Safe Prescribing Practices and Non-Opioid Choices for Medical Professionals

2/1/2021
Housekeeping

- Muted on entry
- Chat is disabled, please use the Q & A function at any point
- Slides and the recording will be sent out afterwards
NSC Mission

The National Safety Council is America’s leading nonprofit safety advocate focused on eliminating the leading causes of preventable death so people can live their fullest lives.
Community-wide coalition working together to reduce substance use and increase mental health among DuPage County Youth, 18 and under

- **Main Focus-Community-level Change:** Community-wide impact utilizing strategies that affect environment and policy.
- **Supporting Focus-Individual-Level Change:** Support and promote existing prevention and treatment services.
Non-Opioid Choices Project

• PLT 1 of 18 coalitions selected to participate in Project.

• **Goal of Project** – $8,000 stipend to raise community awareness of non-opioid options available for pain treatment in postsurgical setting and beyond (acute pain).

• **Project Timeline** – 18 months (Jan. 2020-July 2021)
Acute Use Leads to Long-Term Use

Duration of acute use:
- 1 day – 6% chance of still using that drug a year later
- 8 days – 13.5%
- 31 days – 29.9%

1 in 15 patients who receive Rx painkillers after surgery use them long-term


Source: CDC; MMWR; March 17, 2017. 66(10):265-269.
 Consumers Awareness

Patients say that discussions about opioid and opioid alternatives are often missing from their conversations with physicians prior to surgery.

- 66% don’t talk about addiction...
- 77% do not discuss non-opioid options

Q13. Has your healthcare provider discussed non-opioid alternatives for pain management with you?

(N = 98)

- Yes: 47.96%
- No: 52.04%
Types of Non-Opioids Used in Multimodal Pain Treatment Plans

- NMDA receptor antagonists
- NSAIDs
- Alpha-2 agonists
- Acetaminophen
- Gabapentinoids
- Local anesthetics

Non-pharmacological Therapeutic Options
Complement Traditional Analgesic Options

Patient education is critical!

- Cognitive behavioral modalities: positive imagery or music therapy
- Heating pad
- Ice, elevation, compression
- Aroma-therapy
- Deep breathing

Accreditation & Disclosure

Accreditation:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Illinois Academy of Family Physicians and the DuPage County Health Department. The Illinois Academy of Family Physician is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation:
AMA PRA Category 1 - The Illinois Academy of Family Physicians designates this live internet activity, “Safe Prescribing Practices & Non Opioid Choices for Medical Professionals,” for a maximum of 1.50 AMA PRA Category 1 credit™.

Faculty Disclosure Statement
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Speaker & Faculty Disclosures
Dr. Aaron Weiner, Jordan Esser, Claire Stroer, and Sara Ortega (IAFP Staff) disclosed no relevant financial relationship or interest with a proprietary entity producing, marketing, reselling or distributing health care goods or services.

This program does not include any discussion or demonstration of any pharmaceuticals or medical devices that are not approved by the Food and Drug Administration (FDA) or that are considered “off-label.”
Objectives

01 Identify the history and scope of the opioid epidemic
02 Describe pain and effective ways to treat it
03 Identify the risks and benefits of opioid and non-opioid pain analgesics
04 Apply evidence-based guidelines and approaches
Objectives

05 Describe the prescriber’s role in combating the opioid epidemic

06 Educate patients on opioid use risks and alternatives

07 Describe when to refer to pain management or treatment for substance use disorder
Opioid Definition
Drug Overdoses

Causes more deaths than vehicles crashes

Leading contributor of overdose is opioids.
Overdose Rates

• **2019: 50,042 deaths** due to opioids, 71% percent of all drug overdose deaths (CDC, 2020)
  • Up 4.2% from 2018
  • Total US deaths in Iraq & Afghanistan: 6,841
  • Current leading cause of accidental death, over MVAs (2018: 37,991)

• **137 Americans die daily** from an opioid overdose
  • Thousands treated in EDs daily for misuse

(CDC, 2020) (LaRochelle, 2016)
National Overdose Deaths

Source: National Center for Health Statistics, National Vital Statistics System, Mortality
‘Cries for help’: Drug overdoses are soaring during the coronavirus pandemic

Suspected overdoses nationally jumped 18 percent in March, 29 percent in April and 42 percent in May, data from ambulance teams, hospitals and police shows.

81,000 overdose deaths: June 2019 ➔ May 2020
Figure 2: Percentage change in 12-months ending provisional data on all fatal drug overdoses, 50 states, the District of Columbia, and New York City: Overdose deaths from 12-months ending in June 2019 to 12-months ending in May 2020.

(CDC, 2020)
3 Waves of the Rise in Opioid Overdose Deaths

Other Synthetic Opioids
- e.g., Tramadol and Fentanyl, prescribed or illicitly manufactured

Heroin

Commonly Prescribed Opioids
- Natural & Semi-Synthetic Opioids and Methadone

Wave 1: Rise in Prescription Opioid Overdose Deaths

Wave 2: Rise in Heroin Overdose Deaths

Wave 3: Rise in Synthetic Opioid Overdose Deaths

Why fentanyl is deadlier than heroin, in a single photo

By Allison Bond / September 29, 2016

On the left, a lethal dose of heroin; on the right, a lethal dose of fentanyl.

New Hampshire State Police Forensic Lab
Evolution of a Pandemic
From Rx to Street Fentanyl

45% of people who used heroin were also addicted to prescription opioid painkillers

Overdose deaths involving synthetic opioids other than methadone, which includes fentanyl, increased by 900% from 2013 to 2018

45%

900%


(CDC, 2020)
'Iso,' a deadly new synthetic opioid, has hit American streets

by Dennis Thompson, Healthday Reporter
People Who Are Addicted To...

More Likely To Be Addicted To Heroin.

National Survey on Drug Use and Health (NODUH), 2011-2013
Rates of Opioid Overdose Deaths, Sales And Treatment Admissions 1999-2010

Opioid Sales KG/10,000 Opioid  Deaths/100,000  Opioid Treatment Admissions/10,000

National Vital Statistics System, DEA’s Automation of Reports
Increase In Prescribing Trends

PRIOR TO THE 90s
Opioids not widely marketed for use outside of cancer pain

1996 to 2001
Misleading advertising campaign

2001
Pain management standards
Sources of Prescription Opioids Among Past-Year Non-Medical Users

- Given by a friend or relative for free
- Prescribed by ≥1 physicians
- Stolen from a friend or relative
- Bought from a friend or relative
- Bought from a drug dealer or other stranger
- Other

Percentage of users by number of days of past-year non-medical use:

- Any
- 1-29
- 30-99
- 100-199
- 200-365

Course Correct
Course Correct

HHS.GOV/OPIOIDS

HELP AND RESOURCES
NATIONAL OPIOIDS CRISIS
Purdue Pharma Pleads Guilty, Reaching $8.3 Billion Settlement
# Trending in the Right Direction

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of Prescriptions</th>
<th>Opioid Dispensing Rate Per 100 Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>215,917,663</td>
<td>72.4</td>
</tr>
<tr>
<td>2007</td>
<td>228,543,773</td>
<td>75.9</td>
</tr>
<tr>
<td>2008</td>
<td>237,860,213</td>
<td>78.2</td>
</tr>
<tr>
<td>2009</td>
<td>243,738,090</td>
<td>79.5</td>
</tr>
<tr>
<td>2010</td>
<td>251,088,904</td>
<td>81.2</td>
</tr>
<tr>
<td>2011</td>
<td>252,167,963</td>
<td>80.9</td>
</tr>
<tr>
<td>2012</td>
<td>255,207,954</td>
<td>81.3</td>
</tr>
<tr>
<td>2013</td>
<td>247,090,443</td>
<td>78.1</td>
</tr>
<tr>
<td>2014</td>
<td>240,993,021</td>
<td>75.6</td>
</tr>
<tr>
<td>2015</td>
<td>226,819,924</td>
<td>70.6</td>
</tr>
<tr>
<td>2016</td>
<td>214,881,622</td>
<td>66.5</td>
</tr>
<tr>
<td>2017</td>
<td>191,909,384</td>
<td>59.0</td>
</tr>
<tr>
<td>2018</td>
<td>168,158,611</td>
<td>51.4</td>
</tr>
<tr>
<td>2019</td>
<td>153,260,450</td>
<td>46.7</td>
</tr>
</tbody>
</table>

Source: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
Trending in the Right Direction

2006

Source: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
Trending in the Right Direction

Source: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
Your View: Live Poll
Pain Definition

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

International Association for the Treatment of Pain
Additional Key Terms

- USE
- MISUSE
- TOLERANCE
- WITHDRAWAL
- CHEMICAL DEPENDENCE
- PSYCHOLOGICAL DEPENDENCE
- ADDICTION
- DIVERSION

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Number Needed To Treat (NNT)

NNT = number of people who must be treated by a specific intervention for one person to receive a certain effect.

Lower #s more effective

NNT of 1.5 is very good

NNT of 2.5 is considered good

50% PAIN RELIEF considered effective pain treatment+

+Cochrane org.2014
Efficacy of Pain Medications For Acute Pain

Number of people needed to treat for one person to get 50% pain relief

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone 15 mg</td>
<td>4.6</td>
</tr>
<tr>
<td>Oxycodone 10 mg + acetaminophen</td>
<td>2.7</td>
</tr>
<tr>
<td>Naproxen 500 mg</td>
<td>2.7</td>
</tr>
<tr>
<td>Ibuprofen 200 mg + acetaminophen</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Cochran research cited in the NSC white paper, Evidence for the Efficacy of Pain Medication

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Opioid Efficacy vs Perception

(Blue) Cochran research cited in the NS white paper, Evidence for the Efficacy of Pain Medications: (Green) NSC Rx Study-08. Please rank the following medications in terms of how successful you feel they are at providing pain control or relief. (Total n=201).
Medication Alternatives

- NSAIDs
- Acetaminophen
- Anticonvulsants
- Tricyclics
- SNRIs
- Muscle relaxants
- Topicals
## Non-Opioid Analgesics: NSAIDS

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Antipyretic</td>
<td>✓ GI and renal side effects</td>
</tr>
<tr>
<td>✓ 2.7 NNT for 50% pain relief (Ibuprofen 200 mg)</td>
<td>✓ Increased cardiovascular risk</td>
</tr>
<tr>
<td>✓ Anti-inflammatory</td>
<td>✓ Interference with blood thinners</td>
</tr>
<tr>
<td>✓ Oral, IM and IV options</td>
<td>✓ Lower does are less likely to cause these issues</td>
</tr>
</tbody>
</table>
Non-Opioid Analgesics: Acetaminophen

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Antipyretic</td>
<td>✓ No anti-inflammatory properties</td>
</tr>
<tr>
<td>✓ 3.5 NNT for 500 mg for 50% pain relief</td>
<td>✓ Acute liver injury in high doses or chronic dosing</td>
</tr>
<tr>
<td>✓ Safe in almost all patients at &lt;4g per day</td>
<td></td>
</tr>
<tr>
<td>✓ Minimal GI side effects</td>
<td></td>
</tr>
<tr>
<td>✓ Oral and IV options</td>
<td></td>
</tr>
</tbody>
</table>
### Non-Opioid Analgesics: Tricyclic Antidepressants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Can be used daily to prevent/treat pain, once a day dosing</td>
<td>✓ Dry mouth, sweating, dizziness, blurred vision, drowsiness and constipation</td>
</tr>
<tr>
<td>✓ 3+ NNT</td>
<td>✓ Cardiovascular (arrhythmia, palpitations and hypotension)</td>
</tr>
<tr>
<td>✓ Less anticholinergic action and side effects with Imipramine and Nortriptyline</td>
<td>✓ Sedation and urinary retention</td>
</tr>
<tr>
<td>✓ More anticholinergic activity and side effects with Amitriptyline but may be more efficacious</td>
<td>✓ Acute liver injury in high dose</td>
</tr>
<tr>
<td></td>
<td>✓ Cognitive/confusion</td>
</tr>
<tr>
<td></td>
<td>✓ Gait disturbances/falls</td>
</tr>
</tbody>
</table>
## Non-Opioid Analgesics: SNRIs

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Can be used daily to prevent/treat pain,</td>
<td>✓ Nausea, somnolence, dry mouth, constipation, reduced appetite,</td>
</tr>
<tr>
<td>once to twice a day dosing</td>
<td>diarrhea, hyperhidrosis and dizziness</td>
</tr>
<tr>
<td>✓ Antidepressant</td>
<td>✓ Rare elevations of plasma, glucose, hepatic enzymes or blood pressure</td>
</tr>
<tr>
<td>✓ 3+ NNT</td>
<td>reported with Duloxetine</td>
</tr>
</tbody>
</table>

- Antidepressant
- 3+ NNT
Non-Opioid Analgesics: Anti-seizures

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Can be used daily to prevent/treat pain, twice to three times per day dosing</td>
<td>✓ Dizziness, somnolence, peripheral edema, weight gain, asthenia, headache and dry mouth</td>
</tr>
<tr>
<td>✓ 3+ NNT</td>
<td></td>
</tr>
</tbody>
</table>
### Non-Opioid Analgesics: Topical Analgesics

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Can be used daily to prevent/treat pain</td>
<td>✓ Local adverse reactions (skin irritation)</td>
</tr>
<tr>
<td>✓ Generally safe with low absorption</td>
<td></td>
</tr>
</tbody>
</table>

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Non-pharmacological Treatments For Chronic Pain
Non-pharmacological Treatments For Chronic Pain

- Cold/Heat
- Diversion
- Modifying Environmental
- Positioning/Repositioning
- Relaxation/Imagery
- Diet
- Exercise

©2020 National Safety Council
CDC Guidelines
General Prescribing Guidelines

Use NON-OPIOID Therapies FIRST.

DO NOT USE OPIOIDS ROUTINELY for chronic pain

ASSESS RISKS and harm

Start low and go slow. 3 DAYS OR LESS IS OFTEN SUFFICIENT

Monitor and discontinue
Determining When To Initiate/Continue Opioids For Chronic Pain

- Selection of Therapy
- Establishment of Treatment Goals
- Discussion of Risks and Benefits
RECOMMENDATION #1

• *Nonpharmacologic* therapy and *nonopioid pharmacologic* therapy are preferred for chronic pain.

• Clinicians should consider opioid therapy only if expected **benefits** for both pain and function are anticipated to **outweigh risks** to the patient.

• If opioids are used, they should be **combined** with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
RECOMMENDATION #2

• Establish treatment goals before beginning opioid therapy
  • Initial
    • Pain
    • Function
  • Ongoing
    • Meaningful improvement in pain and function that outweigh RISKS
RECOMMENDATION #3

• Before starting and periodically during opioid therapy discuss with patients basic facts, as well as known risks and benefits
  • Set appropriate pain expectations
  • Educate about true risks and benefits
  • Create safety to report if they’re concerned about dependency
  • Emphasize need for disposal
Patient Expectations Impact Decision to prescribe opioids

Patient Expectations Are A Barrier to prescribing alternatives to opioids

Nsc Rx Study 011. Which of the following would you say impacts your decision to prescribe opioid pain medication to patients? (Total-n+=201);
Q15. Which of the following, if any, do you feel are barriers to prescribing NSAID or other alternatives to opioid pain medication? (Total-n+=201).
Q19 What is your likelihood you would visit your doctor again if they offer a range of alternative painkillers for discussion? (Total-n+=1.014)

Don’t know painkillers contain opioids or it is a felony to share them

Unconcerned about addiction, but most have reason to worry given risk factors

Overestimate benefits and underestimate risks of addiction or death
8 Opioid Safety Principles for Patients

1. NEVER TAKE AN OPIOID PAIN MEDICATION THAT IS NOT PRESCRIBED TO YOU

2. NEVER ADJUST YOUR OWN DOSAGE

3. NEVER MIX WITH ALCOHOL

4. USING SLEEP AIDS AND ANXIETY MEDICATION WITH OPIOIDS IS DANGEROUS

8 Opioid Safety Principles

5. ALWAYS DISCLOSE ALL OF YOUR MEDICATION TO PROVIDERS

6. KEEP TRACK OF WHEN YOU TAKE YOUR MEDICATION

7. KEEP MEDICATION IN A SAFE PLACE

8. DISPOSE OF UNUSED MEDICATION

Opioid Logistics

Selection of immediate-release or extended release and long-acting opioids

Dosage considerations

Duration of treatment

Considerations for follow-up and discontinuation
RECOMMENDATION #4

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
RECOMMENDATION #5

When opioids are started, clinicians should prescribe the lowest effective dosage.

Risk-related Cut-offs:

– ≥50 morphine milligram equivalents (MME)/day
– ≥90 MME/day

“Start Low/Go Slow”
RECOMMENDATION #6

• **Long-term opioid use often begins with treatment of acute pain.**

• **3 days or less** will often be sufficient; more than 7 days will rarely be needed.
Many Prescribe Opioids For Longer Than The CDC Guideline

**CDC GUIDELINES**

1% 29% 70%

**NUMBER OF DAYS DOCTORS ORDINARILY PRESCRIBE OPIOIDS**

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RECOMMENDATION #7

• Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks:
  • Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
  • If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
Assess Patients

- Evaluation of risk factors
- Review of PDMP data
- Use of urine drug testing
- Consideration for co-prescribing benzodiazepines
- Arrangement of treatment
RECOMMENDATION #8

• Before starting and periodically during continuation of opioid therapy, clinicians should evaluate personal risk factors for opioid-related harms.
• Clinicians should incorporate into the management plan strategies to mitigate risk.
Screening Frequency

Actions taken before prescribing opioids

- Screen for history of opioid use: 84%
- Screen for history of illegal drug use: 77%
- Screen for history of illegal/prescription drug abuse: 77%
- Check with state Prescription Drug Monitoring Program: 57%
- Screen for family history of illegal/prescription drug abuse: 32%
- Screen for smoking: 24%
- Check for history of incarceration: 14%
- None of the above: 5%

NSC Rx Study Q12. Which of the following do you regularly do before prescribing a patient an opioid pain medication? (Total n=201)
Use Risk: Assessment Tools

(Practical Pain Management, 2019)
Use Risk: Assessment Tools

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid misuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high risk are at increased likelihood of future misuse and related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, as well as non-pain populations.

http://www.drugabuse.gov/nismatic-medical-health-professionals

Opioid Risk Tool

Opioid Conversion Equivalents Table

<table>
<thead>
<tr>
<th>DRUG</th>
<th>PARENTERAL</th>
<th>ORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10 mg</td>
<td>30 mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>NA</td>
<td>20 mg</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>100 mcg</td>
<td>15 mcg TD</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg</td>
<td>7.5 mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>5 mg</td>
<td>10 mg</td>
</tr>
</tbody>
</table>
# Current Opioid Misuse Measure (COMM)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>5. In the past 30 days, how often have you seriously thought about hurting yourself?</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
RECOMMENDATION #9

• PDMP:
  – Clinicians should review PDMP data when starting opioid therapy for chronic pain
  – Clinicians should review periodically during opioid therapy for chronic pain
    • Ranging from every prescription to every 3 months.

• Most States have mandatory PMP regulations
  – Up from 3 just a few years ago
RECOMMENDATION #10

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

- ATIVAN
- KLONOPIN
- VALIUM
- XANAX
IF PRESCRIPTIONS FROM MULTIPLE SOURCES, HIGH DOSAGES, OR DANGEROUS COMBINATIONS

Do not dismiss patients from care - use the opportunity to provide potentially lifesaving information and interventions.
RECOMMENDATION #11

- **Urine drug testing (UDT):**
  - Before starting opioid therapy
  - At least annually

- Familiarize yourself with the metabolites of various controlled substances and detection windows

---

**Table: Opioids**

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Metabolites</th>
<th>Detection Window</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>Buprenorphine, Buprenorphine glucuronides, Buprenorphine metabolites</td>
<td>26–42 hours</td>
</tr>
<tr>
<td>Norbuprenorphine, Glucuronides</td>
<td>Buprenorphine metabolites</td>
<td>15–150 hours</td>
</tr>
<tr>
<td>Codeine</td>
<td>Included in many preparations; morphine metabolite; may be a contaminant if &lt; 2% of morphine</td>
<td>1.9–3.9 hours</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Actiq, Duragesic, Fentora, Lazanda, Sublimaze, Subsys, Ionsys</td>
<td>3–12 hours</td>
</tr>
<tr>
<td>Norfentanyl</td>
<td>Fentanyl metabolite</td>
<td>9–10 hours</td>
</tr>
<tr>
<td>Heroin</td>
<td>Diacetylmorphine, depe, smack, dust; parent drug not detected.</td>
<td>0.1–0.25 hours</td>
</tr>
<tr>
<td>6-acetylmorphine</td>
<td>Heroin metabolite; 6-monoacetylmorphine, 6-MAM</td>
<td>&lt; 1 day</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Anaesia, Damason-P, Hydrocan, Lorcet, Lortab, Maxidone, Norco, Panacct, Vicodin, Zydone</td>
<td>3.4–8.8 hours</td>
</tr>
<tr>
<td>Norhydrocodone</td>
<td>Hydrocodeine metabolite</td>
<td>&lt; 1 day</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Dilaudid, Exalgo; morphine and hydrocodeine metabolite</td>
<td>1.5–3 hours</td>
</tr>
<tr>
<td>Meperidine</td>
<td>Demerol, Mepergan</td>
<td>2–5 hours</td>
</tr>
<tr>
<td>Norexomerperidine</td>
<td>Meperidine metabolite</td>
<td>18–24 hours</td>
</tr>
<tr>
<td>Methadone</td>
<td>Dolphine, Methadose</td>
<td>15–55 hours</td>
</tr>
<tr>
<td>EDDP</td>
<td>Methadone metabolite; 2-ethylidone-1,3-dimethyl-2,3-diphenylpyrrolidine</td>
<td>15–55 hours</td>
</tr>
<tr>
<td>Morphine</td>
<td>Included in many preparations; Aromorph, Avinza, DepoOx, Duramorph, Kadian, MS Confin; poppy seeds (low concentrations expected); heroin metabolite</td>
<td>1.3–3.7 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Oxycodone, Roxicodone, Xtampa (with acetaminophen: Endocet, Percodan, Roxicet; with aspirin: Endodan, Percodan, Roxiprin, with ibuprofen: Combunox)</td>
<td>3–6 hours</td>
</tr>
<tr>
<td>Noroxycodone</td>
<td>Oxycodone metabolite</td>
<td>1–3 days</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>Numorphan, Opana, oxycodone metabolite</td>
<td>7.5–9.5 hours</td>
</tr>
<tr>
<td>Noroxymorphone</td>
<td></td>
<td>1–3 days</td>
</tr>
</tbody>
</table>

(ARUP, 2019)
Naloxone
Naloxone

- Reverses an overdose for 30-90 minutes
- Narcan and Evzio are two easiest-use options
- Narcan well-covered by the vast majority of insurance carriers, including Medicaid
- Available via a standing order in Illinois
NALOXONE CO-PRESCRIBING

• Physicians can provide a prescription for naloxone for patient at risk for overdose

• CDC Guidelines for providing naloxone
  – history of overdose,
  – history of substance use disorder
  – higher opioid dosages (≥50 MME/day)
  – concurrent benzodiazepine use
Your View: Live Poll
Levels of Evidence-Based Guidelines

NATIONAL

STATE

LOCAL

SPECIALTY SOCIETY
Levels of Evidence-Based Guidelines

- National
- State
- Local
- Specialty Society
Inherited Patients & Tapers
Initial Steps

- Establish correspondence with referring/treating clinician
- Confirm medications and dosage
- Check PMP
- Conduct urine toxicology screen
- Assess for current misuse
Common Patient Perspectives

Wish they could **get off the opioids**
- Fear pain
- Fear withdrawal

Fear of **judgement** by family and friends

Worry that nobody believes **them** about their pain
The Patient Interaction

Discuss risks/benefits of opioids

Ideally taper off

Reassure patient

Clear Communication is essential

Present with other treatment options

Lower doses of opioids, lower risks
The Taper

• Patients using opioids as-needed and non-daily do not require a taper
• Longer on opioids, the slower it should be
• Goal may be to decrease, not discontinue
• Tailer the taper to the patient
  • Anxiety
  • Duration of opioid use
  • Comorbidities
  • Withdrawal
Different Types of Tapers

• 10% decrease of original dose per week is usually well-tolerated

• Some tolerate a more rapid taper of 20-50% per week
  • Taper of <20% per week to minimize risk of withdrawal

• Consider interval dosing when lowest possible dose is reached

It’s OK to pause, re-start, or change methodologies
Taper Best Practices

• Optimize non-opioid pain management
• Ensure psychosocial support is present
• Watch for and address symptoms of withdrawal
  • Insomnia, vomiting, diarrhea
• Watch for anxiety, depression, and deviations from plan
• Don’t add other controlled substances to taper
When to Consider Detox

- Patient deviation from taper plan
- Patient preference
- Rapid taper is necessary
- Medical complications
Pain Management & Addiction Treatment
RECOMMENDATION #12

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.
Substance Use Disorders

- The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) no longer uses the terms "substance abuse" and substance "dependence"
- Substance use disorders occur when the recurrent use of alcohol and/or drugs:
  - Causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
  - According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.
4 Pharmacological Treatment Options

01. Detox followed by abstinence

02. Detox followed by Buprenorphine

03. MAT with Buprenorphine

04. MAT with Methadone
2016 Opioid Use Disorder Treatment Study

**TREATMENT ➔ OUTCOME**

**MAT** ➔ BEST OUTCOMES

**COUNSELING WITHOUT MAT** ➔ 2X MORTALITY RATE

**LEFT RESIDENTIAL TREATMENT** ➔ 4-FOLD MORTALITY INCREASE

**LEFT MAT** ➔ 2X MORTALITY RATE

How does MAT help?

- Biopsychosocial
How Buprenorphine Works

Opioids replaced and blocked by buprenorphine.
Buprenorphine competes with the full agonist opioids for the receptor. Since buprenorphine has a higher affinity (stronger binding ability) it expels existing opioids and blocks others from attaching. As a partial agonist, the buprenorphine has a limited opioid effect, enough to stop withdrawal but not enough to cause intense euphoria.

Opioid receptor is empty. As someone becomes tolerant to opioids, they become less sensitive and requires more opioids to produce the same effect. Whenever there is an insufficient amount of opioid receptor activated, the patient feels discomfort. This happens in withdrawal.

Opioid receptor filled with a full agonist. The strong opioid effect of heroin and pain pills can cause euphoria and stop the withdrawal for a period of time (4-24 hours). The brain begins to crave opioids, sometimes to the point of an uncontrollable compulsion (addiction), and the cycle repeats and escalates.

Perfect fit – Maximum opioid effect.

Buprenorphine still blocks opioids as it dissipates.

Over time (24-72 hours) buprenorphine dissipates, but still creates a limited opioid effect (enough to prevent withdrawal) and continues to block other opioids from attaching to the opioid receptor.

The above illustrations are for educational purposes and do not accurately represent the true appearance.

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How does MAT help?

- Biopsychosocial
- Harm reduction
  - No needles, no drug dealers, less overdose
- Can integrate/promote psychosocial care
- Can provide structure and accountability with drug screens, consequences
- Potential for ambulatory detox
First-Line Medications

- **Methadone**
  - Full agonist, long half-life
  - Most established opioid substitute
  - Generally requires daily or frequent clinic visits

- **Buprenorphine + Naloxone**
  - Partial agonist, long-half life; less physical dependence, easier taper
  - Naloxone induces withdrawal when injected; lower overdose & mortality rates than methadone
  - Higher dropout rate than with methadone

- Comparable efficacy for both substances
- Buprenorphine sometimes preferred for safety and ease of use

(Dennis et al., 2014) (Soyka, 2015)
Other MAT Medications

• Naltrexone
  • Opioid antagonist, non-narcotic
  • Available in 28-day depot injection
  • Less intense treatment
  • Requires 7 days without opioids to initiate
  • Impacts reward system – also used for alcohol use disorder, and off-label for eating disorders, and self-harming behaviors
Summary

• The opioid overdose epidemic continues to grow
• We’ve made progress with prescribing, although we must continue to hold the line
• Alternatives to opioids are numerous and can be effective – even more so than opioids in some situations.
• Evidence-based options exist for screening and treatment for addiction - don’t hesitate to use them!
What can we do?

• Adopt best-practice guidelines
  • Be thoughtful about pain treatment modality choices
  • Assess for risk before prescribing opioids
  • Start low and go slow

• Educate, communicate, and create safety in the doctor/patient relationship

• Engage in regular screenings

• Continue to provide support and linkage to treatment in the case of chemical dependency

• Support ongoing overdose mitigation initiatives
WARN ME LABELS

Tell medical professionals you take opioids seriously when you add this label to your insurance card. This can spark a conversation about your prescriptions, risks and options.

ASK THESE QUESTIONS:

• Am I being prescribed an opioid?
• If so, is there a non-addictive alternative?
• If not, is a short-term prescription possible?
• Do I have any medical conditions that could increase my risk?

STOPEVERYDAYKILLERS.ORG
Thank You!