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"

ADDITION 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 patients1 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.

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“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.”
Rational: The identification and treatment of pain is an important component of the plan of care. Patients can expect 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”

“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**.

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 ... acknowledged 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.

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.”

California doctor convicted of murder in overdose deaths of patients
Senators Hatch and Wyden: Do your jobs and release the sealed opioids report
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
Where is the largest source of Rx opiates for non-medical use?

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Sources of opioids for non-medical purposes

- Friend or Relative: 70%
- Prescribed: 20%
- Other: 10%

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%)
Number of Narcotic Prescriptions by Prescriber Specialty

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
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**
Opioid Induced Hyperalgesia

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

Hypothalamic hypogonadism

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

Disturbed Sleep Architecture

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

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

What’s the difference?

Heroin 6-MAM Morphine
Heroin
Hydrocodone
Morphine
Oxycodone
Heroin
Safer Alternatives
1. Use behavioral and physical therapies before medication, particularly opioids.

https://stacks.cdc.gov/view/cdc/38440(Visited 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
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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E. All the above
Standard of Care

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

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

4. Mental Illness
   - ADD/OCD/Bipolar/Schizophrenia
   - Depression – separate scoring

5. Hx Preadolescent Sexual Abuse
Opioid Risk Tool (ORT)

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

opioidrisk.com
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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B. Pain management
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Morphine Milligram Equivalency (MME) by Prescriber Specialty

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 Fill * Morphine Equivalent Units among Narcotic Prescriptions
Primary care is the 1\textsuperscript{st} largest Rx of lorazepam. **Who is the 2\textsuperscript{nd} ?**

A. Surgery  
B. Pain management  
C. Psychiatry  
D. Primary care  
E. Oncology
Primary care is the 1\textsuperscript{st} largest Rx of lorazepam. \textbf{Who is the 2\textsuperscript{nd} ?}

A. Surgery
B. Pain management
C. \textbf{Psychiatry}
D. Primary care
E. Oncology
Lorazepam Milligram Equivalency (LME) by Prescriber Specialty

Aggregate LME of Prescription Fills 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)

Note: Excludes prescribers missing primary specialty classification
Other specialty includes specialties not classified elsewhere
LME= Number of Pts * Lorazepam Equivalent Units among Sedative Prescriptions
Doctor Shopping and Overdose Death: 2009-2012

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 sites.
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 …

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
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...
Transitioning Off Opioids
“Plant the seed!”
"Primum non nocere"

First Do No Harm!