

HH ECHO

Best Practice prescribing Controlled Substances

9/15/22

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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*

Phases of the opioid epidemic

- 1. pharmaceutical opioids
- 2. heroin
- 3. fentanyl
- 4. *methamphetamine epidemic*

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?

Talk overview

- Review state regulations and laws about opioids
- Understand the clinical reasoning behind the above
- Assessing function in addition to pain
- Setting goals of opioid therapy
- Assembling a multidisciplinary pain team
- High risk groups for receiving opioids
- Opioid tapers

Changes to the CDC opioid guideline

- Eliminates the use of any MME targets
 - Why?
 - Is this a good thing?
- Strengthens language about tapering
- Strengthens language about offering MOUD

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

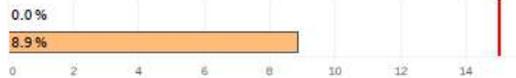
Numerator = 2 / Denominator = 6



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 OPIP to be 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

Two hours mandatory opioid prescribing education

- If you are not enrolled in OPIP you have a required 2 hours of opioid CME
- You will be prompted on this when renewing your license
- If you received an OPIP report, you are enrolled in the program and therefore exempt
- If you are unsure if you are exempt, email me (within HH) or email dhs.opioid@state.mn.us and ask them if you are enrolled in opip (and for a copy of your report)

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***

Exceptions to the PMP law

- the patient is receiving palliative care, or hospice or other end-of-life care
- the patient is being treated for pain due to cancer or the treatment of cancer
- the prescription order is for a number of doses that is intended to last
-the patient five days or less and is not subject to a refill
- the prescriber and patient have a current or ongoing provider/patient relationship of a duration longer than one year
- the prescription order is issued within 14 days following surgery or three days following oral surgery or follows the prescribing protocols established under the opioid prescribing improvement program.

Patient Request

[? Patient Rx Request Tutorial](#)

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

* Indicates Required Field

Patient Info

First Name*

Partial Spelling

Last Name*

Partial Spelling

Date of Birth*

Date of Birth Range

 ▾

Prescription Fill Dates

No earlier than 1 year from today

From*

To*

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

Acute pain prescribing limits

- 7 days for acute pain for adult

- 5 days for acute pain for pediatric

- 4 days for dental pain including tooth extraction or refractive surgery

- "acute pain" means pain resulting from disease, accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably expects to last only a short period of time

- If, in the professional clinical judgment of a practitioner, more than the limit specified is required to treat a patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat the patient's acute pain

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?

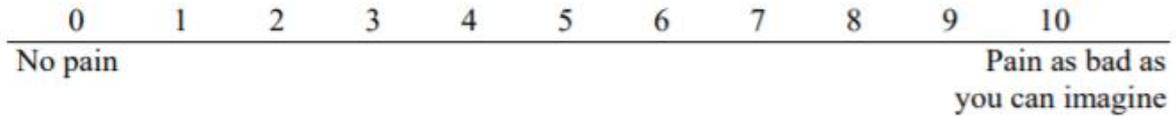
- Ask patients about a “typical day.” Have the patient give specific examples of her limitations, abilities and activities.
- For example, note the difference between:
“The favorite part of my week is when I babysit my grandkids. I get down on the floor with them and help them play LEGOs”

....and....

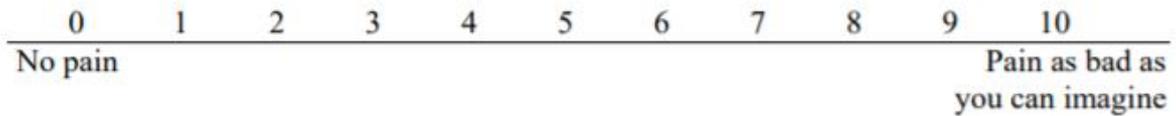
“I am in so much pain I can’t even babysit my own grandkids” she says as she begins crying

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

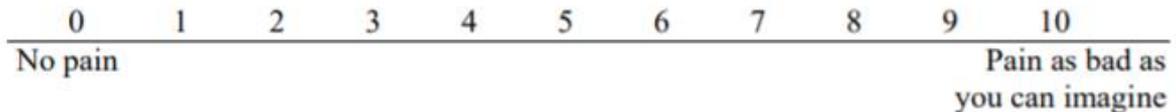
1. What number best describes your pain on average in the past week?



2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?



3. What number best describes how, during the past week, pain has interfered with your general activity?



PEG scale:
Useful tool
for
assessment
of pain and
function

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 any chronic disease must adapt to it, including expectations, frustrations, limitations
- Many patients with chronic pain also have undertreated 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
 - Recent Annals of internal medicine article on CBT for pain

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>

Training requirements for the buprenorphine license have been waived

Many good and free training resources available online

It is quick and easy to apply for a buprenorphine license

Buprenorphine licenses are helpful for inpatient and outpatient clinicians!



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FAQs About the New Buprenorphine Practice Guidelines

FAQs About the New Buprenorphine Practice Guidelines

1. Do I still need to apply for the X waiver?

Yes, these guidelines exempt eligible practitioners from certification requirements related to training and the provision of psychosocial services, which were previously necessary when dispensing or prescribing buprenorphine for the treatment of opioid use disorder (OUD) to 30 or fewer patients. Submission and approval of a Notice of Intent (NOI) remains legally necessary in order to use buprenorphine in the treatment of patients with OUD.

To indicate the qualified training exemptions when applying on the NOI website, applicants must select a training source or the system will bump them out. To apply, mid-level practitioners (APRNs and PAs) should check SAMHSA's Providers Clinical Support System (PCSS) in "CERTIFICATION OF QUALIFYING CRITERIA," then enter "practice guidelines" in the text box for the date.

Physicians should select "Other" in "CERTIFICATION OF QUALIFYING CRITERIA," then enter "practice guidelines" in the text box for the city of the training. The training date should be the application date.

Further information regarding how to submit a NOI and obtain a waiver,

www.samhsa.gov/medication-assisted-treatment/practitioner-resources/faqs

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

What is the best approach to successfully taper?

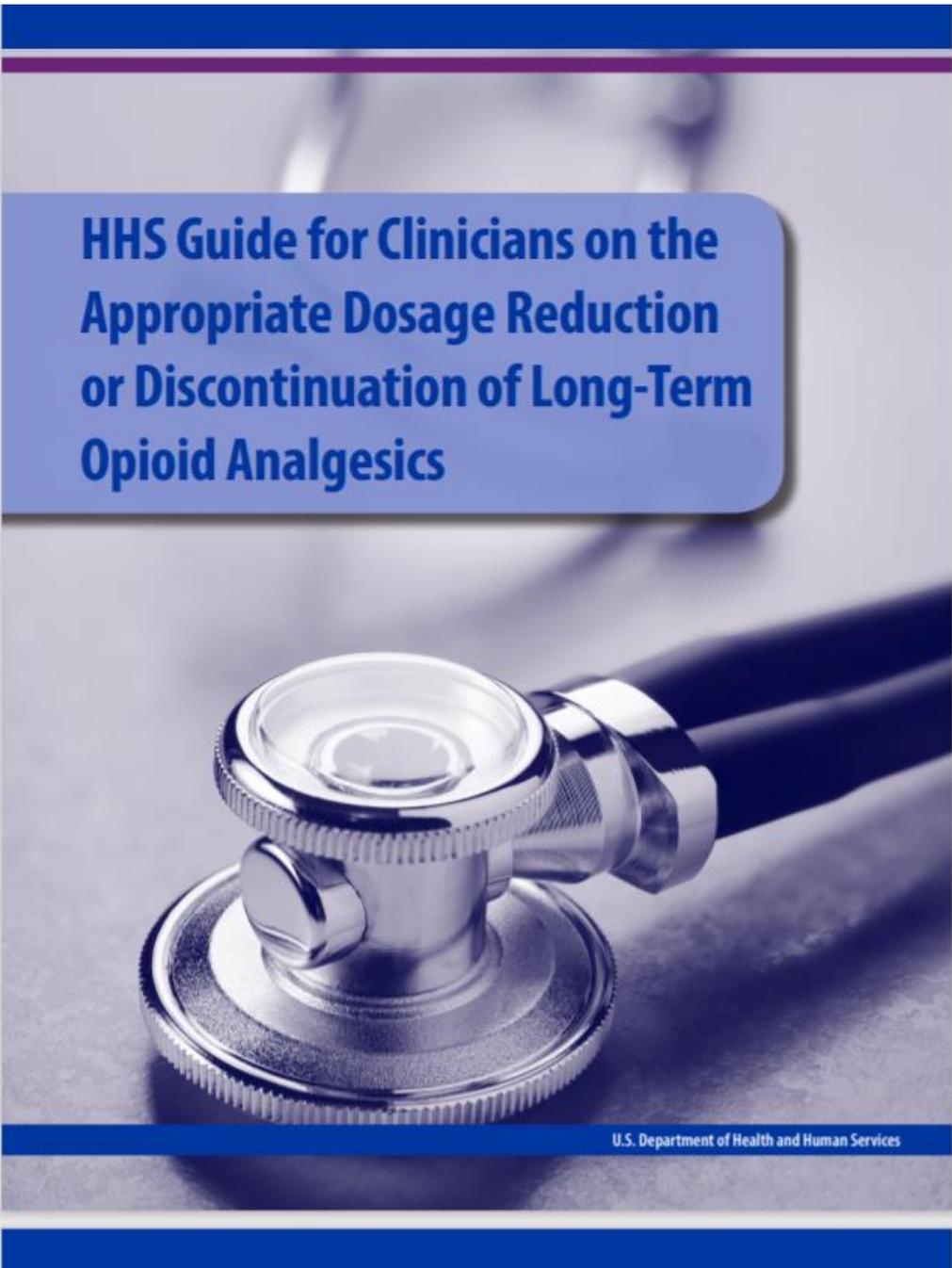
- Do not taper stable patients
- Change all opioids to long acting
- Change all opioids to short acting
- Add medical cannabis
- Get the dose under the target MME of 90 first then reevaluate
- Open-ended taper without any defined structure

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
- Suicides
- Cardiovascular deaths
- Pain and suffering
- Mental health crisis
- Social crisis
- “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

Best 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>



Demystifying Opioids Package

Opioid Use Disorder Algorithms
&
Tapering Frequently Asked Questions (FAQs)

March 2019

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