The Opioid Crisis.

Jennifer Stephens DO
Lehigh Valley Health Network, Jennifer.Stephens@lvhn.org

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Research Day 2017:
Crossing the Bridge from Inquiry to Quality

The Opioid Crisis

Jennifer Stephens, DO, FACP
Medical Director, LVPG & LVHN ACO

Goals for this Presentation

- Current State
  - Country / State / Local
- The LVHN model
  - Opioid stewardship
  - Addiction management
- Nursing Considerations
- Open Forum

Current State

- The prescription painkiller and heroin overdose epidemic is the *most significant public health crisis* facing the country
- ~ 50 million people suffer chronic pain
- At least 91 Americans die every day from an opioid overdose

Harris Poll Insights

- Nearly ½ of Americans
  - Have taken rx based opioids
- 31% have personally experience opioid dependency or abuse
  - Themselves, friend, family member
- 77 million Americans personally affected by the opioid epidemic
- 9/2017 http://www.theharrispoll.com/

- 1/10 Americans know someone who has died from opioid addiction

- 47% feel the epidemic can affect them
- 52% feel it is a bigger crisis than what the media portrays

- 62% agree the solution isn't on the streets

- Nearly ½ feel prescription opioids are the SAME as heroin
- 57% feel opioids are AS BIG of a problem as heroin

- 54% feel opioid abusers should be treated the same as heroin users

- 49% **do not know** if opioids and heroin are similar or different

- 11% believe they ARE different

Moment to Pause

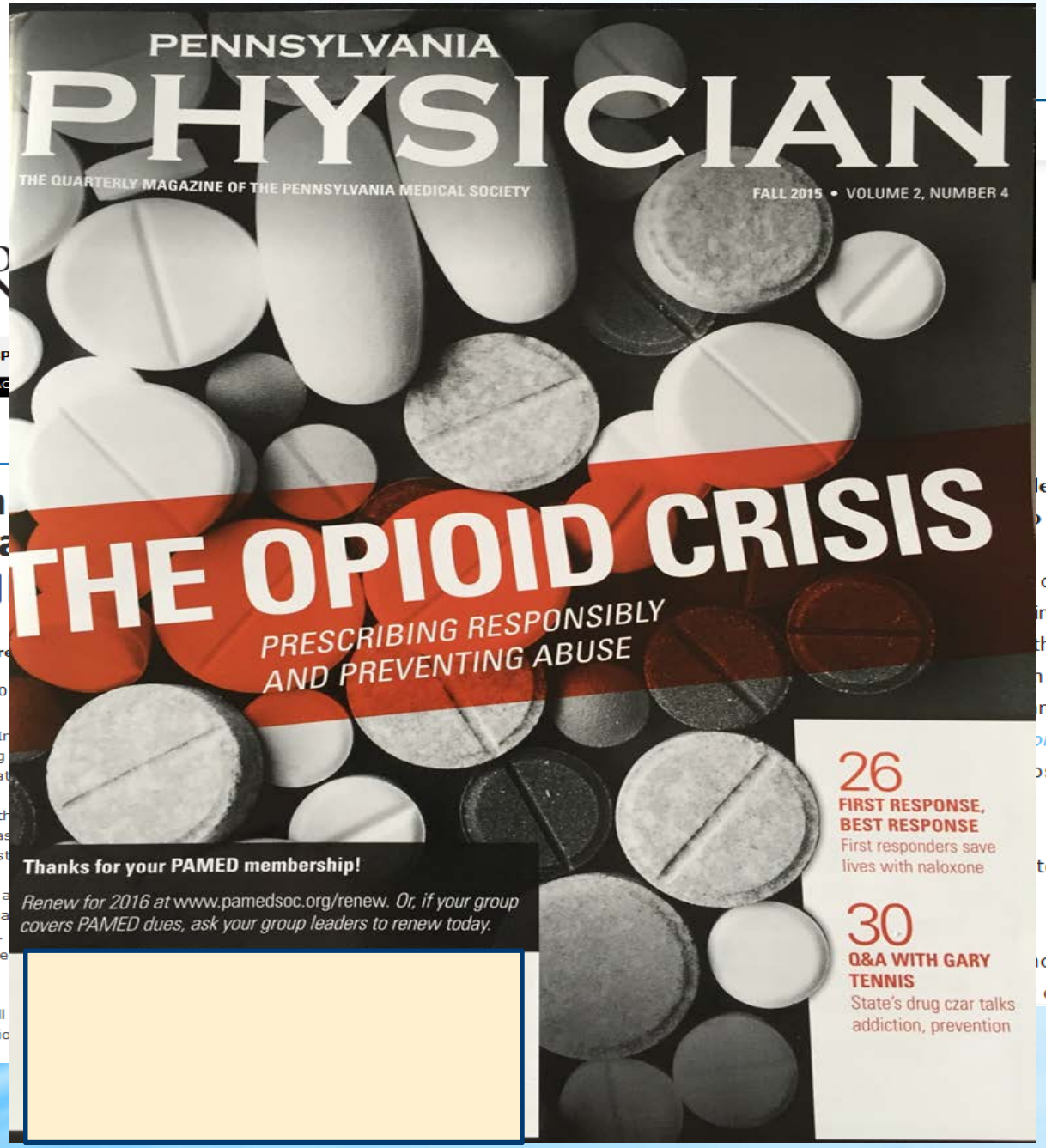
- As a Nurse caregiver, how do you feel about this?
- Have you ever been affected personally?
- What attitudes, knowledge and skills do you bring into your encounters with patients?
  - Consciously or Unconsciously

Chronic Pain – Why is this so difficult?

- Affects nearly 1/3 of all adults
- 1 in 4 primary care visits includes a complaint regarding pain
- Pain is always subjective
  - Self report of pain = single most reliable indicator
  - It is invisible – no clear biomarker

Background

- A uniform pain threshold does not exist
  - Same stimuli = different response
  - Pain tolerance varies among and within
    - Factors include: heredity, energy level, coping skills, and prior experiences with pain
- Patients with chronic pain may be more sensitive to pain and other stimuli



The MILFO
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NEWS NOW

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WASHINGTON – In
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RESOURCES

651

leaths among young
#opioid overdose

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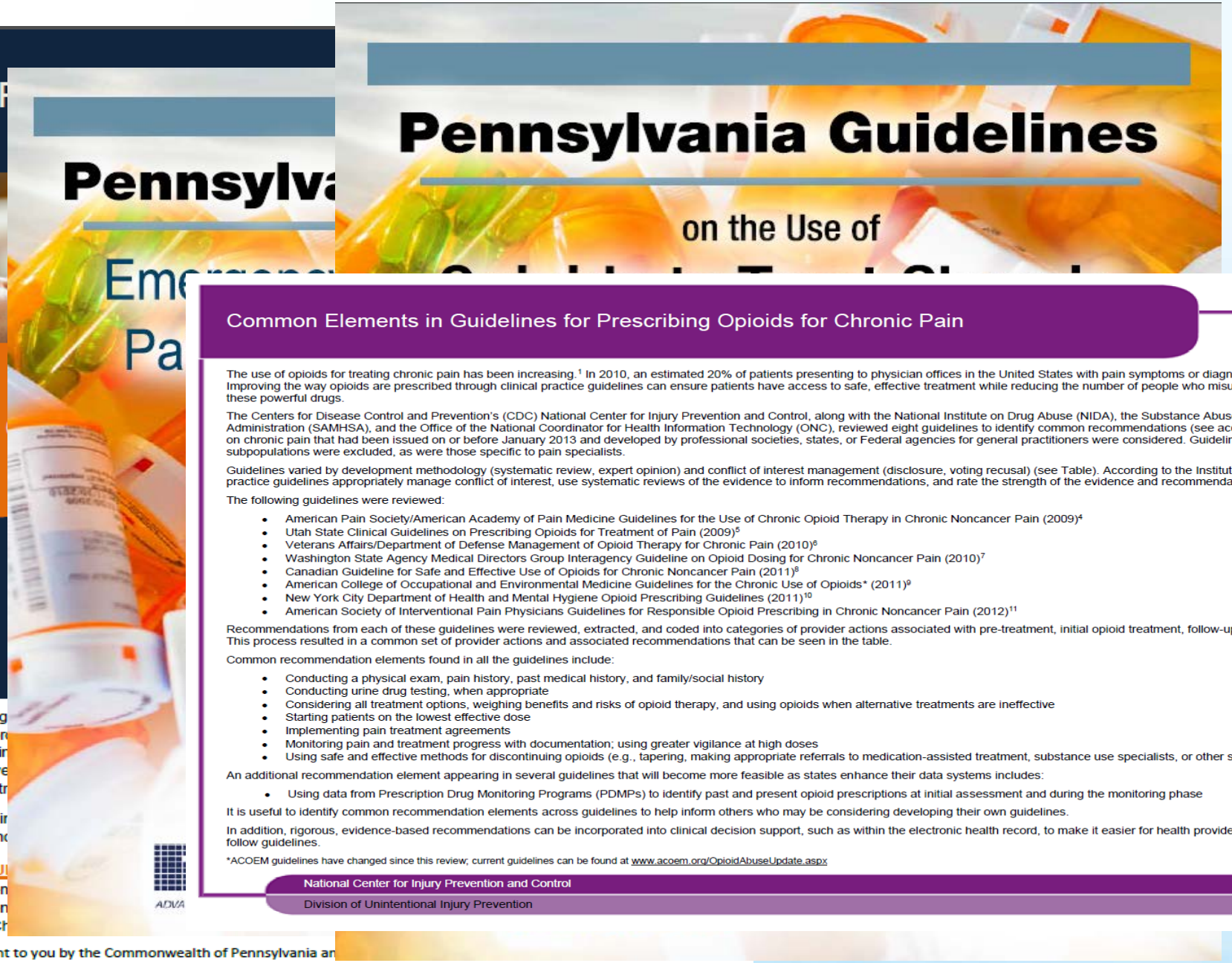


Common Elements in Guidelines for Prescribing Opioids for Chronic Pain

The use of opioids for treating chronic pain has been increasing.[1] In 2010, an estimated 20% of patients presenting to physician offices in the United States with pain symptoms or diagnoses were prescribed opioids.[2] Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safe, effective treatment while reducing the number of people who misuse, abuse or overdose from these powerful drugs.

The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control, along with the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the National Coordinator for Health Information Technology (ONC), reviewed eight guidelines to identify common recommendations (see accompanying Table). Guidelines on chronic pain that had been issued on or before January 2013 and developed by professional societies, states, or Federal agencies for general practitioners were considered. Guidelines for specific conditions or subpopulations were excluded, as were those specific to pain specialists.

Guidelines varied by development methodology (systematic review, expert opinion) and conflict of interest management (disclosure, voting recusal) (see Table). According to the Institute of Medicine, trustworthy clinical practice guidelines appropriately manage conflict of interest, use systematic reviews of the evidence to inform recommendations, and rate the strength of the evidence and recommendations.[3]

The following guidelines were reviewed:

- American Pain Society/American Academy of Pain Medicine Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain (2009)[4]
- Utah State Clinical Guidelines on Prescribing Opioids for Treatment of Pain (2009)[5]
- Veterans Affairs/Department of Defense Management of Opioid Therapy for Chronic Pain (2010)[6]
- Washington State Agency Medical Directors Group Interagency Guideline on Opioid Dosing for Chronic Noncancer Pain (2010)[7]
- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain (2011)[8]
- American College of Occupational and Environmental Medicine Guidelines for the Chronic Use of Opioids* (2011)[9]
- New York City Department of Health and Mental Hygiene Opioid Prescribing Guidelines (2011)[10]
- American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Noncancer Pain (2012)[11]

Recommendations from each of these guidelines were reviewed, extracted, and coded into categories of provider actions associated with pre-treatment, initial opioid treatment, follow-up, and discontinuation phases. This process resulted in a common set of provider actions and associated recommendations that can be seen in the table.

Common recommendation elements found in all the guidelines include:

- Conducting a physical exam, pain history, past medical history, and family/social history
- Conducting urine drug testing, when appropriate
- Considering all treatment options, weighing benefits and risks of opioid therapy, and using opioids when alternative treatments are ineffective
- Starting patients on the lowest effective dose
- Implementing pain treatment agreements
- Monitoring pain and treatment progress with documentation; using greater vigilance at high doses
- Using safe and effective methods for discontinuing opioids (e.g., tapering, making appropriate referrals to medication-assisted treatment, substance use specialists, or other services)

An additional recommendation element appearing in several guidelines that will become more feasible as states enhance their data systems includes:

- Using data from Prescription Drug Monitoring Programs (PDMPs) to identify past and present opioid prescriptions at initial assessment and during the monitoring phase

It is useful to identify common recommendation elements across guidelines to help inform others who may be considering developing their own guidelines.

In addition, rigorous, evidence-based recommendations can be incorporated into clinical decision support, such as within the electronic health record, to make it easier for health providers to follow guidelines.

*ACOEM guidelines have changed since this review; current guidelines can be found at www.acoem.org/OpioidAbuseUpdate.aspx

National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention

Higher Quality – Decreased Death

- Guideline-concordant care evaluation
  - 17K VA pts; 2000 – 2010 timeframe
  - Included:
    - Mental health services, substance abuse treatment, and physical rehabilitation
    - Less mortality within first 6 months of opioid therapy
  - Mental care = 50% less mortality
- Discordant care
  - Benzos / sedatives + opioids = 1.5 x mortality
  - No BH support = 2.5 x mortality

JGIM 2/2016

LVHN Approach

Moving forward, as the leader for healthcare delivery in the Lehigh Valley,

LVHN must have a vision and strategy to heal, comfort and care for our patients caught in this public health crisis.

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.™

What Is Our Role?

#1 – Do No Harm

- Be appropriate stewards of medication and treatment
- Integrated Evaluation
  - Appropriateness
  - Multidisciplinary approach
  - Close monitoring, risk mitigation

LVHN Infrastructure

- Opioid Steering Committee: Dr. Stephens
- Linkage to Treatment: Dr. Cannon & Paige Roth
  - Addiction Liaison (Grant funded) - ED
  - HOST program (Partnership with MARS)
- Opioid Stewardship: Dr. Beauchamp & Dr. McNeill
  - Ambulatory and Inpatient Provider Toolkit & outreach/education
  - Quality assurance and metrics
- OB/GYN/Pediatrics Connections Program: Dr. Esernio-Jenssen, Dr. Donoghue, Dr. Flicker & Dr. Boyle
  - MAT for pregnant women
  - Standardization of management of Neonatal Abstinence Syndrome

2014-16 Project Intervention

- Defining LVHN Standard – Extensive work
  - Toolkit development (online / hard copy)
- Initial Toolkit
  - General Information
  - First visit / Follow up visit
    - Documentation / Clinical pain assessments
    - Risk assessments / UDS
    - Patient documentation / education / CSA / IC
  - Opiate Prescribing Recommendations
    - Start up / Maintenance / Weaning / Drug-Drug risks

Collaborative Multidisciplinary Pain Committee

- Composition:
  - Primary Care, Pain management, Behavioral health, Addiction medicine, Physiatry
- Solicit cases for discussion
- Supportive dialogue re: case
- Documentation support for provider
- Identification of resources needed

- Meets Quarterly – ambulatory predominate

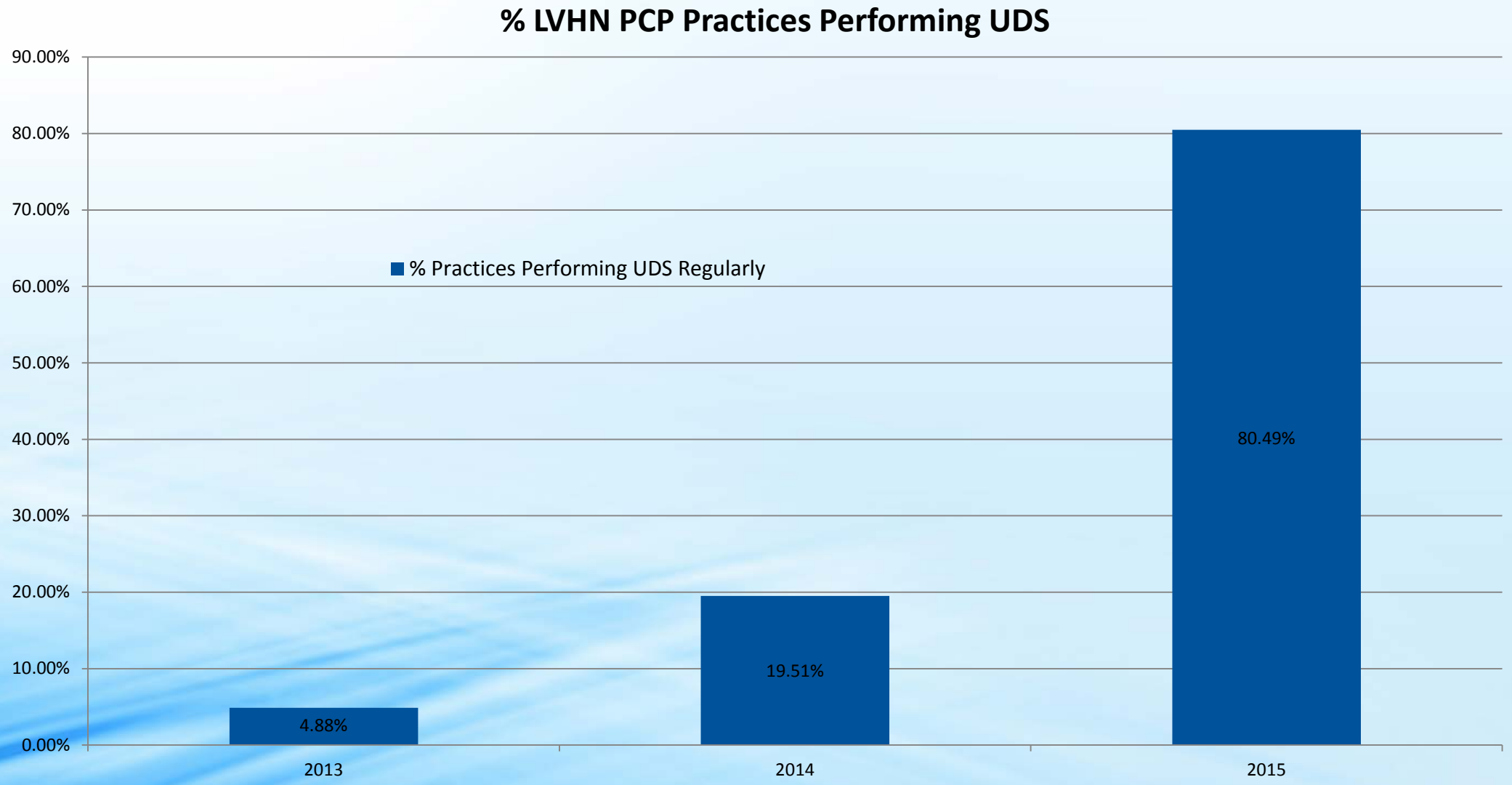
UDS Facilitation

- Vendor Promotion
  - Millennium vendor
    - Reporting model
  - HNL vendor
    - Development of reporting to optimize
    - Development of testing resources
      - NOW - Oral Swab functionality
- Standard UDS Protocol Development

Naloxone Prescribing

- Educational distribution
  - Electronic methods
- Prescribing Resource liaison
  - Link to Addiction Specialist
- Resources posted on Intranet site

Practice Performance Statistics



Opioid Stewardship Committee Membership

Gillian Beauchamp, Co-lead – Inpatient Toolkit
Kevin McNeill, Co-lead – Outpatient Toolkit

Gail Pitsko – Committee Coordinator
Bernadette Maron
Paige Roth
Rovinder Sandhu – Surgical Toolkit Liaison
Shuisen Li – Inpatient Toolkit Liaison
Amanda Flicker – OB/GYN Toolkit Liaison
Debra Esernio-Jenssen – Pediatrics
Sean Stockhausen
Gail Stern
Karen Snowden
Joshua Rosental – data analytics
Michelle Hartzell
Lynn Shay
Michael Lloyd

Opioid Stewardship Subcommittee Goals and Current Activities

- Opioid Toolkit Expansion:
  - Resources for inpatient and outpatient providers caring for acute, sub-acute *and* chronic pain in collaboration – currently under final revision and approval from LVHN Departments
- Data analytics:
  - MME, naloxone prescribing, controlled substance agreements, informed consent, co-prescribing, UDS/OFT, risk assessment tools, pain and functional assessment tools. PDMP registration and query.
- MAT Hub-and Spoke
- Epic Tools:
  - SmartSets, Order panels/Order Sets
- PDMP Workflows, Outreach to practices
- Inpatient pathway & quality metrics (Matthew McCambridge)
- Education & Outreach

Schedule and Provide Opioid Toolkit Outreach Education Sessions

- PHO activities
- Outpatient clinics/offices
- Surgical grand rounds
- Emergency medicine grand rounds
- Medicine grand rounds
- GLIVPA
- Quarterly IM/FM meeting
- APC quarterly meeting
- Family Medicine grand rounds

Opioid Toolkit Updates

- Updated bedside screening: PEG
- Updated laboratory information: saliva testing; workflows
- Inpatient workflow:
  - Risk assessment & mitigation: BPA and order-sets
  - Bedside education regarding side effects, opioid dependence/addiction and related resources
  - Discharge protocols:
    - Bowel regimen
    - Opioid weaning regimen
    - Documentation in EPIC by surgeon regarding expected duration of post-op opioid therapy (for ED and outpatient reference)
- Guidelines for management of specific conditions: chronic abdominal pain, chronic back pain, GYN complaints etc. - for ED, inpatient and outpatient
- Outpatient opioid taper + management of opioid withdrawal
- Medication Disposal
- PDMP guidelines/workflows/resources
- Naloxone prescribing

Develop EPIC Tools to Assist Providers with Opioid Stewardship

- Rapid risk assessment screening tool with easily accessible results
- Quick link to PDMP website – possible integration of PDMP into EPIC
- Implementation of a time stamped 'PDMP accessed' flag
- Quick access to PDF of most recent PDMP results (so PDMP can be checked once per admission and referenced by all subsequent providers)
- Clinical opioid withdrawal scale – incorporation into epic for future use in the administration of Medication Assisted Therapy (MAT) in the ED, ambulatory and inpatient settings

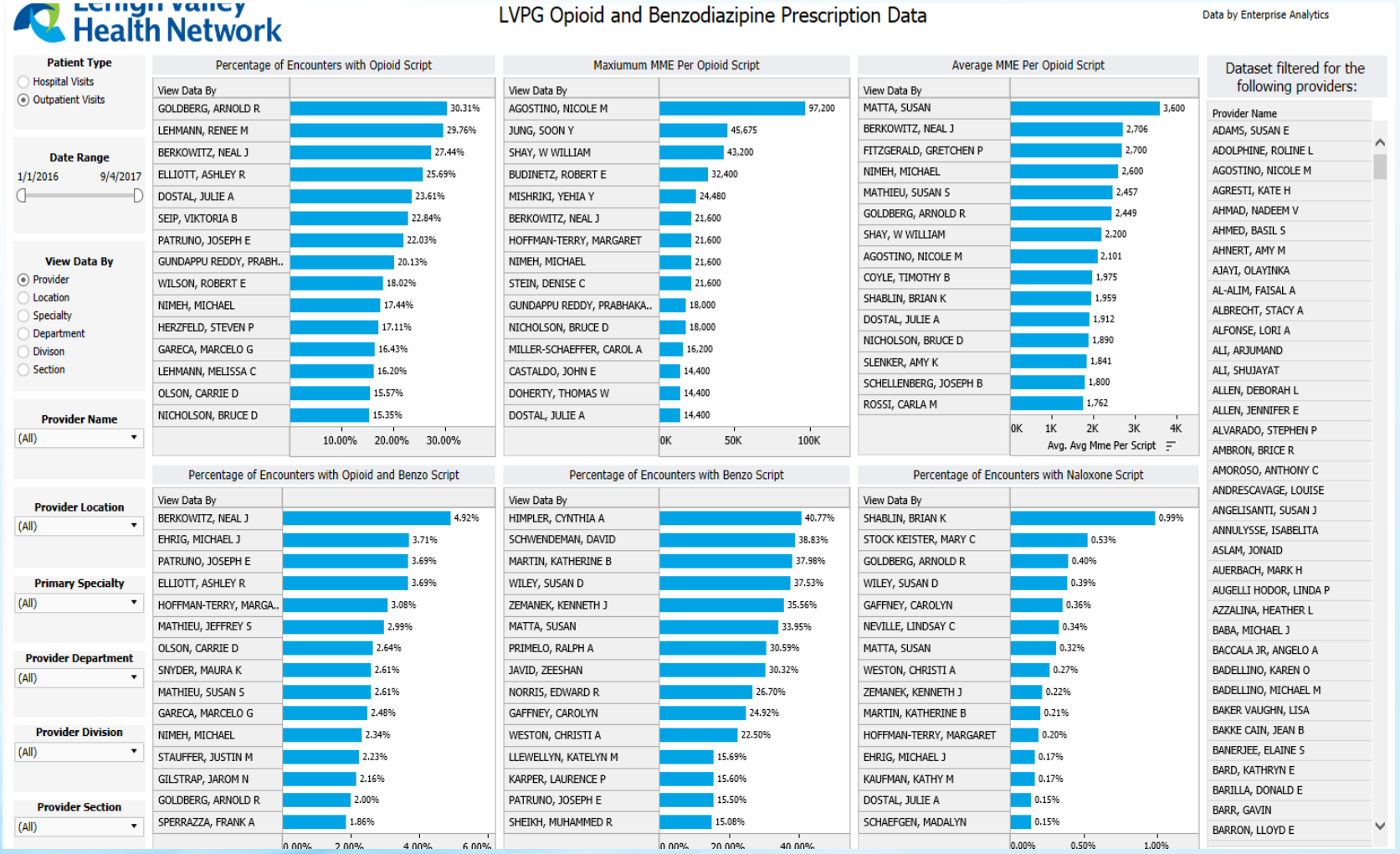
Make It Happen

- Standard Work
- Defined Processes
- Accountability

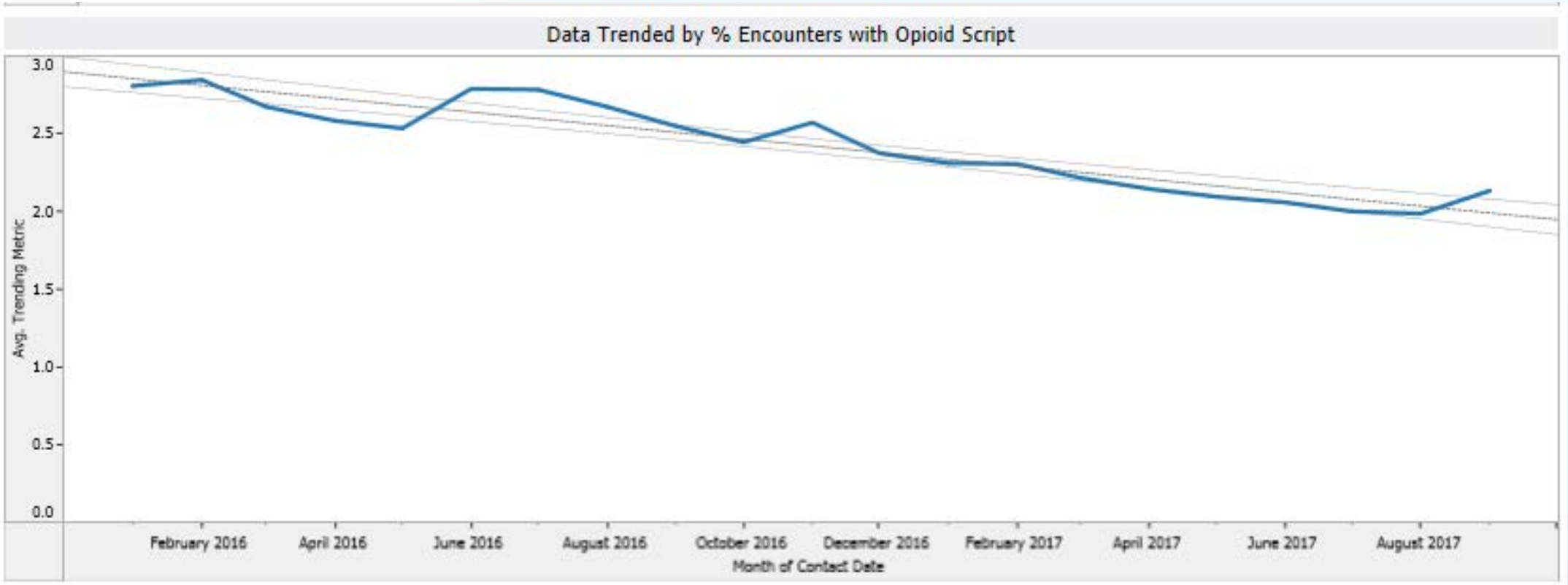
Pain Management Intranet Website
http://painmanagement.content.lvh.com

Opioid / Benzodiazepine Rx Data

- Tracks prescribing trends of LVH physicians
- Tracks encounters with opioid, benzodiazepine, and naloxone scripts
- Looks at both hospital encounters and ambulatory visits, with the ability to view by provider, location, specialty and department



Dashboard is organized to show the top 15 providers, departments, specialty, or location. The end user has the ability to choose how they want the data pivoted. Additional parameters are available for time frame, provider, location, specialty, department, division, and section.



I MAY NOT BE THERE YET,
BUT I'M CLOSER
THAN I WAS YESTERDAY

Approach is 2-Fold

#1 - Opioid Stewardship

- Controlling the prescribing / monitoring
  - Ambulatory, Inpatient, Specialty driven
  - Education / Process / Guidelines / Accountability
  - Across the care spectrum

#2 - Addiction Management / Liaison work

- Supporting the risk / downstream complications

Brain Disease Model of Addiction

- Accepted by:
  - NIDA
  - NIAAA
  - ASAM

The NEW ENGLAND JOURNAL of MEDICINE

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REVIEW ARTICLE

Dan L. Longo, M.D., Editor

Neurobiologic Advances from the Brain Disease Model of Addiction

Nora D. Volkow, M.D., George F. Koob, Ph.D., and A. Thomas McLellan, Ph.D.

N Engl J Med 2016; 374:363-371 | January 28, 2016 | DOI: 10.1056/NEJMra1511480

Share:

Article | References | Citing Articles (54) | Metrics

This article reviews scientific advances in the prevention and treatment of substance-use disorder and related developments in public policy. In the past two decades, research has increasingly

Addiction

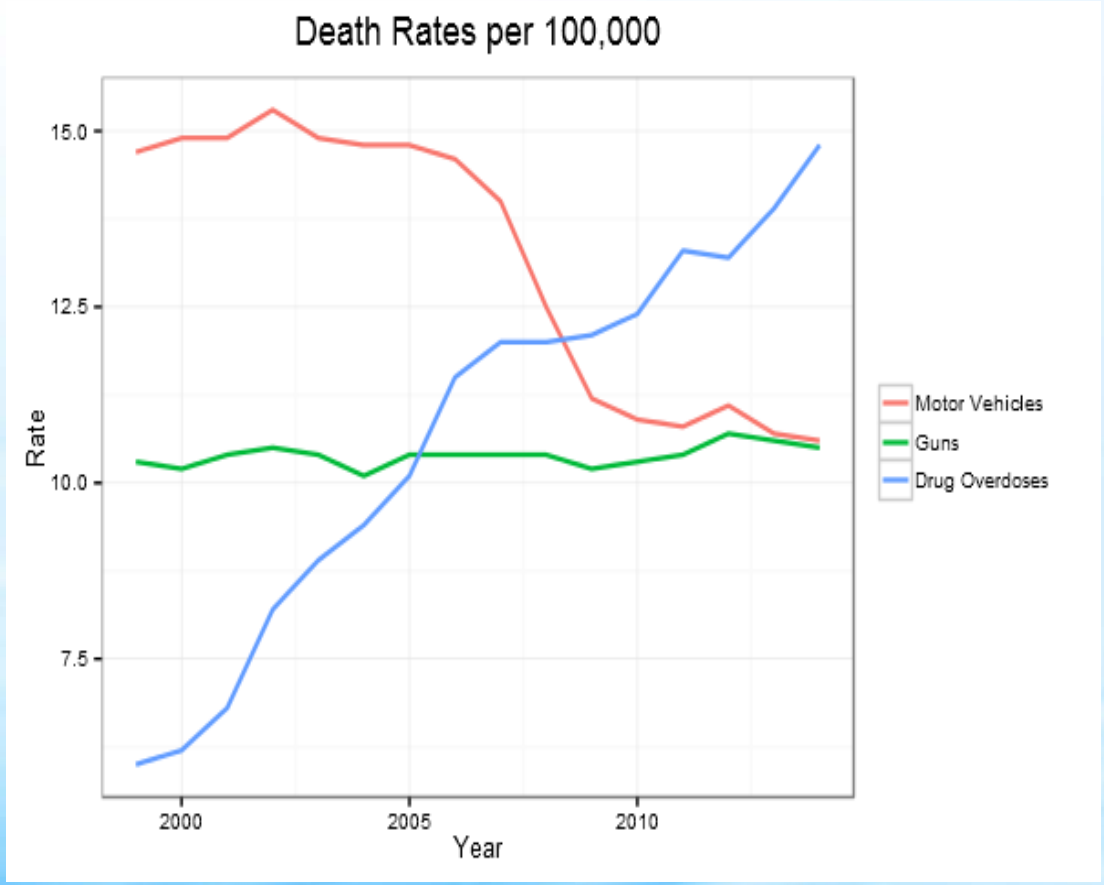
- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations
- Individual pathologically pursuing reward and/or relief by substance use and other behaviors

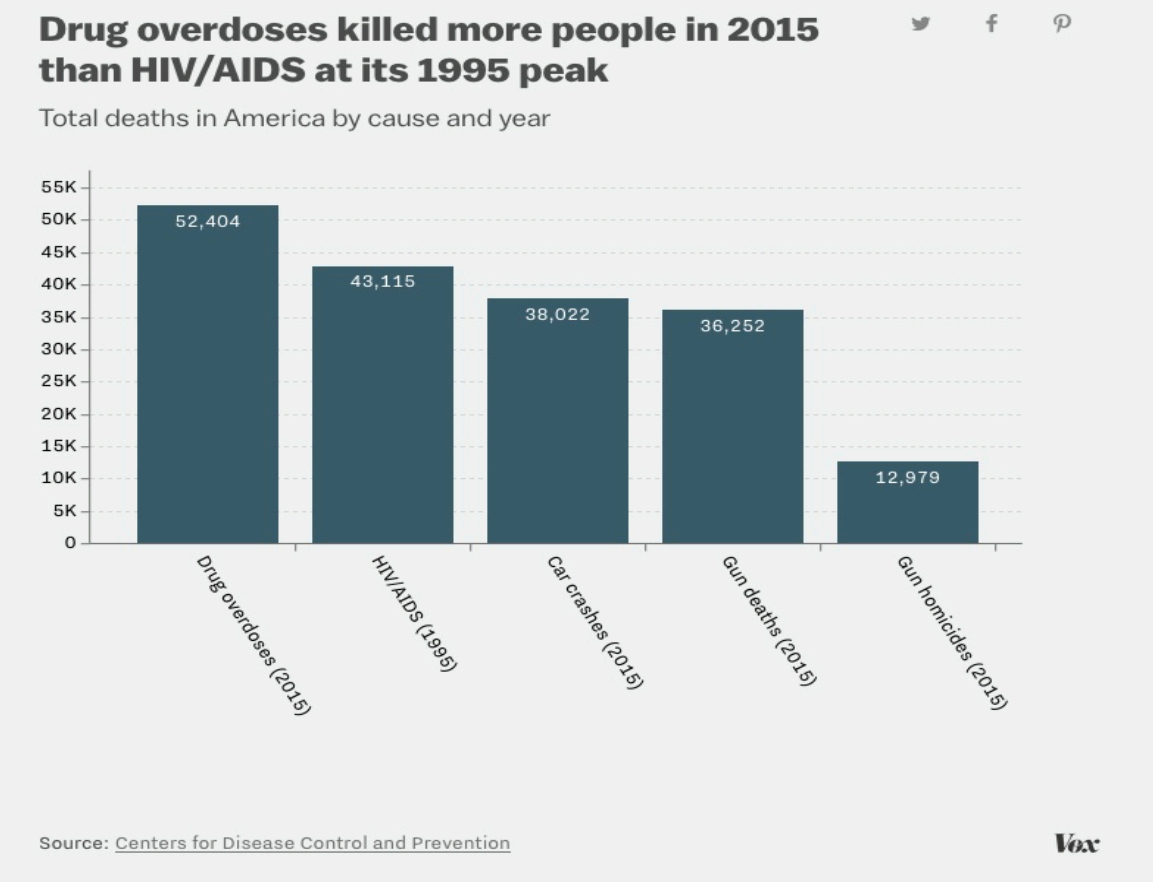
American Society of Addiction Medicine short definition

Addiction

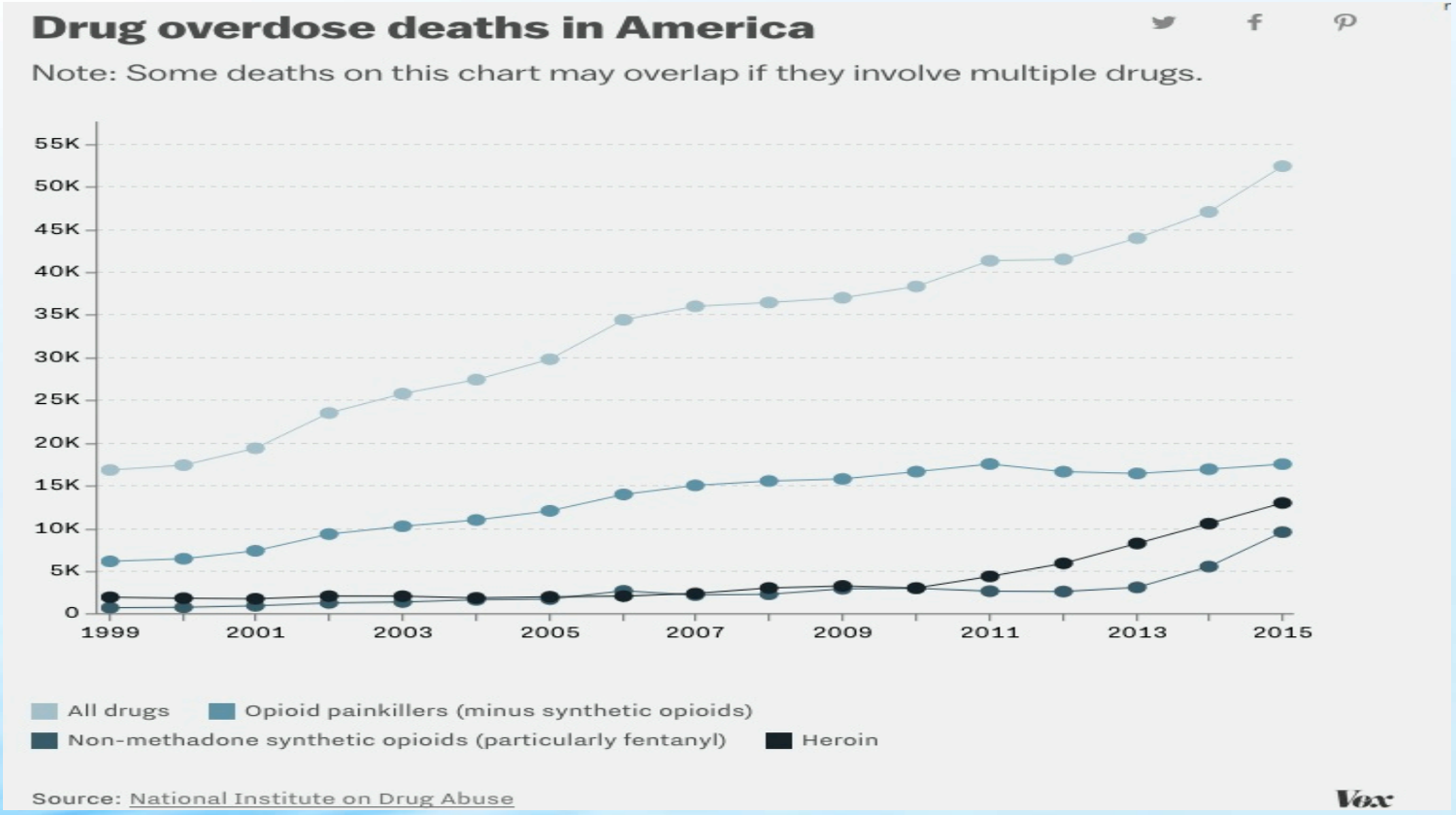
- Inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response
- Like other chronic diseases, often involves cycles of relapse and remission
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death

Disease of Epidemic Proportions

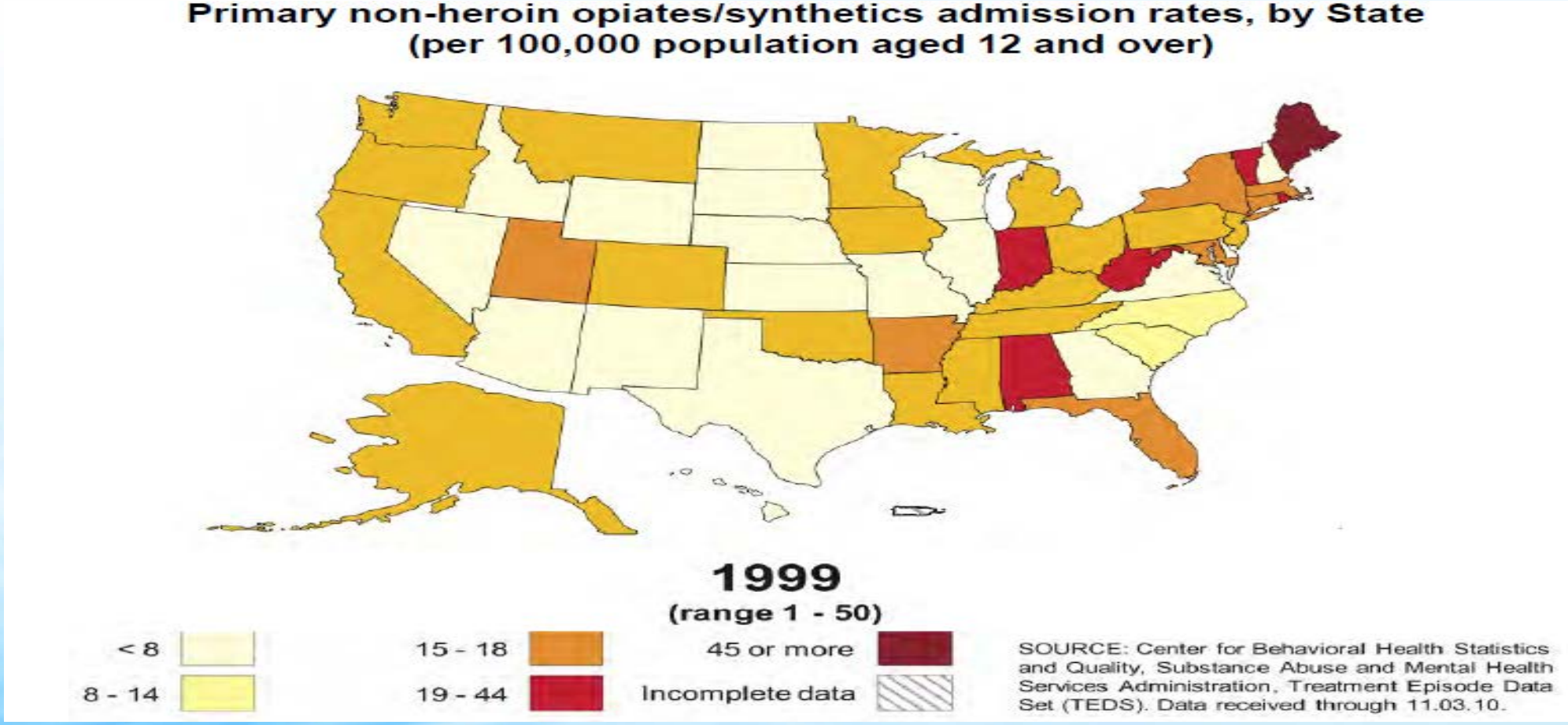




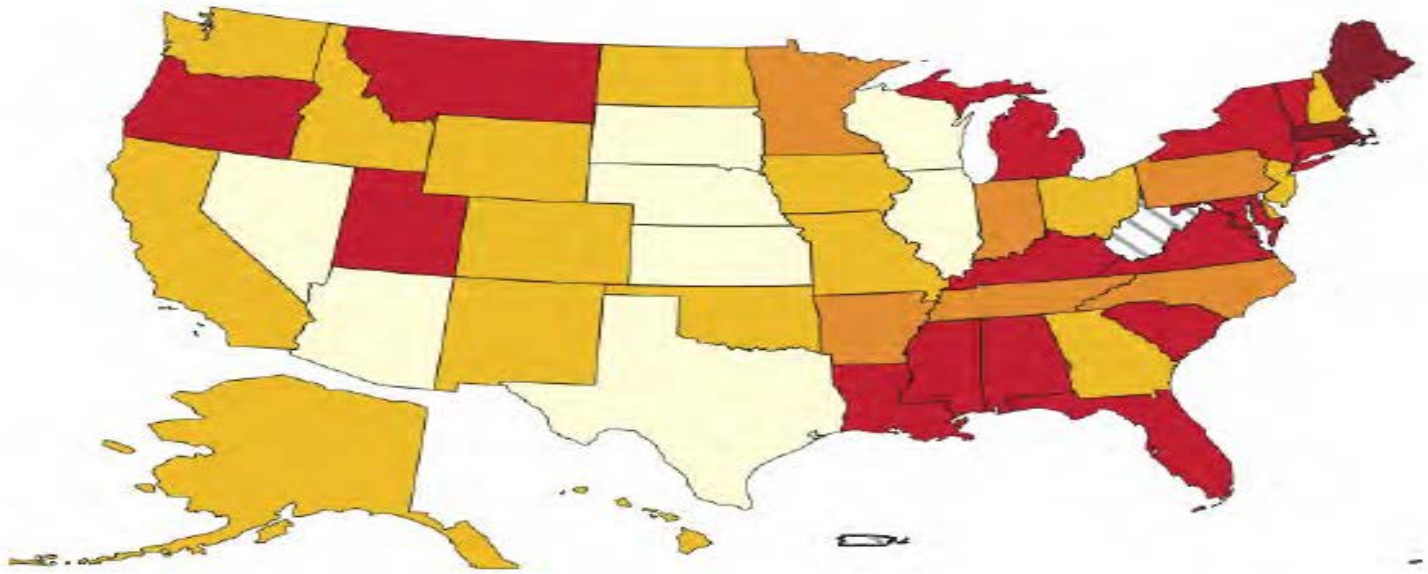
Opioids Involved 60%



Increased Healthcare Burden



Primary non-heroin opiates/synthetics admission rates, by State
(per 100,000 population aged 12 and over)



2001
(range 1 – 71)

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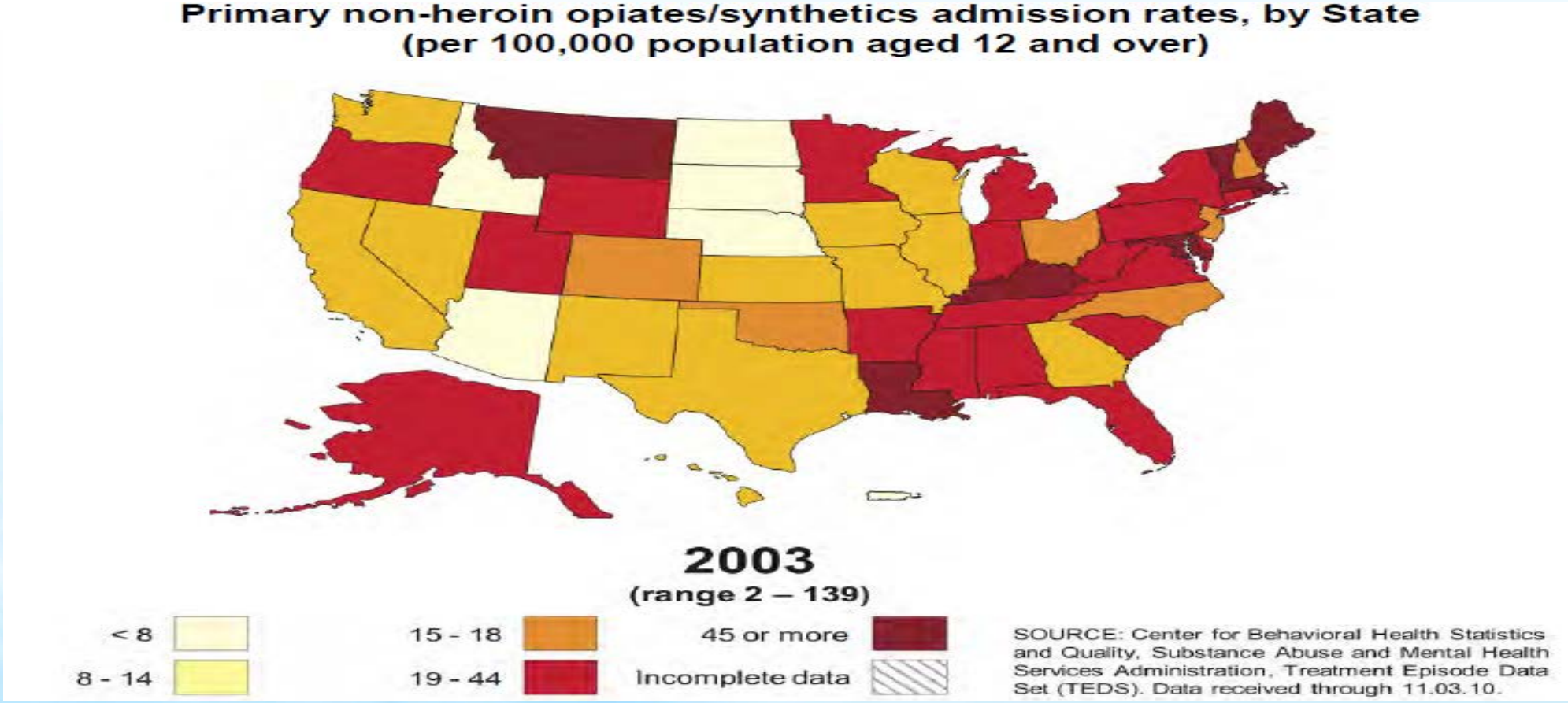
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.


Primary non-heroin opiates/synthetics admission rates, by State
(per 100,000 population aged 12 and over)
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SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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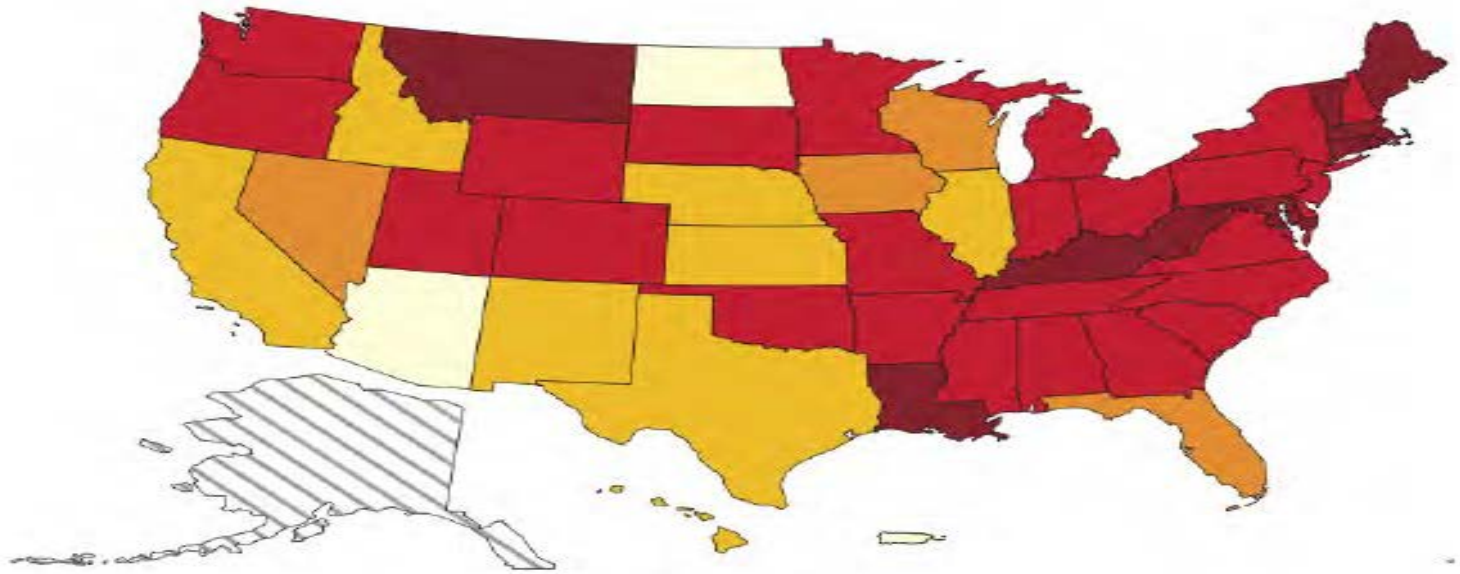
(per 100,000 population aged 12 and over)



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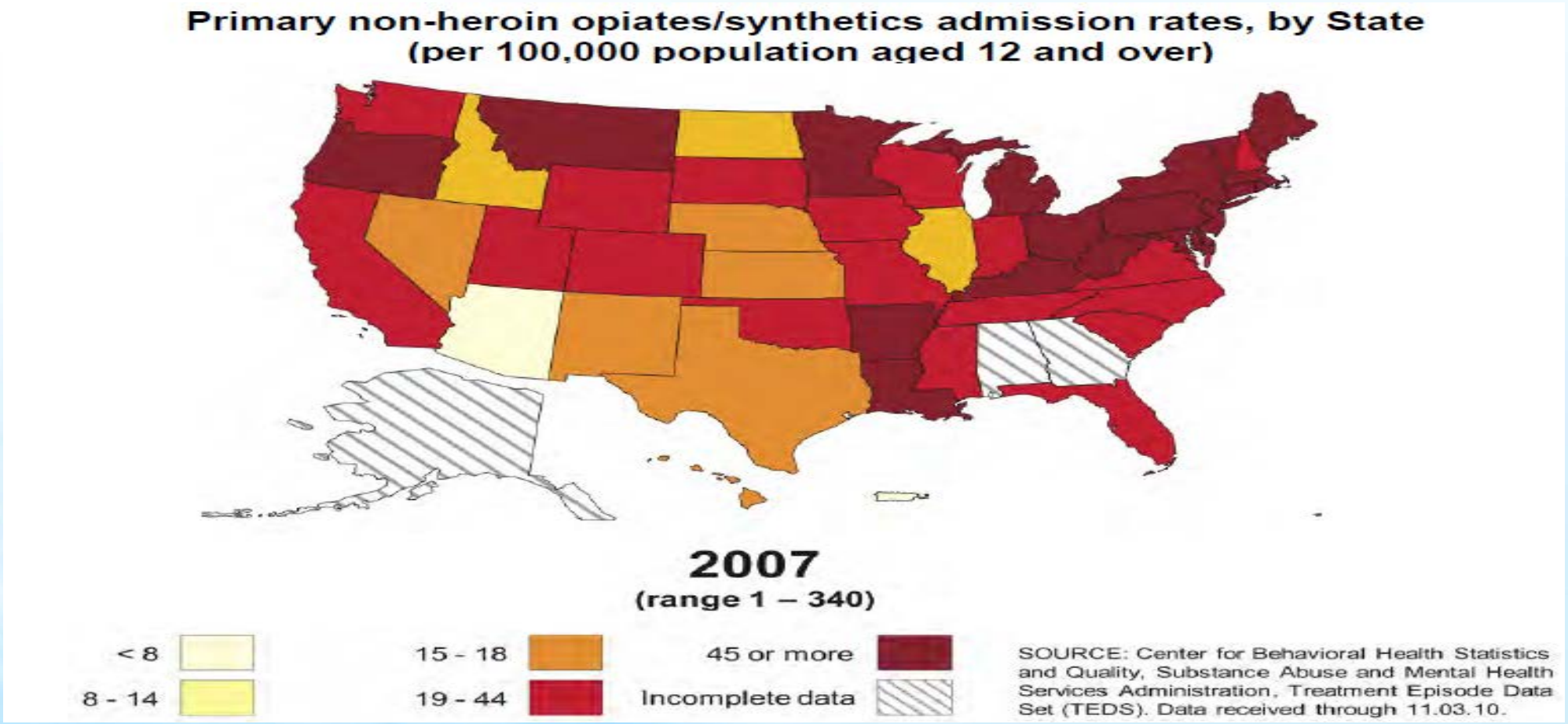
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(per 100,000 population aged 12 and over)
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(range 1 – 340)
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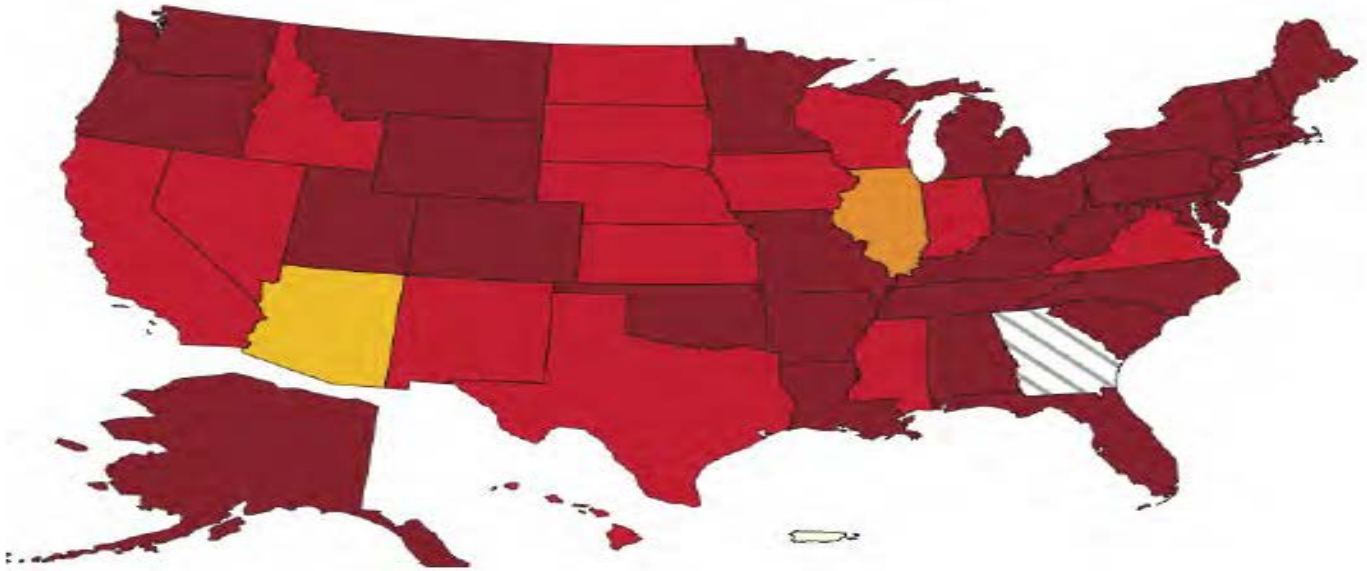
19 - 44
45 or more
Incomplete data
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State
(per 100,000 population aged 12 and over)



2009
(range 1 – 379)

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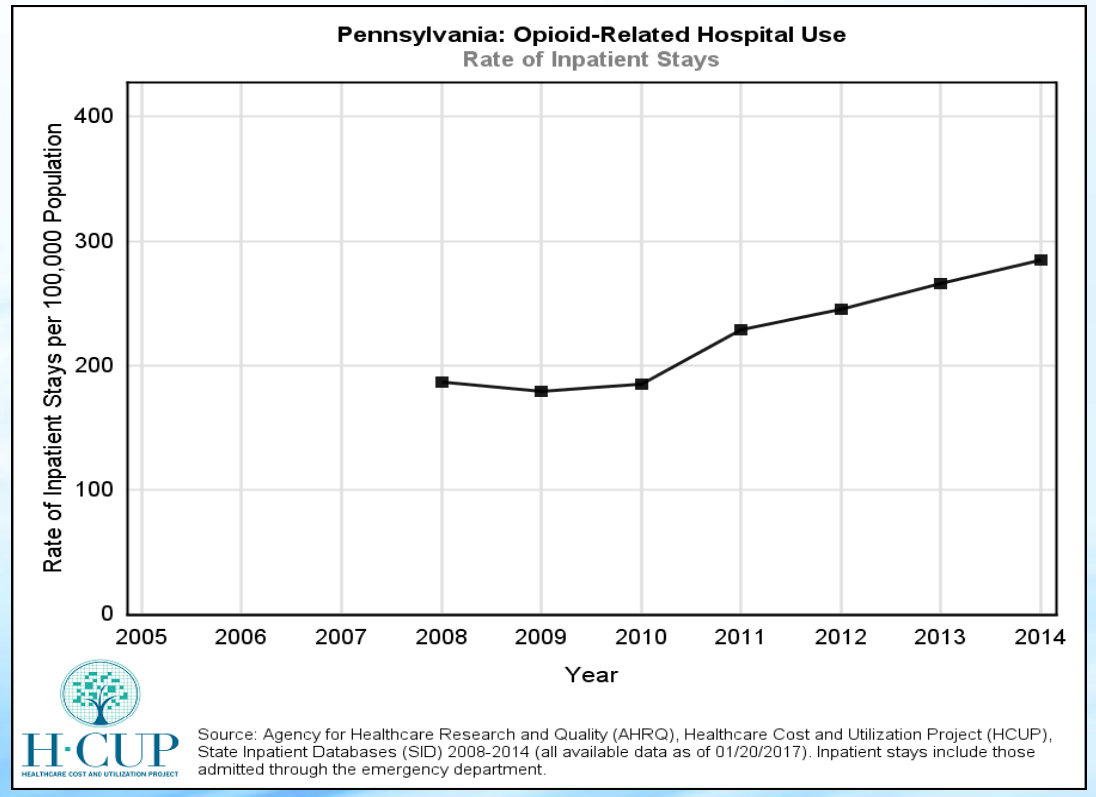
8 - 14	19 - 44	Incomplete data

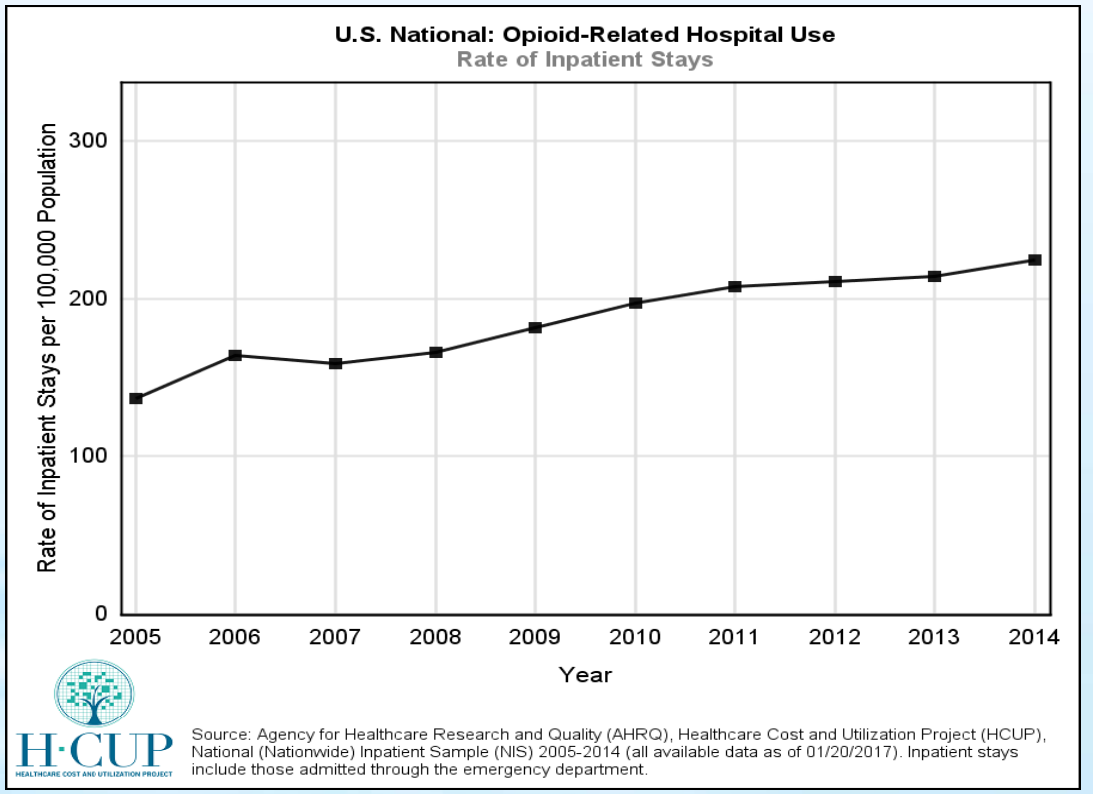
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

PA Higher than US Average

PA



US



Current Situation

- 10 Pennsylvanians died/day from opioid overdose in 2015 (over 3500/year)

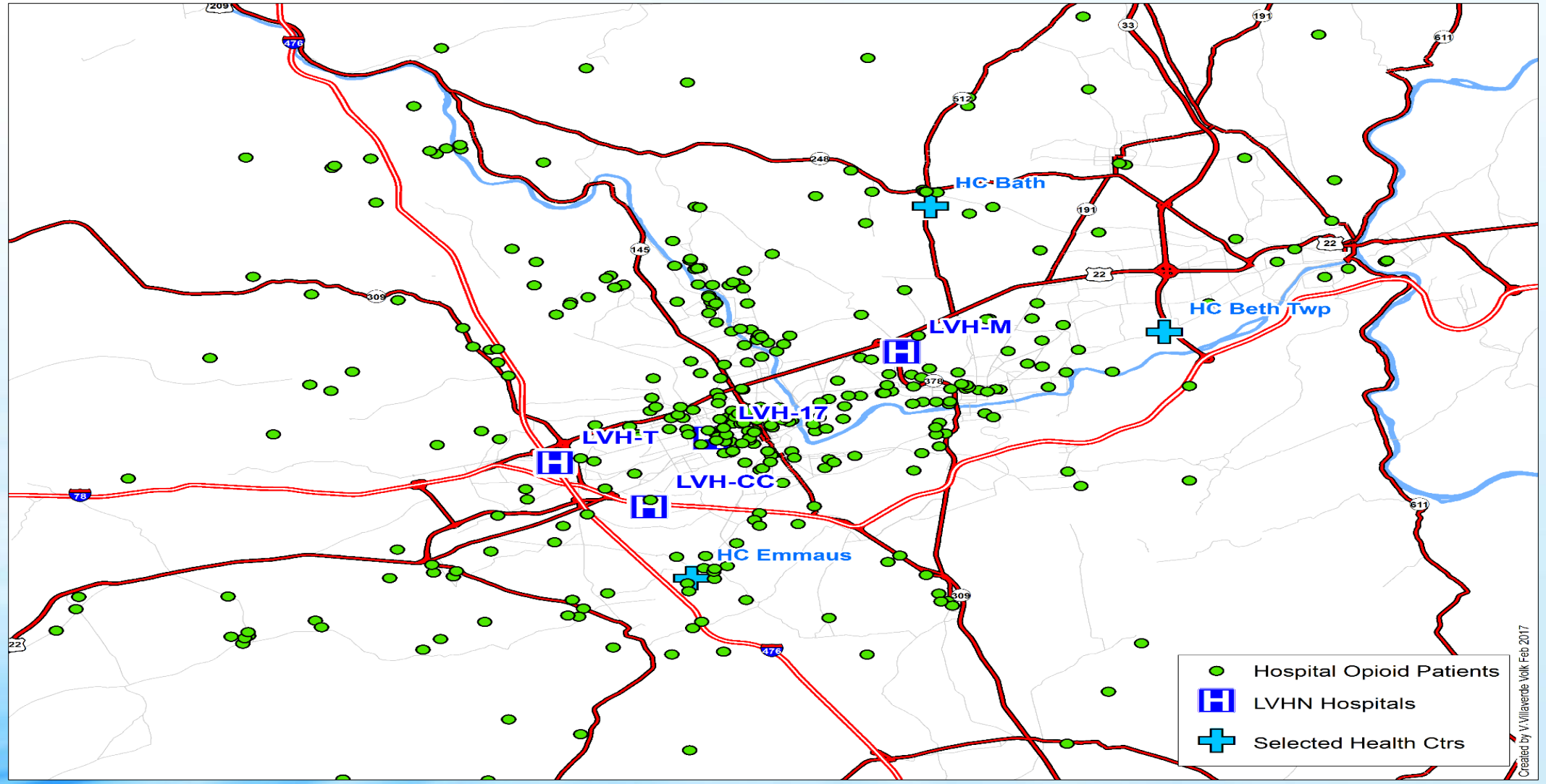
- 1 in 10 patients with OUD receive treatment

	Self Pay Balance	Bad Debt
2016	$826,074	$693,228
2017 to date	$450,913	$92,477

Lehigh County

- 2016 =
  - 157 people died from a drug overdose
- 2017 = Surpassed 2016 already
  - *167 (as of 10/19/17)*
- LVHN treats 125 patients/mo for OUD
  - 75% with ED recidivism within 1 year

17th & Chew Street



CY16 LVHN Opioid Patients

How to Best Treat this Disease?

- Evidence-based Recommendations
  - SBIRT (Screening / Brief Intervention / Referral to Treatment)
    - With warm Hand-Off to treatment facility
  - Medication Assisted Treatment (MAT)
    - Linked to counseling services
  - Multidisciplinary approach
    - Medical
    - Behavioral Health
    - Social Services

Medication Assisted Treatment

- Buprenorphine (suboxone)
  - Partial agonist replacement therapy
  - Reduces cravings and withdrawal symptoms
  - Highly effective in preventing relapse and decreasing death rate by overdose
  - Allows patients to start outpatient program without requiring inpatient detox
    - Reduce strain on overburdened system
    - Make treatment more accessible to more people at the time that they need it
  - Few primary care offices are providing service locally

Medication Assisted Treatment

- Naltrexone (vivitrol)
  - Stops cravings without replacement therapy
  - Monthly injection
  - Requires detox prior to injection
    - Effectively administered from inpatient or residential programs including jail/prison
  - Requires long term follow up
    - Many people leaving treatment programs abandon naltrexone due to gaps in care
  - Few primary care offices provide service locally

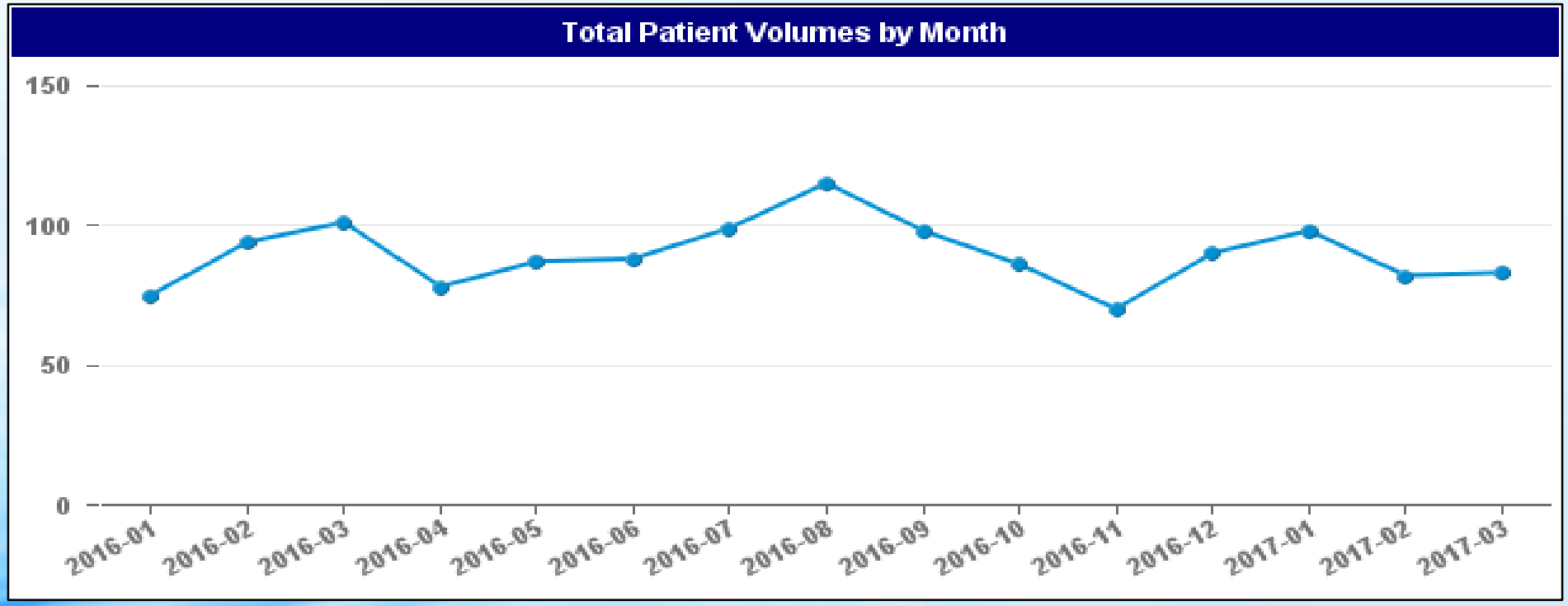
LVHN's Historical Standard

- Passive Referrals
  - No Assessment or warm hand-off
  - D/C with list of phone numbers
  - Puts burden on patient to navigate system
  - Very little MAT practice
  - Siloed rather than collaborative and multidisciplinary

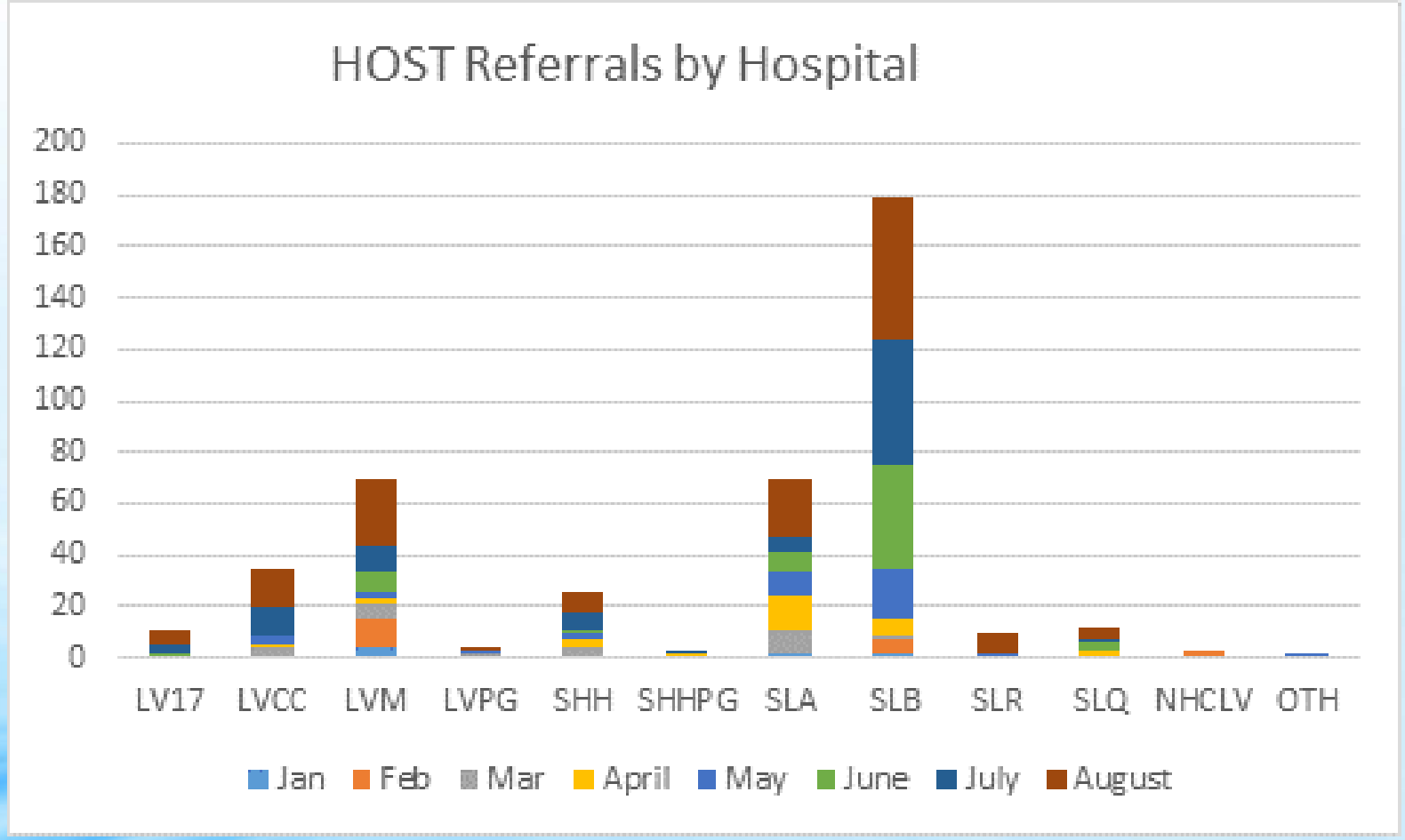
What Are We Seeing?

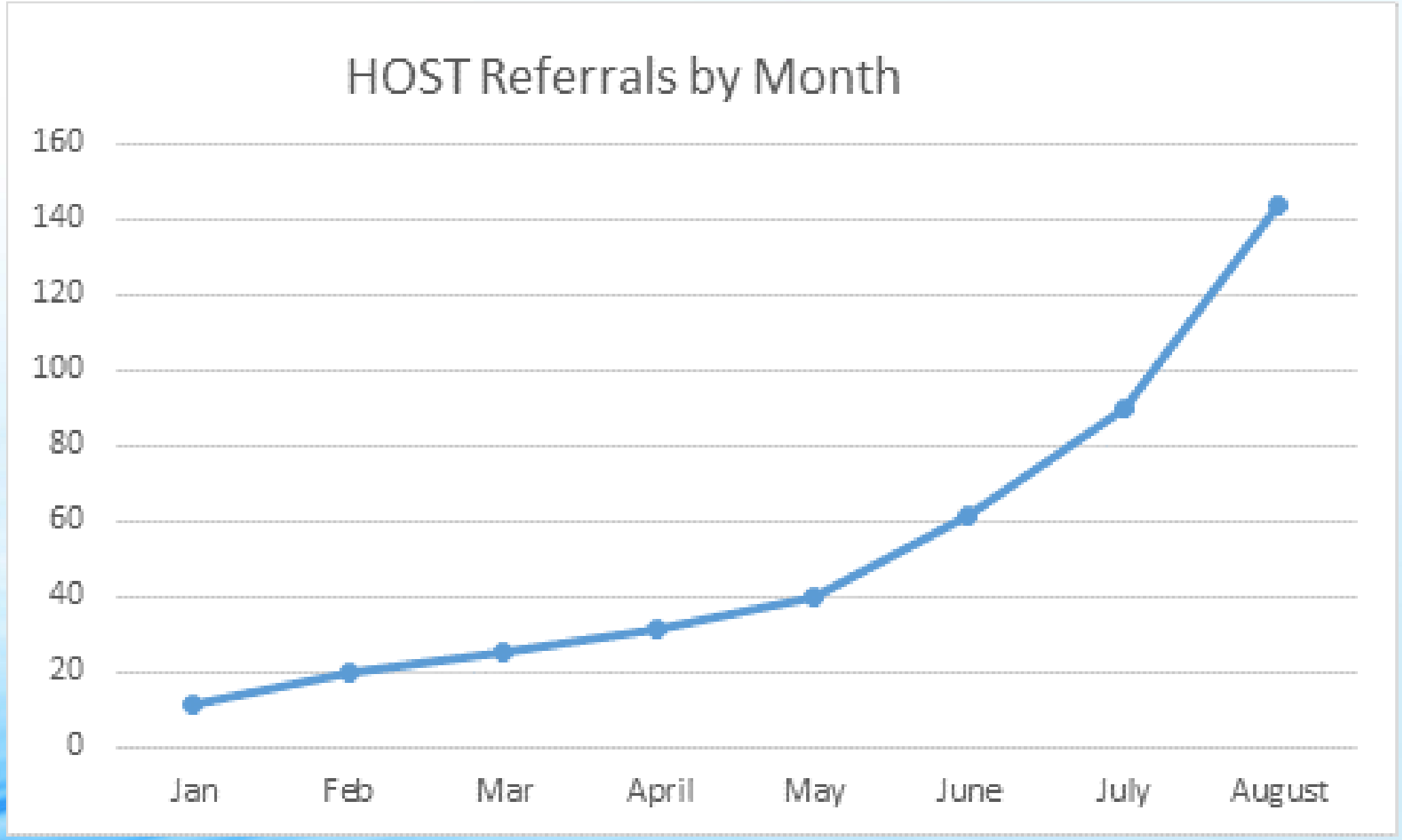
Significant Opportunity for SBIRT and Warm Hand-Off

Number of OUD Patients **Without** PES Evaluation or Assessment and Warm Hand-Off by Addiction Recovery Liaison



Updated Data – Liaison Impact




HOST Referrals by Month
160
140
120
100
80
60
40
20
0
Jan
Feb
Mar
April
May
June
July
August

Elevating the Standard

- Linkage to Treatment Initiative
  - Addiction Recovery Liaison
  - Collaboration with County D&A Providers
    - HOST (Hospital Opioid Support Team) program
  - Break down silos
    - Bringing multiple specialties together to keep focus on unified network-wide approach

Clinical Providers

- DOEHM, Section of Medical Toxicology
  - 4 Board certified toxicologists & certified MAT providers
- Outpatient MAT providers
  - AAO / HCV
  - NHCLV
  - Small # of other providers
- Challenge –
  - Requires tight linkage to BH / CM resourcing

Nursing Role In the Opioid Epidemic

- Many of the ~ 51.4 million people yearly who undergo an inpatient surgical procedure in the US are discharged with a prescription for opioid analgesia
- Research indicates that patients may not sufficiently know how to safely manage their prescription medications
- This lack of knowledge may lead to prescription drug misuse and abuse

CDC recommendations for safe storage and disposal of opioids

- If nurses have the education, they may be able to make a difference with patient education, preventing potential adverse patient events

- Key learning:
  - 19% kept opioid medications out in the open
  - 46% of patients kept unused opioids for extended periods
  - 9% of patients shared pain medications w/ family or friends
  - 39% were unaware opioid could result in a fatal overdose if used by others

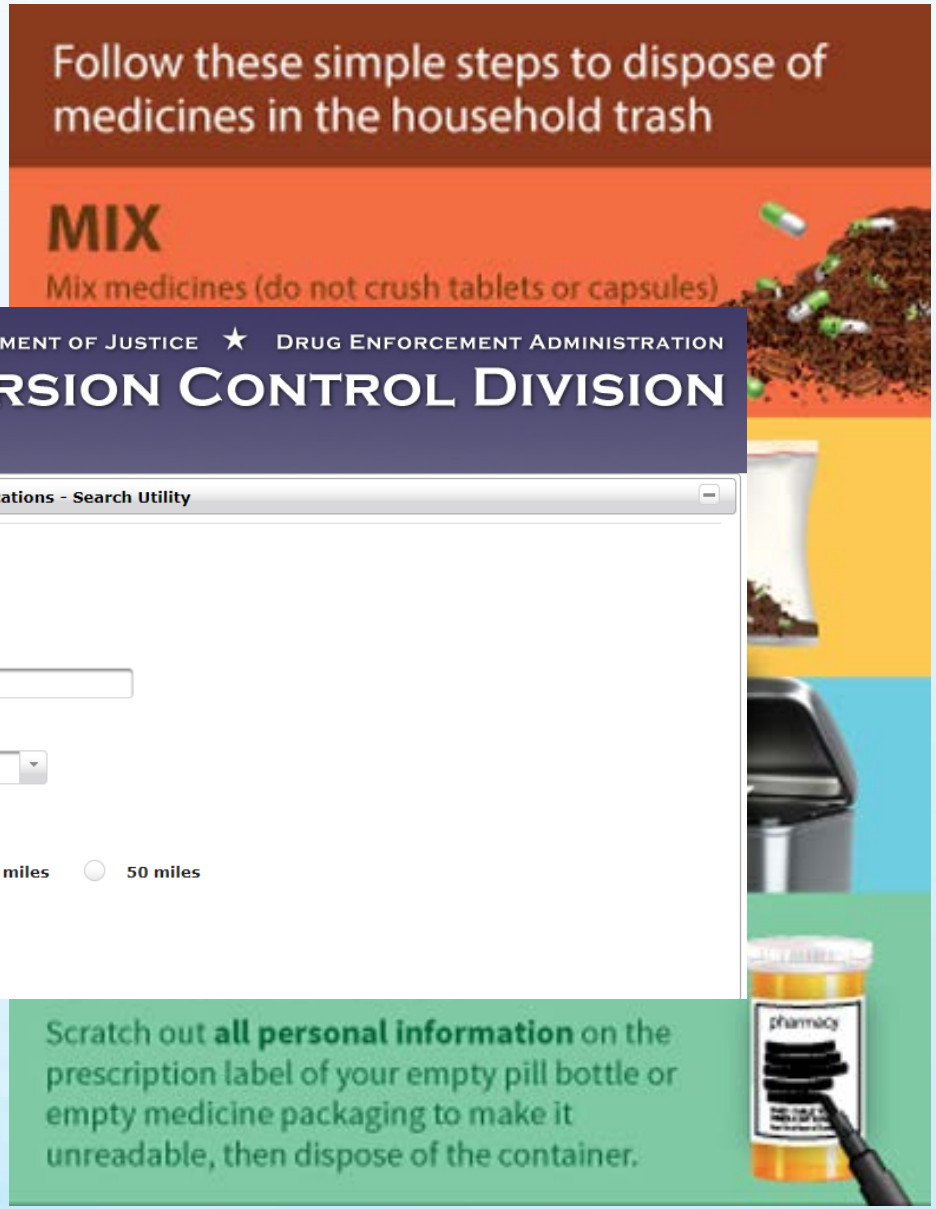
- http://www.ascopost.com/issues/august-10-2017/an-educational-program-for-safe-handling-of-opioids/

Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- ☐ Never take opioids in greater amounts or more often than prescribed.
- ☐ Follow up with your primary health care provider within ____ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- ☐ Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- ☐ Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- ☐ Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- ☐ Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- ☐ If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.


Follow these simple steps to dispose of medicines in the household trash
MIX
Mix medicines (do not crush tablets or capsules)
U.S. Department of Justice ★ Drug Enforcement Administration
Diversion Control Division
Controlled Substance Public Disposal Locations - Search Utility
Zip Code:
-Or-
City:
State:
- Select State -
Search Radius:
5 miles
10 miles
20 miles
50 miles
Search
Scratch out all personal information on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable, then dispose of the container.
pharmacy

Fentanyl Patches

- Blake, 2 yr old boy
  - 2011

Read this important information before using:

Fentanyl Patches

Brought to you by the Institute for Safe Medication Practices

ISMP

[Extra care is needed because fentanyl is a high-alert medicine.]

High-alert medicines have been proven to be safe and effective. But these medicines can cause serious injury if a mistake happens while taking them. This means that it is very important for you to know about this medicine and take it exactly as directed.

Before you use the patches

- ☐ ❶ **Use for long-term chronic pain only.** Fentanyl patches should **ONLY** be used to treat long-term chronic pain by people who have previously taken high doses of prescription pain medicine (opioids) for 7 or more days without relief. Otherwise, the medicine can cause serious breathing problems.
- ☐ ❷ **Use intact patches.** Never cut the patches or use damaged patches (could result in an overdose).
- ☐ ❸ **Avoid broken skin.** Apply patches only on skin without cuts or sores. Do not shave the area before applying the patch.

Storing and discarding the patches

- ☐ ❾ **Store patches safely.** Keep new patches far away from the reach or discovery of children. Do not let children see you apply patches or call them stickers, tattoos, or Band-Aids. This could attract children and encourage them to mimic your actions.
- ☐ ❿ **Dispose of patches safely.** Safely discard used or unneeded patches by folding the sticky sides together and flushing them down the toilet. Some of the medicine remains in each patch even after use, which could harm others who come into contact with it. As a precaution, this medicine is one of just a few medicines that the US Food and Drug Administration says must be flushed down the toilet for disposal rather than discarded in the trash.

STOP

Do not use fentanyl patches to treat short-term pain after surgery!

Fentanyl patches should **ONLY** be used by people with long-term chronic pain who have been taking high doses of prescription pain medicine (opioids) for 7 or more days without relief. Otherwise, the medicine can cause you to breathe too slowly or stop breathing.

ISMP © 2012

For more information to help keep you safe, visit: www.consumermedsafety.org

https://www.pharmacist.com/proper-disposal-fentanyl-patches-can-save-lives-0

Nursing Role In the Opioid Epidemic

- Patient's knowledge of safe opioid use increased significantly following nurse-focused opioid education

Key Nurse Learning

Addiction Risk Factors

- **Genetic predisposition**
- **Psychological factors**
  - (e.g., stress, personality traits like high impulsivity or sensation seeking, depression, anxiety, eating disorders, personality and other psychiatric disorders)
- **Environmental influences**
  - (e.g., exposure to physical, sexual, or emotional abuse or trauma, substance use or addiction in the family or among peers, access to an addictive substance; exposure to popular culture references that encourage substance use)
- **Starting alcohol, nicotine or other drug use at an early age**

The more risk factors present, the greater the chance

Key Nurse Learning

Risk Factors for Death

- Middle-aged and White
- Concomitant benzodiazepine usage
- More likely to have chronic or acute pain, substance use disorders, and other psychiatric diagnoses
- Less likely to have cancer

- Higher maximum daily doses compared with lower maximum daily doses (100 mg/day or more vs. 1 mg to less than 20 mg/day) across all subgroups examined, including those with cancer, substance use disorders, chronic and acute pain

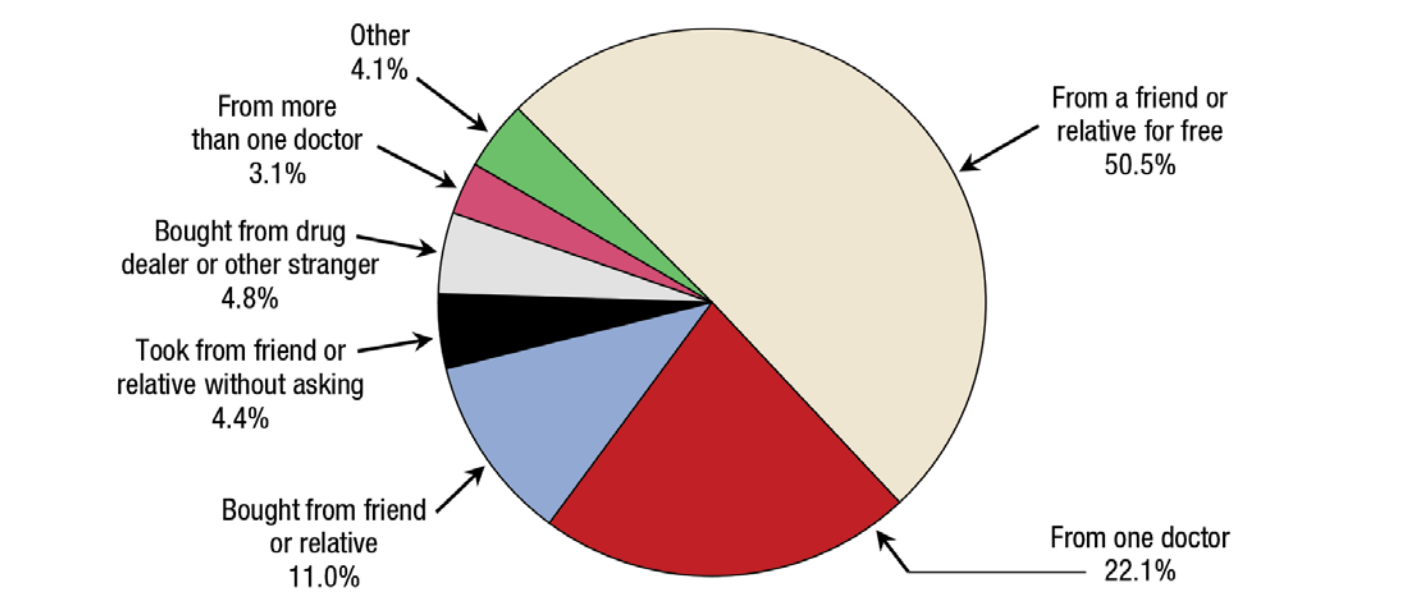
- Having PRN opioids ONLY compared with having regularly scheduled opioids was associated with an increase in risk of opioid overdose among patients with cancer

- Receiving both as-needed and regularly scheduled doses was not associated with overdose risk after adjustment.

http://www.uofmhealth.org/News/opioid_psychiatry_0405

Key Nurse Learning

- How non-medical users obtain opioids:



https://www.samhsa.gov/data/sites/default/files/report_2686/ShortReport-2686.html

Key Nurse Learning

- Defining opioid tolerance
  - A phenomenon that occurs when an individual over time requires greater amounts of a drug to continue to obtain the original degree of its desired, therapeutic effect
  - Tolerance occurs in everyone – independent of ever becoming addicted to opioids
  - It is a physiological function and will occur as long as one takes the medication on a regular or daily basis for an extended period of time
  - The significance of this = for many, if not most people, opioid pain medications do not work well indefinitely

http://www.nursinglibrary.org/vhl/bitstream/10755/601758/1/3_Costello_M_p72008_1.pdf

Ethical Dilemma

- Should the field of chronic pain management continue a wide-scale practice of long-term opioid management for chronic pain patients who are neither elderly nor terminal when most of those patients will become tolerant to high doses of opioids long before they ever become elderly or terminal?
- Should we continue to privilege the present relief of chronic pain over painful acute or terminal conditions of the future?

Nursing Influence

- Profoundly impact patient education
- Opportunity to influence / prevent bad outcomes

- Connecting to LVHN resources
- Developing your own skills
- Evaluating your attitudes to this population

Summary Slide

- Current health crisis – affects so many
- Difficult to treat an invisible complaint
- Multiple guidelines now exist
- LVHN developed model of:
  - Opioid stewardship / Linkage to Addiction treatment
  - Education / Epic updates / Data – Opportunities
  - Resources are around to support your staff / patients
  - Warm handoffs are the key for all approaches
- Nursing Role
  - Clinical management – Patient education – Disposal
  - Understand addiction RF / overdose RF
  - Understand opioid tolerance / challenges

- Continue to educate yourself / others – you make a difference!

Thank you