Noontime Knowledge Session

Update on Opioid Prescribing and Tapering Strategies

July 23, 2019

Noon-1:00pm

OneCare Vermont

onecarevt.org

Welcome

Susan Shane, MD
Medical Director

Agenda

#	Agenda Item & Presenter	Time
1	Susan Shane, MD OneCare Vermont 1. Welcome 2. Introduction 3. Session Details & Objectives	Noon-12:05pm
2	Presentation by: Charles Maclean, MD	12:05pm-12:45pm
3	Questions and Answers	12:45pm-1:00pm
Thank you!		

Monitoring Form

Date: 07/23/2019
Update on Opioid Prescribing and Tapering Strategies

Title of Program: OneCare Vermont Noontime Knowledge

Where: OneCare Vermont – Mountainside Conference Room & via WebEx

Please list speaker/moderator:
Norman Ward, MD
Charles MacLean, MD

Please list all planning committee members:
Dr. Norman Ward
Dr. Susan Shane
Emily Martin, RN
Tawnya Safer, BS

Purpose Statement/Goal of this activity: To provide education to attendees from a subject matter expert on the current best practices around opiate prescribing and tapering practices.

Learning objectives (*do not use "understand"*): By the end of this activity, the learners will be able to grasp the epidemiology of opioid prescribing in primary care and post-operative settings and participants will be able to discuss approaches to tapering chronic opioid therapy.

Do the speakers or any of the planners have anything to disclose?☐Yes ☒No
If yes, please list all potential conflicts of interest: None
If yes, were the potential conflicts resolved: ☐Yes ☐No ☒NA
Did this activity receive any commercial support (*grants or in-kind*)?☐Yes ☒No
If yes, please list all organizations and support type: N/A

In support of improving patient care, The Robert Larner College of Medicine at The University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
The University of Vermont designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
This program has been reviewed and is acceptable for up to 1 Nursing Contact Hours.

Presenter Bio

Charles MacLean, MD |General Internist | UVM Health Network Medicine

Dr. MacLean is a Professor of Medicine and Associate Dean for Primary Care at the Larner College of Medicine at UVM, where he directs the Office of Primary Care and AHEC Program.

He has completed research on a variety of topics in population health and primary care, including: clinical support systems for diabetes, automated screening and brief intervention for substance abuse, and use of the EMR for population health.

As an educator, he is a faculty member in the Center for Clinical and Translational Science, an Academic Detailer for the Vermont Academic Detailing Program, and helps direct the UVM Project ECHO.

He is currently working on projects related to opioid prescribing in primary care and in post-operative settings

Session Objectives

1. Understand the epidemiology of opioid prescribing in primary care and post-operative settings

2. Be able to discuss approaches to tapering chronic opioid therapy

Accreditation Designation Statement

In support of improving patient care, this activity has been planned and implemented by The Robert Larner College of Medicine at The University of Vermont and OneCare Vermont. The University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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ANCC:
This program has been reviewed and is acceptable for up to 1 Nursing Contact Hours

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Opioid Prescribing & Tapering Strategies

Updated July 2019

Charles MacLean, MD

Acknowledgments

UVM Office of Primary Care
Connie van Eeghen, DrPH, MHSA, MBA
Mark Pasanen, MD
Liz Cote, BA

Vermont Academic Detailing Program
Amanda Kennedy, PharmD, BCPS
Rich Pinckney, MD MPH
Gary Starcheski, RPh
Jocelyn VanOpdorp, PharmD, BCPS

Outline

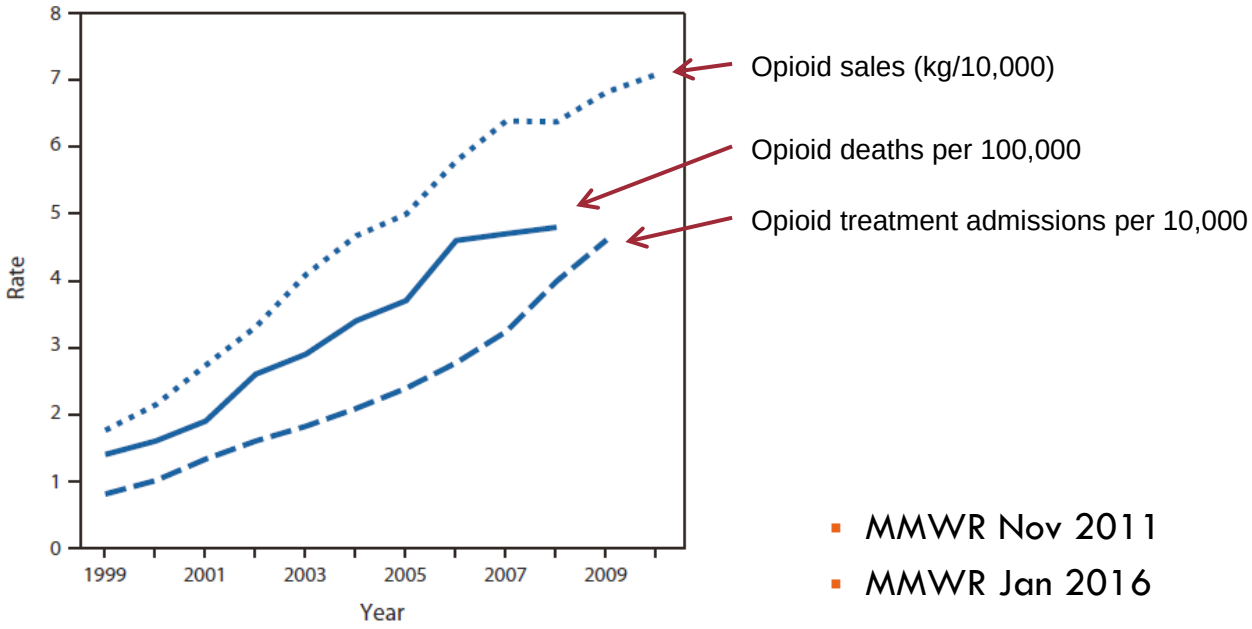
- Scope of the problem
- Guidelines and Rules
- Update on opioid prescribing
  - Epidemiology of prescribing in VT
  - Post operative prescribing
  - Outpatient prescribing
- Taper chronic opioids when risk outweigh benefits

Take home points

- Opioid prescribing has been decreasing since 2010
- Rules, regulations, and guidelines are probably helping but may have unintended consequences
- Post op prescribing is decreasing and is approaching “right-size”
- Most opioids are prescribed in primary care (which is complex)
- Tapering chronic therapy is challenging

Opioid prescribing in the US

- Increase in opioid prescribing more than tripled 1999-2010
- Overdose deaths tripled between 1999-2008



- MMWR Nov 2011
- MMWR Jan 2016

Downstream health concerns

- Infection
  - Heart valve
  - Blood stream
  - Skin and muscle
  - Bone
  - Hepatitis C and HIV
- Lung damage
- Trauma
- Neonatal abstinence syndrome
- Falls & fractures
- Withdrawal symptoms
- Use of other alcohol or drugs
- Estimated $72.5 billion annual health care costs in the US

Downstream societal costs

- Job Loss
- Family Disruption
- Criminal Activity
- Incarceration
- Effects on children
- Social Stigma
- Loss of housing
- Loss of custody of children

CDC guidelines

Recommendations for Prescribing Opioids for Chronic Pain Outside of Active Cancer, Palliative, and End-of-Life Care

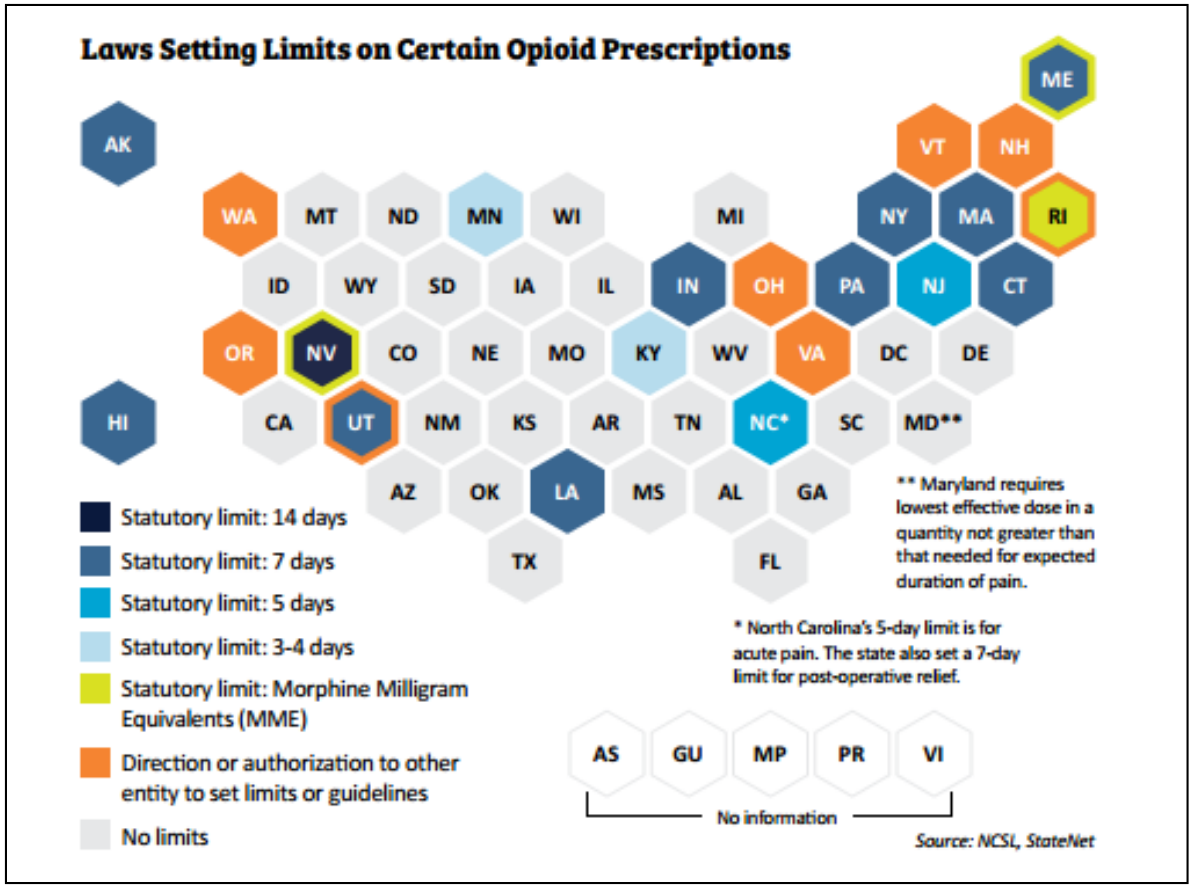
Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.

CDC guidelines 2016 (condensed)

- Use alternatives to opioids whenever possible
- Explain the risks and benefits
  - Informed consent
- Focus on function
- Start low and go slow
- Track progress carefully
  - Surveillance for misuse
- Avoid benzodiazepines

CDC advises against misapplication of the Guideline, April 2019

2016 & 2017 Vermont Rules



-National Conference of State Legislatures, August 2017

VT Prescribing Rules, chronic opioid therapy

- Patient written consent and agreement, updated annually
- Use of PDMP at least annually
- Office assessment
  - Function
  - Risk for aberrant behavior
  - Revisit interval 90 days
- Co-prescribing of naloxone for high dose or concomitant benzodiazepine

VT Prescribing Rules, acute opioid therapy

- Patient written consent and agreement
- Quantity and dose limits
- PDMP if 10+ pills

Managing Opioids Safely and within Vermont Rules

SUMMARY FOR MEDICAL AND DENTAL PRESCRIBERS

Recommend Non-Opioid and Non-Pharmacological Treatment ✔

- Nonsteroidal anti-inflammatory drugs (NSAIDs) and/or acetaminophen
- Acupuncture
- Chiropractic
- Physical therapy
- Yoga

Only prescribe opioids if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, combine with non-opioid alternatives.

Query the Vermont Prescription Monitoring System (VPMS)* ✔

First-time Prescriptions:

- Prior to writing a first opioid prescription for greater than 10 pills (e.g. opioids, tramadol)
- Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
- Prior to starting a patient on a chronic opioid (90+ days) for non-palliative therapy

Re-evaluation: At least annually (at least twice annually for buprenorphine)

- Centers for Disease Control (CDC) recommendation: every prescription, or at least every 90 days

Replacement: Prior to writing a replacement (e.g. lost, stolen) of any scheduled II-IV controlled substance

Provide Patient Education and Obtain Informed Consent ✔

Discuss Risks *in-person* with the patient or legal representative regarding potential side effects, risks of dependence and overdose, alternative treatments, appropriate tapering, and safe storage and disposal of opioids

- CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

Provide Written Patient Education: Use the Vermont Department of Health (VDH) Opioid Patient Information Sheet or a handout that contains all of the same information at a 5th grade reading level or lower. www.healthvermont.gov/sites/default/files/documents/pdf/adap_opioid_patient_information.pdf

Obtain a Signed Informed Consent document from the patient or legal representative that contains all of the required elements stated in the Opioid Prescribing Rule, section 4.3.3.1.

Use Available Resources: The Opioid Patient Information Sheet and an example informed consent document are available in multiple languages and may be found online at: www.healthvermont.gov/news-information-resources/translated-information/language.
Additional resources may be found at: www.healthvermont.gov/alcohol-drugs/professionals/help-me-stay-informed and www.cdc.gov/drugoverdose

Prescribe Nasal Naloxone when Indicated ✔

High Dose: 90+ Morphine Milligram Equivalent (MME) per day

Concomitant benzodiazepine: Patients prescribed both an opioid and a benzodiazepine (CDC recommends avoiding these combinations)

CDC: History of overdose, history of substance use disorder, 50+ MME per day prescriptions

Arrange for Evidence-based Treatment for Patients with Opioid Use Disorder ✔

CDC: Offer evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

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OFFICE OF PRIMARY CARE

**Prescriber registration with the VPMS is mandatory. For the complete rules, visit the Vermont Prescription Monitoring System Rule (7/1/17) and Rule Governing the Prescribing of Opioids for Pain (3/1/19) found at www.healthvermont.gov. CDC Guidelines: Dowell D, et al. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. JAMA. 2016 Apr 19;315(15):1624-45. PMID: 26977696*

Complete Continuing Education Requirements

Complete at least two hours of continuing education for each licensing period on the topic of Controlled Substances. Visit vtad.org, your licensing board, or check with your professional society for information and available courses.

Prescribe the Lowest Effective Dose of Immediate-release Opioids

- For acute pain, prescribe 0-5 days of therapy. See table below.
- Prescription limits only apply to first prescriptions for opioid naïve patients
- Include the maximum daily dose or a "not to exceed" equivalent on the prescription

Evaluate Patients Regularly Using Best Practices

- Reevaluate patients (and document) at least every 90 days (both VT Rules and CDC)
- Calculate MME. Consider 50-89 daily MME a "yellow light" and 90+ MME a "flashing red light."
- Use evidence-based tools to evaluate pain and function (e.g. PEG), and potential for abuse and diversion (e.g. COMM)
- CDC: A 30% improvement in PEG score is clinically meaningful. If benefits do not outweigh risks, taper opioids.
- CDC: Use urine drug screening prior to initiating opioids. Rescreen at least annually.

Document, Document, Document

- Medical evaluation, including physical and functional exams and assessment of comorbidities
- Diagnoses which support the use of opioids for chronic pain and whether to continue opioids
- Individual benefits and risks, using evidence-based tools (e.g. RAPID3, SOAPP, COMM)
- Non-opioid and non-pharmacological treatments tried and trial use of the opioid
- VPMS query
- Patient discussion about the risk of overdose, including any precautions the patient should take
- VDH Opioid Patient Information Sheet provided
- That the prescriber has asked the patient if he or she is currently, or has recently been, dispensed methadone or buprenorphine or prescribed and taken any other controlled substance
- Signed Controlled Substance Treatment Agreement: update at least annually
- Acknowledgement that a violation of the agreement will result in a re-evaluation of the therapy plan

Opioid Prescription Limits for Acute Pain (Prescribe Immediate-Release Formulations)

PEDIATRICS		
Consider discussing the benefits and risks of prescribing an opioid to a pediatric patient with a colleague or specialist. Use extreme caution. Calculate dose for patient's age and body weight. Consider the indication, pain severity, and alternative therapies. Limit prescriptions to 3 days or less with an average MME of 24 or less. Do not write additional prescriptions without evaluating the patient.		
ADULTS	**Average Daily**	**Total RX**
MINOR PAIN (Examples: sprains, headaches, tooth extraction)	No opioids	No opioids
MODERATE PAIN (Examples: non-compounded bone fractures, soft tissue surgery, most outpatient laparoscopic surgery)		
Hydrocodone 5mg	MME: 24 / 0-4 tablets	0-5 days / 0-20 tablets
Oxycodone 5mg	MME: 24 / 0-3 tablets	0-5 days / 0-15 tablets
SEVERE PAIN (Examples: non-laparoscopic surgery, joint replacement, compound fractures)		
Hydrocodone 5mg	MME: 32 / 0-6 tablets	0-5 days / 0-30 tablets
Oxycodone 5mg	MME: 32 / 0-4 tablets	0-5 days / 0-20 tablets

Extreme pain (beyond severe) in adults is limited to a 7 day max with a 350 MME max. This should be rare. Prescribing outside of this table (i.e. exceptions) must be clearly documented. For the complete rules, visit the Rule Governing the Prescribing of Opioids for Pain (3/1/19) found at www.healthvermont.gov. CDC Guidelines: Dowell D, et al. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. 2016 Apr 19;315(15):1624-45. PMID: 26977696

Google “Vermont AHEC”

- Academic Detailing
- Improving Opioid Prescribing

Epidemiology

Questions

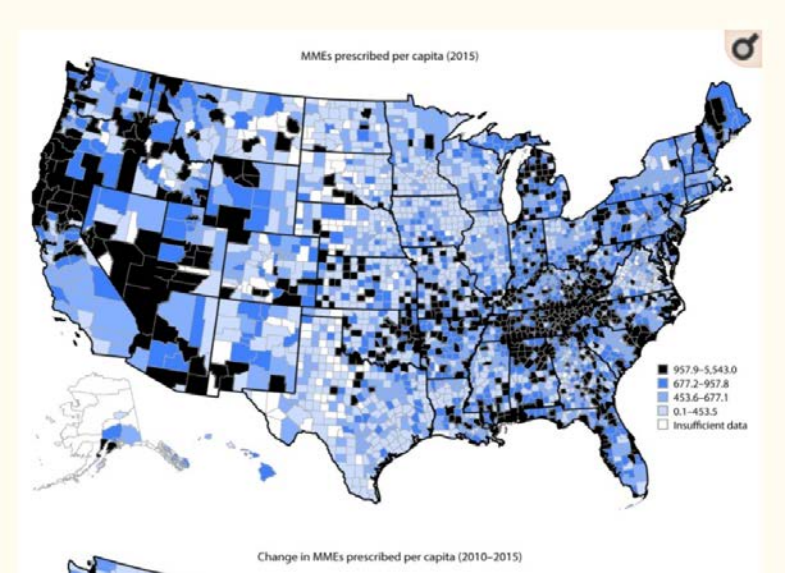
- Who is prescribing?
- What are the changes over time?
- How can we do a better job?

Most opioids are prescribed in primary care

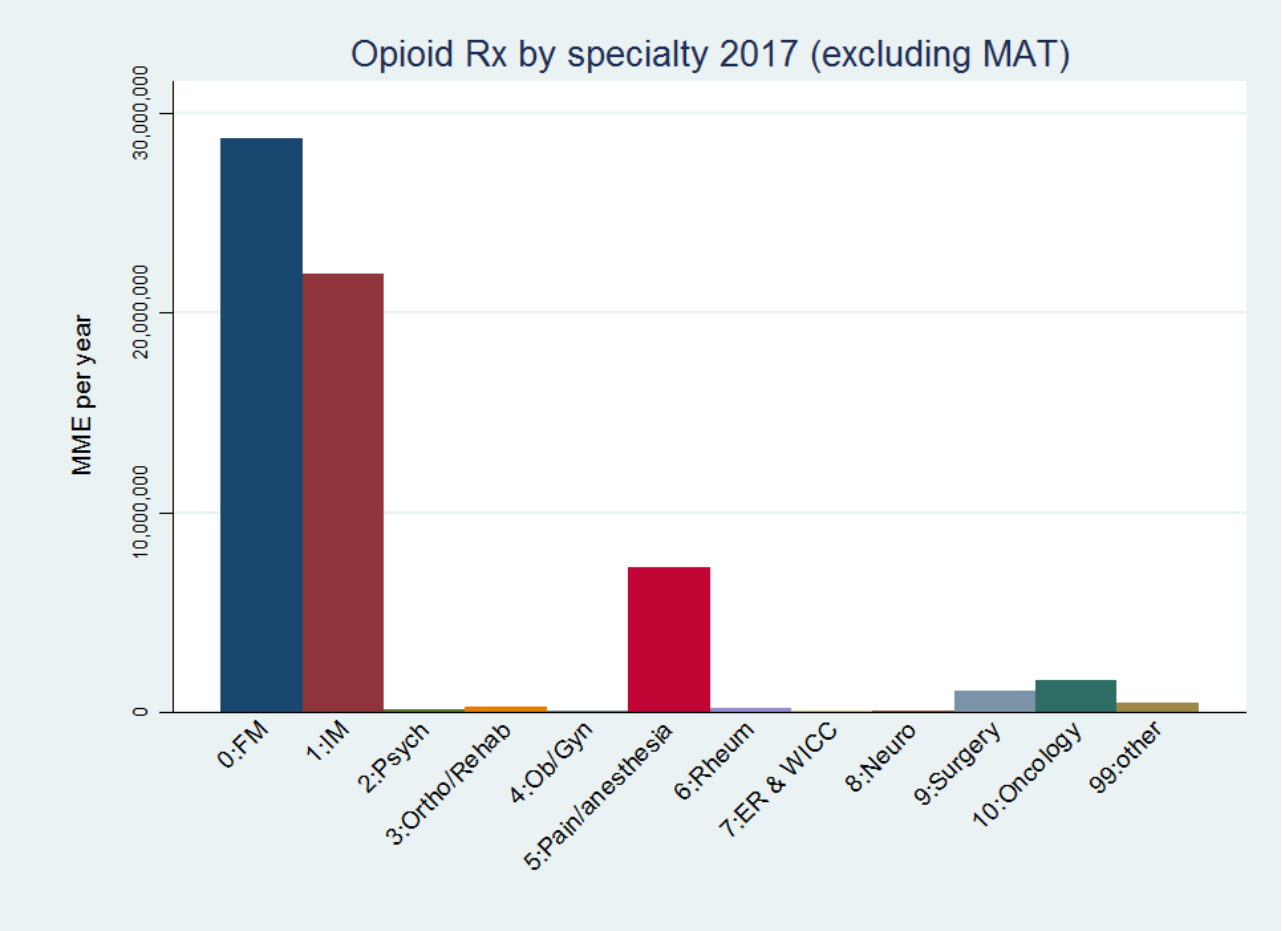
- IMS Health National Prescription Audit, 2007-2012
  - Primary Care ~ 44% of MME
    - Levy et al. Am J Prev Med; 2015. Trends in Opioid Analgesic-Prescribing Rates by Specialty, U.S., 2007-2012
- Ohio Prescription Drug Monitoring Program, 2010-2014
  - FM & IM = 47% of pills
    - Weiner et al. Pain Medicine 2018

Peak opioids was 2010

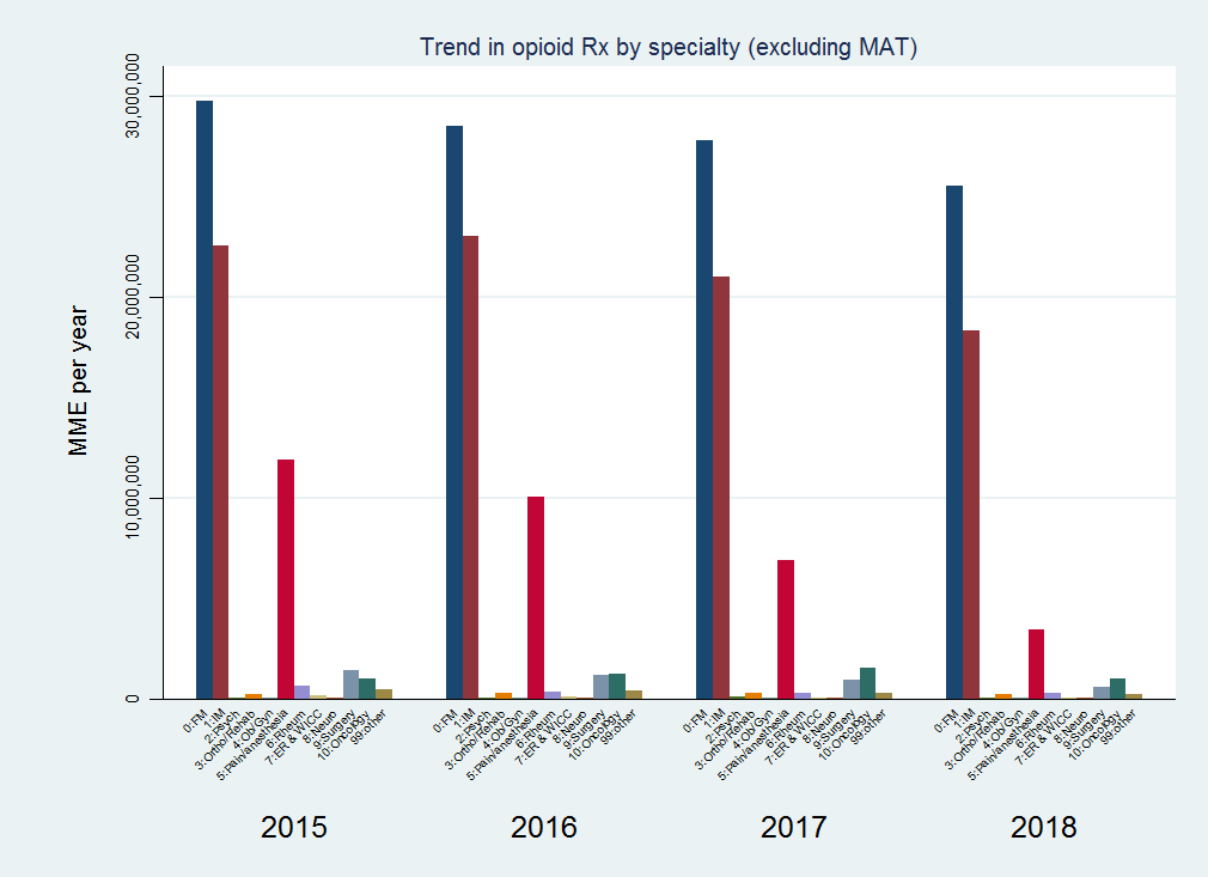
- Quintiles IMS prescribing data, 2016-2015
  - Peak opioids 782 MME per capita in 2010, decreased to 640 MME by 2015 (-18%)
  - 2015 still three times per capita rates in 1999
    - Guy et al 2017. MMWR doi: 10.15585/mmwr.mm6626a4



Who is prescribing in UVMMC population?



What is the trend over time?

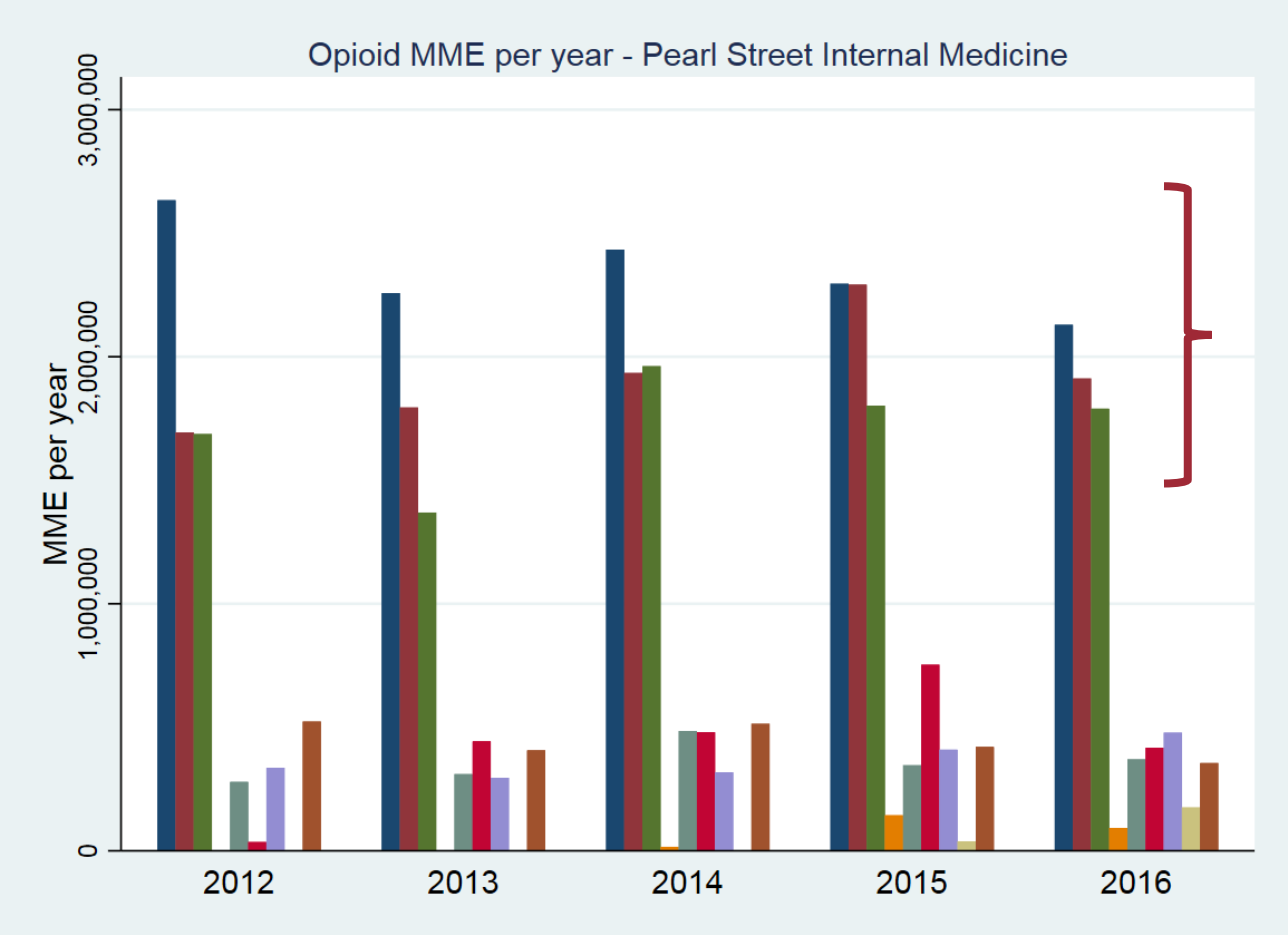


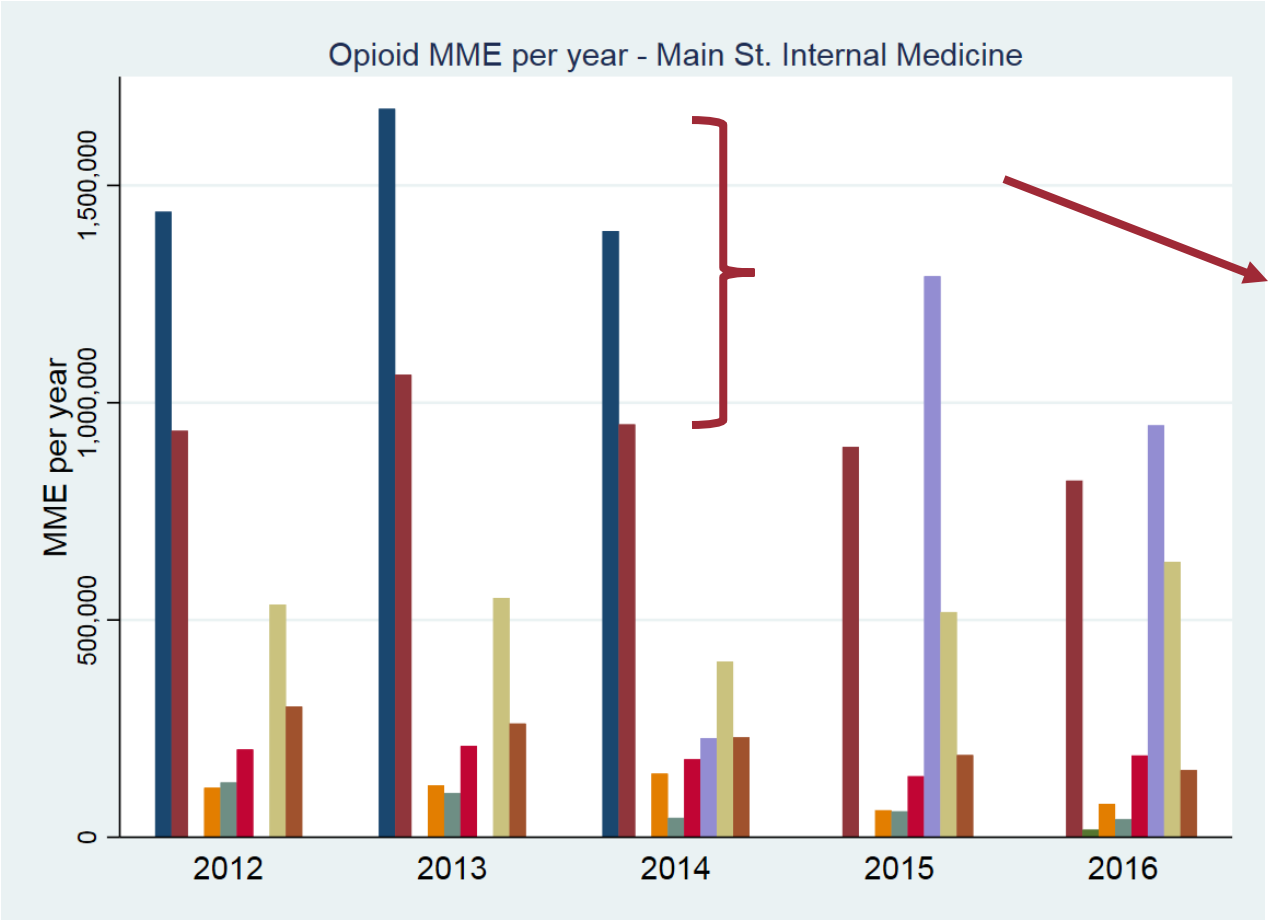
Population summary of opioid prescribing

- 9.1% of 62,000 subjects received an opioid in 2018

- Of those on an opioid:
  - Chronic –25.1%
  - High dose – 5.1%

  - GABA agonist co-prescription
    - Any GABA use – 32%
    - Weekly use – 20%
    - Daily use – 9%


Opioid MME per year - Pearl Street Internal Medicine
MME per year
0
1,000,000
2,000,000
3,000,000
2012
2013
2014
2015
2016


Opioid MME per year - Main St. Internal Medicine
MME per year
0
500,000
1,000,000
1,500,000
2012
2013
2014
2015
2016

Primary Care QI Projects

Or…implementing the guidelines

Opioid QI Projects – 2012-2019

- Rationale
  - Public health problem
  - Standards of care are changing
  - A small number of cases can cause a lot of office drama/disruption/splitting/night calls/etc
  - Prescribers need more implementation, less education

- QI facilitator using LEAN management approach to improve prescribing in community practices
  - Funded by VDH

Primary care strategies

- Referral to a comprehensive pain clinic
- Peer consultation
- Opioid council
- Team-based care
  - "Pain Team"
  - "MAT-style" team

Which of these strategies would you most like to see established?

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Opioid Prescription Management Toolkits

Opioid Prescription Management Toolkit for Chronic Pain Sustainable Solutions for Vermont:
Practice Fast Track and Facilitators Toolkits

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What are these toolkits and why were they created?

These toolkits collect the best practice strategies for managing opioid prescriptions in primary care (and other) ambulatory settings. The strategies resulted from a two-year project (The Opioid Prescribing Quality Improvement Project, 2012-2014) to identify the most helpful methods used to create predictable and well-managed opioid prescribing patterns for physicians, nurse practitioners, and physician assistants and their patients.

What are some of the best practice strategies for managing opioid prescriptions?

New regulations about the prescribing of chronic opioids require the use of consent forms/treatment agreements and use of the prescription monitoring system. The standard of care supported by boards of medical practices across the country recommend, under certain circumstances, a variety of practice strategies to safely prescribe and monitor chronic opioid treatment. These strategies include assessing risk for misuse, use of pill counts and urine drug testing, best-practice documentation, and standardizing prescribing intervals to minimize communication issues among patient, office staff and prescriber, and others.

What are some of the results from the opioid prescribing two-year project?

All ten practices enrolled in the project reported positive results from the best practice strategies they chose to implement from the toolkit. The strategies helped prescribers standardize their approach and increase confidence in managing opioid prescriptions, helped practices change their support systems, and increased provider and staff satisfaction regarding the way opioid prescriptions are managed.

Who should read these toolkits and how are they different?

Fast Track Toolkit: This toolkit is intended for ambulatory care practices whose leaders, providers, and staff want to improve the process of managing opioid prescriptions for their chronic pain, non-palliative care patients. It is for practices with a team ready to make a quick start on a few of the 17 strategies and provides practical advice on getting started, how to adjust practice workflow, and how to implement changes. The toolkit includes an extensive appendix with policies, sample tools, and references.

Facilitator Toolkit: This toolkit is intended for practices that have not yet made a decision to work on opioid prescription management and need to develop a rationale, leadership support, and team to work on this topic. It provides three stages of development: preparation, design (of workflow), and implementation. It provides detailed guidance on measurement, team facilitation, work flow analysis, and follow up. It is best used by facilitators, staff, or leaders interested in supporting a transformative change in opioid prescription management. It includes the same appendix as the Fast Track Toolkit, with additional materials to support facilitation.

Improving Opioid Prescribing Toolkit - Practice Fast Track (PDF)

Improving Opioid Prescribing Toolkit - Facilitator Manual (PDF)

Primary care summary

- Wide variability in prescribing within practices
  - Patient factors (age, co-morbidities, tolerance)
  - Prescriber factors (duration in practice, setting, schedule, style)

- "Typical" Annual prescribing
  - 90 patients total
    - 5-20 "chronic" patients
  - MME 250,000 (25K-1.6M)
- Benchmarking and peer comparison across prescribers will likely be useful for exploration of variability

Post-operative prescribing

What is the contribution of post-operative prescriptions to the opioid supply?

Mayo H. Fujii, MD MS
Ashley C. Hodges
Ruby L. Russell
Kristin Roensch, MD
Bruce Beynnon, PhD
Thomas P. Ahern, PhD MPH
Peter Holoch, MD
Jesse S. Moore, MD
S. Elizabeth Ames, MD
Charles D. MacLean, MD

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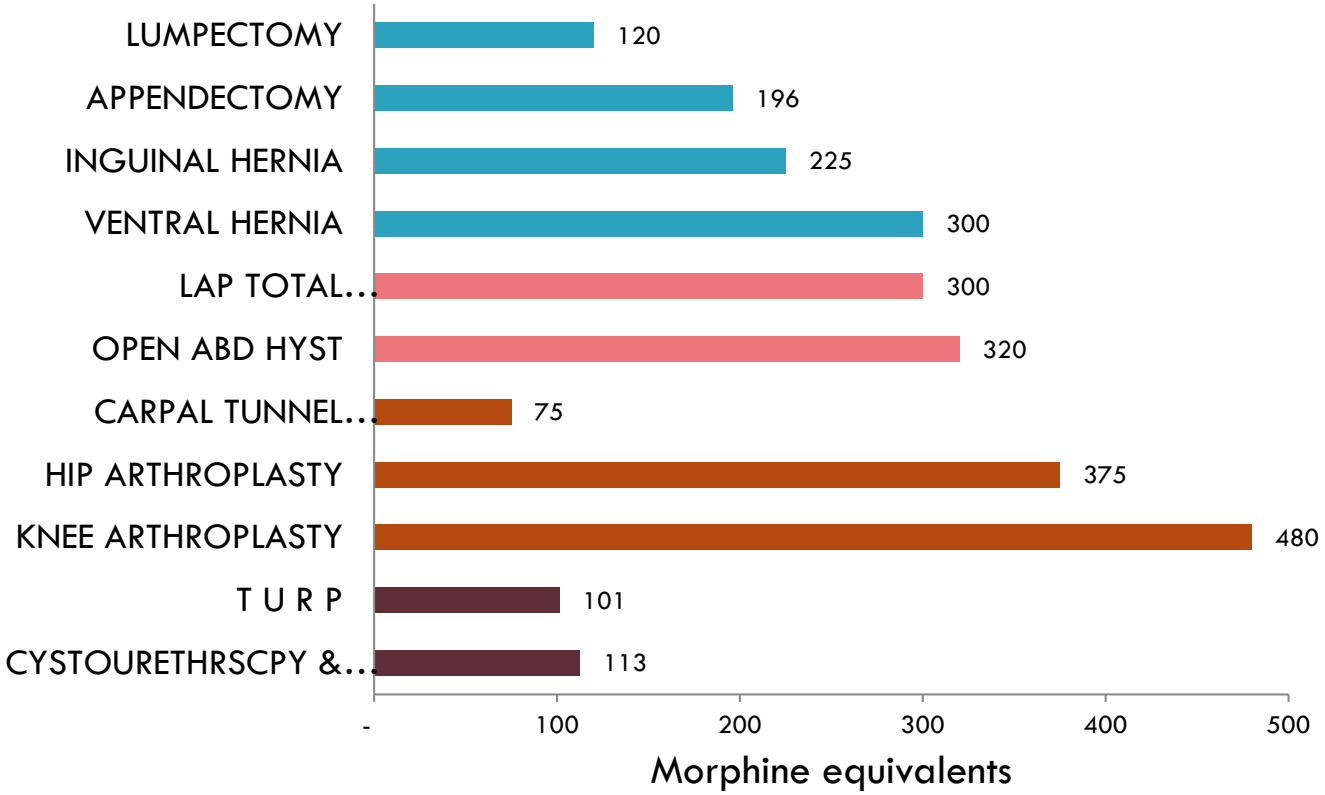
Background and study design

- Background
  - Variability in post-operative discharge prescribing
- Goals
  - Assess current opioid prescribing at discharge over 1 year
  - Develop standard approaches
- Methods
  - ~ 11,000 operations
  - 66% outpatient
  - Ortho, Gen surg, Ob/gyn, Urology

MME for common surgeries



Patient perspective

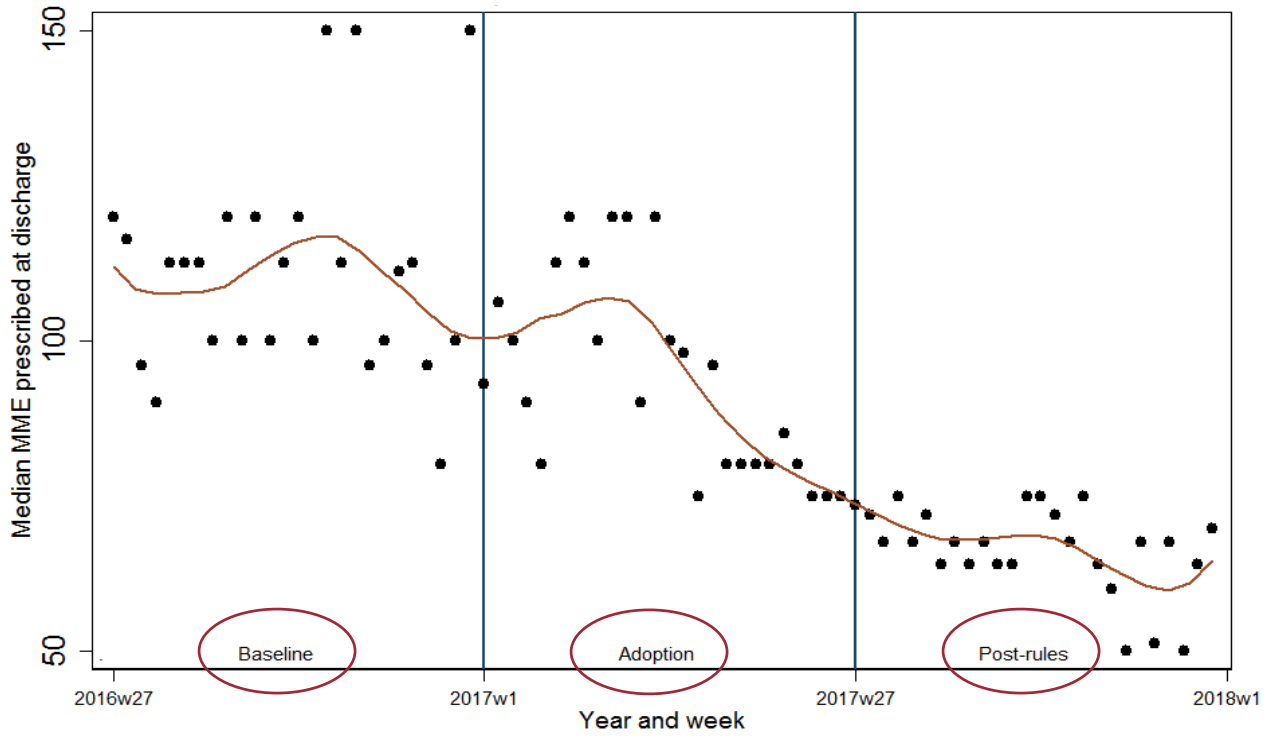
- Phone call one week post-op
- “How many pills do you have left?”

Patient use

- General & orthopedic surgery
  - 93% of patients were given an opioid
    - 12% did not fill
    - 29% did not use at all
    - Most used less than prescribed
  - Overall about 30% of prescribed opioid were used

- Fujii et al, 2018. J Am Coll Surg, 226(6):1004-1012

Post operative trend after July 2017 rules



- MacLean et al, 2019. Pain Medicine; 20:1212

Prescriptions at discharge after selected surgical procedures before and after organizational and policy changes

	Baseline period (Jul-Dec 2016)			Post-rule period (Jul-Dec 2017)			
Specialty, procedure	**Number of procedures**	**Proportion with any opioid**	**MME [a] prescribed median (Q1-Q3)[b]**	**Number of procedures**	**Proportion with any opioid**	**MME [a] prescribed median (Q1-Q3)[b]**	**Difference in median MME [95% CI] [c]**
Overall	**5,981**	**71%**	**113 (0-240)**	**5,872**	**64%**	**68 (0-150)**	**-45 [-50, -40]**
General Surgery [d]	**1,420**	**73%**	**80 (0-160)**	**1,413**	**71%**	**64 (0-80)**	**-16 [-24, -8]**
Appendectomy (laparoscopic)	108	94%	106 (80-155)	67	78%	64 (30-72)	-36 [-55, -17]
Cholecystectomy (laparoscopic)	155	94%	120 (80-160)	134	85%	64 (45-80)	-56 [-73, -39]
Colectomy, partial (lap or open)	69	77%	160 (75-240)	82	68%	80 (80-150)	-80 [-123, -37]
Hernia (inguinal, ventral, incisional)	177	90%	96 (64-160)	235	95%	64 (48-80)	-32 [-44, -20]
Mastectomy, partial	102	73%	48 (0-80)	86	65%	40 (0-72)	-8 [-21, 6]
Gynecology	**827**	**62**	**75 (0-200)**	**785**	**60**	**60 (0-80)**	**-15 [-29, -1]**
Hysterectomy (laparoscopy)	114	92%	225 (160-263)	132	91%	75 (75-80)	-150 [-164, -136]
Hysterectomy (open)	28	96%	260 (225-320)	37	89%	80 (75-150)	-200 [-241, -159]
Laparoscopy	25	88%	113 (75-120)	28	96%	75 (38-75)	-38 [-61, -14]
Urethral sling procedure	47	70%	60 (0-113)	35	86%	37.5 (32-75)	-23 [-49, 4]
Orthopedic Surgery	**2,464**	**78%**	**225 (75-450)**	**2,441**	**75%**	**113 (50-300)**	**-112 [-133, -92]**
Carpal tunnel release	152	39%	0 (0-100)	170	43%	0 (0-50)	0 [-20, 20]
Hip arthroplasty	144	88%	594 (450-775)	154	84%	375 (238-520)	-225 [-290, -160]
Knee arthroplasty	146	77%	523 (300-700)	119	91%	500 (280-650)	-20 [-93, 53]
Knee arthroscopy	98	97%	155 (96-225)	136	91%	67.5 (64-80)	-83 [-109, -56]
Lumbar arthrodesis	40	77%	513 (388-880)	40	90%	450 (250-735)	-75 [-300, 150]
Rotator cuff repair (arthroscopic)	42	100%	533 (450-600)	33	100%	268 (225-400)	-272 [-357, -188]
Trigger finger release	33	27%	0 (0-100)	38	29%	0 (0-25)	0 [-12, 12]

HOW TO SAFELY TAKE OPIOID PAIN MEDICINE

Opioid pain medicines are sometimes prescribed to keep you comfortable after surgery or an injury. Here are some tips if you are prescribed these medicines.

TAKE ONLY AS PRESCRIBED

Opioids can be dangerous if not taken as prescribed.

Check your instructions carefully—opioids are often prescribed AS NEEDED, not around the clock.

Common side effects include feeling:
Sleepy, Dizzy, Itchy, Constipated, Sick to your stomach, Foggy

NEVER MIX

Never mix opioids with alcohol, sleeping pills, muscle relaxers, and certain anti-anxiety medicines.

Mixing these can cause serious side effects, including overdose and death.

Tell your doctor about ALL other medicines you're taking.

DISPOSE SAFELY

Dispose of your leftover opioid pills safely.

Never throw them in the garbage or flush them.

Drop them at a permanent drug disposal site.
Call 2-1-1 to find one in Vermont.

LEARN MORE

Get additional tips on taking pain medicine safely after surgery. Watch our video at **www.vtad.org**

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TIPS FOR SAFE OPIOID PRESCRIBING AFTER SURGERY

1. REVIEW

Review safe and effective prescribing amounts and durations for common surgeries and procedures.
See the table at the right for examples. ⟶

2. DISCUSS

Discuss these recommendations with your medical staff, and develop standards for your practice or department.

3. SHARE

Share these standards with your whole team, including nurses, medical assistants, and office staff, so everyone is on the same page.

4. FOLLOW

Continue to follow Vermont's rules for prescribing opioids, including discussing the **benefits and risks of opioids**, especially side effects and interactions with other medications.

5. REMIND

Remind patients to store their opioid prescriptions safely, ideally in a locked box or drawer, and to dispose of leftover pills at an approved location.

CALL 2-1-1 PATIENTS CAN CALL 2-1-1 TO FIND A PRESCRIPTION DISPOSAL LOCATION NEAR THEM

TYPICAL OPIOID PRESCRIPTIONS FOR COMMON SURGERIES IN MMEs
(Morphine Milligram Equivalent)

Procedure	Proportion with an opioid prescribed	MME prescribed, median
Appendectomy (laparoscopic)	78%	64
Cholecystectomy (laparoscopic)	85%	64
Hernia (inguinal, ventral, incisional)	95%	64
Mastectomy, partial	65%	40
Knee Arthroscopy	97%	68
Hip Arthroplasty	88%	375

We've created a patient education video on taking opioids safely after surgery.

ASK EVERY PATIENT TO WATCH THE VIDEO BEFORE THEIR PROCEDURE AT: WWW.VTAD.ORG

FOR MORE INFORMATION AND LATEST RESEARCH ON OPIOID PRESCRIBING TRENDS IN VERMONT, VISIT WWW.VTAD.ORG

The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM

Tapering opioids

When to consider tapering

- Discuss at time of initiation of opioids!
- When risks may outweigh benefits because:
  - Lack of effect
  - Side effects
  - Co-morbid risk factors
  - High dose (90 MME)
  - Concomitant benzodiazepine
  - High risk behavior or other red flags

Meta analysis, Busse, et al 2018

Original Investigation

December 18, 2018

Opioids for Chronic Noncancer Pain

A Systematic Review and Meta-analysis

Jason W. Busse, DC, PhD[1,2,3,4]; Li Wang, PhD[1,2,5]; Mostafa Kamaleldin, MB BCh[6]; et al

» Author Affiliations | Article Information

JAMA. 2018;320(23):2448-2460. doi:10.1001/jama.2018.18472

Key Points

Question Is the use of opioids to treat chronic noncancer pain associated with greater benefits or harms compared with placebo and alternative analgesics?

Findings In this meta-analysis that included 96 randomized clinical trials and 26 169 patients with chronic noncancer pain, the use of opioids compared with placebo was associated with significantly less pain (−0.69 cm on a 10-cm scale) and significantly improved physical functioning (2.04 of 100 points), but the magnitude of the association was small. Opioid use was significantly associated with increased risk of vomiting.

Meaning Opioids may provide benefit for chronic noncancer pain, but the magnitude is likely to be small.

SPACE trial

JAMA | Original Investigation

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravely, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

IMPORTANCE Limited evidence is available regarding long-term outcomes of opioids compared with nonopioid medications for chronic pain.

OBJECTIVE To compare opioid vs nonopioid medications over 12 months on pain-related function, pain intensity, and adverse effects.

DESIGN, SETTING, AND PARTICIPANTS Pragmatic, 12-month, randomized trial with masked outcome assessment. Patients were recruited from Veterans Affairs primary care clinics from June 2013 through December 2015; follow-up was completed December 2016. Eligible patients had moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. Of 265 patients enrolled, 25 withdrew prior to randomization and 240 were randomized.

INTERVENTIONS Both interventions (opioid and nonopioid medication therapy) followed a treat-to-target strategy aiming for improved pain and function. Each intervention had its own prescribing strategy that included multiple medication options in 3 steps. In the opioid group, the first step was immediate-release morphine, oxycodone, or hydrocodone/acetaminophen. For the nonopioid group, the first step was acetaminophen (paracetamol) or a nonsteroidal anti-inflammatory drug. Medications were changed, added, or adjusted within the assigned treatment group according to individual patient response.

MAIN OUTCOMES AND MEASURES The primary outcome was pain-related function (Brief Pain Inventory [BPI] interference scale) over 12 months and the main secondary outcome was pain intensity (BPI severity scale). For both BPI scales (range, 0-10; higher scores = worse function or pain intensity), a 1-point improvement was clinically important. The primary adverse outcome was medication-related symptoms (patient-reported checklist; range, 0-19).

Supplemental content

Author Affiliations: Center for Chronic Disease Outcomes Research,

CONCLUSIONS AND RELEVANCE Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

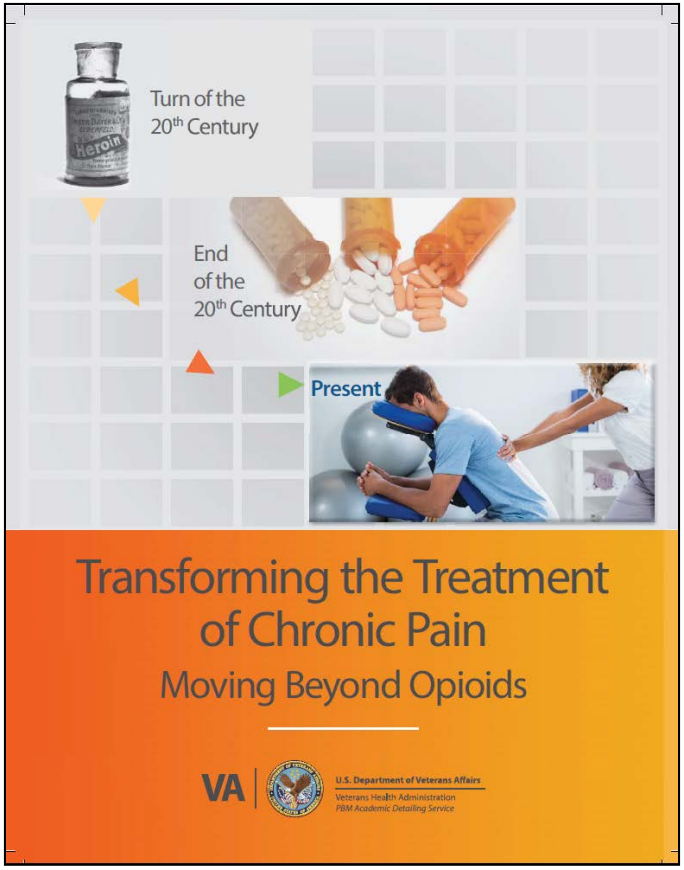
Tapering evidence-1

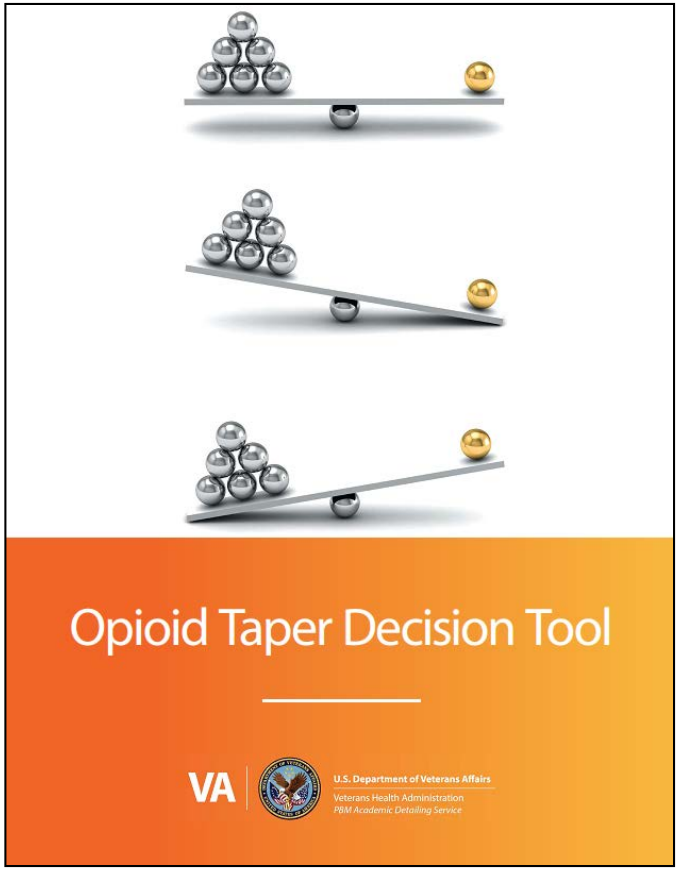
- Cochrane Review, 2017
  - *No evidence for the efficacy or safety of methods for reducing prescribed opioid use in chronic pain*
    - Note: conclusions limited by lack of well-designed, definitive studies
  - *"The findings to date are mixed: reductions in opioid consumption after intervention, and often in control groups too"*

- Eccleston, 2017. Interventions for the reduction of prescribed opioid use in chronic non-cancer pain. Cochrane Database Syst Rev **11**: Cd010323.

Tapering evidence-2

Two resources from the VA





Tapering categories

- Voluntary taper
- Involuntary
- Possibly Aberrant
- Aberrant
  - Criminal behavior
  - No opioid on UDS

General Approach to Evaluating the Patient

Situation	Characteristics	Goal	Strategy
Voluntary			
Patient: *"I don't want to take this anymore."*	Patient interested in tapering and willing to try pain management strategies other than opioids	Dose reduction or discontinuation	Everything is negotiated, including taper speed.
Involuntary			
Patient: *"Nothing else works for me."*	Not interested in tapering and not willing to try pain management strategies other than opioids	Dose reduction or discontinuation	Attempt to taper with cooperation (e.g. use motivational interviewing to create a plan). If patient is unwilling to engage in a plan, proceed with involuntary taper. Consider use of bubble packs to monitor taper.
Aberrant (unclear)			
Provider: *"I don't know what's going on, but opioids don't feel like a good choice for this patient."*	Provider is no longer comfortable prescribing opioids for this patient.	Discontinuation	Involuntary taper to prevent withdrawal. Consider use of bubble packs to monitor taper and consider a faster taper speed.
Aberrant (diversion or addiction)			
multiple lost prescriptions, early refill requests, "red flag" in urine screen, etc.	Would not be responsible for provider to prescribe opioids	Discontinuation	Do not prescribe opioids. If patient has a substance use disorder, call local Hub or Community Health Team social worker for evidence-based treatment

VA recommendations

- Reduce by 5-20% per month
  - Some may require a slow taper of 2-5% per month
- Consider a pause for 2-4 weeks between some steps
- Team approach with mental health

If you are interested in upping your opioid prescribing and tapering game…

- Read the VA materials with your colleagues
- Meet with your colleagues to develop a practice strategy
- Contact your Blueprint facilitator for assistance implementing the Opioid Toolkit
- Sign up for an AD session on “Advanced Opioids”
- Contact the Office of Primary Care regarding a possible next round of technical assistance supported by CDC
- Join the possible next round of Project ECHO

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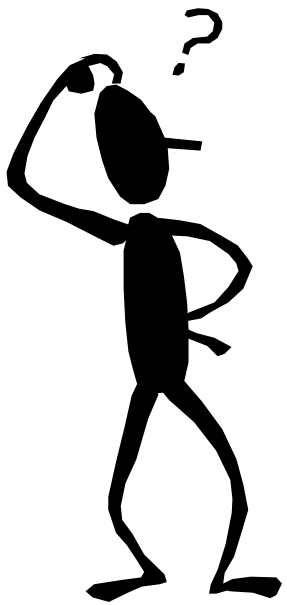
  - Nissa Walke
  - Pam Farnham
  - Regional facilitators

Resources

- CDC guidelines
  - http://www.cdc.gov/drugoverdose/prescribing/guideline.html
  - See also the phone app with includes an opioid calculator
- www.PainEDU.org
  - SOAPP, COMM (screening tools for misuse)
- Safe and Effective Opioid Prescribing for Chronic Pain (BU)
  - www.opioidprescribing.com
- Prescriber's Clinical Support System for Opioid Therapies
  - www.pcss-o.org/
- Vermont Prescription Monitoring System
  - http://healthvermont.gov/adap/VPMS_reports.aspx
- Brandeis PDMP Center of Excellence
  - http://pdmpexcellence.org
- UVM Office of Primary Care and AHEC Program
  - http://www.med.uvm.edu/ahec/home



UVM CME/CEU

If you are interested in claiming 1.0 Continuing Education Credit Hour for this session please email:

onecareeducation@uvmhealth.org

The following application submission has been accepted.

Title: OneCare Vermont: Noontime Knowledge Sessions FY2020

Thank you for allowing the University of Vermont the opportunity to provide credit for your educational program. As you know, The Robert Larner College of Medicine at The University of Vermont is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing medical education for the healthcare team.

The University of Vermont has approved your application and designates each session a maximum of 1 AMA PRA Category 1 credit(s)™. Each physician should claim only those credits commensurate with the extent of their participation in the activity.

This program has been reviewed and is acceptable for up to 1 Nursing Contact Hours.

Session Evaluation Link:

https://www.surveymonkey.com/r/NoontimeOpioid

Who to Contact with Questions:

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Thank You!

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