# Prescribing Update Fall 2020

Sponsored by the Oklahoma State Medical Association

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# Consequences for Physicians

- Physician Sentenced to 20 Years for Illegal Opioid Distribution, August 21, 2020

- *“Sakkal issued deadly drug cocktails without regard for the repeated warnings he received from employees, patients, pharmacists, another doctor, and the electronic records system.”*

# Consequences for Physicians

- DEA Press Release: August 12, 2020

**TULSA “PILL MILL” DOCTOR PLEAS GUILTY TO OPIOID DRUG CONSPIRACY**

# Opioid Use Causes Increase in Medical Malpractice Litigation

- White paper by the Expert Institute:
  - Over the past 4 years, medication-related claims have been cited as the 4th most common medical malpractice cause of action.
  - Opioid prescriptions make up almost 25% of such claims, making pain medication the most frequent root cause of medical malpractice actions involving prescriptions.

# Opioid Use Causes Increase in Medical Malpractice Litigation

- According to Robert Hanscom, M.D., V.P. of Coverys and co-author of a study: "Physicians continued to renew prescriptions without monitoring patients to see if they were getting better or not, if there were any changes in their clinical status. . . If patients are still in pain, that's red flag. It's not helpful to keep prescribing the same opioid if they're not improving."

# Licensure Board Guidance

- Consult “Compliance and Best Practice for An Act Regulating the Use of Opioid Drugs” available on the OBMLS and Board of Osteopathic Examiner websites.

# Are any of the regulations and other efforts working?

# Opioid Crisis Fast Facts

*Reported by CNN Health, Editorial Research, December 4, 2019

- Prescription opioid volumes peaked in 2011, with the equivalent of 240 billion milligrams of morphine prescribed, according to the market research firm, IQVIA Institute for Human Data Science.

- In 2018, prescription opioid volume fell by 29.2 billion morphine milligram equivalents, a dramatic decline.

# Progress – CDC Stats (from 2015-17)

- The number of individuals who misused pain relievers *decreased from 12.5 to 11.1 million*.
- The number of individuals with pain reliever use disorder *decreased from 2.0 million to 1.7 million*.

# Progress – CDC Stats (from Jan. 2017-Nov. 2018)

- The total MME dispensed monthly by retail and mail-order pharmacies *declined by 25.6%.*
- Number of unique patients receiving buprenorphine monthly from retail pharmacies *increased by 21.9%.*
- The number of naltrexone prescriptions per month from retail and mail pharmacies has *increased more than 46.9%.*
- Naloxone prescriptions dispensed monthly by retail and mail-order pharmacies have *increased by 338%*.

# Oklahoma Statistic

- 19% decrease in the number of opioids prescribed since first pill limit bill (SB 1446) became effective on November 1, 2018.

# AMA Opioid Task Force Statistics

- **37.1%** decrease in opioid prescriptions
- **1M+** naloxone prescriptions in 2019
- **64.4%** increase in the use of state prescription drug monitoring programs from 2018-19.
- Hundreds of thousands of physicians accessing CME on topic
- **85,000+** physicians and health care professionals certified to prescribe buprenorphine in-office.

# Impact of COVID

- AMA Issue Brief: Reports of Increases in Opioid-Related Overdoes (August 14, 2020)
- More than 40 states have reported increases in opioid-related mortality during the pandemic.

## But more progress is needed. . . .

What is the role of physicians and other providers?

What should physicians be doing?

# Interactive Training Series for Healthcare Providers

https://www.cdc.gov/drugoverdose/training/online-training.html.

Applying CDC's Guideline for Prescribing Opioids: An Online Training Series for Providers

This interactive online training series aims to help healthcare providers apply CDC’s recommendations in clinical settings through patient scenarios, videos, knowledge checks, tips, and resources. Providers can gain a better understanding of the recommendations, the risks and benefits of prescription opioids, nonopioid treatment options, patient communication, and risk mitigation. Each stand-alone module is self-paced and offers free continuing education.

# 13 CDC Modules

| | |
|---|---|
| 1 | Addressing the Opioid Epidemic: Recommendations from CDC |
| 2 | Treating Chronic Pain Without Opioids |
| 3 | Communicating with Patients |
| 4 | Reducing the Risks of Opioids |
| 5 | Assessing and Addressing Opioid Use Disorder |
| 6 | Dosing and Titration of Opioids: How Much, How Long, and How and When to Stop |
| 7 | Determining Whether to Initiate Opioids for Chronic Pain |

# 13 CDC Modules

| | |
|---|---|
| 8 | Implementing CDC's Opioid Prescribing Guideline into Clinical Practice |
| 9 | Opioid Use and Pregnancy |
| 10 | Motivational Interviewing |
| 11 | Collaborative Patient-Provider Relationship in Opioid Clinical Decision Making |
| 12 | A Nurse's Call to Action for Safer Opioid Prescribing Practices |
| 13 | Using the Prescription Drug Monitoring Program to Promote Patient Safety in Opioid Prescribing and Dispensing |
| | |

# CDC Fact Sheets

| | |
|---|---|
| 1 | New Opioid Prescribing Guideline |
| 2 | Assessing Benefits and Harms of Opioid Therapy |
| 3 | Prescription Drug Monitoring Programs |
| 4 | **Calculating Total Daily Dose of Opioids for Safer Prescribing** |
| 5 | Pregnancy and Opioid Pain Medications |
| | |
| | **Checklist for Prescribing Opioids for Chronic Pain** |

# CDC Clinical Tools

| | |
|---|---|
| 1 | Quick Reference for Healthcare Providers |
| 2 | Urine Drug Testing |
| 3 | Mobile App (includes MME calculator) |
| 4 | Calculating Dosage |
| 5 | Pocket Guide: Tapering |
| 6 | Fact Sheet |
| 7 | Checklist |
| 8 | Nonopioid Treatments |

# What is the CDC saying?

*"Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose – particularly with high dosages and long-term use."*

# CDC – 3 Principles

- Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.

# CDC – 3 Principles

- When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.

# CDC – 3 Principles

- Clinicians should always exercise caution when prescribing opioids and monitor all patients closely.

# CDC - 12 Guidelines (1)

- **Opioids are not first-line therapy**
  - Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
    - Nonopioids medications
    - Physical treatments
    - Behavioral treatment
    - Interventional treatments (injections)

# CDC - 12 Guidelines (2)

- **Establish Goals for Pain and Function**
  - Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

# CDC - 12 Guidelines (3)

- **Discuss Risks and Benefits**
  - Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

# CDC - 12 Guidelines (4)

- **Use Immediate-Release Opioids When Starting**
  - Clinicians should prescribe immediate-release opioids instead of extended release/long-acting (ER/LA) opioids.

# CDC - 12 Guidelines (5)

- **Use the Lowest Effective Dose**
  - Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to more than 50 MME/day and should avoid increase dosage to more than 90 MME/day or carefully justify a decision to titrate dosage to more than 90 MME/day.

# CDC - 12 Guidelines (6)

- **Prescribe Short Durations for Acute Pain**
  - Long-term opioid use often begins with treatment of acute pain.
  - Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
  - Three (3) days or less will often be sufficient; more than seven (7) days will rarely be needed.

# CDC - 12 Guidelines (7)

- **Evaluate Benefits and Harms Frequently**
  - Evaluate with patients within 1-4 weeks of starting opioid therapy for chronic pain or of dose escalation.
  - Evaluate benefits and harms of continued therapy with patients ever 3 months or more frequently.

# CDC - 12 Guidelines (8)

- **Use Strategies to Mitigate Risk**
  - Clinicians should incorporate into the management plan strategies to mitigate risk including considering offering naloxone when factors that increase risk for opioid overdose are present.
    - History of overdose or substance use disorder
    - Mental health conditions such as anxiety or depression
    - Sleep apnea
    - Older age (65 or older)
    - Pregnancy
    - Higher opioid dosages
    - Concurrent use of Benzodiazepines, Muscle relaxants, Hypnotics or other opioids

# Drug Cocktail – “Holy Trinity”

- Opiate + Benzodiazepine + Muscle Relaxer
  - Combo of Oycodone/Hydrocodone, Alprazolam, & Carisoprodol
  - Oxy, Soma and Xanas

# CDC Assessing Benefits and Harms

- A 30% improvement in pain and function is considered clinically meaningful.

# Assess Harms of Opioid Therapy

- Assess (1)
  - Evaluate for  factors that could increase your patient's risk for harm from opioid therapy such as:
    - Personal or family history of SUD
    - Renal or hepatic insufficiency
    - COPD

# Assess Harms of Opioid Therapy

- Check (2)
  - Consider urine drug testing for other prescription or illicit drugs and check the state PDMP for:
    - Possible drug interactions
    - High opioid dosage
    - Obtaining opioids from multiple providers.

# Assess Harms of Opioid Therapy

- Discuss (3)
  - Ask your patient about concerns and determine any harms they may be experiencing such as:
    - Nausea or constipation
    - Feeling sedated or confused
    - Breathing interruptions during sleep
    - Taking or craving more opioids than prescribed or difficulty controlling use.

# Assess Harms of Opioid Therapy

- Observe (4)
  - Look for early earning signs for overdoes risk such as:
    - Confusion
    - Sedation
    - Slurred speech
    - Abnormal gait

# CDC - 12 Guidelines (9)

- **Review PDMP Data**
  - Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

# CDC Prescription Drug Monitoring Programs

- “State requirements vary, but CDC recommends checking at least once every 3 months and consider checking prior to every opioid prescription.”

# What should I do if I find information about a patient in the PDMP that concerns me?

- “Patients should not be dismissed from care based on PDMP information.  Use the opportunity to provide potentially life-saving information and interventions.”

# What should I do if I find information about a patient in the PDMP that concerns me?

1. Confirm that the information in the PDMP is correct.
2. Assess for possible misuse or abuse.
   a. Offer or arrange for treatment.
3. Discuss any areas of concern with your patient and emphasize your interest in their safety.

# CDC - 12 Guidelines (10)

- **Use Urine Drug Testing**
  - Clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

# CDC Urine Drug Testing

- “All patients on long-term opioid therapy should have periodic urine drug tests. Medical experts agree that an annual UDT for all patients should be standard practice. Subsequent UDTs should be determined on an individual patient basis, at the discretion of the clinician.

# What to discuss with patients **BEFORE** ordering and conducting a UDT

- **Establish provider/patient trust**
  - Requiring a UDT does not imply a lack of trust on the part of the provider; it is part of a standardized set of safety measures offered to all patients taking opioids.

# What to discuss with patients **BEFORE** ordering and conducting a UDT

- **Discuss the purpose of UDTs**
  - What drugs the test will cover, and the expected results (e.g., presence of prescribed medication and absence of other drugs, including illicit drugs, not reported by the patient).

# What to discuss with patients **BEFORE** ordering and conducting a UDT

- **Go over the potential cost**
  - If the UDT is not covered by insurance.
- **Review dosage**
  - Review the time and dose of the opioids most recently consumed by the patient.

# What to discuss with patients **BEFORE** ordering and conducting a UDT

- **Discuss any prescribed or unprescribed drugs**
  - Discuss any other prescribed or unprescribed drugs thte patient has taken; unprescribed drugs may include marijuana or other illicit drugs.

- **Ask the patient what UDT results he/she expects**
  - To aid in eliciting information on other drugs taken as well as to assess his/her understanding of test result interpretation.

# What to discuss with patients **BEFORE** ordering and conducting a UDT

- **Establish the expectation of random repeat testing.**
  - Establish the expectation of random repeat testing depending on treatment agreement and monitoring approach.
- **Review**
  - Review actions that may be taken based on the results of the test.

# Talking with Patients about UDT Results

- “If unexpected results occur when ordering a UDT, remember that the focus is to improve patient safety.  Have a plan in place for communicating results and practice the difficult conversations you may have to have with your patients.”

# Talking with Patients about UDT Results

- CDC Tips
  - Always keep the focus on the patient's well-being and safety.
  - Do not jump to conclusions about unexpected results; have a candid conversation with the patient about possible explanations.

# Talking with Patients about UDT Results

- CDC Tips
  - **Do not dismiss patients from care based on UDT results.**
  - Consider using the CDC mobile app to practice the types of conversations you may encounter with patients.

# Actions to take post-UDT

- Discuss unexpected results with the local laboratory or toxicologist if assistance is needed with interpretation.

- Inform the patient of the test results.

# Actions to take post-UDT

- Take time to discuss unexpected results with the patient and refer to pre-UDT information the patient may have shared with you.
- Review the treatment agreement and focus conversations around patient safety.

# Actions to take post-UDT

- Determine if frequency and intensity of monitoring should be increased and keep the patient informed.

# CDC - 12 Guidelines (11) and (12)

- **Avoid Concurrent Opioid and Benzodiazepine Prescribing**

- **Offer Treatment for Opioid Use Disorder**
  - Usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies.

# CDC Tapering Pocket Guide

- Consider tapering when your patient:
  - Requests dosage reduction
  - Does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale)

# CDC Tapering Pocket Guide

- Consider tapering when your patient:
  - Is on dosages greater than 50 MME/day without benefit or opioids are combined with benzodiazepines
  - Shows signs of substance use disorder (e.g., work or family problems related to opioids use, difficulty controlling use)

# CDC Tapering Pocket Guide

- Consider tapering when your patient:
  - Experiences overdose or other serious adverse event
  - Shows early warning signs of overdose risk such as confusion, sedation or slurred speech

# CDC Tapering Pocket Guide

- “A decrease of 10% per month is a reasonable starting point if patients have taken opioids for more than a year. A decrease of 10% per week may work for patients who have taken opioids for a shorter time (weeks to months).”

# CDC Tapering Pocket Guide

- “Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.”

# Medical Record Documentation

- Physicians who treat patients with chronic pain **MUST** maintain accurate and complete medical records:
  - Copies of the signed informed consent and treatment agreement.
  - Patient's medical history.

# Medical Record Documentation

- Results of the physician examination and all laboratory tests (if you billed for it, it better be there).
- Results of the risk assessment.
- A description of the treatments provided.
- Instructions to the patient, including discussions of risks and benefits.

# Medical Record Documentation

- Results of ongoing monitoring of patient progress.
- Notes of evaluations by and consultations with specialists.
- Results of queries to the State PMP.
- Any other information used to support the initiation, **continuation**, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors.

# DHHS Recommendation

December 19, 2018

- Prescribe or co-prescribe naloxone to individuals at risk for opioid overdose including individuals who:
  - Are on relatively high doses of opioids
  - Take other medications which enhance opioid complications
  - Have underlying health conditions

Thank you for attending and listening!

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