Do No Harm: Putting Safer Pain Management Guidelines into Practice – Module 2

1.1 Introduction

Welcome to the Oklahoma Primary Healthcare Improvement Cooperative's online course - Do No Harm: Putting Safer Pain Management Guidelines into Practice.

This Online Enduring Material educational program is designed for healthcare professionals. The contents of this program are based on the National Academy's Institute of Medicine's white paper Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use and the 2016 CDC, 2017 VA-DOD, 2017 Oklahoma State Department of Health Guidelines for Pain and Opioid management, and Oklahoma law.

The program was developed through a grant from the Oklahoma Department of Mental Health and Substance Abuse Services by the Oklahoma Primary Healthcare Improvement Cooperative of The University of Oklahoma Health Sciences Center and the OU-TU School of Community Medicine. It was released in August, 2019.

1.2 Overview

Hi, I am Steve Crawford, and I will guide you through the second module, the opioid addiction epidemic, in the online continuing medical education course Do No Harm: Putting Safer Pain Management into Practice.

1.3 Planning and Review Committees

The panel of experts who reviewed this course represent primary care clinicians, pharmacists, educators, and specialists in pain, addiction, and palliative care, and a national expert in the epidemiology of the opioid crisis.

1.4 Relevant Disclosure and Resolution

None of the members of the CME Planning committee have a relevant financial relationship or affiliation with commercial interests to disclose.

1.5 Relevant Disclosure and Resolution for Expert Review Panel

None of the expert reviewers have a relevant financial relationship or affiliation with commercial interests to disclose.

1.6

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Accommodations are available by contacting Jan Quayle at 405-271-2350, ext. 8 or e-mail to: jan-quayle@ouhsc.edu.

1.7 Profession Practice Gap Being Addressed

The knowledge gap being addressed in this module is that Oklahoma healthcare providers may be unaware of the incidence, prevalence, and role of prescribing in the opioid overdose crisis in the United States and Oklahoma.

1.8 Objectives

At the completion of this module, you will be able to describe the features of the opioid epidemic in the United States, compare statistics for the United States and Oklahoma, explain how we got here, and what we can do to curb the crisis.

1.9 Opioid Overdose in the U.S.

The rise in opioid associated deaths from 2000 to 2017 in the United States is shown on this slide. Overall, 84.2% of drug overdose deaths were unintentional. It appears the prescription opioids oxycodone and hydrocodone accounted for most of the rise. From 2011 the rate slightly slowed. The recent rise in opioid related deaths is largely due to a cheaper and more dangerous heroin supply and, increasingly, illicit fentanyl mixed with the heroin or sold as heroin.

1.10 Burden of Opioid Harm

Using 2013 data, we see that opioid overdose death is the tip of the iceberg of opioid drug consequences. For every opioid associated overdose death, there were 18 people who had a substance use disorder involving heroin. There were an additional 62 people who had a

substance use disorder involving prescription opioids. There were an additional 377 people who misused opioids in the past year. There were 2,946 people who used prescription opioids in the past year.

In order to reduce deaths, we need to prevent unnecessary exposure to opioids, identify and treat addiction or opioid use disorder, and help patients safely through withdrawal. When overdose has occurred, intensive monitoring and treatment, emphasizing the availability of naloxone, will help reduce subsequent overdose deaths. For the majority of patients who have not needed hospitalization or emergency department visits, screening and treating addiction and mental health problems are important preventive measures clinicians can take in practice. A study published in 2016 titled "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the U.S., 2013" estimated the annual economic burden of prescription opioid overdose, misuse and dependence to be $28.9 billion in healthcare costs alone.

1.11 Opioid Prescribing Rate

Opioid prescribing varies dramatically across the United States. The states with the highest rate of opioid prescribing are located in the South and Midwest. Oklahoma is among those with rates in the second highest quartile.

Although still high, prescribing has decreased from 127.4 per 100 persons in 2012 to 88.1 in 2017.

2006 - In 2006, the opioid prescription rate in Oklahoma was 108.6 prescriptions per 100 people.

2008 – In 2008, the opioid prescription rate in Oklahoma was 111.3 prescriptions per 100 people.

2010 - In 2010, the opioid prescribing rate reached a high of 119.6 prescriptions per 100 people.

2012 – In 2012, the opioid prescribing rate reached an all-time high of 127.4

2014 – In 2014, the opioid prescribing rate fell to 110.9 per 100 persons

2016 - In 2016 there were 97.9 prescriptions per 100 persons.

2017 - In 2017 the prescription rate had decreased to 88.1 prescriptions per 100 persons.

1.12 Opioid Overdose

GoodRx published a map of the US showing the most prescribed medications by state from the past 12 months, March 2017 through February 2018. Hydrocodone was the most frequently prescribed medication in Oklahoma, more than atorvastatin or lisinopril.

1.13 Opioid Drug Supply

This slide shows the role of prescriptions in supporting non-medical opioid use. Infrequent non-medical users of opioids (those reporting use on 1 to 29 days in a year) report obtaining prescription opioids from a friend or relative. A few of these users obtain prescription opioids from more than one physician. Infrequent users rarely obtain drugs by stealing or buying from either a friend or drug dealer.

As frequency of use increases to almost daily, opioid prescriptions are less likely to be obtained for free from friends or relatives and *more* likely to be prescribed by one or more physicians. Very little of the supply of prescription opioids for non-medical use comes from drug dealers or a stranger. According to the study authors, this underscores the need for more judicious prescribing, patient screening, and interventions aimed at reducing medication sharing, selling, and diversion.

1.14 Drug Related Deaths in Oklahoma

In 2016 there were 444 opioid-involved overdose deaths in Oklahoma. This was an overdose death rate of 11.6 deaths per 100,000. Although high, in 2016, it was slightly lower than the 13.3 deaths per 100,000 in the United States. The majority, or 73%, of these deaths were associated with prescription opioids.

Although appearing to make a small impact, the synthetic opioids which include high potency illegal fentanyl are increasing. In 2016 these accounted for 12% of the opioid overdose deaths. Also alarming is the increasing incidence of heroin overdose deaths. These have more than doubled from 26 deaths in 2009 to 53 in 2016. The good news is that prescription opioid overdose deaths have decreased.

1.15 Drug Involved Overdose Deaths in Oklahoma

There has been a rapid increase in drug overdose deaths in Oklahoma. The top blue line shows the continued rise from 2007 to 2016 in the number of deaths involving prescription drugs, illicit drugs, or alcohol. After 2014 there was a decrease in the overdose deaths involving prescription drugs. Overdose deaths involving methamphetamine account for most of the recent increase in overdose deaths overall.

1.16 Prescription Drug Involved Overdose Deaths in Oklahoma

The Oklahoma State Department of Health's Unintentional Poisoning Surveillance System data from 2007 through 2016 shows a decrease in the deaths involving prescribed opioids, benzodiazepines, and muscle relaxants. These changes are coincident with the increased awareness of physicians of the dangers of these medications, decreased opioid prescribing, and the increased use of the Oklahoma Prescription Monitoring program.

1.17 How the Epidemic Developed

Understanding how this epidemic came about can help us reverse it. Before 1990, prevailing medical practice avoided using opioids long-term for fear of addiction. The backlash claimed that clinicians were undertreating pain, particularly at the end of life. The "pain as the fifth vital sign" campaign urged clinicians to treat pain vigorously.

Pharmaceutical detailing promoted the false messages that opioids are safe, rarely addicting, and effective for chronic pain. Opioids were heavily marketed to physicians, and increased prescriptions led to widespread consequences.

New specialties in hospice and palliative care, pain medicine and addiction medicine emerged to advance the science and care of pain and to treat Substance Use Disorders.

Over the past several years, illegal strong and less expensive opioids have come into the drug market and make up the latest wave of opioid involved deaths in the US The public health effects of prescription opioids and heroin are intertwined with about 80 percent of current heroin users reporting that they began with prescription opioids.

For more information about the origins of the opioid epidemic in the U.S., the committee recommends Beth Macy's book, Dopesick: Dealers, Doctors, and the Drug Company That Addicted America published in 2018 by Little Brown and Company.

1.18 What Can We Do?

In response to the epidemic, a state plan was developed and titled "Reducing Prescription Drug Abuse in Oklahoma." The Oklahoma Prescription Drug Planning Workgroup made recommendations for healthcare providers, including Oklahoma's opioid prescribing guidelines and this course.

The science of pain and analgesia has advanced, but few clinicians have been updated on the importance of cautious prescribing and dispensing of opioids to prevent adverse effects, diversion, and the treatment Opioid Use Disorder. Most primary care clinicians receive minimal training in diagnosing and treating substance use disorders in their patients.

1.19 Summary

The data suggest that death from drug overdose remains a large and growing public health crisis in the United States and Oklahoma. Prescription opioids have largely driven the crisis in Oklahoma, with increases in overdose deaths involving heroin and synthetic opioids such as illicit fentanyl. Methadone does not appear to be driving the crisis. The recent decline in opioid prescribing rates suggests that healthcare providers have responded with more knowledge of opioid harm and caution in prescribing. Patients with chronic pain and opioid use disorder require safer and more effective pain care, and quality mental health services.

1.20 Self-Assessment Directions

Please answer the following self-assessment question by selecting the single best answer. You will receive immediate feedback and if you selected an incorrect response you may answer the question again.

1.21

Question 1

1.22

Question 2

1.23

Question 3

1.24

Question 5

1.25 Closing Instructions

You may print a certificate of completion in order to meet the requirements for annual training by clicking on the reports tab.

In addition, the University of Oklahoma Office of Professional Development is providing CE credits. MDs are eligible for AMA PRA Category 1 Credit, Physician Assistants for AAPA Category 1 Credit, and Nurse Practitioners for AANC contact hours and Oklahoma pharmacology hours.

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Click on the web link which will take you to the Office of Professional Development web site where you may register, take a test of knowledge, evaluate your learning experience, and print your CE certificate.