PRESCRIPTION DRUG ABUSE
MEDICAL TASK FORCE

JULY 2014

SAFE PRESCRIBING UPDATE

The Emergency Department *Safe Prescribing* guidelines received an Achievement Award from the National Association of Counties, a national group representing the more than 3,000 Counties. NaCo recognizes innovative projects with achievement awards. Los Angeles County has replicated *Safe Prescribing*, using the same design and similar web site for their 77 ED's. California ACEP has done the same. Any hospital or community in California can use the California ACEP guidelines, add their local logo, and start a similar program. Go to californiaacep.org and look under public health - safe prescribing.

PRESCRIBING TIPS

How do you say "no" nicely to patients? Did you know that Tramadol 50 mg has 1.5 times more morphine equivalents than Vicodin 5 mg? Our task force has published Clinical Guidelines that are very provider friendly and practical. Please encourage your practitioners to review. You can find these at www.SanDiegoSafePrescribing.org. The **Provider Guidelines** for Anyone Who Prescribes Controlled Substances is endorsed by the Public Health Department, Hospital Association, and Medical Society of both San Diego and Imperial County. Under **Educational Material for Practitioners** you will find many useful resources. We call your attention to two additions: **Helpful Prescribing Tips** and **How To Talk to Your Patients About Safe Prescribing**. This later document includes a table of how to answer common patient complaints such as "The Medicines Don't Work".

New Opioid/ Benzo VA Policy

Dr. Pat Hlavin reported that at the VA, a special form and approval is needed to prescribe both opioids and benzodiazepines at the same time for a patient. This new policy will reduce joint prescribing –a good measure considering the risk of adverse interactions. There are some complaints, but Dr. Hlavin believes everyone will get used to it and see the benefit.

Dr. Suraj Achar, from the UCSD PACE program, spoke about the opioid/benzo mix. The evidence is very clear on heightened risk. Pain specialists say that the combo is simply not safe. Benzos require careful weaning. The key messages to doctors is to avoid starting with this combination. There is no evidence that use of this combo is effective, and one-third of overdoses involve these two medications on board at the same time.

***NEXT MEETING:* SEPTEMBER 12, 2014 AT NOON, RIGHT AFTER THE REGULAR EMOC MEETING AT SAN DIEGO COUNTY MEDICAL SOCIETY.**

JUNE 27TH VISIT TO METHADONE CLINIC

A team visited the SOAPMAT methadone clinic in Oceanside. The team included Dr. Roneet Lev, Susan Bower and Linda Bridgeman Smith from County Behavioral Health Services and Angela Goldberg from the San Diego County Prescription Drug Abuse Task Force. The team met with Dr. Laura Rossi and Kathi Morgan of SOAPMAT. San Diego has about 10 privately-run methadone clinics, also known at NTP or Narcotic Treatment Programs. They are regulated by Federal Law 42 CFR, a law that protects client's confidentiality about substance abuse treatment. Highlights of what we learned:

Hours of Operation. Clinics are open 7 days a week, 365 days a week, and generally have early morning hours.

Conditions: Patients are treated for addiction and dependence to opiates, that includes heroin and prescription drugs. There is a 50/50 split in the two conditions, with a rising number of prescription drug dependence.

Types of Programs. Methadone clinics provide Detox or Maintenance programs. Phase I is a 21 day Detox, Phase II is a 180-day Detox, and Phase III is Maintenance. 99% of the patients receive maintenance care. MediCal provides coverage only for Phase I and Phase III. If a patient fails a 21 day program, they must wait 7 days and then enter the 180 program. There is a "2 plus 2" exception granted to some NTP. This means if the patient has failed 2 previous treatment programs, they can enter the maintenance program.

Intake. A new patient receives a comprehensive psychosocial assessment that includes things such an addiction severity index, vital signs, and an interpretive summary. This is similar to a psychiatric intake rather than the standard medical history and physical. It can take several hours.

Dosing. Methadone is dispensed in a liquid form. A first time patient would receive 30 mg, be rechecked after 20 minutes and receive another 10mg. Therefore, the first day dose would be 40 mg. The subsequent dosing would go up and titrated to withdrawal symptoms. One patient addicted to prescription pain medications has a steady state dose of 175 mg. We are told that patients addicted to heroin require smaller dosages than patients with opiate prescription addictions. Dispensing is organized according to "step". At Step zero, all methadone is dispensed at the clinic. At Step 1 the patient may take home a holiday supply. At Step 6, the patient will earn the trust to take home 27 dosages and come in once a month. Random drug testing occurs throughout the steps. Few patients are able to wean their dosages after achieving a steady state dose.

Counseling. Federal law mandates a minimum of 50 minutes of counseling a month to all methadone clinic patients. SOAPMAT staff are proud to provide more than minimum counseling.

Cost. Methadone patients are funded by MediCal or Cash. The Affordable Care Act has a provision that behavioral health care is covered to a similar level as regular health care. ACA has expanded coverage and demand for Methadone Clinic care. The cost of care varies per clinic, but at SOAPMAT runs about $300 a month for cash and $440 for Medi-Cal depending on the amount of counseling. As of January 2014, the San Diego County Health and Human Services Agency became involved in reimbursement of MediCal to the clinics via the local cost sharing plan. Previously clinics billed and collected directly from the state. However, with the ACA, local counties have been given the duty to coordinate care, and this includes the NTPs.

Medical Testing. Methadone patients receive random urine testing at least once a month and at most once a week. Pregnant women are tested once a week. According to Dr. Rossi, about 80% of patients test positive for THC (marijuana), which does not alter their dosage. The testing is used to see if they can move up or down their Step level. Some clinics can do other tests such as RPR (syphilis) or PPD (tuberculosis). They do not test for HIV or do EKGs to look at the QT segment.

CURES. Since NTP are federally regulated, 42 CFR provides privacy to all patients that would not allow the clinics to enter data into CURES. However clinics are encouraged to regularly check CURES reports on their patients. In a case study published by SAMHSA (Substance Abuse and Mental Health Services Administration) 23% of methadone patients were prescribed significant quantities of opiates, benzodiazepines, and other controlled substances by clinicians outside their practice. This means that patients are "double dipping". We will be encouraging NTP to check CURES, but with state or county regulatory changes, we cannot mandate this.

Communication with the Clinics. On occasion, you may have a need to communicate with a methadone clinics regarding patients that you have in common. You may need to know dosages of methadone so you can coordinate with their other medications, or you may need to report that a patient is too sedated from their dose. Currently such communication may not be easy. Your patient needs to know which clinic they go to, you must call when the clinic is open, and you must follow HIPPA guidelines to obtain the information. The County and the PDA Task Force will work to improve coordination and communication so that this vital medical exchange can occur to promote patient safety.

Issues from the Clinic. Dr. Laura Rossi noted that the clinics face specific problems. This includes fighting for child custody for patients who are on methadone, but have clean drugs screens in terms of other illicit drugs. They also discussed "forced titration" where a judge with no medical training will force a client to stay clear of a medication that may be prescribed. She noted that 50% of patients who go to drug court are prescribed Tramadol.

PACE

Dr. Achar from the UCSD PACE program gave an overview of their program. http://www.paceprogram.ucsd.edu. He and his colleagues at UCSD have been involved in education of appropriate prescribing through PACE, the Physician Assessment and Clinical Education program since 1996. When the medical board or hospital administration is involved with investigation prescription drug morbidity or mortality, they may refer the provider to their program.

MTF to Invole Insurance Companies

Members agreed that insurance is a key player in work to avoid prescription misuse. Dr. Lev suggested that we develop a proposal and then have a conversation with the insurers. What prescribing solutions have general consensus? Here are some suggestions of limitations on covered benefits because it can be harmful:

PATIENT SATISFACTION

Patient experience is an important measure, but linking hospital/doctor reimbursement to patient satisfaction is problematic in fighting the prescription drug abuse epidemic. It is readily apparent to the lay community that such links create a challenge for doctors to have the sometimes needed and difficult conversation to say No to patients. A good parent, like a good doctor, needs to say no, even if it is unpopular.

HCAHPS, the hospital consumer assessment of healthcare providers and system, is a hospital-based 32 item survey that measures the patient experience. In 2014, Medicare reimbursement became linked to patient satisfaction. The HCAHPS score is 30% of the total performance score (TPS) in measuring quality of care. Emergency Physicians are the first specialty group to have income tied to patient satisfaction scores, with ED-CAHPS, the Emergency Department Consumer Assessment of Healthcare Providers and Systems. This is a program run by CMS and is expected to start in 2015. CMS is currently testing their survey in 12 different programs and analyzing their data. It is doubtful that they are measuring the effect of the survey on prescribing patterns. While the ACA requires measurement of the patient experience, there is no obligation to tie to reimbursement. AMA and California ACEP have voiced objection to the measure, but have been told that it is a done deal, and are now focusing on how to improve scores. Dr. Roneet Lev has talked to Diane Feinstein's office to voice concern on the effects of prescribing patterns that may be tied to income. There are several cases of physicians being disciplined or even fired for not giving patients what they want. Dr. Leslie Mukau emphasized that we need to act as a team and secure administrative support across the board.

- A maximum of 100 morphine equivalents per day without prior authorization
- Take Soma off the formulary
- No opioid/benzodiazepine combination without prior authorization

Naloxone

Dr. Eric McDonald reported that AB635 authorizes Counties to develop programs for Naloxone distribution via doctors, patrol officers and directly with training to family members. He noted that the County and Sheriff are implementing a pilot program where patrol officers will carry Naloxone to treat opioid overdose. A community group is also training parents and loved ones on how to use Naloxone. He suggested that the Medical Task Force could also develop a tool kit for prescribers to give as indicated. Eric said that the evidence is overwhelming that putting Naloxone in the right hands saves lives. Nathan said that similar legislation is on the horizon to allow pharmacists to also dispense Naloxone.

Naloxone is prescribed to the patient at risk, but given to a family or friend who carries the injection and learns how to use it. Part of the education is that they must call 911 and still take the patient to the hospital even if they wake up and don't want to go. The prescription is recommended for patients at risk for overdose, people who have a prior history of overdose, or who use high morphine equivalents. It is not for every patient who needs a pain prescription.

A subcommittee was formed to create a tool kit on Naloxone that will be published on SanDiegoSafePrescribing.org. This will include Dr. Eric McDonald, Maggie Mendez at the VA, Dr. Nathan Painter from UCSD, SDSU Public health intern CJ Robertson. Rhode Island has developed a model kit that will be reviewed at the next MTF meeting.

The Vision for CURES 2.0

Dr. Lev was part of the advisory group for CURES 2.0 which is expected to be available in 2016. The vision for the new technology is that CURES information will be pushed to your EMR when you are reviewing patient information. Dr. Lev hopes that CURES would be a tool for preventing addiction and not just for detecting doctor shopping. One such method would be to merge the concept of the Medication Agreement with the CURES report. In San Diego we are encouraging a Medication Agreement for any who requires a controlled medication for 3 months of more. At the 3rd month, a provider could receive an alert via CURES that would ask if the patient has a Medication Agreement. The alert can be turned off when an agreement is completed or is no longer warranted. Members discussed that many EMRs, including prescription drug monitoring systems from other states, produce “Alert Fatigue” and are not popular. What would be the priority alerts for CURES? Which are important for prescribers, which for pharmacists? Several key alerts were identified: 1) Morphine Equivalents over 100, 2) Drug interactions such as benzodiazepines and opiates 3) multiple doctors and pharmacies, and 4) Medication Agreement for chronic use. These ideas will be discussed and finalized as recommended priorities at the next MTF meeting. Different numbers of morphine equivalents are considered the cut off before referral for pain management. Dr. Loretta Stenzel shared that she developed a laminated card to use in calculating morphine equivalents for her clinic.

San Diego Rx Report Card

Angela Goldberg distributed the preliminary Rx Report Card that shows relative stability between 2012 and 2013, with increases in heroin overdoses. She called attention to the ninth indicator, which displays rate of pills per resident in the County for opioids, benzos and stimulants. This forms a baseline to measure changes in overall prescribing over time. The San Diego report is a State model and is being replicated for Los Angeles.

What Would You Do? Case Presentation

Help Dr. Loretta Stenzel manage her patient.

A 58-year-old man with severe cervical disc disease and scoliosis, who is visibly bent at the neck and back presents as a new patient. In addition to chronic pain, he has ADD, Anxiety, Diabetes, Hepatitis C, and a chronically high creatinine kinase. His controlled medications include oxycodone 30 mg q 6, MS Contin 100 mg q 8, Adderall 15 mg bid, Valium 10 mg tid, and promethazine 50 mg q 8. His resting heart rate is 110. He states he has been on this regimen for years, and CURES report confirms that he has been on these medications. Should you continue this regimen? If not, what should you change?

Dr. Sujar Achar from PACE made several important comments. If this patient has an adverse outcome from medications you prescribed, you would be liable. There is a 7-fold increase rate of mortality for patients who are taking 100 morphine equivalents per day compared to a dose of 20mg. You do not need to have both the oxycodone and the MS Contin. Benzodiapines need to be weaned carefully, but the stimulants and opiates can handle a quicker wean. What would Dr. Achar refill for this patient? Continue the oxycodone at 30 mg q 6, wean Valium to 5 tid, and stop the MS contin, the Adderall, and the promethazine.

This is a very tough case. Dr. Achar suggested to stay within evidence based practice, work with a team of professionals that are available to you, and be careful of drug interactions. You many need to refer your patients to pain management or addiction help.

Do you have a case you want to present? Please bring it to the next task force meeting for discussion.

Vote NO on 46 - Increased Costs, Decreased Access

MICRA, the Medical Injury Compensation Reform Act, is a California that sets a $250,000 limit on pain and suffering. This does not apply to medical costs or loss of income, just pain and suffering. The trial lawyers have a ballot initiative that will repeal MICRA and increase damages to $1.2 million plus a cost of living adjustment going forward. If this initiative passes we are guaranteed to have a rise in health care costs and loss of access. Who would vote for increase cost of health care? No one. That's why the trial lawyers added a spin: "Stop drunk, overprescribing, and negligent doctors to save lives". They added to the initiative a provision that would mandate every provider to check CURES. They also added drug testing of providers for every negative incident. Don't be fooled. The campaign for NO on changing MICRA is supported by a wide coalition that incudes your own institutions, hospitals, pharmacies, governments, labor unions, teachers, law enforcement, and insurance companies. They understand that the initiative is a trick to increase dollars for trial lawyers and not at all about improving healthcare.

2015 Projects

Conference: We are planning an interdisciplinary conference on Safe Prescribing for March 2015, with Kaiser leading and allowing other practitioners to join.

Video: Members have discussed developing a video on the Patient Medication Agreement that patients can watch when they require more than 3 months of a controlled medication.

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