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MEETING THE OPIOID CHALLENGE

More Tools and Information for Care Coordinators

Tuesday, November 10, 2020

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MN Health Plans Collaborative

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Bringing Wellness Home

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Presenter

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General Internal Medicine Physician

Associate Medical Director, Hennepin Health

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Disclosures

- I am employed by Hennepin Health as Associate Medical Director, and I am speaking as a representative of Hennepin Health today.
- I am employed by Allina Health as a primary care general internal medicine physician. I manage patients with chronic pain and opioid use disorder, however, I am not an Addiction Medicine or Pain Medicine specialist.
- I have no other financial ties to disclose

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To start, a story…
Meredith

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Objectives

- A basic understanding of commonly prescribed opiates and their intended uses
- Understand the role of short-term and long-term opioid use, and ways to identify problematic use
- Changes in prescribing oversight and new data trends in Minnesota and nationally
- Identify resources available for management and treatment of Opioid use Disorder

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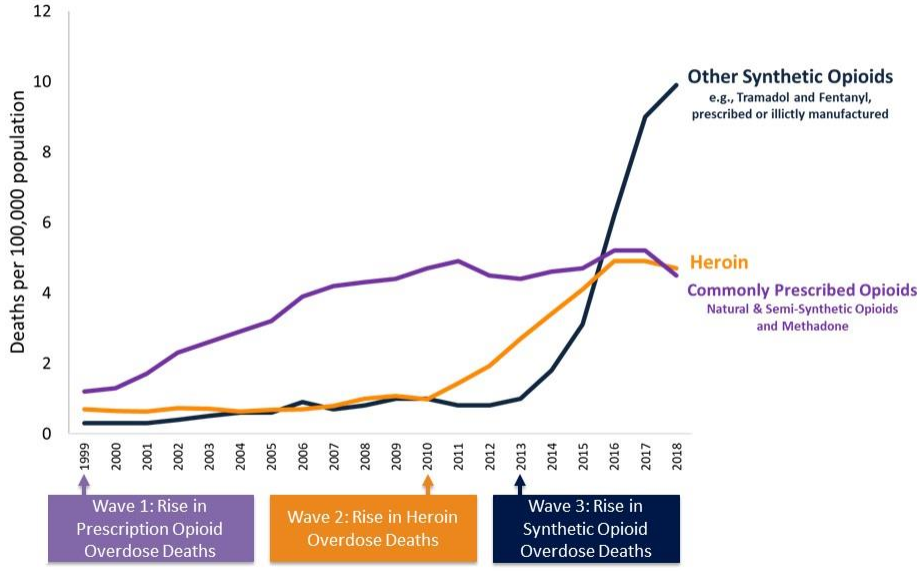
3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

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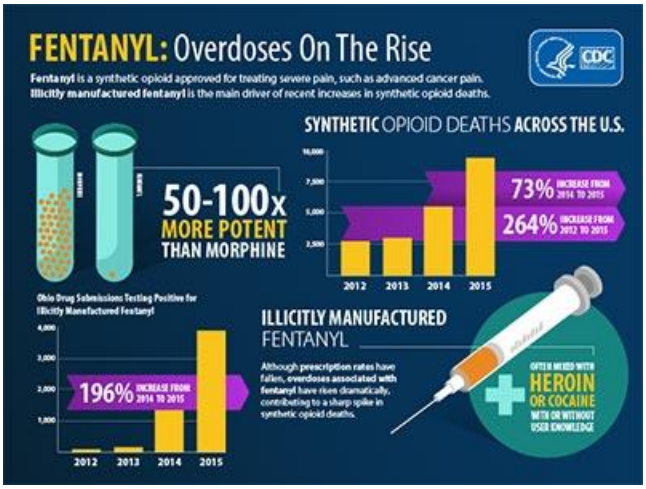

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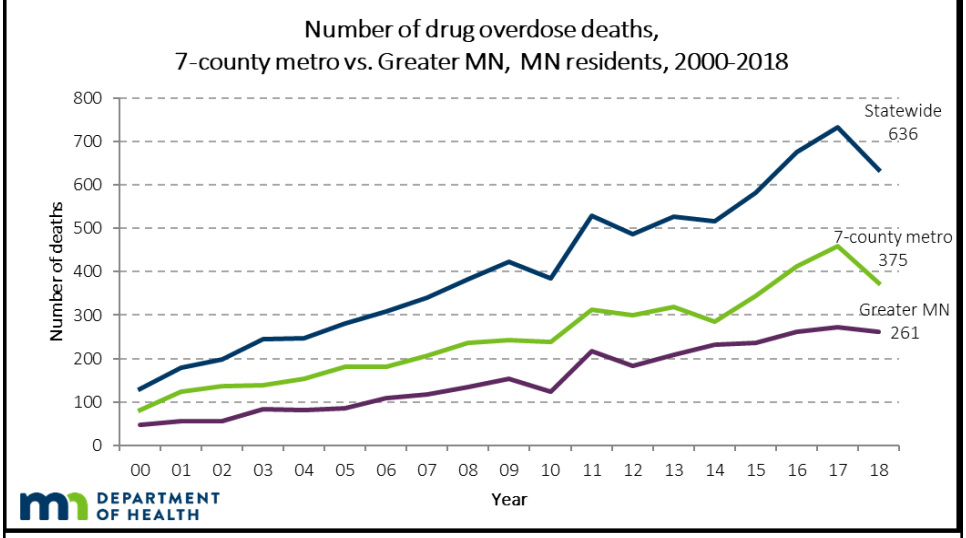

SOURCE: Minnesota death certificates, Injury and Violence Prevention Section, Minnesota Department of Health, 2000-2018

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The Opioid Crisis—The Basics

- National: 2018—67,367 Drug overdose deaths
  - Over 70% involved an opioid
  - 128 deaths per day
  - Leading cause of death under the age of 50
- Minnesota: 2018 343 opioid-involved deaths
  - First year there was a decrease (19%) since 2010
  - However synthetic opioid deaths rose 10%
- Many overdoses include an opioid combined with another drug (such as a benzodiazepine)

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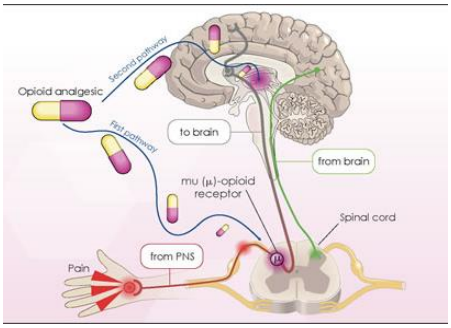
How Opioids Work

- Pathway 1
  - Block pain signal from peripheral nerve to the brain
- Pathway 2
  - Increase dopamine in the brain. A little is good, a lot can be bad.
- Opiates don't take pain away, they make you not care about it.



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The Long and the Short of it…

- Short-acting opioids (Tramadol, T3, Norco, Percocet, Morphine IR, Dilaudid)
  - Indicated for acute pain such as injury or surgery.
  - Occasional pain
  - Initial prescription only for the time needed for tissue recovery. <200 total MME in script. Usually 3-5 days.
  - Opioid naïve vs opioid tolerant
  - In combination with long-acting opiates for breakthrough pain
- Long-acting opiates (MS Contin, Oxycontin, Methadone, Fentanyl Patch, Butrans Patch)
  - Not indicated for opiate naïve patients
  - In chronic pain, can achieve more consistent blood levels, less breakthrough pain
  - The benefits of long-term opioid therapy for chronic non cancer pain are not supported by medical evidence (i.e. Opioids do not work well for chronic pain)

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Nociceptive vs Neuropathic Pain: Why Opioids Don't Work for Chronic Pain

- Nociceptive pain is a normal response to noxious stimuli or tissue damage.
  - We need pain, because it stops us from doing stupid things. Pain tells us to stop doing the thing that is causing tissue damage.
  - Opioids are effective at controlling nociceptive pain.
- Neuropathic pain originates at the level of the nerve
  - Does not correlate with tissue damage.
  - Opioids are NOT effective at controlling neuropathic pain
- Over time, persistent nociceptive pain develops into neuropathic pain. Even after the initial tissue damage is resolved, the pain persists. The brain processes these kinds of pain differently
- Somatization is when an emotional state is expressed as a physical symptom. "Depression Hurts"

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Chronic Pain Management

- Comprehensive, multi-modal approach
  - Non opioid medications—NSAIDS, neuropathic pain meds, antidepressants, muscle relaxers.
  - Physical therapy
  - Behavioral therapy-cognitive behavioral therapy, biofeedback, mindfulness, relaxation
  - Complementary/Integrative therapies
  - In some patients, Chronic Opioid Analgesic Therapy (COAT) may be appropriate. Goal should be to maximize functionality.
- Reframing the goals/expectations of treatment
- Treat concomitant mood disorders
- Internal vs external locus of control

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Signs of Addiction

- Not taking opioids as prescribed
- Breaking rules to obtain opioids
- Continued use despite negative consequences in your life
- Legal consequences
- Taking opioids with other substances

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Opioid Use Disorder: Diagnosis (DSM-V criteria)

- Mild (2-3 criteria), Moderate (4-5 criteria), Severe (6 or more)
  - Larger amounts over longer period than intended
  - A lot of time devoted to efforts to get opioids
  - Unsuccessful efforts to cut down
  - Cravings
  - Recurrent use interferes with responsibilities
  - Continued use despite negative consequences
  - Sacrifice occupational and social activities due to use
  - Use in known hazardous conditions
  - Use despite physical/psychologic problems cause by use
  - Tolerance
  - Withdrawal

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Risk of Addiction

- Several validated scoring tools available
- Opioid Risk tool-self administered
- https://mdcalc.com/opiod-risk-tool-ort-narcotic-abuse
- As a care guide, if you are concerned about a member's use or risk for addiction, if you can answer these questions, may help guide you.
- Only validated in chronic pain population

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

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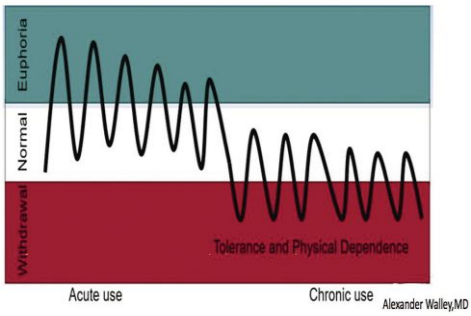
Habituation vs Tolerance vs Addiction

- Habituation/Dependence
  - Physiologic
  - Will happen to all who take opioids long term
  - Withdrawal if opioid is stopped abruptly
- Tolerance
  - Over time it takes more to achieve the same result
  - May lead to dose escalation
  - Many addicts require a dose to feel normal
- Addiction
  - Continued use despite negative consequences
  - CAGE



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A New Era in Prescribing: The call for oversight

- Factors that led to need for oversight
  - Pain as the 5th Vital
  - The role of the pharmaceutical companies
  - Diversion
  - Overprescribing: the transition from acute pain to chronic pain
  - Escalation: dose, and to stronger, illicit opiates
- Tools
  - CDC prescribing guidelines
  - Prescription Monitoring Programs
  - The Board of Medical Practice and Pharmacy
  - The role of payers, like Hennepin Health

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Provider Tools for Chronic Opioid Therapy: The MUST haves

- Risk Assessment Tool
- Set realistic goals and establish comprehensive treatment plan.
- Controlled Substance Agreement
- Random Tox Screens, pill counts
- Prescription Monitoring Program.
- Limited prescriptions, frequent visits
- Narcan

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CDC Prescribing Guidelines

- Opioids are non first-line treatment for chronic pain
- Before starting treatment, establish goals
- Discuss risks/benefits of opioids before and periodically
- Do not start with long acting
- Start low and go slow
- Manage the transition from acute to chronic pain
- Close follow up after dose changes, and at least every 3 months. Evaluate for harm
- Evaluate risk before and periodically
- Check PMP regularly
- Drug testing
- Avoid using benzos with opioids
- Arrange treatment for people with Opioid Use Disorder

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Minnesota Prescribing Limits

- Total opioid dose not exceed 90 MME in chronic opioid users
- 7 day initial prescription for opioid naïve users (90 day look back period)
- No long-acting opioid for naïve users

- https://mn.gov/dhs/opip/opioid-guidelines
- Minnesota has a comprehensive plan with prescribing recommendations (72 pages)
- DHS sends out prescriber reports to providers

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Opioid Equivalency: mg morphine equivalents (MME)

Opioid	Conversion Factor
Morphine (oral)	1
Oxycodone (Percocet, oxycontin, roxicodone)	1.5
Hydrocodone (Norco, Vicodin)	1
Fentanyl patch (mcg) (Duragesic)	2.4
Hydromorphone (Dilaudid)	4
Methadone *	4-12
Codeine (T3)	0.15
Tramadol (Ultram)	0.1
Tapentadol (Nucynta)	0.4

*Methadone equivalency depends on daily methadone dose

www.cdc.gov/drugoverdose/prescribing/guideline.html

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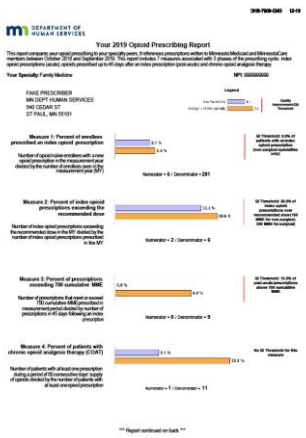
DHS Provider Opioid Scorecard

- 1: % panel prescribed an opioid prescription
- 2: % opioid prescriptions exceeding recommended dose
- 3: % prescriptions > 700 cumulative MM
- 4: % panel with chronic opioid analgesic therapy (COAT)
- 5: %COAT enrollees >90 MME/day
- 6: %COAT enrollees receiving concomitant Benzo
- 7: %COAT patients receiving opioids from multiple providers


DEPARTMENT OF HUMAN SERVICES

Your 2019 Opioid Prescribing Report

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Resources to Get Help

- Primary Care/Mental Health Provider
- 911 if imminent danger
- Hennepin County Front Door (612) 348-4111
- SocialServicesMN.org
- SAMHSA 1-877-726-4727 (Substance Abuse and Mental Health Services)
- Al-Anon or Nar/Anon (for loved ones of the one with the addiction)

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Stopping Opioids

- Negative side effects, not achieving goals of therapy→Slow taper 5-10% every 2-4 weeks
- Aberrant Behavior (failed tox screen, not medications as prescribed, non-compliance with comprehensive treatment plan)→Fast Taper 10%-25% every 2-4 weeks.
- Deal Breaker (diversion, obtaining opioids from illicit source, safety concern) →Immediate discontinuation, manage withdrawal symptoms

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Opioid Use Disorder: Treatment

- Residential/Outpatient Chemical Dependency Treatment
- Aftercare, maintenance therapy, relapse prevention
- Support Group
  - AA/NA (12 step recovery program)
  - SMART (Self-Management and Recovery Treatment) based CBT
  - Life Ring, Women for Sobriety. Rational Recovery, others.
- Medication Assisted Treatment (MAT)
  - Methadone
  - Buprenorphine (Suboxone)

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Medication Assisted Therapy: Standard of Care

- Methadone- Long-acting opiate
  - Daily observed therapy until trust established, then gradually longer takeout doses
  - Dose is titrated until withdrawal symptoms/cravings are controlled
  - Must be done through a Methadone clinic
  - 12 months to lifelong
  - Opioid side effects- constipation, breathing problems, sexual side effects
- Suboxone (buprenorphine/naloxone)
  - Partial Mu agonist (More on this on the next slide)
  - Must be prescribed by Suboxone provider (DEA-X)
  - Sublingual film, dissolving tablet, monthly injection, subQ implant
  - Induction can be done as outpatient, does not require daily visits.
  - Need to be off opioids long enough to experience mild withdrawal symptoms
  - Will "turn off" other opioids

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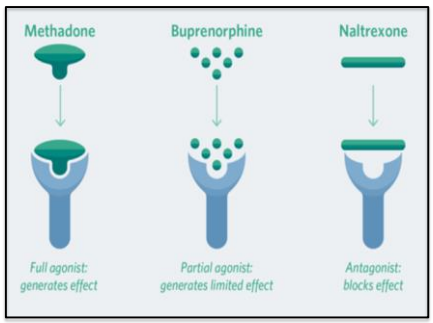
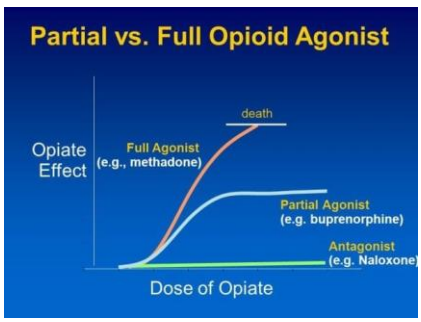
Agonist vs Antagonist





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Dr. Mendiola's Lessons Learned Over the Last 18 years of Prescribing Opioids

- Low risk people can get addicted to opioids by taking their medications as prescribed.
- Safety comes first. First, do no harm. If someone is not a good candidate for opioids, it doesn't matter how bad their pain is, they are not a good candidate.
- Opioids and benzodiazepines can make you forget to breath, which is bad. Don't do it.
- Depression hurts. Depression colors the way people experience pain.
- Narcan (naloxone) saves lives. Every patient on chronic opioids should have Narcan, and family should be trained to administer.
- Medication Assisted Treatment is standard of care for opioid use disorder. (methadone or suboxone)

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The Future of the Opioid Epidemic

- We are making inroads into prescription opioid abuse, but not with illicit opioid use, especially synthetics (fentanyl, carfentanyl)
- Treatment model vs punishment model
- Cracking down on Pharma industry
- Break the trajectory:
  - Short-term opioid for acute pain>>long-term opioid for chronic pain>>tolerance/dependence>>dose escalation>>addiction>>Illicit use/switch from prescription pills to heroin>>fentanyl

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A Final Story…

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Provider Toolkit

Meeting the Challenges of Opioids and PAIN:

PATIENT EDUCATION ON PAIN AND OPIOID PRESCRIPTIONS
ADDRESSING OPIOID PRESCRIPTION PRACTICES
IDENTIFYING SAFE AND EFFECTIVE PAIN MANAGEMENT PROTOCOLS
NONPHARMACOLOGIC AND NON-OPIOID PHARMACOTHERAP ALTERNATIVES

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Provider Toolkit: table of contents

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Alternative Pain Therapy Benefits

Alternative Pain Management Therapies Benefit Coverage
for Minnesota Families & Children (PMAP & MNCare),
Seniors (MSHO & MSC+) and Special Needs BasicCare (SNBC)

While there are many prescription medications available to treat pain, patients and providers may prefer to try alternative treatments for pain, sometimes in conjunction with prescription or over-the-counter pain. Evidence-based alternative therapies may or may not be covered by a patient's insurance. This grid may assist clinicians in determining therapy options that may be covered and therapy options not covered by Medicare and/or Medicaid in Minnesota.

Category	Intervention	Seniors (MSHO & MSC+)	Family & Children (PMAP & MNCare)	Special Needs BasicCare (SNBC)
Behavioral	Behavioral Operant Therapies: • Modeling appropriate behaviors • Assigning tasks in a graded or hierarchical manner that promotes success & reinforcement	Not separately reimbursed – may be provided during an assessment/ session with a qualified/credentialed behavioral health provider.		

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StratisHealth
Pain Management and Opioids Guide for Consumers
https://stratishealth.org/pain-management-and-opioids-guide-for-consumers/
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Understand Pain
What Kind of Pain Do You Have?
Talk with Your Doctor about Pain
Self-Care for Pain Management
Understand Opioids
A Pain Medication
Side Effects and Risks
How to Store and Dispose
Learn more about pain, pain medication, and ways to manage pain with self-care. Also, understand the problem with continued opioid use. Share this information with your family and friends.
This pain management and opioid guide was created by seven Minnesota health plans that are collaborating to reduce the rate of chronic opioid use in the state: Blue Plus, HealthPartners, Hennepin Health, Medica, South Country Health Alliance, and UCare.
Printable Pain Management and Opioids Guide for Consumers > (18-page PDF)
Websites for more facts
Take a minute to review these valuable resources for more information.
Opioid (Narcotic) Pain Medications. Opioid pain medication guide and video by WebMD. (1-minute video)
Rx Awareness: Real stories about the devastation of opioid use disorder and overdose. With the real stories in this campaign, the Centers for Disease Control and Prevention (CDC) aims to increase awareness and knowledge among Americans about the risks of prescription opioids and stop inappropriate use.
BlueCross BlueShield Minnesota
HealthPartners
Hennepin Health
MEDICA
South Country Health Alliance
ucare
This Pain Management and Opioids Guide for Consumers was developed by six Minnesota health plans that are collaborating to reduce the rate of chronic opioid use in the state. Contact your health plan if you need free help interpreting this document: Blue Plus, HealthPartners, Hennepin Health, Medica, South Country Health Alliance, and UCare.
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Thank you!

- Evaluation – https://www.cvent.com/d/c7q5wy
- Certificate of Participation – upon completion of evaluation - https://www.cvent.com/d/c7q5wy
- Recording & Toolkit - https://stratishealth.org/health-plan-performance-improvement-projects-pips/pip-reducing-chronic-opioid-use/

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