The Opioid Epidemic
Implications to Managing Care
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.
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.
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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

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

Robert Lowes
August 14, 2017

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

Published online 2017 Mar 2. doi: 10.9778/cmajopen.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

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

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

Opioid epidemic is a public health emergency
Professional organizations

ADA News
ADA adopts multitiered policy on opioids
January 05, 2017

Reversing the Opioid Epidemic
Explore current resources from the AMA Opioid Task Force to help reverse the nation's opioid epidemic.
Numbers of deaths from opioid drugs

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%

**Who is responsible**

**Sources:**
Solution

Anyone who evaluates and treats patients is responsible for helping to address this epidemic through identification and response.
Organizational Strategies
Safe Prescribing Practices
Organizational strategies

- Staff training
- Scope of duties appropriate for education/training/licensure
- Opioid storage (if stock onsite)
- Diversion monitoring
- Monitor prescribing histories of providers (peer review, OPPE)
- Script-writing safety nets
- Referral relationships

OPPE: ongoing professional practice evaluation
Patient Care Strategies

Safe Prescribing Practices
Chronic pain patients

Determining when to initiate or continue opioids for chronic pain

Nonpharmacologic interventions (and complementary medicine)

Treatment goals

Risk vs. benefits
Nonpharmacologic and nonopioid interventions including complementary medicine

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

Establishing treatment goals

American Academy of Family Physicians Model: Five “R’s” and Two “E’s”

Be Reasonable

Be Reachable

Include patient Recordkeeping (e.g., daily diaries, log)

Revisit and Revise

Use Electronic state prescription drug monitoring programs (PDMPs)

Have an Exit 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

Patient response may include:

• Anger
• Frustration
• Fear
• Loss of control
• Anxiety

Re-evaluation and adjustment of treatment plan
### Barriers to making changes in treatment plans

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Details</th>
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<tbody>
<tr>
<td>Need for pain relief</td>
<td></td>
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<tr>
<td>Cultural, religious, or ideological beliefs</td>
<td></td>
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<tr>
<td>Dependency or addiction</td>
<td></td>
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<tr>
<td>Social/family</td>
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<tr>
<td>Financial</td>
<td></td>
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</tbody>
</table>
| 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.

Tapering: slow and methodical

When is the right time

Reduce 10% every 7 days
Individualize plan

How

Nonpharmacologic strategies
Therapy/counseling/treatment center
Medication-assisted treatment (MAT)

Have alternative plans

Encouragement

Re-evaluation

Checklist for prescribing opioids for chronic pain

When CONSIDERING long-term opioid therapy
- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that nonopioid therapies 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 prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (e.g., PESD scale).
- Schedule initial reassessment within 1–3 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 (e.g., PESD), compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-dosage 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.
- Check that nonopioid 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, 2.375 mg oxycodone).
  - Increase frequency of follow-up, consider offering naloxone;
  - Avoid ≥50 MME/day (≥20 mg hydrocodone, 100 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, necessary for function.
- Insufficient evidence for long-term benefits to lower back pain, headache, and fibromyalgia.

Non-opioid therapies:
Use alone or combined with opioids, as indicated:
- Non-opioid medications (e.g., NSAIDs, TCA, SNRI, and anticonvulsants).
- Physical treatments (e.g., exercise therapy, weight loss).
- Behavioral treatments (e.g., CBT).
- Psychological (e.g., pharmacological [counseling]).

Evaluating risk of harm or misuse:
Known risk factors include:
- Physical drug use, prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (e.g., depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.
- Urine drug testing: Check to perform prescreen on prescription substances and for prescribed prescription drug or illicit substance use.

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

Accessing pain & function using PESD scale:
PES score ≥8 suggests a minimal positive score (90% improvement in two criteria, actively meaning no pain):
61. What number from 0–10 best describes your pain on the past week?
62. “on a scale of 0–10, how bad would you rate your pain?”
63. What number from 0–10 describes how during the past week, pain has interfered with your enjoyment of life?
64. “rate at all” 10 = “terrible interference”
65. What number from 0–10 describes how during the past week, pain has interfered with your general activity?
66. “rate at all” 10 = “terrible interference”

Additional consideration for renewals

If renewing without patient visit:

Check that return visit is scheduled \( \leq 3 \) 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

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 $\geq 50$ MME/day total ($\geq 50$ mg hydrocodone; $\geq 33$ mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid $\geq 90$ MME/day total ($\geq 90$ mg hydrocodone; $\geq 60$ mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals ($\leq 3$ months).

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

"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."

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

Assessing risk and addressing harms of opioid use

Risk mitigation

Patient history

Drug testing

Avoid prescribing benzodiazepines and opioids together when possible

Treatment programs
Risk mitigation strategies

- Evaluation tools
- Contracting
- PDMP
- Documentation
Evaluation tools

- Pain assessment tools
- Dependence/addiction tools
- Sedation monitoring tools
- Patient history tools

Evaluation tools

Pain assessment tools

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

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

## Patient self-reported Accuracy

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
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</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>- For Men more than 5 drinks a day</td>
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<tr>
<td>- For Women more than 4 drinks a day</td>
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<td>Tobacco products</td>
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<td>Prescription Drugs for Non-Medical Reasons</td>
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<tr>
<td>Illegal drugs</td>
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</table>

Evaluation tools

Consistency of use

Documentation
Contracting

Guideline: Using Behavior Contracts To Improve Patient Adherence and Address Behavioral Issues

Using behavior contracts in opioid therapy

Manipulative behavior

Drug-seeking behavior ↔ Noncompliance
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
Avoid prescribing benzodiazepine and opioids together when possible.

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 . . .

Use of PDMPs is increasing

Decrease in opioid prescribing in some specialty areas

Awareness has increased

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

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