Updates in the Opioid Epidemic

Chairperson: Judge Omar Hernandez

Tuesday, May 1st

3:50 – 4:25 pm

MA Utilization Review Regulations & Treatment Guidelines

Diane Neelon

Work Related Injuries Workshop
April 30th & May 1st, 2018

Opioid Alternative Treatment Pathway

Judge Omar Hernandez

Work Related Injuries Workshop
April 30th & May 1st, 2018

Changing Provider Practice Patterns: An Update on Vermont's "Best Practices" Rule

Hon. Phyllis G. Phillips
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Work Related Injuries Workshop
April 30th & May 1st, 2018

The Good News:

- BC/BS of Vermont reports a **20 percent decline** in the number of opioid prescriptions written in the last six months of 2017. Officials attribute this to new rules implemented by the Vermont Dept. of Health governing the **prescribing of opioids for acute pain**.

The Bad News:

- So much work remains to be done, particularly with primary care providers who are prescribing opioids for chronic pain and don't seem to know **how to safely taper**.
- Per *CDC Guideline for Prescribing Opioids for Chronic Pain* (2016) – "Opioid therapy should not be initiated without consideration of an **'exit strategy'** to be used if the therapy is unsuccessful."

Combating the Opioid Epidemic

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Work Related Injuries Workshop
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Disclosures

- 1. I have nothing to disclose
- 2. There is no commercial support for this talk

4 pillars

- 1) Only prescribe opioids when absolutely appropriate
- 2) Offer a prescription for Narcan and education on its use to anyone receiving an opioid prescription.
- 3) Have a working knowledge of therapies which are alternatives to opioids.
- 4) Bring in psychological services sooner than later (including Medication Assisted Treatment).

1) Appropriate use of Opioids

- This is up for debate!!
- 4 areas in which the benefits of opioids likely outweigh the risks (Cancer-related pain, Chemotherapy related pain, acute pain from a severe injury (short term), and acute pain from a significant surgery (short term)). The data on the use of opioids for chronic non-cancer pain is not supportive of its wide-spread use.

From the CDC Guidelines on Opioid use

- "Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate."

Best practices

- Evaluate previous note for red flags prior to prescribing
- Complete a risk profile
- Set up a Treatment plan and monitor functional benefits
- Fully inform the patient of risks/benefits of the therapy
- Check the PDMP
- Utilize Urine drug screens
- Individualize prescriptions
- Utilize pill counts
- Assure that the patient has his/her medication safely stored and knows how to properly dispose of them if needed.

2) Offer a prescription for Narcan and education on its use to anyone receiving an opioid prescription.

- The AMA Opioid Task Force encourages physicians to consider co-prescribing naloxone when it is clinically appropriate to do so.
- Co-prescribing naloxone is supported by a broad range of stakeholders including the World Health Organization, U.S. health agencies (CDC, SAMHSA), state departments of health, and many patient, consumer and other advocacy groups.

Example of a Risk Profile

- ***Opioid Risk Tool (ORT):***
- **Family history of substance abuse:** Alcohol (3), Illegal drugs (2), Prescription drugs (4)
- **Personal history of substance abuse:** Alcohol (3), Illegal drugs (4), Prescription drugs (5)
- **Age** Between16-45 years old? (1)
- **History of preadolescent sexual abuse?** (3 -> females only)
- **History of psychological disease:** ADD (2), OCD (2),Bipolar (2), Schizophrenia (2),Depression (1)
- **Total Risk Score Categories:** Low= 0-3, moderate= 4-7, High= >7

- ***Suicide/Homicide Thoughts/Plans?***
- ***State(s) controlled substance registry was reviewed today***: Inconsistencies?
- ***Previous prescribers:*** **Medical records reviewed?** **Worrisome findings?**
- ***Other significant history***
- History of incarceration?
- History of discharge from another pain provider?
- History of an inconsistent Urine Drug Screen?
- **Urine drug screen collected?**
- **Overall assessment of risk:**
- **Medication contract signed?**

3) Have a working knowledge of therapies which are alternatives to opioids.

- Know which therapies have evidence to back them up (the ODG is a good source).
- Know which therapies are available within close proximity to your patient
- Know which therapies are covered by medical insurance.

4) Bring in psychological services sooner than later.

- Per the ODG “Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work.”

A word on Opioid Use Disorder

- "We must all confront the intangible and often devastating effects of stigma. The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment."
- > Patrice A. Harris, MD, MA, chair AMA Opioid Task Force

Medication Assistance Treatment (MAT)

- According to the CDC: "Clinicians should offer a range of evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with Opioid Use Disorder."

Thank you for your dedication!

Questions?

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