Controlled Substances 2017

EXPLORE Healthcare Summit

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Disclosure

- Member of Speaker's Bureau:
- Jazz
- Endo
- Medtronic
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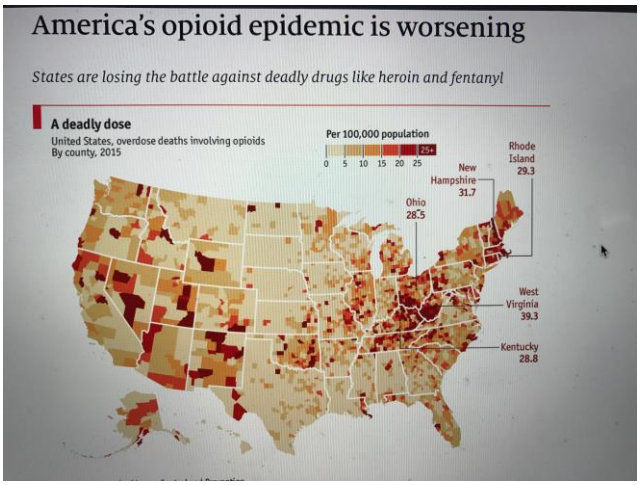
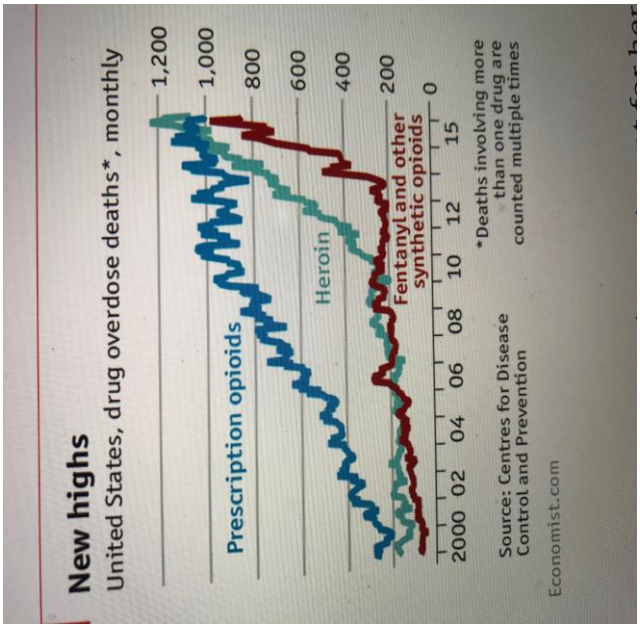
Why This Lecture?

- 20% of patients presenting to physicians offices with noncancer pain symptoms receive an opioid prescription.
- 2012 259 million prescriptions for opioids (72 million in 1991)
- Opioids per capita increased 7.3% from 2007-2012.
- Rates of opioid prescribing vary greatly from state to state that cannot be explained by the underlying health status of the population

- The overall prevalence of common, predominantly musculoskeletal pain conditions (arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches) is estimated at 43% among adults.
- 2015 52,404 lethal drug overdoses
- 20,101 overdose deaths related to Rx
- 12,909 overdose deaths related to heroin
- 2011 420,000 ER visits related to misuse or abuse of narcotic pain relievers.

- Patients aged 15-64 followed for 13 years revealed 1:550 died from opioid related overdose at a median of 2.6 years from their first prescription.
- 1:32 who had MME of greater than 200 died from opioid related overdose.





Learning Objectives

- Define chronic nonmalignant pain
- Understand the depth of the problem
- Understand the CDC's Opioid Prescribing Guidelines

- CDC classifies drug abuse as an epidemic
- 1/3 of people >12 years old who used drugs for the first time in 2009 began with prescription drug for non-medical purpose
- 67% of people who use opioids not prescribed to them obtain them from friends not drug dealers
- National Drug Control Policy

Reasons for Board Actions

- Inadequate initial assessment
- No discussion of the risks and benefits
- Not monitoring the patient's clinical course
- Not documenting the reason for dose escalation or discussion of alternative treatments
- Not using REMS tools:
  - Treatment agreements
  - Screening tools
  - Urine drug screens

CDC Guidelines for Primary Care

- Established March 15, 2016
- Based on literature review
- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

- When starting opioid therapy for chronic pain, clinicians should prescribe IR and not ER/LA medications
- Use lowest effective dose. Carefully reassess evidence of individual benefits and risks when considering increasing dosage to greater than 50 MME/day, and should avoid increasing to greater than 90 MME/day or carefully justify a decision to titrate dosage to greater than 90 MME/day.

- When opioids are used for acute pain use lowest effective dose. Three days or less will often be sufficient; more than 7 days will rarely be needed.
- When starting or increasing dosage evaluate within 1-4 weeks. Re-evaluate patient every 3 months or sooner. If benefits do not outweigh risks, optimize other modalities and taper medication.

- Evaluate risk factors for opioid related harms
- Check PDMP
- Use urine drug screening to identify prescribed substances and undisclosed use.
- Avoid concurrent benzodiazepine and opioid prescribing.
- Arrange treatment for opioid use disorder if needed. (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies)

- Pearson P3 test
- Opioid Risk Tool
- Psychological Screening

The Problem

- Inadequate training
- Limited or no exposure to opioid prescribing in Medical/Osteopathic Schools
- Limited or no exposure to prescribing in postgraduate training
- Patient expectation that pain should be controlled by medication.
- Constraints on coverage of multimodality therapies.

Oklahoma PMP

Check On Initial RX, every 6 mos after initial

- Need to use it!!!
- Need to document use!!!
- Need to take action!!!!
- New system in place as of 7/30/2016
- Tracks Morphine Milligram Equivalents
- Email alerts….act on them!

Chronic Nonmalignant Pain

- Unrelated to cancer
- Persists more than 90 days after surgery or beyond the usual course of the disease or injury causing the pain

CDC Guidelines For Primary Care Physicians

- Exceptions:
  - Cancer pain
  - Injury
  - Prescribing for other than chronic nonmalignant pain

Good Practices

- History and Physical Exam
- Documentation of Pathology
- UDS/PMP
- Frequent evaluations
- No Early refills
- Be able to justify prescribing medications
- Don’t be afraid to say NO!
- Treatment Agreement/Pain Contract
- Informed Consent
- Make reasonable opioid conversions (globalrph)

Informed Consent and Treatment Agreement

- Shared decision between physician and patient
- Discuss risks and benefits of treatment plan
- Discuss safe storage and disposal of medications
- Use written informed consent and treatment agreement

Treatment Agreement

- Anticipated benefits of chronic opioid treatment
- Potential long/short-term AEs (constipation, cognitive and sedative)
- Impaired motor skills (driving and other tasks)
- Drug-drug interactions
- Define and discuss:
  - Addiction, tolerance and physical dependence
  - Consequences of opioid misuse & overdose

Treatment Agreement

- Limited evidence of the benefit of Long-term opioid therapy
- Prescribing policies and expectations
- Refills (early, late, lost or stolen medications)
- Reasons that may cause a change/discontinuation of treatment plan

Responsibilities

- Joint:
  - Informed consent and treatment plan
  - Goals of treatment

Responsibilities

- Patients responsibility for safe medication use
  - Not using more medication than prescribed
  - Not using the opioid in combination with alcohol, non-prescribed CS or illicit drugs
  - Storing medications in a secure location, safe disposal
  - Single prescriber of opioid
  - Periodic drug testing

Physician's Responsibility

- Be available to care for unforeseen problems
- Appropriate prescribing of CSs
- Always be responsible for the safety and well being of the patient

Concerning Behaviors

- Early refills, lost or stolen prescriptions
- Multiple sources
- Intoxication or impairment
- Illicit or un-prescribed drugs
- Recurring misuse
- Deteriorating function
- Failure to comply with treatment plan

What Do I Do

- Office visit every other month
- Prescription Pick-Up Appointment
- Use primarily long acting/tamper resistant medications
- Check PMP every visit
- Routine screening UA's
- Pill counts on demand
- Psychological Screen, P3 and ORT

Conclusion

- Is the opioid doing more to the patient than for the patient?
- The CS can be the problem, the solution or both
- 30 seconds to say yes, 30 minutes to say no
- Separate motive from the behavior
- Entrance and exit strategy
- Naloxone decreases death rates from overdose by 9%

References

- 1. Karch, Steven B. (2008) Pharmacokinetics and pharmacodynamics of abused drugs. Boca Raton: CRC Press. pp. 55-56. ISBN 1-4200-5458-9
- 2 Vallejo, R.;Barkin, R. L.; Wang, V.C. (2011). "Pharmacology of opioids in the treatment of chronic pain syndromes". Pain physician 14(4): E343-E360. PMID 21785485

Resources

- American Academy of Pain Medicine
  - Patient agreement www.painmed.org/Workarea/DownloadAsset.aspx?id=3203
  - Patient Agreement Form

Resources

- www.drugabuse.gov/nidamed-medical-healthcare-professionals
- www.globalrph.com
- www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm