Our Opioid Epidemic

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 CHAIR, MOA PRESIDENTIAL TASK FORCE ON SAFE OPIOID USE

The Opioid Mortality Crisis Continues...
In the US for 2014, opioids killed …

- Almost 29,000 people, more than any year on record
- More than 10,500 people died from heroin overdose

Objectives – The physician will be able to:

- Identify important trends in morbidity and mortality caused by opioids
- Demonstrate the link between physician behavior and opioid addiction
- Relate the importance of using appropriate opioid writing protocols in daily practice
- Discuss the continuum between opioid prescribing and heroin addiction
- Describe several screening protocols for assessing patient depression and addiction
- Apply morphine equivalence conversion tools
- Evaluate appropriate physician prescription writing behaviors
- Create an appropriate office protocol for appropriate opioid prescription writing.
DEFINITIONS

- **Opium**
  - Fluid obtained from the poppy plant
- **Opiate**
  - A substance derived from opium
- **Opioid**
  - Substance with morphine-like actions, but not derived directly from the poppy plant

Papaver Somniferum “Poppy Plant”

OPIATES

- **Opium Comes from the Poppy Plant - Papaver Somniferum**
  - An erect herbaceous annual or biennial which grows in 3 major areas of the world: Southeast Asia, Middle East, and Latin and South America
  - 50 to 150 cm tall
  - Stems are slightly branched
  - Leaves are large, erect, and oblong
  - Petals are 4 - 8 cm in length
  - Petal colors are white, pink, purple, and violet
After flowering, the petals drop in a few days leaving bulbous green capsules atop the stalks. These are the seed pods.

Incisions are made in the pods and the milky fluid that oozes out is air dried. This must be done while the pods are still green.
Prescription painkiller sales and deaths

![Graph showing increases in sales and deaths related to prescription painkillers from 1999 to 2013.](image)

Sources:
http://www.cdc.gov/nvs/health.htm

What replaced the neighborhood ice cream truck...

![Cartoon of a truck labeled "Opioids" and "Heroin" replacing an ice cream truck](image)

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POLITICALCARTOONS.COM
Drug overdose deaths by state, US 2014

Number and age-adjusted rates

2/3 of All Deaths are Directly Related to Prescription Opioids

Opioid Analgesic

Heroin

NCHS/CDC Final Death Data For Each Year
Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

- Opioids
- Heroin
- Cocaine
- Benzodiazepines

Drug Induced Deaths Outpace Motor Vehicle & Firearm Deaths

Source: Centers for Disease Control and Prevention
### DRUG OVERDOSE DEATHS IN PENNSYLVANIA

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<th>Year</th>
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*DDAP, 2014*

### Allegheny County Trends in Accidental Drug Overdose Deaths 2000-2011*

*Data is from Allegheny County Medical Examiners Annual Reports and includes all overdose deaths where these drugs were present at time of death, not necessarily cause of death.
Prescription drugs led to a larger overdose epidemic than illicit drugs ever have.


**Michigan's growing drug and opioid abuse problem by the numbers**

- Prescriptions for individual dosage units of Schedule II drugs increased from 180 million in 2007 to 745 million last year.
- Prescriptions for controlled substances increased from 17 million in 2007 to 21 million last year.
- The number of heroin-related overdose deaths per 100,000 residents increased from 4.9 in 2009 to 9.8 in 2014.

Michigan ranks 18th in the nation for per capita prescribing rates of opioid pain relievers.
Opioid-related Deaths and Prescriptions Written by MI County, 2009-2013

Opioid-related Poisoning Death Rates Per 100,000 MI Residents

- 3.4% - 5.9%
- 2.2% - 3.4%
- 0.5% - 1.9%
- 4.3% - 7.4%
- Less than 4 deaths

Overall MI rate: 2.3 (95% CI: 2.2 - 2.5)

Number of Opioid Prescriptions Written Per 100,000 MI residents

- 56,449.6 - 79,120.0
- 79,120.1 - 88,974.5
- 88,974.6 - 103,781.1
- 103,781.2 - 119,979.4
- 119,979.5 - 145,498.9

Overall MI Rate: 92,792.7

http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_55478_55484---,00.html

For every 1 death there are...

- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 nonmedical users
High Risk Populations

- People taking high daily doses of opioids
- People who “doctor shop”
- People using multiple abusable substances like opioids, benzodiazepines, other CNS depressants, illicit drugs
- Low-income people and those living in rural areas
- Medicaid populations
- People with substance abuse or other mental health issues


Opioid abuse is a continuum!
60-70% of Heroin Users Abused Prescription Opioids First
Who is to blame for this problem?
UNREGULATED, FREE ENTERPRISE-DRIVEN HEALTH CARE AT ITS MOST EFFICIENT...

ACME PAIN CLINIC
“Diversion of prescription pills to the street market promotes the addiction to painkillers that leads to overdose deaths. We are focusing on charging doctors, pharmacists and the networks that are putting this poison on the streets.”

- U.S. Attorney Barbara McQuade

New fix for opioid epidemic takes aim at doctors’ Rx pads

Obama says nation’s doctors key to fixing opioid abuse epidemic
At least **HALF** of all opioid overdose deaths involve a prescription opioid.

*JAMA, March 2014: CDC researchers reported that those at highest risk of overdose are likely to get the drugs from a physician.*
MEDICATION TAKE BACK EVENTS

**MAY 2009**
- 2,874 UNITS COLLECTED

**OCTOBER 2009**
- 7,010 UNITS COLLECTED

**MAY 2010**
- 9,387 UNITS COLLECTED

**OCTOBER 2010**
- 10,010 UNITS COLLECTED

**APRIL 2011**
- 17,349 UNITS COLLECTED

**OCTOBER 2011**
- 13,482 UNITS COLLECTED

**MAY 2012**
- 23,584 UNITS COLLECTED
Pressures to Prescribe

A good idea gone bad
It is no longer possible to simply continue previous practices......
the associated risks of opioid diversion, overdose, and addiction demand change (now).

From the National Institute on Drug Abuse, National Institutes of Health (NIDA), Bethesda, MD and the Treatment Research Institute, Philadelphia


How do we meet this challenge?
In 2016, The CDC Accelerated It’s Campaign Prevent Addiction and Overdose

http://www.cdc.gov/drugoverdose/opioids/heroin.html

Highlights of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain

[OMM]

[ie. MAPS]
2016 CDC Guideline for Prescribing Opioids for Chronic Pain

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy (including OMM) and non-opioid pharmacologic therapy are preferred for chronic pain
   - Consider opioid therapy only if expected benefits for both pain and function outweigh risks to the patient

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function
   - Continue opioid therapy only if there is clinically meaningful improvement in pain and function

1Adapted from 16 MMWR / March 15, 2016 / Vol. 65

2016 CDC Guideline for Prescribing Opioids for Chronic Pain (Continued)

3. Discuss known risks and realistic benefits of opioid therapy before starting and periodically during opioid therapy

4. Prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids when starting opioid therapy for chronic pain

5. Prescribe the lowest effective dosage when starting opioids
   - Use caution when prescribing opioids at any dosage
   - Carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day
   - Avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day

1Adapted from 16 MMWR / March 15, 2016 / Vol. 65
Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

6. For acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no greater quantity than needed for the expected duration
   - Three days or less will often be sufficient; more than seven days will rarely be needed

7. Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
   - If benefits do not outweigh harms of continued opioid therapy, optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids

1Adapted from 16 MMWR / March 15, 2016 / Vol. 65
2016 CDC Guideline for Prescribing Opioids for Chronic Pain (Continued)

Assessing Risk and Addressing Harms of Opioid Use

8. Evaluate risk factors for opioid-related harm and mitigate risk
   - Offer naloxone when factors that increase risk for opioid overdose exist
   - Risk factors include history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use

1Adapted from 16 MMWR / March 15, 2016 / Vol. 65
Assessing Risk and Addressing Harms of Opioid Use

9. Review the patient’s history of controlled substance prescriptions using state database to determine misuse or abuse
   ▶ Review data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months
   ▶ Identify patterns for doctor shopping or disjointed coordination of care and address them

1Adapted from 16 MMWR / March 15, 2016 / Vol. 65
2016 CDC Guideline for Prescribing Opioids for Chronic Pain (Continued)

Assessing Risk and Addressing Harms of Opioid Use

10. Use urine drug testing before starting opioid therapy and consider repeating annually to assess misuse or abuse
11. Avoid prescribing opioid pain medication and benzodiazepines concurrently
12. Offer or arrange evidence-based MAT (usually with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

Guidance for Primary Care Providers on Safe and Effective Use of Opioids for Chronic Non-cancer Pain

- Establish an opioid treatment agreement
- Screen for
  - Prior or current substance abuse
  - Depression
- Use random urine drug screening judiciously
  - Shows patient is taking prescribed drugs
  - Identifies non-prescribed drugs
- Do not use concomitant sedative-hypnotics
- Track pain and function to recognize tolerance
- Seek help if dose reaches 120 mg MED, and pain and function have not substantially improved

http://www.agencymeddirectors.wa.gov/opioiddosing.asp
MED, Morphine equivalent dose
Open-source Tools Added to June 2010 Update of Opioid Dosing Guidelines

- Opioid Risk Tool: Screen for past and current substance abuse
- CAGE-AID screen for alcohol or drug abuse
- Patient Health Questionnaire-9 screen for depression
- 2-question tool for tracking pain and function
- Advice on urine drug testing

CAGE, “cut down” “annoyed” “guilty” “eye-opener”

http://www.agencymeddirectors.wa.gov/opioiddosing.asp#DC

Screening for Addiction Risk

- Measures for screening for addiction risk
  - STAR/SISAP\(^1\)
  - CAGE AID\(^2\)
  - Opioid Risk Tool (Emerging Solutions in Pain)\(^3\)
  - SOAPP (see painedu.org)\(^4\)

- Psychiatric interview assessment of risk
  - Chemical
  - Psychiatric
  - Social/Familial
  - Genetic
  - Spiritual


What do we hope to achieve?

**We hope to:**
- Prevent Death with Naloxone
- Stabilize Addiction with MAT
- Establish Long Term Treatment Goals for Successful Recovery
- Change Opioid Prescribing Habits
- Shrink the Supply and Demand of Illicit Drugs