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

• 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

<table>
<thead>
<tr>
<th>Role</th>
<th>VCU Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Gerard Moeller, MD</td>
</tr>
<tr>
<td>Administrative Medical Director</td>
<td>Vimal Mishra, MD, MMCi</td>
</tr>
</tbody>
</table>
| 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...
Who is Adam?
My Journey: August 2015-May 2016
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
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
In one night, she lost two sons to opioids. She’s on a mission to spare others that unfathomable pain
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
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

- Dentists: 12%
- Family Practice: 30%
- Internal Medicine: 15%
- Orthopedic Surgery: 12%
- Osteopathic Medicine: 12%
- Emergency Medicine: 10%
- General Surgery: 8%
- OB/Gynecology: 6%
- All Others: 4%

IMS Institute for Healthcare Info
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

Opiate Addiction is up

3,203 %

from 2002-2014

Ask oral surgeons to stop prescribing oxycodone & other opiates for wisdom teeth removal

annemoss.com
The use of NSAID, with or without Acetaminophen, offered the most favorable balance between benefits and harms, maximum efficacy with minimal adverse events.
Patients reported minimal or no opioid use after implementation of an opioid–sparing postoperative pathway, and still reported high satisfaction and pain control.
<table>
<thead>
<tr>
<th>Tablets Needed</th>
<th>Description</th>
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<tr>
<td>8 tablets</td>
<td>for oxycodone</td>
</tr>
<tr>
<td>6 tablets</td>
<td>oxycodone/acetaminophen</td>
</tr>
<tr>
<td>6-7 tablets</td>
<td>for hydrocodone/acetaminophen</td>
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</tbody>
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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

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
<table>
<thead>
<tr>
<th>Strategies for Pharmacologic Management of Postop Dental Pain</th>
</tr>
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<tbody>
<tr>
<td>1. <strong>NSAID as the primary agents for managing post-operative pain</strong></td>
</tr>
<tr>
<td>2. <strong>Combining two analgesic agents</strong></td>
</tr>
<tr>
<td>3. <strong>Using adjunct modalities: long acting local anesthetics, intra and postop steroids</strong></td>
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<tr>
<td>4. <strong>Opioids analgesics be reserved for only severe pain</strong></td>
</tr>
</tbody>
</table>
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 evaluating 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.
   a. In general, the shorter the procedure the less likely the patient will suffer severe postoperative pain. Simple extractions, and extraction of periodically involved teeth are less likely to result in postoperative pain than surgical corrections, complicated multiple extractions and extraction of bony impacted third molars.
   b. On the risk of prescribing opioids, patients younger than 10 years old, patients with history of substance use disorder, patients with sleep apnea and patients with benzodiazepines are at higher risk of being adversely affected with opioids.
   c. For additional guidance see Table 1.

B. Unless contraindicated, whenever possible, patients undergoing dentofacial 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 reflux for opioids, the Prescriber 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 (relaxed or 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. Deviations 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's wishes not to be prescribed opioid analgesics. The prescriber will provide the patient with non-steroidal anti-inflammatory drugs and Acetaminophen (APAP) 500 mg for pain.

1. If NSAIDS can be tolerated:
   - Pain Severity
   - Analgesic Recommendation
     - Mild: Ibuprofen (200-400 mg) q4-8 hours pm for pain
     - Mild to Moderate: Step 1: Ibuprofen (400-600 mg) q4-6 hours for relief of pain
       Step 1: Ibuprofen (400 mg) q4-6 hours pm for pain
     - Moderate to Severe: Step 1: Ibuprofen (400-600 mg) with APAP (300 mg) q4-6 hours fixed interval for 24 hours
       Step 2: Ibuprofen (400 mg) q4-6 hours pm for pain
     - Severe: Step 1: Ibuprofen (400-600 mg) with APAP (300 mg) q4-6 hours fixed pain
       Step 2: Ibuprofen (400 mg) q4-6 hours pm for pain

2. If NSAIDS are contraindicated:
   - Pain Severity
   - Analgesic Recommendation
     - Mild: APAP (325-650 mg) q1-4 hours pm for pain
     - Moderate: Step 1: APAP (325-650 mg) q4-6 hours pm for pain
       Step 2: Hydrocodeine (5 mg) q6-8 hours 3-day supply
     - Severe: Step 1: APAP (650-1000 mg) q4-6 hours pm for pain
       Step 2: Hydrocodeine (5 mg) q6-8 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 hydroxypropy-laminophen (APAP) in other medications. Maximum daily dose of APAP is 3,000 mg per day.
- To avoid potential APAP toxicity, consider placing on codeine prescription containing codeine.
- Maximum dose of codeine is 7.5-10 mg per day. Higher maximal daily doses have been reported for patients under a physician's care.
- A decrease in postoperative pain severity has been demonstrated when a nonsteroidal anti-inflammatory drug is administered preemptively.
- Long-acting local anesthetics can delay onset and severity of postoperative pain.
- A non-opioid anti-inflammatory drug (Acetaminophen) 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 hours, maximum 60mg/kg/24 hours.
- Ibuprofen in children <12: 1-4 mg/kg/dose q4-6 hours, maximum 40mg/kg/24 hours.

Reference:
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**

<table>
<thead>
<tr>
<th>Year</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Year</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Percentage</th>
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<tr>
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<td>5443</td>
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<tr>
<td>2015</td>
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<td>2015</td>
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<td>2016</td>
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<tr>
<td>2017</td>
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<tr>
<td>2018</td>
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<td>931</td>
<td>2018</td>
<td>4432</td>
<td></td>
<td>21.01%</td>
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The Future of Postsurgical Pain Management

Opioid Reducing  Opioid Free

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

DFW Oral & Maxillofacial Surgery

Opioid Alternatives

We have multiple ways to control pain in our practice...

Dennis Pedro-Francis, Howard Prince, and Elmer Hattan care about our youth and work toward being innovators in the area of opioid-free oral surgery. Read on to find out what makes us different and how we can treat pain effectively without opioids...

Malmquist

We are constantly humbled and made proud by all our volunteers everyday for the work they do behind the scenes in making their communities a better place to live. Dr. Dale Malskey is no exception to this extraordinary impact made by our oral surgeons and staff in creating solutions to problems they can help solve in their own way.

Recently, Dr. Malskey was interviewed by Dentist Money Digital Marketing.com for his role in combating poverty and drug abuse in his local community, an example of how each of us Malmquist is committed to positive social change through our words and actions, however big or small they may seem.

While Dr. Malskey would like the last person to call attention to his own efforts, we realize the power in spreading a positive message and showing true healing by making a change and changing communities, even if it’s one person at a time.
Drug overdose deaths in the U.S. dropped in 2018 for only the second time in two decades

deads per 100,000 people (age-adjusted)

*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)

![Chart showing the number of fatalities by quarter from 2007 to 2019. The chart includes four quarters each year, indicated by different colors and numbers. The chart shows a general decline in fatalities over the years with a predicted trend for 2019.](chart-image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Q4</th>
<th>Q3</th>
<th>Q2</th>
<th>Q1</th>
<th>Total Fatalities</th>
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<td>2019*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>494</td>
</tr>
</tbody>
</table>

*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.
HEROIN

![Graph showing the number of fatalities from heroin over the years from 2007 to 2019. The graph includes data for Q1, Q2, Q3, and Q4, as well as total fatalities.]

<table>
<thead>
<tr>
<th>Year</th>
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<th>Q3</th>
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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)

<table>
<thead>
<tr>
<th>Year</th>
<th>Q4</th>
<th>Q3</th>
<th>Q2</th>
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<td>2019</td>
<td>14</td>
<td>19</td>
<td>13</td>
<td>19</td>
<td>48</td>
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</tbody>
</table>

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.).
# 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)

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Fatalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>126</td>
<td>120</td>
<td>130</td>
<td>156</td>
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</tr>
<tr>
<td>2008</td>
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<td>151</td>
<td>538</td>
</tr>
<tr>
<td>2009</td>
<td>128</td>
<td>128</td>
<td>134</td>
<td>136</td>
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</tr>
<tr>
<td>2010</td>
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<tr>
<td>2011</td>
<td>141</td>
<td>142</td>
<td>137</td>
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<td>601</td>
</tr>
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<td>2012</td>
<td>142</td>
<td>134</td>
<td>136</td>
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<tr>
<td>2015</td>
<td>167</td>
<td>185</td>
<td>213</td>
<td>208</td>
<td>1138</td>
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<tr>
<td>2016</td>
<td>173</td>
<td>185</td>
<td>213</td>
<td>208</td>
<td>1230</td>
</tr>
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<tr>
<td>2018</td>
<td>173</td>
<td>185</td>
<td>213</td>
<td>208</td>
<td>1268</td>
</tr>
</tbody>
</table>

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

Number of Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
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<th>Q2</th>
<th>Q3</th>
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<td>0</td>
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<td>43</td>
<td>50</td>
<td>70</td>
<td>47</td>
<td>13</td>
</tr>
</tbody>
</table>

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-fluorobutyryl fentanyl and para-fluorobutyryl fentanyl cannot distinguish between the two analogs and therefore in this analysis, the two drugs are grouped together under ‘para-fluorodibutyryl fentanyl’
## Methamphetamine

(Data for 2017 is a predicted total for the entire year)

<table>
<thead>
<tr>
<th>Year</th>
<th>Q4</th>
<th>Q3</th>
<th>Q2</th>
<th>Q1</th>
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<td>38</td>
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<td>35</td>
<td>47</td>
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</tbody>
</table>
COCAINETotal Number of Fatal Cocaine Overdoses by Quarter and Year of Death, 2007-2019*
(Data for 2019 is a Predicted Total for the Entire Year)

<table>
<thead>
<tr>
<th>Year</th>
<th>Q4</th>
<th>Q3</th>
<th>Q2</th>
<th>Q1</th>
<th>Total Fatalities</th>
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</table>
### ALL DRUGS

![Bar graph showing number of fatalities from 2007 to 2019* for different quarters, with a color legend indicating Q4, Q3, Q2, Q1, and total fatalities.](chart)

<table>
<thead>
<tr>
<th>Year</th>
<th>Q4</th>
<th>Q3</th>
<th>Q2</th>
<th>Q1</th>
<th>Total Fatalities</th>
</tr>
</thead>
<tbody>
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<td>2019*</td>
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<td>1546</td>
</tr>
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</table>
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.

- **40 Million** (or >1 in 7) ages 12 and older have a substance problem...
- Heart Conditions (27 Million)
- Diabetes (26 Million)
- Cancer (19 Million)
“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:

Is Addiction a Disease or a Choice?
“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 the 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

- At-Risk
- Mild: 2 or 3
- Moderate: 4 or 5
- Severe SUD: 6 or more

Addiction requires intense medical management of the disease.

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.
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, alimovig, 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
*6 for phone audio
Use chat function for questions
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/HL. Rx seroquel; gave ER precautions.

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
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.
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
*6 for phone audio
Use chat function for questions
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 transforminal 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

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

• Case studies
  • Submit:  www.vcuhealth.org/echo
  • Receive feedback from participants and content experts
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 Motein, 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 Stroud, 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
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](http://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?
Access Your Evaluation and Claim Your CME

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™.
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME

• [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)

• To view previously recorded clinics and claim credit
Access Your Evaluation and Claim Your CME

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Telehealth

About Telehealth at VCU Health

For Patients

For Providers

Virginia Opioid Addiction ECHO

Register Now!

Submit Your Case Study

Continuing Medical Education (CME)

Curriculum & Calendar

Previsio Clinics (2018)

Previsio Clinics (2019)

Resources

Our Team
Access Your Evaluation and Claim Your CME

Previous Clinics (2019)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Informed Care and Treating Those Experiencing Opioid Addiction</td>
<td>01/04/19</td>
<td>Video of Clinic, Slide Presentation</td>
</tr>
<tr>
<td>Led by Courtery Holmes, PhD</td>
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</tbody>
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Learning Objectives:
1. Identify individuals who have experienced trauma.
2. Understand the impact of trauma on human development particularly related to substance use and misuse.
3. Learn components of trauma informed care.

Syringe Exchange

<table>
<thead>
<tr>
<th>Date</th>
<th>Resources</th>
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<tbody>
<tr>
<td>01/15/19</td>
<td>Video of Clinic, Slide Presentation, Needle Exchange Program, Bill to Remove Cooperation Law</td>
</tr>
<tr>
<td>Led by Anna Skarit, MSW, MPH</td>
<td></td>
</tr>
</tbody>
</table>

Learning Objectives:
1. Understand current legislative landscape in regards to syringe exchange in VA.
2. List benefits to clients and community of syringe exchange.
3. Define harm reduction.
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
THANK YOU!

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