WE STILL NEED TO TALK ABOUT PAIN MEDS?: THE OPIOID EPIDEMIC AND SUBSTANCE USE DISORDER

Kevin B. Walker, MD FASA, Medical Director Division of Pain Medicine
THANK YOU’S!

- Doug Furmanek
- Vito Cancellaro
- Alain Litwin
- Richele Taylor
- Necole Stinson
- Rebecca Brannon
- Sara Goldsby
- South Carolina Medical Association
RULES OF ENGAGEMENT!

- Open discussion
- Please be willing to share
- No judgement
- I don’t want to talk the entire time!
LEARNING OBJECTIVES

- Understand the impact of the opioid epidemic in South Carolina, the “WHY”
- Explain opioid stewardship and how it can improve a health system
- Discuss strategies on who to change your health system’s culture through education
- Open discussion of future opportunities
What's the **WHY**
U.S. TRENDS IN OPIOID PRESCRIBING & HIGH DOSES

Source: IQVIA® Transactional Data Warehouse

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All opioids/Overall</td>
<td>72.4</td>
<td>75.9</td>
<td>78.2</td>
<td>79.5</td>
<td>81.2</td>
<td>80.9</td>
<td>81.3</td>
<td>78.1</td>
<td>75.6</td>
<td>70.6</td>
<td>66.5</td>
<td>58.5</td>
</tr>
<tr>
<td>High-dosage</td>
<td>11.5</td>
<td>11.7</td>
<td>11.8</td>
<td>11.5</td>
<td>11.4</td>
<td>8.8</td>
<td>8.3</td>
<td>7.6</td>
<td>7.1</td>
<td>6.7</td>
<td>6.1</td>
<td>5</td>
</tr>
</tbody>
</table>

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
SC AVERAGE DAILY MME OF PRESCRIPTIONS

Average daily MME

<table>
<thead>
<tr>
<th>Year prescription was filled</th>
<th>Average daily MME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>43.39</td>
</tr>
<tr>
<td>2016</td>
<td>42.45</td>
</tr>
<tr>
<td>2017</td>
<td>40.90</td>
</tr>
<tr>
<td>2018</td>
<td>38.09</td>
</tr>
<tr>
<td>2019</td>
<td>35.32</td>
</tr>
<tr>
<td>2020</td>
<td>33.91</td>
</tr>
</tbody>
</table>


PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
SC OPIOIDS QUANTITY VS. FILLED OVER TIME

Average prescription quantity dispensed for CII prescriptions over time

Number of filled CII prescriptions prescribed by SC prescribers over time

17.02% decline since 2016
78.5% of overdose deaths involve Fentanyl
HEALTHCARE CULTURE

"The doctor will see you now—
I can't promise that he'll talk
to you, but he'll see you."

PLEASE DON'T WASTE THE
DOCTOR'S
TIME WITH QUESTIONS
WHOSE RESPONSIBILITY?

“I specialize in referrals to specialists!”

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
CASE FOR CHANGE: FOR THE SYSTEM I WORK FOR

Number of Opioid-Involved Overdose Deaths by County South Carolina, 2021


PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
OPIOID EPIDEMIC !!!
Four Decades Later: Revision of the IASP Definition of Pain and Notes

The currently accepted definition of pain was originally adopted in 1979 by the International Association for the Study of Pain (IASP)

1979 Definition of Pain
An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage

In 2018, IASP constituted a 14-member multi-national task force with expertise in clinical and basic science related to pain, which sought input from multiple stakeholders to determine: “Does the progress in our knowledge of pain over the years warrant a re-evaluation of the definition?”

Expert consultants

IASP council

The public

2020 Revised Definition of Pain
An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage

2020 Revised Definition of Pain Notes
- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors
- Pain and nocepción are different phenomena. Pain cannot be inferred solely from activity in sensory neurons
- Through their life experiences, individuals learn the concept of pain
- A person’s report of an experience as pain should be respected
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being
- Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain

The revised IASP definition of pain: concepts, challenges, and compromises Raja et al. (2020) | Pain
DOI: 10.1097/j.pain.0000000000001939

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
SOCIETAL IMPACT

Opioid addiction increases:
- Patient load
- Strain on emergency rooms and medical offices
- Costs for detoxification programs

The opioid crisis and heroin abuse impact:
- Children and families
- Government programs
- Law enforcement professionals
- Educators
- Health care providers
- Taxpayers

A 2012 study showed that 16% of teens had misused a prescription painkiller at least once.

The increasing number of child welfare cases are due to parental abuse of drugs.

Between 1998 and 2012, the number of drug offenders in federal prisons grew by 63%. By the end of 2012, 52% of federal prisoners were drug offenders.
DANGEROUS TRENDS

SKITTLE PARTY
WHO’S RESPONSIBLE?

“All of us together...”

OPIOID EPIDEMIC
OPIOID STEWARDSHIP
WHERE WE STARTED...

- Developed the “team”
- Mission
- Structure
- Administrative support
- Survey
- Educational endeavors
- Institutional changes
OVERARCHING GOAL OF THE OPIOID STEWARDSHIP COMMITTEE

To develop holistic patient-centered strategies that mitigate pain, optimize recovery and promote well-being for the communities we serve
Opioid Stewardship Committee Charter

Mission Statement
To develop holistic patient-centered strategies that mitigate pain, optimize recovery and promote well-being for the communities we serve.

Purpose
To provide advisement on proposed evidence-based best practices, assist with mitigating barriers, and set the tone and behaviors for system-level coordination.

The Committee serves as an oversight and decision-empowering team for all seven hospital campuses which evaluate, vet, and recommend strategies (including methods, approaches, and processes) and tools (including technologies) for successful opioid prescribing.

The Committee has the authority to research, collaborate, vet, and recommend best practices in an effort to contribute to the goals of improving quality of care, clinical outcomes, and enhancing the patient experience.

Membership
ORGANIZATIONAL STRUCTURE

GMMC Medical Care Committee
Medical Staff Performance Improvement Committee

Opioid Stewardship Committee
Steering Team

Opioid Stewardship Subcommittee
(Includes added representation from ancillary departments)

Data Analytics

Workgroup Streams – Charged with Rolling out Initiatives

Physician  Pharmacy  Nursing  Therapies  Rehabilitation  Community Outreach
HOW DO WE IMPROVE OPIOID SAFETY?

- Redefine patient pain expectations
- Engage patient and families about the harms of opioid therapy
- Increase prescriber awareness
- Implement a data-driven process for improving safe prescribing
- Work with rehabilitation programs and community outreach programs
- Change the health culture of safe and appropriate prescribing
PRACTITIONER PULSE CHECK ON OPIOIDS

What is your specialty?
- Medicine: 46%
- Surgery: 8.7%
- Anesthesiology: 17.1%
- Orthopedics: 10.5%
- Pediatrics: 8.7%
- Obstetrics Gynecology: 10.5%
- Other: 8.7%

What is your job title?
- Attending Physician: 53.1%
- Advanced Practice Provider: 11.9%
- Nurse: 26.8%
- Pharmacist: 11.6%
- Resident: 9.8%
- Other: 2.2%

I feel pressured to prescribe opioids.
- Strongly agree: 27%
- Somewhat agree: 25.3%
- Neither agree nor disagree: 16.0%
- Somewhat disagree: 15.6%
- Strongly disagree: 13.5%

Most patients would be receptive to using non-opioids.
- Strongly agree: 29.9%
- Somewhat agree: 26.8%
- Neither agree nor disagree: 12.2%
- Somewhat disagree: 7%
- Strongly disagree: 9.8%

There is a national opioid epidemic.
- Strongly agree: 89.3%
- Somewhat agree: 9.4%
- Neither agree nor disagree: 2.2%
- Somewhat disagree: 0.9%
- Strongly disagree: 0.1%

Patients have unrealistic expectations about pain control.
- Strongly agree: 34.4%
- Somewhat agree: 9.8%
- Neither agree nor disagree: 5.7%
- Somewhat disagree: 16.9%
- Strongly disagree: 36.2%
OPIOID STEWARDSHIP
PHILOSOPHY FOR PROCESS IMPROVEMENT

Measurement:
Understand problems through data collection

Feedback and Awareness:
Share data with providers

Develop Clinical Support Tools

Opioid Stewardship:
Analyzes data, Identifies gaps and barriers in care or practice

Initiates process improvement strategies
DATA-DRIVEN APPROACH TO CHANGE

EMR data generated & reviewed by Opioid Stewardship Committee (OSC)

Data reviewed with Department Chair

Data (blinded or unblinded) presented by the Department Chair to practitioners

Needs Assessment Opportunities identified

Data is vetted through random chart review

Outliers vetted High performers identified

OSC assists with *individualized plan* for the department
Vaginal Deliveries:
Average Total Discharge MME by Provider (95% Confidence Interval)

[Graph showing average total discharge MME by provider code, with providers in green, blue, and red indicating statistical significance.]

**Statistical Significance Note:**
- Providers in Green are significantly lower than overall
- Providers in Blue are No Different than overall
- Providers in Red are significantly higher than overall

**Goal:** No more than 75 MMEs

**Data Source:** Oct ‘17 – Dec ‘18

**Note:** Graph excludes MDs with < 20 Vaginal Delivery encounters with an opioid prescription at discharge
Ordering MD: Orthopedics

Average Total Discharge MME (95% Confidence Interval)

Note: Graph excludes surgeons with < 30 discharges with an opioid prescription

Statistical Significance Note:
Providers in Green are significantly lower than overall
Providers in Blue are No Different than overall
Providers in Red are significantly higher than overall

Data Source: Jan '17 – Jul '18
Emergency Departments:
Average Discharge MME (95% Confidence Interval)

Statistical Significance Note:
Providers in Green are significantly lower than overall
Providers in Blue are No Different than overall
Providers in Red are significantly higher than overall

Note: Graph excludes MDs with < 50 ED discharges with an opioid prescription

Data Source: Jul '17 – Jun '18
Opioid Average Total Discharge MME (Morphine Milligram Equivalent) by Year
Hospital Encounters (includes hospitalizations, inpatient and outpatient surgery visits, ED and urgent care visits)

<table>
<thead>
<tr>
<th></th>
<th>Sep '18 to Aug '19</th>
<th>Sep '19 to Aug '20</th>
<th>Sep '20 to Aug '21</th>
<th>Sep '21 to Aug '22</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of RX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep '18 to Aug '19</td>
<td>31,557</td>
<td>11,353</td>
<td>1,236</td>
<td>9,515</td>
</tr>
<tr>
<td>Sep '19 to Aug '20</td>
<td>32,409</td>
<td>12,460</td>
<td>1,536</td>
<td>9,415</td>
</tr>
<tr>
<td>Sep '20 to Aug '21</td>
<td>33,433</td>
<td>12,545</td>
<td>2,185</td>
<td>8,989</td>
</tr>
<tr>
<td>Sep '21 to Aug '22</td>
<td>39,008</td>
<td>14,326</td>
<td>2,782</td>
<td>10,741</td>
</tr>
</tbody>
</table>

* Statistically significant reduction compared to prior time frame (all p values < 0.05)
STRATEGIES…
STRATEGY #1: EDUCATION... EDUCATION...
Figure 19: Education is Critical to the Delivery of Effective, Patient-Centered Pain Care and Reducing the Risk Associated With Prescription Opioids
PATIENT EDUCATION

- Get an accurate medication history
  - Identify naive vs. tolerant pain patients
- Set realistic pain expectations for patients
  - Begins with education in anesthesia pre-assessment
  - Nurse liaisons communicating pain plan of care to patients
- Focus on function, not pain score
- Alternative therapies
  - Non-pharmacological therapies (ice, heat, positioning, quiet time)
  - Multimodal therapy
- Explain risks of opioids including side effects
- Use whiteboards as a communication tool
**PATIENT EDUCATION**

**Prescription Opioids: What You Need to Know**

You have been prescribed an opioid pain medicine, also called a narcotic. What follows is important safety information and common questions people have about opioids.

**What are opioids?**
Examples are hydrocodone, oxycodone and tramadol. Opioids come in different forms, but have the same effects and can harm you.

**What are side effects?**
With opioids, a fine line exists between pain control and dangerous side effects.

Common side effects may include the following:
- Constipation
- Confusion
- Dry mouth
- Depression
- Upset stomach
- Dizziness

**Note:** Opioids can reduce your ability to learn new things. It also can hinder your ability to drive or operate machines.

**Serious side effects of opioid use are addiction, overdose and even death.**

**How can I avoid serious side effects?**
- Use the lowest dose of opioids for the shortest time.
- Use opioids as prescribed.
- Avoid alcohol when taking opioids.
- Do not take nerve pills, muscle relaxers or sleeping pills.
- Using these with opioids can cause you to stop breathing.
- NEVER take opioids that are not yours. Pills may look the same but can contain a different type of opioid and in a higher amount.

**What are signs of an overdose?**
Stop taking the drug, seek medical help at once or call 911 if you have ANY of the following:
- Garbled speech
- Heavy or unusual snoring
- Extreme tiredness
- Hallucinations (seeing things that are not there)
- Severe dizziness
- Slow heart rate
- Purple-colored lips or fingers

**What are options to taking opioids?**
Ask your provider about other ways to manage your pain. These options may work better—and carry fewer risks.

Here are some options:
- Other pain relievers approved by your doctor
- Exercise
- Physical therapy
- Counseling to help avoid triggers that cause pain and stress

**How can I keep my family safe?**
- Keep opioids locked up and out of children’s reach.
- Do not leave loose pills out.
- Keep opioids in their original bottle. Monitor pill numbers.
- NEVER share or give away opioids.

**How can I safely get rid of expired or unused medicine?**
The best way to dispose of medicine is in a secure drop box. You can find medicine drop boxes at these locations:

**Greenville County**
- Greenville County Sheriff’s Office, 4 McGehee St., Greenville
- Greenville Memorial Hospital, 700 Grove Rd., Greenville
- Greer Memorial Hospital, 830 S. Buncombe Rd., Greer
- Greer Police Department, 102 S Main St., Greer
- Hillcrest Memorial Hospital, 729 S Main St., Simpsonville
- Travelers Rest Police Department, 6711 State Park Road, Travelers Rest

**Laurens County**
- Laurens County Memorial Hospital, 22725 Highway 76 East, Clinton

**Oconee County**
- Oconee Memorial Hospital, 298 Memorial Drive, Seneca

**What are additional resources I can consult?**
- Contact your doctor or pharmacist with opioid-related questions.
- Visit www.cdc.gov/drugoverdose to learn the risks of opioid abuse and overdose.
- Visit FAVOR of Greenville for information on its unique recovery and rehabilitation programs: https://favorgreenville.org
- Visit the Phoenix Center to learn about programs that treat substance abuse disorders. http://www.phoenixcenter.org
CULTURE CHANGE – OLD PRACTICE

TREATMENT

- Adjuncts (Neurontin / Clonidine)
- NSAIDs, Tylenol
- Extended Release Opioids
- Short-acting or IV Opioids

WEANING
CULTURE CHANGE – CURRENT PRACTICE

- Extended Release Opioids
- Short-acting or IV Opioids
- Adjuncts (Neurontin / Clonidine)
- NSAIDs, Tylenol
- Non-Pharmacologic Therapies

TREATMENT

WEANING
TREATMENT OF ACUTE PAIN

- Chronic opioid use often starts with treatment of acute pain
- 1 of 8 opioid naïve patients who receive narcotics after a procedure becomes persistent users
- Patients traditionally use less than 15% of total opioid RX

3 days or less will usually be sufficient...  
>7 days rarely needed

Practice Changes:
- Re-evaluation of patient
- Re-engagement in pain management plan

CDC Guideline for Prescribing Opioids for Chronic Pain, 2016.  
http://turntheidex.org/treatment/
THE WHY BEHIND THE REALITY

morphine

hydrocodone

hydromorphone

codeine

oxycodone

heroin

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
PROGRESSION TO ADDICTION

Normal Balance → Increased Tolerance & Preoccupation → Overpowering Addiction
SOURCE OF OPIOID MISUSE

Prescriptions from More Than One Doctor (1.1%)
Stole from Doctor’s Office, Clinic, Hospital, or Pharmacy (0.8%)

Prescription from One Doctor (35.7%)

Got through Prescription(s) or Stole from a Health Care Provider¹ 37.5%

Some Other Way 5.5%

Bought from Drug Dealer or Other Stranger 6.2%

From Friend or Relative for Free (37.0%)

Given by, Bought from, or Took from a Friend or Relative 50.8%

Bought from Friend or Relative (9.2%)
Took from Friend or Relative without Asking (4.6%)

83.8% of the friends or relatives were prescribed the pain reliever by a single doctor

SAMHSA. (2020). 2019 National Survey on Drug Use and Health

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
WHERE TO START?

Figure 17: A Risk Assessment Is Critical to Providing the Best Possible Patient-Centered Outcome While Mitigating Unnecessary Opioid Exposure
MAGIC IN A BOTTLE !!

AND

VERSUS

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
FEDERAL OVERSIGHT

- 2014: C-II designation for hydrocodone
- 2016: CDC Guidelines on Chronic Pain
- 2022: Revised CDC Guidelines
CONSEQUENCES: 2016 CDC OPIOID GUIDELINES

- **2012**: Opioid prescriptions peaked at **255 million**

- **2016**: **214 million** opioid prescriptions were dispensed

- **2017**: Opioid prescriptions **dropped by over 22 million**
  - Prescribers began to deprescribe opioids inappropriately
    - Many dependent patients experienced withdrawal
    - Sought illegal manners of attaining opioids or other drugs (heroin)

- **2019**: FDA states the deprescribing of opioids can lead to patient harm from the rapid discontinuation of opioids
  - Providers & patients work together to slowly taper opioid therapy
2022 CDC GUIDELINE SUMMARY

- 2022 CDC Guidelines are intended to improve clinician and patient communication about benefits / risks of pain treatment
  - Improve the effectiveness and safety of pain treatment
  - Mitigate pain
  - Improve function and quality of life for patients with pain
  - Reduce risks associated with opioid pain therapy

- Evidence to guide optimal pain management remains limited

- Patient-clinician communication are key to treatment decisions

- Updated guideline can help inform those decisions
HOW TO MANAGE?...LEGACY PTS

- August 2019:
  - Pain Management Associates closed in Greenville County
    - Leaving 25000 patients seeking care

- May 2021:
  - Lags Medical Center pain management clinics closed...
    - Leaving 20000 patients without care
RISKS OF DISCONTINUATION

A. Illicit Opioid Use after Taper or Discontinuation of Long-Term Opioid Therapy

- Heroin Use: Adjusted Odds Ratio = 1.57
- Illicit Opioid Pain Reliever Use: Adjusted Odds Ratio = 1.75

B. Emergency Department Visits and Opioid-Related Hospitalizations after Taper or Discontinuation of Long-Term Opioid Therapy

- Patients with no opioid-related event, 51%
- Patients with opioid-related event, 49%

Each additional day of taper was associated with a 1% lower likelihood of an opioid-related event.

C. Mental Health Crises and Overdose Events among Patients Continuing or Tapering Long-Term Opioid Therapy

<table>
<thead>
<tr>
<th>Event</th>
<th>Patients continuing opioid use</th>
<th>Patients tapering opioid use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Crises</td>
<td>3.3</td>
<td>5.5</td>
</tr>
<tr>
<td>Overdose Events</td>
<td>7.6</td>
<td>9.3</td>
</tr>
</tbody>
</table>

D. Death from Suicide or Overdose after Taper or Discontinuation of Long-Term Opioid Therapy

<table>
<thead>
<tr>
<th>Days of Opioid Therapy before Discontinuation</th>
<th>Adjusted Hazard Ratio for Fatal Oversed or Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 30</td>
<td>1.67</td>
</tr>
<tr>
<td>31–90</td>
<td>2.80</td>
</tr>
<tr>
<td>91–400</td>
<td>3.95</td>
</tr>
<tr>
<td>&gt; 400</td>
<td>6.77</td>
</tr>
</tbody>
</table>


PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
Steps in Caring for Patients with Chronic Pain Who Have Received Long-Term Opioid Therapy from a Previous Clinician.

1. **Review the case with the former clinician if possible.** Try to develop a treatment plan that slowly adjusts to your style of management while avoiding a radical divergence from the previous plan of care.

2. **Consider providing a therapeutic bridge for the patient until a plan of care is determined, given the risks associated with stopping opioid therapy.** Abruptly tapering or stopping opioid therapy can be dangerous for multiple reasons. Opioids may be crucial for the patient’s condition (e.g., sickle-cell disease), and the patient may be at risk for other harms when opioids are tapered or discontinued (see figure).

3. **Develop a patient-centered care plan.** If a taper is needed, empower the patient to make decisions, including which medications to taper first and how fast. Successful tapers may take years.

4. **Assess the patient for opioid use disorder and start discussing medication options right away.** Patients may find it challenging to accept an opioid use disorder diagnosis; give them time.

5. **Document opioid stewardship and the rationale for the treatment plan.** Investigations into opioid prescribing are often based on insufficient documentation.
# TREATMENT OF WITHDRAWAL SYMPTOMS

## Consider Use of Adjuvant Medications During Taper

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication Details</th>
</tr>
</thead>
</table>
| Withdrawal symptoms (not effective for anxiety, restlessness, insomnia, and muscular aching) | Clonidine 0.1-0.2 mg oral every 6-8 hours; hold dose if blood pressure <90/60 mmHg (0.1-0.2 mg 2-4 times daily is commonly used in the outpatient setting)  
  - Recommend test dose (0.1 mg oral) with blood pressure check one hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks  
  - Reevaluate in 3-7 days; taper to stop; Average duration 15 days  
  - Baclofen 5mg 3x daily may increase to 40 mg total daily dose  
  - Revaluate in 3-7 days; average duration 15 days  
  - May continue after acute withdrawal to help decrease cravings  
  - Should be tapered when baclofen is discontinued  
  - Gabapentin start at 100-300mg and titrate to 1800-2100mg divided in 2-3 daily doses  
  - Can help reduce withdrawal symptoms and help with pain and sleep |
| Anxiety, dysphoria, lacrimation, rhinorrhea | Hydroxyzine 25-50 mg three times a day as needed  
  - Diphenhydramine 25 mg every 6 hours as needed |
| Myalgias                  | NSAIDs (e.g. naproxen 375-500 mg twice daily or ibuprofen 400-600 mg four times daily)  
  - Acetaminophen 650 mg every 6 hrs as needed |
| Sleep disturbance         | Trazodone 25-300 mg orally at bedtime |
| Nausea                    | Prochlorperazine 5-10 mg every 4 hrs as needed  
  - Promethazine 25mg orally or rectally every 6 hours as needed  
  - Ondansetron 8mg every 12 hours as needed |
| Diarrhea                  | Loperamide 4 mg orally initially, then 2mg with each loose stool, not to exceed 16 mg daily  
  - Bismuth subsalicylate 524 mg every 0.5-1 hour orally, not to exceed 4192 mg/day |
NEED FOR OPIOIDS

“Opiophobia”  “No pain left behind”

Responsible Opioid Pharmacotherapy
CONCLUSION

- Opioid epidemic requires a huge cultural shift where **EVERYONE** takes responsibility
- State and Federal regulatory bodies are identifying key metrics to identify adoption of opioid reduction strategies
- EDUCATION!! Set **REALISTIC** patient expectation
- Consider alternative therapies prior to prescribing opioid
- Be **INTENTIONAL** about opioid prescribing
  - Reassess, Reassess, Reassess
- Educate on diversion risks & how to safely store/dispose of opioids CDC Guidelines are guidelines **not** scripture
- Opioids stewardship can improve your community
HIGH USE AREAS - PRODUCT AVAILABILITY

- Anesthesia narcotic packs

<table>
<thead>
<tr>
<th>Year</th>
<th>Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Ketamine 50mg, Hydromorphone 4mg, Fentanyl (2) X 250mcg vials, Midazolam (2) X 5mg vials</td>
</tr>
<tr>
<td>2017</td>
<td>Ketamine 50mg, Hydromorphone 2mg, Fentanyl (2) X 100mcg vials, Midazolam 5mg vial</td>
</tr>
<tr>
<td>2018</td>
<td>Ketamine 30mg, Hydromorphone 1mg, Fentanyl 100mcg vial, Midazolam 2mg syringe</td>
</tr>
<tr>
<td>2019</td>
<td>Ketamine 30mg, Hydromorphone 0.5mg syringe, Fentanyl 100mcg vial, Midazolam 2mg syringe</td>
</tr>
</tbody>
</table>

- Emergency Room standardization
  - Reinforce WHO recommendations on pain
  - Standardize to lowest dosage forms available
LOCAL, STATE, AND FEDERAL OUTREACH

- E.C.H.O. Empowering Communities for Health Outcomes
- Speaking Opportunities
  - Prisma Health Grand Rounds
  - SC Birth Outcomes Initiative
  - SC Medical Association
  - American Dental Association
  - Governor's Opioid Summit
- Aligning with state political partners
  - Reports sent to Senator Graham and Governor McMaster outlining our ongoing opioid stewardship efforts
  - Research grants establishing best practices for SC through DAODAS
- National efforts:
  - Prisma Health Upstate efforts incorporated into the US Senate Congressional Testimony on Combating the US Opioid crisis
MOVING THE NEEDLE IN SOUTH CAROLINA

JOINT ADVISORY OPINION ISSUED BY THE SOUTH CAROLINA STATE BOARDS OF MEDICAL EXAMINERS, NURSING AND PHARMACY REGARDING THE USE OF LOW DOSE KETAMINE INFUSIONS FOR THE MANAGEMENT OF PAIN THROUGHOUT THE GREENVILLE HEALTH SYSTEM

The State Boards of Medical Examiners, Nursing and Pharmacy hereby approve this request, but emphasize that the approval of low dose Ketamine infusions for the management of pain applies only to the Greenville Health System. Any other provider interested in developing a similar program should submit a request for review and input from the Healthcare Collaborative Committee.

Alternatives to Opioids (ALTO®)
Acute Pain Protocols

Formulated: April 12, 2019
Revised: December 6, 2019; July 10, 2020

The South Carolina State Board of Medical Examiners, the South Carolina State Board of Pharmacy, and the South Carolina State Board of Nursing acknowledge that:

It is within the scope of practice for an RN to administer/monitor low dose Ketamine via continuous infusion and intravenous push (in ED and PACU ONLY) with physician orders for specific cases of acute pain management in patients who with opioid-tolerance, intractable post-operative pain, poorly controlled chronic pain, palliative care, or patients suffering from extreme opioid side effects in an acute care setting.
LOCAL, STATE, AND FEDERAL INVOLVEMENT

PRIVILEGED AND CONFIDENTIAL
protected pursuant to S.C. Code Ann. §§44-7-390 et seq. and 40-71-10 et seq.
FUTURE NEEDS?
SUPPORT THE SCMA THEY SUPPORT YOU...

Doctor of the Day
Earn CME credit and gain valuable insight into the procedures and personalities that shape the laws of our state.
NOW WE ARE HERE TO SHARE…
Thank You

Email Contacts:

• Kevin Walker, MD FASA Kevin.Walker@PrismaHealth.org