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I no longer accept gifts, lunches, or anything “free” from pharmaceutical companies.

Deschutes County (2012)



- Population: 160,140
- Total opioid prescriptions written: 136,941



Too many pills!

- **How did we get here?**
- **Why does it matter?**
- **What are we doing about it?**

The 3 legged stool for community engagement: The 3 Ps

- Prescribers (Health Professionals): Need to learn about current best practices concerning the treatment of Chronic Complex Non-Cancer Pain (CCNP)
- Patients: Need behavioral and other supports to learn to manage their chronic pain without reliance on opioids
- Public: Need to understand the changes in scientific understanding of pain management so they can support their loved ones. Need to learn about naloxone.



Provider Responsibility



The reason we have so many pills in circulation



Is because we write for so many pills

If we don't solve this problem as a community, we are only passing it on to the next provider.



That's how you got your "legacy patients" in the first place!

Oregon Pain Guidance

(formerly Opioid Prescribers Group)



Attendees: Physicians, Mid-level providers, Nurses, Substance Abuse Counselors, CCOs, Therapists, Pharmacists, Medical specialty (Pain Medicine, ED), Dental, Community Justice Partners

We need to re-invent the wheel



By adopting the best practices we create ourselves we have a sense of “ownership”

Oregon Pain Guidance (OPG)

- Public Health initiative to reduce opioid overdoses by addressing the problem at its core: medical providers
- CME and dinner provided
- OPG evolution:
 - Brainstormed >
 - Created guidelines >
 - guideline acceptance
- Topics for discussion:
 - Trauma Informed Care
 - Benzodiazepines
 - Challenging conversations
 - Oregon Medical Board
 - 120 MED policy
 - Best practices
 - Addiction
 - Treatment of back pain
- Small discussion groups



OPG Steering Committee

- Representatives from: CCOs, FQHC, PH, ED, person living with chronic pain, behavioral therapist
- Meet for 2 hours twice a month
- Follow through on projects, brainstorm, update, and prepare for monthly meetings

Challenges



- Some providers working independently in rural setting
- Some are part of large primary care groups
- Some work for FQHCs with provider supports unique to their setting

Challenges

- Old concepts die hard
 - The Ducks don't win *every* game.
- Prescribers really don't believe the data.



There are psychodynamics involved

Some of us have a hard time saying “no.”

We want our patients to like us

We avoid conflict

Our “legacy” patients are dependent on opioids

Our reputations can suffer when we say “no.”

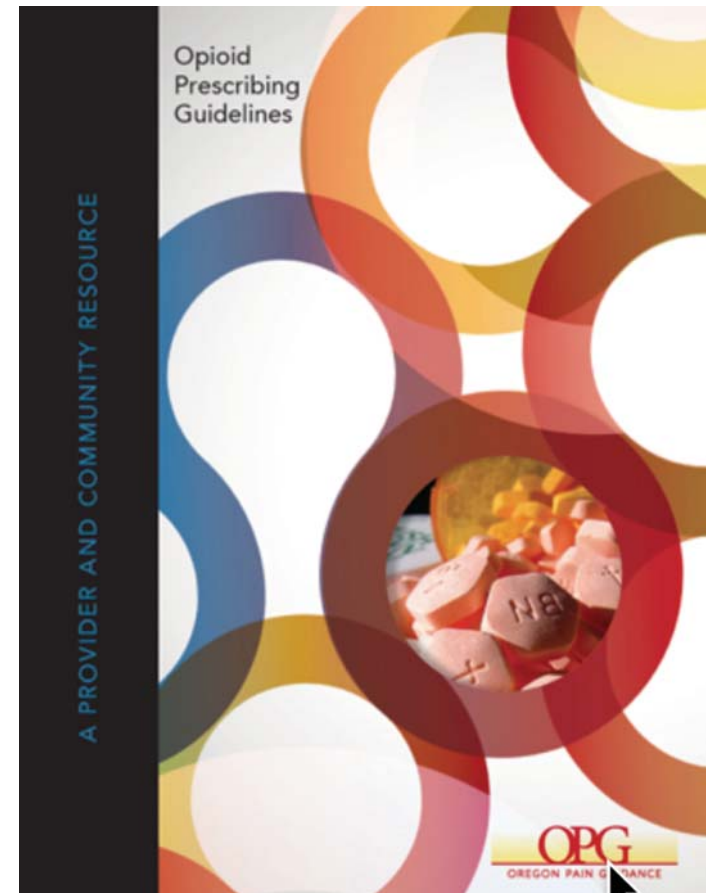
It gives us some “external” courage



**"Tell your wife that the X-ray shows
that you do have a backbone."**

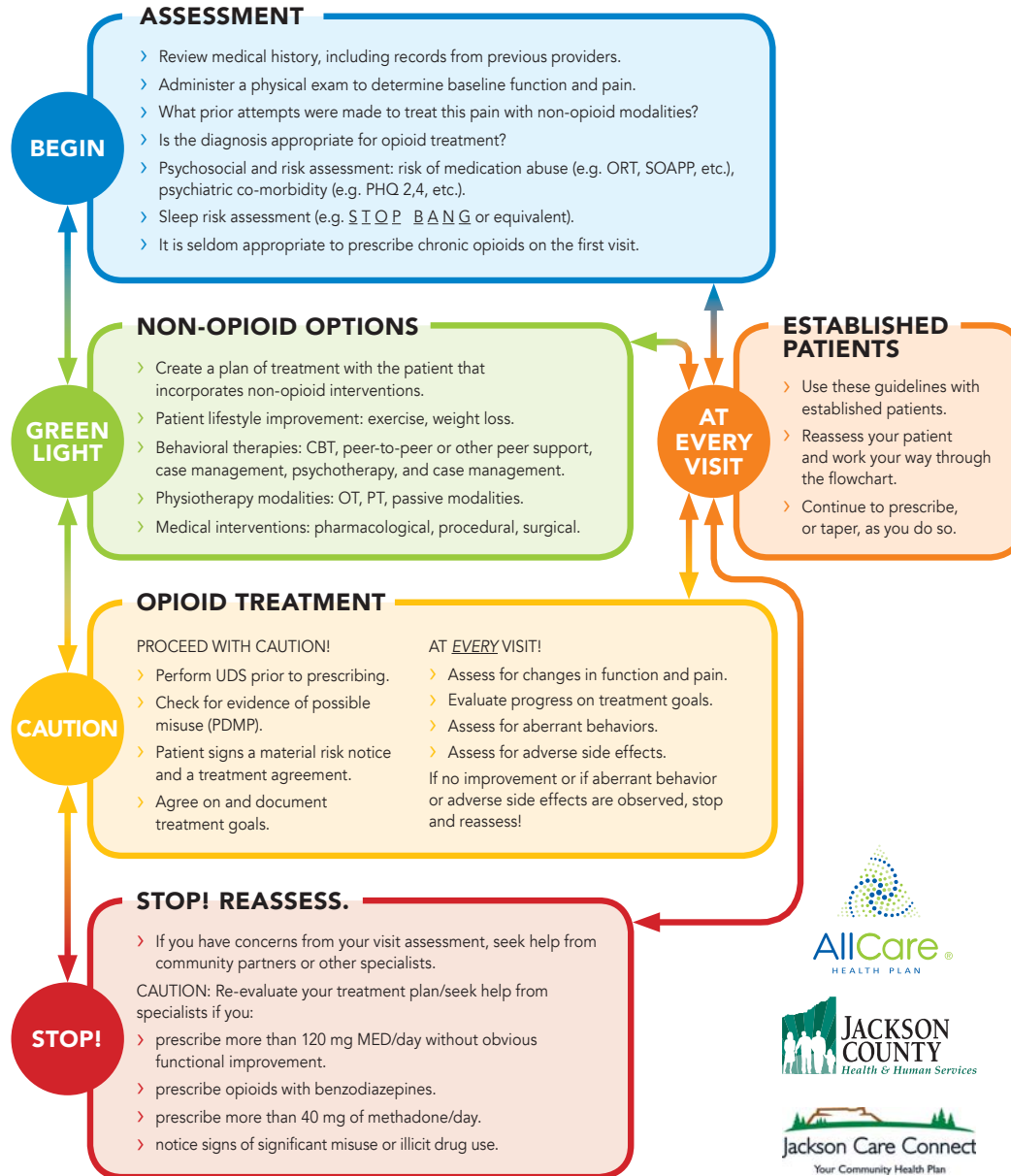
Summary of guidelines:

- Assess prior to prescribing!
- Encourage non opioid treatments (They really work).
- Measure functional improvement.
- Review a material risk notice
- Query the PDMP
- Compassionately say “No” when necessary
- Keep MED low, avoid methadone, don’t combine benzos and opioids.
- Assess for aberrant behaviors (UDS, PDMP, pill counts, call backs)
- Co-prescribe naloxone
- Collaborate with community partners because you can’t do this alone.



GUIDELINES FLOWCHART

FOR THE EVALUATION AND THE TREATMENT OF COMPLEX CHRONIC NON-CANCER PAIN



TAPERING FLOWCHART

START HERE

Consider opioid taper for patients with opioid MED > 120/methadone > 40, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, or concurrent opioid use.

- 1 Explain to the patient the reason for the taper: "I am concerned..."
- 2 Determine rate of taper based on degree of risk.
- 3 If multiple drugs involved, taper one at a time (e.g., start with benzos, follow with opioids).
- 4 Set a date to begin, provide information to the patient, and set up behavioral supports, prior to instituting the taper. See page 26 of OPG guidelines.

OPIOID TAPER

Opioids (not methadone)

Basic principle: For longer acting drugs and a more stable patient, use slower taper. For shorter acting drugs, less stable patient, use faster taper.

- 1 Utilize the drug the patient is taking as the tapering medication. If you switch medications, follow MED equivalency chart and then reduce the dose by 25–50% as starting dose. Metabolic variability can be quite significant. Utilize a 90% dose reduction if switching to methadone. See dose calculator link below.
- 2 Decrease total daily starting dose by 5–15% per week in divided doses.
- 3 See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
- 4 After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the process down.
- 5 Consider adjuvant medications: antidepressants, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

Methadone

Basic principle: Very long half life may necessitate a more protracted tapering process. Otherwise follow opioid principles.

MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and transdermal)
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg†
Oxycodone	20mg
Oxymorphone	10mg

Link to Morphine Equivalent Dosing (MED) Calculator

agencymeddirectors.wa.gov/mobile.html



OREGON PAIN GUIDANCE

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support very important. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

- 1 **Slow taper:** Calculate total daily dose. Switch from short acting agent (alprazolam, lorazepam) to longer acting agent (diazepam, clonazepam). Upon initiation of taper reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
- 2 First follow up visit 2–4 days after initiating taper to determine need to adjust initial calculated dose.
- 3 Reduce the total daily dose by 5–10% per week in divided doses.
- 4 After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the taper.
- 5 Consider adjunctive agents to help with symptoms: trazodone, buspirone, hydroxyzine, clonidine, antidepressants, neuroleptics, and alpha blocking agents.

- 1 **Rapid taper:** See the tapering guidelines on page 28 of the OPG guidance documents.

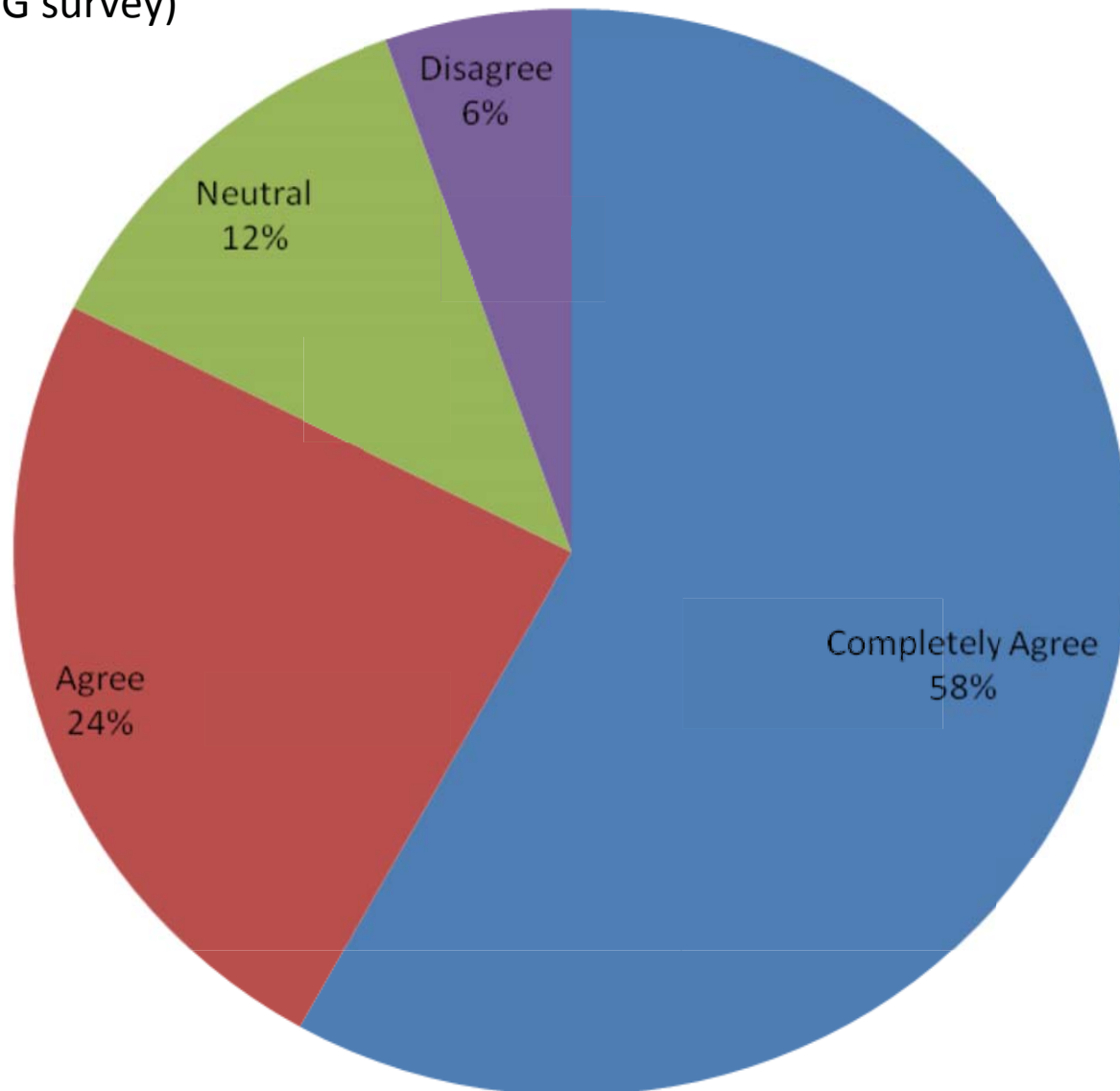
Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg

www.oregonpainguidance.com

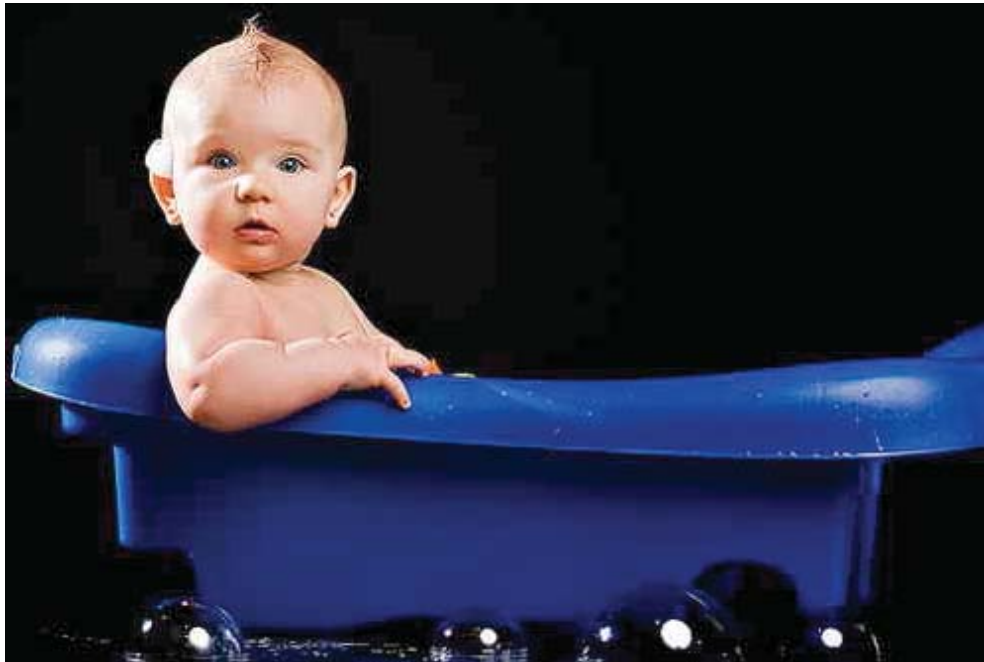
Agreement with MED < 120 Standard Among Chronic Opioid Prescribers

(analysis of 112 JaCo and JoCo
prescribers: OPG survey)



We do need to provide compassionate care to those with certain painful conditions

We don't want to throw the baby out with the bathwater



Opioids have a role to play

- In the treatment of acute and post surgical pain
- In cancer and other deteriorating painful conditions
- In some chronic conditions, when utilized at safe doses

- **Provider resources**
- **Patient resources**
- **Public resources**
- **Supported by Medicaid insurance plans and Public Health**
- **Please link us to your websites.**

The screenshot shows the Oregon Pain Guidance website. At the top left is the OPG logo with the text "OREGON PAIN GUIDANCE". To the right is the tagline "Pain management guidance and tools for patients, families and healthcare professionals." There are links for "CONTACT US" and "SEARCH OUR SITE". A banner image shows hands writing on a document, with a text box stating: "The United States has less than 5% of the world's population yet consumes 80% of the world's supply of painkillers." Below this are two main navigation buttons: "Patients and Families" and "Healthcare Professionals", both with "SELECT »" buttons. A paragraph of text describes the organization's mission: "Oregon Pain Guidance (OPG) is a group of healthcare providers from Jackson and Josephine Counties in Southern Oregon, who are working together on standardizing community guidelines and best practices for treating patients with chronic pain. An improved quality of life for people with chronic pain can be achieved when patients and their families work closely with their healthcare providers. This website provides educational information, news, community resources and upcoming events for both the public and healthcare providers." At the bottom, it lists sponsors: "Sponsored by" with a "Learn More »" button, and logos for AllCare Health Plan, Jackson Care Connect (Your Community Health Plan), and Jackson County Health & Human Services.

www.oregonpainguidance.org

“A Thoughtful Approach to Pain Management” Conference



Pain Conference

- Speakers from all over North America
- Over 200 participants last year
- Open to all healthcare professionals
- 2 days: lecture and workshop format
- 9 months of planning by the conference committee
- May 20 and 21, 2016: Asante CME

2ND ANNUAL MOVING THROUGH CHRONIC PAIN: A COMMUNITY RESPONSE



May 28, 2015, 4:00 p.m. – 7:00 p.m.

Jackson County Health & Human Services Building
1005 E. Main Street. Building 3, Medford, OR 97504

Who Should Attend:

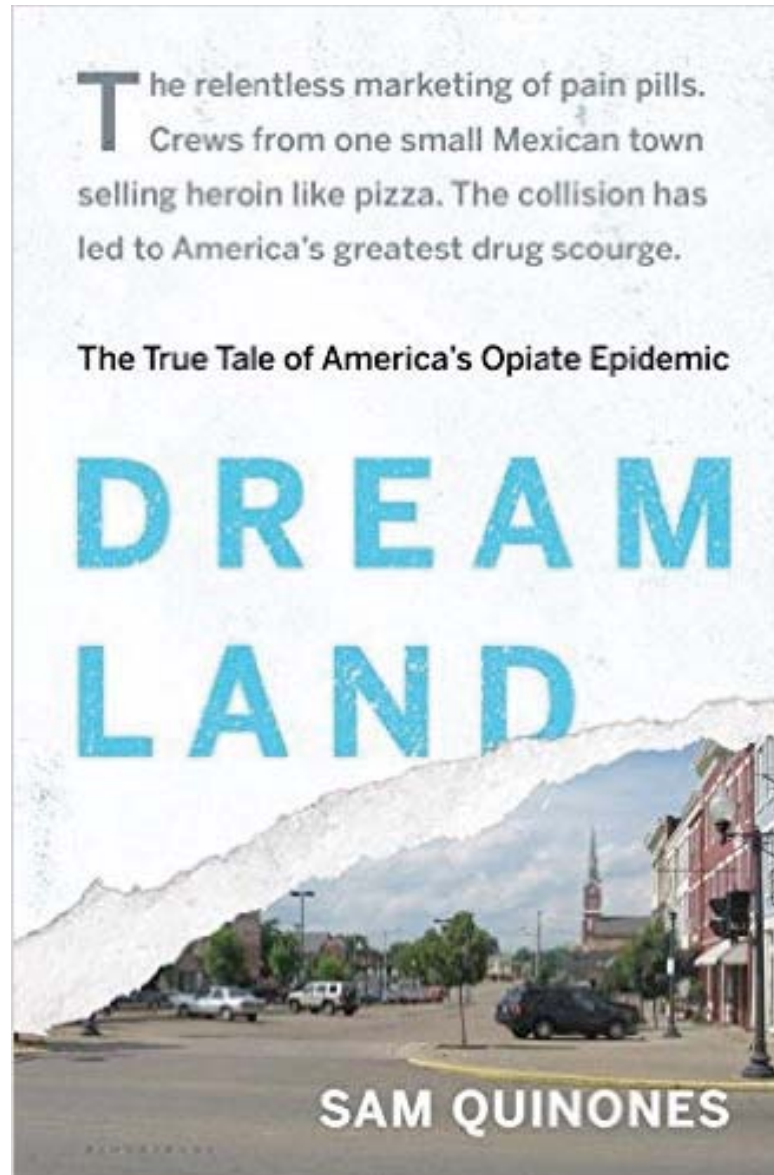
Community Members Living with Chronic Pain and Supportive Family Members



Free to the Public

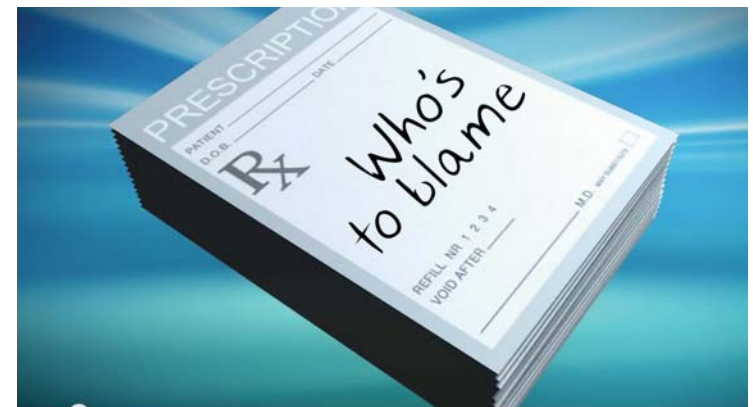
Free Dinner

Community “book club”





Educating the Public through TV spots



Providing local alternatives to opioids

- Pain Resiliency Program
- By referral from Primary Care
- Support by CCOs
- Curriculum:
 - Evaluation, orientation
 - “Pain School”
 - Peer to Peer support
 - Movement therapy
 - Behavioral support
 - Feedback to Medical Home





The Dissemination concept

Critical mass: If enough providers understand the guidelines, word of mouth and peer pressure will lead to adoption.

Information is transmitted via the pilot's providers, OPG, KOBI messaging, website, consults, conferences,

Interdisciplinary Action Committee: IDAC

- Problem focused monthly meetings
- Participants:
 - District Attorney
 - Sheriff, Police
 - Drug Court
 - Public Health
 - Substance Abuse treatment
 - Southern Oregon University
 - Parole and probation



Naloxone

- Oregon allows bystander use
- Medford Police were one of the first in the State to initiate naloxone use by their officers.
- MPD has 10 “saves” to date. APD on board.
- Plans for broader community use



Partnership with Oregon PDMP

- PDMP sends quarterly de-identified aggregate prescribing data
- Encouraging providers to sign up for and delegate PDMP query (in office sign-up)
- Creating a provider PDMP education video
- Piloting a dashboard for professional prescribing information



Where does our support come from?

- Direct Financial
 - Coordinated Care Organizations (CCOs)
 - Jefferson Regional Health Alliance (JRHA)
 - Grants: Federal, CCOs
- In-Kind Support
 - Jackson County HHS
 - Oregon Health Authority
 - CCOs: thought leaders, 120 MED policy, Web development, attendance at meetings
 - Local A&D providers, MH,
 - Oregon Medical Board
 - Others

Working hand in hand with the CCOs

- Both have adopted 120 MED policy:
 - They will not pay for opioid medication without an approved tapering plan in place
 - Messaging to both the patient and the provider
- They have behavioral outreach to local providers
- They support various community educational projects
- They serve on the OPG Steering Committee

Other Collaborations

- Oregon Medical Board
- Tri County website integration
- Continued strong CCO collaboration
- Group practice consultation

Thank You



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