New Hampshire Medical Society

For the Betterment of the Public Health since 1791

Opioid Prescribing Improvement Project

(*A work in progress)*

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The Problem

- Rising misuse of prescribed opioids…need to lead change.. or be told how to change
- Challenges
  - Limited evidence related to best practices in opioid prescribing
  - Limited awareness of available evidence and consensus based recs
  - Lack of tools to support best practices
  - Office system limitations to support prescribing

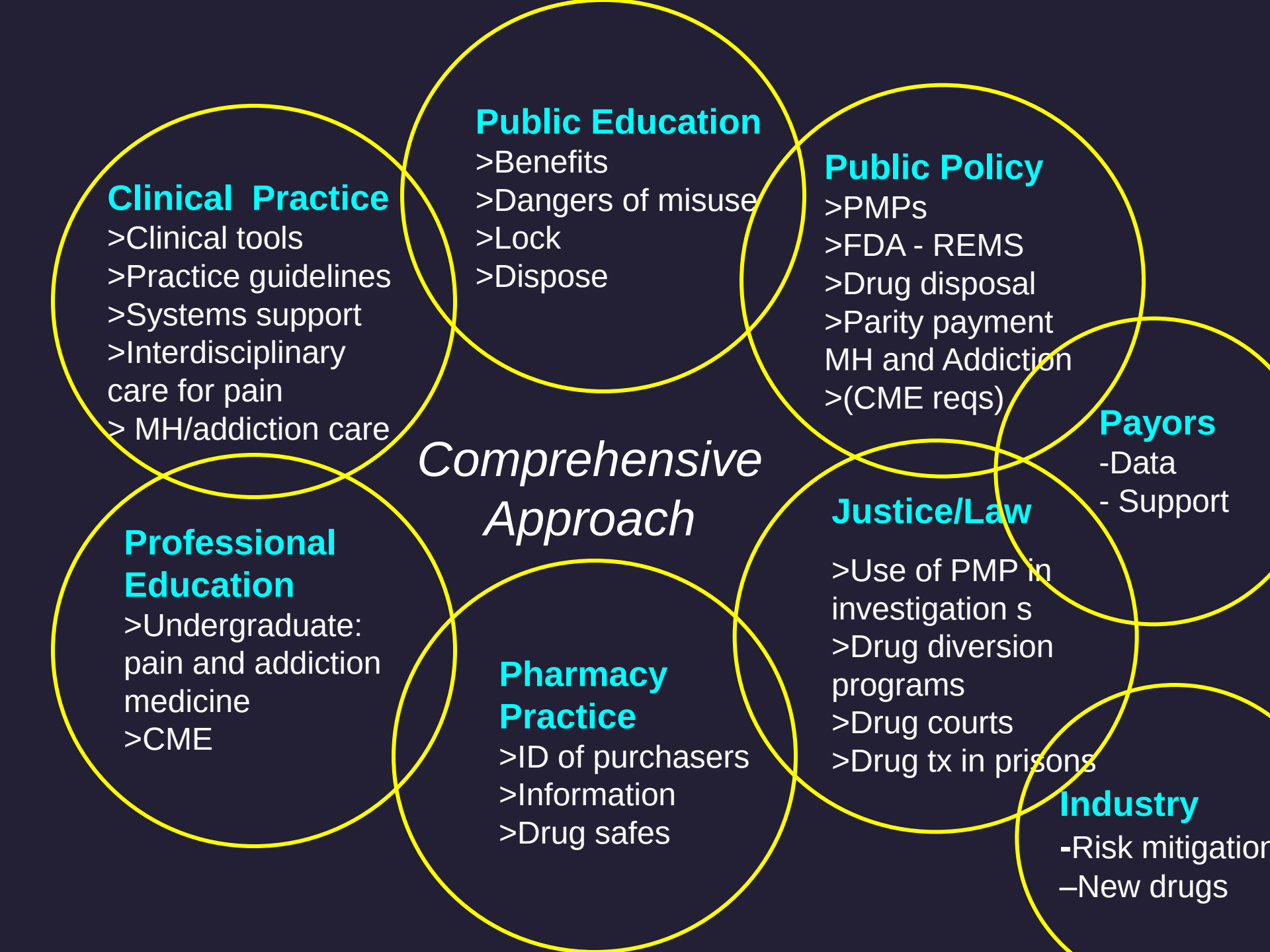
Tackling the Problem

NHMS Task Force *on* Pain & Prescription Drug Misuse

- Open process
- Interdisciplinary: PCP (MDs, NPs, PAs), Pain, Psychiatry, Physiatry, Addiction Med
- Volunteer, unfunded
- Largely non-academic, intended as clinical improvement, not research

Tackling the Problem

- Initial foci
  - Sketch map of statewide solutions
  - Support a PMP
  - Optimize clinical prescribing in NH


Public Education
>Benefits
>Dangers of misuse
>Lock
>Dispose
Clinical Practice
>Clinical tools
>Practice guidelines
>Systems support
>Interdisciplinary care for pain
> MH/addiction care
Public Policy
>PMPs
>FDA - REMS
>Drug disposal
>Parity payment MH and Addiction
>(CME reqs)
Payors
-Data
- Support
Comprehensive Approach
Professional Education
>Undergraduate: pain and addiction medicine
>CME
Justice/Law
>Use of PMP in investigation s
>Drug diversion programs
>Drug courts
>Drug tx in prisons
Pharmacy Practice
>ID of purchasers
>Information
>Drug safes
Industry
-Risk mitigation
–New drugs

Tackling the Problem
Optimize Prescribing

- Integrate clinical and evidence based opioid guidelines (APS, DHMC, Utah)
- Embed links to:
  - Printable clinical tools
  - Information and consultation resources
  - Further guidelines and education
- Where possible, links self updating
- Post online at NHMS with links to others
  - Online campaign CME

Tackling the Problem
Optimize Prescribing

- Engage key organizations in State
  - Board of Medicine
  - Board of Pharmacy
  - Centers of Excellence in Addictions
  - Professional organizations
- Dissemination possibilities
  - Inform at NHMS visits to med staff meetings
  - Academic detailing process, serial meetings
  - Regional learning collaboratives to promote office based systems change (IHI -PDSAs)

1. Position of opioids in treatment of chronic non-terminal pain (CNTP)

a. CNTP is a diverse chronic disease. Patient empowerment important to care.
b. CNTP often benefits from multidimensional treatment addressing physical, psycho-spiritual and social dimensions of pain. *Link here to chronic pain treatment information and guidelines, local treatment providers, pain organizations, and patient resources.*
c. A trial of opioid therapy appropriate: moderate-severe pain adversely affects function or quality of life, benefits outweigh risks, other txs not effective, available or appropriate

2. Patient selection & risk stratification

a. Conduct pain history, physical examination, appropriate testing. Document pain etiology & relevant co-occurring factors *Template for initial evaluation*
   - PE exemption for psychiatrist etc working with PCP
b. Assess opioid misuse risk. *Opioid risk screening tools/info*
c. COT in higher risk patients only if able to implement more intensive management. Consider consultation *Management of higher risk patients*
d. Avoid or minimize in pregnancy, counsel patients, anticipate risks to pt and newborn

High Risk OB Centers . Info on pain management in pregnancy.

3. Opioid management planning

a. Risks/benefits discussion. Optimum management: written informed consent, exceptions at discretion of the provider.
Examples of opioid informed consent & agreement

b. The plan of care discussion: goals of treatment, responsibilities patient & provider, conditions for continuation & discontinuation. Optimum management: written agreement, exceptions at discretion of provider.
Examples of opioid informed consent and agreement

4. Initiation, titration, revision of COT

a. Frame initial treatment with opioids a trial

b. Individualize opioid selection, initial dosing, and titration based on health status, prior opioid use, risks, progress to goals,

c. Consider opioid rotation for adverse effects or inadequate benefit despite increases

Equianalgesic opioid chart. Opioid rotation information.

d. Manage >200mg/ day MS equiv as higher risk

e. Methadone use with care, but by clinicians familiar with its use. *Guidelines for methadone use in pain*

5. Monitoring

a. Reassess regularly. 1-3 months usual, +/-
b. Document pain, function, progress towards goals, side effects, AEs. *Documentation tools*
c. Address opioid side effects. *Side effect ,anagement chart.*
d. Optimum practice : routine UDTs all patients annually, higher risk more often. Exceptions at discretion of clinician. *UDT information*
e. Note aberrant behaviors and restructure care as indicated. *Aberrant behaviors checklist. Care of higher risk patients.*
f. Consultation as indicated. *Pain, addiction, MH resources.*

6. Discontinuation of opioids

a. Indications for discontinuation: no progress, persistent adverse effects, non-adherence - despite adjustment of care
b. Taper to avoid withdrawal if physically dependent *Withdrawal protocols*
c. Arrange treatment for conditions leading to non-adherence when present
   MH, addiction teatment resources. Buprenorphine. Methadone.

7. Team management

a. Patients should have primary care medical home for coordination of care, may or may not be prescriber
b. Encourage communication and care coordination between specialists and PCMH *Patient Centered Medical Home resources links*

8. Legal Issues

a. Be familiar with relevant State and Federal regulations *Federal Controlled Substances Act. State CSA. Board of Medicine Rules.*
b. Management of criminal behaviors
c. Management of disruptive and violent patients

9. Care system and other policies

- Be aware of institutional or systems policies which may be more restrictive

DHMC, CORE, VA-DOD, APS-AAPM opioid guidelines

10. Other resources

- Online tools, templates, publications, educational opportunities

Results

- Increased collaborative good will
  - Between clinician groups
  - Between diverse stakeholder groups
- Outcomes in terms of practice to be seen

Lessons Learned

- Multidisciplinary input cultivates broad acceptance of the concept.
- Others to be learned

Next Steps

- Plan dissemination and measurement of change
- Online posting with
  - Link to key other sites
  - Opportunity for recommendations from users
- Develop system for site maintenance and revision
- Funding for:
  - Dissemination
  - Outcomes Measurement