Mississippi State Department of Health

Mississippi Morbidity Report

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Opioid Prescribing in Mississippi for Chronic Pain— CDC Guideline for Healthcare Providers

Prescriptions for opioids in the U.S. have quadrupled since 1999, leading to unintentional overdose deaths, dependency and increased heroin use. Mississippi is a leading prescriber of prescription opioids, with 1.2 opioid prescriptions for every citizen in 2012.

Summary of CDC Recommendations for the Use of Opioids for Chronic Pain:

- **Use non-opioid treatments first. There is insufficient evidence to support efficacy of long term opioids.**
- **Start low and go slow. Start with 3 to 7 days of treatment and use the lowest possible dose.**
- **When required, use short acting opioids versus long acting or sustained release formulations.**
- **Check the state's Prescription Drug Monitoring Program (PDMP) with every prescription or every 3 months.**
- **Avoid concurrent prescribing of opioids and benzodiazepines.**
- **Check a urine drug screen before initiating opioids and at least annually thereafter.**
- **Connect patients with opioid use disorders to appropriate treatment including medication-assisted treatment and behavioral therapy.**

Background:

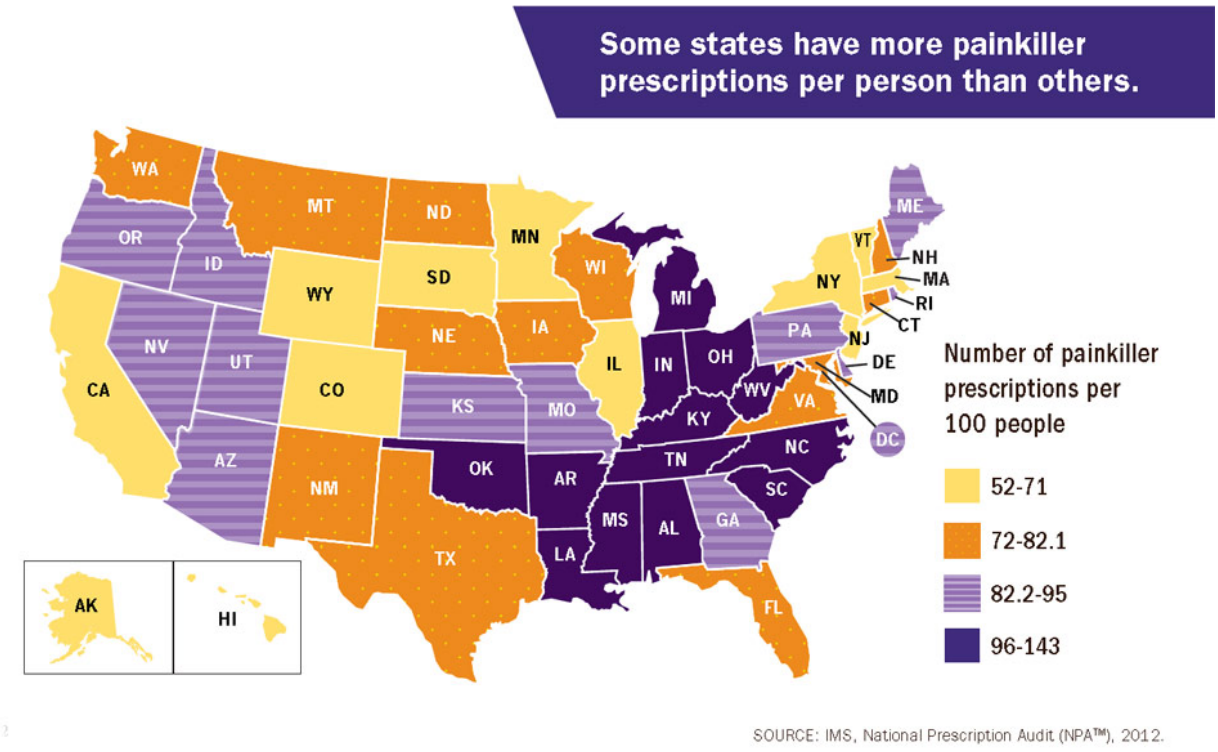
Over the past two decades, a marked increase in the use of opioid pain relievers has resulted in an explosion of opioid dependency and overdose deaths, and has fueled an epidemic of heroin addiction. Since 1999, opioid prescriptions have increased fourfold, and from 1999 to 2014 165,000 Americans have died from overdoses of prescription pain-killers. Opioid prescribing practices have driven a resurgence in heroin use, with four of five heroin users starting with prescription opioids. Given the serious consequences of long-term opioid use, the Centers for Diseases Control and Prevention (CDC) has released a guideline for management of chronic pain syndromes based on extensive review of evidence based practices.

Epidemiology of Opioid Usage and Chronic Pain:

Opioid prescriptions in the U.S. have increased 7.3% from 2007 to 2012, with healthcare providers prescribing 259 million prescriptions for opioid pain medication in 2012. The 1999-2002 National Health and Nutrition Examination Survey estimated that 14.6% of adults have current widespread or localized pain lasting at least 3 months. According to more recent data from the 2012 National Health Interview Study 11.2% of adults report having daily pain. As long-term opioid usage presents a high risk of overdose and opioid use disorder it is important to establish realistic voluntary guidelines to assist healthcare providers in the prescribing process of opioid medications.

Mississippi is a leading prescriber of opioid painkillers, prescribing 1.2 opioid prescriptions for every man, woman and child in 2012 (Figure). Hydrocodone is the most commonly prescribed opioid in Mississippi, with 145,846 prescriptions and 8,343,259 dosage units dispensed for the month of July 2016 alone (Table). There have been variable changes in prescribing patterns as demonstrated in the Table that may reflect a diminution of controlled substance prescribing or other factors such as the transition of hydrocodone from a DEA Schedule III drug to Schedule II in 2014.

Figure



Table

Snapshot of Top Five Controlled Substance Prescriptions in MS

Month	Rank (doses): 1	2	3	4	5
Jan 2013	Hydrocodone (10,404,330)	Alprazolam (3,109,115)	Zolpidem (1,366,215)	Tramadol (2,861,468)	Clonazepam (1,563,671)
July 2015	Hydrocodone (9,347,009)	Alprazolam (2,922,405)	Tramadol (3,235,436)	Oxycodone (3,102,456)	Amphetamine (1,822,969)
July 2016	Hydrocodone (8,343,259)	Alprazolam (2,691,726)	Oxycodone (2,981,140)	Tramadol (2,963,705)	Amphetamine (1,841,603)

Summary of CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*:

Long-term opioid use for chronic pain is associated with significant morbidity and mortality. Although opioid use for acute pain is clearly effective, there is insufficient evidence that long-term opioids are effective for chronic pain. These recommendations, grouped into the three areas below, are intended to improve communication between healthcare providers and patients pertaining to the risks and benefits of therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy.

Determining When to Initiate/Continue Opioids Usage for Chronic Pain: Non-pharmacologic therapy and non-opioid pharmacologic therapy are recommended as initial approaches to chronic pain. Provider and patient should have a line of communication to determine if pain and patient function outweigh risks of opioid use to the patient. Only when pain exceeds these standards should opioid prescribing should be considered but it is also coupled with non-pharmacologic therapy and non-opioid pharmacologic therapy. Realistic goals for pain and function should be discussed with the patient before opioid therapy for chronic pain is initiated. Throughout the process of opioid usage patients and clinicians should thoroughly discuss risks and benefits of opioid therapy and availability of non-opioid therapies.

Opioid Selection, Dosage, Duration, Follow up and Discontinuation: According to CDC guidelines healthcare providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. The lowest effective dosage should be prescribed with careful consideration to avoid no greater quantity than needed for the expected duration of pain. Benefits and risks should be evaluated with patient within 1-4 weeks of initiating opioid therapy or dose escalation. This line of communication should be continued with patients every 3 months or more frequently as needed with the goal to taper opioids to lower or discontinue usage.

Risk and Addressing Harms of Opioid Use: During the risk evaluation process of opioid-related harm clinicians should consider factors that increase risk of overdose such as prior history of overdose, history of substance abuse, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use. History of controlled substance use should be reviewed using the Mississippi Prescription Monitoring Program (MS-PMP) with every new prescription or at least every three months to identify risk for overdose, including concurrent benzodiazepine use, or to identify potential abuse behaviors. Urine drug testing should be conducted before initiating opioid therapy and repeated at least annually to identify substance and illicit drug abuse. For patients with identified opioid use disorder clinicians should offer or link to evidence-based treatments.

What Mississippi Providers Can Do:

The Mississippi State Department of Health recommends that Mississippi providers review the full *CDC Guideline for Prescribing Opioids for Chronic Pain** and the associated infographic** and follow the recommendations outlined in order to minimize harms from prescription opioids. Clinician should maintain awareness of the risks of opioid usage for chronic pain and have an open dialogue with patients, especially in certain special populations (older adults and pregnant women) and patients with conditions posing special risks (history of substance abuse).

* CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 Recommendations and Reports / MMWR March 18, 2016 / 65(1);1–49 https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

**Infographic: http://www.cdc.gov/drugoverdose/pdf/guideline_infographic-a.pdf

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WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately

50%

of prescription opioids dispensed

Nearly

2 million

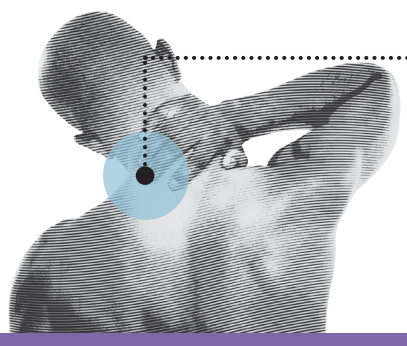
Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids

MYTH VS TRUTH

	MYTH	TRUTH
1	Opioids are effective long-term treatments for chronic pain	While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
2	There is no unsafe dose of opioids as long as opioids are titrated slowly	Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.
3	The risk of addiction is minimal	Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

WHAT CAN PROVIDERS DO?



First, **do no harm**. Long-term opioid use has uncertain benefits but known, serious risks. CDC's ***Guideline for Prescribing Opioids for Chronic Pain*** will support informed clinical decision making, improved communication between patients and providers, and appropriate prescribing.

PRACTICES AND ACTIONS

USE NONOPIOID TREATMENT

Opioids are not first-line or routine therapy for chronic pain *(Recommendation #1)*

In a systematic review, opioids did not differ from nonopioid medication in pain reduction, and nonopioid medications were better tolerated, with greater improvements in physical function.

START LOW AND GO SLOW

When opioids are started, prescribe them at the lowest effective dose *(Recommendation #5)*

Studies show that high dosages (≥100 MME/day) are associated with 2 to 9 times the risk of overdose compared to <20 MME/day.

REVIEW PDMP

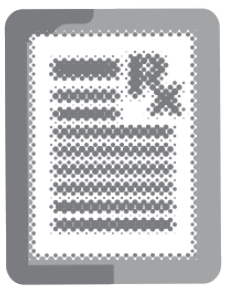
Check prescription drug monitoring program data for high dosages and prescriptions from other providers *(Recommendation #9)*

A study showed patients with one or more risk factors (4 or more prescribers, 4 or more pharmacies, or dosage >100 MME/day) accounted for 55% of all overdose deaths.

AVOID CONCURRENT PRESCRIBING

Avoid prescribing opioids and benzodiazepines concurrently whenever possible *(Recommendation #11)*

One study found concurrent prescribing to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.



OFFER TREATMENT FOR OPIOID USE DISORDER

Offer or arrange evidence-based treatment (e.g. medication-assisted treatment and behavioral therapies) for patients with opioid use disorder *(Recommendation #12)*

A study showed patients prescribed high dosages of opioids long-term (>90 days) had 122 times the risk of opioid use disorder compared to patients not prescribed opioids.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Mississippi
Provisional Reportable Disease Statistics
July 2015

		Public Health District									State Totals*			
		I	II	III	IV	V	VI	VII	VIII	IX	July 2016	July 2015	YTD 2016	YTD 2015
Sexually Transmitted Diseases	**Primary & Secondary Syphilis**	0	0	2	0	12	4	0	5	10	**33**	18	181	116
	Early Latent Syphilis	0	1	3	0	12	5	0	2	7	**30**	34	276	239
	Gonorrhea	75	46	85	44	148	44	34	68	70	**614**	†	3,790	†
	Chlamydia	159	126	176	118	408	134	88	138	186	**1533**	†	11,235	†
	HIV Disease	4	1	2	0	11	5	2	5	3	**33**	65	255	351
Mycobacterial Diseases	**Pulmonary Tuberculosis (TB)**	1	0	0	0	3	0	1	0	0	**5**	6	23	33
	Extrapulmonary TB	0	0	0	0	0	0	1	0	0	**1**	0	7	5
	Mycobacteria Other Than TB	4	1	1	3	8	1	1	3	5	**27**	28	219	277
Vaccine Preventable Diseases	**Diphtheria**	0	0	0	0	0	0	0	0	0	**0**	0	0	0
	Pertussis	0	0	0	0	0	0	0	0	0	**0**	1	1	7
	Tetanus	0	0	0	0	0	0	0	0	0	**0**	0	1	0
	Poliomyelitis	0	0	0	0	0	0	0	0	0	**0**	0	0	0
	Measles	0	0	0	0	0	0	0	0	0	**0**	0	0	0
	Mumps	0	0	0	0	0	0	0	0	0	**0**	0	0	0
	Hepatitis B (acute)	0	0	0	0	1	0	0	1	0	**2**	4	11	31
	Invasive *H. influenzae* disease	0	0	0	0	0	0	0	1	0	**1**	1	36	26
	Invasive Meningococcal disease	0	0	0	0	0	0	0	0	0	**0**	0	0	0
Enteric Diseases	**Hepatitis A (acute)**	0	0	0	0	0	0	0	0	0	**0**	0	3	0
	Salmonellosis	9	8	1	6	25	11	7	14	10	**91**	175	420	532
	Shigellosis	1	0	0	0	0	0	0	1	0	**2**	16	33	69
	Campylobacteriosis	0	0	0	1	1	0	1	7	6	**16**	28	113	112
	***E. coli* O157:H7/STEC/HUS**	0	1	0	0	1	0	0	1	1	**4**	3	13	13
Zoonotic Diseases	**Animal Rabies**	0	0	0	0	0	0	0	0	0	**0**	0	1	0
	Lyme disease	0	0	0	0	0	0	0	0	0	**0**	2	0	2
	Rocky Mountain spotted fever	0	0	0	0	2	1	0	0	1	**4**	17	33	49
	West Nile virus	0	0	0	1	3	0	0	0	0	**4**	8	8	8

*Totals include reports from Department of Corrections and those not reported from a specific District.