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NAVIGATING THE OPIOID EPIDEMIC

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THE DOCTORS COMPANY
medical ~~mal~~practice insurance

YOUR PATIENTS AND YOUR PRACTICE ARE AT RISK

As the death toll from opioid-related harms continues to rise, so does uncertainty about how doctors can help patients safely relieve pain. And new research suggests that opioid-related overdose deaths may have been significantly underreported.[1]

> "With approximately 142 Americans dying every day, America is enduring a death toll equal to September 11th every three weeks,"[2] says the President's Commission on Combating Drug Addiction and the Opioid Crisis. In response, the president has declared a national public health emergency. Several governors have also declared emergencies for their states.

Just as opioid addiction and overdose impact families from all walks of life, the opioid crisis affects doctors and providers across the practice spectrum.

Dr. Roneet Lev, chief of the Emergency Department at Scripps Mercy Hospital in San Diego, puts the problem to doctors in plain, personal terms: "Does your name show up on a Prescription Drug Monitoring Program (PDMP) report of someone who died from a medication you prescribed?" She explains, "Unfortunately, some medications we prescribe with good intentions end up causing harm."[3]

THE OPIOID CRISIS

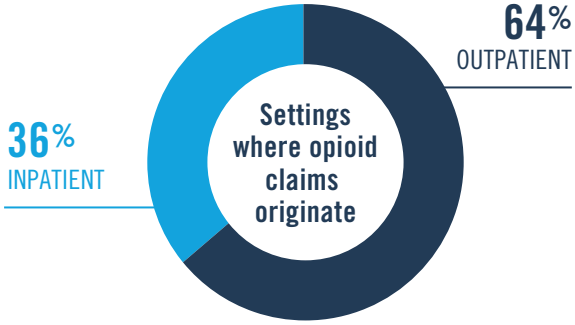
1. The United States consumes 99 percent of the world's hydrocodone.
2. The number of annual opioid prescriptions written in the United States is roughly equal to the number of adults in the country.
3. Thirty-eight percent of teens have misused or abused prescription drugs obtained from the home medicine cabinet.
4. One of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years after the first prescription.
5. In 2015, 19,000 Americans died of an opioid overdose, and the death rate from all opioids (including heroin) now exceeds the death rate from motor vehicle accidents.[4]

> Former Centers for Disease Control (CDC) Director Tom Frieden noted: "We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.[5]

ANALYSIS OF OPIOID-RELATED CLAIMS

The Doctors Company studied 272 claims that closed between 2007 and 2015 in which opioids resulted in patient harm. Contributing factors to opioid-related claims included:

- Inappropriate selection and management of therapy.
- Errors in patient monitoring.
- Inadequate patient assessment for risks and contraindications to opioids.



- Failure in communication among providers.
- Insufficient documentation and/or support for clinical decision making.
- Failure to take psychiatric and/or abuse history.
- Communication errors with patients and their families, including insufficient warning of risks of opioids.
- Patient factors, including noncompliance with treatment plans and follow-up appointments.

The study revealed that 64 percent of the claims originated in the outpatient setting.

FIGURE 1

Outpatient settings

78%	Physicians' offices and hospital clinics
10%	Ambulatory and day surgery centers
9%	Emergency rooms
3%	Patient's home

The specific opioids that lead to claims in both the inpatient and outpatient settings were also identified.

FIGURE 2

Opioids involved in claims

	INPATIENT	OUTPATIENT
Methadone	4%	16%
Oxycontin	3%	9%
Dilaudid	34%	10%
Morphine	24%	15%
Fentanyl	16%	11%

THE UNUSUAL NATURE OF OPIOIDS

Prescription opioids (mu receptor agonists) are no less addictive than heroin, and the increase in prescription opioids fuels illicit drug use. The dramatic increase in heroin addiction and related deaths has accelerated as a result of the low street price of heroin, compared to the relatively high cost of Percocet.[6]

While physicians prescribe many medications with high risk/benefit ratios and a narrow therapeutic window, the high opioid complication rate is unique—largely because opioids induce euphoria, have a high potential for addiction, and have a therapeutic endpoint (i.e., suppression of pain) that is subjective. Healthcare providers must work to prevent opioid misuse and addiction while protecting the well-being of patients experiencing the devastating effects of acute or chronic pain.

WHEN TO PRESCRIBE OPIOIDS, AND HOW TO PRESCRIBE SAFELY

Dr. Tom Frieden, former director of the CDC, has characterized prescribing an opioid as a "momentous decision." Below, we share some key considerations from the CDC's guidelines*.[7]

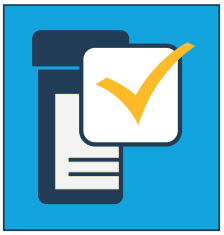
The Basics

According to the CDC, prescribers should:

- Avoid prescribing opioids for chronic pain (three-plus months) except for cancer patients and palliative care for end of life.
- When prescribing opioids for acute pain (post injury or surgery): "Start low and go slow."
- Choose faster-acting options instead of extended-release/long-acting (ER/LA) medications.[8]
- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that nonopioid therapies have been tried and optimized.
- Discuss benefits and risks (e.g., addiction, overdose) with patient. Evaluate risk of harm or misuse.
- Discuss risk factors with patient.
- Check PDMP data.
- Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (i.e., PEG scale).
- Schedule initial reassessment within one to four weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.[9]

THE PRESCRIBER'S DOZEN

Below, we summarize the CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care. To read the CDC's complete guidelines, go to www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm#B1_down.



Determining When to Initiate or Continue Opioids for Chronic Pain

1. Consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If prescribing opioids, combine them with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Establish treatment goals with all patients, including realistic goals for pain and function. Consider how therapy will be discontinued if benefits do not outweigh risks.
3. Before starting and periodically during opioid therapy, discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

*The CDC guidelines are guidelines, not rules. They are not enforceable, and are not applicable to all patients in all cases. These guidelines do not replace a physician's judgment regarding an individual patient's needs, or a physician's judgment regarding whether benefits outweigh risks in a given instance.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. Prescribe immediate-release opioids instead of ER/LA opioids.
5. Prescribe the lowest effective dosage. Use caution when prescribing opioids at any dosage.
6. For acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
7. Evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, optimize other therapies and work with patients to taper opioids to lower dosages or to discontinuation.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, evaluate risk factors for opioid-related harms. Incorporate 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 morphine milligram equivalents (MME) per day, or concurrent benzodiazepine use, are present.
9. 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 or her at high risk for overdose.
10. 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.
11. Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Note: All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guidelines for evidence ratings.

WHEN DISCUSSING A PRESCRIPTION, "ASK ME 3"

To promote clear communication, the National Patient Safety Foundation offers a patient education program called "Ask Me 3."

The Ask Me 3 program is a time-efficient, effective tool that encourages the patient to participate in his or her own healthcare by understanding the answers to three questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

The Ask Me 3 approach involves letting the patient speak a little longer at the start of an appointment, prior to the physician interrupting, knowing that most patients won't speak for more than two minutes. Fewer interruptions can lead to less confusion and more clarity on the part of patients. The Ask Me 3 program also

encourages attention to communication factors like the respective seating levels of physician and patient. Most importantly, during the visit, the patient is provided with a preprinted Ask Me 3 form and instructed to write down the answers to the three questions in the presence of the physician.

Educational materials to implement the Ask Me 3 program may be downloaded free from www.npsf.org/askme3.[10]

TAPERING A PRESCRIPTION FOR OPIOIDS

To make life easier for physicians and safer for patients, the CDC has prepared their *Pocket Guide: Tapering Opioids for Chronic Pain*.[11] Major points include:

Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient:

- Requests dosage reduction.
- Does not have a clinically meaningful improvement in pain and function (i.e., at least 30 percent improvement on the 3-item PEG scale).
- Is on dosages ≥50 MME per day without benefit or opioids are combined with benzodiazepines.
- Shows signs of substance use disorder (i.e., work or family problems related to opioid use, difficulty controlling use).
- Experiences overdose or other adverse event.
- Shows early warning signs for overdose risk such as confusion, sedation, or slurred speech.

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications.

Opioid tapering tips

HOW TO TAPER
Go Slow Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.
Consult Use extra caution and care in conversations with patients during pregnancy, due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.
Support Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.
Encourage Tell patients "I know you can do this" or "I'll stick by you through this."
CONSIDERATIONS WHEN TAPERING
Adjust Adjust the rate and duration of the taper according to the patient's response.
Monitor Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
Reduce Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

In addition to the CDC guidelines, the following suggestions are useful:

- **Rule number one** is don't prejudge patients as being pain seeking when there is a potential for missed diagnosis.
- **The gold standard** is for patients to use one provider and one pharmacy for all chronic medications.
- **Do not use the emergency department** as a referral for patients who run out of medications or extra shots. Many emergency departments have established guidelines that refer patients back to their physicians for all chronic medications.
- **The PDMP makes you a better doctor** by telling you more than doctor shopping information. It gives you medication names and dosages and the names of the doctors prescribing them. Take one to two minutes to check that your patient has no drug interactions or co-prescribing. If your patient is already receiving opioids from another provider for a different diagnosis, you do not need to prescribe more.
- **Use medication agreements** for patients who need more than three months of a controlled medication. This can include opioids, benzodiazepines, and stimulants.
- **Give clear discharge instructions**. Warn patients not to drive when taking opioids, sleep aids, or anything that causes them to not be fully alert. Warn patients to keep medications secure.
- **Treat addiction with compassion**, like other medical illnesses. About one percent of the population suffers from addiction, and only 10 percent get appropriate treatment. There is often a genetic association, and it is useful to ask about a family history. Learn your community resources for addiction. Addiction referral can be helpful for patients you are weaning from multiple medications.[12]

Suggested responses to patient questions and scenarios

PATIENT QUESTION	DOCTOR ANSWER
"Can't I have something for pain?"	"Yes, let me check your medical record for the best choice."
"The medicines don't work."	"Can you please tell me how you take the prescription?"
"My prescription was stolen."	"Did you file a police report?"
"I have chronic pain."	"For your safety, you need your medications coordinated by one doctor and one pharmacy."
"I received extra pain medications elsewhere."	"Let's do a drug specimen today." "I see you received 20 pills from the emergency department, what happened?" "OK, to stay on the same schedule, this month I will write 100 tablets (120 minus 20)."
PATIENT SCENARIO	**DOCTOR RESPONSE**
A case of clear doctor shopping.	"I am concerned because your medications can be addicting. I am going to refer you to someone who can help with this."
A case of need to stop an opioid prescription.	"The medication no longer appears to be as beneficial as it once was. As the benefits of the opioids no longer outweigh the risks, we need to discontinue this approach and together find a safer and more effective means of dealing with your pain."

COMPLIMENTARY OPIOID MANAGEMENT COURSES

The Doctors Company is pleased to offer complimentary on-demand continuing education courses that focus on opioid prescribing and management. Find details on these and all of our on-demand courses and upcoming seminars and webinars at thedoctors.com/cme.

SUMMARY

Opioids are powerful, and the risk of their misuse, accidental or otherwise, rises when patients don't understand their medications, highlighting the value of clear communication. The doctor-patient relationship is as important as ever.

In communicating directly with patients and families, those delivering care have a special and vital role to play in reducing harm from opioids to keep their patients and their practices safe.

Remember,

- Start low and go slow.
- Do not start without a plan to stop.
- For more help with opioid safety, consider taking one of our complimentary continuing education courses. Visit thedoctors.com/cme for details.

CASE STUDY

INNOVATION IN PAIN MANAGEMENT AND OPIOID ADDICTION: NORTH AMERICAN PARTNERS IN PAIN MANAGEMENT

One practice on Long Island, New York, has developed an innovative, personalized approach to pain management—and to helping patients wean themselves off addiction to opioids.

"We literally have this problem on our doorstep every day," said Adam E. Shestack, MD, a member of the medical staff at North American Partners in Pain Management (NAPPM). Dr. Shestack is also Director of Outpatient Pain Medicine Services at Syosset and Plainview Hospitals, and serves as a pain management specialist at North Shore University Hospital in Manhasset.

"In our practice, we see new patients daily with legitimate pain management issues who are on enormous amounts of narcotics or opioids," said Dr. Shestack. "For years, opioids were first-line therapy for pain. Now, with primary care physicians no longer prescribing opioids, these patients don't know what to do. They've never had their pain managed by anything other than medication. They have nowhere else to go."

Patients in Nassau County do have somewhere to go—NAPPM.

A division of North American Partners in Anesthesia, NAPPM focuses on short and long-term pain relief with interventional pain management solutions that can also help restore functionality and ease mobility. NAPPM's physicians are board certified in anesthesiology and pain medicine, and are trained to manage complex acute or chronic pain. The practice, led by John Stamatos, MD, also employs a board-certified psychiatrist who specializes in addiction psychiatry, advanced practice nurses certified in pain management, and a family nurse practitioner.

"For some patients who come to us, they have been on high doses of medication for so long that they no longer remember where their pain comes from," Dr. Shestack said.

He adds that patients who do not have access to a practice like NAPPM usually end up in one of three places: in emergency rooms, in detox units, or somewhere where they can obtain medication illegally—not to get high, but to prevent withdrawal from medication prescribed to them for many years.

"These patients are also often suffering from depression, some can no longer work, and for many their relationships are failing," said Dr. Shestack. "Some are on anxiety medication. For those also on narcotics, they are at risk for morbidity or mortality."

The NAPPM pain management specialists first stabilize these patients, then begin learning about their pain and their history. "When we have patients who tell us they can no longer get medication, we call their primary care physicians for verification. We talk to prescribers too, so we can learn why medication is no longer being prescribed."

Once they become patients of the practice, a personalized risk tool for every patient is put into motion:

- Patients are subject to urinalysis on a random basis.
- Clinicians run New York's Internet System for Tracking Over-Prescribing (I-STOP) at each patient visit.
- Doctors follow up on notes from other providers, including physical therapists, also at each visit.

At NAPPM, opioids are the last line of treatment. "We'll prescribe them only when everything has failed," says Dr. Shestack. "And by 'everything else,' I mean all medications, injections, spinal cord stimulations; all other evaluations and treatments. Only then will we prescribe opioids to help meet the goals of therapy."

Addicted patients are often referred to NAPPM's addiction psychiatrist, Maryn Sloane, MD. Dr. Sloane also operates A Second Chance Center, NAPPM's pain management mental health center.

"Dr. Sloane helps patients reveal other issues in their lives, including substance abuse, sexual abuse, history of alcoholism—there is often a strong correlation between these issues and their addiction," said Dr. Shestack.

Patients who maneuver through the system to simply obtain drugs are also treated at NAPPM. "Let's say a patient tests for cocaine," said Dr. Shestack. "So I won't prescribe anything. But I also won't kick them out of the practice. We'll treat them on an outpatient basis. They have a chronic illness. They need treatment too."

This approach to pain management and opioid addiction is unique, and succeeds because of the relationships with patients. "We want to know a patient's goals," said Dr. Shestack. "We find out their baseline work functionality, their personal relationships, their physical expectations. It's different for every patient. And we treat them all."

He added that the practice tried to involve families and friends whenever possible, so everyone is on the same page and supports their loved ones and keeps them motivated.

"We're looking for better modalities now," he concluded. "Narcotics are not the treatment of choice. They change you as a person. People come in asking us to treat their pain. We'll do that, but our goal is to improve their functioning. When you can work, when your relationships improve, when you have better range of motion, you'll focus less on your pain. I'm a firm believer in that."

Learn more at NAPPM.com.

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