

“The Opioid Epidemic: Improving Opioid Safety for Patients Through Prescriber, Patient, & Family Education”

Presented by:

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Webcast Questions and Answers

*(Answers are in **bold**)*

Questions:

1. How often is the prescription monitoring program utilized?
 - a. **By law in our state it has to be checked for first opioid and benzo script for script >7 days and then every 90 days. Our pain clinic staff and acute pain service checks with every opioid prescription that is written.**
2. Was there education on the danger of prescribing opioids when benzo's have also been prescribed?
 - a. **Yes with all sedating medications not just benzo's.**
3. Have you posted to prescription disposal site or locations around your hospital?
 - a. **We have the website link in our educational handouts, video and on our opioid safety website.**
4. You're recommending that people flush narcotics? There is evidence that medications can pollute waters, and contaminate food and water supplies.
 - a. **We only recommend this is there is concern for serious harm. We took the verbiage from the FDA website.**
<https://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm>.
5. How much of your outstanding presentation can we 'borrow' love the 4 steps for example, can we use this?
 - a. **You are welcome to borrow the 4 steps (Monitor, Secure, Transition, & Dispose). If you want to use any of our resources on our website you are welcome to them. <http://www.nationwidechildrens.org/opioid-safety>. Just please reference our work.**

6. What does "zero hero" mean? "Wingman"? Sounds powerful.
 - a. **Nationwide Children's Hospital is committed to the safety and care of its patients. The idea of zero harm has led to our nationally recognized "Zero Hero" program. "Zero" is the only acceptable goal, and one that we all strive for. The "Wingman" is everyone in the team has accountability for ensuring patient safety and needs to speak up if there is a concern to seek input from the team and look out for each other.**

7. What is the average reduction in the number of Rx/Pills @ NCH in a 6 month period? How aggressive were you in trying to bring this down?
 - a. **We started at 10% because we really did not know how many extra doses we were sending home that patients did not need to adequately treat their pain. With follow up phone calls, asking at follow up visits, and seeing how many doses hospitalized patients are taking prior to discharge we have been able to decrease our home going doses from 25 doses per RX to about 17 doses per RX from 2015 to December 2017. Also, prescribing laws changed in Ohio the end of August 2017 for acute pain. We are only to prescribe for 5 days for kids and 7 days for adults with no more than 30 MED per day for acute pain unless justified in documentation so this may have impacted our numbers over the past several months as well. These new rules have had a negative impact on some of our more extensive surgeries and needing refills for home however; there has also been a positive impact for more thoughtful prescribing for others. Fortunately we now have e-prescribing at our hospital so this is a little less of a problem. We also have many efforts going on in various departments to look at # doses prescribed by each provider for the same surgery and see who might be prescribing more than others and still effectively treating patient's pain and also asking patients and families how many doses patients are taking to have a better idea of how many to prescriber for especially for outpatient surgeries. It is still a lot of work in progress.**

8. How do you treat patients truly suffering from pain?
 - a. **I think all of our patients are truly suffering from pain however the treatment plan may be different for each type of pain as well as each patient. We are trying to do a better job with multimodal individualized pain treatment plans for each patient as well. The suffering part of pain also might be anxiety, depression, or something else so being sure we are asking all the right questions from our patients is so important as opioid is not the end all to treat pain.**

9. In regards to safety/risk factors w/opioid prescribing, does your program promote co-prescribing opioids with Naloxone to reduce OD fatalities? Research demonstrates the communities that promote co-prescribing naloxone have fewer deaths.
 - a. **We have not done this for acute pain nor have we felt this was necessary for a patient in the pain clinic. It is certainly a good thing to always consider if there are risks. Our Opioid Medication Assistance Program always co-prescribes and some of our adult clinics that treat chronic pain do as well. We did put a policy in place for nurses to be able to use naloxone if there were concerns in any patient that they overdosed on an opioid. Certainly something to consider in the future for us....**

10. Is acute dental pain in children addressed in this program?
 - a. **We do address in our model to empower the family to question if they feel a prescriber is prescribing more opioids than the parent thinks is needed. With our new rules in Ohio hopefully we will see dentist prescribe less as well.**

11. Was there education on the danger of prescribing opioids when meds such as Adderall are also being used?
 - a. **We address prescribing opioids with other sedating medications as well as risk factor for possible opioid misuse with family or patient history of mental health and/or substance abuse. We need to get better asking those screening questions for prescribing for acute pain at our hospital and are focusing on those efforts in the very near future. We are going to present a medical and surgical ground rounds and what at the important questions to ask and know about risk when prescribing opioids. We are looking to bring in a family to talk about how prescribers can miss a person with risk factors when not asking the right question. We hope this will be a powerful message for prescribers.**

12. UW Div. Pain Medicine research says most powerful treatments for chronic pain are restored sleep and CBT. Any reason why these aren't in the amazing NCH program?
 - a. **We talk about deep breathing, distraction as this initial education is was more geared toward the acute patient. However, in our new Pain Management learning module with the new JC standard these are addressed specifically and we very much address these in our patients with chronic pain. Thank you for pointing this out!**

13. Is your organization seeing an increase in gabapentin abuse?
- a. **Possibly. We do at times have patients who should be taking their gabapentin and their UDS is negative for it. When we test our chronic kids we do a comprehensive screening so we can see many of their medications and have learned to ask the patient when they last took their medications prior to them giving the drug screen. We have unfortunately seen some of our parents taking our patients medications as well.**
14. Why isn't naloxone recommended in this video about safety for children's pain? It's critical and useful!
- a. **Good point. We don't use it much here except for what was stated above however, it would be a good question to ask our pediatric colleagues to see what they are doing. We may be adding this to any revisions of the educational materials and video we make in the future.**
15. The 4 year old who died of a fentanyl ingestion probably wouldn't have it naloxone always went home with any opioids. There is no safe dose of an opioid. What's the downside of empowering families?
- a. **That was a case study we found and good point. From the case study it was not clear if the grandmother had naloxone and I don't recall that anyone even suspected a fentanyl patch ingestions when they found the child.**
16. What do you suggest for chronic pain management for things like back pain in the primary care setting for patients with substance abuse histories or who are high risk due to family members substance abuse?
- a. **A multimodal approach to therapy is necessary – NSAIDs, MSK relaxants, anticonvulsants, PT, exercise, possible interventional therapy. Opioids should only be utilized for chronic non-malignant pain if all other modalities fail and it is deemed that the benefit outweighs the risk. So for example in the case of back pain the first thing to do is to determine the pathology. Is this an arthritis, a disk herniation involving nerves and radicular pain? Studies have shown that for general back pain disk degeneration (arthritis) one of the only effective therapies is conditioning (PT/Exercise). If there is concern about significant pathology consider a referral to physical medicine rehab or pain management.**

17. How do we deal with young patients who has history of ALL or malignancy who complain of pain? MRI, CT head/spine/thoracic and LP are negative. Giving IV Toradol make them appear high example their eyes roll as soon as you give them the Med. They're not EOL patients. They're on Flexeril also.
- a. **The first thing to try to understand is what is the pain generator – this involves a good pain assessment as imaging may be negative for pathology. Have they had treatment for the malignancy that has caused a neuropathic pain syndrome? Have they had surgeries that could cause chronic pain? I don't understand why they would appear 'high' with Toradol as this is a NSAID. Flexeril is a muscle relaxer and can also cause sleepiness. In these cases a referral to pain medicine or palliative care may be helpful.**
18. What would be your suggestion in regard to having naltrexone available in an outpatient chemotherapy infusion center for patients with active heroin abuse and currently receiving chemotherapy in the outpatient clinic? Should it be available in case the patient come to the clinic with recent use and sign of overdose? Would we need consent to use the naltrexone in the patient prior to starting their treatment?
- a. **If a patient is receiving treatment of any kind in a clinical setting and becomes sedated with respirations less than 10, then this is an emergent clinical situation and would require you to utilize naloxone for reversal. You would not need consent if they are overdosed and sedated. You would not use naltrexone/naloxone on someone who was intoxicated but did not have respiratory depression. It would be important to look into whether your clinics have policies in place for this situation.**
19. I have a current hospitalized patient who may be discharged to a facility for care of recent BKA and severe PVD in R LE. He currently is receiving a Fentanyl patch at 50 mcg, Gabapentin recently increased to 800 tid, Cymbalta at 30 mg. The problem with this patient is he at first requested Dilaudid for BTP, but has requested oxycodone 15 mg q 4 hours and takes q4 hours and does not change his pain rating despite use of oxycodone of 75 mg to 90 mg/24 hrs. He is requesting to return home alone but this will not happen d/t safety. Patient dose admit to active ETOH hx when he is at home.
- a. **Without seeing the patient I can only make some general recommendations. In this case if his pain rating does not change with the**

use of oxycodone, then it should not be continued. You would want to maximize the non-opioids. If he has normal renal function and can tolerate it then you can try to further increase the gabapentin to 1200 mg q8h and duloxetine to 60 mg daily. Given that he may be at higher risk for abuse you may want to minimize breakthrough opioids which may require increasing the fentanyl patch.

20. What is the magnitude of renal risk with NSAIDs? Are any known to be less toxic?
- a. **I am not aware of any differences between NSAIDs and renal toxicity. Selective COX 2 may cause less gastropathy. In general one should avoid NSAIDs in patients with renal disease. In those without renal disease, one would use caution in the elderly, those with underlying cardiac disease and hypertension to minimize renal toxicity. If you plan to treat with chronic NSAIDs you should regularly check renal function.**
21. What do you suggest of someone (counselor) that works at a MAT program coordinating care with a provider that is not open to their mutual patients being in MAT programs, to help ensure that the patients care is not disrupted?
- a. **First it would be important to understand the provider's concerns about their patient being in MAT. If he/she is opposed to this type of treatment at all, then it may be necessary to find the patient another provider. If the patient has an addiction problem that is being treated in MAT then this is the priority.**
22. For acute pain in a patient on buprenorphine or methadone, do you typically discontinue the MAT drug or continue and use higher doses of opioids?
- a. **Generally methadone is continued and one treats with opioids for the acute pain. There are several different possibilities with buprenorphine. If it is a planned admission you could wean the buprenorphine and then treat the acute pain with opioids and if resolved you would then restart methadone. In the case of an unplanned admission you could stop the buprenorphine but know that for about 72 hours you may have to utilize higher doses of opioids to overcome the antagonism. In all cases multimodal therapy (non-opioids, nonpharmacologic, regional interventional techniques) should be used for the opioid sparing effect.**

23. Could you explain how you assess unexplained pain progression relative to unchanged pathology...given the relatively poor correlation of pathology and pain plus inability to restage/image to verify pathological progression?
- a. **The first thing to do is a comprehensive pain assessment. Has the nature of the pain changed? Are you seeing more neuropathic type components to the pain? Is there an increase in anxiety, depression, or insomnia? If you can discern no changes based on your assessment, you may have to assume there is either tolerance or opioid induced hyperalgesia. If escalating doses of opioids are not effective then it may be hyperalgesia. In either case you may need to evaluate if there are non-opioids that you can add to the regimen. You may need to consider rotation of opioids to possibly include methadone (if you are experienced with prescribing) that can possibly reverse tolerance.**
24. So how can we as inpatient nurses guide prescribing providers to an appropriate pain management program when they already have a preconceived bias towards a chronic pain patient who is now hospitalized and their pain is not being controlled?
- a. **It is important to have open communication with the provider to better understand their concerns. If this is a patient who is already on chronic opioid therapy now with an acute pain problem then the patient may not respond to standard doses of opioid therapy. It is important also to look at the pain management plan and ensure that multimodal therapy (non-opioids, adjuvant medications, nonpharmacologic modalities) are being utilized. One may also have to work with the patient on their expectations. Pain control should focus on function, not on a pain severity number as someone with chronic pain may always live at a higher pain severity, but yet be able to function.**
25. What would you recommend for patient admitted to hospital reporting high methadone or Suboxone dosage as home regimen when unable to verify outpatient Rx.
- a. **Individuals on methadone maintenance usually have an ID card from the clinic. When you cannot verify the dose (such as a weekend), you may give a dose of methadone daily (generally up to 30 mg daily) until able to verify the dose. If it takes several days to verify the dose you may have titrate slowly back up to the outpatient dose if the patient has received a lower**

dose in the hospital for several days. In the case of Suboxone, if the patient is being admitted for pain you may want to just discontinue the Suboxone while hospitalized and treat with an opioid. Since Suboxone is dispensed by the pharmacy through a prescription written by a physician you should be able to contact the pharmacy or have the patient /family bring in the prescription bottle to verify.

26. Do you have any experience with sickle cell patients and if so any advice for prescribing to this population when there may be substance use issues?
- a. **Yes I have experience and one would use the same guidelines – starting with an accurate assessment to determine the source of pain. Is it an acute pain due to vaso-occlusive crisis or a chronic pain secondary to a pathology such as avascular necrosis? One would treat based on the characteristics of the pain and use multi-modal analgesia. I would use caution utilizing high dose clinician administered IV boluses of opioids and recommend PCA in the inpatient setting where the patient may have severe pain and require IV analgesia to prevent triggering of the reward system.**
27. Is there a tool whether that be the ORT or the SOAPP that you recommend as more reliable?
- a. **These tools have been validated in the population of chronic nonmalignant pain but not cancer related pain. The SOAPP has been demonstrated to be more sensitive than the ORT. The clinical interview is the most sensitive. The ORT may be easier to administer in some cases as only five questions.**
28. If someone is getting Vivitrol injections, how is acute pain managed?
- a. **It will be necessary to utilize as many non-opioid options possible such as regional blocks, adjuvant therapies. In the cases where opioids may be required you may need to use up to 20 times the usual dose to overcome the opioid antagonist effects of Vivitrol. In these cases the patient should be in a monitored setting.**
29. What are the "unique characteristics of methadone" that lead to increased risk for overdose?
- a. **Half-life of 24-150 hours and many drug/drug interactions that can increase the serum levels of methadone may increase risk for overdose. Analgesic**

effect may only be 6-12 hours but accumulation of drug may lead to over sedation.

30. What advice would you give to clients in recovery for SUD regarding how to talk to their PCP about their pain management while advocating for their recovery.
- a. **The most important thing for the patient is to be honest with their PCP about their addiction and their current efforts to be active in recovery. There are PCPs who may also have waivers to provide buprenorphine treatment so alignment with this type of provider may be helpful.**
31. Michigan does not delegate any non-physician access of MAPS (Michigan version of PDMP). Is there a recommendation for nurses to be allowed to access that program?
- a. **Consider contacting the program to find out what the plans are for non-clinicians to be able access programs. In the three states where I have been practicing, as a NP I could delegate non-clinicians to access the PDMP as well as RNs. This type of access will be important as many prescribers may not be willing to check the PDMP prior to prescribing.**
32. In our chronic pain practice, our patients bring back unused opiates and they destroy them in front of the staff in kitty litter once the med is dissolved in hot water by the patient.
- a. **I would be cautious about this practice. Health care providers are not allowed to 'take back' opioids so although it is being done by the patients in the office, I would be concerned that it may be misconstrued that the provider is involved in this practice. In addition, this type of disposal is not consistent with the FDA guidelines for disposal.**
33. Out of the assessment tools mentioned for screening for opioid risk, which do you recommend?
- a. **We are currently utilizing the SOAPPR in our clinic for initial screening and the COMM for those on therapy. Both of these tools have been cross-validated. As I said, they have not been validated in patients with cancer related pain, but we hope that the use of the tool may allow us to better predict which patients may have higher risks.**

34. Do you know of any Fed and state law, which prohibits hospice nurse to pick up opioid med for hospice patient at a local pharmacy?
- a. **You should check with your state laws and board of nursing. If you work for a hospice, they should also have policies in place with regards to this issue. From my limited understanding, it may be against the law but may be state by state specific.**
35. How do you prevent some of the "doctor shopping" since patients may not tell you the other doctors they have visited?
- a. **Checking the PDMP and utilizing a patient provider agreement which states that analgesics will only be obtained through one provider (or clinic setting) are some measures to prevent 'doctor shopping.'**
36. Would you recommend increase of fentanyl patch when patient is comfortable at 50 mcg and reports he takes oxy for pain "just in case"? And perhaps convert to morphine tabs q 6 hours?
- a. **There is no need to titrate the Fentanyl patch if patient is not consistently utilizing 3 or more doses of breakthrough opioids daily. If you are concerned about the 'likeability component of oxycodone, you could rotate to morphine which may have less likeability.**
37. Great fast pace. We had a palliative care SUD patient who sold her Fentanyl patches to a teenager (so she could buy her drug of choice) and the teen died.
- a. **Sad case – we have to try to do the best we can to safeguard the patient and the general public.**
38. I have successfully managed severe pain with buprenorphine by increasing the dose in patients on maintenance for opioid use disorders. It is a good option for high risk cases.
- a. **Thanks for the information. I agree it can be useful if one is comfortable with the use of buprenorphine. It would be important to ensure that the MAT prescriber is aware and that you (if you do not have DEA waiver) are clear in your documentation that you are prescribing for pain management.**

39. What is your experience with confronting pts with substance use issues within the context of treating them for legitimate chronic or acute pain issues?
- a. **It is always difficult to have these conversations. If you have evidence from a urine drug screen or PDMPs then this can be the basis for your conversation. I always try to emphasize that I want to treat the pain, but need to do it in a safe way.**
40. Do you think the risk stratification approach would be appropriate for non-palliate patients with past or present substance use disorder?
- a. **Yes I think one could utilize some stratification approach as most of the tools will also give you guidance of the relative risk. You would then add the clinical indicators and the MEDD to your evaluation.**
41. The last conference I attended last month reviewed that use of opioids with benzos is no longer recommended. I have been converting to Cymbalta when benzos have been present with opioid use. What do you suggest?
- a. **Yes the use of opioids and benzodiazepine can increase the risk of over sedation and increased morbidity. If someone has an underlying anxiety disorder that is not currently treated with an SSRI/SNRI then starting one would be an option. Duloxetine (Cymbalta) may be a consideration especially if there is concurrent neuropathic pain or MSK pain. Other SSRIs such as escitalopram, paroxetine, etc. may also be effective but in all cases may take 3-4 weeks to take effect. However in some cases with people with advanced disease I have continued to prescribe benzodiazepines but I educate patients and families of the risks associated with co-morbid use.**
42. We have a patch for patch Fentanyl exchange program in Ontario Canada and people have been busted for making fake patches to return to their pharmacy.
- a. **Individuals can always find ways to abuse. All we can do is try our best to minimize the harm.**
43. What about divided doses of buprenorphine for pain management in MAT? Is this done in practice, and do patients find this effective?
- a. **Yes there are cases where this is done and it can be effective. It is very important to have clear documentation.**