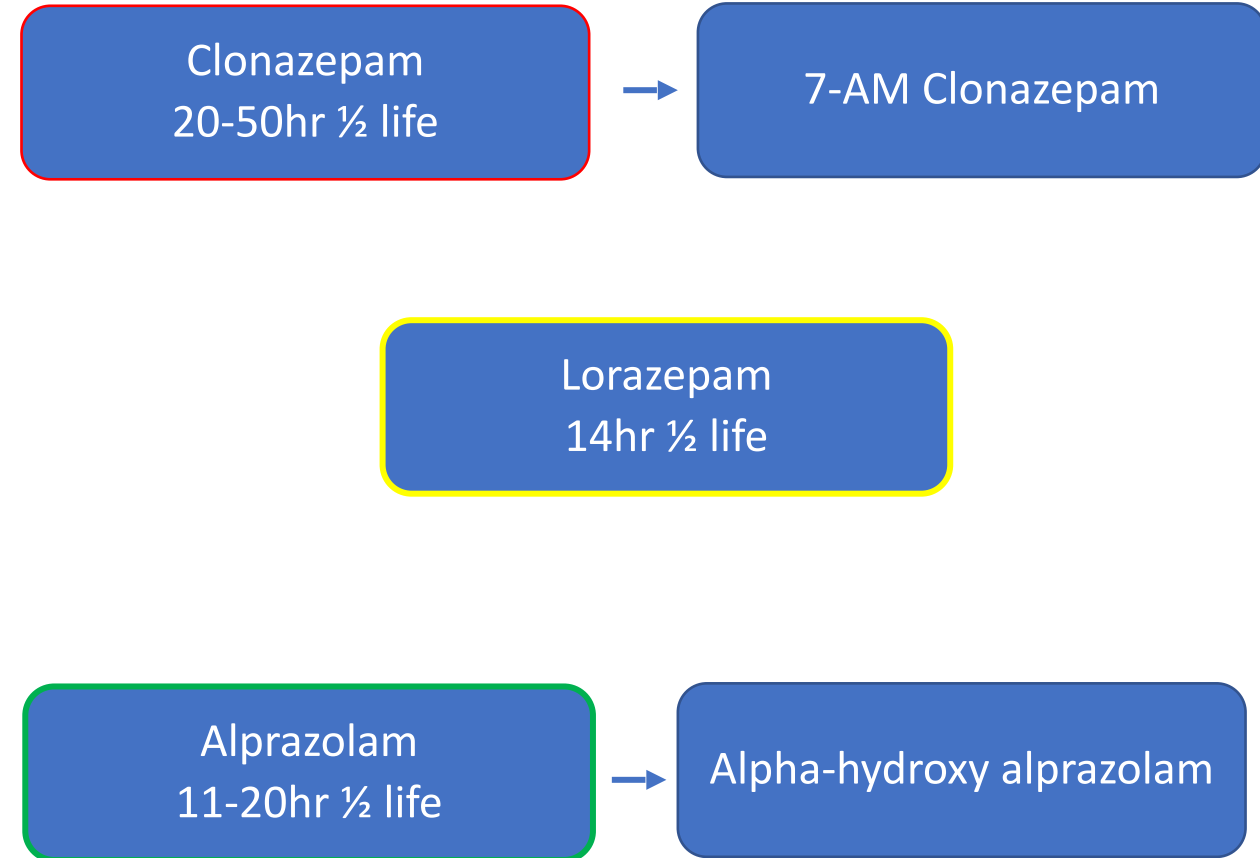
https://premierbiotech.com/innovation/opi-vs-oxy/

Opioids Metabolism



http://insourcedx.com/services/compliance/udt/drug_metabolism.html

Benzodiazepines Metabolism



http://insourcedx.com/services/compliance/udt/drug_metabolism.html

Urine Drug Screens

The most commonly ordered drug screens are for:

- Cocaine metabolites
- Amphetamines
- Phencyclidine
- Marijuana metabolites
- Opiate metabolites.

The **U.S. Department of Transportation** requires testing for these five substances when conducting urine drug screenings for transportation employees

https://www.protocoldrugtesting.com/

Urine Drug Screens

The Accuracy of Immunoassay

It varies..

-high predictive value for marijuana and cocaine,

-lower predictive value for opiates and amphetamines.

Many commonly prescribed medications can cause positive immunoassay tests

https://www.wcpo.com/news/national/urine-screens-are-big-business-report-shows-costs-quadrupled-from-2011-to-2014

Reducing UDS Tampering

- Request removal of any unnecessary outer clothing
- Remove anything in the collection area that could be used to adulterate or substitute a urine specimen
- Request the display and removal of any items in the patient's pockets, coat, hat, etc.

https://www.synthetix5.com/synthetic-urine-belt-kit/

https://peepack.com/product/peepack-sterile-urine-kit-3-pack/

Reducing UDS Tampering

- Require all other personal belongings (e.g., briefcase, purse) to remain with the outer clothing
- Instruct the patient to wash and dry his or her hands (preferably with liquid soap) under direct observation and not to wash again until after delivering the specimen
- Place a bluing agent in the commode and turn off the water supply to the testing site

https://www.zoomtesting.co.uk/bluing-tablets/

Methods and Criteria for UDS

Collection Methods and Criteria

- Direct observation of specimen collection (when required)
- **Sample size:** 30 mL or more
- **Temperature:** between 90°F (32.2°C) and 100°F (37.7°C)
- **Urine pH:** 4.5 to 8.5

- Use of an approved chain of custody form to track specimen handling

Methods and Criteria for UDS

Findings Suggestive of Adulterated, Diluted, or Substituted Specimens

General: Temperature < 90°F or > 100°F

Unusual appearance (e.g., bubbly, cloudy, clear, dark)

Adulterated: Nitrite concentration >5 mg per dL

Urine pH < 3 or ≥ 11

Diluted/Substituted: Creatinine concentration < 2.0 mg per dL

Drugs that cause a false positive on UDS

Opiates

Dextromethorphan,
fluoroquinolones,
quinine,
verapamil‡

diphenhydramine,
poppy seeds,
rifampin,

Duration of Detectability: One to three days

‡—In methadone assays only.

Drugs that cause a false positive on UDS

Phencyclidine

dextromethorphan

diphenhydramine ibuprofen

imipramine

ketamine

meperidine

thioridazine

tramadol

venlafaxine

Duration of Detectability: 7 to 14 days

Drugs that cause a false positive on UDS

Benzodiazepines

Oxaprozin and Sertraline

Duration of Detectability: 3 days for short-acting agents (e.g., lorazepam). Up to 30 days for long-acting agents (e.g., diazepam).

Cocaine

Topical anesthetics containing cocaine

Duration of Detectability: 2-3 days with occasional use, Up to 8 days with heavy use.

Drugs that cause a false positive on UDS

Amphetamines

Amantadine (Symmetrel),
Bupropion (Wellbutrin),
Chlorpromazine,
Desipramine (Norpramin),
Fluoxetine (Prozac),

L-methamphetamine
(in nasal decongestants*),
Labetalol (Normodyne),
Methylphenidate (Ritalin),
Phentermine,
Phenylephrine,

Phenylpropanolamine,
Promethazine(Phenergan),
Pseudoephedrine,
Ranitidine (Zantac),
Thioridazine,
Trazodone (Desyrel)

Duration of Detectability: Up to 3 days. *Current immunoassays have corrected the false-positive result for nasal decongestants containing L -methamphetamine.

Drugs that cause a false positive on UDS

Tetrahydrocannabinol

Dronabinol -(Marinol),

NSAIDs-ibuprofen, naproxen (Naprosyn), and sulindac (Clinoril),

PPIs- (pantoprazole [Protonix])

Duration of Detectability: 3 days with single use, 5-7 days with use around 4X per week, 10-15 days with daily use, **More than 30 days with long-term, heavy use**

Testing: Pill Counts

The main goal of a pill count is **to prevent diversion, misuse and abuse.**

https://www.affirmhealth.com/blog/pill-counts-a-tool-for-medication-adherence-and-diversion-reduction

https://www.youtube.com/watch?v=v6gyDV8YOuQ

Testing: Pill Counts

Request that the patient bring all unused pills to an appointment in the original container.

Notify the patient the **day before or the same day** as the appointment.

Check if the number of pills in the container match what the expected number would be if the patient followed the prescribed dosage.

Testing: Pill Counts

Do Pill Counts Work?

One recent, but small, study followed frequency of medication nonadherence using methods including **pill counts**.

The results: Patient indicated they missed 25% of their prescribed doses. However, **objective measures including pill counts showed that participants missed 40% to 43% of their prescribed doses**. ($p < 0.01$ for pill counts).

Conclusions: individuals tend to overestimate their adherence when self-reporting. Physicians should exercise caution with patient report of adherence and **use objective measures when possible.**

Schaefer MR, Wagoner ST, Young ME, Rawlinson AR, Kavookjian J, Shapiro SK, Gray WN. Subjective Versus Objective Measures of Medication Adherence in Adolescents/Young Adults with Attention-Deficit Hyperactivity Disorder. J Dev Behav Pediatr. 2018 Jul 11.

Testing: Pill Counts

Do Pill Counts Work?

One case study on the topic revealed two concerns:

1) The **assumption** that if a patient has the correct number of pills for that point in a prescription interval then they are unlikely to be abusing their opioids.

2) Patients describe **short term rental of opioids** from illicit dealers in order to circumvent pill counts.

The study concluded that :

Pill counts do not assure non-diversion of opioids and provide additional cash flow to illicit dealers.

Viscomi CM, Covington M, Christenson C. Pill counts and pill rental: unintended entrepreneurial opportunities. Clin J Pain. 2013 Jul;29(7):623-4.

Testing: Pill Counts

Do Pill Counts Work?

A 2012 study evaluated adherence to practice guidelines including the use of **Universal Precautions**, in primary care clinics located in Caldwell County, NC. The study's intervention was the:

1) signing of pain contracts;
2) Requiring of patients to undergo random urine drug testing; and
3) **requiring of random pill counts.**
4) Use of PDMP

The outcome measure was opioid pill confiscations by the County Narcotics before, during, and after intervention.

Bujold E, Huff J, Staton EW, Pace WD. Improving use of narcotics for nonmalignant chronic pain: a lesson from Community Care of North Carolina. J Opioid Manag. 2012 Nov-Dec;8(6):363-7.

Testing: Pill Counts

Do Pill Counts Work?

The North Carolina study showed **opioid pill confiscations decreased by 300%.**

60% of providers report an improvement in the management of chronic pain patients,
65 % increased confidence when treating patients with chronic pain; and,
60% reported using the opioid registry.

Pill counts when combined with Universal Precautions did result in improved management of opioid use.

Bujold E, Huff J, Staton EW, Pace WD. Improving use of narcotics for nonmalignant chronic pain: a lesson from Community Care of North Carolina. J Opioid Manag. 2012 Nov-Dec;8(6):363-7.

Case Study:

Your 55 YO tree harvester has returned for his second visit.

His A1C is now 10.2%

You refer him to a local endocrinologist and focus on his opioid use.

What is the best way to determine he's using his opioids as ordered?

A) UDS

B) BOP

C) A pill count

D) the word of his wife who is here to attest to his need of opioids and his compliance

Case Study:

To set the appropriate expectations, you complete a UDS today.
The results come back the next day and show THC.

At this point the best course of action is to:

A) Inform the patient he will be dismissed.
B) Repeat the test.
C) Order a confirmation on the same sample.
D) Ask the patient to return for an interview.

Stopping Opioids

"**It must be done slowly and carefully,**" says **Adm. Brett P. Giroir**, MD, assistant secretary for health for HHS. "**If opioids are going to be reduced in a chronic patient it really needs to be done in a patient-centered, co** ... **ay**."

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

Risks of rapid opioid taper

Consider tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

https://twitter.com/aafp 11 Oct 2018 With Dr. Cook Physician of the year

https://www.npr.org/sections/health-shots/2019/10/10/768914092/dont-force-patients-off-opioids- abruptly-new-guidelines-say-warning-of-severe-ri

Stopping Opioids

Consider tapering to a reduced opioid dosage when

The patient:

- Requests a dosage reduction.
- Does not have clinically meaningful **improvement in pain and function** (e.g., at least **30% improvement on the 3-item PEG scale**)
- Is on dosages **≥ 50 MME/day** **without benefit** or opioids are combined with benzodiazepines

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

Stopping Opioids

Consider tapering to a reduced opioid dosage when:

- Patient shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use), or
- **experiences overdose** or other serious adverse event, or
- shows early warning signs for overdose risk such as confusion, sedation, or slurred speech.

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

Stopping Opioids

Tapering plans

Should be **individualized** and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications.

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

https://www.imdb.com/title/tt0096320/

Stopping Opioids-Go Slow

Tapering plans

A decrease of **10% of the original dose per we** is a reasonable starting point.

Slower tapers (e.g., 10% per month) for long term opioid users.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

https://www.sd42.ca/district-school-calendars/

Stopping Opioids-Consult

Tapering plans

Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

Stopping Opioids-Support

Tapering plans

Make sure patients receive appropriate **psychosocial support**.

If needed, work with mental health providers, arrange for treatment of opioid use disorder, and

Offer naloxone for overdose prevention.

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

Stopping Opioids-Encourage

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first. Tell patients “**I know you can do this**” or “**I’ll stick by you through this.”**

https://drugfree.org/learn/drug-and-alcohol-news/another-opioid-epidemic-challenge-addiction-counselors/

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

Stopping Opioids-Follow up

Adjust, Monitor, Reduce

Adjust the rate and duration of the taper according to the patient's response.

Don't reverse the taper; however, the rate may be slowed or paused while **monitoring** and managing withdrawal symptoms.

Reduce: Once the smallest available dose is reached, the interval between doses can be extended and **opioids may be stopped when taken less than once a day.**

https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

Stopping Opioids

Despite tapering, **Patients may have withdrawal symptoms when opioids are completely discontinued**. These symptoms should be managed supportively.

Traditional withdrawal management medications such as:

clonidine,

tramadol, and

muscle relaxants are

generally ineffective.

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician.* 2012 Aug 1;86(3):252-258

Stopping Opioids

Temporary use of **nonbenzodiazepine** sleep aids can be helpful.

Follow-up visits should be scheduled frequently fc ongoing multimodal pain management and encouragement that **function will improve over weeks to months.**

https://www.mooremedical.com/index.cfm?/Trazodone-HCl-Tablets/&PG=CTL&FN=ProductDetail&PID=1143&spx=1

D. BERLAND, MD, and P. RODGERS, MD, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician.* 2012 Aug 1;86(3):252-258

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The latest opioid bill

How to help the Heroin users

The 2018 WV Opioid Legislation-SB 273

WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Enrolled

Committee Substitute

for

Committee Substitute

for

Senate Bill 273

[Passed March 9, 2018; in effect 90 days from passage]

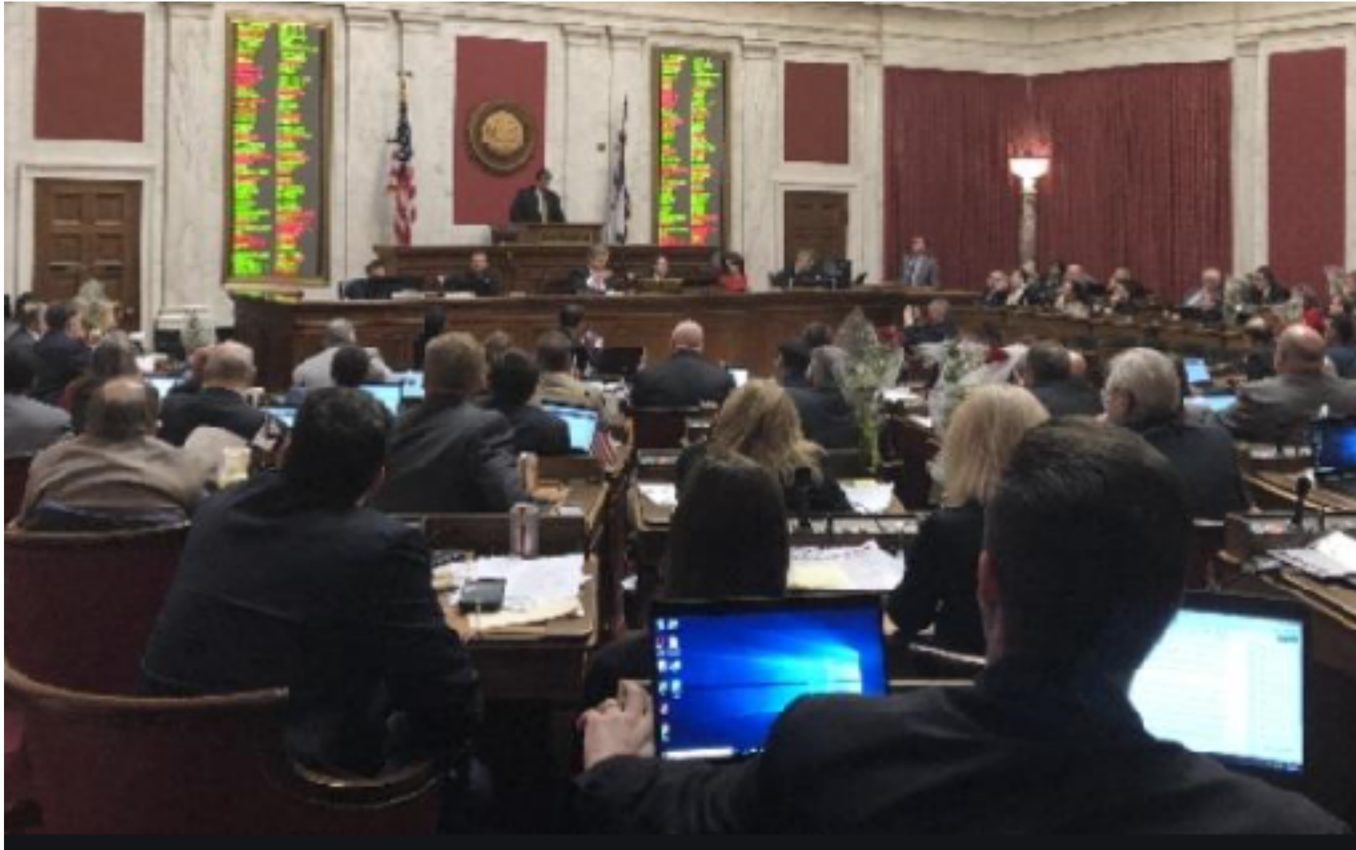
A summary of **SB 273** is available on the WVBOM website:

https://wvbom.wv.gov/article.asp?id=55&action2=showArticle&ty=CTTS

The entirety of **SB 273**:

https://legiscan.com/WV/bill/SB273/2018

The 2018 WV Opioid Legislation-SB 273



SB 273 was amended during the 2019 by passage of **HB 2768**

HB 2768's amendments to the ORA became **effective on June 7, 2019.**

https://www.wsaz.com/content/news/Members-of-WVaHouse-of-Delegates-respond-to-education-omnibus-bill-passing-in-Senate-505327291.html

House Bill 2768

- Clarifies that the Opioid Reduction Act **applies only to Schedule II opioid drugs**;
- Clarifies that the Opioid Reduction Act **does not apply** to a patient being prescribed, or ordered, any medication **in an inpatient setting at a hospital**;
- Clarifies that a prescription for a four-day supply of a Schedule II **opioid drug issued to a patient in the emergency room** for outpatient use **is not an initial prescription**;

https://wvbom.wv.gov/article.asp?id=69&action2=showArticle&ty=CTTS

House Bill 2768

- Clarifies that, “[t]he physical exam **should be relevant to the specific diagnosis** and course of treatment, and should assess whether the course of treatment would be safe and effective for the patient;”

- Clarifies that **a narcotics contract is not required until the issuance of a third prescription for a Schedule II** opioid drug and adds a new provision that a narcotics contract must include whether another physician is approved to prescribe to the patient;

House Bill 2768

- Clarifies that a **pharmacist is not responsible** for enforcing the requirements of the Opioid Reduction Act;

- Allows for a subsequent Schedule II opioid drug **prescription less than six days after the initial prescription**; and,

House Bill 2768

- Amends the ORA in circumstances when a practitioner acquires a patient from another practitioner, at a different practice or practice group. .

- **The first Schedule II opioid drug prescription issued by the new practitioner to the acquired patient is considered an initial prescription**, such that the prescription **must be limited to a seven-day supply**, unless the acquiring physician and the previous prescriber are members of the same practice group.

The 2018 WV Opioid Legislation-SB 273

§16-5H-2. Definitions.

“**Chronic pain**” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for **longer than three continuous months**. For purposes of this article, “chronic pain” does not include pain directly associated with a terminal condition.

The 2018 WV Opioid Legislation-SB 273

More Definitions..

ARTICLE 3A.

“**Pain**” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

“**Acute pain**” means a time limited pain caused by a specific disease or injury.

“**Chronic pain**” means a noncancer, non-end of life pain lasting more than three months or longer than the duration of normal tissue healing.

The 2018 WV Opioid Legislation-SB 273

"**Pain management clinic**" means all privately-owned pain management clinics, facilities, or offices not otherwise exempted from this article and which meet both of the following criteria:

(1) Where in any month more than **50%** of patients of the clinic are prescribed or dispensed Schedule II opioids or other Schedule II controlled substances specified in rules promulgated pursuant to this article for chronic pain resulting from conditions that are not terminal; and

(2) The facility meets any other identifying criteria established by the secretary by rule.

The 2018 WV Opioid Legislation-SB 273

“**Addiction**” means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is characterized by inability to consistently abstain; impairment in behavioral control; craving; diminished recognition of significant problems with one’s behaviors; interpersonal problems with one’s behaviors and interpersonal relationships; a dysfunctional emotional response; and as addiction is currently defined by the American Society of Addiction Medicine.

The 2018 WV Opioid Legislation-SB 273

Steps to Compliance:

1. Determine if patient is **exempt.**
2. Determine the **type of controlled substance** being used.
3. Determine if controlled substance treatment began prior to **1/1/2018.**

The 2018 WV Opioid Legislation-SB 273

Who is Exempt?

- Patients with active cancer
- Hospice patients
- Palliative care patients
- Patients in long term care facilities
- Controlled substances being used to treat a substance use disorder
- **Patients in an inpatient setting at a hospital-HB 2768**

The 2018 WV Opioid Legislation-SB 273

Management Determined by TYPE and TIME

TYPES:

1. **Schedule II Opioids,**
2. ~~Schedule II Non-Opioids-Benzodiazepines~~, per HB 2768
3. ~~Non-Schedule II Opioids,~~ per HB 2768

TIME: Either before or after **1/1/18**

The 2018 WV Opioid Legislation-SB 273

Opioids That Are C II and Began Prior to 1/1/18..

No changes

Yearly review of **PDMP** and documentation

Physical Exam every **3** months. Not from SB273 but per professional guidelines and standards of care.

The 2018 WV Opioid Legislation-SB 273

Opioids that are Not C II

No changes

Review PDMP prior to prescribing and at least yearly. Document the review.

Examples: Tramadol, Some formulation of codeine

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

First Prescription

1. Ask if the patient has a **Non-Opioid Advanced Directive**? **NOAD**

2. Inform the patient .. they can fill the Rx in a lesser quantity.

3. Are there multiple serious **risks** from opioids?

4. If the patient is a **minor** then **the parent or guardian must be aware** of the reasons why the prescription is necessary.

5. Limited to **seven** days worth of medication by PCP.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18
First Prescription -Document:

6. Non-opioid medications that have been tried.
7. Non-Pharmacological approaches tried.
8. Substance abuse history.
9. Plan for determining the cause of pain.
10. CSMP/PDMP database reviewed.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Second Prescription

HB 2768 allows a subsequent prescription **less than six days after issuing the initial prescription**.

HB 2768 provide that the **narcotics contract is not required until the third prescription** for the Schedule II opioid drug.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Second Prescription-Document:

1. Rationale for the 2nd Prescription.

2. That there is not an undue **risk** of abuse, addiction or diversion.

3. Discussion of the risks of addiction, dependence, and overdose and the dangers of taking opioids with alcohol, benzodiazepines, or other depressants;

4. **Discussion** of alternative treatments.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Third Prescription

1. **Consider referral to pain management.**
2. Discuss the benefits of being referred and the risks of choosing not to be referred.
3. If the patient declines pain management then you must:
4. **Document: that the patient knowingly declined treatment** from a pain clinic or pain specialist.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Third Prescription

Review, every three months,

- the course of treatment,
- any new information about the etiology of the pain, and
- the patient's progress toward treatment objectives and
- document the results of that review.

Periodically make efforts to either..

- stop the use of the controlled substance,
- decrease the dosage,
- try other drugs or treatment modalities and
- document with specificity the efforts undertaken.

Assess the patient risk of dependence and document the assessment.

The 2018 WV Opioid Legislation-SB 273

West Virginia Controlled Substances Monitoring Act

§60A-9-7. Criminal penalties; and administrative violations.

(f) Any practitioner who **fails to register with the West Virginia Controlled Substances Monitoring Program and obtain and maintain online or other electronic access to the program database** as required .. shall be subject to an administrative penalty of $1,000 by the licensing board of his or her licensure .. The provisions of this subsection shall become effective on July 1, 2016

Prescribers are required to register with the WVBOP and Check BOPs!!

The 2018 WV Opioid Legislation-SB 273

The WVBOP

Compiles and reports to licensing boards provider prescriber data.

§30-3A-4. Abnormal or unusual prescribing practices.

(a) Upon receipt of the **quarterly report ..** the licensing board shall notify the prescriber that he or she has been identified as a potentially **unusual or abnormal prescriber**. The board may take appropriate action, including .. an investigation or disciplinary action based upon the findings .. in the report.

(b) A licensing board may upon receipt of .. information independent of the quarterly report .. **initiate an investigation into any alleged abnormal prescribing or dispensing practices of a licensee.**

The 2018 WV Opioid Legislation-SB 273

§60A-5-509. Unlawful retaliation against health care providers**.**

(a) A .. provider has **the right to exercise .. professional judgment** to decline to .. prescribe narcotics without being subject to actual or threatened acts of reprisal.

(b) It shall be **unlawful for any person .. to engage in any form of threats or reprisal** .. the purpose of which is to punish, embarrass, deny, or reduce privileges or compensation .. as a result of, or in retaliation for, the refusal of .. that provider to .. prescribe narcotics.

(c) **Any person or entity who violates the foregoing .. shall be liable in the amount of three times the economic loss** sustained as a direct and proximate result of the reprisal.

Break

How to help the Heroin User

How to help the Heroin User

- Continue efforts at responsible prescribing.
- **Connect patients to new, well funded, statewide efforts at treatment.**

Comprehensive Behavioral Healthcare Centers

United Summit Center - Main Office

Mental health and substance abuse services for: Harrison Marion Lewis Doddridge Taylor Gilmer Braxton and Preston Counties.

FMRS Health Systems Inc. - Main Office

Mental health and substance abuse services for: Fayette Monroe Raleigh and Summers Counties.

Appalachian Community Health Center - Main Office

Mental health and substance abuse services for: Randolph Barbour Upshur and Tucker Counties.

Eastridge Health Systems - Main Office

Mental health and substance abuse services for: Berkeley Jefferson and Morgan Counties.

HealthWays Inc. - Main Office

Mental health and substance abuse services for: Brooke and Hancock Counties.

Logan Mingo Area Mental Health Inc. - Main Office

Mental health and substance abuse services for: Logan and Mingo Counties.

Northwood Health Systems Inc. - Main Office

Mental health and substance abuse services for: Marshall Ohio and Wetzel Counties.

Potomac Highlands Guild - Main Office

Mental health and substance abuse services for: Grant Hampshire Hardy Mineral and Pendleton Counties.

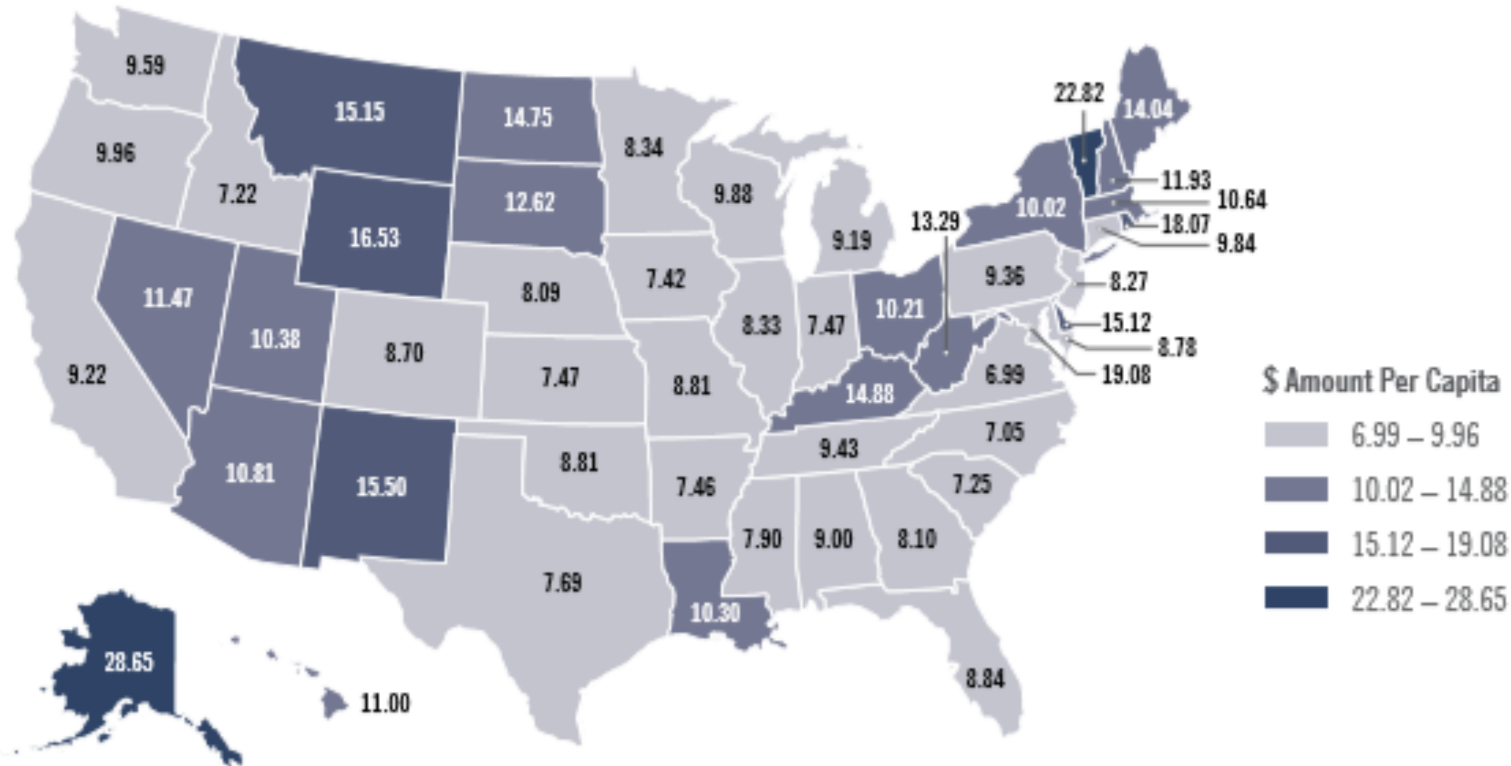
Prestera Center - Main Office

Mental health and substance abuse services for: Boone Cabell Clay Kanawha Lincoln Logan Mason Putnam and Wayne Counties.

Seneca Health Services Inc. - Main Office

Mental health and substance abuse services for: Greenbrier Nicholas Pocahontas and Webster Counties.

Improved Funding for Treatment :



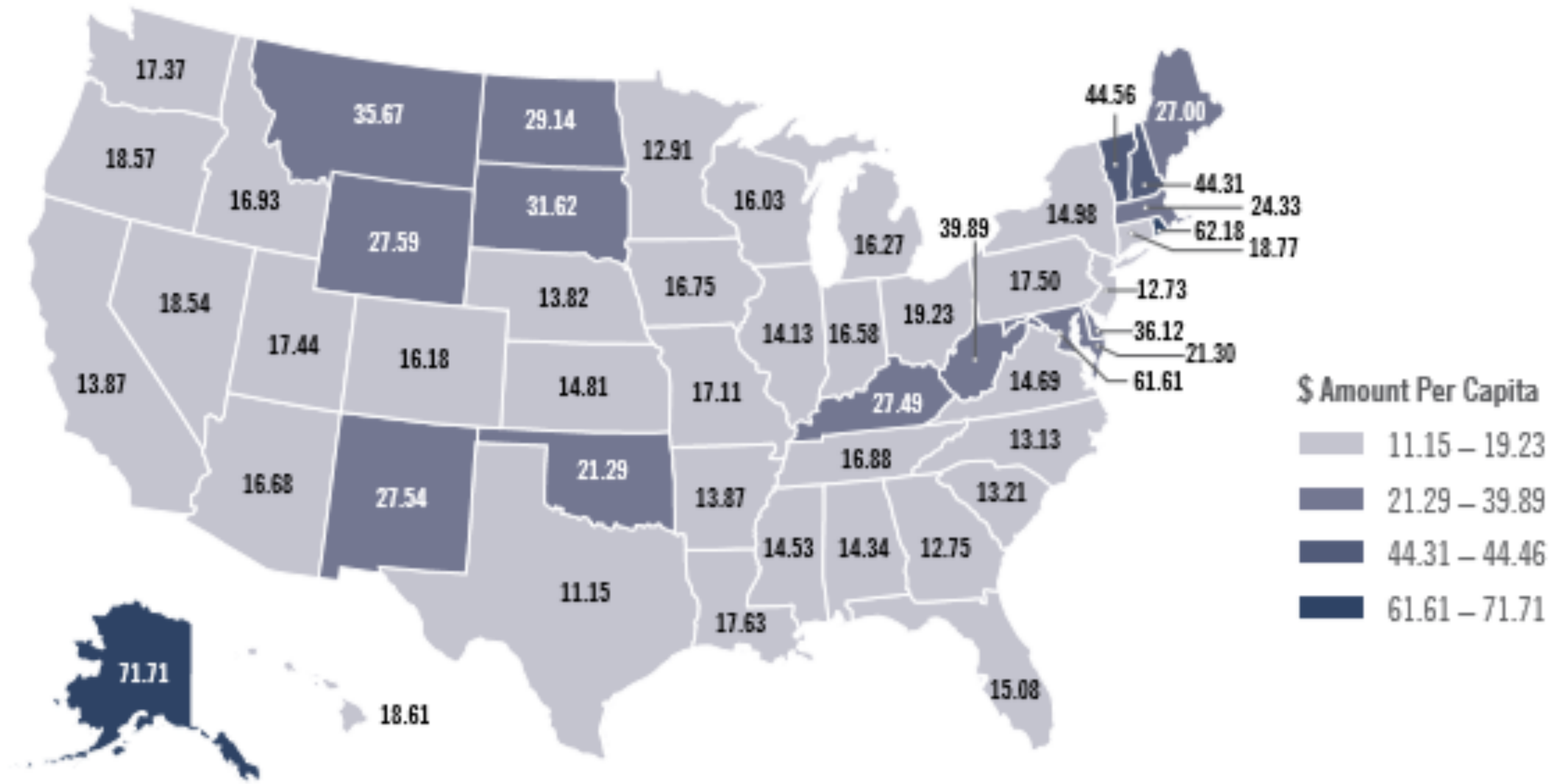
WV Spend 2017:

$13.29

per person

file:///C:/Users/Tracy/AppData/Local/Microsoft/Windows/INetCache/IE/72LIXKAY/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf

Improved Funding for Treatment :



WV Spend 2018:

$39.89

per person

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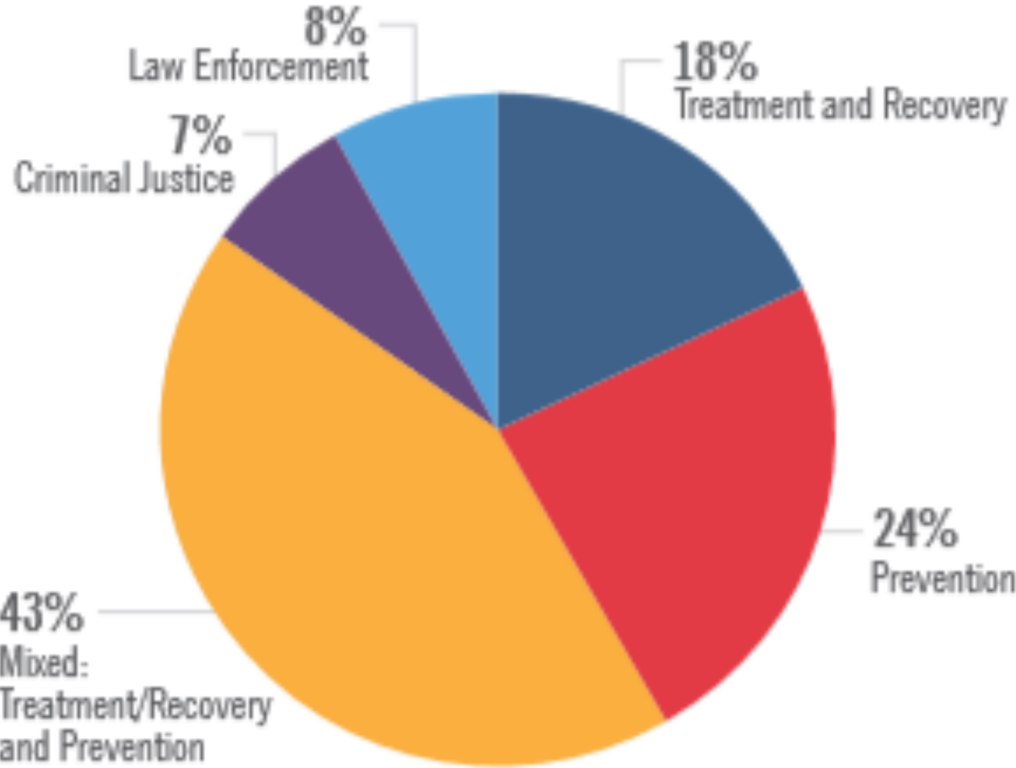
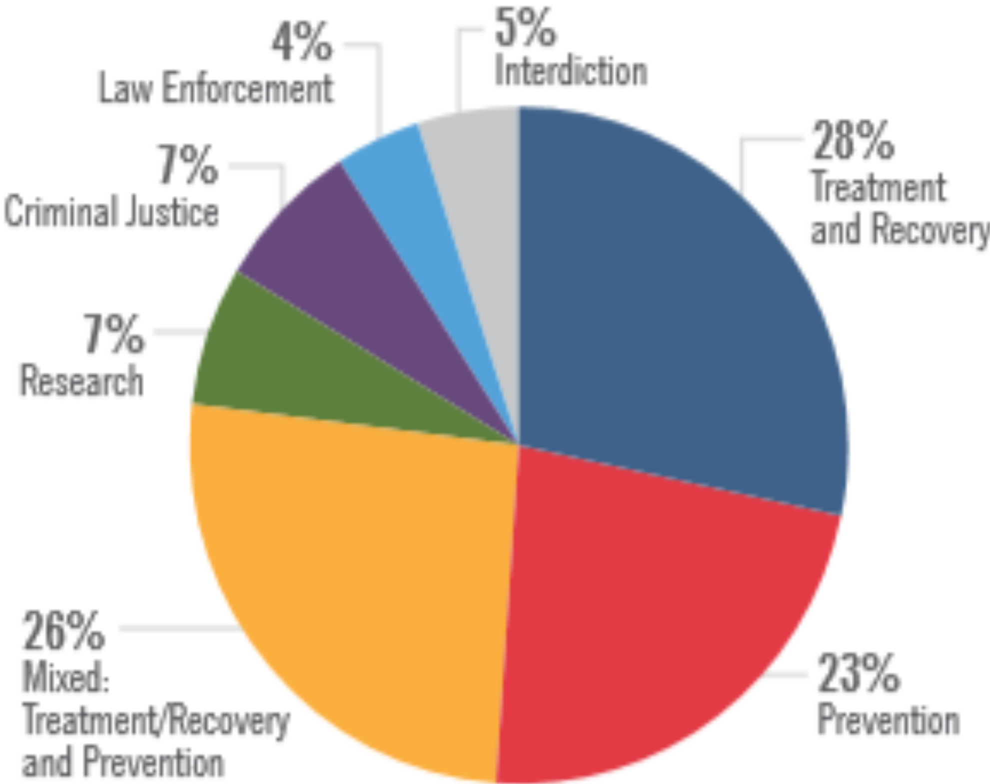
Improved Funding for Treatment :





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How to help the Heroin User

Get Involved

In the last year's round of funding, the U.S. Department of Health and Human Services awarded agencies in WV more than $35M to address substance abuse. Those grants include:

State Opioid Response Grants: $28M to the WVDHHR

Expanding Access to Quality Substance Use Disorder and

Mental Health Services: $7.5M to more than 20 WV FQHCs

Rural Communities Opioid Response Program: $400,000 to MU Research and Community Care of WV

Behavioral Health Workforce Education and Training Program: $200,000 to WVU

Rural Health Opioid Program: $179,000 to Community Connections, Inc.

Wendy Holdren, West Virginia receives more than $35 million to fight opioid epidemic Register-Herald Reporter,

The Role of WV Physicians

- Become **accepted partners** in the opioid death epidemic.
- Turn the focus to Illegal Medications and **addictions**.
- Identify at risk patients.
- Guide them to treatment.
- **We should be offering MAT,** (House Bill 3132 passed in 2019 with goal of making office-based treatment more accessible)

How to help the Heroin User

Rapid screening for substance misuse or substance use disorders can be performed in the primary care setting with a validated single-question screening tool. **(LOE: C)**

Patients with hazardous substance use or substance use disorders may benefit from **brief** counseling by their primary care physician. **(LOE: B)**

Office-based pharmacotherapy for opioid dependence using buprenorphine is safe and effective. **(LOE: A)**

A Primary Care Approach to Substance Misuse, B. Shapiro, MD; D. Coffa; and E. McCance-Katz, MD PhD, *Am Fam physician.* 2013 Jul 15;88(2):113-121**.**

How to help the Heroin User

Patients with substance use disorders may benefit from identification and treatment of comorbid psychiatric disorders. **(LOE: A)**

Patients with substance use disorders should be routinely screened for intimate partner violence. **(LOE: C)**

A Primary Care Approach to Substance Misuse, B. Shapiro, MD; D. Coffa; and E. McCance-Katz, MD PhD, *Am Fam Physician.* 2013 Jul 15;88(2):113-121**.**

How to help the Heroin User

Single-question screen

for Substance Use Disorders

"How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"

If positive you can expand to the 10 question screening tool.

This tool has 90% to 100% sensitivity and 74% specificity for substance use disorder.

Scoring:

1-3 points= moderate risk, monitor and reassess patient.

> 3 points= substance abuse or dependence.

How to help the Heroin User

Drug Abuse Screening Test-10

1. Have you used drugs other than those required for medical reasons?
2. Do you use more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs
8. Have you engaged in illegal activities to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?

How to help the Heroin User

It takes a Community

CDC Director,
Dr. Robert Redfield :

“Clearly, this area has seen and experienced the opioid epidemic in the flesh…I think that experience has really galvanized the community here to come together in a thoughtful way to try to develop an approach to make an impact on this epidemic.”

http://wvmetronews.com/2018/08/27/cdc-director-visits-west-virginia-to-understand-opioid-crisis-response/

How to help the Heroin Users

Mutual Help Meetings

Examples and Resources:

- Alcoholics Anonymous (http://www.aa.org)
- Narcotics Anonymous (www.na.org)

Appropriate Patients: Patients at any stage of readiness, including ongoing substance use

How to help the Heroin User

Medically Supervised Withdrawal

(“detoxification”)

Examples and Resources: Outpatient or inpatient treatment

Appropriate Patients: Patients with **physical dependence** on alcohol, opioids, benzodiazepines, etc., and have withdrawal syndrome

How to help the Heroin User

Outpatient Treatment

Examples and Resources: Outpatient drug-free treatment, opioid agonist therapy (office or outpatient), naltrexone therapy

Appropriate Patients: Patients with relatively stable and safe living environments

How to help the Heroin User

Residential Treatment

Examples and Resources:

- Therapeutic community model,
- short-term residential treatment,
- 12-step residential treatment,
- intensive inpatient treatment

Appropriate Patients: Patients who need stable living environment; patients with severe addiction/comorbidities who may be at high risk of relapse, emotional crisis, or behavioral problems

How to help the Heroin User

Have an Organizational Plan:

Review your local resources and if you cannot provide care directly, then refer as appropriate.

If your organization has an **opioid crisis action plan**, review it. If not, help to create one.

The state has put together a resource to help the individual seeking treatment, but, the site can be used to help build your organization's action plan.

1-844-HELP4WV
ONE Call.
ONE Text.
ONE Click.
INSTANT HELP.

Get Help

1-844-Help-4-WV
For immediate help for any West Virginian struggling with an addiction or mental health issue - call or text 24/7.

Done.

References-first half hour:

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The Drug epidemic - Opioid

- In April 19, 2016 **CDC released Guidelines for Prescribing Opioids for Chronic Pain.**
- **WE have noticed some change in the number of prescription.**
- **Many patients switched to street drugs instead.**
- In 2016, West Virginia had the highest rate of opioid-related overdose deaths in the United States—a rate of 43.4 deaths per 100,000—and up from a low 1.8 deaths per 100,000 in 1999.
- the majority of deaths attributed to synthetic opioids and heroin.
- This epidemic started by Physicians in our state.