Teaching Safe Prescribing to Primary Care Residents

Thursday, June 4, 2015

We strongly encourage you join the call by receiving a call-back.

If you choose to dial-in, please be sure to use your **attendee #** found under the "Event Info" tab.

California HealthCare Foundation

California Improvement Network — Better Ideas for Care Delivery

Today's Speakers

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Improving Chronic Pain Treatment in Residency Programs

Diana Coffa, MD
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The Problem

"To hear about pain is to have doubt; to experience pain is to have certainty."

Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World*, 1987

The Problem

Increasing concerns about opioid risks, including overdose and addiction, lead to increased anger and frustration

The Problem

- Doctors often do not like caring for patients with chronic pain
  - It is hard to be good at something you do not like to do
  - It is hard to learn about something when your teachers do not seem to be engaged with it
  - It is hard to empathize with someone who you wish wasn't there

How are residents different than other providers?

Emotional differences

- More vulnerable to feeling overwhelmed
- Less likely to be able to distinguish between pain and addiction
- Less tolerant of patient dissatisfaction
- More compelled to fix things that may not be fixable
- Less jaded

How are residents different?

Logistical Differences

- Different preceptors who have different practices
- Patients may not have same continuity, have trouble scheduling regular appointments
- Variable training in medical school

Strategies for supporting residents in caring for Chronic Pain patients

1. Consistent policy throughout clinic
2. Controlled substances review committee
3. Resident rotation through pain support group

Consistent Policy

- Initial assessment
  - Include assessment of addiction and overdose risk
    - Opioid Risk Tool
    - Mental health assessment
  - Include assessment of function
    - Physical, emotional, social, sleep
- Reassessment
  - Frequency
    - Monthly for moderate to high risk patients
    - Q3 months for low risk and stable patients
  - Monitor for functional improvement

Consistent Policy

- Refill policy
  - Early refills allowed? One a year? Never? Based on risk assessment?
  - Does the PCP need to write the refill?
- Monitoring for misuse
  - Urine drug screen and CURES report at least annually for ALL patients on opioids
  - Otherwise based on risk assessment and with dose changes

Consistent Policy

- Response to concerning behaviors
  - Guidelines for how to responding to common concerning behaviors
  - Teach residents differential diagnoses for common behaviors
  - Teach about addiction:
    - Neurobiology: a chronic disease, not a moral issue
    - D/c'ing opioids should be paired with referral to substance use treatment: buprenorphine, methadone, and counseling
    - Never fire or abandon a patient just because of addictive behavior: you have made a new diagnosis that requires care

Consistent Policy

- Teach residents how to remain compassionate through tough conversations with patients:
  - Lisinopril analogy
    - If a patient on lisinopril had a BP of 90/40, you would d/c the lisinopril. You would not do it to punish them but to help them. This is not about the patient having done something wrong, it is about the medication being unsafe in the patient's current circumstance
  - Encourage residents to identify their compassionate reason for discontinuing the medication and to stay in touch with that throughout the conversation
  - "I am concerned about you and will keep working with you"
  - "I care about your safety"
  - "If you cannot function without opioids, buprenorphine is a safer option for people who have trouble managing their opioid use"

Consistent Policy

- Concerning behaviors -- options for response include:
  - Immediate d/c prescription pain meds if signs of diversion, falsification of rx
  - Increase monitoring to narrow differential dx for behavior
  - Taper opioids and provide medications for withdrawal symptoms
  - Refer for medication-assisted treatment (buprenorphine works well for mixed pain and opioid use disorder)

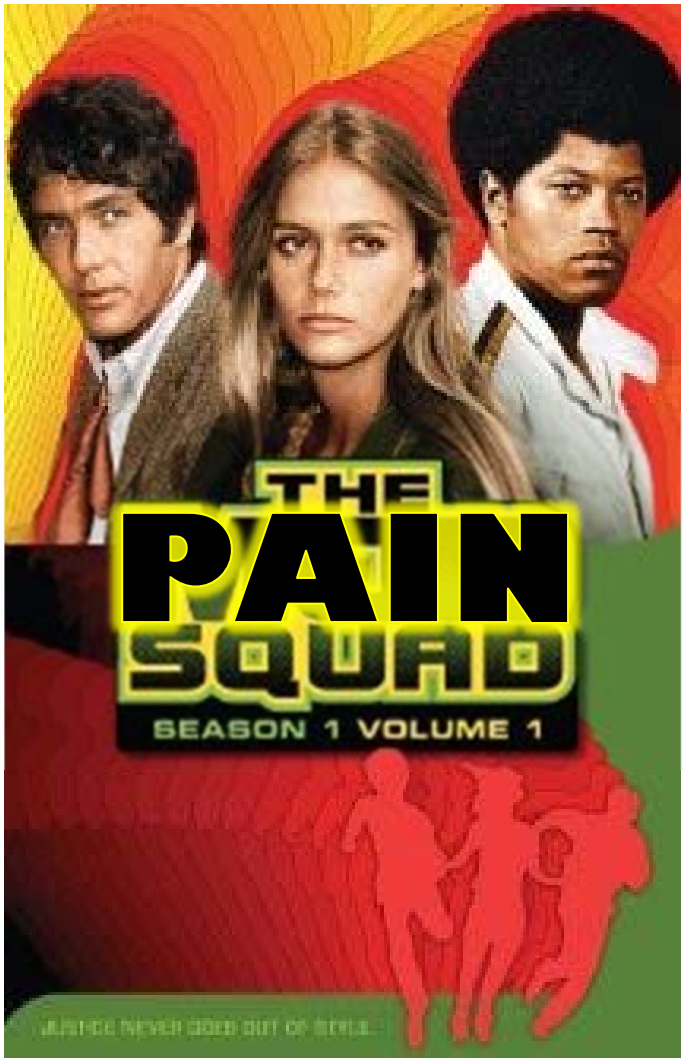
Consistent Policy

- Response to Abnormal Urine Drug Test
  - If drug is absent –understand the cause; d/c opioids if diversion
    - Does lab have sufficient sensitivity?
    - Did patient take opioids the day of the test?
  - If non-opioid illicit drugs are present, either require drug treatment or d/c
    - Risk of overdose and diversion is increased
  - If other opioids are present, not prescribed by PCP
    - Consider pseudoaddiction and improve pain management plan – increase monitoring
    - Consider taper and/or referral to substance use treatment

Controlled Substances Review Committee

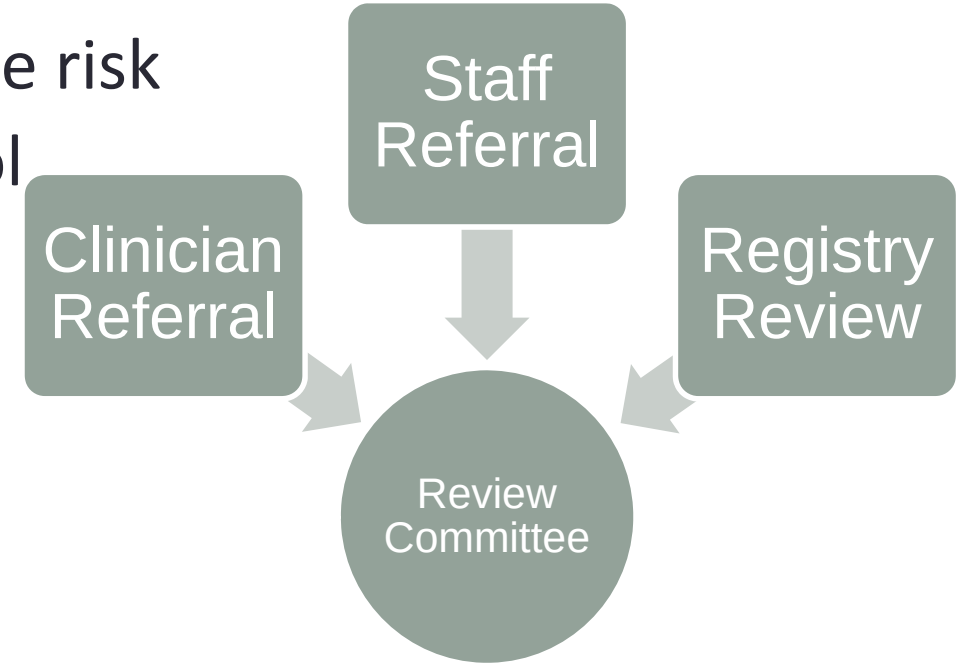
Two primary tasks:

- Review patient cases
- Develop policy and manage pain-related QI projects



Case Reviews

- Solicit referrals from providers, RNs, MAs, clerks, and behavioral clinicians
  - Worried about opioid misuse
  - Worried about overdose risk
  - Inadequate pain control
- Case-find using registry
  - Positive urine drug test
  - High dose
  - Request for transfer



Case Reviews

- Review medical record
  - Medications
  - Non-medication pain management
  - Opioid risk assessment
  - History of yellow or red flags
  - Social and psychological factors
- Discuss with multidisciplinary team:
  - Psychologists, RN, MA, clerk, data manager, NP, PA, MD
  - PCP invited as well

Pharmacologic

- Neuroleptics
- Antidepressants
- Anesthetics (lidocaine patch)
- Muscle relaxants
- Topicals (capsacin)
- Opioid medications/Tramadol
- Procedural pain clinic:
  - baclofen pumps, etc.
- Buprenorphine
- Naloxone

Physical

- Physical Therapy/Physiatry consults
- Joint injections
- Spine injections
- Surgery
- Stretching/strengthening exercises
- Recommendations for pacing daily activity
- Heat or ice
- Trigger point injections

Complementary and Alternative Medicine

- Acupuncture
- Mindfulness Based Stress Reduction and meditation
- Yoga classes
- Tai-chi classes
- Massage
- Strain-counterstrain
- Anti-inflammatory diets and herbs
- Supplements
- Guided imagery

Cognitive and Behavioral

- Pain group
- Individual therapy
- Brief cognitive and behavioral interventions in clinic
- Visualization, deep breathing, meditation
- Sleep hygiene
- Gardening, being outdoors, going to church, spending time with friends and family, etc.

Pain	
Medication Changes	
	Opioids
	Increase
	Taper
	Anti-epileptic medications
	Antidepressant
	NSAID/Tylenol
	Topical (lidocaine, capsacin)
	Immune modulators
	Rheum referral
	Muscle relaxants
	Withdrawal symptom pack: Clonidine 0.1mg BID PRN malaise, anxiety. Loperamide PRN diarrhea. Ondansetron 4mg q8 PRN nausea. Trazadone 50mg nightly PRN insomnia.
	Naloxone prescription
Procedures	
	Joint injection
	Trigger point injection
	Orthopedics appointment
	Neurosurgery appointment
	Epidural steroid injection
	Mt. Zion pain clinic for local block or pump
	Ice
	Heat
Movement based	
	Physical therapy
	Supervised/graded physical activity

Movement based	
	Physical therapy
	Supervised/graded physical activity
Behavioral and Psychological	
	Individual therapy
	Spine health group
	Chronic pain group
	Pelvic pain group
	Depression/anxiety group
	Social engagement plan
	Pacing
Complementary and Alternative	
	Counterstrain
	Massage
	Acupuncture
	Chiropractic
	Anti-inflammatory eating pattern
	Herbs or supplements
	Meditation Class
	Gratitude journal
	Joy practice
	Yoga
	Tai Chi
Diagnostics	

Substance Use Disorder	
	Taper medications
	Make prescribing contingent on entry into residential treatment
	Make prescribing contingent on entry into residential treatment or methadone clinic
	Buprenorphine treatment
	Methadone treatment
	TAP referral
	Referral to needle exchanges
	Safe injection counseling, harm reduction counseling
	Recommend naloxone training at needle exchange http://www.sfaf.org/client-services/health-services/syringe-access/site-schedule.html
	Prescribe naloxone intranasal

Getting Buy-in

- Invite PCP to the discussion
- Discuss plan with PCP and solicit modifications or feedback
- When everyone agrees to plan, place in EMR

Chronic Pain Group

Chronic Pain Group

- Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT) and relational model
- Better functional outcomes than opioids[1]
- Equal or better pain management outcomes[1]
- Combination of
  - Self management teaching
  - Education
  - Cognitive reframing and thought management
  - Social support

1. Morley S et. al. Systematic review and meta-analysis of randomized controlled trials of cognitive behavior therapy and behavior therapy for chronic pain in adults, excluding headache. Pain, March 1999, 80:1-2, pp 1-13

Chronic Pain Group

- Weekly meeting
  - 12 sessions= 1 dose
  - May repeat x2, then encourage graduation
- Topics include:
  - Hope and acceptance
  - Communicating with your health care team
  - Thoughts and pain
  - Anger and pain
  - Emotional pain and physical pain
  - Closing your Pain Gates
  - Increasing your social support
  - Sleep and pain

Chronic Pain Group

- Every session also includes
  - Personal check-in
  - An experiential exercise
    - Meditation
    - Visualization
    - Deep breathing
  - A personal project (homework)

Sample Session

1:30 Three deep breaths

1:35 Check-in

1:50 Topic: How thoughts affect pain and how pain affects thoughts

2:25 Stretch break

2:30 Exercise: mindfulness meditation

2:40 Personal project: noticing your thoughts

2:50 Three deep breaths

2:55 Take home points

Impact on Patients

- “I realized I’m not alone.”
- “I still have pain, but now I can live with it. It doesn’t bother me the way it did.”
- “After just the first session, everything changed. I have hope now.”

Impact on Residents

- Increased interest in chronic pain patients
- Increased empathy
- Exposure to group visit model
- “I actually enjoyed working with chronic pain patients!”

Chronic Pain Group

- We are happy to host guests and share our manual
- If you would like a copy of the manual for the group, please email me at

Diana.Coffa@ucsf.edu

Resident Education on Opioid Safety: Additional Methods

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Resident Education on Opioid Safety: Additional Methods

1. “Classroom Learning”: Formal & Informal Teaching
2. Systems Training: Using a chronic pain registry and panel management
3. Program Innovation: Intra-Nasal Naloxone for Overdose Prevention

Traditional Didactics

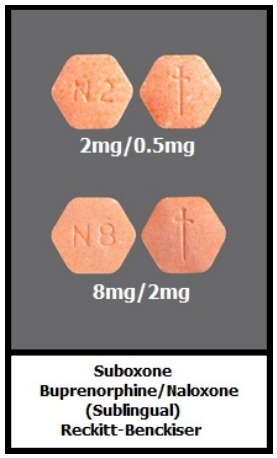
- **Intern Immersion** lecture (2 hours; R1s)
  - Burden of chronic pain
  - Unequal treatment of pain
  - Chronic opioid therapy – current understanding of evidence
  - Risks of treatment
  - Safety and monitoring of patients on therapy
    - *CLINIC SYSTEMS OF CARE*
- **Pre-clinic Conferences** (40 min; R1-R3, every year)
  - Urine Drug Screen Interpretation
  - Clinical Cases: Responding to Concerning Behaviors while Preserving Motivational Interviewing Techniques

Traditional Didactics

- **Screening, Brief Intervention, and Referral to Treatment [SBIRT] Curriculum** (16 hours, R2-R3)
  - Motivational interviewing
  - Skill-focused: role-plays, peer-peer feedback, fish-bowl exercises
  - Booster sessions on chronic pain and difficult conversations
  - Medication-assisted treatment & site visits
- **Resident Core Curriculum Lecture** (1.5 hours, all R2-R3s)
  - Safe Opioid Prescribing for Chronic Pain

From Teaching to Practice: Medication-Assisted Treatment for Opioid Use Disorders

- Buprenorphine-naloxone training for residents
  - SBIRT: lecture on medication-assistant treatment & site visit to the SF Office-based Buprenorphine Induction Clinic (OBIC)
  - Buprenorphine-Naloxone Training for Residents
  - Primary care residents rotate in OBIC clinic & can accept patients who have stabilized on a dose



Informal Teaching

- One-on-one case discussions
- Chart review by primary preceptor and MD lead for chronic pain
- Observation of resident-patient visits
- Controlled Substance Review committee attendance or feedback
- Ambulatory M&M

Systems Training: Chronic Opioid Registry

- All patients taking opioids for ≥ 3 months are entered into our registry
  - Identified by ICD-9 code
  - EMR: eClinicalWorks; Registry Database: i2i
  - Track the following:
    - Last urine drug screen
    - Date of last pain assessment/agreement
    - Morphine equivalent dosage
    - Benzodiazepine co-prescribing

Chronic Opioid Registry

- Registry Functions
  - Quality metrics are reported to the health plan as part of P4P (up to date pain agreement and urine drug screen)
  - Generates individualized provider reports to see how you are doing
  - Enables outreach to patients
  - Identifies patients not recently seen

Chronic Opioid Registry

- Residents use of the registry
  - Review individual patient list (outreach, problem-solving)
  - Compare metrics to other providers
  - Compare dosages to other providers
  - Teachable moments
    - “I have so few patients”
    - “I never realized how high that dose was”

Run Date: 12/4/2014 9:44:41 AM
Location: All
Provider: All
Patient Count: 5

Patient Search Results

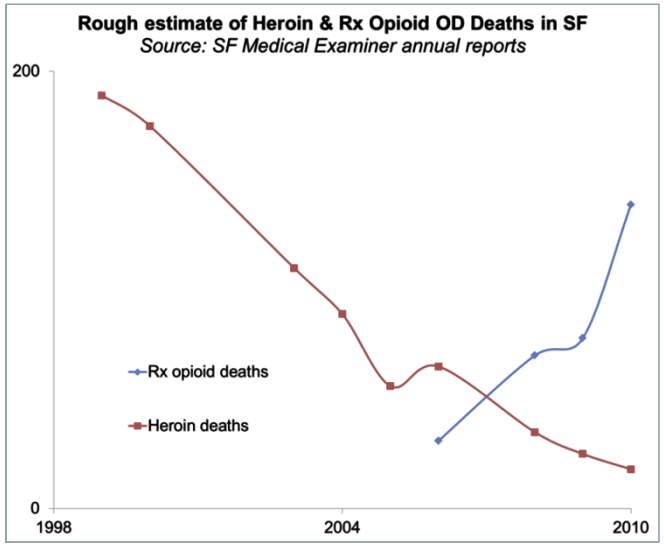
Name	Med Rec#	DOB	Provider	Financial Class.	Age	Gender	Race	Total Morphine EQ (Last Value)
xxxxxxxx	xxxxx		JANE M. PERLAS, NP	Medicare	45 Yrs	M	Black	39.00
xxxxxxxx	xxxxx		JANE M. PERLAS, NP	Medicare	57 Yrs	M	Hispanic	45.00
xxxxxxxx	xxxxx		JANE M. PERLAS, NP	MEDI-CAL-CAP	44 Yrs	M	White	78.00
xxxxxxxx	xxxxx		JANE M. PERLAS, NP	Medicare	62 Yrs	M	White	40.00
xxxxxxxx	xxxxx		JANE M. PERLAS, NP	MEDI-CAL-CAP	21 Yrs	M	Hispanic	366.00

Results (Pain Registry GMC)

Prescribed Benzodiazepines (Last Value)	Pain Mgmt Agreement (Last Date)	Pain Assessment (Last Date)	Cocaine (Metab.) Screen, Urine (Last Date)	Cocaine (Metab.) Screen, Urine (Last Value)	Naloxone (Last Date)	Naloxone Decline (Last Date)	CURES Report (Date) (Last Date)	Committee Review (Last Date)	NextAppte
	7/2/2014	3/26/2014	1/24/2014	Negative	3/26/2014		3/17/2014		12/17/20
Y	10/23/2013	10/23/2013	11/12/2014	Negative	10/23/2013		3/26/2014		12/10/20
	7/23/2014	2/5/2014	5/8/2014	Negative	3/5/2014		3/12/2014		12/15/20
Y	10/23/2013	10/23/2013	10/23/2013	Negative	10/24/2013		3/26/2014		12/10/20
Y	4/2/2014	4/2/2014	11/12/2014	Negative			7/23/2014		12/8/201

Program Innovation: Intra-Nasal Naloxone for Overdose Prevention

- Epidemic of unintentional overdose from prescription opioids



Morbidity and Mortality Weekly Report

Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999–2008

On November 1, 2011, this report was posted as an MMWR *Early Release on the* MMWR *website (http://www.cdc.gov/mmwr).*

Abstract

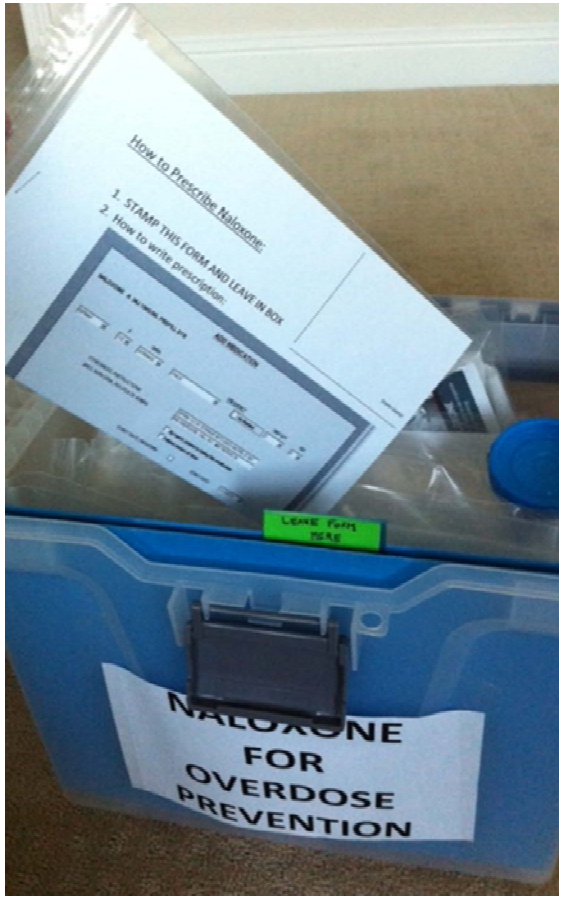
Background: Overdose deaths involving opioid pain relievers (OPR), also known as opioid analgesics, have increased and now exceed deaths involving heroin and cocaine combined. This report describes the use and abuse of OPR by state.

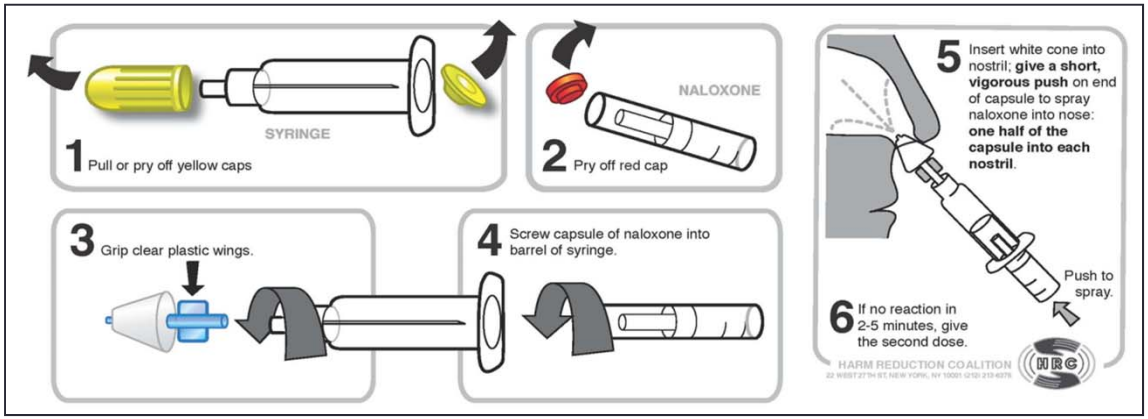
Methods: CDC analyzed rates of fatal OPR overdoses, nonmedical use, sales, and treatment admissions.

Intra-Nasal Naloxone Project

- Collaborated with the San Francisco DPH to begin distribution of intra-nasal naloxone to all patients taking chronic opioid therapy for pain, and others that may benefit from it.

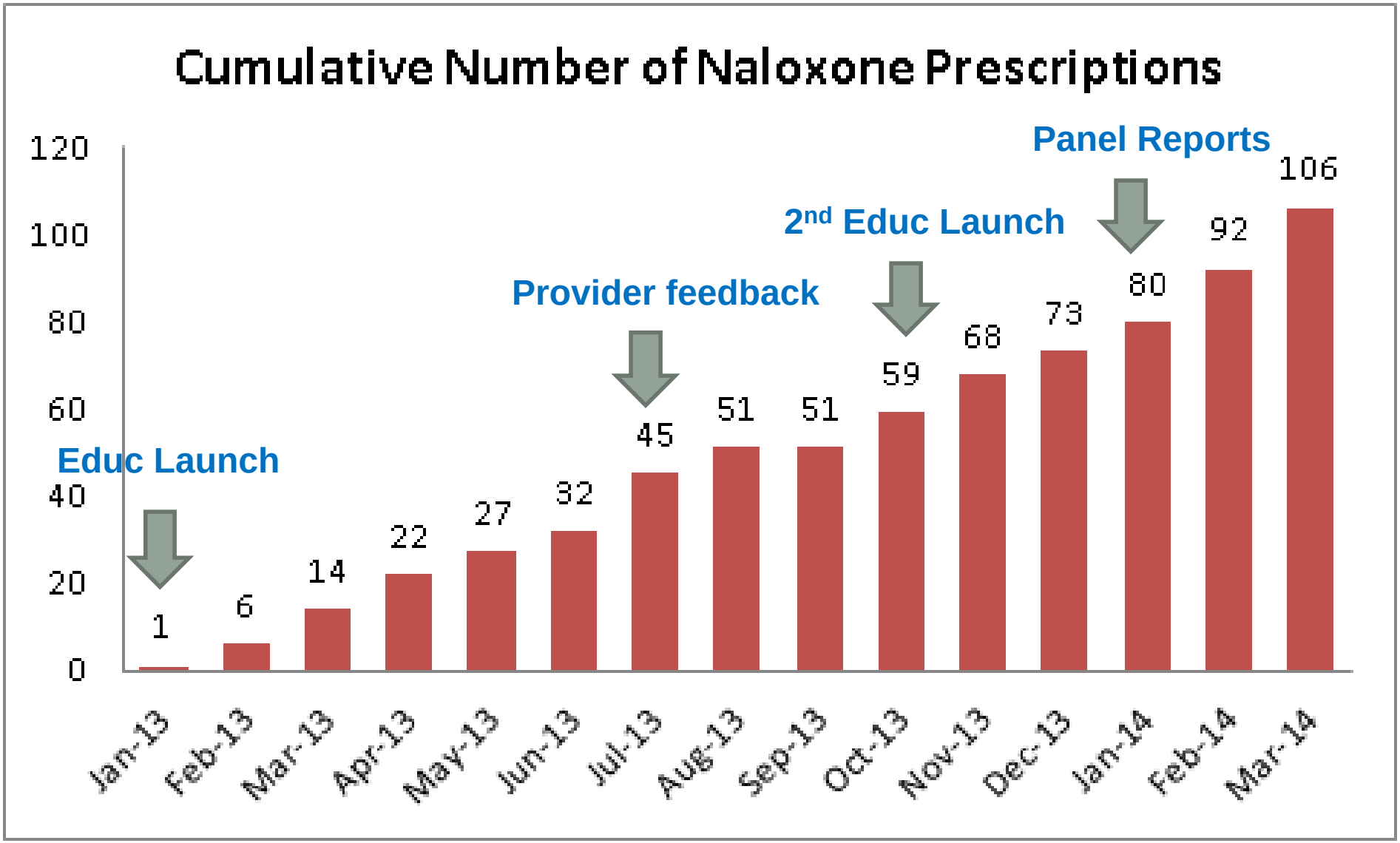
Intra-Nasal Naloxone





Intra-Nasal Naloxone Workflow

- Provider identifies candidate patient →
- Provider prescribes medication →
- Provider does training for patient and/or caregiver & gives she/he the “kit” →
- Patient goes to pharmacy to pick up medication →
- Provider manages any problems related to rx


Cumulative Number of Naloxone Prescriptions
120
100
80
60
40
20
0
Educ Launch
Provider feedback
2nd Educ Launch
Panel Reports
1
6
14
22
27
32
45
51
51
59
68
73
80
92
106
Jan-13
Feb-13
Mar-13
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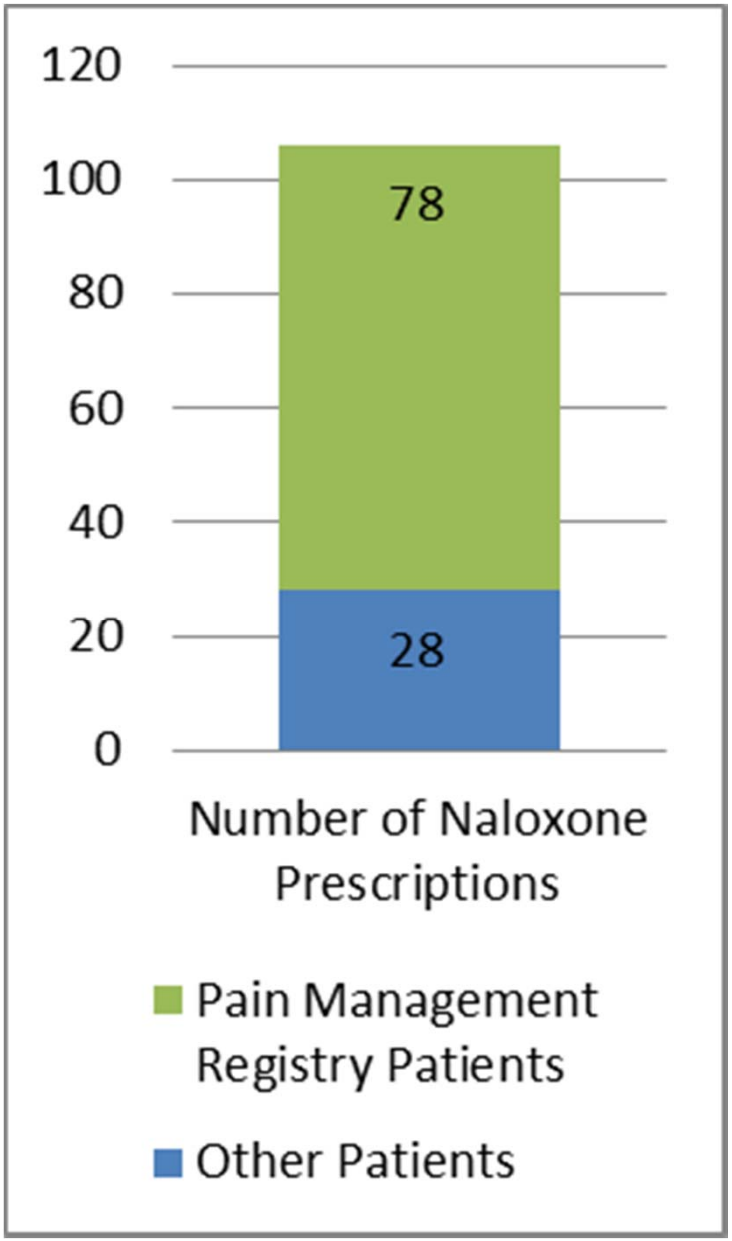

~25% of registry patients received Naloxone in >1 yr

Intra-Nasal Naloxone & Residents

- Limited prior experience talking with patients about unintentional overdose and opioid safety
- Powerful tool to add to opioid conversations
- Early adopters
- Idea spread

Idea Spread

- Intra-nasal naloxone expanded to hospitalized patients at SFGH (resident QI project)

Lessons Learned

- Traditional didactics on chronic opioid therapy are important
  - Limited exposure in medical school
  - Elevate the topic; make it rigorous
  - Include practical skill-training (difficult conversations and MI)
- A disease registry can be useful to understand the burden of disease, patients for outreach, and personal performance.
- Intra-nasal naloxone provided an opportunity for residents to learn about opioid safety and have constructive conversations with their patients about risks/benefits of treatment.