Teaching Residents Appropriate Opioid Prescribing

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

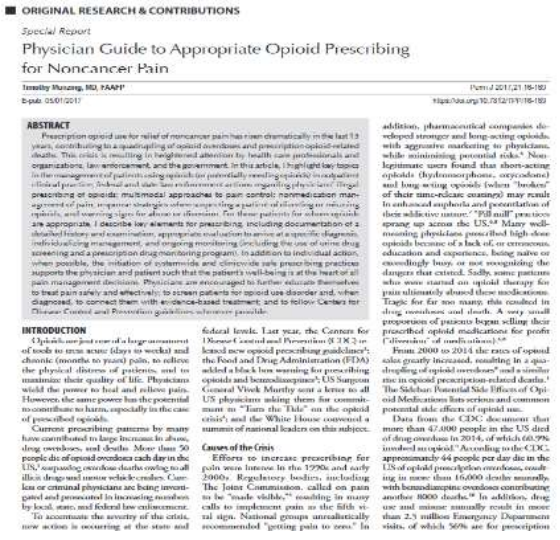
Disclosure

- Drs. Munzing, Cummins and Murray have no relevant financial interests to disclose

Goals & Objectives: Participants will be able to:

- Discuss the roots of the opioid crisis
- Incorporate standard of care elements and patient safety when managing pain by residency programs
- Implement specific strategies to monitor patients when opioid prescribing is indicated

Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain (Dr. Tim Munzing SCPMG) May 1, 2017



ORIGINAL RESEARCH & CONTRIBUTIONS

Special Report

Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain

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ABSTRACT

Prescription opioid use for relief of noncancer pain has risen dramatically in the last 15 years, contributing to a quadrupling of opioid overdoses and prescription opioid–related deaths. This crisis is resulting in heightened attention by health care professionals and organizations, law enforcement, and the government. In this article, I highlight key topics in the management of patients using opioids for potentially needing opioids in outpatient clinical practice. Federal and state law enforcement actions regarding physicians' illegal prescribing of opioids; multimodal approaches to pain control; nonmedication management of pain; important strategies when supporting a patient in tapering or reducing opioids; and warning signs for abuse or diversion. For those patients for whom opioids are appropriate, I describe key elements for prescribing, including documentation of a detailed history and examination, appropriate evaluation to arrive at a specific diagnosis, individualizing management, and ongoing monitoring (including the use of urine drug screening and a prescription drug monitoring program). In addition to individual action, when possible, the initiation of systemwide and clinicwide safe prescribing practices supports the physician and patient such that the patient's well-being is at the heart of all pain management decisions. Physicians are encouraged to further educate themselves to treat pain safely and effectively; to screen patients for opioid use disorder and, when diagnosed, to connect them with evidence-based treatment; and to follow Centers for Disease Control and Prevention guidelines whenever possible.

INTRODUCTION

Opioids are just one of a large armament of tools to treat acute (days to weeks) and chronic (months to years) pain, to relieve the physical distress of patients, and to maximize their quality of life. Physicians wield the power to heal and relieve pain. However, the same power has the potential to contribute to harm, especially in the case of prescribed opioids.

Current prescribing patterns by many have contributed to large increases in abuse, drug overdoses, and deaths. More than 50 people die of opioid overdoses each day in the US,[1] surpassing overdose deaths owing to all illicit drugs and motor vehicle crashes. Careless or criminal physicians are being investigated and prosecuted in increasing numbers by local, state, and federal law enforcement.

To accentuate the severity of the crisis, now action is occurring at the state and federal levels. Last year, the Centers for Disease Control and Prevention (CDC) released new opioid prescribing guidelines[2]; the Food and Drug Administration (FDA) added a black box warning for prescribing opioids and benzodiazepines[3]; US Surgeon General Vivek Murthy sent a letter to all US physicians asking them for commitment to "Turn the Tide" on the opioid crisis[4]; and the White House convened a summit of national leaders on this subject.

Causes of the Crisis

Efforts to increase prescribing for pain were intense in the 1990s and early 2000s. Regulatory bodies, including The Joint Commission, called on pain to be "made visible,"[5] resulting in many calls to implement pain as the fifth vital sign. National groups unrealistically recommended "getting pain to zero." In addition, pharmaceutical companies developed stronger and long-acting opioids, with aggressive marketing to physicians, while minimizing potential risks.[6] Nonlegitimate users found that short-acting opioids (hydromorphone, oxycodone) and long-acting opioids (when "broken" of their time-release coatings) may result in enhanced euphoria and potentiation of their addictive nature.[7] "Pill mill" practices sprang up across the US.[8] Many well-meaning physicians prescribed high-dose opioids because of a lack of, or erroneous, education and experience, being naïve or exceedingly busy, or not recognizing the dangers that existed. Sadly, some patients who were started on opioid therapy for pain ultimately abused these medications. Tragic for far too many, this resulted in drug overdoses and death. A very small proportion of patients began selling their prescribed opioid medications for profit ("diversion" of medications).[8,9]

From 2000 to 2014, the rates of opioid sales greatly increased, resulting in a quadrupling of opioid overdoses[9] and a similar rise in opioid prescription–related deaths.[1] The Sidebar, Potential Side Effects of Opioid Medications lists serious and common potential side effects of opioid use.

Data from the CDC document that more than 47,000 people in the US died of drug overdose in 2014, of which 60.9% involved an opioid.[9] According to the CDC, approximately 44 people per day die in the US of opioid prescription overdoses, resulting in more than 16,000 deaths annually, with benzodiazepine overdoses contributing another 8000 deaths.[10] In addition, drug use and misuse annually result in more than 2.5 million Emergency Department visits, of which 56% are for prescription

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 patients1 who were monitored conservatively. 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
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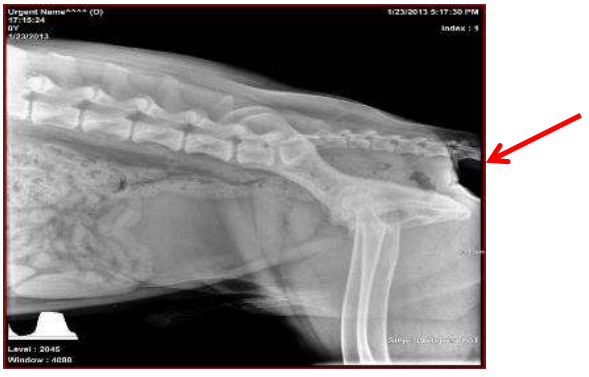
1. Inch H, Whitmore HL, Shapiro S, Lewis GP, Slobod T, Shaw D. Comprehensive drug surveillance. JAMA. 1970;213:1643-48.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:364.

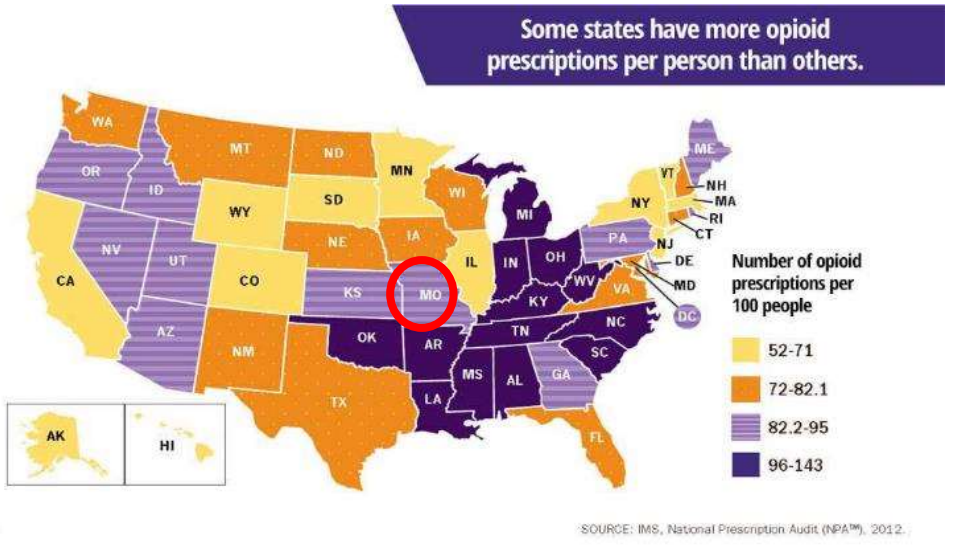
Outdated Information is Wrong

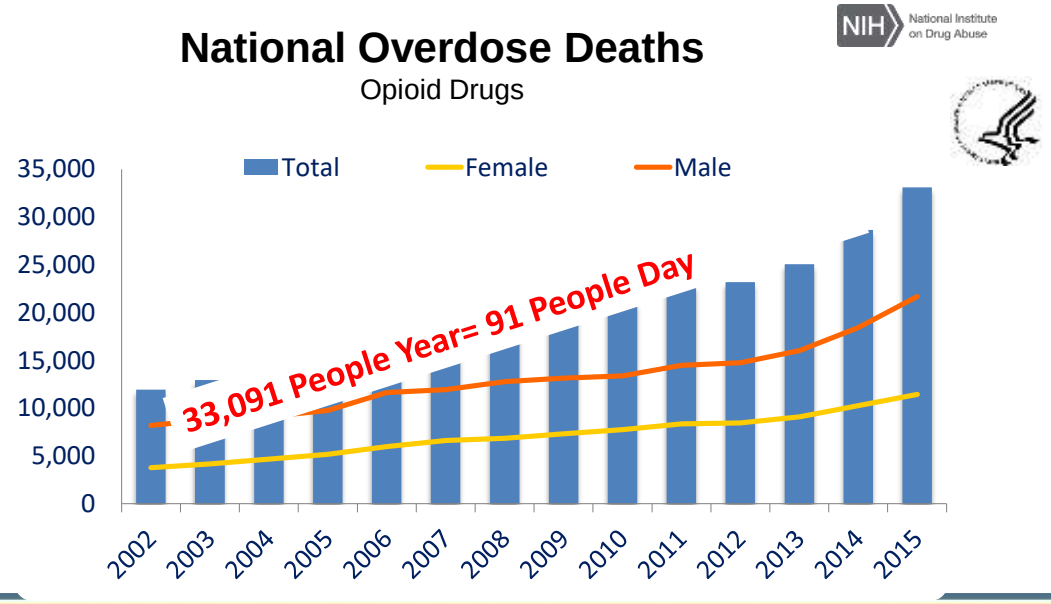
- "The risk of addiction is much less than 1%"
- Porter J, Jick H. Addiction rare in pain patients treated with narcotics. New Eng J Med. 1980 Jan 10;302(2):123
- Pain 5th Vital Sign
- 1990's Physicians encouraged to treat pain aggressively (assumed no harm)

Undercover states this is his "Back MRI" What Do You See???



Conviction – 17 counts – 3 years in prison – September 2016

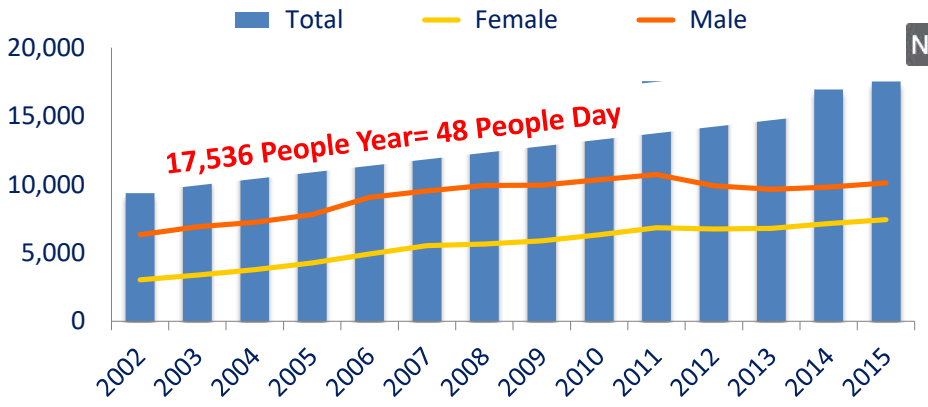




Source: National Center for Health Statistics, CDC Wonder

National Overdose Deaths

Prescription Opioid Pain Relievers



NIH National Institute on Drug Abuse

Source: National Center for Health Statistics, CDC Wonder

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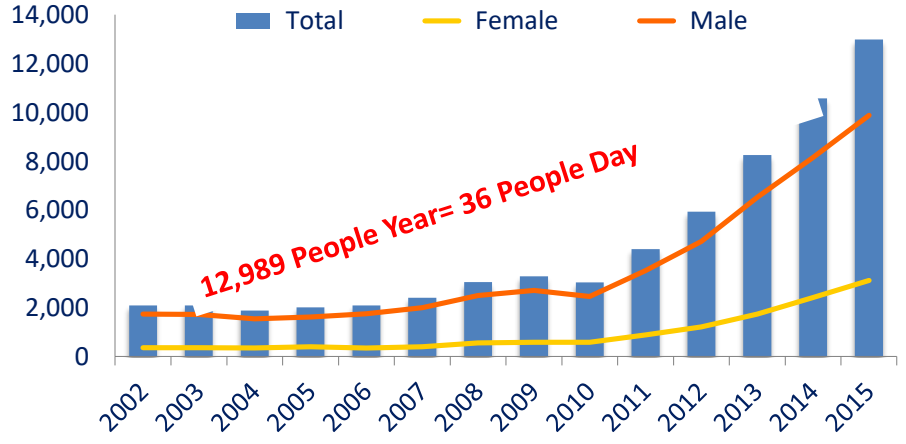
National Overdose Deaths

Heroin



NIH National Institute on Drug Abuse

Source: National Center for Health Statistics, CDC Wonder

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Poll Question:
Which of the following predict misuse of prescription opioids?

A. Race
B. Literacy
C. Disability
D. Socioeconomic status
E. All of the Above
F. None of the Above

Cultural Competence

Do Not Predict

- Gender
- Race
- Literacy
- Disability
- Socioeconomic status

Predict

- Hx EtOH/drug abuse*
- Hx EtOH/drug-related criminal conviction
- FHx EtOH/drug abuse
- Psychiatric disorder
- Includes nicotine

Opioid Risk Tool - Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction. Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Universal Precautions for Opioid Prescribing

- Evaluate the need
- Assess risk
- Select the specific opioid - treatment
- Discuss – informed consent – written agreement
- Monitor closely
- Document thoroughly

General Principles

- Act like a doctor
- 90- day cliff (or much shorter - 3-5 days???)
- Non-pharmacologic alternatives and adjunct treatments
- **Non-opioid alternatives – multiple modalities**
- Start low and go slow – very limited prescription numbers
- Trust but verify
- Documentation – be thorough!

Poll Question

Opioid Prescribing: A patient receives and takes an opioid prescription for an injury. Of patients taking the medication for 8 days, what percent will be on an opioid one year later?

A. 1.5%
B. 6.5%
C. 13.5%
D. 20.5%

Likelihood of Chronic Opioid Use

- Increased - **3rd day** of Rx and each additional day after the 3rd day
- Sharpest increase – after 5th and 31st day
- 2nd refill
- 700 morphine mg equiv. cumulative dose
- Initial 10-day or 30-day supply
- Opioid Use 1 year later
  - 1 day – 6%
  - 8 days –13.5%
  - 31 days –29.9%

CDC MMWR – March 17, 2017 / 66(10); 265-269

2016 CDC Guidelines for Controlled Substances

- Avoid benzodiazepines with opioids [increases risk of overdose death ten-fold versus only opioid use]
- Periodic benefit / risk evaluation, including PDMP and Urine Drug Screen
- Non-pharmacologic and non-opioid tx – first line
- Chronic pain – avoid opioids – risk outweighs benefits for most

2016 CDC Guidelines for Controlled Substances Con't

- Discuss risk / benefits with patients and document
- Establish realistic goals – prior to opioid starts
- Start immediate release – avoid Methadone as first line – higher risk
- Additional precautions if dose exceeds 50 MME mg /day

2016 CDC Guidelines for Controlled Substances Con't

- "Generally avoid increasing the dosage >= 90 MME mg/day
- Should only give 3 days max for acute pain for most non-traumatic, non-surgical pain
- Avoid combinations – short and long acting opioids
- Concerns – may limit opioids for some for whom they may benefit

CDC Prescribing Guidelines (2016)- Published JAMA – March 15, 2016

Pain Management Basics

- **Multiple strategies**
  - **Non-pharmacologic**
  - **Pharmacologic**
  - **Procedures**
  - **Opioids**
  - **Devices**

The **5 A's** Plus

- **Analgesia:** rating of average pain, worst pain, and pain relief
- **Activity:** progress in patient's functional goals
- **Adverse Effects:** nausea, dizziness, drowsiness, other forms of impairment, etc.
- **Affect:** impacts to mood, anxiety, depression, ability to be happy, etc.
- **Aberrant behaviors:** taking meds as prescribed, illicit drug use

• Reference: 1. Executive Committee of the Federation of State Medical Boards of the United States, Inc. Model policy on the use of opioid analgesics in the treatment of chronic pain. July 2013. (Sourced 25/2/14) www.fsmb.org/pdf/pain_policy_july2013

The 5 A's **Plus**

- Prescription Drug Monitoring Program (PDMP)
- Urine Drug Screening (UDS)
- Updated History, Exam, and Assessment
- Taper medications when possible
- Include the Morphine Equiv Dosing – Every visit

• Reference: 1. Executive Committee of the Federation of State Medical Boards of the United States, Inc. Model policy on the use of opioid analgesics in the treatment of chronic pain. July 2013. (Sourced 25/2/14) www.fsmb.org/pdf/pain_policy_july2013

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Kaiser Permanente Opioid Actions (Southern California)

- Use of generic vs brand opioids (less diverted)
- Opioids < 90 mg/day
- Initial fill – 3 days
- Eliminate use of Soma (Carisoprodol)
- Use short acting opioids

Kaiser Permanente Opioid Results (Southern California)

- 98% reduction – Rx over 200 pills
- 95% reduction in brand name opioid-acet meds
- 72% reduction- Rx of long acting opioids
- 90% decrease in opioid Rx with benzodiazepines and carisoprodol

Poll Question

Red Flags: Which red flags confirm opioid abuse / diversion?

A. Early Refill
B. Escalating Dosing
C. Multiple pharmacies used
D. All of the above
E. None of the Above

Identify Potential Red Flags in PDMP

- Early Refills
- MED > 100 mg / day
- Multiple concurrent prescribers
- Multiple pharmacies
- Combinations (i.e. Opioid, Benzodiazepine, Soma)
- Escalating dosing by provider
- Escalating prescriptions by patient

Additional Potential Red Flags

- Inconsistent UDT results
- Patients driving a long distance for care
- Multiple family members – identical or similar meds
- Drug overdoses
- Buy/ give / sell meds
- Use of THC – even with Marijuana Card

Dangerous / Common Combinations

- **"Holy Trinity" –**
  - Oxycodone, Benzodiazepine, Soma
- **"Houston Cocktail" –**
  - Norco, Xanax, Soma
- **"Sizzurp" –**
  - Promethazine with codeine cough syrup, Jolly Ranchers candy, fruit flavored cola

Poll Question – MED Dosing

MED Dosing: Which oral opioid is strongest mg to mg?

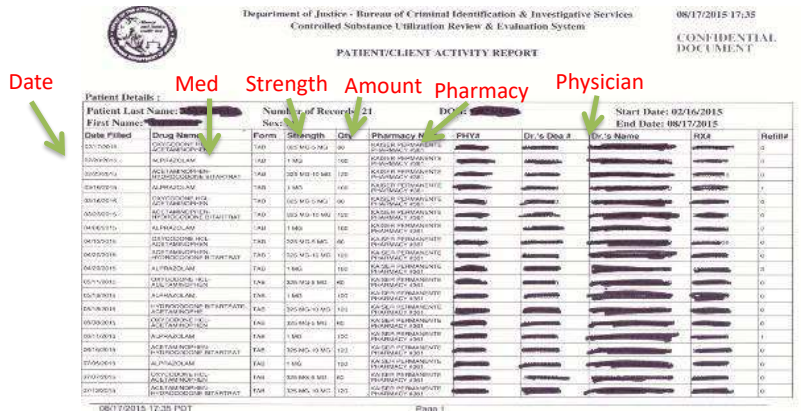
A. Oxycodone
B. Hydrocodone
C. Morphine
D. Oxymorphone
E. Methadone

Morphine Equivalent Dosing

Drug	Brand	Relative Strength	100 mg/d MED Equiv
Morphine	Methadose	1	100
Hydrocodone	Norco, Vicodin	1	100
Oxycodone	OxyCodone Roxycodone	1.5	66
Hydromorphone	Dilaudid	4	25
Oxymorphone	Opana	5	20
Methadone		10 +	10
Fentanyl	Duragesic	100	42

Adapted from Opioid Calculator - Available at http://agencymeddirectors.wa.gov/mobile.html

Physician Drug Monitoring Program (PDMP) – [Example]



Opioid Dosing Calculator –

Morphine Equivalent Dosing (mg/day) – *(Oral dosing except Fentanyl)*

OPIOID DOSE CALCULATOR

Optional:	Patient name:	
	Today's date:	**August 17, 2016**
Instructions:	Fill in the mg per day* for whichever opioids your patient is taking. The spreadsheet will automatically calculate the total morphine equivalents per day.	
Opioid (oral or transdermal):	**mg per day*:**	**Morphine equivalents:**
codeine	0	0
fentanyl transdermal (in mcg/hr)	0	0
hydrocodone	40	40
hydromorphone	0	0
methadone		
up to 20mg per day	0	0
21 to 40mg per day	0	0
41 to 60mg per day	0	0
>60mg per day	0	0
morphine	0	0
oxycodone	30	45
oxymorphone	0	0
TOTAL daily morphine equivalent dose (MED) =		**85**

* Note: All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mcg per hour

Available at http://agencymeddirectors.wa.gov/mobile.html

Resident Teaching Opportunities

- Imbed opioid patient safety into the system (make it your DNA)
- Noon conferences
- Hospital rounds
- Pain management workshops
- Chart reviews

Additional Issues and Questions???

- How to deal with early refills?
- Multiple prescribers – physician generated?
- Are opioid medications really needed?
- How do I treat an addict in pain?
- Inheriting patients on high dose opioids?
- Do I refill when covering for a colleague?
- When do I refer to pain management?

Key Appropriate Prescribing Elements (Summary)

- Thorough evaluation prior to prescribing, including behavioral/mental health
- Current / past Alcohol & Drug use / abuse
- Opioid Risk Evaluation (Opioid Risk Tool)
- Assessment/Goals – as specific as possible
- Individualize treatment – Function > Pain Improvement – Multi-modal tx

Key Appropriate Prescribing Elements (Summary)

- Start low and go slow – up titrate and down titrate
- Trust but verify what your patients say
- Only one opioid at a time if at all possible
- Avoid opioid and benzodiazepine combination
- Long acting opioids have lower addictive qualities
- Document MED, UDS, PDMP

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Improving Patient Safety and Outcomes

References

- Medical Board of California Guidelines for Prescribing Controlled Substances for Pain – 1994, 2003, 2007, and 2014
- "Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain"; Permanente Journal, Timothy Munzing; 2017
- DEA Regulation 21 C.F.R. 1306.04 – Purpose of issue of prescription
- "Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study"; Annals of Internal Medicine, Kate Dunn, PhD, et al; January 19, 2010 [MED dosing information / risks]
- "Use of Opioids for the Treatment of Chronic Pain" – American Academy of Pain Medicine, **http://www.painmed.org/files/use-of-opioids-for-the-treatment-of-chronic-pain.pdf**
- Washington State Agency Medical Directors' Group – in conjunction with the Interagency Guideline on Opioid Dosing for Non-cancer Pain

References

- Drug Enforcement Administration
- Centers for Disease Control - Overdose and Overdose death statistics
- "Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain", American Pain Society – American Academy of Pain Medicine Opioids Guideline Panel – February 2009 – Journal of Pain - http://www.jpain.org/article/S1526-5900(08)00831-6/fulltext
- National Forensic Laboratory Information System (NFLIS) data – found at: http://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2012/sept_2012/houston/drug_trends_1002.pdf

Books

- **Dreamland: The True Talk of America's Opiate Epidemic**; Author: Sam Quinones
- **American Pain: How a Young Felon and His Ring of Doctors Unleashed America's Deadliest Epidemic**; Author: John Temple
- **Drug Dealer, MD: How Doctors were Duped, Patients Got Hooked, and Why It's So Hard to Stop**; Author: Anna Lembke

Opioid Prescribing Review

- **"Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain", The Permanente Journal**
- ***Author – Timothy Munzing, MD***
- **https://doi.org/10.7812/TPP/16-169**

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Poll Question:

Enter your email address to be included in any follow-up communication from the presenter(s).

Please…

Complete the session evaluation.

Thank you.

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