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Key Inforbits

- About Opioids
- Pain Management
- Opioid Misuse & Addiction
- Naloxone Accessibility
- Opioid Prescribing Updates
- State Efforts to Regulate Opioids
- Pharmacist's Role

June is National Safety Month!

Available from: http://www.painpathways.org/opioid-safety/

ABOUT OPIOIDS[1]

Opioids are a class of medication that are commonly prescribed for pain and work by reducing the perception of pain. Approximately 20% of patients who present to a physician's office with pain not related to cancer or pain-related diagnoses receive an opioid prescription. From the span of 2007 to 2012, opioid prescriptions increased by 7.3% per capita with a total of 259 million prescriptions for opioids written in 2012. Opioid prescribing rates increased for family practice, general practice, and internal medicine when compared to other specialties. The CDC's *Guideline for Prescribing Opioids for Chronic Pain* helps address and implement strategies to overcome the challenges that healthcare providers and systems face with prevention, assessment, and treatment of chronic pain. The scope of the guideline is aimed at primary care clinicians, since they account for approximately 50% of all dispensed opioid prescriptions and the prescribing rate among them is growing rapidly.

PAIN MANAGEMENT

Pain is a very subjective condition that differs greatly among patients, which may complicate proper management. Generally, pain may be described as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage". This description may be further broken down to give two distinct therapeutic definitions of pain.[2]

Acute pain may be described as the useful physiological process by which the body sends alerts of potential damage or other harmful situations.[2] This is in contrast to chronic pain, which is typically used to describe long-lasting, continuous pain. The duration of chronic pain is controversial. It may be defined as pain lasting from 3 to 6 months after the time of injury, or pain lasting longer than the normal time for the injury to heal.[1-3]

Types of Pain[2]		
	Acute pain	**Chronic pain**
Cause	• Bodily injury or disease	• Changes in nerve function, potential psychological manifestations, or incurable diseases such cancer
Goal of therapy	• Pain reduction during the healing process	• Allowing for normal daily functionality and improved quality of life
General treatment	• Non-opioid analgesics up to opioids[4]	• Long-acting or short-acting opioids individually or in combination[4]
Duration of therapy	• Can be a few weeks to a few months depending on the severity of the injury and/or patients' needs	• Often persists throughout the patient's lifetime
Other treatment considerations	• Typically few	• Patients often suffer from insomnia, depression, and other disorders as a result of their chronic pain. • Tolerance may frequently occur requiring dosage alterations. • Chronic use of opioid analgesics often carries negative connotations that may affect a patient's relationship with friends and family.

Management of chronic pain is a continuous cycle of assessing, monitoring, and adjusting a patient's therapy. Patients are initially assessed for their need of opioid therapy based on their pain levels and response to non-opioid therapy. If deemed candidates, they will begin the long-term process of monitoring response to their therapy and titrating based on their needs. Patients with acute cases of pain are generally treated with low occurrence of complications. Patients with chronic pain struggle through a constant day-to-day fight to find relief; what once provided near-perfect relief yesterday may now fail to provide relief today. Pain perception varies among patients leading to differences in tolerability. Due to the nature of pain, diligence and patience are crucial in all levels of care.[1,2]

OPIOID MISUSE AND ADDICTION[1,2,5]

Know The Difference	
Tolerance	People taking opioids can experience reduced efficacy over time due to exposure to the drug, requiring an increased dose in order to maintain pain relief.
Dependence	People who experience physiological withdrawal symptoms after abrupt discontinuation of opioids.
Addiction	Neurological disorder that is characterized by drug-seeking behavior and continued use of opioids despite harmful consequences.
Pseudoaddiction	When a person's behavior suggests addiction, but these behaviors arise from unrelieved pain.

Risk Factors	
Mental illness	Low income
History of substance abuse	Overlapping prescriptions
History of alcohol abuse	Use of multiple providers
Living in rural areas	Use of multiple pharmacies

- According to the CDC, 28,000 people died from an opioid overdose in 2014, over half of these overdoses involved prescription opioids.
- The amount of prescription opioids sold in the US and the amount of deaths from opioids have quadrupled since 1999
- From 1999-2014, >165,000 deaths due to opioid pain medication overdose
- In 2014, nearly 2 million Americans (≥ 12 years) either abused or were dependent on prescription opioids.

NALOXONE ACCESSIBILITY[6-8]

Evzio®	Narcan®
0.4 mg / 0.4 mL autoinjector	4mg / 0.1 mL
 Available from: http://www.evzio.com/hcp/	 Available from: http://www.opiant.com/products/

- Naloxone works by competing with and blocking opioids at opioid receptors. It is currently available as an injectable and nasal spray.[6]

- According to the Food and Drug Administration (FDA), naloxone is a prescription drug. However, states have the authority to decide who may write and dispense certain prescriptions.[7]
- According to Alabama Code, Section 20-2-280, a licensed physician may prescribe opioid antagonist directly or by standing order to an individual, or family members and friends of an individual, at risk of opioid overdose.[8]
- A licensed pharmacist may then dispense naloxone to patients in Alabama by a direct prescription written by the physician, or under a collaborative practice agreement with physicians and pharmacies.[8]

OPIOID PRESCRIBING UPDATES[1,5]

CDC Guideline for Prescribing Opioids for Chronic Pain	
Goals of CDC Guideline Update	**Focus Areas to Formulate Recommendations**
• 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 • Reduce the risks associated with long-term opioid therapy • Reduce the risks associated with opioid use disorder and overdose.	• Determining when to initiate or continue opioids for chronic pain • Opioid selection, dosage, duration, follow-up, and discontinuation • Assessing risk and addressing harms of opioid use
What's New in the Guideline	
Dosage Recommendations; Assessing Risks and Harms; Monitoring and Discontinuing	

Why is an update needed?

A. Helps providers make informed decisions about pain treatments for patients 18 and older in primary care settings.
B. Focuses on the use of opioids in treating chronic pain.
C. Aims to implement best practices for responsible prescribing to decrease risks involved with opioids

Recommendations Formulated	
Recommendation 1	Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Consider opioid therapy if benefits outweigh risks for both pain and function
Recommendation 2	Clinicians should establish realistic treatment goals for pain and function with all patients and how to discontinue opioid therapy if the benefits do not outweigh the risks before the initiation of opioid therapy for chronic pain; only consider continuation of opioid therapy if clinically meaningful.
Recommendation 3	Clinicians should discuss before and periodically during opioid therapy the risks and realistic benefits of opioid therapy with their patients and the responsibilities associated with both sides during therapy management.

Recommendation 4	At initiation of opioid therapy, use immediate-release opioids
Recommendation 5	At initiation of opioid therapy, prescribe at the lowest effective dose. Assess benefits and risks when increasing dosages to ≥ 50 morphine milligram equivalents (MME)/day (Morphine milligram equivalents table available at http://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf)
Recommendation 6	Do not prescribe extended-release or long-acting opioids for acute pain. If opioids are used for acute pain, the quantity should not exceed the expected duration of pain severe enough to require opioids. Sufficiency seen with 3 or less days of treatment.
Recommendation 7	Clinicians should follow-up and re-evaluate risk of harm with patients within 1-4 weeks of initiation of opioid therapy or of dose escalation. Benefits and risks of continued therapy should be assessed with patient every 3 months
Recommendation 8	Clinicians should evaluate for risk factors for opioid-related harm before starting and periodically during continuation of opioid therapy. Management strategies should be implemented to decrease risk. Consider offering naloxone to patients with increased risk of opioid overdose
Recommendation 9	Check the prescription drug monitoring program (PDMP) for high dosages and prescriptions from other providers
Recommendation 10	Use urine drug testing to identify prescribed substances before and during treatment at least annually to assess for other prescribed medications and illicit drugs.
Recommendation 11	Avoid concurrent benzodiazepine and opioid prescribing
Recommendation 12	Arrange/offer treatment for opioid use disorder, if needed, by using medication assisted treatment with buprenorphine or methadone in combination with behavior therapies.

How will the update benefit Primary Care Providers?

- Decrease harm to patients
- Supports informed clinical decision making
- Improved communication between patients and providers
- Improvements on appropriate prescribing

Ways to Implement Changes		
I	**Use non-opioid treatment where possible**	Opioids are not first-line or routine therapy for chronic pain
II	**Start Low and Go Slow**	Prescribe at the lowest effective dose High dosages (≥100 MME/day) are associated with 2-9 times the risk of overdose compared to <20 MME/day
III	**Review PDMP**	Decreases drug abuse by checking for high dosages and prescriptions from other providers
IV	**Offer treatment for Opioid Use Disorder**	Study showed patients prescribed high dosages of opioids for >90 days had **122 times** the risk of opioid use disorder compared to patients not prescribed opioids.

V	**Avoid Concurrent Prescribing**	Avoid prescribing opioids and benzodiazepines concurrently

STATE EFFORTS TO REGULATE OPIODS[9-11]

Date	State Bill	Details
May 2016	Rhode Island Bill S-2823 Sub A	• First attempt in Rhode Island to establish legal limits on opioid prescribing. • Applies to opioids used to treat acute pain from injuries or surgeries, not for chronic pain. • Prescribing limit based on dosages (MME) rather than days • Bill limits initial (opioid-free for ≥ 60 days) prescription for adults to 30 MME/day for a maximum of 20 doses • Downfall with bill: dosage limit can allow doctors to prescribe lower doses over a longer time period and still be within the legal limit.
April 2016	Maine LD 1646	• Mandates prescriber participation in the Prescription Monitoring Program (PMP) • Sets limits for the strength and duration of opioid prescriptions • Requires prescribers to submit opioid prescriptions electronically beginning next year and undergo addiction training every two years.
March 2016	Massachusetts Bill H.4056	• Gives a seven-day limit on first-time prescriptions of opioid drugs or minors • Exceptions will be given to patients with cancer or palliative care • Focuses on intervention, education, and prevention • Seven-day limit can help reduce the amount of prescription drugs that can be diverted to abuse or misuse. • Includes proposal to verbally screen students in schools to identify students who are addicted or at risk of addiction to drugs • Establishes liability protection from civil lawsuits for anyone who administers the naloxone to some suspected of overdosing • Requires doctors to check a Prescription Monitoring Program each time an addictive opioid is prescribed. • Incorporates education about opioid addiction into annual high school sports training and driver education. • Establishes five-year drug stewardship program, which drug manufacturers must participate in, to collect and dispose of unneeded prescription medication.

PHARMACIST'S ROLE

A pharmacist is unable to actually know what a patient is feeling at a given moment. Close and constant interaction and monitoring is needed in pain management with the overall goal of improving quality of life by finding the patient relief and with an acceptable level of functionality. Since this data is so subjective, a pharmacist must rely on and interpret the patients' own perceptions of their pain in order to gauge the efficacy of their therapy. A good bank of questions may help simplify this process and quickly supply useable information.[2,4,12]

Potential assessment questions include:[2,12]

- How much pain are you in when you haven't taken your pain medication?
- How much pain are you in when you do take your pain medication?
- Do you notice any pain in between doses of your pain medication?
- Do you feel as though your pain medication is helping control your pain?
- How many times a week would you say you miss a dose of your pain medication?
- How many times a week would you say you take your pain medication dose early?
- Have you been having any side effects from your pain medication?

These questions may be placed on a numerical scale as well to give quantifiable information

It is important to remember that every patient is different and attempts to gather information should be tailored for each case. Some patients may still be in a considerable amount of pain while others are on medicine stronger than what they need. Some patients may seem to be addicted to opioids but have actually become tolerant to them and require more. Unfortunately, there also patients who are abusing their medication or even diverting it for personal gain. The spectrum of patient-types requires all pharmacists to don a nonjudgmental attitude towards opioid use. All patients with chronic pain should have a history of their pain recorded and updated regularly to monitor the course of their therapy to serve as a basis of patient assessment.[1,4]

Pharmacists serve as the front line for medication use and are not just limited to ensuring medication efficacy. A pharmacist should strive to heal those around them, ease their concerns, and safeguard a patient's future. This isn't done through judgment or scrutiny, but rather by developing a positive relationship with the patients. They are fighting their own daily battles and require help and guidance from their pharmacist. More is not always better. In the end, it is left to the pharmacist to discern what is best for the patient.[1,4,12]

The last "dose" …

"Clearly, the overuse and abuse of prescription drugs has evolved into a national epidemic and a public health emergency."
- Colleen Haines, Anthem vice president of clinical and specialty pharmacy

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