Opioid Abuse

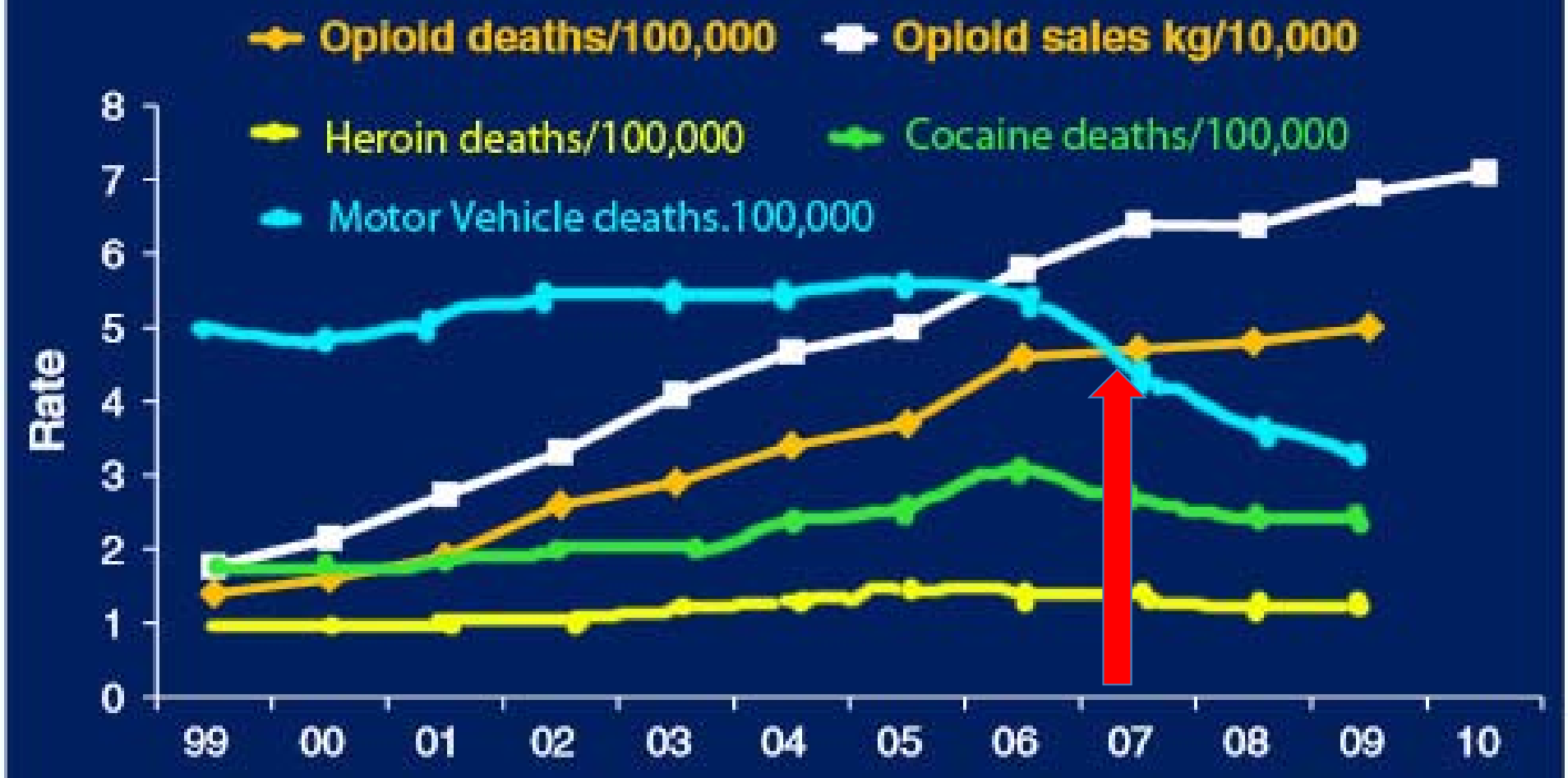
November 2, 2016

What's The Problem?

The United States uses an estimated 27,400,000 grams of hydrocodone annually compared with 3,237 grams for Great Britain, France, Germany, and Italy combined.[8] There is some concern that management of patient expectations and successful litigation for undertreatment of pain may potentially contribute to the discrepancy of opioid use in the United States compared with that in other countries.

- Hydrocodone: One year
  - 27.4 million grams
  - 95% of world supply
  - 3,237 grams

Opioid analgesic death rates and sales, U.S., 1999-2010



National Vital Statistics System (99-09); Automated Reports Consolidated Orders System (99-10); crude rates per 10,000 population for kilograms of OPR sold.

The New York Times | http://nyti.ms/1wFZGcs

Heroin's Death Toll Rising in New York, Amid a Shift in Who Uses It

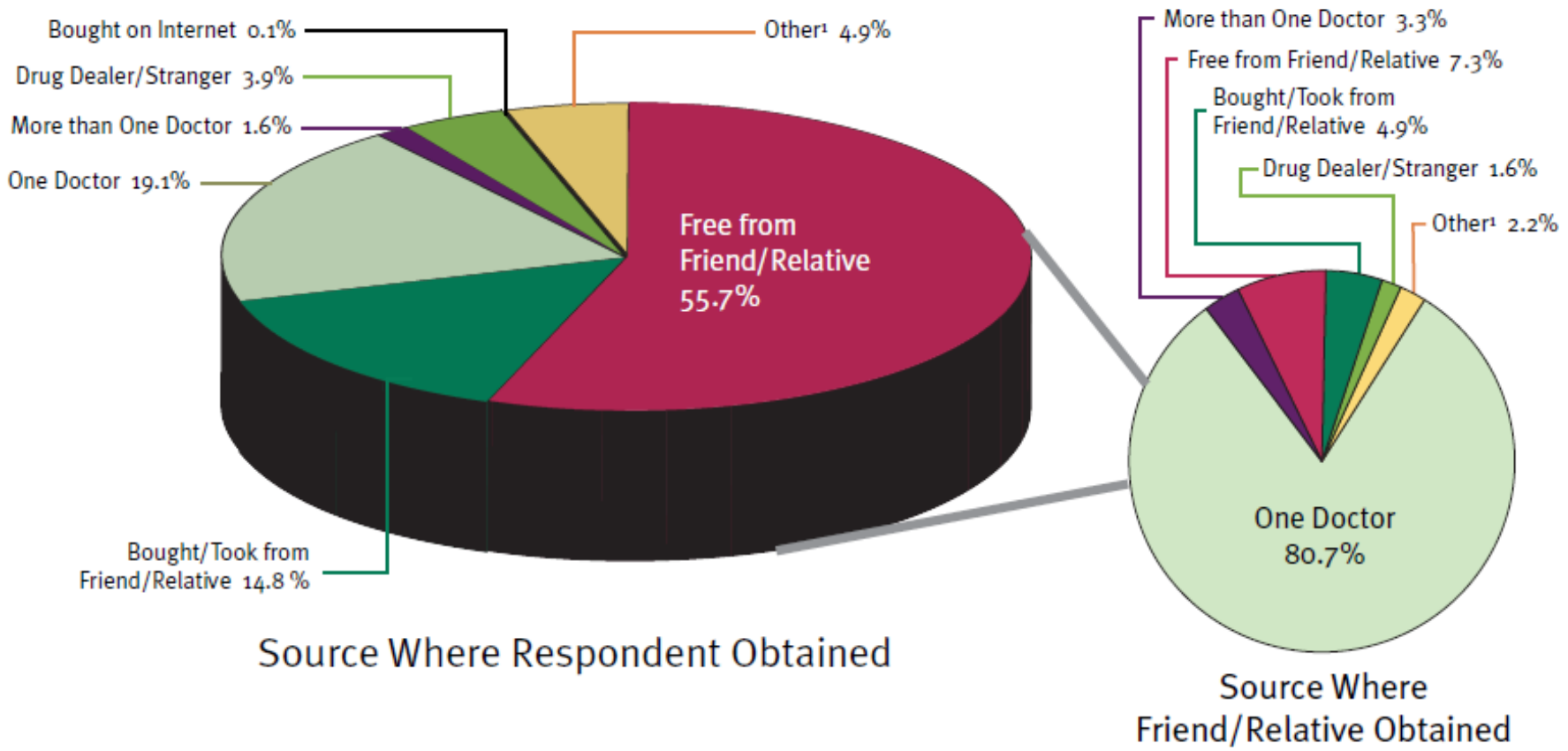
By J. DAVID GOODMAN AUG. 28, 2014

A heroin crisis gripping communities across the country deepened in New York last year, with more people in the city dying in overdoses from the drug than in any year since 2003.

In all, 420 people fatally overdosed on heroin in 2013 out of a total of 782 drug overdoses, rising to a level not seen in a decade in both absolute numbers and as a population-adjusted rate, according to preliminary year-end data from the city's health department.

The death toll from heroin has more than doubled over the last three years, presenting a growing challenge to city officials who have so far been unable to reverse the rise. By contrast, amid a concerted effort to stem prescription pill abuse, especially on Staten Island, overdoses from opioid pills leveled off during the same time period, with 215 deaths recorded in 2013.

Where Are the Opioids Coming From?



Note: Totals may not total to 100% because of rounding or because suppressed estimates are not shown.
[1]The Other category includes the sources: "Wrote Fake Prescription," "Stole from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."

Fig. 9. *Where pain relievers were obtained for most recent nonmedical use among past year users aged 12 or older: 2006 .*
Source: www.oas.samhsa.gov/nsduh/2k6nsduh/2k6results.pdf

Why Do We Prescribe so Many Opioids?

- We care about suffering
- Time pressures on visits
- Patient satisfaction pressures
- No reimbursement for treatment and evaluation of addiction

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

OPIOIDS

***Contributors**: Evidence-based Practice Opioids Panel - Panel members represent several disciplines including: occupational medicine, family medicine, internal medicine, sports medicine, emergency medicine, physical medicine and rehabilitation, pain medicine, addiction medicine, neurology, orthopedic surgery, neurosurgery, addiction psychiatry, pharmacology, toxicology, infectious disease, addiction counseling, pharmacology, and anesthesiology.*

HISTORY OF OPIOIDS

Opium is derived from the opium poppy and its use for the treatment of pain was described in the Ebers Papyrus more than 4000 years ago. Opiate refers to natural opium alkaloids, while opioid refers to either natural or synthetic derivatives. Opioid use was largely unregulated until increased recognition of morbidity from opioid use led to the passage of the Harrison Narcotics Act in 1914, making it illegal for physicians to prescribe opioids to treat addiction. International laws to restrict the sale of opioids were promulgated in the 1930s. (Stayner 12)

In the 1990s, Portenoy and Foley opined that long acting opioids for chronic, non-cancer pain was safe, effective with less than 1% risk of addiction and with no upper dose limit. Pharmacy companies then marketed proprietary and highly profitable opioids to physicians and potential patients. (Portenoy 86; Bannwarth 99; Bovill 87)

In 1999, the Oregon Board of Medical Examiners disciplined a physician for not prescribing enough pain medication; similarly, other lawsuits for undertreatment of pain have been filed. (Bilder v. Oregon Board of Medical Examiners 99; Hoffman 03; Jefferson L. Rev 04-05) In 2001, a California jury convicted a doctor of elder abuse for undertreating a patient's pain. (Garcia 13) In 2000, the Veterans Administration launched the National Pain Management Strategy, recognizing pain as the "5th Vital Sign" and calling providers "barriers to pain treatment" due to fear of patient addiction and adverse effects. (Dept Veterans Affairs 00; Merboth 00) Also, in 2000, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a pain management standard requiring recognition of the rights of patients to appropriate pain management. (Berry 00)

The combination of physician promotion, industry marketing and regulatory activities appears to have inadvertently launched the greatest reported iatrogenic and advocagenic epidemic of fatalities in U.S. history.

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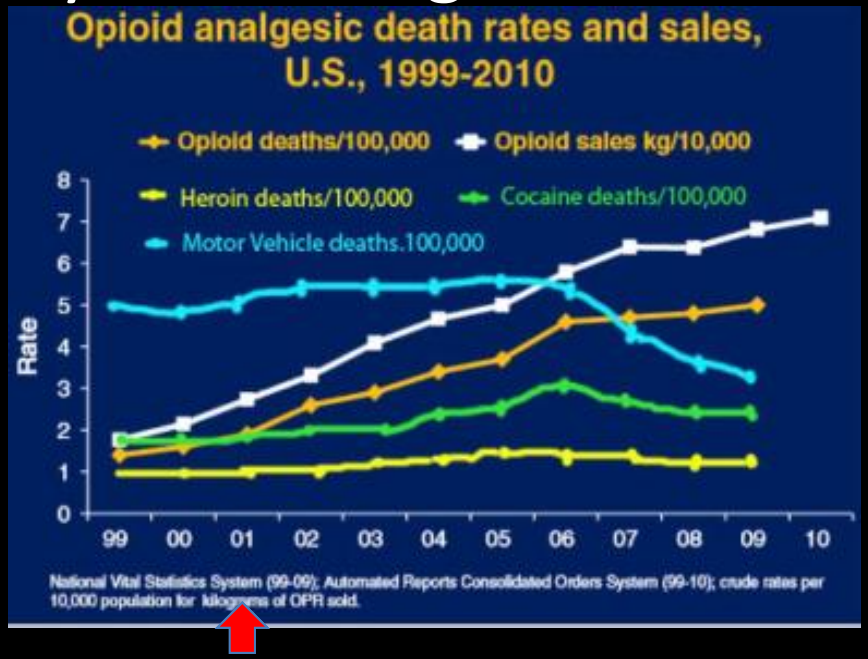
Iatrogenic & Advocatogenic

- International Association for the Study of Pain
- Veterans Administration 1999 “5th vital sign”
- JCAHO 2001– rigorous pain standards
- Pharmaceutical company marketing



Who's Prescribing?

- Emergency rooms
- Dental offices
- Physicians, Dentists, APRNs and PAs just trying to do what's right

Who Are the Addicts?

- HPI: Mary is a 42 yr old employed secretary with mechanical cervical and lumbar pain since age 35 after MVA
  - Prescribed Vicodin and Flexeril at time of injury
  - Now admits to using Vicodin
  - PCP continued to prescribe Vicodin until PDMP identified 4 doctors across state all prescribing Vicodin, Percocet and benzodiazepines
  - Fired from his practice
- PMH: depression, anxiety disorder, h/o cholelithiasis, s/p lap cholecystectomy, pre-menopausal, h/o nicotine use since age 18 (1ppdX7yrs)
- SHX: married and lives with her 2 children, employed as secretary
- ROS: irregular menses, frequent neck and lower back pain
- PE: VSS, unremarkable
- Labs: CBC, Basic Metabolic Panel, Hep B/C Negative, HIV Negative, Urine Drug Screen positive for opiates and oxycodone
- Has tried Suboxone but found she continue to have significant cravings, is now buying Vicodin and Percocets from an acquaintance
- Is worried about health, has commercial insurance through employer but has had difficulty finding an opioid treatment program that will accept her insurance

What Are the Risk Factors?

- Past or present addictions to other substances, including alcohol and tobacco
- Family history of substance abuse problems
- Younger in age, especially teens or early 20s
- Certain pre-existing psychiatric conditions
- Lack of knowledge about prescription drugs and their potential harm

SDSMA Efforts to Address the Issue of Opiate Analgesics for Chronic Non Cancerous Pain

Opiate Analgesics for Chronic Non-Cancer Pain

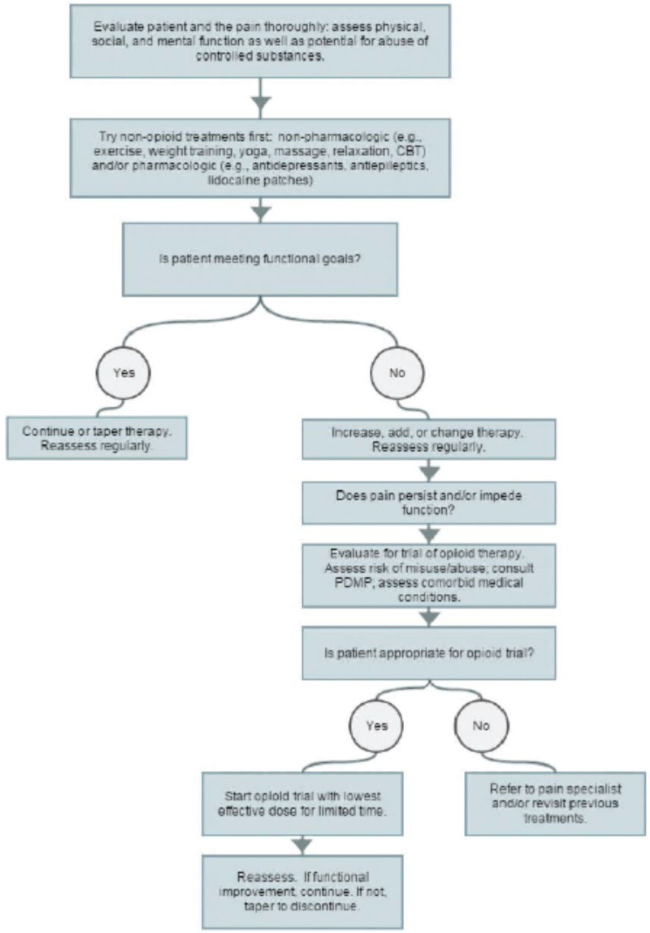
Recommendations from the Committee on Pain Management and Prescription Drug Abuse

South Dakota State Medical Association

May 1, 2016

Table of Contents:

Figure 3. Algorithm for pain management



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Checklist for Prescribing Opiates for Chronic, Non-Cancer Pain

The following checklist is designed to aid primary care providers who use opiates to improve function in patients with chronic pain. Specifically, this checklist is for treating adults (18+) with chronic pain > 3 months, excluding cancer, palliative, and end-of-life care.

CHECKLIST

When CONSIDERING long-term opiate therapy

- ☐ Review patient's medical and psychosocial history.
- ☐ Evaluate risk of harm or misuse.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opiates.

If RENEWING without a patient visit

Continuation versus Initiation - REASSESSING at return visit

- ☐ Check that non-opiate therapies optimized.
- Continue opiates only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- ☐ Evaluate risk of harm or misuse.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).
- ☐ Patients who may need more frequent or intense monitoring include:
  - Those with a prior history of an addictive disorder or past substance abuse;
  - Patients with an unstable or dysfunctional social environment;
  - Those with comorbid psychiatric or medical conditions;
  - Those who are taking benzodiazepines; and

REFERENCE

EVIDENCE ABOUT OPIATE THERAPY

- Benefits of long-term therapy for chronic, non-cancer pain is not well supported by evidence.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIATE THERAPIES

- Use alone or combined with opiates as indicated:
- Procedures (eg, intra-articular corticosteroids)

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

ASSESSING PAIN AND FUNCTION USING PEG SCALE

- PEG score = average 3 individual question scores
- Q1: What number from 0 - 10 best describes your pain in the last week?
- Q2: What number from 0 - 10 describes how, during the past week, pain has interfered with your enjoyment of life?
- Q3: What number from 0 - 10 describes how, during the past week, pain has interfered with your general activity?

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

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Appendix I: Sample Patient/Provider Agreement

[Directions for Use – it is it is recommended that the provider create a pre-printed form with the provider's name inserted anywhere the words "your health care provider" are used; doing so should help avoid confusion and will otherwise make the form more user-friendly for both the patient and the provider.]

Opiate Pain Medication

Treatment Agreement and Informed Consent

Safe and effective treatment with opiate pain medications requires your understanding and your cooperation as is outlined below. Please read each item and check the box if you understand and agree to comply with the statement. If you do not understand the statement, or if you do not agree to it, please discuss the item with your healthcare provider.

Examples of opiate pain medications include, but are not limited to morphine, hydrocodone, oxycodone, hydromorphone, fentanyl and methadone.

I the patient understand and agree as follows:

Agreement Basics.

☐ 1. Your routine opiate pain medications need to be prescribed only by **your health care provider, Dr.** _____, or another healthcare provider that he/she may choose and name in writing. Do not ask for or accept opiate pain medications from other health care providers.

☐ 2. You may only get your opiate pain medications from one designated pharmacy. You have selected _____. Your pharmacy choice can be changed by notifying **your health care provider** in advance.

☐ 3. Do not take opiate pain medications at a larger dose or more often than has been prescribed. If I take too much pain medication or more often than prescribed, I understand that I could have complications and I could die. If I am not satisfied with my treatment, I am to call my **health care provider**.

☐ 4. Do not give or sell your opiate pain medications to anyone. Do not take opiate pain medications prescribed or otherwise obtained from any source except **your health care provider**. Do not take drugs from non-medical sources. Do not take illegal drugs.

☐ 5. You must give an honest and complete past medical history, including prior opiate treatment, current medications (including over-the-counter medications), current and past non-medical drug use, chemical dependency treatment, and psychiatric diagnoses and treatment. You should consent to communication among your current and past health care providers.

☐ 6. Inform any other healthcare provider who treats you that you have an Opiate Pain Medication Treatment Agreement with **your health care provider**.

☐ 7. Contact **your health care provider** before taking any outpatient opiate pain medication that may be prescribed by an emergency room or at hospital discharge. Contact **your health care provider** when you have been treated with opiate pain medications in an emergency room. This Agreement does not prevent you from being treated with opiate pain medications in an emergency room or when you have been admitted to a hospital.

☐ 8. You are required to undergo laboratory drug testing promptly when asked. This may

14. Prescription form or pill loss may cause you to lose your access to opiate pain medications. Lost prescription forms or pills will not necessarily be replaced.

15. If your behavior causes **your health care provider** to become concerned about a chemical dependency
be made.

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is low.

☐ 22. Any of your healthcare providers can find out from the South Dakota Prescription Drug Monitoring Program (the "Program") about all opiate medications you fill at pharmacies in South Dakota and surrounding states. **Your health care provider** is obligated to report your prescriptions to the Program. Doctor shopping is a crime in South Dakota.

☐ 23. Routine opiate use may suppress the pituitary gland. This is most significant in men. An annual testosterone blood level test can monitor for this in men. Decreased testosterone can cause sweating, depression, decreased libido, and it can have an adverse effect on bone health. Tapering down or off opiates returns pituitary function to norma

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I the patient acknowledge and agree to the contents of this document and consent to treatment with opiate pain medication as proposed by **my health care provider.**

Patient Name: _____

Patient Signature: _____ Date_____

Doctor Name: _____

Doctor Signature: _____ Date_____

However,
Changing Prescribing Patterns Alone WILL NOT Solve This Problem

Other Issues that Need to be Addressed – Direct To Consumer Ads

- Results of a Food and Drug Administration survey, released in 2004
  - Only 40 percent of physicians believe their patients understand the possible risks of prescription drugs;
  - 65 percent believe DTC ads confuse patients about the relative risks and benefits; and
  - 75 percent of physicians believe DTC ads cause patients to think that the drug works better than it does – many physicians felt pressure to prescribe something when patients mentioned DTC ads.
- The United States and New Zealand are the only two countries in the world that allow direct-to-consumer advertising of prescription drugs.
  - Advertising dollars spent by drug makers have increased by 30 percent in the last two years to $4.5 billion – Kantar Media 2014
- November 2015, the AMA calls for a ban on direct to consumer advertising.
  - According to the AMA, “Direct-to-consumer advertising also inflates demand for new and more expensive drugs, even when these drugs may not be appropriate.”

Other Issues that Need to be Addressed – Poverty

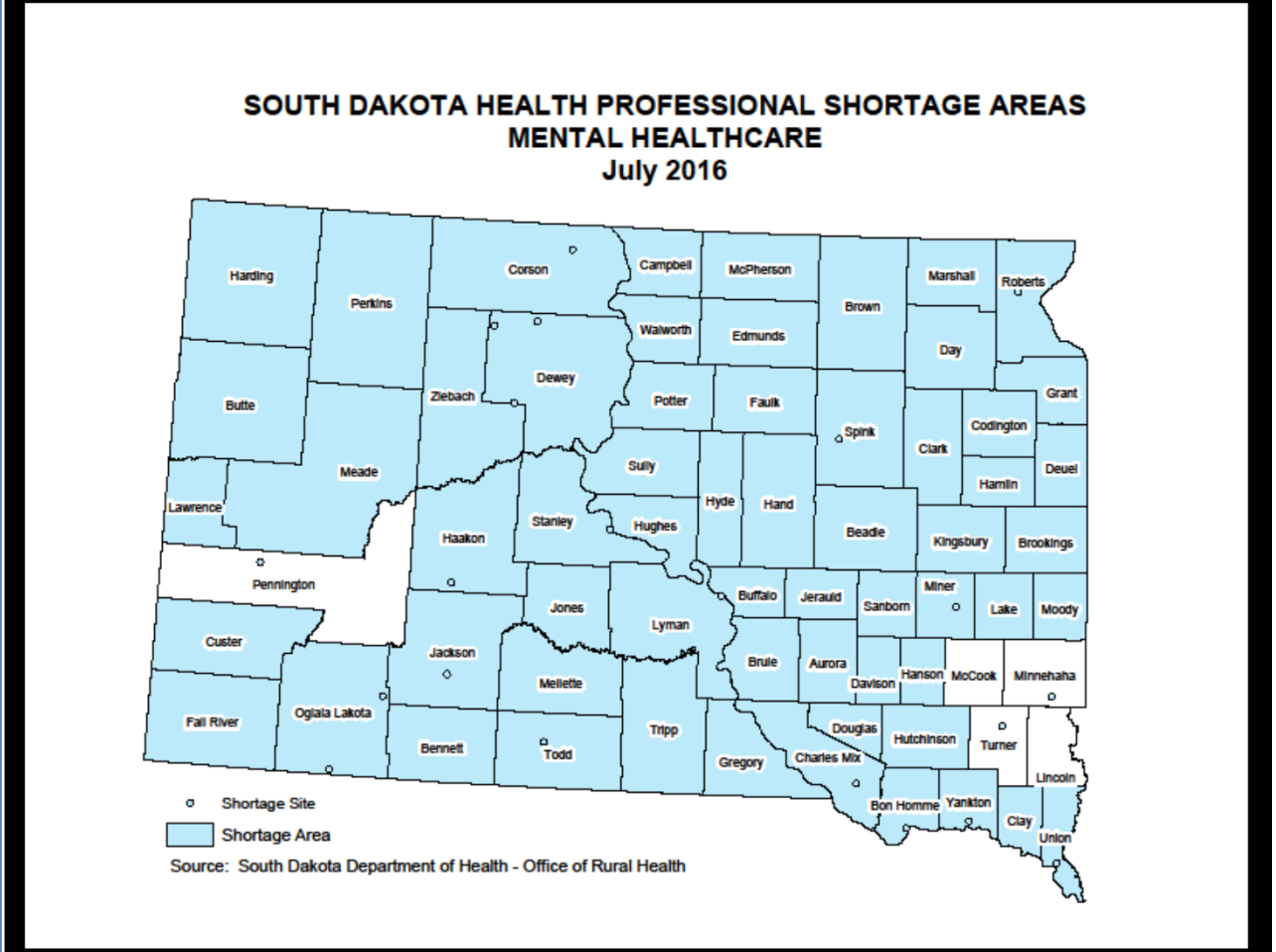
- While opioid addiction and abuse is not only seen among the poor, a study by the National Bureau for Economic Research found that there was a positive relationship between poverty and substance abuse, even when controlling for various familial factors—implying that substance abuse may even be a casual factor of poverty.
- Poverty and addiction are interlinked. Conjoined at the hip, both issues feed off each other and their effects strengthen their respective feedback loops. Poverty leads to mental states which can lead to drug abuse which leads to addiction, which begets crime, which leads to worse employment prospects.

Other Issues that Need to be Addressed – Access to Mental Health

Report finds 56% of US adults with a mental illness do not receive treatment

In "To Your Health," the Washington Post (10/19, Nutt) reports, "Twenty percent of adults (43.7 million people) have a mental health condition, and more than half of them do not receive treatment," according to Mental Health America's "annual assessment of Americans with mental illness." Among young people, despite the fact that depression rates are on the increase, "80 percent of children and adolescents get either insufficient treatment or none at all," the report reveals.

On its website, Fox News (10/19) reports, "Health care reform has expanded mental health care coverage for Americans," the report "suggests, but about 56 percent of US adults with a mental illness still do not receive treatment." About "19 percent of adults with mental illness" who live "in states that didn't expand Medicaid remain uninsured." Another "13 percent of these adults" live "in states that did expand Medicaid," but still "remain uninsured." Finally, some 1.2 million people with mental illnesses are incarcerated and lack mental health care access.



Other Issues that Need to be Addressed – Access to Care

- Access to and insurance coverage of alternative treatment methods and/or rehab services;
- Access to pain specialists
- Access to and insurance coverage of drug addiction treatment

Next Steps

- Continue to work with prescribers on prescribing patterns
- Ensure systems and processes in place for improve addiction treatment
  - Good Samaritan protections for those who seek medical treatment for possible drug overdose
- Ensure coverage of alternative treatment and rehab options