Excessive Opioid Prescribing

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Medical Director Health and Human Services, Jackson County Oregon

Learning Objectives and Goals

- What are the public health consequences of excessive opioid prescribing?
- Identify the factors which led to a generation of excessive prescribing and the factors which make dose reduction difficult.
- Demonstrate the morbidity and mortality associated with opioid use and misuse.
- Discuss the collaborative efforts needed to evaluate and educate patients, providers, and the general public regarding the best practices for the treatment of chronic pain.
- Understand what role epidemiology and data collection play in creating an environment for successful practice change.

Jackson County Oregon
Population 206,412

Jackson County averages over 250,000 opioid prescriptions per year*

JACKSON COUNTY
Health & Human Services

* Prescription Drug Monitoring Program

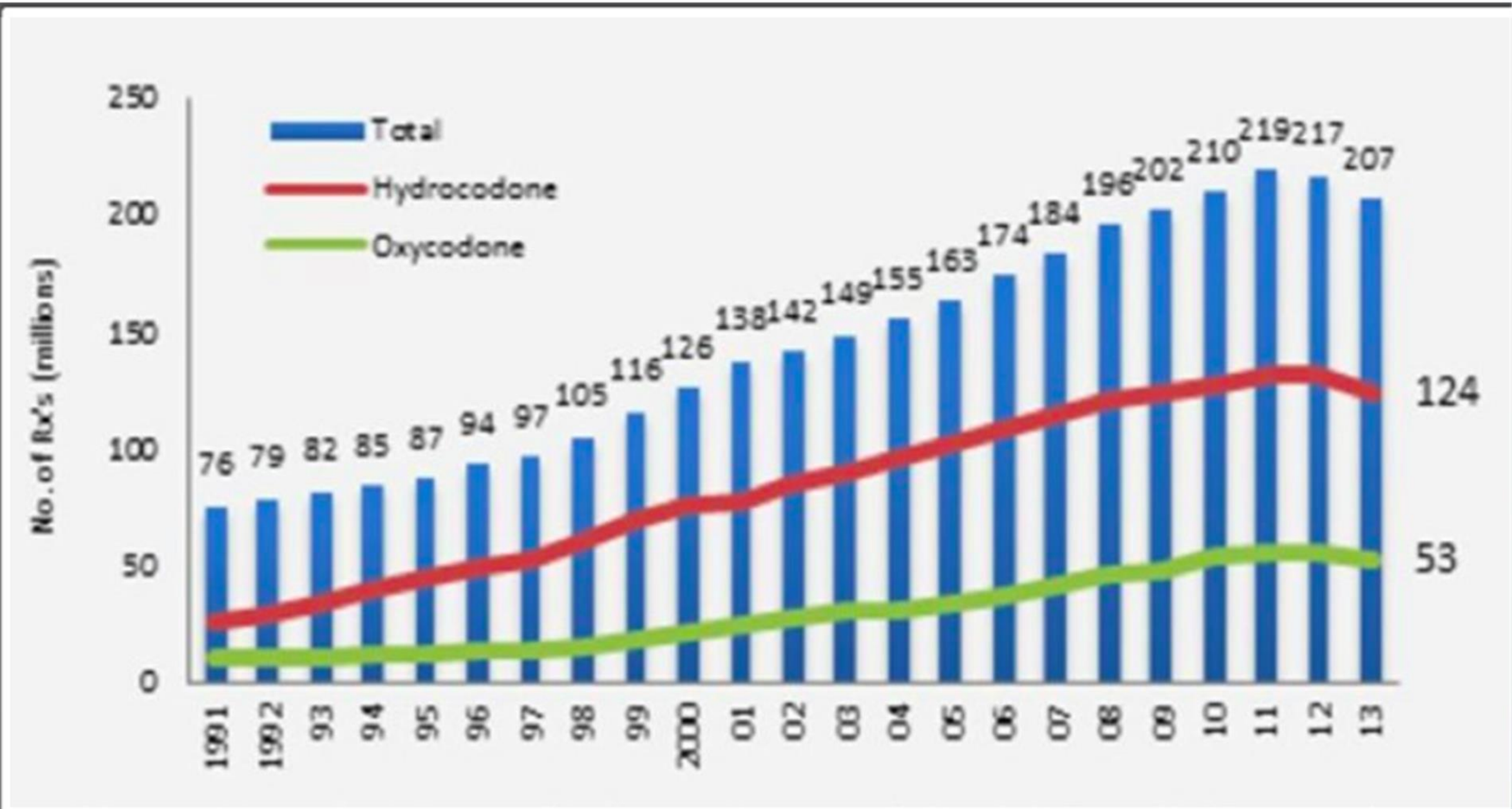
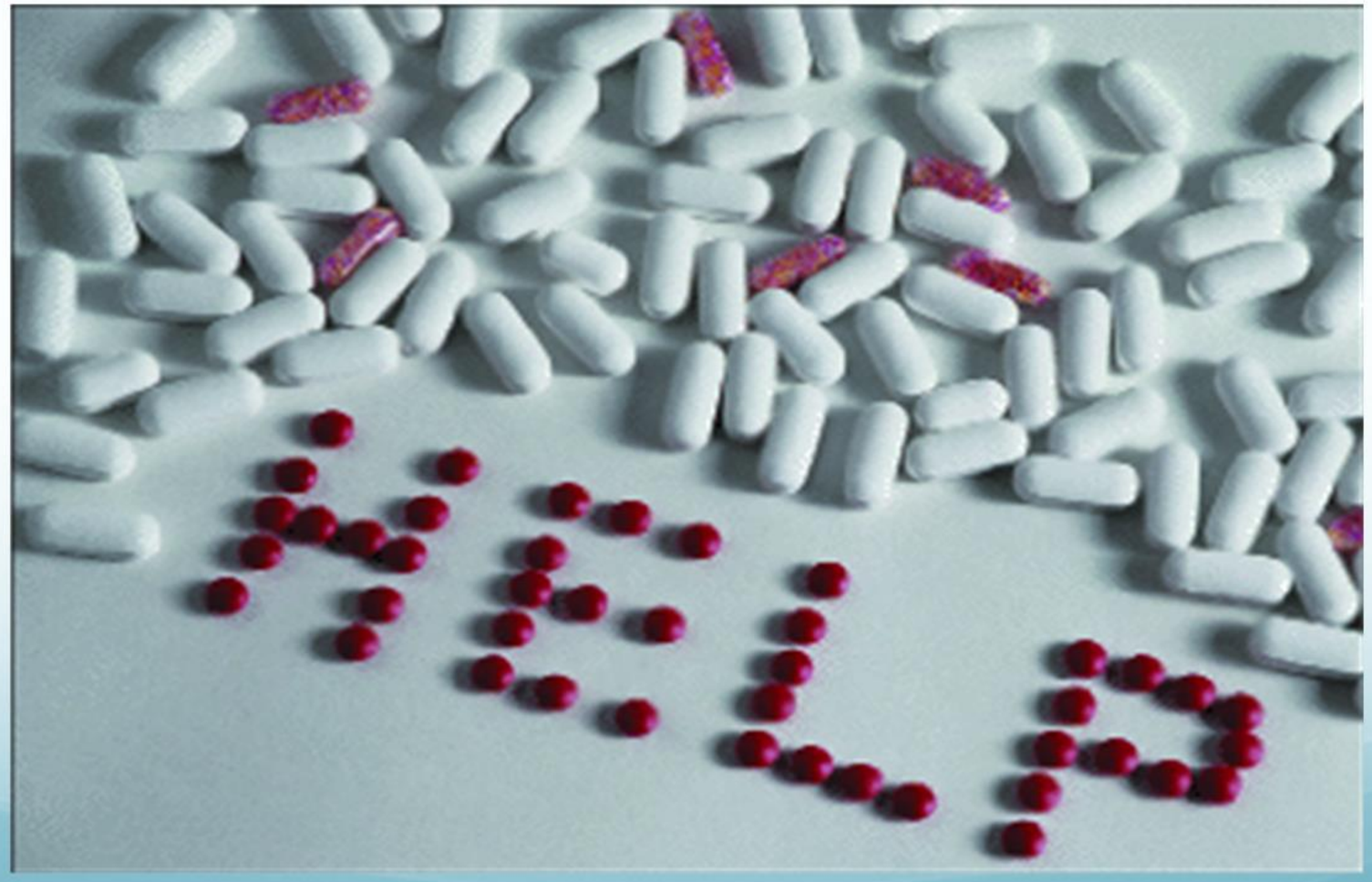
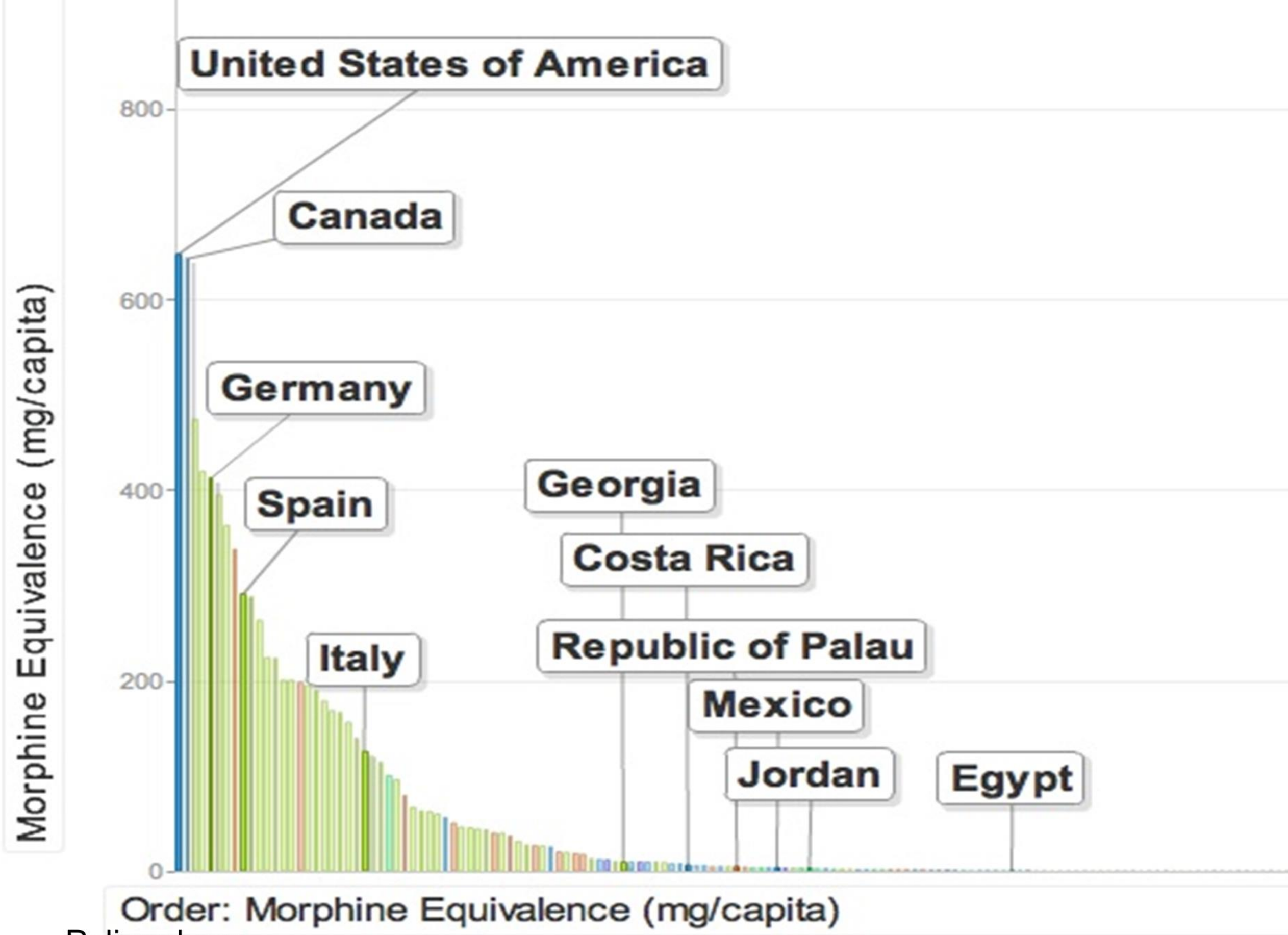


Figure 1 - Opioid Prescriptions Dispensed by US Retail Pharmacies IMS Health, Vector One: National, years 1991-1996, Data Extracted 2011. IMS Health, National Prescription Audit, years 1997-2013, Data Extracted 2014.

Opioid Consumption in US

- We are 4.6% of the world's population and consume 80% of the world supply of opioids.

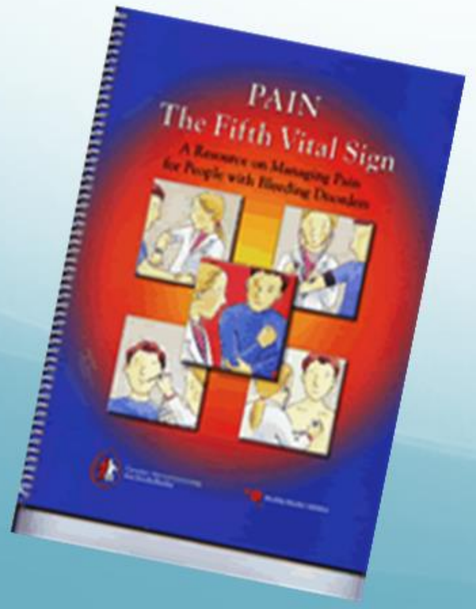


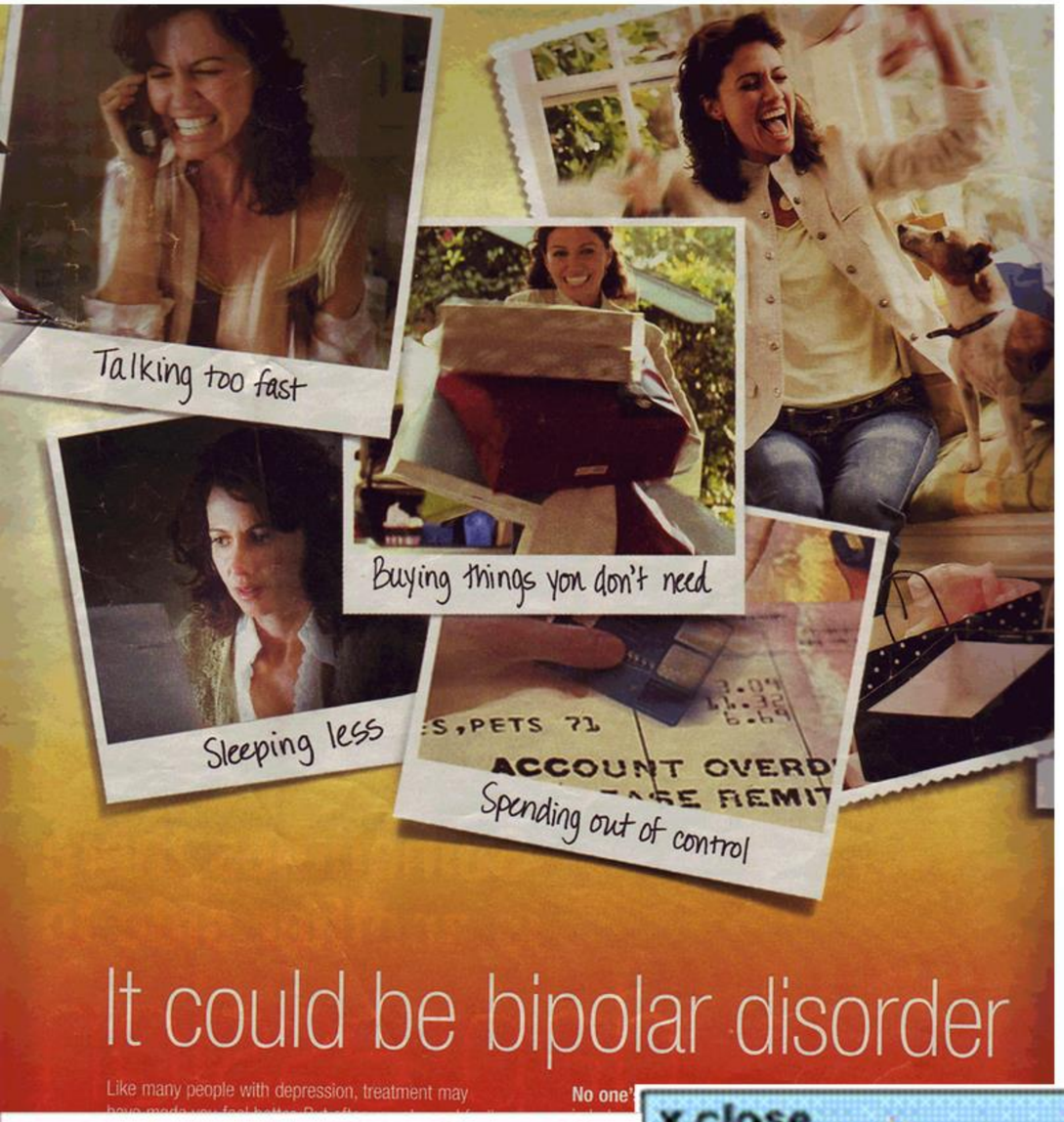

United States of America
Canada
Germany
Spain
Georgia
Costa Rica
Republic of Palau
Italy
Mexico
Jordan
Egypt
800
600
400
200
0
Morphine Equivalence (mg/capita)
Order: Morphine Equivalence (mg/capita)

Palimed.org

How did this happen?

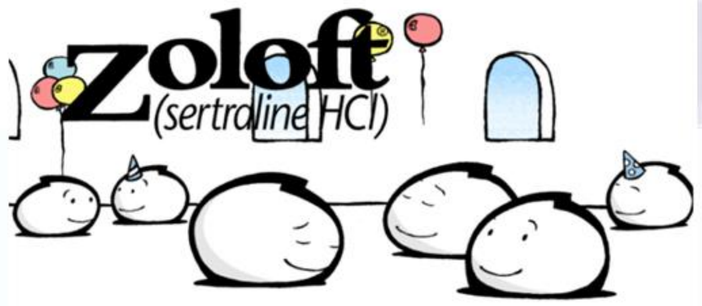
- We recognized under-treatment of some pain conditions in US
- We thought that we could apply the principles for treating acute and cancer pain to chronic non-malignant pain
- Belief that those with pain were less likely to abuse opioids; i.e.: at less risk for abuse/addiction
- Leading to the Joint Commission Pain Management Standards Jan 1, 2001





You Could Have Adult ADHD.

A serious, treatable condition that affects many adults.



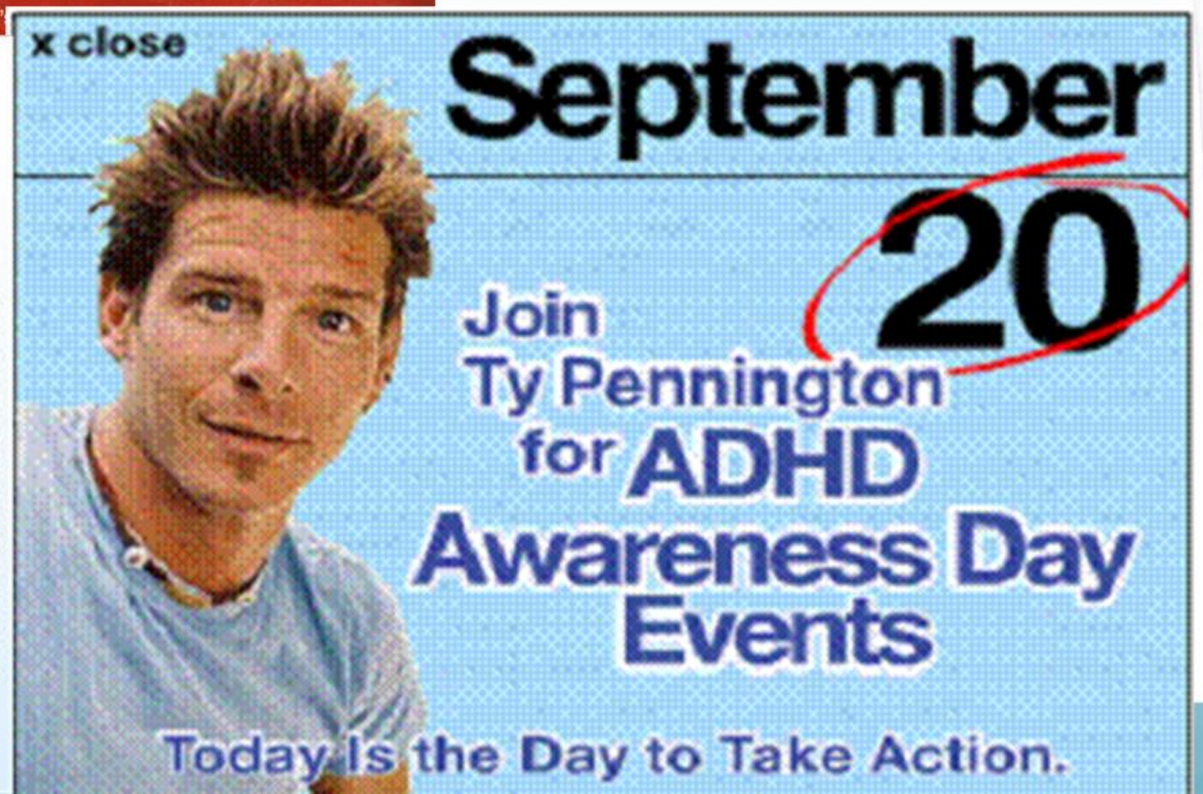
Could Zoloft be right for you?

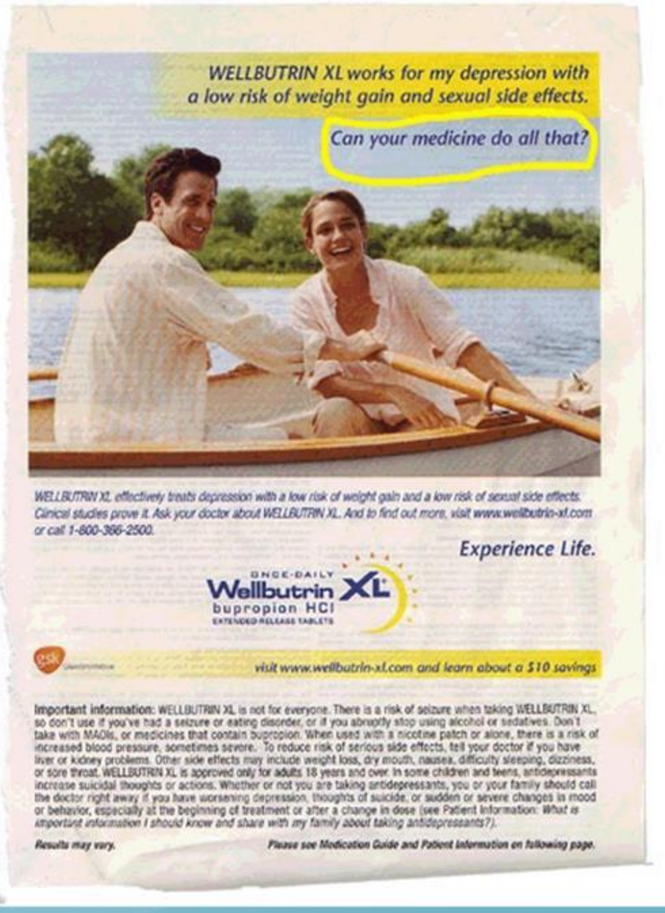
Take this self-quiz.

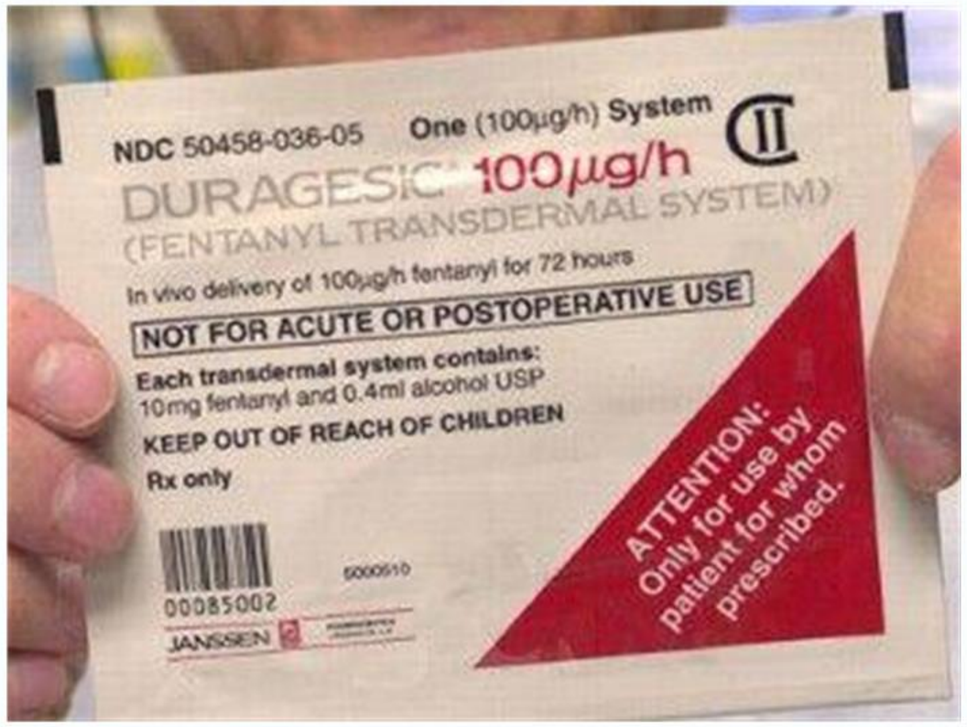
Have you experienced any of the following?
Check those that apply or might possibly apply:

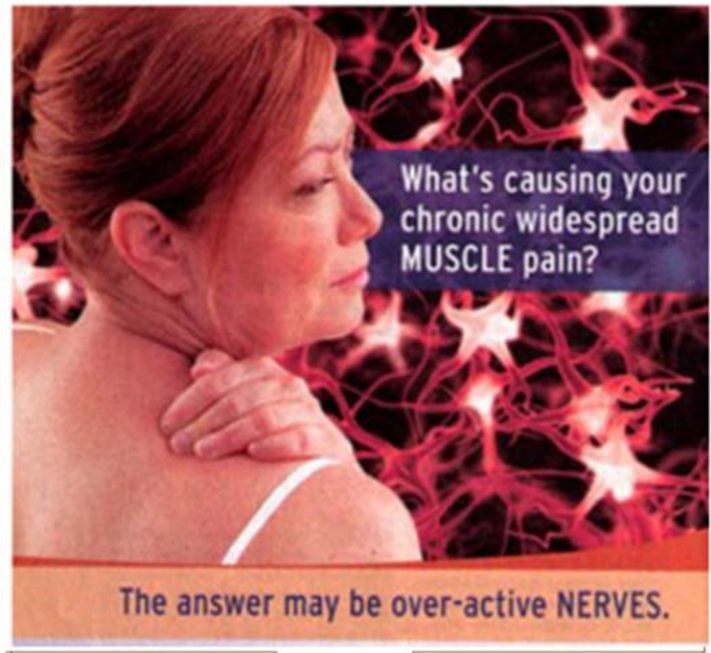
Trouble concentrating?	○YES	○NO
Crying or thoughts of crying?	○YES	○NO
Feelings of sadness?	○YES	○NO
Low energy, fatigue?	○YES	○NO
High energy, restlessness?	○YES	○NO
Loss of interest in certain activities?	○YES	○NO
Unexplained pain or headaches?	○YES	○NO
Lack of motivation?	○YES	○NO
Stress?	○YES	○NO
Worry?	○YES	○NO
Lack of involvement with family or friends?	○YES	○NO
Over-dependence on family or friends?	○YES	○NO

If you took this quiz, Zoloft is probably right for you.
Ask your doctor about Zoloft.







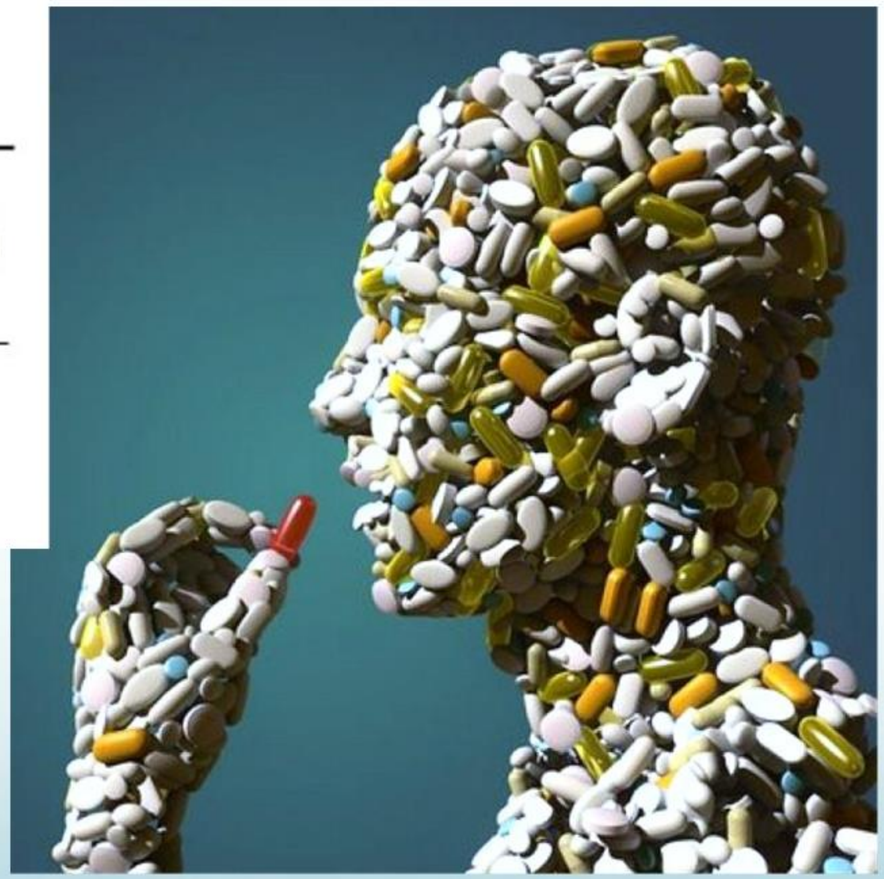


OxyContin® II

(OXYCODONE HCl CONTROLLED-RELEASE) TABLETS

10 mg	20 mg	40 mg
10 OC	20 OC	40 OC

80 mg	160 mg
80 OC	160 OC



Abbo-Pac® UNIT DOSE

NDC 0074-1949-12
100 Tablets
Abbo-Pac®

vicodin®

hydrocodone bitartrate and acetaminophen tablets, USP

Each tablet contains:
hydrocodone bitartrate . . . . . 5 mg
acetaminophen . . . . . 500 mg

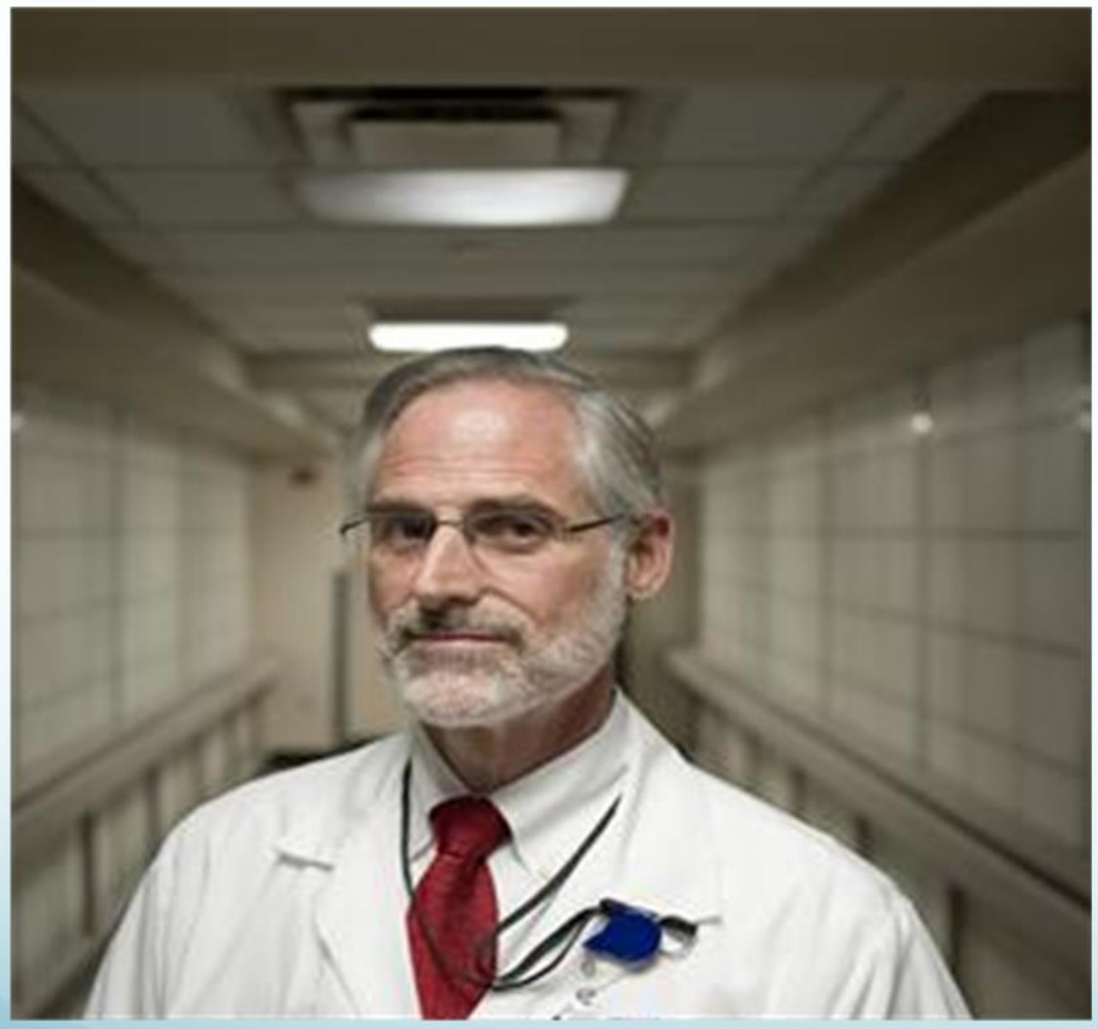
Tamper-Evident: Do not accept if sealed blister unit has been broken or opened.

THIS PACKAGE FOR HOUSEHOLDS WITHOUT YOUNG CHILDREN

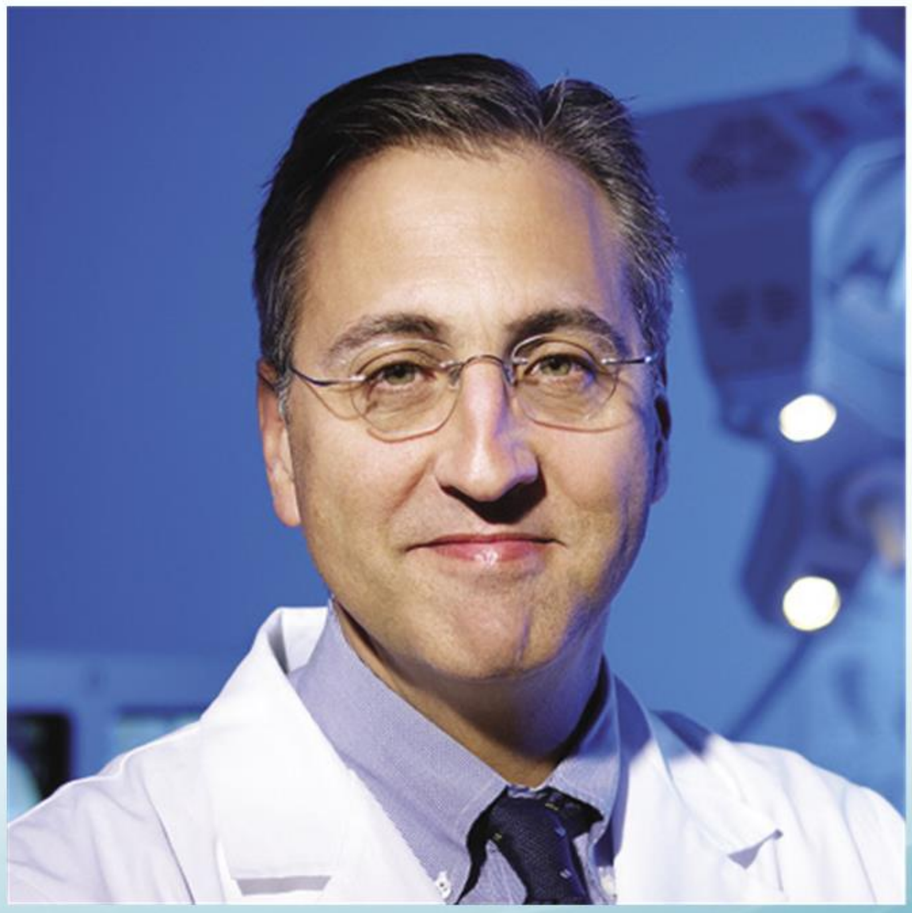
Abbott

Influential Medical Leaders promoting opioid use

Russell Portenoy



Scott Fishman



Influential Licensing agencies

OREGON BOARD OF MEDICAL EXAMINERS

BME REPORT

FALL 2003

www.bme.state.or.us

Inside:

NEW LAW CLARIFIES PATIENTS' RIGHTS TO ACCESS MEDICAL RECORDS

By Mike Sherman
BME Complaint Resource Officer

Rarely does a day go by that the BME does not receive several telephone calls, from either patients or licensees, regarding a patient's right to copies of their medical records. It is clear from the type of questions received that there is misunderstanding in the medical community regarding patient rights and medical records.

To make matters more interesting, the 2003 Oregon Legislature passed House Bill (HB) 2305, making state patient-records laws comply with federal Health Insurance Portability and Accountability Act (HIPAA) regulations. This bill took effect upon passage and made some significant changes in state law regarding patient's access to medical records.

HB 2305 was meant to complement HIPAA, and needs to be read in conjunction with the federal regulations. I will attempt to summarize some of the more important changes the Oregon bill and HIPAA make. The BME is in the process of changing its administrative rule on the release of records to incorporate these changes.

The law gives patients the right to access their medical records personally, or to have them sent to an authorized person or organization. The law gives a very broad definition of information that the patient is entitled to obtain, and includes "information Ê that relates to the past, present, or future physical or mental health of an individual" in any form. The law also includes billing information as information the patient is entitled to obtain.

Unlike the previous law, HB 2305 does not exempt the release of records of another health care provider which may be contained in the record. The new law allows the health care provider to require a written release from the requesting patient in a format very similar to the one specified by the old law (ORS 192.525, which has been repealed).

As in the old law, current law does allow certain exemptions to the general requirement to release information. There is an exemption for release for information which would harm the health of the patient. Psychotherapy notes are exempt as is information compiled, in anticipation of, or for, litigation. If the medical record contains information obtained from someone **other than a healthcare provider** under a promise of confidentiality, then that information may be exempted if releasing the information would tend to identify the source.

HB 2305, like the previous law, allows charging a fee for reproducing records. However, the new law specifies the amount which may be charged. HB 2305 allows a fee of $25 for the first ten pages of written material and 25 cents a page for orders of more than 10 pages. When X-rays or other non-written materials are ordered, the actual cost of reproducing the items may be charged. Inability to pay is not grounds to withhold medical records. **Additionally, the law does not exempt the release of records when a patient's bill is not paid in full. Records should not be withheld for that reason.**

In summary, HB 2305 and HIPAA:

- Give patients broad access to their medical records in the possession of the licensee who receives the request.
- Patients may request all or part of the record.
- Patients may request that the information be sent to them or to another person.
- Licensees may require a written release and require the patient to specify which part of the record they wish to obtain.
- A fee, which is specified in the statute, may be charged.

Please keep in mind that this article is a summary, and is not intended to substitute for a detailed reading of the current law. If questions arise concerning medical records, feel free to contact the Board's Complaint Resource Officer at (503) 229-5770. ■

Joint Commission

on Accreditation of Healthcare Organizations

Changes in medical practice

- Providers have less time with their patients
- They are more reliant on pharmaceuticals for their treatments
- Influenced by insurance formularies e.g. methadone
- So called best practices e.g. 5th vital sign

Pseudoscientific Evidence…

- "Only 4 documented cases of addiction among 11,882 patients treated with opioids."
- Cited over 690 times (Google scholar)
- PORTER, J., & JICK, H. (1980). Addiction rare in patients treated with narcotics. *New England Journal of Medicine.* 1980 Jan*; 302 (2):123.*

Pseudoscientific Evidence

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ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
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Boston Collaborative Drug
Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

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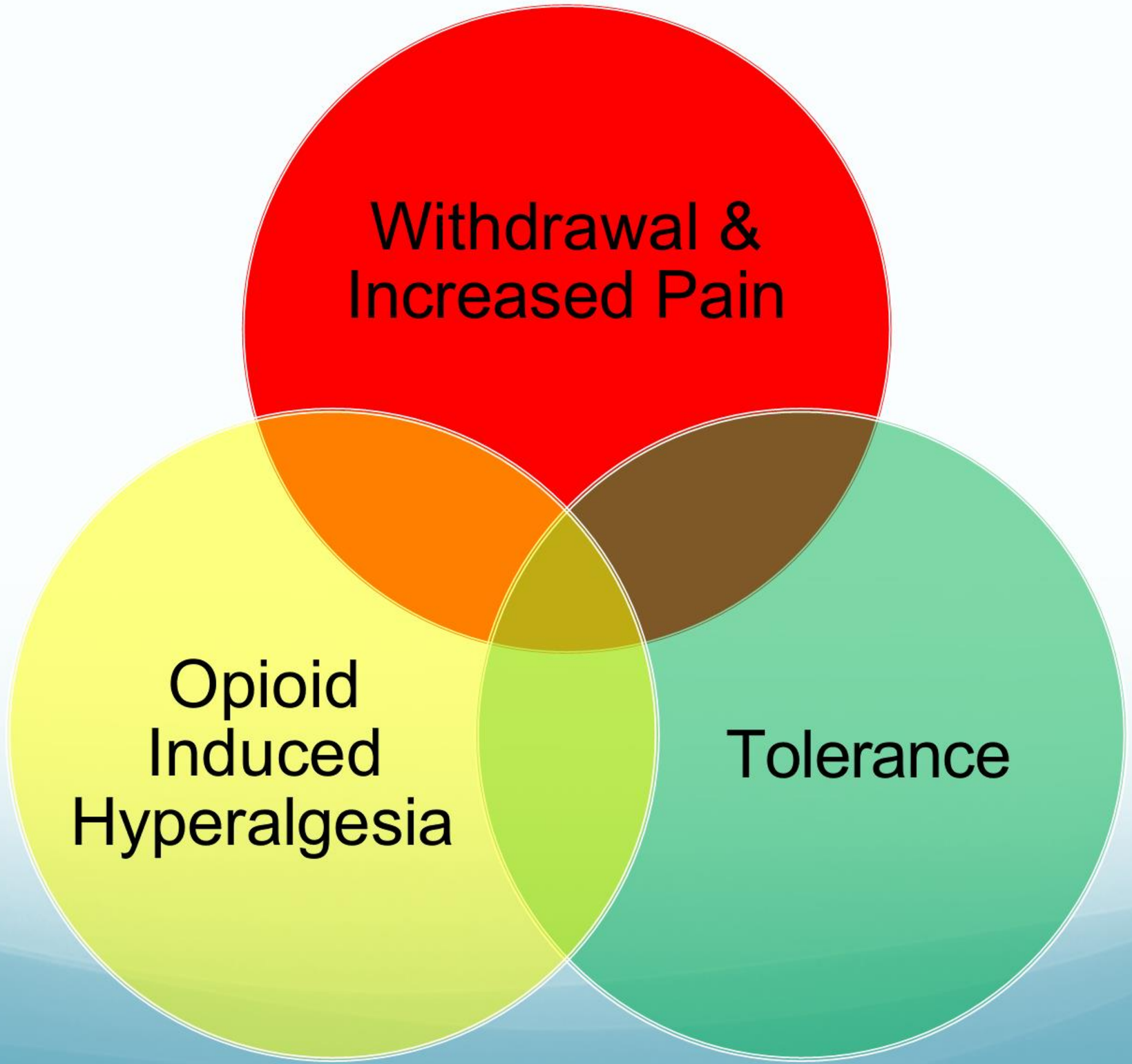
40138 Bologna, Italy

Senate Investigations 2007 and 2012 of Purdue Pharma: maker of Oxycontin

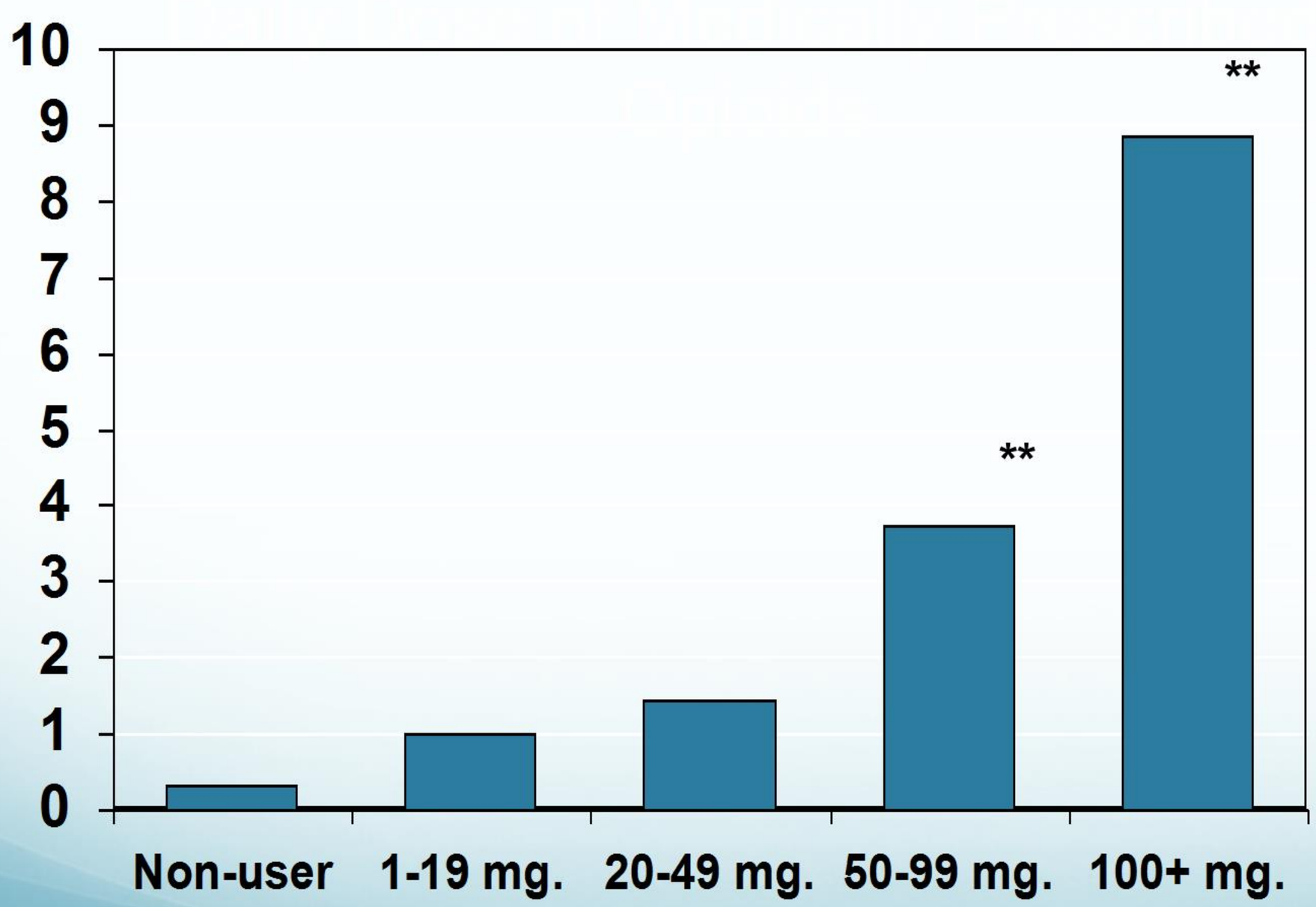
- Fined $600 million for misleading the public about the painkiller's risk of addiction 2007
- Investigating financial manipulation of the Joint Commission(JCAHO), Federation of State Medical Boards, and the American Pain Foundation.
- Dr. Scott Fishman (American Pain Foundation) and other pain experts are being investigated

Dose Escalation with Opioid Use



As the dose increases, so does mortality

Mortality risk compared to Morphine Equivalent Dose (MED)



9-fold increase in risk relative to low-dose patients

** Significant increment in risk $p<0.05$

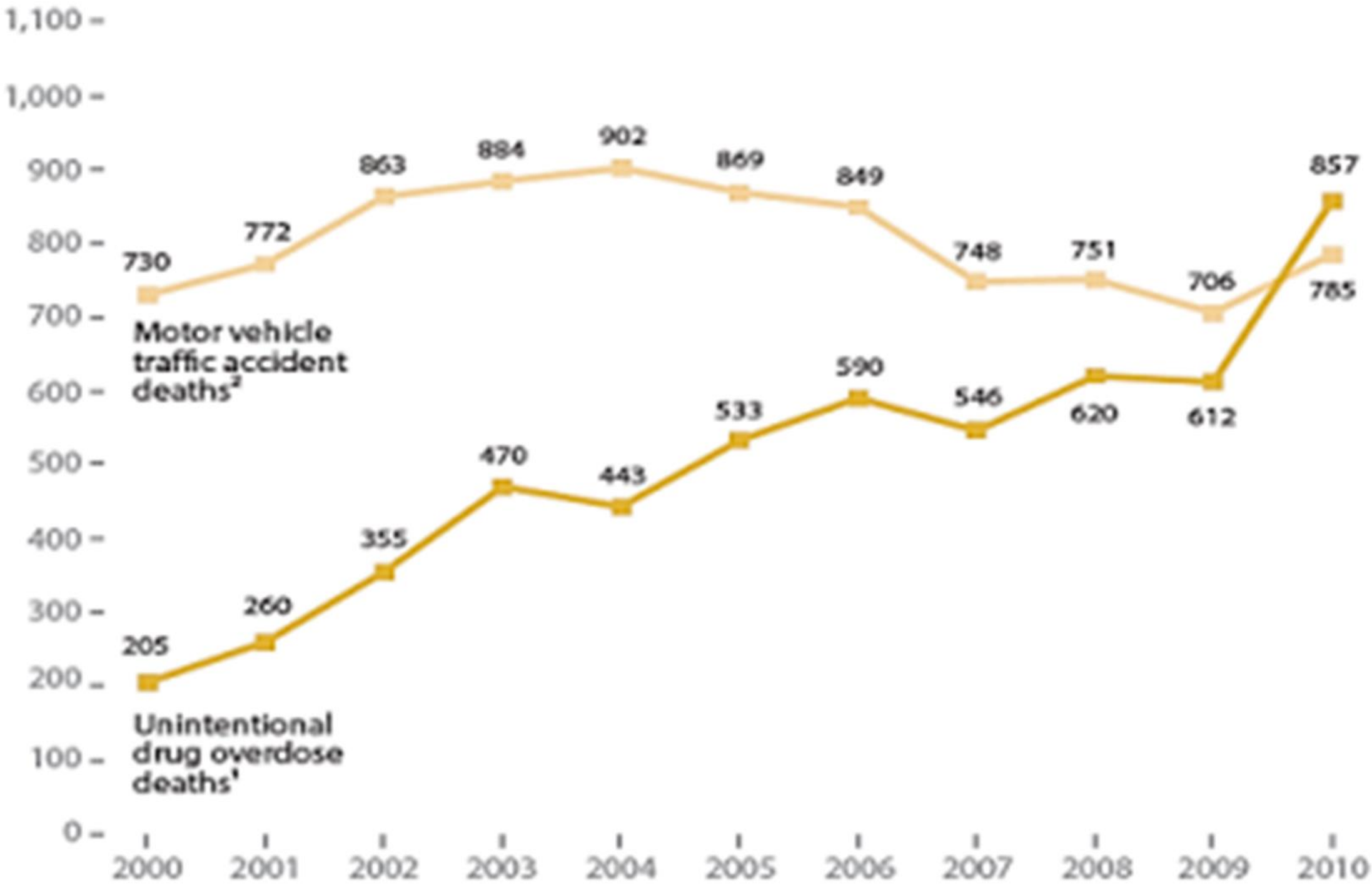
Dunn et al., Annals Int Med, 2010

Primary Care Treatment "Menu"

Reduction in Pain Intensity NRS

- Physical fitness: 30-60%
- CBT/Mindfulness: 30-50%
- Sleep restoration: 30-40%
- Opioids: ≤ 30%
- Tricyclics: ≤ 30%
- Antiepileptics: ≤ 30%
- Acupuncture: ≥ 10+%

Number of deaths due to unintentional drug overdoses compared with deaths due to motor vehicle traffic accidents



Overdose deaths US

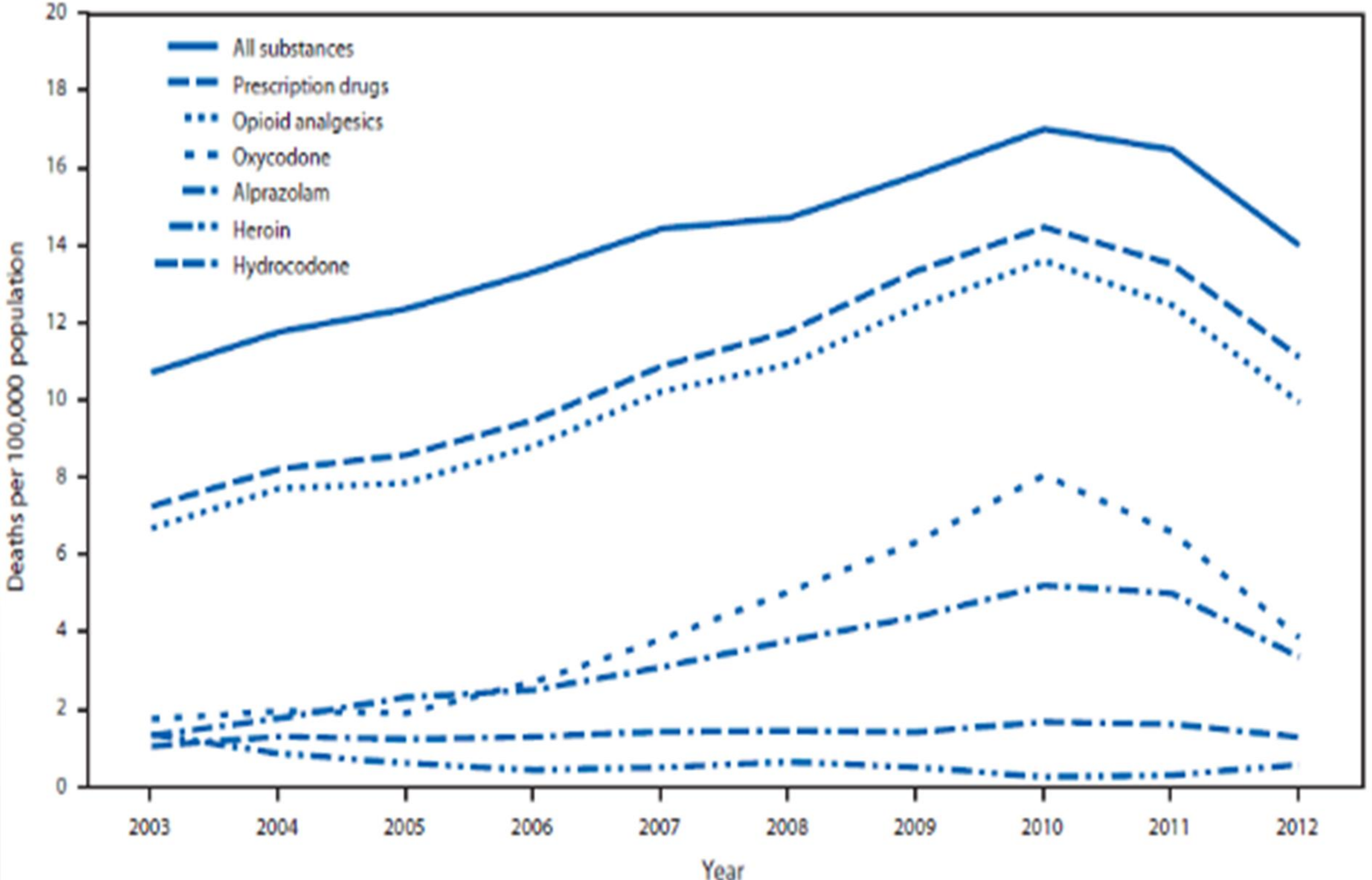
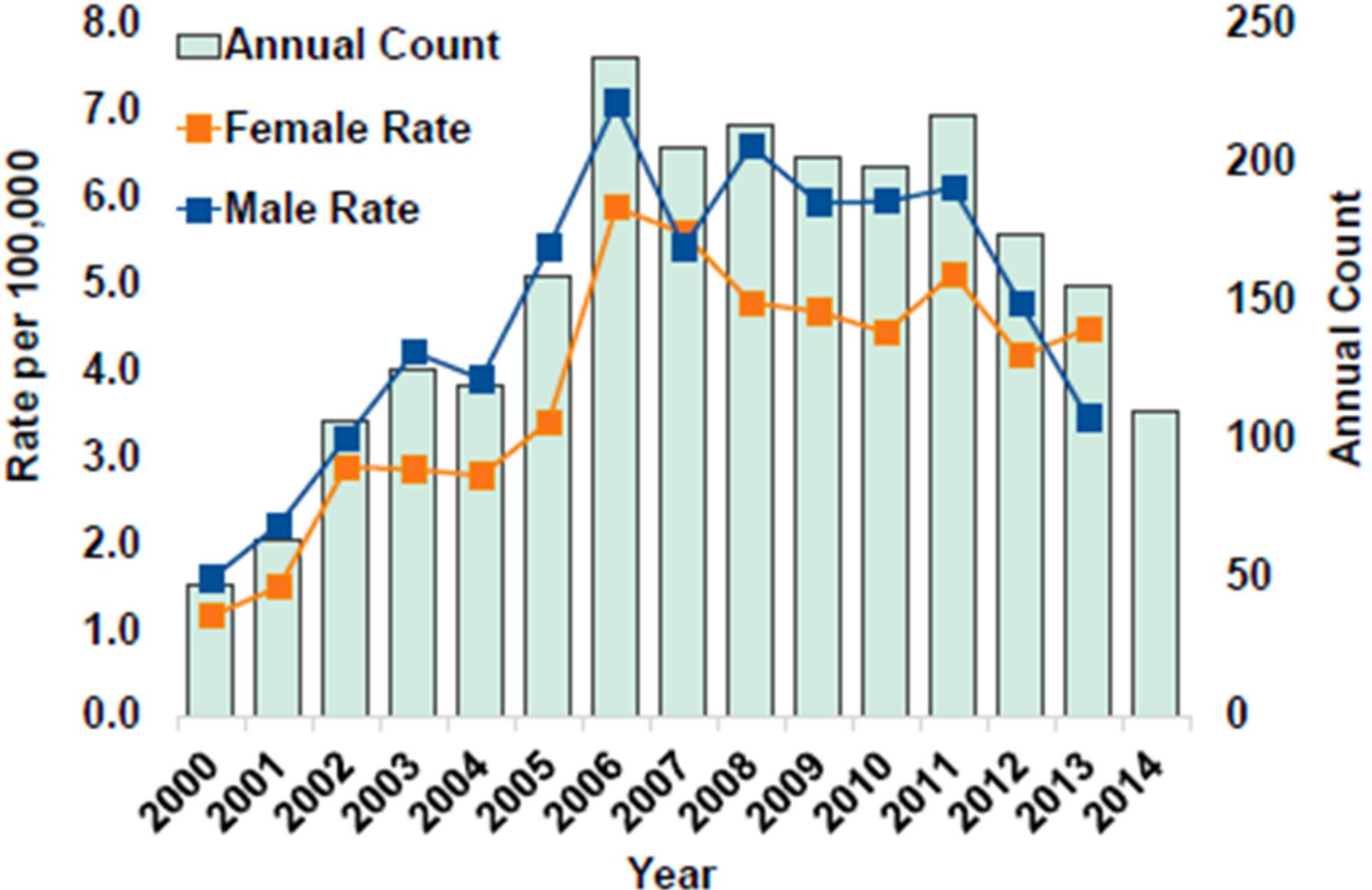
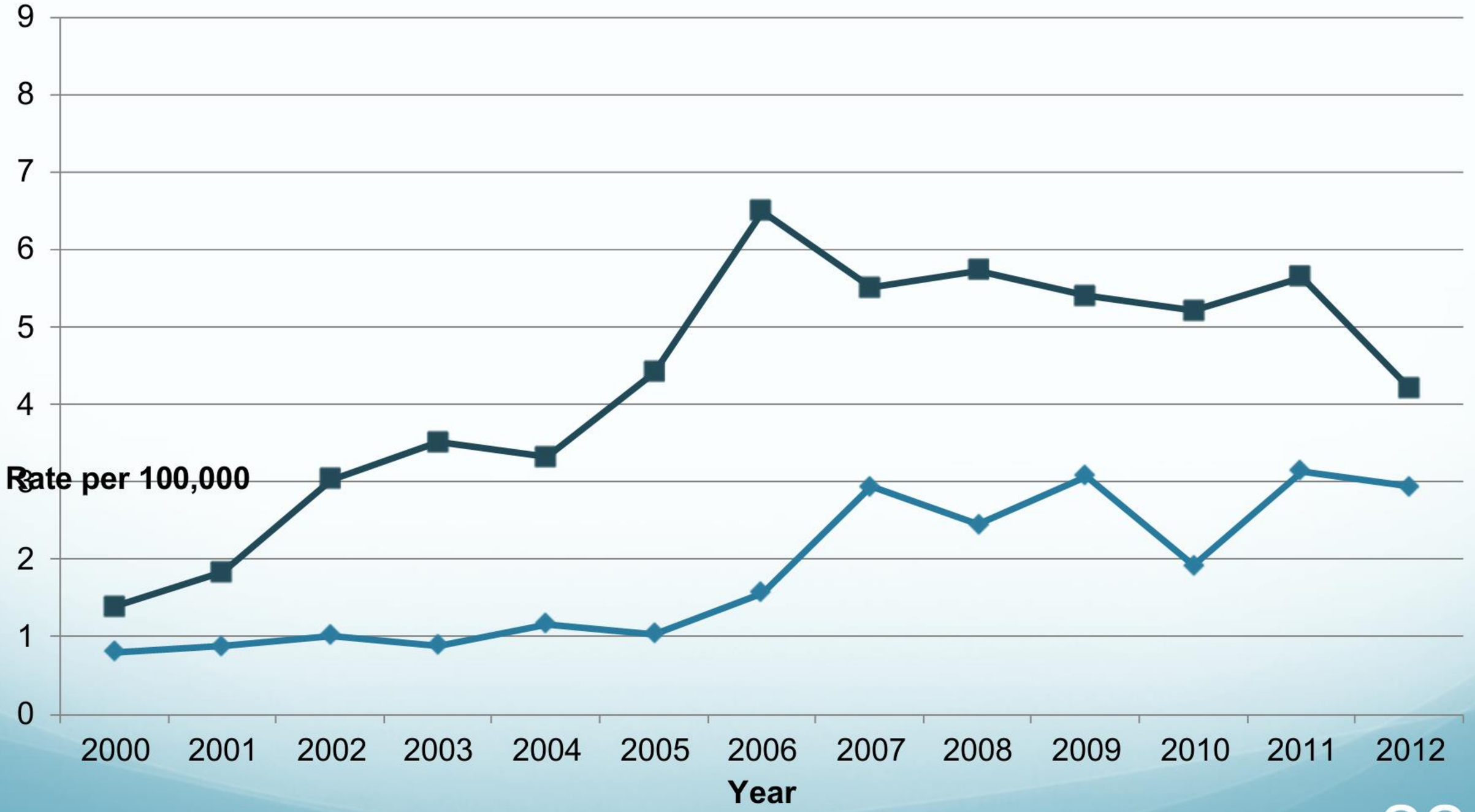


Figure 1. Unintentional and Undetermined Prescription Opioid Poisoning Deaths and Death Rates, Oregon, 2000–2013

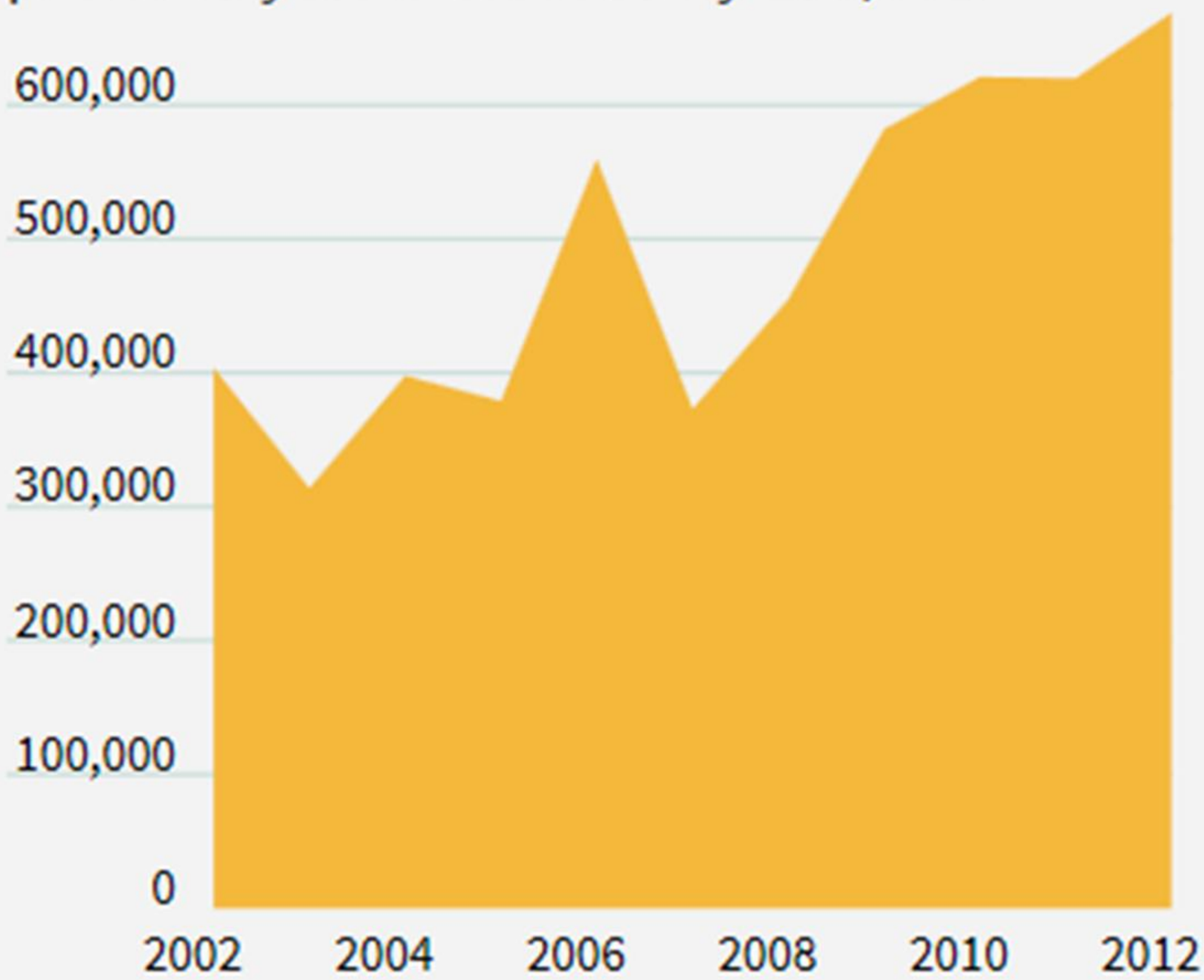


Unintentional or undetermined prescription opioid and heroin overdose death rate by year, Oregon, 2000-2012



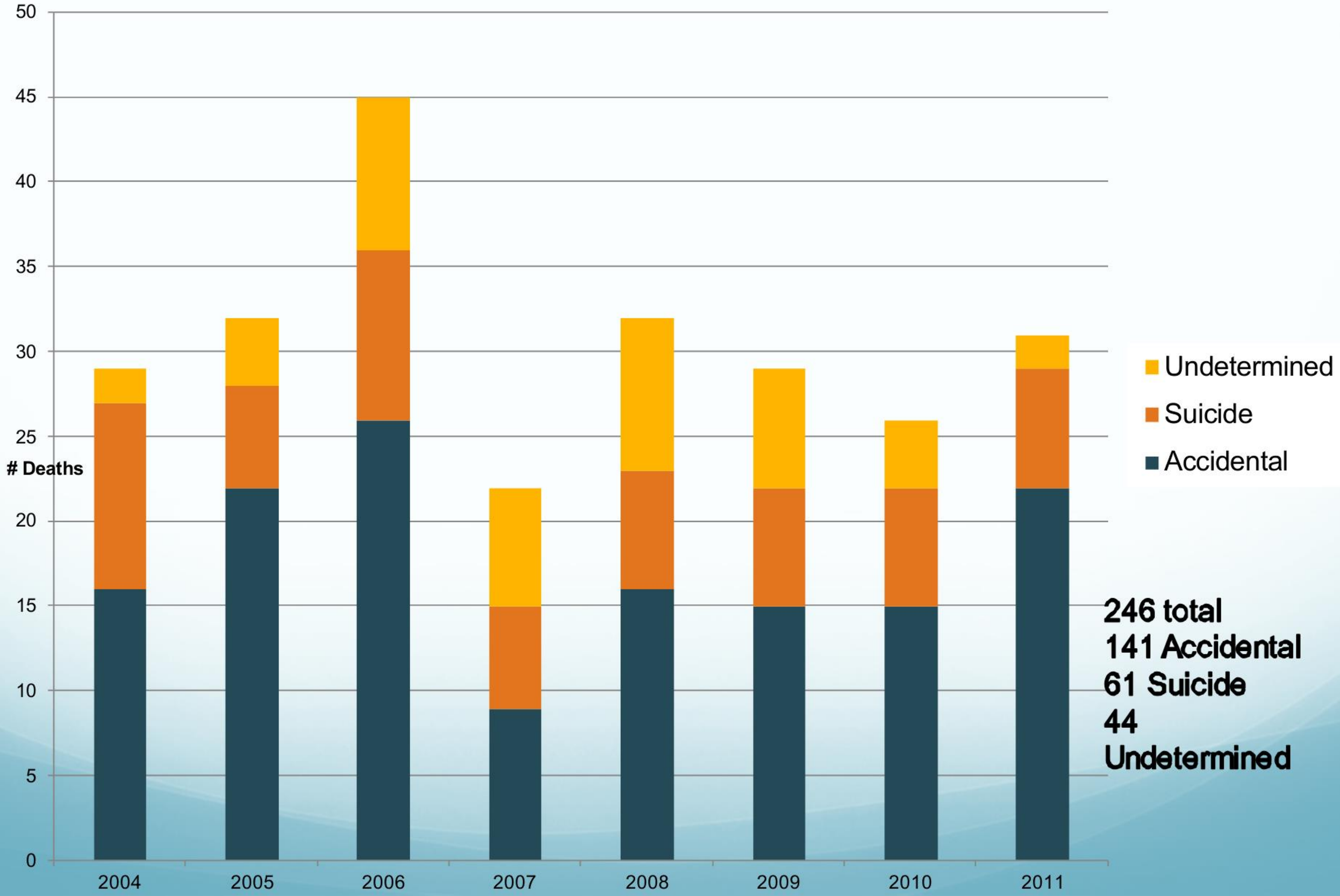
U.S. HEROIN USE BY YEAR

Between 2002 and 2012, the number of people who reported using heroin within the previous year increased by 265,000.

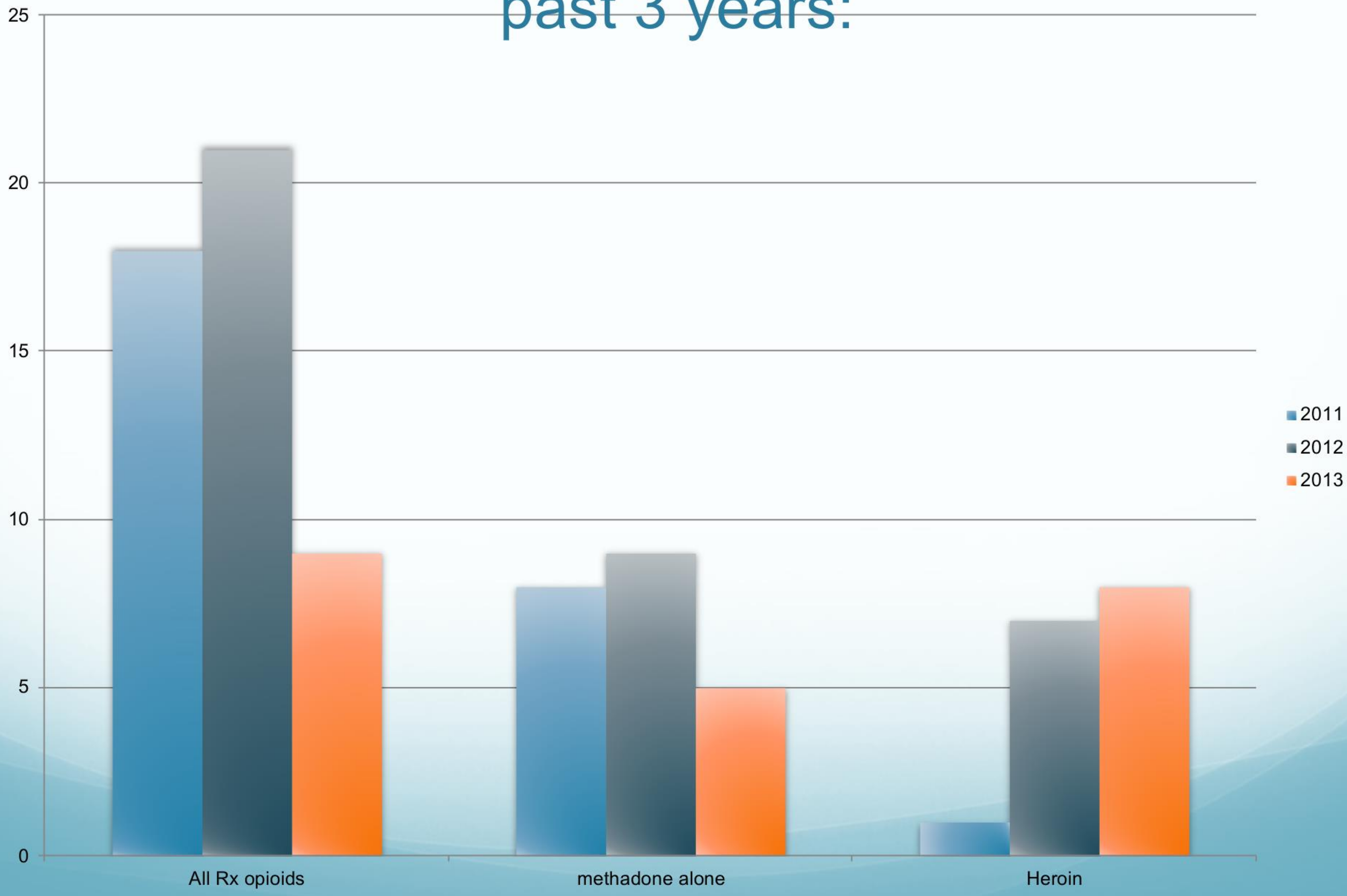


Source: Substance Abuse and Mental Health Services Administration

Overdose Deaths 2004-2011 Jackson County Oregon



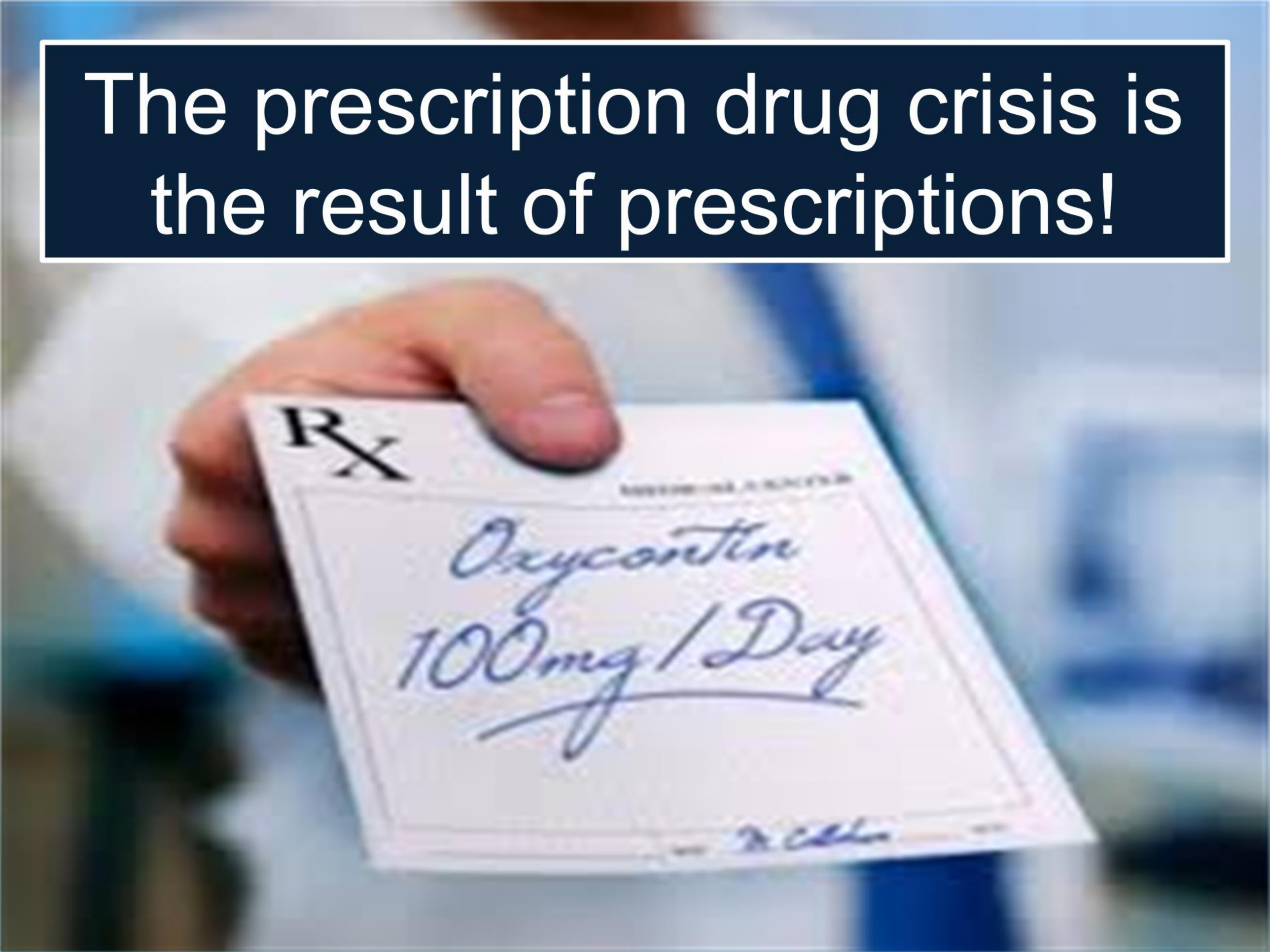
Jackson County accidental overdose data for the past 3 years:



Where does overdose data come from?

- Individual dies and is investigated by the deputy Medical Examiner or Coroner
- Data integrity can depend upon recognition of the problem and other factors
- If no crime is suspected, evidence collection varies greatly depending on jurisdiction and available funding.

The prescription drug crisis is the result of prescriptions!



Oregon Pain Guidance (OPG)

- Started as a public health initiative to reduce opioid overdoses by addressing the problem at its core: medical providers

- OPG evolution:

Brainstormed >

Created guidelines >

Worked toward

guideline acceptance

OPG
OPIOID PRESCRIBERS GROUP

GUIDELINES

FOR THE EVALUATION AND TREATMENT OF COMPLEX CHRONIC NON-CANCER PAIN

BEGIN

ASSESSMENT [1]

› Review medical history, including records from previous providers.
› Administer a physical to determine baseline function and pain.
› What prior attempts were made to treat this pain with non-opioid modalities?
› Is the diagnosis appropriate for opioid treatment?[2]
› Psycho-social and risk assessment: Risk of medication abuse (e.g., ORT), Psychiatric co-morbidity (e.g., PHQ-4).
› Sleep risk assessment (e.g., STOP BANG or equivalent).

GREEN LIGHT

NON-OPIOID OPTIONS

› Create a plan of treatment with patient that incorporates non-opioid interventions.
› Patient Lifestyle Improvement: exercise, weight loss.
› Behavioral Therapies: support/education groups, case management, psychotherapies.
› Physiotherapy Modalities: OT, PT, passive modalities.
› Medical Interventions: pharmacological, procedural, surgical.

AT EVERY VISIT

SUBSTANCE ABUSE REFERRALS

› Know your community partners and use them!
› Co-management with outside specialists is encouraged with all pain treatment plans.

CAUTION

OPIOID TREATMENT

PROCEED WITH CAUTION!

› Perform UDS prior to prescribing.[4]
› Check for evidence of existing abuse (PDMP).
› Patient signs a treatment agreement.[6]
› Agree and document treatment goals.

AT *EVERY* VISIT!

› Assess for changes in function and pain.
› Evaluate progress on treatment goals.
› Assess for aberrant behaviors.[7]
› Assess for adverse side-effects.[8]

If no improvement or aberrant behavior or adverse side effects are observed, stop and reassess!

STOP!

STOP! REASSESS

› If you have concerns from your visit assessment, seek help from community partners or other specialists.

CAUTION: Re-evaluate your treatment plan/seek help of specialists if you are:

› Prescribing more than 120 MED/day without obvious functional improvement.[9]
› Prescribing opioids with benzodiazepines.
› Prescribing more than 40 mg of methadone/day.

AllCare®
HEALTH PLAN

Summary of guidelines:

- Don’t prescribe opioids for CCNP on the first visit: Assess the patient!
- Encourage non opioid treatments. They really work.
- Titrate treatment against functional improvement.
- Learn how to compassionately say “No.”
- Keep MED below 120, and methadone below 40 mg.
- Incorporate assessment for aberrant behaviors into your management (UDS, PDMP, pill counts, call backs)
- Don’t combine benzodiazepines and opioids
- Seek assistance when necessary

WWW.OREGONPAINGUIDANCE.ORG

- Provider resources
- Patient resources
- Public resources
- Supported by Medicaid insurance plans and Public Health
- Please link us to your websites

What are we doing in Jackson County?

- Medicaid Insurance Plans adopting 120 MED policy
- Providing education to the public, providers, patients
- Providing alternative therapies for chronic pain patients, that don't rely on opioids
- Looking for data to drive decision making

This is where you come in

We need epidemiologic data to drive our efforts

What data do we need?

- Accurate overdose trends:
  - ED and hospital admits
    - What drugs were involved?
    - What combination of drugs?
    - What post discharge actions were taken?
  - Medical Examiner reports: with toxicology results.
    - Variation in local ME reports
    - Correlation with Prescription Drug Monitoring Program (PDMP) data
  - Drug-drug combinations (opioids plus benzodiazepines e.g.)
  - Linkage of prescriber, pharmacy, insurance claims data

- What will that tell us?
  - Whether specific interventions were reducing mortality and morbidity.

Data: Morphine Equivalent Dose (MED)

- All prescribed opioids can be reduced to a morphine dosage equivalent. E.g. 30 mg of Oxycodone = 40 MED.
- Electronic Medical Records hold that data. However, very hard to obtain.
- PDMP. Need changes to what data they collect so they could provide MED.
- Pharmacy, CCO and other payer's data.
- What will that tell us?
  - Whether providers are actually changing their prescribing patterns in response to PH actions
  - Common language to provide feedback to prescribers

More:

- Treatment program admissions:
  - Graduation rates analyzed by drug of choice
  - Treatment success measured by long term abstinence.
- Who is doing the prescribing?
  - Granular feedback to the prescribers concerning their prescribing behaviors.
- What interventions make a difference in prescribing patterns?
- Where are the knowledge gaps for prescribers?

Thank You

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