CIAO Time Presents:

Patient Abandonment:

The Impact of Losing Access to Long-term Opioid Therapy

The Center for Innovation in Academic Detailing on Opioids

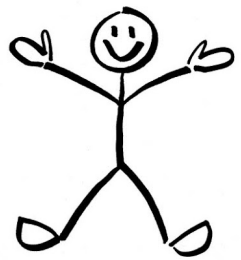
San Francisco Department of Public Health

May 9, 2023

Agenda

1. **Intros**
2. **Case Study:** impact of a pain specialist's license being suspended
3. **Resources:** Inherited Patients Toolkit
4. **Activity:** Mock academic detailing visit
5. **Q&A**

Please submit questions in the Chat!



Content warning:
This presentation contains references to suicide, which some individuals may find distressing.

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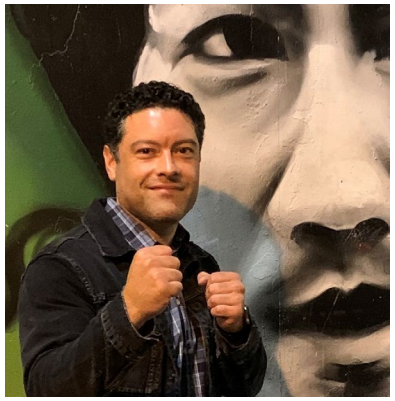

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The Center for Innovation in Academic Detailing on Opioids

Our vision: We aim to decrease opioid-related morbidity and mortality by promoting balanced approaches to opioid management.

Our mission: We collaborate with healthcare providers to improve opioid and chronic pain-related care through innovative training and technical assistance services.

Case Studies: Abandoned Patients

Points to Consider About the Following Cases

- These are *real* patients impacted by the suspension of a pain specialist's license to prescribe controlled substances

- We are not passing judgment or commenting on the prescribing practices of the clinician whose license was suspended. We are here to discuss the impact on two of the patients (of the 240 affected by this clinic closure)

VICE

The DEA Shut Down a Pain Doctor. Now 3 People Are Dead.

After a California doctor was labeled an "imminent danger" to the public, the consequences were devastating for his patients and their families.

KH By Keegan Hamilton

This Couple Died by Suicide After the DEA Shut Down Their Pain Doctor

“There are millions of chronic pain patients suffering just like me," Danny Elliott wrote before ending his life. "Nobody cares."

KH By Keegan Hamilton

The New York Times

‘Entire Body Is Shaking’: Why Americans With Chronic Pain Are Dying

Jan. 3, 2023

Ben Hickey

Case study: Suicide Linked to a Pain Specialist's License Suspension

The patient:

Danny Elliot, age 61, who suffered from migraine-like HAs for 30+ years after being accidentally electrocuted

- "I have these sensations like my brain is loose inside my skull... My eyes hurt so bad that it hurts to blink."
- Prescription fentanyl provided some pain relief. Non-opioid strategies (e.g. acupuncture) and other prescription opioids were inadequate.
- His most recent provider's license was suspended by the DEA in late 2022 (the third since 2018). **A week later, both he as his wife died by suicide.**

Danny Elliot's Note

“I just can't live with this severe pain anymore, and I don't have any options left... There are millions of chronic pain patients suffering just like me because of the DEA. Nobody cares. I haven't lived without some sort of pain and pain relief meds since 1998, and I considered suicide back then. My wife called 17 doctors this past week looking for some kind of help. The only doctor who agreed to see me refused to help in any way. What am I supposed to do?”

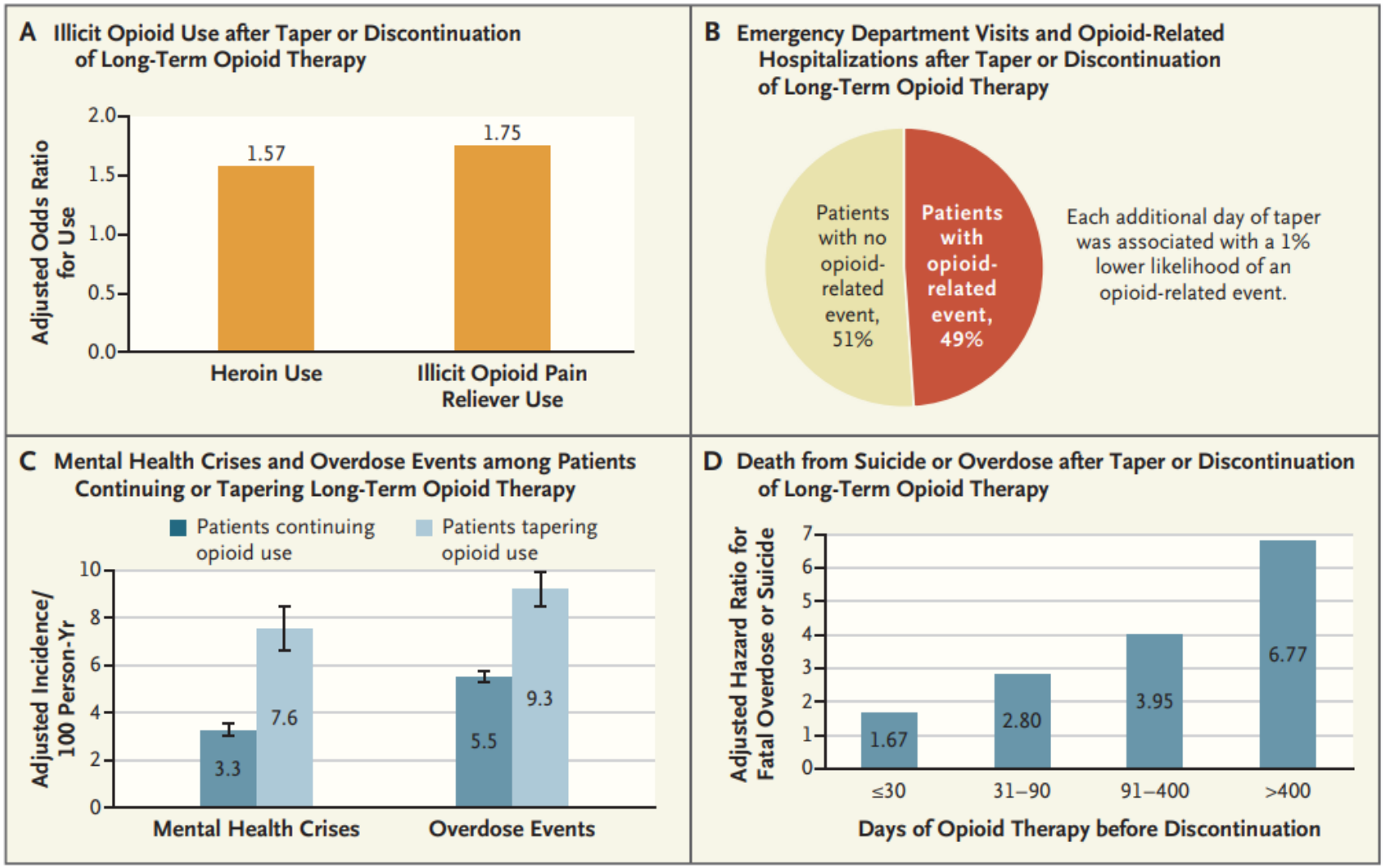
Case Study: Former Nurse and Chronic Pain Patient

The patient:

Anne Fuqua is a former RN with dystonia, a condition which causes painful muscle spasms.

- Her pain specialist lost their license to prescribe controlled substances when the DEA took action against their clinic.
- She was provided only a list of emergency rooms and a flier with addiction treatment hotlines after losing access to her opioid prescription.
- Her pain "went from well-controlled to not controlled at all."
- **"I don't want to die."**

Morbidity and Mortality related to opioid tapering or discontinuation



Risks Conferred by Tapering or Discontinuing Long-Term Opioid Therapy.

Among patients who have their long-term opioid therapy discontinued or tapered, there is an increased risk of illicit opioid use (Panel A), a high incidence of emergency department visits and opioid-related hospitalizations (Panel B), an increased incidence of mental health crises and overdose events (Panel C), and an increased risk of death from suicide or overdose (Panel D). I bars in Panel C indicate 95% confidence intervals. Data are from Coffin et al.,[2] Mark and Parish,[3] Agnoli et al.,[4] and Oliva et al.[5]

More on the risks of tapering or discontinuing opioids

When abandoned patients present to care, the immediate treatment plan should NOT be to taper.

Mandatory opioid tapering for patients on stable long-term opioid therapy without evidence of opioid misuse does NOT reduce short-term harm via suicide, overdose, mental health crisis and withdrawal.

Two other recent studies of large cohorts of patients showed that

1. Rate of **overdose, withdrawal or mental health crisis** was over **1.5 times as high** for patients experiencing a taper compared to patients not tapered (Fenton et al, 2022)
2. For patients discontinued or tapered off opioids who had previously been on long-term stable opioid therapy WITHOUT evidence of misuse, there was a small absolute increase in incidence of overdose and suicide events within 1 year. (Larochelle et al, 2022)

What not to miss in caring for an abandoned patient

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suicidepreventionlifeline.org

A note on risk of suicide

- In a study of suicide decedents in a retrospective cohort from the National Violent Death Reporting System, more than half of suicide decedents with chronic pain died of firearm-related injuries and 16.2% died by opioid overdose (Petrosky et al, 2018)
- Chronic pain may be a risk factor for suicide
- Screening for suicidal thoughts, plans, past attempts and intent is crucial for inherited patients

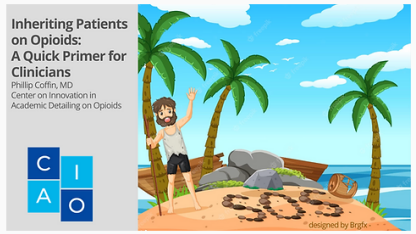
Inheriting Patients on Long Term Opioids: A Toolkit

Notwithstanding overprescribing of opioid medications, efforts to reduce opioid prescribing also carry risks. Perhaps most problematic is the sense of abandonment experienced by patients. Tens of thousands of U.S. patients receiving opioids are forced to find new providers each year. Few clinicians are willing to take on the care of these patients, and even fewer provide the type of continuity necessary for a safe transition of care.

The materials included here are directed at clinicians and regulators; they are for informational purposes only and do not represent medical or legal advice.

Featured in the toolkit:

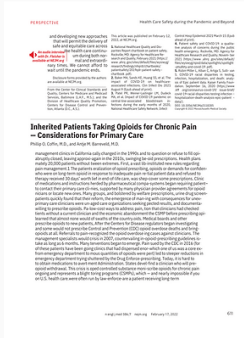
- 5 minute video from Dr. Phillip Coffin reviewing steps to support patients who have lost their provider
- Two articles focused on inherited patients and patients on long-term opioid therapy
- Documentation template for patients on opioids for chronic pain
- Example SmartPhrase for Epic
- Example policy on managing inherited patients on legacy or long-term opioids
- Example letter to clinicians regarding continuity of care for patients treated with buprenorphine for opioid use disorder



Inheriting Patients on Opioids: A Quick Primer for Clinicians

This <6 minute talk by CIAO Medical Director, Phillip Coffin MD, briefly reviews steps to support patients who have lost their provider.
References here.

March 2023


Inherited Patients Taking Opioids for Chronic Pain — Considerations for Primary Care

Inherited Patients Taking Opioids for Chronic Pain - Considerations for Primary Care

Dr. P Coffin and Dr. A Barreveld review the issue of inheriting patients prescribed opioids in this *New England Journal of Medicine* perspective.

February 2022

CENTER FOR INNOVATION IN ACADEMIC DETAILING ON OPIOIDS

Opioids for Chronic Pain: Documentation Template

Suggested components of documentation	*You can use these suggestions to create your own EMR Smart Phrase!*
Pain history Complete OLDCARTS for pain complaint. **TIPS:** Treatment: pain medications, non-pharmacologic therapies, surgeries. Severity: PEG scale includes functional impact of pain. *See "Current pain assessment" below.*	**Onset:** **Location:** **Duration:** **Characterization:** **Aggravating:** **Relieving:** **Treatment history:** **Severity:**
Other relevant history **Imaging:** x-ray, MRI, ultrasound. **Labs:** related to disease processes or substance related. **Prior notes:** past diagnoses, ROI from other providers. **Other medications:** non-opioid medications.	**Imaging:** **Labs:** **Prior notes:** **Other medications:**
Current pain assessment The 3-question PEG reflects average pain and impact on enjoyment and function over past week (pg. 14)	**Past week average pain:** **Past week pain interference on life enjoyment:** **Past week pain impact on general activity:**
Physical exam Complete **focused** exam yearly or more frequently.	**PE:**
Risk factor assessment Includes mental health/psych hx Guides clinical decision-making (pg. 15).	**Risk factors include**:
Opioid use disorder screening Use DSM-5 (pg. 25).	**OUD criteria noted** (0-11):
Urine drug screen (pg. 17)	**UDS** results / date / plan
Control substance agreement or consent (pg. 18)	**Controlled substance agreement** review date
Prescription drug monitoring program (pg. 19)	**PDMP** results / date
Naloxone (pg. 22)	**Prescribed/discussed naloxone** date
Plan Include rational for plan and future goals. **TIPS:** continuity of care, obtainable goals, and minimizing patient risks make a strong rational.	**Plan:**

*Page numbers refer to **Opioids and Chronic Pain: A Guide for Primary Care Providers**, available at www.ciaosf.org/materials

Sample language for discussing chronic pain management with patients:

On transitioning care:

"It's tough to transition from one provider who knows you to a new provider who is not familiar with your history and care. At this first visit, I want to focus on getting to know you and refilling whatever prescriptions you may need; in the future we'll come up with a plan of care together."

On the value of naloxone:

"Any opioid has risk of adverse effects like slowed breathing or overdose, which is why I offer naloxone to all my patients."

On the use of urine drug screens:

"I sometimes use urine drug screening for patients who use controlled substances, but I would never change or stop your prescription based on one-time r

On proposing a taper:

"Taking opioids for a long time changes the way your body
Often, people can actually have less pain when they decide
We'll check in periodically, and always make decisions toge

On opioid use disorder and treatment options:

"You may be experiencing an opioid use disorder. This does
some opioid medications can be more dangerous for you. T
use disorder: methadone, which you would get at a special
opioid that I prescribe; and extended-release naltrexone, an

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855-300-3595 (M – F, 9am – 8pm EST), or nccc.ucsf.edu

Our consultants provide clinicians with guidance on a range of topics, including:

- Assessing and treating opioid, alcohol, and other substance use disorders
- When/how to initiate medications for opioid use disorder
- Toxicology testing: when to use it and what it means
- Identifying and managing withdrawal
- Approaches to adjust opioid-based pain regimens to reduce risk of misuse and harm
- Harm reduction and overdose prevention strategies
- Discuss useful communication and care strategies to support patients living with, or at risk for, substance use disorders
- Substance use in special populations

Our team includes expert physicians, pharmacists, and advanced practice nurses with considerable experience managing substance use disorder. *No protected health information is collected during our consultations.*

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA HIV/AIDS Bureau (HAB) and Bureau of Primary Health Care (BPHC), awarded to the University of California, San Francisco

Takeaways

- Patient abandonment is medical negligence.
- There are significant risks of morbidity and mortality when patients don't have their stable, long-term opioid prescription refilled, including mental health crisis, hospitalization, overdose and death including suicide.
- Prevent suicide and overdose risk for abandoned patients.
- Consider using communication tools (e.g. clinic policies, documentation templates) to standardize approaches to caring for patients who have been abandoned.

Academic Detailing Visit Demonstration

Mock Academic Detailing Visit

What to watch for...

Steps of a Visit

- Introduction
- Needs Assessment
- Key Messages
- Handling Objections
- Summary & Closing

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Thank you!

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