# The Tale of Two Standards

## THE OPIOID & BENZODIAZEPINE SAGA CONTINUES, TWO YEARS LATER…

TALIA CARTER OCTOBER 2022

# Conflict of Interest/Disclosures

- Presenter's Name: Talia Carter
- I have the following relationships with commercial entities: None
- Speaking Fees for current program
  - I have received a speaker's fee from CPhM for this learning activity
- This program has received no financial or in-kind support from any commercial or other organization

# Thanks to…

# My Team!

Prescribing Practices Program

**Dr Marina Reinecke**
MBChB, CCFP (AM), ISAM
PPP Medical Consultant

**Michael Wiebe**
BSc. (Pharm), BSc. (Hons)
PPP Analyst

For past talks, ME files, ideas, support, & laughs as paddle we upstream

# PPP Mandate

*PPP utilizes a **quality improvement approach** to promote prescribing practices that are informed by current **evidence** and reflective **of best practices**.*

*Our **educational approach** balances patient safety with a registrant's duty to be a guardian for public safety.*

# Learning Objectives

1) To review the intent and essence of the Standards of Practice (SOPs) for Prescribing Opioids and Benzodiazepines/Z-drugs

2) To review how CPSM ME work relates to these SOPs & PPP work

3) To revisit pearls of these prescribing SOPs

4) To recognize the valuable role pharmacists play in supporting prescribers

5) To share clinical perspective and support communication with patients about opioid and/or benzodiazepine medications

6) To discuss some common questions related to the SOPs

7) To review the role PPP can play to support registrants around SOPs

# Poll Question

# All of the Above!

- We get it (we live it)…
- The Prescribing SOPs impact us, our practice, patients, peers, family, friends
- It can be challenging
- Change is hard

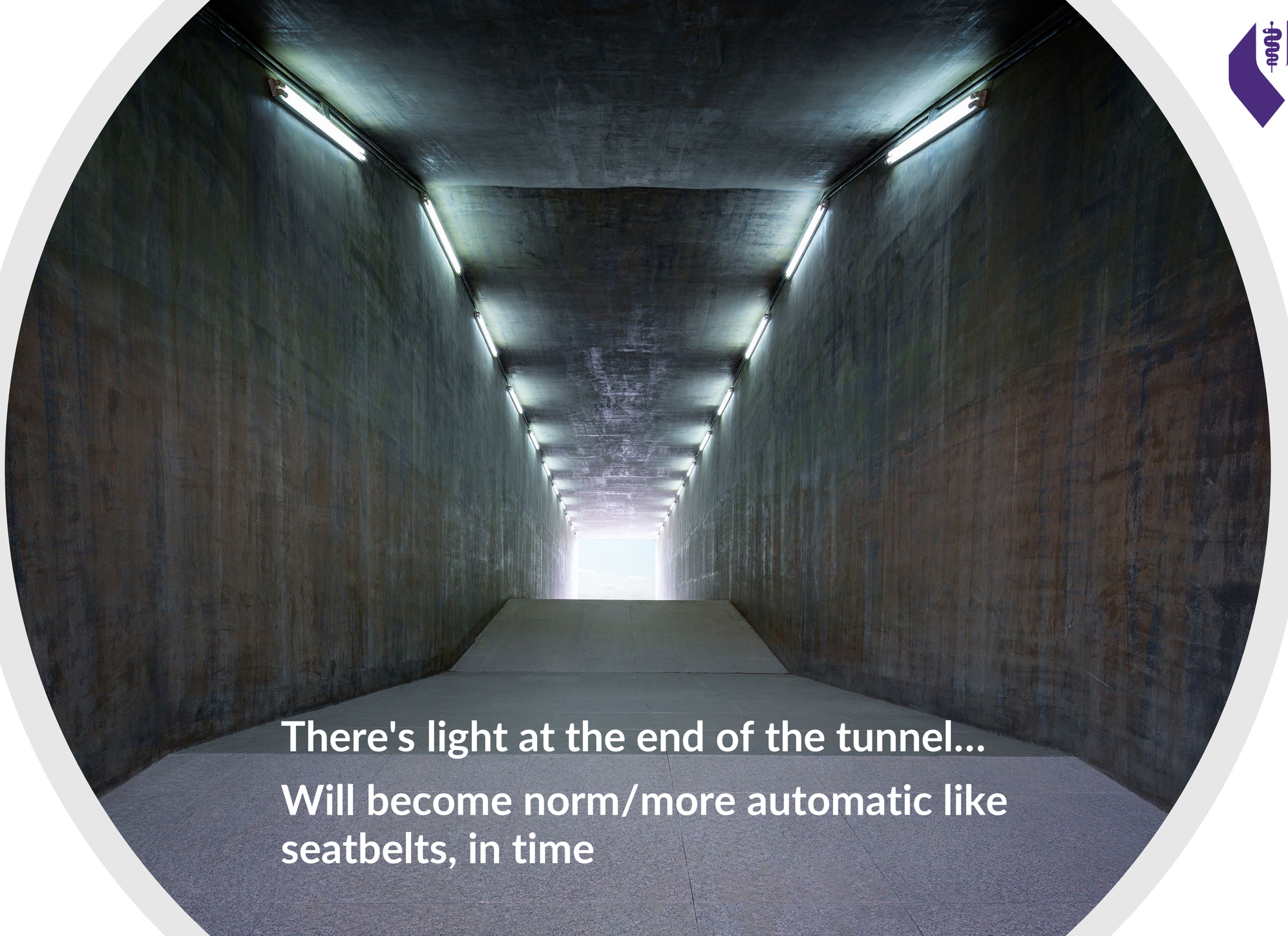
… So why do these Standards exist?


Canada Safety Council Ad reminding drivers and passengers to wear seatbelts from a December 1975 edition of The Review (eastern ON newspaper)

Seatbelt use first became compulsory in ON in 1976 (1984 in MB)

https://thereview.ca/2020/07/14/differences-and-similarities-between-mandatory-masks-in-2020-and-mandatory-seatbelts-in-1976/

**35 times more likely to be killed**
**5 times more likely to be seriously injured when not wearing a seatbelt** – MPI



There's light at the end of the tunnel...

Will become norm/more automatic like seatbelts, in time

## HERE ARE THE RESULTS OF 1,000 PEOPLE STARTING AN OPIOID FOR CHRONIC PAIN[1,2]

*These people have persistent problematic pain despite optimized non-opioid therapy.

**112 more people will have noticeable pain relief**

**58 more people will have constipation/upset stomach**

**55 people will develop an opioid use disorder***

**2 people will have an overdose and live**

**1-2 people will die from an overdose***

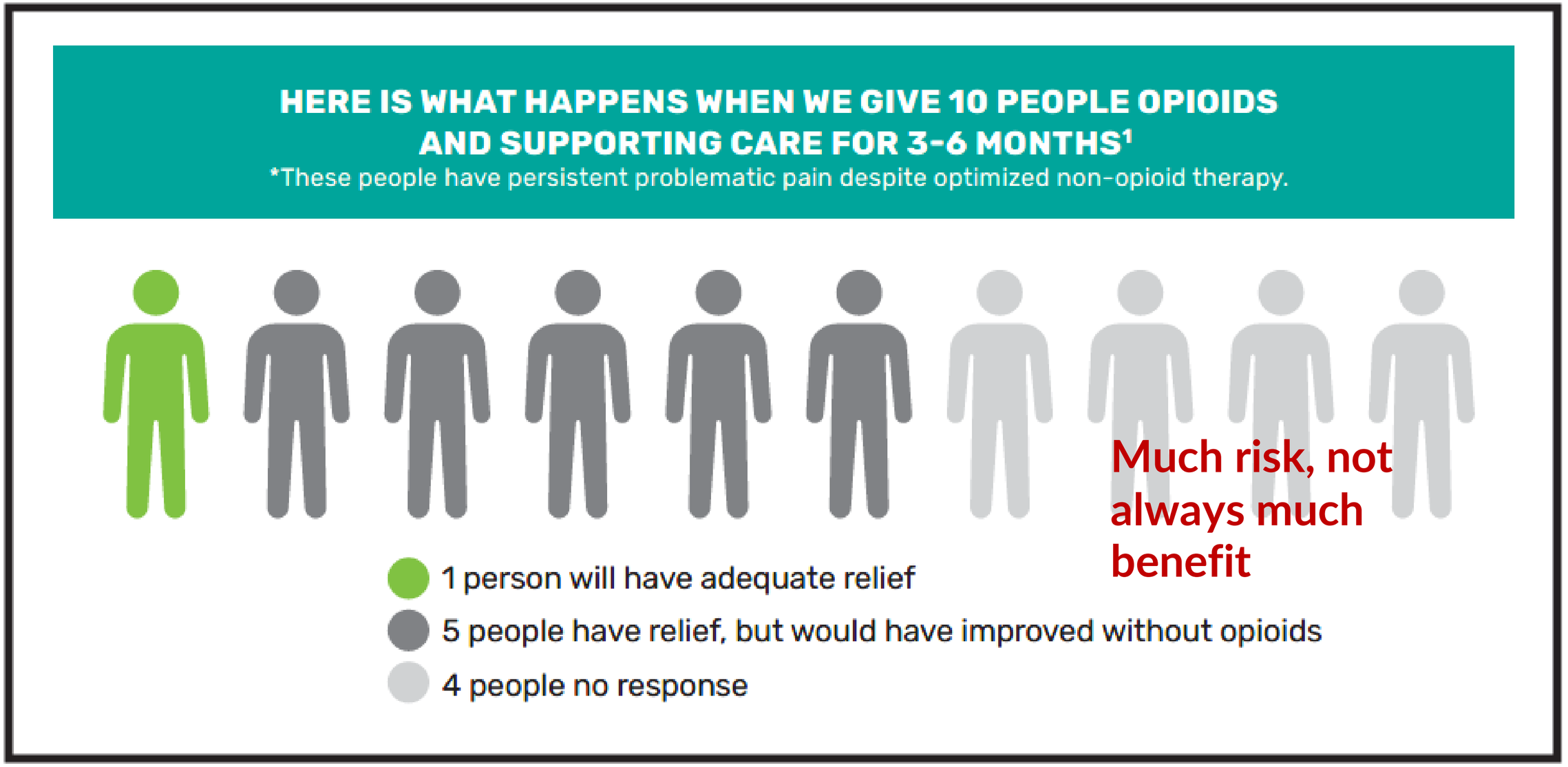
An individual could experience one or more of these results. There is no way to predict which outcomes an individual will experience.

*For 1,000 people with a substance use disorder, 90 people would develop an opioid use disorder, 10 people would have non-fatal overdoses and 5 people would have fatal overdoses.

For 1,000 people with an active psychiatric disorder, 80 people would develop an opioid use disorder, 3 people would have non-fatal overdoses and 2 people would have fatal overdoses.

**Just as scary as stats if not wearing a seatbelt!**

Available via https://www.napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids




**Infographic references**

Reference: Busse J. The 2017 Canadian guideline for opioids for chronic non-cancer pain. Hamilton, ON. 2017.
MAGIC APP The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. (2018) Accessed at http://nationalpaincentre.mcmaster.ca/guidelines.html
Available via https://www.napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids

## Risks of Benzodiazepines in General

Benzodiazepines and Z-Drugs carry significant risk such as:

- Sedation, confusion, drowsiness and postural instability contributing to the risk of falls and subsequent fractures;
- Impairment of psychomotor skills, judgment, and coordination increasing the risk of motor vehicle accidents;
- Negative effects on cognition and memory, delirium, drug-related pseudo dementia and a possible link to cognitive decline and Alzheimer's disease;
- Dependency and abuse potential;
- Risky interaction with medications or herbals;
- Sleep automatism (in the case of Z-Drugs), including food binging, and even driving while asleep or in a sleep-like state.

Even more problematic in older patients…

The risk of motor vehicle accidents, falls, and hip fractures, leading to hospitalization and death, can **more than double in older adults**

Number needed to treat with a benzodiazepine/Z-Drug for improved sleep is 13, whereas

Number needed to harm is only 6!

Glass J, Lanctot K, Herrmann N, Sproule B, Busto U. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. *BMJ*. 2005; 331(7526):1-7. doi:10.1136/bmj.38623.768588.47

# Risks Compound… more meds more risk

Concurrent prescribing of opioids & benzodiazepines/Z-drugs should be avoided

Prescribing 2 or more benzodiazepines/Z-drugs together should be avoided

Consider & discuss risks of combining with other sedating/psychoactive meds and substances

**“… polypharmacy is defined as the concurrent prescribing of five or more medications with sedating and/or psychoactive properties**

Notwithstanding… it is important to note that the inherent risks of polypharmacy also apply in situations where licit (e.g., alcohol and cannabis), or illicit drugs/prescription medications and/or over-the-counter medications with sedating and/or psychoactive properties, are combined with prescribed medications with similar properties

… it is important for the prescriber to educate patients regarding these risks on a regular basis”

*Managing Polypharmacy, Benzodiazepines, Alcohol, & Polysubstance Use in the Context of Opioid Agonist Therapy (CPSM 2022, p. 1)

# So why Prescribing SOPs (thou shalts)?

## CPSM Mandate - To protect the public & ensure quality in the practice of medicine

- Evidence-informed & promote safe and ethical care of all patients

  Try to strike the **best balance possible between benefits & risks**, while remembering **duty to care** (e.g., pain management, Code of Ethics & Professionalism)

- Outline expectations to **balance individual care & public safety**
- **Set clear expectations** around prescribing and promote best practice
- Enable **quality improvement** and inform complaints & investigations processes
- **SOPs are a framework for physicians**

  To explore all possible treatment options with patients, to promote communication, and assist them in making the best choices for themselves

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

**Frequently Asked Questions**

**Prescribing Benzodiazepines & Z-Drugs**
**Medical Purposes**

## *I've never abused my pills - why can't I have more than a month at a time?*

While it may not feel like the risks, harms, or concerns apply to you, CPSM and doctors must set parameters to promote public safety. That means *drawing a line* between safe and unsafe amounts of medication that can be available at one time. This line must balance the needs and lifestyles of both well and unwell community members. CPSM has made similar prescribing rules for benzodiazepines and z-drugs, as with opioid pain medications, because of the known risks of these medications. The Standard makes firm recommendations, or rules, for prescribing and dispensing intervals to limit the supply of these drugs in the community and promote safety. These recommendations are also to ensure that doctors are taking a frequent and active role in managing the use of these medications.

Part of SOP Contextual Info & Resources
(CPSM 2021, p. 5)

# CME Death Review

- Review of deaths in adults 18-65 involving prescription & non-prescription medication (focus on meds with ↑ risk of serious harm & sedating/psychoactive properties)
- **Continue to review a significant number of accidental overdose deaths related to medications prescribed by physicians**
- All prescribers involved in the patient's care receive:
  - Standard cover letter
  - Summary of the ME report
  - Case-specific feedback utilizing standardized quality indicators

- **Letters are primarily educational in nature, to promote registrant reflection on prescribing practices**

# CME Death Review

- CME Death Review Program offers **high-impact regulation**
  - What happened with this death and what can we learn?
  - Opportunity to provide **case-based education** & to **promote self-reflection**
  - Encourage physicians to implement of universal precautions with high-risk medications
  - Case-based learning promotes ability to identify high-risk medication regimes & patient circumstances that may warrant a highly structured approach to care

→ in living patients

- Aligns with CPSM mandate to **protect the public** & **promote quality medical care**

# CME Death Review – MB Themes Emerge

1) Major contributor to medication-related overdose deaths in MB is **POLYPHARMACY**
    - ↑ number sedating/psychoactive meds = ↑ risk
    - Patients rarely die from one prescription med alone
    - Top 2 classes contributing to opioid OD's = benzodiazepines & antidepressants (2014-2017)
    - Leading sedative-hypnotics contributing to deaths = alprazolam & zopiclone (2016/2018)

2) Deaths involving **multiple sedating/psychoactive meds** most often from a **single prescriber**

3) Sedating OTC meds (e.g., diphenhydramine, dimenhydrinate) contribute to many accidental overdose deaths per year

4) Post-mortem toxicology trends have shifted dramatically with COVID-19 & land border closures:
    - More fatal (usually accidental) overdoses involving one or more illicit drugs (i.e., fentanyl or methamphetamine) & blood levels dramatically higher than pre-pandemic

# ME Case Example

Feb 2022

- 45 yo male, Hx of cardiovascular disease, hypertension
- Reportedly watching TV & sleeping in hotel bed with spouse
- Spouse awoke to him struggling to breathe and making choking noises, unable to rouse, called EMS
- Resuscitation on scene, in transport, and at hospital unsuccessful

**COD: Fentanyl Toxicity**

**Accidental**

# ME Case – Toxicology

Feb 2022

| Toxicology: | | Therapeutic Range (in ng/ml unless specified) |
|---|---|---|
| Codeine(free)* | 0 ng/ml | 10-100 |
| Morphine(free) | 0 ng/ml | 10-80 |
| *Codeine was detected in the qualitative drug screen but was insufficient for quantitation. | | |
| Oxycodone | 96 ng/ml | 10-100 |
| Oxymorphone* | 3.2 ng/ml | |
| *Therapeutic blood concentrations of oxymorphone are not established. Existing data suggests reference ranges similar to hydromorphone (1-30 ng/ml) | | |
| Alprazolam | 23 ng/ml | 25-55 |
| Alpha-hydroxyalprazolam | 0 ng/ml | |
| Diphenhydramine | 91 ng/ml | 14-112 |
| Fentanyl* | 33 ng/ml | |
| *Within 24 hours of the application of a 100 ug/hr transdermal patch, the expected serum concentration is 1.9-3.8 ng/ml. | | |
| Gabapentin | 10 ug/ml | 2-20 ug/ml |

# ME Case – DPIN

Feb 2022

**DPIN Review:**

| Medication | Directions per DPIN | Quantity/Date Dispensed |
|---|---|---|
| Alprazolam | 0.5 mg QD | 14-day supply dispensed December 1, 2020 |
| Alprazolam | 1 mg QD | 14-day supply dispensed November 12, 2020 |
| Gabapentin | 600 mg QD | 30-day supply dispensed November 12, 2020 |
| Tylenol #3 | 30 Q14 days | 14-day supply dispensed December 1, 2020 |
| Tylenol #3 | 30 Q14 days | 14-day supply dispensed November 12, 2020 |
| Amlodipine | 10 mg QD | 30-day supply dispensed November 12, 2020 |

Controlled biweekly dispensing is noted.

**Concerns**

1. Concurrent prescribing of an opioid and a benzodiazepine.

**Not the scariest DPIN**, but highlights how sedating/psychoactive meds can compound with non-prescribed substances & OTC

# ME Case – Recommendations

Feb 2022

- Awareness of ↑ number of accidental medication overdose deaths related to OTC use – diphenhydramine commonly implicated!
- Regular UDS & asking about OTC/other (street) drug use is **very important screening** for patient safety & consistent with SOPs

***Please note that the Standard of Practice for Prescribing Opioids section 2i states:** ***Require baseline urine drug testing prior to initiating an opioid trial, and require random and/or periodic urine drug testing on an annual basis, or more frequently if there are concerns.***

- Consult! With Pharmacist re: OTCs, consider referral to Addiction Specialist (CARMA) if OUD suspected, discuss non-judgmentally with patient

# Prescribing SOPs Pearls

- **Optimize other treatment modalities:** non-pharmacological first, then optimize opioid/benzodiazepine/Z-drug medications
- Review **DPIN**, eChart, or consult with a pharmacist to obtain DPIN info
- Comprehensive Assessment, History, & Exam are needed – Re-assess regularly
- Lowest effective dose for the shortest possible time
- **Avoid concurrent prescribing** of opioids & benzos/Z-drugs, multiple benzos/Z-drugs, use caution with polypharmacy.
- Monitor adherence & potential for other substance use – UDS can be important tool
- Consult with experts, collaborate with pharmacy, gather a team as able

# Prescribing SOPs Pearls – Document!

- **Discuss with patient & document:**
  - Treatment goals & discontinuation strategy
  - Set realistic expectations for modest benefit
  - Risks associated with treatment & the impairment caused by these drugs
- Document exceptional circumstances & the plan – prescribers are reminded the pharmacy requires this information
- Long-term use must be supported by current clinical evidence: **rare**
  - Thorough documentation of effectiveness with benefits outweighing harms is **required**

# Prescribing SOPs Pearls – Prescriptions

- Explicit instructions must be provided to the patient re:
  - **Appropriate use, quantity, number of days supply is intended to last**
- **Dispensing interval**, indicating the number of days the supply is anticipated to last, must be noted on the prescription (e.g., dispense X tablets every Y days)
- Only write a prescription for a **maximum of three months**, with **dispensing to be authorized for no more than a one-month supply**
- On an **exceptional basis**, members may authorize a dispensing interval of up to three months for patients in remote communities, or travelling, if the patient has been on a stable long-term prescription (including snowbirds)
  - Such exceptions should be written on the prescriptions!

# Prescribing SOPs Pearls

- A trial of tapering is almost always indicated in the context of long-term use, sometimes repeatedly over time, especially as patients age

**7. Continued Prescribing of Opioids for Patients with Non-Cancer Pain**

Continued prescribing of opioids for patients with non-cancer pain under Parts II-VI must only occur if there is documentation of:

i. measurable clinical improvement in pain, function, and quality of life evaluations and

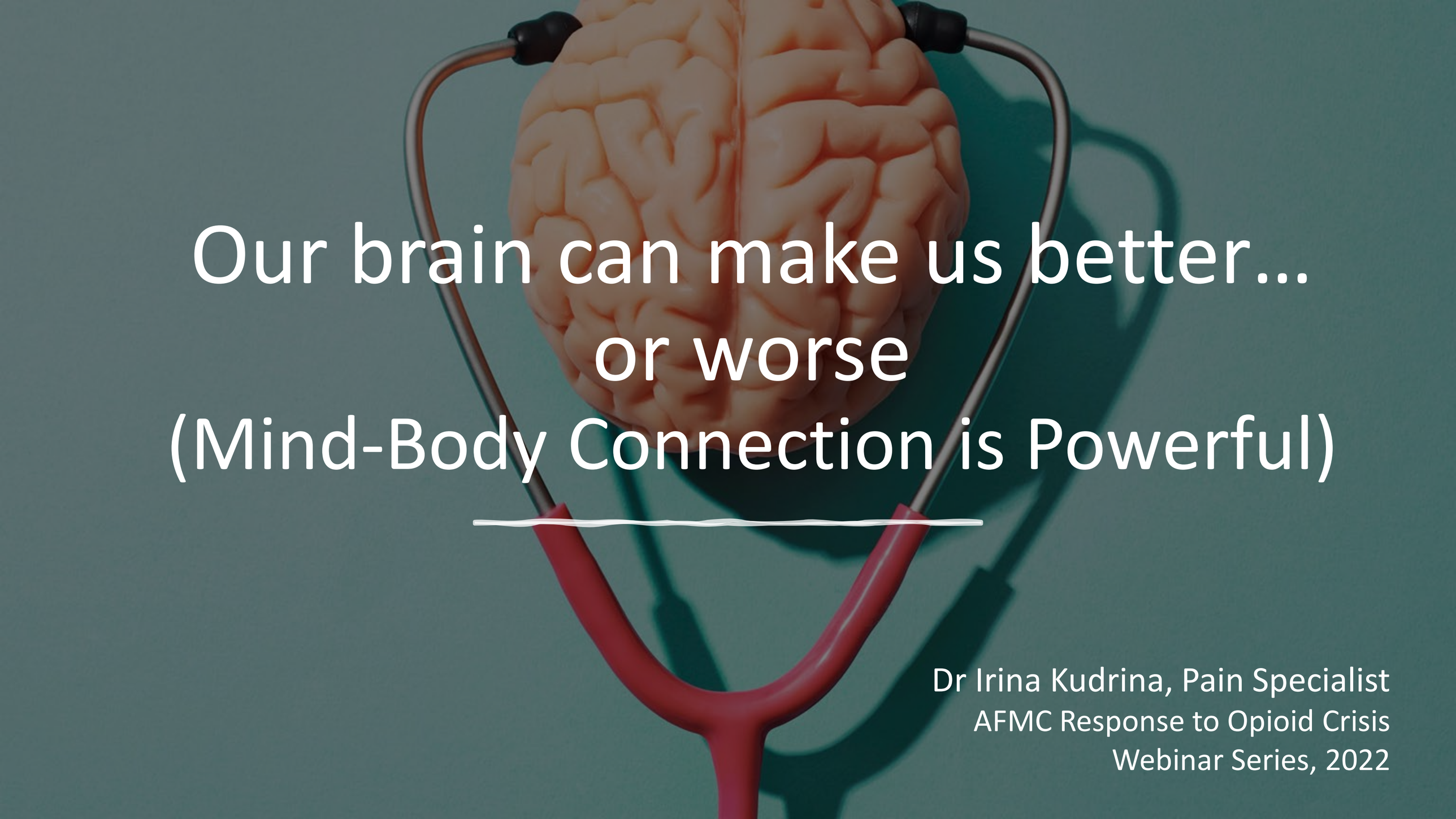
ii. maintenance of a satisfactory level of improvements in these parameters which outweighs the risks of continued opioid treatment.

Continuing to prescribe opioids, or even the same dose of opioids, solely on the basis that they have been prescribed previously is not acceptable.

**BUT!**

# Prescribing SOPs – Clinical Thoughts

- **Abrupt tapers or discontinuation NOT recommended**
- Slow & steady can win the race (gradual is best unless significant safety issue)
- CHANGE is HARD for ALL OF US – understanding & compassion breed patience
- Tapering can be difficult, but possible – celebrate small wins
  - Help patients know what to expect from dose decreases – explain possible withdrawal symptoms, reassure will pass in time, discuss ways to cope
  - Even SMALL step downs count & not everyone must get to ZERO
  - Give it time… many don't experience benefits (↑ cognition/life engagement) until later
  - Settle back to "baseline" before next step, some need "taper honeymoons" with acute stress or time to build coping skills before continue (but avoid going back up!)



# Our brain can make us better… or worse (Mind-Body Connection is Powerful)

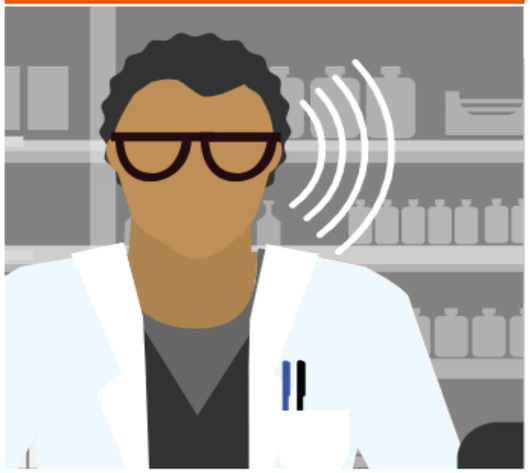
Dr Irina Kudrina, Pain Specialist

AFMC Response to Opioid Crisis
Webinar Series, 2022

# Tips for Difficult Conversations

- Lean in – with body language AND intention, even for the hard stuff
- Don’t take it personally – Keep perspective to keep inner calm
  - Separate your personal self from the clinical picture – even if patients are angry or accusatory, or “dumping” difficult thoughts & feelings
  - Set boundaries for how you/fellow staff expect to be treated – respect works both ways
- Respond, don’t react
  - Take a breath, drop your shoulders, LISTEN, pause, then respond
  - Try not to argue, dispute, or fix – let them feel, express, & validate their experience (fear, frustration, anger, worry, sadness)
  - Offer support & education when/if ready – empower choice where you can
- Cultivate compassion over judgment or labelling

## STOP
**AND LISTEN**



**STOP & LISTEN** to your patients. Patients are more likely to engage when you communicate your concern for their wellbeing.

**LEARN MORE**

## DROP
**STIGMA AND TALK ABOUT OPIOIDS**

**DROP STIGMA AND TALK ABOUT OPIOIDS** Avoid assumptions about a patient's pain, life situation or willingness to talk. Share accurate information about opioids.

**LEARN MORE**

## ROLL
**WITH RESISTANCE**

**ROLL WITH RESISTANCE** and encourage patients to work with you. Focus goals on what the patient wants to improve their quality of life -not only on pain scores.

**LEARN MORE**

**Success is engaging in an ongoing conversation about safe opioid use.**

n-toolkit-engaging-effective-conversations-about-opioids#

https://www.napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids

**Patient Centered Care**

≠ giving patients what they ask for despite harms

Our Practice requires clinical reasoning & discretion applied to **shades of grey**…

based in knowledge, experience, evidence, standards, & individual contexts that incorporate patient needs, values, & preferences

# Common Questions

**To help with patient access, can prescribers write opioid and benzo prescriptions for 30-day supply, to be released every 28 days?**

- Not in keeping with spirit of the SOPs
  - Potential for stockpiling over time
  - Need balance patient access with risk of large quantities available for personal & public safety
  - Intention for patients to use meds “as prescribed” – extras overtime can lead to overuse & can be difficult for tapering patients to have surplus supply
- Giving an extra 1-2 days of meds on one occasion (either separate Rx or a note on same Rx) may be a reasonable alternative to accommodate patient, in exceptional circumstances
- Ultimately, need to avoid consistently giving more than 30 days of meds in a 30-day period

# Common Questions

**Are opioid/benzo prescriptions only valid for 3 months after the day it was written? What if the Rx still has tablets remaining to be dispensed after the 3 months have elapsed?**

- Use **professional judgment** & **discretion**
- Spirit of SOP is re-assessment (in-person) by prescriber to determine appropriateness of medication (ideally q 3 mo, i.e., maximum duration for Rx – more frequent as needed)
- So, “best/better practice” if “expire” after 3 months, however, may be a situation where pharmacist could fill a prescription if quantities remained, *but reassessment by the prescriber may be advisable*
  - Must consider on individual case basis for filling refills or part fills
  - Must balance patient need & safety, considering patient context, medical Hx, indication, psychosocial status, safety… Can certainly **collaborate with prescriber**
  - **Document** rationale & plan!

# Common Questions

**Similarly….**

**Is it required for prescribers to assess all patients receiving opioid or benzo prescriptions every 3 months or can pharmacists just fax refill requests**?

- SOPs set framework for physicians to take a frequent, active role in managing these medications
  - Regular, in-person, re-assessment promotes quality medical care, monitoring, communication, & assessment of ongoing benefits and risks
  - May not always be possible (exceptional circumstances) – bridging & supporting patient in **collaboration** with prescriber is also in keeping with spirit of the SOPs – *want to avoid abrupt discontinuation of these meds*
  - **Document** rationale & plan for follow up

https://cpsm.mb.ca/news/prescribing-supplying-opioids-benzodiazepines-z-drugs-to-travellers-or-snowbirds



# No exceptions to Standards, even for Snowbirds!

## PRESCRIBING/SUPPLYING OPIOIDS, BENZODIAZEPINES/Z-DRUGS TO TRAVELLERS OR "SNOWBIRDS"

**November 09, 2021** | **Prescribing Practices**

*Updated August 31, 2022*

CPSM Standards for Prescribing Opioids and Benzodiazepines and Z-Drugs came into effect on September 30, 2018, and November 1, 2020, respectively. The College of Registered Nurses of Manitoba (CRNM) Practice Direction for RN(NP) Opioid Prescribing to Treat Non-Cancer Pain has been in effect since March 2020. On April 15, 2021, the College of Pharmacists of Manitoba (CPhM) Companion Document to the CPSM Standards of Practice was also approved.

### Prescribing and Dispensing of Opioids and Benzodiazepines

On an exceptional basis, prescribers may only authorize a dispensing interval of up to three months for these medications


See all news

Archives

2022 - September
2022 - August
2022 - July
2022 - June
2022 - May
2022 - April
2022 - March

# CPSM PPP Role

- Answer inquires to help providers interpret & apply the SOPs
- Individual case discussion & support
- Support more effective communication with physicians

  (need **physician name & patient demographics** by secure email or fax)
- Physician education, advice, guidance on tricky cases
- Collaborate with CPhM

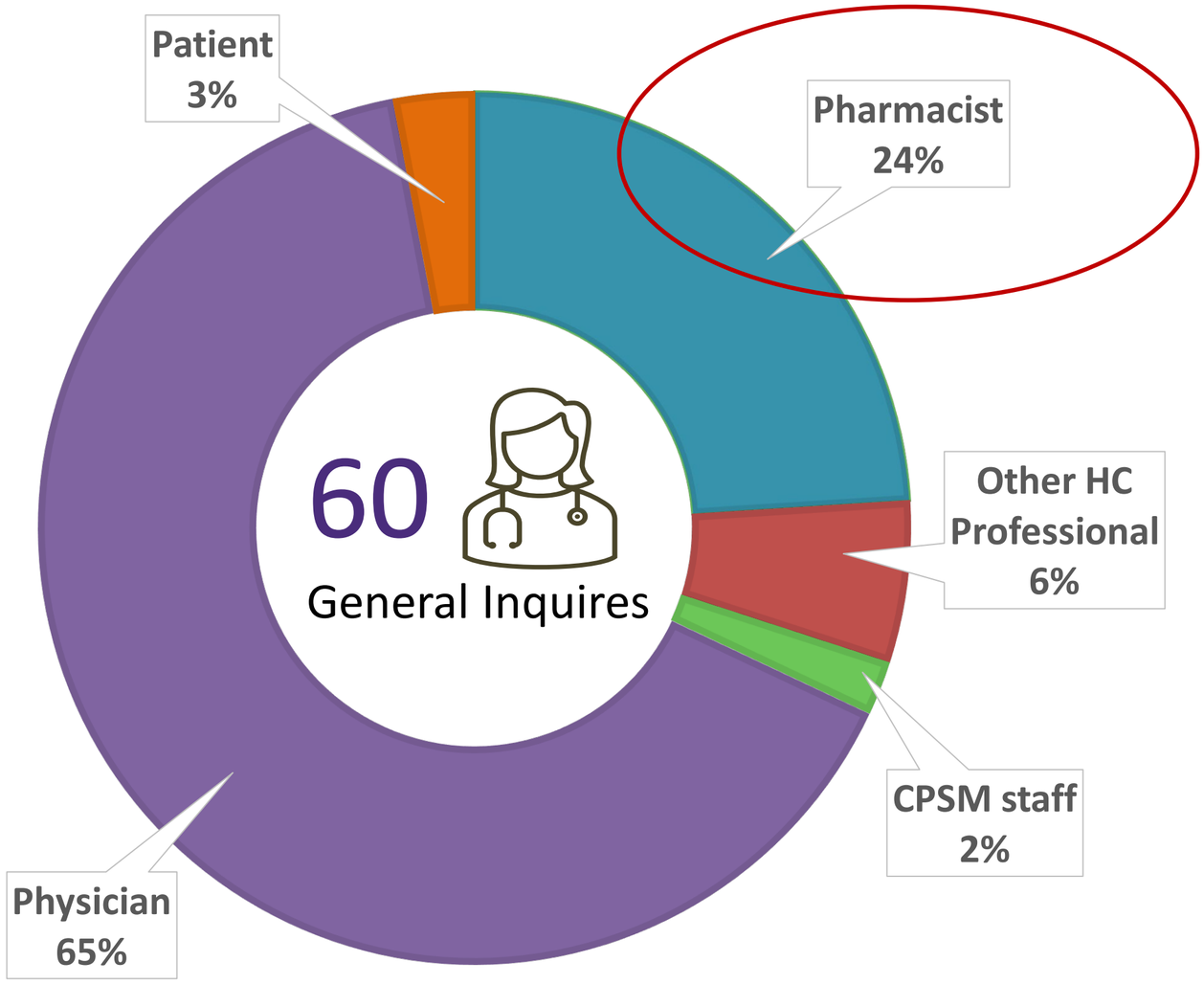
28% 

General Inquires were re: **Benzo/Opioid SOPs**

May 2021-April 2022

# CPSM Collaboration

## Inquiry Source May 2021-April 2022




When Benzo/Z-Drug SOP first came into effect (2020)

Who was Calling?

- 63% Pharmacists seeking guidance
- 15% Physicians seeking guidance
- 15% Patients/Community with questions
- 7% CPSM colleagues, in-house collaboration

Nov 2020-Sept 2021

# Questions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