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Maryland Addiction Consultation Service

1-855-337-6227

www.marylandMACS.org

Opioid Prescribing in Primary Care
Where are we now?

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Maryland Addiction Consultation Service (MACS)

Provides support to prescribers and their practices in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance with addiction and behavioral health resources and referrals
- Technical assistance to practices implementing or expanding office-based addiction treatment services
- MACS TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning

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"I'm right there in the room, and no one even acknowledges me."

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Learning objectives

1. Review the context and scope of the CDC Guidelines for opioid prescribing
2. Review strategies that may help primary care prescribers feel more comfortable or positive about prescribing opioid medications in their practices
3. Integrate best practice recommendations into clinical decision making when prescribing controlled medications.

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Chronic Pain and Prescription Opioids

- At least 11% of Americans experience daily or chronic pain
- Opioids frequently prescribed for chronic pain
- Primary care providers commonly treat chronic, non-cancer pain
  - Account for 45-50% of opioid pain medications dispensed
  - Report concern about opioids and insufficient training

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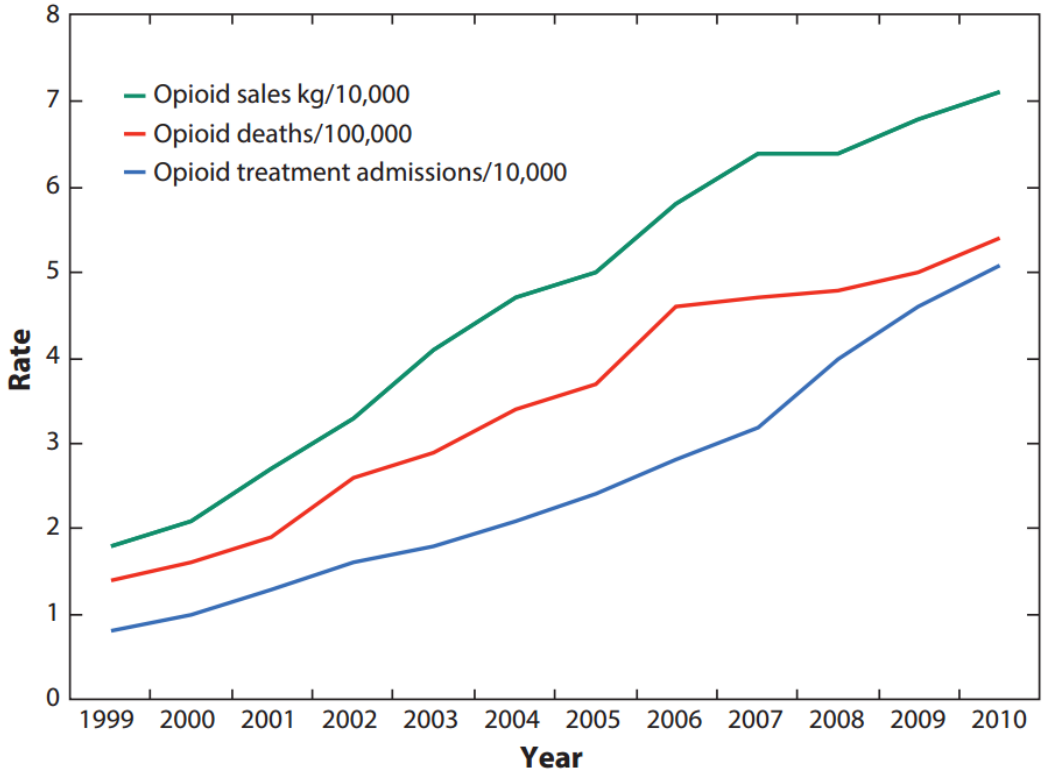
Increasing prescribing associated with increasing morbidity and mortality



Source: Annu. Rev. Public Health 2015. 36:559–74

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Attempts to reduce inappropriate opioid prescribing

- Insurance company policies
- State Medical Boards
- Requirements to PDMP
- Limitations of days of prescription or dose

2016 Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain

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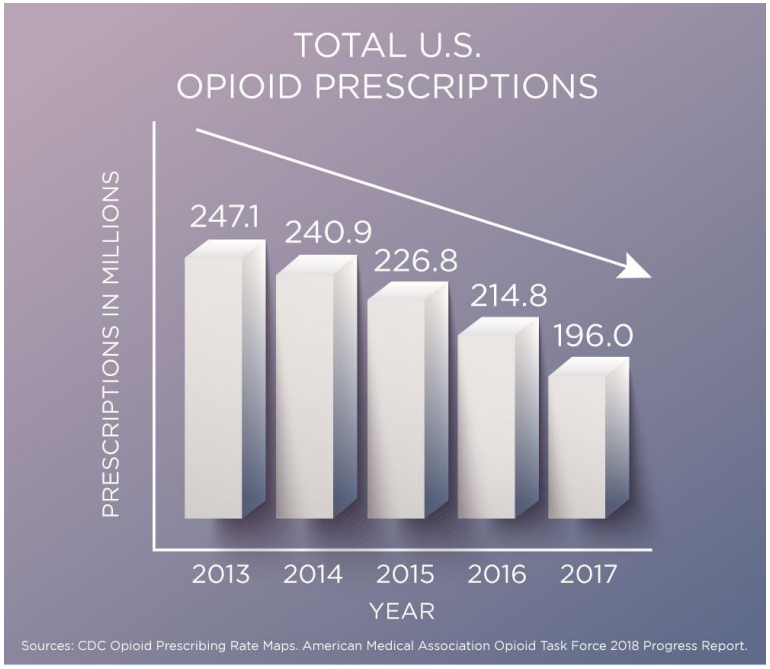
Results

- The prescribing rate has decreased annually by 4.9% from 2012 through 2016
- For high dosage opioids (≥90 MME/day), the rate annually decreased by 9.3% from 2009 to 2016



Source: core-rems.com

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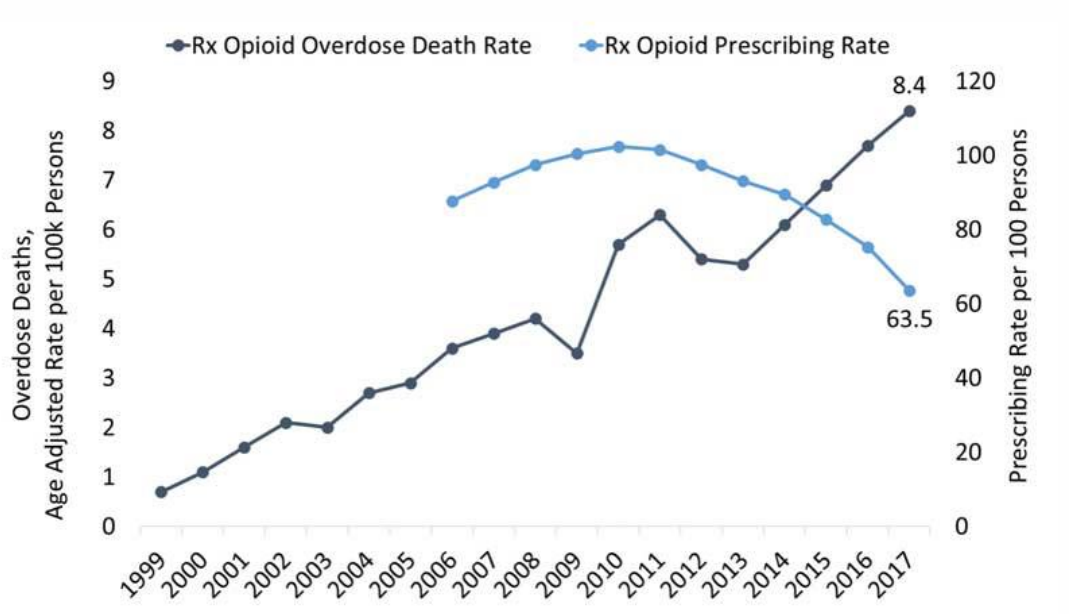
Ohio as a case study

- Declining rate of prescribing
- Deaths still rising



Source: drugabuse.gov

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Guideline for Prescribing Opioids for Chronic Pain

Purpose, use, and primary audience

- Primary Care Providers
- Treating patients greater than 18 years of age with chronic pain (>3mos)
- Outpatient settings
- Does not include active cancer treatment, palliative care, and end-of-life care

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What is a guideline?

- "Guidelines are recommendations intended to assist providers and recipients of care and other stakeholders to make informed decisions. Recommendations may relate to clinical interventions, public health activities, or government policies."

-WHO 2003, 2007

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What is EBM?

- Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients‘ predicaments, rights, and preferences in making clinical decisions about their care.
  - Sackett, et al. BMJ January 1996

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CDC Guidelines at a Glance

1. Nonopioid treatments first
2. Goals and Exit Strategy
3. Periodically review risk/benefit & responsibilities
4. Start with immediate release preparations
5. Use lowest effective dose (<90 MME preferred)
6. Acute pain: Use shortest duration (3-7 days)
7. Chronic pain: Reassess within 1-4 weeks
8. Consider naloxone & other risk reduction strategies
9. Review PDMP
10. Urine screening prior to initiation and at least annually
11. Avoid prescibing opioids and benzodiazepines together
12. Offer or arrange evidence-based treatment for opioid use disorder (MAT, buprenorphine)

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Case study

- Mary Ann, 65 yoF
  - Headaches
  - Referred by neurology
  - “I’ve been to 7 doctors and I’m so irritated”
  - “I’m at the end of the road”
  - Has trialled multiple medications and interventions: topamax, neurontin, NSAIDs, triptans, physical therapy

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Case study

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  - Has trialled multiple medications and interventions: topamax, neurontin, NSAIDs, triptans, physical therapy
  - Taking tramadol BID with inadequate relief. Neurologist wants to wean her
  - UDS concordant
  - PDMP appropriate

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What would you do?

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How likely are PCPs to accept new patients taking prescription opioids for pain management?

- 81% primary care “reluctant” to accept new patient currently prescribed an opioid Gudin J, et al "Drug misuse in America 2019: Physician perspectives and diagnostic insights on the evolving drug crisis" AAPM 2020; Abstract LB004.)

- “Many of the guidelines and policies have achieved the desired result of reduced opioid prescribing. However, stakeholders have expressed concern that these new policies have led physicians to stop prescribing opioids completely, even to certain patients for whom the benefits of opioids may outweigh the risk”

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University of Michigan study

- Secret shopper study – “Access to primary care clinics in patients with chronic pain receiving opioids”
- 40% of primary care clinics won’t take on patient on chronic opioid
- Opioid-prescribing policies and guidelines aimed at reducing inappropriate opioid prescribing may lead physicians to stop prescribing opioids. Patients may thus encounter difficulties finding primary care practitioners willing to care for them if they take opioids.

https://ihpi.umich.edu/news/taking-opioids-pain-may-make-it-harder-find-primary-care

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Mary Ann

- Agreed to take over tramadol Rx
- Added tapentadol ER
- Performed occipital nerve block
- Still assessing her improvement

Case #2

- 70 yoF using a walker, current prescription for oxycodone 10 mg BID but her current prescriber states he cannot prescribe more
- Severe hip OA
- Pain anteriorly over left hip, localized swelling
- Reports minimal benefit with prior injection
- Has been advised to get hip arthroplasty but doesn't currently have insurance

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What would you do?

- Refer to ortho to prescribe until surgery?
- Refer to pain management?
- Continue her care in primary care clinic?

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If you think there's no clear answer…

- Maybe its because there's not one right thing to do
- Large study from Virginia – Analyzed EHR data for 84,029 patients, interviewed 16 clincians
- Clinicians report multiple difficulties in weaning patients from chronic opioids, including medical contraindications of nonopioid alternatives and difficulty justifying weaning by stable long-term patients.

- Chronic opioid prescribing in primary care: Factors and Perspectives. Annals of Family Medicine Vol 17 (3) 2019

Case #3

- 35 yoM prescribed oxycodone 30 mg TID started by your predecessor in clinic
- No sedatives or stimulant concurrently
- In the last year, UDS negative for oxycodone x 1, most recent UDS +nonprescribed fentanyl for the first time ever

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What would you do?

- Refer for pain management?
- Refer for OUD?
- Treat for OUD?

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Pearls for complicated cases

- If you have concerns over PDMP prescriptions from multiple sources, high dose, or dangerous combinations – **discuss** safety concerns with the patient/other prescribers including risk for OD
- Consider OUD if indicated and discuss those concerns with the patient
- Do not dismiss from care – use the opportunity to provide potentially lifesaving information and interventions

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Take homes:

- "Absence of evidence is not evidence of absence. "
  - You've got to look at the one case presenting in front of you
- Take the opportunity to say "I do that"
  - Treat the patient
  - Refer for more specialized treatment when truly needed

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Questions?

Type Questions into the chat or Raise hand

Additional questions:

1-855-337-MACS (6227)
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