



REDUCING OPIOID OVERDOSE, MISUSE AND DEPENDENCY

A GUIDE FOR CCOs

Oregon Health Authority
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Reducing Opioid Overdose, Misuse and Dependency: A Guide for CCOs

Although opioids have a place in treating patients, health care prescribing of opioids for pain has generated an epidemic of prescription drug overdose mortality and morbidity, as well as substance use disorder and unstable pain care over the last fifteen years. In fact, drug overdose has surpassed motor vehicle crashes as a cause of death in Oregon and the US.

This guide is a resource to help CCOs develop a comprehensive approach to reducing opioid overdose, misuse, and opioid use disorder. CCOs play an important role in helping their members/patients manage pain while minimizing the risk of adverse effects due to opioid use.

Things to consider:

- Use of opioids for long-term management of chronic non-cancer pain lacks evidence of benefits, and may lead to poor results and negative side effects
- The risk of adverse outcomes, including death, increase with co-prescribing, especially with opioid/benzodiazepine combinations
- Research in pain management using alternative therapies has shown good results for management of chronic non-cancer pain
- Medication assisted treatment (such as buprenorphine, methadone and naltrexone) prescribed for opioid use disorder can stabilize patients and improve social functioning
- Naloxone is effective in reversing overdose when co-prescribed with opioids and/or used in community based lay rescue
- Prescription Drug Monitoring provides prescribers and pharmacies with

information on patient Rx history, which may identify drug seeking, patient safety or patients at risk for opioid use disorder.

The strategies outlined in the following pages are considered promising practices and interventions to help reduce the epidemic of adverse effects associated with opioid use, and should not replace clinical judgment by clinicians. CCOs are encouraged to work with internal and external partners, including administrators, quality improvement staff, clinicians, hospitals, epidemiologists, researchers, clinical advisory panels, local health departments, and pain guidance groups.

This guide is a “living” document, and may change as new interventions, strategies, and policies are developed. The information in this guide should not be considered a sole source of information, strategies, or references for reducing opioid overdose, misuse, and opioid use disorder.

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Strategy: Use Opioid Prescribing Guidelines for Pain Management

Reducing the risk of prescription opioid overdose and misuse begins in the clinic. Starting patients on opioids presents a substantial risk of long-term use, so careful consideration of how patients are selected and managed for opioid treatment is important. A **five step approach** to treating patients with chronic complex non-cancer pain is described in the [model](#) Oregon [Opioid Prescribers Guidelines](#) developed by the (Southern) Oregon Pain Guidance Group). The five steps include:

1. Practice assessment: standard clinic policies should be established around chronic pain treatment
2. Patient assessment: risk assessments help determine whether opioids are appropriate for a patient
3. Non-opioid treatment: chronic pain treatment is best started with non-opioid treatments with functional goals in mind
4. Patient reassessment: following non-opioid treatment, if low-dose opioid treatment may benefit a patient, patients must be informed of opioid risks and benefits
5. Follow-up visits: pain treatment is a process. Providers should periodically follow up with patients to assess safety and progress toward treatment goals.

The Oregon Pain Guidance Group has developed [treatment guidelines](#) for healthcare providers.

The guidelines include:

- Assessment tools and flowcharts for treatment management
- Aberrancy screening tools
- Patient/provider communication tools (e.g. treatment agreements)
- Guidelines to non-opioid treatment options
- Tapering guidelines
- Guidelines on handling special issues (e.g. managing patients on opioids and benzodiazepines; handling difficult conversations with patients)

CCOs are strongly encouraged to implement prescribing guidelines in clinical settings, encourage and incentivize contract providers to implement the prescribing guidelines, and develop policies to assure use among prescribers.

Resources:

[CDC Guideline for Prescribing Opioids for Chronic Pain](#)

[CDC Guideline For Prescribing Opioids for Chronic Pain Fact Sheet](#)

[Oregon Opioid Prescribing Guidelines](#)

Strategy: Use Opioid Prescribing Guidelines in Emergency Departments

Prescribing opioids to patients in emergency departments (EDs) can pose unique challenges. While pain relief is important when a person needs emergency care, treating pain is a complex process. Prescribing guidelines for opioids were developed by The Oregon Chapter of the American College of Emergency Physicians (OCEP), and in Washington State through a collaboration of several organizations. These guidelines include important facets of prescribing opioids in the context of EDs. Some features of the ED guideline recommendations:

- To the extent possible, one medical provider should provide all opioids to treat a patient's chronic pain
- Administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged
- Emergency medical providers (EMPs) should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen
- EMPs should not provide replacement doses of methadone for patients in a methadone treatment program
- Long-acting or controlled-release opioids (e.g., OxyContin®, fentanyl patches and methadone) should not be prescribed in EDs
- Access the Oregon Prescription Drug Monitoring Program online, *before prescribing any controlled substances*
- EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse (see SBIRT link below)
- Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, should be in an amount that will last until the patient is reasonably able to receive follow up care for the injury. In most cases, this should not exceed 7 day supply.

CCOs are encouraged to review the entire *Guidelines* and engage EDs and providers in utilizing the *Guidelines* in practice.

Resources:

[Oregon ED Prescribing Guidelines:](#)

[Washington ED Prescribing Guidelines](#)

[OHA Screening Resources and Tools](#) (SBIRT)

Strategy: Use the Oregon Prescription Drug Monitoring Program to Assess and Manage

The Oregon Prescription Drug Monitoring Program (PDMP) operates a web-based data system that contains information on controlled prescription medications dispensed by Oregon licensed retail pharmacies. Pharmacies are required by law to submit data 72 hours after a prescription is dispensed for all Schedule II – IV controlled substances dispensed. Controlled substances reported include opioids, sedative hypnotics, benzodiazepines, stimulants, and other drugs. The PDMP has been in operation since 2011.

The primary purpose of the PDMP is to provide practitioners and pharmacists a tool to improve health care and patient safety. Authorized system users (which can include provider delegates such as clinical office staff) can logon to the PDMP web-based system and request a report of the controlled substance medications dispensed to their patients. Prescription records include information on the dispenser, prescriber, and name and quantity of drug.

What role does the PDMP play in reducing opioid overdose? The Oregon PDMP is a critical component of assessment and management before and during pain treatment. Providers and their delegates can check the PDMP when seeing new patients, when writing a new or renewal of a prescription for a controlled substance, periodically monitor the prescription history and use of their patients, identify problematic or inappropriate prescription access and use, use information from the patient report to coordinate care with other prescribers identified in the report, and use the PDMP in conjunction with Opioid Prescribers Guidelines to better manage patient pain treatment.

As of January 2018, medical and pharmacy directors will be allowed access to the PDMP for overseeing the operations of their respective entities. Medical Directors will have access to Prescriber Activity Reports, which displays a summary of prescriptions prescribed by specified DEA number and the corresponding patient and pharmacy information. Pharmacy directors will have access to Dispenser Activity Reports which display a summary of prescriptions dispensed at specified location and the corresponding patient and prescriber information.

Resources:

PDMP web portal (user access and registration): <https://oregon.pmpaware.net/>

For information on how to register, look up patient information refer to: <https://oregon.pmpaware.net/support>

[Example](#) of Prescriber Activity Report:

Strategy: Provide Coverage for Non-Opioid Chronic Non-Cancer Pain Treatment Therapies

Opioids may lack efficacy in relieving chronic non-cancer pain long-term, and are inferior to sleep restoration, manipulation therapy, acupuncture, massage, mindfulness training/CBT, and physical exercise in providing long-term benefit to patients. Unfortunately, because alternative therapies may not be covered under private and public health insurance plans, many people do not have access to non-pharmacological pain management options.

Chronic non-cancer pain is different than acute pain and often requires different interventions than acute pain, including pain rehabilitation through multidisciplinary teams. Multi-disciplinary teams should consist of two or more professions working collaboratively to meet patients' needs. CCOs are encouraged to review policies around providing coverage for non-pharmacological pain management and evaluate how pain management practices and policies (especially around complex chronic non-cancer pain) may impact their client/patient populations. Clients are eligible through the Oregon Health Plan for multimodal pain care for conditions of the back and spine, including for low back pain.

The Health Evidence Review Commission recommends assessing patients with back pain using a validated assessment tool (e.g. STarT Back Assessment Tool¹) to determine their risk level for developing chronic pain.¹ Although further research is needed to identify cost-effectiveness, evidence indicates that a person-centered, interdisciplinary approach to pain management that includes medical, cognitive-behavioral, and psychoeducational interventions can increase function and quality of life in people with non-cancer chronic pain. Multidisciplinary pain management approaches must be integrated to be maximally effective, and should:

1. **Manage comorbid conditions** that contribute to pain, including insomnia, depression, anxiety, chemical dependency, and post-traumatic stress disorder.
2. **Provide cognitive-behavioral and movement therapy interventions** that address common pain-related issues such as fear of movement, catastrophizing, and exercise avoidance.
3. **Provide access to psychoeducational programs** that teach self-management skills such as problem solving; realistic goal setting; gentle, safe physical exercise; relaxation; and mindfulness. Access to such resources is growing rapidly in Oregon; one program taught in community and clinical settings is:
 - Stanford Chronic Pain Self-Management Program: a workshop given two and a half hours, once a week, for six weeks, in community settings and facilitated by two trained leaders, one or both of whom are peers living with chronic pain. Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, isolation, and poor sleep 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) pacing activity and rest, and, 7) how to evaluate new treatments.

¹ STarT Back is an evidence-based systematic approach to assessment and decision making for the treatment of patients with back pain. Information can be found at <http://www.keele.ac.uk/sbst/startbacktool/>

Resources:

[State of Oregon HERC Coverage Guidance: Lower Back Pain: Non Pharmacological / Non-Invasive Interventions 11-13-14](#)

Becker N., Sjøgren P, Bech P, Olsen AK, Eriksen J (2000). Treatment outcome of chronic non-malignant pain patients managed in a Danish multidisciplinary pain centre compared to general practice: a randomized controlled trial. *Pain*, 84: 203-211.

Caudill M, Schnable R, Zuttermeister P, Benson H, Friedman R (1991). Decreased Clinic Use by Chronic Pain Patients: Response to Behavioral Medicine Intervention. *Clinical Journal of Pain* 7: 305-310.

Flor H, Fydrich T, Turk DC (1992). Efficacy of multidisciplinary pain treatment centers: a meta-analytic review. *Pain* 49:221-230.

Foster, G., Taylor, SJ, Eldridge SE, Ramsay J, Griffiths CJ (2007). Self-management education programmes by lay leaders for people with chronic conditions. *Cochrane Database of Systematic Reviews*, 4.

Leeuw M, Goossens MEJB, Linton SJ, Crombez G, Boersma K, Vlaeyen JWS (2007). The fear-avoidance model of musculoskeletal pain: Current state of scientific evidence. *Journal of Behavioral Medicine* 30:1, 77-94.

LeFort SM, Gray-Donald K, Rowat KM, Jean, ME (1998). Randomized controlled trial of a community-based psychoeducation program for the self-management of chronic pain. *Pain* 74 (2-3): 297-306.

Morley S, Eccleston C, Williams A (1999). Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. *Pain*. 1999 March 80: (1-2):1-13.

Turk DC (2002). Clinical effectiveness and cost-effectiveness of treatments for patients with chronic pain. *Clinical Journal of Pain* 18(6):355-65.

Strategy: Co-Prescribe Naloxone When Prescribing Opioids for At-Risk Patients

Naloxone is the antidote for opioid overdose—it saves lives. Naloxone is not a controlled substance-- it can be prescribed by any health care provider with a medical license. The drug has been used for decades to reverse overdose associated with opioids. In fact, naloxone “rescue” programs are emerging among first responder organizations, such as emergency medical services, law enforcement agencies, and public health needle exchange programs. Pharmacists can co-prescribe naloxone for patients and provide patient counseling/training. Naloxone can be prescribed to patients for use in an overdose emergency, and Oregon law allows naloxone to be prescribed to third party individuals who may witness a friend’s or relative’s overdose (not unlike epinephrine for emergency use by lay people). Training for naloxone no longer requires clinical oversight, and any individual can get basic education through OHA’s naloxone training protocol. CCOs can support the practice of co-prescribing naloxone by providers, and can review policies that make it easier for providers to co-prescribe.

Reasons to prescribe naloxone may include (but are not limited to):

- Patient has a history of opioid intoxication or overdose
- Patient has a suspected history of substance abuse or non-medical opioid use
- Patient is on a high dose (> 50 mg morphine equivalent per day)²
- Patient is starting on methadone or buprenorphine for addiction
- Patient starting on an opioid and one or more of the following applies:
 - has a history of smoking, COPD, asthma, emphysema, sleep apnea, respiratory illness
 - has a concurrent benzodiazepine (or other sedative) prescription
 - has a concurrent antidepressant prescription
 - has a history of HIV/AIDS, renal dysfunction, cardiac illness, hepatic illness

Alcohol use or abuse is suspected.

Patient is at risk of witnessing an overdose.

Providers can discuss an emergency overdose plan with patients when prescribing naloxone.

Resources:

[Prescribe to Prevent.](#)

Prescribe to Prevent: [Instructions for Health Care Providers:](#)

[OHA naloxone training:](#)

[Toolkit for Pharmacists](#)

² See Prescribe to Prevent, Instructions for Health Care Providers, in the resources section

Strategy: Provide Medication Assisted Treatment for Opioid Use Disorder

Opioids are a highly dependence and tolerance inducing substance, and many patients being treated with opioids for an extended time period may develop symptoms of opioid use disorder (OUD). OUD is a chronic, yet treatable and manageable addictive disorder that can be marked by symptoms including taking more opioids or at greater frequency than prescribed,, “drug seeking” behaviors or frequent requests to refill prescriptions earlier than scheduled, and the use of illicit opioids. Physical dependence and associated withdrawal symptoms alone are not adequate criteria for a diagnosis of OUD; patients suspected of having developed an OUD must be appropriately assessed and evaluated by a qualified professional to determine the presence and severity of a potential addictive disorder to determine the most appropriate level of care.

Medication assisted treatment (MAT) is an approach to the treatment of OUD that uses agonist, partial agonist and antagonist opioid medications (e.g. buprenorphine, methadone and naltrexone) along with counseling and behavioral therapies. The combination of MAT and behavioral therapies is an evidenced-based practice for treating opioid use disorder, and is considered the “gold standard” for the treatment of OUD. MAT can help sustain recovery and improve social functioning for many people struggling with OUD.

Despite proven effectiveness as a treatment adjunct, MAT utilization in primary care and community treatment settings is low, and in Oregon, outside of 15 opioid treatment programs (OTPs), MAT is available in few locations. Reasons for low rates of adoption in primary care and other settings include a lack of staff understanding of the MAT medications, organizational philosophies or staff perceptions about use of these medications, the cost of medications, lack of coordination with community based opioid use disorder treatment for detoxification and stabilization of patients, lack of coordination with mental health providers for cognitive therapies, or lack of trained qualified providers to oversee this treatment (especially in the use of buprenorphine to treat opioid use disorders).

Given the low uptake, the resources cited below will aid the CCO in increasing MAT in your community. Opportunities exist for providers to integrate MAT into primary care and in substance use disorder treatment. Offering a full range of effective and coordinated treatments options, including medications and evidence-based behavioral treatment programs, can result in improved treatment outcomes among patients struggling with opioid use disorders.

MAT can and should be coordinated with other support strategies that focus on recovery and improving cognitive, and social functioning. MAT relieves cravings and withdrawal symptoms in patients with OUD, allowing them to focus on their recovery, increase their engagement in positive and productive activities of daily life, and improves their overall quality of life

Resources:

[SAMHSA, Medication-Assisted Treatment website](#)

[SAMHSA, Clinical Guidelines for the use of Buprenorphine in the Treatment of Opioid Addiction](#)

[SAMHSA, Buprenorphine Waiver Management](#)

[Stay Safe Oregon, OPG, Medication-Assisted Treatment Website](#)

Strategy: Implement Patient Review and Restriction (“Lock-in”) Programs

Patient Review and Restriction Programs (PRR), or “lock-in” programs identify patients/clients who are at risk for prescription drug abuse or overdose, ensuring that they receive controlled substance prescriptions only from designated prescribers and/or pharmacies. Lock-in programs are intended to prevent patients/clients from obtaining excessive quantities of prescription drugs through multiple visits to physicians, clinics, and pharmacies. Patients with excessive access to prescription drugs are at higher risk of overdose, and may also expose others (such as family or friends) to the risk of drug overdose. State Medicaid lock-in programs are present in most US states, although programs can be implemented within health systems, by insurers, or CCOs.

PRR programs can reduce unnecessary health care utilization, misuse and abuse of prescription drugs, and can substantially reduce medical costs. Medicaid patients have a higher risk of opioid overdose death, hospitalization, and ED visits, even compared to patients without insurance. Published and unpublished studies suggest that cost savings of PRRs can be substantial:

- An evaluation by Washington State estimated that every \$1 invested in the state PRR resulted in \$12 of savings, and a total estimated \$120 million in savings through 2012
- Hawaii’s PRR restricted 270 patients between 1977 and 1983, with a total estimated cost savings of \$2 million (in 2012 dollars)
- Missouri’s PRR saved an estimated \$1.8 to \$10.9 million per year (\$6.8 to \$41.3 million in 2012 dollars)
- Ohio’s PRR led to monthly dosage reductions of >40%

PRR programs vary in their approach to identifying and selecting patients or clients for restriction, and the types and duration of restriction involved. Initial identification of patient/client candidates for enrollment should be predetermined and specific, and can be based on:

- The number of pharmacies in which a patient has accessed controlled substances (currently, in the past, or within a certain time period). Multiple pharmacies used to fill controlled substance prescriptions might indicate possible abuse or drug-seeking behavior.
- The number of prescribers a patient has used to access controlled substances (currently, in the past, or within a certain time period). Some patients have multiple providers due to complex medical needs. However, when multiple prescribers are providing the same patient with controlled substance prescriptions, it may be a sign of abuse or drug-seeking behavior.
- Days supply exceeded (for example: patients receiving > 120 days supply of controlled substances who do not have cancer, HIV, lupus, chemotherapy, palliative care, or receiving neoplastic or HIV agents). An excessive supply of controlled substances could indicate misuse or abuse.
- Through referral (e.g. providers, pharmacies)
- Claims review
- A combination of the above factors, or similar factors

The document *Patient Review and Restriction Programs: Lessons Learned from State Medicaid Programs* details the specific criteria various states have used in PRR programs (link below) to select at-risk patients/clients. A clinical review should proceed once a defined threshold of observed drug access has

been surpassed. Further review of medical records can determine whether a patient's activity is medically appropriate.

Interventions may proceed by:

- Warning letters to the patient
- Warning letters to a patient's providers/prescribers
- Patient/client lock-in for a specified time period (e.g. 1-3 years)

In order to ensure proper patient care, PRRs should build in patient protections to prevent an undue burden on patients/clients, such as written notification to patients, a patient appeal process, and unrestricted emergency services (see [Table 1](#) of the *Using Patient Review and Restriction Programs to Protect Patients at Risk of Opioid Misuse and Abuse* at the link below for other examples).

Resources:

Centers for Disease Control and Prevention. Patient Review and Restriction Programs: Lessons Learned from State Medicaid Programs. 2012.

http://www.cdc.gov/homeandrecreationalafety/pdf/PDO_patient_review_meeting-a.pdf

The Pew Charitable Trusts: Using Patient Review and Restriction Programs to Protect Patients at Risk of Opioid Misuse and Abuse: <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2015/07/using-patient-review-and-restriction-programs-to-protect-patients-at-risk-of-opioid-misuse-and-abuse>

Chinn FJ. Medicaid recipient lock-in program— Hawaii's experience in six years. *Hawaii Medical Journal*; 44(1):9–18. January, 1985.

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