Reducing Opioid Prescribing

"Primum non nocere"

Bret Bielawski, DO FACP

Disclosures

Objectives

- Be able to articulate to a patient the reasons why you are **NOT** going to prescribe opioids
- List the four main standards of care when **judiciously** prescribing opioids
- Be able to articulate why it is **time to taper off** opioids

Overview

- **Why** this occurred
- **Avoiding Opiates**
- **Four** Standards of Care
- Time to **Reassess**

How did this start?

*"only four cases of **reasonably** well documented addiction"*

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

NEJM 1980 302:123

Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases

Russell K. Portenoy and Kathleen M. Foley

Pain Service, Department of Neurology, Memorial Sloan-Kettering Cancer Center, and Department of Neurology, Cornell University Medical College, New York, NY 10021 (U.S.A.)

(Received 10 June 1985, accepted 28 October 1985)

"We conclude that opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse."

Pain 25 (1986) 171-186

Joint Commission Pain Standard PC.01.02.07

- **Rational:** The identification and treatment of pain is an important component of the plan if care. **Patients can <u>expect</u> that their health care providers will ask them about whether they have pain.** When pain is identified the individual is assessed based on his or her clinical presentation and in accordance with the care, treatment, and services provided by the organization.

The “5th Vital Sign”

Lanser P, Gesell S. Pain management: the fifth vital sign. Healthc Benchmarks 2001;8:68–70, 62.

JACHO Guide
2001

- “Some clinicians have **inaccurate** and **exaggerated concerns**" about addiction, tolerance and risk of death.”

- "This attitude prevails despite the fact **there is no evidence that addiction is a significant issue** when persons are given opioids for pain control.”

- The Joint Commission published a guide sponsored by ***Purdue Pharma***.

www.rwjf.org/en/grants/grant-records/1997/07/supporting-quality-improvement-and-jcaho-standard-setting-for-pa.html

Purdue settles OxyContin charge for $600M

Drugmaker in plea agreement with Justice Department over charges of misleading and defrauding doctors and consumers.

May 10 2007: 1:48 PM EDT

NEW YORK (CNNMoney.com) -- The maker of OxyContin, Purdue Pharma LP, agreed Thursday to a $600 million penalty as part of a plea deal with the Justice Department on a felony charge of misleading and defrauding physicians and consumers, the government said.

Three of the company's executives, including its CEO, general counsel and former chief medical officer, have separately agreed to pay $34.5 million in penalties. The company and the three men appeared in federal court Thursday to plead guilty.

The company also agreed to subject itself to independent monitoring and a remedial action program.

"Purdue ... acknolwedged that it illegally marketed and promoted OxyContin by falsely claiming that OxyContin was less addictive, less subject to abuse and diversion, and less likely to cause withdrawal symptoms than other pain medications - all in an effort to maximize its profits," said U.S. Attorney John Brownlee.

OxyContin maker to pay $19.5M settlement

"With its OxyContin, Purdue unleashed a highly abusable, addictive and potentially dangerous drug on an unsuspecting and unknowing public. For these misrepresentations and crimes, Purdue and its executives have been brought to justice," he added.

Purdue Pharma is privately owned. ■

http://money.cnn.com/2007/05/10/news/companies/oxycontin/index.htm?cnn=yes

Federation of State Medical Boards

- "**No disciplinary action will be taken** against a practitioner based solely on the quantity and/or frequency of opioids prescribed."

www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf. Accessed April 17, 2013

Los Angeles Times

California doctor convicted of murder in overdose deaths of patients

Rowland Heights doctor Hsiu-Ying "Lisa" Tseng and her attorney Tracy Green, left, listen as Tseng was convicted of second-degree

STAT | Reporting from the frontiers of health and medicine

https://www.statnews.com/2016/06/27/opioid-addiction-orrin-hatch-ron-wyden/?s_campaign=stat:rss

FIRST OPINION

Senators Hatch and Wyden: Do your jobs and release the sealed opioids report

A TIMES INVESTIGATION

OxyContin goes global — "We're only just getting started"

By HARRIET RYAN, LISA GIRION AND SCOTT GLOVER

DEC. 18, 2016

What is the largest source of Rx opiates for non-medical use?

a) **Prescribed** by > 1 **physician**
b) **Bought** from a **drug dealer/stranger**
c) **Given** by **friend/relative**
d) **Bought** from a **friend/relative**
e) **Stolen** from a **friend/relative**

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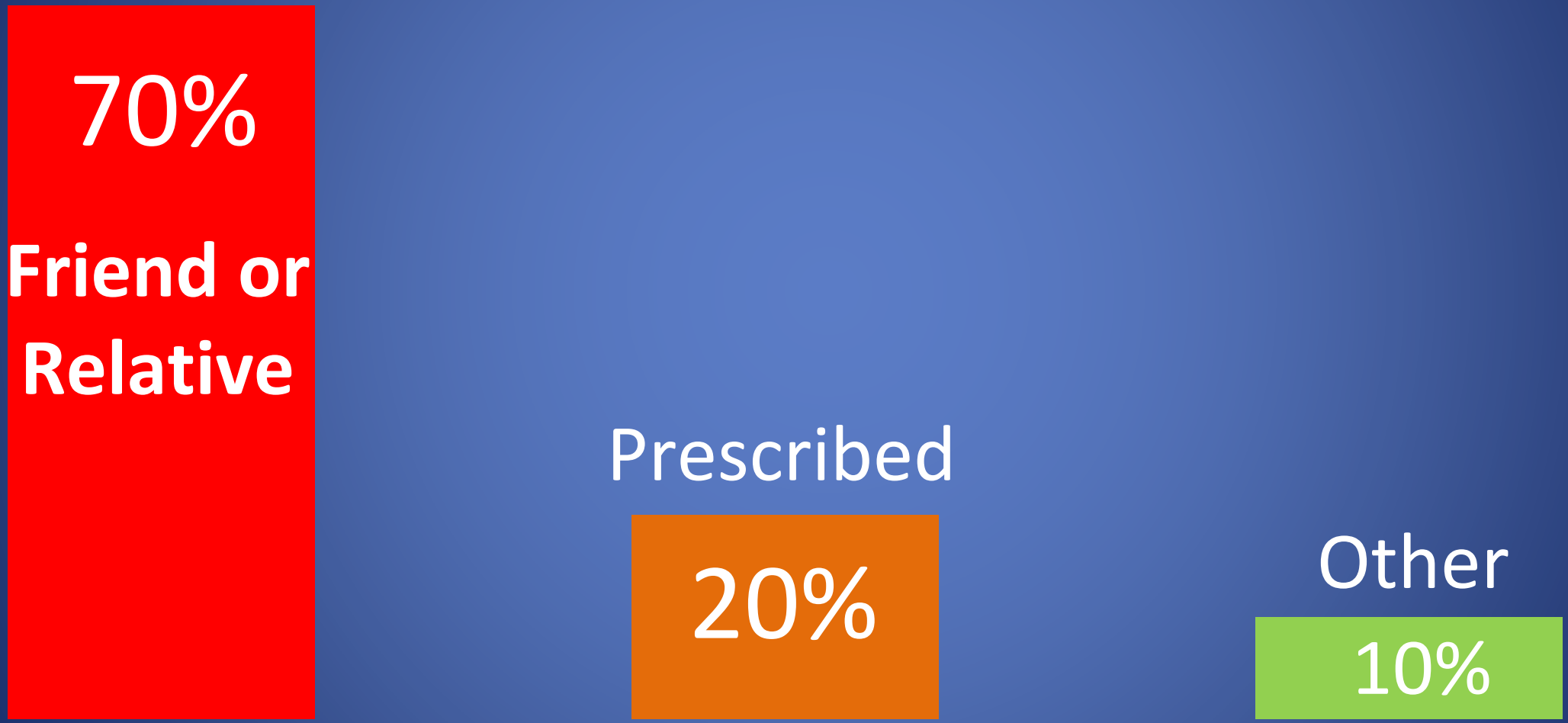
Sources of opioids for non-medical purposes



Jones CM, Paulozzi LJ, Mack KA. Sources of Prescription Opioid Pain Relievers by Frequency of Past-Year Nonmedical Use: United States, 2008-2011. JAMA Intern Med. 2014

Who Rx the most opioids in MI ?

A. Surgery

B. Pain management

C. ER/UC

D. Primary care

E. Oncology

Who Rx the most opioids in MI ?

A. Surgery (9%)

B. Pain management (10%)

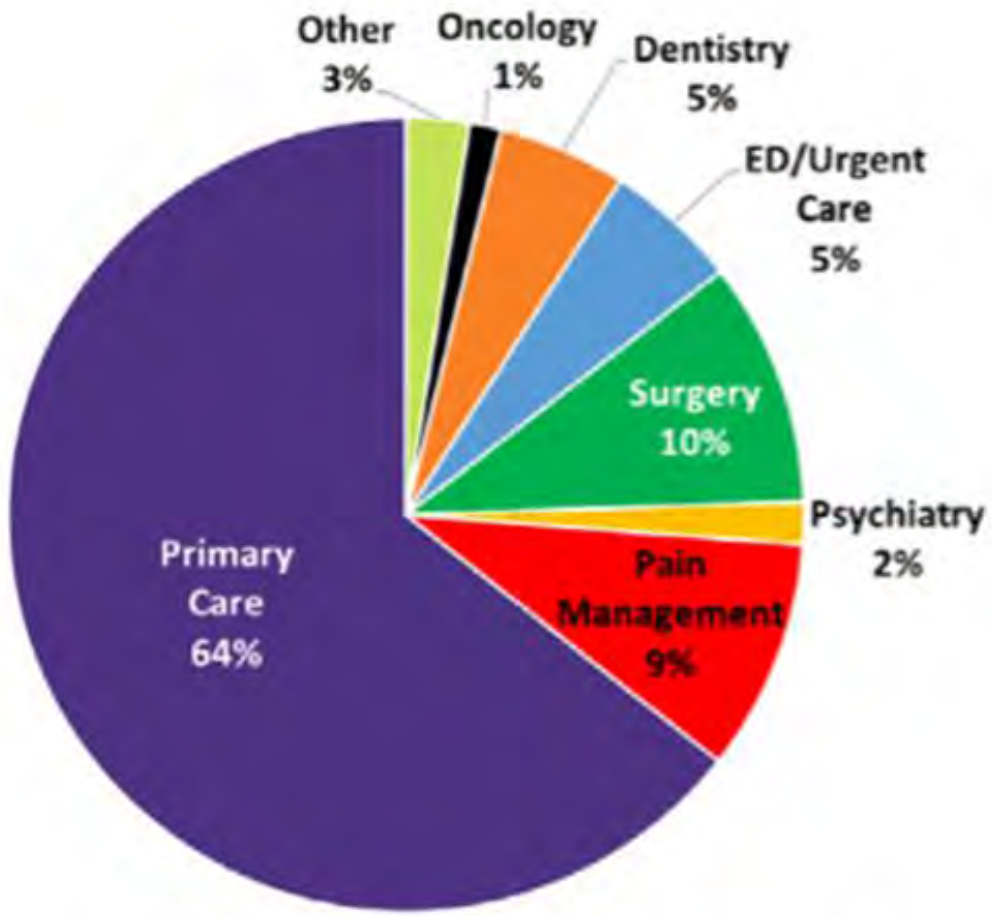
C. ER/UC (5%)

D. Primary care (64%)

E. Oncology (1%)

Prescriptions Written by Prescriber Specialty

APPRISS HEALTH



Number of Narcotic Prescriptions by Prescriber Specialty

Source: Michigan PDMP Oct. 23, 2012-Oct. 23, 2017 supplemented by NPPES NPI file
Note: Narcotic prescriptions exclude prescriptions classified as Buprenorphine MAT. Prescribers are characterized by their primary specialty. Excludes prescribers missing primary specialty classification. Other specialty includes specialties not classified elsewhere.

“This is why I’m not going to prescribe narcotics . . .”

Which of the following is not associated with opioids?

A. Opioid induced hyperalgesia
B. Hypothalamic hypogonadism
C. Physical dependence
D. Disturbed sleep architecture
E. Improved pain control with higher doses

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B. Hypothalamic hypogonadism
C. Physical dependence
D. Disturbed sleep architecture
E. **Improved pain control with higher doses**

Opioid Induced Hyperalgesia

- **Paradoxical increase** in pain
- **Diffuse allodynia** unrelated to the original pain source
- **Increasing pain** with **increasing dosage**

Lee, Marion et al. (2011) “A Comprehensive Review of Opioid-Induced Hyperalgesia.” *Pain Physician*, 14:145-161

Hypothalamic hypogonadism

- **Low testosterone and estrogen**.
  - Osteoporosis
  - 57% long acting and 35% short acting

American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2—guidance. Pain Physician. 2012 July;15:S67–116.

Disturbed Sleep Architecture

- Opioids decrease total sleep time, sleep efficiency, delta sleep, REM sleep and increase time spent in light sleep.[1]

Benyamin R, Trescot AM, Datta S, et al.
Opioid complications and side effects.
Pain Phys 2008;11:S105-S120

Tolerance

A condition in which **higher doses** of a drug are **required** to produce the **same effect** as during initial use.

Physical Dependence

An **adaptive** physiological state that occurs with **regular** drug **use** and results in a **withdrawal syndrome** when drug use is stopped.

Withdrawal: 4-24 hours

“Flu-like and leaky”

- Fever/Sweating
- Rhinorrhea
- Muscle cramps
- N/V/D/Abd cramping
- Insomnia
- Mydriasis
- Piloerection

Addiction

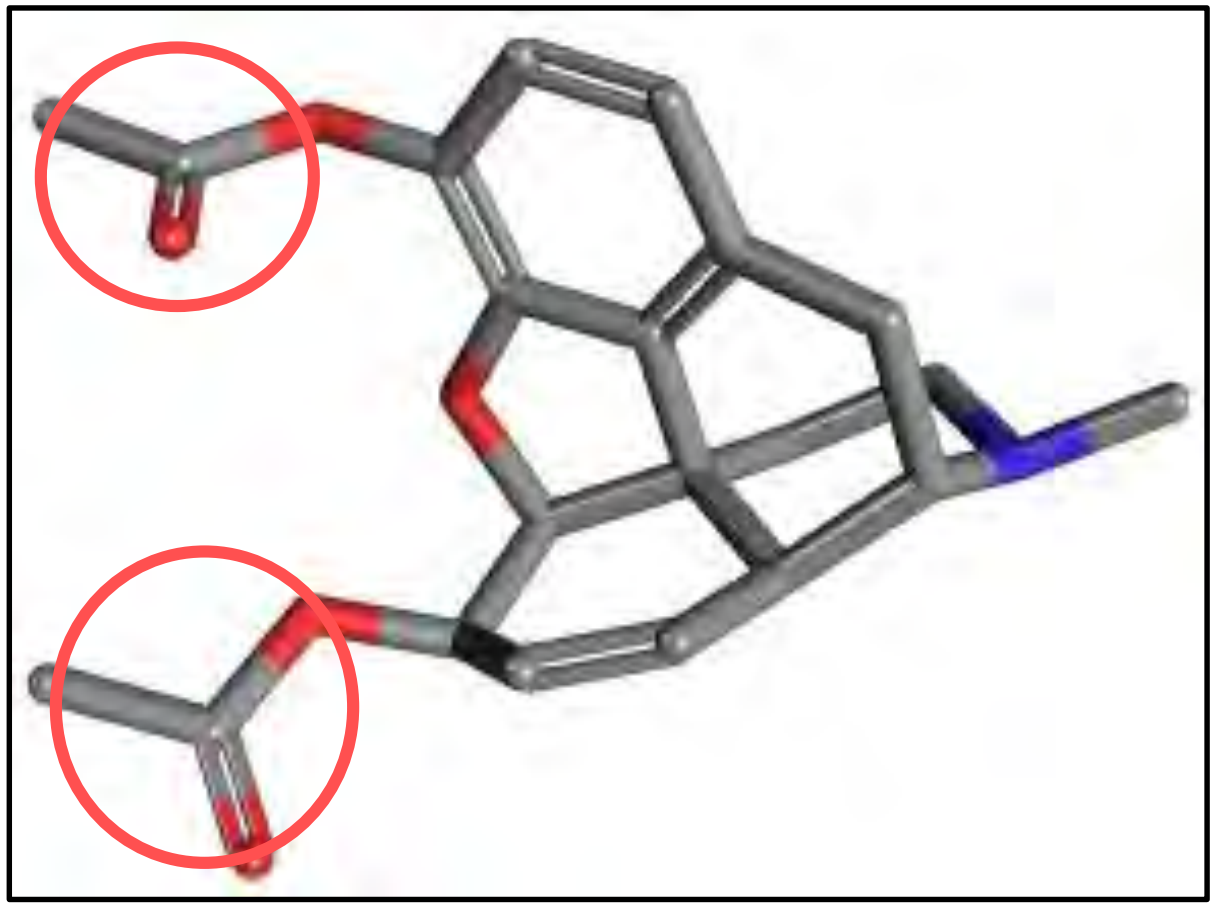
Compulsive use of a drug and **overwhelming involvement** with its **procurement** and use.

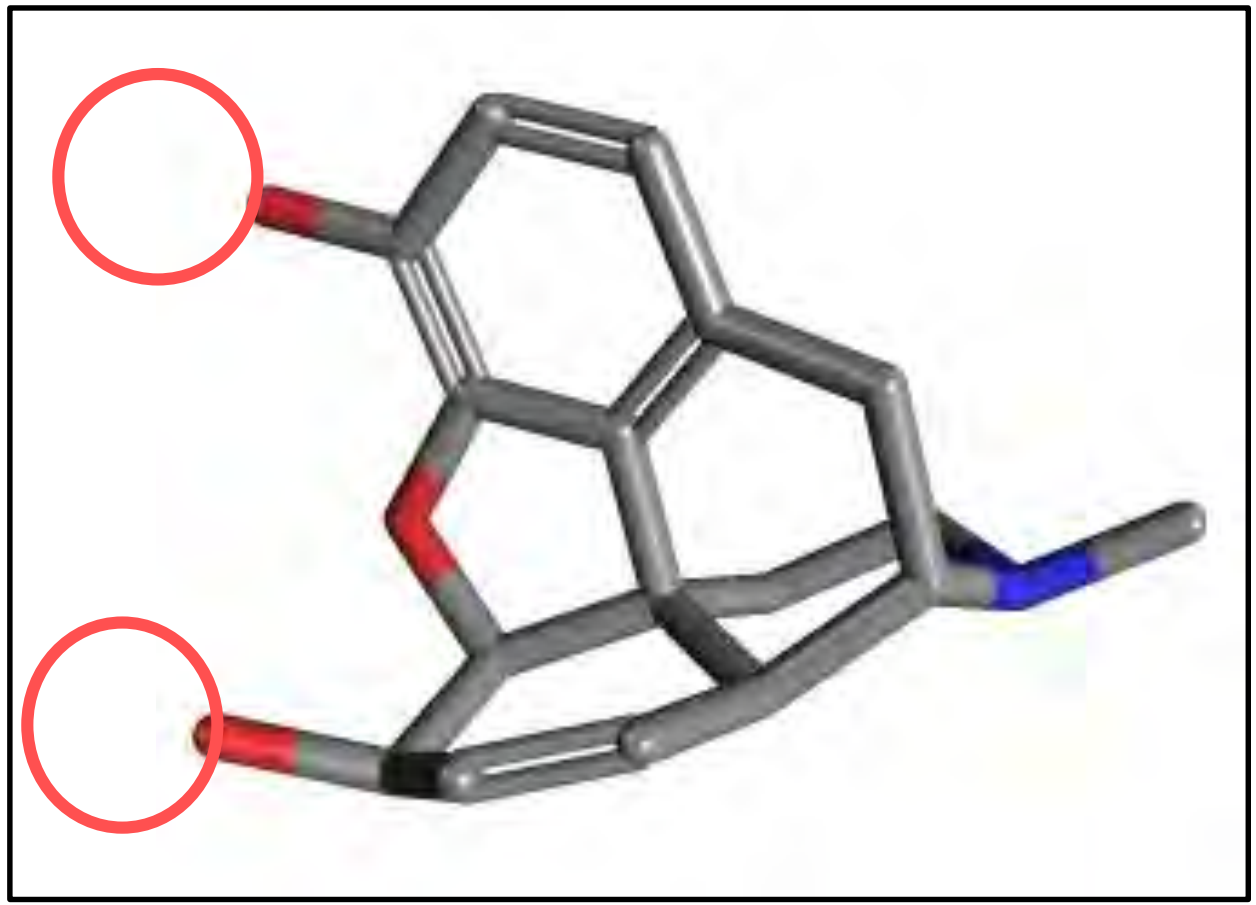
~80% heroin users started with prescription opioids

Jones CM. Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002-2004 and 2008-2010. Drug Alcohol Depend. 2013;132(1-2):95-100.

What's the difference?

Heroin → **6-MAM** → **Morphine**

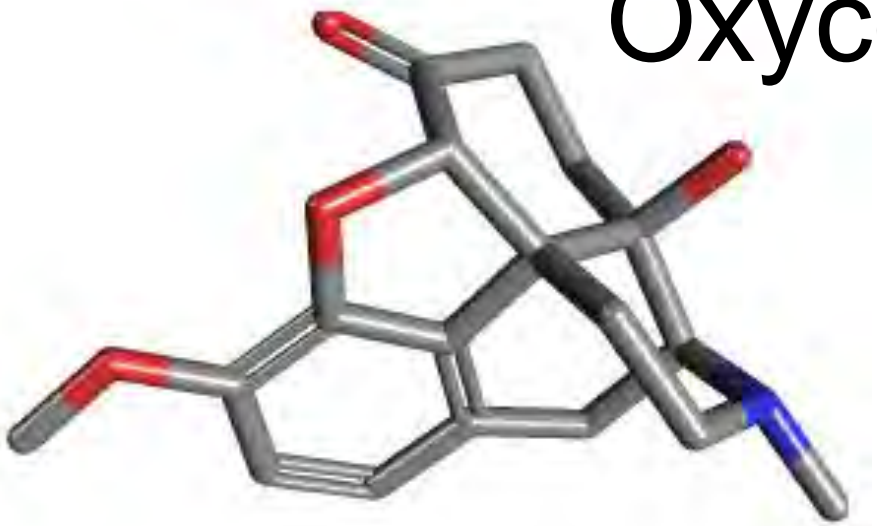




Hydrocodone

Morphine

Heroin



Oxycodone


OXYCONTIN
100-650 MGTB

Safer Alternatives

CDC Guideline for Prescribing Opioids for Chronic Pain - 2016

1. Use behavioral and physical therapies **before** medication, particularly opioids.

https://stacks.cdc.gov/view/cdc/38440(Accessed 10-2016)

Safer Alternatives

- Heat and cold treatments
- Exercise (Home Exercise Program), Handouts
- Yoga
- Physical and occupational therapy

Safer Alternatives

- Emotional and psychological support
- Mindfulness training
- Acupuncture
- OMM

World Health Organization Analgesic Ladder

Sustained release opioid or continuous infusion + short-acting opioid PRN ± non-opioid ± adjuvant agent

Short-acting opioid PRN ± non-opioid around the clock ± adjuvant agent

Acetaminophen or NSAIDs

Safer Alternatives

- Non-opioid medication
  - Compounded agents
  - Lidocaine patches
  - Gabapentin
  - Pregabalin
  - Duloxetine

American Society of Anesthesiologists®

Which of the following is the most important step(s) to take before prescribing opioids?

A. Risk assessment
B. MAPS
C. Urine Drug Screen
D. Pain Management Agreement
E. All the above

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D. Pain Management Agreement
E. All the above

Standard of Care

- Risk assessment
- MAPS
- Urine Drug Screen (UDS)
- Pain Management Agreement

Standard of Care

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Opioid Risk Tool (ORT

1. Age: 16-45

2. Hx Substance Abuse
   - Alcohol
   - Illegal Drugs
   - Prescription Drugs

3. Family Hx Substance Abuse
   - Alcohol
   - Illegal Drugs
   - Prescription Drugs

Table 1. Opioid Risk Tool: *Check box if factor applies (0–3 points—low risk, 4–7 points—moderate risk, ≥8 points—high risk).*

FACTOR	MALE PATIENTS	FEMALE PATIENTS
Family history of substance abuse		
• Alcohol	❑ 3 points	❑ 1 point
• Illegal drugs	❑ 3 points	❑ 2 points
• Prescription drugs	❑ 4 points	❑ 4 points
Personal history of substance abuse		
• Alcohol	❑ 3 points	❑ 3 points
• Illegal drugs	❑ 4 points	❑ 4 points
• Prescription drugs	❑ 5 points	❑ 5 points
Age between 16 and 45	❑ 1 point	❑ 1 point
History of preadolescent sexual abuse	❑ 0 points	❑ 3 points
Psychiatric disease		
• Attention deficit disorder, obsessive–compulsive disorder, bipolar disorder, schizophrenia	❑ 2 points	❑ 2 points
• Depression	❑ 1 point	❑ 1 point

Opioid Risk Tool (ORT)

4. Mental Illness
   - ADD/OCD/Bipolar/Schizophrenia
   - Depression – separate scoring
5. Hx Preadolescent Sexual Abuse

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FACTOR	MALE PATIENTS	FEMALE PATIENTS
Family history of substance abuse		
• Alcohol	❑ 3 points	❑ 1 point
• Illegal drugs	❑ 3 points	❑ 2 points
• Prescription drugs	❑ 4 points	❑ 4 points
Personal history of substance abuse		
• Alcohol	❑ 3 points	❑ 3 points
• Illegal drugs	❑ 4 points	❑ 4 points
• Prescription drugs	❑ 5 points	❑ 5 points
Age between 16 and 45	❑ 1 point	❑ 1 point
History of preadolescent sexual abuse	❑ 0 points	❑ 3 points
Psychiatric disease		
• Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	❑ 2 points	❑ 2 points
• Depression	❑ 1 point	❑ 1 point

Opioid Risk Tool (ORT)

- Low Risk 0-3
- Moderate Risk 4-7
- High Risk ≥ 8

opioidrisk.com

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Standard of Care

- Risk assessment
- MAPS
- Urine Drug Screen (UDS)
- Pain Management Agreement

Who Rx the highest doses (MME) in MI?

A. Surgery

B. Pain management

C. ER/UC

D. Primary care

E. Oncology

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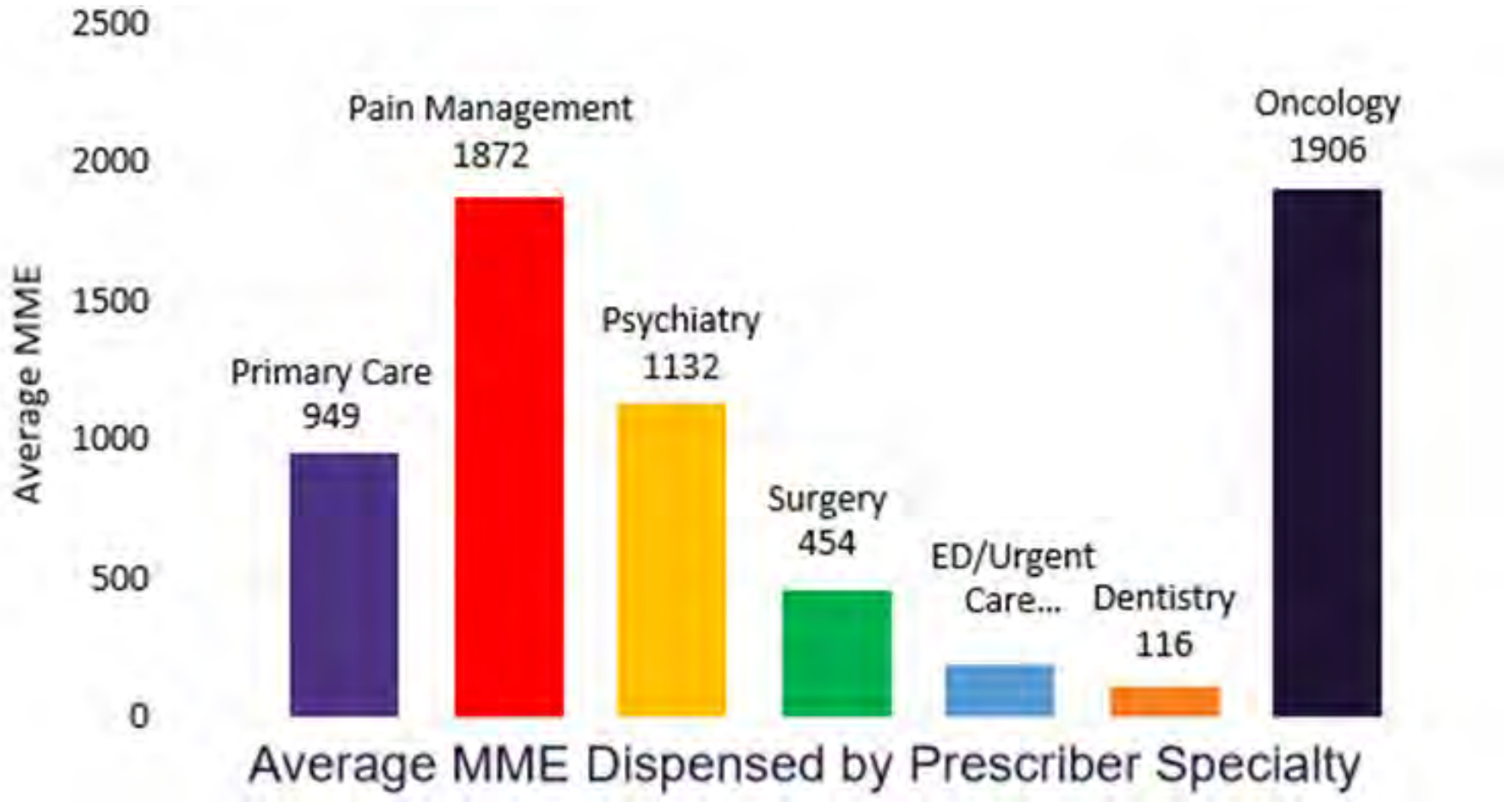
Morphine Milligram Equivalency (MME) by Prescriber Specialty



Source: Michigan PDMP Oct. 23, 2012-Oct. 23, 2017 supplemented by NPPES NPI file
*Note: Narcotic prescriptions exclude prescriptions classified as Buprenorphine MAT. Prescribers are characterized by their primary specialty. Narcotic MME excludes prescriptions classified as Buprenorphine MAT; Excludes prescribers missing primary specialty classification; Other specialties include specialties not classified elsewhere; MME= Number of Pills * Morphine Equivalent Units among Narcotic Prescriptions*

Primary care is the 1st largest Rx of lorazepam. **Who is the 2nd ?**

A. Surgery

B. Pain management

C. Psychiatry

D. Primary care

E. Oncology

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B. Pain management

C. Psychiatry

D. Primary care

E. Oncology

Lorazepam Milligram Equivalency (LME) by Prescriber Specialty

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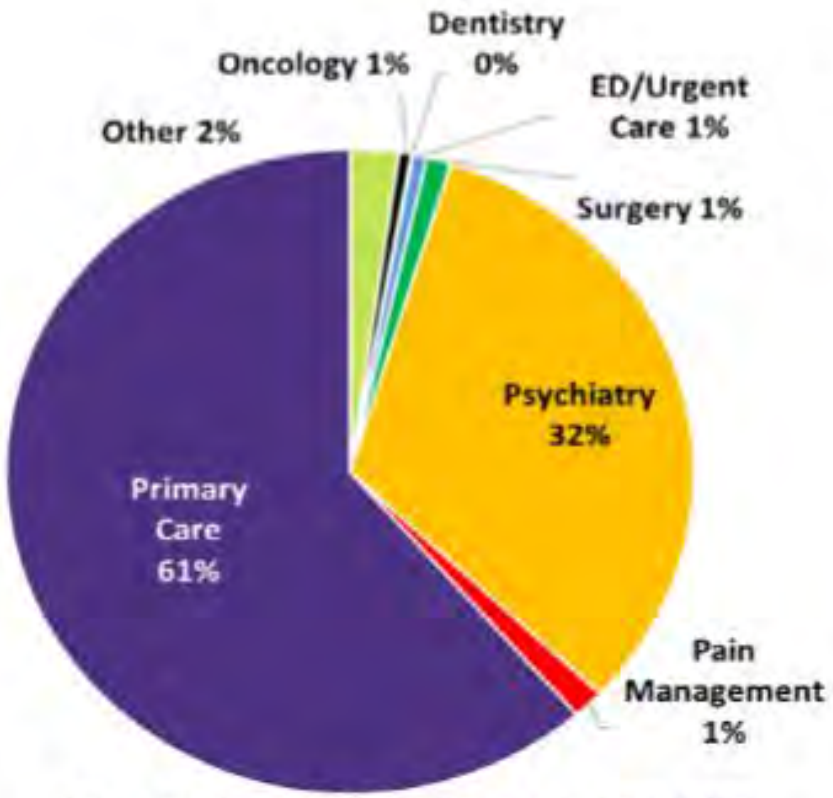
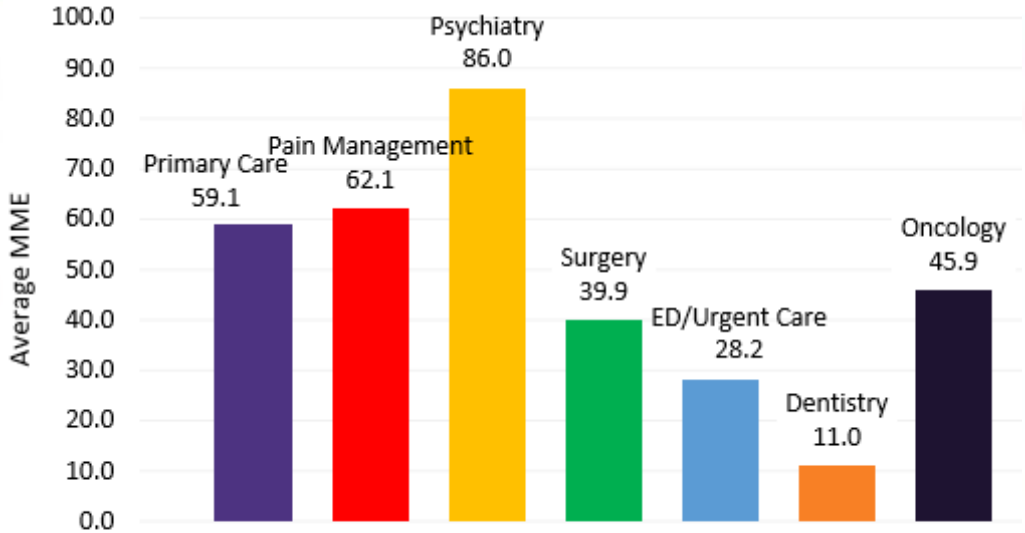


Aggregate LME of Prescription Fills by Prescriber Specialty



Average LME Dispensed by Prescriber Specialty

Psychiatry accounts for 32% of aggregate LMEs dispensed and the specialty's average LME per dispensation is 86.0 (1.46 times that of primary care)

Source: Michigan PDMP Oct. 23, 2012-Oct. 23, 2017 supplemented by NPPES NPI file
Note: Excludes prescribers missing primary specialty classification
Other specialty includes specialties not classified elsewhere
*LME= Number of Pills * Lorazepam Equivalent Units among Sedative Prescriptions*

Doctor Shopping and Overdose Death: 2009-2012

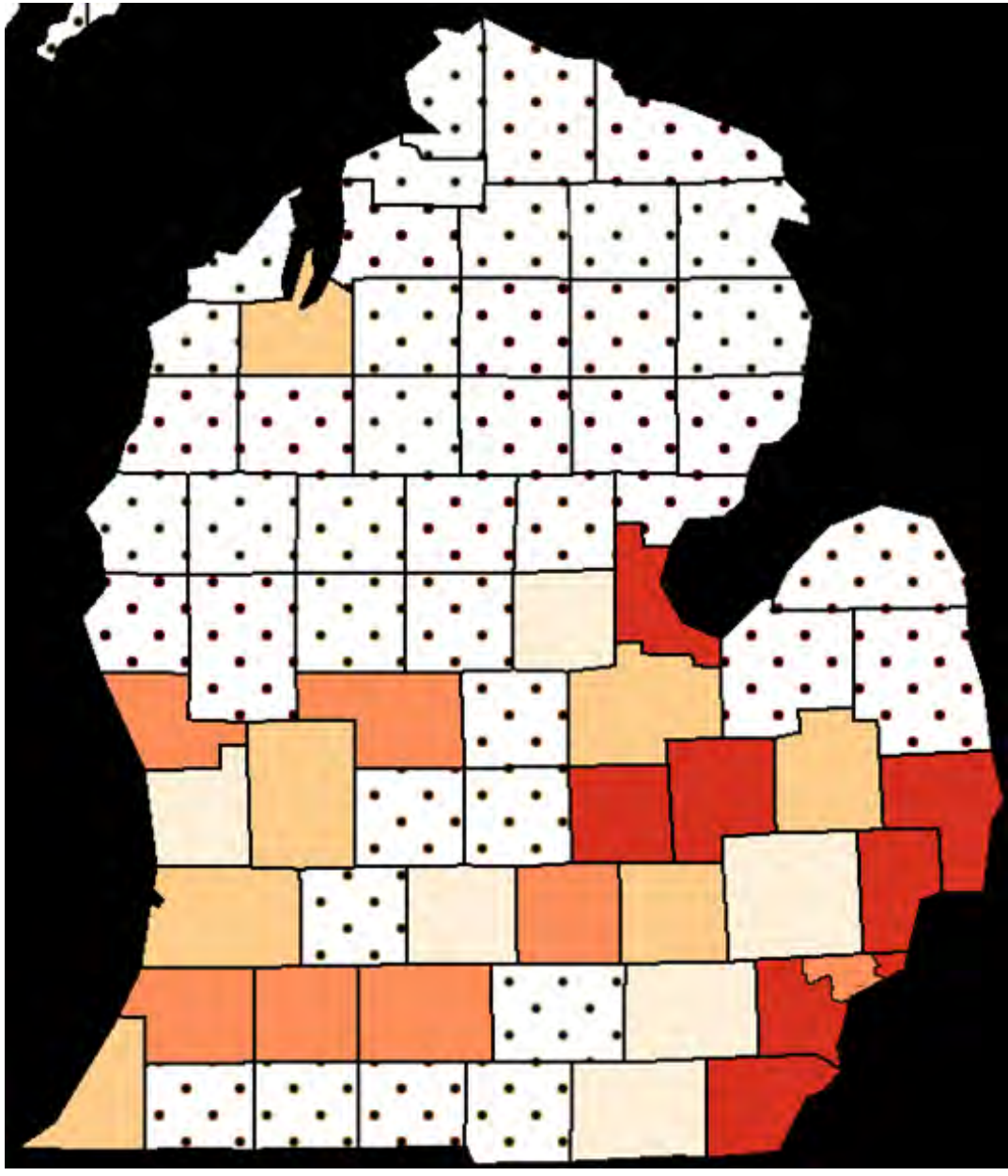
< 25 Deaths

1.4-2.3/100^3

2.4-3.1

3.2-4.1

4.6-6.0



A Profile of Drug Overdose Deaths Using the Michigan Automated Prescription System (MAPS)

Office of Recovery Oriented Systems of Care Staff: Su Min Oh

Standard of Care

- Risk assessment
- MAPS
- Urine Drug Screen (UDS)
- Pain Management Agreement

Drug Testing

- Detect **non-prescribed** drugs
- Detect the **absence** of drugs
- Point Of Care testing (in office)
  - High rates of false +/-
  - No toxicologist to consult

Standard of Care

- Risk assessment
- MAPS
- Urine Drug Screen (UDS)
- Pain Management Agreement

But, wait, there's more . . .

Store SECURELY

Encourage those on opioids to: Store SECURELY

- *"Is there a more secure area to keep your pills besides your"*:
  - Drawer at work
  - Purse
  - Glove box
  - Medicine Cabinet

Dispose PROPERLY

Dispose PROPERLY

- Do you really need to save them *"just in case"?*
  - Give them a list of disposal site

How to Dispose of Unused Medicines

- *Take drugs out of their original containers and mix them with an undesirable substance, such as used coffee grounds …*

www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm107163.pdf (Accessed 5-2015)

Never SHARE

Encourage those on opioids to: Never SHARE

- Felony
- Don’t want to create any more addictions

What are you going to change?

Three classes

- Patients not on opioids
  - **work hard** provide more effective and safer options
- Patients on opioids
  - **reassess** frequently
- Opioid addiction
  - **Families Against Narcotics**

FAN

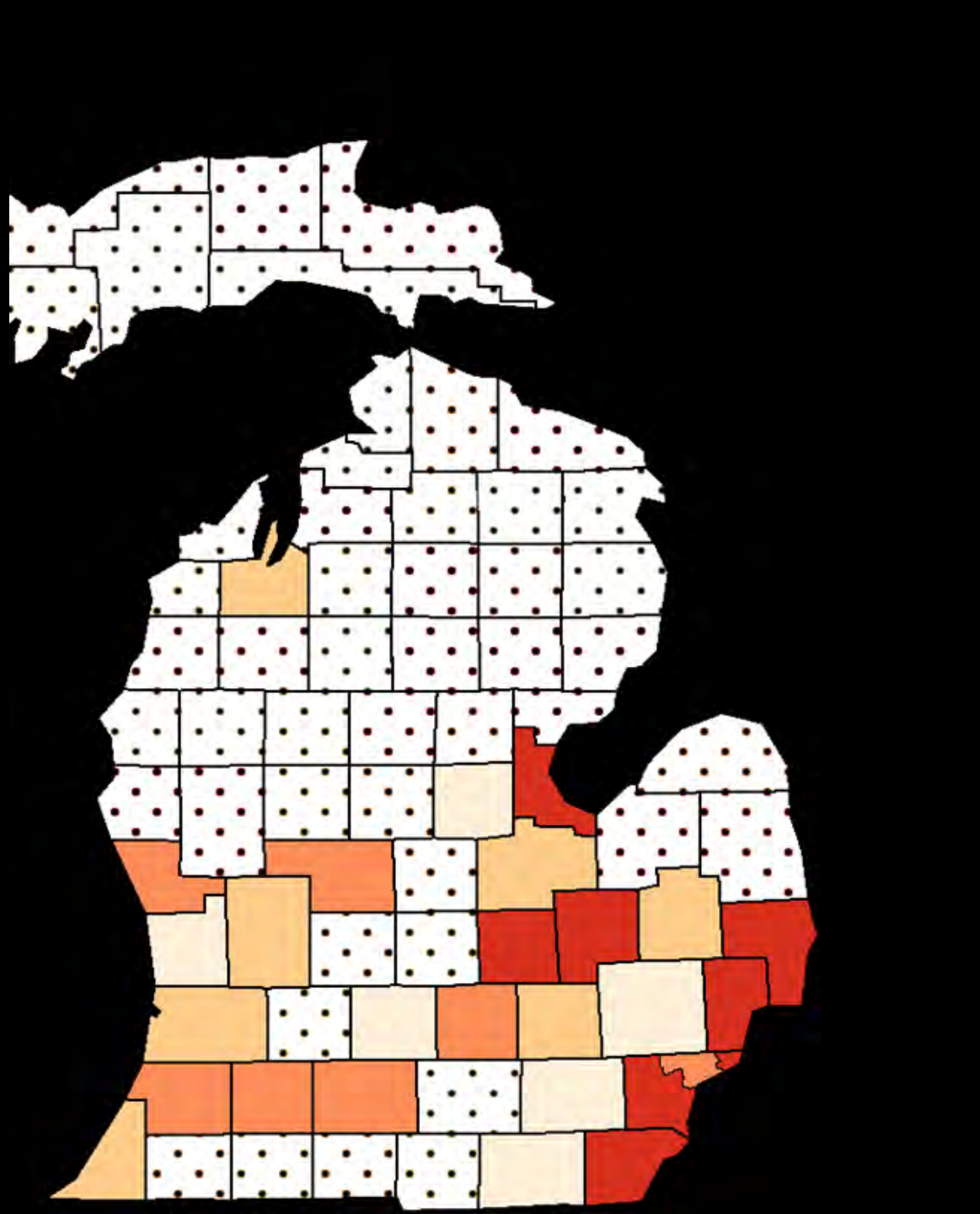
Families Against Narcotics

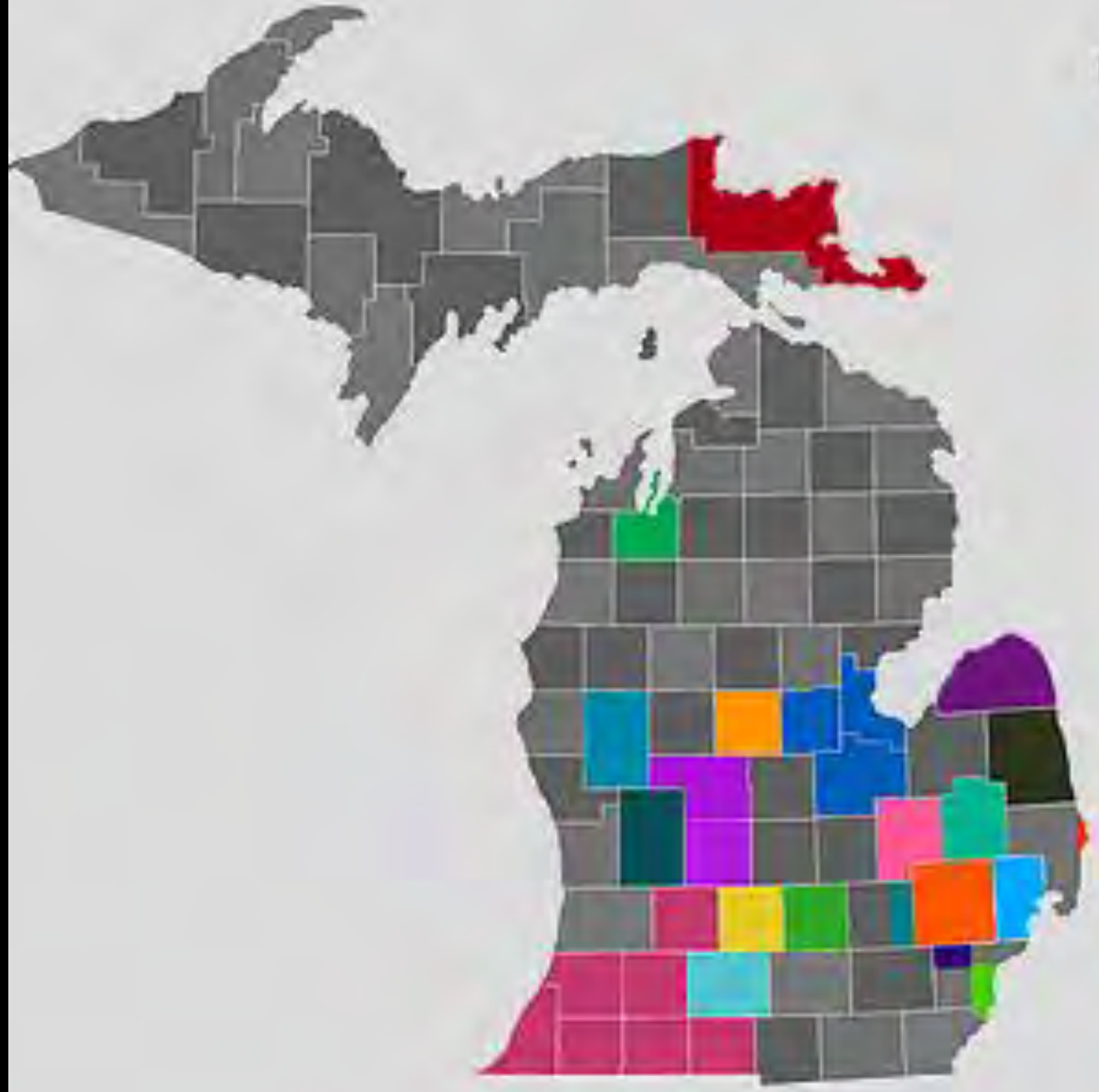
Your *connection* for information, resources, and support.

THE NEW FACE OF ADDICTION

Each day over 2,000 teens abuse a prescription drug for the first time. Many try it for fun thinking they're safe, others are prescribed painkillers by doctors, often to treat sports-related injuries.

For some, that decision will change their lives forever...





CHAPTERS

MACOMB
ACHC OAKLAND
CALHOUN
CHIPPEWA
DOWNRIVER
[illegible]
GENESEE
GRAND RAPIDS
GRAND TRAVERSE
GREAT LAKES BAY REGION
HURON
LAPEER
MONTCALM / IONIA
NEWAYGO
NORTHWEST WAYNE
PORT HURON/BLUEWATER
OKEMOS / INGHAM
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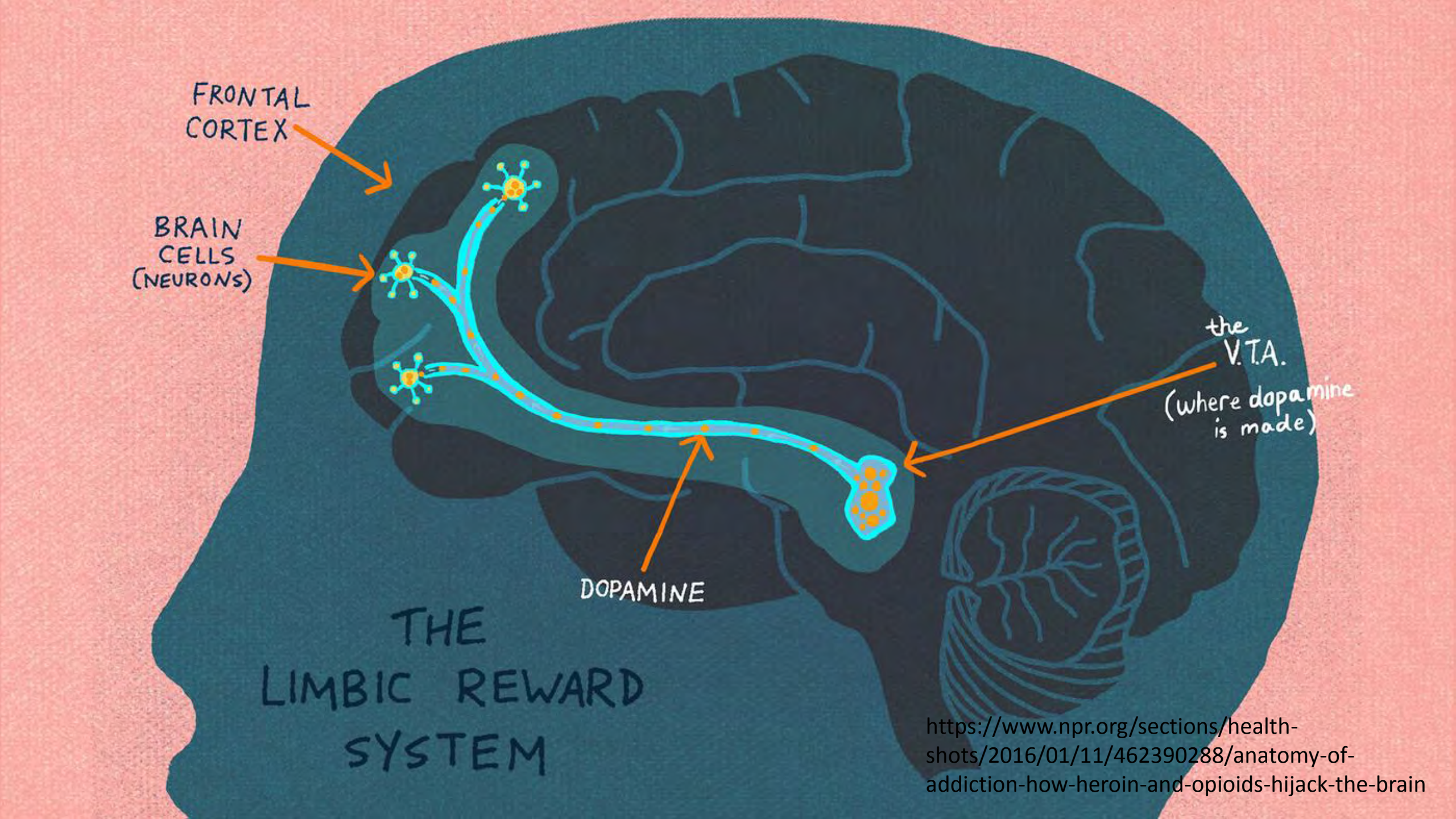
SANILAC
SOUTHWEST MICHIGAN
SOUTHWEST OAKLAND-LIVINGSTON



https://www.npr.org/sections/health-shots/2016/01/11/462390288/anatomy-of-addiction-how-heroin-and-opioids-hijack-the-brain

Transitioning Off Opioids

“Plant the seed!”

“Primum non nocere”

First Do No Harm!