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A collaborative approach to improve outcomes for complex chronic non-cancer pain

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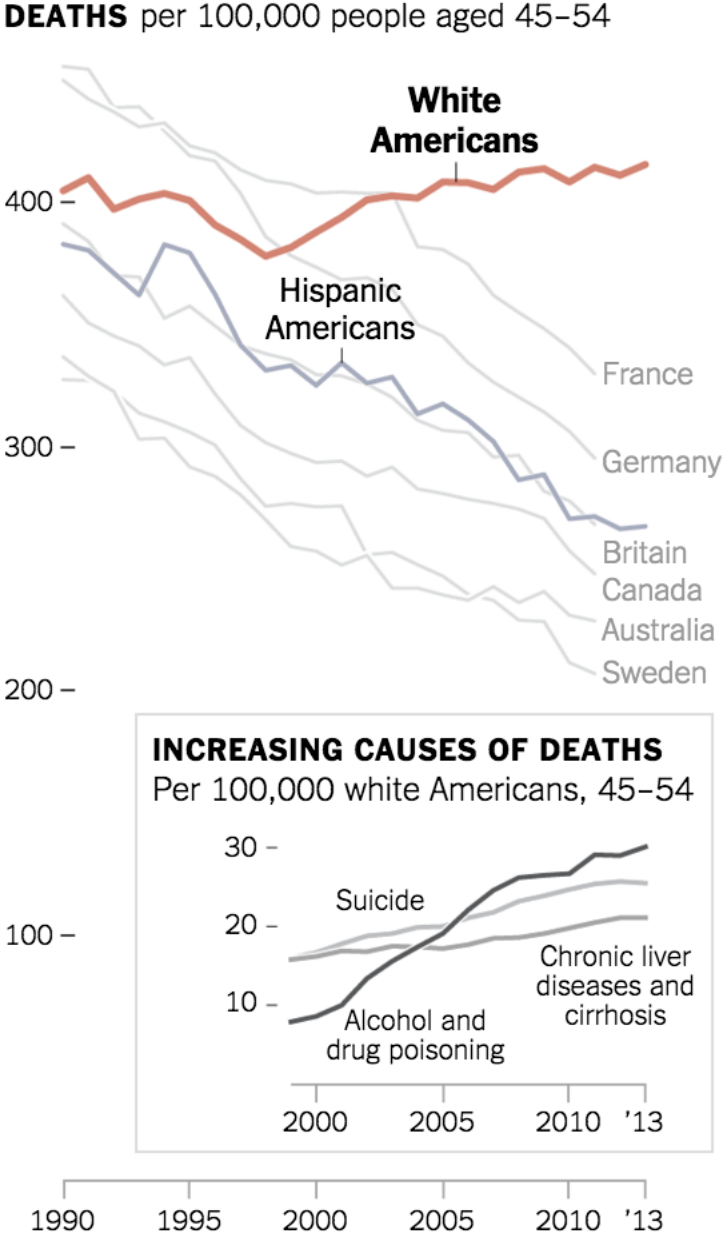
I no longer accept gifts, lunches, or anything “free” from pharmaceutical companies.

Too many pills!

- How did we get here?
- Why does it matter?
- What are we doing about it?



Sources: Anne Case and Angus Deaton; PNAS

By The New York Times

Summary of the mortality data for white middle aged Americans:

- Angus Deaton and Anne Case
- Suicides ,substance abuse, and overdoses
- Decline in mortality for Hispanics and African Americans
- Associated with HS education or less.

Too many pills!

- How did we get here?
- Why does it matter?
- What are we doing about it?

The 3 legged stool for community engagement: The 3 Ps

- Prescribers (Health Professionals): Need to learn about current best practices concerning the treatment of Chronic Complex Non-Cancer Pain (CCNP)
- Patients: Need behavioral and other supports to learn to manage their chronic pain without reliance on opioids
- Public: Need to understand the changes in scientific understanding of pain management so they can support their loved ones. Need to learn about naloxone.

Provider Responsibility

The reason we have so many pills in circulation

Is because we write for so many pills

If we don’t solve this problem as a community, we are only passing it on to the next provider.

That’s how you got your “legacy patients” in the first place!

Oregon Pain Guidance

(formerly Opioid Prescribers Group)

Attendees: Physicians, Mid-level providers, Nurses, Substance Abuse Counselors, CCOs, Therapists, Pharmacists, Medical specialty (Pain Medicine, ED), Dental, Community Justice Partners

We need to re-invent the wheel

By adopting the best practices we create ourselves we have a sense of “ownership”

Oregon Pain Guidance (OPG)

- Public Health initiative to reduce opioid overdoses by addressing the problem at its core: medical providers
- CME and dinner provided
- Video conference with Josephine County
- OPG evolution:

  Brainstormed >

  Created guidelines >

  guideline acceptance

Ongoing education and discussion

- Topics for discussion:
  - Trauma Informed Care
  - Benzodiazepines
  - Challenging conversations
  - Oregon Medical Board
  - CCO 120 MED policy
  - Best practices for pain management
  - Addiction
  - Treatment of back pain
  - “Dreamland” discussion with the author
  - Re-writing the OPG guidelines
- Followed by small discussion groups

OPG Steering Committee

- Representatives from: CCOs, FQHC, PH, ED, person living with chronic pain, Social worker
- Meet for 2 hours twice a month
- Follow through on projects, brainstorm, update, and prepare for monthly meetings

Challenges: non-uniform practices

- Some providers working independently in rural setting
- Some are part of large primary care groups
- Some work for FQHCs with provider supports unique to their setting

Challenges

- Old concepts die hard
  - The Ducks don't win *every* game.
- Prescribers often don't really believe the data concerning opioid management.

There are psychodynamics involved

Some of us have a hard time saying "no."

We want our patients to like us

We avoid conflict

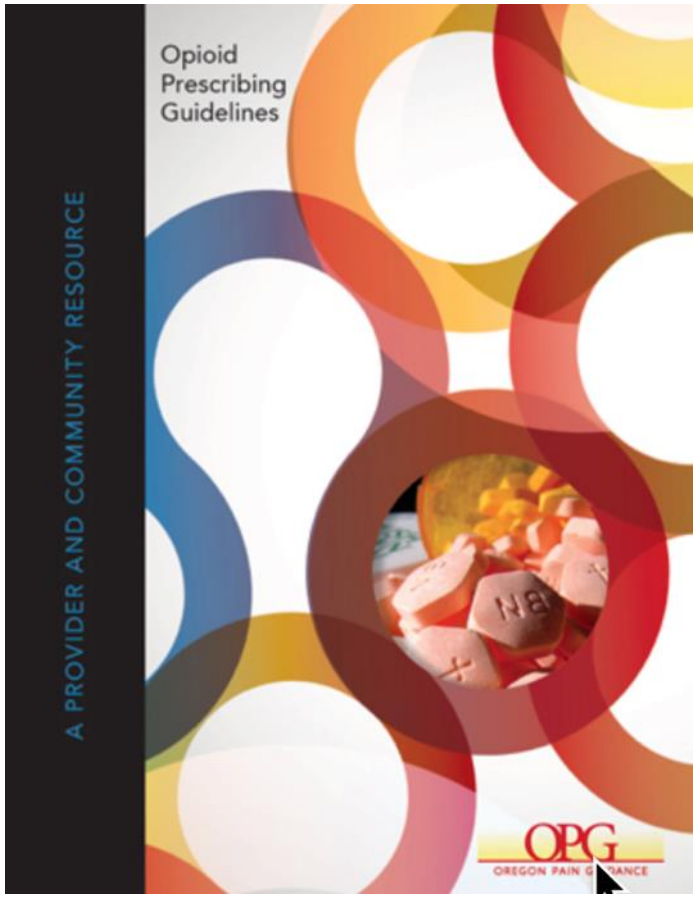
Our "legacy" patients are dependent on opioids

Our reputations can suffer when we say "no."

It gives us some “external” courage

"Tell your wife that the X-ray shows that you do have a backbone."

Summary of guidelines:



- Assess prior to prescribing!
- Encourage non opioid treatments (They really work).
- Measure functional improvement.
- Review a material risk notice
- Query the PDMP
- Compassionately say “No” when necessary
- Keep MED low, avoid methadone, don’t combine benzos and opioids.
- Assess for aberrant behaviors (UDS, PDMP, pill counts, call backs)
- Co-prescribe naloxone
- Collaborate with community partners because you can’t do this alone.

GUIDELINES FLOWCHART

FOR THE EVALUATION AND THE TREATMENT
OF COMPLEX CHRONIC NON-CANCER PAIN

OPG
OPIOID PRESCRIBERS GROUP

BEGIN — ASSESSMENT

- Review medical history, including records from previous providers.
- Administer a physical exam to determine baseline function and pain.
- What prior attempts were made to treat this pain with non-opioid modalities?
- Is the diagnosis appropriate for opioid treatment?
- Psychosocial and risk assessment: risk of medication abuse (e.g. ORT, SOAPP, etc.), psychiatric co-morbidity (e.g. PHQ 2,4, etc.).
- Sleep risk assessment (e.g. S T O P B A N G or equivalent).
- It is seldom appropriate to prescribe chronic opioids on the first visit.

GREEN LIGHT — NON-OPIOID OPTIONS

- Create a plan of treatment with the patient that incorporates non-opioid interventions.
- Patient lifestyle improvement: exercise, weight loss.
- Behavioral therapies: CBT, peer-to-peer or other peer support, case management, psychotherapy, and case management.
- Physiotherapy modalities: OT, PT, passive modalities.
- Medical interventions: pharmacological, procedural, surgical.

AT EVERY VISIT — ESTABLISHED PATIENTS

- Use these guidelines with established patients.
- Reassess your patient and work your way through the flowchart.
- Continue to prescribe, or taper, as you do so.

CAUTION — OPIOID TREATMENT

PROCEED WITH CAUTION!

- Perform UDS prior to prescribing.
- Check for evidence of possible misuse (PDMP).
- Patient signs a material risk notice and a treatment agreement.
- Agree on and document treatment goals.

AT *EVERY* VISIT!

- Assess for changes in function and pain.
- Evaluate progress on treatment goals.
- Assess for aberrant behaviors.
- Assess for adverse side effects.

If no improvement or if aberrant behavior or adverse side effects are observed, stop and reassess!

STOP! — STOP! REASSESS.

- If you have concerns from your visit assessment, seek help from community partners or other specialists.

CAUTION: Re-evaluate your treatment plan/seek help from specialists if you:

- prescribe more than 120 mg MED/day without obvious functional improvement.
- prescribe opioids with benzodiazepines.
- prescribe more than 40 mg of methadone/day.
- notice signs of significant misuse or illicit drug use.

AllCare HEALTH PLAN

Jackson County Health & Human Services

Jackson Care Connect
Your Community Health Plan

TAPERING FLOWCHART

START HERE

Consider opioid taper for patients with opioid MED > 120/methadone > 40, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, or concurrent opioid use.

1. Explain to the patient the reason for the taper: "I am concerned…"
2. Determine rate of taper based on degree of risk.
3. If multiple drugs involved, taper one at a time (e.g., start with benzos, follow with opioids).
4. Set a date to begin, provide information to the patient, and set up behavioral supports, prior to instituting the taper. See page 26 of OPG guidelines.

OPIOID TAPER

Opioids (not methadone)

Basic principle: For longer acting drugs and a more stable patient, use slower taper. For shorter acting drugs, less stable patient, use faster taper.

1. Utilize the drug the patient is taking as the tapering medication. If you switch medications, follow MED equivalency chart and then reduce the dose by 25–50% as starting dose. Metabolic variability can be quite significant. Utilize a 90% dose reduction if switching to methadone. See dose calculator link below.
2. Decrease total daily starting dose by 5–15% per week in divided doses.
3. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
4. After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the process down.
5. Consider adjuvant medications: antidepressants, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

Methadone

Basic principle: Very long half life may necessitate a more protracted tapering process. Otherwise follow opioid principles.

MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and transdermal)
Morphine (reference)	**30mg**
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg†
Oxycodone	20mg
Oxymorphone	10mg

Link to Morphine Equivalent Dosing (MED) Calculator

agencymeddirectors.wa.gov/mobile.html

OPG
OREGON PAIN GUIDANCE

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support very important. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

1. **Slow taper:** Calculate total daily dose. Switch from short acting agent (alprazolam, lorazepam) to longer acting agent (diazepam, clonazepam). Upon initiation of taper reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
2. First follow up visit 2–4 days after initiating taper to determine need to adjust initial calculated dose.
3. Reduce the total daily dose by 5–10% per week in divided doses.
4. After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the taper.
5. Consider adjunctive agents to help with symptoms: trazodone, buspirone, hydroxyzine, clonidine, antidepressants, neuroleptics, and alpha blocking agents.

1. **Rapid taper:** See the tapering guidelines on page 28 of the OPG guidance documents.

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg

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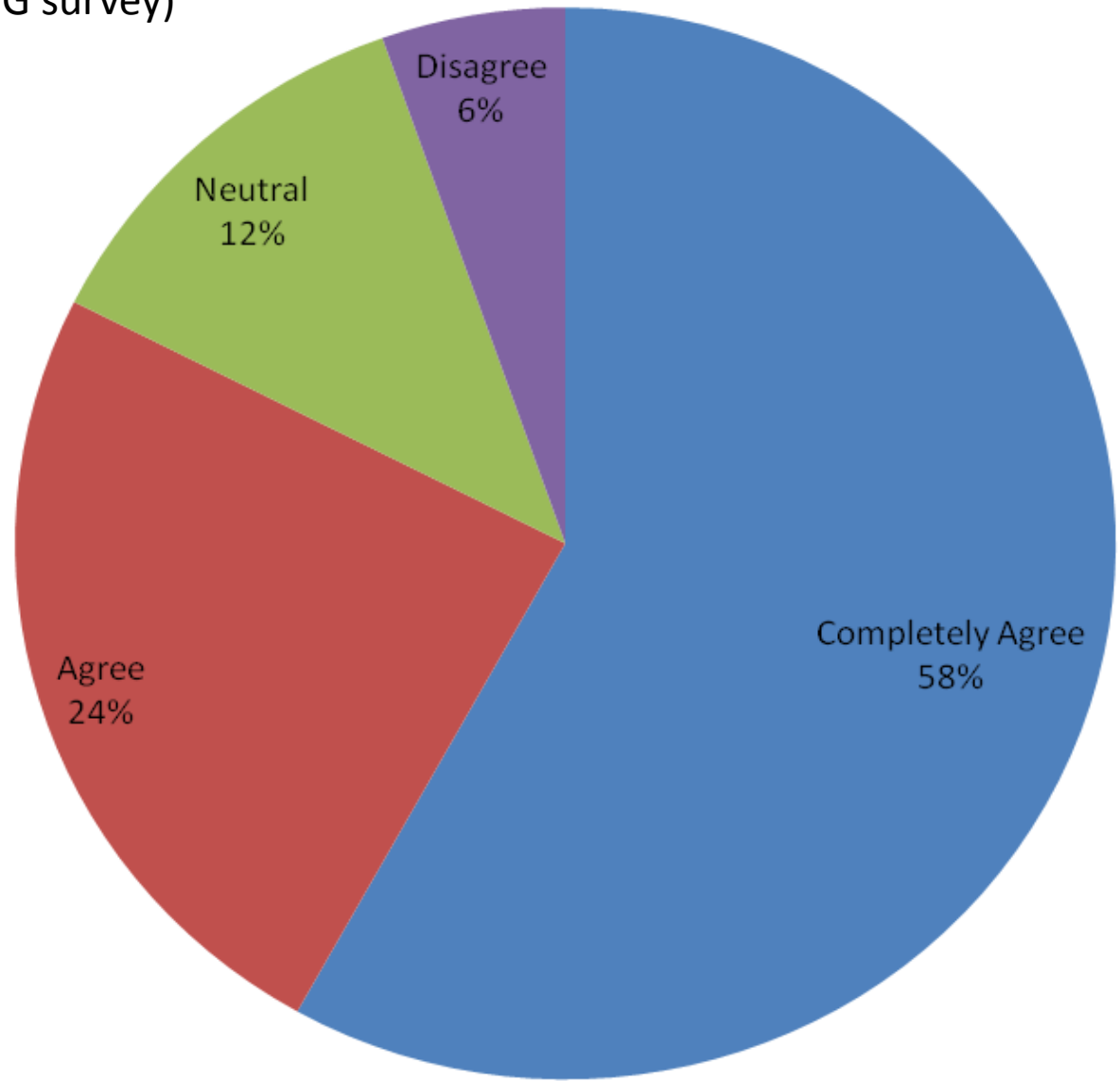
Agreement with MED < 120 Standard Among Chronic Opioid Prescribers

(analysis of 112 JaCo and JoCo prescribers: OPG survey)



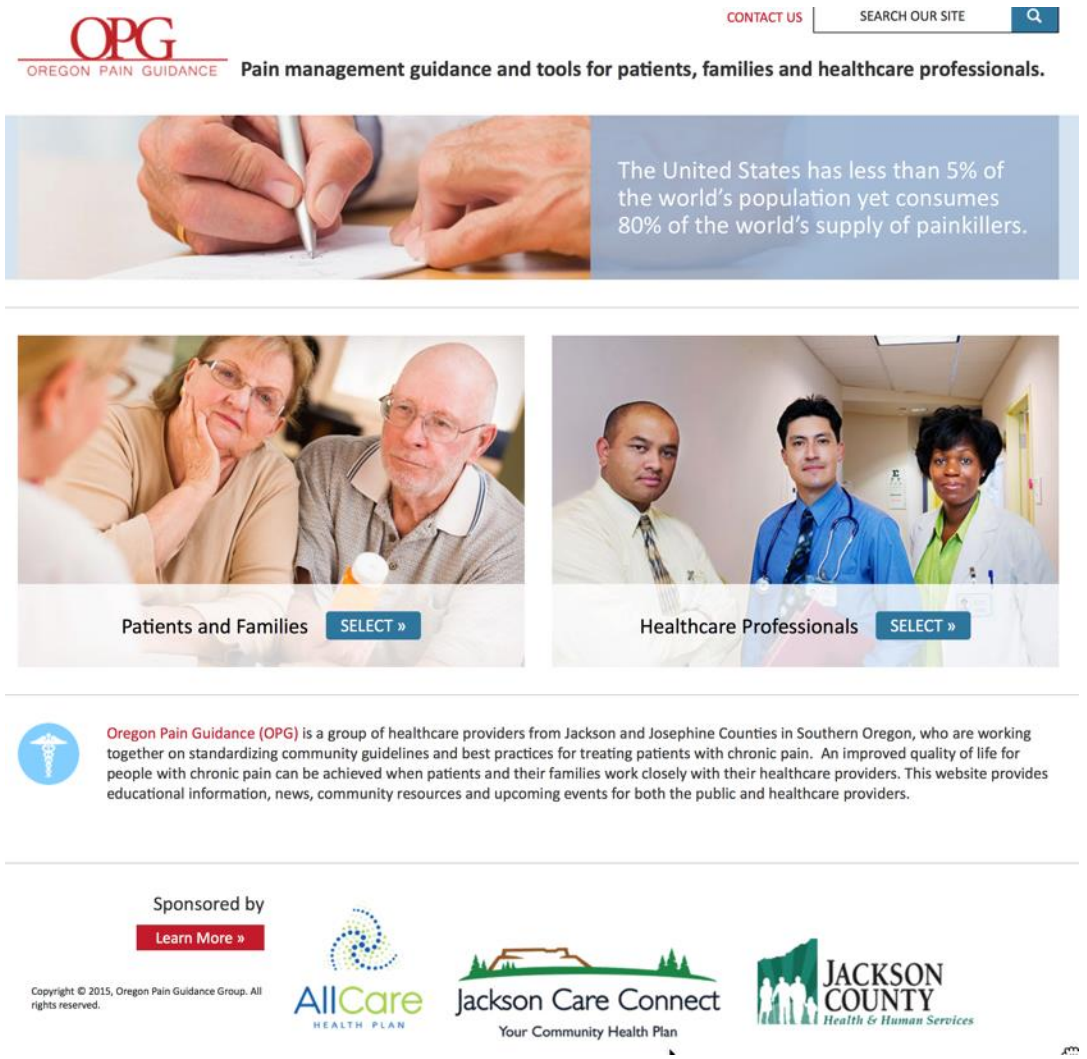
We do need to provide compassionate care to those with certain painful conditions

We don't want to throw the baby out with the bathwater

Opioids have a role to play

- In the treatment of acute and post surgical pain
- In cancer and other deteriorating painful conditions
- In some chronic conditions, when utilized at safe doses

- **Provider resources**
- **Patient resources**
- **Public resources**
- **Supported by Medicaid insurance plans and Public Health**
- **Active re-write being undertaken currently**
- **Please link us to your websites.**



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“A Thoughtful Approach to Pain Management” Conference

A Thoughtful Approach to Pain Management

- Speakers from all over North America
- Over 200 participants last year
- Open to all healthcare professionals
- 2 days: lecture and workshop format
- 9 months of planning by the conference committee

May 20 and 21, 2016: Asante CME

2nd Annual Moving Through Chronic Pain: A Community Response

May 28, 2015, 4:00 p.m. – 7:00 p.m.

Jackson County Health & Human Services Building
1005 E. Main Street. Building 3, Medford, OR 97504

Who Should Attend:
Community Members Living with Chronic Pain and Supportive Family Members

Jackson County Health & Human Services

OPG Oregon Pain Guidance

AllCare Health Plan

Jackson Care Connect
Your Community Health Plan

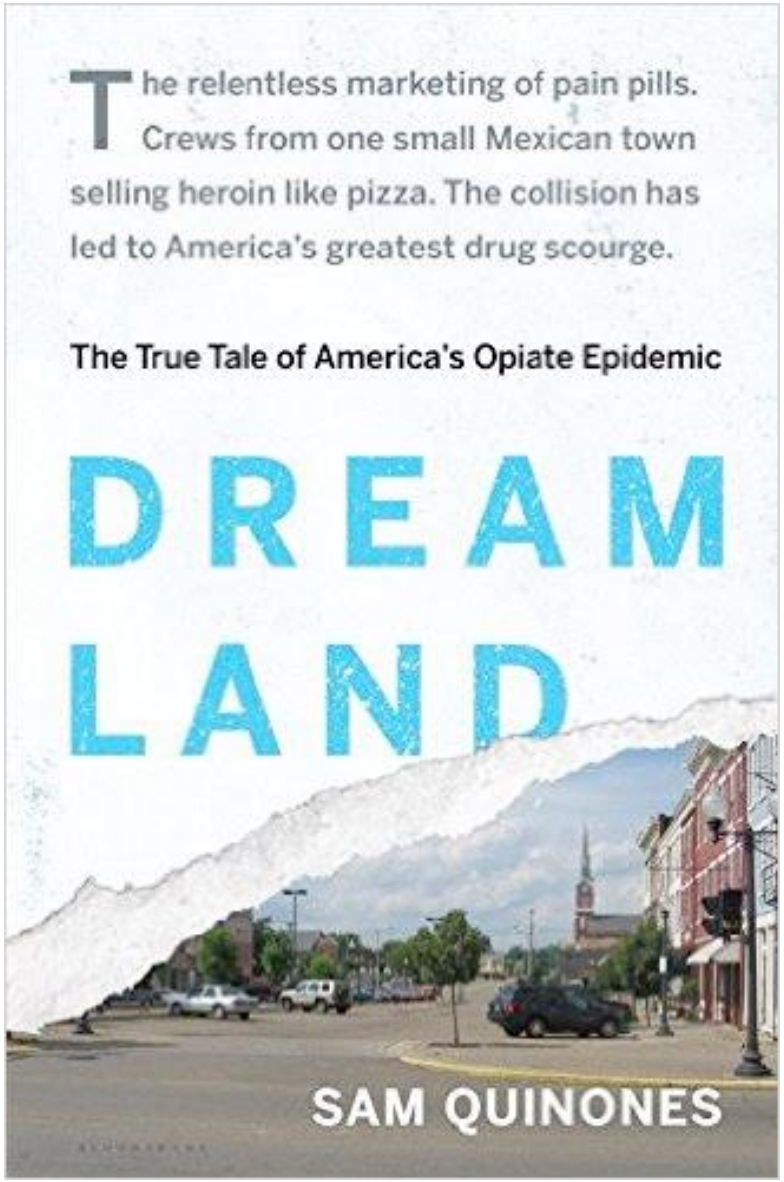
JRHA

Rogue Valley Council of Governments

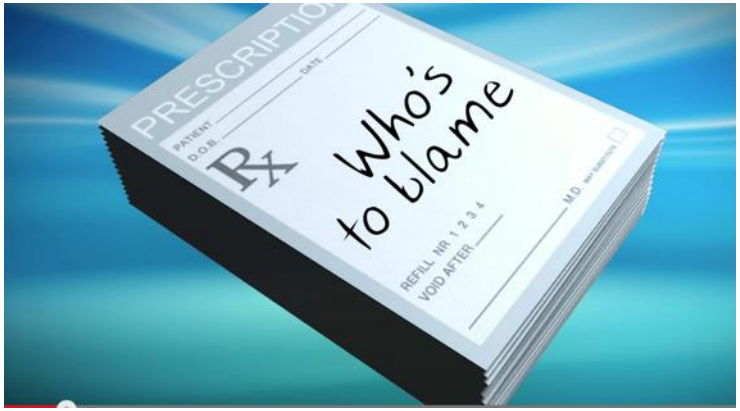
Free to the Public

Free Dinner

Community “book club”



Educating the Public through TV spots



Providing local alternatives to opioids

- Pain Resiliency Program
- By referral from Primary Care
- Support by CCOs
- Curriculum:
  - Evaluation, orientation
  - “Pain School”
  - Peer to Peer support
  - Movement therapy
  - Behavioral support
  - Feedback to Medical Home

The Dissemination concept

Critical mass: If enough providers, and the public, understand the guidelines, word of mouth and peer pressure will lead to adoption.

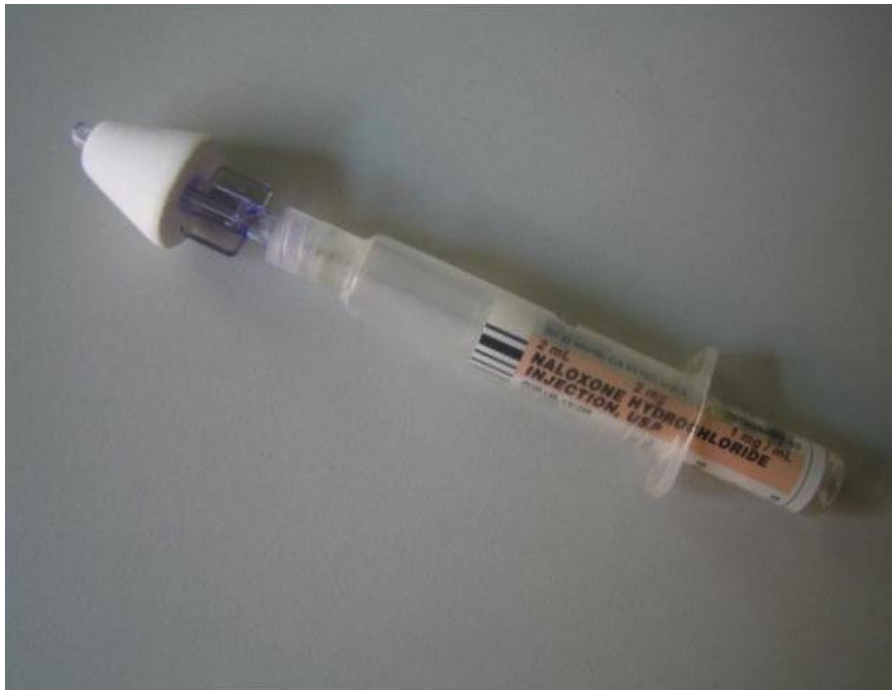
Information is transmitted via the pilot's providers, OPG, KOBI messaging, website, consults, conferences,

Interdisciplinary Action Committee: Collaboration between community justice and Public Health

- Problem focused monthly meetings
- Participants:
  - District Attorney
  - Sheriff, Police
  - Drug Court
  - Public Health
  - Substance Abuse treatment
  - Southern Oregon University
  - Parole and probation

Naloxone in Jackson County

- MPD, APD, PTPD all have naloxone in their patrol cars
  - County Sheriff and CPPD soon to follow
  - MPD has 10 “saves” to date.
- Allied (MAT clinic) and a number of local clinics are following suit.
- Local CCOs are funding naloxone.



Partnership with Oregon PDMP

- PDMP de-identified data can help guide policy
- Encouraging providers to sign up for and delegate PDMP query (in office sign-up)
- Creating a provider PDMP education video
- Piloting a dashboard for professional prescribing information

Oregon Health Authority

Where does our support come from?

- Direct Financial
  - Coordinated Care Organizations (CCOs)
  - Grants: Federal, CCOs

- In-Kind Support
  - Jackson County HHS
  - Oregon Health Authority
  - CCOs: thought leaders, 120 MED policy, Web development, attendance at meetings
  - Local A&D providers, JCMH,
  - Oregon Medical Board
  - Community providers

JACKSON COUNTY
Oregon

Jackson Care Connect
Your Community Health Plan

allcare health™

PrimaryHealth of Josephine County
Your Community Health Plan

Working hand in hand with the CCOs

- Both have adopted 120 MED policy:
  - They will not pay for opioid medication without an approved tapering plan in place
  - Messaging to both the patient and the provider
- They have behavioral outreach to local providers
- They support various community educational projects
- They serve on the OPG Steering Committee

Other Collaborations

- Oregon Medical Board
- Tri County website integration
- Continued strong CCO collaboration
- OrCRM & Lines for Life
- OHA
  - Part of a CDC grant to disseminate grass roots efforts to establish safe prescribing practices for pain management

Thank You

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