Opioid Stewardship: 16 Tips

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Acknowledgment

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Goals & Objectives:

The purpose of this session is to:

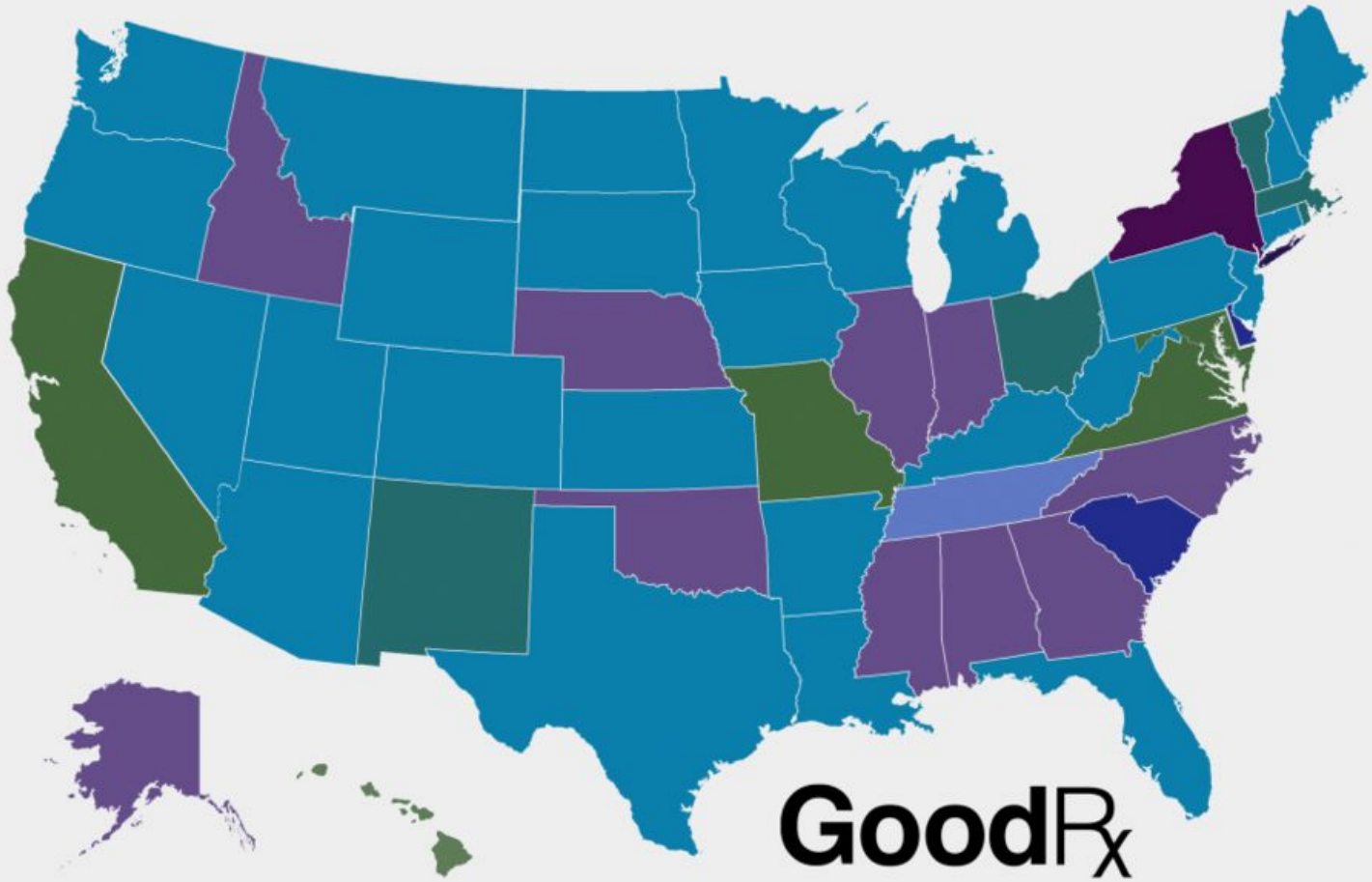
1) Introduce the ‘16 tips’ for proper prescribing of controlled substances.

2) Improve your level of comfort when working with chronic pain and/or SUD patients.

3) Improve your management of patients you intend to discharge with CPD prescription.

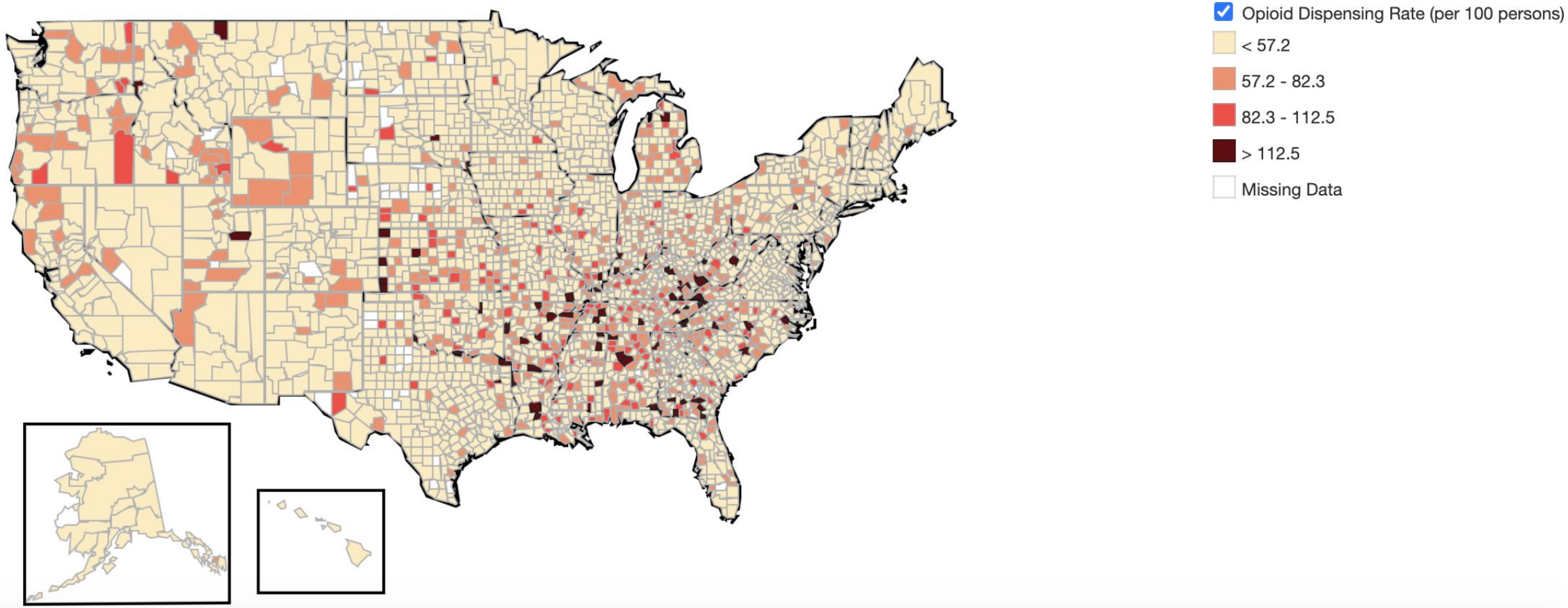
The United States of Drugs

The most prescribed medication in each of the 50 states (2018)



Levothyroxine (Synthroid)
Hydrocodone / Acetaminophen (Norco, Vicodin)
Atorvastatin (Lipitor)
Lisinopril (Prinivil, Zestril)
Amphetamine salt combo (Adderall)
Amlodipine (Norvasc)
Buprenorphine / Naloxone (Suboxone)

Data represents volume of US prescriptions by state filled at pharmacies during 12 months ending February 2018. Data comes from several sources, including pharmacies and insurers, and provides a representative sample of nationwide US prescription drug volume. For more info, visit goodrx.com/blog


Opioid Dispensing Rate (per 100 persons)
< 57.2
57.2 - 82.3
82.3 - 112.5
> 112.5
Missing Data

An estimated **1.9M**
AMERICANS
have OUD related to
opioid painkillers;
589K, related to
heroin.[2]

Overdose Update: 2020 Jefferson County Overdose EMS Runs

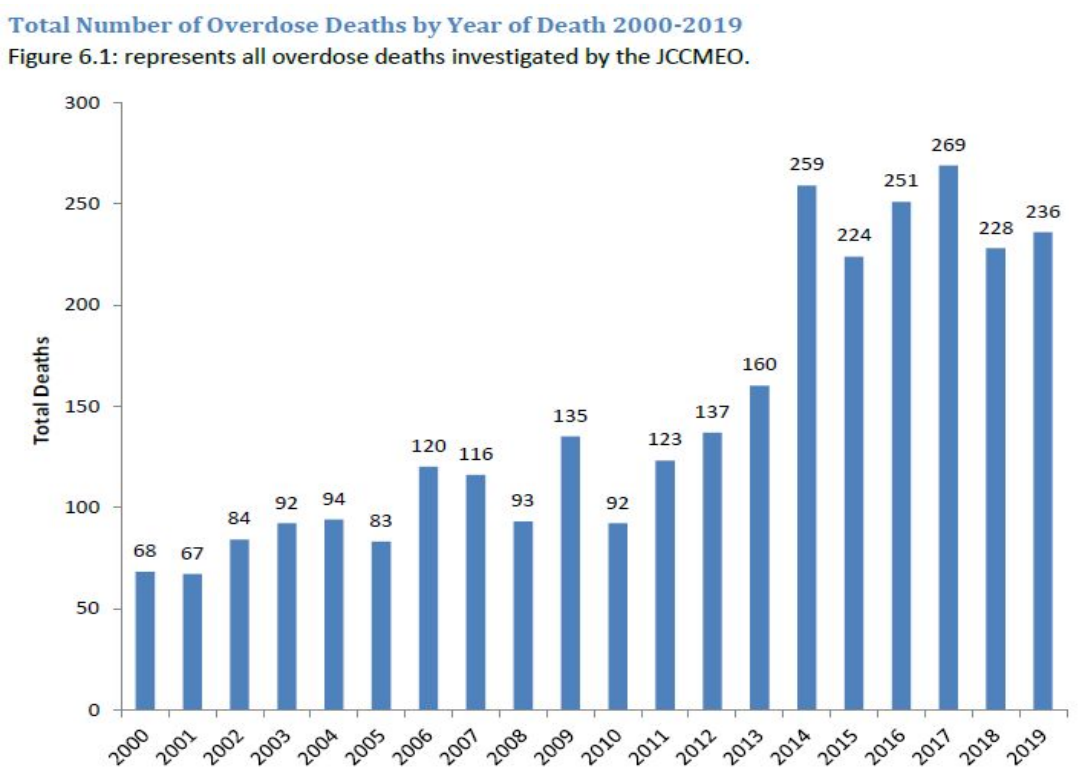
Month	# of overdose EMS runs
January	182
February	165
March	168
April	168
May	225
June	185
July	218
August	225
September	208
October	212
November	221
December	236

Overdose Update: 2020 Jefferson County ER Visits for Overdose

Month	# of ER visits
January	97
February	91
March	122
April	109
May	147
June	132
July	163 (5.6 per day)
August	110
September	130
October	138
November	151
December	150

*SOURCE: Data on emergency department visits obtained from the Alabama Department of Public Health syndromic surveillance program.
https://www.alabamapublichealth.gov/infectiousdiseases/syndromic-surveillance.html

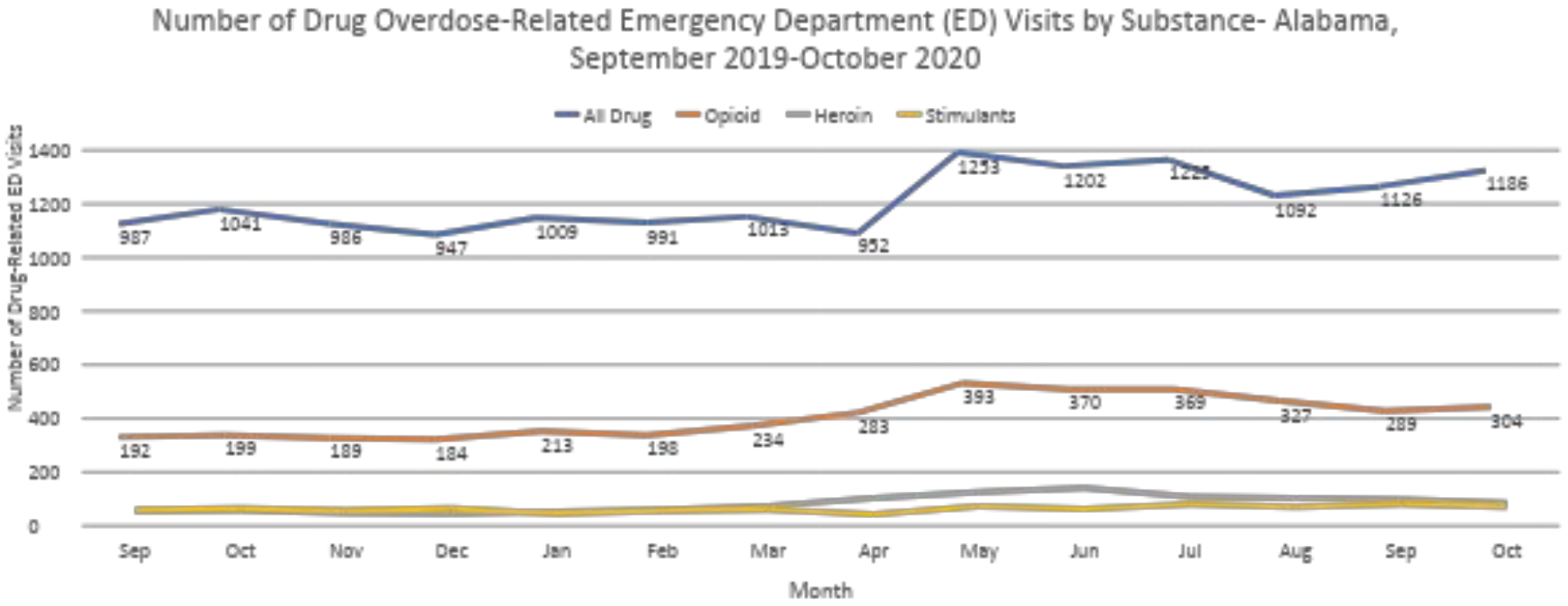
Overdose Update: 2020 Jefferson County Overdose Deaths



	1/1/19 – 10/31/19	1/1/20 – 10/31/20	% change
Opioid	144	179	+36.80
Other drug	49	43	-12.24
Total	193	222	+15.02

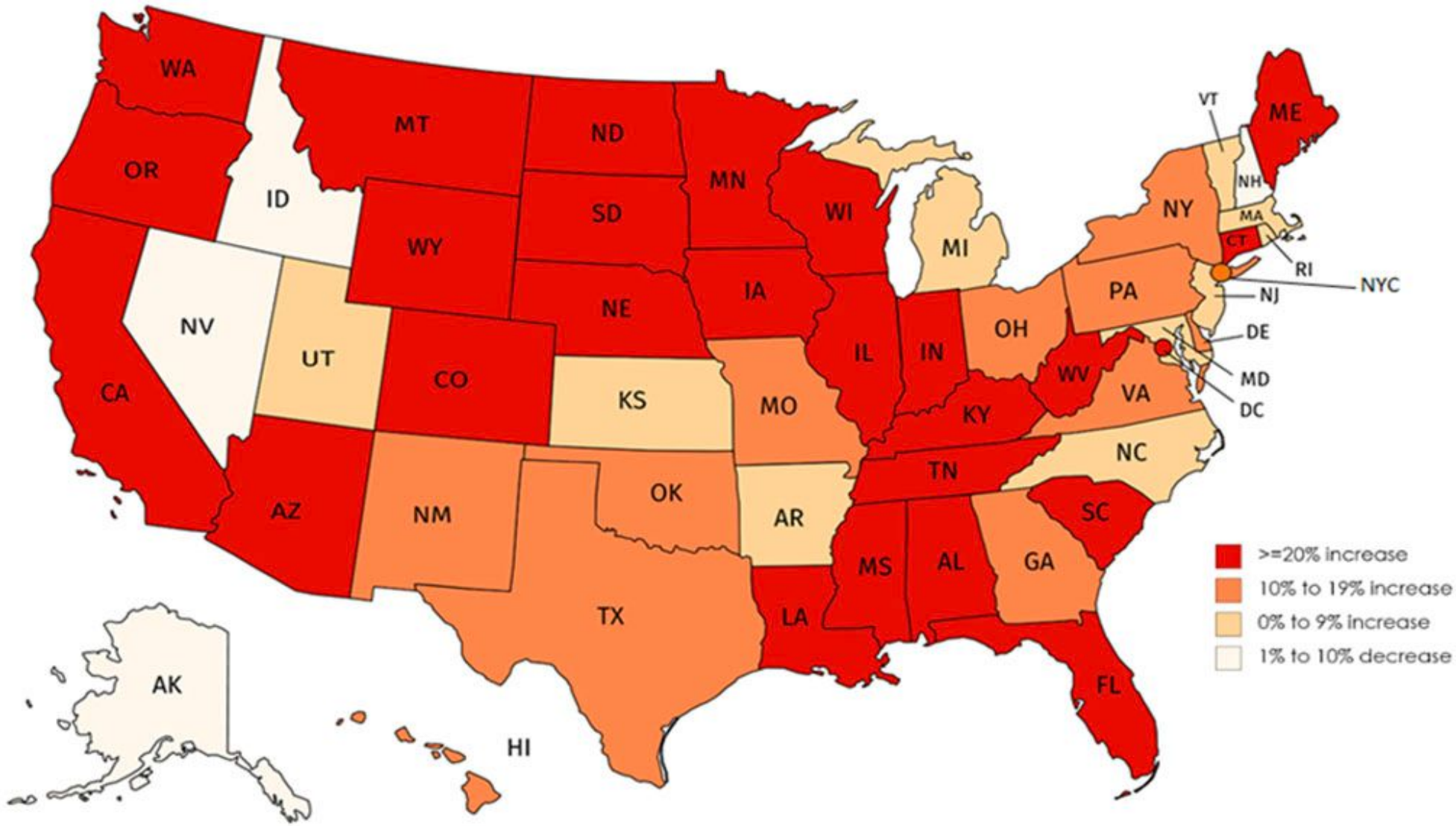
Update as of 1/5/2021: 261confirmed overdose deaths in Jefferson County for 2020 with 211 of those opioid related (176 for 2019).

Overdose Situation in Alabama



Data on emergency department visits obtained from the Alabama Department of Public Health Syndromic Surveillance program.

Selected ESSENCE Query Fields:
Data Source: Facility Location
Site: Alabama
CCDD Category: CDC All Drug Overdose v1; CDC Opioid Overdose v2, CDC Heroin Overdose v4; CDC Stimulant v3
Facility Type: Emergency Care
Has Been Emergency: Yes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VA
PA
NY
VT
NH
ME
MA
CT
RI
NJ
NYC
DE
MD
DC
AK
HI
>=20% increase
10% to 19% increase
0% to 9% increase
1% to 10% decrease

Overview of the Proper Prescribing Practices - The 16 Tips

Tip #1

- AVOID MISPRESCRIBING

CNN health Food Fitness Wellness Parenting Vital Signs

Doctors increasingly face charges for patient overdoses

By Michael Nedelman, CNN

Updated 5:19 AM ET, Mon July 31, 2017

California doctor charged with murder in several opioid-related deaths

Thomas Keller is a neurologist and pain management doctor in Santa Rosa.

By **Karma Allen**

August 15, 2019, 8:48 PM • 4 min read

Ten Reasons Physicians Misprescribe – the 10 ‘D’s

- 1) **Dated** □ fail to keep up with current EBM, practice guidelines.
- 2) **Disabled** □ impaired due to SUD
- 3) **Dishonest** □ prescribes for personal gain
- 4) **Duped** □ failure to detect deception
- 5) **Dismayed** □ lack of time to properly address issues/screen for SUD
- 6) **Dysfunctional** □ failure to say “no”
- 7) **Disempowered** □ hierarchical power play
- 8) **Dodging** □ work avoidance; easier to write the prescription than see/deal with the patient
- 9) **Disregard** □ for scope of practice
- 10) **Disorganized** □ bad charting/documentation

Example Clinical Policy

Clinic Policy Regarding Patients on Long-term Controlled Substances
(opioids, benzodiazepines and stimulants)

New Patients with a History of Long–term Use of a Controlled Substance

Before a new patient with a history of long-term controlled substance prescription use receives the first prescription from a clinic physician, our clinic record must contain: the medical records, urine comprehensive drug scan, MAPS search results and, if long term use is anticipated, a completed controlled substance contract.

Medical records. These new patients must provide medical records documenting previous medical work-up regarding the complaint necessitating these prescriptions and notes from previous physicians that prescribed these medications.

Obtain relevant medical records from previous providers. The patient is responsible for having this information sent. This clinic will provide to the patient forms for release of information along with the fax number and mailing address of our clinic. The previous physician's office should send the information directly to this clinic. This clinic will also provide to the patient the clinic phone number to verify that the patient's medical records have been received and to make appointments.

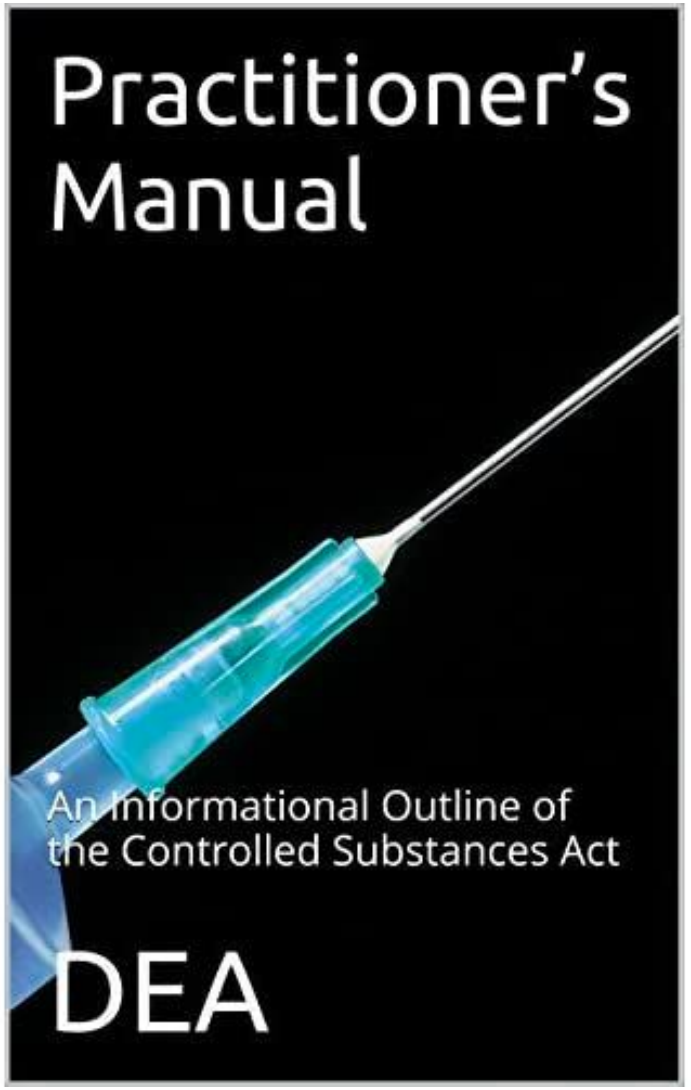
The Initial clinic note should follow the suggested format outline and must be complete for elements of the Past, Family and Social histories that could put a patient at risk for medication problems. It should include a detailed prescription history (last time/date controlled substance taken).

Urine comprehensive drug screen ("DRUG COMP"). DRUG COMP is combined immunoassay screening and gas chromatography/mass spectroscopy that together detect specific synthetic opioids along with morphine/codeine, benzodiazepines and drugs of abuse such as amphetamines, THC, and cocaine It will also detect many common prescription meds such as tramadol, cyclobenzaprine, and TCAs. (A SAMHSA Drug 5 or Drug 6 immunoassay screen is inadequate due to difficulty of interpretation and problems with false positives and negatives.)

Order a DRUG COMP screen for all new patients. To avoid false negatives, inform the lab in the test order if a specific opioid should be present (particularly methadone, fentanyl and buprenorphine).

Tip #2

- Be familiar with the DEA Practitioner's Manual.
  - Online version or
  - 62-page PDF
  - *This is the standard to which you will be held.



Tip #3

- Use validated screening tools for primary and secondary prevention.
  - Screen for substance misuse and be able to recognize substance use disorder (DSM-V).
    - CAGE, CAGE-AID
    - SOAPP-R, SOAPP-8
    - COMM, COMM-9
  - Consider assessing SUD risk prior to CPD prescribing.
    - ORT

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:

1. Have you ever felt that you ought to cut down on your drinking or drug use?

☐ YES ☐ NO

2. Have people annoyed you by criticizing your drinking or drug use?

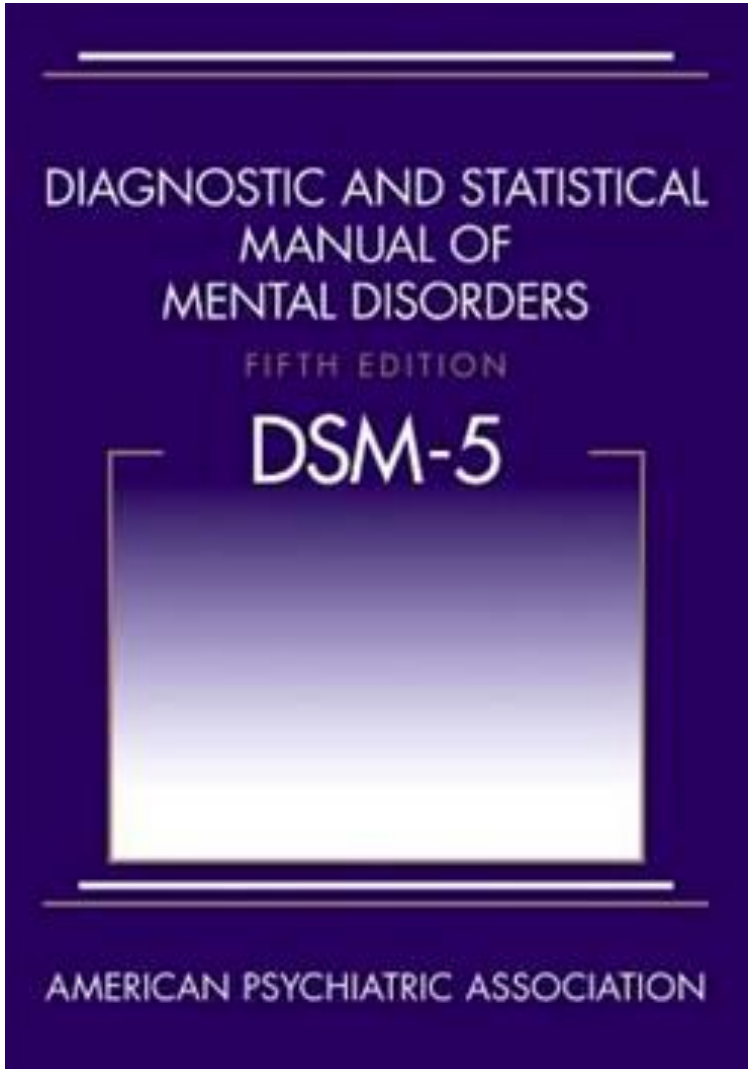
☐ YES ☐ NO

3. Have you ever felt bad or guilty about your drinking or drug use?

☐ YES ☐ NO

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

☐ YES ☐ NO



- **In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:**
  - Opioids are often taken in larger amounts or over a longer period than was intended.
  - There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
  - A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
  - Craving, or a strong desire or urge to use opioids.
  - Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
  - Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
  - Important social, occupational, or recreational activities are given up or reduced because of opioid use.
  - Recurrent opioid use in situations in which it is physically hazardous.
  - Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
  - Exhibits tolerance.
  - Exhibits withdrawal.

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

https://www.mdcalc.com/opioid-risk-tool-ort-narcotic-abuse

Tip #4

- Conduct complete **SBIRT** if substance abuse screen is positive.

SBIRT

- **Screening** □ ask if the patient uses any controlled substances or street drugs
- **Brief Intervention** □ determine if the patient needs to cut down or quit; help patients explore ambivalence via MI (tip #5).
- **Referral to Treatment** □ Refer any patient unable to cut down or quit on their own.

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

CONCLUSION

doi:10.1111/add.13675

Screening, Brief Intervention and Referral to Treatment: implications of SAMHSA's SBIRT initiative for substance abuse policy and practice

Thomas F. Babor[1], Frances Del Boca[1] & Jeremy W. Bray[2]

University of Connecticut School of Medicine, Farmington, CT, USA[1] and University of North Carolina at Greensboro, Greensboro, NC, USA[2]

Tip #5

- Use motivational interviewing to promote behavior change as part of the SBIRT.

Motivational Interviewing: Open Questions, Affirmation, Reflective Listening, and Summary Reflections (OARS)

- Open:
  - How can I help you with ___?
  - Help me understand ___?
  - How would you like things to be different?
- Affirm:
  - I appreciate that you are willing to meet with me today.
  - You are clearly a very resourceful person.
  - You handled yourself really well in that situation.
- Reflect:
  - So you feel…
  - It sounds like you…
  - You're wondering if…
- Summarize:
  - Let me see if I understand so far…
  - Here is what I've heard. Tell me if I've missed anything.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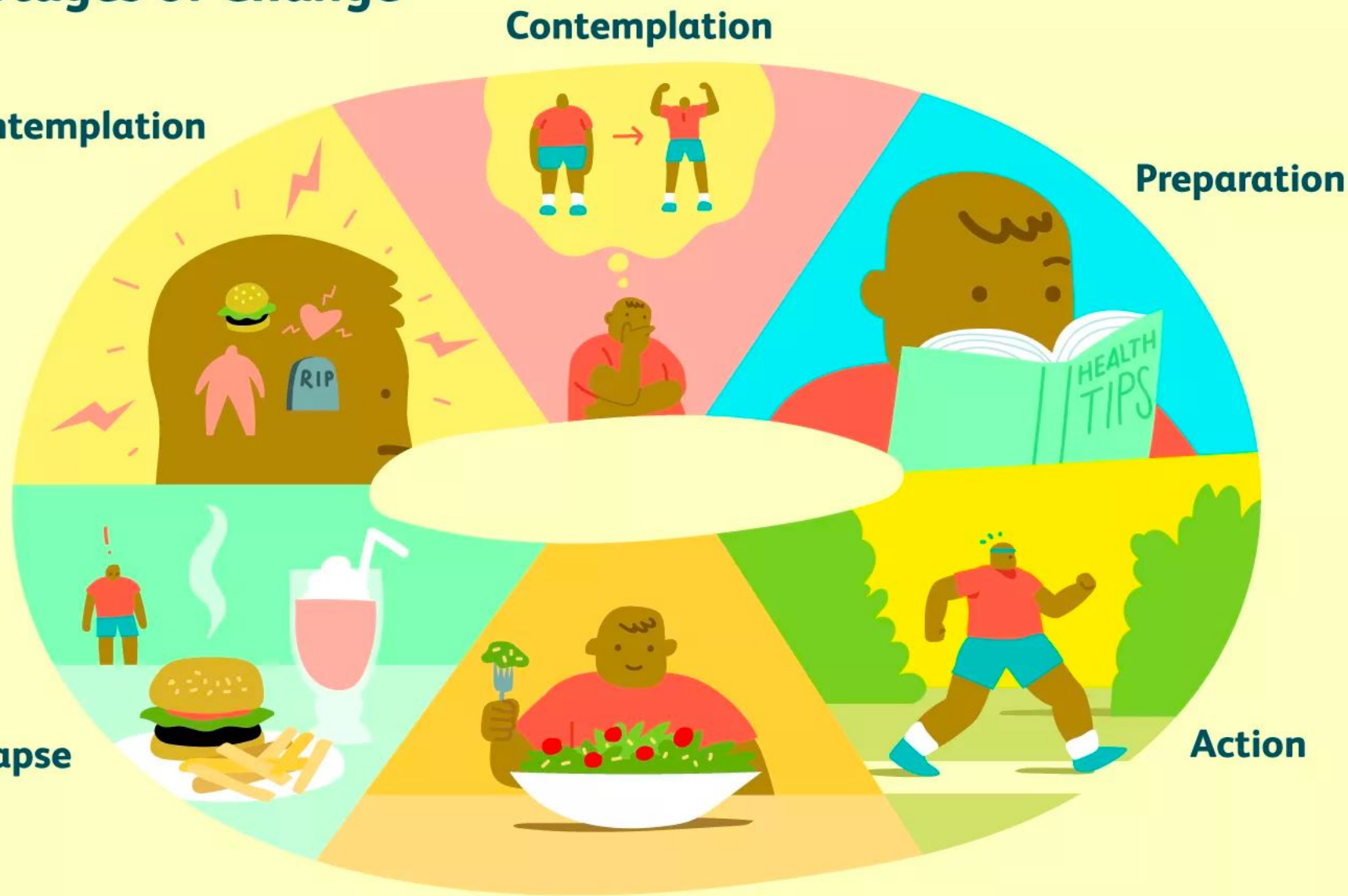
9
10
Not ready to change
Not sure
Ready to change

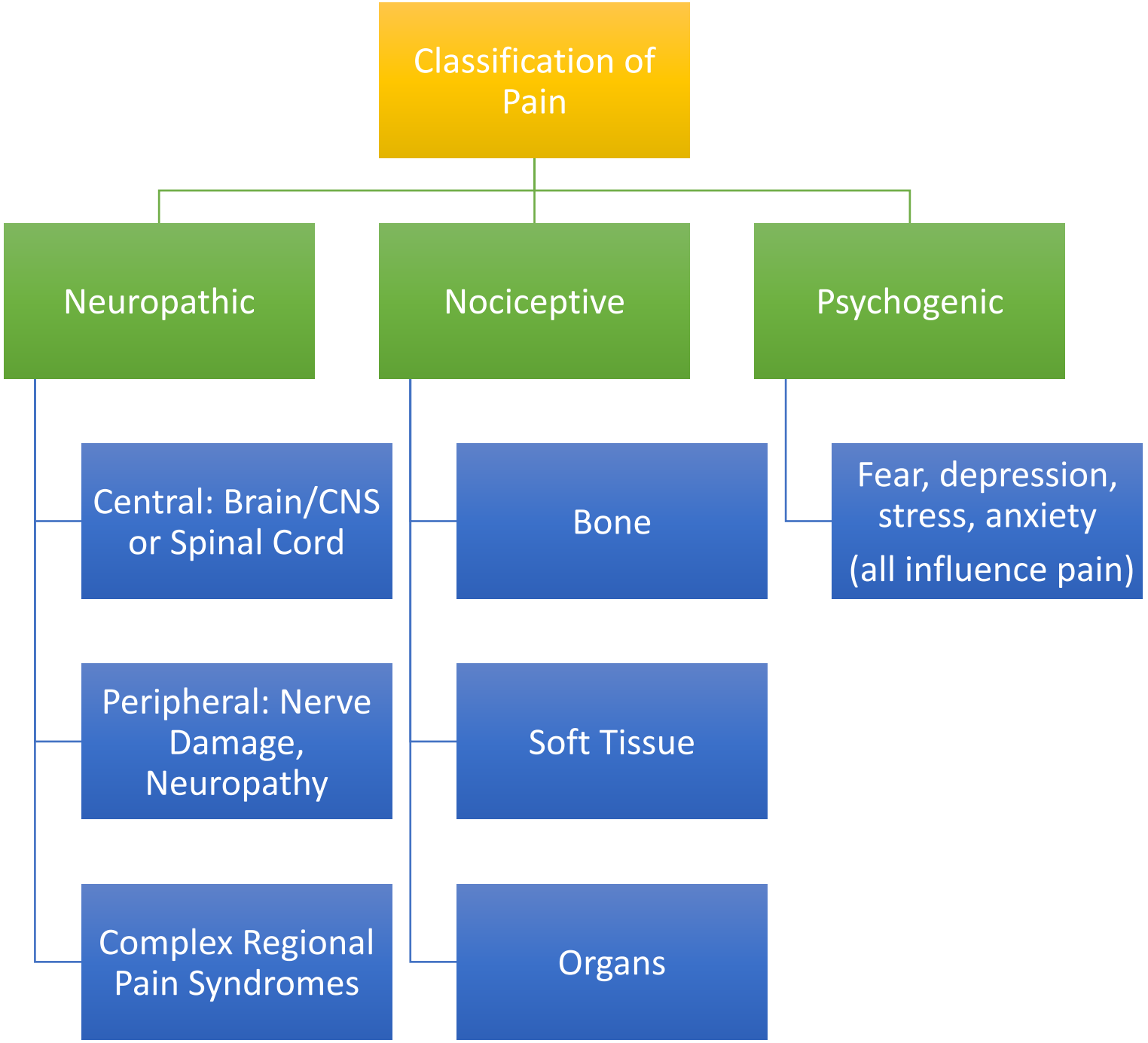
The Stages of Change



verywell

Tip #6

- Treat pain appropriately.
  - Not all pain requires narcotics.


Classification of Pain
Neuropathic
Nociceptive
Psychogenic
Central: Brain/CNS or Spinal Cord
Peripheral: Nerve Damage, Neuropathy
Complex Regional Pain Syndromes
Bone
Soft Tissue
Organs
Fear, depression, stress, anxiety
(all influence pain)

Tip #7

- Consider/Use adjuvant treatments when appropriate.

Medication Options	Non-Medication Options
TCAs	Ice/Heat
SNRIs	Exercise/PT
Anticonvulsants (e.g. Depakote)	TENS unit
Gabapentin or Pregabalin	Yoga, Tai Chi, etc.
Muscle relaxers	Cognitive Behavioral Therapy
Bisphosphonates	Mindfulness-Based Stress Reduction (MBSR)
Neutraceuticals (glucosamine and chondroitin)	Pain rehabilitation
Other: topical lidocaine, botulinum toxic, etc.	Chiropractor/Acupuncture

Tip #8

- Register for and use your state's prescription drug monitoring program (PDMP) appropriately.

Do PDMPs Work?

Making a Difference: State Successes

New York
75% ↓

2012 Action:

New York required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a 75% **drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.

Florida
50% ↓

2010 Action:

Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices.

2012 Result:

Saw more than 50% **decrease in overdose deaths** from oxycodone.

Tennessee
36% ↓

2012 Action:

Tennessee required prescribers to check the state's prescription drug monitoring program before prescribing painkillers.

2013 Result:

Saw a 36% **drop in patients** who were seeing **multiple prescribers** to obtain the same drugs, which would put them at higher risk of overdose.

SOURCES: NY, TN: PDMP Center of Excellence at Brandeis University, 2014. FL: Vital Signs Morbidity and Mortality Weekly Report, July 1, 2014.

Tip #9

- When prescribing a CPD, apply a comprehensive and systematic approach to documentation.

In addition to standard H&P and MDM, document:

- Number of previous office/clinic visits for pain complaint
- Risk for SUD (e.g. via ORT).
- PDMP review.
- Previous or current use of alternative/adjunct therapies (and results).
- Justification for CPD selection (pain source/type or indication) and prescription details (e.g. # of pills, length, refills, etc.).
- Informed consent for CPD use (written or verbal).
- Consider a CPD agreement (“pain contract”).

Tip #10

- Implement the Five A's on follow-up visits for patients with chronic pain.

Five A's

- Analgesia
  - Is pain controlled with current management?
  - Are there any signs of physiologic dependence (tolerance, withdrawal)?
- Activities
  - Are ADLs and sleep improved, unchanged, or worse?
- Adverse events
  - Adverse drug reactions or side effects?
- Aberrancy
  - E.g. request for early refill, inaccurate pill counts, concern for diversion (negative UDS)
- Affect
  - Impact on mood, mental health

*Chronic CPD use can be warranted and appropriate HOWEVER, consider whether the patient meets SUD criteria (which may, in turn, warrant SBIRT, particularly if moderate or severe). Consider routine use of SOAPP-R or COMM for chronic opioid use patients.

Screener and Opioid Assessment for Patients with Pain Revised (SOAPP-R)

Questionnaire Supplement to the Study Data Tabulation Model Implementation Guide for Human Clinical Trials

Prepared by

CDISC and Analgesic Clinical Trial Translations, Innovations, Opportunities, and Networks (ACTTION)

[redacted]

Notes to Readers

This implementation guide is intended to be used with other CDISC User Guides for specific Therapeutic/Disease Areas and follows the CDISC Study Data Tabulation Model Implementation Guide for Human Clinical trials.

Revision History

Date	Version	Summary of Changes
2012-03-03	0.1	Screener and Opioid Assessment for Patients with Pain Revised (SOAPP-R) Draft
2012-08-07	1.0	Screener and Opioid Assessment for Patients with Pain Revised (SOAPP-R)

Tip #11

- Emphasize an interprofessional team approach for patients with chronic pain.

Treating Chronic Pain is a Team Effort.

- Pharmacy
- PCP
- Pain medicine specialist
- Psychiatry/Addiction Specialist

https://www.icsi.org/guideline/pain/develop-pain-treatment-plan/

https://www.aafp.org/family-physician/patient-care/care-resources/pain-management/aafp-chronic-pain-management-toolkit.html

Tip #12

- Familiarize yourself with local substance use disorder treatment options and resources to assist patients.


Recovery
Relapse


OPIOID RECOVERY TEAM
GET WAIVERED

Tip #13

- Prevent, identify, and intervene early for patients at risk of an accidental overdose.

Tip #14

- Stay abreast of new state prescribing laws.

Photo Credit: nga.gov

Tip #15

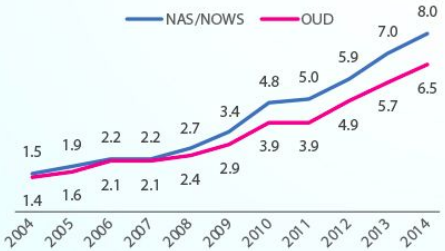
- Provide informed consent and pregnancy prevention for women of childbearing potential.
  - Discuss risk/benefits, including risk of NAS.
    - All opioids cross the placental barrier.
    - Opioid use in pregnancy is associated with prematurity, low birth weight, increased risk of spontaneous abortion, sudden infant death syndrome and infant neurobehavioral abnormalities.

DRAMATIC INCREASES IN MATERNAL OPIOID USE DISORDER AND NEONATAL ABSTINENCE SYNDROME

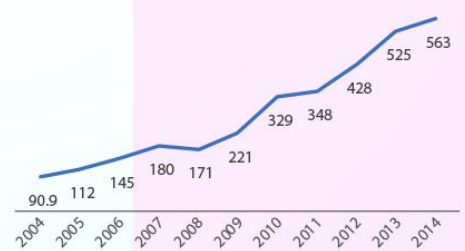
Opioid use during pregnancy can result in a drug withdrawal syndrome in newborns called **neonatal abstinence syndrome**, or **neonatal opioid withdrawal syndrome** (NAS/NOWS), which causes **costly** hospital stays. A recent analysis showed that an estimated **32,000** babies were born with this syndrome in the United States in 2014, a more than **5-fold increase** since 2004.

EVERY ~ 15 MINUTES, A BABY IS BORN SUFFERING FROM OPIOID WITHDRAWAL.

NAS/NOWS and Maternal Opioid Use Disorder on the Rise
Rates per 1,000 Hospital Births



Growing Hospital Costs for Treatment of NAS/NOWS
Inflation-Adjusted U.S. Dollars (millions)



Honein et al. Pediatrics 2019, Winkelman et al. Pediatrics 2018, Haight et al. MMWR 2018.

NIH National Institute on Drug Abuse

DRUGABUSE.GOV

Tip #16

- Manage conflict with patients using effective communication techniques.
  - Apply standard treatment guidelines and principles to all patients.
  - Listen; recognize and validate emotions.
  - Consider use of MI and shared decision making.
  - Avoid anger; its not personal.
  - Avoid threatening statements or holding medications ‘hostage.’

Communication Techniques

- **Repetition:** repeating verbatim individual contributions to confirm understanding
- **Probing:** asking follow on questions to better understand and clarify the meaning of the verbal message
- **Summarizing:** giving a summary of what has been said. Similar to paraphrasing, but it condenses the content of what has been said
- **Rephrasing:** repeating back in your own words what you understand someone else to be saying

Tip Summary

1) Avoid the 10 D's.
2) Know the DEA standard.
3) Recognize/identify SUD.
4) Conduct SBIRT.
5) Engage in MI.
6) Consider source of pain and treat appropriately.
7) Consider non-opioid treatment.
8) Use the PDMP.
9) Document CPD use appropriately.
10) Use 5 A's for follow-up.
11) Engage interprofessional approach.
12) Know local SUD resources.
13) Prevent overdose.
14) Stay current on new laws.
15) Consider/consent women of childbearing potential.
16) Manage conflict effectively.