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RISK MANAGEMENT STRATEGIES TO COMBAT OPIOID PRESCRIPTION ABUSE AND ADDICTION

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The Current Epidemic

Opioid overuse and abuse has been deemed an epidemic in the United States.[1] Opioids, including prescription pain medication and illegal drugs such as heroin, are now the leading cause of injury deaths in the United States. Wisconsin is not immune from this epidemic. Approximately 163,000 people in Wisconsin are believed to be addicted to some form of opioid currently[2]. More people now die in Wisconsin from drug overdoses than from motor vehicle accidents, suicide, or firearms; and prescription opioids now account for more overdose deaths than heroin and cocaine combined[3].

This article discusses three ways of combatting the opioid abuse crisis that providers should be aware of:

- New Wisconsin legal requirements regarding prescription of opioids
- Practice guidelines recently promulgated by the CDC and the Wisconsin Medical Examining Board concerning opioids
- Practical risk management tips regarding use of opioids

Wisconsin Laws Regarding Opioids

In Wisconsin, the Heroin, Opiate, Prevention and Education (HOPE) Agenda[4] has resulted in more than 15 enacted pieces of legislation to date. Most significant for providers are new requirements to check the State Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances in certain situations, and to report the dispensing of monitored drugs to the PDMP more promptly than before.

The PDMP is a statewide electronic database that tracks the prescribing and dispensing of certain monitored prescription drugs, which are essentially any Schedule II, III, IV or V controlled substance plus any other drug added by the Pharmacy Examining Board (PEB). The PDMP is designed to help healthcare professionals identify patients who may be at risk for drug misuse or addiction, and to inform providers' prescribing decisions. The data is available to physicians, pharmacists, and, in limited form, law enforcement officials and researchers.

Under Wisconsin Act 266, which was passed in 2015, physicians and other prescribers must check the PDMP before writing a prescription for more than a 3 day supply of any monitored prescription drug. This includes all controlled substances, not just opioids. Under the prior law, Wisconsin Act 362 which was enacted in 2009, PDMP data was available to prescribers to help them make decisions, but prescribers were not required to check the PDMP.

More specifically, as of April 1, 2017, prescribers will be required to review the patient's PDMP data before, and for each time, they prescribe a monitored drug for more than a 3 day supply. While the task of querying the PDMP can be delegated to staff, the prescriber must review the data. Stated exceptions to this requirement include:

- If the patient is receiving hospice care.
- In an emergency.
- Where the PDMP is not operational.

Wisconsin Act 266 (2015) also requires dispensers of monitored prescription drugs to report each dispensing to the PDMP within 24 hours or by the end of the next business day. Previously, under Wisconsin Act 362 (2009), dispensers had seven days to submit such information to the PDMP. For purposes of the PDMP, "dispensers" include pharmacies and practitioners who actually dispense monitored prescription drugs. Physicians who prescribe or administer, but do not dispense monitored drugs are not required to submit data to the PDMP.

The original Wisconsin PDMP, though useful, was regarded as not extremely user friendly and did not integrate with electronic health record systems. The State is in the process of redesigning the PDMP to make it more user friendly, integrate better with EHRs, and provide more and customized data to users. Wisconsin's ePDMP ("enhanced") is scheduled to be operational by April 1, 2017, when prescribers will be required to check the PDMP before, and for each time, they prescribe a controlled substance for more than 3 days.

CDC and Wisconsin Prescribing Guidelines

Two important sets of guidelines for Wisconsin prescribers have been released in the past 8 months. The Centers for Disease Control and Prevention (CDC) released Guidelines for Prescribing Opioids for Chronic Pain in March 2016,[5] and the Wisconsin Medical Examining Board (MEB) issued its own opioid prescribing guidelines in July 2016[6].

The CDC guidelines focus on the risks versus the benefits of long-term opioid treatment, other than for active cancer, palliative and end-of-life care, and provide important risk management guidance for prescribers. In summary, the CDC recommends that:

- Non-pharmacologic therapy and non-opioid pharmacologic therapy are the preferred modalities for the treatment of chronic pain, and where opioid therapy is used it should be implemented in association with non-pharmacologic therapy and non-opioid pharmacologic therapy.
- Clinicians should establish realistic treatment goals with patients before commencing opioid therapy for chronic pain.
- Clinicians should discuss known risks and benefits and agree on patient and clinician responsibilities before commencing opioid treatment.
- When commencing opioid treatment for chronic pain clinicians should use immediate release opioids instead of extended release or long acting opioids, and use the lowest effective dose.
- In the case of acute pain, clinicians should prescribe the lowest dose of immediate release opioids and should only prescribe a sufficient quantity of opioids to treat the expected duration of acute pain (usually three days or less).
- Within one to four weeks of commencing opioid treatment for chronic pain or increasing the dose, and once every three months thereafter, clinicians should evaluate the balance of benefits and harms of the treatment, and where harms outweigh the benefits look to reduce or stop the opioid dosage and implement other treatments to address pain.
- Before starting opioid treatment for chronic pain and periodically thereafter, clinicians should develop and incorporate a management plan to alleviate opioid related risks. This plan may include the prescription of naloxone where there is a history of overdose or substance abuse, higher opioid dosages or the simultaneous use of benzodiazepines.
- Prior to commencing opioid use and periodically thereafter, clinicians should review their State prescription drug monitoring program (PDMP) to check whether the patient is receiving other opioids or other dangerous combinations that may increase the risk of overdose.
- The concurrent use of opioids and benzodiazepines should be avoided.

- Where a patient presents with an opioid use disorder the clinician should offer or arrange for an evidence based treatment, which could include behavioral therapy or the use of buprenorphine or methadone.

- As predicting risk is difficult, the CDC recommends that clinicians conduct a urine drug test prior to initiating opioid use for chronic pain, and then conduct subsequent tests at least annually.

The Wisconsin MEB opioid prescribing guidelines closely track those issued by the CDC. However, while the CDC guidelines focus on opioid use for chronic pain, the MEB guidelines apply more broadly and address the use of opioids in treating acute and chronic pain in adults, other than for active cancer, end-of-life, or palliative care.

The MEB states clearly that opioids pose a potential risk to all patients and summarizes the recommend approach as follows:

- Identify and treat the cause of the pain and use non-opioid therapies
  - Don't use opioids routinely for chronic pain.
  - Combine non-pharmacologic therapies with non-opioid analgesics for acute and chronic pain.
  - Where opioids are used, combine them with non-pharmacologic therapies and non-opioid analgesics.
- Start low and go slow
  - Check the Wisconsin PDMP (Prescription Drug Monitoring Program) before prescribing any controlled substance for more than a 3 day supply[7].
  - Prescribe the lowest effective dose.
  - Start with immediate release, not extended release/long acting opioids.
  - Only prescribe a limited quantity to cover the expected duration of severe pain.
- Do close follow-up
  - Regularly monitor patients.
  - Determine the balance between pain control and harm.
  - Where harm is observed, seek out alternatives and reduce or stop the use of opioids.

Many physicians will also be required to complete CME specifically related to opioid prescribing. The MEB rule, which will take effect before the end of 2016, will require Wisconsin-licensed physicians holding a Drug Enforcement Administration (DEA) license to complete two credits of MEB-approved CME regarding its newly released guidelines for both the current and next CME cycles. Physicians who have already completed their required 30 hours of CME for the current cycle will still need to meet this requirement by the end of the current cycle[8].

Risk Management Tips Regarding Opioids

Individual practitioners and healthcare facilities can use risk management tools to reduce the risks associated with prescription opiates.

For example, physicians and other practitioners should.

- Make decisions about prescribing opioids with an understanding of the clinical guidelines promulgated by the CDC and Wisconsin MEB.

- Be aware of policies that may be issued by other sources such as the FDA and national medical specialty societies that address the issue of safe and responsible opioid prescribing.

- Consider conservative, alternative, and non-medication measures for treating pain, such as over-the-counter medications, physical therapy, electrical stimulation, chiropractic care, acupuncture, massage, pregnancy belts or other types of binders and braces, compresses, mindful meditation, and self-hypnosis.

- Thoroughly understand and discuss with patients the risks and benefits of opioids before prescribing them.

- Comply with Wisconsin requirements to check with the PDMP before prescribing monitored drugs for more than three days beginning April 1, 2017.

- Be familiar with techniques that can be used to treat patients addicted to opioids, including frequent monitoring, counseling and other social services, and drug intervention treatment such as use of buprenorphine to relieve the physical cravings of opiate dependency.

- Stay up to date on the literature surrounding opioid prescribing and management, as well as legislative activity regarding opioids.

Hospitals and clinics can also employ risk management measures in the fight against prescription opioid abuse and addiction. Some health systems are changing how their doctors prescribe, dispense, and treat pain, in some cases cutting prescription painkiller rates by up to 50 percent or more, according to a recent study by the California Health Care Foundation[9]. For example.

- Kaiser enlisted the help of pharmacy, medical staff, and information technology to issue an alert whenever a prescriber attempts to order a high dose opioid. Unless an exception is made, only doctors in pain management, oncology, or palliative care are allowed to write new prescriptions for those high-dose drugs.

- Opioids can be prescribed for only 30 days, and cannot be renewed any earlier.

- In the emergency room, opioid prescriptions are issued for just a 3 day supply.

- Pharmacists are allowed to question doctors who prescribe high-quantity, high-dose prescriptions, greater than 200 tablets or more than 120 morphine milligram equivalents a day.

- Doctors deemed "outliers" -- with high rates of opiate prescriptions -- are offered peer advice on pain management alternatives and how to taper patients to lower dosages[10].

Healthcare systems are also using other risk management strategies to address opioid abuse, including:

- Educating medical staff, including allied health practitioners, about the use and efficacy of conservative, alternative, and non-opioid measures to manage pain.
- Training staff about the care and treatment of patients with substance abuse disorders, including care coordination with other healthcare providers, training clinicians, pharmacy, and security personnel in overdose prevention and response, and providing them with naloxone rescue kits.
- Staffing clinics that serve high risk patients with social workers, pharmacists, and therapists, in addition to doctors and nurses.
- Developing guidelines for, and training providers about, maternal-child health, such as when and how to screen pregnant women for opioid abuse, how to assess babies' symptoms, how to wean according to those symptoms, when mothers can safely breast feed, computerized checklists and videos showing babies' high-pitched cries, clenched fists and tremors, and information sheets for parents.

Conclusion

While there is no overnight solution to the opioid abuse crisis, healthcare providers can contribute to the response. Progress toward alleviating this epidemic can be made through risk management measures that address the prescribing, dispensing, and pain management treatment approaches used by providers.

References & Resources

Wisconsin Heroin, Opiate, Prevention, and Education (HOPE) Agenda website.

http://legis.wisconsin.gov/assembly/hope

Creating a WPMP Database account.

http://www.dsps.wi.gov/Documents/PDMP/Brochures/Registration_Tips.pdf

Resource card for logging in to the WPMP site.

http://www.dsps.wi.gov/Documents/PDMP/Brochures/Query_Tips.pdf

Online brochure for the WPMP.

http://www.dsps.wi.gov/Documents/PDMP/Brochures/Practitioner.pdf

Resource for President's Proposed Bill.

https://www.whitehouse.gov/blog/2016/02/01/preventing-epidemic-opioid-abuse-and-heroin-use

Wisconsin Guidelines for Prescribing Opioids & Assessment Tool.

Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care" approved in late July 2016.

https://dwd.wisconsin.gov/wc/medical/pdf/CHRONIC%20OPIOID%20CLINICAL%20MANAGEMENT%20GUIDELINES%20.pdf

Link to actual MEB document/guidelines.

http://dsps.wi.gov/Documents/Board%20Services/Other%20Resources/MEB/MEB_Guidelines.pdf

Link to CDC Resources.

http://www.cdc.gov/drugoverdose/prescribing/resources.html

End Notes

1. *Trust for America's Health & Robert Wood Johnson Foundation. The Facts Hurt: A State-by-State Injury Prevention Report. June 2015. Available at http://www.healthyamericans.org/reports/injuryprevention15.*
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