Prescribing Opioids 101

The Pain That Won't Go Away

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January 24, 2018

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Learning Objectives

- Describe changes in opioid use disorder epidemiology
- Appreciate pressures on opioid prescribing from federal agencies, state boards, insurers
- Define the tenets of safe opioid prescribing
- Incorporate new information about alternatives to analgesics into practice

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OPIOID EPIDEMIOLOGY

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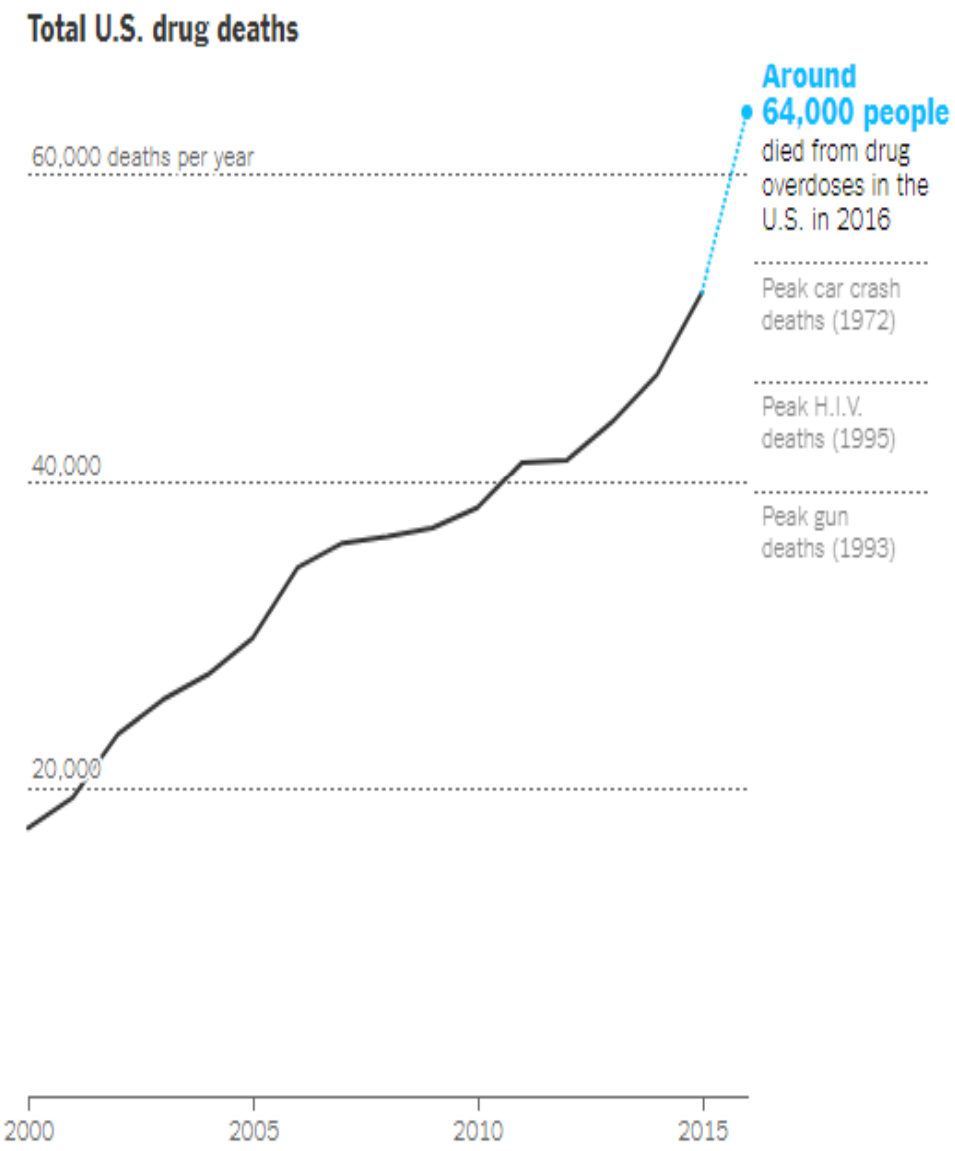
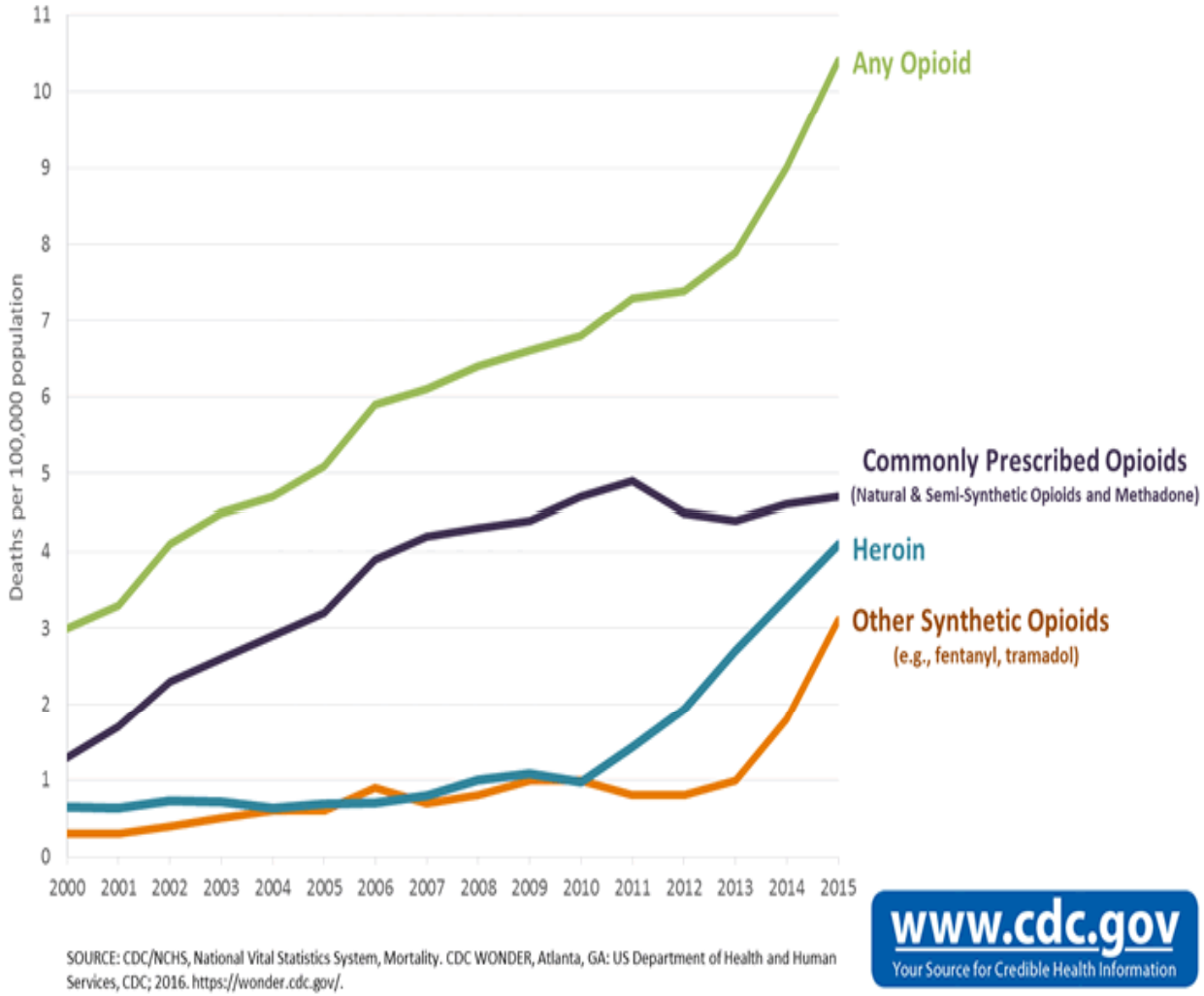


Ref: NY Times *The Upshot* 9/2/2017



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.

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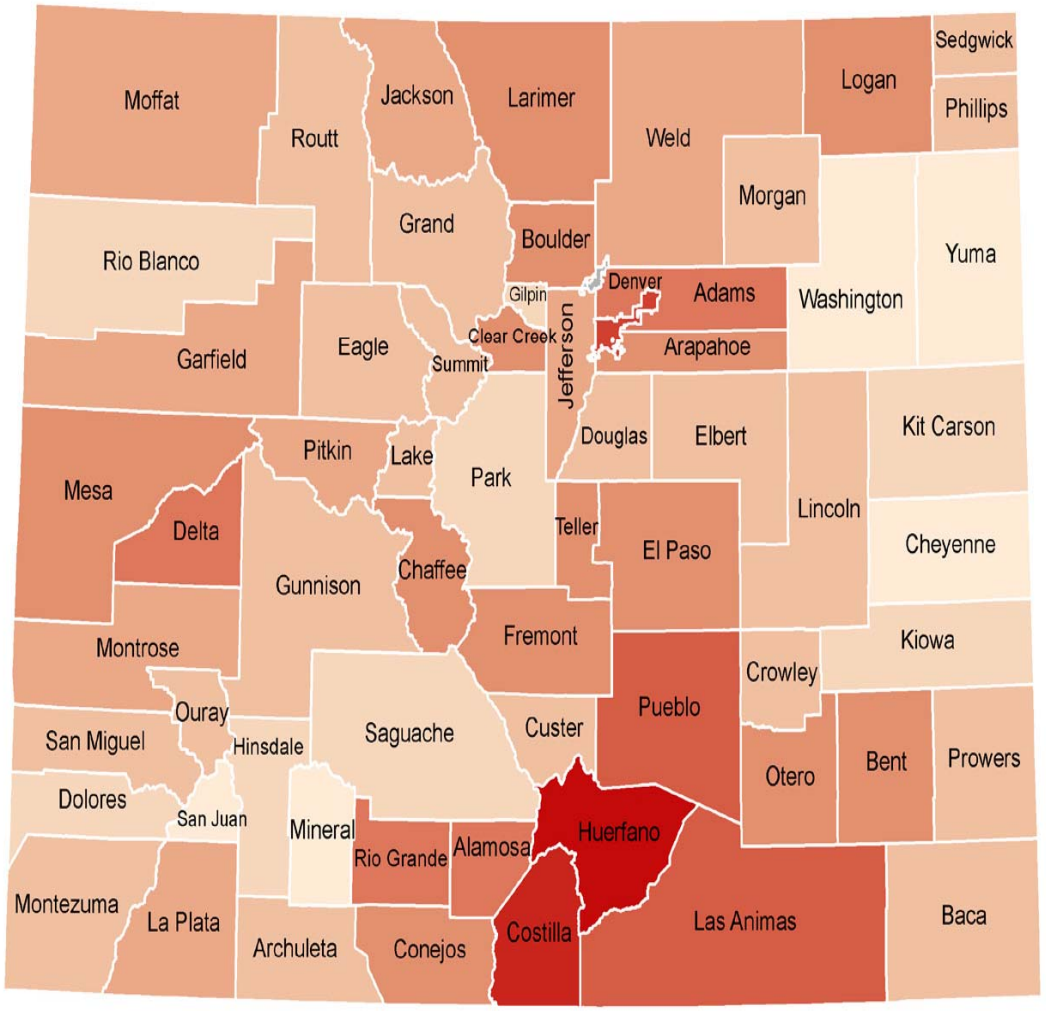

Colorado drug overdose death rates by county: 2002

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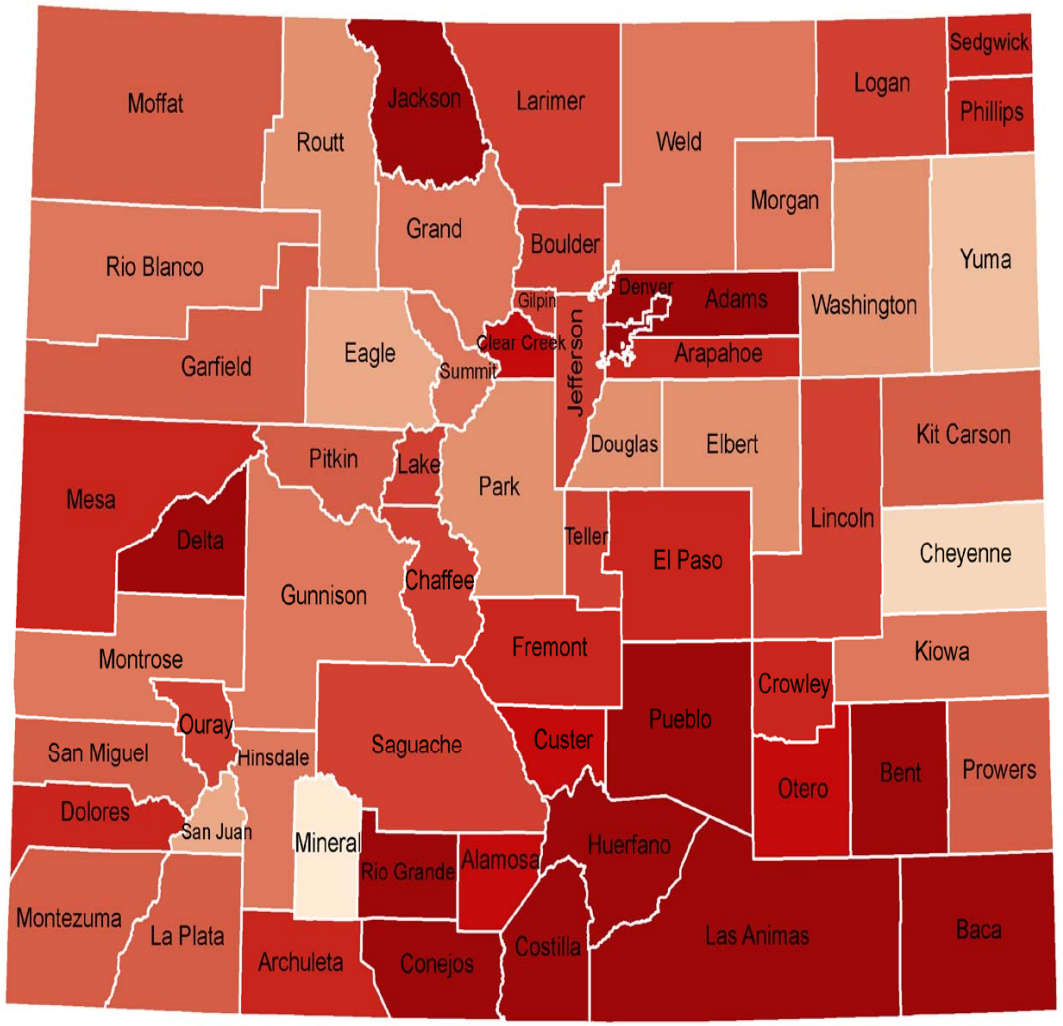

Colorado drug overdose death rates by county: 2014

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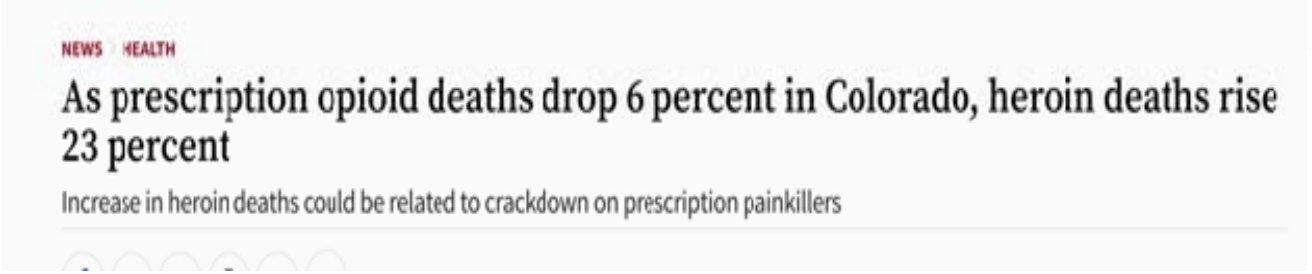
Locally things are a bit better


NEWS HEALTH

As prescription opioid deaths drop 6 percent in Colorado, heroin deaths rise 23 percent

Increase in heroin deaths could be related to crackdown on prescription painkillers

- Colorado opioid death rate fell slightly:
  - 2015: 472
  - 2016: 442
    - Biggest gains in death rates from semi-synthetic opioids hydrocodone, oxycodone (259 to 188)
- Heroin deaths increased substantially:
  - 2015: 160
  - 2016: 197

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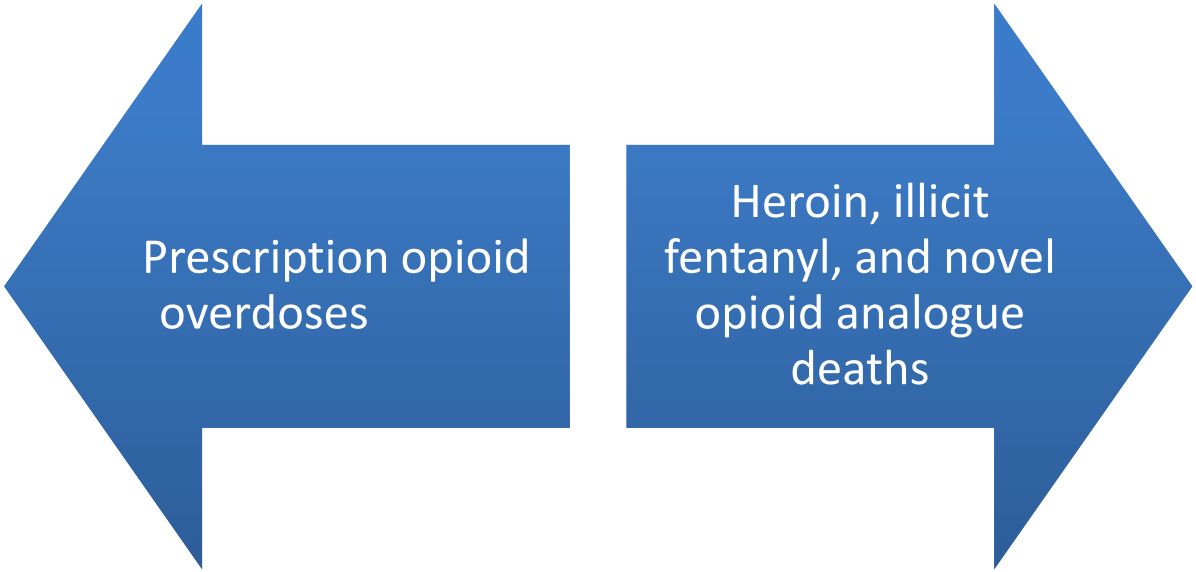
So is this no longer a prescribing problem?

Under doctors' control



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NOT under doctors' control

Still our problem

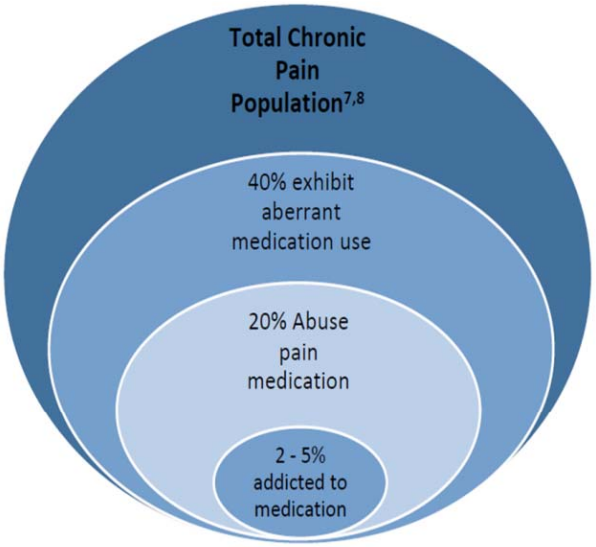
- Opioid analgesic prescriptions still 300% higher than 1999
  - 1999: 180 MME
  - 2015: 640 MME

CDC Vital Signs 2017-07

Rates of misuse of prescribed opioids

- Reid et al: 24-31% in outpatient clinics
- Katz & Fanciullo: 20-40%
- Rates may be underestimated because of
  - Exclusion of high-risk patients from trials
  - High rates of dropout/premature termination

- Rates of diversion: ?
- Most diverted drugs started off as prescriptions from physicians



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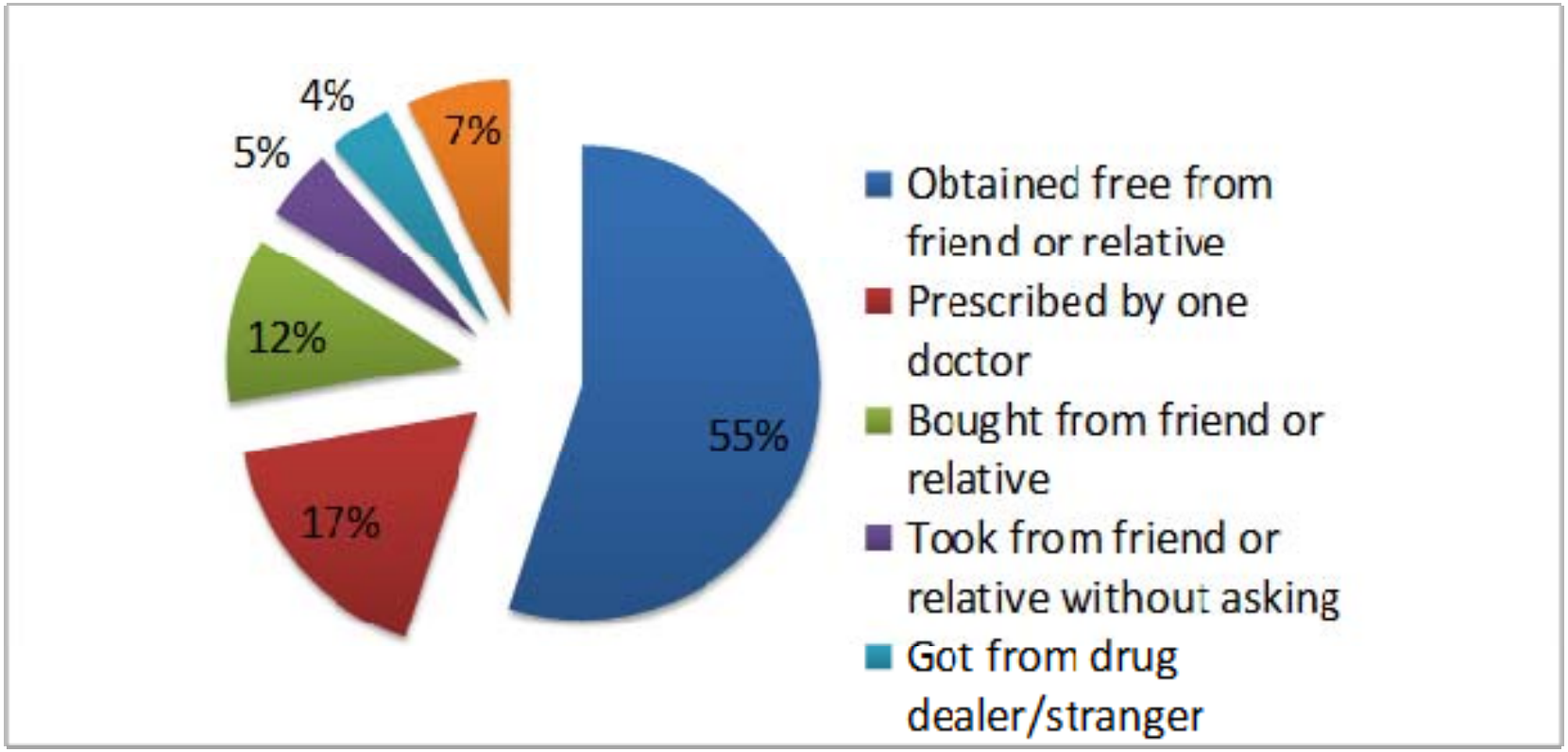
Sources of diverted opioids



MOST HEROIN USERS BEGIN WITH PRESCRIPTION OPIOIDS

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Risk diversion $5 a pill streetrx.com

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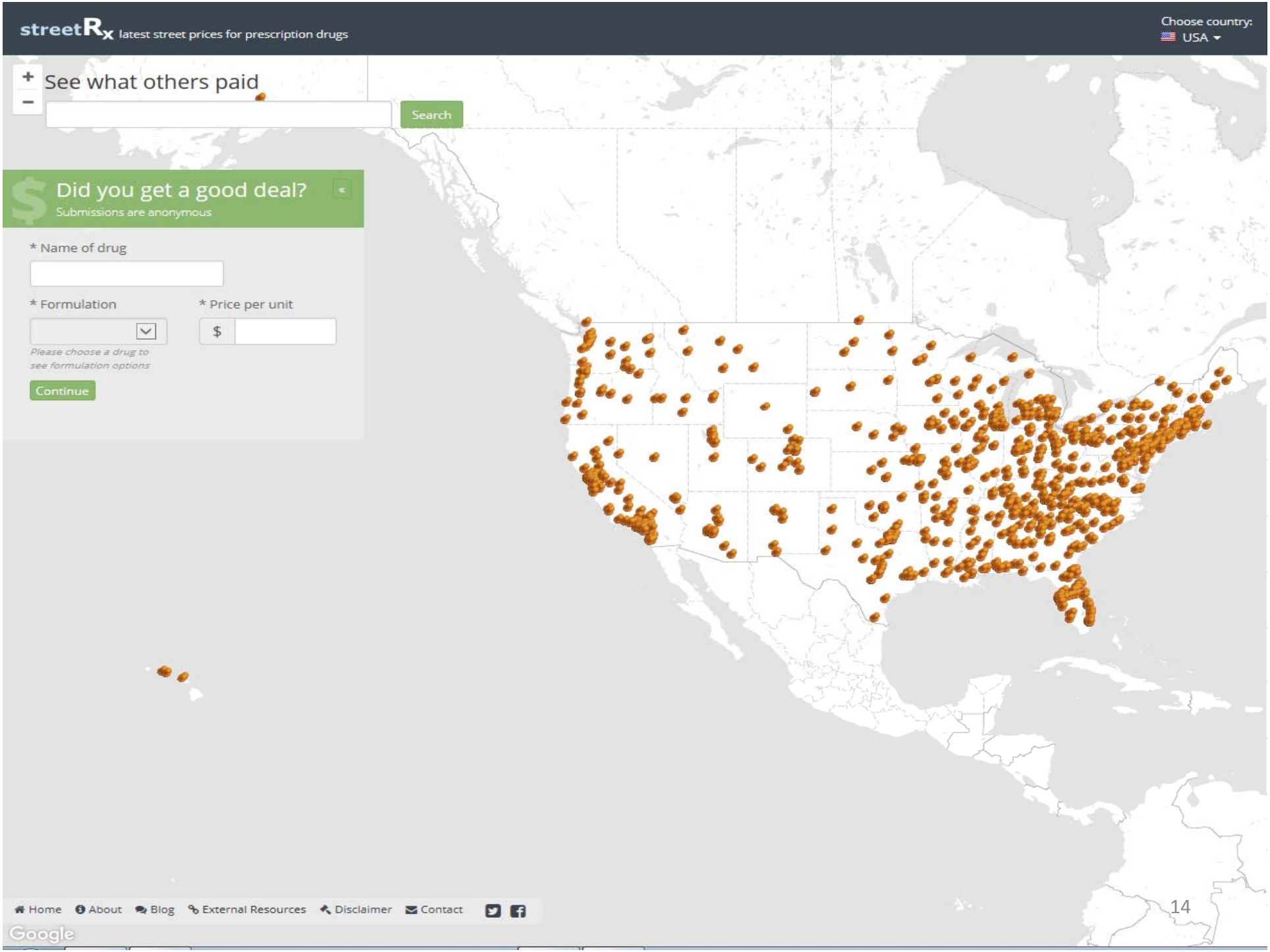
streetRx latest street prices for prescription drugs
Choose country:
USA
See what others paid
Search
Did you get a good deal?
Submissions are anonymous
* Name of drug
* Formulation
* Price per unit
$
Please choose a drug to see formulation options
Continue
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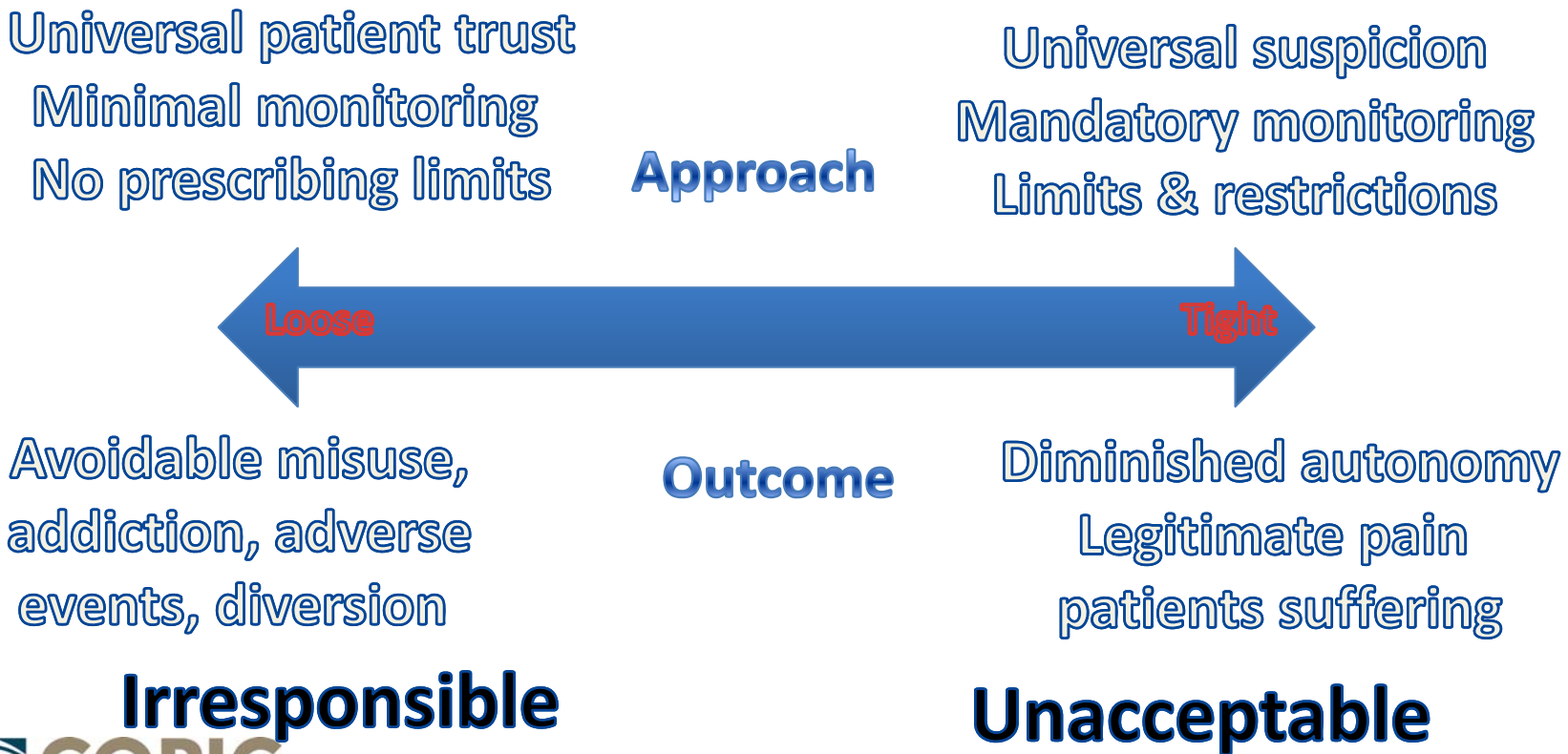
Achieving balance

- How do we prescribe opioids appropriately and effectively for the patients who need them?
- How do we avoid contributing to the epidemic of opioid misuse?

Continuum of opioid prescribing



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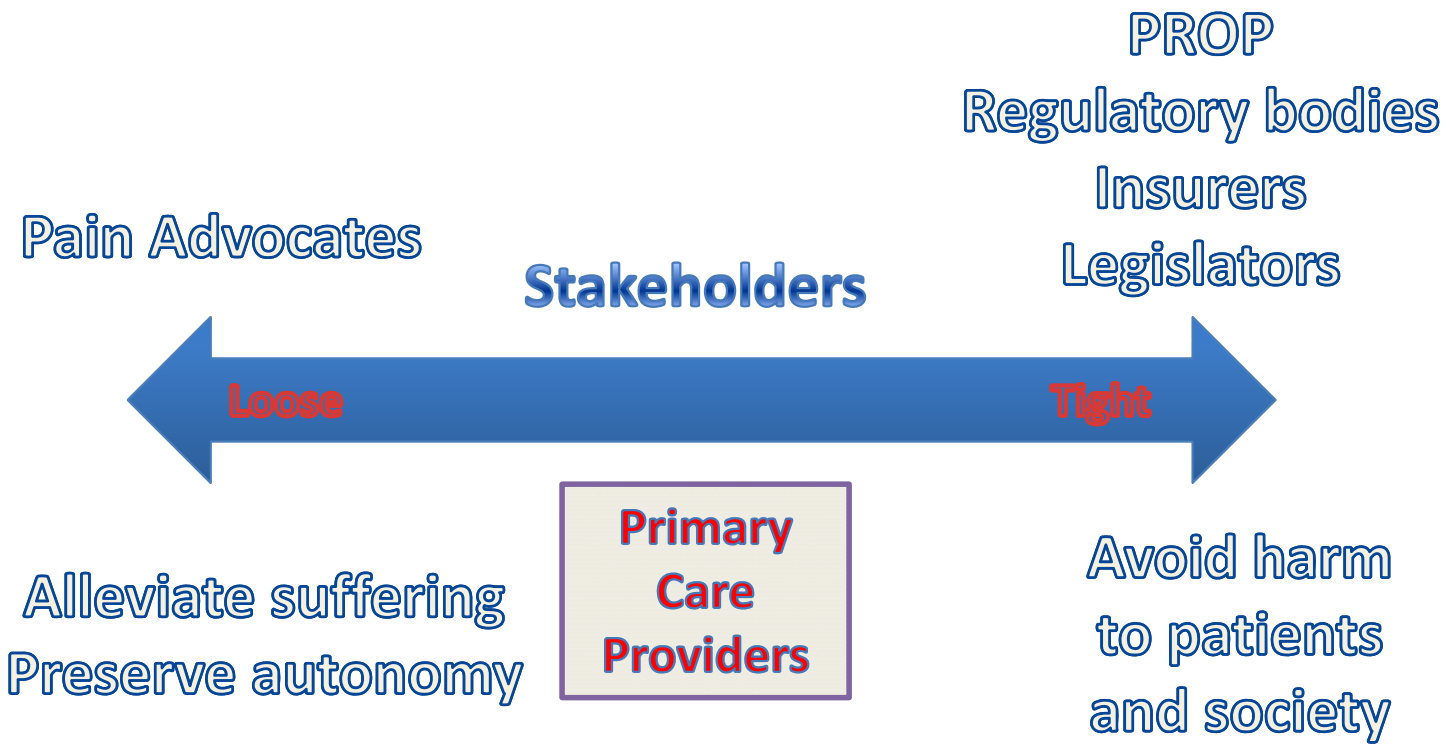
Continuum of opioid prescribing



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INSURERS, LEGISLATION, AND GUIDELINES

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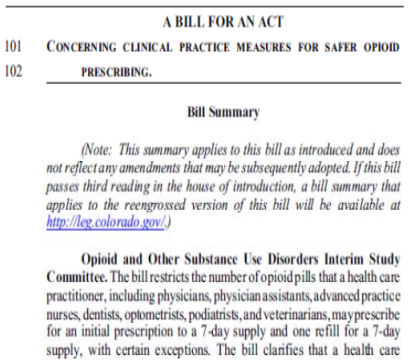
In response to opioid epidemic, payers mandate limits to high-dose opioids

- CO Medicaid (7/2017)
  - Prescriptions exceeding 250 milligrams of morphine equivalents (MME) will require a PAR
- Centers for Medicare and Medicaid (CMS) (1/2017)
  - **Cumulative Opioid Morphine Equivalent Dose (MED) Point-of-Sale (POS) Edit.**
    - Soft ‘edit’ for ≥ 120 MME
    - Hard ‘edit’ for ≥ 200 MME

They are also restricting opioids for acute pain

- Colorado Medicaid 7/2017
  - Limits acute pain prescriptions to 7 days maximum
    - Can write 2 more prescriptions before PAR required
- Colorado Interim Opioid Committee Bill
  - Limits prescribers to one 7-day supply plus one 7-day refill
  - Must check PDMP before refill



A BILL FOR AN ACT

101 CONCERNING CLINICAL PRACTICE MEASURES FOR SAFER OPIOID
102 PRESCRIBING.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov/.)

Opioid and Other Substance Use Disorders Interim Study Committee. The bill restricts the number of opioid pills that a health care practitioner, including physicians, physician assistants, advanced practice nurses, dentists, optometrists, podiatrists, and veterinarians, may prescribe for an initial prescription to a 7-day supply and one refill for a 7-day supply, with certain exceptions. The bill clarifies that a health care

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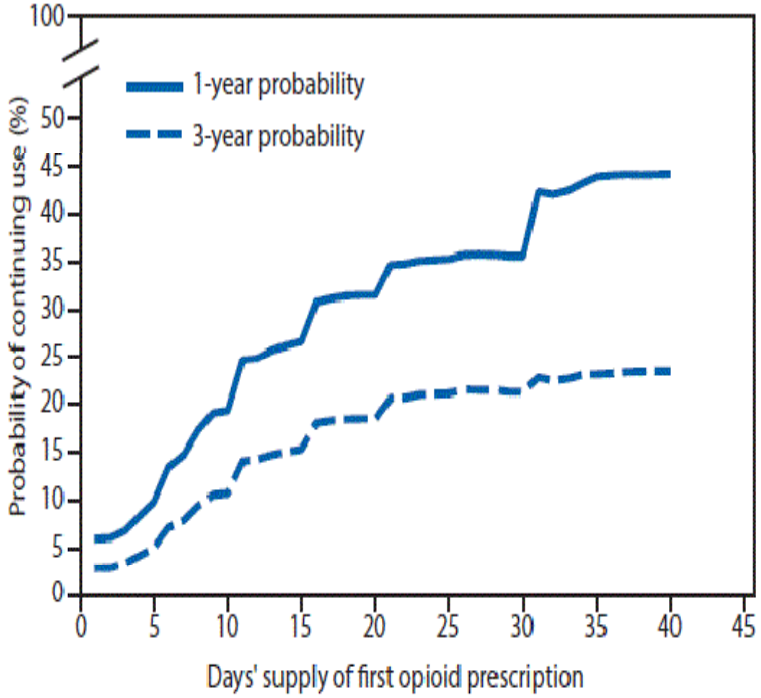
1 and 3 year probabilities of continued opioid use among naïve patients by # of days supply



Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use—United States, 2006–2015. MMWR 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

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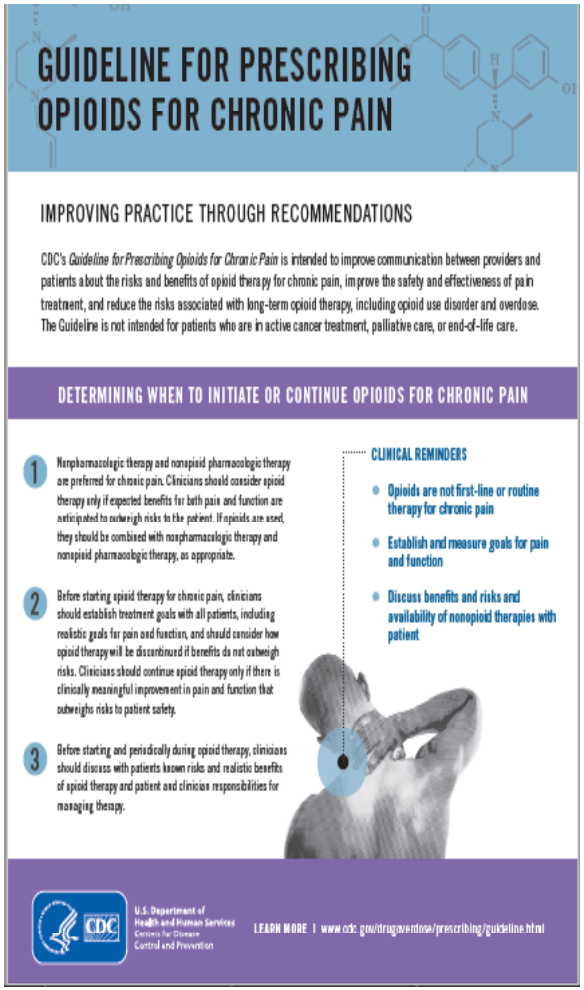
CDC Guidelines



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

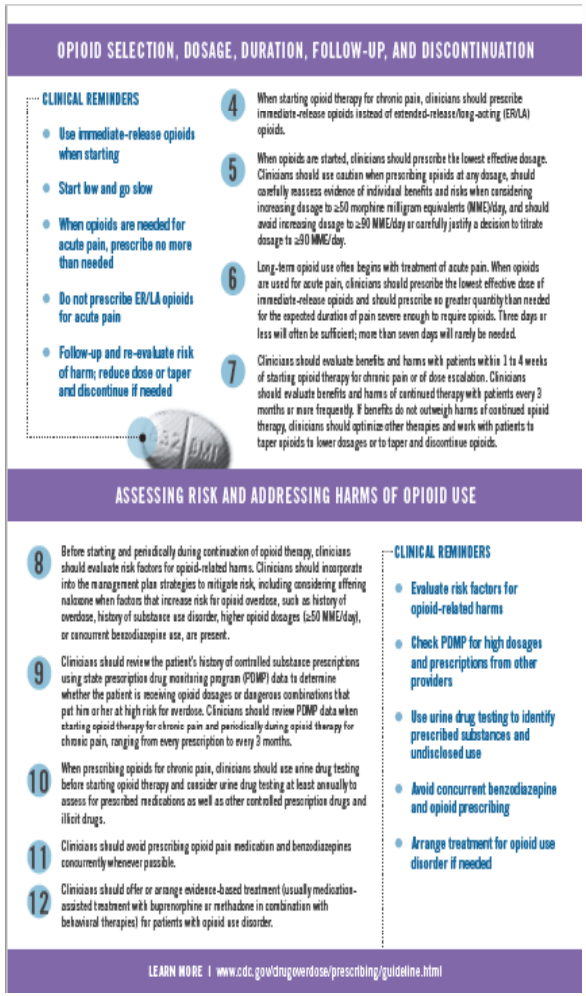
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- 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

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html



OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully assess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. 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.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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Ideal opioid prescribing in a single slide

- **Maximize non-opioid modalities**
- **Assess risk** with a screening tool:
  - ORT, SOAPP
- **Check PDMP and UDT** at initiation and periodically during treatment
  - At least yearly
  - CDC: PDMP monthly
- Use informed consent/**contract**
- Have a **risk-benefit discussion** with patient
- **Initiate with short-acting** opioids
- Use **low or moderate doses,** generally **≤50 MME** & definitely ≤90 MME
- Set specific **functional goals**
- **Outline exit strategy** at initiation
- **Don't co-prescribe sedatives, especially BZDs**
- Prescribe **naloxone**
- Stress safe storage & disposal
- Use an **ongoing monitoring tool** to assess pain relief, function, side effects
- **Re-evaluate within 1-4 weeks**
- **Ongoing assessment** of risks & benefits at least **every 3 months**
- Address minor red flags with education, more intensive monitoring
- Multiple minor red flags or major red flag should result in cessation
- **Refer for evidence-based SUD treatment for patients with OUDs**
- **Continue to care for patient after weaning off opioids**

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For acute pain: prescribe at low dose for as short a duration as possible: generally ≤3 days and definitely ≤7

Recent trends take home points

- For the foreseeable future, providers will feel pressure to prescribe

  fewer opioids

  at lower doses

  for shorter durations

  to fewer patients

- Pressure comes from insurers, state regulations, and national guidelines

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CANDIDATE SELECTION

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32 year old male with alcohol-induced chronic pancreatitis. History of major depression. Multiple claimed allergies to pain medications, asking for oxycodone.

63 year old married female with OA of knees & hips, s/p GI bleed secondary to NSAID use. Inadequate pain relief with APAP. No history of substance abuse or psychiatric disease.

Choosing candidates for opioid therapy

- Patients likely to benefit from therapy include:
  - Fully engaged patients
    - Seeking relief via pharmacologic and non-pharmacologic methods
  - Patients with clear disease processes
  - Older patients

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Choosing candidates for opioid therapy

- Patients at higher risk of abuse:
  - Younger age
  - History of substance abuse
    - Active
    - Past
  - Psychiatric illness:
    - Depression, bipolar, anxiety disorders
    - Schizophrenia
    - Personality disorders
    - Problems with temper

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Other risk factors for abuse

- Heavy tobacco use
- Childhood sexual abuse
- History of criminal activity, legal problems
- Risk-taking behavior
- Regular contact with high-risk behavior or environments

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Jamison et al. 2011
Webster LR et al. 2005

‘Legacy’ patients on opioids?

- Thousands in Colorado
- Many are poor candidates
  - Started on opioids for inappropriate indications
  - Repeated evidence of aberrant behaviors
- Some on high dose opioids

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Legacy patients

- You don't have to act right away
  - Take some time to assess patient, develop therapeutic relationship
  - Consider tapering trial for:
    - Adverse event or overdose
    - Aberrant behavior
    - Patient request

Franklin GM. *Neurology* 2014

Another overlooked high-risk group of opioid users: the unborn!

- Use extreme caution when prescribing opioids to women of childbearing age
- Must ask about family planning
- Recommend definitive birth control (IUD, Nexplanon, etc.) whenever possible

Neonatal Abstinence Syndrome

- Impacts 60-80% of infants exposed to heroin or Rx opioids in utero
- 4-fold increase in antepartum maternal opioid use from 1.9/1000 hospital births in 2000 to 5.6/1000 in 2009
- 3-fold increase in NAS from 1.2/1000 to 3.4/1000 live births

SCREENING TOOLS TO PREDICT ABUSE RISK

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Pre-screening to predict abuse

- ORT: Opioid Risk Tool
- DIRE: Diagnosis, Intractability, Risk, and Efficacy
- SISAP: Screening Instrument for Substance Abuse Potential
- SOAPP and SOAPP-R

- Studied in small, selected groups only
- Results have not been validated in larger studies
- Modest positive and negative likelihood ratios

SOAPP Questions

How often do you have mood swings?
How often do you smoke a cigarette within an hour after you wake up?
How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?
How often have any of your close friends had a problem with alcohol or drugs?
How often have others suggested that you have a drug or alcohol problem?
How often have you attended an AA or NA meeting?
How often have you taken medication other than the way that it was prescribed?
How often have you been treated for an alcohol or drug problem?
How often have your medications been lost or stolen?
How often have others expressed concern over your use of medication?
How often have you felt a craving for medication?
How often have you been asked to give a urine screen for substance abuse?
How often have you used illegal drugs in the past 5 years?
How often, in your lifetime, have you had legal problems or been arrested?

Pre-screening tool comparison

- Convenience sample of 48 patients discharged from a Tennessee pain clinic
- SOAPP vs. ORT vs. DIRE vs. clinical interview by staff psychologist
- Patients discontinued for:
  - High-risk behaviors (positive utox for non-prescribed drugs, doctor shopping)
  - Low risk behaviors (repeated missed appointments)

Moore TM, et al. A comparison of common screening methods for predicting aberrant drug-related behavior among patients receiving opioids for chronic pain management. Pain Medicine 2009.

Pre-screening tool comparison

Measure	Entire sample	High-risk pts (34)	Low-risk pts (14)
Clinical Interview	0.77	0.76	0.79
SOAPP	0.73	0.82	0.50
ORT	0.45	0.44	0.43
DIRE	0.17	0.09	0.36

Moore TM, et al. A comparison of common screening methods for predicting aberrant drug-related behavior among patients receiving opioids for chronic pain management. Pain Medicine 2009.

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Name, MR#, Pat#, DOB

DENVER HEALTH MEDICAL CENTER

CHRONIC OPIOID THERAPY INITIATION CHECKLIST

Date: ____/____/____ Time: _____
MM DD YY

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Does patient wish to have a free interpreter provided? ☐ Yes ☐ No ☐ N/A

☐ In-person used ☐ Telephone interpreter used ☐ Language line used Interpreter name/number _____

☐ Patient declined interpreter services & requested family/other person interpret._____ (Name)

Other communication aids requested? ☐ Yes ☐ No ☐ N/A If Yes:_____

- This form should be completed for patients with pain for greater than 90 days who are expected to require ongoing opioid pain medication.
- Excludes patients receiving pain medications for cancer related pain and palliative care.

☐ History, physical, psychology screen, sleep evaluation, functional assessment other diagnostic work-up for pain and pain diagnosis documented in chart

☐ What is/are the pain diagnosis/diagnoses?_____

_____

☐ Other non-opioid modalities optimized

☐ Baseline urine toxicology performed; negative for illicit drugs or non-prescribed narcotics

☐ Checked Colorado Prescription Drug Monitoring Program (www.hidinc.com/copdmp) for evidence of multiple physician/pharmacy use.

☐ Patient Consent/Agreement About Narcotic (Opioid) Pain Medications form #F18-101 reviewed and signed

☐ Enter SOAPP 14 Score (from other side)= _____ Higher risk (≥7) Low risk (≤7)

☐ Is this patient a favorable candidate for chronic opioid therapy? ☐ Yes ☐ No

☐ Opioid medication regimen entered into electronic medication profile

☐ Follow-up appointment for patient to be scheduled for 4 weeks or less

Care Provider Signature/Title Date (mm/dd/yy) Time (00:00) (Pager & Provider #)

Attending Signature/Title Date (mm/dd/yy) Time (00:00) (Pager & Provider #)

F61-221 (2/13) Page 1 of 2

Name, MR#, Pat#, DOB

DENVER HEALTH MEDICAL CENTER

CHRONIC OPIOID THERAPY INITIATION CHECKLIST

SOAPP-14

For the following questions answer: 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after waking up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
Total Score:					

SPANISH:

Para responder a las siguientes preguntas: 0 – Nunca, 1 – Pocas veces, 2 – A veces, 3 – A menudo, 4 – Muy a menudo

1. Con que frecuencia usted tiene cambios de humor?	0	1	2	3	4
2. Con que frecuencia usted fuma un cigarillo en la primera hora despues de despertarse?	0	1	2	3	4
3. Cuantas veces alguno de los miembros de su familia, incluyendo padres y abuelos, tenian problema con el alcohol o las drogas?	0	1	2	3	4
4. Cuantas veces alguno de sus amigos cercanos tenian un problema con el alcohol o las drogas?	0	1	2	3	4
5. Con que frecuencia otras personas le sugirieron que usted tiene problemas con drogas o alcohol?	0	1	2	3	4
6. Cuantas veces usted ha asistido a una reunion de AA o de NA?	0	1	2	3	4
7. Cuantas veces has tomado medicamentos en la forma que no han sido recetados?	0	1	2	3	4
8. Cuantas veces has sido tratado por un problema de alcohol o drogas?	0	1	2	3	4
9. Con que frecuencia tus medicamentos han sido extraviados o robados?	0	1	2	3	4
10. Con que frecuencia otros le han expresado su preocupacion por el sobre uso de sus medicamentos?	0	1	2	3	4
11. Con que frecuencia usted ha sentido un ansia de medicamentos?	0	1	2	3	4
12. Cuantas veces te han preguntado por muestras de orina para un examen de drogas?	0	1	2	3	4
13. Cuantas veces has consumido drogas ilegales (ejemplo: marihuana, cocaina, etc.) en los ultimos cinco años?	0	1	2	3	4
14. Cuantas veces en tu vida, has tenido problemas legales o has sido arrestado?	0	1	2	3	4
Puntaje toal:					

F61-221 (2/13) Page 2 of 2

32 year old male with pancreatitis. Personal and family histories of alcoholism. History of depression. ORT = 8 (high risk)

63 year old female with osteoarthritis. No personal or family history of substance abuse or mental illness. SOAPP = 4 (low risk)

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NARCOTIC CONTRACTS

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Opioid contracts

- Weak evidence supporting their use
  - 4 studies of fair to weak quality
  - 7-23% decrease in opiate misuse in patients on contracts relative to control group
  - Active group usually involved multiple interventions including UDT

Starrels JL, et al. Ann Int Med. 2010;152: 712-720

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Reviewing the contract: crucial time to set reasonable expectations and EXIT STRATEGY

- Opiates can be expected to work in about 40% of patients
- Opiates may lower pain by at most 30-35%
- 40-50% of patients will drop out on their own
- If no response after 3 months, further treatment unlikely to be helpful

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URINE TOXICOLOGY TESTING

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Many abusers don't show 'red flags'

- 122 patients in two university pain clinics followed for 3 years and monitored for addictive behaviors
- Regular utox performed on all patients
- 17% had prior history of substance abuse

	Behavioral issues present	No behavioral issues present	Totals
Utox +	10 (8%)	26 (21%)	36 (29%)
Utox -	17 (14%)	69 (57%)	86 (71%)
Total	27 (22%)	95 (78%)	122

Katz et al. *Anesth Analg* 2003

Just test everyone

- Unreliable to use any of the following alone:
  - Physician intuition: may miss 60% of abuse
  - Patient report: underreport by 50% compared to UDT
  - Observation
  - Documented prior history

Turk D et al. Predicting Opioid Misuse by Chronic Pain Patients. Clin J Pain 24:497-508, 2008

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They don't know what they don't know

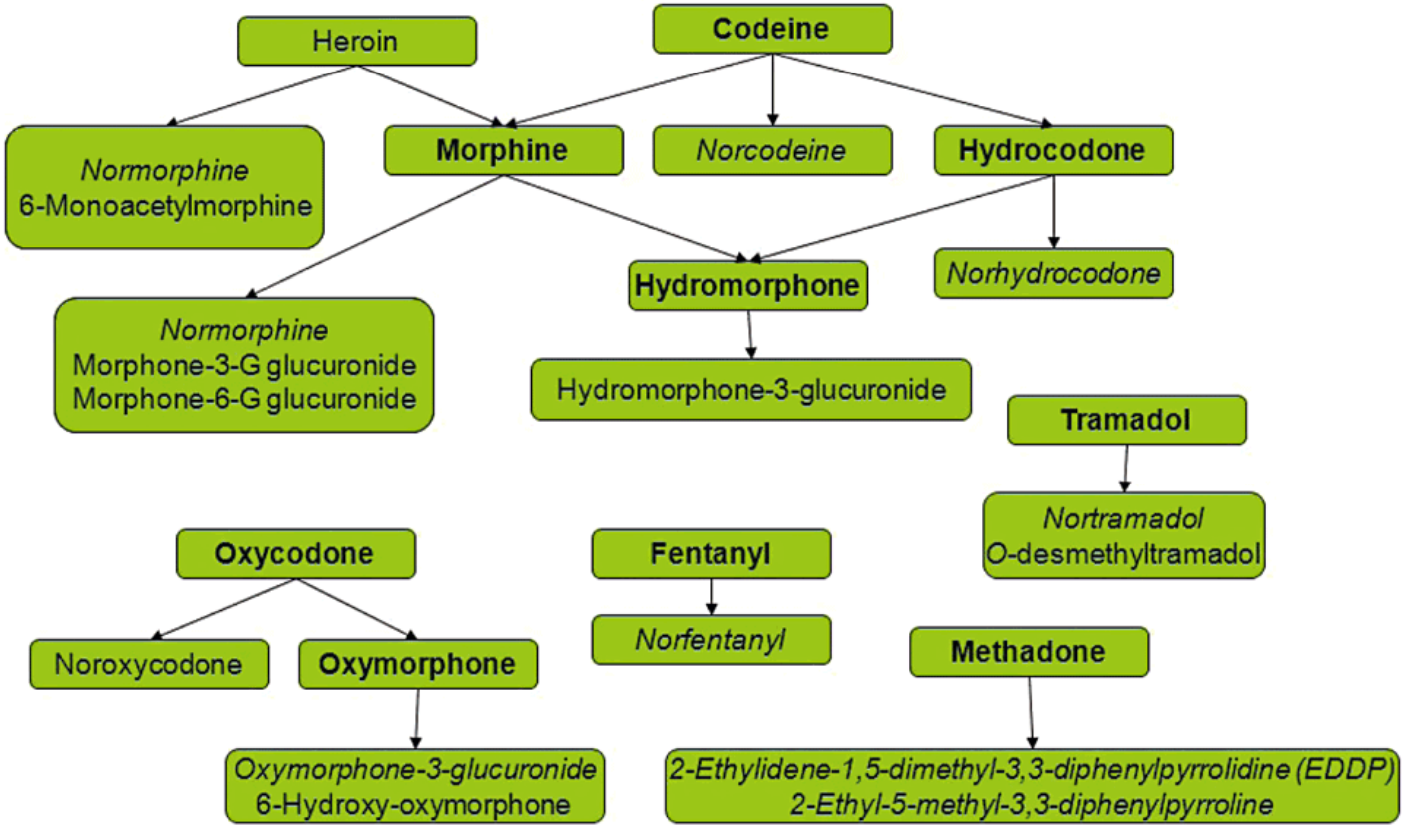
- 99 Internal Medicine residents surveyed
- Mean score 3/7
- 56% felt confident in their ability to interpret UDTs
- 73% of these scored ≤3
- Adolescent medicine-practicing PCPs survey
  - Only 12% aware that oxycodone not detectable on routine opioid screen

Starrels JL, et al. *J Gen Int Med* 2012; 27:1521-1527
Reisfield GM, et al. Urine drug test interpretation: what do physicians know? *J Opioid Manag* 2007

Approximate urine retention times

Drug	Detection Time
Amphetamines	1-3 days
Benzodiazepines	1-3 weeks (long-acting)
Cocaine	1-3 days
Marijuana (infrequent user)	4-5 days
Marijuana (chronic smoker	weeks
Methadone	72
Opioids	48-72

Opioid metabolism



Notes:
-Pharmaceutical Opioids in **BOLD**
-Inactive Metabolites in *ITALICS*
-Only small amounts of hydrocodone (11%) following codeine administration and hydromorphone (2.5%) following morphine administration are found in the urine.

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False positives and negatives

Drug	Selected Interferences
Cocaine	Zolpidem (-) Salicylates (-) Fluconazole (-)
THC	Hemp products (+) Efavirenz (+) Pantoprazole (+) Ibuprofen (-) Zolpidem (-)
Amphetamines	Phenylpropanolamine (+) Ephedrine (+) Phentermine (+) Trazodone (+) Bupropion (+) Selegeline (+) Zolpidem (-)
Benzodiazepines	Indomethacin (+) Ketoprofen, flurbiprofen, fenoprofen (+) Oxaprozin (+)
Opiates	Poppy seeds (+) Quinolones (+)

Monitoring for alcohol

- Short urinary detection time (8-12 hours after last ingestion)
- Instead order alcohol metabolites:
  - Ethyl glucuronide
  - Ethyl sulfate
  - Detectable for up to 80 hours
- Present within about 1 hour, usually detectable for 2-3 days

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Urine drug testing su mary

- UDTs should be done at l
  everyone receiving C routinely on higher-risk
  - Guidelines t
  - Followin ne will miss a large perc ers
  - U detect illicit drug use or possible div

JUST KNOW WHAT YOUR DOING OR ASK FOR HELP!

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Urine drug testing summary

- Know the limits of your testing strategy
  - Abnormal UDT does not diagnoses SUDs
  - Send the right tests for the right drugs
    - Oxycodone and metabolites
    - Clonazepam
    - Ethyl glucuronide or sulfate for alcohol
    - Cocaine test is reliable
- Repeat testing is frequently necessary to get a real sense of what's going on

NALOXONE

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Naloxone

- "Clinicians should incorporate into management plan strategies to mitigate risk, including considering offering naloxone" for patients at increased overdose risk, including:
  - **Hx previous OD**
  - **Hx SUD**
  - **Higher dose opioids (≥50 MME/day)**
  - **Concurrent benzodiazepine use**

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Naloxone types

Intranasal

Evzio auto-injector

Injectable

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Naloxone in primary care

- Safety net primary care clinics
- Nearly 2000 patients
- 38.2% prescribed naloxone
- 47% decrease in opioid-related ED visits per month
- 63% fewer visits at one year

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Coffin PO, et al. *Annals Int Med* 2016

SO WHAT DO WE DO IF WE'RE NOT PRESCRIBING OPIOIDS?

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Quiz Question

- In a 12 week study of neck pain, which of the following modalities was found to be the least effective?

A) Spinal manipulation therapy

B) Medications, including NSAIDs/APAP, and muscle relaxant or opioids for non-responders

C) Home exercises with advice

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Ann Intern Med. 2012;156:1-10

The focus is away from medications

Annals of Internal Medicine

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CLINICAL GUIDELINES | 4 APRIL 2017

Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians FREE

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians (*)

- "Given that most patients with acute or subacute LBP improve over time regardless of treatment, *clinicians and patients should select non-pharmacologic treatment with superficial heat, massage, acupuncture, or spinal manipulation*."

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Annals of Internal Medicine

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- "For…chronic low back pain…select nonpharmacologic treatment with *exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction, tai chi, yoga, motor control exercise, progressive relaxation, EMG biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation.*"

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Multidisciplinary rehab

- Bio-psycho-social model
  - Synonyms: multi-modal, comprehensive, interdisciplinary
- Defined as including at least 2 different medical specialties
  - Typically include MH professionals and physical therapists
  - May also include PMR, Ortho, NS, nursing, CAM modalities
- "Sports medicine" approach to physical disability
    - Avoids passive modalities
    - Goal of restoring physical capacity
- "Crisis intervention" approach to chronic psychosocial factors

Kamper et al. *BMJ* 2015

Multidisciplinary biopsychosocial rehabilitation for chronic low back pain: Cochrane systematic review and meta-analysis

- 41 studies/6858 subjects
- Rehabilitation included physical component plus:
  - Psychological component and/or
  - Social or work-targeted component
- Rehab delivered by professionals from at least two different healthcare backgrounds
- Compared with non-multidisciplinary intervention

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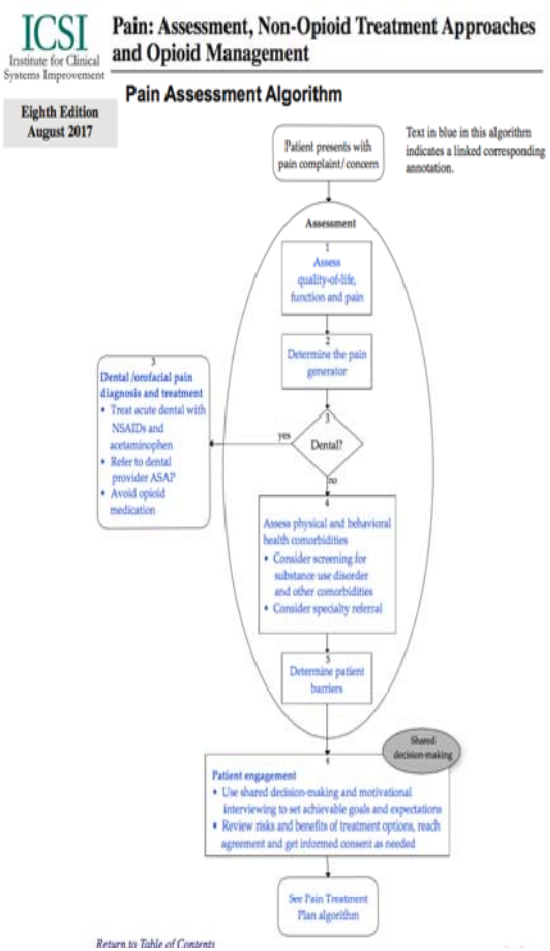
The new way to assess pain



- Determine the pain generator
- Assess function, quality of life
- Assess behavioral health co-morbidities
- Set self-management goals using shared decision-making

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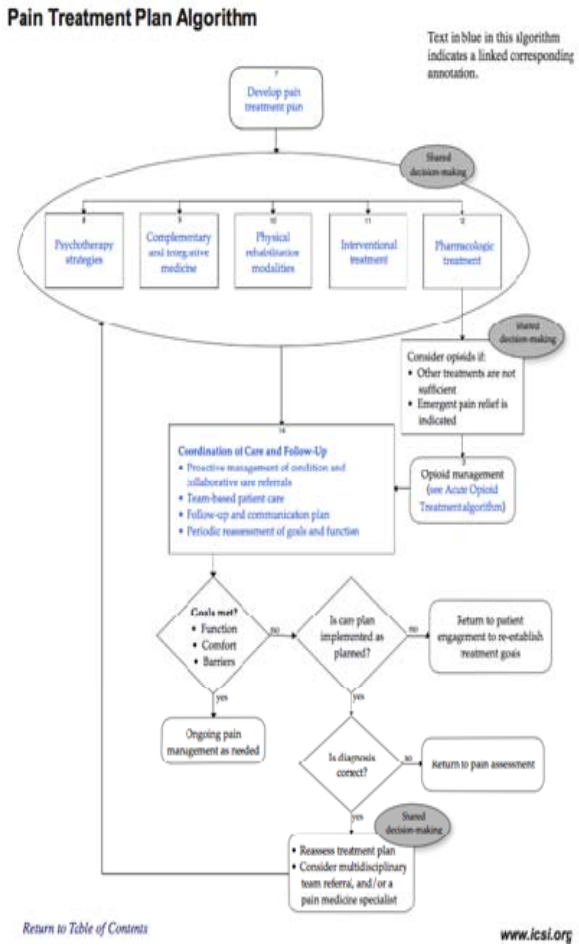
The new way to treat pain



- Psychotherapy
- CAM
- Physical rehabilitation modalities
- Interventional treatment
- Pharmacologic treatment

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Non-opioid pain management take-home points

- The focus is firmly away from pharmacology and towards physical and psychological therapies
- Involve the patient, set self-management goals
- “Alternative” therapies are no longer alternative but are first-line, standard of care, and evidence-based (sometimes)

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Summary

- Opioid overdose deaths continue to rise, driven largely by illicit use
- We still prescribe far more opioids now than in decades past, and the trend is towards (much) tighter prescribing
  - Insurers, legislators, and guidelines are driving this
- Pain management now focuses on biopsychosocial model & non-pharm treatment

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Summary

- Safe opioid prescribing isn't difficult but requires a lot of time & a lot of steps
  - CDC guidelines have the largest footprint and are straightforward
  - CO Quad Board policy recently updated

Don't take off if you can't land the plane

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END

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MARIJUANA FOR PAIN

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Marijuana for pain

- Best evidence for neuropathic pain
  - 5 systematic reviews; best is Whiting et al. 2015
  - 28 RCTs/2,454 participants
    - 17 trials neuropathic pain
    - Other pain states: MSK, RA, cancer pain, MS
  - Effect size similar to other neuropathic agents
    - NNT: 3.2
- Also fair quality evidence for spasticity treatment

The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research, National Academies Press 2017

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Recreational marijuana and opioid deaths

- Interrupted time series design, 2000-2015
- 0.7 deaths/month reduction in opioid-related deaths (CI -1.34 to -0.03)
- Legalization associated with short-term reductions in opioid-related deaths (-**6.5%**)
- Consistent with JAMA Internal Medicine study (Bachhuber et al 2014) showing 25% reduction in death in multiple states


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Recreational Cannabis Legalization and Opioid-Related Deaths in Colorado, 2000–2015

Melvin D. Livingston PhD, Tracey E. Barnett PhD, Chris Delcher PhD, and Alexander C. Wagenaar PhD

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So should we prescribing marijuana for pain?

- 133% increase in pediatric ED visits for marijuana intoxication
- “Priming” phenomenon?
  - COT patients who test positive for marijuana on urine toxicology more likely to have another drug present in the future

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