Maine Quality Counts presents…

Provider Lunch and Learn

Chronic Pain & Responsible Opioid Prescribing

December 2, 2014 (12PM – 1PM)

Remember to dial in to hear the audio!
866.740.1260, Access Code: 6223374#
Who We Are

Maine Quality Counts (QC) is a regional health improvement collaborative that brings together people who give care, get care and pay for care to improve health care quality throughout Maine.
Our Mission

QC is transforming health and health care in Maine by **leading, collaborating and aligning** improvement efforts.

- Maine Patient Centered Medical Home Pilot
- Community Care Teams
- Aligning Forces for Quality (AF4Q)
- Behavioral Health Integration
- Quality Counts for Kids / First STEPS Initiative
www.mainequalitycounts.org
QC Learning Community Webinars

• **Monthly webinars:**
  - Provider Lunch & Learn: 1st Tues/mo – 12N
  - Transforming Health Series: 3rd Thurs/mo – 12N
  - Brown Bag Forum: 4th Tues/mo – 12N

• **Next Webinar:**
  - Thurs., December 18th at 12N

• What Matters Most: Lessons Learned Leading Child Health Quality Improvement Work in Maine
  Presenter: Amy Belisle, Director, QC for Kids
Delivering Health Care QC 2015 or Health?

Wednesday April 1st

Maine Quality Counts

Augusta Civic Center
Augusta Maine

Featuring Keynote Speaker
Atul Gawande, MD, MPH

Registration opening mid-February.
Join our mailing list for updates:
www.mainequalitycounts.org
Important Webinar Notes

• To minimize background noise, all lines will be muted
  • To unmute your line, press *7
  • To mute your line, press *6

• To ask questions or share comments, use one of two ways:
  1. Raise Your Hand button (press *7 to unmute your line)
  2. Type in chat box on the lower left-hand side of the screen

• Please state your name and organization before asking your question or sharing your comment
Noah Nesin, MD, FAAFP, is a distinguished physician leader with a state-wide reputation. He was previously the Medical Director of Health Access Network and he worked as a family physician in the Lincoln area for almost 30 years. Dr. Nesin joined the Penobscot Community Health Care Clinical Leadership Team in March 2013, and works closely with other Quality Management Leaders and Providers to help them achieve high levels of measurable quality and provider and patient satisfaction.
Responsible Opioid Prescribing
Maine Quality Counts
December 2, 2014

Noah Nesin, MD, FAAFP
Chief Medical Officer
PCHC
Disclosures:

• I am employed by PCHC.
• PCHC gets reimbursed by MCPC for some of the time that I put into the MCPC (@ 2 hours/week).
• That payment comes from MPCA, who manages the initiative.
• MPCA is paid by MQC, who received the grant.
• Grant is administered by PIEM
• PIEM has funding for this initiative from Pfizer Independent Grants for Learning and Change (IL&C).
How Did We Get Here?

1. First I dig a hole...
2. Then I jump in!
3. How did I get here?
Poor Boundaries

**Providers**
Mostly well intentioned pain specialists and others wished to alleviate suffering and improve quality of life for those with chronic pain.

**Industry**
PhRMA wished to develop and market medications that served that interest and generated profits.
How Did We Get Here?

"And with 10 being the highest, you're sure you're only at a 6?"
Fertile Ground

- Targeting of rural, poor states
- Targeting of unsophisticated (naive?) providers
- Knowledge vacuum
- Lack of physician and provider self efficacy
- Willing specialists leading the way
- Some corrupt physicians
Leading to the Birth of...

The American Pain Foundation:

• Heavily funded by Purdue, Cephalon and others
• No ceiling dose for opioids for chronic pain
• Shut down in May, 2012 after US Senate launched an investigation
“Pseudoaddiction”

• Coined by Dr. David Haddox and Dr. David Weissman
• Based on a single case of a 17 year old leukemia patient with pneumonia and chest wall pain being treated as an inpatient
• Embraced by APF and Federation of State Medical Boards (also receives funding from PhRMA)
“Pseudoaddiction”

“It led us down a path that caused harm. It is already something we are debunking as a concept.”

--Dr. Lynn Webster, President Elect of AAPM
The American Academy of Pain Medicine & The American Pain Society

- In 1996 issued joint statement stating that chronic pain should be treated with opioids and the risk of addiction is low (<1%)
- Chair of group issuing the statement was Dr. David Haddox
- Statement was removed from AAPM website in fall of 2011
- APS now states that evidence for benefit of opioids in the treatment of chronic pain is low quality or insufficient.
And...

• In 2006 Purdue Pharma paid a $635 million fine for its deceptive marketing of Oxycontin.
• Purdue Pharma’s CEO paid $11 million personal fine.
• Purdue Pharma made over $3 billion from Oxycontin in 2010 alone.
• Dr. David Haddox is now VP of Health Policy at Purdue Pharma.
And...

- AHRQ September 30, 2014: “Evidence of long-term opioid therapy for chronic pain is very limited, but suggests an increased risk of serious harms that appears to be dose-dependent.”
There are no studies of...

- Long term opioid therapy vs. no or non-opioid therapy
- Variations in effectiveness based on type of pain and patient characteristics
- Outcomes related to pain, function or quality of life compared to non-opioid therapy.
Where Are We?

- 1991...76 million opioid Rxs
- 2011...219 million opioid Rxs 😞
- Up to 70% of people with chronic pain are receiving improper treatment (according to NIH).
The Harm
The Harm

[Map showing Kilograms of prescription painkillers per 10,000 people, with states color-coded from light green to dark green, indicating varying levels of prescription drug use.]
The Harm

- Risk of addiction is 30 to 40%.
- 169 Mainers died of drug overdose in 2010.
- 95% of those were prescription drugs.
- 174 Mainers were admitted for prescription drug overdose in 2009.
- Crime rates up 5.4% between 2010 and 2011.
- 40% of crime in Maine related to drug abuse.
The Harm

• 779 babies born with NAS in Maine in 2012, over 900 in 2013
• Charges per baby over $50,000
• 15% of Maine high school students report non-medical use of prescription drugs in last year, 7% in last month.
• Maine leads the nation in the rate of prescriptions for long acting opioids (21.8 Rx/100 people vs. national average of 10.3)
• 265% increase in deaths from prescription opioid overdose in men since 1999, **400% in women**
What is “High Dose?”

≥100 Morphine Equivalents

*Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.*
The Harm

• Opioid Induced Hyperalgesia (OIH)
  o State of nociceptive sensitization with paradoxical response
  o Increased sensitization to painful stimuli and pain from ordinary non-painful stimuli (alldynia)
  o Indication for weaning/discontinuing doses
The Harm

- We prescribe when there is no indication and when there are contraindications.
- We ignore recurring non-reassuring behaviors.
- We don’t consider the household or community environment into which we place these drugs.
- We devalue effective alternatives.
- We treat “pain” but not addiction.
- We use dangerous combinations of meds.
- We don’t like what we’re doing and we do little to change it.
How Do We Get Out of Here and Where Do We Want to Go?
We in primary care are uniquely positioned to make an immediate, positive and enduring impact on the quality of life and outcomes for our patients, for our providers and for our community. We have to solve this.
Where Do We Start?

• How about a definition of pain?

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. It is a subjective phenomenon.

*International Association for the Study of Pain (IASP)*
Pain Types

• Nociceptive pain is functional pain.
• Neuropathic pain is maladaptive pain.
• Chronic pain is dysfunctional pain with more widespread and ill defined pathophysiology.
  o Associated with less insight into emotional component, worse outcomes and misapplication of acute treatments
  o People with high ACE scores have exaggerated inflammatory response to stress. High ACE is strongest predictor for chronic pain.
Where Do We Start?

• Open our minds and eyes.
• Recognize our personal and professional deficiencies and barriers.
• Improve our knowledge.
• Improve our self-efficacy.
• Develop an evidence based and reality informed approach to the management of chronic pain.
• Compassion!
Prescribers’ Barriers

• Complaints to the Licensing Board
• Withdrawal
• Uncertain of treatment alternatives (with little confidence in them)
• Lack of self efficacy
• Time constraints
• Emotional energy
• Conflict avoidance
• Empathy
# Prescriber’s Fears - Withdrawal

## Opioid Withdrawal

- NOT deadly
- Mainly Cholinergic Effects:
  - Yawning
  - Lacrimation
  - Rhinorrhea
  - Pupilary dilation
  - Piloerection
- CV:
  - Rare tachycardia from agitation, hypovolemia
- Myalgias /arthralgias
- Dysphoria, Restlessness, Irritability, Agitation, Tremors

## Benzodiazepine /Alcohol Withdrawal

- Potentially Deadly
- Mainly CNS Effects:
  - Delirium,
  - Increased reflexes
  - Disorientation,
  - Psychosis
  - Anxiety
  - Seizures
- CV:
  - Hyperthermia, Hypertension, Hyperventilation, Tachycardia
- Not characterized by pain
## Comfort Packs

<table>
<thead>
<tr>
<th>Withdrawal Symptom</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea/Vomiting</td>
<td>Antiemetics</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide or Octreotide</td>
</tr>
<tr>
<td>Cholinergic Overload</td>
<td>Clonidine</td>
</tr>
<tr>
<td>Spasms/ Twitching</td>
<td>Muscle Relaxants</td>
</tr>
<tr>
<td>Aches</td>
<td>NSAIDS</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Low-Abuse Sleeping Agents</td>
</tr>
</tbody>
</table>

*Antiemetics:*
- **Antiemetics**
- Loperamide or Octreotide

*Clonidine:*
- Clonidine

*Muscle Relaxants:*
- Muscle Relaxants

*NSAIDS:*
- NSAIDS

*Low-Abuse Sleeping Agents (trazodone):*
- Low-Abuse Sleeping Agents (trazodone)
Other Treatments

“No, this won't help your back, but I'm getting great reception for the big game!”
“But Nothing Else Works”

- SNRI, TCA, SSRI
- RA: DMARDs
- Anticonvulsants
- NSAID
- CBT
- Physical Therapy
- OMT
- Support Groups
- Exercise
- Weight Loss
- Acupuncture
- Massage
- Chiropractic
- Tai Chi
“I’m the one with the medical degree. I’ll determine if your back is bothering you or not.”
Where Do I Start?

• Compassionate language
• Intentional management of acute prescriptions
• Strengthen knowledge of risks/benefits of all treatment options
• Don’t be fatalistic
• Know the meds you do prescribe.
• Don’t use opioids in circumstances when they shouldn’t be used.
• Gain your proper role in the management of this important problem.
• Educate patients and caregivers (and staff and colleagues and public)
• If chronic opioids are part of the treatment plan use drugs and doses that limit risks and use tools to properly assess risk, monitor use and evaluate for important adverse effects/toxicities.
• Don’t work in isolation.
Communicate Risks of Opioids

“There are very significant risks associated with opioids.”

- Accident
- Injury
- Accidental overdose
- Premature death
- Driving
- Becoming the victim of a crime
- Dependence
- Addiction
"I’ve been thinking a lot about your care. As new information becomes available it is more and more apparent that these medications are not the right ones for your problem, and I think we need to move to a safer and more effective treatment plan. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together."
Or...

“I’ve been thinking a lot about your care. As new information becomes available it is more and more apparent that your dose is unsafe, offers no benefit and may be making your pain worse. I think we need to reduce your dose to a safer level. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together.”
Tapering Plan for Client with Chronic, Non-Cancer Pain

Please Fax to: Narcotic Review Program (360) 725-2122

Client's Name: [Blank]  Client ID#: [Blank]

Short and long acting narcotics should be tapered separately; first taper the short acting agent, then taper the long acting.

**Tapering short acting narcotics:** As a general rule, if the % of total MED is < 10% of the initial total MED of all narcotics, taper by 10% of the initial total dose (milligrams) every 3 days. If the % of the total MED is > 10% of the initial total MED, taper by 10% of the initial total dose (milligrams) every week.

**Tapering long acting narcotics:** As a general rule, taper by 10% of the initial total dose (milligrams) until down to 30% of the initial total dose (milligrams). Then, taper by 10% of the remaining 30% of the initial taper (milligrams).


According to the Agency Medical Directors Opioid Guidelines, symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1-0.2mg orally q6hours or Catapress-TTS 1 patch/weekly. Sleep problems can be treated with zolpidem and/or low dose tricyclic agents, such as doxepin 10-50mg qhs. **DO NOT TREAT WITHDRAWAL SYMPTOMS WITH ADDITIONAL OPIOIDS OR BENZODIAZEPINES.**

<table>
<thead>
<tr>
<th>Initial Total Dose</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid Type</strong></td>
<td><strong>Baseline Opioid</strong></td>
</tr>
<tr>
<td>Short Acting</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Long Acting</td>
<td>[Blank]</td>
</tr>
</tbody>
</table>
# Dose Equivalency Calculator

## Opioid Dose Calculator

**Instructions:** Fill in the mg per day™ for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day.

To add this calculator to your smartphone or tablet home screen, go to Android or iPhone/iPad.

<table>
<thead>
<tr>
<th>Opioid (oral or transdermal):</th>
<th>mg per day: *</th>
<th>Morphine equivalents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Tapentadol</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

**Patient's Name:**

**Today's Date:** October 16, 2013
Pain Matrix

- Very sensitive to context
- Can be activated by emotional stimuli
- Activated by descriptions of other’s pain
- Activated by rejection (also increases inflammatory response)
- Can reduce pain if properly stimulated
- Improving insight on emotional component improves outcomes
Resources

- Best Advice for People Taking Opioids – Dr. Mike Evans
- AMDG Guideline on Opioid Dosing for Non-cancer Pain
- Physicians for Responsible Opioid Prescribing (SUPPORTPROP.ORG)
- MCPC
- “Fault Lines Opioid Wars” – Al Jazeera America
- nnesin@pchc.com
ME CPC 1 Participating Practices

• Bucksport Regional Health Center
• CMMC Family Medicine Residency
• EMMC Center for Family Medicine
• Harrington Family Health Center
• DFD Russell Medical Center
• Sacopee Valley Health Center
• Scarborough Family Medicine
• St Joseph’s Internal Medicine
ME Chronic Pain Collaborative 2
Project Goals

• Improve patient safety and outcomes by improving chronic pain management and quality of care using...
  – Chronic pain change package
  – Team-based care
  – Interprofessional education
Project Partners

• Maine Quality Counts
  – grantee, project leadership, PCMH expertise

• University of New England
  – Interprofessional Education (IPE)

• Community Health Center / Weitzman Quality Institute
  – Project ECHO Pain
  – Evaluation partner
Opportunity for Maine Practices!

• Participation offered as opportunity for up to 15 primary care practices
• Will use structured selection criteria to select practices
• Practices asked to sign Memorandum of Agreement with practice commitment to...
  – Identify leadership team
  – Implement best practices
  – Participate in learning activities
ME CPC2 Timeline

• Application Period: *Feb 1, 2015 – Feb 15, 2015*

• Application Review / Selection of Pilot Sites: *by March 1, 2015*

• Notification of Pilot Sites & Applicants: *March 7, 2015*

• Pilot Site Participation (anticipate ~ 14 months): *April 1, 2015 – May 31, 2016*

• Initial ME CPC2 Learning Session: *April 2015*

• Post-Pilot Evaluation: *Jun – Aug 2016*
Upcoming QC Learning Community Webinars

• Thursday, December 18 (12pm ET – 1pm ET)
  QC 2014 Transforming Health Series
  – Lessons Learned Leading Child Health Quality Improvement Work in Maine
    Presenter: Amy Belisle, Director, QC for Kids

• Tuesday, January 6 (12pm ET – 1pm ET)
  Provider Lunch and Learn
  – Physician Quality Reporting System and Value Based Modifier
    Presenter: Healthcentric Advisors, New Englands QIN-QIO

Register at http://www.mainequalitycounts.org/page/896-679/qc-learning-community