A Paradigm Shift in

Management

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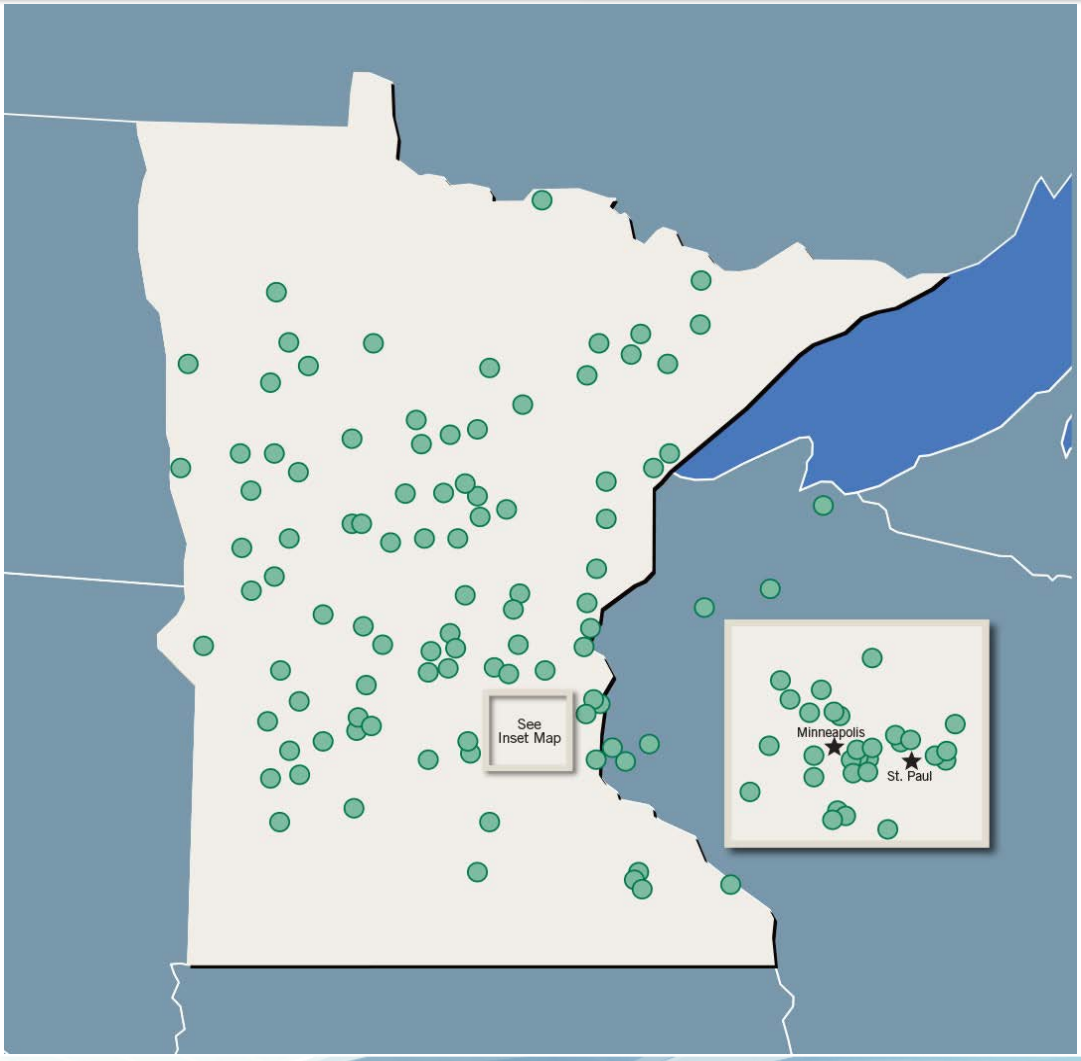
Today's Objectives

- Comprehensive pain assessment
- Non-opioid approaches to pain management
- New approaches to manage a patient who is already on chronic opioids for pain

ICSI: Who We Are

- Independent, non-profit organization
- Formed in 1993 by Mayo Clinic, HealthPartners and Park Nicollet
- Collaboration of 50+ medical group and hospital members representing approximately 8,500 physicians
- Also supported by non-profit MN health plans and grants

ICSI Membership Map



ICSI Pain Documents

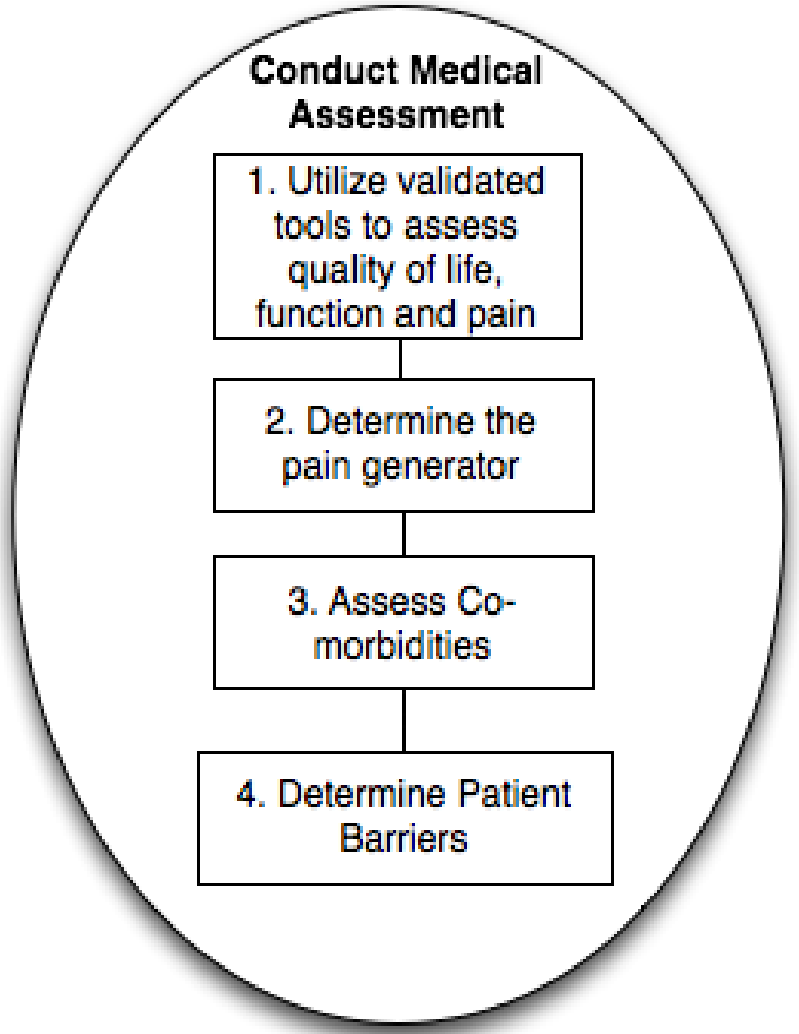
ICSI replaced two existing documents:

- Acute Pain Assessment and Opioid Prescribing Protocol
- Assessment and Management of Chronic Pain guideline

October 2016 revision: *Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management Guideline*

- Focus on function and quality of life with pain
- Evidence-based alternative treatment options
- Managing patients already using opioids

Pain Assessment Algorithm



Assessment of Pain

- Use validated tools to assess functional status, pain intensity and quality of life
- Pain is a normal part of life
- Pain elicits an emotional response
- There is no such thing as legitimate or illegitimate pain

International Association for the study of pain 2014

Pain Generators

- The goal is to treat the underlying pain generator
- Patients may have several:
  - Neuropathic
  - Musculoskeletal
  - Inflammatory (including dental)
  - Visceral
- Opioid induced pain should be considered, especially when there are indeterminate causes (e.g. hyperalgesia, tolerance and withdrawal)

Assess for Comorbidities

- Physical and behavioral comorbidities often coexist with pain
- Consider screening patients in pain for substance use disorders (SUDs)
  - If a patient screens positive for alcohol and other drugs, follow up with the full DSM-5 criteria
  - Patients with a SUD are at highest risk of harms from opioid analgesics

Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA 2011;305:1315-21.
Volkow ND, McLellan AT. Opioid abuse in chronic pain – misconceptions and mitigation strategies. N Engl J Med 2016;374:1253-63.

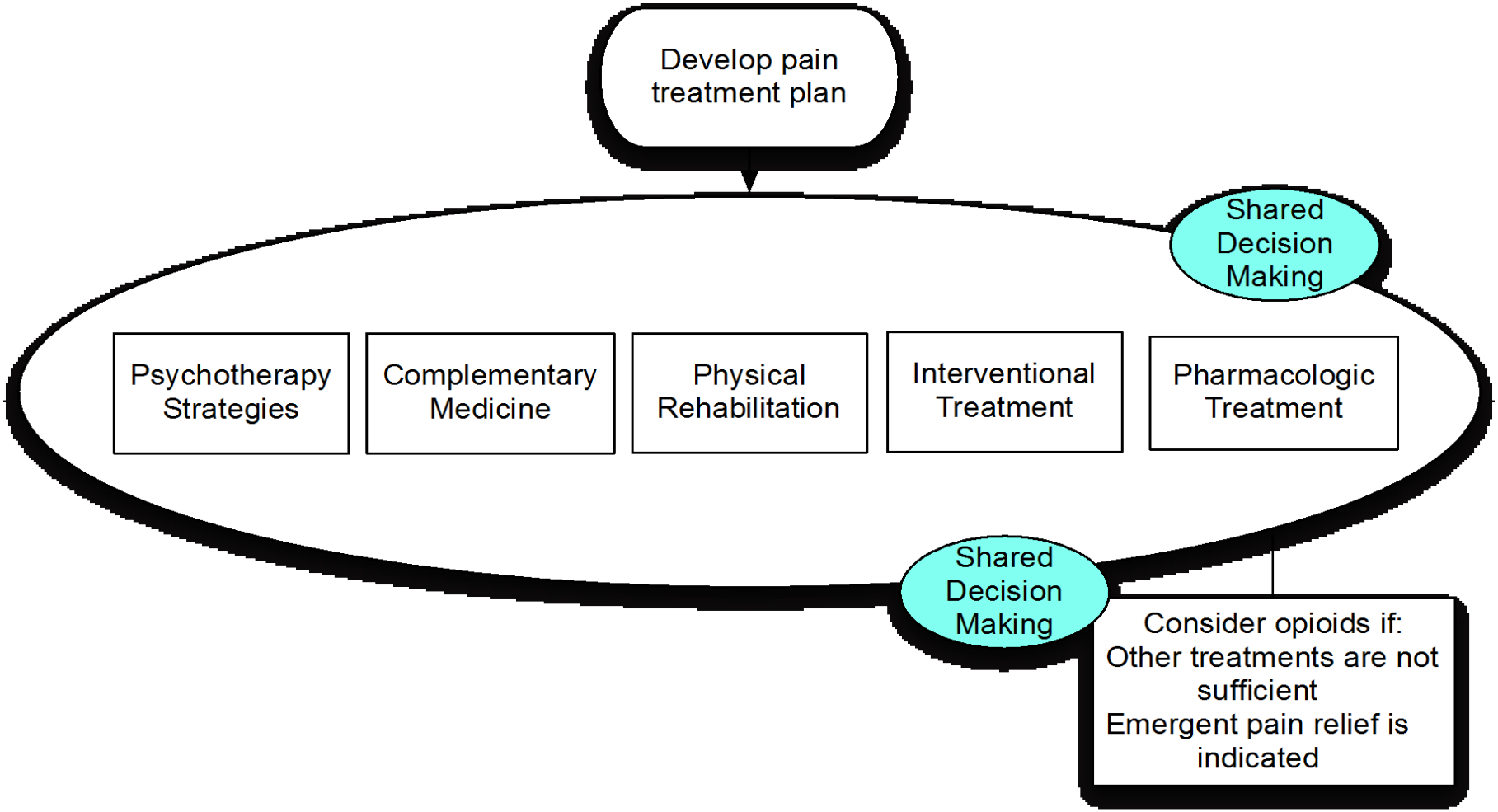
Determine Patient Barriers

- Understand patient barriers: financial, housing, employment, lifestyle, transportation, social support, education, etc.
- Determine how they might contribute
- If the pain is not resolving, determine whether new barriers are impacting treatment

Patient – Provider Relationship

It takes time to understand your patient's needs, to build a trusting relationship, to learn what barriers exist, and whether their goals are realistic or not.

Pain Treatment Plan Algorithm



Develop a Systems Approach to Pain

- A multidisciplinary approach is recommended
- Engage in dialogue with your community to identify the gaps in care
- Develop referral sources for:
  - psychiatry
  - physical therapy
  - pain medicine
  - treatment for substance use disorder
  - pharmacy support

Effective Psychotherapy Strategies

- Cognitive Behavioral Therapy and mindfulness-based stress reduction are recommended for patients with a chronic pain diagnosis
- Relaxation therapies and hypnosis can be helpful in pain management

Complementary and Integrative Medicine

Evidence is lacking on these topics; however, NIH has some information available:

- Acupuncture (musculoskeletal pain)
- Qi-gong and Healing Touch Therapy (fibromyalgia, neck pain and elderly patients)
- Tai-chi and yoga (chronic low back pain)
- Herbals and supplements (anti-inflammatory)
- Medical Cannabis (no clear benefit for non-cancer pain)

Effective Physical Rehabilitation Modalities

- Active exercise for treatment for chronic pain
- Physical therapy with clinical improvement
- Passive modalities more effective as adjunct to active therapy
  - Massage
  - Spinal manipulation therapy
  - Ultrasound
  - TENS

Standaert CJ, Friedly J, Erwin MW, et al. Comparative effectiveness of exercise, acupuncture, and spinal manipulation for low back pain. Spine 2011;36:S120-30.

Falla D, Lindstrøm R, Rechter L, et al. Effectiveness of an 8-week exercise programme on pain and specificity of neck muscle activity in patients with chronic neck pain: a randomized controlled study. Eur J Pain 2013;17:1517-28.

Pharmacologic Treatment

- Consider NSAIDS, acetaminophen, anti-depressants, and anti-convulsants
- Sedative hypnotics, including benzodiazepines, use only less than 1 week for acute muscle spasms
- Non-sedative hypnotic muscle relaxants should be used for less than 4 weeks
- Don’t use carisoprodol (Soma) for pain

Richards, et al: Muscle relaxants in IA; www.jrheum.org ; Van Tulder, et al; Muscle relaxants for non-specific low back pain. Cochrane Database Syst Rev 2003;(2):CD004252

ABCDPQRS Screening Before Opioids

- Alcohol use
- Benzodiazepines and other drug use
- Clearance and metabolism of drug
- Delirium, dementia and falls risk
- Psychiatric comorbidities
- Query the prescription monitoring program
- Respiratory insufficiency and sleep apnea
- Safe driving, work, storage and disposal

Initiating Opioids For Acute Pain

- Initial treatment for pain should be no more than 20 low-dose short-acting opioids OR three days of medication, whichever is less (total dose no greater than 100 Morphine Milligram Equivalent)
- This includes patients presenting with:
  - acute pain
  - acute on chronic pain
  - patients already on chronic opioids
  - patients with opioid tolerance, or on methadone
- Clinicians should offer naloxone to the patient and their family

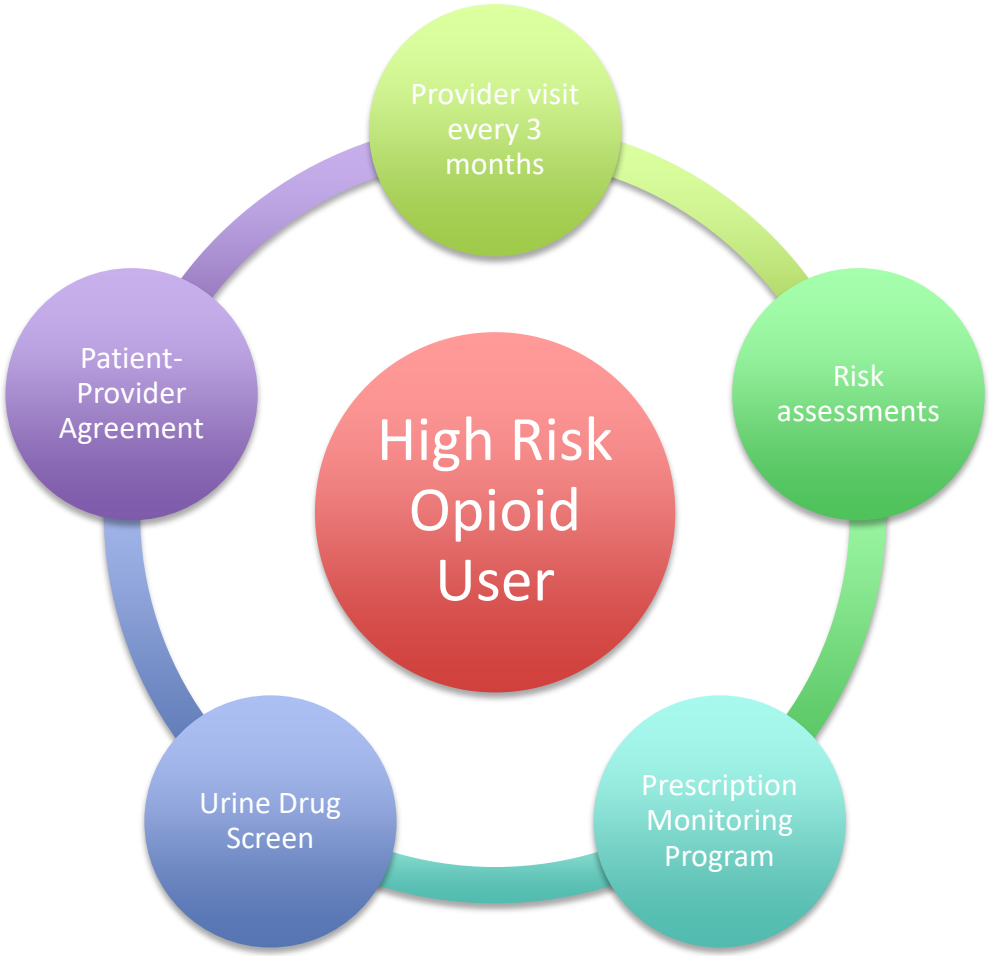
Ongoing Opioid Treatment for Pain

- Avoid opioids to treat patients with chronic pain
- Every effort should be made to keep an opioid dose under 100 MME/day
- Consider referral to pain medicine if 100 MME/day is reached
- Avoid opioids with benzodiazepines or substance use disorder
- If concomitant use is unavoidable, opioids should be less than 50 MME/day and all prescribers must communicate about dosing

Monitoring Risk for Opioid Misuse/Overuse

- Monitor patient at least every three months
- Use opioid risk assessment tools
- Review Patient - Provider Agreement
- Query Prescription Monitoring Program (PMP) at least twice per year
- Urine Drug Screen at least once per year
- Consider opioid use disorder
- Offer taper or discontinuation of opioids at intervals of six months

Refer High Risk Patients to Treatment



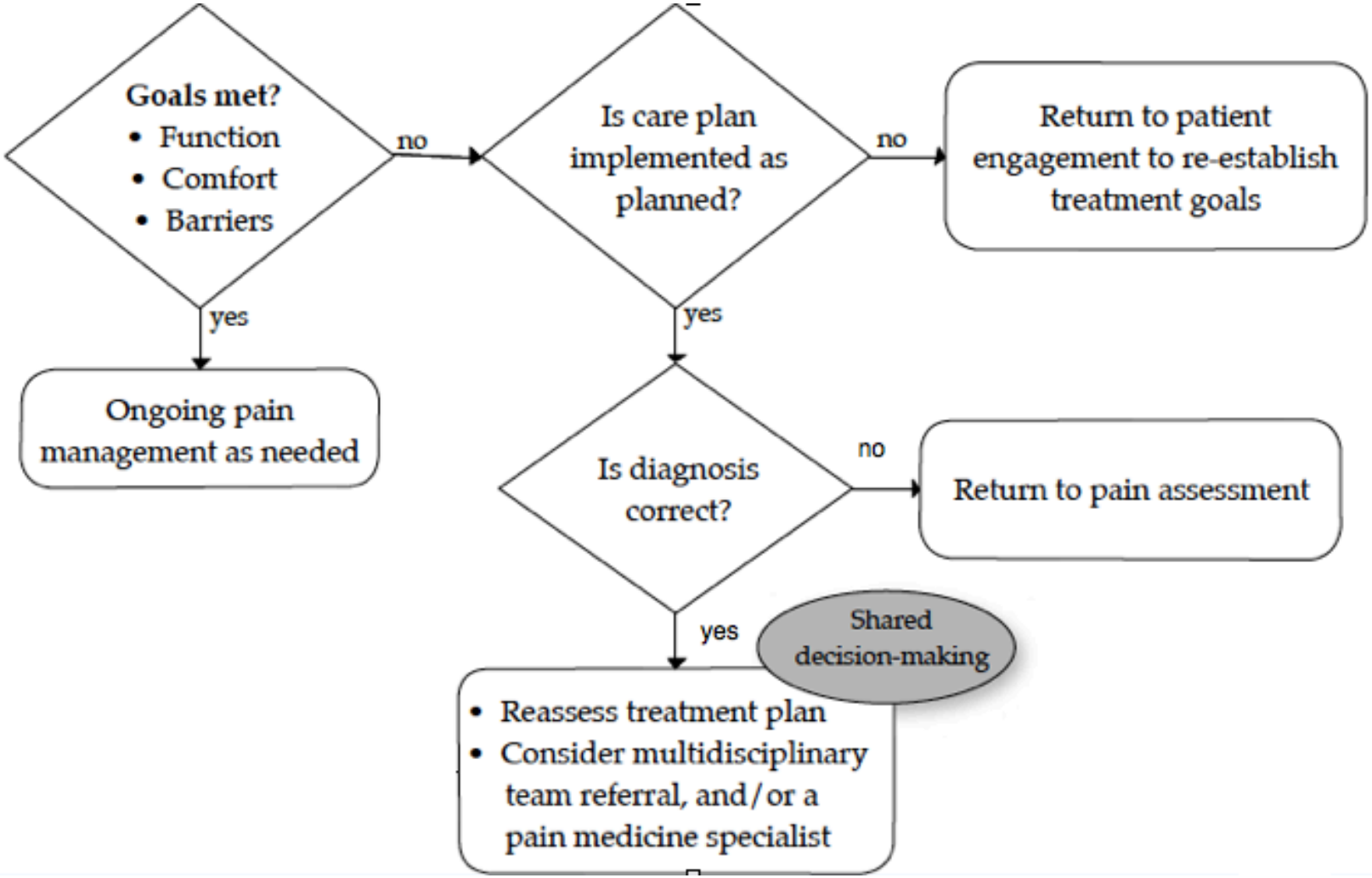
Patient - Provider Agreements

- High-risk patients (use ABCDPQRS)
- Daily use of opioids >30 days
- Patient transfers to a new clinic already on opioids
- Episodic use up to 90 days over the course of a year
- If none of the above, initiate after 90 days of opioids have been prescribed

Prescription Monitoring Program (PMP)

- If prescribing in dental, emergency department and urgent care settings, and when doses are changed
- If concerns of substance use disorder, overdose, diversion, polypharmacy, or indeterminate pain mechanism
- For stable chronic users PMP checks should be at least twice per year
- Consider querying when initiating opioid therapy

Trouble-shooting Unresolved Pain



Implementation at Entira Family Clinics

David Thorson, MD

Family Practice and Sports Medicine

Getting our provider's attention

Treat yourself / A Bieber Opioid Ballad by zdogmd

https://youtu.be/OAa1clWcFOc

Opioid Epidemic and Our Culture

- We have unknowingly been part of the problem
- Old information was wrong
  - Addiction does occur even if used for acute pain
  - Treating to a pain scale of 0 can lead to addiction
  - Scheduling meds to stay ahead of pain
  - Long acting are safer than short acting
- Addiction can start with the first prescription of opioids

Paradigm Shift in Treatment

- Focus on understanding pain generators
- Improved diagnosis and treatment
- Opioids should be last resort to treat pain but are at times appropriate
- Offer patients taking chronic opioids a taper at 6 month intervals to facilitate discontinuation

Entira Family Clinics

- Independent Physician owned and led group
- 65 physicians and 13 advanced practice providers
- 12 clinics from West St. Paul to Shoreview
- Participated with ICSI since inception
- 5 clinical practice committees direct the approval and implementation of care guidelines

Neuromuscular Committee

- Reviewed the ICSI Pain guideline compared to current practice
- Acute pain and acute opioid process going well
- Changes recommended to treatment and documentation of chronic opioid use for pain
- Updated our policy for management of chronic pain, CSA, and the patient information letter
- Recommended changes be made in the HPI chronic pain section of our EHR

First Opioid Refill

Important decision point is when you decide to refill the initial acute opioid prescription

- Evaluate for cause of pain again
- Evaluate for addiction risk
- Treat the cause of the pain, not just the pain
- Check PMP
- Obtain a Controlled Substance Agreement
- Use shared decision making and informed consent
- Communicate with primary physician

Updating the Chronic Pain HPI Format

- Used Clinical Content designers to meet measurement / quality parameters
- Start date was January 1, 2017
- Added important documentation triggers to:
  - Improve the process of chart audit
  - Allow us to measure treatment process
  - Help guide providers to document correctly

Imbedding Guidelines Into Our EHR

- Use committees to decide what to imbed
- Hardwire some decision-making steps
- Add screening tools
- Structured data for analytics and measurement
- Identify the diagnosis codes that will be used, e.g. ICD-10 for chronic pain + the site

Chronic Opioid use Documentation Goals

- Controlled Substance Agreements obtained and on file (updated to reflect new policies)
- Patients on chronic opioids seen every 3 months with rare exceptions
- Document function, pain, QOL assessment using PEG tool
- PMP checked initially and at least twice yearly and documented in the chart
- Urine toxicology obtained at least once a year
- Document opioid risk assessment with DIRE tool

PEG: Assessing Pain Intensity and Interference

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Krebs EE, Lorenz KA, Bair MJ, et al. Development and initial validation of the PEG, a three item scale assessing pain intensity and interference. J Gen Intern Med 2009;24:733-38.

D.I.R.E Scoring Tool

Determines suitability for long-term opioid use

- Diagnosis
- Intractability
- Risk
  - Psychological
  - Chemical Health
  - Reliability
  - Social Support
- Efficacy Score

Belgrade MJ, Schamber CD, Lindgren BR . The DIRE score: predicting outcomes of opioid prescribing for chronic pain. *J Pain.* 2006; 7: 671-81. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16942953 Accessed on: 2013-09-12.
Passik SD, Kirsh KL, Casper D. Addiction-related assessment tools and pain management: instruments for screening, treatment planning and monitoring compliance. *Pain Med.* 2008; 9: S145-S166.

Major Documentation Goals for MME

- Calculate and document Morphine Milligram Equivalents (MME) by using an agreed upon MME calculator for devices
- MME dose over 100 should generate a pain clinic referral or presence of a previous referral
- MME dose over 50 with co-administered Benzodiazepines should generate a pain clinic referral

Additional Provider Training

- Taper should be considered every 6 months
- Long-acting opioids with tamper-proof formulations are reserved for patients with established opioid tolerance
- Understand and be able to refer for Substance Use Disorder
- We are arranging for speakers on addiction and substance use disorder
- We will have referral sources for access to pain consultation in a timely manner (2-4 weeks)

For questions contact Audrey Hansen

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View and download the guideline at:

www.icsi.org