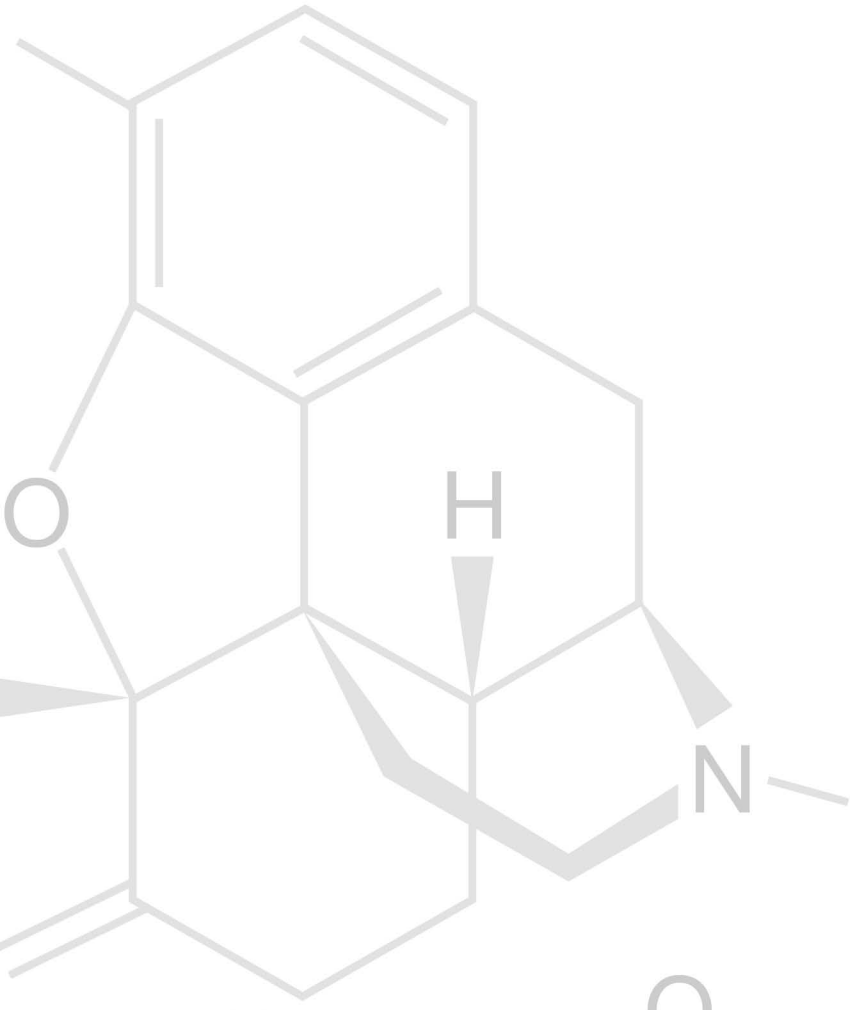
FOR PRESCRIBERS

ADDRESSING THE OPIOID CRISIS

IN THE ACUTE CARE SETTING



ADDRESSING AMERICA'S DRUG EPIDEMIC

NSC.ORG

NATIONAL SAFETY COUNCIL®

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National Safety Council
Itasca, IL

Professional Background:

Attending Physician, Assistant Professor
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President-Elect
DC Chapter, American College of Emergency Physicians (ACEP)
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NSC MISSION

The National Safety Council eliminates preventable deaths at work, in homes and communities, and on the road through leadership, research, education and advocacy.

OBJECTIVES

1. Reinforce the scope and etiology of the opioid epidemic.
2. Describe acute pain and its effective treatment.
3. Compare the risks and benefits of opioid and non-opioid analgesics for pain management.
4. Become familiar with evidence-based guidelines for pain management at multiple organizational levels.

OBJECTIVES

5. Describe patient and prescriber misconceptions surrounding opioid use.
6. Become an advocate for safer analgesic prescribing.
7. Understand the basics of opioid use disorder treatment.
8. Become familiar with keys sources of information and services available to prescribers.

OPIOID DEFINITION

20.8 MILLION PEOPLE IN THE U.S. ARE LIVING WITH A SUBSTANCE USE DISORDER

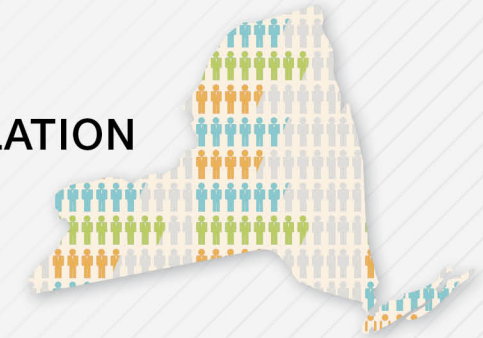
NUMBER OF PEOPLE
WHO HAVE DIABETES

1.5
TIMES

THE NUMBER OF
PEOPLE WHO HAVE **ALL**
CANCERS COMBINED

19+
MILLION

MORE THAN THE POPULATION
OF NEW YORK STATE

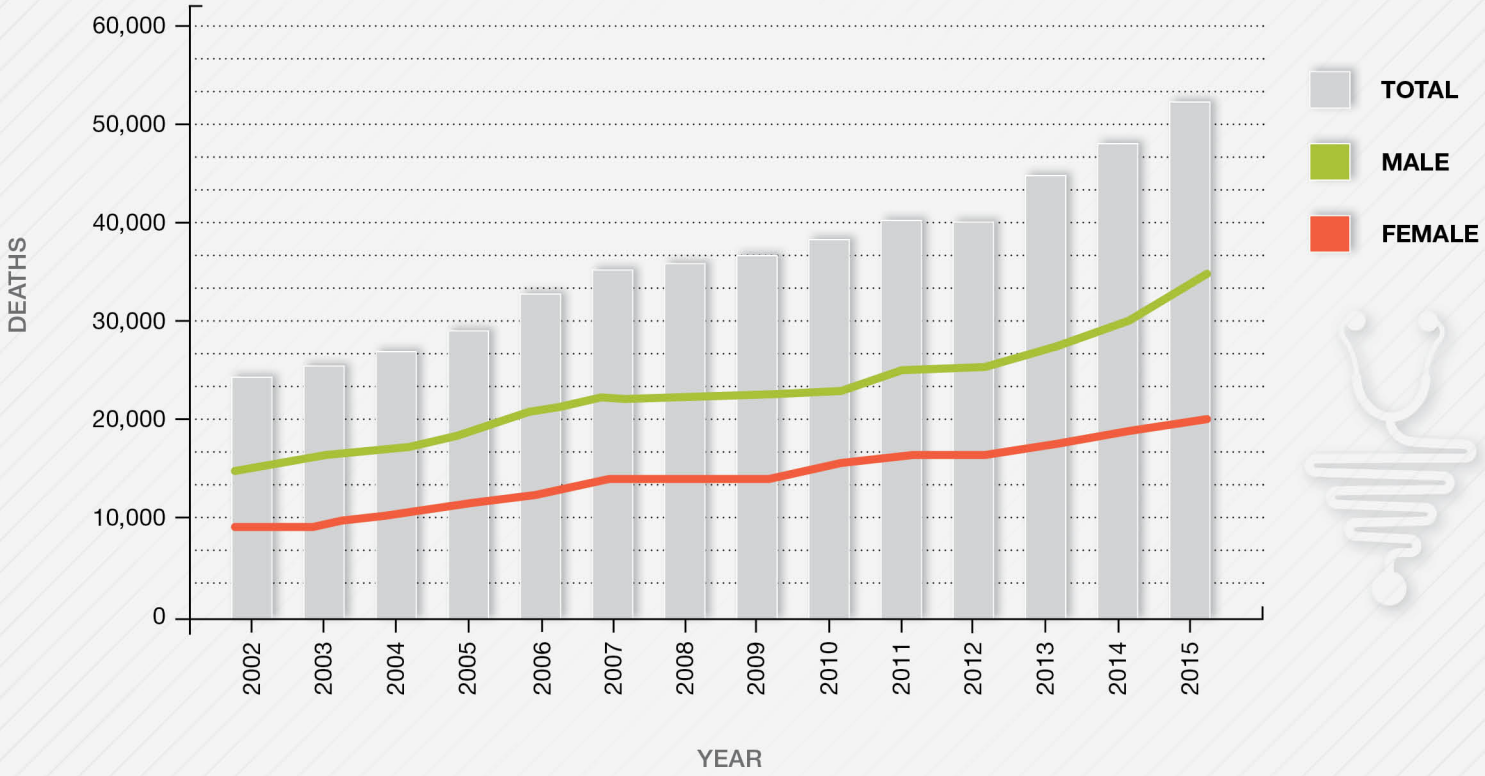


DRUG **OVERDOSES**

Cause more deaths than vehicle crashes

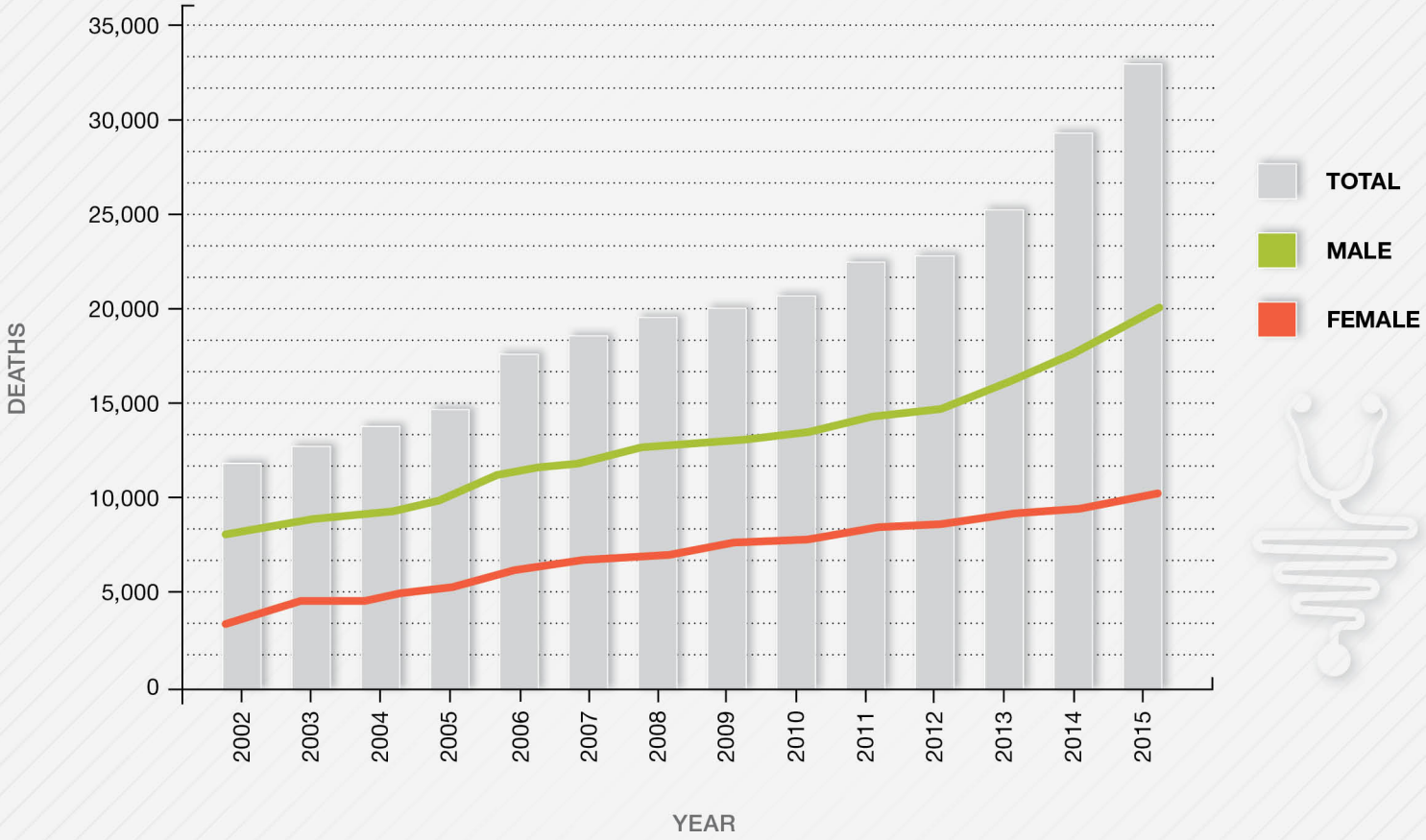
Biggest contributor is **prescription painkillers**

NATIONAL OVERDOSE DEATHS
NUMBER OF DEATHS FROM **ALL DRUGS**



National Center for Health Statistics, CDC Wonder

NATIONAL OVERDOSE DEATHS
NUMBER OF DEATHS FROM **OPIOID DRUGS**



National Center for Health Statistics, CDC Wonder

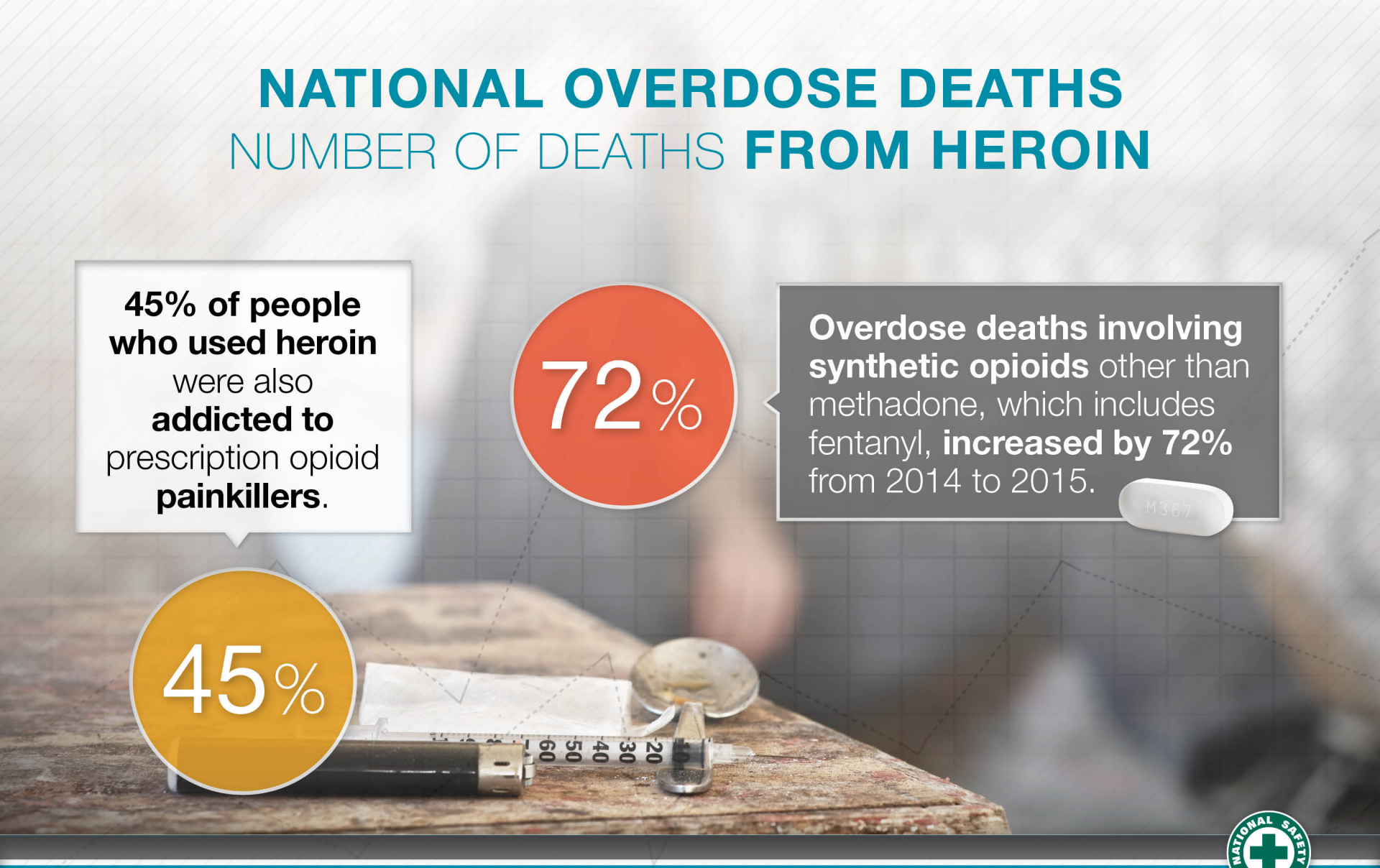
NATIONAL OVERDOSE DEATHS
NUMBER OF DEATHS **FROM HEROIN**

45% of people who used heroin were also **addicted to** prescription opioid **painkillers**.

45%

72%

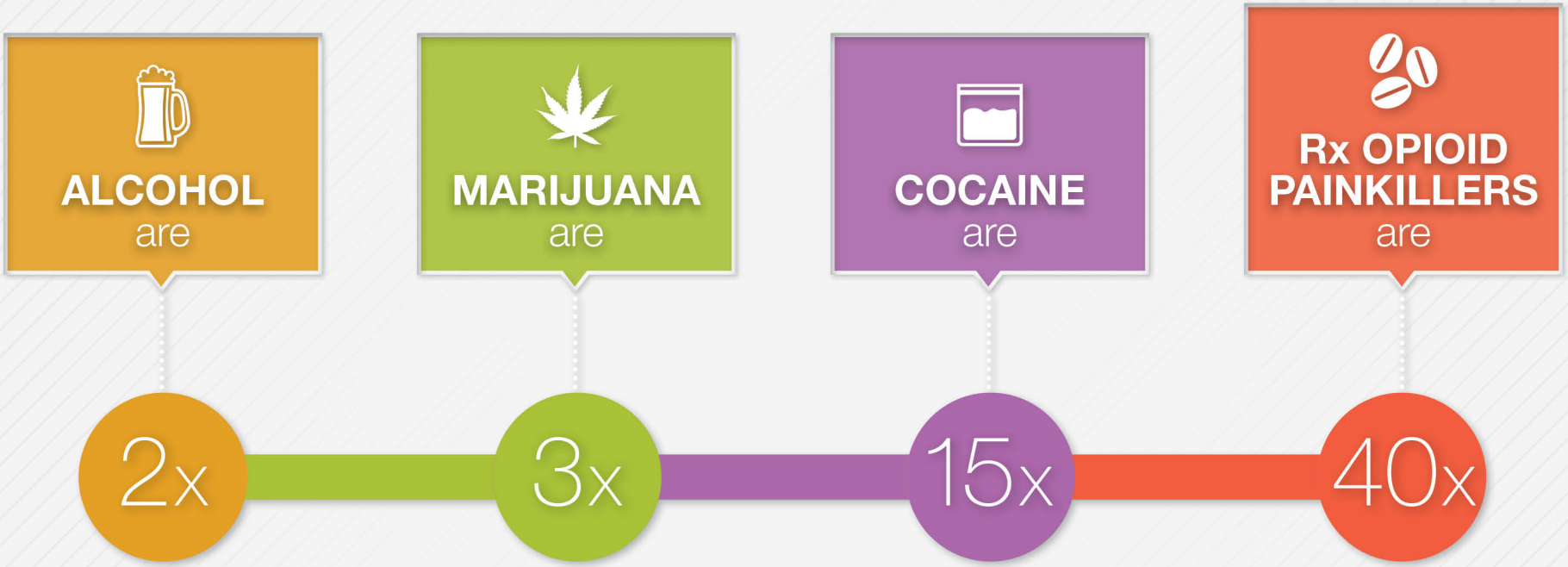
Overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, **increased by 72%** from 2014 to 2015.



Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths - United States, 2010–2015. MMWR Morb Mortal Wkly Rep. ePub: 16 December 2016. DOI: http://dx.doi.org/10.15585/mmwr.mm6550e1.

Peterson AB, Gladden RM, Delcher C, Spies E, Garcia-Williams A, Wang Y, et al. Increases in fentanyl-related overdose deaths - Florida and Ohio, 2013-2015. Morb Mortal Wkly Rep. 2016;65(33):844-9.

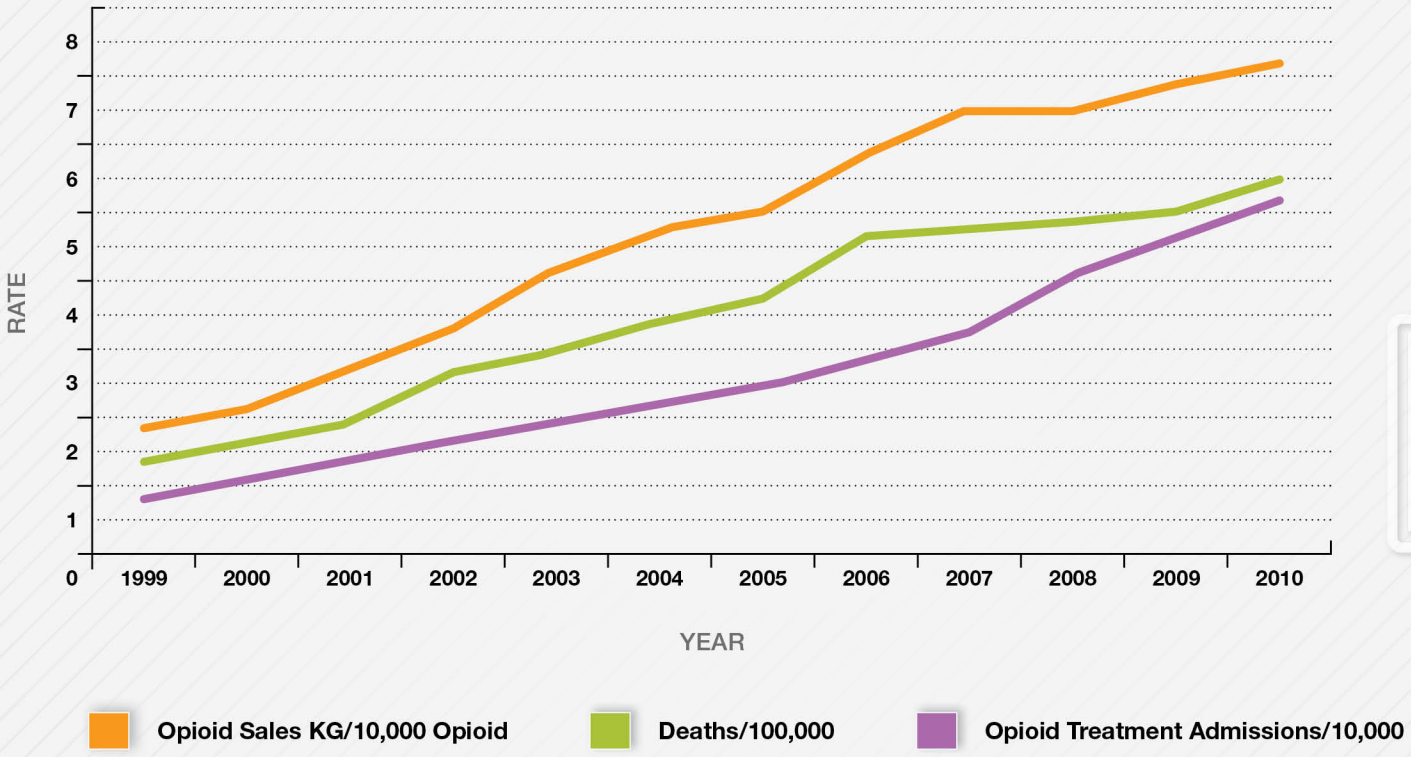
PEOPLE WHO ARE **ADDICTED TO** …



… MORE LIKELY TO BE **ADDICTED TO HEROIN.**

National Survey on Drug Use and Health (NSODUH), 2011-2013

RATES OF **OPIOID OVERDOSE DEATHS**, **SALES** AND **TREATMENT ADMISSIONS**, 1999-2010



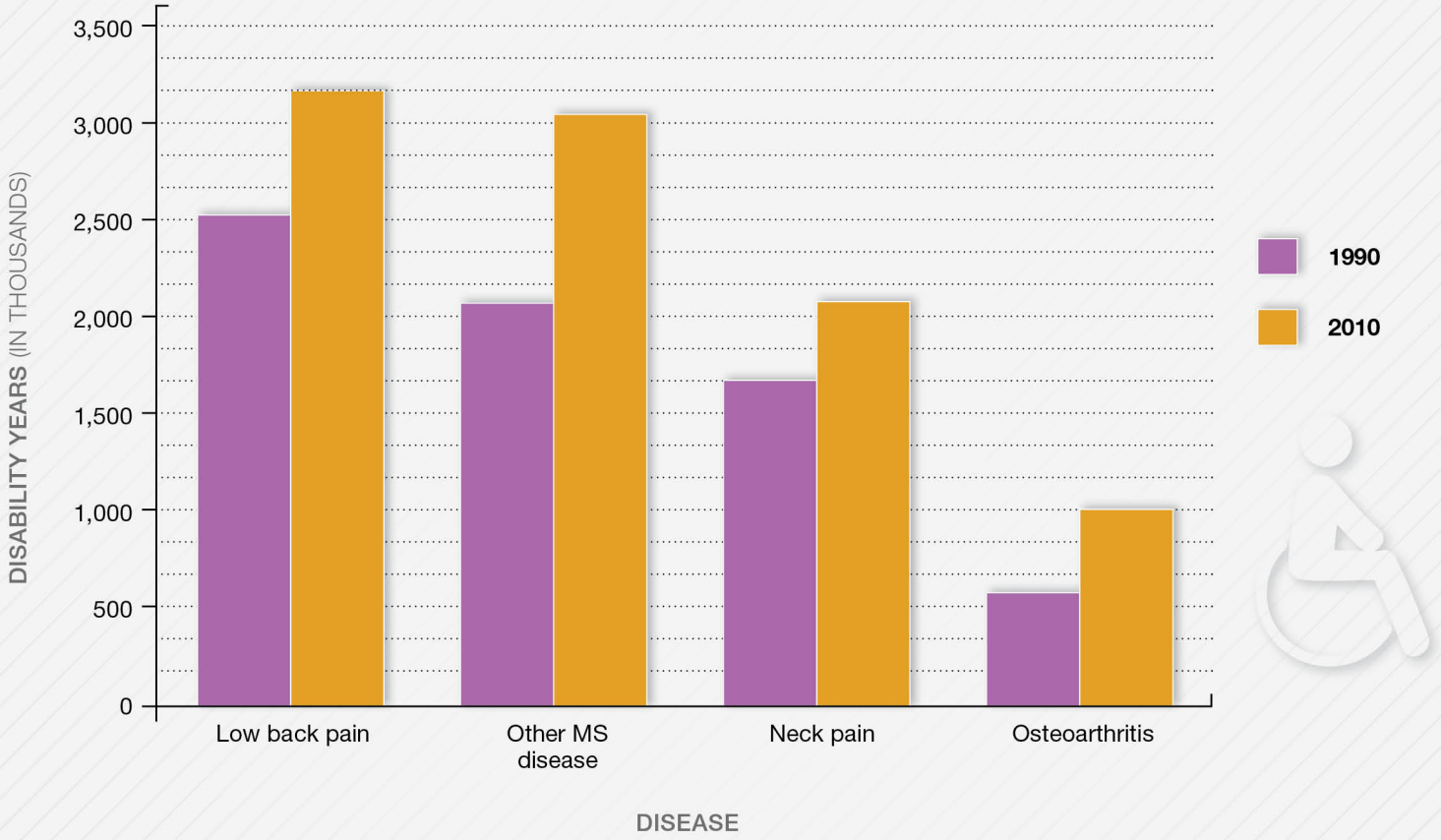
National Vital Statistics System, DEA's Automation of Reports

INCREASE IN **PRESCRIBING TRENDS**

STATE OF U.S. HEALTH

YEARS LIVED WITH DISABILITY

(IN THOUSANDS)



Murray, C. (2013). The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA : The Journal of the American Medical Association, 310(6), 591–608.

PAIN DEFINITION

An unpleasant **sensory** and **emotional** experience associated with actual or potential tissue damage, or described in terms of such damage

ACUTE PAIN

< 3 months

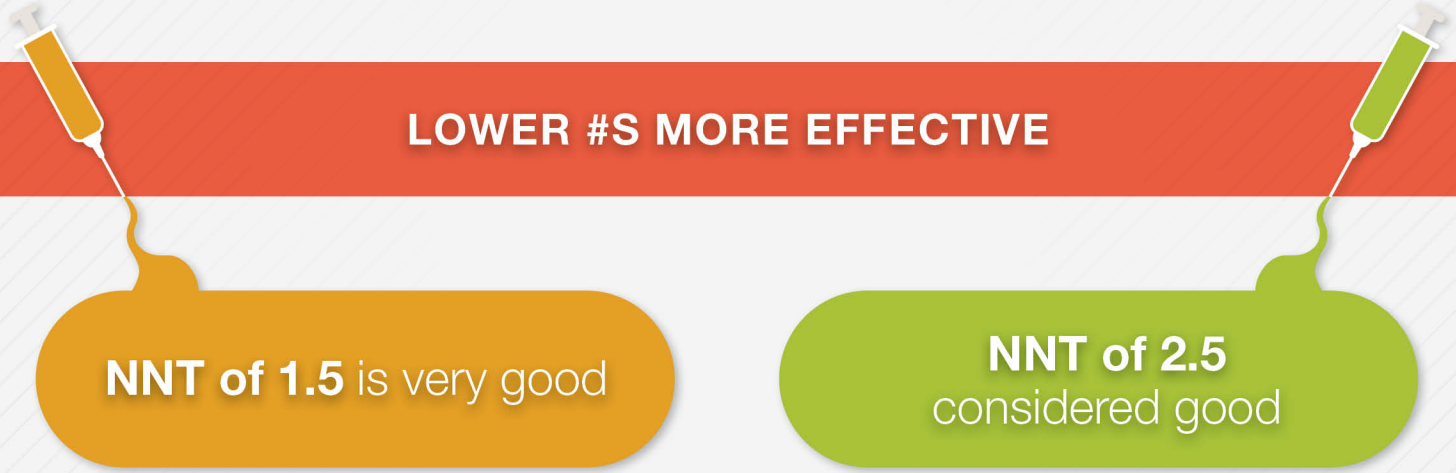
CHRONIC PAIN

> 3 months

International Association for the Treatment of Pain

NUMBER NEEDED TO TREAT (NNT)

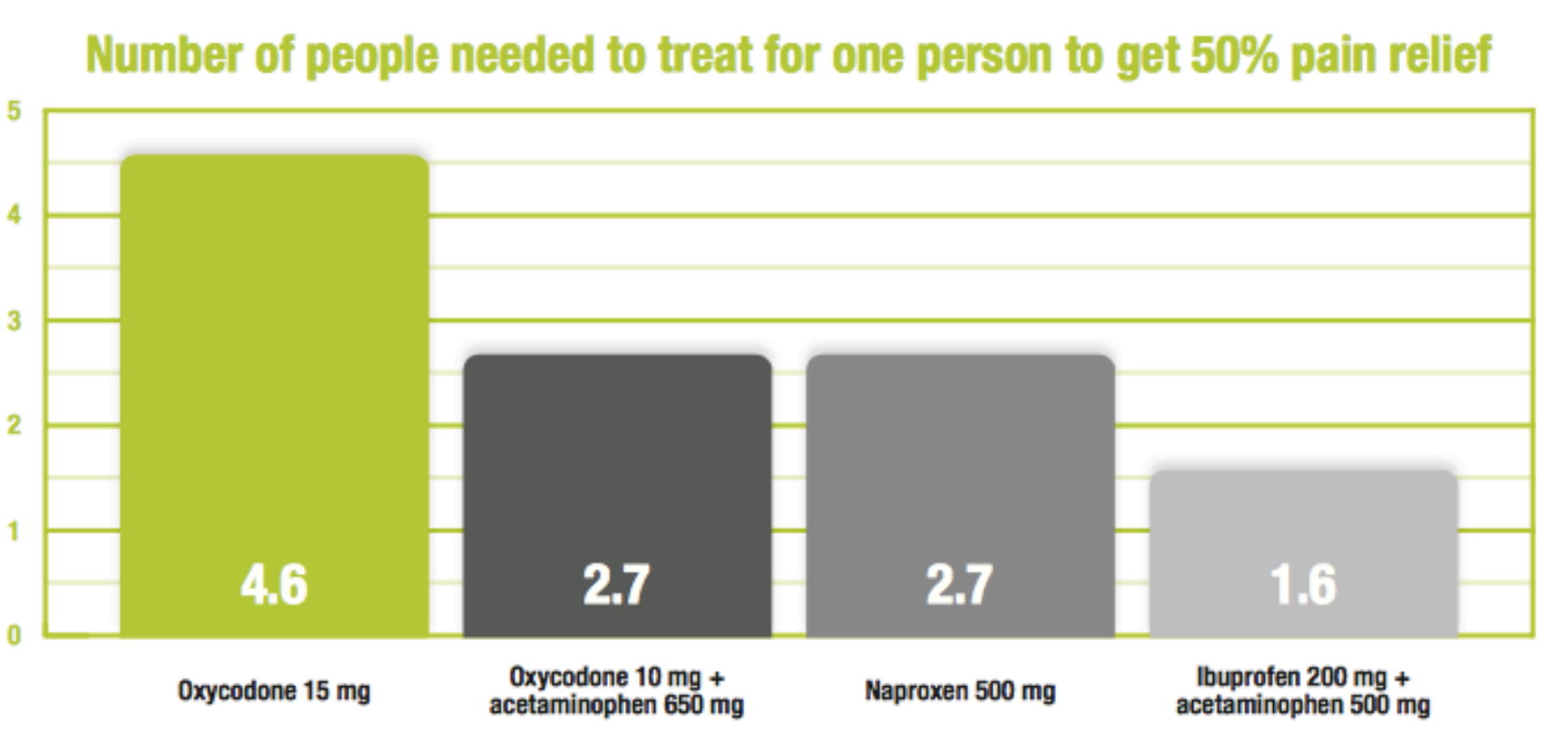
NNT = number of people who must be treated by a specific intervention for 1 person to receive a certain effect



50% PAIN RELIEF CONSIDERED EFFECTIVE PAIN TREATMENT.†

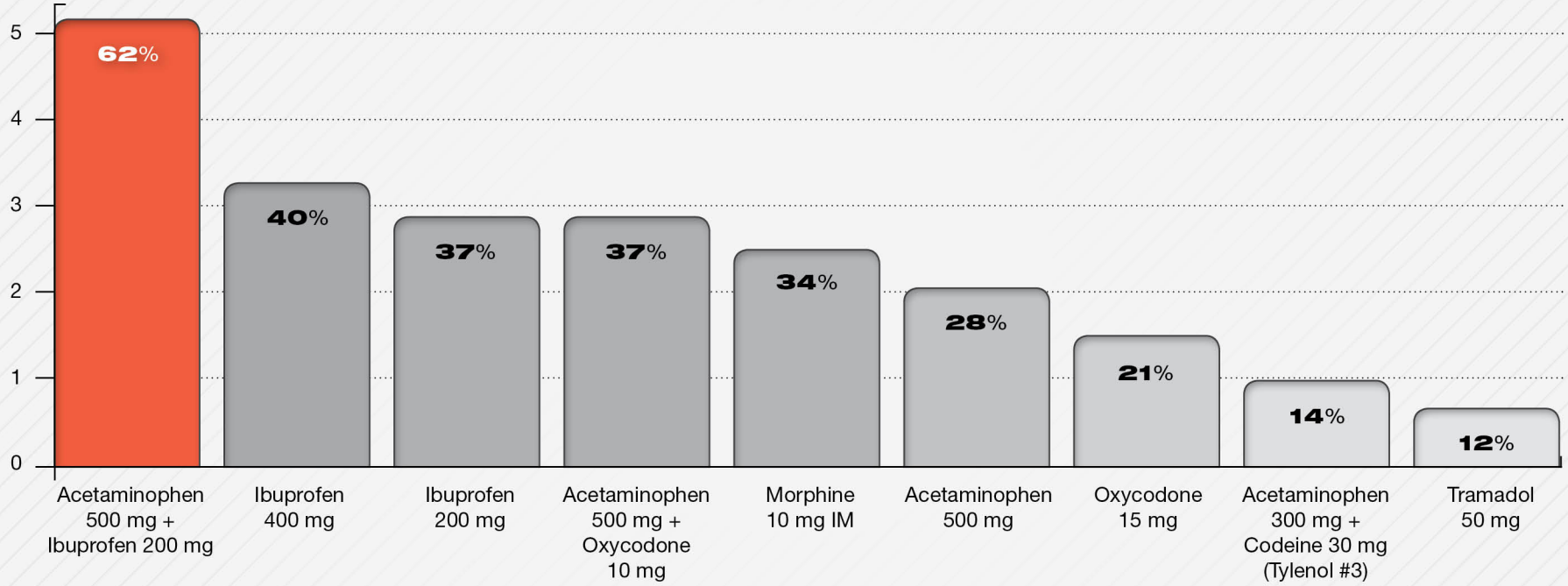
†*Cochrane, org. 2014*

EFFICACY OF MEDICATIONS
FOR ACUTE PAIN



Cochrane research cited in the NSC white paper, Evidence for the Efficacy of Pain Medications

EFFICACY OF PAIN MEDICATIONS
FOR ACUTE PAIN



Cochran research cited in the NSC white paper, Evidence for the Efficacy of Pain Medications

OPIOID ANALGESICS

NON-OPIOID ALTERNATIVES

- Acetaminophen
- NSAIDs
- Anticonvulsants
  - Gabapentin, Pregabalin
- Tricyclic Antidepressants
  - Amitriptyline, nortriptyline…etc.
- Other Antidepressants
  - SNRI – Cymbalta, Savella, Effexor
- Muscle Relaxants
  - Flexeril, Skelaxin, Zanaflex…etc.
- Topicals

"KEEP OPIOID NAÏVE PATIENTS OPIOID NAÏVE"

NON-OPIOID ANALGESICS: **ACETAMINOPHEN**

BENEFITS	RISKS
✓ Antipyretic	✓ No anti-inflammatory properties
✓ 3.5 NNT for 500 mg for 50% pain relief	✓ Acute liver injury in high doses or chronic dosing
✓ Safe in almost all patients at <4g per day	
✓ Minimal GI side effects	
✓ Oral and IV options	

NON-OPIOID ANALGESICS: **NSAIDS**

BENEFITS	RISKS
✓ Antipyretic	✓ GI and renal side effects
✓ Anti-inflammatory	✓ Increased cardiovascular risk
✓ 2.7 NNT for 50% pain relief (Ibuprofen 200 mg)	✓ interference with blood thinners
✓ Oral, IM and IV	✓ Lower doses are less likely to cause these issues

NON-OPIOID ANALGESICS: **ANTI-SEIZURES**

BENEFITS	RISKS
✓ Can be used daily to prevent/treat pain, twice to three times per day dosing ✓ 3+ NNT	✓ Dizziness, somnolence, peripheral edema, weight gain, asthenia, headache and dry mouth

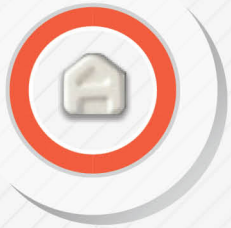
NON-OPIOID ANALGESICS:
TRICYCLIC ANTIDEPRESSANTS

BENEFITS	RISKS
✓ Can be used daily to prevent/treat pain, once a day dosing	✓ Dry mouth, sweating, dizziness, blurred vision, drowsiness and constipation
✓ 3+ NNT	✓ Cardiovascular (arrhythmia, palpitations and hypotention)
✓ Less anticholinergic action and side effects with Imipramine and Nortriptyline	✓ Sedation and urinary retention
✓ More anticholinergic activity and side effects with Amitriptyline but may be more efficacious	✓ Cognitive/confusion
✓ Can help with sleep	✓ Gait disturbance/falls

NON-OPIOID ANALGESICS: **SNRIs**

BENEFITS	RISKS
✓ Can be used daily to prevent/treat pain, once to twice a day dosing ✓ 3+ NNT	✓ Nausea, somnolence, dry mouth, constipation, reduced appetite, diarrhea, hyperhidrosis and dizziness ✓ Rare elevations of plasma glucose, hepatic enzymes or blood pressure reported with Duloxetine

COMMONLY PRESCRIBED
BENZODIAZEPINES



ATIVAN

HALCION

KLONOPIN

ROHYPNOL

VALIUM

XANAX

NON-OPIOID ANALGESICS: **TOPICAL ANALGESICS**

BENEFITS	RISKS
✓ Can be used daily to treat/ prevent pain	✓ Local adverse reactions (skin irritation)
✓ Generally safe with low absorption	

NON-PHARMACOLOGICAL TREATMENTS

FOR PAIN

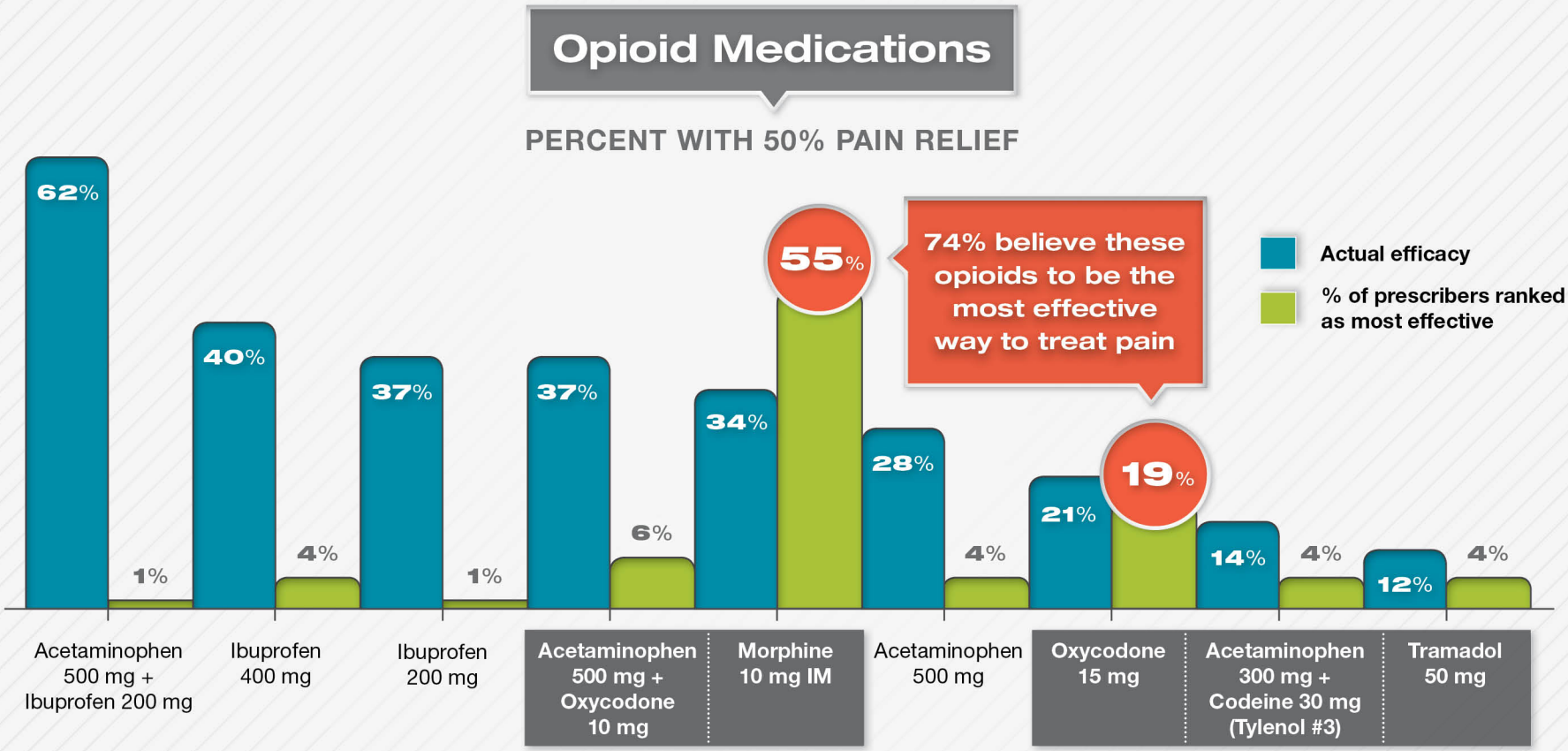
NON-PHARMACOLOGICAL TREATMENTS

FOR PAIN

INTERVENTIONAL TECHNIQUES

- Muscular injections
  - Trigger point injections
- Joint injections
  - Shoulder, knee, bursa, etc.
- Nerve blocks
  - Occipital nerve block for headache
  - Stellate ganglion block for complex regional pain syndrome
  - Dental anesthesia
- Spine
  - Epidural steroid injection
  - Sacroiliac joint procedures (injection, radiofrequency)
  - Facet procedures (injection, radiofrequency)
- Neuromodulation
  - Spinal cord stimulators/peripheral nerve stimulators
  - Implantable pain pumps
- Botulinum Toxin A
  - Chronic migraine
  - Possible treatment for chronic pain

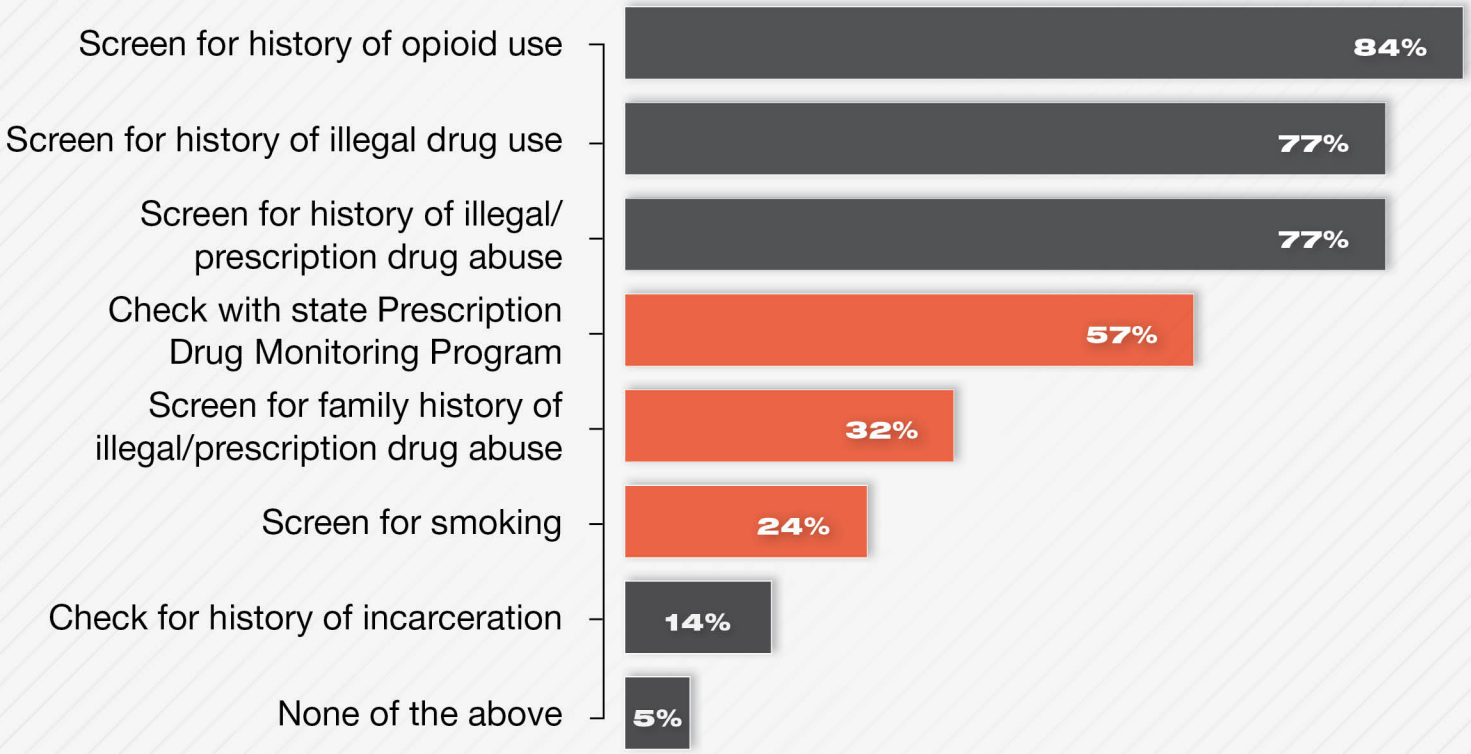
OPIOIDS EFFICACY & SAFER ALTERNATIVES



(Blue) Cochran research cited in the NSC white paper, Evidence for the Efficacy of Pain Medications; (Green) NSC Rx Study – Q8. Please rank the following medications in terms of how successful you feel they are at providing pain control or relief. (Total –n=201)

ONLY 32% SCREEN
FOR FAMILY HISTORY OF ADDICTION

Actions taken **before** prescribing opioids



Source: NSC Rx Study - Q12. Which of the following do you regularly do before prescribing a patient an opioid pain medication? ? (Total - n=201)

PRESCRIPTION OPIOID PAINKILLERS:
NSC PUBLIC OPINION POLL, 2015

Don't know painkillers contain opioids or it is a felony to share them

Unconcerned about addiction, but most have reason to worry given risk factors

KEY FINDINGS

PUBLIC POLL

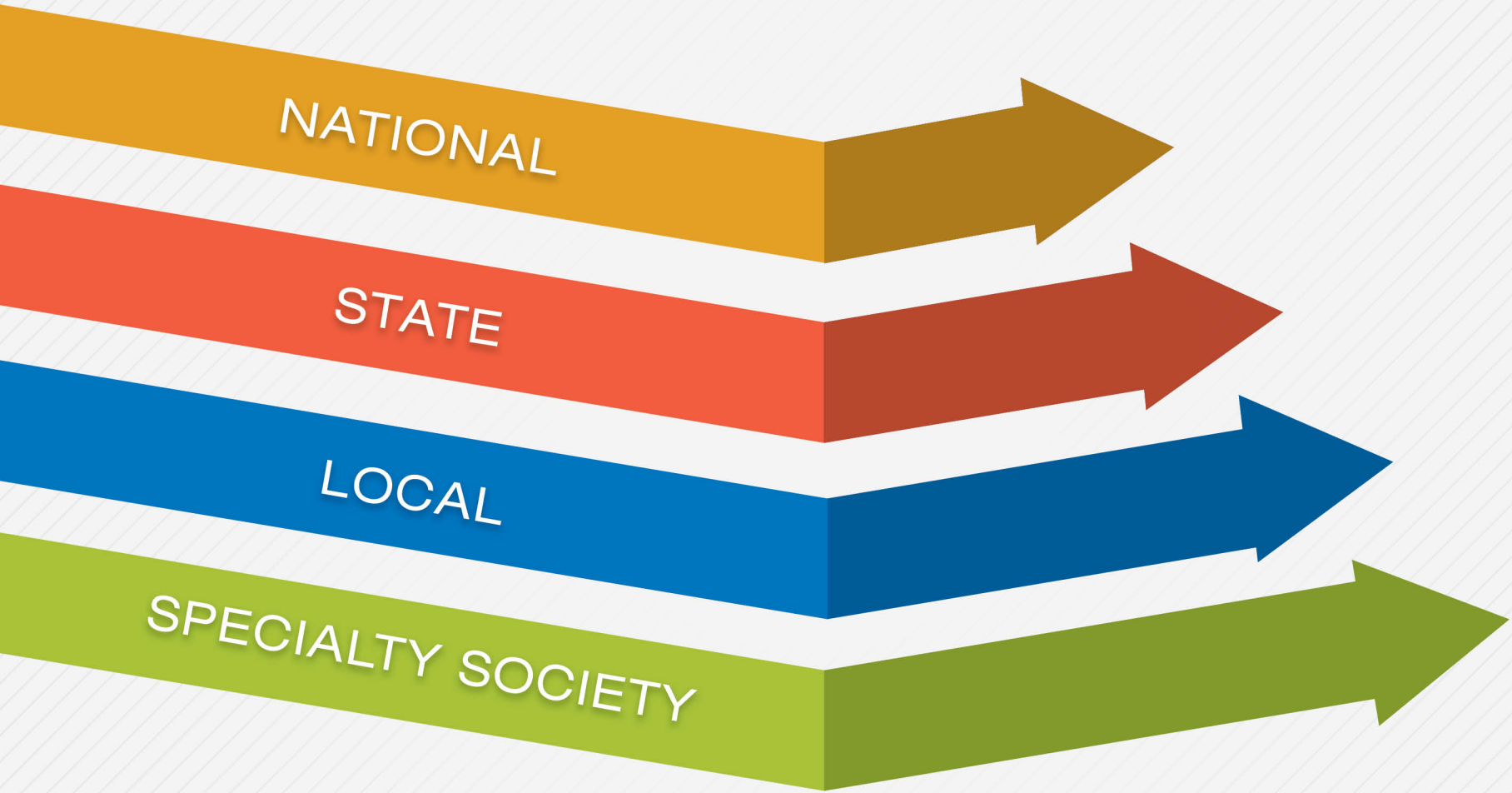
Overestimate benefits and underestimate risks of addiction or death

PATIENT EXPECTATIONS IMPACT DECISION TO PRESCRIBE OPIOIDS

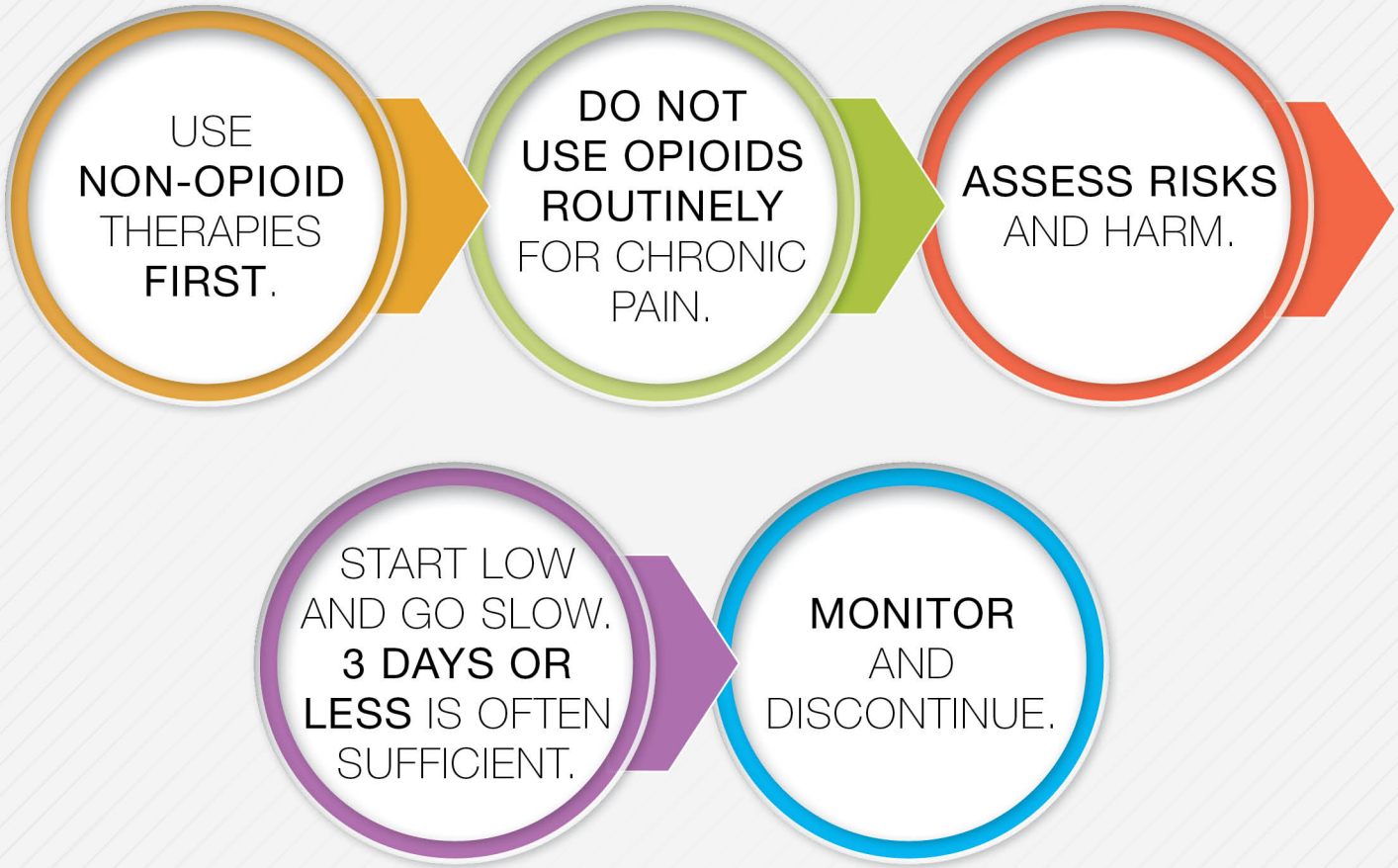
PATIENT EXPECTATIONS ARE A BARRIER TO PRESCRIBING ALTERNATIVES TO OPIOIDS

NSC Rx Study: Q11. Which of the following would you say impacts your decision to prescribe opioid pain medication to patients? (Total - n=201); Q15. Which of the following, if any, do you feel are barriers to prescribing NSAID or other alternatives to opioid pain medication? (Total - n=201); Q.19 What is your likelihood you would visit your doctor again if they offer a range of alternative painkillers for discussion? (Total – n=1,014)

LEVELS OF **EVIDENCE-BASED GUIDELINES**



GENERAL **PRESCRIBING GUIDELINES**



CDC GUIDELINES

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

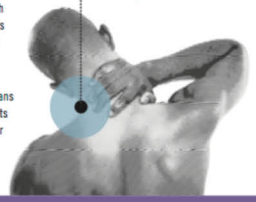
CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid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

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

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

CLINICAL REMINDERS

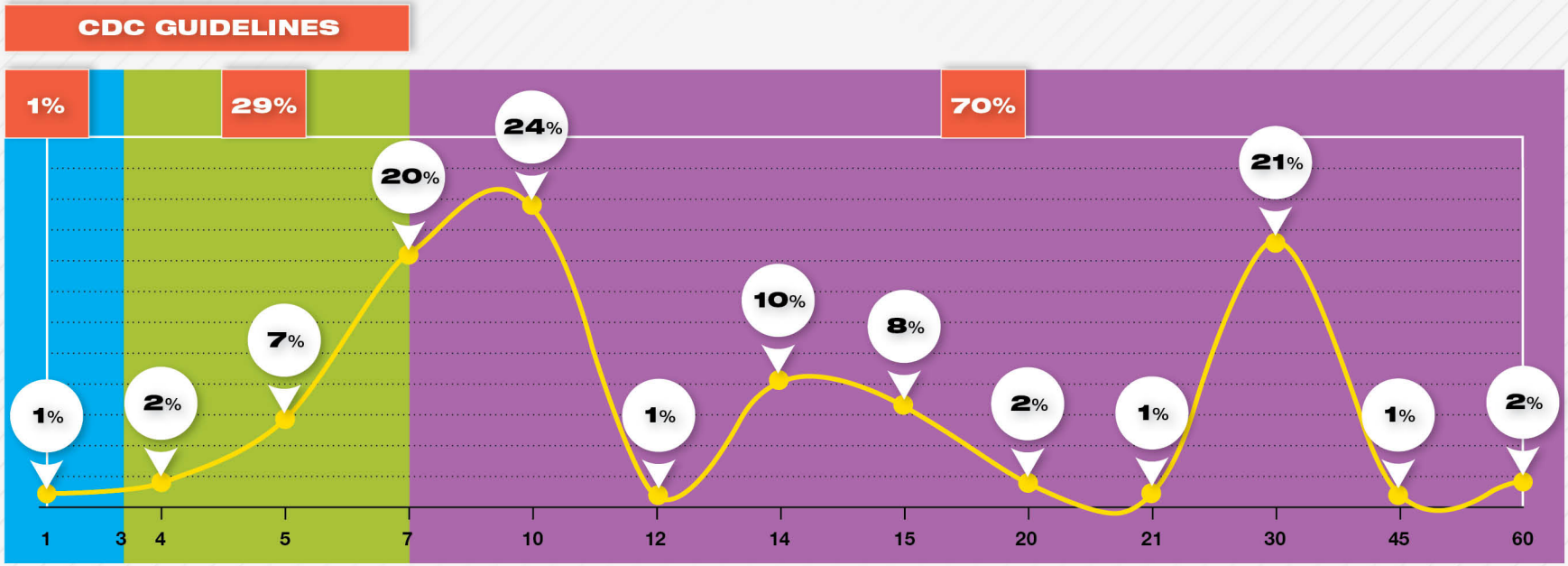
- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



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

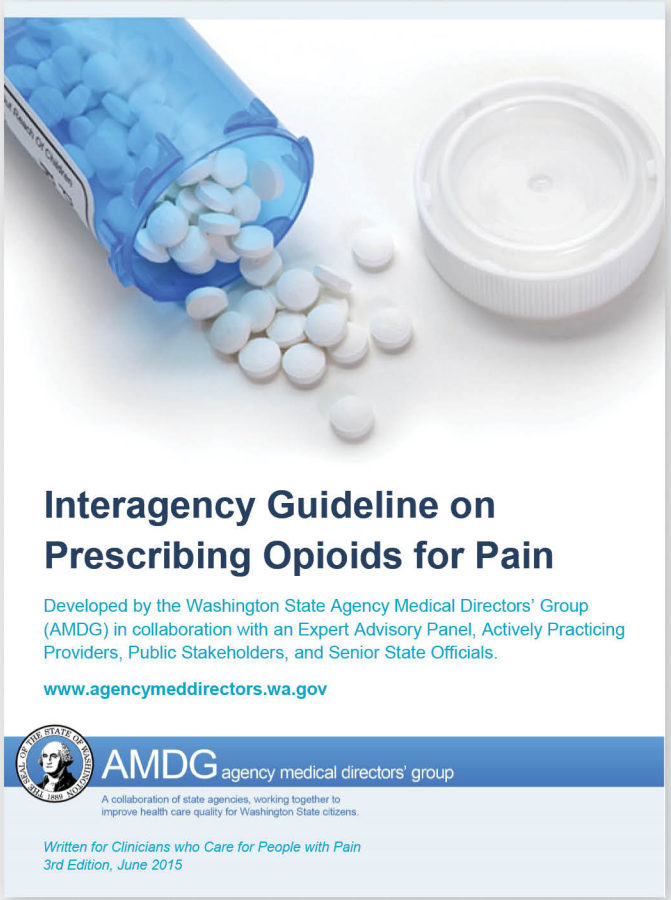
LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

MANY PRESCRIBE OPIOIDS
FOR LONGER THAN CDC GUIDELINE



NSC Rx Study – Q10. For what period of time do you ordinarily prescribe opioid pain medication? (Total - n=201)

STATE GUIDELINES



ER IS FOR EMERGENCIES PROGRAM

RESULTS AFTER ONE YEAR:

- ✓ MEDICAID VISITS FOR CONTROLLED SUBSTANCES DOWN 25%
- ✓ MEDICAID ED COSTS DOWN $34 MILLION

WASHINGTON ED OPIOID
PRESCRIBING GUIDELINES

- Use single prescriber
- Avoid IV/IM formulas
- No opioid replacement scripts
- No LA/ER scripts
- Enforce photo IDs
- 30 pill limit
- Employ SBIRT
- Distribute outpatient resources at POC
- Follow pain contracts
- Contact PCP for acute visits
- Clarify legal concerns

Washington State Medical Association | WSMA

ENA® EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

American College of Emergency Physicians
WASHINGTON CHAPTER
ADVANCING EMERGENCY CARE

Washington State Hospital Association

wsma.org/doc_library/ForPatients/KnowYourChoices/ErisForEmergencies/epodioidabuseguidelinesfinal.pdf

SPECIALTY SOCIETY GUIDELINES

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACOEM
AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

ACEP CLINICAL POLICY
ON OPIOID PRESCRIBING

FOUR **CRITICAL** AREAS

01 Utility of PDMPs

02 Management of acute low back pain

03 Short-acting schedule II vs short-acting schedule III opioids

04 Benefits vs harms of opioids for acute exacerbations of chronic pain

acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/SPIN_trial/Redirects_Control/Opioids%202012%20Clinical%20Policy%20Guideline.5.pdf

LOCAL GUIDELINES
ALTO PROGRAM PROTOCOLS

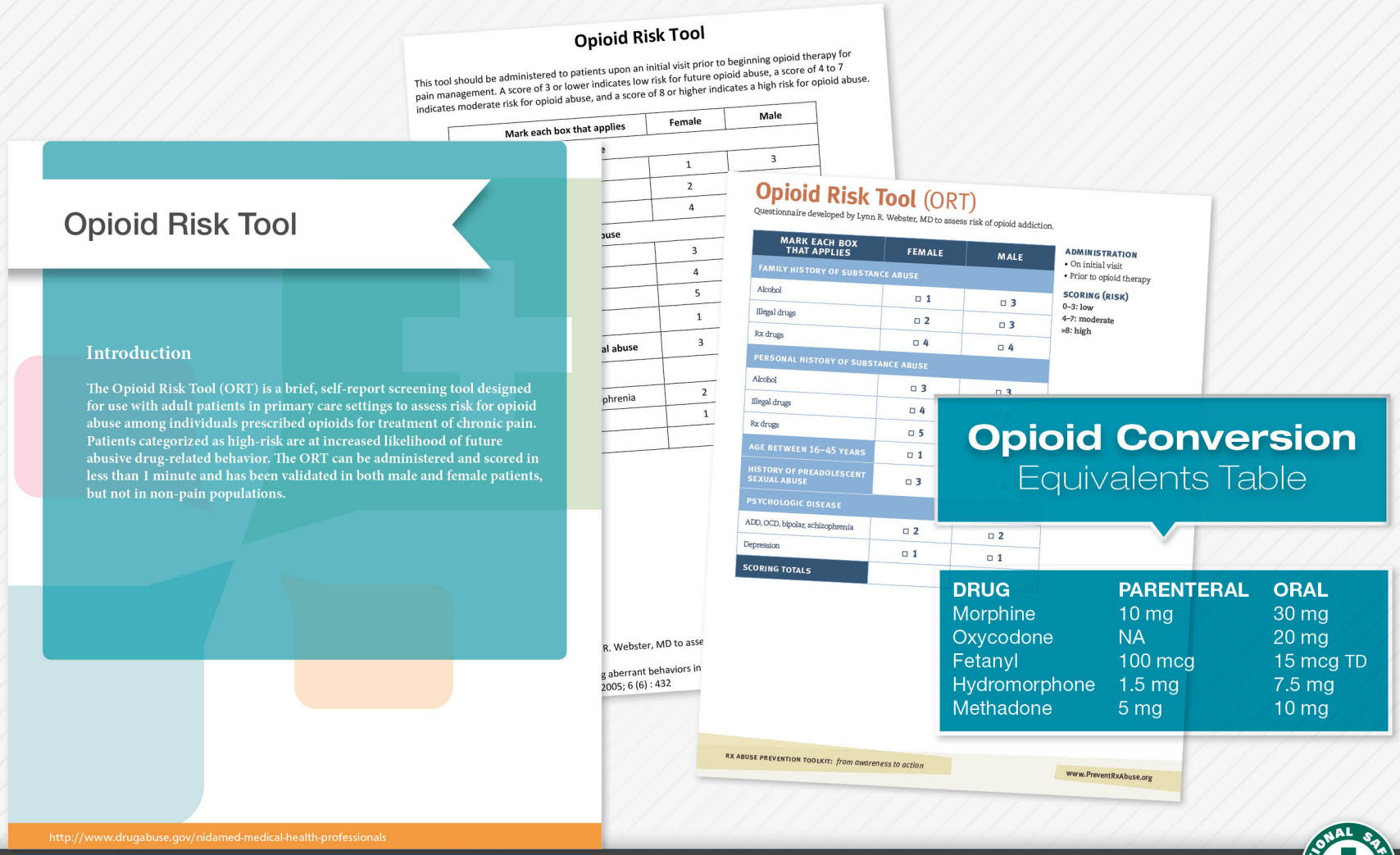
HEADACHE/MIGRAINE	• Metoclopramide, Ketorolac, IV fluids, Sumatriptan – *If <50% relief, then* • Magnesium, Valproic acid, Dexamethasone – *If <50% relief, then* • HaloperIdol – *If <50% relief, then* • Observation with neuro consult
EXTREMITY FRACTURE OR DISLOCATION	• Nitrious oxide + intranasal Ketamine – *Set up for block* • Ultrasound-guided regional Anesthesia
MUSCULOSKELETAL PAIN	• Ibuprofen + Acetaminophen • Lidocaine or Diclofenac patches • Cyclobenzaprine or Diazepam • Trigger-point or other soft tissue injection
LUMBAR RADICULOPATHY	• Ibuprofen + Acetaminophen • Cyclobenzaprine or Diazepam • Gabapentin • Lidocaine patch • Ketamine infusion + drip
RENAL COLIC	• Ketorolac + Acetaminophen + IVF • Cardiac Ildocaine – 1.5 mg/kg IV, max 200 mg

LaPietra, Alexis. Cutting Edge Pain Management/ ACEPnow, August 2016,15-16.

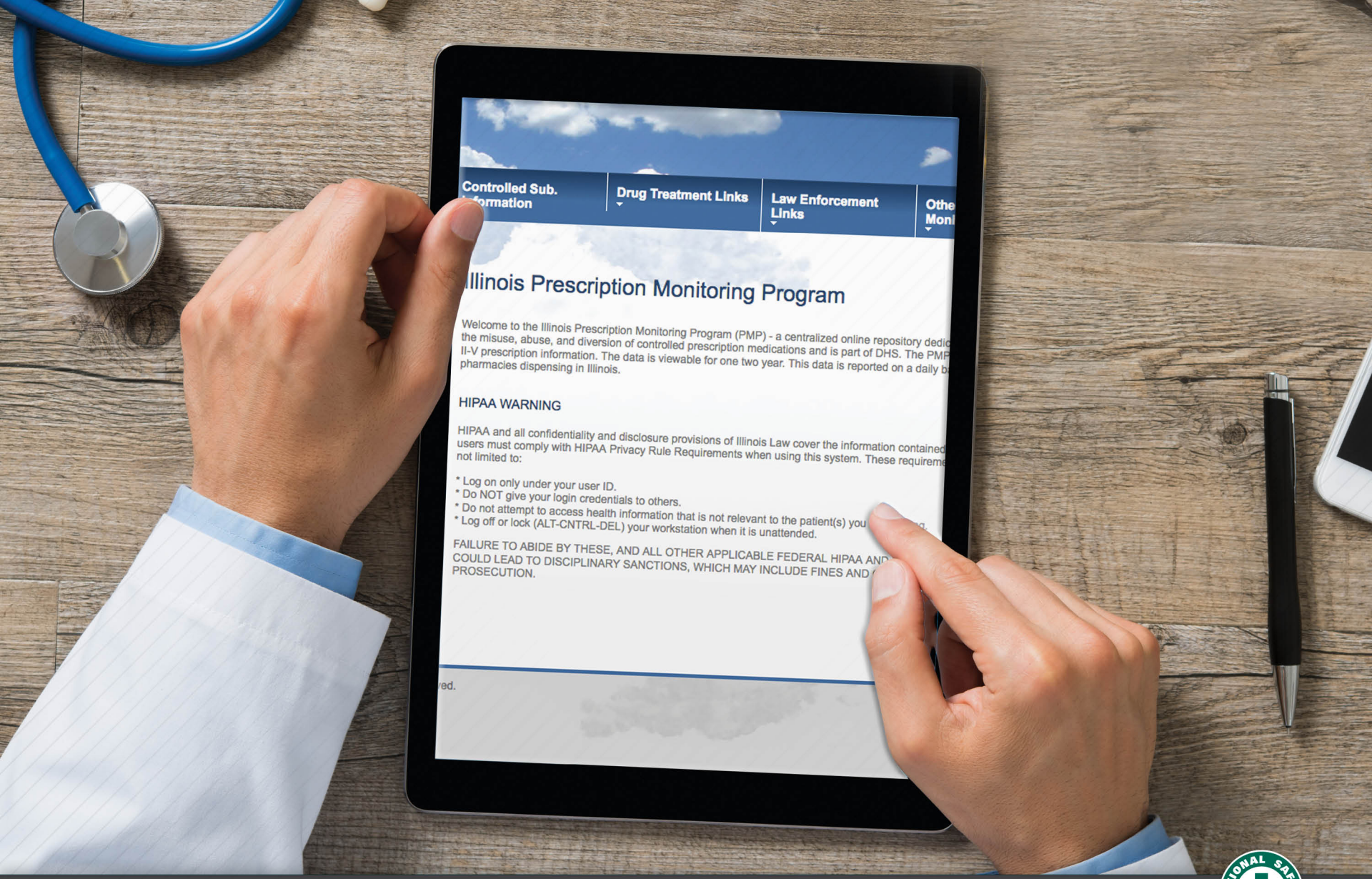
IF YOU MUST USE OPIOIDS…

- ✓ Start low, go slow and reassess
- ✓ Use MME calculators
- ✓ Limit use of combination products
- ✓ Treat Tramadol as an opioid
- ✓ Exercise caution in elderly
- ✓ Counsel patients appropriately

USE **RISK ASSESSMENT TOOLS**



https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
http://www.prescriberesponsibly.com/sites/default/files/pdf/risk/Opioid%20Risk%20Tool.pdf



PATIENT EDUCATION STRATEGIES

8 OPIOID SAFETY PRINCIPLES

1	2	3	4
NEVER TAKE AN OPIOID PAIN MEDICATION THAT IS **NOT PRESCRIBED** TO YOU.	**NEVER ADJUST** YOUR OWN DOSE.	**NEVER MIX** WITH ALCOHOL.	USING SLEEP AIDS AND ANXIETY MEDICATIONS WITH OPIOIDS IS **DANGEROUS**.

American Academy of Pain Medicine: pcss-o.org/wp-content/2015/01/AAPM-PPT-Slides-3.12.15.pdf

8 OPIOID SAFETY PRINCIPLES

5	6	7	8
ALWAYS DISCLOSE ALL OF YOUR MEDICATIONS TO PROVIDERS.	**KEEP TRACK** OF WHEN YOU TAKE MEDICATIONS.	KEEP MEDICATIONS IN A **SAFE PLACE**.	**DISPOSE** OF UNUSED MEDICATIONS.

American Academy of Pain Medicine: pcss-o.org/wp-content/2015/01/AAPM-PPT-Slides-3.12.15.pdf

TREATING OVERDOSE AND OPIOID USE DISORDER: MEDICATIONS

- OD Reversal
  - Naloxone
- Opioid Agonists
  - Methadone
  - Buprenorphine
- Opioid Antagonists
  - Naltrexone

NALOXONE:
ACUTE CARE CONSIDERATIONS

Management of opioid overdoses

- ✓ Patient monitoring
- ✓ Re-dosing
- ✓ Fentanyl

Prehospital considerations

- ✓ Third party prescribing/ standing orders
- ✓ Case study: Baltimore

4 TREATMENT OPTIONS

01

Detox followed by abstinence

02

Detox followed by Naltrexone monthly shots

03

MAT with Buprenorphine

04

MAT with Methadone

2016 OPIOID USE DISORDER
TREATMENT STUDY

TREATMENT	OUTCOME
MAT	**BEST OUTCOMES**
COUNSELING WITHOUT MAT	**2X** MORTALITY RATE
LEFT RESIDENTIAL TREATMENT	**4-FOLD** MORTALITY INCREASE
LEFT MAT	**2X** MORTALITY RATE

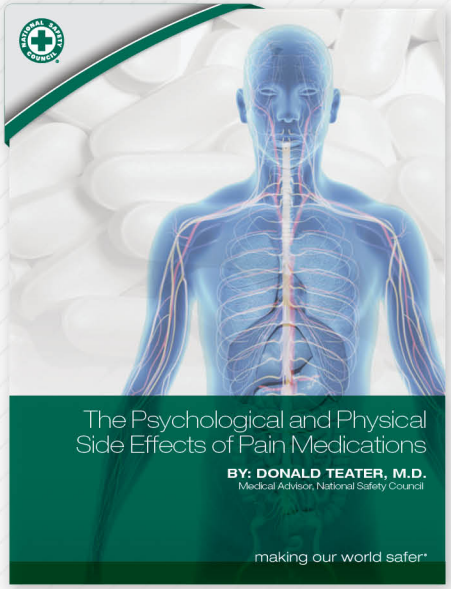
Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., & Millar, T. (2016). Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England. Addiction, 111(2), 298–308. http://doi.org/10.1111/add.13193

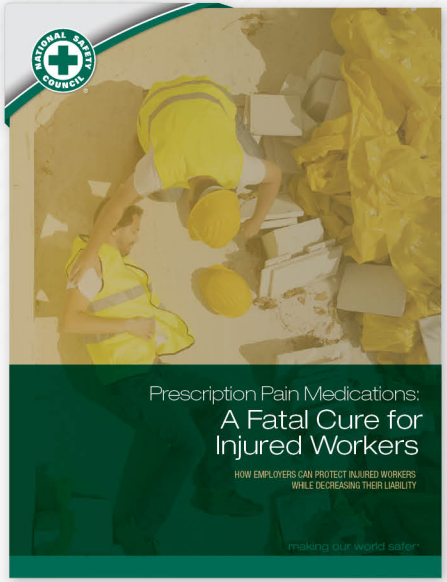
PHYSICIAN ADVOCACY

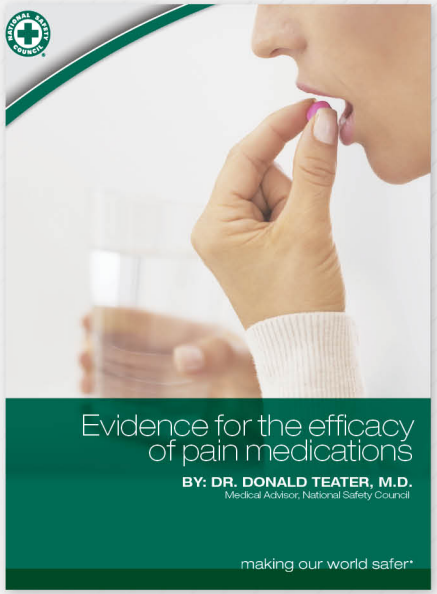
PHYSICIAN ADVOCACY

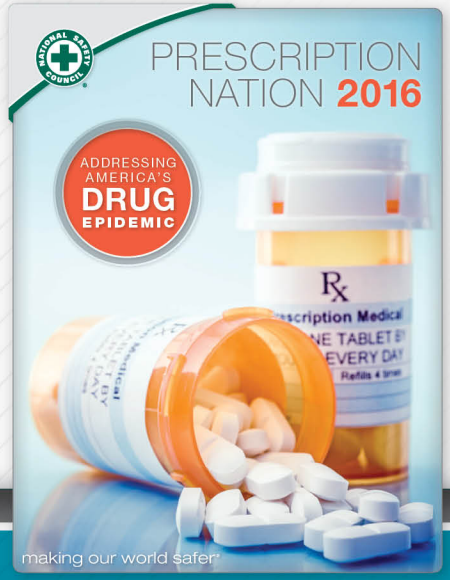
PHYSICIAN ADVOCACY

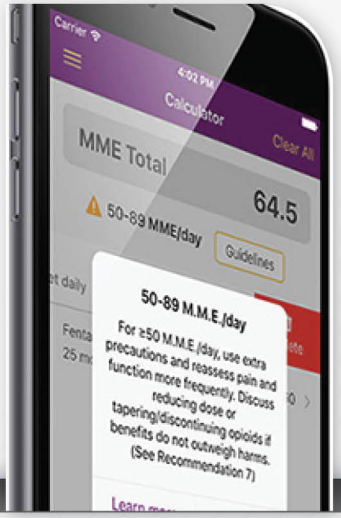
SUPPORT
COMMUNITY,
STATE AND
FEDERAL EFFORTS











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QUESTIONS

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