

**OPIOID EPIDEMIC
DO NOT BE A CONTRIBUTOR!
OPTOMETRY'S RESPONSIBILITY**

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OUTLINE

- Definition of terms
- Origin of opioid epidemic
- Early and more Recent Laws

DEFINITION OF TERMS

- **Aberrant drug-related behavior**
 - Behavior outside agreed-upon treatment plan
- **Abuse**
 - Any drug use/intentional self-administration for nonmedical purpose
 - pleasure-seeking, consciousness altering
-

DEFINITION OF TERMS

- **Addiction**
 - Chronic, neurobiological disease (genetic, psychosocial, and environmental factors)
 - Behaviors including:
 1. Craving
 2. Impaired drug use control over drug use
 3. Compulsive use
 4. Continuation inspite of despite harm
- **Diversion**
 - Intentional transfer of controlled substance from legitimate distribution/dispensing channels

DEFINITION OF TERMS

- **Misuse**
 - Use of medication other than as directed/indicated - willful /unintentional - harm results or not
- **Physical Dependence**
 - State of physical tolerance manifested by drug class-specific withdrawal syndrome produced by:
 1. abrupt cessation
 2. rapid dose reduction
 3. decreasing blood level of the drug
 4. administration of an antagonist
 Physical dependence not same as addiction
- **Tolerance**
 - State of adaptation when drug induces changes result in decrease of drug's effects over time

ORIGINS OF OPIOID USE EPIDEMIC

- **Early to mid 1800's :**
 - **Opium dens of West Coast**
 - **Patent medicines with opium**
 - **Morphine derived from opium – “non-addicting” and addiction in stomach**
- **1850's**
 - **Morphine injectable to avoid “addiction” by ingestion**
 - **Frequent use in Civil War – Soldier's Disease: morphine addiction**

ORIGINS OF OPIOID USE EPIDEMIC

- **Late 1800's to 1930**
 - **Substituted morphine use to combat alcohol addiction/abuse**
 - **Morphine for women – menstrual/menopausal disorders – keep women from drinking in public**

“...convenient, gentele drug for a dependent lady who would never be seen drinking in public”

ORIGINS OF OPIOID USE EPIDEMIC

- **Cocaine**
 - 1844 refined
 - 1883: Use in Germany for soldiers to endure fatigue during battle
 - 1884: Freud used to treat morphine addition-sent to fiancé so she was more lively
 - 1885: Coca-cola produced from unrefined coca leaves – 1906 formula changed
- **Heroin**
 - 1889 Bayer Company refined
 - 10 times more potent than morphine and non-addicting
 - 1925 opium importation for heroin production finally banned

FEDERAL LAWS

- **1906 Pure Food and Drug Act**
 - Required labelling of opiate contents
- **1914 Harrison Narcotic Act:**
 - Criminalization of recreational use of Opium, Morphine, Cocaine
 - Drugs still legally available requiring registration, documentation, taxation
- **1946** Enacted laws to control synthetic drug
- **1956** Narcotic Control Act: Enhanced existing laws including marijuana/opiates

FEDERAL LAWS

- **1970 Federal Comprehensive Drug Abuse Prevention and Control Act** -Controlled Substance Act (CSA)
 - Provided rehabilitation services for substance use disorder
 - Regulation/distribution of controlled substances
 - Regulation of Import-Export of controlled substances
- CSA administered by Drug Enforcement Agency (DEA)

Throughout history – Enacting laws did not curb illicit use of drugs
Evolving new drugs and abuse

DEA DRUG SCHEDULES

- **Schedule I Drugs:** High potential for abuse/addiction with no medical use (heroin, LSD, methamphetamine)
- **Schedule II Drugs:** High potential for abuse/addiction (opioids, stimulants)
- **Schedule III Drugs:** Less potential for abuse/addiction (buprenorphine, products >90 mg of codeine, ketamine)
- **Schedule IV Drugs:** Low potential for abuse/addiction (alprazolam, clonazepam, diazepam, lorazepam, phenobarbital)
- **Schedule V Drugs:** Even lower potential for abuse/addiction (antitussives, antidiarrheals, and analgesics)

DEA DRUG SCHEDULES

• Five classes of drugs:

1. **Opioids:** not as effective for neuropathic pain
2. **Sedative-Hypnotics:** lower arousal levels - reduce nervous system excitability
3. **Stimulants:** enhancing activity of central and peripheral nervous systems
4. **Hallucinogens**
5. **Anabolic steroids**

PUSH FOR PAIN MANAGEMENT

- 1960s: Pain management became field of medicine
- 1970s: Pain (research journal) and Internal Association for the Study of Pain
- 1980s: Prominent pain specialists push "low incidence of addictive behavior" associated with opioids

Pushed for increased use of the drugs to treat long-term, non-cancer pain

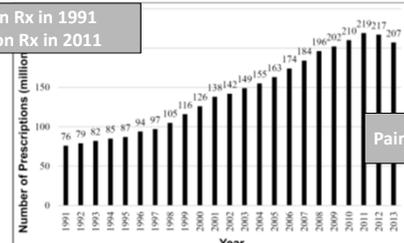
- Thus started the ..."20-year campaign, backed by the pharmaceutical industry, that convinced many physicians they could prescribe opioids more freely, and with a clean conscience..."

A short history of pain management. Collier. CMAJ. 2018 Jan 8; 190(1): E26-E27

JOINT COMMISSION STANDARDS

2001 Joint Commission on Accreditation of Healthcare Organizations (now The Joint Commission), issued pain management standards

Figure 1. Opioid Prescriptions Dispensed by U.S. Retail Pharmacies, 1991-2013.



Pain: 5th Vital Sign

2018 JOINT COMMISSION STANDARDS

New standards for pain assessment in effect in 2018

1. Identify psychosocial risk factors affecting self-reported pain
2. Involve patients in developing treatment plan, measurable goal setting and realistic expectations
3. Focus reassessment on pain impairment of physical function
4. Monitor opioid prescribing patterns
5. Promote non-pharmacologic pain treatment approaches

Joint Commission's Pain Standards: Origins and Evolution. David Baker. May 27, 2017

HEALTH CARE PROVIDERS ATTITUDES

- "Sufferer" outlook: willing to prescribe easily
- "Seeker" outlook: exhibiting mistrust of self-reported pain

COST TO SYSTEM

- 130 people in US die from opioid overdosing DAILY
- “The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.”

From NIH National Institute on Drug Abuse: Opioid Abuse Crisis. <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>

COST TO SYSTEM

- **Big Pharma role:**
- 1990s: pharmaceutical companies tell medical community prescription opioid pain relievers are not addicting when prescribed for pain
- 2017: > 47,000 Americans died from opioid overdose
- (prescription opioids, heroin, and illicitly manufactured fentanyl)
- 2017: 1.7 million people in US suffered from prescription opioid substance use disorders
- 2017: 652,000 suffered from heroin use disorder
- Pockets of high abuse in US

JUST THE FACTS

- 21 - 29 % of patients prescribed opioids for chronic pain misuse them
- 8 -12 % develop an opioid use disorder
- 4 - 6 % who misuse prescription opioids transition to heroin
- 80 % who use heroin first misused prescription opioids
- 30% increase in opioid overdoses: July 2016 to September 2017 for 52 areas in 45 states
- 70% increase in opioid overdoses Midwestern region: July 2016 to September 2017
- 54% increase of opioid overdoses in large in 16 states

From NIH National Institute on Drug Abuse: Opioid Abuse Crisis. <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>

OTHER IMPACTS

- Rising incidence of neonatal abstinence syndrome
 - Neonates born addicted
- Increase in injection drug use added to spread of infectious diseases
 - HIV
 - Hepatitis C
- Life expectancy in US went down by about 3 months from 2000-2015 due to opioid overdoses (Contribution of Opioid-involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015 Dowell, et al. JAMA. 2017;318(11):1065-1067. doi:10.1001/jama.2017.9308)

HEAL

- NIH HEAL (Helping to End Addiction Long-termSM) Initiative
- aggressive, trans-agency effort to speed scientific solutions to stem the national opioid public health crisis
- The NIH HEAL InitiativeSM will bolster research across NIH to improve treatments for opioid misuse and addiction and enhance pain management.

<https://www.nih.gov/research-training/medical-research-initiatives/heal-initiative>

PAIN DEFINITIONS

- **Acute Pain:** Typically sudden with known cause -injury, surgery, infection
- **Chronic Pain:** Lasting longer than 3 months typically from underlying condition, such as arthritis
- Neuropathic vs non-neuropathic pain

APPROACHES TO REASONABLE ACUTE PAIN CONTROL

- American Pain Society and American Academy of Pain Medicine task force clarified the classification of acute pain, the role of psychosocial factors, multimodal pain management, new non-opioid therapy, and the effect of the “opioid epidemic” in their joint report.
- Suggested that opioid treatment as short as 10 days can lead to opioid dependency and up to 15% of surgical patients may become dependent following the perioperative use of opioids
- Recent advances in acute pain management: understanding the mechanisms of acute pain, the prescription of opioids, and the role of multimodal pain therapy. Wardhan et al. F1000Res. 2017; 6: 2065.

APPROACHES TO REASONABLE ACUTE PAIN CONTROL

- Psychosocial factors - anxiety or tendency to magnify/dread pain and feel helpless in context of pain (pain catastrophizing) play major role in development of chronic pain
- SCOPE trial (Stepped Care to Optimize Pain care Effectiveness) studied the independent effects of depression, anxiety, and pain catastrophizing on pain outcomes
- Concurrent use of primarily non-opioid analgesics to take advantage of the additive, if not synergistic, effects that produce superior analgesia while decreasing opioid use and opioid-related side effects
- Recent advances in acute pain management: understanding the mechanisms of acute pain, the prescription of opioids, and the role of multimodal pain therapy. Wardhan et al. F1000Res. 2017; 6: 2065.

ACUTE PAIN MANAGEMENT-STEPS TO CONSIDER

- 1. Non-drug pain management**
Hot-cold compresses, artificial tears, bandage CL, etc
 - 2. NSAIDs**
Decrease opioid consumption by 25–30% (Topical NSAIDs, oral NSAIDs)
 - 3. Acetaminophen**
Be highly selective with additive not necessarily synergistic effect when combined with NSAIDs
 - 4. Tramadol**
Weak opioid agonist (binds to μ -opioid receptor-inhibiting serotonin/norepinephrine reuptake)
- Recent advances in acute pain management: understanding the mechanisms of acute pain, the prescription of opioids, and the role of multimodal pain therapy. Wardhan et al. F1000Res. 2017; 6: 2065.

ACUTE PAIN MANAGEMENT-STEPS TO CONSIDER

- 5. Ketamine**
NMDA-blocking ability and has emerged as front-runner in for perioperative pain (Use in eyecare??)
- 6. Gabapentin and pregabalin**
Anticonvulsants but are also neuromodulators (reduce neuronal excitability)
- 7. Opioid-Acetaminophen combinations**
Postoperative pain management, work synergistically, reducing pill burden

Recent advances in acute pain management: understanding the mechanisms of acute pain, the prescription of opioids, and the role of multimodal pain therapy. Wardhan et al. F1000Res. 2017; 6: 2065

PROVIDER DOCUMENTATION RULES - PRESCRIBING

February 2019

- 15 states acute pain opioid prescribing limit - 7-day supply
(Alaska, Hawaii, Colorado, Utah, Oklahoma, Louisiana, Missouri, Indiana, West Virginia, South Carolina, Pennsylvania, New York, Maine, Connecticut, Massachusetts)
- 3 states acute pain opioid prescribing limit - 5-day supply
(Arizona, North Carolina, New Jersey)
- 1 state limit opioid prescribing initial limit to 14 days (Nevada)

PROVIDER DOCUMENTATION RULES - PRESCRIBING

- Minnesota 4 day limit for acute dental or ophthalmic pain
- 3-4 day limit on initial opioid prescribing (Tennessee, Kentucky, Florida)
- **Post surgical procedures**
- Arizona, Nevada - 14 day supply
- North Carolina 7-day supply

PATIENT CONTRACTS IF PRESCRIBING

Contracts designed to promote good communication, clear expectations, and trust between provider and patients

1. Inform of addition possibilities
2. No more Rx if patient breaks agreement
3. Discusses need to taper off if on for more than specific time to avoid withdraw symptoms
4. Use no illegal substances while using Rx Opioids
5. Will not misuse prescription medication
6. Will not share medication
7. Will refill only as due and not early
8. Add pharmacy information and not pharmacy hop

PRESCRIPTION DRUG MONITORING PROGRAMS (PMDP)

PDMPs Best practices:

1. Universally used prior to prescribing
2. Real time updates for accurate data and information
3. Actively managed to be accurate
4. Easy access and Use

PRESCRIPTION DRUG MONITORING PROGRAMS (PMDP)

PDMP resulted in changes in prescribing behaviors, reduced use of multiple providers by patients, and decreased substance abuse treatment admissions in states with good programs

Currently Missouri is only state without a PDMP

49 states, District of Columbia and Guam have legislation authorizing the creation and operation of a PDMP

ABUSE DETERRENT OPIOID FORMULATIONS

- Properties consist of physical and/or chemical means by which the pills resist manipulation and create a barrier to unintended administration, such as chewing, nasal snorting, smoking, and intravenous injection
- Majority of opioid abuse is by swallowing so ?? Impact of abuse deterrent formulations
- Not abuse proof not tamper proof but ABUSE DETERRENT

[Understanding Abuse Deterrent Opioids - FDA](#)

Abuse-Deterrent Categories 

Physical/chemical barriers	• Prevent chewing, crushing, cutting, grating, or grinding and can include chemical barriers like gelling agents or solvents to limit mechanical manipulation
Agonist/antagonist combinations	• Antagonist added to release upon manipulation and interfere, reduce, or defeat euphoria associated with abuse
Aversion	• Added substances to produce unpleasant effect upon manipulation e.g. nasal irritant
Delivery system	• Release designs or drug delivery that offers resistance to abuse e.g. sustained-release depots
New molecular entities and prodrugs	• New molecular entity or prodrug with different receptor binding profiles, need for enzymatic activation, CNS penetration, or other novel effects
Combination	• Two or more of the above methods combined to deter abuse
Novel approaches	• A new approach or technology not captured in aforementioned categories

SPOTTING DRUG SEEKING PATIENTS

Do not be fooled

- Signed to watch for potential abuse
- Communications with colleagues when indicated
- Must be seen right away and toward end of day
- Calls or comes in after regular hours
- Traveling through town, visiting friends or relatives , does not live in your town
- Feigns physical problems that may be inconsistent with findings to obtain narcotics
- States specific non-narcotics do not work or allergic
- States that prescription has been lost or stolen so wants replaced

SPOTTING DRUG SEEKING PATIENTS: DOS –DON'TS

DO:

- Perform appropriate, thorough examination and document results and questions
- Request picture I.D., or other I.D. and Social Security number and photocopy documents
- Call previous provider or pharmacy to confirm story
- Confirm telephone number provided by patient
- Confirm current address at each visit
- Write prescriptions for limited quantities IF you prescribe

DON'T:

- DO NOT "take their word for it" if suspicious
- DO NOT dispense drugs just to get rid of drug-seeking patients
- DO NOT prescribe controlled substances outside the scope of practice or in absence of formal practitioner-patient relationship

SECURING YOUR PRESCRIPTION PADS AGAINST THEFT

DEA Guidance for Safeguards for Prescribers

- Keep all prescription blanks in a safe place where cannot be stolen; minimize number of pads in use
- Write out actual amount prescribed in addition to number to discourage alterations of the prescription order
- Use prescription blanks only for writing prescriptions - not for notes
- Never sign prescription blanks in advance
- Assist pharmacist if call to verify information about prescription order to ensure the accuracy of prescription
- Contact nearest DEA field office to obtain or to furnish information regarding suspicious prescription activities
- Use tamper-resistant prescription pads

ERX VERSUS WRITTEN PRESCRIPTIONS

- E-prescribing for Controlled Substances is permitted in all states and many states require E-prescribing – check with your specific state
- When combining Erx with comprehensive medication history reduces prescriber and pharmacy hopping, enables better prescription tracking, and reduces fraud

PROVIDING EDUCATIONAL MATERIALS FOR PATIENTS

- Waiting room information on opioid abuse and resources for help if addicted- non intrusive
- Opioid discussions with patients
- Patient Use Contracts if prescribing

ARE OPIOIDS NECESSITY IN EYE CARE

- How often are Opioids REALLY necessary in eye care
- Always try non-drug and non-opioid approaches first
- Case for opioids: When alternatives just do not help
 - Patient with thorn penetration into eye, question of toxin reaction, acute severe pain without relief from NSAIDs/acetomenophin or tramadol- prescribed opioid for 48 hours provided relief

WHEN OPIOIDS ARE NECESSARY

1. **Educate your patients** about safe use of prescription opioids
2. **Remind your patients** that medications should be stored out of reach of children – and in a safe place
3. **Talk to your patients** about the most appropriate way to dispose of expired, unwanted and unused medications.

SPOTTING DRUG-SEEKING PATIENTS/PRACTICE VISITORS

- Be wary of practice visitors who are not patients
- Be wary of visitors asking to use the bathroom
 - Drugs can be wrapped in plastic - placed underneath or in toilet tanks for later pick up
 - Vents and cold air return ducts present nooks where users can put their drugs
 - Behind light switches covers and outlet plates
 - In dropdown grid ceiling panels
- Be careful to control where visitors to practice can go within practice

DILATING DRUGS AND THEIR ROLE IN DRUG ABUSE

- Reports of dilation drops being stolen from practices...WHY?
- Reported the use of tropicamide as injectable by intravenous drug
 - help with the symptoms of opiate withdrawal
 - reported hallucinogenic and euphorogenic effects
- Earliest report was United Kingdom in August 2011
- Known as 'seven-monther' — the amount of time it takes to kill
- Reports including Internet blog reports by drug users —...indicated the effect to be "enjoyable" and "fun," but also "horrific," "scary" and "dangerous."
- Least you think this is isolated...several reports in Optometry Office in Asheville, NC of person stealing dilation drops from practices

DEA DRUG DISPOSAL SITES

- <https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1>

NAXOLONE

Naxolone access

- 41 states have legalized its sale without a prescription
- Many states have Health Department standing orders to allow pharmacist to dispense
- Other locations: many needle exchange programs and community organizations that work with drug abuse

Naxolone Use

- Binds to opioid receptors in the brain in place of opioid drugs preventing opioids from binding
- Can temporarily reverse an overdose
- **Naloxone** begin within 2-5 minutes after the medication is administered

SUMMARY

1. Seriously consider if opioids are necessary
2. Seriously consider alternative pain management: ibuprofen/acetaminophen
3. Maximum initial Rx for acute pain – know your state Minimum necessary is good rule of thumb
4. Be very alert to possibility of drug seeking patients

•Thank you!!