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PEACE OF MIND | EXPERTISE | CHOICE | THE MEDPRO GROUP DIFFERENCE

The Opioid Epidemic

Implications to Managing Care

Program speaker

Today's speaker is Christine M. Hoskin, RN, MS, CPHRM, Senior Patient Safety and Risk Consultant, MedPro Group (Christine.Hoskin@MedPro.com)

Christine has been involved in risk and quality management throughout her career, providing oversight of clinical education, epidemiology, safety, accreditation, risk management, quality improvement, and nursing.

She has experience in a range of care settings — including both inpatient and outpatient facilities, primary care, specialty care, dental care, and rehabilitation — and with various patient populations. These opportunities have enabled Christine to develop a strong understanding of the challenges and opportunities facing healthcare providers and organizations.

Christine is a registered nurse. She earned her bachelor of science in nursing degree and master's degree from Nebraska Methodist College of Nursing and Allied Health. Additionally, Christine is a member of the American Society for Healthcare Risk Management and holds a certificate in healthcare risk management.

Program speaker

Today's speaker is Katie Bosch Baeverstad, M.D., Physician Advisor, MedPro Group (Katie.Baeverstad@MedPro.com)

Katie Bosch Baeverstad, M.D., is a physician advisor to MedPro Group. She has staffed and taught family medicine residents, medical students, and physician assistant students in her office and in the emergency department.

Prior to her role at MedPro Group, Dr. Baeverstad practiced emergency medicine with the Parkview Hospital System in Fort Wayne, Indiana, and surrounding communities. Prior to her emergency department career, she was a solo practitioner doing family medicine with obstetrics.

Dr. Baeverstad received a bachelor of arts degree in biology from Hope College and her medical degree from the State University of New York Upstate Medical Center. She completed her residency training through the Fort Wayne Medical Education Program in Fort Wayne, Indiana.

Designation of continuing education credit

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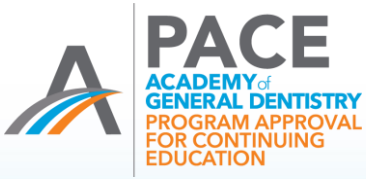
MedPro Group designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



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Today's faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at MedPro Group have reported that they have no relevant financial relationships with any commercial interests.

Objectives

At the conclusion of this program, participants should be able to:

- Identify organizational strategies to address opioid management within a facility.
- Identify prescribing considerations when initiating opioid therapy.
- Discuss strategies for effectively adjusting opioid therapy treatment plans.
- Identify nonopioid treatment options for pain management.
- Discuss the role all providers have in battling the opioid epidemic.

Opioid crisis — no boundaries

News > Neurology

93-Year-Old 'Pill Mill' Physician Gets 10 Years in Prison

Robert Lowes
August 14, 2017

Almost half of all opioid misuse starts with a friend or family member's prescription

Health Jul 31, 2017 5:00 PM EDT

An Illinois doctor traded drugs for sex and cash. He just pleaded guilty.

One family loses two sons to opioid epidemic: It's 'overwhelming'

Donna Freydkin
TODAY

Oct. 17, 2017 at 9:29 AM

CMAJ Open. 2017 Jan-Mar; 5(1): E184–E189. PMCID: PMC5378545
Published online 2017 Mar 2. doi: 10.9778/cmajo.20160013

Fatal overdoses involving hydromorphone and morphine among inpatients: a case series

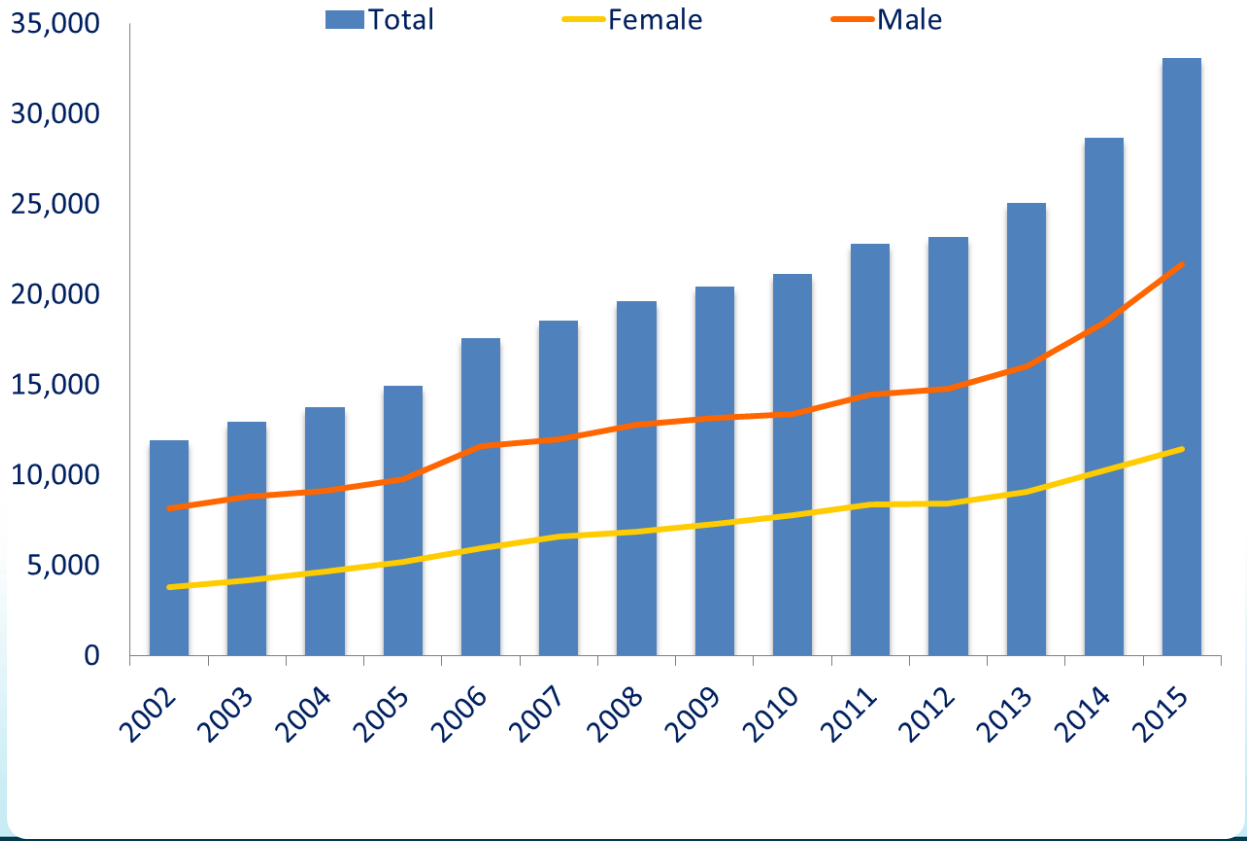
Amanda Lowe, BScFS, (Hons), MSc, Michael Hamilton, MD, MPH, Julie Greenall BScPhm MHSc, Jessica Ma, BScPhm, Irfan Dhalla, MD, MSc, and Nav Persaud, MD, MSc

Opioid epidemic is a public health emergency

Professional organizations

National overdose deaths

Numbers of deaths from opioid drugs



Source: National Institute on Drug Abuse. (2017). Overdose death rates. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

Who is responsible

In the past, it was reported that 20% of all prescribers are responsible for 80% of all OPR prescriptions

Opioid prescribing rates:

- pain medicine 48.6%
- surgery 37%
- physical medicine/rehabilitation 36%
- primary care providers 50%
- dentistry 28.9%
- emergency medicine 28.7%

Yet . . .

- emergency medicine dropped 8.9%
- dentistry dropped 5.7%
- orthopaedic surgery dropped 13.4%

OPR: ordering, prescribing, or referring

Sources: CDC. (2011). Policy impact: Prescription painkiller overdoses. Retrieved from www.cdc.gov/drugoverdose/pdf/PolicyImpact-PrescriptionPainkillerOD-a.pdf; Levy, B., et al. (2015). Trends in opioid analgesic-prescribing rates by specialty, U.S., 2007-2012. *American Journal of Preventive Medicine, 49*(3):409-413; Athena Insight. (2017). Orthopedic surgeons prescribing fewer opioids. Retrieved from www.athenahealth.com/insight/orthopedic-surgeons-prescribing-fewer-opioids; CORE. (2017). Who else is prescribing opioids? Retrieved from http://core-rems.org/who-is-prescribing-opioids

Solution

Anyone who evaluates and treats patients is responsible for helping to address this epidemic through identification and response.

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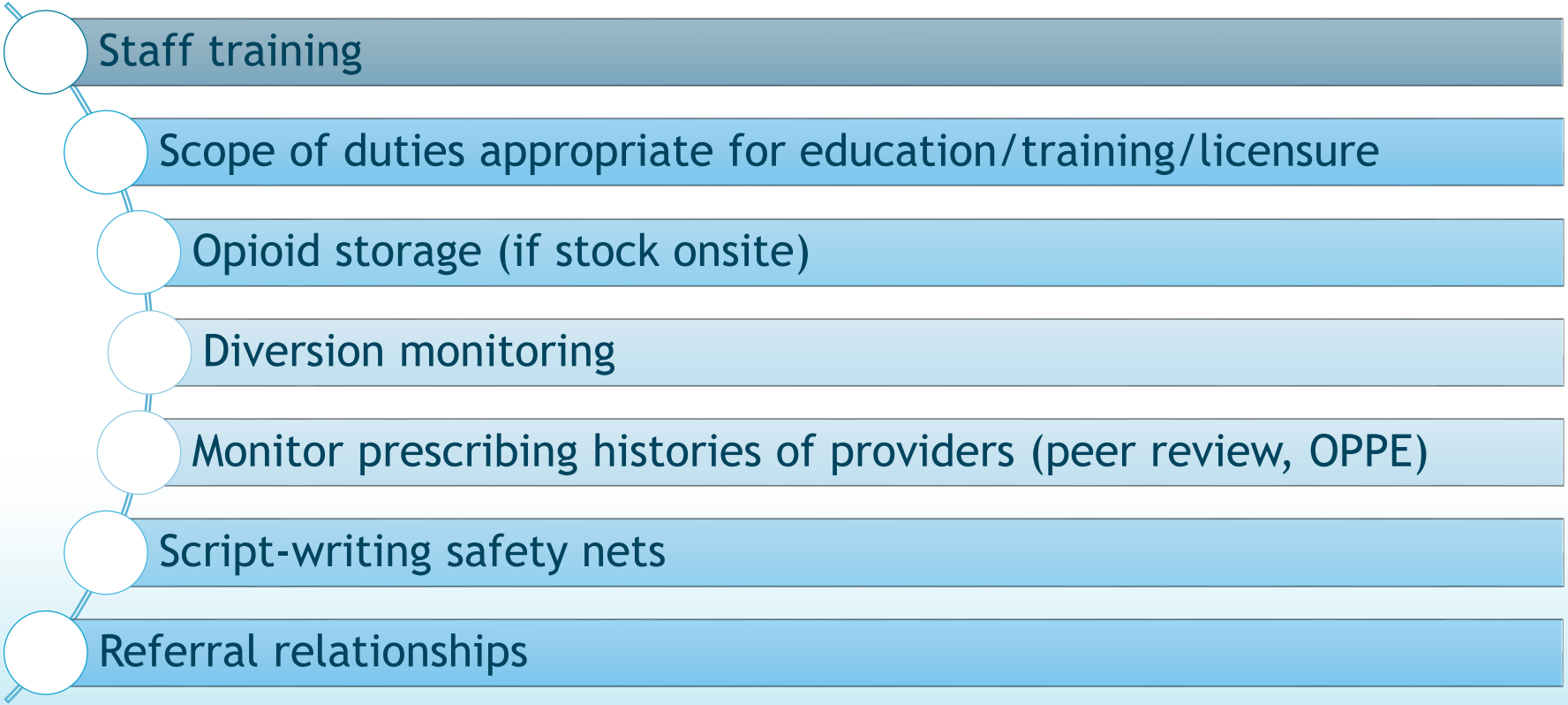
Organizational Strategies

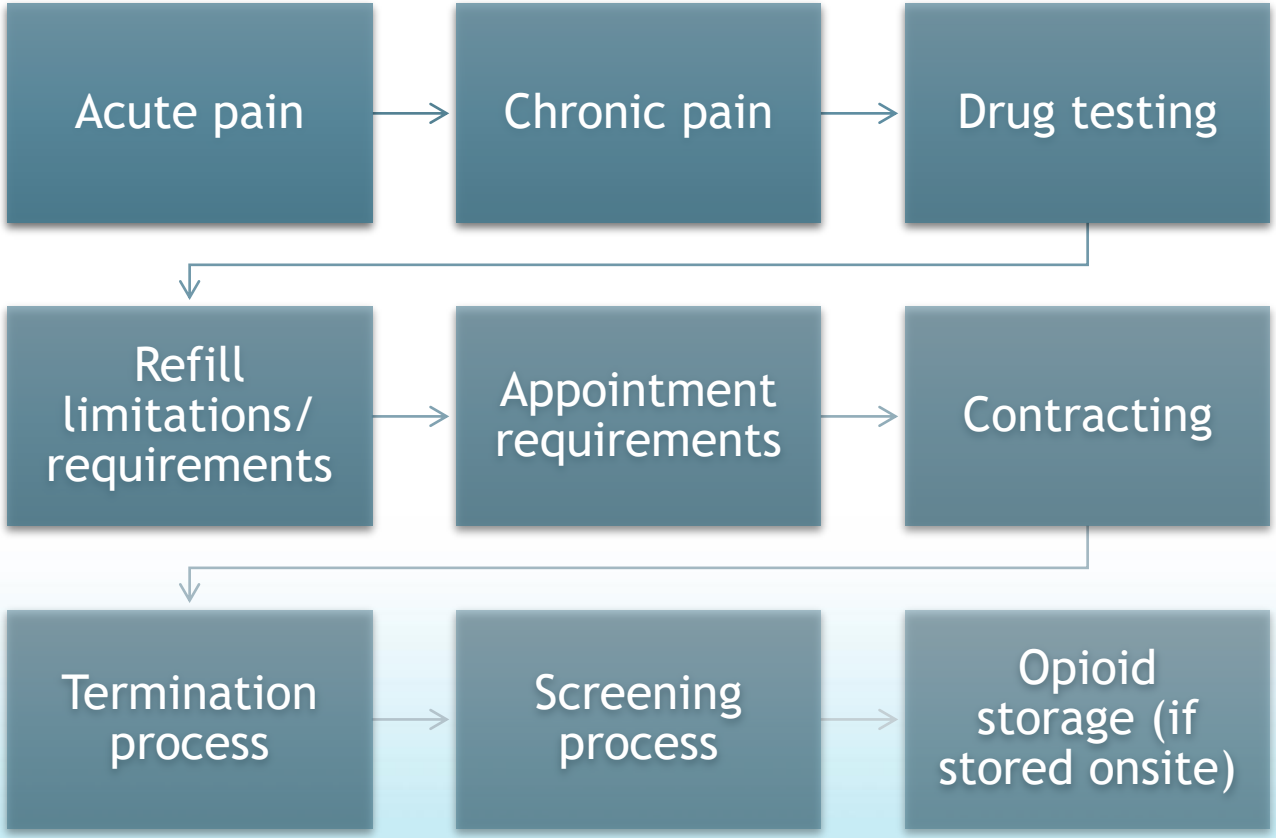
Safe Prescribing Practices

Organizational strategies



OPPE: ongoing professional practice evaluation

Opioid management procedures



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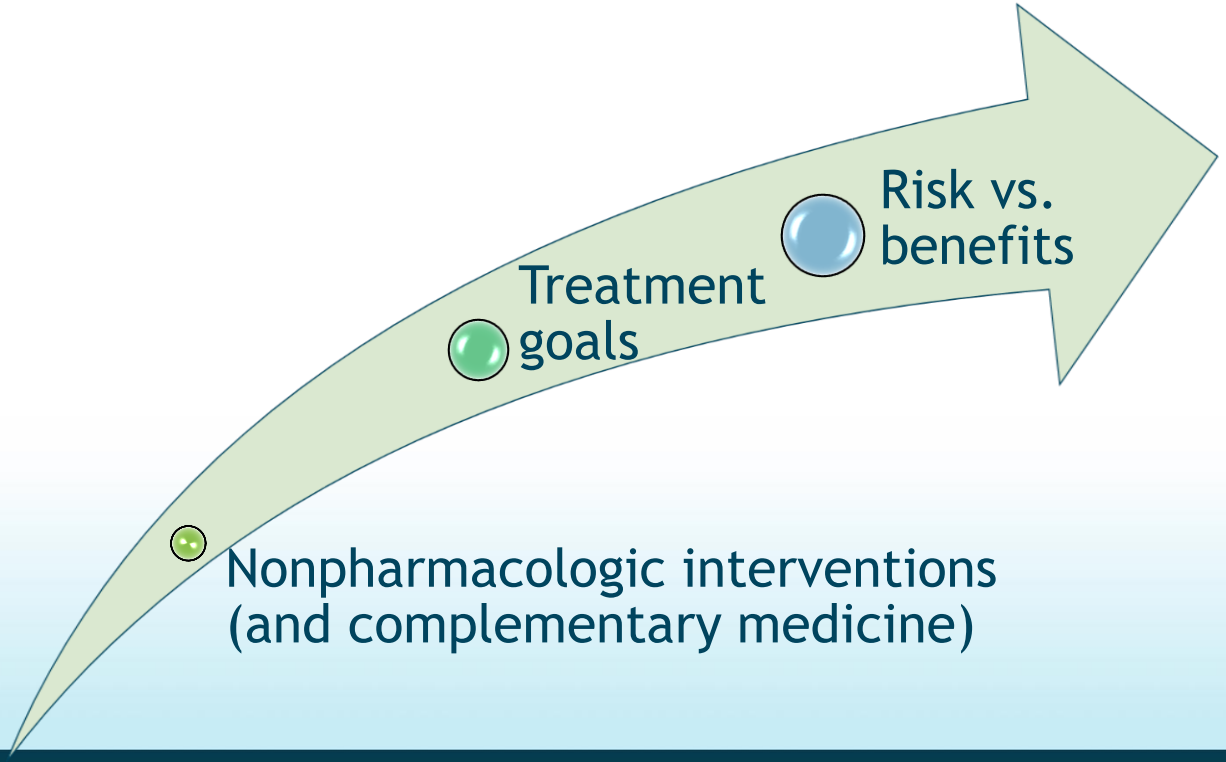
Patient Care Strategies

Safe Prescribing Practices

Chronic pain patients

Determining when to initiate or continue opioids for chronic pain



Nonpharmacologic and nonopioid interventions including complementary medicine

- Behavioral
- Cognitive
- Energy based
- Environmental
- Interventional
- Physical/ exercise
- Spiritual
- Psychological
- Alternative medicine
- Nonopioid medication

Source: Centers for Disease Control and Prevention. Nonopioid treatments for chronic pain. Retrieved from www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

Establishing treatment goals

American Academy of Family Physicians Model: Five “R’s” and Two “E’s”
Be **R**easonable
Be **R**eachable
Include patient **R**ecordkeeping (e.g., daily diaries, log)
Revisit and **R**evise
Use **E**lectronic state prescription drug monitoring programs (PDMPs)
Have an **E**xit strategy

Risk vs. benefits of continued opioid treatment

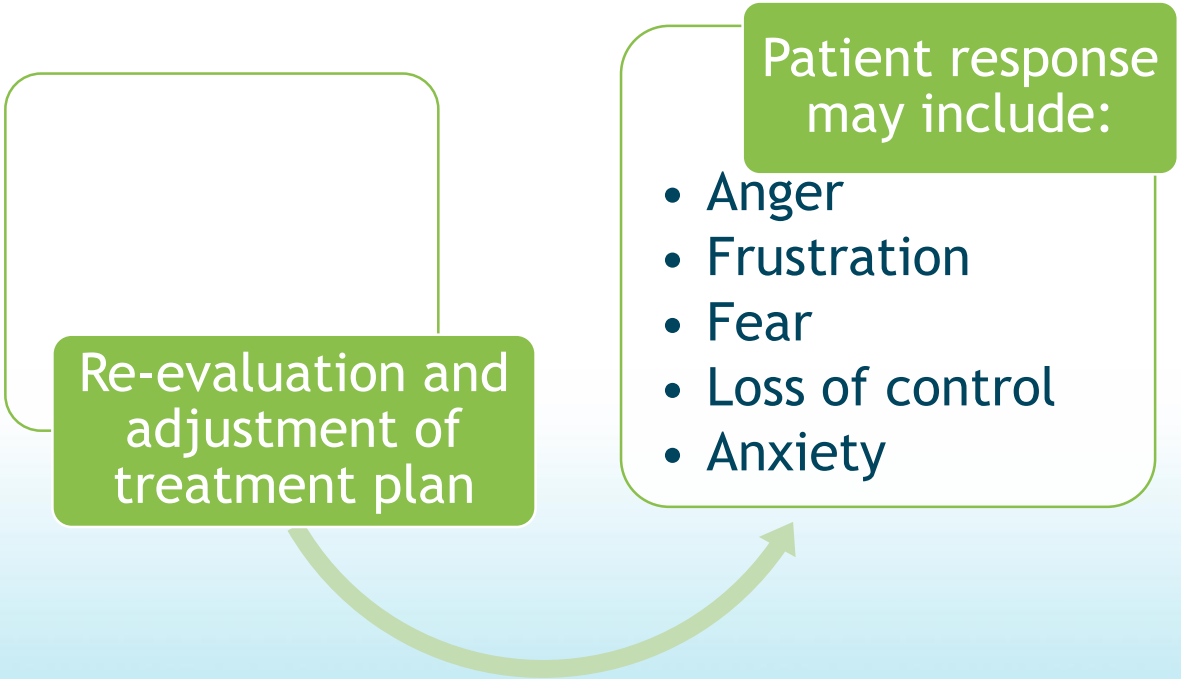
Include these in discussion:

- Risks
- Benefits
- Alternatives

Document discussions

The challenge

Starting over with your current chronic pain patient population



Barriers to making changes in treatment plans

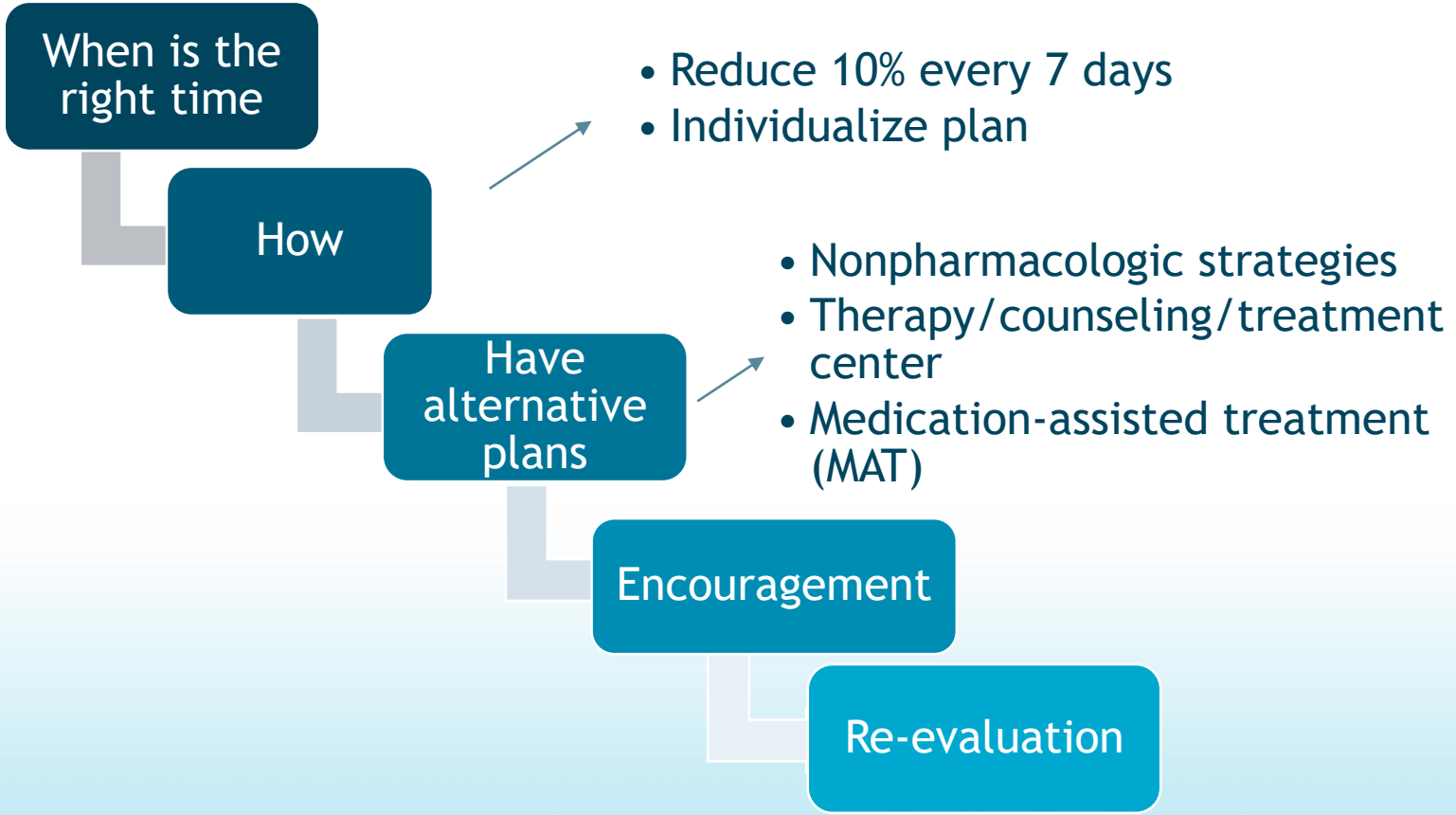
- Need for pain relief
- Cultural, religious, or ideological beliefs
- Dependency or addiction
- Social/family
- Financial
- Health literacy
  - Understand condition
  - Patients have the capacity to understand the information shared with them

No means no

- Realize that “no” hurts.
- Try the toddler principle.
- Take responsibility for “won’t” versus “can’t.”
- Be firm, yet calm.
- Use the “broken record” technique.
- Work up a contract.
- Show faith.

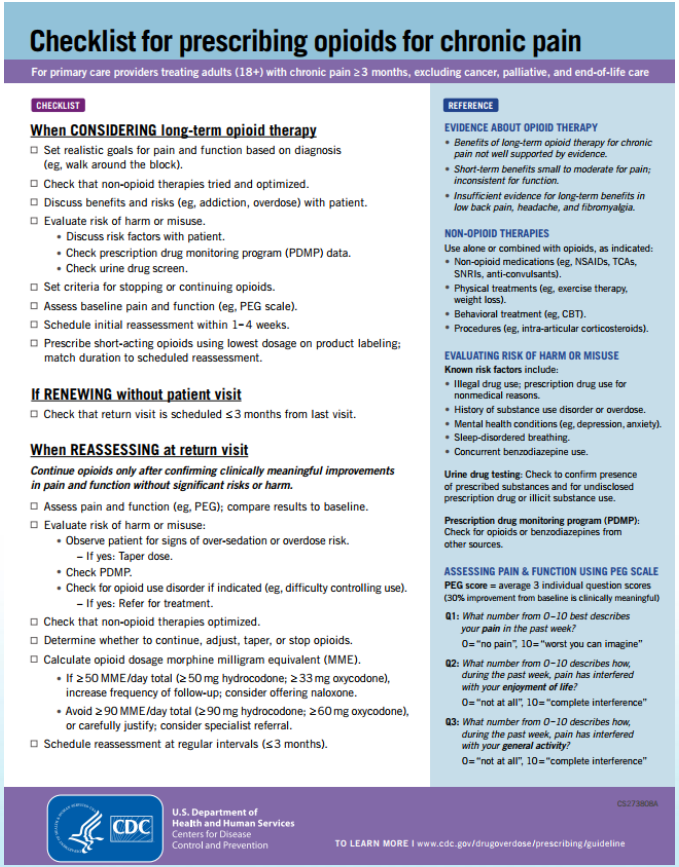
Source: Spickerman, F. (2004). The fine art of refusal. *Family Practice Management*. Retrieved from www.aafp.org/fpm/2004/0200/p80.html

Tapering: slow and methodical



Source: Centers for Disease Control and Prevention. *Pocket guide: tapering opioids for chronic pain*. Retrieved from www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Checklist for prescribing opioids for chronic pain



Checklist for prescribing opioids for chronic pain

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

CHECKLIST

When CONSIDERING long-term opioid therapy

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

If RENEWING without patient visit

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

When REASSESSING at return visit

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

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

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

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

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

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

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

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

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

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

ASSESSING PAIN & FUNCTION USING PEG SCALE

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

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS273808A

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

Source: Centers for Disease Control and Prevention. Checklist for prescribing opioids for chronic pain. Retrieved from www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

Additional consideration for renewals

If renewing without patient visit:

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

Reassessing patient at return visit

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

- Assess pain and function (e.g., PEG scale); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of oversedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (e.g., difficulty controlling use).
    - If yes: Refer for treatment.

PEG: Pain, Enjoyment, General Activity

Source: Centers for Disease Control and Prevention. *Guideline for prescribing opioids for chronic pain.* Retrieved from www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

Reassessing patient at return visit

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

- Check that nonopioid therapies are optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

Source: Centers for Disease Control and Prevention. *Guideline for prescribing opioids for chronic pain.* Retrieved from www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

Red flags — Physical signs

- Noticeable elation/euphoria
- Marked sedation/drowsiness
- High blood pressure
- Confusion
- Constricted pupils
- Slowed breathing
- Intermittent nodding off or loss of consciousness
- Constipation
- Flu-like symptoms may indicate withdrawal (headache, nausea/vomiting, diarrhea, sweating, fatigue, anxiety, inability to sleep)

Red flags — Other signs

- Urine screens are not consistent with prescriptions/doses ordered
- Missed appointments
- PDMP (multiple scripts, prescribing concerns)
- Doctor shopping
- Financial problems
- Social withdrawal
- Needing script refilled early (lost, stolen, etc.)

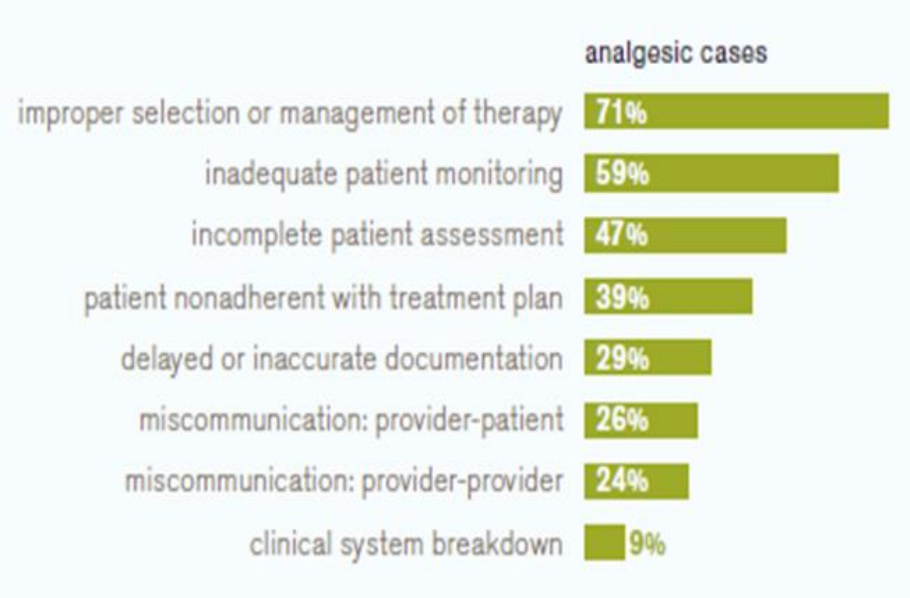
Long-term opioid therapy considerations

- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that nonopioid therapies have been tried and optimized.
- Discuss benefits and risks (e.g., addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check PDMP data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (e.g., PEG [Pain, Enjoyment, General Activity] scale).
- Schedule initial reassessment within 1 to 4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

Opioid management (for all patients)

Opioid selection, dosage, duration, follow-up, and discontinuation

- Immediate release vs. extended release
- Lowest effective dosage
- Quantity
- Re-evaluation



Source: CRICO. (2016). Medication-related Malpractice Risks (2016 CRICO Strategies National CBS Report). Retrieved from www.rmf.Harvard.edu/Malpractice-Daa/Annual-Benchmark-Reports/Risks-in-Medication

Lowest effective dosage

Start low and go slow.

"When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME) per day, and should avoid increasing dosage to ≥90 MME per day or carefully justify a decision to titrate dosage to ≥90 MME per day."

Source: Centers for Disease Control and Prevention. *Guideline for prescribing opioids for chronic pain.* Retrieved from www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

Quantity control

Treat acute pain with minimal supply and re-evaluate.

Address chronic pain.

Encourage use of drug take-back programs.

Adhere to refill guidelines.

Re-evaluation

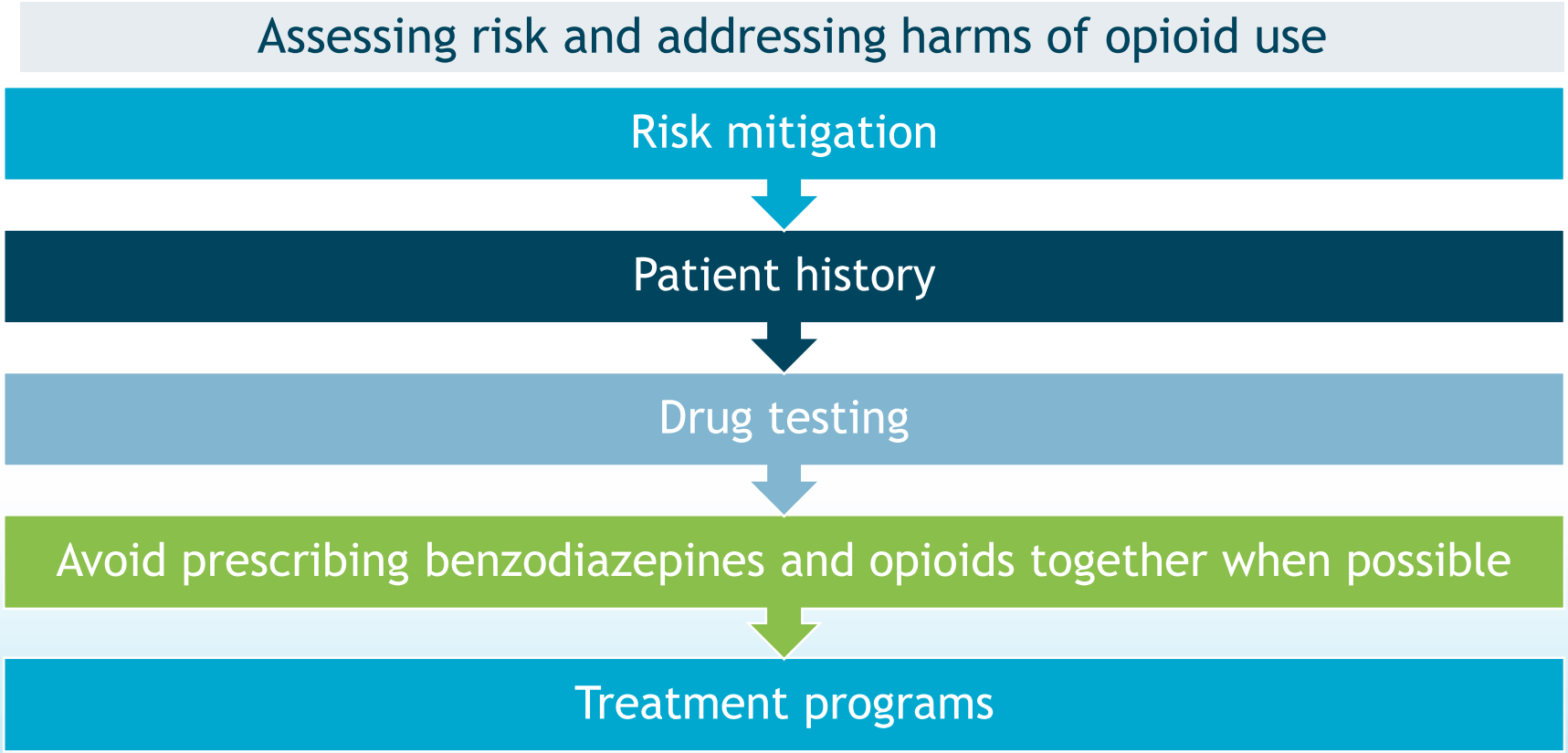
After initiation of opioid therapy

After changes to opioid therapy plan

Minimum of every 3 months on maintenance for chronic pain management

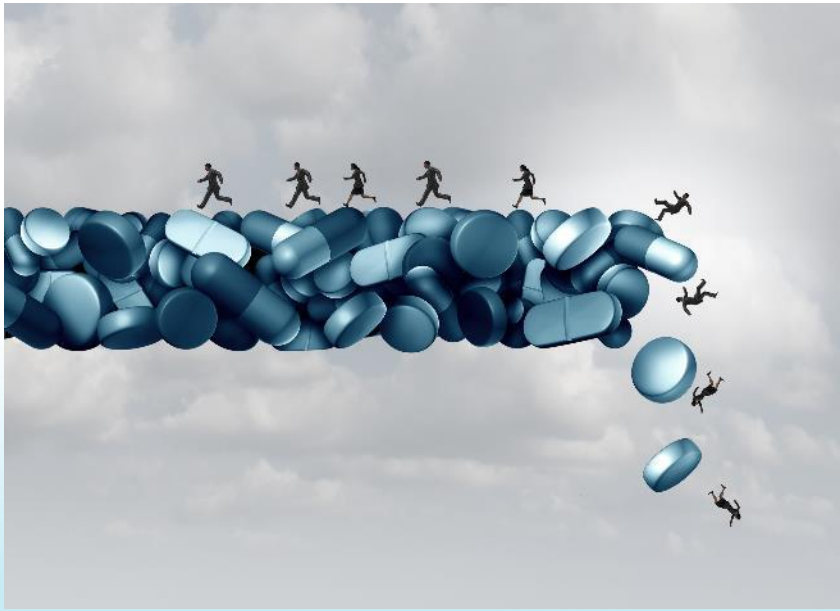
Always consider nonopioid options to replace or supplement opioid therapy plan

Opioid management

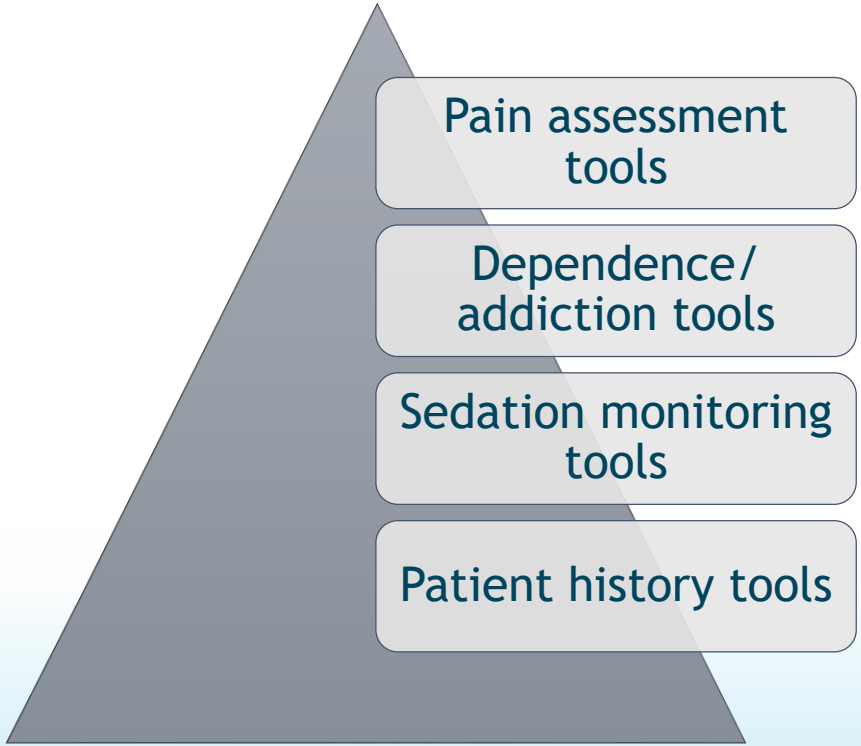


Risk mitigation strategies

- Evaluation tools
- Contracting
- Documentation
- PDMP



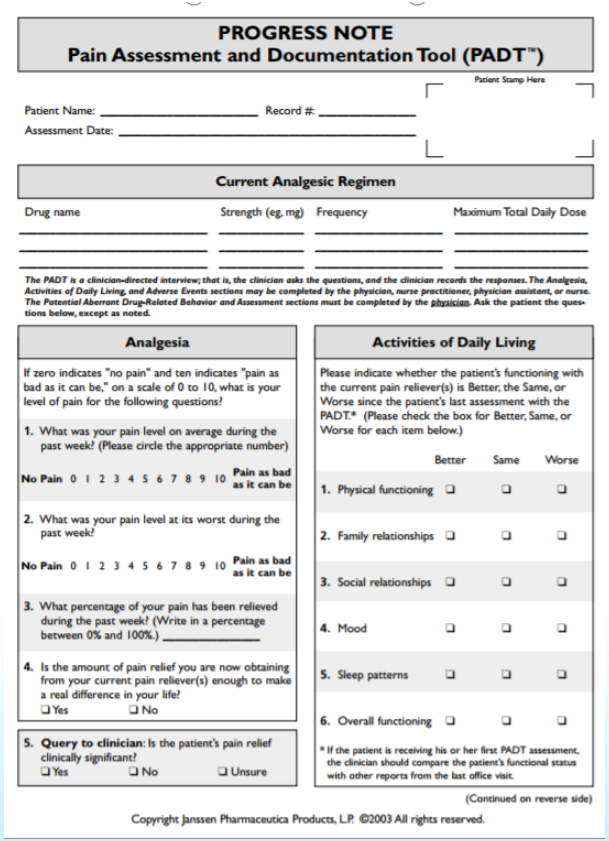
Evaluation tools



Evaluation tools

Pain assessment tools

- Selection
  - Meets needs as a provider
  - Health literacy/ understandable to the patient
- Consistency of use



PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Patient Stamp Here

Patient Name: _____ Record #: _____
Assessment Date: _____

Current Analgesic Regimen

Drug name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.) _____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?
❑ Yes ❑ No

5. **Query to clinician:** Is the patient's pain relief clinically significant?
❑ Yes ❑ No ❑ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	❑	❑	❑
2. Family relationships	❑	❑	❑
3. Social relationships	❑	❑	❑
4. Mood	❑	❑	❑
5. Sleep patterns	❑	❑	❑
6. Overall functioning	❑	❑	❑

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

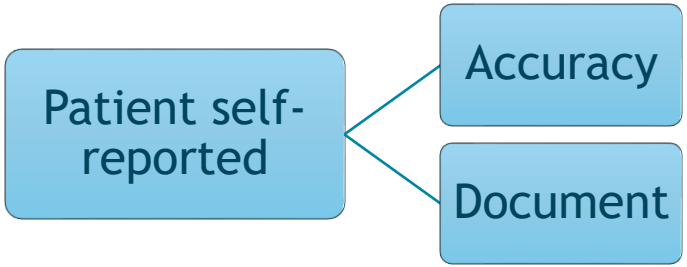
(Continued on reverse side)

Source: Janssen Pharmaceuticals. (2016). Pain assessment resources. Retrieved from www.prescriberesposibly.com/pain-assessment-resources

Case study: Dental procedure with sedation

- **Patient**: Male, mid-teens
- **Chief complaint**: Need for tooth extraction
- **Case overview**: Presented for a tooth extraction. His parent signed an informed consent for mild to moderate sedation. After being discharged to home, the patient began to act aggressively and was combative; he was taken to the emergency department where he suffered a seizure with a resulting altered mental state.
- **Outcome**: He was diagnosed with encephalopathy secondary to polypharmacy (related to the sedation medications) and postconcussive syndrome (sustained when he was combative and being transferred to the emergency department).

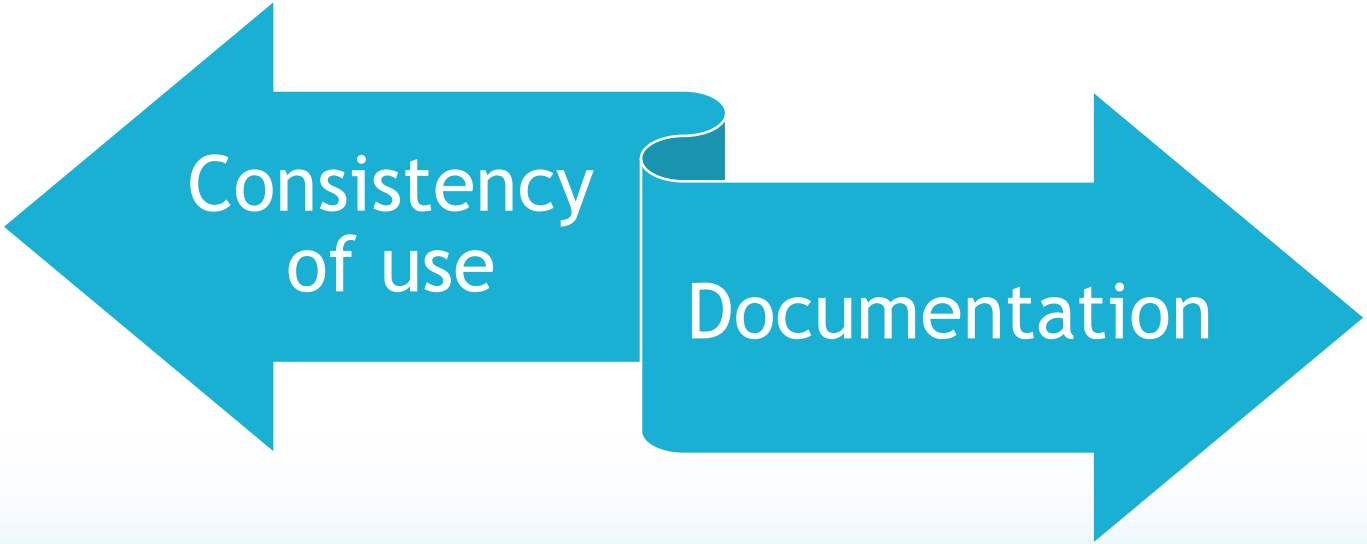
Evaluation tools



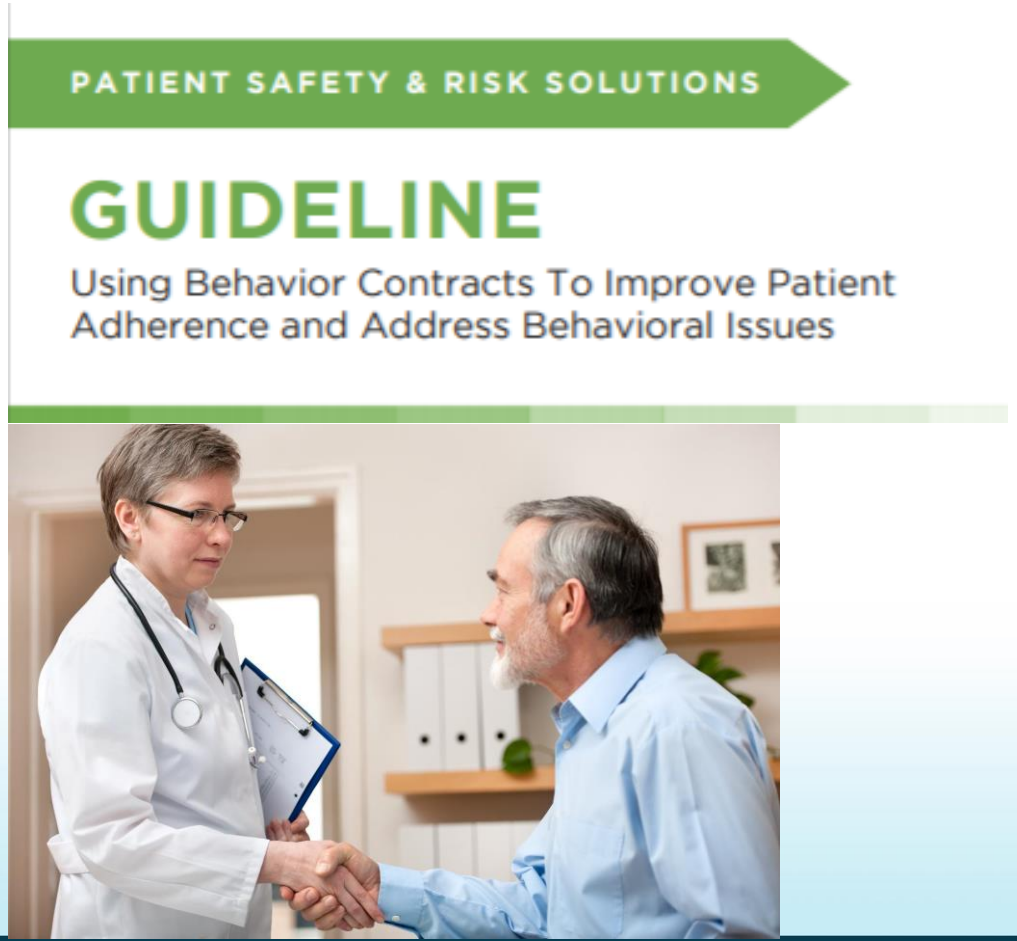
In the past year, how many times have you used the following?					
Drug Type	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol -For Men more than 5 drinks a day -For Women more than 4 drinks a day					
Tobacco products					
Prescription Drugs for Non-Medical Reasons					
Illegal drugs					

Source: National Institute on Drug Abuse. (2012). Resource guide: Screening for drug use in general medical settings. Retrieved from www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen

Evaluation tools

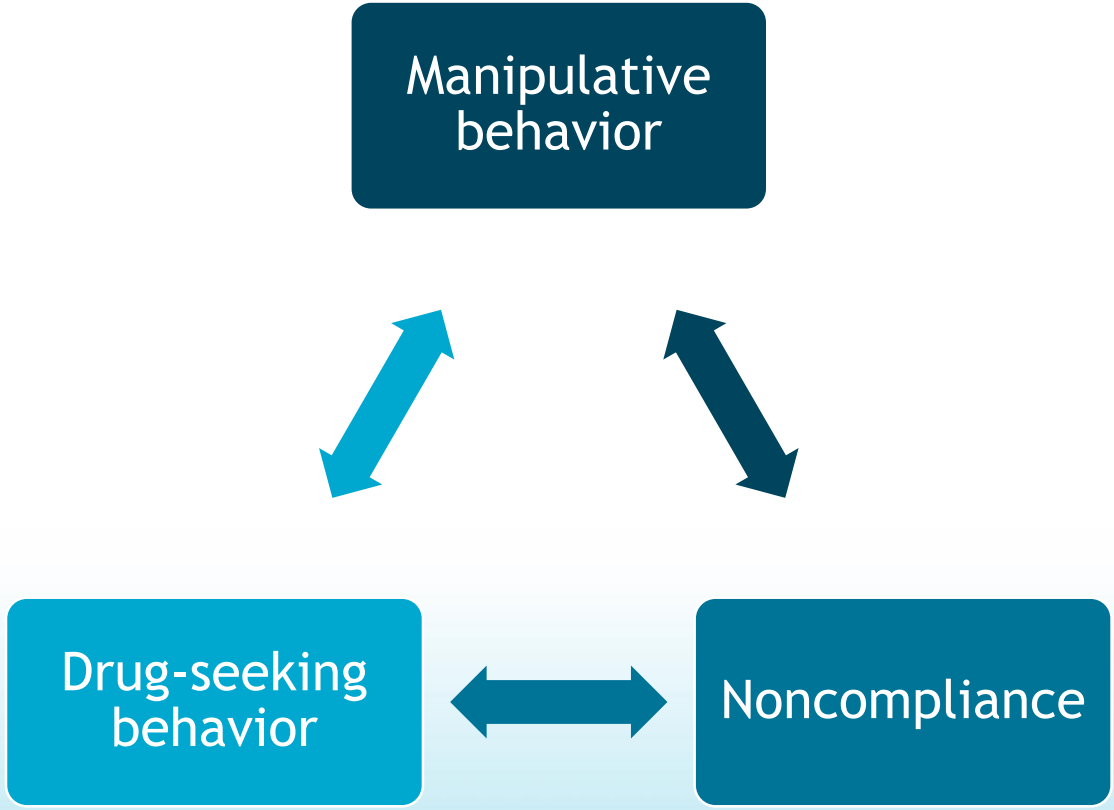


Contracting

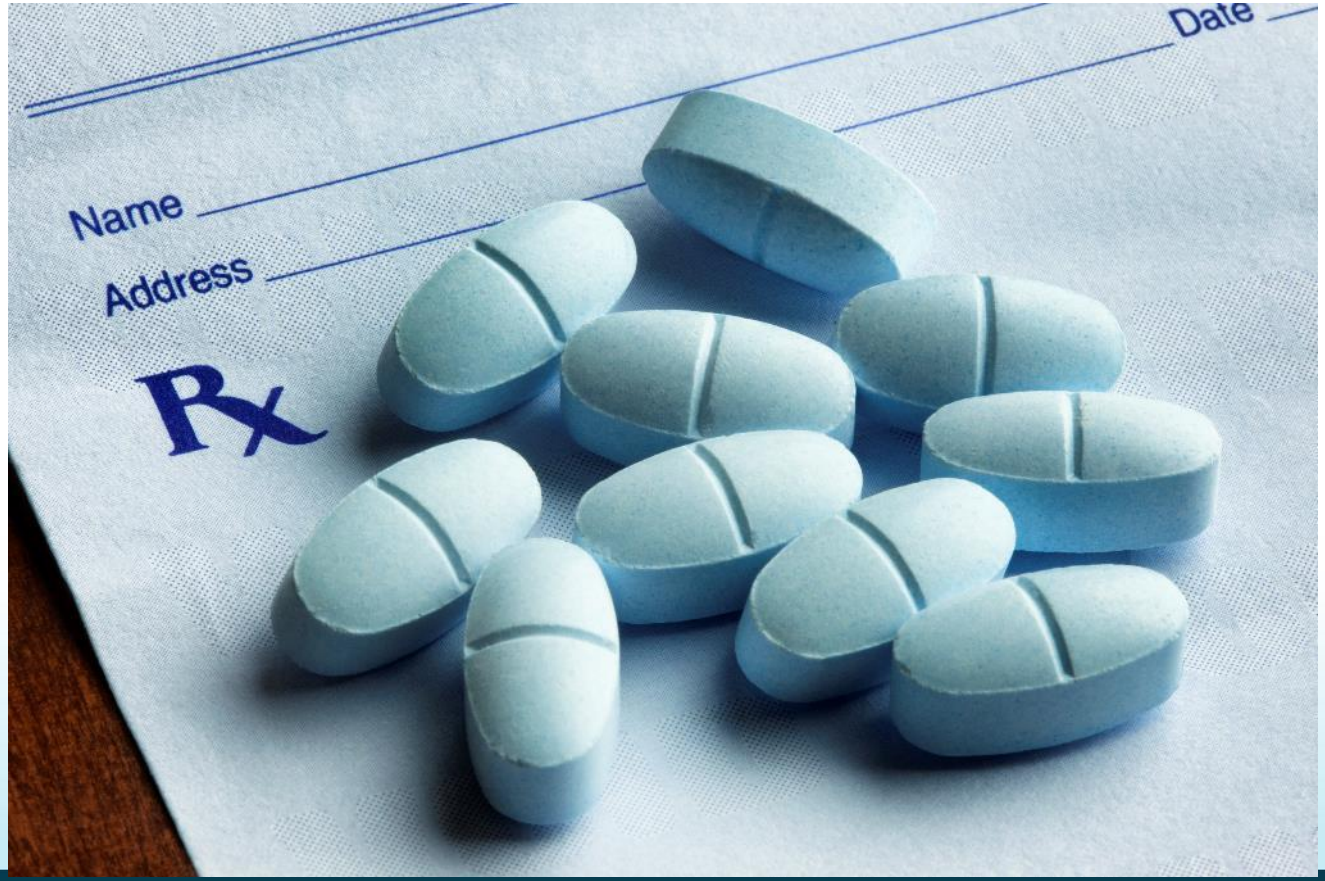


Source: MedPro Group. (2017). *Guideline: Using behavior contracts to improve patient adherence and address behavioral issues.* Retrieved from www.medpro.com/documents/10502/2837997/Behavior+Contracts.pdf

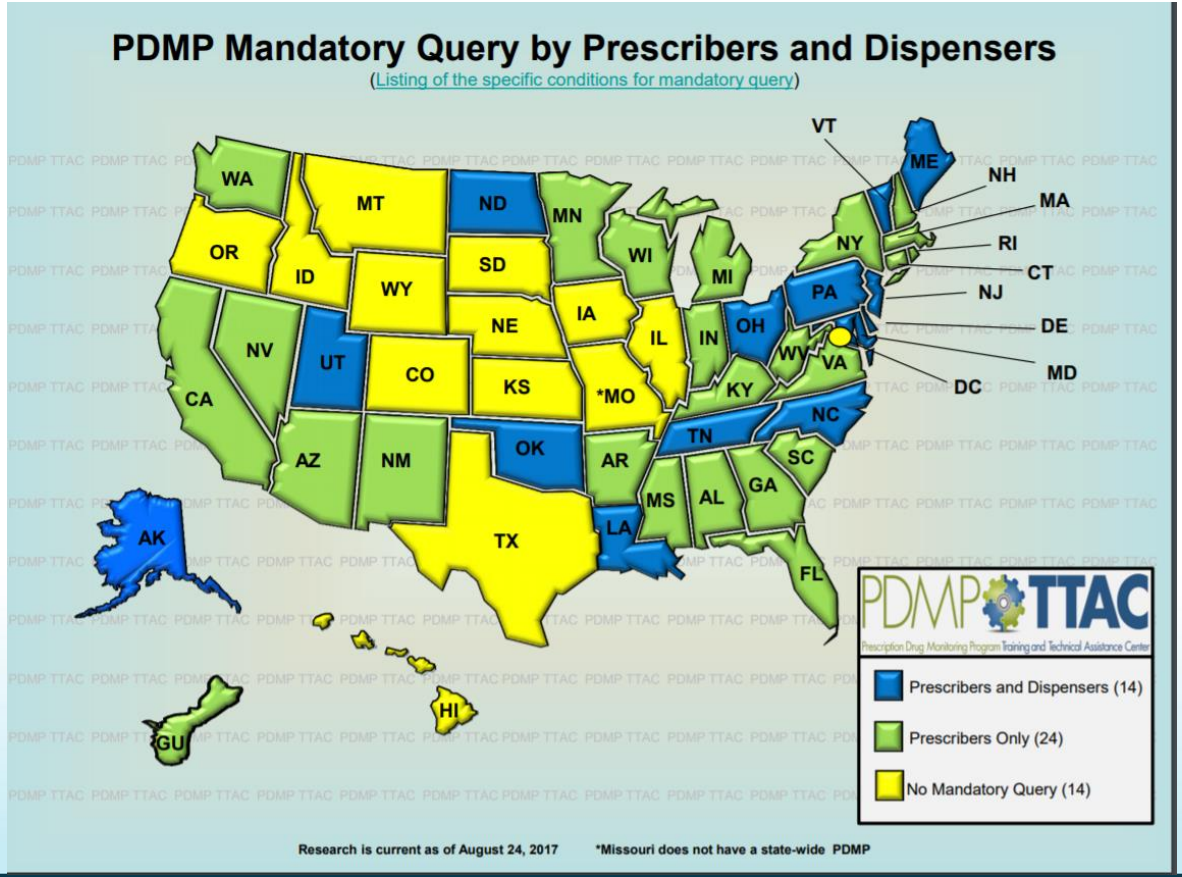
Using behavior contracts in opioid therapy



Prescription Drug Monitoring Program



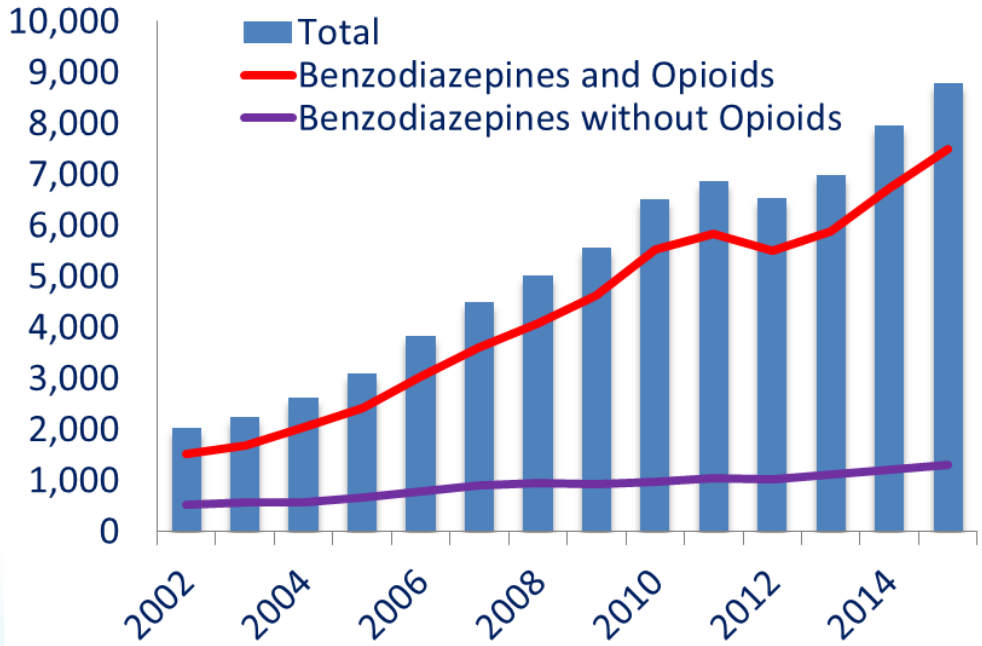
PDMP mandatory query by prescribers and dispensers



Drug testing

- Useful in determining adherence to treatment plan
- Random vs. every visit
- Process for obtaining specimen

Opioid involvement in benzodiazepine overdose



Avoid prescribing benzodiazepine and opioids together when possible.

Source: National Institute on Drug Abuse. (2017). Overdose death rates. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

Case study: Improper opioid prescribing

- **Patient:** Male, late thirties
- **Chief complaint:** Chronic pain, previous narcotic and heroin dependency
- **Case overview:** Presented to critical access hospital with complaints of radiating low back. He was diagnosed with muscle spasms, treated with non-narcotics, and referred to a pain management specialist/family medicine physician. Patient was treated for several weeks without opioids and was referred to a neurosurgeon. Upon that referral, he was given a 5-day script for diazepam and acetaminophen/hydrocodone. At a pre-neuro visit MRI, he was given meperidine. Several days later, patient called the office stating his girlfriend destroyed his pills. A 5-day replacement supply was called to the pharmacy. One day later, he returned to the office complaining of additional pain, and his narcotic scripts were refilled for 2 weeks (diazepam, acetaminophen/hydrocodone, hydrocodone/ibuprofen).
- **Outcome:** Two days later, the patient was found dead. Toxicology revealed an overdose of acetaminophen/hydrocodone and diazepam.

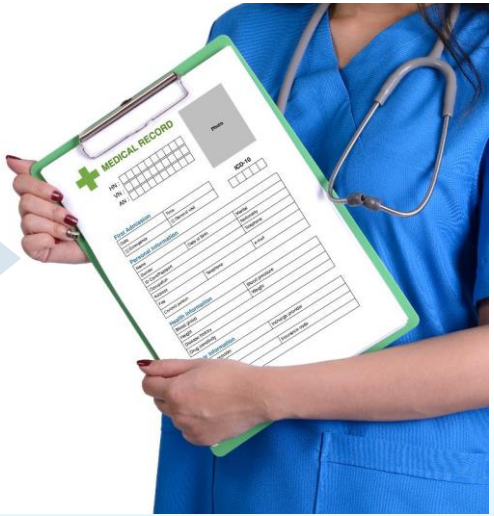
Documentation

Data tool for performance improvement activities

Secures and ensures reimbursement

Communication tool

Health record is the single source to memorialize all care provided to the patient



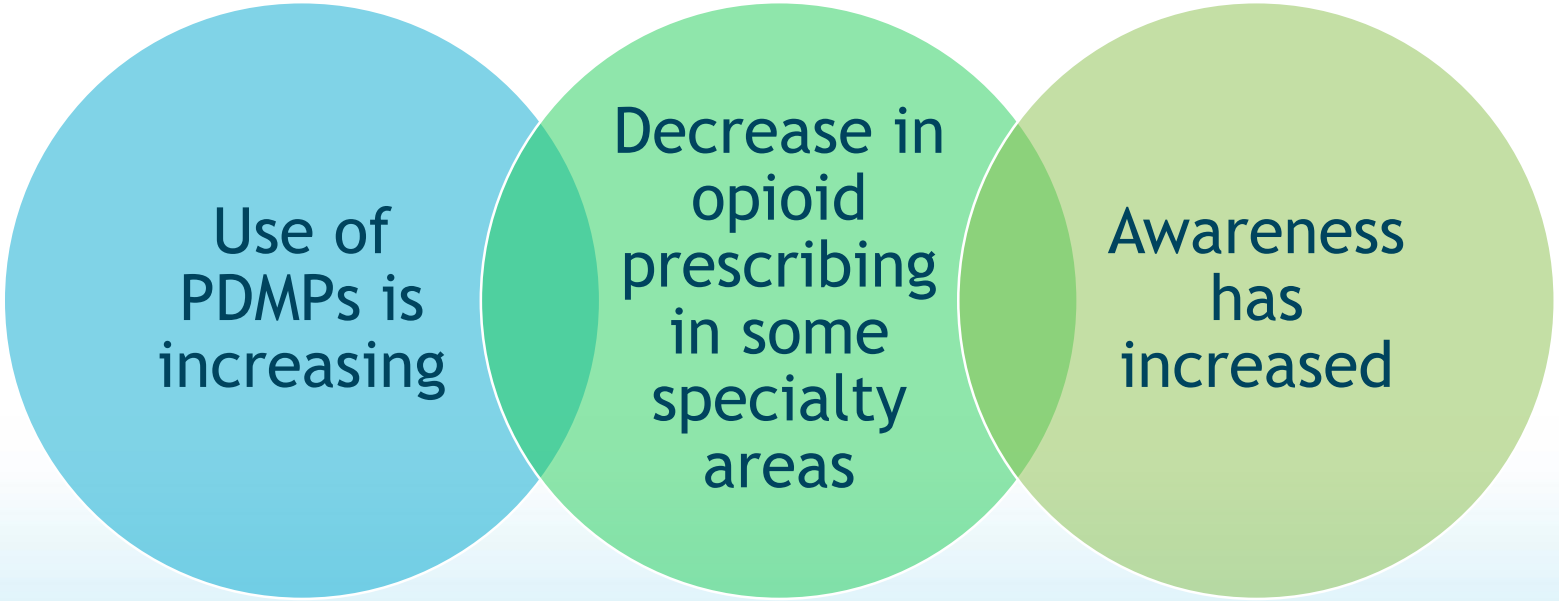
Treatment programs

Treatment options

Resources in your community

Conclusion

Progress is being made . . .



. . . but we have a long way to go.

Resources

- Centers for Disease Control and Prevention. (2017). Understanding the epidemic. Retrieved from www.cdc.gov/drugoverdose/epidemic/index.html
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