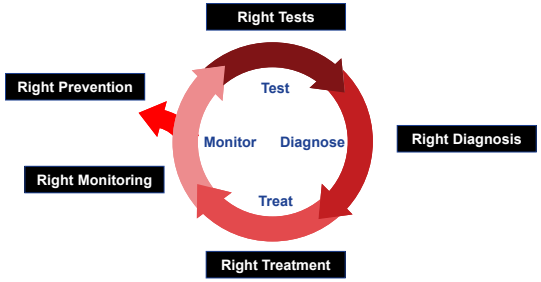
## The 5 Rights of Pain Care ®



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## Welcome

**Charles Denham, MD**

Chairman, TMIT Global

**TMIT High Performer Webinar**
**November 16, 2023**

**Webinar 210**

 

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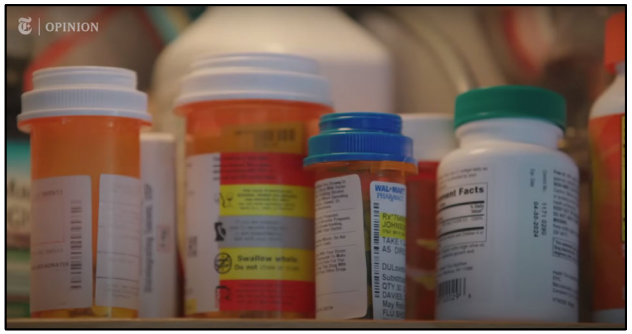
## The Opioid Crisis Is a Tragedy, but America's Response Created a Second One | NYT Opinion

The New York Times




https://www.youtube.com/watch?v=9IVYSLv-zUA 5 Minutes



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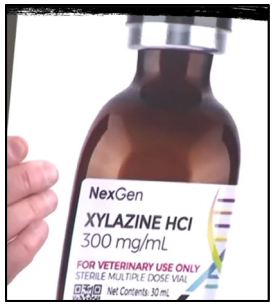
https://www.youtube.com/watch?v=WApQgQ-mP4U



4

## The TRANQ: The Zombie Effect




https://www.youtube.com/watch?v=bRj3Sa-Q41A



5

## Fentanyl: Why are so many Americans are Dying


https://www.youtube.com/watch?v=lmxF2owm3Gg



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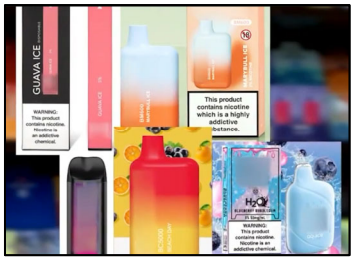
## Death of a Teenager – Fentanyl in Vape Pod

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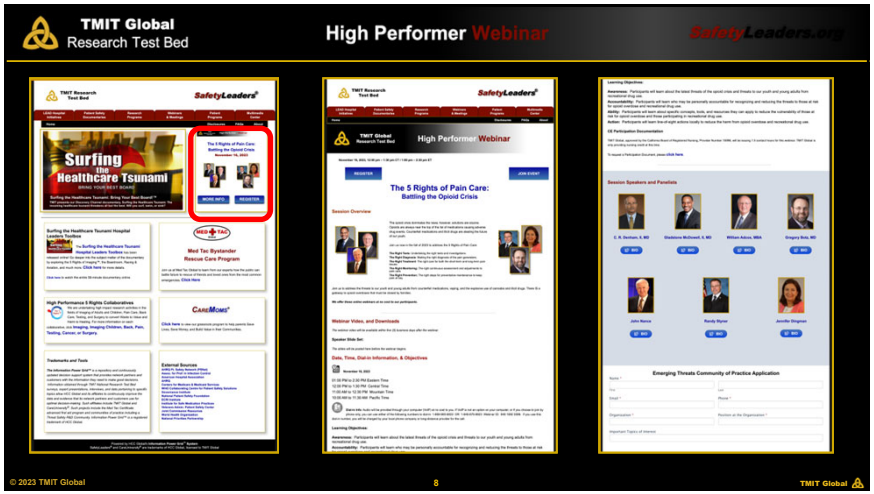


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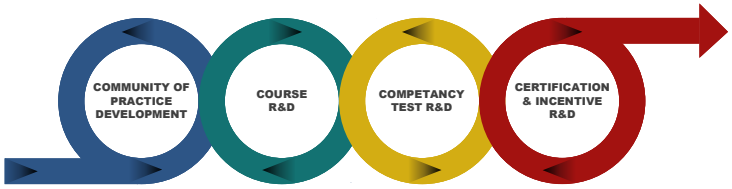
## CareUniversity®

TMIT Global Research Test Bed

MED TAC Global

SafetyLeaders®

### Learning Management System



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## CareUniversity®

TMIT Global Research Test Bed

MED TAC Global

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### Certificates for Med Tac Program

STOP THE BLEED SAVE A LIFE

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
100+years

American Heart Association.
Heartsaver® First Aid CPR AED



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High Performer Webinar

SafetyLeaders.org

### Pain Care and Opioid Crisis Series Speakers and Reactors


Jennifer Dingman


Vicki King


John Nance JD


Randy Styner


Dr. Gladstone McDowell


Chief William Adcox


Gregory Botz MD


Charles Denham MD



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### Current 2023 Workplace Violence & Fraud Series









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## Workplace Violence Series 2023 Speakers and Reactors


Jennifer Dingman


David Morris PhD JD


Vicki King


John Nance JD


Randy Styner


Ann Rhoades


C. Clements MD PhD


Chief William Adcox


Gregory Botz MD


Charles Denham MD



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## Voice of Patient and Family

### Jennifer Dingman

Founder, Persons United Limiting Substandard and Errors in Healthcare (PULSE), Colorado Division
Co-founder, PULSE American Division
TMIT Patient Advocate Team Member
Pueblo, CO



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If you wish to follow us on Twitter,
go to: http://twitter.com/TMIT1
or use #safetyleaders hashtag

Also, go to:
www.facebook.com/SafetyLeaders
and related sites



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## Our Purpose, Mission, and Values

**Our Purpose:**
We will measure our success by how we protect and enrich the lives of families…patients AND caregivers.

**Our Mission:**
To accelerate performance solutions that save lives, save money, and create value in the communities we serve and ventures we undertake.

**Our ICARE Values:**
Integrity, Compassion, Accountability, Reliability, and Entrepreneurship.



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## Disclosure Statement

The following panelists certify that unless otherwise noted below, each presenter provided full disclosure information; does not intend to discuss an unapproved/investigative use of a commercial product/device; and has no significant financial relationship(s) to disclose. If unapproved uses of products are discussed, presenters are expected to disclose this to participants. None of the participants have any relationship medication or device companies discussed in their presentations.

Dr. Gladstone McDowell has nothing to disclose
Vicki King has nothing to disclose
John Nance JD has nothing to disclose
Chief William Adcox has nothing to disclose
Dr. Botz has nothing to disclose
Randy Styner has nothing to disclose
Jeni Dingman has nothing to disclose

Charles Denham, MD, is the Chairman of TMIT; a former TMIT education grantee of CareFusion and AORN with co-production by Discovery Channel for *Chasing Zero* documentary and Toolbox including models; and an education grantee of GE with co-production by Discovery Channel for *Surfing the Healthcare Tsunami* documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers. HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. He does not currently work with any pharmaceutical or device company and has not done so for more than 5 years. His current area of research is in threat management to institutions including conflict of interest, healthcare fraud, and continuing professional education and consumer education including bystander care. Dr. Denham has been a collaborator with the late Professor Christensen at Harvard Business School.

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David Grinsfelder has not
Randy Styner has nothing
Chief William Adcox has
Danny Policichio nothing
Dr. Gladstone McDowell
Dr. Botz has nothing to di
Charlie Denham III has no
Jeni Dingman has nothing

**The TMIT Global High Performer Webinar Series has been entirely funded by private family philanthropy. No direct, indirect, or affiliated financial support has ever been or ever will be provided by healthcare pharmaceutical or device companies.**

Charles Denham, MD, is t ction by Discovery Channel for *Chasing Zero* on by Discovery Channel for *Surfing the Healthcare Tsunami* documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers. HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. He does not currently work with any pharmaceutical or device company and has not done so for more than 5 years. His current area of research is in threat management to institutions including conflict of interest, healthcare fraud, and continuing professional education and consumer education including bystander care. Dr. Denham has been a collaborator with the late Professor Christensen at Harvard Business School.

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*Survive & Thrive Guide*


CareUniversity Med Tac Bystander Rescue Care

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*Head Heart Hands Voice*


CareUniversity Med Tac Bystander Rescue Care

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Survive & Thrive Guide: Keeping Your Family Safe
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3,100 Hospitals in 3,000 Communities
500 Subject Matter Expert Pool Developed over 39 Years
500 Subject Matter Experts
Turn the Science into Safety™
CareUniversity
Med Tac Bystander Rescue Care

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Insider Threat
Cyber
Violence
Espionage
Sabotage
Theft
Suicide
R&D Ethics Issues
Cardiac Arrest
Choking & Drowning
Opioid Overdoxe
Anaphylaxis
Major Trauma
Common Accidents
Transportation Accidents
Bullying
CareUniversity
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Med Tac Bystander Rescue Care

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Emerging Threats
Community of Practice
The Healthcare Threat Safety Spectrum
Academic Fraud
Patient Safety Errors of Omission
Workplace Employee Bullying
Administrative Misconduct
Cyber & I.P. Theft
Invisible Threats
Invisible Threats
Invisible Threats
Traditional Risk Issues
Invisible Threats
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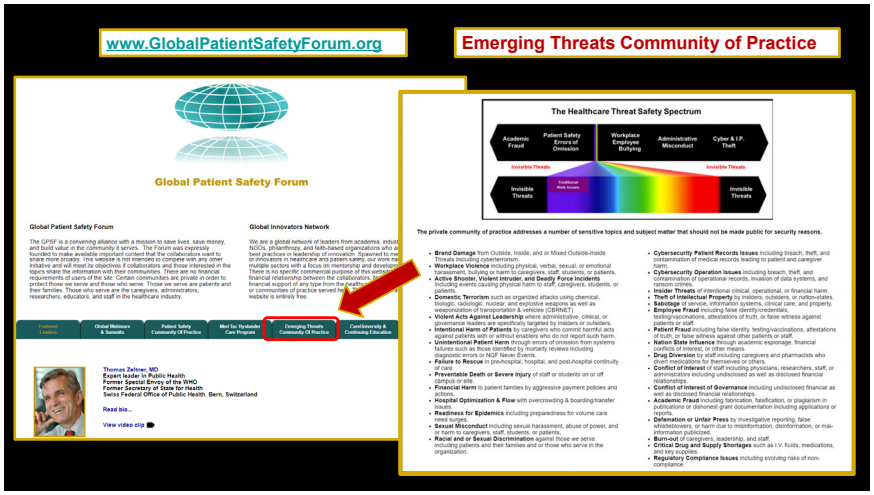
www.GlobalPatientSafetyForum.org
Emerging Threats Community of Practice
Global Patient Safety Forum
The Healthcare Threat Safety Spectrum

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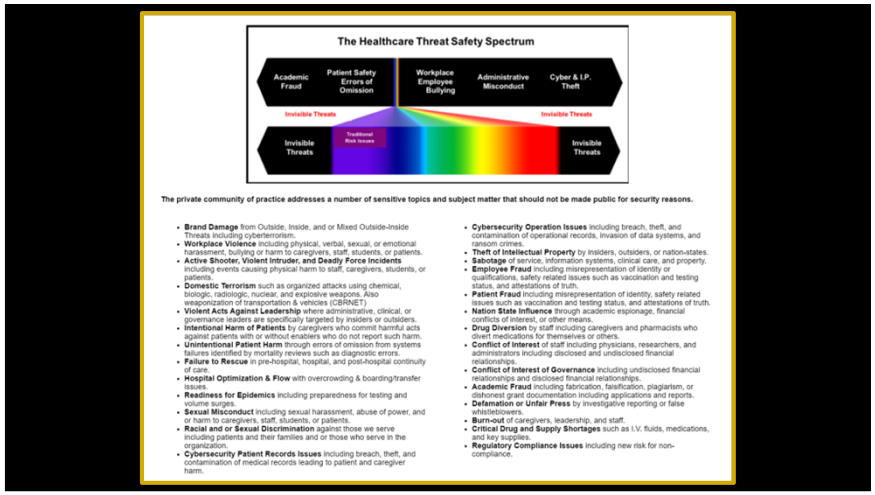
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Academic Fraud
Patient Safety Errors of Omission
Workplace Employee Bullying
Administrative Misconduct
Cyber & I.P. Theft
Invisible Threats
Invisible Threats
Invisible Threats
Traditional Risk Issues
Invisible Threats
The private community of practice addresses a number of sensitive topics and subject matter that should not be made public for security reasons.
• Brand Damage from Outside, Inside, and or Mixed Outside-Inside Threats including cyberterrorism.
• Workplace Violence including physical, verbal, sexual, or emotional harassment, bullying or harm to caregivers, staff, students, or patients.
• Active Shooter, Violent Intruder, and Deadly Force Incidents including events causing physical harm to staff, caregivers, students, or patients.
• Domestic Terrorism such as organized attacks using chemical, biologic, radiologic, nuclear, and explosive weapons. Also weaponization of transportation & vehicles (CBRNET).
• Violent Acts Against Leadership where administrative, clinical, or governance leaders are specifically targeted by insiders or outsiders.
• Intentional Harm of Patients by caregivers who commit harmful acts against patients with or without enablers who do not report such harm.
• Unintentional Patient Harm through errors of omission from systems failures identified by mortality reviews such as diagnostic errors.
• Failure to Rescue in pre-hospital, hospital, and post-hospital continuity of care.
• Hospital Optimization & Flow with overcrowding & boarding/transfer issues.
• Readiness for Epidemics including preparedness for testing and volume surges.
• Sexual Misconduct including sexual harassment, abuse of power, and or harm to caregivers, staff, students, or patients.
• Racial and or Sexual Discrimination against those we serve including patients and their families and or those who serve in the organization.
• Cybersecurity Patient Records Issues including breach, theft, and contamination of medical records leading to patient and caregiver harm.
• Cybersecurity Operation Issues including breach, theft, and contamination of operational records, invasion of data systems, and ransom crimes.
• Theft of Intellectual Property by insiders, outsiders, or nation-states.
• Sabotage of service, information systems, clinical care, and property.
• Employee Fraud including misrepresentation of identity or qualifications, safety related issues such as vaccination and testing status, and attestations of truth.
• Patient Fraud including misrepresentation of identity, safety related issues such as vaccination and testing status, and attestations of truth.
• Nation State Influence through academic espionage, financial conflicts of interest, or other means.
• Drug Diversion by staff including caregivers and pharmacists who divert medications for themselves or others.
• Conflict of Interest of staff including physicians, researchers, and administrators including disclosed and undisclosed financial relationships.
• Conflict of Interest of Governance including undisclosed financial relationships and disclosed financial relationships.
• Academic Fraud including fabrication, falsification, plagiarism, or dishonest grant documentation including applications and reports.
• Defamation or Unfair Press by investigative reporting or false whistleblowers.
• Burn-out of caregivers, leadership, and staff.
• Critical Drug and Supply Shortages such as I.V. fluids, medications, and key supplies.
• Regulatory Compliance Issues including new risk for non-compliance.

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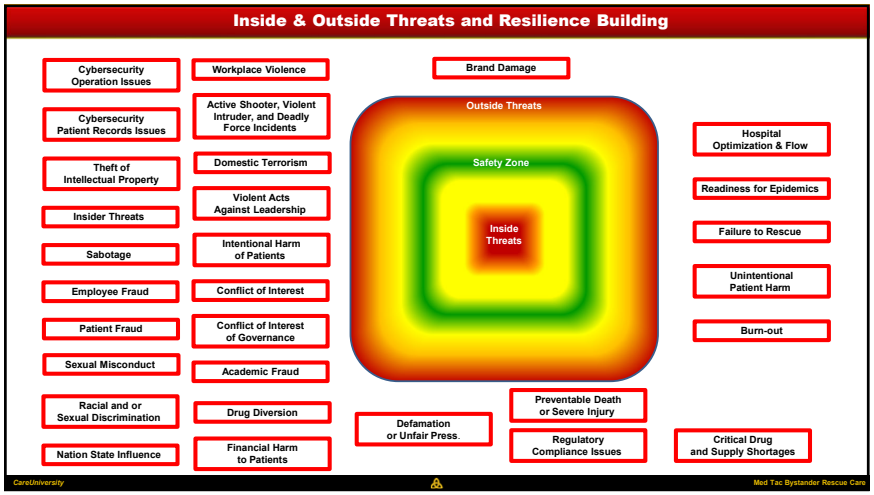
Inside & Outside Threats and Resilience Building
Cybersecurity Operation Issues
Cybersecurity Patient Records Issues
Theft of Intellectual Property
Insider Threats
Sabotage
Employee Fraud
Patient Fraud
Sexual Misconduct
Racial and or Sexual Discrimination
Nation State Influence
Workplace Violence
Active Shooter, Violent Intruder, and Deadly Force Incidents
Domestic Terrorism
Violent Acts Against Leadership
Intentional Harm of Patients
Conflict of Interest
Conflict of Interest of Governance
Academic Fraud
Drug Diversion
Financial Harm to Patients
Brand Damage
Outside Threats
Safety Zone
Inside Threats
Defamation or Unfair Press.
Preventable Death or Severe Injury
Regulatory Compliance Issues
Hospital Optimization & Flow
Readiness for Epidemics
Failure to Rescue
Unintentional Patient Harm
Burn-out
Critical Drug and Supply Shortages
CareUniversity
Med Tac Bystander Rescue Care

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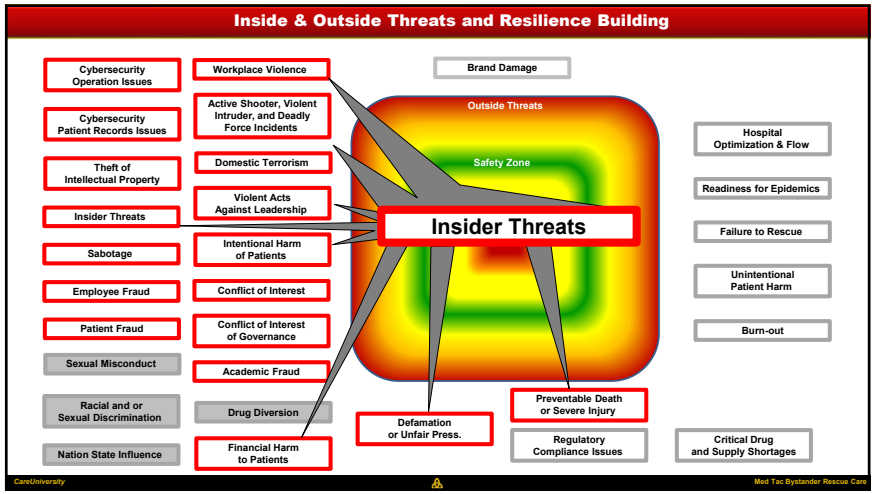
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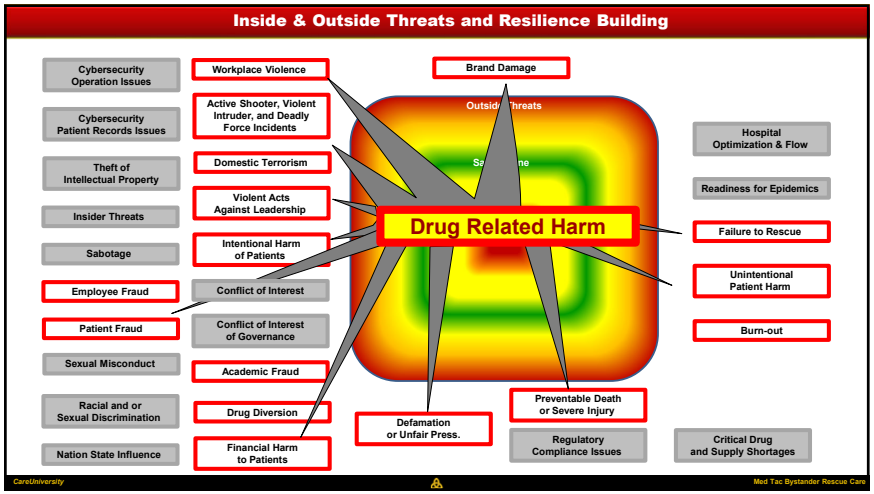
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## Emerging Threats: The Fraud Factor



TMIT High Performer Webinar October 21, 2021
https://www.safetyleaders.org/webinaroctober2021/



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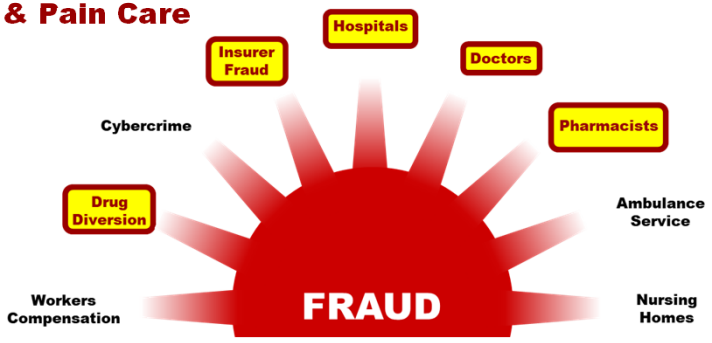
## The Fraud Factor & Pain Care



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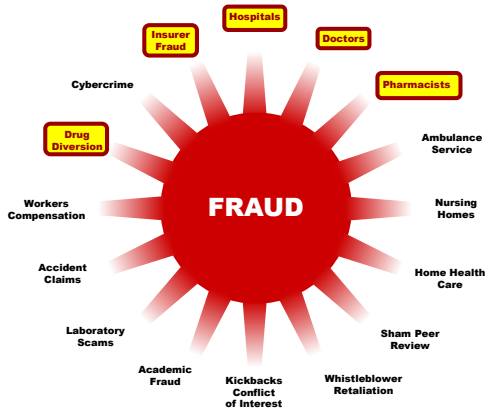


## Fraud Definition

In law, fraud is intentional deception to secure unfair or unlawful gain, or to deprive a victim of a legal right. Fraud can violate civil law (e.g., a fraud victim may sue the fraud perpetrator to avoid the fraud or recover monetary compensation) or criminal law (e.g., a fraud perpetrator may be prosecuted and imprisoned by governmental authorities), or it may cause no loss of money, property, or legal right but still be an element of another civil or criminal wrong.

Source: https://en.wikipedia.org/wiki/Fraud



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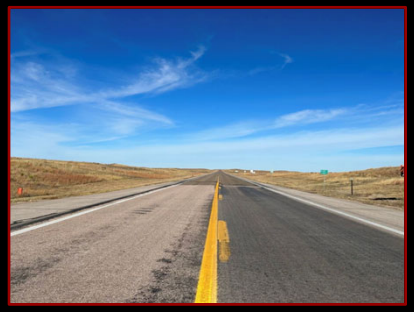
*In The News…*

WSJ 10-06-23

## Your Ambulance Is on the Way. ETA: 65 Minutes.

At least 4.5 million people nationwide live in an ambulance desert, where they are farther than a 25-minute drive from an ambulance station.

More than 55 ambulance providers have closed since December 2021, according to a log of news reports compiled by the American Ambulance Association and the Academy of International Mobile Healthcare Integration.



Source: https://www.wsj.com/us-news/your-ambulance-is-on-the-way-eta-65-minutes-0431facd?mod=Searchresults_pos1&page=1



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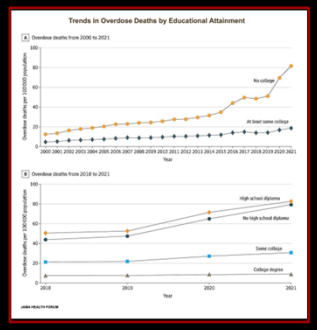
*In The News…*

PAIN NEWS NETWORK

10-06-23

## Lack of Education Is Fueling Overdose Crisis

Anti-opioid activists have long claimed that excessive prescribing of opioids over a decade ago created an "epidemic of addiction" that lingers to this day. Once hooked on prescription opioids, patients turned to stronger and more lethal drugs — like heroin and illicit fentanyl — sending the overdose rate to record levels.

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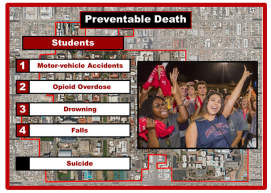
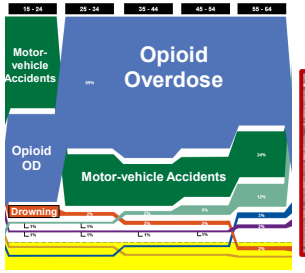
*Top Causes of Unintentional Death By Age - 2020*

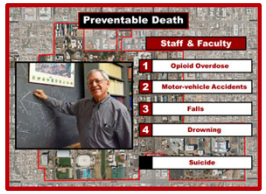
**2020 Data**

**Students**




**Faculty & Staff**




Total unintentional deaths by age group: 15,117 | 31,315 | 31,057 | 27,819 | 28,915

Total Suicide Deaths: 44,298

Source: Adapted from the National Safety Council Injury Facts, 2020 Edition

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SafetyLeaders.org

## Safety of Rising Freshmen: Battling Failure to Rescue


TMIT High Performer Webinar
August 17, 2023
Webinar 207

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## The Problem: Failure to Rescue


CareUniversity  Med Tac Bystander Rescue Care

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## The Solution: Bystander Rescue Care

**Cardiac Arrest**

Sudden Cardiac Arrest: There is an epidemic of SCA with one quarter of the SCA events in children and youth occurring at sporting events. CPR and AED use have a dramatic impact on survival.
*Possible Lives Saved in the US: 41 adults every hour and 19 children per day. 25% of SCA deaths in children occur at such events – 4 per day.*

**Choking & Drowning**

Choking: More than 100,000 lives have been saved with the Heimlich Maneuver. Most choking deaths are preventable.
*Possible Lives Saved in the US: 13 per day*

Drowning: By population, drowning and near drowning events are very common. Since much of the OC population is near water, the numbers are likely much greater.
*Possible Lives Saved in the US: 11 per day*

**Opioid OD & Poisoning**

Opioid Overdose and Poisoning: An exploding opioid OD crisis is gripping our nation with a great toll on families. Narcan opioid reversal agents, rescue breathing and positioning, and rapid EMS response saves lives. Awareness drives prevention.
*Possible Lives Saved in the US: There are 293 OD deaths per day. Up to 11 lives may be saved per hour.*

**Anaphylaxis**

Anaphylaxis & Life Threatening Allergies: Many events are unreported; however 22% occur in children without a prior diagnosis of allergies. More than one in twenty adults will have an anaphylactic event in their lifetime. Epinephrine auto-injectors save lives within minutes.
*Possible Lives Saved in the US: 2 per day*

**Major Trauma**

Major Trauma & Bleeding: Bystander care especially for major bleeding using Stop-The-Bleed techniques of wound pressure, bandages, and tourniquets can have an enormous impact on survival.
*Possible Lives Saved in the US: 14 per hour*

**Infection Care**

Infection Care: Epidemics, pandemics, and seasonal infections are a leading cause of death. Prevention, preparedness, protection, and performance improvement strategies and tactics are critical to save lives and inform all Med Tac efforts. They are a feature of all Med Tac Bystander Rescue Care.
*Possible Lives Incalculable – More than 1 Million from COVID alone. Almost 1,000 per day from sepsis.*

**Transportation**

Non-traffic Related Vehicular Accidents: The incidence of non-traffic related drive-over accidents near schools and home is greater than 50 per week. More than 60% of the drivers are a parent or friend.
*Possible Lives Saved in the US: Including adults, there are 1,900 deaths per year; many are preventable.*

**Bullying**

Bullying & Workplace Violence: Bullying and abuse of power in schools and at work can lead to suicide, workplace violence, violent intruders, and active shooter events.
*Possible Lives Saved in the US: Difficult to estimate, however the consensus is that they are likely to be very significant.*

Sources: CDC and Other Sources



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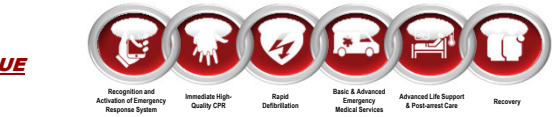
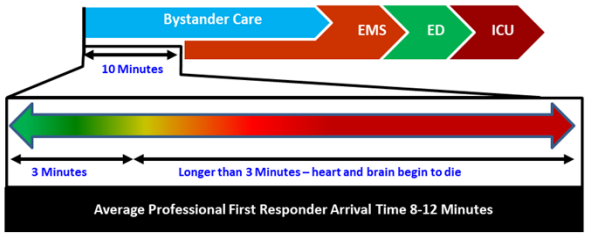
## The Problem:
***FAILURE TO RESCUE***

## The Solution:
***Bystander Care***



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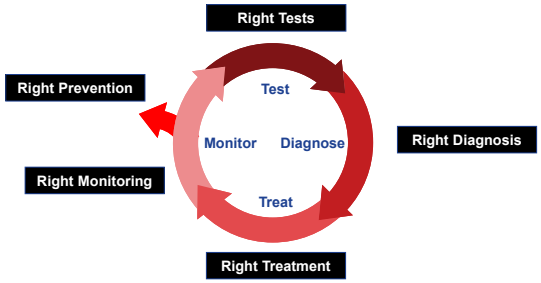
## The 5 Rights of Pain Care ®




**Source:** Denham, CR; McDowell, GM CareUniversity CME Program



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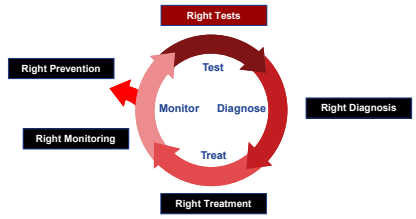
## The 5 Rights of Pain Care ®




**Right Tests:** Caregivers and patients need to make sure that the right tests are undertaken to make the right diagnosis of the sources of pain.

**Right Diagnosis:** Pain often has causes, requiring a thoughtful approach to understanding the pain generators in order to undertake the right treatment.

**Right Treatment:** Optimal pain relief often requires an integrated strategy of multiple tactics. The right combination with a team-based approach has enormous potential.

**Right Monitoring:** When caregivers, patients, and families record the impact of pain care, the tactics can be fine-tuned to the patient and an integrated approach can be taken.

**Right Prevention:** Certain pain scenarios are related to what patients are doing in their daily lives. For instance, back pain can be impacted by safer ways of doing work and exercise can strengthen muscular support and a reduction in pain generation.

**Source:** Denham, CR; McDowell, GM CareUniversity CME Program



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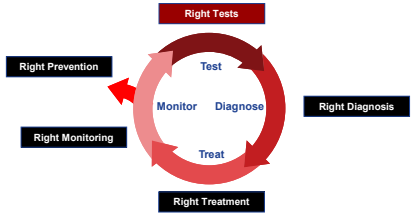
## The 5 Rights of Pain Care ®




**Right Tests:** Caregivers and patients need to make sure that the right tests are undertaken to make the right diagnosis of the sources of pain.

**Source:** Denham, CR; McDowell, GM CareUniversity CME Program

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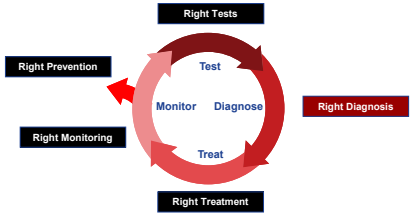


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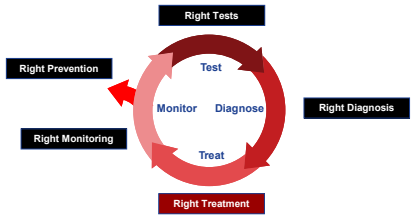


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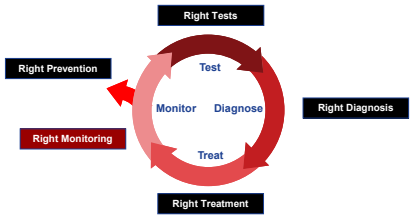


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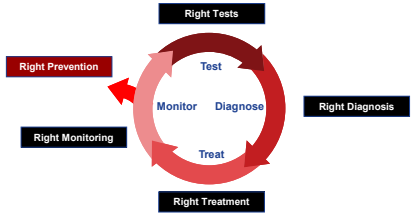


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TMIT National Research Test Bed — High Performer Webinar — SafetyLeaders.org

## The 5 Rights of Pain Management
## Prior Presentation Webinar #125

**Gladstone C. McDowell, II, MD**

Pain Management Specialist
Urologic Oncologist
Director, Task Force Leader
Texas Medical Institute of Technology (TMIT)
Austin, TX

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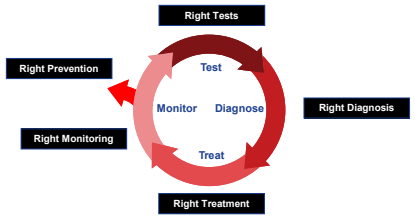
## The 5 Rights of Pain Care ®

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*The 5 Rights of Pain Care*

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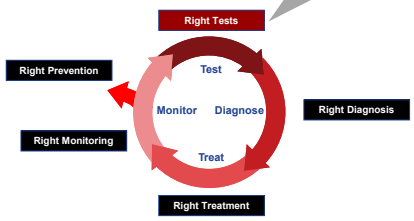


- **Pain is Subjective:** Many factors can impact pain age, gender, culture, communication, experience, and genetics are all important factors.
- **What are the Pain Generators:** The most important factor here is the history and physical exam.
- **Imaging is Important:** MRI, CT, ultrasound, PET, bone scans, and plain films may all be important.
- **Lab Work:** Such as Vitamin D, renal function, hepatic function, and urine drug screen, and pharmaco-genomics. Metabolism is important and structures involved in processing pain are important.

**Source:** Denham, CR; McDowell, GM CareUniversity CME Program

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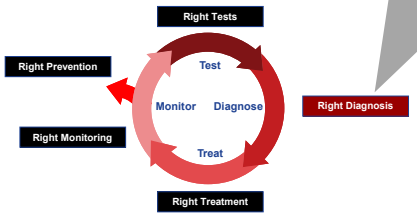
## The 5 Rights of Pain Care ®




Right Diagnosis

**Right Diagnosis:** Pain often has causes requiring a thoughtful approach to understanding the pain generators in order to undertake the right treatment.

- **Causes Must Be Understood:** The pain generators are important to be fully understood.
- **Look Beyond Global Pain Approach:** When we understand the pain generators, we can much more effectively map the proper pain solutions against those generators rather than a global approach using opioids.
- **Fine Tuned Solutions:** We can much more effectively care for our patients over time if we have a solid grasp of the evolution of the pain scenarios that are negatively impacting their lives.

Source: Denham, CR; McDowell, GM CareUniversity CME Program

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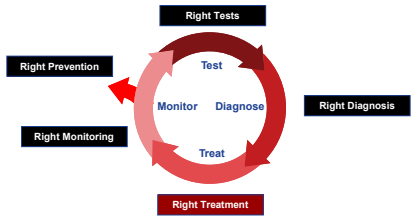
## The 5 Rights of Pain Care ®




- **Right Combination:** An integrated team based approach with the right caregivers providing the proper interventions at the right time..
- **Comprehensive Medical Management:** Non-opioid approaches and comprehensive approaches that use them targeting the pain generators with carefully laid plans.
- **Integrative Care Tools:** Acupuncture, chiropractors, healing touch, physical therapy, water aerobics, healing touch, and yoga have great value.
- **Minimally Invasive Procedures:** Injections of steroids, spinal cord stimulators, targeted drug delivery with non-opioids may be much better than opioids. These can prevent surgery in some patients.

**Right Treatment:** Optimal pain relief often requires an integrated strategy of multiple tactics. The right combination with a team-based approach has enormous potential.

Source: Denham, CR; McDowell, GM CareUniversity CME Program

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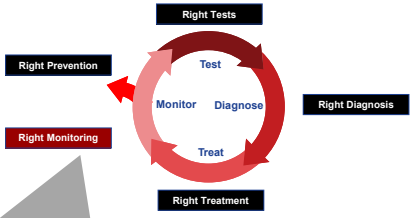
## The 5 Rights of Pain Care ®

- **Historically Poor Monitoring:** In the past we probably did not monitor patients well enough during and after treating them.
- **Carefully Study Baseline Pain Control:** We need to carefully monitor patients through initial interventions and use the baseline to compare against their evolution over time.
- **Lab Work:** Metabolic panels, CBC, testosterone, estradiol, and comparisons to initial lab work.
- **Compliance and Adherence:** Key to make sure patients are following directions properly.
- **Pain Agreements:** We hold patients to them to keep their commitments.




**Right Monitoring:** When caregivers, patients, and families record the impact of pain care, the tactics can be fine-tuned to the patient and an integrated approach can be taken.

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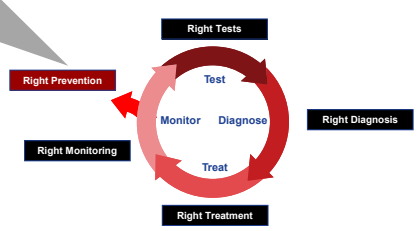
**Right Prevention:** Certain pain scenarios are related to what patients are doing in their daily lives. For instance, back pain can be impacted by safer ways of doing work and exercise can strengthen muscular support and a reduction in pain generation.

## The 5 Rights of Pain Care ®

- **Back Pain:** How daily work and physical movement is undertaken can have real impact on back pain.
- **Exercise:** Can strengthen the core and reduce the risk for pain generation to occur.
- **Sit – Stand Desks:** Allow patients to get up more often, maintain better posture, and reduce risk for pain over time.
- **Movement and Stretching:** Regular movement and stretching can prevent pain scenarios.
- **Physical Therapy:** We often have patients see such therapists to help them reduce the risk for the pain scenario to return.




Source: Denham, CR; McDowell, GM CareUniversity CME Program

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## The 5 Rights of Pain Care ®

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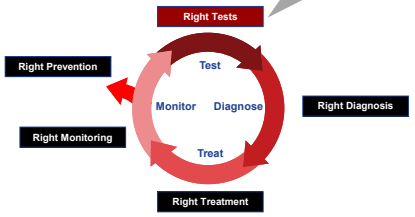


| Condition | Number affected | Source |
|---|---|---|
| Chronic Pain | 100 million Americans | Institute of Medicine of The National Academies |
| Diabetes | 25.8 million Americans (diagnosed and estimated undiagnosed) | American Diabetes Association |
| Coronary Disease | 16.3 million Americans | American Heart Association |
| Stroke | 7.0 million Americans | |
| Cancer | 11.9 million Americans | American Cancer Society |

**Source:** Denham, CR; McDowell, GM CareUniversity CME Program

  

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Right Tests

## Frequency Of Pain

| Condition | Number affected | Source |
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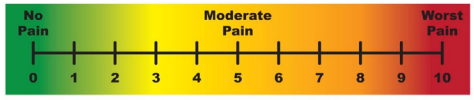
Right Diagnosis

## Pain Screening

- Pain intensity scales can be used as part of a comprehensive pain assessment
  - Assess "current" pain as well as "usual," "worst," and "least" pain in the last 24 hours
  - For a comprehensive assessment, include "worst pain in past week," "pain at rest," and "pain with movement"
- Numeric rating scale
  - Patient verbally describes pain on a scale from 0 ("no pain") to 10 ("worst pain you can imagine")
  - Patient circles number, on a scale of 0 to 10, that best indicates pain intensity




**Mild (1-3)** **Moderate (4-6)** **Severe (7-10)[1]**



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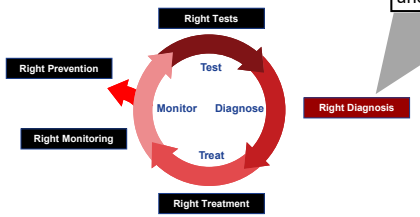


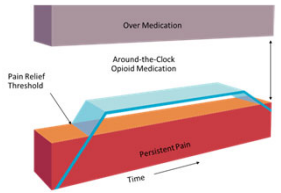


**Source:** Denham, CR; McDowell, GM CareUniversity CME Program

  

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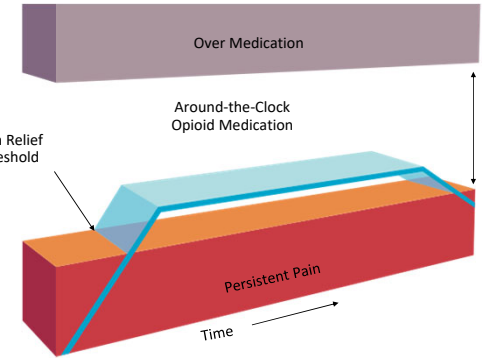
Right Diagnosis

## Balance of Over Medication versus Under Medication



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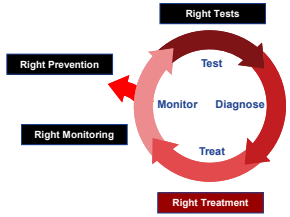


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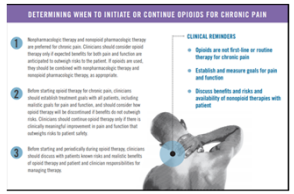


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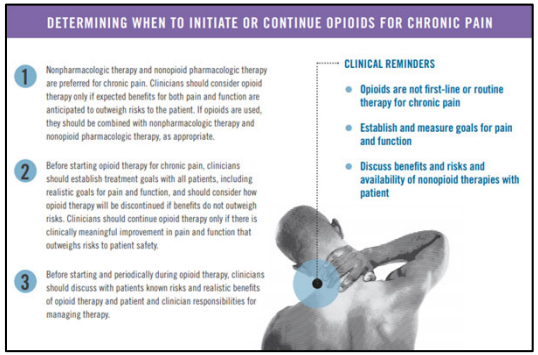
Right Treatment

CDC Centers for Disease Control and Prevention

Aug. 31, 2018

## The 5 Rights of Pain Care ®

## Guideline for Prescribing Opioids for Chronic Pain




**Source: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf**



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Right Treatment

CDC Centers for Disease Control and Prevention

Aug. 31, 2018

## The 5 Rights of Pain Care ®

## OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

**CLINICAL REMINDERS**

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.



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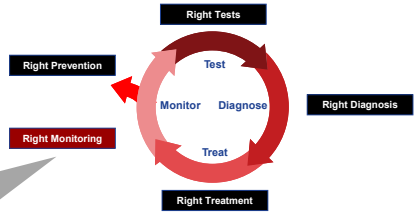
## The 5 Rights of Pain Care ®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Right Monitoring

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Aug. 31, 2018

## ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

**CLINICAL REMINDERS**

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

Source: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

  

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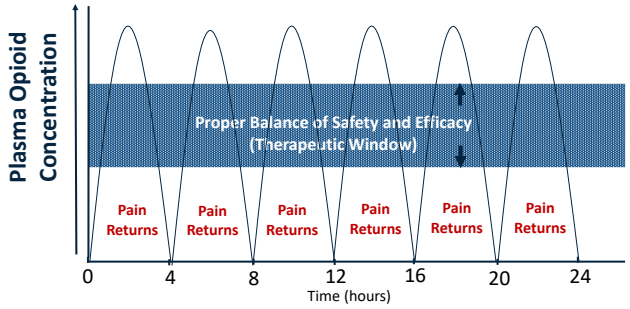
Right Monitoring

**Adverse Effects: Sedation, Euphoria, Dysphoria, Nausea**

**Fluctuating Opioid Levels Observed with Short-acting Opioids**



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Right Monitoring

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Aug. 31, 2018

## Checklist for Prescribing Opioids for Chronic Pain

**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).

Source: https://stacks.cdc.gov/view/cdc/38025

  

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*The 5 Rights of Pain Care*

Right Monitoring

**Nothing is perfectly effective…..**

| Physical Therapy | Injections | Oral Medications | Spine Surgery | Spinal Cord Stimulation | Targeted Drug Delivery |
|---|---|---|---|---|---|
| How many visits? | How many rounds? | Drug? Dose? Long-term challenges? | Success rate? | Target? Frequency? | Drug? Dose? Patient selection? |

1. Vargas-Shaffer G. *Can Fam Physician.* 2010; 56(6):514-517.

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*The 5 Rights of Pain Care*

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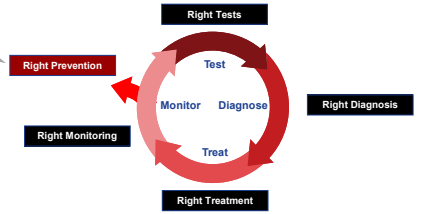
***The 5 Rights of Pain Care*** ®


**Source:** Denham, CR; McDowell, GM CareUniversity CME Program

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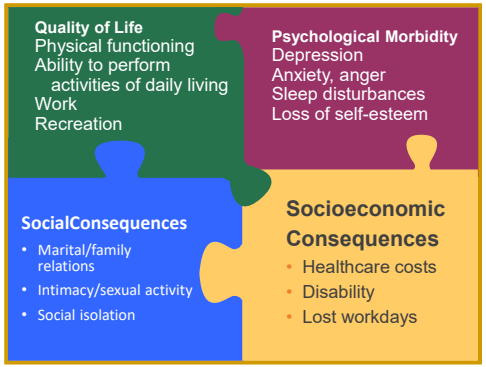
*The 5 Rights of Pain Care*

Right Prevention

***Domains Of Pain***

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TMIT National Research Test Bed

High Performer Webinar

SafetyLeaders.org

***The Opioid Crisis: Security Leader Perspective***

**Chief Bill Adcox**

**Chief Security Officer**
**MD Anderson Cancer Center**
**Chief of Police – UT Health Science Center**
**Houston Texas**

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## The TRANQ: The Zombie Effect – Full Program



https://www.youtube.com/watch?v=bRj3Sa-Q41A



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## Pain Care and Opioid Crisis Series Speakers and Reactors


Jennifer Dingman


Vicki King


John Nance JD


Randy Styner


Dr. Gladstone McDowell


Chief William Adcox


Gregory Botz MD


Charles Denham MD



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## Voice of Patient and Family

### Jennifer Dingman

**Founder, Persons United Limiting Substandard and Errors in Healthcare (PULSE), Colorado Division**
**Co-founder, PULSE American Division**
**TMIT Patient Advocate Team Member**
**Pueblo, CO**



71

## Fight the Good Fight…

## Finish the Race…

## Keep the Faith…



72

Everyone is a Patient

and

Everyone CAN BE a Caregiver



73



## ADDITIONAL RESOURCES



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INFORMATION DISORDER MACHINES

ASU

### False Narratives & Weaponizing Information

- **Mis-information:** when false information is shared, but no harm is meant.
- **Dis-information:** when false information is knowingly shared to cause harm.
- **Mal-information:** when genuine information is shared to cause harm, often by moving information designed to stay private into the public sphere.

Source: Claire Wardle and Hossein Derakhshan "Information Disorder"



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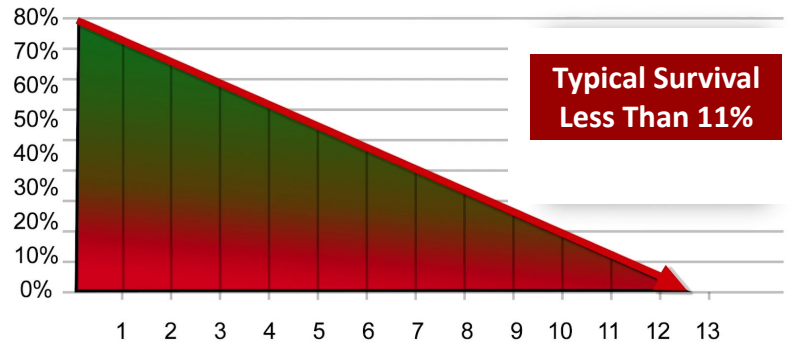
### Survival Loss Over Time for Sudden Cardiac Arrest




Minutes Until CPR and AED Use

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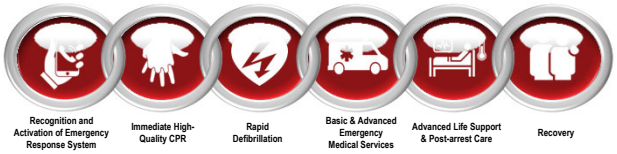
## Cardiac Arrest Chain of Survival




**Bystander Care**


**3 Minutes from Drop to Shock**



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## Trauma Chain of Survival


**Bystander Care**

**3 Minutes from Gun Shot to Stop the Bleed**



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## *Freshmen Survive & Thrive™ Checklists*

### High School Freshmen:

**Basic Actions:**
- ❑ Phone 911 – Automatically call ICE Parents
- ❑ Know Local Hospitals – Level 1 Trauma Centers
- ❑ Review Family FEMA Checklist for Disasters

**Sudden Cardiac Arrest:**
- ❑ Consider Cardiac Screening – EKG & Ultrasound
- ❑ Get CPR-AED Certified

**Choking & Drowning**
- ❑ Learn Heimlich Maneuver & Rescue Position

**Life Threatening Allergies**
- ❑ Venom, Meds, Food Allergies and Epinephrine Auto-injectors

**Opioids and Poisoning**
- ❑ Counterfeit Pills, Fentanyl, THC, and Nicotine Poisoning
- ❑ Vaping Dangers
- ❑ Narcan and Rescue Skills

**Major Trauma**
- ❑ Stop the Bleed Training
- ❑ Understanding Concussions

**Infections**
- ❑ Clean a Cut Save a Life
- ❑ COVID, Flu, and Pandemics

**Transportation Accidents**
- ❑ Non-traffic Drive-over Accidents
- ❑ Traffic Accidents, Risk Taking, and Substance Impairment

**Bullying & Suicide**
- ❑ Physical, Emotional, and Cyber-bullying
- ❑ Suicide Risk and Rescue

### College Freshmen:

**Basic Actions:**
- ❑ Medical Power of Attorney – college, home, and recreation US States
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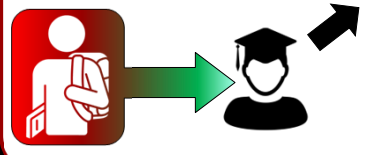
**High School Freshmen**





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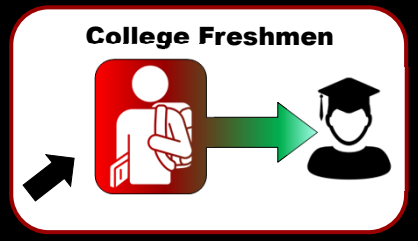
## Freshmen Survive & Thrive™ Checklists

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