OPIOID MANAGEMENT &COMPLEMENTARY OPTIONS

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DISCLOSURE

- I HAVE NO FINANCIAL RELATIONSHIPS TO DISCLOSE
- INDEPENDENT OWNER OF YOUR SHINING LIFE, LLC/AMBROSIA AROMATICS… HELPING PEOPLE SUPPORT & MANAGE PAIN/STRESS WITH NATURAL THERAPIES

OBJECTIVES

- REVIEW CDC GUIDELINES, MICHIGAN OPEN GUIDELINES, INTERAGENCY REPORT
- DISCUSS/IDENTIFY OUD (OPIOID USED DISORDER); MAT
- REVIEW TYPES OF PAIN; NON OPIOID PAIN MEDS
- ACUTE PAIN(POST-OP) OPIOID MGMT
- REVIEW TAPERING; MME REVIEW
- IDENTIFY AZ STATUES/LAWS FOR PA OPIOID PRESCRIBING
- INTRODUCE COMPLEMENTARY CONSIDERATIONS

MY START, MY JOURNEY, MY TRANSITION

- Graduated PA school 2000, ~20 years ago
- Spine Triage for Neurosurgery 2 years
- PMR 5 years
- Ortho Spine Surgery/Ortho Trauma 7 years
- Pain Management 5 years
- 6 years ago: Certified/Registered Aromatherapist
- 1 year ago: Stress Management Coaching Certification
- Currently Pain Mgmt Coordinator for local FQHC
  and Part-time PMR PA-C

HOW ABOUT THE AUDIENCE HERE?

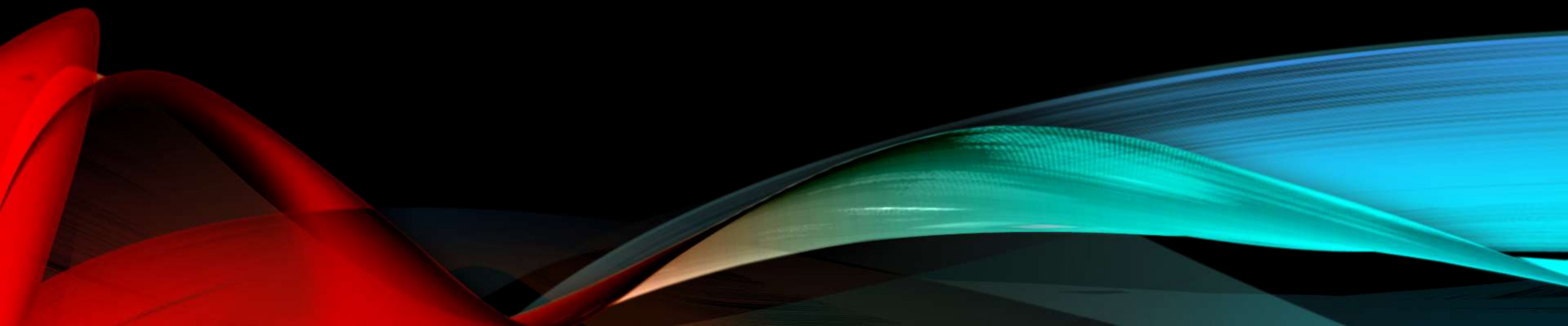
- YEARS EXPERIENCE? 0-5? 6-10? 10+?
- ORTHO? OTHER SURGERY? OTHER SPECIALTY?
- AZ OR OTHER STATE

- PERSPECTIVES ON OPIOIDS & PATIENTS:
  - TOO RESTRICTIVE
  - OPIOIDS SERVE A SHORT TERM PURPOSE
  - PATIENTS SHOULD HAVE OPIOIDS, I JUST DON'T WANT TO BE THE ONE DOING IT

It's a Stretch

HOW DID WE GET HERE?
PAIN IS THE 5TH VITAL SIGN…NEGLECT OF PATIENT IF NOT TREATED …PAIN IS SUBJECTIVE..
OPIOID CRISIS…OPIOID EPIDEMIC??

AND…THE PENDULUM SWINGS THE OTHER WAY…



CDC Guidelines, 2016

- Establish pain and functional goals. Have a plan for opioid discontinuation
- Discuss known risks and benefits regularly, as well as patient and clinician responsibilities
- Initiate opioid therapy with short-acting preparation NEVER START with long acting opioid
- Start with lowest effective dose, avoid doses of > 90mg/day and carefully justify doses higher than this.
- Clinicians should use urine drug screening (UDS) before starting opioid therapy and consider UDS at least annually to assess for prescribed medications and other controlled substances.

Centers for Disease Control and Prevention. *Guideline for Prescribing Opioids for Chronic Pain.* 2016. www.cdc.gov/drugoverdose/prescribing/guidelines.html.

"I can give you a pill for that."

Risk factors opioid misuse:

- past or current substance abuse
- (untreated) psychiatric disorders
- younger age
- family history of substance abuse
- Opioid mortality prevalence is higher in people who are middle aged and have substance abuse and psychiatric comorbidities.
- (Pre)adolescent sexual abuse

Webster, Lynn R.; Anesthesia & Analgesia, Volume 125,Number 5, November 2017, pp.1741-1748(8)
DOI:https://doi.org/10.1213/ANE.0000000000002496

OUD Definition- Opioid Use Disorder

- OUD has also been referred to as "opioid addiction.“
- About 2.1 million Americans had opioid use disorder in 2016. (ILLICIT VS RX?)
- OUD is defined in the DSM-5 as a problematic pattern of opioid use leading to clinically significant impairment or distress.
- OUD was previously classified as Opioid Abuse or Opioid Dependence in DSM-IV.
- DSM-5 Diagnostic Criteria for OUD

In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Exhibits tolerance *
- Exhibits withdrawal *

MEDICATED ASSISTED TREATMENT(MAT)

- WAIVER FOR PA/NP
- NEED 24 HOURS TRAINING; UP TO 8 HRS IN TRAINING; REMAINDER ONLINE
- CAN RX SUBOXONE, METHADONE OR VIVITROL FOR OUD
- LIMITED # PATIENTS PER YEAR CAN BE MANAGED

- BUPRENORPHINE CAN BE RX'D FOR PAIN (BUTRANS PATCH, BELBUCA, BUP TABS) NOT RELATED TO OUD AND WAIVER NOT NEEDED

TYPES OF PAIN
&
PHARM/NON-PHARM CONSIDERATIONS

- **Three types of pain**
  - *Nociceptive: activate the pain receptors; usually assoc with medical condition;* first line= NSAIDs
  - *Visceral pain: organ pain;* first line very dependent upon viscera involved but usually antidepressant/anti-epileptic drugs
  - *Neuropathic pain*: *injury to central or peripheral nervous system; dysfunctional neuronal firing; may lack active tissue damage despite cont. symptoms; complex*; first line usually antidepressant/anti-epileptic drugs, local anesthetics

*Many people have both esp. chronic pain; VERY IMPORTANT to differentiate b/c they respond differently to treatments

❖ Non-Opioid Pharmacotherapy for pain should be directed towards the type of pain

Non-opioid categories

- ***Primary analgesics:*** *NSAIDs, ASA, APAP*
- ***Anticonvulsants:*** *Gabapentenoids, Topiramate, etc.*
- ***Anesthetics:*** *Lidocaine*
- ***Antidepressants:*** *TCAs and SNRIs*
- ***Muscle Relaxers:*** *baclofen, tizanadine, cyclobenzaprine,etc*
- ***Topicals:*** lidocaine, NSAIDs, capsaicin
- ***Misc. drugs***: ketamine, naltrexone

Osteoarthritis management

Nonpharmacological treatments:

- Exercise & Weight loss
- Gentle ROM/mvmt; Tai Chi
- Physical Therapy/Aquatic therapy (can transition to independent therapy)
- Infrared therapy (not thermal); Heat (thermal) & ice

Medications(all delivery):

- First-line: Acetaminophen, oral NSAIDs, topical NSAIDs, PLO creams
- Second-line (office based): intra-articular steroids, intra-articular hyaluronic acid, PRP, Stem Cell

Procedures (specialists):

- Knee pain: Genicular nerve blocks/ RFA
- Back Pain: MBB's, RFA, poss. ESI
- *** DRG SCS***

MEDICATIONS FOR NEUROPATHIC PAIN

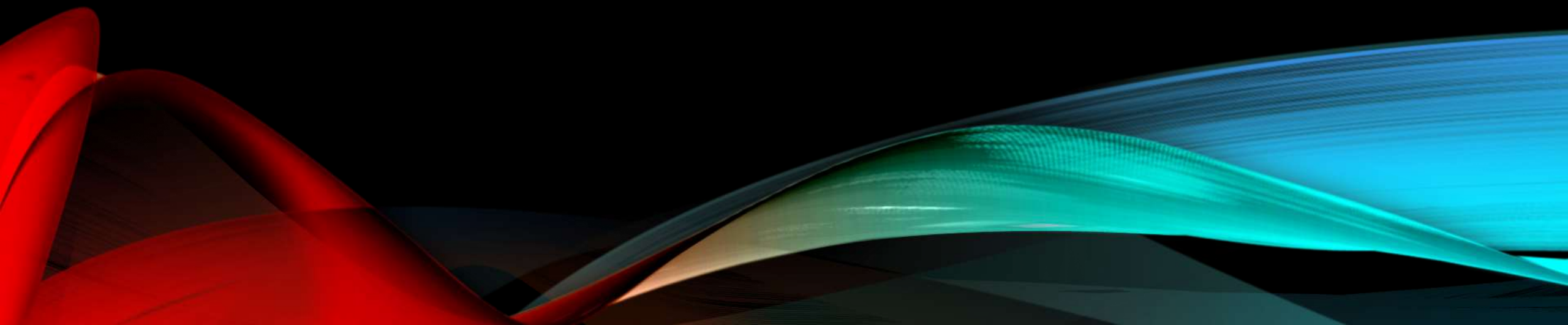
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Gabapentin/Pregabalin
- Topical lidocaine
- Tri-cyclic antidepressants (TCAs)

Muscle Relaxers

- **Act by various mechanisms:**
- Direct effect on muscle tone: **baclofen, tizanadine**
- Direct effect on Acetyl choline receptor: **Botox**
- Effects mediated by higher cortical centers: **cyclobenzaprine, methocarbamol, chlorzoxazone**

ACUTE PAIN, PERI-OP & POST-OP MED MGMT.

RECOMMENDATIONS & CONSIDERATIONS



FOCUS ON ACUTE & CHRONIC PAIN

- Acute Pain has abrupt onset
- Typically injury or identifiable cause
- Pre-/peri-/post- operative
- Usually lasting not more than 4 wks

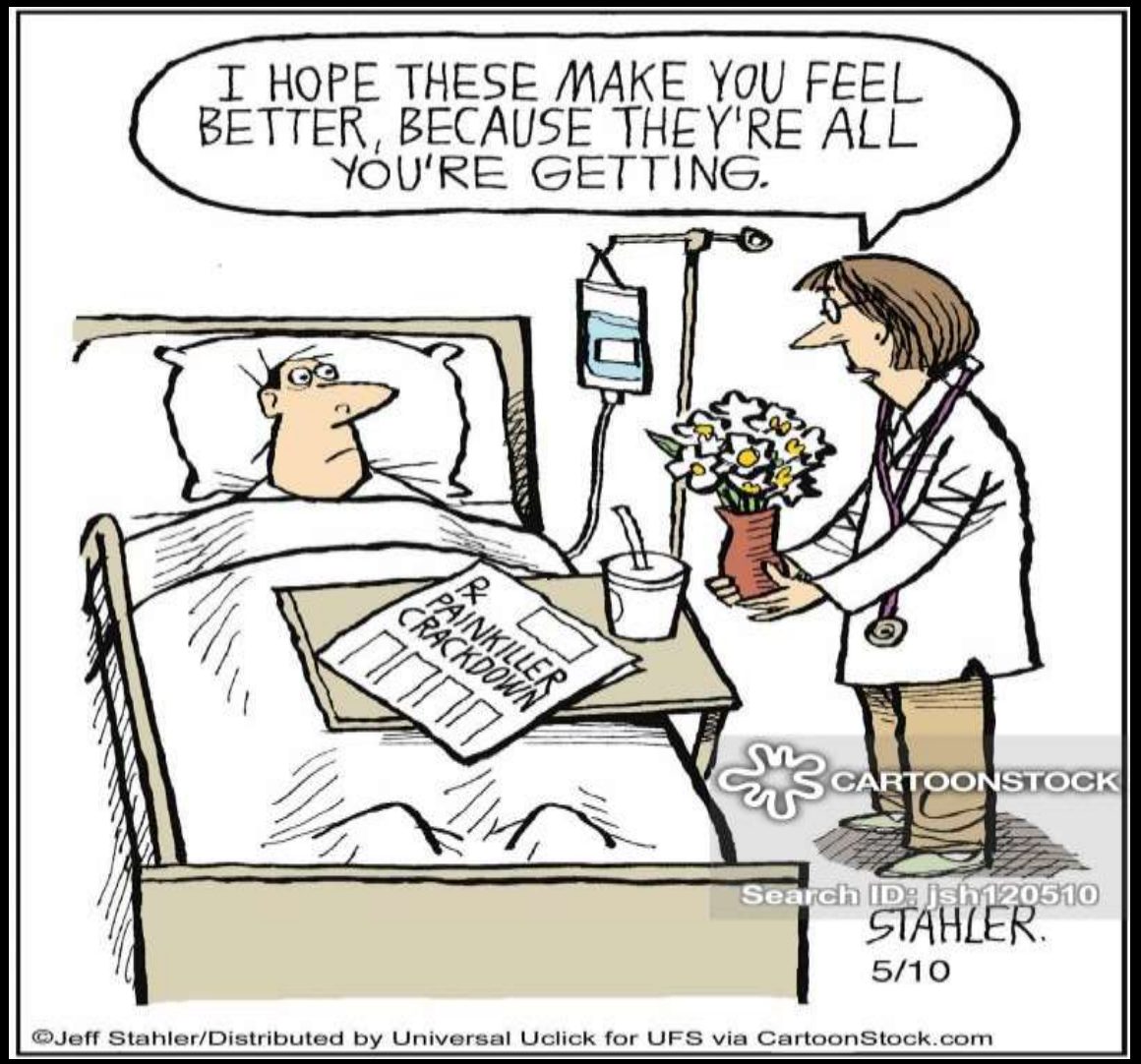
- Biggest concern with opioids for acute pain????

- Chronic pain can occur from injury, inflammation, medical conditions, sometimes unknown
- Pain that lasts beyond 3 months or beyond "expected" normal healing
- Concern about effectiveness of chronic opioid therapy vs. risk of misuse, addiction, overdose

ACUTE PAIN:CONCERNS?

- Overprescribing quantity of meds post-op/procedures can lead to "leftovers"
- 72% of opioids Rx'd by surgeon go unused by patient whom Rx'd for (1)
- 6-10% of surgical patients become persistent opioid users (being considered a significant complication) (2)
- According to SAMHSA, from a 2009 survey, 40-50% of people who have abused opioids, initially received a pill from someone who had "leftovers"

- Guidelines have been created (SUGGESTING)Rxing # of pain meds for certain surgical procedures
- In AZ there is a 14 day limit for opioids Rx'd post-op


I HOPE THESE MAKE YOU FEEL BETTER, BECAUSE THEY'RE ALL YOU'RE GETTING.
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EVIDENCE BASED REASONS TO CHANGE POST-OP PRESCRIBING HABITS

- Refer to Michigan-OPEN.org (Opioid Prescribing Engagement Network)
- Patients who were Rx'd fewer opioids took fewer opioids w/o ⬆ in pain
- Previous slides % only some of the EBM outcomes
- These recommendations serve for those NOT on opioids preceding year
- Recommend:

  -Setting expectations(there will be pain; meds help cope)but focus on goals:

  -Eating, moving, deep breathing, sleeping

  -Use NSAIDS, Tylenol on schedule, opioids for severe pain & only for this pain

  -Discuss: N/V/constipation/dependence/addiction/OD/diversion

Acute Care Opioid Treatment and Prescribing Recommendations:

Summary of Selected Best Practices

These recommendations are to be used as a clinical tool, but they do not replace clinician judgment.

Surgical Department

Preoperative Counseling: For patients not using opioids before surgery

- Discuss the expectations regarding recovery and pain management goals with the patient.
- Educate the patient regarding safe opioid use, storage, and disposal.
- Determine the patient's current medications (e.g., sleep aids, benzodiazepines), and any high-risk behaviors or diagnosis (e.g., substance use disorder, depression, or anxiety).
- Do NOT provide opioid prescription, for postoperative use, prior to surgery date.

Intraoperative

- Consider nerve block, local anesthetic catheter or an epidural when appropriate.
- Consider non-opioid medications when appropriate (e.g., ketorolac).

Postoperative

- Meperidine (Demerol) should NOT be used for outpatient surgeries.
- If opioids are deemed appropriate therapy, oral is preferred over IV route.
- Ensure all nursing, ancillary staff and written discharge instructions communicate consistent messaging regarding functional pain management goals.

For patients discharged from surgical department with an opioid prescription

- The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law.
- Non-opioid therapies should be encouraged as a primary treatment for pain management (e.g., acetaminophen, ibuprofen).
- Non-pharmacologic therapies should be encouraged (e.g., ice, elevation, physical therapy).
- Do NOT prescribe opioids with other sedative medications (e.g., benzodiazepines).
- Short-acting opioids should be prescribed for no more than 3-5 day courses (e.g., hydrocodone, oxycodone).
- Fentanyl or Long-acting opioids such as methadone, OxyContin and should NOT be prescribed to opioid naïve patients.
- Consider offering a naloxone co-prescription to patients who may be at increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving higher doses of opioids (e.g., >50 MME/Day).
- Educate patient and parent/guardian (for minors) regarding safe use of opioids, potential side effects, overdose risks, and developing dependence or addiction.
- Educate patient on tapering of opioids as surgical pain resolves.
- Refer to opioidprescribing.info for free prescribing recommendations for many types of surgeries.
- Refer and provide resources for patients who have or are suspected to have a substance use disorder.

PDOAC | Prescription Drug & Opioid Abuse Commission | OPEN | INJURY PREVENTION CENTER | MDHHS

Updated and Approved by the PDOAC June 26, 2018

MANAGING YOUR PAIN AFTER SURGERY WITHOUT OPIOIDS

Recent studies have shown that your surgical pain can be managed using non-opioid, over-the-counter pain medications (acetaminophen and ibuprofen).

How much pain will I have after surgery?

- You can expect to have *some* pain after surgery.
  - This is normal and part of the healing process.
  - Your surgical pain is typically worse the day after surgery, and quickly begins to get better.
- Everyone feels pain differently.
- The goal is to manage your pain so you can do the things you need to care for yourself and heal:
  - Eat
  - Breathe deeply
  - Walk
  - Sleep

How will I manage my pain at home?

You will manage your pain after surgery by taking acetaminophen (Tylenol) and ibuprofen (Motrin or Advil) **around the clock** while you are awake. **Alternating** these medications allows you to get the best pain control.

How do I alternate my medications?

- Take 650mg of Tylenol (2 pills of regular strength, 325mg Tylenol) every 6 hours while awake.
  - ➡ Do not take more than 3000mg of Tylenol in 24 hours.
- **Alternate** with 600 mg of Motrin (3 pills of 200 mg) every 6 hours while awake.
  - ➡ Do not take more than 3200mg of Motrin in 24 hours.
- **Alternating** these medications means you are taking a dose every 3 hours.

Obtained from website: Michigan Open-org

- This is an example of how to alternate your medications, if you start at 12pm:

12:00 PM	Tylenol 650 mg (2 pills of 325 mg)
3:00 PM	Motrin 600 mg (3 pills of 200 mg)
6:00 PM	Tylenol 650 mg (2 pills of 325 mg)
9:00 PM	Motrin 600 mg (3 pills of 200 mg)
Continue alternating every 3 hours for 3 days, until no longer needed.	

What else can I do to help manage my pain?

Pain medications are only one part of your pain management plan. While taking your medications, you can also:

- Use heating pads, or ice packs, as directed by your surgeon. Never put ice directly on your skin – use a towel to wrap the ice packs.
- Try non-drug options such as relaxation, distraction (listening to music, reading, talking to others), mindful breathing, or daily reflections.

What if I still have pain?

- You will receive a prescription for a small amount of an opioid pain medication (like Oxycodone or Tramadol).
- You may use your opioid for *severe pain* in **the first 24 hours** after surgery.
    - Severe pain is pain that does not allow you to function (eat, breathe deeply, walk or sleep) and is not manageable using your scheduled Tylenol and Motrin.
- Do not take more than 1 opioid pill every 4-6 hours, and only if needed for *severe pain*.
- If you are having trouble managing your pain, call your surgeon or the number you were given at discharge.
    - Never take more opioid pills, more often, than prescribed.
    - Do not use your opioid pills for anything other than your *severe* surgical pain. For example, do not use your opioids to help you manage anxiety, to help you sleep or for other pain that is not from your surgery.
- Stop taking the opioids as soon as possible.

Obtained from website: Michigan Open-org

PERI-/POST OP MULTIMODAL APPROACH

- Consider multimodal analgesia
  - txs targeting different sites
  - txs using different mechanisms
  - different classes of drugs
  - drug & non-drug options
  - non-pharmacological options

APPROACH PERI & POST-OP INPATIENT

Non-oral considerations

- IV Acetaminophen
- IV Ketorolac
- IV PCA with limits & days ex: w/in 48hrs
- IV ketamine (bolus/infusion)
- Regional blocks
- Epidural analgesia
- Local infiltration of anesthetic
- Ice, elevation

Oral considerations

- If not IV NSAIDS or acetaminophen, then oral
- Oral ER opioids with IR
- Gabapentin if neuropathic pain

*Topical NSAIDS/anesthetic

NON-PHARMACOLOGIC OPTIONS

- PROM/continuous (PT, CPM)
- Cold/compression
- Acupuncture

  Has systematic reviews, meta-analyses that demonstrate reduced pain & reduced use of opioids
- TENS (Amer.Pain Soc. recommends though limited evidence)
- Massage therapy (studies don't show improved outcomes)
- Infrared/laser/light
- Heat (later post-op phase)

*** "The manuscript containing this data is currently under review for publication. Michigan OPEN will make the data public upon completion of the review and publication process." ***

**Suggested recommendations for post-op opioids for THA:

Oxycodone 5mg #30, which allows for Tylenol & NSAIDS regimen as noted previously

**Suggested recommendations for post-op opioids for TKA:

Oxycodone 5mg #50, which allows for Tylenol & NSAIDS regimen as noted previously

- Interestingly, if you Rx Hydrocodone instead, the Qty remains same,
  Yet MME is less for Hydrocodone. Also limits the Tylenol regimen because of Hydro/APAP
- Consider Hydromorphone? but remember the MME conversion (4:1) (see MME chart)
- ER/LA opioids not recommended (outpatient) post-op, esp. in opioid naive patients

POINTS TO CONSIDER

Among opioid-naïve patients undergoing common surgical procedures, 6-10% continue filling opioid prescriptions 3-6 months after surgery.[1,2] 72% of opioids prescribed by surgeons go unused by patients.[3]

- For patients taking opioids preoperatively, prescribers are encouraged to use their best judgment.
- As part of post-operative pain care, Michigan OPEN strongly advocates **patient counseling** prior to surgery, and the use of over-the-counter medications, when indicated.

POINTS TO CONSIDER, CONT…

- I would encourage your patients who are on chronic opioid mgmt. to discuss post-op mgmt. with their pain provider prior to surgery
- It is worth your time to contact the pain mgmt. provider regarding this to discuss a plan
- In my experience (as the pain mgmt. provider), I preferred to manage the post-op meds as there was no duplicate meds, confusion or issues at pharmacy (most often the surgeon was more than obliged for me to do so)
- VERY IMPORTANT: if a patient is on MAT or buprenorphine product PLEASE discuss a plan with that provider who is prescribing; also important to involve anesthesia ahead of time

According to JAMA surg May 2017, a large study demonstrated among a population of **opioid-naïve** patients, who were given a course of opioids for pain following surgery, **6%** became new chronic opioid users.

Those with hx (/or current) of: tobacco use, alcohol/substance abuse, anxiety, depression, other pain disorders and comorbid conditions were those at higher risk of becoming chronic opioid users.

- Do you have a risk assessment/evaluation protocol for elective surgical cases?
- Do you have a preoperative consultation/planning protocol at your facility?
- Do you have a peri-op/post-op team in place to implement multi-modality approach?
- Do you have behavioral interventions in the pre- and post –op periods?

HOW TO TAPER OFF OPIOIDS

SUGGESTIONS & GUIDELINES

ALWAYS CONSULT WITH CLINICAL PHARMACY OR PAIN SPECIALIST IF NOT COMFORTABLE WITH TAPER OR HAVE OTHER CONCERNS

IF RELATED TO POST-OP:

- NOTE: Taper Schedules vary
- This is dependent on many factors; MME, duration of use, Behavior health

  - IF a patient wasn't on meds prior to surgery, this need not be a long slow taper
  - If counseling & expectations were reviewed ahead of time you can limit: "I will only Rx ---- #---- for ----days/weeks".

    -If patient still using meds & you agree to Rx, should reduce by 10-20% per week

    -AND reiterate non-opioid meds & non-pharm options

IF NOT RELATED TO POST-OP:

- Consider the factors but usually rule of thumb is:

  -10% reduction per week (if abuse confirmed, can reduce every few days)

  -reassess more often-see patient weekly or every 2 weeks

  -consider clonidine 0.1mg BID for withdrawal symptoms (caution HypoTN)

  -OR tizanidine (another alpha-2 agonist); help with spasm/anxiety (dizzy,sedate)

Calculating Morphine Milligram Equivalents (MME)

OPIOID	CONVERSION FACTOR
Codeine	0.15
Fentanyl Transdermal (in mcg/hr.)	2.4
Hydrocodone	1
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Calculating Total Daily Dose of Opioids for Safer Dosage. www.cdc.gov/drugoverdose/prescribing/guideline.html

Hydromorphone ___
Tramadol ____

*Buprenorphine

EXAMPLE OF FAST/SLOW TAPER:
POST-OP PT USING NORCO 5/325 2 TABS PO Q 6HRS (8 TABS/DAY; 40MG/DAY;40MME)

FAST TAPER (OVER 10 DAYS)

1 TAB Q 6HR; 4 PER DAY x 1 day

1 TAB Q 8HR; 3 PER DAY x 3 days

1 TAB Q 12 HR; 2 PER DAY x 3 days

1 TAB Q 24 HR; 1 PER DAY x 3 days

Then discontinue

SLOW TAPER (OVER 3 WKS)

7 TABS/PER DAY; FOR 3 DAYS

6 TABS/PER DAY; FOR 3 DAYS

5 TABS/PER DAY; FOR 3 DAYS

…….CONTINUE

1 TAB/ PER DAY; FOR 3 DAYS

Then discontinue

PATIENT WITH MORE TOLERANCE OR HIGHER MME OR OTHER CONCERNS FOR SLOW TAPER

Oxycodone 5mg 2 tabs q 4 hrs= 12 tabs per day= 60mg oxy (90 MME!)

Reduce by 10% per week: 10% x 60mg= 6mg= 1 tab or 15% is about 2 tabs/day

WEEK 1: 1-2 TABS Q 4 HRS (10 TABS PER DAY) = 70 tabs on Rx

WEEK 2: 2 TABS Q 6 HRS (8 TABS PER DAY) = 56 tabs on Rx

WEEK 3: 1 TAB Q 4 HRS (6 TABS PER DAY) = 42 tabs on Rx

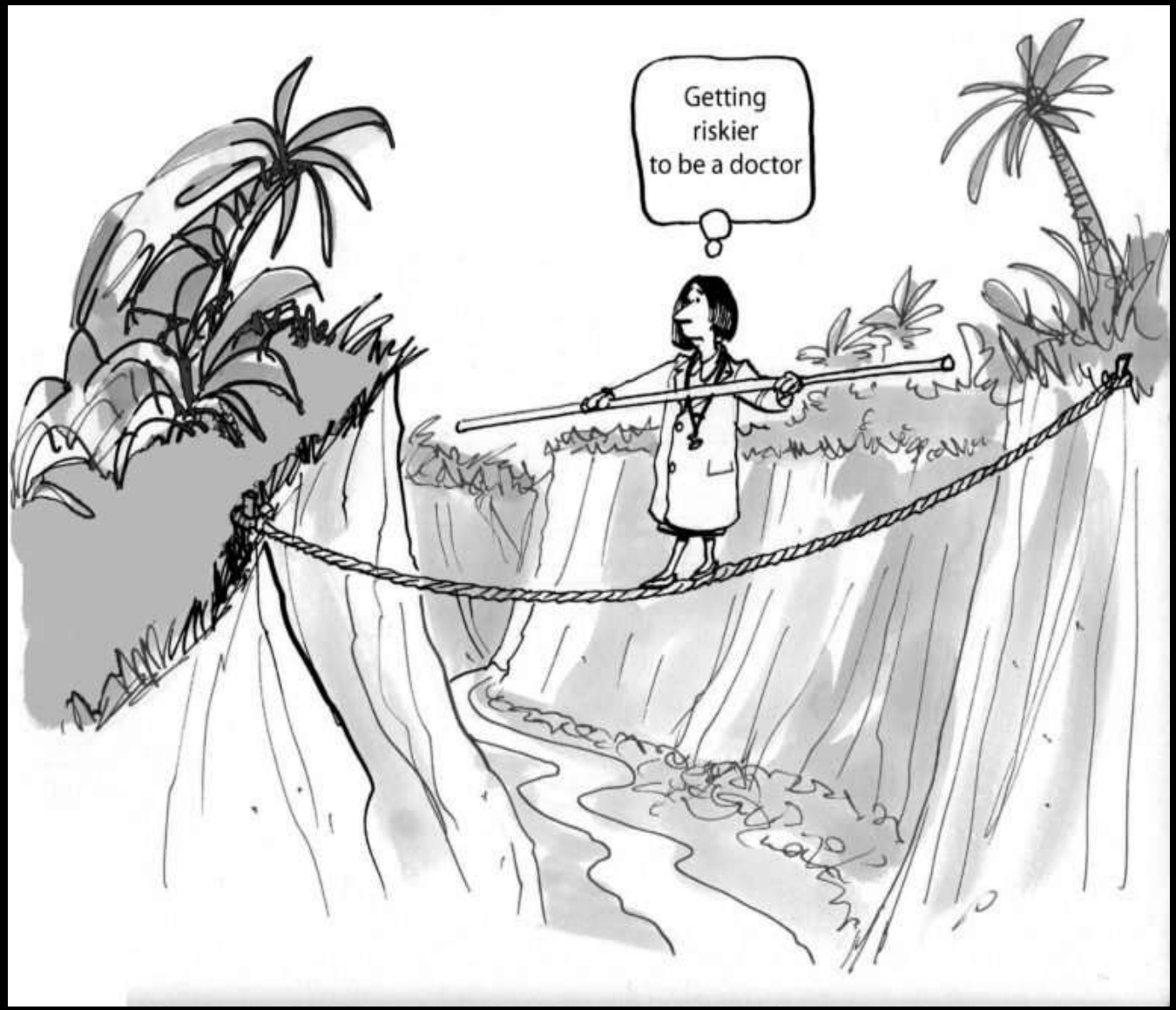
WEEK 4: 1 TAB Q 6 HRS (4 TABS PER DAY) = 28 tabs on Rx

WEEK 5: 1 TAB Q 12 HRS (2 TABS PER DAY) = 14 tabs on Rx

WEEK 6: 1 TAB Q DAY (1 TAB PER DAY) = 7 tabs on Rx

SUGGESTIONS

- Recommend providing these Rx's each as weekly with TB filled dates
- Recommend having some tapering schedules written up ahead of time or in EMR to be printed out
- Recommend having reference tables easily accessible for yourself
- Recommend having these Tapering Rx's in EMR to save a lot of time
- Recommend having Tapering tables in EMR (10% reduction/25%/ Fast/Slow)


Getting
riskier
to be a doctor

PRESCRIPTION MONITORING DATABASES

- Each state designates a state agency to oversee the pharmacy board reporting
- Each state may have their own "name" ; AZ: CSPMP
- **PDMPASSIST.ORG** : List of each state "agency/title" & contact info
- **AZ: MUST register for CSPMP** (other statutes/regulations to follow like: MUST review & document PMP before RX given)
- Contact your board or local agency to find your state statutes/laws

Arizona Opioid Guidelines

https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf

MITIGATION- AZ STATUTES FOR ALL PRESCRIBING PROVIDERS

- Must be registered with the Arizona controlled substance prescription monitoring program (PMP) if you have a DEA license (2017)
- Must check the PMP before any new prescription or change in prescription for a schedule II, III, IV drug, and then at least quarterly (some exemptions)
- If issuing a new prescription for > 90MME, must consult with a physician board certified in pain or an opioid assistance referral service that is designated by DHS (OAR line), and document consult recommendations in patient's chart
- Must prescribe Naloxone if patient is on >90MME
- All oversight Boards have access to review of PMP without open investigation

PRESCRIBING LAWS- AZ

- **Initial prescription for a schedule II opioid limited to no more than 5 days; 14 days if following surgical procedure (some exemptions)**
- NO **dispensing** of schedule II opioids, except for MAT (if waivered)
- If **dispensing** Schedule III,IV,V or non-opioid II, must be registered with PMP clearing house and submit daily reports, including zero reports, for these controlled substances.
- **New prescription limit: 90MME; ***Consult with specialist if higher dose needed, or if increasing dose above 90MME in established patients with chronic pain**
- Can prescribe methadone or low dose buprenorphine for pain
- Can prescribe, dispense or administer Naltrexone and Naloxone
- **Can only RX CSII opioid electronically after 1/1/20** (S1108/H2075: 2/14/19)

Physician Assistants prescribing authority-AZ

- If qualified: PAs can be certified for 90 day prescription privileges for NON opioids or benzodiazepines in schedule II or III class; (if certified by national commission or has 45 hours in pharmacology, or clinical management of drug therapy)

- Clarification that INDEED PAS' HAVE THIRTY-DAY PRESCRIPTION PRIVILEGES FOR SCHEDULE II, III, IV AND V CONTROLLED SUBSTANCES THAT INCLUDE OPIOIDS AND BENZODIAZEPINES (signed by Gov. 2/14/19)

- A prescription for schedule II or III that is an opioid or benzodiazepine is not refillable without written consent of the supervising physician (physician consult must be documented in chart)

Not many PA's are aware of this- Needs to be arranged/discussed with supervising doc

Physician Assistants prescribing authority-AZ continued..

- All RX orders issued by PA shall contain name, address, phone number of the PA
- Shall issue orders for controlled substances under the PA's DEA number
- Except for samples provided by manufacturers, all drugs dispensed by PA shall be prepackaged by a pharmacist (No dispensing of CSII opioids)

Opioid Assistance Referral Line

AZ Poison Control Center: OAR line

Opioid Assistance + Referral Line for Arizona Providers: 1-888-688-4222

- Patients taking high doses of MME
- Consults for new starts of >90MME
- Patients that require an exit strategy from their current opioid regimen (including tapering)
- New patients on multiple controlled substances
- Challenging patients with pain and mental health/substance use comorbidities
- Patients with acute opioid overdose or toxicity
- Patients with acute opioid or benzodiazepine withdrawal
- Patients that require MAT
- Patients that require local referrals to behavioral health or substance use disorder treatment
- ****Available 24/7******

Initial (5 day) fill exceptions

Provides the following exceptions to the initial fill limits if the patient:

- Has an active oncology diagnosis
- Has a traumatic injury, not including a surgical procedure
- Is receiving hospice care
- Is receiving end-of-life care
- Is receiving palliative care
- Is receiving skilled nursing facility care
- Is receiving treatment for burns
- Is receiving medication assisted treatment (MAT) for a substance abuse disorder
- Is an infant being weaned off opioids at the time of hospital discharge

90 MME DOSE LIMITS EXCEPTIONS

For a patient who:

- Needs refill or extension of an existing prescription issued within the previous 60 days
- has an active oncology diagnosis
- has a traumatic injury, not including a surgical procedure
- is receiving hospice care
- is receiving end-of-life care
- is receiving palliative care
- is receiving skilled nursing facility care
- is receiving treatment for burns
- is receiving MAT for a substance abuse disorder
- is hospitalized

PAIN MGMT. BEST PRACTICES INTER-AGENCY TASK FORCE REPORT RELEASED MAY, 9, 2019

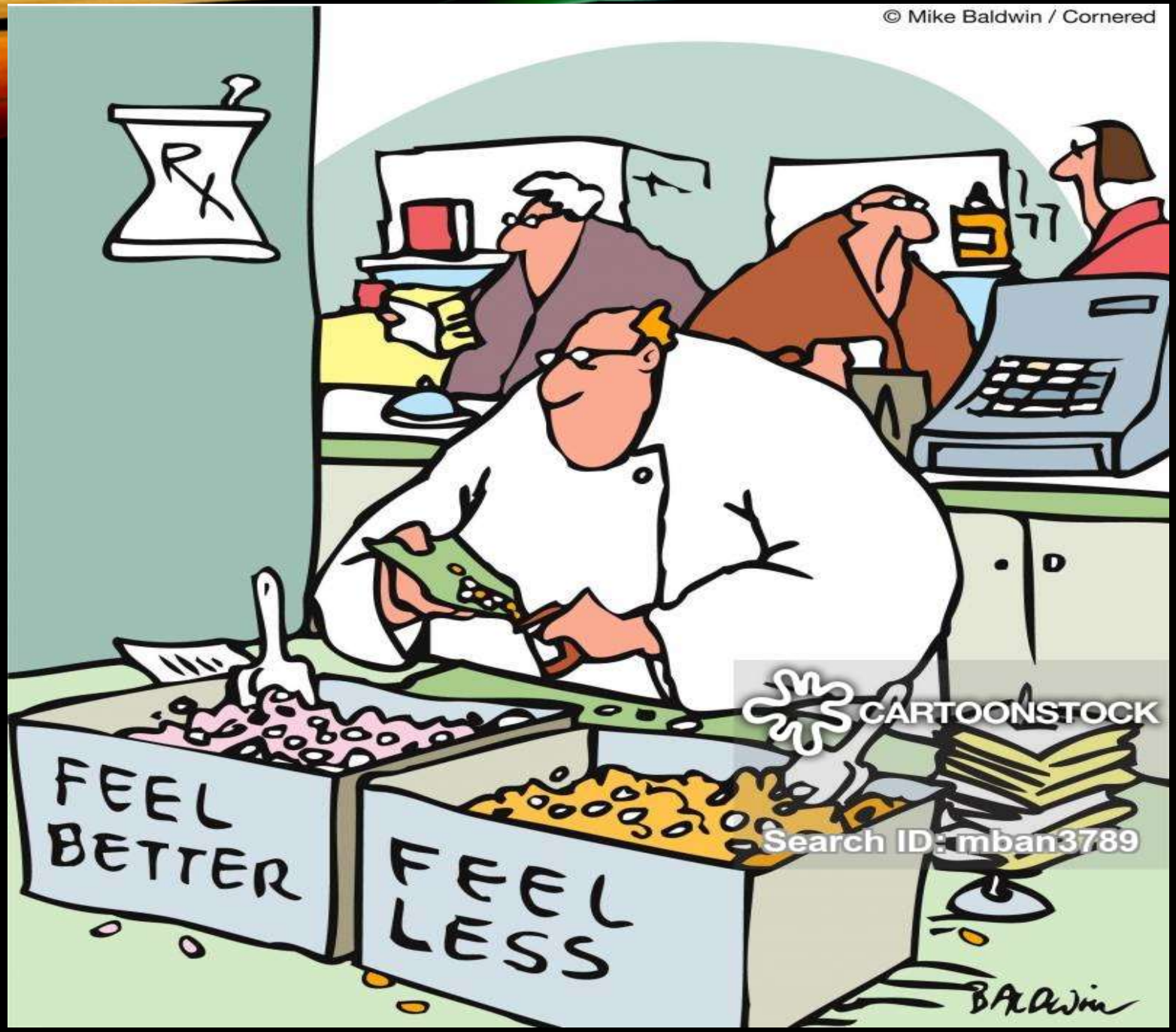
- https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html
- Was convened "to address acute & chronic pain in light of ongoing opioid crisis
- To identify inconsistencies & gaps; to make recommendations for best practices
- Almost 110 page document; divided into sections, relevant to groups or topics
- Focus on acute pain (for this lecture consider post-op or traumatic)

SUPPORT FOR:

- Restorative therapies
  - Mvmt better than rest(usually)
  - TENS (Ltd evidence)
  - Massage(more studies needed)
  - Traction (quest effectiveness)
  - Heat/Ice (ice THA POD2; heat LBP)
  - Therap US (recent studies may support)
  - Bracing (new studies:short periods may help)
- Behavioral approaches
  - Behavioral Therapy
  - Cognitive Behav Ther (CBT)
  - Accept/Commit Therapy (ACT)
  - MBSR
  - Emotional Aware./Expression(EAET)
  - Biofeedback
  - Relaxation therapy
  - Hypnotherapy

COMPLEMENTARY/INTEGRATIVE (NOT EXHAUSTIVE OR INCLUSIVE)

- Acupuncture (CMS just approved for LBP..supervised by provider)
- OMM/DO/Chiro
- Massage
- MBSR
- Yoga
- Tai Chi
- Spirituality
- Art/Music Therapy
- Supplements: ALA, L-carnitine transferase, Vit C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Rx
FEEL BETTER
FEEL LESS
CARTOONSTOCK
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OVERVIEW OF COMPLEMENTARY THERAPIES

- AROMATHERAPY/ESSENTIAL OIL THERAPY
- LIGHT THERAPY (LOW LEVEL LIGHT THERAPY)
- PHOTOTHERAPY
- YOGA/GUIDED STRETCHING
- TRACTION UNITS/INVERSION TABLES
- HYPERBARIC O2
- CRYOTHERAPY
- TENS THERAPY
- CBD
- PILATES

OVERVIEW OF COMPLEMENTARY THERAPIES CONTINUED..

- ACUPUNCTURE/ACUPRESSURE
- GUIDED VISUALIZATION/HYPNOSIS
- MEDITATION/BREATHING TECHNIQUES
- DRY NEEDLING
- OMM/CHIRO
- QI GONG/TAI CHI
- MASSAGE
- KINESIO TAPING

DR. PAUL WINTERTON

- Orthopedic surgeon
- Harvard medical school grad
- Board certified foot/ankle & shoulder reconstruction
- Uses Essential oils in the office, pre- & post surgery, inpatient, outpatient
- *BOOK: Clinical Aromatherapy, Jane Buckle*

SUGGESTIONS FOR ESSENTIAL OILS:

Anti-nausea/emetic

Peppermint

Ginger

Cardamom

Spearmint

Fennel

Coriander

Caraway

Anise

*(*Inhalation pre and/or post;*

Systemic into bloodstream; lasts ~2 hrs)

Topical Pain (or inhale)

*(*always dilute; use carrier oil)*

*Wintergreen (ASA like)

*Birch (ASA like)

Plai

Eucalyptus

Peppermint

Balsam copaiba

Sweet Marjoram

Lavender

Frankincense

*Bergamot (phototoxic)

Lemongrass

Anxiety/Soothe (inhale)

Bergamot

Lavender

Sweet Orange

Sweet Marjoram

Ylang Ylang

Lemon

Cedarwood

Patchouli

Vetiver

PHOTOBIOMODULATION THERAPY

- A FORM OF LIGHT THERAPY THAT UTILIZES NON-IONIZING FORMS OF LIGHT
- LASERS, LED, BROADBAND; VISIBLE & INFRARED SPECTRUM
- NONTHERMAL PROCESS CAUSING CELLULAR CHANGES AT BIOLOGIC LEVEL
- CAN RESULT IN: ALLEVIATION OF PAIN & INFLAMMATION, PROMOTION OF WOUND HEALING & TISSUE REGENERATION
- INCREASES NITRIC OXIDE FROM CELLS, INCREASES CIRCULATION
- SCIENCE & TECHNOLOGY HAS BEEN AROUND OVER 50 & 30 YEARS RESPECTIVELY
- THOUSANDS OF RESEARCH PAPERS ON LIGHT THERAPY
- SAFE, NON-INVASIVE, NON-TOXIC

PBM PRODUCTS

- MOST FAMILIAR WITH INLIGHT MEDICAL SYSTEM
- CLASS II MEDICAL DEVICE, FDA CLEARED FOR INCREASING CIRCULATION/DECREASING PAIN
- NEOPRENE IMBEDDED LEDS
- POLYCHROMATIC (USING 2 OR 3 "COLOR" WAVELENGTHS SIMULTANEOUSLY)
- HAVE SUGGESTED ORTHO GROUPS AND PAIN MGMT GROUPS TO CONSIDER OFFERING AS A SERVICE
- LLLT devices: handheld; skilled provider application; "beds"; stand up devices

WHO'S USING:

PHYSICAL THERAPISTS, CHIROPRACTORS, ACUPUNCTURISTS, MASSAGE THERAPISTS, PERSONAL TRAINERS..INDIVIDUALS AT HOME

A FEW RESOURCES

- **YOU TUBE VIDEOS:** FOR MUCH OF THE PREVIOUS MENTIONED
- **APPS:** MBSR, MEDITATION, GUIDED IMAGERY
- **WEB:** UNIVERSITY OF AZ ANDREW WEIL CENTER FOR INTEGRATIVE MEDICINE (FOR PROVIDERS..THOUGH SOME COURSES AVAIL ARE FOR PATIENTS)
- DUKE INTEGRATIVE MEDICINE
- STILLPOINT AROMATICS (rec'd my training & oils I use exclusively)
- AROMATICS INTERNATIONAL , NAHA, AIA (LEARN ABOUT AROMATHERAPY..)
- HEALTH JOURNEYS (GUIDED IMAGERY STREAMING OR CD)
- TALK ABOUT LIGHT.com (lot of articles, Q&A, info, direct contact with DNM,NP)
- www.Pubmed.org
- PPM : Practical Pain Management

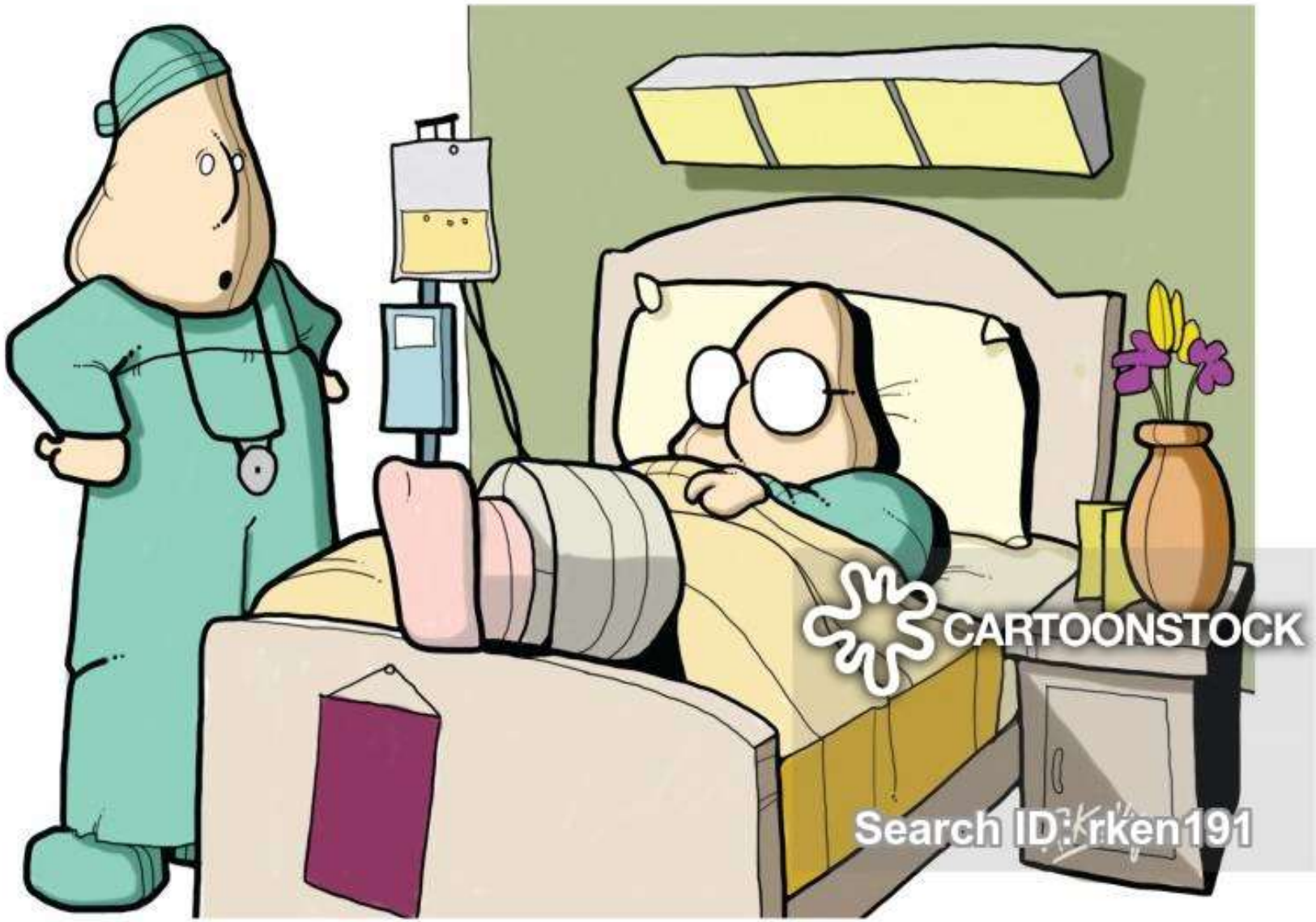
Resources continued..

Opioid conversion:
www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

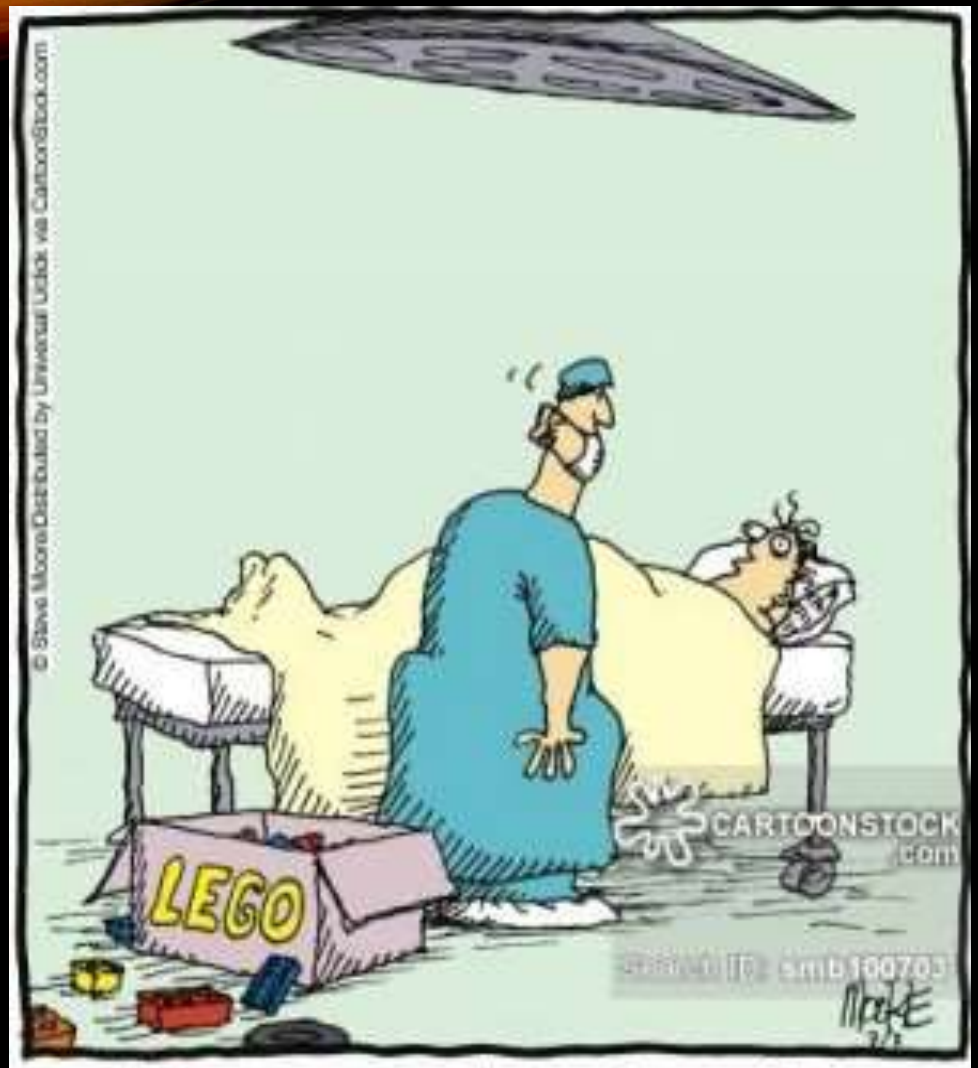
Opioid calculator: clincalc.com/opioids
App: Opioid Converter (www.globalrph.com)

PJ Cardona-Certified LED Light therapist- Scottsdale AZ
Educate, introduce LLLT
Handouts for more info-for your practice, share with patients, try yourself?

For any questions, guidance, direction etc on topics discussed, happy to be of assistance
My contact: YOURSHININGLIFE3@gmail.com 928.310.1394



Well, the knee replacement surgery went fantastic...
but, we had no idea what you wanted to replace it with.
So... we put in a lung.



"Surgery went well, Mr. Moore. I had a lot of fun rebuilding your knee joint."

THANK YOU FOR YOUR TIME & ATTENTION ON THIS VERY COMPLEX TOPIC …

WHICH CAN MAKE FOR EXCELLENT DINNER CONVERSATION …

THOUGH IT MAY OR MAY NOT LEAD TO FOOD BEING THROWN ACROSS THE TABLE …

QUESTIONS?