Mihom News

Opioids: Guiding Their Use in Medicine While Restraining Their Misuse in the Community

By: Bridgitte Broxton ARNP-C, CDE, CWCN

Physicians and practitioners are challenged with balancing the need for providing adequate pain control for their patients in acute pain with the need to protect them from the potential addictive effects that opioids carry. Over the last couple of years, new regulations were established to tighten control of their misuse. Every day, more than 130 people in the United States die after overdosing on Opioids. According to the CDC, more than 47, 000 Americans died from the opioid overdose in 2017 alone. Additionally, in that same year, an estimated 1.7 million people in the United States succumbed to a substance use disorder related to prescription opioid pain relievers. Even closer to home, there were more than 28,400 overdose deaths in Florida in the year 2017. These numbers are so staggering and it is a problem that all healthcare workers must own and should pool their resources, in an effort to solve this epidemic.

Florida is now one of approximately 24 states that have passed legislation pertaining to prescription of opioids. The new laws, which came into effect on July 1st, 2018 govern both opioids and even some other non- opioid scheduled drugs. For non- opioid scheduled medications, such as steroids, anti- seizure meds, and stimulants, such as Adderall and Ritalin, and Xanax, the restriction causes providers to check a statewide database when prescribing drugs before a prescription is written for them. This process is intended to flag possible abusers of these medications, as it will show other prescriptions written, as well as the date they were prescribed by all other providers. In Florida, there is a 3 to 7day limit on the prescription of opioids for acute pain. E-FORCE, Florida's prescription drug data-

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June is Migraine and Headache Awareness Month

By: Bridgitte Broxton ARNP-C, CDE, CWCN

June is migraine and headache awareness month. This gives us, as healthcare workers and parents, the opportunity to learn more and better guide others about recognition and treatment of migraine headaches. The americanmigrainefoundation.org website provides tips for identifying the 10 most common migraine triggers. Stress is number one on the list. Additional triggers are: changes in sleep patterns, hormones, caffeine and alcohol, changes in weather, diet, dehydration, light, smell, and medication overuse. The exact cause for migraines is not known, but physicians agree that brief changes in your brain activity bring them on. These changes affect the blood vessels and nerve signals as well.

Common food triggers are: bananas, beans, chocolate, caffeine, corn, citrus fruits, cultured dairy products like yogurt, nut and nut butters onions, tomatoes, cheese and wine.

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base was created by the Legislature in 2009 to encourage safer prescribing of controlled substances and is still in use today. Under the new regulation, providers who fail to check the database can suffer penalties including disciplinary action against their license. On August 6 2018, the State Department of Health made "Take Control", an educational website to educate the public about the new regulations. The website includes FAQs and even encourages questions by contacting the Florida Department of Health at Takecotrol@FLhealth.gov. Besides establishing prescription limits, the law also mandates continuing education on controlled substance prescribing for providers and expands the use of the EFORCE database. This additional training is also required of ARNPs and PAs , who have DEA licenses, since effective January 1st, 2017, Florida changed the law allowing them to apply for DEA registration to prescribe controlled substances also.

According to Dr. Ronald Litman, "The rate of fatal overdoses due to oral formulations of semisynthetic opioids, such as oxycodone and hydrocodone, has risen steadily since 2000, and in 2017 was greater than that of heroin". Many individuals who abuse opioids progress from an initially legitimate legal use of opioids, to misuse and possible addiction. Therefore, opioids should be prescribed only when necessary, in the least effective dose, and for the shortest duration of time. Prescribing more opioid than necessary can result in leftover pills, which are then available for inappropriate use. Not all acute pain requires treatment with opioids. Also, a major potential barrier to appropriate dosing of opioid analgesics is that it is difficult to predict the intensity and duration of pain after an injury or surgery. We all have difference tolerance to pain. Some variables that effect our pain tolerance include, but are not limited to: patient demographics, culture, history of alcohol, drug or opioid use, as well as history of anxiety or depression.

Mandated continuing education for the prescribing of controlled substances stresses that the goal for pain control of patients should be a tolerable level of pain that allows optimal physical and emotional function and not zero pain. Strategies include tapering opioids as quickly as possible, while patients continue with non-opioid analgesics and non- pharmacologic therapy. Examples of these include ice or heat applications, elevation, immobilization, rest, relaxation techniques or meditation when appropriate. It is suggested that if opioids are necessary, providers should screen for risk factors of abuse or misuse, such as a history of substance abuse disorder and mental disorders. It is recommended that prescribers use short acting opioids over longer acting agents. Examples of short acting agents are hydromorphone, oxycodone alone or in combination with acetaminophen, ibuprofen or aspirin. Examples of longer acting agents include: Fentanyl, morphine and Oxycontin. Providers and all health care workers should assess for non- analgesic use of opioids, such as sleep or to address mood rather than pain. Nurses and providers, this may be a teaching opportunity exclusively if assessed early before the problem starts rather than an intervention. Clinicians in the home health arena are in a prime position to take notice of potential misuse of these medications, especially during the admission process, since patients provide a list of medications they take during this time. If opioids are listed, nurses should ask the question, "What are you taking this medication for?". Additionally, clinicians should re- evaluate patients who do not follow the expected course of recovery or require higher than expected doses of opioids. We should aim to involve family members in discussions with the patient on risks and benefit of opioids and discuss safe storage and disposal of them. Patient who are identified as abusing their prescriptions for opioids, should be referred to programs that taper them off safely.

Provider compliance with the new regulations are monitored. The 3 day supply limit can be increased to a 7 day supply. If this is the case, providers must write on the prescription" Acute pain exemption" to authorize the pharmacist to dispense the higher limits. The prescriber must adequately document in the patient's chart the need for the extension and that alternative treatment options failed or are not adequate. There are certain exemptions in place that providers should be aware of, which include treatment for cancer and palliative care, since these constraints are in place with the purpose of deterring inappropriate prescription writing that contribute to the problem at hand. Penalties for violations range from civil to criminal, including mandatory incarceration and monetary sanctions. Additionally, providers can have their authority to prescribe controlled substances revoked or suspended. These new regulations serve as constant reminders to providers that the opioid epidemic is growing and that restrictions are needed to reduce the staggering statistics. We are challenged to balance the need to protect patients from misuse of these medications, while providing them with adequate pain control that they deserve. The Hippocratic Oath says it best, "Above all, do no harm".

*Article Citations noted on page 4.

Juicy Watermelon Salad

8 Cups Cubed Seedless Watermelon
1 small red onion cut into rings
1 cup coarsely chopped toasted almonds
1 cup baby spinach or arugula
1/3 cup balsamic vinaigrette
3 Tbls Canola Oil
Blue Cheese crumbles to taste

In a large bowl, combine watermelon and onion; cover and refrigerate until cold, about 30 minutes. Just before serving, add nuts and greens to watermelon mixture. In a small bowl, whisk vinaigrette and oil; drizzle over salad and toss to coat. Sprinkle with cheese.

Refreshing Cucumber Salad

6 Cucumbers sliced
3 Roma Tomatoes Diced
1/2 cup Mayonnaise (Hellman's is my favorite)
1/2 cup Sugar
1 cup Vinegar
Salt and Pepper to Taste
Squeeze of Lemon

In a large bowl, combine all ingredients. All ingredient measurements are to your personal taste. Chill to bring out the flavors.

June is Migraine Month (from page 1)

Tyramine is a natural compound that forms in protein rich foods as they age. Certain cheeses are high in tyramine, such as blue, brie, cheddar, feta, mozzarella, muenster, parmesan, and swiss cheese. Another ingredient, MSG (monosodium glutamate), the main ingredient in soy sauce and meat tenderizers, can also spark a headache within as little as 20 minutes! Nitrates and nitrites, which are chemicals found in many cured and processed meats, such as hot dogs, ham and bacon, can also cause migraines. Once they get into your system, these potential triggers can cause your blood vessels to swell, which can bring on a headache. Medications used to treat headaches such as NSAIDs (non- steroidal anti- inflammatory drugs) and acetaminophen, as well as triptans (migraine specific drugs) and promethazine, can be used to treat the symptoms which are often occur with these headaches. Common symptoms of migraines include blurred vision, nausea, vomiting, sensitivity to light and sound, abdominal pain and severe headache. Providers should recommend that their patients keep a food diary in order to better identify the triggers for the migraine .

Statistics show that 1 in 10 school age children have migraines. Most people have their first attack during their teens or early twenties. They are most common during the peak productive years, between the ages of 25 and 50 years of age. Usually, these headaches resolve overtime. However, there are certain risk factors associated with episodic migraines progressing to chronic headaches, which include: obesity, depression, anxiety, and the use of opioids to treat attacks.

For additional questions and for continued learning, the americanmigrainefoundation.org website, whose mission is to "mobilize a community for patient support and advocacy, as well as drive and support impactful research that translates into advances for patients with migraines," can be utilized.

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Months of the Year

Best Care from Mihom to Yours...

G P G G R O H F L W V Q A P L E K P
E U S Q V C O X A F A D N X V M E F
M P H R R T S M K U Y P Q Y P L G F
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JANUARY

FEBRUARY

MARCH

APRIL

MAY

JUNE

JULY

AUGUST

SEPTEMBER

OCTOBER

NOVEMBER

DECEMBER

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