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NEWSLETTER OF THE NEW MEXICO ASSOCIATION OF NURSE ANESTHETISTS

MESSAGE FROM THE PRESIDENT

Fellow CRNAs,

I just finished placing an epidural. It was a common scenario: a patient writhing in pain; emotionally and physically exhausted; a quick procedure; and the miracle of epidural pain relief. We have the COOLEST job.

Recently, several CRNAs, including members of the NMANA board of directors, met with Bernailillo County Clerk Mrs. Maggie Toulouse Oliver, candidate for Secretary of State. As we explained our profession and our concerns to her she replied with words to the effect of: 'Thank you. Thank you for making me comfortable when I was in labor.

Legislators. Patients. The public. They need us, because we safely get them through one of the most painful, trying times of their lives. From the clinic to the OR suite, CRNAs have the awesome responsibility (meant both ways) of seeing people safely through to recovery. That privilege is ours because of the CRNAs before us who fought to keep our practice alive and growing.

This year is a big election year, including here in New Mexico. I encourage you to be active. Write a letter; make a phone call; meet a legislator. Tell them how valuable you are in your community.

As my term as President expires, I consider it a great honor to have represented our profession in Santa Fe and in numerous meetings with legislators. We have fought hard for patient and CRNA interests in the state. As I look at the future of anesthesia practice in New Mexico I see change. But whether that change is good or bad is for us to influence through our actions and voices.

To those of you who have written letters, met with legislators, or advocated in any way for our profession, I thank you. Thank you for helping to ensure that I can keep doing this awesome job: making people comfortable.

Andrew Passey , NMANA President

REGISTER TODAY

NMANA is proud to announce our first annual Balloon Fiesta Nurse Anesthesia Education Conference. We have partnered with ce2you.com to bring New Mexico the most up-to-date and hands on USGRA education.

This is a conference for CRNAs by CRNAs. Join us this October 7-9 at the world famed Hyatt Tamaya Resort and Spa. We will also feature our Region director, Alison Carter, as well as a representative from the NBCRNA for national updates. AANA approved for 18 CEs.

Register today at NMANA.org

CALLING ALL CRNAs!!!

We need you! Your state association represents your profession and stays on top of any issue that has the potential to negatively affect your livelihood, and patient safety. Several board positions will be available in October! Nominate someone you know, or nominate yourself to serve a two year term on the board. Travel is infrequent, but the opportunity to learn and serve is abundant! For more details, or to send in your nomination, contact Cindy Mock, NMANA secretary by September 1st, 2016. (cmock73@gmail.com)

TAKE ACTION - PROPOSED RULE ON VETERAN HEALTHCARE

In 2014 the VA collectively analyzed their current system and proposed a new model to improve access to timely, high-quality health care for Veterans. The Veterans Access, Choice and Accountably Act of 2014 was signed into law and requested an Independent Assessment of the VA's health care delivery systems and management processes.

In September 2015, The Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs Volume I: Integrated Report, was released. The recommendation concluded using existing resources and formalizing full nursing practice authority throughout VHA would improve access to care and decrease wait times.

The Veteran population is growing in numbers and complexity far outside the ability of the current costly healthcare model. With more than 1,700 facilities providing care to the Veteran population, the VHA is the nation's largest healthcare system. This system serves over 21 million veterans.

The proposed rule ensures that each APRN is privileged up to their level of education and expertise. This rule would make the VHA consistent with the existing U.S. Military service branches, which allow CRNAs and other APRNs to practice to the full scope of their education and abilities. Institution of the proposed rule would create universal standards for APRNs throughout the VHA healthcare system.

The federal agency is taking public comments now. Your comment will make a difference! TAKE ACTION NOW by submitting your comment on the following link. www.veteransaccesstocare.com

A Quick Reference for Managing Buprenorphine in the Perioperative Setting

July 14, 2016

by Jackie Kaiser CRNA

Prescription drug abuse is a real and epidemic issue plaguing our patient population. According to the national Institute on Drug Abuse it is estimated that between 24.6 and 36 million people abuse opioids worldwide [4]. Treatment for drug abuse has evolved from methadone clinics to, now, an office setting with buprenorphine based formularies.

Buprenorphine is a semi-synthetic opioid that has a strong partial mu receptor affinity with slow dissociation and is an antagonist at the k opioid receptors. As an analgesic, buprenorphine is at least 40 times more potent than Morphine, but it has a ceiling affect giving it a good safety profile. Buprenorphine is ideal to treat opioid and heroin abuse because it can be adjusted rapidly and has a low abuse potential when combined with naloxone. The use of buprenorphine has shown to increase the likelihood of long term abstinence and to reduce morbidity and mortality. Patients have markedly improved social and mental functioning such that they can hold jobs, avoid crime and violence, and reduce their exposure to blood borne infection. Patients also tend to engage more readily in counseling and other behavioral interventions essential to recovery [1].

Buprenorphine has shown great potential for successfully treating drug abuse. However, it poses unique challenges for perioperative management of patients using this medication because of its high affinity and slow dissociation from opioid receptors. Buprenorphine's opioid-blocking action can persist for several days after discontinuation of the medication, which makes conventional pain therapy difficult. These patients have a significantly increased tolerance for opioids and may require extremely high doses to achieve analgesia. Some methods that have proven to be effective are the use of non-opioid analgesics, including preemptive administration of celecoxib or gabapentin, postoperative ketorolac administration, use of local, such as preloading of the incision sites with local anesthetic before incision, regional to include continuous catheters and epidurals, or a combination of these techniques. [2]

Although there are currently no conventional therapies for effectively managing patients taking buprenorphine in the perioperative and postoperative areas, hospitals and surgical facilities are adopting guidelines that are proven to be successful. Minor Operations that only require local with sedation or monitored anesthesia care because of minimal anticipated pain, the recommend regimen is: 1. Continue buprenorphine maintenance therapy and titrate a short-acting opioid analgesic to effect. 2. Maximize non-opioid analgesia, regional techniques and adjunctive therapy; i.e. acetaminophen, NSAIDs. 3. OB patients: both laboring and elective/non elective C- sections recommend not stopping the buprenorphine for these pregnant patients. Plan a CSE for C-sections so that the epidural catheter may be used afterwards [3]. 4. Although an estimated 55% to 94% of infants born to opioid-dependent mothers in the United States show signs of opioid withdrawal, buprenorphine has been reported to produce little or no autonomic signs or symptoms of opioid withdrawal [1]. Major Operations that are elective admissions with anticipated moderate to severe pain, the recommend regimen is: 1. The patient must be tapered off of the buprenorphine to a short acting opioid for approximately 5 days prior to surgery. This is to be done by the prescribing physician. If this is not done for an elective case the patient is recommended to be cancelled and rescheduled. 2. Anticipate patient's course will be similar to a chronic opioid tolerant patient. 3. Regional analgesia – consider epidural or peripheral nerve catheter. 4. IV PCA with or without basal rate. 5. Maximize adjuncts, i.e. Ketamine or low-dose ketamine infusions. 6. Maximize non-opioid therapy, i.e. Acetaminophen, NSAIDS, gabapentin. 7. Restarting buprenorphine is done at the discretion of the prescribing physician [5]. Major Operations that are urgent or emergent admissions where tapering off buprenorphine is not an option, the recommend regimen is: 1. Discontinue buprenorphine. 2. Anticipate patient's course will be similar to a chronic opioid tolerant patient. 3. Regional analgesia – consider epidural or peripheral nerve catheter. 4. IV PCA with or without basal rate. 5. Maximize adjuncts, e.g. Ketamine or low-dose ketamine infusion. 6. Maximize non-opioid therapy, e.g. Tylenol, NSAIDS. 7. It is important to remember that the dose requirement of an opioid may drop as the buprenorphine dissociates from the mu receptor, which may take 24-72 hours after the last dose this scenario requires a monitored setting such as ICU, to avoid opioid induced respiratory depression from the high dose opioids 8. Restarting buprenorphine is done at the discretion of the prescribing physician [3].

The population of patients managed with buprenorphine is growing. We, as anesthesia providers, must be aware of current successful treatments and anticipate a multimodal collaborative approach when managing these patients in the perioperative and postoperative setting. Patients need to be educated on the expectations of postoperative analgesia and the need for close monitoring after major surgeries.

References:

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[2] Bryson, E. MD; Gevirtz, C. MD, MPH; Frost, E. MD. Perioperative Implications of Buprenorphine Maintenance Treatment for Opioid Addiction. Anesthesiology Clinics. 2011:49(1):147-155.

[3] Chern, S., Isserman, R., Chen, L., Ashburn, M., & Liu, R. (2012). Perioperative pain management for patients on chronic buprenorphine: A case report. Journal of Anesthesia Clinical Research, 3(250). p.1-4. Accessed July 13, 2016.

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[5] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. http://buprenorphine.samhsa.go

ARE YOU REGISTERED WITH THE PRESCRIPTION MONITORING PROGRAM?

New Mexico's drug overdose death rate has been one of the highest in the nation for most of the last two decades. New Mexico deaths due to prescription drugs (particularly opioid pain relievers) have increased dramatically. In addition to the high death rates, drug abuse is one of the most costly health problems in the U. S. In 2007, it was estimated that prescription opioid abuse, dependence, and misuse cost New Mexico $890 million.

Last year, overdose deaths rose to 536; making New Mexico the second highest death rate per capita at 26.4 per 100,000, compared to the national rate at 12.4 per 100,000 population. During 2010-2014, 53% of drug overdose deaths were caused by prescription drugs. Medical examiner data indicate that the most common drugs causing unintentional overdose deaths were prescription opioids (e.g., methadone, oxycodone, morphine 48%). In New Mexico and nationally, overdose death from prescription opioids has become an issue of enormous concern.

As of July 2013, New Mexico implemented an active Prescription Monitoring Program (PMP). All providers who carry a DEA and CSR License must register with this program. This program tracks prescribing practices in an effort to prevent fraud, waste, and abuse. It allows providers access to monitor their own prescribing and also to track their patients access to prescriptions. It is a restricted access online database created to reduce the diversion of these controlled substances while serving as a valuable tool for medical practice and patient care.

If you have not registered with the PMP please refer to the following link and do so. This is MANDATORY. http://www.nmpmp.org/

HONORING LENORE DUDGEON

NMANA is sad to share that on April 3, Past President Lenore Dudgeon passed away. Lenore worked tirelessly to promote CRNAs in New Mexico. Besides serving as president, she held various board positions as well as devoting time to lobby in Santa Fe and Washington DC. We are proud to announce a PAC cocktail party at our October Balloon Fiesta Education meeting to honor her memory. Lenore will be greatly missed but her legacy of advocating for the profession lives on.

NMANA Board of Directors

President
Andrew Passey
passeyak@gmail.com

Treasurer
Morgan Morrow
mmorrowcrna@gmail.com

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cmock73@gmail.com

Public Relations
Chris Lindquist
christylou60@gmail.com

Membership Outreach Coordinator
Ira Saunders
irasaunders@hotmail.com

Federal Political Director
Allen Mandeen
amandeen@msn.com

Member
Jennifer Shunick
jscoppens@hotmail.com

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Jackie Kaiser
slyjack16@aol.com

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cfelt77@gmail.com