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Aligning Pain Care in our Communities

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Our Project

- Standardization of care for opioid treated chronic non cancer pain patients across Mayo Clinic Health System Southwest WI
  - Including portions of Iowa, Minnesota, and Wisconsin
  - Using education, collaboration and quality improvement

Disclosure and Funding

- Rod Erickson
  - No relevant financial disclosures
- Dave Onsrud
  - No relevant financial disclosures
- Disclosures for Planners and Reviewers in handout materials

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Project Goal

- Aligning Pain Care in Our Communities is designed to:
  - Realize a reduction in misuse of opioids in managing chronic pain
  - Achieve consistency across physicians in safe opioid prescribing
  - Improve identification of depression in patients with chronic pain
  - Engage community resources in the treatment of patients with chronic pain

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Today's Learning Objectives

1. Review the education and QI project
2. Identify and address the universal precautions of treating chronic pain with opioids
3. Review key elements and staff responsibilities and next steps

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Introduction

- Who is involved in the program
- Who are our site leaders
- Introduction
  - People
  - Jeopardy
- Universal Precautions
- PDMP
- Pain Agreement
- Urine Drug Screens
- Wrap up discussion and future directions

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Let's get started

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Question 1

1. The rate of increase in opioid use in the US from 1998 to 2008
   a) What is 2 fold increase
   b) What is 4 fold increase
   c) What is 6 fold increase
   d) What is 5% decrease

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Question 1

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   a) What is 2 fold increase
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   c) What is 6 fold increase
   d) What is 5% decrease

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Question 2

2. The number of drug overdose deaths has been increasing while the number of traffic deaths has been decreasing. This was the ratio of drug overdose deaths to traffic deaths in 2014.

   a) What is 10% more traffic deaths to drug deaths
   b) What is equal number of deaths from each
   c) What is 10% more deaths from overdose
   d) What is 50% more deaths from overdose

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Question 2

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a) What is 10% more traffic deaths to drug deaths
b) What is equal number of deaths from each
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d) What is 50% more deaths from overdose

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Question 3

3. This was the number of Americans abusing prescription drugs in 2010
a) What is 4 million
b) What is 6 million
c) What is 8 million
d) What is 1 billion

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   a) What is 4 million
   b) What is 6 million
   c) What is 8 million
   d) What is 1 billion

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Question 4

4. This is the dollar cost of chronic pain the US for including both treatment and lost productivity.
   a) What is $365 billion
   b) What is $465 billion
   c) What is $565 billion
   d) What is $635 billion

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Question 4

4. This is the dollar cost of chronic pain the US for including both treatment and lost productivity.
   a) What is $365 billion
   b) What is $465 billion
   c) What is $565 billion
   d) What is $635 billion

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Question 5

5. Despite a major increase in opioid prescriptions, surveys show this much change in pain control in the US in the past 10 years.
   a) What is no change
   b) What is 25% decrease in pain
   c) What is 25 % increase in pain
   d) What is 50 % increase in pain

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Question 5

5. Despite a major increase in opioid prescriptions, surveys show this much change in pain control in the US in the past 10 years.
   a) **What is no change**
   b) What is 25% decrease
   c) What is 25 % increase
   d) What is 50 % increase

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CDC Guidelines

- The Center for Disease Control has issued 12 guidelines for prescribing long term opiates for managing non-cancer pain
  - The CDC 12 point recommendations and a checklist are provided in your handouts.

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Community Priorities

- Don't share
- Lock your meds
- Dispose of properly

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Universal Precautions

- Historic maxim: "Pain is what the patient says".
- New maxim: "Anyone complaining of pain is suffering from something; the clinician's job is to try to figure out the cause of the suffering and to formulate a plan for reversing erosion of the patient's quality of life".

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Universal Precautions

- No data to support focusing on one population or setting to predict misuse
  - Prescribers must be vigilant of all patients
- We must often be suspicious, but rarely judgmental
- Treating everyone with the same screens, diagnostic tests, and administrative procedures can help remove bias and level the playing field

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Three Elements

- Pain Agreement
- Prescription Drug Monitoring Program-PDMP
- Urine Drug Screening

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Case A: John

John is a 48 year old man with chronic neuropathic pain in his legs. His treatment includes: oxycodone ER 10 mg twice a day. He had a good response to this treatment and was stable on this regimen for 2 years. There have been no concerns about his medication use or use of other substances.

After a detailed discussion with the patient, you elected to start a trial of an increased dose of oxycodone 10 mg three times a day.

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Case A: John

After changing John's oxycodone therapy, you should:

a) Sign an updated treatment agreement.
b) Document the change in the Treatment Plan.
c) Schedule a follow-up visit.
d) All of the above.

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Case A: John

- Answer d) All of the above.

- All changes to opioid therapy should be documented and reflected in an updated treatment agreement, and documentation of care plan.

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Treatment Agreement "Pain Contract"

- When should it be used?
- Who does the paper work?
- Where does it go in chart?
- Who checks it?
- Other items

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- Contract for Controlled Medication
- System Requirements
  - One provider
  - One pharmacy
  - Multiple copies: medical record, patient, pharmacy and clinic paper copy

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Case B

Which one of the following clinical scenarios is most suggestive of a serious violation of a treatment agreement that can lead to the termination of long-term opioid therapy for chronic non-cancer pain?

a) The patient calls for an early refill (5 days early) due to an acute worsening of the chronic pain after moving furniture.
b) The patient missed a scheduled physical therapy appointment.
c) The patient had made three requests over the past several months to increase the dose of his opioid medication due to worsened pain.
d) Targeted urine drug test is negative for prescribed methadone; a "pill count" documents presence of 6 out of the expected 30 tablets in the patient's medication bottle.

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Case B

- Answer: d)

- Opioid diversion is considered a major violation of the treatment agreement; therefore it often constitutes grounds for discontinuation of opioid prescribing and termination of the agreement.

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Prescription Drug Monitoring Program

- Discussion about PDMP
  - What is it
  - Who can check it
  - When should it be checked
  - Who will check it

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Case C: Mary

- Mary is a 56 year old woman with chronic leg pain on morphine extended release 40 mg once-daily and morphine short-acting 15-30 mg prn, up to 6 tablets per day. You have a high-level of clinical suspicion she is misusing opioids based on:
  - repeated requests for early refills
  - several urine drug test results that showed unprescribed opioids,
- You call her asking to schedule a clinic visit to discuss these concerns.
  - She misses this appointment, then calls the following day asking for a refill, 8 days early
  - She says she is unable to come for an appointment because she has been traveling.
- You check the Prescription Drug Monitoring Program database
  - She received prescriptions for opioids and benzodiazepines two days ago from the Emergency Department in a nearby town.

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Case C: Mary

Which approach is most appropriate in this clinical situation?

a) Switch to buprenorphine therapy for pain management
b) Switch to methadone therapy for pain management
c) Initiate slow taper of the prescribed opioids
d) Discontinue opioids

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Case C: Mary

- Answer: d) Discontinue opioids

- Although opioid taper is preferred, an abrupt discontinuation of long-term opioid therapy may need to be implemented if it is not safe or appropriate to prescribe a taper.

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Wisconsin Prescription Drug Monitoring Program-PDMP

- The goal of the Wisconsin PDMP is to improve patient care and safety, and reduce abuse and diversion of prescription drugs in Wisconsin. It contains information submitted by pharmacists and practitioners who dispense monitored prescription drugs to patients.
  - Practitioners may delegate the task of accessing and querying the PDMP for information
  - The dispensers do not violate HIPAA by disclosing health information to the PDMP without patient consent.
  - Wisconsin PDMP allows clinicians to access data on the monitored prescription drugs dispensed in 14 states.

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Urine Drug Screens

- Discussion of urine drug screens
- Who should be tested and when
- Different tests - PAINO
- How are the tests ordered

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Urine Drug Screens

- Universal screening for **all** patient on long term opioids
- ***UDT frequency is based on clinical judgment***
  Depending on patient's display of aberrant behavior and whether it is sufficient to document adherence to treatment plan
  - High risk may need more often (1-3 months)
  - Low risk may need less often (6-12 months)

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Patient D: Holly

- Holly is a 54 year old woman treated with morphine ER 30 mg twice a day and oxycodone prn. She is calling to request a refill.
  - She followed the Clinic Policy and called 72 hours in advance of being due for the refill.
  - The medical assistant (MA), when completing the refill encounter, documents that the medical record and Prescription Drug Monitoring Program's data are consistent with patient's reports.
  - The MA notes the patient is overdue for urine drug testing, as the prior one was completed over a year ago, and pends the order for the recommended pain management profile in addition to the requested medications.
  - The clinician reviews the record, documents absence of prior red flags, signs the pended orders, and recommends that the patient leave a urine sample.

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Patient D: Holly

Which one of the following statements is correct?

a) The patient should not be told in advance, before coming to the clinic for prescription pick-up, about the need for urine testing, as such testing would then not be considered random.

b) The patient can be told in advance that, when coming to the clinic, she will need to leave a urine sample for drug testing prior to being able to pick-up her prescriptions.

c) The patient is not allowed to leave a urine sample at a different clinic than the one through which opioid prescriptions are issued.

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Patient D: Holly

- Correct answer: b)

- Providing patients with an up-to 24-hour notice about the need to come to the clinic for random urine drug testing is appropriate.

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Case E: Jocelyn

Jocelynn is a 45 year old woman with chronic low back pain, treated with morphine extended release 30 mg three times a day and clonazepam 1 mg twice a day. Her urine drug screening test is "positive for opiates and negative for benzodiazepines."

These results can be explained by:

a) She is taking morphine but not clonazepam
b) She is taking morphine and clonazepam
c) She is taking clonazepam and using heroin
d) Any of the above may be correct

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Case E: Jocelyn

- Correct answer: d) Any of the above may be correct

- Screening urine drug tests (UDTs) are cheaper than the confirmatory-level tests and can quickly provide results. However, they can yield false positive and false negative results. The confirmatory-level tests are very sensitive and specific, and can verify the findings of a screening test.

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Interpretation of Results

Positive Result

Demonstrates recent use
- Most drugs in urine have detection times of 1-3 d
- Chronic use of lipid-soluble drugs: test positive for ≥1 wk

Does not diagnose
- Drug addiction, physical dependence, or impairment

Does not provide enough information to determine
- Exposure time, dose, or frequency of use

Negative Result

Does not diagnose diversion
- More complex than presence or absence of a drug in urine

May be due to maladaptive drug-taking behavior
- Bingeing, running out early
- Other factors: eg, cessation of insurance, financial difficulties

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Interpretation of UDT Results

- Use UDT results in conjunction w/ other clinical information
- Do not ignore the *unexpected* positive result
- Investigate unexpected results
  - Schedule appointment w/ patient to discuss unexpected/abnormal results
  - Discuss w/ the lab
- Chart results, interpretation, & action
- May necessitate closer monitoring &/or referral to a specialist

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Summary

- Introduced the concept of universal precautions
  - Treatment Agreement
  - PDMP
  - Urine Drug Screens
- What is now being done?
- Which would you like to incorporate?
- Who will look at how to incorporate this into the practice?

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Next Steps

- Determine your opioid treated chronic pain patients
  - Using the PDMP identify patients you have prescribed opioids in past 4 months
  - Review and modify list.
  - Send to Janel Tunison for registry creation:
    - Tunison.Janel@mayo.edu
  - Work with Janel to conduct chart audit to determine your baseline measures on the universal precautions

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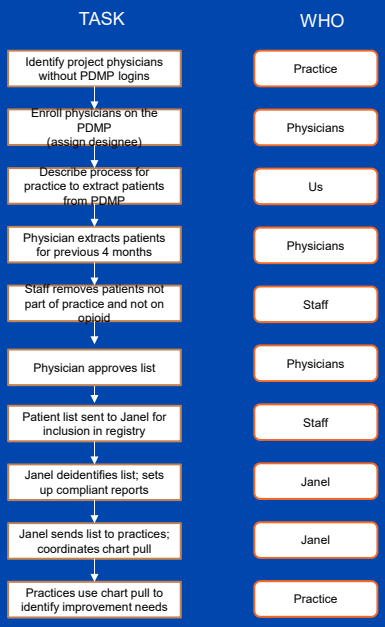

Next Steps

- Second academic detailing meeting with Dr. Cheri Olson being scheduled to address quality improvement processes and helping determine your clinic's areas of emphasis for improvement
- Maintenance of Certification Part II and Part IV will be offered for the improvement project and detailed at second meeting

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Thank You!

- Complete today's survey for CME credit and project information
- Complete the Part II questions for MOC Part II credit
- Questions?

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