Consequences of the Opioid Crisis and the Federal Response

CDC Perspective

Grant Baldwin, PhD, MPH
Director, Division of Unintentional Injury Prevention

Pain, Pain Management and the Opioid Epidemic
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2002 Rapid Increase in Drug Overdose Death Rates by County

SOURCE: NCHS Data Visualization Gallery
2007 Rapid Increase in Drug Overdose Death Rates by County

SOURCE: NCHS Data Visualization Gallery
Rapid Increase in Drug Overdose Death Rates by County

SOURCE: NCHS Data Visualization Gallery
Quarter billion opioid prescriptions in 2012
Rise in Rx overdose deaths since 2000 and recent increase in heroin & fentanyl deaths

Commonly Prescribed Opioids
like oxycodone or hydrocodone

Heroin

Methadone

Synthetic opioids
like fentanyl

From 1999 to 2014, more than 165,000 people died from overdose related to prescription opioids.

Pillars of CDC Activity

- **Improve data** quality and track trends
- **Strengthen state efforts** by scaling up effective public health interventions
- **Supply healthcare providers with resources** to improve patient safety
CDC Overdose Prevention in States Initiative

Five Components

PDMPs
System-Level
Evaluate Policy
Surveillance
Rapid Response
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html

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

Focus on four priority areas to maximize the uptake and use of the opioid prescribing guideline for chronic pain outside of active cancer, palliative, & end-of-life care

1. Translation and Communication
   Develop tools and resources about the guidelines for a variety of audiences – including providers, health systems, and the general public.

2. Clinical Training
   Educate providers through medical schools and ongoing continuing medical education (CME) activities.

3. Health System Implementation
   Educate providers, integrate into EHRs and other clinical decision support tools, adopt and use quality metrics, and leverage within broader coordinated care activities.

4. Insurer/Pharmacy Benefit Manager Implementation
   Proactive use of claims information and improvement in coverage and service delivery payment models – including reimbursement for clinician counseling; coverage for non-pharmacological treatments; and drug utilization review or prior authorization.
**Checklist for prescribing opioids for chronic pain**
For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

**CHECKLIST**

**When CONSIDERING long-term opioid therapy**
- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse:
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling match duration to scheduled reassessment.

**If RENEWING without patient visit**
- Check that return visit is scheduled ≤3 months from last visit.

**When REASSESSING at return visit**
*Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.***
- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
  - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
  - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME):
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤3 months).

**REFERENCE**

**EVIDENCE ABOUT OPIOID THERAPY**
- Benefits of long-term opioid therapy for chronic pain well supported by evidence.
- Short-term benefits small to moderate for pain, measurement for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

**NON-OPIOID THERAPIES**
Use alone or combined with opioids, as indicated:
- Non-opioid medications (eg, NSAIDs, TCA, SNRI, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

**EVALUATING RISK OF HARM OR MISUSE**
Known risk factors include:
- Illegal drug use: prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

**ASSESSING PAIN & FUNCTION USING PEG SCALE**
PEG score = average of individual question scores (50% improvement from baseline is clinically meaningful)

Q1: What number from 0–10 best describes your pain in the past week?
0 = "no pain", 10 = "worst you can imagine"
Q2: What number from 0–10 describes how during the past week, pain has interfered with your enjoyment of life?
0 = "not at all", 10 = "complete interference"
Q3: What number from 0–10 describes how during the past week, pain has interfered with your general activity?
0 = "not at all", 10 = "complete interference"
A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:
- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?

High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering naloxone as well as prescribing it for patients taking 50 MME/day or more.

Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

WHEN SHOULD I CHECK THE PDMP?

State requirements vary, but CDC recommends checking at least once every 3 months and consider checking prior to every opioid prescription.

Provider & Patient Materials Developed

http://www.cdc.gov/drugoverdose
Training

- Training modules for clinicians
  - Online modules
  - CME credits

- Guideline-concordant education
  - Medical schools
  - Nursing schools
  - Pharmacy schools
Health Systems Interventions

- Clinical Quality Improvement
  - Create guideline-concordant quality improvement processes.

- Clinical decision supports in electronic health records

- Coordinated Care Plan
  - Incorporates recommendations to benefit health system operations.
  - Assists in safely managing patients on long-term opioid therapy.
Tracking Progress with Quality Measures

**RECOMMENDATION FIVE**

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) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day.

**EXAMPLE**

**POSSIBLE QUALITY IMPROVEMENT METRICS**

1. The proportion of patients who are given a new prescription for an opioid (i.e., no prescription in the previous 6 month period) who are prescribed more than 50 MME or 90 MME.

2. The number of days patients were prescribed opioid therapy prescribed a dosage of 50 morphine milligram equivalents (MME) or more per day.

3. The number of days patients were prescribed opioid therapy prescribed a dosage of 90 morphine milligram equivalents (MME) or more per day.
Five things insurers can do to address the opioid epidemic

1. Cover non-pharmacologic therapies like exercise and cognitive behavioral therapy
2. Make it easier to prescribe non-opioid pain medications
3. Reimburse patient counseling, care coordination, and checking PDMP
4. Promote more judicious use of high dosages of opioids using drug utilization review and prior authorization
5. Increasing access to evidence-based treatment of opioid use disorder
Effectiveness and adverse effects of non-pharmacologic, non-invasive treatments for common chronic pain conditions

SYSTEMATIC REVIEW
Letter from the Surgeon General

Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do it safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught—not correctly—that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly—almost enough for every adult in America to have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly 2 million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients’ pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. Please take the pledge. Together, we will build a national movement of clinicians to do three things:

First, we will educate ourselves to treat pain safely and effectively. A good place to start is the TurnTheTideRx pocket guide with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.

Vivek H. Murthy, M.D., M.B.A.
19th U.S. Surgeon General