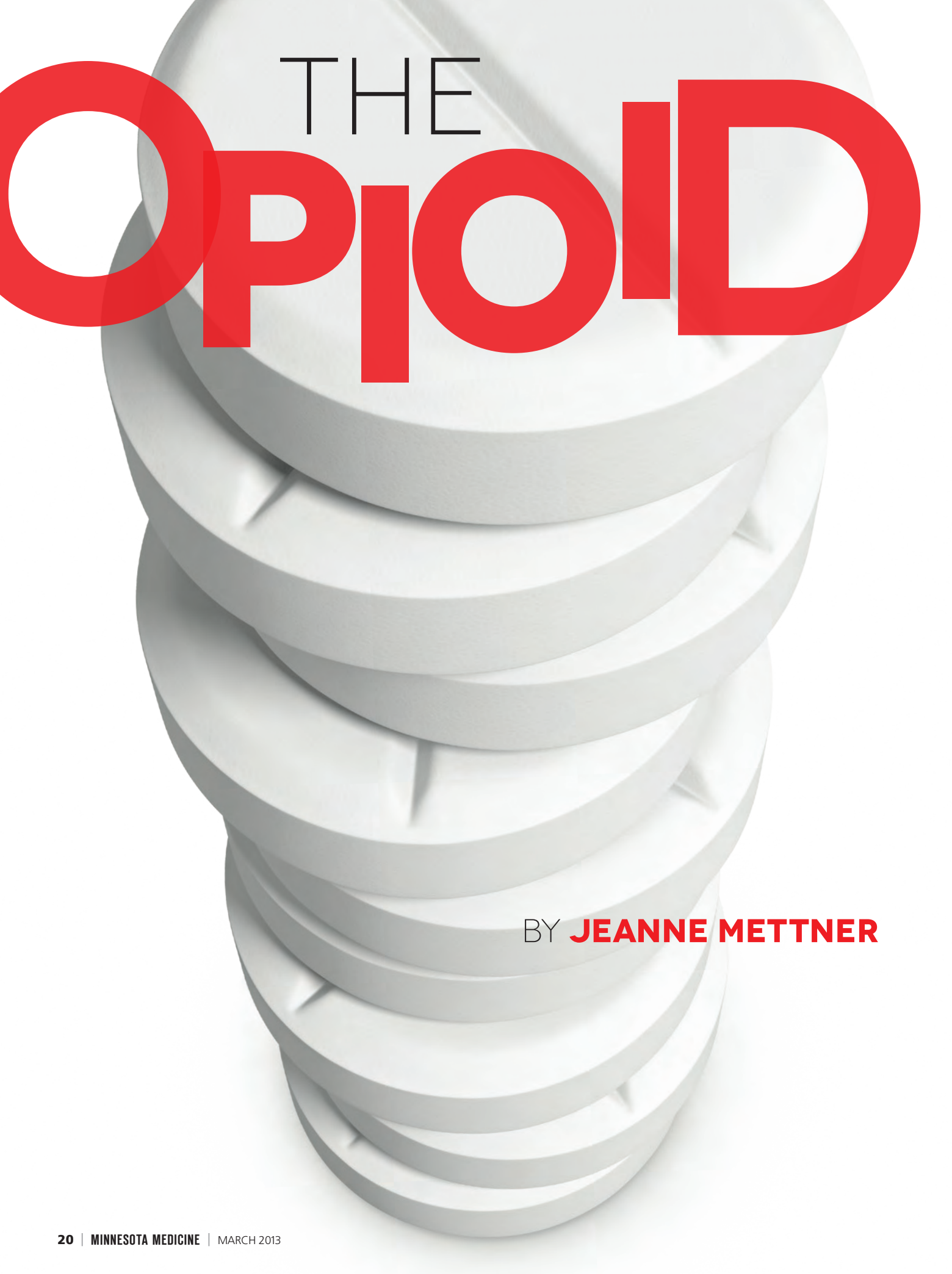
THE OPIOID



BY **JEANNE METTNER**

CRISIS

COMBATTING MISUSE THROUGH **BETTER PRESCRIBING**

Pain has always been a nemesis to human beings, but in the late 1990s, the quest to conquer it reached a fever pitch in the United States. Professional associations such as the American Pain Foundation were calling untreated pain an "epidemic." In 1995, the American Pain Society championed a campaign that labeled pain the "fifth vital sign," urging clinicians to assess it at every office visit just as they would a patient's blood pressure, heart rate and respiration rate. Around the same time, drug manufacturers began aggressively marketing powerful, long-acting opioid formulations. They even enlisted some pain specialists to help create a body of scientific research dispelling concerns about the risk of addiction and dependence on these drugs.

Worries about safety also were alleviated by entities such as the Joint Commission, which noted in its 2000 pain-management standards that "there is no evidence that addiction is a significant issue when persons are given opioids for pain control." In addition, the Federation of State Medical Boards in 1998 recommended that doctors not face regulatory action for prescribing even high doses of narcotics for pain.

As restrictions loosened, physicians began relying heavily on drugs such as oxycodone (Percocet), hydrocodone (Vicoden), fentanyl and sustained-release oxycodone (OxyContin). Medicine had written the last chapter on pain—we thought.

Fast-forward to 2013. A plethora of statistics tell a different story. Centers for Disease Control and Prevention figures show that between 1999 and 2008, the sale of opioids rose 300 percent. Now more than 14,800 people die annually from unintentional overdoses of opioids, a number that exceeds that of overdose deaths from cocaine and heroin combined. For every death reported, nine people enroll in substance abuse treatment, 35 visit emergency departments, 161 report they are abusing or dependent on opioid medications and 461 report nonmedical uses of opioids, according to the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. When asked about prescription drug use, about 9 million people report long-term (more than three months) medical use of opioids and about 5 million report nonmedical use of them (without a prescription or medical need).

In Minnesota, the number of overdose deaths from opioids has skyrocketed in the past decade—up 450 percent from 42 deaths in 2000 to 191 in 2010. (The overdose death rate is relatively low: 7.2 per 100,000 people compared with 11.9 per 100,000 nationally.) Legal distribution of all opioids increased 72 percent statewide between 2005 and 2011. A joint investigation by the *St. Paul Pioneer Press* and the *Duluth News Tribune* found that the largest increases occurred in Ramsey County and the northwestern corner of the state, and that Duluth had the highest prescription opioid distribution rate in Minnesota—5,000 g per 10,000 population. Among the communities hit hardest were Indian reservations. On the Red Lake, White Earth and Leech Lake reservations, tribal leaders declared "public health emergencies" because of opioid misuse.

Not surprisingly, Minnesota's physicians are rethinking their positions on opioid prescribing and pain management. "We've had 15 years of being hyper aware of patients' pain and bending over backwards to do something about it, using these numeric scales and smiley faces to analyze and assess pain at every office visit, being encouraged to ask and treat," says Paul Johnson, M.D., an internal medicine physician and director of Hennepin County Medical Center's (HCMC) Coordinated Care Clinic.

"Now the pendulum is swinging back to, 'We must first do no harm.' Sure, when we give patients an opioid, they like the medication, and they like you for giving the medication; but are we really helping them to be more functional and meet other life goals? Those are the questions we need to be asking now more than ever."

Johnson and others throughout Minnesota are asking such questions as they explore ways to improve their opioid prescribing practices and ensure these drugs are used safely and for legitimate purposes. Here's a look at some of those efforts.

FORTY-MINUTE ASSESSMENT

For nearly a year, HealthPartners' primary care services team has had in place a systemwide opioid management strategy for patients seeking treatment for chronic pain. The centerpiece of this initiative is a requirement for a comprehensive 40-minute assessment with their primary care physician. Both new and established patients who have been taking opioids more than three months must be evaluated.

As part of the assessment, the patient takes a urine drug test, completes a brief pain inventory, signs a controlled substance agreement, completes a screening questionnaire for depression and reviews two pages of information on the appropriate use of opioids for chronic pain. The primary care provider reviews the patient's medical history, conducts the exam, helps the patient set goals, discusses the care plan, checks the state's Prescription Monitoring Program database to see if the patient has other prescriptions for controlled substances, and reviews with the patient the results of their drug test and pain and depression screenings. The patient may also receive medication counseling from a pharmacist during the visit.

The patient then signs the controlled substance agreement, which stipulates, among other things, that he or she will keep regular appointments, undergo periodic drug screens, obtain all prescriptions from a single physician and through a single pharmacy, and obtain refills no earlier than the designated date and only during regular office hours (the idea being not to use the emergency department or urgent care for routine medical care or management of chronic pain). The document is then scanned and added to the patient's electronic medical record so other providers he or she may be seeing are aware of it.

"We look at patients' goals in terms of pain and function and their ability to do the everyday things they find important; we talk about safety in terms of where you keep your prescriptions, the side effects, and the potential for addiction, diversion and sedation," says Beth Averbeck, M.D., associate medical director of primary care at HealthPartners. "With this program in place, we have an opportunity to have a more open discussion with our patients about these medications."

Although it is too early to assess outcomes, researchers are collecting data on the degree to which the primary care program is being used. To date, more than 1,140 patients have undergone an assessment visit, 1,850 have opioid care plans documented in their electronic medical record and 1,250 have signed controlled-substance agreements. "The data demonstrate solid implementation of the program's systemwide approach," Averbeck says. "And with that comes consistency: No matter which physician or provider they see, patients will be hearing the same message."

PRE-OP PAIN CONSULTS

Two years ago, orthopedic surgeons and pain specialists at the University of Minnesota Medical Center, Fairview, noticed that the patients most at risk for postoperative pain were those who were already using opioids, had a history of chemical dependency or addiction, or had mental health problems, and decided to try to improve pain management in those populations.

Now, about a week before their surgery, at-risk patients undergo a consultation with a pain specialist who analyzes their situation, listens to their concerns and sets up a plan for managing their pain postoperatively. The plan includes using mindful meditation, guided imagery and anxiolytics, when appropriate, to deal with their anxiety. It also includes the use of pre- and postoperative analgesics that act at different levels of the pain pathway, rather than opioids alone.

The topic of tapering off opioids following surgery is also discussed. Involving patients in these talks gives them confidence about the pain management plan, says Orlando Charry, M.D., a pain specialist with Fairview's Pain Management Center and director of interventional services. "In short, we are reassuring the patient that the surgical team has all their ducks in a row, including with their pain management."

Charry and his colleagues, who are studying how the initiative is affecting outcomes, found that at-risk patients who underwent a preoperative pain consultation had better pain control and were able to meet the goals of their physical therapy while having a shorter hospital stay than healthy patients who did not undergo a consultation. Among those who were on opioids long-term, none had to increase their dosage, and 20 percent were able to taper off of the medication. Notably, hospital costs for the preoperative consult group were 31 percent lower than those for the controls.

Charry and his team presented these and other findings at the International Association for the Study of Pain's 2012 World Congress on Pain. "From the context of a university medical center, where we are seeing complicated cases that are referred by other specialists, this was an especially surprising and positive finding," he says, adding that they are continuing to collect data.

TWO-TABLET LIMIT

Several years ago, Chris Johnson, M.D., was feeling frustrated by a scenario that was playing out repeatedly in the emergency department at Methodist Hospital. Patients with a history of opioid use would come in complaining of chronic pain, spend three or more hours receiving intravenous opiates such as Dilaudid, then either be hospitalized, sometimes for days, during which they received more IV opiates, or go home with another opioid prescription. "It was a very unsatisfying experience, that whatever the pain was—chronic headaches, chronic backache, chronic abdominal pain—the patient would come in tearful and desperate, and they would go through this process repeatedly," recalls Johnson, an emergency medicine physician with Park Nicollet Health Services who works at Methodist. "You look for the long-term good, you want them to be independent, working, all the things that lead you to be happy and healthy. ... It just wasn't helping."

Johnson worked with Park Nicollet administrators to form a committee to look at the issue. He also began meeting with the medical directors of pain management clinics from throughout the Twin Cities to learn how they handled patients with chronic pain. The committee eventually developed a policy for Park Nicollet physicians. Says Johnson: "We learned that you can't just tell the doctor, 'Do the right thing' without implementing a policy for support." He explains that doing the right thing is often harder than doing the wrong thing. "Telling a patient 'No, I will not give you this prescription' can cause an individual physician to take on all these extra burdens and risks—an angry patient, prolonged office visits, delay of care of other patients, reports of complaints and dissatisfaction, and possibly reprimands." He says having a system-wide policy takes the burden off the physician and makes doing the right thing "almost as easy as doing the wrong thing."

In 2009, the team implemented the policy in Park Nicollet's urgent care centers and Methodist's emergency department. Now when a patient with chronic pain presents with either a flare up of their chronic pain or new pain, the attending physician is expected to examine the patient for an acute condition and use the Minnesota Prescription Monitoring Program database to get information about the individual's prescription history. Patients with chronic pain who have been on opioids for more than three months are no longer given IV doses of opioids but instead get just two tablets of their prescription opioid. Johnson says the policy is working well. "It's reduced admissions, discouraged emergency department visits and freed up resources to manage other issues," he says.

SIGNS OF THE TIMES

Sanford Health's pain management division has instituted a multifaceted initiative to decrease the incidence of opioid misuse. One aspect is educating physicians about opioid prescribing through grand rounds presentations, which are teleconferenced to Fargo, Sioux Falls, Bemidji, Walker, Bismarck, Thief River Falls and other Sanford locations. These sessions emphasize "how to treat pain, not how to stay out of trouble when prescribing drugs—and how to think of pain in such a way that the therapies you institute are working to restore function," says William Dicks, M.D., a pain specialist and family physician who practices at the Sanford Clinic in Bemidji. Dicks has presented at and helped plan the grand rounds presentations.

One of Dicks' primary concerns is that physicians are often too quick to prescribe opioids. "Pain still equals narcotics to so many physicians, and yet it's been shown that ibuprofen and other NSAIDs are as effective for pain as hydrocodone," he says.

Another part of the approach is to reduce the likelihood that patients will ask for opioids. For example, when patients are referred to the pain management clinic at Sanford Bemidji, they receive a packet of information, along with an introductory letter, before their first visit. "In that letter, we state that an appointment at the pain clinic does not mean we are going to treat you with narcotics, and in fact, we are going to discourage their use," Dicks says.

In addition, Sanford has placed signs at the registration desks in its satellite clinics in Cass Lake and Walker, communities where drug abuse has been prevalent, that read: "No refill prescriptions for controlled substances will be given for chronic pain." A clinic spokesperson says the signs and letter open the door to conversations with patients.

According to Dicks, Sanford's initiative is reducing opportunities for opioid misuse and diversion. "It works beautifully," he says.

PEER REVIEW

Paul Johnson, M.D., director of HCMC's Coordinated Care Clinic, became interested in the issue of opioid prescribing when he saw how varied physicians' practices were in terms of writing prescriptions, monitoring use of certain drugs and responding to potential misuse. For the past two years, he and his colleagues have been creating a standard approach that HCMC physicians can adopt with regard to opioid management. This includes getting them to regularly use the state's Prescription Monitoring Program database, accessing other states' monitoring programs and doing routine urine testing to check for opioid misuse in patients. "We need universal precautions—to screen everyone—because we really can't tell who is misusing opioids, using them with other substances or illegally distributing them," he says.

In addition, HCMC created an opioid oversight committee in the fall of 2011. The group, which includes addiction specialists, primary care doctors, a pharmacist, a nurse and pain physicians, meets once a week over the noon hour to review particularly challenging cases submitted by other clinicians. The person requesting the review typically attends the meeting in order to present additional information, if necessary, and hear the ensuing discussion of the case. After the committee makes its recommendation, the physician "is able to go back to the patient and have those difficult discussions," Johnson says. "Having a group

DECREASING DOSES

In January 2012, the Minneapolis Veterans Affairs Medical Center started transitioning patients from sustained-release OxyContin to other opioids and reducing high-dose prescriptions to lower and safer doses.

Primary care physicians and other providers throughout the Minneapolis VA have undergone training, attended presentations and received support materials demonstrating the harm of prescribing opioids that exceed 200 mg morphine equivalent per day (MEQ/d). Now, every two months, primary care providers receive a list of patients who are considered high-risk opioid users—either because they are on OxyContin or because they are using opioids at doses that exceed 200 MEQ/d. "These higher doses are most likely to be associated with unintentional overdoses," says Erin Krebs, M.D., an internal medicine physician who has worked on the initiative. In addition to transitioning these patients to lower and safer doses of opioids, the VA offers them classes on coping with chronic pain; mind-body healing techniques such as biofeedback and meditation, yoga and tai chi; and other interventions.

By the end of 2012, the Minneapolis VA had seen an 88 percent decrease in the number of patients taking OxyContin, a 44 percent decrease in patients taking opioids at doses of 200 MEQ/d or higher, and even a 10 to 25 percent decrease in the number of patients on doses of 50 to 100 MEQ/d. Krebs and others involved in the initiative also have heard stories from patients that illustrate the program's success: "They tell us that as their dose is coming down, they are getting their life back," she says. "If you just keep upping the dose of pain medication in a patient, it can be hard to know if that patient is gaining anything at all."

AS OPIOID MISUSE CONTINUES TO GARNER ATTENTION, physicians are rethinking the way they treat patients with chronic pain, and health systems are creating new policies around opioid prescribing. Even the American Pain Society, which espoused pain as "the fifth vital sign," has issued guidelines calling for the close monitoring of patients on prescription opioids for chronic pain. Still, research published in the February 2011 issue of the *Journal of General Internal Medicine* found that less than half of patients on opioid therapy are seen by their primary care provider at least once every six months—and only 8 percent underwent urine drug testing during their treatment.

Charlie Reznikoff, M.D., a general medicine physician at HCMC, believes that even with new policies in place, physicians will continue to face uncertainty when it comes to treating pain. "It's hard to find objective tests for pain, objective tests that provide answers to the questions, 'Am I giving too many opioids?' or 'Am I not giving enough?'" he says. Opioid prescribing, he insists, will always require physicians to invest their time, professional judgment and clinical acumen.

To some, legislation is the key to broad-sweeping reform. In Illinois, primary care doctors are now required by law to refer patients on long-term opioids for chronic

of peers review your circumstance and having the recommendation in your hip pocket is a really helpful thing."

Although it's not yet known what effect this is having on opioid misuse among HCMC patients, the feedback the committee has received thus far from prescribers has been positive. Says Johnson, "Physicians tell us that they are more comfortable with the prescribing environment; they feel they have somewhere to go if they have a challenging patient."

pain to a pain specialist. In Massachusetts, any doctor who wants to prescribe an opioid must first look the patient up on the state's drug-monitoring system. Minnesota has not yet passed such laws. But Sanford's Dicks is one who believes such legislation may be needed: "Things have to start happening legislatively," he says. "There are just too many deaths, and too much ugliness. Misuse of these drugs is ruining families and disrupting lives."

To others, the problem of opioid abuse won't be solved until more understand the roots of chronic pain. "Unfortunately, a lot of times, chronic pain is seen as something that is purely physical; but when pain has been going on for months, years or decades, it has to be looked at with a different lens—particularly the lens of mental and spiritual health," notes Fairview's Charry. "If we forget those areas, we are missing the boat completely."

Reznikoff agrees. "What if the culture of medicine would shift such that no one would ever prescribe opioids without thinking about other addictions and mental illness? Just to take those things into consideration would be a positive change." **MM**

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