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EXAMPLE ONLY

Narcotic Report Card

Provider A

January 1, 2018 – December 31, 2019

The following report is proprietary information and constitutes trade secrets of The MetroHealth System and may not be disclosed in whole or part to any external parties without the express consent of The MetroHealth System. This document is intended to be used internally for The MetroHealth System discussion.

Why am I receiving this?

The Office of Opioid Safety reviews provider prescribing patterns using data collected from the Ohio Prescription Drug Monitoring Portal (OARRS). This includes data for attendings, residents, and advanced practice providers. The prescribing provider is then compared to other prescribing providers in their specialty. This data includes any institution the provider is associated with during the time period. Averages are based on that specialty group only. A report is retrieved from OARRS for each provider in a specialty group. The time period reviewed for this analysis is 2018 and 2019. Each provider report is compiled into one report for provider comparison.

The narcotic prescribing report cards are **informational only**. Our goal is to provide data that can help you understand your prescribing patterns relative to your peers in the context of the CDC Guidelines for Prescribing Opioids for Chronic Pain.

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CDC Guidelines

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

1) 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.

2) Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3) Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy

4) When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5) When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6) Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

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CDC Guidelines

7) Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

8) Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9) Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10) When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11) Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12) Clinicians should offer or arrange evidence-based treatment (usually medication assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

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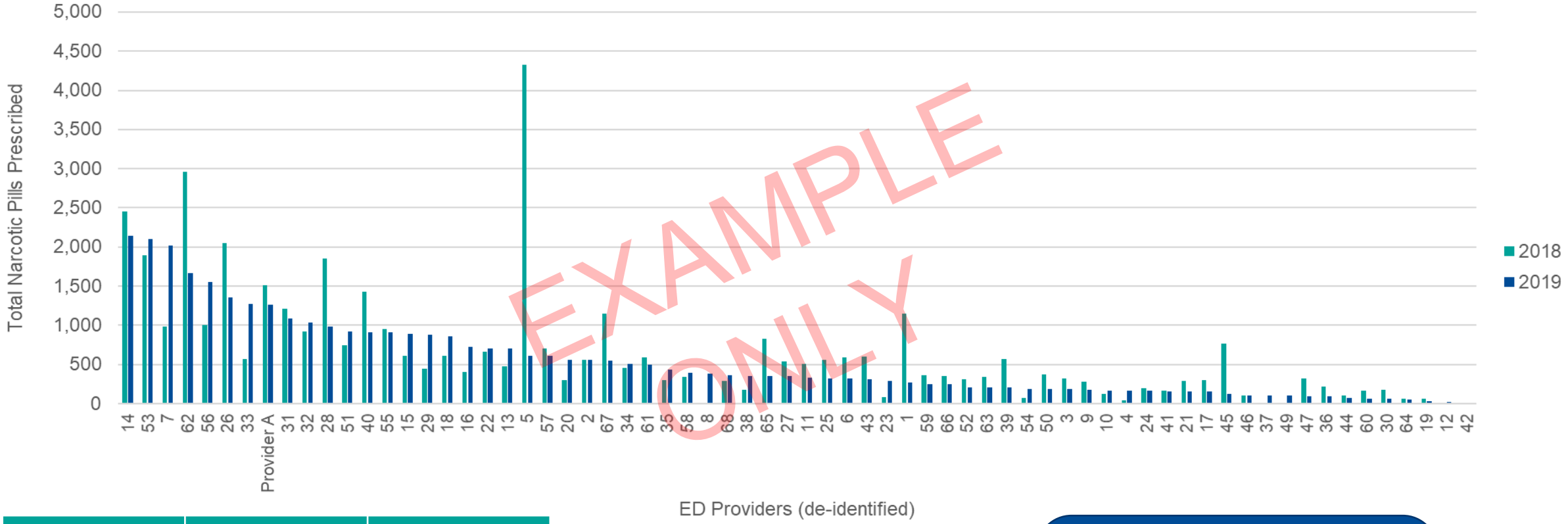
Graph 1- Total narcotic pills prescribed and filled as reported by OARRS for 2018 & 2019

OARRS Data



	2018	2019
Provider A	1,506	1,263
Average	662	528
	128% Higher	**139% Higher**

*See slide 11 for drug category key

CDC Recommendation #1
- Opioids are not first-line therapy.

CDC Recommendation #6
- Prescribe short durations for acute pain.

Graph 2- Total narcotic prescriptions prescribed and filled as reported by OARRS for 2018 & 2019

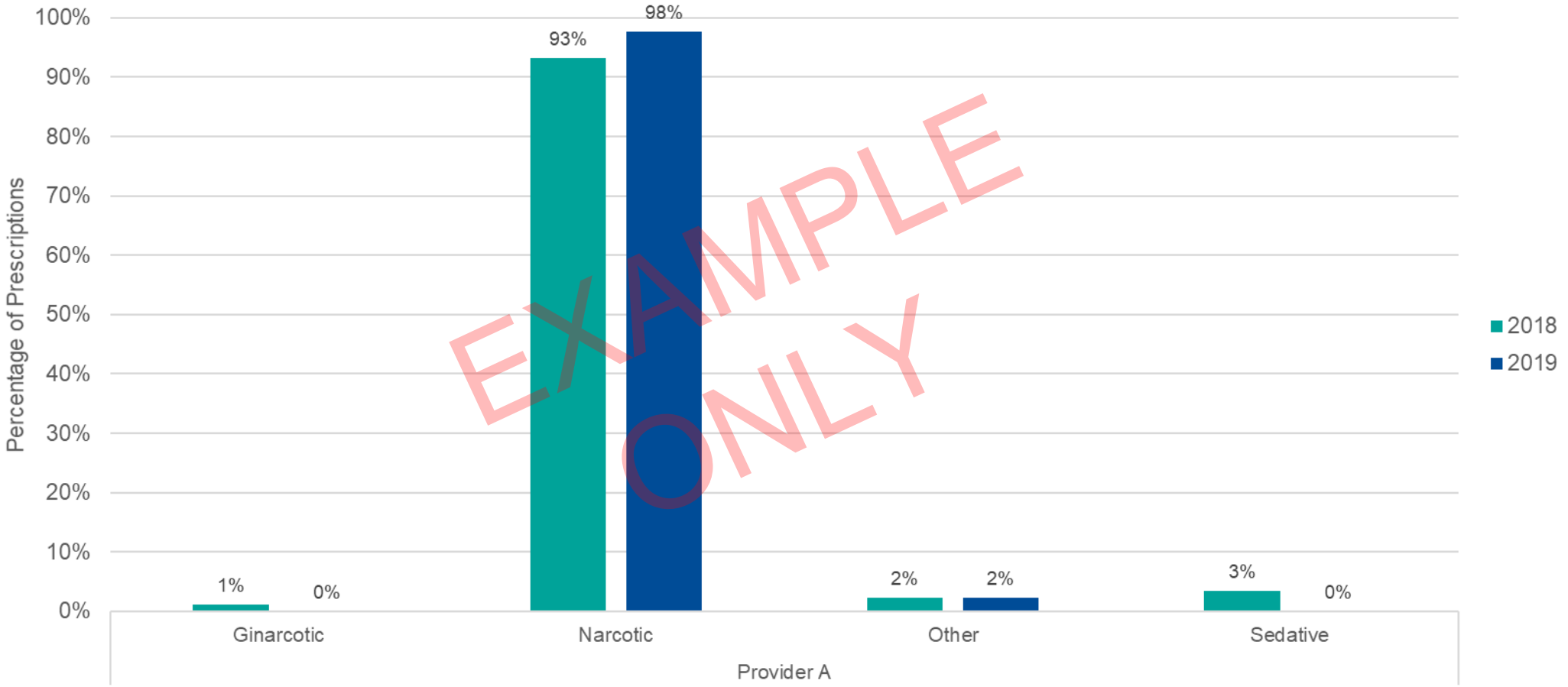
OARRS Data

	2018	2019
Provider A	78	81
Average	48	40
	63% Higher	**103% Higher**

*See slide 11 for drug category key

Graph 3- Percentage of medications prescribed and filled by OARRS category for 2018 & 2019.

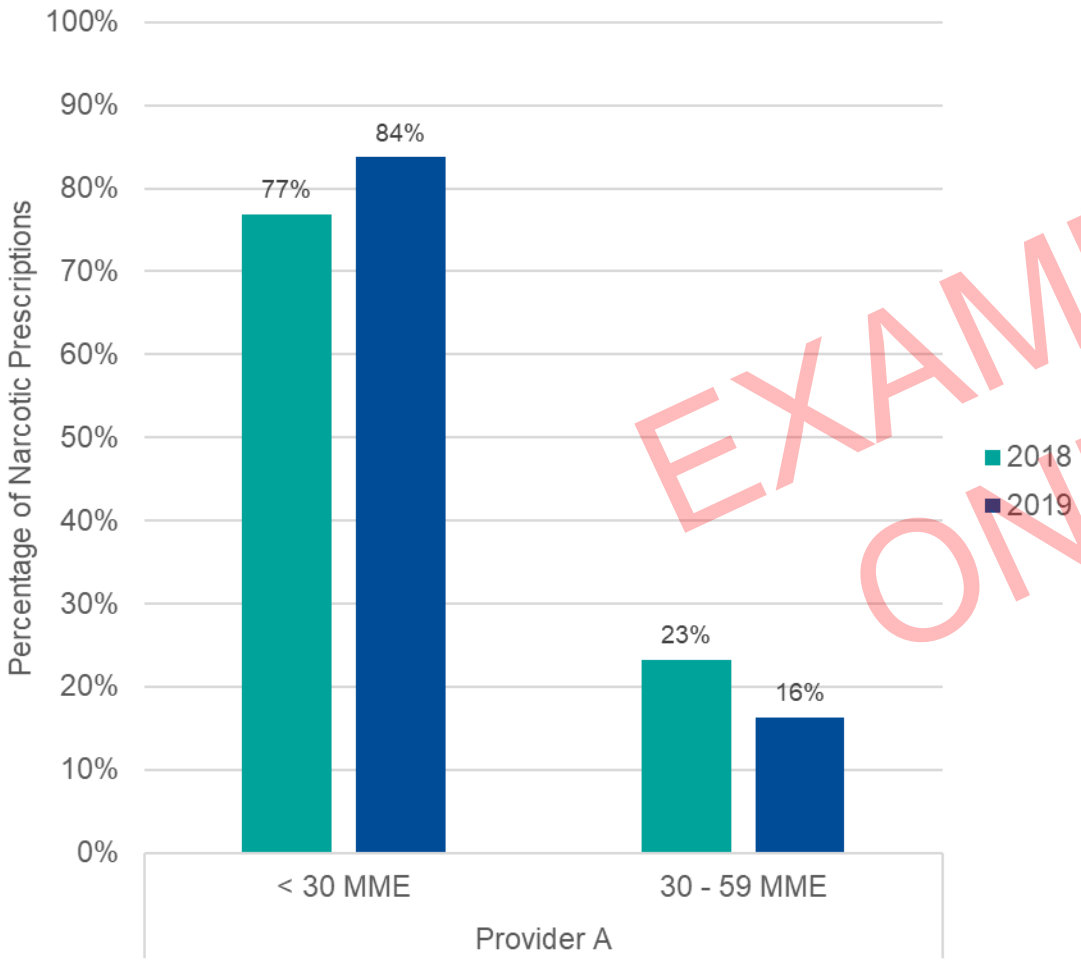
OARRS Data



*See slide 11 for drug category key

Graph 4- MME Percentage of narcotic prescriptions for 2018 & 2019.

OARRS Data



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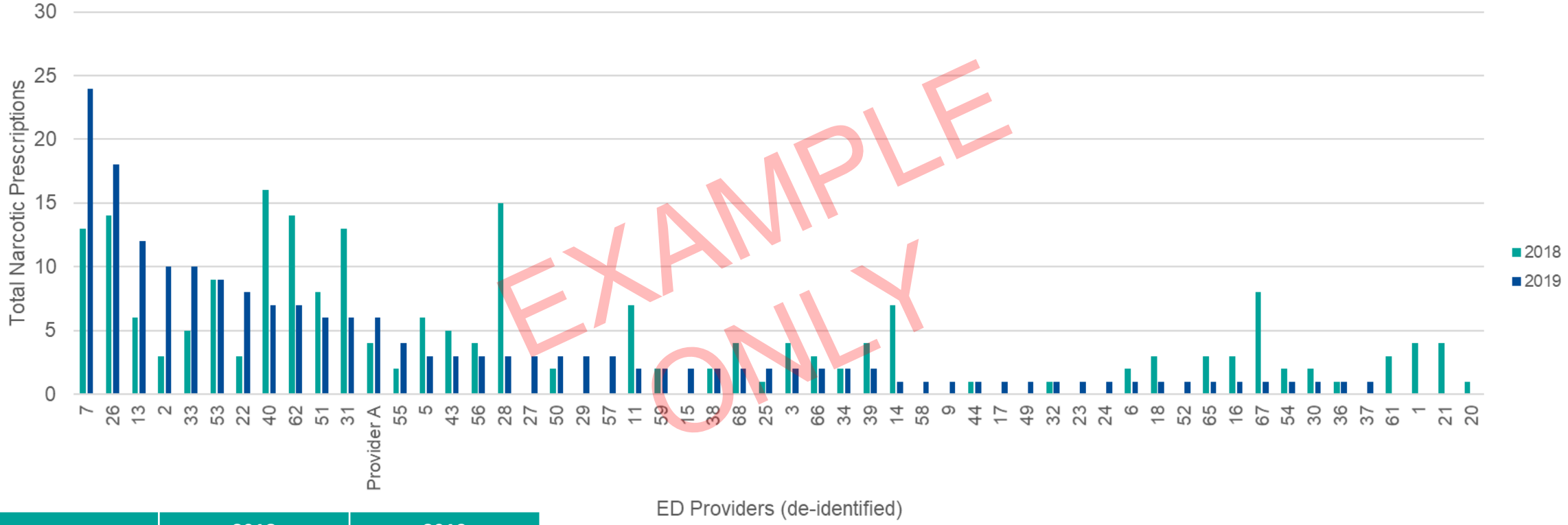
The CDC Recommendation #5

- The lowest effective dose should be prescribed.
- Extra caution should be taken with > 50 MME per day.
- If patients do not experience improvement in pain and function, discuss alternatives and work to taper and discontinue.
- ≥ 90 MME dosage should be considered for a pain consult.

*See slide 11 for drug category key

Graph 5- Total narcotic prescriptions prescribed and filled with a back related diagnosis for 2018 & 2019.

OARRS Data

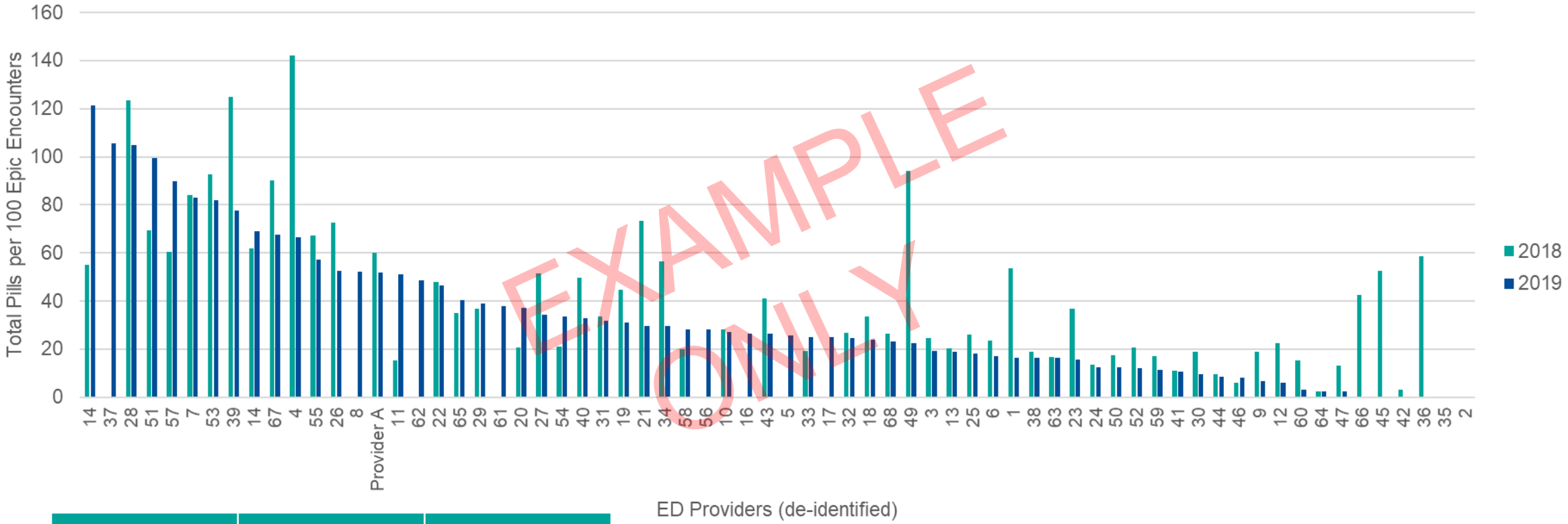


	2018	2019
Provider A	4	6
Average	5	4
	20% Lower	**50% Higher**

*See slide 11 for drug category key & slide 12 for back related diagnoses

Graph 6- Narcotic pills per 100 Epic encounters

Epic Prescribing Data



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	2018	2019
Provider A	60	52
Average	36	33
	67% Higher	**58% Higher**

*See slide 11 for drug category key

Table 1- Multiple controlled substances prescribed and filled on the same day for 2018 & 2019

You have 0

ID	Provider A
TABLE 1- MULTIPLE RX SAME DAY	
PATIENT	**Total Rx**

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CDC Recommendation #11

- Avoid prescribing concurrent opioid and benzodiazepine prescribing whenever possible.
- Avoid prescribing opioids and other CNS depressants (muscle relaxants and hypnotics) whenever possible.

Drug Category Key

Drug Category Key					
Narcotic		Other	Sedative	Stimulant	Ginarcotic
Acetaminophen- Codeine	Hydromet	Cyclobenaprine	Diazapam	Vyvanse	Diphenoxylate - Atrop
Belladonna- Opium	Hydromorphone	Gabapentin	Eszopiclone	Dextroamp - Amphetamin	
Butalb- Acetamin- Caff- Codeine	Lorcet	Narcan	Isomethept - Dichloralp - Acetamin	Methylophenidate	
Cheratussin	Lortab	Naltrexone	Lorazepam		
Codeine- Guifen	Morphine	Naproxen	Lyrica		
Fentanyl	Oxycodone		Phenobarbital		
Guaiatussin	Oxycodone- Acetaminophen		Pregabalin		
Hydrocodone- Acetaminophen	Promethazine		Zolpiden		
Hydrocodone- Chlorphen	Tramadol				
Hydrocodone- Homatropine	Virtussin				

Narcotic Data Exclusions
Buprenorphine
Suboxone

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Back Related Diagnoses Included
Low back pain
Lumbago
Muscle spasm of back
Other specified dorsopathies
Other spondylosis
Pain in thoracic spine
Radiculopathy
Sciatica
Strain of muscle, fascia, and tendon of lower back

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Resources

CDC Guidelines for Prescribing Opioids for Chronic Pain

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

CDC Training for Providers

https://www.cdc.gov/drugoverdose/training/index.html

CDC Opioid Guideline Mobile App

https://www.cdc.gov/drugoverdose/prescribing/app.html

CDC Information for Providers

https://www.cdc.gov/drugoverdose/providers/index.html

Ohio Department of Mental Health and Addiction Services

https://mha.ohio.gov/Researchers-and-Media/Combating-the-Opioid-Crisis/Opioid-Prescribing-Guidelines

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