

# **Alameda County Safety Net Working Group Opioid Prescribing**

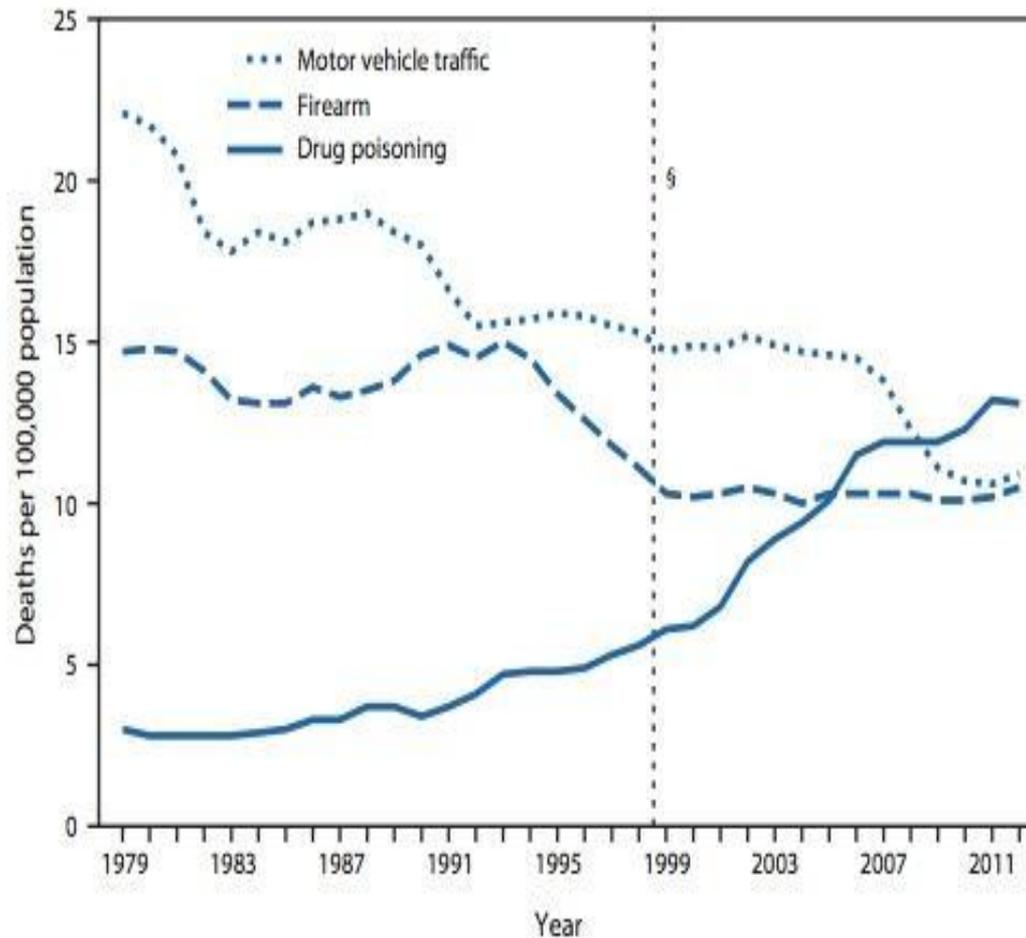
## **Welcome!**

May 28, 2015

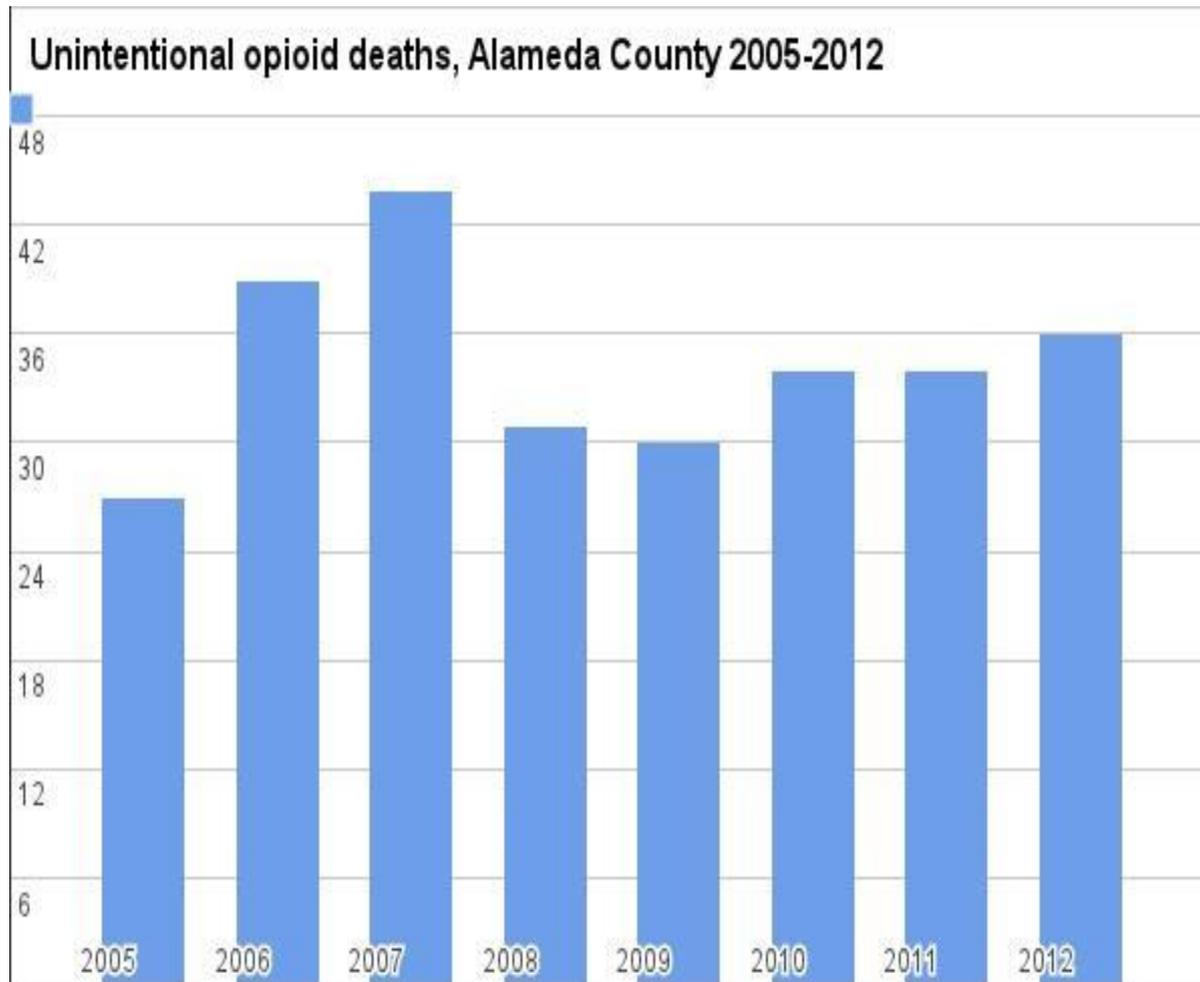
Oakland, California

# Nationwide

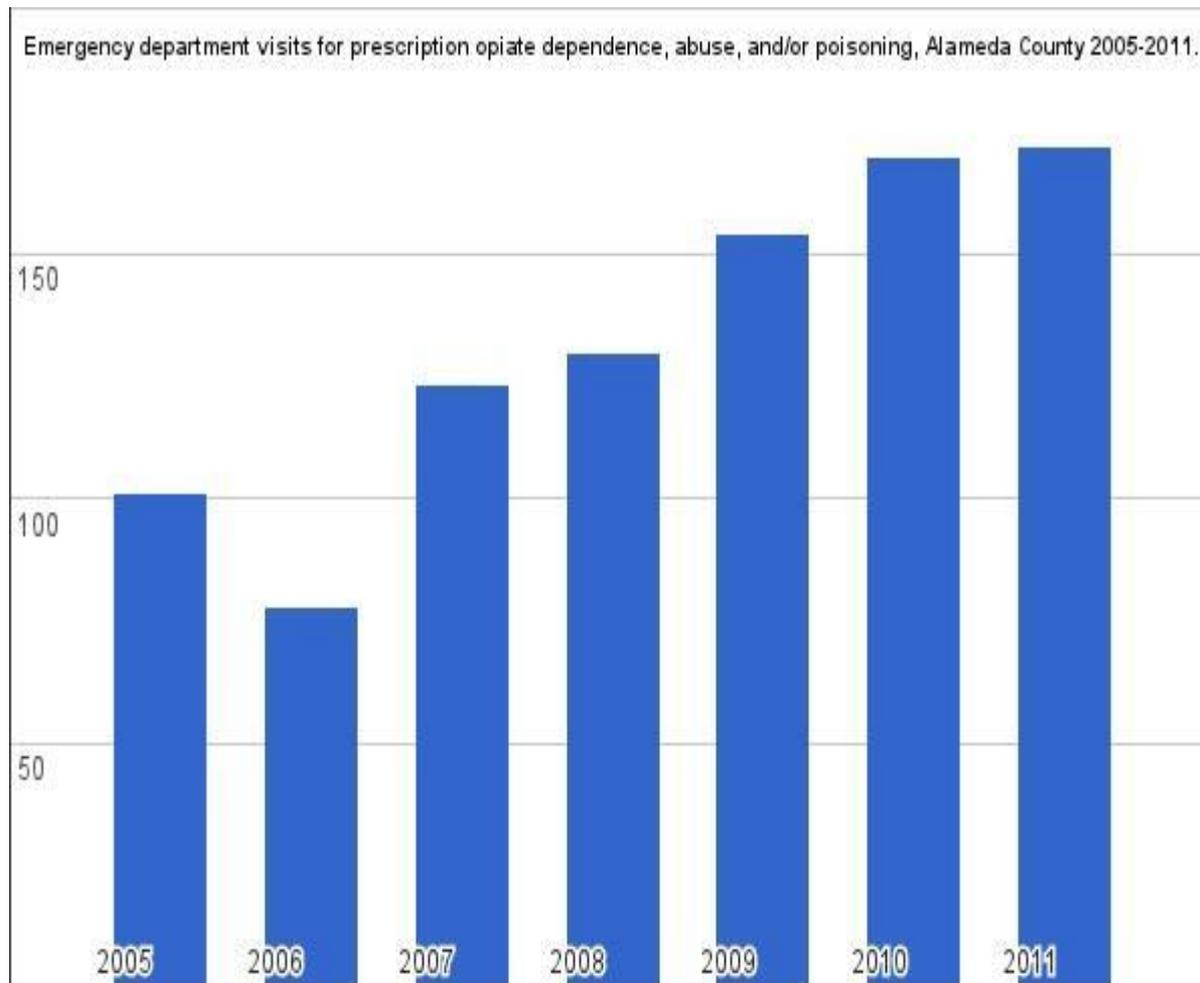
Death Rates\* for Three Selected Causes of Injury†—  
National Vital Statistics System, United States, 1979–2012



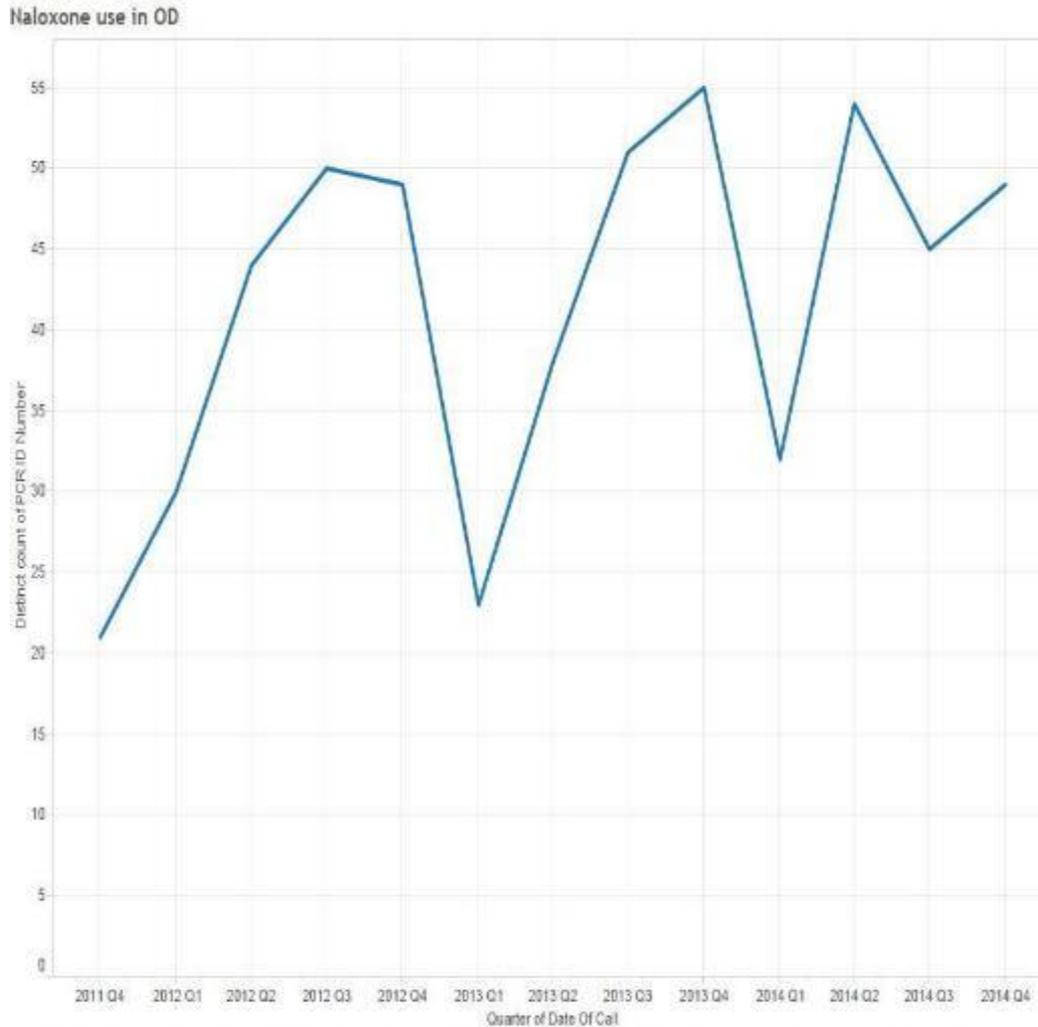
# Opioid overdose deaths have appeared stable in Alameda County....



# Opioid related ED visits are increasing in Alameda County

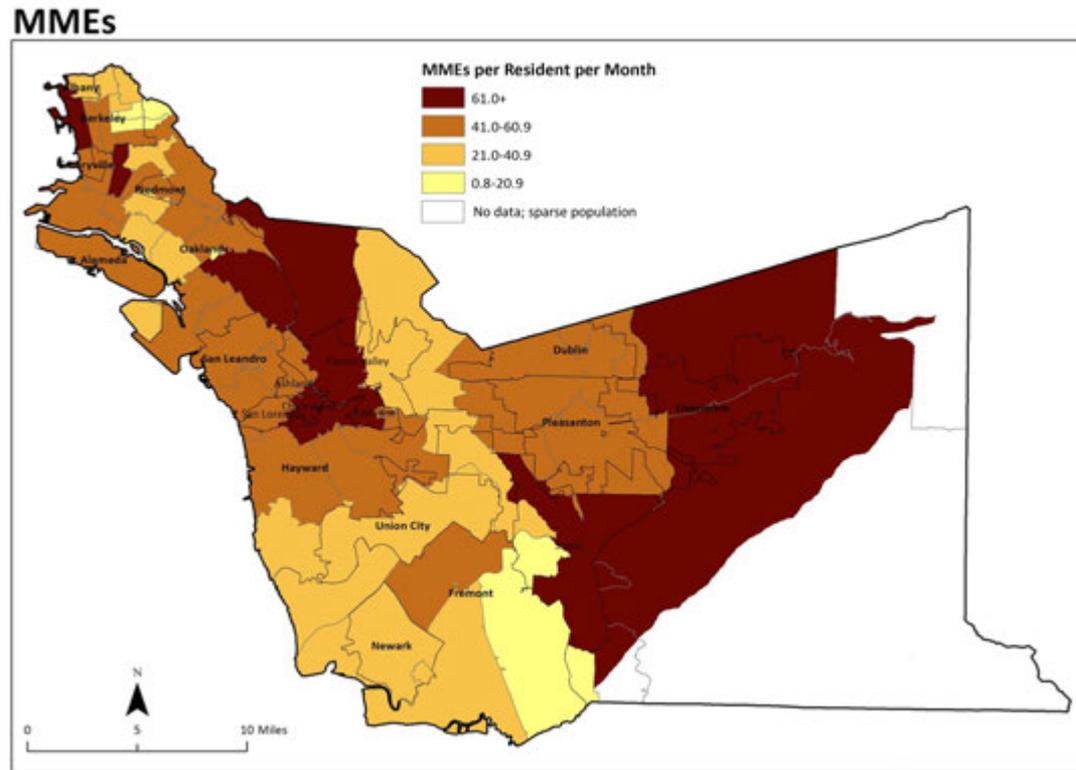


# EMS naloxone deployments 2012-2014



The trend of distinct count of PCR ID Number for Date Of Call Quarter. The data is filtered on Agency, Intervention and Primary Impression. The Agency filter keeps Alameda City FD, Albany FD, Berkeley FD, Paramedics Plus and Piedmont FD. The Intervention filter keeps Narcan (Naloxone). The Primary Impression filter keeps Overdose/Poisoning/Ingestion.

# Opioids in use in Alameda County



# And deaths are only one form of harm attributable to opioid misuse.....

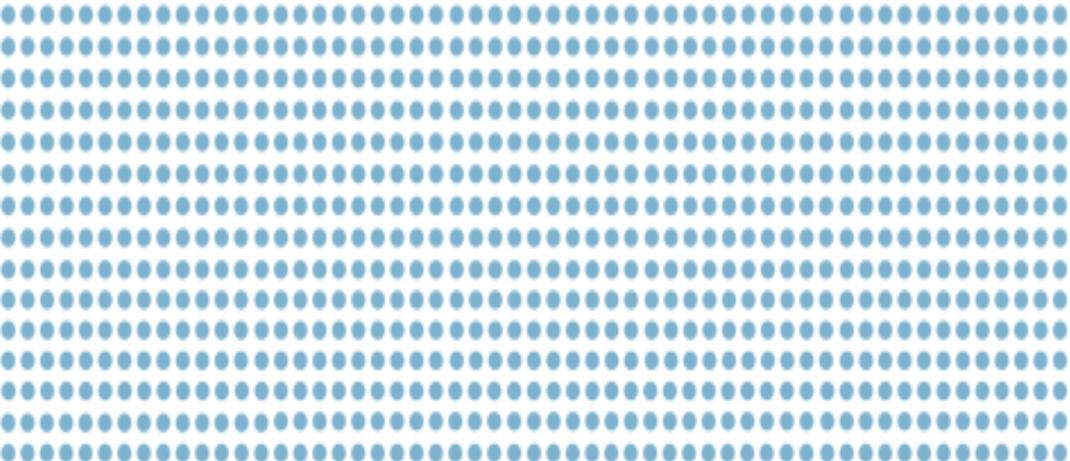
For every **1** death there are...



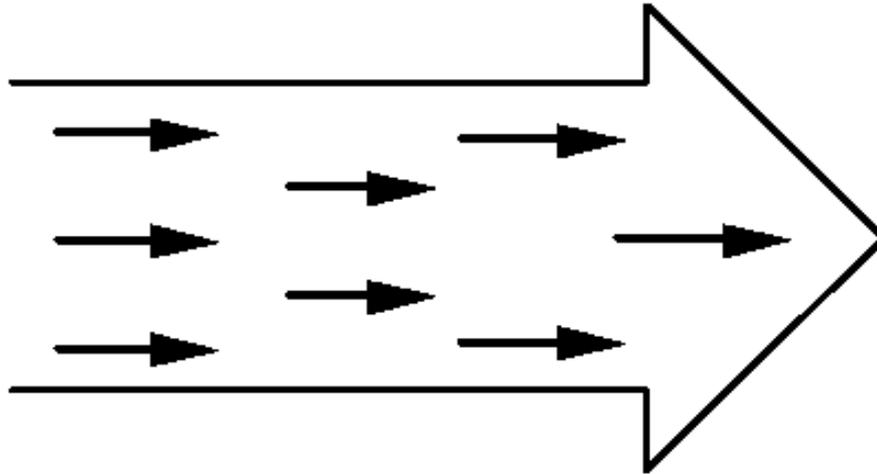
 **10** treatment admissions for abuse<sup>9</sup>

 **32** emergency dept visits for misuse or abuse<sup>6</sup>

 **130** people who abuse or are dependent<sup>7</sup>

 **825** nonmedical users<sup>7</sup>

# Creating Alignment



# Acknowledgement

## California Health Care Foundation

- Guidance and references
  - Funding for today
- Statewide leadership on this topic

# **GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN**

**MEDICAL BOARD OF CALIFORNIA**

**NOVEMBER 2014**

[http://www.mbc.ca.gov/licensees/prescribing/pain\\_guidelines.pdf](http://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf)

# Highlights (and rationale) from guidelines

| <b>Risk factors for overdose</b>                                   | <b>Guideline recommendations</b>   |
|--|--|
| - High daily dose (i.e. 100 MMEs)                                  | - Dose-ceilings  |
| - Taking w other sedating agents (benzos, EtOH, carisoprodol, etc) | - Avoid co-prescribing w benzos and other sedating agents                            |
| - Substance use disorder   | - Risk stratification tools (i.e. ORT)<br>- Urine tox screening                      |
| - Co-occurring mental illness                                      | - Screen and treat   |
| - Doctor shopping (i.e. diversion)                                 | - Obtain old medical records first<br>- PDMPs (e.g. CURES)<br>- Utox and pill counts |

Dunn KM. AIM 2010;152:85.  
Hall AJ. JAMA 2008;300:2613.  
Bohnert AS. JAMA  
2011;305:1315.

# Opioid Risk Tool (ORT)

| Mark each box that applies               |  | Female   | Male   |
|--|--|--|--|
| 1. Family history of substance abuse     | <ul style="list-style-type: none"> <li>■ Alcohol</li> <li>■ Illegal drugs</li> <li>■ Prescription drugs</li> </ul>   | <input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 4 | <input type="checkbox"/> 3<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4 |
| 2. Personal history of substance abuse   | <ul style="list-style-type: none"> <li>■ Alcohol</li> <li>■ Illegal drugs</li> <li>■ Prescription drugs</li> </ul>   | <input type="checkbox"/> 3<br><input type="checkbox"/> 4<br><input type="checkbox"/> 5 | <input type="checkbox"/> 3<br><input type="checkbox"/> 4<br><input type="checkbox"/> 5 |
| 3. Age (mark box if 16-45 years)         |  | <input type="checkbox"/> 1   | <input type="checkbox"/> 1   |
| 4. History of preadolescent sexual abuse |  | <input type="checkbox"/> 3   | <input type="checkbox"/> 0   |
| 5. Psychological disease                 | <ul style="list-style-type: none"> <li>■ Attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia</li> <li>■ Depression</li> </ul> | <input type="checkbox"/> 2<br><input type="checkbox"/> 1                               | <input type="checkbox"/> 2<br><input type="checkbox"/> 1                               |
| Low (0-3)    Moderate (4-7)    High (≥8) | Scoring totals   | <input type="checkbox"/>   | <input type="checkbox"/>   |

## Scoring:

Low risk 0-3

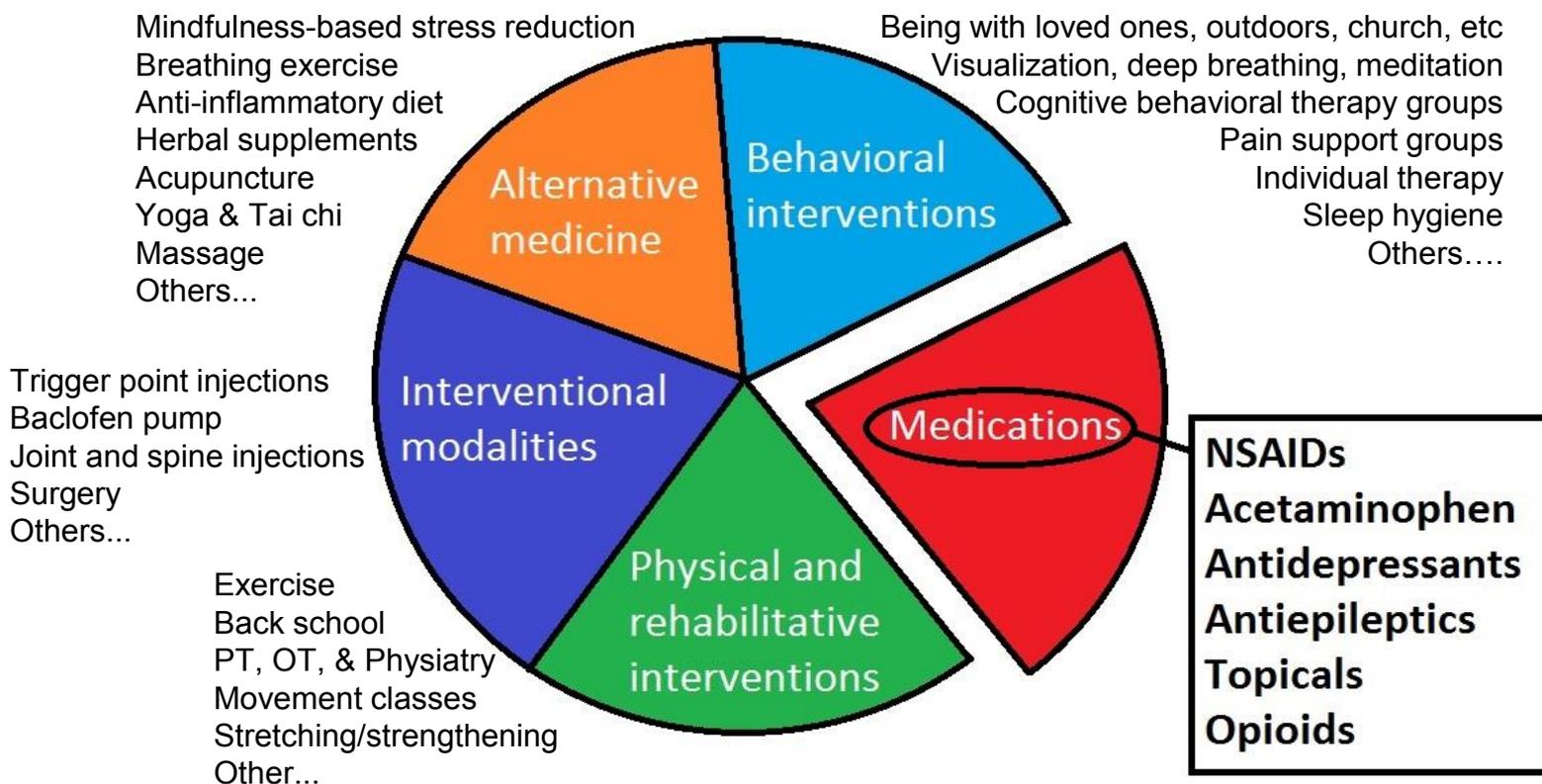
Medium 4-7

High risk ≥8

## High risk:

- **91% sensitive for aberrant drug related behavior**
- **Positive LR =14**

# Opioids are only one small piece of the pie!



# Have clearly defined goals

- Developed in partnership w patients
- Improvement in function, mood, QoL, etc.
  - Pain is subjective and difficult to quantify
- Clear timeline for achieving goals

# Consider 30% improvement a success!

| <b>Primary Care Treatment Menu</b> | <b>Reduction in pain intensity NRS</b> |
|------------------------------------|--|
| Physical fitness                   | 30-60 percent                          |
| CBT/Mindfulness                    | 30-50 percent                          |
| Sleep restoration                  | 30-40 percent                          |
| <b>Opioids</b>                     | <b>≤30 percent</b>                     |
| Tricyclics                         | ≤30 percent                            |
| Antiepileptics                     | ≤30 percent                            |
| Acupuncture                        | ≥10+ percent                           |

Source:  
David Tauben, MD  
UW Center for Pain Relief

# Other important guideline elements

Don't abandon patients if misuse is detected!

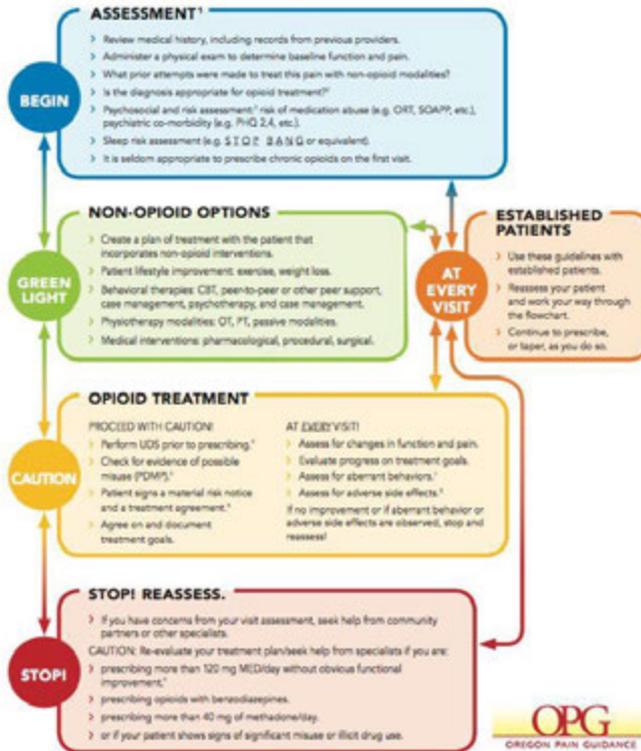
- Continuing care ≠ continuing opioids
  - May actually be the converse
- Refer to addiction treatment
  - Addiction is a chronic disease characterized by *remission and relapse*

Consider co-prescribing naloxone

- Evidence-based therapy to reduce OD

## GUIDELINES FLOWCHART

FOR THE EVALUATION AND THE TREATMENT OF COMPLEX CHRONIC NON-CANCER PAIN



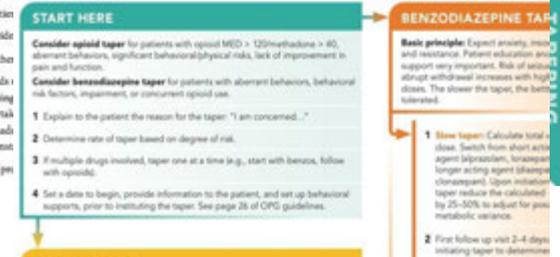
## TAPERING

### Opioid Taper/Discontinuation

Opioid therapy should be tapered down or discontinued if any of the following situations occur:

- A. The medication fails to show significant analgesia despite incremental dose increases.
- B. MED is in excess of 120mg, or methadone dose is in excess of 40mg, without clear sustained improvement in pain and function.
- C. Trials of different opioids at equivalent doses fail to provide adequate analgesia.
- D. Signs
- E. Side effects
- F. Patient
- G. Elixirs
- H. Other

### TAPERING FLOWCHART



| Opioids (not methadone)             | Methad     |
|-------------------------------------|------------|
| Basic oral route: For longer acting | Basic oral |

### MED for Selected Opioids

| Opioid               | Approximate Equianalgesic Dose (oral and transdermal)* |
|----------------------|--|
| Morphine (reference) | 30mg   |
| Codeine              | 200mg  |
| Fentanyl transdermal | 12.5mcg/hr   |
| Hydrocodone          | 30mg   |
| Hydromorphone        | 7.5mg  |
| Methadone            | Chronic: 4mg <sup>1</sup>                              |
| Oxycodone            | 20mg   |
| Oxymorphone          | 10mg   |

### Benzodiazepine Equivalency Chart

| Drug                       | Half-life (hrs) | Dose Equivalent |
|----------------------------|-----------------|-----------------|
| Chlordiazepoxide (Librium) | 5-30 h          | 25mg            |
| Diazepam (Valium)          | 20-50 h         | 10mg            |
| Alprazolam (Xanax)         | 6-20 h          | 0.5mg           |
| Clonazepam (Klonopin)      | 18-39 h         | 0.5mg           |
| Lorazepam (Ativan)         | 10-20 h         | 1mg             |
| Oxazepam (Serax)           | 3-21 h          | 15mg            |
| Triazolam (Halcion)        | 1.6-5.5 h       | 0.5mg           |

www.oregonpainguidance.org

# Continuum of community interventions for opioid misuse

