



**Responsible Opioid Prescribing
Governor's Task Force Meeting**

July 27, 2017

- O*pi*oids (noun)
 - A class of drugs that includes the illicit drug heroin as well as the legal prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.

Opioid Consumption

80% of worldwide opioid consumption is from the United States which represents only 5% of the world's population

Manchikanti, L. Therapeutic opioids, 2008.

How Many People Addicted?

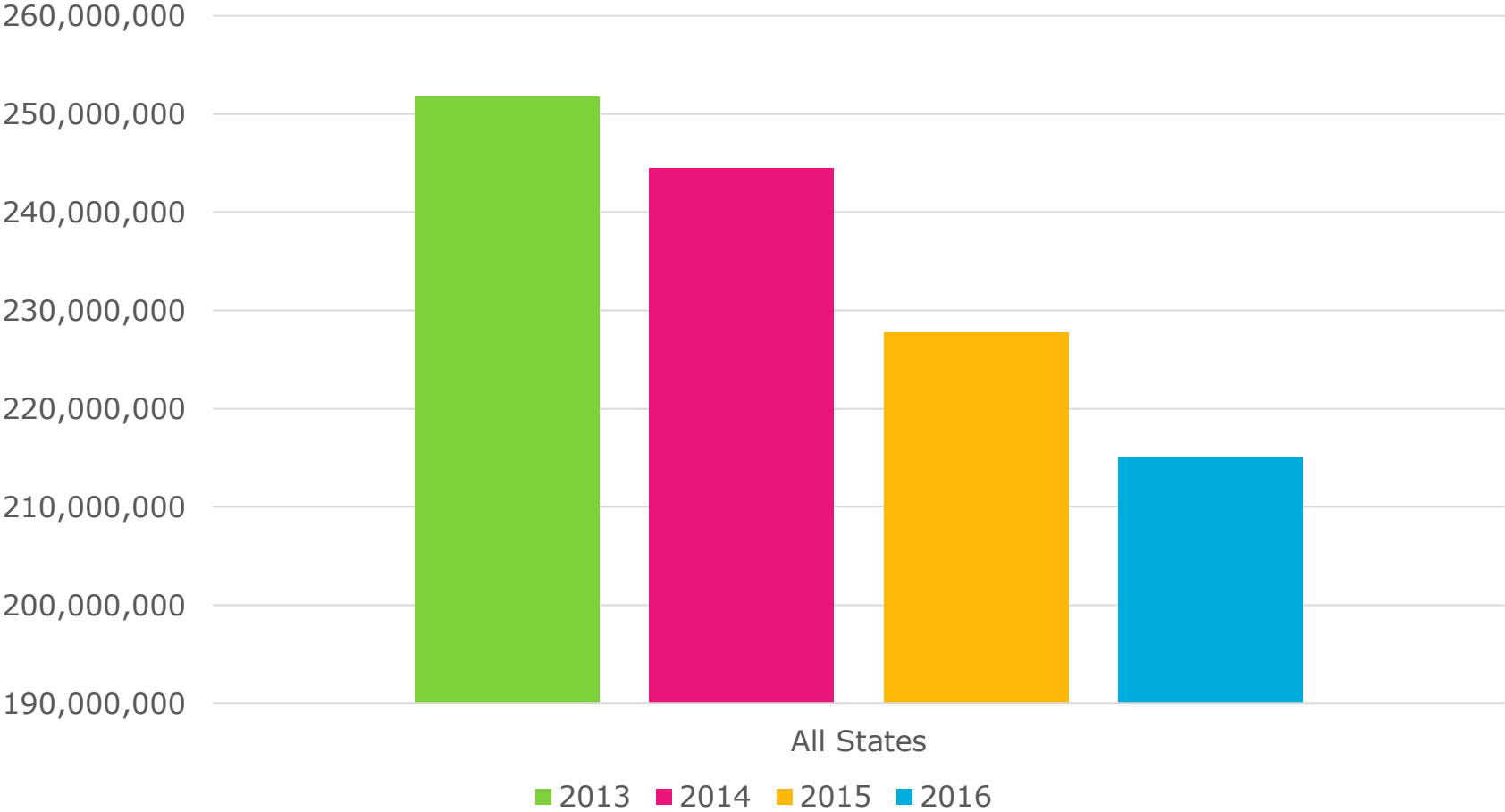
It is estimated that between **26.4 million** and **36 million people** abuse opioids worldwide, with an estimated **2.1 million people** in the United States suffering from substance use disorders related to prescription opioid pain relievers in 2012 and an estimated **467,000** addicted to heroin.

www.drugabuse.gov

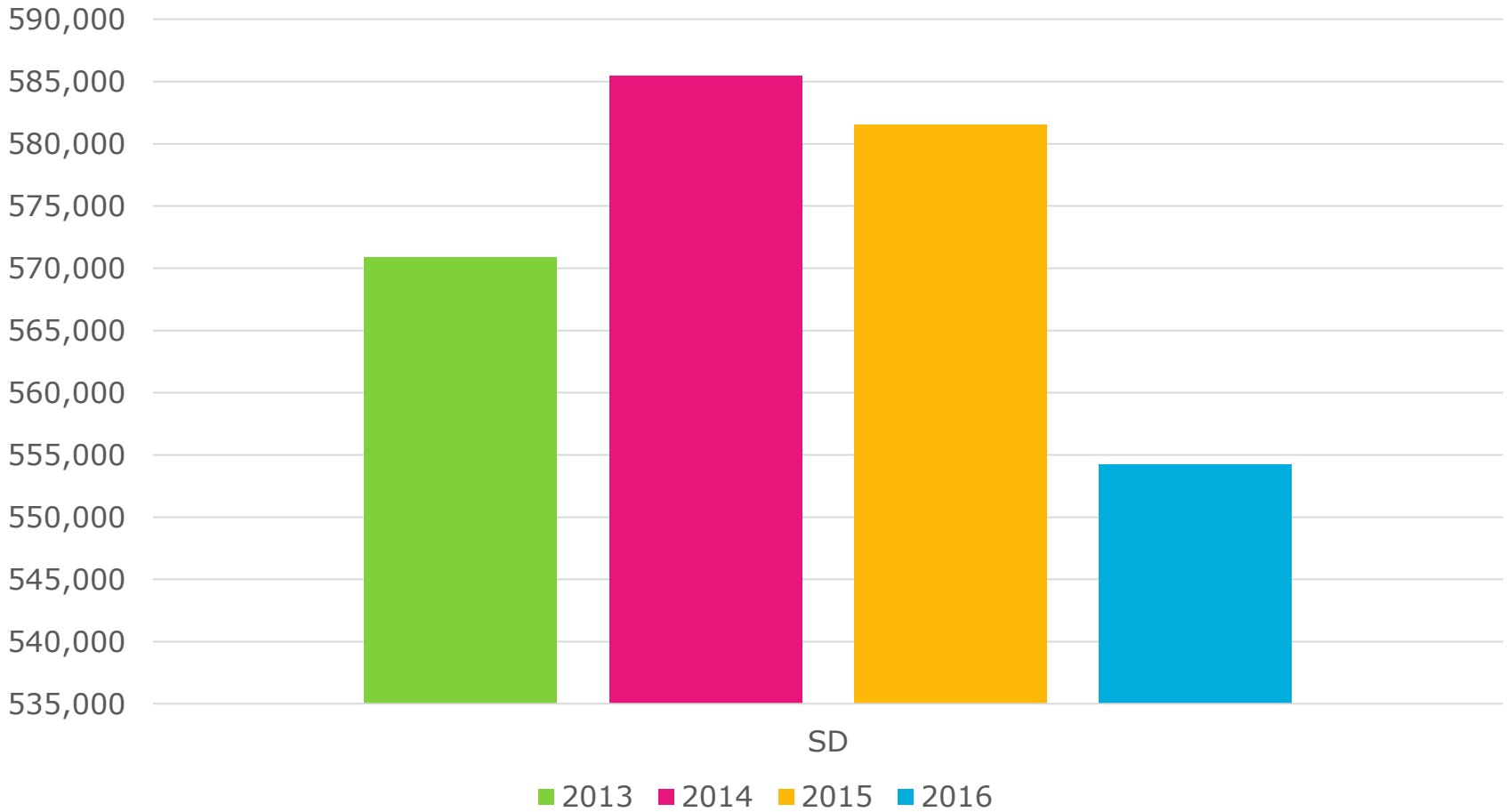
How Many Patients Become Addicted?

There also has been a shift in the demographic of **opioid addiction** over the last few decades. In the 1960s, more than 80 **percent** of people who began using **opioids** initiated with heroin; today, nearly 80 **percent of opioid users** reported that their first regular **opioid** was a prescription pain reliever

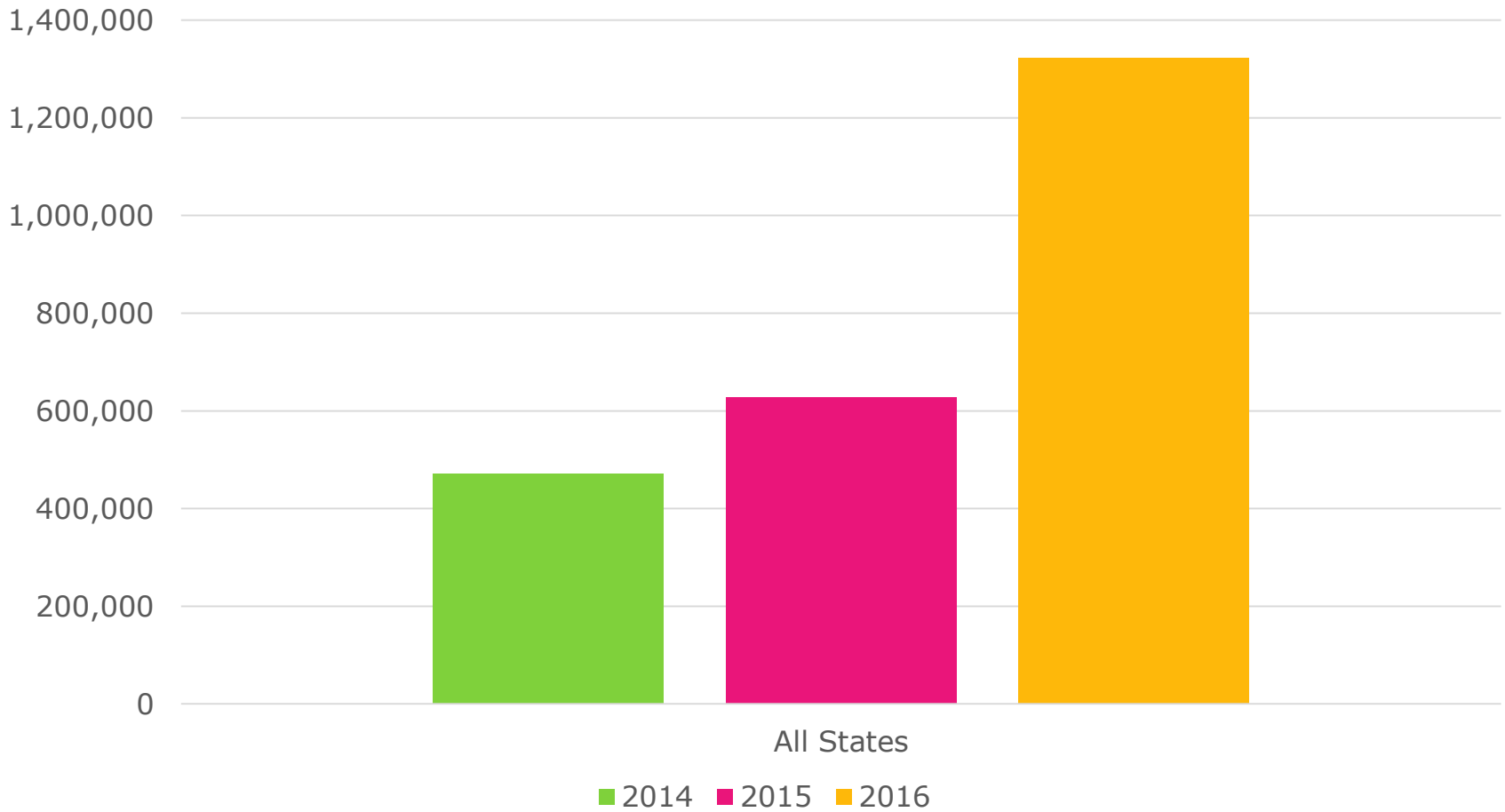
National Retail Filled Prescriptions: All Opioid Analgesics, 2013-16



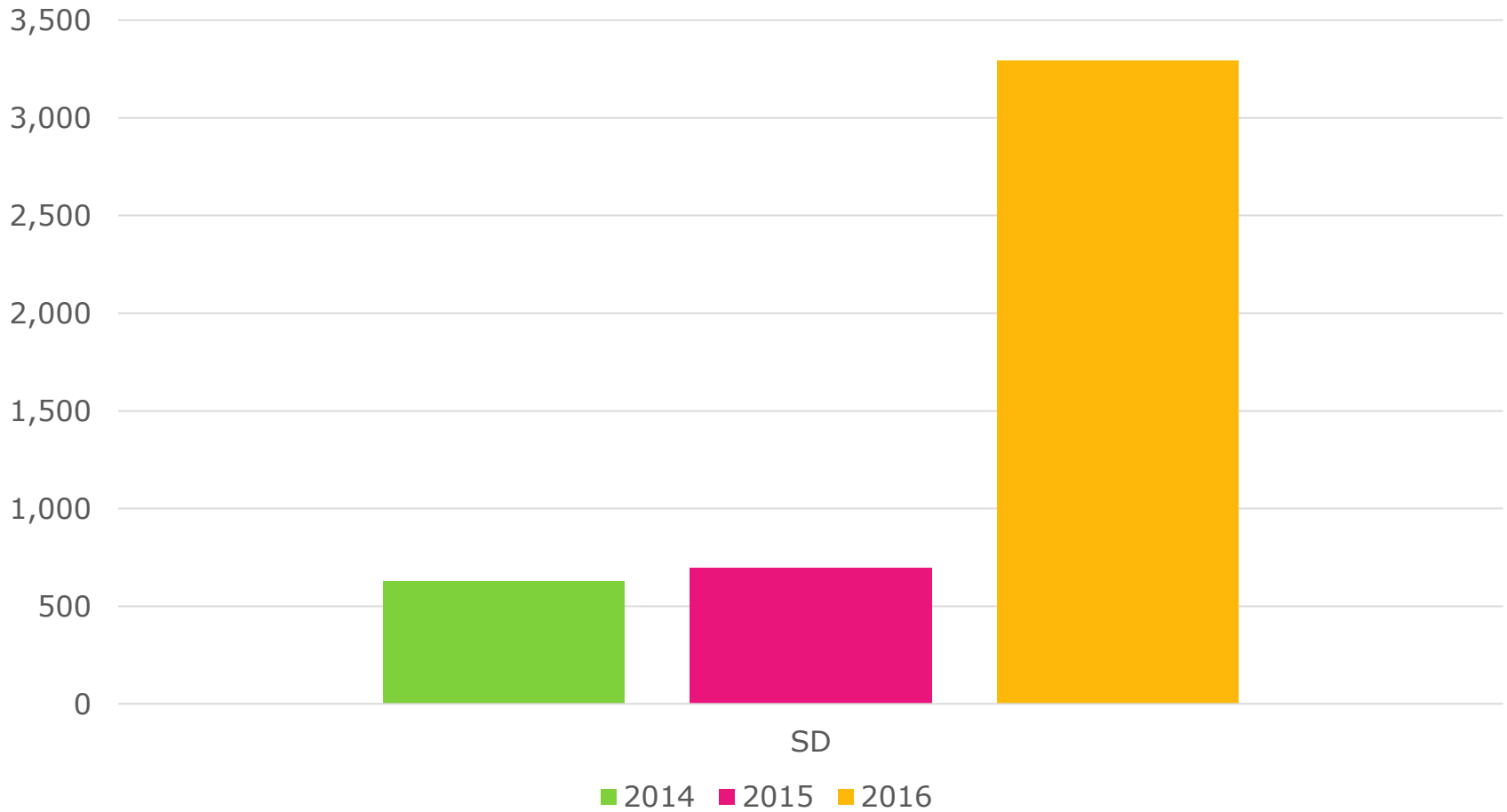
SD Retail Filled Prescriptions: All Opioid Analgesics, 2013-16



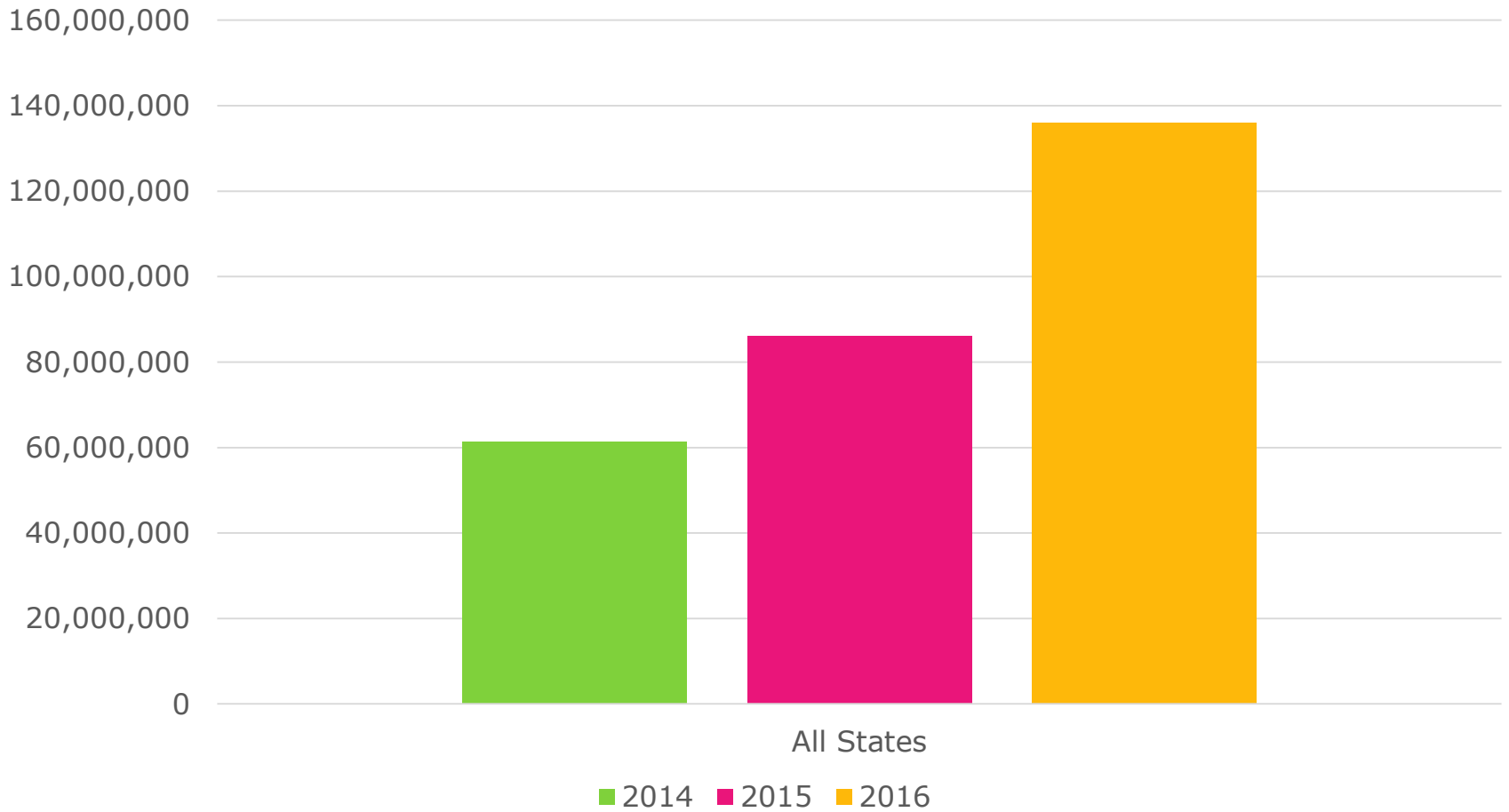
National PDMP Registrations, 2014-16



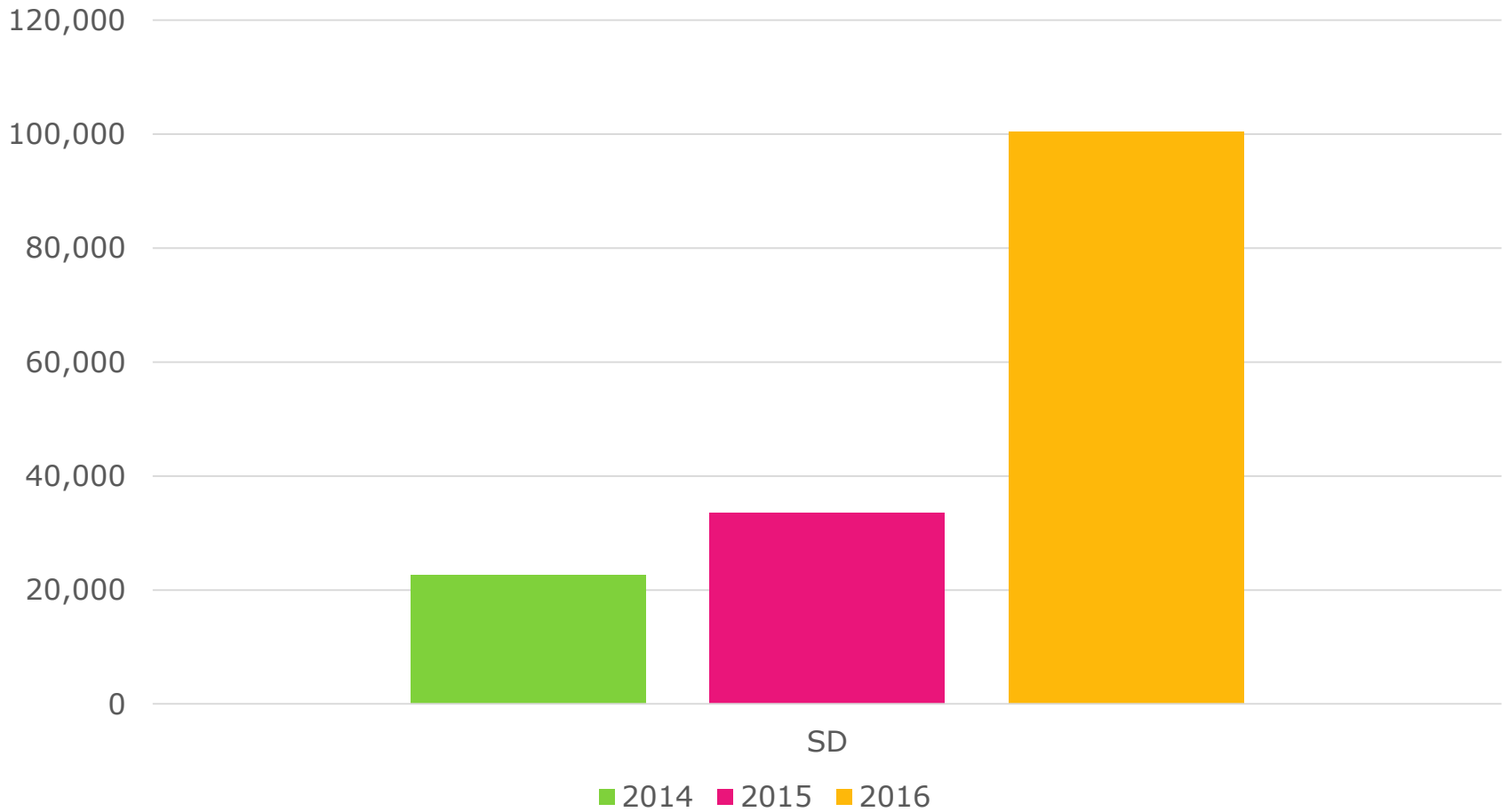
SD PDMP Registrations, 2014-16



National PDMP Queries, 2014-16



SD PDMP Queries, 2014-16





HEALTH

Opioid Prescriptions Fall After 2010 Peak, C.D.C. Report Finds

By ABBY GOODNOUGH JULY 6, 2017



RELATED COVERAGE



C.D.C. Painkiller Guidelines Aim to Reduce Addiction Risk MARCH 15, 2016



Opioid Prescriptions Drop for First Time in Two Decades MAY 20, 2016

RECENT COMMENTS

Kip Hansen 39 minutes ago

I have yet to see any actual evidence that the heroin epidemic is

Are We Making Progress?

Making a Difference: State Successes



2012 Action:

New York required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a 75% **drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.



2010 Action:

Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices.

2012 Result:

Saw more than 50% **decrease in overdose deaths** from oxycodone.



2012 Action:

Tennessee required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

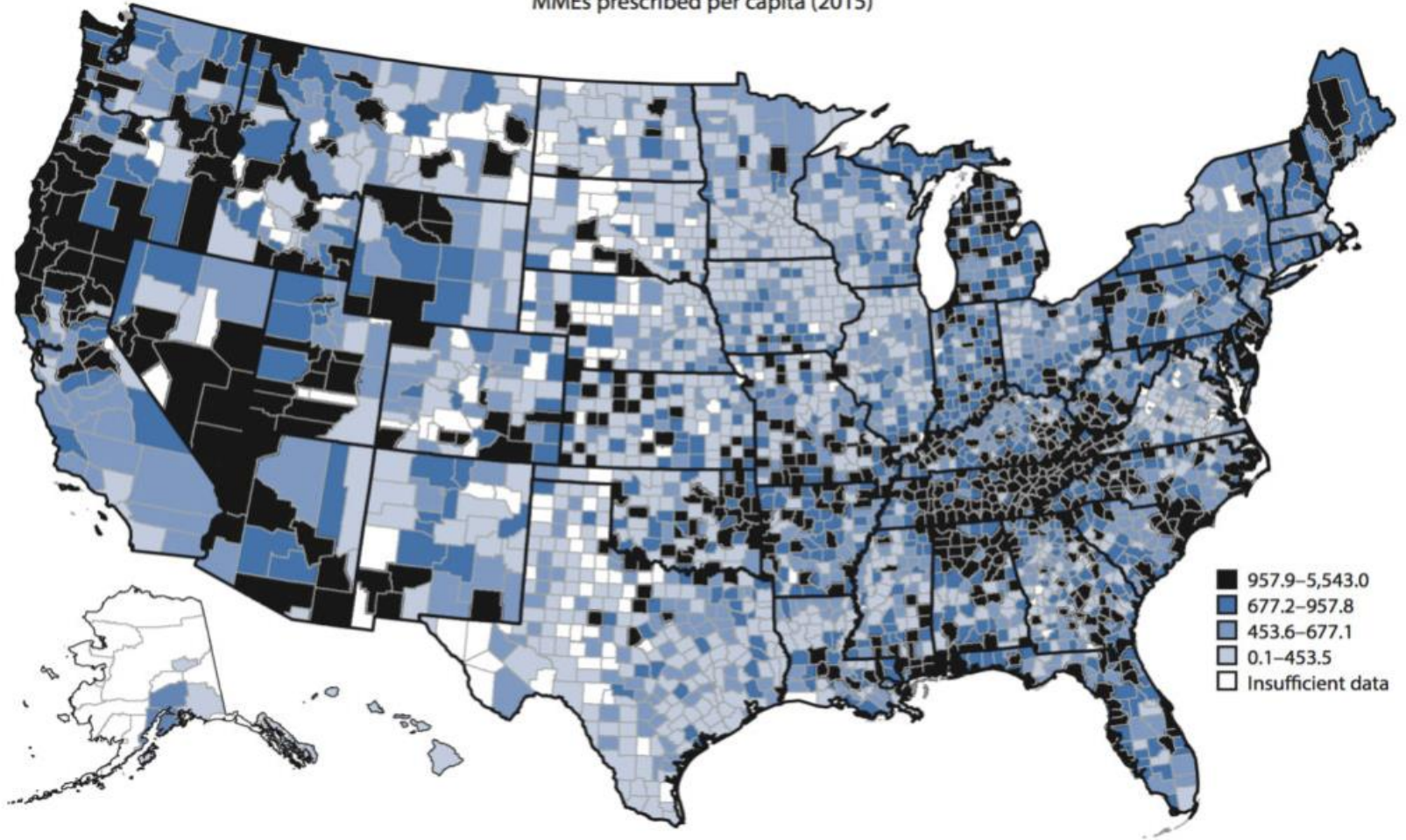
Saw a 36% **drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.

What's Really Going On

- New York
 - Opioid deaths from 2014 to 2015 increased 20.4%
 - Heroin deaths from 2014 to 2015 increased 28.6%
 - 825 to 1,058
- Florida
 - Opioid deaths from 2014 to 2015 increased 22.7%
 - Heroin deaths – no data
- Tennessee
 - Opioid deaths from 2014 to 2015 increased 13.8%
 - Heroin deaths from 2014 to 2015 increased 43.5%
 - 148 to 205
- *Opioid deaths from prescription and illicit combined



MMEs prescribed per capita (2015)



Morphine milligram equivalents of opioids prescribed per capita in 2015.

ODC

Prevention of Opioid Overdose

- Increase availability of opioid dependence treatment
 - Make psychosocial support available
 - Use opioid maintenance treatments such as buprenorphine
 - Support detox and treatment with opioid antagonists such as naltrexone
- Reduce irrational or inappropriate opioid prescribing
- Monitor opioid prescribing and dispensing
- Limit inappropriate OTC sales of opioids

World Health Organization

Two Important Goals

- Provide access to pain medications for those who need them
- Manage the variety of risks posed by prescription opioids

- Key strategies to ensure patient safety and prevent diversion
 - Incorporate evidence-based guidelines into practice
 - Implement reliable patient management processes to assess, monitor and communicate
 - Provide training, tools and education

MMIC Brink, Summer 2017

SDSMA White Paper

Opiate Analgesics for Chronic Non-Cancer Pain

Recommendations from the Committee on Pain Management and Prescription Drug Abuse

South Dakota State Medical Association

Pain Management and Prescription Drug Abuse

The problem of prescription drug abuse and its related health consequences is a significant public health problem. The SDSMA is at the forefront on this issue by providing physicians with helpful, evidence-based guidelines for prescribing opiate analgesics to both effectively treat pain and minimize patient risk. Through a special committee on pain management and prescription drug abuse, the SDSMA has developed a whitepaper, *Opiate Analgesics for Chronic Non-Cancer Pain*, to serve as a resource for physicians and prescribers when treating patients for chronic, non-cancer pain. Over the past several months, our committee has researched evidence-based guidelines based on a review of the literature by a diverse group of highly trained physicians.

Download the SDSMA whitepaper, *Opiate Analgesics for Chronic Non-Cancer Pain*.

Download the [checklist for prescribing opiates for chronic, non-cancer pain](#).



Click for Full Whitepaper.pdf

Special Edition 2016

ADDRESSING THE CHALLENGES OF PRESCRIBING CONTROLLED DRUGS



South Dakota
medicine

SPECIAL EDITION

THE JOURNAL OF THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

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Evidence-Based Guidelines

- Evaluate patients and stratify risks
- Develop a treatment plan and goals
- Obtain informed consent and develop treatment agreement
- Initiate an opioid trial
- Monitor and adapt the treatment plan
- Require periodic and unannounced drug testing
- Adapt treatment
- Consult with and refer to others as needed
- Discontinue opioid therapy
- Document in medical records
- Comply with statutes and regulations

Patient Management Processes

- Assess risk of addiction using risk stratification tool
- Query state PDMP
- Assess pain, function, behavioral health and drug-related behaviors
- Obtain informed consent for therapy
- Monitor pain and function, opioid risk and progress toward treatment goals
- Use treatment agreements for long-term opioid therapy

Checklist for Prescribing Opiates

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.
- Review results of all physical examinations and laboratory tests, including screening assessments.
- Check that non-opiate therapies tried and optimized.
- Evaluate risk of harm or misuse.
 - Confirm that the appropriate state prescription drug monitoring program (PDMP) has been accessed.
 - Check urine drug screen.
- Obtain an informed consent.
 - Discuss benefits and risks (eg, addiction, overdose) with patient.
- Assess baseline pain and function (eg, PEG scale).
- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Prescribe short-acting opiates using lowest dosage on product labeling; match duration to scheduled reassessment.
- Set criteria for stopping or continuing opiates.
- Schedule initial reassessment within 1-4 weeks.

If RENEWING without a patient visit

- Check that return visit is scheduled \leq 3 months from last visit. Schedule visit earlier than 3 months if patient is requesting a prescription refill earlier than prescription instruction/dosage.

Continuation versus Initiation - REASSESSING at return visit

- Check that non-opiate therapies optimized.
- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate progress against agreed-upon treatment for pain relief and function.
 - Continue opiates only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- Evaluate risk of harm or misuse:
 - Observe patients for signs of over-sedation or overdose risk. If yes – taper dose.
 - Check PDMP.
 - Check for opiate use disorder if indicated (eg, difficulty controlling use). If yes – refer for treatment.
- Determine whether to continue, adjust, taper, or stop opiates, and document reasoning in clinic record.
- Calculate opiate dosage morphine milligram equivalent (MME).
 - If \geq 50 MME/day total (\geq 50mg hydrocodone; \geq 33mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid \geq 100 MME/day total (\geq 100 mg hydrocodone; \geq 66mg oxycodone), or carefully justify; consider specialist referral.
- 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;
 - Those in occupations demanding mental acuity;
 - Older adults;
 - Patients with an unstable or dysfunctional social environment;
 - Those with comorbid psychiatric or medical conditions;
 - Those who are taking benzodiazepines; and
 - Those who are taking other medications that may interact with an opiate – to include at-risk alcohol consumers.

REFERENCE

EVIDENCE ABOUT OPIATE THERAPY

- Benefits of long-term therapy for chronic, non-cancer pain is not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIATE THERAPIES

- Use alone or combined with opiates as indicated.
- Non-opiate medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.
- At-risk alcohol consumption (eg, binge drinking).

ASSESSING PAIN AND FUNCTION USING PEG SCALE

- PEG score = average 3 individual question scores
- 30% improvement from baseline is clinically meaningful

- Q1: What number from 0 - 10 best describes your pain in the last week?
0 = "no pain," 10 = "worst you can imagine"
- Q2: What number from 0 - 10 describes how during the past week, pain has interfered with your enjoyment of life?
0 = "not at all," 10 = "complete interference"
- Q3: What number from 0 - 10 describes how, during the past week, pain has interfered with your general activity?
0 = "not at all," 10 = "complete interference"

NOTE: Always document assessments as required by applicable law, including any applicable administrative rules or regulations.



Click to View Larger Checklist.pdf

- Educate clinicians on pain management, evidence-based guidelines, assessment tool use, risk stratification, opioid use disorder and medication-assisted treatment
 - Online webinars and educational materials
 - Presentations throughout the state
 - Tool kit for assessment, risk stratification and patient management

Education Proposal

July 20, 2017

Ms. Kiley Hump
Health Lab Building
615 East 4th
Pierre, SD 57501

RE: Prescription Drug Diversion and Abuse

Intent

The purpose of this letter is to indicate the interest in working with the South Dakota Department of Health to conduct a 12-month prescriber educational campaign to reduce prescription drug diversion and abuse.

Background

The nonmedical use and abuse of prescription drugs is a serious health problem in this country, and although most people take prescription medications responsibly, an estimated 52 million people – 20 percent of those 12 and older – have used prescription drugs for nonmedical reasons at least once in their lifetimes.

Currently, prescription drug overdose is the leading cause of accidental death in the US, with 52,404 lethal drug overdoses in 2015. The current level of prescription opiate abuse nationwide has been described as an “epidemic” by the Centers for Disease Control and Prevention.

While South Dakota had the lowest number of opiate deaths in 2015 when compared to any other state in the US, including D.C., prescription drug abuse is a problem to which South Dakota is not immune. In 2015, we lost 27 of our family members and friends to an opiate-related drug overdose.

Therefore, the SDSMA believes that we need to work with prescribers to improve patient management; reduce opiate prescribing; and to promote alternative interventions in health care.

Problem Statement

1. Deaths from prescription painkillers have reached epidemic levels in the past decade.
 - a. The number of prescription painkiller overdose deaths is now greater than the number of deaths from heroin and cocaine combined, and the number of deaths from prescription painkillers has also surpassed the annual number of deaths associated with vehicle accidents.



- Opioid Therapy for Chronic Pain
- 10 Tips to Safely Prescribe Controlled Substances
- A Differential Diagnosis for “Pain”
- Opioid Addiction in Pregnancy
- What is Buprenorphine?
- Practical Guide to Opioid Pharmacology
- Pain Psychology, Mental Status Exam and Non-Opioid Options for High-Risk Patients
- Symmetry & Asymmetry in Addiction Medicine
- How to Safely Prescribe Benzodiazepines
- Opioid Prescribing in Primary Care
- Pain Management in the Emergency Department
- An Editorial on Pain
- The Opioid Epidemic
- Opioid Addiction and Pain: A Quagmire for Healthcare Professionals

Live Training Events

- Offered to prescribers and dispensers at locations across the state
 - Year 1 - Physicians
 - Year 2 - Physician Assistants, Nurse Practitioners, Dentists
- Physician-led presentations
 - Engage all stakeholders in promoting and attending events

Toolkit Sample – Patient Education

- Chronic Pain Treatment – Controlled Substances
- Chronic Pain Treatment – Distraction Techniques
- Chronic Pain Treatment – Important Information About Your Medications
- Chronic Pain Treatment – Manage Your Pain
- Distraction Techniques – Attention Diversion for Chronic Pain
- Distraction Techniques – Five Steps for Managing Intense Pain Episodes
- Distraction Techniques – Types of Mental Activities
- Relaxation Techniques – Pacing Yourself
- Relaxation Techniques – Stretching Routine
- Risks – One Page Patient Form
- Risks – Pain Agreement

Toolkit Sample – Physician Education

- Consent and Treatment Forms – Medication Agreement
- Consent and Treatment Forms – Opioid Treatment Agreement
- Consent and Treatment Forms – Pain Agreement
- Pain Assessment Form – Global Pain Scale
- Pain Assessment Form – Opioid Dosing for Chronic Non-Cancer Pain
- Patient Form
- Screening Form – Audit Questionnaire Screen for Alcohol Misuse
- Screening Form – CAGE-AID Questionnaire
- Screening Form – Depression Scale
- Screening Form – Generalized Anxiety Disorder Questionnaire
- Screening Form – Opioid Risk Tool
- Screening Form – PHQ-9 Checklist, Scoring
- Screening Form – Stop Bang Questionnaire
- Screening Form – When to Use Screening Tools

Toolkit Sample – Physician Education

- Treatment Protocols – Chronic Illness with Pain Visit #1 Checklist
- Treatment Protocols – Community Safe Prescriber
- Treatment Protocols – Prescription Opioid Abuse in Chronic Pain
- Treatment Protocols – Universal Precautions

Opioid Education Advisory Committee

Reconvene and expand whitepaper group to review curriculum and toolkit

SD Academy of Family Physicians

SD Chapter, American College of Emergency Physicians

SD Chapter, American College of Physicians

SD Chapter, American College of Surgeons

SD Foundation for Medical Care

SD Orthopedic Society

SD Osteopathic Association

SD Society of Physical Medicine and Rehabilitation

SD State Medical Association

SD Dental Association

SD Academy of Physician Assistants

Nurse Practitioner Association of SD

SD Pharmacy Association

State Dental, Medical, Nursing and Pharmacy Boards

Prescription Drug Monitoring Program

Additional Strategies

- Integrate PDMP reports into health information technologies including health information exchange, EHR systems, and pharmacy dispensing software systems to streamline provider access
- Improve the comprehensiveness of PDMP reports by initiating or increasing interstate PDMP data exchange
- Discuss value of other strategies including prescribing rules (e.g., limits on refills, numbers of pills, informed consent, treatment plan)

On the Solution

- Every day, more than 90 Americans die from opioid overdoses.
- We have overexposed the population to prescription opioids, a highly addictive drug.
- Yet it's important to ensure that people get the treatments they need.
- Many patients suffering from opioid addiction have problems at work, in their personal relationships, have legal problems and serious health issues.
- There is too much emphasis on physicians to solve this problem. Addiction is socioeconomically complicated and a multi-generational trauma. Physicians are given 10 minutes to put that all together. It's unrealistic and isn't going to solve the problem.
- We need to better inform family members, friends of people who have become addicted to prescription drugs, anybody who is going to be prescribing so they can stop the kinds of behaviors contributing to the problem.

On the Solution

- We need to get financial incentives for using medications out of our health care system.
- Ultimately, we need to come up with a better solution to treating pain than the current addictive opioid class of drugs.

SOUTH  DAKOTA
STATE MEDICAL ASSOCIATION

Values. Ethics. Advocacy.