The Opioid Epidemic: Update and Best Practices for Internal Medicine, 2018

April 8, 2018
disclosures

• none
objectives

• Discuss recent facts about the epidemic, 2018
• Discuss what is changing in our country.
• List the affect of opioids on women.
• Articulate what the US government and regulatory bodies saying.
• Describe best practices for Prescribing Controlled Substances.
  – Treatment of acute pain, chronic pain and addiction
• Be introduced to Medication Assisted treatment
• Recognize diversion
• Be able to recognize Red Flags and Aberrant Behavior
Physician education

• Baylor-Scott & White video

• [https://vimeo.com/259051303/eb660abf54](https://vimeo.com/259051303/eb660abf54)

• 2 hours, 10 minutes
• Comprehensive
• Has scripts at the end for communication skills
NO NEW CASES
How the Epidemic of Drug Overdose Deaths Ripples Across America

By HAEOYOUN PARK and MATTHEW BLOCH  JAN. 19, 2016

Overdose deaths per 100,000

2003  2004  2005  2006

2007  2008  2009  2010

2011  2012  2013  2014

Ochsner Health System

The New York Times
Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010

https://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm?s_cid=mm60e1101a1_w. Updated with 2009 mortality and 2010 treatment admission data.
Worrisome Trends and Associations

CDC. MMWR Nov 4, 2011 / 60(43);1487-1492. 
Figure 4. Primary heroin admission rates, by state or jurisdiction: 2002-2012
(per 100,000 population aged 12 and older)

2002
(range <1 – 656)

2004
(range 0 – 597)

2006
(range 0 – 637)

2008
(range <1 – 618)

2010
(range 2 – 616)

2012
(range 3 – 730)

KEY YEAR: 2002

< 32
32 – 118
119 – 386
387 – 640
641 or more
Incomplete data

NOTES: See Chapter 1.
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.17.13.
Figure 7. Primary non-heroin opiates/synthetics admission rates, by state or jurisdiction: 2002-2012 (per 100,000 population aged 12 and older)

2002 (range 0 – 109)
2004 (range <1 – 167)
2006 (range <1 – 271)
2008 (range 1 – 395)
2010 (range 2 – 363)
2012 (range <1 – 443)

KEY YEAR: 2002

< 18
18 – 27
28 – 40
41 – 88
89 or more
Incomplete data

NOTES: See Chapter 1.
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.17.13.
Cardinal features of the Epidemic

- Diversion of tablets
- Addiction
- Chronic pain
- Psychiatric illness
- Overutilization

- Marianne Maumus, MD
What is changing in our country, government and healthcare system?

2018
All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH)

France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

LIFE EXPECTANCY DECREASE IN THE U.S.

The CDC reported that life expectancy in the U.S. dropped for the first time in decades.

Infants born after 2015, during the opioid crisis boom, have a slightly shorter lifespan than those born in 2014.
CDC director Thomas Frieden said-

“This is a doctor driven epidemic”

“America is awash in opioids; urgent action is critical.”
Interesting facts

- 91 opioid overdoses deaths per day, 2017
- One death every 17 minutes
- More OD deaths than breast cancer last year
- Opioids are the most frequently prescribed class of drugs prescribed in the US.
- The number of patients who abuse drugs last year exceeded the number of total cancer patients in the US.
The Economic Impact of OPIOIDS

$55 Billion/Year
In health and social costs related to prescription opioid abuse

$20 Billion/Year
Emergency department and inpatient care for opioid poisonings

Source: The U.S. Department of Health and Human Services

2007
Prescribing behavior

Some states have more painkiller prescriptions per person than others.

Number of painkiller prescriptions per 100 people
- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.
NO NEW CASES
Gender differences

• Deaths from prescription painkiller overdoses among women have increased more than 400% since 1999, compared to 265% among men.

• Women:
  – more likely to have chronic pain
  – to be prescribed painkillers
  – are given higher doses for longer periods of time than men.
  – Women become dependent more quickly than men.

• Neonatal Abstinence Syndrome has increased by 300% between 2000-2009.

• https://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/index.html
Women: Argument for Evidence based screening with the ORT.

• 1 in 5 women experience some sort of child sexual abuse

• Child abuse is a risk factor for the initiation and escalation of substance use among women.

• The ORT is a validated tool in the literature and reflects real pathology in the community.

• Failure to screen places 20% of women at risk for a lifetime of addiction.
2010 National Survey on Drug Use and Health – Substance Abuse and Mental Health Administration

• 16.2 % of pregnant teens and 7.4 % of pregnant women use illicit drugs

• Complications
  – Medical – MRSA infections, dental disease, seizure disorders, STD
  – Psychiatric disorders – 70%
  – Obstetrical complications – pre-term, fetal growth restriction
  – Neonatal Abstinence Syndrome
  – Sudden Infant death syndrome
  – Long Term sequelae – poor nutrition, neglect, abuse, mental delay, developmental delay
Household opioid prescriptions increase overdose risk for young children

Researchers looked at health data of Ontario children under the age of 10 who were treated in emergency departments for acute opioid overdose. They compared the likelihood that their mothers had been prescribed opioid vs. non-opioid painkillers before the child’s overdose episode.

Risk of severe overdose in children whose mothers had been prescribed opioids:

nearly 2.5 times higher
than children whose mothers had been prescribed non-opioid pain medications.

Institute for Clinical Evaluative Sciences
ices.on.ca

SickKids

2017
NO NEW CASES
Purdue Pharma - CNN report 2/11/18

- Announced it will stop promoting opioids to doctors
- Cut sales force in half.
- Company now routinely directs doctors to 2016 CDC Guidelines
- DEA “has expressed concern” of the company’s marketing of OxyContin to treat a wide range of conditions to doctors who were not adequately trained in pain management.
- In 2007, paid $634.5 million in criminal and civil fines for misleading advertising OxyContin as less addictive.
What is the government and regulatory bodies saying about the opioid epidemic?

President Obama – ACA, and the Substance Abuse and Mental Health Parity Act.

President Trump:
- October 26, 2017, President Trump directed the Department of Health and Human Services (HHS) to declare the opioid misuse and overdose epidemic a national public health emergency

FDA – black box warning for opioids and benzodiazepines, 2017.

CDC - Go to site for the latest information about the epidemic
- treating chronic pain without opioids
- [https://www.cdc.gov/drugoverdose/training/nonopioid/index.html](https://www.cdc.gov/drugoverdose/training/nonopioid/index.html)
- 2016 CDC chronic pain guideline

Federation of State Medical Boards:
- April, 2017 published a new policy for the *Use of Opioids Analgesics in the Treatment of Chronic Pain*
- Excellent review of chronic pain management, find online
The Joint Commission- new standards implemented for January 2018, highlights:

- Required to have an Opioid Stewardship Team
  - Safe opioid prescribing is identified as an organizational priority for the hospital.
  - Identify high risk patients
  - Monitor high risk patients
  - Facilitating clinician access to the PMP
  - The hospital provides non-pharmacologic pain treatment
  - Hospital educates patient and family on discharge
  - The hospital minimizes risk associated with treatment
  - The hospital develops a pain treatment plan based on evidence-based practices, patient’s clinical condition, past medical history, and pain management goals.
    - Realistic expectations and measurable goals
    - Discuss objectives
    - Provide education
The Joint Commission

- Hospital reassesses patient’s response to treatment
  - Document the response
  - Document progress toward goals, including functional status
  - Document side effects
  - Document risk factors for adverse events

- The hospital provides staff and licensed independent practitioners with resources and programs to improve pain assessment and management, and safe use of opioids

- The hospital provides information to staff on available resources for referral of patients with complex pain management needs

- Organization performance improvement activities to improve quality of care, treatment and services.

- Conducting performance review activities on pain assessment and management

Hospital collects data – to identify areas that need change
The Fifth Vital Sign

The Subjective pain scale:
- not a true vital sign.
- not objective like other vital signs.
- may assist in the treatment of acute pain
- not adaptable to patients on chronic narcotic therapy
- Initial studies used it as a screening tool to evaluate if further questioning and a more thorough pain evaluation was warranted
- It is not an accurate measure of pain.

  See more at: http://www.physiciansweekly.com/pain-5th-vital-sign/#sthash.sGqn3JOL.dpuf


How HIPAA Allows Doctors to Respond to the Opioid Crisis

HIPAA regulations allow health professionals to share health information with a patient's loved ones in emergency or dangerous situations — but misunderstandings to the contrary persist and create obstacles to family support that is crucial to the proper care and treatment of people experiencing a crisis situation, such as an opioid overdose. This document explains how health care providers have broad ability to share health information with patients' family members during certain crisis situations without violating HIPAA privacy regulations.

HIPAA allows health care professionals to disclose some health information without a patient's permission under certain circumstances, including:

- Sharing health information with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an incapacitated patient and the information shared is directly related to the family or friend's involvement in the patient's health care or payment of care. For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission.

- Informs persons in a position to prevent or lessen a serious and imminent threat to a patient's health or safety. For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.

HIPAA respects individual autonomy by placing certain limitations on sharing health information with family members, friends, and others without the patient's agreement.

- For patients with decision-making capacity, a health care provider must give a patient the opportunity to agree or object to sharing health information with family, friends, and others involved in the individual's care or payment for care. The provider is not permitted to share health information about patients who currently have the capacity to make their own health care decisions, and object to sharing the information (generally or with respect to specific people), unless there is a serious and imminent threat of harm to health as described above.

HIPAA anticipates that a patient's decision-making capacity may change during the course of treatment.

- Decision-making incapacity may be temporary and situational, and does not have to rise to the level where another decision maker has been or will be appointed by law. If a patient regains the capacity to make health care decisions, the provider must offer the patient the opportunity to agree or object before any additional sharing of health information.

For example, a patient who arrives at an emergency room severely intoxicated or unconscious will be unable to meaningfully agree or object to information-sharing upon admission but may have sufficient capacity several hours later. Nurses and doctors may decide whether sharing information is in the patient's best interest, and how much and what type of health information is appropriate to share with the patient's family or close personal friends, while the patient is incapacitated so long as the information shared is related to the person's involvement with the patient's health care or payment for such care. If a patient's capacity returns and the patient objects to future information sharing, the provider may still share information to prevent or lessen a serious and imminent threat to health or safety as described above.

HIPAA recognizes patients' personal representatives according to state law.

- Generally, HIPAA provides a patient's personal representative the right to request and obtain any information about the patient that the patient could obtain, including a complete medical record. Personal representatives are persons who have health care decision-making authority for the patient under state law. This authority may be established through the parent-child relationship between the parent or guardian of an emancipated minor, or through a written directive, health care power of attorney, appointment of a guardian, a determination of incompetence, or other recognition consistent with state laws to act on behalf of the individual in making health care related decisions.

For more information visit: https://www.hhs.gov/hipaa

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1 HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 and, for purposes of this guidance, the HIPAA privacy and security regulations.

2 This guidance does not discuss the requirements of other federal or state laws that apply to individuals' health information, including the federal regulations that provide more stringent protections for the confidentiality of substance use disorder patient records maintained in connection with certain federally assisted substance use disorder treatment programs (42 CFR Part 2 implementing 42 U.S.C. §5000a-2). HIPAA does not interfere with other laws or medical ethics rules that are more protective of patient privacy.

3 See 45 CFR §§ 164.510(b)(1) and 164.510(b)(3).

4 See 45 CFR § 164.522(e)(1).

5 HIPAA still requires that a disclosure to prevent or lessen a serious and imminent threat must be consistent with other applicable laws and ethical standards. 45 CFR § 164.512(b) (1). For example, if a state's law is more restrictive regarding the communication of health information (such as the information can only be shared with treatment personnel in connection with treatment), then HIPAA compliance hinges on the requirements of the more restrictive state law.
How HIPAA Allows Doctors to Respond to the Opioid Crisis, see it here),

- **Allows** professionals to share health information with loved ones in emergency and dangerous situations
- **Broad ability** to share information in a crisis **without** the patient’s permission
- May use professional judgment, (eg. Overdose)
- May disclose to **Family and close friends** who are involved in the care of the patient
- Information is **directly related** to the family or friend’s involvement with the care.
  - Patient must be incapacitated or unconscious
  - Can still inform persons who are in position to prevent or lesson a serious and imminent threat to a patient’s health or safety. (such as continuing opioid abuse)
Capacity

- Does the patient have ability to understand relevant information, appreciate the situation, reason and manipulate information rationally, and communicate a choice effectively?
- Can change with the clinical situation, is temporary.
- Respect capacity if there is no imminent threat to health or safety.
- **Document that continued use of opioids is a serious threat to health and safety.**
- Put patient safety over privacy.
Press Gainey: 2018 HCAHPS survey to measure pain communication, not management

- **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** survey's questions about pain during the hospital stay will change effective Jan. 1, 2018.

- three new questions about pain communication will replace the previous questions about pain management.

- The **Centers for Medicare and Medicaid Services** removed the survey's pain management measures from the **Hospital Value-Based Purchasing (VBP) Program**.

- The 2018 HCAHPS survey will ask adult discharged patients the following:
  - During this hospital stay, did you have any pain? (yes and no.)
  - During this hospital stay, how often did hospital staff talk with you about how much pain you had? (never, sometimes, usually, and always.)
  - During this hospital stay, how often did hospital staff talk with you about how to treat your pain? (never, sometimes, usually, and always.)
Initial Resistance: HCAHPS
Physicians Who Prescribe Less Have Same Patient Experience 2016

Opioid Prescribing Rate vs. Press Ganey Mean Score by Physician

To Ease Fears, Removed Patient Satisfaction for Pain Despite Lack of Correlation
More uncomfortable thoughts on Press Gainey

• > 50 % of doctors believe that patient surveys influence them to prescribe more opioids
• Metrics were based on patient experience, not on the patient’s health outcome
• Surveys are an administrative tool to change physician behavior.
• Metric used for hiring, firing, raises, promotions, demotions and other major career decisions

• Annals of EM, October 2013 article: demonstrated that there was lack of association between Press Gainey satisfaction scores and analgesic administration in the ED
• Did using the Press Gainey survey tool affect physician prescribing? - Question not answered.
## New state laws - Louisiana

<table>
<thead>
<tr>
<th>Act #76</th>
<th>Act #82</th>
<th>Act #88</th>
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<tbody>
<tr>
<td>(Senate Bill 55)</td>
<td>(House Bill 192)</td>
<td>(House Bill 490)</td>
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- **Act #76 (Senate Bill 55)**
  - Requires Accessing a Patient’s PMP Every 90 Days for Patients on Opioids >90 days.
  - Auto Enroll Prescribers into the PMP Who Get a New License and at Renewal (Every 3 years)
  - Require 3 Hours of Continuing Education Prior to License Renewal

- **Act #82 (House Bill 192)**
  - Limit Opioid Prescriptions to Seven Days for a Patient’s First Prescription

- **Act #88 (House Bill 490)**
  - Create an Advisory Council on Heroin and Opioid Prevention and Education
Louisiana Board of Pharmacy

PMP now has an Auto-Registration Process!

• This process no longer requires a notary

• For those prescribers who successfully enter the correct personal information and “Individual Access Code” in the registration process, they will immediately be given access to the PMP.

• Providers can contact the Prescription Monitoring Program (PMP) for assistance in identifying the missing records at (225) 925-6496, option "2".
No New Cases
Internal Medicine and Primary care

- Primary care physicians were taught to treat pain with opioids 1990-2016.
- There was no differentiation between acute pain and chronic pain.
- Opioid dependency and addiction was left untreated with limited resources.
- Primary care physicians felt the brunt of the patient’s unmet psychosocial needs.
**Care Pathway for the Prevention of Addiction**

**Acute Pain**
- Treat and prevent using opioid sparing techniques
- Stop opioid medication

**Chronic Pain**
- Start:
  - Antiseizure medication
  - TCA
  - SNRI
- Stop opioid therapy
- Biopsychosocial Approach:
  - CBT
  - Acceptance therapy
  - Functional rehabilitation
  - Distraction

**Opioid Dependency (Conscious)**
- Initiate chronic pain pathway

**Addiction (Unconscious)**
- Initiate opioid dependency pathway

**Withdrawal Pathway:**
- Establish rapport
- Observe and document behavior
- Complete medical and surgical evaluations
- Treat painful conditions
- Make consistent plan of narcotic withdrawal
- Discuss withdrawal symptoms and explain that patient may have to endure some hyperalgesia type pain until this process is complete
- Discuss plan in detail with patient, nurse and family, if available
- May use written patient/physician/hospital contract if needed
- Use alternative pain relieving remedies, reassurance, cognitive therapy, distraction
- Do not abandon patient in pain
- Evaluate capacity to make decisions
- Recruit family support
- Ongoing management of painful condition

**Addiction Psychiatry**
- Wean opioid to lowest dose tolerated
- Document capacity
- Stabilize behavior disturbance
- DC offending substances

**Substance Abuse Clinic for Long Term Care**
- Refer to addiction psychiatry
- Consider medication assisted treatment (Suboxone)
- Refer to substance abuse clinic for long term care
Assessing Opioid Risk

ORT >3

Current/update
- Opioid history
- Pain history
- Psychiatry history

DOSE
- MEDD >90
- benzo

PMP

Urine drug screen

Opioid complications:
- withdrawal
- SE
- overdose
- gastroparesis
- hyperalgesia
- analgesic HAs
- Narcotic Bowel Syndrome

Aberrant Behaviors:
- Lost script
- Reluctance to wean
- Altering a prescription
- Doctor shopping
- Multiple pharmacies
- Multiple allergies
- Request specific therapy
- Provider splitting
- Request anti-histamine
- Self-inflicted wounds
- Source of pain changes
- Reluctant to self-care
- More….

Drug Effects:
- Dependence
- Tolerance
- Addiction
- Pseudo-tolerance
- Pseudo-addiction

Marianne Maumus, MD
Diagnosis

- Acute pain
- Chronic pain syndrome
- Opioid Dependence
- Opioid Use Disorder
- Substance abuse disorder
- Acute Opioid withdrawal
- Opioid overdose

- Add any known psychiatric disorder

- Noncompliance of medication
Acute pain - Most can be treated without opioids

- Rest
- Ice compression
- Elevation
- Joint and Trigger point injections
- Accupuncture
- Massage
- TENS units
- PT/OT
- Exercise
- CBT
- Sleep hygiene

- Acetaminophen
- NSAIDS
- Cox 2 inhibitors
- Anticonvulsants
- TCA
- Topicals- capsaicin and lidocaine
- Patches
Evidence for the efficacy of pain medications
BY: DR. DONALD TEATER, M.D. National Safety Council;, 2014

• Looked at NNT post-operative pain
• Over-the-counter pain medications are more effective for acute pain than prescribed painkillers
Acute pain - Short term use of opioids may be appropriate

• Pain is the body’s form of self-protection. It is a transient thing in routine circumstances.
• Need good physician judgment
• CDC guidelines – 2-3 days of therapy
• Discuss risks, reasons for not prescribing
• Explain some pain is to be expected
• Need to do a risk assessments
  – ORT
  – PMP
  – UDS
Chronic pain

- Both emotional and sensational components
- Opioids not effective and could potentiate chronic pain
- Changes the nervous system occur with neuroplasticity
- Emotional triggers take greater importance in the pain response
- Pain pathways change centrally and peripherally – wind up, allodynia, hyperalgesia, central sensitization
- If you reduce the emotionality then you can reduce the pain.
- Needs a comprehensive biopsychosocial approach
- Patient education about neurophysiology of chronic pain works!
Chronic pain treatment

- Focus on function, not on pain scales
- Use long acting once daily (preferably non-opioid) meds instead of prn meds to take the focus off the condition.
- Get the patient involved with a pleasurable activity
- Reassurance and positive re-enforcement
- CBT – find a mental health professional who can help
  - Reduce negative thoughts
  - Helps with understanding their condition
  - Learn to change thinking patterns
  - Stop reactive, repetitive thinking
  - Mindfulness meditation
  - Helps w trauma, anxiety, depression,
Chronic pain treatment – goal is to improve functional status

- Acetaminophen
- NSAIDS
- Topicals
- Patches
- TCA, SNRIs
- Anticonvulsants
- Muscle relaxers

- Fix underlying problem
  - Biomechanics
  - Emotional problems
  - Sleep disturbance

- Exercise - affects MSK, CV systems and the brain
- Address barriers
- Pain cycle – negative feedback loop
Opioid and chronic pain

- Establish goals and function, discuss an exit strategy at the onset.
- Contract – controlled substance agreement
- Discuss risk and benefits, harms
- Risk assessment: psych, opioid and pain history, ORT, PMP, UDS.
- Avoid benzodiazepines, alcohol, soma, antihistamines
- Higher doses have higher fatalities
- Follow every 3 months
Opioid induced hyperalgesia

• When opioids make the pain worse!
• Heightened sensitivity to nociceptive stimuli
• Escalating opioid dose fails
• Tapering improves the pain
Opioid dependence

- Can begin as soon as 5 weeks after starting opioids
- Physical and mental
- Withdrawal symptoms
- Tolerance

Need to be weaned.

Withdrawal symptoms an last 3 months after cessation

Weaning:
- Slow tapers have less discomfort
- Last few milligrams is the hardest
- Can slow the taper if needed

Use alternatives
- CBT and psychosocial support
- Benzodiazepines need tapers due to risk of seizures.
When to stop and taper opioids

- If pain worse
- Tolerance develops
- If contract, controlled substance agreement is broken.
- Evidence of SUD (substance use disorder) or misuse.
- If behavior is uncontrolled
- Complications
  - Withdrawal
  - Severe constipation
  - Falls
  - Respiratory depression
Interventional pain management

• Refer if failing treatment, functional limitation, looking for options before surgery, need a more comprehensive evaluation

• Multi-disciplinary approach: PT, pain psychology – CBT, trigger point injections, nerve blocks, joint injections, epidural steroid injections, spinal cord stimulators

• They don’t taper opioids. They don’t treat SUD.

• If fails, patient goes back to the PCP – refer to surgery, or addiction psychiatry, start MAT, palliative care.
Functional restoration program
Interdisciplinary pain program

• Accept a broad range of patients
• Outpatient program 4-5 days per week, 3-4 weeks
• An array of activities: PT/OT, group therapies, CBT, etc.
• Goal centered
• Pt must be an active participant and plays a central role in regaining quality of life.
• Need well defined outcomes
• Proven to reduce opioids and improve function
• Can build a collaborative model w primary care and PM&R
Addiction

- Continuing to take opioids despite the harm
- A neuropathology of the motivational reward system
- Usually an underlying psychiatric disorder
- Dependence and tolerance plus other factors:
  - Craving
  - Persistent desire
  - Time spent obtaining opioid
  - Failure to fulfill roles at home and work
  - Giving up social and occupational responsibilities
Treatment of Addiction

https://store.samhsa.gov/product/SMA18-5063FULLDOC.

• Only 10% of opioid dependent patients are being treated
• Need to address psychosocial problems
• Remove environmental cues
• Treat chronic pain with alternatives
• MAT – suboxone or methadone

• Primary care doctors who have a opioid dependent and addicted patients should consider taking the 8 hour course to prescribe suboxone
  – To keep their patients stable within the healthcare system.
Medication Assisted Therapy

- Methadone – need Behavioral Health Clinic to dispense.

Need to develop relationships with the MAT programs in your area.
  - Take advantage of the federal funding.
  - Look for programs that offer individualized attention and care and address psychosocial needs.
Suboxone – contains buprenorphine and naloxone

• Benefits:
  – Lower OD rate
  – Less risk of abuse
  – Less risk of diversion
  – Less addictive behaviors
  – Retains patients in treatment programs
  – Patients more likely to effectively address psychosocial factors
  – Blocks the affects of other opioids in the brain
  – Covered by medicaid

• Traditionally used in heroin addicts
• Also used for prescription addicts
Suboxone:

• Partial opioid agonist – has milder affects
  – Fills brains receptors without causing as much of a high
• More difficult to abuse
• Added naloxone blocks other opioids from the brain’s receptors
• Can be prescribed from a doctor’s office.
• In studies of opioid discontinuation programs vs opioid replacement programs: the replacement group have better adherence and outcomes
Suboxone dangers

- Long term
- Can produce dependence in users
- Need long tapers under medical supervision
- Need to have a comprehensive treatment program
- If not used properly can lead to withdrawal symptoms
- Sublingual film
- Injecting can lead to death
- Fatalities when used with benzodiazepines or alcohol
MAT DEA waiver training

- Providers Clinical Support System:
  - 8 hour course
  - Pcssnow.org
  - Allows you to prescribe bupenorphine to treat SUD
  - Free
  - Live, Webinar and online
  - For practicing physicians and residents, nurse practitioners, physician assistants
  - There are Residency training programs available.
Naloxone

- Antidote
- Nasal spray or IM injection
- Halts respiratory depression
- Need 2 doses at home because short acting
- Families need instruction
- Give to all patients with MEDD>90, all who have undergone withdrawal, all with SUD, all who take both opioids and benzodiazepines.
Diversion

- means the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use.
  - Uniform Controlled Substances Act (1994)

- “Diversion” means “Any criminal act involving a prescription drug.”
  - National Association of Drug Diversion Investigators
diversion

- Can occur at any point along a supply chain
- Occurs within and outside of health care facilities
- 57% of all diverted drugs comes from medicine chests of friends and family, stolen or purchased
- Commonly diverted drugs:
  - Ephedrine, pseudoephedrine
  - Benzodiazepines
  - Opioids
    - Hydrocodone/acetaminophen – most commonly prescribed drug in the US, 131.2 million prescriptions
  - ADDHD meds
    - Netflix video: “TAKE YOUR PILLS”
Diversion in the hospital

- Health facilities – opioids are the most common drugs diverted

- Harm to the patient:
  - left in pain
  - can receive a contaminated drug in place of the diverted one
  - unsterile dilutions can lead to sepsis
  - Can divert diseases like Hep C and HIV
Diversion – health care worker place

• Anesthesiologists – highest rate of addiction, obtain their drug through diversion

• Form of Theft - to support an addiction, or for sale
  – Unopened vials
  – Substituted or diluted dosages
  – Residual drug left in a syringe
  – only administering a fraction of the normal amount to the patient and then add water or saline.
  – Taking discarded syringes or vials form sharps container
Diversion examples (from online)

- Trusted visitors remove fentanyl patches from patients.
- Patients override safety mechanisms - steal security keys to PCA pumps
- A nurse sewed a secret pocket to hide fentanyl syringes
- A radiology tech injected himself with 50% of syringe containing fentanyl, then filled it up with saline, for the patient, and this way infected several patients with Hepatitis C.
- Sharps container found in stairwells
Diversion: Reducing diversion is a shared responsibility Providers, Pharmacists, Manufacturers, Distributers

- Red flag warning signs

- Pharmacists
  - Ensure prescribing for a legitimate medical purpose
  - Have legal requirement to contact providers to establish legitimacy
  - Complete a drug utilization review
  - Decipher illegible prescriptions
  - Validate prescriber’s authority – check the DEA registration
  - access the PMP

- Physicians
  - proper evaluations, evidence based prescribing
  - Screen for diversion and non-medical use
  - Need a proper patient physician relationship
Diversion prevention

• Recognize diverters:
  – doctor shoppers – the biggest group of diverters
  – elderly - divert for economic reasons into their neighborhoods
  – Pill brokers – use the elderly to deceive their physicians, target older physicians
  – Friends and family members – divert left over tablets

• Prevention:
  – Reduce # of tablets
  – Use alternatives first
  – Proper risk assessments for misuse before initiating opioid therapy
  – Following evidence based practices
  – Shorter duration of treatment for acute pain
  – Recognizing misuse and stop controlled substances
  – Understand that some drugs have more abuse potential then others
Red Flags: doctors

- Patients who travel far and request substance on the first day
- Patient who come in groups and all request a substance
- Sedated, confused, intoxicated, exhibits withdrawal symptoms, has physical signs of drug abuse
- Multiple unexplained dose escalations
- Non-adherence to the treatment plan
- Uses a route of administration other than prescribed
- Seeks medications from non-coordinated sites of care- ED, urgent care, walk-in clinics
- Unintentional overdose
- Behavior or PMP report provided evidence of obtaining prescriptions from multiple sources without providers knowledge of other providers
More Red flags: doctors

- Discharged from another physician for egregious behavior
- Patient pressures physician to prescribe, makes direct threats
- Patient resist changes in the treatment plan despite clear evidence of adverse physical or psychological effects from the drug
- Refuses to sign opioid agreement/contract
- Patient request prescription be written in names of other people.
Red flags: pharmacy

- Patient travel in groups, have the same script from the same provider
- Presents script written for other people
- Patient presents a script that the pharmacist knows was declined at another pharmacy
- Script looks altered
- Pharmacist aware the provider’s DEA # was revoked
More Pharmacy Red Flags:

- Patient presents the same script to multiple pharmacies.
- Presents scripts for highly abused controlled substances.
- Patient has several scripts, but only wants the controlled substance.
- Hx of untruthfulness when filing controlled substance prescriptions.
- Patient presents scripts for large supplies.
- Has scripts for cocktails – opioid, benzo, muscle relaxant.)
Illicit/ illegal behavior

- Patient indicates drugs will be sold or shared.
- Prescriber’s DEA registration or state license revoked or suspended.
- Prescriber is writing script outside of scope of practice
- Patient alters, forges, sells, rewrites prescriptions
- Patient is diverting, selling, or getting drugs from others
Aberrant behavior tips:

• Look for multiple behaviors – increases likeliness of

• One behavior does not confirm SUD

• Need to be taken in the appropriate clinical context
Aberrant behavior - clues

• Appears to be faking,
• exaggerating pain severity, excess emotionality
• offers only a vague medical history
• Brings their own medical records to the visit
• will not provide name of regular or previous physician
• has unusual knowledge about opioid medications
• uses street names, request large quantities, specific drugs, aggressive complains.
• insist on paying cash even though he has insurance
Aberrant behaviors

- Losing a script; Claiming a script was stolen
- Pattern of early refills
- Using drug without approval for other symptoms
- Drug hoarding
- Claim of allergy
- Refusal to taper when indicated
- Concurrent use of alcohol, other drugs.
- Non-medical uses of opioids, use for a coping method
- Intolerance to alternatives
- Refusal to try non-opioid remedies
- Refusal for CBT, psychosocial care, rehab, PT/OT
Aberrant behaviors in the appropriate clinical context.

- Patient do travel far to specialty clinics.
- Patient do get familiar with their medications in chronic disease states.
- Patients may lack understanding what a true allergy is.
- Look for patterns of behavior over time.
- Aberrant behaviors are patient specific and need a differential diagnosis.
We Swung the Pendulum to the Other Side

No Opioids for Chronic Pain
Goal – Help Patients Manage

Opioids for All Pain
Goal – Eliminate Pain
NO NEW CASES