LEARNING OBJECTIVES

1) Discuss lack of consistent protocols for opioid prescribing within healthcare organizations and barriers to changing practices.
2) Educate the necessity for appropriate risk assessment prior to prescribing opioids.
3) Guide participants through use of guidelines and UConn Health policy in opioid prescribing.

THE WHAT AND THE WHY OF CLINICIAN PRESCRIBING PRACTICES

Universally lack of consistent protocols for opioid prescribing
Prescribing opioids without appropriate risk assessment
Lack of institutional/organizational/office support and structure to opioid prescribing and monitoring
Time constraints in practice
Lack of understanding that structures in place will reduce harm to patients and lessens prescriber burden
Difficulty in accessing resources such as state databases
Challenges with e-prescribing

IT IS A QUALITY METRIC

The Merit-Based Incentive Payment System (MIPS), a payment mechanism starting in 2019, is based on 4 performance categories:
- Quality
- Resource Use
- Clinical Practice Improvement Activities
- Meaningful Use of EHR

Currently: metric looks at follow up for all patients 18 and older prescribed opiates for longer than six weeks
The Future: MIPS considering 30-day RX requires medication agreement
CT state laws

Ref: [https://www.vox.com/2017/3/18/14954626/one-simple-way-to-curb-opioid-overuse-prescribe-them-for-3-days-or-less](https://www.vox.com/2017/3/18/14954626/one-simple-way-to-curb-opioid-overuse-prescribe-them-for-3-days-or-less)
CDC GUIDELINES: RECOMMENDATION #6

Opioid prescriptions for acute pain should be limited to 3 days in most circumstances.

3 days or less will often be sufficient; >7 days will rarely be needed.

Alignment with CT state law - Public Act 16-43: for patients over age 18 an initial opioid prescription shall not exceed a 7-day supply (3 days for minors) without justification.

(Recommendation category A; Evidence type: 4)

PSSST! GUESS WHAT?

OPIOIDS IN CHRONIC PAIN...

SPACE trial
- 12-month randomized with masked outcome assessment at VA (n=240)
- Q: Mod-to-Severe chronic back pain or hip or knee OA pain despite analgesic use, do opioids (O) result in pain-related function than non-opioids (NO)?
- 3.4 vs. 3.3 points on an 11-point scale at 12 months, O vs. NO
- Opioids were not superior for improving pain-related function over 12 months.
- Results do not support initiation of opioid therapy for moderate to severe chronic back, or hip or knee OA pain.


PHARMACOLOGIC PAIN MANAGEMENT


DEFINING QUALITY CHRONIC PAIN MANAGEMENT

- Consistent policies
- Quality/EBM driven/scheduled visits
- Informed consent in plain language
- Medication agreements
- Urine toxicology
- Pharmacology education
- Resources for co-existing addiction

OPIOID TASK FORCE

OTF TOOLBOX

- Toolbox overview
- Welcome Letter
- Policy
- Medication agreement
- Alternative therapies
- Naloxone rescue
- How to use / implement OiT
POLICY AND MEDICATION AGREEMENT

3 months on opioids = chronic prescribing

Chronic prescribing requires monitoring as for any chronic disease
- 3 month visits
- CTPMP monitoring
- Urine toxicology screening
- Risk assessment
- Attainment of functional goal(s)

WHAT IS A GOOD VISIT

1. Assessing treatment efficacy
   a. The "4 R's of pain"
      1. Analgesia — level of patient medication compared to before
      2. Activities of daily living — more or less functional
      3. Anxiety, affect, or other behavioral changes
      4. Patient-perceived level of illness

2. Has the patient experienced any adverse effects of opioid pain medication? Have functional gains been seen during the treatment?

3. Does the patient's condition respond to other treatments for pain, such as psychology, physical therapy, regular exercise, or other medication to prevent insomnia?

4. Is there evidence of drug toxicity, including managing the medication? If so, what are the consequences? Are there specific concerns? Are there any other treatments for pain, such as physical therapy, regular exercise, or other medication to prevent insomnia?

5. What is the patient's current level of pain, or is the pain resolved?

6. Is the patient experiencing some relief from the opioid pain medication? Are there additional effects or side effects?

7. Do you need to taper opioid pain medication completely, or is it being used at an optimal level?

8. Is the patient’s current level of pain, or is the pain resolved?

9. Are you the patient's primary care or pain management provider?

10. Are you the patient’s primary care or pain management provider?

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29. Are you the patient’s primary care or pain management provider?

30. Are you the patient’s primary care or pain management provider?
WHEN TO DISCONTINUE

- Addiction (to opioids or other substance)
- Adverse effects
  - Serious adverse events: overdose, falls, MVA/DUI, suicide attempt
  - Adverse effects not responsive to dose lowering: urinary retention, sedation, hyperalgesia
- Failure to meet treatment goals
  - No significant improvement for risk
  - Diversion

OPIOID TAPERING

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal, while maximizing pain treatment with nonpharmacologic medications.

- Go slow! A decrease of 10% of the original dose per week is a reasonable starting pace.
- Some patients who have taken opioids chronically for years may need even slower tapers (e.g., 10% per month).

Consider risk factors when tapering (e.g., unstable heart disease, pregnancy)

Monitor for behavioral changes, behaviors concerning for SUD

Provide encouragement and support

Recommendations for an opioid taper plan

**Week 1:**
- Morphine controlled-release: 30 mg PO in the morning and 15 mg at bedtime
- Morphine immediate-release: 15 mg PO every 12 hours

**Week 2:**
- Morphine-controlled release: 15 mg PO twice daily
- Morphine immediate-release: 15 mg PO every 12 hours

**Week 3:**
- Morphine controlled-release: 15 mg PO in the morning
- Morphine immediate-release: 15 mg PO every 12 hours

**Week 4:**
- Morphine immediate-release: 15 mg PO once daily

**Example Taper**

**PATIENT DISCUSSION TIPS**

- Start the conversation with
  - **"We need to have a difficult conversation"**
- Be clear on your plan
  - **"I am going to give you one more chance"** vs. **"I am not going to prescribe opioid pain medications for you."**
- Maintain the relationship
  - **"I still want to help you"** or, **"I will still be your doctor."**
- Remember to discuss behaviors and facts rather than the person and feelings

**HOW TO OPERATIONALIZE THE NEW POLICY**

- Office managers should have them in rooms or with support staff
- Patient on chronic opioids is scheduled
- If you have not used any of these tools in the past
- Let the patient know this is done for everyone, no patient profiling
- Nursing can bring in the agreement, make them aware of the new policy and give them time to read it while waiting for you
- Review chart for:
  - Agreement (need to sign the new one)
  - A functional goal
  - Last chronic pain apt
  - Check CTPMRS
  - Verify recent urtox (6 months) and appropriate findings

**YOUR NOTE**

- You can use a template to document what is needed in the chart
  - Level of pain management
  - Aberrant behavior
  - Aberrant uses
  - Any additional prescribers
  - Adverse effects
  - Functional goal
  - RTC 3 months chronic pain management
- Added steps to make life easier
  - Electronic prescribing
  - Document in the notes to pharmacist last utox, agreement signed, date you checked the CTPMRS
  - Can link to a diagnosis – sometimes I write failed therapies in PMH

**OUTSIDE RESOURCES**
UCONN’S PROJECT ECHO

“Hub”: panel of experts
- Bruce Gould, MD (Team Lead)
- Surita Rao, MD (Addiction Psychiatry)
- Kyounghae Kim, PhD, APRN (Ortho & Pain)
- Kevin Chamberlin, PharmD (Pharmacy)

“Spokes”: Community Health Accreditation and Certification

Schedule (for now):
- #2 Friday videoconferences per month
- 1.5 hours (noon-1:30p)
- Structured case presentations (from spoke)
- Short didactic portion
- Long-term didactic curriculum

Figure 1. Framework for Opioid Weaning:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Schedule</th>
<th>Pain Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>No apparent addiction/patient able to tolerate opioid taper</td>
<td>Gradual taper over 4 or more weeks</td>
<td>Provide opioid pain management with medication, physical therapy, psychological support, and other resources</td>
</tr>
<tr>
<td>Patient unable or unwilling to taper or engage in opioid taper</td>
<td>Taper over several weeks, or maintain current opioid dose with additional support e.g., opioid agonist antagonists, addiction medicine services, etc</td>
<td>Provide opioid pain management with medications, physical therapy, psychological support, and other resources</td>
</tr>
<tr>
<td>Patient’s status is consistent with previously observed behaviors</td>
<td>Coordination of opioid pretend/identifying providers for addiction medicine specialist</td>
<td>Provide opioid pain management in accordance with medical, physical therapy, psychological support, and other resources</td>
</tr>
</tbody>
</table>


ECHO vs. Telemedicine

UCONN HEALTH

ECONSULTS – HOW IT WAS RECEIVED

CT COMPREHENSIVE PAIN CENTER (CCPC)

Request for funding from Office of Health Strategy’s (OHS) State Innovation Model (SIM) initiative

Objectives:
1) Chronic pain consultative service for PCPs treating patients with chronic pain (target: Fall 2019);
2) Opioid Use Disorders (OUD) clinic to provide medication-assisted treatment (MAT), including buprenorphine and parenteral naltrexone, to patients who suffer from both chronic pain and OUD.

HOPEFUL HORIZON

PAIN MANAGEMENT: USING GUIDELINES AND BEST PRACTICES AT UCONN HEALTH

Robson Andrews, MD, MS, FACP
Director of Ambulatory Education
Associate Program Director, Internal Medicine
Associate Professor of Medicine

Kevin Chamberlin, PharmD, FASCP
Associate Clinical Professor & Assistant Department Head, Pharmacy Practice
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