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Prescribing for Chronic Pain and Drug Overdose Death

Michael Landen, MD, MPH
State Epidemiologist
New Mexico Department of Health
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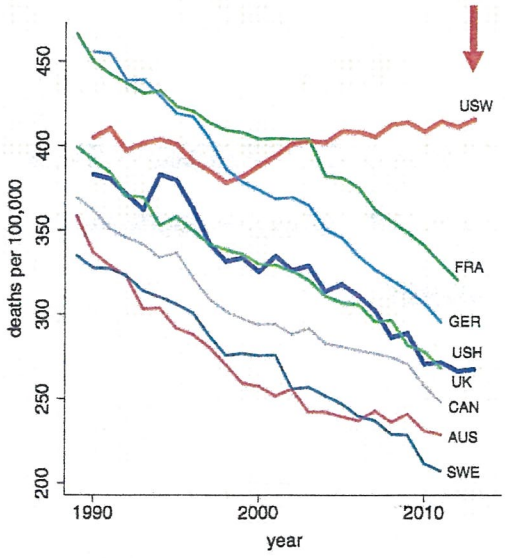
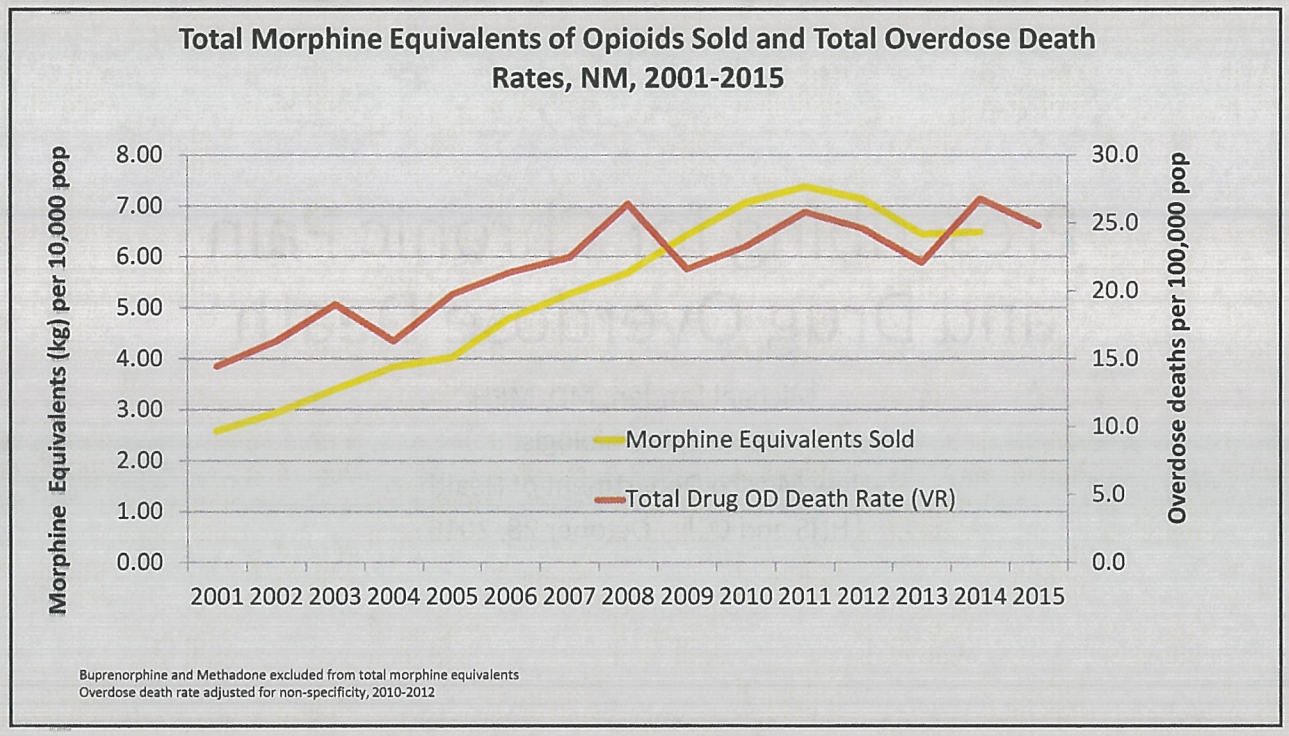
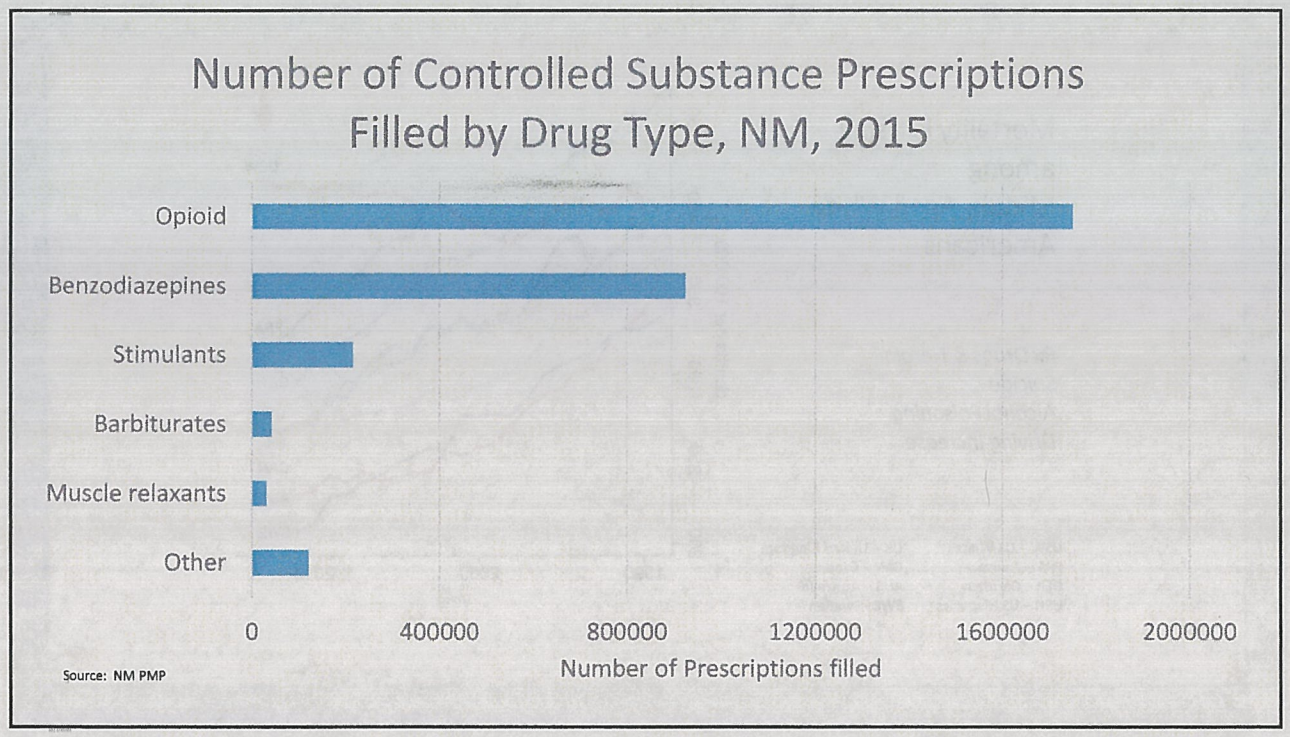
Mortality is rising among Middle-Aged White Americans

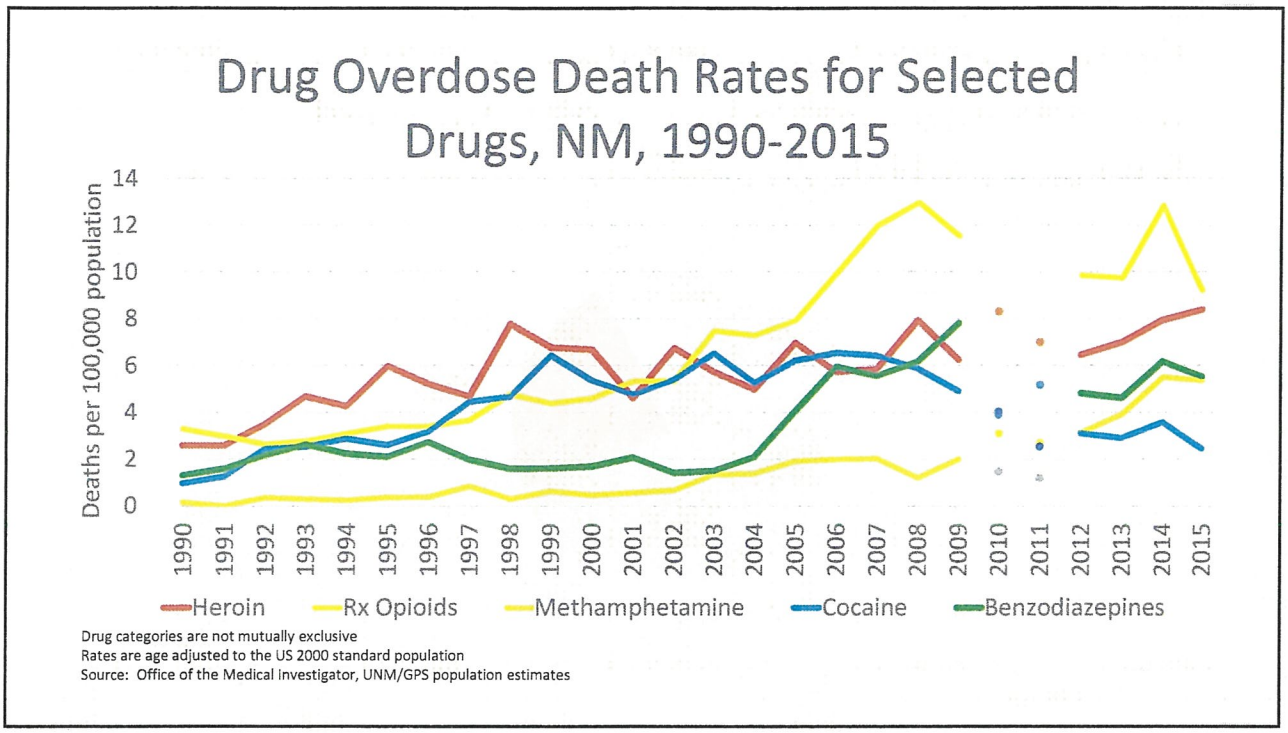
Rx Drugs & Heroin
Suicide
Alcohol Poisoning
Driving Increase

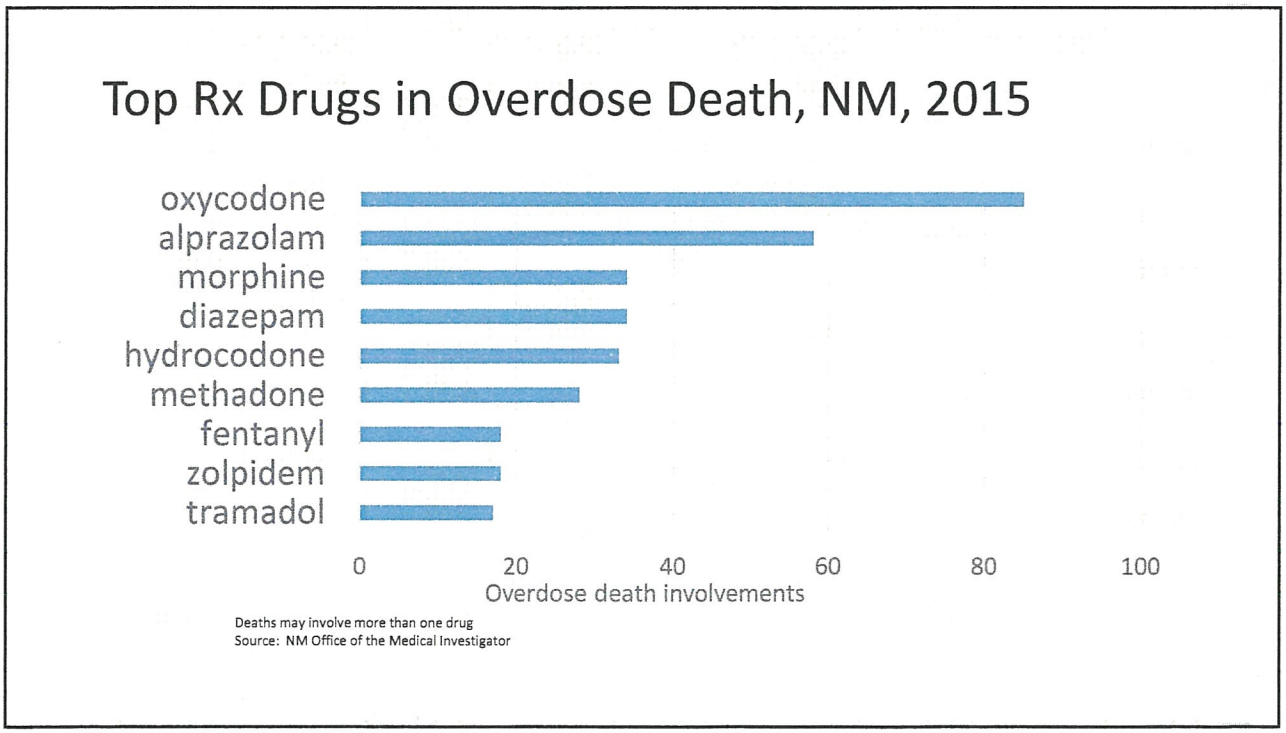
USW – US Whites
FRA – France
GER – Germany
USH – US Hispanics
UK – United Kingdom
CAN – Canada
AUS – Australia
SWE - Sweden



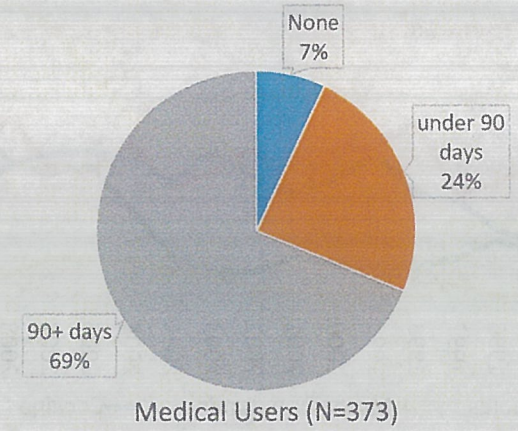

Total Morphine Equivalents of Opioids Sold and Total Overdose Death Rates, NM, 2001-2015
Morphine Equivalents (kg) per 10,000 pop
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Overdose deaths per 100,000 pop
Morphine Equivalents Sold
Total Drug OD Death Rate (VR)
2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Buprenorphine and Methadone excluded from total morphine equivalents
Overdose death rate adjusted for non-specificity, 2010-2012


Number of Controlled Substance Prescriptions Filled by Drug Type, NM, 2015
Opioid
Benzodiazepines
Stimulants
Barbiturates
Muscle relaxants
Other
0
400000
800000
1200000
1600000
2000000
Number of Prescriptions filled
Source: NM PMP


Drug Overdose Death Rates for Selected Drugs, NM, 1990-2015
Deaths per 100,000 population
14
12
10
8
6
4
2
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Heroin
Rx Opioids
Methamphetamine
Cocaine
Benzodiazepines
Drug categories are not mutually exclusive
Rates are age adjusted to the US 2000 standard population
Source: Office of the Medical Investigator, UNM/GPS population estimates

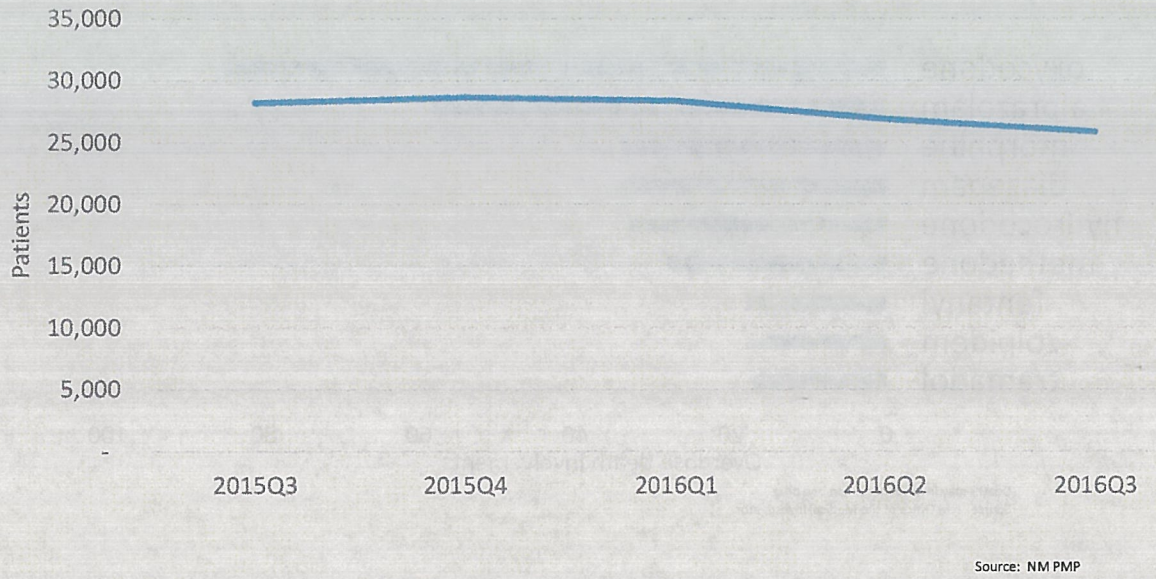

Top Rx Drugs in Overdose Death, NM, 2015
oxycodone
alprazolam
morphine
diazepam
hydrocodone
methadone
fentanyl
zolpidem
tramadol
0
20
40
60
80
100
Overdose death involvements
Deaths may involve more than one drug
Source: NM Office of the Medical Investigator

Opioid Prescription Coverage in the Past 6 Months for Overdose Deaths Involving Controlled Substances, NM, 2012-2014

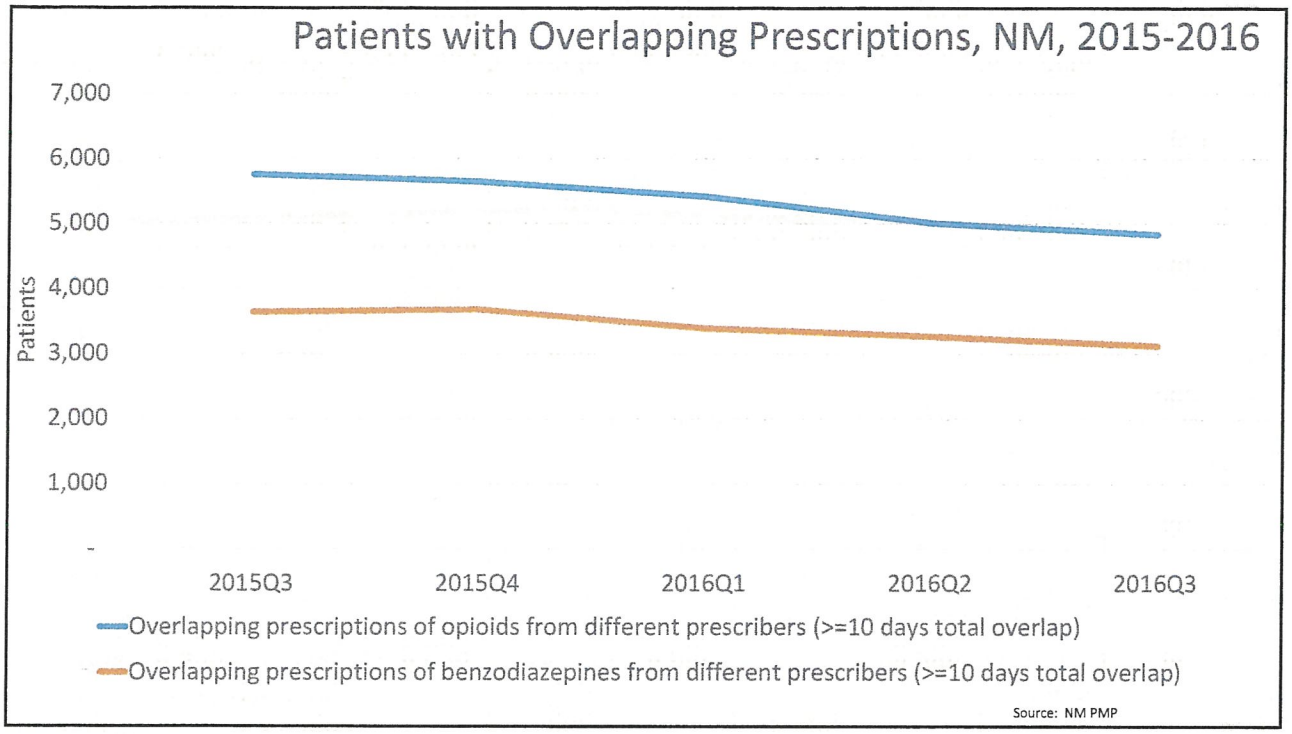


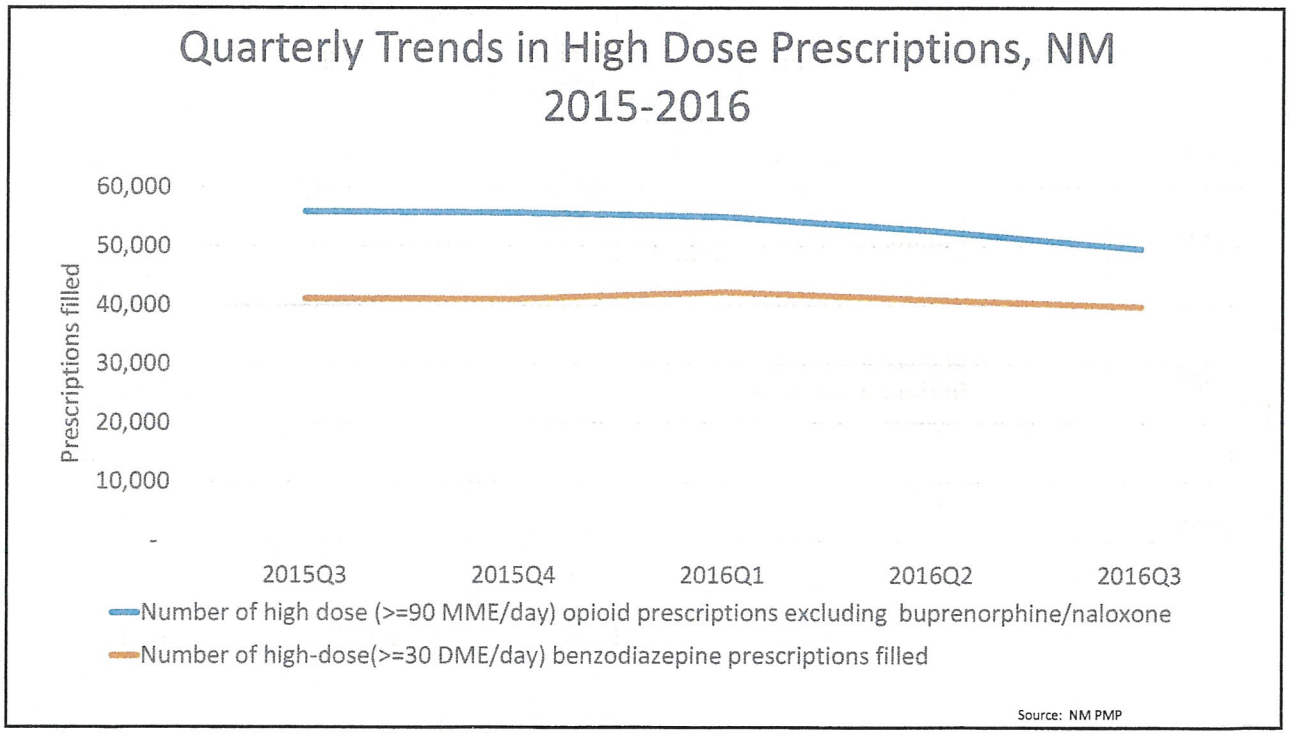
Medical users were those who had recent prescriptions for at least some of the controlled substances involved in their death.
Source: Linked OMI and PMP data

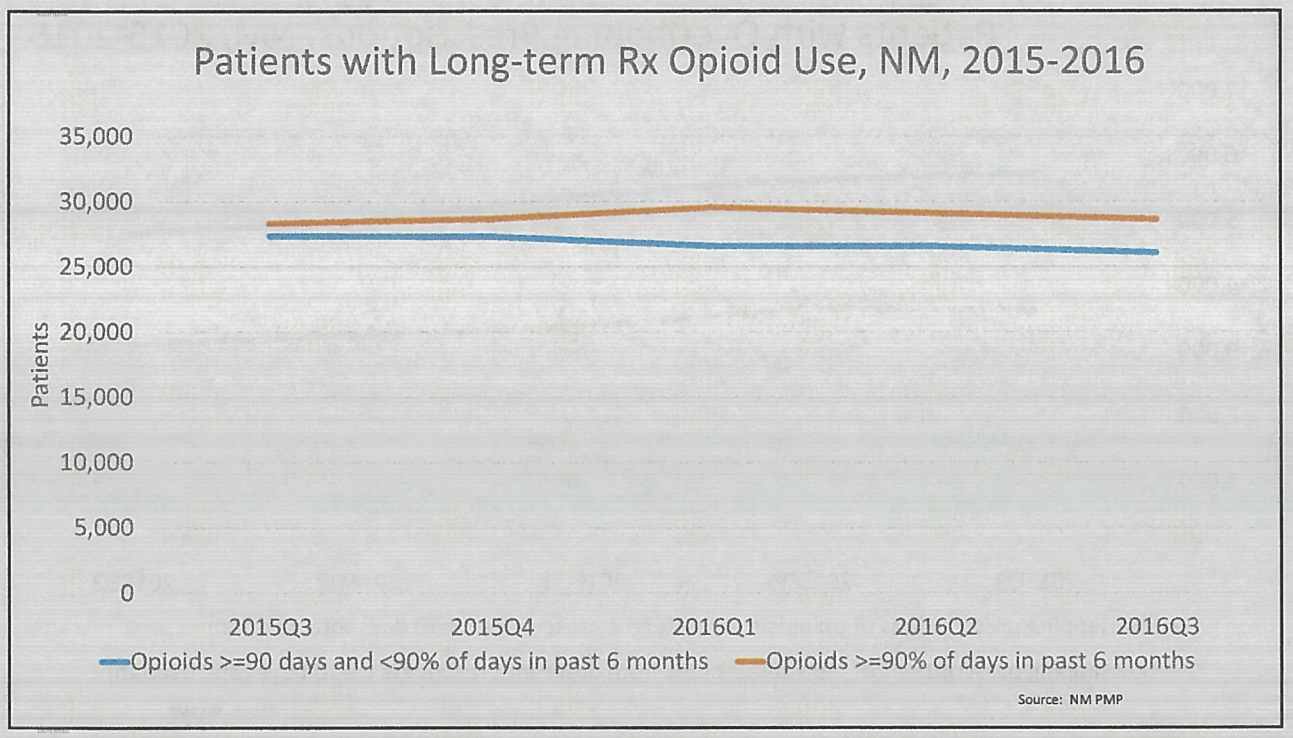
Patients with Concurrent Opioid and Benzodiazepines (>=10 days overlap), NM, 2015-2016

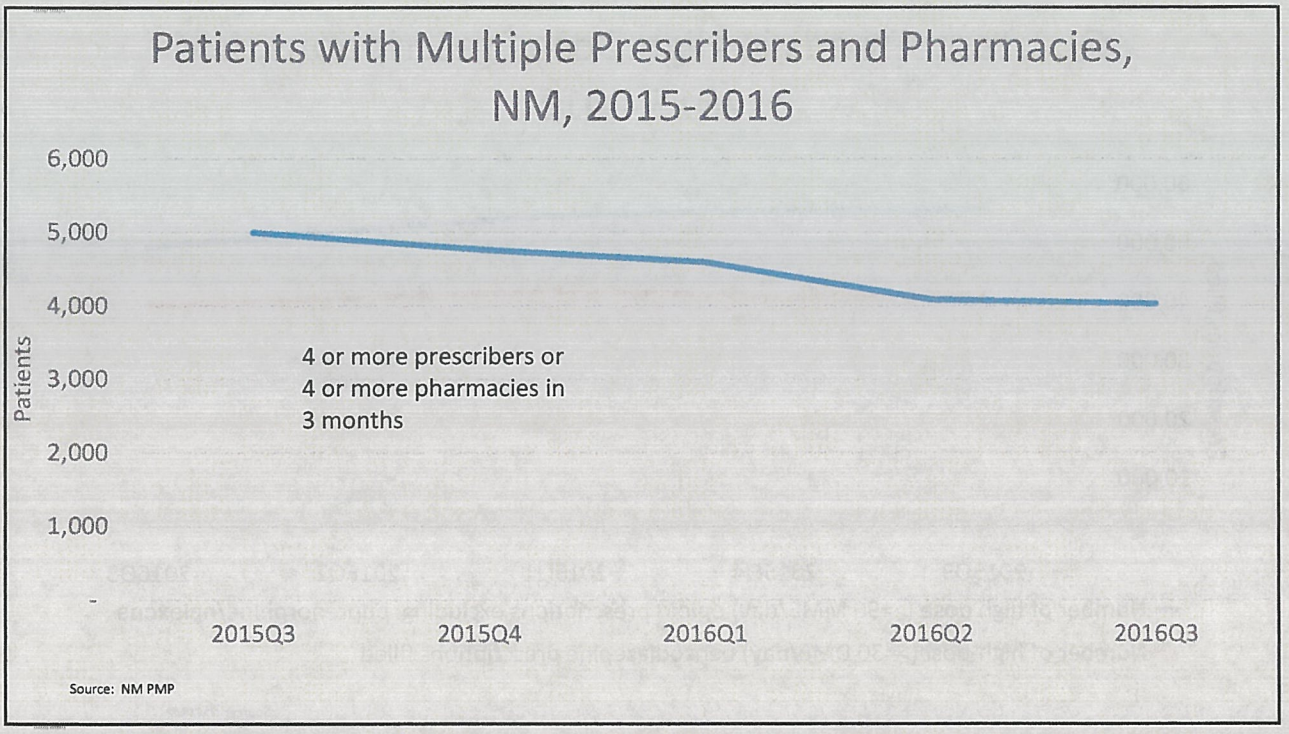


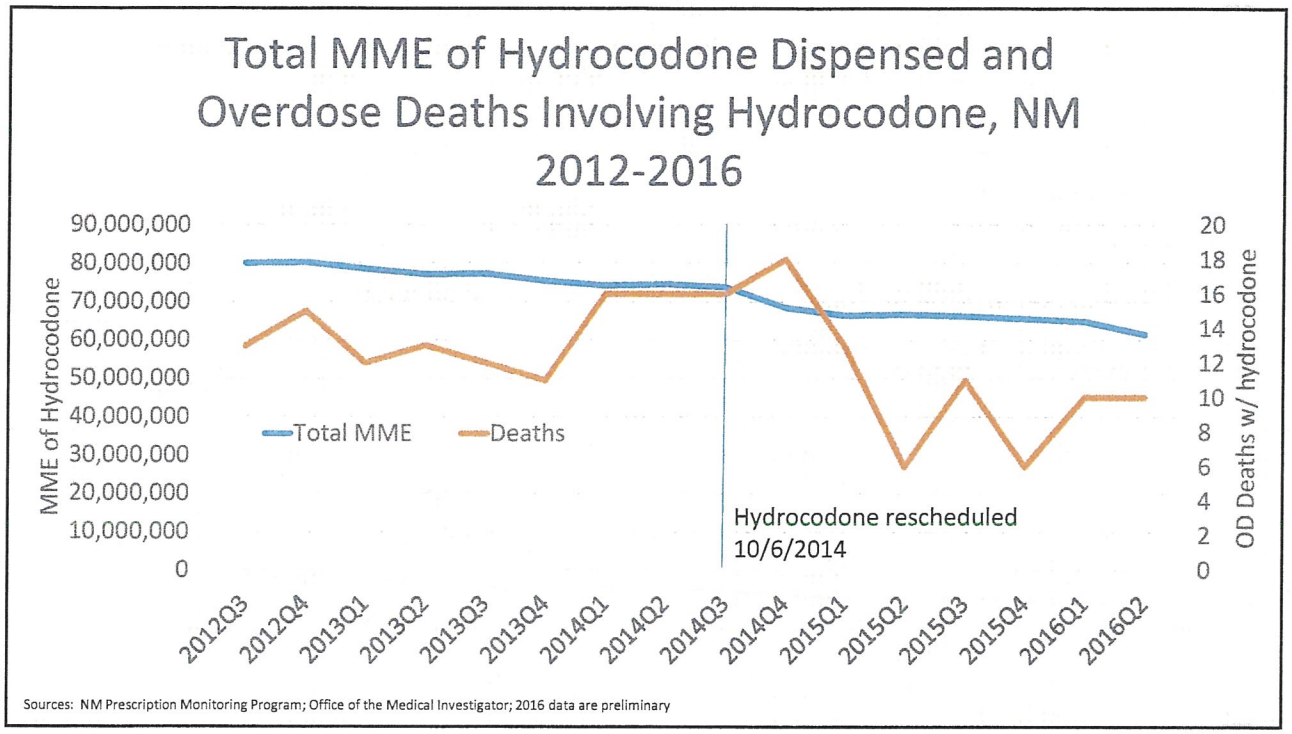
Source: NM PMP

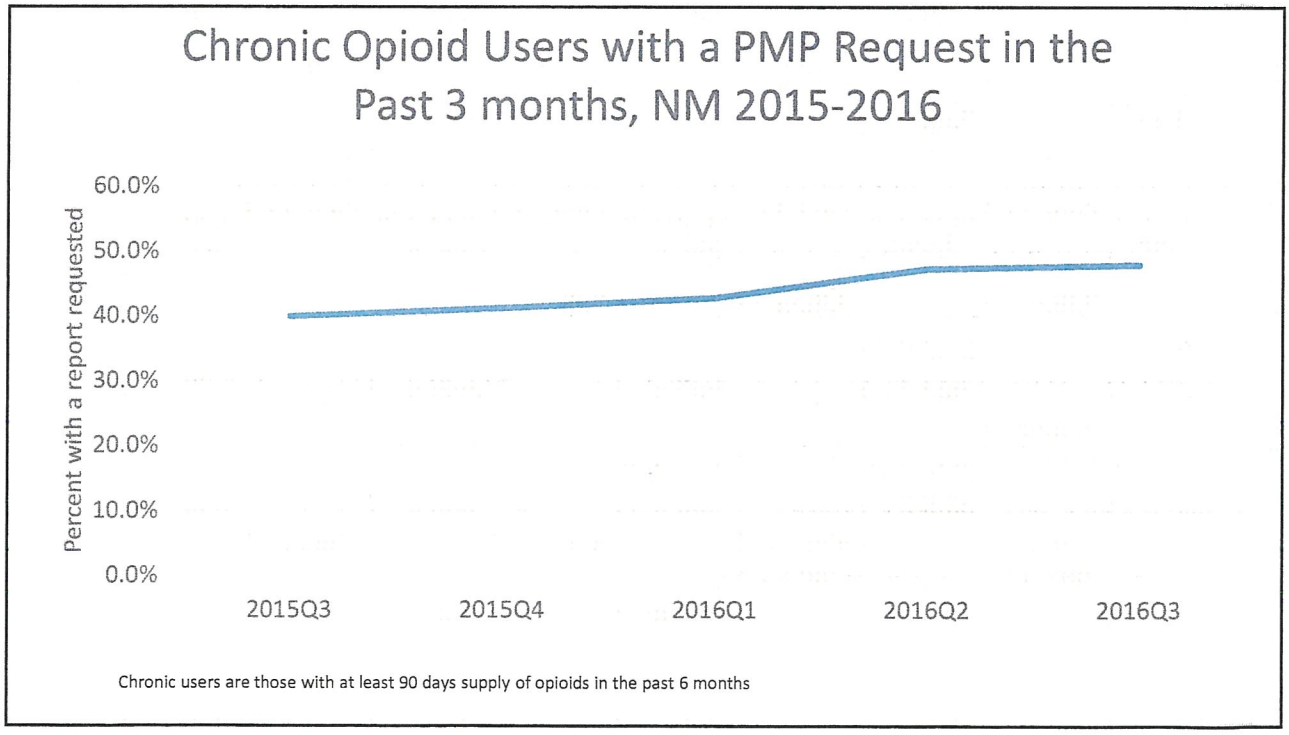

Patients with Overlapping Prescriptions, NM, 2015-2016
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Patients
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
Overlapping prescriptions of opioids from different prescribers (>=10 days total overlap)
Overlapping prescriptions of benzodiazepines from different prescribers (>=10 days total overlap)
Source: NM PMP

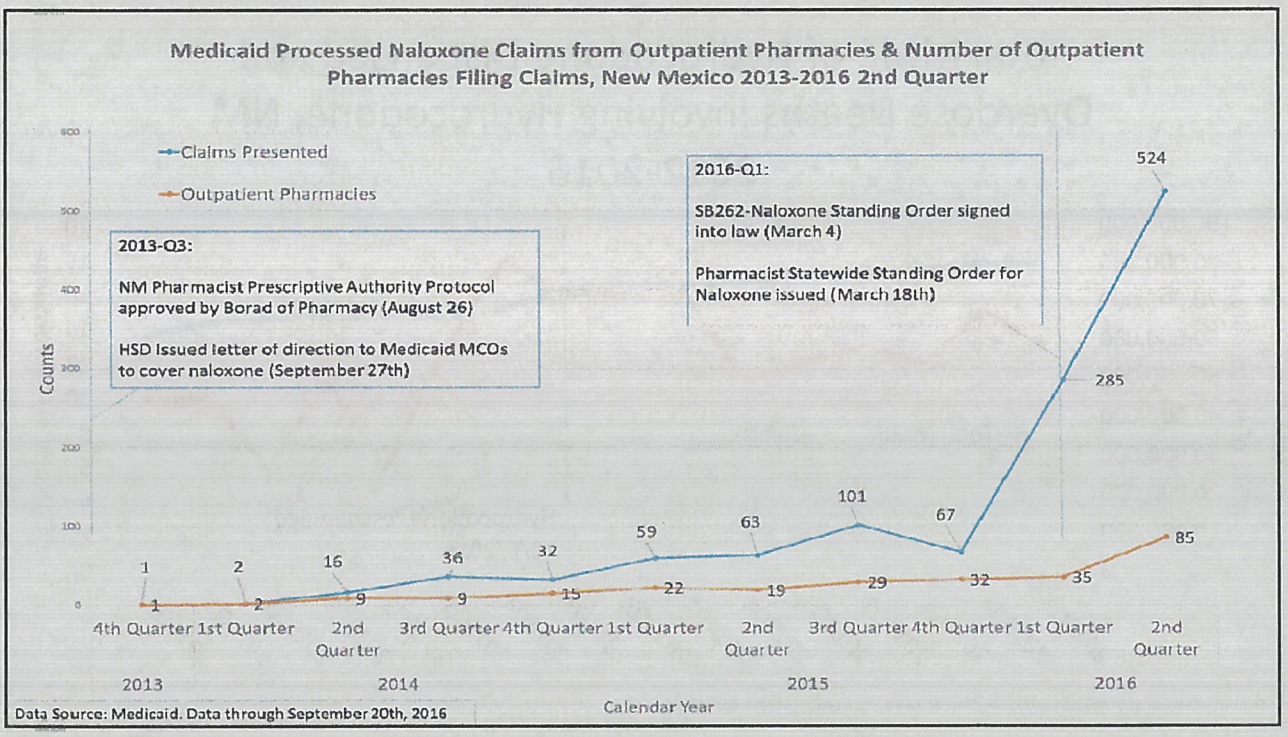

Quarterly Trends in High Dose Prescriptions, NM 2015-2016
60,000
50,000
40,000
30,000
20,000
10,000
-
Prescriptions filled
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
Number of high dose (>=90 MME/day) opioid prescriptions excluding buprenorphine/naloxone
Number of high-dose(>=30 DME/day) benzodiazepine prescriptions filled
Source: NM PMP


Patients with Long-term Rx Opioid Use, NM, 2015-2016
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Patients
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
Opioids >=90 days and <90% of days in past 6 months
Opioids >=90% of days in past 6 months
Source: NM PMP


Patients with Multiple Prescribers and Pharmacies, NM, 2015-2016
6,000
5,000
4,000
3,000
2,000
1,000
-
Patients
4 or more prescribers or
4 or more pharmacies in
3 months
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
Source: NM PMP


Total MME of Hydrocodone Dispensed and Overdose Deaths Involving Hydrocodone, NM 2012-2016
MME of Hydrocodone
90,000,000
80,000,000
70,000,000
60,000,000
50,000,000
40,000,000
30,000,000
20,000,000
10,000,000
0
OD Deaths w/ hydrocodone
20
18
16
14
12
10
8
6
4
2
0
Total MME
Deaths
Hydrocodone rescheduled 10/6/2014
2012Q3
2012Q4
2013Q1
2013Q2
2013Q3
2013Q4
2014Q1
2014Q2
2014Q3
2014Q4
2015Q1
2015Q2
2015Q3
2015Q4
2016Q1
2016Q2
Sources: NM Prescription Monitoring Program; Office of the Medical Investigator; 2016 data are preliminary


Chronic Opioid Users with a PMP Request in the Past 3 months, NM 2015-2016
Percent with a report requested
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
Chronic users are those with at least 90 days supply of opioids in the past 6 months



The Council

- Full Name: Prescription Misuse and Overdose Prevention and Pain Management Advisory Council
- Governor appointed, DOH administered
- Key recommendations on:
  - Within one day data reporting to Prescription Monitoring Program
  - Chronic pain survey
  - Naloxone standing order (HB277, SB262)
  - PMP use frequency (SB263)
  - Managed care naloxone, MAT, opioid and benzodiazepine use/access
  - Quarterly prescribing measures
  - CDC Guideline on Prescribing Opioids for Chronic Pain

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

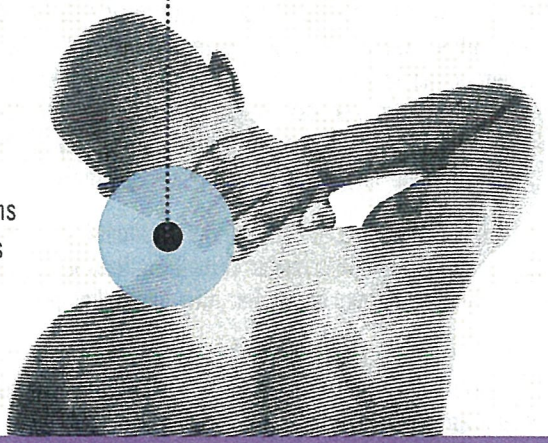
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

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

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

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

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

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

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.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html