Central Oregon Health Council

Pain Standards Task Force
PacificSource Community Solutions – Boardroom
2965 NE Conners Ave, Bend OR 97701

Agenda: April 6, 2016 from 7:00am-8:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. 7:00-7:05 **Introductions—All**

2. 7:05-7:15 **CDC Opioid Guidelines and Updated PSTF Intention Letter—Dr. Swanson**

3. 7:15-7:25 **PDMP Training Update & Clinic Sign-ups—Rebeckah Berry**

4. 7:25-7:30 **Pain 101 Workshop Sub-Committee Volunteers—Dr. Swanson**

5. 7:30-7:40 **PSAs for Patient Education—Dr. Swanson**
   Action: **Patients needed who are willing to share their story**

6. 7:40-8:00 **Monthly Updates—Dr. Swanson**
   - **HERC Update—Dr. Little**
   - **Chronic Pain Program Model Meeting w/ Mark Altenhofen—Dr. Pierson**
   - **CCO's and Coverage of Alternatives—Dr. Swanson**
   - **Update on Alternatives Document—Dr. Rudback & Dr. Toffolo**
   - **Living Well with Chronic Pain for Central Oregon—Dr. Swanson**
   - **Learning the "Dog & Pony Show" on 4.20.16—Dr. Swanson**
   - **Naloxone Education—Rebeckah Berry**
   - **Grand Rounds—Rebeckah Berry**
   - **RNCC Presentation from 3.29.16—Dr. Swanson**

Consent Agenda:
- **Approval of the draft minutes dated March 2, 2016 subject to corrections/legal review**

Dear Colleague:

In response to the concerning rise of opioid related deaths & health care costs in our community the Pain Standards Task Force for the Central Oregon Health Council was developed to create standardized community guidelines and best practices for treating patients suffering from chronic or persistent non-cancer pain. These guidelines were recently revised to be consistent with national guidelines published by the Centers for Disease Control in March 2016. The Pain Standards Task Force seeks your endorsement of the following clinician guidelines:

- Compassionate, supportive, and patient-centered treatment approach to patients with chronic or persistent non-cancer pain.

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Consider opioid therapy only if expected benefits for both pain and function is anticipated to outweigh risks to the patient.

- Before starting opioid therapy for chronic pain establish treatment goals with all patients. This includes realistic goals for pain and function and consideration for how opioid therapy will be discontinued if benefits do not outweigh risks.

- Use caution when prescribing opioids at any dosage. When opioids are started, prescribe the lowest effective dosage***. Carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day. Avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.***

- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

- Continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety

- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Evaluate benefits and harms of continued therapy every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

- Avoid polypharmacy of chronic controlled substances, particularly combining benzodiazepines with opiate therapy.

- Judicious use of narcotics particularly beyond a period of 6 weeks for acute conditions.

- Evaluate risk factors for opioid-related harms before starting and periodically during continuation of, opioid therapy. Incorporate into the management plan strategies to mitigate risk, including the following:

- Offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
- Assessment of risk of abuse of each patient prior to beginning or continuing a chronic controlled substance.

- Before starting and periodically during continuation of opioid therapy, incorporate the following safeguard into routine practice to minimize the potential for the abuse and diversion of controlled substances. These safeguards include the following but are not limited to:

  - A written controlled substance agreement as a standard part of treatment.

  - Consistent use of Materials Risk Notice

  - Urine toxicology screening (UDS) should be conducted prior to initiation of opioid therapy and clinicians should follow Washington Interagency Guidelines (http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf) for periodic UDS during continuation of opioid therapy. Washington Interagency Guidelines are as follows:

Risk Category	**Recommended UDT Frequency**
Low Risk by ORT	Periodic (e.g. up to 1/year)
Moderate Risk by ORT	Regular (e.g. up to 2/year)
High Risk by ORT **or** opioid doses >120 mg MED/d	Frequent (e.g. up to 3–4/year)
Aberrant Behavior (lost prescriptions, multiple requests for early refill, opioids from multiple providers, unauthorized dose escalation, apparent intoxication etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)

  - Regular consultation of the Oregon State Prescription Drug Monitoring Program (PDMP).

  - Use of evidence-based methods for reduction of narcotic use and alternative pain management therapies for chronic or persistent non-cancer pain.

• If needed, referral to appropriate programs for opioid addiction management.

I, _____, support these Central Oregon Community Standards for chronic or persistent non---cancer pain. By signing this intention letter I understand I am expressing my support of these guidelines and my signature is not legally binding.

Signature: _____ **Date:** _____

Email: _____ **Organization:** _____

Please scan/email this form to: rebeckah.berry@cohealthcouncil.org
or mail to: COHC, PO Box 6689, Bend OR 97708

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

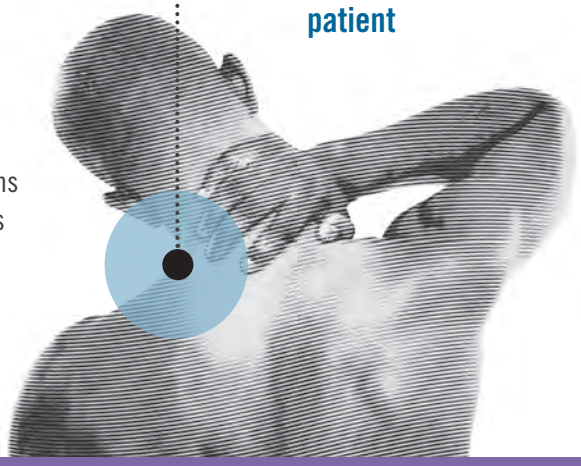
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

MINUTES OF A MEETING OF
THE PAIN STANDARDS TASK FORCE
CENTRAL OREGON HEALTH COUNCIL
March 2, 2016 from 7-8:00am

Task Force Members Present
Kim Swanson, Chair (St. Charles Medical Group)
Gary Allen (Advantage Dental)
Rebeckah Berry (Central Oregon Health Council)
Wil Berry (Deschutes County Behavioral Health)
Muriel DeLaVergne-Brown (Crook County Health Department)
Shanna Geigle (Veterans Affairs)
Maria Hatcliffe (PacificSource)
Alison Little (PacificSource)
Steve Mann (COIPA and High Lakes Healthcare)
Kyle Mills (Mosaic Medical)
Laura Pennavaria (La Pine Community Health Center)
Christine Pierson (Mosaic Medical)
Kerie Raymond (Hawthorn Healing Arts Center)
Rob Ross (St. Charles Medical Group)
Marie Rudback, DC (Endeavor Chiropractic, LLC)
Scott Safford (St. Charles Medical Group)
Divya Sharma (Mosaic Medical and COIPA)
Julie Spackman (Deschutes County Health Services)
Rick Treleaven (BestCare Treatment Services)
Tom Watson (Rebound Physical Therapy)

Guests Present:
Donna Mills (Central Oregon Health Council)

Absent
Robert Andrews (Desert Orthopedics)
Patty Buehler (InFocus Eyecare)
David Holloway (Bend Memorial Clinic)
Janet Kadlecik (Work Capacities)
Jennifer Laughlin (St. Charles Health Systems)
Jessica LeBlanc (Mosaic Medical & Bend Treatment Center)
Sharity Ludwig (Advantage Dental)
Tina Patel (PacificSource)
James Toffolo (The Good Health Medical Group)
Pamela Tornay (Central Oregon Emergency Physicians)

1. **Introductions & Opening Remarks**
    - Members introduced themselves and their respective organizations and guests were welcomed to the meeting.

2. **Review of 2016 Draft Aims**
    - Mr. Rick Treleaven spoke and said that we are missing what the alternatives are going to be for 2016.
    - Dr. Rob Ross felt that many individuals that use pain medications are an issue. These individuals have established methods of taking their prescriptions.
    - Dr. Steve Mann believes that the solutions to this are outside of the medical model.
    - Dr. Kim Swanson shared that Living with Chronic Pain is now a funded program due to the PSTF support and they will provide peer support. She offered a reminder that this is not a war against opioids but a war against the abuse of them.
    - Dr. Wil Berry felt that the situation would get worse before it gets better.
    - Dr. Tom Watson shared that exercise programs are available through the Recreational Department (Bend Parks and Recreation).
    - Dr. Divya Sharma inquired as to what Jackson City had chosen to cover as benefits for their OHP members (below the line alternatives covered).
    - Ms. Muriel DeLaVergne-Brown said she believes the community education piece is missing.
    - Ms. Rebeckah Berry asked what the education focus should be around.
    - Dr. Christine Pierson expressed that public awareness and listening to the success stories are important.
    - Mr. Treleaven believed that there is a need for more materials for alternative therapies and information on the available programs.
    - Dr. Pennavaria felt that a sub-committee would be needed to work on this.
    - Dr. Mann wondered what was covered and what is available that has show success.
    - **ACTION**: Ms. Berry and Dr. Swanson will make edits to the 2016 Aims.

3. **PDMP Dashboard**
    - The dashboard was completed and updated, and is now ready for dissemination. The dashboard includes OHA-provided information on overdose hospitalizations and overdose deaths. The PDMP de-identified data for Central Oregon is the source of the remaining provided information.
    - The goal is to update this information every six months.

4. **Intention/Endorsement Letter**
    - The verbiage of the intention/endorsement letter was changed to include that the form is not legally binding.
    - Dr. Sharma stated the letter needs a signature line to be added.
    - **ACTION**: Ms. Berry will update the letter and place it on the website.

5. **Learning the dog and pony show:**
    - The Jackson County visit has been scheduled for 4.20.16 with a return back to Bend at noon on 4.21.16.
    - Dr. Swanson feels that one or two physicians are needed to be involved in this process.

- One of the goals will be to observe their community provider meeting to assess how to get individuals engaged through educational opportunities

6. PDMP Clinic Sign-Up days:

- PDMP is willing to train trainers. A discussion ensued about whom this should be. It was questioned if individual clinics should be sending a representative. It was also pondered if one person for the region would offer adequate coverage to train and register others.
- The question was raised as to why Deschutes has such low PDMP registration rates.
- Someone suggested that perhaps it is because Deschutes has a lot Specialists vs. PCP's. Someone asked if it could be determined who has not yet enrolled.
- Ms. Berry said that PDMP has this information but it cannot be readily shared with the public.
- Ms. Berry stated that she is willing to be trained. Dr. Swanson and Maria Hatcliffe will also become trained.

7. Naloxone Coverage Update (Injection and Nasal)

- The atomizer attachment kits are available for approximately $6.00 dollars to go in conjunction with the injectable Naloxone (the latter of which PacificSource covers).
- Public Health can acquire the Nasal Spray kits for approximately $30.00 dollars.
- Mr. Treleaven asked if Central Oregon Health Council funds would be available to assist with the cost.
- It was shared that the Veterans Administration covers both the injectable and nasal versions.
- Naloxone is not currently available through 340B drug pricing.
- Ms. Maria Hatcliffe mentioned the risk of a potential needle stick when someone comes out of an overdose. The patients that are administered Naloxone are agitated and swing their limbs violently.

8. Grand Rounds

- The next Grand Rounds is scheduled to take place on April 29, 2019. The goal of the talk by Dr. McIlveen and Dr. LeBlanc will be to educate on M.A.T.s and encourage more Primary Care Physicians to become trained to do maintenance treatment for individuals with opioid dependence.
- At the PSTF meeting, a vote was taken whether or not to have a tapering speaker. The vote was in favor of scheduling Dr. Paul Coelho to present.

9. Updates

- Pain 101 Conference
    - It was shared that partnering with the Pain Society will not be able to take place due to time constraints and conflicts. An autumn conference of a full or a half day session on how to manage chronic pain patients is the aim currently. A sub-committee will be created to work on this. The potential date for this workshop is September 23, 2016.
- Living Well With Chronic Pain
    - Regional enrollment for training is now open. Interested individuals need to have already been trained in the Living with Chronic Conditions program to participate.
    - An additional training will be offered to new trainers in the summer.

    - Classes will be offered throughout the region.
- Dr. Mann reported that the COHC Board of Directors and Provider Engagement Panel rallied and a letter of support went out endorsing HB 4124. This bill was unanimously approved.
- Mr. Mark Altenhofen of the Chronic Pain Program
    - Dr. Pierson reported that Mr. Altenhofen is engaged in teaching communities how to develop pain programs. She shared that Mosaic has spent time with him on the phone and he has been very accessible. An initial in-person meeting with Mr. Altenhofen is scheduled for March 18, 2016.
- Mr. Treleaven mentioned that the RHIP includes meeting the work set out by the PSTF and there would be a mechanism for moving initiatives forward through the RHIP Substance Use & Chronic Pain workgroup.
- Dr. Swanson will be presenting at the next RNCC meeting on March 29, 2016.