PAIN MANAGEMENT: USING GUIDELINES AND BEST PRACTICES AT UCONN HEALTH

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LEARNING OBJECTIVES

1) Discuss lack of consistent protocols for opioid prescribing within health care 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

HOW'D WE GET HERE?

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

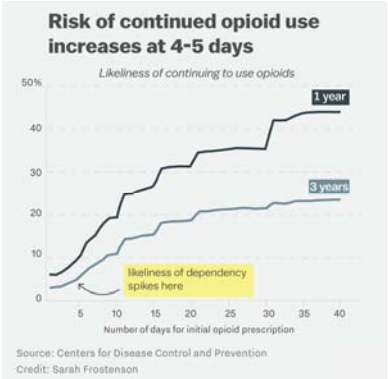
The Merit-Based Incentive Payment System (**MIPS**)- payment mechanism starting 2019 based on 4 performance categories

- *quality*
- *resource use*
- clinical *practice improvement* activities
- *meaningful use* of an 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 Accessed: Aug 7, 2018

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)

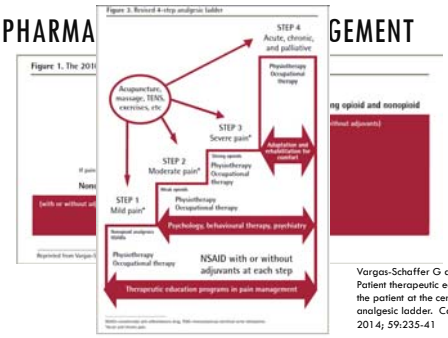
PSSST! GUESS WHAT? OPIOIDS IN CHRONIC PAIN…

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

Krebs EE, et al. JAMA. 2018;319(9):872-882.

PHARMA…GEMENT



Vargas-Schaffer G and Cogan J. Patient therapeutic education: placing the patient at the centre of the WHO analgesic ladder. Can Ram Physician 2014; 59:235-41

OPIOID TASK FORCE

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

OTF TOOLBOX

Toolbox overview

- Welcome Letter
- Policy
- Medication agreement
- Alternative therapies
- Naloxone rescue

How to use / implement

ORT

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)

C. POLICY :	1. All patients prescribed opioids for treatment of CNMP for 3 months or longer will be required to participate in a Medication Agreement. 2. Agreements are valid for 1 year and must be renewed if treatment continues. 3. Practitioners will adhere to all requirements of state law including checking CPMRS prior to the initial prescription and at 3 month intervals. 4. A risk assessment tool, such as Opioid Risk Tool (ORT), will be used to assessment risk for future addiction. 5. The use of opioids for CNMP should be reserved for patients where pain relief has not been achieved through other means and the pain is impacting the patient's quality of life. 6. Patients who do not adhere to the terms of the agreement including random urine testing, pill counts, and adjunctive pharmacologic and non-pharmacologic therapies (physiotherapy) will not be eligible to receive long term opioid prescriptions from any UConn Health Practioner.
D. SCOPE :	Applies to all UConn Health Providers who prescribe opioids for CNMP with the exception of patients with Sickle Cell Disease.

UConn Health

Chronic Opioid Therapy – Provider Follow up Checklist

Follow up Checklist:

- ☐ Patient is attending Q3 month visits for opioid check in (mandated by the DEA)
- ☐ Patient is participating in ALL aspects of a multidisciplinary care program as indicated including:
  - Mental health care, Physical therapy, compliance with other medications, specialist appointments, PCP office appointments, random utox or pill counts
- ☐ Considered alternative and/or adjunctive chronic pain medications (Duloxetine, Gabapentin, Pregabalin, TCA, Cyclobenzaprine)
- ☐ Checked CTPMP (must be done at least every 3 months as per CT State Statute) and it appeared as though the patient was in compliance with conditions of the opioid agreement
- ☐ Reviewed prior utox (perform at least every 6 months), perform new utox if needed
- ☐ Medication agreement is on file and less than 1 year old, if more than 1 year old, new agreement signed today
- ☐ I have discussed intranasal Narcan with the patient, prescribed it, and provided the patient with a list of pharmacies that dispense it
- ☐ Patient has been recommended a stimulant laxative (Senna) if needed for constipation

WHAT IS A GOOD VISIT

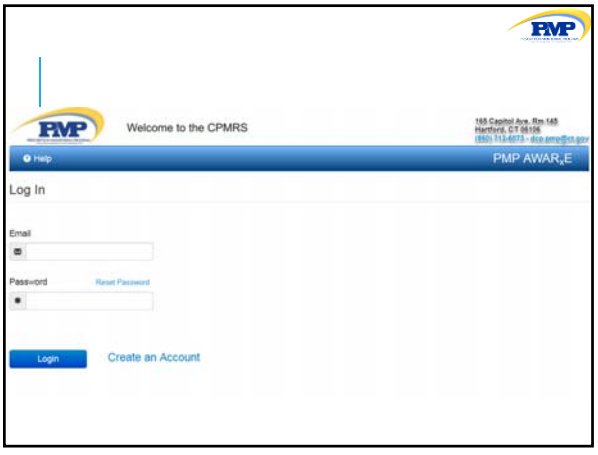
1. Assessing treatment efficacy:
   a. The "Four A's of Pain"
      i. Analgesia – level of pain on medication compared to before
      ii. Activities of daily living – more or less functional
      iii. Adverse effects – mild, severe, life-threatening
      iv. Aberrant drug-taking behaviors
   b. Re-evaluate the treatment plan and goals of treatment
2. Has the patient's function improved with the use of opioid pain medication? Were functional goals set at any point during the treatment?
3. Is the patient participating in other treatments for pain: pain psychology, physical therapy, regular exercise, water therapy, non-opioid medications to prevent tolerance?
4. Is there evidence of diverting, selling, or misusing the medication? Did you check the state database for prescription monitoring? Urine screens appropriate? Requests for early refills or lost medications?
5. Has the patient been abusive or threatening to clinic staff?
6. Is the patient having side-effects of the opioid pain medication? Are these dose-sensitive side effects or not?
7. Do you need to stop opioid pain medication completely, or is lowering the dose an option?
8. Is medical or recreational marijuana legal in your state? What is your clinic's policy about marijuana use for patients who are prescribed opioid pain medication for long-term non-cancer pain?
9. Are you and the patient in compliance with your clinic policy on non-malignant chronic pain opioid therapy?

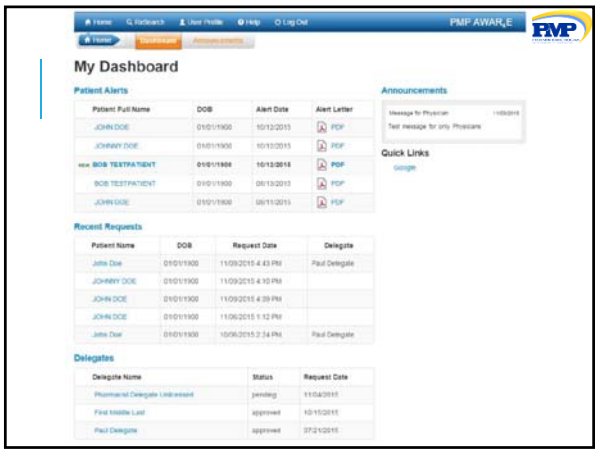
Comparison of Risk Assessment Tools

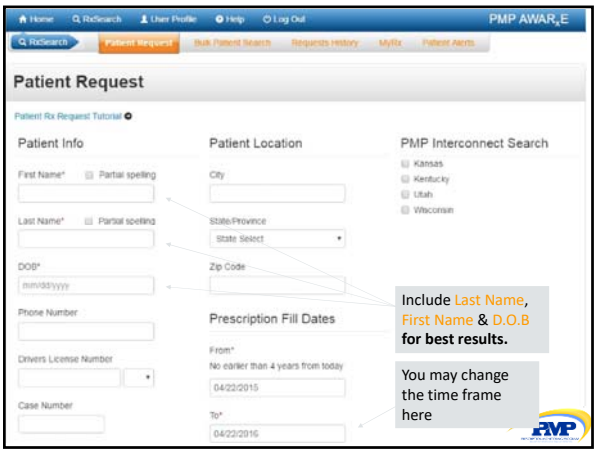
	Question Formats	Indications	Advantages	Pitfalls	Scoring	Validated
SOAPP[1]	5, 14, 24	1° Care, Assess for high abuse risk, suitability for long term opioid tx, preferable to ORT in high-risk populations	Best psychometrics, less susceptible to deception, 5-10 minutes	Dependent on patient reporting, Copyrighted	Numeric, simple to interpret	Yes, 14 quest ion studied in 396 pts
SOAPP-R[2]	24	Primary Care	5 minutes, Cross-validated, Less susceptible to overt deception c/t SOAPP	Less sensitive and less specific than SOAPP	Numeric, simple to interpret	Yes, 283 pts
ORT[3]	5	Categorizes patients as low risk, moderate risk, and high risk	Less than 1 minute, simple scoring, high sensitivity & specificity when stratifying patients	1 question in the ORT is limited by patient's knowledge of family history of substance abuse	Numeric, simple to interpret	Yes, (male and female), Preliminary Validation in 185 patients at 1 pain clinic, high degree of sensitivity and specificity
DIRE[4]	7, by pt interview	risk of opioid abuse and suitability of candidates for long term opioid therapy	2 minutes, score correlates well with patient's compliance& efficacy of long term opioid therapy	Prospective validation needed	Numeric, simple to interpret	7, Retrospective validation only of 61 pts over 38 months

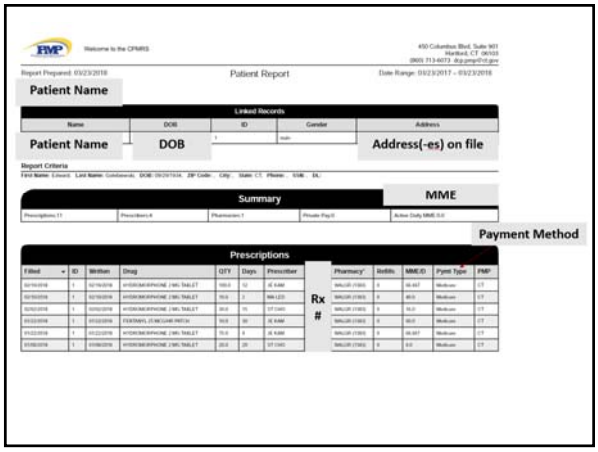
1)J Pain Symptom Manage 2006;32:287–93 2)J Pain. 2008 April; 9 (4): 360-372 3)Pain Med 2005;6:432–42 4)J Pain 2006;7:671–81

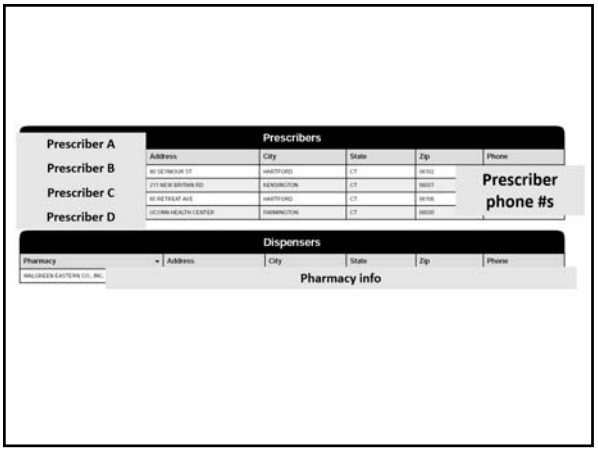
Farah JR. Precision Medicine Tools for the Management of Pain and Addiction. June 6, 2017.











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 slowly!

- A decrease of **10% of the original dose per week** is a reasonable starting point
- 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

https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Example Taper

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

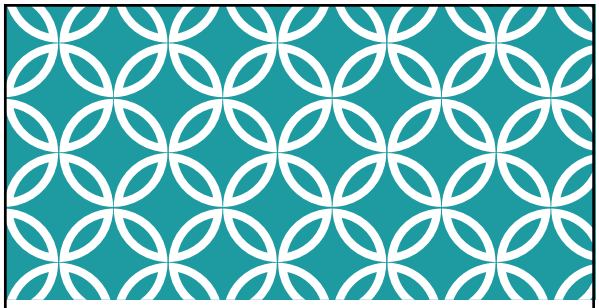
PATIENT DISCUSSION TIPS

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



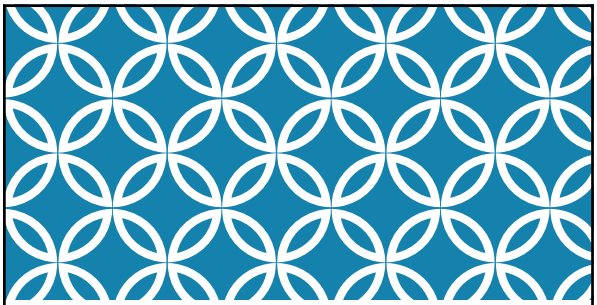
HOW TO OPERATIONALIZE THE NEW POLICY

OTF TOOLKITS

- 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 utox (6 months) and appropriate findings

YOUR NOTE

- You can use a template to document what is needed in the chart
  - Level of pain management
  - Abberant behavior
  - Abberant utox
  - 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

http://huskyhealthct.org/providers
Accessed: Aug 9, 2018

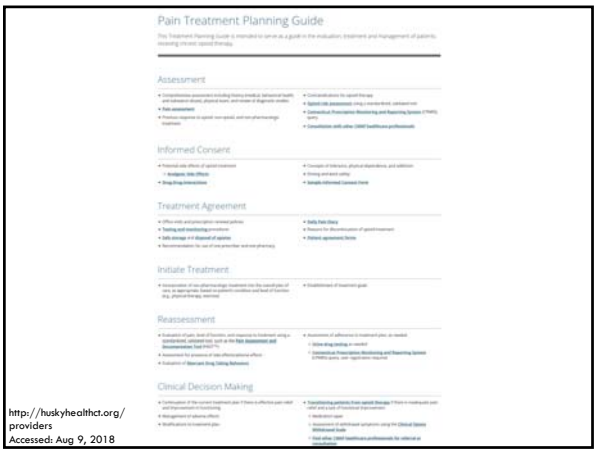


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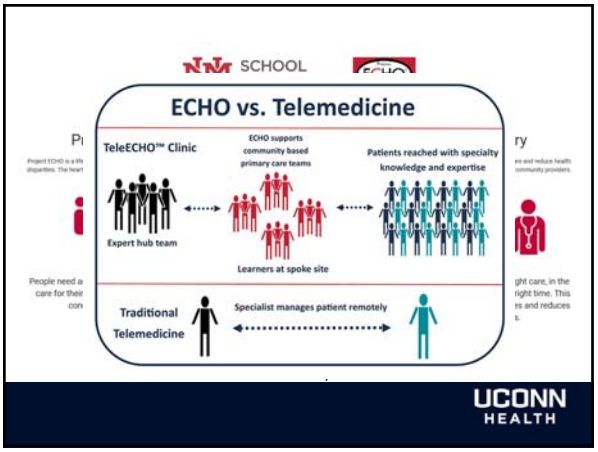
Figure 1. Framework for Opioid Weaning

Patient	Schedule	Pain Management Options
No apparent addiction/ patient able to tolerate outpatient taper	Gradual taper over 4 or more weeks	Provide nonopioid pain management with medications, physical therapy, psychosocial support, and other resources
Patient unable or unwilling to engage in outpatient taper	Trial gradual taper over several weeks, or maintain least amount of opioid possible until additional resources become available (e.g., inpatient opioid program, addiction medicine services, etc)	Provide nonopioid pain management with medications, physical therapy, psychosocial support, and other resources
Patient's status is consistent with dangerous opioid behaviors	Cessation of opioid prescribing, provision of medication for withdrawal, and referral to an addiction medicine specialist	Provide nonopioid pain management with medications, physical therapy, psychosocial support, and other resources

Source: Mackey S, Lahidji S, Schonwald G, Newmark J. Safe Opioid Prescribing and Risk Evaluation and Mitigation Strategies (REMS) Online CME Course. Stanford University School of Medicine. November 2, 2015.

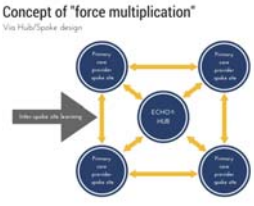


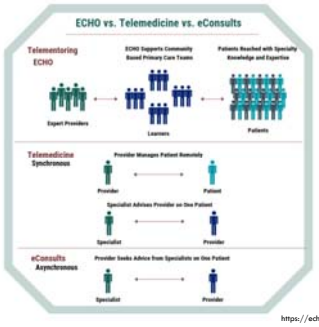
UCONN'S PROJECT ECHO

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

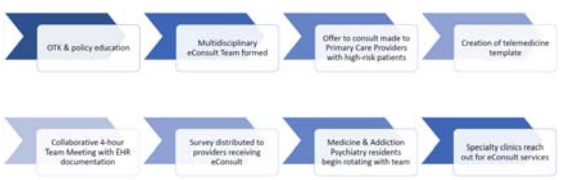
"Spokes": CHCACT

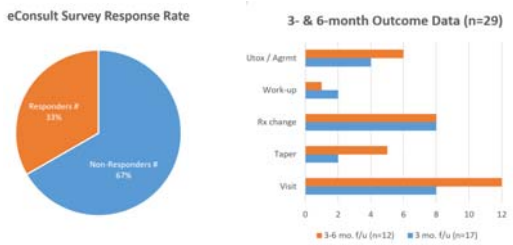
Schedule (for now):
- #2 Friday videoconferences per month
- 1.5 hours (noon-1:30p)
- Structured case presentation (from spoke)
- Short didactic portion
- Long-term didactic curriculum



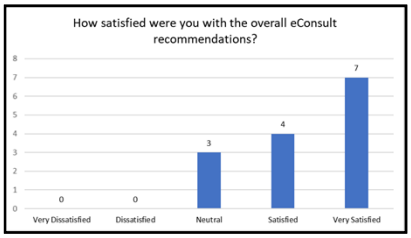


https://echo.unm.edu/ Accessed: Oct 14, 2019.





ECONSULTS – HOW IT WAS RECEIVED



HOPEFUL HORIZON

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.

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