Allina Health

Pain Guidelines

2019 Allina Health Pain Symposium

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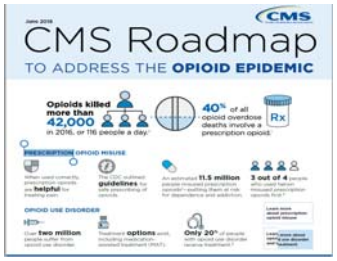
Objectives

- Discuss Allina's history of engagement on pain management
- Data trends
- How is Allina changing it's providers prescribing habits?
- Allina's evolving care goals around pain management
- Review of various clinical practice guidelines

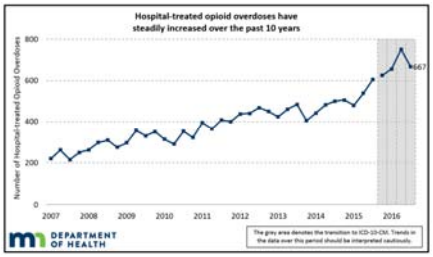
Epidemics: Addiction & Overdose



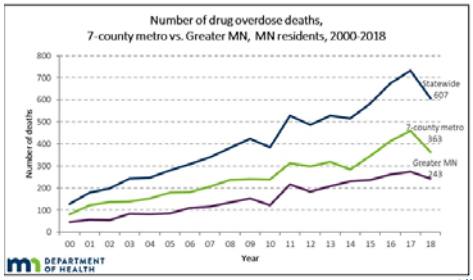
68,577 Drug Overdoses in 2018

58,220 American military deaths during Vietnam War (1954-1975)

Non-Fatal, Hospital-Treated Opioid Overdoses



Drug overdose deaths in Minnesota



History

- Controlled Substance Program Committee
- Controlled Substance Provider Report
- Case Western Reserve University course
- Opioid Care Goal 2016-2018
- e-Rx of opioids, 2018
- Formation of Allina Health Pain Management Executive Steering Committee
- Revised Opioid Care Goal 2019
- Allina Health Quality Committee requests in-house Pain Management CME
- Primary Care partnering with Addiction Medicine on community-based Suboxone providers

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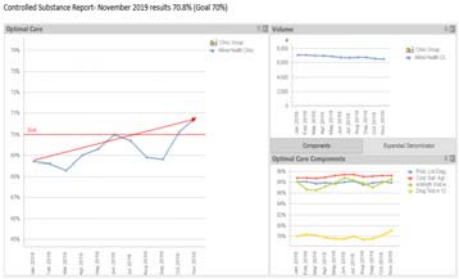
Controlled Substance Management Care Goals, 2016-2018



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Allina's Response

Measure	2016	2017	2018	2019 YTD (July)
Opioid pills dispensed	24 M	22 M	18 M	10 M
Number of unique patients with opioid RX > 20 pills	75,097	64,270	49,515	30,779

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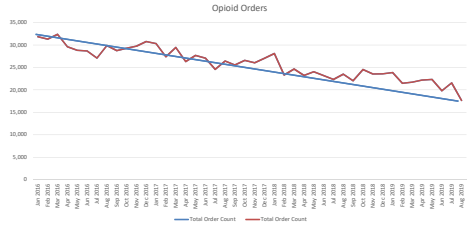
Reduction in Opioid Orders Across Allina



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Clinical Pain Guidelines

- CDC Guideline for Prescribing Opioids for Chronic Pain
  - https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm
- Institute for Clinical Systems Improvement (ICSI), Pain: assessment, Non-Opioid Treatment Approaches and Opioid Management
  - https://www.icsi.org/wp-content/uploads/2019/01/Pain.pdf
- Minnesota Department of Health, Department of Human Services, Minnesota Opioid Prescribing Guidelines
  - https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines_tcm1053-337012.pdf

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Clinical Practice Guidelines

- Clinical practice guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances. —Institute of Medicine (1990)
- What is the purpose of Clinical Practice Guidelines?
  - To describe appropriate care based on the best available scientific evidence and broad consensus;
  - To reduce inappropriate variation in practice;
  - To provide a more rational basis for referral;
  - To provide a focus for continuing education;
  - To promote efficient use of resources;
  - To act as focus for quality control, including audit;
  - To highlight shortcomings of existing literature and suggest appropriate future research.

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Opioid prescribing and patient satisfaction

Primary Care CG-CAHPS patient experience ratings for top 10 opioid prescribers*			
	2015	2018	
Clinician communication dimension (% top box) mean	94.4	94.0	P=0.23
Rate doctor 0-10 (% rating 9-10) mean	86.8	88.2	P=0.42
*Opioids as a percent of all medication orders declined from 20.2% (2015) to 7.1% (2018) RX>200 decreased 44%			

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CDC Guideline for Prescribing Opioids for Chronic Pain

Recommendations organized into three areas:

1. Determining when to initiate or continue opioids for chronic pain
2. Opioid selection, dosage, duration, follow-up and discontinuation
3. Assessing risk and harms of opioid use

CDC Opioid Guideline Mobile App:

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1. Determining when to initiate or continue opioids for chronic pain

- Opioids are not first-line therapy for chronic pain
- Establish goals for pain and function
- Discuss risks and benefits

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2. Opioid selection, dosage, duration, follow-up and discontinuation

- Use immediate-release opioids when initiating treatment
- Use the lowest effective dose
- Prescribe short durations for acute pain
- Evaluate benefits and harm frequently
  - Allina shared decision making tools (AKN->Pt Education->PE Catalog->SDM)
    - Considering Your Options for Low Back Pain
    - Considering Your Options for Long-term (Chronic) Low Back Pain
    - Should You Use a Prescription Opioid Medicine for Short-term Pain Relief?
    - Considering Your Non-Opioid Options for Pain

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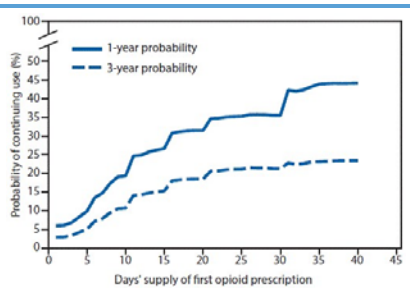
Risk of New Chronic Use by Days Supply of Initial Rx



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3. Assessing risk and harms of opioid use

- Use strategies to mitigate risk
  - Pts with sleep-disordered breathing – CHF, obesity, OSA
  - Pregnancy
  - Pts with renal or hepatic insufficiency
  - Geriatrics
  - Pts with mental health conditions, SUD, prior nonfatal overdose
- Review prescription drug monitoring program data
- Utilize urine drug testing
- Avoid concurrent opioid and benzodiazepine prescribing
- Offer treatment for opioid use disorder

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ICSI Aims and Measures

- Assess Quality-of-Life, Function and Pain
- Determine the Pain Generator
- Dental Pain Diagnosis and Treatment
- Assess Physical and Behavioral Health Comorbidities
- Determine Patient Barriers
- Patient Engagement (SDM)
- Develop Pain Treatment Plan
- Psychotherapy Strategies

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ICSI Aims and Measures (continued)

- Complementary and Integrative Medicine
- Physical Rehabilitation Modalities
- Interventional treatment
- Pharmacologic Treatment
- Opioid Management
  - ABCDPQRS Risk Assessment
  - Controlled Substance Agreement
  - Follow-up visits at least once a quarter
  - Offer D/C of opioids or taper at six month intervals
- Coordination of Care and Follow-up

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ICSI Post-OP Prescribing MME Benchmarks

Surgical Grouping: Orthopedic Procedure Description	# procedures	# Rx	% Rx	Benchmark (2018 25th Percentile MME) MAX	2018 Mean MME	Minimum/ Maximum MME
Bilateral Knee Replacement Surgery	33	24	73%	300	392	90-1050
Carpal Tunnel Surgery	888	670	75%	50	105	15-1800
Joint Replacements (Hip)	766	600	78%	240	335	50-1500
Joint Replacements (Knee Revision)	58	41	71%	320	443	140-1200
Joint Replacements (Knee)	1136	945	83%	300	411	75-2250
Other Knee Arthroscopy with Treatment	379	340	90%	150	197	38-1350
Other Open Surgery of The Knee	184	161	88%	280	361	90-1050
Scopes (Knee Ligament Repair)	314	297	95%	225	304	70-675
Scopes (Knee Meniscectomy)	1311	1121	86%	100	160	38-1500
Therapeutic Arthroscopy of The Hip	138	121	93%	225	288	53-990
Scopes (Rotator Cuff)	670	625	92%	300	348	30-1250
Scopes (Shoulder)	508	468	88%	225	318	25-1050
Total Shoulder Replacement	106	89	84%	240	332	40-1050

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DHS Minnesota Opioid Prescribing Guidelines

- Three principles:
  1. Prescribe the lowest effective dose and duration of opioids when an opioid indicated for acute pain (<100 MME or 3 days)
  2. The post-acute pain period (up to 45 days after an acute event) is the critical timeframe to halt progression to chronic opioid use
  3. The evidence to support chronic opioid analgesic therapy (COAT) for chronic pain is insufficient at this time, but evidence of harm is clear. Providers should avoid initiating COAT therapy and carefully manage patients who remain on opioid medication

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Acute Pain Phase Prescribing

- Use multimodal analgesia (NSAID/APAP) as first-line tx
- Provide documentation of pt's presentation of pain and diminished physical function, documentation using pain scale
- Know the status of patient's risk factors for opioid harm
- Check the MN PMP
- Avoid prescribing more than 100 MME of low-dose, short-acting
- Prescribe no more opioids than will be needed for initial tissue recovery following more extensive surgery or trauma. Limit intial Rx to 200 MME
- Use appropriate non-opioid medications to manage acute oral or facial pain, limit to 100 MME

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Acute Pain Phase Prescribing (continued)

- Avoid prescribing opioids to patients with history of Substance Use Disorder
- Consult with prescriber or pharmacist trained in pharmacology of Suboxone when Rx opioids for patient on Suboxone for SUD
- For a new injury in a patient on COAT, opioid dose for the new injury will be same as opioid-naïve patient
- Manage acute pain in COAT pts undergoing invasive procedures with additional pain resources – pain specialist, anesthesia
- For COAT pts w/o verifiable new injury, do not increase opioid dose for acute pain at a new site, or acute exacerbation of chronic pain

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Post-Acute Pain Phase Prescribing

- Assess and document pain and function at each f/u visit
- Strongly consider re-evaluation of the etiology of the pain for those patients who do not demonstrate expected improvements
- Asses and document risk factors for opioid-related harm and chronic opioid use during the post-acute phase
- Introduce multi-modal therapies to all pts in the post-acute phase
- Prescribe opioids in multiples of 7 days, no more than 200 MME per 7 days
- Avoid prescribing in excess of 700 MME cumulative

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Post-Acute Pain Phase Prescribing (continued)

- Pts should D/C opioid therapy as tissue healing progresses. Consider a formal taper schedule if pt demonstrates withdrawal symptoms. Taper generally accomplished over two weeks
- For pts on COAT and additional opioid for acute pain, taper patients to pre-surgical or pre-injury dose as tissue healing progresses. Develop a coordinated pain management plan prior to surgery
- Develop a referral network for mental health, SUD, pain education and pain management

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Chronic Pain Opioid Prescribing Recommendations

- Perform thorough assessment of mental health prior to initiating COAT
- Establish specific, measurable treatment goals w the pt prior to initiating COAT –focus on function and quality of life
- Assess potential barriers to active participation in tx plan by pt
- Identify in tx plan the person who will coordinate care, pharmacy
- Complete Controlled Substance Agreement
- Make every effort to keep daily dose < 50 MME/day
- Limit duration of RX to one month. OV every 3-4 months

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Chronic Pain Opioid Prescribing Recommendations

- Offer to taper to a reduced dose or D/C at every OV
- Prescribe immediate-release opioid when initiating COAT
- Avoid routine rotation or substitution of opioids
- Avoid using methadone interchangeably with other LA opioids
- Exercise extreme caution when considering Fentanyl tx
- Complete UDS prior to COAT in a new patient and 1-2/year in established pt
- Monitor COAT pts for opioid use disorder, offer evidence-based tx options

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