Risk Mitigation Strategies to Reduce Opioid Overdoses

Clinician Outreach and Communication Activity (COCA) Call
December 6, 2016
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Planners have reviewed content to ensure there is no bias.

This presentation will include discussion of the unlabeled use of a product or products under investigational use.
Objectives

At the conclusion of this session, the participant will be able to:

- Describe the evidence for opioid prescribing risk mitigation strategies.
- Review different opioid prescribing risk mitigation strategies.
- Summarize steps that clinicians can take when concerning information is discovered through prescription drug monitoring program checks and urine drug testing.
- Evaluate factors that increase risk for opioid overdose and determine when co-prescribing naloxone would be beneficial.
Mark your calendar for the upcoming opioid prescribing call

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 6</td>
<td>Risk Mitigation Strategies</td>
</tr>
<tr>
<td>December 13</td>
<td>Effectively Communicating with Patients about Opioid Therapy</td>
</tr>
</tbody>
</table>
TODAY’S PRESENTER

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Today’s Presenter

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Disclaimer

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry.
CDC Guideline for Prescribing Opioids for Chronic Pain:

Risk mitigation strategies: Prescription Drug Monitoring Programs (PDMPs), urine drug testing, and naloxone

Deborah Dowell, MD, MPH

December 6, 2016
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/mmwr.html
JAMA: The Journal of American Medical Association

Deborah Dowell, Tamara Haegerich, and Roger Chou

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Published online March 15, 2016
Evidence

• Most fatal prescription opioid overdoses associated with*
  – high total daily opioid dosages and/or
  – receiving opioids from multiple sources
PDMP provides information on both these risk factors

• Urine drug tests can provide information about drug use that is not reported by the patient

• Naloxone distribution associated with decreased opioid overdose deaths at the community level**


Most prescription opioid overdose deaths involve multiple sources and/or high dosages

Check PDMP for high dosages and dangerous combinations

- Clinicians should review the patient’s history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

(Recommendation category A: Evidence type: 4)
If you find concerning information in the PDMP, take action to improve patient safety

• Discuss safety concerns including increased overdose risk
• For patients receiving high total opioid dosages
  – consider tapering to a safer dosage
  – consider offering naloxone
• Consider opioid use disorder and discuss concerns
• If patients are taking benzodiazepines with opioids
  – communicate with others managing the patient
  – weigh patient goals, needs, and risks
• Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions
**WHAT IS A PDMP?**

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

**WHEN SHOULD I CHECK THE PDMP?**

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

**WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?**

- **High Dosage**: Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients using 50 MME/day or more.
- **Multiple Providers**: Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.
- **Drug Interactions**: Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

**WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?**

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

1. **Confirm that the information in the PDMP is correct.** Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.
2. **Assess for possible misuse or abuse.** Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.
3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**
Test urine for prescribed opioids and other drugs

- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

(Recommendation category B: Evidence type: 4)
Initial urine drug testing

- Start with an immunoassay panel for
  - prescribed opioids
  - other controlled substances
  - illicit drugs that increase risk for overdose
- Do not test for drugs that would not affect patient management
- Be familiar with testing panels used in your practice and how to interpret results
Discussing urine drug testing with patients

• Explain that drug testing is used to improve safety
• Explain expected results
  – presence of prescribed medication
  – absence of unreported drugs, including illicit drugs
• Ask about use of prescribed and other drugs and if there might be unexpected results
• Provide an opportunity for patients to disclose changes in their use of prescribed opioids or other drugs
Confirming unexpected results

• Discuss unexpected results with
  – Local laboratory or toxicologist
  – Patient

• If unexpected results are not explained, confirm with a selective test such as gas or liquid chromatography/mass spectrometry
Use unexpected results to improve patient safety

• Do not dismiss patients from care based on a urine drug test result

• Consider as appropriate
  – Change in pain management strategy
  – Tapering and discontinuing opioids
  – More frequent re-evaluation
  – Offering naloxone
  – Treatment for substance use disorder
Evaluate and address risks for opioid-related harms

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (>50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A: Evidence type: 4)
How to prescribe naloxone

• Resources for prescribing naloxone available at http://prescribetoprevent.org
  – Sample prescribing directions
  – Information for patients and their family or household members
  – Information for pharmacists

• Naloxone co-prescribing can be facilitated by collaborative practice models with pharmacists
Risk mitigation strategies: Prescription Drug Monitoring Programs (PDMPs), urine drug testing, and naloxone

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Risk mitigation strategies: case

- Beth, a 65 year old woman with rheumatoid arthritis and mild joint deformity, who is transferring care due to insurance changes
- Adherent to disease-modifying RA treatment that has been partially effective
- Prescribed #60 oxycodone/acetaminophen 5/325 mg each month for 10 years and denies adverse effects or symptoms of opioid use disorder - total opioid dose 15 mg MED
- Has no prior urine testing, prescription drug monitoring program checks, or controlled substances agreement
Risk mitigation strategy outline

- Prescription drug monitoring programs (PDMP)
- Urine toxicology testing
- Controlled substances agreements
- Apply these strategies in a lower risk case
Strategy: prescription drug monitoring program

- Can identify patients with high risk prescribing
- From a state perspective, can identify very high risk patients who may require specific interventions
- States that require PDMP checks prior to prescribing show reduction in patients with multiple prescribers
- Some evidence that physicians who have access to PDMP data prior to prescribing may prescribe more opioids
- Results may be difficult to interpret
Strategy: prescription drug monitoring program

Case:
- Two prescriptions in the past year from a dentist for hydrocodone/acetaminophen 5/325 mg (#10)
- One prescription from an emergency department visit after an ankle sprain (oxycodone 5 mg #12)

Opportunity to discuss:
- Risks of co-prescribing of opioids
- Potential toxicity of additional acetaminophen
- Importance of patient reporting outside prescribing
- Document discussion in medical record
Strategy: urine toxicology testing

- Can assist in safety monitoring and diagnosing substance use disorders
- Complex to interpret
  - Screening tests vary in sensitivity and specificity
  - False positive and false negative results are common
  - Patterns of results more important than a single test
  - Best used as a trigger for closer follow up and repeat tests
Strategy: urine toxicology testing - Pitfalls

- **Opioids**
  - False positive: poppy seeds
  - False negative: oxycodone on opioid screens – need specific test

- **Amphetamine/methamphetamine**
  - False positive: bupropion, trazodone, decongestants, etc

- **Benzodiazepine**
  - False positive: sertraline
  - False negative: clonazepam, lorazepam
Case
- Urine toxicology negative for prescribed oxycodone
- Specific test also negative
- Patient reports taking medication prior to activity, not every day
- Low dose, intermittent use can result in negative tests

Urine toxicology testing can be useful for safely monitoring and addiction assessment, but many pitfalls

Discuss unexpected results with the lab you are using, as test characteristics vary
Strategy: controlled substances agreement

- Common approach to informing patients of opioid risks and clinic policies, and anticipating potential problems.
- Present rationale as providing informed consent for all patients regarding a potentially risky treatment.
- Emphasize no dose escalation without prior consultation – “let me be the doctor”.
- Can be coupled with assessment of patient side effects, ranging from sedation to constipation to depression to loss of control.
Strategy: controlled substances agreement

- Case:
  - In the last year or two, the patient has noted less energy and more difficulty concentrating later in the day after taking opioids
  - Almost fell after taking two tablets on an especially active day
  - Expresses interest in additional non-medication approaches
Risk mitigation strategies – conclusions

- Important components for monitoring safety of long term opioid prescribing
- Prescription drug monitoring program and urine toxicology checks can be useful, but their limitations must be understood
- Patient education about the risks of prescribing and clinic policies provides an opportunity to avoid problems and reconsider opioid prescribing
Risk mitigation strategies: Prescription Drug Monitoring Programs (PDMPs), urine drug testing, and naloxone

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Mr Thomas is a 46 yr old man with low back pain persisting for 8 yrs, and initiated when he was injured at work.

Apart from back pain, he has no other health issues and takes no medications other than opioids.

He has not worked since the injury.

He has some residual low back and left leg pain, and evidence on MRI of slight encroachment of L4 nerve root due to foraminal stenosis.
Safe management of high dose opioid case

- He is not considered a suitable candidate for surgery.
- Epidural steroid injections have provided some relief in the past but he is not interested in receiving any more injections because “it doesn’t last long enough to be worth it”.
- He has tried physical therapy, but feels that it has not helped and he is not willing to try more.
- He takes 30 mg methadone 3 times daily, plus oxycodone IR 10 mg, up to 6 daily
- Total opioid dose 1170mg MMD
He has always been a compliant patient, although he has not had a UDT since early in the course of treatment, the PDMP has never been checked, and there is no opioid agreement on file.

The provider recently learned about the CDC Guideline for Prescribing Opioids for Chronic Pain, and when looking at the CDC’s recommendations, realized that his patient was on opioid doses that were no longer considered safe.

What must the provider do now to improve the safety of the current regime?
First

- Speak to the patient and his family about the new information that has emerged about serious safety considerations related to high dose opioids.
- Explain that new measures need to be taken in order to comply with today’s standard of care.
- Explain that one measure will be to gradually taper the opioid to a safer dose, or to discontinuation.
- Explain that the taper can be done slowly so that there is no unpleasant withdrawal, that most people feel better on a lower dose, and that pain relief is not compromised.
First

- Prescribe naloxone and explain to patient and family why this has become necessary, and how and when to use it.

- If the patient is upset, wait until next visit to start the taper.
Evaluate for comorbidities that could increase risk

<table>
<thead>
<tr>
<th>Comorbidities</th>
<th>Recommended actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression or anxiety</td>
<td>Counseling and possible medication</td>
</tr>
<tr>
<td>PTSD or history of abuse/trauma</td>
<td>Consider psychiatric referral</td>
</tr>
<tr>
<td>Poor sleep</td>
<td>Consider sleep study, teach sleep hygiene</td>
</tr>
<tr>
<td>Sleep apnea</td>
<td>Consider formal assessment and treatment</td>
</tr>
<tr>
<td>Obesity</td>
<td>Consider nutritional consult</td>
</tr>
<tr>
<td>Constipation</td>
<td>Treat with diet, stool softener and gentle laxative</td>
</tr>
<tr>
<td>Risk of misuse or abuse</td>
<td>Get baseline from opioid risk screener</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Screen for reaction times, discuss driving risks</td>
</tr>
<tr>
<td>Dementia</td>
<td>Protect against falls</td>
</tr>
<tr>
<td>Medication issues</td>
<td>CNS depressants, anticholinergics</td>
</tr>
</tbody>
</table>
Third

- Get a baseline UDT
- Check the PDMP
- Write up a goal directed opioid agreement and explain why it is needed
Explain tapering options:

1) Slow taper starting with either long acting or short acting (not both)
2) Rapid taper with suboxone induction (not option if tapering methadone)
3) Adjuncts for depression or anxiety during taper (eg small dose of TCA)
4) If also on a benzodiazepine, choose between opioid and benzodiazepine
Depending on results of UDT, PDMP and medical evaluation, decide upon:

- speed of taper
- possible need for immediate discontinuation (rare, only if needed for safety)
- future frequency of provision of prescriptions
- UDT schedule
- PDMP review schedule
- need for additional providers (eg psychology/psychiatry, PT, group therapy)
If addiction is diagnosed, refer for addiction treatment and do not prescribe opioids for pain once addiction treatment is started. Continue treating pain using non-opioid modalities.
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- **Using the Webinar System**
  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
  - “Type” your question
  - “Click” ask

- **On the Phone**
  - Press Star (*) 1 to enter the queue
  - State your name
  - Listen for the operator to call your name
  - State your organization and then ask your question
Thank you for joining!

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**What:** All call recordings (audio, webinar, and transcript)

**Where:** On the COCA Call webpage

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<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 22</td>
<td>Guideline for Prescribing Opioids for Chronic Pain</td>
</tr>
<tr>
<td>July 27</td>
<td>Non-Opioid Treatments</td>
</tr>
<tr>
<td>August 3</td>
<td>Assessing Benefits and Harms of Opioid Therapy</td>
</tr>
<tr>
<td>August 17</td>
<td>Dosing and Titration of Opioids</td>
</tr>
<tr>
<td>November 29</td>
<td>Assessment and Evidence-based Treatments for Opioid Use Disorder</td>
</tr>
</tbody>
</table>
Upcoming COCA Call
registration is not required

Gearing up for the Travel Season: How Clinicians Can Ensure Their Patients are Packed with Knowledge on Zika Prevention

- **Date:** Thursday, December 8, 2016
- **Time:** 2:00 – 3:00 pm (Eastern)
- **Presenters:**
  - Dr. Mary Tanner – CDC
  - Dr. Allison Taylor Walker – CDC

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