How Community-Based Pharmacists Can Partner with Clinicians in Reducing Opioids for Chronic Non-Cancer Pain

Presenters:
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June 28, 2018

Learning Objectives

1. Describe how to establish multi-disciplinary teams to support chronic pain patients.

2. List options by which pharmacists and prescribers can work together for best patient outcomes, and describe how pharmacists can improve communication strategies with physicians and other prescribers to improve outcomes for chronic pain patients.

3. Describe how realistic goals for pain management and restoration of function are developed with patients, and describe alternative therapies for chronic pain management.

4. Discuss how to counsel patients and caregivers about use, misuse, abuse, diversion and overdose.
Disclosure

Gerard Greskovic declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

Laney Jones declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

What is pain?
Definitions of pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage…”

It is unquestionably a sensation in part or parts of the body, but it is always unpleasant and therefore also an emotional experience (Merskey, 1994)

Pain is a psychological state: part sensation and part emotion
Pain Cycle

Sleep
- Pain and Anxiety make it hard to sleep. Lack of sleep makes pain worse and decreases energy.

Energy
- Coping with pain drains energy. Lack of energy makes it hard to be active and stay in shape.

Activity
- Pain and lack of energy make it hard to be active. Lack of exercise worsens pain.

Mood
- Chronic pain and the limits it puts on your life can lead to depression, anger, and anxiety. These feelings make coping with pain harder.

Relationships

Eating Habits

Normal Activities

Finances

Pain, Emotions, & Memory

Over time, chronic pain becomes more closely associated with memory and emotion than with sensory functions.

Pain/Emotion Chart

- Lack of Forgiveness
- Lack of Emotional Support
- Stress
- Emotional Burden
- Financial Woes
- Lack of Flexibility
- Fear of Change
- Isolation
- Big Ego
- Tension & Jealousy
- Lack of Pleasure
- Depression
How do we treat pain?

Multidisciplinary Approach

• Pain effects all aspects of life ... medications alone are not the answer. We need to address the physical, emotional, social and spiritual aspects of pain as well.

• Biopsychosocial Model
Goal Establishment

• Goals need to be…
  – Prioritization of an agreed upon framework for pain management
  – Individualized and patient-centric
  – Collaboration between patient and clinician
  – Functionality and behavior based, NOT simply pain control
  – Well-defined
  – Attainable and REALISTIC (Set patient up for success NOT failure)
  – Re-visited and updated regularly

• Can be formulated around…
  – Emotional well-being
  – Physical activity
  – Relationship-based
  – Sleep improvement
  – Social/family activity participation
  – Employment
  – Coping mechanisms

Treatment Modalities
Physical Therapy and Exercise

- Traditional physical therapy
- Graded Motor Imagery
- Recreational Walking
- Isolation Exercises
- Anti-gravity therapy
- Aquatic Therapy
- Massage therapy
- Yoga

Diet and Nutrition

- Weight management programs
- Chronic disease maintenance and management
- Decrease intake of inflammatory substances

Fighting Pain in 5

<table>
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<tr>
<th></th>
<th>Go Nuts</th>
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<th>Fatty Fish</th>
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<tr>
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<td>Nuts, almonds, pecans and Brazil nuts, oats</td>
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<td>Salmon, mackerel, sardines, herring, tuna and trout</td>
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<tr>
<td>3</td>
<td>Fowl, cinnamon, ginger, rosemary, garlic, curcumin, onions, oregano, cloves and turmeric, honey</td>
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<td>Berries, pomegranate, cherries, grapes, carrots, beans, sweet potatoes, and avocados</td>
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<td>5</td>
<td>Kale, spinach, cauliflower, cabbage, and broccoli</td>
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Psychology and Spirituality

- Individual or Group Counseling
- Art Therapy
- Stress Management
- Addiction counseling
- Spirituality and forgiveness
- Mindfulness and Relaxation
- Recreational Therapy

Cognitive Behavioral Therapy

A type of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence behaviors

**Goals**
- Reduce the severity of pain
- Optimize individual’s functioning/productivity
- Reduce suffering and emotional distress
- Improve overall quality of life

**Techniques**
- Goal setting
- Motivational Interviewing
- Psychoeducation
- Relaxation strategies
- Mindfulness
- Pacing / Activity Cycling
- Cognitive techniques
- Values work
- Health behavior change
- Assertive communication skills
- Relapse Prevention
Mindfulness / Stress management

- Mindfulness means living in the moment and awakening to experience. When you're mindful, you observe your thoughts and feelings from a distance, without judging them as good or bad.
  - Management Techniques
    - Formal
    - Informal
    - Mindful Living

- Stress can provoke pain
  - Management Techniques
    - Yoga based relaxation
    - Diaphragmatic breathing
    - Stretching
    - Stress management

Pharmacologic Treatments

- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Antidepressants
- Anticonvulsants
- Topical
- Acetaminophen
- Muscle Relaxants
- Opioid-like Analgesics
- Interventional Therapies
  - Steroid Injections
  - Neuromodulation
- Opioids
Argument Against Using Opioids

- Lack of evidence on long term efficacy
- Long term use linked to increased risk of addiction and higher morbidity/mortality
  - 3 out of 4 heroin users started out by using prescription pain medications
  - Accidental overdose
    - Dose escalations
    - Combination therapies
- Long term use can lead to cycle of tolerance, hyperalgesia and worsening pain
### CDC Guidelines

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<tr>
<th>When to initiate or continue</th>
<th>How to use</th>
<th>How to assess risk</th>
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<tr>
<td>Benefits outweigh risk</td>
<td>Lowest effective dose</td>
<td>Prior to start and during treatment</td>
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<tr>
<td>Significant improvement</td>
<td>Reassess risk benefits</td>
<td>Offer naloxone</td>
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<tr>
<td></td>
<td>Limit quantities</td>
<td>Urine drug screening</td>
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### Opioid Epidemic
Opioid Epidemic

“Of all the nations of the world, the United States consumes the most habit-forming drugs per capita….”

Dr. Hamilton Wright, New York Times 1911

Discussion:

How We Got Here

**The NEW ENGLAND JOURNAL OF MEDICINE**

**ADDITION MADE IN PATIENTS TREATED WITH NARCOTICS**

To the Editor—Recently, we reviewed our current file to determine the incidence of narcotic addiction in 39,948 hospitalized medical patients who were immunocompromised. Although there were 11,189 patients who received at least one narcotic per year, this study was not designed to assess the incidence of addiction. The trial was considered major in only one instance. The drugs administered were epidural or two agents. Prednisolone was used, and the study was not designed to assess the incidence of narcotic addiction in the overall population of medical patients with no history of addiction.

Jenni Parke, RN
Macon, GA
Barnes Calloway Drug Formulation Program


N Engl J Med 2017; 376:2194-2195

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Pain as the “Fifth” Vital Sign


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Overdose Deaths Nationwide

**Drugs Involved in U.S. Overdose Deaths, 2000 to 2016**

- Among the more than 100,000 drug overdose deaths estimated in 2016, the sharpest increase occurred among deaths related to fentanyl and fentanyl analogs (synthetic opioids) with over 20,000 overdose deaths. Source: CDC WONDER
Overdoses at Geisinger

Geisinger’s Plan

- Appropriate prescribing
  - Medication Therapy Disease Management (MTDM) pain program
  - Order sets
    - non-opioid 'med cocktails'
    - prescribing limits (e.g. ED, Postop)
  - Provider AND patient education
  - ProvenCare Pain
  - E-scribing of controlled drugs
- Population management
  - System developed dashboards
  - Health plan initiated dashboards
- Clinical and decision support tools
  - Best practice alerts
  - Integration of PDMP into EHR
- Outpatient addiction services
  - Geisinger Marworth
  - Center of Excellence/MAT clinic(s)
- Community engagement
  - #HadEnough
  - Medication Take-Back program
- Policy influence
  - State prescribing guidelines
- Research
  - Epidemiology of addiction
  - Genetic links to abuse
  - Acute pain treatment guidance in EHR
Geisinger Ambulatory Pharmacy Programs

MTDM Pain Program

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<th>Location</th>
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<td>5.5</td>
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<td>0</td>
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<td>1</td>
<td>1*</td>
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<td>12</td>
<td>12</td>
<td>12</td>
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<td>Patient encounters per month</td>
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<td>217</td>
<td>767</td>
<td>1,064</td>
<td>1,229</td>
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MTDM Pain Program Goals

**Patient Safety**
- Identify and treat high-risk population
- Decrease emergency room visits and hospitalizations for pain/overdose
- Mitigate risk for opioid abuse/diversion
- Reduce risk of intentional or accidental overdose

**Patient Focused Care**
- Educate patient
- Work with patient to establish realistic goals and exit strategy
- Enhance patient functionality
- Improve overall quality of care and patient satisfaction

**Treatment Optimization**
- Minimize use of chronic high dose opioids
- Actively incorporate opioid sparing adjuvant medications
- Collaborate and utilize available interdisciplinary and community resources
- Decrease overall cost of care

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Role of MTDM Pain Pharmacists

- Full assessment of patient based upon bio-psycho-social model of chronic pain management

- Screening for potential drug-drug interactions, drug-disease interactions, and unsafe medication combinations

- Initiation of non-narcotic and co-analgesic medications to alleviate dependence on opioids

- Perform risk assessments for opioid misuse and abuse

- Titration and tapering of narcotic pain medications when appropriate
Role of MTDM Pain Pharmacists

- Coordination of care with non-pharmacologic treatment modalities
  - Interventional pain management, physical therapy, complementary and alternative medicine modalities, TENS units, and others
- Consistent utilization of medication usage agreements
- Abuse/diversion monitoring:
  - Urine toxicology screens
  - Pill counts
  - Prescription Drug Monitoring Program
- Extensive patient education (to be discussed later)
- Partner with Addiction Trained Social Worker

Role of Addiction Trained Social Worker

- Take history related to substance use and mental health
- Identify specific risk factors for opioid therapy
- Identify barriers to pain management treatment
- Guide patients to local mental health and Drug and Alcohol support resources
- Address concerning behaviors (e.g. sharing medicine and inconsistent toxicology screens)
Referrals to MTDM Pain

Provider-initiated
- Potential opioid candidate
- Prescribed ≥ 2 opioids
- Prescribed methadone for pain management
- Rapid dose escalations of opioids
- Opioid induced hyperalgesia/De-escalation of opioids
- Adjuvant failure
- Inadequate pain control
- Risk assessment for potential abuse/diversion
- ≥ 120 morphine equivalents per day (MED)

Automated*
- High morphine equivalents (≥ 200mg MED)
- Combination of opioids and benzodiazepine
- Recent ED visit for refractory pain OR overdose with or without naloxone administration

*Generated off Geisinger’s controlled drug prescribing dashboard

Referring provider must have signed a collaborative practice agreement for pain management in place with MTDM pharmacist(s)

Discussion:

How can (or do) pharmacists fit into this multidisciplinary care model?
**Chronic Pain Patient Flow**

**Primary Care**
- FC: Patients will be managed by their PCP unless the patient’s morphine equivalency exceeds 100 mg/day

**Medication Therapy Disease Management**
- MTD: Patient education of medication treatment and tailored care plans

**Medical Pain Management**
- MP: Physician-led treatment of complex chronic pain patients, including medication management

**Multidisciplinary Pain Program**
- MD: Multidisciplinary treatment for complex chronic pain patients that demonstrate an adequate motivation to proceed with a rehabilitation approach

**Interventional Treatments**
- IT

**Psychological Treatments**
- PT

**Medication Therapy Disease Management**
- MD

**Addiction Counseling**
- AC

**Physical Therapy**
- PT

**Chronic Pain Patient Flow**

**MAT Clinic**

- Specialty Addiction Clinics staffed by:
  - 1.0 Addiction Trained (AT) Physician
  - 1.0 Licensed AT Pharmacist
  - 2.0 PA-C or CRNP
  - 2.0 Licensed LPN
  - 3.0 Addiction Coordinator
  - 1.5 Patient Access Representative
  - 0.33 Licensed RN Case Manager

- Locations
  - Bloomsburg (Opened March 30, 2017)
  - Wilkes Barre (Opened September 18, 2017)
  - Williamsport (Goal June 2018)
  - Scranton (Late 2018)
**MAT Clinic Model**

**Initial**
- Discuss pertinent diagnoses
- Discuss appropriate levels of care and multi-disc. team
- Ensure that patient is not on any other controlled substance or medications of concern
- Referral to other specialists, as necessary

**Follow-up**
- Discuss efficacy of treatment, assessment of compliance, etc.
- Review previous urine toxicology screen and other laboratory results
- Discuss compliance with mandatory counseling
- Order necessary follow-up labs, screenings, and medication refills
MAT Clinic Early Results

Unique # of Patients: 702

Engaged Mortality Rate: 0.45
* = Clinic Openings

Clinic Ramp-Up

Discussion:

What do you see your role as a retail pharmacist in the opioid epidemic?
Retail Pharmacy Roles

- Education
- Gatekeeper Functions
- Community Collaborations
- Appropriate Prescribing

- Patient/Caregiver
- Provider
- Community
- Self-education
Patient/Caregiver Education

- Videos
- Workshops
- One-on-One Counseling Sessions
  - Need for naloxone
  - Why long term opioid use harmful
- Patient Focused Literature
  - Pain Fact Sheets
  - Opioid Fact Sheets
  - Naloxone Fact Sheets
  - Alternate Treatment Options Sheets

Best practices in Pain Medication Use and Patient Engagement

- Patient population
  - Children
  - Emergency departments
  - Elective surgery
  - Chronic & acute pain patients

*grant sponsored by the Cardinal Health Foundation
Grant Awardee Examples

- Video (Advocate Health Care, Nationwide Children's Hospital)
- Brochure (Loma Linda University, MetroHealth)
- Pain scale app (Loma Linda University)
- Prevention
  - Safe storage of medication (Johnstown Free Medical Clinic)
  - Medication return bins (Tuba City Regional)

Talking Points: Patient/Caregiver

- People in pain want to understand pain
- Education can lead to positive outcomes
  - Changes perception, meaning, and context of pain
  - More accurate understanding decreases fear of movement
  - Leads to positive outcomes
    » Improved pain
    » Improved functioning
    » Willingness to engage in physical therapy
    » Less fear and catastrophizing
- Empowers patients
- Instills hope
- Overwhelming need to educate public on opioids, alternative treatment options, appropriate medication storage and disposal, and Narcan availability/usage
Talking Points: Opioid Dangers

- Doctors used to think that opioids were safe and effective when used for long periods of time to treat chronic pain.

- New information has taught us that long-term opioid use can lead to multiple problems including loss of pain relieving effects, increased pain, unintentional death, OUD, and problems with sleep, mood, hormonal dysfunction, and immune dysfunction.

- We now know that the best treatments for chronic pain are not opioids. The best treatments for chronic pain are non-drug treatments such as psychological therapies and rehabilitation therapies and non-opioid medications.

Talking Points: Behavioral Pain Management

- Behavioral pain management can
  - work to manage the ways that pain affects your life besides just your body
  - work with you to help you learn new skills that you can use to better manage and cope with your pain to get back to living a life that looks more like the one you want to be living
  - help you learn new ways of thinking about your pain, living with your pain, relaxing, and coping with your pain and the way it affects your life, relationships, activities, and emotions

- Research has shown that these skills can actually help train your brain to think differently about the pain and form different patterns of connections in your brain that help you experience the pain differently.
Provider Education

Internal Survey: Takeaways

- To decrease ‘Blaming’ behaviors among clinicians toward people with substance use disorders, focus should be on increasing knowledge about substance use disorder

- To decrease ‘Blaming & Stigmatizing’ behaviors among clinicians toward people with substance use disorders, focus should be on increasing familiarity among clinicians and improving adherence to Best Practices around prescribing controlled substances and opioid pain management.

- Provider education efforts should focus on helping clinicians provide education to patients, on establishing alignment in prescribing practices, and ensuring clinicians are adequately informed.
Provider Education
Internal Survey: Takeaways

• Participants on average do not educate all patients who they believe to be opioid-addicted on how to access naloxone

• Some common open text responses on 'concerns about combatting the opioid epidemic in PA':
  • Lack of educational programs/training/resources at all levels of medical personnel
  • Need for consistent collaboration efforts across disciplines
  • Society may rely too heavily on Narcan....'patients who get saved with Narcan are just going to go back to using...so why bother?'
  • Physicians question effectiveness of alternative pain treatments
  • Providers do not feel MAT is a great option....'most patients just end up abusing buprenorphine instead of the original opioid'

Grant Awardee Examples

• Team based care approach (Virginia Mason)

• Electronic tools (Penobscot Community Health Care, MetroHealth, Johnstown Free Medical Clinic)

• Comprehensive treatment plans (Weill Cornell Medicine, Advocate Health Care)
Community Education

- Attendance at local high school basketball games
- School assembly
- Parent teacher conferences
- 'Town Halls'
- Sponsored events
  - Church
  - Chamber of Commerce
  - Local Business Organizations
  - Local Charities/Community Organizations
  - Local/Regional/State Pharmacy Groups
- Federal/State legislative groups

- Medication disposal boxes
- Naloxone Initiatives
  - Standing orders
  - Collaborative practice
- MAT Collaboration/Dispensing
- Conduit to Community Resources
- Community Partnerships
- Pharmacy Organization Involvement
Medication Disposal Boxes

Opportunity Exists

Source Where User Obtained

- More than One Doctor (2.8%)
- One Doctor (21.2%)
- Free from Friend/Relative (52.9%)
- Other (4.3%)

Source Where Friend/Relative Obtained

- One Doctor (83.8%)
- More than One Doctor (3.3%)
- Free from Friend/Relative (5.1%)
- Bought/Took from Friend/Relative (4.6%)
- Drug Dealer/Stranger (4.3%)
- Other (1.2%)

Naloxone Initiatives

Pennsylvania

- Standing orders
  - April 2015
    - Allows for distribution of naloxone by law enforcement and fire fighters
  - October 2015
    - Allowed for layperson access to naloxone

- Education and Distribution Programs
  - Adapt Pharma Partnership for access in schools
  - Prevention Point Pittsburgh

Credit: Mia Lussier, Geisinger summer intern
Discussion:

Do you offer naloxone to your patients with their opioid prescription (if you work in a state that has a standing order)?

- Prescriber Monitoring Tools
  - PDMP
  - Clinic prescribing dashboards
  - Health Plan utilization dashboards
  - Medicare Part D prescribing map

- Addiction/Diversion
  - ‘Red Flags’
  - Risk screening tool utilization
  - Understanding addiction
PDMP

Roles

• Identifying patients potentially abusing/diverting meds (and thus may need substance abuse resources)
• Monitoring prescribing habits and patterns by medical boards or govt. agencies Informing community or population based strategies and/or resource allocation
• Identifying patients potentially abusing/diverting meds (and thus may need substance abuse resources)

Demonstrated the ability to decrease opioid usage in general, decrease prescribing of CIIIs, and decrease drug related overdose deaths….one study in 2016 estimated that if all states had an enhanced PDMP program, they could prevent 600 deaths/year. BUT…..they are ONLY effective if they are used

PDMP

Challenges

• Communication gaps when query requirements change
• Stigma over PDMP (e.g. ‘big brother watching’)
• May not cross over state lines
• Short term will likely see increase in heroin use
• Increased burden on addiction treatment centers
• Logistics and time requirements
System Prescribing Dashboard

Monitoring/Tracking at Prescriber, Region, and System Level
- Real-time data on outcomes and prescribing patterns ('eye-opening')
- Monthly report-outs
  - Pharmacy and Medical Director partnership
  - Targeted Interventions
- 'Education needs' assessment

Population Level Decision Making
- Identify patient population
- Identify areas of opportunity or 'hot spots'
- Align resource(s) with need
- Auto-referrals to additional resources, such as clinical pain pharmacist

System of Care for Patients with Chronic Pain Grant 1G07

System of Prescribing Dashboard

SYSTEMWIDE CONTROLLED SUBSTANCE PRESCRIBING

<table>
<thead>
<tr>
<th>Total patients on opioids</th>
<th>Orders for patients on benzos &amp; opioids</th>
<th>Cumulative MED</th>
<th>MED per patient</th>
<th>Orders for patients with MUA</th>
<th>Orders for patients with toxicology report</th>
<th>Orders for patients with ED visits in last year</th>
<th>Orders for patients with naloxone admin at ED</th>
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<tr>
<td>First Draft</td>
<td>Concept</td>
<td>TOTAL NUMBER</td>
<td>MED Number</td>
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| Geisinger Primary Care Providers Panel View - Including Historical Opioid Orders

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Health Plan Utilization Dashboards

- Appropriate prescribing and abuse monitoring via….
  - Prior Authorization process around MED and day supply limits

- Weekly reports on….
  - Members who have filled a prescription for an opioid and then a prescription for suboxone
  - Cumulative opioid MED report for Medicare members with greater than or equal to 10% increase in MED of their prescribed opioids

- Monthly report on….
  - GHP Family members with claims for drugs that exceed 120 MED over a 90 day period, filled prescriptions at 3 or more pharmacies and prescribed by 3 or more prescribers over a 6 month period

- Outreach to providers as needed

Medicare Part D Map
‘Red Flags’

- **Patient**
  - Appearance
  - Behavior
  - Opioid agreement refusal
  - Urine tox screen refusal
  - Rx for large quantity for acute issue or post-op course
  - Long distance travel to pharmacy or MD
  - Cash payment when insured

- **Monitoring tool discrepancies**
  - ‘Cocktails’ of abusable drugs or multiple opioids

- **Multiple…**
  - Dose escalations
  - Rxs from ‘non-coordinated’ sites
  - Prescribing physicians
  - Rxs but only wants opioid Rx filled

- **Prescription**
  - Refusal to fill at other pharmacies
  - Adulterated appearance
  - MD scope of practice mismatch

**Discussion:**

Do you counsel your patients about misuse and abuse?
Risk Assessment Tools

PEG validated. 3 item tool to assess pain intensity, interference with enjoyment of life and interference with general activity (Wolfe, 2009)
PEG score = average the Equations. 30% Improvement is clinically meaningful

The following are some quick questions for their pain. Please circle. There are no right or wrong answers.

Print Name ______________________

1. How often do you have pain?
2. How often have you felt the need to treat your pain?
3. How often have you become impatient with your doctor?
4. How often have you felt that things are too overwhelming that you can’t handle them?

Understanding Addiction

“Equal opportunity disease”
- Can happen to anyone in spite of age, sex, race, socioeconomic status
- Heroin users in the 1970’s and 80’s:
  - urban minority
- Heroin users today:
  - White men and women (many introduced through prescriptions opioids)

Is it their choice?
- Initial decision to misuse a substance is voluntary
- Stopping is not always voluntary
  - it is commonly misunderstood
- Changes in the brain over time due to substance misuse impair:
  - Self-control
  - Ability to make sound decisions
  - Create an intense impulse to continue using desired substance
do we need references
Greskovic, Gerard, 5/26/2018
Understanding Addiction

• Individual Risk Factors:
  – Family history of abuse or addiction
  – History of mental disorder
  – History of physical abuse or neglect
  – Household instability
  – History of substance use during adolescence

• In persons with genetic predisposition, the reward (i.e. release of dopamine) can be up to 10X greater than in "normal" brain

![ normal vs addict brain illustration ]

• Medication Management/Pain Consult Service
  – Example: Geisinger MTDM Program

• Opioid Tapering

• Carepath Development
• Multi-disciplinary Team
Opioid Tapering: Indications

- Severe adverse effects
- Lack of benefit or effectiveness
- Evidence of illegal or unsafe behaviors
- Signs/symptoms of substance use disorder
- Patient desire to discontinue
- Non-adherence
- Reduced/inadequate functioning and quality of life
- Goals of treatment are not met

Opioid Taper: Challenges

**Patient**
- Recognizing other comorbid conditions
- Non-compliance
- Prescribed high doses of opioids
- Fear

**Provider**
- Uncertainty and minimal education to manage patient reactions
- Information/explanation for taper insufficient
- Biopsychosocial assessment
Opioid Tapering: Steps

- Patients may refuse – it is their right!
- Reinforce your rationale
- High emphasis on education
- Share success stories
- Engage social network
- Write out your plan
  - Incorporate coping mechanisms
- Focus on the improved function
- Be fact-based not emotion-based
- Assess for substance use disorder and behavioral health

Opioid Tapering: Carepath
Discussion:

What barriers to your role do you foresee?
Multidisciplinary Program Build
Critical Steps

Needs Assessment
- Clinician Request
- System Initiative
- Data Analytics

Feasibility
- Financials/Reimbursement
- Clinician/Leadership Support
- Spatial logistics
- Justification (i.e. cost/benefit analysis)

Operational Foundation
- EHR build
- Staffing/Resources
- Collaborative Agreement/Clinician Partnership

Education
- Clinician
- Pharmacist
- Patient

Potential Barriers
Buy-in
Stigma
Logistics
Current Guidelines
Lack of Resources
Knowledge Gaps
Multidisciplinary Program Build

Justification

- Cost reduction/ROI:
  - Improve treatment of pain, decrease cost of pain and decrease misuse of opioids
    - Average annual direct healthcare cost to treat ONE patient with chronic pain=$32,000….can we impact this with better treatment?
    - Decrease system utilization: opioid misusers are 25x more likely to require hospitalizations

- Patient/Provider satisfaction:
  - Decrease in provider turnover (cost of physician turnover → over $1 million due to lost revenue, start-up costs, and recruitment)

- Improvement in physician access through medication mgmt. programs

- Increase in community visibility = increase in store traffic

- Revenue generation
  - Direct billing/contracting with providers/payors


Questions