Welcome

Managing Pain Safely Forum Eureka

Marya Choudhry
QIP Project Manager

OBJECTIVES

- To educate the audience regarding the impact of opioids in our communities
- To provide practical tools for communicating with patients and family members regarding opioid use
- To raise awareness regarding safe and at-risk prescribing behaviors
- To provide a vehicle for networking with other healthcare professionals and stakeholders regarding community efforts

PARTNERSHIP HEALTHPLAN of CALIFORNIA

LOGISTICS

- Folders
  - Agenda
  - Presenter Biographies
  - Reference Materials
  - CURES Brochure
  - PHC and NCCN Contact List
  - Evaluation
- CME Logistics
- Q&A Process

PARTNERSHIP HEALTHPLAN of CALIFORNIA

HOUSEKEEPING

- Restroom Locations
- Electronic Devices
- WIFI Code: Marina
- Presentation Materials Online

PARTNERSHIP HEALTHPLAN of CALIFORNIA

GROUND RULES

- Begin and end on time
- Be open-minded – respect all ideas and opinions
- Use technology sparingly and place on silent
  - If you must take a call, please step out of the room
- Be engaged – participate
- Have fun!!!

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Let's get started . . .

PARTNERSHIP HEALTHPLAN of CALIFORNIA

LET'S GET STARTED

ENJOY THE FORUM!

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PHC's Managing Pain Safely Initiative

Robert Moore, MD, MPH
Chief Medical Officer

©Pittsburg Post-Gazette

PARTNERSHIP
HEALTHPLAN
of CALIFORNIA

Interventions

- Education
- HealthPlan Pharmacy Prior Authorization Changes
- Additional options for treating pain
- Community activation
- Aligned incentives

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Pharmacy Prior Authorization Changes

- Step I: Scrutinize justification for high doses of **expensive** Opioids
- Step II: Scrutinize **escalation** of high dose opioids (no matter what the price)
  - Request justification for dose escalation, pre-approve stable dose
  - Only approve escalating dose with acceptable medical justification
  - Peer-to-peer conversations where-ever possible
- Step III: Scrutinize all prescriptions for all **stable** high doses of Opioids
  - Request explanation for stable high dose
  - Difficult cases may require supporting documentation of mental health, pain specialist or pain medication oversight committee
  - Track responses with PHC-level Registry of patients on high dose opioids

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Additional options for treating pain

- Expanded Benefits
  - Podiatry
  - Chiropractic
  - Acupuncture
  - OMT
- Formulary Changes
  - Duloxetine made formulary
  - Other adjunctive non-opioid treatments covered
- Behavioral Health
  - Smooth access to supportive behavioral health treatment
  - Mindfulness/Relaxation self help tools

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Community Activation

County Coalitions:

- 8 of 14 PHC counties with active county coalitions
- Goals
  - Agree upon and disseminate standards for use of opioids and other controlled substances
  - Nurture sense of urgency at local level
  - Developed shared commitment to making improvement, with mutual accountability
  - Ensure all parts of community work together towards a common purpose, instead of working at odds with each other
- Essential elements: convening organization; local leaders
- CHCF grant support available

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Interventions

Aligned Incentives

- Intrinsic Incentives
  - Stay on the right side of the Medical Board and Department of Justice
  - Increases PCP access: decreased time on patients with chronic pain to have more time to care for other patients
- Supplementary Financial Incentives
  - Primary care pay for performance program (PCP QIP)
  - Pharmacy QIP
  - 340B QIP

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Looking Ahead in 2015

April – December 2015

- Implementation of Safe Use Now
- Support development of local Pain Management Oversight Committees
- Develop a mechanism for categorizing patients on high doses of opioids for targeted treatments
- Piloting support for interdisciplinary teams to support opioid tapering
- Targeted interventions for patients newly prescribed opioids
- Pilot provision of eConsult services for complex patients on high dose opioids
- Continued offerings of educational opportunities
- Education and coordination around addiction screening and treatment
- Education of Hospitalists, Emergency Department Prescribers, Pharmacies

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Long-Term Goals

What have others achieved?

- Multnomah County, Oregon: 75% decrease in opioid use, 40% decrease in opioid overdose deaths over a 3 year period
- Kaiser: 91% decrease in high dose opioids for non-cancer, non-terminal pain over 3 years

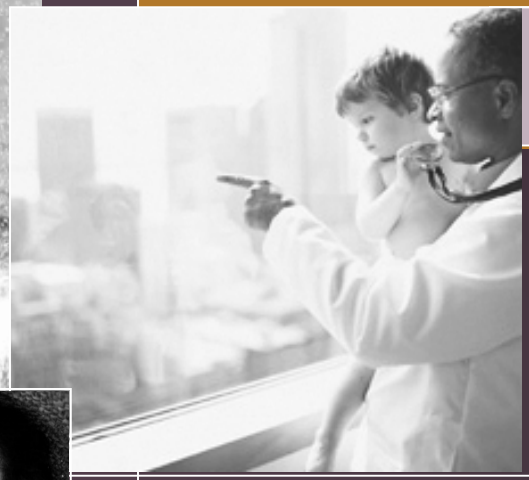
Other possibilities:

- Reduction in neonatal abstinence syndrome
- Decrease drug diversion

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Questions?



The North Coast Clinics Network

Trisha Cooke
Project Director

About us

North Coast Clinics Network

- A consortium of 13 community health centers (CHCs) serving the rural North Coast since 1995.
- Member clinics provide quality primary medical, dental and mental health services for all ages and income levels regardless of ability to pay.
- In 2014, NCCN member clinics provided over 249,000 visits for 58,000+ patients-one third of the region's population.

Partner Organizations

Network Partners:

- Open Door Community Health Centers
- Redwoods Rural Health Center
- Southern Trinity Health Services

Community Partners

- Partnership HealthPlan
- Humboldt-Del Norte Independent Practice Association
- St. Joseph Health System-Humboldt
- Mad River Community Hospital
- Humboldt County DHHS

Focus Areas

NCCN exists to assist member clinics in their efforts to meet the needs of this community and the needs of the clinics themselves through...

- **information sharing**
- **community education**
- **shared administrative activities**
- **direct services projects**

Health Home Definition

Health Home: (noun)

Pronunciation: [*mi casa, su casa*]

1. a one-stop shop with "no wrong door"
2. engages patients as empowered members of the care team
3. expands the concept of the traditional medical home model to include shared decision-making, comprehensive care management and strong coordination of community and social supports with the goal of promoting healthy choices and behaviors

Chronic Pain Initiative

- **Active participation in IPA Chronic Pain Initiative**
- **Opioid Risk Evaluation and Mitigation Strategy training**
- **Educational materials and TA for providers and staff**
- **Communication training for providers and staff**

Thank You!

TRISHA COOKE

PROJECT DIRECTOR
NORTH COAST CLINICS NETWORK
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Chronic Pain and Prescription Drug Abuse Project

Mary Meengs, Medical Director

Humboldt Independent Practice Association

Project Mission Statement

Develop and implement community standards and supporting infrastructure for:

- Diagnosis and treatment for chronic pain, providing patients with optimum care consistent with the risks of treatment;
- Diagnosis and treatment for acute pain recognizing the risks of treatment, across providers and settings prescribing opiates; and
- Strategies for minimizing misuse and diversion of prescription pain medications.

The context for the project is Humboldt's high rate of patients seeking care for chronic pain, high rate of opiate prescriptions, and high rates of mortality and morbidity relating to drug (often prescription) abuse.

The project recognizes the difficulties faced by patients with chronic pain and by clinicians who must diagnose and treat patients, some of whom intend to misuse prescribed medications and will strive for balance in this difficult and complex activity.

The key strategy will to understand the current knowledge about these subjects, developing standards and practical workflow for adoption by all clinicians and settings in the County.

Participants

- Humboldt IPA
- DHHS—Public Health & ASAP
- Partnership Health Plan
- St. Joseph Health, Humboldt
- Mad River Community Hospital
- UIHS
- Community Pharmacists
- Individual Providers
- North Coast Clinics Network

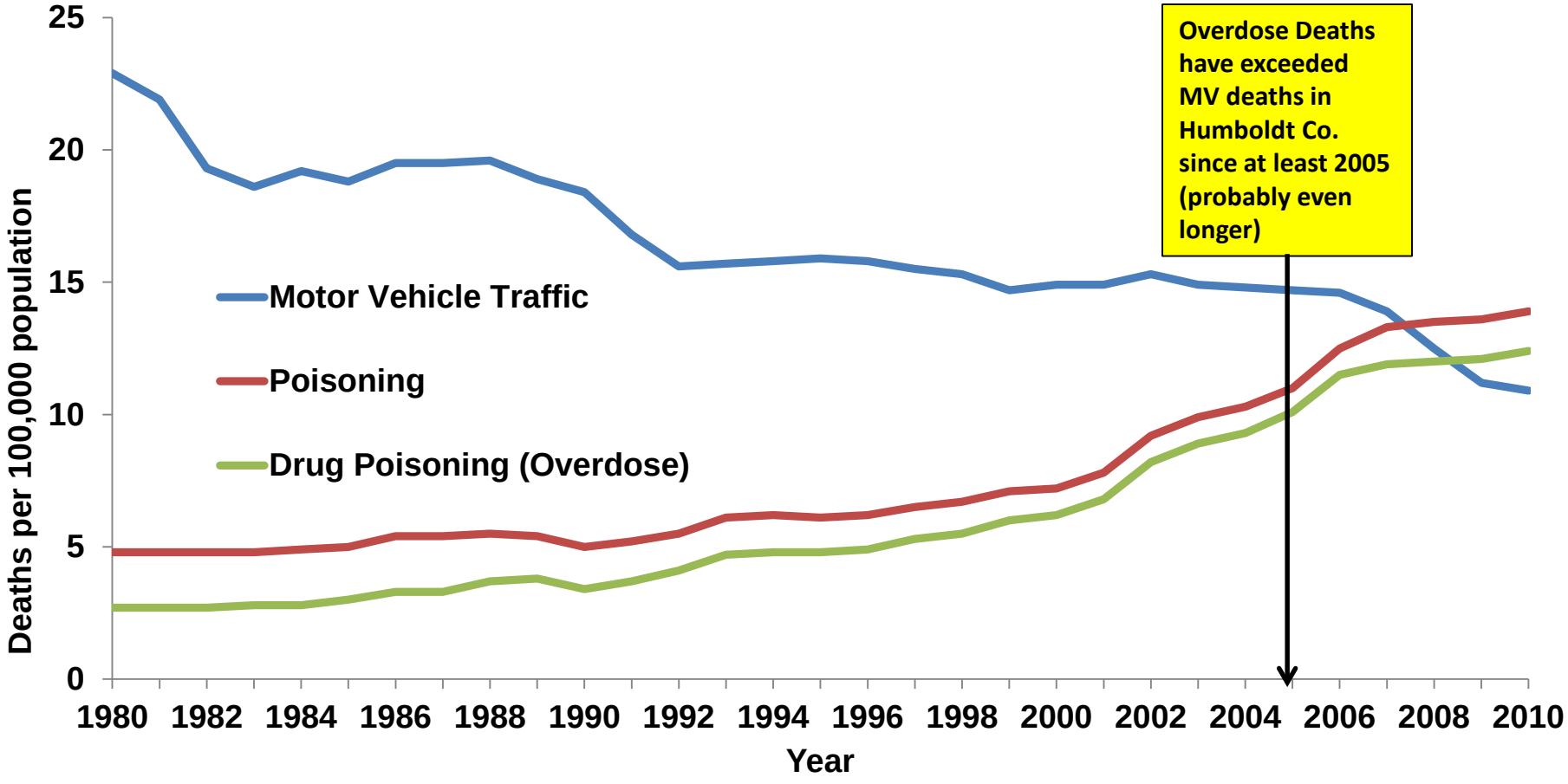
Work Groups

- Standards and Guidelines
- Communication and Care Coordination
- Data (Public Health)
- Pain Board
- Resource Inventory
- Marketing and Public Outreach

Drug and Alcohol Abuse in Humboldt County: Brief Overview

Ron Largusa MSPH
Epidemiologist
County of Humboldt DHHS-Public Health

USA: Overdoses > Motor Vehicle Traffic Injuries



Source: NCHS Data Brief, December, 2011, Updated with 2009 and 2010 mortality data. Presented at 2013 CSTE Annual Conference. Pasadena, CA. June 2013

Drug-Induced Deaths

Rates (age-adjusted) per 100,000 persons

- USA (2013): **13.8**
  - California (2013): **11.1**
    - Humboldt County Analysis (2010-2014):
      - Drug-Related: **45.3**
        - » Unintentional OD: **24.9**
      - Alcohol-Related: **39.6**
- Healthy People 2020 Objective: No more than **11.3** per 100,000

Sources: National Center for Injury Prevention and Control, CDC; 2015 CA County Health Status Profiles.

Prescription Rx—Opioid Analgesics

- In the United States (1999-2011):
  - The age-adjusted rate for opioid-analgesic poisoning deaths nearly quadrupled from 1.4 per 100,000 in 1999 to 5.4 per 100,000 in 2011.
  - Natural and semisynthetic opioid analgesics, such as hydrocodone, morphine, and oxycodone, were involved in 11,693 drug-poisoning deaths in 2011, up from 2,749 deaths in 1999

Chen LH, Hedegaard H, Warner M. Drug-poisoning deaths involving opioid analgesics: United States, 1999–2011. NCHS data brief, no 166. Hyattsville, MD: National Center for Health Statistics. 2014

Humboldt County Unintentional Overdose Deaths by Drug Type

DRUG TYPE	2010	2011	2012	2013	2014	Total
MULTI-DRUG TOXICITY	20	28	12	16	18	***94***
OPIATES & OPIOIDS	7	4	12	7	6	***36***
METHAMPHETAMINE	5	4	8	4	5	***26***
HEROIN	0	2	0	1	1	***4***
OTHER DRUG	1	0	4	3	1	***9***
ALCOHOL	1	1	0	1	3	***6***
	34	*39*	*36*	*32*	*34*	*175*

Definitions:

Alcohol = Acute, fatal alcohol poisioning

Multi-Drug Toxicity = Any combination of 2+ drugs (including alcohol, licit, and illicit drugs)

Other Drug = Any individual drug not listed here, causing ~1 annual fatality

Opiates & Opioids = includes morphine, methadone, oxycodone, fentanyl, etc.

Source: Co. of Humboldt DHHS—PH Vital Statistics

Humboldt County Deaths from Suicide by Intentional Poisoning by Type of Substance

Suicides by Poisoning YEAR

DRUG TYPE	2010	2011	2012	2013	2014	Total
MULTI-DRUG TOXICITY	3	2	5	5	7	*22*
OTHER DRUG-RX	1	2	3	0	0	*6*
OPIATE/OPIOID	2	1	0	1	2	*6*
INHALED TOXIC GAS	0	0	2	0	0	*2*
OTHER POISON	0	1	0	0	0	*1*

Definitions:

Multi-Drug Toxicity = Any combination of 2+ drugs, including alcohol, licit, and illicit drugs. Individual drugs are often not specified on the death certificate.

Other Drug-RX = Represents individual types of prescription and over-the-counter drugs used for intentional self harm

Opiate/opioid = Includes licit and illicit drugs of this class (Heroin, Morphine, Oxycodone, etc.)

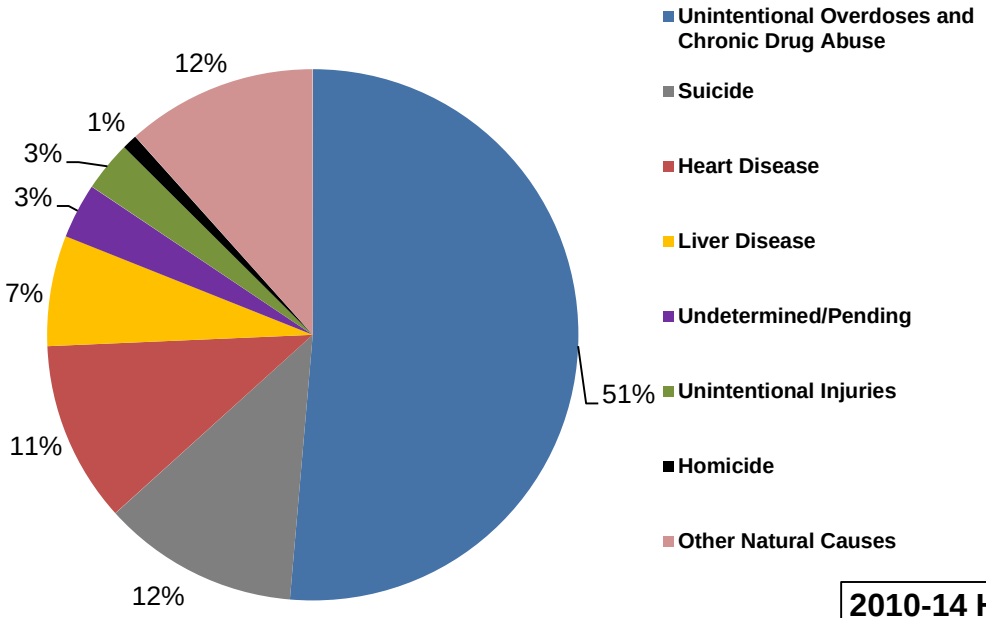
Inhaled Toxic Gas = Poisoning by CO asphyxiation from combustion exhaust (i.e. gas engines) or other toxic gases

Other Poison = Self-induced death caused by toxicity by substance(s) not otherwise listed.

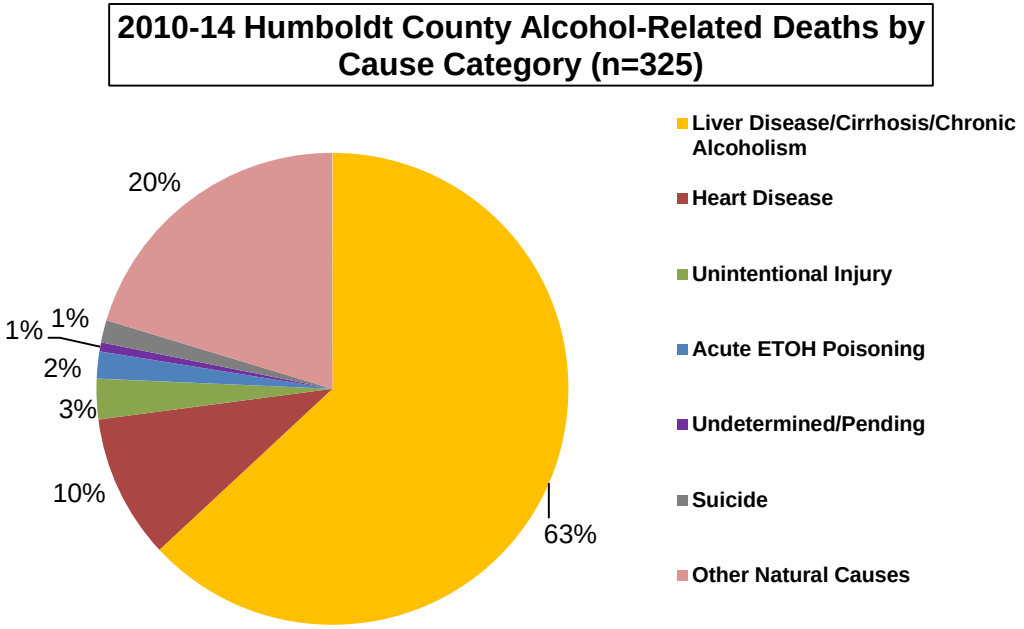
Source: Co. of Humboldt DHHS—PH Vital Statistics

Humboldt County Causes of Death by:

1. Drugs



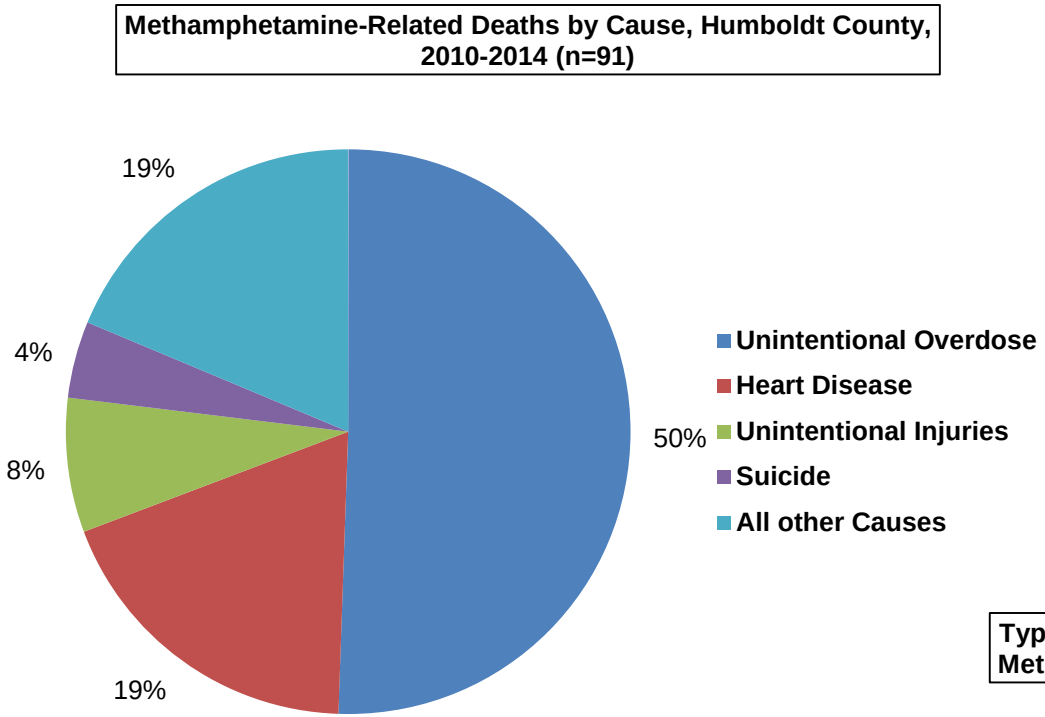
2. Alcohol



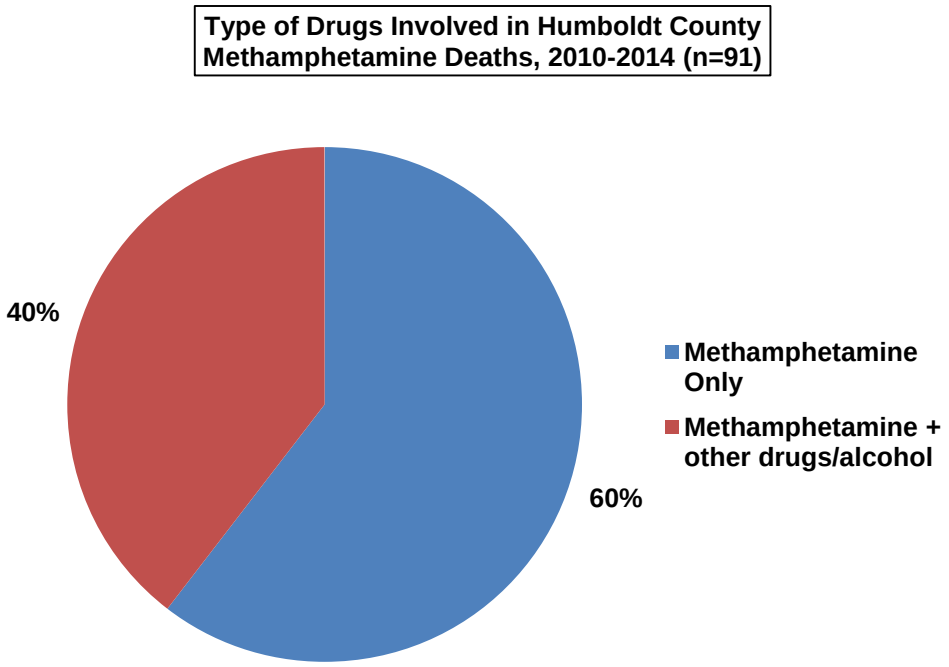
Source: Co. of Humboldt DHHS—PH Vital Statistics

Humboldt County Methamphetamine-Related Mortality:

1. Methamphetamine deaths by cause



2. Methamphetamine deaths by combination of drug types



Source: Co. of Humboldt DHHS—PH Vital Statistics

What are we doing about it?

From the CDC Drug Overdose Page (http://www.cdc.gov/drugoverdose/):

How CDC Is Fighting the Prescription Drug Overdose Epidemic

CDC remains committed to advancing a public health approach to preventing drug overdose death and applies its scientific expertise to help curb the epidemic in three ways:

1. Improving data quality and surveillance to monitor and respond to the epidemic
2. Strengthening state efforts by scaling up effective public health interventions
   & Local
3. Equipping health care providers with the data and tools needed to improve the safety of their patients

PRESCRIPTION DRUG MONITORING PROGRAM Controlled Substance Utilization Review and Evaluation System (CURES)

Objective: Increase in CURES users and registrants in Humboldt County, September 2013-June 2014

- Total number of approved CURES users in Humboldt County as of September 2013.
  - LEA (Law enforcement agencies) - 5
  - Pharmacists- 30
  - Physicians – 42
  - Total-77

- Total number of approved CURES users plus CURES registrants in Humboldt County as of June 2014.
  - LEA - 5
  - Pharmacists- 34
  - Physicians – ***90 (includes 48 new registrants)***
  - Total-129

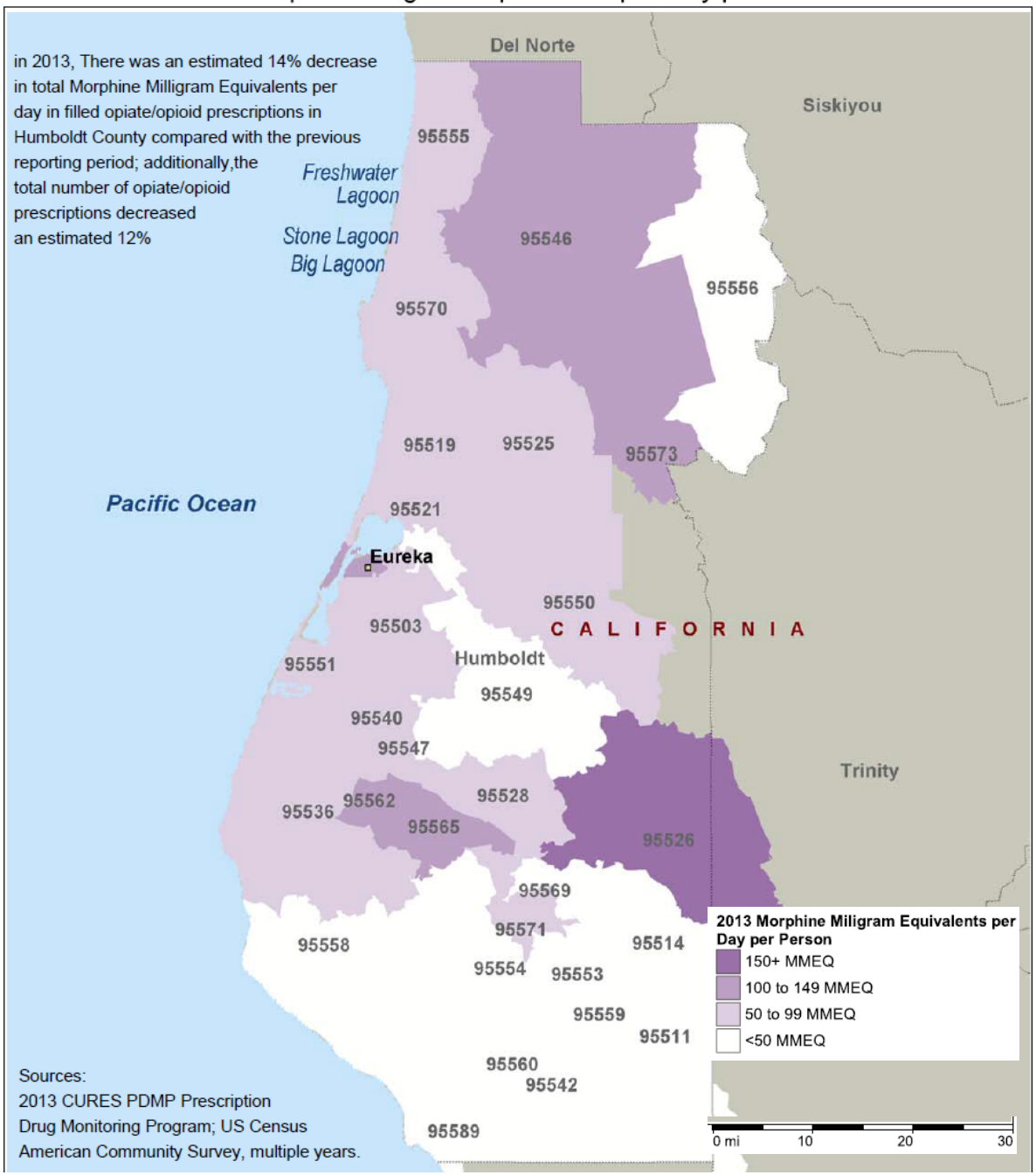
- Percentage increase of CURES users plus registrants in Humboldt County September 2013-June 2014:
  - LEA: 0.0%
  - Pharmacists: 13.3%
  - Physicians (includes PA/FNP): ***114.3%***
  - Total: ***67.5%***

(CURES user information courtesy of PDMP CURES; Registrant information courtesy of Humboldt-Del Norte Medical Society)

2010-2012:


Morphine Milligram Equivalents per Day per Person
Del Norte
Siskiyou
95555
Freshwater Lagoon
Stone Lagoon
Big Lagoon
95546
95556
95570
95519
95525
95573
95521
Pacific Ocean
Eureka
CALIFORNIA
95550
95503
95551
Humboldt
95549
95540
95547
Trinity
95536
95562
95528
95565
95526
95569
Shasta
95571
95514
95558
95554
95553
95559
95511
95560
95542
95589
Morphine Milligram Equivalents per Day per Person
150+ MMEQ
100 to 149 MMEQ
50 to 99 MMEQ
<50 MMEQ
Sources: PDMP CURES 2010-2012 Prescription Drug Monitoring Program; US Census American Community Survey, Multiple years.
0 mi
10
20
30
Mendocino

2013:


2013 Morphine Miligram Equivalents per Day per Person
in 2013, There was an estimated 14% decrease in total Morphine Milligram Equivalents per day in filled opiate/opioid prescriptions in Humboldt County compared with the previous reporting period; additionally,the total number of opiate/opioid prescriptions decreased an estimated 12%
Del Norte
Siskiyou
Trinity
Humboldt
CALIFORNIA
Pacific Ocean
Freshwater Lagoon
Stone Lagoon
Big Lagoon
Eureka
95555
95546
95556
95570
95519
95525
95573
95521
95550
95503
95551
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95540
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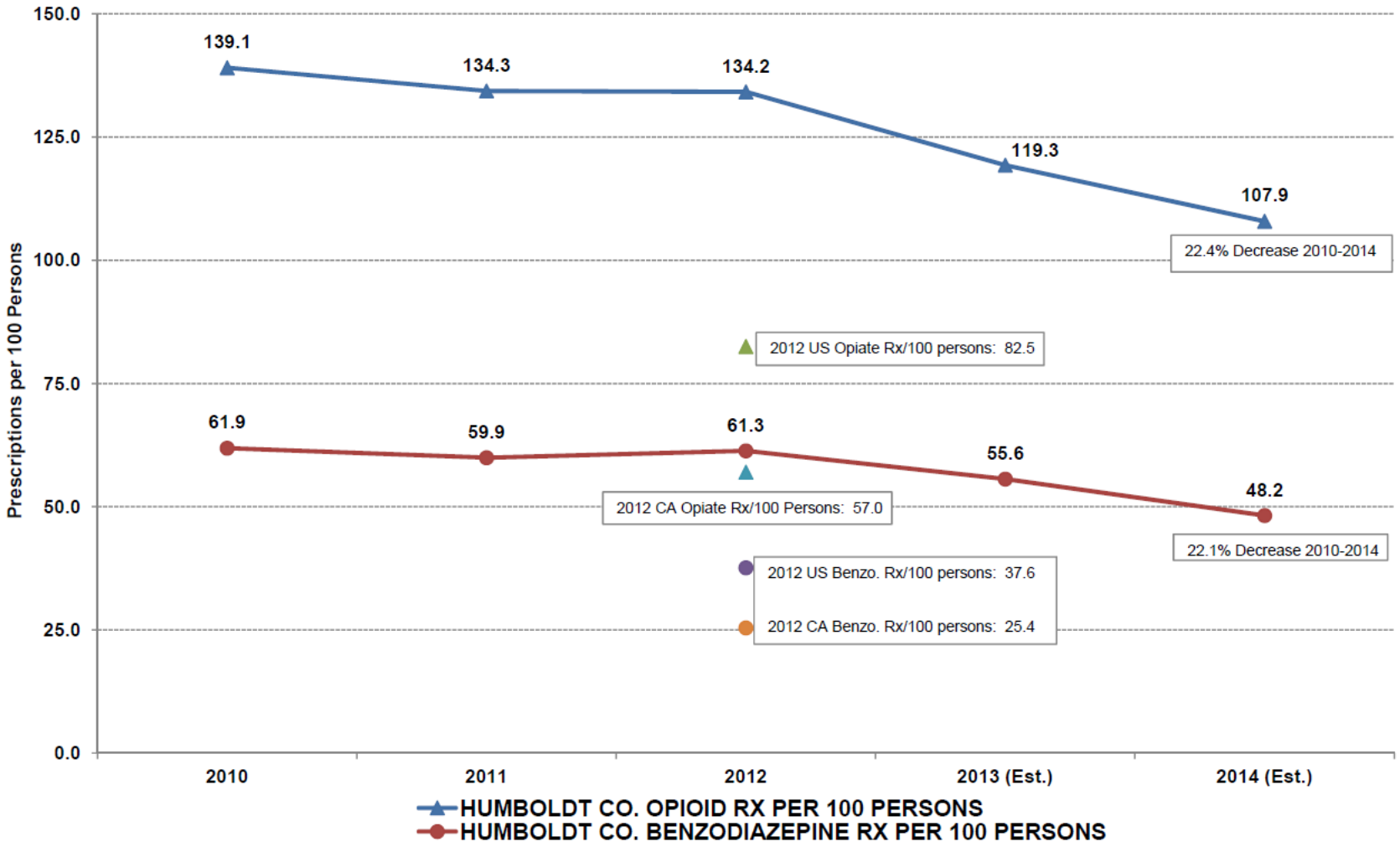
2013 Morphine Miligram Equivalents per Day per Person
150+ MMEQ
100 to 149 MMEQ
50 to 99 MMEQ
<50 MMEQ
0 mi
10
20
30
Sources:
2013 CURES PDMP Prescription Drug Monitoring Program; US Census American Community Survey, multiple years.

Humboldt County Opioid and Benzodiazepine Prescriptions per 100 Persons, 2010-2014



Sources: CURES-PDMP, Multiple Years.
Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines--United States 2012. MMWR. July 4, 2014. Vol. 63. No. 26.

For questions, contact Ron Largusa MSPH, Epidemiologist, County of Humboldt DHHS-Public Health. (707)-268-2187. rlargusa@co.humboldt.ca.us. Prepared 2/2015

Questions?

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http://maritime-executive.com/media/images/article/Photos/Law_Politics/Cropped/prison-fence_16X9.jpg

Prescribing Trends: Making Fences into Guardrails

Bryan Coleman, PharmD, RPh

Staff Pharmacist, Cloney's Prescription Pharmacy

http://thescoopblog.dallasnews.com/files/2015/02/IMG_0346.jpg

Questions

- Who decides what is a legitimate medical purpose?
- What is the usual course of professional treatment?
- What are some signs that a person is seeking medications for purposes other than a legitimate medical need?

Laws that Guide Controlled Substance Dispensing

Controlled Substances Act:

To be valid, a prescription for a controlled substance must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. The practitioner is responsible for the proper prescribing and dispensing of controlled substances.

State Pharmacy Law:

A licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient.

Notwithstanding any other law, a licentiate shall dispense drugs and devices pursuant to a lawful order or prescription **unless** one of the following circumstances exists:

- (1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or **the prescription is contrary to law**, or the licentiate determines that the prescribed drug or device **would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.**
- (2) The prescription drug or device is not in stock.

Simplified Terms

To be valid:

A prescription for a controlled substance must be issued for a medical purpose by a practitioner acting in the usual course of practice.

To be invalid:

A prescription must be issued for a purpose other than a medical purpose or by a practitioner not acting in the usual course of practice or both.

Why is it so hard to prescribe controlled substances for pain today?

CVS to pay $22M penalty for unlawful prescription drug distribution in Sanford

By Desiree Stennett
Orlando Sentinel
contact the reporter

2015

SHARELINES

CVS fined for drug distribution practices uncovered in DEA

MAY 13, 2015, 1:05 PM

CVS Health has agreed to pay a $22 million pe
investigation that found employees at two ph
without legitimate prescriptions.

The investigations into the two CVS pharmacies wa
mills. The stores are on Orlando Drive and West Fi

In 2012, the DEA banned the stores from dispensi
OxyContin, Vicodin, Ritalin and Xanax among oth

"Prescription drug addicts were traveling to Florid
distribution of prescription drugs, for access to phy

2013

Corresponding Responsibility

A pharmacist also needs to know there is a corresponding responsibility for the pharmacist who fills the prescription. An order purporting to be a prescription issued **not in the usual course of professional treatment** or in legitimate and authorized research is an invalid prescription within the meaning and intent of the CSA (21 U.S.C. § 829). **The person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties** provided for violations of the provisions of law relating to controlled substances. A pharmacist is required to exercise sound professional judgment when making a determination about the legitimacy of a controlled substance prescription. Such a determination is made before the prescription is dispensed. The law does not require a pharmacist to dispense a prescription of doubtful, questionable, or suspicious origin. To the contrary, **the pharmacist who deliberately ignores a questionable prescription when there is reason to believe it was not issued for a legitimate medical purpose may be prosecuted along with the issuing practitioner, for knowingly and intentionally distributing controlled substances. Such action is a felony offense, which may result in the loss of one's business or professional license**

Corresponding Responsibility

State law:

- (a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist **shall contact the prescriber** to obtain the information needed to validate the prescription.

- (b) Even after conferring with the prescriber, a pharmacist **shall not** compound or dispense a controlled substance prescription where the pharmacist **knows or has objective reason to know** that said prescription was not issued for a legitimate medical purpose.

The Cases of Local Doctors

- 3 Doctors with local ties in the past 10 years
  - 2 with decisions recorded
  - 1 pending
- Little documentation of past medical history prior to dispensing when patient came from outside practice
- Large quantities of opioids with little to no documentation for plan of treatment, benefit of treatment, rationale for increased doses.
- Prescribed frequently abused combinations of narcotics, benzos and muscle relaxants without psychiatric consultation or evaluation of drug abuse potential

What is the Usual Course of Professional Treatment?

- Medical Board of California:
  Guidelines for Prescribing Controlled Substances for Pain
  - Published Nov 2014
  - 90 pages in length
    - 19 pages of Guidelines
    - 71 pages of appendices including clinical tools, professional papers, references, etc.

Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain

- Provides guidance and tools for:
  - Evaluating pain
  - Assessing patient needs for pain medication
  - Risks of using controlled substances (adverse affects, likelihood of abuse/diversion)
  - Developing a treatment plan
  - Evaluating outcomes
  - Deciding when to discontinue treatment

Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain

- Describes the need for differing approaches:
  - In the Emergency Department
  - In Workman's Compensation cases
  - In patients with substance abuse history

Best Practices in Controlled Substance Prescribing

- Chart Everything
  - Pharmacies don’t want to call, but if we do your staff will need to have information readily available
    - Reasons for early fills
    - Need for dosage escalation
    - Medical Necessity for high risk drug combinations (Opioid+benzo+muscle relaxer)

Common Red Flags

- Requests for early refills of prescriptions
- Prescriptions written for duplicative drug therapy
- Age or presentation of patient (e.g., youthful patients seeking chronic pain medications)
- Long distances traveled from the patient's home to the prescriber's office or to the pharmacy
- Initial prescriptions written for strong opiates
- Irregularities in the prescriber's qualifications in relation to the type of medication(s) prescribed
- Prescriptions that are written outside of the prescriber's medical specialty
- Prescriptions for medications with no logical connection to an illness or condition
- Prescriptions written for potentially duplicative drug therapy
- Nervous patient demeanor
- Excessively celebratory patient demeanor
- Cash payments

Best Practices in Controlled Substance Prescribing

- Pre-emptive notation on the prescription is helpful when:
  - Patient is getting an early fill (e.g. Pt going to Texas from 9/1/15 to 9/10/15)
  - Patient has a legitimate need for a supplemental prescription (e.g. MVA 8/9/15 for addt'l acute pain)
  - Patient is known to have seen another provider for same/similar medication (e.g. recent surgery/dental procedure)
  - Switching same/similar medications (d/c morphine on rx for oxycodone)

Your Patients Rx will likely be denied for:

- Multiple early fills (Kid stole 1/11, dropped down sink 2/5, someone spilled water on me and they got wet 2/27, going on vacation 3/16)
- Multiple doctors writing for same/similar meds. (Norco 5/325 #90 1 tid from pcp, Norco 5/325 #12 1 tid prn from dentist)
- Combinations of drugs that don't make sense. Norco 5/325 for back pain+Tylenol #3 for headaches + Promethazine-Codeine for cough

Questions?

References

- Controlled Substances Act 21 CFR § 1306 http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_04.htm
- DEA Pharmacist's Manual 2010 edition p30 http://www.deadiversion.usdoj.gov/pubs/manuals/pharm2/pharm_manual.pdf
- CCR Title 17 Division 16 Article 8 Section 1761 http://www.pharmacy.ca.gov/laws_regs/lawbook.pdf
- Guidelines for Prescribing Controlled Substances for Pain. Medical Board of California. Nov 2014 http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf
- Kirchmeyer v Jutila (2014) http://www2.mbc.ca.gov/PDL/document.aspx?path=%5cDIDOCS%5c20140326%5cDMRAAAEC2%5c&did=AAAEC140326221057292.DID&licenseType=A&licenseNumber=20189
- Kirchmeyer v Olsgard (2014) http://www2.mbc.ca.gov/PDL/document.aspx?path=%5cDIDOCS%5c20141107%5cDMRAAAEC3%5c&did=AAAEC141108001610502.DID&licenseType=G&licenseNumber=25166#page=1
- Yaroslovsky v Fisher (2005) http://www2.mbc.ca.gov/PDL/document.aspx?path=%5cDIDOCS%5c20091104%5cDMRAAABI6%5c&did=AAABI091104232713015.DID&licenseType=G&licenseNumber=48224#page=1

Group Exercise

Marya Choudhry
QIP Project Manager

GROUP EXERCISE

- At your tables, take **10 minutes**:
  - Discuss greatest challenges regarding opioids
  - Rank your top 3

PARTNERSHIP HEALTHPLAN of CALIFORNIA

BREAK

PARTNERSHIP HEALTHPLAN of CALIFORNIA

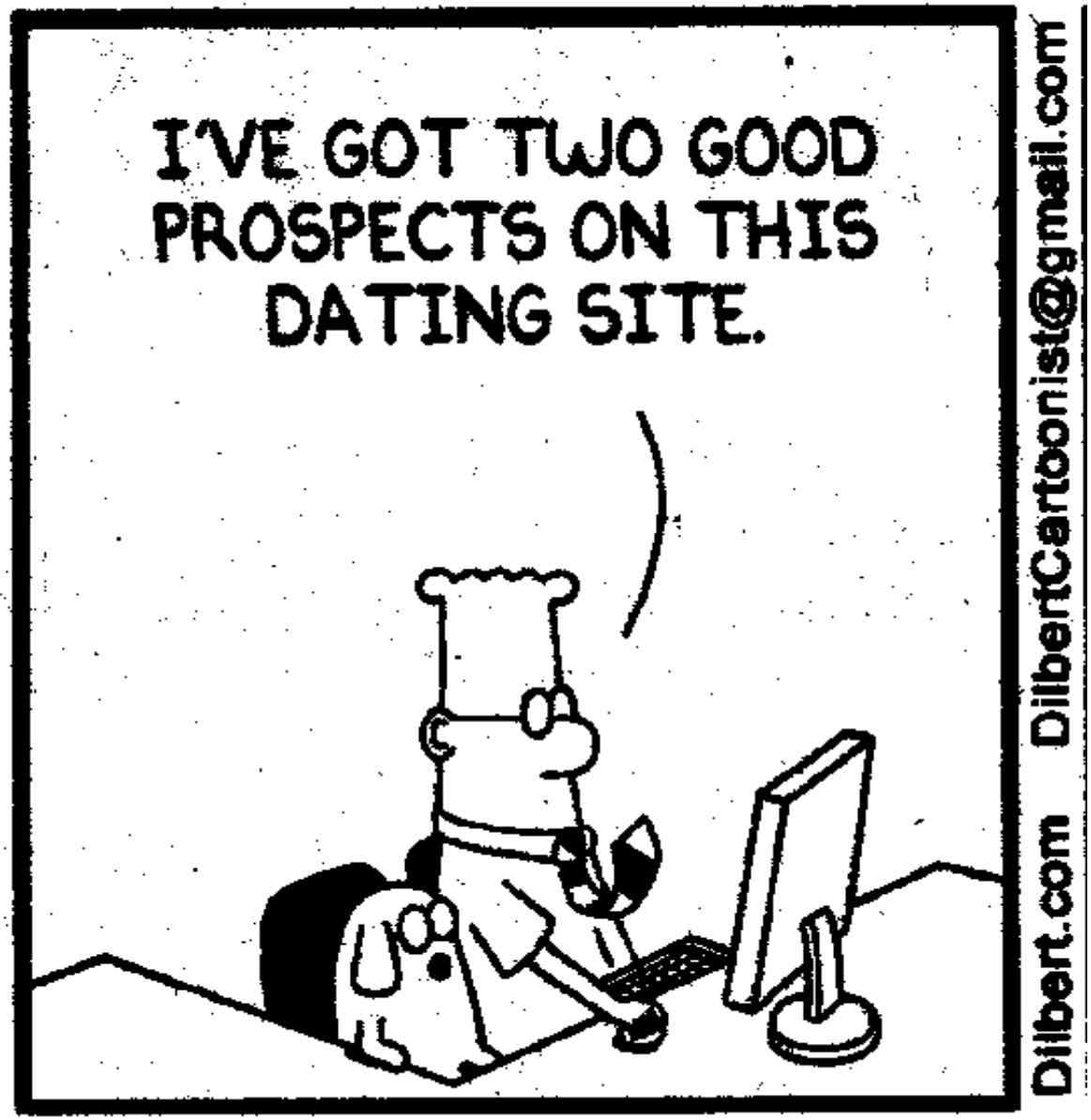
“Recognition and Management of Prescription Opioid Failure

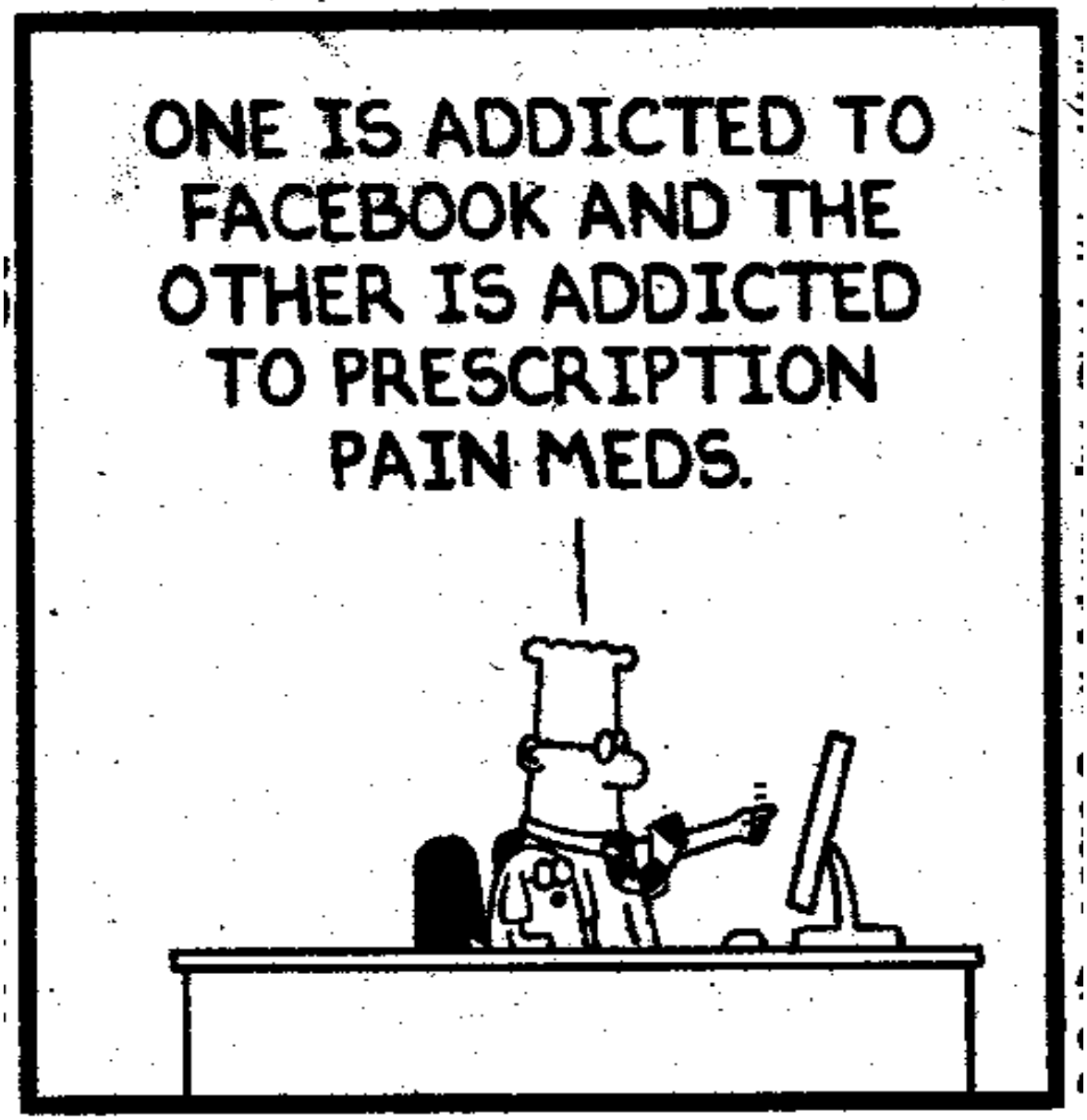
William Morris, MD, MPH

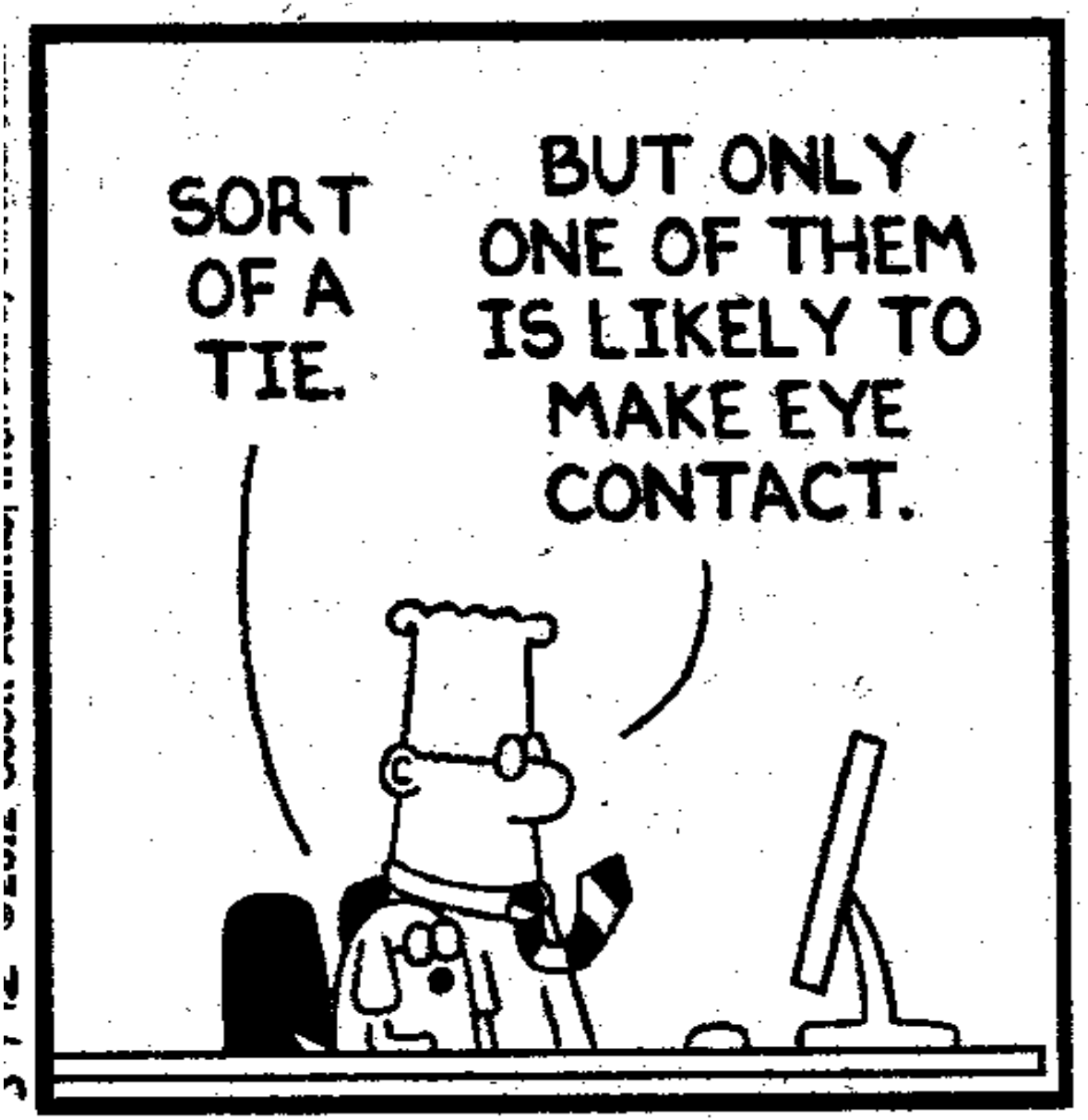
Palliative Care and Supportive Services

PAMF Santa Cruz

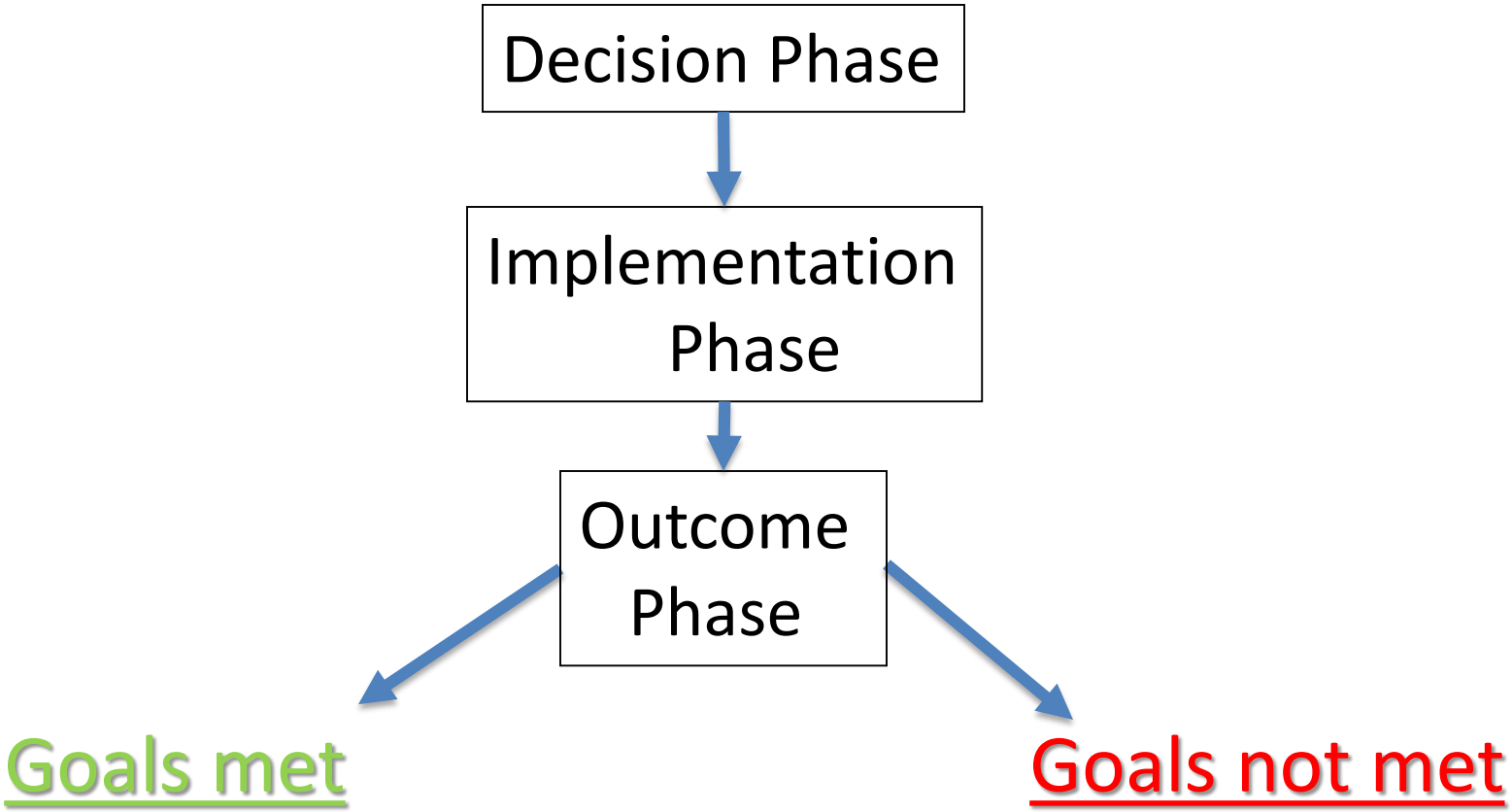
DILBERT


I'VE GOT TWO GOOD PROSPECTS ON THIS DATING SITE.
Dilbert.com DilbertCartoonist@gmail.com


ONE IS ADDICTED TO FACEBOOK AND THE OTHER IS ADDICTED TO PRESCRIPTION PAIN MEDS.


SORT OF A TIE.
BUT ONLY ONE OF THEM IS LIKELY TO MAKE EYE CONTACT.

Summary Process for Prescription Opioid Therapy



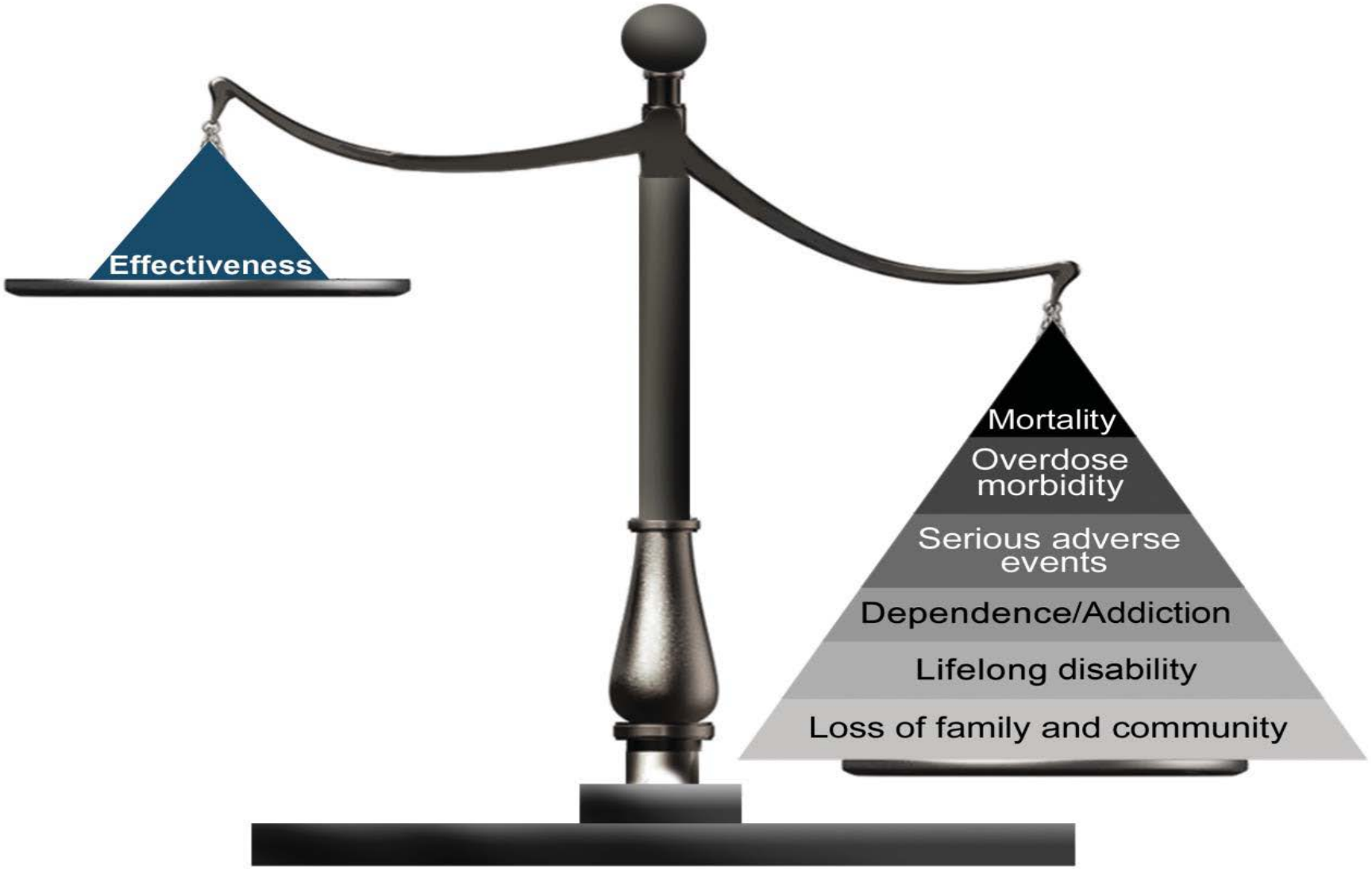
“No study of opioid therapy versus placebo or no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, or quality of life.”

National Institutes of Health
Pathways to Prevention Workshop:
The Role of Opioids in the treatment of Chronic Pain. September 29-30, 2014
DRAFT EXECUTIVE SUMMARY, pg 26

"Although there is evidence for significant pain relief in the short term (average duration of trials 5 weeks range 1-16 wks) there is no substantial evidence for maintenance of pain relief over longer periods of time, or significant evidence for improved physical function"

Franklin, GM. Opioids for Chronic Noncancer Pain: A position paper of the American Academy of Neurology *Neurology.2014;83:1277-84 (*pg 1278)

Opioids for Chronic Noncancer Pain



Opioids for Chronic Noncancer Pain: A position paper of the American Academy of Neurology. 2014

Opioid Efficacy in Chronic Pain: Summation of Evidence

- **Observational data and RCTs**
  - Modest efficacy (20-30% reduction), usually with lower doses
  - Limited functional data available
  - Duration: Observational studies majority <2 yrs, RCTs <4 months
  - Up to 60 -70% drop out due to adverse effects or lack of analgesia
- **Epidemiologic data**
  - Reduction in population pain prevalence not evident
  - Function appears to be worse in those on chronic opioids

Ballantyne JC, Mao J. NEJM. 2003
Kelso, et al. Pain. 2004
Eisenberg E, et al. JAMA. 2005
Eriksen J, et al. Pain. 2006
Furlan, et al. CMAJ. 2006
Gomes T, et al JAMA Int Med. 2013
Martell BA, et al. Ann Intern Med. 2007
Noble, et al. J Pain Symptom Manage. 2008
Sjogren P, et al Clin J Pain. 2010
Cochrane Database Systemic Rev. 2010
Manchikanti L, et al. Pain Physician. 2011

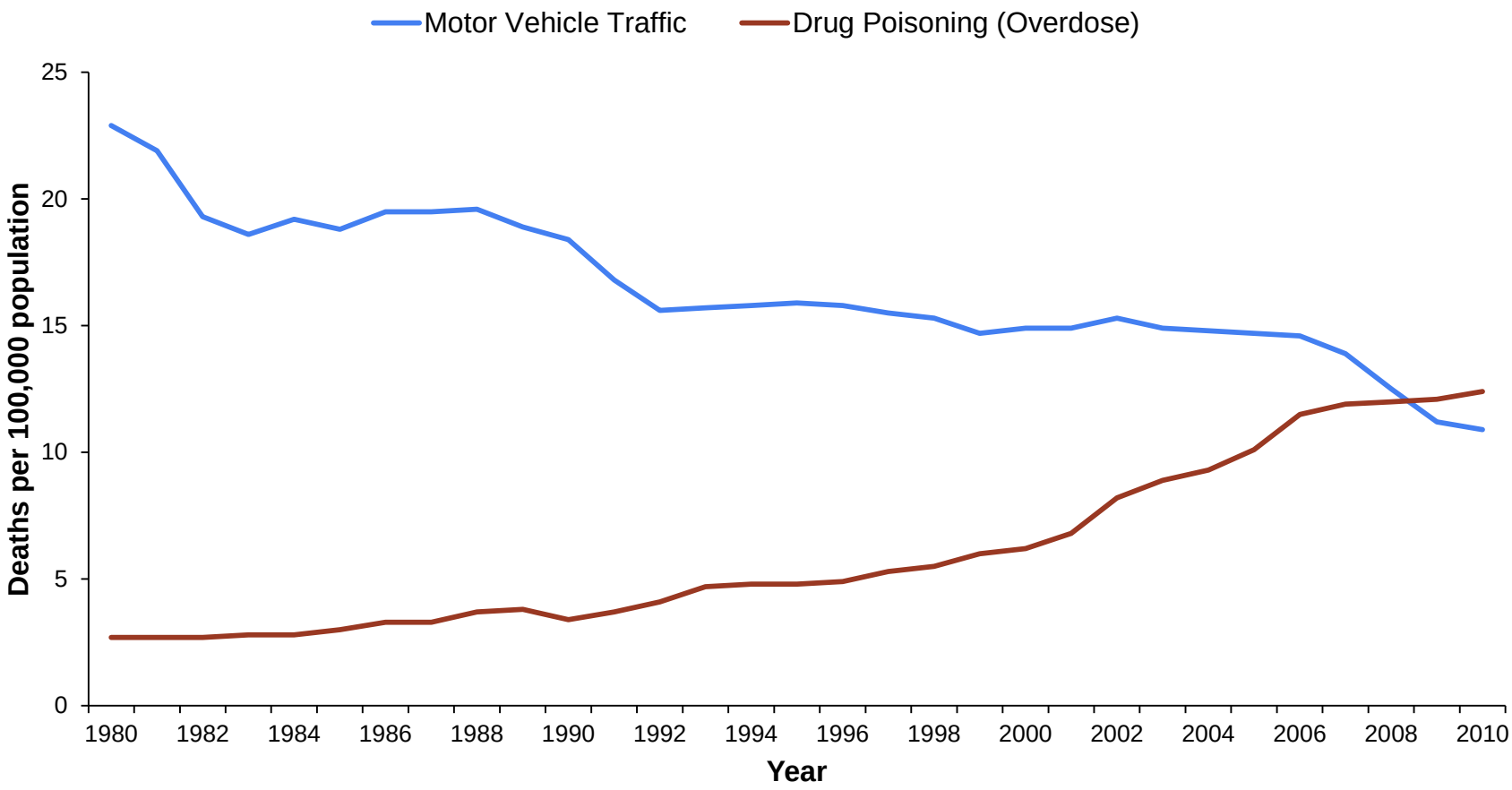
Have we been paying attention?

"…our review addresses specific questions about dose and toxicity in light of recent studies that suggest a need to modify current practices in the use of opioid therapy for chronic pain."

"…prolonged, high-dose opioid therapy may be neither safe or effective."

- Ballantyne JC, Mao J. Medical Progress: Opioid Therapy for Chronic Pain. *NEJM*. **2003**; 349(20): 1943-1953.

Motor Vehicle Traffic, Poisoning, and Drug Poisoning (Overdose) Death Rates United States, 1980–2010



NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data.

However…

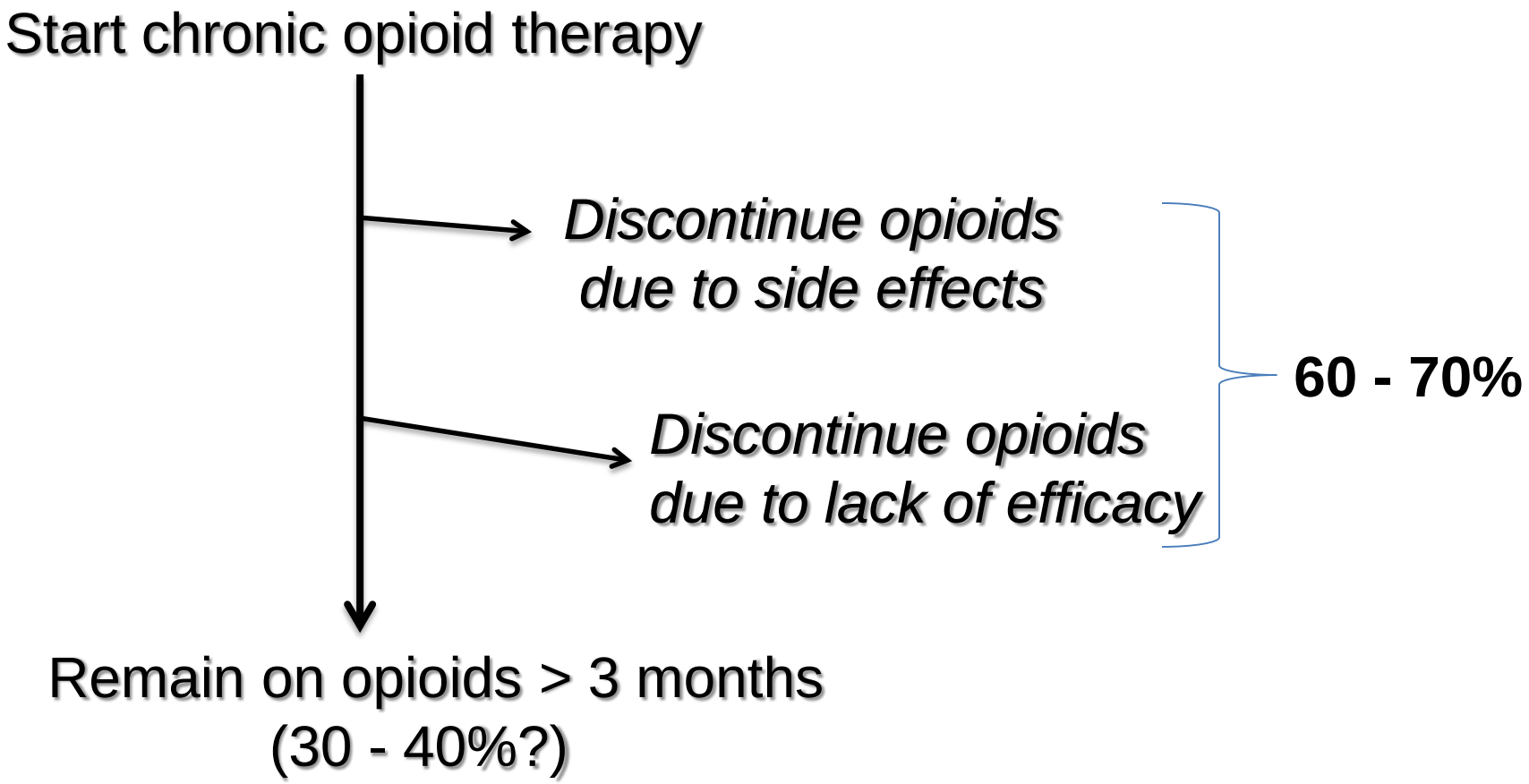
"Patients, providers, and advocates all agree there is a **subset of patients for whom opioids are an effective treatment method for their chronic pain**, and limiting or denying access to opioids for these patients can be harmful."

NIH - Pathways to Prevention Workshop:
The Role of Opioids in the treatment of Chronic Pain,
September, 2014. (**pg 9)**

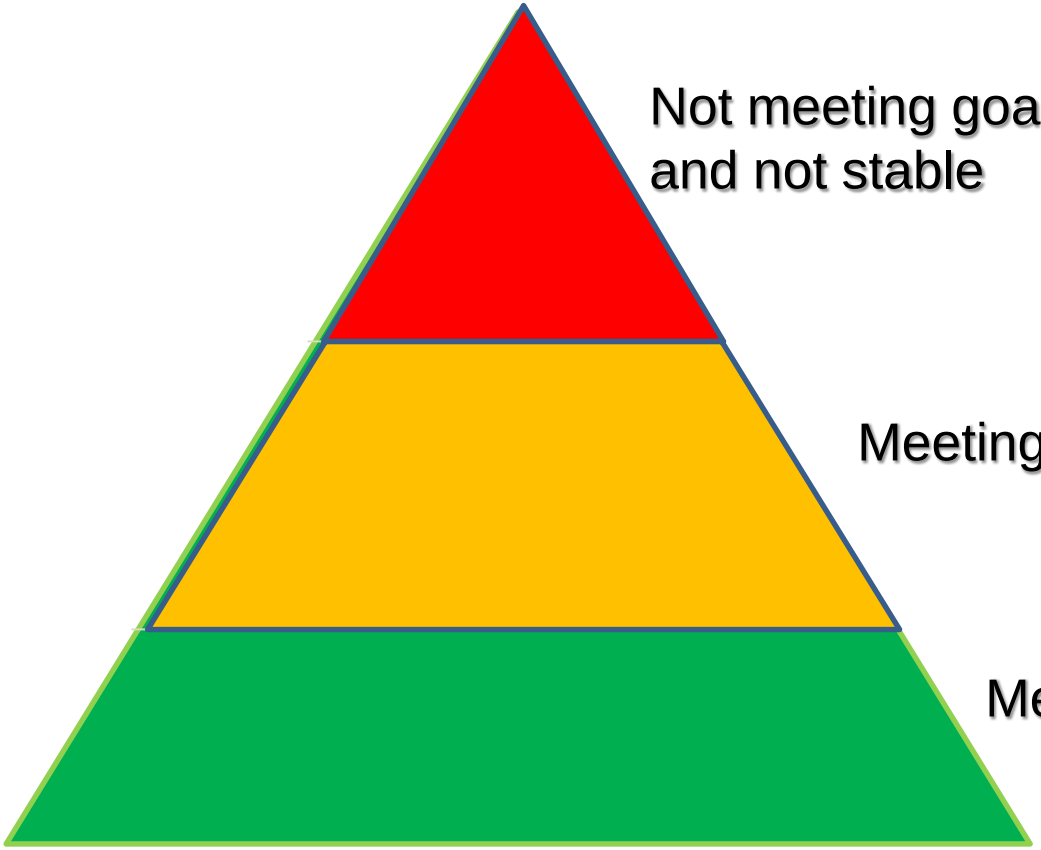
The Challenge of Chronic Opioid Therapy

- GIVEN:
  - Chronic opioid therapy may benefit some patients with chronic pain.
  - The risks of chronic opioid therapy appears to outweigh the benefits in a large proportion of patients
- HOW CAN WE:
  - ***safely*** utilize chronic opioid therapy for patients in chronic pain for whom opioids remain ***effective***.
  - Recognize and manage those patients for whom chronic opioid therapy has failed

Chronic Opioid Therapy
Observed Outcomes: 0-3 Months



Chronic Opioid Therapy
Observed Outcomes: >3 Months



Not meeting goals (analgesia and function) and not stable

Meeting goals, but not stable

Meeting goals and stable.

Outcomes Phase – When Goals are Met:

- Monthly med renewal visits
  - Document pain score and side effects
  - Treat side effects
  - Urine tox screen, random and if indicated,
- Comprehensive Reassessment visits Q 3-6 months – ARE GOALS IN AGREEMENT BEING MET?
- The “4 A’s”
  - Analgesia?
  - Activity?
  - Acceptable SE profile?
  - Aberrant behaviors?
- “collateral” information important to gather

Graded Chronic Pain Scale

- ***"In the last month, how would you rate your pain?*** Use a scale from 0-10, where 0 is no pain and 10 is pain as bad as could be (that is, your usual pain at times you were in pain)"
- ***"in the last month, how much has pain interfered with your daily activities?*** Use a scale from 0-10, where 0 is no interference and 10 is unable to carry on any activity"

Aberrant Opioid-Related Behaviors

- Examples:
  - Noncompliance
  - Lost prescriptions
  - Early refills
  - ED, urgent care visits for meds
  - Seeking euphoria
  - Medical “coping”
  - Monopolization of visits

Aberrant Opioid-Related Behavior Survey Tools

- Addiction Behaviors Checklist

  Wu, et al. *J. Pain Symp Manage.* 2008;32(4):342-51.

  – Clinician considers presence of behaviors since last visit and within current visit

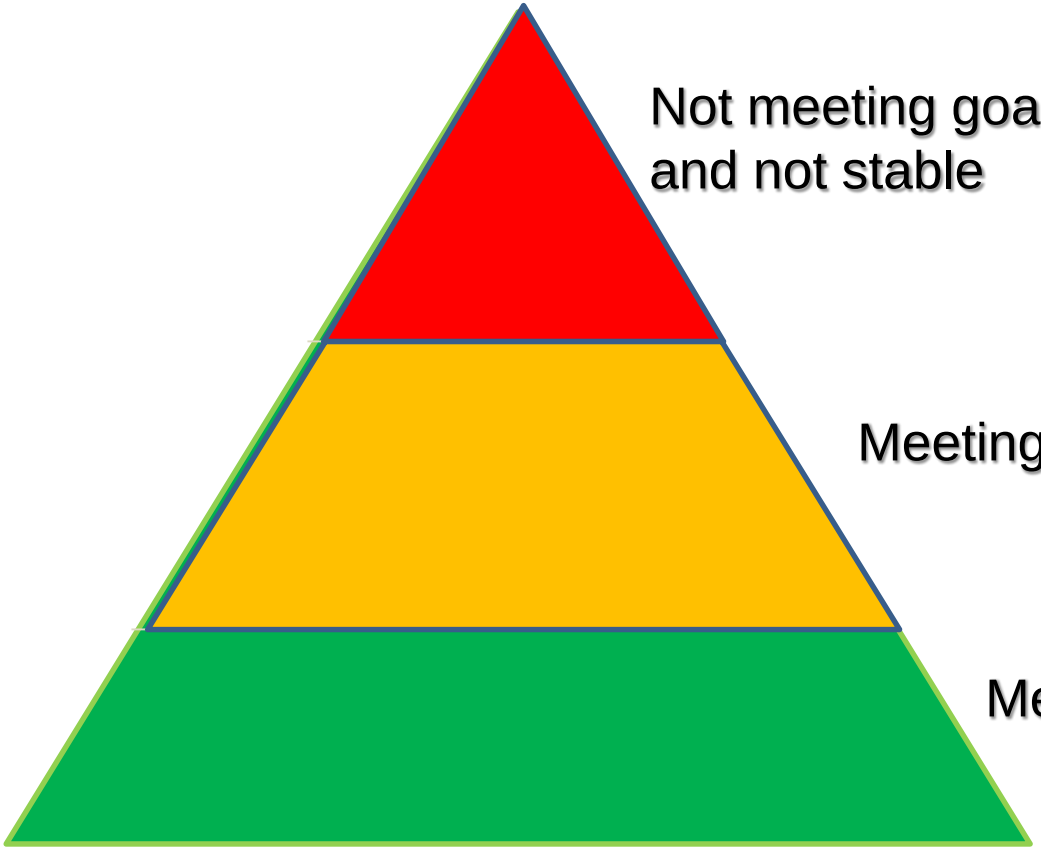
  – e.g. ran out of meds early? Reports worsening relationship with family?

- Current Opioid Misuse Measure

  Butler, et al. Pain. 2007;130:144-56.

  – 17 questions asked of patient with 0-4 response

Chronic Opioid Therapy
Observed Outcomes: >3 Months



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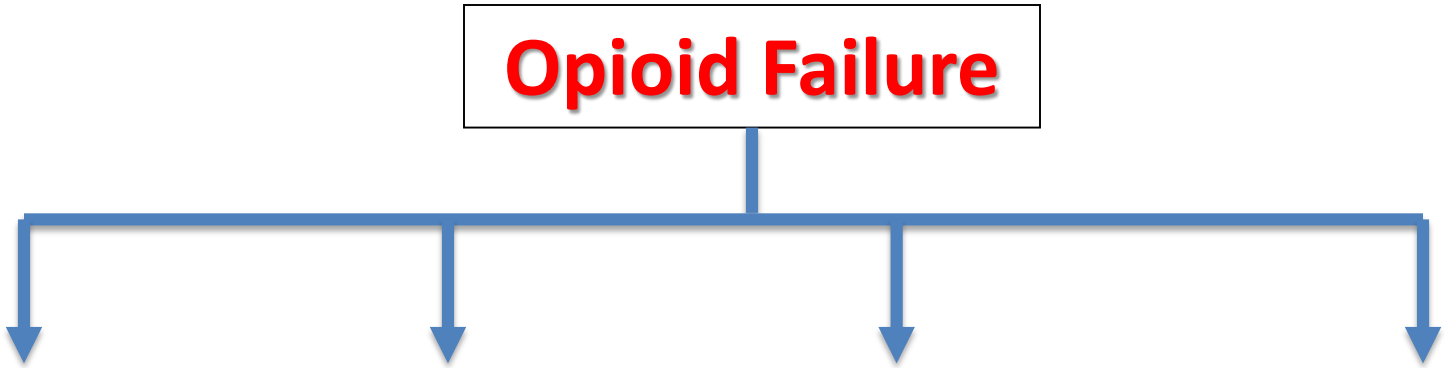
Opioids Fail

OPIOID FAILURE *– proposed definition:*

Taking greater than 120mg MED ***for*** greater than 3 months duration ***with***

Pain scores consistently > 5/10 ***and/or***
Inadequate function ***and/or***
Intolerable/dangerous adverse SEs ***and/or***
Aberrant behaviors/addiction

Opioid Failure - *assessment of etiology*



Ineffective dosage
- inadequate titration
- Dz progression

Excessive side effects
- GI
- respiratory
- cognitive
- other

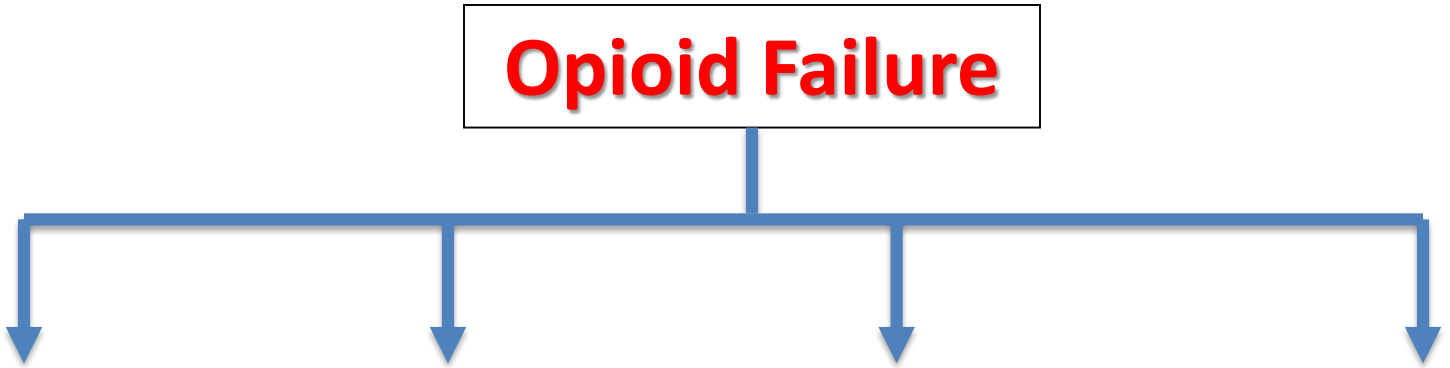
Ineffective analgesia
- tolerance
- opioid resistant pain
- opioid induced hyperalgesia
- opioid induced toxicity

Aberrant opioid-related behaviors
- non-addiction
- addiction
- Med coping

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a NIH Pathways to Prevention Workshop. *Ann Int Med*. 162(4) 2015.

- Overdose
- Abuse and addiction
- Fractures
- Myocardial infarction
- Motor vehicle accidents
- No study evaluated risk for falls, infections, psychological, cognitive, or GI harms

Opioid Failure - *assessment of etiology*



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Aberrant opioid-related behaviors
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“Confusing Panopoly of Terms and Definitions”

- Addiction
- Habituation
- Dependence
- Substance abuse
- Substance dependence
- Substance misuse
- Physical dependence
- Psychological dependence
- Opioid use disorder

Evolution of Terminology

- Liaison Committee on Pain and Addiction (LCPA)
  - American Pain Society
  - American Academy of Pain Medicine
  - American Society of Addiction Medicine
  - 1991-2001 created consensus definitions

LCPA Consensus Definitions

- “Addiction” favored over “dependence”
- Clear separation of concepts of physical dependence, tolerance, and addiction
- Addiction as a chronic disease
- Utility of distinguishing addiction from other forms of aberrant drug behavior

Tolerance

- “a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time”

Physical Dependence

- “a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.”

Addiction

- “a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving”

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DSM-V

- Combined categories of substance abuse and substance dependence into a single category: “Substance Use Disorder” measured from mild to severe.
- Each substance is addressed as a separate use disorder, but all are based on the same overarching criteria

DSM-V
Opioid Use Disorder Criteria

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.

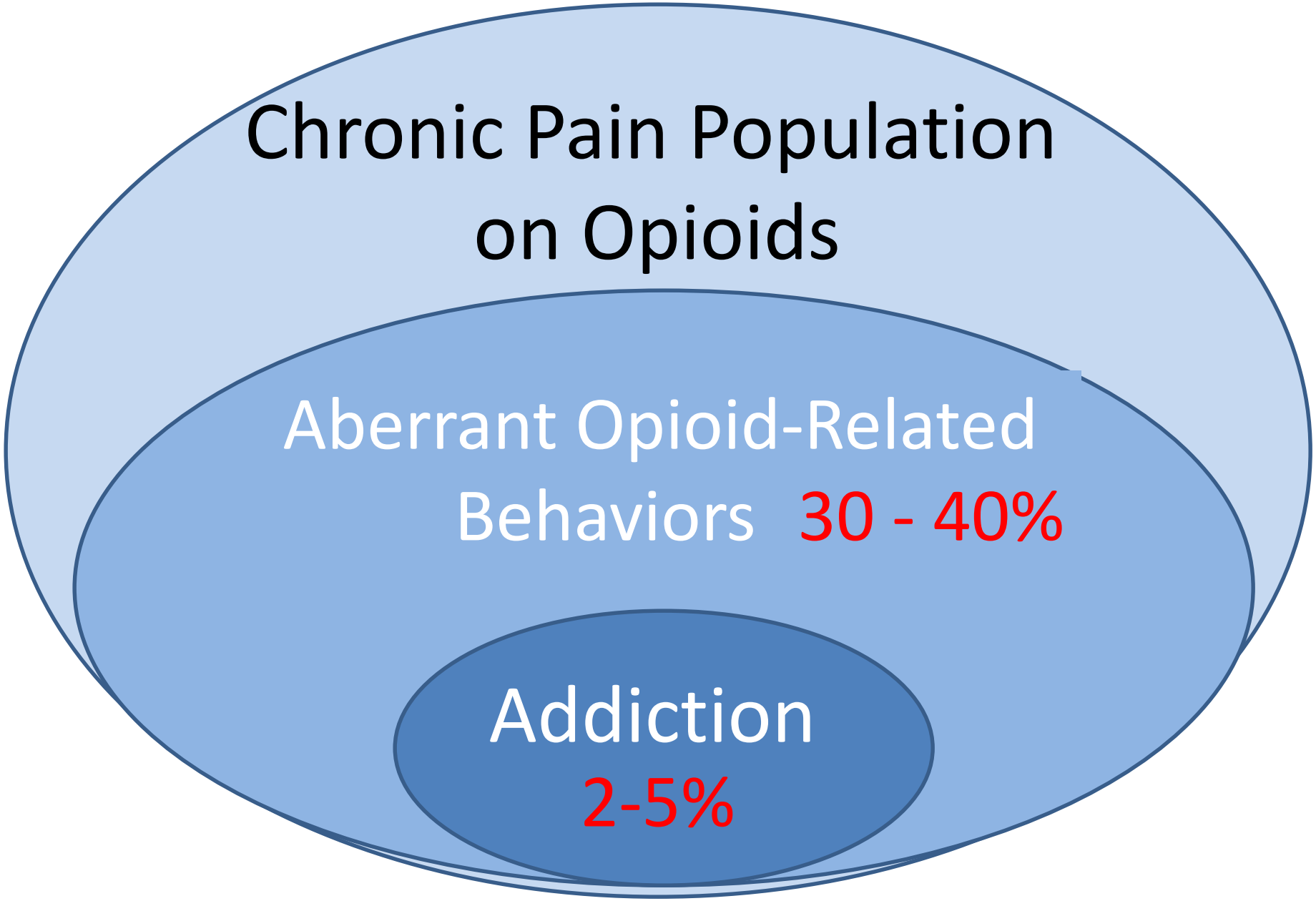
DSM-V
Opioid Use Disorder Criteria (cont.)

8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of an opioid.
    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
    b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

DSM-V
Opioid Use Disorder Criteria (cont.)

Mild = 2-3 symptoms
Moderate = 4-5 symptom
Severe = 6 or more

- Diagnostic criteria perform equally well across race/ethnicity groups
- Individuals from economically deprived areas overrepresented
- Most prevalent in white middle-class, especially females


Chronic Pain Population on Opioids
Aberrant Opioid-Related Behaviors 30 - 40%
Addiction
2-5%

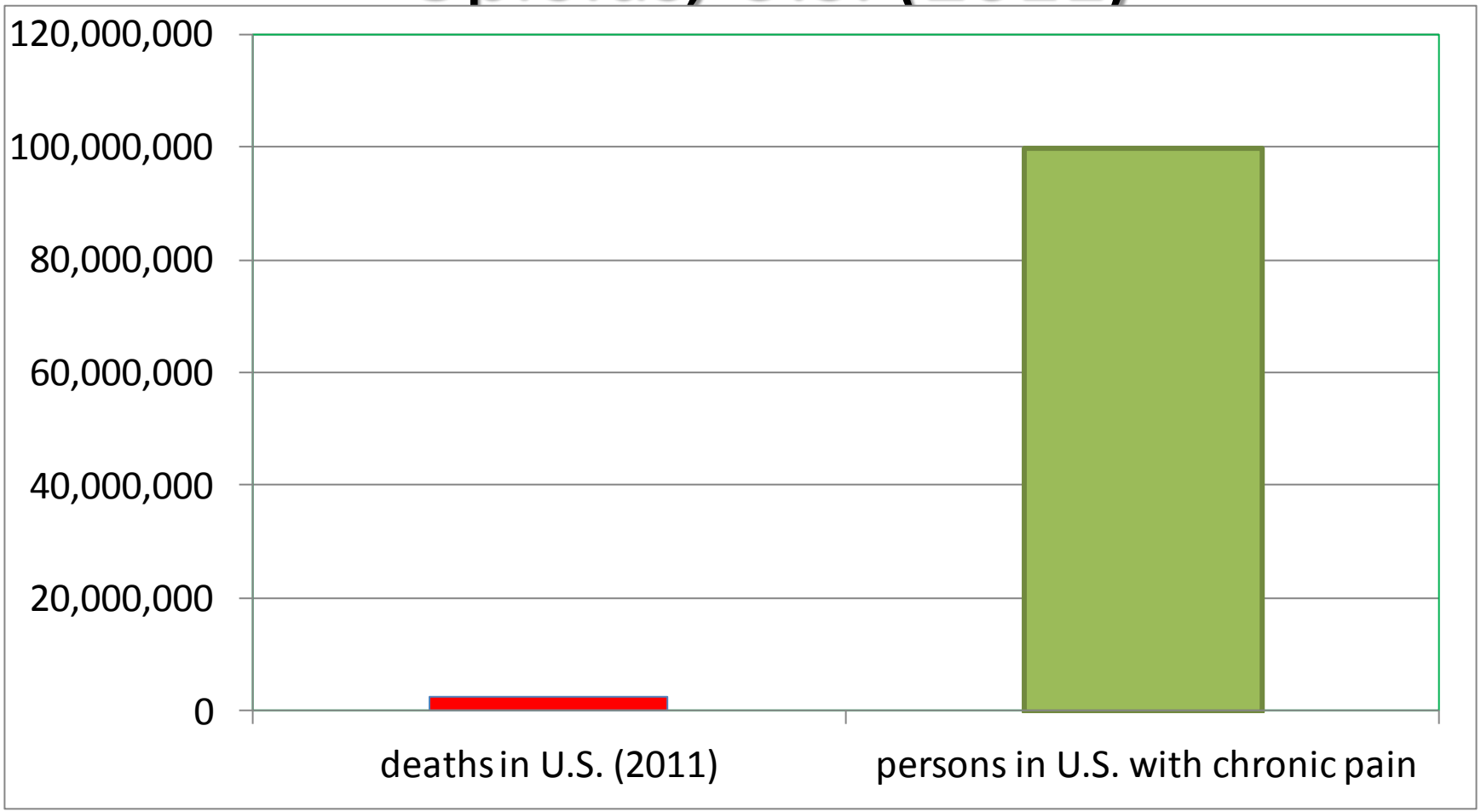
Why do Patients Stay on COT if Rx Goals are not Being Met?

- Because doctors keep prescribing
- Aberrant behaviors
- Addiction
- "Total pain" : physical, psychological, social, emotional, and spiritual elements
  - "Terribly Sad Life Syndrome"

    Ballantyne JC, Sullivan MD. What are we Treating with Long-term Opioid Therapy?" **Arch Int Med.** 2012: 172(5); 433-4.
  - MLS = "Messed up Life Syndrome"

    Jim Kohut MD, PAMF Neurosurgeon

Potential Markets for Prescription Opioids, U.S. (2011)



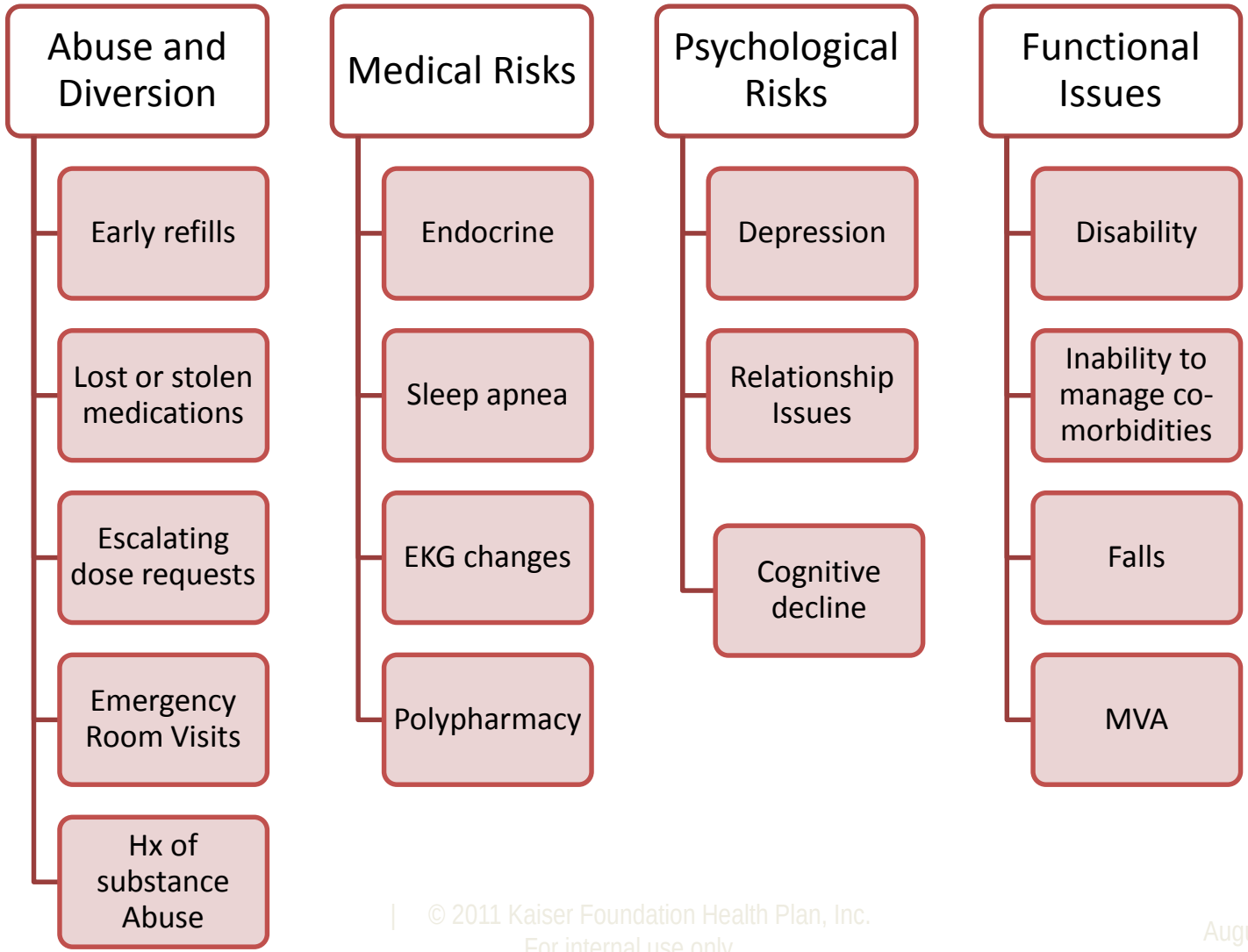
Data sources: CDC vital statistics report (cdc.gov/nchs/data/nvsr),
Institute of Medicine Report (2011) "Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research"

Observations re: Chronic Opioid Therapy Management Errors

- Assuming opioids = only way to Rx severe pain
- Multiple opioids of same type (ER, IR)
- High doses without pain specialist input
- Continued dose escalation despite lack of significant improvement (analgesia/function) and/or low functional status (reported by sig others, not patient)
- Absence of weighing benefit against risk
- Assuming aberrant behaviors = addiction
- Missed (or buried) Hx of abuse, addiction, Psych

Identifying Clinical Risk of Opioid Use

Andrea Rubinstein, MD The Permanente Medical Group, Santa Rosa



Opioid Failure - *Management*

How we often respond:

- Increase opioid dose
- Restrict opioids
- Moral judgment : patients labeled as “bad”
- Discharge patient
- Fear of weaning

How we should respond:

- Recognize when opioids have failed - weigh RISK vs BENEFIT
- Carefully assess reason for opioid failure
- Explore possible underlying drivers for “Total Life Pain”
- Communicate compassionately to patients
- Non-judgmental: opioids have failed, ***not*** the patient
- Non-abandonment
- Firm but supportive weaning
- Buprenorphine option

Having the Conversation

- Clearly lay out my concerns –
  - first focus on lack of analgesia and side effect
  - Discuss known adverse effects of opioid therapy
  - specific examples of aberrant opioid-related behaviors (if present)
- Present your assessment that risk of harm is greater than benefit
  - If I have relationship with patient, I focus on my wanting the best for them
  - If first visit, I focus on my ethical obligation to “do no harm”
- Refer back to opioid agreement if you have one

Patient Education

- Importance of pain to survival
- We can block pain short term, but long term…?
- Body does end around on opioid pain blockade
- Opioids less effective, sincere efforts to provide relief by increasing dose leads to worse side effects
- Actually increase pain? (OIH)
- Tell stories about patients whose pain decreased when they got off of opioids: doesn't always happen, but function always improves!
- Acknowledge that weaning is scary, reassure won't be abandoned

Having the Conversation (cont.)

- “It doesn’t make sense to keep doing something that is more likely to harm you than help you, does it?”
- I acknowledge that this is not an easy problem to deal with
- Don’t back them into a corner - I remind them;
  - My diagnosis could be wrong
  - I would not be offended if you transferred care to another physician
  - I will not abandon you

" An important barrier preventing clinicians from discontinuing opioids is the lack of knowledge, confidence, and skill in how to taper opioids safely in patients who are physically dependent "

Alford, DP. *JAMA*. 2013 Oct 2; 310(13): 1351-2.

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Rules of Thumb for Tapering

Andrea Rubinstein, MD
Kaiser Permanente, Santa Rosa

1. The longer on opioids the slower you go
2. Most patients tolerate 10% reductions
3. Virtually no one tolerates 25% reductions well
4. Going slowly is better than stopping or giving up
5. Written taper plan is helpful

(**http://hrsa.dshs.wa.gov/pharmacy/pdf/TaperSchedule.xlsx**).

Taper Observations

- Most patients choose a slow taper
  - Wade into cold mountain lake or jump?
  - What does our experience with quitting smoking teach us?
- Backslides
- The longer on, the harder to get off - “Lost generation?”
- Take care to preserve therapeutic relationship
  - “right to pain control”, threats to report, SI
- Role for experienced psychological counselors

Taper Observations (cont.)

- Abstinence syndrome: nausea, diarrhea, myalgias, myoclonus, sweats
  - Clonidine 0.1-0.2mg po Q 6 hrs prn, monitoring for hypotension
  - Anti-depressants for irritability/mood
  - Gabapentin for neuropathic pain symptoms
  - Avoid benzodiazepines
  - Sometimes you need a transition medication (buprenorphine) “nicotine patch of COT”

Buprenorphine

Partial mu receptor agonist, kappa and delta antagonist

Need special training (8hrs on line possible) to prescribe: pharmacology and induction process

Subutex/Suboxone (+naloxone):

Sublingual tabs (2, 8 mg) and film (2,4,8,12 mg)

SL buprenorphine is 80x more potent mg for mg than po morphine:

[2mg SL tab = 160 mg po morphine]

Discontinuation of Chronic Opioid Therapy – What Happens?

Rome JD et al. *Mayo Clinic* (2008)

Hooten WM, et al. *Pain Med.* (2007)

Crisostomo RA, et al. *Am J Phys Med Rehabil.* (2008)

Townsend CO, et al. *Pain.* (2008)

Murphy JL, et al. *Clin J Pain.* (2013)

Discontinuation of Opioid Medications – What Happens? (cont.)

- These studies include approx 2,000 pts with chronic pain, Rx'd with and without opioids.
- 3 wk multidisciplinary programs, outpt, CBT approach with emphasis on weaning of opioids in patients using them.
- All studies report significant improvement in physical and social function in pts weaned from opioids; = or > than pts not on opioids.

Questions?

THE ART AND VERY LITTLE SCIENCE OF TAPERING

ANDREA RUBINSTEIN, MD (VIA VIDEO RECORDING)

CHIEF OF PAIN MANAGEMENT

KASIER PERMANENTE

PARTNERSHIP HEALTHPLAN of CALIFORNIA

THE ART AND VERY LITTLE SCIENCE OF TAPERING

- The Art & Very Little Science of Tapering (42 min)

  http://youtu.be/rj_fjlrHnVQ

PARTNERSHIP HEALTHPLAN of CALIFORNIA

BREAK

PARTNERSHIP HEALTHPLAN of CALIFORNIA

INITIATING SUCCESSFUL PATIENT CONVERSATION

WILLIAM MORRIS, M.D, MPH

CLINICIAN, PALLIATIVE CARE CONSULT SERVICE

DOMINICAN HOSPITAL, SANTA CRUZ, CA.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Open Door Community Health Centers

Bill Hunter, M.D.

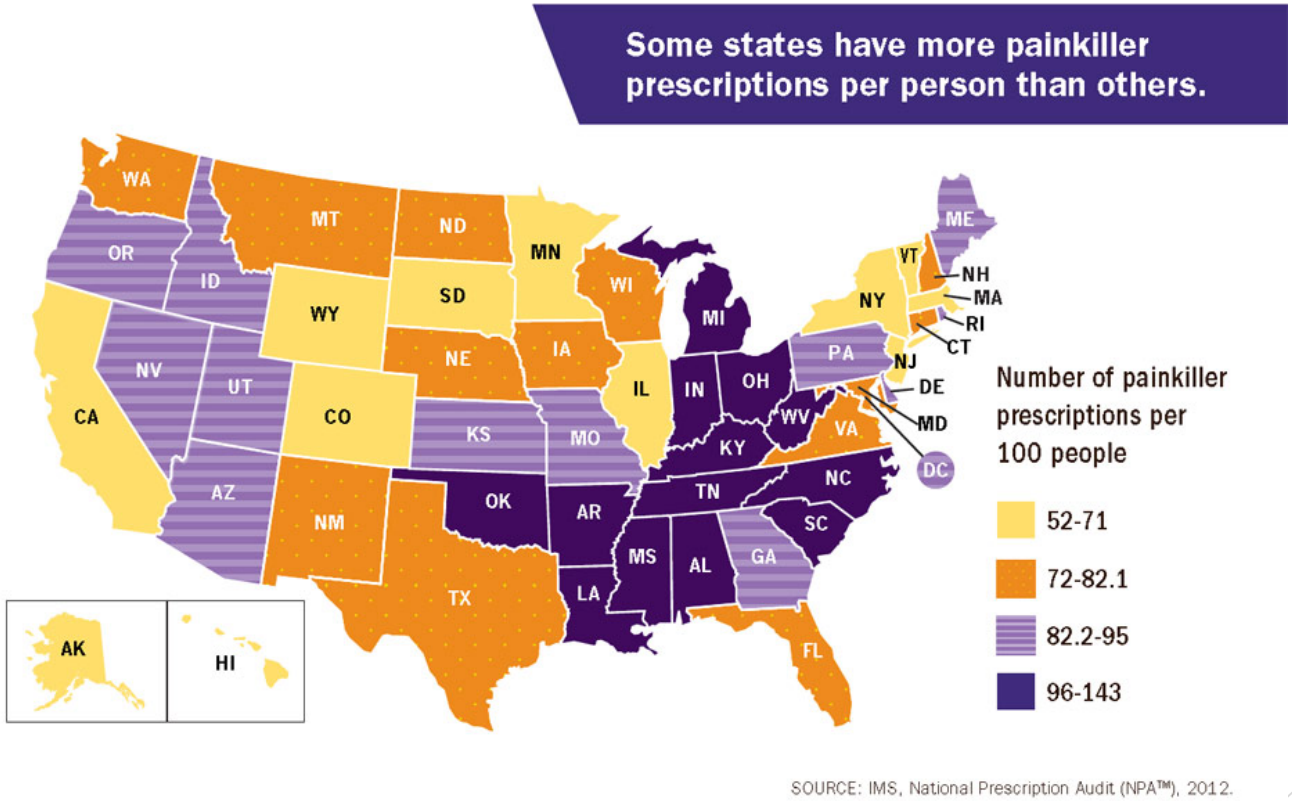
Kelvin Vu, D.O.

August 27, 2015

June 15, 2015


JUNE 15, 2015
TIME
They're the most
powerful
painkillers
ever invented.
And they're creating
the worst addiction
crisis America
has ever seen.
By Massimo Calabresi

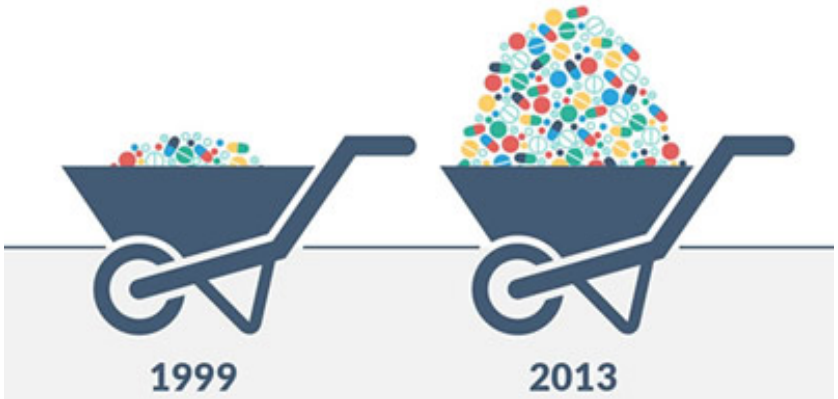
Opioid Prescription



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

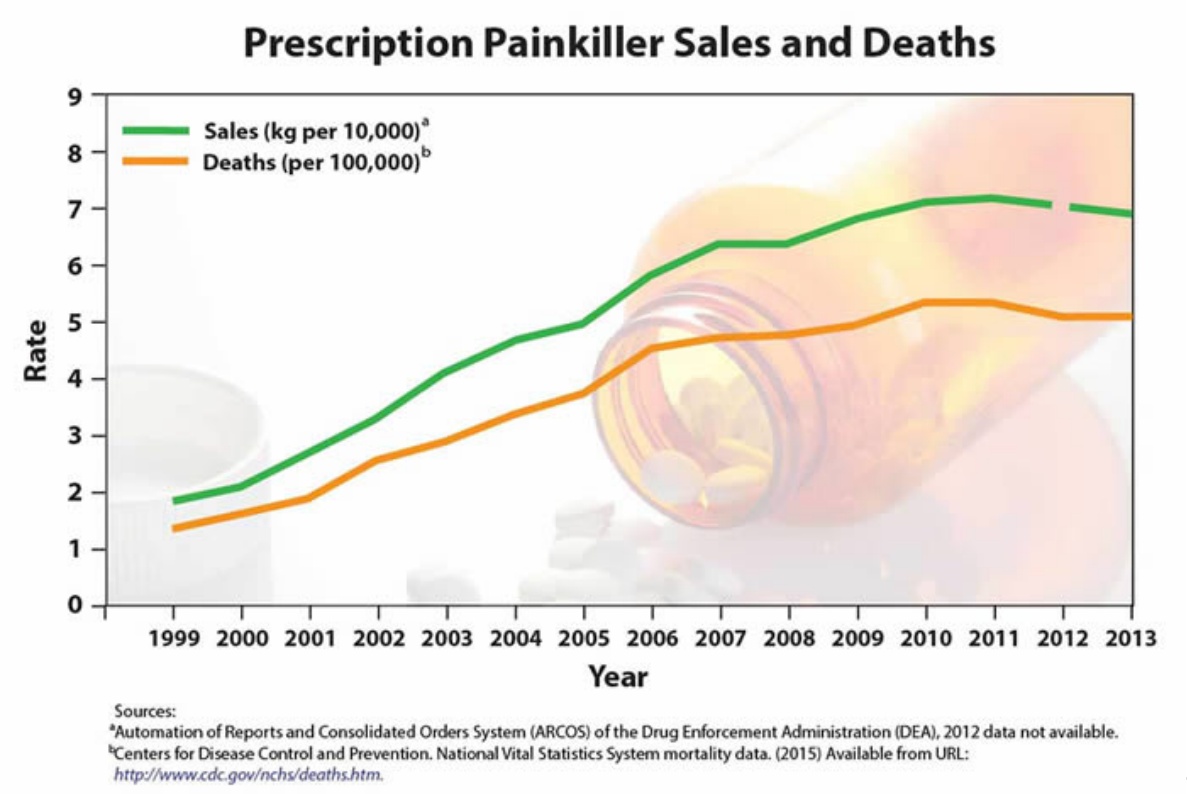
More Prescription Painkillers, Same Pain

From 1999 to 2013,
the amount of prescription painkillers prescribed & sold in the U.S. nearly **QUADRUPLED.**



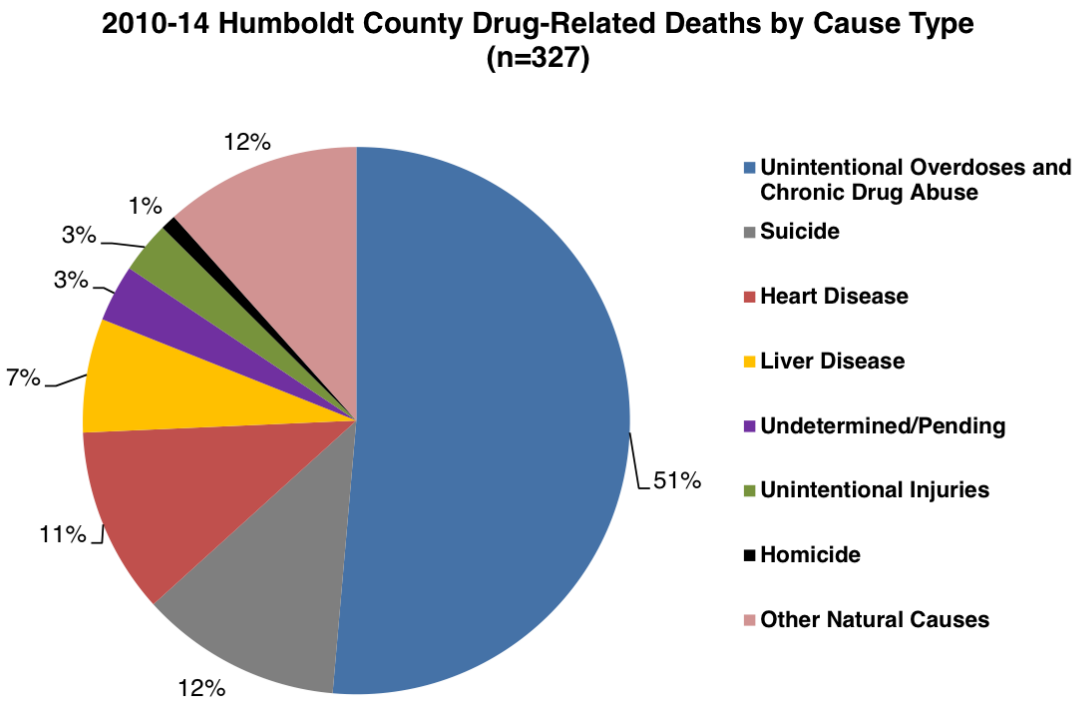
Yet there has not been an overall change in the amount of pain that Americans report.

More Prescription Painkillers, More Deaths



Sources:
[a]Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2012 data not available.
[b]Centers for Disease Control and Prevention. National Vital Statistics System mortality data. (2015) Available from URL: *http://www.cdc.gov/nchs/deaths.htm.*

Humboldt County



Buprenorphine Program

- Opioid dependence
- Chronic pain

Multi-disciplinary Approach

- Addiction counselor
- RN/case manager
- Behaviorist
- MA/lab assistant
- Physician

- Group visits
- Individual visits

Access to Care

- 3 sites:
- Eureka
- Arcata
- Crescent City

- Suboxone Summit

Buprenorphine Program - Eureka Site

- 6 physicians: 4 Family Physicians, 2 Psychiatrists
- Expansion of program
- Increase access
  - Pregnant, recently hospitalized, chronic pain patients
- Standardized practice guidelines

Phases

- Phase I (<3 months): 2 group meetings/week
- Phase II (3-9 months): 1 group meeting/week
- Phase III (>9 months): 2 group meetings/month

Future Plans

- Buprenorphine Program for adolescents
- Access to Naloxone

Questions?

North Coast Clinics Network

GROUP EXERCISE

Trisha Cooke
Project Director
North Coast Clinics Network

GROUP EXERCISE

- At your tables, take **10 minutes**:
  - Discuss what you have learned from the forum today and come up with SMART goals to address some of the challenges identified.
  - Rank your top 3 goals and report

PARTNERSHIP HEALTHPLAN of CALIFORNIA

CLOSING REMARKS

Jeff Ribordy, M.D Regional Medical Director
Partnership HealthPlan of California

PARTNERSHIP
HEALTHPLAN
of CALIFORNIA

SUMMARY OF THE DAY

PARTNERSHIP
HEALTHPLAN
of CALIFORNIA

WHERE DO WE GO FROM HERE?

PARTNERSHIP HEALTHPLAN of CALIFORNIA

FUTURE DIRECTIONS

- MAINTAIN GAINS
  - DATA COLLECTION AND DISSEMINATION
- CONTINUED EDUCATION
  - SUPPORTING PROJECT ECHO
  - OTHER CONFERENCES
  - TOOLKIT (http://www.partnershiphp.org/Providers/HealthServices/Pages/MPSToolKit.aspx)
- NEW TARGETS
  - BENZODIAZEPINES
  - CHRONIC HEADACHE (https://attendee.gotowebinar.com/register/5507504688359700737)
- NEW AND EXPANDED TREATMENT MODALITIES
  - BUPRENORPHINE
  - GROUP CLASSES
  - BIOFEEDBACK

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FUTURE DIRECTIONS

- SUPPORT LOCAL PAIN MANAGEMENT OVERSIGHT COMMITTEES
  - HELPS TO TARGET IMPROPER OPIOID USE
- TARGETED TREATMENTS FOR COMPLEX PATIENTS ON HIGH DOSE OPIOIDS
  - eCONSULT PILOT PROGRAM
- EDUCATION AND COORDINATION – ADDICTION SCREENING AND TREATMENT OPTIONS

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Innovative Ideas

ER Places Bowl Full of Percocet in Waiting Room, Lowers Visits

By **Lord Lockwell** - Jan 31, 2014

96.7k SHARES Facebook Twitter Reddit +

HANOVER, NJ – Local emergency medicine physicians have developed a ground breaking way to reduce the number of patients they will see during a shift. The new policy mimics a common Halloween tradition: leave a bowl full of candy outside with a sign that says '*Take One*' -allowing one to get drunk and not be bothered by children.

Placing a large bowl of Percocet in the waiting room has drastically cut down on the number of patients checking in at Holy Cross Hospital's ER. "We basically say you are on the honor system," Dr. Runofsky told *Gomerblog,* quenching concerns about patients taking too many pills home. "They came here demanding 'Pain Drugs' so help yourself."

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Government Intervention

Emergency Medicine | Full Articles | Internal Medicine | Pain Medicine

FDA Bans Any Narcotic with the Letter "D" or a Vowel in It

By **Dr. 99** - Aug 2, 2015

1.4k SHARES Facebook Twitter Reddit +

Atlanta, GA – The Food & Drug Administration (FDA) finally came to its senses today by agreeing to ban any narcotic that contains the letter D or a vowel in it. The long-awaited ban, which hopes to curb annoying drug-seeking patients and allow healthcare practitioners to actually practice medicine for once, starts today.

"HALLELUJAH!!" exclaimed emergency physician Todd Walters, running up and down the ED in excitement. "Can I do a dance? I think I'm gonna do a dance. VICTORY!!!! This is a great day for doctors and nurses nationwide!"

"OH BOY, OH BOY!" said giddy nurse Elaine Stevens, rubbing her hands together in eager anticipation. "This is HUGE! Now when patients ask for that drug that begins with the letter D – as if they're fooling us with their bad acting – I can tell them the only D they're getting is a discharge!"

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CLOSING HOUSEKEEPING ITEMS

- Leave the following on your table or the registration desk:
  - Evaluation
  - Badge

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PRESENTER ACKNOWLEDGEMENTS

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