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Maine Medical Association

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

#OP19

OPIOID CLINICAL UPDATE 2019

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Speaker:
Elisabeth Fowlie Mock, MD, MPH, FAAFP

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FOOD & SCHEDULE

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Disclosures/Disclaimers

- MICIS does not accept any money from pharmaceutical companies/commercial interests
- Speakers and planners have no significant or relevant financial relationships to disclose
- Handouts for this presentation may include “off label use” of medications
- Recommendations are general, prescribers should individualize decisions to each patient

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Education Credits

- MD/DO: pilot to e-submit to BOLIM/BOM
- All: green CME forms at exit table
- Other certificates: from Adcare

- New offering: 1:1 Academic Detailing (Individual Coaching) for Prescriber-2019

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Objectives

- Review latest research relating to opioid & pain prescribing practices
- Constantly consider harm reduction
- Discuss opioid use disorder and treatments

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CHANGING FOCUS ON OPIOID PRESCRIBING

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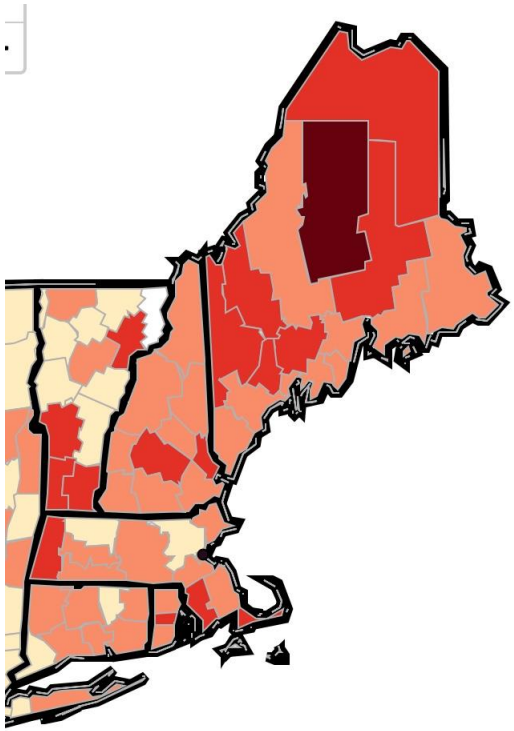
US Prescribing Rates by County



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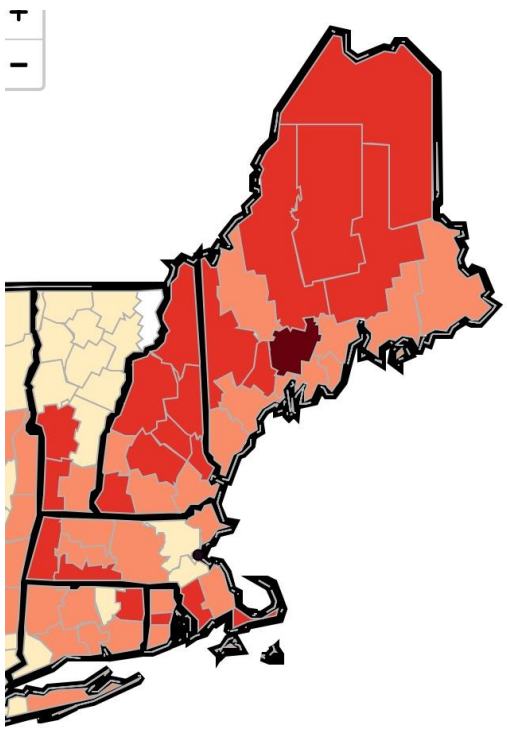

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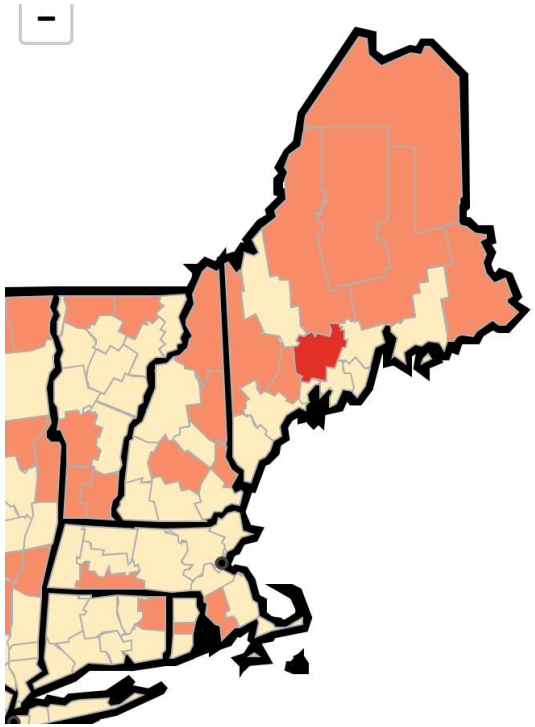

2017

Source: CDC

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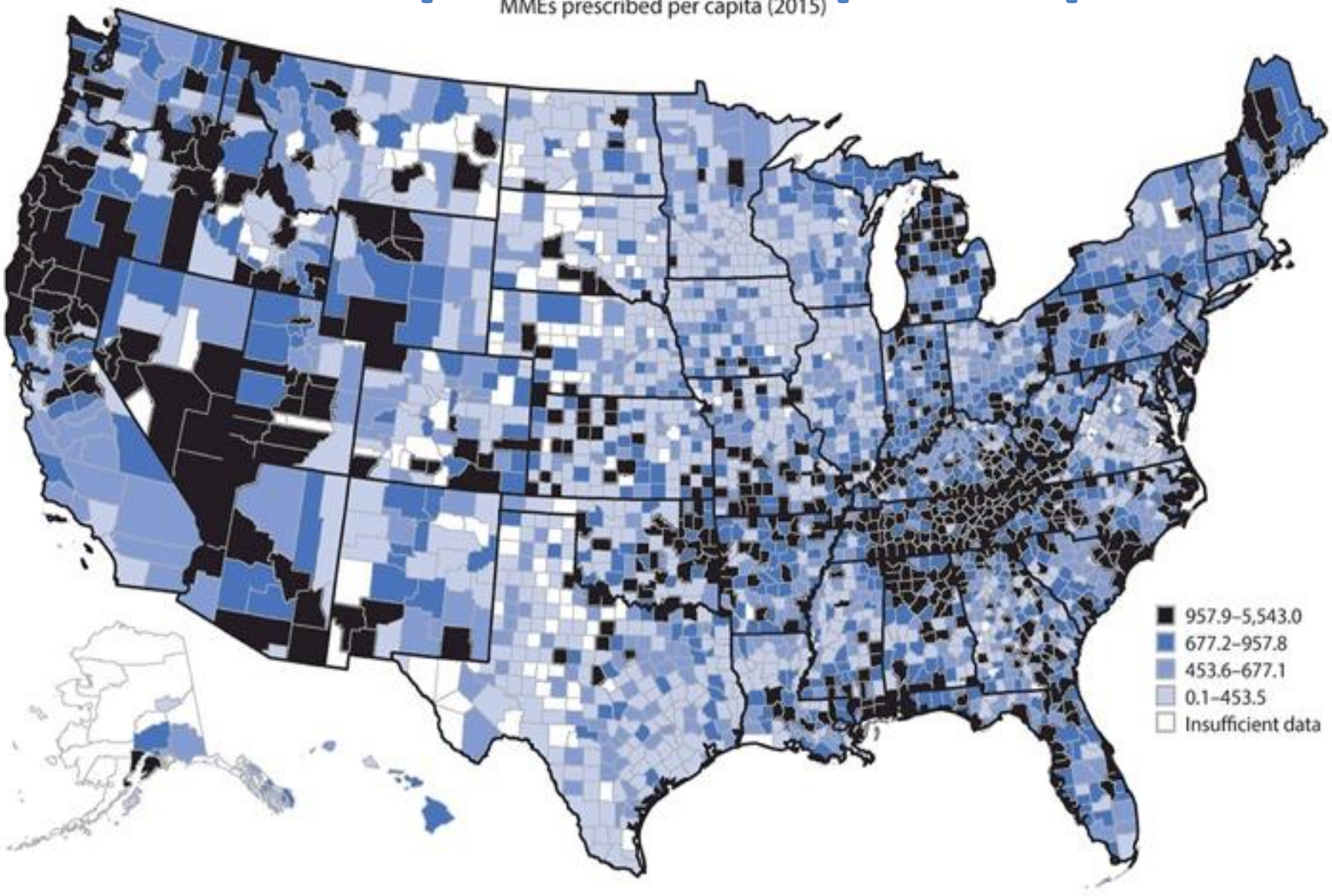
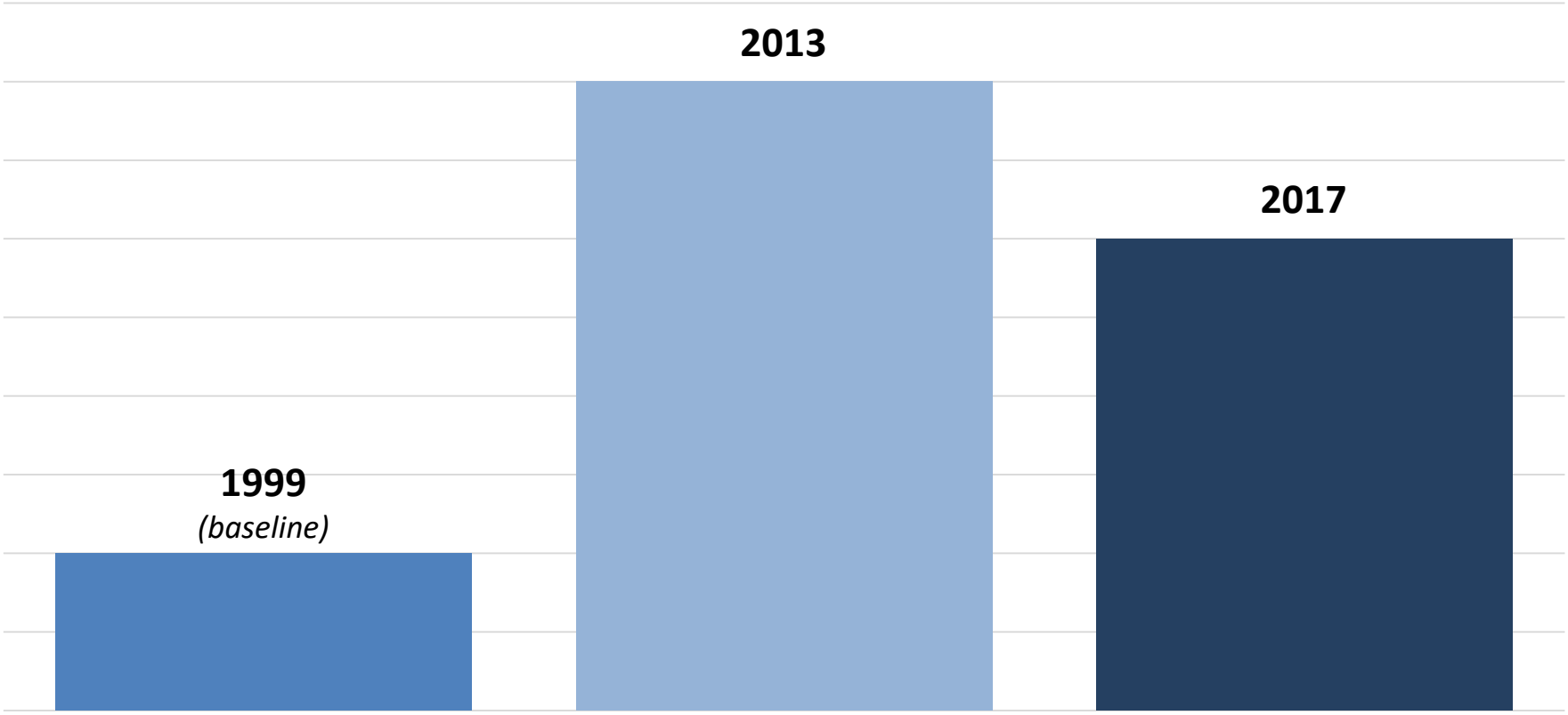
MMEs prescribed per capita



US Opioid prescribing rates: improving but still 3x>1999



Source: CDC

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DISCUSS YOUR RECENT/ CURRENT PAIN PRESCRIBING PRACTICES (ACUTE OR CHRONIC)

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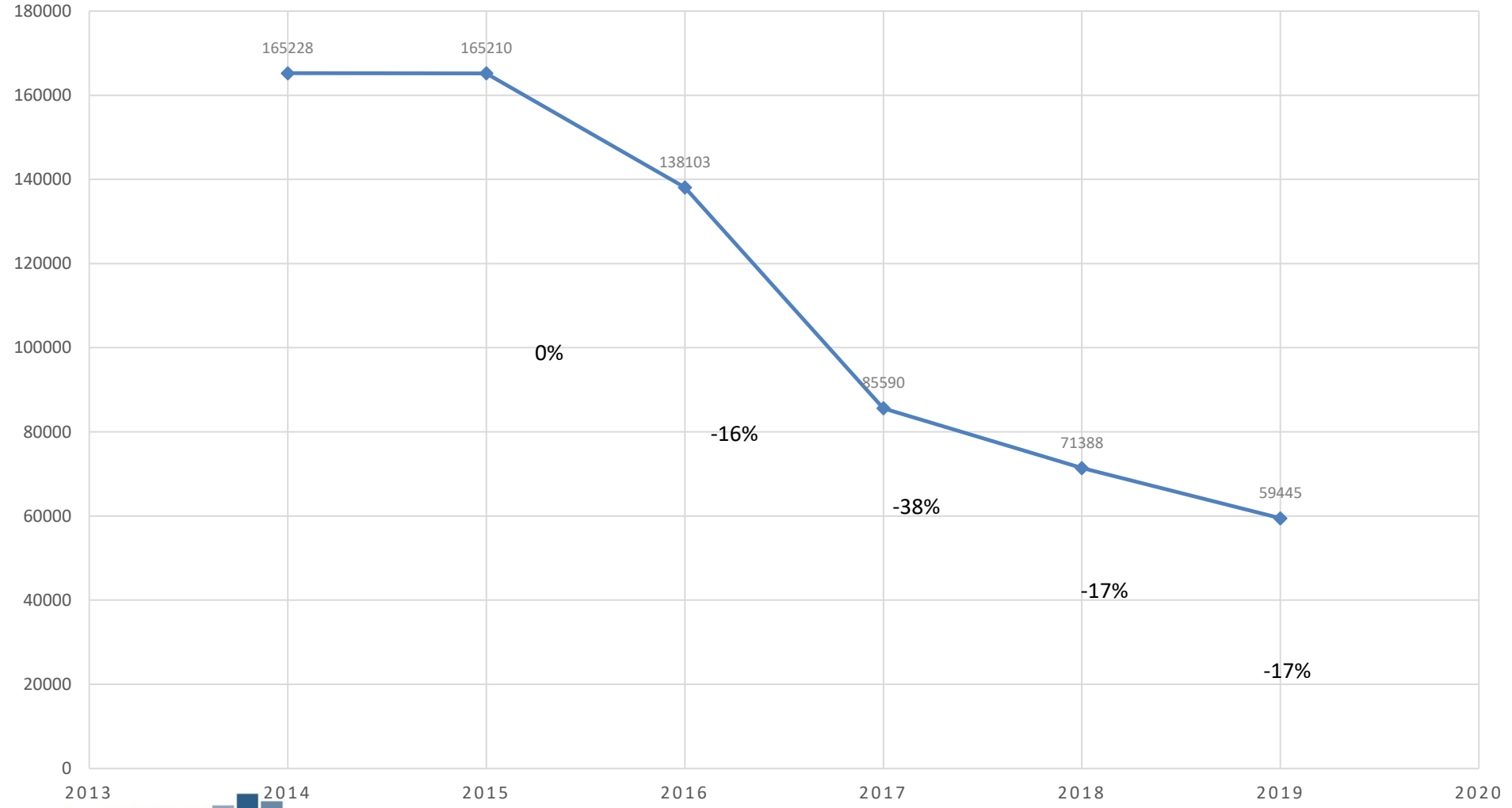
Number of Dispensations for rx >100 MME-Maine



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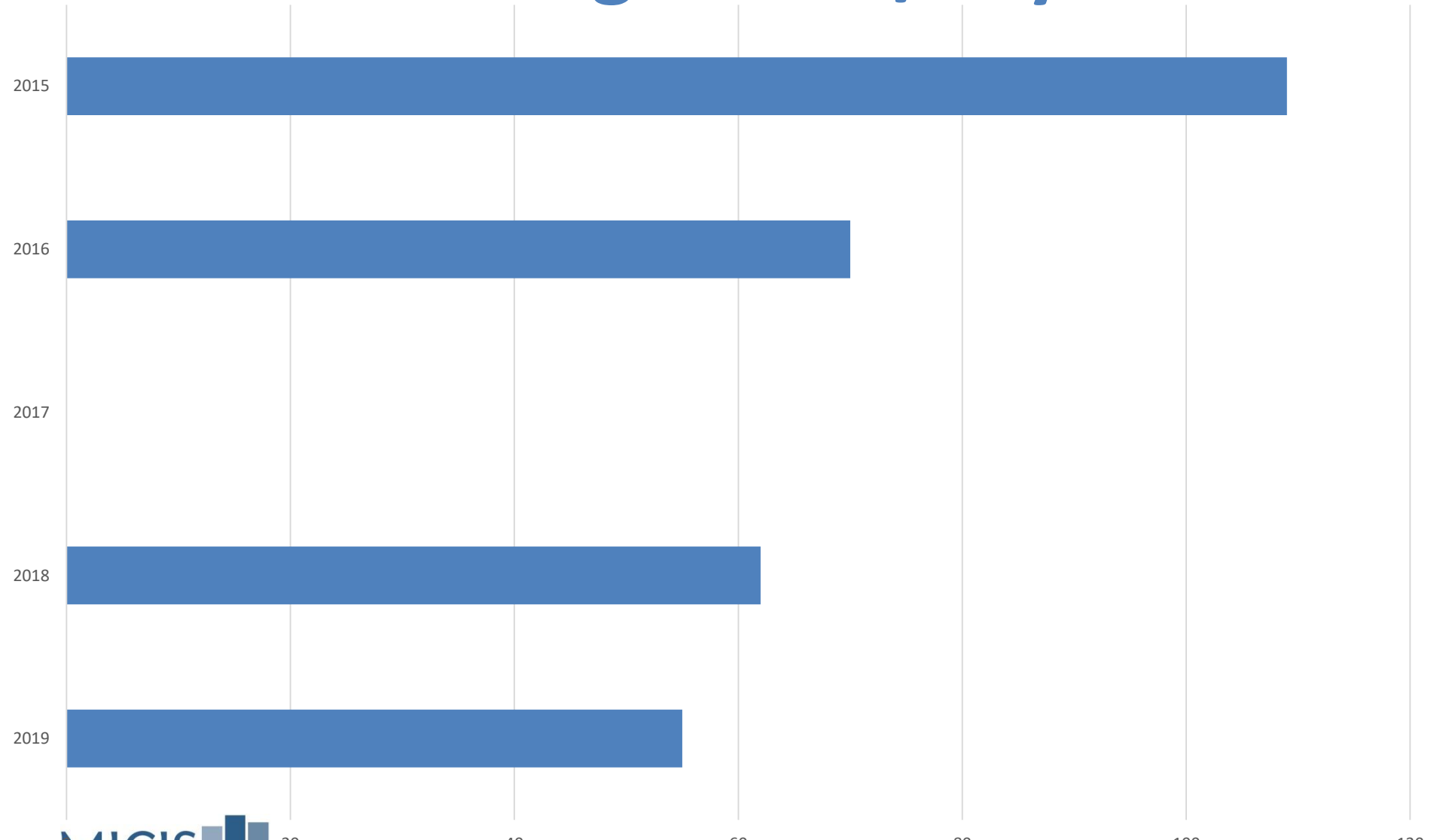
Average MME/day



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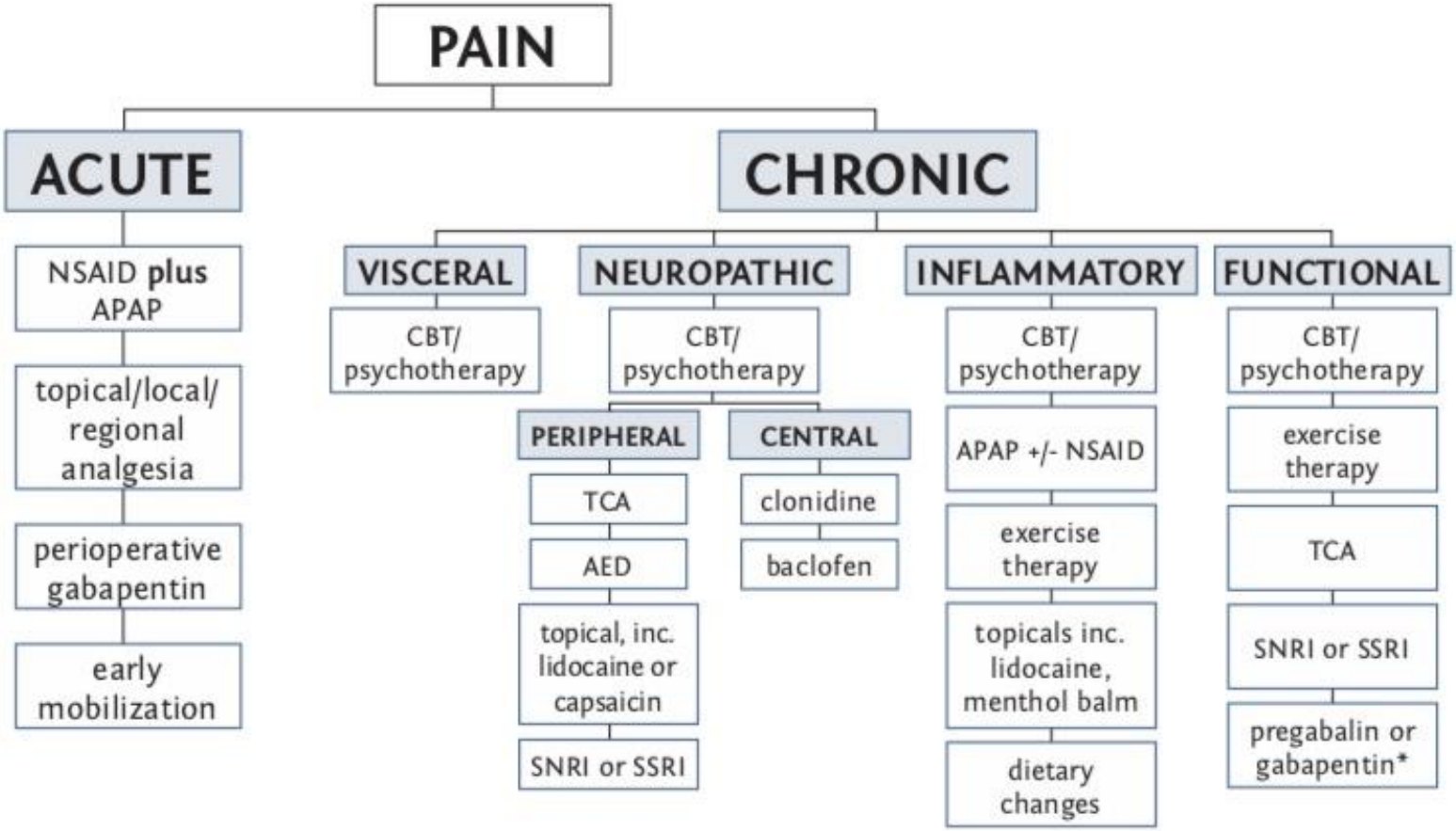
Current Best Practice Recommendations for Pain

- Multimodal & multidiscliplinary
- Grounded in scientific evidence
- Biopsychosocial view
- Coordinated & integrated
- Population-based but tailored to individual
- **3 day supply for acute**

Pain Management Interagency Taskforce, 2018

MICIS | Alternative Treatments for Pain



*pregabalin and gabapentin have potential for misuse and additive sedative effects when combined with opioids.

Sources: multiple | micismaine.org | Revised 5/19

MUCH OF MAINE CHAPTER 488 IS ECHOED FROM CDC RECS

2016 CDC GUIDELINES & THEIR APPLICATION

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CDC guidelines are based on the **lack of evidence that** higher opioid dosages confer long-term benefits for pain relief.

Most people have equal or better function and pain once tapered but the devil is in the details: who, when, how fast?

Alternatives to opioids:

https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

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DISCUSSION-HOW TO APPROACH PTS STILL ON CHRONIC OPIOIDS

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CLARIFICATION OF 2016 CDC GUIDELINES

- Consider population
- No hard limits, individualize care
- No abrupt tapering or discontinuation
- MME thresholds should not apply to MAT

Dowell, NEJM, April 2019

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CLARIFICATION OF 2016 CDC GUIDELINES

- In patients already on high doses:
  - Maximize nonopioid tx
  - Review risks empathetically
  - Collaborate w/pts who agree to taper

Dowell, NEJM, April 2019

CLARIFICATION OF 2016 CDC GUIDELINES

- In patients already on high doses:
  - Taper slowly, minimize w/d sxs
  - Individualize taper pace
  - Closely monitor pts who continue on high doses
  - Mitigate OD risk in pts who continue on high doses

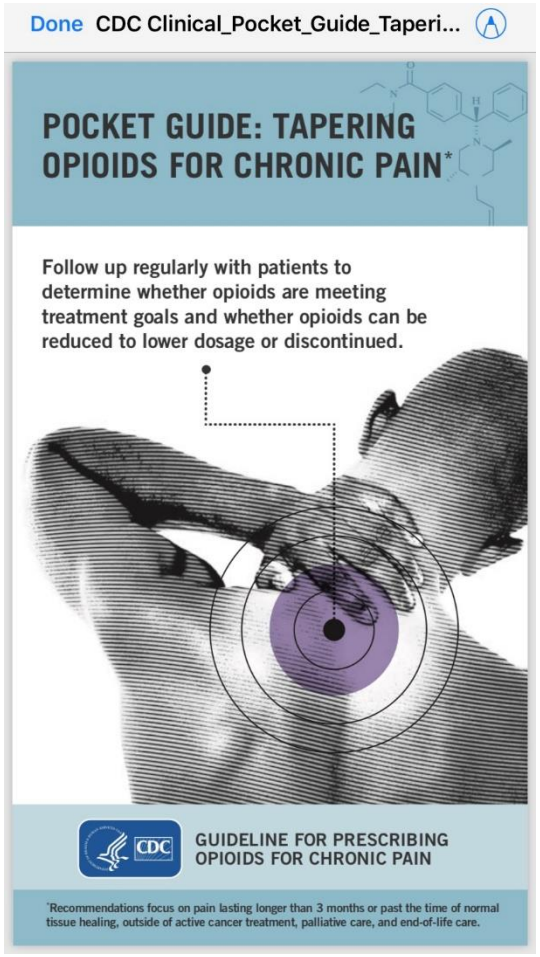
Dowell, NEJM, April 2019

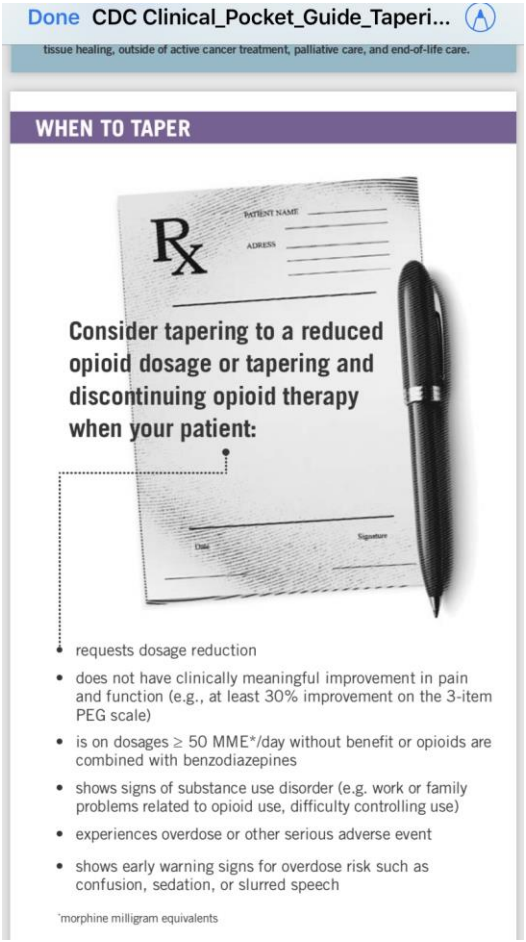
BRAVO-Stanford CME on tapering

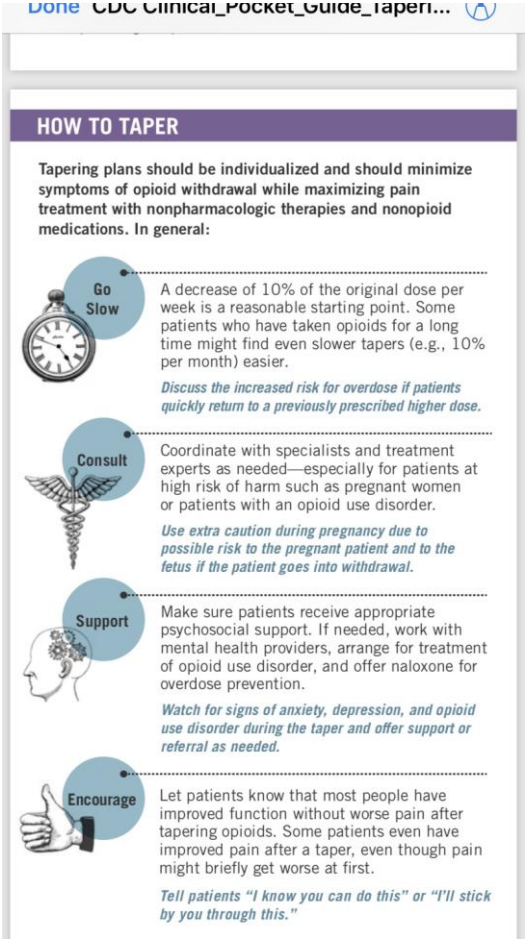
- **B**roach subject
- **R**isk benefit calculator
- **A**ddiction happens
- **V**elocity matters (+ validation)
- **O**ther options/strategies for coping w/pain
  - "Prescription Opioid Dependence"

Chou & Lembke, 2019

CDC Tapering Pocket Guide







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https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

PERI-OPERATIVE OPIOIDS/ACUTE PAIN

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Post-operative risks of opioids

- 6% chance of opioid-naïve pts becoming chronic opioid users after a post-operative course of opioids
- Higher risk in:
  - Tobacco users
  - Past or current alcohol use disorder/substance use disorder
  - Anxiety or depression dx
  - Other chronic pain syndrome
  - Comorbid conditions

Brummett, 2017; Moore, 2018

Post-op delirium

- Those who report greater post-op pain at rest are at increased risk for delirium
- Those treated with opioids are at increased risk of delirium
- The moral of this story: be aggressive in treating post-op pain, but avoid opioids if at all possible

Marcantonio, 1994

gabapentin

- **peri**operative administration may reduce the incidence and intensity of postoperative pain up to six months after surgery
  - otolaryngology
  - orthopedics
  - mastectomy
  - abdominal/pelvic operations

Hah, 2018

Surgical Education Study

- Operation-specific guidelines disseminated
- Initial number of opioids decreased by more than half
- No increase in subsequent opioid refills

Hill, Ann Surg, 3/18

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LANGUAGE & STIGMA REVIEW

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Words Matter: Improving the Substance Use Conversation, A Guide for Health Care Teams

Person with OUD

Substance exposed infant

Substance misuse

Unexpected findings in urine

In recovery

http://mainequalitycounts.org/wp-content/uploads/2018/10/QC-Substance-Use-Conversation-Guide.pdf

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OTHER STUDIES OF INTEREST

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SPACE Randomized Clinical Trial

- 240 VA patients
- 2 non-blinded arms: opioids & nonopioid medications
- No significant difference on pain-related function over 12 mos
- Pain intensity significantly better/less in nonopioid group (p=.03)

Krebs, 2018

Older adults w/arthritis

Pts rx'd opioids ~2x risk of

out of hospital cardiac death vs

comparable pts rx'd nonselective NSAIDs

(+ inc risk of hospitalization,

+ inc risk all-cause mortality)

Solomon, 2010

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Athenahealth study

- >30k PCP rx records over 3+ years
- Pts in the most rural counties had an 87% higher chance of receiving an opioid prescription (vs large metropolitan counties)
- Odds of receiving an opioid rx decreased in all counties after 2016 CDC Opioid Rx Guidelines released

Garcia, 2019

J of American Dental Association Systematic Review-April 2018

- Combinations of ibuprofen and acetaminophen
  - Highest assoc w/tx benefit
  - Highest proportion of maximal pain relief
- Opioid medications assoc most frequently w/acute adverse events

Moore, 2018

Hardwire Harm Reduction Strategies in All Medical Practices

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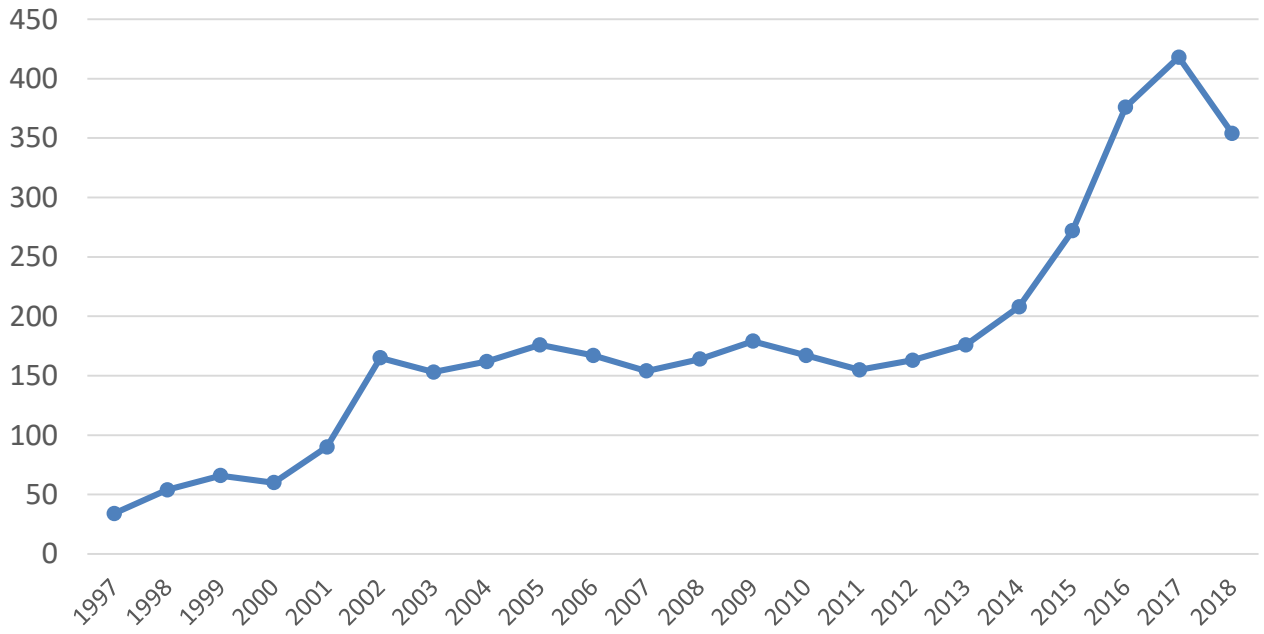
Maine Overdose Deaths



2018 overdoses involving opioids: **80%**

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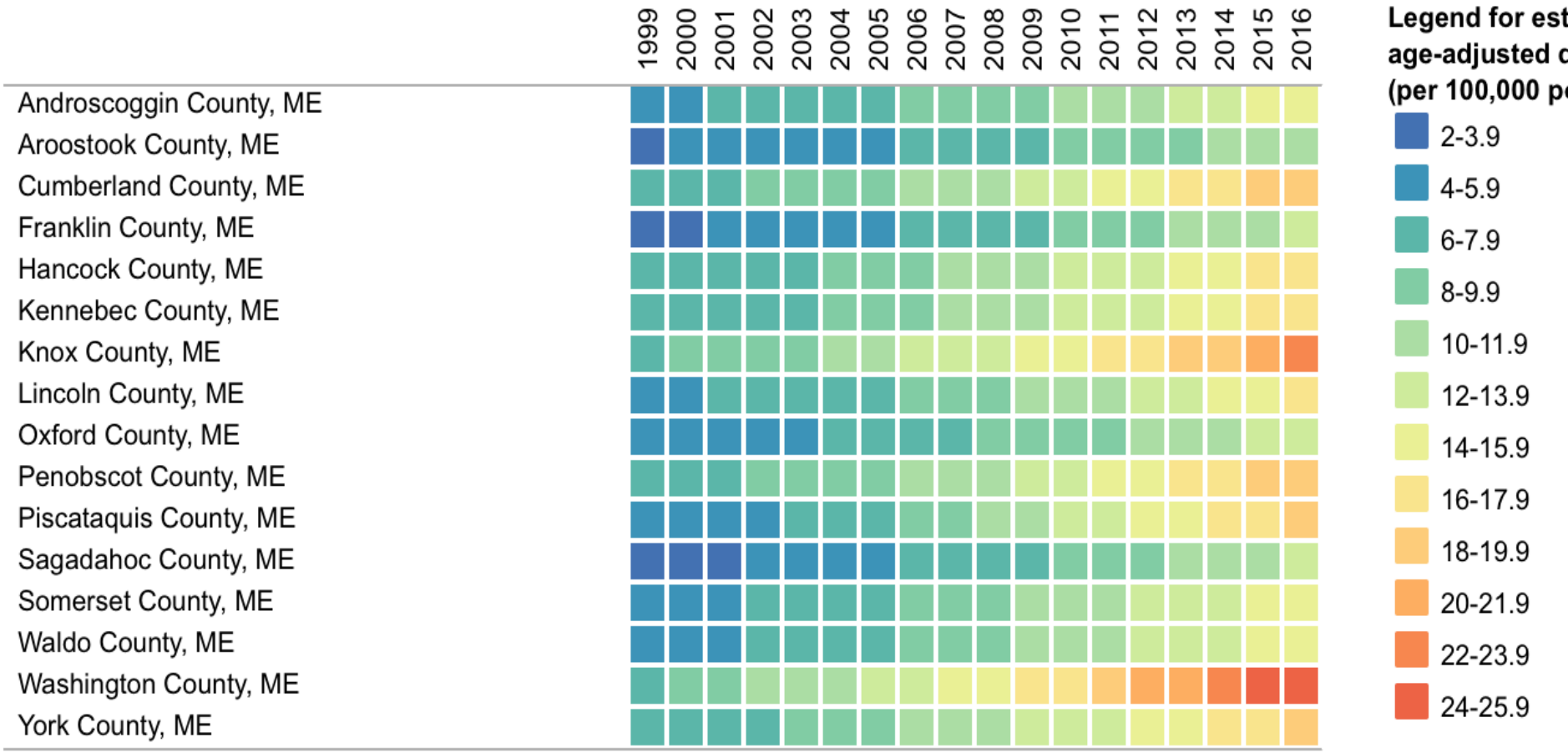
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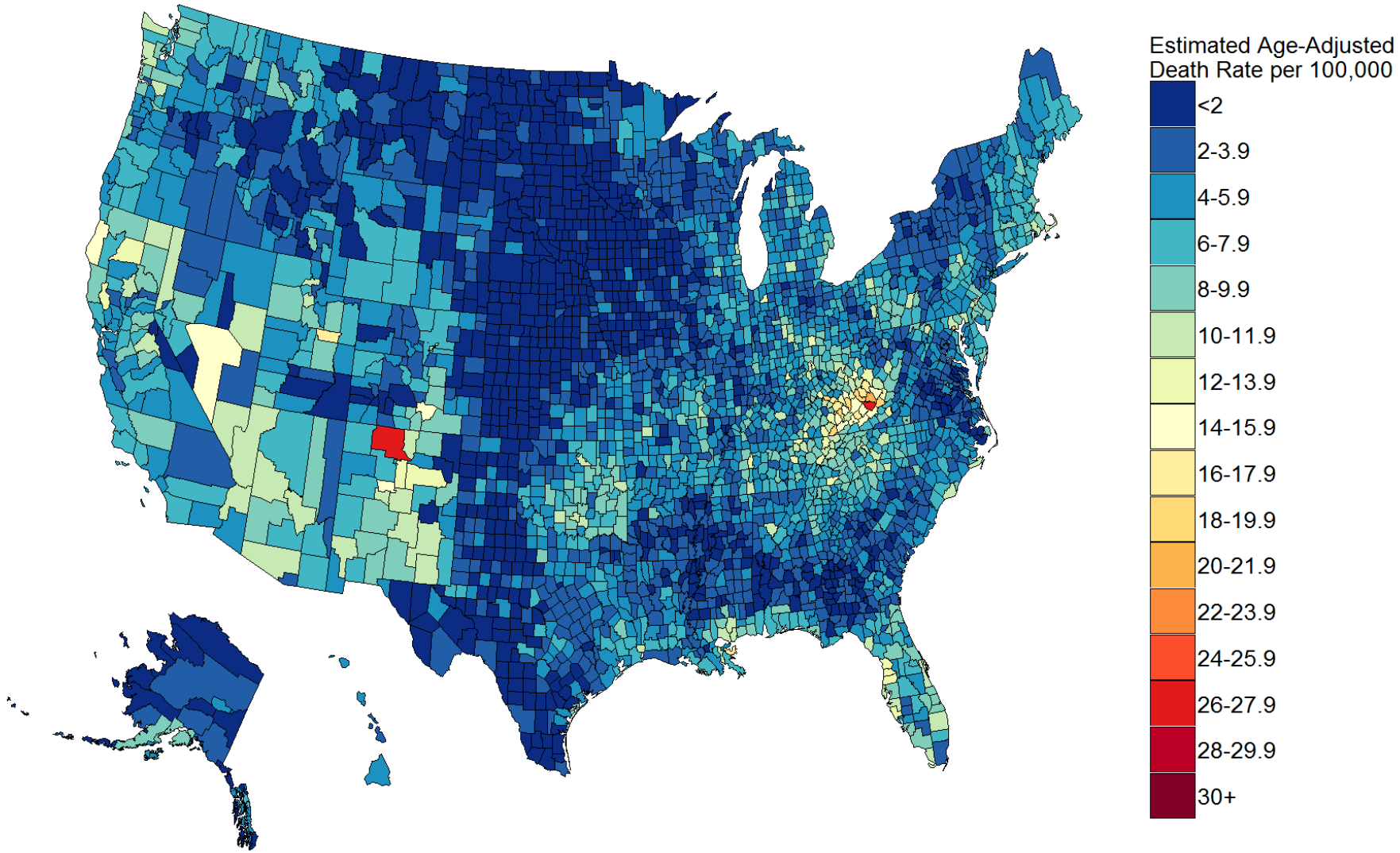
24-25.9

Source: CDC

Harm Reduction

- Prescribe opioids using conservative management strategies
- Limit supplies to 3 days for acute pain
- **Avoid** co-prescribing with benzodiazepines
- Exhaust nonopioid and nonpharmacologic treatment strategies (for acute or chronic)
- Document informed consent
- **Do** co-prescribe naloxone

1999



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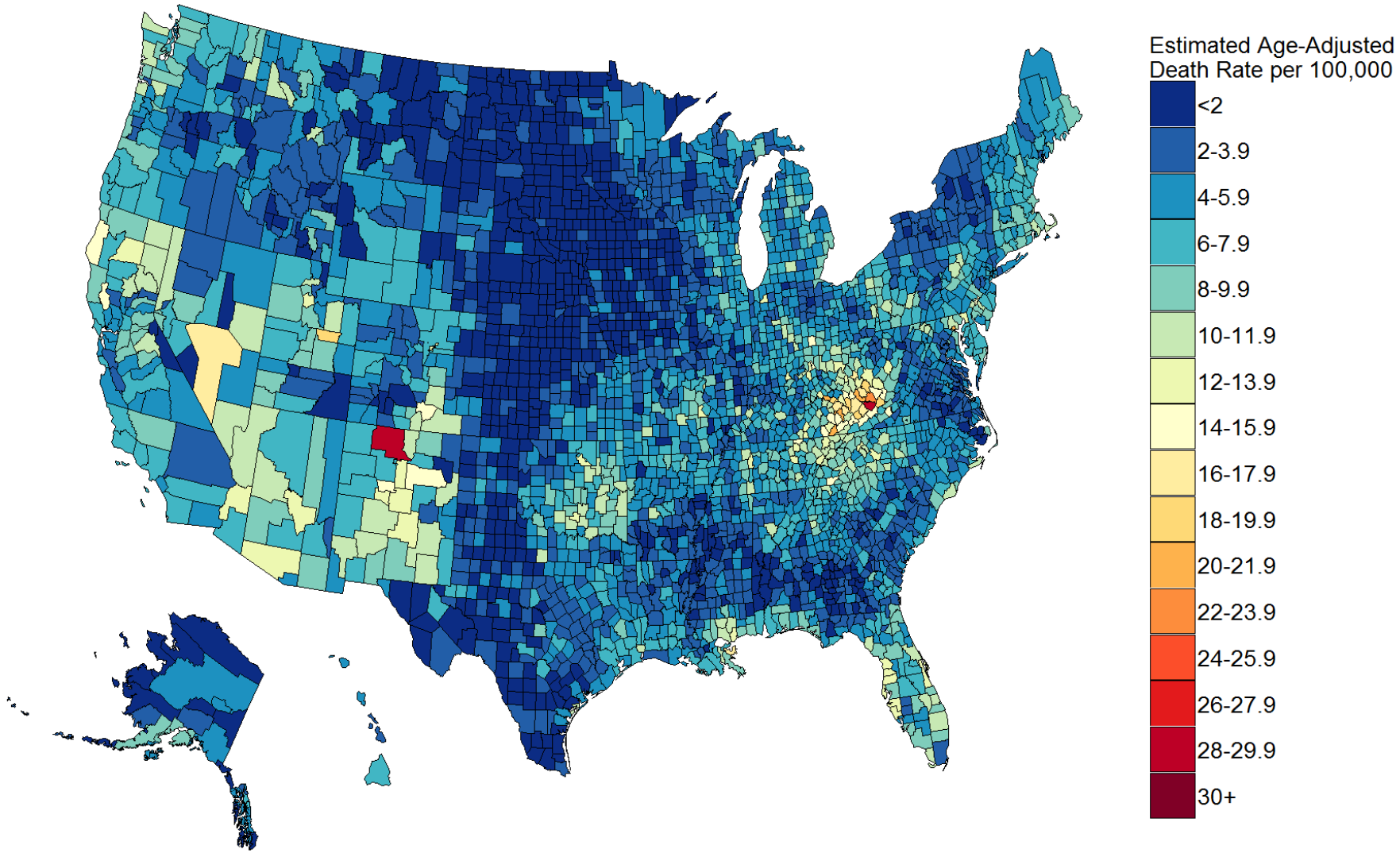

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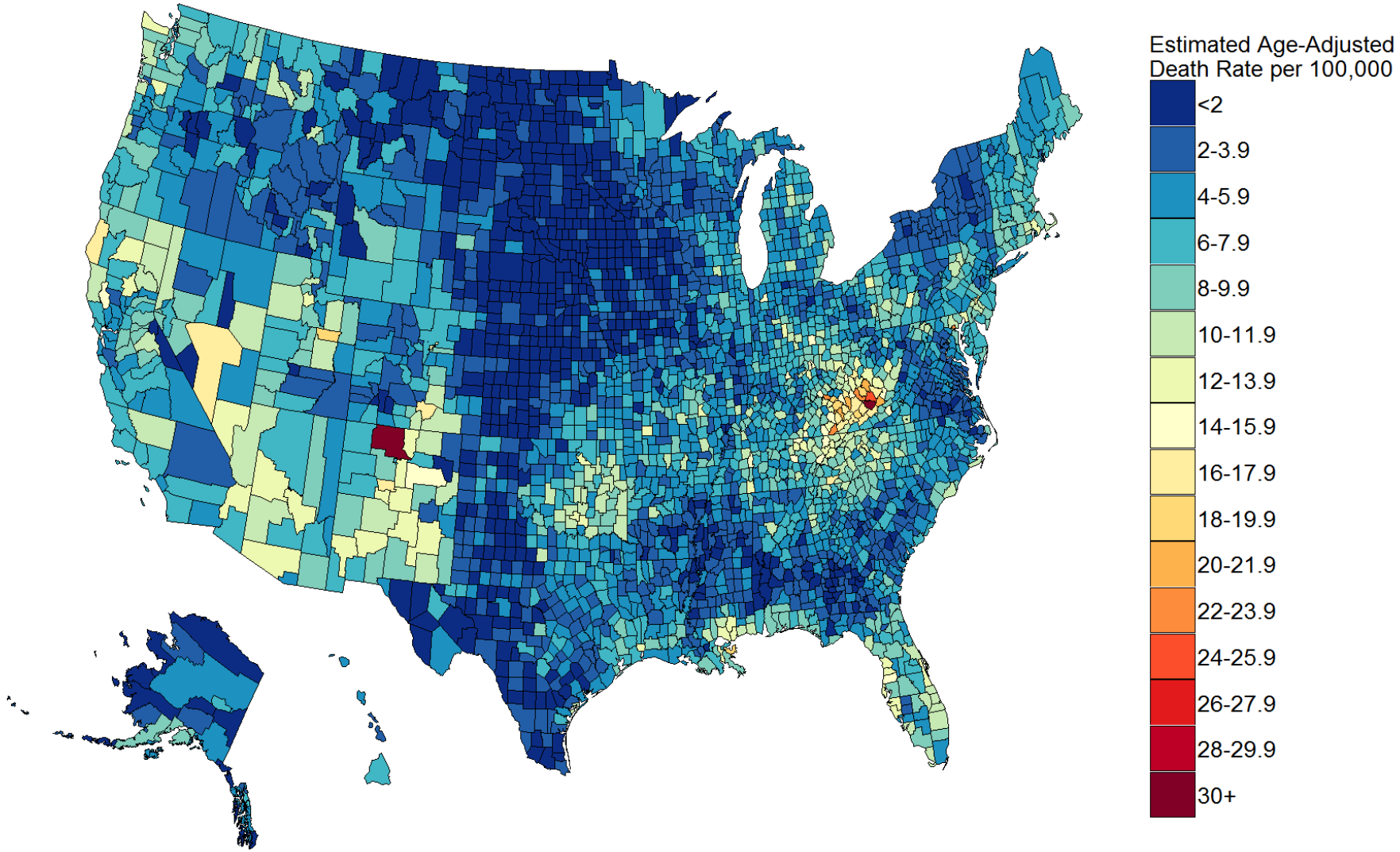
2001



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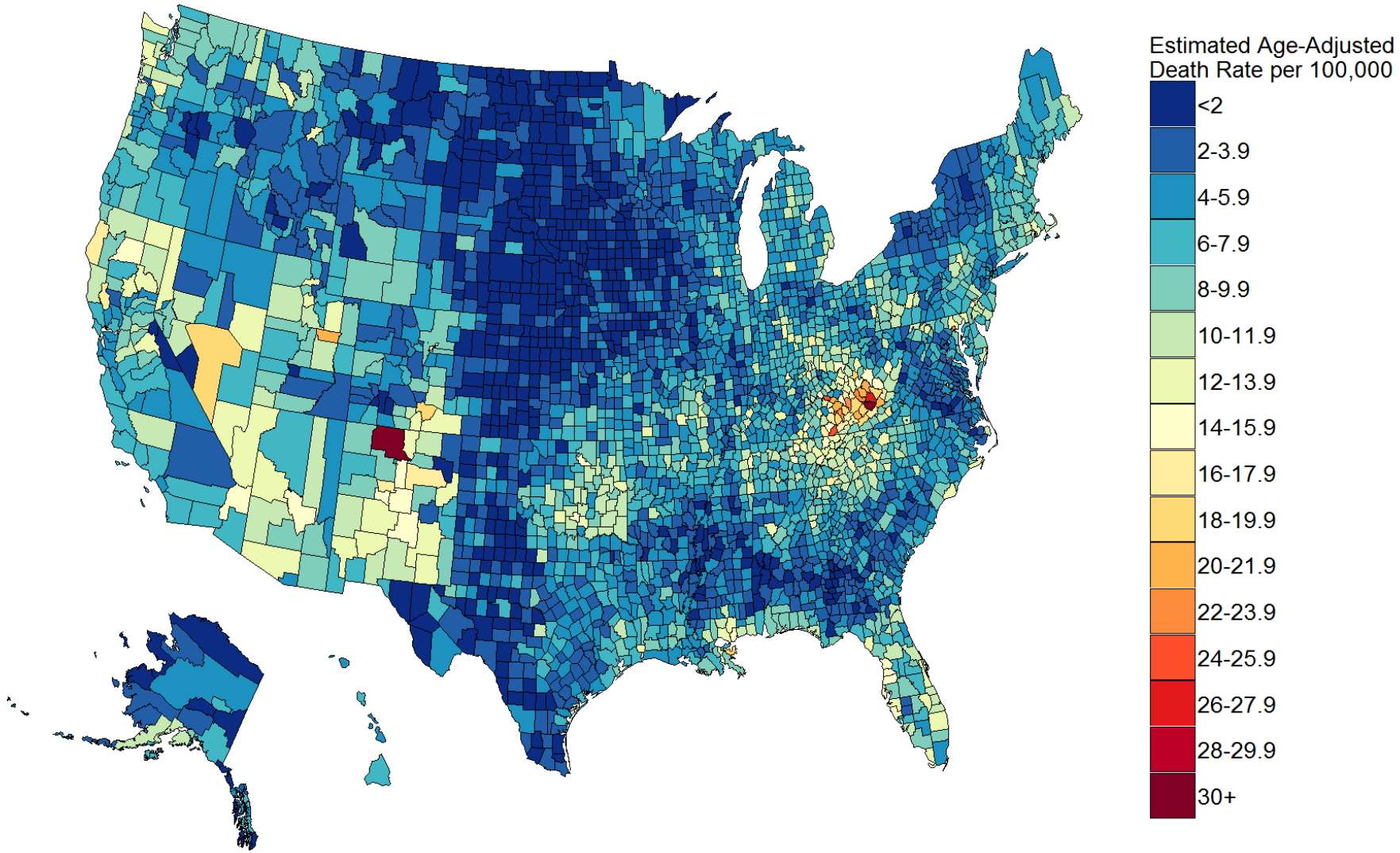
2002



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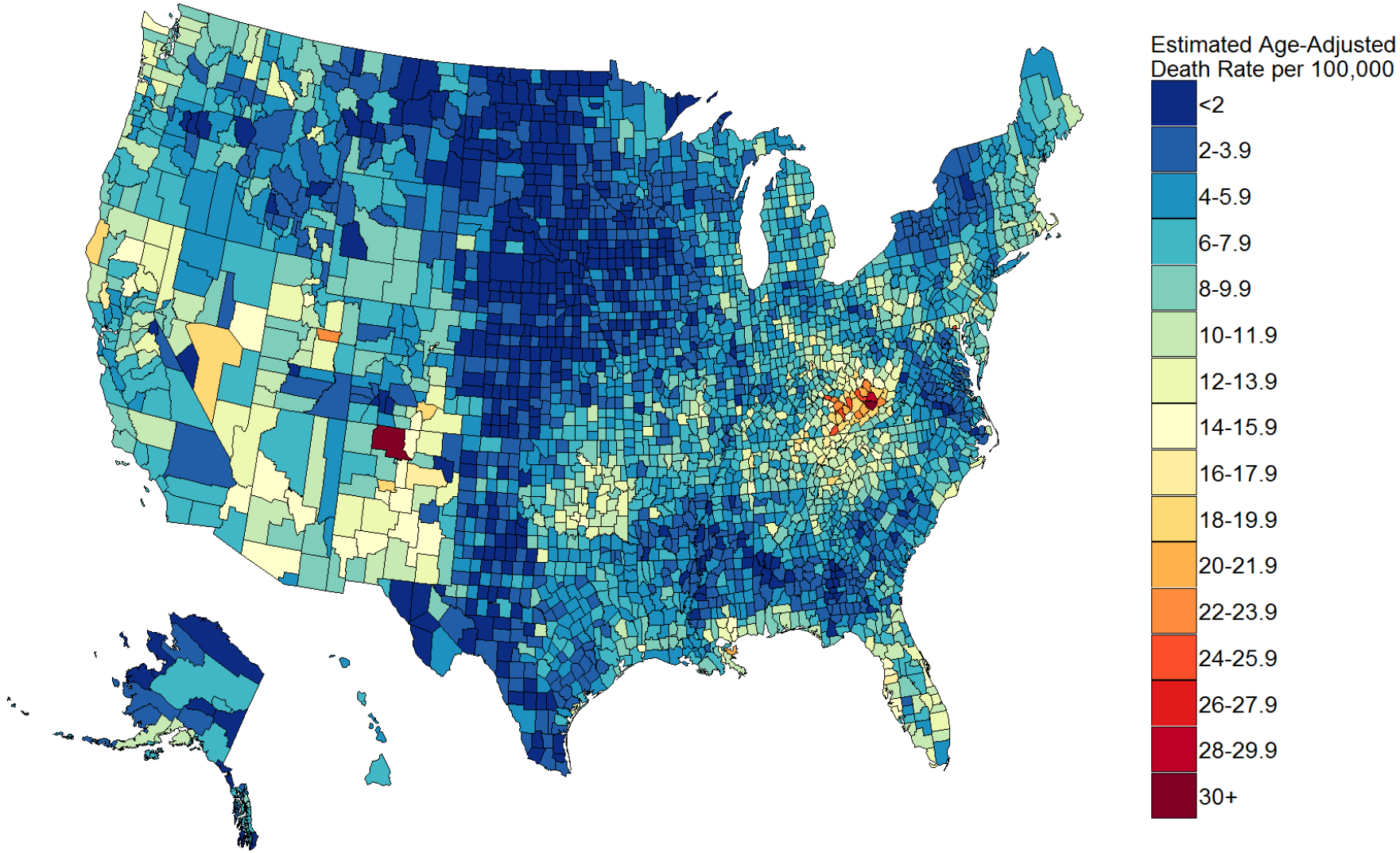
2003



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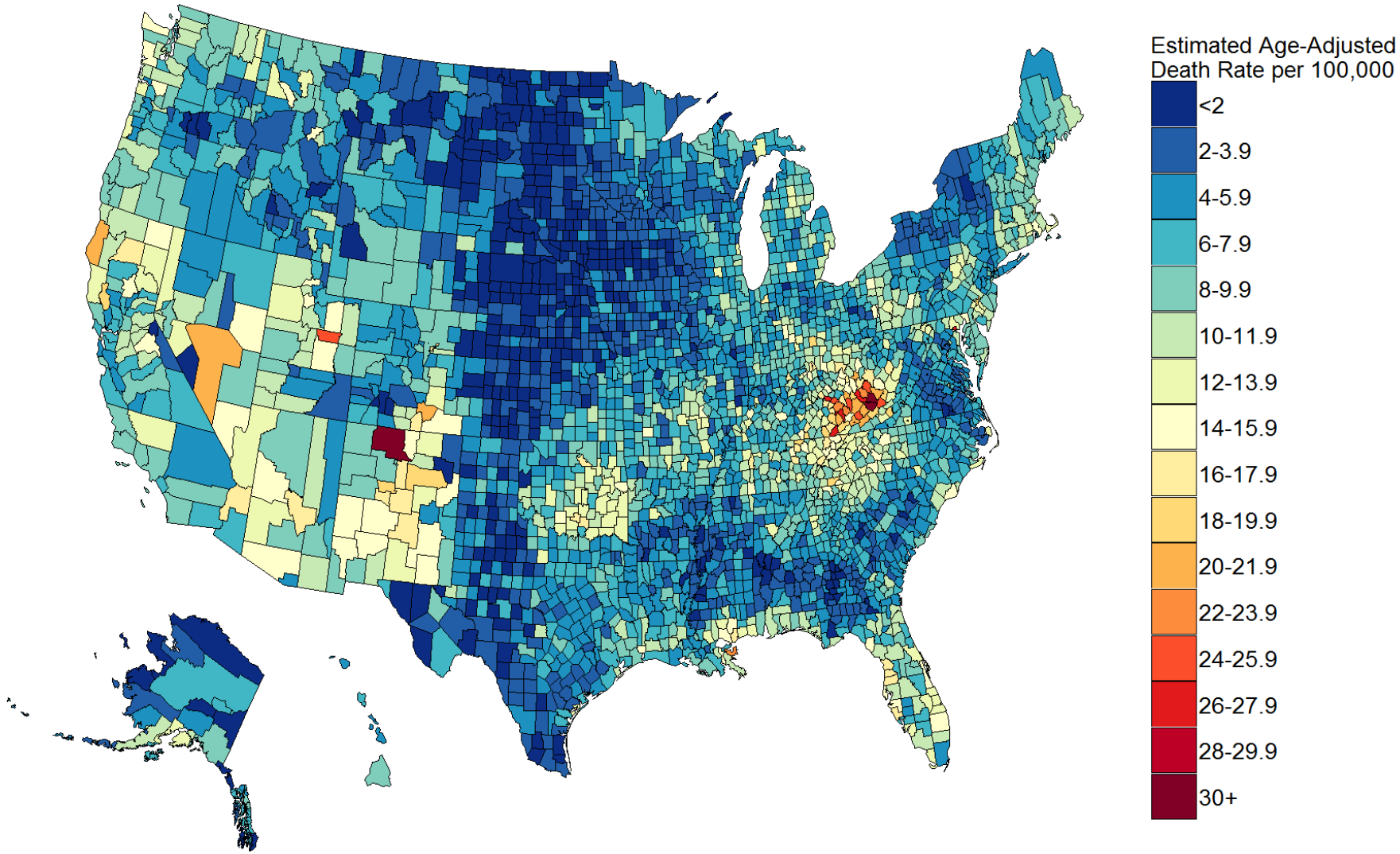
2004



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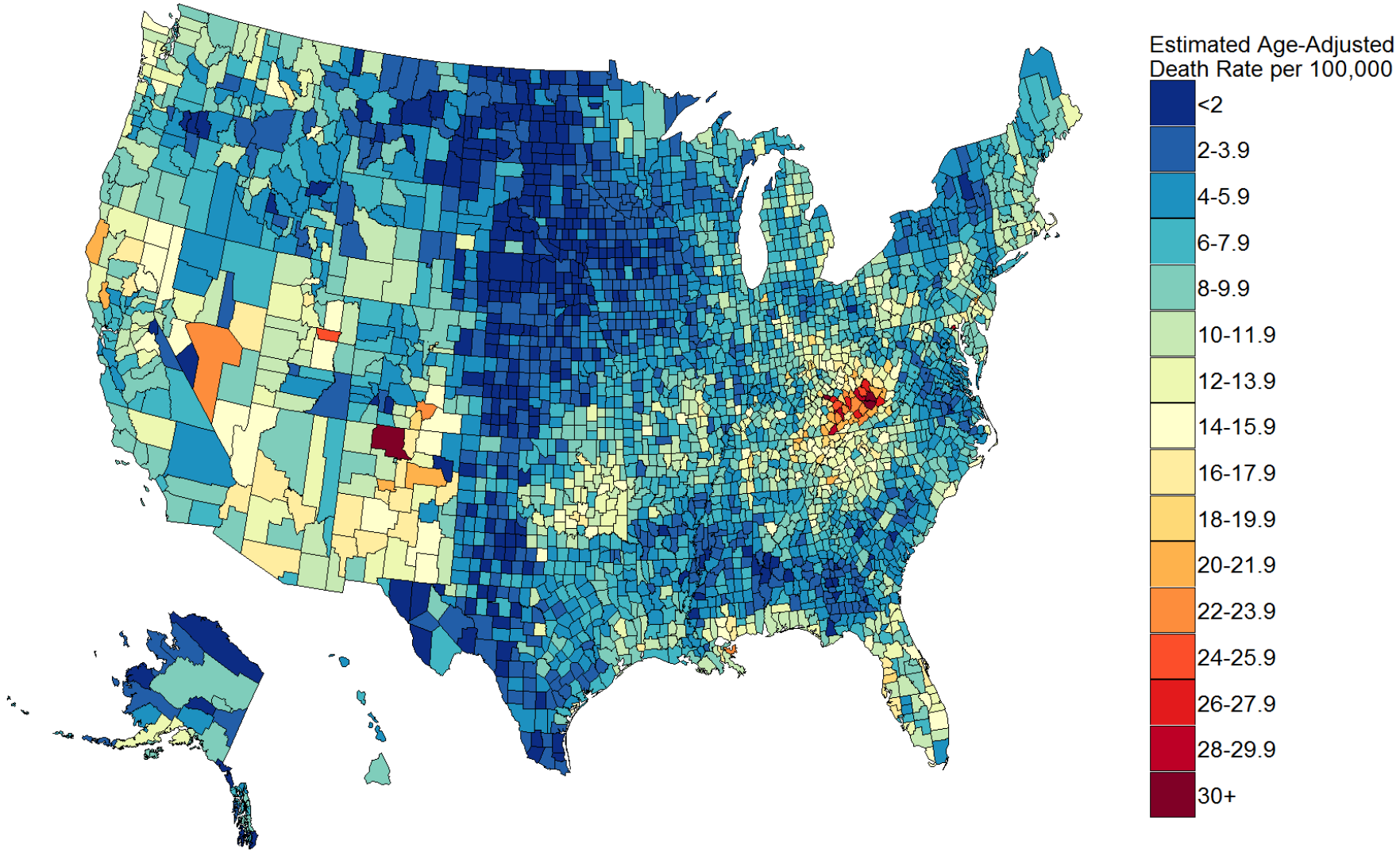

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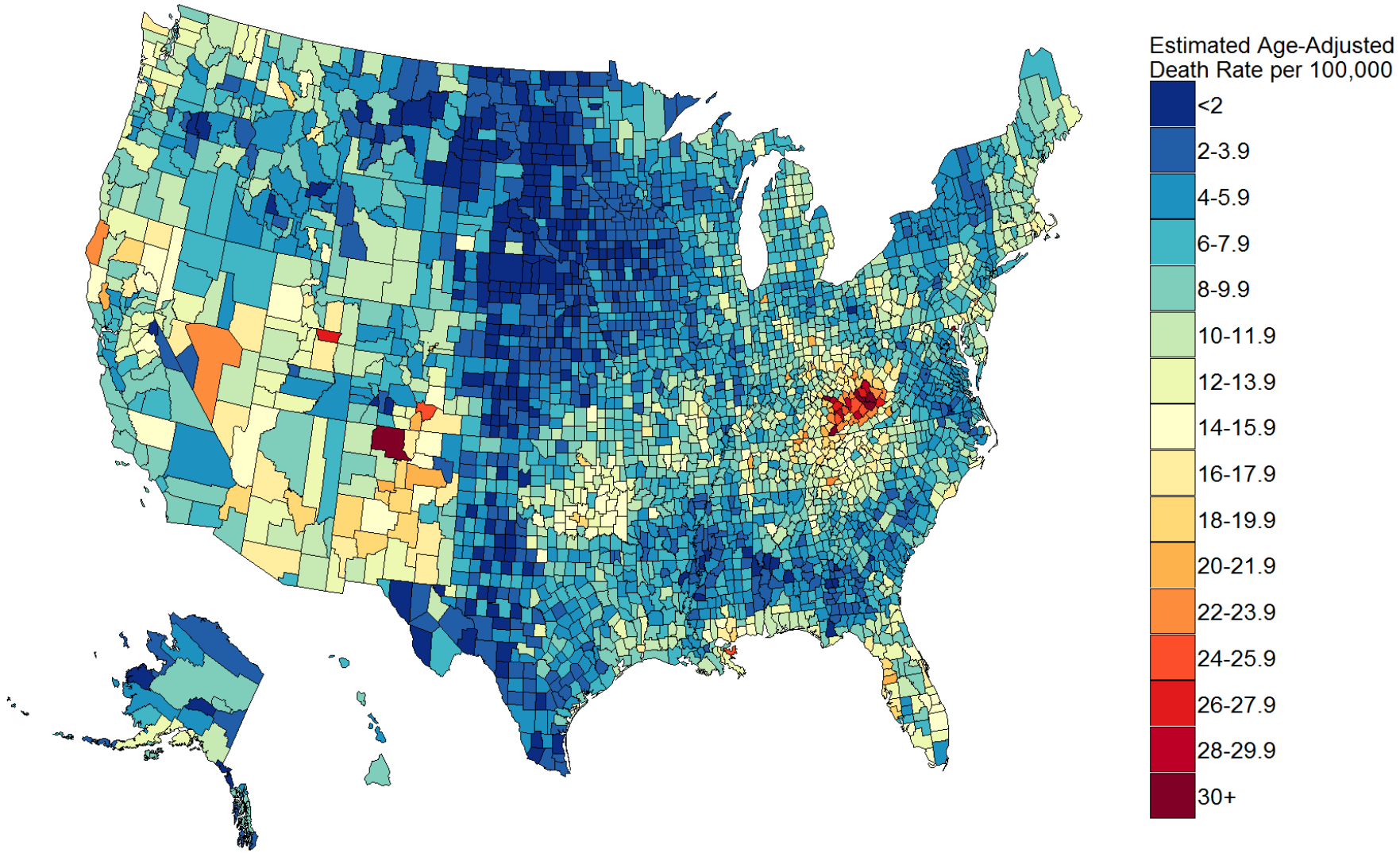

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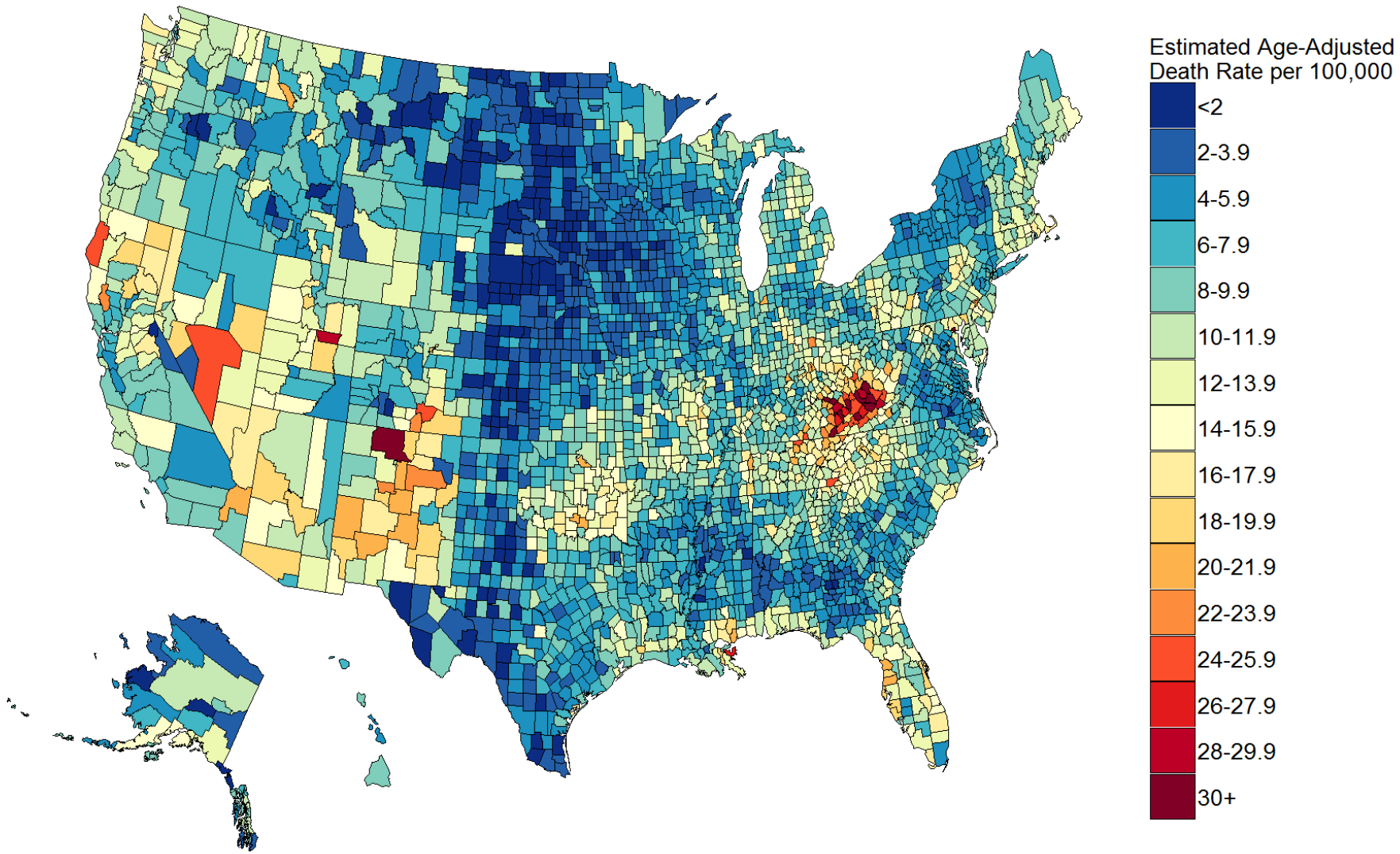

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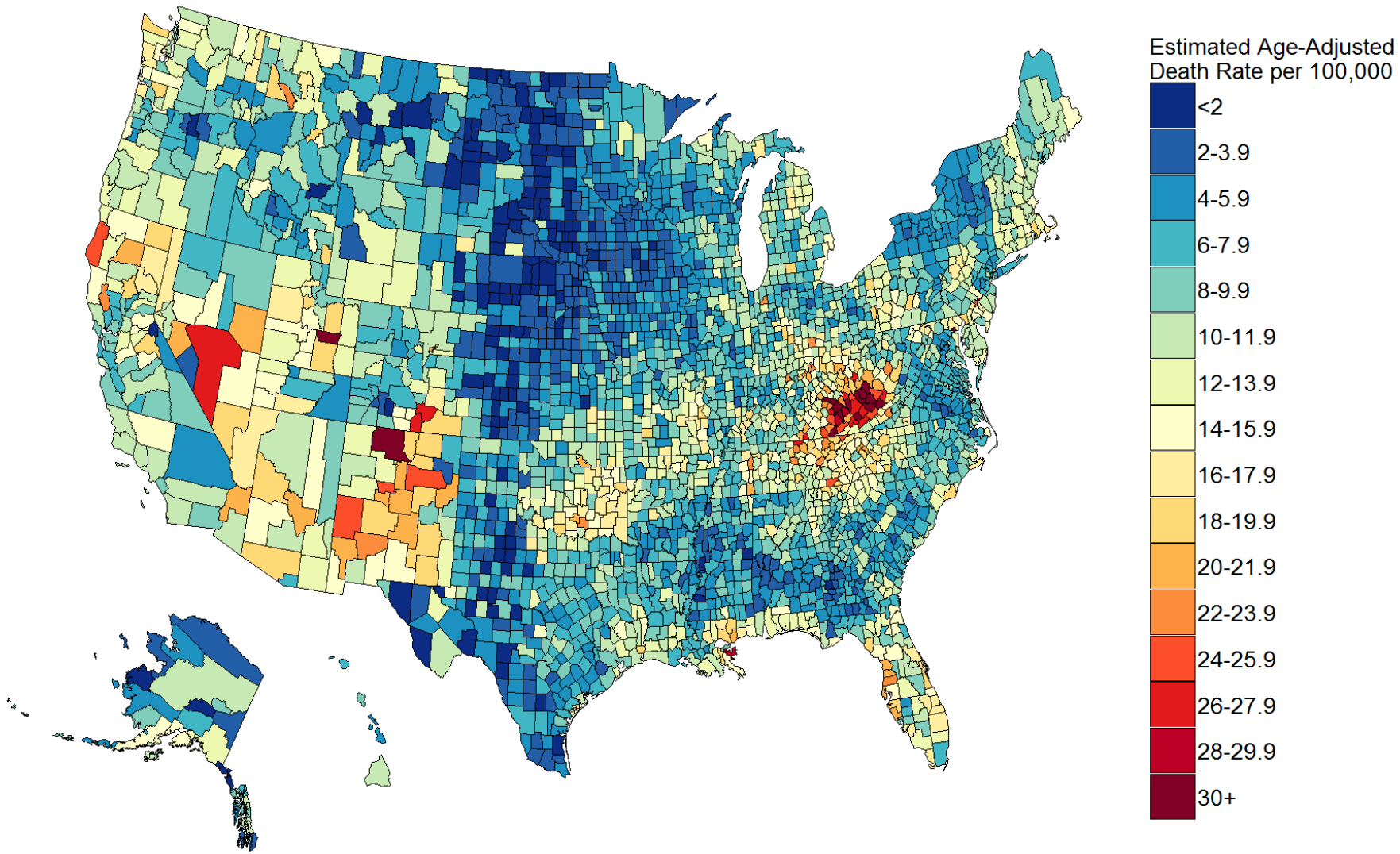

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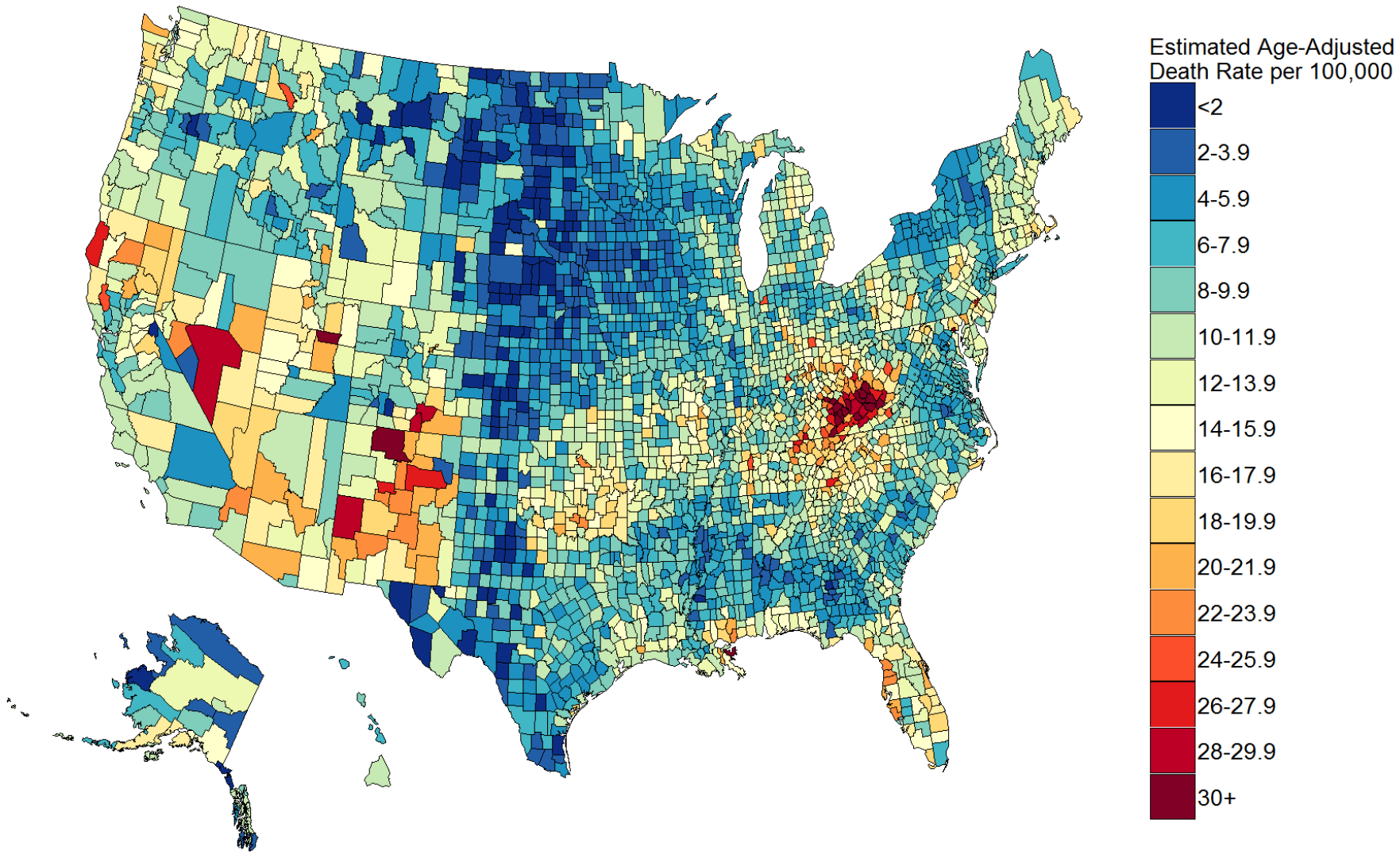

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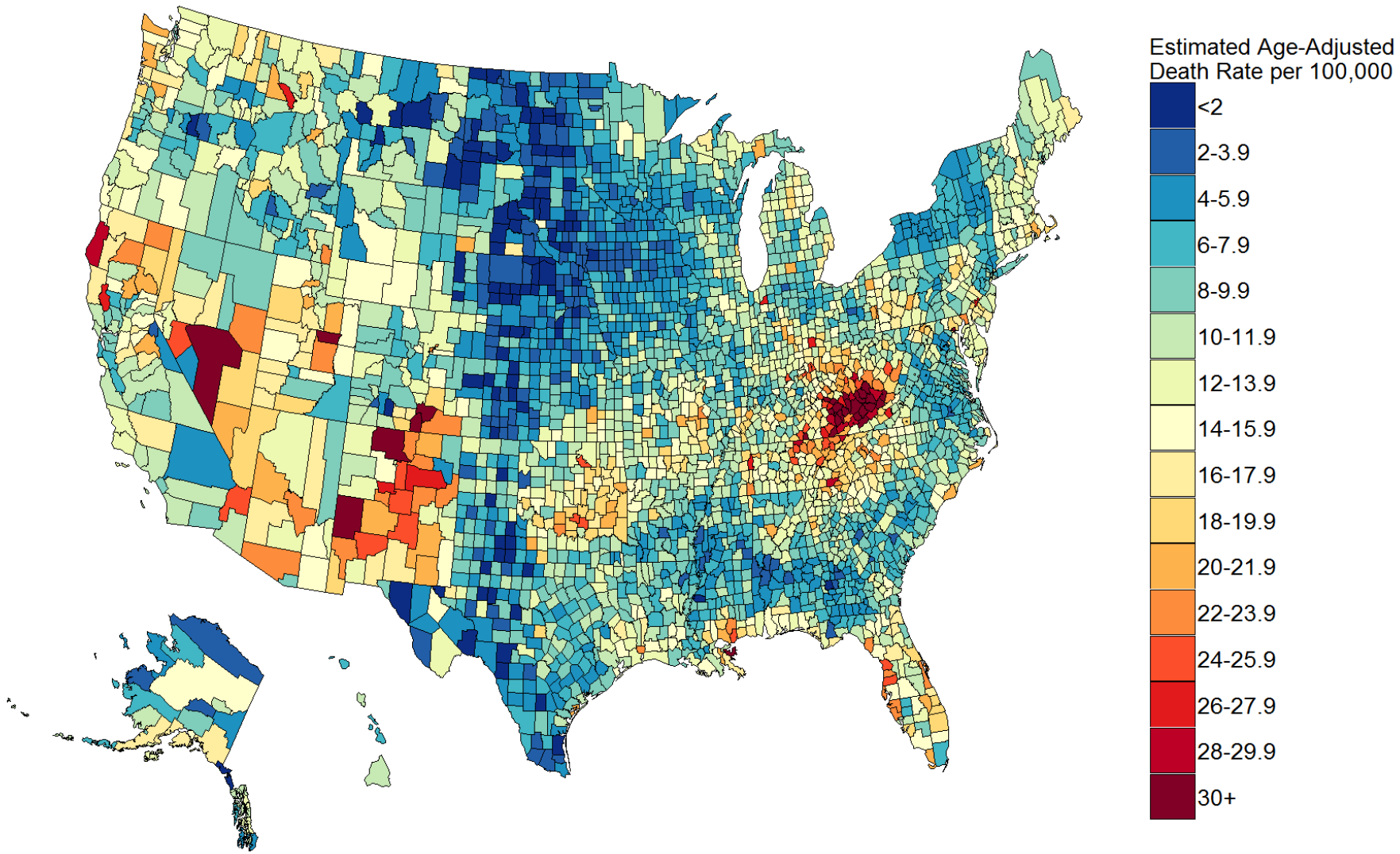

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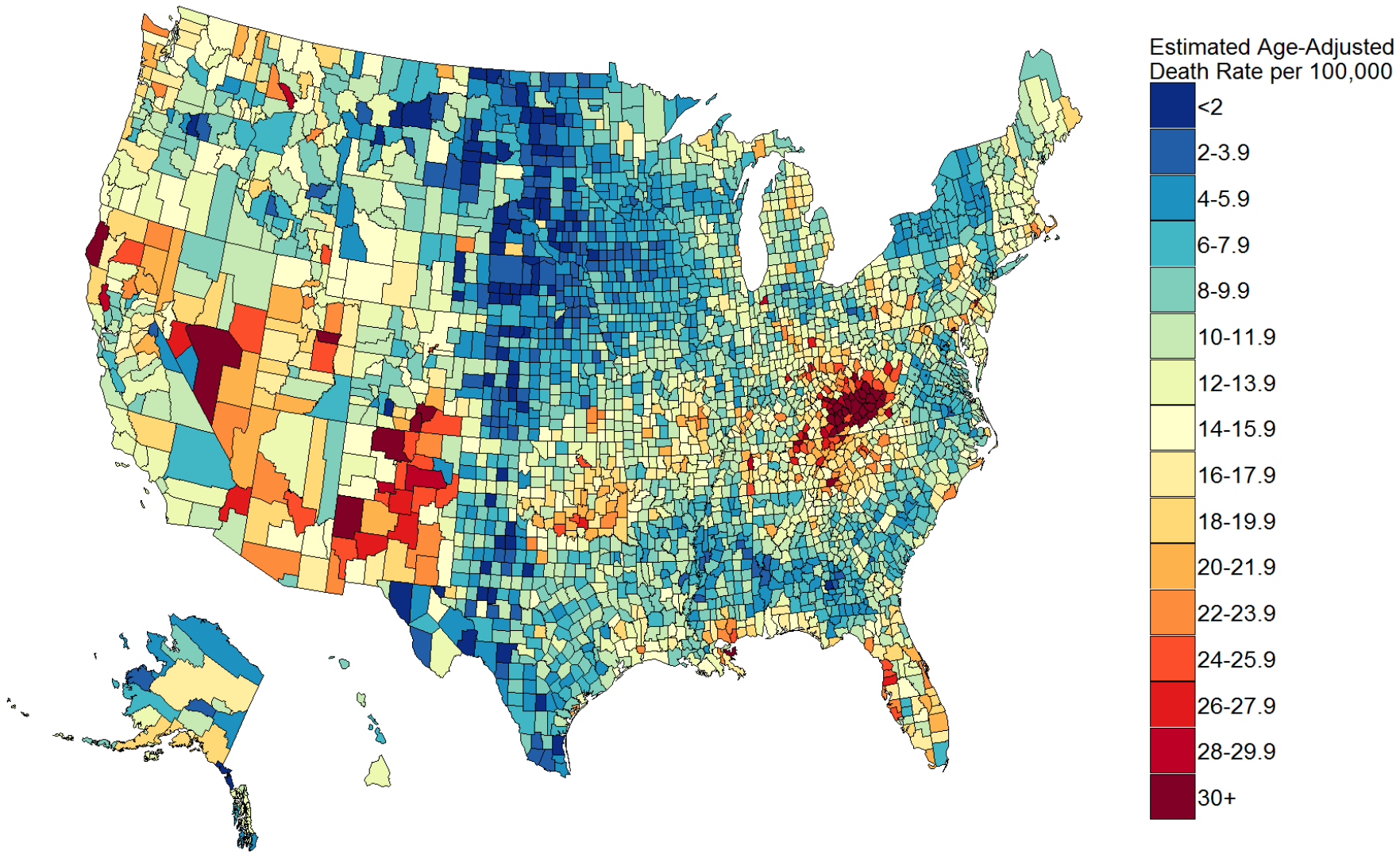
2011



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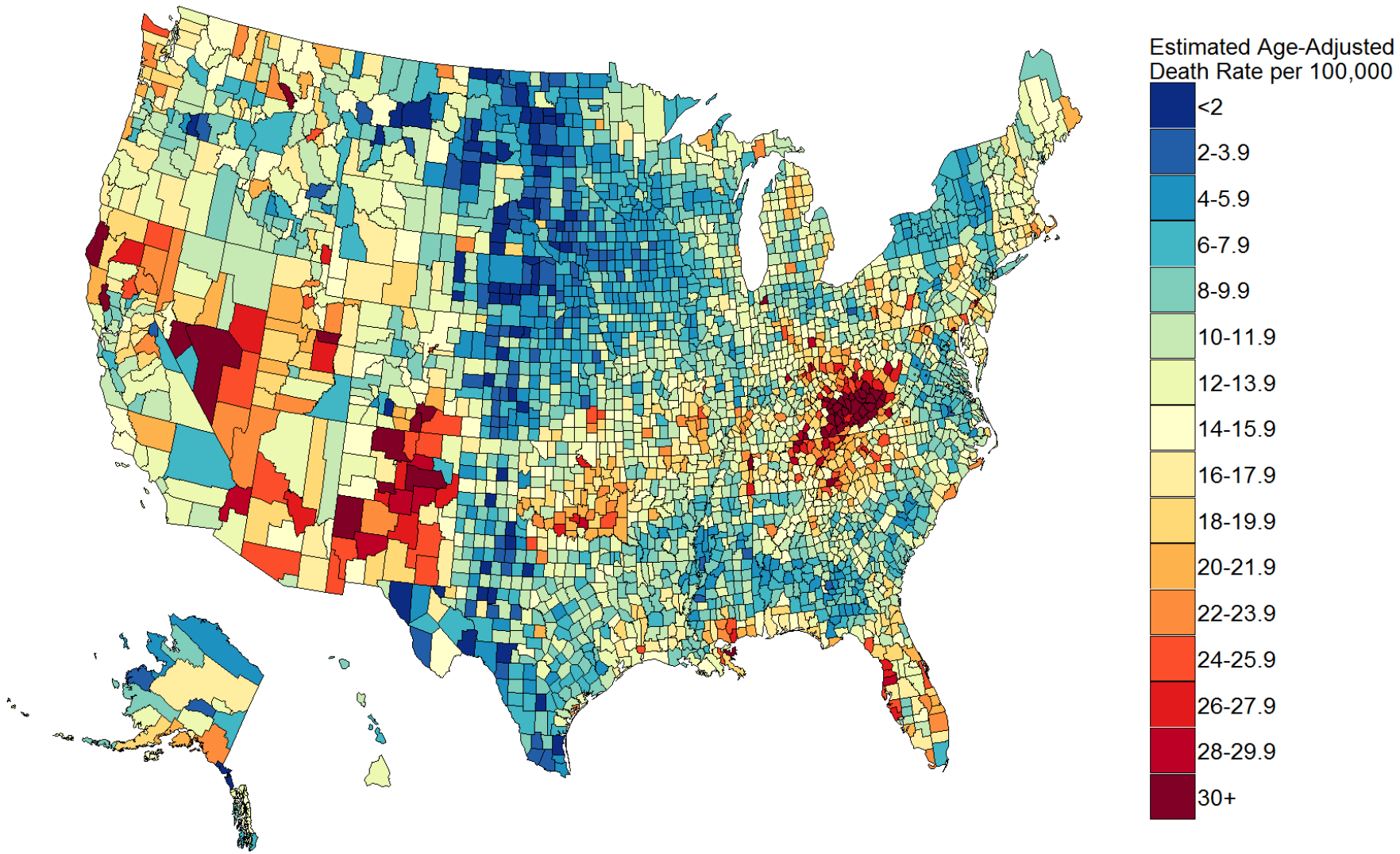

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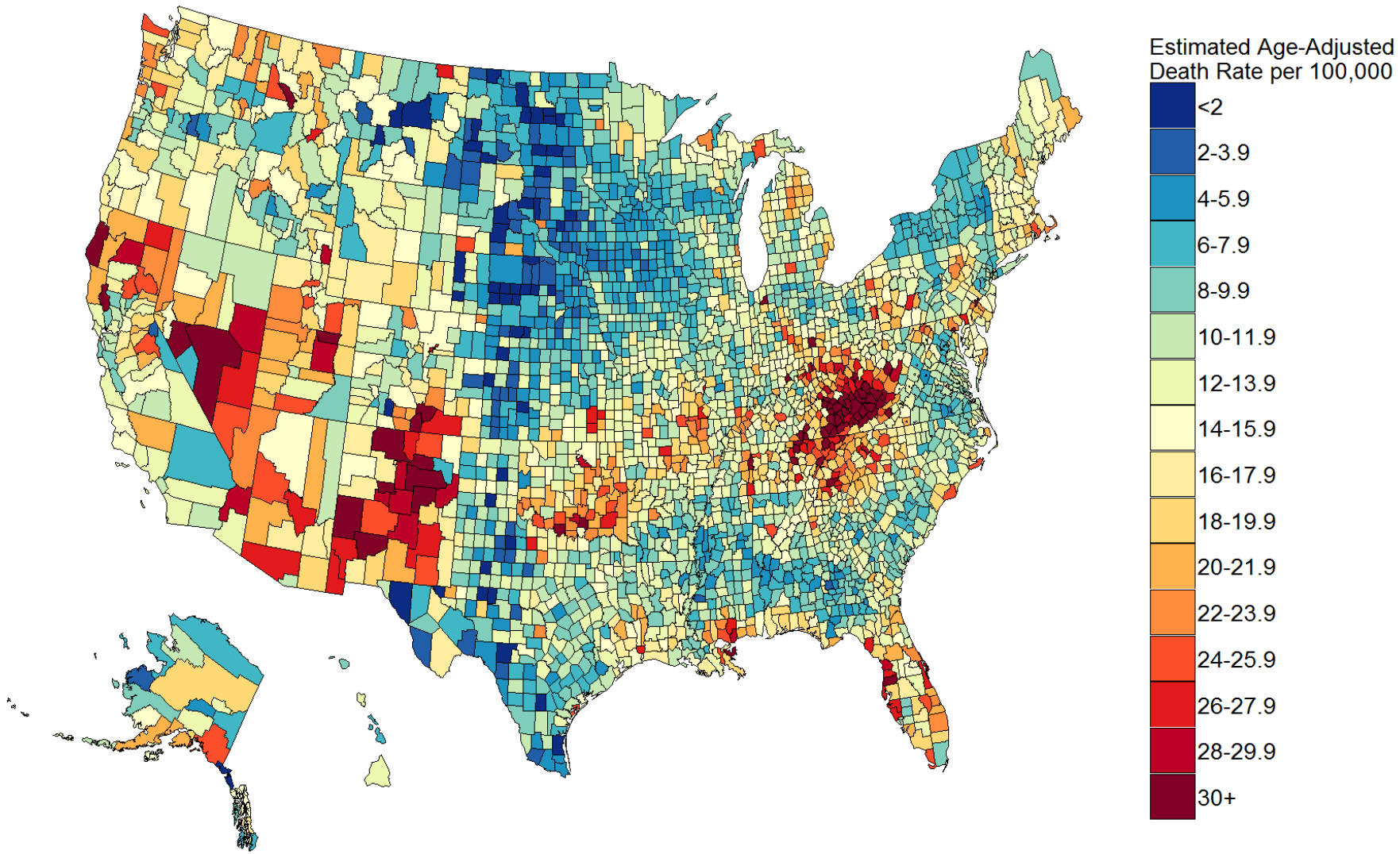

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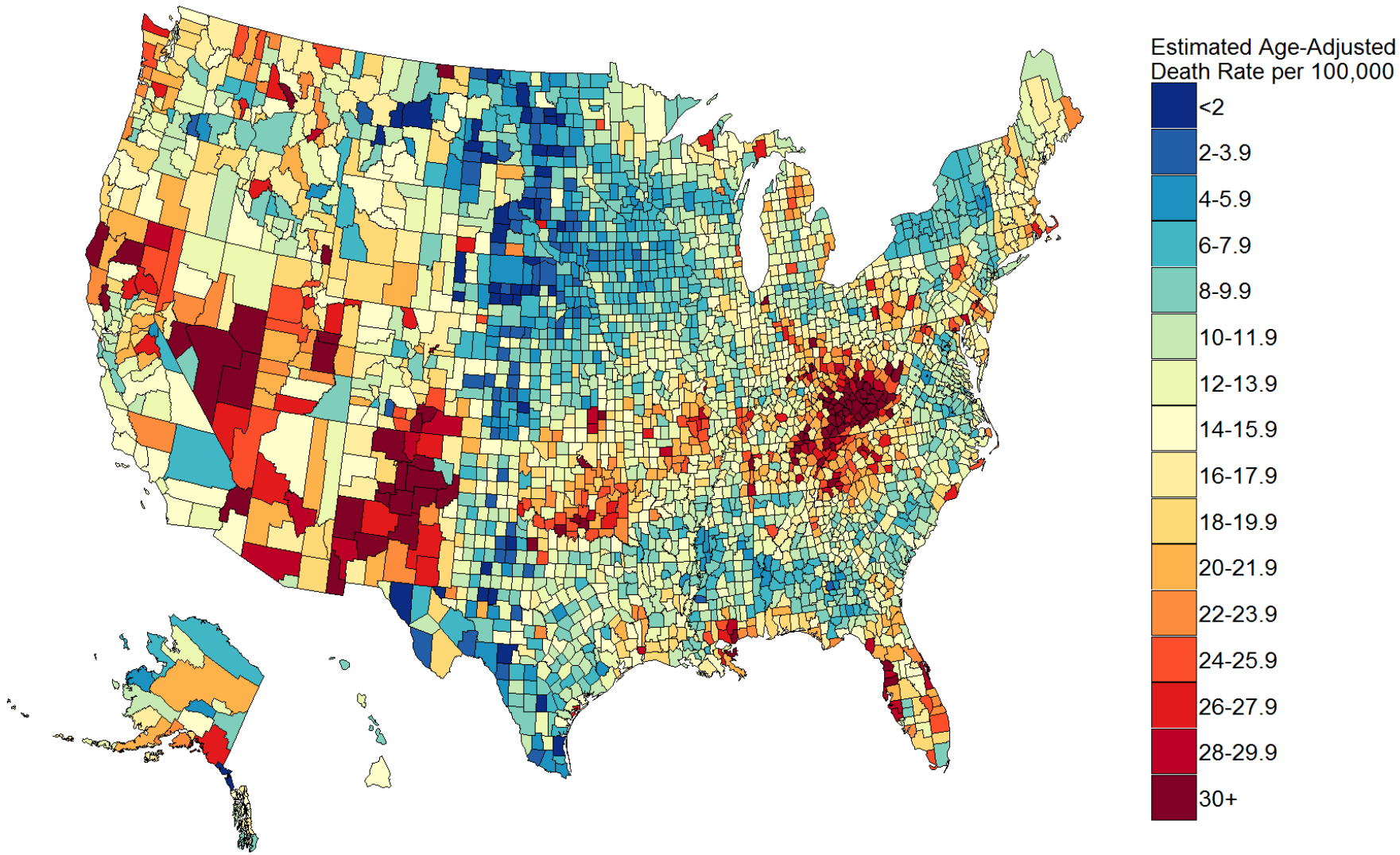

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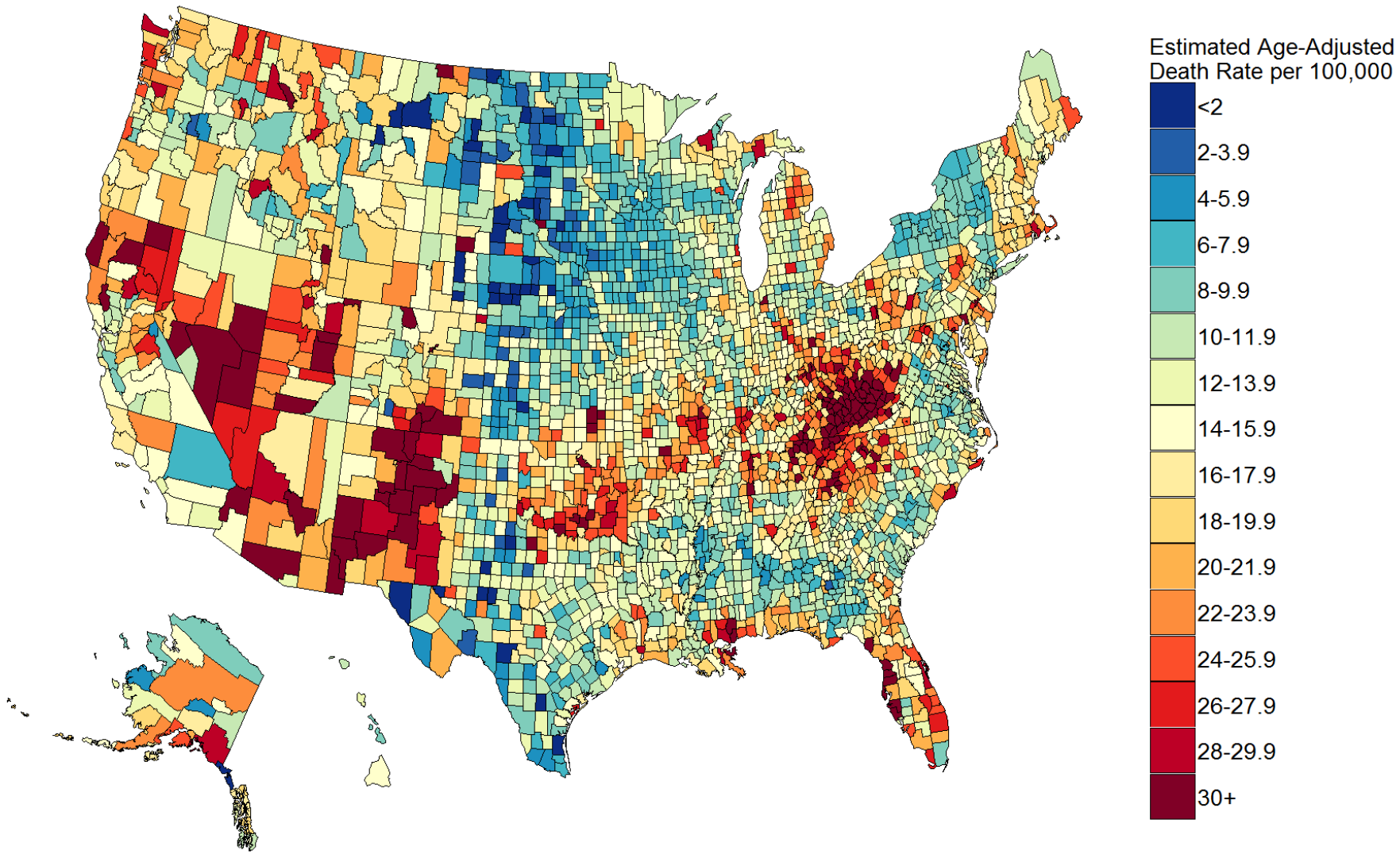
2015



SOURCE: *National Center for Health Statistics, National Vital Statistics System, mortality data (http://www.cdc.gov/nchs/deaths.htm).*

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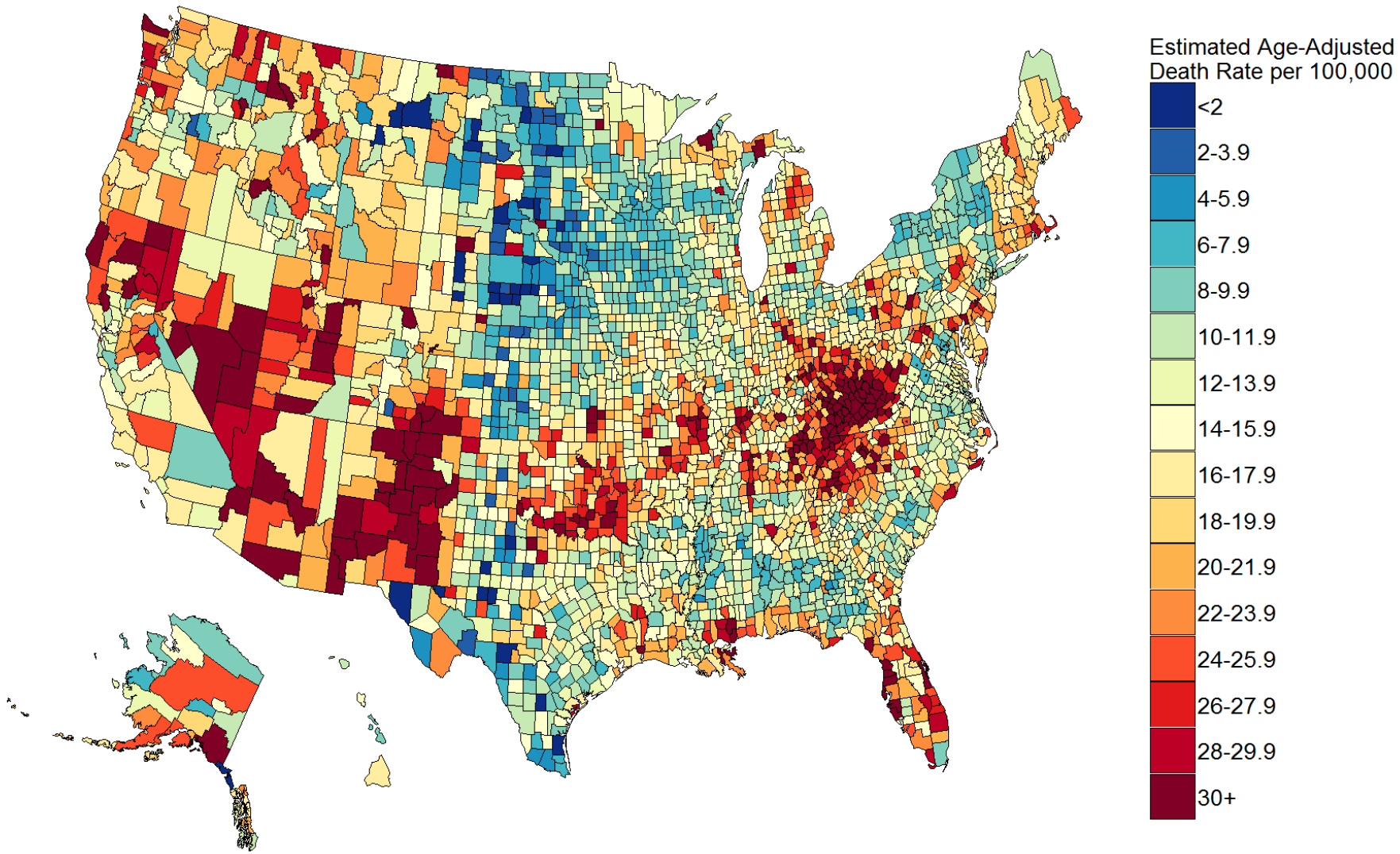
2016



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Drugs Involved with Overdose 2011-2016

- Most frequently involved drug
  - 2011: oxycodone
  - 2012-2015: heroin
  - 2016: fentanyl [likely illicit]
- Cocaine consistently ranked 2nd or 3rd
- Heroin & methamphetamine OD rates tripled, fentanyl doubled

Hegegaard, 2018

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Drugs Involved with Overdose 2011-2016

- 70% of 2016 OD deaths from heroin or fentanyl involved at least one other drug
  - #1: each other
  - #2: cocaine
  - #3: alprazolam
  - *alcohol was excluded from this study

Hegegaard, 2018

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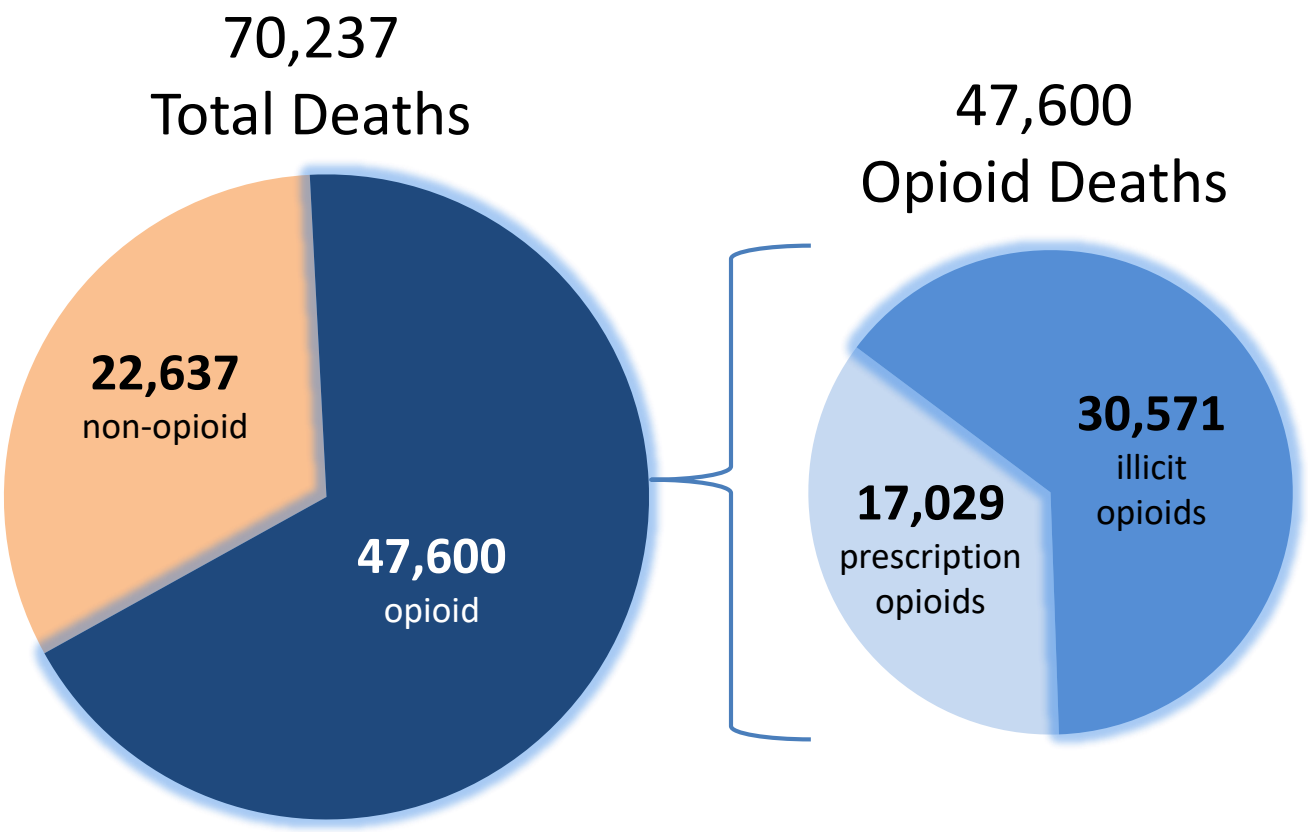
2017 US Overdose Deaths



Source: CDC Wonder

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SAVE LIVES FIRST

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The Quirion Challenge

- Obtain and carry naloxone on your person
  - Legal for 3rd party rx & use
  - Good Samaritan immunity
  - Considerations for rx/payment/cost
  - PCHC: (207) 404-8000 x2232 or x1157

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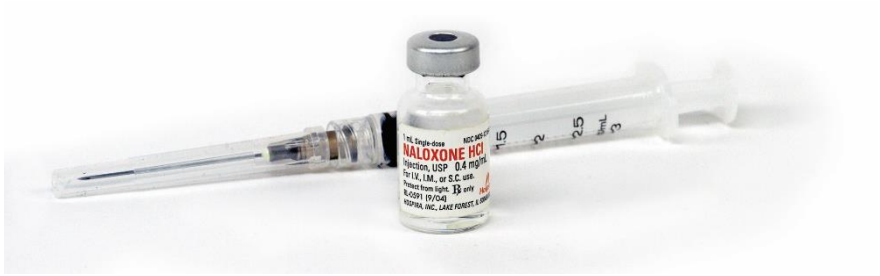
Naloxone Products

naloxone vial for IM



naloxone prefilled syringe & nasal atomizer

naloxone nasal spray

naloxone auto injector

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Naloxone survey form Maine.gov

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Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Substance Abuse and Mental Health Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 287-2595; Fax: (207) 287-9152
TTY: Dial 711 (Maine Relay)

NALOXONE SURVEY FORM

DATE OF REQUEST:

FNAME:

LNAME:

TITLE:

AGENCY:

PHYSICAL ADDRESS1:

PHYSICAL ADDRESS2:

CITY/STATE/ZIP:

TELEPHONE:

EMAIL:

Number of Dual-Kit, Intra-Nasal Naloxone your organization can reasonably distribute/utilize within the next six months:

Number of Intra-Muscular Naloxone doses your organization can reasonably distribute/utilize within the next six months:

Does your organization already have a source (Foundation, Distributor, Vendor) to purchase Naloxone? ☐YES ☐NO
Is your organization already distributing/utilizing Naloxone? ☐YES ☐NO
If YES, whose Standing Order are you operating under?

Will your organization need training or technical assistance? ☐YES ☐NO

Please fax or email this form to: (207) 287-9152; SAMHSAdmin.DHHS@maine.gov

Note: The Department is in the preliminary stages of identifying and documenting the need for additional Naloxone within the State of Maine. Your completion of this survey will help us establish an efficient distribution system. Our intention is to supplement, not supplant, existing inventories of Naloxone statewide.

Identifying those at highest risk

- Ask the questions & start the conversation:
  - Have you ever misused prescription drugs or used street drugs?
  - Do you or family members use tobacco, marijuana or alcohol on a regular basis?
  - Do you have any psychiatric diagnoses?

Then, refer for treatment

- Know the opioid use disorder treatment options in your community or know who to contact to find out
- Patients on MAT (medication assisted treatment) are less likely to:
  - Die
  - Commit crimes
  - Continue using illicit substances

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Patients w/OUD

- If on buprenorphine at time of hospital admission:
  - 53% reduction in hospital readmission @30d
  - 43% reduction in hospital readmission @90d

Moreno, 2019

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SUPPORT ACT 2018

- Expands providers who can obtain x-waiver *(NPs, PAs, CNSs, CRNSs, and CNMs)*
- *Expands limits for all to 100 immediately if*
  - *Board Certified in Addiction Medicine* ***OR***
  - *Working in a "qualified practice setting"*

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Evolving programs in Maine

- RISE: Rapid Induction Starting in the ED
- Bangor Bridge Clinic-PCHC 7 days a week
- Many, many other programs developed and developing focusing on medical aspects of OUD and overdose prevention
- Newly created Director of Opioid Response-2019, multiple appointments in DHHS

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FINAL TOPIC TO PONDER RELATED TO EVOLVING SUBSTANCE USE

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DEPT. OF PUBLIC HEALTH JANUARY 14, 2019 ISSUE

IS MARIJUANA AS SAFE AS WE THINK?

Permitting pot is one thing; promoting its use is another.

By Malcolm Gladwell

In Summary...

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Take Home Messages

Opioid prescribing has decreased but is still triple the level of 1999

Evidence is mounting that opioids do not improve outcomes for chronic pain

Focus on non-drug and non-opioid therapies for acute and chronic pain—taper slowly with lots of support

Prescribe naloxone

Know the MAT resources in your community or, better yet, become one!

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Maine Medical Association

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor

Ricker Hamilton, Commissioner

EXTRA SLIDES

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Take Home Messages

- Opioid prescribing has decreased but is still triple the level of 1999
- Evidence is mounting that opioids do not improve outcomes for chronic pain
- Focus on non-drug and non-opioid therapies for acute and chronic pain
- Prescribe naloxone
- Know the MAT resources in your community, or better yet, become one!

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QC MAR Resources

- https://mainequalitycounts.org/what-we-do/population-health/naloxone-and-mat-resources/

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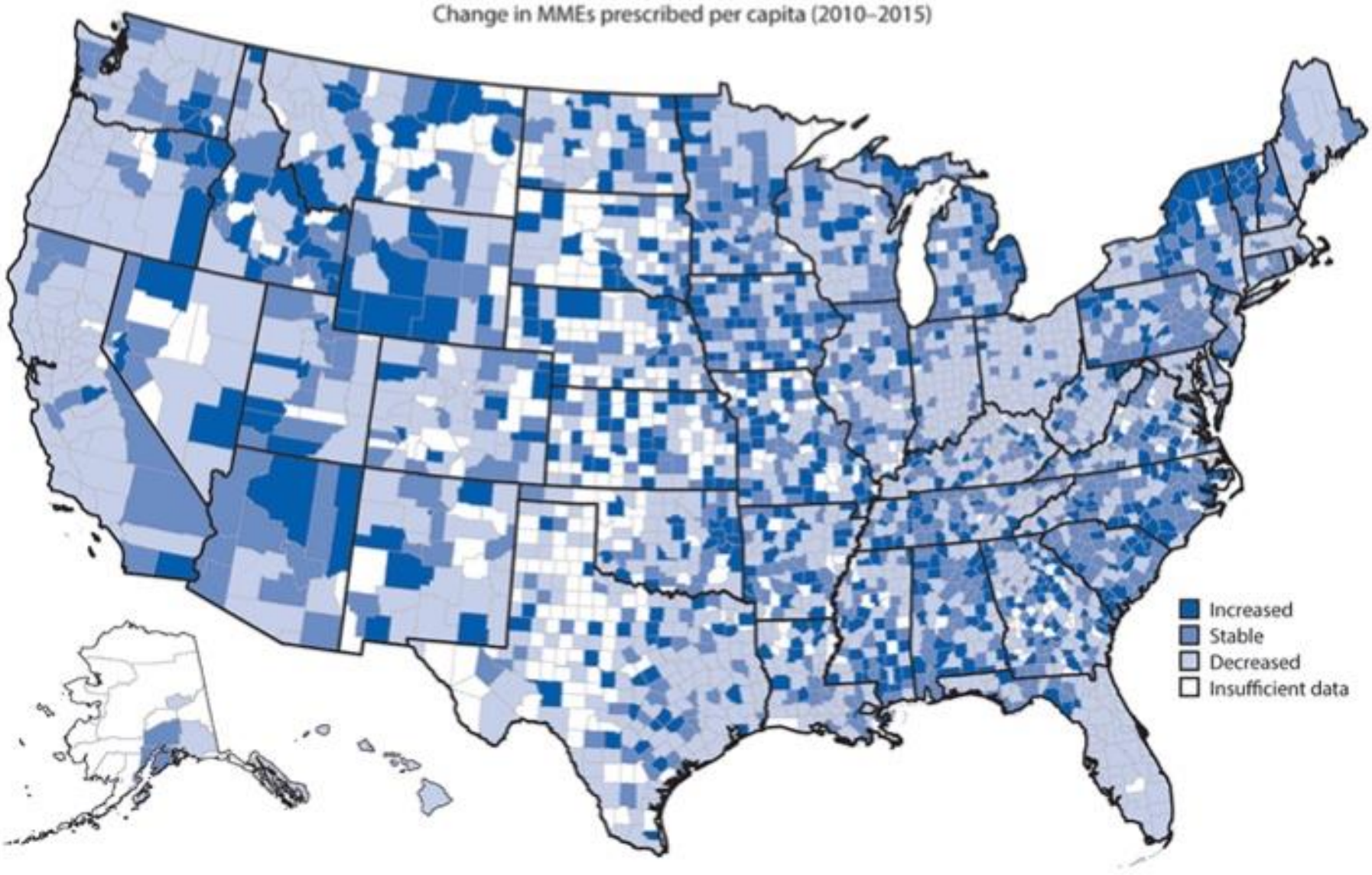
Change in MMEs rx'd 2010-15



Opioid Side Effects

- Nausea and/or vomiting
- Fatigue, sedation and/or delirium
- Constipation
- Opioid Use Disorder/addiction
- Dizziness & unsteadiness:
  - Fracture (case-control study, >21k pts)

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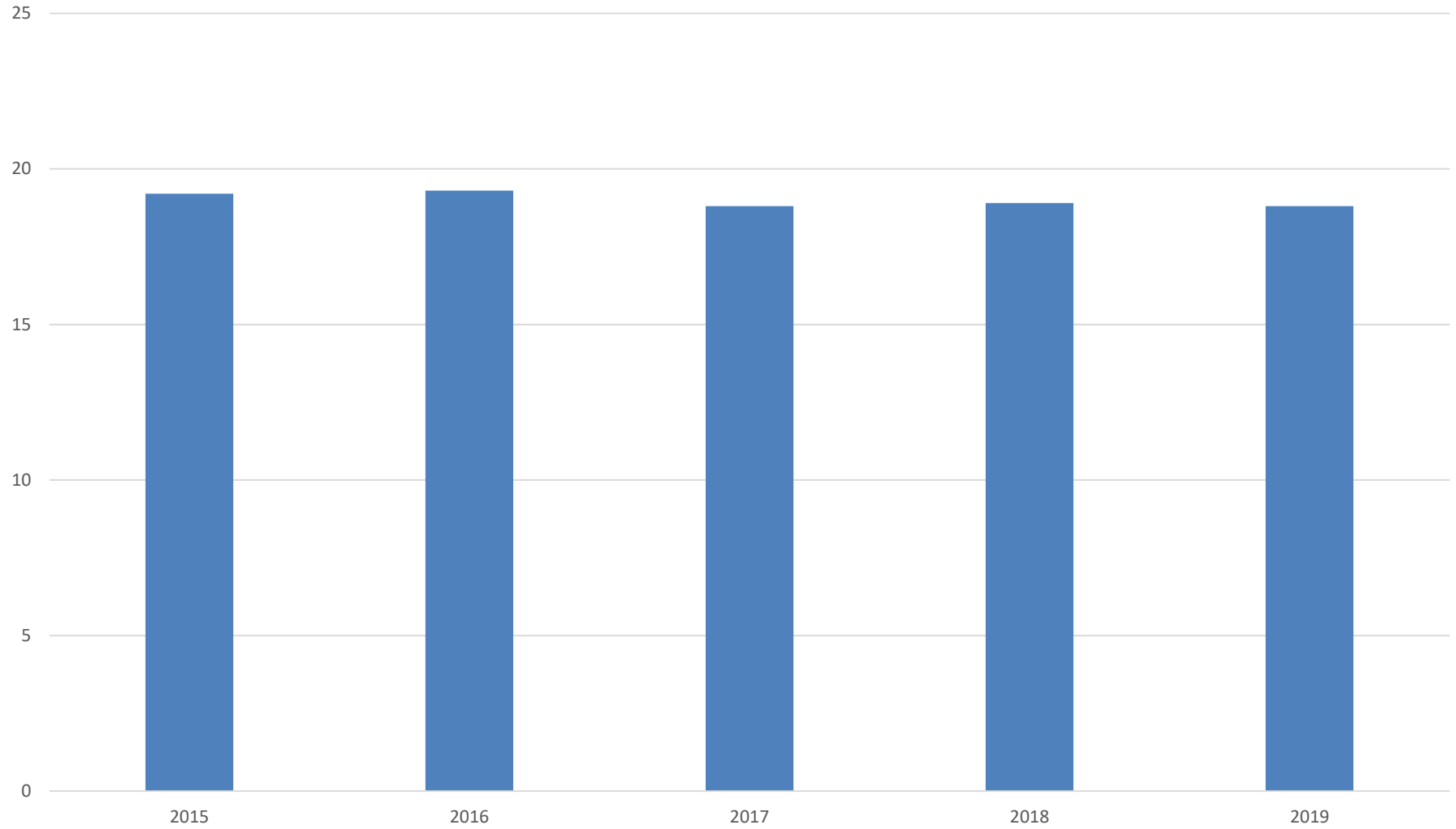
Average day supply



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