Disclosures

• None
Learning Objectives

• Define universal precautions for prescribing opioids
• Identify the value of and tools for risk assessment
• Describe the main components of treatment agreements
• Identify an appropriate formulary
• Integrate urine toxicology screens into your practice
The Scope
Prescription Opioid Sales, Deaths and Treatment: 1999-2010


Sarah Bagley, MD, Addiction Medicine Fellow, Boston University
Controlled substance doses prescribed and overdose deaths in R.I.

- Painkillers
- Stimulants
- Sedatives
- Overdose deaths

Source: Rhode Island Department of Health, R.I. Medical Examiner, Journal calculations

http://www.providencejournal.com/topics/special-reports/overdosed/
Drug overdose deaths outnumbered motor vehicle traffic deaths in 10 states in 2005

Sarah Bagley, MD, Addiction Medicine Fellow, Boston University
By 2010, drug overdose deaths outnumbered motor vehicle traffic deaths in 31 states

CDC NVSS, MCOD. 2010

Sarah Bagley, MD, Addiction Medicine Fellow, Boston University
Preventable Death: Accidental Drug Overdose in Rhode Island

Traci C. Green, MSc, PhD, and Edward F. Donnelly, RN, MPH

Far more deaths from overdoses than car crashes in R.I.

The number of people who have died from a drug overdose was double the number killed in motor vehicle accidents in recent years.

Source: Rhode Island Department of Health, R.I. Medical Examiner, National Highway Traffic Safety Administration

Notes: The number of motor vehicle accident fatalities for 2013 was not available. Overdose deaths include only those considered accidental and exclude suicides. Overdose fatality counts for 2012 and 2013 are preliminary. The 253 overdose deaths in 2013 may include non-Rhode Island residents.

http://www.providencejournal.com/topics/special-reports/overdosed/
CHALLENGES AHEAD
The 5 Best Practices

1. Use a universal precautions approach
2. Assess potential risks before prescribing
3. Use treatment agreements
4. Create a formulary
5. Use urine toxicology screens
UNIVERSAL PRECAUTIONS
When prescribing opioids, what does “universal precautions” refer to?

A. Isolating patients who require opioids from the rest of your patients.
B. Treating each individual patient who needs opioids differently.
C. Identifying the cause for the pain syndrome, along with risks and benefits of treatment with opioids... every time you prescribe.
D. Gloving up before writing a prescription.
Universal Precautions

• Same process, every time
• Frame the encounter
  – What is the medical condition we are treating?
  – What are the risks and benefits of prescribing opioids?

Alford DP. Chronic back pain with possible prescription opioid misuse. JAMA 2013; 309: 919-925.
Sample Informed Consent for Treatment with Opioids for Non-Cancer related Chronic Pain

Benefits and Risks

My diagnosis is ____________________________.

I am being prescribed ________________ as part of my treatment for pain. I understand that ________________ is an opioid (morphine-like) drug and that using this drug has both benefits and risks.

I have been offered alternatives to being treatment with this opioid:

Yes _____  No _____

Benefits

Being treated with an opioid drug offers certain benefits. These potential benefits include:

- Better control of my pain, which may produce improvements in how I feel and function physically.
- An increased ability to function in my personal and professional relationships, as well as an improved sense of overall well-being.
- A decrease in the intensity of the pain I feel.
Risks

Being treated with an opioid drug increases certain risks. These potential risks include:

- A chance that I might become physically dependent on the opioid drug if I use it for a long time.
- The experience of withdrawal symptoms — including yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, “goose flesh,” abdominal cramps, and diarrhea — when I try to stop using this drug. These symptoms might begin 24 to 48 hours after my last dose and might last for up to three weeks.
- A chance that I might become addicted to this drug, especially if I have had previous problems with drug or alcohol abuse. Addiction, which means I am unable to control my use of the drug, is different from physical dependence.
- A chance that this drug might not help improve my functioning or decrease my pain.
- The experience of side effects such as skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, edema, sedation, or the possibility of impaired

Adapted for use by the Rhode Island Department of Health, April 11, 2013
RISK ASSESSMENT
Risk Assessment

• Risk factors for overdose

• Opioid risk tools
Annals of Internal Medicine

Opioid Prescriptions for Chronic Pain and Overdose
A Cohort Study
Kate M. Dunn, PhD; Kathleen W. Saunders, JD; Carolyn M. Rutter, PhD; Caleb J. Banta-Green, MSW, MPH, PhD; Joseph O. Merrill, MD, MPH; Mark D. Sullivan, MD, PhD; Constance M. Weisner, DrPH, MSW; Michael J. Silverberg, PhD, MPH; Cynthia I. Campbell, PhD; Bruce M. Psaty, MD, PhD; and Michael Von Korff, ScD

ORIGINAL CONTRIBUTION

Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths

Amy S. B. Bohnert, PhD
Risk Factors

• High dose per 24 hours ($\geq 50$-$100$ mg of morphine or equivalent)
Risk Factors

• High dose per 24 hours (≥ 50-100 mg of morphine or equivalent)

• Comorbid substance use disorder

• Depression or other mental health disorder

• Sedative-hypnotic use
Tools for Assessing Pain and Risk

• PEG

• AUDIT-C

• SOAPP

• Miscellaneous drug and alcohol screens
  – Single-item screener
  – NIDA Quick Screen
  – Family history
Tools for Mental Health Screening

- PHQ-2 or PHQ-2
- GAD-2 or GAD-7
- Primary Care PTSD Screen
TREATMENT AGREEMENTS
Which of the following is TRUE about treatment agreements?

A. They are legally binding documents.
B. Most allow several prescribers as long as the patient uses one pharmacy.
C. It is important to avoid the word “addiction” in the agreements because patients can be frightened by this.
D. They include information about what behavior might lead to discontinuation.
Rationale

• Provide a road map for physicians and patients
• Facilitate key communication
• Set expectations and obligations
• Identify responsibilities
• Outline plan for monitoring
Pain Medicine Agreement

This agreement is for patients who are prescribed a type of pain medicine called opioids. These are sometimes called narcotics.

Name(s) of your medicine

The purpose is to describe how you and your doctor will use and follow your pain medicine so that your health can be improved and your pain can be reduced.

My pain & goals:

My pain is (describe):

What (activities) do I hope to be able to do?

I understand that my pain will probably:

I understand that the pain medicine may:

It is important not to miss appointments. Treating pain often includes physical therapy.

I will try additional treatments that my doctor may recommend.

Medical Primary Care Unit agreement for treatment of acute and chronic pain

This is an agreement between (the patient) and Dr. (the doctor) concerning the use of narcotic painkillers (opioid analgesics) for the treatment of either an acute or chronic pain problem. This medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome including nausea, vomiting diarrhea, aches, sweating, chills) that may occur within 24-48 hours of last dose. I understand that opioid withdrawal is quite uncomfortable but not a life-threatening condition. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life-threatening for a baby.

3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else’s life in jeopardy.

5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

6. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early
Common Elements

✓ Agreement between specific physician and patient
✓ Acknowledgment that opioid unlikely to eliminate pain
✓ One prescriber
✓ One pharmacy
✓ Review of risks and side effects
Common Elements

- Instruction to take as prescribed or call doctor if change needed
- No early refills
- No off-hours refills
- Avoidance of alcohol, benzos, illicits
- Storage in a safe place
Common Elements

✓ Attendance at all follow-ups
✓ Cannot give or sell medication
✓ Random urine drug testing
✓ Treatment trial, not a binding contract
✓ Consequences for not following agreement
Pain Medication Agreement

I, ____________________________, agree to the following rules:

- I will use only ONE pharmacy for my medication
  - My pharmacy is: ________________

- I will keep my medication in a safe place and away from children

- I will get my pain medication from ONE doctor

- I will see a mental health provider or pain doctor, if needed

- I will have urine tests to see if I have been using prescription drugs or street drugs

- If a different doctor, dentist or emergency room gives me pain medication, I will let my primary care doctor know right away

- I will NOT share or sell my medication

Date: ____________________________

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If asked, I will bring in my pain medication bottles and my pills will be counted.

I understand that lost or stolen prescriptions will NOT be replaced.

Refills

- I will call for my refills ONLY in the daytime during regular office hours.
- I will NOT call on Saturday, Sunday, or holidays for my prescription refills.

<table>
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<th>Saturday</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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</tr>
</tbody>
</table>

- I will NOT call for pain medication at night.
- I will call for refills at least 3 days before my pick-up day.
- I will pick up my prescription on the same day of the week every time. My pick up day will be:

  - Tuesday
  - Wednesday
  - Thursday
  - Friday

- I will answer phone calls from my doctor's office and go to my appointments.
- I will talk to my doctor before taking extra pain medication.
- I will follow these rules. If I do not, then my doctor may no longer prescribe my medication.

© 2012 Institute for Education on Health and Research
Which of the following is TRUE about treatment agreements?

A. They are legally binding documents.
B. Most allow several prescribers as long as the patient uses one pharmacy.
C. It is important to avoid the word “addiction” in the agreements because patients can be frightened by this.
D. They include information about what behavior might lead to discontinuation.
Which medication is NOT a good option for chronic pain treatment?

A. Acetaminophen with codeine

B. Meloxicam

C. Morphine sustained release

D. Gabapentin
Acute Pain

- Acetaminophen 325-650 mg PO every 4 hours prn
- Ibuprofen 200-800 mg PO 3-4 times daily
- Naproxen 250-500 mg PO twice daily
- Oxycodone 5-10 mg PO every 4-6 hours prn
- Morphine IR 15-30 mg PO every 4-6 hours prn
Episodic Pain
[ unresponsive to non-opioids ]

- Oxycodone 5-10 mg PO every 4-6 hours prn
- Morphine IR 15-30 mg PO every 4-6 hours prn
- Oxycodone or morphine IR + acetaminophen 325-650 mg PO every 6 hours
Chronic Pain

- Ibuprofen 200-800 mg PO 3-4 times daily
- Naproxen 250-500 mg PO twice daily
- Meloxicam 7.5-15 mg PO daily
- Morphine SR 15-30 mg PO every 8-12 hours
What’s Missing?

- OxyContin®
- Dilaudid®
- Percocet®
- Vicodin®
- Tramadol
Methadone

**PROS**
- Effective pain med
- Long half life → fewer highs and lows
- Inexpensive

**CONS**
- QT prolongation
- Long half life → caution up-titrating
- Stigma
Adjunctive Therapies

- Gabapentin 300 mg PO at bedtime; may titrate to 600 mg three times daily
- Pregabalin 50-100 mg PO three times daily
- Amitriptyline 25-50 mg PO at bedtime daily
- Venlafaxine 37.5-150 mg PO daily
- Duloxetine 20-60 mg PO daily
Topical Therapies

- Lidocaine patch or gel
- Capsaicin patch or cream
- Diclofenac cream
- Heat and cold

“No appointment necessary.”
Which medication is NOT a good option for chronic pain treatment?

A. Acetaminophen with codeine
B. Meloxicam
C. Morphine sustained release
D. Gabapentin
URINE TOXICOLOGY SCREENING
Urine Toxicology Screening

- Understanding your lab
- Interpreting results
- Discussing with patients
Clinical Vignette

• 83-year-old woman
• Severe spinal stenosis
• Taking Tylenol #3® (acetaminophen with codeine) 1XD prn and hs

• What are the expected results of her urine drug screen?
Clinical Vignette

• Urine toxicology reveals the presence of codeine, morphine, and hydromorphone

• Is this an expected or unexpected result?

• Are the results appropriate or inappropriate?
Types of Urine Drug Testing

• Screening: enzyme-based immunoassay
  – Fast and cheap, but...
  – A little tricky

• Confirmatory testing: gas (or liquid) chromatography and/or mass spectrometry
  – Slow and expensive, but...
  – Highly sensitive and specific
Interpreting the Results: Urine Drug Testing HPI

- Last dose?
- How much?
- Any other pain medicine?
- Any other drugs?
Drugs of Abuse Screen

- Amphetamines
- Barbiturates
- Benzodiazepines
- Cannabinoids
- Cocaine
- Methadone
- Opiates
- Oxycodone/oxydormone
- Phencyclidine
- Propoxyphene
Drugs of Abuse Screen

- Amphetamines
- Barbiturates
- Benzodiazepines
- Cannabinoids
- Cocaine
- Methadone
- Opiates
- Oxycodone/oxymorphone
- Phencyclidine
- Propoxyphene
Unexpectedly Negative

• False negative
  – Fast-metabolizer
  – Last dose too long ago

• Lab error

• Diversion or deception

• Order confirmatory testing
Unexpectedly Positive

- False positive
- Metabolites
- Lab error
- Sample contamination
Opioid Metabolism Basics

• Active and inactive metabolites

• Drug-drug interactions

• Some opioids produce metabolites chemically identical to other opioid medications
Opioids with Active Metabolites Identical to Pharmaceutical Opioids

- Codeine $\rightarrow$ morphine, hydrocodone
- Morphine $\rightarrow$ hydromorphone
- Hydrocodone $\rightarrow$ hydromorphone
- Oxycodone $\rightarrow$ oxymorphone
- Heroin $\rightarrow$ morphine
Back to the Clinical Vignette

• Prescribed Tylenol #3® (acetaminophen with codeine)

• Tested positive for codeine, morphine, and hydromorphone
  – Expected or unexpected?
  – Appropriate or inappropriate?
Language For Introducing Drug Testing

• As part of treating [pain] with medications like [X], I order urine tests to get more information about how safe they are for my patients.

• The test measures a number of medications and drugs that could interfere with your treatment.

• This is something that I do with all patients on these medications.

• If I find something unexpected, we’ll talk about it and work together to address it.
PUTTING IT TOGETHER
Goals
Development/Recruitment
Members
Practices

THE MULTIDISCIPLINARY PAIN COMMITTEE
Goals

• Resident education/support
• Safe prescribing practices
• Monitoring
• Connection to resources
Development/Recruitment

- Initially funded by hospital-based risk management grant
- Recruitment of members
- Policy development
Members

• Internal medicine clinic providers (attending physicians, nurse practitioners, residents)
• Clinical social worker
• Substance abuse social worker
• Psychiatry nurse practitioner
• Clinical pharmacist with pain management background
Reasons to Refer

• Age < 40
• History of substance use
• Unclear pain disorder
• Opioid use > 50mg morphine daily

• Concerned? Uncomfortable? Refer!
Ongoing Practices

• Monthly meetings
• Review of chart/imaging/outside records/urine toxicology results
• Review prescription monitoring program
• Documentation of recommendations
• Communication with providers
Patient's chart reviewed at the Multidisciplinary Pain Committee meeting on March 22, 2013.

He has been experiencing neuropathic pain. He is currently on Oxycodone IR 15mg 2XD and gabapentin 600mg 3XD. His insurance does not cover Oxycodone SR (Oxycontin), and he had previously had little effect with Morphine Sulfate.

Action Taken:
03/22/2013 05:04:27 PM EDT > Thank you, I was present at pain committee meeting and recommendations.
03/22/2013 05:11:06 PM EDT > called and left msg with patient re: recommendations to not start cymbalta and consider cutting oxycodone in half and taking it up to 3-4 times a day (max dose...
Challenges

• Communicating with emergency department and other disciplines
• Electronic health record
• Physician familiarity with prescribing policies
• Legacy regimens
Opportunities
The EHR

• Alert pop-ups
• Built-in risk assessment tools
• Checkbox in/near medication list
• Order sets for pain management
• Treatment agreement in EHR
• Agree on an ICD code
Summary

• Use the same process (identify pain syndrome, discuss risks and benefits) every time you prescribe opioids for chronic pain.
• Assess risks for misuse.
• Use a treatment agreement.
• Identify an appropriate formulary for your practice.
• Integrate urine toxicology screens into your prescribing patterns.
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