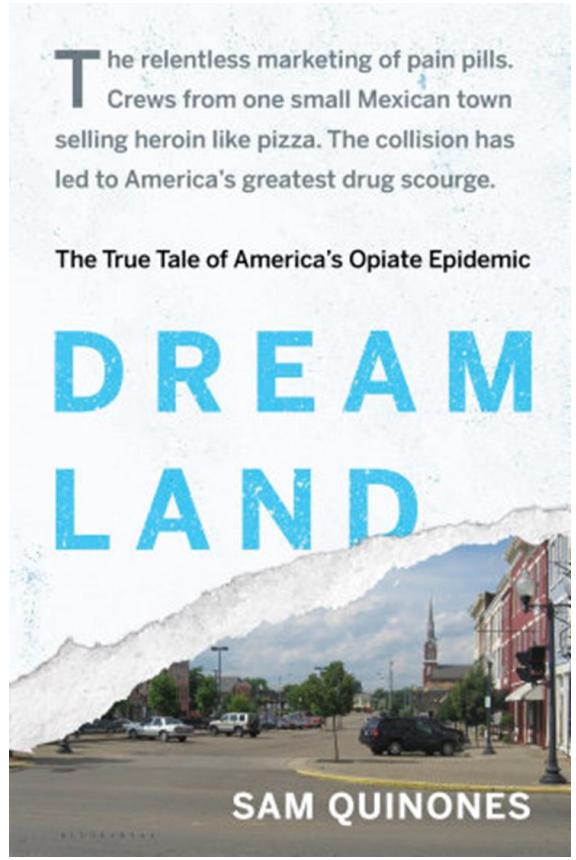
Update in the Opioid Prescribing Guidelines

Brian Bachelder, MD

President – Ohio State Medical Association

Cleveland Clinic / Akron General

Center for Family Medicine



Objectives

- Discuss the recent Ohio opioid prescribing guidelines for:
  - ED / Urgent Care
  - Acute
  - Chronic

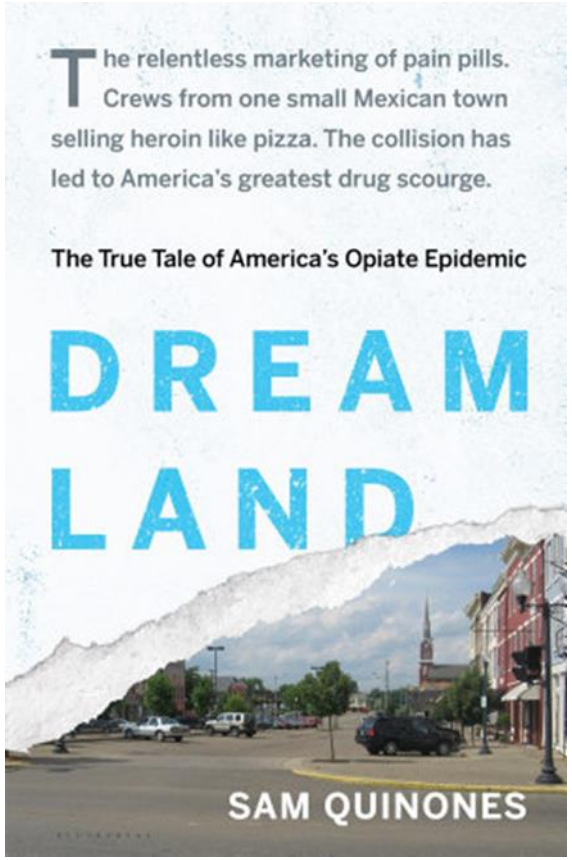
N Engl J Med. 1980 Jan 10;302(2):123.

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
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154 Boston University Medical Center

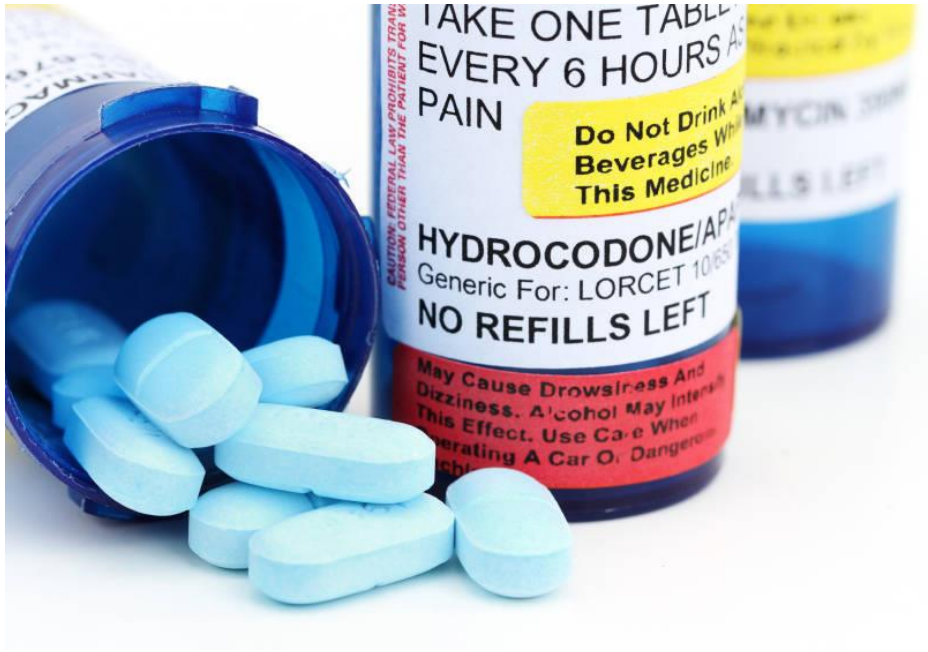
1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.



Opioid Problem

- 259 million Rx's written
  - Enough for every American adult to have a bottle of pills in 2012
- 1.9 million people
  - Abused or were dependent on prescription opioid pain medications in 2013 (per DSM–IV criteria)
- 165 thousand overdose deaths
  - Related to opioid pain medication in the United States from 1999-2004

One Requirement



One Requirement

Check OARRS!!!

* https://www.ohiopmp.gov/Portal/Default.aspx

All the rest are *Guidelines*

“This guideline provides a general approach to the outpatient management of acute pain. It is not intended to take the place of clinician judgement, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.”

State Medical Board of Ohio Letter

Based upon our review of OARRS data from August 2016, it appears that you may not be in compliance with Ohio law. If you appear in our monthly report for not being registered or not checking patients in OARRS prior to prescribing or personally furnishing an opioid analgesic or benzodiazepine, the Board could take administrative action against your license and impose a fine of up to $20,000 for failure to comply with the law.

OSMA Reply

The Ohio State Medical Association (OSMA) immediately took issue with the letter, questioning how it might be possible that roughly one-third of all licensed Ohio physicians could be considering in violation of rules governing the prescribing of opioids.

Guidelines: ED and Urgent Care / Opioids

- Check OARRS!
- No more than 3 days
- No long-acting opioids or Injectable Rx's
- No replacement Rx's
- Photo ID's or photograph for chart
- Case reviews / frequent visitors
- Med agreements and Rx details about potential addiction
- Refer to PCP

* http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-ED-Acute-Care.pdf

ER and Acute Care Facilities

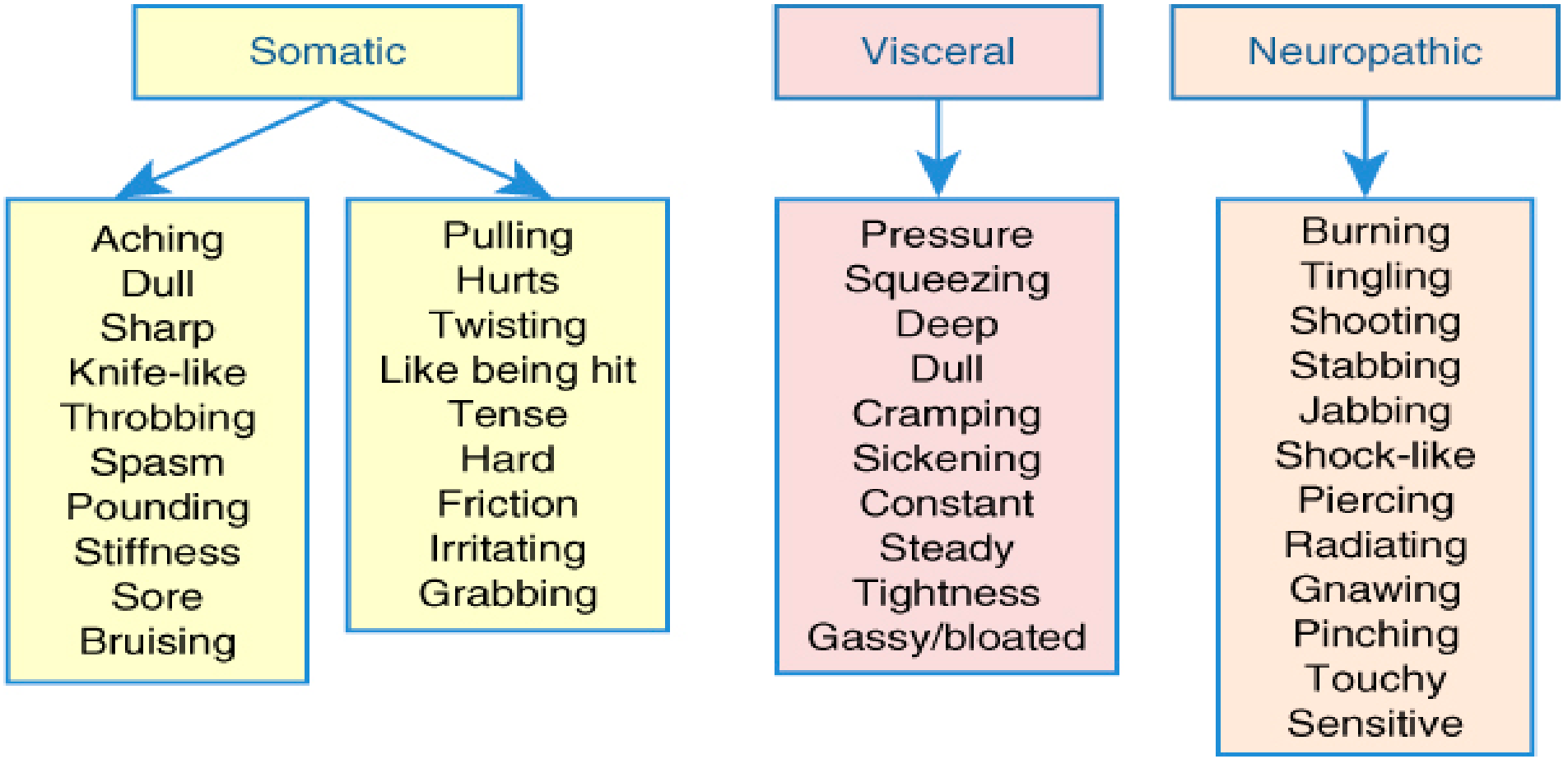
http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-ED-Acute-Care.pdf

Guidelines: Office Acute Pain

- H & P
- Pain Assessment
- Psychological Factors
- Education
- Plan
- Goals / Expectations

- Non-pharmacologic – 1st line
  - Ice, heat, positioning, bracing, stretching
  - Massage, Physical Therapy acupuncture/accupressure, chiropractic manipulation
  - Biofeedback, psychotherapy
- Non-opioid pharmacology
  - Use in combination with non-pharm
  - Educate on proper use, importance of maintaining therapy, expectation for duration and degree of symptom improvement

Skin, MS / CV, GI, Renal / Nerves



Non-opioid Pharmacology

- Somatic Pain
  - Acetaminophen
  - Non-steroidal anti-inflammatory drugs (NSAIDS)
  - Corticosteroids

Alternatives include the following: gabapentin/pregabalin, skeletal muscle relaxants, serotonin-norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors and tricyclic antidepressants.

* http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf

Non-opioid Pharmacology

- Visceral Pain
  - Acetaminophen
  - Non-steroidal anti-inflammatory drugs (NSAIDS)
  - Corticosteroids

  Alternatives include the following: dicyclomine, skeletal muscle relaxants, serotonin-norepinephrine reuptake inhibitors, topical anesthetics and tricyclic antidepressants.

* http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf

Non-opioid Pharmacology

- Neuropathic Pain
  - Gabapentin/pregabalin
  - Serotonin and norepinephrine reuptake inhibitors
  - Tricyclic antidepressants

  Alternatives include the following: other antiepileptics, baclofen, bupropion, low-concentration capsaicin, selective serotonin reuptake inhibitors and topical lidocaine

* http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf

Guidelines: Office Acute Pain / Opioids

- Check OARRS!
- H & P
- Pain Assessment
- Psychological Factors
- Education
- Plan
- Goals / Expectations
- Chronic guidelines if >12 weeks

- Reserve for severe cases *or*
- Ineffective alternatives
- Least potent and minimum #
- Avoid with benzo's or sedatives
- Weaning, storage, disposal
- < 7days
- Re-evaluate q 14 days
- Re-assess if > 6 weeks

Acute Pain Prescribing Guidelines

http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf

http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Acute-pain-infographic.pdf

Guidelines: Chronic Pain / Opioids

- Check OARRS! (q 90 days)
- Failed conservative Rx
- H & P
- Pain Assessment / Progress
- Psychological Factors
- 4 A's
  - Activities of daily living
  - Adverse effects
  - Analgesia
  - Aberrant behavior
- 80 mg MED
- > 3 months
- Avoid benzo's and sedatives
- Informed Consent / CSA
  - UDS
  - One pharmacy / One provider
  - Consequences
- Pain Management Consultants

OARRS Requirements

- Initial Rx
- Q 90 days
- Document OARRS check in medical record
- Can copy report into chart
- Border counties must check neighboring state

OARRS Exceptions

- Hospice or terminally ill
- < 7 days
- Cancer or associated condition
- Location (hospital, SNF, residential facility administration)
- Acute surgical, invasive procedure, or OB pain
- OARRS not available

* http://www.pharmacy.ohio.gov/Documents/Pubs/Special/OARRS/H.B.%20341%20-%20Mandatory%20OARRS%20Registration%20and%20Requests.pdf

Sample Patient Agreement Forms

https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf

Other Resources

- Ohio.gov – Mental Health and Addiction Services:

  http://mha.ohio.gov/Default.aspx?tabid=828

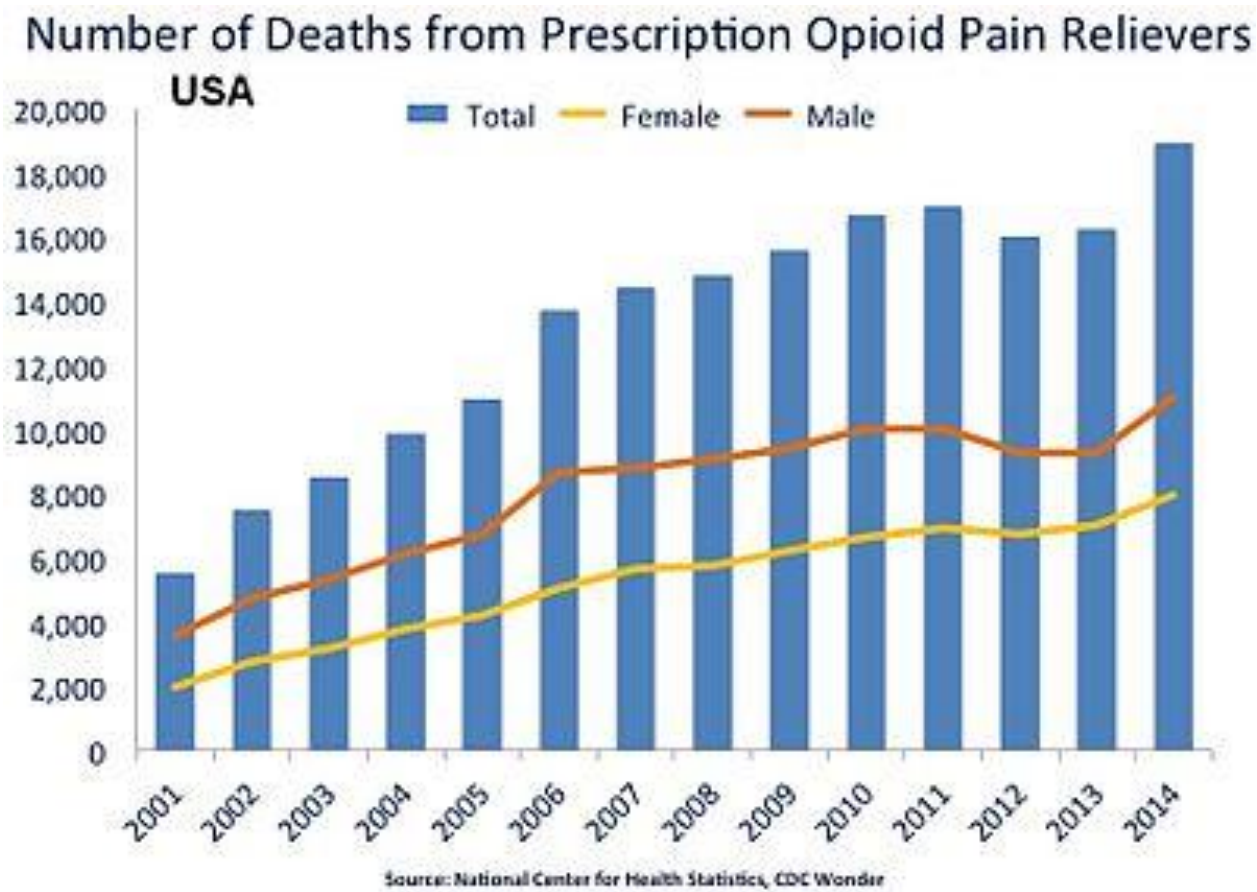
- "Draft CDC Guideline for Prescribing Opioids for Chronic Pain." Centers for Disease Control and Prevention, 12 Jan. 2016. Web. 28 Jan. 2016. http://www.cdc.gov/drugoverdose/prescribing/guideline.html

Summary: Progressive Opioid Prescribing Guidelines for a Safer Ohio

	From Emergency Department & Acute Care Facilities	For Chronic, Non-Terminal Pain	For Acute Pain Outside of Emergency Department
Release Date	April 2012	October 2013	January 2016
Specific Goals	Stop inappropriate prescribing from ED & Urgent Care Centers	Ensure long-term patient safety	Limit first use of opioids and decrease availability of unused opioid medications
Prescribing Limitations	• No more than 3 days • No long-acting opioids	• "Press pause" at ≥ 80 mg MED • Caution with co-prescribing of benzodiazepines	• Consider non-pharmacologic and non-opioid therapies • Limit pills per script • No long-acting opioids
OARRS Recommendations	Check prior to prescribing	• Check every patient at ≥ 80mg MED • By law, OARRS check required for >12 weeks	• Check prior to prescribing • By law, OARRS check required in most cases for ≥ 7 days of use *(As of April 2015)*
Key Additional Clinical Steps	Referral to Primary Care	12 weeks a trigger for re-evaluation of pain, function, medication effectiveness & SBIRT	2 weeks a trigger for re-evaluation
Associated Metrics	• TBD: Survey by ODH; Additional data & trends through OARRS	• # patients at ≥ 80mg MED • Proportion of prescriptions ≥ 120 pills/prescription • Proportion and # patients on both opioid & benzodiazepines	• # patients receiving *new* opioid prescription for acute pain • See aggregate quarterly measures
Aggregate Quarterly Measures for all guidelines	• % of prescriptions with associated OARRS check • # patients receiving opioids per quarter • Total opioid pills prescribed per quarter; • Average MED per prescription		
Sample Patient Vignette	Patients who are narcotic-seeking, doctor shopping and/or diverting opioids	Patients with addiction or tolerance to medications; those at greater risk for harm	Patients seeking pain relief following injuries or procedures

Acronyms: ED=Emergency Department; MED=Morphine Equivalent Daily Dose; OARRS=Ohio Automated Rx Reporting System (prescription drug monitoring program); SBIRT=Screening, Brief Intervention, and Referral to Treatment for substance abuse

??? Questions ???


Number of Deaths from Prescription Opioid Pain Relievers
USA
Total
Female
Male
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Source: National Center for Health Statistics, CDC Wonder