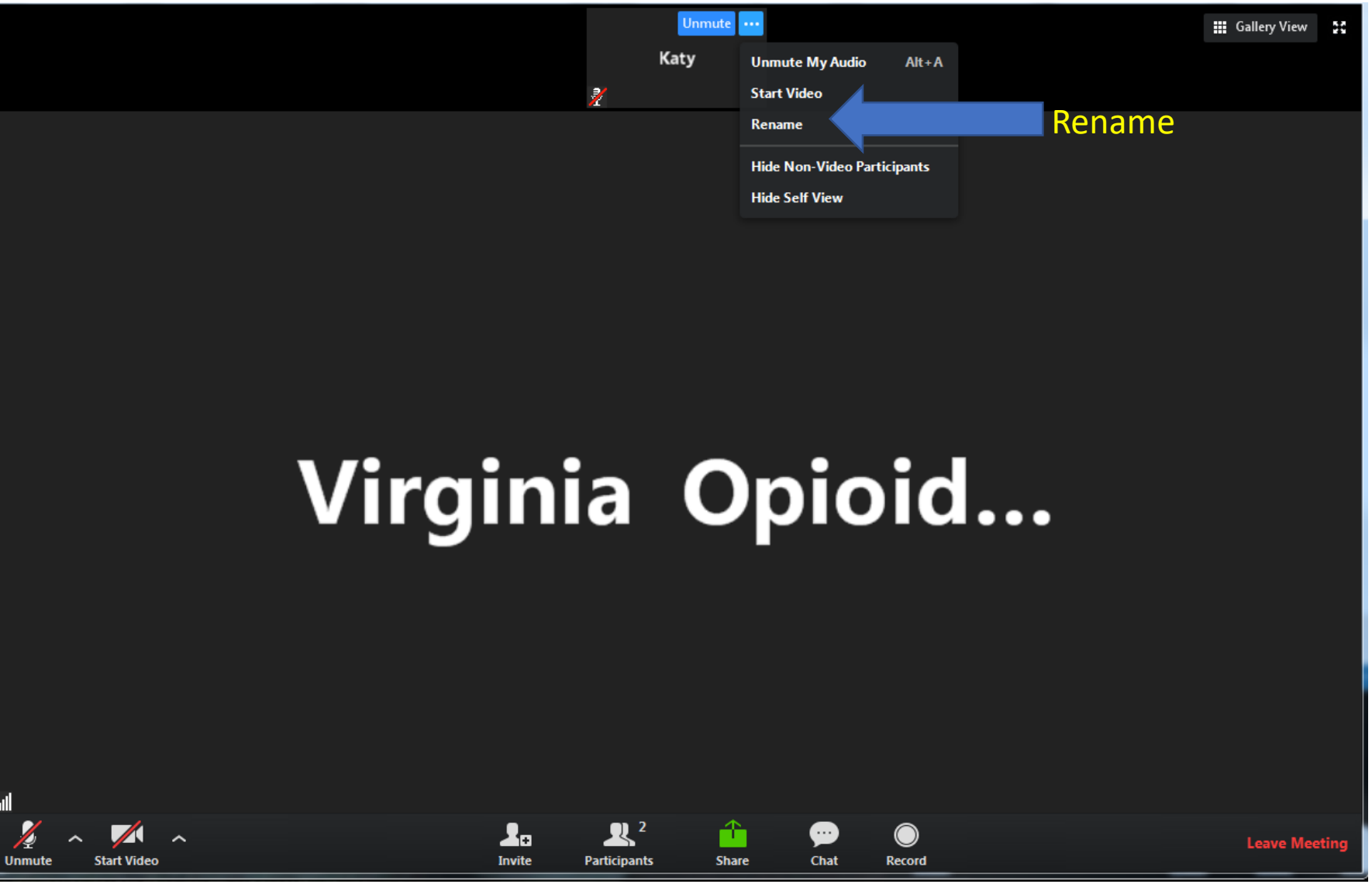
Virginia Opioid Addiction ECHO* Clinic

August 16, 2019

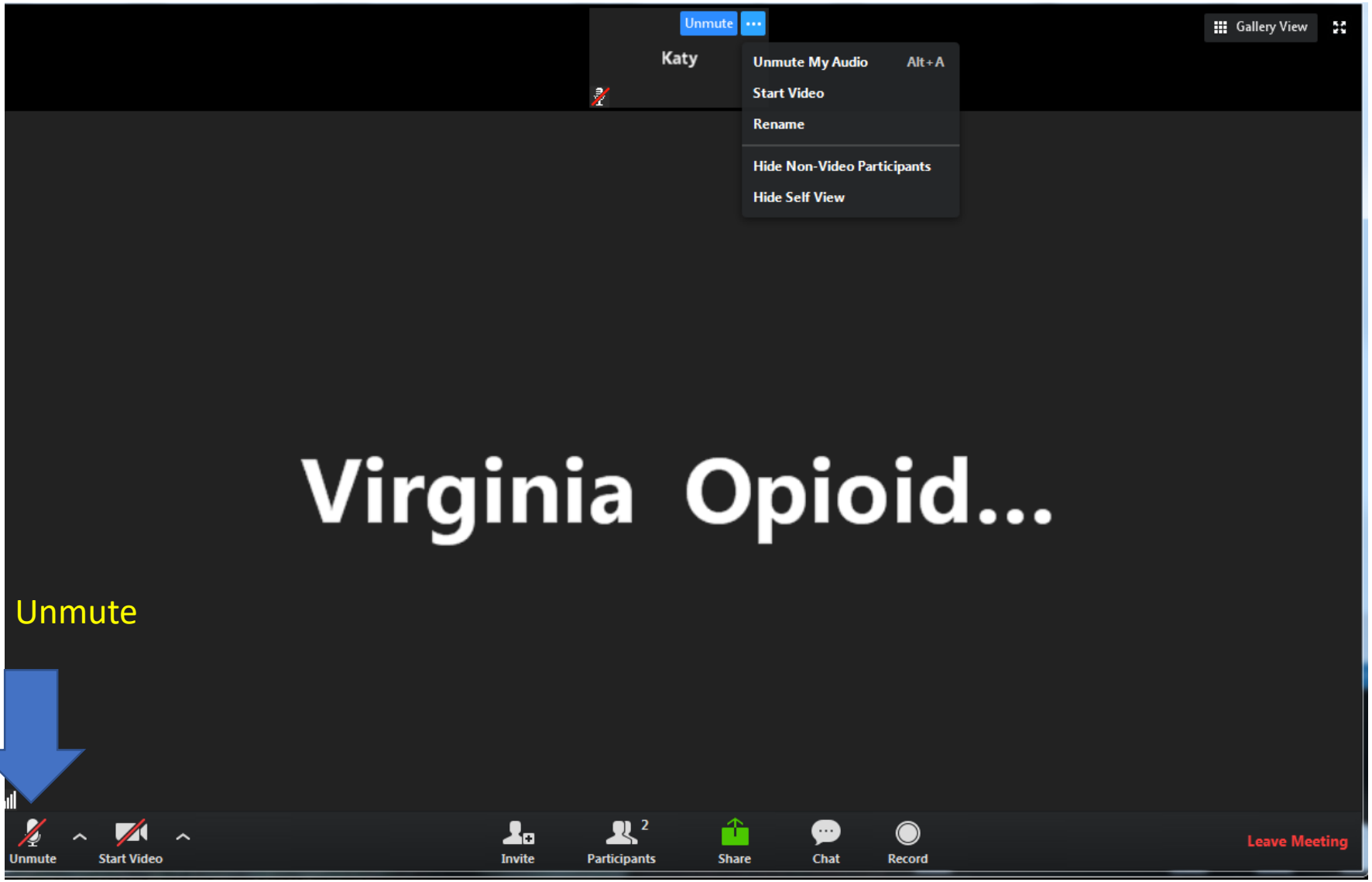
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



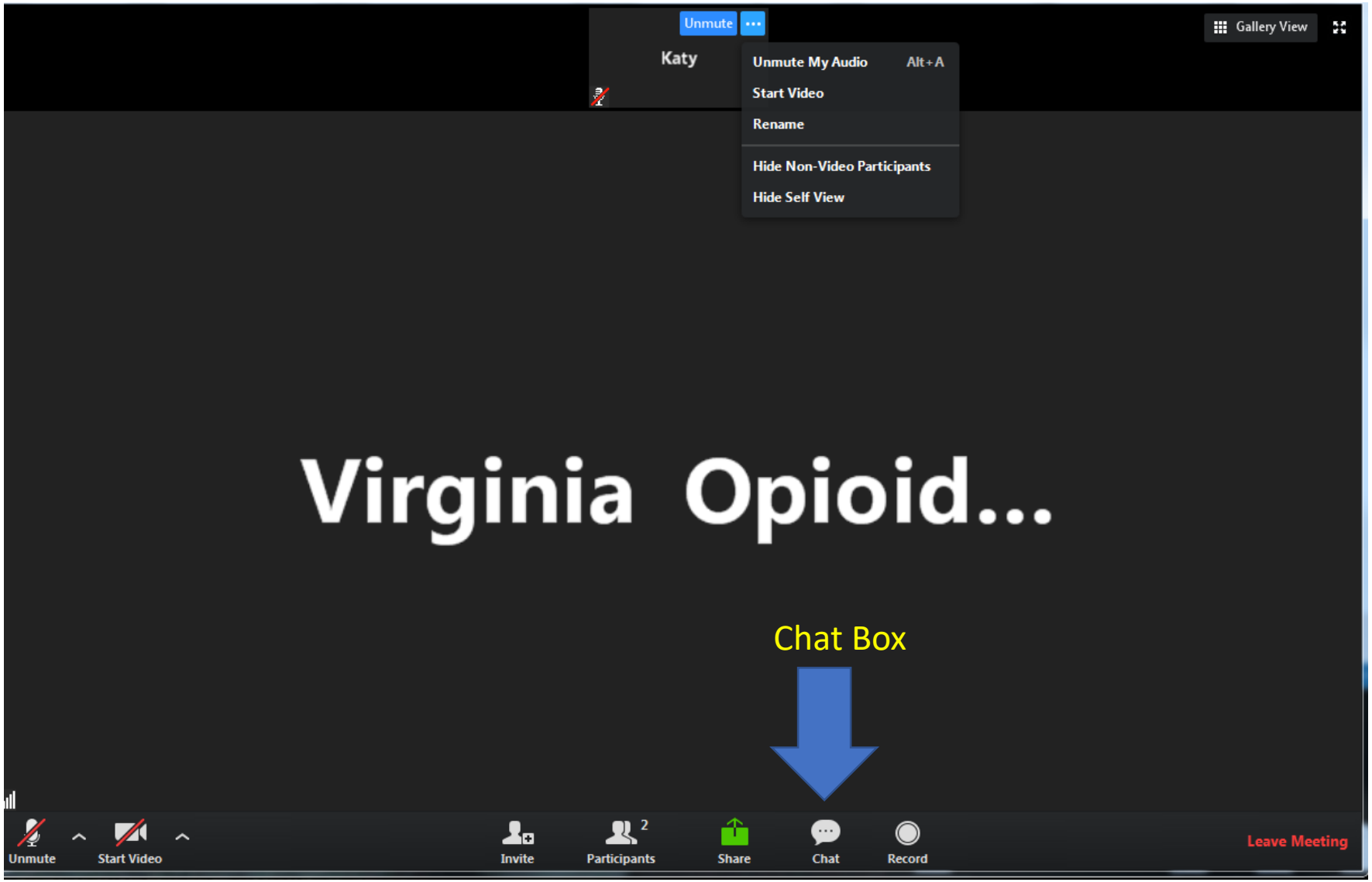
- Rename your Zoom screen, with your name and organization

Helpful Reminders



- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine
VDH Virginia Department of Health
VDHLiveWell.com
Virginia Department of Behavioral Health & Developmental Services
Project ECHO
Virginia Commonwealth University

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in substance use disorder
- Website Link: www.vcuhealth.org/echo

Hub Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub and Principal Investigator	Vimal Mishra, MD, MMCi
Clinical Expert	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Kanwar Sidhu, MD
Didactic Presentation	Omar Abubaker, DMD, PhD
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

Introductions:

- Name
- Organization

Reminder: Mute and Unmute to talk

*6 for phone audio

Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Pain Management and Prescribing Practices with Dental and Surgical Procedures**
   II. **Omar Abubaker, DMD, PhD**
II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Disclosures

There are no financial conflicts of interest to disclose.

There is no commercial or in-kind support for this activity.

Pain Management and Prescribing Practices with Dental and Surgical Procedures

Virginia Opioid Addiction ECHO

A. Omar Abubaker, DMD, PhD, Professor, Chair
Department of Oral and Maxillofacial Surgery
Virginia Commonwealth University

August 16, 2019

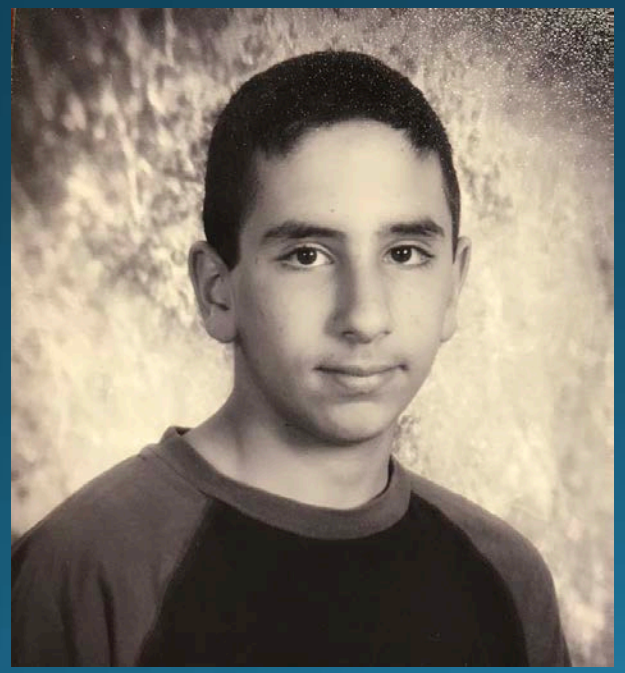
Learning Objectives

At the conclusion of this, the learner should be able to:

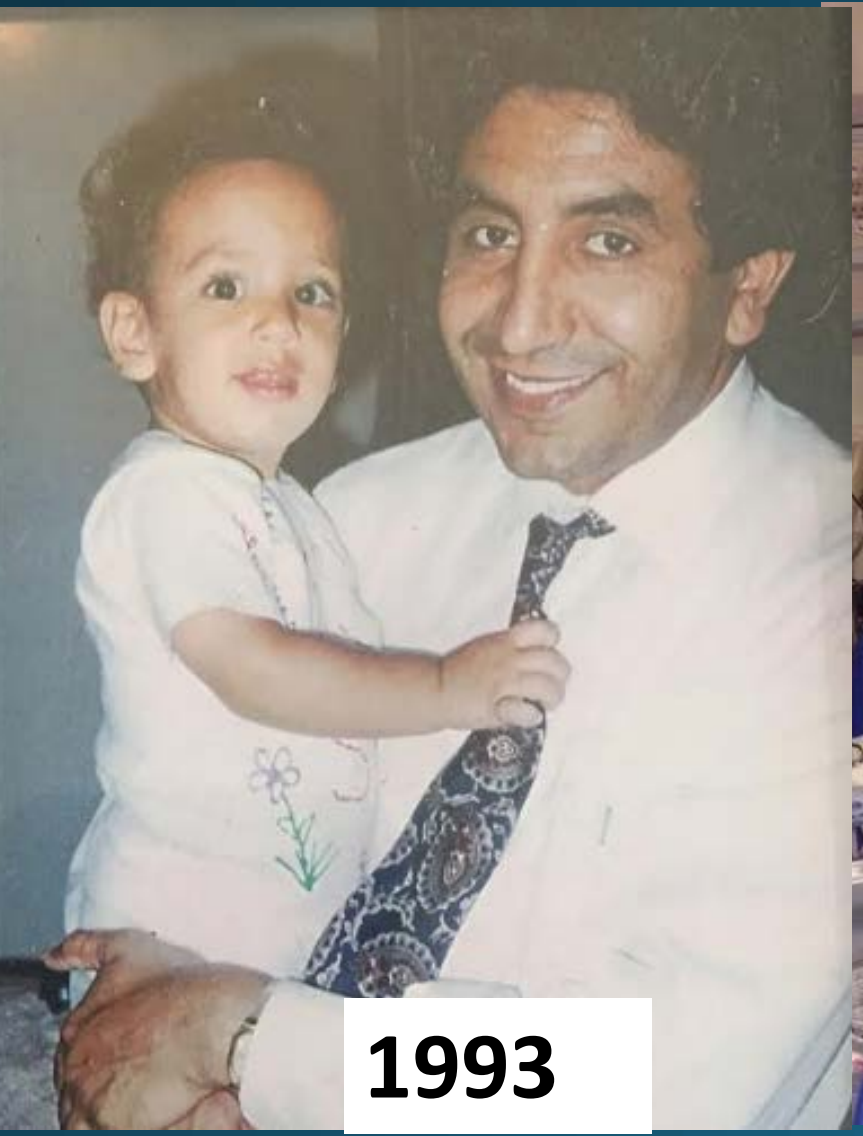
- Appreciate the impact of the opioid epidemic on affected families
- Understand the basis of teaching pain management by VCU OMFS Department as a model
- Describe the current teaching of the opioid epidemic to OMFS Residents and Dental Students

Disclosure and disclaimer

I am just a dad…

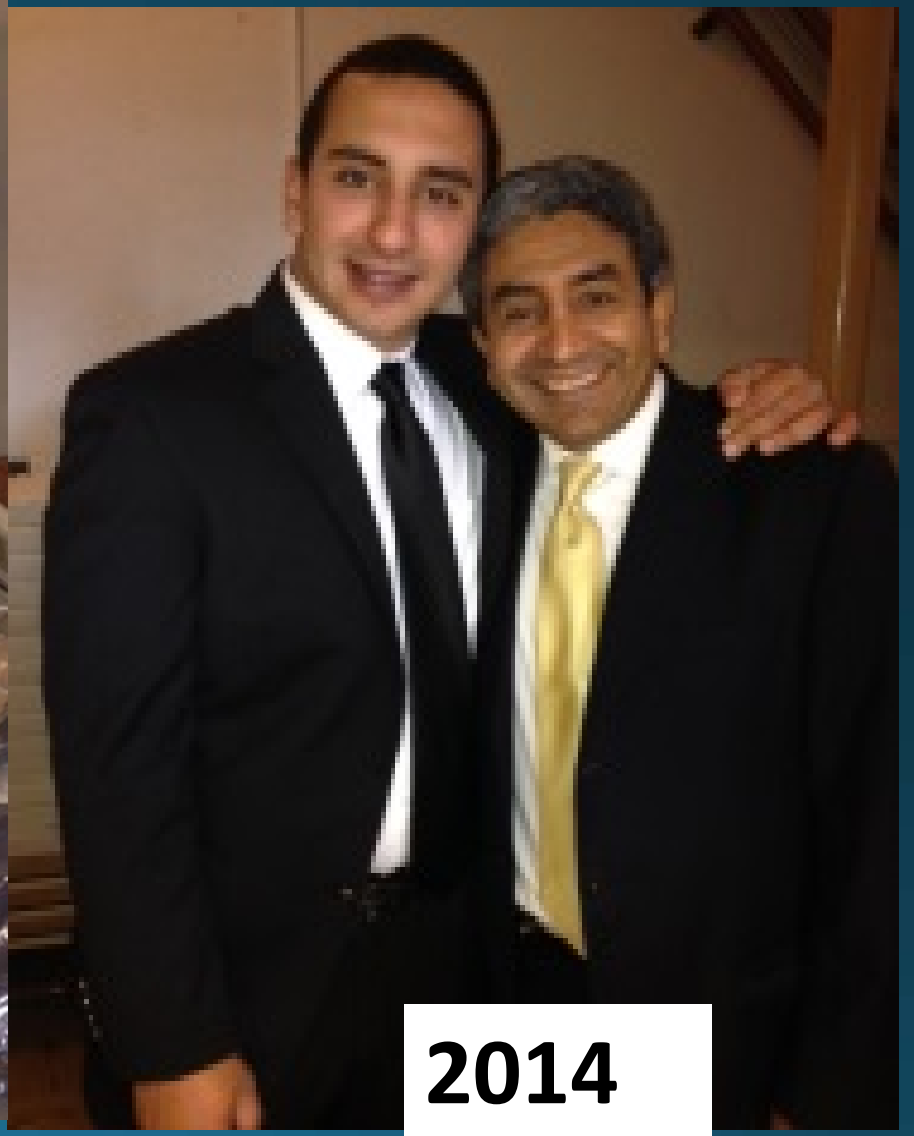


Adam's Story...



1993

2013



2014

Who is Adam?

My Journey: August 2015-May 2016

King's College London

THE UNIVERSITY OF ADELAIDE

VCU
VIRGINIA COMMONWEALTH UNIVERSITY

In recognition of the successful completion of the required course of study, the presidents of the below-named universities, by virtue of the authority vested by said universities, hereby confer upon

Abubaker Omar Abubaker

the degree of

Post-Baccalaureate Graduate Certificate in Addiction Studies

With all the rights, honors, distinctions and privileges thereto appertaining.
In testimony whereof we have caused the signatures of the duly authorized university officials to be hereunto affixed on this 24th day of December, in the year 2016.

The Duke of Wellington
Chairman of the College Council
King's College London

Vice Admiral the Honourable Kevin Scarce AC CSC RAN (Rtd)
Chancellor
University of Adelaide

John A. Luke Jr.
Rector of the Board of Visitors
Virginia Commonwealth University

Professor Edward Byrne AC
President and Principal
King's College London

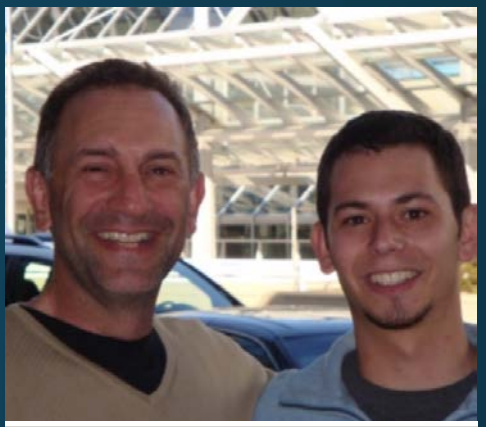
Professor Warren Bebbington
Vice-Chancellor and President
University of Adelaide

Michael Rao
President
Virginia Commonwealth University

My Journey Into the Darkness

'My son died of a disease that is preventable and we do not prevent it, treatable and we do not treat it, and undeniable but we continue to deny it'

Gary Mendell, Founder and CEO, Shatter Proof Foundation



HEALTH

No Family Is Safe From This Epidemic

As an admiral I helped run the most powerful military on Earth, but I couldn't save my son from the scourge of opioid addiction.

JAMES WINNEFELD NOV 29, 2017

W
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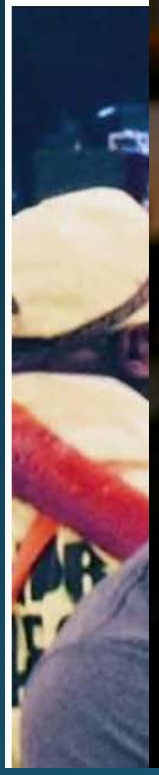
By Ryan

Upda



HEALTH

In one night, she lost two sons to opioids. She's on a mission to spare others that unfathomable pain

By MEGAN THIELKING @meggophone / AUGUST 15, 2017

Tens of Thousands Die,
Hundreds of Thousands Families Suffer
And No Family Is Safe,
Including Yours.....

What We Practice, What We Teach…

Opioids Analgesics ARE NOT Safe For Everybody

Use of Opioids for Acute Pain..2016

Opioids used to treat acute pain can lead to "long-term" use and this risk increases with the length of the *initial prescription*.

Risk Factors for Opioid Use Disorders in Adult Postsurgical Patients

- History of substance use and abuse
- Use of "sedative hypnotics"
- Any chronic physical malady/chronic pain
- Younger age/older age
- Family history of SUD

The Journey of The Opioid Epidemic: How Did We Get There?

First Wave (1999-2010): Prescription Medications

Second Wave (2010-….): Heroin

Third Wave (2014-----): Synthetic Opioids/Mixtures

The Opioid Epidemic: How Did We Get There?

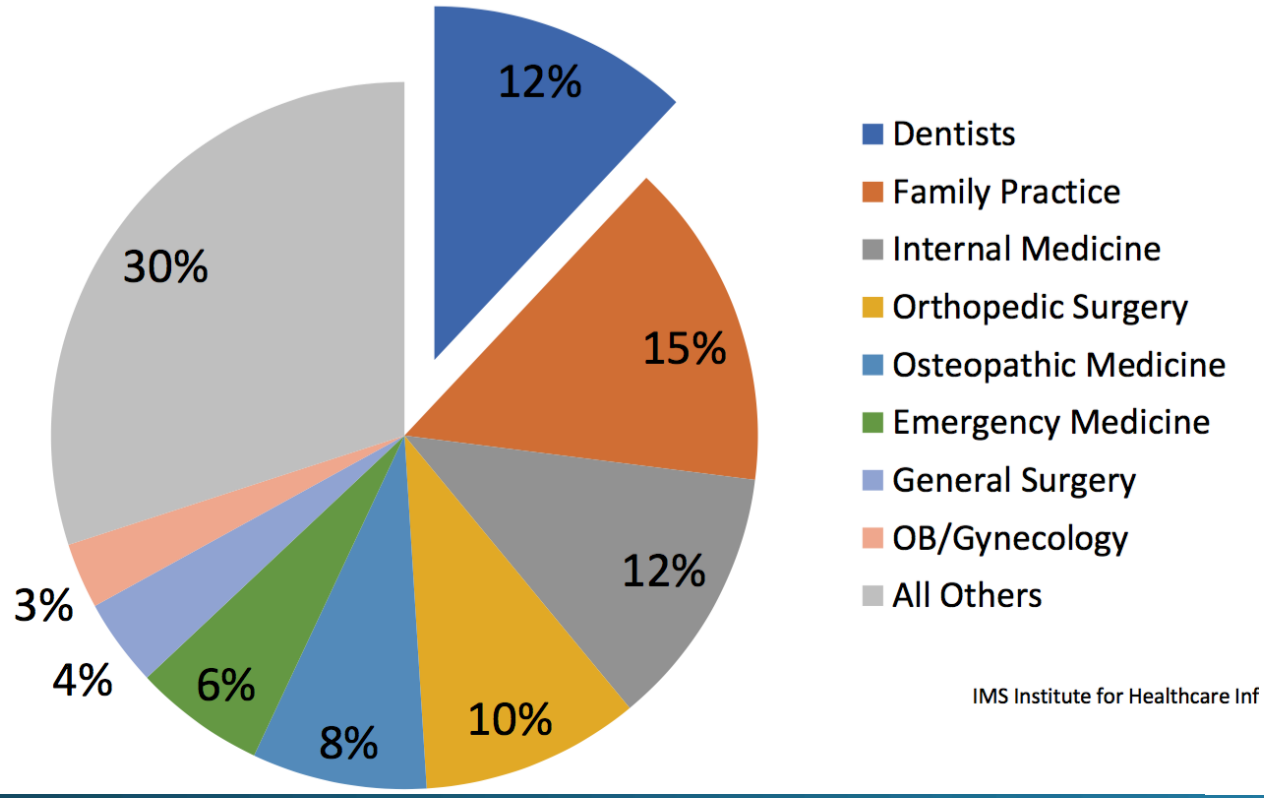
Pain management → Adults → Substance Use Disorder

Pain management → Adolescence → Substance Use Disorder

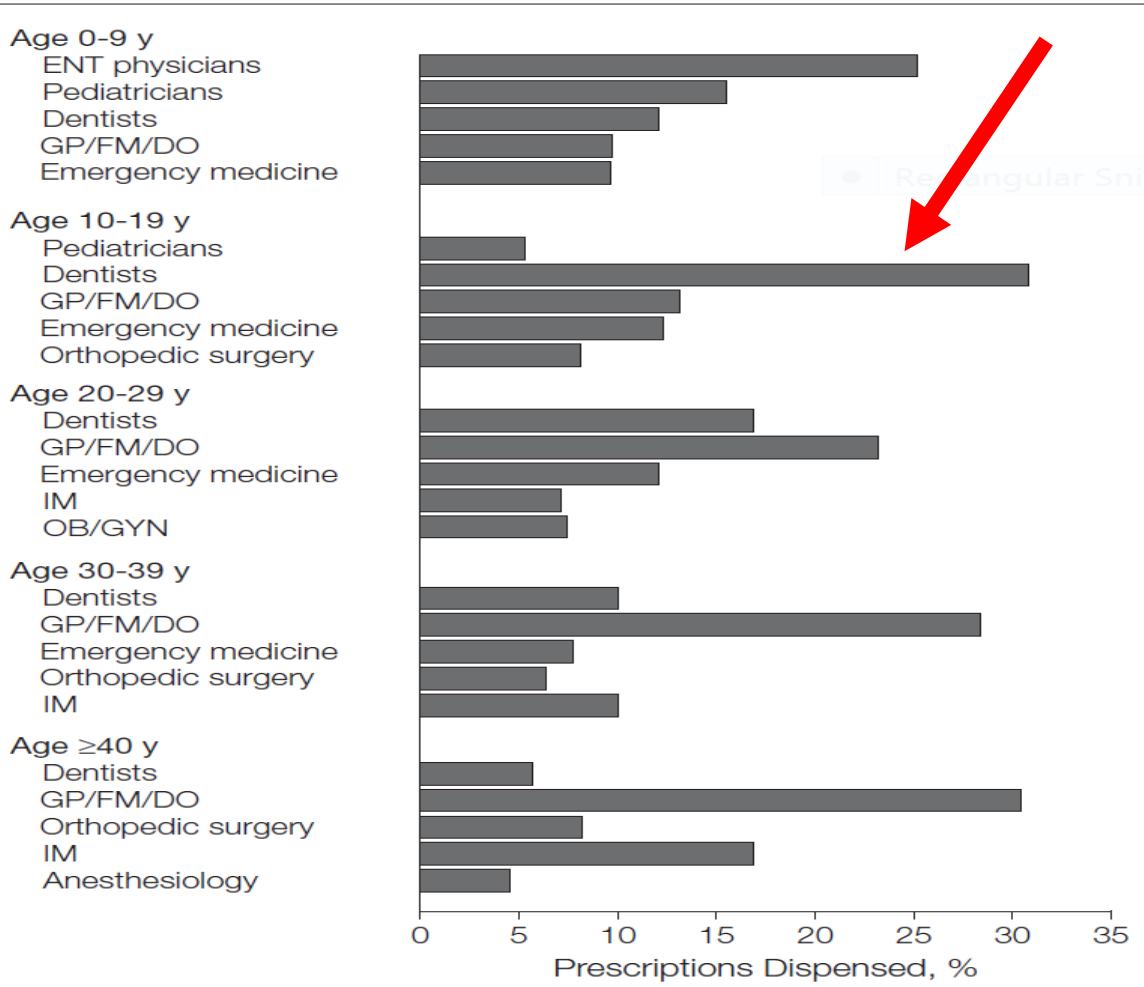
Experimentation!! → Adolescence → Substance Use Disorder

The Journey of The Opioid Epidemic: How Did We Get There?

Prescribers of Immediate Release Opioids



IMS Institute for Healthcare Inf



Prescribing Patterns Of Dentists

The average quantity of opioids prescribed was 20 of hydrocodone.

Approximately 92% of wisdom teeth patients are opioid-naïve patients

100 Million Prescription Opioids Go Unused Each Year Following Wisdom Teeth Removal

- 46% of parents (70% healthcare workers parents) do not feel comfortable with their children being prescribed opioid analgesics after extraction of wisdom teeth

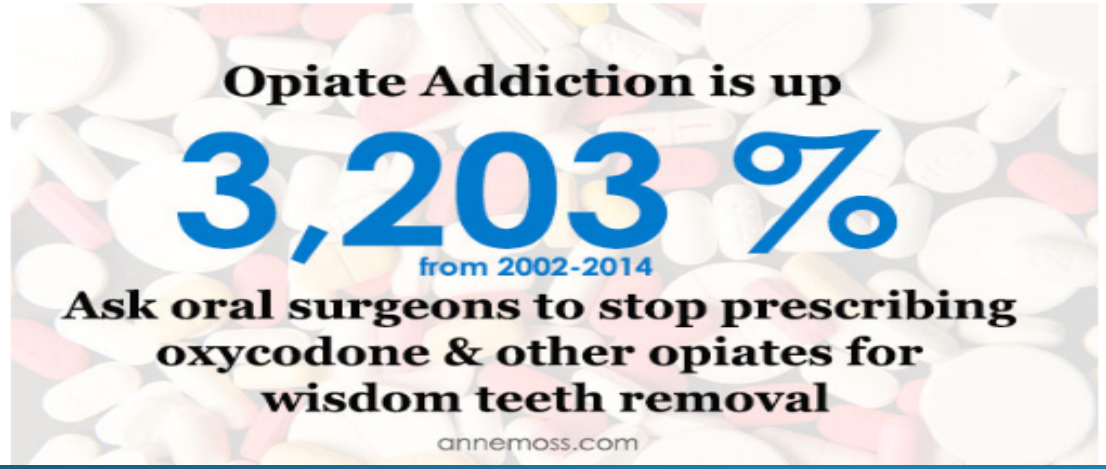
Ask your oral surgeon to stop prescribing oxycodone for teen wisdom teeth removal

And parents please stop asking for it.

Seven percent of patients prescribed narcotic or opioid analgesics will become addicted.* Some statistics put it as high as 10%. Still others will abuse it or sell it. Do you want that to be your kid?

If you've never had an opiate, percocet, oxycodone or vicodin, you shouldn't risk it either.

One pill can trigger an addiction



Benefits and harms associated with analgesic medications used in the management of acute dental pain

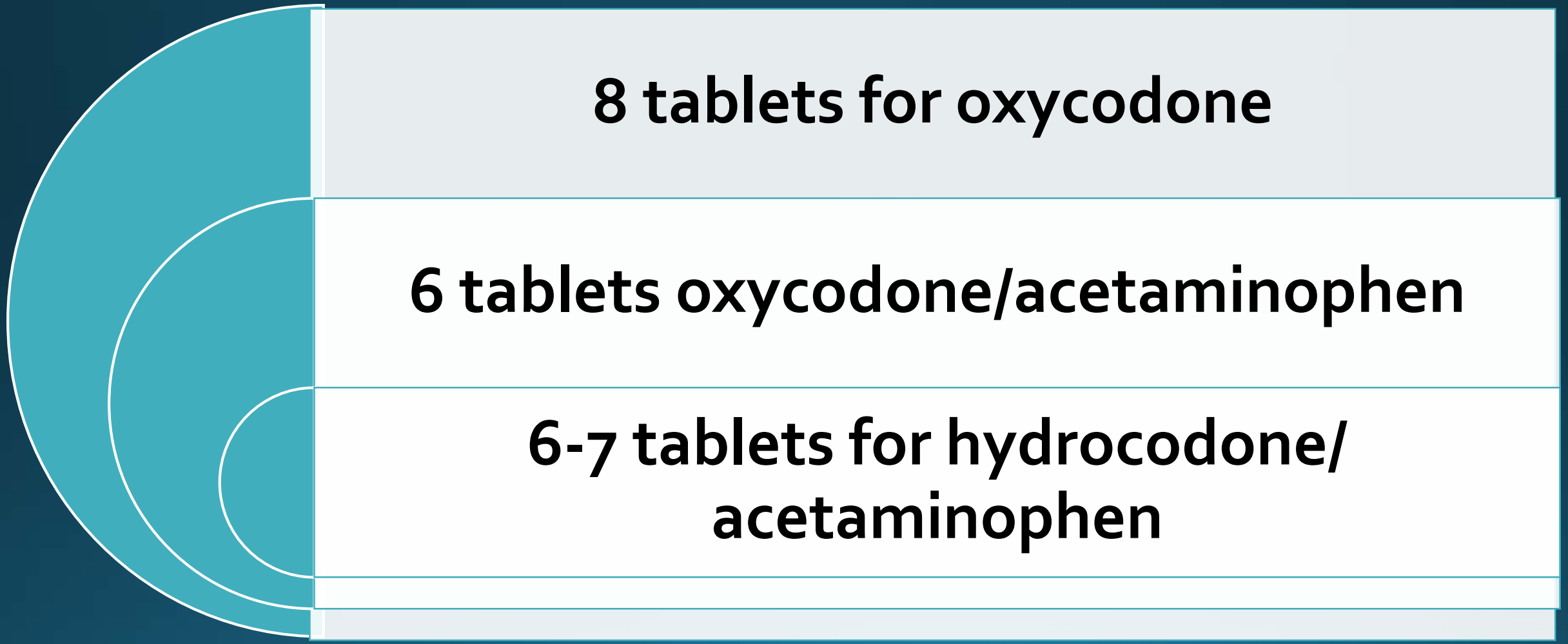
"The use of NSAID, with or without Acetaminophen , offered the most favorable balance between benefits and harms, maximum efficacy with minimal adverse events.."

ORIGINAL SCIENTIFIC ARTICLE

Patient Satisfaction and Pain Control Using an Opioid-Sparing Postoperative Pathway

Patients reported minimal or no opioid use after implementation of an opioid –sparing pathways, and still reported high satisfaction and pain control.

Maximum Number of Tablets Needed For Pain Control After Wisdom Teeth Extraction



Strategies for Proper Prescribing At VCU Oral and Facial Surgery Department

Assessment of the expected severity of post-operative pain

Assessment of the risk of exposure to opioids

Strategies for Proper Prescribing Protocol At VCU Oral and Facial Surgery Department

-Mild

-Moderate

-Severe

-Low

-Moderate

-High

Pain Relief Toolkit

Preoperative Pain Relief Discussion

Postoperative Pain Relief

Preoperative Screening Questionnaires

Safe Use, Storage, and Disposal

AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Toolkit for Effective Management of Postoperative Acute Dental Pain

Preoperative discussion of the goals of postoperative pain management

- Multimodal pain therapy

-Pharmacological management

-Adjunct modalities of pain control

Preoperative Discussion of Postop Pain

- Set goals for pain control
- Review the risks / possible side effects of prescribed medications
- Discuss modes of disposal of the unused opioid medications

Strategies for Pharmacologic Management of Postop Dental Pain

- NSAID as the primary agents for managing post-operative pain
- Combining two analgesic agents
- Using adjunct modalities: long acting local anesthetics, intra and postop steroids
- Opioids analgesics be reserved for only severe pain

VCU OMFS New Pain Management Protocol: Providers

Virginia Commonwealth University/ Oral and Maxillofacial Surgery

GUIDELINES FOR PRESCRIBING AFTER ORAL SURGERY PROCEDURES

I. Purpose

A. To establish guidelines for safe postoperative opioid prescribing for acute pain. These guidelines are intended to supplement and not replace the individual prescriber's clinical judgment.

II. Guidelines:

A. In the process of entertaining alternatives to prescribe postoperative pain medications, the prescriber should make an effort to estimate the severity of expected postoperative pain, the expected duration of the pain, and to assess patient's individual risk from prescribing opioids. For example:

a. In general, the simpler the procedure the less likely the patient will suffer severe postoperative pain. Simple extractions, and extraction of periodontally involved teeth are less likely to result in postoperative pain than surgical extractions, complicated and multiple extractions and extraction of bony impacted third molars.
b. On the risk of prescribing opioids, patients younger than 20 years old, patients with history of substance use disorder, patients with sleep apnea and patients on benzodiazepines are at higher risk for being adversely affected with opioids.
c. For additional guidance see table 1

B. Unless contraindicated, whenever possible, patients undergoing dentoalveolar surgery should be administered Ibuprofen 400 milligrams (mg) preoperatively.

C. Providers should prescribe non-steroidal anti-inflammatory drugs (NSAIDs) as first-line analgesic therapy, unless contraindicated. If NSAIDs are contraindicated, providers should prescribe Acetaminophen (APAP) as first-line analgesic therapy.

D. If prescribing for more than 7 days, or when prescribing for refill for opioids, the Prescription Drug Monitoring Program (PDMP) database for the patient must be reviewed.

E. When postoperative opioids are indicated following surgery that is typically expected to produce severe pain, the provider should choose the lowest potency opioid necessary to relieve the patient's pain. The duration of therapy should be for a short period.

F. Opioids should not be prescribed to a patient who is already prescribed opioid medications by another provider for chronic pain (related or unrelated to current problem). Patients prescribed opioids by another provider for their current condition may be prescribed opioids by a VCU OMFS provider after direct communication with the original prescribing provider or review of the patient's current prescription, and it is agreed that the VCU OMFS will be the only prescriber of opioids in such situations. If it is detected that a patient has more than one prescriber of opioid medications, all VCU OMFS opioid prescriptions will cease.

G. Deviation from the prescribing guidelines should be documented and include a detailed explanation of why the deviation was necessary.

H. Special considerations should be paid to patients who are in recovery from SUD and/or receiving opioid Maintenance Therapy (OMT). This includes respecting the patient wishes not to be prescribed opioid analgesics, assurances to adequately treat their pain, use of preemptive NSAID, long-acting local anesthetics and consultation with their OMT prescriber regarding postoperative opioid analgesics.

If NSAIDS can be tolerated:

Pain Severity	Analgesic Recommendation
Mild	Ibuprofen (200-400 mg) q4-6 hours prn for pain
Mild to Moderate	**Step 1:** Ibuprofen (400-600 mg) q6 hours: fixed intervals for 24 hours **Step 2:** Ibuprofen (400 mg) q4-6 hours prn for pain
Moderate to Severe	**Step 1**: Ibuprofen (400-600 mg) with APAP (500 mg) q6 hours: fixed interval for 24 hours **Step 2**: Ibuprofen (400 mg) with APAP (500 mg) q6 hours prn for pain
Severe	**Step 1:** Ibuprofen (400-600 mg) with APAP (500 mg) q6 hours: prn for pain **Step 2:** Ibuprofen (400-600 mg) with APAP (650 mg) **OR** (5mg) hydrocodone q6 hours: 3-day supply.

If NSAIDS are contraindicated:

Pain Severity	Analgesic Recommendation
Mild	APAP (650-1000 mg) q6 hours prn for pain
Moderate	**Step 1:** APAP (650-1000 mg) q4-6 hours prn for pain **Step 2:** Hydrocodone (5 mg) q6 hours: 3-day supply.
Severe	**Step 1:** APAP (650-1000 mg) q6 hours: prn for pain **Step 2:** Hydrocodone (5 mg) q6 hours: 3-day supply.

Additional Considerations

- ***Discussion with patients the possible risks and complications of opioid analgesics and care and disposal of unused medications***
- *Patients should be warned to avoid acetaminophen, or N-acetyl-p-aminophenol (APAP), in other medications. Maximum daily dose of APAP is 3,000 mg per day. To avoid potential APAP toxicity, consider prescribing an opioid rescue medication containing ibuprofen.*
- *Maximum dose of ibuprofen is 2,400 mg per day. Higher maximal daily doses have been reported for osteoarthritis when under the direction of a physician.*
- *A decrease in postoperative pain severity has been demonstrated when a nonsteroidal anti-inflammatory drug is administered pre-emptively.*
- *Long acting local anesthetics can delay onset and severity of postoperative pain.*
- *A perioperative corticosteroid (dexamethasone) may limit swelling and decrease postoperative discomfort after third-molar extractions.*
- *Acetaminophen with codeine should NOT be the first drug of choice in children less than <12.*
- *Acetaminophen in children <12: 10mg/kg/dose, q4-6 hr. maximum 90 mg/Kg/24 hours.*
- *Ibuprofen in children <12: 4-10mg/kg/dose q4-6 hours, maximum 40mg/Kg/24 hours*

References:
Dionisio, Richard C. et al.(2011). Prevention of prescription opioid abuse. *The Journal of American Dental Association*, 142(7), 800-810.
Thorson, D. et al. (2014). Acute pain assessment and opioid prescribing protocol. *Institute for Clinical Systems Improvement.*

VCU OMFS New Pain Management Protocol: Patients

How To Safely Manage Your Postoperative Pain and Dispose of Your Leftover Prescription Medications

You will be given one or two prescriptions for pain medication that will help you safely and successfully manage your postsurgical pain. Your doctor will determine which and how much of each to use depending on the extent of your surgery and the expected pain severity. Here are some helpful steps on how to use these medications

For mild pain (1-3 on a scale of 1 to 10) take over-the-counter Motrin, Ibuprofen or Advil (take one or two 200mg tablets every 4 hours) as needed

For mild to moderate pain (3-8 on a scale of 1-10) use the prescription strength Ibuprofen (400mg-600mg) written for you by the doctor. You can take one tablet every 6 hours starting when you get home and continuing for at least 4 doses. *If you are still experiencing pain 1 hour after taking this medication go to Option 3.*

If you are getting pain relief from the Ibuprofen, but it is not lasting until the next dose (6 hours later), take Tylenol (325 or 500mg) 3 hours after you take the Ibuprofen, alternating the two medications every 3 hours.

For moderate to severe pain (8-10 on a scale of 10) take one over-the-counter regular strength Tylenol (Acetaminophen)(325mg tablet). If the pain is very severe, take one tablet of extra strength Tylenol (500mg) instead. You can take this medication every 6 hours along with one 600mg Ibuprofen. (Do not exceed 6 tablets of Tylenol (3000 mg) or 4 tablets of Ibuprofen (2400 mg) within 24 hours).

For severe pain: If you *are still experiencing SEVERE pain* *1 hour after taking the medications in Option 3, then take* the opioid medication (Hydrocodone/Acetaminophen) prescribed by your doctor (if applicable). You can take this medication every 6 hours for pain that is not relieved by Ibuprofen or Tylenol alone or in combination.

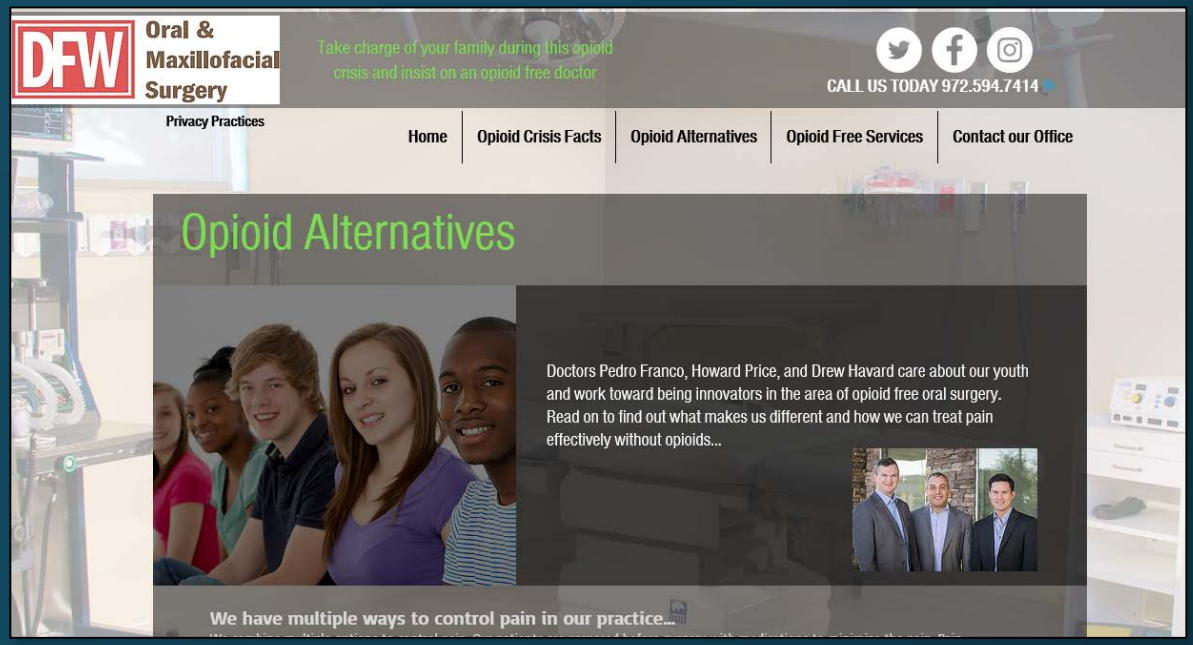
Results of Dental Pain Management Protocol and Education At VCU School of Dentistry

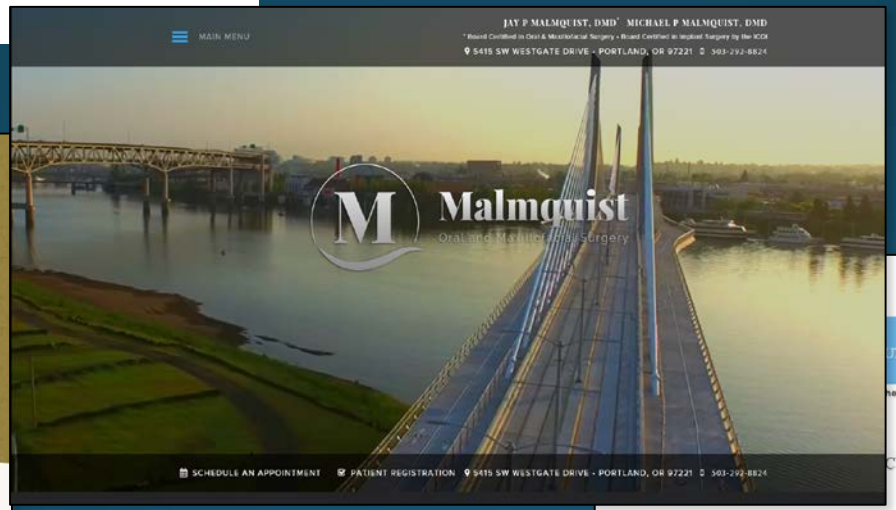
VCU Oral and Maxillofacial	17.31	26043	VCU Oral	57841	45.03%
2013	25.85	5457	2013	9560	57.08%
2014	17.40	5443	2014	9370	58.09%
2015	16.10	5436	2015	10913	49.81%
2016	15.46	5232	2016	11818	44.27%
2017	11.09	3544	2017	11748	30.17%
2018	7.98	931	2018	4432	21.01%

The Future of Postsurgical Pain Management

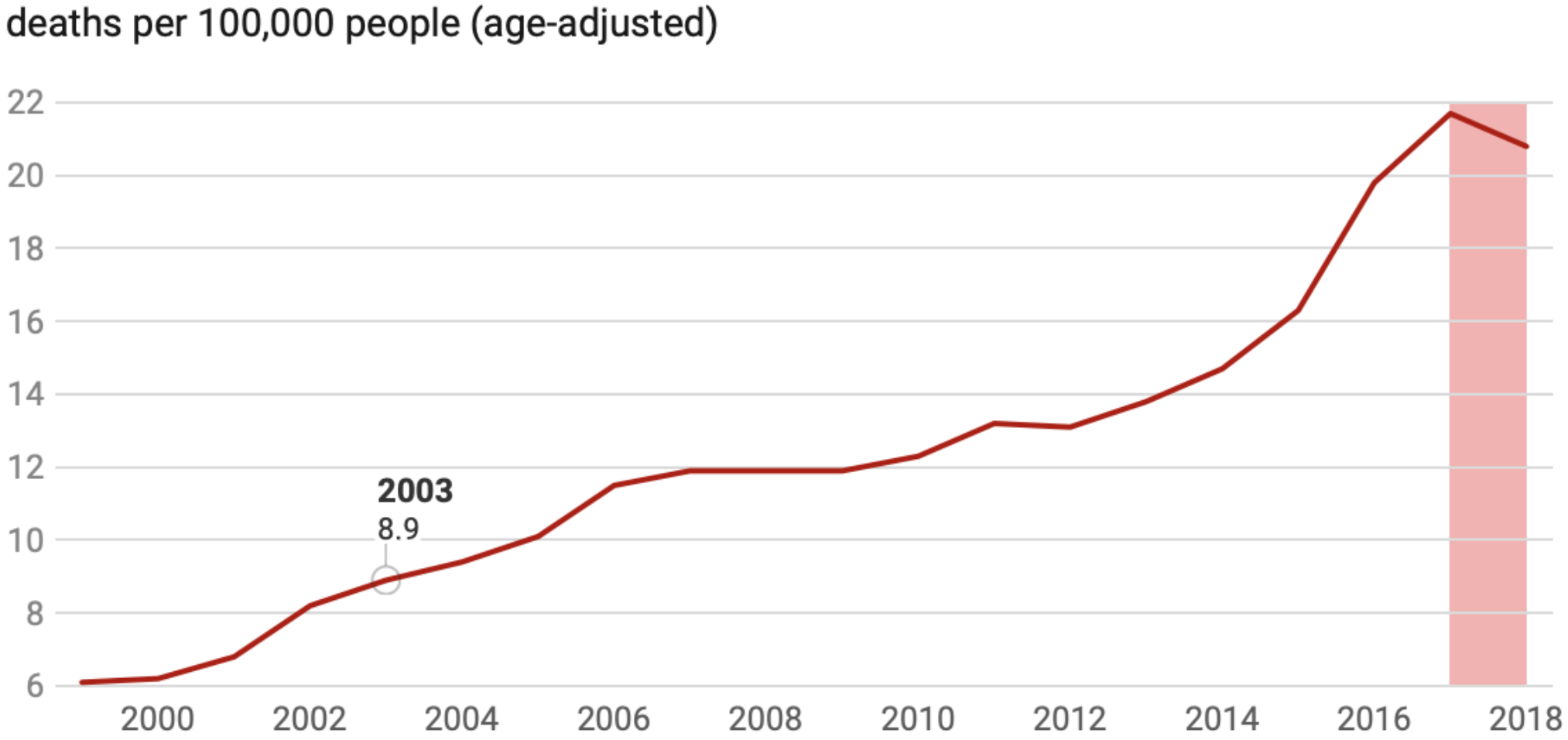
Opioid Reducing → Opioid Free

Will Opioid-Free Surgery Become the New Standard of Care?





Drug overdose deaths in the U.S. dropped in 2018 for only the second time in two decades



**data for 2018 are for the second quarter of the year*

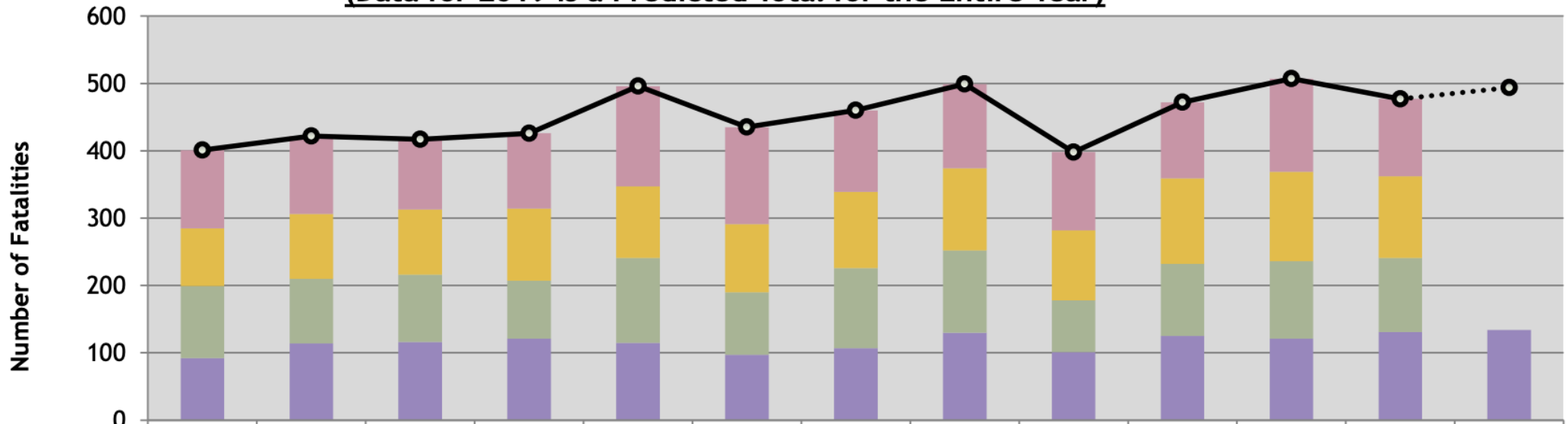
Chart: Elijah Wolfson for TIME • Source: U.S. National Center for Health Statistics • Get the data

Despite the modest improvement in national overdose death in 2018, nationally and locally, there is yet much to be done …

PRESCRIPTION OPIOIDS (EXCLUDING FENTANYL)

Total Number of Fatal Prescription Opioid Overdoses (Excluding Fentanyl) by Quarter and Year of Death, 2007-2019*

(Data for 2019 is a Predicted Total for the Entire Year)

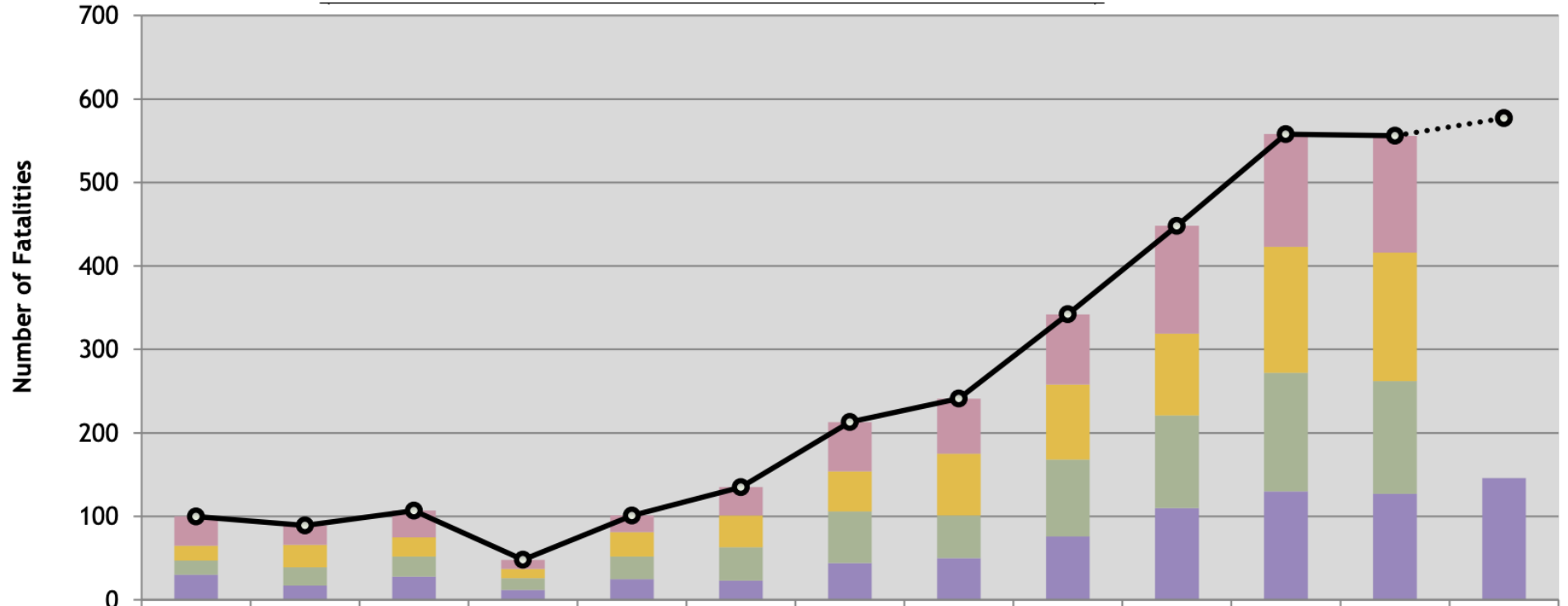


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	116	116	104	112	149	144	121	125	116	113	138	115	
Q3	86	96	97	107	106	101	113	122	104	127	133	121	
Q2	107	96	100	86	126	93	119	122	77	107	115	110	
Q1	92	114	116	121	115	97	107	130	101	125	121	131	134
Total Fatalities	401	422	417	426	496	435	460	499	398	472	507	477	494

[1] 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescriptions opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these true prescription opioids.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

HEROIN



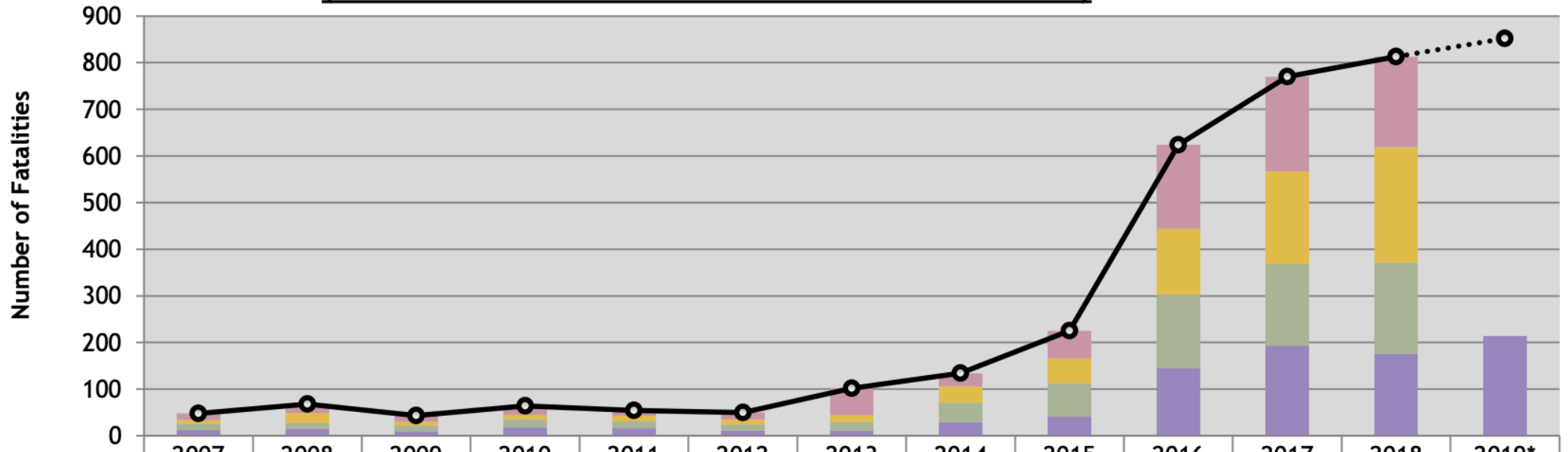
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	35	23	32	11	20	34	59	66	84	129	135	140	
Q3	18	27	23	11	29	38	48	74	90	98	151	154	
Q2	17	22	24	14	27	40	62	51	92	111	142	135	
Q1	30	17	28	12	25	23	44	50	76	110	130	127	146
Total Fatalities	100	89	107	48	101	135	213	241	342	448	558	556	577

VDH VIRGINIA DEPARTMENT OF HEALTH

FENTANYL

Total Number of Fatal Fentanyl Overdoses by Quarter and Year of Death, 2007-2019*

(Data for 2019 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	14	19	13	19	11	15	58	28	59	180	203	194	
Q3	8	22	8	9	11	11	14	35	53	141	199	248	
Q2	14	12	12	18	16	13	19	42	72	158	175	195	
Q1	12	15	10	18	16	11	11	29	41	145	193	176	214
Total Fatalities	48	68	43	64	54	50	102	134	225	624	770	813	852

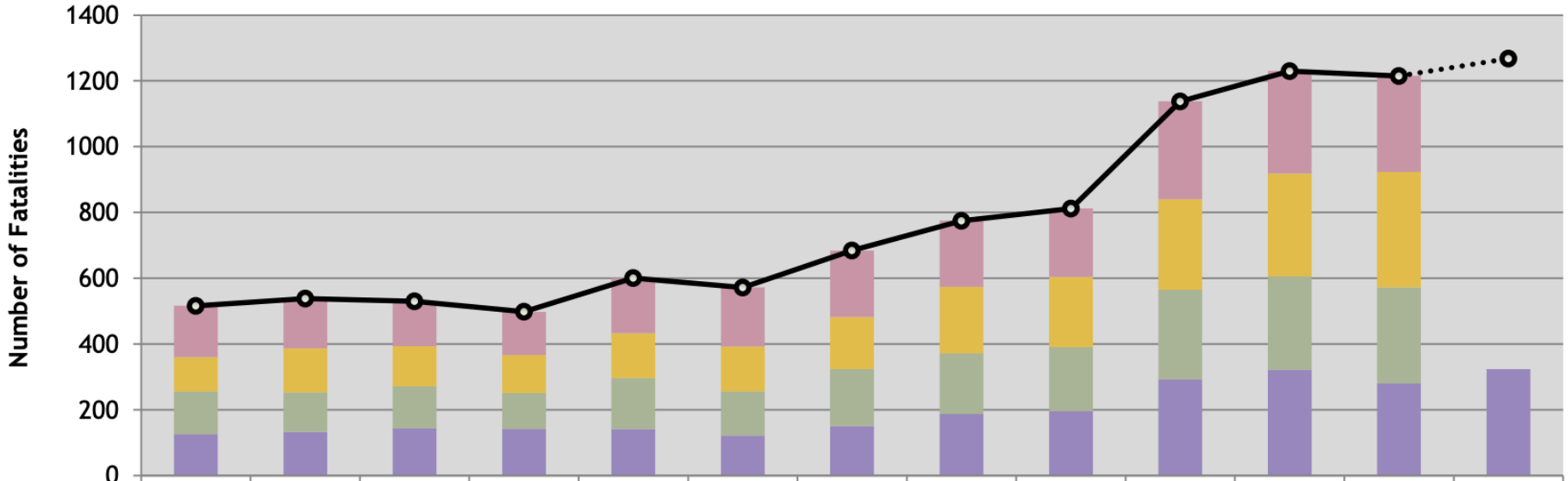
[1] Historically, fentanyl has been categorized as a prescription opioid because it is mass produced by pharmaceutical companies. However, law enforcement investigations and toxicology results have demonstrated that several recent fentanyl seizures have ***not*** been pharmaceutically produced, but illicitly produced. This illicit form of fentanyl is produced by international drug traffickers who import the drug into the United States and often, mix it into heroin being sold. This illicitly produced fentanyl has been the biggest contributor to the significant increase in the number of fatal opioid overdoses in Virginia.

[2] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

ALL OPIOIDS

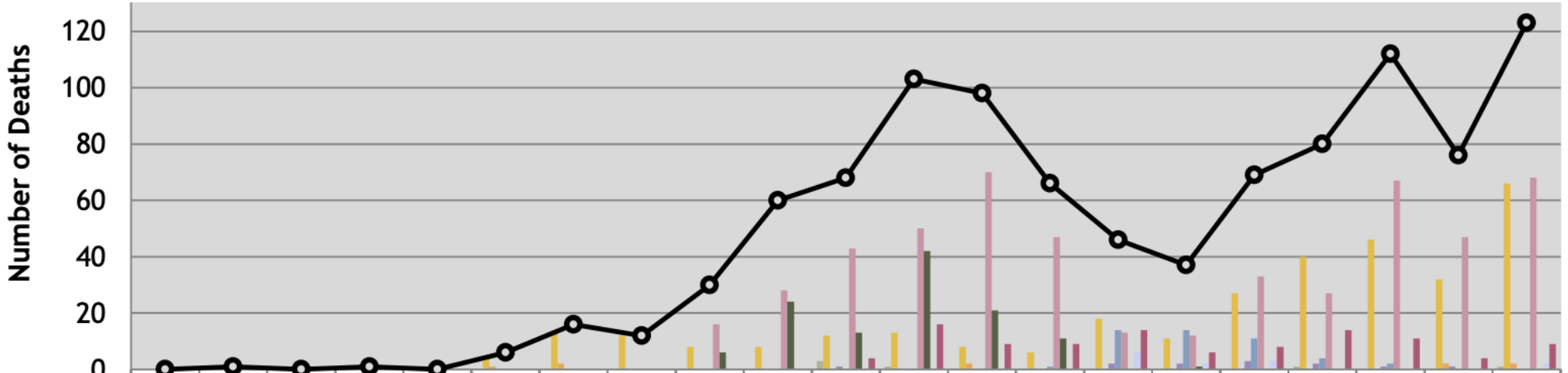
Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2019*
(Data for 2019 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	156	151	136	131	168	179	202	201	208	298	312	292	
Q3	104	134	122	116	136	137	158	202	213	275	312	351	
Q2	130	120	128	109	156	134	173	185	195	272	284	292	
Q1	126	133	144	142	141	122	151	187	196	293	322	280	324
Total Fatalities	516	538	530	498	601	572	684	775	812	1138	1230	1215	1268

[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, U-47700, and opioids unspecified
[2] 'Opioids Unspecified' are a small category of deaths in which the determination of heroin and/or one or more prescription opioids cannot be made due to specific circumstances of the death. Most commonly, these circumstances are a result of death several days after an overdose, in which the OCME cannot test for toxicology because the substances have been metabolized out of the decedent's system.
[3] Fatal opioid numbers have changed slightly from past reports due to the removal of fentanyl from the category of prescription opioids, as well as the addition of buprenorphine, levorphanol, meperidine, pentazocine, propoxyphene, and tapentadol added to the list of prescription opioids.

FENTANYL ANALOGS



	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
	2014				2015				2016				2017				2018				2019*
3-Methyl Fentanyl	0	0	0	0	0	0	0	0	0	0	3	1	0	0	0	0	0	1	0	0	1
Acetyl Fentanyl	0	1	0	1	0	5	14	12	8	8	12	13	8	6	18	11	27	40	46	32	66
Butyryl Fentanyl	0	0	0	0	0	1	2	0	0	0	0	0	2	0	0	0	0	0	0	2	2
Carfentanil	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	2	3	2	1	1	0
Cyclopropyl Fentanyl	0	0	0	0	0	0	0	0	0	0	0	0	0	1	14	14	11	4	2	0	0
Despropionyl Fentanyl**	0	0	0	0	0	0	0	0	16	28	43	50	70	47	13	12	33	27	67	47	68
Furanyl Fentanyl	0	0	0	0	0	0	0	0	6	24	13	42	21	11	0	1	0	0	0	0	0
Methoxyacetyl Fentanyl	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	2	3	0	0	0	2
Para-Fluoroisobutyryl Fentanyl***	0	0	0	0	0	0	0	0	0	0	4	16	9	9	14	6	8	14	11	4	9
Total Fentanyl Analog Fatalities	0	1	0	1	0	6	16	12	30	60	68	103	98	66	46	37	69	80	112	76	123

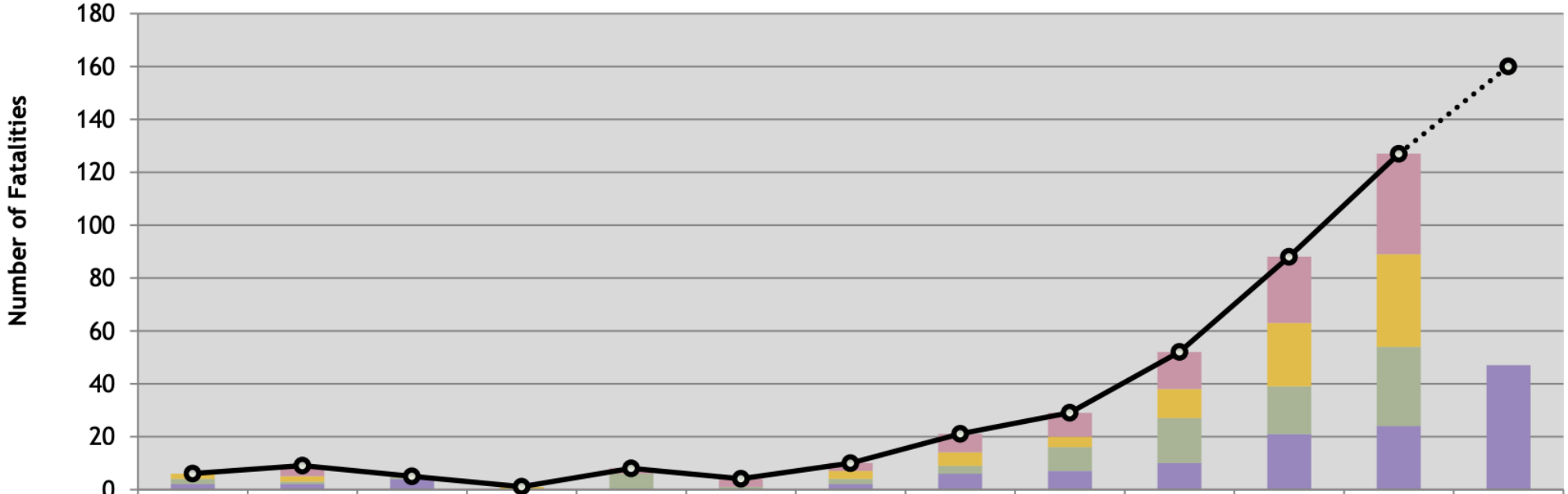
[1] Each fentanyl analog is tallied by each time it caused or contributed to death (analyzed from either toxicology or the cause of death statement) and therefore the total number of analogs will far exceed the actual number of fatalities

[2] Despropionyl fentanyl is a major metabolite of furanyl fentanyl. Therefore, numbers presented in the 'despropionyl fentanyl' category control for furanyl fentanyl (despropionyl deaths without furanyl fentanyl).

[3] In certain cases, specialized testing through an outside laboratory is needed for toxicology testing. In this laboratory, their testing for para-fluoroisobutyryl fentanyl and para-fluorobutyryl fentanyl cannot distinguish between the two analogs and therefore in this analysis, the two drugs are grouped together under 'para-fluoroisobutyryl fentanyl'

METHAMPHETAMINE

(Data for 2019 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	0	4	0	0	2	3	3	7	9	14	25	38	
Q3	2	2	0	1	0	0	3	5	4	11	24	35	
Q2	2	1	1	0	6	1	2	3	9	17	18	30	
Q1	2	2	4	0	0	0	2	6	7	10	21	24	47
Total Fatalities	6	9	5	1	8	4	10	21	29	52	88	127	160

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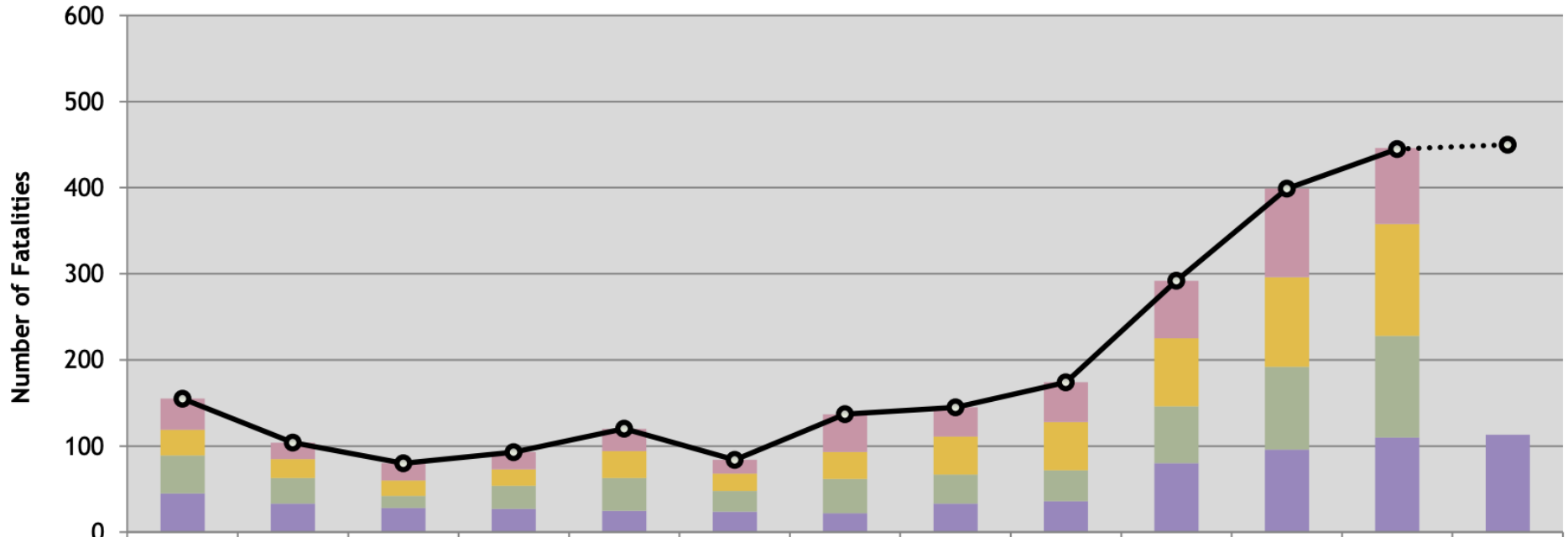
Protecting You and Your Environment

COCAINE

Total Number of Fatal Cocaine Overdoses by Quarter and Year of Death, 2007-2019*
(Data for 2019 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	36	19	20	20	26	16	44	34	46	67	103	88	
Q3	30	22	18	19	31	20	31	44	56	79	104	130	
Q2	44	30	14	27	38	24	40	34	36	66	96	118	
Q1	45	33	28	27	25	24	22	33	36	80	96	110	113
Total Fatalities	155	104	80	93	120	84	137	145	174	292	399	445	450

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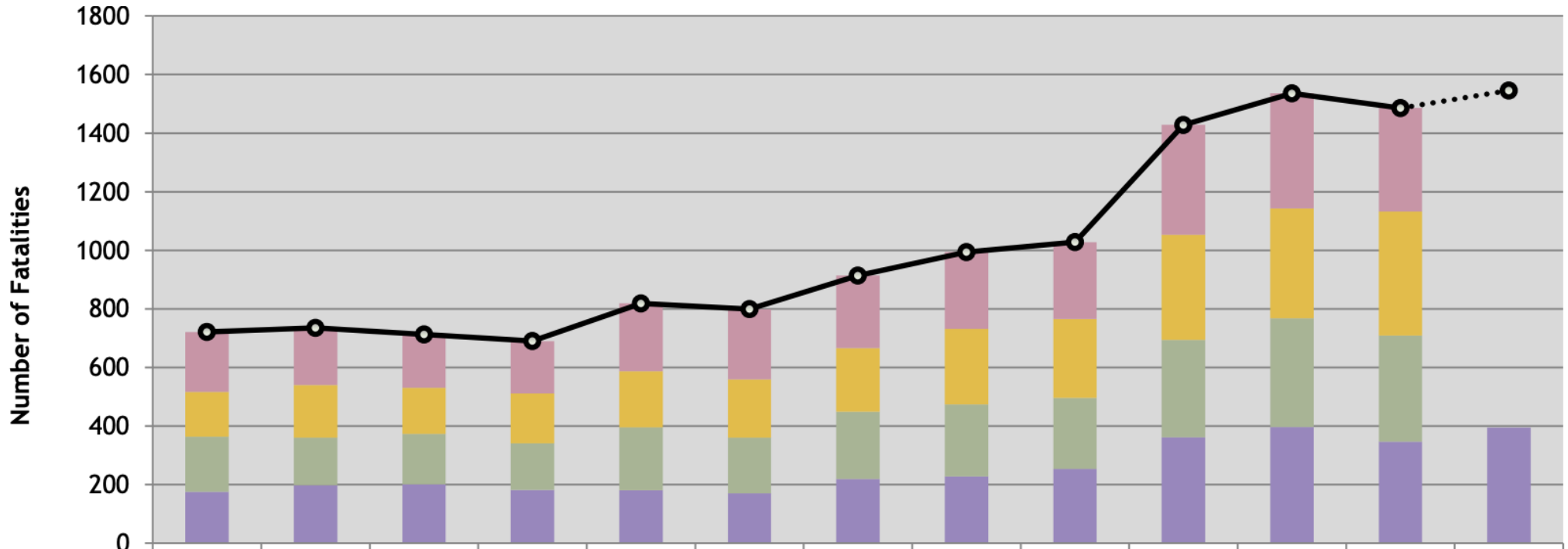
Protecting You and Your Environment

ALL DRUGS



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	
Q3	152	180	157	170	191	199	217	257	270	359	375	423	
Q2	188	162	172	159	215	190	230	246	243	332	371	363	
Q1	176	198	201	182	181	170	219	228	253	362	397	346	395
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1536	1486	1546

JAMA Network | Open™

Original Investigation | Substance Use and Addiction

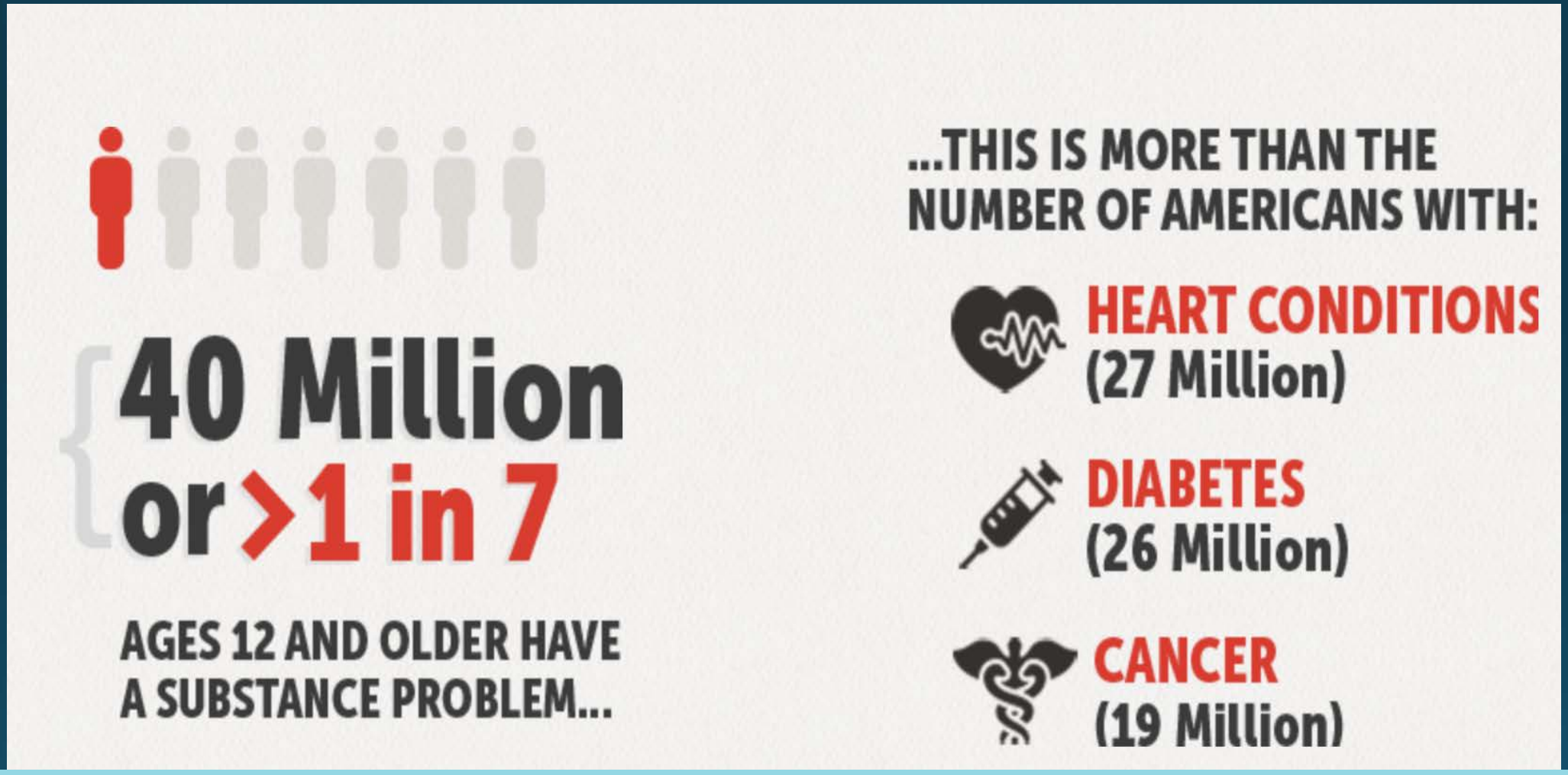
Prevention of Prescription Opioid Misuse and Projected Overdose Deaths in the United States

JAMA Netw Open. 2019 Feb 1;2(2):e187621. doi: 10.1001/jamanetworkopen.2018.7621.

Qiushi Chen, PhD; Marc R. Larochelle,MD, MPH; Davis T.Weaver, BS; Anna P. Lietz, BA; Peter P. Mueller, PhD; Sarah Mercaldo, PhD; Sarah E.Wakeman, MD; Kenneth A. Freedberg, MD, MSc; Tiana J. Raphel, BA; Amy B. Knudsen, PhD; Pari V. Pandharipande,MD, MPH; Jagpreet Chhatwal, PhD

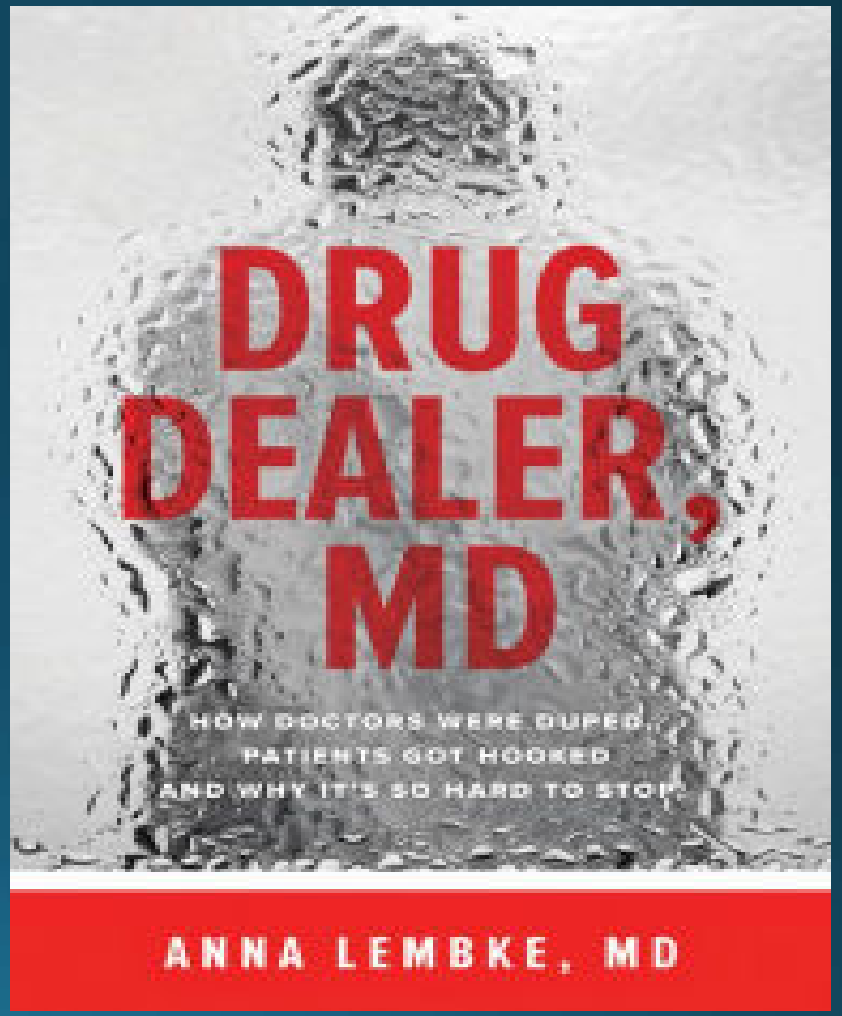
- **Targeting prescription opioid misuse may have only a modest effect, (3.0% to 5.3% decrease in opioid overdose deaths).**
- **Multipronged approach additional policy interventions are urgently needed to change the course of the epidemic.**

"The Elephant in the Room"



Only 11% are getting the help they need.

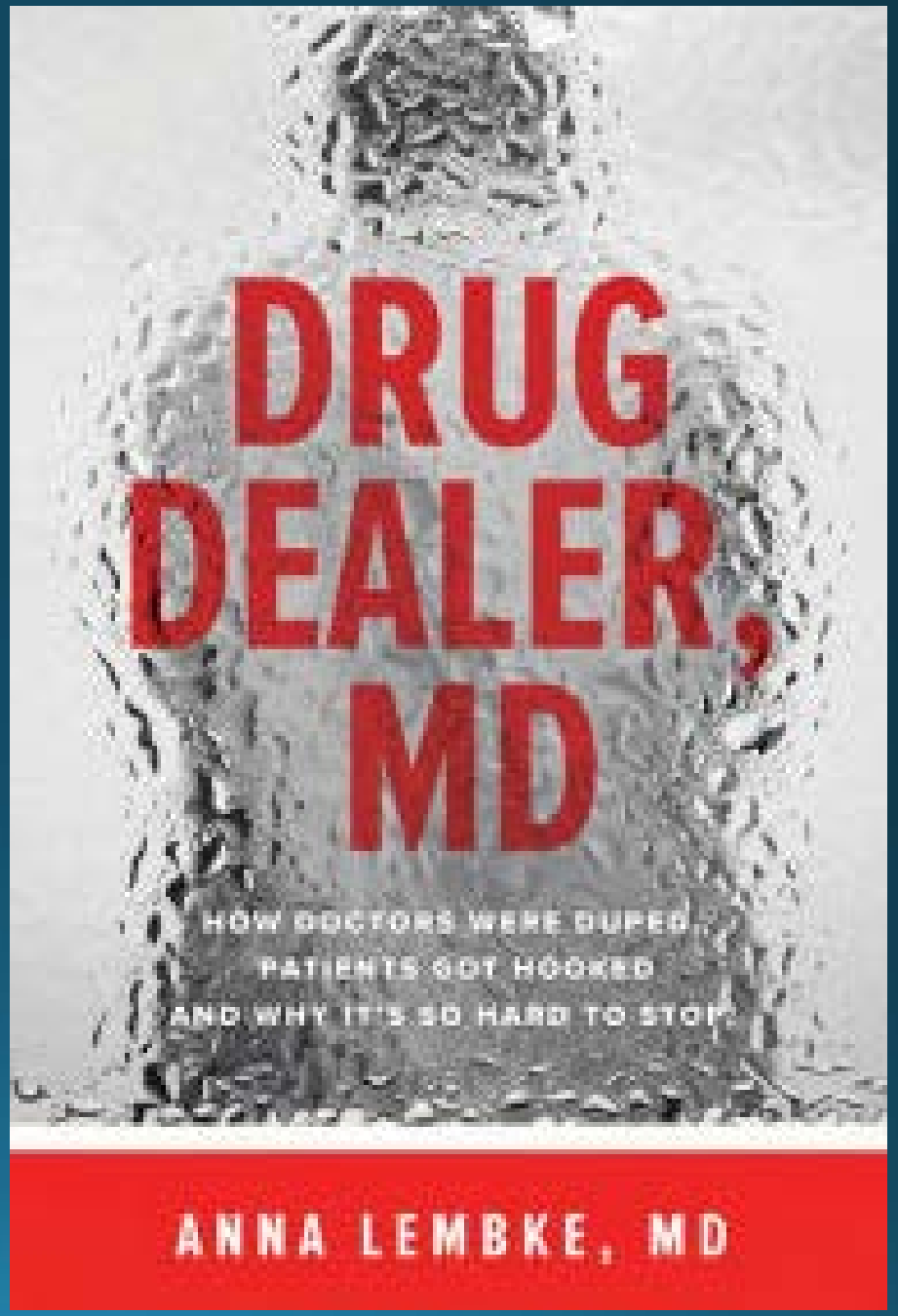
“As long as the system continues to ostracize patients with addiction, …., the prescription drug epidemic will continue, as will the suffering of millions of people with untreated addiction.”



Have of all accepted the answer to the most important question of all regarding the issue of addiction?

We Are Still Struggling With The Central Question:

“Medicine must once and for all embrace addiction as a disease, not because science argues for it, but because it is practical to do so.”



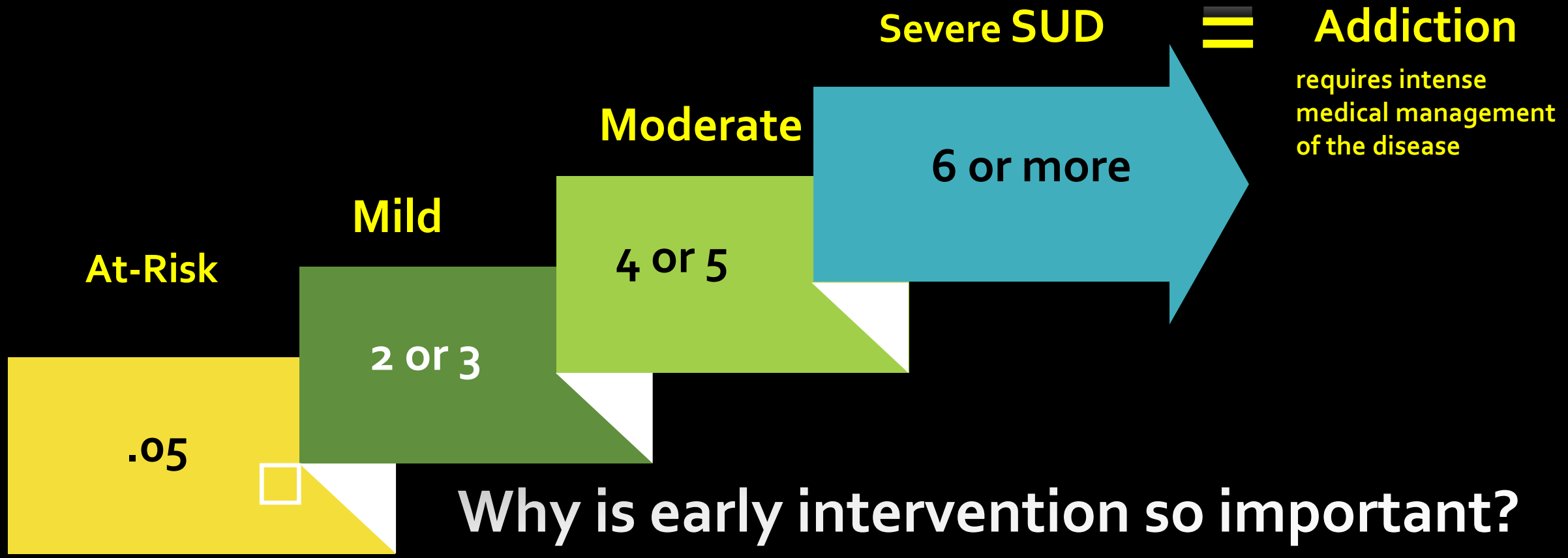
What Happens If We Call Addiction a Disease?

- Addicts are patients
- Addicts have the same rights as all patients
- Treat addiction in our healthcare system instead of in criminal justice system, shackling our patients with criminal histories
- Stigma associated with the disease disappears and addicts would not be stigmatized for their disease

Criteria for a Substance Use Disorder

1. Hazardous use
2. Social or interpersonal problems related to the use
3. Neglected major roles in life(work, school,etc)
4. Withdrawal
5. Tolerance
6. Used larger amounts/longer
7. Repeated attempts to control use or quit
8. Much time spent using
9. Physical or psychological problems related to use
10. Activities given up to use
11. Craving

Severity Levels of Substance Use Disorder



Why is early intervention so important?

Because like cancer and other health conditions, it worsens over time

Thank you for your attention!

Any Questions or Comments?

Abubaker@VCU.edu

Case Presentation #1
Ashley Wilson, MD

- 12:35-12:55 [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Case Presentation #1
Ashley Wilson, MD

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How could we best serve this patient in the context of her severe anxiety and benzodiazepine dependence? Recommendation for benzo taper? Are you aware of any community resources that could be helpful for her? Do you recommend any other treatments or medication changes?

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

29yo CF; born in Fairfax and raised in Charlotte w/ older sister. Worked as recreation therapist; lives with parents, who recently moved from GA to live with her.
Currently unemployed. Previously worked for 2 years at psychiatric facility. Has a 5 year old son-- chronically ill, has been on ventilator for the entirety of his life. Fiance'/ child's father was initially around but no longer present.
Mother is very supportive; present at all appointments. Patient's father and maternal family are also supportive.

Reminder: Mute and Unmute to talk
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Case Presentation #1
Ashley Wilson, MD

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Medical Diagnoses-- Polyarteritis Nodosa, Multiple DVTs, Fibromyalgia, Graves Disease, Pseudoseizures, ADHD, Migraines, Stroke, Preterm Delivery, Depression, Anxiety, Hypertension, hx of chronic nausea and vomiting leading to extensive dental issues
Previously in Pain Management

Current Medical treatments-- ongoing dental restoration (appointments weekly), upcoming nerve biopsy (suspected small fiber neuropathy), recent "genetic testing" done by PCP (outside) and upcoming 24 hr urine (r/o pheochromocytoma?)
On multiple medications, including synthroid, verapamil, lovenox, aimovig, isosorbide mononitrate, daily prednisone, lyrica, rizatriptan, (cymbalta, ambien, ativan, xanax, and suboxone at time of initial presentation)

Trauma hx- Ex BF drove from NY to Charlotte and tried to break into her house; police were called. He was never found. Stroke at age 21; premature delivery to son

Mental Health- previously on ativan 2-4mg q4-6 hrs for anxiety; currently sees pain psychologist + therapist
previously in 7 day opioid detox
on adderall throughout grade school and college

Previously in Pain management, told that pain meds made her pain worse--> rehab: started on suboxone----> SAIOP: continued suboxone; restarted ativan at total of 2mg/ day
Pain mgmt referred her to Motivate clinic

Reminder: Mute and Unmute to talk
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Case Presentation #1
Ashley Wilson, MD

What interventions have you tried up to this point ?
Additional case history (e.g. treatments, medications, referrals, etc.)

6/18/19- started at Motivate clinic. no issues with illicit use; taking suboxone as prescribed (8-2mg; 1.5 film/ day). Anxiety is primary concern. Increased Cymbalta and wrote short supply of alprazolam (0.5mg BID); also wrote lorazepam 0.5mg BID.

7/2/19- Anxiety is worse; having panic attacks 1-2x/ week
D/c alprazolam and increased lorazepam to 1mg TID with option to take an additional 1mg as needed for breakthrough-- took QID consistently

7/9/19- Panic attacks increasing in frequency and duration; last "hours." Asks for resumption of alprazolam for weekly dental appointments (2mg one hr before procedure and 2mg at time of procedure). Wrote for alprazolam for 1-2 dental appointments; continued lorazepam 1mg QID.

7/12/19- Mother calls office-- Panic attack lasting all day; Mom going out of town this weekend, next appointment is next Tues. --> Recommended ER; patient doesn't want to go. No SI/HI. Rx seroquel; gave ER precautions.
--> 7/16: Panic attacks worse. Not relieved by benzos. Seroquel caused chest and arm soreness. D/c seroquel. Started olanzapine. Continue lorazepam; alprazolam only for dental appt. Continue with pain psychologist and therapist.

7/23; 7/30-- Anxiety "all day"; d/c olanzapine; started abilify; discussed need to taper benzos soon. Pt wishes to wait until after family beach trip. Next appt in 2 weeks.

8/9-- Mom called stating daughter was "a mess" and had run out of benzos for anxiety. Refilled enough lorazepam to get to her appointment on 8/13.
-->8/13- No change; patient distraught when discussing benzo taper. Discussed IOP and PHP. Declined. Continue lorazepam 1mg QID for now and alprazolam only for dental appointments. Discussed that there would be no early benzo refills. Taper cymbalta + start pristiq; D/c abilify; ordered TSH, fT3, fT4, called PCP re: testing there

Case Presentation #1
Ashley Wilson, MD

What is your plan for future treatment? What are the patient's goals for treatment?

Wean benzos; recommended continuing with pain psychologist and therapist but also attending groups at Motivate clinic; re-consider higher level of care; continue suboxone

REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.

Reminder: Mute and Unmute to talk
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Case Presentation #2
Manhal Saleeby, MD

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
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Case Presentation #2
Manhal Saleeby, MD

Please state your main question(s) or what feedback/suggestions you would like from the group today?

None compliance, self medication, addictive behavior 60-year-old white male

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

60 years old white male who works as an employed engineer lives with wife no kids with good social support moved recently to Virginia
The patient smokes 2 packs a day does not drink alcohol and he used marijuana only as a teenager

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Underwent 2 lumbar fusions L4-5 and S1 in 2001 and 2002 with chronic back pain and radicular pain and was referred by his family physician after his 1st visit with the patient.
The patient otherwise healthy not on any meds with the exception of gabapentin 800 mg every 6 hours ibuprofen over-the-counter and L limited supply of hydrocodone 10 mg was given to him by his PCP just enough to last until his visit with us
The plan was a transforaminal block and gradual taper of his gabapentin since he did not feel it was helping and to consider starting him on Lyrica(per his request).
A prescription was given for gabapentin 600 mg every 6 hours, procedure scheduled

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Case Presentation #2
Manhal Saleeby, MD

What interventions have you tried up to this point ?
Additional case history (e.g. treatments, medications, referrals, etc.)

The patient wanted to try injections and has questions about spinal cord stimulator, had injections in the past and they did help, said that he was on OxyContin 80 mg 3 times a day at 1 point and fentanyl patches 100 mcg for several years, he gradually weaned off the meds and does not want to go back again.
We did a 2 level transforaminal block after which the patient called within couple of days complaining of excruciating pain.
The patient called the office said that he is out of his gabapentin 800 mg because he doubled up on it and he was taking ibuprofen 200 mg, 10 tablets every 6 hours and he confirmed with the nurse that he was taking 40 tablets a day

What is your plan for future treatment? What are the patient's goals for treatment?

The patient was brought for an earlier appointment, he asked for a short term supply of hydrocodone until his visit with the neurosurgeon for a spinal cord stimulator trial.
The patient does not want to go back on high-dose opioids however he has been self medicating with gabapentin and ibuprofen and started asking about short-term opioids

Other relevant information

Bursts of anger followed by periods of calm.
Wants to continue to work full-time and not asking for disability

End of Case Study

Reminder: Mute and Unmute to talk
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Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/virginia-opioid-addiction-echo-thank-you

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- Palliative Care ECHO +
- Sickle Cell Disease ECHO +

Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- **Michael Bohan, MD** from Meridian Psychotherapy
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Michael Fox, DO** from VCU Health
- **Shannon Garrett, FNP** from West Grace Health Center
- **Sharon Hardy, BSW, CSAC** from Hampton-Newport News CSB
- **Sunny Kim, NP** from VCU Health
- **Thokozeni Lipato, MD** from VCU Health
- **Caitlin Martin, MD** from VCU Health
- **Faisal Mohsin, MD** from Hampton-Newport News CSB
- **Stephanie Osler, LCSW** from Children's Hospital of the King's Daughters
- **Jennifer Phelps, BS, LPN** from Horizons Behavioral Health
- **Crystal Phillips, PharmD** from Appalachian College of Pharmacy
- **Tierra Ruffin, LPC** from Hampton-Newport News CSB
- **Jenny Sear-Cockram, NP** from Chesterfield County Mental Health Support Services
- **Daniel Spencer, MD** from Children's Hospital of the King's Daughters
- **Cynthia Straub, FNP-C, ACHPN** from Memorial Regional Medical Center
- **Barbara Trandel, MD** from Colonial Behavioral Health
- **Bill Trost, MD** from Danville-Pittsylvania Community Service
- **Art Van Zee, MD** from Stone Mountain Health Services
- **Sarah Woodhouse, MD** from Chesterfield Mental Health

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Submit Feedback

Opportunity to formally submit feedback

- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?

Claim Your CME and Provide Feedback

- www.vcuhealth.org/echo

- To claim CME credit for today's session
- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

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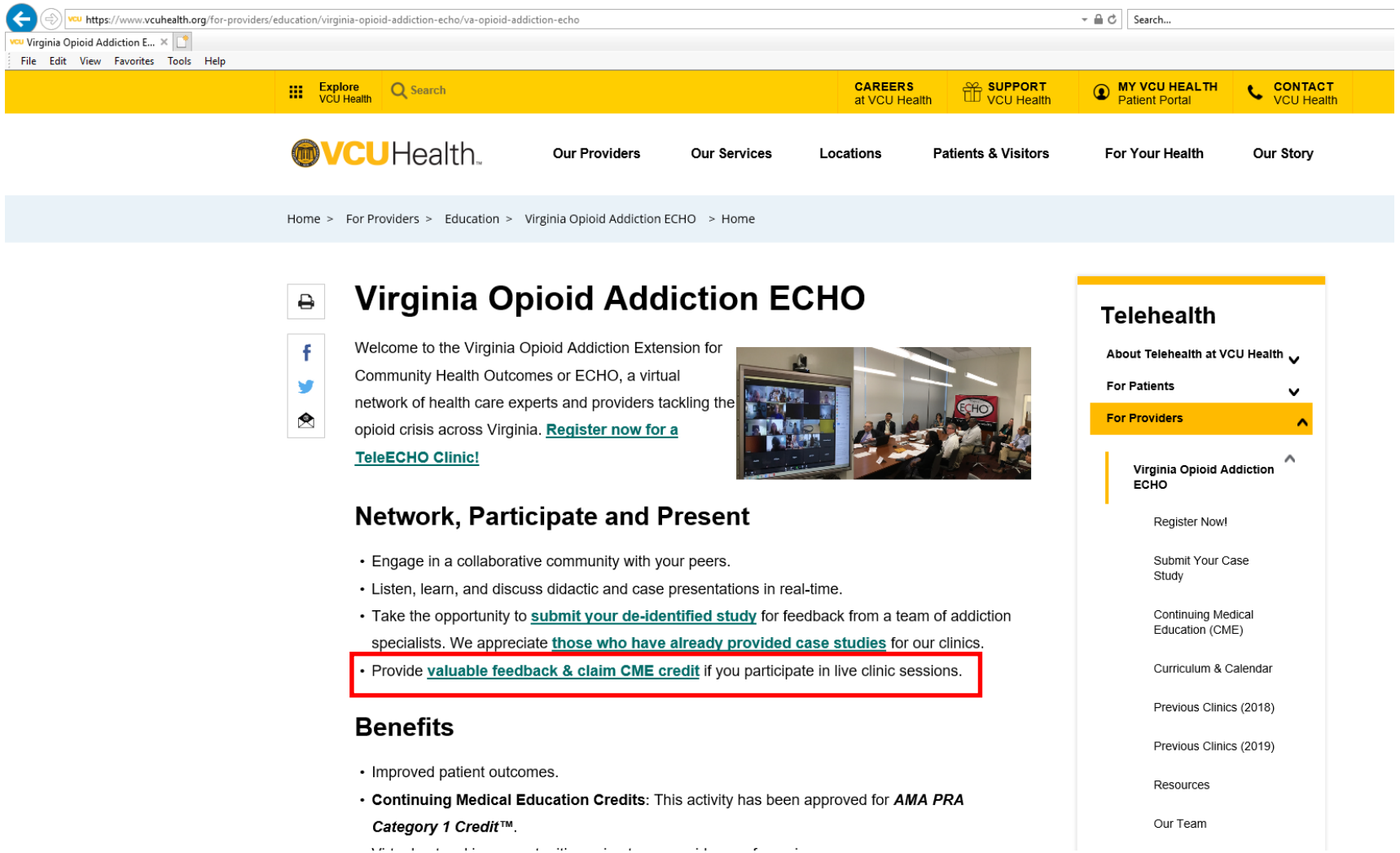

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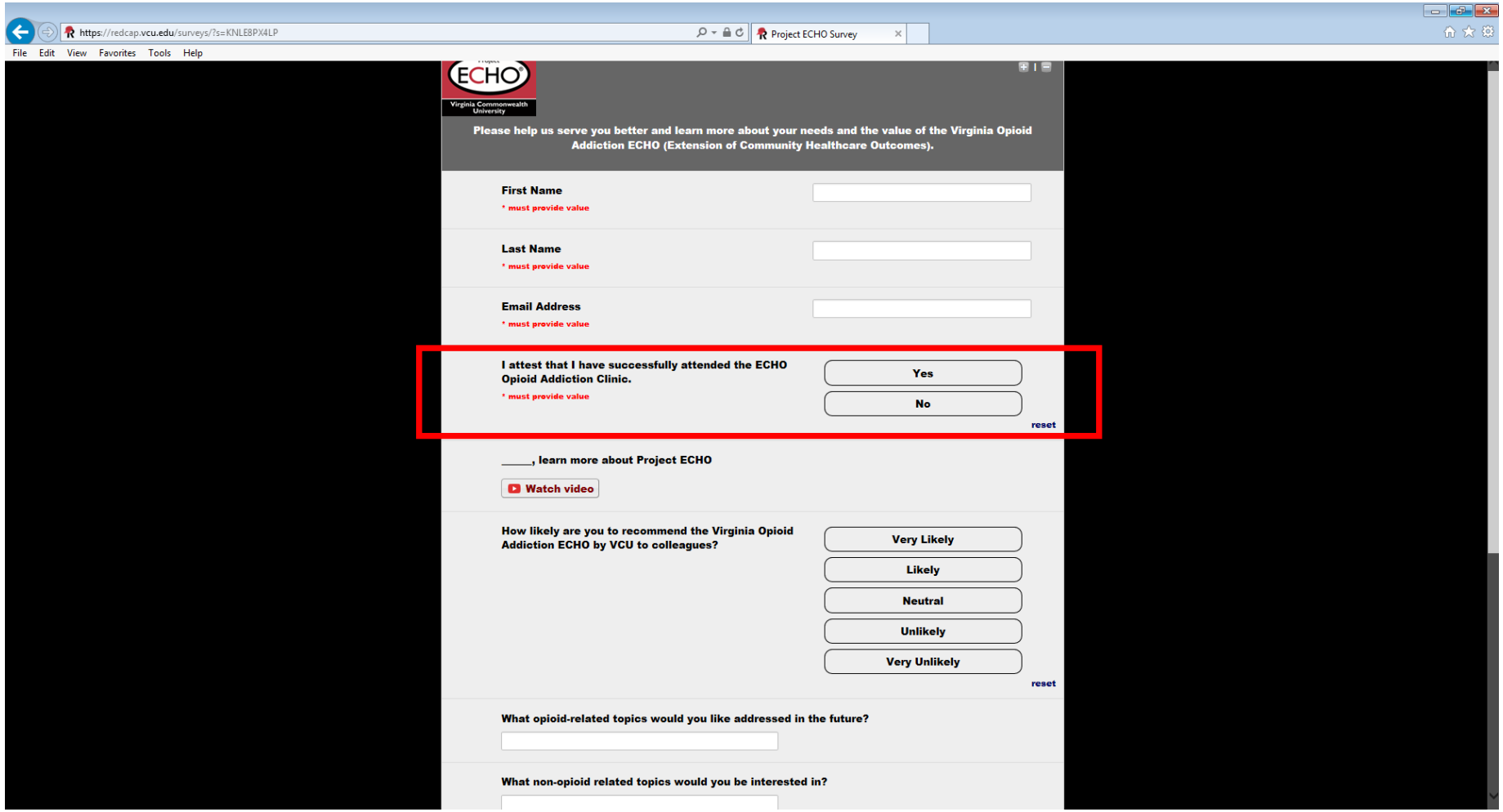

Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/va-opioid-addiction-echo

Virginia Opioid Addiction E...

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Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. **Register now for a TeleECHO Clinic!**

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to **submit your de-identified study** for feedback from a team of addiction specialists. We appreciate **those who have already provided case studies** for our clinics.
- Provide **valuable feedback & claim CME credit** if you participate in live clinic sessions.

Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits**: This activity has been approved for ***AMA PRA Category 1 Credit™***.

Telehealth

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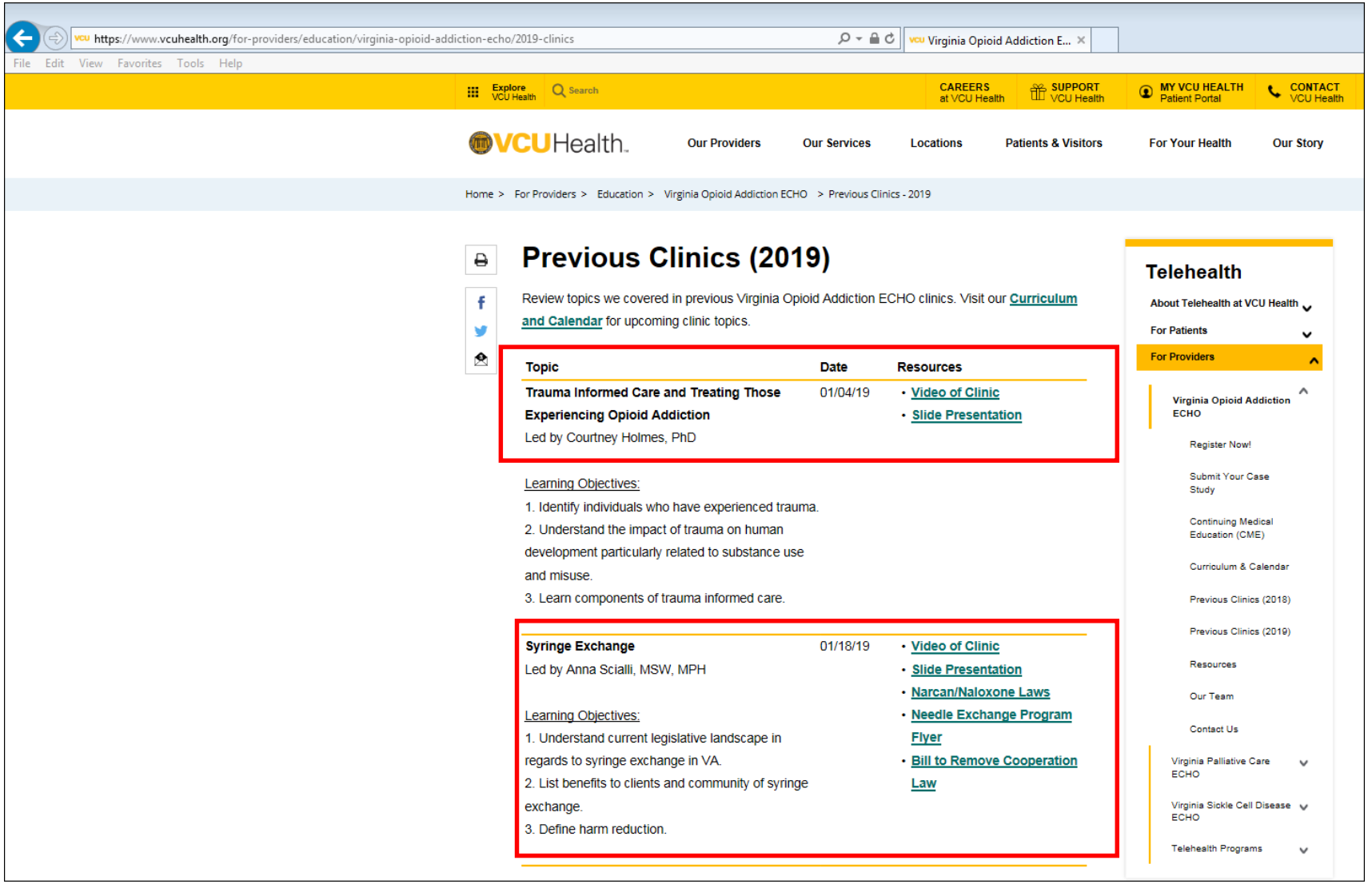
    - Previous Clinics (2019)
    - Resources
    - Our Team

Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Thank you for attending our Summer Opioid ECHO,

We will Resume in the Fall!

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

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Resources

Pain Relief Toolkit: https://aaos.org/PainReliefToolkit/?ssopc=1

Fatal Drug Overdose Quarterly Report: http://www.vdh.virginia.gov/content/uploads/sites/18/2018/07/Quarterly-Drug-Death-Report-FINAL-Q1-2018.pdf