Impact of Opioid Prescribing Rules in Post Acute and Long Term Care

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History

• 2017 Washington state legislature passed House Bill 1427 aimed at addressing the opioid epidemic
• Mandated that by January 1, 2019 the commission must adopt rules establishing requirements for prescribing opioid drugs
• Rulemaking was preferred over placing standard care in state law in order to:
  – Ensure rules were written by clinicians and not politicians
  – Updating state law is very difficult
  – Regulatory process is more robust and inclusive
Rules Overview

• Rules differ for differing professions
  – ARNP rules went into effect November 1, 2018, 4 hour CME required
  – Podiatrist rules went into effect November 1, 2018
  – Osteopathic board adopted slightly differing rules
  – Dental rules have not been adopted yet
  – Allopathic physicians (MD’s) and PA’s will follow same rules, 1 hour CME required
Pill Limits

- **Acute Pain:** 7 day supply unless clinically documented
- **Acute Perioperative Pain:** 14 day supply unless clinically documented
- **Subacute Pain:** 14 day supply unless clinically documented
- **Chronic Pain:** no pill limit but consultation required if >120 MED
Impact for Post-Acute and Long Term Care

- Prior to prescribing opioids:
  - History and Physical
  - Screen for Risk Factors
  - Continually evaluate progress & document
  - Risk/benefits if combined use with benzodiazepines, sedative hypnotics, etc...
  - Provide patients with information to patients on the risks of opioids and safe storage/disposal
  - Query the PMP (prescription monitoring program)
    - Hospital dispensed not in PMP
    - SNF dispensed controlled substances may or may not be in PMP
    - VA dispensed not in PMP
# Example Screening Tools

## Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

<table>
<thead>
<tr>
<th>Mark each box that applies</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family history of substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Personal history of substance abuse</strong></td>
<td></td>
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<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Age between 16—45 years</strong></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>History of preadolescent sexual abuse</strong></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Psychological disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Scoring totals**

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## CAGE-AID QUESTIONNAIRE

- **Patient Name:** __________________________ **Date of Visit** ____________

When thinking about drug use, including illegal drug use and the use of prescription drugs other than prescribed:

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever felt you ought to cut down on your drinking or drug use?</td>
<td></td>
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<tr>
<td>Have people annoyed you by criticizing your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt bad or guilty about your drinking or drug use?</td>
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<tr>
<td>Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?</td>
<td></td>
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</tbody>
</table>

**Reviewed By:** __________________________ **Date:** ____________

**Disposition:**
Fact Sheet

Opioid Medication & Pain: What You Need to Know

If you’ve had an injury, surgery or dental work, you are likely to have pain. Pain is a normal part of life and healing. Talk with your doctor about how you can get the most effective pain relief with the least risk.

NON-OPIOID PAIN TREATMENTS HAVE FEWER RISKS

For pain that will likely be gone in a week or two, it is always best to start with non-opioid pain treatments. Opioids may help control pain right away, but they are usually not necessary. Consider other options that may work just as well but have fewer risks.

- Over-the-counter pain relievers
- Physical therapy
- Heat
- Professional help coping with the emotional effects of pain

OPIOIDS ARE STRONG PRESCRIPTION MEDICATIONS

Opioids can be the right choice for treating severe pain. However, medications such as Vicodin, Percocet and OxyContin can be very powerful and are powerful, even if taken as directed. All opioids have serious side effects such as addiction and overdose.

OPIOIDS ARE CHEMICAL COUNSINS OF HEROIN AND ARE HIGHLY ADDICTIVE

You can build up a tolerance to opioids over time, so you need to talk more and more to get the same relief. The higher the dose, the more dangerous opioids are. You can even become addicted after a short time.

If you are prescribed an opioid for short-term pain:

- The prescription should only be for as close as the shortest period of time.
- Take the lowest dose possible for the shortest period of time.
- Always talk with your doctor about managing your pain better without taking prescription opioids.

Commonly prescribed opioids:

- Codeine
- Dilaudid
- Fentanyl
- Hydrocodone (Vicodin)
- Hydrocodone (Hydrocone)
- Methadone
- Meperidine
- Morphine
- Oxycodone (Acomplia)
- Oxycodone (Oxymetaxol)
- Percocet

These are only some of the prescription opioids. If you get a prescription for pain, ask your doctor why it is an opioid.

In Washington, 57% of people currently using heroin were dependent on prescription opioids before they began using heroin.

1 in 5 teens experiment with prescription drugs.

- Nearly 1/3 of young people who have used heroin started off abusing prescription drugs.
- Nearly 1/3 of teens who misused or abused a prescription drug took it 90 days or less before they began taking prescription drugs.

KEEPING KIDS & TEENS SAFE

Sometimes kids and teens are prescribed opioids when they shouldn’t be. Or they may be given a prescription for more pills than they need. Teens may also experiment with drugs they find in their medicine cabinet. Follow these 5 simple guidelines whenever possible:

1. DON’T fill a prescription for more than a 7-day supply for anyone 20 years old or younger.
2. SECURELY STORE opioids away from kids and teens.
3. SAFELY DISPOSE of unused opioids when you are done. Don’t keep them around.

Visit www.takenabysnus.org or www.breefivekab.org to learn more or talk with your pharmacist about disposal options.

Opioids Facts & Figures

1 in 5 teens experiment with prescription drugs.
Operationalizing Pain Management

• History & Physical prior to first prescription
• Required evaluation for each change in phase
  – Acute pain: 0-6 weeks
  – Subacute pain: 6-12 weeks
  – Chronic Pain: >12 weeks
• Optimize non-pharmacologic treatment
• Provide information on risks/benefits and proper disposal of medications
  • *Hospice/Palliative Care is exempt*
Chronic Pain

• Require Treatment Agreements for chronic pain patients
• Periodic review of PMP based on risk category
• Requirement for expert consultation in patients receiving >120 MED (morphine equivalent). Exemptions:
  – Special circumstances: ongoing taper, referral being placed, palliative care/hospice
  – Pain specialists not required (Physical Medicine, Anesthesia, Neurology, Rheumatologist by definition considered a pain specialist)
  – New patient on high opioids exempt IF
    • Previous established written agreement
    • Stable, non escalating
    • History of adherence to treatment plan with PMP queries
    • Documented functional stability
    • Applies for first three months only where consultation not required
Treatment Agreements

Adapted from University of Washington
Treatment Agreement
Tapering Considerations

• Patient Request
• Deterioration in function or pain
• Other treatments indicated
• Evidence of misuse, abuse, substance use disorder or diversion
• Serious adverse event including overdose
• Unauthorized escalation
• Increased dosages without improvement in pain or function
# Tapering

[https://medstopper.com/](https://medstopper.com/)

## MedStopper Plan

**Arrange medications by:** Stopping Priority

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>RED=Highest</td>
<td>oxycodone (Oxycodone) / Narcotic / pain</td>
<td>![icon]</td>
<td>![icon]</td>
<td>![icon]</td>
<td>If used daily for more than 3-4 weeks. Reduce the dose by 25% every 3 to 4 days. Once at 25% of the original dose and no withdrawal symptoms have been seen, stop the drug. If any withdrawal symptoms occur, go back to approximately 75% of the previously tolerated dose.</td>
<td>restlessness, runny nose, goose flesh, sweating, muscle cramps, insomnia, nausea, diarrhea, pain, secretion of tears, increased heart rate, dilation of the pupils, breathlessness, decrease or impairment in daily function</td>
<td>![Details]</td>
</tr>
<tr>
<td>GREEN=Lowest</td>
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</tbody>
</table>

[Details](#)
Pain as a Quality Metric

• MDS queries on pain heavily emphasized in post-acute & long term care
• Tapering opioids in accordance with the proposed guideline may lead to higher pain scores though the guidelines are intended to include UNDERtreated pain
• Inconsistencies in CMS Quality Metrics and guidance on pain management for providers
  – CMS Roadmap for opioid epidemic
  – American Medical Directors listed as stakeholders
  – American Health Care Association *not* listed as stakeholder
• Ongoing risk/benefit/evaluation and if pain/function not improving, patient is a candidate for tapering
MDS Pain Questions

- More detailed than routine shift pain assessments
- 5-day look back
- Pain impact on function
- Best Practices
  - Use pain interventions before your interview
  - Help patients understand 5-day look back
  - Time interviews consistently to ensure no skewing of results
  - Floor nurses should ask probing questions to identify type of pain
  - Assess nonpharmacologic interventions
  - Address past issues (ie: hx of chronic pain syndromes)
# MDS Pain Questions

## J0300-J0600: Pain Assessment Interview

### J0300. Pain Presence

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ask resident: &quot;Have you had pain or hurting at any time in the last 5 days?&quot;</em></td>
<td>0. No → Skip to J1100, Shortness of Breath 1. Yes → Continue to J0400, Pain Frequency 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

### J0400. Pain Frequency

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ask resident: &quot;How much of the time have you experienced pain or hurting over the last 5 days?&quot;</em></td>
<td>1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer</td>
</tr>
</tbody>
</table>

### J0500. Pain Effect on Function

**A.** Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No 1. Yes 9. Unable to answer</td>
<td></td>
</tr>
</tbody>
</table>

**B.** Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No 1. Yes 9. Unable to answer</td>
<td></td>
</tr>
</tbody>
</table>

### J0600. Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B)

**A.** Numeric Rating Scale (0-10)

<table>
<thead>
<tr>
<th>Enter Rating</th>
<th>Question</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ask resident: &quot;Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.&quot; (Show resident 00 - 10 pain scale)</em></td>
<td>Enter two-digit response. Enter 99 if unable to answer.</td>
</tr>
</tbody>
</table>

**B.** Verbal Descriptor Scale

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Ask resident: &quot;Please rate the intensity of your worst pain over the last 5 days.&quot; (Show resident verbal scale)</em></td>
<td>1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer</td>
</tr>
</tbody>
</table>

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*Physicians of Southwest Washington*
Elders are a special population

- Consider changes in opioids based on tolerance and evaluation of patient’s metabolism and renal clearance
- Previously stable patients for many years may require tapering once they reach age 65
- Cancer Pain and End of Life Pain Management are exempt
- Dementia and Delirium may lead to inaccurate answers to questions requiring different assessments
  - PAIN-AD
  - Nursing Reports
Interactions, Co-prescriptions, & Safety Precautions

- Establish care plan with other prescribers
- Document medical decision making when there are interacting medications (benzodiazepines, sedatives, barbituates)
- For high risk patients (on >90 MED) provide current rx of naloxone and ensure naloxone readily available in facility
  - Evaluate PAR levels
  - Ensure providers know to Rx on discharge
Resources

• For patients on >120 MED UW Medicine Consult Hotline satisfies consultation requirement

  1-844-520-PAIN (7246)
  M-F 8:30am-4:30pm

• Washington State Department of Health
References