

Solving the Prescription Opioid Crisis: A Pain Physicians' Perspective

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 Lake Buena Vista, Florida
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Objectives and Outline

1. Understand the epidemic of prescription opioids (5 min)
2. Pain Physicians perspective (5 min)
3. National strategies to control the opioid epidemic (5 min)

PAIN TREATMENT HISTORY OR HOW WE GOT WHERE WE ARE NOW

**Too Little?
1995**

**Too Much?
2016**

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case¹ and Angus Deaton¹ PNAS 2016
Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544
 Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

- Data from 1999-2013 comparisons

Fig. 2. Mortality by cause, white non-Hispanics ages 45-54.

2016 Feb THE NEW ENGLAND JOURNAL OF MEDICINE FDA

SPECIAL REPORT

A Proactive Response to Prescription Opioid Abuse

Robert M. Califf, M.D., Janet Woodcock, M.D., and Stephen Ostroff, M.D.

- In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, *enough for every adult in the United States to have a bottle of pills*¹ [1.http://www.cdc.gov/vitalsigns/opioid-prescribing/](http://www.cdc.gov/vitalsigns/opioid-prescribing/). Accessed August 2016
- Nationally, the annual number of deaths from opioid overdoses now exceeds the number of deaths caused by motor vehicle accidents.

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.
 - Evidence review found that many nonpharmacologic therapies, including physical therapy, weight loss, psychological therapies such as CBT, and certain interventional procedures can ameliorate chronic pain.
 - Multimodal therapies and multidisciplinary biopsychosocial rehabilitation-combining approaches can reduce long-term pain and disability compared with usual care and compared with physical treatments alone.
 - Multimodal therapies are not always available or reimbursed by insurance and can be time-consuming and costly for patients.

- To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis. Evaluations should generally include a focused history, including history and physical exam, with imaging or other diagnostic testing only if indicated.
- For complex pain syndromes, pain specialty consultation can be considered to assist with diagnosis as well as management. Diagnosis can help identify disease-specific interventions to reverse or ameliorate pain; for example, improving glucose control to prevent progression of diabetic neuropathy; immune-modulating agents for rheumatoid arthritis; physical or occupational therapy to address posture, muscle weakness, or repetitive occupational motions that contribute to musculoskeletal pain; or surgical intervention to relieve mechanical/compressive pain.
- The underlying mechanism for most pain syndromes can be categorized as neuropathic or nociceptive.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

- 6) Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
 - Several guidelines on opioid prescribing for acute pain from ER and other settings have recommended prescribing ≤ 3 days of opioids in most cases. Because physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days, limiting days of opioids prescribed also should minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms.

Opioids, Surgery and Postop Pain

- N=147 were reached.
- 5 common outpatient surgery procedures performed at an academic medical center in 2015.
- Postoperative opioid prescriptions entered into the EMR, refill data, and patient outcomes were tabulated.
- Only opioid naïve patients included in the analysis.
- A phone survey was then conducted on all patients who were operated on and received an opioid prescription from June through December 2015.

Hill MV, et al. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. September 14, 2016

- Patients undergoing partial mastectomy were prescribed a range of 0- 50 pills while for partial mastectomy with sentinel node biopsy patients, range was 0 - 60

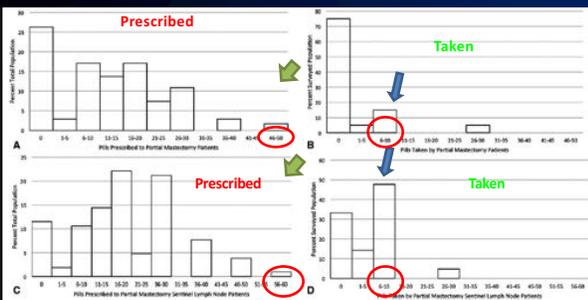
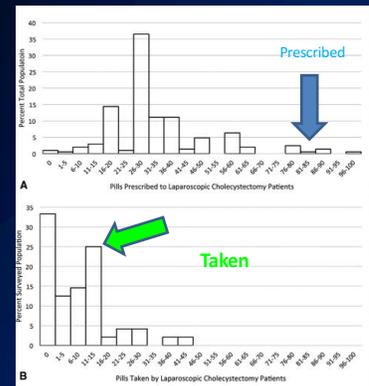


FIGURE 1. Frequency of opioid pills prescribed (A, C) and taken (B, D) after partial mastectomy and partial mastectomy with sentinel lymph node biopsy.

Hill MV, McMahon ML, Stucke RS, Barth RJ. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. September 14, 2016.

Opioids & Lap Chol and Postop pain pills

Hill MV, McMahon ML, Stucke RS, Barth RJ. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. September 14, 2016.



Opioids Surgery and Postop pain pills

Operation	Partial Mastectomy	Partial Mastectomy With Sentinel Node Biopsy	Laparoscopic Cholecystectomy	Laparoscopic Inguinal Hernia Repair	Open Inguinal Hernia Repair	All Cases
Surveys completed	20	21	48	20	18	127
Pills prescribed	415	490	1450	650	540	3345
Pills taken	61 (14.7%)	126 (25.7%)	474 (32.7%)	189 (14.7%)	168 (31.1%)	1018 (26.3%)
Pills remaining	354 (85.3%)	364 (74.3%)	976 (67.3%)	461 (85.3%)	372 (69.9%)	2327 (71.3%)

An "ideal" number of pills to prescribe for each operation was calculated by determining the number of pills that would satisfy approximately 80% of patients' postoperative use.

- For **partial mastectomy** this was calculated to be **5 pills**
- For **partial mastectomy with sentinel node biopsy** this was **10 pills or less**
- For **laparoscopic cholecystectomy** this was **15 pills**
- For **laparoscopic inguinal hernia repair** this was **15 pills**
- For **open inguinal hernia repair** this was calculated to be **15 pills**

Opioids and Surgery and Postop Medications

- A total of **17,167** pills were prescribed for the 642 patients. If these patients were prescribed the "ideal" number of pills for each operation, **7360 pills** (42.9% of the actual number prescribed) would have been prescribed.
- Of the 127 patients with completed phone survey data:
 - 117 had excess pills
 - 9% of these patients disposed of their excess opioids in an FDA approved fashion
 - 5% returned them to a DEA approved collection site
 - 4% flushed them down the toilet
 - > 50%** of the patients didn't recall a disposal method or still had them in their possession

Hill MV, McVahon ML, Stucke RS, Barth RJ. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. Annals of Surgery. Post Author Corrections. September 14, 2016.

The Role for Perioperative Physician ?

- Should it be the perioperative physician to determine the optimal dose of opioids for postoperative pain?
- Should the perioperative physician be prescribing a multimodal analgesia at discharge?

Offering Naloxone to Patients When Factors That Increase Risk for Opioid-Related Harms Are Present

- Naloxone can be administered by lay persons, such as friends and family of persons who experience opioid overdose, can save lives.
- There is evidence for effectiveness of naloxone provision in preventing opioid-related overdose death at the community level through community-based distribution (e.g., through overdose education and naloxone distribution programs in community service agencies) to persons at risk for overdose (mostly due to illicit opiate use), and it is plausible that effectiveness would be observed when naloxone is provided in the clinical setting as well.

Assessing Risk and Addressing Harms of Opioid Use

- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
 - Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. Clinicians should communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.
- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Medical Societies, Pharmacist and Pharmacy and DEA created document: Red Flags for Prescribing

- There were several parties (including ASA) involved with document and over 2 year period including the DEA.
- Red flags warning signs are screening tools that we should be considering before prescribing an opioid for patients.

Red Flag Signs



Initial Visit/Presentation

- Patients who travel to the prescriber's practice as a group and all request controlled substance prescriptions on the same day.
- Patient declines physical examination, or permission to obtain past records, or to undergo diagnostic tests.
- Patient statements and conduct suggest abuse of controlled substances, eg, appears sedated, confused, intoxicated, or exhibits withdrawal symptoms, or had physical signs of drug abuse.

Medication Taking/Supply

- Patient exhibits multiple unexplained dose escalations or other non-adherence to the treatment plan.
- Patient uses a route of drug administration other than the method prescribed, eg, injecting or inhaling oral formulations; ingesting transdermal formulations.
- Patient repeatedly seeks medications from non-coordinated sites of care; possible examples could include the emergency department, urgent care facilities, or walk-in clinics.
- Patient suffers and unintentional (or intentional) overdose.

Patient Behavior/Communication

- Patient behavior or PDMP report provides evidence that the patient is obtaining controlled substance prescriptions from multiple health care practitioners without the prescribers' knowledge of the other prescriptions.
- Patient was discharged from another physician practice for egregious behavior.
- Patient pressures physician to prescribe by implying or making direct threats to the prescriber or staff.

Treatment Plan Related

- Patient repeatedly resists changes in the treatment plan, despite clear evidence or adverse physical or psychological effects from the drug.
- Patient refuses to sign, or fails to comply with, an opioid pain care agreement governing their use of opioid analgesics.

Illicit/Illegal

- Prescriber is made aware that patient alters, forges, or rewrites prescriptions.
- Prescriber receives reliable information that patient is diverting or selling medication, or "borrowing" drugs from others.
- Patient indicates that drugs will be shared with others or sold.
- Patient requests controlled substance prescriptions written in the names of other people for whom the patient is not the designated caregiver.



What are some of the measures taken to Control the Opioid Epidemic

PHARMACY CORRESPONDING RESPONSIBILITY

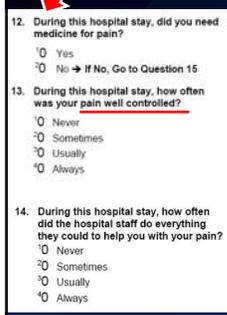
- Pharmacists are accountable for improperly prescribed / dispensed medications.
- DEA mandates on pharmacists "include assessing whether **prescriptions for controlled substances were written for a legitimate medical purpose in the usual course of professional practice.**"
- A pharmacist should not dispense a controlled substance unless he/she concludes that the prescription meets these criteria.



Naloxone access laws, physician co-prescribing on the rise

- In the second quarter of 2015, 4,291 prescriptions were dispensed, a 1,170 percent increase over prescriptions in the fourth quarter of 2013.
- ASA & AMA advocacy and widespread state medical society support has led to more than two dozen new state laws that increase access to naloxone—bringing the national total to more than 45 states with naloxone access laws.

Hospital Care Quality Information from the Consumer Perspective (HCAHPS)



- The intent of the HCAHPS is to provide a standard survey for measuring patient's perspective on hospital care.
- CMS payment to hospital is going to be based on the percentile of the summed score.
- Pain Management for 2015:
 - Rush University: 73%
 - Average for the state: 72%
 - National average: 71%

<http://www.hospitalcompare.hhs.gov/>

CMS proposes eliminating pain management from HCAHPS payment score

- In an effort to combat the opioid addiction raging in the U.S., CMS has proposed removing pain management-related questions on the HCAHPS survey from the hospital payment scoring calculation.
- Many clinicians report feeling pressure to overprescribe opioids because scores on the HCAHPS survey pain management questions are tied to Medicare payments to hospitals.
- Under the proposal, the three pain management questions on the [HCAHPS survey would no longer factor into the Hospital Value-Based Purchasing Program payments from Medicare](#), starting in fiscal year 2018. The questions would remain on the survey, however.

“Report Cards” for Physicians with Opioids Prescriptions: Pilot program in AZ

- Arizona's quarterly reports rate a doctor's prescribing of oxycodone and certain other drugs as normal, high, severe or extreme compared with the state's other doctors in his medical specialty.
- During a two-year pilot program, the number of opiate prescriptions fell 10% in five counties while rising in other counties.
- The report cards also contributed to a 4% drop in overdose deaths in the pilot counties.

Safely Disposing of Unneeded Prescription Opioids

- The DEA has announced it will hold its 12th National Prescription Drug take Back on Saturday, October 22, providing a safe, convenient, and responsible way of disposing of unneeded prescription drugs.
- More than 6.4 million pounds of medication have been collected over the last eleven Take Back Days.
- Local communities and some pharmacies are also establishing ongoing drug take-back programs.

ASA Action Plan on Opioid Crisis

- ASA believes a **multipronged strategy** is necessary to reduce the misuse, abuse, and diversion of prescription opioid medications that have led to unintended consequences, including deaths.
- ASA believes the solutions to this public health epidemic require **collaboration among multiple entities**, including federal and state policymakers and representatives from the judicial branch, physicians and other health care professionals, patients, educators, and public health officials.

ASA Initiatives on the Opioid Crisis

- ASA collaborated with the White House Office of National Drug Control Policy (ONDCP) to develop a wallet-sized card to help families identify the signs and symptoms of an overdose, as well as tips for responding to an overdose.
- ASA has partnered with the AMA and encourages more physicians to register and use state Prescription Drug Monitoring Programs (PDMP); enhance physician education on effective evidence based prescribing, reduce stigma, and enhance access to naloxone and also develop the online portal for CME resources for physician education.

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