Opioid Prescribing: Pitfalls for Occupational Medicine Physicians

Presented by Scott Levy M.D. M.P.H. FACOEM
Assistant Regional Medical Director, Occupational Health Services
The Permanente Medical Group

Acupuncture

- 35 yo male complaining of moderate/severe axial low back pain rated 8/10. OOW.
- No response or improvement with PT or Chiropractic Manipulation
- Acupuncture x 6 sessions performed and patient reports minimal relief lasting a few hours but pain remains at 8/10. Still unable to work.
- Request more Acupuncture?
Opioids

• 35 yo male complaining of moderate/severe axial low back pain rated 8/10. OOW.
• No response or improvement with PT or Chiropractic Manipulation
• Percocet prescribed and patient reports that pain is currently at 8/10. Still unable to work.
• Prescribe more Percocet?

Introduction

• What is the problem?
• How did we get here?
• What does a Primary Treating Provider need to know?

Scope of the Problem

• Affects 116 Million Americans
  – More than heart disease, diabetes and cancer combined
  – #1 reason people out of work
• More than 300 million prescriptions for analgesics
  – 125 million for Vicodin/year

Institute of Medicine – Relieving Pain In America 2011
Prescription Drug Abuse

- All age groups affected
  - Young
    - Fastest growing prescription abuse group
  - Baby Boomers
    - Culture of drug use
  - Elderly
    - Co-morbid medical and psychiatric conditions

Sources of Prescription Drugs

- 70% - Friend or Relative
- 18% - A single health care provider
- Unlike other “illegal drugs” nearly 100% of all prescription opioids on the street originate from a health care providers pen

Opioids in the Workers Compensation System

- Opioids have a strong positive correlation with
  - Cost of claim
  - Duration of claim
  - Med-Legal expense per claim
California Work Comp Institute

- Significant variation in practice styles
  - 1% of physicians prescribe 33% of all opioids
  - 10% prescribe 80% of all opioids

Work Comp Industry

- Looking for ways to better manage opioid use
- Law enforcement supports changes
- Significant legislation anticipated on this topic

National News

**Arrests mark U.S. prescription drug abuse crackdown**

REUTERS, By Nicole Harnish: Reuters - Fri, Oct 18, 2013

TAMPA, Florida (Reuters) - U.S. authorities arrested 22 people in Florida on Friday, including pharmacies and doctors, in a crackdown against prescription drug abuse that officials say is the nation's fastest growing drug problem.
National News

Prescription drug abuse news, articles and information.

White House plans to reduce prescription drug abuse fails short

APRIL 10, 2010 - In the wake of the growing nationwide prescription drug abuse epidemic, the Obama administration plans to unveil a new strategy to combat abuse of painkillers and other addictive medications. The plan, which is expected to be presented to the National Governors Association in Las Vegas, aims to address the root causes of the epidemic and increase access to treatment services.

Prescriptions, doctors are the new drug dealers who fuel the nationwide crisis with addictive painkillers.

WASHINGTON, D.C. - Prescription drugs are now the nation's most abused substances, with painkillers and other addictive medications being the primary tools used by doctors and medical professionals to treat pain and alleviate suffering. The proliferation of prescription drug abuse is fueling a crisis that threatens the health and well-being of millions of Americans. The Centers for Disease Control and Prevention estimate that nearly 100,000 people die each year from prescription drug overdoses, including painkillers and opioid analgesics.

Prescription drug abuse is an epidemic, according to a new study.

WASHINGTON, D.C. - Prescription drug abuse is a major public health crisis in the United States, according to a new study released by the Center for Disease Control and Prevention. The study, which examined data from the National Survey on Drug Use and Health, found that prescription drug abuse has more than doubled since 2002, with nearly 9 million Americans aged 12 or older reporting misuse of prescription drugs in 2010.

Los Angeles Times

Drug deaths now outnumber traffic fatalities in U.S., data show

WASHINGTON, D.C. - A new study released by the Centers for Disease Control and Prevention finds that prescription drug deaths now outnumber traffic fatalities in the United States. The study, which analyzed data from 2000 to 2010, found that over 60,000 people died from drug overdoses in the U.S. during that time, compared to 20,000 traffic fatalities.

What you can do:

- Get help for yourself or a loved one.
- Support addiction treatment programs.
- Advocate for policies that reduce prescription drug abuse.

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Physician Charged With Murder

A review of Dr. Tsaiy's medical records revealed that he had prescribed medication to a patient who later died from an overdose. The records showed that Dr. Tsaiy had prescribed an excessive dose of the medication, which led to the patient's death. The medical board found that Dr. Tsaiy had failed to properly assess the patient's condition, leading to the overdose.

- Failing to get a patient history to explain the origin of the pain
- Failing to get a prior treatment record to assess the medical history he gave was false
- Failing to identify his previous doctors
- Failing to acquire a history of drug or alcohol abuse
- Failing to fill out reports that would prevent the patient from accessing the medication
- Failing to provide a record that the patient gave informed consent to be treated with controlled substances.

Pharmacies Fueling Prescription Drug Trade?

The prescription drug trade is booming and the Drug Enforcement Administration has been working to control it. 

Today, DEA confirmed that it is now investigating Walgreens, the nation's biggest pharmacy.

In Florida, a Walgreens store was investigated after inspectors spotted a suspicious bag filled with prescriptions. The DEA found that the store was selling prescription drugs to the public without proper identification.

One of the stores under scrutiny bought 95,000 doses of oxycodone in 2009 and over 2,400 doses in 2014, about 30 times the amount a typical pharmacy would buy.
How Did We Get Here?

• Patients who are truly in pain are low risk for addiction to opioids.
• The risk of addiction to prescription pain meds for patients with chronic low back pain is less than 1%.


Overview on Opioid Management- A Brief Review of the National Guidelines

• Are opioids appropriate?
  – Risk-Benefit analysis
  • Determine the likelihood of abuse, misuse, or addiction.
  • Obtain a proper history.
  • Is there a contraindication to using opioids?
• Informed consent and agreement including
  – Goals
  – Expectations
  – Risks and alternatives
• Monitor the patient
Risk Benefit Analysis

- Does the patient’s story make sense?
  - Is it verifiable?
    - Medical records available?
    - Prescription drug monitoring program (CURES)?
    - Will your documentation hold up?

- Significant verifiable pain source?
- Does mechanism of injury warrant opioids?
- Does injury of this body part typically require opioids?
- Were other medications attempted first?
- Does the patient have a contraindication to opioids?

Stratifying the Risk

- LOW
  - No personal or family history
    - Substance abuse or psych disorder
- MODERATE
  - + PMHx of substance abuse or underlying psych condition
    - Not currently addicted
- HIGH
  - Current addiction
  - Untreated psych disorder
What is a Contraindication to Opioids?

• High Risk Patients = High risk of problems
  – Prior psychological disorders including but not limited to
    • Personality disorders
    • Depression
    • History of drug abuse/dependence.
    • Drug seeking behavior
  – Consider other risk factors
    • Family history, abuse, neglect, alcohol, legal issues

Goals of Treatment

• Establish goals PRIOR to initiating
  – Goal of treatment with opioids is functional improvement
• Is there any **functional improvement**?
  – If none, trial failed and stop opioids.
  – If partial, consider increase in dose. If no functional improvement, **stop opioids**

What is Functional Improvement?

• Increase in physical activity levels
  – At home or work
  – In the community
• Improved ability to perform ADLs
• Less reliance on medical treatment
• Corresponding decrease in need for work restrictions
Monitoring the Patient

- Pain agreements
- Random urine drug screening
- Surveys
  - Pq9
  - ORT
  - SOAPP

Pain Agreements

- Sets expectations
  - You will not receive medications from anyone but me.
  - Lost medications will not be replaced.
  - Stolen meds can be replaced if you have a police report.
  - You will undergo random drug screens.

Urine Drug Screening

- Detects diversion
- Detects polysubstance abuse
- Minimum 1/year and can increase to 4/year for high risk patients
  - Any time you suspect aberrant behavior.
Opioid Weaning

- As a patient on opioids improves, the expectation is that opioid need/use will decrease.
  - Improvement in function should be paired with decrease in opioids
  - Goal of treatment with opioids is to stop opioids as soon as feasible.

Chronic Opioid Use

- If weaning fails and functional improvement exists when patient is on opioids
  - Pain agreement
  - Random urine drug screens
  - Consider weaning trial yearly

High Risk Patients

- What if a high risk (contraindicated) patient requires opioids?
  - Risk benefit decision should be made
  - Strongly recommend use of pain agreements
  - Treat as any other patient with pain agreement
  - Strongly consider involvement of Psychology and/or chronic pain as early as possible
Recognize side effects

- Constipation
- Nausea
- Vomiting
- Somnolence
- Asthenia including fatigue
- Dizziness

Case

- 25 yo male on percocet for 6 months after suffering a twisting injury while loading furniture onto a truck. C/o axial low back.
- Calls in to state that he missed your appt because he has the flu.
- C/o nausea, vomiting, body aches, fever, sweats and diarrhea. States that his symptoms kept him awake for the past 2 days and he didn’t feel comfortable driving.
- Requests that you refill his meds and he will f/u with you when he is feeling better.

Don’t forget about withdrawal symptoms

- Dysphoric mood
- Sweating
- Craving
- Distress/irritability
- Piloerection
- Nausea or vomiting
- Diarrhea
- Muscle aches/cramps
- Yawning
- Fever
- Lacrimation
- Insomnia
- Rhinorhea
- Dilated pupils
- Anxiety
Weaning

- For patients on long term opioids stopping meds should not be abrupt due to withdrawal symptoms
- All patients on long term opioids should have a weaning trial at least yearly

Signs of Potential Abuse

- Shows up without an appointment
- Requests an appointment at the end of the day
- Telephone/arrive after office hours when staff are anxious to leave
- Reluctant to have thorough physical exam, diagnostic tests, or referrals
- Fail to keep appointments
- Unwilling to provide past medical records or names of HCPs
- Unusual stories

When to get help?

- Managing pain in a high risk patient
  - Significant underlying psych condition
  - Active addiction
  - Polysubstance abuse
  - Drug seeking behavior
- Difficulty weaning someone off opioids
- High dose of opioids
- Concurrent use of opioids and benzos
Driving and Opioids

- Incapacitating pain
- Fluctuating dose of opioids
- ACOEM
  - Avoid driving for 2 weeks after changing the dose of an opioid

KOJ Northern California

- Opioid management protocol implemented across 31 clinics and 120 providers.
  - Data
  - Education
  - Feedback

Frequently Asked Questions

1) If you’re treating a patient with opioids and after 90 days they refuse to sign a pain agreement, how do you proceed?

  - Stop prescribing opioids
2) If a patient claims they are taking a medication and a random drug test fails to demonstrate the substance, do you stop prescribing immediately?

- Reevaluate the case.
- Did the patient report that they ran out of meds 3+ days ago?
- Are there extenuating circumstances that would explain this?

3) If you have a patient who is not showing any functional improvement while on opioids and in fact is having worsening pain, how do you handle this?

Stop prescribing.
May need to wean them if on long term opioids.

4) Although I don’t routinely use opioid medications, I do occasionally inherit these patients from another provider. How do I handle patients already on long term opioids.

Treat like you do everyone else.
Get a pain contract and start getting urine drug screens. Explain to the patient on your first visit with them how you handle opioid medications.
5) I’ve tried everything I can think of for one of my patients including all the nsaid, tylenol, nortriptyline, elavil, etc. and the patient is still in significant pain. What should I do?
Opioids are appropriate for a subset of our patients and perfectly acceptable to use as long as you use them properly.

Thank You

• For any additional questions, please feel free to contact me at anytime.

• Scott.Levy@KP.org