

Arizona Opioid Prescribing Summit: A working meeting to draft prescribing guidelines
Courtyard Scottsdale Salt River, Eaglemark Ballroom
5201 North Pima Road, Scottsdale, Arizona 85280
March 15, 2014

MEETING NOTES

Welcome and Introductions/Overview of the Day

Dr. Cara Christ (Deputy Director and Chief Medical Officer, Arizona Department of Health Services [ADHS]) welcomed participants, who then introduced themselves. Sheila Sjolander (Assistant Director, Division of Public Health Prevention Services, ADHS) provided an overview of the day, noting that participants would be reviewing and making recommendations on proposed guidelines in the afternoon after hearing from several experts in the field. Slides for Ms. Sjolander's remarks were provided in the meeting packets.

National Perspective on Prescription Drug Abuse and Misuse

Dr. Len Paulozzi (Medical Epidemiologist, CDC Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control) provided comments from a national perspective. He shared data showing that drug poisoning death rates have surpassed death rates from motor vehicle crashes in recent years and that Arizona rates are among the highest. Dr. Paulozzi also provided comparative information on state guidelines related to chronic pain pre-treatment, initial opioid treatment, follow-up, and discontinuation. He reported that there is wide variation in awareness of guidelines and an overall low level of adherence. He described numerous challenges to adherence and shared some data on changes in prescriber behavior post-guidelines adoption in Washington State and Utah. His conclusions were that State guidelines for opioid prescribing are proliferating, that existing guidelines are similar, that there are challenges to educational intervention, and that clear evidence of effectiveness is difficult to obtain. Slides for Dr. Paulozzi's presentation were provided in the meeting packets.

Arizona Perspective—A Look at the Problem and the Arizona Prescription Drug Misuse and Abuse Initiative

Phil Stevenson, Ph.D. (Director, Statistical Analysis Center, Arizona Criminal Justice Commission) provided data related to the misuse and abuse of opioids in Arizona, including emergency department discharge data and inpatient hospitalization rates for drug-related conditions, cases of neonatal abstinence syndrome, and drug-induced death rates. He also described the Arizona Prescription Drug Misuse and Abuse Initiative, a multi-systemic approach for reducing health and criminal justice consequences, and shared process evaluation results. Lessons learned include: 1) the prescription drug monitoring program needs improvement; 2) there are issues related to reimbursement and patient satisfaction in emergency departments; 3) there is a need for prescriber guidelines; 4) there is a need for patient education; 5) referrals to treatment are needed; 6) the report card process needs improvement; and 6) it is difficult to reach adults with the Rx360 curriculum. Slides for Dr. Stevenson's presentation were provided in the meeting packets.

Example of Guidelines for Consideration

Dr. Aram Mardian (Chief of Chronic Pain Management Program, Phoenix VA Health Care System) and Dr. Trupti Patel (Deputy Chief Medical Officer, Division of Behavioral Health Services, ADHS) worked together to review existing guidelines and draft a set of proposed guidelines for use in today's meeting. The proposed guidelines are high level and, once finalized, will be augmented by background information and further explanatory comments. Dr. Patel presented the proposed Acute guidelines and Dr. Mardian presented the proposed Chronic guidelines. Slides of both presentations were provided in the meeting packets.

Discussion: What is the most important thing to consider when developing guidelines for Arizona? What concerns do you have that must be addressed as we move forward?

Participants worked at their tables, mainly with colleagues from their own discipline/field, to address the questions posed above. Some of the comments shared with the full group were as follows.

It is important to consider/concerns include:

- Education for providers and the public—most commonly mentioned topic
- Where the guidelines “live,” who implements them, and who is responsible for the training (because the guidelines are open to interpretation)
- Use of clear and simple language, definitions
- Guidelines that are practical, not onerous
- The need for tools for providers
- Policies and practices related to refills in general
- Getting buy-in, especially from the largest prescribers
- How to address acute pain issues in the presence of chronic pain
- Stratification
- Stating what can be done versus what cannot, offering alternatives
- Adopting universal precautions as opposed to risk assessment
- How to identify drug misuse
- Lag in the availability of information from the prescription drug monitoring program
- Increase in other drugs if opioids are decreased
- Healthcare system issues
- Access to alternatives and adjunct services
- Exceptions
- Need for evaluation
- Use prescriber-neutral language; change language to “prescriber”
- Need to differentiate between PCPs and pain medicine specialists.
- Need to encourage smaller refills.
- Need to specify what should be done as well as what should not be done.
- Guidelines should be tailored to opioid naïve vs tolerant vs dependent.
- Pregnancy should be mentioned.
- Use of guidelines by attorneys as standard of care is a concern - they should be reviewed by an attorney and should be as simple as possible.

Professional Education Opportunities

Dr. Dan Derksen (Director of the Center for Rural Health, Chair Public Health Policy and Management Section, University of Arizona Mel and Enid Zuckerman College of Public Health) spoke about the need for access to treatment and professional education.

Review Proposed Guidelines and Make Recommendations

Each of the proposed guidelines was reviewed by the full group and comments recorded.

Guideline	Recommendation	Comments
<p>Acute Guideline #1: Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice. It should be determined that other non-opioid pain medications or therapies will not provide adequate pain relief.</p>	<p>Include this guideline; may want to address comments in guideline or companion information.</p>	<ul style="list-style-type: none"> • Even for acute cases, history should be considered. • Stratification is important to consider, e.g., opioid naïve, opioid tolerant. • Even for acute cases, the guidelines need to address appropriate dosage. • Need to clarify who determines that the severity of the pain warrants the choice—the patient or the prescriber.
<p>Acute Guideline #2: When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. This should be based on the usual duration of pain severe enough to require opioids for that condition.</p>	<p>Include this guideline; may want to address comments in guideline or companion information.</p>	<ul style="list-style-type: none"> • What is “usual”? It is hard to say, but it is based on clinical judgment. • Need to reassess after a reasonable period during which functional improvement has been assessed. • Reassessments should be in person, but in some practices the patient may not actually see the original prescriber. • A factor in dispensing more than the mean number is not having the patient come back. • There was discussion about providing suggested amounts, but many did not support this. • The prescriber should discuss amounts with the patient. • Discuss with patient expected duration of treatment • These guidelines are macro level.
<p>Acute Guideline #3: The patient should be counseled on the following regarding any prescription of opioid:</p> <ul style="list-style-type: none"> ✓ Store the medications securely. ✓ Sharing with others is prohibited. ✓ Dispose of medications properly when the pain has resolved to prevent non-medical use of medications. ✓ Opioids are intended for short-term use only. 	<p>Include this guideline; may want to address comments in guideline or companion information.</p>	<ul style="list-style-type: none"> • The patient counseling should be documented. • Prescriber should explain the reasons for these guidelines. • Explain why sharing is prohibited. May want to use a different word (it is illegal). • Add something about taking as prescribed, not self-escalating. • Add something about not driving. • Add something about not giving to pets. • Patients may not remember if the counseling is done post-op. • Multiple channels of information are key; repeat the admonitions.

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		<ul style="list-style-type: none"> Information can be provided by the pharmacy also. Health literacy is important; direct the patient to resources available online. Need to explain how to dispose properly, as there is conflicting information. Prescribers cannot control for compliance.
<p>Acute Guideline #4: Long acting opioids should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted.</p>	<p>Include this guideline; suggest language change.</p>	<ul style="list-style-type: none"> Need to address stratification. Need patient education. Need to address pre and post hospitalization. When would long acting be needed? Drop the exception clause. Say “generally.” Decisions need to be made with consideration of the patient’s other medications.
<p>Acute Guideline #5: The continued use of opioids should be considered carefully, including assessing the potential for abuse. If persistence of pain suggests the need to continue opioids beyond the anticipated time period, then the patient should be carefully reevaluated.</p>	<p>Include this guideline; suggest language change.</p>	<ul style="list-style-type: none"> Change “abuse” to “misuse.” Change “beyond the anticipated time period” to “beyond acute care.”
<p>Acute Guideline #6: For treatment of both acute and chronic pain, the Prescription Drug Monitoring Program (Arizona’s Controlled Substances Prescription Monitoring Program or CSPMP) should be checked prior to prescribing opioids.</p>	<p>Include this guideline (but see comments); may want to address comments in guideline or companion information.</p>	<ul style="list-style-type: none"> Improvements in the prescription drug monitoring program are needed. It is not real time. Also need to allow for a designee in the practice, not just the prescriber, to enter the system. It will be good if the Senate Bill passes. Ask the patient, too. Using the prescription drug monitoring program is part of a comprehensive approach; it is not the only safeguard. What about liability? Practicality? Some felt that this guideline should not be included if the Senate Bill does not pass; others supported its inclusion. This guideline was supported for the behavioral health system. “Prescribing” or “dispensing”? Is there a measure of effectiveness of checking the prescription drug monitoring program? Don’t need to check every patient every time.
<p>Chronic Non-Terminal Pain Guideline #1: A comprehensive medical and pain related evaluation including assessment for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.</p>	<p>Include this guideline; may want to address comments in guideline or companion information.</p>	<ul style="list-style-type: none"> Include nicotine. It is a major addiction. Need to address patients who come to the prescriber already on opioids. What about medical marijuana in the assessment of addiction? Need to include information on this.
<p>Chronic Non-Terminal Pain Guideline #2: A goal directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere</p>	<p>Include this guideline; may want to address</p>	<ul style="list-style-type: none"> Need patient education; echo the acute guidelines on this. What if needed services are not covered by

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with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks and the patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive behavioral therapy.	comments in guideline or companion information.	<p>insurance? Should the guideline state “if services are available”?</p> <ul style="list-style-type: none"> • What about medical marijuana? Need to include information on this. Is it one or the other? Hopefully the prescription drug monitoring program and the ADHS medical marijuana files will be linked.
Chronic Non-Terminal Pain Guideline #3: The provider should assess for risk of abuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.	Include this guideline; suggest language change.	<ul style="list-style-type: none"> • What about inherited patients? • Change “abuse” to “misuse.” • Change “adverse effects” to “adverse events.” • There are tools but they are imprecise. The opioid risk tool is a good resource. • Better to use universal precautions such as drug testing. • What should be done if you have a high risk patient? • Addiction disorders are not curable, even if the patient is not currently using substances.
Chronic Non-Terminal Pain Guideline #4: Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal directed trial lasting ≤90 days should always be the starting point. Continuing opioid treatment after the treatment trial should be a deliberate decision that considers the risks and benefits of chronic opioid treatment for that patient. A second opinion or consult may be useful in making that decision.	Include this guideline; may want to address comments in guideline or companion information.	<ul style="list-style-type: none"> • This guideline is too lengthy. Break it up or otherwise shorten it. • Question the use of the word “always.” • Is 90 days too long? Start sooner. • Which diagnoses are considered chronic pain?
Chronic Non-Terminal Pain Guideline #5: When a trial of opioid therapy is determined to be appropriate, patients and family members should be engaged in an educational, shared decision making, and informed consent process. The provider should obtain and document informed consent including discussion of risks, benefits, and conditions under which opioids are prescribed. Documentation of this discussion is ideally accomplished by using a signed Opioid Pain Care Agreement (OPCA).	Include this guideline; may want to address comments in guideline or companion information.	<ul style="list-style-type: none"> • Say family should be involved “if possible.” • Add “or stopped.” • Clarify that there may be “life threatening risks.” • For those with an OPCA, they should get their meds from their OPCA prescriber. • Provide examples, e.g., use of alcohol, benzos. • This is going to be difficult for hospitals. Often don’t have pain management specialists. • The prescription drug monitoring program should include information on whether the patient has an OPCA. • Encourage long acting vs short acting opioids for chronic pain, but use with caution due to risk of dose escalation.
Chronic Non-Terminal Pain Guideline #6: Clinicians treating patients with opioids for chronic pain should maintain records documenting the	Include this guideline; may want to address	<ul style="list-style-type: none"> • Explain what “aberrant behavior” is.

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evaluation of the patient, treatment plan with measurable goals, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant behavior observed.	comments in guideline or companion information.	
Chronic Non-Terminal Pain Guideline #7: For patients on chronic opioid therapy (COT), monitoring progress with and adherence to treatment goals is essential and represents an opportunity to optimize the care plan and the overall benefit to risk profile. Appropriate monitoring for COT includes (1) regular assessment with face to face encounters (2) assessment of response to therapy including assessment of the 6 A's (analgesia, activity, aberrant drug related behaviors, adverse effects, affect, and adjuncts), (3) periodic query of the AZ CSPMP, and (4) periodic completion of UDT. Frequency of monitoring should be determined by risk category.	Include this guideline; may want to address comments in guideline or companion information.	<ul style="list-style-type: none"> • Reference is made to “face to face”—what about telemedicine?
Chronic Non-Terminal Pain Guideline #8: Clinicians should consider consultation for patients with complex pain conditions, patients with serious comorbidities including mental illness, patients who have a history or evidence of current drug addiction or abuse, or when the provider is not confident of his or her abilities to manage the treatment.	Include this guideline; may want to address comments in guideline or companion information.	<ul style="list-style-type: none"> • There is an issue re: access to specialists; it is a capacity issue. • Might want to say “if not confident of ability to properly diagnose or manage.” • Chronic pain is not an acute situation; need to take needed time.
Chronic Non-Terminal Pain Guideline #9: An opioid treatment trial should be discontinued if the goals are not met and opioid treatment should be discontinued at any point if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated.	Include this guideline; suggest language change.	<ul style="list-style-type: none"> • Change “adverse effects” to “adverse events.” • Should treatment be discontinued if the patient is opioid dependent? This does not mean abandoning the patient, but rather providing alternatives, tapering, etc. Need to address this issue in the background information for this guideline. • Might want to say “goals for functional improvement” or “therapeutic effects are not seen.” • Be cautious about discontinuation, e.g., emergency room situation. • This should apply more broadly than in a “treatment trial.” • Need documented patient education for prescriber’s protection and patient’s well-being. • Need provider education re: opioid cessation, e.g., humane methods. • Providers should be knowledgeable of and use addictionology resources. • Need to look at risks and maybe bring patients back sooner.
Chronic Non-Terminal Pain Guideline #10: COT should be used in the lowest possible doses to achieve treatment goals. Opioid related adverse events increase with doses > 50-100 mg/d MED and	Include this guideline; may want to address comments in	<ul style="list-style-type: none"> • Need to include a calculator in the toolbox for prescribers so they know MED. • Maybe the prescription drug monitoring program could have an automatic

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reaching these doses should trigger a re-evaluation of therapy.	guideline or companion information.	calculator/flag system, e.g., red, green, yellow. <ul style="list-style-type: none"> • Trigger should be built into EMRs • Consider opioid induced hyperanalgesia. • Some commented that they liked the range provided in the guideline and that the dosage triggers an evaluation. • Interprofessional approaches produce better care—there is evidence to support this.
Chronic Non-Terminal Pain Guideline #11: Combined use of opioids and benzodiazepines should be avoided.	This guideline needs further discussion.	<ul style="list-style-type: none"> • Add qualifiers. • Add informed consent. • What about inherited patients? There are legal issues. • Add “for treatment of chronic pain.” • Pain management specialists may be an exception to this guideline. • There may be pushback if this guideline is so black and white. • Some people need both. • Combined use of these drugs is capable of producing respiratory depression. • Maybe a day’s supply or no refills or don’t refill until... • Use other modalities. • Should add carisprodol
Chronic Non-Terminal Pain Guideline #12: Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use and who are prepared to conduct the necessary careful monitoring. Methadone should not be prescribed to opioid naïve patients.	Include this guideline; may want to address comments in guideline or companion information.	<ul style="list-style-type: none"> • Can do if experienced. • Don’t say “should not.” •

Participants discussed what is missing from the proposed guidelines and noted a need to address the following:

- Pain management in the chronic pain patient who is experiencing acute pain (This should be addressed in the patient’s pain management agreement.)
- Inherited patients
- Women of childbearing age
- Medical marijuana
- Complimentary Alternative Medicine (CAM)
- Hospitalized patients (coordination of care)
- Discontinuation without supervision
- Use of surveillance data, data analysis, monitoring
- Stratification of patients (it was noted that this is key and should be near the top)
- Disasters affecting Arizona, whether they occur in the state or not
- Inclusion of patient requirements in OPCAs
- Distinguish opioid naïve patients

It was recommended that some of the longer guidelines be streamlined. One participant recommended rank ordering the guidelines. A list of acronyms was suggested.

The importance of patient and provider education was underscored, as was the need to do something about “bad prescribers.”

Moving Forward

Tomi St. Mars (Chief, Injury Prevention Office, ADHS) and Sheila Sjolander engaged the participants in a discussion of next steps. The proposed guidelines will be revised based on today’s input. The rationale for each will be written. The next draft will be sent out for substantive comments. Endorsements will be requested (logo placement on the guidelines). The final product will be rolled out and a communication plan implemented.

Hopefully, the guidelines will be posted on the ADHS website with links on the Medical Board and key association websites. Other ideas for education included the following:

- Health plans and Arizona Area Health Education Centers (AHECs) should be able to help with education.
- There could be exhibits at upcoming conferences.
- A symposium or interactive webinars might be considered, with cross-disciplinary case examples.
- There should be a central repository for educational resources.
- The prescription drug monitoring program could do e-blasts.
- There could be PSAs for patient education purposes.
- There could be posters and/or videos in doctor’s offices, emergency departments, etc.
- The AHCCCS work group could play a role.

Evaluation of implementation and effects will be important. Arizona should look at what other states have done in this regard and develop/implement an evaluation plan that addresses both process and outcomes. Anyone who is interested in helping with this should let Sheila Sjolander know.

Wrap-Up

Dr. Cara Christ thanked everyone for their participation and encouraged them to stay involved in this effort.