Reducing Opioid Prescribing – Education for Physicians & Patients

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DISCLOSURE: Neither Dr. Hanlin nor any member of his immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services. The content of his material(s)/presentation(s) in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

LEARNING OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. List important statistics related to the opioid epidemic.
2. Discuss the origins of the current opioid situation.
3. Use patient education to help patients reduce their opioid use.
Reducing Opioid Prescribing – Education for Physicians and Patients

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Disclosures

• I have no conflicts of interest to disclose
• I am a member of “Physicians for Responsible Opioid Prescribing” (PROP)
  – I have seen documents from pro-opioid presentations referring to this group as an “Anti-Opioid Cult”
My Background

- Air Force Flight Surgeon 4 years
- Rural Practice 2 years
  - Jonesville, SC (pop. 1,400)
- Teaching in Family Medicine Residencies 22 years
  - Part of the time with Nurse Practitioners
- Paid chart review related to the appropriate use of Controlled Substances
  - Federal Drug Enforcement Administration (DEA)
  - South Carolina Board of Medical Examiners
- Currently Vice Chair of Medical Staff Affairs and Quality, Department of Family Medicine, Greenville Health System
- Chair of GHS Opioid Reduction Task Force
Learning Objectives

• List important statistics related to the opioid epidemic
• Discuss the origins of the current opioid situation
• Use patient education to help patients reduce their opioid use
Outline

• Is there a problem?
• How did we get here?
• What do we do now?
• Discussion
• References
• Resources
Is there a problem?

Many of the slides or data are from the CDC
CDC Guideline for Prescribing Opioids for Chronic Pain

Robert B. Hanlin, MD, FAAFP

Note: Slides with an * in the title were added by me.
THE EPIDEMIC
Chronic Pain and Prescription Opioids

- 11% of Americans experience daily (chronic) pain
- Opioids frequently prescribed for chronic pain
- Primary care providers commonly treat chronic, non-cancer pain
  - account for ~50% of opioid pain medications dispensed
  - report concern about opioids and insufficient training
• Nearly 2M Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014.
Opioid Sales and Deaths*

Prescription Painkiller Sales and Deaths

Sources:
*Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2012 data not available.
Opioid Sales and Deaths*

• Note the statistic on the previous slide:
  – Approximately 7 kg / 10,000 population per year
  = 7,000 gm / 10,000 population per year
  = 0.7 gm / person per year
  = 700 mg / person per year
  = 2 mg EVERY DAY FOR EVERY PERSON IN THE UNITED STATES!
Opioid Overdose Deaths Are Still Increasing*


www.cdc.gov/drugoverdose
Opioid Overdose Deaths Are Still Increasing*

Drug overdose deaths involving opioids, by type of opioid, United States, 2000-2014

Deaths involving any opioid
Natural & semi-synthetic opioids (e.g., oxycodone, hydrocodone)
Heroin
Other synthetic opioids (e.g., fentanyl, tramadol)
Methadone

SOURCE:
Heroin and Fentanyl Deaths*

• Are Heroin and Fentanyl deaths related to physician prescriptions for legal opioids?
Heroin and Fentanyl Deaths Are Related To Prescription Opioids*

- 79% of Heroin addicts started with Prescription Opioids
- 1% of Prescription Opioid addicts started with Heroin
- Most Fentanyl deaths are from illegally manufactured Fentanyl, which was mixed with Heroin
U.S. Death Rate Increased in 2015*

• First increase in 10 years

• Causes:
  – Firearms
  – Drug Overdoses
  – Suicide
  – Alzheimer’s Disease
Motor Vehicle Traffic, Poisoning, and Drug Poisoning (Overdose) Death Rates
United States, 1980–2010*

[Graph showing trends in deaths per 100,000 population for Motor Vehicle Traffic, Poisoning, and Drug Poisoning (Overdose) from 1980 to 2010.]

Motor Vehicle Deaths Are Decreasing Because of Better Designs: Vehicles and Highways*

- Society expects everything to get safer over time
- Controlled drug prescribing has become more dangerous over time
- We must change
- It’s not OK to say “I’ve always done it this way”
### Drug Overdose Deaths 2013-2015*

<table>
<thead>
<tr>
<th>Year</th>
<th>State</th>
<th>Age-Adjusted Rate</th>
<th>Number of Deaths</th>
<th>Annual Increase in Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>South Carolina</td>
<td>13.0</td>
<td>620</td>
<td>--</td>
</tr>
<tr>
<td>2014</td>
<td>South Carolina</td>
<td>14.4</td>
<td>701</td>
<td>81</td>
</tr>
<tr>
<td>2015</td>
<td>South Carolina</td>
<td>15.7</td>
<td>761</td>
<td>60</td>
</tr>
</tbody>
</table>
Opioid Prescriptions by Specialty – Medicare Data

- Family practice: 161.1 claims per prescriber type, 15,312,091 total claims
- Internal medicine: 122.0 claims per prescriber type, 12,785,839 total claims
- Nurse practitioner: 55.0 claims per prescriber type, 4,081,282 total claims
- Physician assistant: 57.4 claims per prescriber type, 3,089,022 total claims
- Orthopedic surgery: 134.2 claims per prescriber type, 2,622,297 total claims
- Physical medicine and rehabilitation: 348.2 claims per prescriber type, 2,314,358 total claims
- Anesthesiology: 484.2 claims per prescriber type, 2,120,474 total claims
- Interventional pain management: 1,124.9 claims per prescriber type, 2,097,975 total claims
- Emergency medicine: 51.0 claims per prescriber type, 1,251,182 total claims
- Pain management: 921.1 claims per prescriber type, 1,251,182 total claims
- General practice: 110.0 claims per prescriber type, 988,926 total claims
- Rheumatology: 203.3 claims per prescriber type, 866,103 total claims
- General surgery: 46.2 claims per prescriber type, 797,573 total claims
- Neurology: 64.4 claims per prescriber type, 785,381 total claims
- Dentist: 8.4 claims per prescriber type, 728,735 total claims
- Hematology/oncology: 84.9 claims per prescriber type, 623,748 total claims
- Geriatric medicine: 207.7 claims per prescriber type, 378,203 total claims
- Urology: 35.8 claims per prescriber type, 353,845 total claims
- Neurosurgery: 106.3 claims per prescriber type, 345,643 total claims
- Podiatry: 20.6 claims per prescriber type, 257,759 total claims
- Oral surgery (dentists only): 51.2 claims per prescriber type, 252,329 total claims
- Nephrology: 27.1 claims per prescriber type, 205,643 total claims
- Medical oncology: 74.2 claims per prescriber type, 186,712 total claims
- Cardiology: 8.4 claims per prescriber type, 185,092 total claims
- Otolaryngology: 15.3 claims per prescriber type, 136,418 total claims

Claims, No.

Claims per prescriber type vs Total claims
Medicare Opioid Costs by Prescriber Prescription Rates

The graph shows the cumulative value of Medicare opioid costs and prescription rates across different percentages of top Medicare prescribers. The x-axis represents the top Medicare prescribers considered in percentage, while the y-axis shows the cumulative value percentage. Different lines represent different types of costs and claims, with specific percentages indicated at various points on the graph.
Opioid Prescriptions by Prescriber NAME – Publicly Available Medicare Data

Medicare Part D Opioid Prescribing Mapping Tool

The opioid prescribing rate interactive mapping tool shows geographic comparisons, at the state, county, and ZIP code levels, of de-identified Medicare Part D opioid prescription claims – prescriptions written and then submitted to be filled – within the United States. This mapping tool allows the user to see both the number and percentage of opioid claims at the local level and better understand how this critical issue impacts communities nationwide. The data used in this mapping tool is from calendar years 2013 and 2014 Medicare Part D prescription drug claims prescribed by health care providers and does not contain beneficiary information. By openly sharing data in a secure, broad, and interactive way, CMS and the U.S. Department of Health and Human Services (HHS) believe that this level of transparency will inform community awareness among providers and local public health officials.

Note: the map will automatically adjust between state, county, and zip-code levels as users zoom in or out. Zooming is available by clicking on the zoom buttons in the top left corner of the map, or by using the mouse wheel or keyboard “+” or “−” keys. Users can navigate the map by dragging with the mouse or by using the keyboard arrow keys.

Opioid Mapping Tool  View Prescriber Level Opioid Rates  Download Opioid Map Data  Part D Prescriber Look-up Tool

Access the Detailed Methodology Document.

Additional information can be found at our Frequently Asked Questions page.
## Opioid Prescriptions by Prescriber NAME
### Top 10 Prescribers in SC by Rate

<table>
<thead>
<tr>
<th>NPI</th>
<th>NPPES Provider Last/Org Name</th>
<th>NPPES Provider First Name</th>
<th>NPPES Provider Zip Code</th>
<th>NPPES Provider State</th>
<th>Specialty Description</th>
<th>Total Claim Count</th>
<th>Opioid Claim Count</th>
<th>Opioid Prescribing Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>188198632</td>
<td>TERRY</td>
<td>JOSHUA</td>
<td>29425</td>
<td>SC</td>
<td>Student in an Organized Health Care Education/Training Program</td>
<td>14</td>
<td>14</td>
<td>100.00%</td>
</tr>
<tr>
<td>179004670</td>
<td>TAYLOR</td>
<td>JESSICA</td>
<td>29425</td>
<td>SC</td>
<td>General Surgery</td>
<td>20</td>
<td>19</td>
<td>95.00%</td>
</tr>
<tr>
<td>192225531</td>
<td>CAMPBELL</td>
<td>VICTOR</td>
<td>29651</td>
<td>SC</td>
<td>Orthopedic Surgery</td>
<td>38</td>
<td>36</td>
<td>94.74%</td>
</tr>
<tr>
<td>172002063</td>
<td>IAQUINTO</td>
<td>JOHN</td>
<td>29203</td>
<td>SC</td>
<td>Orthopedic Surgery</td>
<td>104</td>
<td>98</td>
<td>94.23%</td>
</tr>
<tr>
<td>127553624</td>
<td>PEACOCK</td>
<td>EDGAR</td>
<td>29204</td>
<td>SC</td>
<td>Oral Surgery (dentists only)</td>
<td>227</td>
<td>212</td>
<td>93.39%</td>
</tr>
<tr>
<td>107357769</td>
<td>KRAMER</td>
<td>ARI</td>
<td>29303</td>
<td>SC</td>
<td>General Surgery</td>
<td>133</td>
<td>124</td>
<td>93.23%</td>
</tr>
<tr>
<td>186148412</td>
<td>EISON</td>
<td>THOMAS</td>
<td>29650</td>
<td>SC</td>
<td>Orthopedic Surgery</td>
<td>59</td>
<td>55</td>
<td>93.22%</td>
</tr>
<tr>
<td>143716822</td>
<td>MULLANEY</td>
<td>JOSEPH</td>
<td>29464</td>
<td>SC</td>
<td>Diagnostic Radiology</td>
<td>13</td>
<td>12</td>
<td>92.31%</td>
</tr>
<tr>
<td>133615640</td>
<td>GEIER</td>
<td>CARL</td>
<td>29464</td>
<td>SC</td>
<td>Orthopedic Surgery</td>
<td>13</td>
<td>12</td>
<td>92.31%</td>
</tr>
<tr>
<td>169918189</td>
<td>LIOGIER-1 WHEYBACK</td>
<td>LUIS</td>
<td>29425</td>
<td>SC</td>
<td>Neurological Surgery</td>
<td>37</td>
<td>34</td>
<td>91.89%</td>
</tr>
</tbody>
</table>
Is there a problem?
YES!
How did we get here?
How did we get here?
Does any of this sound familiar?

- Physicians are under-treating pain
- Pain is what the patient says it is
- Pain is the fifth vital sign
- Pain should be re-evaluated within one hour
- Pain control is on the CMS Patient Experience Surveys (HCAHPS and CG-CAHPS)
- Patients don’t get addicted when you treat acute pain
What should we do now?

Guidelines
CDC
SC Medical Board
Need for Opioid Prescribing Guidelines

- Previous opioid prescribing guidelines have been developed by several states and agencies but were inconsistent

- Most recent national guidelines are several years old and don’t incorporate the most recent evidence

- Need for clear, consistent recommendations
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
Purpose, Use, and Primary Audience

- **Primary Care Providers**
  - Family medicine, Internal medicine
  - Physicians, nurse practitioners, physician assistants

- **Treating patients ≥18 years with chronic pain**
  - Pain longer than 3 months or past time of normal tissue healing

- **Outpatient settings**

- **Does not include active cancer treatment, palliative care, and end-of-life care**
Clinical Evidence Review

- 2014 AHRQ sponsored review for NIH Pathways to Prevention
- Updated searches through 2015
- Review of effectiveness of long-term opioid therapy
- Key Questions addressed
  - Effectiveness and comparative effectiveness
  - Harms and adverse events
  - Dosing strategies
  - Risk mitigation strategies
  - Effect of opioid use for acute pain on long-term use
Opioid Benefits?*

• AHRQ Review:
  – 4,209 articles reviewed.
  – Only 39 articles had useful data.
  – The number of studies comparing the risks and benefits of long-term opioid treatment vs. non-opioid treatment for chronic pain:
Opioid Benefits?*

• AHRQ Review:
  – 4,209 articles reviewed.
  – Only 39 articles had useful data.
  – The number of studies comparing the risks and benefits of long-term opioid treatment vs. non-opioid treatment for chronic pain:

ZERO
Opioid Risks?*

• AHRQ Review:
  – 4,209 articles reviewed.
  – Only 39 articles had useful data.
  – Some low-quality studies showed statistically increased risks for:
    • Addiction
    • Overdose
    • Fracture
    • Myocardial Infarction
    • Motor Vehicle Accidents
    • Erectile Dysfunction
Clinical Evidence Summary

- No long-term (> 1 year) outcomes in pain/function; most placebo-controlled trials ≤ 6 weeks
- Opioid dependence in primary care: 3%-26%
- Dose-dependent association with risk of overdose/harms
- Inconsistent results for different dosing protocols; initiation with LA/ER increased risk of overdose
- Methadone associated with higher mortality risk
- No differences in pain/function with dose escalation
- Risk prediction instruments have insufficient accuracy for classification of patients
- Increased likelihood of long-term use when opioids used for acute pain
CDC conducted additional review to assess:

- Benefits and harms associated with opioid therapy
- Values and preferences of providers and patients
- Resource allocation (costs)
- Effectiveness of non-pharmacologic and non-opioid pharmacologic therapies
Effective nonpharmacologic therapies: exercise, cognitive behavioral therapy (CBT), interventional procedures

Effective nonopioid medications: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), anticonvulsants, antidepressants

Opioid-related overdose risk is dose-dependent

Factors that increase risk for harm: pregnancy, older age, mental health disorder, substance use disorder, sleep-disordered breathing

Providers lack confidence in ability to prescribe safely and are concerned about opioid use disorder

Patients are ambivalent about risks/benefits and associate opioids with addiction
Organization of Recommendations

- The 12 recommendations are grouped into three conceptual areas:
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use

- WE WILL NOT REVIEW THE 12 CDC RECOMMENDATIONS TODAY. THE REFERENCE IS ON THE NEXT SLIDE.
For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
Visit: www.cdc.gov | Contact CDC at: 1-800-CDC-INFO or www.cdc.gov/info

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
What should we do now?

How to reduce opioid prescribing
If you suspect opioid use disorder (OUD)

- Discuss with your patient and provide an opportunity to disclose concerns.
- Assess for OUD using DSM-5 criteria. If present, offer or arrange MAT.
  - Buprenorphine through an office-based buprenorphine treatment provider or an opioid treatment program specialist
  - Methadone maintenance therapy from an opioid treatment program specialist
  - Oral or long-acting injectable formulations of naltrexone (for highly motivated non-pregnant adults)
- Consider obtaining a waiver to prescribe buprenorphine for OUD (see http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management)
TOOLS AND RESOURCES
Tools and Materials

- **Provider and patient materials**
  - Checklist for prescribing opioids for chronic pain
  - Fact sheets
  - Posters
  - Web banners and badges
  - Social media web buttons and infographics

- **CDC Opioid Overdose Website**
  
  [www.cdc.gov/drugoverdose/index.html](http://www.cdc.gov/drugoverdose/index.html)
Tools and Materials*

- **TurnTheTideRX.org**
  - Pocket Card mailed to every physician in the US by the US Surgeon General in December.
Reducing Opioid Doses: Principles*

- Treating chronic pain is within the scope of Primary Care.
  - It is not reasonable to say, “I don’t treat chronic pain.”
  - There aren’t enough “Pain Specialists” to see every patient with chronic pain.
  - It is reasonable to say, “There is no proven benefit of opioids for chronic pain.”
Reducing Opioid Doses: Principles*

- I think we are now doing a good job of monitoring patients on chronic opioid medication
- Our next goal should be how to reduce opioid dosages
- There are not many useful tools to help with reducing opioid doses currently available
Reducing Opioid Doses: Principles*

Two very important concepts:

- Patients on > 50 Morphine Equivalent Dose (MED) per day are at increased risk of accidental overdose and death.
  - This is also referred to as “Morphine Milligram Equivalents (MME)"

- Opioid-Induced Hyperalgesia
  - Pain stays the same or INCREASES with increasing opioid dose.
  - Perhaps the body’s response to chronic blockade of pain receptors is to manufacture more pain receptors.
Reducing Opioid Doses:
Opioid Induced Hyperalgesia

- A Study of 23 Patients on High Dose Opioids**
  - Opioid doses included:
    - 1200 mg/day oxycodone
    - 480 mg/day oxycodone
    - 400 mg/day morphine
    - 125 micrograms/hour fentanyl
  - Patients were slowly tapered off of all opioids, up to six months
  - Average pain score ON opioids = 8
  - Average pain score OFF opioids = 3

Tapering Opioids

- Work with patients to taper opioids down or off when:
  - no sustained clinically meaningful improvement in pain and function
  - opioid dosages ≥50 MME/day without evidence of benefit
  - concurrent benzodiazepines that can’t be tapered off
  - patients request dosage reduction or discontinuation
  - patients experience overdose, other serious adverse events, warning signs.
Tapering Opioids*

- Taper slowly enough to minimize opioid withdrawal
  - A decrease of 10% per week is a reasonable starting point
  - If you taper too quickly, the patient will experience withdrawal
    - Usually not dangerous, but very uncomfortable
    - The patient may believe the symptoms are from their underlying pain disorder
    - Rapid tapers are associated with 50% of patients finding another provider to prescribe opioids

- Access appropriate expertise for tapering during pregnancy

- Optimize nonopioid pain management and psychosocial support
  - At least 50% of patients on chronic opioids also have a mental health disorder
  - If you don’t treat the mental health disorder, the success rate of getting patients off opioids is low
Reducing Opioid Doses:
Principles: *IT IS MY JOB*
Reducing Opioid Doses: Principles*

**Conclusion**

- We can, and should, reduce opioid doses.
- Most primary care doctors do not know how to do this.
- Most primary care doctors see the need for patient education:
  - Brochures?
  - Chronic Pain education classes.
- I have seen these needs in:
  - My practice.
  - My department
  - Other GHS departments
  - All of GHS
- I am starting an “Opioid Reduction Task Force.”
Reducing Opioid Doses: Principles*

- **Discussion**
  - What has worked in your practices to reduce opioid prescribing?
  - What barriers do you see to reducing opioid prescribing?