Fulfilling our Obligation to Improve Opioid Safety

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SCHOOL OF MEDICINE
INDIANA UNIVERSITY

Learning Objectives

1. Learn the specifics of Indiana's new acute pain opioid legislation and understand its goal of limiting opioid prescribing, recognize when it is to be applied, and learn documentation requirements to provide more than 7 days of supply.
2. Understand why extra precaution should be used when prescribing opioids for individuals under the age of 25, patients with personal history of substance misuse or addiction, patients taking benzodiazepines or other sedatives, patients with unstable mental health issues or patients with respiratory conditions.
3. Learn the reasons certain historical and physiologic factors must be considered when initiating or continuing prescribing opioids and identifying high risk clinical situations wherein opioids should likely not be continued, especially in primary care.

”uncertainty” principled or not

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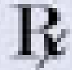
110922A12345 #00001

Lic. #: A12345
DEA #: AA7654321
NPI #: 789456123

Name Shirely Hurtz DOB 6/06/6

Address 123 Diversion Way Date 5/22/18 M/F



Percocet 5 mg

Sig.- 1-2 po each 4-6 hrs prn pain
Disp.- 120

Refill NR 1 2 3 4 5 Void After ________ ❑ Spanish

❑ Do Not Substitute-Dispense As Written

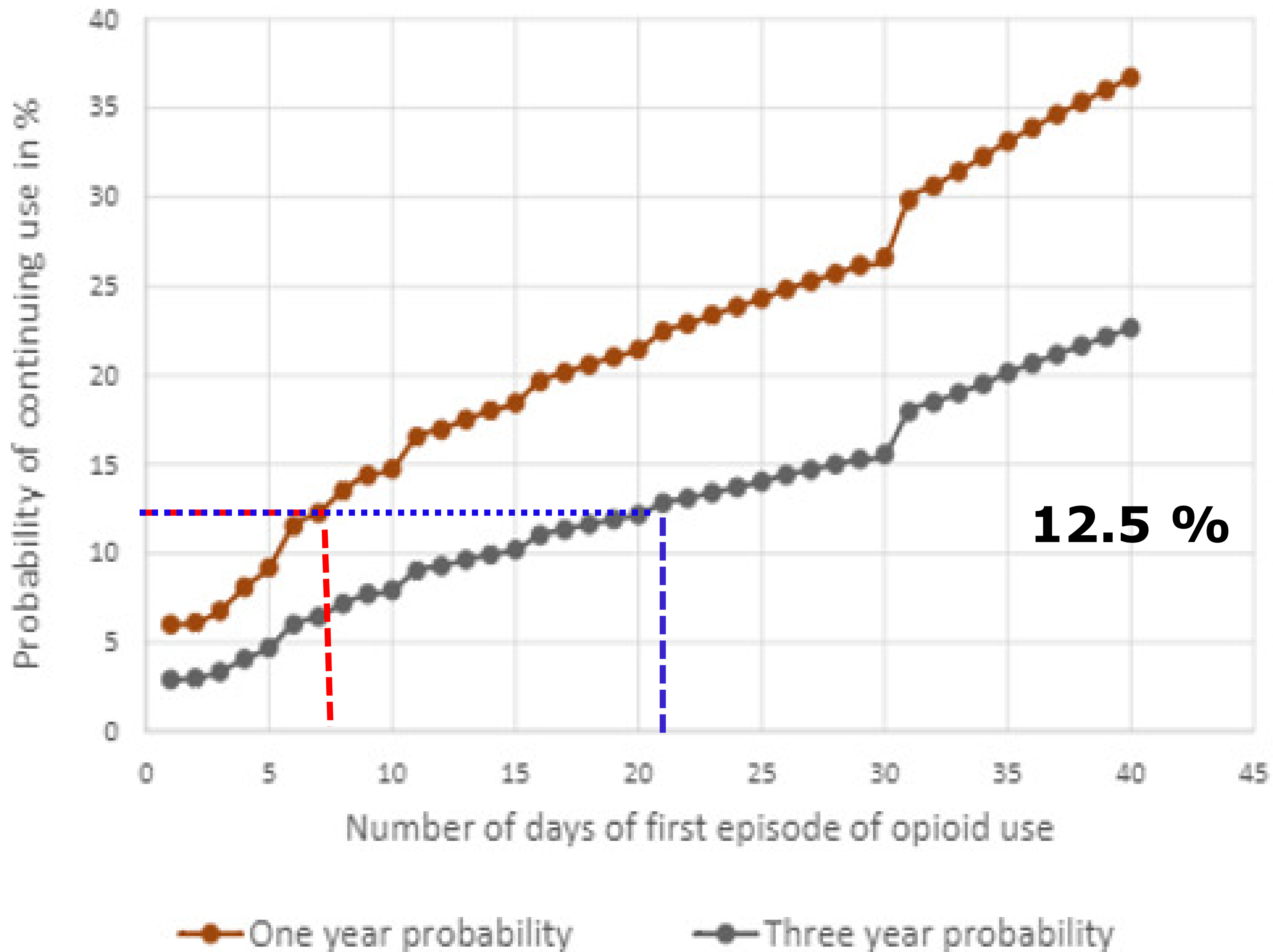
Sue D. Goode
Signature

SEE BACK FOR LIST OF SECURITY FEATURES

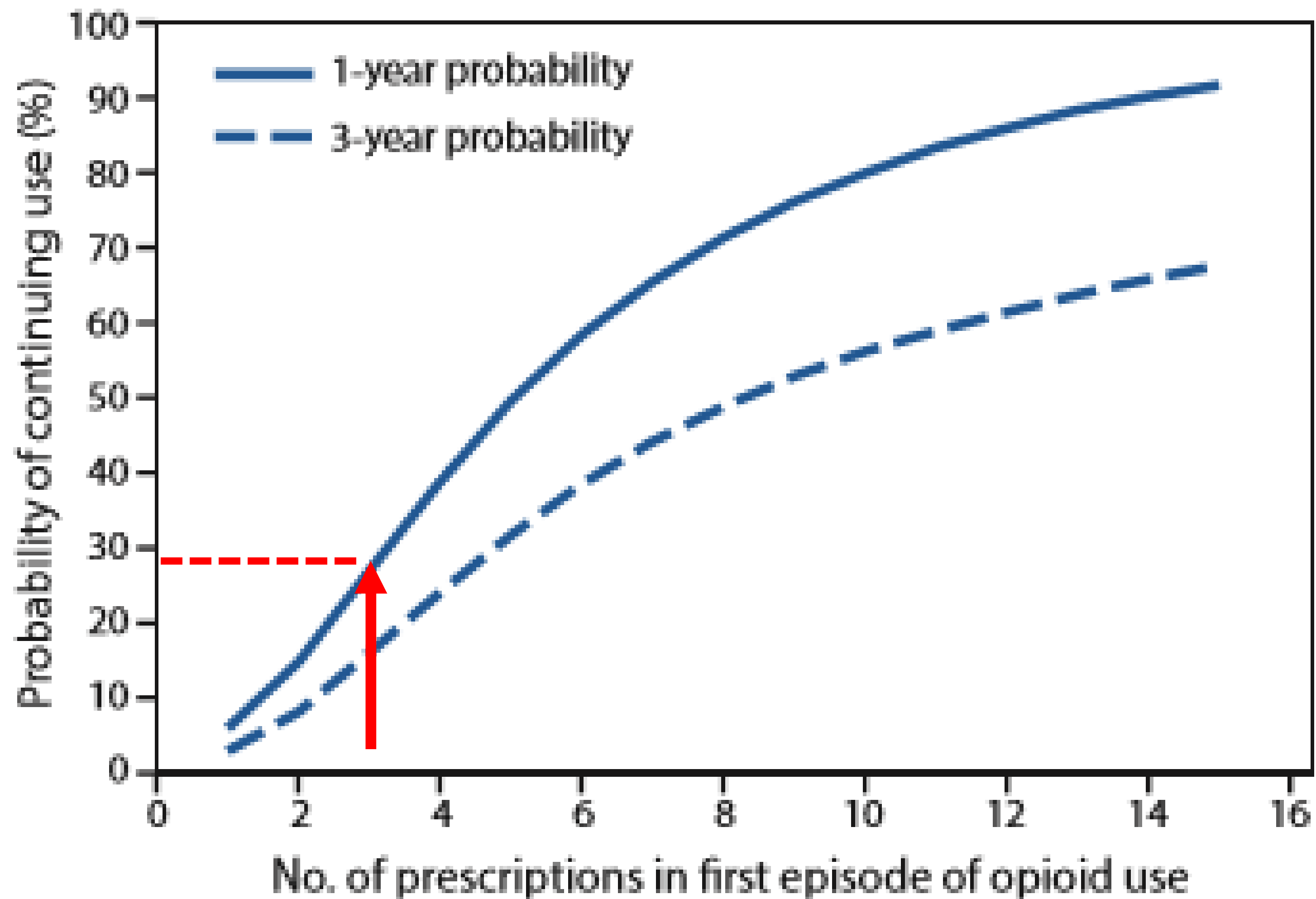
The capacity for *hope* is the most significant fact of life. It provides human beings with a sense of destination and the energy to get started.

Norman Cousins
Anatomy of an Illness

Balance Safety and Efficacy



OUD 13



MMWR / March 17, 2017 / Vol. 66 / No. 10

Points of Interest

- If an opioid naïve person is given a 7 day Rx for opioids there is a 12.5 % chance of this person being on opioids @12 months
- Tramadol and high dose a initiation were predictive of long term use
- A 21 day Rx is associated with 12.5 % risk of being on opioids at 3 years
- Similarly, the more Rxs one receives, the more likely opioid use will continue to 12 months or even 36 months

General Surgery in Vermont – Opioid Pills

- N 127 of 330 total patients
- Pill = 5 mg oxycodone
- Phone survey
- Based on patient recall

TABLE 2. Opioid Pills Taken

Operation	Partial Mastectomy	Partial Mastectomy With Sentinel Node Biopsy	Laparoscopic Cholecystectomy	Laparoscopic Inguinal Hernia Repair	Open Inguinal Hernia Repair
Surveys completed	20	21	48	20	18
Pills prescribed	415	490	1450	650	540
Pills taken	61 (14.7%)	126 (25.7%)	474 (32.7%)	189 (14.7%)	168 (31.1%)
Pills remaining	354 (85.3%)	364 (74.3%)	976 (67.3%)	461 (85.3%)	372 (69.9%)

1.9% obtained a refill

Ann Surg 2016

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	3	6	10	9	9.3

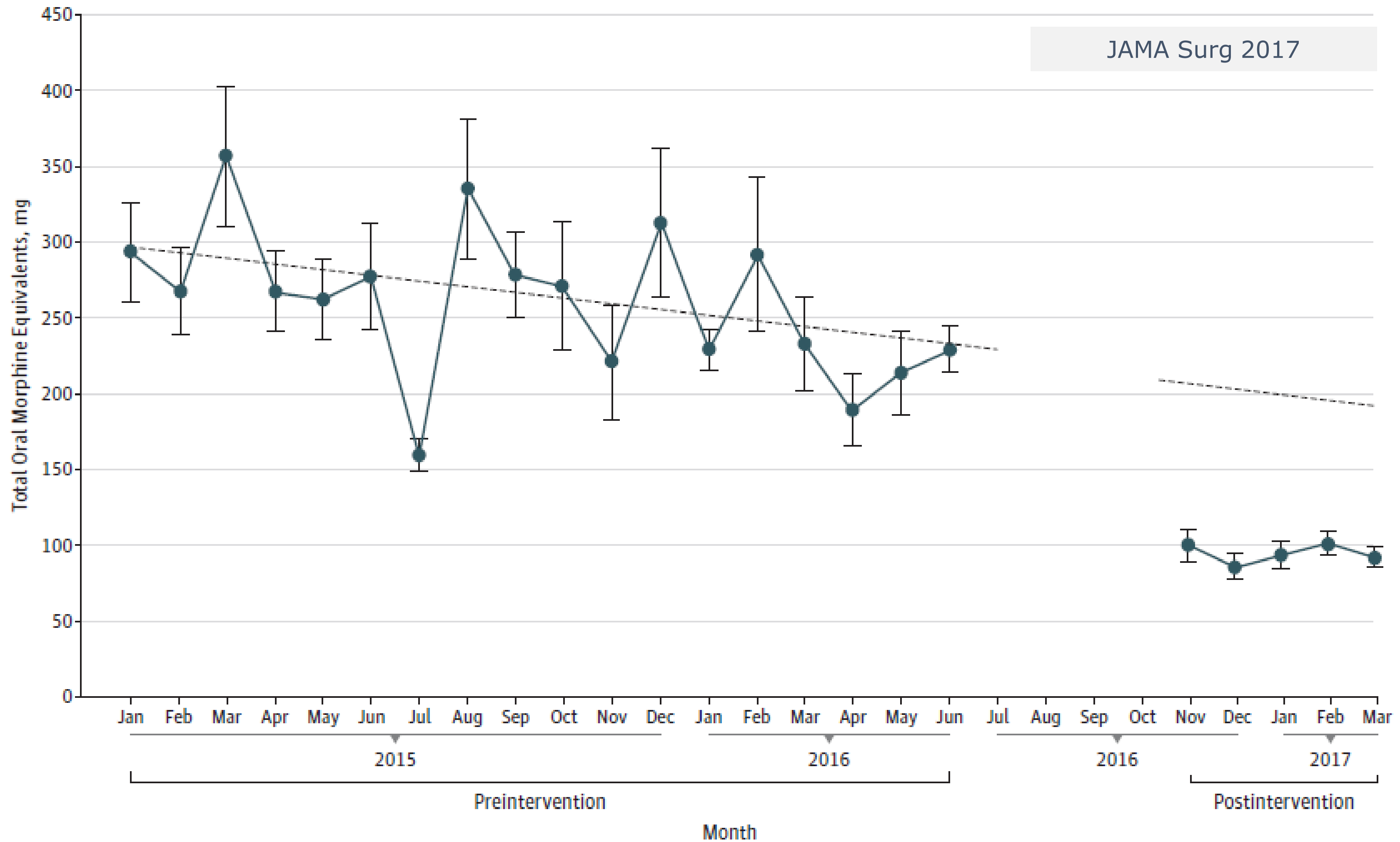
Average number of pills used

Ann Surg 2016

Defining Optimal Length of Opioid Pain Medication – Prescription After Common Surgical Procedures

- **Cohort study of 215,140**
- Median observed prescription lengths were
  - 4 days for general surgery procedures
  - 4 days for women's health procedures
  - 6 days for musculoskeletal procedures
- Rx lengths associated with lowest refill rates
  - 9 days for general surgery
  - 13 days for women's health,
  - 15 days for musculoskeletal procedures

AMA Surg 2018; 153(1):37-43



Following the implementation of evidence-based prescribing guidelines, opioid prescriptions were significantly reduced from an equivalent of approximately 45 pills of hydrocodone, 5 mg, to approximately 15 pills ($P < .001$). The dashed line represents the expected decline in prescribing prior to the study intervention.

Reduction of from 45 to 15 pills per prescription using guidelines

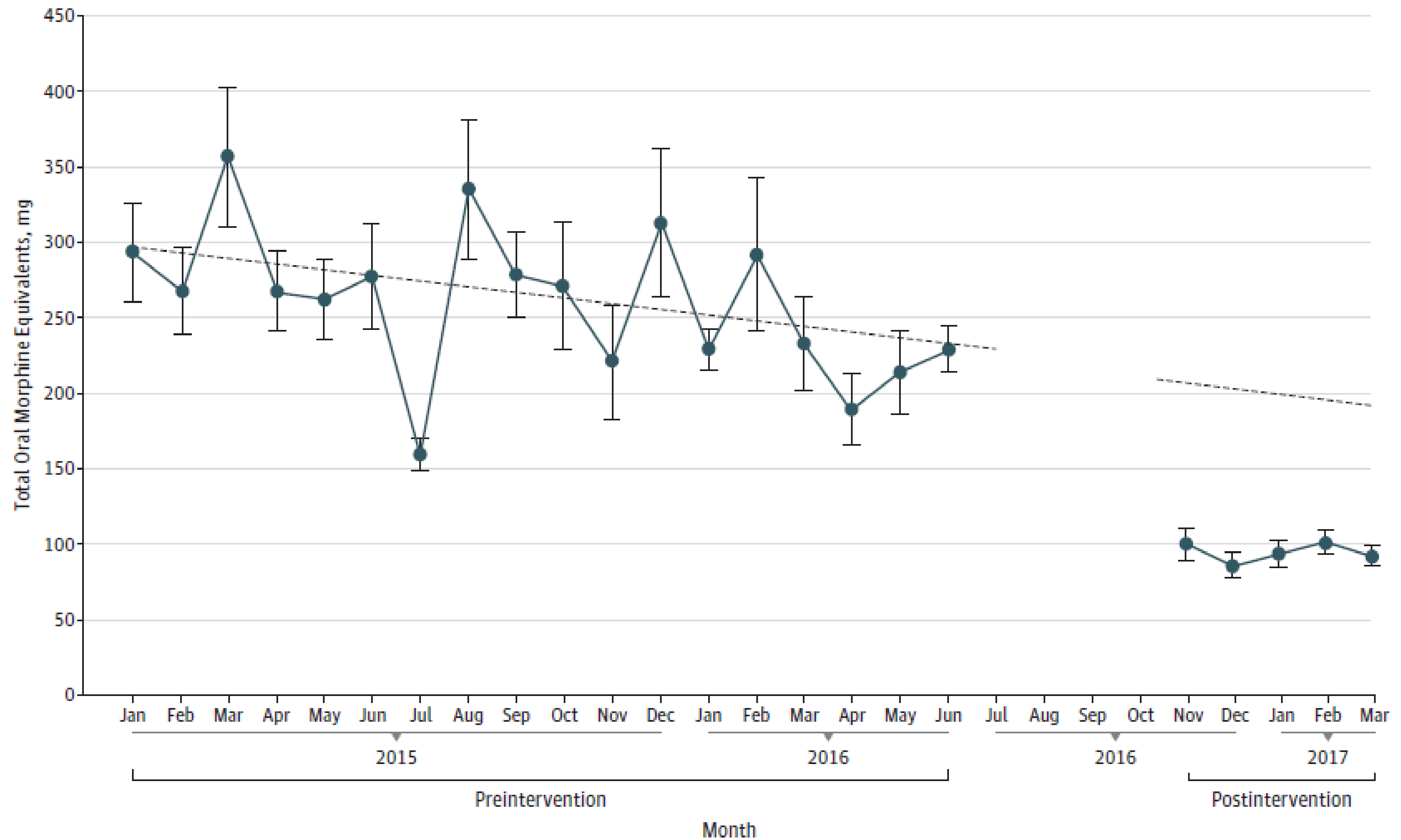
Post-op Prescription Guidelines – Elective Laparoscopic Cholecysectomy

- **University of Michigan**
- **November 2016 to March 2017**
- **Median opioid prescribed 250 to 75 mg**
- **Median opioid used from 30 to 20 mg (*P* = .04), with no change in Pain Score**
- **2.5% Pts requested refills vs. 4.1% in the pre-guideline**
- **APAP/NSAID use from 21 to 49 % (little home change)**

Reduction in opioid prescribing through evidence-based prescribing guidelines

JAMA Surg 2017

Figure. Reduction in Postoperative Opioid Prescribing After Implementation of Prescribing Guidelines.



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This represents 7000 fewer pills among this cohort

eSB 226: 7 Day *Emergency* Rules

- July 1, 2017
- Exclusions For Emergency Rule
  - MAT, cancer, palliative/hospice
- Adult 1st time Rx *by the prescriber*
- All persons < 18 yrs.
- Professional judgement out
- Partial Refill Request

eSB 226: 7 Day *Emergency* Rules

1) If the prescription is for an adult who is being prescribed an opioid for the first time by the prescriber, the initial prescription may not exceed a seven (7) day supply.

2) If the prescription is for a child who is less than eighteen (18) years of age, the prescription may not exceed a seven (7) day supply

- **Partial Refill Request**
- **Professional judgement out & document**

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- Partial Refill Request
  - Guardian/legal representative of patient or Patient
  - 30 days and then forfeit remainder
- Professional judgement out & document:
  - "professional judgement" on Rx

eSB 226: 7 Day *Emergency* Rules

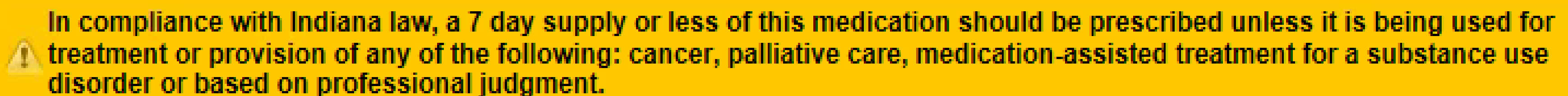
- Partial Refill Request
  - Guardian/legal representative of or the Patient
  - 30 days and then forfeit remainder
  - E.g. may elect to fill 12 of 24 tablet Rx and determine if more is required before 30 days

- Professional judgement out & document
  - If > 7 days of opioids are to be given, there must be language in the medical record justifying the professional judgement of longer duration Rx

Epic and Eskenazi

"the prescriber shall document in the patient's medical record the *indication that a drug other than an opiate was not appropriate* and that the patient is receiving palliative care or that the prescriber is using the *prescriber's professional judgment for the Exemption*"

BestPractice Advisory - Mackie,Palmer J



Acknowledge Reason

Cancer | Palliative care | Substance use disorder | Professional judgment documented | Intend to prescribe 7 days or less

Dismiss

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Lic. #: A12345
DEA #: AA7654321
NPI #: 789456123

110922A12345 #00001

Name Ima Seguro DOB 12/17/57

Address Date 10/31/17MF

Oxycodone/APAP 7.5 mg/325 mg

Sig. 1 *po* each 6-8 hr for 3 days, 1 po each 8-12 hr x 3 days, 1 po each 24 hr prn for 3 days # 44 to last 14 days . Disp. Forty-four (44) Fill on 10/31/2017 (professional judgement > 7 days indicated)

Refill NR 1 2 3 4 5 Void After ☐ Spanish

☐ Do Not Substitute-Dispense As Written

Anna Gesic MD

Signature

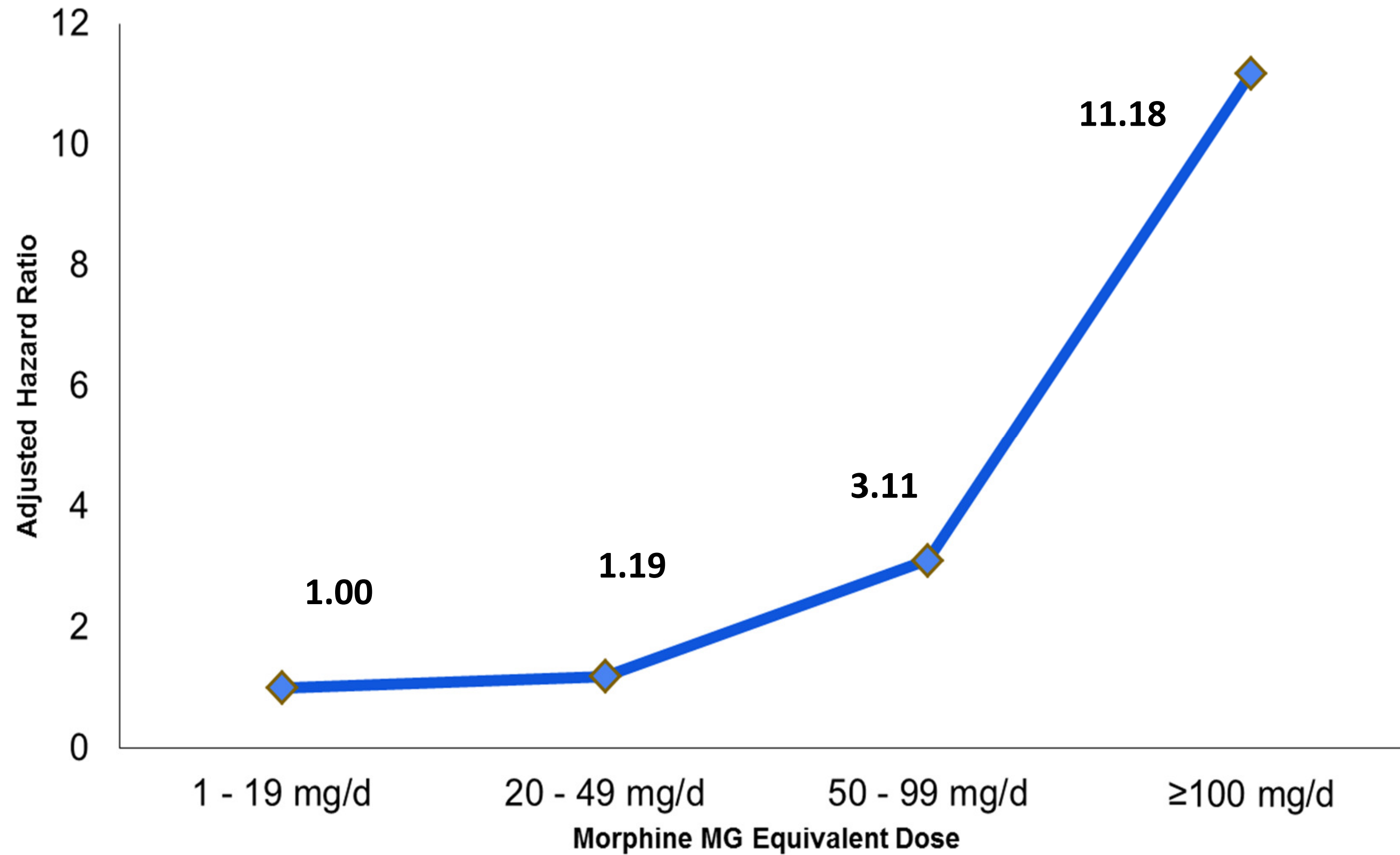
SEE BACK FOR LIST OF SECURITY FEATURES

Incentivizing Opioid Use

FIGURE 3: Manufacturer Yearly Payment Totals, 2012-2017

	2012	2013	2014	2015	2016	2017	Total
Purdue	$824,227.86	$973,328.00	$812,451.95	$935,344.00	$558,067.52	$50,135.00	**$4,153,554.33**
Janssen	$239,902.85[36]	$99,250.00	$126,000.00				**$465,152.85**
Depomed	$73,080.00	$135,300.00	$113,600.00	$350,000.00	$318,257.47	$80,879.48	**$1,071,116.95**
Insys	$14,040.00	$68,000.00	$34,200.00	$530,025.00		$2,500,000.00	**$3,146,265.00**
Mylan				$15,000.00	$2,500.00	$2,750.00	**$20,250.00**
Total	**$1,151,250.71**	**$1,275,878.00**	**$1,086,251.95**	**$1,830,369.00**	**$878,824.99**	**$2,633,764.48**	**$8,856,339.13**

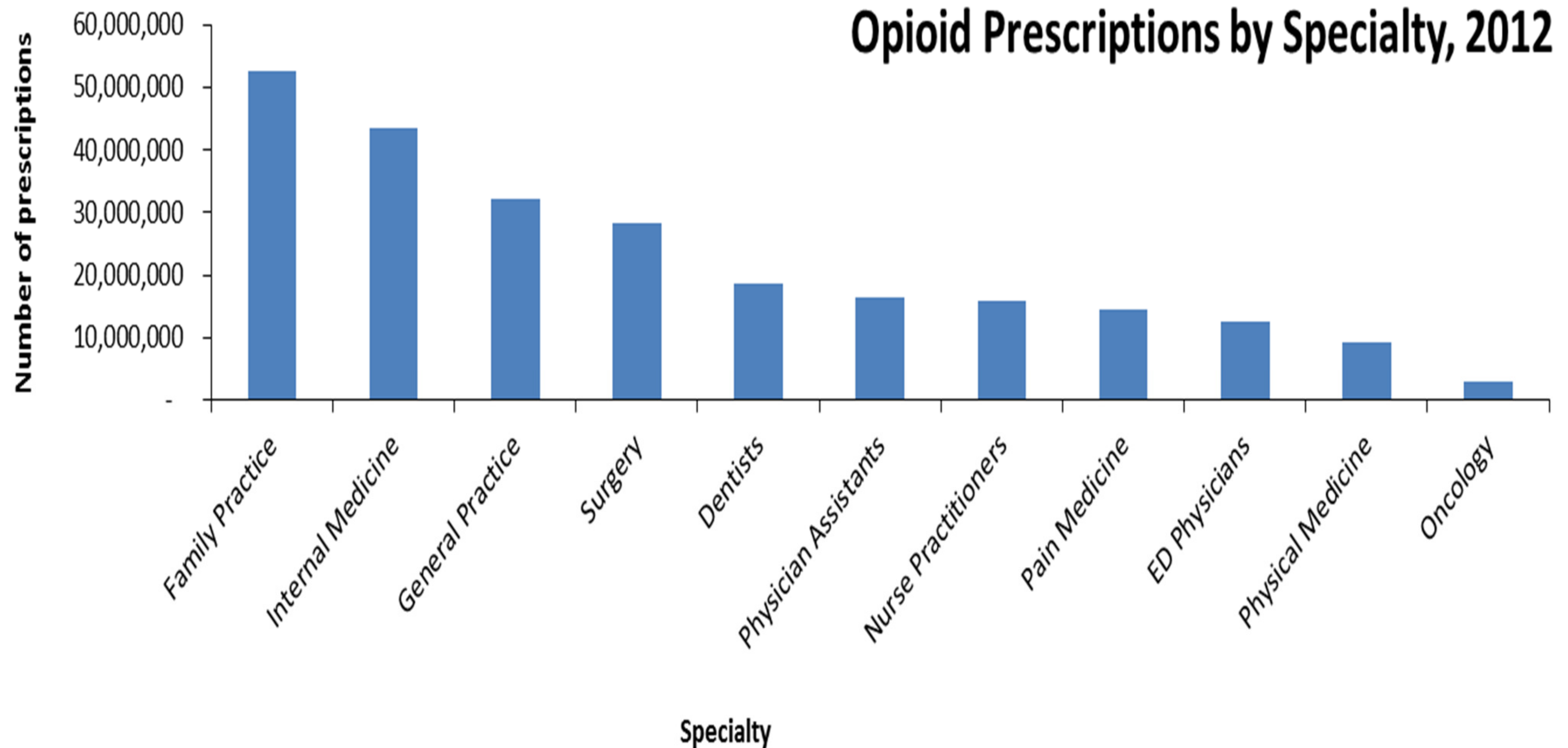
High Opioid Dose and Overdose Risk



* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure

Ann Int Med 2010;152:85-92

Primary care providers prescribe the most opioids



IMS Health, National Prescription Audit, United States, 2012

Percentage of patients seeing multiple doctors

(Patients w/ Hx overdose vs. Patients w/o Hx overdose)

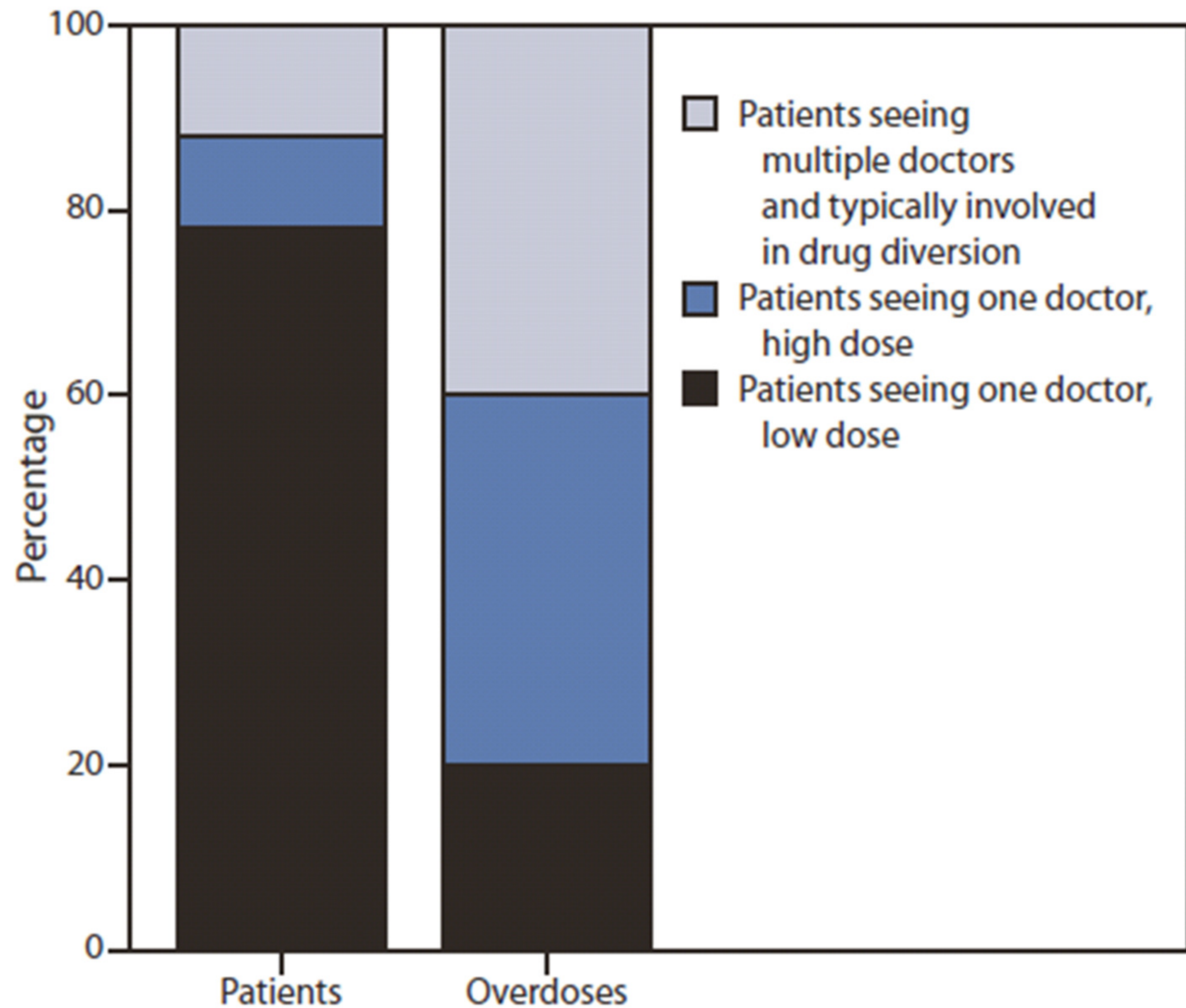
NOTICE

Patients with overdoses

- saw multiple doctors, and
- got higher dose prescriptions

more frequently

than patients without overdoses

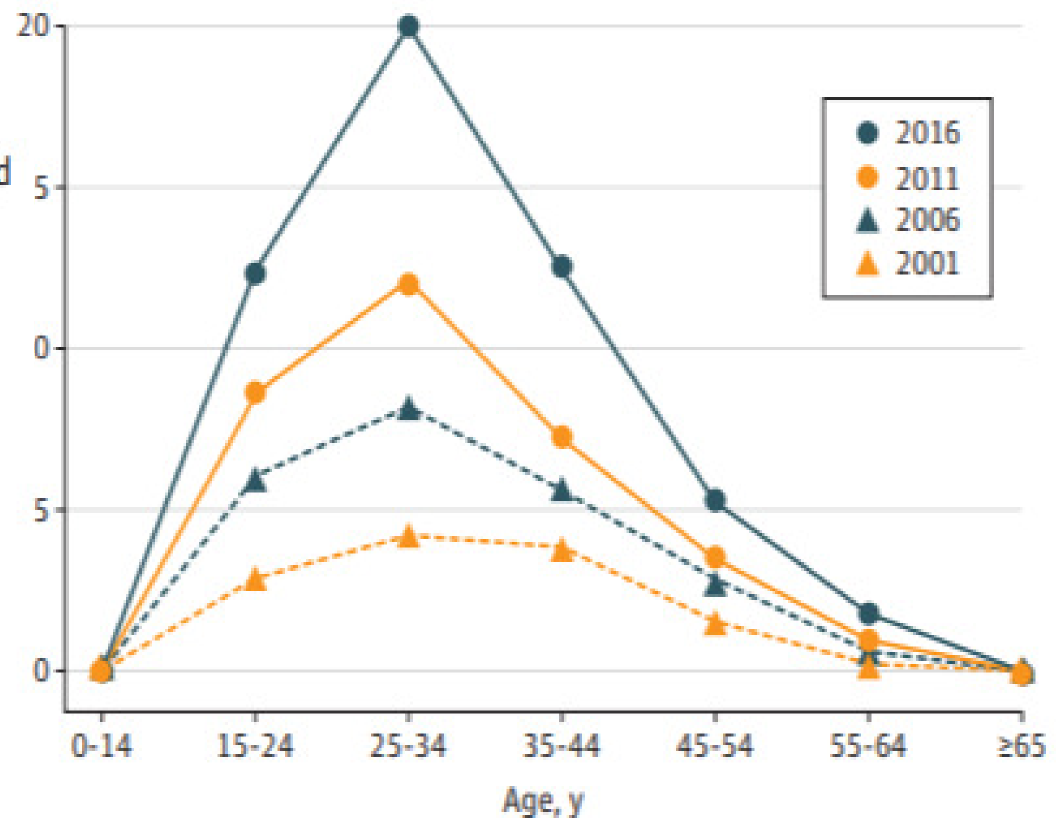


http://www.cdc.gov/mmwr/preview

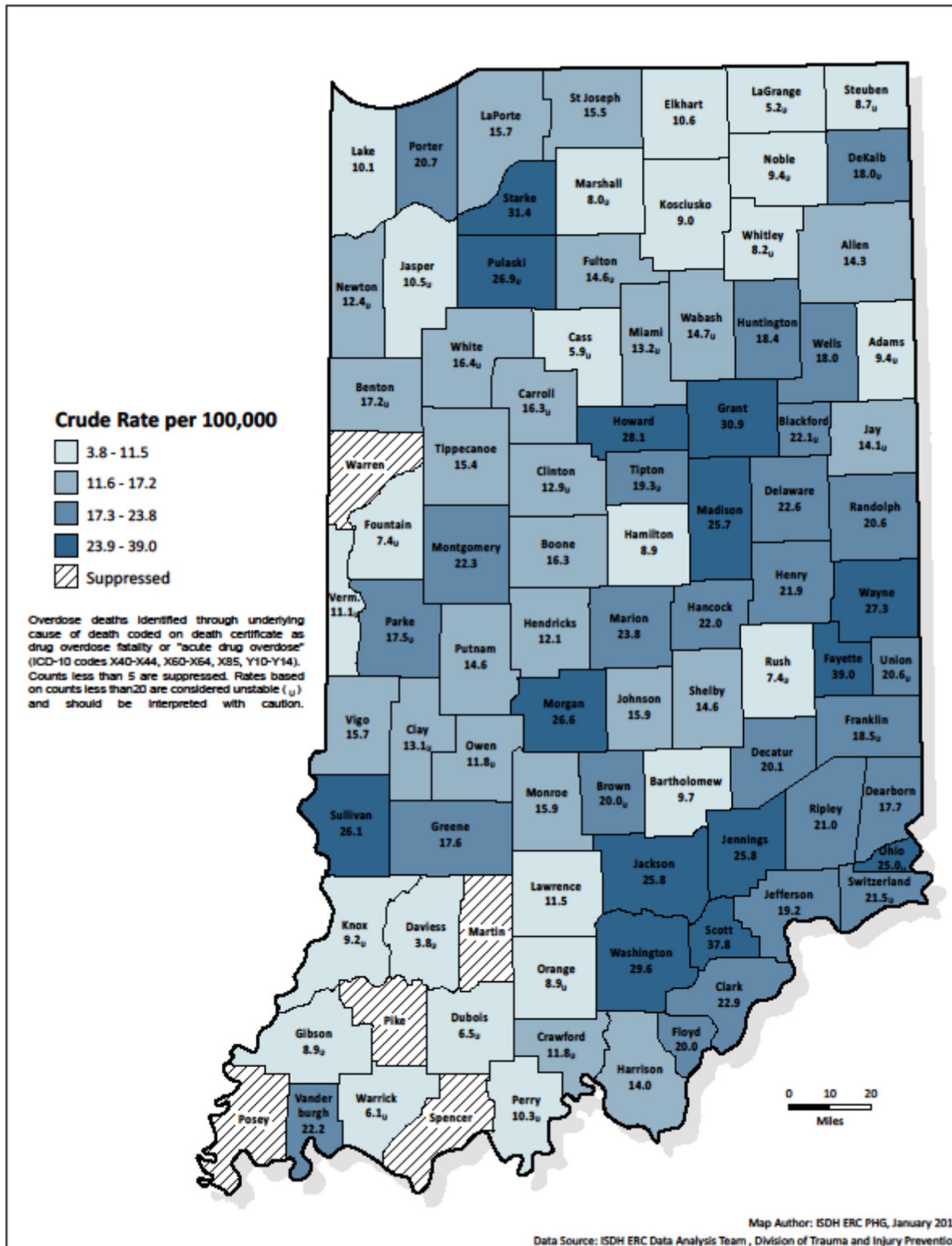
Opioids Killing Higher % Each 5 Years

Figure. Proportion of Deaths Related to Opioid Use by Age Group in 2001, 2006, 2011, and 2016

The proportion of deaths in each age group that involved an opioid was calculated using opioid-related death data and all-cause mortality data. Death data were obtained from the Centers for Disease Control and Prevention WONDER online database. This analysis was performed at four 5-year time intervals between 2001 and 2016.



JAMA Network Open. 2018;1(2):e180217.



2-04

DEATH CERTIFICATES

Overdose as cause of death (Jan 2017)

- **GREATER THAN 60% of all recent deaths in IN are opioid related**
- **13 or more counties had the highest rate**

(24-39 per 100,000)

2016 Pharmacy Dispensing Data by County, IN

County	# Opioid Rx/100 Hoosiers
Jasper	122.5
Howard	122.7
Knox	129.6
Floyd	131.9
Lawrence	132.8
Vanderburgh	137.8
Scott	149
US average	66.5
Indiana movement	83.9 from 109

Late to the Dance

- Eskenazi Health **2011**
- American Academy of Neurology **2014**
- National Safety Council **2014**
- Most Legislatures *by* **2015**
- Centers for Disease Control Guidelines **2016**
- IU's Grand Challenge **2017** and $ 50,000,000
- **American Dental Association 2018**
  - Supports Mandates on Opioid Prescribing and Continuing Education

2016 - FDA Black Box Warning

Health care professionals should **limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants** only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol.

Opioid SR and Benzo

1. greater pain, pain interference with life, and lower feelings of self-efficacy with respect to their pain
2. being prescribed “higher risk” (>200 MED)
3. antidepressant and/or antipsychotic medications
4. substance use (including more illicit and injection drug use, alcohol use disorder, and daily nicotine use)
5. greater mental health comorbidity and Health Costs

Pain Medicine 2015; 16: 356–366

Naloxone or Flumazenil

- W.VA, N= 1,049,000 on controlled Rx
- Forensic data base, N=600 RIP
- Rx for opioid/benzo 6 mo. antecedent to being a decedent

Medication(s)	OR of RIP
Benzo	7.2
Opioid	3.4
> 1 Rx for both	14.9

Med Care 2012;50:494–500

Number of Americans on Long-term Opioids

10 Million

Opioid overdose deaths rose 28 percent in 2016, to 42,000 men, women and children

Ann Intern Med 2017; 167:181–191

Universal Precautions for Opioids

2014 Indiana Medical Licensing Rules- Chronic Pain

- Perform your own evaluation
- Risk Assessment including for substance abuse
- Mental health assessment
- Review and Sign Treatment Agreement
- Functional Goals
- Educate on NAS and inquire about ETOH
- Periodic Scheduled Visits
- INSPECT Query on initiation and each 3-4 months
- UDM initially and then risk based- 2-4/year
- Reassessment is required when MED ≥ 60 mg/d

Three Objectives:

Any truth is better than indefinite doubt

1. Prescription Drug Monitoring Program
   - INSPECT
2. Drug Monitoring with confirmation
   - Urine
   - Blood
   - Saliva
3. Pill Counting
   - **Day 7-10 or Day 21-25**
   - Providers- hands-off
   - www.drugs.com/pill_identification

UDM is **standard of care** when prescribing opioids or considering

- Detecting illicit substances
- ETG/ETS and fentanyls
- Monitoring patient adherence to prescribed medications
- UDM - at initiation of an opioid trial & then each 2,4,6, or 10 months
- Interpretation is critical: Confirmatory

Treatments

- *EDUCATION*
- Progressive Exercise
- Aerobic/strength
- PT/OT
- Service to others
- Yoga/Tai Chi
- *Massage*
- Acupuncture**
- *Chiropractic*
- Heat, TENS, Ice
- Pacing Activity
- Purpose/Service
- Cognitive Behavioral Therapy - Mind-Body
- Diaphragmatic breathing
- Relaxation Response
- Guided Imagery & Meditation
- Goal Setting
- Fun/Bliss/enjoyment
- Non-opioid medicine
- Sleep Changes
- Food as Medicine
- *EDUCATION*

Only need to exercise on days you eat

Optimize Non-Opioid Medications

MSK/Inflammatory pain

- Acetaminophen
- NSAIDS
- Topical anesthetics (lidocaine)
- Anti-inflammatory cream
- Steroid injections
- Muscle relaxants

Restore Sleep

- Melatonin, TCA's
- Trazadone, doxepin

Neuropathic Pain

- TCA's
- SNRI's
- Topical anesthetics
- Neuropathic creams
- Anticonvulsants
- Alpha linolenic acid

Patient Education
Long-term Opioid Risks

- Hyperalgesia
- Affective Challenges
- Immunosuppression
- Falls/fractures
- Myocardial Infarction
- Androgen deficiency/Decreased libido
- Osteoporosis
- Opioid tolerance/dependence/addiction
- Respiratory Depression
- Death
- ***Iatrogenic Relapse***

Non-Opioid Modalities

- Medications
  - Therapeutic weans
- Interventions
  - Nerve blocks/ablations
  - Steroid injections
  - Trigger point injections
  - Stimulators
  - Alpha-stimulators
  - E-acupuncture

Prescribing Opiates: Informed Consent

- Discuss the risks and benefits of opioid TX
- Provide clear explanation to help patients understand key elements of treatment plan.
- Alcohol admonition
- Counsel women of child-bearing age about the potential for neonatal abstinence syndrome (NAS)

Exercise additional precaution with Adolescent Brain (<24 years old)

- **90%** adults with substance abuse began smoking, drinking or using drugs < 18yo (tob./etoh & drugs)
  - Primed to take risks, Immature decision making, judgment, impulse control
- **Addictive substance use physically alter brain structure & function faster & more intensely than in adults**
  - Interferes with brain development
  - Further impairing judgment
  - Significantly increase the risk of addiction

CDC Guideline for Prescribing Opioids 2016

- Exercise Therapy
  - Can improve pain & function chronic low back pain
  - Can improve function & reduce pain in OA knee, OA hip
  - Can improve well being & physical function in fibromyalgia
- Cognitive Behavioral Therapy- small positive effect on disability and can improve pain & function
- Avoid short and long acting opioids (unless end of life)
- Use lowest dose, additional precaution at 50MED/day
- Avoid dosage >90MED/day (if not improved DC or taper)

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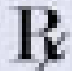
Lic. #: A12345
DEA #: AA7654321
NPI #: 789456123

110922A12345 #00001

Name Miss. B. Havyor DOB 4/06/86

Address 321 Sobriety Lane Date 5/22/18 M/F



Oxycodone/APAP 5 mg/325 mg

Sig.1-2 po each 6-8 hrs for 2 days,1 po each 6-10 hr for 2 days, 1 po each 8-12 hr as needed for 2 days, stop.
(do not exceed 8/day)
Disp.- thirty-two (26)

Refill NR 1 2 3 4 5 Void After ____________ ☐ Spanish

☐ Do Not Substitute-Dispense As Written

P. G. Yuan MD
Signature

SEE BACK FOR LIST OF SECURITY FEATURES

Is Opioid Weaning Safe & Effective

- Weaning more effective if patient engaged, feels dignified and respected
- Dose reduction must be balanced with stability of pain/function, avoiding harm related to mental health or medical issues
- 67 Studies evaluating LTOT tapering– limited by low-quality
- Common themes included multidisciplinary therapy, emphasis on nonphamacologic intervention & self care strategies
- Findings suggest that pain, function, & quality of life may improve during and after opioid dose reduction

Ann Intern Med. 2017;167:181–191. doi: 10.7326/M17-0598

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Ann Intern Med. 2017;167:181–191

Complex Persistent Dependence

- Grey area between dependence & addiction
- Patients (often on high-dose opioids/co-morbid psych conditions) who worsen with opioid taper
- Extended withdrawal symptoms
  - Anxiety, depression, sleep disturbance, fatigue, dysphoria, irritability, decreased ability to focus, deficits in executive function
- Poor pain control, psychiatric instability, functional decline, misuse
- If >90 MED, significant dysfunction, misuse, suggest Buprenorphine as mode to taper opioids

Substance Abuse, DOI: 10.1080/08897077.2017.1381663

How to manage opioid dependent chronic pain patients

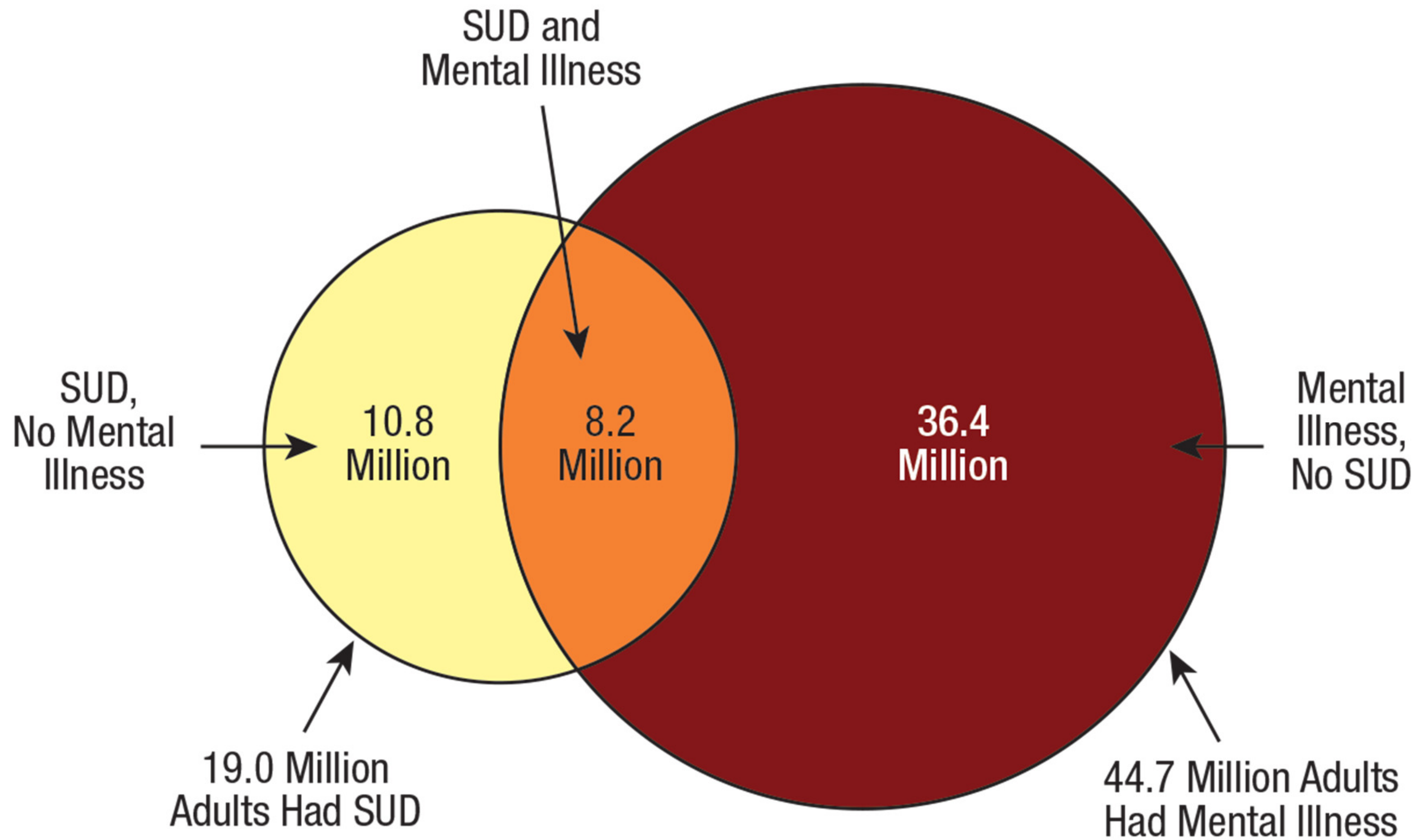
EDUCATION

- **Require "pain" specific appt for any patients on controlled substance**
- Inform patient & family about new safety data, info/laws regarding serious short & long term risks of chronic opioid use
- Educate office staff in order to do UDM, INSPECT & any forms (PHQ-9, pain inventory, COMM/ORT) before provider starts visit

Empathetic care

Do not abandon your patient

Overlap of **Mental Illness** and **SUD**



2016 NSDUH

Never start that which you will not stop: Exit Strategy at Onset

"It sort of makes you stop and think, doesn't it"

NSDUH (SAMSHA) Data 2015

- **National survey of 51,200 people from 50 states and D.C. in 2015**
- **Survey results indicated that 38% of U.S. population used an opioid in 2015 (i.e. approx. 91.8 million people)**
- **Among Adults with opioid Rx**
  - 12.5% reported misuse
  - Among these 12.5%, 16.7% indicated they had a OUD
- **Of all adults who reported misusing opioids**
  - 40% with a Rx, and 60% without an Rx
  - Among the 60%, 41% obtained opioids illicitly free from friends & family
- **Among adults who misused opioids 63% reported relief of pain as motivation**

Ann Intern Med. 2017;167(5):293-301

Low Hanging Fruit?

- prevalence of opioid abuse in chronic pain patients ranges between 20-24% across health-care settings.
  - Pain 2010, 150(2):332–339
- Lifetime prevalence of DSM-V OUD those on chronic opioids
  - 9.7 % moderate & 3.5 % severe OUD
  - Substance Abuse and Rehabilitation 2015:6 83–91

10-18% - my opinion for prevalence in those on opioids for chronic pain

Risk of OUD

Compared to no opioid prescription, the adj. odds ratios were

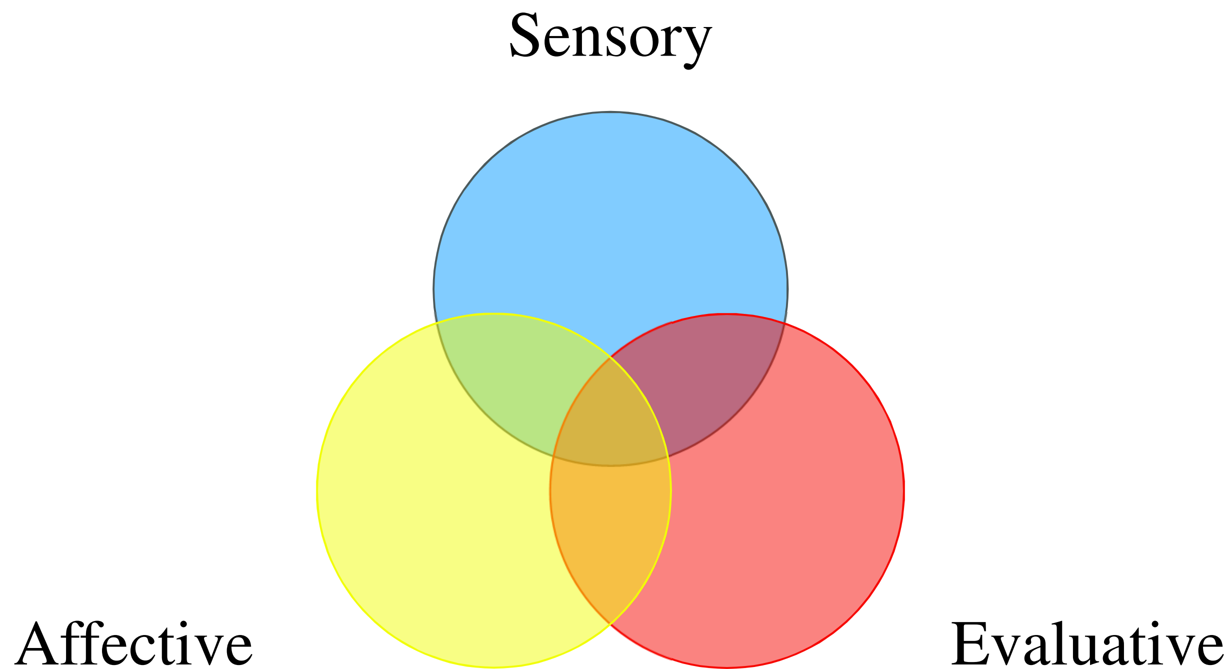
- 15 for 1- 36 MED/day
- 29 for 36-120 MED/day
- 122 for ≥120 MED/day

Clin J Pain.2014;30(7):557-564

No mindless, know mindful

1. Know the patient & contextual
2. Know the internal milieu
3. Know more than opioids
4. No more needless risks
5. Know and communicate with others

Bio-psycho-social Model



<u>Control not Cure</u>

New Normal with Realistic Optimism

Is there any chance of getting my testicles back?

Population-based, observational study using data from many sources

- Substance abuse indicators decedents 94%
- Prevalence of diversion decedents 18-24%
- Opioid analgesics used decedents 93%
- Multiple substances implicated 79%
- Had Past Med history of SUD 78 %
- Rx from 5 or more clinicians in the year prior to death was more common among women

JAMA. 2008;300(22):2613-2620

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain The SPACE Randomized Clinical Trial

- moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. 240 were randomized.
- Primary outcome Brief Pain Inventory (BPI) interference scale
- Secondary outcome was pain intensity (BPI severity scale)
- Each Arm had 3-tiers and opioid Arm went to 100 MED
- Pain intensity was signif. better in nonopioid group over 12 months

- **CONCLUSIONS** Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

JAMA March 6, 2018 Volume 319, Number 9

Are Opioids Effective for Pain?

- Studies <16 weeks
- Opioids vs placebo for pain
  - Moderate reduction in pain
  - Small improvement in function
  - Limited by high-drop out rates, excluded patient with h/o SUD

Morphia:
Hyperalgesia & Allodynia

If any man want to learn sympathetic charity, let him keep pain subdued for six months by morphia, and then make the experiment of giving up the drug. By this time he will have become irritable, nervous and cowardly. The nerves, muffled, so to speak, by narcotics, will have grown to be not less sensitive, but *acutely, abnormally capable of feeling pain* and of *feeling as pain a multitude of things not usually competent to cause it.*

S.W. Mitchell

Condition	Prevalence Chronic Pain Patients
Depression	33% - 54%[22,23]
Anxiety Disorders	16.5% - 50%[22,24]
Personality Disorders	31% - 81%[25,26]
PTSD	49% veterans[27]; 2% civilians[24]
Substance Use Disorders	15% - 28%[22,25]
PTSD, posttraumatic stress disorder.	

Gen Hosp Psychiatry. 2012;34(1):46-52
Curr Psychiatry Rep. 2006;8(5):371-376.
J Clin Psychol Med Settings. 2011;18:145-154
SCOPE of Pain Boston Universtiy

16% with mental illness get 51% of opioids

J Am Board Fam Med 2017;30:407– 417

I wish I could show you,
when you are lonely or in darkness,
the astonishing light of your own being

Hafiz

Associated with Risk of Opioid OD or SUD

Table 3. Factors Associated with the Risk of Opioid Overdose or Addiction.

Factor	Risk
Medication-related	
Daily dose >100 MME*	Overdose,[8] addiction[8]
Long-acting or extended-release formulation (e.g., methadone, fentanyl patch)	Overdose[14,41]
Combination of opioids with benzodiazepines	Overdose[42]
Long-term opioid use (>3 mo)†	Overdose,[43] addiction[44]
Period shortly after initiation of long-acting or extended-release formulation (<2 wk)	Overdose[45]
Patient-related	
Age >65 yr	Overdose[46]
Sleep-disordered breathing‡	Overdose[47]
Renal or hepatic impairment§	Overdose[48]
Depression	Overdose, addiction[49]
Substance-use disorder (including alcohol)	Overdose,[50] addiction[49]
History of overdose	Overdose[51]
Adolescence	Addiction[52]

N Engl J Med 2016;374:1253-1263.

Three Objectives:

Any truth is better than indefinite doubt

1. Prescription Drug Monitoring Program
   - INSPECT

3. Drug Monitoring
   - Urine
   - Blood
   - Saliva

2. Pill Counting
   - Early and late
   - Providers- hands-off

Risk Stratification
More Than Classic Aberrancy

- Physical condition
- Family history
- Social/Domestic
- Mental Health
- PDMP
- *Rx* Combinations
  - benzos
- Stable housing?
- Toxicology data
- Releases from Providers
  - “fired”

- Age <45, esp. < 25
- Tobacco use
- ETOH use
- Chaos/ Life Trauma Hx
- Legal history
  - Web inquiries EZ
  - DOC-site
- Abuse (sexual) history
  - Esp. when young
- Repeated traumas
  - Non-sports related

Making Pill Counts Count
Adherence and Diversion

- Write for 28 days, not 30 days
- Time *Rx*s such that the person will have some medication left at next appt.
- Request to bring in *Rx*s to each appt.
- Require 24 hr show for immediate counts
  - Day 24-26
  - Day 7-9
  - Pill Identifier(Pill finder) – Drugs.com
  - *www.drugs.com/pill_identification*

Prescription Drug Monitoring Program

- Use PDMP regularly for new and established patients to detect unsafe patterns of medication acquisition.
- PDMP is free and easy to use; www.in.gov/inspect
- PDMP query @ initiation
- *Min. 4 times per year (CDC)*

Thank you Pharmacists !

Mr. William Stone

- 55 Chronic LBP pain >10 yrs.
- COT for ~ 4.5 yrs.
- Knee
    - Mild-moderate tricompartment
- Facet degeneration, DDD
- L4-5 fusion in 2015
- Hydroc. 7.5/325 each 6-8 hr “prn”
- Tramadol 3/day Miralax, PPI, CPAP, Paroxetine, “T”
- Temazepam 15 mg/ night “prn”

William B. Stone

- Care-giver to mother, 83
- Disability 2016**
  - Half-Price Books
- 2 early RFs in last 8 months
- 2016- UDM + hydrocodone
  - No metabolites or tramadol
- Etoh- 230, 198, 347 (1987-1995)
- Cocaine + 1994
- FHx Etoh and cocaine

Willie B. Stone

Now

What?

62 male artist with pain since mva in 1994. multiple pelvic/ sacral fractures difficulties w/ bowel/bladder since - had 8" colon paralysis & R sided penile numbness. Left para-spinal pain and some wrap around R hip to thigh to "acid burning in calf"

7.5 hydro/APAP 42/28 d

- Wt. 202 lbs
- Phq9=14
- Vit D = 19
- Yard- county warning
- Pottery- rare
- Second Helpings- too painful
- Crying at times, sour affect and not engaged
- + inversion table
- Cannabis use

10 mg tid

- wt 192
- Phq9= 0
- Vit D = 53
- Yard and garden and fence
- Teaching and had show
- Regular and enjoyable
- Not crying, laughing and engaged
- +inversion table
- Urine Tox all fine > 18 months

Heigh-ho heigh-ho its off to Refill Status Quo

Naloxone, Education and Rx

Opioid Care Paradox: Mindful Medicine

Standard Approach, Individual Treatment

1) Establish the **relationship** and Hope
   - ✓ Motivation(s)
2) Educate and Engage as a Team
3) Remove opiocentric perspectives
4) Treat and Monitor as a Team
5) Focus on **Fun**ctionality
6) Poly-diagnosis & polymodal treatmer
7) Improved Outcomes
   - ➢ Safety, functionality, **$** & pain

The Ultimate Goal
Repatriation

pmackie@iu.edu

Resources

- MLB Final Rules
- http://www.in.gov/legislative/iac/irtoc.htm?id=2.3&hdate=20141105&ldate=20141105
- Poster/Flyer—Bitterpill.IN.gov
  - http://www.in.gov/bitterpill/files/First_Do_No_Harm_Poster.pdf
- CDC Guidelines
  - https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

Eskenazi Health's Integrative Pain Program
The First 14 Weeks

Improvement	1/13	5/15	3/16
Fatigue	17	38	28
Pain	*14*	*22*	*30*
Exercise	100	70	80
Pain Interfering	*46*	*30*	*19*
Emotions Interfering	36	53	33
Non-Rx to control Sx	*13*	*40*	*20*
ER visits last 6 mo	59	46	67
Hospitalized last 6 mo	*84*	*67*	*44*

2012-2014 over 50 % reduction in short acting opioids

Polyneuropathy

- N 2892 with polyneuropathy
  - 1464 treated with opioids < 90 days
  - 545 treated with opioids > 90 days
- Control 14435 with 780 on opioids > 90 days
- 82 % written by Int. Med and Fam. Med
- 52% for MSK pain and 24% for polyneuropathy
- > 90 day group 56% female and > co-morbidity
  - MI, CHF, PVD, CVA, *dementia*
  - DM, Renal Dz & *COPD*

JAMANeurol.2017;74(7):773-779

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No functional status markers were improved by long-term use of opioids

Of all the remedies it has pleased almighty God to give man to relieve his suffering, none is so universal & so efficacious as opium

Measure	Adj. Odds Ratio
Require assist device	1.9
Trouble with ADL	1.7
No longer working	1.3
Depression	1.53
Opioid OD	5.12
Opioid Dependence	2.85
Continues with pain	2.5
Trouble bathing	1.6
Opioid Abuse	3.97

American Academy of Neurology Position paper

“Opioids for chronic non-cancer Pain”

"Whereas there is evidence for significant short-term pain relief, there is no substantial evidence for maintenance of pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction."

Neurology. 2014 Sep 30;83(14):1277-84

CDC Guideline for Prescribing Opioids 2016

- In summary “ Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited with **insufficient evidence to determine long-term benefits**, though evidence suggests **risk of serious harms that appears to be dose – dependent**”