

HH ECHO

Best Practice prescribing Controlled Substances

10/1/20

Charles Reznikoff, MD

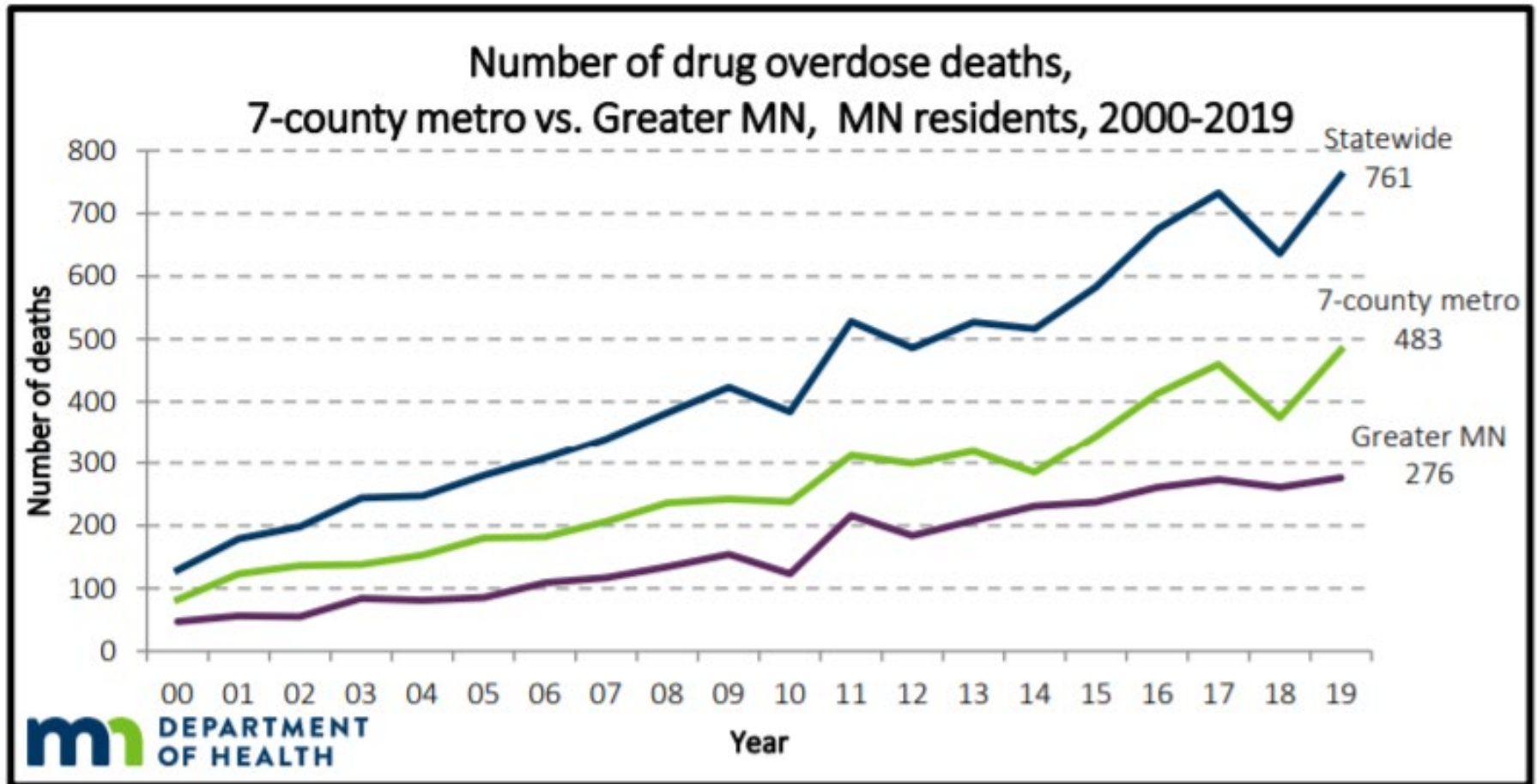
Charles.Reznikoff@hcmed.org

Hennepin Healthcare

Associate Professor of Medicine, University of Minnesota

MN overdose deaths rebounded in 2019 to highest total yet

Figure 1: The number of drug overdose deaths increased in 2019



NOTE: Data are preliminary and likely to change when finalized.

12 Month-ending Provisional Number of Drug Overdose Deaths

Based on data available for analysis on: **8/2/2020**

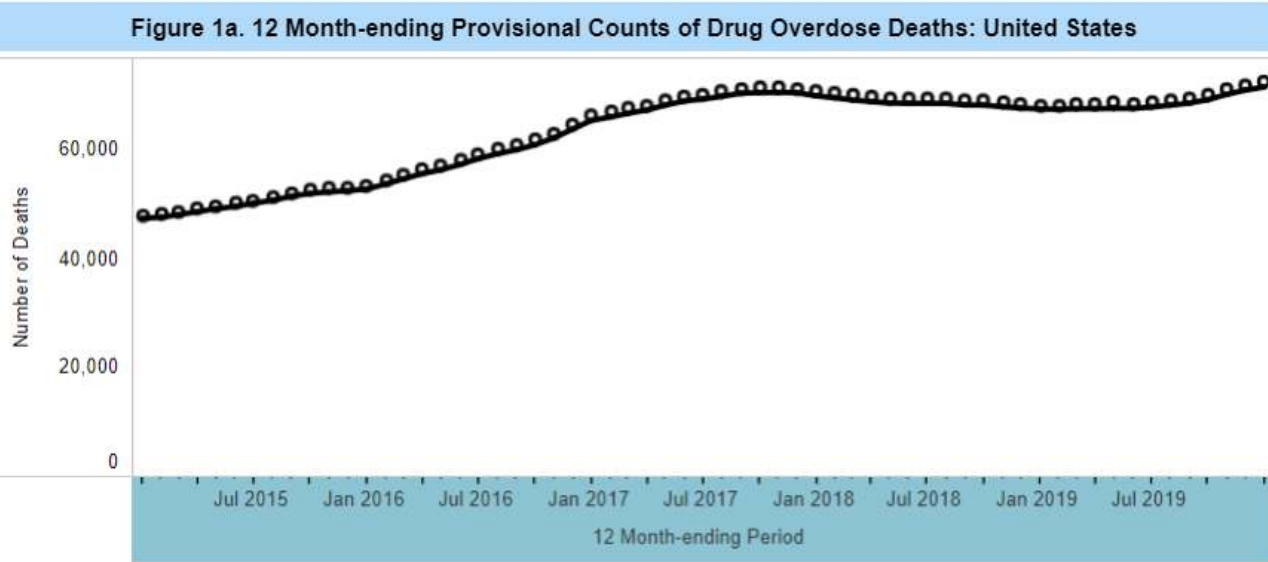
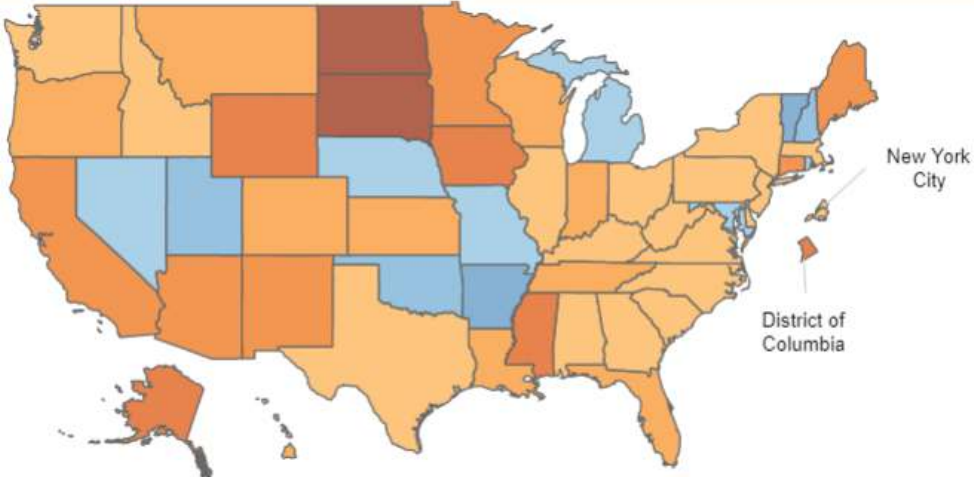


Figure 1b. Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: January 2019 to January 2020



Select predicted or reported number of deaths

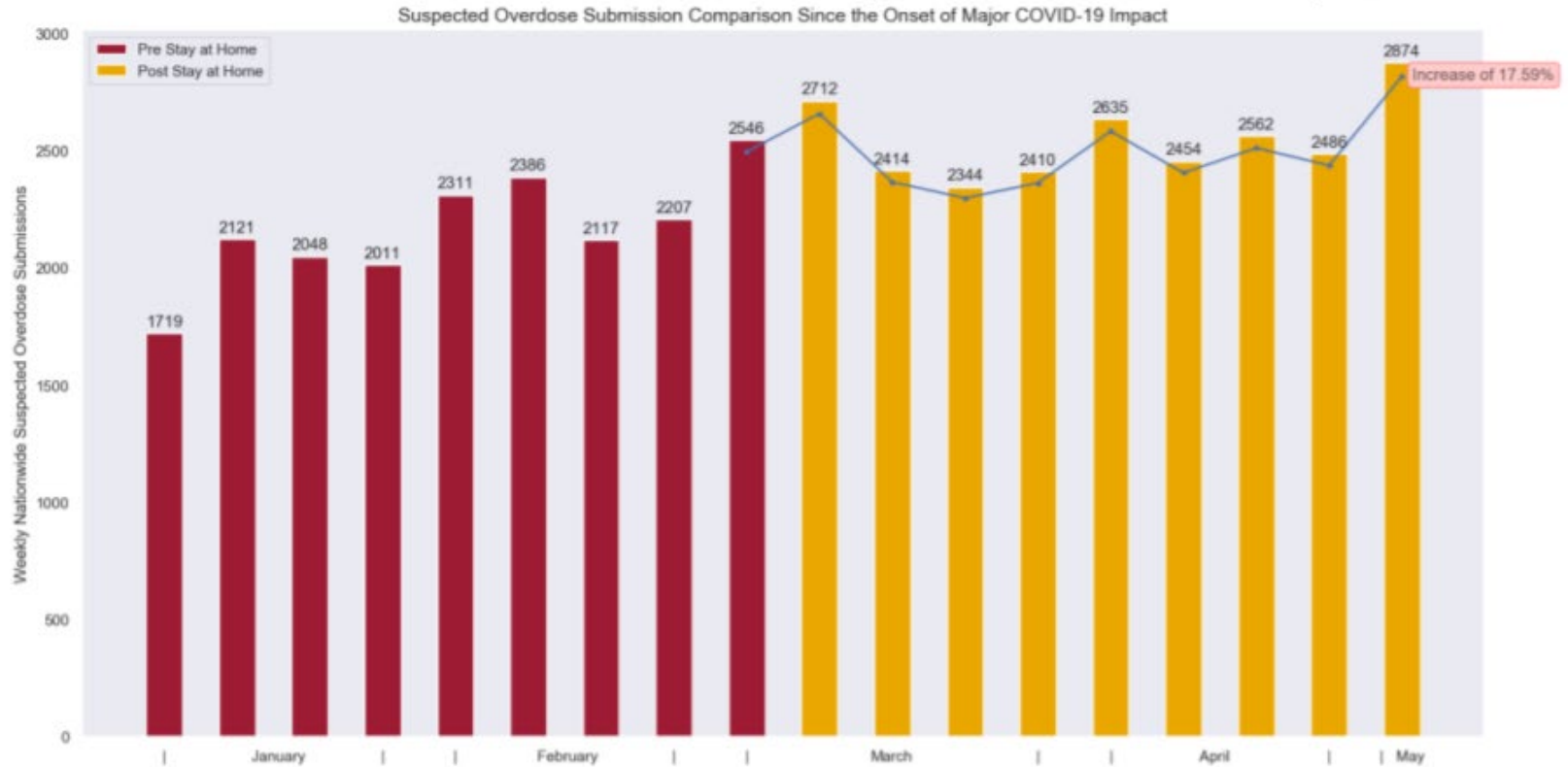
● Predicted
○ Reported

Percent Change for United States

6.6 ▲

Preliminary data shows overdose deaths increased from COVID

Figure 2: ODMAP submissions January 1, 2020 to March 18, 2020 compared to March 19, 2020 to May 19, 2020



Phases of the opioid epidemic

- 1. pharmaceutical opioids
- 2. heroin
- 3. fentanyl
- 4. ???????

Phases of the opioid epidemic

- 1. pharmaceutical opioids
- 2. heroin
- 3. fentanyl
- 4. *abrupt* discontinuation of prescribed opioids

Phases of the opioid epidemic

- 1. pharmaceutical opioids
- 2. heroin
- 3. fentanyl
- 4. *MOUD and multidisciplinary pain teams managing chronic pain patients*

The opioid epidemic is
progressing.

You can help save lives!

How you treat chronic pain
is important

Learning Objectives

- Set meaningful goals when treating chronic pain
- Understand the state regulations/laws of opioid prescribing
- Construct a multidisciplinary team
- Tapering Opioids collaboratively to improve patient safety

Margaret's Story: chronic pain, new to town, establishing care

- 72-year-old woman with obesity, DM2, HTN, major depressive d/o, and chronic pain from osteoarthritis of her knees
- She had her records sent to you, showing very good medication adherence and clinic attendance
- You resume treatment for DM2, HTN, and depression, all of which are stable
- Would you resume her pain treatment?

Margaret's pain treatment

- Her medications include:
 - Long acting Oxycodone 40 mg BID
 - Oxycodone 5 mg four times daily as needed
 - As needed OTC ibuprofen
 - Cyclobenzaprine 10 mg QHS as needed
- What is her daily MME?
- Why does that matter?

DHS' Seven Sentinel Measures

1. Index opioid prescribing rate
2. Index opioid prescription dose
3. Rate of prescribing over 700 cumulative MME in the post-acute pain period (“post-acute pain”)
4. Chronic opioid analgesic therapy (“COAT”) prescribing rates
5. High dose (>90 MME/day) COAT prescribing rate
6. Concomitant COAT and benzodiazepines
7. COAT patients receiving opioids from multiple providers

(Applies to Medicaid patients only)

Five **Quality Improvement** Thresholds

- 1. Index opioid prescribing rate***
- 2. Index opioid prescription dose**
- 3. Rate of prescribing over 700 cumulative MME in the post-acute pain period**
4. Chronic opioid analgesic therapy prescribing rates
- 5. High dose (>90 MME/day) COAT prescribing rate**
- 6. Concomitant COAT and benzodiazepines**
7. COAT patients receiving opioids from multiple providers

*Surgical specialties exempted from measure #1

Your 2019 Opioid Prescribing Report

This report compares your opioid prescribing to your specialty peers. It references prescriptions written to Minnesota Medicaid and MinnesotaCare members between July 2018 and June 2019. This report includes 7 measures associated with 3 phases of the prescribing cycle: index opioid prescriptions (acute); opioids prescribed up to 45 days after an index prescription (post-acute), and chronic opioid analgesic therapy.

Your Specialty: Family Medicine

NPI: 9999999999

FAKE PRESCRIBER
MN DEPT HUMAN SERVICES
540 CEDAR ST
ST PAUL, MN 55101



Measure 1 (Acute)

Percent (%) of enrollees prescribed an index opioid prescription

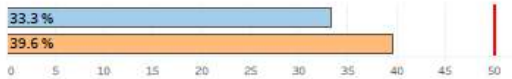
Numerator = 6 / Denominator = 281



Measure 2 (Acute)

Percent (%) of index opioid prescriptions exceeding the recommended dose

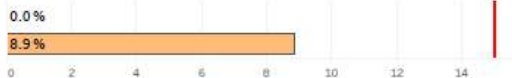
Numerator = 2 / Denominator = 6



Measure 3 (Post-Acute)

Percent (%) of prescriptions exceeding 700 cumulative MME in the 45 days following an index opioid prescription

Numerator = 0 / Denominator = 9



Measure 4 (Chronic)

Number of enrollees receiving opioids who are on Chronic Opioid Analgesic Therapy (COAT)

1 / 11 (No Quality Improvement threshold attached to this measure)

Measure 5 (Chronic)

Percent (%) of COAT enrollees exceeding 90 MME/day (High-dose COAT)

Numerator = 0 / Denominator = 1



Measure 6 (Chronic)

Percent (%) of enrollees receiving COAT who received a concomitant benzodiazepine

Numerator = 0 / Denominator = 1



Measure 7 (Chronic)

Number of enrollees prescribed COAT who received an opioid prescription from two or more additional providers

0 / 1 (No Quality Improvement threshold attached to this measure)

Comprehensive information is available at: <https://mn.gov/dhs/ooip>

Comments or questions about your report can be submitted here: <https://mn.gov/dhs/ooip/quality-improvement-program/> or by e-mailing dhs.ooipid@state.mn.us

Your OPIP Specialty Identification

Your NPI Number

Your Name Mailing Address

DHS Contact Information (for the reports)

MN DHS Opioid Report

- ***Do not panic!***
- The measures are made to account for exceptions
- The QI projects will be user friendly and meaningful
- Do not make clinical decisions to protect your license which adversely affect patients
- Do the right thing for your patient and trust us to have a rational program
- Read more and get involved:
 - <https://mn.gov/dhs/opip/>

What is DHS trying to achieve with its opioid reports?

- Minimize the number of new patients started on chronic opioid therapy for pain as much as medically appropriate
- Maximize the safety and quality of care for those already on chronic opioid therapy for pain without harming those patients

MN Prescription Monitoring Program (PMP)

- In Minnesota, starting January 2021, the PMP must be queried at the time of every opioid prescription
 - Many exceptions to this law!
- PMP can be integrated into electronic record systems
- PMP offers a variety of valuable information about patients receiving opioids
- PMP allows a clinician to search for prescriptions in most other states
- Delegates can be allowed access to query on behalf of a provider
 - Quarterly audits of delegates is required

Patient Request

[? Patient Rx Request Tutorial](#)

[Can't view the file? Get Adobe Acrobat Reader](#)

* Indicates Required Field

Patient Info

First Name*	Last Name*
<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Partial Spelling	<input type="checkbox"/> Partial Spelling
Date of Birth*	Date of Birth Range
<input type="text" value="MM/DD/YYYY"/>	Search using exact DOB <input type="button" value="v"/>

Prescription Fill Dates

No earlier than 1 year from today

From*	To*
<input type="text" value="08/05/2019"/>	<input type="text" value="08/04/2020"/>

Patient Location

Search accuracy can be improved by including the address

Zip Code

PMP InterConnect Search

To search in other states as well as your home state for patient information, select the states you wish to include in your search.

A	<input type="checkbox"/> Alabama	<input type="checkbox"/> Alaska	<input type="checkbox"/> Arizona	<input type="checkbox"/> Arkansas		
C	<input type="checkbox"/> Colorado	<input type="checkbox"/> Connecticut				
D	<input type="checkbox"/> Delaware	<input type="checkbox"/> District of Columbia				
F	<input type="checkbox"/> Florida					
I	<input type="checkbox"/> Idaho	<input type="checkbox"/> Illinois	<input type="checkbox"/> Indiana	<input type="checkbox"/> Iowa		
K	<input type="checkbox"/> Kansas	<input type="checkbox"/> Kentucky				
L	<input type="checkbox"/> Louisiana					
M	<input type="checkbox"/> Maine	<input type="checkbox"/> Maryland RxGov	<input type="checkbox"/> Massachusetts	<input type="checkbox"/> Michigan	<input type="checkbox"/> Military Health System	<input type="checkbox"/> Mississippi
						<input type="checkbox"/> Montana
N	<input type="checkbox"/> Nevada	<input type="checkbox"/> New Jersey	<input type="checkbox"/> New Mexico	<input type="checkbox"/> New York	<input type="checkbox"/> North Carolina	<input type="checkbox"/> North Dakota
O	<input type="checkbox"/> Ohio	<input type="checkbox"/> Oklahoma				
P	<input type="checkbox"/> Pennsylvania	<input type="checkbox"/> Puerto Rico				
R	<input type="checkbox"/> Rhode Island					
S	<input type="checkbox"/> South Carolina	<input type="checkbox"/> South Dakota				
T	<input type="checkbox"/> Tennessee	<input type="checkbox"/> Texas				
V	<input type="checkbox"/> Virginia					
W	<input type="checkbox"/> Washington PMP	<input type="checkbox"/> West Virginia	<input type="checkbox"/> Wisconsin			

Note the option to search for prescriptions in most other states.

PMP
queries
are easy

Back to Margaret's pain treatment

- She reports good pain control on her regimen
- She reports good function, but is mostly sedentary
- Records show no evidence of “aberrant” opioid use
- Past urine toxicology are appropriate
- She has not seen a physical therapist in years
- She declines surgery and interventional consultations

How do you assess function?


- Ask patients about a “typical day.” Have the patient give specific examples of her limitations, abilities and activities.
- For example, note the difference between:
“The favorite part of my week is when I babysit my grandkids. I get down on the floor with them and help them play LEGOs”

....and....

“I am in so much pain I can’t even babysit my own grandkids” she says as she begins crying

Goal setting for pain treatment with opioids

- Not all goals for pain treatment are appropriate goals!
- Some goals are not shared by the doc or patient!
- Examples of such goals for opioid prescribing include:
 - Optimizing pain control
 - Optimizing patient function
 - Optimizing patient satisfaction
 - Minimizing patient effort or financial burden
 - Safety, minimizing risk to the patient
 - Absence of aberrant behavior and addiction
 - Compliance with regulations and guidelines
 - Tapering opioids
 - Gain diagnostic clarity



**Discuss
balancing
these goals
with patient**

Multidisciplinary Pain Teams

- The new standard of care treating chronic pain is to employ *multidisciplinary pain team*
- ***What do you think a multidisciplinary pain team needs to include?***
- Telemedicine challenges the delivery of multidisciplinary pain care, but it is still possible

Examples of multidisciplinary pain team components....

- Medical management of pain (and monitoring)
- Pain psychology
- Pharmacy, PharmDs
- Physical therapy
- Integrative or complementary medicine
- Interventional and surgical treatments
- Addiction Medicine
- Toxicology/laboratory
- Sleep Medicine
- Case management, social work

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse:
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your pain in the past week?*

0 = "no pain", 10 = "worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?*

0 = "not at all", 10 = "complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your general activity?*

0 = "not at all", 10 = "complete interference"

Good overview of multidisciplinary pain care (For reference)

https://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf



Mental Health Assessment

- A patient with a chronic disease must adapt to it, including expectations, frustrations, limitations
- Many patients with chronic pain have comorbid mental health diagnoses
- Mental health diagnoses predict worse outcomes when prescribing opioids for pain
 - Including opioid addiction and overdose
- Treatment of mental health diagnoses and providing pain psychology likely improves response to treatment, while minimizing unwanted outcomes
 - Prospective evidence is incomplete on this

The Importance of Addiction Medicine when Treating Pain

- Opioid “addiction” is Moderate or Severe Opioid Use Disorder (OUD)
- 10% or more of patients treated long term with opioids for chronic pain develop OUD
- OUD the most serious side effect of chronic opioid therapy (other than death)
- Chronic Pain and OUD commonly coexist and can be co-treated successfully
- OUD diagnosis allows for initiation of life saving therapy

Establishing OUD Diagnosis

- Diagnostic interview is the only way to establish a diagnosis of OUD
 - OUD screening tools available, but none are great
 - Any doc can do a diagnostic interview with practice
 - If unable, an Addiction trained clinician can do the diagnostic interview (this creates delays and barriers)
 - See Demystifying Opioids packet later in this talk for diagnostic algorithm

DSM-5 substance use disorder criteria

2-3 Mild
4-5 Moderate
>5 severe

*Not user-
friendly!*

Criteria for Substance Use Disorders

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

DSM-5 Opioid Use Disorder Criteria: An Organized Approach

Category	Criteria
Impaired control	<ul style="list-style-type: none"> • Use in larger amounts or longer periods than intended • Unable to cut down or control use • Excessive time spent to obtain, use, or recover • Craving or preoccupation
Social impairment	<ul style="list-style-type: none"> • Failure to fulfill major role obligations (work, home, school) • Persistent or recurrent use-related social or interpersonal problems • Important social, occupational, or recreational activities given up
Risky use	<ul style="list-style-type: none"> • Recurrent physically hazardous use • Use despite persistent physical or mental harm from drug
Physical dependence	<ul style="list-style-type: none"> • Tolerance • Withdrawal <p style="color: red; text-align: right;">Not counted if would have happened from the licit Rx alone</p>

Margaret is considering a taper

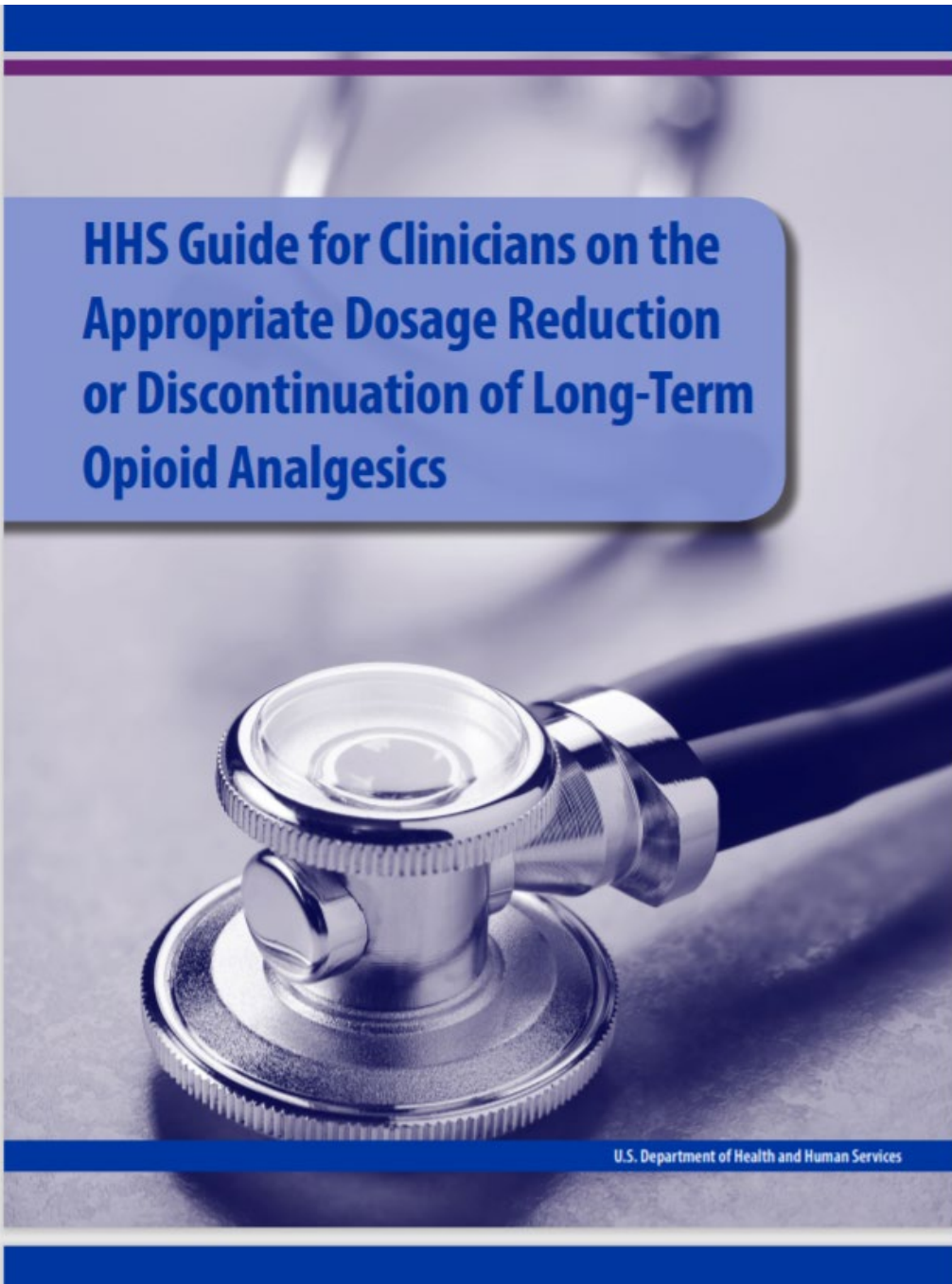
- After talking to her family and doing home physical therapy, the patient is interested in a taper
- She wants to know your proposed taper protocol
- She is not sure what a taper means, and asks for an explanation
- She is anxious about being in pain
- She still has not demonstrated any aberrant opioid behaviors

How to lower a patient's dose

- “Taper” “detox” and “wean” are misleading, loaded words: they imply a successful endpoint of zero
- Opioid dose decreases should be collaborative using shared decision making, but can be done against the patient's wishes if required for patient safety
- Decrease the dose only as tolerable to the patient, allow time between changes to acclimate
- Pause tapers for stress and mental health symptoms
- See the patient more frequently during the taper
- Retention in treatment and long term follow up is a goal
- Do not write out a rigid schedule of dose changes
- Addictions may emerge, representing life-threatening danger to patient. Get a stat addiction consult!
- The taper progresses until the risk/benefit ratio is optimized, not necessarily to zero opioids
- No one knows if/which patients can safely fully “tapered” to zero

Risks of rapid tapers and sudden discontinuation

- Emergency department visits
- Overdoses
- Pain and suffering
- Mental health crisis
- Social crisis
- Other medical problems
- Precipitating an opioid addiction



**HHS Guide for Clinicians on the
Appropriate Dosage Reduction
or Discontinuation of Long-Term
Opioid Analgesics**

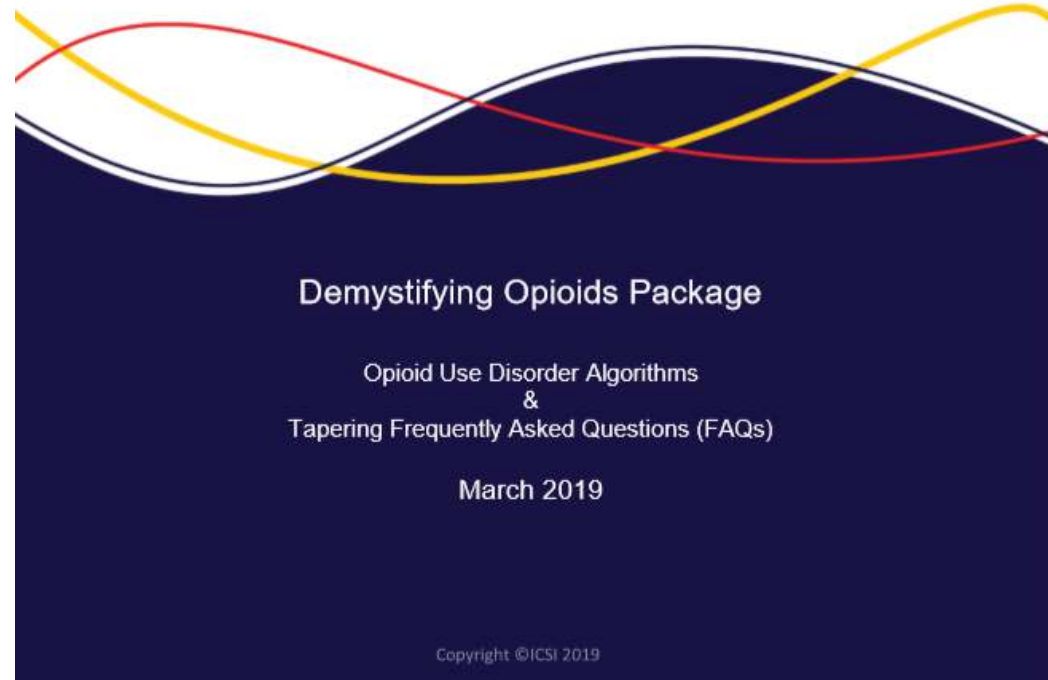
U.S. Department of Health and Human Services

Tapering
guidance for
your reference

https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Page%20version_HHS%20Guidance%20for%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf

Reference with multiple tips including tapering advice, diagnosing OUD in pain patients

<https://www.icsi.org/wp-content/uploads/2019/04/DemystifyingOpioidsPacket4.1.19.pdf>



Learning Objectives

- Set meaningful goals when treating chronic Pain
- Understand the state regulations/laws of opioid prescribing
- Construct a multidisciplinary team
- Tapering Opioids collaboratively to improve patient safety

Big Picture Chronic Pain on Opioids

- Patients with chronic pain on chronic opioids are a complex, suffering, morbid group of patients with mortality risk
- They require careful medical management and multidisciplinary care
- Be knowledgeable and alert for addiction
- The primary care clinician has an indispensable role helping the patient navigate, organize and prioritize their treatment program

Questions?

Please contact me at

Charles.Reznikoff@hcmed.org