Rising to the Call to Tackle the Opioid Crisis: Pharmacists and Pharmacy Technicians in Action

See the Bigger Picture

When Dispensing Opioids

Sarah Pointer, Pharm D
Clinical Director of the Illinois Prescription Monitoring Program

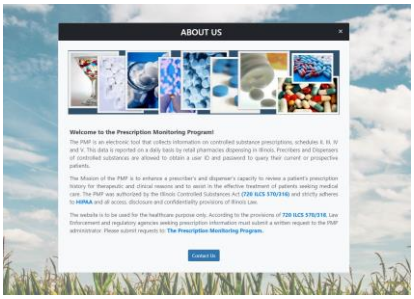
Conflict of Interest

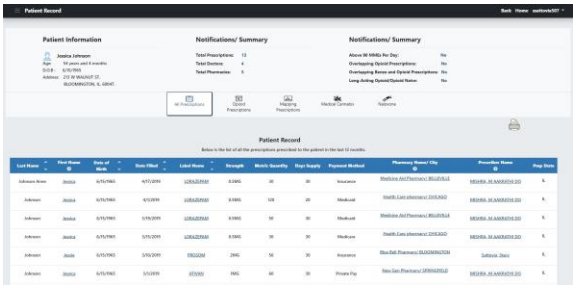
The speaker (Sarah Pointer) has no conflicts of interest to disclose.

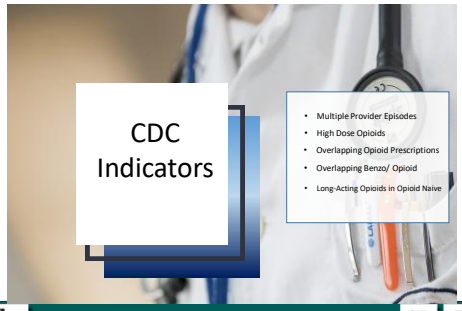
ILPMP
Illinois Prescription Monitoring Program

Learning objectives for Pharmacists and Technicians

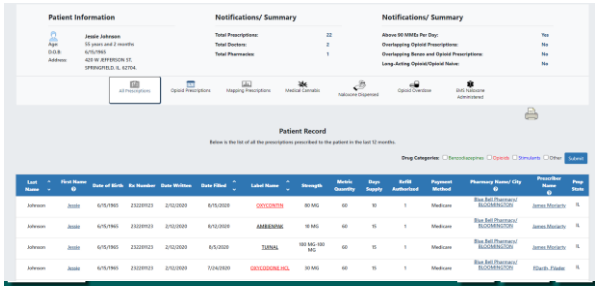
- Promote Provider Awareness of the PMP and PMPnow
- Identify methods of improved accessibility that have contributed to increased utilization of the PMP



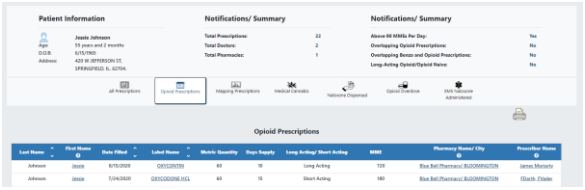




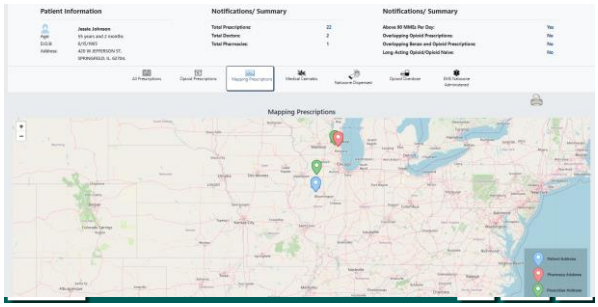
All Prescriptions



Opioid Prescriptions

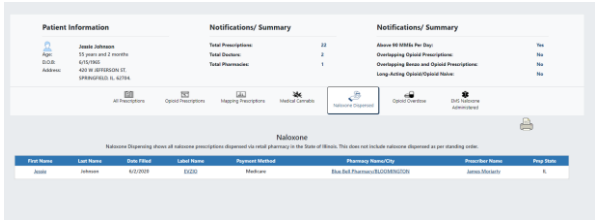


Mapping Prescriptions

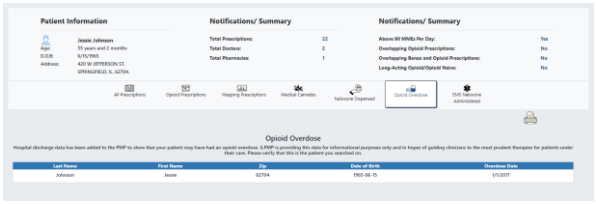


Medical Cannabis

Naloxone Dispensed

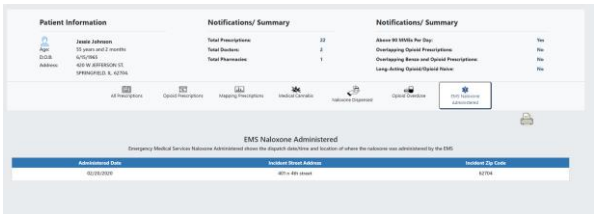


Opioid Overdose

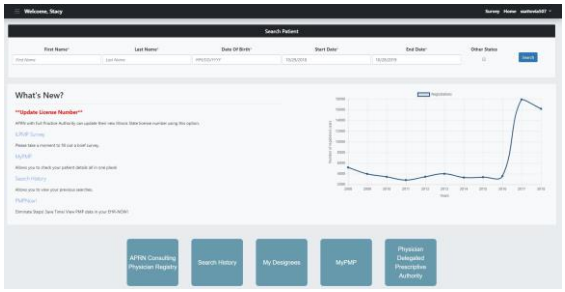


2020 ICHP Annual Meeting OUR TEAM CAN

EMS Naloxone Administered



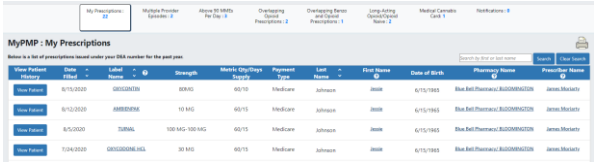
2020 ICHP Annual Meeting OUR TEAM CAN



Benefits of MyPMP

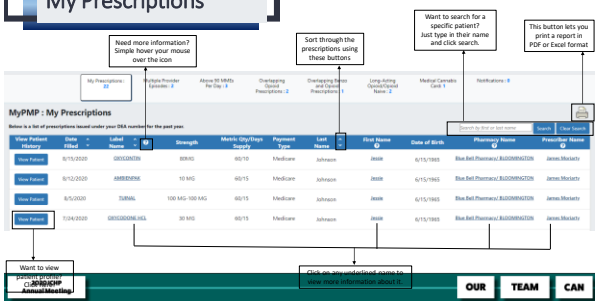
- Consolidated information
- Easy access
- New and Improved design
- Ability to make an informed decision

MyPMP Home Screen



By Default, this page displays total prescriptions within the last 12 months attributed to your DEA number(s)

My Prescriptions



Other than controlled substance prescriptions dispensed, what other data can be found in the PMP?

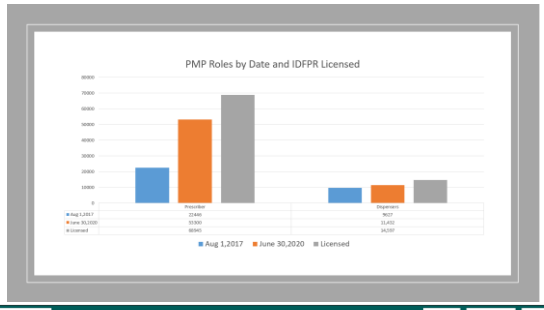
Public Act 100-0564

Mandated registration by prescribers

Mandated utilization by prescribers

Mandated EHR integration

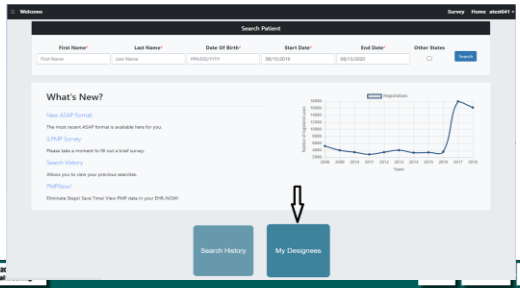
Mandated registration by prescribers



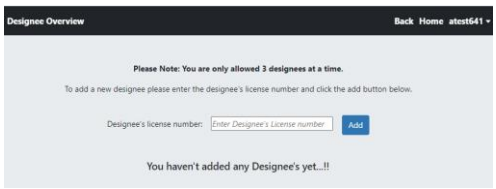
Mandated utilization by prescribers

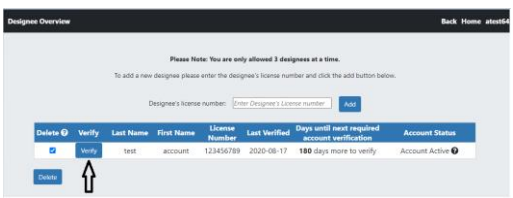
PMP Utilization?

- Click the "My Designee" tile to Add, Remove or Recertify/Verify your Designees.

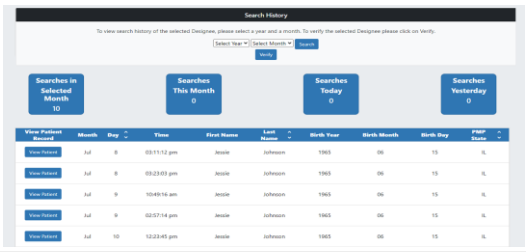


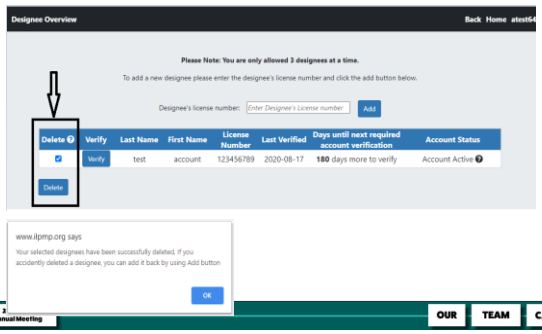
Add Designee:





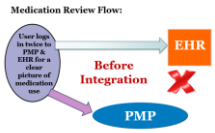
- Select the year and month for which you wish to view the search history of your designee. Click the "Search", it will appear as follow



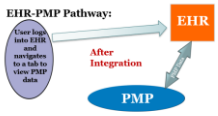


EHR Integration = PMPnow

PMP Website



PMPnow

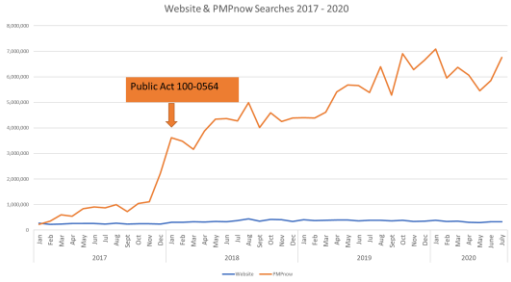


PMP now

The PMP automated connection

10,907

Individual connection points including hospitals pharmacies, physician practices, local health departments, dental, optical, long term care facilities, and treatment centers.



Total PMP Searches by Year

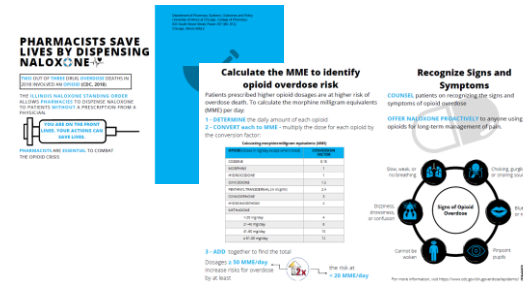
Year	Searches
2013	1,431,538
2014	2,232,916
2015	2,713,137
2016	4,698,186
2017	13,377,213
2018	48,893,466
2019	71,603,732

Increased utilization can be seen as a direct result of improving ease of access to PMP data. Which of the following methods have been implemented to improve PMP access?

A. Designee Capabilities
B. PMPnow
C. Direct Link to the website
D. A and B
E. All of the above

Additional Pharmacy Related Activities


OPIOID RELATED DEATHS ARE ALARMINGLY HIGH IN YOUR COUNTY
BUT NALOXONE DISPENSING STILL REMAINS LOW
AS A PHARMACIST
YOU CAN MAKE A DIFFERENCE
BY DISPENSING UNDER THE ILLINOIS STANDING ORDER FOR NALOXONE
PRSRT STD
US POSTAGE
PAID
CHICAGO,IL
PERMIT #4860
WHO SHOULD RECEIVE NALOXONE?
Patients, family members, or friends of / with:
chronic opioid therapy
long-acting opioids
high dose opioids
recent increase in opioid dose
a history of opioid overdose or abuse
a recent opioids re-initiation
concurrent opioid and benzodiazepine use
QUICK TIPS TO COUNSEL
Choose non-offensive words and be empathetic
"what kind of concerns do you have about naloxone?"
Introduce it as a life preserver
"Just like how a life preserver can save a life during an unforeseen emergency, naloxone can prevent an accident from happening to you or your loved ones."
IS NALOXONE COVERED BY INSURANCE?
YES, IT IS:
MEDICARE, MEDICAID, AND MOST PRIVATE HEALTH INSURANCE PLANS COVER NALOXONE FOR THE TREATMENT OF OPIOID OVERDOSE.


PHARMACISTS SAVE LIVES BY DISPENSING NALOXONE
Calculate the MME to identify opioid overdose risk
Patients prescribed higher opioid dosages are at higher risk of overdose death. To calculate the morphine milligram equivalents (MME) per day:
1 - DETERMINE the daily amount of each opioid
2 - CONVERT each to MME - multiply the dose for each opioid by the conversion factor:
3 - ADD together to find the total
Dosages > 50 MME/day increase risks for overdose by at least
1.2x
the risk at > 20 MME/day
Recognize Signs and Symptoms
COUNSEL patients on recognizing the signs and symptoms of opioid overdose
OFFER NALOXONE PROACTIVELY to anyone using opioids for long-term management of pain
Signs of Opioid Overdose
Slow, weak, or no breathing
Choking, gurgling, or snoring sounds
Blue lips or nails
Pinpoint pupils
Cannot be woken
Extreme drowsiness or confusion


What can you do?

Review and Implementation of CDC Guidelines for Prescribing Opioids for Chronic Pain

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UChicago Medicine

Saturday, October 3, 2020

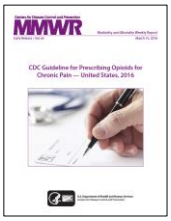
Conflicts of Interest /Disclosures

- Mark Greg, Chris Herndon, and Randall Knoebel have no actual or potential conflicts of interest
- Mark Greg, Chris Herndon, and Randall Knoebel will not be discussing off-label uses of medications in this presentation

Objectives

1. Summarize the CDC recommendations for prescribing opioids in patients with chronic pain
2. Identify patients at risk for experiencing opioid related toxicity through risk assessment factors
3. Describe various non-pharmacological measures that can be used to assist in managing pain
4. Discuss the application of the CDC recommendations for use of opioids in chronic pain to various pharmacy practice settings
5. Explore strategies to reduce stigma in opioid use so that it is never a barrier to patients receiving appropriate treatment

March 2016



Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep.* 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

September 2018

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.* 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Available at: https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf. Accessed June 6, 2020.

Is your health system actively involved with implementing the CDC guidelines for prescribing opioids for chronic pain?

- Yes
- No
- Unsure

CDC Recommendations for Prescribing Opioids in Patients with Chronic Pain

- Nonopioid and nonpharmacologic therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- Providers should always exercise caution when prescribing opioids and monitor all patients closely.

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain*. 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Page 3

Describe in as few words as possible how the CDC opioid guidelines have impacted your practice

Determining When to Initiate or Continue Opioids for Chronic Pain

- Opioids are not first-line therapy.
- Establish goals for pain and function.
- Discuss risks and benefits.

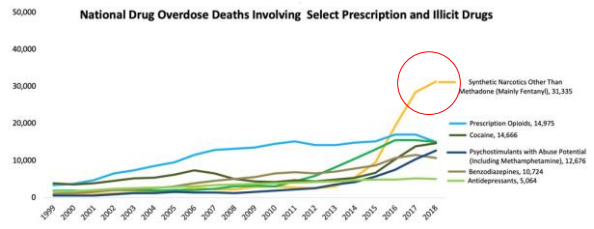
Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain*. 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Page 4

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

- Use immediate-release opioids when starting.
- Use the lowest effective dose.
- Prescribe short durations for acute pain.
- Evaluate benefits and harms frequently.

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain*. 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Page 5

Are Prescription Opioids Still the Problem?



Source: CDC.gov/drug overdose

The Studies Behind the Guidelines…

Hazard ratios for the relationship between recent opioid dosage level and overdose

Opioid dosage level	Number of overdoses[a]	Person-years	Overdose rate[a] (95% C.I.) per 100,000 person years	All overdose events Hazard ratio (95% C.I.)[a,b]	Serious overdose events Hazard ratio (95% C.I.)[b,c]
0	6	16,780	36 (13-78)	0.21 (0.12, 0.80)	0.19 (0.05, 0.68)
1–<20	22	13,776	160 (100-231)	1.00	1.00
20–<50	6	2,311	260 (95-565)	1.44 (0.57, 3.62)	1.19 (0.40, 3.60)
50–<100	6	886	677 (249-1317)	3.73 (1.47, 9.50)	3.11 (1.01, 9.51)
100+	11	614	1791 (894-2995)	8.87 (3.99, 19.72)	11.18 (4.80, 26.03)
Any opioid use	45	17,582	256 (187-336)	5.16 (2.14, 12.48)	8.39 (2.52, 27.98)

Abbreviation: C.I., confidence interval

[a]Overdose defined as opioid-related overdose death, or non-fatal event defined as definite or probable opioid-related overdose.

[b]Adjusted for smoking, depression, substance abuse, comorbidity, pain site, age, gender, recent sedative-hypnotic prescription and recent initiation of opioid use.

[c]Overdose defined as opioid-related overdose death, or serious non-fatal event (n=40).

Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010;152:85– 92. http://dx.doi.org/10.7326/0003-4819-152-2-201001190-00006

The Opioids Behind the Guidelines…

Most common[b] opioids prescribed during follow-up (% of cohort)

Hydrocodone	46.3%
Oxycodone	24.5%
Codeine combination	11.6%
LA morphine (long-acting)	6.2%
Propoxyphene	4.9%
Oxycodone CR (controlled release)	2.5%
Tramadol	1.7%
Hydromorphone	0.9%
Methadone	0.7%

MME for Commonly Prescribed Opioids

Opioid	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone: 1-20 mg/day	4
Methadone: 21-40 mg/day	8
Methadone: 41-60 mg/day	10
Methadone: ≥61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol†	0.4

(† Tapentadol is a mu receptor agonist and norepinephrine reuptake inhibitor. MMEs are based on degree of mu-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely mu receptor agonists.)

Dunn KM, Saunders KW, Rutter CM et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010;152:85– 92. http://dx.doi.org/10.7326/0003-4819-152-2-201001190-00006

The Co-prescribing Behind the Guidelines…

Sedative-hypnotic use (% of cohort)

Prescribed any sedative-hypnotic during follow-up	74.7%
Prescribed muscle relaxants during follow-up	52.3%
Prescribed benzodiazepines during follow-up	42.7%
At least 45 days of sedative-hypnotics prescribed in one or more 90 day period	31.9%

Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010;152:85– 92. http://dx.doi.org/10.7326/0003-4819-152-2-201001190-00006

Which equianalgesic dose calculator do you use in your practice / facility?

A. CDC conversion table
B. Johns Hopkins Opioid Conversion Calculator
C. MDCalc
D. Practical Pain Management
E. McPherson Demystifying Table
F. "I don't know"

Assessing Risks and Addressing Harms of Opioid Use

- Use strategies to mitigate risk.
- Review prescription drug monitoring program (PDMP) data.
- Use urine drug testing (and understand nuances).
- Avoid concurrent opioid and benzodiazepine prescribing.
- Offer treatment for opioid use disorder.

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.* 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Pages 5-6

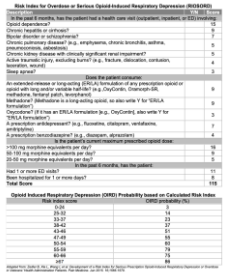
Validated Risk Assessment Tools

Acronym of tool[a]	Number of questions	Completion	Time to complete
SOAPP®-R	24 items	Self-report	< 10 minutes
DIRE	7 items	Clinician administered	< 5 minutes
ORT	5 items	Clinician administered	< 5 minutes
COMM	40 items	Self-report	< 10 minutes
CAGE	4 items	Either	< 5 minutes
PDUQ	42 items	Clinician administered	20 minutes
STAR	14 items	Self-report	< 5 minutes
SISAP	5 items	Clinician administered	< 5 minutes
PMQ	26 items	Self-report	< 10 minutes

a – SOAPP®-R (Screener and Opioid Assessment for Patient's in Pain-revised); DIRE (Diagnosis, Intractability, Risk, and Efficacy); ORT (Webster's Opioid Risk Tool); COMM (Current Opioid Misuse Measure); CAGE (Cut-down, Annoyed, Guilt, Eye-opener); PDUQ (Prescription Drug Use Questionnaire); STAR (Screening Tool for Addiction Risk); SISAP (Screening Instrument for Substance Abuse Potential); PMQ (Pain Medication Questionnaire)

Assessing for Risk of Overdose

STOP-BANG	
Snoring Do you snore loudly?	Yes / No
Tired Do you often feel tired or fatigued?	Yes / No
Observed apnea Has anyone observed you stop breathing while asleep?	Yes / No
Blood Pressure Do you have or are you treated for high blood pressure	Yes / No
BMI > 35 kg/m^2	Yes / No
Age >50	Yes / No
Neck circumference >40 cmg	Yes / No
Gender (male?)	Yes / No
High risk of OSA with 3 or more "Yes" answers	


Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)

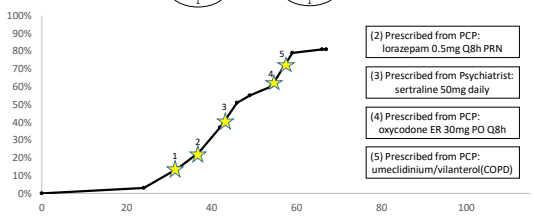
Factors	Yes	Points
In the past 6 months, has the patient had a health care visit (outpatient, inpatient, or ED) involving:		
Opioid dependence?		13
Chronic hepatitis or cirrhosis?		9
Bipolar disorder or schizophrenia?		7
Chronic pulmonary disease? (e.g., emphysema, chronic bronchitis, asthma; excluding sleep apnea)		5
Chronic kidney disease with clinically significant renal impairment?		5
Active traumatic injury, excluding burns? (e.g., fracture, dislocation, contusion, laceration, wound)		4
Sleep apnea?		3
Does the patient consume:		
An extended-release or long-acting (ER/LA) formulation of any prescription opioid or opioid with long and/or variable half-life? (e.g.,OxyContin, Oramorph-SR, methadone, fentanyl patch, levorphanol, Methadone? (Methodone is a long-acting opioid, so also write Y for "ER/LA formulation")		9
Buprenorphine? If it has an ER/LA formulation (e.g., OxyContin), also write Y for "ER/LA formulation"?		3
A prescription antidepressant? (e.g., fluoxetine, citalopram, venlafaxine, amitriptyline)		3
A prescription benzodiazepine? (e.g., diazepam, alprazolam)		4
Is the patient's current maximum prescribed opioid dose:		
>100 mg morphine equivalents per day?		16
50-100 mg morphine equivalents per day?		9
20-50 mg morphine equivalents per day?		5
In the past 6 months, has the patient:		
Had 1 or more ED visits?		11
Been hospitalized for 1 or more days?		8
Total Score		118

Opioid Induced Respiratory Depression (OIRD) Probability based on Calculated Risk Index

Risk Index score	OIRD probability (%)
0-24	3
25-32	14
33-37	23
38-42	37
43-46	55
47-49	65
50-54	69
55-59	79
60-66	75
≥67	89

Algate from: Zedler B, Xie L, Wang L, et al. Development of a Risk Index for Serious Prescription Opioid-Induced Respiratory Depression or Overdose in Veterans Health Administration Patients. Pain Medicine. doi:10.1111/pme.12754

Meet WR, 47 YOF with 3 failed back surgeries and hypertension; Height: 5'6"; Weight: 210 lbs
Opioid regimen (stable for last 2 years): Oxycodone ER 30 mg PO Q12h; Oxy IR 10 mg PO Q4h PRN



(2) Prescribed from PCP: lorazepam 0.5mg Q8h PRN

(3) Prescribed from Psychiatrist: sertraline 50mg daily

(4) Prescribed from PCP: oxycodone ER 30mg PO Q8h

(5) Prescribed from PCP: umeclidinium/vilanterol(COPD)

Non-pharmacological Measures That Can Be Used to Assist in Managing Pain

- physical therapy
- exercise therapy
- counseling / psychotherapy
- weight loss
- electroanalgesia: spinal cord stimulators / TENS / PENS
- non-invasive therapies could include Medical Nutritional Therapy, Wound Care, Acupuncture, Osteopathic Manipulations and Chiropractic care

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.* 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Page 47

What could you do within your practice environment to…?

- Review prescription drug monitoring program (PDMP) data?
- Alert prescribers to at-risk patients based upon PDMP data?
- Alert prescribers to concurrent opioid and benzodiazepine prescribing in at-risk patients?
- Use non-pharmacological therapy to assist in pain management?

Hospital Pharmacy

- Use of opioid alternatives for pain management
- Enhanced recovery after surgery
- MME calculator built into EMR
- Monitor for MME > 50 plus benzo or MME >90
- Add naloxone Rx for at-risk patients
- Medication Assisted Therapy (MAT)
- Illinois Prescription Drug Monitoring Program check
- Referral to pain management clinic

Community Pharmacy

- Limit quantities to ≤ 3 days for acute treatment(?)
- MME calculator built into Rx processing software
- Illinois Prescription Drug Monitoring Program check
- Monitor for MME > 50 plus benzo or MME > 90
- Hard edits
- Patient/caregiver counseling
- Add naloxone Rx for at-risk patients per (State of Illinois Standing Order)
- Screening Brief Intervention Referral for Treatment (SBIRT)

Ambulatory Primary Care

- Identify and address the root cause of pain
- Opioid Risk Tool
  https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
- Use of non-opioids and opioid alternatives for pain management
- Illinois Prescription Drug Monitoring Program check
- MME calculator built into EMR
- Monitor for MME > 50 plus benzo or MME > 90

Ambulatory Primary Care - continued

- Add naloxone Rx for at-risk patients
- Opioid Treatment Agreement (OTA) for chronic ≥ 90 days continuous therapy
- UDS or UTOX and appropriate interpretation
  - Role of medical / recreational marijuana and CBD
- Screening Brief Intervention Referral for Treatment (SBIRT)
- Referral to pain management clinic
- Medication Assisted Therapy (MAT)

The Challenges:

- Provider education
- Payer barriers
- Naloxone co-prescribing
- Risk mitigation strategies and interpretation
- Inappropriate weans, hard limits, and abrupt discontinuation
- Referral misperceptions
- Fear of opioid-alternatives including ketamine and lidocaine
- Understanding the CDC recommendation limitations

Principles for Talking with Patients about Opioids

- Keep the primary focus on outcomes patients care about.
- When discussing risk, focus on the medications.
- Develop a differential diagnosis for patient behaviors that cause concern.
- Focus on what patients can do to improve their quality of life.

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.* 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Pages 85-86.

Effective Patient Communication and Education

- Remember the importance of the patient-provider relationship.
- Use a patient-centered, empathic communications style.
- Use suggested approaches to working collaboratively with patients when dealing with difficult and sensitive issues
- Talk with patients about Urine Drug Testing (UDT).
- Review the model approaches for working with patients through difficult situations and consider adapting the suggested language to your practice.
- Use patient education resources to help patients understand the risks of opioid therapy and different ways of managing chronic pain that patients find helpful. (Toolkit Part L)

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.* 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Pages 86-87

Stigma…

- Stigma is a social 'marking' that detracts from a person or group in a way that does not support or build up a person.
- We all have a little bit of stigma, it comes from an overgeneralization across an entire group of patients.
- Patients are often fired from a practice, which doesn't happen with other diseases (i.e., we don't fire patients with uncontrolled diabetes)
- The words we use make a big difference (i.e., "Addicts", "Dirty vs. "Clean" Urine)
- Person centered language is key (i.e., "a person with a substance use disorder," "a person that uses drugs")
- Focus on making life better vs. a moral failing. - It's a chronic medical condition!

Empathy is key

Having Difficult Conversations

- Introducing a change in practice
- Introducing monitoring for opioid harms
- Introducing dose reduction, tapering, and hyperalgesia
- Introducing nondrug approaches to managing chronic pain
- Talking with patients about medication supply
- Responding to unexpected findings, UDT or PDMP results, or concern for substance use disorder or diversion

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain*. 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Pages 87-91.

Provider Practice-based Initiatives

- Signage in waiting area, lobby, exam rooms
- Provider awareness programs to ask the question
- EHR prompts - Epic-based Best Practice Advisory (BPA)
- Brochures/flyers with addiction medicine treatment programs and locations in exam rooms
- Providers, medical assistants, practice managers, front desk staff with access to addiction medicine treatment location information

https://www.cdc.gov/rxawareness/resources/signs.html

Alternative Quality Metrics

- Comparing naloxone co-prescribing against national trends
  - 4.7:1000 opioid prescriptions
- Ensuring standard assessment of patient risk for overdose
  - CDC 50mg MME
  - Concurrent benzodiazepine
  - RIOSORD assessment tool
- Wean discussion, attempt, and documentation vs. “a number”
- Adjuvant trials
- Non-pharm modality trials
- % providers DATA waivered in health system

Zedler BK et al. *Pain Med*. 2018;19(1):68-78.

Example Data Assessment to Guide Educational Efforts in My Institution

- Triage of mother in cases of neonatal abstinence syndrome
- Naloxone co-prescribing rates in chronic pain or opioid use disorder
- Documentation of informed consent, goal setting at MME thresholds
- Appropriate UDS ordering interpretation for clinical situation
- Current (within one-year) signed and review CS agreement
- Documentation of adjuvant analgesic contraindications when long term opioids continued

Summary

- Opioids are not first-line therapy for managing chronic pain.
- Regardless of your practice setting, you can assist with appropriate opioid prescribing.
- Use resources to maximize patient interactions surrounding opioid use
- Prescription opioids, while increasingly less culpable, still contribute to misuse and overdose
- Several agencies have issued guidance on safe prescribing of opioids
- Health systems should use clinical common sense in setting metrics to ensure continued access to care

References

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep.* 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.* 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Available at: https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf. Accessed June 6, 2020.

Supplemental Materials

Toolkit Part K. Working Collaboratively with Patients Receiving Long-term Opioid Therapy: Principles and Examples

CDC Resources

- Guideline resources: CDC Opioid Guideline Mobile App
- Training: Communicating with Patients
- Checklist: PDO Checklist for Prescribing Opioids
- Brochure: Pharmacists on the Front Lines
- Fact sheet: Prescription Drug Monitoring Programs
- Pocket guide: SAMHSA Pocket Guide for Medication-Assisted Treatment (MAT)

Centers for Disease Control and Prevention. *Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain*. 2018. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Atlanta, GA. Page 85

Complex Persistent Opioid Dependence

- No uncontrollable craving or compulsive use
- No harmful use that is not medically directed
- Withdrawal drug opposite effects (dysphoria, hyperalgesia)
- Difficulty tapering
- Stress-like symptoms
- Reward deficiency

Ballantyne JC et al. *Pain*. 2019;160(12):2655-2660.

Questions?

Naloxone Bystander Training

Andrew Merker, Pharm.D., BCPS, BCIDP, AAHIVP
Assistant Professor - Department of Pharmacy Practice
Midwestern University

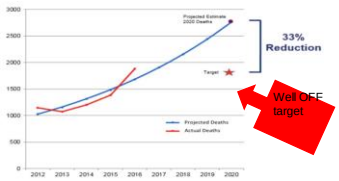
Objectives

1. Integrate identification and steps of opioid overdose management when counseling others on naloxone, as an essential role of all healthcare professionals
2. Compare key elements of administration and access to all four formulations of naloxone with consideration for the IL standardized procedures and naloxone statewide standing order
3. Support bystander response by obtaining and carrying naloxone to be able to respond to an opioid overdose in the community

Illinois Opioid overdose deaths exceed projections

Still More work to be done despite 2012 initiatives

Year	Actual Deaths	Projected Deaths
2012	1149	1021
2013	1072	1157
2014	1203	1310
2015	1382	1484
2016	1889	1680
2017	2202	1903
2018	2169	2155
2019		2441
2020		2765



The State of Illinois' Opioid Action Plan's goal to reduce projected deaths by 33% in three years
http://dph.illinois.gov/sites/default/files/publications/illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf

Rise in deaths across ALL opioids

Largest increase seen in fentanyl analogues

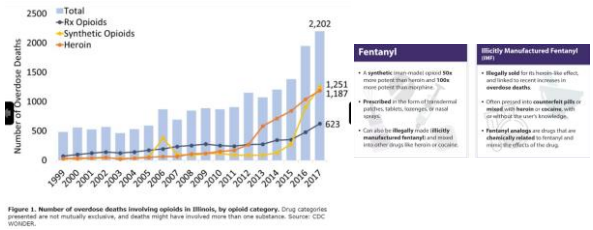
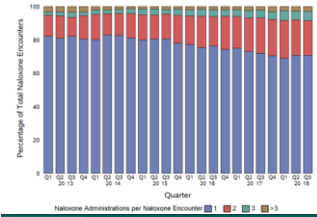


Figure 1. Number of overdose deaths involving opioids in Illinois, by opioid category. Drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Source: CDC WONDER.

Increase in opioid potency

requiring more naloxone per event

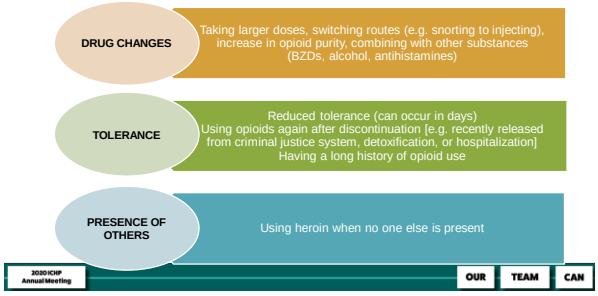
Figure 9. Naloxone administrations per EMS overdose response by quarter, 2013-2018



- Policy supports expanded access
- Medical professionals should counsel more
- Beneficial for more people to carry naloxone (including ourselves)

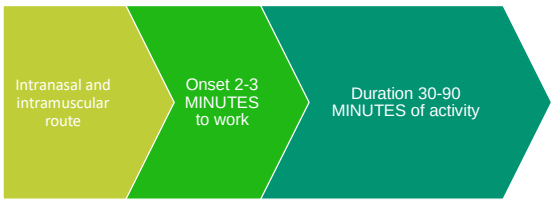
Source: IDPH Division of EMS and Highway Safety
http://www.dph.illinois.gov/sites/default/files/publications/010219oppsopioid-semiannual-report.pdf

Risk factors for overdose



STEPS TO RESPOND TO AN OPIOID OVERDOSE

Naloxone basics

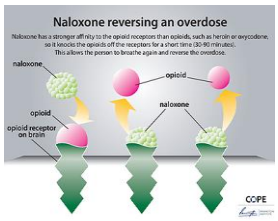


*Naloxone can also administered subcutaneous and IV in the hospital

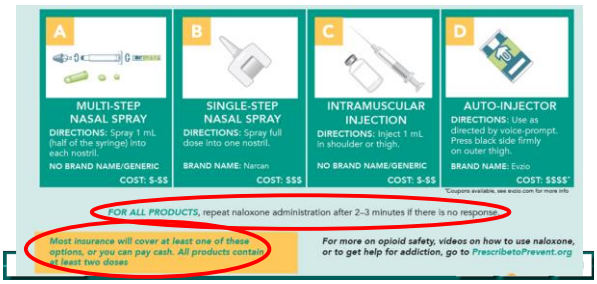
*After naloxone wears off, person can overdose again if long-acting opioids are still in their system

Mechanism of Action

- Opioid receptor antagonist that reverses clinical and toxic effects of **opioids only**
- Blocks opioid action on the brain and **restores breathing**
- Does not reverse the effects of cocaine, methamphetamine, or benzodizpine overdoses
- **No potential for abuse and does not cause euphoria**



Four formulations of naloxone



Intranasal naloxone

1. Check nostrils for obstructions
2. Remove from package (do not press plunger until ready to give naloxone)
3. With one finger holding down opposite nostril, insert the tip of the device into the nostril
4. Press firmly to administer full dose (only one dose per device)
5. Continue rescue breathing at 1 breath every 5 seconds until patient starts breathing independently
6. If no response in 2-3 minutes, administer second dose, alternating nostrils and holding down opposite nostril with one finger

Image courtesy of Illinois Department of Public Health (IDPH)

Prefilled syringe with mucosal atomization device (MAD)

1. Clear nostrils of obstructions
2. Assemble prefilled syringe and MAD
   a. Remove colored caps off Luer-lock syringe and prefilled ampule
   b. Gently twist and attach prefilled 2mL ampule and MAD to luer-lock syringe
3. With one finger holding down opposite nostril, insert the tip of the device in the nostril slightly up and outward (towards the top of the patient's ear)
4. Depress plunger firmly and quickly to administer first 1mL for half the dose and administer the remaining 1 mL in opposite nostril to complete the full dose
5. Continue rescue breathing at 1 breath every 5 seconds until patient starts breathing independently
6. If no response in 2-3 minutes, repeat steps 2-6

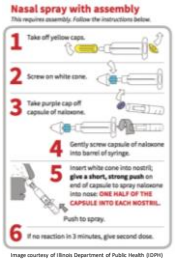


Image courtesy of Illinois Department of Public Health (IDPH)

Video Link in Resources

Naloxone intramuscular injection

1. Remove cap from vial
2. Using 1 - 1 ½ inch needle to draw up 1 mL of 0.4mg naloxone into syringe
3. Remove excess air if any
4. Inject into muscle at a 90° angle into upper arm or thigh muscle
5. May be injected through clothing, alcohol swabs to clean via and site are not required.
6. Continue rescue breathing at 1 breath every 5 seconds until patient starts breathing independently
7. If no response in 2-3 minutes, repeat steps 1-5, injecting at least 1 inch apart from previous injection site

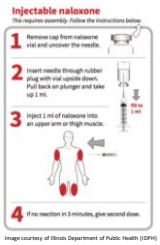


Image courtesy of Illinois Department of Public Health (IDPH)

Naloxone auto-injector

1. Remove outside cover and follow voice instructions
2. Pull off **red safety guard**
3. Place **black end** against patient's outer thigh, then press down firmly against outer thigh for 5 seconds (should hear a click)
4. Can be administered through clothing
5. Each device contains one dose. Repeat in 2-3 minutes if no response with second dose. Each kit comes with 2 doses and a trainer with no active medication for practice.

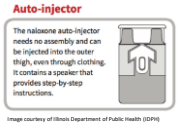


Image courtesy of Illinois Department of Public Health (IDPH)

Why should I carry naloxone?

- Life-saving drug
- Cost effective
- Used for > 40 years
- In Illinois anyone can be trained to administer naloxone
- Extremely safe
  - Non-toxic and no drug interactions
  - No psychoactive or euphoric effects
  - May be used in pregnant women, children, and animals
  - Causes NO HARM even if no opioids in the system

Recognizing signs of an opioid overdose

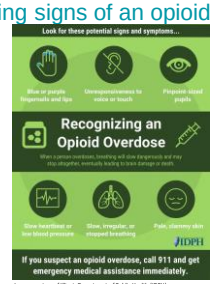


Image courtesy of Illinois Department of Public Health (IDPH)

STEPS to respond to an opioid overdose

1. Check for response.
2. Call 911. No matter what
3. Give naloxone. If no response in 2-3 minutes, repeat dose.
4. Give rescue breaths or chest compressions.
5. Stay with person until help arrives.

Check for breathing and clear blocked airways (nose and mouth)

when breathing resumes, place in

DO NOT

- Inject person with salt solution or milk
- Give cocaine, black coffee
- Put person in bath of cold water
- Put person in bed to sleep it off

Recovery position:

1. Tilt head back and open airway
2. Turn to one side, bend top arm and place under head
3. Bend top leg and rest of floor

What to Expect After Administration

- **Repeat dose every 2-3 minutes if no response (no limit to how many doses can be given)**
- Always call ambulance (person can overdose on multiple substances and naloxone will only work on opioids, opioid overdose can recur after naloxone wears off)
- **Stay with the person** until ambulance arrives
- Once breathing independently, place in **recovery position**
- Naloxone can precipitate withdrawal symptoms - **calmly explain** situation to the person (note person's response in prior video)

How long does naloxone take to start having an effect?

A. 2-3 minutes
B. 5-10 minutes
C. 11-20 minutes
D. 20-40 minutes

How long does naloxone last?

A. About 2 minutes
B. About 20 minutes
C. About 60 minutes
D. About 120 minutes

A person collapses from a suspected opioid overdose in line at the grocery store. You pull out your naloxone and notice it expired Feb 2019. In addition to performing rescue breathing, what should you do regarding naloxone administration?

A. Administer full dose
B. Administer half dose
C. Ask others if they have naloxone
D. Do not administer

LEGISLATIVE RESPONSE

Jan 2010: Drug Overdose Prevention Program[1] [DOPP] (IL Public Act 096-0361)

Amended the Alcoholism and Other Drug Abuse and Dependency Act

- Anyone who has received proper training **can legally administer naloxone and is immune from criminal prosecution** for the unauthorized practice of medicine or the possession of an opioid antidote
- **Healthcare professionals who prescribe and dispense naloxone are not subject to disciplinary or other adverse action** under any professional licensing statute
- Provided grant funding for projects related to overdose prevention, education, and naloxone distribution

[1] http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=096-0361

June 2012: Emergency Medical Services Access Law, aka "Good Samaritan Law"[2] (IL Public Act 097-0678)

Amended the IL Controlled Substances Act (720 ILCS 570/414 new)

- Established limited **immunity from criminal prosecution of drug possession** for any individual seeking emergency medical assistance in either themselves or another individual experiencing overdose

[2] http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=097-0678

Sept. 2015 Heroin Crisis Act, aka "Lali's Law"[3]

(IL Public Act 099-0480 [HB1])

Amended The Pharmacy Practice Act (225 ILCS 85/19.1 new) and The Good Samaritan Act (745 ILCS 49/36 new)

- Authorized a standing order for **retail pharmacists to dispense naloxone without a prescription**
- Pharmacists who dispense or administer naloxone under standing order are not subject to disciplinary action under Section 19.1 of the Pharmacy Practice Act, or the standing order

[3] http://www.ilga.gov/legislation/publicacts/99/099-0480.htm

Illinois Naloxone Standing Order

- Patients may be reluctant to ask for naloxone at the pharmacy so providers can still write prescription to encourage pick up
- Anyone can walk into any pharmacy and ask to use the IL naloxone standing order to get your naloxone including you!
- **All insurances are required to cover at least one naloxone formulation – minimal copays


IDPH

Illinois Naloxone Standing Order

Illinois Drug Overdose Prevention Programs

Free naloxone kits

- RUSH Substance Use Intervention Team (SUIT) clinic 1611 W Harrison St, Chicago, IL 60612
- Chicago Recovery Alliance (CRA) 3110 W Taylor St. Chicago, IL 60612
  - mobile unit with multiple locations
- Community Outreach Intervention Project (COIP) 4754 W. Madison St. Chicago, IL 60644 (multiple locations)
- Live4Lali 3255 N Arlington Heights Rd #508, Arlington Heights, IL 60004

Changing the narrative – 3 easy counseling tips

Avoid stigmatizing language that can discourage patients from carrying naloxone

- Patients may be more receptive to "**breathing emergency**" instead of overdose
- Use analogies that patients can relate to: Just like it's important to have a "**fire extinguisher**" in your home even though you don't plan on setting the house on fire, it's important to have naloxone in case of emergency.
- Reference your patient's "**risk factor(s)**" like asthma, COPD, organ dysfunction, heart failure, antihistamines, smoking, sleep apnea to emphasize importance of having naloxone for respiratory risks with opioids even if they are taken as prescribed.
- AVOID terms "**drug addict, junkie**" that further stigmatize naloxone/opioid use disorder
- Motivational interviewing tips
- Refer to "**1-833-2FINDHELP**" for concerns or questions about referral to treatment

Go to your pharmacy to get your naloxone!

- *We know no other medication that kills as many people as opioids.*

Strangers sprang into action to save a life on the subway. What if policymakers shared these values? | Perspective

Updated: June 25, 2019 - 10:21 AM

The train wasn't crowded on an early evening in May as Perrone got on in Old City. Suddenly, a young man burst into the subway car and yelled, "Narcan! Does anyone have Narcan?" Perrone, who always carries Narcan with her, said she did and the young man led her quickly through the train to where another young man was lying face up, purple-blue, clearly not breathing. A bystander was conducting CPR, while another had called 911, and a third had dispatched someone in search of Narcan.

Perrone relaxed a bit, and looked around. EMS came about 10 minutes later, and took the man to the emergency department. It would have been too late without the collective action of the subway riders. "You are the heroes," she said, tears streaming, "You just saved his life."

This story is reenacted many times a day, in homes and streets, in businesses and libraries and restaurants. It shows that ordinary bystanders can identify an overdose and know what to do. It wasn't Perrone's presence as an emergency medicine physician that saved the young man; it was a group of strangers, one of whom carried Narcan, all united in the belief that this man was somebody, and that his life mattered.

Thank you!

- With this lecture, you are now trained to administer naloxone in response to an opioid overdose. Please pick up your naloxone at your local pharmacy.

Acknowledgement

- Tran Tran, PharmD, BCPS

Resources

- Prescribe to Prevent
  - https://prescribetoprevent.org/
- Nalaxone Administration Videos
  - Intramuscular
    - https://prescribetoprevent.org/wp2015/wp-content/uploads/How-To-IntramuscularConverted.mp4
  - Intranasal
    - https://prescribetoprevent.org/wp2015/wp-content/uploads/How-To-IntranasalConverted.mp4
  - Auto-injector
    - https://prescribetoprevent.org/wp2015/wp-content/uploads/How-To-Auto-InjectorConverted.mp4

Questions

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