Reversing the opioid epidemic-And Improving Care for Chronic Pain

FDA/Duke Opioid Conference **Feb 15, 2018**

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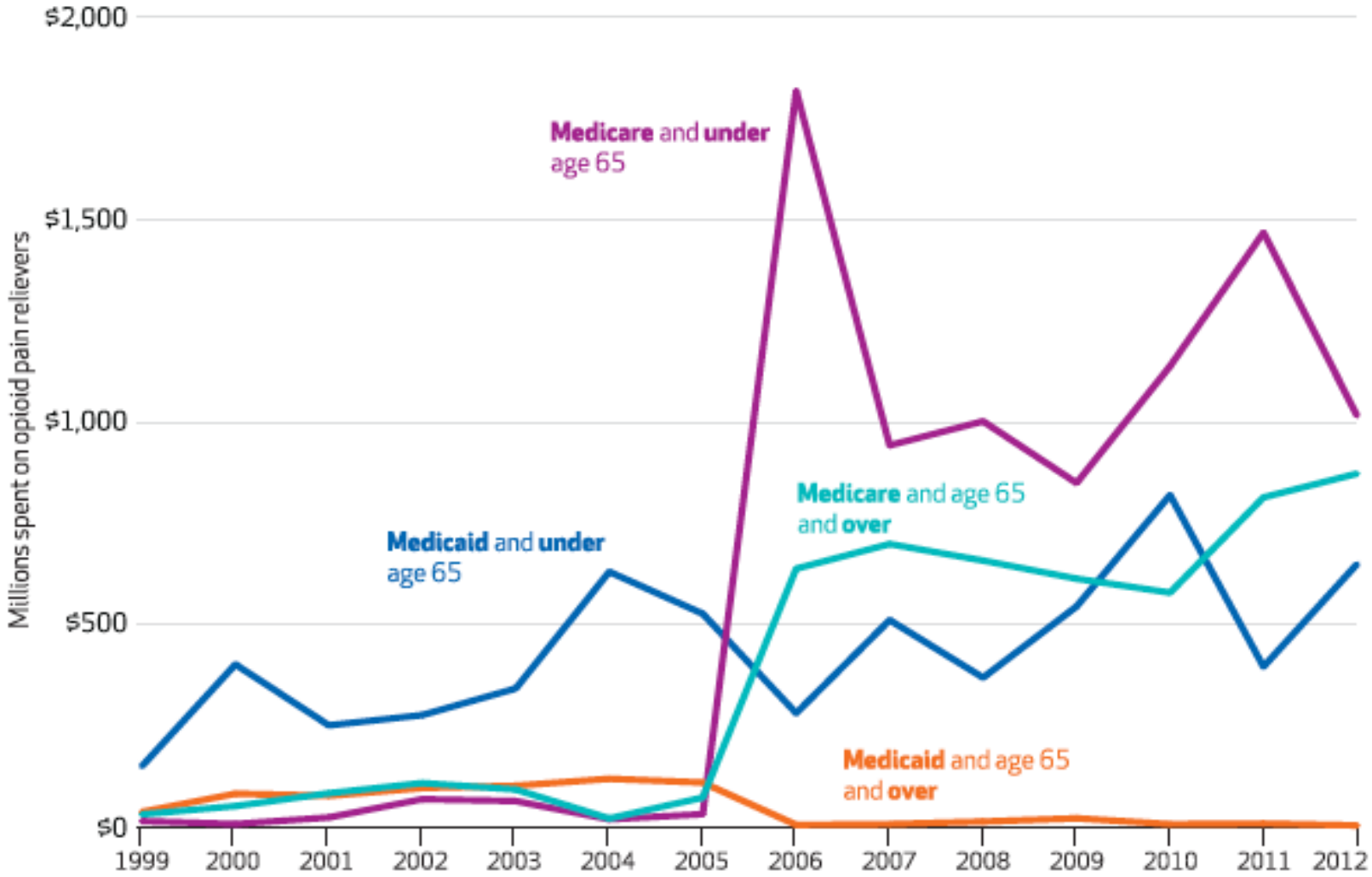
The worst man-made epidemic in modern medical history

- Over 200,000 deaths
- Many more hundreds of thousands of overdose admissions
- Millions addicted and/or dependent
  - Degenhardt et al Lancet Psychiatry 2015; 2: 314-22; POINT prospective cohort: DSM-5 opioid use disorder: **29.4%**
- Spillover effect to to SSDI* and to heroin (40% new initiates started on Rx opioids)

*Franklin et al, Am J Ind Med 2015; 58: 245-51

US expenditures for opioid pain relievers for enrollees in Medicare or Medicaid, by age group and year



SOURCE Authors' analysis. **NOTES** Expenditures were adjusted by the Medical Expenditure Panel Survey's pharmaceutical price index, which used 2009 as the base year. Medicare spending for both elderly and nonelderly enrollees increased significantly ($p < 0.01$) from 2005 to 2006.

Zhou C, Florence CS, Dowell. Payments for Opioids Shifted Substantially To Public And Private Insurers While Consumer Spending Declined, 1999-2012. Health Aff (Millwood). 2016 May 1;35(5):824-31. doi: 10.1377/hlthaff.2015.1103.

Early opioids and disability in WA
WC. Spine 2008; 33: 199-204

- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days(median)
- 14% on disability at one year
- **Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment for pain, function, injury severity**

Summary of
2015 Interagency Guideline on Prescribing Opioids for Pain

AMDG agency medical directors' group
A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

See full guideline at
www.AgencyMedDirectors.wa.gov

All pain phases

- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don't prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

Acute phase (0–6 weeks)

- Check the state's Prescription Monitoring Program (PMP) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain

- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

Subacute phase (6–12 weeks)

- Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)

- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient's risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

over

When to discontinue

- At the patient's request
- No CMIF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guideline

Considerations prior to taper

- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn't on high-dose opioids or doesn't have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

How to discontinue

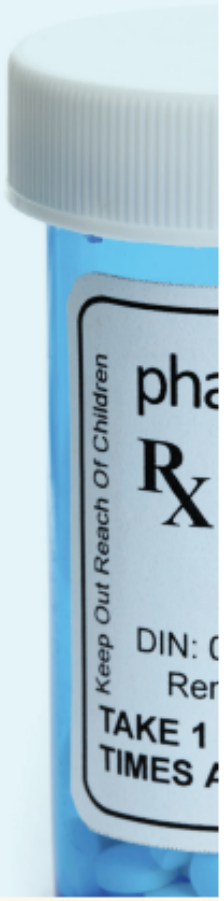
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient's response.
- Don't reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.

Recognizing and treating opioid use disorder

- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naloxone (especially if you suspect heroin use) and educate patient's contacts on how to use it.

Special populations

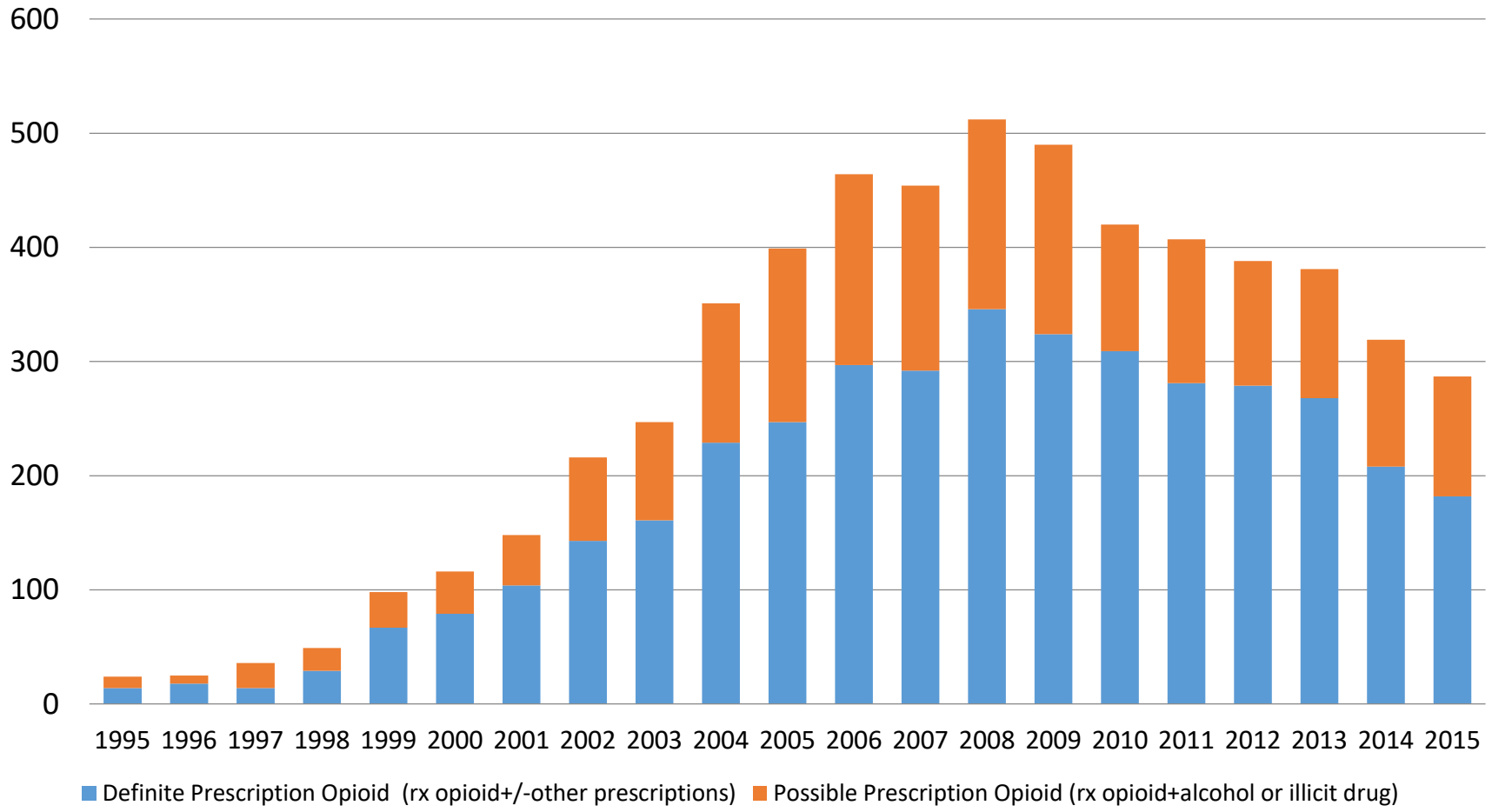
- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25–50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.



Check out the resources at
www.AgencyMedDirectors.wa.gov

- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

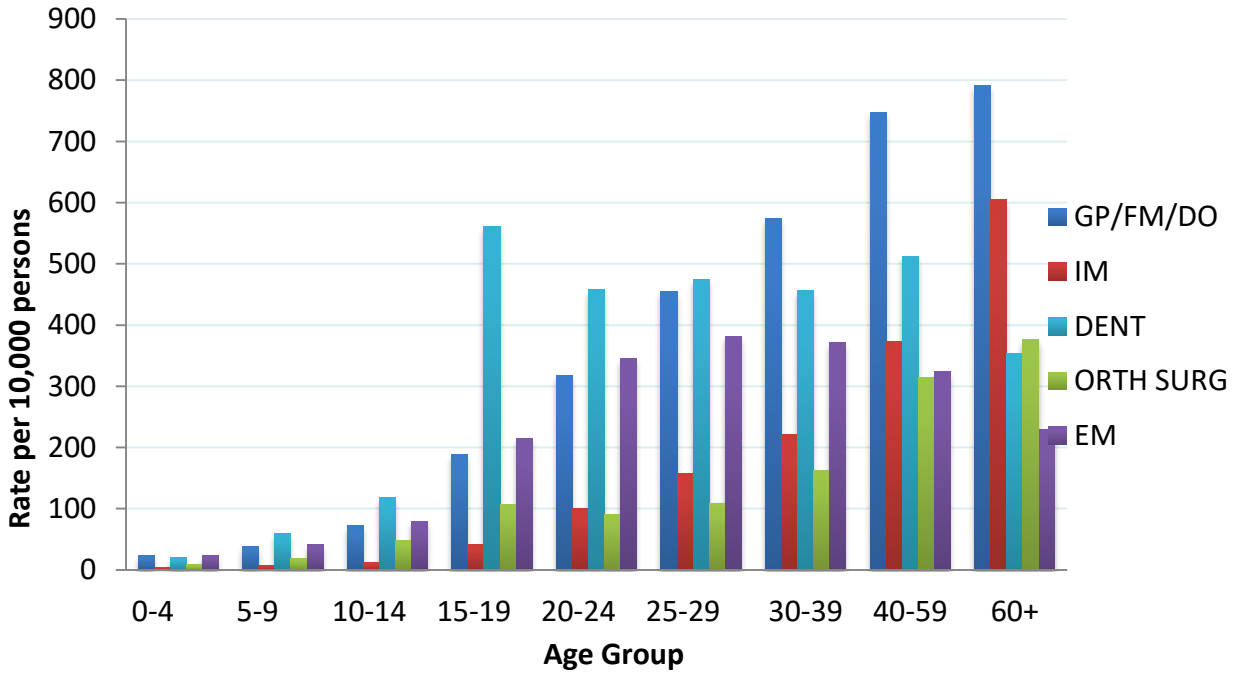
Washington Unintentional Prescription Opioid Deaths
1995 – 2015
44% sustained decline



Source: Washington State Department of Health

Dentists and Emergency Medicine Physicians were the main prescribers for patients 5-29 years of age

5.5 million prescriptions were prescribed to children and teens (19 years and under) in 2009



Source: IMS Vector ®One National, TPT 06-30-10 Opioids Rate 2009

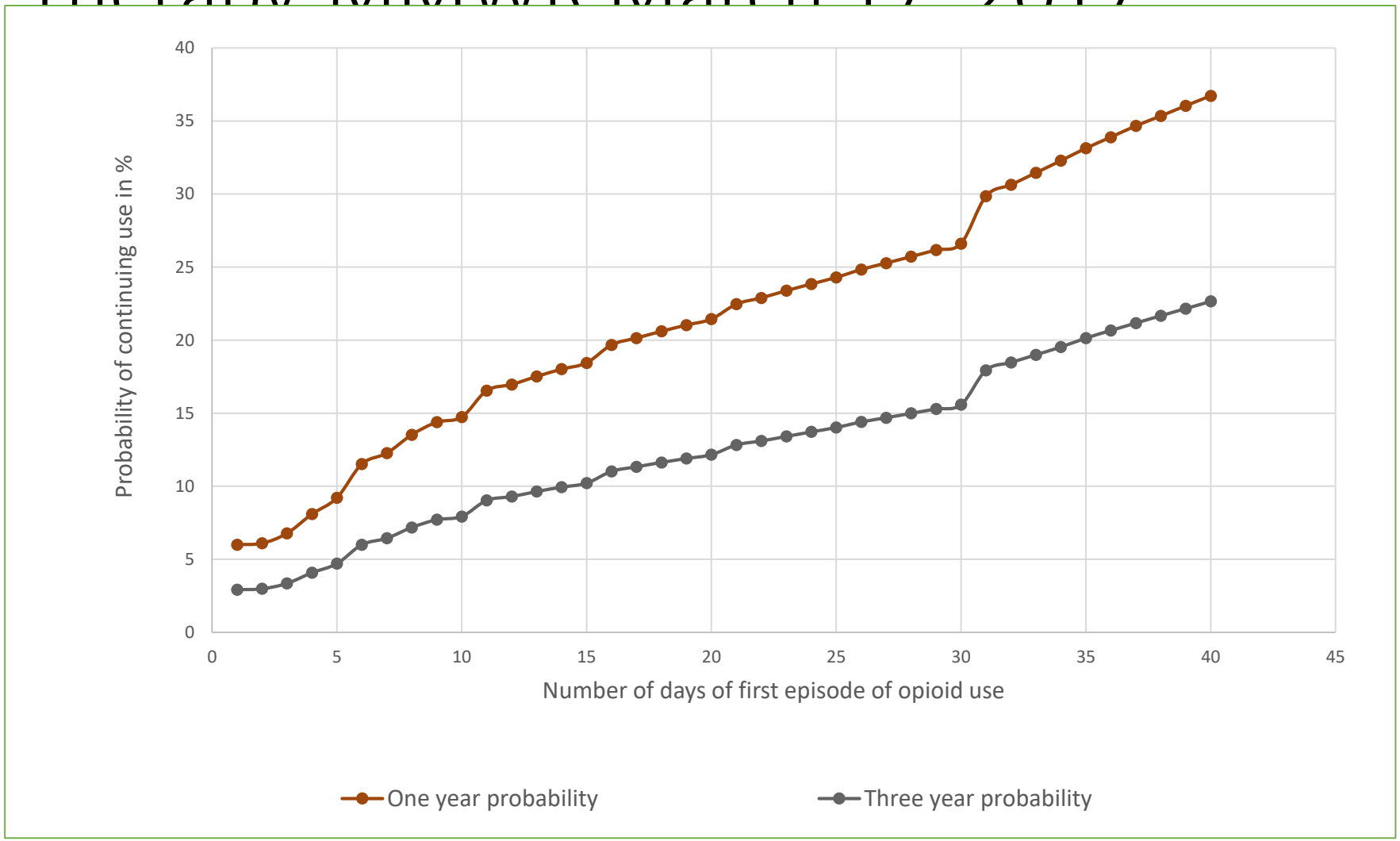
Acute Opioid Prescribing by Specialty

Table 6: **Number of pills by specialty, youth age 14–19:** Means, medians, and selected quantiles of the number of tablets dispensed per prescription to children age 14–19 with acute opioid prescriptions between July 1 and December 31, 2015 ($N = 33{,}835$).

Provider specialty	N	mean	median	75th %tile	90th %tile	99th %tile
State Total	33,835	23.7	20.0	30.0	36.0	80.0
Dentist	13,345	22.3	20.0	30.0	30.0	40.0
Emergency Medicine	2,560	15.2	15.0	20.0	20.0	30.4
Family Medicine	1,295	20.6	20.0	25.0	30.0	60.9
Obstetrics & Gynecology	593	27.7	30.0	30.0	40.0	80.8
Oral & Maxillofacial Surgery	946	24.4	20.0	30.0	30.0	50.0
Orthopaedic Surgery	931	48.9	40.0	60.0	80.0	130.0
Otolaryngology	538	39.5	30.0	50.0	70.0	90.0
Pediatrics	475	18.9	16.0	24.0	30.0	60.0
Podiatrist	354	30.4	30.0	40.0	60.0	81.9
Student	385	22.7	20.0	20.0	40.0	90.0
Surgery	683	33.0	30.0	40.0	50.0	80.0
other	839	28.0	22.0	30.0	50.0	100.0
unknown	10,891	23.6	20.0	30.0	40.0	90.0

Source: DOH Prescription Monitoring Program Data

Continued Use by Initial Days of Therapy-MMWR March 17, 2017



Shah et al. MMWR 2017 Mar 17;66(10):265-9

Dental Guideline on Prescribing Opioids for Acute Pain Management

September 2017

Developed by the Dr. Robert Bree Collaborative and Washington State Agency Medical Directors' Group in collaboration with actively practicing dentists and public stakeholders

AMDG agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

DR. ROBERT BREE COLLABORATIVE

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Bree/AMDG Dental Guideline Recommendations

- Conduct a thorough history including dental and medical
- **Prescribe non-opioid analgesics as first line**
- Consider pre-surgical or pre-emptive medication
- **If an opioid is warranted, follow the CDC guideline (lowest effective dose of immediate-release opioids; ≤ 3 days will be sufficient)**
  - **Limit to 8-12 tablets for adolescents and young adults through 24 years old**
  - Avoid opioids when patient/parent requests no opioid prescription or patient is in recovery and at high risk of relapse for SUD
- Educate on appropriate use, duration and adverse effects of opioids and share information on disposal of leftover opioids
- Support patients with SUD who are undergoing dental procedure

Why consider post-op pill/duration recs?

- The vast majority of pills prescribed post-op are left over and may be used for subsequent misuse or diversion

Voepel-Lewis et al, JAMA Pediatrics 2015; 169: 497-8- leftover pills in kids via parent diaries

- T&A 52 pills dispensed 44 pills left (day 4)
- MSK 34 pills dispensed 30 pills left
- Minor abd, GU,periph proc 31 pills dispensed 28 pills left

From: **New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults**

JAMA Surg. 2017;152(6):e170504. doi:10.1001/jamasurg.2017.0504

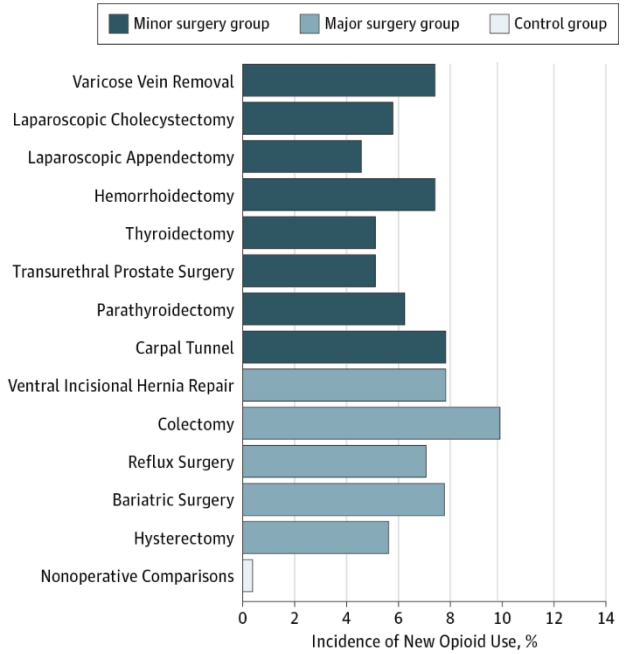


Figure Legend:

Incidence of New Persistent Opioid Use by Surgical ConditionThe incidence of new persistent opioid use was similar between the 2 groups (minor surgery, 5.9% vs major surgery, 6.5%; odds ratio, 1.12; SE, 0.06; 95% CI, 1.01-1.24). By comparison, the incidence in the nonoperative control group was only 0.4%.

Brat et al, *BMJ* 2018;360:j5790 http://dx.doi.org/10.1136/bmj.j5790

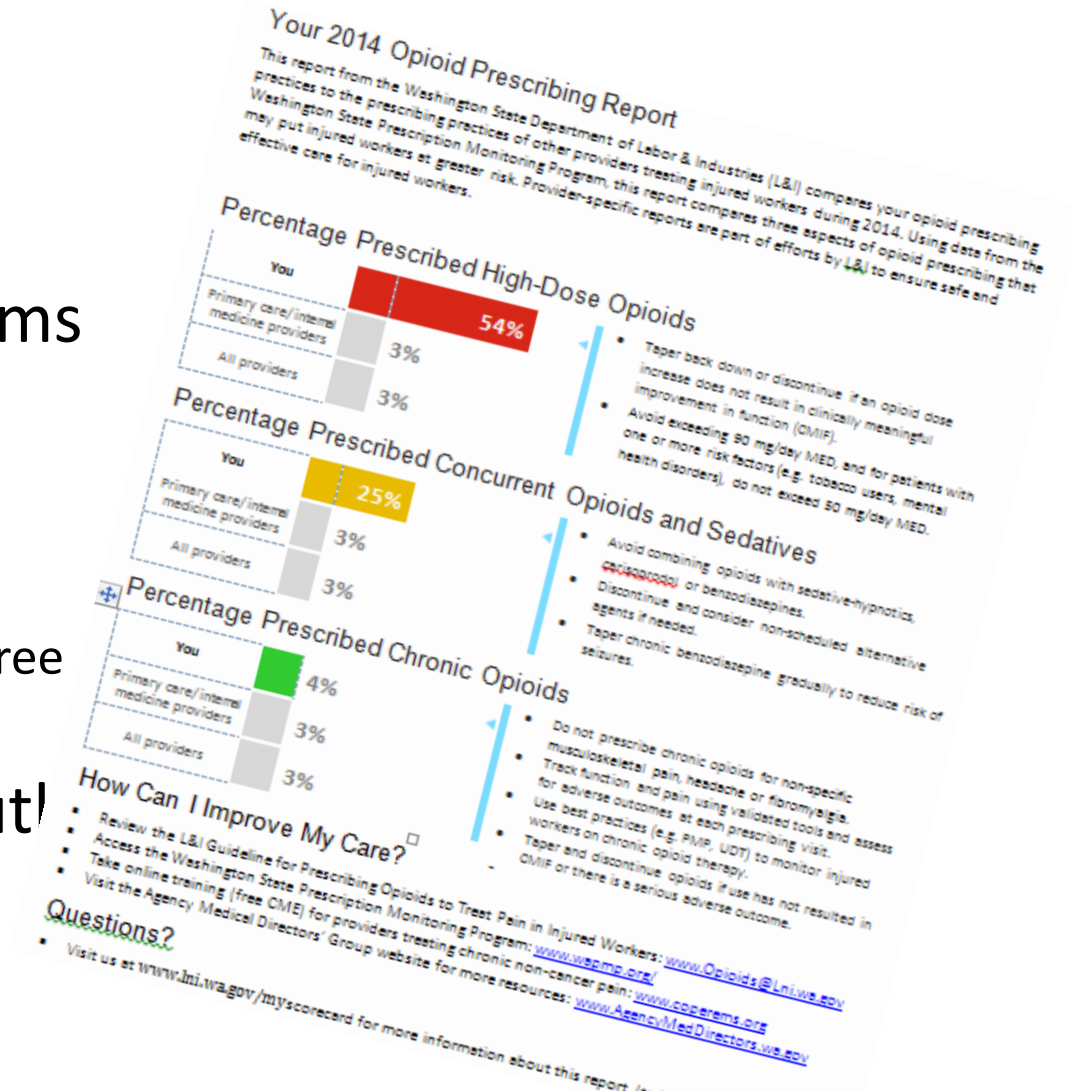
- 37.6 million commercially insured 2008-2016
- 1 million opioid naïve patients undergoing surgery
- Composite outcome dependence, abuse or overdose
- Total duration of opioid use was the strongest predictor of misuse, with each refill and additional week of opioid use associated with an adjusted increase in the rate of misuse of 44.0%
- Highest risk in 15-24 yr age group

DRAFT Duration of Opioids for Postoperative Pain

Adolescents ≤ 24 years old	
Dental extractions (e.g. third molar, wisdom tooth)	• Prescribe ≤ 3 days (8 to 12 tablets) of immediate release opioids in combination with an NSAID or acetaminophen for severe pain
Adults	
Minor Procedures	
Dental extractions or simple oral surgery (e.g. graft, implant)	• Prescribe ≤ 3 days (e.g. 8 to 12 tablets) of immediate release opioids in combination with an NSAID or acetaminophen for severe pain
Minor surgery (e.g. hernia repair, laparoscopic appendectomy, carpal tunnel release, laparoscopic cholecystectomy, biopsy, meniscectomy)	• Prescribe ≤ 3 days (e.g. 8 to 12 tablets) of immediate release opioids for severe pain
Moderate Procedures	
Moderate surgery (e.g. ACL repair, rotator cuff repair, discectomy, laminectomy)	• Prescribe ≤ 7 days (up to 42 tablets) of immediate release opioids for severe pain. Continued opioid use requires appropriate re-evaluation by the surgeon
Major Procedures	
Major surgery (e.g. lumbar fusion, knee replacement, hip replacement)	• Prescribe the lowest effective dose and shortest duration of immediate release opioids. • Do not discharge with more than a 14-day supply of opioids. Continued opioid use requires appropriate re-evaluation by the surgeon • Taper off opioids within 6 weeks after surgery
Patients on Chronic Opioid Therapy	
Elective surgery in patients on chronic opioid therapy	• Prescribe the lowest effective dose of immediate release opioids for acute pain. • Resume chronic regimen if patients are expected to continue postoperatively • Taper opioids to preoperative doses or lower within 6 weeks after surgery

Metrics to guide both “state-of-the-state” and provider quality efforts

- Use a common set of metrics
- Start with public programs
- Establish a process for public/private implementation (e.g. WA statutory, governor appointed “Bree Collaborative”)
- Use metrics to notify outl prescribers



WA Bree Opioid Metrics

General prescribing	
• Prevalence of opioid use	% with ≥1 opioid Rx of all enrollees, by age
Long-term prescribing	
• Chronic opioid use	% with ≥60 days supply of opioids in the quarter
• High dose use	% with doses ≥50 and ≥90 mg/day MED in chronic opioid users
• Concurrent use	% with ≥60 days supply of sedatives among chronic opioid users
Short-term prescribing	
• Days supply of first Rx	% with ≤3, 4-7, 8-13, and ≥14 supply among new opioid patients
• Transition of chronic use	% new opioid patients transitioning to chronic use the next quarter
Morbidity and Mortality	
• Opioid overdose deaths	Rate of overdose deaths involving opioids
• Non-fatal overdoses	Rate of non-fatal overdoses
• Opioid use disorder	Rate of opioid use disorder among patients with ≥3 quarters of use

Improve systems/community capacity to treat pain/addiction

- Deliver coordinated, stepped care services aimed at improving pain and addiction treatment
  - Cognitive behavioral therapy and graded exercise to improve patient self-efficacy
  - Opioid overdose case management by ED to identify behavioral health needs, evaluate for MAT, notify providers involved and discuss recommendations (e.g.Vermont spoke and hub)
- Increase access to pain and addiction experts (e.g. WA telepain)

Emerging examples of stepped care management/collaborative care for pain

- VA Health System Stepped Care Model of Pain Management
  - Dorflinger et al. A Partnered Approach to Opioid Management, Guideline Concordant Care and the Stepped Care Model of Pain Management. J Gen Int Med 2014; Suppl 4, 29: S870-6.
- Vermont Spoke and Hub regional support for medication assisted treatment for opioid use disorder/severe dependence
- WA state Centers of Occupational Health and Education/Healthy Worker 2020

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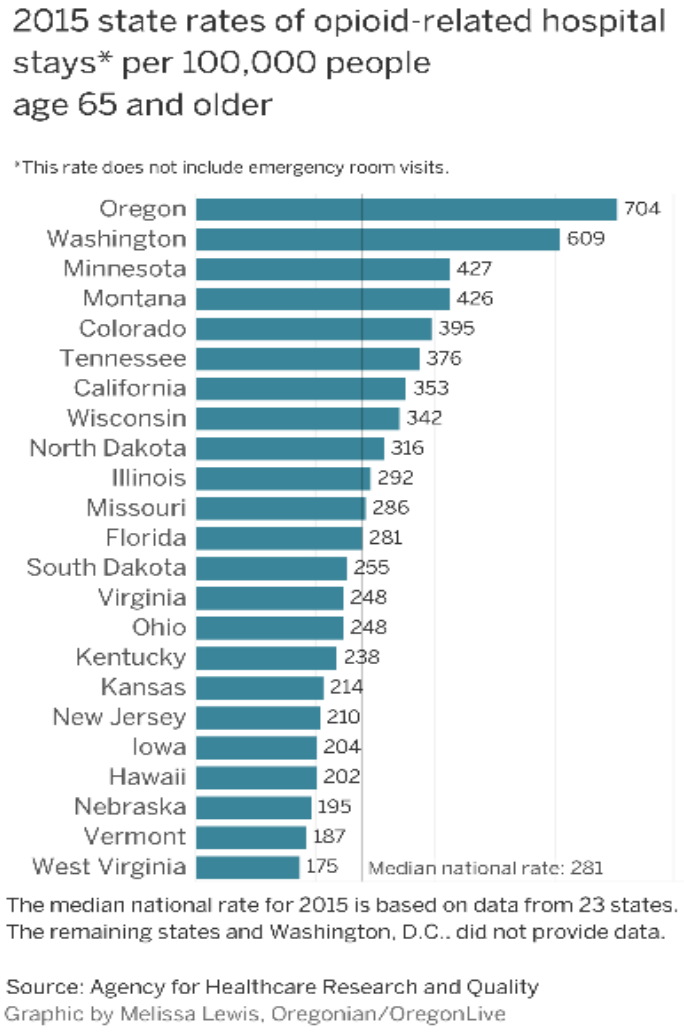
Prescribing Opioids in Older Adults

- Goal – Reduce risk of falls
  - ➢ Follow same best practices for prescribing opioids (AMDG)
  - ➢ Prescribe immediate-release opioids at the lowest effective dose (AMDG)
    - Initiate opioid therapy at a 25% to 50% lower dose than that recommended for younger adults



THANK YOU!

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