Managing the Pain:
Using an Interdisciplinary Consultation Team to Educate Residents (and Faculty) About Challenging Controlled Medication Practices

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No Disclosures

Objectives

Describe the development & implementation of an interdisciplinary consultation team for patients taking long-term controlled medications

Evaluate the benefits & challenges of using this team to educate residents on best practices when prescribing long-term controlled medications

Consider an action plan for implementing an interdisciplinary consultation team within one's own program

UNC SCHOOL OF MEDICINE

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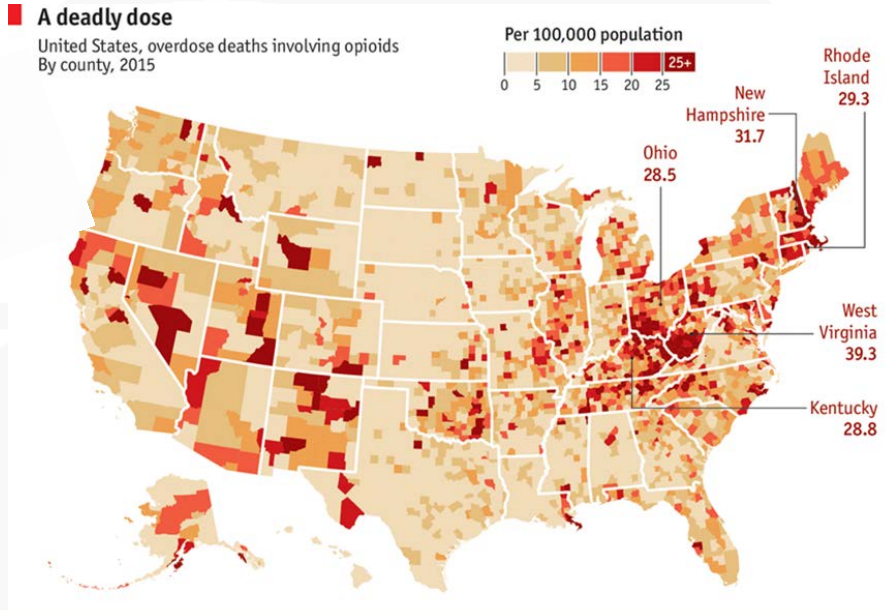
The Opioid Epidemic Is This Generation's AIDS Crisis

By Andrew Sullivan



Economic Impact of the Opioid Epidemic:

- **55 billion** in health and social costs related to prescription opioid abuse each year[1]
- **20 billion** in emergency department and inpatient care for opioid poisonings[2]

Source: Pain Med. 2011;12(4):657-67.[1] 2013;14(10):1534-47.[2]

On an average day in the U.S.:

- More than **650,000 opioid prescriptions** dispensed[1]
- **3,900 people** initiate nonmedical use of prescription opioids[2]
- **580 people** initiate heroin use[2]
- **78 people** die from an opioid-related overdose*[3]

*Opioid-related overdoses include those involving prescription opioids and illicit opioids such as heroin

Source: IMS Health National Prescription Audit[1] / SAMHSA National Survey on Drug Use and Health[2] / CDC National Vital Statistics System[3]

Controlled Medication Policy

ESSENTIAL:

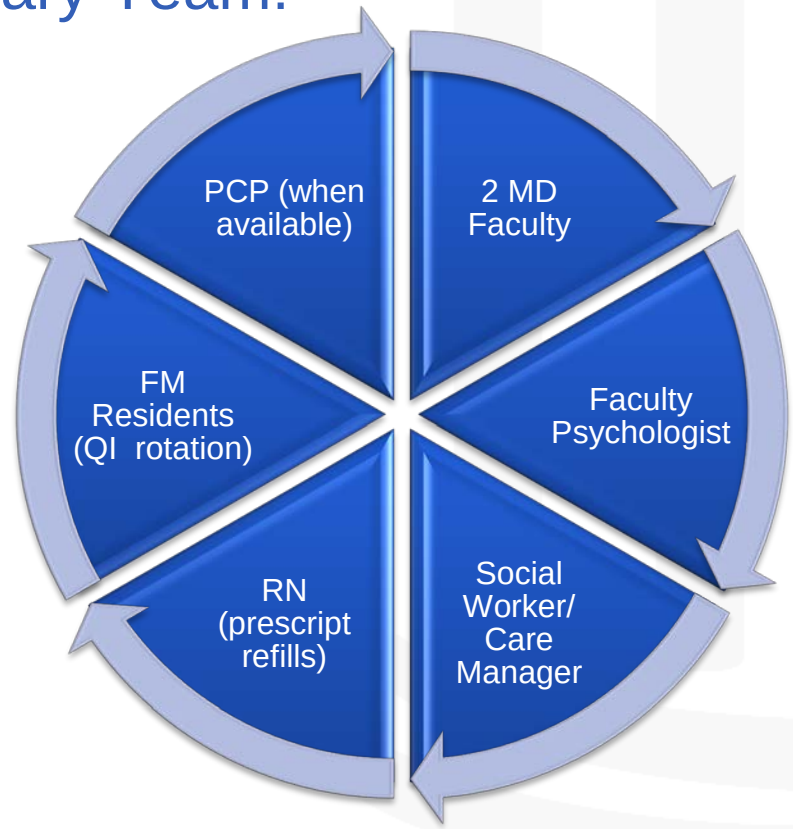
- To establish practice wide (FMC) standards of care for prescribing and maintaining patients on controlled medications
- To educate residents about the logistics and challenges of caring for patients on controlled medications
- To assist staff and clinicians in providing safe and effective medical care for patients on controlled medications

Controlled Medication Policy

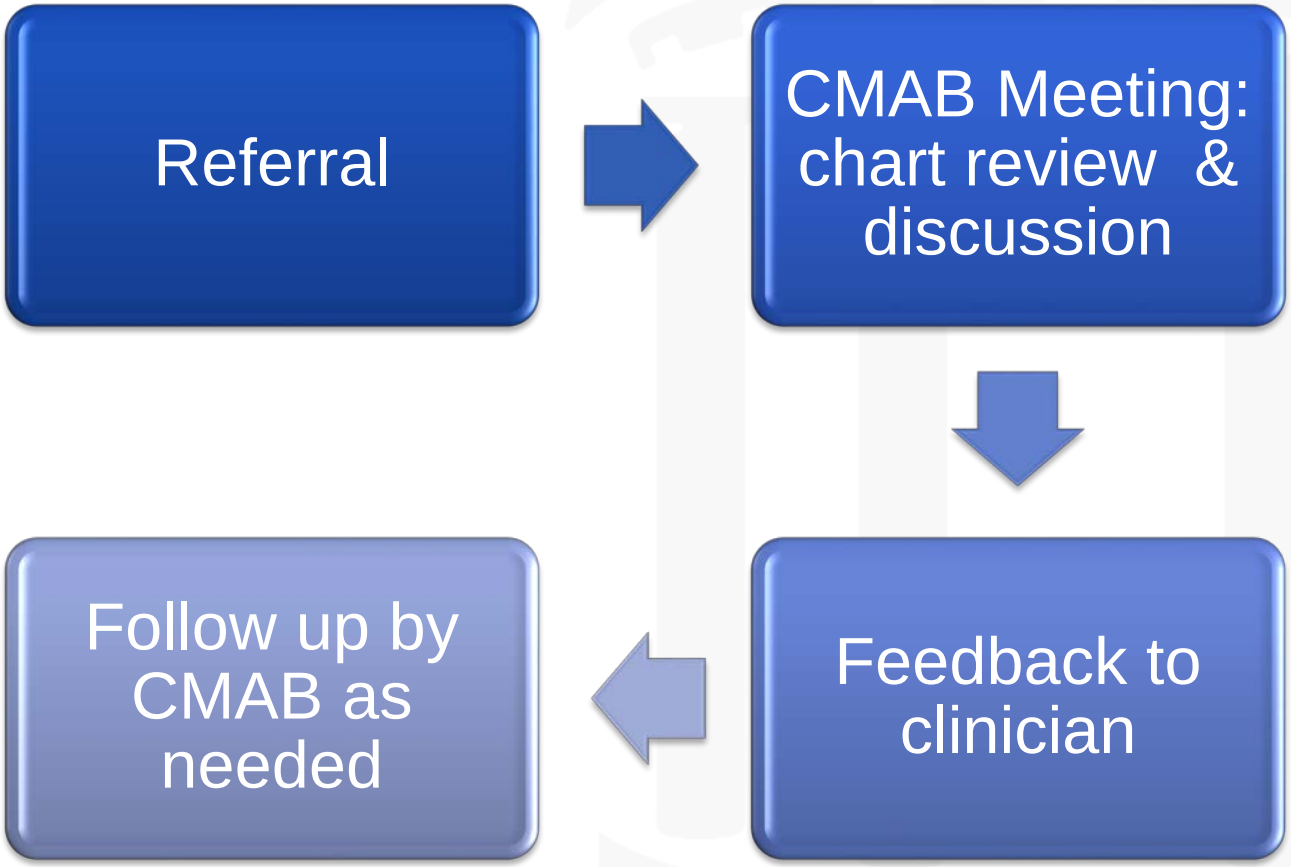
- Versions in use at UNC Family Medicine Center (FMC) for >10 years
- New version developed by multidisciplinary FMC committee in 2015
- Committee led by Dr. Bossenbroek-Fedoriw
- Guide for prescribing long term (>90 days) controlled medications by residents and faculty clinicians
- **+** Specific guide for treatment of chronic non-cancer pain with long term opioid therapy

Controlled Medication Advisory Board

- Established in late 2015
- Led by a clinician “champion”
- Interdisciplinary Team:



How Does It Work



Review Elements

History	Monitoring	Risk Considerations	Safety Considerations
• Diagnosis • Prior Eval & Tx • Medication List • Controlled Medication Agreement	• Urine Screens • NC Prescription Database	• Opioid Risk Tool • Psychiatric Hx • Substance Use • Med interactions • Calculate MEDs	• Naltrexone • EKG (Methadone)

Consult Request

1. Reason for Consult: (drop down list)
2. Etiology of chronic pain:
3. Past diagnostic workup:
4. Past consultations: (drop down list)
5. Complicating co-morbidities (include psychiatric diagnoses and history of substance misuse):
6. Non-opioid therapies tried:
7. Medication history and current meds/doses x duration of time on this regimen:
8. Functional assessment:

   Pain, Enjoyment and General Activity:

   1. What number describes pain on average in the last week?
   2. What number describes how pain has interfered with your enjoyment of life in the last week?
   3. What number describes how pain has interfered with your general activity in the past week?
9. Most recent NCCSRS report and recent urine tox screen results:
10. Any concerning aberrant behaviors?

11. Opioid Risk Tool - **total score**:
    1. Family History of Substance Abuse:
       Alcohol:
       Illegal Drugs:
       Prescription Drugs:
    2. Personal History of Substance Abuse:
       Alcohol:
       Illegal Drugs:
       Prescription Drugs:
    3. Age 16-45?:
    4. Hx/of preadolescent sexual abuse?:
    5. Psychological Disease:

Risk Category:

Low Risk: 0 to 3

Moderate Risk: 4 to 7

High Risk: 8 and above

Female patient in her 50's with incomplete quadriplegia S/P gunshot wound to cervical spine at age 16

1. **Reason for Consult:**

   PCP feels current treatment plan is appropriate and qualifies for exemption from MED limit

2. Etiology of chronic pain: *Severe DJD in hips and DDD lumbar spine*
3. Past diagnostic workup: *X-rays*
4. Past consultations: *Sports Medicine*
5. Complicating co-morbidities (include psychiatric diagnoses and history of substance misuse): *No psych issues*
6. Non-opioid therapies tried: *Medications including NSAIDS, Cymbalta, gabapentin. Steroid hip injection by Sports Medicine*
7. **Medication history and current meds/doses x duration of time on this regimen:**

   Stable for 5 yrs. on oxycodone 40 mg. QID (MED=240 mg.) Previously on same dose of oxycontin

8. **Functional assessment**:

Pain, Enjoyment and General Activity:

- What number describes pain on average in the last week? ***3***
- What number describes how pain has interfered with your enjoyment of life in the last week? ***3***
- What number describes how pain has interfered with your general activity in the past week? ***1***

9. **Most recent NCCSRS report and recent urine tox screen results:**

Unable to give urine specimen due to neurogenic bladder without lying down for a while

10. Any concerning aberrant behaviors?

None. Always on time for refills and totally straight forward

11. Opioid Risk Tool - total score= 0

1. Family History of Substance Abuse:
   - Alcohol: no
   - Illegal Drugs: no
   - Prescription Drugs: no

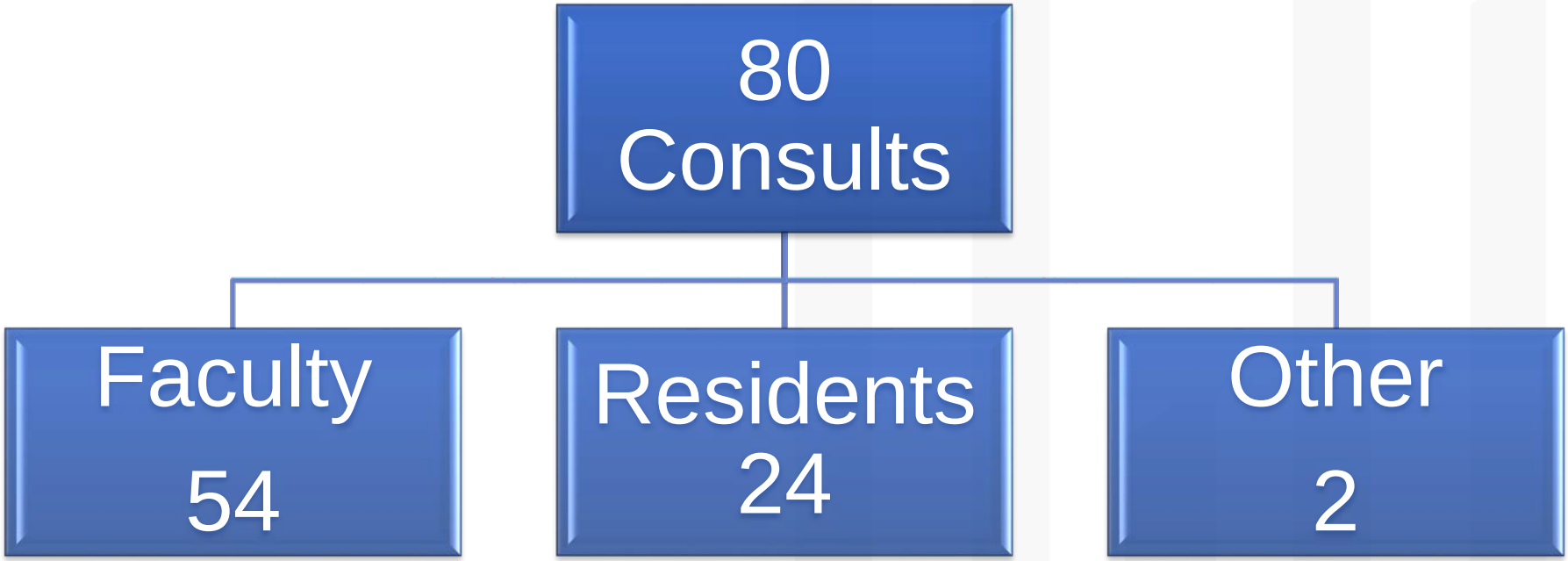
2. Personal History of Substance Abuse:
   - Alcohol: no
   - Illegal Drugs: no
   - Prescription Drugs: no

3. Age 16-45?: no
4. Hx of preadolescent sexual abuse?: no
5. Psychological Disease: none

CMAB REVIEW & RESPONSE

- **Treatment Plan requires revision**: Overall, patient is **high risk for accidental overdose** due to taking **high dose opioids** (MED 240mg.) and **concomitant benzodiazepines**
- **Recommend changing patient's oxycodone to oxycontin**… [and] **decreasing her oxycodone/acetaminophen by 5-10 mg every 1-2 months**… to a total of oxycontin 40mg BID and oxycodone 5mg TID
- Patient is also **taking chronic benzodiazepines**. She qualifies for an exemption to the policy given her significant medical illness
- Patient must have **regular urine tox screens every 6 months with benzo and opioid confirmation**
- **Consider referral to pain psychology**
- Patient should be **prescribed rescue Naloxone**

December 2015-March 2017

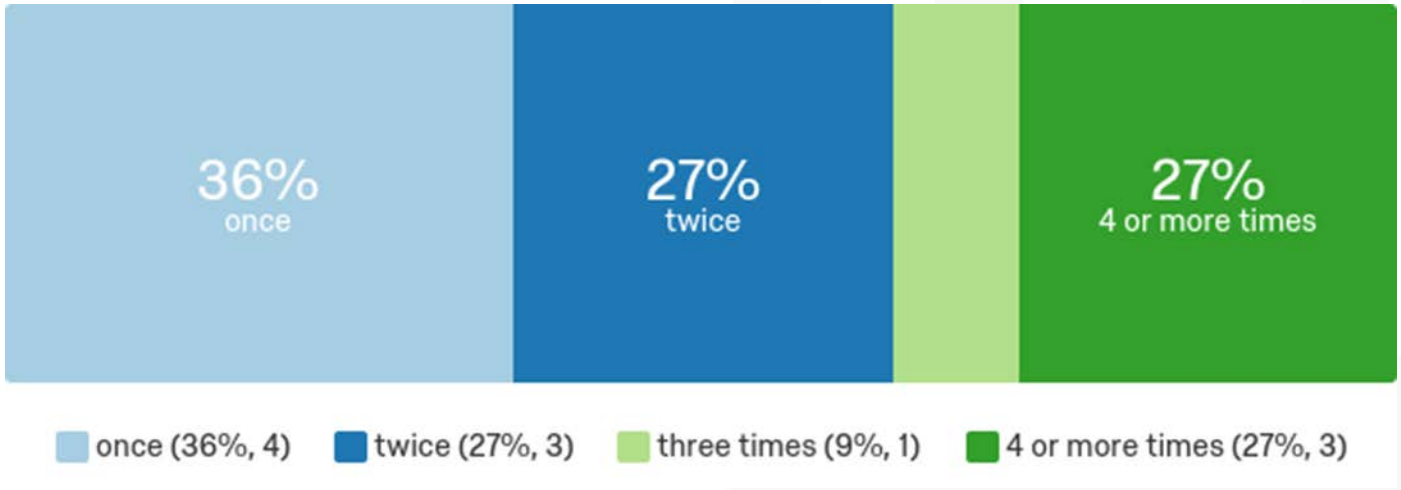


CMAB Feedback Survey

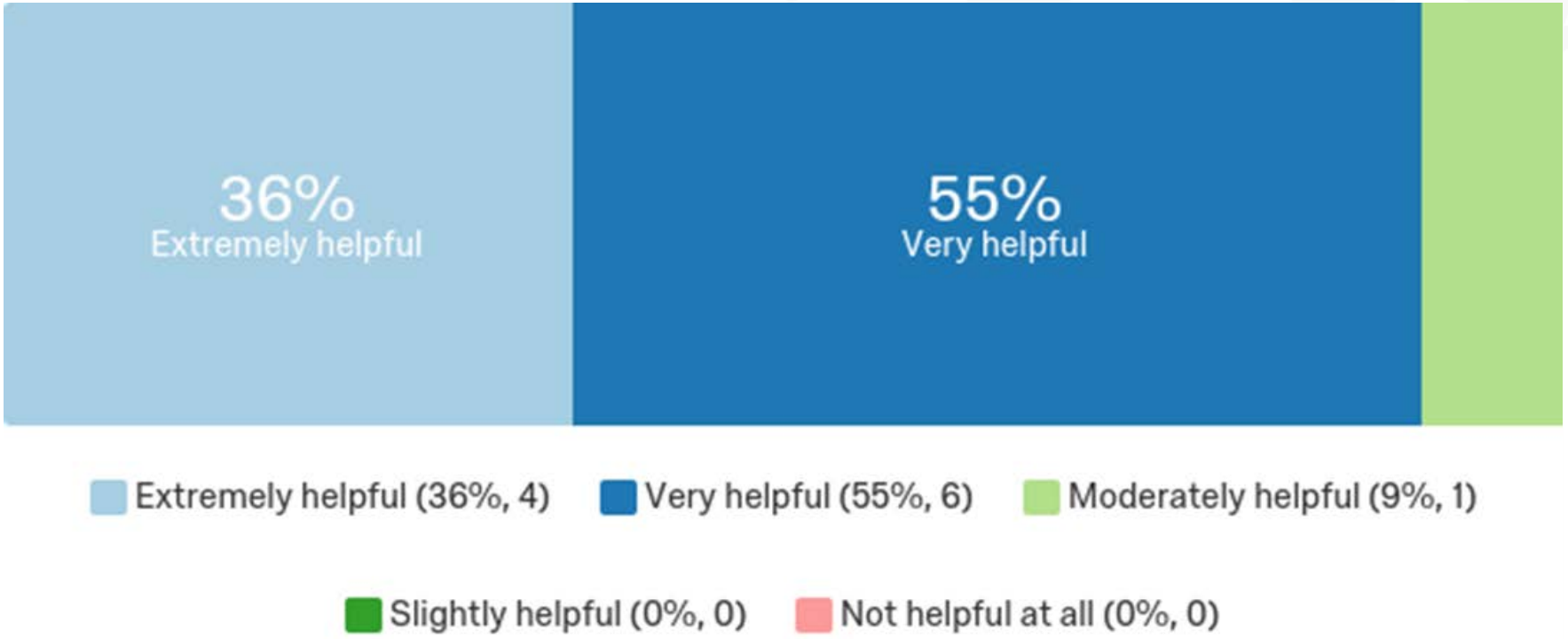
- Response Rate
  - » Residents = 12/24 = 50%
  - » Faculty = 21/54= 39%

- 33% had consulted CMAB (n = 11)

How many times have you submitted consultation requests to the CMAB?



How Helpful Was the Consult?



Benefits?

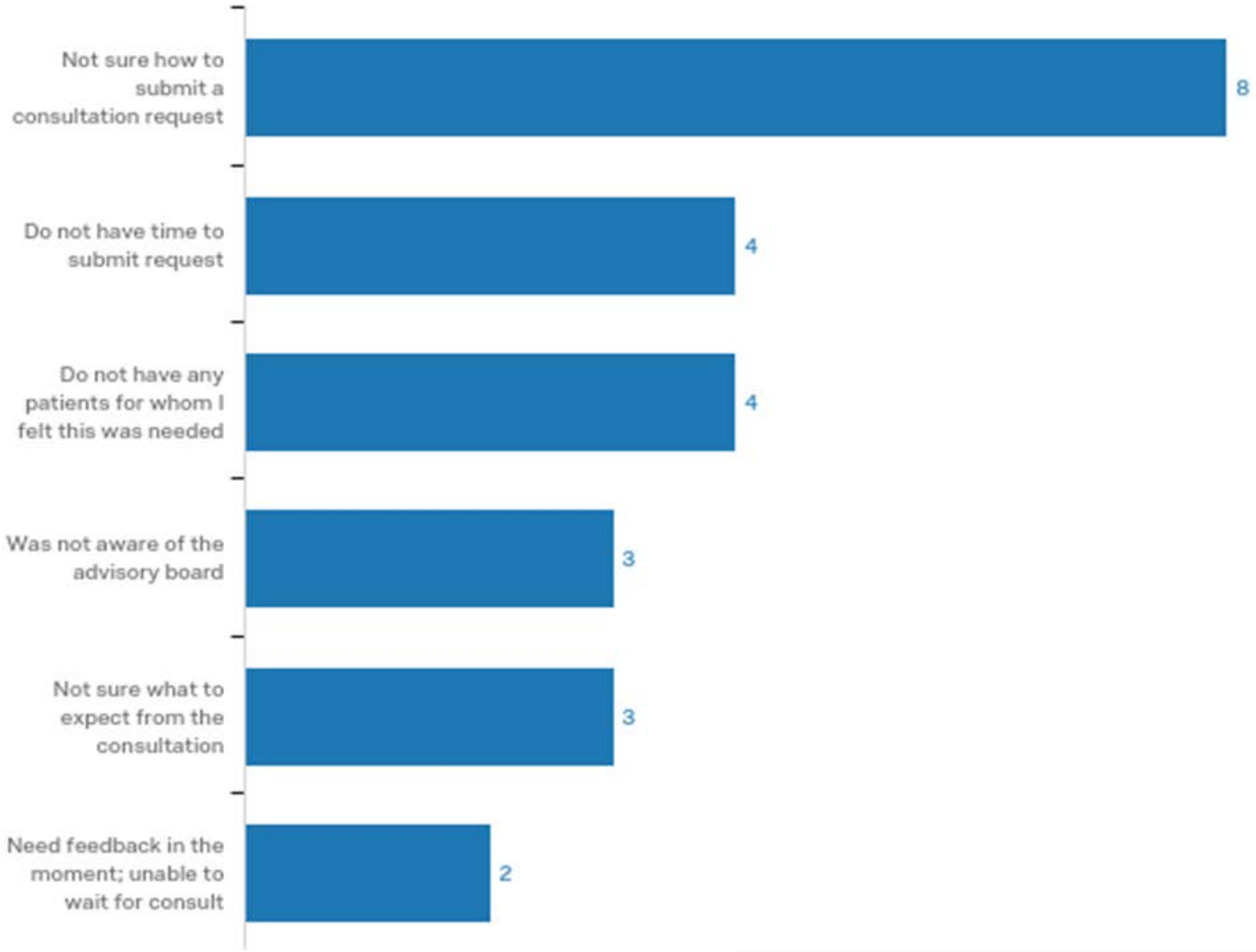
"Reassurance, helped me formulate thoughts and plans in a systematic way"

"Largely they verified my sense that patients weren't following the agreement we outlined or that their quantity was way above current guidelines."

"Gave me extra credibility when I recommend changes to a patient. The changes were often backed up by the committee opinion. That also helps me have extra power to help patients lower their doses of dangerous medications."

"Multiple insights into care. Great for fresh eyes and new multimodal ideas."

Barriers


Not sure how to submit a consultation request
8
Do not have time to submit request
4
Do not have any patients for whom I felt this was needed
4
Was not aware of the advisory board
3
Not sure what to expect from the consultation
3
Need feedback in the moment; unable to wait for consult
2

Implementation Discussion