NHA Opioid Toolkit

Nebraska Hospital Association

The influential voice of Nebraska's hospitals

Dear Healthcare Leaders,

According to the website www.doseofreality.nebraska.gov, every three days someone dies of a drug overdose in Nebraska. Nationally, more than 52,000 people died of drug overdoses in 2015 according to the CDC. Drug overdoses sharply increased during the first nine months of 2016 according to the National Centers for Health Statistics. They were driven by increases in opioid deaths, especially from heroin and Fentanyl. But for many people, their first exposure to opioids is through prescription painkillers.

In early 2018, the Nebraska Hospital Association Board of Directors authorized the formation of a NHA Steering Council on the Opioid Epidemic to develop a toolkit to assist NHA members in the following areas:

- Crafting recommendations regarding appropriate prescribing to reduce the risk of substance use/misuse disorders.
- Developing recommendations regarding screening and appropriate treatment for those who are addicted.
- Addressing appropriate expectations on the part of the public regarding opioid use.

The development of this toolkit has been a collaborative effort on the part of many. The Nebraska Medical Association and the Nebraska Pharmacists Association provided invaluable support and insight into the nuances of this epidemic.

Participants of the Steering Council included representatives from Bryan College of Health Sciences and Bryan Independence Center, the Nebraska Department of Health & Human Services, and individual hospitals and health systems, including CHI Health, Nebraska Methodist Health System, Nebraska Medicine, Community Medical Center in Falls City, Boone County Health Center in Albion, Butler County Health Care Center in David City, Great Plains Health in North Platte, Box Butte General Hospital in Alliance and Fremont Health in Fremont.

The NHA thanks both the members of the Steering Council and the content contributors for their valuable input.

Sincerely,

Ann Schumacher, Chair
NHA Opioid Steering Council

***The information included in this toolkit is current as of November 2018. For any updates to this information, visit https://www.nebraskahospitals.org/quality_and_safety/addressing-the-opioid-epidemic.html**

Disclaimer:
Medication Assisted Treatment (MAT) prescribers listed on page 55 may only accept specific insurance plans or may not be taking new patients. Some prescribers could be focused on treatment of pain management while others may be prescribing Buprenorphine for Medication Assisted Treatment for substance use disorder specifically, which are not delineated in the list.

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Nebraska Area Health Education Center Program

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1

ADDRESSING APPROPRIATE PRESCRIBING TO REDUCE THE RISK OF SUBSTANCE USE/MISUSE DISORDERS

ACUTE PAIN FLOW SHEET

For the evaluation and treatment of acute pain

ASSESSMENT

Begin

- Patient presents after an acute injury (trauma, surgical procedure).
- Evaluate the clinical situation and determine your expected recovery time based on clinical evaluation, literature, your experience and the patient's general condition.
- Educate the patient regarding expectations for healing and duration and intensity of pain. Some pain is to be expected and it will diminish over time.

NON-OPIOID OPTIONS

Green Light

- Advise appropriate behavioral modifications, for example, initial rest followed by graded exercise of the affected body area.
- Provide external pain-reducing modalities, for example, immobilization, heat/cold and elevation.
- Advise appropriate OTC mediations with specific medications, doses and duration, as you would any pharmacologic modality.

OPIOID TREATMENT

Caution

- If considering opioids, first ask about risks for opioid misuse, for example, previous addiction history, overdose history and suicidality.
- If opioids are contraindicated, clearly state to the patient and document in the chart a note that the risk of treatment overshadow the benefits. Stress other modalities of pain modification.
- When prescribing opioids, use the lowest possible dose for the shortest amount of time. Most acute painful situations will resolve themselves in three to seven days. In most cases, three days of opioids will be sufficient.

STOP AND REASSESS

Stop!

- If the patient asks for additional opioids and you have prescribed the amount that in your professional judgment should have sufficed, have the patient return for an evaluation. At that follow-up visit, you or your staff should:
  - Be sure there is no unforeseen complication requiring further testing or treatment.
  - Be sure there is no evidence of substance use complicating treatment. A PDMP query is advised and a UDS might be indicated at this time.
  - Only prescribe additional opioids if you feel it is clinically appropriate. Otherwise, continue to reinforce non-opioid modalities of pain control.

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

CHRONIC PAIN FLOW SHEET

For the evaluation and treatment of chronic non-cancer pain

ASSESSMENT

Begin

- Evaluate the original tissue injury and determine nociceptive, neuropathic or central characteristics of the pain perception.
- Assess the risk of prescribing opioids to a patient through assessment tools: ACE, Pain Catastrophizing Scale, PHQ-15, STOP-BANG, functional (e.g. Oswestry) or abuse (e.g. ORT) assessments and trauma/ PTSD screening.
- Obtain and review prior records, or for an established patient, re-familiarize yourself with your patient's past history and evaluations.
- A UDS and query of the PDMP prior to assuming prescribing and periodically thereafter, but no less than yearly.

NON-OPIOID OPTIONS

Green Light

- Exercise, restorative sleep and behavioral supports should be a major component to any pain management program.
- A team approach to care is essential to achieve functional improvement and improved quality of life.

ONGOING MONITORING

Ongoing

- Monitor all patients on chronic opioids.
- Every visit:
  - Evaluate the progress toward functional goals. Strongly consider weaning in the absence of functional improvement on opioids.
  - Screen for appropriate medication use.
- Periodically assess (no less than annually):
  - Urine drug screening
  - Pill counts
  - Callbacks
  - PDMP query

OPIOID TREATMENT

Caution

- Rarely prescribe opioids on the first visit.
- Discuss the risks vs. benefits of opioids and get a signed material risk notice.
- Create a care plan that includes functional goals.
- Discuss the plan for dose reduction (see tapering flow sheet).
- Co-prescribe Naloxone rescue kit to a loved one or family member.

STOP AND REASSESS

Stop!

- Benzodiazepines should not be taken at the same time as opioids.
- Methadone should be used rarely, and if so, in low doses (<30 mg/d).
- Respiratory disease (COPD, sleep apnea, etc.) narrows the window of safety with opioids.
- Evidence of substance abuse, past or present.
- Illegal activities regarding medication or illicit drugs.
- Lack of functional improvement.

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

OPIOID TAPERING FLOW SHEET

START HERE

Consider opioid taper for patients with opioid MME > 90 mg/d or Methadone > 30 mg/d, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

OPIOIDS

Basic principle: For longer-acting drugs and a more stable patient, use slower taper. For shorter-acting drugs, less stable patient, use faster taper.

1. Use an MME calculator to help plan your tapering strategy. Methadone MME calculations increase exponentially as the dose increases, so Methadone tapering is generally a slower process.
2. Long-acting opioid: Decrease total daily dose by 5-10% of initial dose per week.
3. Short-acting opioids: Decrease total daily dose by 5-15% per week.
4. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts and PDMP to help determine adherence.
5. After ¼ to ½ of the dose has been reached, with a cooperative patient, you can slow the process down.
6. Consider adjuvant medications: antidepressants, Gabapentin, NSAIDs,Clonidine, anti-nausea, anti-diarrhea agents.

MME for Selected Opioids

Opioid	Approximate Equianalgesic Dose (Oral and transdermal)	Opioid	Approximate Equianalgesic Dose (Oral and transdermal)
Morphine	30 mg	Codeine	200 mg
Fentanyl transdermal	12.5mcg/hr	Hydrocodone	30 mg
Hydromorphone	7.5mg	Methadone Chronic	4 mg
Oxycodone	20 mg	Oxymorphone	10 mg
Tapentodol	75 mg	Tramadol	300 mg

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

BENZODIAZEPINE TAPERING FLOW SHEET

START HERE

Consider Benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment or concurrent opioid use.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support will be critical. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

Slow Taper	Rapid Taper
1. Calculate the total daily dose. Switch from short-acting agent (Alprazolam, Lorazepam) to longer-acting agent (Diazepam, Clonazepam, Chlordiazepoxide or Phenobarital). Upon initiation of taper, reduce the calculated dose by 25-50% to adjust for possible metabolic variance.	1. Pre-medicate two weeks prior to taper with Valproate 500mg BID or Carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-Benzodiazepines. Follow the usual safeguards (lab testing and blood levels) when prescribing these medications.
2. Schedule first follow-up visit two to four days after initiating taper to determine if adjustment in initial calculated dose is needed.	2. Utilize concomitant behavioral supports.
3. Reduce total daily dose by 5-10% per week in divided doses.	3. Discontinue current Benzodiazepine treatment and switch to Diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.
4. After ¼ to ½ of the dose is reached, you can slow the taper with cooperative patient.	4. Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.
5. With cooperative patients who are having difficulty with this taper regimen, you can extend the total time of reduction to as much as six months.	
6. Consider adjunctive agents to help with symptoms: Trazodone, Hydroxyzine, neuroleptics, anti-depressants, Clonidine and alpha-blocking agents.	

Benzodiazepine Eqivalency Chart

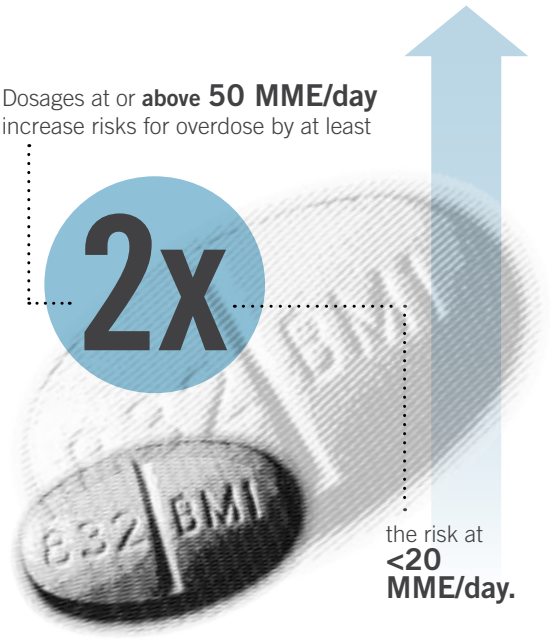
Drug	Half-life (hrs)	Dose Equivalent
Chlorodiazepoxide (Librium)	5-30 h	25mg
Diazepam (Valium)	20-50 h	10mg
Alprazolam (Xanax)	6-20 h	0.5mg
Clonazepam (Klonopin)	18-39 h	0.5mg
Lorazepam (Ativan)	10-20 h	1mg
Oxazepam (Serax)	3-21 h	15mg
Triazolam (Halcion)	1.6-5.5 h	0.5mg
Phenobarbital (barbiturate)	53-118 h	30mg

Source: Nebraska Department of Health & Human Services For updated information, visit dhhs.nebraska.gov

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

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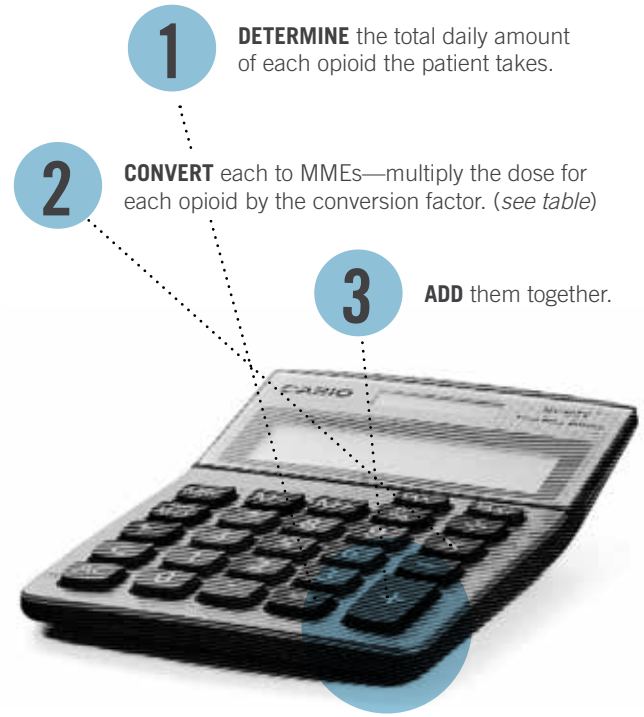
LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

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

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (**PDMP**): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

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CS273808A

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

SOFA
The Society for Opioid Free Anesthesia

Non-Opioid Analgesics

Drug	Dose	Contraindication Side Effect	Considerations
Celecoxib Ketorolac	200-400 mg 15-30 mg	C: renal failure, gi bleed, thrombotic event, CABG, age >60, thrombocytopenia	
Dexamethasone	4-12 mg	S/E increased glucose levels	Dose dependent effect on pain and PONV
Gabapentin	300-1200 mg	S/E: post-op sedation with higher doses	600 mg decreases PONV
Pregabalin	75-150 mg	S/E: angioedema, thrombocytopenia, rhabdomyolysis, increased pr interval	faster absorption than Gabapentin
Ketamine	0.2-0.5 mg/kg 2-10 mcg/kg/min	Do not need Versed at these doses	Prevents opioid tolerance & opioid induced hyperal-gesia
MgSO4	30-50 mg/kg 10 mg/kg/hr	C: Renal failure S/E: limits ACh release, use caution in neuromuscular disease. Prolongs NMB	Labs not needed. Dose not correlated to analgesic effect.
Nitrous Oxide	50%	C: pul htn, B12 anemia, low O2 sat	50% ET = 15mg morphine
Clonidine	2-5 mcg/kg IV 5-7 mcg/kg PO 0.2-0.5 mcg/kg/hr	S/E: bradycardia, hypotension	Anxiolytic, prevent post-operative shivering
Dexmedetomidine	1 mcg/kg/10 minutes 0.2-1 mcg/kg/hr	S/E: bradycardia, hyper/hypotension, less severe than clonidine	
Acetaminophen	1G or 15 mg/kg <50 kg	C: liver failure/dysfunction	PO or IV
Duloxetine	60 mg	C: pediatrics, MAOI, linezolid, methylene blue	
Esmolol	0.5-1 mg/kg 5-500 mcg/kg/min	C: bradycardia, AV block	
Lidocaine	1.5 mg/kg bolus 2-3 mg/kg/hr intra-op 1.3 mg/kg/hr post-op	C: AV block, Seizures	1.5 mg/kg/hr if concerned about metabolism

Blue = anti-inflammatory *Green = Glutamate* *Red = Substance P* *Yellow = Miscellaneous*

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PROTOCOL FOR
OPIOID FREE ANESTHESIA FOR SPINES

Pre-medicate in ASU with:

- Acetaminophen 650-975 mg (repeat intraoperatively with rectal suppository at 6-8 hours or IV Acetaminophen if available)
- Gabapentin 600-1200mg
- Celebrex 200-400mg (clear with surgeon)

Induction:

- Midazolam 1-2 mg
- Dexmedetomidine 0.5-1 mg/kg over 10 minutes
- Lidocaine 2 mg/kg
- Ondansetron 4 mg
- Dexamethasone 10 mg (please ensure that surgeon is okay with that)
- Ketamine 0.5 mg/kg
- Propofol 1 mg/kg

Maintenance:

- Ketamine 2-5 mcg/kg/min
- Lidocaine 1.5-2 mg/kg/hr
- Dexmedetomidine 0.15-0.3 mcg/kg/hr (If intra-op wakeup test likely, then low dose or eliminate infusion and then re-dose at the end)
- Propofol 50-100 mcg/kg/min
- Rocuronium 10-20 mg/hr
- MgSO4 30-50 mg/kg
- +/- clonidine 2-5 mcg/kg earlier in the case (will help with lowering BP as often requested and longer acting analgesia than dexmedetomidine)

This technique can be modified for essentially any general cases, and can be especially helpful for large abdominal cases (TAH/BSO, large hernias, bowel resections and lysis of adhesions), consider using regional (i.e. TAP blocks or similar) additionally for these large abdominal cases.

In patients with HIGH preoperative opioid tolerance consider adding opiates to the mix (remifentanil/sufentanil drips or front loading with hydromorphone, morphine, or methadone) depending on length of surgery and opioid tolerance.

In patients who received pre-op Celecoxib please keep in mind that an additional dose of Ketorolac at the end of surgery might be too much.

A few additional points to consider:

Ketamine can interfere with BIS/ Sedline monitoring. The machines will interpret the more “active” EEG as a patient, who is more awake and therefore one can get false high readings.

Wake-up tests are not uncommon for large corrective spine surgeries. Consider not using Dexmedetomidine or using a lower dose to ensure prompt wake up if necessary (We think it is Dex that keeps the patients asleep)

Magnesium can interfere with neuro-monitoring, particularly MEP. In large scoliosis correction surgeries we see changes in evoked potentials quite often. While Magnesium infusion is still an option it might not be the best drug for these cases. It can be added to the anesthetic at the end of surgery once neuro-monitoring is complete to aid with post-operative pain control. As always close communication with the neurophysiologists is recommended.

If at all possible continue Ketamine infusion post-operatively to help with post-op pain treatment.

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

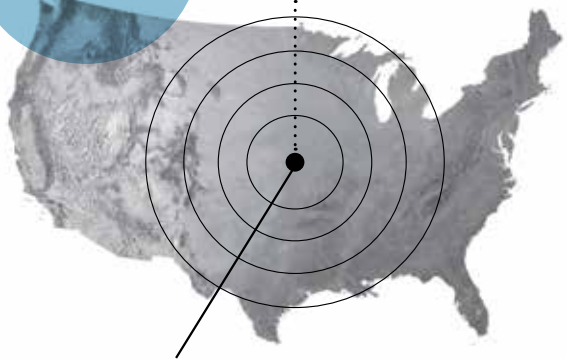
WHAT IS A PDMP?

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

249M prescriptions for opioids were written by healthcare providers in 2013

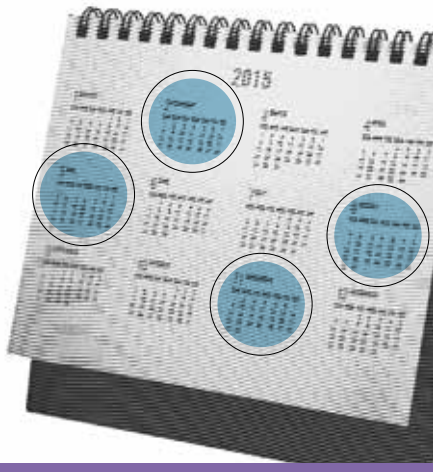


enough prescriptions for every American adult to have a bottle of pills

Improving the way opioids are prescribed will ensure patients have access to safer, more effective chronic pain treatment while reducing opioid misuse, abuse, and overdose. Checking your state's PDMP is an important step in safer prescribing of these drugs.

WHEN SHOULD I CHECK THE PDMP?

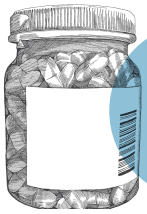
State requirements vary, but CDC recommends checking at least once every 3 months and consider checking prior to every opioid prescription.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

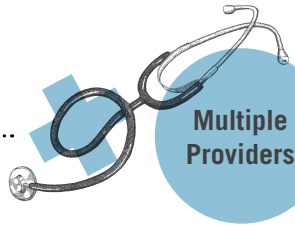
LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?



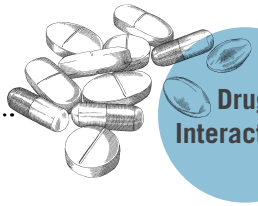
High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.



Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.



Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1. **Confirm that the information in the PDMP is correct.**
   Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2. **Assess for possible misuse or abuse.**
   Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**

HOW CAN I REGISTER AND USE THE PDMP IN MY STATE?

Processes for registering and using PDMPs vary from state to state.

For information on your state's requirements, check The National Alliance for Model State Drug Laws online:

www.namsdl.org/prescription-monitoring-programs.cfm

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

LB931: Provide requirements for opiate and controlled substance prescription - Effective July 19, 2018
When prescribing an opiate for a patient younger than 19 years of age for outpatient use for an acute condition, the prescription cannot be written for more than a 7-day supply; unless, in the professional medical judgment of the practitioner, more than a 7-day supply of an opiate is required.

A longer prescription is allowed to treat such patient's medical condition or chronic pain management, or pain associated with a cancer diagnosis or for palliative care.

- The practitioner may issue a prescription for the quantity needed to treat such patient's medical condition or pain and document the medical condition triggering the prescription of more than a 7-day supply of an opiate in the patient's medical record and shall indicate that a non-opiate alternative was not appropriate to address the medical condition.
- If the practitioner has not previously prescribed an opiate for such patient, the practitioner shall discuss with a parent or guardian of such patient the risks associated with use of opiates and the reasons why the prescription is necessary.

Prior to the first prescriptions for an opiate and again if a third prescription is issued, opiate prescribers must now discuss certain information with the patient or patient's parent or guardian, including risks of addiction and overdose, reasons why the practitioner deems the prescription necessary, and alternative treatments that may be available. Practitioners are NOT required to make note of this required discussion in the patient's medical record. Persons taking receipt of dispensed schedule II, III and IV opiates must provide valid identification prior to taking receipt of the prescription, unless the person picking up the medication is personally and positively known to the pharmacist or dispensing practitioner. An exception is provided for patients who reside in a licensed healthcare facility.

LB556 (Howard) Change provisions relating to prescriptions for controlled substances and the prescription drug monitoring program
Information required for prescribers (other than veterinarians) must now include a patient identifier number; number of refills authorized; available prescription directions and any other information as required by the Dispenser's Implementation Guide for the prescription drug monitoring program developed by in collaboration with DHHS. The statewide health information exchange/PDMP may release data collected for statistical, public research, public policy, or educational purposes after removing information which identifies the patient or prescriber.

LB556 allows for the distributions of the prescription drug information and any other data collected pursuant to the PDMP to: other state prescription drug monitoring programs; state and regional health information exchanges; the medical director and pharmacy director of the Division of Medicaid and Long-Term Care, the medical directors and pharmacy directors of Medicaid-managed care entities, the state's Medicaid drug utilization review board, and any other state administered health insurance program or it's designee if any such entities have a current data-sharing agreement with the statewide health information exchange, and if such release is in accordance with the HIPPA; organizations which facilitate the interoperability and mutual exchange of information among state prescription drug monitoring programs or state or regional health information exchanges; or electronic health record systems or pharmacy-dispensing software systems for the purpose of integrating prescription drug information into a patient's medical record.

LB556 Inserts a new subsection defining practitioner to include physicians, physician assistants, dentists, pharmacists, podiatrists, optometrists, and various advanced practice nurses (excludes hospitals and veterinarians). Changes a practitioner's duty to consult with a patient about the risks related to a controlled substance; rather than have that conversation before the initial prescription and the third prescription, the bill instead requires the conversation if it has not been had in the last 60 days. Allows other members of the patient care team who are under the direct supervision of or in consultation with the prescribing practitioner to have the conversation about risks with the patient. Clarifies that the duty to have this conversation does not apply to a prescription given for a hospice patient or for the course of treatment for cancer or palliative care.

LB557 (Lindstrom) Change provisions relating to prescriptions for controlled substances (amended into LB556)
Requires the prescribing practitioner involved in the course of treatment as the primary prescribing practitioner or as a member of the patient's care team who is under the direct supervision or in consultation with the primary prescribing practitioner to discuss with the patient the risks of controlled substances and opiates, unless such conversation has already taken place within the last 60 days. Does not apply to hospice, cancer, or palliative care treatment.

For purposes of the requirement above and the limitation on prescriptions for patients under 18 years of age, prescribing practitioner includes: physician, a physician assistant, a dentist, a veterinarian, a pharmacist, a podiatrist, an optometrist, a certified nurse midwife, a certified registered nurse anesthetist, a nurse practitioner, a scientific investigator, a pharmacy, a hospital, or any other person licensed, registered, or otherwise permitted to distribute, dispense, prescribe, conduct research with respect to, or administer a controlled substance in the course of practice or research in this state, including an emergency medical service.

ED Opiate-Free Pain Options by Indication

Musculoskeletal Pain: Acute on chronic opiate-tolerant OR acute opiate naïve
No IV access - Intranasal Ketamine 50mg (0.5ml)
Acetaminophen 1000 mg PO/IV
Ibuprofen 600mg PO or Ketorolac 15mg IV/IM
Trigger Point injection - Lidocaine 1% 1-2ml subQ
Cyclobenzaprine 5mg PO or Diazepam 5mg PO/IV
Dexamethasone 8mg PO/IV
Ketamine 0.2mg/kg IV over 5-10 min
Lidoderm patch to most painful area, MAX 3 patches
Gabapentin 300mg PO (neuropathic component of pain)

Recurrent Primary Headache/Migraine
Acetaminophen 1000mg PO/IV
Ibuprofen 600mg PO or Ketorolac 30mg IV/IM
1 liter Normal Saline Bolus
Sumatriptan 6mg subQ
Cervical or Trapezius Trigger Point Injection with Lidocaine 1% 1-2ml IM
Metoclopramide 10mg IV
Promethazine 12.5mg IV
Magnesium 1gm IV over 60 minutes
Valproic Acid 500mg/50ml NS IV over 20 minutes
Levetriacetam 1000mg/100ml NS IV over 15 minutes
Dexamethasone 8mg IV (migraine only)
Haloperidol 2.5mg IV over 5 min
Lidocaine 1.5mg/kg in 100ml NS over 10 minutes (max 200 mg)
If tension component: - Cyclobenzaprine 5mg PO or Diazepam 5mg PO/IV

Extremity Fracture or Joint Dislocation
Consider regional anesthesia: e.g. nerve blocks: wrist, ankle, ulnar, radial, etc.
Immediate therapy: (steps 1-3 while setting up for block) - Intranasal Ketamine 50mg (0.5ml) - Acetaminophen 1000mg PO/IV
Followed by setting up for: - Ultrasound guided regional anesthesia ○ Joint dislocation and extremity fracture ■ Lidocaine 0.5% peri-neural infiltration (Max 5mg/kg)
If unable to do ultrasound-guided regional anesthesia: - Ketamine 0.2mg/kg in 50ml NS IV over 5-10 min

Abdominal Pain
Metoclopramide 10mg IV
Diphenhydramine 25mg IV
Promethazine 25mg IV
Dicyclomine 20mg PO
Haloperidol 2.5mg IV over 5 min
Lidocaine 1.5mg/kg in 100ml NS over 10 min (Max 200mg)
Ketamine 0.2mg/kg in 50ml NS IV over 5-10 min
Sumatriptan 6mg subQ
Capsaicin 0.025% topical

Renal Colic
Acetaminophen 1000 mg PO/IV
1 liter normal saline bolus
Ketorolac 15mg IV
Lidocaine 1.5 mg/kg in 100 ml NS over 10 min (Max 200mg)
Intranasal Ketamine 50mg (0.5 ml)

Bryan CRETE AREA MEDICAL CENTER

Opioid Prescribing/Management Guideline Checklist (Based on ASIPP 2012)

1.0 Assessment & Documentation	2.0 Establish Diagnosis	3.0 Establish Medical Necessity	4.0 Establish Treatment Goals
❑ Patient Intake Form complete	❑ CT	❑ Physical diagnosis & multiple modalities of treatment	30% improvement in function or reduction in pain is common
❑ Physical assessment complete	❑ MRI	❑ Pain is moderate to severe	For intervention techniques, 50% reduction in pain scores and disability scores
❑ ORT complete	❑ X-ray	❑ Suspected organic problem	BEST TO USE NUMERIC SCALES TO ASSESS/RE-EVALUATE
❑ PDMP checked	❑ Neurologic study	❑ Documented failure to respond to other treatments /medications	❑ Oswestry Disability Index
❑ UDT initial complete	❑ Psychologic evaluation	ALL OF THE ABOVE MUST BE CHECKED TO MEET MEDICAL NECESSITY	❑ Pain Scale (0-10)
	❑ Precision diagnostic intervention		❑ Neck Disability Index
	❑ Consultations		❑ Employment status
	❑ Other		❑ Activity Status

5.0 Assess Therapy Effectiveness	6.0 Informed Decision-Making	7.0 Initial Treatment	8.0 Adherence Monitoring
❑ Right type of opioid for the type of pain	❑ Discuss potential benefits and risks	❑ Risk stratification: DIRE or ABC checklists	❑ Dependent on risk stratification: High, Med, Low
❑ Long-term vs short-term management	❑ Discuss results of overdose: withdrawal with stoppage, death, increase risk with alcohol or other medication use	❑ Select Drug and Dose limits (MED) ❑ Select Drug and Dose limits (MED) Keep dose (ALARA) as low as reasonably achievable	❑ Use Monitoring Algorithm
❑ Special populations: Elderly, children, adolescents, depression/anxiety	❑ Instruct medication needs to be securely stored and not shared	Low dose= up to 40 mg of MED Mod. dose = 41-90 mg of MED High dose = > 91 mg of MED	❑ Monitoring tools: ABC checklist, UDS, PDMP
❑ Consider contraindications	❑ Signed treatment agreement/informed consent	❑ Patient education	❑ Continue/discontinue opioid

9.0 Monitor/Manage Side Effects	10.0 Final Phase	11.0 Documentation
❑ May need discontinuation if S.E. indicates	AFTER FIRST 8-12 WEEKS OF THERAPY	❑ Complete and accurate record of all intervention, treatments, medical care
❑ May need bowel regime to manage constipation	❑ Goals met: Continue therapy/ continue to monitor/wean or discontinue	
❑ Review driving under influence of opioids recommendations	❑ Goals not met: Wean/discontinue therapy	

CHI Health
Imagine better health.℠

Consistent Messaging

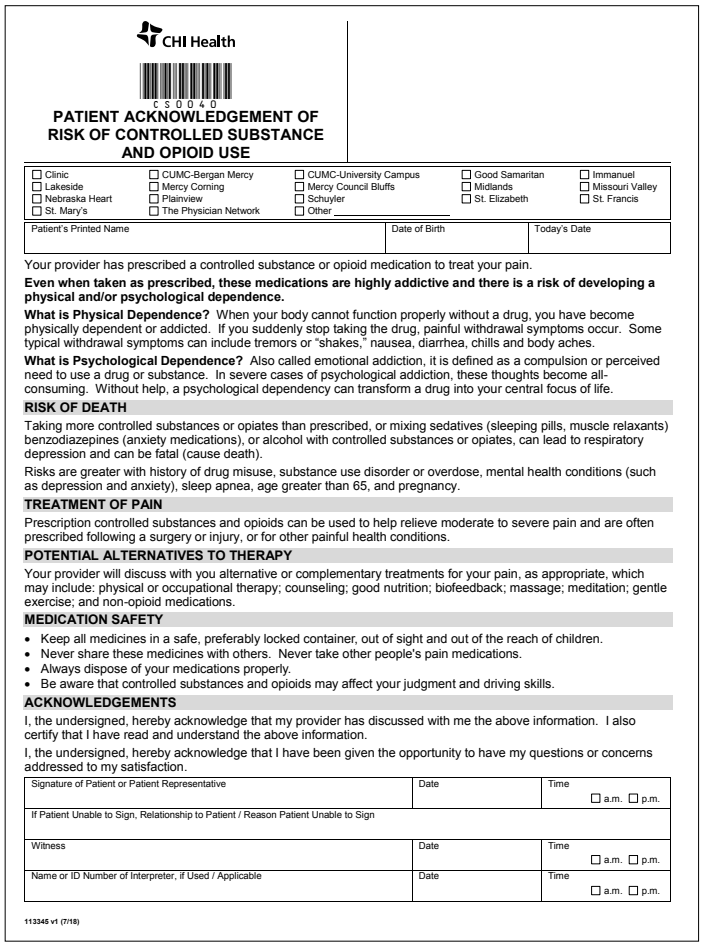
Beginning July 19, 2018, ALL CHI Health entities in Nebraska and Iowa will utilize a universal form across the division.

The **"Patient Acknowledgment of Risk of Controlled Substance and Opioid Use"** will be used in both the inpatient and outpatient settings.

Ambulatory Clinic Settings

The **"Patient Acknowledgment of Risk of Controlled Substance and Opioid Use"** will be completed:

- Prior to the **FIRST** prescription of a Schedule II medication for pain
- Prior to the **THIRD** prescription of a Schedule II medication for pain
- Existing prescriptions - prior the **NEXT SCHEDULED** prescription **RENEWAL**
- **ANNUALLY** for all patients on long-term use of Schedule II medications for pain



CHI Health

CS0040

PATIENT ACKNOWLEDGEMENT OF RISK OF CONTROLLED SUBSTANCE AND OPIOID USE

☐ Clinic	☐ CUMC-Bergan Mercy	☐ CUMC-University Campus	☐ Good Samaritan	☐ Immanuel
☐ Lakeside	☐ Mercy Corning	☐ Mercy Council Bluffs	☐ Midlands	☐ Missouri Valley
☐ Nebraska Heart	☐ Plainview	☐ Schuyler	☐ St. Elizabeth	☐ St. Francis
☐ St. Mary's	☐ The Physician Network	☐ Other _____		

Patient's Printed Name	Date of Birth	Today's Date

Your provider has prescribed a controlled substance or opioid medication to treat your pain.

Even when taken as prescribed, these medications are highly addictive and there is a risk of developing a physical and/or psychological dependence.

What is Physical Dependence? When your body cannot function properly without a drug, you have become physically dependent or addicted. If you suddenly stop taking the drug, painful withdrawal symptoms occur. Some typical withdrawal symptoms can include tremors or "shakes," nausea, diarrhea, chills and body aches.

What is Psychological Dependence? Also called emotional addiction, it is defined as a compulsion or perceived need to use a drug or substance. In severe cases of psychological addiction, these thoughts become all-consuming. Without help, a psychological dependency can transform a drug into your central focus of life.

RISK OF DEATH

Taking more controlled substances or opiates than prescribed, or mixing sedatives (sleeping pills, muscle relaxants) benzodiazepines (anxiety medications), or alcohol with controlled substances or opiates, can lead to respiratory depression and can be fatal (cause death).

Risks are greater with history of drug misuse, substance use disorder or overdose, mental health conditions (such as depression and anxiety), sleep apnea, age greater than 65, and pregnancy.

TREATMENT OF PAIN

Prescription controlled substances and opioids can be used to help relieve moderate to severe pain and are often prescribed following a surgery or injury, or for other painful health conditions.

POTENTIAL ALTERNATIVES TO THERAPY

Your provider will discuss with you alternative or complementary treatments for your pain, as appropriate, which may include: physical or occupational therapy; counseling; good nutrition; biofeedback; massage; meditation; gentle exercise; and non-opioid medications.

MEDICATION SAFETY

- Keep all medicines in a safe, preferably locked container, out of sight and out of the reach of children.
- Never share these medicines with others. Never take other people's pain medications.
- Always dispose of your medications properly.
- Be aware that controlled substances and opioids may affect your judgment and driving skills.

ACKNOWLEDGEMENTS

I, the undersigned, hereby acknowledge that my provider has discussed with me the above information. I also certify that I have read and understand the above information.

I, the undersigned, hereby acknowledge that I have been given the opportunity to have my questions or concerns addressed to my satisfaction.

Signature of Patient or Patient Representative	Date	Time ☐ a.m. ☐ p.m.
If Patient Unable to Sign, Relationship to Patient / Reason Patient Unable to Sign		
Witness	Date	Time ☐ a.m. ☐ p.m.
Name or ID Number of Interpreter, if Used / Applicable	Date	Time ☐ a.m. ☐ p.m.

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Hospital Settings

The **"Patient Acknowledgment of Risk of Controlled Substance and Opioid Use"** will be completed:

- At discharge for all patients prescribed Schedule II medications for pain

Ambulatory Documentation

- Signed and witnessed acknowledgment will be scanned into the electronic medical record
- Provider responsible to document components of law have been met:
  - Risk of addiction and overdose
  - Reasons why prescription is necessary
    - Medical necessity if > 7-day supply is needed
  - Alternatives to treat pain that may be available
  - Iowa only: PMP reviewed
  - Nebraska: Best practice to review PDMP and document

Howard County MEDICAL CENTER

Controlled Substance Policy for Pain Control

SUBJECT: Controlled Substance Policy for Pain Control	RESOURCES: LB931, CDC guidelines for prescribing opioids for chronic pain
	Page 1 of 2
DEPARTMENT:	
EFFECTIVE DATE:	
APPROVED BY:	REVISED:

POLICY: Howard County Medical Center (HCMC) Acknowledges compliance with controlled substance prescribing and education for patients regarding the risks of controlled substance and opioid use.

PURPOSE: To have a standardized practice in the clinic among providers when prescribing and educating patients on the use of controlled substances and opioid use.

DEFINITIONS:

Provider: Any licensed medical provider who is able to prescribe controlled substances.

Controlled Substances: Any Scheduled II-IV drug used for pain control.

Opioid: Class of medications that act on opioid receptors and are highly addictive.

Pain Management Agreement: Signed agreement made between a patient and a provider utilizing the form adapted from the American Academy of Pain Medicine.

Acute Pain: Sudden and usually sharp in feeling. Serves as a warning sign or threat to the body. Can be caused by broken bones, burns, cuts, surgery, etc.

Chronic Pain: An unpleasant sense of discomfort that persists or progresses over a long period. Typically persists over time and is often resistant to medical treatments and is not from cancer.

Prescription: Medication that is written to be filled at a pharmacy by a provider to treat a disease or treat a medical condition.

MME: Milligram Morphine Equivalent (MME) is a value assigned to represent their relative potencies.

Attached documents: Patient Acknowledgment of Risk of Controlled Substance and Opioid Use, Pain Management Agreement.

RATIONALE: Guidelines for prescribing opioids for chronic pain is intended to improve communication between providers and patients about risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid use disorder and overdose. The guideline is not intended for patients who are in active cancer treatment, palliative care or end-of-life care.

Howard County MEDICAL CENTER

SUBJECT: Controlled Substance Policy for Pain Control	RESOURCES: LB931, CDC guidelines for prescribing opioids for chronic pain
	Page 2 of 2
DEPARTMENT:	
EFFECTIVE DATE:	
APPROVED BY:	REVISED:

IMPLEMENTATION:

- When prescribing a controlled substance for the first time the provider will provide the Patient Acknowledgment of Risk of Controlled Substance and Opioid Use see attached. This will be put in the chart and a copy to the patient.
    - This acknowledgment will cover the risks and alternatives to opioid therapy.
    - The patient and the provider will sign (If the patient is a minor, the guardian will sign).
    - If the prescription is for more than 7 days, the reason will be documented on this form.
    - It is also noted on the acknowledgment form that if the patient is using opioids for chronic pain control that the prescription will be written for 30 days and that the patient will need to be seen every 90 to 180 days while receiving this treatment.
    - Patients 18 years or younger should not be prescribed more than 7 days of opioids (unless there is documentation in the chart on why it's in the patient's chart).
- The Patient Acknowledgment of Risk of Controlled Substance and Opioid Use form will be reviewed after the third prescription and then yearly for patients with chronic opioid use.
- Patients receiving opioids for chronic pain should be seen by the ordering provider every 90-180 days to discuss goals and reinforce patient education about opioid use. And to discuss non opioid treatment options.
- Providers will have a goal of keeping the MME less than or equal to 50 MME/day, if dosing greater than 50 MME/day is required the risk and benefits should be weighed.
- If a patient requires more than 90 MME/day of opioids, the provider will need to document the rationale in the patient's chart.
- Naloxone for the patient to have at home should be considered if the patient is receiving more than 90 MME/day.
- Providers will also avoid prescribing opioids and Benzodiazepines concurrently whenever possible.
- The provider will place patients on the Pain Management Agreement at their discretion for the best patient care.

METHODIST

Data-Driven Opioid Guardianship
A Health Care System's Blueprint for Change

The Opioid Guardianship Program is a large-scale project spanning across Nebraska Methodist Health System focused on adhering to all opioid-related regulatory requirements and reducing unnecessary opioid prescription and usage.

Project Goals

- Adhere to all related regulatory requirements
- Reduce unnecessary narcotics prescribing and usage
- Create a roadmap for the Opioid Guardianship Program

Primary Metric

- Opioid prescribing at Discharge - Morphine Milligram Equivalent (MME)
  - Goals to be set after initial analysis complete

Secondary Metrics – used to guide individual improvement efforts

- Inpatient opioid use
- Multi modal usage
- Patient education
- PDMP utilization

Data Task Force Planned Actions

- Additional analysis of opioid prescriptions per total prescriptions.
- NMHS to benchmark against local/regional VA hospitals.
- Total pills prescribed to dashboard.
- Partnership with NeHii to further improve PDMP access and features.
- Educate providers on best way to access and utilize the PDMP/PMP and better understand workflow issues.

Pharmacy Task Force Planned Actions

- Create plans to operationalize new initiatives passed for CMS, MU, JC that may require PDMP review prior to opioid prescribing and EPCS.
- Continue to work with Cerner for additional tools as well as investigate how to incorporate existing tools into the prescriber workflow.
- Integrated MME calculator.
- Investigate 2 prescription method for surgical patients to reduce leftover medications while addressing provider issues around weekend calls.
- Investigate potential changes to pain management protocols.

Clinic Task Force Planned Actions

- Tracking of PDMP use and policy.
- Standardizing location of pain contracts in EMR, renewal process, and maintenance policy.
- PDMP education.
- Continue communication and education with high prescribing providers based on data dashboard.
- Informatics support to set up favorites and PDMP access and MME calculator.

Data-Driven Opioid Guardianship
A Health Care System's Blueprint for Change

Hospital Enhanced Recovery Task Force Planned Actions

- Expanding Enhanced Recovery efforts across system.
- Reduce opioid discharge Rx as appropriate.
- Considering standardization of discharge narcotics based on type of surgery.
- Continued investigation of alternative pain control medications and methods.

The Joint Commission Task Force Planned Actions

- Addition of opioid education to patient discharge summary to help ensure education compliance.
- Pain PI is revising comfort menu in order to make it easier and more accessible for nursing to utilize.
- Purchase and implementation of capnography equipment.
- Review of opioid patient education compliance.

Community Task Force Planned Actions

- Continued partnership with NeHii.
- Continue to partner and educate throughout the region both within NMHS and interested community alliances.

Conclusion

Instituting a healthcare system-wide Opioid Guardianship Program required leadership support, project management, continuous improvement expertise, and creating an opioid database so as to develop a data driven approach to institute change by identifying and reducing unnecessary prescribing and adhering to Nebraska LB 931.

Colorado ALTO Project

Pain Pathways by Indication

Headache/Migraine

Immediate/First-Line Therapy:
1 L 0.9% NS + high-flow oxygen
Ketorolac 15 mg IV
Metoclopramide 10 mg IV
Dexamethasone 8 mg IV
Trigger point injection with lidocaine 1%

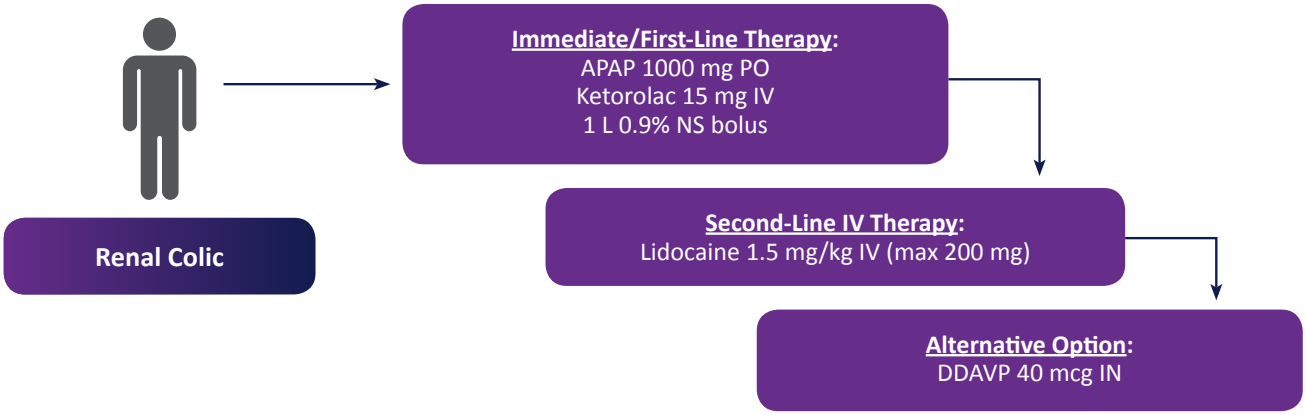
Alternative Options:
APAP 1000 mg PO + ibuprofen 600 mg PO
Sumatriptan 6 mg SC
Promethazine 12.5 mg IV OR prochlorperazine 10 mg IV
Haloperidol 5 mg IV
Magnesium 1 g IV
Valproic acid 500 mg IV
Propofol 10-20 mg IV bolus every 10 min

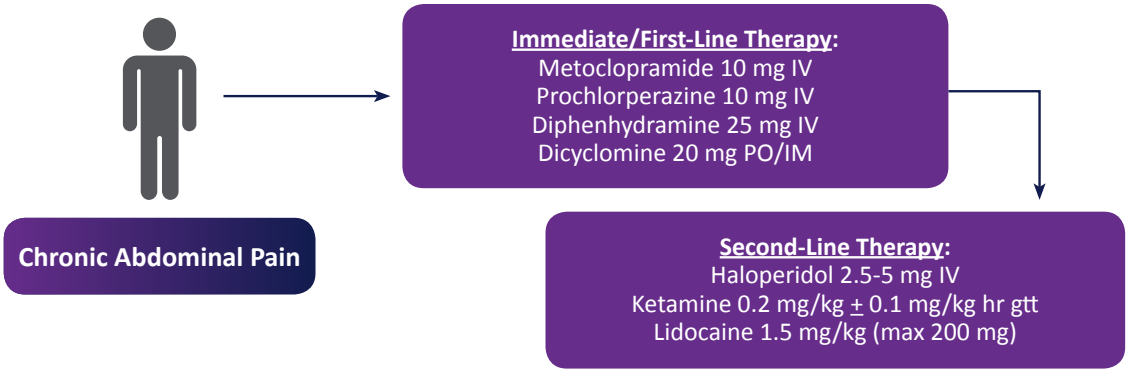
If Tension Component:
Cyclobenzaprine 5 mg OR diazepam 5 mg PO/IV
Lidoderm transdermal patch

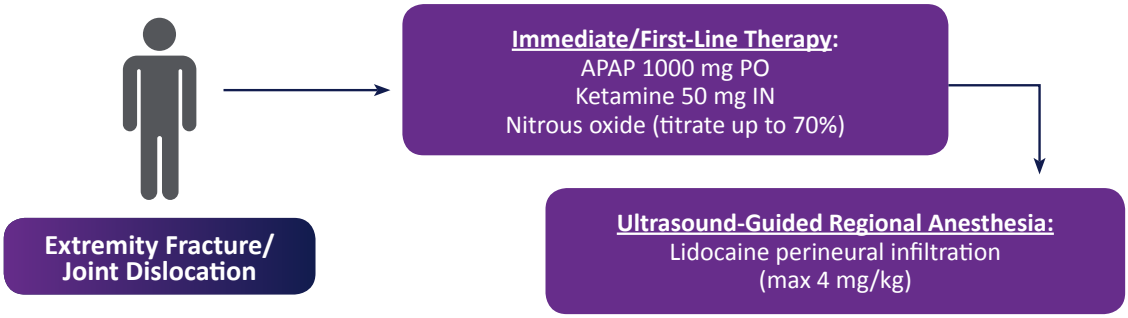
Musculoskeletal Pain

Non-IV Therapies:
APAP 1000 mg PO + ibuprofen 600 mg PO
Cyclobenzaprine 5 mg PO OR diazepam 5 mg PO
Gabapentin 300 mg PO
Lidoderm patch (max 3 patches)
Ketamine 50 mg IN
Trigger point injections with lidocaine 1%

IV Therapy Options:
Ketamine 0.2 mg/kg IV ± 0.1 mg/kg/hr gtt
Ketorolac 15 mg IV
Dexamethasone 8 mg IV
Diazepam 5 mg IV







These treatment pathways are not intended to and should not replace clinician judgement or clinical expertise. They are a guide to possible treatment options that maybe considered, in the context of a patient's clinical condition and comorbidities, for the treatment of patients in pain.

c|h|a
Colorado Hospital Association

UPDATED MAY 2018

2

ADDRESSING APPROPRIATE SCREENING & TREATMENT FOR THOSE WITH SUBSTANCE USE/MISUSE DISORDERS

Pitfalls in the Treatment of PWIDs (People Who Inject Drugs)

- It is not uncommon for clinicians to assume that drug users don't care about their health; such mis-perceptions are noticed by patients. Fearing this negativity and condescension, many drug users avoid the emergency department by trying to "doctor" themselves.
- Some providers automatically under-treat or minimize pain when they suspect drug-seeking behavior, or perform procedures (e.g., abscess drainage) with inadequate anesthesia in order to "teach the patient a lesson."
- Health care providers occasionally bring in other colleagues to gawk at patients without their permission.
- However, these insensitive "Look at the crazy thing this junkie did to herself/himself!" conversations are inappropriate.
- Nurses and doctors should not contact law enforcement without the patient's knowledge.
- Vague or unrealistic aftercare plans are futile.
- Long speeches and shaming life lectures about drug use can and should be replaced by educational information about risk reduction.
- Patients often overhear health care providers talking about them negatively outside of the room or behind a curtain. Assuming the patient can't hear them, clinicians can be heard warning other providers about the "druggie" or "drug seeker."

Counseling Patients with Substance Abuse/Misuse Disorders

DO	DON'T
• Use neutral language when referring to drug use. • Assess the patient's readiness to change. • Respect the patient's decisions regarding treatment. • Encourage patients to be honest with providers about any drug use. • Make information available that is specific to the needs of the patient. • Remember harm principles: - Accept and don't condemn patients who use drugs. - Offer resources without pressure or judgment. - Improve quality of life for patients with opioid use disorders. - See the individual as a person rather than their addiction.	• Use negative terminology such as "addict" or "junkie." • Tell the patient they are ruining their life or are going to die. • Attempt to pressure the patient to begin substance abuse treatment. • Make assumptions about the mental or physical health of patients with opioid use disorders. • Let the stigma associated with intravenous drug use affect how a patient is treated.

Source: Colorado Chapter, American College of Emergency Physicians "2017 Opioid Prescribing & Treatment Guidelines"

National Institute on Drug Abuse
Advancing Addiction Science

Chart of Evidence-Based Screening Tools and Assessments for Adults and Adolescents

Tool	Substance Type		Patient Age		How Tool is Administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Screens						
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription Medication, and other Substance Use (TAPS)	X	X	X		X	X
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	X	X	X	See APA Adapted NM ASSIST tools	See APA Adapted NM ASSIST tools	X
Alcohol Use Disorders Identification Test-C	X		X		X	X
Alcohol Use Disorders Identification Test	X		X			X
Opioid Risk Tool		X	X		X	
CAGE-AID	X	X	X			X
CAGE	X		X			X
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Assessments						
Tobacco, Alcohol, Prescription Medication, and other Substance Use (TAPS)	X	X	X		X	X
CRAFFT	X	X		X	X	X
Drug Abuse Screen Test (DAST-10)*						
For use of this tool, please contact Dr. Harvey Skinner		X	X		X	X
Drug Abuse Screen Test (DAST-20: Adolescent version)*						
For use of this tool - please contact Dr. Harvey Skinner		X		X	X	X
NIDA Drug Use Screening Tool (NMASSIST)	X	X	X			X
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X

*Tools with associated fees

To download the PDFs associated with these screening tools and assessments, and other validated tools, visit:
https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools

Source: NIH National Institute on Drug Abuse

Substance Use Levels of Care

Level of Care/Type of Service	Description	Length of Stay
Substance Use Evaluation	Licensed counselor or other practitioner with substance use assessment in their approved scope of practice interviews and assesses the potential existence of a diagnosable substance use disorder. If indicated, will make a level of care recommendation.	Typically a 2-3 hour process that includes a collateral interview and testing.
Medical Detox/Inpatient	Hospitalized inpatient care for the medically unstable patient unable to attend substance use programming. Includes daily physician visits and intense medical monitoring by nursing staff.	Stay typically lasting 1-5 days. Individualized as needed.
Social Detox	24-hour bedded care with minimal physician or nursing oversight. Includes no programming or therapy.	Stay typically lasting 1-5 days. Individualized as needed.
Short-Term Residential	24-hour residential care with intense substance use programming from 9 am - 9 pm. Includes group therapy, individual sessions, family sessions, lectures, discussions, and recreational activities.	Stay typically lasting 5-30 days. Individualized as needed.
Partial Care/Day Treatment	An outpatient level of care that includes at least 6-8 hours of programming. Includes group therapy, individual session, family sessions, lectures, discussions, and recreational activities.	Typically 3-5 days per week and lasts 1-6 weeks. Individualized as needed.
Intensive Outpatient	An outpatient level of care that includes at least 3 hours of programming. Includes group therapy, individual session, family sessions, lectures, discussions, and recreational activities.	Typically 3-5 days per week and lasts 1-8 weeks. Individualized as needed.
Outpatient	An outpatient level of care that includes individual therapy, group therapy, and family sessions. On occasion, this level is individual sessions only.	Typically one group per week and 1-2 individual sessions per month and lasts 4-16 weeks. Individualized as needed.
Drug & Alcohol Education	An outpatient level of care that is a didactic presentation of education. This is a minimal intervention aimed to educate individuals to change their substance use patterns.	Typically a one-day offering lasting 6-8 hours or spread into shortened classes over several weekends.

NDHHS Division of Behavioral Health

FY 18 Mental Health (MH) and Substance Abuse (SA) Services Contracted Through Regional Behavioral Health Authorities (Regions)

The Nebraska Department of Health & Human Services (NDHHS) Division of Behavioral Health is designated by federal and state law as the state's single authority for mental health and substance use disorders. The Division directs the administration and coordination of the public behavioral health system.

Nebraska is split into six Behavioral Health "Regions." These are local units of governments that the state partners with to do planning and service implementation for behavioral health. The Regions purchase services from providers in their area. If necessary, services are purchased from other service providers across the state.

The map below shows Nebraska's Behavioral Health Regions. The table that follows provides contact information for each Region.

Behavioral Health Regions

Region 1	(308) 635-3173	http://region1bs.net	**Region 4**	(402) 370-3100	www.region4bhs.org
Region 2	(308) 534-0440	www.r2hs.com	**Region 5**	(402) 441-4343	www.region5systems.net
Region 3	(308) 237-5113	www.Region3.net	**Region 6**	(402) 444-6573	www.regionsix.com

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 1 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Box Butte General Hospital Mary Mockerman 2101 Box Butte Avenue Alliance, NE 69301 (308) 762-4357	Crisis Response - MH Emergency Psychiatric Observation - MH	
Cirrus House Brent Anderson 1509 1st Avenue Scottsbluff, NE 69361 (308) 635-7876	Community Support - MH/SA Day Rehab - MH Day Support - MH Supported Employment - MH	Supported Employment - MH/SA (TA) Youth Transition Services - MH (TA)
CrossRoads Resources Joan Yekel 651 West 4th Street Chadron, NE 69337 (308) 532-3920	Crisis Response - MH Emerg. Community Support - MH/SA Outpatient Therapy - MH	Outpatient Therapy - MH
Human Services, Inc. Glenda Day Nina Benjamin 419 West 25th Street Alliance, NE 69301 (308) 762-1488	*Short Term Residential - SA/WSA 24 Hour Crisis Line (Region-wide) Assessment - SA Community Support - SA Crisis Assessment - SA Intensive Outpatient - SA Outpatient Therapy - SA	
North East Panhandle Substance Abuse Center Victor Gehrig 305 Foch Street Gordon, NE 69343 (308) 282-1101	*Short Term Residential - SA/WSA *Social Detox - SA Assessment - SA Outpatient Therapy - SA	
Region 1 Behavioral Health Authority Lisa Simmons 18 West 16th Street Scottsbluff, NE 69361 (308) 635-3173	Crisis Response - MH Emergency Community Support - MH Housing Related Assistance - MH-SA	Professional Partner - MH Housing Related Assistance - MH
Regional West Medical Center Gina Hallam 4021 Avenue B Scottsbluff, NE 69361 (308) 630-1268	*Acute Inpatient - MH *EPC Services - MH *IPPC - MH *Sub-acute Inpatient - MH	
Western Community Health Resources Sherry Reztlaff 300 Shelton Street Chadron, NE 69337 (308) 432-8979	Community Support - MH/SA Emergency Community Support - MH Peer Support - MH	Youth Transition Services - SA (TA)

*Indicates Bed-based Service (TA) Transition Age WSA (Women's Set Aside Service)

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 2 Catchment Area	Adult Services	Children/Transition Age/Youth Services
CenterPointe Topher Hansen 2633 P Street Lincoln, NE 68503 (402) 475-8717	*Dual Residential - SA	
CHI Health-Richard Young Behavioral Health Michelle Hansen 1755 Prairie View Place Kearney, NE 68845 (308) 865-2000	*Acute Inpatient - MH *EPC Services - MH	
Goodwill Industries of Greater Nebraska Becki Koehler 300 East 3rd Street Room 332 North Platte, NE 69101 (308) 461-7010	Supported Employment - MH/SA	
Great Plains Health Tamara Martin-Linnard 601 W. Leota North Platte, NE 69101 (308) 696-8000	*Acute Inpatient - MH *EPC Services - MH *Sub-acute Inpatient - MH	
Houses of Hope Jay Conrad 1124 North Cotner Blvd. Lincoln, NE 68505 (402) 435-3165	*Halfway House - SA *Short Term Residential - SA	
Lexington Regional Health Center 1201 N. Erie Lexington, NE 68850 (308) 324-8308	Medication Management - SA Outpatient Therapy - SA	
Lutheran Family Services Pegg Siemek-Asche 120 East 12th Street North Platte, NE 69101 (308) 978-5677	Assessment/Evaluation - SA Intensive Outpatient - SA	
Mary Lanning Health Care Jerry Shaw 715 N. St. Joseph Ave. Hastings, NE 68901 (402) 461-5315	*Acute Inpatient - MH *EPC Services - MH	
Region II Human Services Kathy Seacrest 110 North Bailey North Platte, NE 69101 (308) 534-6029	24 Hour Crisis Line (Region-wide) Assessment - SA (Justice) Client Assistance - SA Community Support - MH/SA/WSA Crisis Response - MH Day Rehab - MH Day Support - MH Emergency Community Support - MH Medication Management - MH Medication Support - MH Outpatient Dual - MH/SA/WSA Outpatient Therapy - MH/SA//WSA Recovery Support - SA	Outpatient Therapy - MH/SA Professional Partner - MH

Region 2 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Regional West Medical Center Gina Hallam 4021 Avenue B Scottsbluff, NE 69361 (308) 630-1268	*Acute Inpatient - MH *EPC Services - MH	
St. Monica's Behavioral Health Services for Women Mary Barry-Magsamen & Gail Javorsky 2109 South 24th Street Lincoln, NE 68502 (402) 441-6767	*Short Term Residential - SA/WSA *Therapeutic Community - SA	
West Central NE Joint Housing Authority Jeanette Krajewski 333 East 2nd Street Ogallala, NE 69153 (308) 284-7315	Housing Related Assistance - MH/SA	Housing Related Assistance - MH (TA)

Region 3 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Behavioral Health Specialists Neil Broders 4432 Sunrise Place Columbus, NE 68601 (308) 370-3140	*Short Term Residential - SA *Social Detox - SA	
Center for Psychological Services, P.C. Jesica Vickers 125 East 31st Street Kearney, NE 68847 (308) 234-6029	Peer Support - MH	FEP Outpatient Therapy - MH (TA) Peer Support - MH
CHI Health Richard Young Behavioral Health Michelle Hansen 1755 Prairie View Place Kearney, NE 68845 (308) 865-2000	*Acute Inpatient - MH *EPC Services - MH *IPPC - MH/SA *Sub-acute Inpatient - MH 24 Hour Crisis Line (Region-wide) Medication Management - MH Outpatient Therapy - MH	Crisis Inpatient - MH Medication Management - MH Outpatient Therapy - MH
Encounter Telehealth Terri Brame 2121 Avenue B., Ste. 3 Kearney NE 68847 (402) 398-2282	Medication Management - MH	Medication Management - MH
Families Care Karla Bennetts 4009 6th Avenue, Ste. 55 Kearney, NE 68845 (308) 237-1102		Parent Peer Support - MH (TA) Transitional Youth Advocate - MH (TA)
Friendship House Chase Francl 406 W. Koenig Grand Island, NE 68801 (308) 382-0422	*Halfway House - SA Outpatient Therapy - SA	

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 3 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Goodwill Industries of Greater Nebraska Tonya Ingram 1804 S. Eddy Street Grand Island, NE 68802 (308) 627-6449	Community Support - MH/SA Day Rehab - MH Day Support - MH Emergency Community Support - MH Supported Employment - MH/SA	FEP SE Services - MH/SA (TA)
Lutheran Family Services Tylynne Bauer Great Western Bank Building 1811 West 2nd St., Ste. 300 Grand Island, NE 68803 (402) 342-7007	Outpatient Therapy - MH	
Mary Lanning Health Care Kim Kern 715 N. St. Joseph Ave. Hastings, NE 68901 (402) 460-5635	*Acute Inpatient - MH *EPC Services - MH *IPPC - MH/SA *Sub-acute Inpatient - MH 24 Hour Crisis Line (Region-wide) Emergency Community Support - MH Medication Management - MH Outpatient Therapy - MH	Medication Management - MH
Mid-Plains Center for Behavioral Healthcare Services, Inc. Corrie Edwards 914 Baumann Drive Grand Island, NE 68801 (402) 385-1040	*Social Detox - SA Crisis Stabilization - MH/SA Medication Management - MH Outpatient Dual - MH/SA Outpatient Therapy - MH/SA	Medication Management - MH FEP Outpatient Therapy - MH (SA) Multi-systemic Therapy - MH
Region 3 Behavioral Services Beth Baxter 4009 6th Avenue, Ste. 65 Kearney, NE 68845 (308) 237-5113	Emergency Community Support - MH Housing Related Assistance - MH Peer Support - MH	Housing Related Assistance - MH Professional Partner - MH
South Central Behavioral Services, Inc. Susan Henrie 3810 Central Avenue Kearney, NE 68848 (402) 463-5684	*MH Respite *Psych Residential Rehab - MH ACT Team - MH Assessment - SA Community Support - MH/SA Crisis Response - MH Day Rehab - MH Day Support - MH Emergency Community Support - MH Intensive Outpatient - SA Outpatient Therapy - MH/SA/WSA	Outpatient Therapy - MH
St. Francis Alcohol and Drug Treatment Center Brenda Miner 2620 W. Faidley Avenue Grand Island, NE 68801 (308) 398-5435	*Short-term Residential - SA Intensive Outpatient - SA Outpatient Therapy - SA/WSA	Outpatient Therapy - SA
Telecare Corp. Kelly Dorfmeyer 2231 Lincoln Road Bellevue, NE 68005 (402) 291-1203	*Secure Residential - MH	

Region 3 Catchment Area	Adult Services	Children/Transition Age/Youth Services
The Bridge, Inc. Jill Gregg 907 South Kansas Hastings, NE 68901 (402) 462-4677	*Therapeutic Community - SA/WSA	
The Link Tom Barr 1001 Norfolk Avenue Norfolk, NE 68701 (402) 371-5310	*Dual Residential - SA	
Women's Empowering Life Line Donny Larson 910 West Park Avenue Norfolk, NE 68701 (402) 371-0220	*Dual Residential - SA Medication Management - MH	

Region 4 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Behavioral Health Specialists Neil Broders 900 West Norfolk Avenue Norfolk, NE 68701 (402) 370-3140	*Short Term Residential - SA *Social Detox - SA Assessment - SA Community Support - MH/SA Crisis Response - MH Intensive Outpatient - SA Medication Management - MH Outpatient Therapy - MH/SA	Outpatient Therapy - MH/SA
CHI Health Richard Young Behavioral Health Michelle Hansen 1755 Prairie View Place Kearney, NE 68845 (308) 865-2000	*Acute Inpatient - MH *EPC Services – MH/SA *IPPC - MH *Sub-acute Inpatient - MH Medication Management - MH Outpatient Therapy - MH/SA	*Crisis Inpatient - MH Medication Management - MH
East Central District Health Department Rebecca Rayman 321 1st Avenue Columbus, NE 68601 (402) 562-8950	Assessment - SA Mediation Management - MH Outpatient Therapy - MH/SA	
Faith Regional Health Services Tony Mobley 1500 Koenigstein Norfolk, NE 68701 (402) 644-7388	*Acute Inpatient - MH *EPC Services - MH *IPPC - MH/SA *Sub-acute Inpatient - MH	
Goodwill Industries of Greater Nebraska Becki Koehler 3020 18th Street, Ste. 3 Columbus, NE 68601 (308) 316-1780	Community Support - MH/SA Day Rehab - MH Day Support - MH Emerg. Community Support - MH/SA Supported Employment - MH	
Great Plains Health Tamara Martin-Linnard 601 W. Leota North Platte, NE 69101 (308) 696-8000	*Acute Inpatient - MH *EPC Services - MH	

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 4 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Heartland Counseling Services Jennifer Jackson 917 West 21st Street South Sioux City, NE 68776 (402) 494-3337	Assessment - SA Community Support - MH Crisis Response - MH Day Support - MH Intensive Outpatient - SA Medication Management - MH Outpatient Dual - MH/SA Outpatient Therapy - MH/SA Recovery Support - MH/SA	Outpatient Therapy - MH/SA
Liberty Centre Services Patty Skokan 900 East Norfolk Avenue Norfolk, NE 68701 (402) 370-3503	*Crisis Respite - MH *Psych Residential Rehab - MH Community Support - MH/SA Day Rehab - MH Day Support - MH Emergency Community Support - MH Intensive Community Services - MH/SA Recovery Support - MH/SA Supported Employment - MH	
Mary Lanning Health Care Jerry Shaw 715 North St. Joseph Ave. Hastings, NE 68901 (402) 461-5315	*Acute Inpatient - MH *EPC Services - MH *IPPC - MH/SA	
Midtown Health Center Kathy Nordby 302 West Phillip Avenue Norfolk, NE 68701 (402) 371-8000	Assessment - MH Medication Management - MH Outpatient Therapy - MH	
Oasis Counseling International Mark Stortvedt 333 West Norfolk Avenue #201 Norfolk, NE 68701 (308) 379-2030	Assessment - SA Intensive Outpatient - SA Medication Management - MH Medication Support - MH Outpatient Therapy - MH/SA	Intensive Outpatient - SA Outpatient Therapy - MH/SA
Region 4 Behavioral Health Ingrid Gansebom 206 Monroe Avenue Norfolk, NE 68701 (402) 370-3100	Assessment - SA Crisis Response - MH Intensive Outpatient - SA Housing Related Assistance - MH Outpatient Therapy - MH/SA	Professional Partner - MH Housing Related Assistance - MH
Telecare Corp. Kelly Dorfmeyer 2231 Lincoln Road Bellevue, NE 68005 (402) 291-1203	*Secure Residential - MH	
The Link Tom Barr 1001 Norfolk Avenue Norfolk, NE 68701 (402) 371-5310	*Dual Residential - SA *Halfway House - SA Peer Support - SA Recovery Support - SA	

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 5 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Women's Empowering Life Line Donny Larson 910 West Park Avenue Norfolk, NE 68701 (402) 371-0220	*Crisis Respite - SA *Dual Residential - SA/WSA *Intermediate Residential - SA/WSA Assessment - SA Medication Management - MH Peer Support - SA Outpatient Therapy - MH/SA	
Associates in Counseling & Treatment Rachel Mulcahy 601 N. Cotner Blvd., Ste. 119 Lincoln, NE 68506 (402) 261-6667	Assessment - SA	
Blue Valley Behavioral Health Jon Day 1123 South 9th Street Beatrice, NE 68310 (402) 228-3386	Emergency 24 Hour Clinician - MH Assessment - MH/SA Community Support - MH Intensive Outpatient - SA Medication Management - MH Outpatient Therapy - MH/SA/WSA	Assessment - MH/SA Intensive Outpatient - MH Outpatient Therapy - MH/SA
CenterPointe Topher Hansen Michelle Nelson 2633 P Street Lincoln, NE 68503 (402) 475-8717	*Dual Residential - SA *Psych Residential Rehab - MH Emergency 24 Hour Clinician - MH Community Support - MH/SA Day Rehab - MH Medication Management - MH Outpatient Therapy - MH/SA Peer Support - MH/SA Recovery Support - MH/SA Supported Living - MH	Outpatient Therapy - SA SOAR - SA
Fremont Health Medical Center Dottie Heffernan 450 East 23rd Street Fremont, NE 68025 (402) 941-7855	*Acute Inpatient - MH *Sub-acute Inpatient - MH	
Houses of Hope Jay Conrad 1124 North Cotner Blvd. Lincoln, NE 68505 (402) 435-3165	*Halfway House - SA	
Lincoln Medical Education Partnership (LMEP) Kelly Madcharo 4600 Valley Road Lincoln, NE 68510 (402) 327-6851	Assessment - SA Family Support Advocacy - SA Outpatient Therapy - SA	
Lutheran Family Services Shirley Terry 2301 O Street Lincoln, NE 68510 (402) 441-7940	Assessment - SA Community Support - MH Emergency Community Support - MH Intensive Outpatient - SA Medication Management - MH Medication Support - MH Outpatient Therapy - MH/SA Peer Support - MH	

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 5 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Mary Lanning Health Care Jerry Shaw 715 North St. Joseph Ave. Hastings, NE 68901 (402) 461-5315	*Acute Inpatient - MH *EPC Services - MH *Sub-acute Inpatient - MH	
Mental Health Association Kasey Moyer 2817 South 14th Street Keya House Lincoln, NE 68508 (402) 441-4371	Hospital Diversion - MH Supported Employment - MH	
Mental Health Crisis Center Scott Etherton 825 J Street Lincoln, NE 68502 (402) 441-8276	*EPC Services - MH Emergency Crisis Assessment - SA	
PIER (CenterPointe) Topher Hansen & Michelle Nelson 2633 P Street Lincoln, NE 68503 (402) 475-8717	ACT Team - MH	
Region V Systems C.J. Johnson 1645 N Street Lincoln, NE 68508 (402) 441-4343	*Short-term Res - MH Community Support - SA Medication Support - MH/SA Recovery Support - MH Supported Housing - MH/SA	Professional Partner - MH Professional Partner - MH (TA)
St. Monica's Behavioral Health Services for Women Mary Barry-Magsamen & Gail Javorsky 2109 South 24th Street Lincoln, NE 68502 (402) 441-6767	*Short-term Residential - SA/WSA *Therapeutic Community - SA/WSA Community Support - MH/SA Intensive Outpatient - SA Outpatient Therapy - MH/SA/WSA Peer Specialist - MH	
TASC (Collaboration -LFS, HoH, BVBH & The Bridge) Arnold Remington 643 South 25th Street, Ste. 11 Lincoln, NE 68510 (402) 474-0419	Crisis Response - MH Emergency Community Support - MH/SA Intensive Community Services - MH/SA Recovery Support - SA	
Telecare Corp. Kelly Dorfmeyer 2231 Lincoln Road Bellevue, NE 68005 (402) 291-1203	*Secure Residential - MH	
The Bridge Behavioral Health Phil Tegeler 721 K Street Lincoln, NE 68508 (402) 477-3951	*CPC Services - SA *EPC Services - MH *Intermediate Residential - SA/WSA *Short-Term Residential - SA *Social Detox - SA *Emergency ST Crisis Respite - MH/SA	
Touchstone (Collaboration - Houses of Hope & CenterPointe) Jay Conrad, Topher Hansen, Jill Wertz 2633 P Street, Lincoln, NE 68503 (402) 474-4343	*Short-Term Residential - MH/SA	

Region 6 Catchment Area	Adult Services	Children/Transition Age/Youth Services
A.R.C.H. Ron Smith 604 South 37th Street Omaha, NE 68105 (402) 346-8898	*Halfway House - SA/WSA	
BAART Diana Meadors 1941 South 42nd Street, Ste. 210 Omaha, NE 68105 (402) 341-6220	Opioid Treatment Program - SA	
Capstone Behavioral Health Brian Andersen 1941 South 42nd Street, Ste. 328 Omaha, NE 68105 (402) 614-8444	Assessment - SA Outpatient Therapy - MH	
CenterPointe Topher Hansen 1490 North 16th Street Omaha, NE 68105 (402) 429-2278	*Dual Residential - MH/SA *Short-Term Residential - SA Community Support - SA Peer Support - SA	
Charles Drew Tiffany White-Welchen 600 South 27th Street Omaha, NE 68105 (402) 457-1224	Outpatient Therapy - MH	
CHI Health Immanuel Amy Strain 6901 North 72nd Street Omaha, NE 68122 (402) 572-3249	*Acute Inpatient - MH *EPC Services - MH Assessment - SA Outpatient Therapy - SA	
CHI Health Lasting Hope Recovery Center Robin Conyers 415 South 25th Avenue Omaha, NE 68131 (402) 717-5320	*Acute Inpatient - MH *EPC Services - MH *Sub-Acute Inpatient - MH	

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 6 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Community Alliance Carole Boye 4001 Leavenworth Street Omaha, NE 68105 (402) 341-5128	*Acute Inpatient - MH *EPC Services - MH *Psych Residential Rehab - MH ACT Team - MH Community Support - MH Day Rehab - MH Homeless Transition Services - MH Hospital Diversion - MH Intensive Community Services - MH Medication Assistance - MH Medication Management - MH Medication Support - MH Outpatient Therapy - MH Peer Support - MH SOAR - MH Supported Employment - MH	
Douglas County CMHC Sherry Glasnapp 1490 N 16th Street Omaha, NE 68105 (402) 444-7676	*Acute Inpatient - MH *CPC Services - SA *EPC Services - MH *Social Detox - SA Assessment - SA Crisis Assessment - MH Day Treatment - MH Interpreter Services - MH Intensive Case Management - MH Intensive Outpatient - SA Medication Management - MH Medication Support - MH Outpatient Therapy - MH Outpatient Medications - MH Peer Support - MH	
East Central District Health Department Good Neighbor Elissa Olson 2740 North Clarkson Fremont, NE 68025 (402) 563-9224 ext. 212	Medication Management - MH Medication Support - MH Outpatient Therapy - MH	
Fremont Health Medical Center Dottie Heffernan 450 East 23rd Street Fremont, NE 68025 (402) 941-7855	*Acute Inpatient - MH *EPC Services - MH Interpreter Services - MH	
Friendship Program Katherine Young 7315 Maple Street Omaha, NE 68134 (402) 393-6911	Community Support - MH Day Rehab - MH Peer Support - MH	
Heartland Family Services Heather Bird 2101 South 42nd Street Omaha, NE 68105 (402) 552-7461	*Therapeutic Community - SA/WSA Assessment - SA Intensive Outpatient - SA Medication Management - MH Medication Support - MH Outpatient Therapy - MH/SA	Crisis Response - MH Outpatient Therapy - MH

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Region 6 Catchment Area	Adult Services	Children/Transition Age/Youth Services
Lutheran Family Services Marti Wilson 120 South 24th Street Omaha, NE 68102 (402) 342-7007	*Therapeutic Community - SA/WSA Assessment - SA Community Support - MH Crisis Response - MH Intensive Outpatient - SA Interpreter Services - MH Medication Management - MH Mediation Support - MH Outpatient Therapy - MH/SA Peer Support - MH Urgent Outpatient - MH	Crisis Response - MH Outpatient Therapy - MH
NE Urban Indian Health Donna Polk-Prim 2240 Landon Court Omaha, NE 68102 (402) 346-0902	Assessment - SA Outpatient Therapy - SA	
NOVA Treatment Community Pegg Siemek-Asche 8502 Mormon Bridge Road Omaha, NE 68152 (402) 991-8508	*Short-term Residential - MH/SA *Therapeutic Community - MH/SA	
OneWorld CHC Gloria Gonzalez-Kruger 4920 South 30th Street Omaha, NE 68107 (402) 502-8937	Assessment - SA Interpreter Services - MH Medication Management - MH Mediation Support - MH Outpatient Therapy - MH/SA	
Region 6 Behavioral Healthcare Patti Jurjevich 4715 South 132nd Street Omaha, NE 68137 (402) 444-6573	Medication Support - MH Peer Support - MH Psychiatric Emergency System - MH Supported Housing - MH/SA	Professional Partner - MH Supported Housing - MH
Salvation Army Michelle Bobier 415 South 25th Avenue Omaha, NE 68131 (402) 898-5974	*MH Respite - MH Community Support - MH Emergency Community Support - MH Intensive Community Services - MH Peer Support - MH	
Santa Monica Heather Kirk 401 South 39th Street Omaha, NE 68131 (402) 558-7088	*Halfway House - SA/WSA	
Telecare Corp. Kelly Dorfmeyer 2231 Lincoln Road Bellevue, NE 68005 (402) 291-1203	*Secure Residential - MH	

Source: Nebraska Department of Health & Human Services. For updated information, visit dhhs.nebraska.gov

Medication Assisted Treatment Providers

BELLEVUE

Brian Finley, M.D.
Nebraska Medicine Bellevue | 402-779-7207

GRAND ISLAND

John Markus, M.D.
VA Nebraska-Western Iowa Healthcare | 308-382-3660

LEXINGTON

Francisca Acosta-Carlson, M.D.
Lexington Regional HC | 308-324-8308

Travis Barkmeier, NP
Lexington Regional Health Center | 308-324-8308

LINCOLN

Walter Duffy, M.D.
Alivation Health | 402-476-6060

Matthew Glenn, M.D.
Pine Lake Health | 402-423-4200

Kelsey Hohlen, PA
Nebraska Spine and Pain | 402-323-8484

John Massey, M.D. | 402-858-0117

Jennelea Montanez, PA
Nebraska Spine and Pain | 402-630-5546

David Rutz, M.D.
East Lincoln Family Health | 402-483-7507

Bradley Sawtelle, M.D.
East Lincoln Family Health | 402-483-7507

Scott Schmidt, D.O.
Pine Lake Behavioral Health | 402-434-2730

Helen Trotter, NP
CenterPointe-Touchstone | 402-474-4343

Rhonda Woodside, NP
Ideal Option | 877-522-1275

MACY

Mark Morgan, M.D.
Carl T. Curtis Health Education Center | 402-837-5381

NORFOLK

Jean Allen, NP
Midtown Health Center | 402-371-8000

Raymond Heller, M.D.
Midtown Health Center | 402-371-8000

Daniel Wik, M.D. | 402-316-3250

Holly Young, APRN | 402-316-3264

NORTH PLATTE

Janet Bernard, M.D.
Great Plains Health | 308-534-4440

Narayana Koduri, M.D.
Great Plains Health | 308-696-7251

OMAHA

Alena Balasanova M.D.
UNMC Department of Psychiatry | 402-552-6007

Kevin Balter, M.D.
Midwest Pain Clinics | 402-391-7246

Jacqueline Chanlatte, M.D.
Omaha Medical Group | 402-552-2212

John Cook, M.D.
Midwest Pain Clinics | 402-391-7246

Michael Coy, M.D.
Coeur Collaborative Care | 402-800-2990

Joshua Dahlke, M.D.
Methodist Women's Hospital & Perinatal Center | 402-815-1970

Alex Dworak, M.D.
OneWorld Community Health Center | 402-734-4110

Jeffrey Edwards, M.D.
Medical Pain Relief Clinic | 402-894-9990

Rita Fowler, PA
Omaha Pain Physicians | 402-614-1999

John Franzen, M.D.
UNMC Department of Psychiatry | 402-552-6007

Kurt Gold, M.D.
Progressive Rehabilitation | 402-933-2016

Kelly Hoover, PA
Inroads to Recovery | 402-932-2248

Alan Jensen, M.D.
Jensen Clinic PC | 402-397-6060

David Johnson, PA
Midwest Pain Clinics | 402-391-7246

Venkata Kolli, M.D.
CHI Health Lasting Hope | 402-717-5550

Bethany Levy, PA
OneWorld Community Health Center | 402-734-4110

Kristina McCutchen, PA
Omaha Pain Physicians | 402-614-1999

Matthew Nadler, M.D.
Midwest Pain Clinics | 402-391-7246

Cynthia Paul, M.D.
Ceur Collaborative Care | 402-800-2990

Syed Sattar, M.D.
Inroads to Recovery | 402-932-2248

Matthew Stottle, M.D.
Omaha Pain Physicians | 402-614-1999

Erin Strufing, PA
Nebraska Pain and Spine | 402-496-0404

Kenneth Zoucha, M.D.
UNMC Department of Psychiatry | 402-552-6002

O'NEILL

Joshua Thoendel, M.D.
Avera St. Anthony's Hospital | 402-336-2901

*For updates on MAT providers, visit http://dhhs.ne.gov/behavioral_health/Pages/beh_behindex.aspx and click on "Buprenorphine Treatment."

Bryan CRETE AREA MEDICAL CENTER

Opioid Management Established Patient Checklist

Assessment

☐ H&P/ ROS completed by provider

☐ Patient assessment completed

Medication Assessment

☐ Current medications reviewed

☐ PDMP checked

☐ Checked for Opiate, Benzodiazepine, other lethal drug cocktails

Diagnostics, Alternative Treatments and Medical Necessity

☐ What Diagnostics have been performed?

☐ What alternative therapies or treatments have been tried?

☐ Medical Necessity has been established

Referral and/or Consultation

☐ Consider referral to pain clinic

☐ Other consult: Neuro, psychologic, surgeon, alternative, etc…

Set Goals

☐ Both functional and reduction of pain

☐ Reduction of opiate dose

Re check

☐ ABC checklist

☐ Algorithm for Low, Med, High risk

☐ Assess goal progress

3

ADDRESSING APPROPRIATE EXPECTATIONS ON THE PART OF THE PUBLIC REGARDING OPIOID USE

Patients who receive opioids should be educated about their side effects and potential for addiction, particularly when being discharged with an opioid prescription.

Overdosing on Opioids Can Happen by Accident

Due to their effect on the part of the brain which regulates breathing, opioids in high doses can cause slow breathing (respiratory depression) and death. It is especially dangerous to combine opioids with alcohol or sedatives, like Benzodiazepines (e.g., Lorazepam/Ativan, Alprazolam/Xanax, Diazepam/Valium). Combining opioids with alcohol and sedative medications increases the risk of respiratory depression and death, and combinations of opioids, alcohol and sedatives are often present in fatal drug overdoses.

Opioid Drugs are Addictive

Up to 1 out of 4 people receiving long-term opioid therapy in a primary care setting struggles with addiction. Addiction is a chronic illness with symptoms of uncontrollable cravings, inability to control drug use, compulsive drug use, inability to meet work, social or family obligations, and use despite doing harm to oneself or others. The cravings in addiction are rooted in changes to the brain. One aspect of recovery is the process of reversing, to the extent possible, these brain changes.

Side Effects

In addition to the serious risks of overdose and addiction, the use of prescription opioids can have a number of side effects, even when taken as directed. You can develop tolerance to opioids, which means you might need more of the medication for the same pain relief. You can develop physical dependence on opioids, which means that you have symptoms of withdrawal, like drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea and tremors, if you suddenly stop taking the medication.

Other side effects include constipation, nausea, vomiting, dry mouth, sleepiness, dizziness, confusion and increased sensitivity to pain.

For Patients Taking Opioids

If you and your prescriber choose opioids to manage your pain, follow these steps to help avoid risk of addiction or overdose:

1. **Start low and go slow.** Your prescriber should give you the lowest dose for the shortest amount of time possible.
2. **Never take opioids in greater amounts or more often than prescribed.** Otherwise addiction or overdose become more likely.
3. **Avoid taking opioids with alcohol.** Mixing can increase your risk of overdose.
4. **Avoid mixing opioids with the following medications** when possible (unless otherwise advised by your prescriber):
    - Sedatives or tranquilizers, including Benzodiazepines (such as Xanax and Valium)
    - Muscle relaxants (such as Soma or Flexeril)
    - Sleeping pills or hypnotics (such as Ambien or Lunesta)
    - Other prescription opioid pain relievers

However, there may be circumstances where prescribing opioids with these medications is necessary and acceptable. Also, your prescriber may use urine drug tests and check your prescription history to help make prescribing decisions that ensure your safety.

5. **Follow up regularly with your health care professional** to monitor how the medication is working, side effects, or signs of opioid use disorder (like addiction).
6. **If you're taking opioids for an extended period of time, you should taper** – with the guidance of your health care professional – as your pain subsides until you're off opioids completely. If you're taking high doses or long-term opioids, consider having Naloxone on hand. Opioids aren't made for long-term use; the more you use them, the more your body builds a tolerance. You'll have the same level of pain, but need more opioids – increasing your chances of overdose or addiction. Long-term use of opioids can be appropriate for some patients receiving active cancer treatment, palliative care and/or end-of-life care.

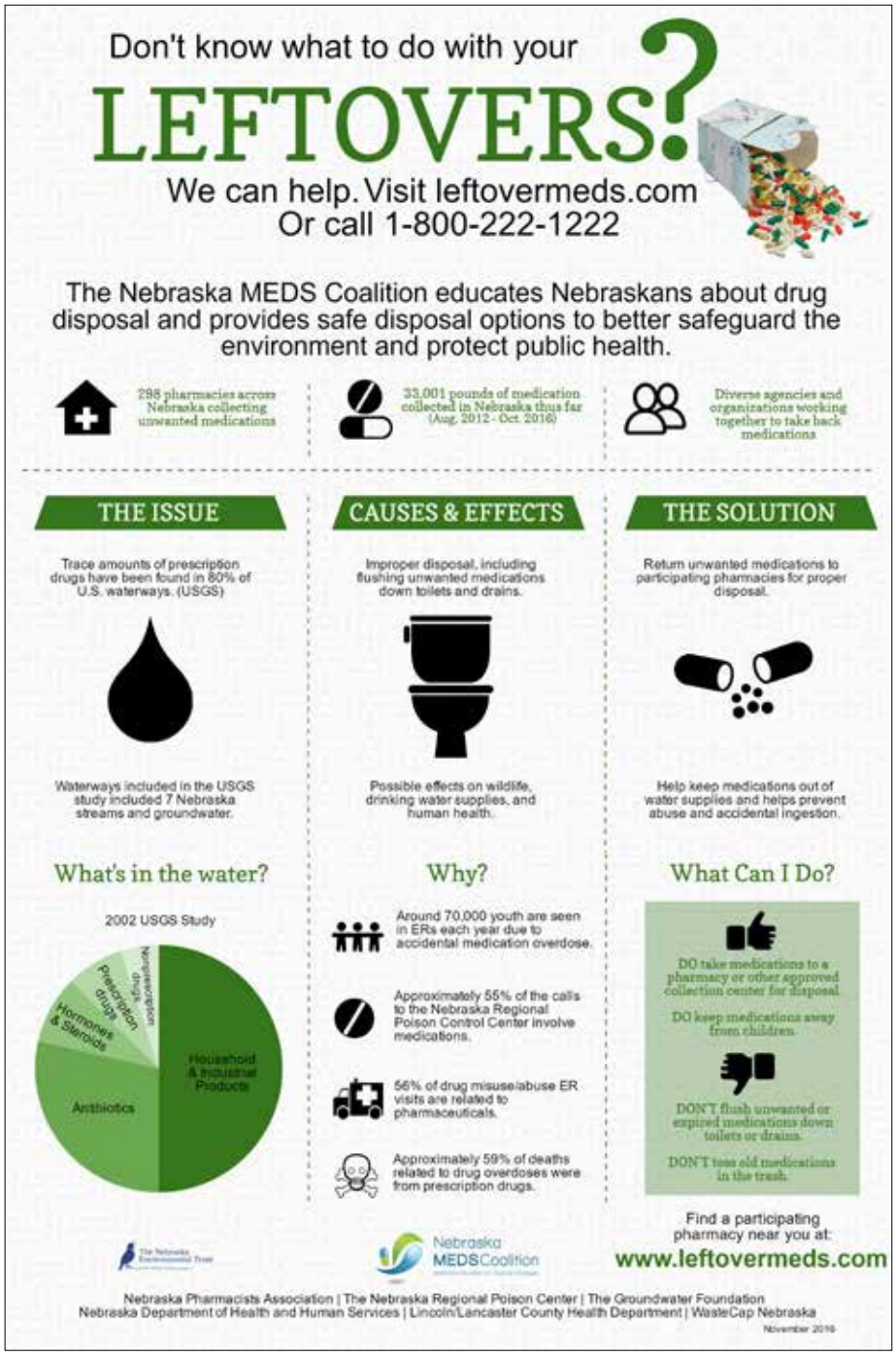
Source: Turning the Ride: For Patients (2016) https://turnthetiderx.org/for-patients/#

Nebraska Medication Disposal Program

Unused or expired medication can fall into the wrong hands and lead to accidental poisoning or illegal use. Medications should not be flushed down the toilet or put in the trash. If disposed of improperly, medications can harm the environment. The ability to safely dispose of unused medications is an important strategy in the fight to reduce unnecessary opioids in circulation.

Nebraska MEDS is a coalition of state and community partners dedicated to educating patients about safe disposal of prescription and over-the-counter medications. Nebraska MEDS has implemented educational efforts and supports a pharmacy-based medication disposal program utilizing the Sharps Compliance Takeaway Environmental Return System. Patients can take their unwanted, expired, controlled or non-controlled medications to the participating pharmacists who will assist them with the disposal process.

To locate a participating pharmacy, you can access https://www.nebraskameds.org/ and click on Disposal Locations to search for a specific location. Medication Disposal Locations provides a complete list of all pharmacies participating. Every day is a take-back day when you return your unwanted, unneeded or expired medications to a participating pharmacy.



Prescription Drug Abuse and Misuse

Misuse and abuse can lead to addiction, which can cause overdose and even death.

Keep unused and expired medications from falling into the wrong hands.

Take them back!

www.leftovermeds.com
1-800-222-1222

ABUSE VS. MISUSE

According to the Food and Drug Administration, the difference between drug abuse and misuse is determined primarily by intention. (1)

DRUG ABUSE = taking a drug, especially at higher doses than prescribed, to get a euphoric feeling.

DRUG MISUSE = using medication to self-treat, not according to a healthcare provider's directions.

Both drug abuse and misuse can be harmful and even fatal.
More Americans die every day from drug overdoses than from motor vehicle crashes (Office of National Drug Control Policy).

ABUSE AND MISUSE FACTS & FIGURES

Sales of prescription opioids in the U.S. quadrupled from 1999 to 2014. (2)

Results from a national survey on drug use indicate that in 2015, approximately 40% of high school seniors said it was "fairly easy" or "very easy" to get narcotics such as vicodin, oxycontin, percocet, etc. (3)

In 2015, there were 145 drug overdose deaths in Nebraska, triple the number reported in 1999. (4)

According to a national survey, almost 15 million Americans misused a prescription drug in 2014. (5)

What Can I Do?

Ensure medications are safely stored in your home.

Periodically check your medicine cabinet for expired prescription and over-the-counter medications, as well as medications you are no longer using.

Take back expired, leftover, and unused medications to a participating pharmacy.

Find a participating pharmacy near you: **www.leftovermeds.com**

The Nebraska Environmental Trust

Nebraska MEDSCoalition

Nebraska Pharmacists Association | The Nebraska Regional Poison Center | The Groundwater Foundation
Nebraska Department of Health and Human Services | Lincoln/Lancaster County Health Department | WasteCap Nebraska

November 2016

References: (1) http://www.fda.gov/forconsumers/consumerupdates/ucm220112.htm (2) http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w - fig2
(3) http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2015.pdf (4)http://journalstar.com/news/local/911/after-opioids-learning-to-feel-pain-normally-again/article_ec489bba-4cd2-58a6-bbd2-3e469780b4f8.html (5) http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab1-1a

Source: https://www.nebraskameds.org/

COLUMBUS COMMUNITY HOSPITAL

PROMOTING SAFER AND MORE EFFECTIVE PAIN MANAGEMENT

UNDERSTANDING PRESCRIPTION OPIOIDS

Opioids are natural or synthetic chemicals that relieve pain by binding to receptors in your brain or body to reduce the intensity of pain signals reaching the brain. Opioid pain medications are sometimes prescribed by doctors to treat pain. Common types include:

- Hydrocodone (e.g. Vicodin)
- Oxycodone (e.g. OxyContin)
- Oxymorphone (e.g. Opana) and
- Morphine

Opioids can have serious risks including addiction and death from overdose.

As many as 1 in 4 people receiving prescription opioids long term in a primary care setting struggles with addiction.

1 in 4

Americans engaged in non-medical use of opioid pain medication in the last month.

4.3 million

OPIOIDS AND CHRONIC PAIN

Many Americans suffer from chronic pain, a major public health concern in the United States. Patients with chronic pain deserve safe and effective pain management. At the same time, our country is in the midst of a prescription opioid overdose epidemic.

PRESCRIPTION OPIOID
AN EPIDEMIC IN

COLUMBUS COMMUNITY HOSPITAL

COLUMBUS COMMUNITY HOSPITAL

Working Together to Deliver Safe, Compassionate, Evidence-based **Pain Management** to the Patients We Serve

OUR MISSION is to partner with patients, their families and clinicians to deliver safe, compassionate, evidence-based pain management across the care continuum while providing guidance to those delivering care.

OUR GOAL is to reduce the number of opioids which become uncontrolled in our community.

Why Focus on **Pain Management?**

Nebraska DHHS Reports:

- The number of drug overdose deaths, the majority from prescription drugs, has **quadrupled** since 1999 from 36 deaths to 149 deaths in 2015.
- Hospitalizations for drug dependence increased from 1,150 to 1,474 per 100,000 persons.
- The CDC reports **over 2 million** Americans age 12 and older either abused or were dependent on opioid pain relievers in 2015.
- Statewide, the opioid-related death rate **rose** from 2.4/100,000 to 3.0/100,000 **in 2015.**
- **Chronic pain** impacts more Americans than diabetes, heart disease, cancer and stroke.

Pain Management

ASSESSMENT:
- Evaluate and determine estimated recovery time.
- Educate the patient regarding expectations for healing and duration and intensity of pain.

NON-OPIOID OPTIONS:
- Brief rest, intermixed with graded physical activity/exercise
- External pain-reducing modalities such as immobilization, heat/cold and elevation.
- OTC medications with specific instructions on doses and duration.

OPIOID TREATMENT:
- Access PDMP prior to prescribing.
- Assess for opioid risk.
- Determine if the risks of treatment outweigh the benefits.
- Use the lowest possible dose for the shortest amount of time; less than three days in most cases.

STOP AND ASSESS:
If patient requests more opioids beyond what you feel is appropriate in your clinical judgment:
- Assess for unforeseen complications.
- Assess for substance abuse.
- Reinforce non-opioid modalities of pain control.

Pain Management Minimum Standards

- Document pain assessment scores using the appropriate pain assessment tool.
- Access the Prescription Drug Monitoring Program (PDMP) prior to prescribing opioids.
- Assess opioid risk prior to prescribing using Opioid Risk Assessment (ORT) or Screener and Opioid Assessment for Patients Revised (SOAPP-R).
- Every inpatient must have a documented pain assessment score and acceptable level of pain within 24 hours of admission and once per day after the initial assessment.
- Order a scheduled, non-opioid pharmacologic agent(s) if there are not contraindications when an opioid medication if prescribed.
- Offer patient integrative therapy solutions for pain management.
- Prescribe no more than three to five days of opioids when indicated for acute pain.
- Educate patient on how to dispose of unused medications.

Higher Dosage, Higher Risk

Dosages at, or above 50 Morphine Equivalents (MME) per day, double people's risk of overdose. Calculating the total daily dose of opioids helps identify patients who may benefit from close monitoring, reduction or tapering of opioids. Prescribe the lowest effective dose.

Columbus Community Hospital • 4600 38th Street • Columbus, NE 68602-1800 • 402-564-7118 • www.columbushosp.org

How to safely use opioids

- *Start low and go slow.* Take the lowest dose and amount needed to manage your pain. Unlike antibiotics, you don't need to finish the entire prescription.
- Your risk of becoming dependent on or addicted to opioids increases as you take more (higher doses) or take for a longer period of time.
- Always store your medication in a safe place, out of reach of others (including visitors, children, friends and family).
- Never share or sell your prescription opioids.

Your provider can give you options

The CDC recommends using **the smallest amount for the shortest time.**

You always have the option of asking your pharmacist to **fill a smaller amount** than what was prescribed.

It's important to have realistic expectations for the treatment of your pain. Always reach out to your doctor of pharmacist if you have any questions about your pain therapy options.

Safe disposal options

It's important to safely dispose of opioids and other medications you no longer use. Your local pharmacy or police department can offer a solution or help you determine the best disposal method for you and your family.

You can also find help for addiction and pain management at:

samhsa.gov
or
The National Helpline at
1-800-662-HELP
or
cdc.gov/drugoverdose/patients

COLUMBUS COMMUNITY HOSPITAL

Let's talk about **prescription opioids**

When prescribed and taken properly, prescription opioids can be used to relieve moderate to severe pain following surgery, injury, or for certain chronic health conditions.

But there's more you need to know about opioids.

- Don't take more than you need or for longer than needed for your pain.
- Your risk of becoming addicted to opioids increases as you take more (higher doses) or take for a longer period of time.
- Safely dispose of any unused medication immediately after treatment has ended.

CDC reports that more than 40 people die every day from overdoses involving prescription opioids.

COLUMBUS COMMUNITY HOSPITAL
www.columbushosp.org

Prescription opioids come with some serious risks, including but not limited to:*

- Overdose that could lead to sudden death
- Physical dependence – you may have symptoms of withdrawl after the medication has stopped
- Depression

Overdose risk increases when you combine your opioids with the following drugs:

- Alcohol
- Benzodiazepines (such as alprazolam and diazepam)
- Other sedatives
- Other opioids, including prescription and illicit forms, such as heroin

Talk with your doctor or pharmacist about any other medications that you are taking with your opioids.

* This is not a comprehensive list of all risks or side effects. Please review the information provided with your prescription and consult your primary care provider of pharmacist for additional information.

The following conditions may increase your risks associated with opioids:

- History of drug misuse, or overdose
- Certain mental health conditions (such as depression or anxiety)
- Older patients (over 65 years old)
- Pregnancy

Each day, more than 1,000 people are treated in emergency departments as a result of not using their opioid medication correctly.

Opioids by the numbers

- 1 in 4 people who receive prescription opioids long-term for non-cancer pain struggles with addiction.
- Today, nearly half of all U.S. opioid overdose deaths involve a prescription opioid.

Pamphlet information adapted from: cdc.gov and WalMart.

DO

- Talk with your provider about other treatment options, such as:
  - Over-the-counter pain relievers like acetaminophen, ibuprofen, or naproxen (Tylenol, Motrin, Aleve)
  - Physical therapy, exercise, or weight loss
  - Ice or heat therapy
  - Learn how to modify physical, behavioral and emotional triggers of physical pain
- Dispose of any unused medications after your treatment has ended
- Call 911 immediately if you take too much of your medication, experience shortness of breath, or a child takes your medication
- Talk to your doctor or pharmacist if you are concerned about the risk of overdose

DON'T

- Give your medication to others or leave your medications in an unsecure place where others might have access
- Take more than the prescribed amount of your medication
- Take it for longer than needed or to treat another injury or condition later
- Drink alcohol while taking opioids
- Take with other medications, especially those that cause drowsiness, without talking to your doctor or pharmacist

Bryan CRETE AREA MEDICAL CENTER

Letter Informing Patients of Guidelines

Dear Crete Area Medical Center patient,

Crete Area Medical Center's goal is to give patients the best and safest care. Today about 105 deaths happen each day due to overdoses from prescription narcotics. There are standard prescribing recommendations that CAMC plans to use for pain management, thus, reducing and/or preventing overdoses.

These recommendations discuss topics such as: the risks and benefits of narcotic use for chronic pain, treatment plans, and medication misuse and overdose.

If you are a patient that is being treated with narcotics for chronic pain, you can expect your provider to review your treatment plan at your next visit.

This review may include:

- Establishing goals for your chronic pain management
- Discussion on the risks and benefits of narcotic use for chronic pain management
- Evaluating effectiveness and /or risks of current chronic pain treatment plan
- Consideration of nonnarcotic treatment options for chronic pain

As your healthcare provider, we are a partner in your "health." We are committed to giving you the safest and most effective care.

Sincerely,

CAMC Medical Staff

Great Plains Health

Your menu of pain control and comfort options

Controlling your pain and ensuring a positive patient experience.

Thank you for choosing Great Plains Health. Please discuss your pain control goals and comfort options with your nurse and doctor.

You know how you're feeling better than anyone. We hope this menu makes it easier for you to talk with us about your pain control therapy.

1 Comfort items

- *Warm compress*
- *Ice pack*
- *Warm blanket*
- *Warm washcloth*
- *Extra pillow*
- *Neck pillow*
- *Air mattress topper*
- *Pillow to raise your knees or ankles*
- *Humidification for your oxygen tube*
- *Saline nose spray*
- *Mouth swab*

2 For those times when medication is needed

- *If you think your pain requires medication, talk to your nurse.*
- *Discuss pain medication combinations with your nurse or doctor.*
- *Let your nurse know after 45 minutes if your pain medication is not working.*
- *Discuss with your nurse if you have a pain regimen at home that works.*

3 Comfort actions

- *Re-positioning*
- *Walk in the hall*
- *Bath or shower*
- *Gentle stretching / range of motion*

4 Relaxation options

- *Ear plugs*
- *Eye shield / sleep mask*
- *Stress ball*
- *Personal headphones*
- *Visit from clergy*
- *Get Well Network*
- *Quiet / uninterrupted time (discuss this with your nurse)*

5 Keep boredom at bay

- *Book or magazine*
- *Movies on Get Well Network*
- *Deck of cards*
- *Puzzle book (crossword puzzles, word searches, Sudoku)*
- *Video games*

We look forward to discussing these options with you. If you need additional items or have any questions, please ask your healthcare provider. Our goal is to make your experience the best possible.

601 W. Leota St. | North Platte, NE 69101 | gphealth.org

Howard County MEDICAL CENTER

PATIENT ACKNOWLEDGMENT OF RISK OF CONTROLLED SUBSTANCE AND OPIOID USE

Patient Name: _____ Date: _____

Your provider has prescribed a controlled substance or opioid medication to treat your pain. **Even when taken as prescribed, these medications are highly addictive and there is a risk of developing a physical and/or psychological dependence.**

What is Physical Dependence? When your body cannot function properly without a drug, you have become physically dependent or addicted. If you suddenly stop taking the drug, painful withdrawal symptoms occur. Some typical withdrawal symptoms can include tremors or "shakes," nausea, diarrhea, chills and body aches.

What is Psychological Dependence? Also called emotional addiction, it is defined as a compulsion or perceived need to use a drug or substance. In severe cases of psychological addiction, these thoughts become all- consuming. Without help, a psychological dependency can transform a drug into your central focus of life.

RISK OF DEATH

Taking more controlled substances or opiates than prescribed, or mixing sedatives (sleeping pills, muscle relaxants) benzodiazepines (anxiety medications), or alcohol with controlled substances or opiates, can lead to respiratory depression and can be fatal (cause death). Risks are greater with history of drug misuse, substance use disorder or overdose, mental health conditions (such as depression and anxiety), sleep apnea, age greater than 65, and pregnancy.

TREATMENT OF PAIN

Prescription controlled substances and opioids can be used to help relieve moderate to severe pain and are often prescribed following a surgery or injury, or for other painful health conditions.

POTENTIAL ALTERNATIVES TO THERAPY

Your provider will discuss with you alternative or complementary treatments for your pain, as appropriate, which may include: physical or occupational therapy; counseling; good nutrition; biofeedback; massage; meditation; gentle exercise; and non-opioid medications.

MEDICATION SAFETY

- Keep all medicines in a safe, preferably locked container, out of sight and out of the reach of children.
- Never share these medicines with others. Never take other people's pain medications.
- Always dispose of your medications properly.
- Be aware that controlled substances and opioids may affect your judgment and driving skills.

MEDICATION REFILLS

Prescription controlled substances and opioids will only be prescribed for a 30-day period. You can request a refill from your pharmacy for additional medications. Patients on controlled substances or opioids will need to be seen by a provider every 90 days in the office to evaluate pain and pain control.

PRESCRIPTION FOR GREATER THAN SEVEN-DAY SUPPLY (complete, if applicable)

❑ I certify that the above-named patient requires more than a seven-day supply of medications for the medical condition listed below and a non-opioid alternative is not appropriate to address this condition.
List Medical Condition necessitating more than a seven day supply: _____

_____

ACKNOWLEDGMENTS

I, the undersigned, hereby acknowledge that my provider has discussed with me the above information. I also certify that I have read and understand the above information.
I, the undersigned, hereby acknowledge that I have been given the opportunity to have my questions or concerns addressed to my satisfaction.

Signature of Patient or Patient Representative	Date	Time ❑ a.m. ❑ p.m.
Provider Signature	Date	Time ❑ a.m. ❑ p.m.

Howard County MEDICAL CENTER

PATIENT AGREEMENT: PAIN TREATMENT WITH OPIOID MEDICATIONS

Patient Name: _____ Medical Record Number: _____

I, _____, understand and voluntarily agree that:
(Initial each statement after reviewing):

_____ I will keep (and be on time for) my scheduled appointments with the doctor and other members of the treatment team.
_____ I will participate in all other types of treatment that I am asked to participate in.
_____ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.
_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.
_____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.
_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.
_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.
_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.
_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see.
_____ I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new med.
_____ I will use only one pharmacy to get all on my medicines:
Pharmacy name _____ Phone #: _____
_____ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.
_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.
_____ I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.
_____ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.
_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

PAIN TREATMENT PROGRAM STATEMENT

We here at _____ are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

Patient signature	Patient name printed	Date
Provider signature	Provider name printed	Date

**Adapted from the American Academy of Pain Medicine.*

Original copy to Medical Records Department, provide copy to patient

Nebraska Hospital Association

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