WELCOME

PARTNERSHIP HEALTHPLAN of CALIFORNIA

NORTHERN REGION MANAGING PAIN SAFELY FORUM

MARYA CHOUDHRY

MAY 28, 2015

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

LOGISTICS

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

HOUSEKEEPING

- Restroom Locations
- Electronic Devices
- WIFI Access: hgi2015
- Presentation Materials Online

http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx

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!!!

LET'S GET STARTED

Let's get started . . .

LET'S GET STARTED

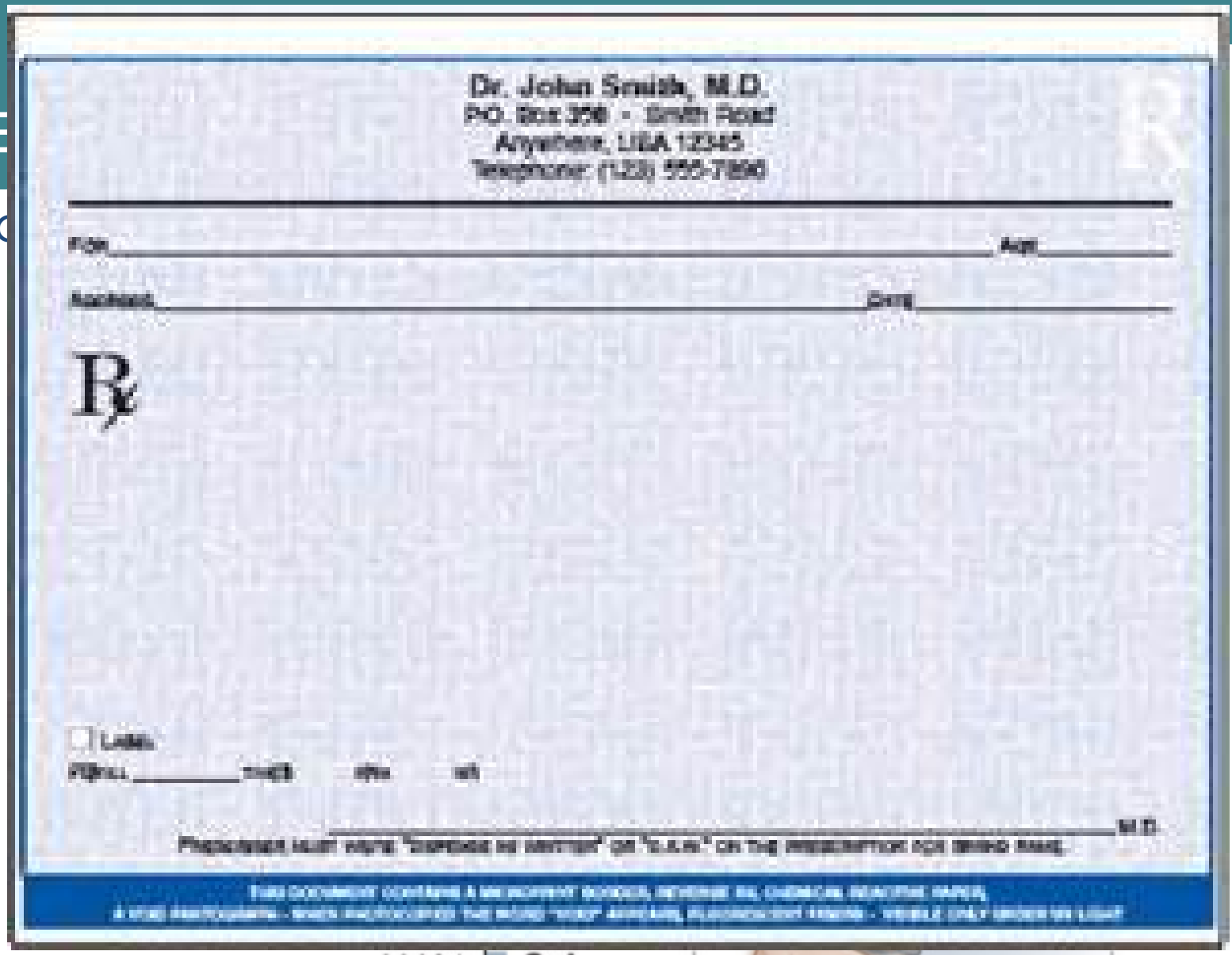
ENJOY THE FORUM!

PHC'S INITIATIVE TO REDUCE OPIOID OVERUSE

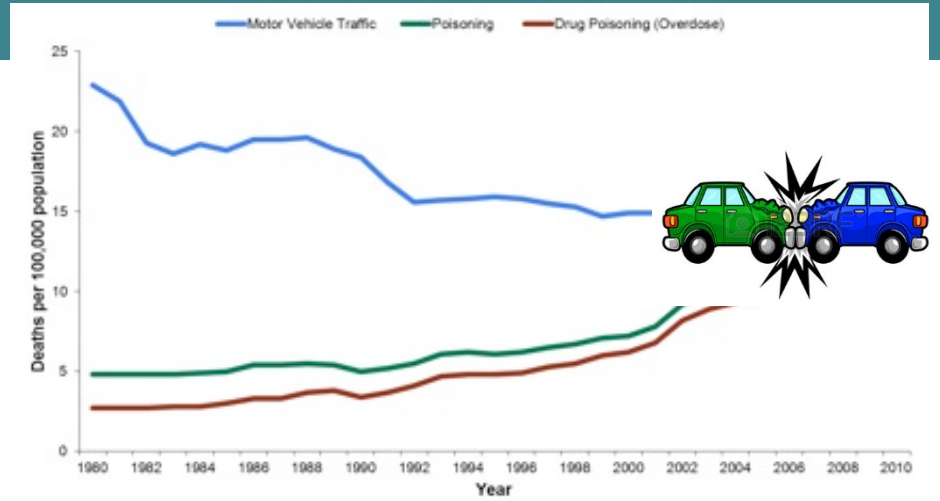
MARSHALL KUBOTA , MD

TODAY'S E

- C

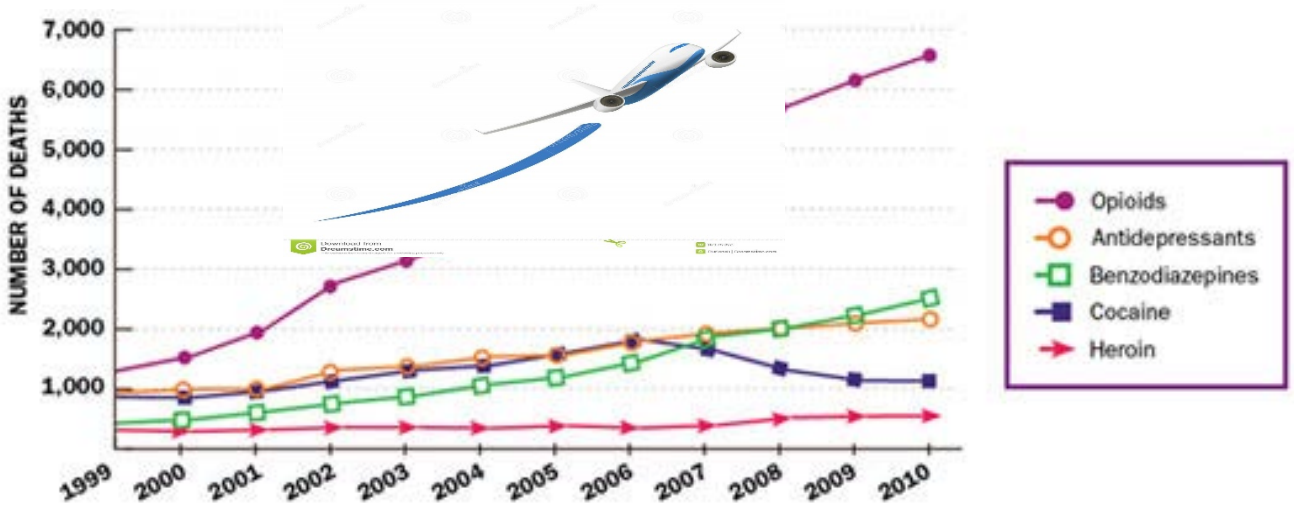


DEATHS DUE TO PRESCRIPTION OPIOID OVERDOSE

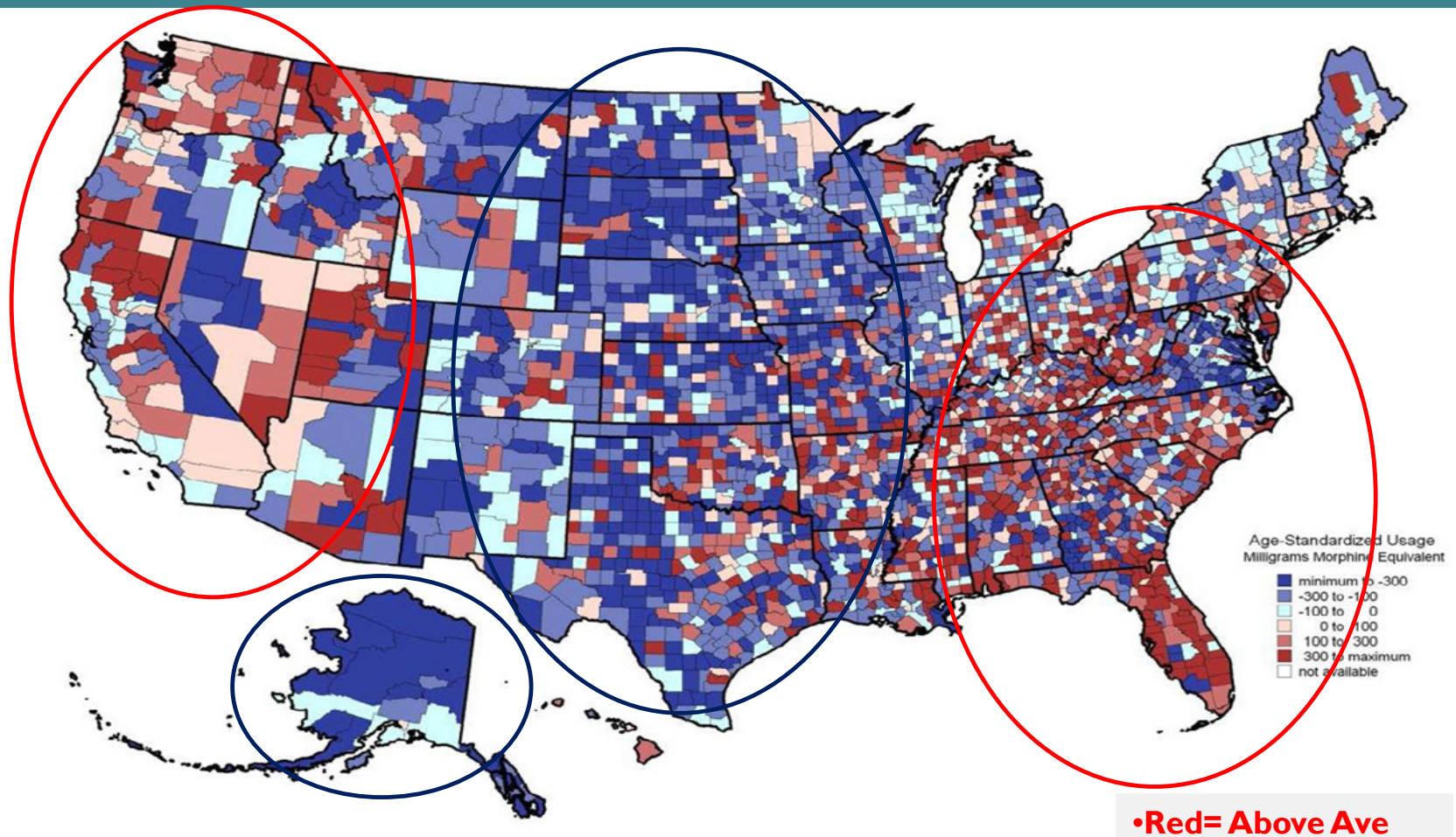


U.S. Drug Overdose deaths surpass Motor Vehicle deaths

Mortality Increase due to Opioids



OPIOID DISPENSING BASED ON COUNTY

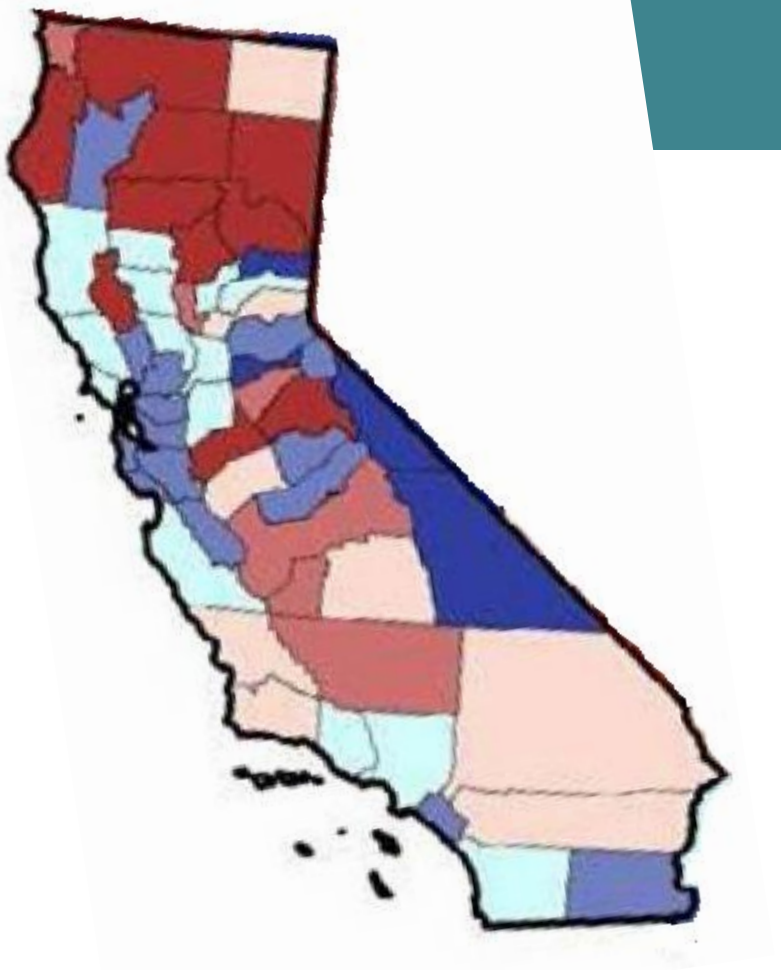


The Journal of Pain http://www.jpain.org/content/covergallery

- Red= Above Ave
- Blue = Below Ave
- Pink = US Ave

CALIFORNIA OPIOID USE

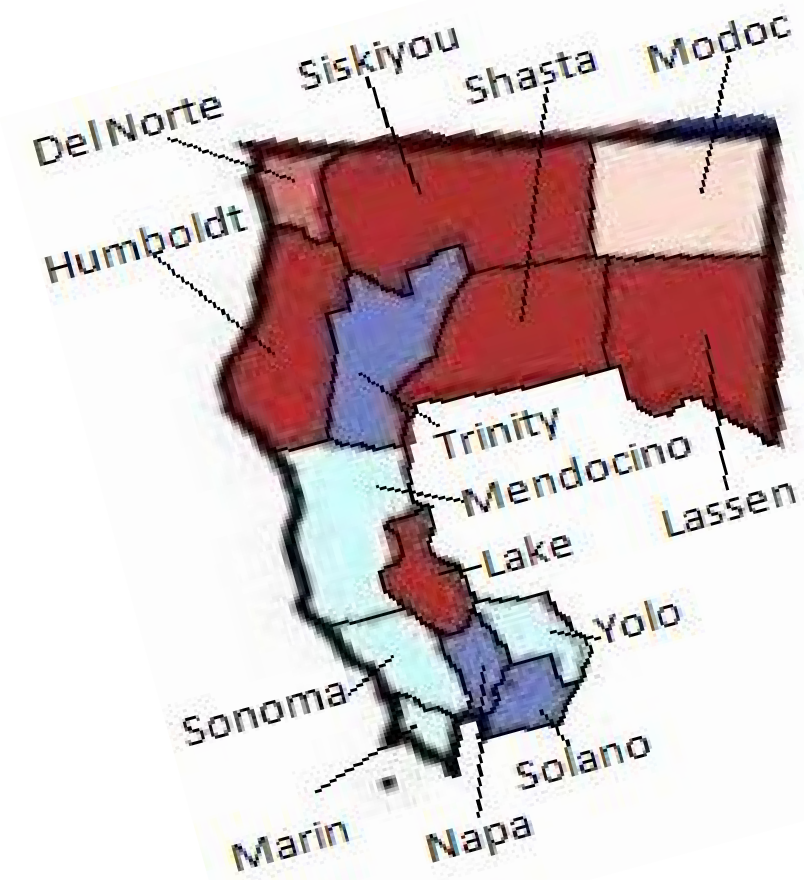
- As of 2008, California as a whole, dispensed only 68 percent of the national county average per resident
- However, variation in California is huge, with the highest rates being in Northern Californian Counties



•Red= Above Ave
•Blue = Below Ave
•Pink = US Ave

The Journal of Pain http://www.jpain.org/content/covergallery

PARTNERSHIP COUNTIES OPIOID USE



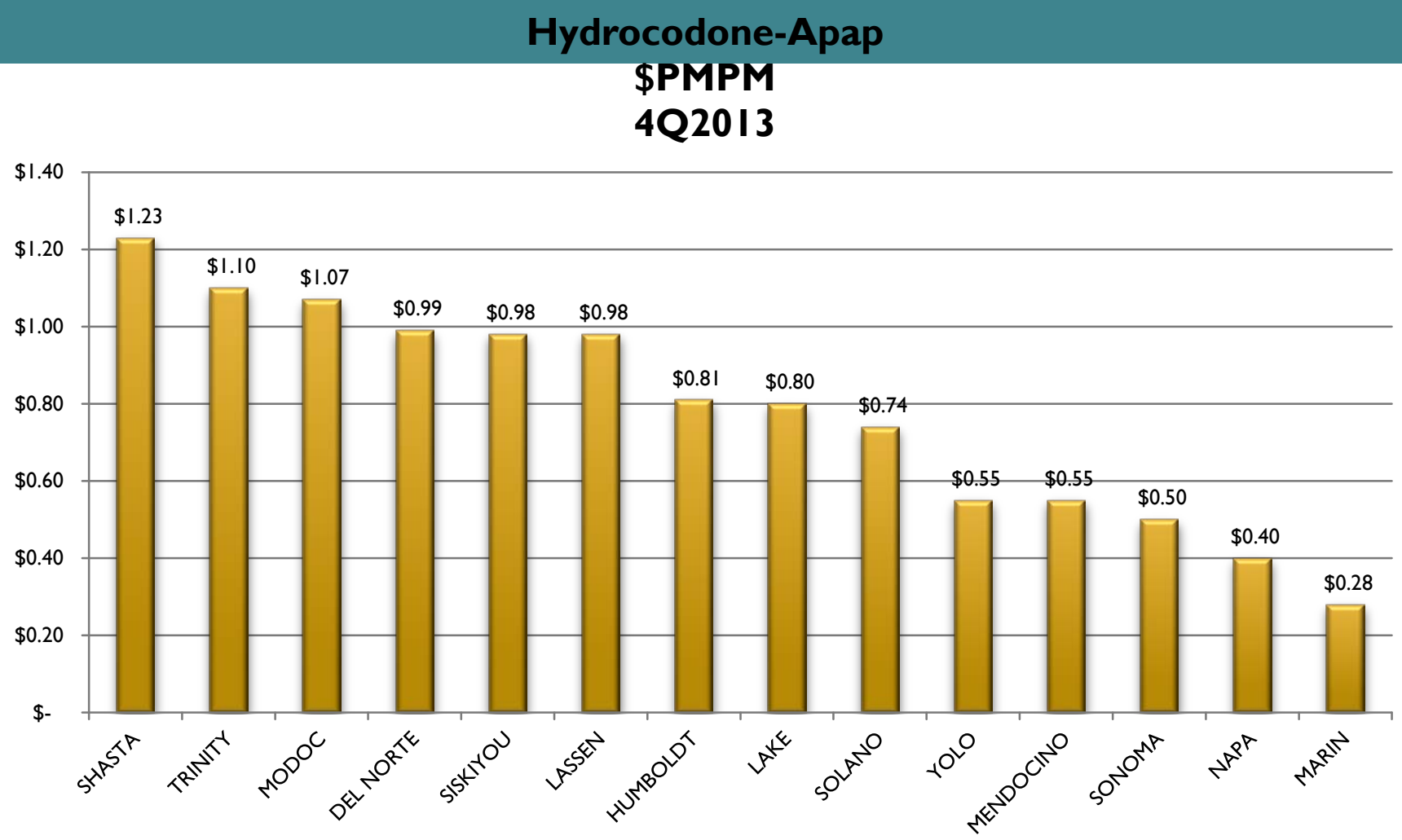
- **Red= Above Ave**
- **Blue = Below Ave**
- **Pink = US Ave**

The Journal of Pain http://www.jpain.org/content/covergallery

THE CASE OF HYDROCODONE

- Brand name: Vicodin; also available in Generic
- Number 1 prescribed medication in the United States
- 95% of the world's hydrocodone consumed in the United States

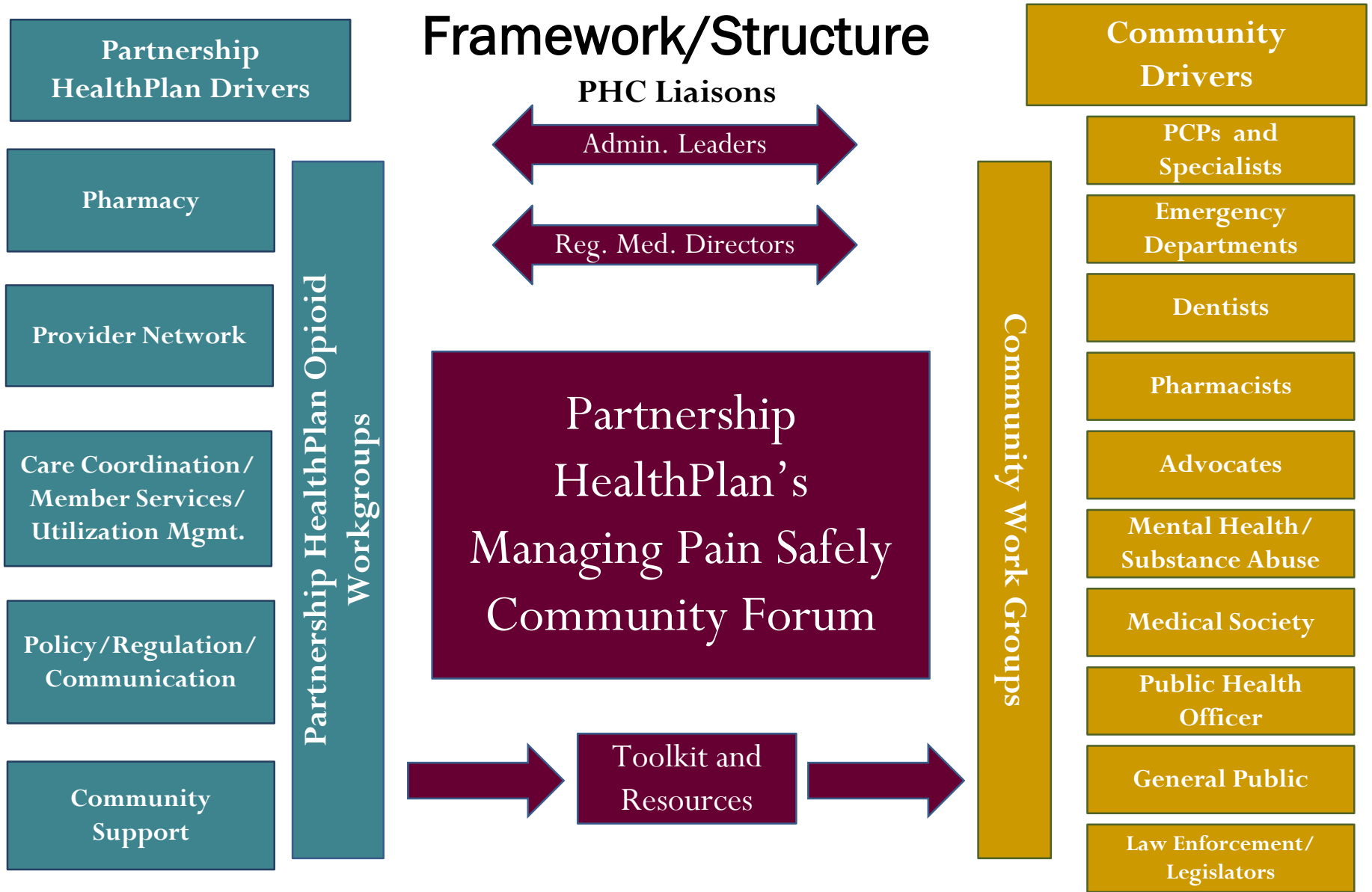
HIGH VOLUME USE - HYDROCODONE



MANAGING PAIN SAFELY
A LOOK BACK AT 2014

- March, 2014 – Managing Pain Safely Initiative
  - Goal – To optimize the use of medication and other modalities so that pain is treated appropriately, depending on the needs of the patient, informed by current medical science
  - Developed PHC framework to tackle the problem
    - Steering Committee
    - 5 workgroups

Managing Pain Safely Framework/Structure



PHC'S FIVE WORKGROUPS

Pharmacy	• Formulary Enhancements
	  • TAR process to decrease inappropriate escalations
	  • Identify medications to support tapering

Provider Network	• Survey providers to assess needs • Develop provider toolkit • Develop and offer educational opportunities

Care Coord./UM/ Memb. Svcs.	• Develop internal processes to support formulary changes
	  • Care Coordination escalation team
	  • Staff education (including process flow maps/scripts)

Community Support	• Support established community initiatives • Initiate new community efforts
Policy/Regs./ Communication	• Serve as liaison to government representatives • Coordinate opportunities for information sharing and raising awareness

MANAGING PAIN SAFELY INTERVENTIONS

- Education
- Health Plan Pharmacy Prior Authorization Changes
- Additional options for treating pain
- Community Activation
- Aligned Incentives

MANAGING PAIN SAFELY INITIATIVES

- Education
  - Prescribers
    - Concentrate on Primary Care Prescribers
    - Others may follow
  - Public health and health community
  - Internal education for PHC
  - Members (OUCH team- Outreach and Understanding Can Help)
  - Public and elected representatives

KEY EDUCATIONAL MESSAGES

- Categories of Opioid Use
  - New – because:
    - 50% of patients hospitalized without surgery are prescribed opioids ; over half are discharged on them
    - Of people prescribed opioids for 30 days, half were still on them 3 years later (CDC)
  - Escalating – "Not my fault, I got them that way"
    - In a 6 month PHC survey of persons on > 120 MEDs, 30% got a dose increase
  - Continuing high-dose – safety, efficacy
- Changing understanding of how to use opioids
  - Former understanding: "no maximum dose"
  - Chronic use of opioids can result in hyperalgesia and decreased functioning, overdose, death and diversion

PCP PROVIDER EDUCATION

- Phcprimarycare.org blog postings
- Email dissemination to medical directors of health centers and groups to forward to front-line providers
- In person CME events
- Webinars
- Recorded videos of trainings
- Provider newsletters
- In person regional meetings with Medical Director leadership
- Project ECHO (Extension for Community Health Outcomes)
- Safe Use Now: Customized Provider Risk profiles and advice
- Toolkit on website:
  - http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx

HEALTH PLAN PHARMACY CHANGES

- Prior Authorization Changes: Implementation
  - 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 when needed
  - 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

MANAGING PAIN SAFELY INTERVENTIONS

- Additional options for treating pain
  - Expanded Benefits
    - Podiatry
    - Chiropractic and Acupuncture
      - To avoid initiating, escalating, or to assist with tapering opioids
  - Formulary Changes
    - Duloxetine made formulary
    - Reduce maximum dose of methadone approved
    - Encourage use of naloxone for safety (State carve out)
  - Behavioral Health
    - Smooth access to supportive behavioral health treatment
    - Mindfulness/Relaxation self help tools
  - Future considerations
    - Group classes
    - Biofeedback

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 leader

MANAGING PAIN SAFELY INTERVENTIONS

- Aligned Incentives
  - Intrinsic Incentives
    - Increases PCP access: decreased time on patients with chronic pain to have more time to care for other patients
    - Improved clinician satisfaction with profession
    - Stay on the right side of the Medical Board and Department of Justice
  - Supplementary Financial Incentives
    - Primary care pay for performance program (PCP QIP)
      - Use of drug screens
      - Incentivize increased availability of buprenorphine certification

MANAGING PAIN SAFELY
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

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

HOW SUCCESSFUL HAVE WE BEEN?

- Opioid Use:
  - From January to December 2014:
    - 36% reduction in use of Long Acting Opioids
    - 14% reduction in overall opioid drug use
    - Saving about $250,000 per month
- Health Outcomes:
  - 2014 (preliminary data) compared to 2013 (state confirmed)
    - Reduced non-suicide drug/alcohol overdose deaths by 28-35% in counties where we have data.

KEYS TO SUCCESS

- Communicate a compelling need
  - Rising overdose deaths (3 fold in last 15 years), surpassing automobile associated deaths
  - Increased drug abuse from diversion (5% of all adults)
  - Chronic opioids make chronic pain worse
  - 3 Fold increase in neonatal abstinence syndrome over last decade
  - PCP visits for patients taking chronic opioids crowding out other patients, contributing to decreased PCP access and decreasing job satisfaction of many PCPs
- Provide a picture of success
  - Case study: Multnomah County, Oregon
- Communicate the path to success
  - Disseminate best practices, customized to the audience
- Leadership commitment of energy and resources
- Add some aligned incentives

Q&A

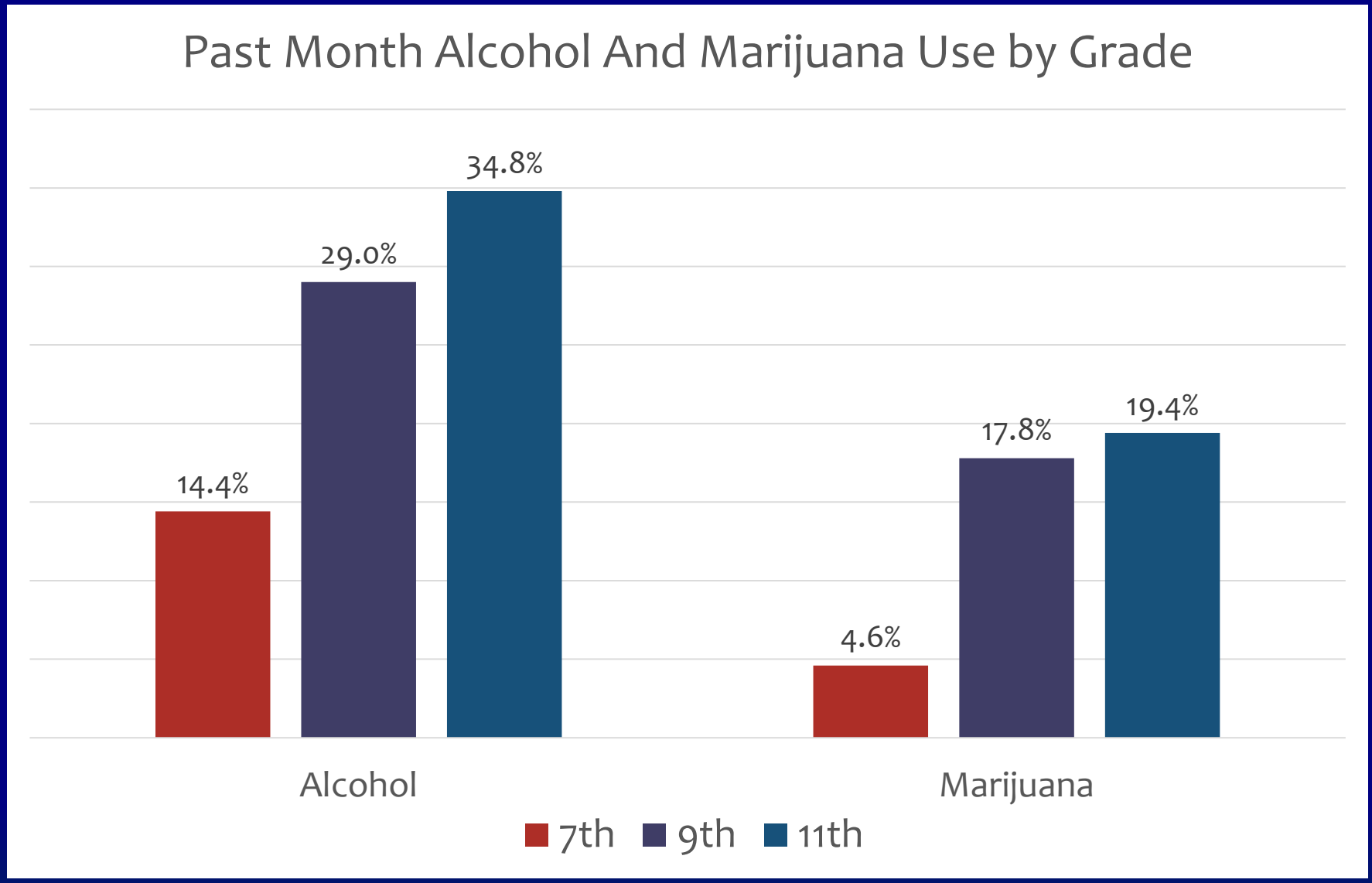
Marshall Kubota, MD

mkubota@partnershiphp.org

Rx Opiate Abuse

Andrew Deckert, MD, MPH,
Health Officer,
Shasta County HHSA—Public Health
May 28, 2015

Teen Substance Use is Prevalent in Shasta County



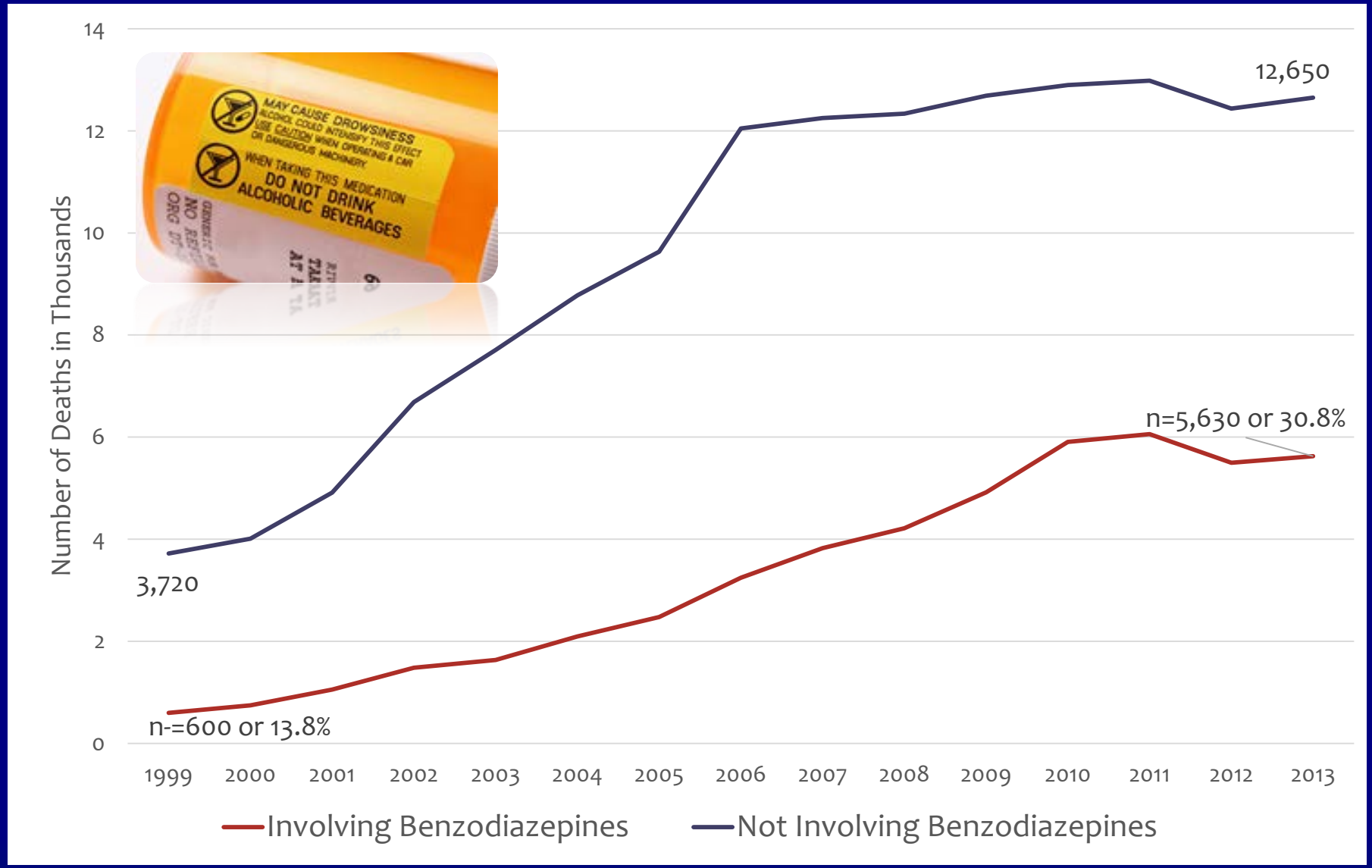
Source: Healthy Kids Survey 2008-2010

Any Diagnosis of Cannabis Abuse or Dependence -- 2013

- 922 hospital admissions
  - Shasta County was ranked 2nd highest in CA for these marijuana-associated hospital admission rates
- 493 emergency department (ED) visits
  - Shasta County was ranked 17th highest in CA for these marijuana-associated ED visit rates

- Data Source: *Epicenter.cdph.ca.gov, 4/9/15*

Number of opioid-analgesic poisoning deaths, by involvement of benzodiazepines: U.S., 1999-2013



Source: CDC Wonder
ICD 10 Multiple Cause of Death codes: T40.2-T40.4 Opioids, T42.4 Benzodiazepines

WHAT ARE OPIOIDS?

Illegal Drugs:

- Heroin

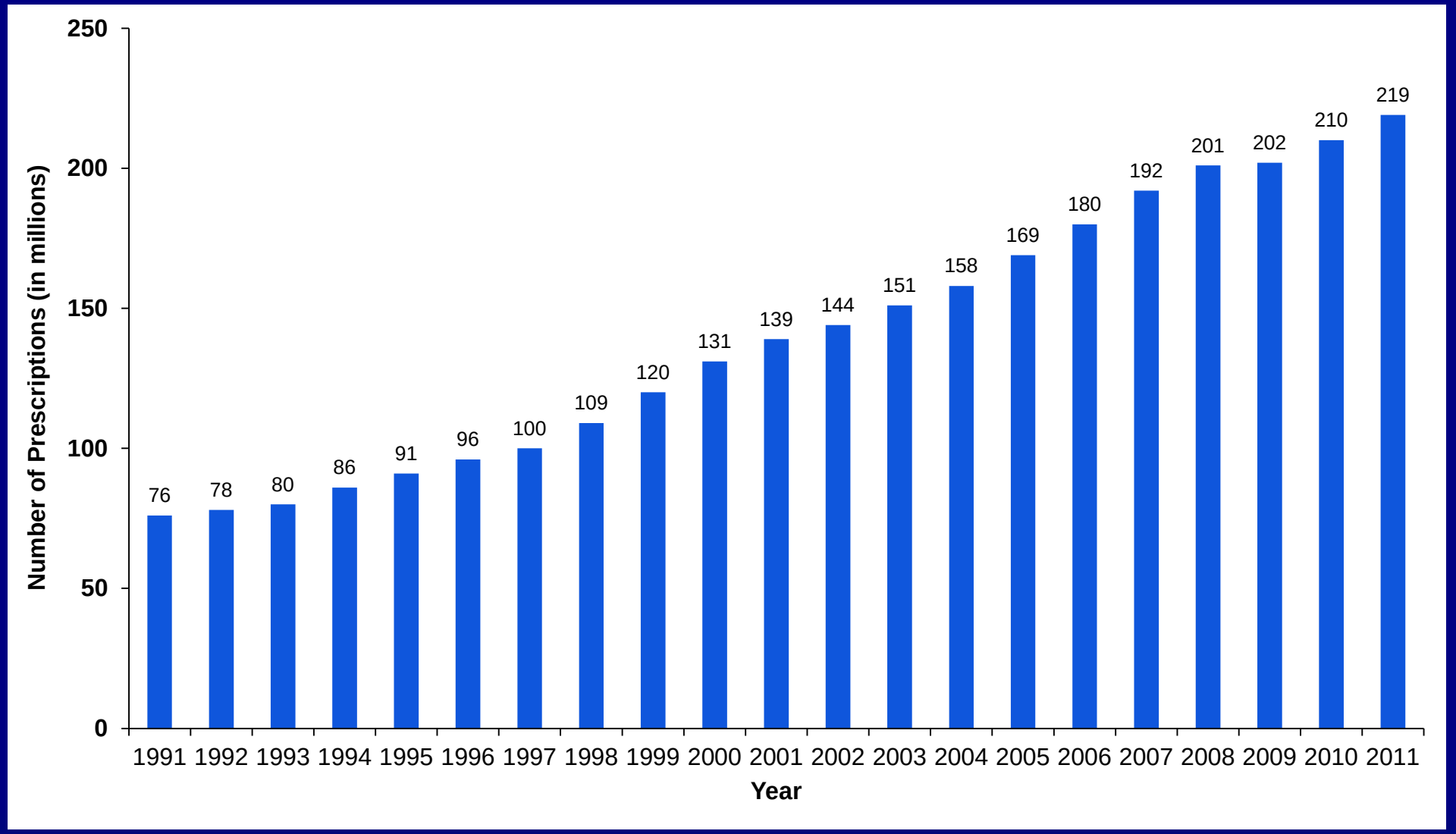
Prescription (Rx) medications used to treat pain:

- Morphine
- Codeine
- Methadone
- Oxycodone (OxyContin, Percodan, Percocet)
- Hydrocodone (Vicodin, Lortab, Norco)
- Fentanyl (Duragesic, Fentora)
- Hydromorphone (Dilaudid)
- Buprenorphine (Subutex, Suboxone)

Illegal Use of Rx Drugs

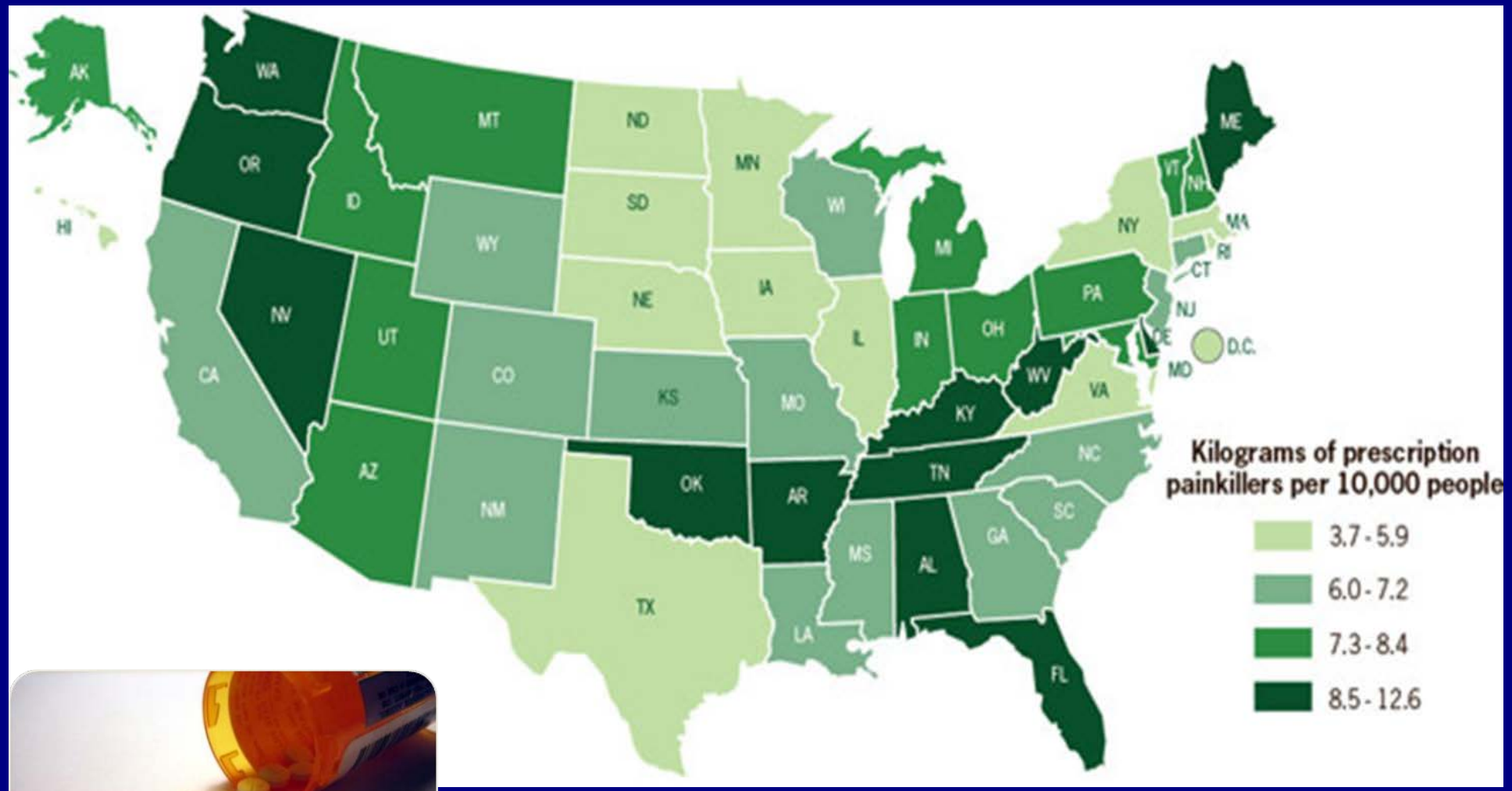
- RX opiates not prescribed to user
- RX drugs not used as prescribed, e.g. diversion (sold)

Opioid Prescriptions Dispensed by Retail Pharmacies—U.S., 1991–2011

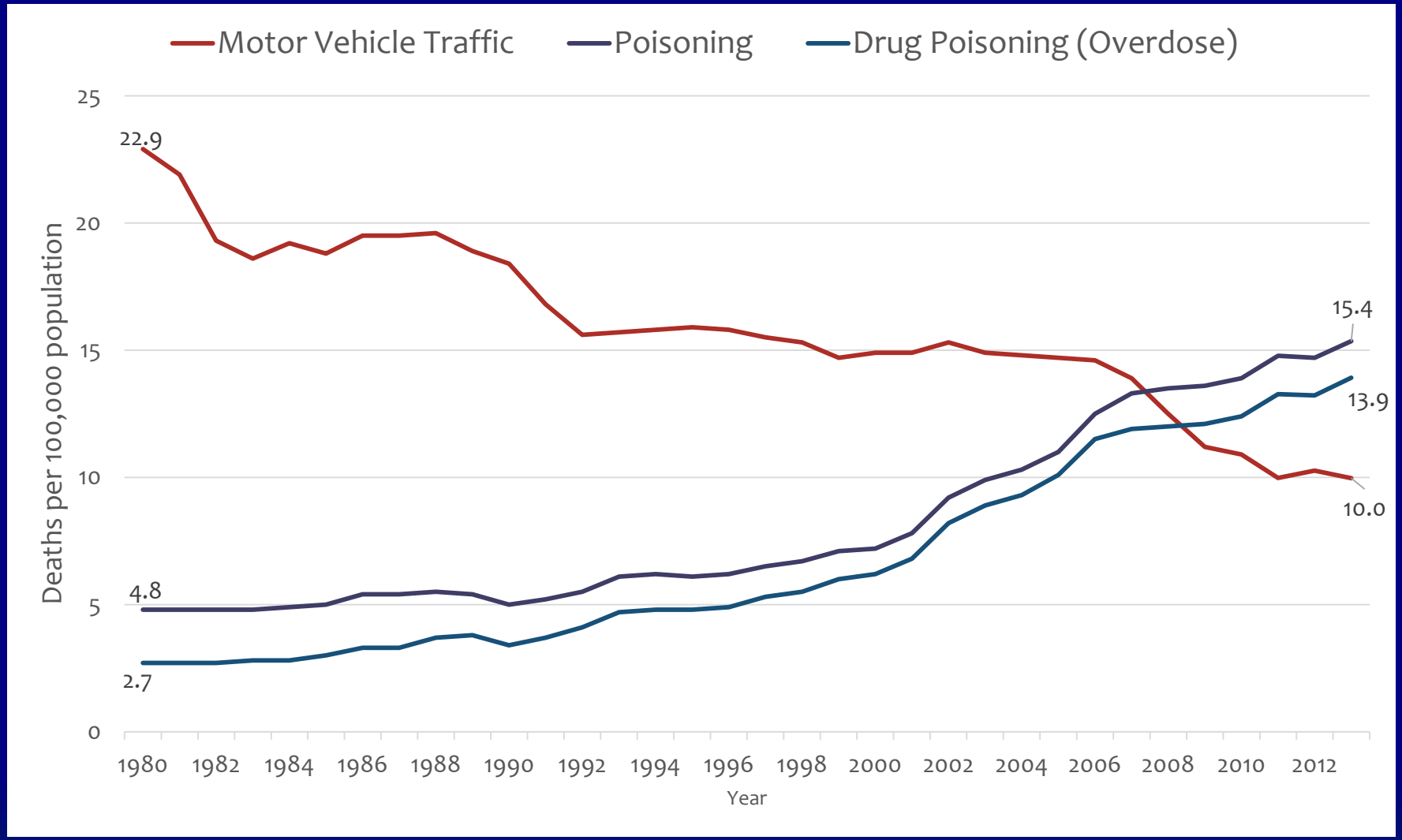


IMS Vector One. From "Prescription Drug Abuse: It's Not what the doctor ordered." Nora Volkow National Prescription Drug Abuse Summit, April 2012. Available at http://www.slideshare.net/OPUNITE/nora-volkow-final-edits.

Prescription painkillers sold by state

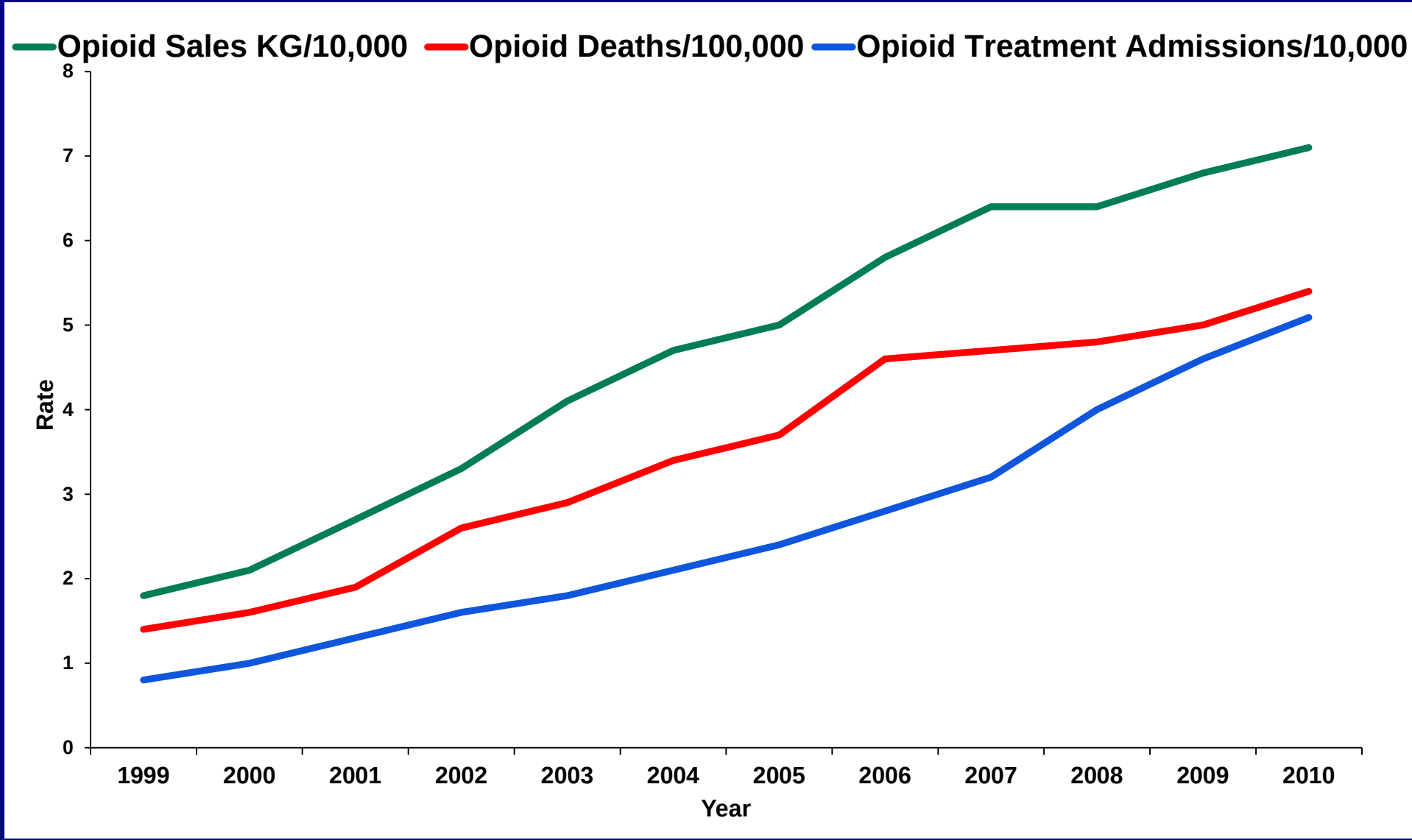


Motor Vehicle Traffic, Poisoning, and Drug Poisoning (Overdose) Death Rates
U.S., 1980–2013



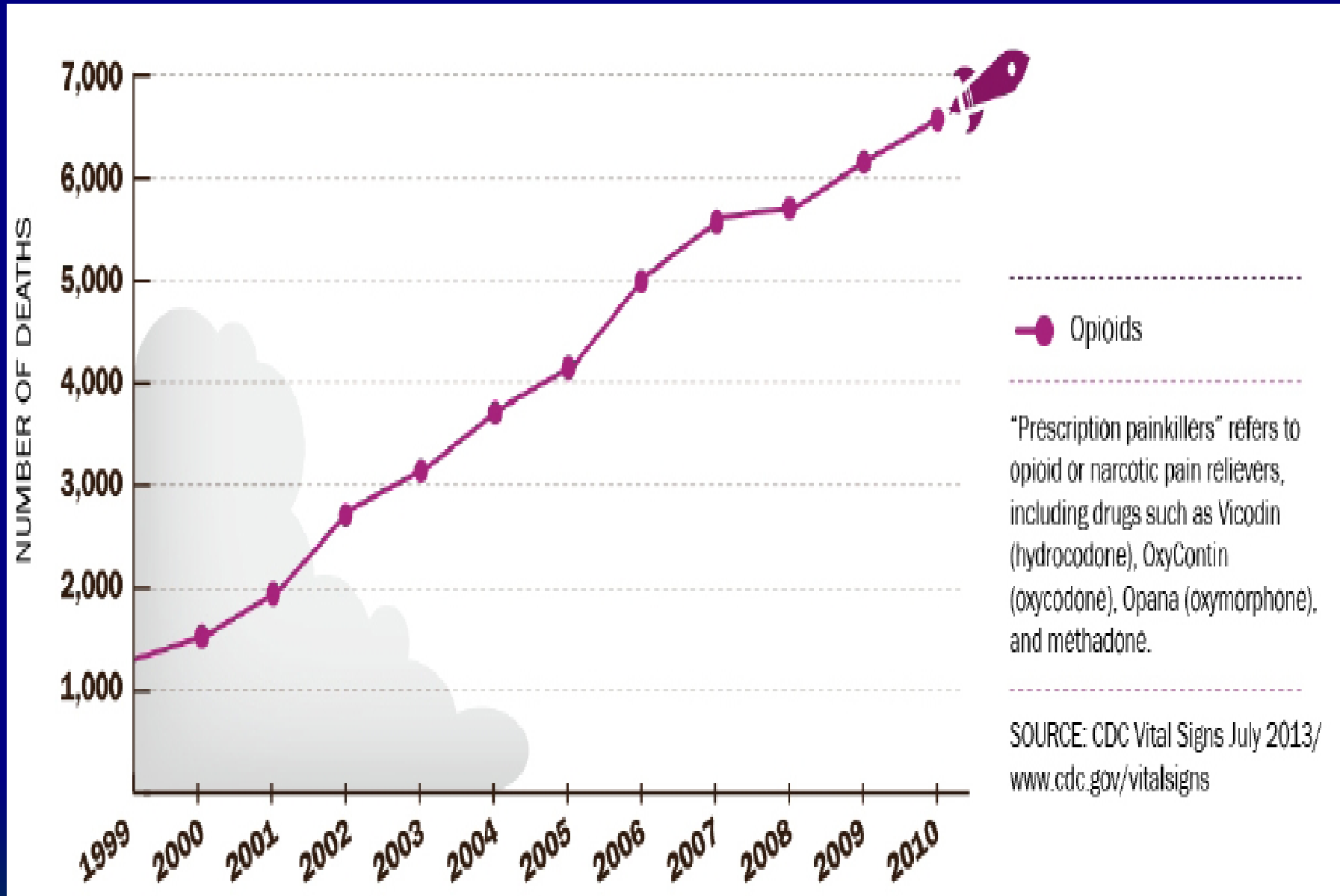
NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data. 2011-2013 added using CDC Wonder.

Rates of Opioid Overdose Sales, Deaths and Treatment Admissions, U.S., 1999–2010

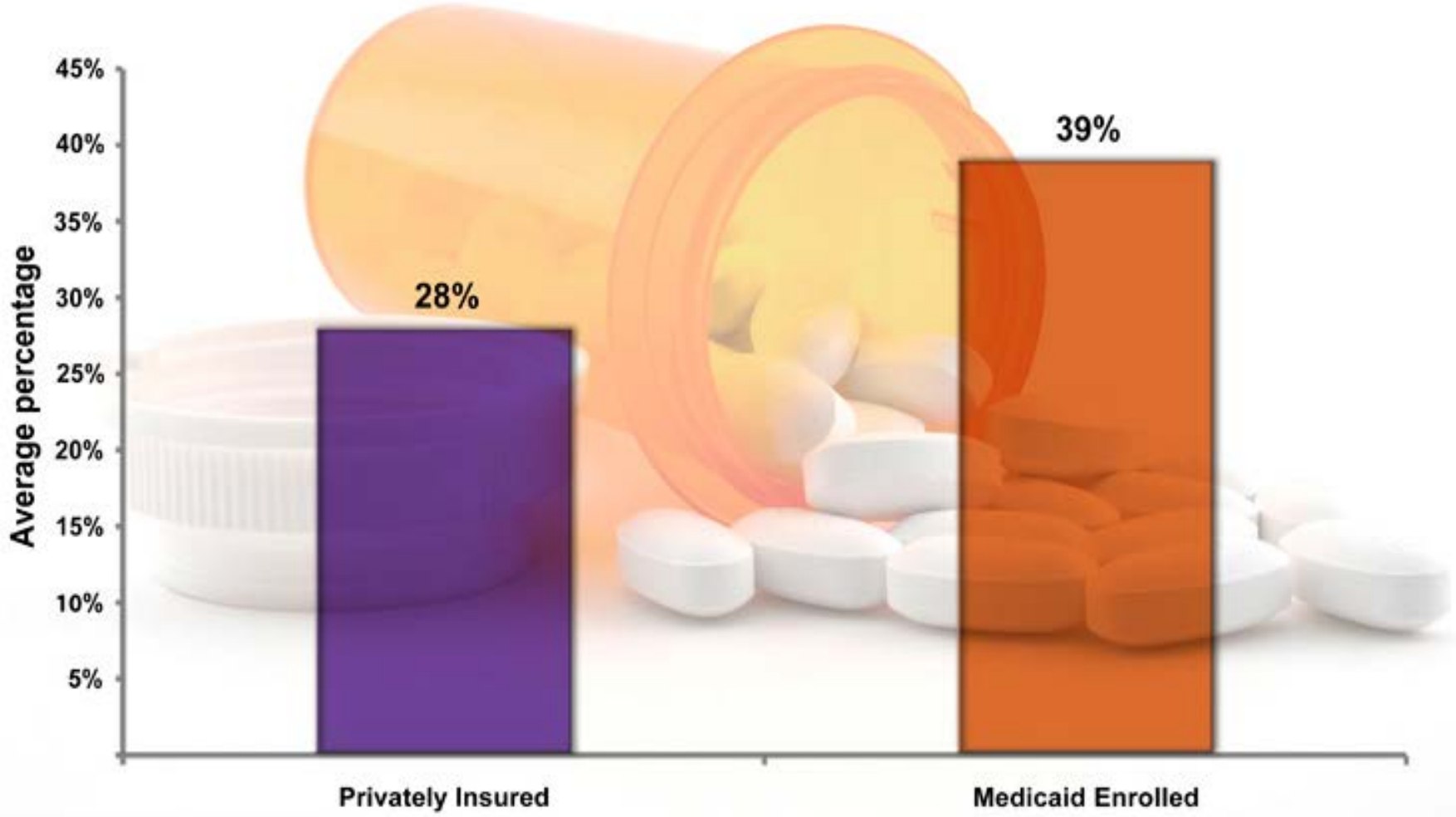


CDC. *MMWR* 2011. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm?s_cid=mm60e1101a1_w. Updated with 2009 mortality and 2010 treatment admission data.

Prescription painkiller deaths have skyrocketed in women since 1999

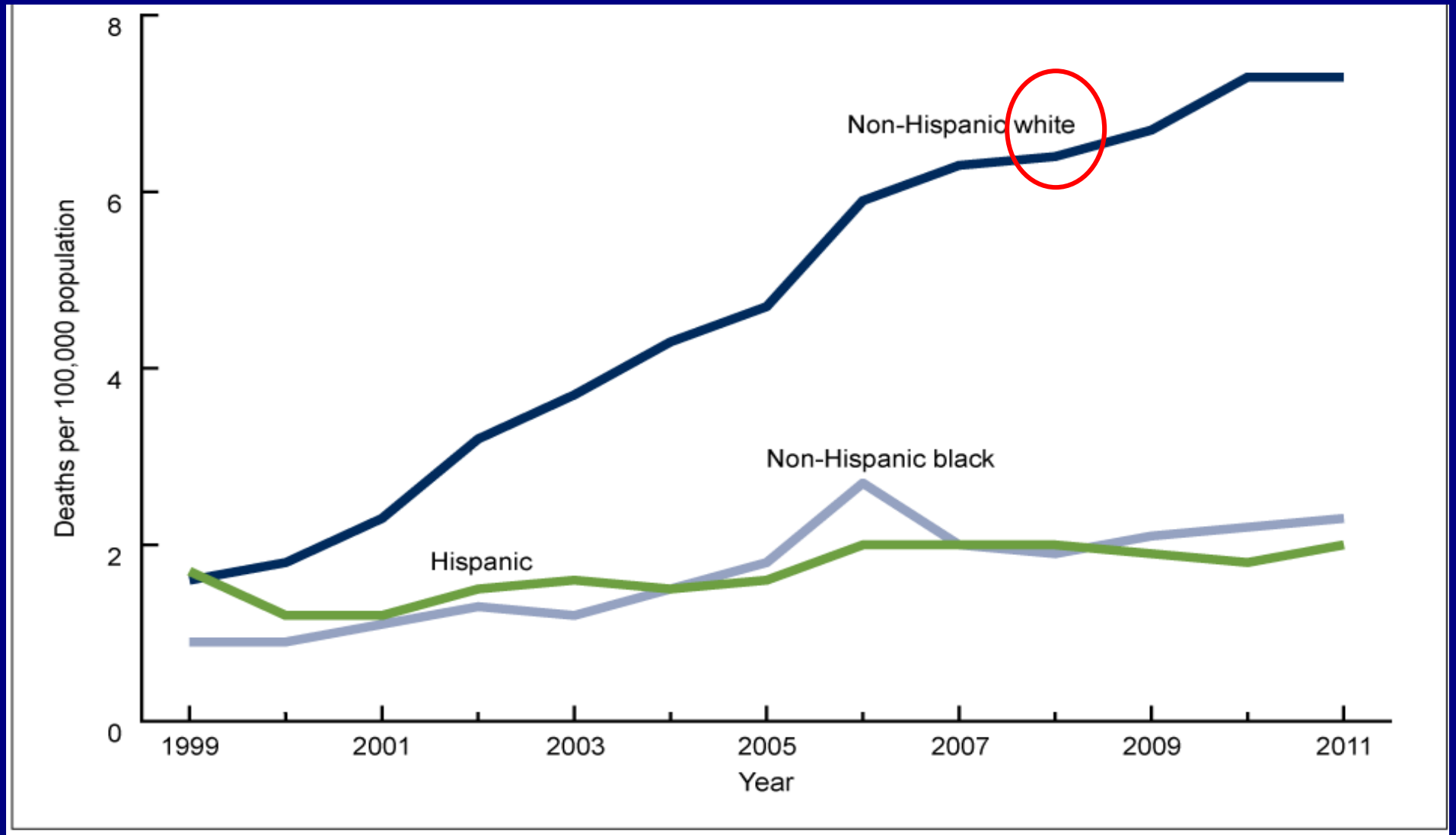


Women aged 15-44 years who filled a prescription for an opioid medication, 2008-2012



CDC. MMWR. Jan 23, 2015 / 64(02);37-

Age-adjusted opioid-analgesic poisoning death rates, by race and ethnicity: U.S., 1999-2011



NOTES: Deaths for Hispanic persons are underreported by about 5%. See "Deaths: Final Data for 2010." Access data table for Figure 5 at: http://www.cdc.gov/nchs/data/databriefs/db166_table.pdf#5.

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality File.

National Poll

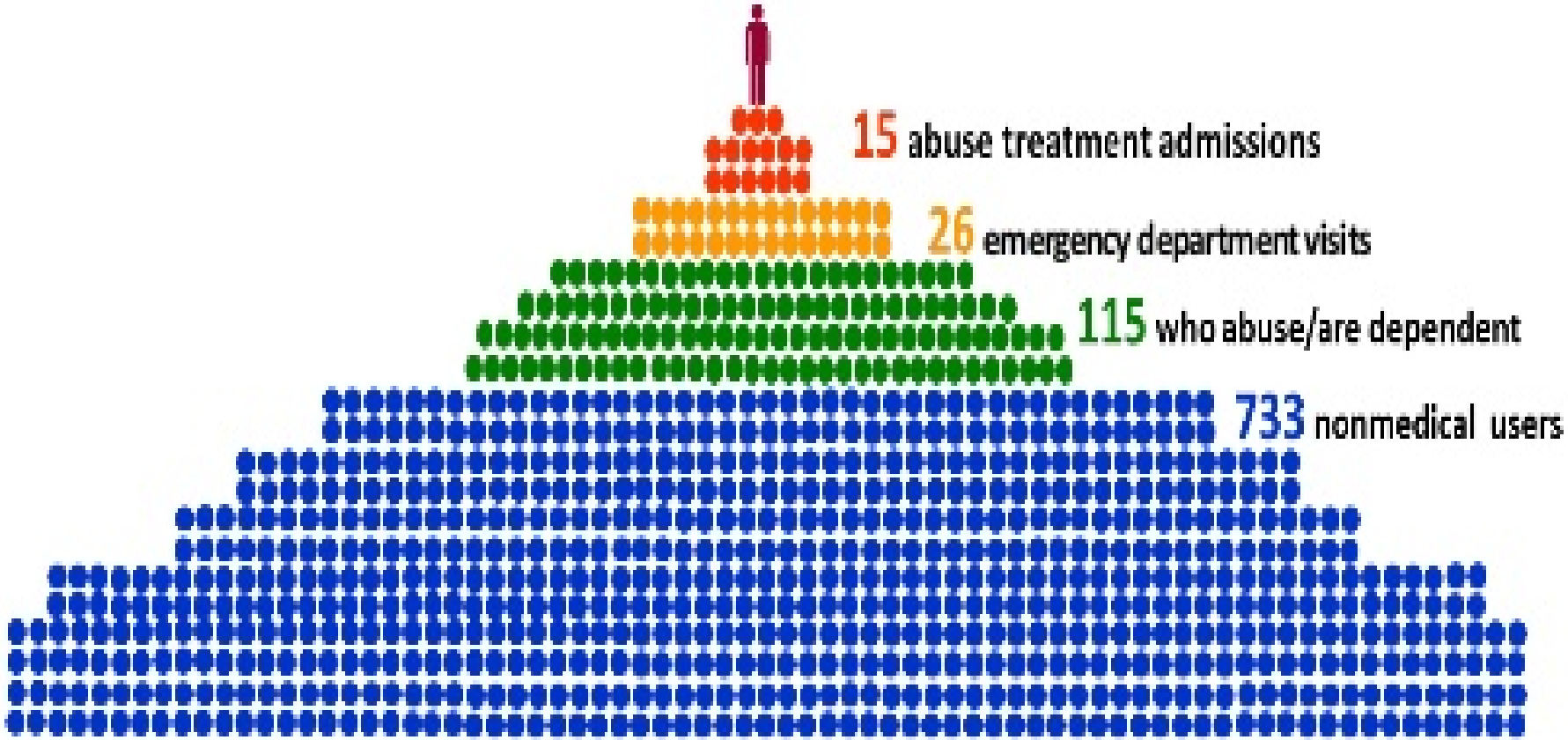
Methodology:

- Conducted an online survey with a nationally representative sample balanced to U.S. Census figures for gender, age geographic region, and ethnicity.
- To qualify for the study, respondents had to be 18 or older.
- Fieldwork was completed between January 30th thru February 5th, 2015.

Key Takeaways:

1. **Americans don't know their painkillers contain opioids, or that it is a felony to share them.**
2. **Opioid users are unconcerned about addiction, but most have reason to worry.**
3. **Opioid users overestimate the benefits of opioids and underestimate the risks of addiction or death.**

For every 1 prescription opioid overdose death in 2010 there were...



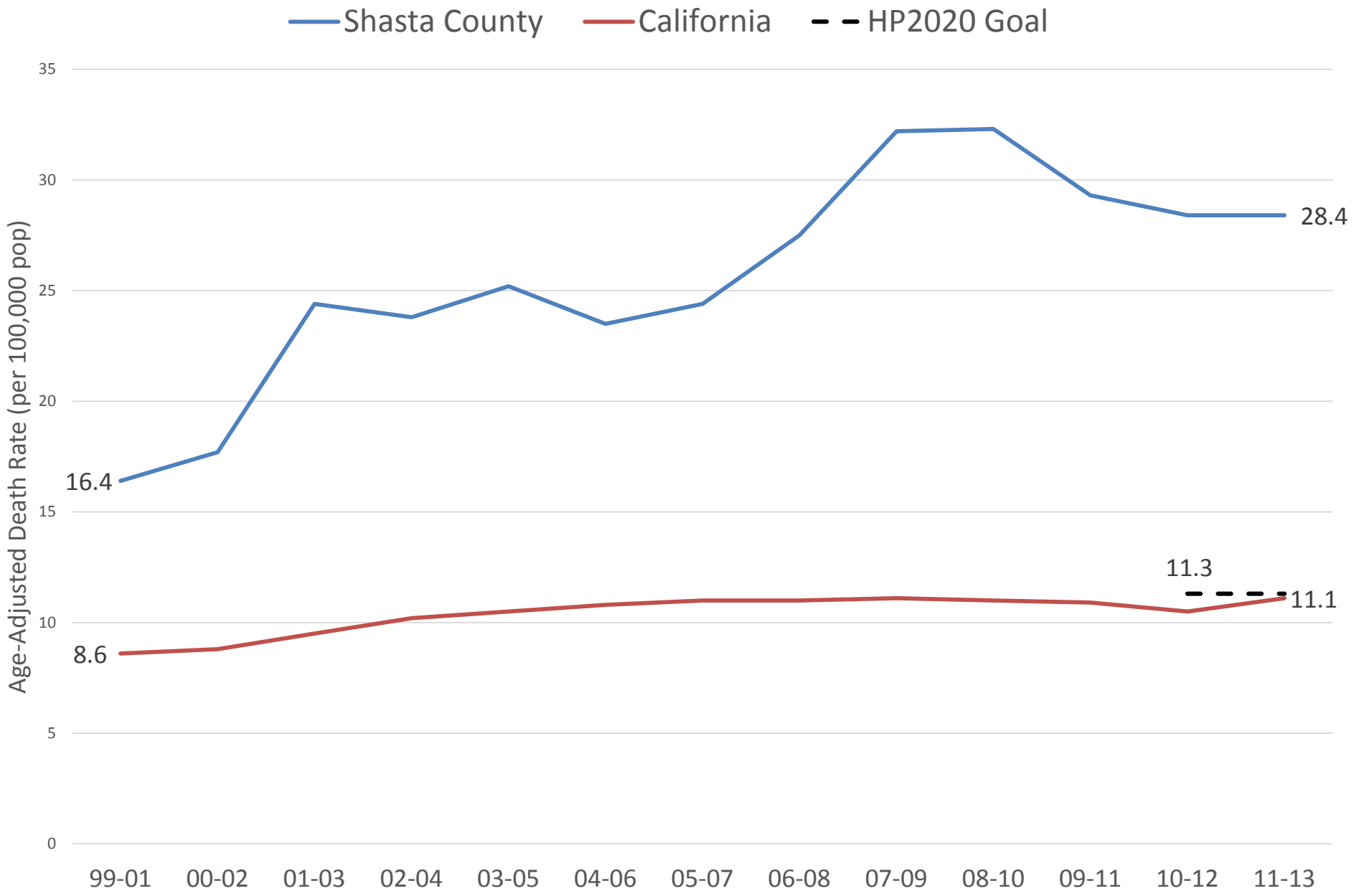
$4,350,000 in healthcare-related costs

Shasta County Estimates

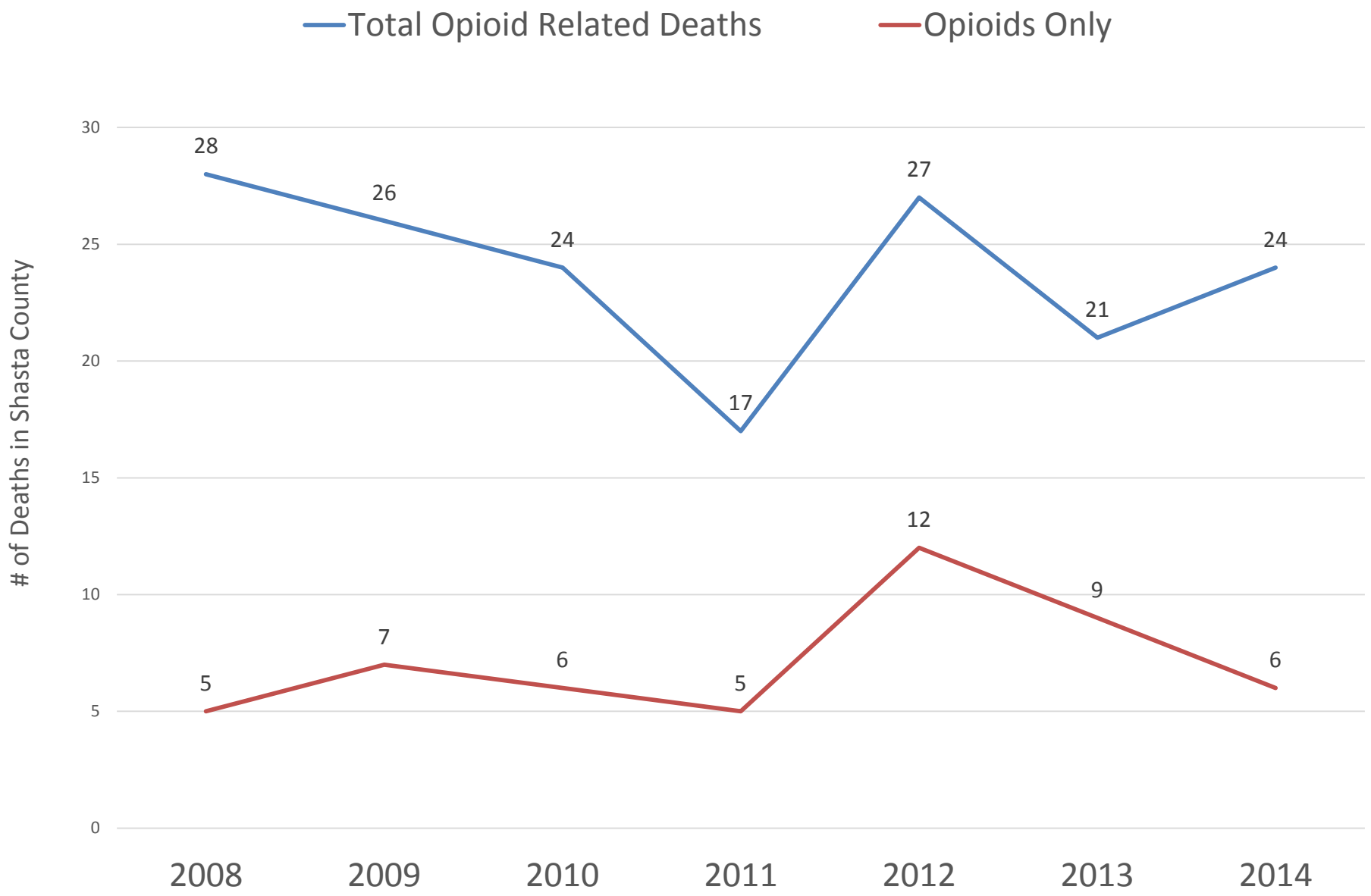
- Based on 25 opiate-related deaths of Shasta County residents in 2013, there were an estimated:
  - 375 abuse tx admissions
  - 650 ED visits
  - 2,875 who abuse/are dependent
  - 18,325 non-medical users of Rx opiates
  - Many $ in health care related and other costs

Drug Related Death Rate

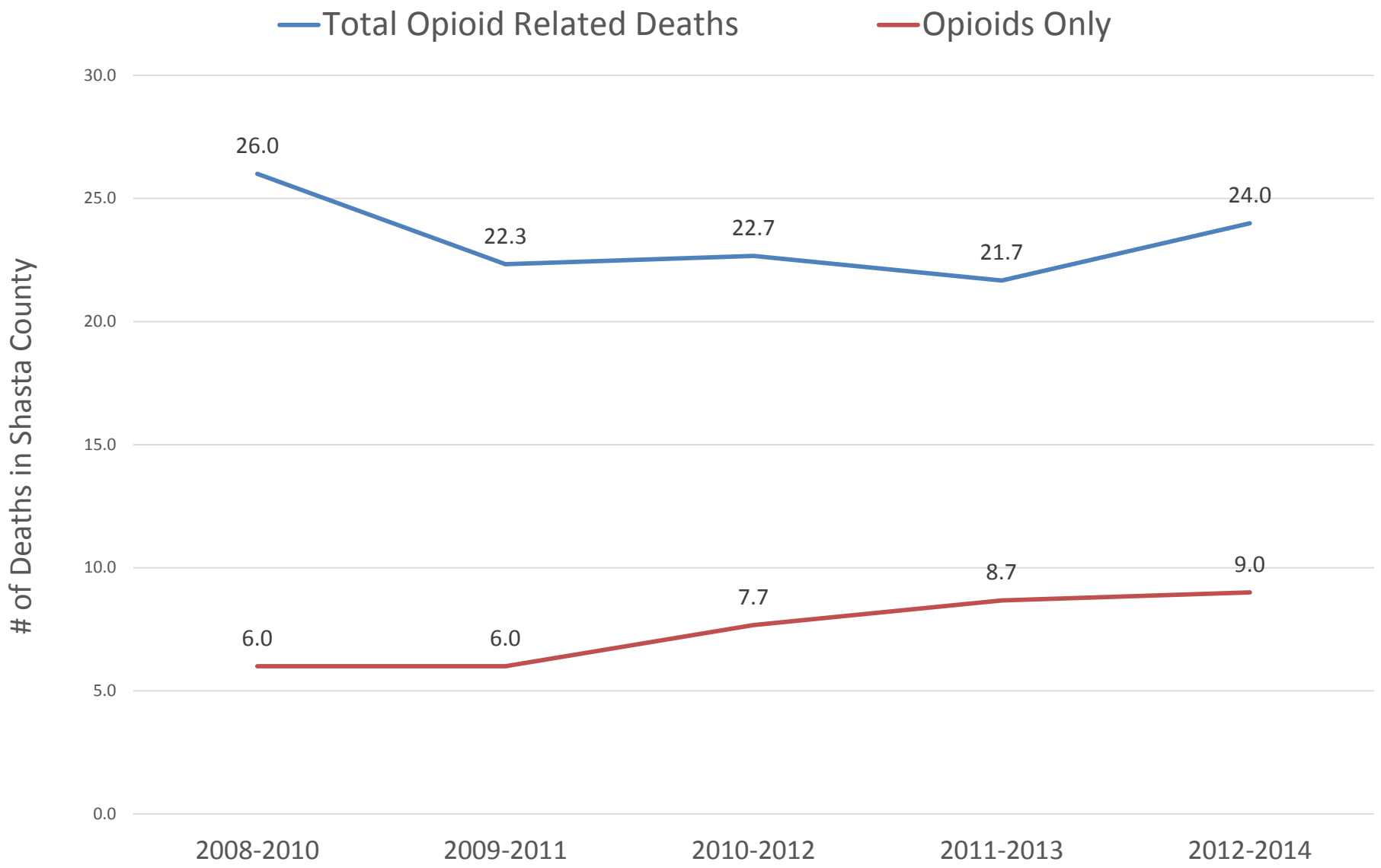
Data Source: *County Health Status Profiles*

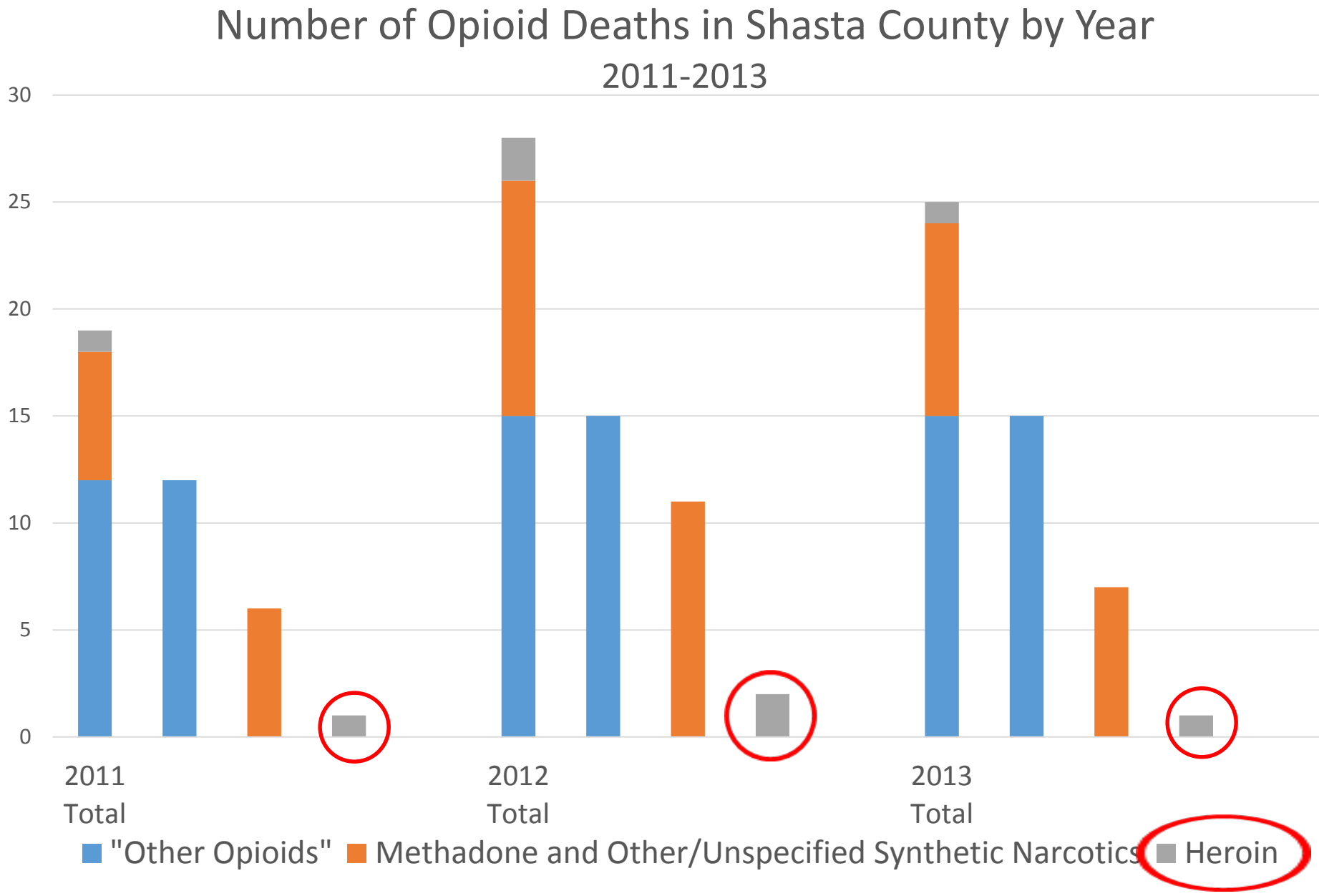


 # Opioid Related Deaths in Shasta County 2008 to 2014



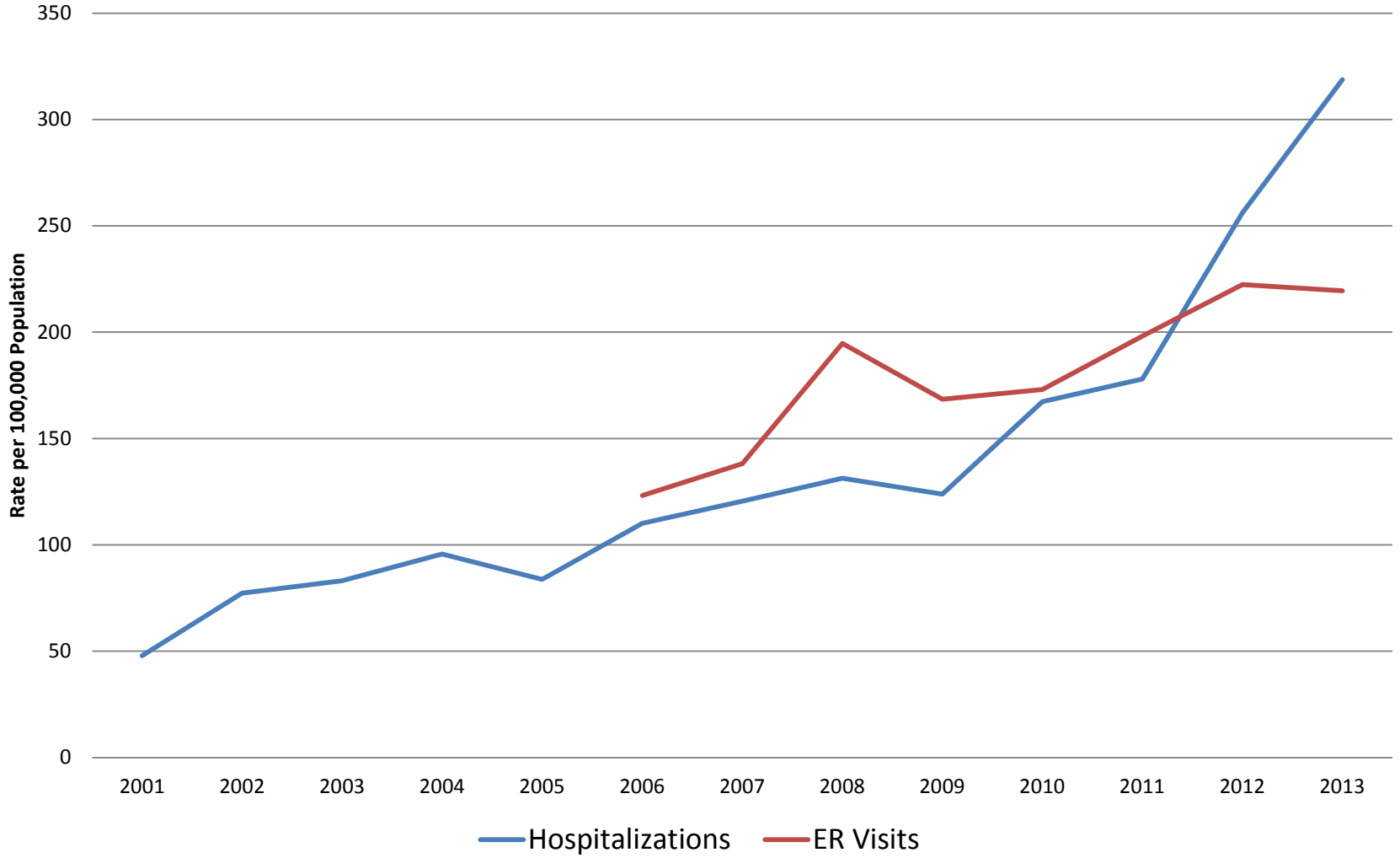
3-Year Average Annual Opioid-Related # Deaths
Shasta County 2008 to 2014





- Source: CDC WONDER, Multiple Causes of Death
- ICD 10: T40.1-.4,.6

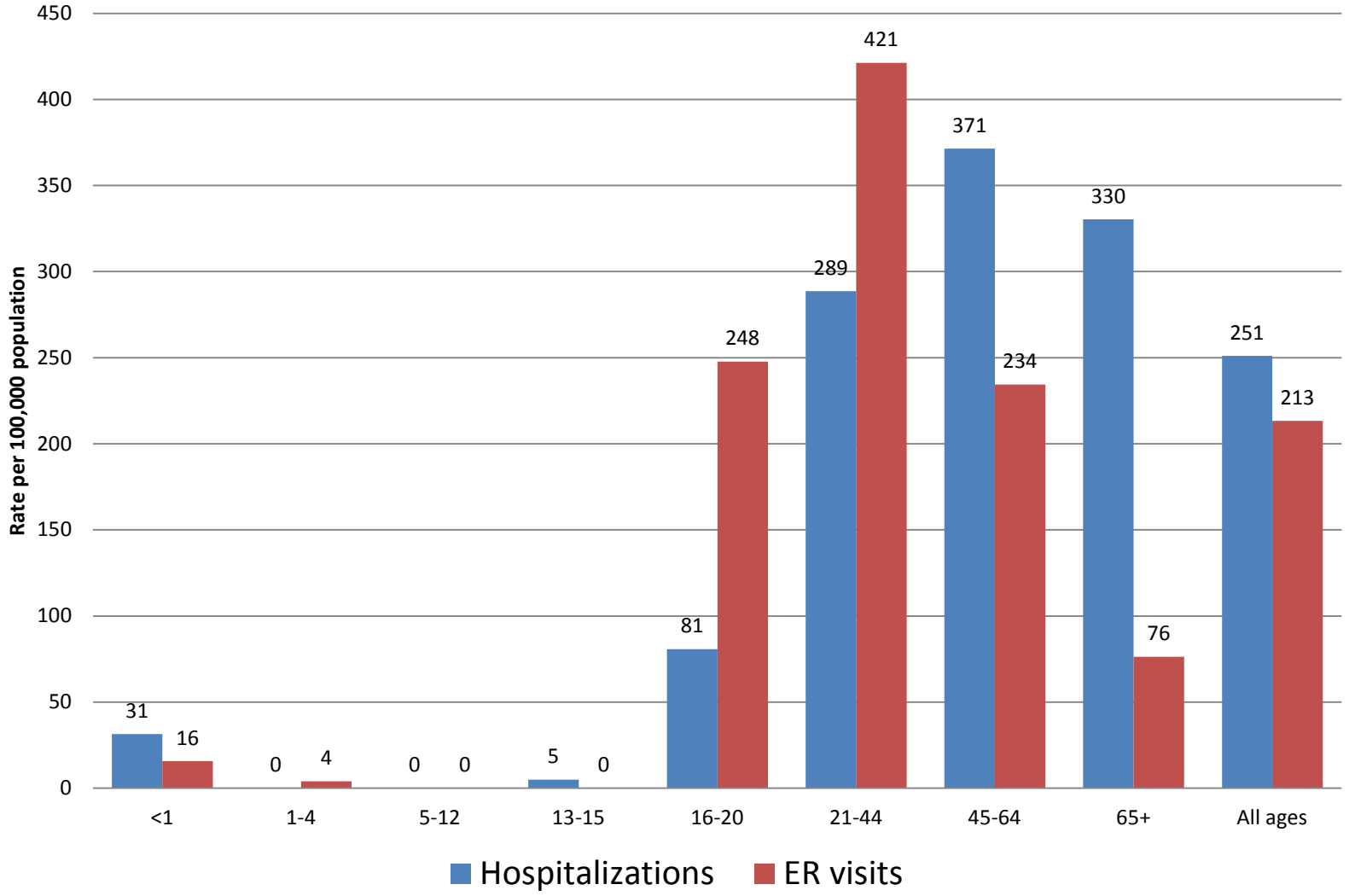
ER visits and hospitalizations with a diagnosis* of opioid dependence/abuse@, 2001-2013 among Shasta County residents



Data Source: California Office of Statewide Health Planning and Development, Patient Discharge and Emergency Department Datasets, 2001-2013; California Department of Finance

*Primary or any Secondary Diagnosis
@Dependent and Nondependent Abuse: ICD codes 304.00-304.03, 34.70-304.73, and 305.50-305.53

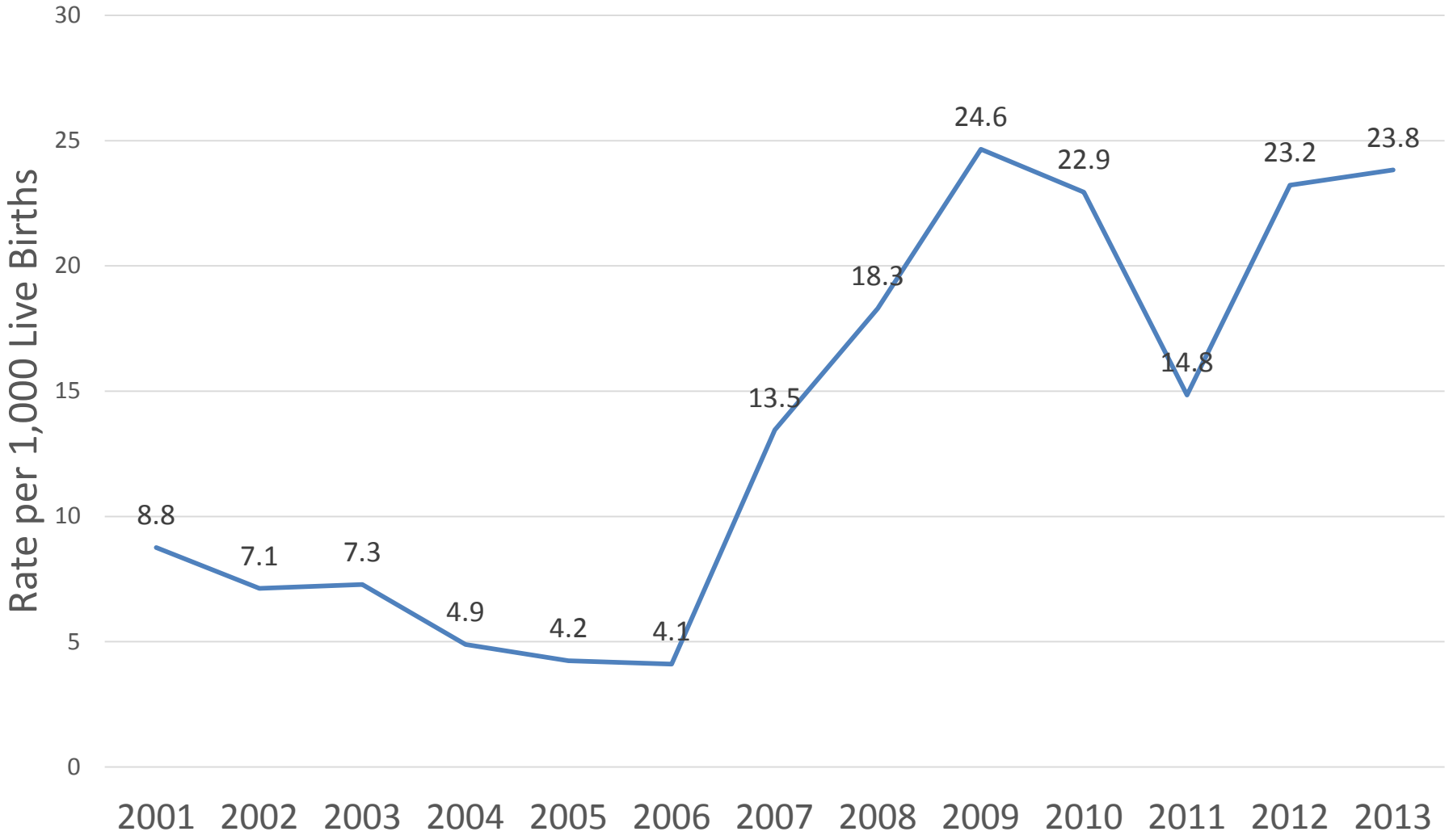
ER visits and hospitalizations with a diagnosis* of opioid dependence/abuse@, 2011-2013 among Shasta County residents by age



Data Source: California Office of Statewide Health Planning and Development, Patient Discharge and Emergency Department Datasets, 2011-2013; California Department of Finance

*Primary or any Secondary Diagnosis
@Dependent and Nondependent Abuse: ICD codes 304.00-304.03, 34.70-304.73, and 305.50-305.53

Rate of Shasta County Newborns with Narcotics

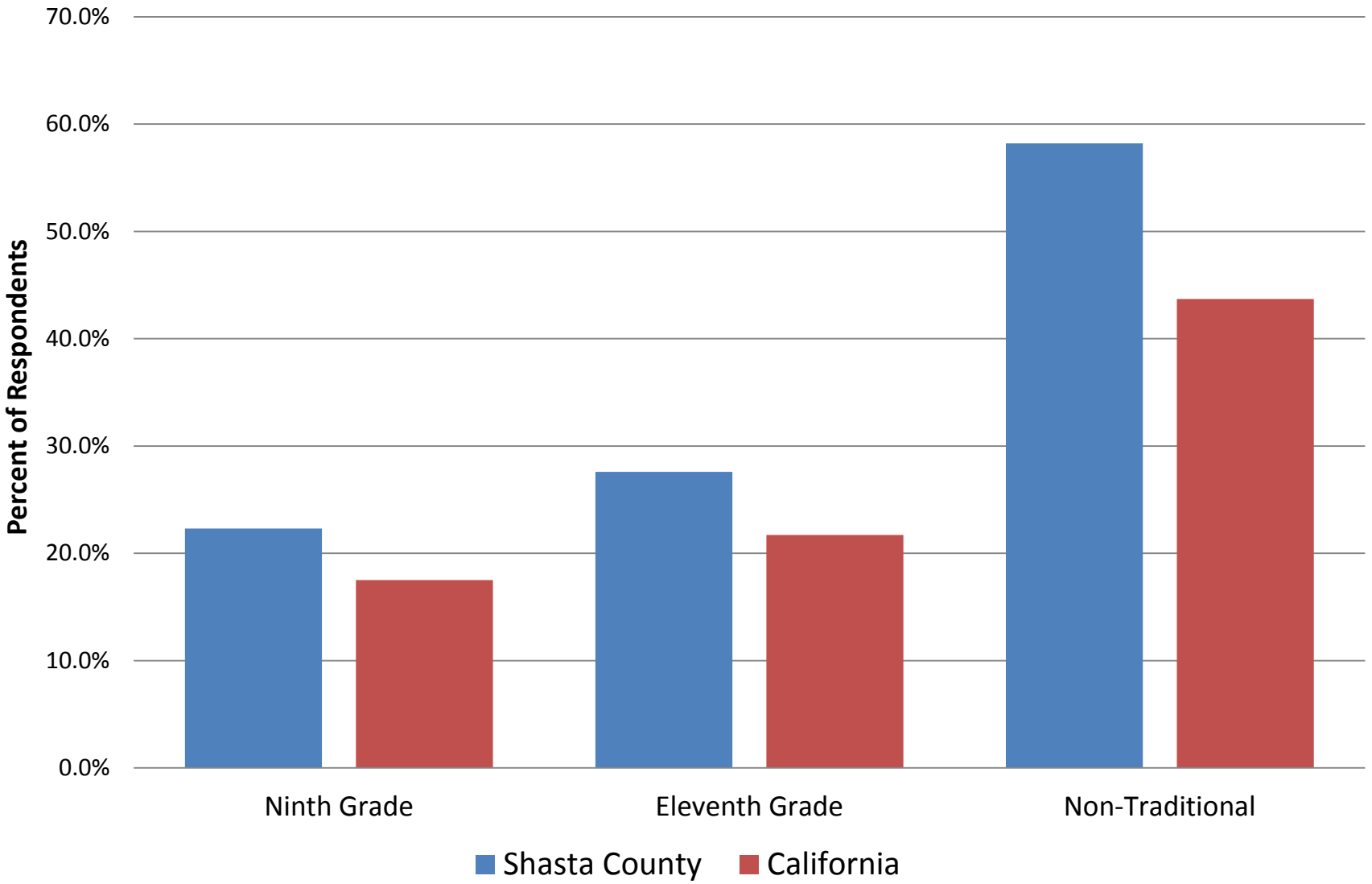


Source: OSHPD Hospitalizations

ICD 9: 7795 (Drug Withdrawal in Newborn) or

76072 (Narcotics affecting fetus or newborn via placenta or breast milk)

Lifetime Recreational Use of Prescription Painkillers in Ninth and Eleventh Grade Students, 2008-2010



Data Source: California Healthy Kids Survey, California Department of Education (Safe and Healthy Kids Program Office) and WestEd (Health and Human Development Department).

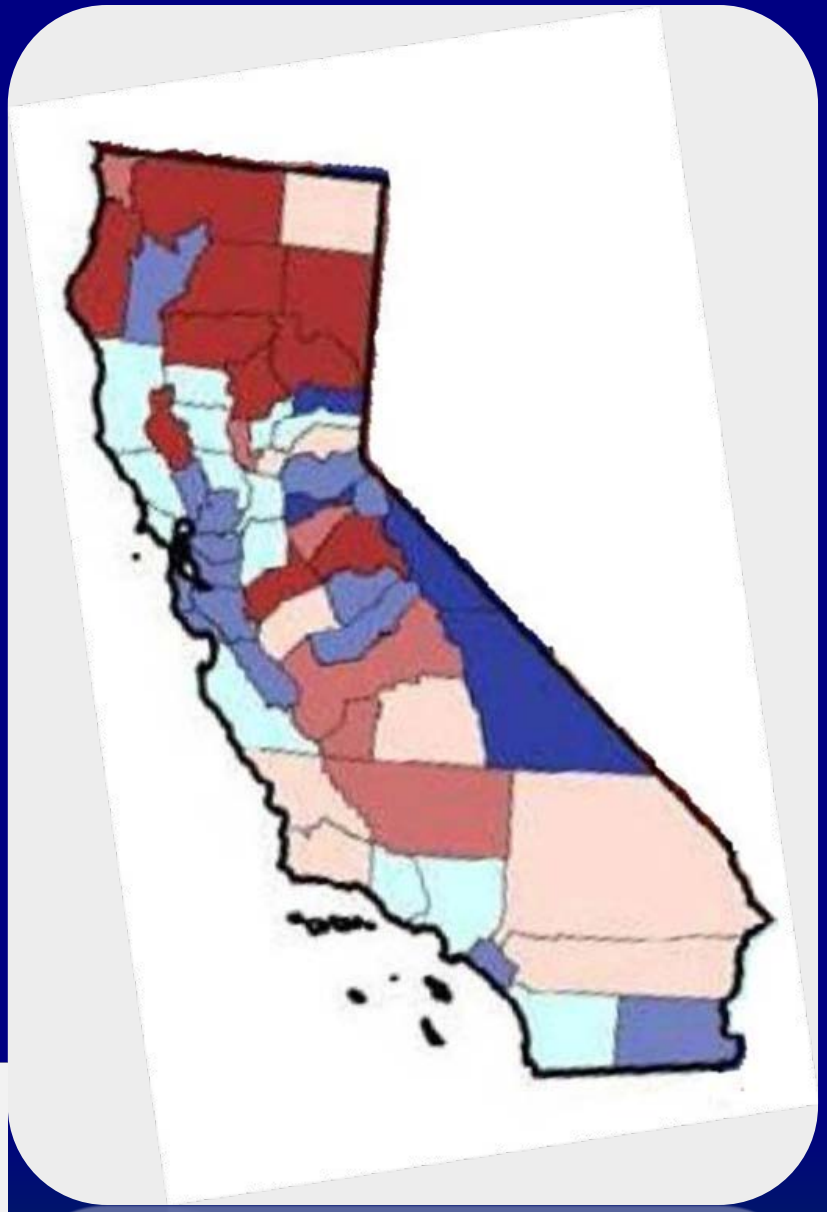
Economic Costs

- $72.5 billion in health care costs[1]
- Opioid abusers generate, on average, annual direct health care costs 8.7 times higher than nonabusers[2]

1. Coalition Against Insurance Fraud. Prescription for peril: how insurance fraud finances theft and abuse of addictive prescription drugs. Washington, DC: Coalition Against Insurance Fraud; 2007.
2. White AG, Birnbaum, HG, Mareva MN, et al. Direct costs of opioid abuse in an insured population in the United States. *J Manag Care Pharm* 2005;11(6):469-479.

California Opioid Use

- As of 2008, California as a whole, dispensed only 68% of the national county average of Rx opioids per resident
- However, variation in California is huge, with the highest rates being in far northern Californian counties



•Red= Above Ave
•Blue = Below Ave
•Pink = US Ave

Intervention Points

- Pill mills
- Problem prescribing
- EDs and hospitals
- Pharmacies

- Insurer and pharmacy benefit managers
- General patients & the public
- People at high risk of overdose
- Pharmaceutical opiate manufacturing and marketing practices

DRUG	RETAIL PRICE	STREET VALUE
Schedule II		
OxyContin 40mg	$5.66/tablet	$20–$40/tablet
oxycodone 40mg	$4.54/tablet	$6–$8/tablet
morphine 100mg	$4.16/tablet	$60/tablet
Actiq 400mg	$26/lozenge	$30–$40/lozenge
fentanyl 50mcg	$24/patch	$25–$40/patch
methadone	$0.19-$0.23/tablet	$10–$20/tablet
Ritalin	$1.11/tablet	$8–$15/tablet
Adderall	$4.23/tablet	$5–$7/tablet
Schedule III		
Vicodin	$1.47/tablet	$6–$10/tablet
hydrocodone/APAP	$0.43/tablet	$6–$10/tablet
Schedule IV		
Valium	$3.30/tablet	$4/tablet
diazepam	$0.39/tablet	$4/tablet
Adipex	$2.13/tablet	$3–$6/tablet
(phentermine) Xanax 2mg	$3.28/tablet	$4/tablet
alprazolam	$0.42/tablet	$4/tablet
Schedule V		
promethazine with codeine	$3.35/fl.oz.	$7.50–$10/fl.oz.

Clinical Guidelines

- Improve prescribing and treatment
- Basis for standard of accepted medical practice for purposes of licensure board actions
- Several consensus guidelines available
- Common themes among guidelines

The Journal of Pain, Vol 10, No 2 (February), 2009: pp 113-130
Available online at www.sciencedirect.com

ELSEVIER

Opioid Treatment Guidelines

Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain

Roger Chou,[1] Gilbert J. Fanciullo,[2] Perry G. Fine,[3] Jeremy A. Adler,[4] Jane C. Ballantyne,[5] Pamela Davies,[6] Marilee I. Donovan,[7] David A. Fishbain,[8] Kathy M. Foley,[9] Jeffrey Fudin,[10] Aaron M. Gilson,[11] Alexander Kelter,[12] Alexander Mauskop,[13] Patrick G. O'Connor,[14] Steven D. Passik,[15] Gavril W. Pasternak,[16] Russell K. Portenoy,[17] Ben A. Rich,[18] Richard G. Roberts,[19] Knox H. Todd,[20] and Christine Miaskowski,[21] for the American Pain Society–American Academy of Pain Medicine Opioids Guidelines Panel

[1] Oregon Evidence-based Practice Center, Department of Medicine, Department of Medical Informatics and Clinical Epidemiology, Oregon Health and Science University, Portland, Oregon.
[2] Pain Management Center, Department of Anesthesiology, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire.
[3] Pain Research Center, Department of Anesthesiology, University of Utah, Salt Lake City, Utah.
[4] Pacific Pain Medicine Consultants, Encinitas, California.
[5] Division of Pain Medicine, Department of Anesthesia and Critical Care, Massachusetts General Hospital, Boston.
[6] Seattle Cancer Care Alliance, Seattle, Washington.
[7] Pain Management Clinic, Kaiser Permanente Northwest, Portland, Oregon.
[8] School of Medicine, Neurological Surgery and Anesthesiology, University of Miami, Miami, Florida.
[9] Pain and Palliative Care Service, Department of Neurology, Memorial Sloan-Kettering Cancer Center, New York, New York.
[10] Samuel S. Stratton Department of Veterans Affairs Medical Center, and Albany College of Pharmacy & Health Sciences, Albany, New York.
[11] Pain and Policy Studies Group, Paul P. Carbone Comprehensive Cancer Center, University of Wisconsin, Madison.
[12] Epidemiology and Prevention for Injury Control (EPIC) Branch, California Department of Health Services, Sacramento, California (retired 2005).
[13] New York Headache Center, New York, New York.
[14] Section of General Internal Medicine, Yale University School of Medicine and Yale-New Haven Hospital, New Haven, Connecticut.
[15] Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, New York, New York.
[16] Laboratory of Molecular Neuropharmacology, Department of Molecular Pharmacology and Chemistry, Memorial Sloan-Kettering Cancer Center, New York, New York.
[17] Department of Pain Medicine and Palliative Care, Beth Israel Medical Center, New York, New York.
[18] School of Medicine, Division of Bioethics, University of California Davis.
[19] School of Medicine and Public Health, University of Wisconsin, Madison.
[20] Pain and Emergency Medicine Institute, Beth Israel Medical Center, New York, New York.
[21] Department of Physiological Nursing, University of California, San Francisco.

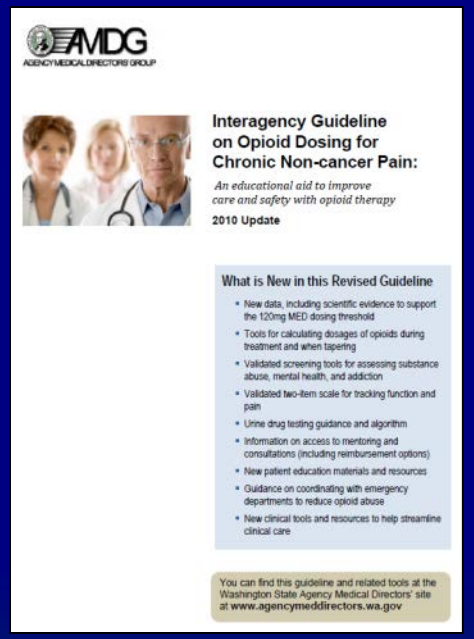
Abstract: Use of chronic opioid therapy for chronic noncancer pain has increased substantially. The American Pain Society and the American Academy of Pain Medicine commissioned a systematic review of the evidence on chronic opioid therapy for chronic noncancer pain and convened a multidisciplinary expert panel to review the evidence and formulate recommendations. Although evidence is limited, the expert panel concluded that chronic opioid therapy can be an effective therapy for

This article is based on research conducted at the Oregon Evidence-based Practice Center with funding from the American Pain Society (APS). The authors are solely responsible for the content of this article and the decision to submit for publication.

Address reprint requests to Dr Roger Chou, 3181 SW Sam Jackson Park Road, Mail Code BICC, Portland, OR 97239. E-mail: chour@ohsu.edu

1526-5900/$36.00

doi:10.1016/j.jpain.2008.10.008



AMDG
AGENCY MEDICAL DIRECTORS' GROUP

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain:

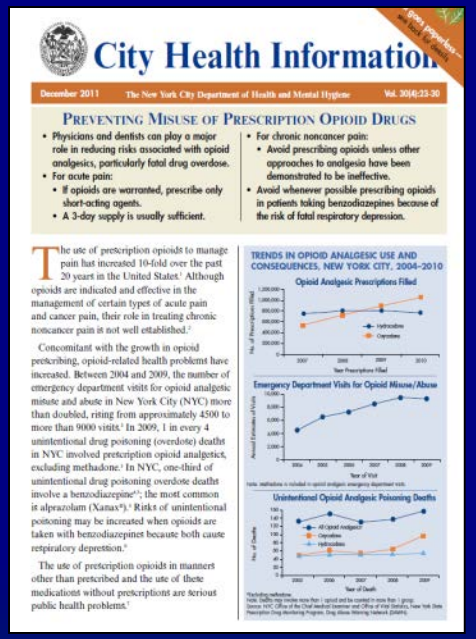
An educational aid to improve care and safety with opioid therapy

2010 Update

What is New in this Revised Guideline

- New data, including scientific evidence to support the 120mg MED dosing threshold
- Tools for calculating dosages of opioids during treatment and when tapering
- Validated screening tools for assessing substance abuse, mental health, and addiction
- Validated two-item scale for tracking function and pain
- Urine drug testing guidance and algorithm
- Information on access to mentoring and consultations (including reimbursement options)
- New patient education materials and resources
- Guidance on coordinating with emergency departments to reduce opioid abuse
- New clinical tools and resources to help streamline clinical care

You can find this guideline and related tools at the Washington State Agency Medical Directors' site at www.agencymeddirectors.wa.gov



City Health Information

December 2011 The New York City Department of Health and Mental Hygiene Vol. 30(4):23-30

PREVENTING MISUSE OF PRESCRIPTION OPIOID DRUGS

- Physicians and dentists can play a major role in reducing risks associated with opioid analgesics, particularly fatal drug overdose.
- For acute pain:
  - If opioids are warranted, prescribe only short-acting agents.
  - A 3-day supply is usually sufficient.
- For chronic noncancer pain:
  - Avoid prescribing opioids unless other approaches to analgesia have been demonstrated to be ineffective.
  - Avoid whenever possible prescribing opioids in patients taking benzodiazepines because of the risk of fatal respiratory depression.

The use of prescription opioids to manage pain has increased 10-fold over the past 20 years in the United States.[1] Although opioids are indicated and effective in the management of certain types of acute pain and cancer pain, their role in treating chronic noncancer pain is not well established.[2]

Concomitant with the growth in opioid prescribing, opioid-related health problems have increased. Between 2004 and 2009, the number of emergency department visits for opioid analgesic misuse and abuse in New York City (NYC) more than doubled, rising from approximately 4500 to more than 9000 visits.[3] In 2009, 1 in every 4 unintentional drug poisoning (overdose) deaths in NYC involved prescription opioid analgesics, excluding methadone.[4] In NYC, one-third of unintentional drug poisoning overdose deaths involve a benzodiazepine[4,5]; the most common is alprazolam (Xanax®).[4] Risks of unintentional poisoning may be increased when opioids are taken with benzodiazepines because both cause respiratory depression.[6]

The use of prescription opioids in manners other than prescribed and the use of these medications without prescriptions are serious public health problems.[7]

TRENDS IN OPIOID ANALGESIC USE AND CONSEQUENCES, NEW YORK CITY, 2004–2010

Opioid Analgesic Prescriptions Filled

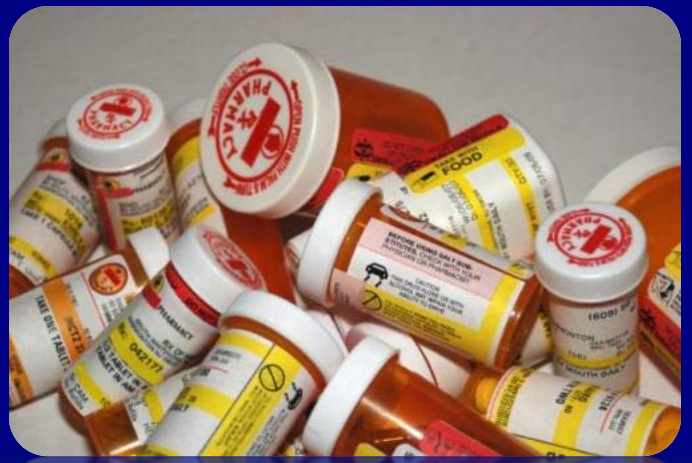
Emergency Department Visits for Opioid Misuse/Abuse

Unintentional Opioid Analgesic Poisoning Deaths

Pharmaceutical companies

Orange and Santa Clara counties and City of Chicago each sue 5 big pharma companies in 2014

“In order to expand the market for opioids and realize blockbuster profits, (big pharma) needed to create a sea-change in medical and public perception that would permit the use of opioids for long periods of time to treat more common aches and pains, like lower back pain, arthritis, and headaches.”



Local Law Enforcement and Public Health Team up for Rx Drug Take Back

- The FDA recommends NOT disposing of most medications down the drain.

- Redding Police, Shasta Co Sheriff, Shasta HHSA-Public Health and federal Drug Enforcement Administration (DEA)

- September 27, 2014- Mt. Shasta Mall – 412 lbs collected
  2010-2014 nine local take back events = 4, 141 lbs collected

- DEA new regs Oct. 2014:
  - Allow pharmacies, hospitals & clinics with pharmacies to run year-round unused medication drop-offs on-site.

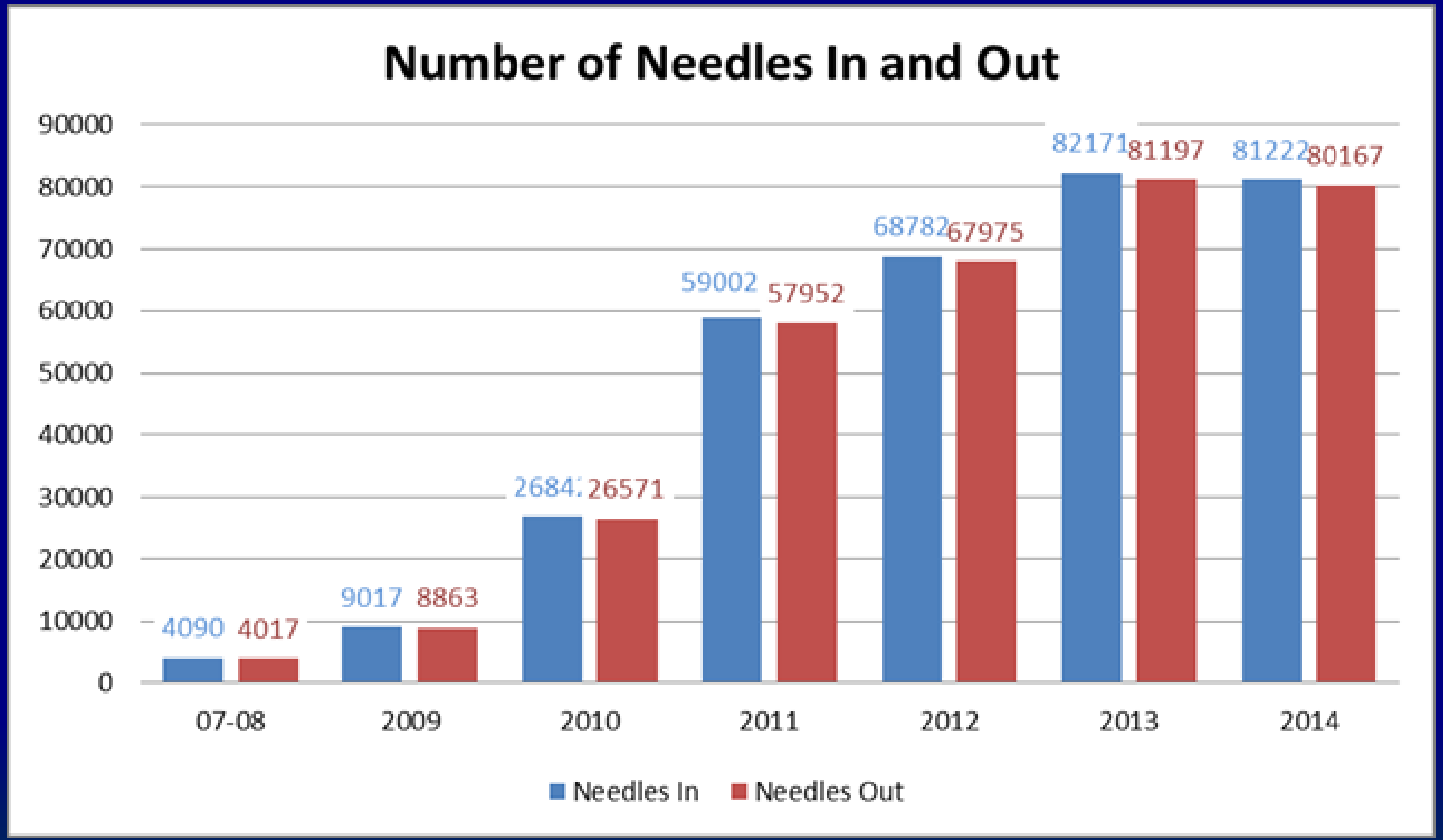
Changing Face of Heroin Use

- 1960s--80% of heroin users, who were mostly young city dwellers, initiated heroin first
- recent years--75% of heroin users started using heroin after getting into opioid painkillers first… Older, more suburban/rural

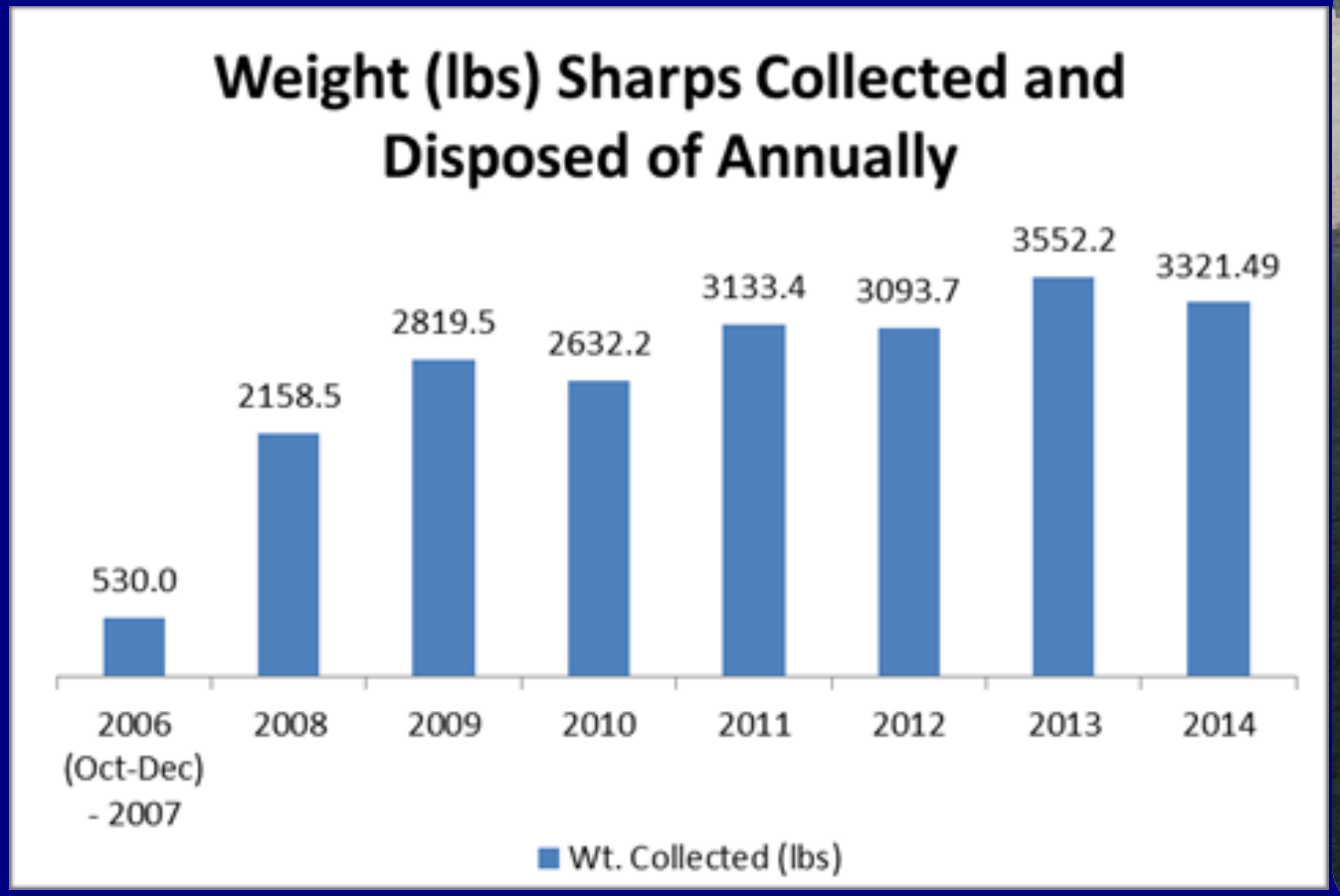
T. Cicero et al *JAMA Psychiatry.* 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

Shasta Co Syringe Exchange Program

Total Syringes--In: 331,126 Out: 326,742



Sharps Collection Stats



Total pounds collected

Oct-06 through 2014 = **<u>21,241.0</u> lbs**

For more information:

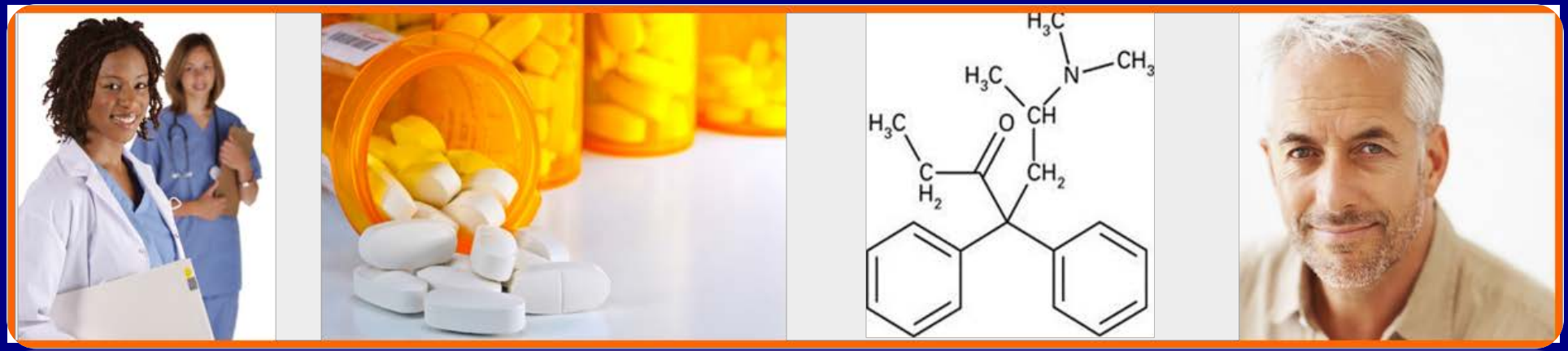
Andrew Deckert, MD, MPH

530-225-5594

adeckert@co.shasta.ca.us

or Wendy Millis 530-245-6858

wmillis@co.shasta.ca.us



Abuse & Diversion of Rx Opioids

Ivan Petrzelka, PharmD, JD, MBA

NoRxAbuse.org

Disclosure

I have no conflict of interest, whether real or apparent. I have no financial interest in any company, product, or services that may be mentioned in this presentation, including grants, gifts, stock holdings, and honoraria.

Prescription Drug Abuse

- Use without prescription
- Use in a manner other than prescribed
- Use to induce certain experience or feeling

Up to 30% of opioid users may be abusing Rx meds

CDC & NIDA

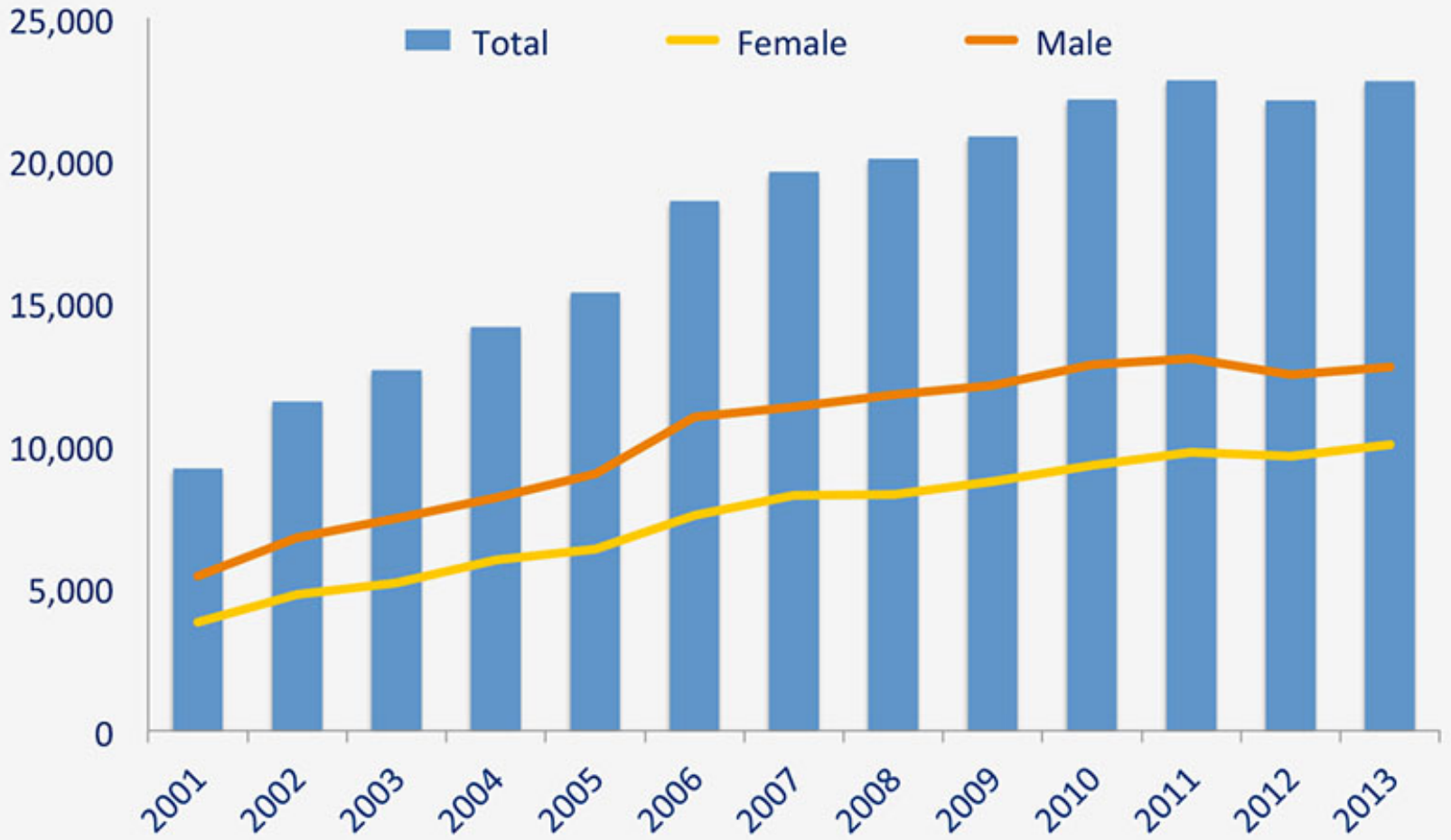
Status Quo

- Prescription opioids are the fastest growing cause of death in the US
- CDC declared prescription drug abuse a “National Epidemic”
- Drug overdose deaths more than tripled since 1990
- The US consumes >90% of world’s production of Hydrocodone & >80% of Oxycodone

NIH National Institute on Drug Abuse

National Overdose Deaths

Number of Deaths from Prescription Drugs

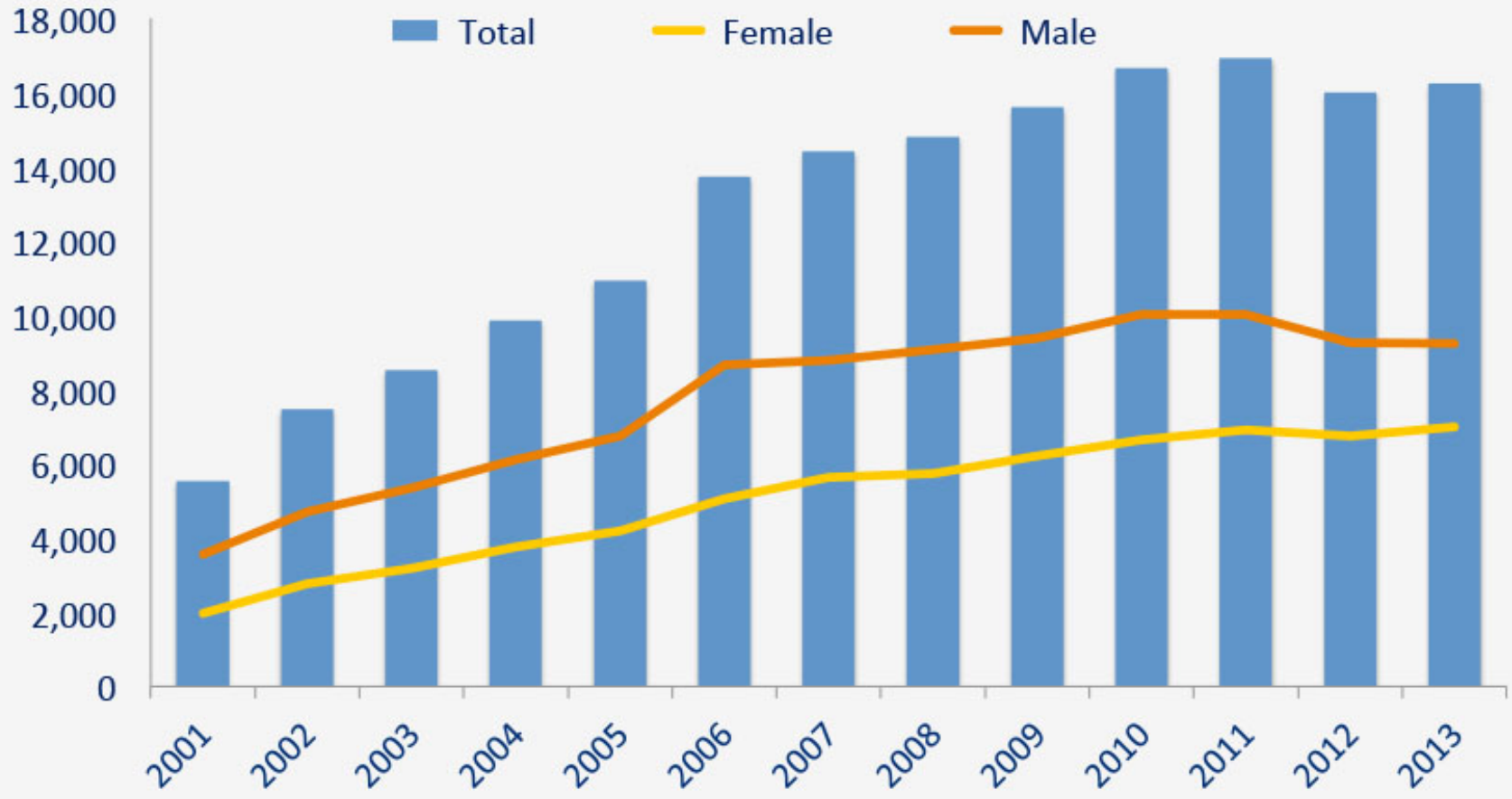


Source: National Center for Health Statistics, CDC Wonder

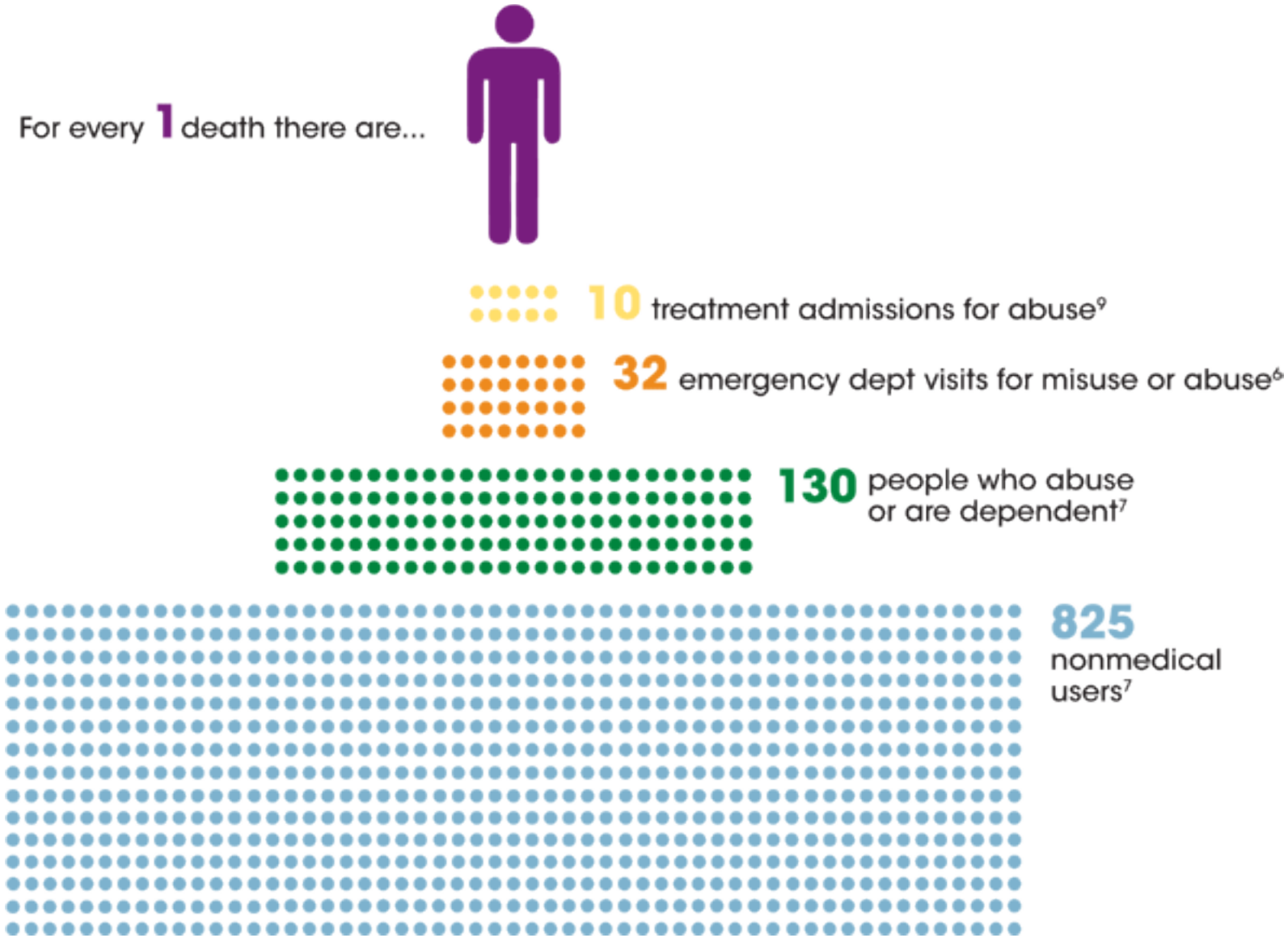
NIH National Institute on Drug Abuse

National Overdose Deaths

Number of Deaths from Rx Opioid Pain Relievers

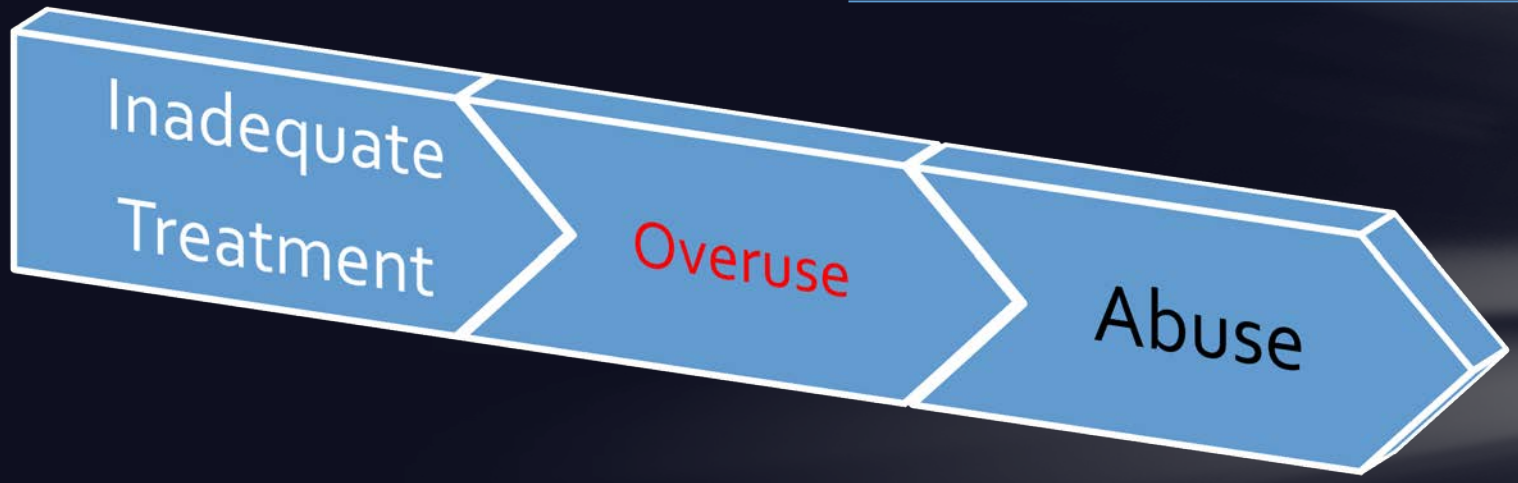


Source: National Center for Health Statistics, CDC Wonder



http://www.cdc.gov/homeandrecreationalsafety/rxbrief/

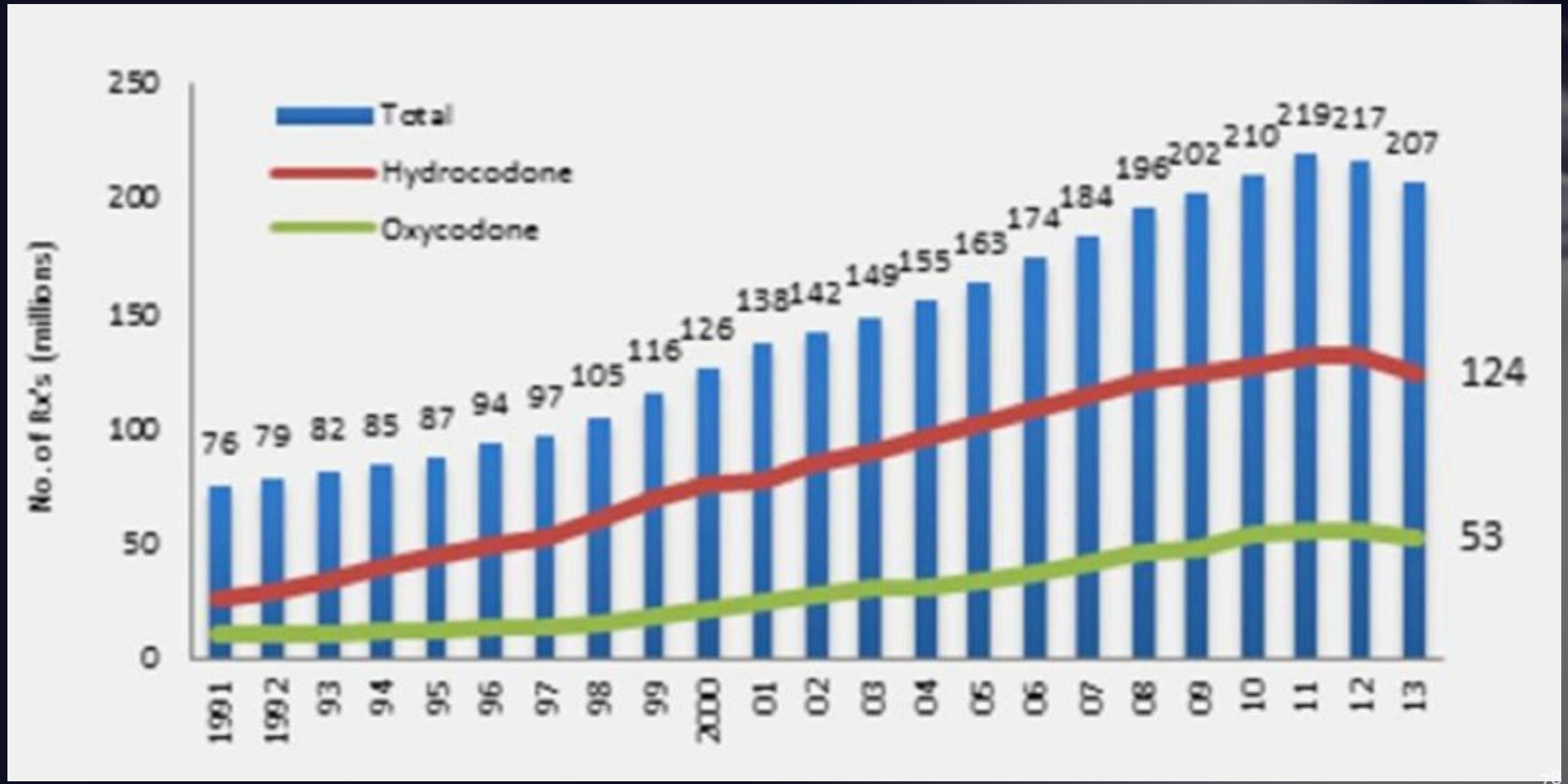
How Did We Get Here?



- OxyContin® introduction in 1996 – Purdue Pharma
- Pain as 5th Vital Sign initiative (VA 1999)
- Decade of Pain Control & Research 2001-2010 (HR3244)


wondershare™

US Opioid Prescriptions 1991-2013 (retail)

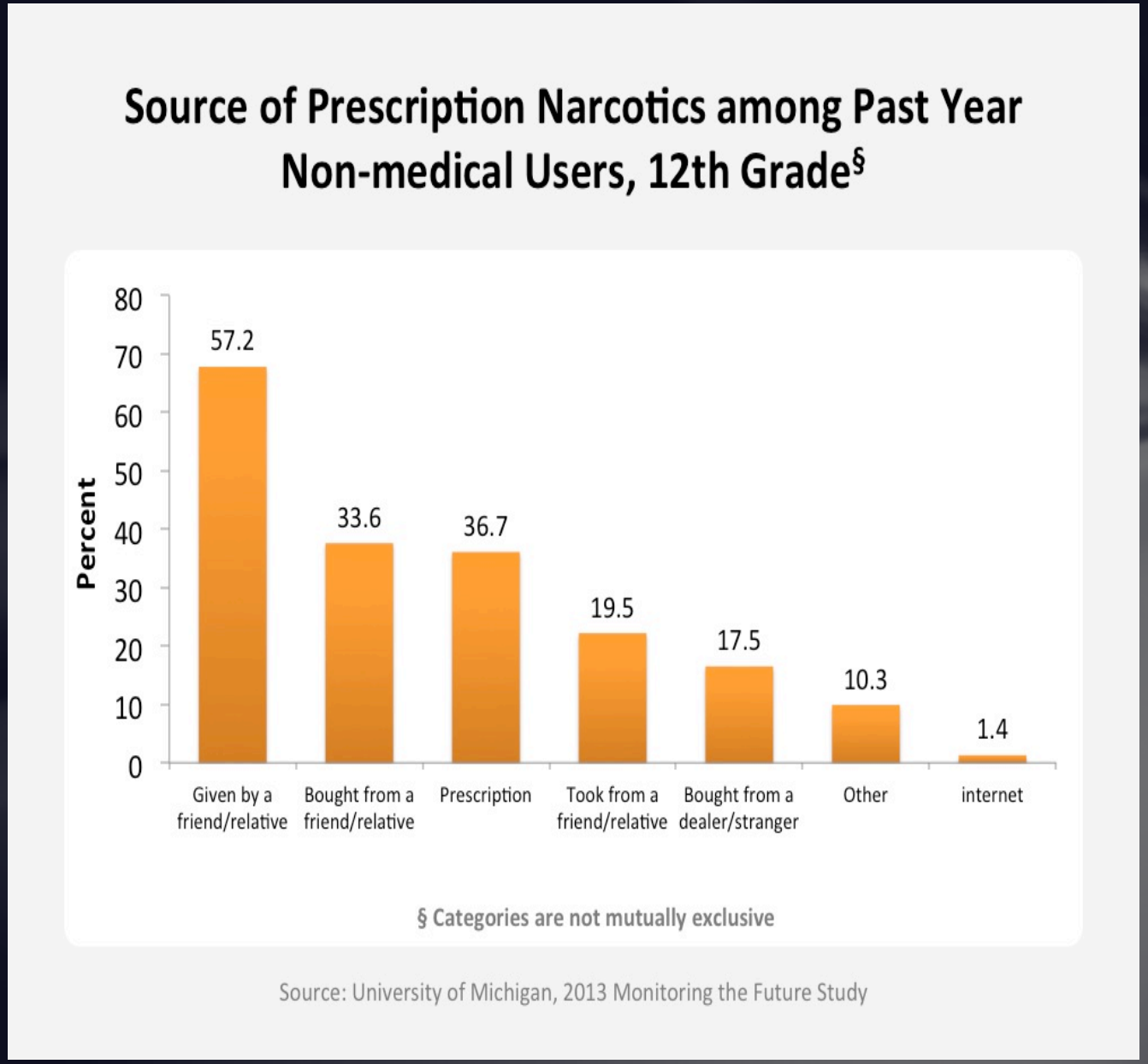


Why Rx Drugs?

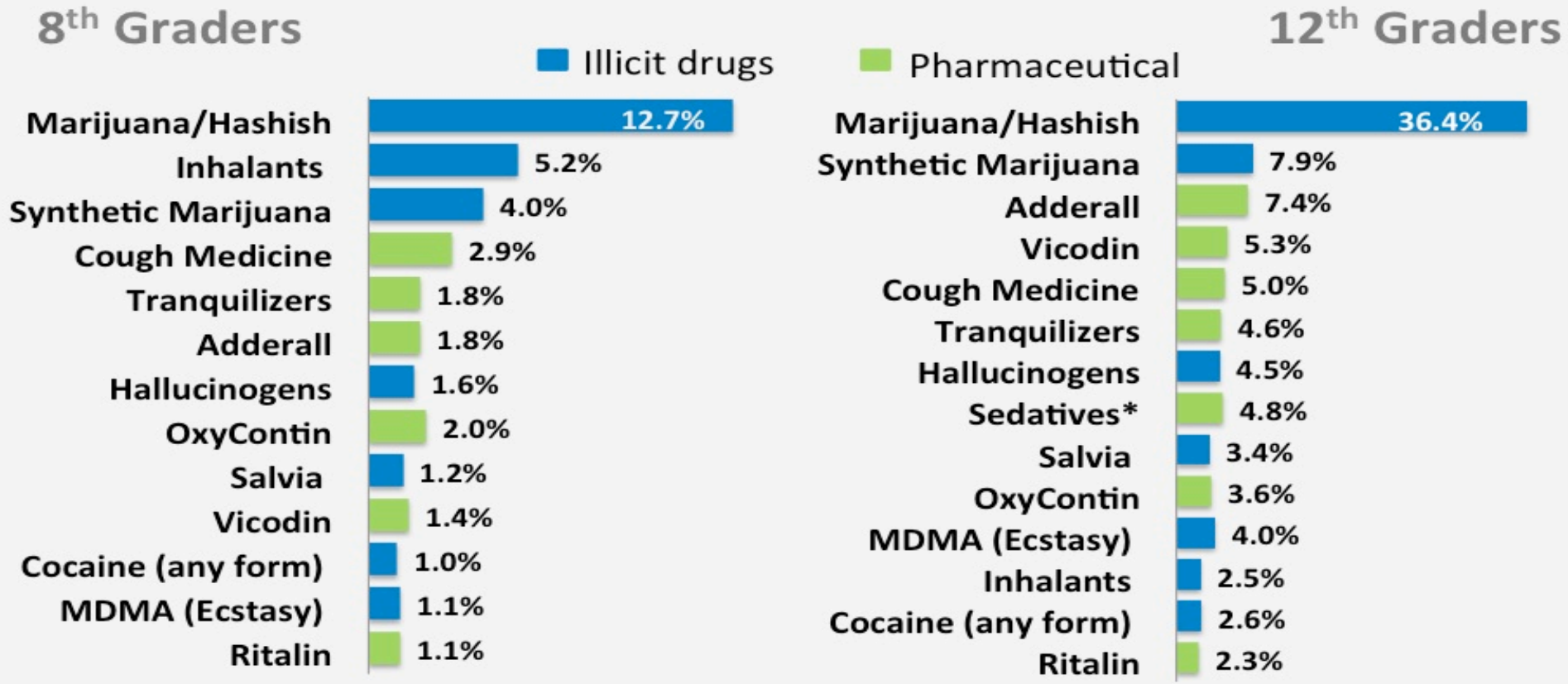
Accessibility

Perception of safety

Social Acceptability of Abuse



Top Drugs among 8th and 12th Graders, Past Year Use



* Only 12th graders surveyed about sedatives use

Source: University of Michigan, 2013 Monitoring the Future Study

Frequently Abused Rx Drugs

- Opioids (IR preferred)
  - Hydrocodone
  - Oxycodone
  - Methadone
  - Hydromorphone
  - Codeine
- Muscle Relaxants
  - Carisoprodol
  - Cyclobenzaprine
  - Methocarbamol
- Benzodiazepines
  - Alprazolam
  - Diazepam
- Stimulants
  - Methylphenidate
  - Amphetamine Salts
  - Dextroamphetamine
- Synthetic Opioids
  - Tramadol

Popular Cocktails

"TRINITY"

- Hydrocodone
- Carisoprodol
- Alprazolam

"HOLY TRINITY"

- Oxycodone
- Carisoprodol
- Alprazolam

Regulatory Response

- **Focused on supply side of the problem, but no focus on demand side.**
- Increased scrutiny on all parties involved in CS distribution chain
- Increased enforcement efforts
- DEA fines up to $10,000 per violation of some provisions of CSA
- Limits imposed on wholesalers & pharmacies – poorly articulated standards
- Mandatory CURES registration (01/2016)

Shared Responsibility for Proper Prescribing & Dispensing of CS

- Rx for controlled substance must be issued for **legitimate medical purpose in the usual course of practice** [21 CFR §1306.04(a), HSC §11153]
- Prescriber is **primarily** responsible, but the RPh has **corresponding** responsibility for proper dispensing. [HSC §11153]
- RPh is **obligated to inquire** into legitimacy of Rx when appropriate. [In Re Pacifica Pharmacy, BOP precedential decision No. 2013-01]

Unintended Consequences

- **Limited access to pain meds for legitimate patients**
- **Adverse impact on Prescriber-Pharmacist relationship – AMA resolution- Pharmacy Intrusion into Medical Practice (2013)**
- Various inconsistent legislative attempts to maintain patient access to pain management medications – conflict with regulatory agencies
- Increased use of Heroin

Solutions

- **Educate your patients and caregivers**
- Evidence-based prescribing guidelines (MBC Nov 2014)
- Use non-opioids first
- Explore other treatment modalities (e.g., acupuncture, chiropractic manipulations, etc.) – payers need to get on board

EDUCATION IS MORE POWERFUL THAN REGULATION

Thank You

ipetrzelka@charter.net

NoRxAbuse.org

www.GeminiLawOffice.com

Resources

- National Drug Threat Assessment Survey 2013 (www.deadiversion.usdoj.gov)
- DEA Pharmacy Diversion Awareness Conferences (August 2013 & Sep. 2014)
- http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse
- http://mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf
- National Institute on Drug Abuse (www.drugabuse.gov)
- CDC Wonder – 2015 updated stats (www.cdc.gov)
- Brandeis University – PDMP Center of Excellence (www.pdmpexcellence.org)
- Monitoring the Future national survey results on drug use: 1975-2014: Overview, key findings on adolescent drug use. Ann Arbor: Institute for Social Research, The University of Michigan.
- 2013 AMA Conference (http://www.ama-assn.org/resources/doc/omss/a13-proceedings.pdf)

GROUP EXERCISE

MARYA CHOUDHRY

PROJECT MANAGER

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GROUP EXERCISE

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA

BREAK

RATIONAL AND IRRATIONAL USE OF OPIOIDS

LEONARD SOLONIUK, MD

PAIN SPECIALIST, REDDING, CA

Rational and Irrational Use of Opioids

Leonard Soloniuk, MD

No Disclosures

No Off-Label Uses Discussed

Objectives

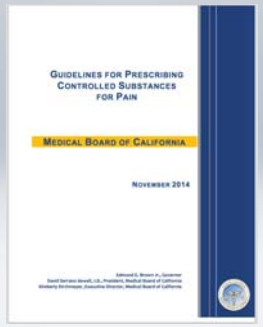
For Opioid Prescribing:

- Review irrational and rational decision making
- Discuss complications and co-morbidities
- Discuss patient work-up to optimize risk/benefit

Rational and Irrational: Initiation of Therapy

Irrational	Rational
• No documentation of presence of recognized medical indications	• Appropriate work-up with history, exam, testing, "establishing a diagnosis and medical necessity"
• Not reviewing patient and family mental health and substance abuse history	• Risk stratification for addiction, medical co-morbidity, psych, meds
• Not sensitive to transition from acute to chronic	• Re-evaluation when acute pain becomes chronic
• Using opioids in isolation	• Opioid therapy as part of a multi-modality program
• Not using opioids when appropriate	• Using opioids as part of care continuum

Medical Board Standards



PATIENT EVALUATION AND RISK STRATIFICATION

The nature and extent of the clinical assessment includes:

- Completing a medical history and physical examination.
- Performing a psychological evaluation.
- Psychological assessment should include risk of addictive disorders.
- Establishing a diagnosis and medical necessity

Pain Management: Guidelines for Prescribing Controlled Substances for Pain
Medical Board of California. November 2014
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

Indications

Conditions less likely to respond to opioid therapy

- Fibromyalgia
- Chronic headache
- Irritable bowel syndrome

Conditions more likely to respond to opioid therapy

- OA, RA
- Chronic spinal pain

Addiction: not an appropriate without special licensing.

Conventional Practice for Medical Conditions for Chronic Opioid Therapy Smith HS Pain Physician 2012; 15:ES1-ES7

Rational and Irrational: Initiation of Therapy

Irrational	Rational
• Not reviewing patient and family mental health and substance abuse history	• Risk stratification for addiction, medical co-morbidity, psych. meds

Risk Factors for Opioid Abuse

- Young age (45 or younger)
- Family history of substance abuse
- Past history of substance abuse
- History of DUI or drug charges
- Major mental disorders
- History of childhood sexual abuse (especially female patients)

Krashin D, Sullivan M, Ballantyne J What Are We Treating with Chronic Opioid Therapy? Curr Rheumatol Rep (2013) 15:311

Risk Assessment Tools: Examples

Tool	# of items	Administered
Patients considered for long-term opioid therapy:		
ORT Opioid Risk Tool	5	By patient
SOAPP® Screener & Opioid Assessment for Patients w/ Pain	24, 14, & 5	By patient
DIRE Diagnosis, Intractability, Risk, & Efficacy Score	7	By clinician
Characterize misuse once opioid treatments begins:		
PMQ Pain Medication Questionnaire	26	By patient
COMM Current Opioid Misuse Measure	17	By patient
PDUQ Prescription Drug Use Questionnaire	40	By clinician
Not specific to pain populations:		
CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs	4	By clinician
RAFFT Relax, Alone, Friends, Family, Trouble	5	By patient
DAST Drug Abuse Screening Test	28	By patient
SBIRT Screening, Brief Intervention, & Referral to Treatment	Varies	By clinician

Collaborative for REMS Education

Opioid Risk Tool (ORT)

Mark each box that applies	Female	Male
1. Family Hx of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal Hx of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Age between 16 & 45 yrs	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals:		

Administer

On initial visit

Prior to opioid therapy

Scoring *(risk)*

0-3: low

4-7: moderate

≥8: high

Webster LR, Webster RM. *Pain Med.* 2005;6:432-42.

Collaborative for REMS Education

Example of Risk Benefit Analysis

Adapted from Rubenstein

Rational and Irrational: Initiation of Therapy

Irrational	Rational
• Using opioids in isolation	• Opioid therapy as part of a multi-modality program

Treatments for Chronic Pain

The nature and extent of the clinical assessment…includes:

- Psychological therapies
- Physical therapies: PT, Chiropractic, massage, acupuncture
- Opioid and non-opioid medications.
- Injection and surgical therapies

Rational and Irrational: Initiation of Therapy

Irrational	Rational
• Not using opioids when appropriate	• Using opioids as part of care continuum

When to Consider a Trial of Opioid Therapy for Chronic Pain

- Pain is moderate to severe
- Failed to adequately respond to non-opioid & non-drug interventions
- Potential benefits are likely to outweigh risks
- No alternative therapy is likely to pose as favorable a balance of benefits to harms

Rational and Irrational: Continuation, Part 1

Irrational	Rational
• Not monitoring response to therapy	• Assessment of the 4A's
• Not assessing and treating sequelae of opioid therapy	• "B.E.S.T." Work-up: Bone Density, EKG, Sleep Study, Testosterone
• Not monitoring PDMP (CURES)	• Monitoring CURES, frequency based on risk
• Not monitoring UDT	• Unannounced UDT, frequency based on risk
• Not reassessing when MED (morphine equivalent dose) > 120	• Re-assessing high dose opioid therapy

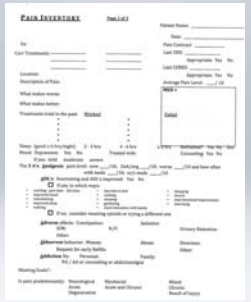
4 A's of Monitoring Opioid Therapy

- **Analgesia**
- **Activities** of daily living
- **Adverse** side effects
- **Aberrant** drug-taking behaviors
- (MBC adds **Affect**: the patient's behavior and mood are appropriate.)

4 A's: Adverse Effects

- CNS: sedation
- Pysch: co-morbid mental disease
- GI: constipation, Narcotic Bowel Syndrome
- GU: urinary retention
- Endocrine: Opioid-induced hypogonadal state
- Pulmonary: respiratory depression
- Opioid-induced hyperalgesia

4 A's of Monitoring Opioid Therapy


PAIN INVENTORY

Courtesy of Dr. Danny Drew

Rational and Irrational: Continuation, Part 1

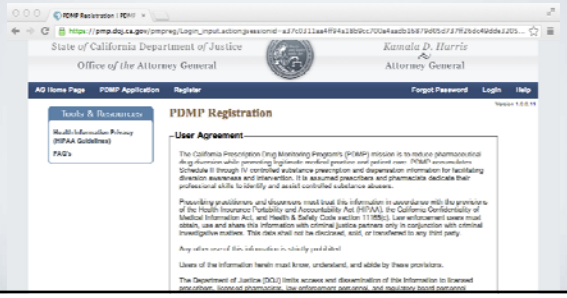
Irrational	Rational
• Not assessing and treating sequelae of opioid therapy	• "B.E.S.T." Work-up: Bone Density, EKG, Sleep Study, Testosterone

Rational and Irrational: Continuation, Part 1

Irrational	Rational
• Not monitoring PDMP (CURES)	• Monitoring CURES, frequency based on risk

Prior to Opioid Therapy: CURES / PDMP

California Prescription Drug Monitoring Program (PDMP)

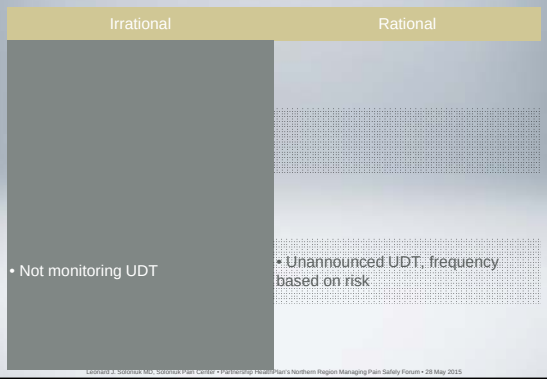


Prior to Opioid Therapy: CURES / PDMP

When to Consider a Trial of Opioid Therapy for Chronic Pain

- Pain is moderate to severe
- Failed to adequately respond to non-opioid & non-drug interventions
- Potential benefits are likely to outweigh risks
- No alternative therapy is likely to pose as favorable a balance of benefits to harms

Rational and Irrational: Continuation, Part 1



Urine Drug Testing (UDT) Why test?

- Help to identify drug misuse/addiction
- Assist in assessing adherence during opioid therapy
- Support decision to refer
- Suggested by multiple guidelines

- **Goal:** Confirm presence of prescribed medications
- **Goal:** Confirm absence of non-prescribed medications

UDT: Types of Testing

- Point-of-care testing (POCT)
- Enzymatic/EIA testing
- GC/MS or LC/MS

PCT: Inadequate for Clinical Decision Making

Pro

- Inexpensive
- Rapid results
- Screen for drug families
- Low complexity / CLIA waived

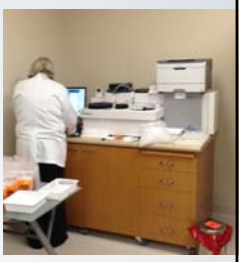
Con

- High false positive and false negative rate
- Subject to cross-reactivity
- Limited compounds tested

SAMHSA. Clinical Drug Testing in Primary Care. Technical Assistance Publication (TAP) 32. HHS Publication No.(SMA) 12-4668. Rockville, MD: SAMHSA, 2012.

Urine Drug Testing (UDT) Enzymatic/EIA testing

- Moderate or High Complexity
- Classify substance as present or absent according to cutoff
- Many do not identify individual drugs within a class
- Subject to cross-reactivity / false positives



Gourlay DL, et al. Urine Drug Testing in Clinical Practice. The Art & Science of Patient Care. 2010. Ed 4.

Urine Drug Testing (UDT) LC/MS or GC/MS

- Liquid chromatography–mass spectrometry (**LC/MS**)
- Gas chromatography–mass spectrometry (**GC/MS**)

- High Complexity
- "The gold standard"
- Allows quantitation
- Takes longer

Owen GT et al. Urine Drug Testing: Current Recommendations and Best Practices Pain Physician 2012; 15:ES119-ES13

Urine Drug Testing (UDT) What to Test

The "RPD Standard": ≥1:400 unexpected

- Validity testing
- Prescribed controlled substances and metabolites
- Commonly abused substances in Shasta and Tehama Counties

Owen GT et al. Urine Drug Testing: Current Recommendations and Best Practices Pain Physician 2012; 15:ES119-ES13

Urine Drug Testing (UDT)
What to Test, cont'd

opioids / metabolites
- morphine
- hydrocodone
- hydromorphone
- oxycodone
- oxymorphone
- codeine
- 6-AM (Heroin metabolite)
- fentanyl
- buprenorphine
- tapentadol
- methadone
- tramadol

Owen GT et al. Urine Drug Testing: Current Recommendations and Best Practices Pain Physician 2012; 15:ES119-ES13

Urine Drug Testing (UDT)
What to Test, cont'd

- opioids
- benzodiazepines
- carisoprodol and meprobamate
- barbiturates
- amphetamine
- methamphetamine
- cocaine and metabolite (benzolecgonine)

Owen GT et al. Urine Drug Testing: Current Recommendations and Best Practices Pain Physician 2012; 15:ES119-ES13

Urine Drug Testing (UDT)
What to Test, cont'd

Shasta/Tehama County
- propoxyphene
- ketamine
- pregabalin
- buprenorphine

Consider:
- Phencyclidine (PCP)
- LSD
- 3-4 methylene-dioxymethamphetamine/ MDMA (ecstacy)


The Positive Inconsistent in Urine Drug Testing at a Community Specialty Pain Clinic

Nguyen N, Workman T, Soloniuk L. The Positive Inconsistent in Urine Drug Testing at a Community Specialty Pain Clinic. Poster session presented at: The Association for Mass Spectrometry Applications to the Clinical Lab. 7th Annual Conference; 2015 March 28- April 1; San Diego, CA.

Urine Drug Testing (UDT)
Difficult to detect

Difficult to detect
- "Spice"
- "Bath salts"
- GHB
- Volatiles: "huffers"
- Sporadic use

Owen GT et al. Urine Drug Testing: Current Recommendations and Best Practices Pain Physician 2012; 15:ES119-ES13

Urine Drug Testing (UDT) How Often to Test

- Initiation of opioid therapy
- Change of therapy
- Low risk: 2/year
- Moderate risk: quarterly
- High risk: Monthly

Owen GT et al. Urine Drug Testing: Current Recommendations and Best Practices Pain Physician 2012; 15:ES119-ES13

Rational and Irrational: Continuation, Part 1

Irrational	Rational
• Not reassessing when MED (morphine equivalent dose) > 120	• Re-assessing high dose opioid therapy

Rational and Irrational: Continuation, Part 2

Irrational	Rational
• Not considering Opioid-Induced Hyperalgesia (OIH) in unresponsive patients	• Considering OIH in unresponsive pts: consider trials opioid rotation, tapering, alternate therapy
• Using methadone as a 1st or 2nd line opioid	• Using methadone as a last resort
• Not considering community risks associated with opioids	• Considering patient, clinic, and community impacts of prescribing
• Not assessing input from pharmacist, family and community	• Using info from outside sources

If inadequate analgesia, consider…

- Undertreatment
- Disease progression vs co-morbidity
- Drug diversion / abuse
- Tolerance
- Opioid-induced hyperalgesia

Opioid-induced Hyperalgesia (OIH)

- Paradoxical increase in pain with chronic opioid therapy
- Suspect OIH when opioid effect wanes with no disease progression
- Unexplained pain reports or diffuse allodynia
- Treatment: wean down/off opioids, supplementation with NMDA receptor modulators, opioid rotation

Marion Lee, MD, Sanford Silverman, MD, Hans Hansen, MD Vikram Patel,MD, and Laxmaiah Manchikanti, M D A Comprehensive Review of Opioid-Induced Hyperalgesia Pain Physician 2011; 14:145-161

Opioid Rotation Risks

- "the current paradigm used for opioid rotation can be dangerous and lead to potentially fatal outcomes"
- Use of current opioid equi-analgesic dose tables can be fatal

Webster LR, Fine PG "Overdose Deaths Demand a New Paradigm for Opioid Rotationpm" Pain Medicine 2012; 13: 5 71–574

Rational and Irrational: Continuation, Part 2

Irrational	Rational
• Using methadone as a 1st or 2nd line opioid	• Using methadone as a 3rd or 4th line opioid

Root Cause Analysis for Opioid-Related Deaths

- physician error due to knowledge deficits
- patient non-adherence
- comorbidities, including substance use disorders
- presence of additional CNS-depressant drugs
- sleep-disordered breathing
- **methadone represented less than 5% of opioid prescriptions dispensed but implicated in one third of opioid-related deaths**

Webster LR et al An Analysis of the Root Causes for Opioid-Related Overdose Deaths in the United States. Pain Medicine 2011; 12: S26–S35

Potential Risk Factors in Methadone Deaths

Risk factors: respiratory depression
- age
- Medically compromised
- Liver or pulmonary pathology
- Sleep apnea
- Polysubstance use
- Opioid-naïve/low tolerance
- High doses of methadone
- Rapid titration

Risk factors: TdP
- Female gender
- Electrolyte imbalance
- Liver or cardiac pathology
- Unexplained syncope or seizures
- Other drug and medication use especially those that impact QTc or inhibit CYP 3A428
- Prolonged QTc
- High doses of methadone

Vania Modesto-Lowe, MD, MPH1, Donna Brooks, MS and Nancy Petry, Ph Methadone Deaths: Risk Factors in Pain and Addicted Populations J Gen Intern Med. 2010 April; 25(4): 305–309.

Rational and Irrational: Continuation, Part 2

Irrational	Rational
• Not considering community risks associated with opioids	• Considering patient, clinic, and community impacts of prescribing

Rational and Irrational: Continuation, Part 2

Irrational	Rational
• Not assessing input from pharmacist, family and community	• Using info from outside sources

Rational and Irrational: Stopping

Irrational	Rational
• Considering withdrawal symptoms as dangerous	• Re-evaluate and taper/detox when no improvement or unsafe use
• Continuing if unsafe or no functional improvement or no analgesia	• Re-evaluate and taper when no improvement or unsafe use
• Stopping when opioids are working	• Continuing opioid therapy when effective and reasonable risk/benefit
• Not being able to say "No"	• Being able to discontinue therapy

Opioid Withdrawal

- Uncomfortable but not dangerous
- Contrast to risk with benzo/barbiturate withdrawal
- Special populations: pregnant women, neonates
- Risk/benefit calculation in patient with opioids on UDT
- Risk/benefit calculation in patient with aberrant behavior

Rational and Irrational: Stopping

Irrational	Rational
• Continuing if unsafe or no functional improvement or no analgesia	• Re-evaluate and taper when no improvement or unsafe use

Rational and Irrational: Stopping

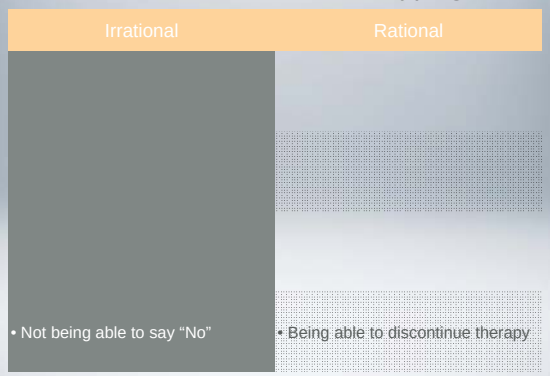
Irrational	Rational
• Stopping when opioids are working	• Continuing opioid therapy when effective and reasonable risk/benefit

When to continue opioids:

California Work Comp
Medical Treatment Utilization Schedule (MTUS)
CHRONIC PAIN MEDICAL TREATMENT GUIDELINES:

- If the patient has improved functioning and pain

Rational and Irrational: Stopping



Resources

- Pain Management: Guidelines for Prescribing Controlled Substances for Pain
- Medical Board of California. November 2014
- http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

- Oregon Pain Guidance group (OPG)
- http://www.southernoregonopioidmanagement.org/healthcare-professionals

- Opioid Risk Tool
- http://www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf

- STOP BANG Questionnaire for sleep apnea
- http://www.sleepapnea.org/assets/files/pdf/STOP-BANG%20Questionnaire.pdf

Thank You

THE ART AND VERY LITTLE SCIENCE OF TAPERING

ANDREA RUBINSTEIN, MD (VIA VIDEO RECORDING)
CHIEF OF PAIN MANAGEMENT
KASIER PERMANENTE

THE ART AND VERY LITTLE SCIENCE OF TAPERING

- The Art & Very Little Science of Tapering (42 min) http://youtu.be/rj_fjlrHnVQ

The Art and (very Little) Science of Tapering Opioid Medications

Who, Why, When and How

Andrea Rubinstein, MD
Chief, Department of Chronic Pain
Santa Rosa

 |

KAISER PERMANENTE®

Objectives

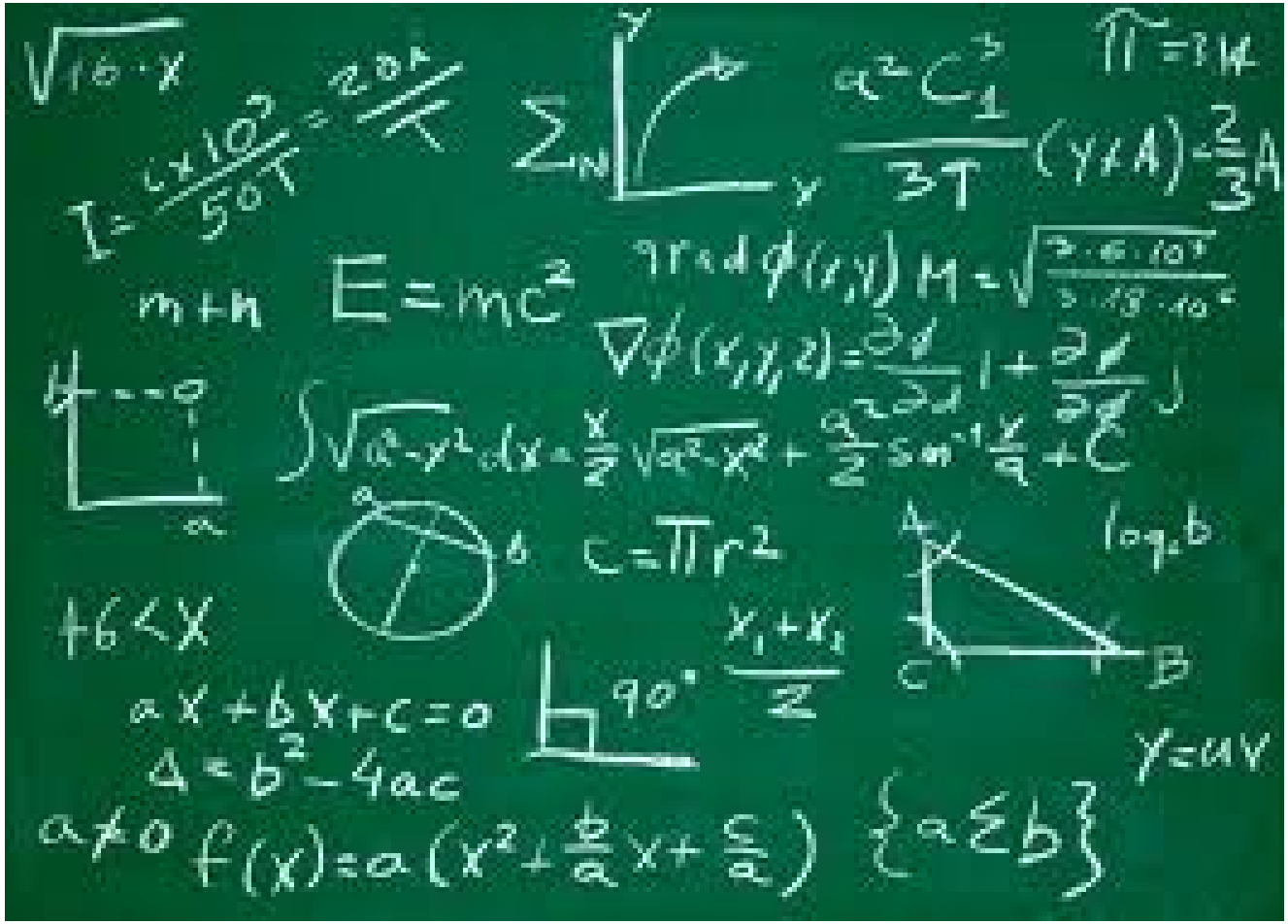
- Identify situations when tapering is appropriate
- Learn to design most appropriate type of taper for particular patients
- Gain skills at trouble shooting taper problems to avoid derailing

Disclosure

All persons involved with the planning and presenting of this activity have not had any financial relationships in the past 12 months with any commercial interest or any proprietary entity producing health care goods or services that is relevant to this CME activity.

KAISER PERMANENTE®

Warning



KAISER PERMANENTE®

What is an Opioid Taper?

A opioid taper is a progressive decrease in the amount of opioid taken

with a goal of leading to reduced risk and or opportunity for greater overall quality of life

for the patient.

 |

KAISER PERMANENTE®

The Bottom Line:

Do not start a medication you do not know how to stop.

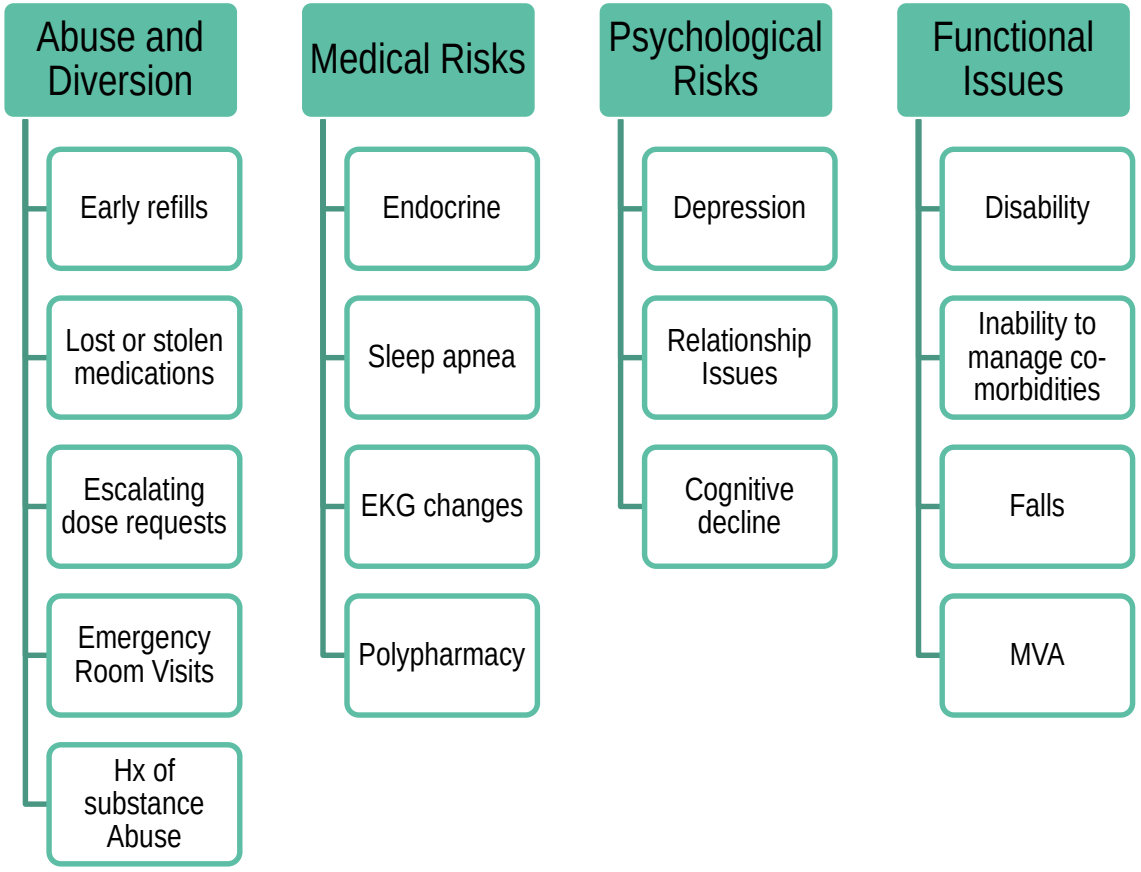
When to Taper

When what the drug is doing TO the patient is more than what the drug is doing FOR the patient.

 |

KAISER PERMANENTE®

Identifying Clinical Risk of Opioid Use



 |

KAISER PERMANENTE®

Who to Consider for Taper

- Motivated patients
- Young patients
- Patients who say “it’s not working” or “it takes the edge off”
- Patients with diagnosable hyperalgesia
- Patients with declining function despite opioids
- Patients on opioids and complex polypharmacy
- Patients whose underlying pain issue may have resolved

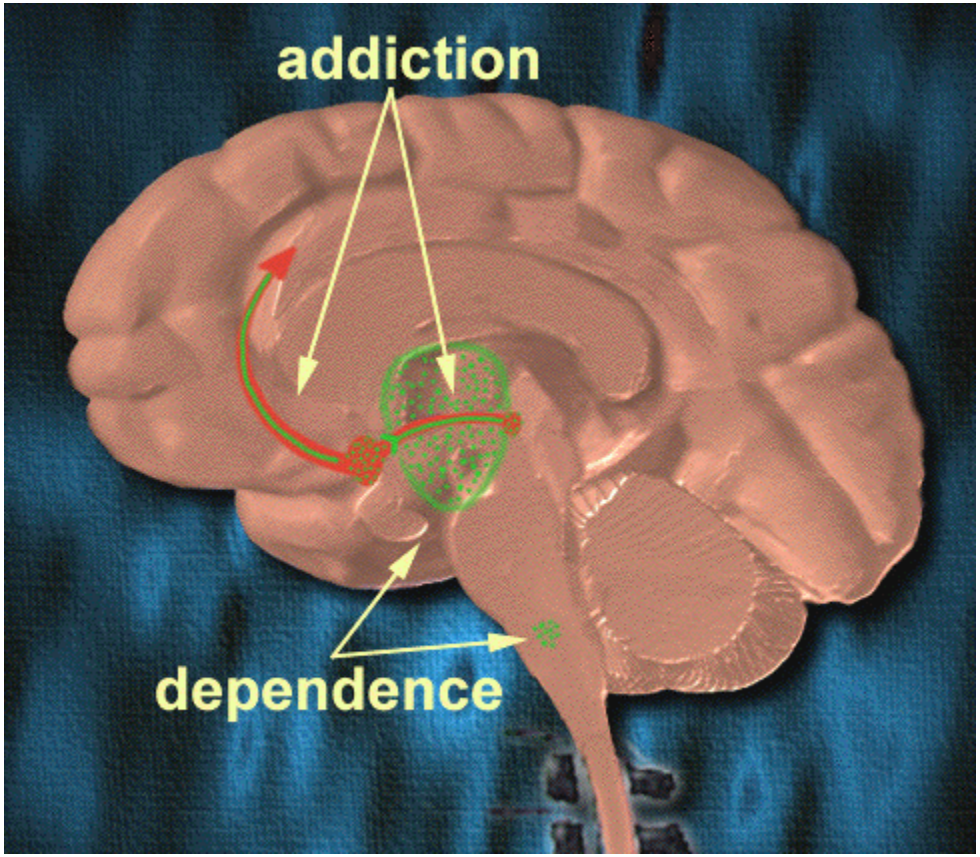
Who not to taper

- Addicted Patients
- Palliative Care Patients
- Psychiatrically fragile or unstable patients
- Pregnant patients

 |

KAISER PERMANENTE®

Digression: Dependence vs. Addiction



National Institute of Drug Abuse 2007

KAISER PERMANENTE®

Reasons NOT to not taper

- “It takes the edge off….”
- “I have more pain when I skip a dose so I know it is doing something…”
- “I tried to stop before and my pain got out of control”
- “It is the only thing that lets me work 16 hours per day”
- “I cant figure skate competitively without this”

Opioids are not performance enhancing drugs

KAISER PERMANENTE®

Types of Tapers

- Physician Directed Taper
- Patient Directed Taper
- Rapid Taper
- Group Taper
- Inpatient Taper

Rules of Thumb for Tapering

1. The longer on opioids the slower you go
2. Medications not used daily can be stopped without a taper
3. Use only one “small currency “ opioid
4. Down is easier than off
5. First 1/3 is easier than 2/3
6. Last 1/3 is hard and last 10% is really hard
7. Most patients tolerate 10% reductions
8. Virtually no one tolerates 25% reductions well
9. Going slowly is always better than stopping or giving up
10. The best taper is the one that works

 |

KAISER PERMANENTE®

Tapering and Opioids

This factsheet accompanies the Guid pioid Therapy for Chronic Pain. It was created to aid with th (VA) and Department of Defense (DoD) employees who utiliz plicable regulations and policies throughout the course of care and pat

- Methadone:
- Decrease dose by 20-50 ntil you reach 30 mg/day
- Then decrease by 5 mg/ ive days to 10 mg/day–
- Then decrease by 2.5 e days

- Morphine SR/CR
- Decrease dos cent per ach 45 mg/day
- Then decrease by 15 mg/day every two to five days

- Oxycodone CR:
- Decrease dose by 20-50 percent per day until you reach 30 mg/day
- Then decrease by 10 mg/day every two to five days

KAISER PERMANENTE®

Case 1 :

- SS is a 46 y.o. male with low back pain/failed back syndrome now with residual axial low back pain and sciatica type pain on the left.
- High dose opioids about 720 mg daily equivalent of morphine dose basically stable since 2007 but vague about his actual daily dose saying “well, it is more than that”
- Recent hospitalized for 11 days for pain control following a fall that broke several ribs. At that time he was also taking Demerol on a "prn" basis. (0-600 mg daily)

Filtered: Schedule Level (C-II High abuse potential; C-III Moderate dependence; C-IV Limited Depen

Date	AMB/IP	Medication	Order Detail
2/6/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
2/27/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
3/23/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
4/18/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
5/14/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
6/8/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
7/2/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
7/26/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
8/21/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
8/21/2012 (O)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
9/14/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
9/14/2012 (O)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
10/9/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
10/31/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
11/27/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
12/19/2012 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
1/14/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
1/15/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
2/8/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
3/4/2013 (S)	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...
[illegible]	AMB	morphine (MSIR) 30 mg Oral Tab	Take 6 tablets orally 4 ...

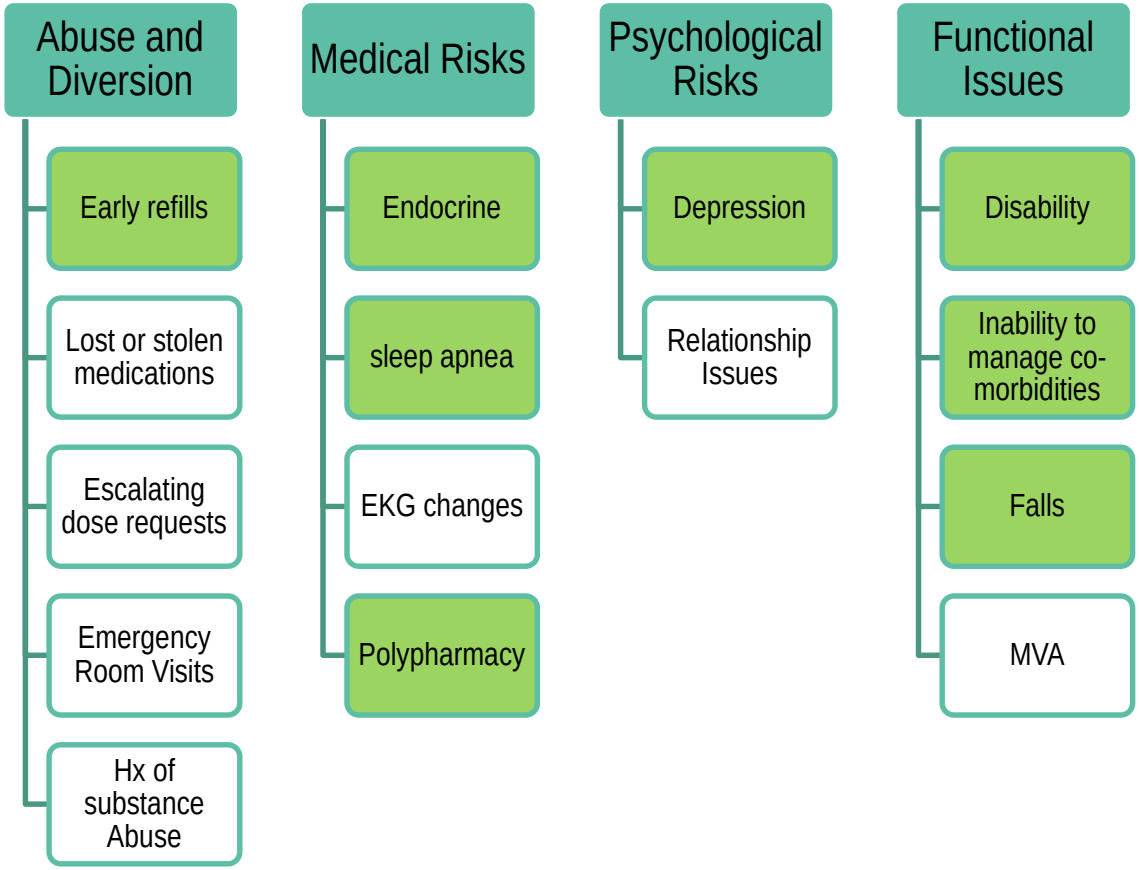
Case 1 SS: risk> benefit

- Moderate obesity
- Function is poor “I just lay on the couch all day"
- Diabetes HgbA1c 9.3
- Testosterone 50ng/dl
- Moderate obstructive sleep apnea
  - Moderate Obstructive Sleep Apnea
    Average Oxygen Saturation: 93%
    Lowest Oxygen Saturation: 83%
- Uses Zolpidem for sleep prn
- Intermittent use of Promethazine or prochlorperazine for nausea of unknown etiology
- Depression on 120 mg daily of Cymbalta

Taper?

Don’t Taper?

Identifying Clinical Risk of Opioid Use



 |

KAISER PERMANENTE®

STEP 1: The Buy in

- Forwarn
- Option to return
- Reassure
- Educate and Encourage
- Support
- Treatment Plan in Writing

KAISER PERMANENTE®

Physician Directed Taper

Name: SS

DRUG TO TAPER	PILLS SIZE	dosage	# TIMES DAILY	TOTAL DAILY DOSE
MORPHINE	30	8	4	960
	15			

GOAL DOSE	INTERVAL	start date	% reduction min	% reduction maximum
100	1	5/3/2013	5	15

Friday MORPHINE Taper Schedule for SS

date	% drop	Daily mg	#/DAY	# RX	mg change
5/3/2013	5	900.0	30.0	210	60.00
5/10/2013	5	855.0	28.5	200	45.00
5/17/2013	5	810.0	27.0	189	45.00
5/24/2013	6	765.0	25.5	179	45.00
5/31/2013	6	720.0	24.0	168	45.00
6/7/2013	6	675.0	22.5	158	45.00
6/14/2013	7	630.0	21.0	147	45.00
6/21/2013	7	585.0	19.5	137	45.00
6/28/2013	8	540.0	18.0	126	45.00
7/5/2013	8	495.0	16.5	116	45.00
7/12/2013	9	450.0	15.0	105	45.00
7/19/2013	10	405.0	13.5	95	45.00
7/26/2013	11	360	12.0	84	45.00
8/2/2013	13	315	10.5	74	45.00
8/9/2013	14	270	9.0	63	45.00
8/16/2013	6	255	8.5	60	15.00
8/23/2013	6	240	8.0	56	15.00
8/30/2013	6	225	7.5	53	15.00
9/6/2013	7	210	7.0	49	15.00
9/13/2013	7	195	6.5	46	15.00
9/20/2013	8	180	6.0	42	15.00
9/27/2013	8	165	5.5	39	15.00
10/4/2013	9	150	5.0	35	15.00
10/11/2013	10	135	4.5	32	15.00
10/18/2013	11	120	4.0	28	15.00
10/25/2013	13	105	3.5	25	15.00
11/1/2013	14	90	3.0	21	15.00
11/8/2013	17	75	2.5	18	15.00

Physician Directed Taper

Name: SS

DRUG TO TAPER	PILLS SIZE	dosage	# TIMES DAILY	TOTAL DAILY DOSE
MORPHINE	30	8	4	960
	15			

GOAL DOSE	INTERVAL	start date	% reduction min	% reduction maxir
0	1	5/3/2013	25	50

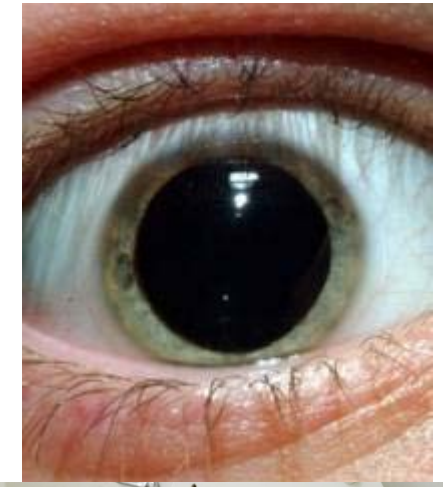
Friday MORPHINE Taper Schedule for SS

date	% drop	Daily mg	#/DAY	# RX	mg change
5/3/2013	25	720.0	24.0	168	240.00
5/10/2013	25	540.0	18.0	126	180.00
5/17/2013	33	360.0	12.0	84	180.00
5/24/2013	25	270.0	9.0	63	90.00
5/31/2013	33	180.0	6.0	42	90.00
6/7/2013	25	135.0	4.5	32	45.00
6/14/2013	33	90.0	3.0	21	45.00
6/21/2013	33	60.0	2.0	14	30.00
6/28/2013	25	45.0	1.5	11	15.00
7/5/2013	33	30.0	1.0	7	15.00
7/12/2013	50	15.0	0.5	4	15.00
	100	0.0	0.0	0	15.00

Case 1: The Plan

- Discontinue meperidine (no taper)
- Weekly check-ins with our medication nurse
- Taper morphine by 45 mg a week
  - MS IR 30 mg tablets
  - Taper: take 30 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 28.5 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 27 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 25.5 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9
  - Taper: take 24 tablets daily in 6 divided doses x 7 days (TUESDAY)3/9

Withdrawal



Case 1: Follow up

- Seen in office recently on 540 mg Morphine daily (1/3)
- Having difficulty with last taper drop
- 8% dosage drop was hard
- Change dosage drop to 15 mg
  - MS IR 30 mg tablets
- Taper: take 17 1/2 tablets daily in 6 divided doses x 7 days (TUESDAY)
- Taper: take 17 tablets daily in 6 divided doses x 7 days (TUESDAY)
- Taper: take 16 ½ tablets daily in 6 divided doses x 7 days (TUESDAY)
- Taper: take 16 tablets daily in 6 divided doses x 7 days (TUESDAY)

Document so covering partners can follow

Case 1

- Went through 7 days worth of medications in 3 days
- Offered buprenorphine
- Stabilized on buprenorphine 32 mg per day
- Moderate pain control but “overall I feel much better”

Case 2:

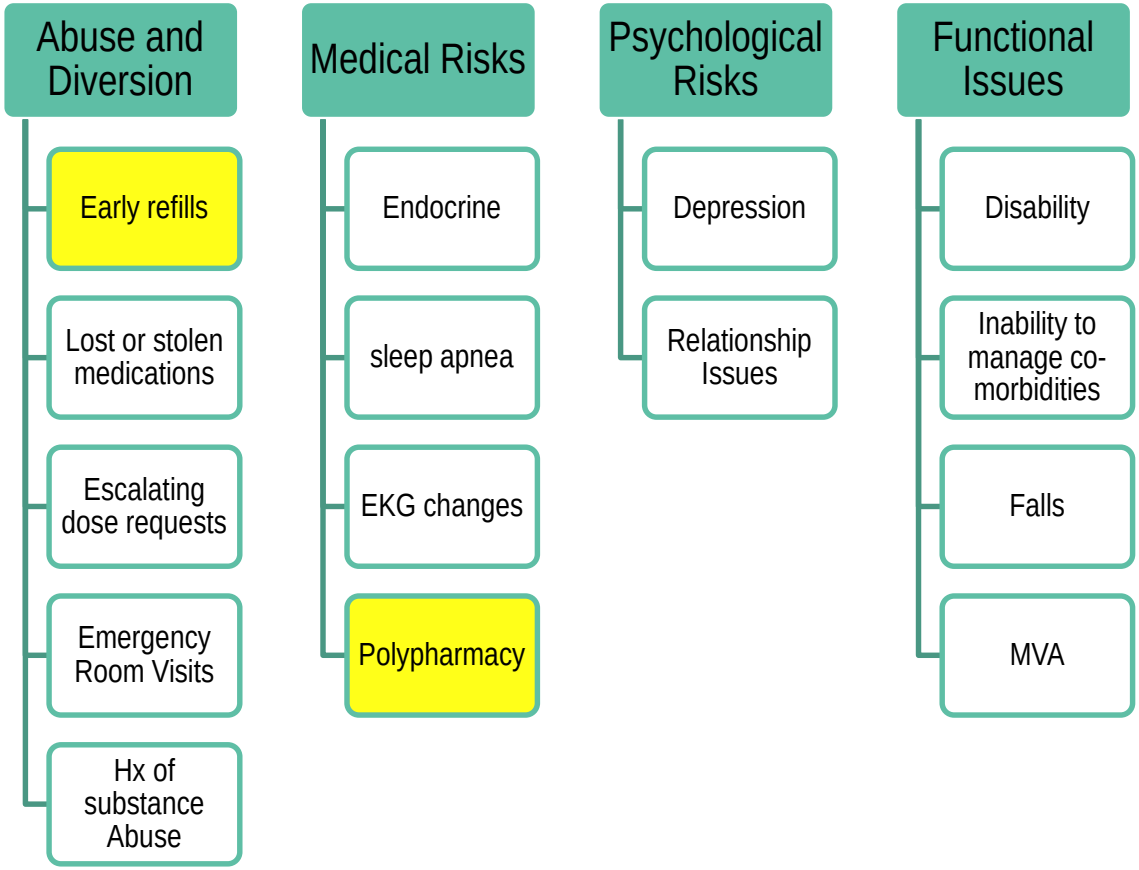
- KH 33 y.o. woman with deep achy pain from hips to knees. Symptoms began with “sciatica” type symptoms. High functioning, with good efficacy of medications. Now wants to get pregnant but VERY anxious about doing the taper
- Current regimen:
  - Oxycontin 40 BID (120MSE)
  - Norco 10/325 8 tablets daily (80 MSE)
  - Occasional Percocet
- Also uses nortryptiline, tizanidine, bentyl, miralax

Refill History

Filtered: Schedule Level (C-II High abuse potential; C-III Moderate dependence; C-V Limited abuse pot

Date	AMB/IP	Medication	Order Detail
2/1/2013 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
12/31/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
12/6/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
11/3/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
10/2/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
9/6/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
8/8/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
7/11/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
6/10/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
5/17/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
4/19/2012 (O)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
4/19/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally 3 t...
3/21/2012 (S)	AMB	OXYCONTIN 40 mg Oral 12hr SR Tab	Take 1 tablet orally eve...

Identifying Clinical Risk of Opioid Use



KAISER PERMANENTE®

Case 2: Patient Directed Taper

- Calculated her oxycodone equivalent
  - Morphine 200 mg = (200)(.75)= 150 oxycodone
- Changed to Oxycodone IR 5 mg tablets
  - Eliminated OxyContin
  - Eliminated Hydrocodone
- Instructions to reduce from 30 tablets per day every few days as she tolerates.
- Weekly check-ins by email or phone
- After 60 days she is on 80 mg oxycodone (50%)
- After 6 months she is on 60 mg oxycodone (60%)
- Pain is the same

 |

KAISER PERMANENTE®

Case 2

- Got pregnant
- Changed to buprenorphine
- Self tapered off buprenorphine during pregnancy
- Delivered healthy baby recently

Troubleshooting the Taper

- Reassure Reassure Reassure
- Adjuvant medications
  - Clonidine
    - 0.1-0.2 mg BID or TID
  - Immodium
  - Benzodiazepines only at the last 7 days
- Hold or slow the taper at 1/3s
- Watch the clock
- The lower the dose the slower you go
- PAWS

 |

KAISER PERMANENTE®

Buprenorphine

- *If a physician prescribes, dispenses or administers buprenorphine (Suboxone®/Subutex®) for the treatment of pain or for any other reason, a DEA registration is required because both products are Schedule III controlled substances. The DATA waiver specifically authorizes qualified practitioners to treat narcotic dependent patients, using FDA approved Schedule III-V narcotic controlled substances for maintenance and detoxification. The DATA waives the requirement for obtaining a separate DEA registration as a narcotic treatment program for physicians using the approved drugs for maintenance and* detoxification; however, it does not apply to physicians using Suboxone® or Subutex® for the treatment of pain. A physician using Suboxone® or Subutex® for the treatment of pain would be required to register with DEA as practitioner with Schedule III privileges.

Sincerely, Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration,
U.S. Department of Justice

http://www.helpmegetoffdrugs.com/wst_page9.html

Summary

- The goal is to make the patient better
- Risk benefit assessment
- Design appropriate taper type
- Modify the taper as appropriate
- Goal is not always off
- Sometimes opioids are not the biggest problem

Andrea Rubinstein

3559 Roundbarn Blvd

Santa Rosa, CA 95403

andrea.L.rubinstein@kp.org

707-571-3931

KAISER PERMANENTE®

GROUP EXERCISE

BARBARA SELIG

PROJECT MANAGER II

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GROUP EXERCISE

- At your tables, take **10 minutes**:
  - Discuss what tapering practices you can begin to adopt now (tomorrow, next week, next month, future)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

BREAK

INITIATING SUCCESSFUL PATIENT CONVERSATION

CANDY STOCKTON, MD

MEDICAL DIRECTOR

SHINGLETOWN MEDICAL CENTER

GROUP EXERCISE

MARYA CHOUDHRY

MICHAEL VOVAKES, MD

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GROUP EXERCISE

- At your tables, take **10 minutes**:
  - Identify 1- 2 patients that you will initiate "successful conversations" with
  - What will you say and/or do differently?

Safe Prescribing Committee

David Canton, D.O., M.P.H., JD.
Chief Medical Officer
Shasta Community Health Center

The Start

- Pain Committee
- Primary Care guidelines
- Med Management Agreement
- Cross coverage

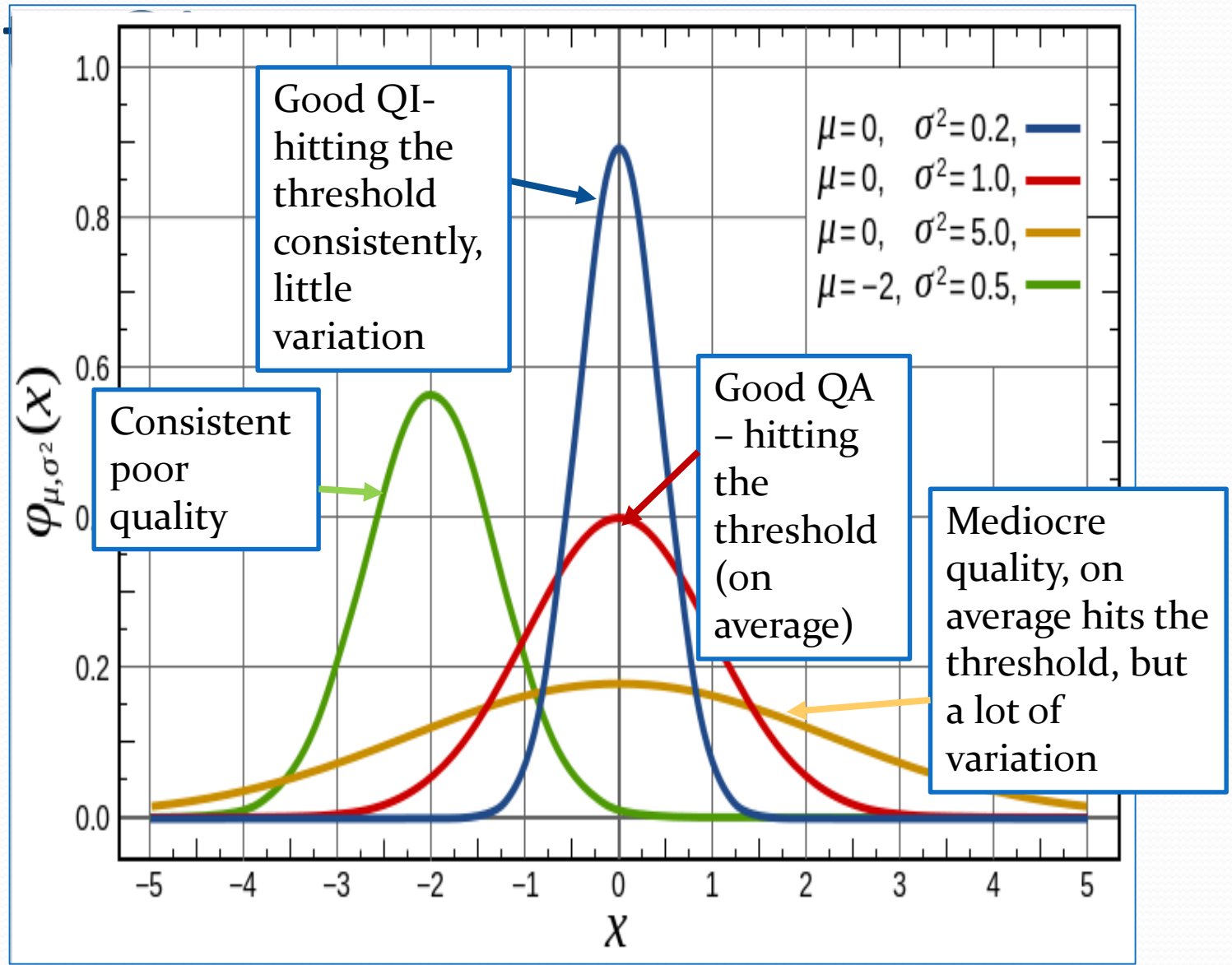
The Committee

- Meetings
- Make up
- Authority

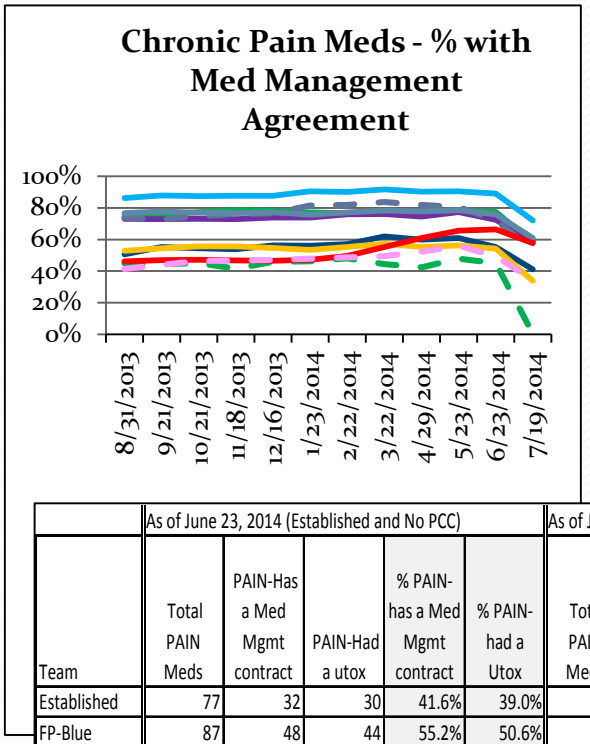
Next Step

- Controlled substances
  - Benzo's and their cousins
  - Marijuana
- Med Manage Agreement
- Urine Tox

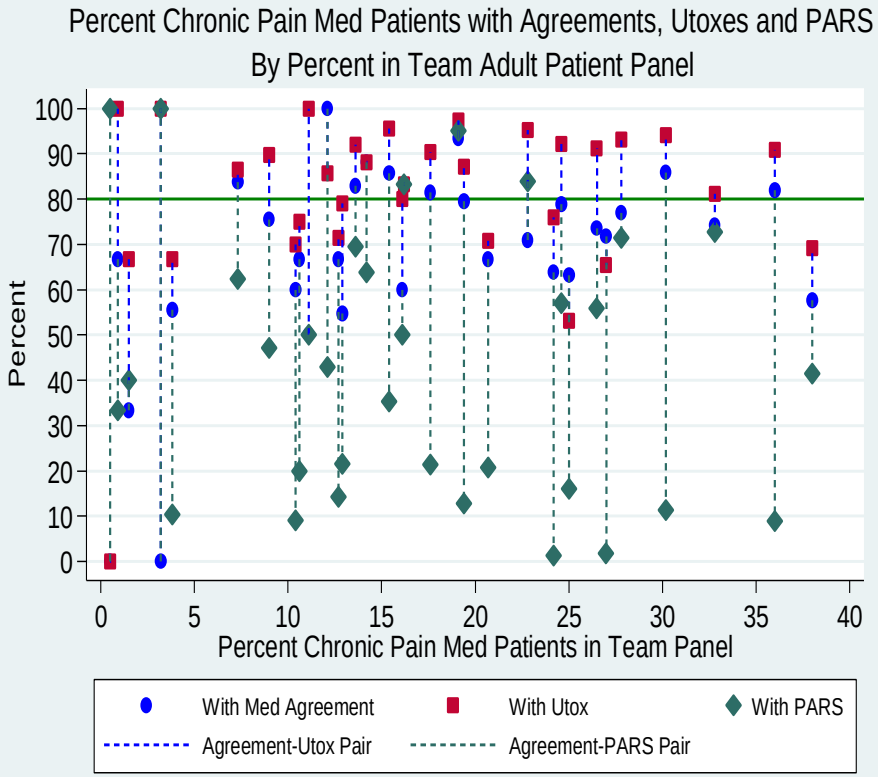
A graphic look at moving from QA



Numerous report formats "tested"



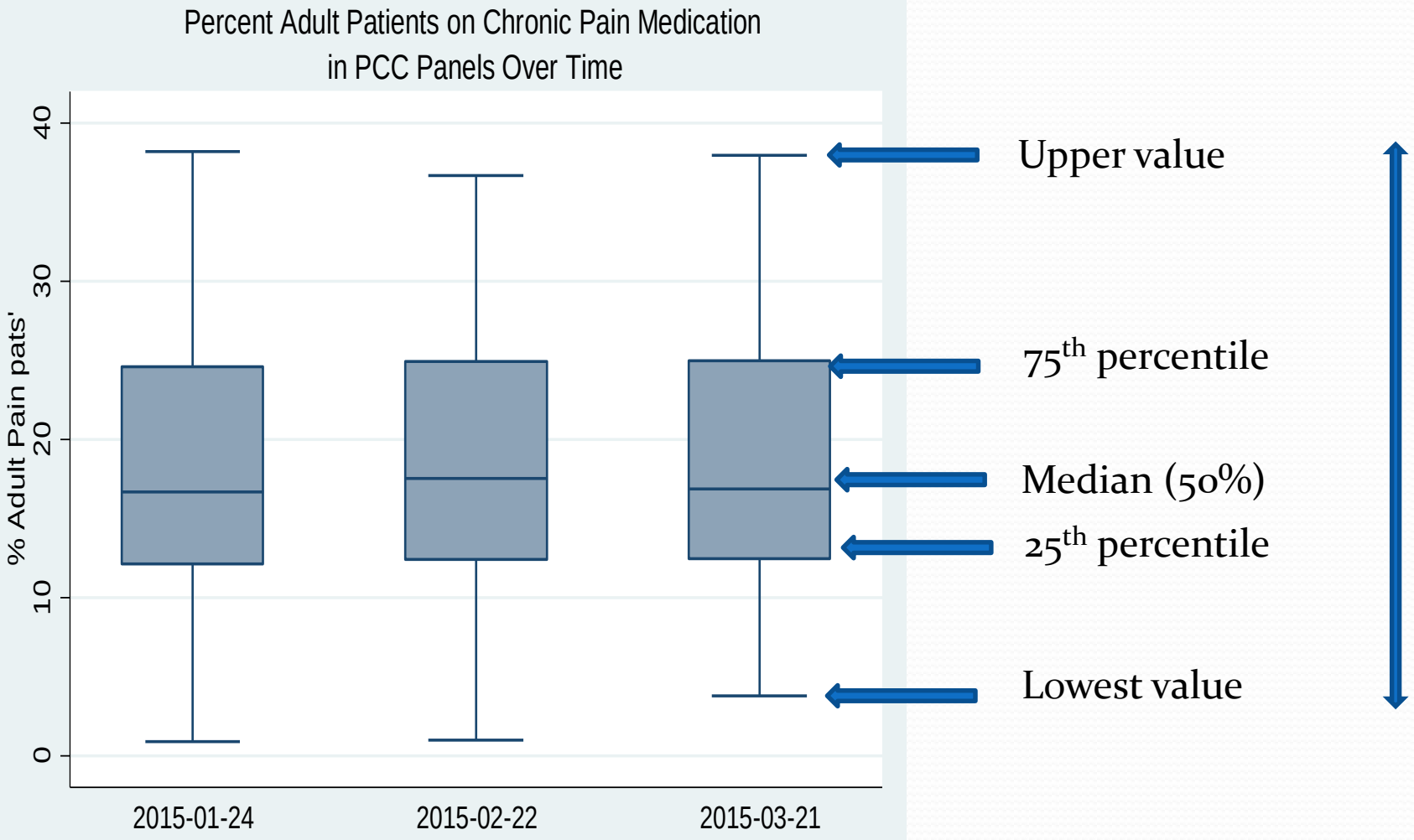
	As of June 23, 2014 (Established and No PCC)					As of July 19, 2014 (Established and No PCC)							
Team	Total PAIN Meds	PAIN-Has a Med Mgmt contract	PAIN-Had a utox	% PAIN-has a Med Mgmt contract	% PAIN-had a Utox	Total PAIN Meds	PAIN-Has a Med Mgmt contract	PAIN-Had a utox	% PAIN-has a Med Mgmt contract	% PAIN-had a Utox			
Established	77	32	30	41.6%	39.0%	93	21	26	22.6%	28.0%			
FP-Blue	87	48	44	55.2%	50.6%	107	44	49	41.1%	45.8%			
FP-Gold	531	288	320	54.2%	60.3%	684	231	371	33.8%	54.2%			
FP-Green	430	333	295	77.4%	68.6%	533	310	363	58.2%	68.1%			
HOPE	20	9	12	45.0%	60.0%	5	0	1	0.0%	20.0%			
HV	230	205	174	89.1%	75.7%	314	226	237	72.0%	75.5%			
No PCC	84	26	18	31.0%	21.4%	162	23	24	14.2%	14.8%		↓	↓
PEDS	11	3	3	27.3%	27.3%	14	2	2	14.3%	14.3%		↓	↓
Purple	265	192	177	72.5%	66.8%	327	193	209	59.0%	63.9%		↓	↓
RES	494	356	339	72.1%	68.6%	601	319	393	53.1%	65.4%		↓	↓
SL	379	288	274	76.0%	72.3%	429	261	302	60.8%	70.4%		↓	↓
SPC	567	376	321	66.3%	56.6%	714	412	409	57.7%	57.3%		↓	–
UC	223	110	67	49.3%	30.0%	269	92	79	34.2%	29.4%		↓	–
Grand Total	3398	2266	2074	66.7%	61.0%	4252	2134	2465	50.2%	58.0%		↓	↓



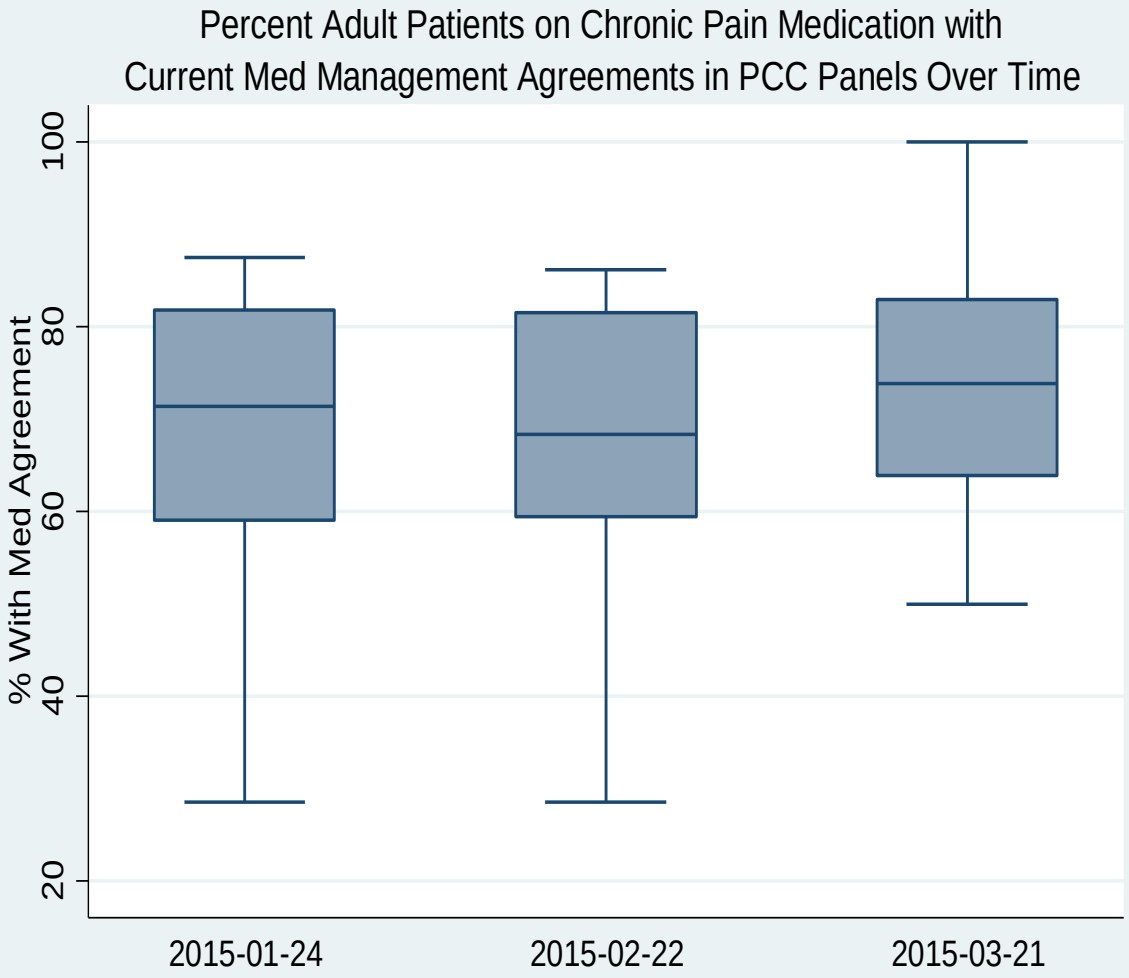
Mar 21 2015.

Are we making progress?

Proportion of patients on opioid medications has remained fairly stable

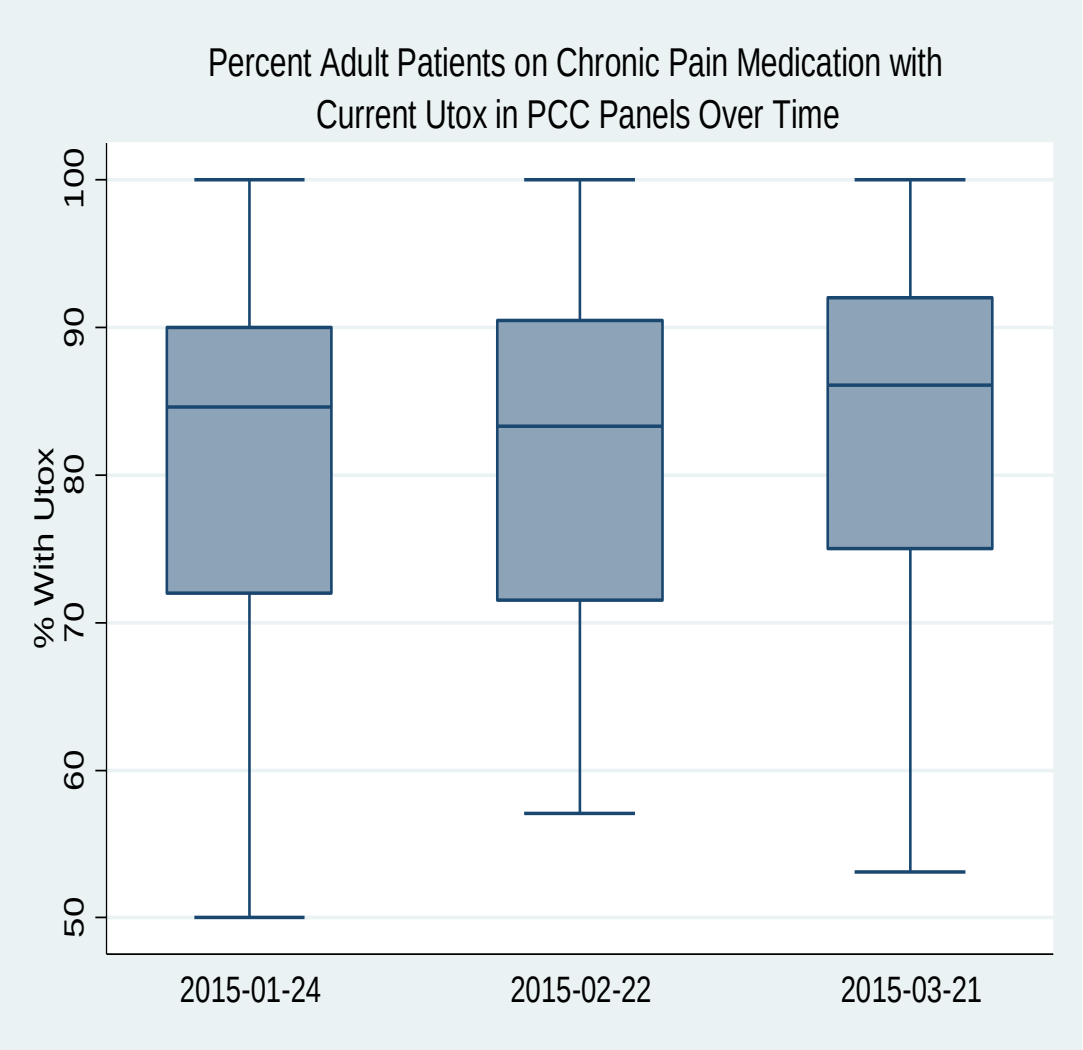


Proportion of patients with current med management agreements is increasing



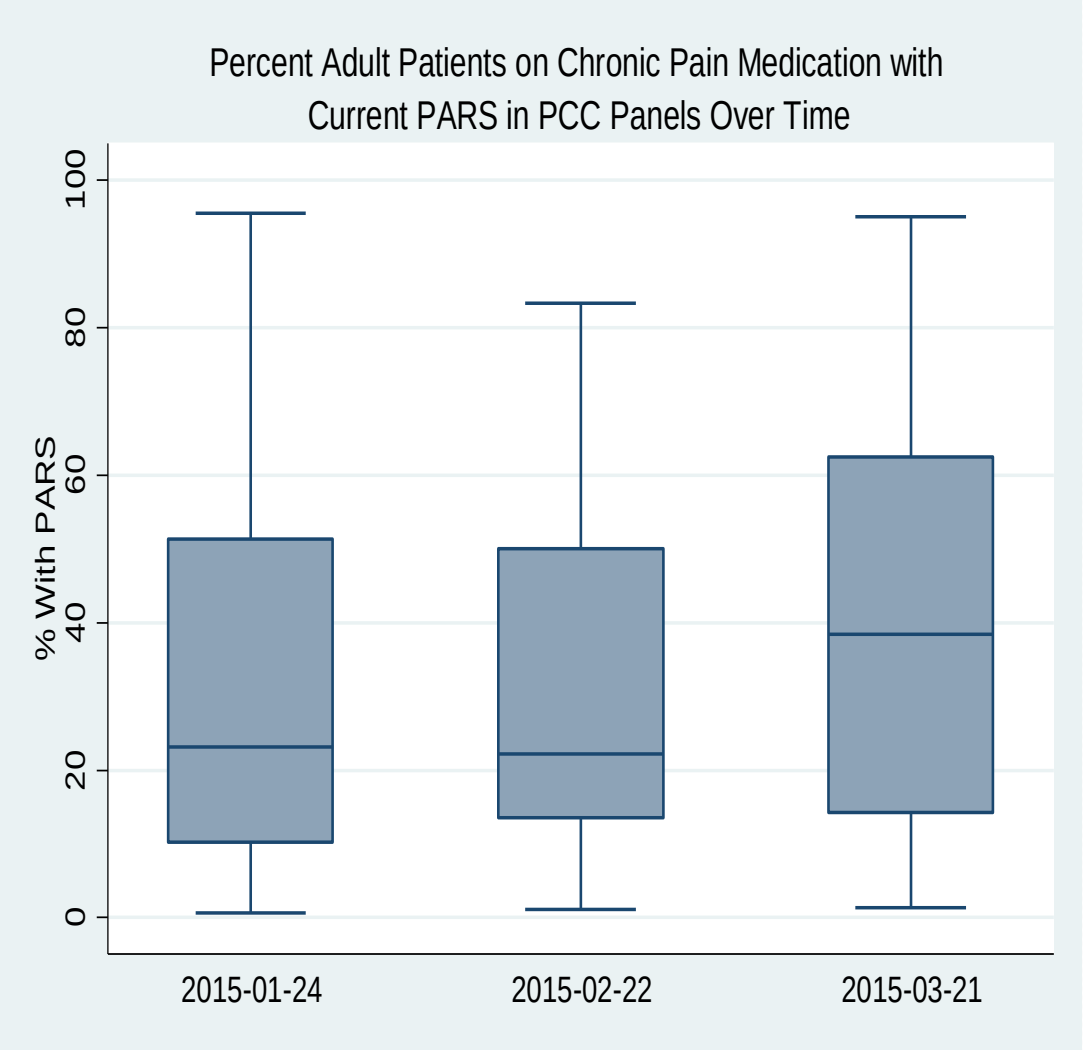
Less variation is good. Means that teams are more consistently getting/updating med management agreements.

Proportion of patients with current utoxes is increasing



Less variation is good. Means that teams are more consistently doing utoxes.

Proportion of patients with current PARS/CURES is increasing



More variation is good. Means that teams are getting PARS reports.

Lessons Learned

- Needed a clear (and repeated) articulation of policies and guidelines
- Provided patient information about the policy
- Try out different data presentations – not all will work, not all will work forever
- Enjoy the success

Questions
Comments

dcanton@shastahealth.org

Changing the Culture of Opiate Prescribing in your Office

Candy Stockton, M.D.
Shingletown Medical Center

Have a clear plan

- Make sure that all providers understand the plan; don’t forget your support staff, administration, and boards.
- Your staff will be responding to phone calls, dealing with refill requests and patients who walk in, and managing patients who arrive for visits
- Your administration (and boards) may receive complaints from patients

Keep your goals in mind

- Patient safety
- Compassionate Care
- Decreased legal and medical liability
- Less stressful work environment for staff
- Less frustration for your providers

Have a clear policy in regards to marijuana

- “Don’t ask, don’t tell” is a terrible policy in patient care
- Be consistent
- Give a lead in time if your policy is a significant change for your patients

Where to anticipate problems: Logistics

- 28 v. 30 day refills
- “It’s not my fault. I had to call for a refill, I couldn’t get an appointment on time”
- “I can’t afford the urine drug testing, I don’t have insurance”
- Know what your toxicology testing means and don’t be afraid to ask questions

Where to anticipate problems: Early refills

- “I’m sure my prescription is due tomorrow, I filled my last one 30 (28) days ago”
- “I ran out of my medications early, you can’t make me go into withdrawal—you took an oath”
- “But I had to take more, I fell down the stairs; see my bruises”
- “But I’m going to be traveling to Oregon for two weeks to take care of my sick _____, so I need it early this time”

Where to anticipate problems: Toxicology Screens

- “I can’t give a urine sample today, I went while I was waiting for my appointment”
- “Please don’t make me give a sample today, it will show marijuana, but I just used a little at a party”
- “I don’t know where the meth in my drug screen came from, someone must have put it in my drink”
- “Well, of course it doesn’t show my Norco, I don’t take it when I’m having a good day, only when I need it”

Where to anticipate problems: Coordinating with specialists

- “I need that xanax for my anxiety, and my psychiatrist says I can take it”
- “My back doctor said I could double up on my Morphine until my surgery”
- “I’m taking the Norco my orthopedist gave me for my knee surgery last week and the Vicodin you give me—because that’s for my back pain”

Where to anticipate problems:
Vacation coverage

- Schedule your follow up's so you can accommodate this. Give an extra prescription, leave a prescription to be picked up, or leave a clear plan for your back-up provider.
- Train your staff to check refill dates on patients who are moved because a provider is out sick/unexpectedly.

Punishment！！！

- Remember that the “punishment” for breaking the rules is that “those patients” become yours. That’s worse than any discipline I can threaten my providers with.

CLOSING REMARKS

MARSHALL KUBOTA MD

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

SUMMARY OF THE DAY

WHERE DO WE GO FROM HERE?

POSSIBLE DIRECTIONS

- MAINTAIN GAINS
  - DATA COLLECTION AND DISSEMINATION
- CONTINUED EDUCATION
  - SUPPORTING PROJECT ECHO
  - OTHER CONFERENCES
  - TOOLKIT
- NEW TARGETS
  - BENZODIAZEPINES
  - CHRONIC HEADACHE
- NEW AND EXPANDED TREATMENT MODALITIES
  - BUPRENORPHINE
  - GROUP CLASSES
  - BIOFEEDBACK

CLOSING HOUSEKEEPING ITEMS

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

PRESENTER ACKNOWLEDGEMENTS

- Marshall Kubota, M.D.
- Michael Vovakes, M.D.
- Andrew Deckert, M.D.
- Ivan Petrzelka, PharmD, JD, MBA
- Leonard Soloniuk, M.D.
- Candy Stockton, M.D.
- David Canton, DO, MPH, JD
- Volunteers (Renee, Brooke, Monica)