ADA American Dental Association®

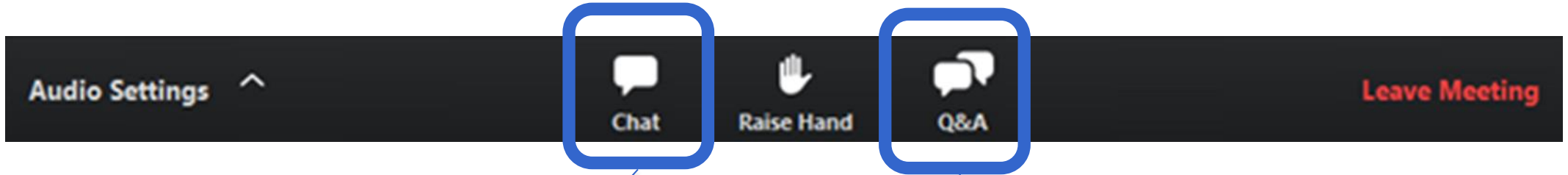
PCSS Providers Clinical Support System

Pharmacological Approaches to Dental Pain Management: Navigating Substance Use Risk

Kimberly A. Sanders, PharmD, BCPS
David Lesansky, DMD
May 24, 2023

ADA C·E·R·P® Continuing Education Recognition Program

To interact during the webinar:



Questions for the Technical Team

Questions for the presenter(s)

Disclosures

- Dr. Kimberly A Sanders has no relationships to disclose.
- Dr. David Lesansky has no relationships to disclose.

Target Audience

- This webinar is aimed at dentists, administrative staff, physicians, social workers, pharmacists, students and educators, and interprofessional teams.

- The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

Kimberly A. Sanders, PharmD, BCPS

Kimberly Sanders, Pharm.D., is a clinical assistant professor in the Division of Practice Advancement and Clinical Education at the UNC Eshelman School of Pharmacy. She also has a shared appointment as an assistant professor in the UNC Adams School of Dentistry. Sanders earned her Doctor of Pharmacy degree from Purdue University. She completed a one-year pharmacy practice residency at the University of Cincinnati Medical Center as well as a two-year academic postdoctoral research fellowship in pharmacy practice model advancement at UNC Eshelman School of Pharmacy. She is a board certified pharmacotherapy specialist. She also serves on North Carolina's Dental Opioid Workgroup led by the NC DHHS Oral Health Section and actively provides continuing education presentations on opioid prescribing and medication-related topics to dental providers across the state.

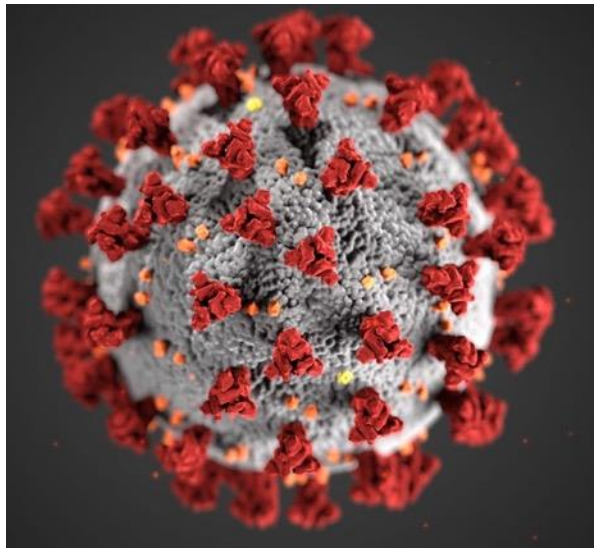
David Lesansky, DMD

David Lesansky, DMD earned his BS and DMD from the University of Florida. He is currently an owner dentist at University Dental Associates; Vice President of Clinical Care for University Dental Associates, Charlotte/Raleigh and Secretary to the Board of Directors. He has been practicing in the University area since 2010 and finds the relationships he's forged with his patients and patient families to be the most rewarding part of his job. Dr. Lesansky is an ADA Wellness Ambassador and passionate about mental health issues.
When not practicing dentistry, Dr. Lesansky is an avid photographer.

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Discuss safe pharmacological management of acute dental pain.
  - Navigate conversations and education for opioid use and misuse.
  - Describe the focus areas of the NC Dental Opioid Action Plan.
  - Discuss the need for referral for patients and providers.

Tale of Two Epidemics



Social determinants of health create greater vulnerability

Isolation may increase the risk of overdose deaths

Treatments and support systems may be disrupted

Social isolation increases the risk for addiction

Post-Pandemic Issues
- Trauma era
- Following those who regressed
- Access to recovery

AMA Issue Brief on opioid-related OD during COVID pandemic. https://www.ama-assn.org/system/files/2020-12/issue-brief-increases-in-opioid-related-overdose.pdf

PCSS Providers Clinical Support System

Acute Dental Pain

Pharmacological Approaches To Acute Dental Pain And Patient Considerations

- Appropriateness and individualization of prescribing
  - Pain type should drive treatment (e.g. tissue injury, nerve damage)
  - Co-morbidities
- Non-narcotic alternatives and efficacy
  - Scheduled vs. PRN
  - Enhanced with acetaminophen
  - Evaluate if patient really needs the “just-in-case” opioid prescription
- Develop a practice policy/protocol addressing the risk mitigation measures

Six Key Recommendations

1. If patients express desire to avoid opioids, alternative pain medications should be offered when clinically appropriate
2. Avoid prescribing opioids post-surgery if pain can be comfortably managed with NSAID/APAP
3. Non-pharmacological measures advised – cold and heat therapy; distraction therapy
4. Maximize non-narcotic pain medication (NSAIDs/APAP) with scheduled doses before opioids are considered unless contraindicated
5. Shared decision-making process with clinicians and patients
   - Fully informed of risks/benefits including addiction risk
6. Consideration of medical contraindications, risks for addiction, and aversion to such risks

Farooqi OA, et al. Int J Oral Maxillofac Surg 2020;49:397-402.
Moore PA, Hersh EV. JADA 2013;144(8):898-908. doi: 10.14219/jada.archive.2013.0207.

CDC Guidelines 2022

- Released November 2022
- Now include guidance related to painful acute conditions and pain related to procedures (dental)
- Expanded scope to include additional clinicians beyond PCPs
- Emphasis on alternatives and flexibility
- Classify pain:
  - Acute (< 1 month)
  - Subacute (1-3 months)
  - Chronic (> 3 months)

Providers Clinical Support System

Dowell D, et al. CDC. MMWR Recomm Rep 2022;71:1–95.

CDC Guidelines 2022 – 4 Key Areas

- Determining whether or not to initiate opioids for pain
- Selecting opioids and determining opioid dosages
- Deciding duration of initial opioid prescription and conducting follow-up
- Assessing risk and addressing potential harms of opioid use

Providers Clinical Support System

Dowell D, et al. CDC. MMWR Recomm Rep 2022;71:1–95.

Acute Pain:
Determining Whether to Initiate Opioids

- Nonopioid therapies are at least as effective as opioids for many common types of acute pain.
- Maximize use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate
- Only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient
- Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid

Dowell D, et al. CDC. MMWR Recomm Rep 2022;71:1–95.

PCSS Providers Clinical Support System

Adult Acute Orofacial Pain Guidance Management

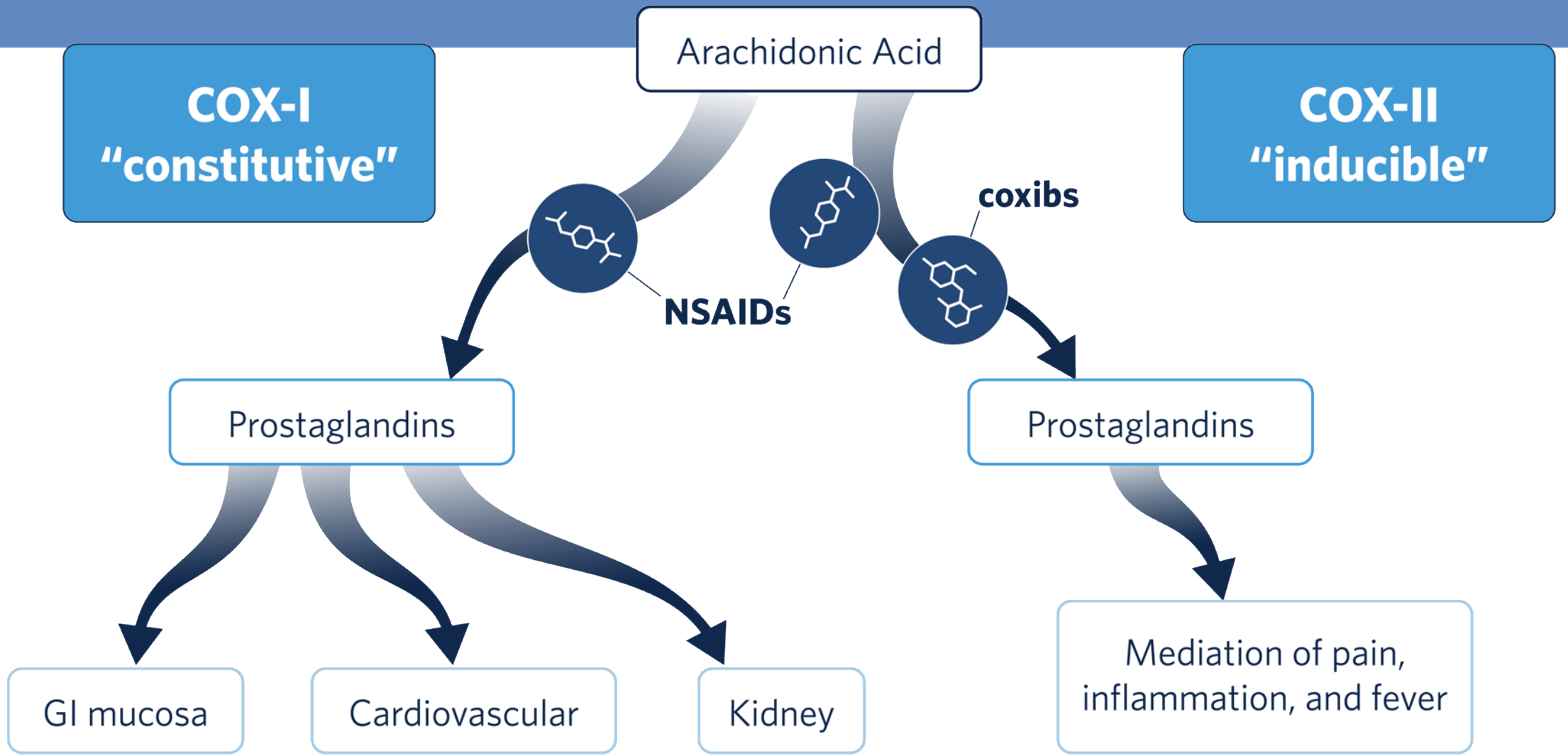
Pain Level	Treatment Examples	
Mild	OTC/Rx ibuprofen, naproxen, ketoprofen PRN	Ibuprofen 200-400 mg PO every 4-6 hours PRN
Mild-to-Moderate	Ibuprofen 400 mg to 600 mg every 4-6 hours for first 48-72 hours prn	Ibuprofen 400-600 mg PO every 6 hours x 24 hours, then every 4-6 hours PRN
Moderate-to-Severe	- Rx dose NSAID administered prior to procedure or immediately afterward - Administer a longer acting local anesthetic 0.5% bupivacaine - Post-op administration of Rx NSAID + APAP 650 mg for 48-72 hrs	Ibuprofen 600 mg + APAP 650 mg every 6 hours x 24 hours, then every 4-6 hours PRN “2-4-24 Regimen”
Severe	Rx Opioid (3-day supply) + APAP combo only if pain relief not achieved	

(AVOID exceeding maximum doses!)

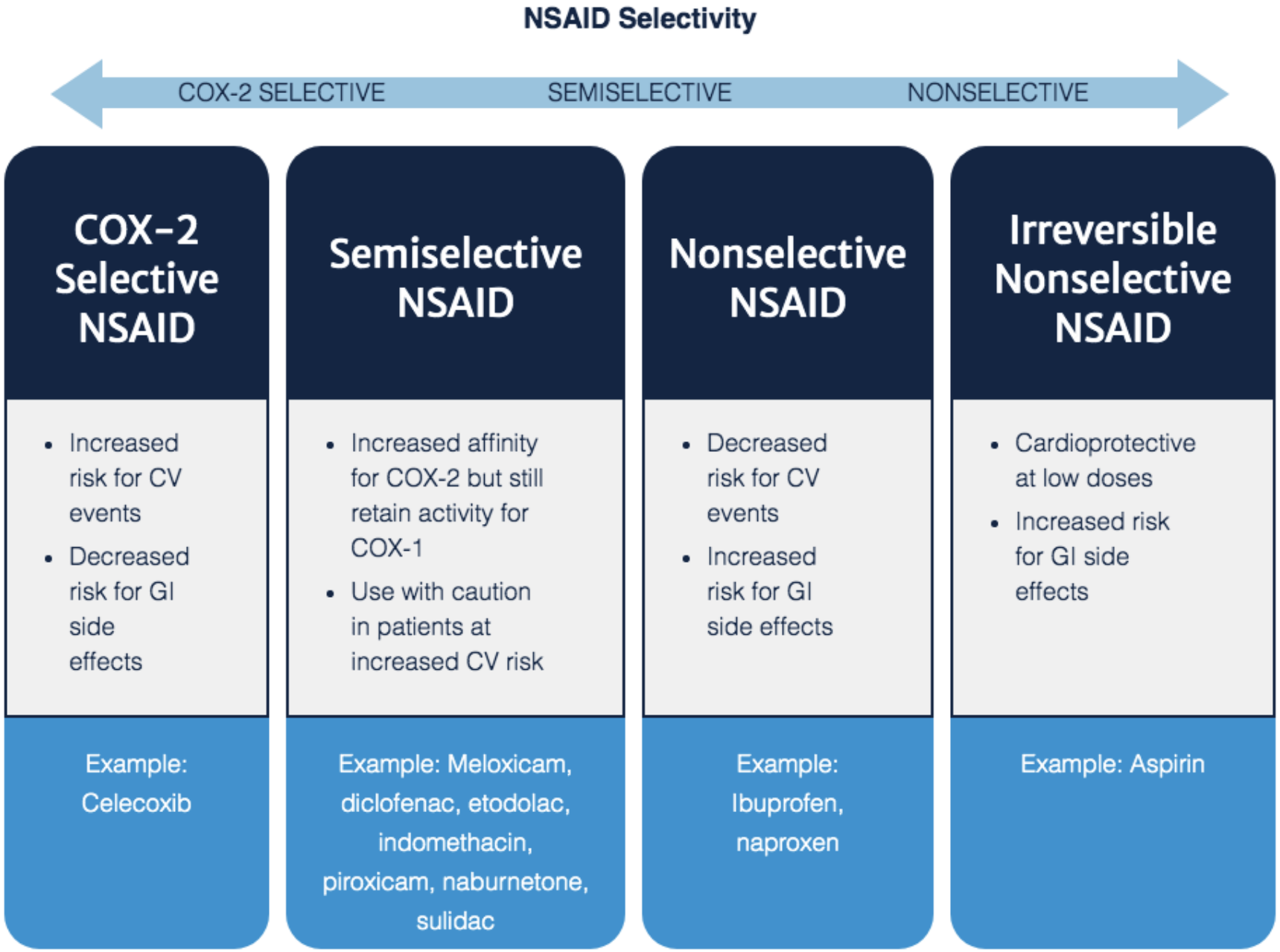
Dionne RA, et al. Compend Contin Edu Dent. 2016; 37:372-379.
Donaldson M. *Compend Contin Educ Dent*. 2017;38:334-335.

PCSS Providers Clinical Support System

Why NSAIDs?



PCSS Providers Clinical Support System



Adapted from: Gritsenko K. (2019) Nonsteroidal Anti-inflammatory Drugs (NSAIDs). In: Khelemsky Y., Malhotra A., Gritsenko K. (eds) Academic Pain Medicine. Springer, Cham. doi.org/10.1007/978-3-030-18005-8_13.

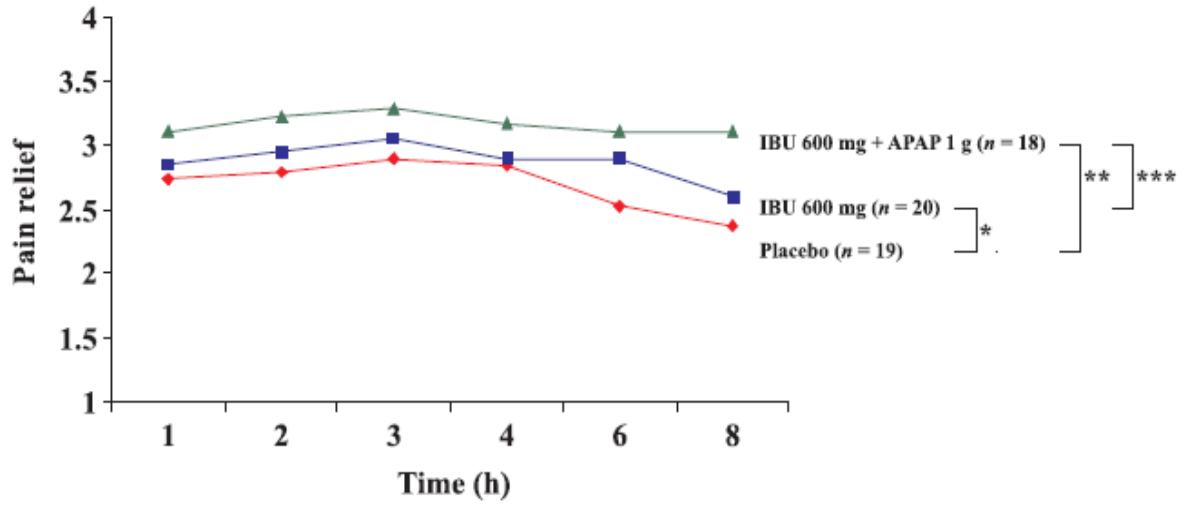
Why Acetaminophen?

- Mechanism for analgesia not well understood
  - Believed to be weak inhibitor of prostaglandin synthesis in the Central Nervous System (weak anti-inflammatory)
  - Work peripherally to block pain impulse

"When Two are Better than One"

Post-operative endodontic pain

- Avoid Ceiling-dose effect



Menhinick KA, et al. Int Endod J 37 (8), 531-541. 8 2004
Moore PA, et al. JADA 2013;144(8):898-908.

PCSS Providers Clinical Support System

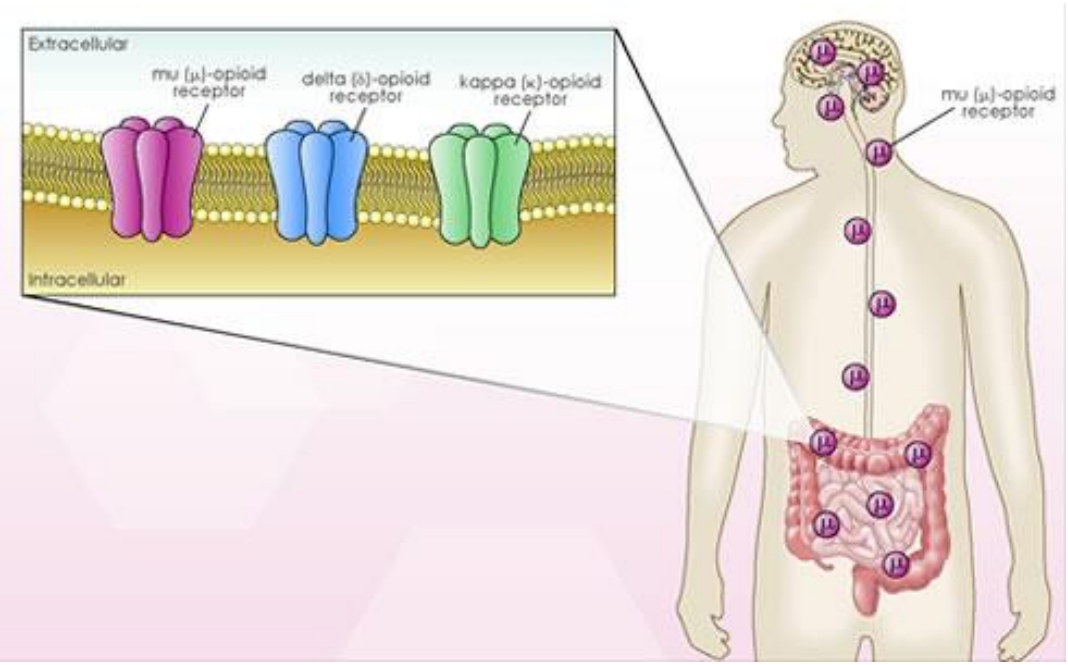
Acetaminophen (APAP)

- Generally safer option
- General Dosing
  - 325 mg – 650 mg every 4-6 hours as needed
  - 500 mg – 1000 mg every 6-8 hours as needed
- Maximum Daily Dose: 3000 mg or 3 g (some references state 4g)
- Provide synergistic effect when combined in alternating schedule with ibuprofen
- In 2013, FDA limited APAP components in combination products
  - Most opioid combos have suboptimal APAP dose in 1 tablet

Moore PA, et al. JADA 2013;144(8):898-908.
Moore PA, et al. JADA 2016;147:530-533

Why Opioids?

- Opioid drugs act in the **<u>brain stem</u> and <u>peripheral receptors</u>** → targeted actions plus adverse effects**:**
  - **<u>mu</u>: *analgesia***, respiratory depression, ***euphoria***, GI motility, miosis
  - **delta:** physical dependence
  - **kappa: *analgesia***, dysphoria, miosis



Waldhoer et al. Opioid receptors.
Annu Rev Biochem. 2004;73:953–90.

Evidence to Support Opioids?

- Opioid-based analgesics are NOT anti-inflammatory, so not drugs of choice for the major categories of nociceptive orofacial pain
- Reserved for small percentage of dental patients with severe, uncontrolled orofacial and postoperative pain
- Best prescribed as combination product with clear instructions for optimal effect

Goodchild JH, et al. *Three Drug Classes Every Dentist Should Know*, Western Books, 2015, Available from: Ebook library (Accessed May 2017)

What about Tramadol in Adults?

- Centrally acting analgesic
  - Weak opioid receptor action
  - Norepinephrine and serotonin reuptake inhibition
- Limited therapeutic advantage for managing acute postoperative pain as monotherapy
- Efficacy (studied at doses of 50-100 mg)
  - Similar to Codeine (at doses of 60 mg) monotherapy
  - Less than opioid combination (Codeine + APAP)

Moore PA. JADA 1999;130:1075-1079
Mehlisch DR, JADA 2002;133:861-871

Caution on Misuse: Tramadol

- Tramadol is a synthetic, centrally-acting analgesic binding to the mu opioid receptor, with inhibited reuptake of serotonin and norepinephrine.
- Opioid-like and atypical withdrawal occurs following downward titration of the dose, or abrupt discontinuation.
- Increased potential for Serotonin Syndrome: "**Triad of Trouble**" = tramadol, trazodone, & SSRI or SNRI.
- Remember: 100 mg = analgesia
  200 mg = opiate-like euphoria/hallucinations
  300 mg = seizures

Haynes A, et al. *Clin Toxicol*. 2016; 54(5): 434-40.

PCSS Providers Clinical Support System

Acute Pain:
Selecting Opioids and Determining Dosages

- If using opioid therapy for acute, subacute, or chronic pain, prescribe immediate- release opioids instead of extended-release and long-acting opioids
- For opioid-naïve patients, prescribe the lowest effective dosage.
- For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage.
  - If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy.

Dowell D, et al. CDC. MMWR Recomm Rep 2022;71:1–95.

PCSS Providers Clinical Support System

Acute Pain:
Deciding Duration of Initial Prescription

- "When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids."

- Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation.

- Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients

Dowell D, et al. CDC. MMWR Recomm Rep 2022;71:1–95.

PCSS Providers Clinical Support System

Assessing Risk and Addressing Potential Harms of Opioid Use

- Before starting, clinicians should evaluate risk for opioid-related harms and discuss risk with patients
- Include strategies to mitigate risk (including offering naloxone)
- Review the patient's history using state prescription drug monitoring program (PDMP) data (determine risk of overdose)
- Consider the benefits/risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances
- Caution when prescribing opioid pain medication and benzodiazepines concurrently (consider whether benefits > risks)
- Offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder (OUD).

Dowell D, et al. CDC. MMWR Recomm Rep 2022;71:1–95.

PCSS Providers Clinical Support System

Patient Considerations for Medical Conditions

Cardiovascular

- Hypertension (HTN)
- Heart Failure
- Coronary Artery Disease (CAD)
- Stroke prevention (Anticoag)
- Atrial Fibrillation

Endocrine

- Diabetes
- Thyroid

Psych/CNS (Mental Health)

- Antidepressants
- Anticonvulsants

Pain

- Nociceptive
- Neuropathic

Gastrointestinal

- GERD/Acid Reflux
- Constipation

Respiratory

- Asthma
- COPD

Patient Considerations: Chronic Pain

- **Questions to ask:**
  - What type of chronic pain do you have?
  - What are you currently taking for pain and how much? (Clarify any and all “as needed” medications and any herbal supplements)
  - Are you currently on a pain contract with a pain specialist/other provider?
    - If any history of taking suboxone, buprenorphine, methadone, naltrexone => avoid opioids
- **Precautions**
  - Avoid “double prescribing”
  - Educate patient on not going over maximum doses (this includes NSAIDS, acetaminophen)
  - Verify with NC PDMP
  - Watch out for other types of medications (benzodiazepines, antidepressants, antipsychotics)

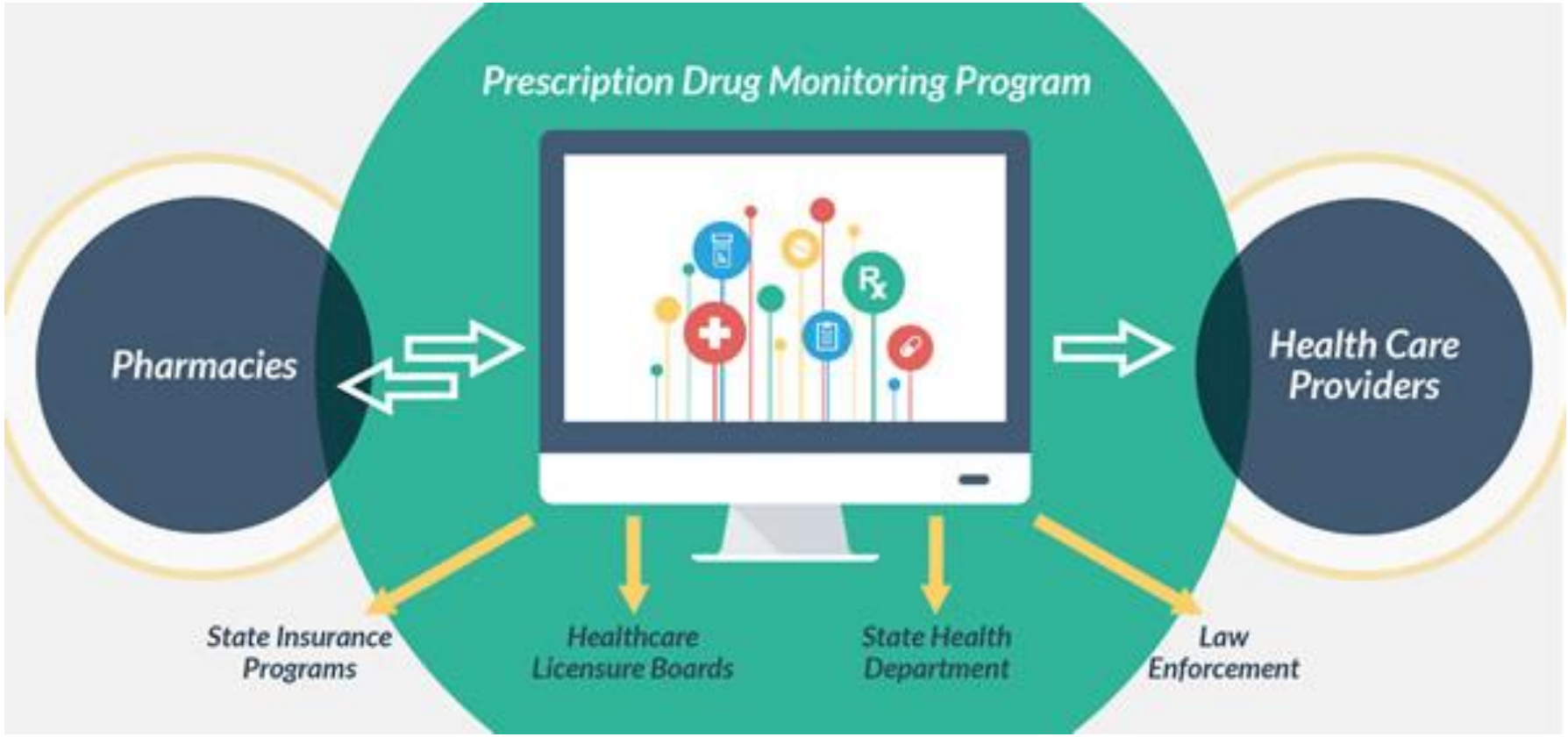
Navigating Conversations and Education for Optimal Treatment (Risk Mitigation/Treatment Toolbox)

Key Risk Mitigation Strategies

The goal of risk mitigation is to make opioid prescribing safer while maintaining access to opioid analgesics for those patients who are benefitting from them.

1. Assess patient history (medical conditions and medications) including screening for substance use
2. Use of the prescription drug monitoring program (PDMP)
3. Optimal patient communication practices and medication consideration for safe treatment (expectations)
4. Appropriate storage and disposal
5. Consideration for naloxone co-prescribing when appropriate.

Prescription Drug Monitoring Program (PDMP)
North Carolina Controlled Substance Reporting System (CSRS)



Patient Report:
- Rx Written Date
- Rx Fill Date
- Drug + Strength
- Quantity
- Days supply
- Prescriber
- Dispensing Pharmacy
- MME/Day
- Payment Type

Reporting Capabilities:
- Narx Score
- Overdose Risk Score
- Red Flags Report

https://www.cdc.gov/drugoverdose/pdmp/index.html
https://northcarolina.pmpaware.net/support

PCSS Providers Clinical Support System

Discussing Expectations

Helping patients set appropriate expectations for postoperative pain is another way to mitigate the prevalence of opioids. Key points to make with patients are noted below:

- Discuss with the patient that the surgery can cause pain, but that current pain management techniques are very good. In many post-operative procedures, the most severe pain the patient may feel is temporary.
- When appropriate, let the patient know that the pain will fade as healing occurs (timing of pain).
- Goal of controlling pain is to restore function (pain free may not always be achievable).
- Two-way communication between the patient and the provider is essential. It is important for the patient to convey realistic assessments of his/her pain.

Provider and patient resources

Substance Abuse and Mental Health Services Administration (SAMHSA) - http://www.samhsa.gov/

- Program directories (behavioral health, opioid treatment, etc.)
- Information topics on substance abuse and mental illness

Morepowerfulnc.org

Alcohol Drug Council of North Carolina - https://www.alcoholdrughelp.org/

National Institute of Drug Abuse (NIDA) - https://www.drugabuse.gov/

- Provider information related to science of drug abuse

Centers for Disease Control and Prevention (CDC) - https://www.cdc.gov/

- Opioid prescribing guidelines and substance abuse statistics

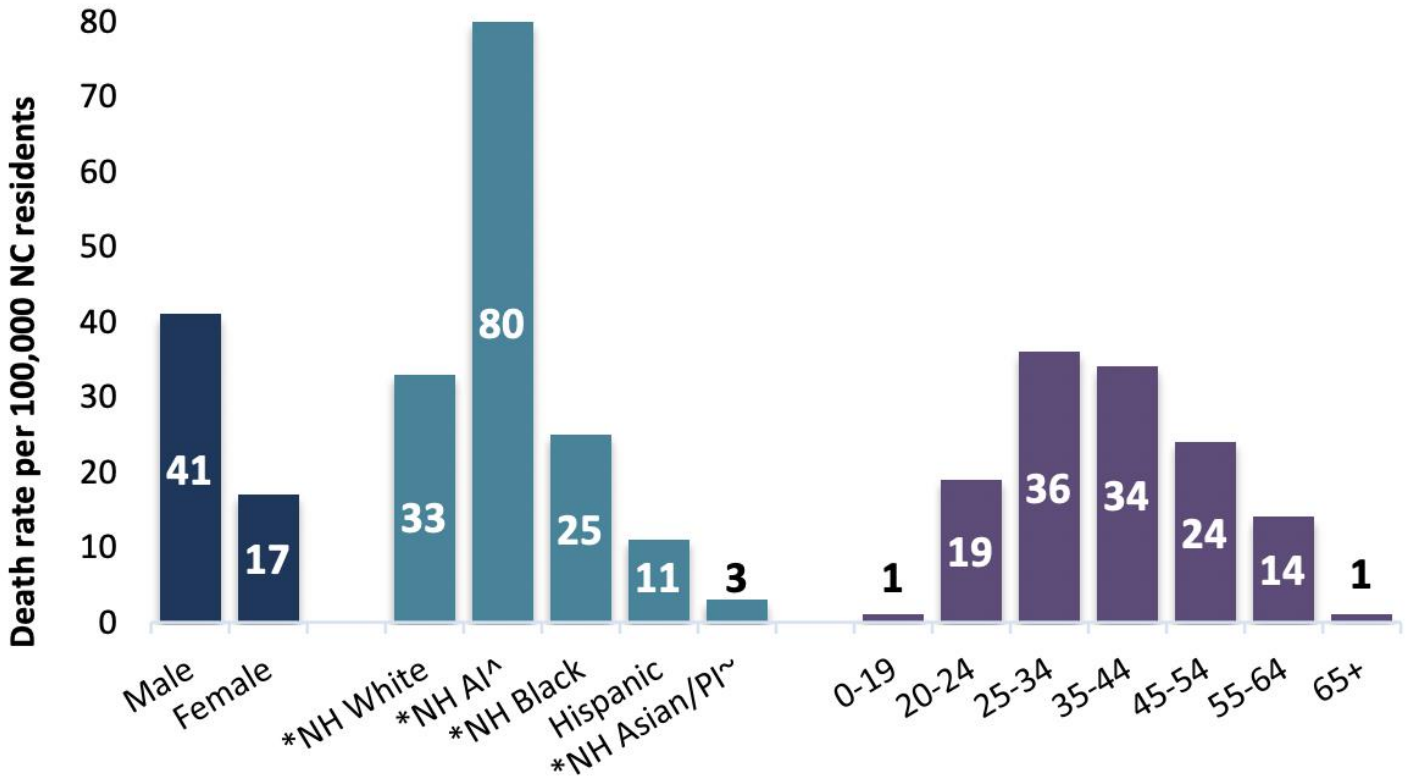
NC OPIOID ACTION PLAN

SB 616 – Heroin & Opioid Prevention & Enforcement (HOPE) Act
Reps. Horn & Murphy / Sens. Davis & McInnis

Protecting families, neighborhoods & communities by giving law enforcement authorities tools & resources to combat the opioid epidemic

PCSS Providers Clinical Support System

Demographic Snapshot, NC-SUDORS, 2020



*NH: Non-Hispanic ^AI: American Indian ~PI: Pacific Islander (Other/Unknown rate is not reported due to ≤ 10 deaths)
Demographic data were available for 100% (n=3075) of NC resident overdose deaths recorded in NC-SUDORS for 2020.
Source: NC-SUDORS, 2020

In 2020, the overdose death rate for male decedents was nearly 2.5 times the rate for female decedents.

American Indians had the highest rate of overdose deaths, almost 2.5 times the rate of the next highest group (NH whites). Overdose rates in historically marginalized populations also increased faster than those of NH white people statewide from 2019-2020.

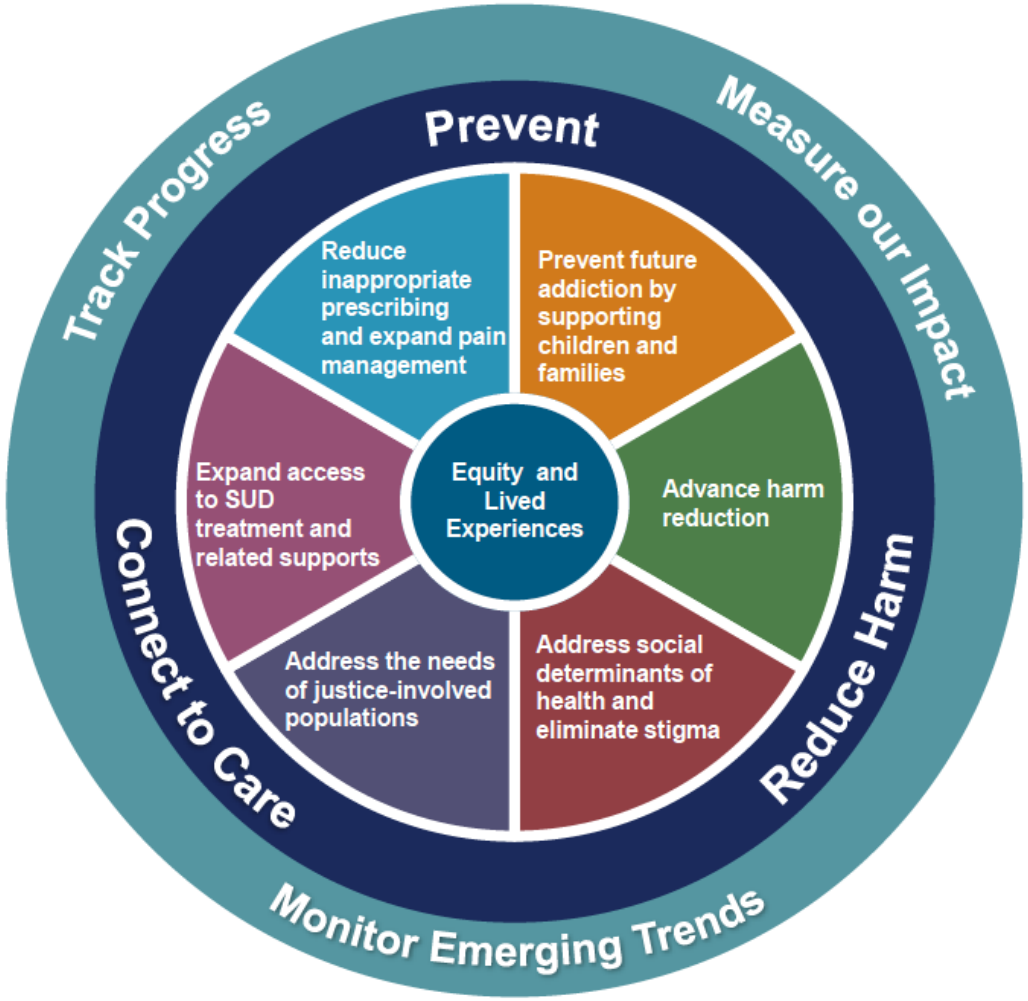
Fatal overdose rates were highest among adults aged 25-44, and were lowest among those 19 and younger and 65 and older.

NORTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES **https://www.injuryfreenc.ncdhhs.gov** **September 2022**

https://injuryfreenc.dph.ncdhhs.gov/DataSurveillance/2020-SUDORSfactsheet.pdf

PCSS Providers Clinical Support System

Opioid and Substance Use Action Plan



The Opioid and Substance Use Action Plan broadens its focus to include **polysubstance use** and **centers equity and lived experience**

https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/opioid-action-plan-data-dashboard
https://files.nc.gov/ncdhhs/Opioid-Action-Plan-2.0-6.11.19-final-web.pdf
https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/north-carolinas-opioid-action-plan

PCSS Providers Clinical Support System

NC DENTAL OPIOID ACTION PLAN

2022-2025

ADA Statements on Opioids

(2016, 2018)

The American Dental Association (ADA) recommends that dentists:

- Follow CDC guidelines for opioid prescribing
- Use nonsteroidal anti-inflammatory analgesics as first-line therapy for acute pain
- Check the state prescription drug monitoring program when prescribing opioids
- Discuss opioid safety, storage and disposal with patients
- Participate in continuing education on opioid prescribing 2018, Version 1

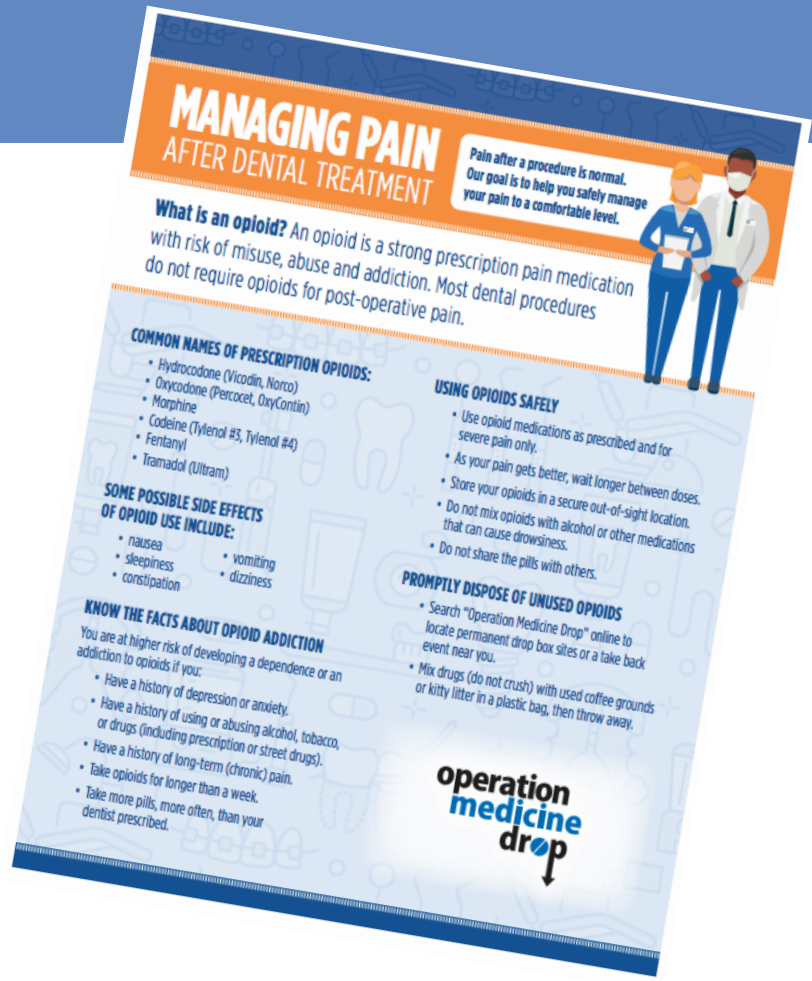
NC Opioid Action Plan Focus Areas

The NC Dental Opioid Action Plan aligns with the NC Opioid Action Plan to implement complementary strategies in the following focus areas:

https://www.dph.ncdhhs.gov/oralhealth/docs/DentalOpioidInfographic.pdf

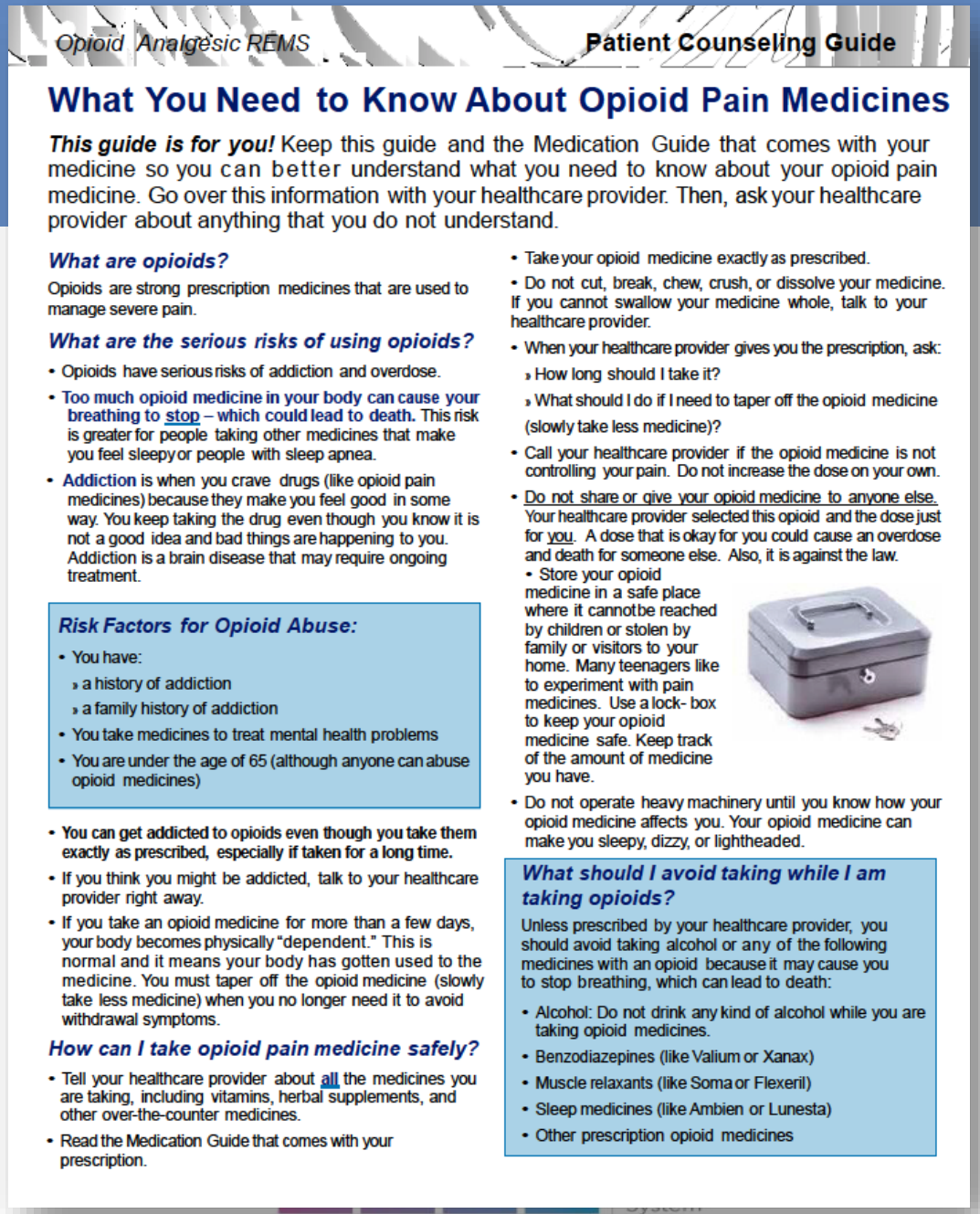
Resources

- More Powerful NC (https://www.morepowerfulnc.org/)
- NCDHHS Oral Health Section and NC Dental Society Resource Page for Dental Patients (https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/opioid-information-providers/information-dental)
- NC Opioid Action Plan Dashboard (https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/opioid-action-plan-data-dashboard)
- Never Use Alone Initiative – Phone number for people isolated during pandemic (800) 484-3731.



Workflow Change Implementation

- Developing and adapting institution policies and protocols
- Advocacy
- Referral processes
- Incorporation of Risk Evaluation and Mitigation strategies (REMS)
  - ***Opioid Analgesic REMS***



Opioid Analgesic REMS **Patient Counseling Guide**

What You Need to Know About Opioid Pain Medicines

This guide is for you! Keep this guide and the Medication Guide that comes with your medicine so you can better understand what you need to know about your opioid pain medicine. Go over this information with your healthcare provider. Then, ask your healthcare provider about anything that you do not understand.

What are opioids?

Opioids are strong prescription medicines that are used to manage severe pain.

What are the serious risks of using opioids?

- Opioids have serious risks of addiction and overdose.
- **Too much opioid medicine in your body can cause your breathing to stop – which could lead to death.** This risk is greater for people taking other medicines that make you feel sleepy or people with sleep apnea.
- **Addiction** is when you crave drugs (like opioid pain medicines) because they make you feel good in some way. You keep taking the drug even though you know it is not a good idea and bad things are happening to you. Addiction is a brain disease that may require ongoing treatment.

Risk Factors for Opioid Abuse:

- You have:
  - a history of addiction
  - a family history of addiction
- You take medicines to treat mental health problems
- You are under the age of 65 (although anyone can abuse opioid medicines)

- **You can get addicted to opioids even though you take them exactly as prescribed, especially if taken for a long time.**
- If you think you might be addicted, talk to your healthcare provider right away.
- If you take an opioid medicine for more than a few days, your body becomes physically "dependent." This is normal and it means your body has gotten used to the medicine. You must taper off the opioid medicine (slowly take less medicine) when you no longer need it to avoid withdrawal symptoms.

How can I take opioid pain medicine safely?

- Tell your healthcare provider about all the medicines you are taking, including vitamins, herbal supplements, and other over-the-counter medicines.
- Read the Medication Guide that comes with your prescription.
- Take your opioid medicine exactly as prescribed.
- Do not cut, break, chew, crush, or dissolve your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider.
- When your healthcare provider gives you the prescription, ask:
  - How long should I take it?
  - What should I do if I need to taper off the opioid medicine (slowly take less medicine)?
- Call your healthcare provider if the opioid medicine is not controlling your pain. Do not increase the dose on your own.
- Do not share or give your opioid medicine to anyone else. Your healthcare provider selected this opioid and the dose just for you. A dose that is okay for you could cause an overdose and death for someone else. Also, it is against the law.
- Store your opioid medicine in a safe place where it cannot be reached by children or stolen by family or visitors to your home. Many teenagers like to experiment with pain medicines. Use a lock- box to keep your opioid medicine safe. Keep track of the amount of medicine you have.

- Do not operate heavy machinery until you know how your opioid medicine affects you. Your opioid medicine can make you sleepy, dizzy, or lightheaded.

What should I avoid taking while I am taking opioids?

Unless prescribed by your healthcare provider, you should avoid taking alcohol or any of the following medicines with an opioid because it may cause you to stop breathing, which can lead to death:

- Alcohol: Do not drink any kind of alcohol while you are taking opioid medicines.
- Benzodiazepines (like Valium or Xanax)
- Muscle relaxants (like Soma or Flexeril)
- Sleep medicines (like Ambien or Lunesta)
- Other prescription opioid medicines

N C Med J. 2017;78(3):202-205.
N C Med J. 2018;79(3):177-178.
Opioid_Analgesic_2018_09_18_REMS_Document.pdf

Disposal of Unused Medications

- Operation Medicine Drop
  - https://ncdoi.com/OSFM/SafeKids/Operation%20Medicine%20Drop.aspx?sec=omd
- DEA Controlled Substance Public Disposal Locations
  - https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1
- National Prescription Drug Take Back Day (April and October)
  - https://www.deadiversion.usdoj.gov/
- Dispose of unused tablets properly:
  - Combine with coffee grinds or kitty litter. Place mixture in a sealed bag.

Patient Case Scenario Discussion

Gloria is a 68-year-old woman who presents with plan for 3 dental extractions…

PMH: Hypothyroidism, Heart failure (Stage C, NYHA II), Atrial fibrillation, Anxiety

1. What questions do you have for the patient to further clarify their medical history?
2. What may you discuss with Gloria prior to the procedure?
3. What pain management treatment strategies would you try?

Medications

- Entresto (sacubitril-valsartan) 24-26 mg BID
- Furosemide 20 mg daily prn
- Carvedilol 12.5 mg BID
- Levothyroxine 88 mcg daily
- Apixaban 5 mg BID
- Acetaminophen 500 mg prn
- Sertraline 50 mg daily
- Alprazolam 0.25 mg BID prn

Patient Case Scenario Discussion

Gary is a 52-year-old man who presents with plan for 4 dental extractions…

PMH: Type II Diabetes (A1c 8.5%), Asthma, GERD, Chronic back pain

1. What questions do you have for the patient to further clarify their medical history?
2. What may you discuss with Gary prior to the procedure?
3. What pain management treatment strategies would you try?

Medications

- Metformin 1000 mg BID
- Ozempic 1 mg SQ once weekly
- Albuterol inhaler 1-2 puffs Q6h prn
- Advair (flucticasone/salmeterol) 250 mcg/50 mcg 1 inhalation BID
- Omeprazole 40 mg once daily
- Tizanidine 4 mg once daily prn

REFERRING FOR HELP

Opioid Epidemic: Addiction Statistics

The opioid epidemic is considered a public health emergency, with 136 deaths per day and climbing.

Key Findings

50K	Almost 50,000 people die every year from opioid overdose.
10M	Over 10 million people misuse opioids in a year.
72%	Opioids are a factor in at least 7 out of every 10 overdose deaths

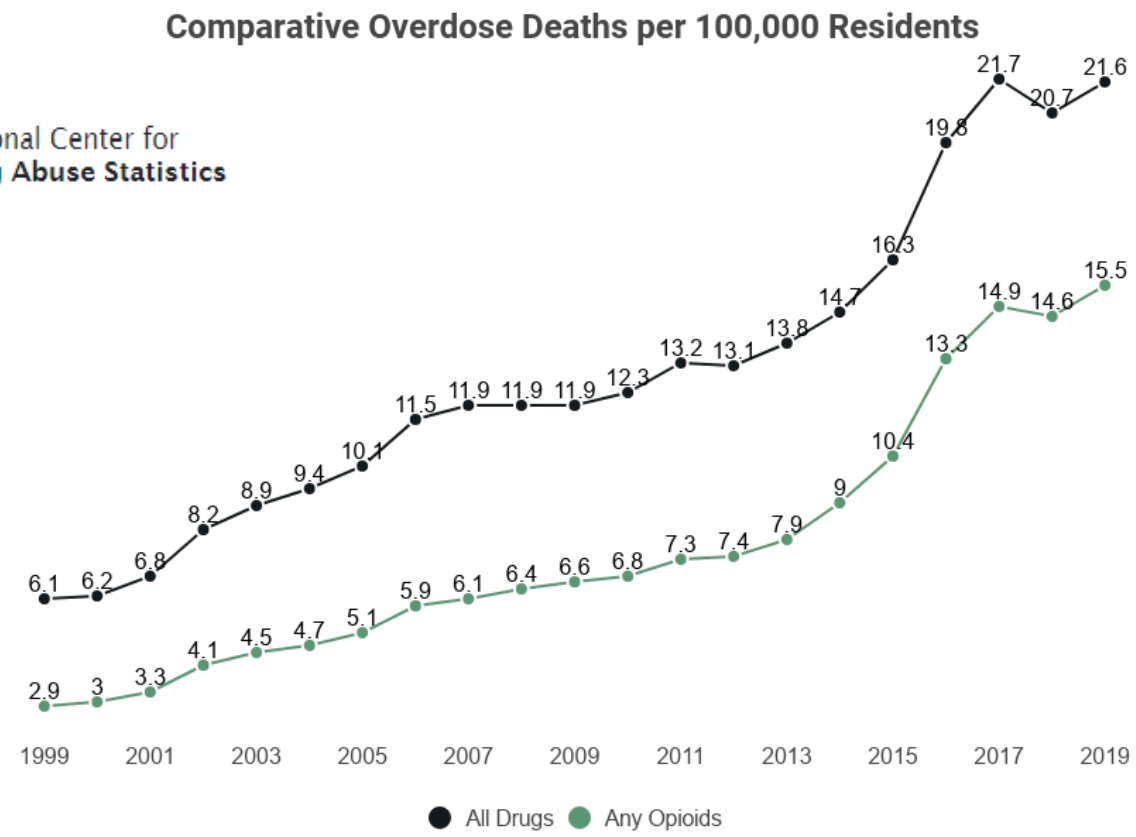
[Opioid Crisis Statistics [2023]: Prescription Opioid Abuse (drugabusestatistics.org)]

NCDAS National Center for Drug Abuse Statistics

PCSS Providers Clinical Support System

[Opioid Crisis Statistics [2023]: Prescription Opioid Abuse (drugabusestatistics.org)]

NCDAS National Center for Drug Abuse Statistics

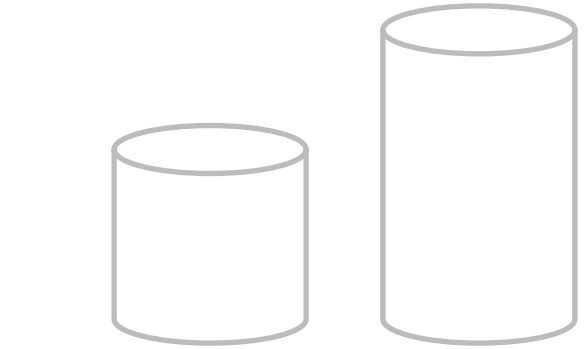


PCSS Providers Clinical Support System

Dentists are MORE likely than non-dentists to become dependent

- Seems counterintuitive…right?

- General population faces a 10%-12% risk of substance dependency.
- Dentists between 12%-19% (According to *Arizona State Board of Dental Examiners*).



Risk of Chemical Dependency

Why (specifically) are dentists at risk?

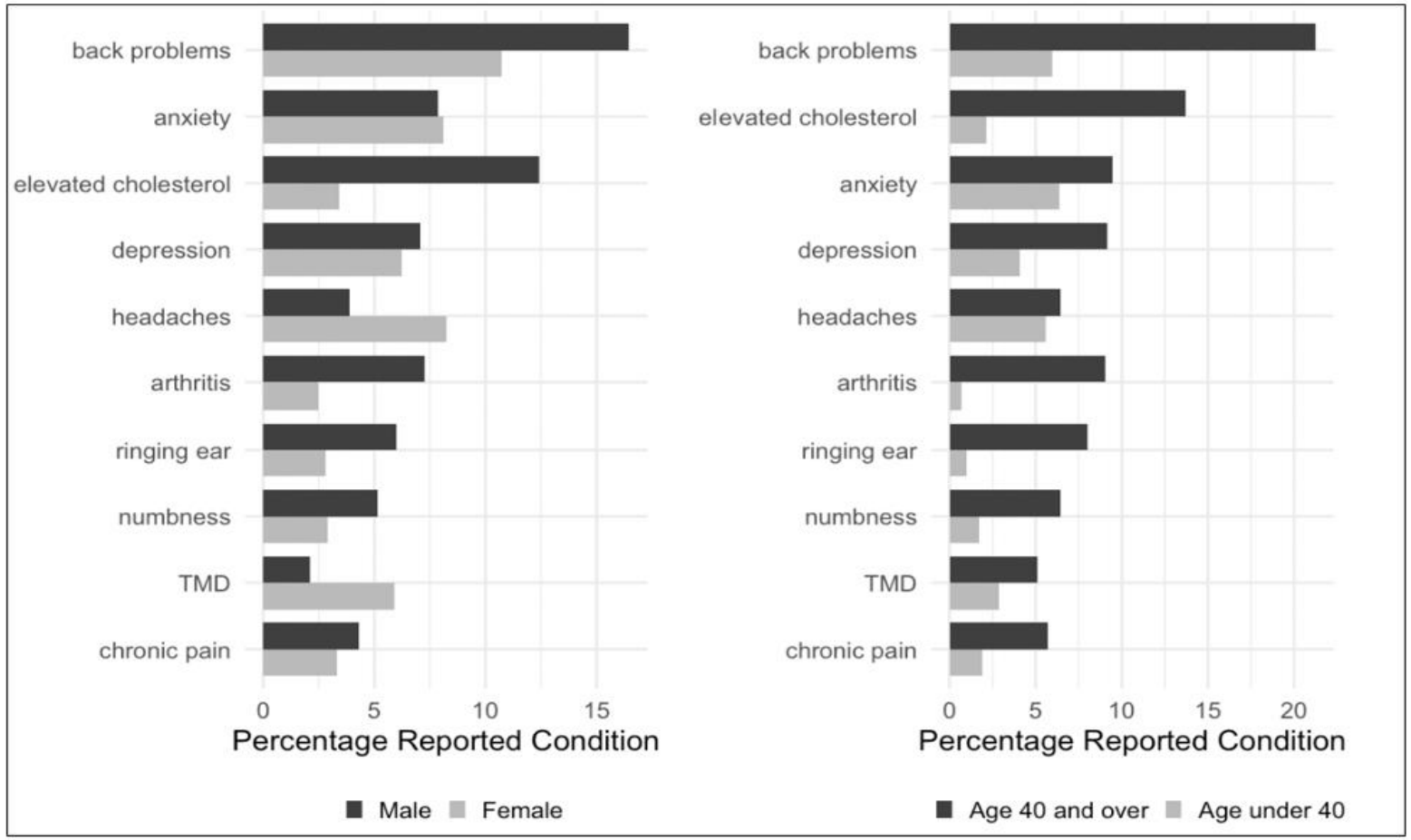
- Nature of work
- Economic impact of COVID
- Staffing
- Finances
- Leadership and operational demands

Why (specifically) are dentists at risk?

- ***Our own physical pain from repeated bodily stress!***

Image courtesy of https://healthlibrary.askapollo.com/what-causes-back-pain/

Self-Reported Medical Condition by Gender or Age, 2021



ADA 2021 Dentist Well-Being Survey

PCSS Providers Clinical Support System

As dentists, we are in a unique position…

- We understand the chemistry and pharmacology of opioids.
  - We know that they stimulate the pleasure receptors of the brain.
  - We know they are highly addictive and the risks involved.
    - Because we know this, we may be tempted to think can *outsmart* the opioids…

- We have access to prescription pads and colleagues…

Dr. Bill

- Bill is a friend of mine and a Wellness Ambassador himself. He has given me permission to share his journey through addiction and recovery.

- Substance dependency needs to be humanized, there needs to be a face put on it for it to be fully understood and the stigma **erased**.

- Bill lectures about his story across the country and knows sharing his experiences has the potential to help other dentists who may be struggling with their own disease.

The Set Up…

- 2 week summer vacation leads to a very busy first week back
- Very busy first week back in a solo practice leads to fatigue
- Fatigue leads to waking up Saturday morning with severe muscle spasms and severe radiating pains
- Severe pain leads to a visit with the orthopedic surgeon on Monday, 8/3/92
- Visit leads to Vicodin
- Vicodin leads to downward spiral

Bill's Risk Factors

- **Genetic** predisposition to addiction.
- Had **experimented** with drugs in college.
- **Stress** from life and practice.
- Marriage started falling apart.
- Thought since he knew the drug and knew the risks, he could *control* it.
- Finally…he had **ACCESS** through many different sources.

The Picture of Addiction

- Vicodin made Bill feel great and made him think it was the answer to all his problems. It removed his fear and made him feel invincible.
- Within one month, he started using more than was prescribed for daily use.
- At his peak, he was taking 25 Vicodin per day.

Finding Sources…

- Addiction made him resourceful, in the worst ways:
  - Stole pills
  - False prescriptions
  - Used samples
  - Considered going to the street for drugs

Thriving is Surviving, Right…?

- His practice was still successful and productive!
  - Full banded ortho cases
  - Implant placements with bone grafting
  - Third molar surgeries
  - 6 days per week, no patients turned away!

- But it took its toll…
  - Lead to physical and mental exhaustion
  - Ended in debt to the IRS over $120,000 with back taxes and penalties
  - Credit card debt was insurmountable
  - Checking account was overdrawn
  - Marriage and friendships torn apart
  - Sick and tired of feeling sick and tired

After 9 Years, Enough is Enough

- His *illness* finally lead to *impairment*.
- Finally, a family group meeting lead to a search for help.
- Illinois State Dental Society's Concerned Dentist Program

Illness versus Impairment…

- Federation of State Physician Health Programs (FSPHP) states:

"A practitioner's illness and impairment exist on a continuum with illness typically predating impairment, often by many years."

  - Illness is the existence of a disease (chemical dependency/abuse).
  - Impairment is a "…classification implying the inability of the person affected by the disease to perform specific activities."

https://www.fsphp.org/

Federation of State Physician Health Programs

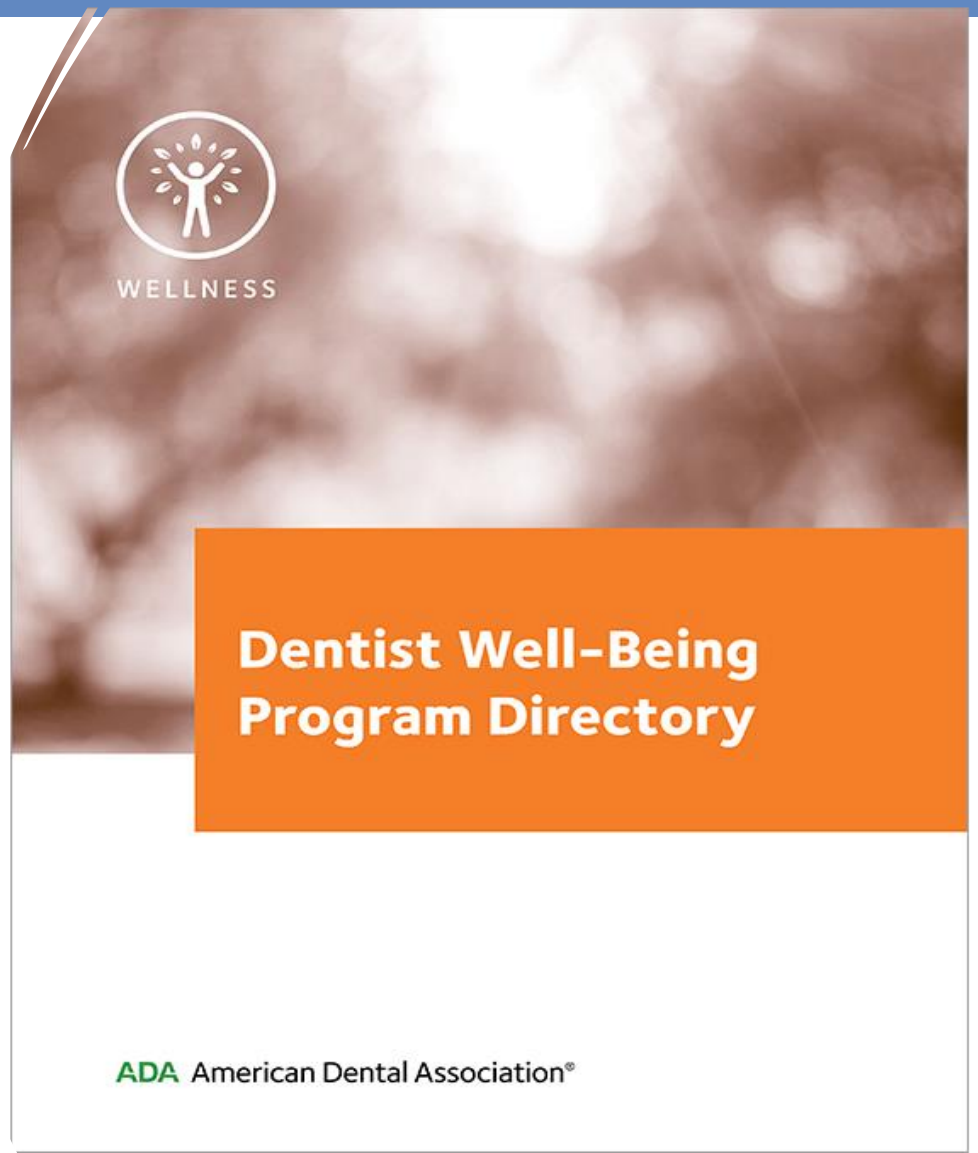
PCSS Providers Clinical Support System

Bill's End is Just His Beginning

- Bill was fortunate that he sought help before he harmed a patient and his license was put in jeopardy.
- Bill has been clean since 2001.
- Bill has a successful and thriving practice.
- Bill is a very vocal ambassador and crusader for providers in need.

Referring if in need of help

- Every state is different.
- North Carolina Caring Dental Professionals (NCCDP)
- ADA Dentist Well-Being Program Directory



North Carolina Caring Dental Professionals

- Voluntary help source
  - Refer yourself
  - Colleague or family member can refer you

- Board of Dentistry's involvement
  - None, if your license is not already under investigation and you maintain your status in a recovery program with regular progress check-ins and don't exhibit a risk to yourself or others.
  - Board can refer practitioners to the NCCDP if a licensee is under investigation.

https://nccaringdental.com/

North Carolina Caring Dental Professionals

- Recognize professional impairment
- Coordinate interventions
- Obtain appropriate levels of assistance
- Provide advocacy
- Monitor recovery
- Maintain confidentiality

https://nccaringdental.com/

North Carolina Caring Dental Professionals

- Executive Director Bill Claytor, Jr., DDS, MAGD
- Funded by portion of yearly license renewals
  with additional funding from North Carolina Dental Society.
- Non-profit agency *independent* of the State Board and State Dental Society.
- Executive membership includes members of the State Board, NCDS, UNC Adams School of Dentistry, ECU School of Dental Medicine, and representative hygienists.

https://nccaringdental.com/

Take Aways…

- No immunity to Opioid use disorder.
- No shame—anyone at anytime is susceptible.
- The stigma needs to be removed.
- Barriers need to be removed.
- Treatment can help.

In the End

“if you see something, say something.”

THANK YOU!

Questions?

Additional Resources

- **ADA.org/Wellness**
- ***pcssNOW.org***

PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

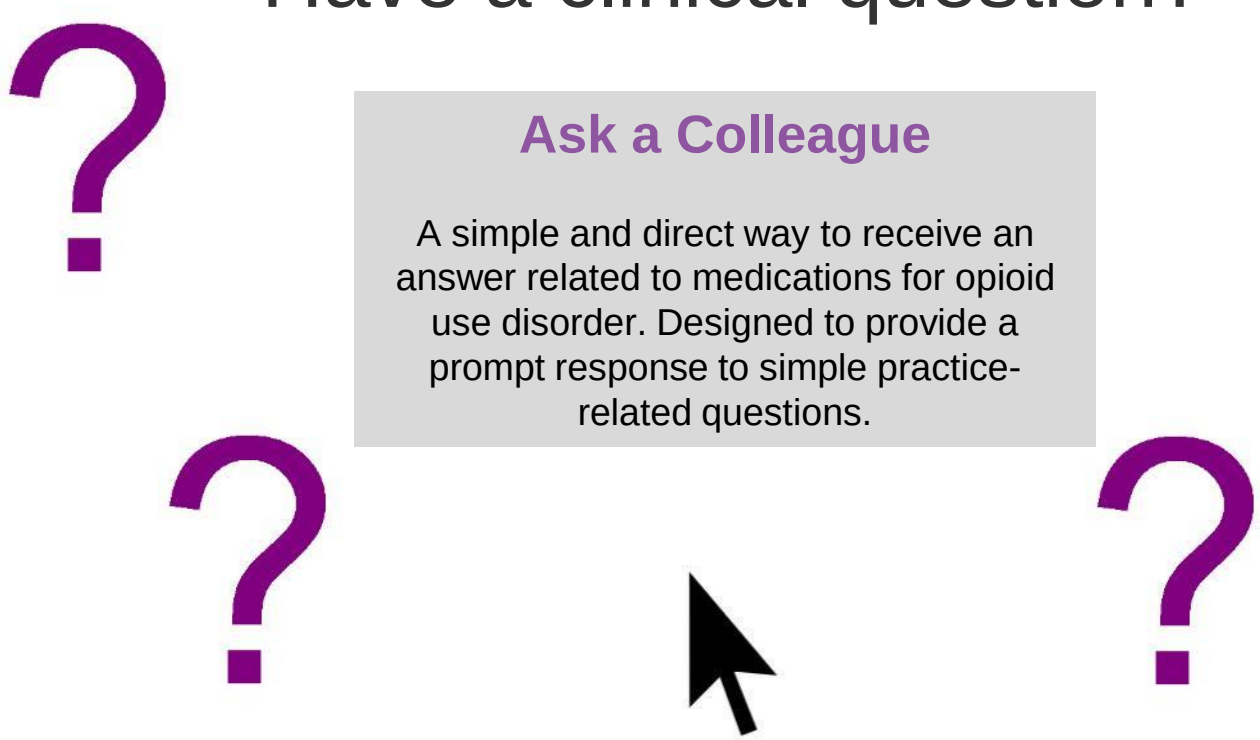
For more information visit:

https://pcssNOW.org/mentoring/

PCSS Providers Clinical Support System

PCSS Discussion Forum

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

PCSS Providers Clinical Support System

PCSS Providers Clinical Support System

PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association for Community Health Centers
American Dental Association	National Association of Social Workers
American Medical Association	National Council for Mental Wellbeing
American Osteopathic Academy of Addiction Medicine	The National Judicial College
American Psychiatric Association	Physician Assistant Education Association
American Psychiatric Nurses Association	Society for Academic Emergency Medicine

PCSS Providers Clinical Support System

@PCSSProjects

www.facebook.com/pcssprojects/

www.pcssNOW.org

pcss@aaap.org

Funding for this initiative was made possible (in part) by grant no. 6H79TI081968 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

ADA C·E·R·P® | Continuing Education Recognition Program

The ADA is a CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

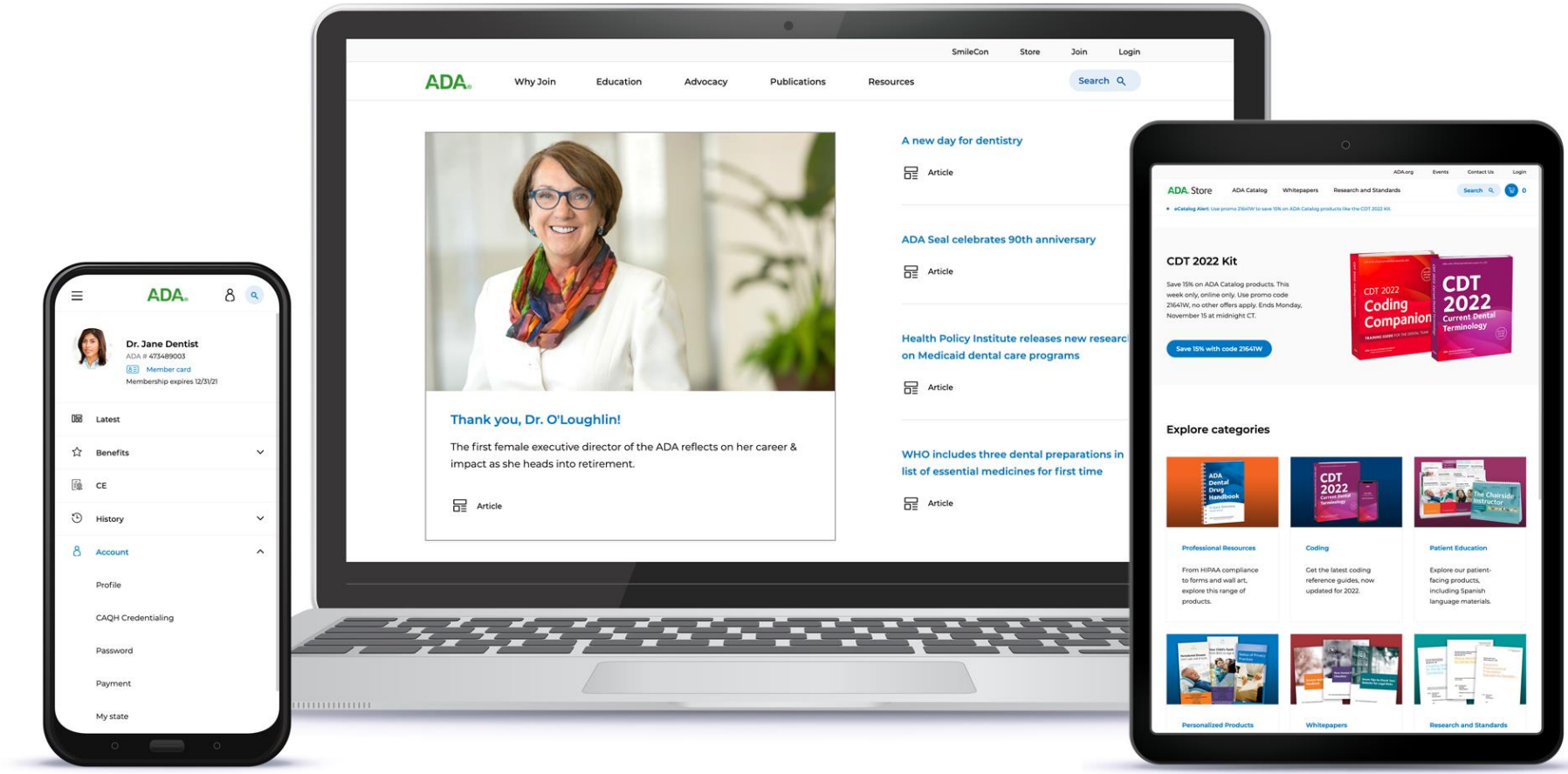
You will receive a CE Verification Letter to the email address you registered with within 7-10 business days.

Questions about CE, please email CE_Online@ada.org

A recording of this webinar will be available on ADACEOnline.org within 2 weeks

CE made easy.

Track your credits & learn about upcoming events in one spot at **ADA.org/MyADA**.



THANKS FOR JOINING US

No matter which path you choose, we're here to support you personally and professionally.

DR. EMMA GUZMAN
member since 2018