CIAO Time Presents:

Opioid Stewardship

The Center for Innovation in Academic Detailing on Opioids

San Francisco Department of Public Health

Agenda

1. Introduction to CIAO
2. Review of Opioid Stewardship and Documentation
3. Academic Detailing Demonstration

* *Please post questions in the **Chat Box***

Our Team

Phillip Coffin, MD, MIA, FACP, FIDSA

(he/him/his)

Medical Director & Clinician Trainer

Phillip is a board-certified and practicing internist, infectious disease specialist, and addiction medicine specialist. He attended or trained at Brown University, Columbia University, the University of California, San Francisco, and the University of Washington.

Brian Wylie, OTD, MPH

(he/him/his)

Program Director

Brian is a San Francisco and Bay Area native. He received a BA from UC Berkeley, an MPH from Harvard, and a Doctor of Occupational Therapy from USC. When he's not at work he likes to write.

Rebecca Martinez, FNP

(she/her/hers)

Clinician Trainer

Rebecca is a board-certified family nurse practitioner, who completed her Master's of Science in Nursing at UCSF in 2014. She has made her professional home at the intersection of substance use management, HIV and hepatitis prevention, and primary care, and is energized by her community on a daily basis.

Bunny Ryder, DNP, PHN, FNP-C

(they/them)

Clinician Trainer

Bunny is a board-certified Family Nurse Practitioner. They completed their Doctorate in Nursing Practice in 2018 from Samuel Merritt University with a focus on sexual and reproductive health education for former foster transitional-age youth. Bunny's clinical background is inclusive of providing mental, sexual, gender-affirming, harm reduction centered, and public health care.

Claire Schutz

(she/her/hers)

Program Assistant

Claire graduated from UC Berkeley with a BA in Public Health and Public Policy. She currently works on the CIAO project at CSUH. She is passionate about health equity, her dogs, and a good coffee.

The Center for Innovation in Academic Detailing on Opioids

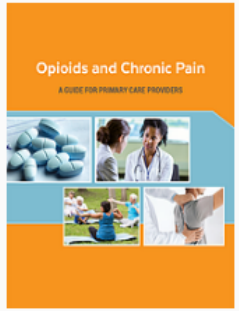
Our vision: We aim to decrease opioid-related morbidity and mortality by promoting balanced approaches to opioid management.

Our mission: We collaborate with healthcare providers to improve opioid and chronic pain-related care through innovative training and technical assistance services.

CENTER FOR INNOVATION IN ACADEMIC DETAILING ON OPIOIDS

HOME ABOUT SERVICES RESOURCES CONTACT US SEARCH...

Our materials



Opioids and Chronic Pain: A guide for primary care providers (book)

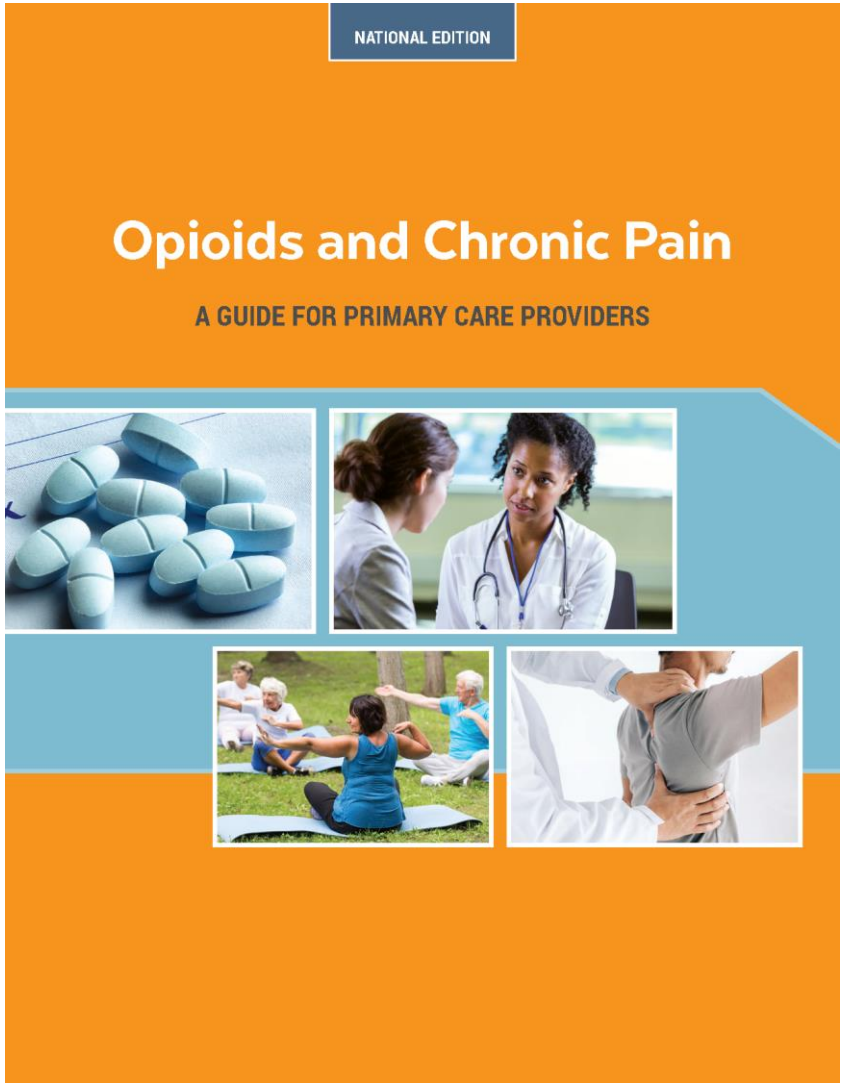
California edition
National Edition

CIAO's Academic Detailing and Technical Assistance Services (PDF)

Managing Chronic Non-Cancer Pain (poster)

California edition
National Edition

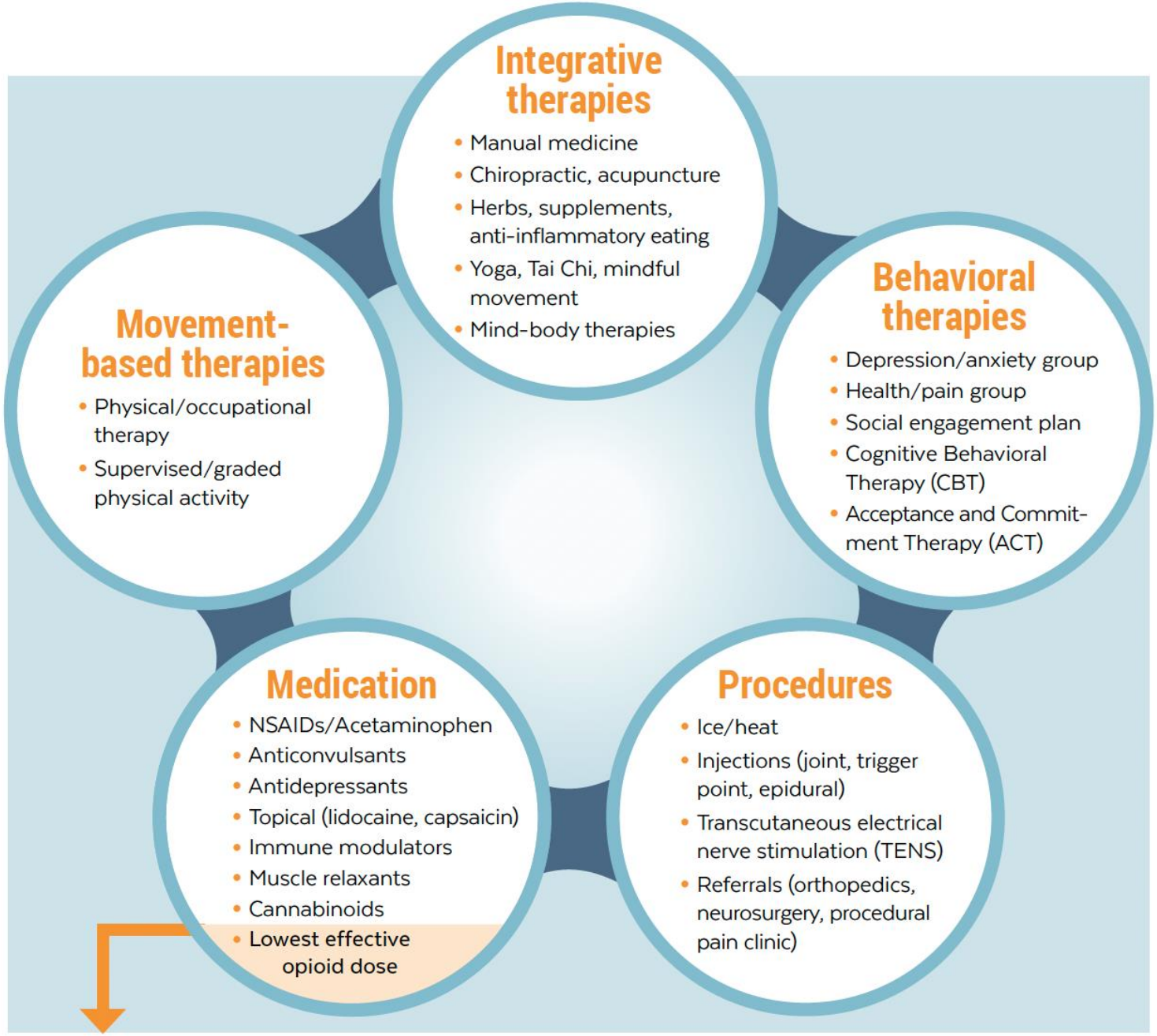
California Pharmacists and Furnishing Naloxone: What you need to know (PDF)

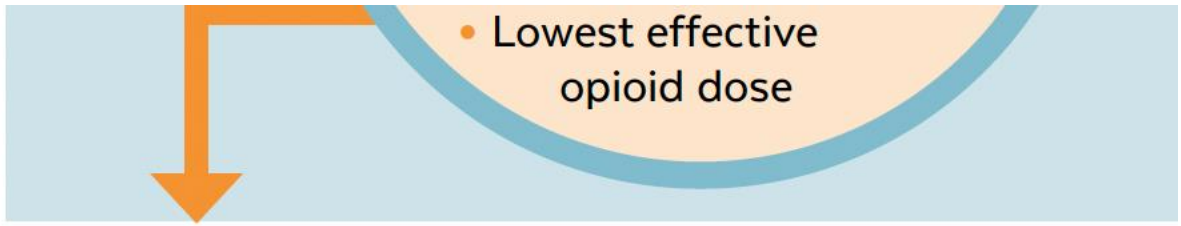


View more of our academic detailing materials at **www.ciaosf.org/our-materials**

First Poll

Managing chronic non-cancer pain





If an opioid medication is part of the treatment plan, take the following steps:

>> **ASSESSMENT OF RISK, ADHERENCE, FUNCTION AND PAIN:** at least annually

>> **INFORMED CONSENT OR CONTROLLED SUBSTANCE AGREEMENT:** at least annually

>> **CONTROLLED SUBSTANCE MONITORING PROGRAM:** check regularly

>> **PRESCRIBE NALOXONE:** at least every two years

Assessments

- Pain and function
- Risk
- Medication adherence
- Substance use
- Use disorder

Risk Assessment

Consider closer monitoring when initiating opioids for patients with these characteristics[17]

- History of Opioid Use Disorder (OUD)
- Concomitant prescription of some psychiatric medications
- Certain mental health diagnoses, such as personality disorders
- History of Substance Use Disorder (SUD)

Opioids and Chronic Pain Guidebook (page 15)

PAIN, ENJOYMENT, GENERAL ACTIVITY (PEG) SCALE FOR ASSESSING PAIN INTENSITY AND INTERFERENCE: A SIMPLE, 3-QUESTION TOOL

1. What number best describes your pain on average in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

CAUTION

Among racial and ethnic minority groups, women, and patients who are elderly or have cognitive impairment, pain can be underrecognized and inadequately treated.[14,15]

The PEG is as valid and reliable as the longer Brief Pain Inventory scale and is sensitive to changes in pain.[16]

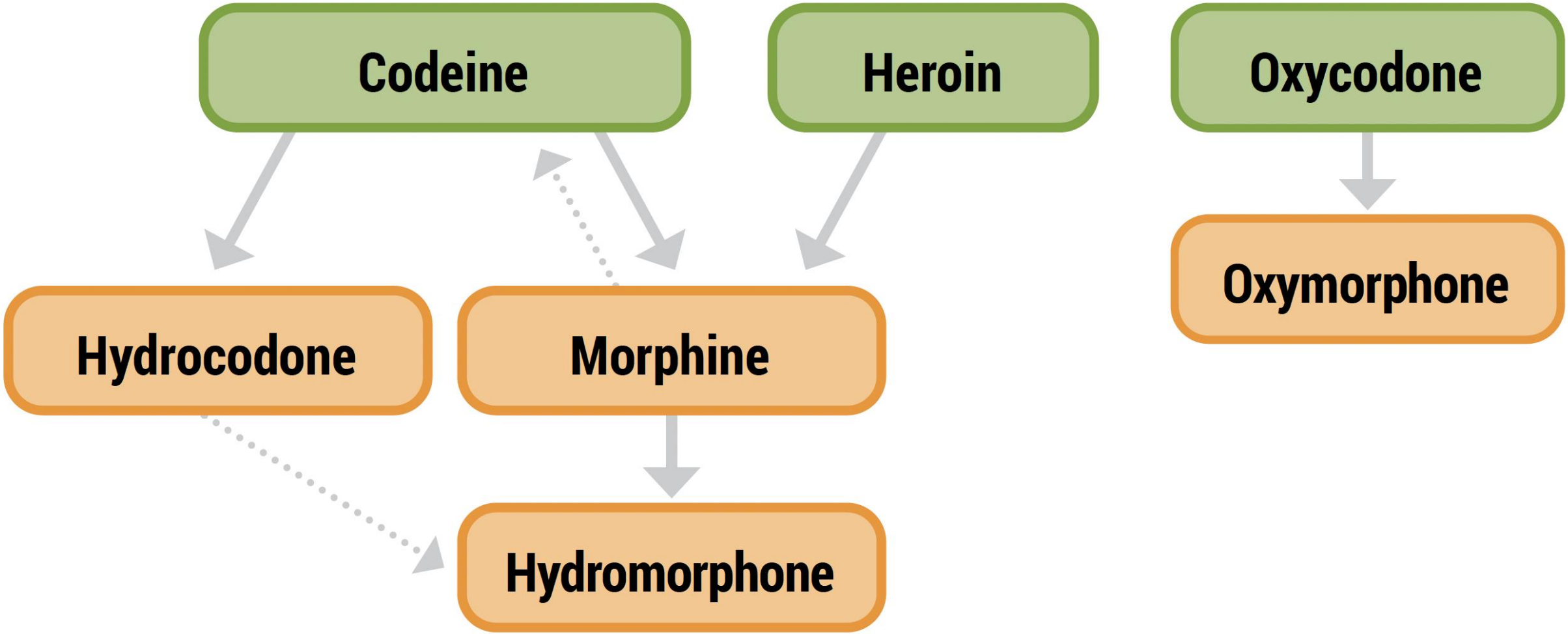
Opioids and Chronic Pain Guidebook (page 14)

Second Poll

Urine Drug Screening

UDS does:	UDS does not:
Support patient care	Prevent opioid-related problems among patients with chronic pain[18]
Detect whether a substance has been used in a particular window of time	Diagnose addiction, dependence or diversion of controlled substances
Guide optimal care, like hemoglobin A1c	Singlehandedly provide justification to stop prescribing opioids for patients

Opioids and Chronic Pain Guidebook (page 16)



Opioids and Chronic Pain Guidebook (page 17)

If UDS results are hard to explain:

- Talk with the patient
- Contact the lab
- Consider mass spectrometry (GC/MS or LC-MS):
  - Lab-based
  - Quantitative
  - Fewer false positives/negatives
  - More expensive

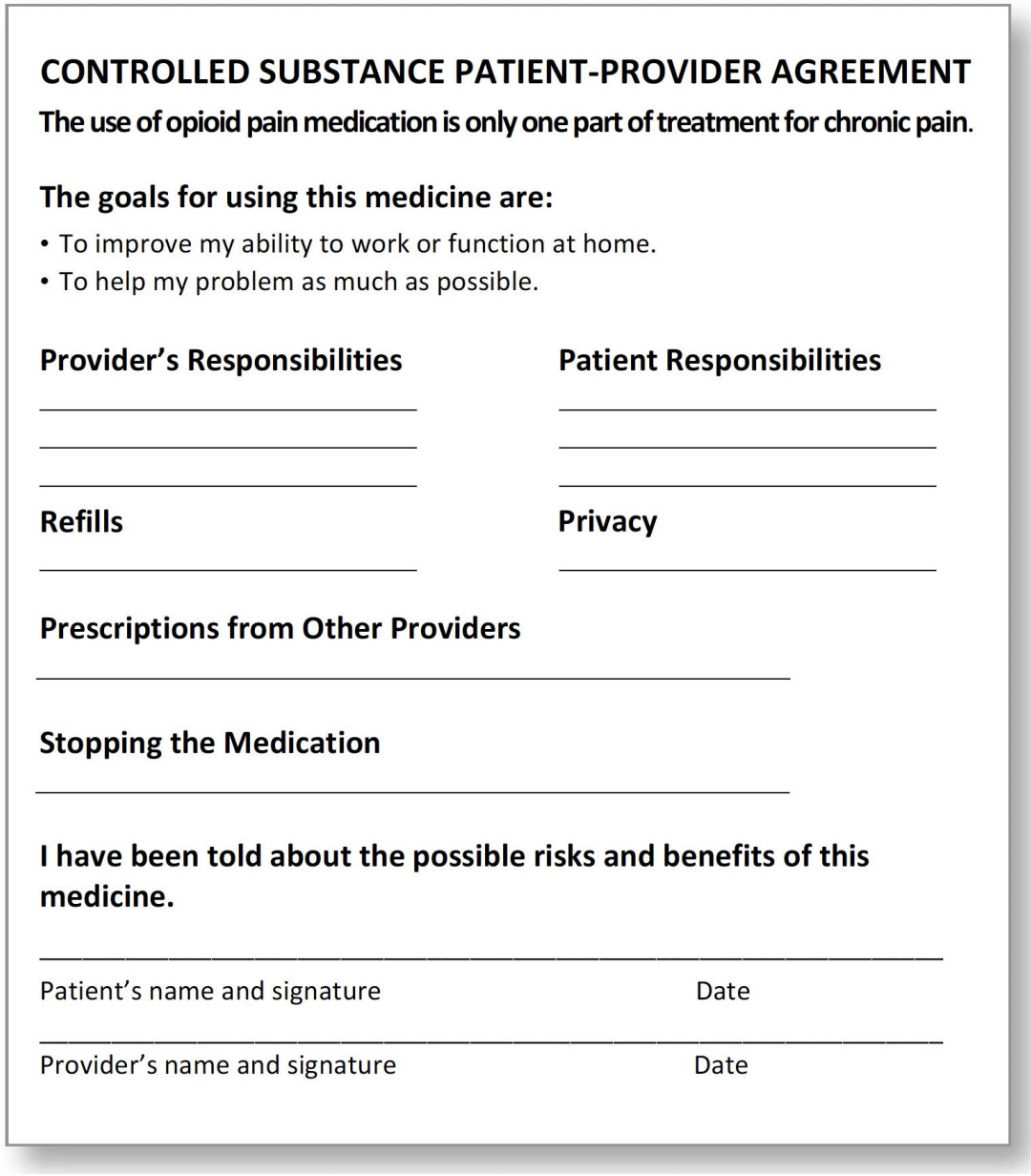
If UDS results are negative, consider:

- Is the patient taking the medication?
- Is the patient taking a lower dose of the medication, or more infrequently?
- Are negative results due to duration of use, body mass, hydration, etc.?

*If long-term suspicion for diversion or SUD, engage with patient to create a plan (e.g. OUD treatment, tapering, referrals).

Opioids and Chronic Pain Guidebook (page 17)

Third Poll



CONTROLLED SUBSTANCE PATIENT-PROVIDER AGREEMENT

The use of opioid pain medication is only one part of treatment for chronic pain.

The goals for using this medicine are:

- To improve my ability to work or function at home.
- To help my problem as much as possible.

Provider's Responsibilities

Patient Responsibilities

Refills

Privacy

Prescriptions from Other Providers

Stopping the Medication

I have been told about the possible risks and benefits of this medicine.

Patient's name and signature Date

Provider's name and signature Date

Informed Consent

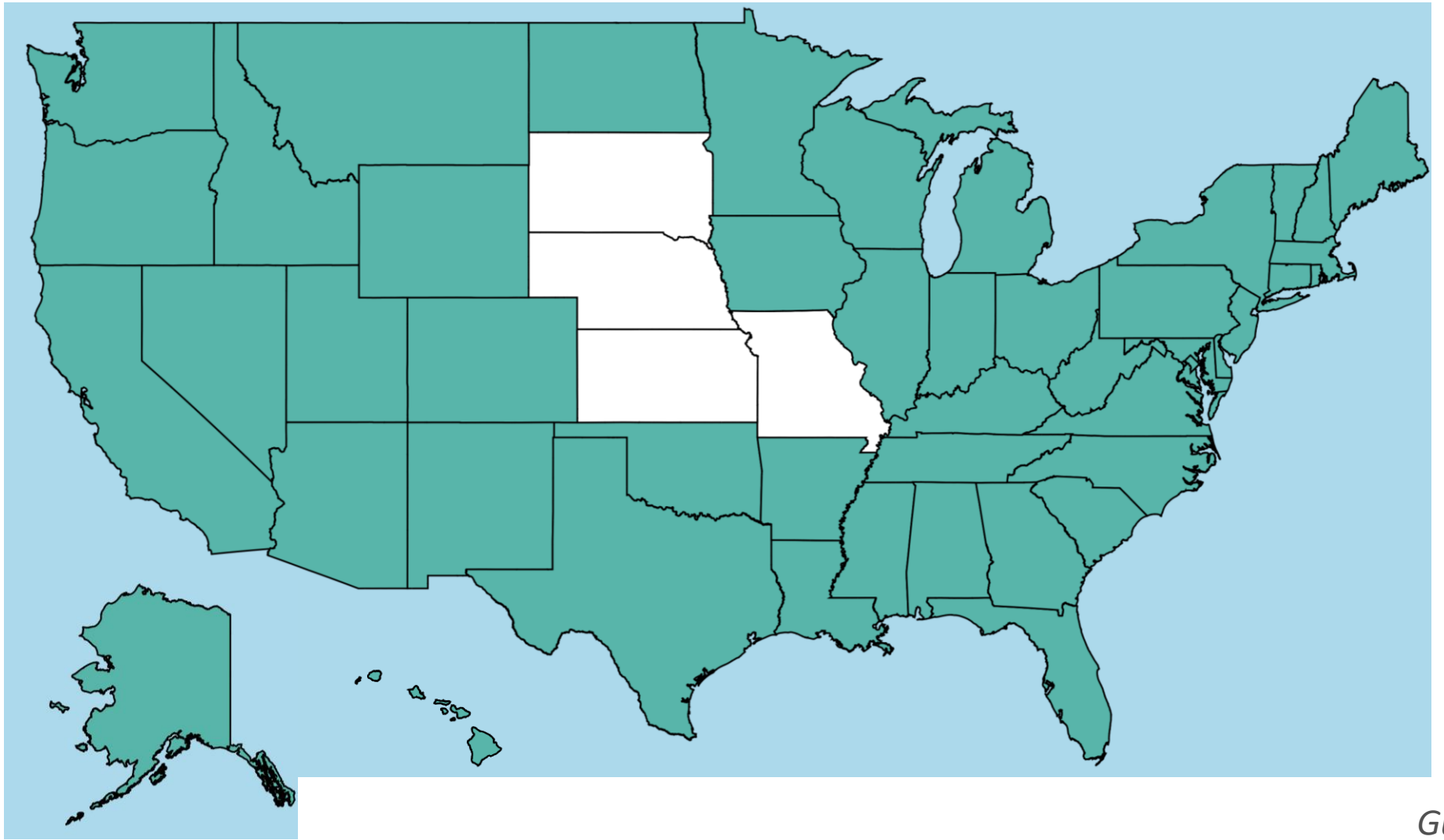
At a minimum, providers should offer written information to patients about the benefits and risks of opioid therapy and document patients' understanding and agreement.

Controlled substance agreement templates are available online:
bit.ly/PA_form

Guidebook (page 18)

Controlled Substance Monitoring Programs

States mandating use by prescribers



Opioids and Chronic Pain Guidebook (p 19)

Overdose Response - Naloxone

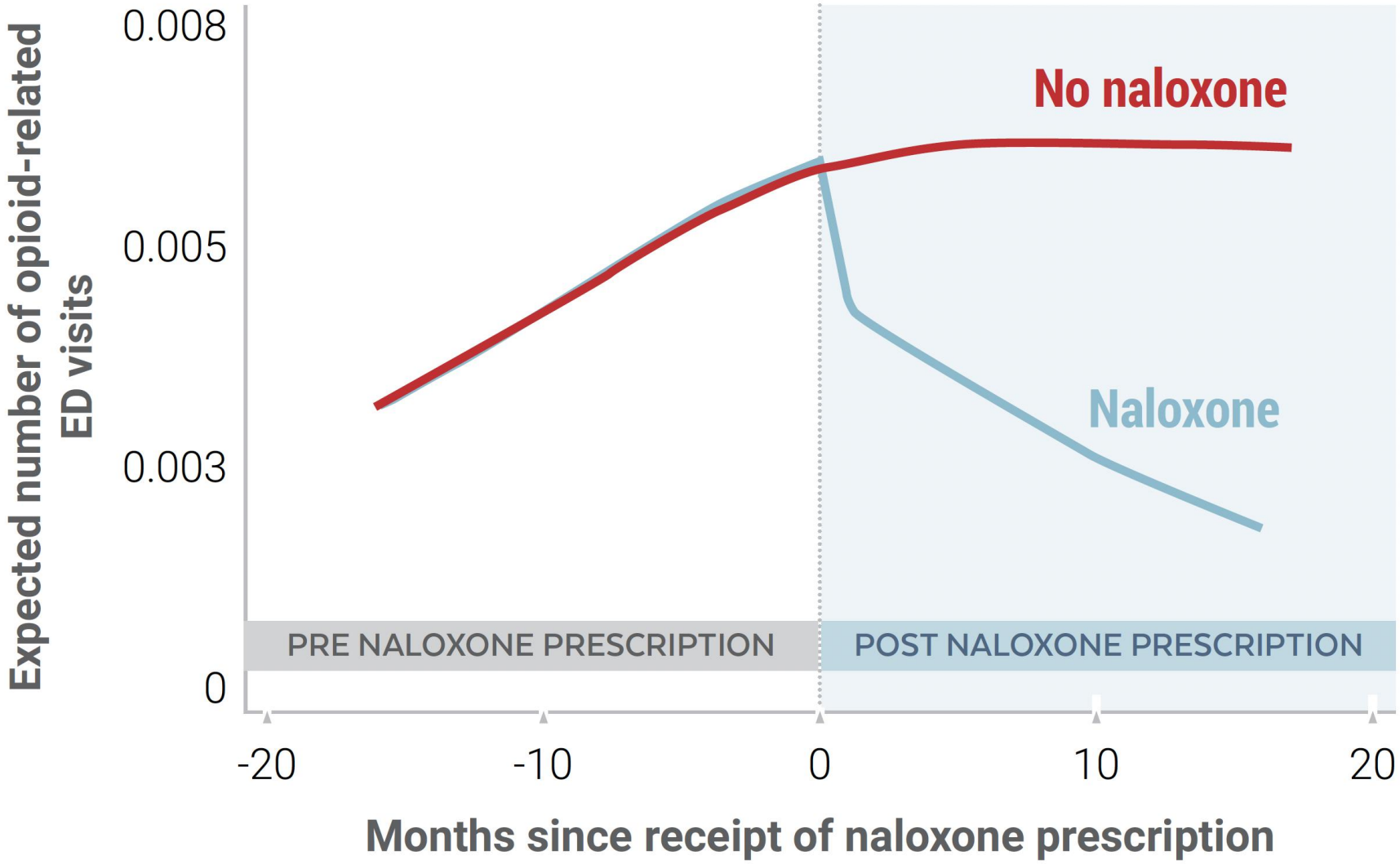
In one study, out of 60 patients on opioid therapy for pain, 37% had stopped breathing or required help to be woken up due to opioids.[20]

45% **of those patients denied overdosing, calling it a bad reaction.**

The word "overdose" may have negative connotations and prescription opioid users may not relate to it. Instead of using the word "overdose", consider language like "accidental overdose" or "bad reaction", or talk about "opioid safety".

Opioids and Chronic Pain Guidebook (page 20)

OPIOID-RELATED EMERGENCY DEPARTMENT VISITS BY RECIPIENT OF NALOXONE PRESCRIPTION AMONG PRIMARY CARE PATIENTS ON OPIOID THERAPY FOR CHRONIC PAIN[22**]



Prescribing naloxone to 29 patients averted 1 opioid-related emergency department visit in the following year.

Opioids and Chronic Pain Guidebook (page 21)

Fourth Poll

Documentation Suggestions

Pain history

Complete OLDCARTS for pain complaint.

Tips:

Treatment: pain medications, non-pharmacologic therapies, surgeries.

Severity: PEG scale includes functional impact of pain.

See "Current pain assessment" below.

Example: 55 y/o cis-gender male seen for initial provider visit. CC: chronic b/l hand pain.
Onset: 10 years ago, no specific injury reported Location: distal interphalangeal joints of hands and feet Duration: 10 years, progressively worse every year Characterization: intermittent sharp pains and numbness in hands and feet Aggravating: cold and rainy weather Relieving: oxycodone (x15 minutes), does not take other meds or do physical therapy Treatment history**:** Oxycodone 30mg 4x/day x10 years. Tapered to 100 tabs last month; does not want opioids anymore, but did not agree to taper & reports more pain. Severity: 5-8/10 PEG scale

Other relevant history

Imaging: x-ray, MRI, ultrasound.

Labs: related to disease processes or substance related.

Prior notes: past diagnoses, ROI from other providers.

Other medications: non-opioid medications.

Current pain assessment

The 3-question PEG reflects average pain and impact on enjoyment and function over past week (pg. 14)

Physical exam

Complete focused exam yearly or more frequently.

Imaging**:** 2012: X-ray bilateral hands: erosions Labs**:** 2012: rheumatoid factor mildly elevated Prior notes**:** distal interphalangeal joint swelling consistent with arthritis; missed rheumatology appointment after referral 9 years ago Other medications**:** previously used gabapentin but stopped: “doesn’t help pain”
Past week average pain: 5 with medication/ 9 without Pain interference on life enjoyment: 6 with medication/ 9 without Pain impact on general activity: 4 with medication/ 7 without
Full range of motion in hands and feet; mild swelling of distal IP joints; sensation intact with sense of numbness in distal and plantar feet

Risk factor assessment Guides clinical decision-making (pg. 15).
Opioid use disorder screening Use DSM-V criteria (pg. 25).
Urine drug screen (pg. 17)
Control substance agreement or consent (pg. 18)
Prescription drug monitoring program (pg. 19)
Naloxone (pg. 22)

Substance use (ETOH & meth) and psychiatric history (schizophrenia controlled with medication) noted.
Patient does not meet the criteria for OUD: 1 criterion noted.
UDS as expected XX/XX/XXXX and YY/YY/YYYY. Repeat every 3 months given risk profile.
Controlled substance agreement reviewed with patient XX/XX/XXXX. Copy given to patient.
PDMP reviewed XX/XX/XXXX; no unexpected prescriptions.
Prescribed intranasal naloxone XX/XX/XXXX. Signs of when to use naloxone reviewed.

Plan

Include rational for plan and future goals.

Tips: continuity of care, obtainable goals, and minimizing patient risks make a strong rational.

I do not treat neuropathic pain with opioids and patient does have some risks. However, for now will continue current dose of oxycodone because patient has done well for years, underwent a challenging recent taper, has no evidence of OUD, and is new to me. Given risks of discontinuation, will work closely with patient to reduce reliance upon opioids. Repeat hand X-rays ordered. Follow UDS every 3 months and continue screening for OUD.

Takeaways

- There are several steps providers are expected to take when prescribing opioids
- Evidence for these interventions is mixed
- Documentation is key to protect patient and provider

Academic Detailing Mock Session

What to watch for…

Steps of a Visit

- Introduction
- Needs Assessment
- Key Messages/Benefits
- Handling Objections
- Summary/Close Visit

Thank you!

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SAN FRANCISCO DEPARTMENT
OF PUBLIC HEALTH

CENTER FOR INNOVATION
IN ACADEMIC DETAILING
ON OPIOIDS

Centers for Disease Control and Prevention
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