



December 9, 2016

**Department of Health and Human Services
Prescription Drug Abuse Advisory Committee**



Welcome and Introductions of Attendees

Alan Dellapenna, Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health

Please share with us...

- **Your name**
- **Your organization/affiliation**



Update: 2016 PDAAC Report

Alex Asbun, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

- **Submitted to the Joint Legislative Oversight Committees on**
 - **Health and Human Services**
 - **Justice and Public Safety**



Loree K. Kallinen, MD, MA, FACS

Safer Opioid Prescribing for Post-Operative Pain



Multimodal pain management of hand surgery patients in the opioid epidemic era

Loree K. Kallianen, MD, MA, FACS

Clinical Associate Professor

Division of Plastic Surgery

9 December 2016





Preliminaries

- Nothing to disclose
- Off label use of dexmedetomidine

Acknowledgements



Physicians

Warren Schubert

Dean Mann

James Fletcher

Cherrie Heinrich

Sue Mi Tuttle

Ashish Mahajan

Martin Lacey

Christina Ward

Kate Pico

Mid-level providers

JoAnn Eller

Ned Bruce

Tara Olson

AnnMarie Fox

Sarah Jorgensen

Jen VanHecke

Brooke Hovick

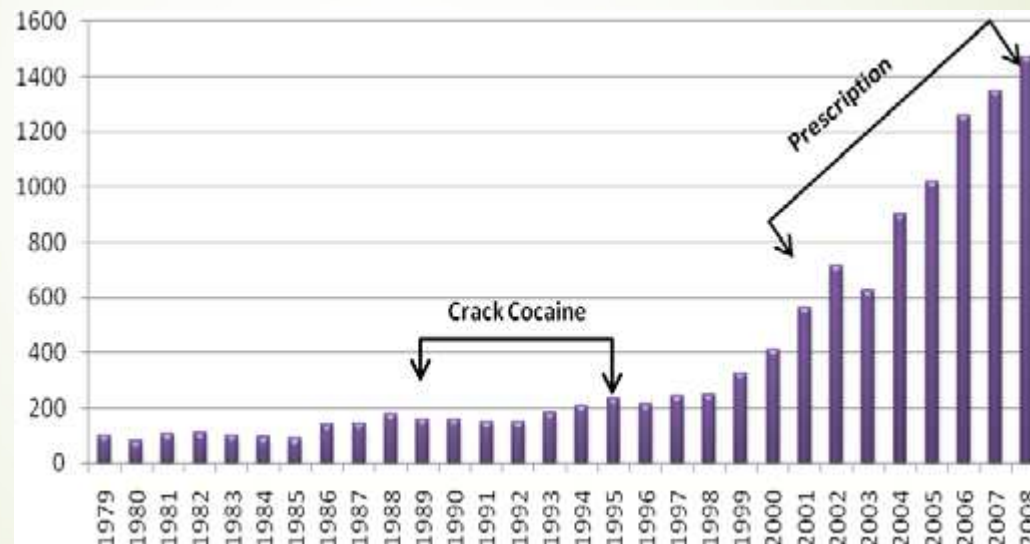
James Johanning



Acknowledgements

- Jason Fowler, MD, PhD
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- J William Mathewson, MD

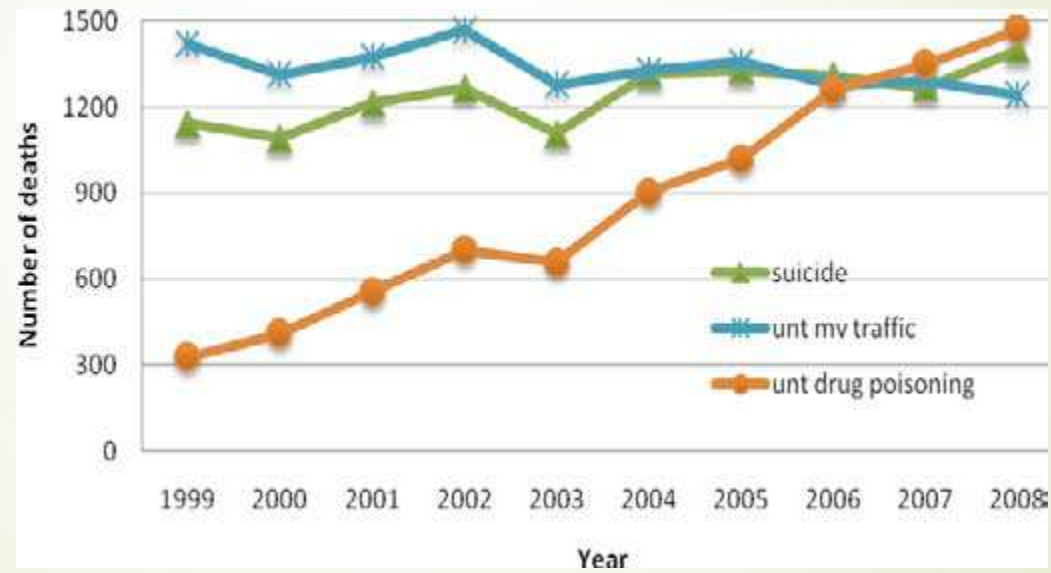
Figure 4. Epidemics of unintentional drug overdoses in Ohio, 1979-2008.



My time in training



Figure 3. Number of Deaths from Motor Vehicle Traffic, Suicide and Unintentional Drug Poisonings by Year, Ohio 1999-2008





Etiology of the epidemic

Altered prescription practices

- Overmedication (pain, the 5th vital sign)
- Increased use of narcotics for many conditions
- Direct to consumer marketing

Diversion (to family, friends, others)

Improper disposal



Our history





“You all do things so differently!”



- 
- Unnecessary variation in care leads to increased cost and complications**

Initial study

- ▶ Narcotic prescription patterns among 5 Plastic Surgeons: R Neumann, JW Mathewson, LKKallinen. AAHS, 2011, 2013.
 - ▶ Range of opioid pills for uncomplicated, nonworkers' compensation carpal tunnel release:
 - ▶ n=30 pts/surgeon,
 - ▶ **mean # pills 7-20 (range 0-40).**
 - ▶ **11-18 pts/ surgeon (of the 30 total each) were prescribed no opioids.**
- ▶ ***Wide variation within and between surgeons suggests no good rationale for prescription size.***



The problems

- Random prescription of opioids
- No idea how well we are controlling pain
- What constitutes an idea prescription size?
- What are the best ways to control perioperative pain?
- How do we get physicians to change prescription patterns?



Challenges to solving the problem

- Changing practice patterns is difficult
 - Inertia
 - Belief that no change is needed (practice is safe and effective)
 - Lack of awareness of risks
 - FEAR of change (of litigation)
 - No awareness of current norms (or no existing norms)



Next step

- ▶ Chart reviews of prescription patterns (initial and refills) for postoperative
 - ▶ trigger fingers,
 - ▶ metacarpal fractures,
 - ▶ deQuervain's releases, and
 - ▶ wrist ganglion cysts
- ▶ Chose a goal initial prescription size based on mean, median, or mode.



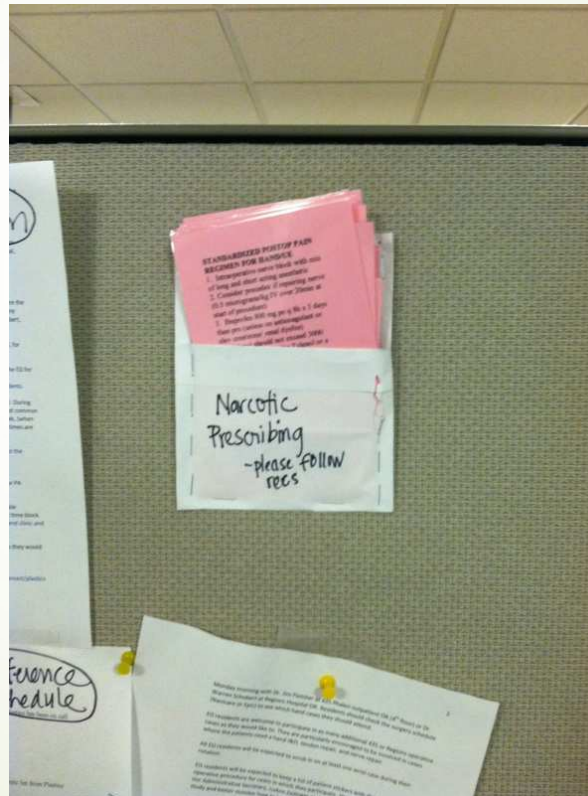
Initial multimodal plan

- ▶ 1. Education
 - ▶ Agreement among faculty
 - ▶ Pink card
 - ▶ Discussion with trainees, midlevels, and nursing staff in clinic and PACU
- ▶ 2. Systemic assists
 - ▶ Electronic health record reminders
 - ▶ Pain policy included in AVS
- ▶ 3. Feedback

Pink Card

- Educational assist device: laminated bright pink 3"x5" card
- Premise:
 - Smaller surgical procedures= fewer opioids,
 - more involved surgical procedures = more opioids
- Additional strategies:
 - pre-incision local blocks (lidocaine, bupivacaine),
 - Vit C for distal radius fractures/crush injuries
 - routine use of NSAIDs for 3 d postoperative,
 - acute use of gabapentin, dexmedetomidine
 - Consider clonidine patch (100mcg, leave on for 1 wk)

Pink Card



Pink card (page 1)

- **STANDARDIZED POSTOP PAIN**
- **REGIMEN FOR HAND/UE**
- 1. Intraoperative nerve block with mix of long and short acting anesthetic
- 2. Consider precedex if repairing nerve (0.5 micrograms/kg IV over 20min at start of procedure)
- 3. Ibuprofen 800 mg po q 8h x 3 days then prn (unless on anticoagulant or elev creatinine/ renal dysfxn)
- 4. Tylenol should not exceed 3000 mg/day if using regular Tylenol or a narcotic with Tylenol.
- 5. Ice to armpit 15 min/1-2x/hour while awake for 3 days then prn
- 6. Elevation of extremity
- 7. see reverse for narcotic recs

7. Narcotic guidelines

- No narcotics: small Moh's (<3 cm, no wide undermining), triggers, nonop Dupuytren's releases, flexor retinacular cysts, nevi, small lumps/bumps
- 10 narcotics: small joint (mucous cysts), carpal tunnel, deQuervain's, operative Dupuytren's, nonop hand fractures, small joint fusion
- 20 narcotics: wrist ganglion cysts, fixation of hand fx, LRTI, nonop scaphoid/distal radius fracture, simple tendon/tendon transfer/tendon stabilization
- 40 narcotics: large trauma, wrist fusion, open carpal surgery, DRUJ recon
- 8. Other: consider acute gabapentin for trauma-assoc neuralgic pain
- 9. Vit C: 500 gm/day x 8 wks for distal radius fractures



Electronic health record

- Changed opioid defaults from 1-2 po q 4-6 hours prn to 1 po q 6 h prn severe pain
- Added non-opioid options to the postop order sheet
 - ibuprofen to be taken on a scheduled basis for 3 days
 - If it isn't prescribed, it's not really a medication in many pt's view
- Added "no additional narcotics" as an alternative check box to minimize the # of calls from nurses in PACU



Pain policy

- ▶ Given to all pts undergoing elective surgery in Plastic/Hand
- ▶ No night/weekend refills of opioids
 - ▶ Answering service will not call us about this issue
- ▶ *A priori* discussion of opioid prescriptions
- ▶ Mention of opioid risks, multimodal pain control strategies

PAIN MEDICATION POLICY

The Department of Plastic and Hand Surgery recognizes that appropriate pain management is an important part of your surgical and recovery process. It is therefore, important that you are aware of our policies regarding dispensing prescriptive (narcotic) pain medications.

This department does not prescribe pain medications in anticipation of surgery. Your primary care physician should manage your pain medication needs until surgery. Following surgery, you will be discharged with an appropriate prescription for pain medication depending on the severity of your surgery or injury. This prescription should last until your first postoperative appointment.

The amount of narcotic pain medication prescribed is related to your surgical procedure or injury and is only one part of your pain management program. Other important parts of pain control include nonsteroidal anti-inflammatory agents (NSAIDS: ibuprofen, naproxyn, celebrex, aspirin), ice, elevation, and rest. Your ability to use NSAIDS may be altered depending on other health conditions and should be discussed with your surgeon. Relaxation techniques such as deep breathing and visualization have been shown to significantly improve pain. A handout is available in our office explaining how to do relaxation techniques.

Our Plastic Surgeons will manage your postoperative pain for a period of one to six weeks following your surgery depending on the type of procedure done. If you have a history of chronic pain, consultation with the pain clinic, physical therapist, or pain psychologist may be considered. If you had been receiving narcotic pain medication from another physician prior to your surgery or injury, you will need to return to that physician for further medical management.

REFILL Policy for Prescriptions:


Pain management will be addressed during your physician visit. Should you need a refill between office visits, you will need to allow twenty-four hours for this to occur. Please call during clinic hours only and before noon on Fridays. We do not refill prescriptions at night or over the weekend.

Under no circumstances will your prescription be refilled on a walk in basis in the clinic or during weekend hours.

RISKS of Narcotic Medications

We are concerned about your overall health and the potentially negative effects of narcotic medications on it. In addition to lack of effectiveness for some types of pain, the side effects of narcotics include nausea, constipation, upset stomach, sexual dysfunction, depression, fatigue, increased sensitivity to pain, addiction, and drug tolerance.

Department of Plastic and Hand Surgery



The arguments against this plan

- “They’ll just call in for more drugs”
- “They’ll go somewhere else”
- “We’ll have bad satisfaction scores”
- “Talking about it takes too much time”
- “Nothing bad is going to happen”



Outcomes

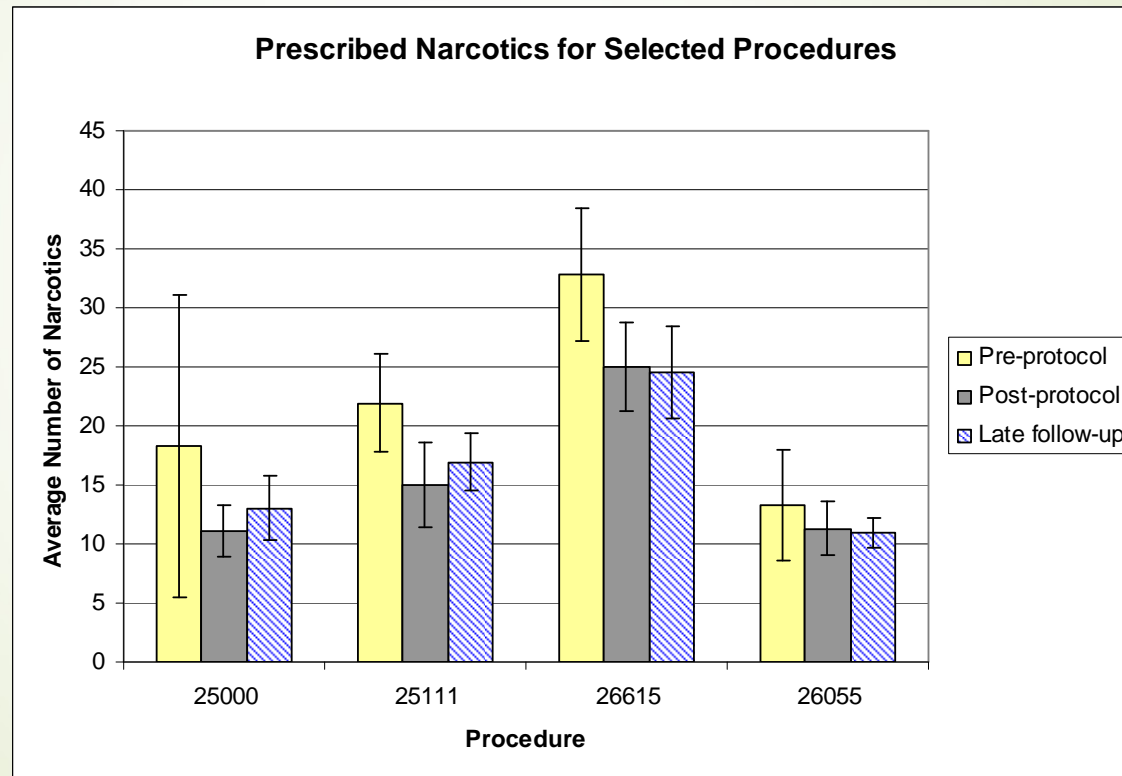
- Chart review done 4 months after start of Pink Card



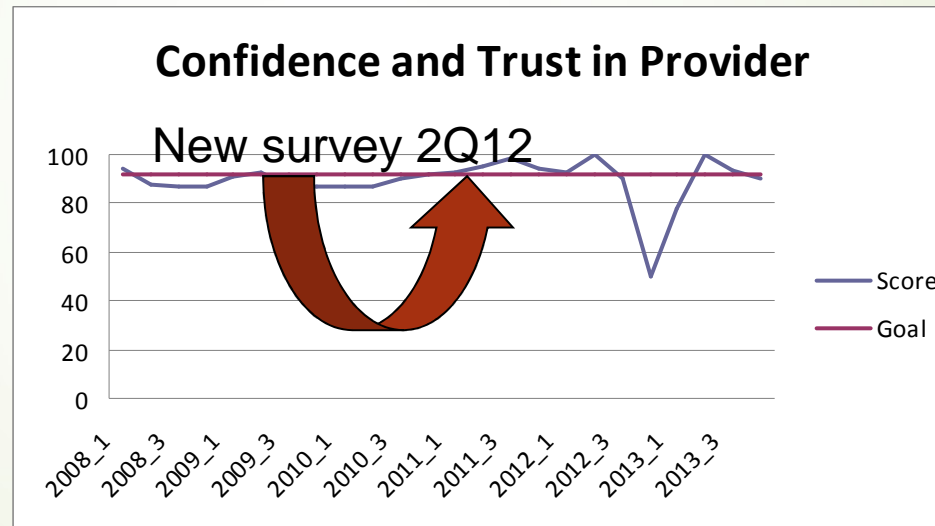
Early post-protocol outcomes for 4 hand surgery conditions

Code	Pre	Post	Change
25111 (ganglion)	X=21.9 (0-40) Mode 20 n=26	X= 15.6 (0-30) Mode=10 N=18	-50%
26615 (orif mc fx)	X=31.7 (20-40) n=7	X=25 (20-40) Mode 20 n=12	-20%
26055 (trigger finger)	X=13.3(0-30) Median 20 N=24	X=11.3 (0-30) Median 10 N=57	-50%
25000 (dequervains)	X=31.4 (0-40) N=6	X=11.1 (10-20) N=9	-65%
64721+26055	X=23.2 (10-30)	X=18 (10-30)	-23%

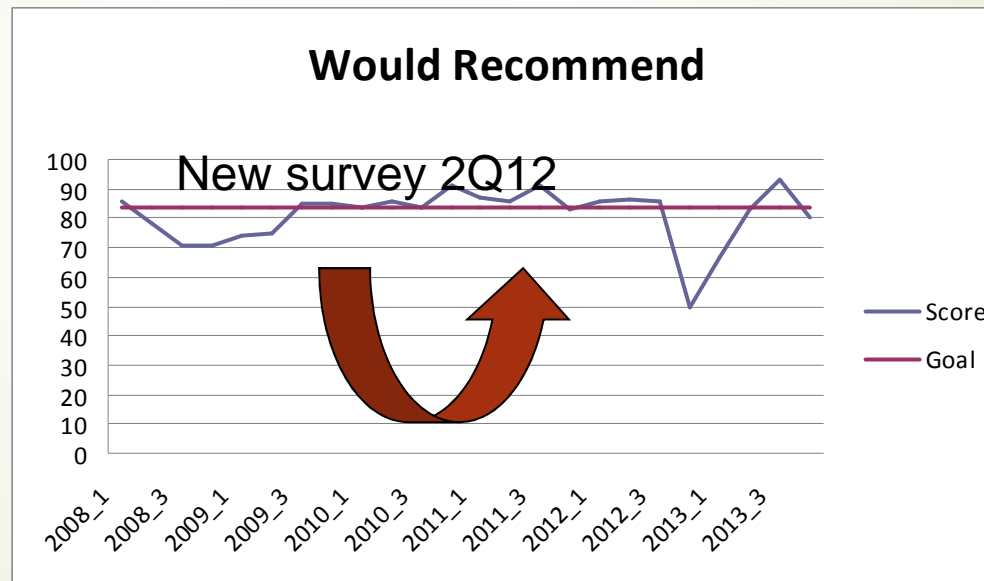
Long term follow up



Satisfaction scores

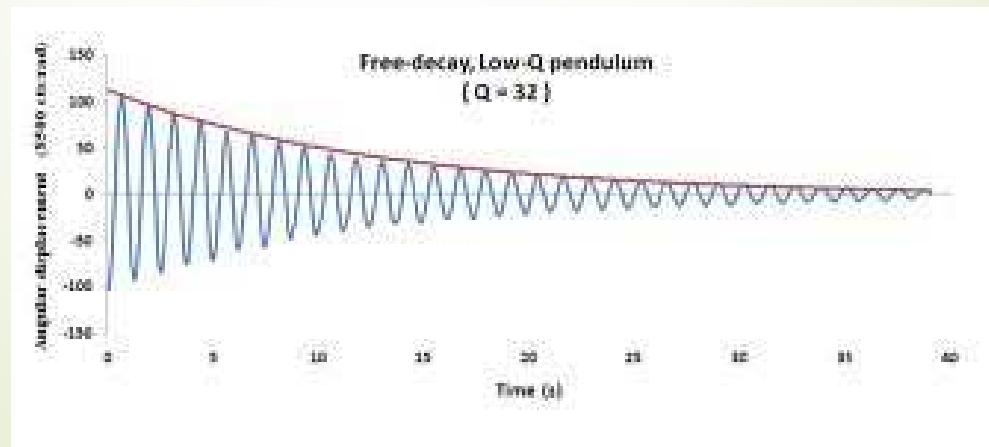


Satisfaction scores





the pendulum swings!







Part II.

- Ongoing feedback to practitioners
- Publication: JHS January, 2015. Others in progress
- Discussion with other surgical groups to encourage standardization of postoperative opioids (Orthopaedics, Ob/Gyn, Urology, General Surgery, Dentistry)
- Postoperative pain survey


The problems

- ▶ Random prescription of opioids
- ▶ What constitutes an ideal prescription size?
- ▶ How do we get physicians to change prescription patterns?
- ▶ No idea how well we are controlling pain



Postoperative pain survey

- 156 Hand Surgery patients
- 82% received opioid prescription
 - only 48% of the 2210 pills were used
 - 20% who were given pain meds didn't use them at all
- Other methods of pain control
 - Ice used by 76%
 - Elevation used by 85%
 - Rest used by 59%
- Preferred method of pain control
 - 55% of patients who took opioids found other things more helpful
 - 37% preferred opioids, 34% ice, 35% elevation, 19% rest



Part III. Perioperative pain order set for all surgical teams

- Creation of additional pink cards for general plastic and orthopaedic surgery conditions
- Preoperative
 - Gabapentin 900mg preop OR 1200 mg night before, morning of, then 600 mg TID x 3 d OR 900 mg night before and morning of
 - Acetaminophen 1000 mg morning of
 - Ibuprofen 800 mg morning of
 - Minocycline 100 mg night before and morning of
- Intraoperative
 - Ketamine OR dexmedetomidine OR clonidine patch
- Postoperative
 - Vit C x 8 wks, paracetamol x 3 d, ibuprofen x 3 d, gabapentin x 3 d, oxycodone for breakthrough, minocycline x 3 d



Conclusions

- It is necessary to change our prescription behaviors
- Simple, cheap measures can change behaviors WITHOUT having a negative impact on pain management or global satisfaction
- Multimodal strategies are most effective
- Discussions with multiple teams necessary
- minimizing the number of opioids prescribed is in our patients' and society's best interest.



Tips for success

- ▶ Start with a pain contract and discussion with the telephone answering service.
- ▶ Review current prescription patterns for common conditions.
- ▶ Education of the entire team is necessary
- ▶ Use consistent reminders to ingrain behaviors
- ▶ Comparison to peer group helpful



Thank you!

Loree_Kalliainen@med.unc.edu

612-708-2517

<https://www.youtube.com/watch?v=OuIFPki6h0E>

Tessie Castillo, Olivia Rich Herndon, Kenny House

Collective Action: A Regional Focus on Wilmington, NC

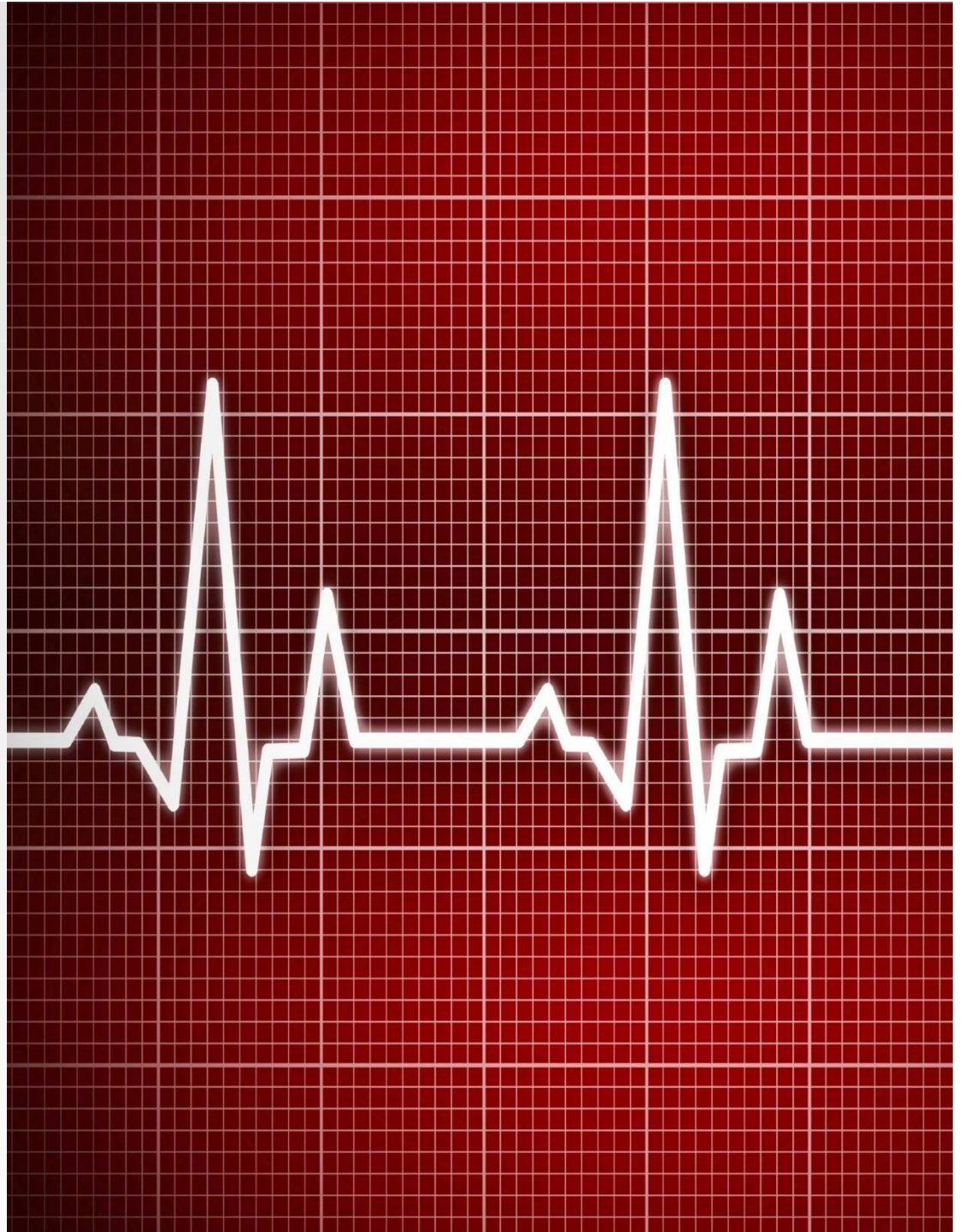




NC Harm Reduction Coalition

TESSIE CASTILLO

ADVOCACY AND COMMUNICATIONS
COORDINATOR



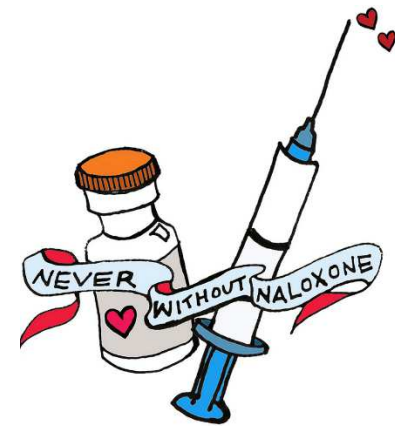
NORTH CAROLINA HARM REDUCTION COALITION

MISSION: ENCOURAGE AND MOTIVATE THE IMPLEMENTATION OF HARM REDUCTION INTERVENTIONS, PUBLIC HEALTH STRATEGIES, DRUG POLICY TRANSFORMATION, AND JUSTICE REFORM IN NORTH CAROLINA AND THE AMERICAN SOUTH THROUGH LEADERSHIP, ADVOCACY, RESOURCE AND POLICY DEVELOPMENT, AND EDUCATION.

NCHRC Programs and Initiatives

Policy Advocacy

- Fair Chance Hiring
- Good Samaritan law
- Needle Exchange Authorization
- Tell an Officer law



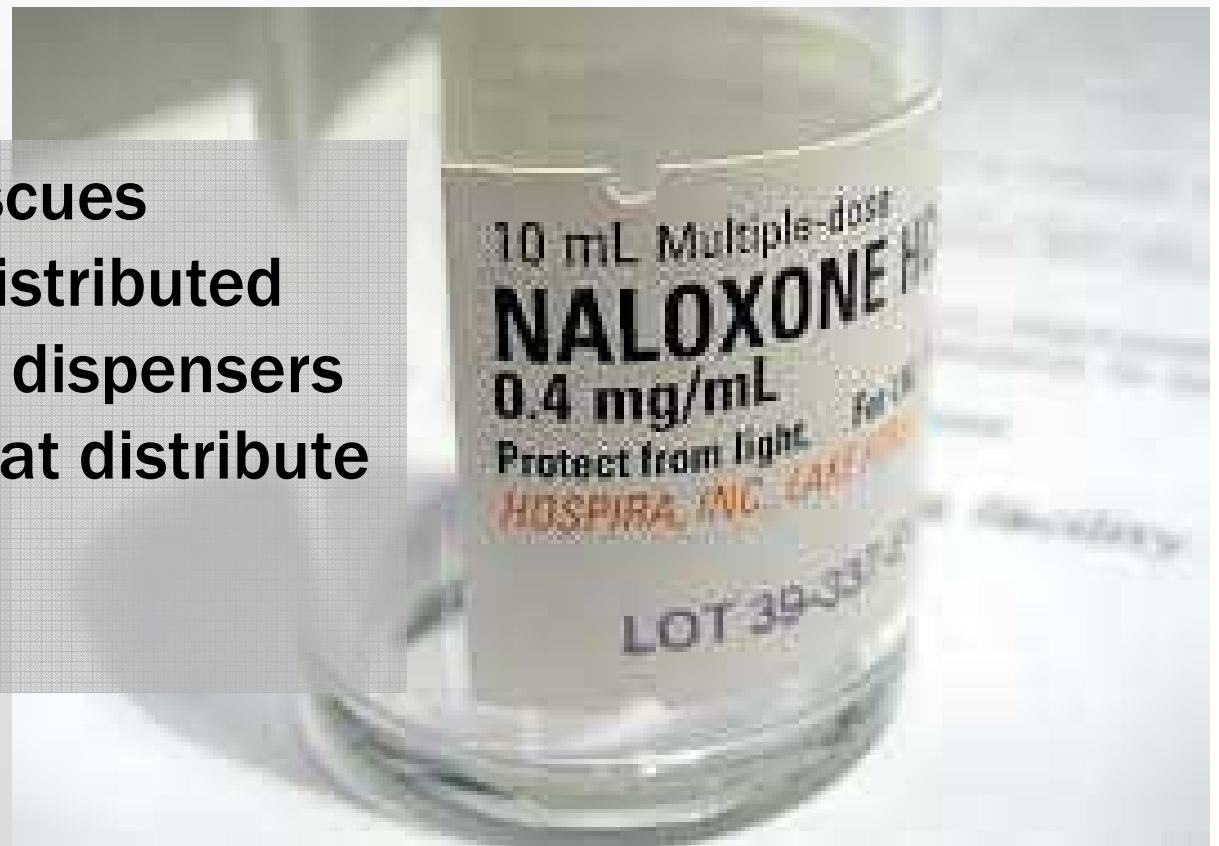
Direct Services

- Community Based Overdose Prevention Program
- Sterile Syringe Access/Exchange Program
- Technical Assistance to Law Enforcement



Naloxone at the Community Level

5,174 rescues
36,616 kits distributed
+100 volunteer dispensers
5 pharmacies that distribute kits

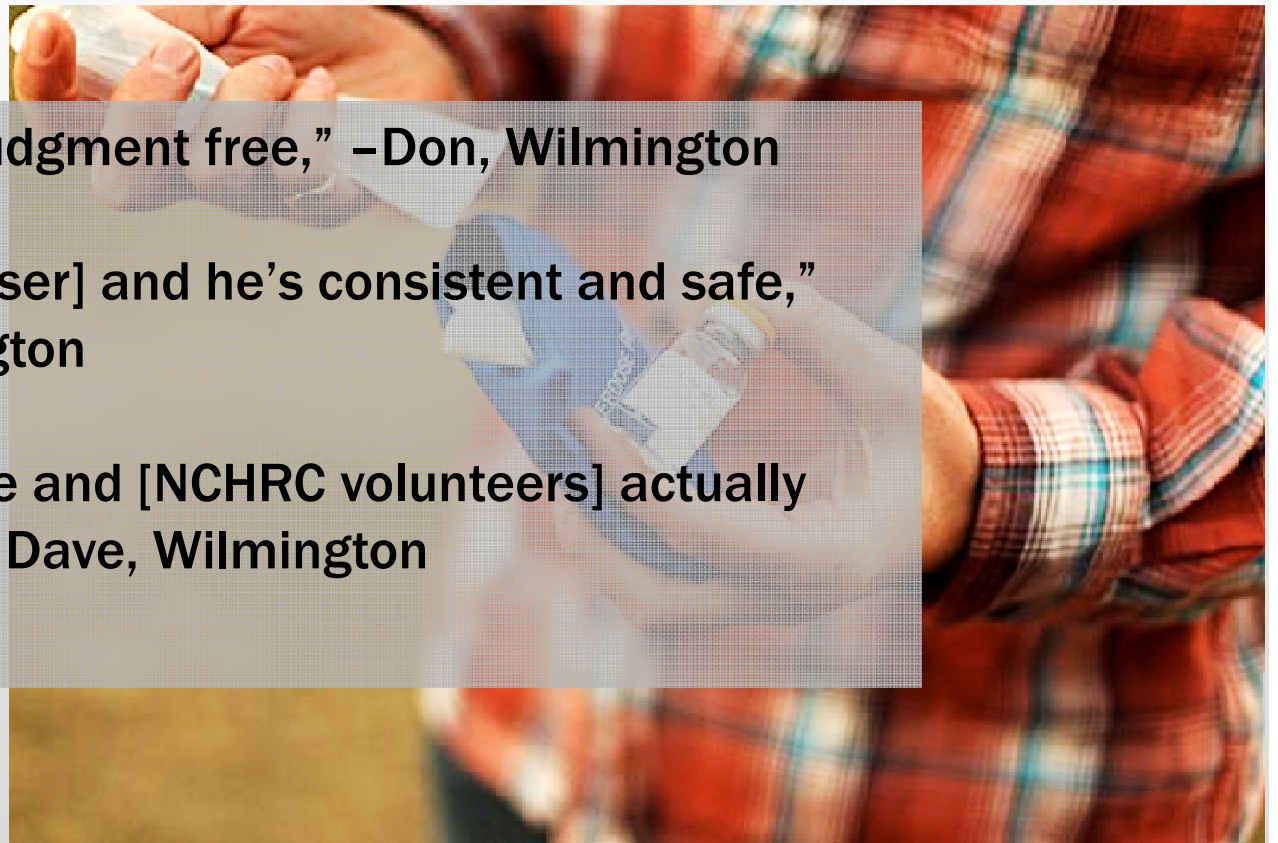


Why do active IV drug users choose harm reduction?

“I felt safe. It’s judgment free,” –Don, Wilmington

**“[Mike is an ex-user] and he’s consistent and safe,”
–Shane, Wilmington**

**“Personal service and [NCHRC volunteers] actually
ask how I am,” –Dave, Wilmington**



Needle Exchange Program in Wilmington

As of July 2016, syringe exchanges were legalized in North Carolina.

The Wilmington Needle Exchange Program has distributed 27,646 needles and collected 34,591 sharps

1. Street Outreach Team: Wednesday evenings
2. Fixed Site: Fridays 1-5pm
3. Delivery: As needed, about 25 meet-ups on a weekly basis



Photo credit: Matthew Born



Key Components of the Wilmington Needle Exchange

- **Networking in Wilmington**
 - Referrals from Pharmacies and Detox
 - Extensive Media coverage
 - Stable Relationships with law enforcement
- **Trust and Rapport with Needle Exchange Participants**
- **Offer more than access to sterile syringes: Support, Treatment information, Naloxone, Testing for HIV/HCV**
- **Wilmington also has 3 types of needle exchange programs: Delivery, Fixed Site, Weekly Street Outreach**



Photo credit: Matthew Born

“It’s good to know what’s out there [treatment options] for when I’m ready,” –Joe, Wilmington

Questions about Wilmington and Harm Reduction Services?

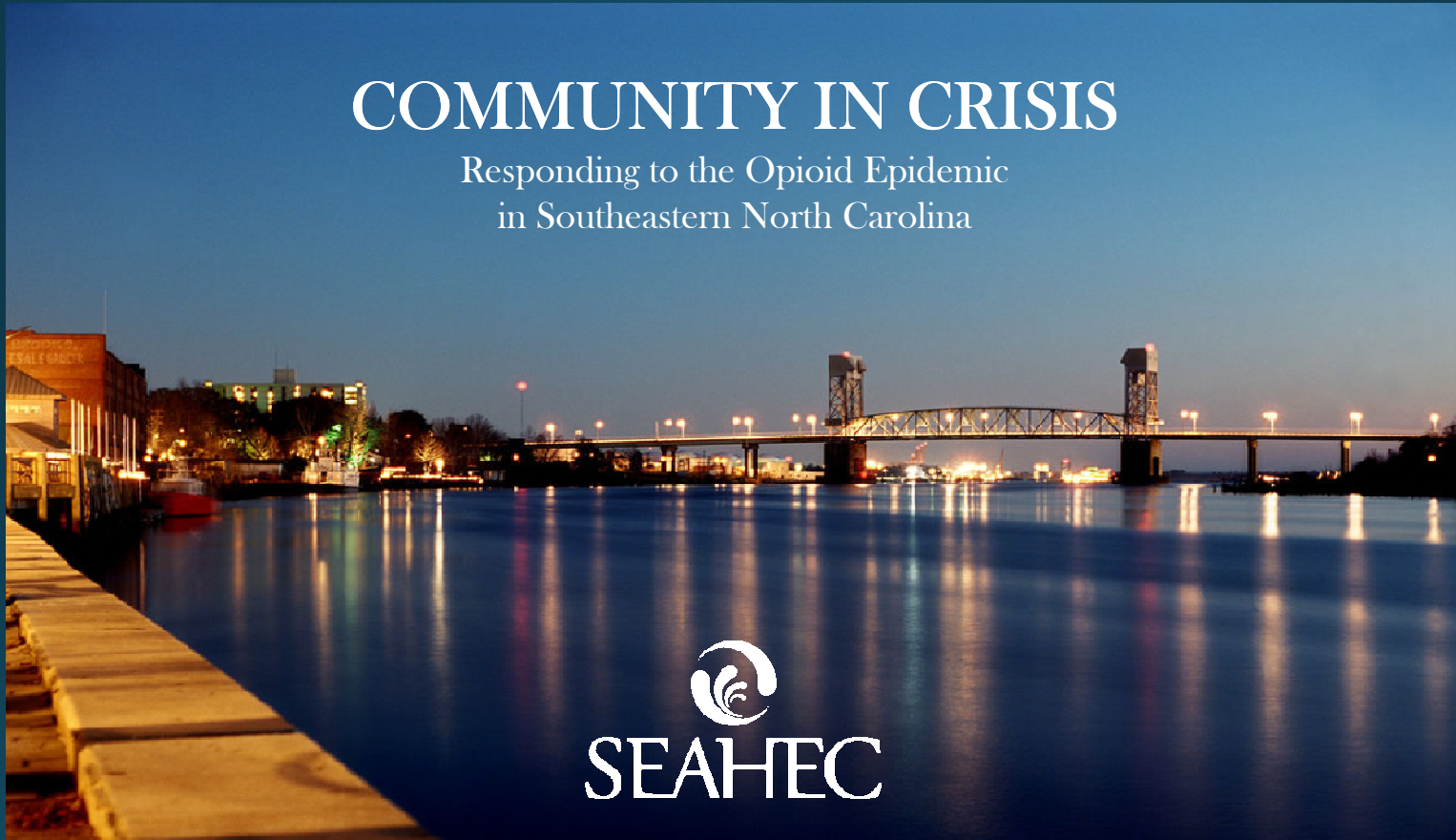
Hyun Namkoong, Harm Reduction Services and Advocacy Coordinator

919-218-4505

hnamkoong88@gmail.com

COMMUNITY IN CRISIS

Responding to the Opioid Epidemic
in Southeastern North Carolina



WHY ARE WE HERE?



#1 in the Nation

For opioid ABUSE



Why SEAHEC?

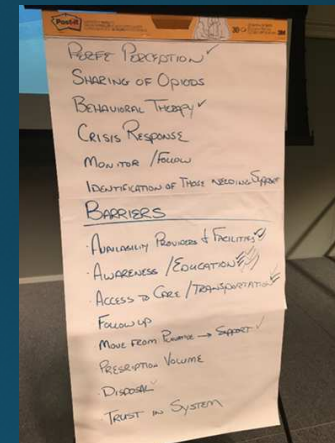
Southeastern North Carolina Regional Health Collaborative



- Leadership from the College of Health and Human Services at UNCW
- Health Directors from Pender, Columbus, New Hanover, Brunswick, Onslow, and Duplin Counties
- SEAHEC

Call to Action: Regional Needs Assessment

- ♦ July 27th, Call to Action with State Health Director
- ♦ Areas of Priority Identified:
 - ♦ Access to Care
 - ♦ Awareness and Education
 - ♦ Punitive System → Supportive System
 - ♦ Crisis Response
- ♦ Resulted in 2-Day Conference
 - ♦ Day 1: Education on Priority Areas
 - ♦ Day 2: Strategies and Solutions for Priority Areas



COMMUNITY IN CRISIS



Responding to the Opioid Epidemic
in Southeastern North Carolina

AGENDA

Time	Topic	Speaker
8:00–8:30am	Registration & Light Breakfast	
8:30–8:35am	Welcome & Overview	
8:35–8:45am	How Did We Get Here?	Randall Williams, MD, FACOG Dep. Sec. for Health Services & State Health Director, Raleigh, NC
8:45–9:30am	The Opioid Epidemic: The Scope of the Problem in North Carolina	Alan Dellapenna, Jr., RS, MPH Branch Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section of North Carolina's Department of Health & Human Services, Raleigh, NC
9:30–10:00am	Response from the US Attorney's Office	Leslie K. Cooley, JD Deputy Criminal Chief, OCC/ETP/Narcotics United States Attorney's Office Eastern District of North Carolina, Raleigh, NC
10:00–10:15am	Break	
10:15–11:00am	Reaching, Teaching, and Treating the Community: A Comprehensive Approach	Fred Wells Bresson II President/CEO of Project Lazarus, Moreauville Falls, NC
11:00–11:45am	Quick Response Team: One Community's Response to the Heroin/Opiate Epidemic	Daniel P. Meloy, CLEP Asst. Township Administrator & Public Safety Director Colerain Township, OH Will Mueller, B.S. EMT-P Asst. Fire Chief, Colerain Township, OH Shana Merrick, MSW, LSW, CDCA Director of Adolescent and Prevention Programming QRT Clinical Provider, Cincinnati, OH
11:45–12:30pm	The Opioid Epidemic: Response from a Major Health System	Larry Greenblatt, MD Duke Health, Durham, NC
12:30–1:30pm	Lunch	
1:30–2:15pm	LEAD Off: An Alternative Incarceration Program	Randy Johnson, LGSW L.E.A.D. Case Manager, Santa Fe, NM Detective Michael J. McCluskey Santa Fe Police Department, Santa Fe, NM Detective Casey Salazar Santa Fe Police Department, Santa Fe, NM
2:15–2:45pm	Planning for the Future: Trillium Health Resources' Recovery Oriented System of Care	Christie Edwards, MS, LCAS, LPC Project Manager, Trillium Health Resources Wilmington, NC
2:45–3:00pm	Break	
3:00–3:30pm	A Place of Refuge: The Faith-Based Community's Role in Fighting the Opioid Epidemic	Pastor Mark Allen Port City Community Church, Refuge Coordinator Wilmington, NC
3:30–4:00pm	Action Plan in Wilmington / Wrap-Up	
4:00–4:15pm	Next Steps Adjour	

#1 in the Nation

For opioid ABUSE



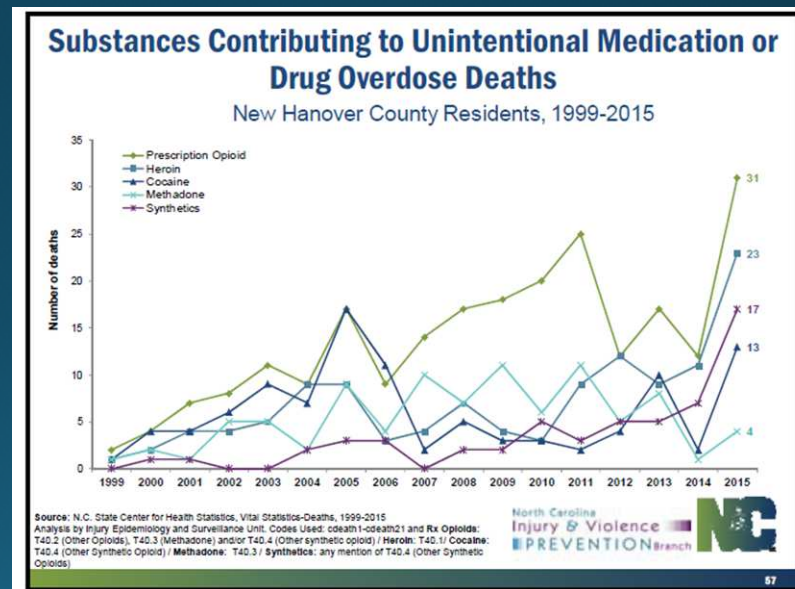
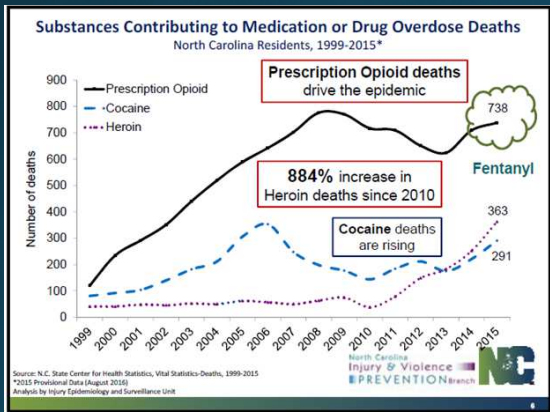
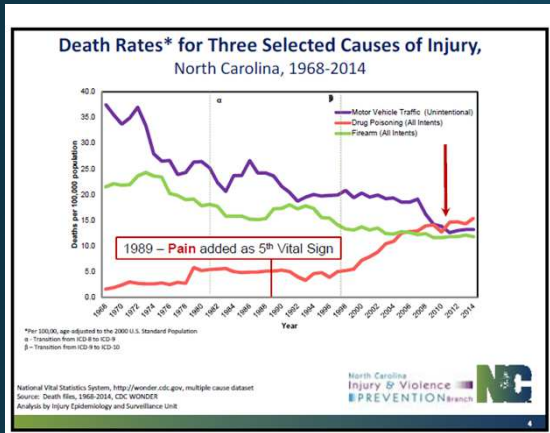
Over 300 participants filled Union Station to hear about best practices for opioid harm reduction from organizations and entities from across the country. Those in attendance included:

- 5 Hospitals and Health Systems
- Law Enforcement from 6 counties
- Behavioral Health and Substance Abuse Agencies representing 26 counties
- Department of Social Services from 4 counties
- Local and State Judicial System Representation
- 8 School Systems, Higher Education, and Academic Institutions
- Pharmacy representation from 3 counties
- First Responders from 7 counties
- 7 Health Departments
- Grassroots Organizations
- Faith Based Community
- Legislators
- Community Members



What did we learn?

What about local impact?



Best Practices Nationwide

LEAD (Law Enforcement Assisted Diversion)

- Allows officers to redirect low level offenders engaged in drugs to community based services instead of jails
- Participants begin working with case managers to access services
- Goal to reduce harm to participant and community
- Diversion in pre-booking bypassing costs and time and provides access to case management

Best Practices Nationwide

Quick Response Team

- Colerain Township in 2011 there was 51 heroin related overdoses
- By 2014 there was 141
- Police, Firefighters and Paramedics working together connected by a social worker/case manager
- When a person receives Narcan, the SW is notified and makes the connection
- Engage patients where they are → 80% enter treatment

Regional Challenge Day

November 4th, 2016

- 1) Communication and Collaboration: Breaking Down Silos
- 2) Learning Together: Educating the Public and Providers about Best Practices
- 3) Communities Taking Action: The Grassroots' Response
- 4) Rethinking Response: An Innovative Response to Crisis, Treatment, and Recovery

Group 1

Communication and Collaboration: Breaking Down Silos

Since Wilmington was named as the number one city in the nation for opioid abuse back in April, it has been clear that many different organizations and initiatives in our region are doing great work to combat the opioid epidemic.

However, in order to increase the effectiveness of our actions and decrease duplication, how can we work together to communicate, collaborate, and disseminate efforts targeting opioid harm reduction? What resources do we need to do this?

The image shows a 'Lean' proposal form titled 'PROPOSAL A3'. The form is filled with handwritten notes in green and black ink. The notes are organized into sections: 'Business Case - Background', 'Problem Statement', 'Proposed Solution', 'Implementation Schedule', and 'Measurement'. The 'Proposed Solution' section contains the most detailed notes, including 'Communication', 'Information Exchange Tool', and 'Team to Coordinate'. The 'Implementation Schedule' section is a table with columns for 'Action', 'Responsible', 'Expected Outcome', and 'By'. The 'Measurement' section is a table with columns for 'Metric', 'Type', 'Baseline', and 'Target'.

Implementation Schedule	
Action	Responsible

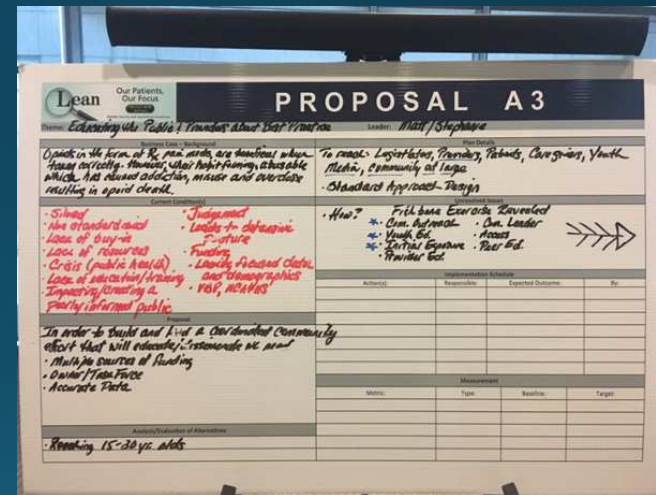
Measurement			
Metric	Type	Baseline	Target

Group 2

Learning Together: Educating the Public and Providers about Best Practices

Opioids in the form of prescription pain medications, when prescribed and taken correctly, are beneficial to appropriate patient populations. However, these drugs are habit forming and abusable which has led to skyrocketing rates of addiction, misuse, and overdose in our region.

How can we educate and disseminate information to providers, prescribers, patients, and the community at large about the dangers of opioids and best practices?

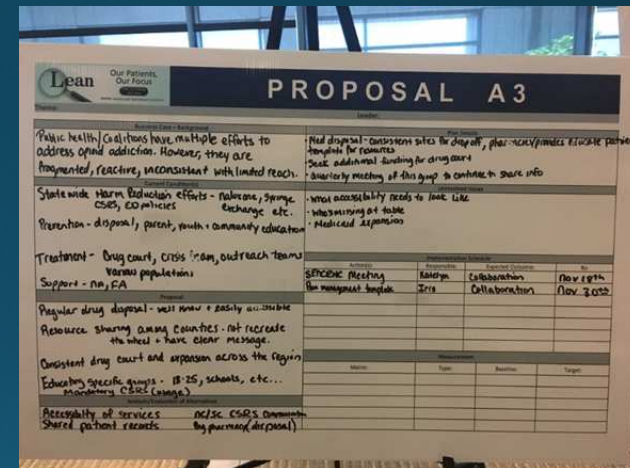


Group 3

Communities Taking Action: The Grassroots' Response

For decades, society has relied on Public Health and Grassroots' response efforts to come up with solutions and strategies for health challenges in our communities. This epidemic will be no different; the opioid epidemic is a public health issue.

What current efforts and initiatives are occurring in public health to combat this epidemic and are they working? What more needs to be done from a public health response and what do we need to do this?



Group 4

Rethinking Response: An Innovative Response to Crisis, Treatment, and Recovery

The opioid crisis is affecting millions of people across the country. The pace of addiction and death is so fast in some locations that statistics can be more overwhelming than helpful. Our current interventions and resources in the region will only get us so far in treating this population. We will only succeed in fighting this epidemic as a community if we engage and align numerous sectors to create systems that can prevent new individuals from becoming dependent on opioids, while supporting those who are currently dependent with innovative treatment, crisis response, and recovery efforts.

What treatment is currently available in our region and how can we better coordinate the care of those who need it? How can we better intervene with those in crisis to engage them in these treatment resources and help keep them in recovery? What further resources are needed to treat this population?

The image shows a hand-drawn proposal form titled "PROPOSAL A3" on a grid background. The form is divided into several sections with handwritten text:

- Business Case/Justification:**
 - High in the nation for opioid misuse, increasing harm due to heroin & other substances
 - Present to elected officials
 - Learn about for coordination of acute care resources 24/7
- Current Conditions:**
 - Fragmented services - siloed vs. comprehensive approach
 - Integration is an issue
 - Initial transparency of data technology - HIPAA
 - Widespread community denial
 - More reactive vs. proactive approach
 - Housing resources & support systems for those in recovery are limited
 - Identify the customer
 - Voice of the customer
 - Demographic data
 - Prevalence education
 - Funding opportunities
- Proposed Solution:**
 - centralized opioid coordination
 - Support navigators
 - 24/7 care
 - Lobby for changes
 - Medical expansion
 - Sharing information
 - Coordination of 24/7 Resources
- Implementation Schedule:**
 - Present to mayor's council Dr. Piro Acknowledged consent 2/2018
- Table:**

Measure	Type	Baseline	Target

Progress to Date

- ◆ Ongoing subgroup meetings with action items
 - Drop boxes, disposal bags
 - Drug Court Enhancement
 - Update on Best Practices for Prescribing for Providers
 - Resource Communication Tool
 - Coordination/Oversight Taskforce Development (Information Flow from Grassroots to Leadership and Back with agreed upon metrics)
 - Research of Best Practices for Mental Health/Substance Abuse “Coordination Center”
- ◆ Engaging elected officials
 - Meetings with elected officials with recommendations
 - Local delegation involved in subgroups
- ◆ Proposal from subgroups’ A3 Proposals at Mayor’s Roundtable
 - Quick Response Team
 - LEAD
 - Enhancing and Expanding Drug Court
- ◆ Seeking funding for strategies

Next Steps

- ◆ Continue to make action oriented progress in the four priority areas by working through subgroups
- ◆ Continue to engage elected officials and others within the State Health system about our plans and progress
- ◆ Community Report Out of Progress
 - Health and Human Services Week at UNCW
 - March 2017



BREAK!



Penny Shelton, Courtenay Wilson, E. Blake Fagan

Learn, Explore, and Clarify

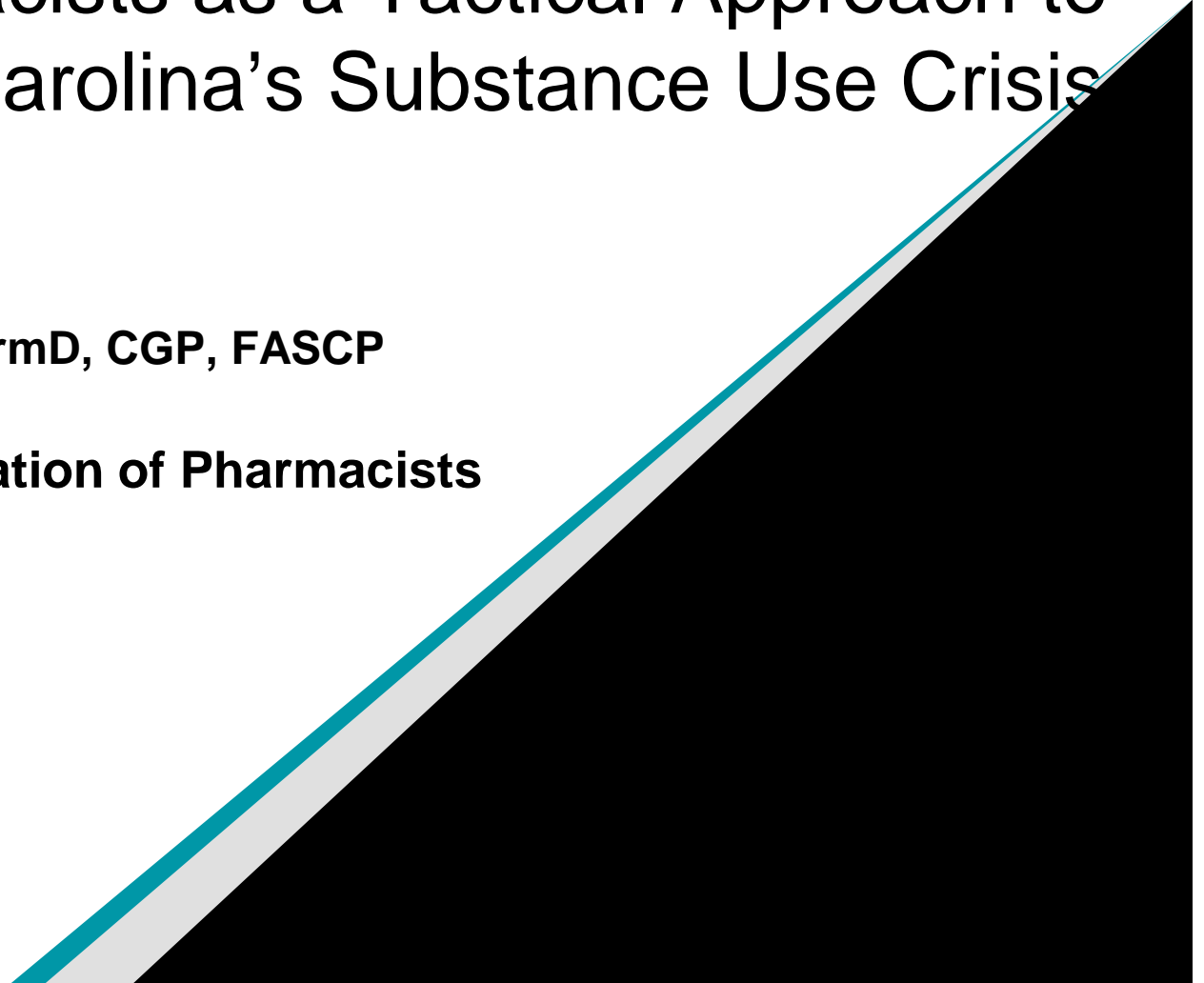
How Pharmacists Can Help with the Opioid Crisis





Pharmacists as a Tactical Approach to North Carolina's Substance Use Crisis

Penny Shelton, PharmD, CGP, FASCP
Executive Director
North Carolina Association of Pharmacists





Objective

Raise awareness as to how pharmacists can help address the opioid crisis.

OPIOID ABUSERS ARE MORE LIKELY TO LIVE IN THE RURAL SOUTH.

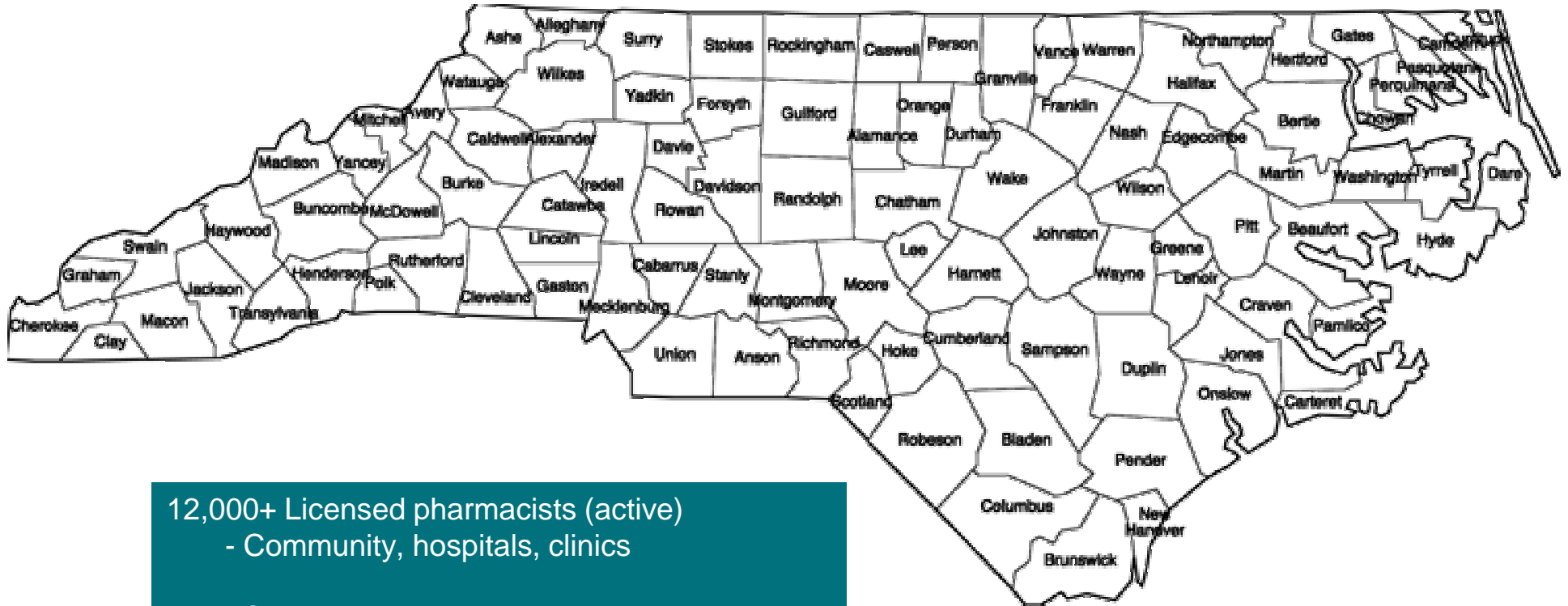
22 out of the top 25 cities for opioid abuse rate are primarily rural and located in Southern states. Opioid abuse rates range from 11.6% of individuals in Wilmington, NC to 7.5% of individuals in Fort Smith, AR who received an opioid prescription. Alabama, Florida, North Carolina, Oklahoma, North Carolina, Tennessee, and Texas have multiple cities that are in the top 25 for opioid abuse rate. The three non-Southern cities in the top 25 are: Terre Haute, IN; Elmira, NY; and Jackson, MI.



BASED ON ABUSE RATE

TOP 25 CITIES

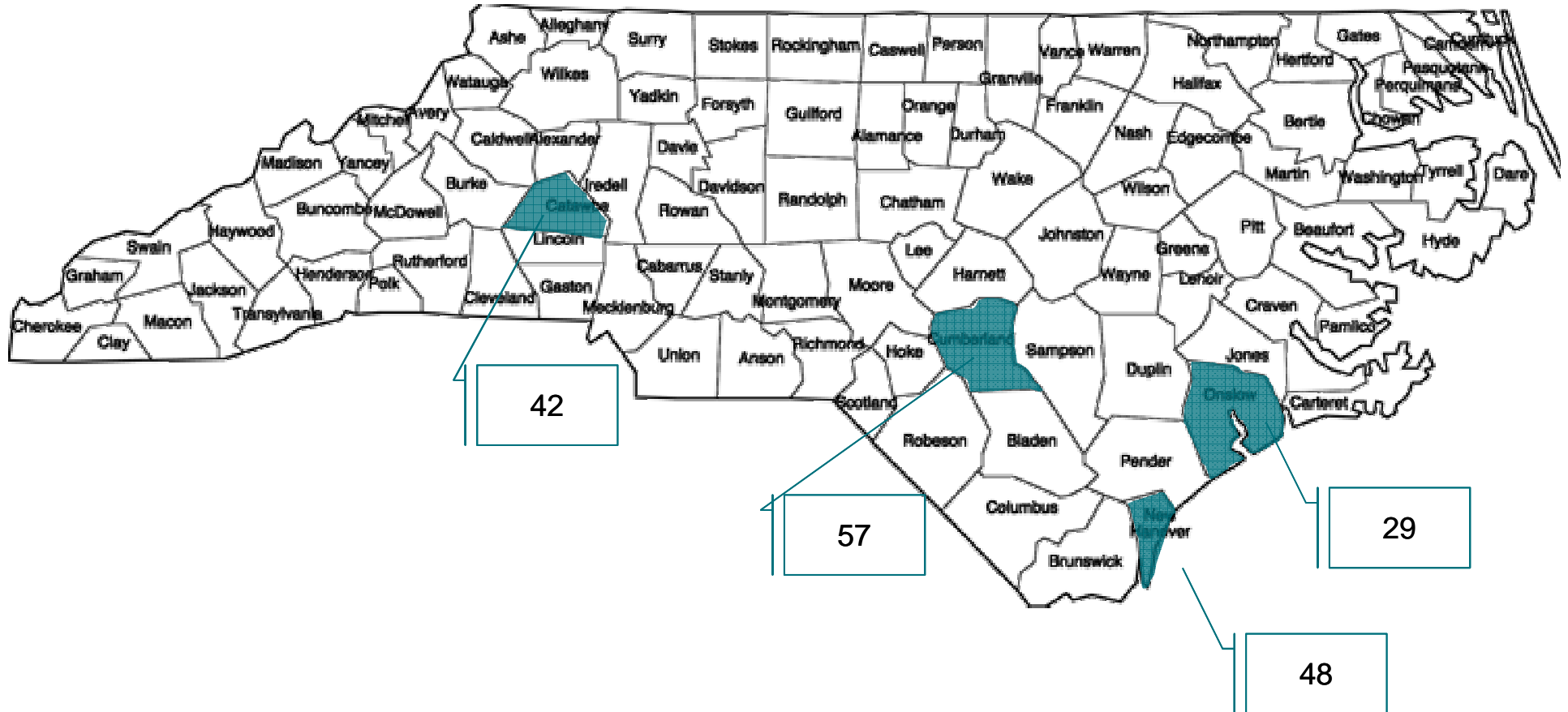
1. Wilmington, NC	>11.6%	9. Johnson City-Bristol, TN-VA	8.6%	16. Oklahoma City, OK	8.0%	22. Jackson, TN	7.7%
2. Anniston, AL	11.6%	10. Texarkana, TX-AR	8.5%	17. Longview, TX	8.0%	23. Baton Rouge, LA	7.5%
3. Panama City, FL	11.5%	11. Tuscaloosa, AL	8.2%	18. Fayetteville, NC	7.9%	24. Jackson, MI	7.5%
4. Enid, OK	10.2%	12. Jacksonville, NC	8.2%	19. Evansville-Henderson, IN-KY	7.8%	25. Fort Sruth, AR	7.5%
5. Hickory, NC	9.9%	13. Amarillo, TX	8.1%	20. Chattanooga, TN	7.7%		
6. Pensacola, FL	9.8%	14. Terre Haute, IN	8.1%	21. Elmira, NY	7.7%		
7. Gadsden, AL	9.1%	15. Odessa, TX	8.0%				
8. Montgomery, AL	8.8%						



12,000+ Licensed pharmacists (active)
- Community, hospitals, clinics

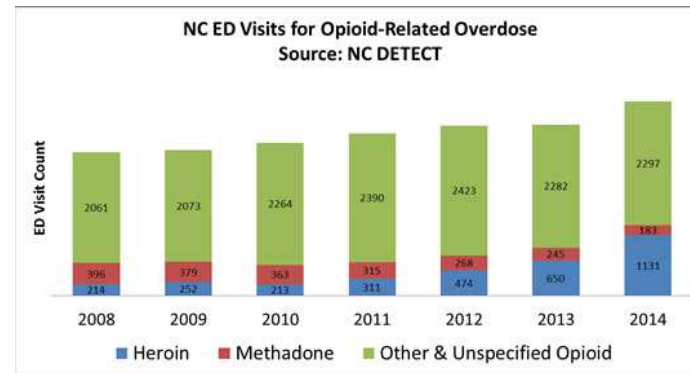
2026 Community pharmacies

Number of Pharmacies Located in Counties with Cities of Highest Opioid Abuse





Pharmacists as a Resource



- Service models to help bridge gap between patients in the community, primary care & behavioral health
- Accessible

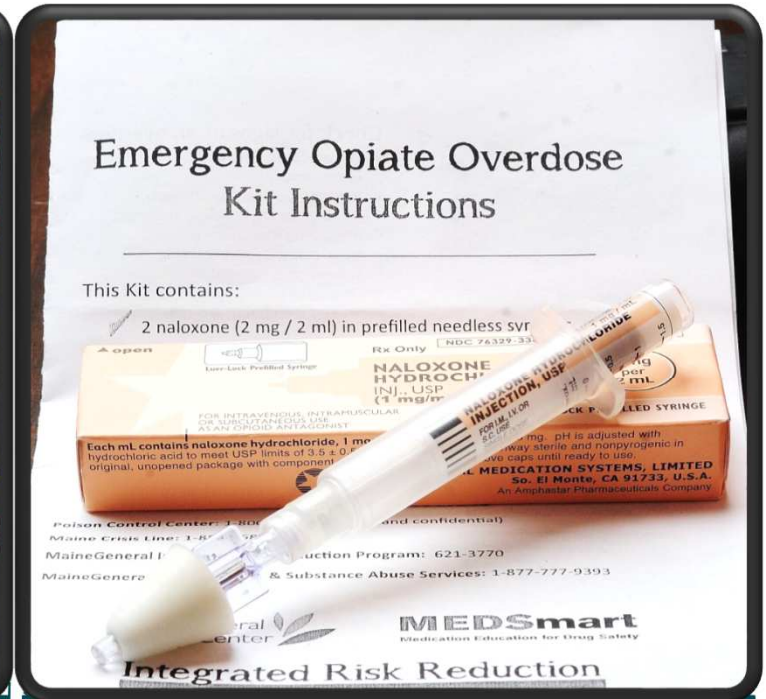
93% of Americans live within 5 miles of a community pharmacy



Pharmacists' Primary Roles To Date



- Monitor patterns of use through CSRS
- Patient education



- Dispensing of naloxone
- Statewide order / CPA



If This,

- Prescription drug misuse and abuse (especially of opioids) has been the fastest-growing
- Average of 580 people in the U.S. initiate heroin each day, and 4 out of 5 started first by misusing Rx opioids
- Greater than 650,000 opioid prescriptions are dispensed daily in the U.S.

Then,

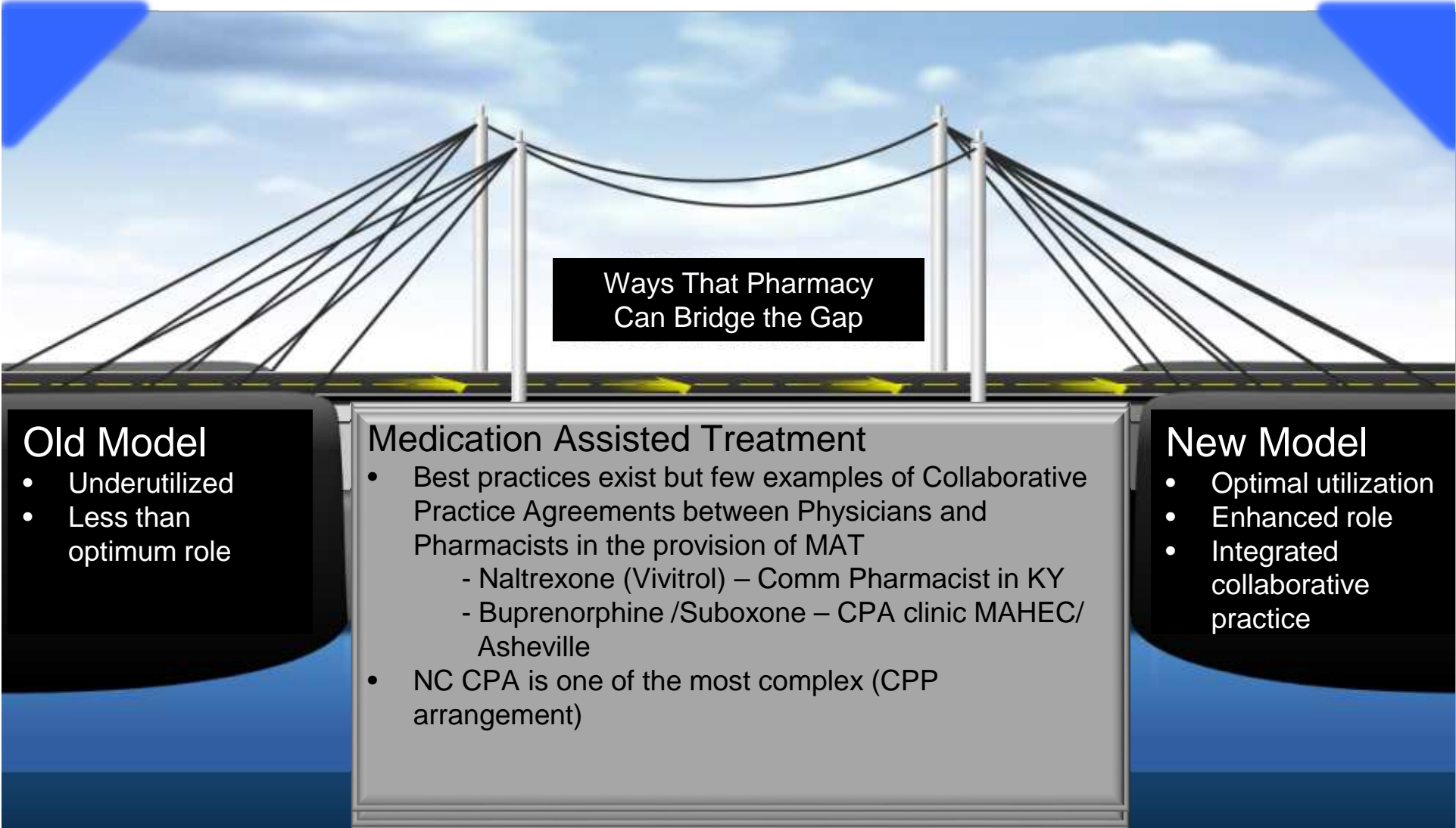
Doesn't it make sense that pharmacists would be called upon to serve a greater role?





“One of the most confounding problems with the opioid epidemic, from a policy perspective, is that nearly every part of the healthcare system has aided and abetted the spread of the epidemic in some fashion”

--Brett Norman



Ways That Pharmacy Can Bridge the Gap

Old Model

- Underutilized
- Less than optimum role

Medication Assisted Treatment

- Best practices exist but few examples of Collaborative Practice Agreements between Physicians and Pharmacists in the provision of MAT
 - Naltrexone (Vivitrol) – Comm Pharmacist in KY
 - Buprenorphine /Suboxone – CPA clinic MAHEC/ Asheville
- NC CPA is one of the most complex (CPP arrangement)

New Model

- Optimal utilization
- Enhanced role
- Integrated collaborative practice



What can the Association do to help?

- Education
 - Strategies for building awareness and reducing stigma
 - SBIRT training for pharmacists
 - Education on enhanced use of CSRS
 - Education on enhanced services (pain management, MAT, integration of SBIRT, etc.)
- Dissemination of information and resources
 - Patient educational materials
 - “How to” service-related toolkits
 - Helping establish and illuminating best practices
 - Helpful links and partners
- Advocacy



Penny Shelton, PharmD, CGP, FASCP
Executive Director
penny@ncpharmacists.org
984-439-1646



PHARMACIST ROLE IN THE OPIOID CRISIS

E. Blake Fagan, MD

Chief Education Officer, Assistant Residency Director, Assistant Medical Director, Director of Rural Health Initiative, MAHEC

Courtenay Wilson, PharmD, BCPS, BCACP, CDE, CPP

Associate Director of Pharmacotherapy, MAHEC

Assistant Professor of Clinical Education, UNC Eshelman School of Pharmacy

MAHEC

- 16 counties of western NC
- 15 considered rural
- Residency Training:
 - Family Medicine
 - OB GYN
 - Pharmacy
 - Dental
 - General Surgery (2017)
 - Psychiatry (2017)
- Robust Behavioral Medicine team



Pharmacy Collaborative Practice

- Five faculty pharmacists within Family Medicine Division
- Two PGY1 pharmacy residents
- Two PGY2 pharmacy residents
- Co-funded with the UNC Eshelman School of Pharmacy

- Direct patient care
 - Pharmacy Clinic
 - Co-visits with physicians
- Comprehensive Medication Management
- Clinical Pharmacist Practitioner license

Pharmacist Role in Opioid Crisis

1. Opioid Stewardship
2. Naloxone Co-Prescribing Program
3. Opioid Dependence Treatment Program

**Pharmacists are responsible for
safe and effective use of medications**

Opioid Stewardship

- Implemented universal precautions
 - Controlled substance agreements
 - Routine urine drug screens
 - State prescription drug monitoring program
- Targeted doses <50-100 morphine milligram equivalent (MME) daily

Opioid Stewardship: Pharmacist Role

- Developed opioid tapers and rotations plans
- Co-wrote clinic controlled substance agreements
- Co-wrote policies and procedures on pain management
- Facilitated pain group with nurse practitioner
- Provided education to medical residents/faculty, pharmacists, and other members of the healthcare team

Future Growth

- CDC Guidelines:
 - Carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 MME
 - Carefully justify a decision to titrate dosage to ≥ 90 MME/day

Patients on Chronic Opioid Therapy, n=709	
Age, average (range)	62.4 (21-101)
Female, n (%)	465 (65.5)
MME/day, average (range)	53.3 (1.5-747.5)
Patients on ≥ 50 MME/day, n(%)	216 (30.5)
Patients on ≥ 90 MME/day, n(%)	117 (16.5)

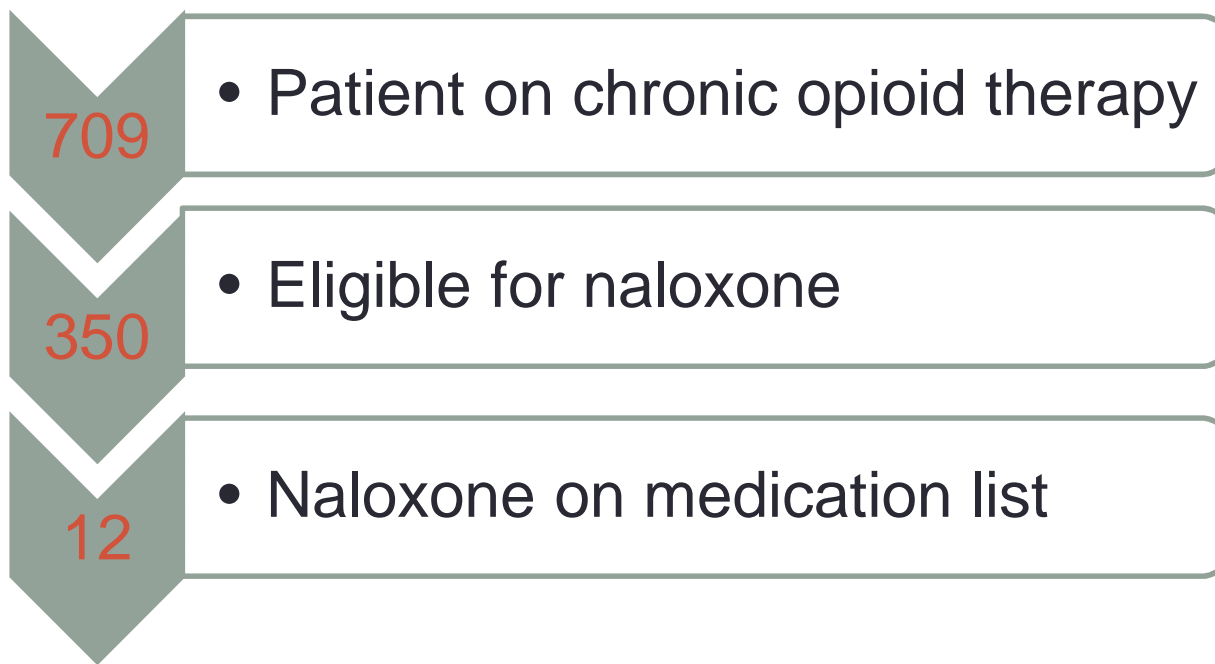
MME: Morphine Milligram Equivalent

Interdisciplinary Peer Review Process

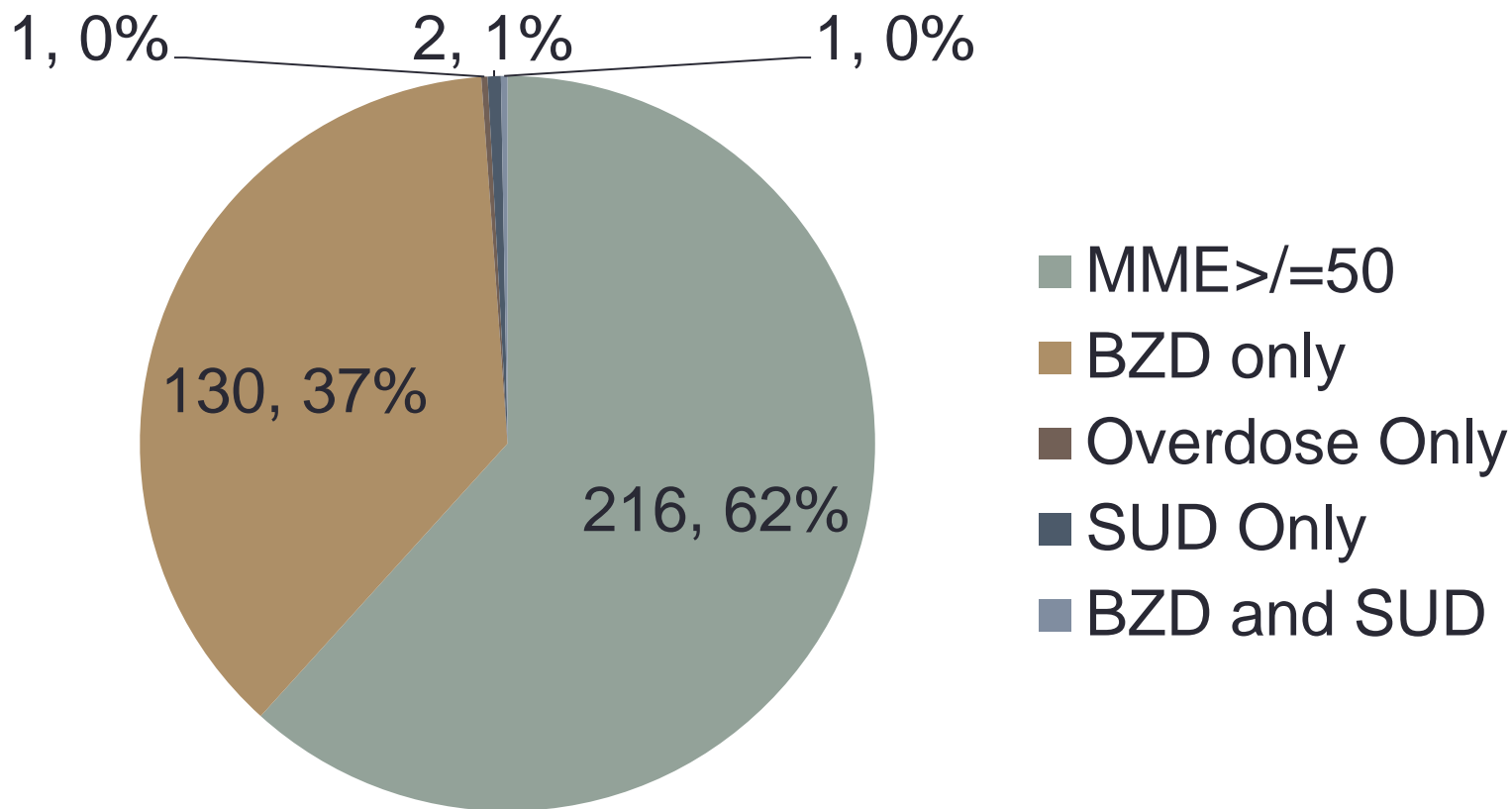
- Pharmacy Resident Project
- Goals:
 - Taper opioid doses down when appropriate
 - Ensure all patients have access to naloxone
 - Help patient if substance use disorder is uncovered
 - Connect patient to resources in the community to help optimize pain management
 - Support primary care physician
 - Screen for HIV, HCV when appropriate
 - Discuss family planning with patients of childbearing age

Naloxone Co-Prescribing Program

- Pharmacy student project
- Criteria for naloxone:
 - ≥ 50 mg MME/day
 - Concomitant benzodiazepine
 - History of overdose or substance use disorder



Indication for Naloxone



MME: Milligram Morphine Equivalent; BZD: Benzodiazepine; SUD: Substance Use Disorder

Opioid Dependence Treatment Program

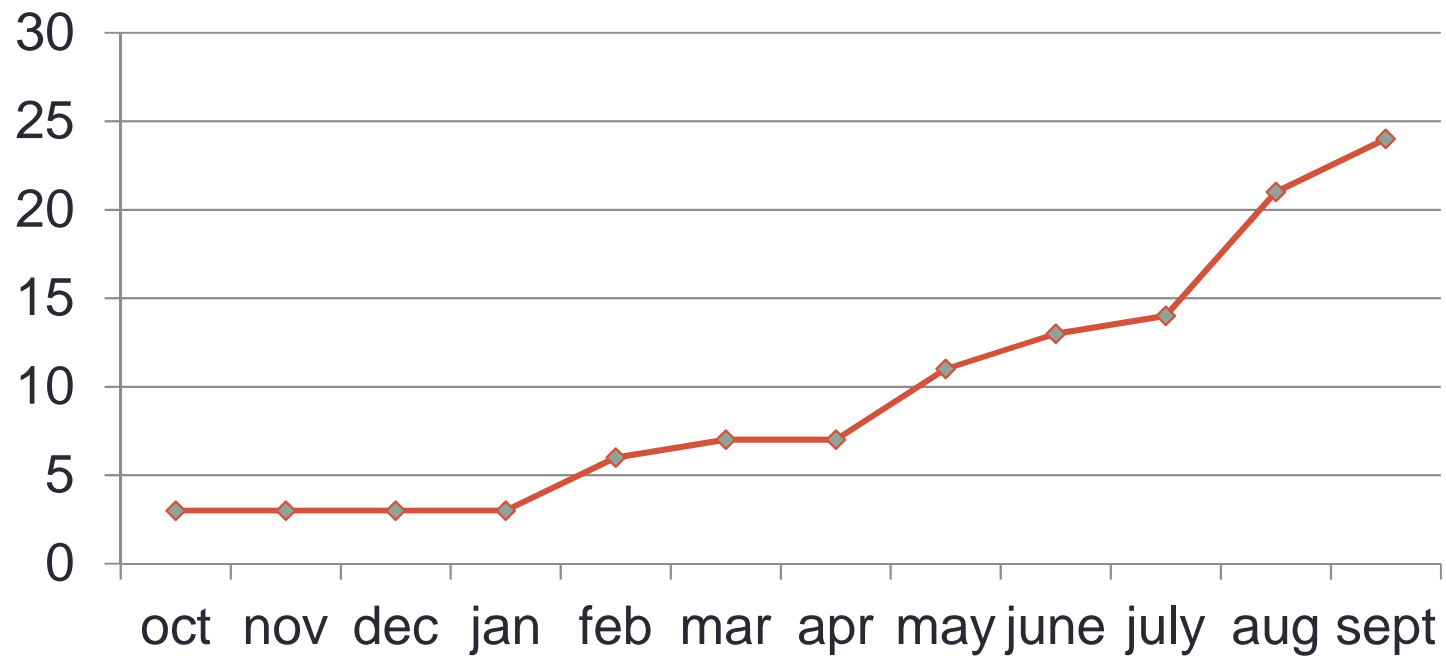
- Identified the need in our area
 - A young mother who is no longer with us...
- Substance use disorder is a chronic, relapsing brain disease
 - 90% of patients who follow abstinence only programs will relapse
 - Medication-assisted treatment with buprenorphine significantly has better treatment outcomes, lower risk of relapse

Program Development

- March-September 2015
- Approval from administration to develop program
- Wrote policies and procedures
- Educated clinical staff, front desk staff, scheduling
- Educated providers
- Held first Buprenorphine Training session

Start Slow, Gain Experience!

ODTP Patients In Year One



Current Impact in the Region

- Family Medicine: 32 patients
- OB GYN: 10 patients
- Appalachian Mountain Community Health Centers: 35 patients

- Two DATA 2000 Training Courses
- 48 physicians received waivers to prescribe

Engaging the Community

- Prevention
 - Schools, community outreach
 - Law enforcement, judicial system
 - Project Lazarus
- Provider Training
 - Emergency Department
 - Primary Care and Specialists
 - Mental Health
 - Dental
 - Community Pharmacy



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2017 Opioid Misuse and Overdose Prevention Summit

Nidhi Sachdeva, Injury Prevention Consultant, Injury and Violence Prevention Branch, NC Division of Public Health

- **Group Brainstorm**
- **Save the Dates: June 27-28, 2017**



Announcements and News

Scott Proescholdbell, Epidemiologist, Injury and Violence Prevention Branch, NC Division of Public Health



Wrap Up and Thank you!

- **To Do**
 - Please complete short PDAAC Satisfaction/Planning Survey
 - Give yourself a high five!
- **Next meeting**
 - **March 10, 2017, 8:30 – 12:30PM** at the NC Division of Public Health, Building 3, Cardinal Room
- **Wishing you a safe and happy holiday season...**
- **THANK YOU!**

