The Role of Clinicians in Addressing the Opioid Overdose Epidemic

Clinician Outreach and Communication Activity (COCA) Call
September 24, 2015
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Objectives

At the conclusion of this session, the participant will be able to:

- Review the epidemiology of opioid-related morbidity and mortality
- Describe the challenges of managing patients with pain conditions as well as patients who have opioid use disorders
- Discuss the FDA-approved treatments for opioid use disorders
- Discuss the steps that can be taken to improve opioid analgesic prescription for the treatment of pain
- Identify the steps that can be taken to incorporate opioid use disorder treatment into clinical practice
TODAY’S PRESENTER

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Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
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University of Washington
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The Clinician’s Role in Addressing the Opioid Overdose Epidemic

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- Discuss the FDA-approved treatments for opioid use disorders
- Discuss the steps that can be taken to improve the prescription of opioid analgesics for the treatment of pain
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Overview

- **Epidemiology**
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  Office of the Assistant Secretary for Planning and Evaluation
  U.S. Department of Health and Human Services

- **Pain management**
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  University of Washington
  Medical Director
  Washington State Department of Labor and Industries

- **Opioid use disorder treatment**
  Melinda Campopiano von Klimo, MD
  Medical Officer
  Center for Substance Abuse Treatment
  Substance Abuse & Mental Health Services Administration
  U.S. Department of Health and Human Services
Rx opioid trends

Past Year Use

Number in thousands

Source: SAMHSA National Survey on Drug Use and Health, 2002-2014
Heroin trends

Source: SAMHSA National Survey on Drug Use and Health, 2002-2014
Overdose Deaths Involving Rx Opioids and Heroin
United States, 1999-2013

Number of Overdose Deaths

Source: CDC/NCHS NVSS Multiple Cause of Death Files 1999-2013.
## Changing demographics of heroin use

<table>
<thead>
<tr>
<th></th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEX</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
</tr>
<tr>
<td><strong>AGE, YEARS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-17</td>
<td>1.8</td>
<td>1.6</td>
<td>--</td>
</tr>
<tr>
<td>18-25</td>
<td>3.5</td>
<td>7.3</td>
<td>109%</td>
</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>58%</td>
</tr>
<tr>
<td><strong>RACE/ETHNICITY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td>--</td>
</tr>
<tr>
<td><strong>ANNUAL HOUSEHOLD INCOME</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
</tr>
<tr>
<td>$20,000–$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
</tr>
<tr>
<td><strong>HEALTH INSURANCE COVERAGE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
<td>--</td>
</tr>
<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
</tr>
</tbody>
</table>

Nonmedical use of Rx opioids significant risk factor for heroin use

3 out of 4 people who used heroin in the past year misused opioids first

7 out of 10 people who used heroin in the past year also misused opioids in the past year

Frequent nonmedical users of Rx opioids and those with abuse/dependence most likely to initiate heroin

Source: Muhuri et al., Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. SAMHSA, 2013
**Heroin Abuse or Dependence and Overdose Deaths Tightly Correlated**

### Graph Description

- **x-axis:** Year from 2002 to 2013
- **y-axis, left:** Rate of past year heroin abuse or dependence per 1,000 persons aged 12 years and older
- **y-axis, right:** Rate of heroin-related overdose deaths per 100,000 persons

#### Data Sources

- **Past Year Heroin Abuse or Dependence:**

### Graph Notes

- The rate of past year heroin abuse or dependence shows a gradual increase from 2002 to 2013.
- The rate of heroin-related overdose deaths shows a sharp increase from 2010 onwards, peaking in 2013.
- The datasets are tightly correlated, indicating a significant increase in overdose deaths as abuse or dependence rates rise.
Other Substance Abuse or Dependence Elevates Risk for Heroin Abuse or Dependence

People with abuse or dependence on:

- **Alcohol**: 2x more likely to have heroin abuse or dependence
- **Marijuana**: 3x more likely to have heroin abuse or dependence
- **Cocaine**: 15x more likely to have heroin abuse or dependence
- **Rx Opioid Painkillers**: 40x more likely to have heroin abuse or dependence

Essential Elements to Stopping the Epidemic

PREVENT People From Starting Heroin
- Reduce prescription opioid painkiller abuse.
- Improve opioid painkiller prescribing practices and identify high-risk individuals early.

REDUCE Heroin Addiction
- Ensure access to Medication-Assisted Treatment (MAT).
- Treat people addicted to heroin or prescription opioid painkillers with MAT which combines the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

REVERSE Heroin Overdose
- Expand the use of naloxone.
- Use naloxone, a life-saving drug that can reverse the effects of an opioid overdose when administered in time.
Treatment need for opioid abuse or dependence exceeds capacity for opioid agonist medication assisted treatment (OA-MAT) in the US

Source: Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication assisted treatment. AJPH. 2015
Rate of Past Year Opioid Abuse or Dependence and Rate of OA-MAT Capacity
(rate per 1,000 persons aged 12 years and older)

Source: Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication assisted treatment. AJPH. 2015
Thank You

The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the US Department of Health and Human Services.
Reversing the opioid epidemic and improving outcomes for your pain patients

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Medical Director
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The worst man-made epidemic in modern medical history

- Over 200,000 deaths
- Many more hundreds of thousands of overdose admissions
- Millions addicted and/or dependent
- Spillover effect to SSDI*

Evidence of effectiveness of COAT

The Agency for Healthcare Research and Quality’s (AHRQ) recent draft report, “The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain,” which focused on studies of effectiveness measured at > 1 year of COAT use, found insufficient data on long term effectiveness to reach any conclusion, and “evidence supports a dose-dependent risk for serious harms”. (AHRQ 2014; Chou et al, Annals Int Med, 13 Jan 2015).
Risk/Benefit of Opioids for Chronic Non-Cancer Pain
-Franklin; Neurology; Sept 2014-Position paper of the AAN-
Opioids should not be used routinely for the treatment of routine musculoskeletal conditions, headaches or fibromyalgia*

*WA DLI opioid guidelines, 2013 http://1.usa.gov/1nYlarL*
WHY NOT PRESCRIBE FOR CHRONIC LOW BACK PAIN?

- Alternative treatments, particularly programs that take a psycho-physical approach, have stronger evidence base\(^1\)
- Opioids generally are deactivating and not activating
- Reduced prescribing for non-specific back pain would significantly reduce overall prescribing and availability, and thus safety – public health benefit
- Eliminating prescribing for common indications that have failed would be a step towards identifying cases that do derive benefit

\textit{Hill et al Lancet 2011;378:1560-71; slide courtesy Jane Ballantyne, MD}
Early opioids and disability in WA WC. Spine 2008; 33: 199-204

- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days (median)
- 14% on disability at one year
- Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment for pain, function, injury severity
Tolerance/dependence inevitable consequence of continued use

TOLERANCE

WITHDRAWAL
SYMPTOMS

CRAVING

OPIOID SEEKING

DEPENDENCE
For the illicit drug user:

- Procurement behaviors

For the pain patient – much more complex:

- Continuous opioid therapy may prevent opioid seeking
- Memory of pain, pain relief and possibly also euphoria
- Even if the opioid seeking appears as seeking pain relief, it becomes an adaptation that is difficult to reverse
- It is hard to distinguish between drug seeking and relief seeking

Responding to the EVIDENCE: Morphine Equivalent Dose RELATED RISK

<table>
<thead>
<tr>
<th>Dose in mg MED</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 mg/day</td>
<td>1</td>
</tr>
<tr>
<td>20-49 mg/day</td>
<td>1.5</td>
</tr>
<tr>
<td>50-99 mg/day</td>
<td>1.88</td>
</tr>
<tr>
<td>&gt;=100 mg/day</td>
<td>4.63</td>
</tr>
</tbody>
</table>

Risk of adverse event increases at >50 mg MED/day

- Risk increases greatly at ≥100 MED/day

2007: WA State AMDG initially recommends 120 MED threshold dose
2012: CT work comp: 90 mg/day MED
2013: OH State Medical Board: 80 mg/day MED
2013: Am College Occ. & Enviro. Med: 50 mg/day MED
2014: CA work comp: 80–120 mg/day MED

Courtesy G. Franklin 2014
Opioid Dosing Policies Since 2007

- 2007: WA AMDG recommended consultation at 120 mg/day MED
- 2010: WA ESHB 2876 directed DOH Boards and Commissions to establish dosing guidance and best practices
- 2012: CT workers comp recommended a threshold at 90 mg/day MED
- 2013: OH Medical Board recommended a threshold at 80 mg/day MED [http://www.med.ohio.gov/pdf/NEWS/Prescribing%20Opioids%20Guidelines.pdf](http://www.med.ohio.gov/pdf/NEWS/Prescribing%20Opioids%20Guidelines.pdf)
- American College of Occupational and Environmental Medicine recommended a threshold at 50 mg/day MED
- 2014: CA Medical Board recommended a yellow flag at 80 mg/day MED [http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf](http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf)
- 2014: CO Department of Regulatory Agencies recommended a threshold at 120 mg/day MED [http://1.usa.gov/1DNPaxT](http://1.usa.gov/1DNPaxT)
- 2015: Minnesota Dept of Human Resources limits all opiate prescriptions to a maximum dose of 120 mg/day MED; [http://bit.ly/1RA87AF](http://bit.ly/1RA87AF)
- CDC guidelines in development (expected Jan, 2016)
WA (2007) Guidance for Primary Care Providers on More Cautious Use of Opioids for Chronic Non-cancer Pain

- Establish an opioid treatment agreement
- Screen for
  - Prior or current substance abuse
  - Depression
- Use random urine drug screening judiciously
  - Shows patient is taking prescribed drugs
  - Identifies non-prescribed drugs
- Do not use concomitant sedative-hypnotics
- Track pain and function to recognize tolerance
- Seek help if dose reaches 120 mg MED, and pain and function have not substantially improved
- Use PDMP initially and for monitoring

http://www.agencymeddirectors.wa.gov/opioiddosing.asp
MED, Morphine equivalent dose
Open-source Tools Added June 2010
Update of WA AMDG Opioid Dosing Guideline

- Opioid Risk Tool: Screen for past and current substance abuse
- CAGE-AID screen for alcohol or drug abuse
- Patient Health Questionnaire-9 screen for depression
- 2-question tool for tracking pain and function
- Advice on urine drug testing

<table>
<thead>
<tr>
<th>OPIOID DOSE CALCULATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid (oral or transdermal)</td>
</tr>
<tr>
<td>codeine</td>
</tr>
<tr>
<td>fentanyl transdermal (in mcg/hr)</td>
</tr>
<tr>
<td>hydrocodone</td>
</tr>
<tr>
<td>hydromorphone</td>
</tr>
<tr>
<td>methadone</td>
</tr>
<tr>
<td>up to 20mg per day</td>
</tr>
<tr>
<td>21 to 40mg per day</td>
</tr>
<tr>
<td>41 to 60mg per day</td>
</tr>
<tr>
<td>&gt;60mg per day</td>
</tr>
<tr>
<td>morphine</td>
</tr>
<tr>
<td>oxycodone</td>
</tr>
<tr>
<td>oxymorphone</td>
</tr>
<tr>
<td>TOTAL daily morphine equivalent dose (MED) =</td>
</tr>
</tbody>
</table>

Available as mobile app: http://www.agencymeddirectors.wa.gov/opioiddosing.asp
Non-fatal Rx Opioid Poisonings in WA Medicaid
There is no safe dose!

• < 50% have chronic opioid use (> 90 days supply)
• 75% of opioid poisonings occurred in cases with prescribed doses < 120 mg MED
• About 45% have sedative-hypnotics in prior month
• 45% have another medication poisoning diagnosis on the same day
• 10-15% have an alcohol diagnosis on the same day
• Most cases have additional opioid prescriptions after poisoning—? Make overdose hospitalizations reportable to the WA DOH
• Over 60% of methadone poisonings occurred in cases that did not have a prescription for methadone in the prior year

Fulton-Kehoe et al. Medical Care 2015; 53: 679-85
Interagency Guideline on Prescribing Opioids for Pain (June, 2015)

• Developed by the Washington State Agency Medical Directors’ Group (AMDG) in collaboration with an Expert Advisory Panel,

• Actively practicing providers, public stakeholders, and senior state officials.


Because there is little evidence to support long term efficacy of COAT in improving function and pain, and there is ample evidence of its risk for harm, prescribers should proceed with caution when considering whether to initiate opioids or transition to COAT.

Although opioids benefit some patients if prescribed and managed properly for appropriate conditions, from a public health perspective, preventing the next group of Washington residents from developing chronic disability due to unnecessary, ineffective, and potentially harmful COAT is a key objective of this guideline.
Clinically Meaningful Improvement

• Clinically meaningful improvement is improvement in pain and function of at least 30%
• Assess and document function and pain using validated tools at each visit where opioids are prescribed
• Recommend use of quick and free tools to track function and pain
  – PEG: Pain intensity, interference with Enjoyment of life, and interference with General activity
  – Graded Chronic Pain Scale: Pain intensity and pain interference
Clinically Meaningful Improvement

• A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (e.g., multiple trauma, spinal cord injury, etc).

• Continuing to prescribe opioids in the absence of clinically meaningful improvement in function (CMIF) and pain, or after the development of a severe adverse outcome (e.g., overdose event) is not considered appropriate care. In addition, the use of escalating doses to the point of developing opioid use disorder, as defined by DSM-V, is not appropriate.
Dosing Threshold

• Avoid COAT if the patient has any FDA or clinical contraindications (e.g. current substance use disorder, past opioid use disorder), history of prior opioid overdose, or pattern of aberrant behaviors

• Use great CAUTION at any dose if the patient has certain risk factors (e.g. mental health disorders, current use of benzodiazepines)

• Do NOT prescribe more than 120 mg/day MED without first obtaining a pain management consult, documented absence of risk factors, and documented CMIF

• There is no safe opioid dose!!
Non-Pharmacologic Alternatives

• Do NOT pursue diagnostic tests unless risk factors or specific reasons are identified
• Use interventions such as listening, providing reassurance, and involving the patient in care
• Recommend graded exercise, cognitive behavioral therapy, mindfulness based stress reduction (MBSR), various forms of meditation and yoga or spinal manipulation in patients with back pain
• Address sleep disturbances, BUT, the greatest risk lies in co-prescribing benzodiazepines and sedative/hypnotics with opioids, even at lower doses of opioids
• Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain
Pharmacologic Alternatives

• Use acetaminophen, NSAIDs or combination for minor to moderate pain
• Consider antidepressants (TCAs/SNRIs) and anticonvulsants for neuropathic pain, other centralized pain syndromes, or fibromyalgia
• Avoid carisoprodol (SOMA) due to the risk of misuse and abuse. Do NOT prescribe muscle relaxants beyond a few weeks as they offer little long-term benefit
• Prescribe melatonin, TCAs, trazodone, or other non-controlled substances if the patient requires pharmacologic treatment for insomnia
State Prescription Monitoring Program (PMP)

• Check the PMP with the first prescription to ensure that the patient’s controlled substance history is consistent with report
• Check the PMP if prescribing opioids during the sub-acute phase
• Check the PMP at a frequency based on the patient’s risk category during chronic therapy to identify aberrant behavior such as multiple prescribers or early fills
Opioid Use in Acute Pain (0-6 weeks)

- The use of opioids for non-specific low back pain, headaches and fibromyalgia is not supported by evidence.
- Help the patient set reasonable expectations about recovery.
- Reserve opioids for pain from severe injuries or medical conditions, surgical procedures or when alternatives are ineffective. If prescribed, shortest duration and lowest necessary dose.
- For minor surgical procedures (eg, impacted wisdom tooth)-prescribe no more than 1-3 days short acting opioid.
- Consider tapering off opioids by 6 weeks as acute episode resolved or if CMIF hasn’t occurred.
Opioid Use in Sub-acute Pain (6-12 weeks)

- Do NOT prescribe opioids if use during acute phase doesn’t lead to CMIF
- Screen for depression, anxiety and opioid risk using validated tools
- Avoid prescribing new benzodiazepines and sedative-hypnotics
- Discontinue opioids if there is no CMIF, treatment resulted in severe adverse outcome or patient has a current substance use disorder or a history of opioid use disorder
Opioid Use During Perioperative Period

- Develop a coordinated time-limited treatment plan for managing postoperative pain, including responsible prescriber
- Avoid escalating the opioid dose before surgery
- Do NOT discharge patient with more than 2 weeks supply of opioid. Continued opioid therapy will require appropriate reevaluation by the surgeon
- Taper off opioids added for surgery as surgical healing takes place
  - Major surgeries should be able to be tapered to preoperative doses or lower by 6 weeks
  - For some minor surgeries, it may be appropriate to discharge patients on acetaminophen, NSAIDs only or with a very limited supply of short-acting opioids (e.g. 2-3 days)
Opioid Use in Chronic Pain (>3 months)

• Prescribe COT only if the patient has sustained CMIF, no contraindications and has failed the use of non-opioid alternatives

• Use extreme caution when prescribing COT in high risk patients.

• Use best (monitoring) practices to ensure effective treatment and minimize potential adverse outcomes

• Avoid methadone unless the provider is knowledgeable of the drug and is willing to perform additional monitoring
When to Discontinue Opioids

- Patient request
- No CMIF as measured by validated instruments for at least 3 months during COT
- Risk from continued treatment outweighs benefit, including decrease in function or concomitant medications
- Severe adverse outcome or overdose event
- Non-compliance with DOH’s pain management rules or AMDG Guideline
- Urine drug tests (UDT) results and/or patient-specific PMP data are aberrant or unexpected
- Drug-seeking, aberrant, or diversion behaviors
How to Taper Opioids

• Start with a taper of \( \leq 10\% \) per week. Rate depends on concurrent treatments or modalities
  – Consider a compulsory taper (2-3 weeks) if the patient does not agree to a voluntary taper or patient with substance use disorder refuse treatment referral

• Prescribe clonidine for withdrawal symptoms such as restlessness, sweating, or tremor

• Use adjunctive therapy during taper or discontinuation (e.g. counseling, psychopharmacological support, SIMP)

• Do NOT reverse taper but it can be slowed. Taper needs to be unidirectional

• Refer patients with opioid use disorder to treatment
Lessons learned from WA effort to reverse opioid epidemic

- Collaboration among state agencies at the highest levels
- Reverse permissive laws from late 1990s that did not represent evidence
- Set opioid dosing and best practice guidelines/rules for acute, subacute and chronic, non-cancer pain
- Establish metrics for tracking progress; track deaths and overdose ED visits and hospitalizations; track high MED and prescribers
- Implement an effective Rx monitoring program
- Encourage/incent use of best practices (web-based MED calculator, use of state PMPs)
- DO NOT pay for office-dispensed opioids
- ID high prescribers and offer assistance (e.g., academic detailing, free CME, ECHO)
- Incent community-based Rx alternatives (activity coaching and graded exercise early, opioid taper/multidisciplinary Rx later)
  - e.g., cognitive behavioral therapy has been found useful in systematic reviews of at least 8 different chronic pain conditions

WA “Bending the Curve”—
30% sustained decline in deaths

Source: Jennifer Sabel PhD, WA State Department of Health, 2014
Reduce the Development of Preventable Disability

- Decrease the proportion of injured workers on chronic opioids*

<table>
<thead>
<tr>
<th></th>
<th>Baseline: 2012</th>
<th>1Q 2013</th>
<th>2Q 2013</th>
<th>3Q 2013</th>
<th>4Q 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of claims</td>
<td>4.9%</td>
<td>4.6%</td>
<td>3.3%</td>
<td>1.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>received with opioids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6–12 wks from injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*2013 opioid guideline for injured workers: [http://1.usa.gov/1nYlarL](http://1.usa.gov/1nYlarL)
What can PCP do to safely and effectively use opioids for CNCP?

- Opioids not first line Rx for most routine conditions (e.g., MSK, HA, FM)
- Use both pharm and non-pharm alternatives

**IF you are using opioids:**
- Opioid treatment agreement
- Screen for prior or current substance abuse/misuse (alcohol, illicit drugs, heavy tobacco use)
- Screen for depression
- Prudent use of random urine drug screening (diversion, non-prescribed drugs)
- Do not use concomitant sedative-hypnotics or benzodiazepines
- Track pain and function to recognize tolerance
- Seek help if MED reaches 80 mg/day MED (OH) and pain and function have not substantially improved
- **Use PDMP!**
THANK YOU!

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Medication Assisted Treatment: what clinicians need to know

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Topics

• Forms of medication assisted treatment (MAT)
• Provider and Program considerations
• Overdose prevention education and naloxone
• Screening
• Integration
Medication Assisted Treatment (MAT)

- Methadone and buprenorphine are approved by the FDA to treat opioid use disorder
  - Both are opioid agonists
- Extended-release injectable naltrexone is approved by the FDA for the prevention of relapse to opioid use after detoxification
  - An opioid antagonist
Comprehensive Treatment

- MAT is one component of the comprehensive treatment of opioid use
- To be of maximum benefit, evidence-based behavioral therapy and case management services must also be provided
- Not all services have to be delivered by the same provider
Which MAT to offer?

- Population served
  - Comorbidity (HIV/HSV, Chronic Pain, other substance use disorder)
  - Pregnancy
- Licensed prescribers
- Staffing
- Pharmacy
- Need to individualize care
Extended Release Injectable Naltrexone

- Monthly injection
- Patient must be medically detoxed first.
- Optimal approach is for patients to receive first dose prior to leaving detox/rehab
- Cannot be used by patients who require opioids for pain
- Also indicated for alcohol use disorder
Extended Release Injectable Naltrexone

- Extended Release Injectable Naltrexone is expensive but covered by many state Medicaid plans
- Can be prescribed/ordered by any licensed prescriber including advanced practice nurses and physician assistants
Naltrexone Resources

Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

Buprenorphine

Formulated with or without naloxone
buprenorphine monoprodutct
(without naloxone) is only for pregnancy
Few interactions with HIV or HCV meds
Can be used in pregnancy
Does not require detoxification to begin
Generics available
Buprenorphine

- Requires physician prescriber
- Patient capacity limited to 30 per provider for first year. After one year of experience may request increase to 100 patients/per provider
- Covered by most state Medicaid
- Becoming certified as an opioid treatment program (OTP) removes the patient capacity limit
Physician requirements to prescribe buprenorphine

- Obtain waiver to Controlled Substances Act by filing “notice of intent to prescribe”
- Licensed and registered with DEA
- One of the following:
  - Board specialization in addiction medicine or addiction psychiatry
  - Completed 8 hour training
  - Investigator in trials to approve buprenorphine
  - Has training or experience approved by state licensing board.
Buprenorphine Resources

How to get a waiver and everything else you need.

http://buprenorphine.samhsa.gov/

Required prescriber training and other resources

pcssmat.org
Methadone

- Requires certification as an opioid treatment program and program DEA registration
  - Dpt.samhsa.gov 240-276-2700
- Methadone must be administered and dispensed at the program

PCSSMAT Training

Providers’ Clinical Support System
For Medication Assisted Treatment

pcssmat.org
Naloxone

- Prescribe to persons at risk for or likely to witness overdose
- Consider using standing order
- Educate on risk reduction
- Motivate to seek MAT

ONLINE NALOXONE TRAINING: http://www.opioidprescribing.com/naloxone_module_1-landing

Download from SAMHSA store
Screening Brief Intervention and Referral to Treatment: SBIRT

SBIRT program and billing information
http://www.samhsa.gov/sbirt

http://attcnetwork.org/national-focus-areas/content.aspx?rc=sbirt&content=STCUSTOM3
Great training resource!

And:
Resource for hospital SBIRT services: hospitalsbirt.webs.com
SAMHSA-HRSA Center for Integrated Health Solutions

- General resources
- MAT implementation resources
- Resources for physicians

http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview
HRSA 16-074 Substance Abuse Treatment Expansion

Grants.gov
Applications due: September 28th!

http://bphc.hrsa.gov/programopportunities/fundingopportunities/substanceabuse/index.html
To Ask a Question

- **Using the Webinar System**
  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
  - “Type” your question
  - “Click” ask

- **On the Phone**
  - Press Star (*) 1 to enter the queue
  - State your name
  - Listen for the operator to call your name
  - State your organization and then ask your question
Thank you for joining!
Please email us questions at coca@cdc.gov

Centers for Disease Control and Prevention
Atlanta, Georgia

http://emergency.cdc.gov/coca
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Upcoming COCA Call/Webinar registration not required

How To Prevent and Control Pediatric Influenza

- Date: Thursday, Oct 1, 2015
- Time: 2:00 – 3:00 pm (Eastern Time)
- Presenter
  - Dr. Hank Bernstein – American Academy Pediatric

For more information visit: http://emergency.cdc.gov/coca
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