University of Pittsburgh

Addressing the Opioid Epidemic: Prescribing Opioids for Non-Cancer Pain

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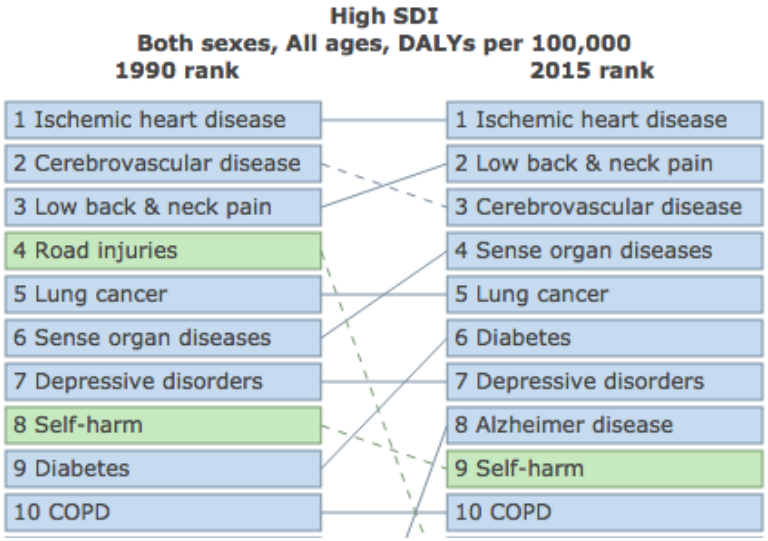
Agenda

- Epidemiology of prescription opioid addiction
- Focus on the decision to prescribe opioids for chronic pain at the point of care
- Identifying those at risk of “opioid problems”
- Adjusting to these risk factors in outpatient care
- Guidelines referred to are the American Pain Society Guidelines for Opioid Prescribing in Non-Cancer Pain, Roger Chou, *J Pain*, 2009, and The CDC Guidelines for Prescribing Opioids for Chronic Pain in Primary Care, 2016

How Back Pain is Taking Over the World (especially in the USA)

- #2 Cause of disability-adjusted life-years in rich nations.

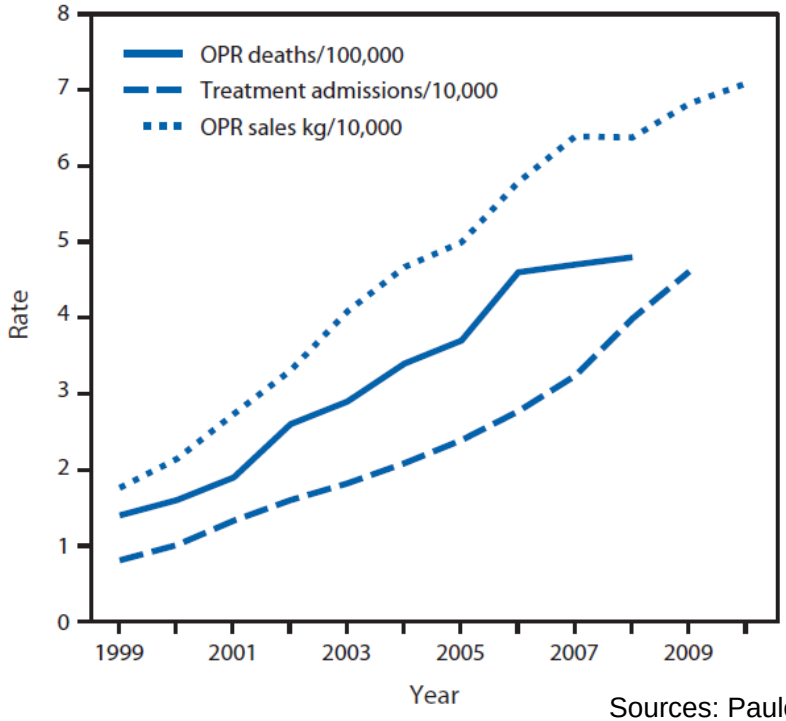


--Vos T, et. al., Global Burden of Disease Study 2015, *Lancet*, 2016

- 100 million US adults with chronic pain
- 50 million with low back pain
- ~35 million seek healthcare for LBP
- 50% of patients with CLBP prescribed opioids

--Taylor-Stokes GS, et., al., Relationship between patient-reported chronic low back pain severity and medication resources. *Clin Ther*, 2011.

Opioid overdose death and hospital admissions have risen with rates of opioid prescribing

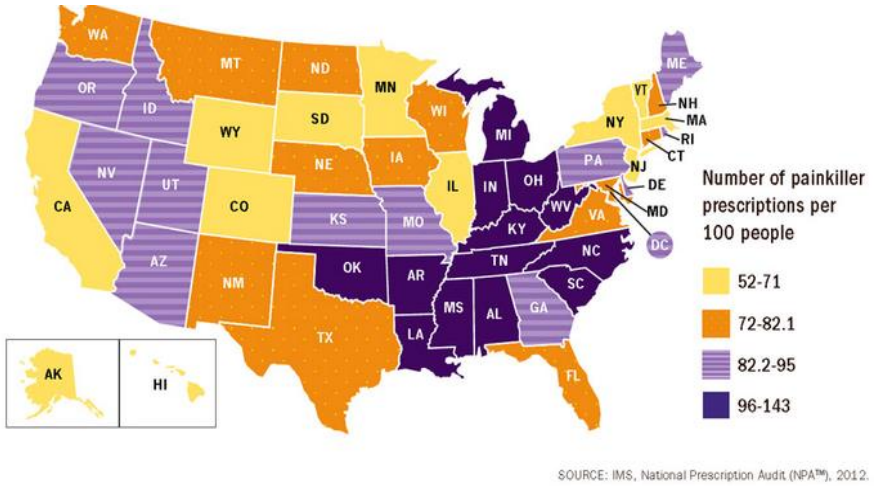


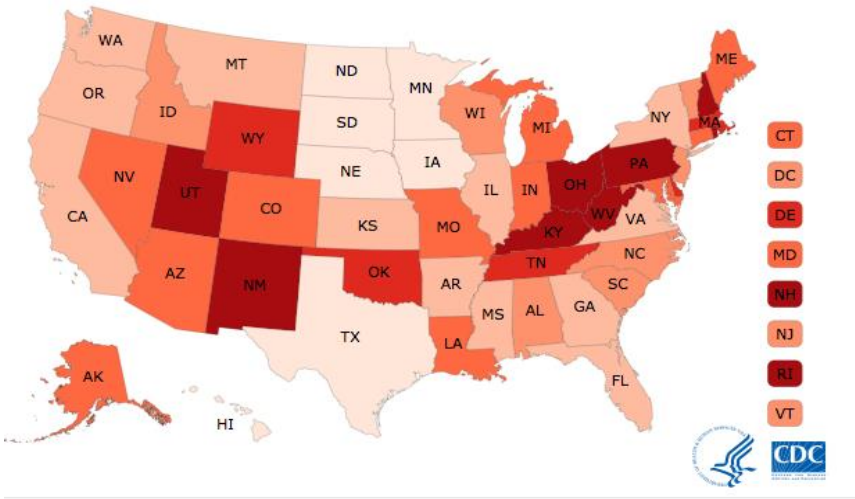
US accounts for

- **4.6% of the world's population**
- **80% of global opioid supply**
- **99% of global hydrocodone supply**

Sources: Paulozzi et al *Journal of Safety Research* 2014;
https://www.asipp.org/documents/ASIPPFactSheet101111.pdf

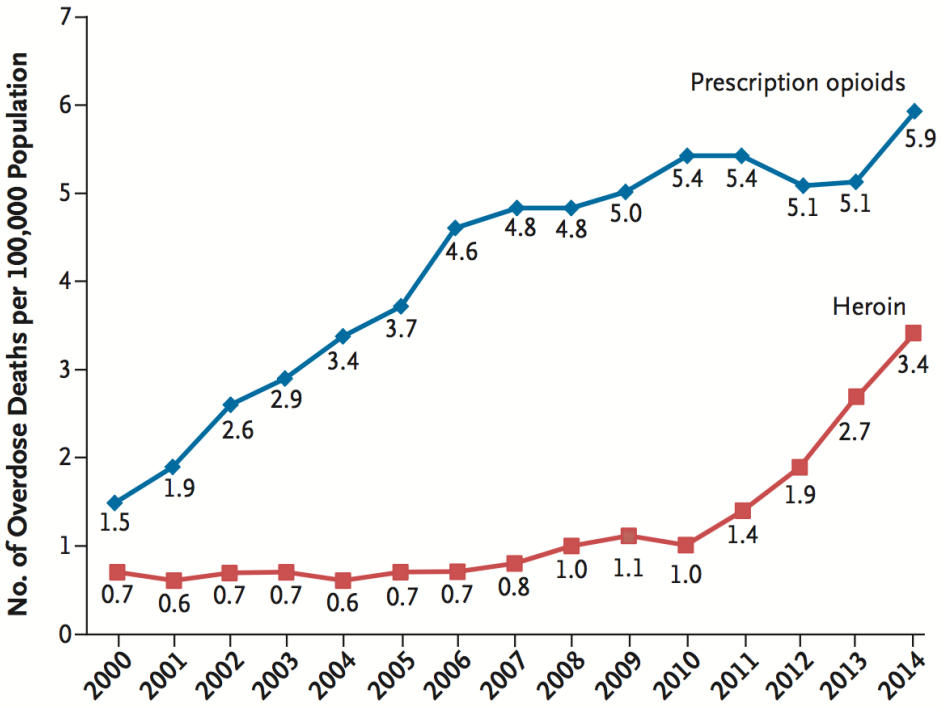
Western PA is in the upper 25% of rates of opioid prescribing and the upper 25% of opioid deaths—CDC, 2016





- We have an opportunity and an obligation to do something profound to solve the crisis here

4-fold increase in opioid overdose since 2000

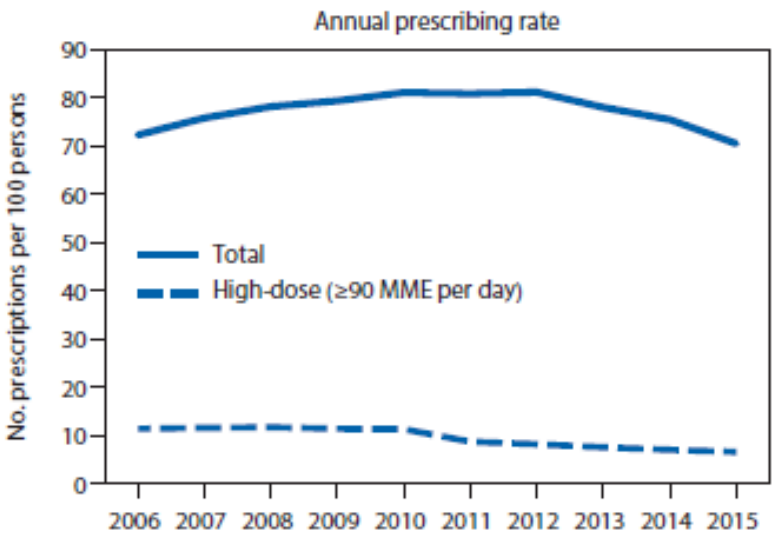


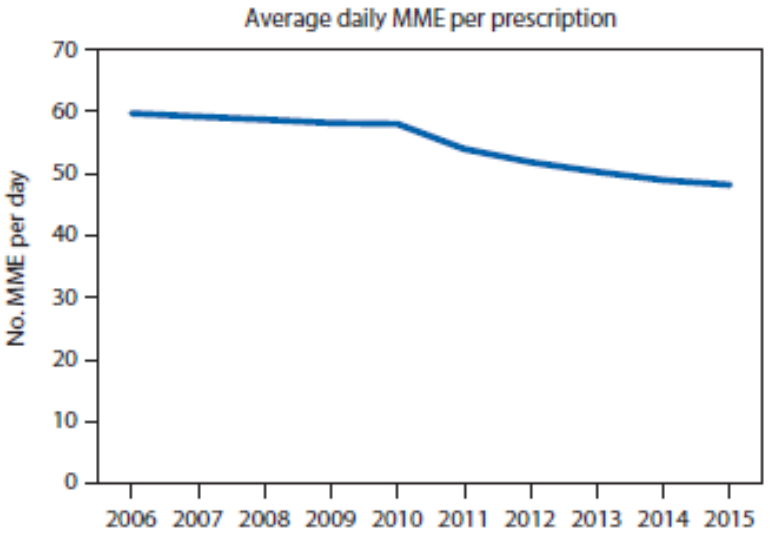
There is no evidence that state policies designed to reduce inappropriate opioid prescribing are leading to increases in heroin use and deaths from illicit opioid use. In fact, such policies have been shown to reduce the amount of opioids prescribed, prescription opioid-involved overdose deaths, and all opioid-involved deaths.[4] Some evi-

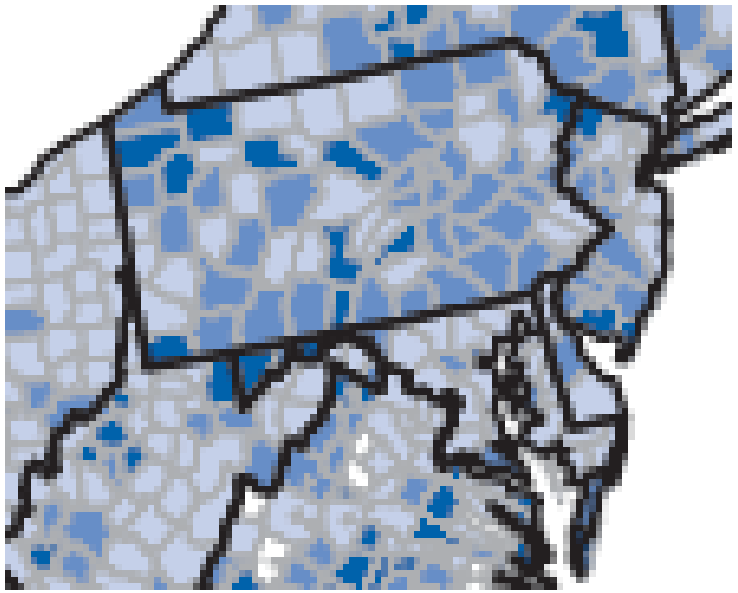
--Schuchat A, Houry D, Guy, GP, *JAMA*, 2017

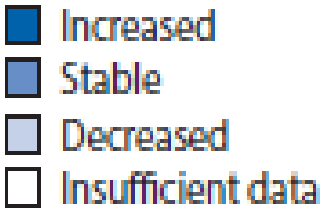
Age-adjusted death rates from CDC reported in Compton *NEJM* 2016

Opioid Prescribing is Decreasing









Morbidity and Mortality Weekly Report (*MMWR*) CDCMMWR,
Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015
Weekly / July 7, 2017 / 66(26);697–704

2 Key Patient Categories

- 1. Non Medical use of prescription opioids in people **without** pain for psychoactive effects

- 2. Medical use of prescription opioids in patients **with** pain leading to addiction

- The availability of prescription opioids to both groups (those with and without pain) is a key driver of the opioid epidemic

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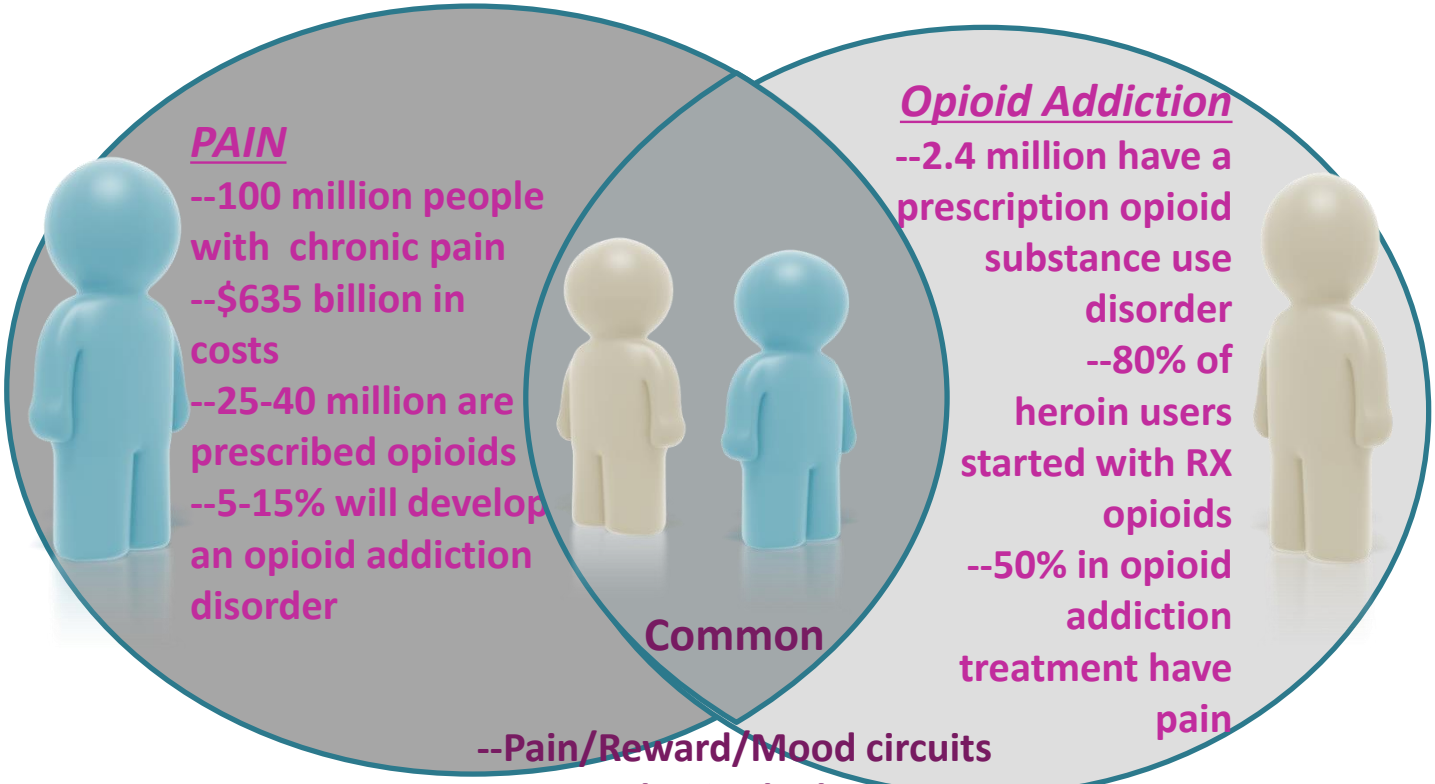
The epidemics of pain and opioid addiction are entwined



--Pain/Reward/Mood circuits overlap in the brain

--Both are chronic diseases

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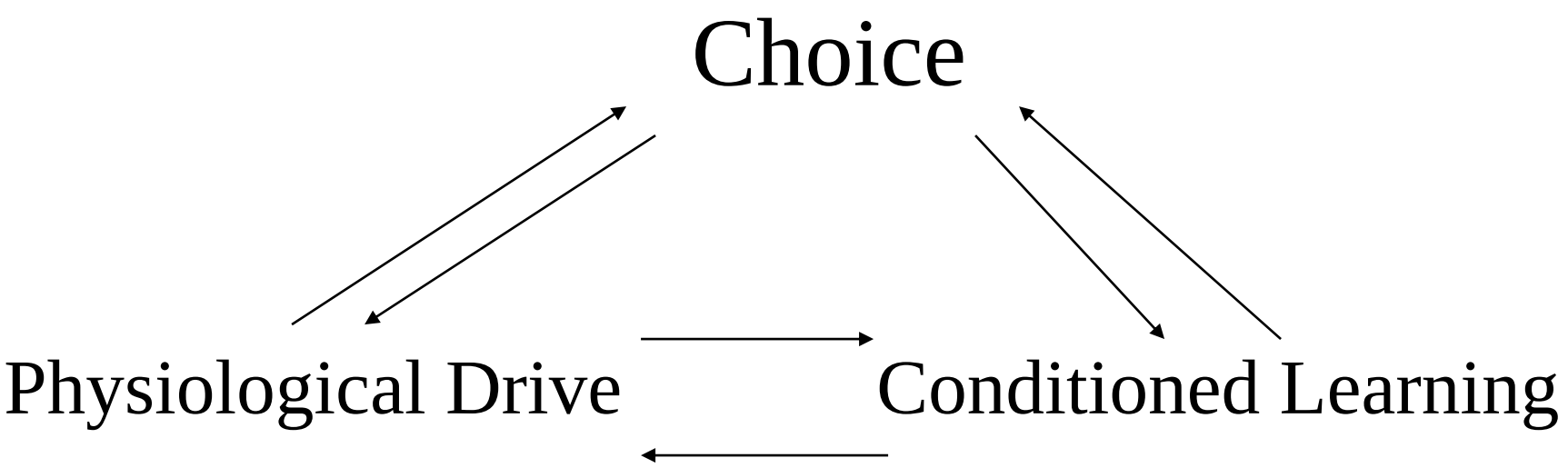
Addiction

A state in which an organism engages in a compulsive behavior

- behavior is reinforcing (rewarding or pleasurable)
- loss of control in limiting intake

Addiction Disorders and Motivated Behavior



- Not a totally free choice.
- The disease of addiction (the biological components) drives the bad choices to use the harmful substance

Opioid Use Disorder and the 5Cs

- DSM-V Opioid Use Disorder Category
  - Now on a continuum—mild, moderate, severe
  - Continuum maps to misuse, abuse, addiction

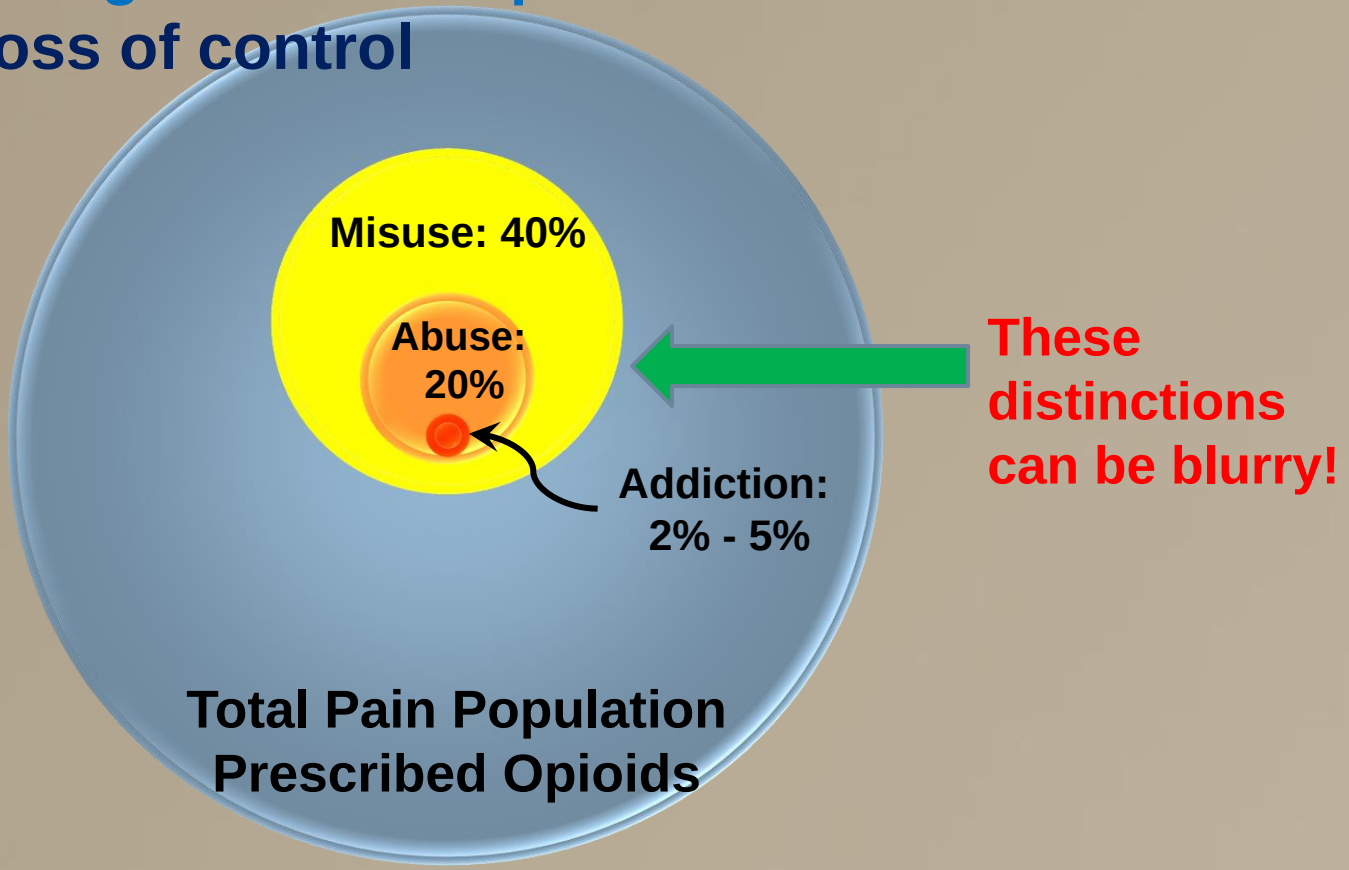
- ASAM and AAPM criteria for prescription opioid addiction:
- **Chronic**
- **Compulsive use**
- **Control - impaired**
- **Craving**
- **Continued use despite harm**

Misuse vs Addiction

Misuse: Inappropriately taking pain medication with a therapeutic intent

Abuse: With negative consequences

Addiction: Loss of control



Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the opioid risk tool. *Pain Med.* 2005

General approaches to opioid prescribing

- What **conditions** respond better to opioids?
- Will the patient, as an **individual** respond well?
- Who will have good, sustained relief at moderate doses?
- Who will follow the rules—no early refills, opioids from 1 MD, no inappropriate self-medication, no drugs, no addiction, no diversion? **THERAPY ADHERENCE**
  - Social risk factors
  - Propensity for misuse or addiction
  - Psychiatric comorbidity
    - Ongoing addiction disorder
    - Depression/anxiety/personality pathology

What does Good Analgesia Mean in Chronic Non-Cancer Pain?

- Approach is improvements for chronic pain which are sustainable (not short-term relief)
- **Sustained improvement in pain—at least 30% improvement and >3 months**
  - **Pain </= 4/10---patients can do most things**
- Significant improvement in function
- Standardized measures
  - Pain, Enjoyment, General Activity Scale

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?*

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"

Farrar J, 2001; Ballantyne J, 2003; Fields HL, 2005

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THE CONDITION

- Cancer pain +++
- Post-operative pain +++
- Acute pain with a clear etiology +++
- Chronic non-cancer pain—summary of trials
  - Musculoskeletal pain of clear etiology—arthritis, ++
  - CLBP +/- Often hard to know etiology—many levels of nervous system involved
  - Neuropathic Pain (due to nerve injury) +

Psycho-Social Selection Process

- Detailed substance use history
  - No active SUD
- Family Sub use Hx
- Current and past psychiatric history
  - Depression or anxiety disorders, personality pathology
- SOAPP—checklist of risk factors
- COMM--checklist of risk factors
- Urine tox at baseline
- PDMP

Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

--CDC, 2016

Over the Past Month Have You:

1. Taken your opioid medication other than the way it was prescribed?
2. Used more than one pharmacy to fill your opioid prescriptions?
3. Received opioid prescriptions from more than one provider?
4. Lost or misplaced your opioid medications?
5. Run out of your pain medication early?
6. Missed any scheduled medical appointments?
7. Borrowed opioid medication from others?
8. Used any illegal or unauthorized substances?

--Jamison RN, *J of PAIN*, 2016

Aberrant Drug-Related Behaviors—Look for clusters of symptoms

More Predictive of ADDICTION or Diversion	Less Predictive
▫ Selling prescription drugs ▫ Prescription forgery ▫ Stealing or “borrowing” drugs from another patient ▫ Injecting oral formulations ▫ Obtaining prescription drugs from non-medical sources (street) ▫ Concurrent abuse of illicit drugs ▫ Multiple unsanctioned dose escalations ▫ Repeated episodes of lost prescriptions	▫ Complaining about the need for higher doses ▫ Drug hoarding during periods of reduced symptoms ▫ Requesting specific drugs ▫ Prescriptions from other physicians **questionable ▫ Unsanctioned dose escalation ▫ Unapproved use of the drug ▫ Reporting psychic effects not intended by the physician

Jaffee 1996

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TAPERING AND DISCONTINUING OPIOID THERAPY

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:

To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).

Work with appropriate specialists as needed—especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.

During the taper, ensure patients receive psychosocial support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

NONOPIOID TREATMENTS FOR CHRONIC PAIN

--Pain education, medications, physical therapy, mental health care, yoga, acupuncture

Opioid Dose?

- Reported that >120 mgs per day of morphine equivalents is associated with greater rates of opioid misuse, inadvertent overdose, and death.
- Recent evidence suggests that many of these complications involved co-prescribing of BZD's (Ativan, Xanax, Valium, Klonipin) and opioids, particularly in patients with major depression and/or anxiety disorders
- So total dose may be less important than the subgroup who is prescribed opioids and BZD co-prescribing.

» Giummarra MJ, *Pain Medicine*, 2014

What to do?

- For any aberrant behavior evaluate for other possible comorbidities—
  - Worsening of the physical condition (cancer, for example)
  - Depression/anxiety/PTSD
  - Missed psych risk factors-Past history of physical or sexual abuse
  - Patients may be self-medicating anxious or depressive feelings
  - Cancer patients may be self-medicating a sense of suffering (not pain per se)
- Misuse—
  - Prescribing smaller quantities (1 or 2 week supply)
  - More strict prn dosing parameters for PO meds
  - Tighter monitoring and more frequent visits

What to do?

- Misuse—
  - More frequent urine tox screens
  - Opioid adherence visits with a medical or behavioral health provider
  - Adherence counseling via motivational interviewing
  - Opioid agreements

- Addiction
  - Consult an addiction medicine provider
  - Even if there is an acute pain situation, the patient is at an increased risk of death due to inadvertent overdose, so precautions are important

Population-Based Strategies at UPMC to Manage Opioids

- HIGHLIGHTS
- 2500 providers completed online opioid education
  - ~500 PCPs and 2000 NPs and PAs
- Expanding multidisciplinary pain and addiction treatment resources in primary care and pain clinics
  - Psychology/Psychiatry/Social Workers with addiction training

Conclusions

- Addiction is a bio-behavioral illness in which the addicted patient only has partial control over his/her behavior
- Providers can follow a structured selection process to decide whether to prescribe opioids for non-cancer pain
- You can use various factors to decide if the patient is at a low, moderate, or high risk of opioid misuse
- There are strategies to manage or decrease opioid misuse
- Good care of chronic pain takes time and expertise, but providers of all specialties can do it
- Guidance materials available
- Good opioid care takes time and resources