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• NIAAA R01 AA024755 (Walton)
• CDCP R49 CE003099 (Cunningham)
What You Will Learn

- Review the Epidemiology of the Prescription Opioid Epidemic
- Discuss the Origins of the Opioid Epidemic
- Discuss the Relationship between Prescription Opioids and Heroin
- Discuss the Role of Safer Opioid Prescribing
- Review the 12 CDC Guidelines for Safer Opioid Prescribing for Chronic Pain
- Alternatives to Opioid Use
- Risk/Benefits of Opioid Use
- IR vs. ER/LA Opioid Therapy
- Opioid Overdose and Dosage
- Acute Care & Post-Surgical Prescribing
- Discuss Safe Opioid Disposal Practices
- Tools and Resources
- Wrap up and Questions
In 2017,

- 47,600 people died from opioid overdose
- 130+ people died every day in 2017 from opioid-related drug overdose
- 2.1 million people had an opioid use disorder
- 900K used heroin; 81K for the first time
- 15,482 deaths due to heroin overdose
- 17K deaths attributed to opioid overdoses on commonly prescribed medications
- 28,466 deaths due to overdoses on synthetic opioids (other than methadone)

COST TO U.S. ECONOMY

- $504 billion

The Opioid Epidemic...by the numbers

1999-2016
- >350,000 died of a opioid overdose

Three waves of the U.S. Opioid Epidemic
- First wave = Increased Prescription Opioid Overdose due to increased Prescribing in early 1990s
- Second wave = Increased Heroin Overdose in the early
- Third wave = Synthetic Opioid Overdoses (e.g., fentanyl)

80% of those who use heroin first misused prescription opioids
In 2017, Michigan ranked 15th out of 51 U.S. States and the District of Columbia in Opioid Overdose Mortality (27.8 deaths per 100,000 people), a 14% increase from 2016.
The Opioid Epidemic...by the numbers

- Number of Michigan fatalities resulting from opioid overdoses has increased exponentially since 1999, accounting for 2,694 deaths in 2017.
- Annual # of opioid overdoses in Michigan now greater either firearm-related deaths or motor vehicle crashes.
- While non-opioid drug overdose deaths have been stable over the past decade, fatal opioid overdoses have been increasing, accounting for >90% of all drug overdose deaths in Michigan in 2017.

Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online.
The Opioid Epidemic…by the numbers

Opioid epidemic has translated into a significant increase in opioid-related ED visit and inpatient hospitalizations

In Michigan, the opioid related hospitalization rate in 2014 was 229.6 per 100,000 residents, a 21.4% increase from 2009.
Origins of the Epidemic…Multi-factorial

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter
Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center

Waltham, MA 02154
More Prescribing = More Opioid Deaths

The impact of the increase in opioid prescribing observed in the late 1990s and early 2000s was a sharp increase in both opioid pain reliever (OPR) overdose deaths and admissions to hospitals for substance use treatment.

U.S. Opioid Pain Reliever (OPR) overdose deaths, treatment admissions and OPR sales (kg/sold) (1999-2010)
Rx Opioids and the Transition to Heroin

- Non-medical use of Rx Opioids is the strongest risk factor for heroin use
  - Majority (~75-80%) of current heroin users initiated their opioid use with non-medical prescription opioid use
  - Only (3-5%) of patients who misuse Rx opioids transition to heroin use
- Rise of heroin overdose deaths occurred before large scale state interventions were instituted, suggesting transition to heroin is not solely an impact of state policies or changes in prescribing practices
- Transition to heroin more likely progression of addiction disease in a subgroup of non-medical prescription opioid users (i.e., those with frequent non-medical use and/or prescription opioid abuse/dependence)
- Transition also likely the result of market forces, including increased accessibility, reduced prices, and higher purity of heroin

Compton W, et al. NEJM. 2016; 374; 154-63; Cicero et al. JAMA Psychiatry; 2014; 71-(7): 821-826
Addressing The Opioid Epidemic

**Prescribing Practices**
- PDMPs (i.e., MAPS)
- Diversion Control/Safe Disposal

**Harm Reduction Strategies**
- Naloxone availability
- Needle exchange

**Community/Patient Education**

**Expanded Access to Treatment Services**

**Improved Data/Research and Surveillance**

**Treatment**

**Supply/Demand**

**Harm Reduction**
Safer Opioid Prescribing Guidelines

With Opioid misuse becoming a national crisis, there was a need for development of clear and consistent guidelines for prescribing.

- Previous guidelines were developed, but inconsistent
- Prior national guidelines were several years old
- Need for clear, consistent guidelines

**Primary Audience:** Primary Care Providers, Nurse Practitioners, Physician Assistants.

**Use:** Treating patients 18 + years of age for chronic pain

*Does not include active cancer treatment, palliative care, and end-of-life care*
Why focus on safer opioid prescribing?

**WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?**

Primary care providers account for approximately **50%** of prescription opioids dispensed.

Nearly **2 million** Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014.

- An estimated **11%** of adults experience daily pain.
- Millions of Americans are treated with prescription opioids for chronic pain.
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids.

Primary care providers commonly treat chronic non-cancer pain and account for **50%** of all prescriptions dispensed.
Why focus on safer opioid prescribing?

Despite safer prescribing approaches in recent years,

The amount of opioids prescribed per person was three times higher in 2015 than in 1999.

180 MME 1999 | US
640 MME 2015 | US

Framework: 12 Recommendations; 3 categories

- Determining when to initiate or continue opioid use in the treatment of chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
Determining when to initiate or continue opioids for chronic pain

Focus area #1

Safer Opioid Prescribing Guidelines
Recommendation 1

Non-pharmacologic therapies and Non-opioid pharmacologic therapy are preferred for chronic pain to opioid use.
The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD; MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blasina, MPH; Tracy Dana, MLS; Christine Bougatsos, MPH; and Richard A. Deyo, MD, MPH

**Background:** Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

**Purpose:** To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

**Data Sources:** MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2003 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

**Study Selection:** Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

**Data Extraction:** Dual extraction and quality assessment.

**Data Synthesis:** No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction, although there are few studies for each of these outcomes; for some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk mitigation strategies is limited.

**Limitations:** Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

**Conclusion:** Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

**Primary Funding Source:** Agency for Healthcare Research and Quality.


For author affiliations, see end of text.

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Chronic pain, often defined as pain lasting longer than 3 months or past the normal time for tissue healing, is common and is a major cause of decreased

The purpose of this review was to evaluate the evidence on the effectiveness and harms of opioid therapy for chronic pain. We updated a prior review (18)
### Alternative Tx Options

**Recommendation 1**

- Opioid Therapy should be considered only if expected benefits for pain and function are anticipated to outweigh the risks to patient.
- If opioids are used for pain control, they should be combined with non-pharmacologic and non-opioid pharmacologic therapy, as appropriate.
- Non-Pharmacologic therapies that have been shown to be effective include:
  - Exercise
  - Exercise + Behavioral Therapies (e.g., CBT)
  - Interdisciplinary rehabilitation
- Non-Opioid Pharmacological Therapies
  - Topical Medications: Lidocaine, Capsaicin
  - First line: Non-steroidal Anti-inflammatory Medications, Acetaminophen
  - Second line: Serotonin/Norepinephrine reuptake inhibitors (SNRIs); Tricyclic antidepressants (TCAs)
  - Neuropathic pain = Gabapentin; Pregabalin
  - Migraines = Beta Blockers; Calcium Channel Blockers; Tripans (acute); Anti-emetics (acute)
- Arthrocentesis and Intra-articular injections of glucocorticoids
What to consider: Recommendation 2 & 3

**Recommendation 2:**
Establish realistic goals for patients treatment and pain before beginning opioid therapy

Discuss how/when opioid therapy will be discontinued if does not prove beneficial.

**Recommendation 3:**
Discuss risks and potential benefits of opioid therapy both before beginning treatment and periodically throughout treatment period.
Establishing Treatment Goals

- Acute vs. Chronic Pain Treatment (>3-months = chronic pain treatment)
- Consider that you are probably starting treatment for chronic pain anytime >30-day supply of opioids

- Before initiating opioid therapy for chronic pain
  - Determine **how effectiveness will be evaluated** (validated scale)
  - Establish **treatment goals** with patients.
    - Written Treatment Plans - outline plan of course, treatment goals, expectations for monitoring, situations for discontinuing or tapering dosage (e.g., failure to adhere to clinic policies)
    - Treatment goals = Pain relief, functional status (e.g., walking the dog, returning to work)
  - Have an **Exit Strategy** if therapy is unsuccessful
    - Plan for tapering and discontinuing opioids

Assess progress using 3-item validated PEG Assessment Scale*
- Pain average (0-10)
- Interference with Enjoyment of life (0-10)
- Interference with General activity (0-10)

*clinically meaningful improvement defined as 30% improvement in scores for both pain and function
Risks/Benefits of Opioid Treatment

- Patients highlight lack of information regarding opioids and concerns re: safety of medications.

- Be explicit/realistic about benefits - - Role in short-term pain management, but no evidence for opioids improving pain/function with long-term use and complete relief of pain unlikely.

- Emphasize goal of improvement in pain and function.
  - Function can improve even when pain present.

- Anticipatory Guidance:
  - Serious (e.g., fatal respiratory depression, opioid use disorder) adverse effects.
  - Common adverse effects (e.g., constipation, tolerance, withdrawal symptoms with cessation).
  - Increased risks of overdose
    - Especially at higher dosages.
    - Combined with other drugs (e.g., benzos = 10X risk than opioid alone) or alcohol.
  - Opioids and driving (initiation, dosage change, combined with CNS depressants).
  - Need for Periodic reassessment to ensure goals are being met, PDMP and urine checks.
  - Safe Storage of Medications and Safe Disposal.
  - Risks to family members and individuals in the community.
Opioid selection, dosage, duration, follow-up and discontinuation

Focus area #2
Recommendation 4:
When beginning therapy, immediate-release opioids should be prescribed instead of extended-release/long acting opioids.

Recommendation 5:
When beginning opioid treatment, start with the lowest effective dosage.

Use caution with any dose
Start low, go slow- reassess pain and function
Increase frequency of follow-ups
IR vs. ER/LA Opioid Therapy

- Risk of overdose higher in patients initiating therapy with LA opioids as compared to those initiating therapy with IR opioids [HR=2.33], especially during the first two weeks of therapy

- No evidence that ER/LA is safer or more effective for management of chronic pain

- Recommendation: ER/LA should be reserved for severe continuous pain in opioid tolerant patients when alternate treatment options are not effective
  - Methadone should be avoided as the first line choice

Risk of Overdose with higher dosing

Rule of Thumb: Start Low & Go Slow

- Similar to other medications, goal is lowest effective dosage and small dose increases.
  - Begin with lower dosage; Titrate slowly
  - Caution when combining multiple drugs (especially in elderly)
  - Assess for potential drug-drug interactions

- If total opioid dosage >50 MME/day
  - Reassess pain, function, and treatment; Increase frequency of follow-up
  - Consider offering naloxone teaching/education and kit for reversal

- Avoid increasing opioid dosages to >90 MME/day. If patient with escalating dosage requirements,
  - Discuss alternate pain therapies
  - Consider tapering opioids
  - Consider pain specialist consultation

- Patients already taking >90 MME/day
  - Re-evaluate continued use of high opioid dosages given potential overdose risk
  - Consider tapering plan
**Recommendation 6:**

For *acute pain* treatment with opioids, low dosage with a short duration of time should be considered, if possible.

3-5 days or less will often be sufficient; more than 7 days will rarely be needed.

**Recommendation 7:**

Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.

Then re-evaluate continued therapy with patients every 3 months or more frequently.

If benefits do not outweigh harms consider alternatives, lowering dosage and/or discontinuation of opioid treatment.
Two Retrospective studies found that in patients receiving an opioid prescription for acute pain treatment (low back pain; post-surgical), there was a greater risk of long term use of opioid therapy.
General Acute Care Opioid Recommendations

- Non-Opioid therapies (NSAIDS, Non-pharmacologic) should be used as first line therapy

- Prescribe the lowest effective dose
  - Prescribe amount to match the expected duration of pain severe enough to require opioids
  - Short acting opioids should be for < 3 days and rarely more than 7 days are needed
  - Do not prescribe additional opioids “just in case”
  - Re-evaluate patients with severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly.

- No replacement of lost or stolen prescriptions (including methadone)
- Do not prescribe ER/LA opioids for acute pain treatment.
- Consider Naloxone co-prescription for patients with >50 MME/day
- Avoid co-prescribing with benzodiazepines
- Utilization of PDMPs in accordance with recently passed Michigan laws
Specialty Specific Acute Care Prescribing Recommendations

- Despite CDC guidelines, remains a gap in recommendations for prescribing, especially for acute care – ED, Dental, Surgical
- New acute care prescribing recommendations developed for EM, dental prescribing, and post-surgical prescribing
- Approved by LARA and Prescription Drug and Opioid Abuse Commission
- Handouts available
### Opioid Prescribing Recommendations for Opioid-naïve Patients

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Hydrocodone (Norco)</th>
<th>Oxycodone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 mg tablets</td>
<td>5 mg tablets</td>
</tr>
<tr>
<td>Codeine (Tylenol #3)</td>
<td>30 mg tablets</td>
<td>20 mg tablets</td>
</tr>
<tr>
<td>Tramadol</td>
<td>50 mg tablets</td>
<td>10 mg tablets</td>
</tr>
<tr>
<td>Laparoscopic Cholecystectomy</td>
<td>15</td>
<td>10</td>
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<tr>
<td>Laparoscopic Appendectomy</td>
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<td>10</td>
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<tr>
<td>Inguinal/Femoral Hernia Repair (open/laparoscopic)</td>
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<td>10</td>
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<tr>
<td>Open Incisional Hernia Repair</td>
<td>30</td>
<td>20</td>
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<tr>
<td>Laparoscopic Colectomy</td>
<td>30</td>
<td>20</td>
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<tr>
<td>Open Colectomy</td>
<td>30</td>
<td>20</td>
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<tr>
<td>Ileostomy/Colostomy Creation, Re-siting, or Closure</td>
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<td>25</td>
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<tr>
<td>Open Small Bowel Resection or Enterolysis</td>
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<td>20</td>
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<tr>
<td>Thyroidectomy</td>
<td>10</td>
<td>5</td>
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<tr>
<td>Hysterectomy</td>
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<tr>
<td>Vaginal</td>
<td>20</td>
<td>10</td>
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<tr>
<td>Laparoscopic &amp; Robotic</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Abdominal</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>Breast Biopsy or Lumpectomy Alone</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Lumpectomy + Sentinel Lymph Node Biopsy</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Sentinel Lymph Node Biopsy Alone</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Simple Mastectomy ± Sentinel Lymph Node Biopsy</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Modified Radical Mastectomy or Axillary Lymph Node Dissection</td>
<td>45</td>
<td>30</td>
</tr>
<tr>
<td>Wide Local Excision ± Sentinel Lymph Node Biopsy</td>
<td>30</td>
<td>20</td>
</tr>
</tbody>
</table>

- M-OPEN Post-Surgical Prescribing Recommendations
- Data shows that when patients prescribed fewer pills, they consume fewer pills with no evidence for changes in their pain or satisfaction scores
- Recommendations based on patient-reported data around post-operative opioid consumption
- Recommendations are designed for opiate naïve patients
- Meet/Exceed self-reported use of 75% patients
- Opioidprescribing.info (more info on post-surgical prescribing)
Follow-Up with Opioid Therapy

- No good evidence regarding the effectiveness of frequent monitoring intervals
  - 3-months of therapy increases risk for opioid use disorder
  - Risk for overdose with ER/LA opioids high during first 2 weeks of therapy
  - Patients w/o significant pain relief at 1 month unlikely to experience relief at 6 months

- Re-evaluate patients within 1-4 weeks of starting long-term therapy or of dosage increase
  - Greatest potential to mitigate risk for opioid use disorder if f/u less than 3 months
  - Consider sooner follow-up for ER/LA opioids and particularly for methadone (3 days)
  - Re-evaluate continued opioid therapy every 3 months

- At follow up, discuss with patients:
  - Opioids continue to meet treatment goals; Benefits continue to be > Risks
  - Common or serious adverse events or early warning signs (e.g., sedation, slurred speech, cravings, difficulty controlling use; greater quantity to control pain, work or family problems)
  - Assess whether opioid dosage can be reduced or discontinued.
Tapering Guidelines

When to taper?
- No sustained clinically meaningful improvement in pain and function
- Opioid dosages >50 MME/day without evidence of clinical benefit
- Concurrent use of benzodiazepines that can not be tapered
- Patients requests reduction or discontinuation of opioid therapy
- Patients experience overdose or other serious adverse events/warning signs.

How to taper?
- No high quality evidence comparing different tapering protocols
- Guidelines in general recommend reducing dosage by 10-50% of original dosage weekly
- 10% dose reduction is a reasonable starting dose and adjust by patient response
  - Taper slowly enough to minimize opioid withdrawal symptoms; consider clonidine for symptoms
  - Slower taper in patients with longer duration of use; may have to pause and restart as tolerated
  - Note – opioid withdrawal in pregnancy associated with spontaneous abortion/premature labor
- Opiates can be stopped when taking less than once a day
- More rapid tapering may be indicated with adverse events (e.g., overdose)
- Optimize non-opioid pain management and psychosocial support
- Referral patients with opioid use disorder to treatment services
Assessing risk and addressing harms of opioid use

Focus area #3
Recommendation 8:

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
Overdose Education & Naloxone Distribution

Patients at potential risk for opioid overdose and/or opioid related harms should be considered for co-prescription with naloxone:

- Prior overdose, opioid intoxication/poisoning
- Substance abuse and/or non-medical opioid use
- Higher dosage opioid use (> 50 MME/day)
- Opioid Pain Med Prescription (and)
  - Are concurrently prescribed methadone/buprenorphine
  - Moderate or Severe Obstructive Sleep Apnea (OSA)
  - Poorly controlled respiratory disease
  - Renal Dysfunction, hepatic disease, cardiac illness
  - Concurrent alcohol or benzodiazepine use or abuse
  - Poorly controlled depression
  - Special Populations (Elderly; Pregnancy)
- Resumption of opioid use after period of abstinence
- Recent incarceration/release from prison with history of opioid use
- Remote ability to access EMS services in an emergency (e.g., rural populations)
OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION IS EFFECTIVE PREVENTION TOOL

Feasibility
- Piper et al. Subst Use Misuse 2008: 43; 858-70
- Doe-Simkins et al. AJPH 2009: 99; 788-791
- Enteen et al. J Urban Health 2010:87; 931-41
- Walley et al. JSAT 2013; 44:241-7

Increased knowledge and skills
- Green et al. Addiction 2008: 103;979-89

No increase in drug use; increase in drug treatment
- Galea et al. Addict Behav 2006:31:907-912
- Doe-Simkins et al. BMC Public Health 2014; 14:297

Cost effective

Reduction in overdose deaths in communities
- Maxwell et al. J Addict Dis 2006:25; 89-96
- Walley et al. BMJ 2013 346:f174
Overdose Education & Naloxone Distribution

- Naloxone Formulations
- Naloxone Kits
- Good Samaritan Laws
- Standing Naloxone Order
Recommendation 9:

Review the patient’s history of controlled substance prescriptions using state PDMP-MICHIGAN AUTOMATED PRESCRIPTION SYSTEM (MAPS)

Review PDMP data before beginning opioid therapy and periodically throughout course of therapy

Recommendation 10:

When prescribing opioids for chronic pain, use urine drug testing before starting opioid therapy

Consider UDS at least annually to assess for prescribed medications use and illicit drugs.
Prescription Drug Monitoring Programs (PDMPs)

What is a PDMP?
- Electronic systems that digitally store, monitor, and analyze controlled substance dispensing data
- 49 states excluding Missouri have implemented a PDMP

What data does a PDMP Collect?
- Patient/Prescriber Info; Dispenser Info on Schedule II-IV drugs

Who can access PDMP data?
- Prescribers; Pharmacies; Law enforcement; State Medical Boards

Why have a PDMP?
- Surveillance and Evaluation Tool
- Outlier prescribers and patients (i.e., “doctor shopping”)

PDMP Effectiveness - Mixed evidence for effectiveness
- Reduced opioid prescribing in several states (Florida; NY; Ohio; Kentucky)
- No similar evidence in NC or when combining results from multiple PDMP/Non-PDMP states
- Smaller increases in treatment admissions in PDMP states (vs. non-PDMP states)
- No clear pattern of reduced overdose mortality in PDMP states overall, but mortality was lower in CA, TX, and NY, as well as immediate drop in mortality followed PDMP implementation in FL
- Mixed findings by state and substance type for diversion
Prescription Drug Monitoring Programs (PDMPs)

What are you looking for when you check PDMP System?

Most fatal overdoses associated with patients receiving opioids from multiple providers and/or from high daily opioid doses

- **High Dosage**
  
  Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.

- **Multiple Providers**
  
  Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

- **Drug Interactions**
  
  Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.
Prescription Drug Monitoring Programs (PDMPs)

Michigan’s Automated Prescription System (MAPS)
- Initially rolled out in 2003 to track Schedule II-V drug prescribing/dispensing
- ~30-35% of eligible providers were registered in system prior to 2016
- April 2017, Michigan’s Department of Licensing and Regulatory Affairs (LARA) upgraded the MAPS platform to Appriss Health PMP AWARx; New MAPS system rolled out May 2017
- **Future Issues**: Electronic Health Record Integration; Clinical Decision Support

Public Act 248 & 249 of 2017 (i.e., Senate Bills 166 & 167)
**Effective June 1, 2018**
- All licensed prescribers in Michigan must be registered with MAPS before prescribing or dispensing a controlled substance to a patient.
- All licensed prescribers in Michigan will be required to query the Michigan Automated Prescription System (MAPS) when prescribing controlled substances to any patient.
- **Exceptions**:
  - Prescriptions written for quantities less than or equal to a 3-day supply.
  - If dispensing occurs in hospital or surgical freestanding outpatient facility and is administered in the facility.
What to consider:

**Recommendation 11:**

Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Possible alternatives: cognitive behavioral therapy, specific anti-depressants approved for anxiety, other non-benzodiazepine medications

*Coordinate care with mental health professionals, when possible*

**Recommendation 12:**

Offer or arrange evidence-based treatment (usually MAT with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

*Discuss concerns with your patient* and provide an opportunity for patient concerns.

Assess for OUD using DSM-5 criteria.
Opioid Use Disorder Treatment

• Counseling and Community Support (without medication)

• **Medication Assisted Treatment (MAT):** a comprehensive method of addressing opioid use disorder by combining medication, behavioral counseling therapy, and case management services
  
  • **Methadone** (opioid agonist) and **Buprenorphine** (partial agonist) are approved by the FDA for treatment of opioid use disorders
  
  • Injectable extended release **naltrexone** (antagonist) is approved by the FDA for prevention of relapse after detoxification
Benefit of Medication Assisted Treatment (MAT)

- Treatment Program Retention
- Reduces opioid use/misuse
- Reduces criminal activity
- Reduces risk of overdose and opioid related overdose deaths
- Reduces risk of HIV, HBV, and HCV infections
- Increases social functioning/rates of employment

RP Mattick et al. Cochrane Database of Systematic Reviews (2009)
RP Mattick et al. Cochrane Database of Systematic Reviews (2014)
ACOG & ASAM. (2012)
How to counsel patients to dispose of opioids?

Safest Method = Opioid Take Back Programs
- Pharmacies
- Law Enforcement Agencies
- Special Take-Back Programs

Drug Disposal Pouches

If no take back programs/can’t drive to site:
1. Remove meds from original container and mix (do not crush) with an unpalatable substance such as kitty litter or used coffee grounds.
2. Place mixture in a sealed bag or container.
3. Throw sealed bag or container in household trash.
4. Scratch out personal information on prescription label and dispose of the container.
Tools and Resources

Additional resources that are available for providers and patients:

Posters
Fact Sheets
Checklists
Education on Epidemic

https://www.cdc.gov/drugoverdose/index.html

https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html

Access the full CDC guideline for prescribing opioids for chronic pain at:

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
Questions?

Patrick Carter, M.D.
Assistant Director, UM Injury Prevention Center
Assistant Professor of Emergency Medicine

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Sarah Stoddard, Ph.D., R.N., C.N.P.
Director, Education Core, UM Injury Prevention Center
Assistant Professor,

Quyen Ngo, Ph.D., L.P.
Core Faculty, UM Injury Prevention Center
Assistant Professor, Department of Emergency Medicine

www.injurycenter.umich.edu