OPIOIDS – CHOOSING WISELY
How did we get here?

- American Pain Society’s Pain as the 5th vital sign campaign
  - adopted by the joint commission and the Veterans Administration as part of the national pain management strategy
  - created expectations of 0 pain as an Achievable goal
Successful campaign
Warrants Detail Rush Limbaugh's Drug Use

DECEMBER 5—Rush Limbaugh illegally purchased hundreds of prescription pills a month and sought a quartet of doctors to fuel his drug addiction, according to search warrant applications unsealed yesterday in Palm Beach County Circuit Court.

Investigators executing the searches, which took place November 25 at offices used by Limbaugh’s South Florida physicians, accused the radio personality of “doctor shopping,” or improperly seeking out practitioners to supply him with an inordinate abundance of painkillers OxyContin, Lorcen, Norco, Hydrocodone, and Kadian, the anti-anxiety drug Xanax, the cholesterol-lowering drug Niacin, and Clonodine, which treats high blood pressure.

Under Florida law, doctor shopping is punishable by up to five years in prison.

The affidavits, one of which you’ll find here, indicate that authorities began investigating the talk-show host last December after meeting with Wilma Clina, Limbaugh’s former maid, and her husband, who told them that they sold Limbaugh “large quantities” of pharmaceutical drugs “over the course of many years.” (5 pages)
Narcotic pain relievers now cause

3 out of 4

Prescription Drug overdoses

40 people Per day Die of Opioid overdose
Reason for Prescribing Opioids

Reasons Rx

- Back pain: 45%
- Headaches: 15%
- PostOp: 20%
- Other: 10%

Medical Economics poll 2016
Early Life Trauma Common Among Chronic Pain Sufferers


97% experience emotional or physical trauma prior to chronic pain

- Sexual abuse: 26.7%
- Physical abuse: 29.7%
- Childhood accident: 32.6%
- Family drug abuse: 36.8%
- Emotional abuse: 48.2%
- Loss of loved one: 75.2%
Risk of death

- risk of death due to other causes was almost 2.4 times higher among long-term opioid users than among individuals without chronic pain.

Life expectancy calculation

- National life insurance company estimates
  - Without chronic narcotic use: 93 years
  - With chronic narcotic use: 73 years
Long acting opioids & mortality

Ray, et al; JAMA 2016;315(22):2415

45,000 people in study
Ave. age 47 years
60% women
55% Medicaid disability
75% back pain
Opioids Cause Greater Personal and Social Problems
Experiences of U.S. Chronic Pain Sufferers

- Need more time off work: 54.00% (Use Opioids), 39.50% (Don’t Use Opioids)
- Family friction: 51.50% (Use Opioids), 32.80% (Don’t Use Opioids)
- Need public assistance: 46.50% (Use Opioids), 22.40% (Don’t Use Opioids)
- Lost their job: 45.70% (Use Opioids), 20.70% (Don’t Use Opioids)
- Make mistakes at work: 25.80% (Use Opioids), 17.80% (Don’t Use Opioids)
- Divorced: 6.60% (Use Opioids), 3% (Don’t Use Opioids)
Opioid Prescribing: Safe Practice, Changing Lives

Presented by CO*RE
Collaboration for REMS Education
www.core-rem.org
Goals

- Maximize normal function – return to normal activities
- Increase patient’s ability to self-manage pain
- Reduce subjective pain intensity
- Reduce health care service needs
- Set time to return to work or normal activities
It’s all about FUNCTION
Pain assessment

- Have a distinct diagnosis for pain
Pain assessment

- Determine the type and nature of pain
- Assess functional status
Pain assessment

- Coping mechanisms
Pain assessment

- Identify contributing factors
  - Comorbid conditions
  - Spiritual or social issues
  - Psychological factors
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<th>Morphine equivalents</th>
<th>Opioid analgesics ratio</th>
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Canadian Guideline for safe & effective use of opioids
Avoiding Opioid Analgesics for Treatment of Chronic Low Back Pain

- 7925 participants (20 Random Clinical Trials)
  - 50% withdrawal from study due to adverse or no effect
  - Mild pain relief in short term
  - Clinical pain relief was not observed >40 mg Morphine equivalents

When to use Opioids for Chronic Pain

- Non pharmacological therapy and non opioid pharmacological therapy are preferred.
  - Opioids should only be used when both the pain and the function are anticipated to outweigh the risk for the patient.
- Treatment goals should be established and all patient’s
  - goals need to be realistic for pain and function
patient should be aware of the risk and realistic benefits of opioids
RED FLAGS in prescribing opioids

- History of overdose
- History of substance abuse
- High dose of opioids (> 50 MME per day)
- Combination medications with sedatives and narcotics
- No relief of pain despite high doses of narcotics
- Patient with very little daily function
- History of illicit drug use
- Multiple prescribers
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
opioid selection

- prescribe immediate release opioids instead of long acting opioids
- prescribed the lowest effective dose
- avoid increasing opioids to the a Morphine mg equivalent of greater than 90 MME/day
opioid selection

- rarely more than 7 days are indicated for acute pain
- the patient should be re-evaluated within 4 weeks of starting an opioid for chronic pain or increasing the dose.
- Patient should be re-evaluated every 3 months
other therapy should be optimized and efforts to taper opioids to lower doses or discontinuation
Long term controlled substance
For Chronic Pain Treatment
Patient/Physician Agreement
Urine drug testing

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).
Pain Nurse Function

- Patient assessment
- Case management and coordination
- Maintenance of pain agreements
- Drug testing
- Assist in the establishment of protocols
- State pharmacy database review
- Writing prescriptions to prepare for physician signatures
- Coordination of telemedicine
RN Assessment

- PCP
- Last appointment with PCP
- Pain contract date
- Pain assessment
  - Location and description
  - Pain scale
  - Highest rating in 30 days
  - Lowest rating in 30 days

- Medications
  - Dose and frequency
  - Effectiveness
  - Other pain medications
  - OTC medications

- General assessment
  - Appearance
  - Speech
  - Vitals
Pharmacy Function

- Evaluate patients with complex medication regimens
- Provide medication patient education
- Assist when care transition is indicated
- Serve as a resource for physicians and nurse
The Illinois Heroin Crisis Act

- **ACTION:**
  
  All physicians and other authorized prescribers must include clear documentation within the medical record for three 30-day sequential prescriptions for any schedule II narcotics. The documentation must include medical necessity for the amount and duration of the prescriptions.
A new Advisory Committee will be established by the state to determine appropriate clinical guidelines for prescriptions.

- Part of this Committee will be a peer-review subcommittee, made up of physicians and pharmacists, which will be tasked with reviewing data from the PMP, including identification of clinicians who may be prescribing or dispensing outside the currently accepted standards of professional practice.
Best practice guidelines state that a comprehensive assessment and documentation is recommended before initiating opioid therapy, including the documentation of a history, medical condition, psychosocial history, psychiatric status, and substance abuse history.

Essentially, the treatment with opioids must indicate that the condition is severe enough and that the medication required is intense enough that it can only be done with opioids.
George

- 66 y/o male with chronic back pain
- Started having back pain 25 years after slipping and falling at the job site.
- Back surgery 8 years ago with temporary improvement
- No benefit from epidural steroids
- Has been treated with hydrocodone and oxycontin for the past 9 years
George

- He continues to have pain (8/10)
- Wants something stronger
tapering strategies

- long-term opiate use induces opiate induced hyperalgesia
  - the brain becomes more sensitive to pain
- no widely accepted tapering protocol
TAPERs

- Methadone: Decrease dose by 20-50 percent per day until you reach 30 mg/day
- Then decrease by 5 mg/day every three to five days to 10 mg/day
- Then decrease by 2.5 mg/day every three to five days

- Morphine SR/CR: Decrease dose by 20-50 percent per day until you reach 45 mg/day
- Then decrease by 15 mg/day every two to five days

- Oxycodone CR: Decrease dose by 20-50 percent per day until you reach 30 mg/day
- Then decrease by 10 mg/day every two to five days
Strategies for tapering:

- slowly tapering the opioid dose and taking into account the following issues:
  - A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
  - If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
  - Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle
Strategies for tapering:

- Pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally:
  - Every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring for often significant hypotension and anticholinergic side effects.

- In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.

Washington State Agency Medical Directors’ Group, 2007
Strategies for tapering:

- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued.
  - Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
  
  Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.
Choosing Wisely