Opioid Abuse

November 2, 2016
What’s The Problem?

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

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

- Opioid deaths/100,000
- Opioid sales kg/10,000
- Heroin deaths/100,000
- Cocaine deaths/100,000
- Motor Vehicle deaths/100,000

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

Source Where Respondent Obtained

- Free from Friend/Relative: 55.7%
- One Doctor: 19.1%
- Bought/Took from Friend/Relative: 14.8%
- Drug Dealer/Stranger: 3.9%
- More than One Doctor: 1.6%
- Other*: 4.9%
- Bought on Internet: 0.1%

Source Where Friend/Relative Obtained

- One Doctor: 80.7%
- More than One Doctor: 3.3%
- Bought/Took from Friend/Relative: 7.3%
- Drug Dealer/Stranger: 4.9%
- Other*: 2.2%

Note: Totals may not total to 100% because of rounding or because suppressed estimates are not shown.

*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
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 anesthesia.

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. (U.S. 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)

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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

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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
Figure 3. Algorithm for pain management

Evaluate patient and the pain thoroughly; assess physical, social, and mental function as well as potential for abuse of controlled substances.

Try non-opioid treatments first; non-pharmacological (e.g., exercise, weight training, yoga, massage, meditation, CBT) and/or pharmacological (e.g., antidepressants, antiepileptics, sedative-hypnotics).

Is patient meeting functional goals?

○ Yes

Continue or taper therapy. Reassess regularly.

○ No

Increase, add, or change therapy. Reassess regularly.

Does pain persist and/or impair function?

○ Yes

○ No

Evaluate for trial of opioid therapy. Assess risk of misuse/abuse, comorbid PCP/IPH, assess control of medical conditions.

Is patient appropriate for opioid trial?

○ Yes

Start opioid trial with lowest effective dose for limited time.

Reassess. If functional improvement, continue if cost, side effects to discontinue.

○ No

Continue or taper therapy. Reassess regularly.

Refer to pain specialist and/or review previous treatments.

Checklist for Prescribing Opiates for Chronic, Non-Cancer Pain

The following checklist is designed to aid primary care providers who are treating patients with chronic pain.

When CONSIDERING long-term opiate therapy

1. How much pain do you have? Is it best described by severity index (mild: 0-3; moderate: 4-6; severe: 7-10)?

2. Is there an established etiology of chronic pain?

3. Have there been prior attempts to control pain with medications?

4. Are there any additional symptoms (e.g., fatigue, insomnia, anxiety, depression)?

5. What are the patient's goals of treatment?

6. What are the patient's concerns about treatment?

7. Can the patient apply external heat, cold, or pressure to the painful area?

8. Does the patient have a history of substance abuse?

9. Does the patient have a history of chronic pain?

10. Is the patient currently taking any medications that could interact with opioids?

11. Are there any contraindications to prescribing opioids?

12. Is the patient's pain responsive to non-pharmacological interventions (e.g., exercise, physical therapy, cognitive-behavioral therapy)?

13. Have there been previous attempts to taper or discontinue opioid use?

14. Is the patient's pain responsive to non-opioid pharmacological interventions (e.g., nonsteroidal anti-inflammatory drugs, tramadol)?

15. Is the patient's pain responsive to non-pharmacological interventions (e.g., acupuncture, mindfulness-based stress reduction)?

If RECOMMEND a trial of opioids

1. Start with the lowest effective dose for the shortest possible time.

2. Monitor effectiveness, side effects, and interactions closely.

3. Consider the patient's overall health and wellbeing.

4. Stop any other medications that may be contributing to pain.

5. Consider the patient's social and family support system.

6. Consider the patient's mental health status.

7. Consider the patient's history of substance abuse.

When RECOMMEND discontinuing opioids

1. Gradual tapering is recommended to minimize withdrawal symptoms.

2. Consider alternative pain management strategies (e.g., physical therapy, cognitive-behavioral therapy).

3. Consider the patient's overall health and wellbeing.

4. Consider the patient's mental health status.

5. Consider the patient's history of substance abuse.

When RECOMMEND increasing opioids

1. Gradual titration is recommended to avoid opioid toxicity.

2. Consider alternative pain management strategies (e.g., physical therapy, cognitive-behavioral therapy).

3. Consider the patient's overall health and wellbeing.

4. Consider the patient's mental health status.

5. Consider the patient's history of substance abuse.
Appendix I: Sample Patient/Provider Agreement

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, 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, hydromorphone, oxycodone, hydrocodone, 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 healthcare 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 healthcare 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 healthcare provider in advance.

3. Do not take opiate pain medications at a larger dose or more often than has been prescribed. If you 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 diagnosis and treatment. Your condition is to communicate 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 healthcare provider.

7. Contact your healthcare provider before taking any opiate pain medication that may be prescribed by an emergency room or on hospital discharge. Contact your healthcare 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 be part of your treatment plan.

9. Do not consume alcohol or other substances.

10. Opiate therapy may be terminated at any time. The decision to discontinue the program is made by your healthcare provider. You will be given an opportunity to explain your reasons for the decision to discontinue.

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

12. If your behavior causes your healthcare provider to become concerned about a chemical dependency problem, referrals for chemical dependency evaluation may be made.

13. Keep your medications combinations to your life in your personal area.

14. Do not handle your opium in another area.

15. Some people do not take opiate medications. Temporarily, doses have been increased to help increase pain control and adjust levels. It takes time for your body to adjust.

16. Do not use opiate medications in an emergency or when you have been admitted to a hospital.

17. Do not change your dose of opiate medications on your own.

18. Some people may feel worse on opiate medications. This can be due to a reaction to the medication or a side effect of the medication. It is important to tell your healthcare provider if you feel worse on the medication.

19. Do not consume alcohol or other substances.

20. Opiate therapy may be continued at any time. The decision to continue the program is made by your healthcare provider. You will be given an opportunity to explain your reasons for continuing the program.

21. Addiction is caused by chemical dependency. When you are dependent on opiate medications, your body adapts to the medication. This can cause withdrawal symptoms to occur when you stop taking the medication.

22. Any of your healthcare providers can find you 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 healthcare provider is required 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 this in men. Decreased testosterone can cause weight loss, decreased libido, and it can have an adverse effect on bone health. Retaining doses of or up to opiate returns pituitary function to normal.

24. Opiates should be kept in a secure place.

25. Opiates should be kept in a secure place.

26. Opiate prescriptions should be kept in a secure place.

27. Names, dates, and amounts should be kept in a secure place and kept with your medical records.

28. What have you done to keep up to date on your treatment?

I the patient acknowledge and agree to the contents of this document and consent to treatment with opiate pain medication as proposed by my healthcare 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