The Team Based Approach to an Opioid Refill Clinic
Disclosures

The Salem Health Pain team - Paul Coelho, MD, Joshua Steenstra, MBA, Ana Ramirez, NCMA, Melanie Nixon, NCMA, have no disclosures. We will not be discussing any off label uses.
Learning Objectives

• Learn how we got into the opioid epidemic
• Describe the Salem Health Pain Clinic approach
• Learn how to develop a team based approach to managing opioids
Agenda

1. A Brief History of Opioid Epidemic
2. SH Pain Clinic Philosophy and approach
3. Team based roles and responsibilities
4. Discussion/Sample cases
US Overdose Deaths in 1980-2017

Peak Incidence Ages 45-54

CDC: https://www.cdc.gov/nchs/products/databriefs/db294.htm
International Opioid Prescribing

By Keith Humphreys  March 23

The U.S. Consumes Many Times as Many Opioids Per Capita as Countries with Similar Levels of Pain


Salem Health Hospitals & Clinics
Salem Oregon Variation

2014 CMS Data

Prescribing Decile by Specialty

https://data.cms.gov/Medicare-Claims/Medicare-Part-D-Opioid-Prescriber-Summary-File-201/e4ka-3ncx/data
OD’s Cluster with High Dose Prescribers


Griporas CA1,2, Karanika S1,3, Velmahos E1, Alevizakos M1, Flokas ME1, Kaspiris-Roussellis C2, Evagelidis IN2, Artelaris P4, Slietos CI2, Mylonakis E5.

Abstract

BACKGROUND: The opioid epidemic is an escalating health crisis. We evaluated the impact of opioid prescription rates and socioeconomic determinants on opioid mortality rates, and identified potential differences in prescription patterns by categories of practitioners.

METHODS: We combined the 2013 and 2014 Medicare Part D data and quantified the opioid prescription rate in a county level cross-sectional study with data from 2710 counties, 468,614 unique prescribers and 46,665,037 beneficiaries. We used the CDC WONDER database to obtain opioid-related mortality data. Socioeconomic characteristics for each county were acquired from the US Census Bureau.

RESULTS: The average national opioid prescription rate was 3.86 claims per beneficiary that received a prescription for opioids (95% CI 3.86-3.86). At a county level, overall opioid prescription rates (p < 0.001, Coeff = 0.27) and especially those provided by emergency medicine (p < 0.001, Coeff = 0.21), family medicine physicians (p = 0.11, Coeff = 0.08), internal medicine (p = 0.018, Coeff = 0.1) and physician assistants (p = 0.021, Coeff = 0.08) were associated with opioid-related mortality. Demographic factors, such as proportion of white (pwhite < 0.001, Coeff = 0.22), black (pblack < 0.001, Coeff = -0.19) and male population (pmale < 0.001, Coeff = 0.13) were associated with opioid prescription rates, while poverty (p < 0.001, Coeff = 0.41) and proportion of white population (pwhite < 0.001, Coeff = 0.27) were risk factors for opioid-related mortality (pmodel < 0.001, R² = 0.35). Notably, the impact of prescribers in the upper quartile was associated with opioid mortality (p < 0.001, Coeff = 0.14) and was twice that of the remaining 75% of prescribers together (p < 0.001, Coeff = 0.07) (pmodel = 0.03, R² = 0.03).

CONCLUSIONS: The prescription opioid rate, and especially that by certain categories of prescribers, correlated with opioid-related mortality. Interventions should prioritize providers that have a disproportionate impact and those that care for populations with socioeconomic factors that place them at higher risk.
Salem Health Pain Clinic

- Opioids are not the answer for chronic non-cancer pain
- CDC Guidelines, PDMP, UDS, Nasal Naloxone
- Structured Processes, clear expectations
- An Echo Chamber
CDC Guidelines

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. OPIOIDS ARE NOT FIRST-LINE THERAPY
   Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. ESTABLISH GOALS FOR PAIN AND FUNCTION
   Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how quickly therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. DISCUSS RISKS AND BENEFITS
   Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4. USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING
   When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. USE THE LOWEST EFFECTIVE DOSE
   When opioids are started, clinicians should prescribe the lowest effective dose. Clinicians should use caution when prescribing opioids at any dose, should carefully reexamine evidence of individual benefit and risks when considering increasing dosage to 20 morphine milligram equivalents (MMEs), and should avoid increasing dosage to 60 MMEs/day or carefully justify a decision to exceed dosage to 90 MMEs/day.

6. PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN
   Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. These days or less will often be sufficient; more than seven days will rarely be needed.

EVALUATE BENEFITS AND HARMS FREQUENTLY

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 2 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS

8. USE STRATEGIES TO MITIGATE RISK
   Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. REVIEW PMP DATA
   Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PMP) data to determine whether the patient is receiving opioid doses or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. USE URINE DRUG TESTING
    When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIPTIONS
    Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. OFFER TREATMENT FOR OPIOID USE DISORDER
    Clinicians should offer or arrange evidence-based treatment focused medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapy for patients with opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Salem Health Hospitals & Clinics
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Standard Work Flow for PDMP Delegates

- Perform your PDMP search the day prior to the patient’s scheduled visit.
The Structured Opioid Refill Clinic

Patient

Opioid Naïve
Screen & Dx
Non-opioid alternatives

Opioid Tolerant
Within CDC
Maintain
Above CDC
Taper
Buprenorphine
Team Based Roles and Responsibilities

• **An Echo Chamber**
  – Leadership
  – Fellowship of team members
  – We are on the same team (all information is shared)
  – Huddle daily

• **Interactions with patients**
  – Telephone calls (scheduling)
  – Patient Visits
Team Based Roles and Responsibilities

• **Telephone Booking New Patients**
  – Socratic questioning and expectations
  – Example: Setting the stage for change

• **New Patient Visits**
  – Chaperoned Visits
  – Example: Communication

• **Follow up Visits**
  – Structured Opioid Refill Clinic
  – Example: Tolerance
When it is no longer Pain…

• Opioid use disorder and Buprenorphine
  – Early refill requests
  – Dose escalations
  – Inconsistent UDS
  – Aberrant behaviors
  – Withdrawal

• It works, we all believe
Discussion
or
Sample Cases
Ron

- 52y/o disabled/retired laborer with chronic back pain.
- No history of addiction, hep C, or aberrant behavior.
- Married x 30yrs with adult children. Prescribed
- OxyContin 60mg QID. (MED 360)
Ron

• Brought Ron and his spouse in. Had a long, difficult discussion about his medication dose.
• I diagnosed DSM 5 Opioid Use Disorder and Rx’d naloxone.

While initially very resistant to change, he eventually consented to induction with Buprenorphine 8mg and stabilized on 16mg/QD.
Linda

- Linda is a 52y/disabled/retired office worker with chronic wide-spread pain (FMS).
- No history of addiction, hep c, or aberrant behavior.
- Married x 25yrs.
- Prescribed hydrocodone 10/325 8 QD, oxycodone IR 30mg 6 QD and OxyContin 80mg TID.
- MED 710
Linda

- Brought Linda in for a discussion about her medication.
- Had the ‘difficult conversation’ about risk and the need for change.
- Diagnosed DSM 5 opioid use disorder.
- She consented to a conversion to buprenorphine.
- At was induced and stabilized with 16mg/QD.
Richard

- 67 y/o C6 incomplete tetraplegic with SCI related pain.
- No history of addiction, hep C, or aberrant behavior.
- Married x 35yrs with grown children.
- Managed on morphine sulfate ER 100mg QID. MED 400
Richard

- Brought Richard and his spouse in for a difficult conversation about his medication dose.
- He initially agreed to a taper of 30mg/mo but suffered miserably due to withdrawal symptoms.
- Given his tolerance, withdrawal symptoms, and inability to taper I diagnosed DSM 5 opioid use disorder.
- With great trepidation he eventually consented to a conversion to buprenorphine and stabilized on 12mg/d.
Margaret

- 31y/o woman with Lupus and psoriatic arthritis.
- Rx’d oxycodone IR 30mg, 72 tabs per day, MED 3200.
- No h/o hep C or IVDA.
- Pill counts and UDS consistent.
- Referral for residential tx was attempted.
- Offered pt. a 12wk taper with planned rotation to buprenorphine when MED < 1,000.
Margaret

- Margaret agreed to a 12wk taper to ~ 900 MED, 2d assisted withdrawal and a rotation to buprenorphine.
- She was induced with 8mg of buprenorphine and stabilized at 16mg.
- Patient is resistant to the diagnosis of OUD and has been referred for counselling with a CADC.
Questions

1. The application of palliative care principles to chronic non-cancer pain in the late 1980s resulted in:
   a. Increased opioid prescribing for non-cancer pain.
   b. Decreased opioid prescribing for non-cancer pain.
   c. No change in opioid prescribing for non-cancer pain.

2: What are the advantages of a “Team-based” approach to chronic pain management?
   a. Reduced provider burnout.
   b. Empowering staff to work at the top of their license.
   c. Better patient care.
   d. All of the above

3: What are some strategies to implement a team-based approach in your clinic?
   a. Obtain delegate status for your MA’s.
   b. Using “Socratic Questioning” when scheduling visits.
   c. Preparing PDMP runs the day prior to patient visits to prepare.
   d. All of the above
Thank you