

The Opioid Crisis: Opportunities for Better Education and Safer Care

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



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AAFP and Opioid Crisis Response

Wanda D. Filer, MD, MBA
AAFP Board Chair



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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

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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

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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



Crooked Docks vs Crooked Docs

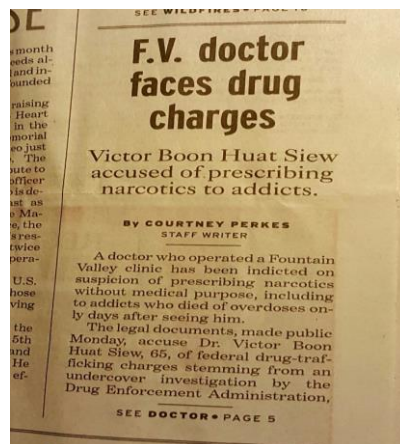


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June 2016 Arrest

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



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Los Angeles Times – Oct. 30, 2015

California doctor convicted of murder in overdose deaths of patients



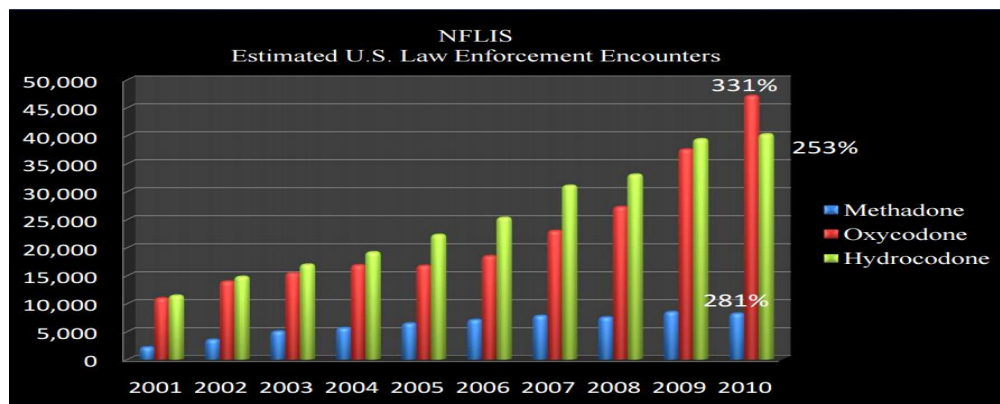
Rowland Heights doctor Hsu-Ying "Lisa" Tseng and her attorney Tracy Green, left, listen as Tseng was convicted of second-degree murder on Friday, for the drug-overdose deaths of three of her patients. (Mark Boster / Los Angeles Times)

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

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Investigators of Physicians

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



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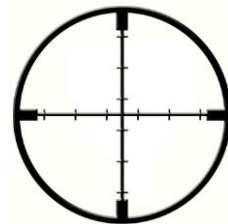
Who Reports Physicians?

- 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

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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**



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

- Education and Experience
- Too Busy
- Naïve



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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

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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!

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Controlled Substance Prescribing: Core Elements

Medical History

Alcohol, Drug, Psych Hx

Physical Exam / Imaging?

Informed Consent

Red Flag Alertness

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

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Controlled Substance Prescribing: Core Elements



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

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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

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Soaring Towards Improved Outcomes and Patient Safety



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A structured chronic pain program and curriculum

Roxanne Fahrenwald, MD



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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

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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

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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

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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

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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)

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New Roll Out

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

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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

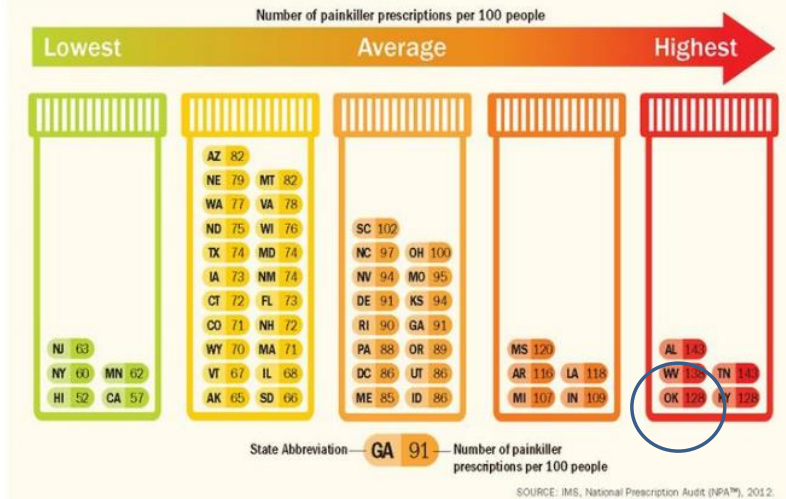


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University of Oklahoma Family Medicine Residency Program

- 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

Health care providers in different states prescribe at different levels.



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The Problem

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

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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

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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

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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

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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)

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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

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University of Oklahoma Family Medicine Residency Program

Ming “Frank” Wu, MD
PGY-3 Resident



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