Substance Use Disorder, Best Practice on Prescribing & Drug Diversion

Julie Linton MS, APRN, CRNA
julia_linton@yahoo.com
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Non-Disclosure

- I have no financial relationships with any commercial interest related to the content of this activity.
- I will **not** discuss off-label use during my presentation.

Objectives

At the completion of this course you will be able to:

- Describe best practices for prescribing controlled substances in WV
- State the signs and symptoms of drug diversion, specifically in the anesthesia provider
- Explain the process for a WV CRNA seeking help for a substance use disorder

Objectives

- WV Senate Bill 437 requires healthcare providers who prescribe, dispense, or administer potentially addicting medications to have specific training
- WV RN's must have an initial 3 hour course on Best Prescribing Practices and Drug Diversion, then a 1 hour course each year
  - **This course is the 1 HOUR REFRESHER**

The scope of the problem

2017 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health:

- An estimated 18 million people (more than 6 percent of those aged 12 and older) have misused medications at least once in the past year
- This is up from an estimated 15.2 million in 2013

- **In 2018, West Virginia providers wrote 69.3 opioid prescriptions for every 100 persons, compared to the average U.S. rate of 51.4 prescriptions. This was among the top ten rates in the U.S. that year; however, it was also the lowest rate in the state since data became available in 2006.**

https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx

US Statistics

80% of the world's opiates

90% of the world's hydrocodone

80% of the world's amphetamines

www.drugabuse.gov

The Data

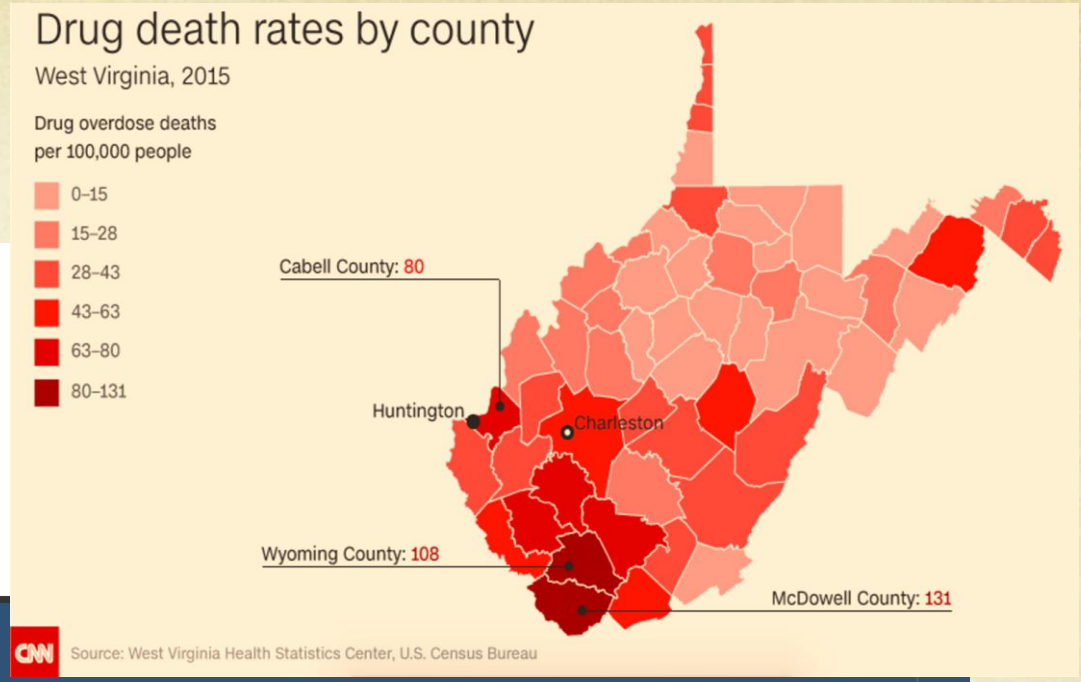
West Virginia

- 702 drug overdose deaths involving opioids in 2018
- 7.2% decline from the previous year
- WV remains the state with the highest number of drug overdose deaths

US Total

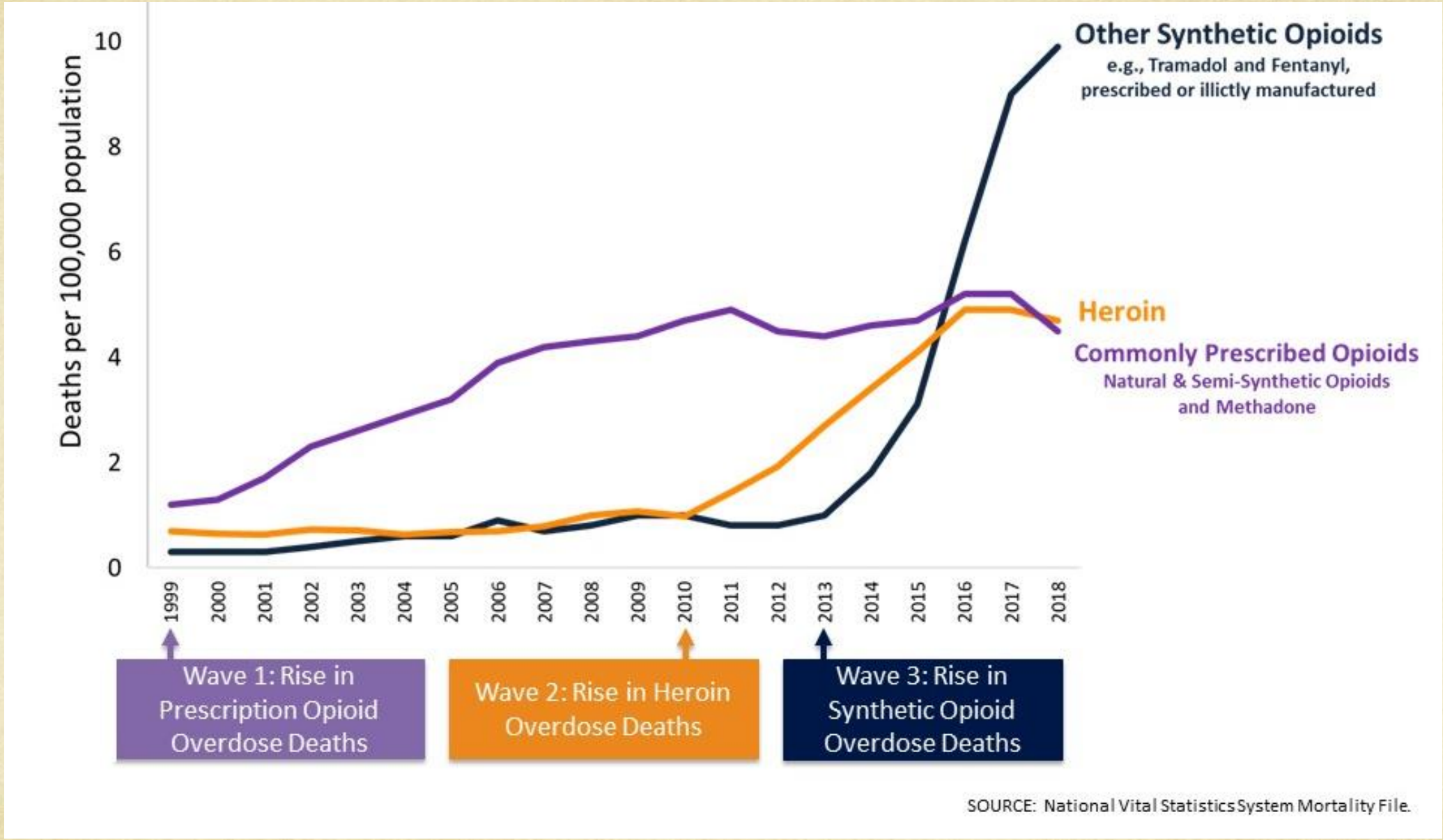
- 67,367 drug overdose deaths in 2018
- 4.6% decline from the previous year – the first time there has been a decline since 1999

Charleston Gazette-Mail
an HDmedia company
A PULITZER PRIZE-WINNING NEWSPAPER



Drug firms shipped 20.8M pain pills to WV town with 2,900 people

By Eric Eyre Staff writer Jan 29, 2018


Deaths per 100,000 population
10
8
6
4
2
0
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Other Synthetic Opioids
e.g., Tramadol and Fentanyl, prescribed or illictly manufactured
Heroin
Commonly Prescribed Opioids
Natural & Semi-Synthetic Opioids and Methadone
Wave 1: Rise in Prescription Opioid Overdose Deaths
Wave 2: Rise in Heroin Overdose Deaths
Wave 3: Rise in Synthetic Opioid Overdose Deaths
SOURCE: National Vital Statistics System Mortality File.

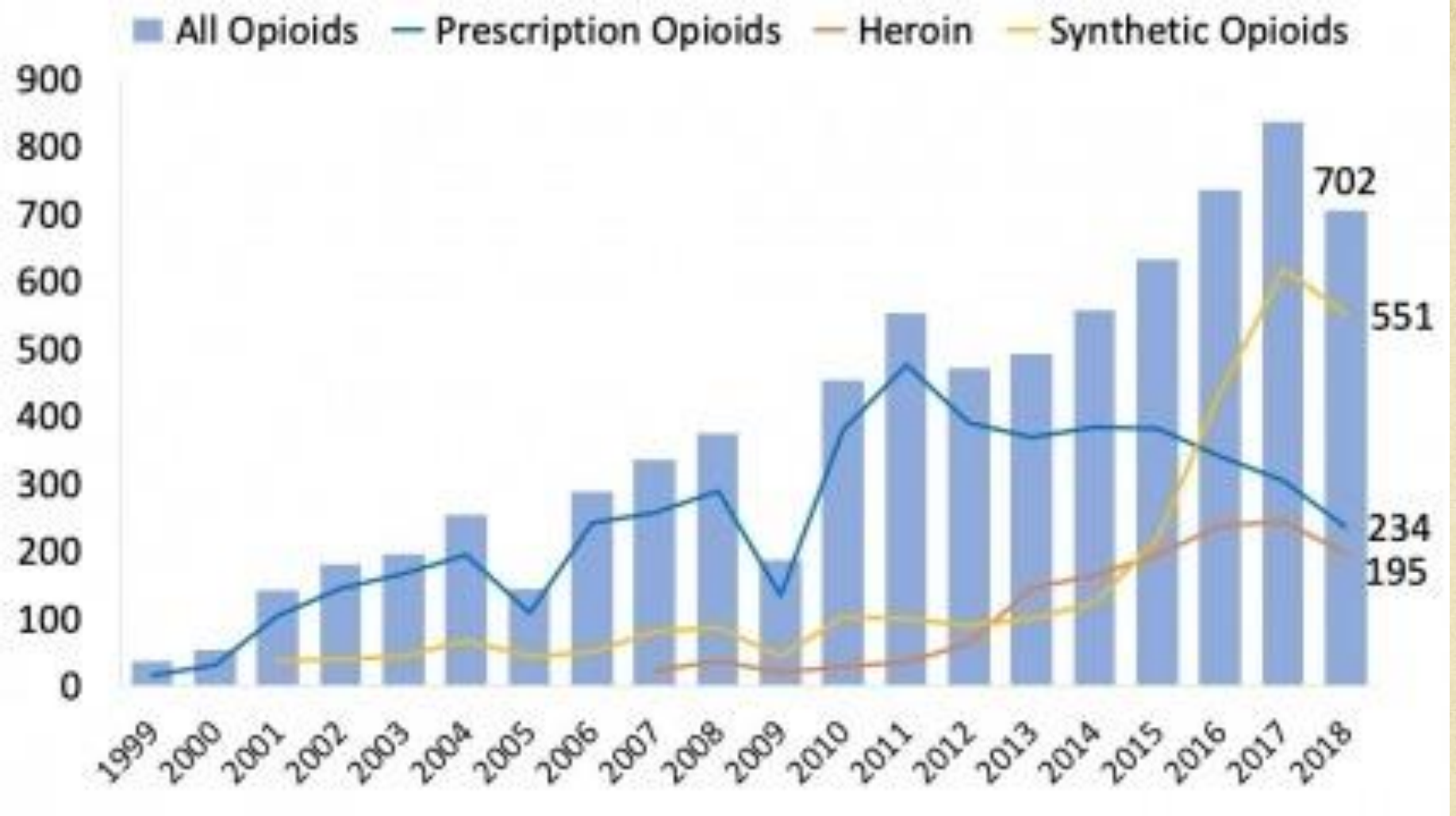


Figure 1. Number of overdose deaths involving opioids in West Virginia, by opioid category. Drug categories presented are not mutually exclusive, and deaths may have involved more than one substance. Source: CDC WONDER, 2020.

NIDA. 2020, April 3. West Virginia: Opioid-Involved Deaths and Related Harms. Retrieved from https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/west-virginia-opioid-involved-deaths-related-harms on 2020, October 6

Definitions

- Dependence – A state in which an organism functions normally only in the presence of a drug, manifested as a physical disturbance when the drug is removed (withdrawal)

- SUD (substance use disorder) – a diagnosis based on evidence of impaired control, social impairment, risky use, and pharmacologic criteria

- Addiction – chronic disease of the brain
  - Manifestations include craving, compulsion, and inability to control behavior

Historical Progression of Classification

- DSM-I and DSM-II – addiction listed with other societally disapproved disorders stemming from personality disorders
- DSM-III – descriptive diagnosis requiring tolerance or withdrawal to diagnose dependence
  - DSM-III R – included physiologic and behavioral symptoms, reflected substance dependence syndrome
- DSM-IV – unchanged from previous description
- DSM-V – all drugs taken in excess directly activate the brain reward system, substance use disorder is defined
  - Defined as mild, moderate, or severe and is determined by the number of diagnostic criteria met by an individual

Stages of addiction

Binge/ Intoxication

- Dopamine increased in the mesolimbic system

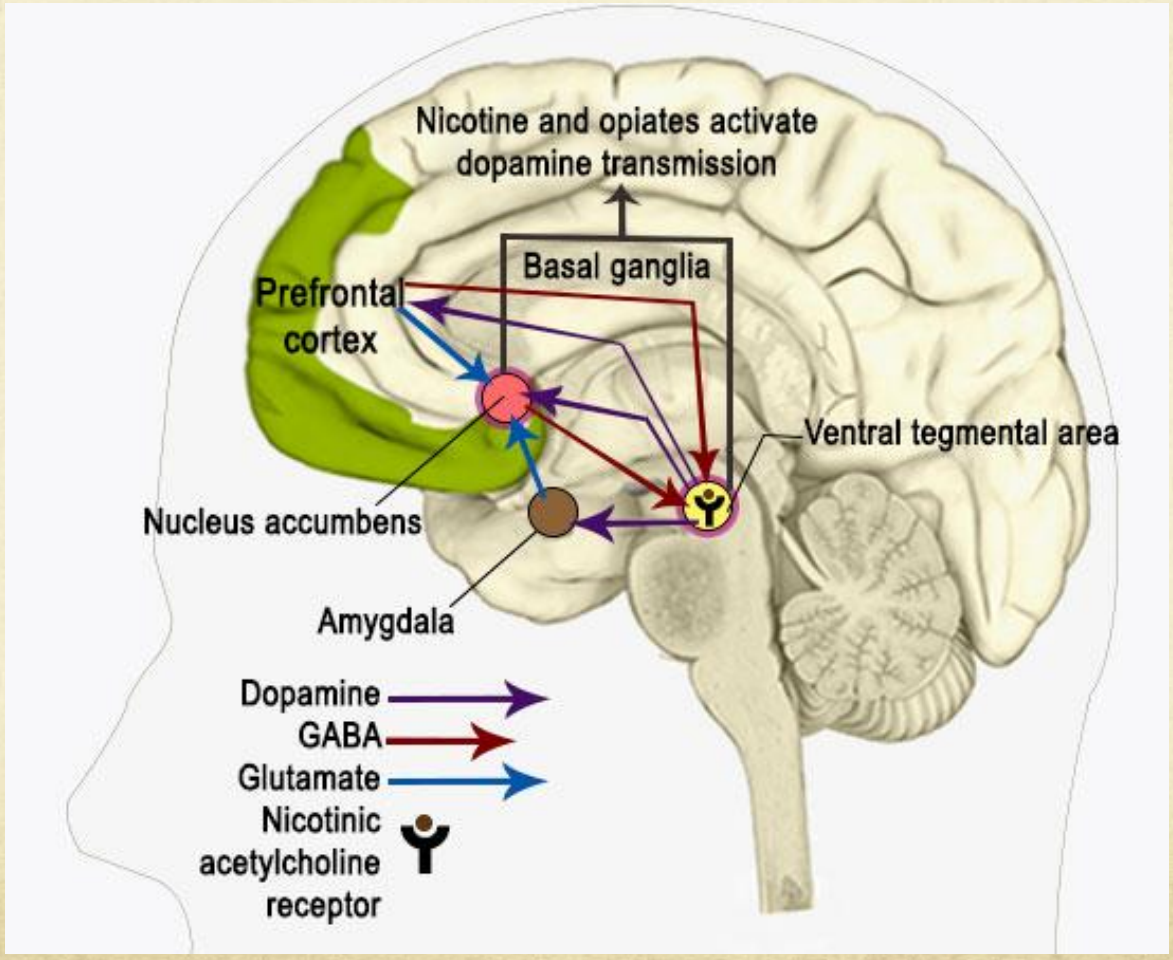
Tolerance

- Less dopamine = negative emotional state = amygdala activiation

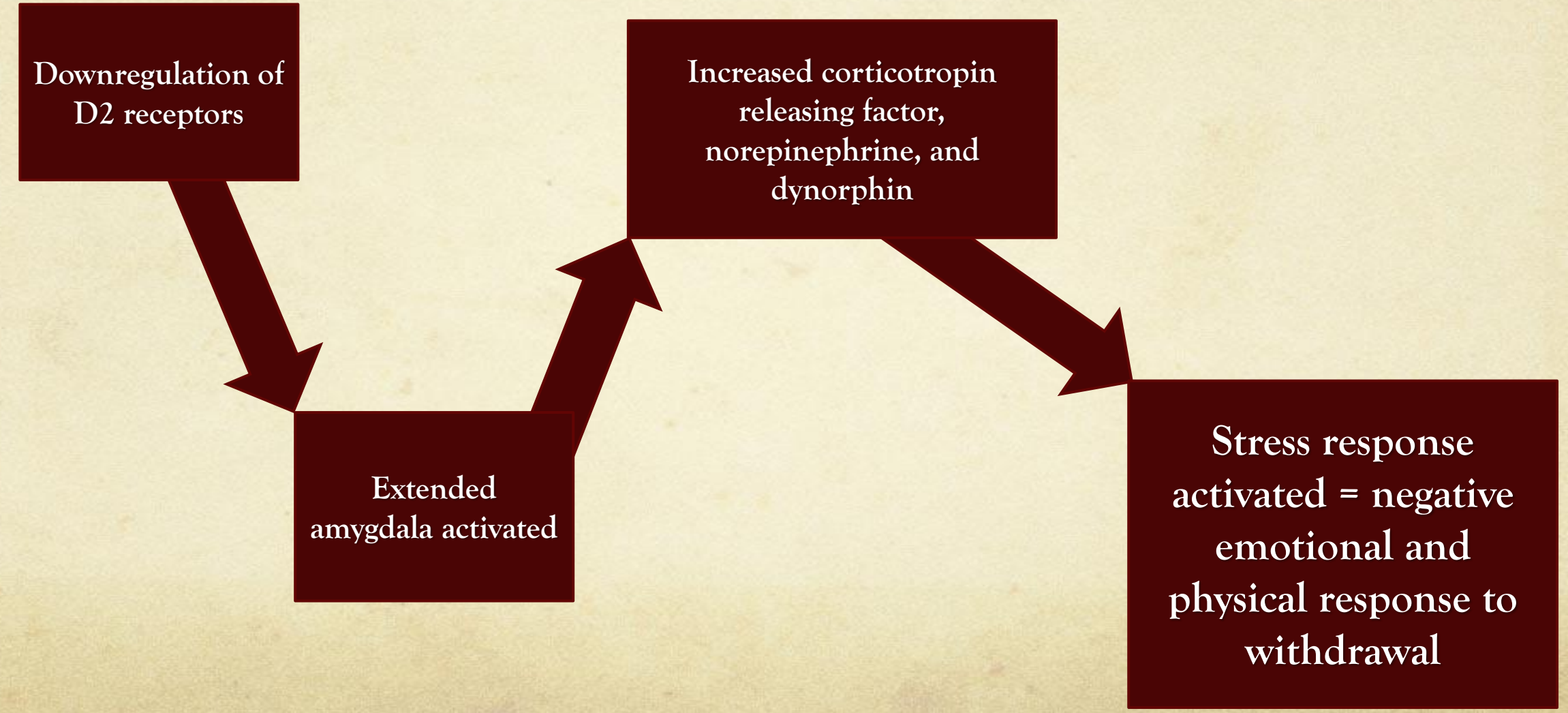
Preoccupation/ Anticipation (craving)

- Amygdala projects to the prefrontal cortex

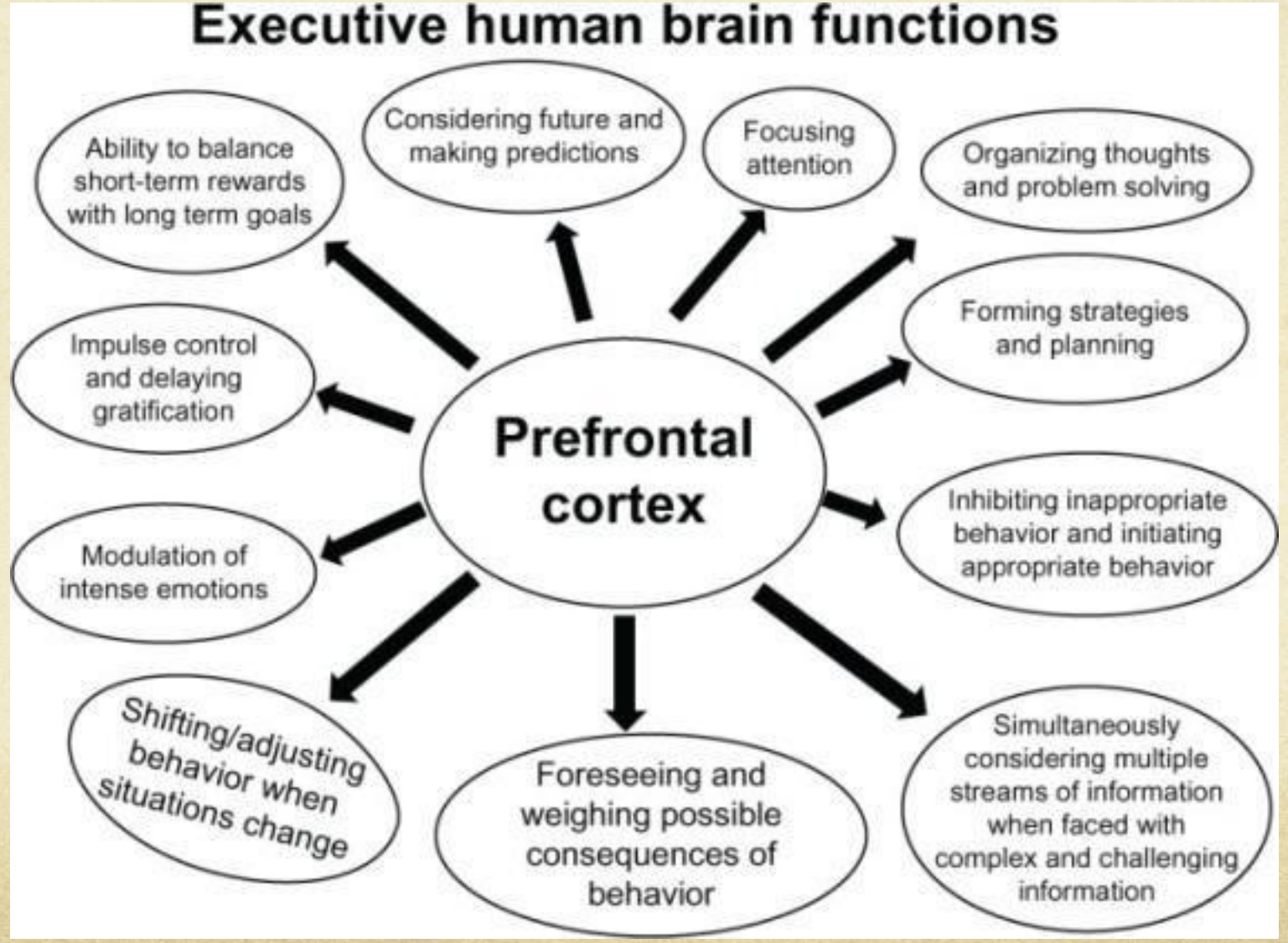
Reward Pathways
Binge/ Intoxication Stage



Tolerance Stage



Preoccupation/ Anticipation Stage



So how did we get here?

80% of the world's opiates

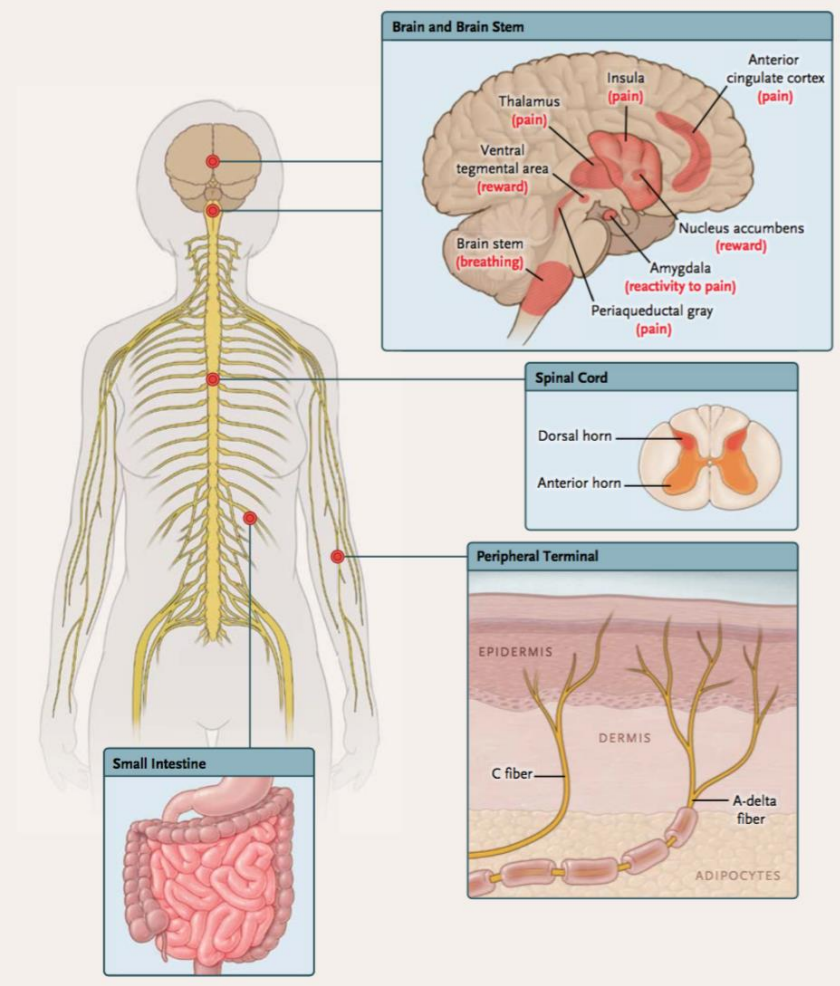
90% of the world's hydrocodone

80% of the world's amphetamines

All aimed at one thing...

Chronic Pain

"Pain is a part of the human condition....
Severe pain can overake our lives, having an impact on us as individuals as well as our family, friends, and community...
The personal story of pain can be transformtive or can blunt the human values of joy, happiness, and even human connectedness.
~ Institutes of Medicine, 2011



Chronic Pain

- Pain > 12 weeks
- Acute pain = injury, damage
- Chronic pain = result of persistent condition or acute pain that was not properly controlled
- 30% of Americans
- Opioid analgesics are the most commonly prescribed class of medications in the US

Chronic Pain Management

- Cost of pain management was estimated around $560 billion in medical costs and lost productivity
- Chronic pain management needs to be multimodal and multidisciplinary
- Transition from opiate-based therapy is essential

Changing Trends…

CLINICAL GUIDELINES | 14 FEBRUARY 2017

Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians (*)

- For pain lasting up to 12 weeks**, nondrug treatments are preferred,** with the strongest evidence for applying heat. There is also evidence for massage, acupuncture, and spinal manipulation. Evidence does support nonsteroidal anti-inflammatory drugs (NSAIDs, such as aspirin and ibuprofen) and muscle relaxants.

- Chronic lower back pain (more than 12 weeks) should initially be treated with practices like exercise, multidisciplinary rehabilitation, acupuncture, and mindfulness-based stress reduction. There is also evidence for practices ranging from tai chi and yoga to biofeedback and cognitive behavioral therapy.

- NSAIDs. Tramadol (a short-acting opioid) or duloxetine (an antidepressant) would be second-line treatments. Other opioids should be a LAST RESORT

But…. “Insurance is more likely to pay for pills than tai chi.”

CDC Opioid Prescribing Guidelines

Guideline Overview

The CDC Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the Guideline include:

1. **Determining when to initiate or continue opioids for chronic pain**
    1. Selection of non-pharmacologic therapy, nonopioid pharmacologic therapy, opioid therapy
    2. Establishment of treatment goals
    3. Discussion of risks and benefits of therapy with patients

2. **Opioid selection, dosage, duration, follow-up, and discontinuation**
    1. Selection of immediate-release or extended-release and long-acting opioids
    2. Dosage considerations
    3. Duration of treatment
    4. Considerations for follow-up and discontinuation of opioid therapy

3. **Assessing risk and addressing harms of opioid use**
    1. Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk
    2. Review of prescription drug monitoring program (PDMP) data
    3. Use of urine drug testing
    4. Considerations for co-prescribing benzodiazepines
    5. Arrangement of treatment for opioid use disorder

https://www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA and WV BOM Best Practices

- Evaluation
- Treatment Plan
- Treatment agreement
- Informed consent
- Periodic review
- Consultation
- Proper record keeping and documentation
- Compliance with controlled substance laws and regulations

All prescribing providers should be using the WV Controlled Substances Monitoring Program

Drug Schedules

- **Schedule I – substances with high potential for abuse with no currently accepted medical use**
  - Examples: heroin, LSD, marijuana, MDMA, methaqualone, peyote
- **Schedule II – high potential for abuse, but less potential than Schedule I drugs with use potentially leading to physical or psychological dependence**
  - Examples: combination products with 15mg or less of hydrocodone, cocaine, methamphetamine, methadone, hydromorphone, meperidine, fentanyl, Dexedrine, Adderall, and Ritalin
- **Schedule III – moderate to low risk of physical dependence. Potential is less than I or II, but more than IV**
  - Examples: drugs with less than 90mg of codeine, ketamine, anabolic steroids, testosterone
- **Schedule IV – low potential for abuse and low risk of dependence**
  - Examples: Xanax, Soma, Darvon, Valium, Ativan, Talwin, Ambien, Tramadol
- **Schedule V – lower abuse potential than Schedule IV and limited quantities of certain narcotics. Generally antitussives, antidiarrheals, analgesics.**
  - Examples: Cough preparations

Sources for misused prescription drugs

- Personal Rx being misused
- Friends and Family
- "Doctor shopping"
- Diversion by a medical professional
- Buying off the street

SUD and Diversion Among Anesthesia Providers

- Approximately 15% of all healthcare providers misuse or abuse drugs or alcohol during their career
- Abuse mirrors general population, but substances differ
- Higher incidence of opioid abuse among anesthesia providers compared to general population
- Bell et al 1999 and 2006 mailed surveys
  - 10% of CRNAs diverted controlled substances
  - Males around 6-10 years of practice most likely to be diverting
  - Only change was a shift from benzos and opiates to fentanyl and propofol

Bryson EO, Hamza H. The drug seeking anesthesia care provider. Int Anesthesiol Clin. Winter 2011;49(1):157-171.

Do You See What I See?
Recognizing Diversion and SUD

- Longer or extra shifts
- Coming in on time off
- No breaks or frequent breaks
- Cases that require large amounts of opiates
- Unusual opiate administration, patients often in pain in PACU
- Changes in behavior
  - Irritability, euphoria, anger, depression
- Long sleeves, pale, weight changes, sweating, “GI bug”
- Frequent wastes or ampule breakages

Signs continued...

- Alcohol can take years to notice
- Opiate abuse is usually noticed over the course of months
- Early identification is key
- While the required dose quickly amplifies over time, a short cessation can cause a dramatic decrease in the required dose. This is why an overdose is often the first sign of a problem.

Peer Intervention

- Report up chain of command
- DON'T "go it alone"
- Know your workplace and state policies
- Have a team that includes peers, family, friends, HR, the appropriate supervisor, and an intervention specialist if possible
- Be organized on who says what and how the intervention will go
- Be nondiscriminatory, nonjudgmental
- Don't let the individual leave alone – they are high risk for suicide

Peer Intervention

Table 6. Overview of facilitating a safe intervention[29]

Planned Intervention	Crisis Intervention
1. Assemble an intervention team, including a trained interventionist.	1. **Do not let the person out of your sight! Do not let them drive!**
2. Gather all the evidence.	2. Get a properly collected drug test.
3. Invite the individual into an intervention meeting. **Do not let the person out of your sight! Do not let them drive!**	3. Include a trained interventionist, family, spouse, and colleagues.
4. Get a properly collected drug test, if necessary.	4. Bring all evidence.
5. Have a bed in a treatment facility ready.	5. Have a bed in a treatment facility ready.
6. Do not let the impaired individual decide treatment. Remember, they are sick.	6. Do not let the impaired individual decide treatment. Remember, they are sick.
7. Only when all else fails, threaten to call the police. Often, this will cause the individual to admit that he/she has a serious problem.	7. Only when all else fails, threaten to call the police. Often, this will cause the individual to admit that he/she has a serious problem.

Self-reporting
What happens?

- You have decided to make the most important decision of your life and get help
- Who you can call
  - WV Restore
  - AANA Peer Assistance
  - State Peer Adviser – Ann Bostic, CRNA
    p: 304-208-0707
    e: anncrna@gmail.com

Contacting WV Restore = Mandatory Reporting

<u>The WV BON will **not know** you are seeking help</u>

- Follow the plan set by WV Restore
- 5-year contract

WV Restore

safety in healing

http://wvrestore.org/

Recovery Steps

- Treatment facility
  - Inpatient
  - Specifically for health professionals
  - Minimum 30 days, Recommended 90 days
- No practice for 1 year
  - Long term disability for at least the year you are out of work
  - Because there are so many resources in place, CRNAs are able to seek help without being fired
- Meetings, counseling, drug testing
- Vivitrol for 6 months when back to work

Getting Help for Yourself and Others

Resources

- State Peer Adviser – Ann Bostic, CRNA
  - p: 304-208-0707
  - e: anncrna@gmail.com
- Julie Linton
  - p: 304-676-3889
  - e: julia_linton@yahoo.com
- WV Restore
  - p: 304-932-7675