Managing Pain in Primary Care in a Complex and Changing World
The Nevada Health Centers Experience

National Rural Health Day
Opioid Abuse Prevention Summit: Tools and Templates for Compliance with AB474

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Objectives
1. How to effectively and efficiently adopt the AB474 Nevada State Law into the daily workflow of a clinic
2. How to treat chronic pain without the use of opioids in primary care

How to effectively and efficiently adopt the AB474 Nevada State Law into the daily workflow of a clinic

• With the example of Nevada Health Centers
• 1- Who we are
• 2- What we currently are doing (before AB 474)
• 3—What we will be doing (with AB 474 implementation)

Who we are: Nevada Health Centers (NVHC)

• Federally qualified community health center
• 40 years of providing care
• 18 health centers all over the state: frontier, rural, sub-urban, urban
• Family Medicine, Pediatrics, Dental Care, Behavioral Health, Pharmacy Services
• Medicaid 41%, Medicare 27%, Commercial Insurance 21%, Uninsured 11%*  

*Sierra Nevada Health Center in Carson City patient encounters 6.01.16 to 1.31.17

What are we currently doing?

• October 2016 start of NVHC “Pain Care Committee”
• Review and update of NVHC’s guidelines
• NVHC guidelines are comprised of
  • CDC guideline for prescribing opioids for chronic pain; CDC, 2016
  • Clinical Guidelines for the use of Chronic Opioid Therapy in Chronic Noncancer Pain; American Pain Society, 2009
  • Use of opioids for the treatment of Chronic Pain; American Academy of Pain Medicine, 2011
• Extra training for pain management and use of tele-medicine
• Attending Project ECHO sessions, University of Nevada
NVHC’s current “Guidelines to the management of chronic non-cancer pain” - Excerpts

Nonpharmacological therapy and non-opioid agents are preferred as first line treatment: CBT, SSRI/SNRI’s, Acetaminophen/NSAID’s, Ointments, heat/ice; LCSW/psychologist/psychiatrist, exercise (e.g. aquatic or resistance exercise), physiotherapy, TENS, massage therapy, and specialist services providing interventional procedures such as epidural or facet‐joint injections.

If opioids are used, they should be combined with non-pharmacologic and non-opioid therapies.

Goal: Prevent starting Opioids

NVHC’s current “Guidelines to the management of chronic non-cancer pain” - Excerpts

• All patients requiring opioid therapy for more than 6 weeks, shall sign a controlled substance contract which shall be scanned in the chart. Each year the controlled substance contract shall be updated.

• Always prescribe the lowest effective dose for any opioid. Great caution should be used if increasing the dosage ≥50 morphine milligram equivalents (MME)/ day.

Goal: Prevent starting Opioids

What we will be doing (with AB 474 implementation)

• Use a Risk Assessment Tool
• Have an Informed Consent
• Have a Prescription Medication Agreement
• Pull and review PMP
• Obtain urine drug screens
• Documentation

What we will be doing (with AB 474 implementation)

1) Components of a written CS prescription

• Patient’s Date of Birth
• International Classification of Diseases Tenth Revision (ICD-10) diagnosis code for the disease being treated with the CS
• The fewest number of days necessary to consume the quantity of the CS dispensed to the patient. If the patient consumes the maximum dose of the CS authorized by the prescribing practitioner.
• Practitioner’s Drug Enforcement Administration (DEA) number
Electronic prescriptions

Benefits of electronic prescriptions:
- Improves workflow efficiencies
- Improves patient safety (interactions)
- Increases security (no tampering with prescriptions)
- Improves patient satisfaction

Electronic prescriptions

E-prescribing of DEA-regulated substances

• Prescribers*:
  - 17.1% in US enabled to e-rx
  - 6.9% in NV enabled to e-rx

• Pharmacies*:
  - 90.5% in US enabled to process e-rx
  - 90.4% in NV enabled to process e-rx

* Data as of June 2017 http://surescripts.com/products-and-services/e-prescribing-of-controlled-substances

1) Components of a written CS prescription

scriptions of Disease Tenth Edition (ICD-10) codes

• Every written CS prescription must include:
  - International Classification of Diseases Tenth Revision (ICD-10) diagnosis code for the disease being treated with the CS
  - A practitioner who prescribes a CS to treat pain for more than 90 consecutive days must:
    - Determine an evidence-based diagnosis for the cause of the pain

2) Factors to Consider Before Writing Any Prescription for a CS

• The number of attempts by the patient to obtain an early refill of the prescription
• Irregular or inconsistent information in the patient’s PMP Report that may indicate the patient is using the CS inappropriately
• Pull drug utilization report (Prescription Monitoring Program-PMP) before initial prescription, and every 3 months
• Have your Medical Assistant pull the PMP report during pre-visit planning
• Review, sign, and scan the PMP report
• Whether there is reason to believe that the patient is not using the CS as prescribed, or is diverting the CS for use by another person;
• Whether there is reason to believe that the patient is using other drugs, including, without limitation, alcohol or another CS that:
  - May interact negatively with the CS prescribed by the practitioner; or
  - Was not prescribed by a practitioner who is treating the patient;
• The need to verify that unauthorized CS are not present in the patient’s body
• Do urine drug screens (UDS) 1-2 times a year (or more often if deemed necessary)
• Identify last UDS during pre-visit planning
• Review, sign, and scan the UDS report
3) Factors to Consider Before Writing An Initial Prescription

- Before writing an initial prescription for a CS, each practitioner must:
  1. Have a bona fide relationship with the patient;
  2. Establish a preliminary diagnosis and a treatment plan;
  3. Perform a Patient Risk Assessment;
  4. Obtain and review the patient’s PMP report;
  5. If after review and assessment of the patient the practitioner writes an initial prescription:
     - It must be for no more than 14 day supply if treatment is for acute pain;
     - It must not be for more than 90 morphine milligram equivalent (MME) daily for an opiate naïve patient (patient who has never received an opioid prescription or the patient’s most recent course of opioid treatment was completed more than 19 days prior to the initial prescription the practitioner is intending to issue); AND
     - The patient completes an Informed Consent.

Perform Risk Assessment

- Before writing an initial prescription for a CS, each practitioner must:
  1. Perform a Patient Risk Assessment.
  2. Use a validated risk assessment tool, embedded into EHR.

- Obtain Informed Consent

- Before writing an initial prescription for a CS, each practitioner must obtain an Informed Consent:
  - The informed written consent must include information concerning:
    1. The potential risks and benefits of treatment using the controlled substance, including if a form of the controlled substance that is designed to deter abuse is available, the risks and benefits of using that form;
    2. Proper use of the controlled substance;
    3. Any alternative means of treating the symptoms of the patient and the cause of such symptoms;
    4. The important provisions of the treatment plan established for the patient pursuant to paragraph (c) of subsection 3 of section 53 of this act in a clear and simple manner.

Opioid Risk Tool

This tool should be administered to patients upon initial visit prior to beginning opioid therapy for pain management. A score of 4 indicates moderate risk for opioid abuse, a score of 6 indicates moderate risk for fraud abuse, and a score of 8 indicates high risk for opioid abuse.

<table>
<thead>
<tr>
<th>Family History of substance abuse</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td>Alcohol</td>
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<td>2</td>
</tr>
<tr>
<td>Rital drugs</td>
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<td>3</td>
</tr>
<tr>
<td>Re drugs</td>
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<td>5</td>
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<tr>
<td>History of prescendental alcohol</td>
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<td>0</td>
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<tr>
<td>Psychological abuse</td>
<td>3</td>
<td>0</td>
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<tr>
<td>AIDs, OIDS, 10 or more subgroups</td>
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<td>2</td>
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<tr>
<td>Prescription</td>
<td>3</td>
<td>1</td>
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<td>Learning tools</td>
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S Hudson, et al

Obtain Informed Consent

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  - The informed written consent must include information concerning:
    1. The potential risks and benefits of treatment using the controlled substance, including if a form of the controlled substance that is designed to deter abuse is available, the risks and benefits of using that form;
    2. Proper use of the controlled substance;
    3. Any alternative means of treating the symptoms of the patient and the cause of such symptoms;
    4. The important provisions of the treatment plan established for the patient pursuant to paragraph (c) of subsection 3 of section 53 of this act in a clear and simple manner;
Obtain Informed Consent

- Embed it into the EHR
- Identify during pre-visit planning if patient needs informed consent
- Have patient read and sign
- Scan it into the EHR

4) Prescribing after 30 days

- A practitioner who prescribes a CS to treat pain for more than 30 days must, not later than 30 days after issuing the initial prescription, enter into a Prescription Medication Agreement with the patient.
- The Agreement must be part of the patient’s record, and the practitioner must update it at least every 365 days while the patient is using the CS or whenever the practitioner changes the treatment plan.

Prescription Medication Agreement

- Embed it into the EHR
- Identify during pre-visit planning if patient needs prescription medication agreement (needs every 365 days)
- Have patient read and sign
- Scan it into the EHR

- Use a Risk Assessment Tool
- Have an Informed Consent
- Have a Prescription Medication Agreement
- Pull and review PMP
- Obtain urine drug screens

Pre-visit planning can aid in identifying whether any of the above are missing or are due
Pre-visit Planning

- If the first time you think about a patient is when he or she checks in, you are already behind.
- Pre-visit planning can help make your patient visits run more smoothly, giving you time to focus on what matters most to the patient.
- Have your team do the pre-visit planning 2-5 days before patient’s appointment.

Pre-visit Planning

- MA identifies: Is the patient on opioids:
  - If identified that patient is on opioids:
    - Has a Risk Assessment Tool been filled out?
    - Has an Informed Consent been signed?
    - Is a Prescription Medication Agreement in place & updated in past year?
    - Has a PMP been reviewed within the past 3 months?
    - When was the last urine drug screen been done?
  - Involve your staff
    - Keep your team updated on policy changes, do staff presentations, explain the “why”, work as a team.

More efficient documentation

- Use “pain management” templates in your EHR.
- Use saved “my phrases” in your EHR and adjust/individualize based on patient.
- Save phrases on word and copy/paste into the chart.

Discontinuing Opioids

- Do not abruptly discontinue chronic opioid therapy, because this can precipitate acute opiod withdrawal.
- Taper opioid therapy gradually:
  - Decrease the dose by 5% to 10% of the starting dose every one to four weeks*
  - It is not unreasonable to take many months to wean some patients off chronic opioid therapy
- If unable to taper off, refer for medication-assisted treatment.


Discontinuing Opioids

- Warn patients about what to expect during each dosage reduction, including a resurgence of pain, which is most often withdrawal mediated and time-limited
- Provide non-addictive medications to lessen symptoms of withdrawal:
  - Anti-nausea meds
  - Anti-diarrheal meds
  - Muscle relaxants
  - Pain meds (NSAIDs, Acetaminophen)
  - Alpha-adrenergic receptor agonists (clonidine)

How to treat chronic pain without the use of opioids in primary care

- Chronic non-cancer pain (pain more than 12 weeks):
  - Low back pain (LBP)
  - Arthritis (osteoarthritis, other arthritis)
  - Neuropathic pain
  - Headache
  - Psychogenic pain
  - ...
Low Back Pain

- **Acute (<4 weeks) & subacute (4-12 weeks) LBP**
  - No treatment (often resolves spontaneously)
  - Massage
  - Superficial heat
  - Spinal manipulation
  - Acupuncture
  - NSAIDs (Ibuprofen, Diclofenac)
  - **Skeletal muscle relaxants**

Ineffective: Benzodiazepines, systemic corticosteroids, acetaminophen


Low Back Pain

- **Chronic LBP (>12 weeks)**
  - Motor control exercises
  - Physiotherapy
  - Tai chi
  - Acupuncture
  - Psychological therapy, including:
    - Cognitive behavioral therapy
    - Mindfulness-based stress reduction
    - CBT
  - NSAIDs
  - Duloxetine
  - Tramadol


Pain Due To Osteoarthritis

- Exercise (muscle strengthening, range of motion, aerobic)
- Physiotherapy
- Weight loss
- Bracing
- Acetaminophen
- NSAIDs
- Duloxetine
- Corticosteroid injections, hyaluronic acid injections
- Glucosamine & chondroitin
- **S-adenosylmethionine (SAM-e)**
- Balneotherapy (mineral baths, etc)
- Capsaicin topical
- Orthopaedic surgery


Summary

- "I believe this patient is a candidate for opioid therapy":
  - Review PMP: consistent
  - Perform Risk Assessment: low risk
  - Review medical records: consistent
  - Perform & review UDS: consistent
  - Obtain informed consent
  - Prescribe opioid
  - If more than 30 days: Obtain prescription medication agreement
  - If more than 90 days: Have an evidence-based diagnosis
Summary

- E-prescribe controlled substances, include ICD-10
- Embed the AB474 requirements into the pre-visit planning
  - Risk Assessment
  - Informed consent
  - Prescription medication agreement
  - PMP
  - UDS
- Use your EHR more efficiently
- Taper patients slowly, consider MAT
- Have a high threshold for starting opioids, prescribe alternatives instead

Thank You!