

Provider Insights: Liability and Risk Mitigation

WINTER 2019

Polypharmacy & The Opioid Crisis: Risk Mitigation Strategies to Assist Healthcare Practitioners

The Opioid Crisis Overview

The misuse, abuse, and diversion of prescription drugs has evolved into a very serious public health and public safety problem in the United States.¹⁻² Abuse and diversion of prescription opioids are of concern, as they now account for more than 75% of all pharmaceutical overdose deaths nationally.³⁻⁵ Drug overdoses now outpace motor vehicle accidents as the leading cause of accidental deaths in the U.S., with 52,404 fatal drug overdoses in 2015. Deaths from opioids are driving this trend. There were 20,101 overdose deaths related to prescription pain medication and 12,990 related to heroin in 2015, according to the American Society of Addiction Medicine.⁶

The crisis does not stop there, the U.S. Food and Drug Administration (FDA) is considering approval for Dsuvia, a single dose 30 microgram tablet of synthetic opioid sufentanil which is prescribed up to twelve doses daily. Take into consideration that “sufentanil is five to ten times stronger than Fentanyl.”³⁸ The Anesthetic and Analgesic Drug Products Advisory Committee has voted 10-3 in favor of Dsuvia. The FDA has yet to approve, but most often agrees with the committee.

Further, the opioid crisis is not just an adult epidemic but also affects children and adolescents. Opioid use has become a growing concern for pediatricians and the families served in pediatric practices. Whereas patients with a prior history of drug use, abuse or misuse, have long been studied, monitored, screened, and treated for adverse outcomes, opioid-naive patients with legitimate medical reasons for

opioid prescriptions may represent a greater risk for opioid complications.⁶

According to the CDC nearly 2 million Americans 12 years of age or older either abused or were dependent on opioid painkillers in 2013.⁷⁻⁸ Other data cited indicates that 2.6% of 100,000 persons in the United States between the ages of 15 and 24 years died of a prescription opioid overdose.⁶ In a study of illicit drug use among teens, opioids accounted for 79% of the significant morbidity and 100% of the deaths.⁶ In 2014, there were more than 460,000 adolescents who were current non-medical users of pain relievers, and 168,000 had an addiction to prescription pain relievers,⁸ demonstrating that this is truly an issue that impacts both adults and children across the nation.

The promising news is in a recent study by the American Medical Association, citing statistics from the Institute for Human Data Science, opioid prescription rates fell by 10% in 2017, the steepest drop in 25 years. All 50 states reported decreases in prescriptions of 5% or more. The report also states that physicians are increasing their use of prescription drug monitoring programs and expanding their treatment capacity.⁹⁻¹⁰

In March 2017, The American College of Physicians (ACP) published a series of recommendations to facilitate the effective treatment and prevention of substance use disorders involving illicit and prescription drugs. Their recommendations state that “Stakeholders should cooperate to: implement evidence-based guidelines for pain management; expand access

to Naloxone for opioid users, law enforcement and emergency medical personnel; expand access to medication-assisted treatment for opioid use disorders; establish a national prescription drug monitoring program; and improve existing monitoring programs.”⁹ According to Crowley, et al. (2017), the ACP believes that physicians must become familiar with (and follow as appropriate), clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologics and nonpharmacologic interventions.”¹⁰ This article provides risk mitigation guidance to healthcare practitioners in addressing the opioid crisis.

Opioid Abuse Risk Factors

Opioids are relatively easy to obtain given the extent to which they are currently prescribed in the United States. Because opioids are legal, regulated and prescribed by physicians, there can be a perception that they are not harmful. Further non-medical use of prescription opioids often is not recognized as potentially harmful and may even be viewed as harmless, especially compared with drugs such as heroin. In general, these prescription drugs are also viewed as socially acceptable. This perception is further supported by popular beliefs that associate heroin as a “dangerous street drug” and prescription opioids with less of a negative connotation.¹⁴

Further, opioid addiction treatment is especially difficult because people have both acute and protracted withdrawal syndromes. Acute withdrawal is very uncomfortable and occurs within hours to days after stopping opioids. It includes nausea, sweating, diarrhea, muscle and joint pains, and a general feeling of sickness.¹¹ Protracted withdrawal can last for months, and even more than a year, and includes depressive-like symptoms such as reduced concentration, low energy level, poor sleep quality, and anhedonia (lack of ability to experience pleasure).¹¹ Providers found relapse rates for those trying to stop using opioids extremely high related to these symptoms. According to the DSM-5; “The risk for opiate use

disorder can be related to individual, family, peer and social environmental factors, but within those domains, genetics plays a major role both directly and indirectly.”¹⁵

Finally, while clinicians cannot change an individual’s genetic makeup or culture, they can impact an individual’s social environment, family, peer and social relationships and internal thought processing regarding healthy versus risky and life-threatening behavior. A major step toward reversing the opioid epidemic can come by educating the professional community in evidence-based practices for identifying, intervening and treating individuals with chronic pain, individuals who would potentially abuse opioids, and individuals with existing opioid use disorder.¹⁶

Polypharmacy Implications in the Opioid Crisis

Further complicating matters in the opioid crisis is use of multiple medications within a given time frame known as polypharmacy. While there is no universal definition, polypharmacy is generally determined based on either the number of medications involved or whether the usage of the medications is deemed unnecessary.³⁹ These medications can be the combination of any prescription drugs, over the counter medications, and dietary and herbal supplements.³⁹⁻⁴⁰ Polypharmacy is frequently an indicator or consequence of prescription drug abuse; however, it can also simply refer to individuals dealing with multiple health conditions who require a variety of medications.⁴⁰

In a study of adults receiving one or more prescriptions from their primary care physician, published in the New England Journal of Medicine, the authors found that 25% of patients had an adverse drug reaction within three months of starting their prescriptions. While 39% of these were preventable errors, most were the result of inappropriate drugs or drug interactions.³⁹ Also, a study of Medicaid-dependent youths indicated that up to 50% of children in outpatient settings and 85% in inpatient and residential settings were

prescribed two or more medications.⁴⁰ Polypharmacy, regardless of whether it is the result of legitimate treatment or prescription drug abuse, can have significant negative consequences, such as adverse drug reactions, drug-drug interactions, and other complications.³⁹⁻⁴⁰

Polypharmacy Treatment Strategies

The following suggested treatment strategies should be employed to assist in effectively preventing the untoward effects of polypharmacy⁴¹⁻⁴²:

1. Obtain an accurate medication and medical history at each visit identifying all medications including over the counter medications, dietary and herbal supplements being utilized by the patient thus allowing the provider to be alert for any potential drug interactions.
2. Link each prescribed medication to the patient's diagnosis and if a medication doesn't match the disease state it may be potentially unnecessary.
3. Identify medications that are treating side effects as the use of multiple medications leads to a higher risk of side effects. Potentially discontinuing one drug causing a side effect can lead to the discontinuation of several drugs.
4. Reconcile medications upon any discharge from the hospital or skilled nursing facility. Evaluating a patient's medication regime and educating a patient upon discharge from a facility is likely to reduce duplicate therapy, reduce inappropriate prescribing, and reduce unnecessary medication. Medication reconciliation has also shown to result in a reduced risk of death in patient's discharged from a skilled nursing facility.⁴²
5. Consulting the CURES database to ensure what Schedule II – IV controlled substances have been dispensed to patients.

Screening, CURES 2.0, Prescribing, Education & Nonpharmacologic Risk Mitigation Strategies

It is important to limit the access of prescription opioids by individuals who would abuse them while still providing adequate pain management to those whom need it. This goal can be accomplished by a thorough evidence-based screening and assessment process in conjunction with education and the employment of nonpharmacologic interventions.

Two specific practice areas of concern with screening, prescribing and education are in dentistry and orthopedics.

Dentistry

Dentists are the fifth most frequent prescribers of opioid pain relievers, according to the U.S. Food and Drug Administration.¹⁷ According to research published in the Journal of the American Medical Association, 42% of dental patients filled a script for an opioid within seven days of a tooth extraction. The most commonly dispensed opioid was hydrocodone (78% of all prescriptions), followed by oxycodone (15%), propoxyphene (3.5%), and codeine (1.6%).¹⁷⁻¹⁸ Patients age 14 to 17 years had the highest proportion of those who filled opioid prescriptions (61%), followed by patients age 18 to 24 years.¹⁷ Also, in 2006, an American Dental Association survey found that while 74% of oral and maxillofacial surgeons preferred that patients use ibuprofen after wisdom teeth extraction, 85% also prescribed an opioid.¹⁷ The oral surgeons association survey found that 99% of members prescribed opioids — usually along with NSAIDs.¹⁸

Orthopedics

Individuals undergoing orthopedic surgery and post-operative care can easily be swept up in the opioid crisis while undergoing pain relief treatment. Orthopedic surgeons are the third highest prescribers of opioids trailing medical physicians and dentists.¹⁹ The American Academy of Orthopaedic Surgeons (AAOS)

advocates physicians need to do their part to address this crisis and promote safe opioid use while ensuring that patients are as comfortable as possible.¹⁹ The AAOS also stresses the use of standardized opioid protocols in all settings, i.e. inpatient, outpatient, and the physician's office to control opioid use. Orthopedic practices should establish protocols/policies to better control and limit opioid prescription dosages as well as appropriate/inappropriate opioid uses for acute musculoskeletal injuries, postsurgical pain, and chronic pain. Surgeons and team members should explain to patients and families that opioid protocols/policies benefit patients and should always be followed.¹⁹

General Overview of Screening, Prescribing, Education and Nonpharmacologic Interventions:

Screening

Screening techniques include a thorough patient history, evaluating risk factors for opioid related harms such as a prior history of drug usage, personal or family history of depression, anxiety, ADD/ADHD, or other psychiatric disorders. Also, the use of validated screening tools for adults such as: The Drug Abuse Screening Test (DAST)²¹ a widely used questionnaire tool for detecting substance use other than alcohol and tobacco that can assist in treatment planning; The Opioid Abuse Risk Screener (OARS)²¹ is a self-administered measure of opioid abuse that includes a wide range of opioid risk factors, including depressive and anxiety symptoms and exposures to traumatic events, and abuse/neglect concerns, as well as any history of substance abuse.¹⁹ Pediatric validated screening tools such as: CAGE-AID²⁰ a questionnaire tool that provides screening for alcohol and drug problems conjointly rather than separately and CFAFFT²¹ a simple six question screening tool asking questions related to drug or alcohol use in a car, to relax, when alone, or screens for issues related to forgetfulness, friends, and trouble. The questions are designed to spell out CFAFFT. These helpful tools can be used to briefly assess for substance use disorders allowing a busy healthcare practitioner to identify if a more in-depth exploration about drug usage is warranted.

Additionally, medication reconciliation is an important element of patient assessment for pain management purposes. For patients who are already taking opioids, medication reconciliation should include determining not just what medications have been prescribed but also what and how much they are currently taking and when they took their most recent dose. This can help clinicians determine whether the patient is opioid naive or opioid tolerant.²¹

When assessing pain clinicians may consider the location, onset, frequency, nature and intensity along with the impact on issues such as function, sleep, and emotional distress. Patients should also be assessed for chronic pain and other conditions that may contribute to pain along with risk factors for opioid related adverse events such as sleep apnea, kidney or liver impairment and associated use of other sedating medications.²²

CURES 2.0

An important aspect to screening is utilization of California's prescription drug monitoring program CURES. California's Prescription Drug Monitoring Program, Controlled Substance Utilization Review and Evaluation System (CURES), allows authorized physicians, law enforcement, and regulatory agencies to view information on Schedule II – IV controlled substances dispensed to patients in California.²³ Pharmacists and direct dispensers are required to report information on all Schedule II – IV controlled substances dispensed, and must do so within seven days of dispensing.²³ The information is then uploaded into CURES. The CURES system has provided prescribers and dispensers with Schedule II – IV prescription data via an online web portal since 2009.²⁴ The system, as currently configured, provides authorized prescribers and dispensers who have registered on the system with prescription detail for an individual patient's prescription records (Patient Activity Report, or PAR), which includes the patient's name, date of birth, and address; drug name, form, strength, quantity, dispensing pharmacy name and license

number; prescriber DEA Certificate number; prescriber name, prescription number; refill number; and date of dispense. A physician can use this information for multiple purposes, including identifying a patient who may be a “doctor shopper,” viewing medications dispensed to the patient that were prescribed by other physicians, and providing a complete picture of scheduled drugs dispensed to a patient.²⁵

The CURES system can be an extremely helpful tool for physicians who are prescribing controlled substances. The Medical Board’s revised “Guidelines for Prescribing Controlled Substances for Pain” emphasizes that physicians should use the CURES PDMP to identify patients who obtain drugs from multiple sources as part of the patient evaluation and risk stratification process.²⁵ The guidelines also recommend that physicians document, in their medical records, that they requested a Patient Activity Report (PAR) from CURES and the outcome of such report.²⁴⁻²⁶

CURES also serve several user populations: Physicians and other prescribers can look up a patient in the database before prescribing a new controlled substance. Pharmacists can also query a patient before dispensing a drug to them. Regulatory investigators like the Medical Board use the system to identify instances of overprescribing or other offenses within their licensing population. Finally, state and federal law enforcement utilize the system as part of their investigations into possible criminal conduct, such as illegal drug diversion.²⁶

Recently, the Department of Justice (DOJ) upgraded the CURES system from CURES 1.0 to CURES 2.0. This update enhances the information that a physician can obtain from the system. In addition to the functionality of the prior system, CURES 2.0 provides an improved user interface and an analytics engine that will provide physicians with critical information regarding at-risk patients. An example of a new feature with the upgraded CURES 2.0 is that prescribers will be able to specify patients with whom they have pain management agreements

to signal to other providers that additional prescribing of controlled substances to these patients could be potentially counter-productive or harmful.^{9,10} The new CURES 2.0 also provides alerts to physicians if a patient meets certain criteria, such as a patient who has obtained prescriptions from six or more prescribers or six or more pharmacies during the last six months. These alerts are viewable on the physician’s dashboard when they sign on to the CURES 2.0 system.²³⁻²⁶

Pursuant to Health & Safety Code §11165, a physician authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances must have submitted an application to the DOJ for registration into the CURES system by July 1, 2016.²³ CURES was certified for statewide use by the DOJ on April 2, 2018. Therefore, the mandate to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II–IV controlled substance becomes effective on October 2, 2018.²³

CURES 2.0 Compliance Criteria

Who is required to Consult CURES?

The law mandates that all California licensed physicians authorized to prescribe scheduled drugs, upon receipt of a Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate, submit an application to access the CURES database. Physicians with an active license and a DEA Controlled Substance Registration Certificate should have submitted an application by July 1, 2016 (Health & Safety Code §11165.1).²³⁻²⁴

In addition to physicians, individuals who have a valid California license as a dentist, naturopathic doctor, optometrist, osteopathic physician, physician assistant, podiatrist, advanced practice registered nurse, or veterinarian and possess a DEA Controlled Substance Registration Certificate must apply to register with CURES. Pharmacists must also apply to register for CURES access upon licensure (Health & Safety Code §11165.1).²³⁻²⁴

Registering for CURES

Applicants must submit and complete an online registration form at

<https://cures.doj.ca.gov/registration/>. Physicians will need to provide a valid email address, license number, and DEA registration certificate number. The DOJ will then validate the identity and license of the applicant electronically with the Department of Consumer Affairs and the DEA. (CURES/PDMP website.)

CURES 1.0 users do not need to re-register as they will be able to access CURES 2.0 with their current user ID and password. Upon first logging into CURES 2.0, they will be required to update their security questions and answers, establish a new password, review their account profile to verify accuracy, make necessary updates, and acknowledge CURES 2.0 Terms and Conditions.²³⁻²⁵

When is CURES Required to be Consulted?

CURES must be consulted unless an exemption applies, which means a physician must query the CURES database and run a patient activity report (PAR) on each patient the first time a patient is prescribed, ordered, or administered a Schedule II-IV controlled substance. The PAR must be run within twenty-four hours, or the previous business day, before prescribing, ordering, or administering the controlled substance. In addition, a physician must also query the database at least once every four months if the controlled substance remains a part of the patient's treatment plan (Health and Safety Code (HSC), § 11165.4(a)(1)(B) .²⁴⁻²⁶

"First time" is defined as the initial occurrence in which a health care practitioner intends to prescribe, order, administer, or furnish a controlled substance to a patient and has not previously prescribed a controlled substance to the patient.⁹

Exemptions from Consultation

Under Health & Safety Code §11165.4(a)(1)(B) a health care practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or

furnishing a controlled substance in any of the following circumstances:²⁵

1. While the patient is admitted to, or during an emergency transfer between a
 - Licensed Clinic, or
 - Outpatient Setting, or
 - Health Facility, or
 - County Medical Facility
2. In the emergency department of a general acute care hospital, and the controlled substance does not exceed a non-refillable seven-day supply.
3. As part of a patient's treatment for a surgical procedure, and the controlled substance does not exceed a non-refillable five-day supply when a surgical procedure is performed at a
 - Licensed Clinic, or
 - Outpatient Setting, or
 - Health Facility, or
 - County Medical Facility, or
 - Place of Practice
4. The patient is receiving hospice care.
5. It's not reasonably possible for a prescriber to access the information in CURES in a timely manner.
 - If another individual with access to CURES is not reasonably available, a five-day supply of the controlled substance can be prescribed, ordered, administered, or furnished as long as there is no refill allowed. In addition, the prescriber must document in the patient's medical record the reason for not consulting CURES.
6. Consulting CURES would result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition.
 - A prescriber may provide a non-refillable five-day supply if they make this determination. The prescriber must document in the patient's medical record the reason for not consulting CURES.

7. Technical difficulties with accessing CURES.

- There are exemptions to consulting CURES if there are technical difficulties accessing CURES, such as CURES is temporarily unavailable for system maintenance, or you experience temporary technological or electrical failure and CURES cannot be accessed (e.g., power outage). A prescriber should contact the CURES Help Desk at (916) 210-3187 or CURES@doj.ca.gov for assistance accessing their CURES account. A prescriber must, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within their control.²⁵

Documentation of CURES

If a physician consults CURES, while its not legally required to document the consultation, it is recommended by the medical board to ensure the consultation is captured in the medical record.²⁵ Documentation can be either a note in the medical record or a print out of the PAR placed in the record.²⁵ However, it is important to note that documentation of an exemption is legally required if it is not reasonably possible to access the information from the CURES database in a timely manner, another physician, who can access the information is not reasonably available, and the quantity of the controlled substance doesn't exceed a non-refillable 5 day supply.²⁴⁻²⁸

CURES Delegation

Physicians can delegate their authority to query CURES to a nurse or medical assistant and they can order patient activity reports on individual patients. It is important to note that consistent with Business and Professions §209, a physician may authorize a delegate to order PARs from CURES. However, the delegate can only request the PAR. The PAR is then sent to the physician's dashboard and only the physician can go in and review it.

Data Correction

The DOJ will not correct any inaccuracies in CURES data. Rather, it maintains that since data contained in CURES is reported to the DOJ by pharmacies and direct dispensers, patients and prescribers should notify the reporting pharmacy or dispenser of any incorrect information in CURES. The DOJ will only accept submissions for corrections from the original reporting pharmacy or dispenser.

Consequences and Liability for not Consulting CURES

Physicians who fail to consult the CURES database pursuant to Health & Safety Code §11165.4 may face disciplinary and administrative sanctions. The law, however, does not create a private right of action against a health practitioner for failure to consult CURES. (Health & Safety Code §11165.4(d); S.B. 482, Stats. 2016, Ch. 708.)²⁷⁻²⁸

CURES Educational Resources Available

For more information, educational resources, and updates, visit:

- The DOJ's CURES/PDMP website, available at <https://oag.ca.gov/cures>. The site contains frequently asked questions, links to registrations, and publications and training videos.
- The Medical Board of California's CURES Update website, available at <https://www.mbc.ca.gov/Licensees/Prescribing/CURES/>.
- CMA's CURES Resource Page, available at <http://www.cmanet.org/cures>.

Prescribing

In prescribing, it is important to follow an approach that step ladders analgesia therapy as suggested by the World Health Organization.²⁹ This approach suggests mild pain being treated

with nonopioid analgesics, moderate pain being treated similarly but adding an opioid if appropriate, and more intense pain being treated with a stronger opioid.

Dosing should begin with the smallest effective dose with short acting opioids being used first. Providers should also anticipate how long the patient is likely to have moderate to severe pain that requires opioid treatment and dispense only enough opioid medication to be used during the expected period of pain. Patient follow up care with an in person clinical assessment, if more opioid pain medications are requested, is recommended in order to ensure additional opioid therapy is clinically appropriate.

Moreover, to address the variability in prescribing practices, hospitals and health care systems should ensure that clinicians and staff have the appropriate resources at their fingertips, including prescribing guidelines, patient education materials on the risks of opioids, and information on non-opioid pain treatment. With these resources, providers can help obviate the long-term use of opioids and have tools to assist in the prevention of opioid use disorder.

CDC Guidelines for prescribing opioids in chronic pain:

The CDC has issued 12 general guidelines for prescribing opioids for chronic pain. Please note: these guidelines are not intended for use when prescribing opioids for active cancer treatment, palliative care or end of life care.³⁰

- Opioids aren't prescribed as initial or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss risks and benefits and availability of nonopioid therapies with the patient
- Use immediate-release opioids when initiating treatment
- Start low and go slow

- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe extended release/long acting opioids or transdermal patch for acute pain
- Follow up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed
- Check PDMP (prescription drug monitoring program) for high doses and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

These general guidelines can be found at:

https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-a.pdf.

A promising evidence-based approach to opioid use disorder is Medication-Assisted Treatment (MAT), which uses a combination of medications, counseling, and behavioral therapies. Recent statutory and regulatory changes have expanded access to MAT by increasing the number of patients each provider can treat and allowing specially trained nurse practitioners and physician assistants to prescribe buprenorphine, an opioid used in MAT.³⁰⁻³²

MAT resources include:³²

- The Substance Abuse and Mental Health Services Administration's free pocket guide for physicians, "Medication-Assisted Treatment of Opioid Disorder," which discusses several types of approved medications, screening and assessment tools, and best practices for patient care.
- Providers' Clinical Support System for MAT (PCSS-MAT), a national training and clinical mentoring project, which provides effective, evidence-based

clinical practices in preventing, identifying, and treating opioid use disorder.

- Project ECHO – Opioid Addiction Treatment recruits family nurse practitioners and physician assistants to receive additional training and experience in behavioral health treatment, such as how to screen patients for several disorders, including opioid use disorder.

Education:

Providers must restrict opioid prescriptions to patients who truly require them. Both the provider and clinical staff must be educated to the risks of opioid misuse and how to appropriately manage and educate patients and parents about opioid related risks.

When a prescription is issued, the patient should be informed that all medications, especially opioids, should be stored in a secure place out of reach of children and adolescents. Also, when the opioid medications are no longer needed for the indication in which they were prescribed, they should be disposed of in a safe manner. The medication should not be stored for future use. This should be emphasized to parents to ensure that their children and adolescents are safe.

Patients should be instructed about the potential for abuse and serious harm if not taken as directed, and parents should be taught the signs of misuse among children and adolescents for whom opioid treatments are prescribed. Opioid side effects and potential dangers of misuse or improper safety storage should be communicated to both the patient and family with subsequent documentation in the medical record reflecting this discussion.

In addition, providers need to perform proper screening for signs of opioid use disorder at regular checkups as well as encounters for pain to help ensure prevention of abuse.

Finally, as we seek solutions to the opioid use disorder epidemic, we must also understand the underlying stigma and biases that we can unwittingly bring to the treatment of patients. While the epidemic affects people of all ages, races, and socioeconomic backgrounds, some caregivers may have mistaken ideas about what an addict “looks like.” These misconceptions may result in some patients stopping needed care if they feel they are given the stigma of an addict. It is imperative that clinicians, hospitals, and health systems better understand and address bias and stigma to prevent this from interfering with a therapeutic patient-clinician relationship.

Nonpharmacologic Interventions:

The CDC’s “Guideline for Prescribing Opioids for Chronic Pain” states, “Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.”³⁰ A January 2018 study by JAMA concluded that the drugs probably don’t even do that much, at least not any more effectively than nonopioid medications. The research, which focused on individuals with chronic back pain or hip or knee osteoarthritis (OA) pain, led authors to an unequivocal conclusion: there’s no support for opioid therapy for moderate-to-severe cases of those types of pain.³²

The CDC’s “Guideline for Prescribing Opioids for Chronic Pain” points out that treatments provided by physical therapists are especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Additionally, a number of studies³³⁻³⁷ show the efficacy of physical therapist interventions in preventing, minimizing, and, in some cases, eliminating pain in patient’s post-surgery, in patients with cancer, and in other clinical scenarios.^{31,38}

Examples of physical, behavioral and cognitive measures can be used to effectively reduce or relieve pain:³²

- Physical measures include massage, heat and cold stimulation, acupuncture, and transcutaneous electrical nerve stimulation (TENS).
- Behavioral measures include tools such as operant conditioning, relaxation, biofeedback, desensitization; as well as exercise, physical therapy, art and play therapy.
- Cognitive measures like distraction, imagery, hypnosis and psychotherapy have also been proven effective for treating pain in children and adolescents.

Group therapy can be very beneficial in treating various mental health conditions such as anxiety and depression that are often associated with withdrawal symptoms. Group therapy can be combined with other treatment modalities as well and the group process supports the personal journey of all individuals towards their own recovery through support from peers as well as through decreasing social isolation.¹⁶

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (H.R.6):

This federal legislation, signed into law in October 2018, includes provisions aimed at reducing opioid use and improving treatment and recovery programs for Substance Use Disorder (SUD). Some highlights of the law are⁴³⁻⁴⁴:

- Institution for Mental Disease (IMD) Exclusion: Beginning October 1, 2019 states can elect to provide Medicaid coverage in qualifying IMD's for individuals ages 21-64 whom have at least one SUD diagnosis for a period of no more than 30 days in a 12-month period.

- The law authorizes the Center for Medicare & Medicaid Innovation to test a model that would provide incentive payments to behavioral health providers that adopt and use certified electronic health record technology to improve care quality and coordination through electronic documentation and exchange of health information.
- Expanded use of telehealth for SUD treatment and Opioid Use Disorder Treatment Demonstration Program arranging opioid use disorder treatment services delivered to applicable beneficiaries by opioid use disorder care teams.
- CMS is required to develop and post on its website guidance for hospitals on pain management strategies and opioid use disorder prevention strategies for Medicare beneficiaries.
- The law also revised the HCAHPS survey beginning January 2020 to remove questions related to "communication about pain" that don't take into account whether the patient was informed about the risks associated with opioid use and non-opioid treatment alternatives.

For further information about this new federal regulation see the entire law at: <https://www.congress.gov/bill/115th-congress/house-bill/6>.

Conclusion

Providers and other healthcare professionals see the devastating effects the opioid crisis is having on patients, families and communities so care must be taken to safely and appropriately prescribe opioids to both adult and pediatric populations. Risk mitigation via accurate patient screening, prescribing, education and nonpharmacologic interventions are the keys to better treatment and results, and assisting patients and their families in battling the opioid crisis.

References

1. Adler, J.A. (2012). Get registered with the CURES program. The California Academy of Physician Assistants (CAPA) NEWS. Available at: <https://capanet.org/2018/10/effective-october-2-2018-pas-must-consult-cures-database-prior-to-prescribing-2/>
2. Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). The NSDUH report: nonmedical use of prescription-type drugs, by county type. Available at: <https://www.samhsa.gov/data/report/results-2013-national-survey-drug-use-and-health-mental-health-detailed-tables>
3. Johnston, L.D., O'Malley, P.M., Bachman, J.G., & Schulenberg, J.E. (2013). Monitoring the Future national results on drug use: 2012 overview, key findings on adolescent drug use. Available at: <http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2012.pdf>; <http://www.drugabuse.gov/monitoring-future-survey-overview-findings-2013>.
4. Jones, C.M., Mack, K.A., & Paulozzi, L.J. (2013). Pharmaceutical overdose deaths, United States. *JAMA*, 309(7):657-659.
5. Injury and Violence Prevention Program, Los Angeles County Department of Public Health. (2011). Drug-related deaths in Los Angeles County, 2000-2009. Available at: http://publichealth.lacounty.gov/ivpp/injury_topics/Poisoning/Drug%20Death%20Data%20Fact%20Sheet%20with%20narrative%20rev%20Jan%202013.pdf.
6. Subramaniam GA, Stitzer ML, Woody G, Fishman MJ, Kolodner K. Clinical characteristics of treatment-seeking adolescents with opioid versus cannabis/alcohol use disorders. *Drug Alcohol Depend*. 2009;99(1-3):141-149.
7. Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. Monitoring the Future. National Survey Results on Drug Use, 1975-2010. Volume I: Secondary School Students. Ann Arbor, MI: Institute for Social Research, University of Michigan; 2011.
8. Fortuna RJ, Robbins BW, Caiola E, Joynt M, Halterman JS. Prescribing of controlled medications to adolescents and young adults in the United States. *Pediatrics*. 2010;126(6):1108-1116. PubMedGoogle ScholarCrossref
9. <http://www.apta.org/PTinMotion/News/2018/06/04/AMAOpoidsReport/>
10. <https://www.health.pa.gov/topics/Documents/Opioids/Pediatric%20and%20Adolescent%20Prescribing%20Guidelines%209-19-17.pdf>
11. Crowley R Kirschner N Dunn AS, for the Health and Public Policy Committee of the American College of Physicians, Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An ACP Position Paper, *Ann Intern Med*. (Epub ahead of print 28 March 2017).
12. Substance Abuse and Mental Health Services Administration. Results From the 2012 National Survey on Drug Use and Health (NSDUH): Summary of National Findings. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2013. NSDUH Series H-46, US Dept of Health and Human Services Publication SMA13-4795.
14. Burghardt LC, Ayers JW, Brownstein JS, Bronstein AC, Ewald MB, Bourgeois FT. Adult prescription drug use and pediatric medication exposures and poisonings. *Pediatrics*. 2013;132(1):18-27.
15. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, 2013 (p.543), Washington D.C.
16. <https://www.relias.com/resource/roadmap-to-fighting-opioid-epidemic/>
17. http://www.aapd.org/assets/1/7/State_of_Little_Teeth_Final.pdf; <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>
18. <https://media.jamanetwork.com/news-item/high-percentage-of-patients-prescribed-opioids-following-tooth-extraction/>
19. https://www.aaos.org/uploadedFiles/PreProduction/About/Opinion_Statements/advistmt/1045%20Opioid%20Use,%20Misuse,%20and%20Abuse%20in%20Practice.pdf
20. Couwenbergh C, Van Der Gaag RJ, Koeter M, De Ruiter C, Van den Brink W. Screening for substance abuse among adolescents validity of the CAGE-AID in youth mental health care. *Subst Use Misuse*. 2009;44(6):823-834.
21. <http://www.aspmn.org/documents/GuidelinesonMonitoringforOpioid-InducedSedationandRespiratoryDepression.pdf>
22. World Health Organization: guidelines on the pharmacological treatment of persisting pain in children with medical illnesses http://apps.who.int/iris/bitstream/10665/44540/1/9789241548120_Guidelines.pdf
23. Office of the Attorney General, State of California Department of Justice. (2014). CURES/PDMP. Available at: <https://oag.ca.gov/sites/all/files/agweb/pdfs/pdmp/cures-mandatory-use.pdf?>
24. <http://publichealth.lacounty.gov/sapc/MDU/SpecialReport/rxApril2014Pub.pdf>
25. <http://www.mbc.ca.gov/Licensees/Prescribing/CURES/101.aspx>
26. Cures 2.0 and Beyond: Background Paper <https://abp.assembly.ca.gov/sites/abp.assembly.ca.gov/files/hearings/CURES%20Background%20Paper%20180131.pdf>
27. <http://www.mbc.ca.gov/Licensees/Prescribing/CURES/101.aspx>
28. Health and Safety Code (HSC), § 11165.4(a)(1)(B)
29. Injury prevention & control: prescription drug overdose. Centers for Disease Control and Prevention website. <http://www.cdc.gov/drugoverdose/data/overdose.html>. Accessed February 8, 2016.
30. CDC Guidelines: https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-a.pdf.
31. <https://www.samhsa.gov/medication-assisted-treatment>
32. *JAMA*. 2018 Mar 6;319(9):872-882. doi: 10.1001/jama.2018.0899.

33. Zosel A, Bartelson BB, Bailey E, Lowenstein S, Dart R. Characterization of adolescent prescription drug abuse and misuse using the Researched Abuse Diversion and Addiction-related Surveillance (RADARS[®]) System. *J Am Acad Child Adolesc Psychiatry*. 2013;52(2):196-204. PubMedGoogle ScholarCrossref
34. Fortuna RJ, Robbins, BW, Caiola E, Joynt M, Halterman JS. Prescribing of controlled medications to adolescents and young adults in the United States. *Pediatrics*. 2010;126(6):1108-1116.
35. Gagnon CM, Scholten P, Atchison J. Multidimensional patient impression of change following interdisciplinary pain management. [Epub ahead of print] *Pain Pract*. 2018 Apr 20. doi: 10.1111/papr.12702.
36. Childs JD, Fritz JM, Wu SS, et al. Implications of early and guideline adherent physical therapy for low back pain on utilization and costs *BMC Health Serv Res*. 2015;15:150. doi: 10.1186/s12913-015-0830-3.
37. Fritz JM, Brennan GP, Hunter SJ. Physical therapy or advanced imaging as first management strategy following a new consultation for low back pain in primary care: associations with future health care utilization and charges. *Health Serv Res*. 2015;50(6):1927-1940. doi: 10.1111/1475-6773.12301.
38. https://www.apta.org/uploadedFiles/APTAorg/Advocacy/Federal/Legislative_Issues/Opioid/APTAOpioidWhitePaper.pdf. FDA Briefing Document Anesthetic and Analgesic Drug Products Advisory Committee (AADPAC). (2018, October 12). Retrieved from U.S. Food and Drug Administration: <https://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndAnalgesicDrugProductsAdvisoryCommittee/UCM622857.pdf>
39. Gandhi TK, Weingart SN, Borus J et al. Adverse drug events in ambulatory care. *New England Journal of Medicine* 2003;348:1556–1564. doi: 10.1056/NEJMsa020703
40. <https://fsph.iupui.edu/doc/research-centers/polypharmacy-among-prescription-drug-users.pdf>
41. <https://www.pharmacytimes.com/publications/issue/2009/2009-01/2009-01-9968>
42. Delate T, Chester EA, Stubbings TW, Barnes CA. Clinical outcomes of a home-based medication reconciliation program after discharge from a skilled nursing facility. *Pharmacotherapy*. 2008;28(4):444-452.
43. https://www.calhospital.org/sites/main/files/file-attachments/hpa_summary_of_hr_6.pdf?
44. <https://www.congress.gov/bill/115th-congress/house-bill/6>.