# Caring for Legacy Patients

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# Objectives

- Participants will be able to define what is meant by legacy patients and legacy prescribing
- Participants will be able to determine risks and benefits of maintaining previous plans of care versus making changes to plans of care
- Participants will be able to identify situations where involuntary tapering may be appropriate

# Disclosures

- I have nothing to disclose

# Example Case

- 49 year old Mr. Green
- Past medical/surgical history
  - Lumbar fusion L4-5 at age 32
  - Femur fracture with hardware reconstruction age 40
  - Suicide attempt  at age 43, took pills, ICU with intubation
- Social history
  - On disability for back pain since age 33, prior work as construction laborer
  - Unmarried & unpartnered, 1 child age 19 lives with his mother
  - No longer drives since an OUI at age 40, lives in a subsidized apartment, limited income
  - Has mother nearby and younger sister as supports to him

# Example Case

- Substances
  - Tobacco, about 15 cigarettes per day
  - Alcohol, history OUI/DWI, currently drinks a 6-pack "every few days"
  - Remote cocaine use, but no other illicit substances
- Relevant problem list
  - Obesity, BMI 35
  - Sleep apnea, not using CPAP
  - Depression with anxiety
  - Hypertension
  - Hyperlipidemia
  - Fatigue

# Example Case

- Current Medications
  - Duloxetine (Cymbalta) 60 mg once daily
  - Atorvastatin 20 mg once daily
  - Lisinopril 20 mg daily
  - Lorazepam 2 mg  tid, since age 40
  - Methadone 10 mg tid, since age 32
  - Oxycodone/Acetaminophen 10/325, 2 tablets qid PRN, but refills this every 28 days and regularly takes 8 pills per day, added at age 40
  - Methylphenidate 10 mg tablets x 4 daily, since age 45

# Example Case

- Mr. Green has been under the care of Eddie's Pain Clinic and Primary Care
- Eddie's recently experienced an abrupt closure for unknown causes
- Patients with appointments at Eddie's arrived for their appointment to find an empty office and a paper sign on the door stating that the office was now closed
- Mr. Green's prescriptions all came from the providers at Eddie's Pain Clinic and Primary Care

# Example Case

- You are a primary care provider working in a health clinic with 6 other providers
- Mr. Green was accepted into the practice and is on your schedule to get established with you today
- He is scheduled for a 40 minute appointment just before your lunch break
- Your office is unable to obtain medical records from the closed clinic

# Legacy Patients

- Defined by the College of Physicians & Surgeons of Nova Scotia

> "Legacy patients are defined as those whose care is taken over by a physician after treatment was initiated by another provider."

College of Physicians & Surgeons of Nova Scotia (2022). Caring for Legacy Patients. https://cpsns.ns.ca/resource/caring-for-legacy-patients/

# Legacy Prescribing

- This is prescribing that continued beyond the usual length of time and are not discontinued after the usual recommended period

Mangin, Lawson, Cuppage, Shaw, Ivanyi, Davis, & Ridson (2018). Legacy drug-prescribing in primary care. Annals of Family Medicine, 16(6), 515-520.

# Navigation

Start Here

End Here

# HPI

- Mr. Green says that he went  to his usual monthly appointment at Eddie's and saw the sign
- He needed his medications refilled that day, so reported to the local emergency department affiliated with your health organization, where providers gave him a 3-day supply of all of his medications
- He was then given an appointment with you
- He needs his medications filled today

# HPI

- Mr. Green explains that opioids were started just prior to his lumbar fusion surgery and they were never discontinued
- He tells you that he lives with lumbar pain 10/10 every day
- He says that his pain pills take the edge off
- He also tells you that his leg still hurts because it has metal in it
- He broke his leg in a single car accident, he says that he fell asleep at the wheel, but did get charged with DWI and lost his driver's license

# HPI

- After losing his license he became very depressed and attempted suicide by taking all of his pain pills and full bottle of acetaminophen
- He then got scared and called his sister before he passed out
- He was brought to the hospital and treated with supportive care, opioid reversal, and was in the ICU intubated for 48 hours
- After his suicide attempt, he was put on duloxetine and lorazepam

# HPI

- He went to counseling and has not been having suicidal thoughts since that time
- He is quite distressed about the closure of his provider's office and is scared that he will go into withdrawal
- He did experience withdrawal after his suicide attempt because he had over taken his opioids

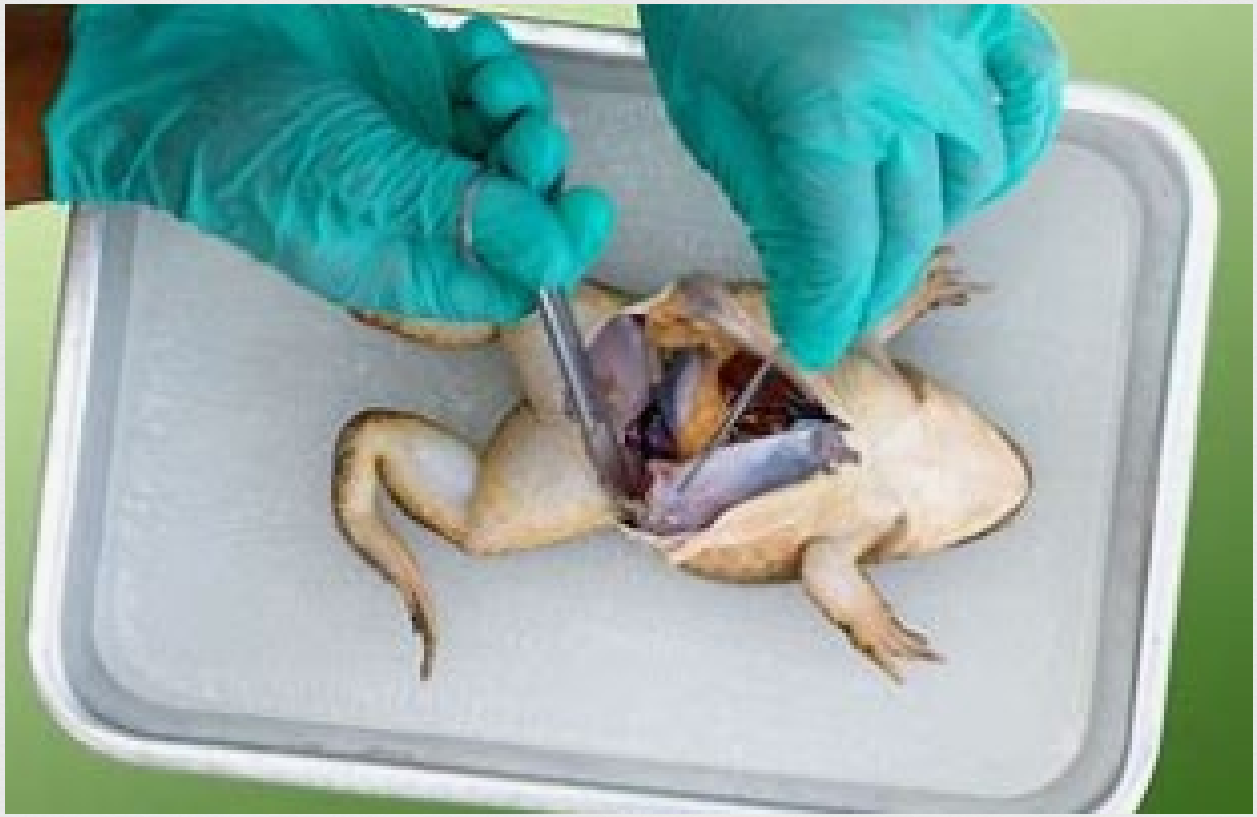
# ROS

- General: + fatigue
- Gastrointestinal: + constipation
- Musculoskeletal: + back pain, + neck pain, + right thigh pain, + bilateral knee pain, + bilateral shoulder pain, + bilateral elbow pain, + bilateral hand stiffness
- Neurological: all negative
- Psychological: + anxiety, + irritability, + difficulty focusing, + difficulty remembering

# Examination

- General: Not ill appearing, sitting comfortably in exam room chair
- VS: 134/80, 85, 14, 98.4F
- HEENT: Normal
- Cardio: Normal rate and rhythm, no cyanosis, radial and pedal pulses present and normal
- Respiratory: Normal
- GI: Non-tender, + bowel sounds
- Musculoskeletal: Fluid gait, able to heel and toe walk without difficulty, full ROM lumbar and cervical spine, tender to light palpation over lower, mid, and upper back.
- Neuro: Normal strength upper and lower extremities, knee jerk, Achilles, triceps, and brachioradialis DTR normal
- Psych: Normal thought process, mildly anxious

# The Dissection



# Decision Making

- What are Mr. Green's priorities for this visit?
- What are your priorities for this visit?
- What worries you about Mr. Green's history that you know?
- What further evaluations would you like to obtain for Mr. Green?
- What changes (if any) would you recommend for his care plan?

# Mr. Green's Priorities

- Prescription medications
- He faces withdrawal if you do not fill his medications TODAY
- He has experienced withdrawal in the past

# Provider Priorities

- To provide evidence-based care for all your patients
- To provide safe care for you patients
- To comply with regulations and recommendations
- To keep this patient from needing emergency care
- To make sure he has had full work up of his painful conditions

# Your Worries

- History of suicide attempt
- Alcohol use disorder with ongoing use
- Apnea and tobacco use
- Multiple controlled medications with questionable indication
- Pain care plan that (medication) exceeds current recommendations
- He continues to have a high level of pain in spite his high risk medications
- He is experiencing a rather decreased level of function
- He seems to lack a personal support system

# Further Evaluations

- How does Mr. Green spend his time?
- Imaging?
- Labs?
- What's on your differential?
  - Hyperalgesia?
  - Rheumatologic conditions?
  - Centralized pain syndroms/fibromyalgia?

# What Changes?

- Changes for today?
- Anticipatory guidance for future changes?
- Making no changes?

# Making Changes Today

- You only get one first date
  - You really need to make a speedy decision on this prescribing
  - Continuing prescribing will send a message that this is ok with you
- There are benefits and risks to making changes today
  - Benefits: begin to improve their safety and move toward evidence-based care
  - Risks: Patient alienation and creating a negative relationship with the patient

# Crafting Changes to Medications

- Duloxetine 60 mg daily
- FDA approval for major depressive disorder, generalized anxiety disorder, diabetic peripheral neuropathy, fibromyalgia, and chronic musculoskeletal pain.
- The balanced activity in serotonin and norepinephrine reuptake inhibition modulates the descending inhibitory pain pathways (Sayed)
- Duloxetine offers modest to moderate improvement for pain with low incidence of drug adverse events (Weng)

Sayed, D., et al. (2024). Systematic guideline by the ASP workgroup on the evidence, education and treatment algorithm for painful diabetic neuropathy. Journal of Pain Res, 13(17), 1461-1501.

Weng, C., et al. (2020). Efficacy and sfety of duloxetine in osteoarthritis or chronic low back pain: A systemic review and meta-analysis. Osteoarthritis Cartilage, 28(6), 721-734.

# Crafting Changes to Medications

- Atorvastatin 20 g daily
- Indicated for primary and secondary prevention for cardiovascular events in those with CV risk factors
- Risks include myalgia, myositis, and rhabdomyolysis and may increase risk of hepatic injury. Also, rare reports of cognitive impairment

FDA.

Khan, D.A., et al. (2022). Drug allergy: A 2022 practice parameter update. Journal of Allergy and Clinical Immunology, 150(6), 1333-1393.

# Crafting Changes to Medications

- Lisinopril 20 mg daily
- Indicated for essential hypertension
- Lowers risk of cardiovascular events including heart failure
- Risks include renal impairment, hypotension, hyperkalemia, angioedema
- Common SE: cough.

FDA.

# Crafting Changes to Medications

- Lorazepam 2 mg, TID
- Indicated for the SHORT TERM management of anxiety disorders
- Risks: CNS depression, respiratory depression, dependence and withdrawal, misuse, paradoxical reactions

FDA.

# Crafting Changes to Medications

- Methadone 10 mg TID
- Indicated for the treatment of pain  where patients are intolerant to other medications or have developed tolerance to other medications (FDA).
- Risks: Respiratory depression, cardiac arrhythmias, drug interactions, overdose risk is higher than other long acting opioids, dependence
- SE: somnolence, nausea constipation, xerostomia, serotonin syndrome, pruritus, diaphoresis, neurotoxicity

Aman, M.M., et al. (2021). The American society of pain and neuroscience (ASPN) best practices and guidelines for the interventional management of cancer-associated pain. Journal of Pain Resources, 16(14), 2139-2164.

# Crafting Changes of Medications

- Oxycodone/APAP 10/325 x 8 per day
- Indicated for the treatment of pain that is severe enough to require an opioid and for which alternative treatments are inadequate.
- Risks: addiction and misuse, respiratory depression, hepatotoxicity, gastrointestinal risks, increase in intracranial pressure, seizure risks

FDA.

# Crafting Changes to Medications

- Methylphenidate 10 mg x 4 times a day
- Indicated for the treatment of attention deficit/hyperactivity disorder (ADHD) and narcolepsy in children and adults
- Risks: increase blood pressure, increased heart rate, exacerbation of pre-existing psychosis, mania, hallucinations/delusional thinking, misuse, decreased appetite, development of tics

FDA

Bies, R., (2023). The risk of methylphenidate pharmacotherapy for adults with ADHD. Pharmaceuticals, 16(9) 1292.

# Where to Go

- Duloxetine has a clear indication for this patient and likely benefits outweigh the risks, most would elect to keep this medication
- Atorvastatin may be indicated based on his cardiovascular risks. We do not have quite enough information to judge indication. However, there are risks of myalgia and maybe cognitive trouble. Consider to trial of stop to this medication and evaluate effect to this patient's pain

# Where to Go

- Lisinopril is likely indicated although we do not have any notes showing diagnosis and monitoring
- Proceed with caution if there is a chance that the methylphenidate is driving the hypertension as changes in that drug could result in hypotensive issues
- Most providers may choose to continue this medication

# Where to Go

- Lorazepam 2 mg TID
- This medication does not have long term indications
- Risks of respiratory depression and premature death increase with this medication along side opioids
- Many providers would consider tapering this medication
- Taper should be low and slow based on longer length of therapy and to reduce destabilization
- 10% reduction every 4-8 weeks. In this case about 0.5 mg at a time.

# Where to Go

- Methadone 10 tid (30 mg daily)
- MME Calculation per CDC
- 30 x 8 = 240 MME

| OPIOID (doses in mg/day except where noted) | CONVERSION FACTOR |
|---|---|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1-20 mg/day | 4 |
| 21-40 mg/day | 8 |
| 41-60 mg/day | 10 |
| ≥ 61-80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |

# And, Where to Go

- Oxycodone/APAP 10/325 x 8 per day
- MME Calculation per CDC
- 80 x 1.5 = 120 MME

- Total opioid MME = 360 in a person who rates his pain very high and has very low function

# If Tapering

- Go slow due to length of therapy
- Reduction of 10% or less every 2-4 weeks
- Taper out the long acting (methadone) first
- Beware of “cliffs”
- Attempt to taper out 30 MME or less in the methadone
- 30 mg = 240 MME, 25 mg = 200 MME, 20 mg = 80!!!!
- Then taper the oxycodone, but that’s linear and easier to do the math
- It is ok to taper both opioid and benzodiazepine together, but more difficult on the patient

# Where to Go

- Methylphenidate 40 mg daily
- He is receiving this medication to help him with his fatigue and he does not have a diagnosis of ADHD
- His anxiety and hypertension could be worsened with this
- If you decide to discontinue this medication, please note that there are withdrawal symptoms for some including dysphoria, fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, psychomotor retardation or agitation (alteration of dopamine system)
- Tapering is recommended

FDA.

# The First Appointment

- What you know
  - You will be prescribing controlled medications to him that day, so start your monitoring process of controlled medication agreement, PDMP check, and urine drug screening. DO NOT SKIP THIS STEP.
  - Given his combination and doses of these medications, you surely want to be sure that he has Narcan in his hands
- What you DON'T know
  - How open is this patient to making medication changes?

# Tapering Conversations

- Reviewing risks and determining perceived benefits
- Does each medication provide more benefit than risk?
- Is there indication for these medications as prescribed?
- Proceed with facts as well as patience for Mr. Green's perspective

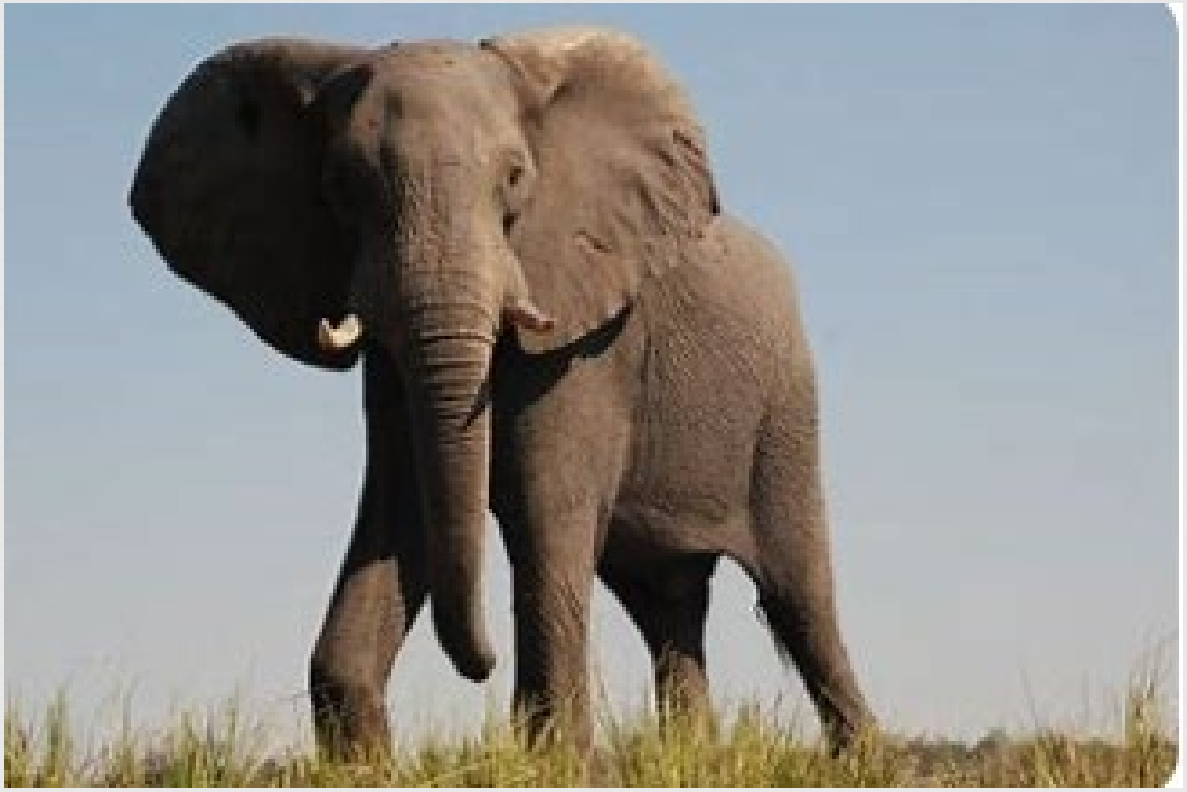
# The Best Case Scenario

- Mr. Green agrees that his controlled medications are not helping as much as he would like
- He is also shocked at how high risk they are
- He didn't know that he lacked indication for the long term benzo and for the methylphenidate
- You make a shared decision to begin a slow tapering of his controlled medications, but he wishes to taper one thing at a time
- He also agrees to take a break from the Atorvastatin to see if it has any effect on his body pain
- You write him prescriptions for all his medications except the Atorvastatin and you start his first reduction in methadone
- He also accepts the prescription for Narcan just in case
- You plan a follow up in 2 weeks to see how he is feeling

# Not as Perfect a Scenario

- Mr. Green tells you that he has never had any problems with these medications and he wishes to continue everything as it is
- He tells you that he feels his life is not worth living if he does not have his current medications
- He makes threats to get “drugs on the street”
- He makes threats to “report” you

# The Elephant in the Room



# Suicide Risk and Opioids

- The risk of suicide is elevated for those on prescribed opioids
- The risk is dose dependent. Higher dose = higher risk. The hazard ratio for someone over 100 MME is 2.15
- Length of therapy also elevates the risk. Mr. Green has 4.44-7.23 times the risk of suicide attempt compared to someone not on opioids
- Risk of suicide is even higher if a person on opioids also has concurrent mental health disorders
- And these people on long term opioids have a higher than usual risk of suicide during tapering of their opiodis

# Suicide Risk and Opioids


- Ilgen, M.A., et al. (2016). Opioid dose and risk of suicide. Pain, 157(5), 1079-1084
- Luo, C., et al. (2022). The association of prescription opioid use with suicide attempts: An analysis of statewide medical claims data. PLoS One, 17(6).
- Sandbrink, F., et al. (2023). The use of opioids in the management of chronic pain: Synopsis of the 2022 updated U.S. Department of Defense clinical practice guideline. Annals of Internal Medicine, 176(3), 388-397.
- Campbell, G., et al. (2016). Prevalence and correlates of suicidal thoughts and suicide attempts in people prescribed pharmaceutical opioids for chronic pain. Clinical Journal of Pain, 32(4), 292-301.

# Suicide Assessment

- 1. Comprehensive Risk Assessment
  - Psychiatric history, previous suicidal behavior, history of brain injury and pain catastrophizing
- 2. Screening Tools
  - PHQ-9, Current Opioid Misuse Measure (COMM)
- 3. Monitor Opioid Dose and Use
  - Higher doses and dose adjustments increase suicidal ideation
- 4. Behavioral Health Involvement
  - Multidisciplinary approach helps both pain and with medication adjustments
- 5. Follow-Up and Monitoring
  - Regular check-in for early identification of SI
- 6. Patient Education and Safety Monitoring
  - Ensure your patient and his or her family know of the risks and who to call if suicidal thoughts or behaviors emerge

# Suicide Assessment


- Sandbrink, F., et al. (2022). The use of opioids in the management of chronic pain: Synopsis of the 2022 updated U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guideline. Annals of Internal Medicine, 176(3), 388-397.
- Jamison, R.N., et al. (2023). Risk factors for self-harm ideation among persons treated with opioids for chronic low back pain. Clinical Journal of Pain 39(12), 643-653.
- Luo, C., et al. (2022). The association of prescription opioid use with suicide attempts: An analysis of statewide medical claims data. PLoS One, 17(6).
- Im, J.J., et al. (2015). Association of care practices with suicide attempts in U.S. veterans prescribed opioid medications for chronic pain management. Journal of General Internal Medicine, 30(7), 979-991.

# The Argument For Tapering

- Providing the latest best care to your patient
- Decreasing risk of adverse medication events
- Decreasing long term risks of memory problems, bone density problems, cardiovascular problems
- Putting the patient in a better position so that they may receive their care anywhere and not be tied to a prescriber or a prescription

Coluzzi, F., et al. (2020). The effect of opiates on bone formation and bone healing. Current Osteoporosis Rep, 18(3), 325-335.
Zhong, G., et al. (2015). Association between benzodiazepine use and dementia: A meta-analysis. PLoS One, 10(5).
Sung, M.L., et al. (2024). The association of prescribed opioids and incident of cardiovascular disease. Journal of Paine, 25(5).

# The Argument Against Tapering

- Tapering can increase symptoms of pain, anxiety, sleeplessness
- Tapering takes time and skill on the part of the provider for difficult conversations and then addressing symptoms that arise
- Your patient is an unwilling participant
- End of life or terminal and painful diagnoses
- Threats of board reports and more

# Use Disorders

- Patients will not always view their behaviors as misuse (taking an extra pill here and there, trying to fill early, taking along side alcohol or other sedatives, changing mode of delivery) because their medication is prescribed to them.
- Validated tools can be helpful including DAST, TAPS, Audit-C)
- You will see evidence of the patient struggling with the medications, using up medications before they're due, experiencing withdrawal.
- This can really derail tapering attempts

Dowell, D., et al. (2022). CDC clinical practice guideline for prescribing opioids for pain – United States, 71(3), 1-95.

# Complex Persistent Opioid Dependence

- A state that arises in patients on long-term opioid therapy
- They exhibit symptoms of opioid dependence without meeting the full DSM-V criteria for opioid use disorder
- Paradoxical worsening of pain, declining function, clinical instability
- NOT OUD as there is not compulsive use of opioids despite harm, but maladaptive physiological dependence

Manhapra, A., et al., (2020). Complex persistent opioid dependence with long-term opioids: A gray area that needs definition, better understanding, treatment guidance, and policy changes. Journal of General Internal Medicine, 35(S3), 964-971.

# The Utility of Buprenorphine

- If someone has CPOD, why change to buprenorphine rather than leave them on usual opioids
- Most opioids are mu agonists with higher risk of sedation and fatal respiratory depression
- Buprenorphine is a partial agonist/antagonist
- An agonist is an "on switch" for a receptor getting full effects
- A partial agonist/antagonist is both an "on switch" and "off switch" giving fewer effects

Warne., T. et al. (2011), The structural basis for agonist and partial agonist action on a B(1) adrenergic receptor. Nature, 469(7329), 241-4.

# Decisions to Continue

- IF you decide to proceed with ongoing high risk care ask the following:
- Do you have the skills to monitor this prescribing?
- Do you feel like you have enough pharmacologic understanding to continue?
- Do you feel it's safe to continue?
- Do you feel it's the right thing to do for this patient?

# Documentation

- If you continue high-risk prescribing, document as if someone will be reviewing the chart!
- Include the following at a minimum:
  - COMPLETE medical history and physical
  - Risk assessment and perceived medication benefits
  - Treatment plan – goals of care
  - Periodic review for efficacy
  - Follow up visits based on risk of prescribing
    - Low <30 MME, every 6-12 months
    - Moderate risk, every 3 months
    - High risk or doses > 90 MME, every 1-3 months

# Documentation

- Periodic review should include:
  - If pain, function, or quality of life have improved or diminished
  - If continuation or modification of medications for pain management treatment is necessary based on the clinician's evaluation of progress towards treatment objectives
  - If there are any new or ongoing comorbidities (COPD, liver or renal failure, sleep apnea) or medications that increase risk for adverse effects
  - Patient adherence to the treatment plan
  - Review of the PDMP
  - Calculate MME if there has been a dosing change

Summary of Maine Chapter 21 Rules - KRHA (krhamaine.com)

# Bullying

# Managing Behaviors

- There are often behaviors exhibited by patients that can make providers and staff uncomfortable
- Often, these behaviors come from CPOD, OUD, or inadequate symptom control
- It may also arise from patient's perceived belief in what they might need to survive

# Managing Behaviors

- Set clear expectations
- Follow standardized protocols
- Emphasize safety

Merlin, J.S. (2018). Managing concerning behaviors in patients prescribed opioids for chronic pain: A delphi study. Journal of General Internal Medicine, 33(2), 166-176.
Wyse, J.H., et al. (2019). Setting expectations, following orders, safety, and standardization: Clinicians' strategies to guide difficult conversations about opioid prescribing. Journal of Generalized Internal Medicine, 34(7), 1200-1206.

# Official Complaints

- Be sure to have a pre-emptive discussion with your risk department related to anything other than a fully engaged taper of medications
- Board complaints may happen, but be sure you are documenting your plan and rationale thoroughly
- More recently, some patients are making complaints with their human rights commissions
- Just be aware of this and do not change what you know is a good plan of care

# The Ethics of Directive Tapering

- Travis Rieder had a very bad "go" at getting off high dose opioids
- In his article, he questions if it is ethical to be directive with tapering
- "Legacy patients are owed a certain amount of deference in choosing their treatment as a results of the situation in which the medical community has placed them."

Rieder, T.N. (2020). Is nonconsensual tapering of high-dose opioid therapy justifiable? AMA Journal of Ethics, 22(8), E651-657.

# Thank YOU!

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