PRESCRIPTION DRUG ABUSE
MEDICAL TASK FORCE

APRIL 2015: Summarizing the April 10, 2015 Meeting Discussion.

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Next Meeting: July 10, 2015 at 8 a.m., right before EMOC, San Diego County Medical Society, 5575 Ruffin Rd. , San Diego. Future date: October 9, 2015

GENETICALLY TAILORED PAIN MANAGEMENT

Jeremy Adler, MS, PA-C, president of the CA Academy of Physician Assistants and pain specialist at Pacific Pain Medicine Consultants in Encinitas/Oceanside gave an eye opening presentation at the Task Force meeting.

A 61-year-old female well managed on OxyContin 10 mg q 12 and Oxycodone 5 mg bid prn is admitted to the hospital and placed on clarithromycin for community acquired pneumonia. Shortly after she has a respiratory arrest, goes to ICU and is reversed with Narcan. She leaves the hospital with good pulmonary outcome, but now in pain because the clinicians were understandably reluctant to place her back on her usual pain regimen that got her in trouble. There was no clinical suspicion for abuse or purposeful overdose, nor was there a change in her longstanding opioid use. The pain clinic ordered genetic testing which showed that her CYP2D6 had a phenotype of poor metabolizer. Oxycodone requires both CYP2D6 and CYP3A4 to metabolize. Therefore, prior to being on antibiotics she was dependent on the CYP3A4 for oxycodone metabolism. The antibiotic affected the P450 system by acting as a CYP3A4 inhibitor and blocked the other metabolic path for oxycodone likely explaining her overdose. With the results of the genetic testing, she was effectively switched to oxymorphone, which is unaffected by her genetic anomaly.

For additional information: A Review of the Role of Genetic Testing in Pain Medicine. Trescot A and S Faynboym Pain Physician 2014; 17:425-45.
http://www.painphysicianjournal.com/2014/september/2014;17;425-445.pdf

Pain Medications 101

Jeremy Adler further noted that genetically, people inherit a P450 metabolism that makes them range from poor metabolizers to ultra-rapid metabolizers which can greatly affect their reaction to pain medications that depend on this metabolic system. Many of the common pain medication have active metabolites that greatly influence their effects, including tramadol, codeine, hydrocodone and oxycodone. The chart below shows various pain medications, their morphine equivalents, and metabolites.

Tramadol (Ultram)

In the table below, please note that the standard Tramadol dose has higher morphine equivalents that the usual Hydrocodone according to conversion table used by the CURES system. Physicians are more tempted to prescribe tramadol because it can be called in, whereas hydrocodone now requires a prescription. However, be aware that Tramadol is a narcotic and is addicting. Tramadol deaths numbered 19 in 2014 and the number will be higher for 2015.

One San Diego Mission

Dr. Marie Mutuc-Wurst and Dr. Roneet Lev reported a big success in the San Diego Safe Prescribing Symposium held on March 11. The conference was attended by nearly 250 professionals from across disciplines and health care setting and was available through the generous sponsorship of Kaiser Permanente. The conference underscored the *One San Diego Mission*:

- **Use one doctor, one pharmacy** for all chronic controlled prescriptions
- **Use CURES.** It makes you a better doctor
- **Use a Medication Agreement** for patients who need controlled substances for three or more months (but not as a "free ticket" for refills)
- **Follow the Emergency Department** and Urgent Care guidelines
- **Avoid** the combination of **opioids and benzodiazepines**

	Dose	Morphine Equivalent	Metabolites Effected by CYP2D6
PRODRUG			
Tramadol (Ultram)	50 mg	5 mg	O-desmethyltramadol
Codeine	15 mg	2.25 mg	Morphine
Hydrocodone	5 mg	1 mg	Hydromorphone
ACTIVE DRUG			
Morphine	1 mg	1 mg	-
Hydromorphone (Dilaudid)	1 mg	4 mg	-
Oxymorphone (Opana)	5 mg	15 mg	-
Methadone	20 mg	60 mg	Affected by R - isomer -CYP2D6/3A4 (analgesic) S -isomer -CYP2B6 (cardiotoxic)
ACTIVE DRUG and ACTIVE METABOLITE			
Oxycodone (Percocet)	5 mg	7.5 mg	Oxymorphone

Methadone - Should This Medication Require Prior Authorization?

Methadone is used in thousands of opioid treatment programs around the county and has previously been encouraged for use in chronic pain management because of its long half-life and less frequent dosing schedule. However, deaths associated with methadone have been climbing and singled out as a problematic medication by the CDC. In San Diego in 2013, we had 46 methadone deaths. A greater percentage of methadone patients were doctor shopping. All 14 patients who received a prescription were from primary care physicians and 6 patients died within a week of most recent prescription.

Jeremy Adler explains that Methadone is a racemic molecule. The R isomer provides analgesia and is metabolized by CYP2D6/3A4. The S isomer is metabolized by CYP2B6, has no analgesia and causes prolonged QT that can lead to sudden death. Patients who carry polymorphisms in their CYP2B6 allele characteristic of poor metabolizers will potentially have increase S isomer methadone and greater risk for cardiac toxicity and death.

Mr. Adler noted that because methadone carried such high risk, his pain clinic will generally routinely obtain genetic metabolizer status on CYP2B6 prior to prescribing methadone and only select those patients who are the most complaint. It is amazing that so many physicians have been educated and encouraged to use methadone when it carries such a high-risk profile.

SAN DIEGO DEATH DIARIES PRESENTATION IN ATLANTA

Dr. Roneet Lev and Dr. Jon Lucas, our County Deputy Chief Medical Examiner, were popular speakers at the National Rx Abuse Summit in Atlanta in April. They presented on their analysis on the intersect between CURES and the 2013 ME database. Dr. Lev talked about the prescriptions given to patients when they were alive, and Dr. Lucas talked about the toxicology results on death. Going through hundreds of CURES reports was like reading a "Death Diary" of patient getting prescriptions, higher doses, multiple ED visits, and finally - the morgue. Even more disturbing is that the 713 providers were good physicians that you would trust with your health and recommend to your family. However, the physicians may not have been checking CURES and had no idea that their patients died. Psychiatrists gave more prescriptions and pills than emergency physicians. We believe that if most of these doctors knew that their patients ended up dead with their prescriptions, they would change their prescribing habits. To this effect, the medical examiner office is working on a feedback system to inform providers when they get a patient that had their name on a CURES report.

A Request from the White House:

California and San Diego Health Plans need to use mechanisms that would curb the PDA epidemic.

Dr. Lev was honored to have a private meeting with Michael Botticelli, Director of the White House Office of National Drug Control Policy. Mr. Botticelli was interested in the many projects lead by the San Diego medical community, and made a request that we involve health plans. Other state health plans have been involved in instituting PPR, Patient Review and Restriction programs that lock in high-risk patients to one doctor and one pharmacy. They also utilize drug utilization review and prior authorization.

Medication Agreements

The "Death Diaries", the 12 month CURES reports on patients who died from prescriptions in 2013 note that nearly 70% of patients were chronic users, meaning they received the same prescription for 3 or more consecutive months. This included any controlled medications, not just pain meds. The PDA Medical Task Force has a short and long version of medication agreement in English and Spanish that reads at a 5th grade level and has endorsements by Public Health. We encourage all specialists who provide controlled medications for 3 months or more to use these agreements. However, Dr. Steven Green, director at Sharp Rees-Stealy cautions that these agreements should not be considered as a "free ticket" for medication refills. Providers still need to make regular assessment on whether patient benefit from continued use.

Dr. Gary Franklin, director of Washington State workman's compensation states that if patients do not show a 30% functional improvement of pain within 6 weeks then pain treatment should not be continued, as risk would outweigh the benefits.

NEW PHARMACY COMMITTEE

Dr. Nathan Painter, at UCSD pharmacy school chairs the newly formed pharmacy committee. This committee, the Medical Task Force, and the countywide task force each focus on what their stakeholders can do about prescription deaths, and collaborate with each other for support and similar messaging. Representatives on the committee include retail, VA, Sharp, Scripps, DEA and UCSD. Be on the look on for the San Diego Physician Magazine article where Dr. Roneet Lev interviewed Dr. Painter on provider/ dispenser relations. The committee will be developing guidelines for providers and dispensers on what to do when prescriptions may be fraudulent.

NALOXONE

Heroin deaths have climbed dramatically in the past few years from around 5,000 to 8,000 nationwide, with San Diego following this upward trend. Opioid deaths have stabilized in the past couple years, but remain unacceptably high. Therefore

ONE CLINIC'S CRISIS AND SOLUTION

Jim Schultz, Medical Director for Neighborhood Healthcare (NHC), described the process of policy change regarding opioids over the last year at NHC. The entire community clinic system provides health care to 750,000 low-income persons across the County. NHC has about 65,000 patients.

For some time NHC has been struggling for solutions to address their chronic pain population. The clinic has been one of the more progressive in term of pain management. They were one of the first to institute medication agreements, they developed group sessions where chronic pain patient can all come in one day for medication refills, counseling sessions, education, and they developed disruptive behavior policies for the frequent abuse that was inflicted on the staff.

Despite all that several things happened. One new young physician quit. He said he loved his job, she loved community medicine, but she did not like her patients. Next, the pain physician who managed the group sessions quit. Then a physician who was adhering to the medication guidelines was reported to the Medical Board by a disgruntled patient who did not receive his demanded narcotics. And finally, the clinic received a call from LAPD about a dead person who had prescriptions with the clinic name.

These events, coupled by dissatisfaction or the staff and physicians lead to a crisis that demanded change. That is why NHC no longer provides chronic pain treatment for any patient with chronic musculoskeletal pain. Patients were given 3 options:

1) Taper over 3 months
2) Go to pain management
3) Change to a different clinic

Dr. Tom Frieden, director of the CDC would probably support the clinic decision. In a recent statement Dr. Frieden stated, "The risk of chronic pain treatment for non-cancerous pain is death. The benefit for chronic pain treatment has not been proven".

Naloxone is encouraged for risk patients and families. Emergency patients who require naloxone should be offered a prescription. The California Pharmacy Board is currently working on the protocol for having pharmacist dispense naloxone over the counter.

Public health intern, CJ Robertson, summarized the one-page information for prescribers, for patients and a graphic one-page on how to use Naloxone. The materials were approved for posting on www.sandiegosafeprescribing. Maggie Mendez, VA pharmacists, noted that nationwide, the VA has distributed 2,700 kits with 46 reversals documented. Questions remain about affordability. Evzio injectable is $600 for a package of 2 with a coupon. There are EMR issues that need to be work out when a prescription is given to a family member.

CURES 2.0

CURES 2.0 will be coming July 2015. Mike Small, CURES director gave an update at a recent conference in Sacramento. Current registrants will be prompted to update their password and declare a medical specialty and board certifications. New features of the system will slowly be released in the following months. This will include a dash board where providers will be alerted if their patients have more than 100 morphine equivalents, 40mg methadone, benzodiazepine/opioid combinations, or 4-4-12 doctor shopping (4 providers and 4 pharmacies within 12 months). Providers will also be able to communicate with other providers that see the same patient.

We explored the possibility of using CURES as a case management tool and alerting any provider that the patient has a medication agreement with another provider. However, this is not possible. CURES does not have the necessary patient identifiers, besides name and birthdate, to insure that this type of communication is a 100% match to the patient we identify. We will have to work with the San Diego Health Information Exchange for this type of communication.

Once the new system is running, providers will no longer need to use the current registration process that requires ID authentications, but the CUREs system will be able to authenticate your ID with the Medical Board on line.

CURES is mandatory for all providers starting January 2016 per SB 809. CURES simply makes you a better doctor. The County Public Health registration process can be accessed at http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/PDMP-CURES.html.

CURES GOLD STANDARD

Dr. Tom Freiden, CDC Medical Director notes there are 3 components for the best PDMP (Prescription Drug Monitoring Program):

- Universal (across all states, we are not there)
- Real Time (only Oklahoma uploads within 24 hours, California mandate is to report within 7 days)
- Actively Managed (Evaluating both patients and providers)

Many medical directors have requested data from CURES to allow for quality improvement tracking of their providers, however, the law does currently not allow this.

Soma Changes at Indian Health Center

The PDA Medical Task Force praises Dr. Dan Calac and Tony Luna at the Indian Health Council who have taken Soma (carisoprodol) off their formula. Soma is often prescribed as a muscle relaxer, but has no muscle relaxer effect. It is quickly metabolized to meprobamate, an addictive tranquilizer that is not available in the US and banned in Europe. Soma has been associated with 30 deaths in 2013.

There's still time to participate in two webinars on Safe Prescribing sponsored by the California HealthCare Foundation

How Plans Can Support Safe Prescribing

Wednesday, May 20 / 12:30 - 2:00 PM Pacific

Two health plans discuss how to reduce opioid overprescribing and create safer communities by partnering with hospitals, clinics, community physicians, health departments, and law enforcement. Hear from:

- Robert Moore, MD, MPH, chief medical officer, Partnership HealthPlan of California
- Amit Shah, MD, medical director, Care Oregon

REGISTER NOW for May 20 Webinar

Teaching Safe Prescribing to Primary Care Residents

Thursday, June 4 / 12:30 - 2:00 PM Pacific

Two urban primary care clinics with residency programs review their approaches to training residents in more effective ways to manage opioid use. Hear from:

- Diana Coffa, MD, residency director, UCSF/SFGH Family Medicine Residency Program
- Azari Soraya, MD, assistant professor of medicine, QI lead for chronic pain management, UCSF School of Medicine

REGISTER NOW for June 4 Webinar

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