OPIOID PRESCRIBING: SAFE PRACTICES AND SAVING LIVES 2018 UPDATE

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SEPTEMBER 29, 2018

UCLA Health

AAAMS
ARMENIAN AMERICAN MEDICAL SOCIETY

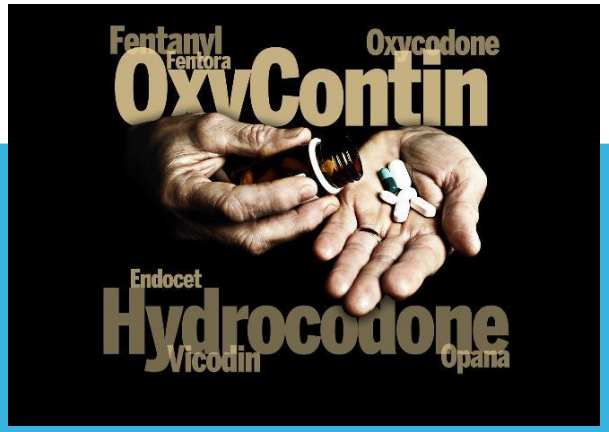
CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

Disclosures

- **American Academy of Family Physicians,**
  Executive Committee, Commission of Education
- **California Academy of Family Physicians,**
  Board of Directors, District IV
- **University of California Los Angeles**
  Family Medicine Department,
  Residency Associate Program Director
  Assistant Clinical Professor
- I have no commercial or private interests to declare

PUBLIC HEATH CRISIS OF OPIOID OVERDOSES IN THE UNITED STATES

- Drug overdose deaths in the US have more than quadrupled since 1999
- 63,632 = total overdose deaths in 2016, a 21% increase from 2015
- Worst addiction epidemic in the U.S. Every day, 44 people in the U.S. die from opioid OD. Nearly 2 deaths/hr
- Prescription opioids, heroin, and synthetic opioids (fentanyl) are the major causes of the drug overdose deaths

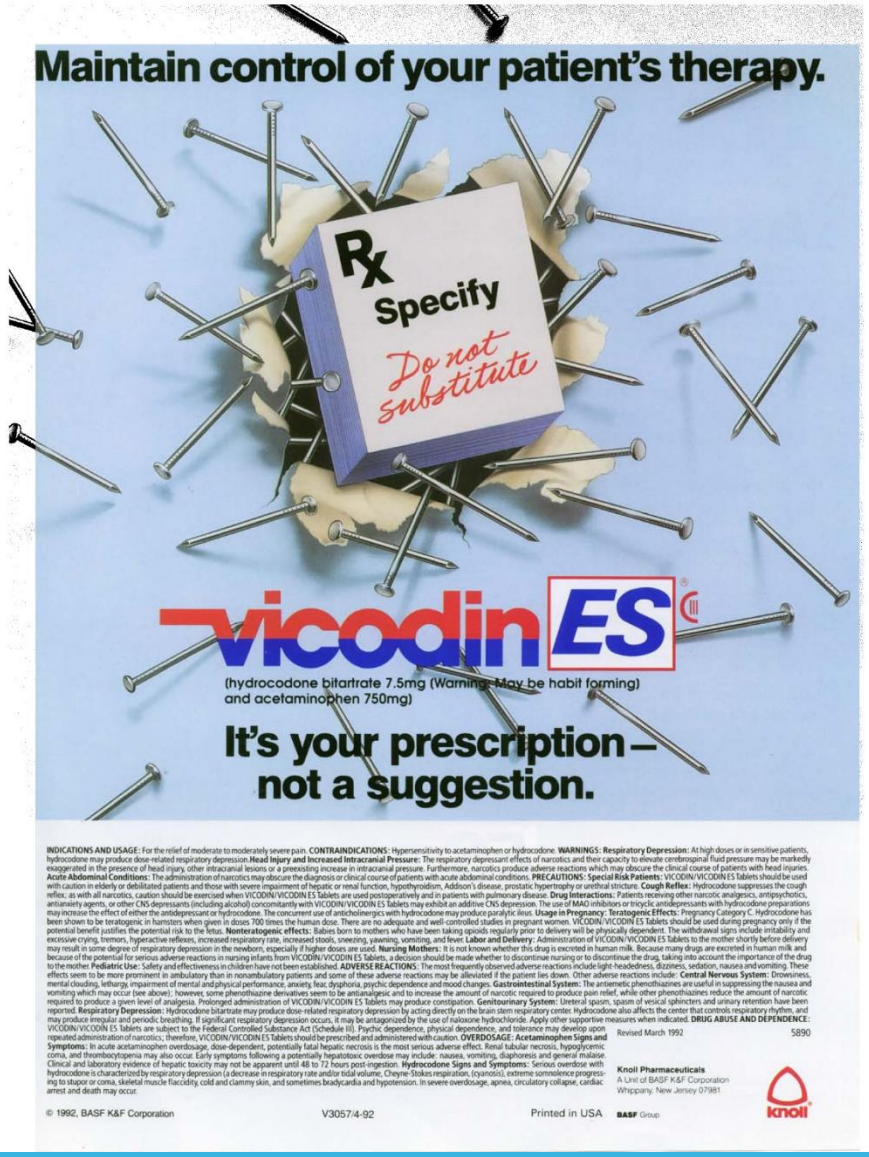


PUSH FOR PAIN CONTROL IN 80's and 90'S

- Under-treatment of pain
- Pain as a human rights issue
- Early data that opioid risks were low
- Pain as 5th vital sign
- Porter J., Jick H., et al, *New England Journal of Medicine*, Jan 1980
  - "the development of addiction is rare in medical patients with no history of addiction"
- Portenoy R., 1986
  - "opioid maintenance therapy can be a safe, salutary and more humane alternative to surgery or to not treating a patient with chronic pain"
- The Joint Commission, 2000
  - "there is no evidence that addiction is a significant issue when persons are given opioids for pain control."

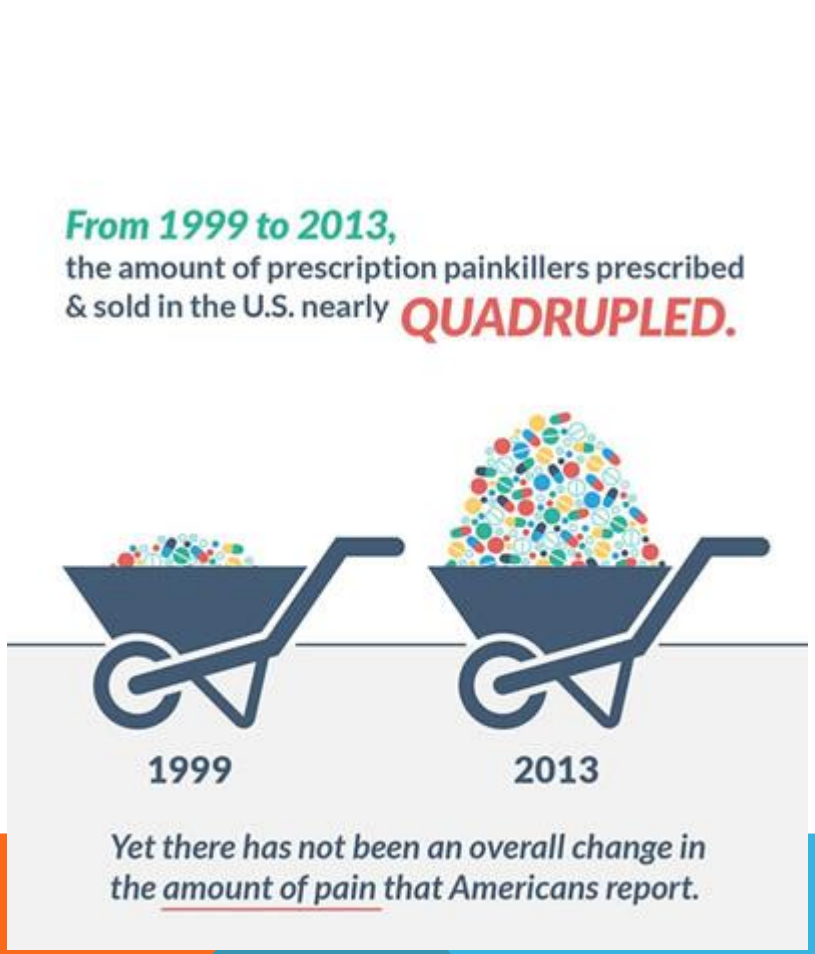
Pain
the 5th vital sign™
American Pain Society

MARKETING FOR PAIN CONTROL IN 1990'S



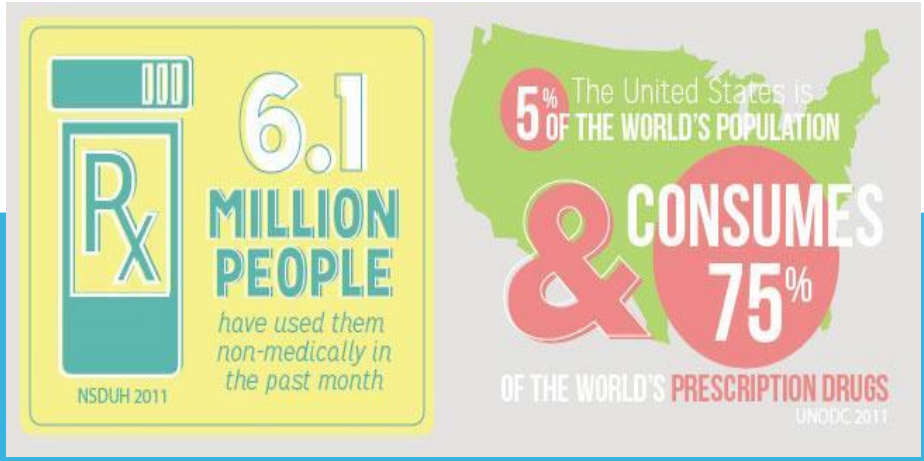
1996: THE BIRTH OF OXYCONTIN

PUBLIC HEATH CRISIS OF OPIOID OVERDOSES IN THE UNITED STATES



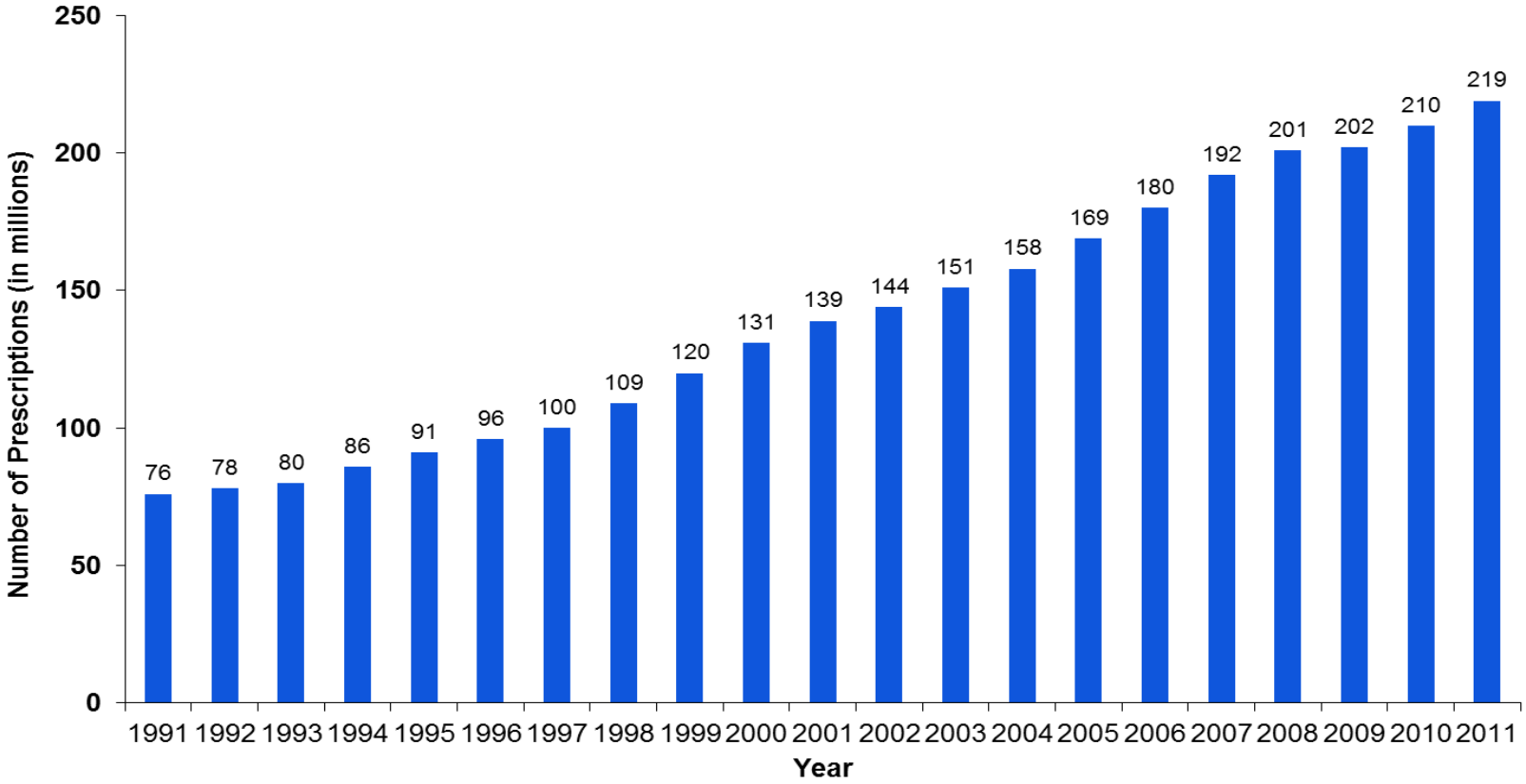
CDC.gov

TIME Magazine, June 15, 2015



CDC.gov

Opioid Prescriptions Dispensed by Retail Pharmacies- United States 1991-2011

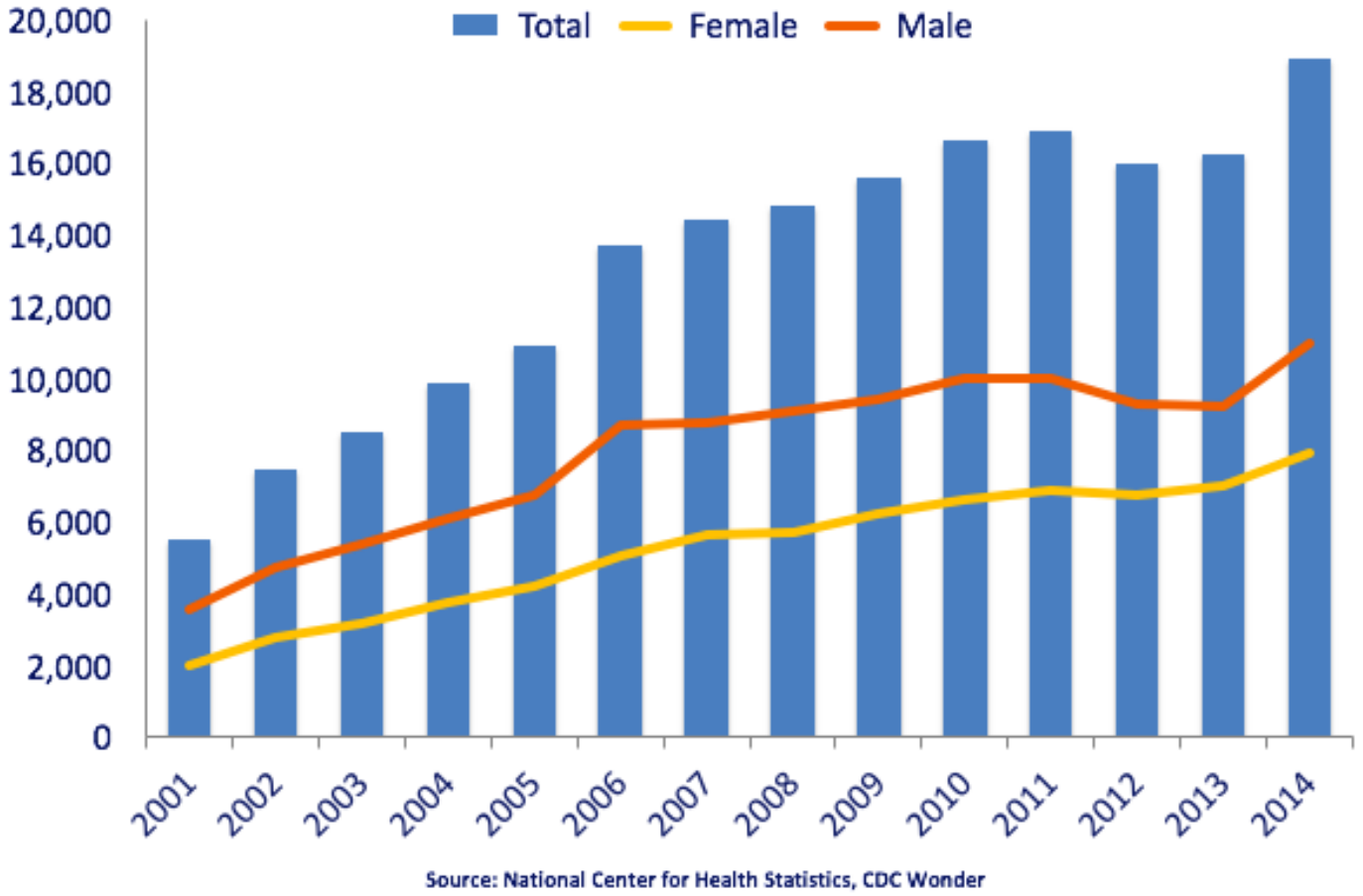


IMS Vector One. From "Prescription Drug Abuse: It's Not what the doctor ordered." Nora Volkow National Prescription Drug Abuse Summit, April 2012.

National Institute on Drug Abuse

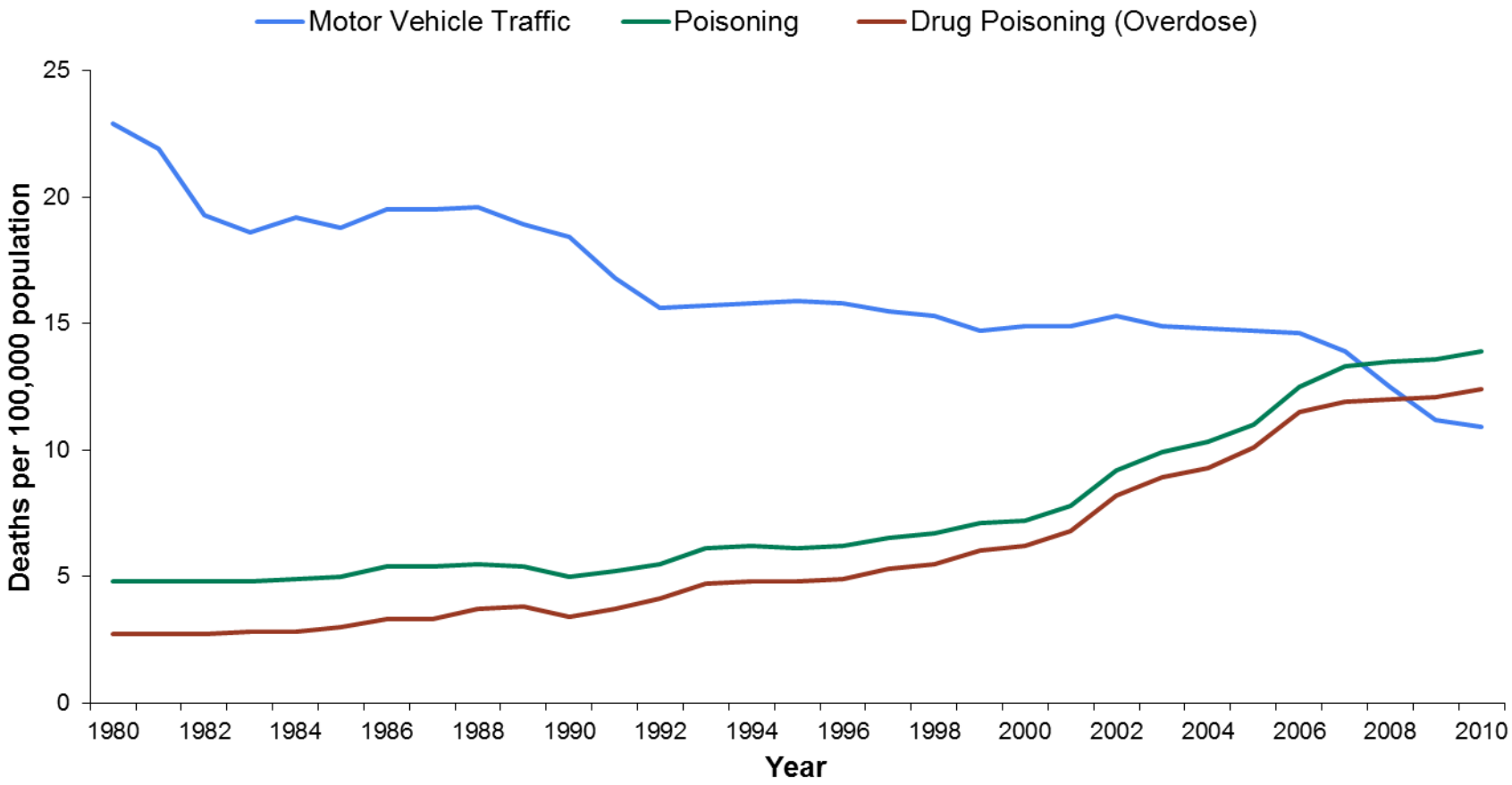
National Overdose Deaths

Number of Deaths from Prescription Opioid Pain Relievers



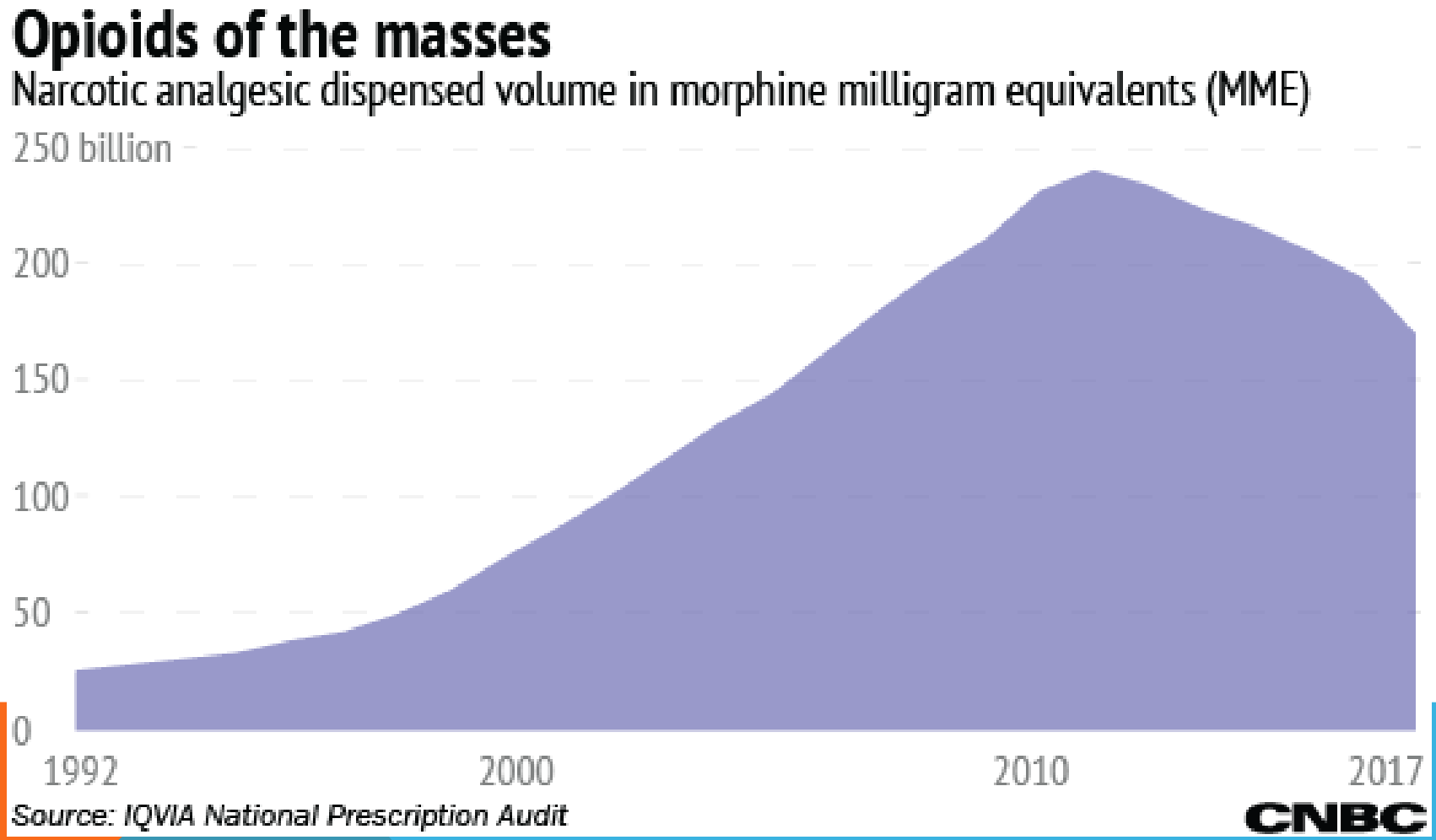
Source: National Center for Health Statistics, CDC Wonder

Motor Vehicle Traffic, Poisoning, and Drug Overdose Death Rates, US 1980-2010



NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data.

Providers starting to prescribe less opioids



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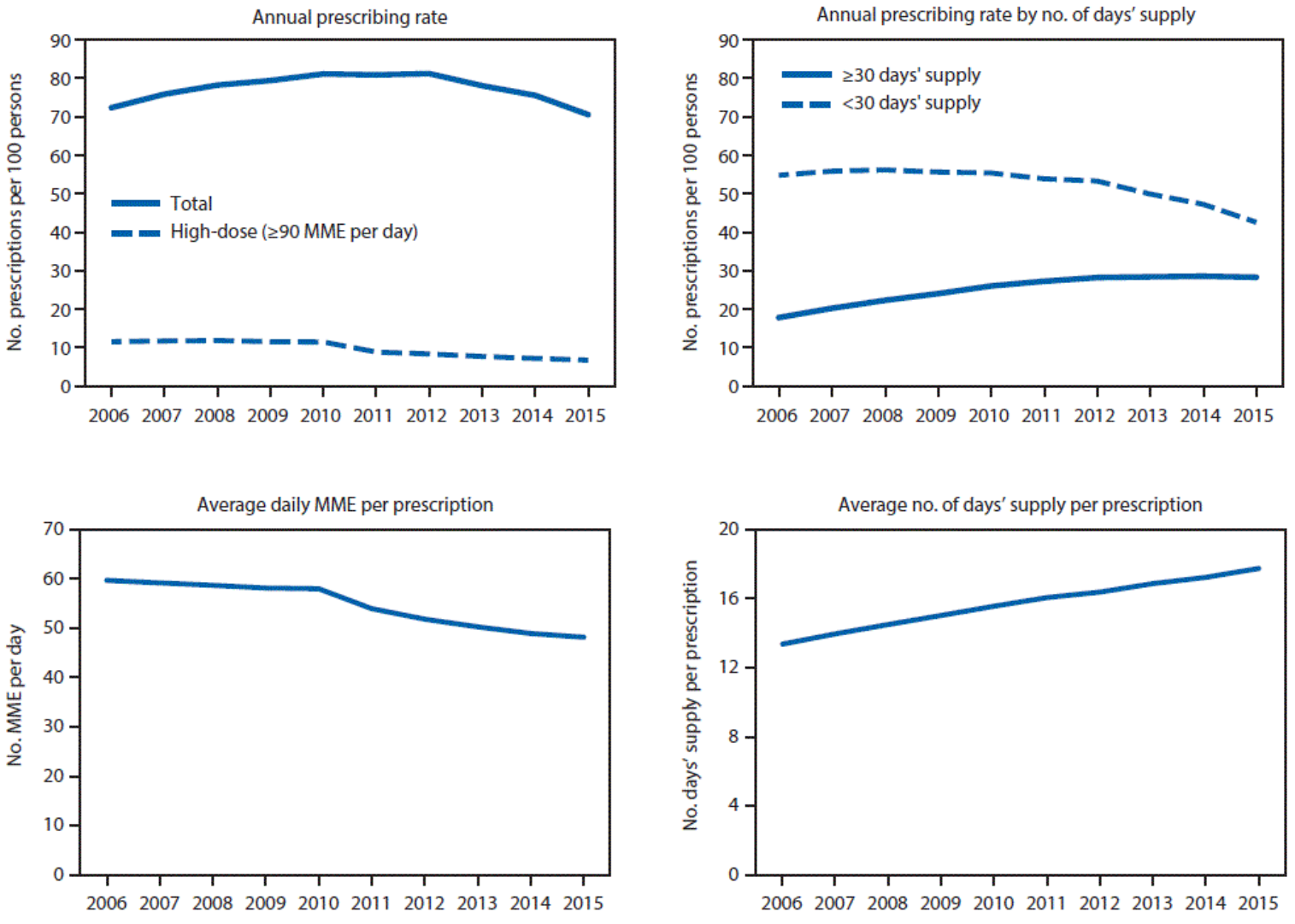
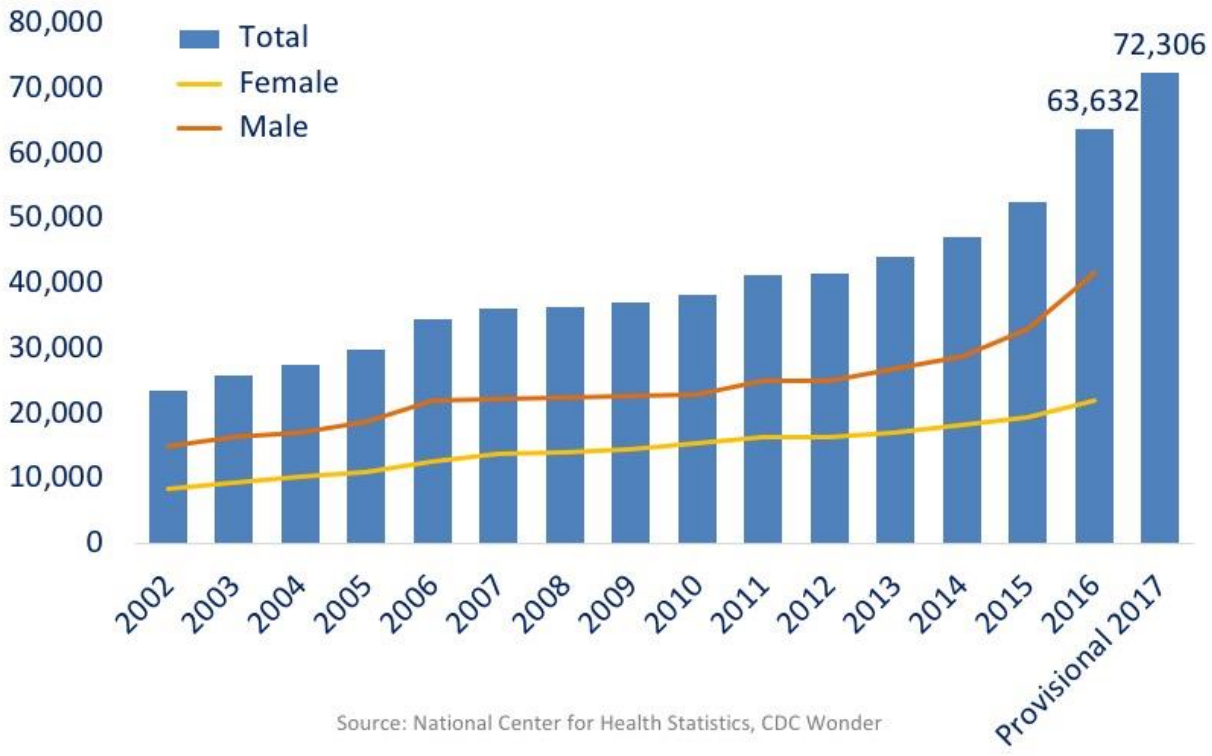


CDC Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704.

National Institute on Drug Abuse

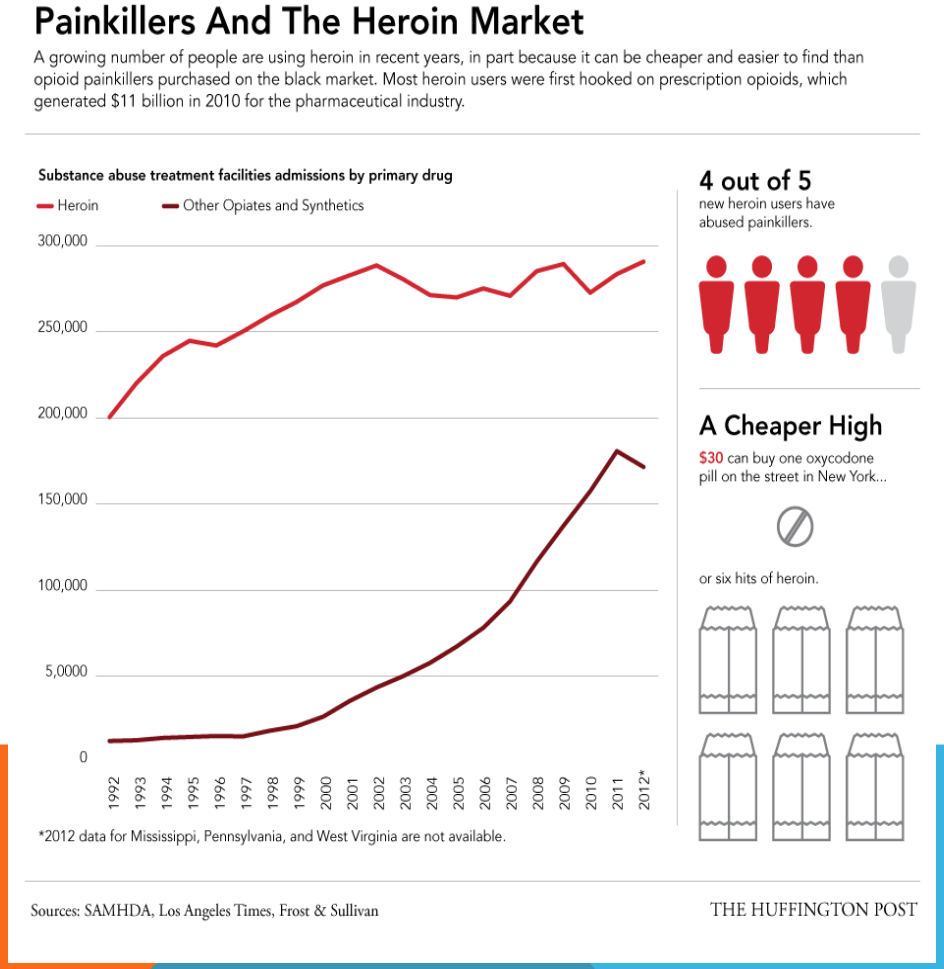
National Overdose Deaths

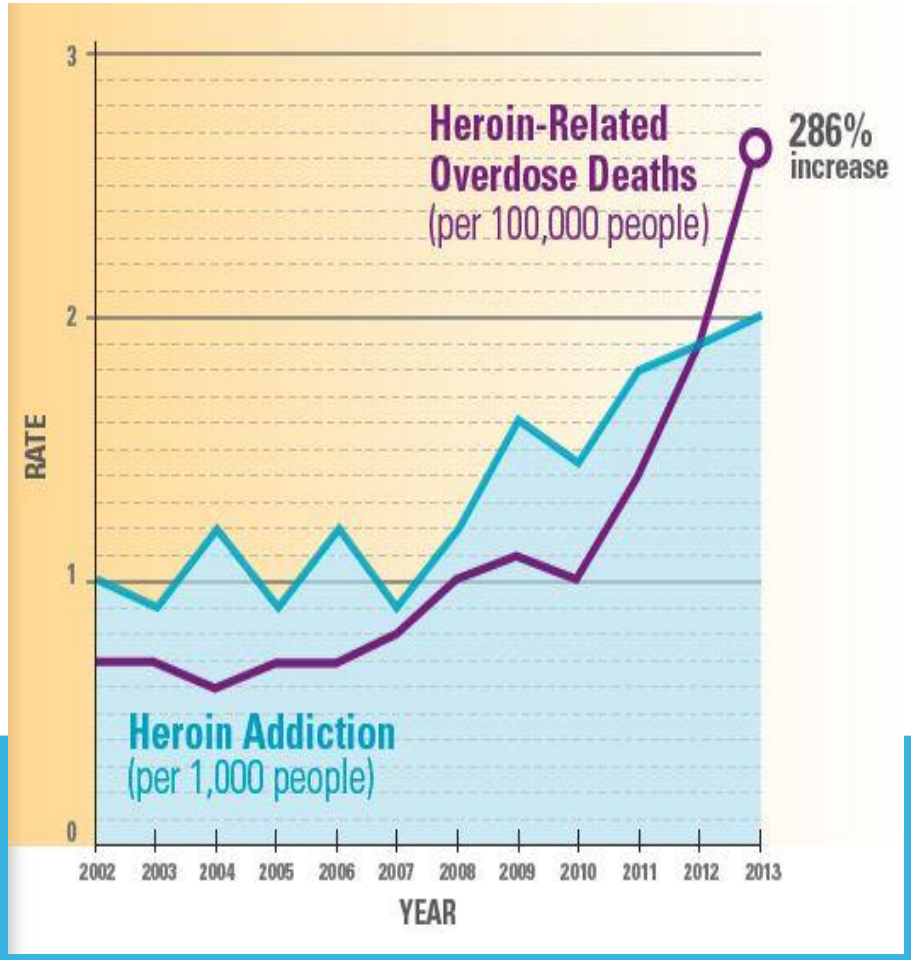
Number of Deaths Involving All Drugs



Source: National Center for Health Statistics, CDC Wonder

Opioid prescribing is now decreasing, but many patients are switching to heroin

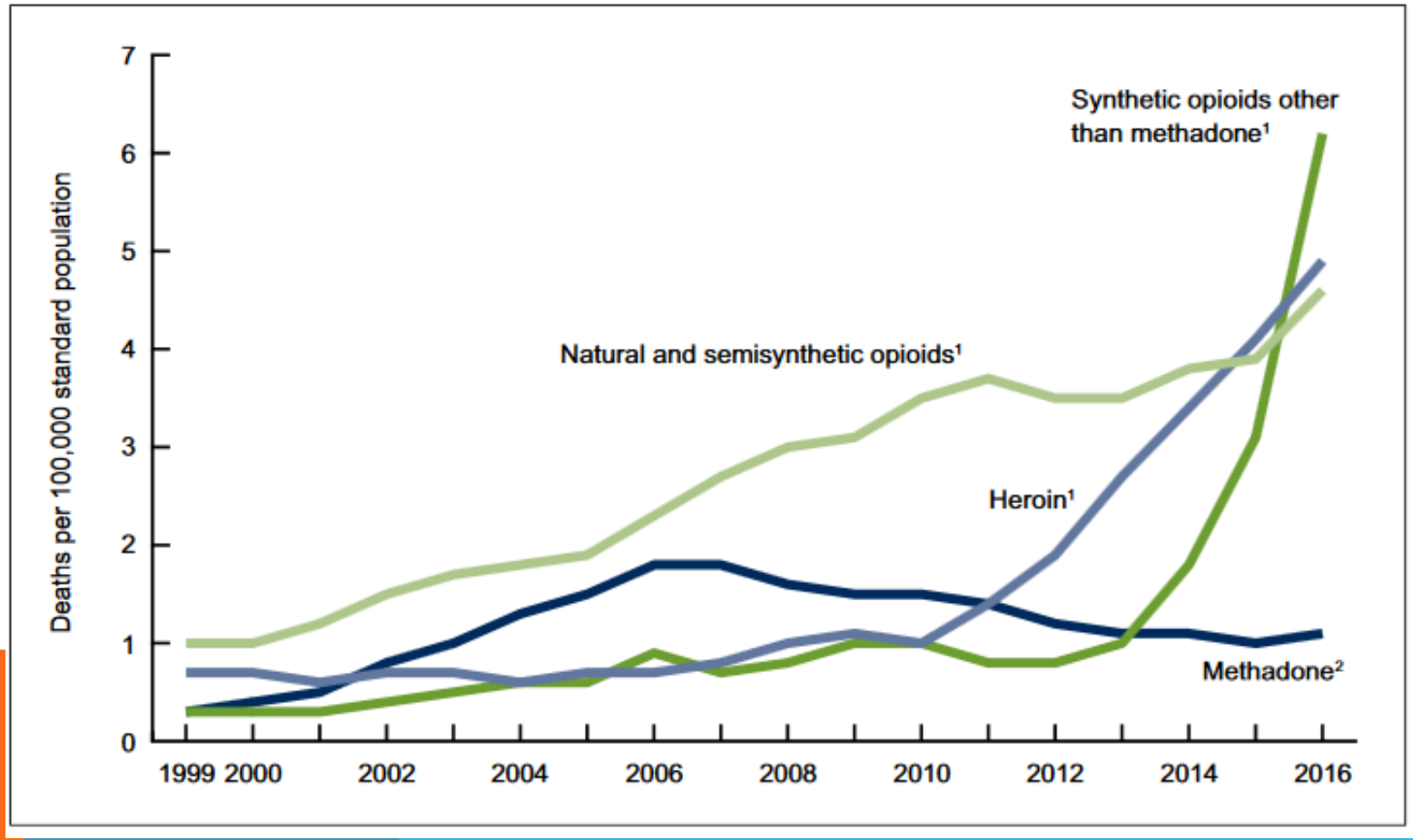




NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data.

Most recent sharp rise due to fentanyl

Figure 4. Age-adjusted drug overdose death rates, by opioid category: United States, 1999–2016



www.cdc.gov/drugoverdose

UNITED STATES DEPARTMENT OF JUSTICE
OFFICE OF PUBLIC AFFAIRS

February 21st , 2011

CDC declares a opioid addiction epidemic in US

April 9th , 2013

States start passing legislation allowing lay persons to administer naloxone

March 10th , 2014

Attorney General Holder, Calling Rise in Heroin Overdoses 'Urgent Public Health Crisis,' Vows Mix of Enforcement, Treatment

August 8th , 2016

Surgeon General, Dr. Vivek Murthy, asks all health care provider to take "The Pledge", launches Turnthetiderx.org, releases CDC Opioid Prescribing Guideline

October 26th , 2017

Trump declares opioid crisis a "public health emergency", but does not declare it a "national emergency" => thus no new funds are requested or allocated

Turnthetiderx.org

-Pocket Guide

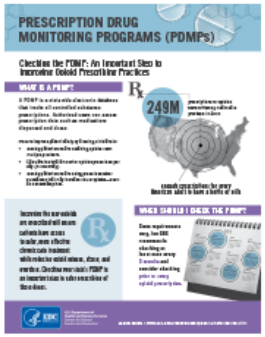
-MME Calculator

-PDMP's

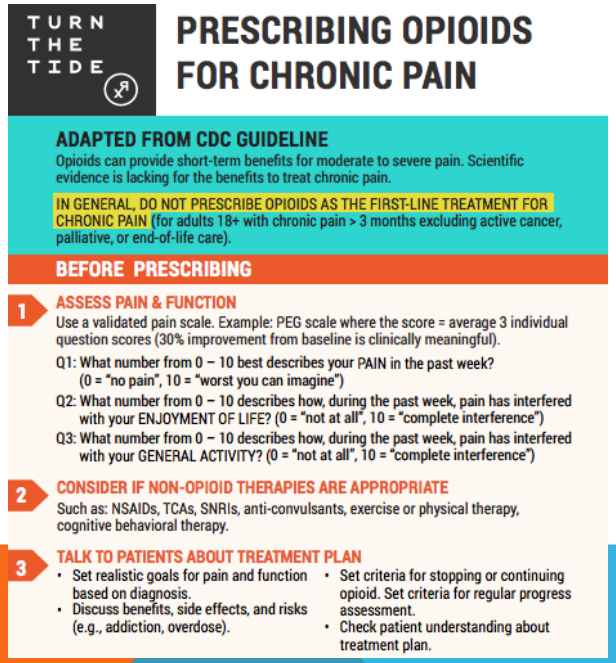
Calculating Total Daily Dose & MME Conversions (2 pages)

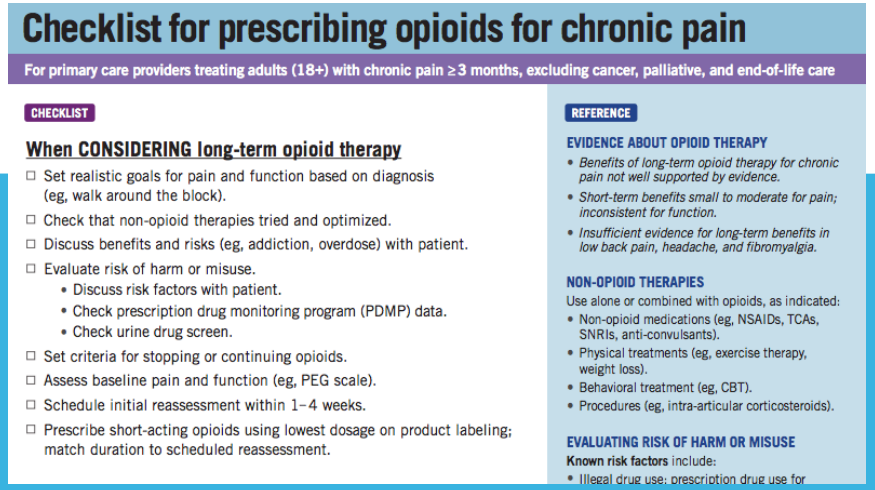
SOURCE: Centers for Disease Control and Prevention, 2016

Prescription Drug Monitoring Programs (PDMPs) (2 pages)



SOURCE: Centers for Disease Control and Prevention, 2016





AN INITIATIVE OF Surgeon General of the United States

WEBSITE CREATED IN PARTNERSHIP WITH PHFE Public Health Foundation Enterprises

100 Million Healthier Lives

CONVENED BY Institute for Healthcare Improvement

SO WHEN DO YOU PRESCRIBE OPIOIDS?

CDC Opioid Prescribing Guidelines

Acute pain

- ⇒ lowest effective dose of immediate-release opioids
- ⇒ => 3 days or less, rarely more than 7 days

Chronic pain

- ⇒ No restrictions for active cancer, palliative, and end-of-life
- ⇒ Line between acute pain and initial chronic pain not always clear
- ⇒ Pain lasting longer than 3 months or past the time of normal tissue healing is generally no longer considered acute

LONG-TERM OPIOID TREATMENT

- ⇒ Set realistic goals regarding pain and function based on dx
- ⇒ Check that non-opioid therapies tried and optimized
- ⇒ Discuss benefits and risks
- ⇒ Set criteria for stopping or continuing opioids
- ⇒ Assess baseline pain or function (PEG scale)
- ⇒ Schedule initial reassessment in 1-4 weeks
- ⇒ Evaluate risk of harm or misuse
  - ⇒ Check prescription drug monitoring program (PDMP) data
    - ⇒ *In California CURES 2.0*
    - ⇒ Check urine drug screen

CURES 2.0

Assessing Pain & Function Using PEG Scale

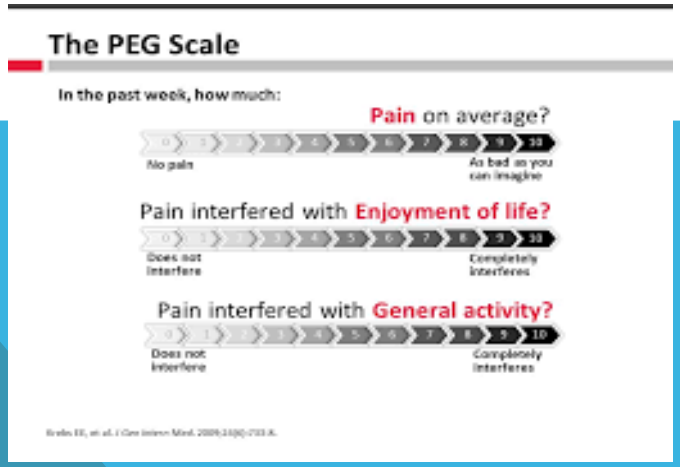
PEG Score = average 3 individual question scores

=> 30% improvement from baseline is clinically meaningful

Q1: *What number from 0-10 best describes your* ***pain in the past week****?*

Q2: *What number from 0-10 best describes how during the past week, pain has* ***interfered with your enjoyment of life****?*

Q3: *What number from 0-10 best describes* ***how*** *during the past week, pain has* ***interfered with your general activity****?*



WHEN REASSESSING AT RETURN VISIT

- ⇒ Assess baseline pain or function (PEG scale), and compare to baseline
- ⇒ Observe patient for signs of over-sedation/overdose risk
- ⇒ Check PDMP
- ⇒ Determine with to continue, adjust, taper, or stop opioids
- ⇒ Calculate opioid dosage morphine milligram equivalent (MME)
  - ⇒ If ≥50 MME/day total (≥50mg hydrocodone; ≥33mg oxycodone)
    - ⇒ Increase freq of f/u; consider offering naloxone
- ⇒ If ≥90 MME/day (≥90mg hydrocodone; ≥60mg oxycodone)
    - ⇒ Carefully document justification; consider specialist referral
- ⇒ Schedule reassessment at regular intervals (<3months)

Calculating MME

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/ acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

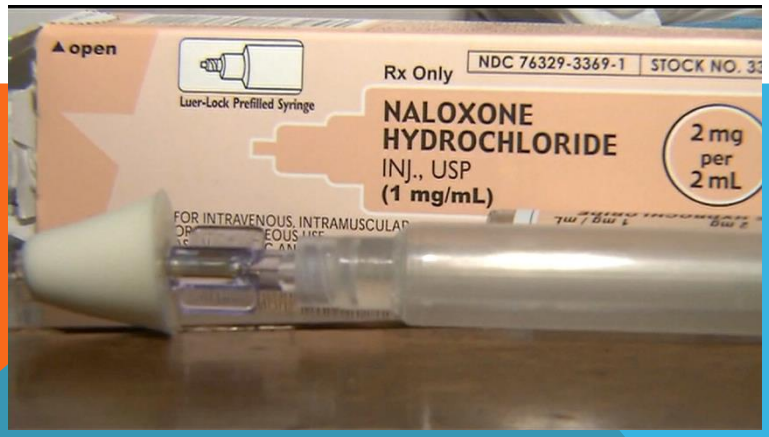
- 90 mg of hydrocodone (9 tablets of hydrocodone/ acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	**CONVERSION FACTOR**
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

NALOXONE (NARCAN)

- reverses the effects of opioids including respiratory depression, sedation and hypotension
- pure opioid antagonist
- antagonizes opioid effects by competing for the μ, κ and δ opiate receptor sites in the CNS
- does not possess the "agonistic" or morphine-like properties characteristic of other opioid antagonists
- in the absence of other opioids it exhibits essentially no pharmacologic activity



LEGISLATIVE CHANGES IN CALIFORNIA

AB 635, Ammiano. Drug overdose treatment: liability.

legislation that supports and provides legal protections for health care providers to prescribe naloxone to be administered by non-medical personnel in cases of suspected life threatening opioid overdose

AB 1535, Bloom. Pharmacists, Naloxone Hydrochloride:

legislation that supports and provides legal protections for pharmacists to prescribe naloxone to patients in accordance with standardized procedures and protocols developed and approved by the Medical Board of California and California State Board of Pharmacy

New Regulations form CA Medical Board

Starting October 2nd, 2018, all California providers who prescribe controlled substance (Class II to IV) are required to check the state's Controlled Substance Utilization Review and Evaluation System (CURES) website.

- Rule applies to ALL schedule II to IV substances: includes opioids, benzodiazepines, and stimulants

- Prescriber only one should check the CURES report by logging into website.

- Prescriber is not allowed to share password to CURES website with anyone

Prescriber may designate a delegate to search for a patient in the CURES database but cannot review the search result, can only forward the search result to the prescribing provider

https://oag.ca.gov/cures/faqs

California Health and Safety Code section 11165.4(a)

New regulations from CA Medical Board

Acute Rx:

- mandatory to check CURES before 1st presciption, unless less than 5 day supply
- CURES can not be check no earlier than 24hrs (or previous business day) before prescribing

Chronic Rx:

- every patient needs a face-to-face visit AT LEAST every 3 months
- check CURES at least every 4 months – now MANDATORY
- Urine Tox screen AT LEAST annually

https://oag.ca.gov/cures/faqs

California Health and Safety Code section 11165.4(a)

New Regulations

CA Assembly Bill 2760 (Wood):

- Signed by Gov. Brown just 2 weeks ago

- Requires all providers to offer a prescription of Naloxone with any opioid Rx if:
  - 90MME /day or above
  - opioid is prescribed concurrently with a benzodiazepine
  - Patient has increased risk for opioid overdose

- Requires provider to provide education and caution regarding overdose symptoms and reversal agents

If prescriber fails to offer naloxone Rx or provide use information
=> shall be referred to the licensing organization for administrative action

CASE 1

History:

31 y/o M presents to urgent care for acute knee pain. Pt reports falling off ladder and hitting his knee while working in his garage last night. He reports being in 9/10 pain and is having difficulty ambulating and bending his knee. He has a history of peptic ulcer disease and reports being intolerant to NSAID's. He also has a history of anxiety that is currently well controlled with Sertraline 100mg Qday and Lorazepam 1mg BID. "I need something strong to ease the pain doc."

Pexam:

large ecchymosis over R patella, +TTP over patella, ROM with flexion and extension limited by pain to 110 degrees, no ligamentous laxity noted, minimal joint line tenderness

Imaging:

R knee Xray -neg for acute fracture, minimal degenerative changes

CASE 1

⇒Would you prescribe opioids for this patient?

⇒ If yes what type? How many days supply?

⇒What else are you required to do for regulatory compliance?

CASE 1

⇒Rx Hydrocodone/APAP 5mg/325mg 1 tab PO Q8H prn severe pain

⇒ 3 tabs x 5mg =15mg hydrocodone/day = 15MME/day

⇒#12 (3 day supply)

⇒1st time you are prescribing opioid to this patient need to check CURES Patient Activity Report

⇒Pt is on both opioids and benzodiazepines required to offer Rx for naloxone

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

CASE 2

History:

55 y/o F presents to your primary care office for acute on chronic back pain. Pt is well known to you. She a h/o of severe spinal stenosis, s/p multiple ESI. She goes to acupuncture and does home physical therapy. Is currently taking Naproxen 500mg bid, Gabapentin 800mg tid, Dialudid 4mg po q4h.

Pexam:

patient in significant discomfort, standing in room because sitting exacerbates her pain, significant pain with flexion and extension of low back, 5/5 motor strength in b/l LE, sensation intact, normal rectal tone

MRI L-spine: significant spinal stenosis L1-L4

CASE 2

⇒Is the opioid regimen appropriate for this patient?

⇒ If not, how would you change it?

⇒What else are you required to do for regulatory compliance?

CASE 2

⇒ convert short acting opioid to long-acting opioid for better pain control, and less risk of abuse

⇒Dilaudid (Hydromorphone) 4mg q4h = 24mg Dilaudid/day

⇒24mg x 4 = 96MME/day

⇒MS Contin 30mg q8h (90MME)

⇒#90 (30 day supply)

⇒Document PEG scale score

⇒Utox now

⇒need to check CURES Patient Activity Report

⇒Provide naloxone prescription, review overdose risks, refer to pain management specialist to co-mange patient

Calculating morphine milligram equivalents (MME)

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21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Take Home Points

- Opioid overdose death rates have dramatically risen and the opioid epidemic in the US is worsening

- Maximize non-opioid therapies for pain management first, make opioids your last option
- CDC guidelines for opioid treatment
  - Treat acute pain for 3 days, rarely more than 7 day
  - If treating pain longer than 3 months then likely chronic pain
  - When treating chronic pain the hallmarks for dosing are ≥50MME/day and ≥90MME/day
- CURES 2.0 database checks are required for controlled substance prescribing starting October 2nd, 2018

- CA Prescribers are required to offer naloxone Rx and counseling for high risk patients starting January 1st, 2019
- Use CDC resources: Turningthetiderx.org

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QUESTIONS? AT THE END