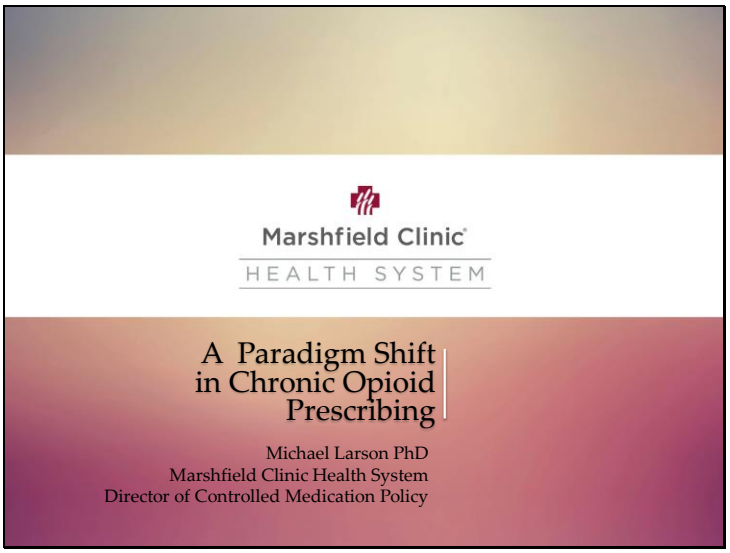
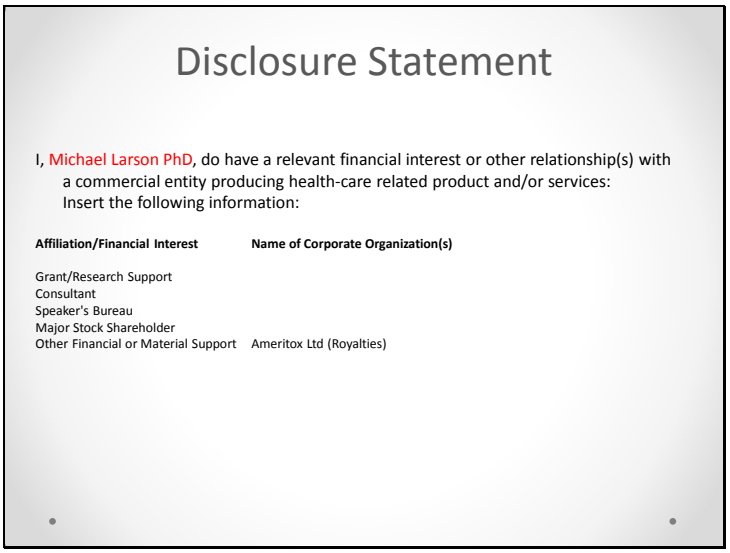
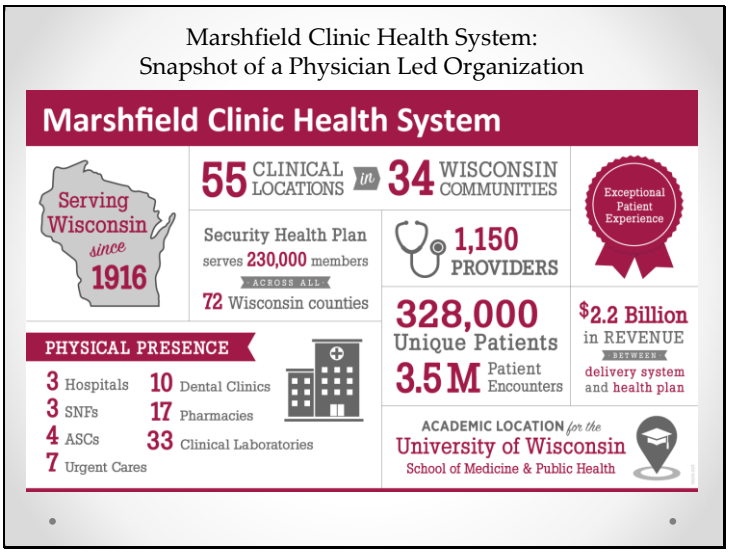
Slide 1


Marshfield Clinic
HEALTH SYSTEM
A Paradigm Shift in Chronic Opioid Prescribing
Michael Larson PhD
Marshfield Clinic Health System
Director of Controlled Medication Policy

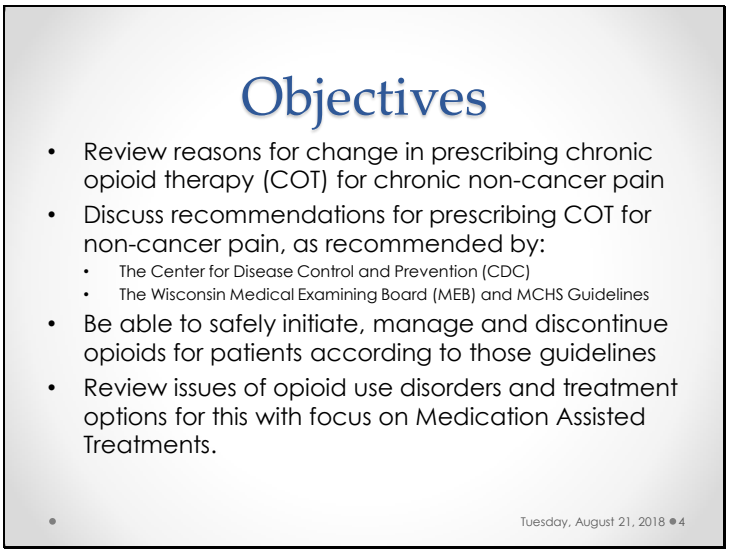
Slide 2


Disclosure Statement
I, Michael Larson PhD, do have a relevant financial interest or other relationship(s) with a commercial entity producing health-care related product and/or services:
Insert the following information:
Affiliation/Financial Interest
Name of Corporate Organization(s)
Grant/Research Support
Consultant
Speaker's Bureau
Major Stock Shareholder
Other Financial or Material Support
Ameritox Ltd (Royalties)

Slide 3


Marshfield Clinic Health System:
Snapshot of a Physician Led Organization
Marshfield Clinic Health System
Serving Wisconsin since 1916
55 CLINICAL LOCATIONS in 34 WISCONSIN COMMUNITIES
Exceptional Patient Experience
Security Health Plan serves 230,000 members
ACROSS ALL
72 Wisconsin counties
1,150 PROVIDERS
328,000 Unique Patients
3.5 M Patient Encounters
$2.2 Billion in REVENUE
BETWEEN
delivery system and health plan
PHYSICAL PRESENCE
3 Hospitals
3 SNFs
4 ASCs
7 Urgent Cares
10 Dental Clinics
17 Pharmacies
33 Clinical Laboratories
ACADEMIC LOCATION for the University of Wisconsin School of Medicine & Public Health

Slide 4


Objectives
• Review reasons for change in prescribing chronic opioid therapy (COT) for chronic non-cancer pain
• Discuss recommendations for prescribing COT for non-cancer pain, as recommended by:
• The Center for Disease Control and Prevention (CDC)
• The Wisconsin Medical Examining Board (MEB) and MCHS Guidelines
• Be able to safely initiate, manage and discontinue opioids for patients according to those guidelines
• Review issues of opioid use disorders and treatment options for this with focus on Medication Assisted Treatments.
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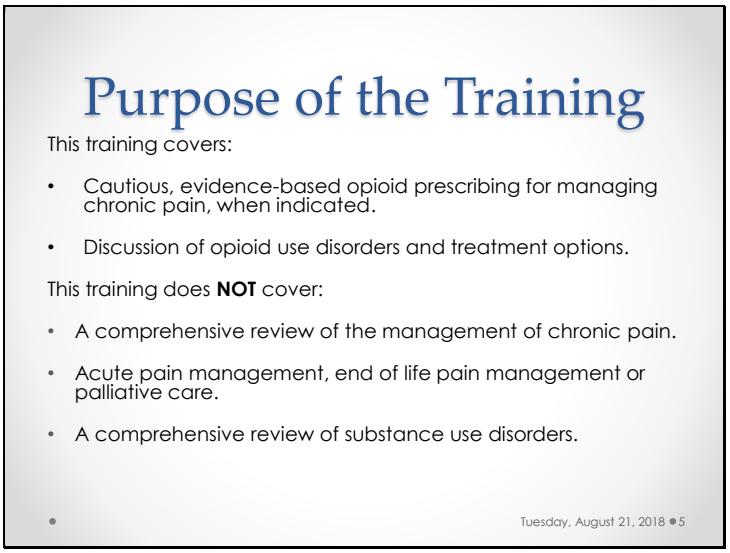
Slide 5


Purpose of the Training
This training covers:
• Cautious, evidence-based opioid prescribing for managing chronic pain, when indicated.
• Discussion of opioid use disorders and treatment options.
This training does **NOT** cover:
• A comprehensive review of the management of chronic pain.
• Acute pain management, end of life pain management or palliative care.
• A comprehensive review of substance use disorders.
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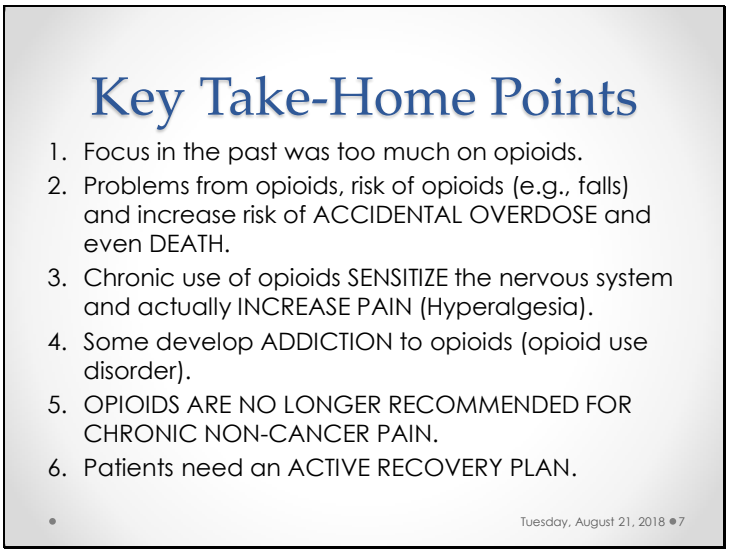
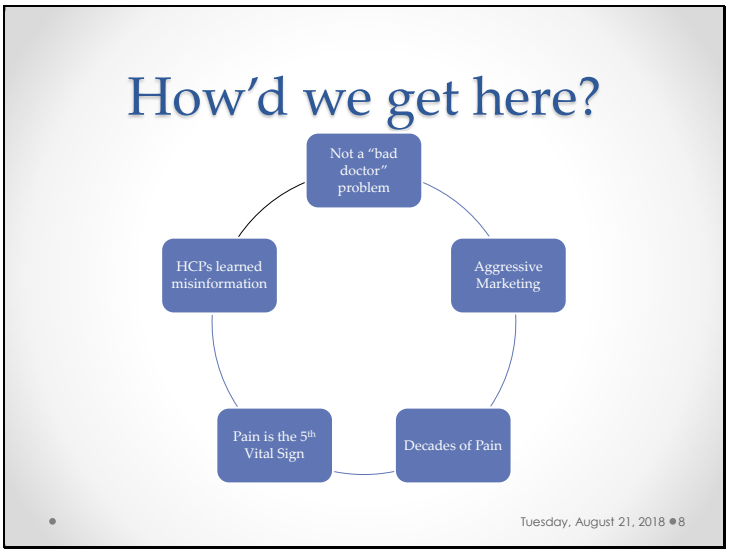
Good Video
Understanding Pain:
Brainman stops his opioids
https://www.youtube.com/watch?v=MI1myFQPdCE

Slide 7


Key Take-Home Points
1. Focus in the past was too much on opioids.
2. Problems from opioids, risk of opioids (e.g., falls) and increase risk of ACCIDENTAL OVERDOSE and even DEATH.
3. Chronic use of opioids SENSITIZE the nervous system and actually INCREASE PAIN (Hyperalgesia).
4. Some develop ADDICTION to opioids (opioid use disorder).
5. OPIOIDS ARE NO LONGER RECOMMENDED FOR CHRONIC NON-CANCER PAIN.
6. Patients need an ACTIVE RECOVERY PLAN.
Tuesday, August 21, 2018 7

Slide 8


How'd we get here?
Not a "bad doctor" problem
Aggressive Marketing
Decades of Pain
Pain is the 5th Vital Sign
HCPs learned misinformation
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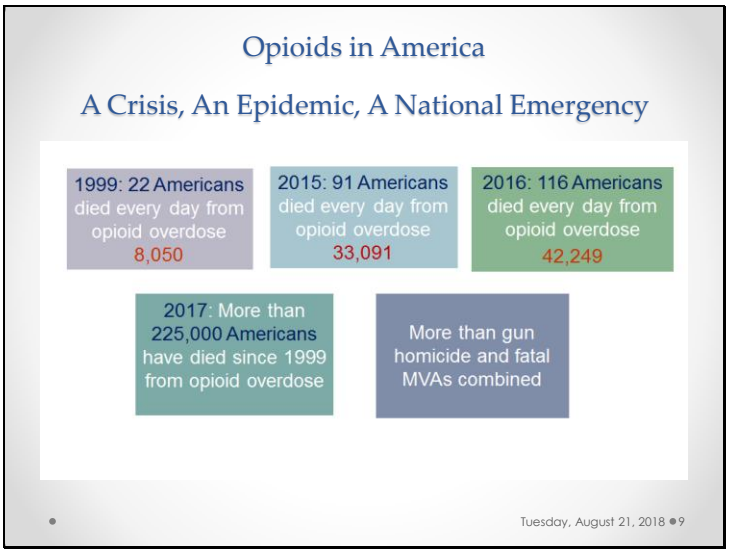
Slide 9


Opioids in America
A Crisis, An Epidemic, A National Emergency
1999: 22 Americans died every day from opioid overdose 8,050
2015: 91 Americans died every day from opioid overdose 33,091
2016: 116 Americans died every day from opioid overdose 42,249
2017: More than 225,000 Americans have died since 1999 from opioid overdose
More than gun homicide and fatal MVAs combined
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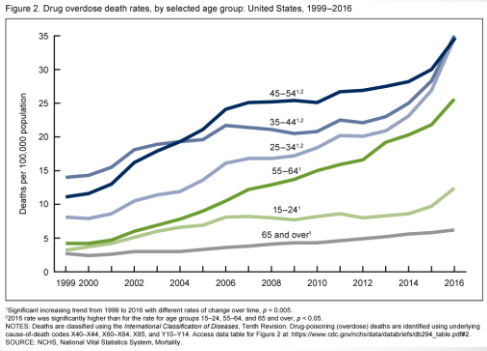
Slide 10

CDC: Drug Overdose Deaths by Age Group (1999-2016)

Highest overall rate of fatal overdose in **ages 25-54**



https://www.cdc.gov/nchs/products/databriefs/db294.htm

Slide 11

Wisconsin Data

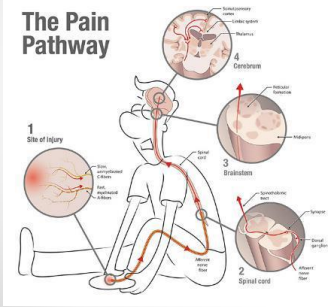
The age-adjusted rates of **drug overdose deaths increased 72 percent** from 2007 to 2016. Both illicit and prescription drug deaths are contributing to this epidemic.

The age-adjusted **mortality rate was 38 percent higher for males than for females**.

Slide 12

What we learned about Acute Pain

Bio-Medical Model



Injury

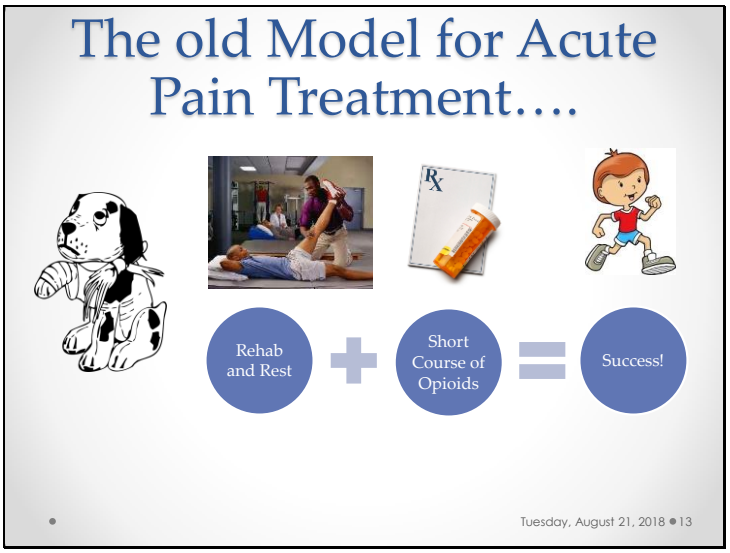
↓

Chemical signals sent to Brain

↓

Ouch!

Slide 13


The old Model for Acute Pain Treatment….
Rehab and Rest
Short Course of Opioids
Success!
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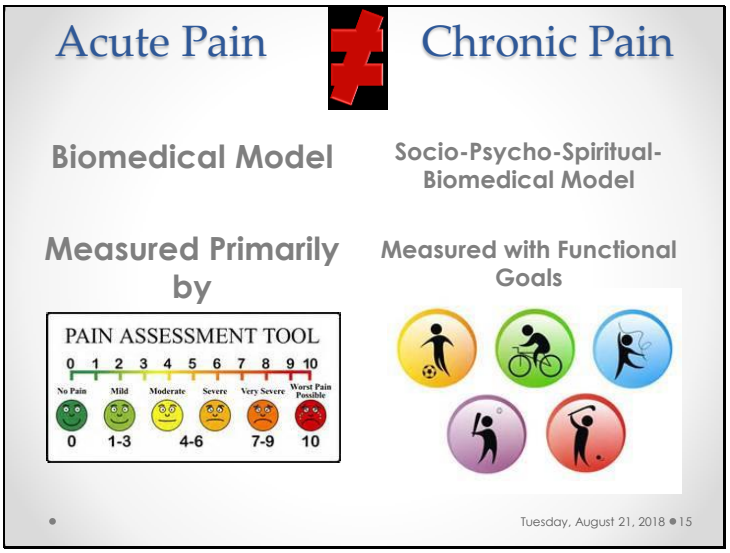
So we tried this same model for chronic pain….

But it didn't work. Why???

Slide 15


Acute Pain
Chronic Pain
Biomedical Model
Socio-Psycho-Spiritual-Biomedical Model
Measured Primarily by
Measured with Functional Goals
PAIN ASSESSMENT TOOL
0 1 2 3 4 5 6 7 8 9 10
No Pain
Mild
Moderate
Severe
Very Severe
Worst Pain Possible
0
1-3
4-6
7-9
10
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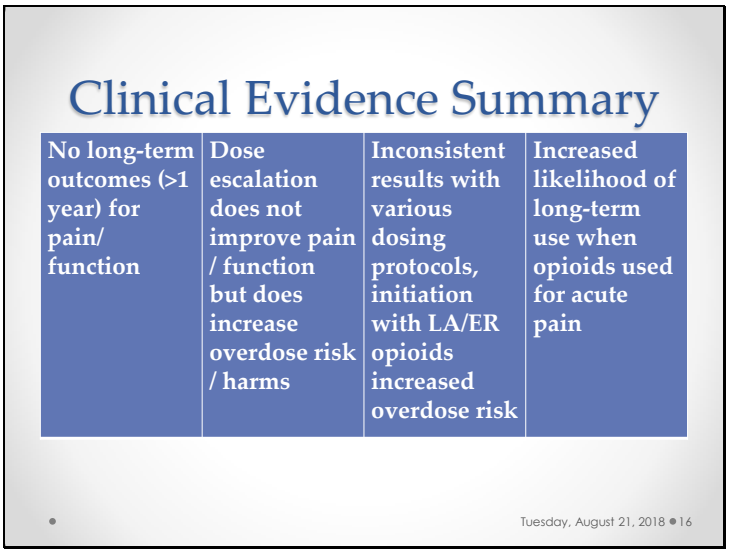
Slide 16


Clinical Evidence Summary
No long-term outcomes (>1 year) for pain/ function
Dose escalation does not improve pain / function but does increase overdose risk / harms
Inconsistent results with various dosing protocols, initiation with LA/ER opioids increased overdose risk
Increased likelihood of long-term use when opioids used for acute pain
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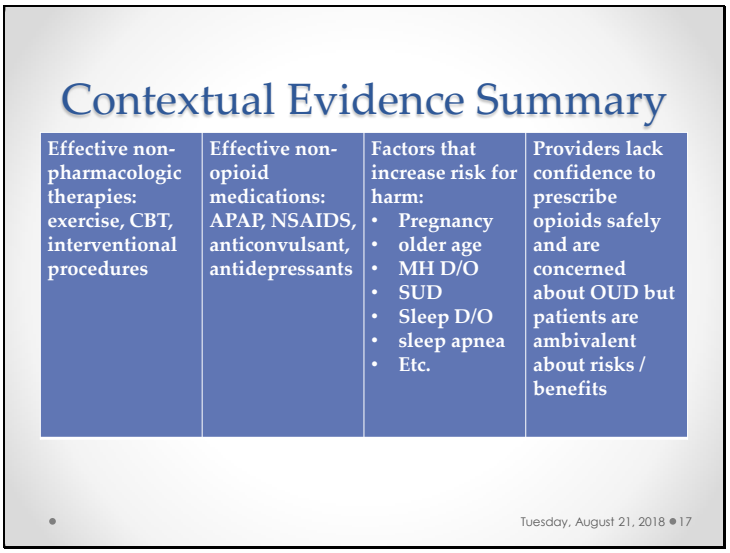
Contextual Evidence Summary
Effective non-pharmacologic therapies: exercise, CBT, interventional procedures
Effective non-opioid medications: APAP, NSAIDS, anticonvulsant, antidepressants
Factors that increase risk for harm:
• Pregnancy
• older age
• MH D/O
• SUD
• Sleep D/O
• sleep apnea
• Etc.
Providers lack confidence to prescribe opioids safely and are concerned about OUD but patients are ambivalent about risks / benefits
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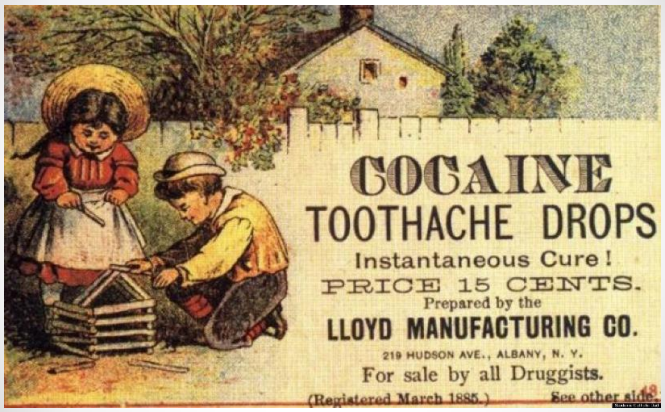
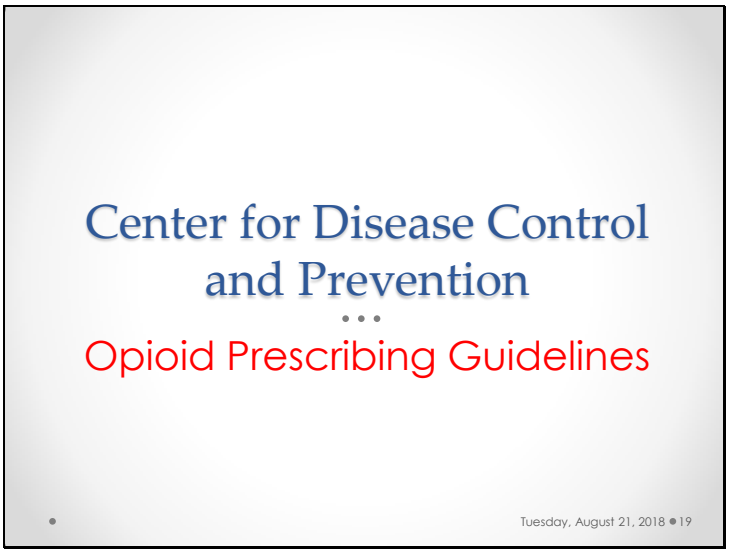
Things Change



Slide 19


Center for Disease Control and Prevention
Opioid Prescribing Guidelines
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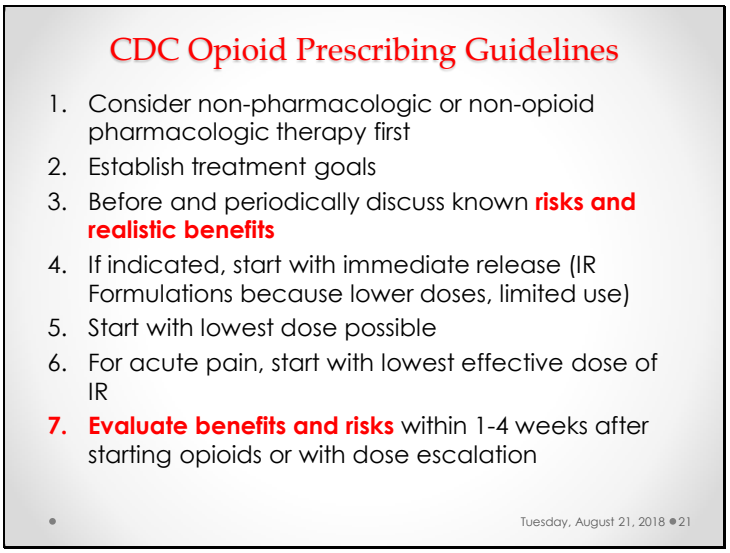
Slide 20

CDC Opioid Guidelines:

Online and now Mobile App

- MME Calculator
- Prescribing Guidance
- Motivational Interviewing Interactive Tool

Slide 21


CDC Opioid Prescribing Guidelines
1. Consider non-pharmacologic or non-opioid pharmacologic therapy first
2. Establish treatment goals
3. Before and periodically discuss known risks and realistic benefits
4. If indicated, start with immediate release (IR Formulations because lower doses, limited use)
5. Start with lowest dose possible
6. For acute pain, start with lowest effective dose of IR
7. Evaluate benefits and risks within 1-4 weeks after starting opioids or with dose escalation
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Center for disease control and prevention
opioid prescribing guidelines
8. Before starting and continually throughout:
• Evaluate risk factors
• Incorporate strategies to mitigate risk
9. Use PDMP before initiating and periodically
10. Use Urine Drug testing (Annually is recommended)
11. Avoid prescribing opioid and benzodiazepines concurrently (New JAMA study examines risk further)
• Boxed Warning regarding the combination of opiates and benzodiazepines
• http://www.fda.gov/Drugs/DrugSafety/ucm518473.htm
12. Offer treatment for opioid use disorder
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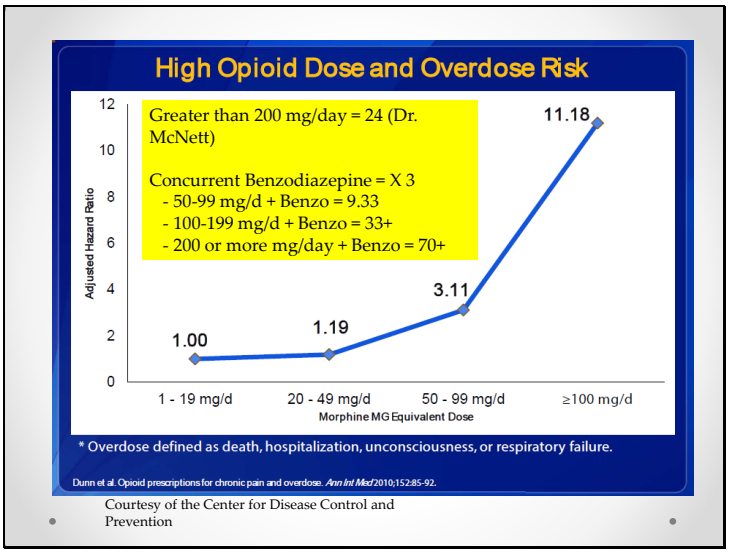

Courtesy of the Center for Disease Control and Prevention

Slide 24

Conversion to Morphine Milligram Equivalents (MMEs)

This is not a conversion table, only to calculate MMEs

Medication	Total Daily Dose X Multiplier	Total Daily 50 mg MMEs	Total Daily 90 mg MMEs	Total Daily 200 mg MMEs
Codeine	x 0.15	333 mg	600 mg	1333
Fentanyl Patch (mcg)	x 2.4	25 mcg (=60 mg MMEs)	37.5 mcg	75-100 mcg
Hydrocodone	x 1	50 mg	90 mg	200 mg
Hydromorphone	x 4	12.5 mg	22.5 mg	50 mg
Butrans (mcg)	x 1.8	27.8 mcg	50 mcg	111 mcg
Morphine	x 1	50 mg	90 mg	200 mg
Oxycodone	x 1.5	33.3 mg	60 mg	133.2 mg
Oxymorphone	x 3	16.7 mg	30 mg	66.8 mg
Tapentadol	x 0.4	125 mg	225 mg	500 mg
Tramadol	x 0.2	250 mg	450 mg	1000 mg

CDC Learn More: www.cdc.gov/drugoverdose/prescribing/guideline.html

Slide 25

Conversion to Morphine Milligram Equivalents (MMEs)

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Medication	Total Daily Dose X Multiplier	Total Daily 50 mg MMEs	Total Daily 90 mg MMEs	Total Daily 200 mg MMEs
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CDC Learn More: www.cdc.gov/drugoverdose/prescribing/guideline.html

Slide 26

Conversion to Morphine Milligram Equivalents (MMEs)

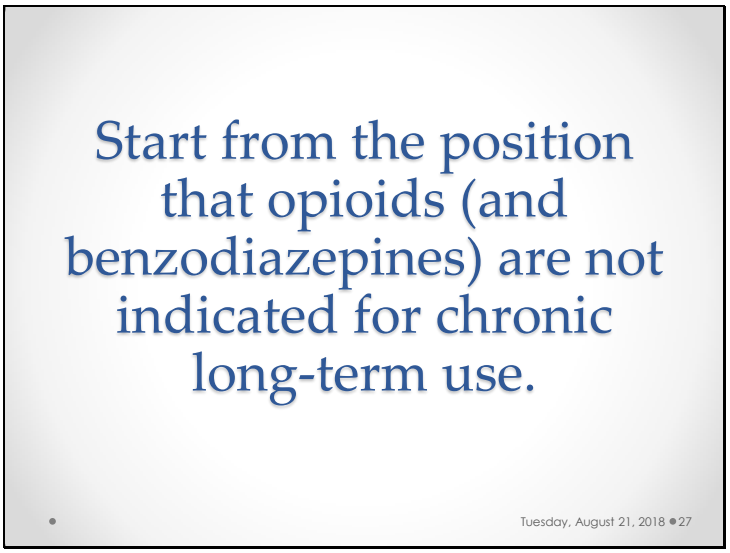
This is not a conversion table, only to calculate MMEs

Medication	Total Daily Dose X Multiplier	Total Daily 50 mg MMEs	Total Daily 90 mg MMEs	Total Daily 200 mg MMEs
Methadone				
1-20 mg/day	x 4	12.5 mg	20+* mg	
21-40 mg/day	x 8			25* mg
41-60 mg/day	x 10			
>/=61	x 12			

Methadone: The conversion factor increases at higher doses. *Due to this, the calculation of MME is different than other medications.

CDC Learn More: www.cdc.gov/drugoverdose/prescribing/guideline.html

Slide 27


Start from the position that opioids (and benzodiazepines) are not indicated for chronic long-term use.
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Wisconsin Medical Examining Board (MEB) and MCHS
Opioid Prescribing Guidelines
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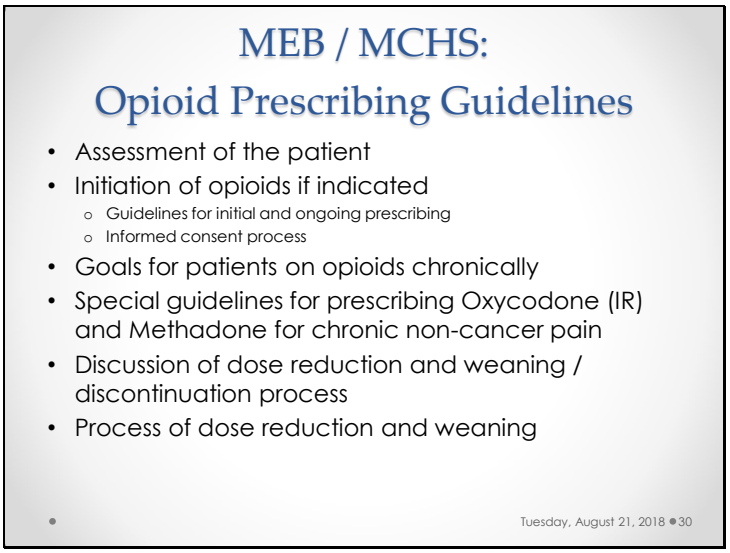
Summary of new guidelines regarding opioids

1. Chronic Opioid Therapy (COT) is not indicated for chronic non-cancer pain.
2. If COT is used, prescribe the lowest effective dose, keeping below 50 mg of morphine milligrams equivalent (MME) for risk mitigation.
3. If COT is used at a higher dose that is associated with increased risk for unintentional overdose (50-90 mg of MME) then mitigate risk by prescribing Naloxone.
4. COT at a dose above 90 mg MME is CONTRAINDICATED due to risk and likelihood of opioid induced hyperalgesia (requires informed consent process).
5. COT combined with benzodiazepines is CONTRAINDICATED due to increased risk of unintentional overdose due to combination (requires informed consent process).

Slide 30


MEB / MCHS:
Opioid Prescribing Guidelines
• Assessment of the patient
• Initiation of opioids if indicated
o Guidelines for initial and ongoing prescribing
o Informed consent process
• Goals for patients on opioids chronically
• Special guidelines for prescribing Oxycodone (IR) and Methadone for chronic non-cancer pain
• Discussion of dose reduction and weaning / discontinuation process
• Process of dose reduction and weaning
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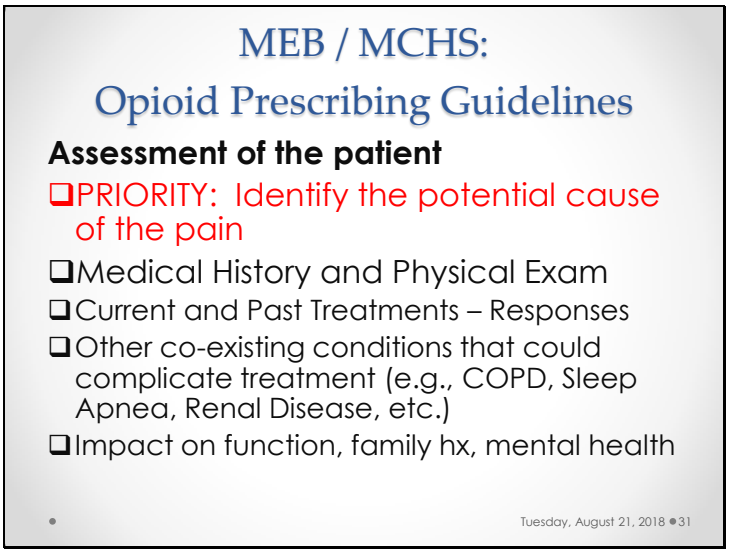
MEB / MCHS:
Opioid Prescribing Guidelines
Assessment of the patient
PRIORITY: Identify the potential cause of the pain
Medical History and Physical Exam
Current and Past Treatments – Responses
Other co-existing conditions that could complicate treatment (e.g., COPD, Sleep Apnea, Renal Disease, etc.)
Impact on function, family hx, mental health
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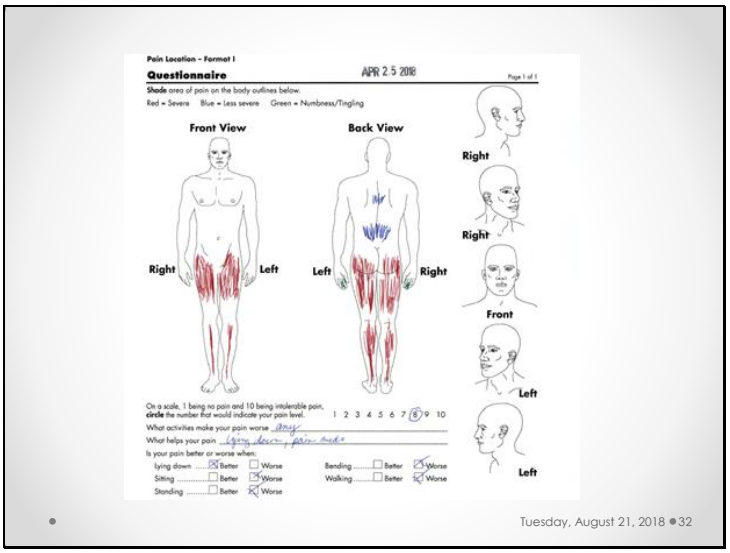
Pain Location – Format 1
Questionnaire
APR 2 5 2018
Page 1 of 1
Shade area of pain on the body outlines below.
Red = Severe Blue = Less severe Green = Numbness/Tingling
Front View
Back View
Right
Left
Left
Right
Right
Right
Front
Left
Left
On a scale, 1 being no pain and 10 being intolerable pain, circle the number that would indicate your pain level.
1 2 3 4 5 6 7 8 9 10
What activities make your pain worse
What helps your pain
Is your pain better or worse when:
Lying down Better Worse
Sitting Better Worse
Standing Better Worse
Bending Better Worse
Walking Better Worse

Slide 33

Assess benefits of current treatment plan

Use Pain Enjoyment General Activity (PEG) Assessment instead of simple pain score

Questions	Score
1) **What number best describes your Pain on average in the past week?** (from 0=no pain to 10=pain as bad as you can imagine)	
2) What number best describes how, during the past week, pain has **interfered with your Enjoyment of life?** (from 0=does not interfere to 10=completely interferes)	
3) What number best describes how, during the past week, pain has **interfered with your General activity?** (from 0=does not interfere to 10=completely interferes)	
Total	

A 30% improvement in PEG Score is considered clinically meaningful.

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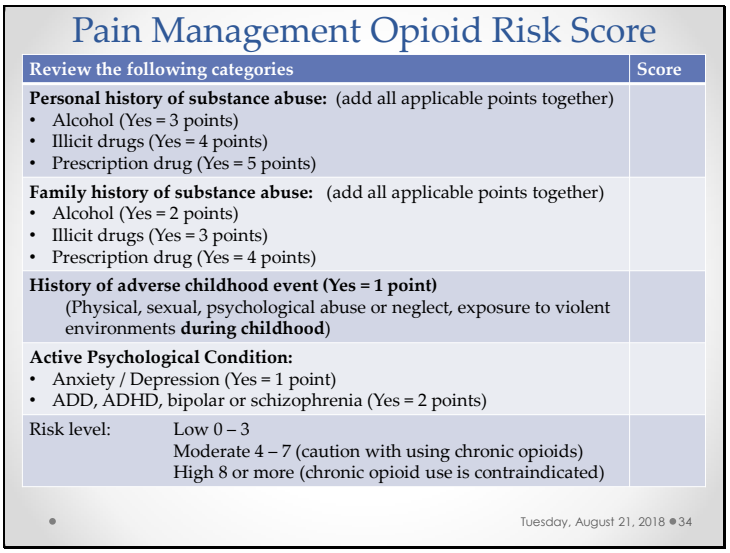

Pain Management Opioid Risk Score

Review the following categories	Score
Personal history of substance abuse: (add all applicable points together) • Alcohol (Yes = 3 points) • Illicit drugs (Yes = 4 points) • Prescription drug (Yes = 5 points)	
Family history of substance abuse: (add all applicable points together) • Alcohol (Yes = 2 points) • Illicit drugs (Yes = 3 points) • Prescription drug (Yes = 4 points)	
History of adverse childhood event (Yes = 1 point) (Physical, sexual, psychological abuse or neglect, exposure to violent environments **during childhood**)	
Active Psychological Condition: • Anxiety / Depression (Yes = 1 point) • ADD, ADHD, bipolar or schizophrenia (Yes = 2 points)	
Risk level: Low 0 – 3 Moderate 4 – 7 (caution with using chronic opioids) High 8 or more (chronic opioid use is contraindicated)	

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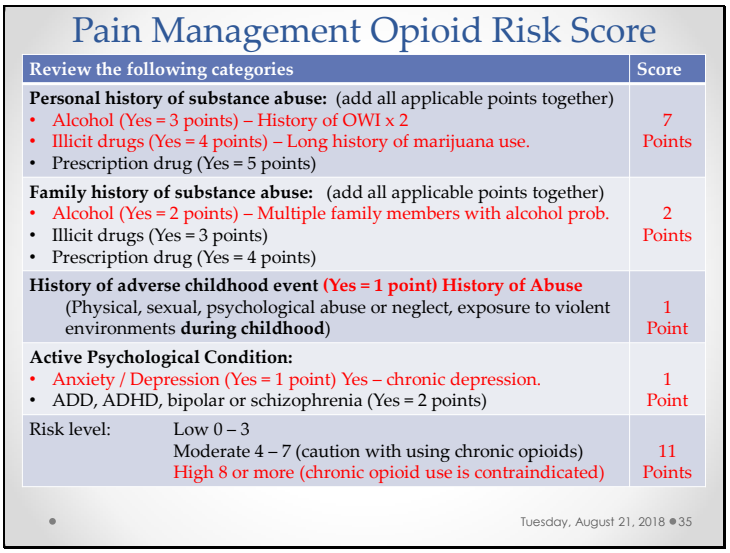

Pain Management Opioid Risk Score

Review the following categories	Score
Personal history of substance abuse: (add all applicable points together) • Alcohol (Yes = 3 points) – History of OWI x 2 • Illicit drugs (Yes = 4 points) – Long history of marijuana use. • Prescription drug (Yes = 5 points)	7 Points
Family history of substance abuse: (add all applicable points together) • Alcohol (Yes = 2 points) – Multiple family members with alcohol prob. • Illicit drugs (Yes = 3 points) • Prescription drug (Yes = 4 points)	2 Points
History of adverse childhood event (Yes = 1 point) History of Abuse (Physical, sexual, psychological abuse or neglect, exposure to violent environments **during childhood**)	1 Point
Active Psychological Condition: • Anxiety / Depression (Yes = 1 point) Yes – chronic depression. • ADD, ADHD, bipolar or schizophrenia (Yes = 2 points)	1 Point
Risk level: Low 0 – 3 Moderate 4 – 7 (caution with using chronic opioids) High 8 or more (chronic opioid use is contraindicated)	11 Points

Slide 36


Assess Risk of Overdose
Consider the RIOSORD: Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression
• Assess risk for accidental overdose.
• Zedler, et. al., Pain Medicine 2015; 16: 1566-1579 (article in Toolkit)
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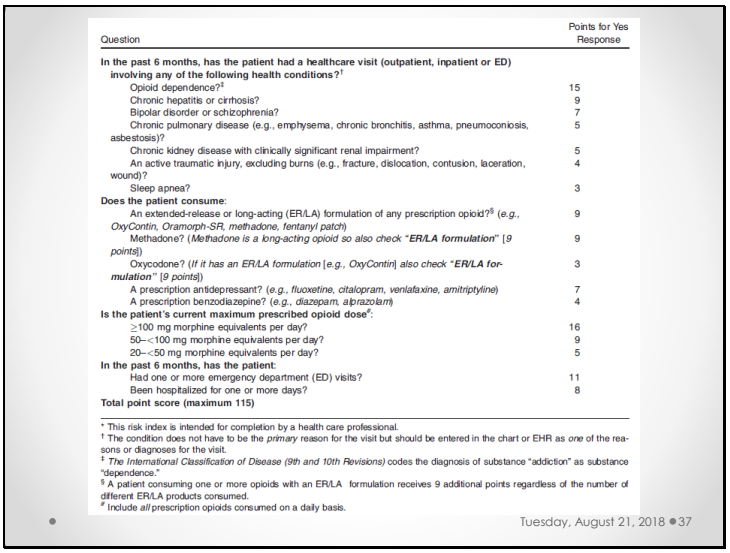

Question	Points for Yes Response
In the past 6 months, has the patient had a healthcare visit (outpatient, inpatient or ED) involving any of the following health conditions?†	
Opioid dependence?‡	15
Chronic hepatitis or cirrhosis?	9
Bipolar disorder or schizophrenia?	7
Chronic pulmonary disease (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)?	5
Chronic kidney disease with clinically significant renal impairment?	5
An active traumatic injury, excluding burns (e.g., fracture, dislocation, contusion, laceration, wound)?	4
Sleep apnea?	3
Does the patient consume:	
An extended-release or long-acting (ER/LA) formulation of any prescription opioid?§ (*e.g., OxyContin, Oramorph-SR, methadone, fentanyl patch*)	9
Methadone? (*Methadone is a long-acting opioid so also check "**ER/LA formulation**" [9 points]*)	9
Oxycodone? (*If it has an ER/LA formulation [e.g., OxyContin] also check "**ER/LA formulation**" [9 points]*)	3
A prescription antidepressant? (*e.g., fluoxetine, citalopram, venlafaxine, amitriptyline*)	7
A prescription benzodiazepine? (*e.g., diazepam, alprazolam*)	4
Is the patient's current maximum prescribed opioid dose#:	
≥100 mg morphine equivalents per day?	16
50–<100 mg morphine equivalents per day?	9
20–<50 mg morphine equivalents per day?	5
In the past 6 months, has the patient:	
Had one or more emergency department (ED) visits?	11
Been hospitalized for one or more days?	8
Total point score (maximum 115)	

* This risk index is intended for completion by a health care professional.
† The condition does not have to be the *primary* reason for the visit but should be entered in the chart or EHR as *one* of the reasons or diagnoses for the visit.
‡ *The International Classification of Disease (9th and 10th Revisions)* codes the diagnosis of substance "addiction" as substance "dependence."
§ A patient consuming one or more opioids with an ER/LA formulation receives 9 additional points regardless of the number of different ER/LA products consumed.
# Include *all* prescription opioids consumed on a daily basis.

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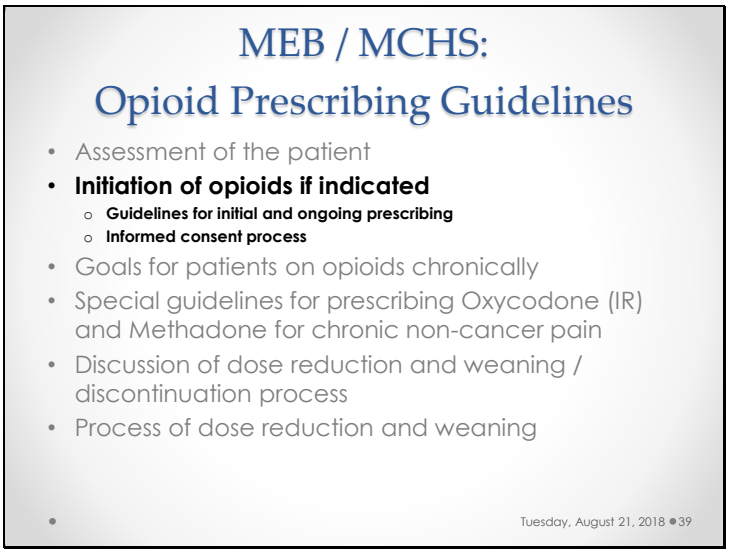
Opioid Induced Respiratory Depression (OIRD) Probability based on Calculated Risk Index

Risk Index Score	OIRD Probability (%)
0-24	3
25-32	14
33-37	23
38-42	37
43-46	51
47-49	55
50-54	60
55-59	79
60-66	75
>66	86

Slide 39


MEB / MCHS:
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• Process of dose reduction and weaning
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MEB / MCHS:
Opioid Prescribing Guidelines

Initiation of opioids if indicated - Guidelines for initial and ongoing prescribing

- Review and Sign Medication Treatment Agreement
  - This should be REVIEWED AND SIGNED when the patient:
    - **HAS been on prescribed opioids or tramadol (or a benzodiazepine or stimulant) for GREATER THAN 3 months** OR
    - **The plan is that they WILL BE ON one of those medications for GREATER THAN 3 months**
- Review ePDMP website ON DATE that prescription is written
- May consider a Urine Drug Test (UDT) here (if concerns about illicit substance use) OR could do after on medication (must be done ANNUALLY)

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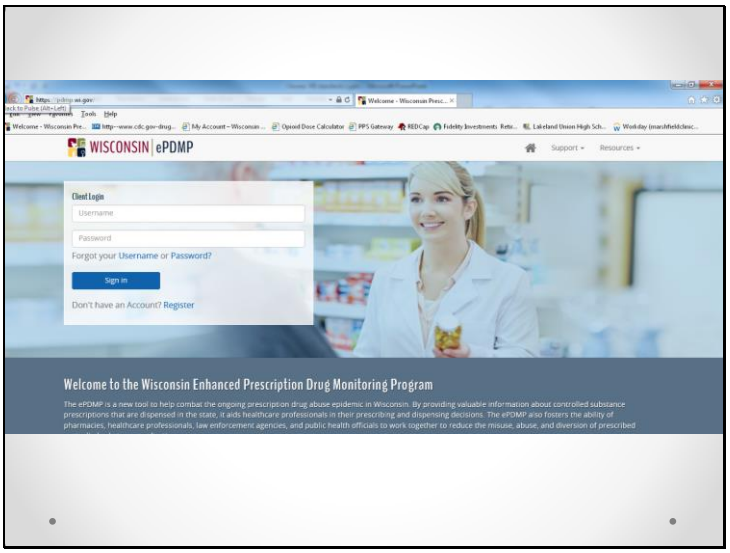
WISCONSIN | ePDMP
Support
Resources
Client Login
Username
Password
Forgot your Username or Password?
Sign in
Don't have an Account? Register
Welcome to the Wisconsin Enhanced Prescription Drug Monitoring Program
The ePDMP is a new tool to help combat the ongoing prescription drug abuse epidemic in Wisconsin. By providing valuable information about controlled substance prescriptions that are dispensed in the state, it aids healthcare professionals in their prescribing and dispensing decisions. The ePDMP also fosters the ability of pharmacies, healthcare professionals, law enforcement agencies, and public health officials to work together to reduce the misuse, abuse, and diversion of prescribed

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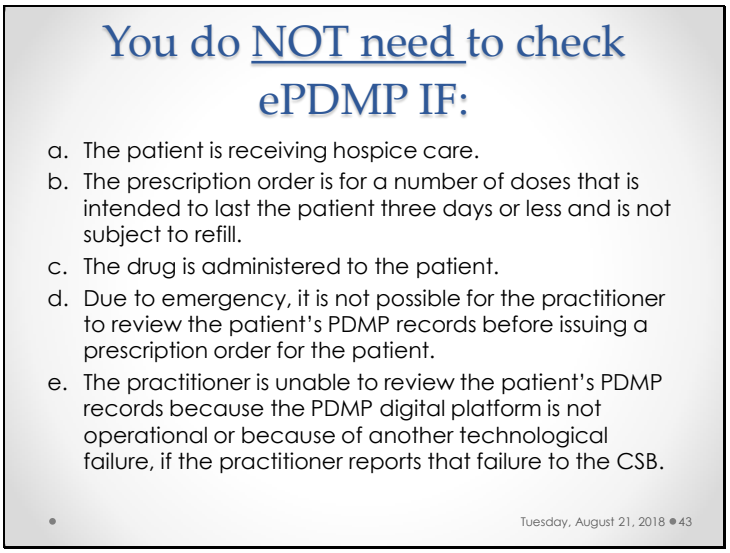
Please Add Delegates

Assign Delegates

- These are your support staff (CMAs, LPNs, RNs) that assist in checking the PDMP and/or preparing prescriptions. RNs can be a delegate or have an individual account.
- **Managers** please assist your prescribers in identifying their delegates.
- **Login** to the Wisconsin PDMP website (Login) and follow the steps under Delegate Management.

Slide 43


You do NOT need to check ePDMP IF:
a. The patient is receiving hospice care.
b. The prescription order is for a number of doses that is intended to last the patient three days or less and is not subject to refill.
c. The drug is administered to the patient.
d. Due to emergency, it is not possible for the practitioner to review the patient's PDMP records before issuing a prescription order for the patient.
e. The practitioner is unable to review the patient's PDMP records because the PDMP digital platform is not operational or because of another technological failure, if the practitioner reports that failure to the CSB.
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Final ePDMP NOTE

Legal advice from the Wisconsin Medical Society regarding Use of Delegates to check ePDMP / PDMP:

1. **Prescribers do not need to perform every check by themselves.**
2. **Delegates can pull PDMP data.**
3. **Delegates cannot be 100% responsible for the review.**
4. **The practitioner must still "review the patient's record from the PDMP".**

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What happens if I do not CHECK the ePDMP?

What are the penalties for failure to review a patient's ePDMP records where required by law?

- Though the Controlled Substances Board has indicated that its priority is to promote educate and train practitioners about the benefits and requirements of the ePDMP, it also has discretion to refer matters of noncompliance to a practitioner's licensing board for investigation.

- Failure by a physician to review a patient's records from the ePDMP before issuing a prescription order where required by law is a form of **unprofessional conduct** that may result in discipline by the Medical Examining Board.

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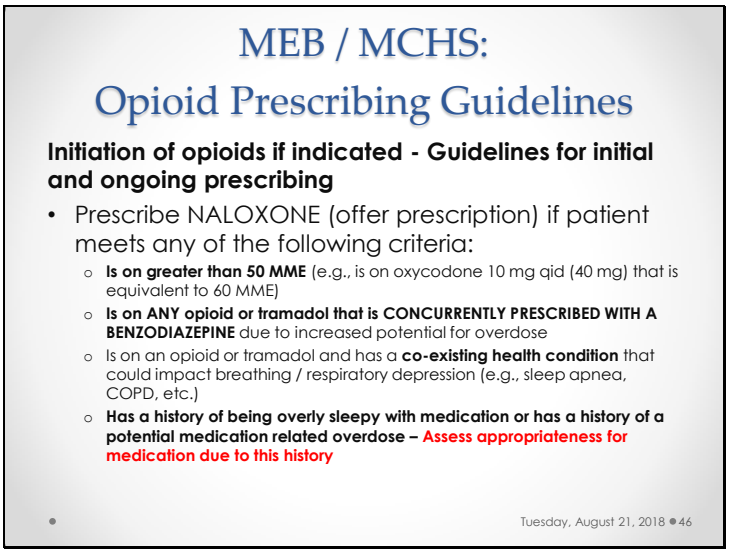
MEB / MCHS:
Opioid Prescribing Guidelines
Initiation of opioids if indicated - Guidelines for initial and ongoing prescribing
• Prescribe NALOXONE (offer prescription) if patient meets any of the following criteria:
o Is on greater than 50 MME (e.g., is on oxycodone 10 mg qid (40 mg) that is equivalent to 60 MME)
o Is on ANY opioid or tramadol that is CONCURRENTLY PRESCRIBED WITH A BENZODIAZEPINE due to increased potential for overdose
o Is on an opioid or tramadol and has a co-existing health condition that could impact breathing / respiratory depression (e.g., sleep apnea, COPD, etc.)
o Has a history of being overly sleepy with medication or has a history of a potential medication related overdose – Assess appropriateness for medication due to this history
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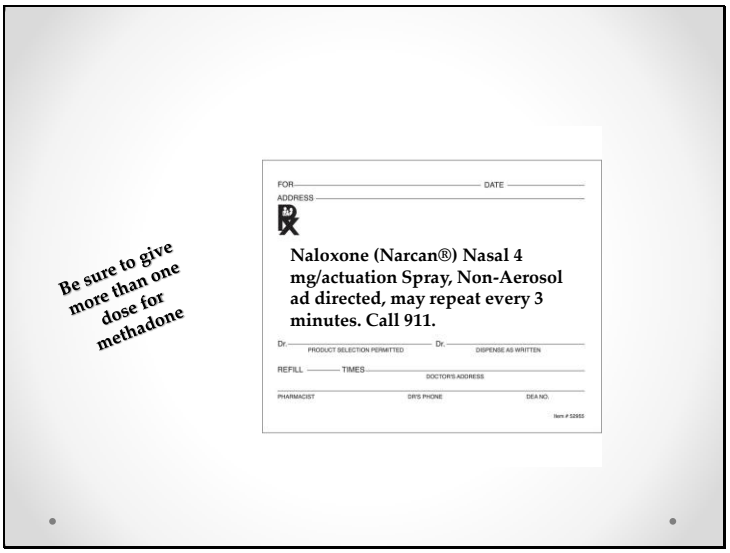
Be sure to give more than one dose for methadone
FOR
DATE
ADDRESS
Rx
Naloxone (Narcan®) Nasal 4 mg/actuation Spray, Non-Aerosol ad directed, may repeat every 3 minutes. Call 911.
Dr.
PRODUCT SELECTION PERMITTED
Dr.
DISPENSE AS WRITTEN
REFILL
TIMES
DOCTOR'S ADDRESS
PHARMACIST
DR'S PHONE
DEA NO.

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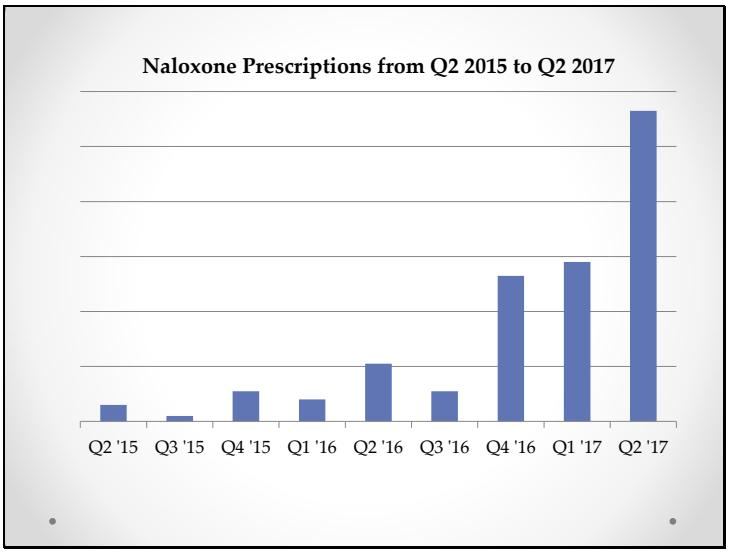
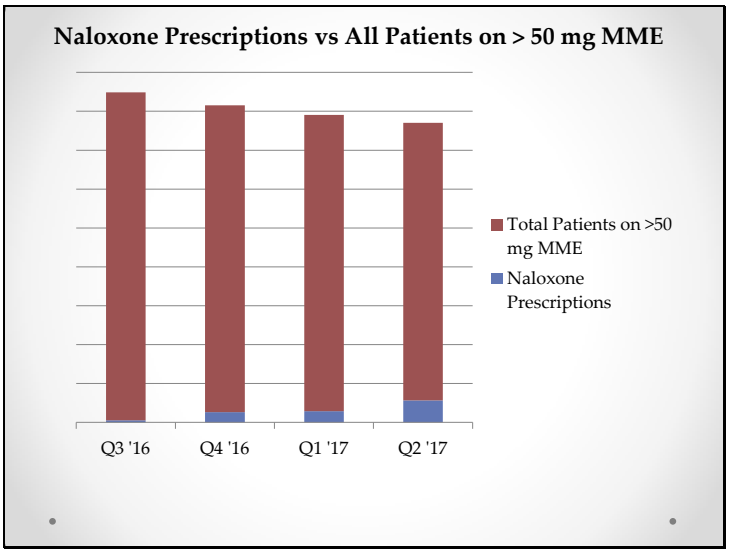

Naloxone Prescriptions from Q2 2015 to Q2 2017
Q2 '15
Q3 '15
Q4 '15
Q1 '16
Q2 '16
Q3 '16
Q4 '16
Q1 '17
Q2 '17

Slide 49


Naloxone Prescriptions vs All Patients on > 50 mg MME
Q3 '16
Q4 '16
Q1 '17
Q2 '17
Total Patients on >50 mg MME
Naloxone Prescriptions

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MEB / MCHS:
Opioid Prescribing Guidelines

Initiation of opioids if indicated - Guidelines for initial and ongoing prescribing

- Start LOW and go SLOW:
  - Prescribe lowest effective dose - This is typically a short-acting / immediate release formulation
    - Hydrocodone is an example
    - **Limit use of oxycodone** due to street value and likely higher potential for abuse / misuse / diversion
  - Time-limited if possible
  - Clear instructions on how to use:
    - Hydrocodone 5/325 mg prn up to tid #90 (note when they should use the medication and how). Test to see how much they actually need.
    - **AVOID:** Hydrocodone 5/325 mg 1-2 prn every 4-6 hours #90. The person could take up to 12/day.
    - **Goal is to AVOID more than 4 short-acting / immediate release doses per day** (too many ups and downs), go to a long-acting then.

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MEB / MCHS:
Opioid Prescribing Guidelines

Initiation of opioids if indicated - Guidelines for initial and ongoing prescribing

- ASSESS progress, side-effects and benefit in 2-4 weeks:
  - Assess how they are using the medication and how it is working
  - Make early corrections in their understanding of when to use the medication
    - "I used my 3 pills all at once so I could mow my lawn but then over did it and was in pain, so I had to use more medication and ran out early".
    - "I knew they would work better if I used them with a beer, so that is what I did".
    - Correct these early on. Goal is to AVOID injury, so may not want them to use the medication to OVERDO.
  - Perform pill counts or assess how much they are using, it will help guide future prescriptions.

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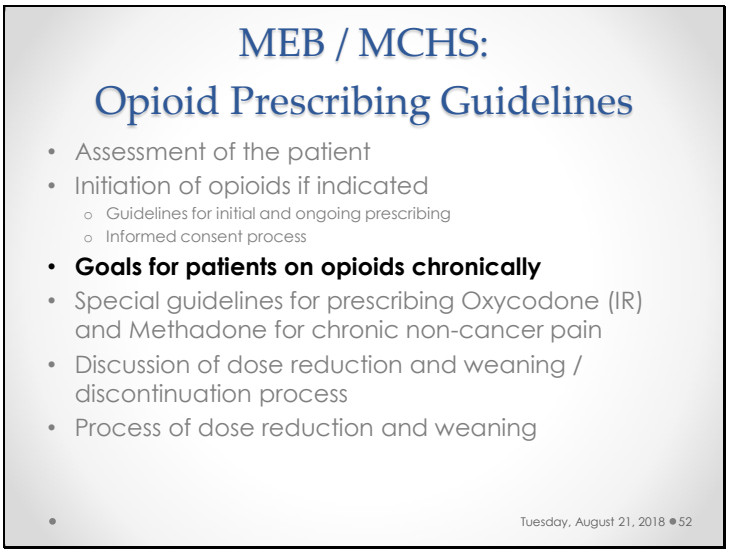
MEB / MCHS:
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• Discussion of dose reduction and weaning / discontinuation process
• Process of dose reduction and weaning
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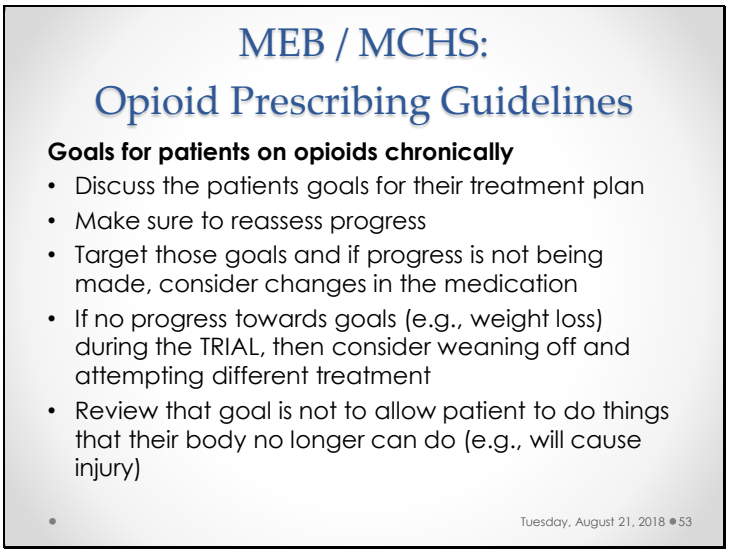
MEB / MCHS:
Opioid Prescribing Guidelines
Goals for patients on opioids chronically
• Discuss the patients goals for their treatment plan
• Make sure to reassess progress
• Target those goals and if progress is not being made, consider changes in the medication
• If no progress towards goals (e.g., weight loss) during the TRIAL, then consider weaning off and attempting different treatment
• Review that goal is not to allow patient to do things that their body no longer can do (e.g., will cause injury)
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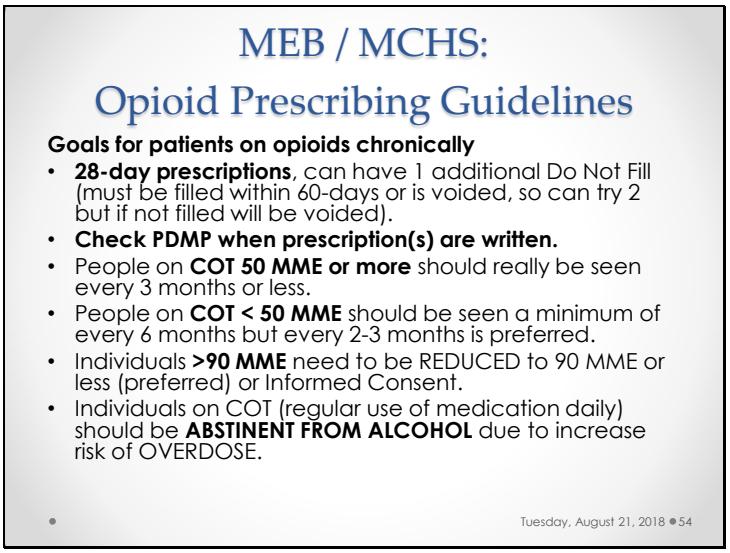
MEB / MCHS:
Opioid Prescribing Guidelines
Goals for patients on opioids chronically
• 28-day prescriptions, can have 1 additional Do Not Fill (must be filled within 60-days or is voided, so can try 2 but if not filled will be voided).
• Check PDMP when prescription(s) are written.
• People on COT 50 MME or more should really be seen every 3 months or less.
• People on COT < 50 MME should be seen a minimum of every 6 months but every 2-3 months is preferred.
• Individuals >90 MME need to be REDUCED to 90 MME or less (preferred) or Informed Consent.
• Individuals on COT (regular use of medication daily) should be ABSTINENT FROM ALCOHOL due to increase risk of OVERDOSE.
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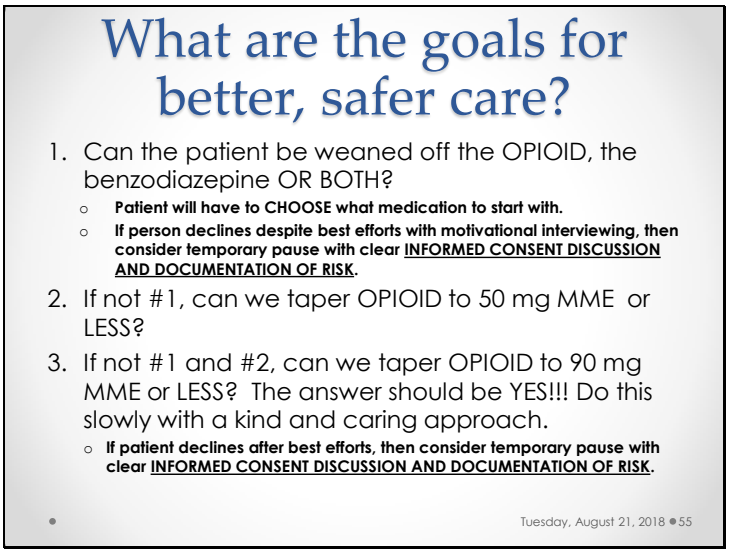
What are the goals for better, safer care?
1. Can the patient be weaned off the OPIOID, the benzodiazepine OR BOTH?
Patient will have to CHOOSE what medication to start with.
If person declines despite best efforts with motivational interviewing, then consider temporary pause with clear INFORMED CONSENT DISCUSSION AND DOCUMENTATION OF RISK.
2. If not #1, can we taper OPIOID to 50 mg MME or LESS?
3. If not #1 and #2, can we taper OPIOID to 90 mg MME or LESS? The answer should be YES!!! Do this slowly with a kind and caring approach.
If patient declines after best efforts, then consider temporary pause with clear INFORMED CONSENT DISCUSSION AND DOCUMENTATION OF RISK.
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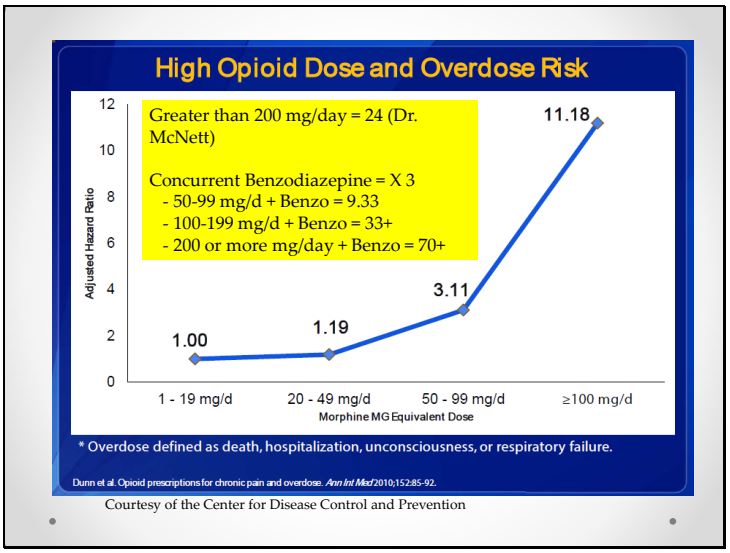

Courtesy of the Center for Disease Control and Prevention

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Informed Consent

If benefits of continued medication therapy as prescribed outweigh the risks, document an **informed consent discussion** in the patient's medical record and the medical decision making supporting the continued use.

- Informed consent discussion includes
  - Purpose, risk, benefits
  - Alternatives available and risks and benefits
  - Patient has had the opportunity to ask questions and receive answers

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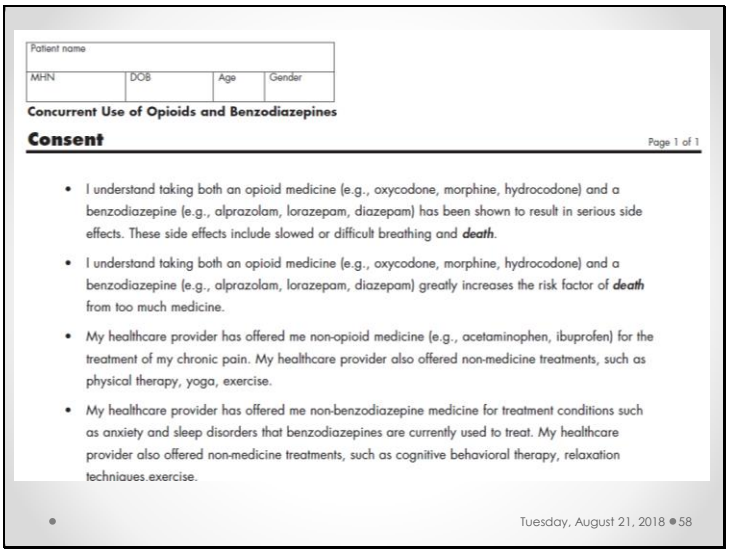

Patient name			
MHN	DOB	Age	Gender

Concurrent Use of Opioids and Benzodiazepines

Consent

Page 1 of 1

- I understand taking both an opioid medicine (e.g., oxycodone, morphine, hydrocodone) and a benzodiazepine (e.g., alprazolam, lorazepam, diazepam) has been shown to result in serious side effects. These side effects include slowed or difficult breathing and ***death***.
- I understand taking both an opioid medicine (e.g., oxycodone, morphine, hydrocodone) and a benzodiazepine (e.g., alprazolam, lorazepam, diazepam) greatly increases the risk factor of ***death*** from too much medicine.
- My healthcare provider has offered me non-opioid medicine (e.g., acetaminophen, ibuprofen) for the treatment of my chronic pain. My healthcare provider also offered non-medicine treatments, such as physical therapy, yoga, exercise.
- My healthcare provider has offered me non-benzodiazepine medicine for treatment conditions such as anxiety and sleep disorders that benzodiazepines are currently used to treat. My healthcare provider also offered non-medicine treatments, such as cognitive behavioral therapy, relaxation techniques.exercise.

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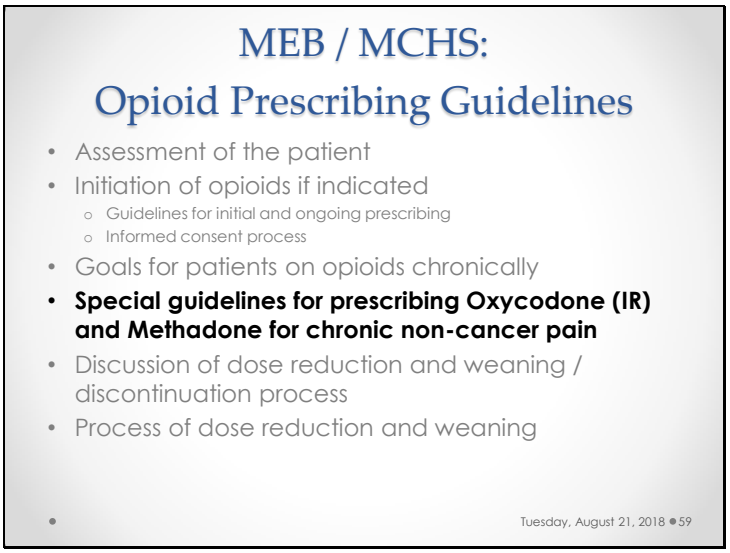
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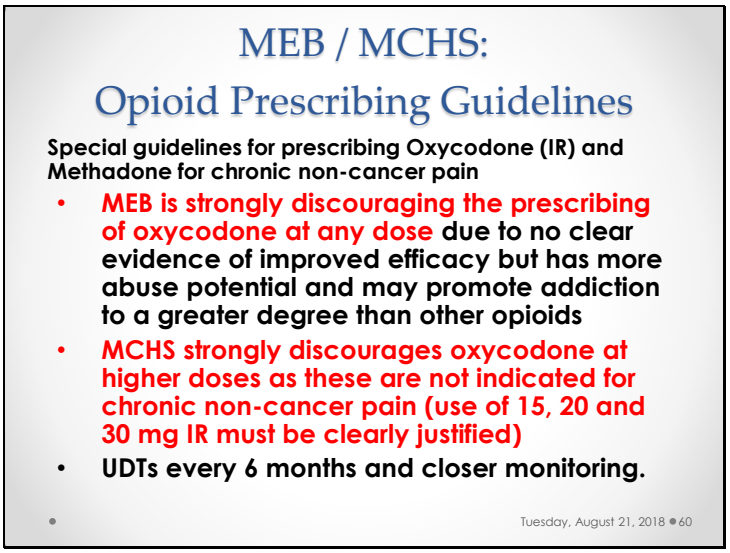
Slide 60


MEB / MCHS:
Opioid Prescribing Guidelines
Special guidelines for prescribing Oxycodone (IR) and Methadone for chronic non-cancer pain
• MEB is strongly discouraging the prescribing of oxycodone at any dose due to no clear evidence of improved efficacy but has more abuse potential and may promote addiction to a greater degree than other opioids
• MCHS strongly discourages oxycodone at higher doses as these are not indicated for chronic non-cancer pain (use of 15, 20 and 30 mg IR must be clearly justified)
• UDTs every 6 months and closer monitoring.
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High Dose Oxycodone IR Prescribing in MCHS

- 15 mg, 20 mg, 30 mg oxycodone IR Tablets.
- 42 Unique Prescribers
- Comparing Q1 2018 with Q4 2016

Receiving High Dose Oxycodone IR (1.2% of all patients on COT) 38% reduction in individuals prescribed these doses.		Opioid agreement YES	Opioid agreement NO
		100% +16% from Q4 2016	3% -16% from Q4 2016
Urine Screen <365 days	81% +16%	81% +18% from Q4 2016	0% -2% from Q4 2016
Urine Screen >365 days or never	16% -19%	19% -5% from Q4 2016	0% -14% from Q4 2016

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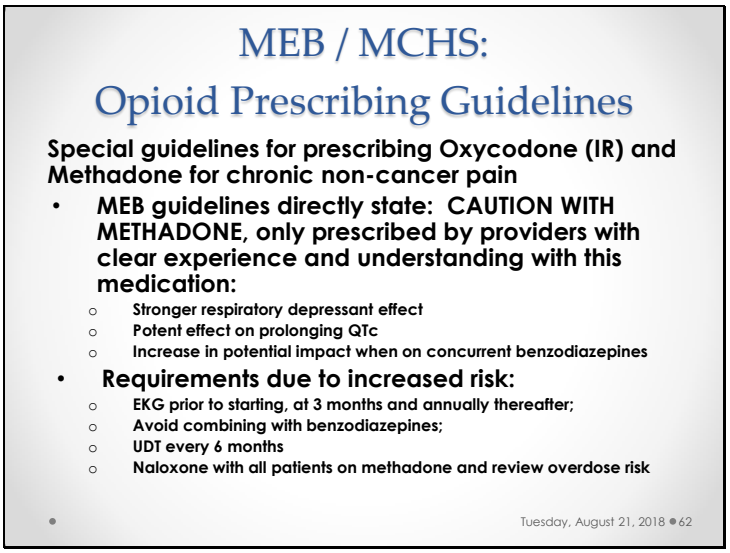
MEB / MCHS:
Opioid Prescribing Guidelines
Special guidelines for prescribing Oxycodone (IR) and Methadone for chronic non-cancer pain
MEB guidelines directly state: CAUTION WITH METHADONE, only prescribed by providers with clear experience and understanding with this medication:
Stronger respiratory depressant effect
Potent effect on prolonging QTc
Increase in potential impact when on concurrent benzodiazepines
Requirements due to increased risk:
EKG prior to starting, at 3 months and annually thereafter;
Avoid combining with benzodiazepines;
UDT every 6 months
Naloxone with all patients on methadone and review overdose risk
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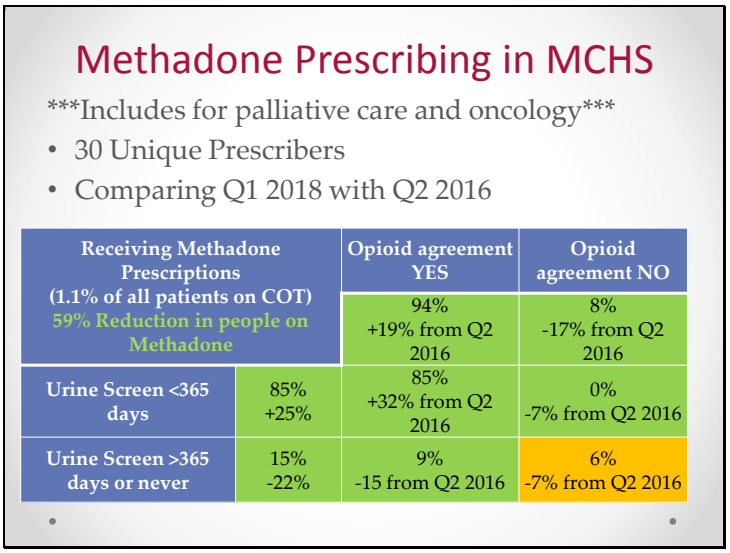
Methadone Prescribing in MCHS
Includes for palliative care and oncology
• 30 Unique Prescribers
• Comparing Q1 2018 with Q2 2016
Receiving Methadone Prescriptions (1.1% of all patients on COT) 59% Reduction in people on Methadone
Opioid agreement YES
Opioid agreement NO
94% +19% from Q2 2016
8% -17% from Q2 2016
Urine Screen <365 days
85% +25%
85% +32% from Q2 2016
0% -7% from Q2 2016
Urine Screen >365 days or never
15% -22%
9% -15 from Q2 2016
6% -7% from Q2 2016

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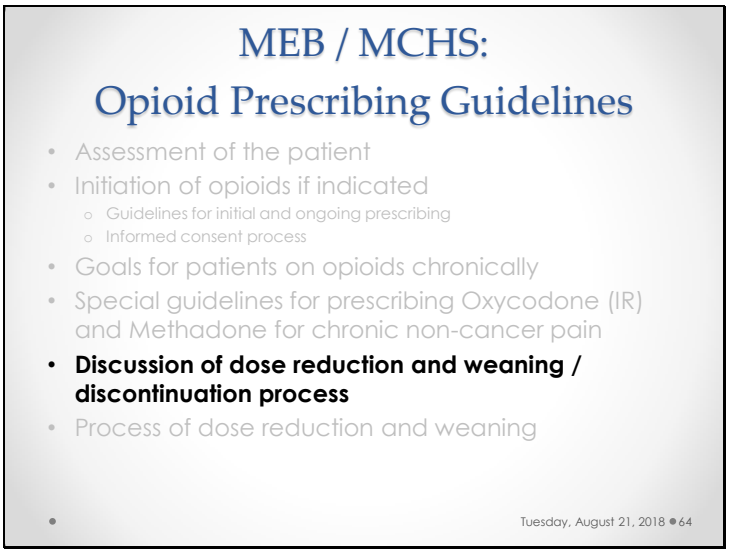
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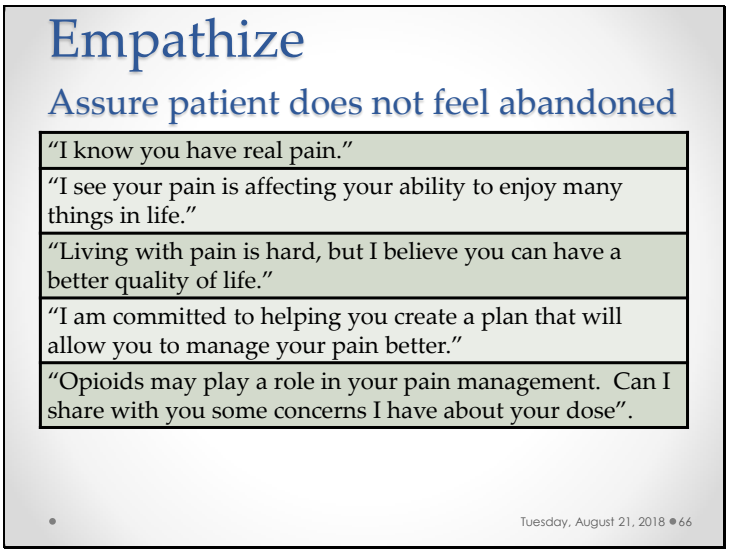
MEB / MCHS:
Opioid Prescribing Guidelines

Discussion of dose reduction and weaning / discontinuation process

- Understand people on opioids for a long-time will have a great deal of **fear** when discussing dose reductions
- They will require time to process information
- Help them understand that their body will change as the opioids are reduced
  - The pain may NOT increase and could improve (hyperalgesia; they have been injuring themselves; changes in system)
  - Their body has adapted to the original injury or surgery, trust the body
  - They may learn to pace themselves better and understand their body

Slide 66


Empathize
Assure patient does not feel abandoned
"I know you have real pain."
"I see your pain is affecting your ability to enjoy many things in life."
"Living with pain is hard, but I believe you can have a better quality of life."
"I am committed to helping you create a plan that will allow you to manage your pain better."
"Opioids may play a role in your pain management. Can I share with you some concerns I have about your dose".
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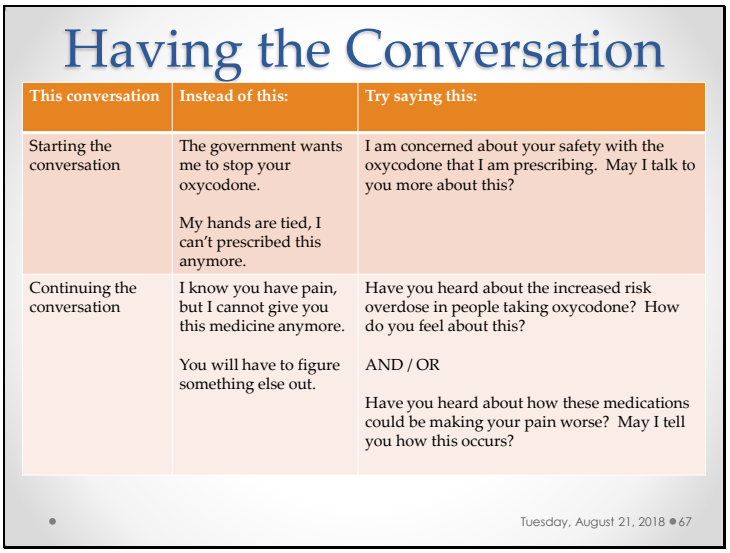
Having the Conversation
This conversation
Instead of this:
Try saying this:
Starting the conversation
The government wants me to stop your oxycodone.
My hands are tied, I can't prescribed this anymore.
I am concerned about your safety with the oxycodone that I am prescribing. May I talk to you more about this?
Continuing the conversation
I know you have pain, but I cannot give you this medicine anymore.
You will have to figure something else out.
Have you heard about the increased risk overdose in people taking oxycodone? How do you feel about this?
AND / OR
Have you heard about how these medications could be making your pain worse? May I tell you how this occurs?
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Having the Conversation

This conversation	Instead of this:	Try saying this:
The overdose conversation	You are going to die if you continue to use this medication, likely in your sleep!	Oxycodone and medications like it, do substantially increase the risk of overdose because it reduces your ability to take in air called respiratory depression. When the dose is high as yours, your risk is 3 x greater (50-90 MME) or 11 x greater (> 90) or 24 x greater (>200). What do you think about this information?
The Hyperalgesia conversation	Just trust me, it makes your pain worse and is probably the cause of all the pain you have!	**Provider:** Hyperalgesia occurs because our body may not be able to tolerate the high dose (that you are on). We now know that this is common. **Patient:** "But it works for me." **Provider:** It only appears as if it works because after your take the medication you feel somewhat better but what we know is happening is that your body has become sensitized to the opioid. That is what is making your pain worse in general.

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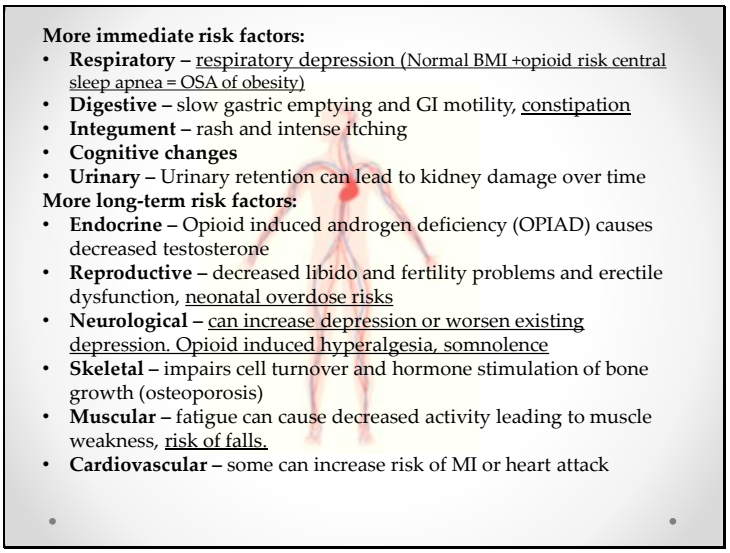
Having the Conversation

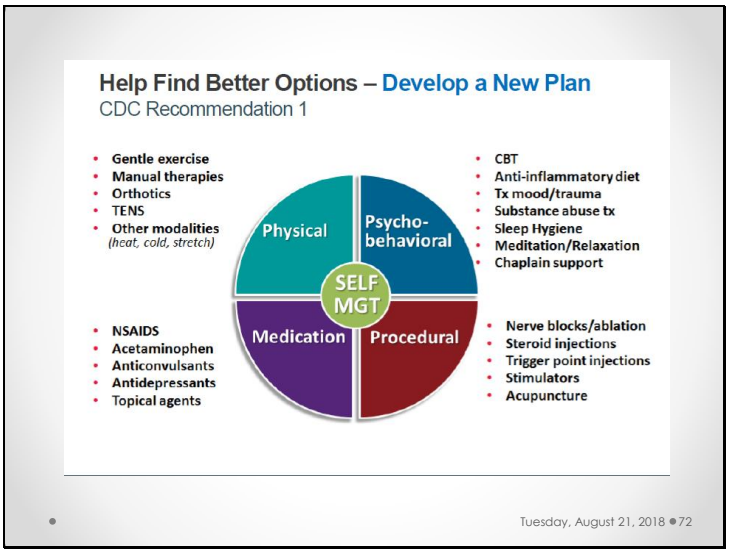
When the conversation starts like this:	Instead of saying this:	Try saying this:
Patient on hydrocodone for 3 years: **Patient requests a higher dose**	- I know you have pain, but I cannot give you more hydrocodone and really we should not be using it at all. - I am going to cut your monthly supply in half this month.	May I talk to you about other treatments that might work better for your pain and are safer in the long run?
Patient has been on morphine SR for 8 years: **Patient asks at appointment why he has been prescribed such a dangerous drug after he hears on the new about the high rates of overdose.**	- That morphine was prescribed by his previous provider. - I never thought it was good for you. - I am not sure how to taper you off of this, so I will send you to the Pain Clinic	Yes, this is a concern to me also. We are realizing that opioids are not the best option for treating pain. Just as treatments change for diseases like diabetes and heart disease, treatments can change for pain also. Let's talk about other options for your pain management.

Slide 70


More immediate risk factors:
• Respiratory – respiratory depression (Normal BMI +opioid risk central sleep apnea = OSA of obesity)
• Digestive – slow gastric emptying and GI motility, constipation
• Integument – rash and intense itching
• Cognitive changes
• Urinary – Urinary retention can lead to kidney damage over time
More long-term risk factors:
• Endocrine – Opioid induced androgen deficiency (OPIAD) causes decreased testosterone
• Reproductive – decreased libido and fertility problems and erectile dysfunction, neonatal overdose risks
• Neurological – can increase depression or worsen existing depression. Opioid induced hyperalgesia, somnolence
• Skeletal – impairs cell turnover and hormone stimulation of bone growth (osteoporosis)
• Muscular – fatigue can cause decreased activity leading to muscle weakness, risk of falls.
• Cardiovascular – some can increase risk of MI or heart attack

Slide 71

Slide 72


Help Find Better Options – Develop a New Plan
CDC Recommendation 1
Gentle exercise
Manual therapies
Orthotics
TENS
Other modalities
(heat, cold, stretch)
Physical
Psycho-behavioral
SELF MGT
Medication
Procedural
CBT
Anti-inflammatory diet
Tx mood/trauma
Substance abuse tx
Sleep Hygiene
Meditation/Relaxation
Chaplain support
NSAIDS
Acetaminophen
Anticonvulsants
Antidepressants
Topical agents
Nerve blocks/ablation
Steroid injections
Trigger point injections
Stimulators
Acupuncture
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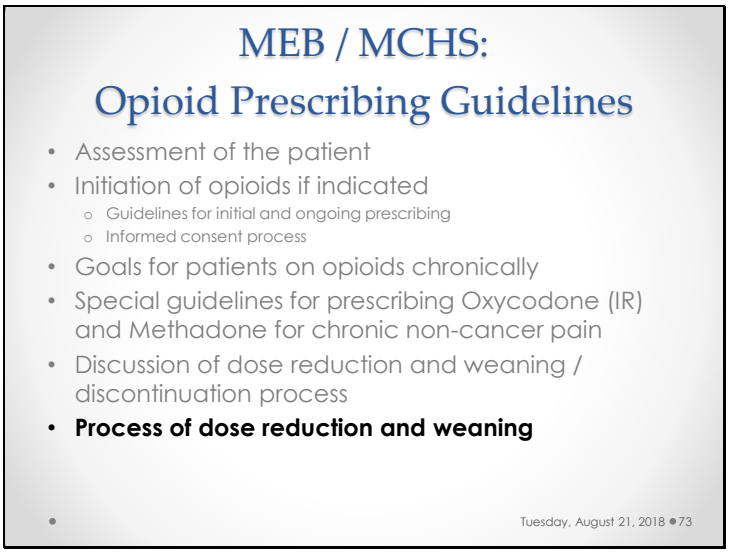
MEB / MCHS:
Opioid Prescribing Guidelines
• Assessment of the patient
• Initiation of opioids if indicated
o Guidelines for initial and ongoing prescribing
o Informed consent process
• Goals for patients on opioids chronically
• Special guidelines for prescribing Oxycodone (IR) and Methadone for chronic non-cancer pain
• Discussion of dose reduction and weaning / discontinuation process
• Process of dose reduction and weaning
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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

General Recommendations:

- **Slow is best**, recommend 10-15% of total daily dose every 4 weeks.
- Can pause at times but be persistent.
- Reduce short-acting first (if on long-acting and short-acting) but may have to add it back in to balance reductions.
  - Goal is to reduce the short-acting onset sensation that is more noticeable
  - People tend to be more connected to the short-acting medication, need to break that first.
  - May add in small doses of short-acting to balance the reduction percentages.

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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

General Recommendations:

EXCEPTIONS: Methadone and Fentanyl

- **Leave the short-acting and reduce methadone FIRST until the person is completely off of methadone**
  - **Methadone is difficult, so go slow all the way thru but VERY SLOW at the end doses (2.5 mg once daily for 1 month is usually the final dose)**
  - **People will likely not feel well for 60-90 Days after last dose of methadone, so then reduce the short-acting that will hide the symptoms**
- **Leave the short-acting and reduce Fentanyl first**
  - **Fentanyl is 2.4 times stronger than morphine and the steps between patches are quite big, so the short-acting will hide some of the % reductions.**
  - **For example: Going from 25 mcg to 12 mcg is more than a 50% reduction or likely going from 60 MME to 28 MME. Need to hide that experience.**

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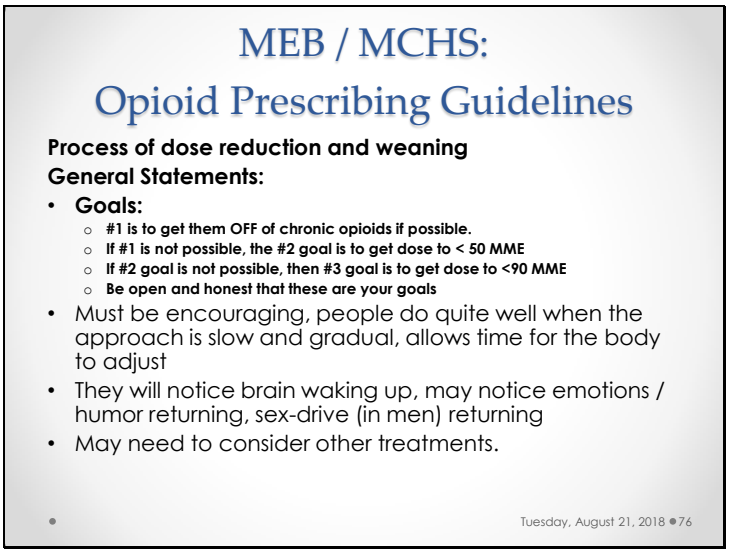
MEB / MCHS:
Opioid Prescribing Guidelines
Process of dose reduction and weaning
General Statements:
Goals:
#1 is to get them OFF of chronic opioids if possible.
If #1 is not possible, the #2 goal is to get dose to < 50 MME
If #2 goal is not possible, then #3 goal is to get dose to <90 MME
Be open and honest that these are your goals
Must be encouraging, people do quite well when the approach is slow and gradual, allows time for the body to adjust
They will notice brain waking up, may notice emotions / humor returning, sex-drive (in men) returning
May need to consider other treatments.
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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

Monitoring Progress:

- See patients every 2 months during the reduction process (minimum)
- Document their changes, question sleep, energy, bowel movements, sex drive, personality or anything else that may be a positive change
- Encourage appropriate pacing as they become more aware of their bodies
- Advise that withdrawal symptoms should NOT be occurring when dose is around 10%, if they are consider slowing the process VS adding medication

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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

Monitoring Progress:

- Advise them on other medications that may be on their list that are already helping with the symptoms and pain (e.g., muscle relaxers or neuropathic pain medications)
  - Can consider clonidine 0.2 mg po bid or different dose
  - Can consider tizanidine 2 mg po tid or different dose
- If pain becomes a concern, they may be open to trialing medications or treatments they have declined in the past, consider:
  - Offering trial of neuropathic or antidepressant
  - Offering trial of physical therapy or procedures

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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

Weaning / discontinuation can be faster if violation of Medication Treatment Agreement

- Can reduce by ~20% every 1-2 weeks due to illicit substance abuse or use of dangerous combinations.
- Can discontinue suddenly if EVIDENCE OF DIVERSION is present (e.g., high dose medication with negative UDT or other information).
- Must complete INCIDENT REPORT / RL Solutions to properly document within our system.

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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

Monitoring Progress:

- **Continue to perform UDTs and Pill Counts** / Refills as you go thru the process. This may help to identify overuse or misuse of the medication early on.
- As the dose reduces if a patient becomes more hostile or angry or misuse is noted, you may be exposing an opioid use disorder that has been medically managed by high doses.
- **KEY QUESTION:** Is person willing to try other treatments for pain OR do they remain focused on only opioids (or receiving other medications – benzodiazepines)

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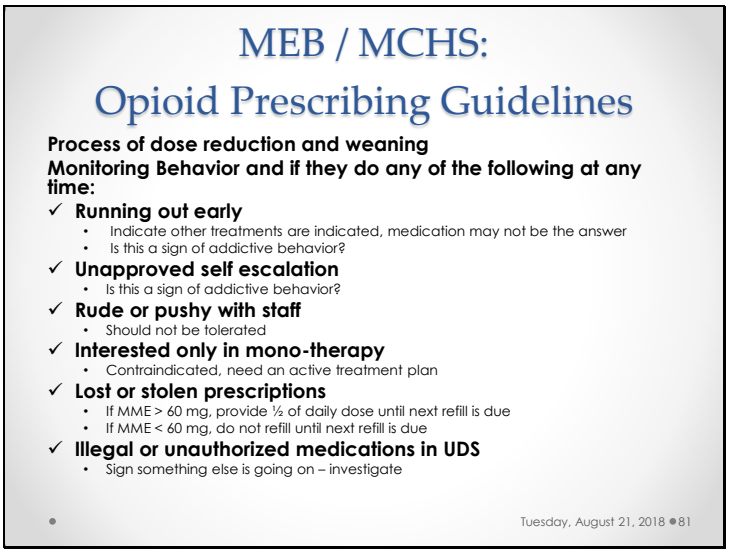
MEB / MCHS:
Opioid Prescribing Guidelines
Process of dose reduction and weaning
Monitoring Behavior and if they do any of the following at any time:
✓ Running out early
• Indicate other treatments are indicated, medication may not be the answer
• Is this a sign of addictive behavior?
✓ Unapproved self escalation
• Is this a sign of addictive behavior?
✓ Rude or pushy with staff
• Should not be tolerated
✓ Interested only in mono-therapy
• Contraindicated, need an active treatment plan
✓ Lost or stolen prescriptions
• If MME > 60 mg, provide ½ of daily dose until next refill is due
• If MME < 60 mg, do not refill until next refill is due
✓ Illegal or unauthorized medications in UDS
• Sign something else is going on – investigate
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MEB / MCHS:
Opioid Prescribing Guidelines

Process of dose reduction and weaning

Monitoring Progress:

- If person is focused on only medications and the reduction may be exposing an Opioid Use Disorder (addiction), then consider:
  - Discussing their "**RELATIONSHIP**" with the medication to tease apart pain issues from how **CONNECTED** they are to the medication.
  - Are they noticing that they **DO NOT FEEL NORMAL** in between doses or on less medication. NOT pain wise but emotionally.
  - Remember these medications have impact on the dopamine system and may experiencing how that system has changed in the context of the chronic opioids.
  - **Engage the patient in a quest to understand this better. PLEASE DO NOT CALL THEM AN ADDICT OR TELL THEM THEY HAVE AN ADDICTION. This is something they have to discover on their own.**

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Opioid Use Disorder (OUD)

Review issues of opioid use disorders (OUD) and treatment options for this with focus on Medication Assisted Treatments (MAT)

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MCHS and Chronic Opioid Therapy
How are we doing as a system?
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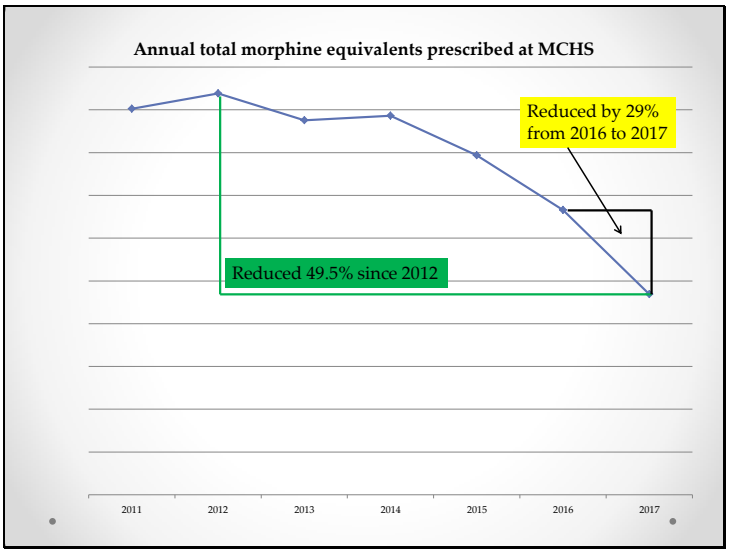
Annual total morphine equivalents prescribed at MCHS
Reduced by 29% from 2016 to 2017
Reduced 49.5% since 2012
2011
2012
2013
2014
2015
2016
2017

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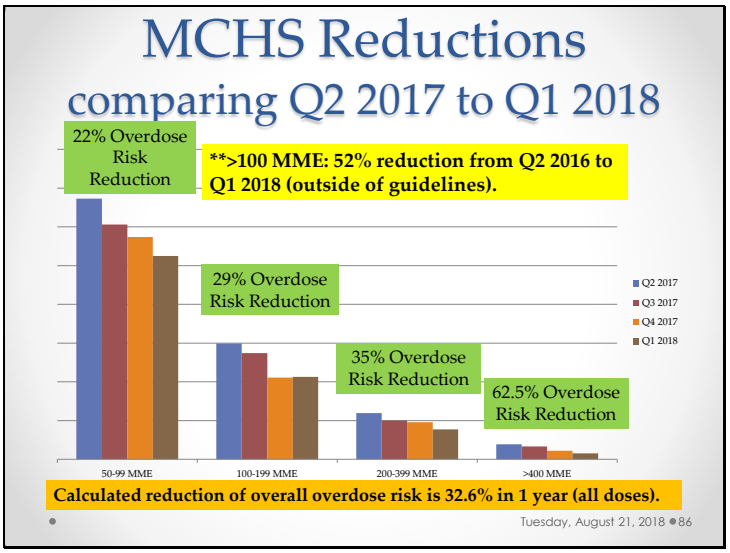
MCHS Reductions
comparing Q2 2017 to Q1 2018
22% Overdose Risk Reduction
**>100 MME: 52% reduction from Q2 2016 to Q1 2018 (outside of guidelines).
29% Overdose Risk Reduction
35% Overdose Risk Reduction
62.5% Overdose Risk Reduction
Q2 2017
Q3 2017
Q4 2017
Q1 2018
50-99 MME
100-199 MME
200-399 MME
>400 MME
Calculated reduction of overall overdose risk is 32.6% in 1 year (all doses).
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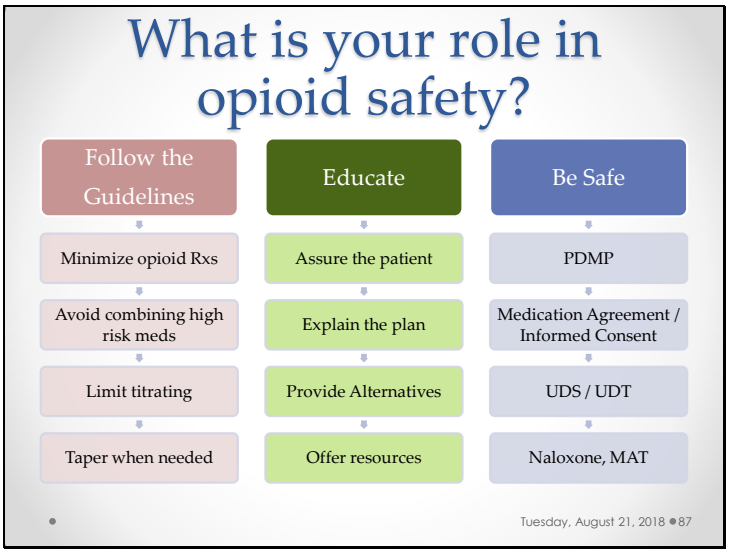
What is your role in opioid safety?
Follow the Guidelines
Minimize opioid Rxs
Avoid combining high risk meds
Limit titrating
Taper when needed
Educate
Assure the patient
Explain the plan
Provide Alternatives
Offer resources
Be Safe
PDMP
Medication Agreement / Informed Consent
UDS / UDT
Naloxone, MAT
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Summary of new guidelines regarding opioids

1. Chronic Opioid Therapy (COT) is not indicated for chronic non-cancer pain.
2. If COT is used, prescribe the lowest effective dose, keeping below 50 mg of morphine milligrams equivalent (MME) for risk mitigation.
3. If COT is used at a higher dose that is associated with increased risk for unintentional overdose (50-90 mg of MME) then mitigate risk by prescribing Naloxone.
4. COT at a dose above 90 mg MME is CONTRAINDICATED due to risk and likelihood of opioid induced hyperalgesia (requires informed consent process).
5. COT combined with benzodiazepines is CONTRAINDICATED due to increased risk of unintentional overdose due to combination (requires informed consent process).

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Way too much information
• Contact Michael Larson PhD with questions or comments. Larson.michael@marshfieldclinic.org
• Remember to complete your Continuing Education evaluation to receive credit.
• If you have specific questions or concerns, please use the Controlled Medications – Shared Email.
• Thank You!
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