

PRESCRIPTION DRUG ABUSE MEDICAL TASK FORCE

JANUARY 2017: Summarizing the December 16, 2016 Meeting Discussion.

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Next Meeting:

February 10, 2017 at noon
San Diego County Medical
Society, 5575 Ruffin Road,
San Diego.

Follow the Numbers: Local Rx Report Card & Dash Board

San Diego's Prescription Drug Abuse Task Force published the 2016 Rx Report Card. The data shows that we have a way to go in curbing the prescription drug abuse epidemic. Unintentional Rx deaths have gone from 267 in 2011, or 9.8 per 100,000 residents to 248 and 7.7 for 2015. The numbers are unfortunately higher than 2014 when we saw 244 deaths or 7.6 per 100,000 residents. Emergency department opioid discharges have doubled from 2011 at 3,278 to 6,866 in 2014. The total ED visits in San Diego County increased by 12.8% during this time. You can find the full report at www.SanDiegoSafePrescribing.org under Statistics.

San Diego data can be compared to California data and other counties using the California Opioid Overdose Surveillance Dashboard. The dashboards and data available through this application are the result of ongoing collaboration between the California Department of Public Health (CDPH), Office of Statewide Health Planning and Development (OSHPD), Department of Justice, and the California Health Care Foundation.

For 2013, San Diego's death rate is 7.6 compared to 4.8 for California. The most dangerous place for opioid related deaths in San Diego County is the 91906 zip code in Campo with 77.8 death rate. We need to reach out to the medical community in this area.

Data is used to track prescribing changes from 2012 and 2015. The number of physicians with Buprenorphine waivers has increased by 26.8% and those with active waivers went up by 12.6%. Methadone prescriptions over 40 mg per day have gone down by 25%. Total MME (morphine milligram equivalents) of >100 went down by 11%. We have made major educational efforts about

methadone and total MME and perhaps this is the result. Doctor shopping with patients using more than 6 doctors or pharmacies went up 3.1% and 16.9% in the past year. This is consistent with the changing health insurance market causing many people to change health plans and physicians.

You can view the California and county dash board at: https://pdop.shinyapps.io/ODdash_v1/ or simply Google "California Opioid dashboard."

My Doctor Made Me A Drug Addict

A member reported that the Department of Justice is investigating a physician after a patient complained that the physician's prescription made him addicted to opioids. Over the years, the medical and patient community were given misinformation about pain medication, leading our country to a devastating path. Now both patients and physicians have become victims. We now have the hard work of undoing the damage that was created and creating a brighter balanced future.

Is Government Practicing Medicine Without A License?

The task force was presented a case where a physician, following the institutional pain guidelines, refused to fill a pain prescription that a patient was demanding. The patient complained to the department of managed health care (DMHC) who demanded that the prescription be written. Without all the details of the case, it smells like interference in the doctor - patient relationship and an obstacle for institutions who are aiming at

When a Noun Becomes a Verb

YOU KNOW YOU HAVE REALLY MADE AN IMPACT ON SOCIETY WHEN A NOUN BECOMES A VERB. A CLASSIC EXAMPLE IS "JUST GOOGLE IT." I LOVE GOING TO WORK AND HEARING THE RESIDENTS OR DOCTORS SAY, "I CURES HIM."

safe prescribing practices. The case emphasizes the importance of having community consensus guidelines like the one we established in San Diego and by the CDC.

Free On-Line Training for Pharmacists

The Last Line of Defense in the Healthcare Team is a free 1-hour CME course for California Pharmacists that was written by Quality Healthcare Concepts with a grand from CHCF. Roneet Lev was one of the contributors to the course. The course is intended for pharmacists, but physicians may enjoy clicking through the power point to find out how pharmacists are trained to deal with potentially unsafe prescriptions.

<http://www.californiapharmacistsopioidsafetytraining.com/>

A Nice Trick to Cover Lidoderm Patches

Dr. Lev talked about a patient who came to the emergency department with back pain because her insurance would not cover lidocaine patches. The task force members stated this is not an uncommon occurrence. Lidoderm 5% patches cost about \$100 for a box of 30 patches. You can apply up to 3 patches no more than twice a day. Unfortunately, Medicare and Medi-Cal will only cover Lidoderm for neuropathic pain per the CMS standard of care guidelines. Although Lidoderm patches are common practice for pain management, there are no controlled studies showing that a patch is better than a Vicodin. The cost of the prescription is clear, the cost of life has not been calculated.

But don't worry. We have discovered a work around. Lidocaine 4% is available over the counter in patches and cream. It is sold as Aspercreme and Salonpas and cost less than \$10 a box. CHG (Community Health Care Group), the largest Medi-Cal beneficiary in San Diego is considering making the 4% OTC patch a covered

benefit.

Shared Case Management

Let's dream big for 2017. For several years, we have heard Kaiser physicians ask the Scripps doctors why they are not following the treatment plan for their patient. The clinics need to know what happened with their difficult patient in the hospital and what social services were offered, and our psychiatric patients need coordinated care as they are bounced from institution to institution. And then there is the City of San Diego community paramedicine program assist the high utilizing patients, but their vast information is not shared with the providers when the patient is at the hospital.

Dan Chavez at San Diego Health Connect is anxious to work with the Prescription Drug Abuse Medical Task Force and the Emergency Medicine Oversight Commission to bring shared case management to San Diego's health care system. It all started with an envy of the EDIE system. The emergency department Information exchange offers shared case plans between any emergency departments that are on the system. EDIE is installed at all the emergency departments in Washington state, Oregon, and several hospitals in LA. We want to have the same EDIE collaboration with the emergency departments, but expand to sharing case management information among all institutions that are part of San Diego Health Connect.

Dr. Lev reported that her vision is to have a Case Management screen as part of San Diego Health Connect. This would be like Medication, Allergies, and Immunizations. But how can this happen? Will case management do single entry to San Diego Health Connect? Will the computer know where to pull information into this screen? Will the lawyers let it happen? Minor details. But these are the big goals of 2017. Wish us luck.

Buprenorphine for Pain

The California Health Care Foundation (CHCF) is promoting the use of buprenorphine for pain in three very specific populations:

1. For people on chronic opioids (without addiction) who are unable to get off opioids for a variety of reasons (frail, psychiatrically unstable, long-term high dose use with severe difficulty tapering past a certain threshold)—they are safer on buprenorphine than staying on other opioids, even at lower dose.
2. For people on opioids for pain with other active substance use disorders (even if they technically do not meet criteria for opioid use disorder)
3. For people with acute pain where opioids are indicated (e.g. surgery, severe trauma) and where history of or active substance use makes opioids high risk

For FAQ about Buprenorphine please refer to the CHCF brochure:

http://www.chcf.org/~media/MEDIA_LIBRARY/Files/PDF/PDF B/PDF BuprenorphineFAQ.pdf

Buprenorphine use for pain does not require a waiver, while a waiver is required when the same drug is used for addiction. The cost for Buprenorphine 8 mg sublingual according to Good Rx at Target pharmacy is \$149.53 for 60 tablets. There is a street value for buprenorphine of \$20 per tablet. We are told that the market on the street is to help with withdrawal symptoms rather than addiction.

Buprenorphine Training

There are several educational programs on buprenorphine. At Vista Community Clinic, all new physicians are required to take the training as part of employment. The clinic uses this training program:

<http://www.buppractice.com/>

MAT GRAND OPENING AND BACK END PREVENTION

Dr. Loretta Stenzel was proud to report that Vista Community Clinic will be rolling out their new MAT, (Medically Assisted Treatment) program, to assist in the successful treatment of opioid use disorder. VCC is one of four clinics in San Diego that was awarded a large SAMSHA grant to improve access to the use of Suboxone, buprenorphine/Suboxone in the primary care setting. Suboxone is reported to decrease mortality of patients with opioid use disorder by 50%, has improved long term treatment retention rate and increases social functioning.

MAT treatment consists of an initial induction period followed by maintenance. During the induction period, patients need to have some degree of withdrawal from their previous medications to avoid unpleasant precipitated withdrawal symptoms. Suboxone helps prevent post-acute withdrawal syndrome (PAWS) that occurs after being off opioids, along with classic withdrawal symptoms, and manifested as depression, anxiety, craving, memory loss, or panic.

Not all patients are suitable for the MAT program. They must plan for frequent (2-3) office visits in the first week, then weekly appointments until they reach a maintenance stage. They must engage in behavioral health services and addiction counseling. If they are on methadone, they must be tapered to 30 mg a day.

California Health Care Foundation (CHCF), Opioid Safety Conference

San Diego was well represented at the CHCF Opioid Safety Coalition - Fall Convening. Linda Bridgeman-Smith and Thomas Lenox led a talk about Engaging Public Officials. Roneet Lev, MD talked about implementing Safe Prescribing and turning guidelines into practice. Dr. Bianca Tribuzio gave highlights on the conference. She was moved by April Rovero's passion in creating an organization-- like Mothers Against Drunk Drivers --who are the face of the opioid epidemic. April's son Joey was a beautiful young man, a senior in college with a promising future and died from an accidental overdose. In San Diego, we have Sherri Rubin and her son Aaron who are a face of the prescription problem. Aaron suffered an overdose of oxycodone that left him with quadriplegia, communicating only with his fingers - 1 for yes, 2 for no.

Dr. Tribuzio highlighted a single slide by Dr. Corey Waller about the neurobiology of addiction. He stated that addiction is a neurobiological disorder characterized by low dopamine. At baseline people need 15 ng/dL of dopamine to get out of bed. The best day of life, like winning the lottery gives you 100 ng/dL. Methamphetamine first time use gives you 1000, THC gives 600 and Heroin around 800. However, with continued use, the body makes less natural dopamine because it is use to the external supply and the dopamine receptors are already saturated. As the body is not making dopamine, people are not happy and not motivated. The body craves dopamine for survival and people who are not making their own dopamine act out in desperation. Dr. Waller notes "behavior is a symptom, not a frustration... Aberrant behavior should be expected."

Dr. Tribuzio enjoyed the lecture by Dr. Andrea Rubinstein, a Kaiser anesthesiologist who practices pain management. In her lecture, she describes the opioid epidemic as "an iatrogenic mess", although 70% of doctors blame the patient for issues related to opioid use or misuse. She said that most chronic pain is not medication responsive and requires psychosocial environmental changes. She approaches opioid tapers like steroid tapers that require buy-in from the patient a slow reduction of 5 - 10%. Not all patients can reach a zero level. You can access the CHCF fall convening lectures at: <http://www.chcf.org/events/2016/events-opioid-safety-coalitions-fall-convenings>

Health Plans and Front End Prevention

The task force had an interesting discussion about prevention and treatment of prescription drug problems. On one end, there is the concept of preventing new starts, stopping the epidemic on the front end. On the other end there is the issue of dealing with the millions of people who are already dependent.

Good news on the front-end prevention aspects is some of the work health plans have taken. CHG, Community Health Group was reluctant to make any formulary changes as it can affect patient complaints and their star rating. They took a chance on making some non-formulary over 6 months ago, for any new prescriptions, leaving the current on-going prescriptions as is. The result was no increased complaints and decreasing the number of prescriptions by over 50%. The next step will be to bring this same methodology to new start opioid prescriptions - that is to limit all new prescriptions from going over 90 MME per day.

Kim Allen, R.Ph, from Sharp Rees Stealy Pharmacy reported they have a trigger for any prescription ≥ 120 MME; verification of dose and prior authorization is required at 200 MME. There is also an alert of ≥ 2 prescribers for an opioid. The Commercial Plan is different, and has a trigger at 90 MME and prior authorization for ≥ 120 MME and > 3 providers.

The issue of placing the pharmacist against the physician was discussed regarding pharmacy benefit limits. The PDA Medical Task Force has written pharmacy scripting that has been useful and academic detailing helps as well.

Cyclical Vomiting Syndrome Treatment

We do not have a standard of care yet for treatment of cyclic vomiting syndrome or cannabinoid hyperemesis syndrome. This is relevant to the opioid epidemic because the terrible vomiting and wrenching and presentation of abdominal pain results of patient asking for pain medication. Unfortunately, many patients with marijuana addiction and gastrointestinal symptoms are treated with opioids. With marijuana legalization, we expect to see an increase of patient with hyperemesis and abdominal pain due to cannabinoid toxicity.

The treatment for acute symptoms Dr. Lev recommends anti-emetics, anxiolytics, and Haldol. For the outpatient setting, Dr. Loretta Stenzel, internal medicine physician and director at Vista Community Medical Group recommends amitriptyline 25 mg once a day. Dr. Bianca Tribuzio, pain specialist at Sharp Reese Stealy, recommends trying baclofen or tizanidine. Opioids should be avoided for marijuana induced abdominal pain.

Patient Satisfaction Scores

"If you never received a patient complaint about not prescribing pain medication that a patient was demanding, then you are probably too lax in your prescribing practices." One physician sees these complaints as a badge of courage. It is much easier to say "yes" and write a prescription, and much harder to explain the issues of safety and say "no".

CMS, the initiator of patient satisfaction scores stated that they will remove the financial incentives of the satisfaction scores and change the pain related questions. A consulting group hired by CMS to change the questions interviewed Dr. Lev regarding the new proposed questions. She stated that the 10 proposed questions still have a heavy emphasis on pain treatment and did not include any safety concerns such as "Where you warned about driving under the influence of pain medication?" or "Where you warned about mixing pain medication with alcohol or anxiety medication?"

Kaiser Health plan in San Diego has removed the "Unabomber" from their satisfaction scores. The "Unabomber" is the patient who given all zeros from all the questions - 0 -0 - 0 - 0 - 0. These surveys are removed from all the statistics.

One of the medical groups in San Diego who prides itself for hiring physicians with good scores, has removed patients with a medication agreement from their scoring statistics.

UCSD Preventive Medicine Project

Dr. David Crabtree, resident at UCSD in preventive medicine, is doing a project on prescription drug abuse by interviewing staff on their perception of pain prescriptions. He may do a comparison with other hospitals after working out the project at his home base at the University.

Case Presentation

Dr. Loretta Stenzel reported on a 56-year-old male with history of Hepatitis C with genotype 4, Methamphetamine, use and Opioid addiction. He has spinal stenosis and had a car accident in 2006. He has restless leg syndrome and depression. He first came to the clinic in 2011 as follow up after hospitalization for pneumonia. In 2013 he had a follow up visit after a head injury when his dog pulled him. He reported having a vapor lock in his car following a DUI. On another visit his was seen for nausea and vomiting and self-tapered amitriptyline because of dry mouth. He was having custody issues with his children and was given counseling referral. He had weight loss and tested positive for H Pylori that was treated.

In 2014, he presented with opioid withdrawal symptoms. He left his pain specialist who was giving him 30 mg a day of methadone and was using marijuana regularly. He also had Hepatitis C, but did not meet criteria for treatment. He was given a referral for a new pain physician.

In June 2016, he requested methadone as his pain physician stopped it, and he stopped amitriptyline. The new treatment plan was to start buprenorphine, Suboxone, but it wasn't simple. He was taking his friend's opioids and had to wait until this was out of his system. He then tested positive on drug screen and still had to wait for buprenorphine. It took a few days and visits, but he eventually was started on the new treatment. He had a hard time dissolving the tablet in his mouth and was changed to Suboxone film instead tablet. He developed nausea and vomiting and blamed the new drug. Anti-emetics did not work, and a week later he stopped Suboxone. He was switched to methadone 10 mg twice a day. He qualified for

hepatitis treatment in November. In December, he was doing better.

Lessons learned. Was the nausea and vomiting from the Suboxone or the marijuana, the H. Pylori, the Hepatitis? The film dissolves faster than the tablets. Consider Zofran with Suboxone for induction.

Suboxone may be a good option, but it's not for everyone. There is no one size fits all for patients with chronic pain and opioid use disorder.

MTF MEETING SCHEDULE

**SAN DIEGO COUNTY MEDICAL
SOCIETY AT 5575 RUFFIN ROAD**

**Meeting Quarterly on Second
Fridays at 12 noon**

- February 10, 2017
- April 14, 2017
- August 11, 2017
- November 10, 2017

One San Diego

The One San Diego vision for safe prescribing practicing, promotes a unified approach to prescribing, whether you are an emergency physician, primary care, pain specialist, surgeon, dentist, psychiatrist, pharmacist, or health plan.

CONTACT INFORMATION

[HTTP://WWW.SANDIEGOSAFEPRESCRIBING.ORG](http://www.sandiegosafeprescribing.org)

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