Local Response to the Opioid Crisis

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January 4, 2018

The Scope of the Problem

- 90 Americans die each day after overdose on opioids
- These include prescription pain medications, heroin or illicitly made medications, such as fentanyl
- In most fatal overdoses, more than one substance involved (e.g., opioids + benzos + alcohol)

How we got here

- Starting in 1990s, prescriptions for opioid pain medications rose dramatically
- APS: Pain is Fifth Vital Sign (1991)
- Pharmaceutical Companies Pushed LA opioids as safe
- Expectation that pain be treated

HWGH, #2

- As opioid prescriptions skyrocketed, widespread misuse and diversion also rose dramatically
- Opioid overdose rates soon began to rise dramatically
- In 2015, 33,000 people died from opioid overdoses, including prescription meds, heroin, illicitly manufactured meds

What happens to prescriptions

- 25% of patients prescribed opioids misuse them
- 8% of patients given opioids develop an opioid use disorder
- 80% of heroin users first misused prescription opioids
- 54% of prescription drug abusers get the drugs from a friend or relative (trade, steal, buy)

Federal Response

- New CDC Guidelines for Opioid Use in Chronic Pain
- FDA: Ordered drug companies to ratchet down opioid production by 25%
- Encouraging abuse deterrent formulations
- DEA: Monitors presciptions; looks for outliers

Others

- AMA: Call to eliminate the “Fifth Vital Sign” (June, 2016)
- JCAHO: New Pain Guidelines effective 2018
- Insurance Companies: Limits on Pain prescriptions, pill limits, formularies to pay for abuse deterrent pills

GUIDELINES

- Focus on Assessment
- Pain Assessment:
  - 4 ‘A’ s
    - Analgesia
    - ADLs
    - Adverse Effects
    - Aberrant Behavior

    (running out of meds early, euphoria, ongoing need for higher doses, diversion)

GUIDELINES, #2

- Risk Assessment
  - ORT: a tool to assess risk of developing misuse
  - CAGE questionnaire
  - Brief Pain Interview
  - Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)

NYS PMP Prior to Opioid Prescription

Guidelines, #3

- Urine Drug Testing
  - Essential for monitoring for abuse and diversion
  - Should be performed at least annually
  - Prescribers should understand how to Interpret results

AAPM Guidelines

- Proper patient selection, Risk vs. Harm
- Informed Consent and Opioid Agreement (Written)
- Clear treatment Goals, including discontinuation if goals not met
- Organized monitoring of pain Intensity and patient function
- Looking for Aberrancy, including UDT
- Non-pharmacologic Treatments (Therapies, modalities, etc)
- One clinician, one pharmacy
- MED less than 90 (and careful justification if greater)

State Response

- NYS requires all physicians who prescribe opioids to take 3 hours CME on safe opioid prescribing
- Pill limits on new prescriptions
- Electronic Prescribing
- Prescription Monitoring Program (I-STOP)
- Harm Reduction: Suboxone waivers, Needle exchange

Local Response/CAP

- Hospital Has Established a Pain Committee to bring institution in line with new JCAHO guidelines
- CAP: Continuing to educate providers on new realities and guidelines
- Look for Outliers and Educate them