Protecting Patients and Practitioners during the Opioid Crisis

2020 Interprofessional Continuing Education Seminar

In support of improving patient care, Idaho State University Kasiska Division of Health Sciences is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
Disclosures

The planners and presenters of this presentation have disclosed no conflict of interest, including no relevant financial relationships with any commercial interests pertaining to this topic.
Objectives

• Utilize CDC and other guidelines in managing acute and chronic nonmalignant pain
• Utilize the Idaho PDMP and other tools to reduce the risk of inappropriate use and diversion of controlled substances
• Conduct comprehensive assessment of patient response and outcomes to opioid therapy
• Create effective healthcare teams to manage pain therapy
• Reduce the risk of a fatal overdose in patients receiving opioid therapy
Part One

Issues, Challenges, and Concerns
Opioid Crisis Issues

- Over-Prescribing and Under-Prescribing
- Lack of Mental Health and Addiction Treatment
- Environmental Factors
- Limited Insurance Coverage for Multimodal Therapy

Others?
Prescribing Challenges

• Many healthcare providers don’t receive extensive education in school about prescribing controlled substances
• Consumers expect prescriptions
• Healthcare providers often dislike confrontation
The Mortality Concern

- ~ 3,000 patients
- 10 months post-overdose
- 91% of patients continued to receive opioid prescriptions
- 61% the same clinician issued prescriptions both pre- and post-overdose

The Morbidity Concern

• Not just a mortality issue
• Also is a morbidity issue
  • HIV and Hep C from injection of Opana and other products
  • Hep A from exposure to unsanitary conditions
• NAS
The Liability Concern

Opioids account for:

Anti-coagulants follow at:

Opioids Top List of Malpractice Claims Linked to Medications - Medscape - Oct 16, 2017
Part Two

Guidelines
CDC Guidelines

• Non-drug and non-opioid therapy are preferred for chronic pain

• Before initiating, set realistic goals for pain and function, and consider when to discontinue

• Continue therapy only if achieving clinically meaningful improvement in pain and function

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
CDC Guidelines

• When starting opioids for acute pain prescribe
  • Immediate-release at lowest effective dosage
  • A quantity for expected duration of pain that is severe enough to require opioids - 3 days or less often sufficient; more than 7 days rarely needed
  • Review state PDMP
CDC Guidelines

• When starting opioids for chronic pain, prescribe immediate-release at lowest effective dosage
• Monitor MME - 50/90 MME
• Review state PDMP
• Follow up in 1 to 4 weeks of starting opioid therapy and after escalating dosage
Idaho BOM Guidelines

- Assessment and evaluation
- Treatment plan and goals
- Informed consent and treatment agreement
- Initiating an opioid trial
- Ongoing monitoring and adapting the treatment plan

Idaho BOM Guidelines

- Periodic and unannounced drug testing
- Consultation and referral
- Discontinuing opioid therapy
- Medical records
- Compliance with laws and regulations
- BOM website link to AAPM/APS statement and sample model pain management agreement
Part Three

Criminal and Civil Enforcement
Unlawful Distribution

US opioid bust hits health professionals

CINCINNATI - Federal prosecutors charged 60 physicians and pharmacists Wednesday with illegally handing out opioid prescriptions in what they say is the biggest crackdown of its kind in U.S. history. Most of the defendants face charges of unlawful distribution of controlled substances involving prescription opioids. Authorities say they gave out about 350,000 prescriptions totaling more than 32 million pills in Alabama, Kentucky, Ohio, Tennessee and West Virginia.

“If so-called medical professionals are going to behave like drug dealers, we’re going to treat them like drug dealers,” said Brian Benczkowski, an assistant attorney general at the Department of Justice. The defendants are accused of writing or filling prescriptions outside the course of medical practices and prescribing them despite having no legitimate medical reasons to do so, he said.

Federal prosecutors said illegal prescriptions are especially devastating to rural communities, where patients often have limited options when seeking medical help. If the doctor those patients see is peddling illegal prescriptions, prosecutors said, the damage to small towns can be dramatic. [Excerpted Report]

Knoxville NewsSentinel, Thursday, 04/18/2019, Page A07
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Knoxville NewsSentinel, Thursday, 04/18/2019, Page A07
Unlawful Distribution

2 East Tennessee doctors found guilty of unlawful distribution of opioids

From staff reports

Knoxville News Sentinel USA TODAY NETWORK – TENNESSEE

Two East Tennessee doctors rounded up by federal authorities in last month’s pill mill crackdown have pleaded guilty to charges of drug dealing.

Dr. Frank McNiel of Knoxville and Dr. Samuel McGaha of Sevierville each pleaded guilty to one count of unlawful distribution of a controlled substance. The charges stem from their roles “in prescribing high doses of opioids with no medical legitimacy,” the U.S. Department of Justice announced in a news release Friday. From 2015 until March 2018, McGaha and McNiel prescribed 212,226 and 59,712 pain pills, respectively, the release states. McGaha admitted writing opioid prescriptions even when patients tested positive for illegal drugs. McNiel — who saw patients out of his home after retiring from Bearden Healthcare Associates in Knoxville — admitted writing prescriptions without evaluating patients and without obtaining medical records to justify opioid use.

McNiel and McGaha are scheduled to be sentenced March 26 before Chief U.S. District Judge Tom Varlan. The federal charge carries a maximum sentence of 20 years in prison, but the doctors are expected to face less time due to their guilty pleas.
Patient Death

Doctor indicted after 4 patients die

A Tennessee doctor who relocated to Indiana after at least four of his patients died of drug overdoses was indicted this week on federal over-prescribing charges. Dr. Darrel Rinehart has been charged with 19 counts of prescribing controlled substances without a legitimate medical purpose. Rinehart is one of 60 medical professionals who were charged as part of a nationwide probe designed to combat the opioid crisis in federal court. Thirty-two of those defendants were charged in Tennessee.

At least five of Rinehart’s patients suffered fatal overdoses that were partially or wholly caused by drugs he prescribed. Six more patients had nonfatal overdoses between 2014 and 2016, according to an expert's review of Rinehart's medical records. One of those patients, to whom Rinehart prescribed at least 11 different drugs, overdosed three times.

Rinehart was caught on undercover video increasing a patient’s opioid prescription without any exam and adding an Adderall prescription after the patient casually asked for “something to help me focus.” [Excepted Report]
After the Raid . . .

Oneida doctor’s office raided by DEA engulfed in overnight fire

Harris Hickman, The Reno Gazette-Journal

An Oneida doctor’s office and adjacent pharmacy raided by state and federal authorities last year in connection with fatal opioid overdoses was engulfed in flames by an overnight fire.

Fire crews with the Oneida Volunteer Fire Department responded to the fire just after 2:30 a.m. Thursday at the Coffey Family Medical Clinic on U.S. 200.

The fire, which spread to a next-door pharmacy and a physical therapy clinic, was at 2:30 a.m. Thursday, according to the Oneida Police Department dispatcher.

The medical practice, run by Dr. David Bruce Coffey, was among those Oneida doctors’ offices raided in June 2018 as part of a multi-agency investigation by the DEA, Tennessee Bureau of Investigation and local authorities.

Coffey’s practice subsequently closed in 2018, although it wasn’t immediately clear whether the office had since reopened.

No injuries have been reported at the fire scene.

Check back for updates on this developing story.
Prince Doctor Pays Fine

The Minnesota Board of Medical Practice reprimanded Dr. Michael Schulenberg and ordered him to pay a civil penalty of $4,648 for prescribing pain medication for the pop megastar in another person’s name. The Board did not name Prince, but the Star Tribune reports he was identified as “Patient No.1” and his longtime friend and bodyguard Kirk Johnson as “Patient No. 2.”
Schulenberg initially told the board he didn’t know painkillers he prescribed for Johnson were intended for Prince. But his story changed last August when he met with board authorities and discussed one clinic visit. No one was criminally charged in his death, and the source of the counterfeit pills that killed him remains unknown.
Idaho BOM Disciplinary Actions

- Overprescribing
- Recordkeeping
- Failure to monitor
- Boundary issues
- Other

Tobacco Redux
Tobacco Redux
Tobacco Redux

**Knoxville NEWS SENTINEL**

MOMDAY, JANUARY 27, 2020

NBA legend Bryant dies in crash

18 killed in helicopter accident

Stephanie Dazio  ASSOCTIATED PRESS

**Fighting for his freedom**

Tennessee man wants conservatorship overturned

Jennifer Bulkin  Correspondent to The Tennessean

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A. NEWS SENTINEL EXCLUSIVE

Pharmacy pushed drug designed for addicted pregnant women

Anita Seiple/Daily Times

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**ROAR**
Tobacco Redux
A big change for old mall tuxedo business

Knoxville Center, formerly East Towne, to close this week

Knox Co. OKs deal for school board
Commissioners surprise Jacobs with lower vote

Tobacco Redux
Eating salads and still 40 pounds overweight? Take a hike

Knoxville looks into workers who blew whistle

At 240 pounds, Spoon is a pet pig on the move

A NEWS SENTINEL EXCLUSIVE
Supplier failed to cut off Newport pharmacy

Records: 83M opiates sent over eight years
Tobacco Redux
Part Four

Treatment and Management
Individuals exposed to traumatic experiences, particularly early childhood adversity, may experience multiple negative consequences:

- More likely to report chronic pain symptoms that interfere with activities of daily living (ADLs)
- More likely to display antisocial behavior
- More likely to seek opioids for pain relief in adulthood
- More likely to engage in drug use involving injectables

Adverse Childhood Experiences

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation
Team-Based Care

**Core Team**
- Primary Care Physician
- Orthopedic Surgeon
- Physical Therapist
- Clinical Nurse Specialist
- Psychiatrist
- Neurosurgeon
- Clinical Psychologist
- Rehabilitation Physician
- Neurologist
- Rheumatologist
- Anesthesiologist

**Wider Team**
- Pharmacist
- Dietician
- Educational Therapist
- Occupational Therapist
- Medical Social Worker
Team-Based Care

• Corresponding responsibility rests with the pharmacist who fills the prescription
• Not a HIPAA violation to ask for diagnoses, labs, etc
• Support clinical management
Medical Records and Documentation

- Results of PDMP check
- Follow up care
- Patient reports of improvement/control

Imprecise

Mr. Jones reports better pain relief on Percocet BID

Accurate

Mr. Jones states “I’ve had much less pain for 2 weeks.” Reports ADLs performed without assistance. “I even walked to the car by myself today.”
ADLs and Functionality

Geriatric Examination Tool Kit

Functional Outcome Instruments

**Basic** Activities of Daily Living (BADL)
1. Katz Index of ADLs
2. Barthel ADL Index

**Instrumental** Activities of Daily Living (IADL) (self-report / questionnaire)
1. LLFDI - Late Life Function and Disability Instrument
2. SF-36 (proprietary; overview on website)
3. FSQ -- Functional Status Questionnaire
4. Lawton-Brody IADL Scale

**OASIS has both BADL & IADL portions** (only used in Home Health)

Functional Mobility instruments
1. Functional Independence Measure (FIM)
   FiM is proprietary. See O’Sullivan 6th ed. p. 325
   Terminology: definitions for Levels of Assistance
2. Physical Mobility Scale (see Appendix on p. 98)

https://geriatrictoolkit.missouri.edu/funct/index.htm
Payment Incentive

• MACRA - Medicare Access and CHIP Reauthorization Act. MACRA replaces the current Medicare reimbursement schedule with a new pay-for-performance program that’s focused on quality, value, and accountability.

• MIPS - Merit-Based Incentive Payment System. Using a composite performance score, eligible professionals may receive a payment bonus, a payment penalty, or no payment adjustment.
Part Five

Outlook for the Future
Research and Practice

• Basic science
  • Biomarkers for pain
  • Genetics
  • Mu opioid receptor ligands – FDA currently looking at a breakthrough product

• Research on who is subject to substance abuse – can we predict addiction
Research and Practice

• Medication advances
  • Precision medicine
  • Naltrexone – monthly injection
  • Probuphine – buprenorphine implant
Research and Practice

- Healthcare practice
  - Starting Medication Assisted Treatment (MAT) in the ED
  - Partial filling of Schedule II controlled substances
- Community pharmacy dispensing methadone (Baltimore pilot project)
- Prescription labeling - indication for use and maximum quantity in 24 hours
Research and Practice

• General
  • Universal family-based drug abuse prevention
    • 54% of those misusing opioids obtain the opioids from parents or other relatives
  • Drug disposal and take back
  • Remove abusers from substance abuse environment
• Practitioner education
  • Academic degree programs
  • Postgraduate education
Part Six

Acknowledgements
My Sincere Thanks for Your Attendance and Attention
Special Thanks

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Protecting Patients and Practitioners during the Opioid Crisis

Cathy Oliphant, PharmD
Professor
ISU College of Pharmacy
More than 70,000 Americans died from a drug overdose in 2017.

www.cdc.gov
Figure 1. **National Drug Overdose Deaths Number Among All Ages, by Gender, 1999-2017**

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December 2018.

Figure 2. National Drug Overdose Deaths Number Among All Ages, 1999-2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018
A person dies every 11 min from an opioid overdose. 130 Americans die every day from an opioid overdose (including Rx and illicit opioids).

Figure 3. National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death (1989-2017) on CDC WONDER Online Database, released December 2018.

Rate of Opioid-Related Overdose Deaths in Idaho

Source: CDC WONDER

Number of Opioid-Related Overdose Deaths in Idaho

Source: CDC WONDER

Figure 8. National Drug Overdose Deaths Involving Benzodiazepines, by Opioid Involvement, Number Among All Ages, 1999-2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018.

Heroin

• An opioid that is synthesized from morphine (extracted from the seed pod of the Asian opium poppy plant)
• Converted to morphine when it enters the brain which then binds to mu receptors

http://www.drugabuse.gov/publications/drugfacts/heroin
Heroin: A Growing Epidemic

- Cheaper and easier to obtain than opioids
- Evidence suggests a relationship between increased non-medical use of opioids and heroin abuse
- Opioid abuse often precedes heroin abuse
- ~50% of heroin users admit to opioid abuse prior to using heroin
- Heroin-related overdose deaths have more than quadrupled since 2010
Figure 5. National Drug Overdose Deaths Involving Heroin
Number Among All Ages, 1999-2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018.

Risk Factors for Opioid Overdose

Unintentional

• Opioid naïve
• Opioid dose too high
• Switch to different opioid
• Polypharmacy
  • Opioids, benzodiazepines, other CNS depressants
• Acute illness
• Comorbidities
• Alcohol use
• Illicit drug use

Prescription drug abuse/overdose

• Taking high doses of opioids
• Doctor shopping
• Obtaining opioid prescriptions from multiple providers and pharmacies
• History of mental illness or substance abuse

Opioid Overdose vs Overmedication

S/S Overdose
- Pinpoint pupils
- Not arousable
- Not breathing or very slow breathing
- Choking, snorting, gurgling
- Bradycardia or no heartbeat
- Cold/clammy skin
- Blue lips/nailbeds

S/S of Overmedication
- Pinpoint pupils
- Arousable
- Breathing but sleepy or intoxicated appearing
- Slurred speech

www.samhsa.gov; www.cdc.gov; www.who.int/substance_abuse
Naloxone: An Antidote

- Naloxone is an antidote for reversal of opioid-induced respiratory and CNS depression.
- Pure opioid antagonist that binds with high affinity to mu, kappa and delta receptors.
  - Greatest affinity for mu receptors.
- Naloxone then displaces opioid agonists.
- Reverses clinical and toxic effects of opioids.
  - May trigger sudden opioid withdrawal symptoms.
Naloxone: Reversal

- Opioids
- Heroin
- *May not* reverse buprenorphine
- No effect on non-opioid overdoses
  - Cocaine
  - Methamphetamine
  - Bath salts
  - Benzodiazepines
  - Alcohol
# Naloxone

## When Given in an Overdose
- Reverses respiratory and CNS depression
- Restores breathing
- Reverses pain control
- May precipitate acute opioid withdrawal
  - Pain
  - Agitation, irritability
  - Diaphoresis
  - Tachycardia

## Action
- Onset of action is ~3 minutes
- No potential for abuse
- No harm to patients who have not taken opioids
Naloxone

- Half-life of 30-90 minutes
- As naloxone wears off, opioids still circulating may bind to opioid receptors causing overdose symptoms to return
# Opioids: Duration of Action

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>3-4 hours</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>4-8 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>3-6 hours; extended release ≤ 12 hours</td>
</tr>
<tr>
<td>Morphine</td>
<td>3-6 hours</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>3-4 hours; extended release ~13 hours</td>
</tr>
<tr>
<td>Meperidine</td>
<td>2-4 hours</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>2-4 hours</td>
</tr>
<tr>
<td>Methadone</td>
<td>24 hours</td>
</tr>
<tr>
<td>Heroin</td>
<td>~3-5 hours (intense euphoria x several minutes; peak effect 1-2 hours; effects wear off in 3-5 hours)</td>
</tr>
</tbody>
</table>
Naloxone: Available Products

• Intranasal
  • Naloxone
  • Narcan

• Intramuscular
  • Naloxone
  • Evzio (auto-injector)
Intranasal Naloxone
Narcan Nasal Spray
Naloxone Intramuscular

[Image of Naloxone Intramuscular medication]

**EVZIO**

**EVZIO Outer Case**
Naloxone Intramuscular
Naloxone: Storage

- Store between 59 and 77°F
  - May be exposed to temperatures of 39-104 °F for short periods of time
- Typically has a shelf-life of 12-18 months
  - Should be visually inspected occasionally to ensure that the fluid is clear/colorless
  - Monitor expiration date and replace as appropriate
- Naloxone use beyond the expiration date may not be as effective; however, in an emergency if may be used if no alternatives are available

Lexi-Comp Drugs; Pharmacist’s Letter; Narcan and Evzio package inserts
Naloxone Access Laws

- All states now have naloxone access laws
  - Laws vary by state:
    - Standing order
    - Collaborative pharmacy practice agreement
    - Prescription
    - Pharmacist prescribing

- Good Samaritan laws vary
  - Idaho – just passed this legislative session
Idaho: Good Samaritan Law

- House Bill 649 encourages people to seek that help.
- “This will save lives. States that have introduced good Samaritan bills with opioids have seen a reduction in deaths up to 30 percent,” said Rep. Mike Kingsley, R-Lewiston.
- The hope is with limited immunity more people will call in an emergency instead of stand by.
- The legislation, now signed into law, provides limited immunity to people acting in good faith who seek medical assistance for either themselves or someone else because of a drug-related medical emergency.
  - “The immunity bill would only extend immunity to those that seek medical assistance for someone, including themselves, “due to the use of a controlled substance.” It stipulates that the person must remain on the scene until emergency personnel arrive and that they cooperate with them. The only legal immunities offered are from prosecution for illegal use, possession or being under the influence of a controlled substance.” (ID County Free Press)
Idaho Law: Opioid Antagonists

- As of 7/1/15, pharmacists may prescribe
- Any person who prescribes, dispenses or administers an opioid-antagonist will not be liable in a civil or administrative action or subject to criminal prosecution
- A layperson is immune from civil and criminal liability when administering naloxone
- Any health professional licensed and registered under this title, acting in good faith and exercising reasonable care, may prescribe and dispense an opioid antagonist
Consider Naloxone For:

- Anyone that has a prescription for opioids – especially if > 50 MME
- Anyone with a history of opioid or heroin abuse
- Family/friends of someone prescribed opioids, that has access to opioids or uses heroin
- Patients on other CNS acting meds, methadone or alcohol
- Patients with renal or hepatic dysfunction or respiratory disease
- Those who are recently released from incarceration or who were abstinent
- Programs and residential facilities that work with at-risk populations
- Anyone that requests it

www.samhsa.gov; www.who; Pharmacist’s Letter
Naloxone: Administration

- Determine if an overdose
- Call 911
- Give rescue breaths
- Give naloxone
- Continue giving rescue breaths until breathing on own or until EMS arrives
- Once breathing on own, turn person on side (rescue position)
- Stay with person until EMS arrives
- May administer a 2nd naloxone dose if no response after 2-3 minutes or symptoms return before EMS arrives

Narcan: Administration

- Keep in original packaging until use
- Place patient lying on back
- Hold spray with thumb on bottom of plunger and 1st/middle fingers on either side of nozzle
- Tilt head back and insert tip of nozzle into one nostril until fingers holding nozzle are on either side of nose
- Firmly press plunger, spraying into nostril
- Patient does not need to inhale during spray
- If no response, repeat in other nostril

www.narcannasalspray.com; Pharmacist’s Letter Jan 2016
1 Identify Opioid Overdose and Check for Response

Ask person if he or she is okay and shout name.
Shake shoulders and firmly rub the middle of their chest.
Check for signs of an opioid overdose:
- Will not wake up or respond to your voice or touch
- Breathing is very slow, irregular, or has stopped
- Center part of their eye is very small, sometimes called “pinpoint pupils”
Lay the person on their back to receive a dose of NARCAN Nasal Spray.

2 Give NARCAN Nasal Spray

REMOVE NARCAN Nasal Spray from the box.
Peel back the tab with the circle to open the NARCAN Nasal Spray.

Hold the NARCAN Nasal Spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

Gently insert the tip of the nozzle into either nostril.
- Tilt the person’s head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into one nostril until your fingers on either side of the nozzle are against the bottom of the person’s nose.

Press the plunger firmly to give the dose of NARCAN Nasal Spray.
- Remove the NARCAN Nasal Spray from the nostril after giving the dose.

3 Call for emergency medical help, Evaluate, and Support

Get emergency medical help right away.
Move the person on their side (recovery position) after giving NARCAN Nasal Spray.
Watch the person closely.
If the person does not respond by waking up, to voice or touch, or breathing normally another dose may be given. NARCAN Nasal Spray may be dosed every 2 to 3 minutes, if available.
Repeat Step 2 using a new NARCAN Nasal Spray to give another dose in the other nostril. If additional NARCAN Nasal Sprays are available, repeat step 2 every 2 to 3 minutes until the person responds or emergency medical help is received.
Narcan Nasal Spray
Administration
Evzio: Administration
**Evzio: Administration**

- Automated device with voice instructions
- Pull off outer case and red safety guard
- Place black end of auto-injector against outer thigh
  - Can administer through clothing
- Press firmly and hold in place for 5 seconds
  - During injection you will hear a click and hiss noise
  - Needle retracts automatically
- Red light flashes when injection complete

Pharmacist’s Letter CE Live Overdose Prevention with Naloxone May 2015; Evzio package insert; www.evzio.com
NASAL SPRAY NALOXONE

1. Remove yellow caps.

2. Twist on white cone (nasal atomizer).

3. Remove cap (red or purple) off end of the naloxone ampule.
4. Gently twist the ampule of naloxone into syringe.

5. Insert white cone into nostril and aim slightly upwards; spray 1/2 of the naloxone ampule into each nostril with a quick, strong push on end of the ampule.

6. If no response in 2 to 3 minutes, administer second dose.
INJECTABLE NALOXONE

1. Remove naloxone vial cap.

2. Remove cap from the needle.
   Turn vial upside down and insert needle through rubber stopper. Pull back on plunger and fill syringe to 1 ml.

   Fill to 1 ml
**3** Inject entire syringe of naloxone into an upper arm or thigh muscle as shown.

**4** If no response in 2 to 3 minutes, administer second dose.
Opioid Overdose Prevention

- Prescription monitoring programs
- Drug take-back programs
- Lock boxes
- Naloxone access programs
- Education
Prescription Drug Monitoring Program (PDMP)

- Statewide electronic database that monitors controlled substances dispensed
- Provides timely information about prescribing and use on a given patient to allow medical professionals to make better informed decisions
- Can help improve opioid prescribing, inform clinical practice and protect patients
- Timely/up-to-date resource as data must be entered by the end of the next business day

Prescription Drug Monitoring Program (PDMP)
Likelihood of Long-Term Use Based on Initial RX

Source: Centers for Disease Control and Prevention, 2017
Patient Centered Approach

• Listen to patient
• Set reasonable goals
• Discuss treatment options
• Provide education
Non-Opioid Alternatives

- Pharmacologic
- Non-pharmacologic

https://www.cdc.gov/drugoverdose/training/nonopioid/508c/index.html;
https://www.asahq.org/whensecondscount/pain-management/non-opioid-treatment/;
Non-Opioid: Pharmacologic

- Acetaminophen
- NSAIDs
- Anticonvulsants
- Antidepressants
- Skeletal muscle relaxants
- Anesthetics
- NMDA antagonists

https://www.cdc.gov/drugoverdose/training/nonopioid/508c/index.html
https://www.asahq.org/whensecondscount/pain-management/non-opioid-treatment/
Non-Opioid: Pharmacologic

Acetaminophen/NSAIDs

• Acetaminophen
  • Uses
    • Osteoarthritis
    • Low back pain
• NSAIDs
  • Uses (inflammatory conditions)
    • Osteoarthritis
    • Low back pain

Anticonvulsants

• Agents:
  • Gabapentin
  • Pregabalin
  • Carbamazepine
  • Topiramate
• Uses:
  • Neuropathic pain

Non-Opioid: Pharmacologic

### Antidepressants

- **TCAs:**
  - Amitriptyline, nortriptyline
- **SNRIs:**
  - Venlafaxine, duloxetine
- **Uses:**
  - Neuropathic pain
  - Fibromyalgia

### Skeletal Muscle Relaxants

- **Agents:**
  - Baclofen
  - Carisoprodol
  - Cyclobenzaprine
  - Metaxalone
  - Methocarbamol
  - Orphenadrine
  - Tizanidine
- **Use:** muscular pain, low back pain

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Non-Opioid: Pharmacologic

Anesthetics

• Lidocaine (patch/gel)
• Topical NSAIDs
• Capsaicin
• Uses:
  • Osteoarthritis
  • Neuropathic pain
  • Musculoskeletal pain

NMDA antagonists

• Ketamine
  • Neuropathic pain
  • Non-neuropathic chronic pain

Non-Opioid: Non-Pharmacologic

- Exercise therapy
- Physical therapy
- Cognitive behavioral therapy
- Massage
- Relaxation techniques
- Acupuncture

https://www.cdc.gov/drugoverdose/training/nonopioid/508c/index.html;
https://www.asahq.org/whensecondscount/pain-management/non-opioid-treatment/;
"Take two tons of aspirin and call me in the morning."
Questions??

- Keep Calm and Carry Naloxone
- Opioid Crisis
- Adverse Withdrawal
- Epidemic Depression
- Drug Abuse
- Opioid Control
- Usage Policing
- Injections Usage
- Addict Treatment
- Deaths Addict