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# Chronic Pain Management with High Dose Opioid Medication

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# Chronic pain management with high dose opioid medication: *Morrisville, Vt*

Josh Cohen

November, 2015

Mentor: Phillip Kiely

# Problem: high dose oxycodone and XR hydromorphone pose serious abuse potential and safety risk

- ▶ VT has passed new legislation rules regulating prescribing practices to minimize the risk of opioid abuse in our communities. “This rule provides legal requirements for the appropriate use of opioids in treating chronic pain in order to minimize opportunities for misuse, abuse, and diversion, and optimize prevention of addiction and overdose.”
- ▶ Long term use of opiate medication for pain leads to tolerance, addiction, abuse, diversion, and adverse effects
- ▶ There is dose dependent evidence of increased risk of overdose, abuse and dependence, fracture, and myocardial infarction
- ▶ Prescribers are responsible for release of these drugs into communities but need to be aware of best practices to ensure safety to themselves, their patients, and their communities

# Cost considerations

- ▶ Nationally, of the 22,767 deaths relating to prescription drug overdose in 2013, 16,235 (71.3%) involved opioid painkillers. Prescription opioid abuse costs were about \$55.7 billion in 2007
- ▶ Vermont's overdose death rate for 2010 is 9.7 per 100,000 population, about 60 deaths/year
- ▶ Street value of oxycodone and hydrocodone are somewhere between \$1-2 per milligram in VT. Therefore, a 30mg daily script has a \$60 daily or \$1680 monthly value. This represents incentive for diversion.

## Prescription costs

### Tablets (Oxycodone-Acetaminophen)

2.5-325 mg (100): \$204.91

5-325 mg (100): \$136.87

7.5-325 mg (100): \$271.54

10-325 mg (100): \$355.08

### Tablets (Percocet)

2.5-325 mg (100): \$743.50

5-325 mg (100): \$1040.57

7.5-325 mg (100): \$1124.22

10-325 mg (100): \$1470.01

### Tablets (OxyCODONE HCl)

5 mg (100): \$54.11

10 mg (100): \$62.50

15 mg (100): \$189.48

20 mg (100): \$110.30

30 mg (100): \$358.93

# Morrisville Community Cost and Perspectives

- ▶ There are 29 patients in the Morrisville Family Health Care practice being treated with chronic high dose opiates that are not abuse resistant, accounting for thousands of Percocet and Oxycodone pills released into the town and greater community (Morrisville, Hyde Park, Eden, Elmore, Hardwick, Stowe and more) per month. This represents a street value of \$30,000-\$50,000 per month and may contribute to adverse health effects and overdose in the community. As a principle source of prescription opioids for the region, this practice must be responsible and accountable for its prescription practices. Interviews with several providers (Kim Bruno, Dave Roy, Phil Kiely) and a community coordinator (Jean Audet) provided feedback about various aspects of prescription narcotics in the region.

# Community perspectives: Prescriber Interviews

## ▶ What is your strategy, pharmacological and otherwise, for managing chronic pain?

- ▶ Kim Bruno: “I make sure to go through lots of modalities like PT, exercise, mental health management, antidepressants, neuromodulators, lidocaine patches, before chronic [opioid] pain meds. Its not perfect because not everyone [patients] is willing to do it”
- ▶ Dave Roy: “I go through the litany of pain medications, clinics, epidurals. I find clinics are typically useless for med management help. Chronic pain groups can help, but I haven’t seen a lot of success with that kind of stuff.”

## ▶ Do the prescribing habits of providers in the practice put the community at risk?

- ▶ KB: “We put the community at risk. Some of us prescribe more than others, some are less stern than others. Loosy goosy habits put the community at risk. We are good about not just blindly refilling and we make patients understand their responsibility. If you don’t believe in chronic pain you wont see it because patients will leave you. Fundamentally it is a risk we need to take.”
- ▶ DR: “Anyone who prescribes is at risk of causing harm. Don’t believe the patients every time ‘the dog ate the pill’. Some people may be pulling the wool over my eyes. The tradeoff is not giving meds to people that really need it, which is as bad if not worse. I have been more aggressively monitoring in that last year and have caught a few people with random urine screens. VPMS has not helped me to bust anybody.”

## ▶ What do you if a narcotics contract is breached?

- ▶ KB: “I have had few breaches and I stopped prescribing. Im not afraid to kick them out. For a couple of patients I switched to long acting formulations, increased frequency of visits, shortened script duration, pill counts and urines”
- ▶ DR: “it depends on what happens. I don’t lose a lot of sleep if its positive for marijuana. If I catch something in a urine I will confront patients and have had to discontinue patients in the past. I will confirm on dominion. If I catch overt diversion I throw them out of practice. But if it’s a legitimate mistake I try to help.”

# Interviews continued

- ▶ **What is your understanding of the research regarding the efficacy of long term pain management with narcotics?**
  - ▶ KB: “Its not great research. This approach is not based in great science. These meds perpetuate pain rather than treat it over time.”
  - ▶ DR: “I know that there is evidence that its not that beneficial. I think regardless of research there is a subgroup of patients that this medicine just seems to work for. I am more judicious about starting patients and increasing dosage now than I used to be.”
- ▶ **How would you feel about using a new standardized template for pain management documentation?**
  - ▶ KB: “I would be all over it”
  - ▶ DR: “I would have to look at it kind of closely and see. It’s a good way to make sure everything is covered but it makes it difficult to think outside the box. I look at anything that is rigid as iffy.”

# Intervention: form a database of at risk patients and assess documentation compliance with VT rules

## ▶ Methodology

- ▶ Practice list obtained of all patients prescribed long term narcotics without anti-abuse formulations
- ▶ Patients taking high dose ( $\geq 30$  mg oxycodone or  $\geq 40$ mg XR hydromorphone) identified from larger group
- ▶ Records of each patient were audited for compatibility with new VT guidelines for effective monitoring and documentation
- ▶ Database created to capture documentation metrics
- ▶ Data analyzed to determine rates of compliance with guidelines
- ▶ Evaluation and recommendations for the future made to practice

# Results

## Compliance with Rule Governing the Prescribing of Opioids for Chronic Pain

Overall compliance: 65%  
Range: 33-92%

Documentation requirements prior to initiating prescription	Percentage Compliant
Medical and physical evaluation	90%
Diagnoses supporting use of medication	97%
Risks and benefits of medication	Incomplete data
Inability to control pain with alternative therapies	Incomplete data
Informed consent	79%
Controlled substance treatment agreement	93%
<b>VPMS query documentation</b>	
Review of prior controlled substance prescriptions	Incomplete data
Repeat query every 120 days	Has not yet started
<b>Prescription requirements</b>	
Prescription has maximum daily dose	100%
Prescription is for a 30 day maximum	100%
<b>Follow up visit documentation requirements</b>	
Whether to continue prescribing	86%
Need for substance abuse consultation	0%
Provider explanation and patient agreement of consequences of agreement violation	7%
Follow up visit every 180 days	93%

# Evaluation

- ▶ Physicians are performing well in the following areas:
  - ▶ writing prescriptions with maximum dosage for a maximum of 30 days (100%)
  - ▶ Documentation of diagnosis (97%)
  - ▶ routine follow up visits (93%)
  - ▶ Controlled substance agreement documentation (93%)
- ▶ Physicians need improvement in the following areas of documentation:
  - ▶ Informed consent (79%)
  - ▶ Explanation of consequences of failure to adhere to contract (7%)
  - ▶ Whether there is need for substance abuse counselling (0%)
- ▶ Limitations
  - ▶ Data for patients who have been on these medications since before EMR records were in use or were initiated by physicians from other practices was often incomplete
  - ▶ It is difficult to measure the effect of prescribing practices and drug abuse with a small sample size in a small community
  - ▶ According to interviews, physicians have different opinions about whether a standardized template would be acceptable within their practices

# Future recommendations

1) A chronic opioid for pain management template should be developed that is used for each initial patient visit. This should include:

- ▶ Diagnosis requiring pain management with high dose opioid: \_\_\_\_\_
- ▶ Risks and benefits of medication discussed? Yes/No
- ▶ Non opioid treatment options are ineffective, not tolerated, or inadequate? Yes/No

2) A chronic opioid for pain management template should be developed that is used for each follow up visit. This should include:

- ▶ Continuation of high dose opioid prescription? Yes/No
- ▶ Patient was made aware of consequences of failure to adhere to controlled substance agreement? Yes/No
- ▶ Substance abuse services recommended? Yes/No

3) An EHR alert should be created to notify physicians when a patient that is missing an informed consent or narcotics contract comes in for an office visit

4) This audit should be repeated in 1 year to measure improvement in documentation

Improvement in the documentation process will remind physicians to address important issues that they may not be talking about now. Because this patient population is at high risk for medication abuse and adverse effects, safety will be improved by making these improvements. Furthermore, the community at large will be safer because responsible medication use is more likely to prevent diversion.

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