What do I do with inherited patients on opioids?
A Webinar for Providers

The Center for Innovation in Academic Detailing on Opioids

San Francisco Department of Public Health

Agenda

1. Introduction to CIAO
2. Overview of LAGS Pain Management Clinics Closures
3. Best Practices in Inheriting Patients on Opioids
4. Managing Patients on Buprenorphine
5. Q&A

* *Please submit questions in the **Q&A***

The information and education presented in this presentation and on the following slides are solely those of the presenters and not necessarily those of the California Department of Public Health (CDPH).

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.

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DHCS Alert (5.27.21): Closure of 29 LAGS Pain Clinics

- **29 pain management centers closed**
- *20,000 patients receiving pain management*

- Affected counties: Los Angeles, Ventura, Santa Barbara, San Luis Obispo, Kern, Tulare, Kings, Monterey, Santa Cruz, Fresno, Madera, Merced, Alameda, Stanislaus, San Joaquin, Sacramento

Published: May 28, 2021

DHCS Alert (5.27.21): Closure of 29 Lags Pain Clinics

Alert:

High numbers of patients on controlled medications may need help connecting to new pain management and/or MAT providers, due to the closure of 29 Lags Medical Centers, which operate high-volume pain management clinics in California.

Request:

DHCS encourages MAT providers to consider the use of buprenorphine for pain indications for patients who are opioid-dependent and have difficulty finding providers to continue full-agonist opioid treatment, when medically necessary. These patients are likely to be at risk, if they are unable to connect to ongoing medical care. Please also prescribe naloxone, where appropriate, as a safety measure. The attached resource list could be used by local organizations to share contact information for local resources.

The California Department of Health Care Services (DHCS) is working with health plans and community organizations to create transition plans for the patients. However, because Lags Medical Centers advertises over 30,000 patients served in California, we anticipate that many patients may have difficulty obtaining new pain management providers, given the suddenness of the clinic closures and the high volume of affected patients.

Sign up for 1:1 Information on Inheriting Patients on Opioids

Due to recent closures of 29 LAGS pain management clinics in California, up to 20,000 patients receiving pain management will be seeking alternative care. Some of these patients may be on long-term opioid therapy for chronic pain, a serious challenge for nearby providers. **Affected providers can register below for a one-on-one educational / informational session with CIAO clinician trainers to discuss these topics.**

Let's Connect

www.ciaosf.org/contact-8

What not to do when inheriting patients...

Key Messages in Inheriting Patients:

- Continuity of care is critical.
- Stopping opioids can be risky.
- Patient-centered care leads to best outcomes and can take time to develop.
- Good documentation is critical to onboard inherited patients.
- Buprenorphine is now much easier to provide!

Getting on the same page with opioids and chronic pain

Patient presentation and pain management strategy

Chronic pain
Not currently receiving opioid therapy

- Avoid opioid therapy

  Risk stratification tools to identify high- or low-risk patients provide no diagnostic value

Chronic pain
Currently receiving opioid therapy

- Develop and use individualized treatment plan
- Do not abruptly taper or discontinue current opioid treatment
- Consider opioid agonist therapy (eg, buprenorphine/naloxone) if evidence of opioid use disorder

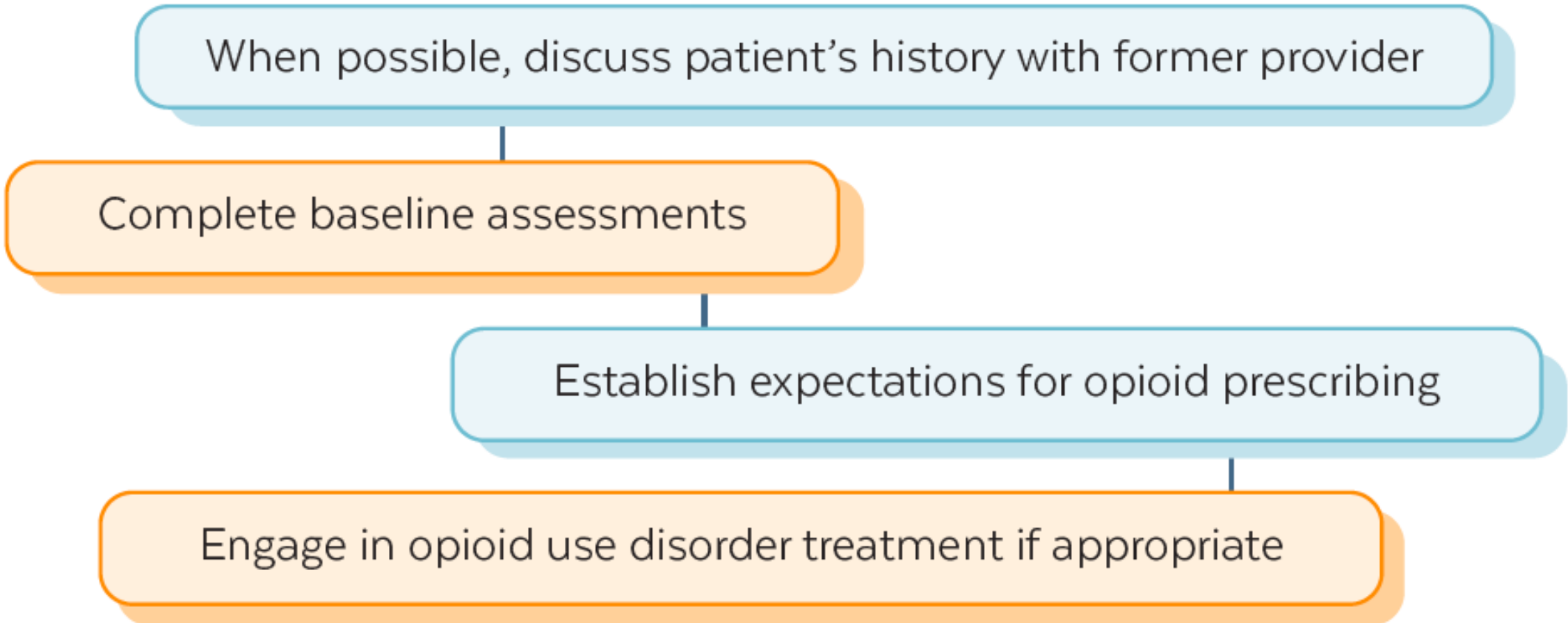
Acute pain
Therapy not initiated[a]

- Avoid opioid therapy in patients with minor to moderate pain conditions
- Consider opioid therapy for patients with severe pain

  Dose and duration should be limited to short, renewable courses (eg, <1 week)

Wood et al, JAMA, 2020

INHERITING PATIENTS ALREADY ON OPIOID THERAPY CAN BE COMPLEX

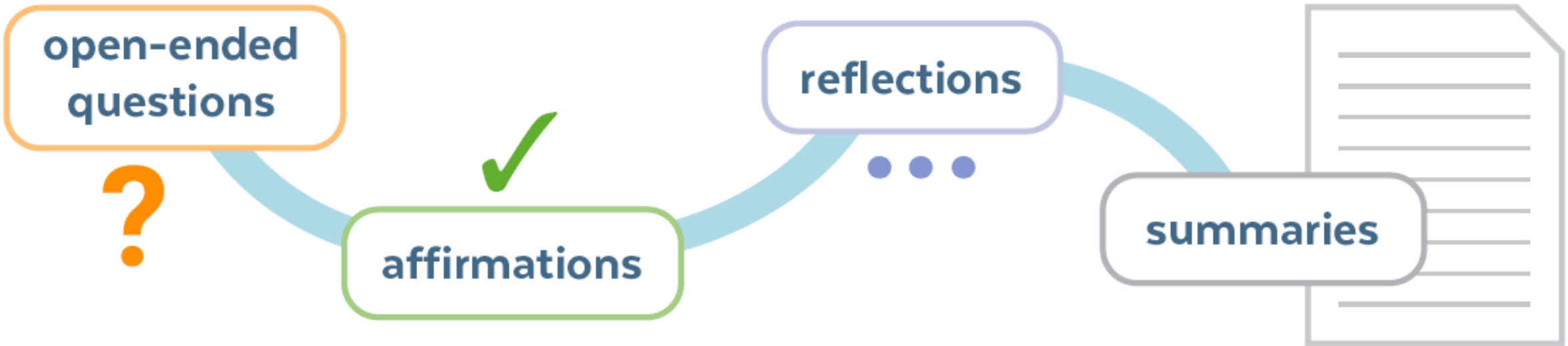


PATIENT ENGAGEMENT

- **Recognize patient** (e.g. psychosocial stressors), **provider** (e.g. time pressure, burnout), **and environmental factors** (e.g. regulatory changes) that lead to challenging conversations.
- Stigma can have a negative impact on the patient-provider relationship and a patient's mental health.[5] Use patient-first language.

Instead of these terms:	Use these:
addict	person with a substance use disorder
dirty urine	unexpected results
abuse	problematic use

- Use motivational interviewing techniques



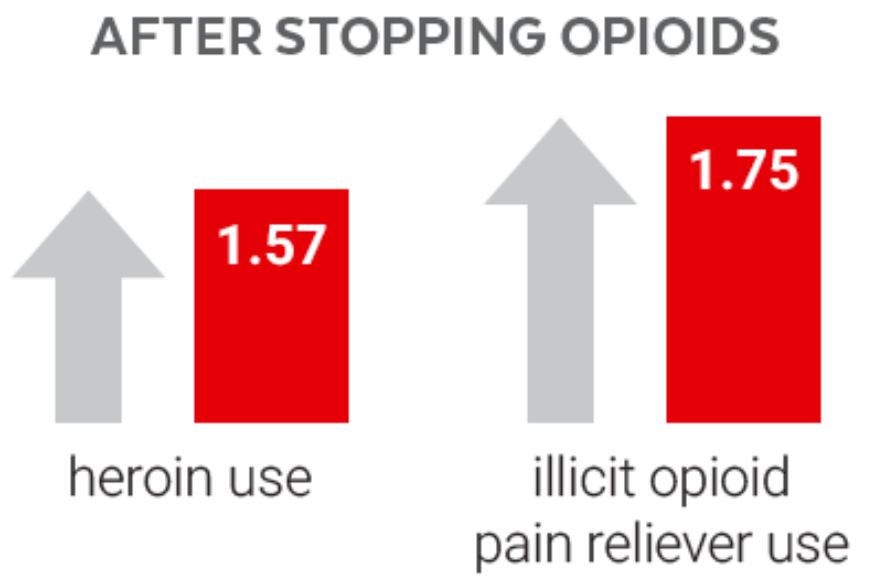
For more information, go to: **motivationalinterviewing.org**

Preparing to reduce opioid dose

Tapering opioids may improve pain, based on a systematic review of 20 studies demonstrating improved or similar pain after a successful taper.[6]

HOWEVER, THERE ARE RISKS TO REDUCING OPIOID THERAPY:

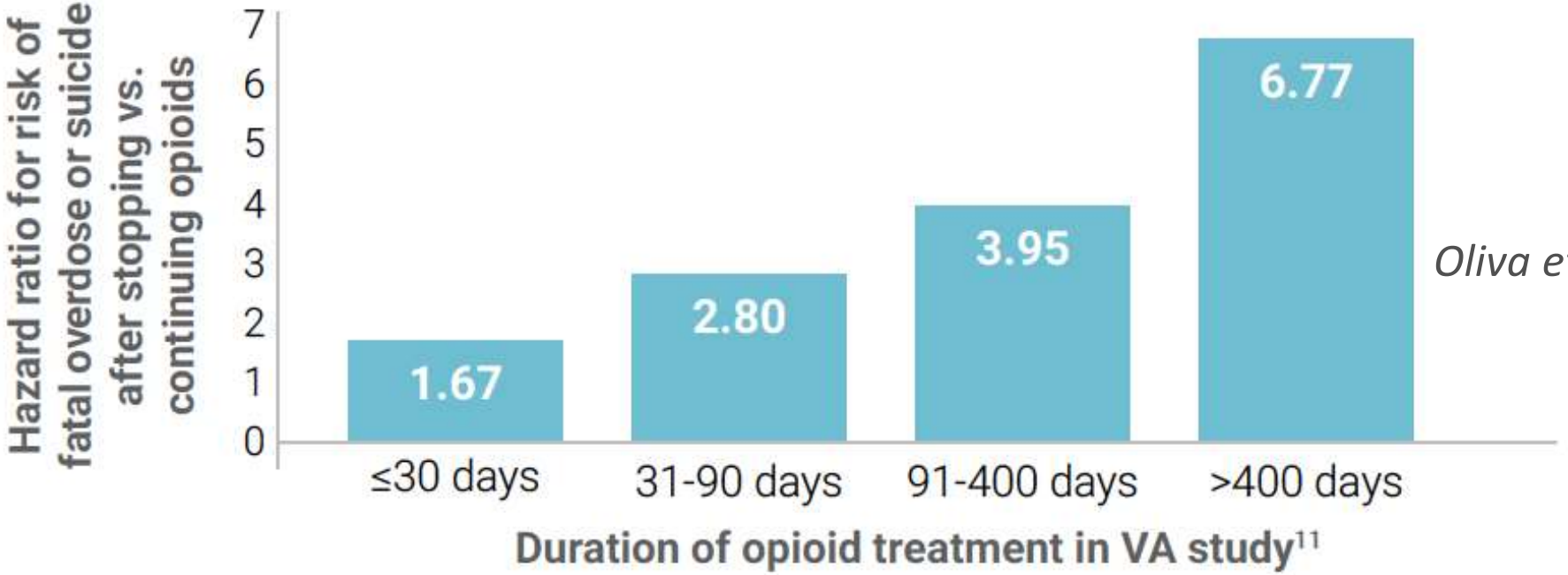
- **Complex persistent dependence:** Patients living with chronic pain may experience neuroplastic effects from long-term opioid use, which may cause increased pain, decreased function, and psychological distress.[7]
- **Increased illicit substance use:** Stopping prescribed opioids increased the chance of more frequent heroin and illicit opioid pain reliever use.[8]



Adjusted odds ratio of increased use[8]
baseline odds ratios 1.0

- **Opioid-related adverse events:**
  Approximately half of Medicaid patients in Vermont had an opioid-related ED visit or hospitalization following discontinuation of high-dose opioids.

- **Mortality:** In a study of 1,394,102 patients in the VA, patients were at greater risk of fatal overdose or suicide after stopping opioid treatment, with increasing risk the longer patients had been treated before stopping.



Oliva et al, BMJ, 2020

FDA and CDC recommend opioid prescribing be individualized for each patient to modulate the risks of changing dose. Go to: **bit.ly/CDC_opioidguide** and **bit.ly/FDA_opioidguide**

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

FDA Drug Safety Communication

CDC Advises Against Misapplication of the *Guideline for Prescribing Opioids for Chronic Pain*

Some policies, practices attributed to the Guideline are inconsistent with its recommendations

Media Statement

CDPH

SUSAN FANELLI
Acting Director

Statewide Opioid Safety Workgroup Member Agencies*

- Board of State and Community Corrections
- CA Board of Podiatry Medicine
- CA Board of Registered Nursing
- CA Conference of Local Health Officers
- CA Department of Aging
- CA Department of Consumer Affairs
- CA Department of Corrections and Rehabilitation
- CA Department of Health Care Services
- CA Department of Industrial Relations
- CA Department of Justice
- CA Department of Managed Health Care
- CA Department of Motor Vehicles
- CA Department of Public Health
- CA Department of Social Services
- CA Health and Human Services Agency

State of California—Health and Human Services Agency
California Department of Public Health

GAVIN NEWSOM
Governor

August 27, 2019

Dear Provider,

Health care providers are essential partners in ending the opioid epidemic in California. Working together, we want to ensure that providers have access to resources and support to help improve patient pain management, while avoiding opioid overdose and dependence.

One of the most challenging situations reported by prescribers is how to respond to patients already on high doses of opioids (> 90 MMEs) or with possible addiction symptoms. These patients are at higher risk and may need your assistance more than ever. Recent concerns about over-prescribing of opioids has led to some misinterpretation resulting in abruptly terminating the use of opioids, which can cause health risks for patients. I want to stress that some pain management situations may involve the use of opioid medications if alternative approaches are not available or effective. It is my hope that we can offer resources to support you as you continue your clinical relationship with your patients to ensure their overall well-being.

Shared decision-making for opioid therapy

Avoid making a decision without an individualized conversation with the patient.

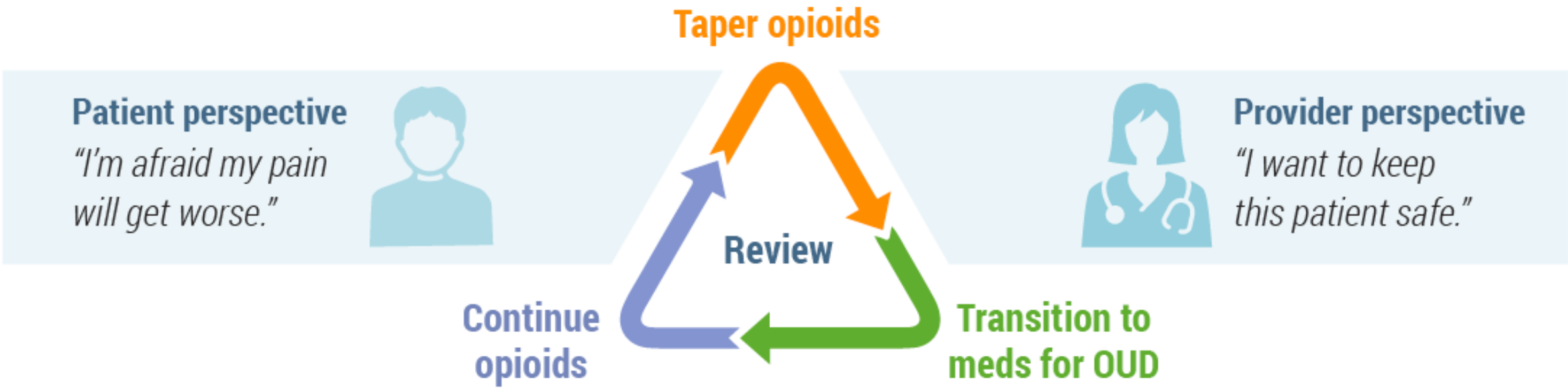
1 Ask the patient to describe perceived risks and benefits.

Patients may identify scenarios with limited benefit or increasing risk such as:

- On opioids after pain condition addressed
- No evidence of pain/function improvement
- Very high dose of opioids
- Other risky medications (e.g. benzodiazepines)
- Adverse effects (constipation, overdose, etc.)
- Worsening comorbidities
- Active opioid use disorder

2 Develop a plan with the patient.

SHARED DECISION-MAKING PROCESS



Communication techniques:

- Validate patient's pain and experience
- Recognize power dynamics
- Empower patient to participate in treatment planning
- Don't judge
- Be flexible
- Prepare for emotion

3 Before implementing change, review and develop a plan for:

- Social issues (e.g. housing, finances, intimate partner violence)
- Alternative pain management strategy (other medication and non-medication strategies)
- Mental health services
- Social support
- Withdrawal medications
- Changes in tolerance and overdose risk

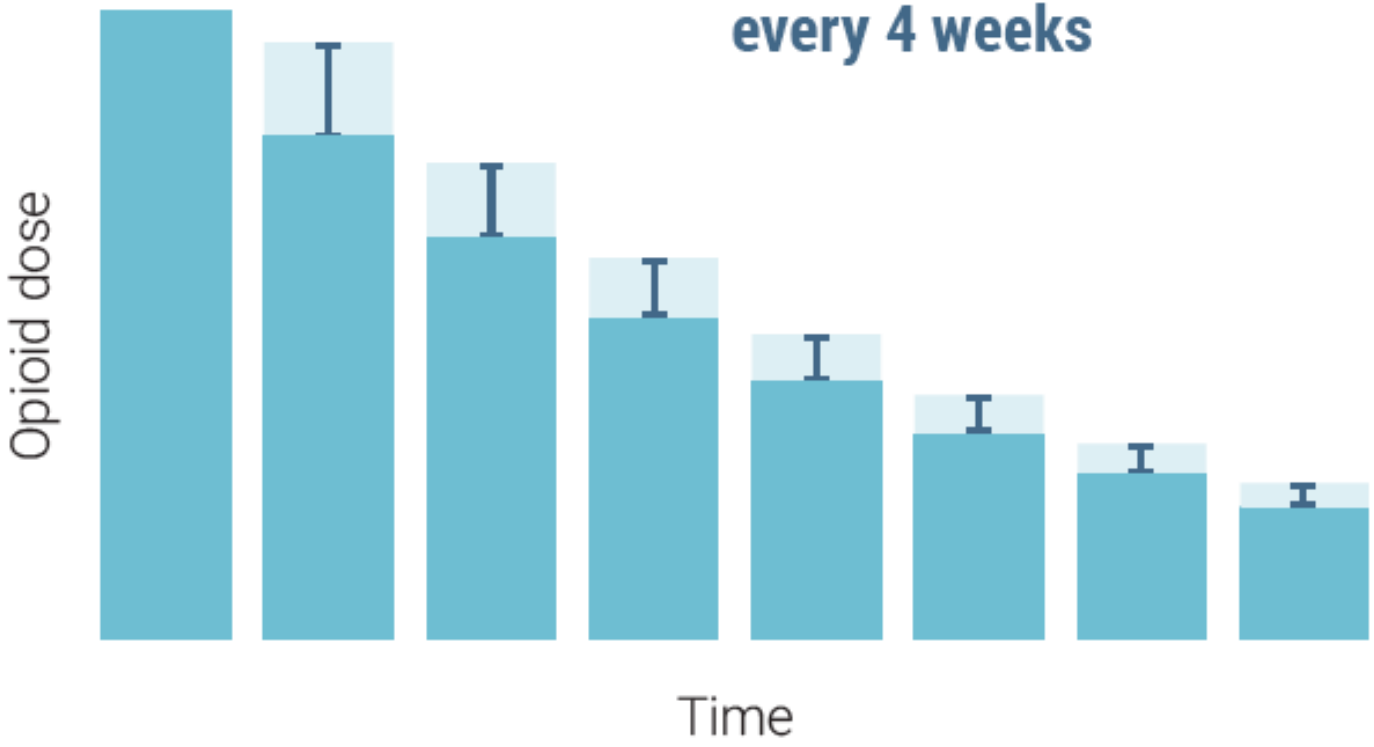
Steps of a taper

1. Get to know the patient's stressors, needs, and pain:
   - don't rush to start a taper immediately: patient buy-in is important
   - individualize the taper plan (see "Example tapers for opioids")
2. Discuss the risks of tapering.
3. Involve patient in the selection of a taper speed and frequency of dose reduction (see "Example tapers for opioids").
4. Tapering should **not** result in withdrawal. However, in some circumstances, you may prescribe adjunctive medications to treat withdrawal symptoms.

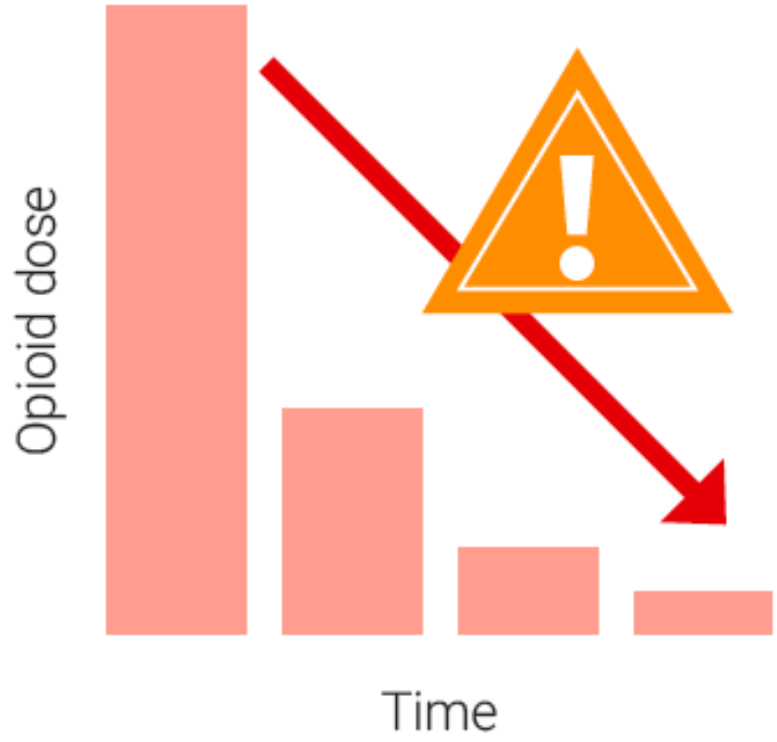
Symptom	Medication
Cold sweats, chills, feeling "jittery"	Clonidine: 0.1 mg tablet
Anxiety, problems sleeping	Hydroxyzine: 50 mg tablet
Nausea or vomiting	Ondansetron: 4 mg tablet
Diarrhea	Loperamide: 2 mg tablet
Body aches or muscle pain	NSAIDS or Acetaminophen

TAPER GOALS

Most commonly, opioid tapers will involve dose reduction of 5-20% of original dose every 4 weeks



Abrupt tapers (>20% of original dose) should be avoided whenever possible



Successful tapers look different for each patient and often include pauses, stops, and dynamic goals. Any reduction may be considered a success.

Documentation Suggestions

Suggested domains	*Example of a patient note for a 55-year-old male presenting with pain and numbness in bilateral hands and feet*
Pain history Include type, duration, and source of pain and previous treatments, labs, and exam notes.	*Onset: 10 yrs ago, no specific injury* *Location: distal interphalangeal joints of hands and feet* *Duration: 10 years, progressively worse every year* *Characterization: occasional sharp pain in feet, occasional numbness in feet while walking, occasional numbness and pain in hands* *Aggravating Factors: cold and rainy weather* *Relieving factors: none, does not take medications or do physical therapy* *Treatment History: prior Gabapentin use but discontinued* *Severity: 7-8/10* *Prior labs and imaging* • *2012: Xray bilateral hands: erosions* • *2012: rheumatoid factor mildly elevated* *Prior exam notes: Distal interphalangeal joint swelling consistent with arthritis* *Pt missed rheumatology appointment after referral 9 years ago*

Documentation Suggestions - Pain

Current pain Include PEG-3[1] baseline and current pain score (out of 10), any trend in scores, other assessments, and unique characteristics of pain.	*Current pain description: aching, stiff, sharp pain in feet; no pain in hands* *PEG-3 (during past week)* • *Average pain: 7-8; 5 while on medications; 9 prior to starting medications* • *Pain interference in enjoyment of life: 9; 4-5 while on medications; 9 prior to starting medications* • *Interference with general activity: 7-8; 4-5 while on medications; 7 prior to medications*
Previous and current therapy Include non-medication therapies, non-opioid medications, and opioids, and rationale for prescriptions/dosage (if necessary).	*History* • *Patient on chronic opioids for baseline bilateral foot/hand pain for 10 years* • *Was on oxycodone 30mg four times a day (120), reduced to 100 tablets in 3 months prior to this visit* • *Did not want to be on opioids but now needs them* *Current prescription: Oxycodone, #100. Last filled XX/XX/XXXX*

Documentation Suggestions – Assessment for Use Disorder

Risk evaluation Include opioid risk tool (ORT)[2] score or similar validated tool for risk assessment, along with previous and current substance use, and relevant social and psychiatric history.	*ORT: 6-7 points, intermediate risk* *Substance use history* • *No family history of substance use disorders* • *Patient drinks 2-3 beers per week currently* • *Crystal meth use stopped 10 years ago after HIV diagnosis; relapsed 6-7 months ago (one time use related to sex); denies current meth use* *Social and psychiatric history* • *Diagnosed with schizophrenia* • *Mood swings and mild depression, low energy and motivation. On X and Y medication*
Opioid use disorder screening Use DSM-V[3] criteria to screen for substance use disorders.	*DSM-V score: 1/10 today. Screened negative for OUD (would compel prompt transition to buprenorphine instead of taper).*

Documentation Suggestions – Stewardship Measures

Urine drug screening (UDS) Include expected and unexpected results, date of most recent UDS	*<u>UDS:</u>* • *As expected XX/XX/XXXX and YY/YY/YYYY* • *Repeat every 3 months*
Controlled substance agreement Include dates discussed/signed	*<u>Most recent controlled substance agreement discussed</u>: XX/XX/XXXX*
Controlled substance monitoring program (CSMP or PDMP) Include dates, unexpected results	*<u>Last PDMP/CSMP check</u>: XX/XX/XXXX; nothing unexpected.*
Naloxone prescription Include date of last prescription	*<u>Last naloxone prescription</u>: XX/XX/XXXX; Has nasal naloxone at home, keeps with opioids.*

Documentation Suggestions - Plan

Plan Include rationale if necessary	*Plan* • *Continue to follow opioid risk tool and DSM-V score closely* • *New bilateral hand XRays ordered this visit* • *Continue current dose of prescription opioids* • *Repeat urine drug screening every 3 months* ***Rationale for high dose*** • *Patient on high dose oxycodone x 10 years, recently tapered by ~20%* • *Although the indication for this dose of opioids is weak, given recent data that tapers/discontinuations of opioid therapy can result in multiple negative outcomes and that there is no urgent reason to make such a change in this patient, I am continuing therapy for the patient* • *I am a new provider for this Pt and I need to get to know Pt better before considering additional changes*

What if the patient has an opioid use disorder?

DSM-5 CRITERIA FOR SUBSTANCE USE DISORDER (SUD)*

USE PATTERNS:

- **More/longer** use than intended
- **Unable to stop** or cut down
- **Excessive time** dealing with opioids
- **Craving**

CONTINUED USE EVEN WHEN:

- **Responsibilities** not fulfilled
- **Social** and interpersonal problems
- **Activities** reduced
- **Physical** hazards from use
- **Health** problems patient knows are caused by opioids

DRUG EFFECTS (ONLY IF NOT PRESCRIBED):

- **Tolerance**: requiring more to achieve effect
- **Withdrawal** symptoms if opioids are stopped

SCORING

Give 1 point *for each domain endorsed by the patient or observed by the clinician.*

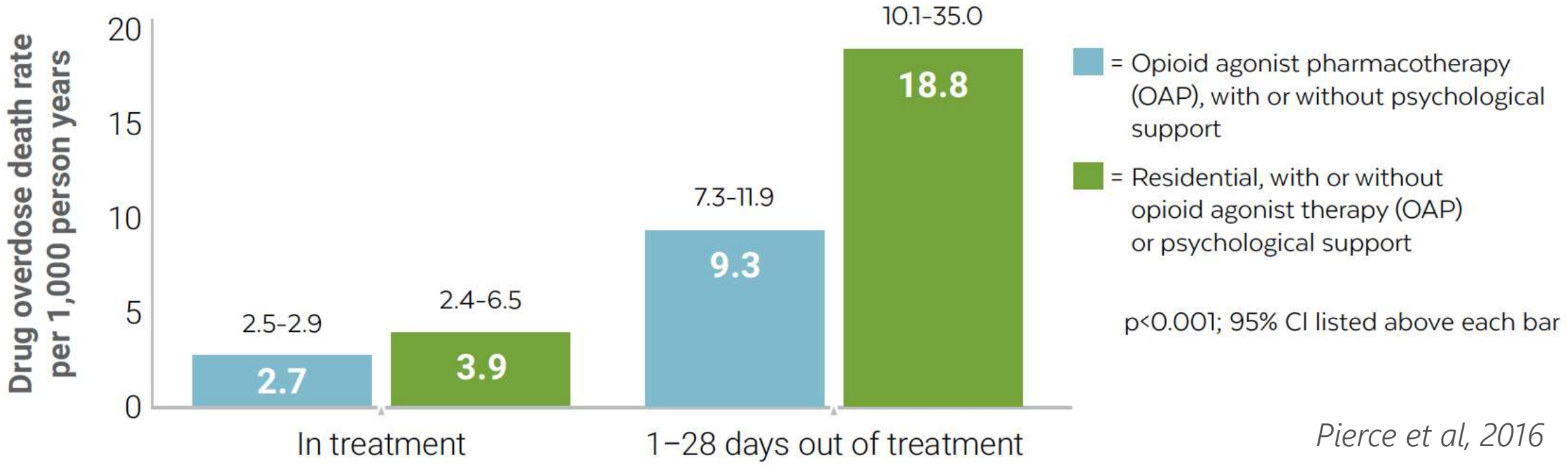
Mild SUD = 2-3

Moderate SUD = 4-5

Severe SUD = 6 or more

Medications for opioid use disorder are the best way to keep a patient safe.

DRUG OVERDOSE DEATH RATE PER 1,000 PERSON YEARS AMONG 151,983 PEOPLE WITH OUD SEEKING TREATMENT IN THE UNITED KINGDOM[24]



Pierce et al, 2016

FDA-APPROVED MEDICATION TREATMENT OPTIONS

- Buprenorphine (with or without naloxone)
- Methadone
- Extended-release naltrexone

Like treatment for other chronic diseases such as diabetes, these medications should be considered long-term therapy.

BEHAVIORAL/PSYCHOLOGICAL INTERVENTIONS

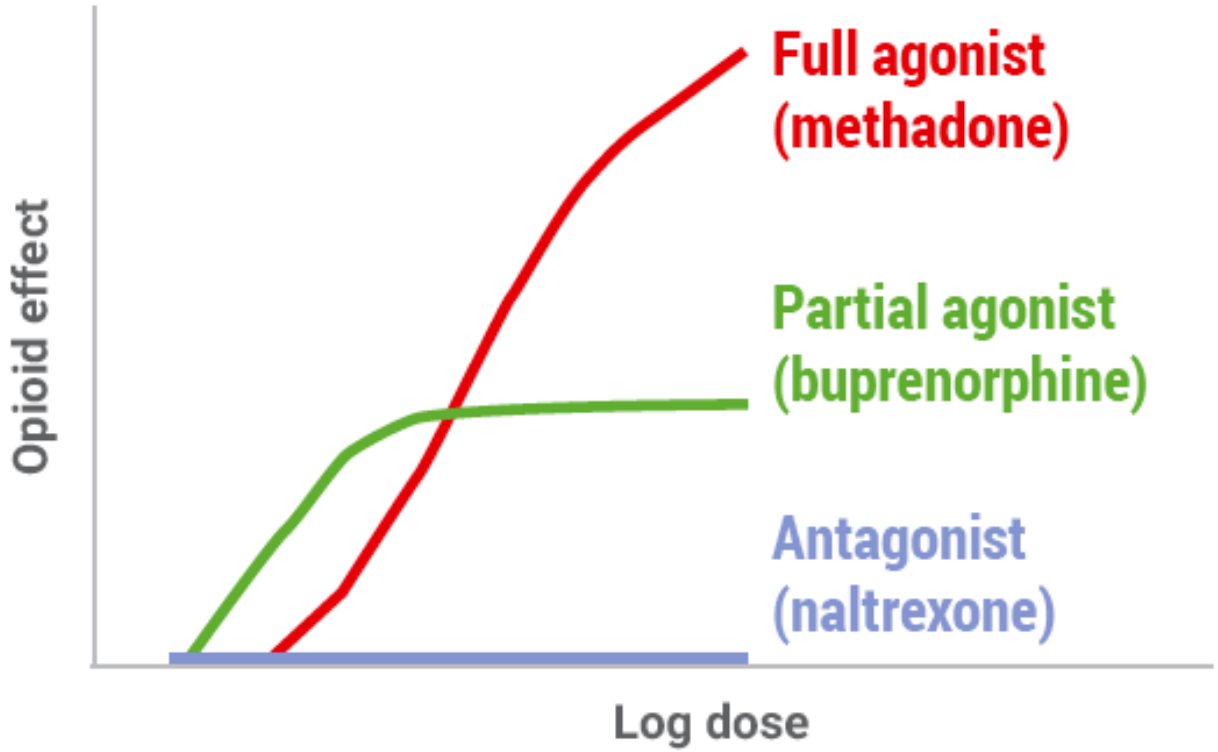
- Outpatient or inpatient rehabilitation and counseling
- Support groups such as Narcotics Anonymous

If not personally providing OUD treatment, a warm hand-off to other providers is critical.

To provide buprenorphine now, just submit a waiver request!

- HHS updated the Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder as of 4/28/2021
- What changed?
  - MDs, DOs, PAs, NPs, CNS, CRNAs, CNMs with a state license and DEA registration can sign up for a waiver and get an X number to treat **up to 30 patients** with buprenorphine ***WITHOUT*** having to do any training and ***WITHOUT*** having to certify that they can provide counseling or other ancillary services.
    - To prescribe buprenorphine to >30 patients, complete the trainings per the old system and meet certain conditions.
- **Sign up to provide buprenorphine and get a DATA 2000 waiver here: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php**

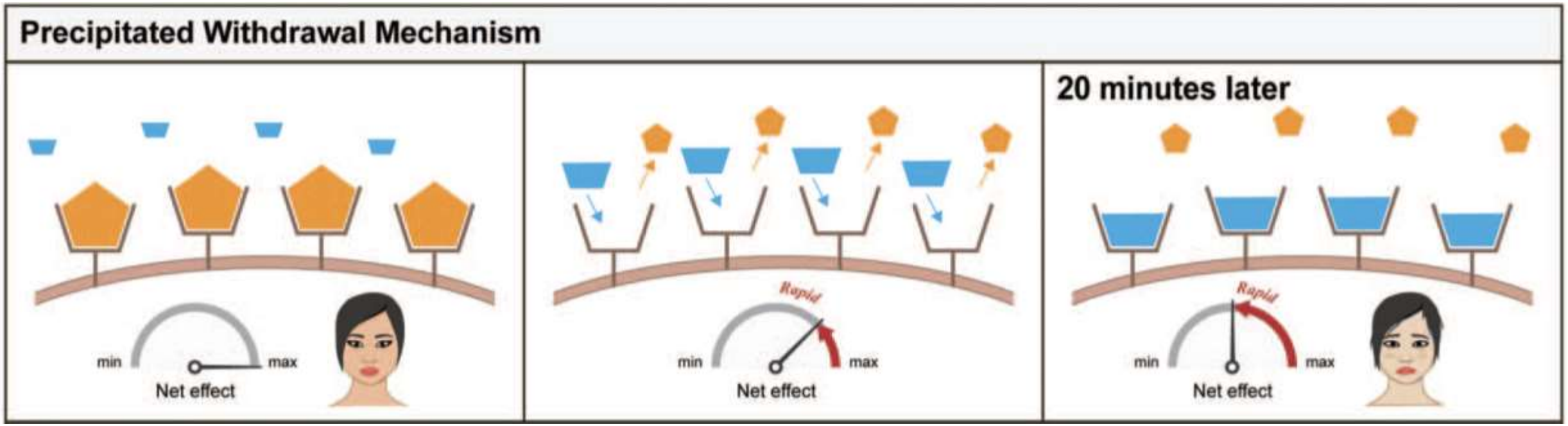
Buprenorphine overview and safety profile



BUPRENORPHINE

- A partial opioid agonist
- Time to peak: 30 min to 3 days depending on formulation
- Has very high affinity, blocking effects of heroin or other opioids

Partial agonists, full agonists and precipitated withdrawal



Ghosh et al, Canadian Journal of Addiction, 2019

SAFETY PROFILE

- Due to the “ceiling effect” of a partial agonist, buprenorphine has:
  - **Low potential for misuse** and diversion
  - **Low risk** of respiratory depression or overdose
  - **Ability to reduce craving and withdrawal** without the euphoria of full agonist
- Maintenance is critical: OUD requires long-term care.
- Buprenorphine treatment is safe and effective during pregnancy.[25]
- Most buprenorphine for OUD treatment is co-formulated with naloxone to discourage diversion or injection of the product.

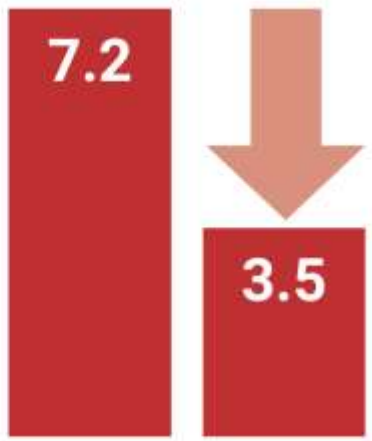
FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks

Safety Announcement

[9-20-2017] Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks. We are requiring this information to be added to the buprenorphine and methadone drug labels along with detailed recommendations for minimizing the use of medication-assisted treatment (MAT) drugs and benzodiazepines together.

STUDIES ALSO SUPPORT USE OF BUPRENORPHINE FOR CHRONIC PAIN

In a study of 35 patients on 200-1,370 morphine equivalent milligrams of opioids for chronic pain, after two months of sublingual buprenorphine:



Pain scores reduced
from 7.2 to 3.5 ($p<0.001$)

Quality of life scores increased
from 6.1 to 7.1 ($p=0.005$)

Range of pain scores = 0-10

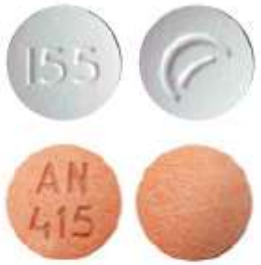
Daitch et al., Pain Medicine, 2014.

Managing Opioid Use Disorder: Prescribing buprenorphine

Formulations

- Keep buprenorphine tablet or film under tongue until dissolved (5-15 min). **DO NOT SWALLOW.**
- OK to cut film in half or quarter pieces.
- Therapy usually involves buprenorphine with naloxone, although the monoformulated product can also be used.

BUPRENORPHINE/NALOXONE (CO-FORMULATED)



Sublingual tablets

Sublingual film

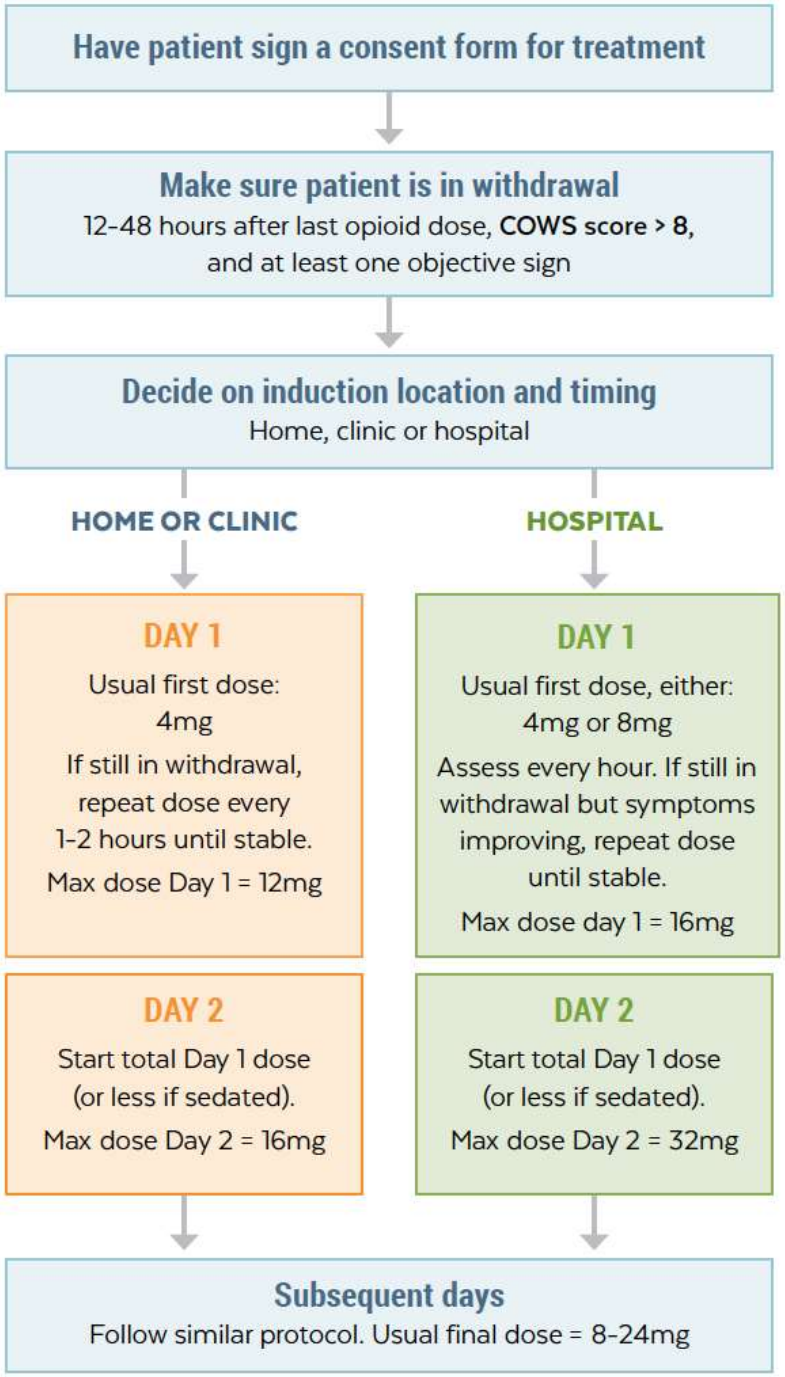
MONOFORMULATED BUPRENORPHINE

Sublingual tablets

Subcutaneous injection

Transdermal patch

Starting Buprenorphine



✓ **CHECK COWS:**

Higher score = less risk of precipitated withdrawal

Clinical Opioid Withdrawal Scale (COWS): mdcalc.com/cows-score-opiate-withdrawal

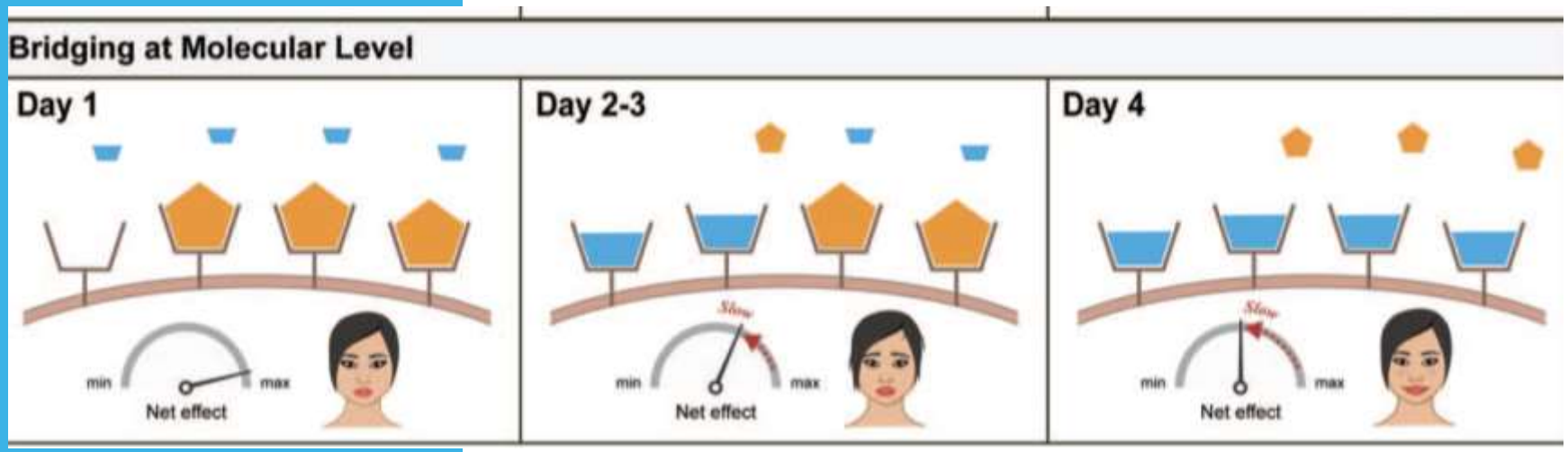
COWS has 11 items and up to 48 points.

Look for subjective symptoms AND at least one objective sign.

- **Subjective**: insomnia, vomiting, diarrhea, restlessness, anxiety, abdominal cramps, diaphoresis, myalgias/arthralgias, hot flashes, dizziness, tearing, goosebumps, shaking, yawning, twitching, sweating
- **Objective**: restlessness, shivering, rhinorrhea, dilated pupils, tachycardia, yawning, piloerection, tremor, sweating, hypertension

Starting Buprenorphine While a Patient is Still on Other Opioids

- Called “overlap initiation” or “micro-dosing”
- Procedure:
  - Start a very low-dose of buprenorphine (e.g. 0.5mg) while patient continues to use full agonist
  - Increase slowly over 3-9 days, with decreasing use of full agonist
- Avoids need for withdrawal and may lower risk of precipitated withdrawal



Ghosh et al, Canadian Journal of Addiction, 2019

Continuing buprenorphine

- **Document OUD in chart.**
- **Optimal dose varies by patient.**
  ≥16mg/day may aid in retention, block other opioids, and reduce relapse, pain, and dysphoria.
- **Follow-up visits**: tailor frequency to patient stability. Weekly visits at start of treatment or when unstable; monthly or longer when stable.

  Review:
  - Buprenorphine adherence, illicit opioid use, UDS, CSMP
  - Mental health and comorbid substance use disorders
  - Healthcare maintenance
- If unsuccessful, consider other OUD medications such as methadone or extended-release naltrexone.

Remember that buprenorphine:

- **Gives patients control** over opioid use.
- **Lowers overdose risk,** even if still using illicit opioids, by binding very tightly to μ receptors.
- **Does not treat other substance use disorders.**

Buprenorphine by Telehealth is Legal and Safe

As of March 31, 2020: Clinicians with a DATA 2000 waiver can prescribe buprenorphine to new and existing patients with OUD via telehealth.

Before and after COVID-19 pandemic:

- Studies in the VA, San Francisco and New York City showed that starting buprenorphine via telehealth was **safe** and potentially **increased access** (*Brunet et al, 2019, Togifi et al, 2020; Mehtani et al, 2020*)

Telehealth is a useful intervention to start and continue patients on buprenorphine.

Key Messages in Inheriting Patients:

- Continuity of care is critical.
- Stopping opioids can be risky.
- Patient-centered care leads to best outcomes and can take time to develop.
- Good documentation is critical to onboard inherited patients.
- Buprenorphine is now much easier to provide!

What is the California Substance Use Line?

Free, confidential, on-demand, 24/7 teleconsultation on substance use evaluation & management for any health care provider in California

Evidence-based, person-centered guidance on topics such as:
• Assessment & treatment of opioid, stimulant, and other use disorders
• Medications for substance use disorder treatment (e.g., buprenorphine)
• Withdrawal management
• Opioid safety and harm reduction
• Special circumstances (e.g., co-occurring pain, polysubstance use, pregnancy)

Staffed by **experienced physicians** and **pharmacists** from the California Poison Control System & National Clinician Consultation Center

For more information, please call or visit our website | Please send program-related inquiries to David Monticalvo, Project Manager (David.Monticalvo@ucsf.edu)

California **Substance Use Line**

(844) 326-2626

References

- Ajay Manhapra MD, Albert J. Arias MD & Jane C. Ballantyne MD (2018) The conundrum of opioid tapering in long-term opioid therapy for chronic pain: A commentary, Substance Abuse, 39:2, 152-161, DOI: 10.1080/08897077.2017.1381663
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Thank you! Questions?

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