Opioid Prescribing Guidelines

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Pain

• Millions of Americans suffer from pain that is chronic, severe, and not easily managed

• Pain from arthritis, back problems, other musculoskeletal conditions, and headache costs U.S. businesses more than $61 billion a year in lost worker productivity
The worst drug epidemic today

Since 1999, the number of prescription painkiller deaths has risen by more than 300%.

45 U.S. citizens die every day from unintentional overdoses on prescription pain relievers.

Nearly 1 in 20 Americans age 12 or older report using prescription painkillers recreationally in the past year.

American’s make up 5% of the world’s population and consume 80% of all opioids sold globally
The Silent Epidemic

• In November 2011, the CDC reported that deaths from Rx Pain Relievers had reached **epidemic proportions**
  • Rx Pain Reliever deaths are greater than heroin and cocaine combined
  • Drug poisoning **deaths have surpassed motor vehicle deaths**
  • ~40 deaths per day and ~15,000 per year (2008) – a **3 fold increase** since 1999
  • Half a million ED visits per year for misuse and abuse (2009)

• There was a **4 fold increase** in the quantity of Rx Pain Relievers sold in the U.S. in the last decade
  • Enough Rx Pain Relievers were prescribed in 2012 to medicate every Arizona adult around-the-clock for **more than two weeks**.
  • In some areas of Arizona, this is as high as 4 weeks

• Arizona remained the 6th highest state in the country for Rx drug misuse among individuals 12+ years in 2012
Women of childbearing age

• Approximately 1/3 of women of childbearing age had an opioid prescription filled each year from 2008-2013
  – 39% of women aged 15-44 on Medicaid
  – 28% of women aged 15-44 on private insurance

• These drugs can increase the risk of birth defects and Neonatal Abstinence Syndrome (NAS)

Pregnant women

• Data from 46 states and DC on 1.1 million women with completed pregnancies was examined from the Medicaid Analytical eXtract from 2000-2007

• 21.6% filled a prescription for an opioid during pregnancy
  – 18.5% in 2000 vs 22.8% in 2007

NAS

• Results from the sudden discontinuation of fetal exposure to substances used or abused by mother during pregnancy

• Withdrawal may occur from both licit (legal/prescribed) and illicit (illegal/misuse of rx drugs).
  – Babies with opioid withdrawal usually exhibit symptoms 1-3 days after birth (some as late as 5 – 10 days)
  – Between 2008-2013, nearly 3 out of every 1,000 babies born in AZ were diagnosed with NAS primarily caused by maternal opiate use
NAS Symptoms

• Symptoms include:
  – Respiratory distress (4 times more likely)
  – Low birth weight (3 times more likely)
  – Difficulty eating (5 times more likely)
  – Difficulty sleeping
  – Trembling
  – Irritability
  – Blotchy skin
  – Seizures (17 times more likely)
  – Longer length of hospital stay (13 days vs 2 days)
    • Avg cost $31,000 (vs $2,500 for non-NAS births)

Source: AZ Dept of Health Services Vital Statistics, 2014
What we are trying to achieve?

• Fewer deaths, ER visits, hospitalizations  
• Prevention of accidental overdoses and addiction  
• Reduction in the number of prescription painkillers  
• Association of State & Territorial Health Officials (ASTHO) Challenge:  
  – Reduce the rate of nonmedical use and the number of unintentional overdose deaths involving prescription drugs 15% by 2015
Why Guidelines?

• CDC and White House Prescription Drug Prevention Plan advocated for states to develop guidelines
• Common strategy of states trying to address this epidemic
• Requested by community practitioners, particularly in communities with coalitions actively addressing issue
• Consistency of practice
These guidelines are not intended to apply to hospice or palliative care patients (as defined by the World Health Organization), patients at end of life or cancer related pain.

The guidelines are not intended to establish any standard of care & are only an educational tool.

The recommendations are not founded in evidence based research but are based on promising interventions and opinion.
ED Guidelines

• Based off criteria developed by Washington State ED community
• Consensus document endorsed by ADHS, ACEP and AZENA
• Intended to help reduce inappropriate use of controlled substances
• Not intended to establish standards of care
• Educational tool
• Promising intervention
• Clinicians MUST use their clinical judgment
ED Guidelines

1. When possible 1 medical provider provides RX for patient’s chronic pain.
2. Use the Prescription Drug Monitoring System.
3. Use of intramuscular or intravenous controlled substances for chronic pain is discouraged.
4. ED’s should not provide replacement RX for controlled substances that were lost, stolen, or destroyed.
ED Guidelines

5. ED’s should not provide replacement doses of methadone for patients in a methadone tx program.

6. Long acting or controlled released opioids should not be prescribed from the ED.

7. Patients should provide identification to pharmacy filling the RX.

8. ED’s are encouraged to photograph patients who present without ID.
ED Guidelines

9. ED’s should coordinate care of patients who frequently visit the ED.

10. ED’s should maintain a list of clinics that provide pain mgt and primary care for all payer types.

11. ED’s should perform SBIRT (Screening, Brief Interventions and Tx) referrals to patients with suspected RX abuse problems.

12. Administration of Demerol is discouraged.
13. For exacerbation of chronic pain, the PMP should be contacted. Patient should receive only enough pills to last until the office opens.

14. Prescriptions for acute injuries should not exceed 30 pills with no refills.

15. ED patients should be screened for substance abuse prior to prescribing for acute pain.
16. ED physician is required to evaluate pain, use clinical judgment when treating but is not required to provide controlled substances for tx.
Acute/Chronic Guidelines

- Based off criteria including VA/DoD Clinical Practice Guidelines, American Pain Society/American Academy of Pain Medicine, American Society of Interventional Pain Physicians, Washington State and Utah.
- Consensus document developed/vetted by medical associations.
- Intended to help reduce inappropriate use of controlled substances.
- Not intended to establish standards of care.
- Educational tool.
- Promising intervention.
- Clinicians MUST use their clinical judgment.
Acute Pain

1. Opioid meds should only be used for tx of acute pain if severity warrants & non-opioid meds/therapies do not provide adequate relief.

2. The number dispensed should be no more than the number of doses needed.

3. Patients should be counseled that:
   - Sharing is illegal, store securely, dispose properly, use is intended for short term, avoid driving/operating machinery if sedated/confused
Acute Pain

4. Long acting should not be used for tx of acute pain including post op pain except in select tolerant patients.

5. Continued use should be considered carefully including assessment for misuse.

6. The CSPDMP should be checked prior to prescribing and periodically if renewing opioid RX.
Chronic Pain Diagnoses:

Examples

Migraine
Back Pain
Fibromyalgia
Ovarian Cysts/Endometriosis
Abdominal Pain
Pelvic Pain
Joint pains
Dental Pain
Chronic Non-Terminal Pain

1. A comprehensive medical & pain evaluation that includes assessing for substance use, psychiatric comorbidities and functional status.

2. Goal directed trial of opioid therapy- benefits should be determined that outweigh the risks. Pt. should agree to participate in other aspects of pain care plan (physical therapy & cognitive behavioral if recommended & available.)
3. Assess for risk of misuse, addiction or adverse effects & perform risk stratification prior to tx.

4. Tx should be limited to short term therapy. If chronic opioid therapy is considered – goal directed trial 30-90 days. A second opinion or consult with pain specialist may be useful.

5. If trial is determined to be appropriate, pt. should be actively engaged, shared decision making and informed consent. Use of Opioid Care Agreement is one way to document this.
6. Obtain & review past medical records when possible. Ongoing documentation includes evaluation, tx plan with clear goals, discussion of risks/benefits, tx prescribed, informed consent, tx results and any aberrant behavior observed.

7. Monitoring progress and adherence to tx plan is essential to pt care. At minimum: regular face to face assessment, response to tx., periodic query to CSPDMP.
8. Consider consultation for pt. with complex conditions, co-morbidities, pregnancy, drug addictions, mental illness or just need help managing the patient.

9. Tx trial should be tapered/DC’d if goals are not met, risk greater than benefit, or illegal behavior is demonstrated.

10. Use the lowest possible dose to achieve tx goal. Adverse event increase with dose > 50-100 mg of morphine equivalent dose/day.
11. Avoid combining opioids & benzos. Only use with great caution & informed consent. Same applies to sedatives/hypnotics.

12. Methadone should only be prescribed by clinicians familiar with its risks. Generally not prescribed to opioid naïve pts - use cautiously if so.
Guidelines available online

• ADHS
  – Clinicians: Clinical Guidelines and Recommendations
    • Prescribing Guidelines
      http://azdhs.gov/clinicians/clinical-guidelines-recommendations/index.php?pg=prescribing
Summary

• Treatment of chronic pain patients in any setting is challenging
• Progress can be made through:
  – Awareness of the RX issue
  – Use of non-opioid tx when applicable
  – Best patient care
  – Using the tools available
Questions?