Teaching Residents Appropriate Opioid Prescribing

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Disclosure

• Drs. Munzing, Cummins and Murray have no relevant financial interests to disclose
Goals & Objectives: Participants will be able to:

• Discuss the roots of the opioid crisis
• Incorporate standard of care elements and patient safety when managing pain by residency programs
• Implement specific strategies to monitor patients when opioid prescribing is indicated
Outdated Information is Wrong

- “The risk of addiction is much less than 1%”
- Pain 5th Vital Sign
- 1990’s Physicians encouraged to treat pain aggressively (assumed no harm)

Undercover states this is his “Back MRI”
What Do You See???

Conviction – 17 counts – 3 years in prison – September 2016
National Overdose Deaths
Opioid Drugs

- 33,091 People Year= 91 People Day

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Prescription Opioid Pain Relievers

Source: National Center for Health Statistics, CDC Wonder

National Overdose Deaths
Heroin

Source: National Center for Health Statistics, CDC Wonder
Poll Question:
Which of the following predict misuse of prescription opioids?

A. Race
B. Literacy
C. Disability
D. Socioeconomic status
E. All of the Above
F. None of the Above

Cultural Competence

Do Not Predict
- Gender
- Race
- Literacy
- Disability
- Socioeconomic status

Predict
- Hx EtOH/drug abuse*
- Hx EtOH/drug-related criminal conviction
- FHx EtOH/drug abuse
- Psychiatric disorder
- Includes nicotine

Universal Precautions for Opioid Prescribing

- Evaluate the need
- Assess risk
- Select the specific opioid - treatment
- Discuss – informed consent – written agreement
- Monitor closely
- Document thoroughly

General Principles

- Act like a doctor
- 90- day cliff (or much shorter - 3-5 days???)
- Non-pharmacologic alternatives and adjunct treatments
- Non-opioid alternatives – multiple modalities
- Start low and go slow – very limited prescription numbers
- Trust but verify
- Documentation – be thorough!
Poll Question

Opioid Prescribing: A patient receives and takes an opioid prescription for an injury. Of patients taking the medication for 8 days, what percent will be on an opioid one year later?

A. 1.5%
B. 6.5%
C. 13.5%
D. 20.5%

Likelihood of Chronic Opioid Use

- Increased - 3rd day of Rx and each additional day after the 3rd day
- Sharpest increase – after 5th and 31st day
- 2nd refill
- 700 morphine mg equiv. cumulative dose
- Initial 10-day or 30-day supply
- Opioid Use 1 year later
  - 1 day – 6%
  - 8 days – 13.5%
  - 31 days – 29.9%

CDC MMWR – March 17, 2017 / 66(10); 265-269
2016 CDC Guidelines for Controlled Substances

- Avoid benzodiazepines with opioids [increases risk of overdose death ten-fold versus only opioid use]
- Periodic benefit / risk evaluation, including PDMP and Urine Drug Screen
- Non-pharmacologic and non-opioid tx – first line
- Chronic pain – avoid opioids – risk outweighs benefits for most

2016 CDC Guidelines for Controlled Substances

- Discuss risk / benefits with patients and document
- Establish realistic goals – prior to opioid starts
- Start immediate release – avoid Methadone as first line – higher risk
- Additional precautions if dose exceeds 50 MME mg /day
• "Generally avoid increasing the dosage >= 90 MME mg/day
• Should only give 3 days max for acute pain for most non-traumatic, non-surgical pain
• Avoid combinations – short and long acting opioids
• Concerns – may limit opioids for some for whom they may benefit

2016 CDC Guidelines for Controlled Substances Con’t

Pain Management Basics

• Multiple strategies
  • Non-pharmacologic
  • Pharmacologic
  • Procedures
  • Opioids
  • Devices
The 5 A’s Plus

- **Analgesia**: rating of average pain, worst pain, and pain relief
- **Activity**: progress in patient’s functional goals
- **Adverse Effects**: nausea, dizziness, drowsiness, other forms of impairment, etc.
- **Affect**: impacts to mood, anxiety, depression, ability to be happy, etc.
- **Aberrant behaviors**: taking meds as prescribed, illicit drug use

www.fsmb.org/pdf/pain_policy_july2013

The 5 A’s Plus

- Prescription Drug Monitoring Program (PDMP)
- Urine Drug Screening (UDS)
- Updated History, Exam, and Assessment
- Taper medications when possible
- Include the Morphine Equiv Dosing – Every visit

www.fsmb.org/pdf/pain_policy_july2013
- Use of generic vs brand opioids (less diverted)
- Opioids < 90 mg/day
- Initial fill – 3 days
- Eliminate use of Soma (Carisoprodol)
- Use short acting opioids

**Kaiser Permanente Opioid Actions (Southern California)**

- 98% reduction – Rx over 200 pills
- 95% reduction in brand name opioid-acet meds
- 72% reduction - Rx of long acting opioids
- 90% decrease in opioid Rx with benzodiazepines and carisoprodol

**Kaiser Permanente Opioid Results (Southern California)**
Poll Question
Red Flags: Which red flags confirm opioid abuse / diversion?
A. Early Refill
B. Escalating Dosing
C. Multiple pharmacies used
D. All of the above
E. None of the above

Identify Potential Red Flags in PDMP
- Early Refills
- MED > 100 mg / day
- Multiple concurrent prescribers
- Multiple pharmacies
- Combinations (i.e. Opioid, Benzodiazepine, Soma)
- Escalating dosing by provider
- Escalating prescriptions by patient
Additional Potential Red Flags

- Inconsistent UDT results
- Patients driving a long distance for care
- Multiple family members – identical or similar meds
- Drug overdoses
- Buy/ give / sell meds
- Use of THC – even with Marijuana Card

Dangerous / Common Combinations

- “Holy Trinity” –
  – Oxycodone, Benzodiazepine, Soma
- “Houston Cocktail” –
  – Norco, Xanax, Soma
- “Sizzurp” –
  – Promethazine with codeine cough syrup, Jolly Ranchers candy, fruit flavored cola
Poll Question – MED Dosing
MED Dosing: Which oral opioid is strongest mg to mg?
A. Oxycodone
B. Hydrocodone
C. Morphine
D. Oxymorphone
E. Methadone

Morphine Equivalent Dosing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand</th>
<th>Relative Strength</th>
<th>100 mg/d MED Equiv</th>
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<tbody>
<tr>
<td>Morphine</td>
<td>Methadose</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Norco, Vicodin</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>OxyCodone, Roxycodeone</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Dilaudid</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>Opana</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td>10 +</td>
<td>10</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Duragesic</td>
<td>100</td>
<td>42</td>
</tr>
</tbody>
</table>

Adapted from Opioid Calculator - Available at http://agencymeddirectors.wa.gov/mobile.html
Physician Drug Monitoring Program (PDMP) – [Example]

Opioid Dosing Calculator – Morphine Equivalent Dosing (mg/day) – (Oral dosing except Fentanyl)

Available at http://agencymeddirectors.wa.gov/mobile.html
Resident Teaching Opportunities

- Imbed opioid patient safety into the system (make it your DNA)
- Noon conferences
- Hospital rounds
- Pain management workshops
- Chart reviews

Additional Issues and Questions???

- How to deal with early refills?
- Multiple prescribers – physician generated?
- Are opioid medications really needed?
- How do I treat an addict in pain?
- Inheriting patients on high dose opioids?
- Do I refill when covering for a colleague?
- When do I refer to pain management?
• Thorough evaluation prior to prescribing, including behavioral/mental health
• Current / past Alcohol & Drug use / abuse
• Opioid Risk Evaluation (Opioid Risk Tool)
• Assessment/Goals – as specific as possible
• Individualize treatment – Function > Pain Improvement – Multi-modal tx

• Start low and go slow – up titrate and down titrate
• Trust but verify what your patients say
• Only one opioid at a time if at all possible
• Avoid opioid and benzodiazepine combination
• Long acting opioids have lower addictive qualities
• Document MED, UDS, PDMP
Improving Patient Safety and Outcomes

References

- “Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain”; Permanente Journal, Timothy Munzing; 2017
- DEA Regulation 21 C.F.R. 1306.04 – Purpose of issue of prescription
- “Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study”; Annals of Internal Medicine, Kate Dunn, PhD, et al; January 19, 2010 [MED dosing information / risks]
- Washington State Agency Medical Directors’ Group – in conjunction with the Interagency Guideline on Opioid Dosing for Non-cancer Pain
References

• Drug Enforcement Administration
• Centers for Disease Control - Overdose and Overdose death statistics

Books

• Dreamland: The True Talk of America’s Opiate Epidemic; Author: Sam Quinones
• American Pain: How a Young Felon and His Ring of Doctors Unleashed America’s Deadliest Epidemic; Author: John Temple
• Drug Dealer, MD: How Doctors were Duped, Patients Got Hooked, and Why It’s So Hard to Stop; Author: Anna Lembke
Opioid Prescribing Review

• “Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain”, The Permanente Journal
• Author – Timothy Munzing, MD
• https://doi.org/10.7812/TPP/16-169

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