Team Based Opioid Refill Clinic

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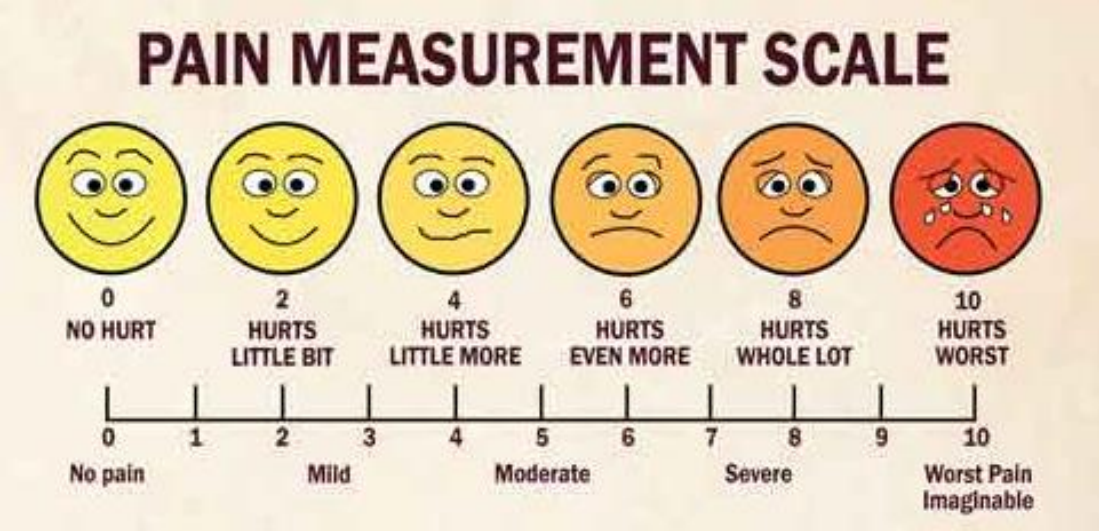
Agenda

- Traditional Opioid Pain Management
- Team Based Opioid Refill Clinic
- Why you should adopt this model

Traditional Opioid Pain Management



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Team Based Opioid Refill Clinic

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Team Based Opioid Refill Clinic

- Specialty Clinic, by referral only
- Administrative Support/Ownership
- Opioids are not the answer
- CDC Guidelines, PDMP, UDS, Nasal Naloxone
- Structured Processes, clear expectations

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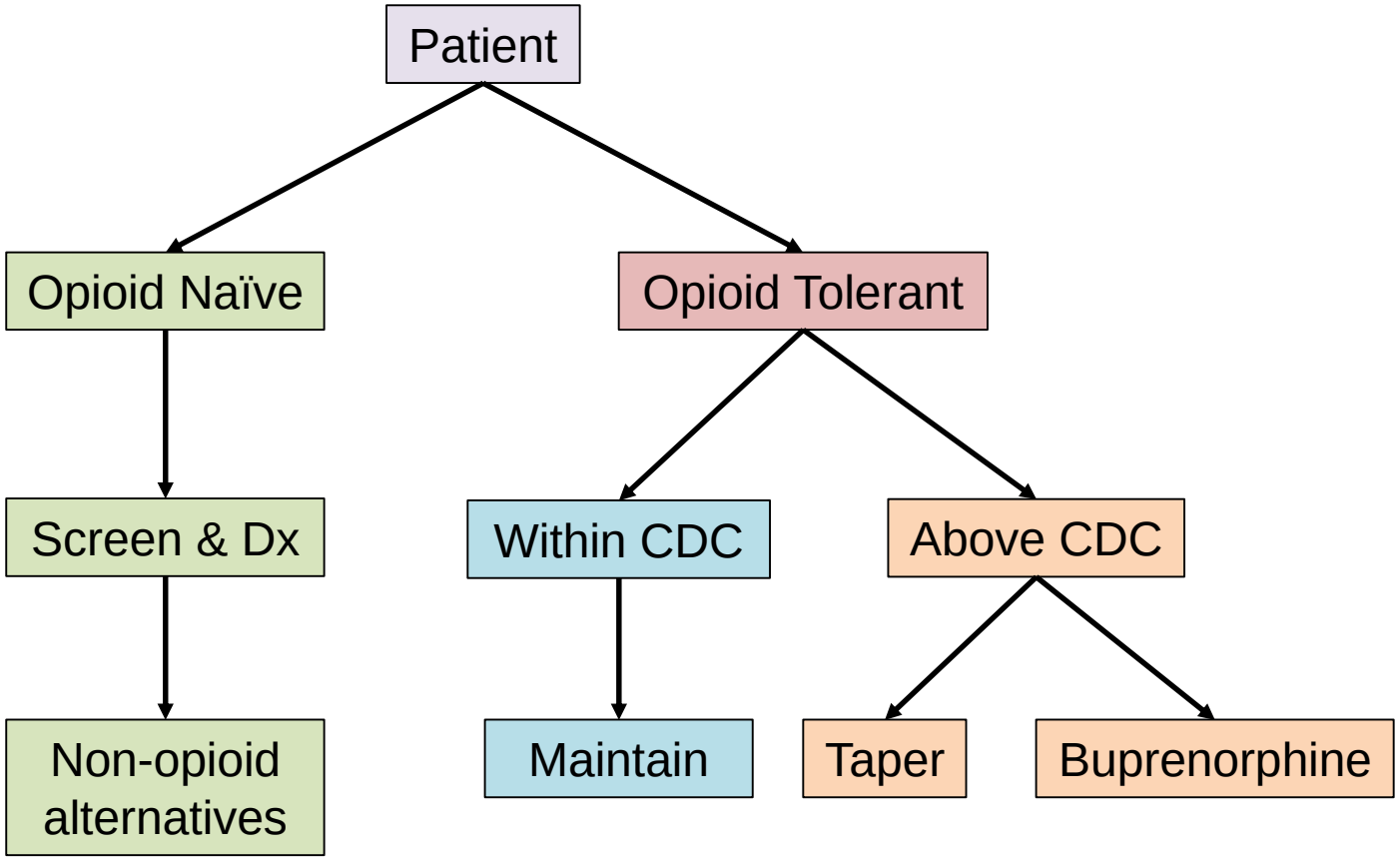
Team Based Opioid Refill Clinic



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Team Based Opioid Refill Clinic

- Set clear expectations and guidelines
  - The process starts before the patient is scheduled

Scheduling Script for an Appointment

- What is your understanding of our role in your care?
- Out clinic prescribes medications according to government guidelines. What have you heard about those guidelines?
- Being referred to our clinic likely means a change in your prescription to a lower dose or different medication all together. Tell me your thoughts about that.

  - PCP Support (closing the back door)
  - Responsible Opioid Prescribing

RESPONSIBLE OPIOID PRESCRIBING FOR CHRONIC NON-CANCER PAIN

Oregon is currently experiencing an epidemic of prescription opioid overdoses. Recent data shows that our state has one of the highest levels of prescribed opioid abuse in the US. Prescription opioid overdose deaths in the US now exceed those due to heroin and cocaine combined, approximately 18,000 people per year. This is a public health crisis that affects

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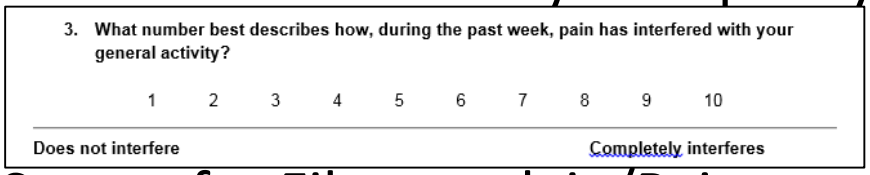
- Keep the primary focus on outcomes patients care about
  - Focus on functionality and quality of life


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

1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

  - Screen for Fibromyalgia/Pain catastrophizing

FMS (M79.7):
#*** FMS: I showed @FNAME@ @HIS@ formal ACR fibromyalgia screening questionnaire and explained that @HIS@ score of *** is consistent with the diagnosis. Fibromyalgia is a 'centralized pain' or 'central sensitivity syndrome' that results in a state of chronic hyperalgesia or pain. Fibromyalgia accentuates other painful diagnoses by functioning as a pain amplifier. Consequently, patients with fibromyalgia and other painful diagnoses - like back pain, or neck

Pain Catastrophizing (F45.1):
#*** Pain Catastrophizing: @FNAME@'s pain catastrophizing scale today was highly elevated at ***/52. This is a powerful predictor of pain severity and sensitivity, disability, pain chronicity, satisfaction with care, and opioid misuse. [1] Moreover, pain catastrophizing is a target for behavioral interventions aimed at diminishing rumination, magnification, and helplessness. In the future @HIS@ may benefit from a referral to behavioral health for CBT/ACT/MBSR.

  - Protecting patients form opioid-related harms

Tolerance:
#*** Tolerance: I was careful to mention to @FNAME@ that opioids are not intended to be used chronically. Moreover, the most pain relief one can expect with opioids is about 30%. [1] But this often diminishes with time due to the development of tolerance. [2] When tolerance occurs the only option to mitigate its effect is either an opioid holiday, or a 35% dose reduction and rotation to another opioid, but not a dose escalation. I will remind @FNAME@ about this at future visits and @HIS@ PEG scores at success

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- When discussing risk, focus on the drugs
  - Drug-related harms can happen to anyone – even when taken as prescribed
  - Risks of being co-prescribed a benzodiazepine/SOMA

Alternatives to Benzodiazepines:
#*** I explained to @FNAME@ that the combination of opioids and benzodiazepines has proven to be unsafe. [1,2] Moreover, a variety of non-benzodiazepine alternatives exist for sleep disorders, anxiety, panic attacks, and agoraphobia. Consequently, I agreed to work with @FNAME@ on a slow taper off *** and a trial of a safer alternative for @HIS@ ***sleep disorder/anxiety/panic attacks/agoraphobia.

  - MED > 90 (CDC Guidelines)

High risk opioid regimen:
#*** High risk opioid regimen: Prior to my entering the exam room my medical assistant *** opened the Oregon Opioid Dose Calculator (https://www.oregonpainguidance.org/opioidmedcalculator/) and showed @FNAME@ @HIS@ dose juxtaposed against the recent CDC dosing guideline recommendations. Both *** and I explained to @FNAME@ that our clinic has adopted the CDC guidelines for safety reasons.[1-3] Consequently, while we are certainly willing to work with @FNAME@ on a harm-reduction plan, it will by necessity involve either a taper or a rotation to buprenorphine. @FNAME@ appeared ***receptive/resistant/precontemplative to my message.

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- Develop a differential diagnosis for patient behaviors that cause concern
  - Diagnose Opioid Use Disorder, treat with buprenorphine
    - Patient is misusing opioids, doctor shopping, over using, unexpected urine results – Consider it a sign of potential opioid-related harm

Opioid Use Disorder (F11.20):
#*** Opioid use disorder: In my medical opinion @FNAME@ meets DSM-V criteria for opioid use disorder.[1] @capHIS@ formal score was ***/11. I explained to @FNAME@ that opioid use disorder is a chronic, relapsing-remitting, lifelong disease. Once it is diagnosed in our clinic full agonist opioids are prohibited as a treatment for chronic non-cancer pain forever thereafter as the risk of relapse is too high. Unlike chronic non-cancer pain, addiction is a potentially fatal disease. However, I did offer @FNAME@ treatment with buprenorphine for @HIM@ addiction. Moreover, I mentioned that a side-effect of buprenorphine treatment is analgesia. In fact, buprenorphine has a morphine equivalence of approximately 30:1

Team Based Opioid Refill Clinic

- Set clear expectations and guidelines
- Keep the primary focus on outcomes patients care about
- When discussing risk, focus on the drugs
- Develop a differential diagnosis for patient behaviors that cause concern

Why you should adopt this model

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

HHS OIG Data Brief • OEI-02-17-00250

Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing

OIG is committed to fighting the opioid crisis and protecting beneficiaries from prescription drug abuse and misuse. It has formed a multidisciplinary team dedicated to addressing this issue. As a part of that effort, we will work with our law enforcement partners and CMS to follow up on the specific prescribers who we identified in this review. We will also continue to conduct investigations and reviews that address the ongoing problems created by opioid misuse. In addition to enforcement, we will identify other approaches to support prevention and treatment efforts. We are also committed to conducting reviews to improve the efficiency and effectiveness of the broader Department efforts.

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Why you should adopt this model

- Sample Case – 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)

Why you should adopt this model

- Sample Case – 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)
  - Brought Ron and his spouse in. Had a long, difficult discussion about his medication dose. I diagnosed DSM V 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.

Patient Outcomes

- Video

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Summary

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Questions?

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Thank you

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