Opioid Epidemic; What Can We Do?

ECHO 12/5/18

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Opioid Epidemic
What Can We Do?

Introductions

- Do you have a case to staff?
  or
- What do you want out of today’s session?
Objectives

- Discuss the opioid epidemic
- Understand opioids and addiction
- Discuss solutions including Good Samaritan Law, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Medically Assisted Treatment (MAT), and Local and National Regulations and Laws
- Review tips to avoid trouble
Opioidphelia to Opioidphobia to Opioidphelia to Opioidphobia to
History

- 3400 BC earliest reference to opium by Sumerians
- 1680 Sydenham's Laudanum introduced in liquid form
- 1806 Sertümer isolated morphine from opium
- 1865 Morphine used for pain during Civil War
- 1898 Heroin synthesized from morphine
- 1909 Congress passed OEA banning importation of opium
- 1916 Oxycodone synthesized
- 1924 The Heroin Act, made heroin illegal in the U.S.
- 1933 Prohibition
- 1960s Abuse of prescription opioids recognized
- 1970 The Controlled Substances Act passed
- 1973 Nixon created the DEA and declared War on Drugs
- 1980 Pain landscape characterized by “opiophobia”
- 1983 Vicodin became generic
- 1990’s Proopioid pain movement
- 2010’s CDC Guidelines, AB -474, PMP
Creating An Epidemic

Table 3. Factors promoting escalation of opioid use in United States.

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<th>Drug Manufacturing and Distribution</th>
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<td>Lack regulations by FDA</td>
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<td>Removal of DEA authority by Martin Act</td>
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<td>Approval of OxyContin and Zohydro</td>
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<td>Approval of OxyContin and Zohydro</td>
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<td>Call for improved approaches to assure the availability of opioids by 21 health care organizations and supported by the DEA in 2001</td>
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<td>Right to pain relief act by legislatures</td>
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<td>Direct to physician marketing with poor science and misinformation</td>
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<td>Passage of Ensuring Patient Access and Effective Drug Enforcement Act (HR-4799) in 2016 weakening and essentially eliminating the DEA enforcement activities against corrupt activities of drug distribution companies</td>
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<td>Portenoy's observational study of 38 patients promoting opioids for chronic noncancer pain</td>
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<td>Invention and promotion of pseudodisease; and breakthrough pain</td>
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<th>Physicians and Promotion of Literature Considered as Peer Reviewed Literature</th>
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<td>Lack of physician education on the use of drugs with high abuse potentials</td>
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<td>Literature provided by the Pharma without differentiation of peer-reviewed literature versus marketing</td>
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<td>Direct to physician marketing</td>
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<td>Shared decision making based on patient demands or doctor’s routine</td>
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<td>To obtain improved satisfaction and revenues</td>
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<td>Provider run pill mills</td>
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</tbody>
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National Overdose Deaths
Number of Deaths from Heroin

Source: National Center for Health Statistics, CDC Wonder
115 AMERICANS
die every day from an opioid overdose (including prescription and illicit opioids.)
Opioid Use and Misuse In Nevada

- Nevada ranks 2nd in the country for prescriptions for hydrocodone - more than 88 million pills dispensed in 2015
- Nevada ranks 2nd in the country for prescriptions for oxycodone - more than 61 million pills dispensed in 2015
- 4,539 emergency rooms visits statewide related to opioid dependence, abuse or poisoning in 2013
- 18,543 ER visits due to opioid dependence, abuse, or poisoning between 2009-2013

Opioid Misuse Can Lead to Death

*Four in five new heroin users started out misusing prescription painkillers.*

94% of respondents in a 2014 survey of individuals in treatment for opioid addiction said they chose heroin over prescription opioids because it was cheaper and easier to obtain.
Types of Opioids

- Natural opioids made from the plant
  - morphine, codeine

- Semi-synthetic opioids created in labs from natural opioids
  - hydrocodone, oxycodone, heroin

- Fully synthetic man-made opioids
  - fentanyl, methadone, tramadol
Opioid receptors

- Opioid receptor activation in the brain and nervous system relieves pain but may also produce pleasurable effects and euphoria.

- Opioid receptor has Mu, Kappa and Delta major subtypes.
  - Mu receptor activation is responsible for the majority of the analgesic properties of opioids and is also thought to be responsible for euphoria and reward.

Danko, 2018
Potential Problems

- **Overdose** – too much opioid receptor activation can shut down the breathing drive

- Lack of oxygen from an opioid overdose may lead to **brain injury in as little as 4 minutes**

- Long term changes to the brain in decision making and behavior regulation

- **Addiction** – a chronic, relapsing brain disease characterized by pathological pursuit of opioids

Danko, 2018
Potential Problems

**Physical dependence** - normal adaptation to opioid exposure creates physiological reliance on the drug

**Tolerance** - need for higher doses to achieve pain relief or euphoric response

**Withdrawal** – wide range of symptoms that occur after stopping or reducing opioids

**Opioid induced hyperalgesia (OIH)** – paradoxical worsening of pain despite aggressive opioid therapy

**Other**: constipation; opioid induced androgen deficiency; infection risks with injection use
The reward circuit

Opioids flood the reward center with dopamine.

Dopamine is a neurotransmitter that regulates pleasure and motivation.

Flooding produces euphoric effects, which gives reinforcement and teaches the user to repeat it.

Hippocampus - Memory Center, Euphoric recall and feelings to motivate person to repeat action - minimal effort with big dopamine reward.

Over time, the brain adjusts to the overwhelming surges of dopamine by producing less dopamine or by reducing the number of dopamine receptors which can impact the reward circuit and reduce the ability to experience any pleasure.
Effects of Drugs on Dopamine Release

Amphetamine

Cocaine

Nicotine

Morphine

Di Chiara and Imperato, PNAS, 1988
All of these brain regions must be considered in developing strategies to effectively treat addiction
Relapse and Addiction

- Permanent
- Preventable
- Predictable
- Progressive
Relapse

Relapse rates for people treated for substance use disorders compared with diabetes, hypertension, or asthma. Relapse is common and similar across these illnesses. Thus, drug addiction should be treated like any other chronic illness; relapse serves as a trigger for renewed intervention.

Source: JAMA, 284:1689-1695, 2000
Senate Bill 459 (2015)
Opioid Overdose Prevention Policy

- Expands access to Naloxone
  - Allows prescribing and/or dispensing to family member, friend, or someone in the position to help another person at risk of overdose
  - Allows law enforcement and emergency medical personnel to carry and administer Naloxone
  - Does not require anyone to prescribe, dispense, carry or administer Naloxone
  - Allows pharmacist with standing orders to store and dispense Naloxone
- Enacts the Good Samaritan Drug Overdose Act
- Requires prescribers to receive continuing education regarding misuse or abuse of prescription drugs
- Mandates utilization of the Prescription Drug Monitoring Program prior to prescribing
Overdose Treatment

Naloxone – short acting antagonist to opioid receptor

Opioid receptor

Opioid

Receptor activated

Naloxone
Naloxone and the Good Samaritan Law

Naloxone - a drug that blocks the effects of the opioid by temporarily reversing the effects of the opioid

- Has been used in hospitals and by emergency personnel for years
- Works in 2-3 minutes (depending on what was used, how much, and other drugs) but wears off faster than an opioid
- Effect lasts approximately 20 minutes
- A second dose may be necessary
Naloxone – Anyone can administer

- No side effects
- No potential for abuse
- Will not harm a person who doesn’t have opioids in his system
- No effect on overdoses resulting from the use of other drugs
- Most overdoses occur in the presence of others who could potentially prevent death
- Research shows people consistently list “fear of police involvement/fear of arrest” as the leading reason for failing to seek immediate help for someone overdosing
Naloxone available in our area

- Northern Nevada HOPES - syringe kit for approximately $25.00
  - contains 2 doses
  - must establish as a patient at HOPES
- Nasal spray and various forms of syringe kits available at pharmacies like CVS and Walgreens - cost depends on insurance or cash payment
  - Available without a prescription, but can’t use insurance without a prescription
Naloxone

- Now available by standing order at Walgreens and CVS
- Naloxone is short acting and many opioids are long acting
Nevada Good Samaritan Law

- Allows a person seeking **medical assistance** for a person who is experiencing a **drug or alcohol overdose** or other medical emergency **may not be arrested, charged, prosecuted or convicted**, or have his or her property subjected to forfeiture, or be otherwise penalized **for violating**: (1) certain provisions of existing law governing controlled substances; (2) a **restraining order**; or (3) a condition of the person’s **parole or probation**, if the evidence to support the arrest, charge, prosecution, conviction, seizure or penalty was gained as a result of the person’s seeking such medical assistance.

- In brief – **no prosecution for simple possession and use**
“Seeks medical assistance” defined as:

a) **Reports a drug or alcohol overdose** or other medical emergency to a member of law enforcement, a 911 emergency service, a poison control center, a medical facility or a provider of medical services;

b) **Assists another person to report** it;

c) **Provides care to a person** experiencing a drug or alcohol overdose or other medical emergency **while awaiting** arrival of **medical assistance**; or

d) **Delivers a person** experiencing a drug or alcohol overdose or other medical emergency **to a medical facility and notifies the appropriate authorities.**
However...

- Immunity from criminal prosecution does NOT prevent any governmental agency from taking action under the Child Protection laws of Nevada.
SAMHSA - Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. SAMHSA

These medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body.

Methadone, buprenorphine, and naltrexone are used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. People may safely take medications used in MAT for months, years, several years, or even a lifetime.

SAMSHA, 2016
More about the Medications

- Methadone – Schedule II controlled substance - used in the oral form as an evidence-based maintenance treatment for documented opioid addiction.
  - Full agonist at the mu opioid receptor, possible overdose, continuous dosing and successful outcomes studies.

- Buprenorphine – Schedule III controlled substance - Partial agonist/partial antagonist at the mu opioid receptor and a partial antagonist at the kappa opioid receptor, will displace other opioids on receptor causing withdrawal, can titrate down or up quickly.

- Naltrexone injectable – Not a scheduled drug – Full antagonist - 28 day mu receptor coverage (work for alcohol as well as opioids)
At the Receptor

**FULL AGONIST**
- long acting activation of the opioid receptor
- Highly regulated

**PARTIAL AGONIST**
- Activates the opioid receptor while blocking other opioids
- Special license to prescribe

**ANTAGONIST**
- Blocks receptor
- Cannot use in detox
- No addiction potential

Danko, 2018
Methadone (schedule II)

AGONIST: long acting activation

- **Regulation**: strict federal guidelines dictate eligibility for methadone maintenance
- **Benefit**: helpful in withdrawal management, reduces cravings, reduces euphoria of subsequent opioid use, efficacy in opioid use disorder, cost effective
- **Risk**: overdose risk, misuse, tolerance, hyperalgesia, cardiac arrhythmias, dependence and addiction

DANKO, 2018
Buprenorphine (schedule III)

Regulation: required certification; patient limits in outpatient treatment

Benefits:
- Withdrawal management
- Maintenance therapy
- Craving reduction
- Daily oral or long-acting implant

Dosing guidelines

Danko, 2018

PARTIAL AGONIST:
- Higher affinity with lower activity
- Activates receptor plus blocks activation of receptor by other opioids
Prescribing Buprenorphine

- Requires waiver to prescribe in outpatient setting

- 30 pts in first year - 100 in 2nd year - recent increase to 275 pts with criteria

Available trainings (approx 8 hours)

- American Academy of Addiction Psychiatry
- American Psychiatric Association
- American Society of Addiction Medicine
- American Osteopathic Academy of Addiction Medicine
- Provider Clinical Support System (PCSS - 8 hr. online and free)
Buprenorphine limitations

- When used in monotherapy has abuse potential
  - Naloxone added in combination as an abuse deterrent
    - Available combination formulations: buprenorphine/naloxone, Suboxone, Zubsolv, Bunavail
- Street value/diversion
  - Highly effective for withdrawal help
- Potential dependence/addiction, opioid agonist
- May induce withdrawal with recent use of opioids
  - Higher affinity for opioid receptor so it will dislodge other opioids from the receptor
Naltrexone (prescription, not controlled)

**Benefits:**
- Prevents opioid intoxication and dependence
- Reinforces abstinence
- Efficacy in opioid and alcohol use
- No addiction/dependence potential

Oral daily dose vs. long acting injection
Vivitrol (long acting Naltrexone)

- 28 day duration
- IM injection
Naltrexone limitations

- Requires completed withdrawal from opioids will induce withdrawal if taken with opioids in the system
  - Requires motivated patient
  - Cannot aid withdrawal management
- Risk: may have increase risk of death from overdose due to decrease in tolerance with receptor blockade (depending upon dose of opioid used in relapse)
Patient with opioid use disorder admitted to a hospital for a primary medical problem other than opioid dependency may be administered opioid agonist such as methadone or buprenorphine to prevent opioid withdrawal.

DATA 2000 waiver is not required for practitioners in order to administer or dispense buprenorphine in this setting.
Counseling

- Does not have to be voluntary to be effective
- Focus on treating the whole person
- Treatment plans change with the individual’s progress
- Essential component of MAT
Why are screening tools important?

Screen for mental health disorders which may impact the risk for substance use disorders

Screen for alcohol use and substance use, which increases risk when co-used with other prescribed substances such as benzodiazepines or opioids

Helps to identify patients who need referrals for help with behavioral health, substance use treatment, or medical needs

Helps to identify patients who may be at higher risk to take controlled substances such as opioids

Substance Induced Disorders – Depression/Anxiety/Relationships
Assessment and Screening for Opioid Use Disorder

- Consumption of opioids and other substances
- Reasons for use – ongoing pain, decrease of negative feelings, sleeping better, less anxiety?
- Recognize substance induced disorders – depression/anxiety
- Cravings for next dose
- Route of consumption – IV, snorting, smoking
- Tolerance – need for higher amounts for same effect?
- Last use history
- Any time that opioid use is interfering with life/routine?
- Prior treatment history
- Medical, Psychosocial, Family history
- Physical examination
- Laboratory analysis
Using Screening Tools

- Individual Screen
- Family Screen
- CAGE
- Alcohol Use Disorders Identification Test (AUDIT)
- Mental Health Screening Tool
- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients with Pain (SOAPP)
- Current Opioid Misuse Measure (COMM)
- Brief Intervention – Motivational Interviewing
- Referral
Individual and Family Screens

**Individual Screen**: Have you ever or do you currently use ......

**Family Screen**: Has anyone in your family ever used or is currently using ......

Tobacco – cigarettes, cigars, snuff, dip, etc.
Cannabinoids – marijuana, CBD oil, hash, dabs, etc.
Alcohol – beer, wine, hard liquor, etc.
Opioids – hydrocodone, hydromorphone, Percocet, Lortab, etc.
Benzodiazepines – Valium, Clonazepam, Xanax, etc.
Stimulants – Ritalin, Khat, Concerta, etc.

*Illicit or street drugs such as:*
Cyocaine – Crack, Coke, etc.
Hallucinogens – LSD, PCP, mushrooms, acid, Ketamine, etc.
Heroin
Methamphetamines
Inhalants – gasoline, glue, paint thinner, glue, etc.
Others – crocodile, molly, bath salts, etc.
C - Have you ever felt that you ought to cut down on your drinking or drug use?

A - Have people annoyed you by criticizing your drinking or drug use?

G - Have you ever felt bad or guilty about your drinking or drug use?

E - Have you ever had a drink or used first thing in the morning? (Eye opener)
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<thead>
<tr>
<th></th>
<th>Question</th>
<th>Options</th>
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<tbody>
<tr>
<td>1.</td>
<td>How often do you have a drink containing alcohol?</td>
<td>Never, Monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week</td>
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<tr>
<td>2.</td>
<td>How many standard drinks containing alcohol do you have on a typical day when drinking?</td>
<td>1 or 2, 3 or 4, 5 or 6, 7 to 9, 10 or more</td>
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<tr>
<td>3.</td>
<td>How often do you have six or more drinks on one occasion?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
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<td>4.</td>
<td>During the past year, how often have you found that you were not able to stop drinking once you had started?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
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<td>5.</td>
<td>During the past year, how often have you failed to do what was normally expected of you because of drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
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<td>6.</td>
<td>During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
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<td>7.</td>
<td>During the past year, how often have you had a feeling of guilt or remorse after drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
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<tr>
<td>8.</td>
<td>During the past year, have you been unable to remember what happened the night before because you had been drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
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<tr>
<td>9.</td>
<td>Have you or someone else been injured as a result of your drinking?</td>
<td>No, Yes, but not in the past year, Yes, during the past year</td>
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<tr>
<td>10.</td>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?</td>
<td>No, Yes, but not in the past year, Yes, during the past year</td>
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</tbody>
</table>
Scoring the AUDIT

Scores for each question range from 0 to 4, with the first response for each question (e.g., never) scoring 0, the second (e.g., less than monthly) scoring 1, the third (e.g., monthly) scoring 2, the fourth (e.g., weekly) scoring 3, and the last response (e.g., daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.
Mental Health Screening Tool

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?
2. Have you ever felt you needed help with your emotional problems, or have had people tell you that you should get help for your emotional problems?
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problems?
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?
5. Have you ever heard voices no one else could hear or seen objects which others could not see?
6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions? If Yes, Did you ever attempt to kill yourself?
Mental Health Screening Tool

7. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?
8. Was there ever a period in our life when you spent a lot of time thinking and worrying about gaining weight, becoming fat or controlling your eating?
9. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event?
10. Have you ever experienced any strong fears?
11. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to other or led to the destruction of property?
12. Have you ever felt people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?
13. Have you ever had a period in your life when you were so full of 
energy and your ideas came very rapidly, when you talked 
non-stop, when you moved quickly from one activity to 
another, when you needed little sleep and believed you could 
do almost anything?

14. Have you ever had spells or attacks when you suddenly felt 
anxious, frightened, uneasy to the extent that you began 
sweating, your heart began to beat rapidly, you were shaking or 
trembling, your stomach was upset, you felt dizzy or unsteady as 
if you would faint?

15. Have you ever had a persistent, lasting thought or impulse to do 
something over and over that caused you considerable distress 
and interfered with normal work or daily life?

16. Have you lost considerable sums of money through gambling or 
had problems at work, in school, with your family and friends 
as a result of your gambling?

17. Have you ever been told by teachers, guidance counselors, or 
others that you have a special learning problem?
Mankoski Pain Scale

0 - Pain Free
1 - Very minor annoyance - occasional minor twinges. No medication needed.
2 - Minor Annoyance - occasional strong twinges. No medication needed.
3 - Annoying enough to be distracting. Mild painkillers take care of it (Aspirin, Ibuprofen).
4 - Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.
5 - Can't be ignored for more than 30 minutes. Mild painkillers ameliorate pain for 3-4 hours.
6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (Codeine, narcotics) reduce pain for 3-4 hours.
7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.
8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.
10 - Unconscious. Pain makes you pass out.
Risk assessment tool: SOAPP

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

Scale of 0 (never) to 4 (often) for each question
Score of 7 or greater = high risk
# Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

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<tr>
<th>Mark each box that applies</th>
<th>Female</th>
<th>Male</th>
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<tbody>
<tr>
<td>Family history of substance abuse</td>
<td></td>
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</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Personal history of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Age between 16—45 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>History of preadolescent sexual abuse</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Psychological disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Scoring totals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMM screening

1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., going to class, appointments)
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor or ER)
4. In the past 30 days, how often have you taken your medications differently than how they are prescribed?
5. In the past 30 days, how often have you seriously thought about hurting yourself?
6. In the past 30 days, how much of your time was spent thinking about opioid medications? (i.e., having enough, taking them)
7. In the past 30 days, how often have you been in an argument?
8. In the past 30 days, how often have you had trouble controlling your anger? (i.e., road rage, screaming)
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?
10. In the past 30 days, how often have you been worried about how you're handling your medications?
11. In the past 30 days, how often have others been worried about how you're handling your medications?
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?
13. In the past 30 days, how often have you gotten angry with people?
14. In the past 30 days, how often have you had to take more of your medication than prescribed?
15. In the past 30 days, how often have you borrowed pain medication from someone else?
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain? (i.e., to help you sleep, relieve stress)
17. In the past 30 days, how often have you had to visit the Emergency Room?

Never - 0
Seldom - 1       Often - 3
Sometimes - 2    Very often - 4

Score of 9 or more = positive
AB 474 – The Governor’s Bill

- Crafted in part by former Chief Medical Officer of Nevada Dr. John DiMuro
- White paper on Governor’s website:
  
  http://gov.nv.gov/NewsandMedia/RX/RXDrugAbuse/
Obtain a patient **risk assessment**

International Classification of Disease 10\textsuperscript{th} Revision (ICD-10) **diagnosis** for the disease being treated and **treatment plan**

Determine if the patient is:

- using prescription as prescribed or diverting (PMP)
- misusing or dependent on any drug
Nevada Prescription Drug Monitoring Program (PDMP)

- Mandatory registration with the state’s PDMP
- [http://bop.nv.gov/links/PMP/](http://bop.nv.gov/links/PMP/)
- [http://bop.nv.gov/resources/ALL/Information_Regarding_AB_474/](http://bop.nv.gov/resources/ALL/Information_Regarding_AB_474/)
1. Opioid are not first line or routine therapy for chronic pain
2. Establish realistic goals for pain and function
3. Discuss risks and benefits and nonopioid therapies available
4. Use immediate-release opioid if starting
5. Use the lowest effective dose possible
6. Prescribe short durations
7. Evaluate benefits and harms frequently
8. Use strategies to mitigate risk
9. Review Prescription Drug Monitoring database
10. Use urine drug testing
11. Avoid concurrent opioid and benzodiazepine prescribing
12. Offer treatment for opioid use disorder

Decreasing Risk

**Prevention**
- Education and programs to prevent use before it begins
- Identifying individuals and communities with high risk factors
- Risk reduction and/or treatment for those who are using substances
- Preventing overdose deaths, naloxone availability

**Risk reduction**
- Safe use practices, counseling regarding co-use with other substances (esp alcohol, benzodiazepines)
- Syringe service programs
- Infection prevention - decrease public health risk (i.e. HIV, HCV)
- Discussing the variety of treatment options available
- Screening and treatment for mental health disorders and medical problems
- Social determinants of health – build social and environmental support
- Utilize referrals, work together, team based strategies
Basic opioid safety to discuss with every patient

- Never take opioids in greater amounts or more often than prescribed
- Follow up with healthcare provider to create a plan on how to manage pain and non medication alternatives
- Never sell or share prescription opioids with anyone
- Store prescription opioids in a secure place out of reach of others
- Safely dispose of unused prescription opioids
  - Resources at www.fda.gov/Drugs/ResourcesForYou
- Have naloxone available
- Communicate medical or social history with treatment team
- Learn about risks of opioid abuse and overdose
- Learn about signs of Opioid Use Disorder and available treatment programs
Pain treatment modalities

- Pharmacologic
- Physical medicine (PT and OT programs, exercise programs)
- Behavioral medicine (CBT, relaxation therapy, psychotherapy, group counseling)
- Neuromodulation (Transcutaneous electric nerve stimulation/TENS, spinal cord stimulation)
- Interventional (Ablative techniques, trigger point injections, epidural injections, nerve blocks)
- Surgical interventions
Pharmacologic options

- Nonopioid analgesic agents (aspirin, acetaminophen, NSAIDs, COX-2 inhibitors)
- Alpha 2 adrenergic agonists
- Antidepressants (TCA and SNRIs)
- Antiepileptic drugs (Gabapentin, pregabalin)
- Muscle relaxants
- NMDA receptor antagonists
- Topical analgesic agents (Lidocaine, Capsaicin cream, topical NSAIDs)
- Opioids
First line treatments for pain

- Nociceptive pain:
  - Acetaminophen
  - NSAIDs

- Neuropathic pain:
  - Antidepressants (TCA or SNRIs)
  - Calcium channel alpha 2 delta ligands (gabapentin, pregabalin)
  - Adjunctive topical therapy

- Opioids only in patients who are low risk for substance use and have persistent pain with nonopioid analgesics and antidepressants

- Evidence for the effectiveness of long-term opioid therapy in terms of pain relief and improved functional outcomes is limited
Setting realistic goals

- Goal is tolerable level of pain that allows optimal physical and emotional function
- Maximize nonopioid analgesics before starting (and during) any opioid therapy
- Only prescribe opioids if the benefits outweigh the risks
- Discuss the risks of opioid medications prior to starting
- Do not prescribe opioid medications to patients taking benzodiazepines or other sedating medications
Who is at high risk?
Risk assessment tools

- Clinical instruments developed to identify patients at risk for misuse or abuse of prescribed opioids
  - SOAPP – Screening and Opioid Assessment for Patients with Pain
  - ORT – Opioid Risk Tool
  - COMM – Current Opioid Misuse Measure
- Awareness of controlled substance regulation/diversion
  - Observed Urine Drug Screening
  - Random call-ins for medication counts between scheduled visits
  - Reviewing Prescription Monitoring Program – Nevada and California access
  - Limiting prescriptions to short supply
  - Updated treatment contract on each patient
  - Supervised/observed dosing – inpatient setting/Buprenorphine
Prescribing in Nevada

Assembly Bill 474 (2017)

- Components of a written controlled substance prescription
- Factors to consider before writing any prescription for a CS
- Factors to consider before writing an initial prescription
- Prescribing after 30 days
- Prescribing after 90 days
- Prescribing after 365 days
Prescribing and Documentation for initial prescription - requirements in Nevada

- Have a relationship with the patient
- Establish a preliminary diagnosis and treatment plan
- Perform a patient risk assessment
- Obtain and review the PDMP report
- Discuss non controlled substance treatment options and indicate why CS is prescribed
- Initial prescription in the state of Nevada must be for 14 days or less; 90 MME or less
- Informed Consent to be reviewed and completed
Verification of medications

- Inpatient medications are not populated to the PDMP
- Methadone Maintenance Programs do not report to PDMP
- Verify reported medications/doses through pharmacy or programs is key
Pain in patients chronically using opioids

- Increase in baseline chronic pain may be due to drug interaction causing decreased effectiveness of existing regimen, new medical problem, development of tolerance, or progression/exacerbation of underlying disease.

- Psychiatric disorders – depression, anxiety, PTSD are more common in patients with chronic pain than in the general population.

- Calculate 24 hour morphine milligram equivalent to help calculate equianalgesic doses for oral, transdermal and intravenous preparations.

- Maximize opioid sparing strategies.
Practice Solutions: Psychosocial Assessment

- Strengthen current assessment skills
  - Better than questionnaires
  - Takes time

- Utilizing a validated Opioid Assessment Tool
  - For initiation/transfer of care
    - ORT - Opioid Risk Tool
    - SOAPP - Screener for Opioid Assessment for Patients w/ Pain
    - COMM - Current Opioid Misuse Measures
    - AUDIT - Alcohol Use Disorder Identification Test

- Screening for psychological health
  - Mental Health Screening Tool 3 - MHST 3
  - Q 90 days
Practice Solutions: PDMP

- Every Chart Prepped for Every Office Visit
  - MA – Chart prep
  - Enter these into the EHR
  - Notified if unable to pull a report
  - If any CA address in chart – CURES report pulled
Practice Solutions: Urine Drug Screens

- Why use drug screens?
- Who use drug screens on?
- Power of drug screens?
- Message of drug screens to patients?
Practice Solutions: Urine Drug Screening/Monitoring

Start with one at initial controlled substance prescription
Regular UDS at intervals concordant with patient risk level
- Low Q 6-12 mo
- Mod Q 2-6 mo
- High Q visit

Used for analyzing:
- Current prescribed controlled substances
- Illicit substances
- ETOH
- Screen for controlled substance from inappropriate source

Powerful tool:
- Can be used to initiate conversation about abnormal findings
- To justify withdrawal of opioid treatment
Practice Solutions: Opioid Agreement

- Not a legal contract
- Re-sign annually
- Initial each article
- Patient also gets a copy
Safer Prescribing: Using technology

- Electronic Prescribing of Controlled substances (EPCS):
- Approved by DEA in 2010
  - Improved Patient Safety
  - Improved Security
  - Workflow Efficiency
  - Reduces doctor shopping
  - Allows for prescriber pattern analysis
  - Increases patient satisfaction
  - Potential improvement in cost savings applications
Practice Solutions: New Opioid Limit Policy

Higher opioids dosing is deadly

Dunn et al., Annals Int Med, 2010
Practice Solutions: Safer Prescribing

- Respiratory depression from opioids is heightened by BZDs
  - Weaning the Benzodiazepines
  - One or the other, not both
    - Regardless of who is prescribing
    - Few exceptions to the rule
Solutions

- Mental Health Disorders and Substance Use Disorders
  - Ask about mood, life circumstances and relationships
  - Ask about substances, ETOH, sedatives, MJ
  - Use Screening Tools
  - UDS consistently

- Monitor use of all controlled substances, and compliance
  - PDMP, CDC Guidelines, AB 474
Getting into Trouble

1. Failure to evaluate patients (no history or physical examination)
2. Failure to make any diagnosis prior to the initiation of treatment
3. Failure to obtain outside medical records or to talk with previous practitioners (any verification at all)
4. Failure to establish goals for treatment (reduction in pain, improvement in function)
5. Failure to suspect misbehavior or substance abuse (no screen for addictive potential and no monitoring through treatment)

Cole, The Pain Practitioner, Vol 12, No. 3
Getting into Trouble

- 6. Failure to Document the diagnosis, treatment plan, goals for treatment, continuing need for medication and lab results.
- 7. Failure to understand what drug testing can and cannot tell you
- 8. Deviation from the agreement/contract (misbehavior is never addressed either verbally or written)
- 9. Blind acceptance of whatever is said by patients
- 10. Trying to bully law enforcement or regulatory agents or assuming an arrogant “I-Know-Best” attitude when confronted by them

Cole, The Pain Practitioner, Vol 12, No. 3
Shift in thinking

- From Pain – the 5th Vital Sign **TO** focus on function and QOL measurements
- From routinely prescribing highly abused substances **TO** Prescribing non-addictive and effective pharmaceuticals
- From treating pain in a vacuum **TO** treating pain as a complex illness that is affected by the external environment
- From treating pain in a fragmented system **TO** building a comprehensive medical practices with the support of the health system
- From letting the industry determine how doctors treat patients **TO** supporting science and collecting data to support our treatments.
We can’t give up on treating chronic pain or using opioids as a tool.

Training, experience, science and compassion should all be balanced when prescribing any substances.

The current opioid environment has been created by past mistakes and can be corrected using a team approach.
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