The Opioid Crisis: Opportunities for Better Education and Safer Care

Moderated by Stan Kozakowski, MD, FAAFP
Director, AAFP Medical Education Division

AAFP and Opioid Crisis Response

Wanda D. Filer, MD, MBA
AAFP Board Chair

Initial Revisionist Attempts

- “Blame” game pushback, ACCEPT our share
- Enough blame to go around
- Pain is the 5th Vital Sign
- Media, Policy and Politics: Federal, State, Local
- Where is the patient? Pain, Addiction, Abandonment, Comorbidities

External Strategy

- Media: New York Times (Wergin), Oz, WSJ and many print publications, NPR, etc.
- Advocacy/DC: Numerous meetings, roundtables
- Chapters (partners) and state govt.
- Pres. Obama/ Charleston WV and task force

Internal Communication

- Education: Where we are, where we need to go, upgrade CME, MOC (ABFM)
- Call to action letter to ALL members
- Public Health: Create Opioid Task Force: Dr. Chuck Rich
- Update our own positions, policies (available)
  - Revised Chronic Pain and Opioid Misuse Position Paper Chronic Pain Management Toolkit for Members available at:

AAFP Policies

- Revised Chronic Pain and Opioid Misuse Position Paper
  - Available here
  - Revised in June 2016
  - Expanded call to action and focus on medication-assisted treatment
  - Provides Family Physician perspective and resources
- AAFP Substance Abuse and Addiction Policy
  - Available here
  - Outlines the Academy's stance on a prescription, illicit drugs and alcohol
  - Highlights the role of the Family Physician in pain management and opioid misuse

AAFP Initiatives and Resources

- Chronic Pain Management Toolkit
  - Available for members at: link to toolkit
  - Tools for pain assessment, medication agreements, physician/patient roles and responsibilities
  - Updated in September 2016: urine drug screening, opioid conversion tool, tapering information with additional tools in progress
- Opioid and Chronic Pain Resources
  - Office-based tools, community and advocacy resources
  - Education
    - AAFP CME Webcast
    - PCSS Medication Assisted Treatment Training (developed with input from AAFP)

Talk to our FM partners

- ABFM: KSAs on pain, great numbers
- STFM
- AFMRD Survey of residencies:
  - Alarming/Opportunity
  - Highly variable, awareness, attitudes
  - Comment section gives critical insights

What now?

- AAFP & Family Medicine need to LEAD in education, solutions, balance
- Opportunity to showcase specialty, patient centered care, advocacy, embrace and promote complexity, systems improvements

Opioids Rx: Defusing the Legal Minefield

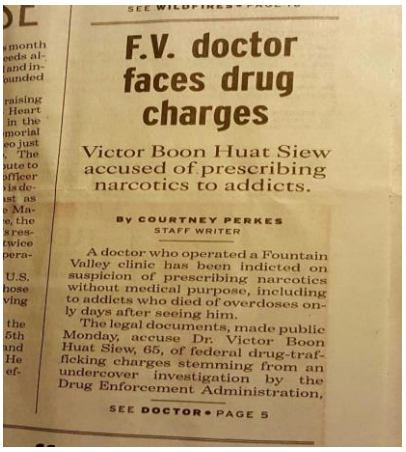
Tim Munzing, MD
Residency Director, Medical Expert – DEA, FBI, Med Board of California

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Crooked Docks vs Crooked Docs

June 2016 Arrest

- >10 Deaths
- 2 Physician Assistants Involved
- Deaths shortly after prescriptions



F.V. doctor faces drug charges

Victor Boon Huat Siew accused of prescribing narcotics to addicts.

BY COURTNEY PERKES
STAFF WRITER

A doctor who operated a Fountain Valley clinic has been indicted on suspicion of prescribing narcotics without medical purpose, including to addicts who died of overdoses only days after seeing him.

The legal documents, made public Monday, accuse Dr. Victor Boon Huat Siew, 65, of federal drug-trafficking charges stemming from an undercover investigation by the Drug Enforcement Administration,

SEE DOCTOR • PAGE 5

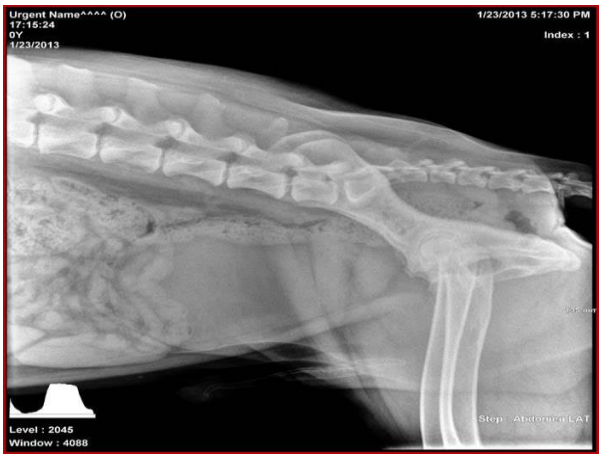
Los Angeles Times – Oct. 30, 2015

California doctor convicted of murder in overdose deaths of patients

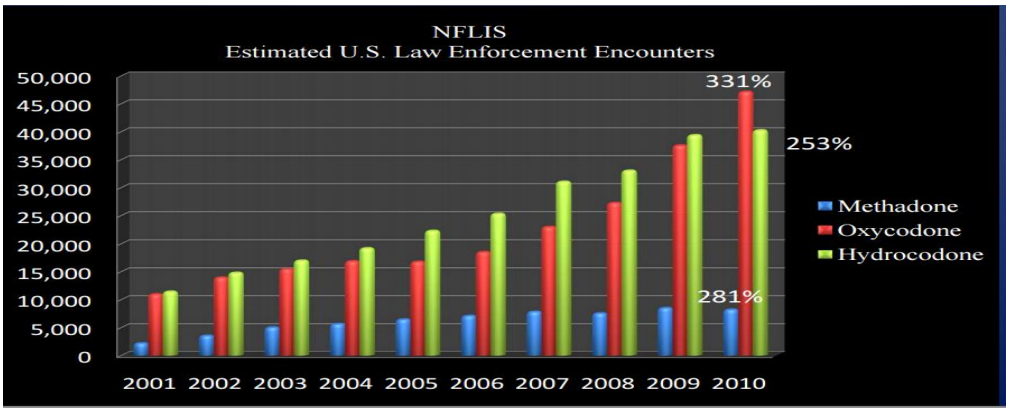
Rowland Heights doctor Hsiu-Ying "Lisa" Tseng and her attorney Tracy Green, left, listen as Tseng was convicted of second-degree murder on Friday, for the drug-overdose deaths of three of her patients. (Mark Boster / Los Angeles Times)

By Marisa Gerber, Lisa Girion and James Queally · Contact Reporters

Undercover X-ray
What Do You See???



Number of Forensic Cases 2001 - 2010



National Forensic Laboratory Information System (NFLIS) data – found at:
http://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2012/sept_2012/houston/drug_trends_1002.pdf

Investigators of Physicians

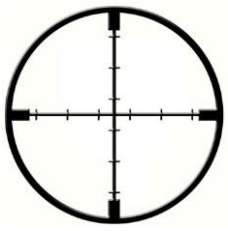
- Drug Enforcement Administration (DEA)
- Local Law Enforcement
- State Medical Boards
- Medicare Audits
- Medi-Cal or Medicaid Audits

Who Reports Physicians?

- Family members of addicts / patients who overdose or die
- Fellow physicians or ERs who see the inappropriately managed patients
- Pharmacists
- Coroners
- Medicare or Medicaid audits
- Informants

Legal Issues

- It is easy to stay out of the crosshairs
- Not being a bad doctor doesn't make you a good doctor
- **Do what is right for the patient, and document it**



Good Doctors: Why do they Miss the Mark???

- Education and Experience
- Too Busy
- Naïve

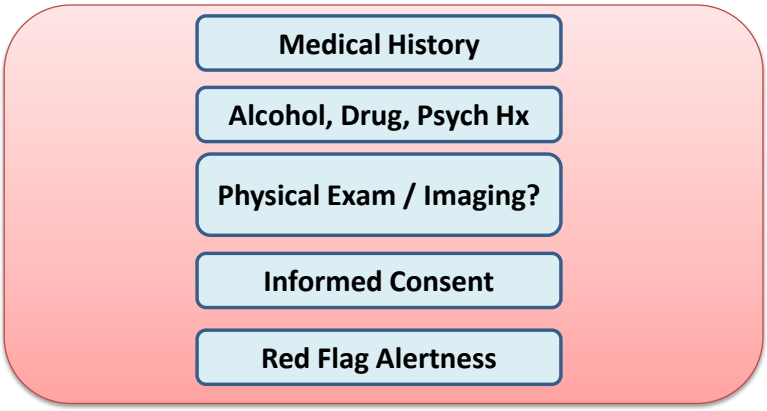
General Principles

- Act like a doctor – evaluate (Hx and Px) and manage appropriately
- Document in detail
- Pain
  - Acute Pain
  - Chronic Pain – requires multidimensional approach, opioids often poor choice

General Principles

- 90- day cliff (or less)
- Non-pharmacologic alternatives and adjunct treatments
- Non-opioid alternatives and adjunct treatments
- Start low and go slow – very limited prescription numbers
- Trust but verify
- Documentation – be thorough!

Controlled Substance Prescribing: Core Elements



Adapted from the Medical Board of California; American Academy of Pain Medicine; American Pain Society

Controlled Substance Prescribing: Core Elements

Adapted from the Medical Board of California; American Academy of Pain Medicine; American Pain Society

Periodic Review: The 5 "A's" Plus

- Analgesia
- Activity or Function
- Adverse Effects
- Affect
- Aberrant behaviors
- Prescription Drug Monitoring Program (PDMP) – CURES in California
- Urine Drug Screening (UDS)
- Updated History, Exam, and Assessment
- **Taper medications when possible**

Adapted from the 4-"A's" - Passik SD, Weinreb HJ. Managing chronic nonmalignant pain: overcoming obstacles to the use of opioids. Adv Ther. 2000;17:70-80.

Prescribing "Red Flags" for Abuse / Diversion

- Early refills / Claims that the medications were lost or stolen
- Drug overdoses
- Use of multiple pharmacies concurrently
- Obtaining Controlled Substances from multiple physicians or doctor shopping
- Excessive amounts
- Drug combinations – Opioids, Benzo, Soma, Adderall
- Obtaining or buying Controlled Substances from family, friends, or others

Prescribing "Red Flags" for Abuse / Diversion

- Use of drug culture street lingo for the names of the medications or other drugs
- CURES reports that provide inconsistent results
- Urine drug screens that provide inconsistent results
- Use / abuse of alcohol
- Use of THC / marijuana
- Driving long distances for visit for opioids

Soaring Towards Improved Outcomes and Patient Safety

AMERICAN ACADEMY OF FAMILY PHYSICIANS

A structured chronic pain program and curriculum

Roxanne Fahrenwald, MD

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Background

Group practice, teaching practice. Unease covering others' patient panels. Concern about diversion, addiction.

- Residency in CHC
  - Attendings, residents, non-physician providers
- Highly variable styles, little to no agreement on scope of practice in caring for patients with pain
- Liberal prescribers, limited prescribers, and worried prescribers
- Residents getting mixed advice
- No uniform core curriculum
- No evidence base for practice or systematic patient assessment

Process and Sources

- Sought models elsewhere
- Scheduled time for focused attending conversation on opiate prescribing practices
- Agreed on need for structured practice and curriculum – some top down
- Sought external advice/ expert

Retreat and Buy-in

- Full day physician retreat 2008
- Invited speaker from Denver to discuss a residency based model
- Provided what evidence there was
- **Agreed to agree** on practice wide model for all including curriculum for residents
  - Agreed to limit to non-cancer related pain

Underlying philosophy

- Most patients with chronic pain are best served by their primary care physician in the context of a patient-centered medical home
- Poor prescribing leads to poor outcomes and will facilitate addiction and diversion - prevention
- Our desire is to improve life, health and safety for patients, providers **and** the public

First Round of Toolkit

- 2008 – used Washington State guidelines
- Studied intake procedures at Pain Clinics
- Made decisions on MED cap for physicians (120 usual max -- 180 cap with review) and for NPPs and interns (20)
  - Higher doses need taper or referral
- Developed three step assessment leading to interdisciplinary care plan, PCP ongoing care, risking and monitoring
- Limited assessment to upper level residents and attending physicians
- Goal: patient care **and** restore function **and** public health protection

Roll Out

- Series of teachings
  - Support Staff – key
  - Attendings and NPPs
  - Residents
- Templates for EMR, check lists for visits
- Part of annual resident orientation and new provider orientation
- Controlled Substance Committee – interdisciplinary to review high need and concerns

Result

- Uniformity and continuity
- Sorting out
  - Rolled all existing patients through process
    - Some left practice
  - Significant loss at first visit (ongoing)
- All staff morale improved and anxiety reduced
- Safer care with expanded focus on function

Process in a Nutshell

- **Visit one**: Review process, agreement, UDS, identify pain generator and history, function and risking, release for old records, review MPDR
- **Visit two**: Review records with patient, complete history, directed PE, identify gaps if any, review MPDR, refer to CSC if red flags or concerns
- **Visit three**: Personal Care Plan – physician plus behavioral health, review MPDR
- NO PRESCRIBING UNTIL COMPLETED
- Follow up – scheduled visits and MPDR review with PCP ongoing
- Must be primary care patient of ours, NOT JUST A PAIN CLINIC

Toolkit Redux 2016

- Interdisciplinary review and update
- New pain and functional assessment tools
- Changes based on CDC revised standards
  - Decreasing MEDs to 50 standard, 90 cap **with** review,
    - Benzodiazepine warning/limitation
    - NPP, interns same – 20 MEDs
  - New Care Plans for existing patients – phase in changes with CS committee input
  - Annual review and update of care plan required (new)

New Roll Out

- Support Staff
- Attendings and NPPs
- Residents
- Care Managers
- Pharmacists

Resources

- DIY – CDC, STFM, AAFP, AMA, Washington State, your state Board of Medical Examiners, PEG scoring, Opiate risk score
- Our program is available

Necessary for success

- **Full practice buy in – uniformity KEY**
- Education for residents and others
- Emphasis on interdisciplinary assessment
  - Public health and individual patient considered
- Emphasis on restoring function and not on pain medicine – NOT an 'opiate' care plan
- Structured plan to readjust medications
- Less than half of patients on opiates

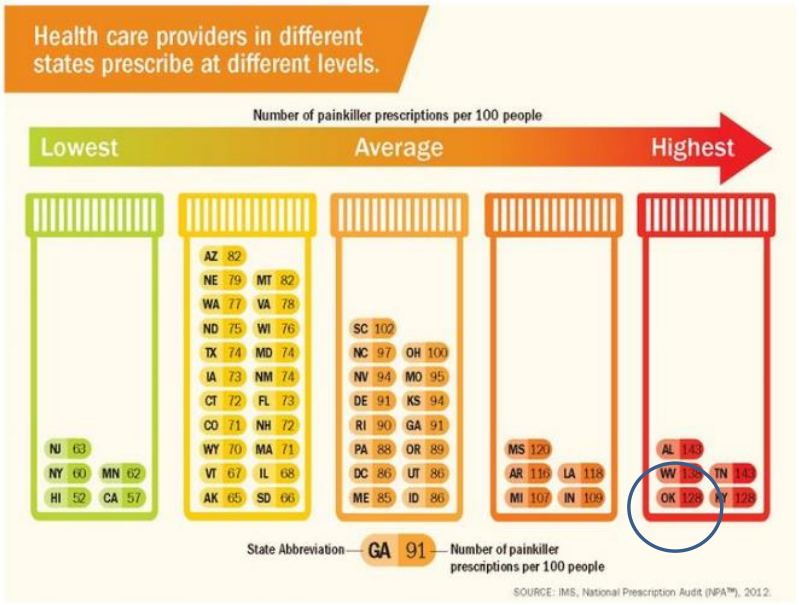
University of Oklahoma Family Medicine Residency Program

Rachel Franklin, MD
Professor and Medical Director

AMERICAN ACADEMY OF FAMILY PHYSICIANS

University of Oklahoma Family Medicine Residency Program

- 12-12-12
- Opposed program/academic institution
- 52,000 patient-visits annually
- 60% Medicaid/20% Medicare
- Level 3 PCMH/ Track 2 CPC+
- Highest acuity patient population in state



The Problem

- No curriculum/standards/guidelines
- No workflow
- Confusion
- Frustration
- Risk
- By 2012, new leadership = new opportunity

The Charge

- Develop standardized, evidence-based curriculum for evaluation of chronic pain
- Create clinical environment within which to deliver curricular care to patients
- Vision: resident obstetric practice

Our Goals

- Balance safety/relief, provide safety net for learners
- Standardize visits
  - Focus on function, not pain score
  - Solution: brief pain inventory
- Document risk assessment
  - Opiate Risk Tool
  - CAGE-AID questionnaire
- Standardize clinic workflows
  - Prescription Monitoring Database review/documentation
  - Controlled Substance Agreements
  - Urine Drug Screening
  - Patient-completed self-assessments

Limitations on Resident Practice

- PGY-1 may not see chronic pain for first 6 months
- Residents must present all patients taking controlled substances for chronic pain
  - Brief history, including likely etiology
  - Follow up: whether functional status better, worse, or stable
  - Patient risk category
  - Current morphine equivalent dose
  - Patient compliance with care plan
  - Results of OBNDD
  - Results of last UDS, if available

Limitations on Resident Practice

- Resident prescriptions initially limited to < or = 100mg morphine equivalent daily (now follow CDC/FDA guidelines)
  - Defined by approved calculation tool
  - Not negotiable
    - Resident with DEA
    - "grandfathered" patient
- Residents may not prescribe
  - Methadone
  - Suboxone
  - Soma (carisoprodol)

Successes

- Curricular structure:
  - 2013: no required curriculum
  - 2014: curriculum inconsistently applied
  - 2015: additional faculty education, edict from residency division
  - 2016: relative consistency, residents express satisfaction
- EMR Documentation:
  - 2013: none existed
  - 2014: launched, inconsistently loaded
  - 2015: education program for staff, faculty, residents
  - End-2015: consistently loaded, inconsistently used by physicians
  - 2016: re-education of faculty and residents

University of Oklahoma Family Medicine Residency Program

Ming “Frank” Wu, MD
PGY-3 Resident

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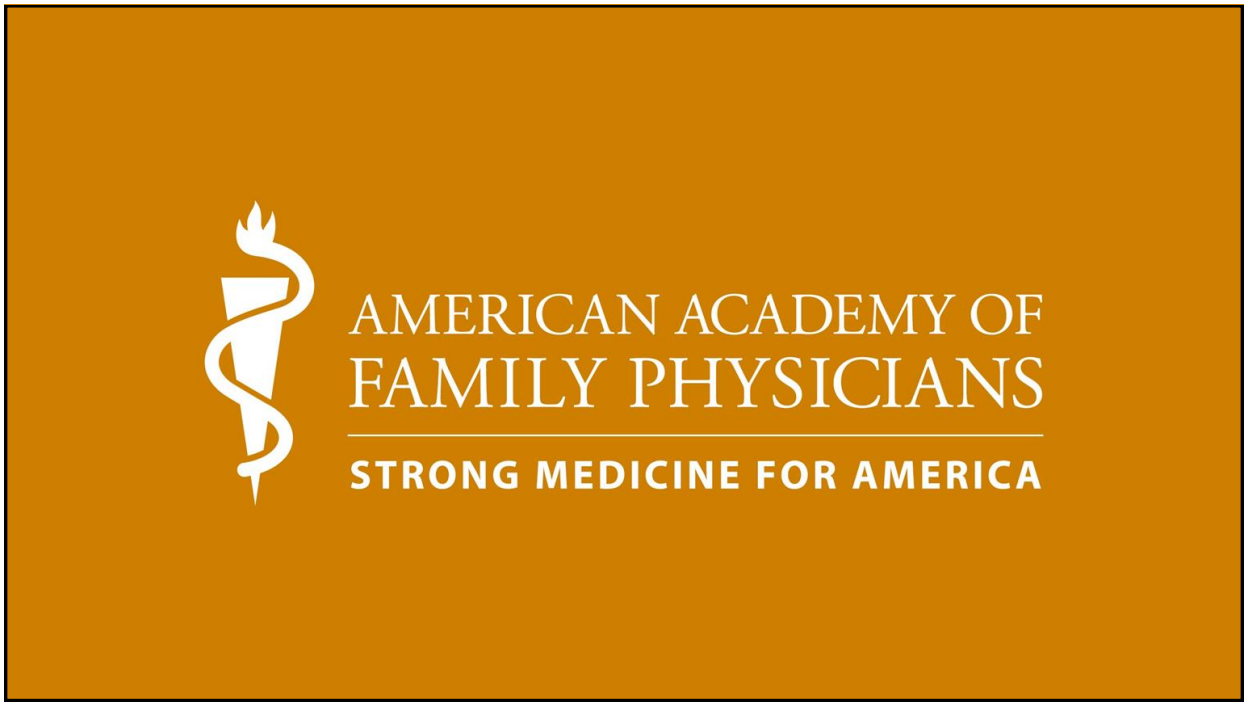
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