Safe and Responsible Opioid Prescribing in an Opioid Epidemic

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Ascension St. Vincent Family Medicine
October 30, 2018

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United States Pain Paradigm

- **USA ~4.5%** of world population
- Consume **99%** global hydrocodone
- Consume **73%** global oxycodone
- Consume **2/3** global illicit drugs

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Narcotic Drugs — Estimated World Requirements for 2018 — Statistics for 2016
https://www.incb.org/documents/Narcotic-Drugs/Technical-Publications/2017/Narcotic_drugs_technical_publication_2017.pdf

The Increase in Therapeutic Opioids Use in the U.S. (mg/person) from 1997 – 2007

Table 6. *The increase in therapeutic opioids use in the U.S. (mg/person) from 1997 to 2007.*

Type	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	% of Change from 1997
Methadone	1.94	2.60	3.47	5.14*	6.81	9.54	13.26	17.03	19.31	23.84	25.50	1214%
Oxycodone	16.68	24.66	34.99	55.11	71.75	80.56	95.97	105.05	110.27	133.33	154.73	899%
Fentanyl	0.28	0.34	0.39	0.53*	0.67	0.87	1.14	1.33	1.40	1.54	1.67	496%
Hydrocodone	32.49	38.93	43.57	50.83	56.15	67.77	80.44	86.70	92.90	107.49	118.70	265%
Morphine	22.20	24.01	24.50	28.11	31.72	36.95	44.30	51.55	54.20	63.03	68.59	209%
Total	73.59	90.54	106.92	139.72	167.1	195.69	235.11	261.66	278	329.23	369.19	402%

* For year 2000 data is not available, the average of 1999 and 2001 was taken.

Source: Data taken from U.S. Drug Enforcement Administration. Automation of Reports and Consolidated Orders System (ARCOS); www.deadiversion.usdoj.gov/arcos/retail_drug_summary/index.html. Access date: 8/25/2010

Source for 2007 data - http://www.justice.gov/ndic/pubs33/33775/dlinks.htm

↑ 402% PER CAPITA

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Epidemic of Chronic Pain

- Lasting >3 months
- Persists beyond what's expected, given degree of pathology
- Elicited by injury/disease
- Likely perpetuated factors pathogenically & physically remote from original cause
- Prevalence of chronic pain in US
  - 10-25%
  - Rate increases with age/ chronic illness/obesity
  - Opioids recommended therapies for management of several types of non-cancer related pain

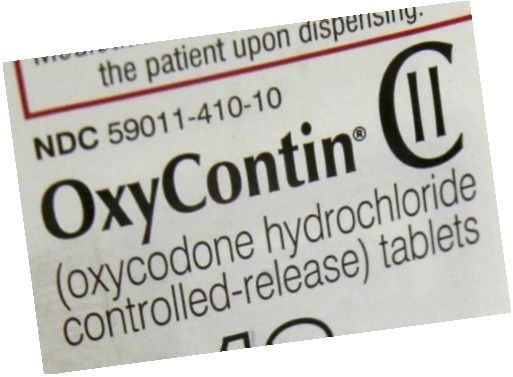
Why the Opioid Increase?

- Liberalization of laws governing opioid prescribing
- Joint Commission Standards – 2000
- Growing public awareness of the right to pain relief
- HCAPS- Patient Satisfaction Surveys
- Aggressive marketing

"The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy"

- Unprecedented Marketing
- No studies support benefit over other opioids
- Sales Reps trained "Risk of Addiction <1%"
- Original FDA Label- Risk of Abuse/Addiction – 1996 "Very Rare"
- Widely abused- crushed, injected, inhaled
- 2007 Purdue Pharma fined $634M
- 2009 OxyContin Sales $3B

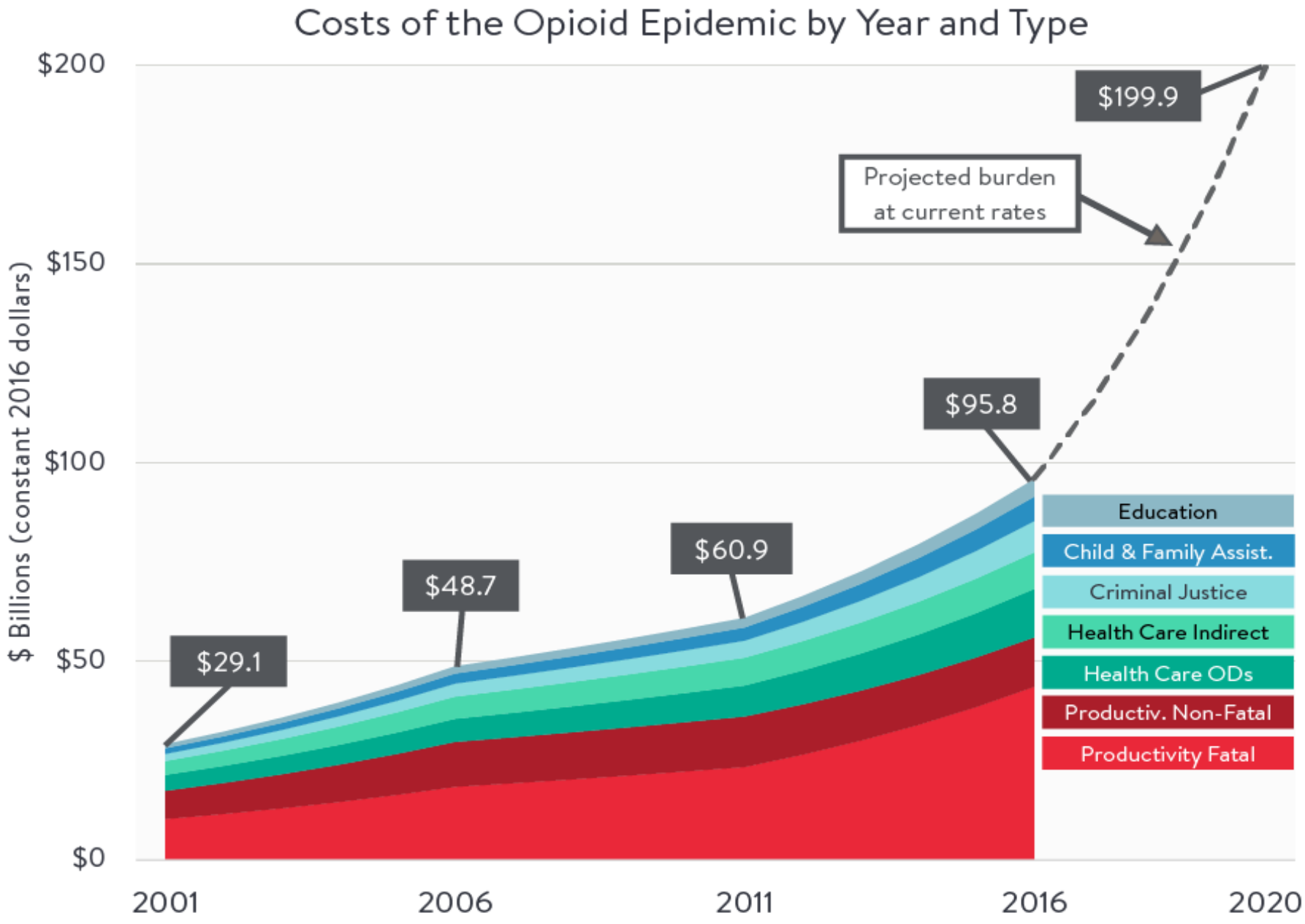
Long Acting/ ER Opioid Evidence



- FDA label LA/ER "the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate."
- There are NO studies showing any benefits of long-acting opioids over short acting opioids
- Long acting opioids increase all-cause mortality when treating non-cancer chronic pain
- Oxycontin 2018 FDA package insert

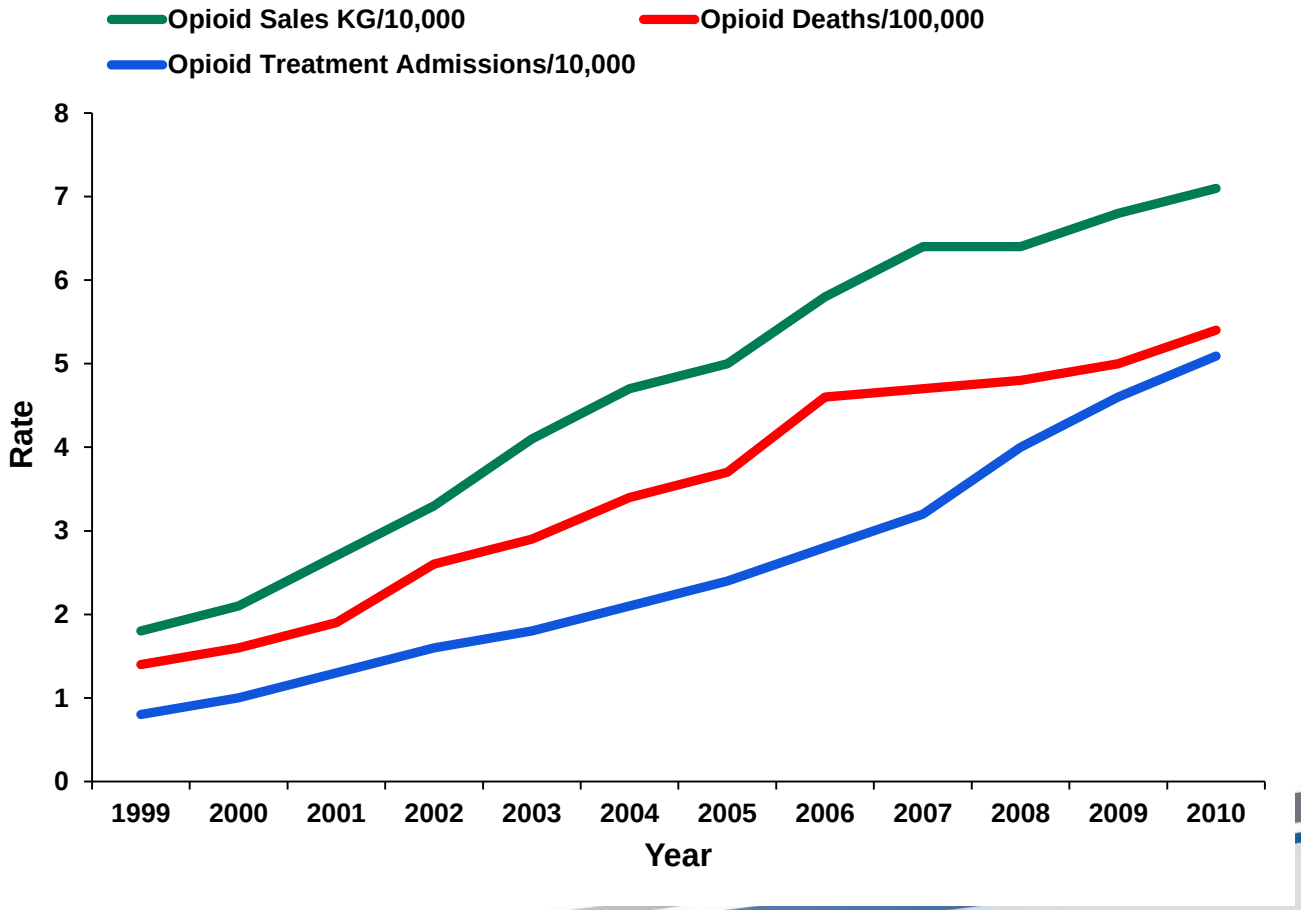
"A double-blind, placebo-controlled, fixed-dose, parallel group, two- week study was conducted in 133 patients with persistent, moderate to severe pain, who were judged as having inadequate pain control with their current therapy. In this study, OXYCONTIN 20 mg, but not 10mg, was statistically significant in pain reduction compared with placebo."

JAMA. 2016;315(22):2415-2423. doi:10.1001/jama.2016.7789



** Data between labeled estimates interpolated using constant growth rates*

Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010



CDC. *MMWR* 2011. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm?s_cid=mm60e1101a1_w. Updated with 2009 mortality and 2010 treatment admission data.

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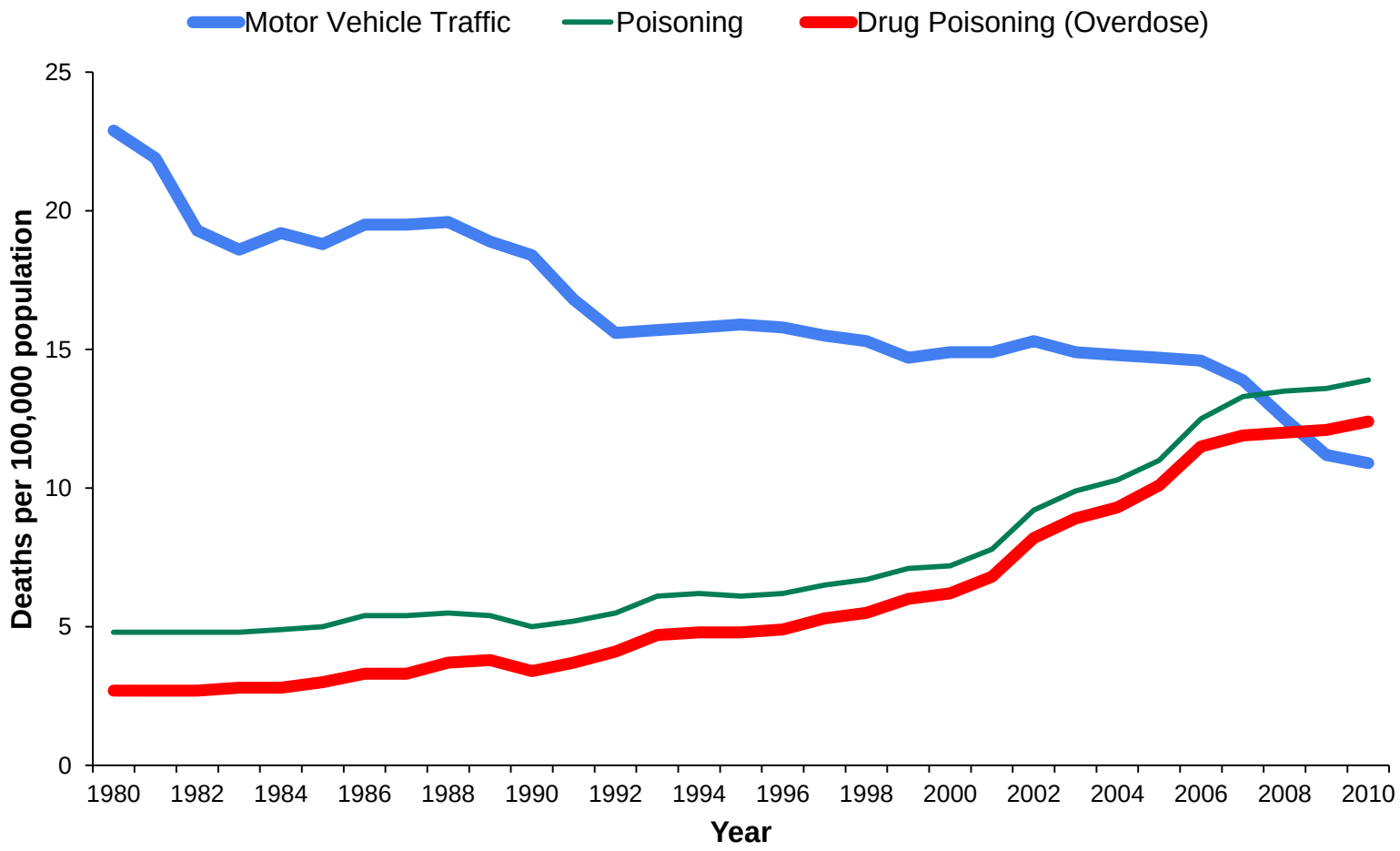
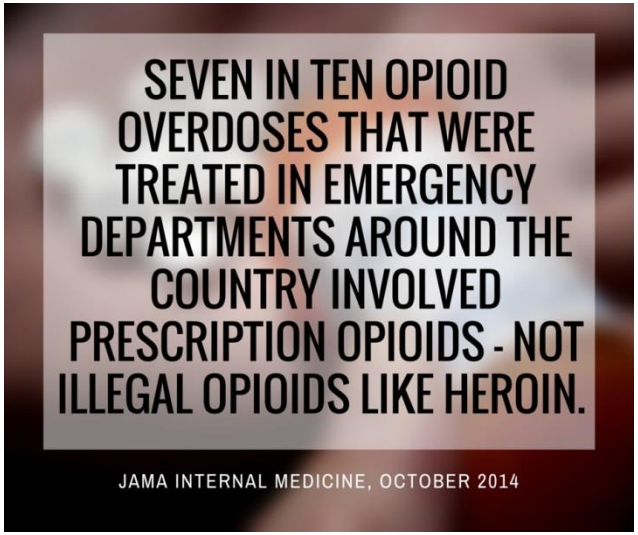
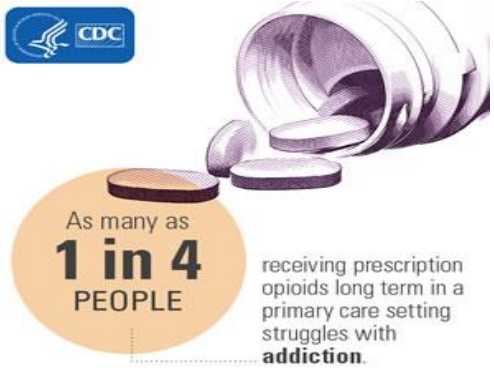
MVA vs. Poisoning Deaths



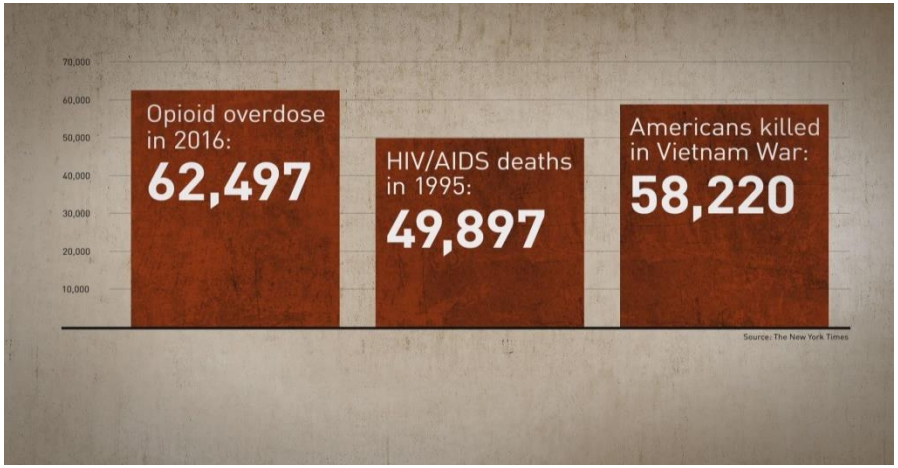
NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data

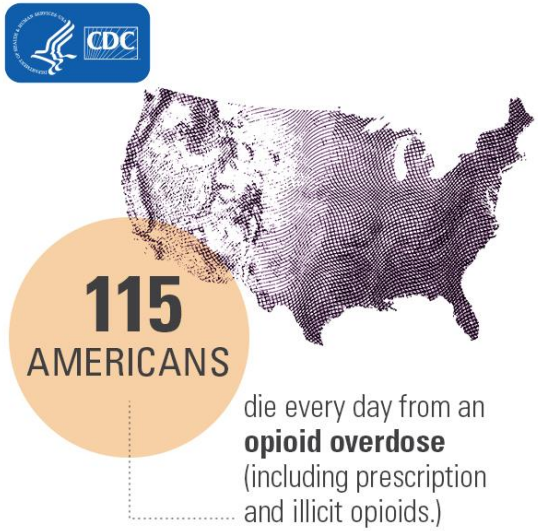

JOHN SMITH
OXYCODONE
Hydrochloride 80mg
2296651-12976
100
10/27/17


SEVEN IN TEN OPIOID OVERDOSES THAT WERE TREATED IN EMERGENCY DEPARTMENTS AROUND THE COUNTRY INVOLVED PRESCRIPTION OPIOIDS - NOT ILLEGAL OPIOIDS LIKE HEROIN.
JAMA INTERNAL MEDICINE, OCTOBER 2014


CDC
As many as
1 in 4
PEOPLE
receiving prescription opioids long term in a primary care setting struggles with addiction.


OPIOID CRISIS
FDA • Pixabay


70,000
60,000
50,000
40,000
30,000
20,000
10,000
Opioid overdose in 2016:
62,497
HIV/AIDS deaths in 1995:
49,897
Americans killed in Vietnam War:
58,220
Source: The New York Times

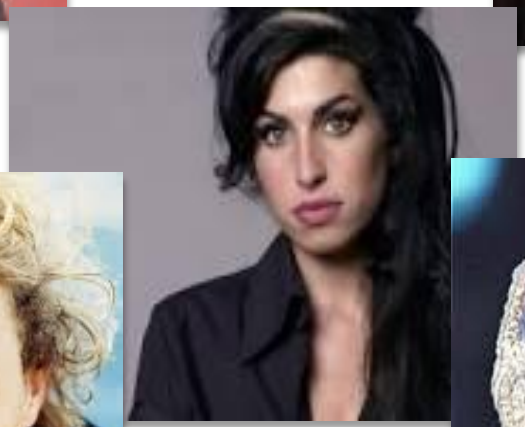

CDC
115
AMERICANS
die every day from an opioid overdose (including prescription and illicit opioids.)

Who Are These People?



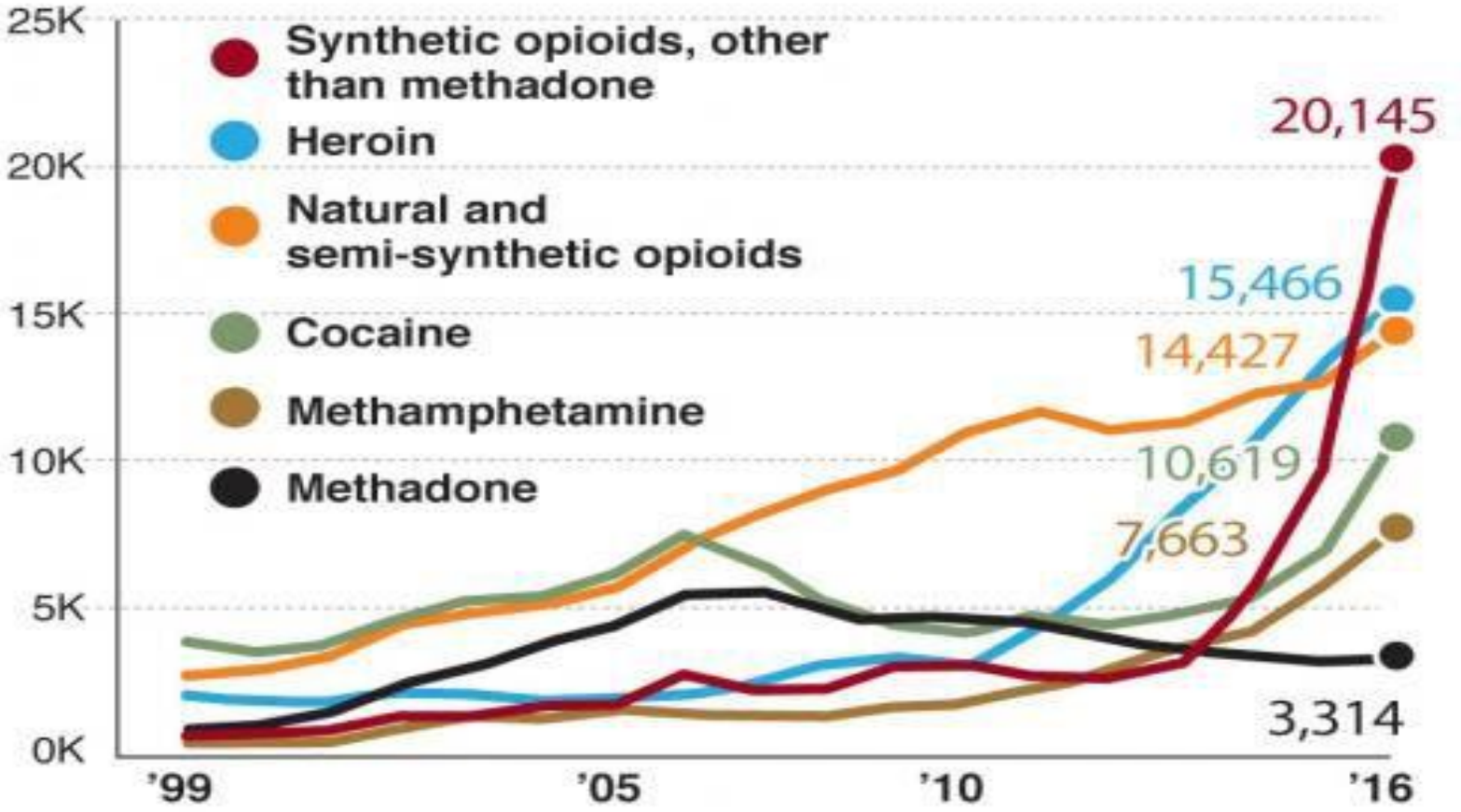







U.S. drug overdose deaths

Among the more than 64,000 drug overdose deaths estimated in 2016, the sharpest increase occurred among deaths related to fentanyl and fentanyl analogs (synthetic opioids), more than 20,000 overdose deaths.



Source: CDC
Graphic: Staff, TNS

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least 3 other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and **death** for users.

People who are addicted to...

ALCOHOL

are

2x

MARIJUANA

are

3x

COCAINE

are

15x

Rx OPIOID PAINKILLERS

are

40x

...more likely to be addicted to heroin.

SOURCE: National Survey on Drug Use and Health (NSDUH), 2011-2013.

Evidence & Expert Opinion for Chronic Opioids

2014 AAN- Opioids for chronic non-cancer Pain

"Whereas there is evidence for significant short-term pain relief, there is no substantial evidence for maintenance of pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction."

2016 CDC Guideline for prescribing opioids

"Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited with insufficient evidence to determine long-term benefits, though evidence suggests risk of serious harms that appears to be dose – dependent."

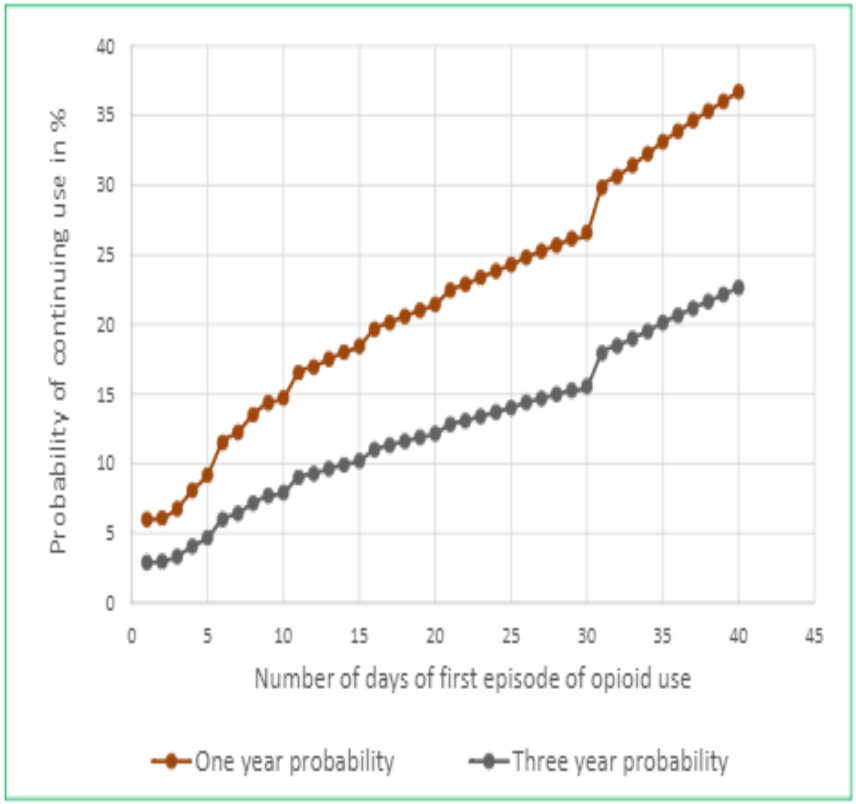
Franklin GM. "Opioids for chronic noncancer pain: A position paper of the American Academy of Neurology". Neurology. 2014 Sep 30;83(14):1277-84

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Acute Pain – every day of an opioid matters

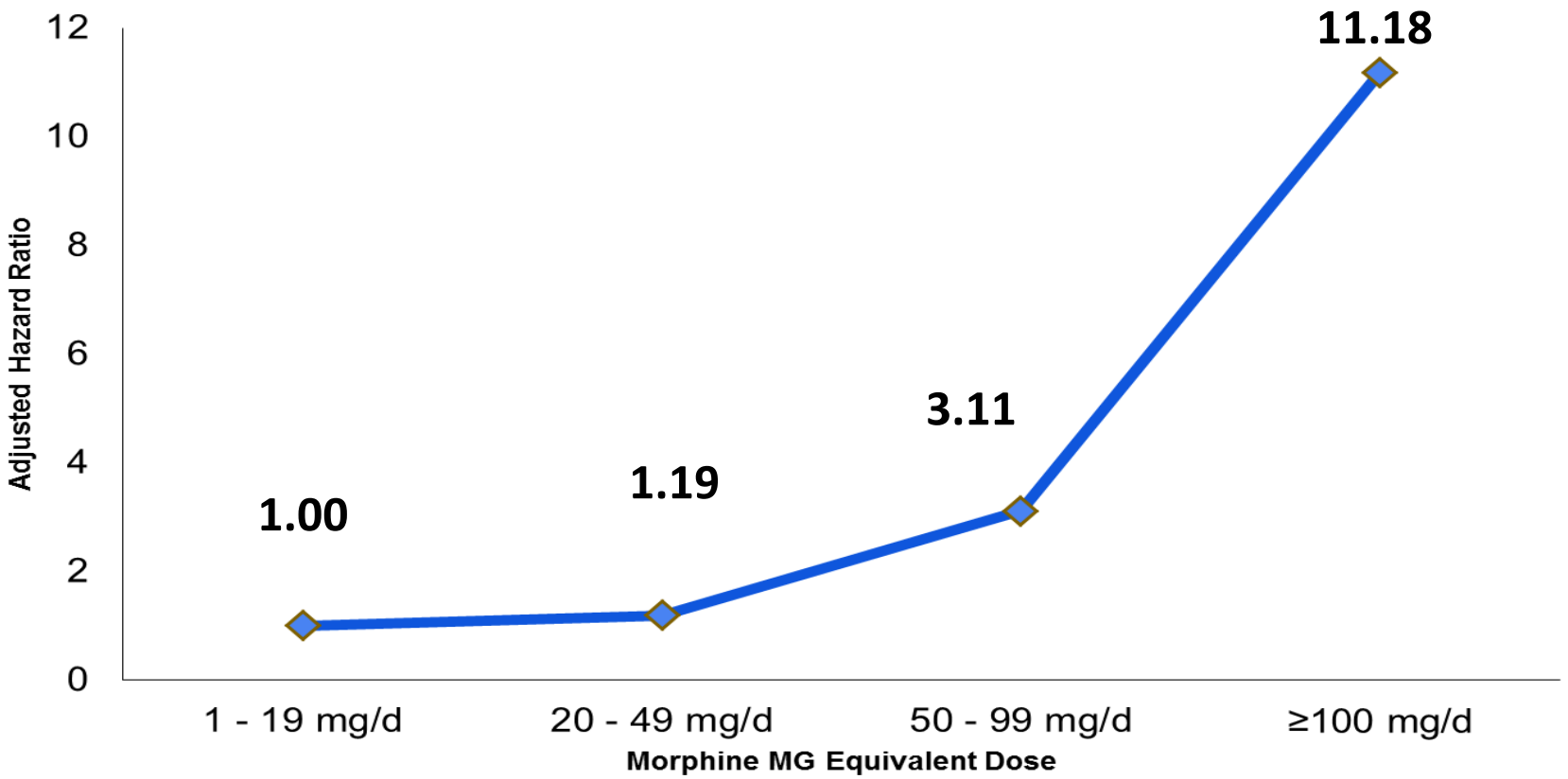
FIGURE 2. One- and 3-year probabilities of continued opioid use, by duration of first episode in days (base case)



Duration is expressed in terms of days (1-40) with increments of 1 day. Discontinuation is defined as 180 opioid-free days and allowable gap to assess continuous opioid use in first episode was 30 days.

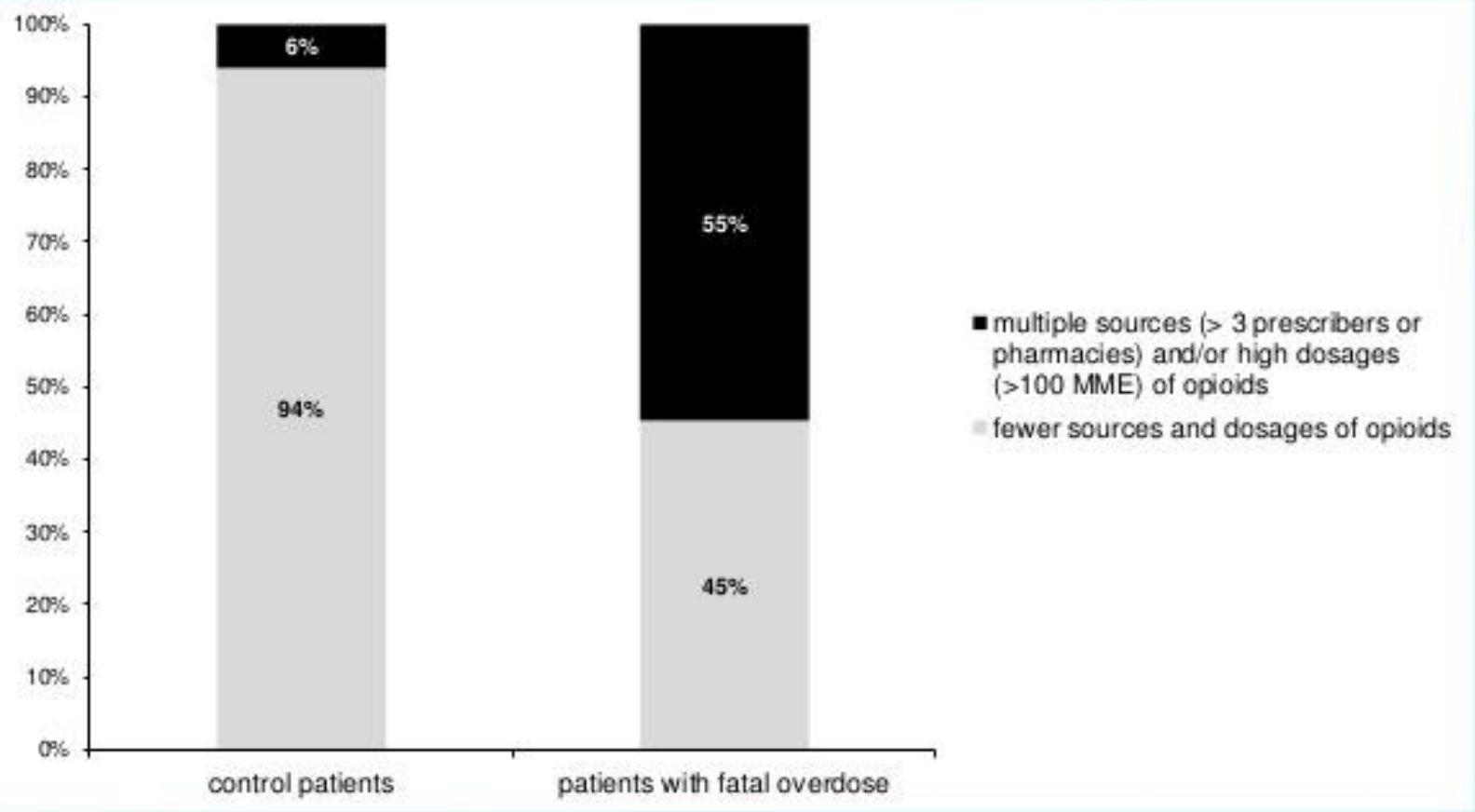
Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66(10):xx

Opioid Dose and Overdose Risk



Dunn et al. Opioid prescriptions for chronic pain and overdose. *Ann Int Med* 2010;152:85-92

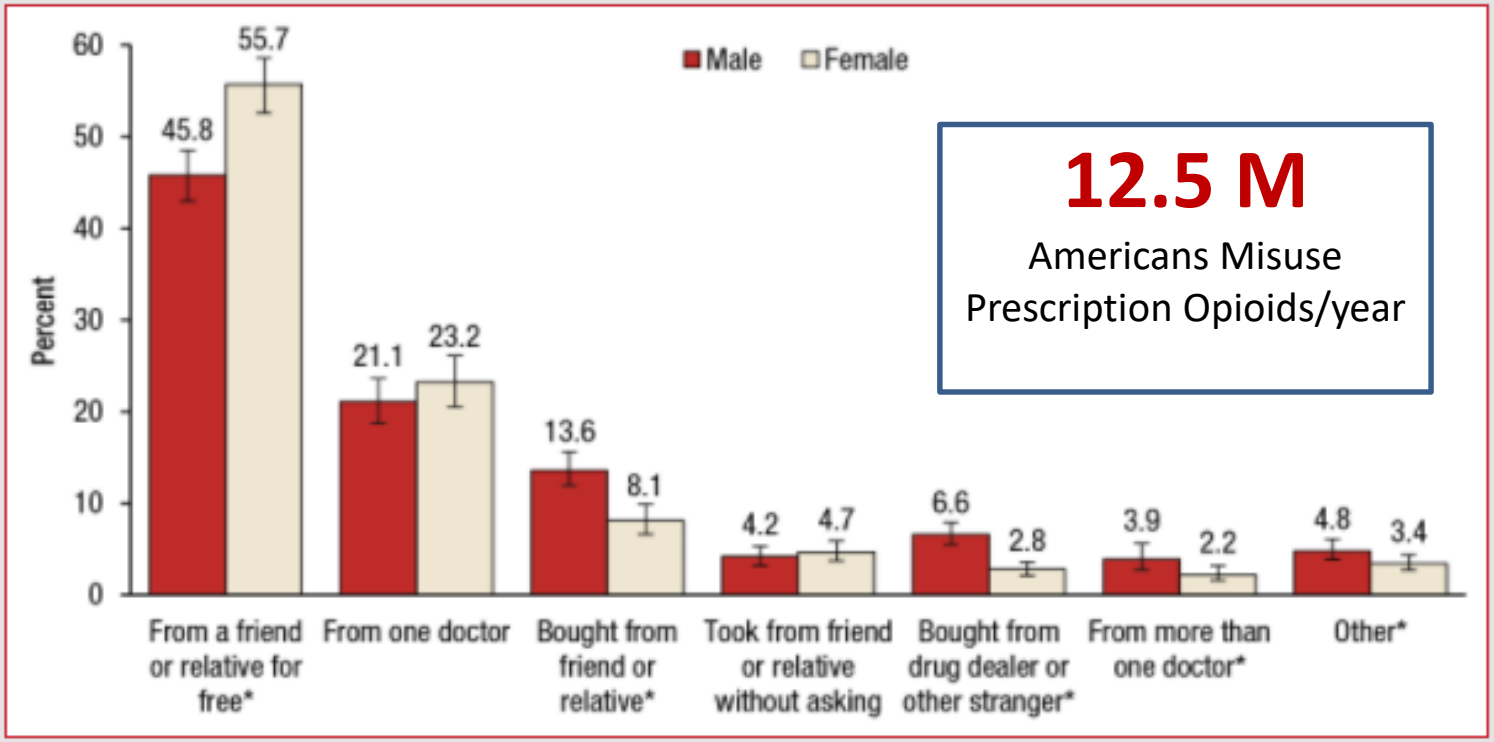
Majority of opioid overdose deaths associated with multiple sources and/or high dosages



Baumblatt JAG et al. High Risk Use by Patients Prescribed Opioids for Pain and its Role in Overdose Deaths. *JAMA Intern Med* 2014; 174: 796-801.

Diversion (non-medical)
Use of Prescription Opioids

Figure 2. Source of prescription pain relievers for the most recent nonmedical use among past year users aged 12 or older, by gender: annual averages, 2013 and 2014



12.5 M

Americans Misuse Prescription Opioids/year

Lipari, R.N. and Hughes, A. *How people obtain the prescription pain relievers they misuse.* The CBHSQ Report: January 12, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD

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Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain - The SPACE Trial

PRAGMATIC, 12-MONTH, RANDOMIZED TRIAL WITH MASKED OUTCOME ASSESSMENT

chronic back pain, hip or knee osteoarthritis pain that occured ~daily for > 6 months

Opioid Group N = 119

Step 1: morphine IR, hydrocodone/acetaminophen, oxycodone IR.
Step 2: morphine sustained-action, oxycodone SA.
Step 3: transdermal fentanyl.

max dosage up to 100 morphine-equivalent mg

Non-Opioid Group N = 119

Step 1: acetaminophen, NSAIDs.
Step 2: nortriptyline, amitriptyline, gabapentin and topical analgesics: capsaicin, lidocaine.
Step 3: pregabalin, duloxetine and tramadol

PAIN RELATED FUNCTION AT 12 MONTHS

BPI Interference Scale (1-10), 10 = worse

3.4 — 3.3

Difference: 0.1 (−0.5 to 0.7), p = 0.58

PAIN INTENSITY

BPI Severity Scale (1-10), 10 = worse

4 — 3.5

Difference: 0.5 (0.0 to 1.0), p = 0.03

MEDICATION RELATED ADVERSE EFFECT OVER 12 MONTHS

Medication related symptom checklist (1-19), 19 = worse

1.8 — 0.9

Difference: 0.9 (0.3 to 1.5), p = 0.03

JAMA. 2018;319(9):872-882.

Krebs et al. | visualmed.org

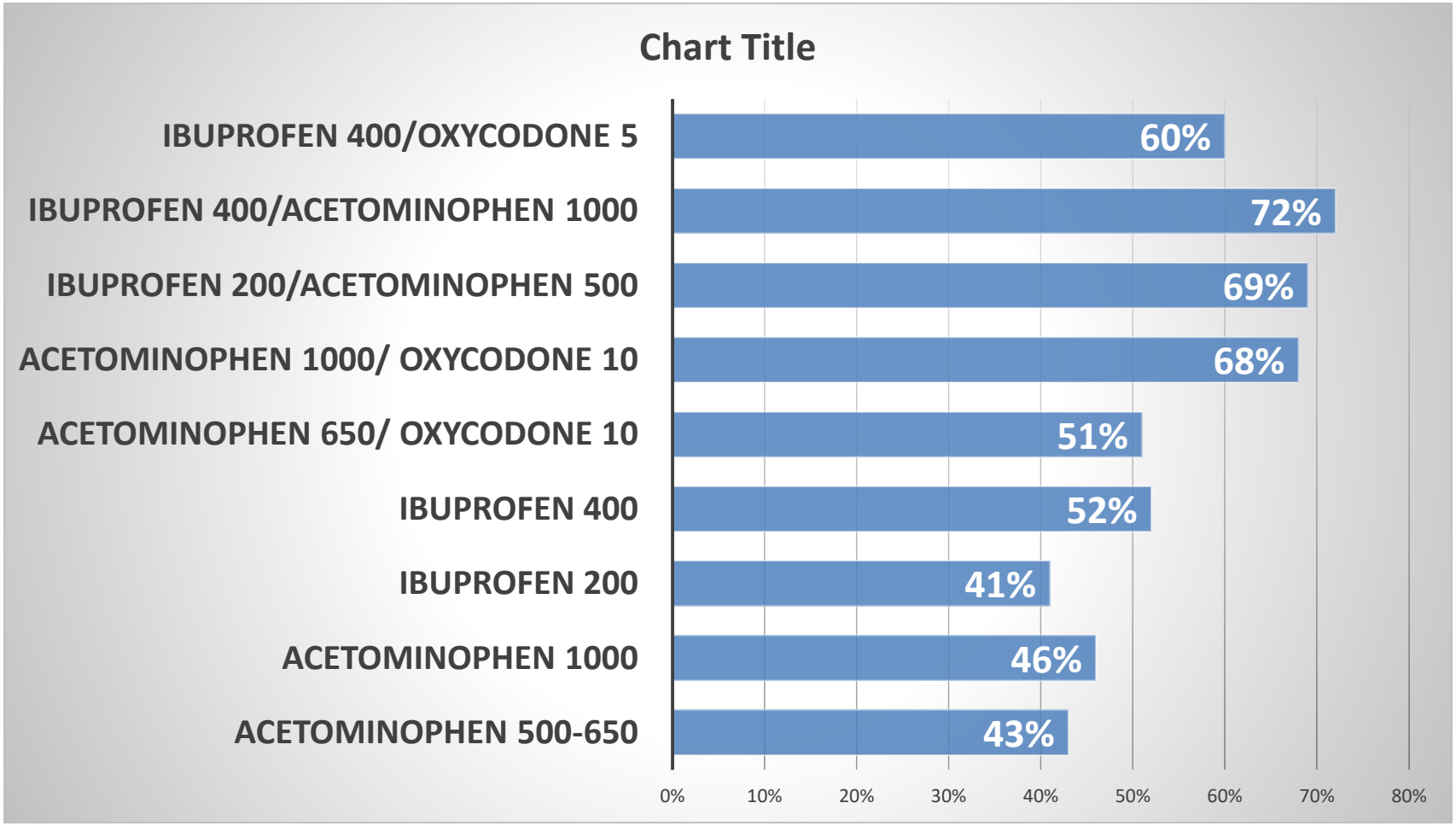
Single Dose Oral Analgesics for Acute Post-Operative Pain Cochrane System Review 2015

- >50,000 patients, 450 clinical studies
- Randomized, double blind trials
- Percent patients 50% pain relief
- Range of results; 30%-70% people achieved 50% relief
- Range of relief; 2-20h
- Placebo Effect = 5-20%

Moore RA, Derry S, Aldington D, Wiffen PJ. Single dose oral analgesics for acute postoperative pain in adults - an overview of Cochrane reviews. *Cochrane Database Syst Rev.* 2015(9):CD008659

Single Dose Oral Analgesics for Acute Post-Operative Pain

Percent of patients 50% pain relief

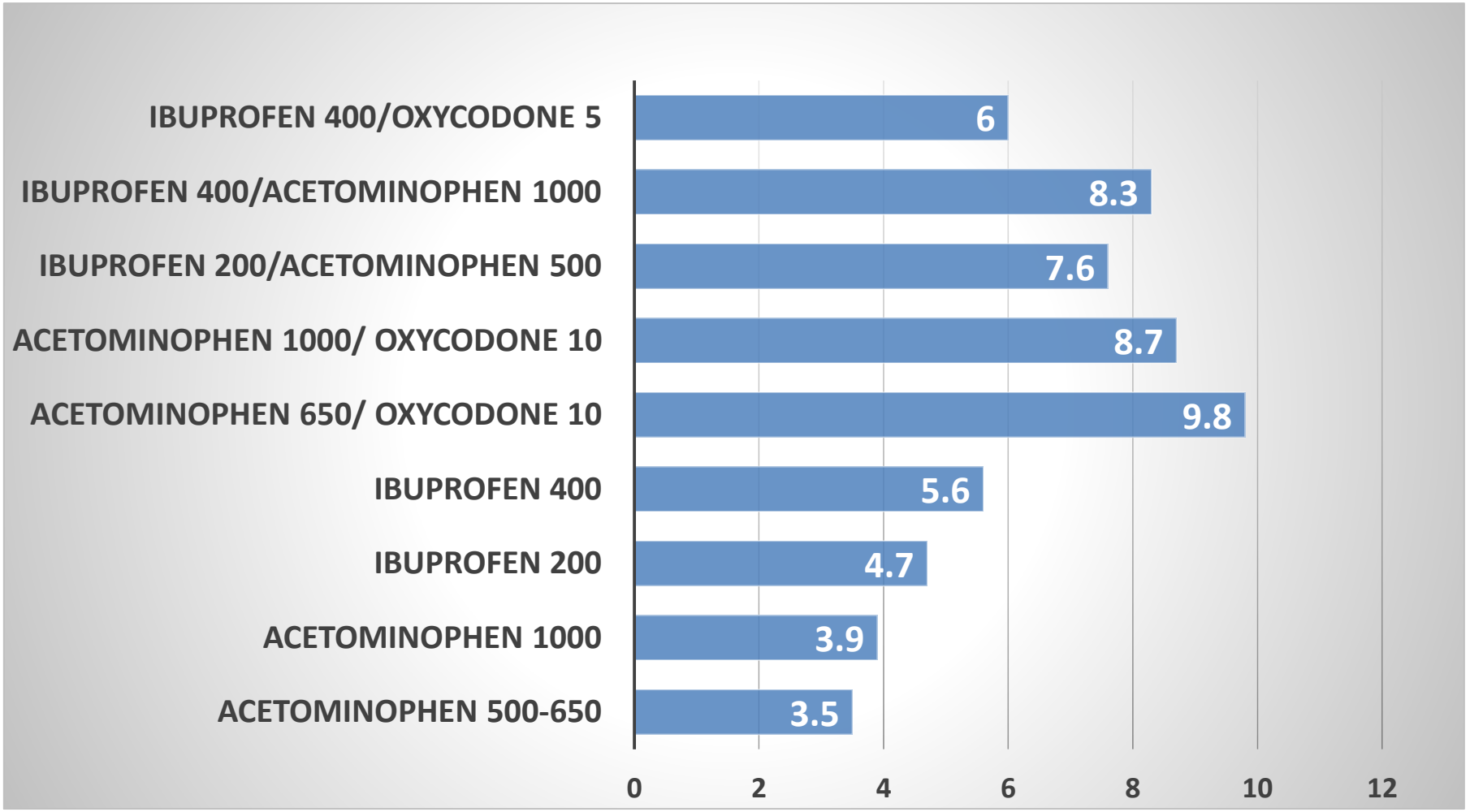


OXYCODONE 5 = PLACEBO

Moore RA, Derry S, Aldington D, Wiffen PJ. Single dose oral analgesics for acute postoperative pain in adults - an overview of Cochrane reviews. *Cochrane Database Syst Rev.* 2015(9):CD008659

Single Dose Oral Analgesics for Acute Post-Operative Pain

Hours to re-medication



OXYCODONE 5 = PLACEBO

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NSAIDS vs. Opioid - Renal Colic

A 2004 Cochran review concluded……..

NSAID & Opioids have = effectiveness
but opioids have more side-effects

Holdgate, A., & Pollock, T. (2004). Nonsteroidal anti-inflammatory drugs (NSAIDs) versus opioids for acute renal colic. *Cochrane Database Syst Rev*(1), CD004137. doi:10.1002/14651858.CD004137.pub2

Surgery; A Gateway to Opioid Use

- Claims data 2013-2014, 13 elective surgeries
- Adults 18-64, continuous private prescription & medical insurance
- No opioid scripts 12 months prior to surgery
- N=36,177
- Minor Surgery (80%)- Varicose Vein, Laparoscopic Cholecystectomy, Laparoscopic appendectomy, hemorrhoidectomy, thyroidectomy, transurethral prostate surgery, parathyroidectomy carpal tunnel
- Major Surgery (20%)- ventral hernia, colectomy, reflux surgery, bariatric surgery, hysterectomy
- Primary Outcome- New persistent opioid use 90d post-op

5.9% Minor Surgery

6.5% Major Surgery

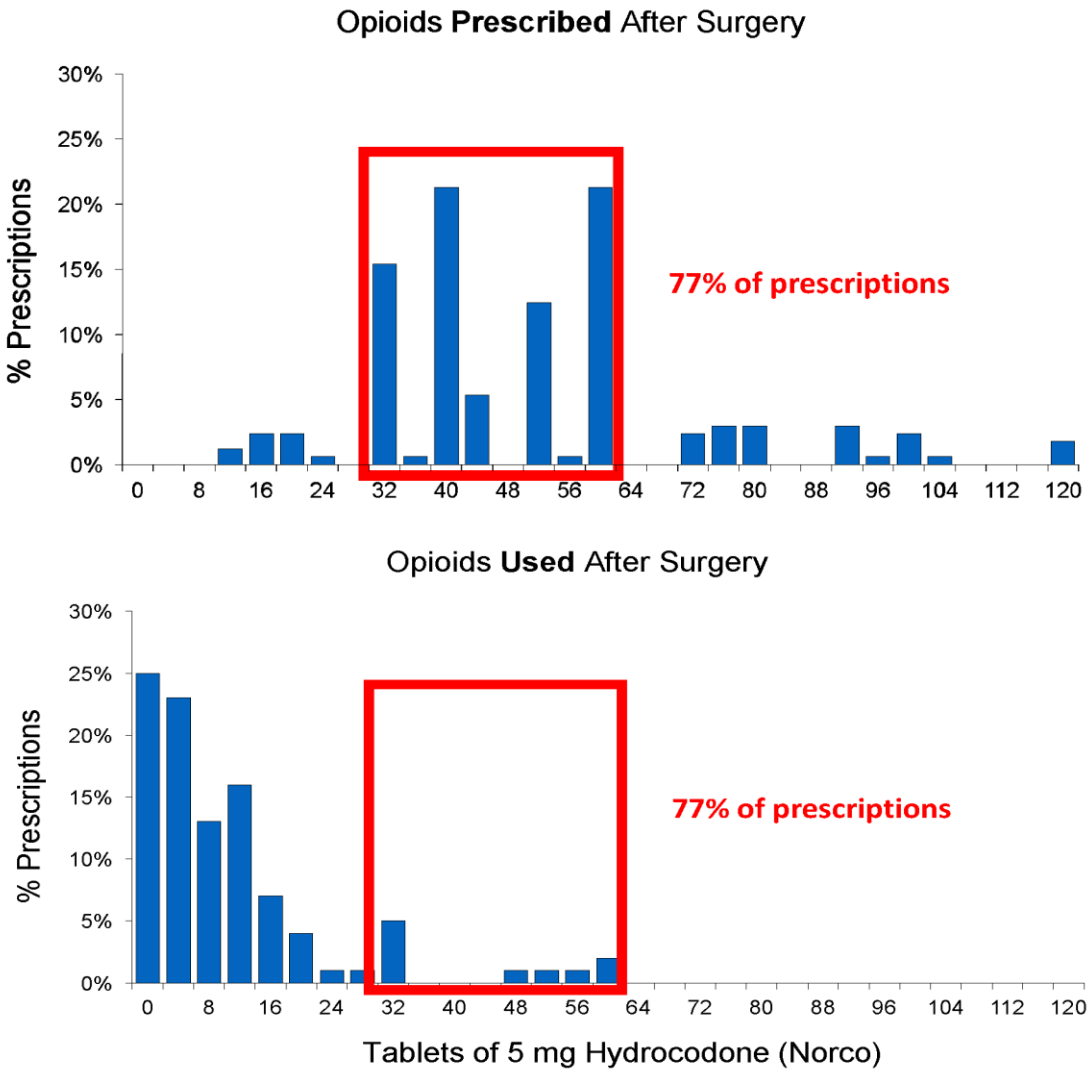
Brummett CM, Waljee JF, Goesling J, Moser S, Lin P, Englesbe MJ, et al. (2017). New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. JAMA Surgery, 152, e170504. doi:10.1001/jamasurg.2017.0504

Surgery; A Gateway to Opioid Use

- Risk Factors for New Persistent Opioid use
- Not dependent on severity of surgery
- Tobacco Use
- Alcohol Use Disorder
- Substance Use Disorder
- Anxiety/Depression
- Pre-Operative Pain- Back, neck, arthritis, central pain disorder

Brummett CM, Waljee JF, Goesling J, Moser S, Lin P, Englesbe MJ, et al. (2017). New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. JAMA Surgery, 152, e170504. doi:10.1001/jamasurg.2017.0504

Lap Choly; Opioid Prescribed vs Opioid Used



Howard R, Waljee J, Brummett C, Englesbe M, Lee J. Reduction in Opioid Prescribing Through Evidence-Based Prescribing Guidelines. *JAMA Surg.* Published online December 06, 2017. doi:10.1001/jamasurg.2017.4436

Howard, R, Waljee JF, Lee JS, Brummett CM, Englesbe MJ. 2017. *Reduction in Opioid Prescribing Through Implementation of Evidence-Based Prescribing Guidelines.* JAMA Surgery, In Press.

Reduction in Opioids through Evidence Based Guidelines

Laparoscopic cholecystectomy

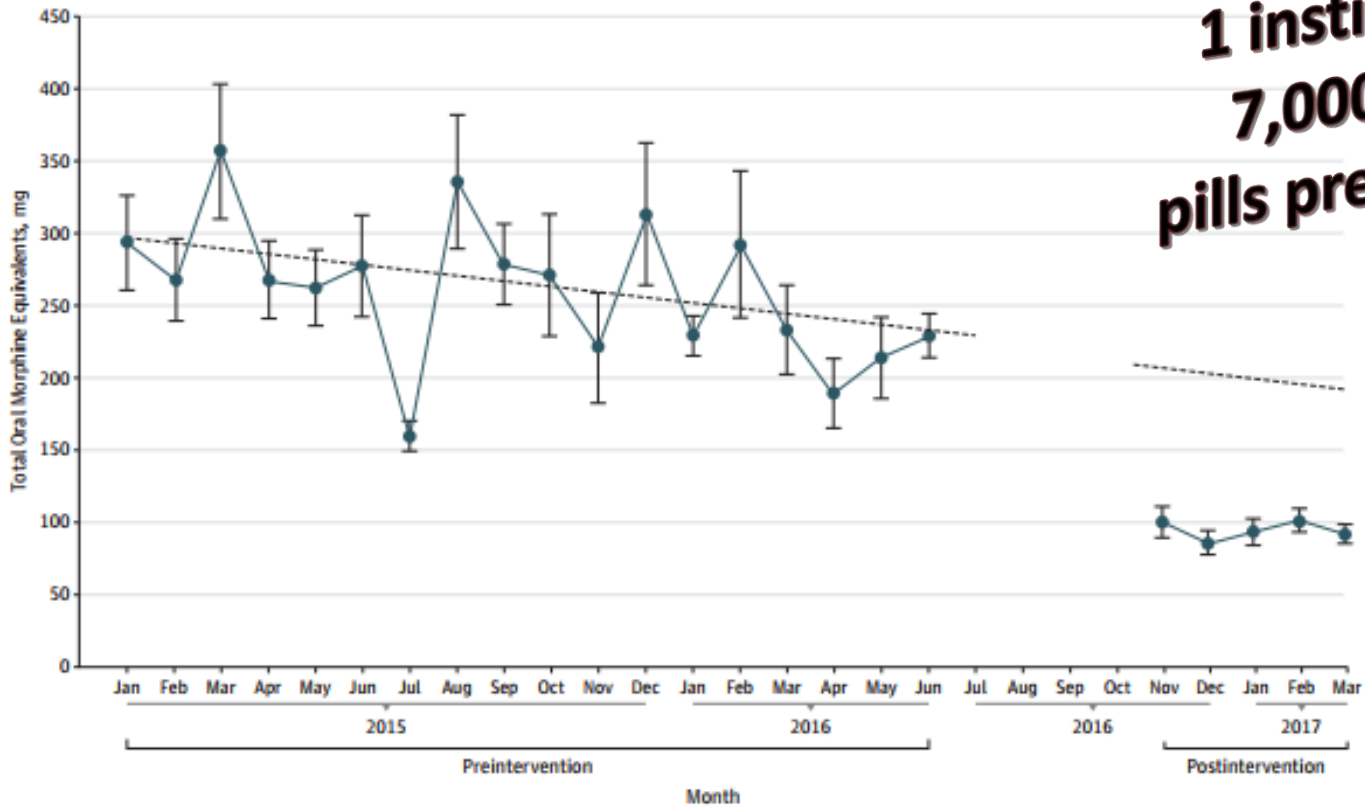
	Pre- Intervention (N=170)		Post-Intervention (N=200)
Refill requested	4.1%	→	2.5%
Mean Opioid given	**50** hydrocodone	→	**15** hydrocodone
Mean Opioid used	**6** hydrocodone	→	**4** hydrocodone
Median Pain Score	**5**	→	**5**

Howard R, Waljee J, Brummett C, Englesbe M, Lee J. Reduction in Opioid Prescribing Through Evidence-Based Prescribing Guidelines. *JAMA Surg.* Published online December 06, 2017. doi:10.1001/jamasurg.2017.4436

Reduction in Opioid Prescribing through Evidence Based Guidelines

1 surgery
1 institution
7,000 less pills prescribed

Figure. Reduction in Postoperative Opioid Prescribing After Implementation of Prescribing Guidelines.



Following the implementation of evidence-based prescribing guidelines, opioid prescriptions were significantly reduced from an equivalent of approximately 45 pills of hydrocodone, 5 mg, to approximately 15 pills ($P < .001$). The dashed line represents the expected decline in prescribing prior to the study intervention.

Howard R, Waljee J, Brummett C, Englesbe M, Lee J. Reduction in Opioid Prescribing Through Evidence-Based Prescribing Guidelines. *JAMA Surg.* Published online December 06, 2017. doi:10.1001/jamasurg.2017.4436

Peri-Operative Opioid Recommendations – 3/2018

Procedure	Hydrocodone (Norco) 5 mg tablets Codeine (Tylenol #3) 30 mg tablets Tramadol 50 mg tablets	Oxycodone 5 mg tablets Hydromorphone (Dilaudid) 2 mg tablets
Laparoscopic Cholecystectomy	15	10
Laparoscopic Appendectomy	15	10
Inguinal/Femoral Hernia Repair (open/laparoscopic)	15	10
Open Incisional Hernia Repair	30	20
Laparoscopic Colectomy	30	20
Open Colectomy	30	20
Ileostomy/Colostomy Creation, Re-siting, or Closure	40	25
Open Small Bowel Resection or Enterolysis	30	20
Thyroidectomy	10	5
Hysterectomy		
Vaginal	20	10
Laparoscopic & Robotic	25	15
Abdominal	35	25
Breast Biopsy or Lumpectomy Alone	10	5
Lumpectomy + Sentinel Lymph Node Biopsy	15	10
Sentinel Lymph Node Biopsy Alone	15	10
Simple Mastectomy ± Sentinel Lymph Node Biopsy	30	20
Modified Radical Mastectomy or Axillary Lymph Node Dissection	45	30
Wide Local Excision ± Sentinel Lymph Node Biopsy	30	20

https://opioidprescribing.info/

OPEN
Opioid Prescribing Engagement Network
engaging patients, educating providers, protecting communities

First, Do No Harm

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Indiana Opioid Laws & Opioid Best Practices

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Indiana Opioid Laws

- 2014 – Chronic Opioid Prescribing Law
- 2017 – 7 Day Prescribing Law
- 2018 – CME requirement
- 2018 – INSPECT requirement

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2014 Indiana Chronic Opioid Law

Any patient ….

- Taking >**60** opioid pills /month >3mo
- Taking an opioid >**15 MME** for >3mo
- Using a transdermal opioid patch >3mo
- Taking tramadol (if greater than 600mg/day) for >3mo
- Taking any dose of an Extended release med not in abuse deterrent form for which one exists
- Exemptions

  Terminal condition, palliative care, Hospice, NH

Morphine Equivalent Dose (MED)
Mg Morphine Dose (MME)

1mg hydrocodone = 1mg morphine

1mg oxycodone = 1.5mg morphine

15mg hydrocodone = 15mg morphine

10mg oxycodone = 15mg morphine

90mg hydrocodone = 90mg morphine

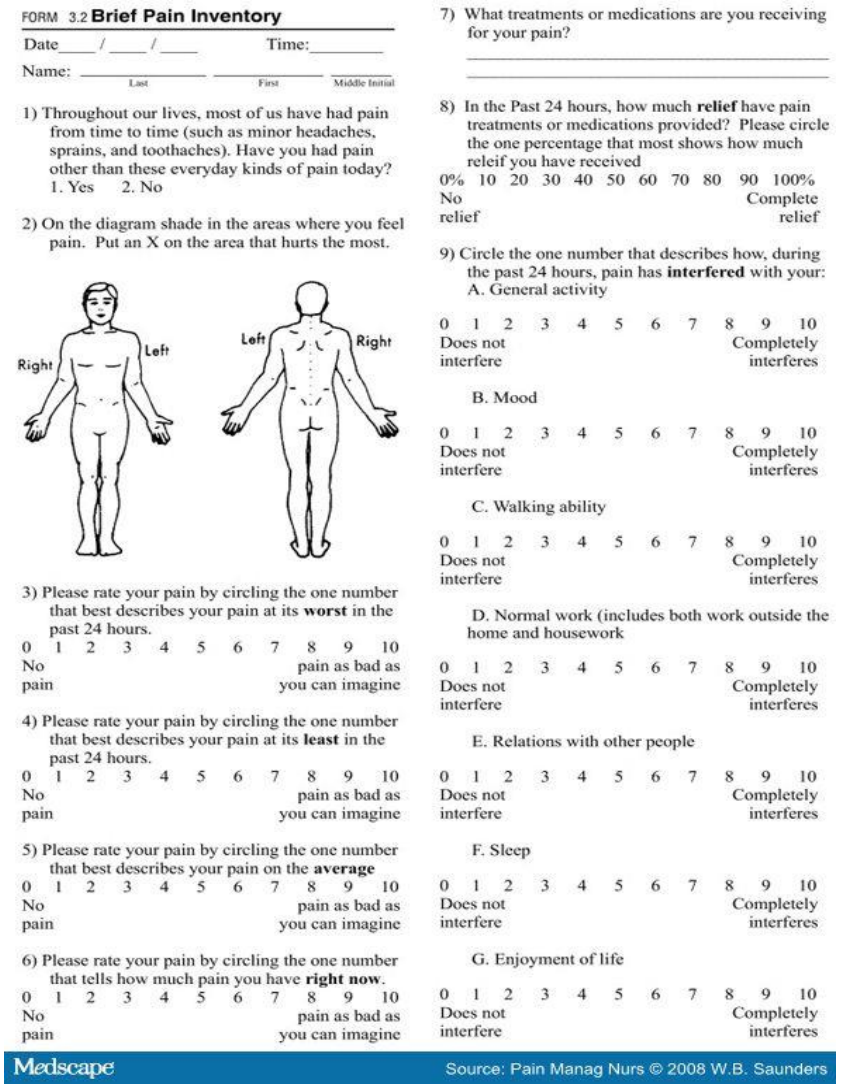
60mg oxycodone = 90mg morphine

http://globalrph.com/medcalcs/opioid-conversions-calc-original-single-agent/

2014 Indiana Chronic Opioid Law

Perform your own evaluation

- Perform appropriately focused history & physical
- Use objective pain assessment tool
- Order appropriate tests
- Obtain & review records of past care
- Utilize non-opioid options



FORM 3.2 **Brief Pain Inventory**

Date____/____/____ Time:_____

Name: _____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.

Right Left Left Right

3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **average**

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much releif you have received

0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:
A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Medscape

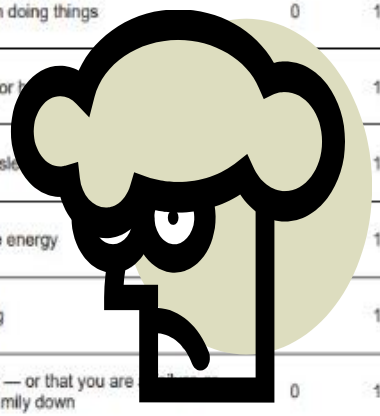
Source: Pain Manag Nurs © 2008 W.B. Saunders

2014 Indiana Chronic Opioid Law Mental Health Risk Stratification

- Mental & Physical health are inextricably linked
- Treatment of underlying mental health issues will often improve response to pain treatment
- PHQ-2,PHQ-9, GAD-7 can be useful, quick, validated tools

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or h		1	2	3
3. Trouble falling or staying asle		1	2	3
4. Feeling tired or having little energy		1	2	3
5. Poor appetite or overeating		1	2	3
6. Feeling bad about yourself — or that you are … have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3



2014 Indiana Chronic Opioid Law
Risk Stratification for Substance Misuse

- Patients with h/o substance use disorder increased risk of harm from opioids
- Ask patients about past or current substance use/abuse (alcohol, prescription medications, illicit drugs or tobacco/e-nicotine) prior to initiating opioids
- Validated tools….
  ORT, Dire, COMM, SOAPP-R, DAST

2014 Indiana Chronic Opioid Law
Risk Stratification

- UDM has evolved to become a **<u>standard of care</u>** when prescribing opioids
- Detect illicit substances
- Monitor adherence to prescribed meds
- Interpretation is critical
- "At any time the physician determines that it is medically necessary, whether at the outset of an opioid treatment or anytime thereafter, a physician prescribing opioids for a patient shall perform or order a drug monitoring test, which must include a confirmatory test."

2014 Indiana Chronic Opioid Law

Urine Drug Monitoring- Medical Necessity

- Reason to believe patient not taking meds
- Reason to suspect diversion
- No improvement in pain
- Reason to suspect patient taking other drugs
- Reason to believe patient using other opioids
- Early refills
- Stolen scripts
- Inconsistent INSPECT
- Previous UDT inconsistent
- Aberrant behaviors
- Apparent Intoxication
- Unauthorized dose escalation
- Reluctant to change meds
- Refusal to participate in work-up
- Substance abuse history
- Health status change
- Co-morbid psych issues
- Evidence of abuse
- Any other relevant factor to making professional judgement

2014 Indiana Chronic Opioid Law
Risk Stratification

- Review state PDMP before initiating opioid therapy.
- Determine whether patient receiving opioid dosages or dangerous combinations that put him or her at risk for overdose
- Check initially/annually

Overridden by SEA 221

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2014 Indiana Chronic Opioid Law
Review & Sign a Treatment Agreement

- Goals of treatment
- Consent drug monitoring / random pill counts
- Prescribing policies, prohibition of sharing medications &requirement to take meds as prescribed
- Information on pain meds prescribed by other physicians / alcohol use
- Reasons that opioid therapy may be changed or discontinued
- Counsel women of child-bearing age about the potential for fetal opioid dependence & neonatal abstinence syndrome (NAS).

2014 Indiana Chronic Opioid Law
Functional Goals

After initial evaluation, establish working diagnosis

Specific
Achievable
Functional Goals

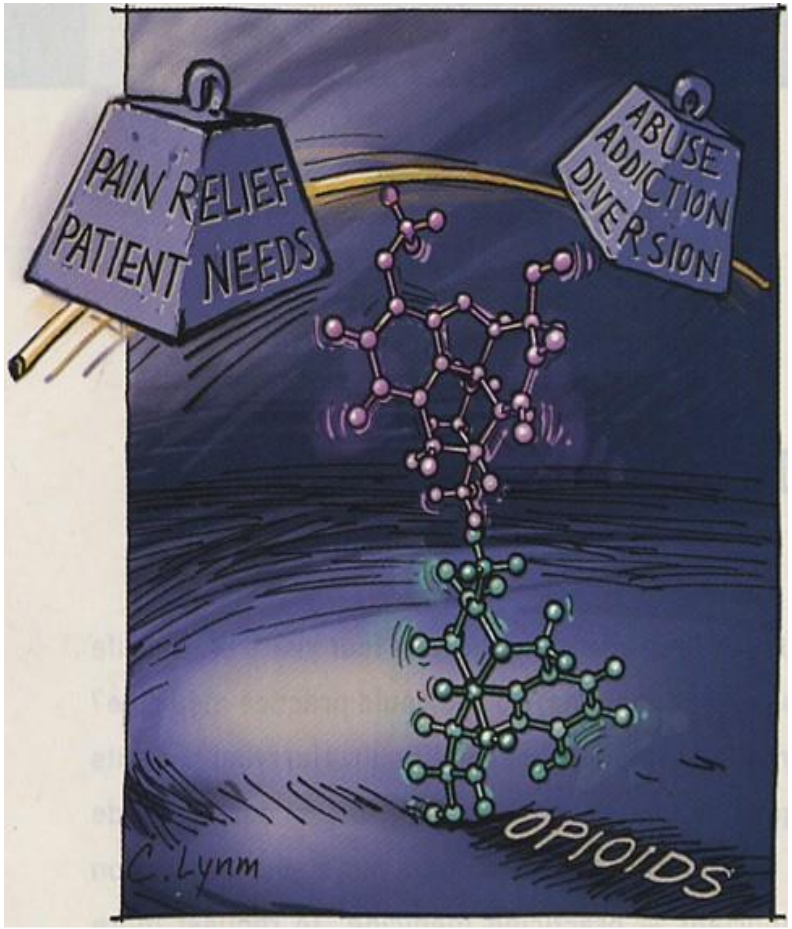
Reframe expectations: A realistic
"Pain Score" target isn't zero!

2014 Indiana Chronic Opioid Law
Periodic Scheduled Visits

- Evaluate patient progress
- Monitor compliance
- Set clear expectations
- Q 4mo, if stable (minimum)
- Q 2mo, if changing meds;
  more often as needed

Affect • Activities of Daily Living • Analgesia
Adverse effects • Aberrant

2014 Indiana Chronic Opioid Law
Reassessment is required if MED ≥ 60 mg/d



- Face-to-face review to reassess your patient
- Formulate/document a revised assessment and treatment plan
- Discuss the increased risk for adverse outcomes (including death) with higher opioid doses if that is what you plan to do

2014 Indiana Chronic Opioid Law

- Do your own evaluation
- Risk Stratify
  - Mental health
  - Risk of Substance Misuse
  - INSPECT
  - Urine Drug Testing
- Treatment Agreement/ Functional Goals
- Regular Visits/ Reassess if greater than 60 MED

2017 – 7d Opioid Prescribing Limit

- Physician issuing initial opioid prescription for a patient may not prescribe more than a 7-day supply
  - Note: Limit applies to that physician's first opioid prescription to that patient
  - No specific exception for practitioners in the same practice
- For an adult patient age 18 or older, there are no quantity limits on subsequent opioid prescriptions written by that physician
- For patients < 18yo, all opioid Rx limited to 7-day supply
- Exceptions to Seven-Day Limit
  - Cancer
  - MAT for a substance-abuse disorder
  - Palliative Care
  - Professional Judgment (Must document in the MR that a non-opiate not appropriate and physician is using his or her professional judgment to prescribe for longer than the 7-day limit)

2017 – 7d Opioid Prescribing Limit

Other Provisions

- Physician must comply if patient or patient's authorized representative requests a smaller amount of an opioid than the physician initially planned to prescribe
  - Physician must document the request, as well as who made it, in the patient's MR
- Allows Indiana pharmacies to partially fill a prescription at the request of patient or patient's authorized representative
  - Under a change to federal law (21 U.S.C. 829), the unfilled portion of an original Schedule II prescription may be filled up to 30 days after the date of the original prescription

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2018 Indiana 2h Opioid CME requirement

Senate Bill 225 (Effective July 1, 2018)

Beginning July 1, 2019 (next physician renewal):

- All practitioners who apply for or renew Indiana Controlled Substances Registration
- Must have completed 2 hours of CME during the previous 2 years
  - CME must address opioid prescribing and opioid abuse
- For physicians CME courses must be approved by the IN Medical Licensing Board or offered by an approved organization

The Indiana Professional Licensing Agency must list approved CME courses on its website

The law sunsets July 1, 2025

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2018 Indiana INSPECT requirement

Senate Bill 221 (Effective July 1, 2018)

Requires checking INSPECT each time before prescribing an opioid or benzodiazepine to any patient (No specific exceptions for hospice, palliative care, or LTC patients)

Effective date depends on situation:

- Applies 7/1/2018 for practitioners with INSPECT integrated into EMR
- Applies 1/1/2019 for practitioners providing services in
  - The ER; or pain management clinic
- Applies 1/1/2020 to practitioners providing services in a hospital
- Applies 1/1/2021 to all practitioners
- Patients on pain management contract –q 90dPractitioners
- MLB Waiver if no internet

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2016 CDC Guideline for Prescribing Opioids

- CBT- small positive effect on disability
- Exercise Therapy- can improve pain and function chronic low back pain
- Exercise Therapy- improve function and reduce pain in OA knee, OA hip
- Exercise Therapy – improve fibromyalgia symptoms, well being and physical function in fibromyalgia
- Exercise and CBT should be used to reduce pain and improve function in chronic pain

2016 CDC Guideline for Prescribing Opioids

- Opioids should only be continued if there is a meaningful improvement in pain & function (30% improvement)
- Avoid prescribing Opioid & Benzo whenever possible
- UDM initiation & annually
- ER Opioids for Severe pain requiring around the clock, long-term opioid tx for which alternative tx inadequate
- Avoid short and long acting opioids (unless end of life)
- Use lowest dose, additional precaution at 50MED/day
- Avoid dosage >90MED/day (if not improved DC or taper)

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2016 - FDA Black Box Warning

Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol.

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Government of Canada

Opioid Changes

- 508 Opioids Relabeled by January 2019
- Non-Cancer Chronic Pain- Ceiling dose =90MME
- Any Non-Cancer Chronic Pain >90MME off-label
- Acute pain limits 3 days

Universal Precautions
Be wary of co-morbid risks with opioids

Patient morbidity/mortality risk is more pronounced for patients…

- **Age <25**
- **Benzodiazepine use/abuse**
- **Alcohol use/abuse**
- **Illicit substance use/abuse**
- **Untreated mental health issues**
  (e.g. depression, hx of suicide)
- **Chronic respiratory problems**
  (e.g. Asthma, COPD, OSA, CHF)

Safe Storage & Safe Disposal

Follow these simple steps to dispose of medicines in the household trash

MIX

Mix medicines (do not crush tablets or capsules) **with an unpalatable substance** such as dirt, kitty litter, or used coffee grounds;

PLACE

Place the mixture **in a container** such as a sealed plastic bag;

THROW

Throw the container **in your household trash;**

SCRATCH OUT

Scratch out **all personal information** on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable, then dispose of the container.

https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm

Thank you!

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