HQIC Community of Practice Call

Reducing Opioid Misuse: Leveraging Alternative Pain Management Therapies

January 11, 2024

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

Welcome!

Shaterra Smith
Social Science Research Analyst
Division of Quality Improvement Innovation Models Testing
iQuality Improvement and Innovations Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Agenda

- Introduction
- Today's topic: Reducing Opioid Misuse: Leveraging Alternative Pain Management Therapies
- Open discussion
- Closing remarks

Genesis for Event

- Leverages the DVA learning infrastructure for cross-task order resources to address opioid reduction
- Listened to your input
  - SOW review
  - Assessment
- Convened CMS subject matter experts
  - Anita Thomas, Leah Kneppar, Sabrina Chakhtoura and Roger Liu

Opening Remarks

Welcome from CMS!

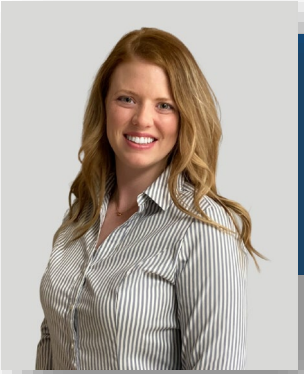
Roger Liu, PharmD
Commander, United States Public Health Services (USPHS)
Centers for Medicare & Medicaid Services (CMS), Seattle
iQuality Improvement and Innovation Group (iQIIG)
Division of Quality Improvement Innovation Models Testing (DQIIMT)

As You Listen, Ponder…

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Meet Your Speakers

Jen Brockman, MHA, BSN, RN
Chief Clinical Program Officer
Iowa Healthcare Collaborative



Susan Bradley, PharmD
Pharmacist Consultant
Stader Opioid Consultants
Director of Education
CMS/IHC Compass Opioid Prescriber Safety and Support Program

Agenda

- Provide background on how IHC supports providers, with a focus on alternatives to opioid-based pain management therapies.
- Review available resources and approaches.
- Discuss/highlight any clinical tools that may assist providers with choosing the most clinically appropriate non-opioid pharmacologic or non-pharmacologic alternative pain management for their patient.
- Discuss how health equity has been incorporated into the resources or trainings.

SUPPORT Act

- 2018 Federal legislation to address opioid addiction
  - The SUPPORT Act: Section 6052 of Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
- Supporting improvement of prescribing practices to advance opioid stewardship alongside eligible clinicians across the nation

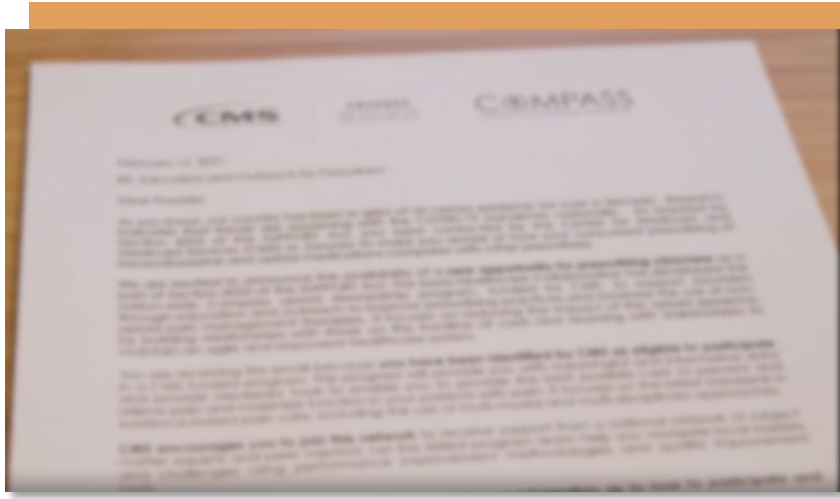
Program Goals

Educate and provide outreach to outlier prescribers of opioids about **best practices for prescribing opioids**

Educate and provide outreach to outlier prescribers of opioids about **non-opioid pain management therapies**

Reduce the number of opioid prescriptions prescribed by outlier prescribers of opioids.

Enrolling Outlier Prescribers



8 Pillars of Opioid Stewardship

Pain and Symptom Control

Side Effects and Risks of Opioid Therapy

Chronic Opioid Therapy(COT) Risk Management

Identification and Treatment

Opioid and Benzodiazepine Therapy Management

Harm Reduction

Communication

Risk Mitigation

Roadmap to Success

Building Knowledge	• 8 Core Lectures – Self Paced • Core Reading list	• Multiple On-Demand Podcast Series
Current Practice and Coaching	• Chart Review • Peer Mentorship and Coaching	
Quality Improvement	• Selected Based on Clinician Need • Based on 8 Pillars of Opioid Stewardship	• Pain Control, Screening & Monitoring, Documentation, Naloxone & Harm Reduction, OUD, etc.
Data and analytics functions	• Burden Reduction • Quarterly Provider Dashboard Dissemination	• Customer Service Feedback Collection
Community of Practice	• iCompass Communications • Attendance of Live Case-based Community of Practice Events	• Submit Case or Questions

Coaching and Education

- Individualized coaching based on provider needs
- Chart review
- Monthly live Grand Round events (Community of Practice)
- Compass On-Call (weekly office hours)
- Multiple podcast series:
  ihconline.org/initiatives/ambulatory/opioid-stewardship-program/podcasts
  - Program Podcast
  - Clinical Case Series (includes mini-series on motivational interviewing)
  - Mini-series on health equity and health disparities
  - Stigma mini-series
  - Expert Spotlight
  - Coaches Top 5 Weekly Article Review

Health Equity

- Podcast mini-series on health equity and health disparities
- Use of National CLAS Standards to target educational topics and develop strategies to support enrolled clinicians
- 5–10-minute focus on health equity topic during monthly Community of Practice events
- Health equity topics in weekly article reviews and corresponding podcasts
- Provider data dashboards inclusive of age, gender, race and ethnicity data

Compass OPSS Toolkits

MULTIMODAL ANALGESIA FOR PAIN CONTROL

OPIOID RISKS + SIDE EFFECTS

RISK MANAGEMENT FOR COT PATIENTS

OPIOID + BENZODIAZEPINE TAPERING

NALOXONE + OVERDOSE PREVENTION

OPIOID USE DISORDER + BUPRENORPHINE

PATIENT COMMUNICATION SKILLS

DOCUMENTATION + CHARTING BEST PRACTICES

- Opioid Prescribing + Treatment Guidance Toolkit
- Opportunities identified:
  - Patient Facing Toolkit
  - Perinatal Substance Use Toolkit

Non-Opioid Pain Management

Treatment Algorithm

Treatment	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1st Line	Nonpharmacological		
	Acute trial of nonsteroidal anti-inflammatory drug/acetaminophen		
	Add topical agent (nonsteroidal anti-inflammatory drug, lidocaine, capsaicin, menthol)		
		Gabapentinoids	
		Serotonin-norepinephrine reuptake inhibitor	
		Tricyclic antidepressant	
2nd Line Intended to be added to 1st-line therapy, when appropriate	Serotonin-norepinephrine reuptake inhibitor	Antiepileptics	Gabapentinoids
	Tricyclic antidepressant		Serotonin-norepinephrine reuptake inhibitor
			Tricyclic antidepressant
	Condition-specific pharmacologic agents		
	Consider referral to specialist		
3rd Line Intended to be added to 1st and 2nd – line therapy, when appropriate	Acute add-on muscle relaxer		
	Interventional therapy		
	Consider short (<7 days) trial of opioid agent* for breakthrough pain		
	Referral to specialist		

*Monoproduct opioid agents are preferred (rather than combination agents) so that acetaminophen can continue to be scheduled around the clock. Monoproducts include morphine sulfate IR, oxycodone IR, and tramadol.

Adopted from the West Virginia Safe & Effective Management of Pain (SEMP) Guidelines. www.sempguidelines.org.

Non-Opioid Pain Management

Table 1 | Summary of Multimodal Analgesic Agents

Type	Example
Nonopioid analgesics	APAP, NSAIDs (Cox-1, 2, 3 inhibitors)
Amine reuptake inhibitors	Duloxetine, venlafaxine, amitriptyline, nortriptyline
Antipsychotics	Haloperidol, olanzapine
Gabapentinoids/antiepileptics	Gabapentin, pregabalin, carbamazepine, topiramate
Glucocorticoids	Dexamethasone, prednisone
Local anesthetics/sodium channel blockers	Lidocaine, bupivacaine
Muscle relaxants/antispasmodics	Cyclobenzaprine, tizanidine, methocarbamol, metaxalone, baclofen, dicyclomine
Other topicals	Capsaicin, diclofenac, lidocaine, menthol

Non-Opioid Pain Management

Condition-Specific Pharmacologic Agents

- **Bursitis/Joint Pain:** steroid injection
- **Headache/Migraine Prevention/Treatment:** steroid, propranolol, antiepileptic, sumatriptan, caffeine, magnesium supplement, BOTOX injections
- **Abdominal Pain:** metoclopramide, prochlorperazine, olanzapine, haloperidol, dicyclomine

Nonpharmacologic Treatments

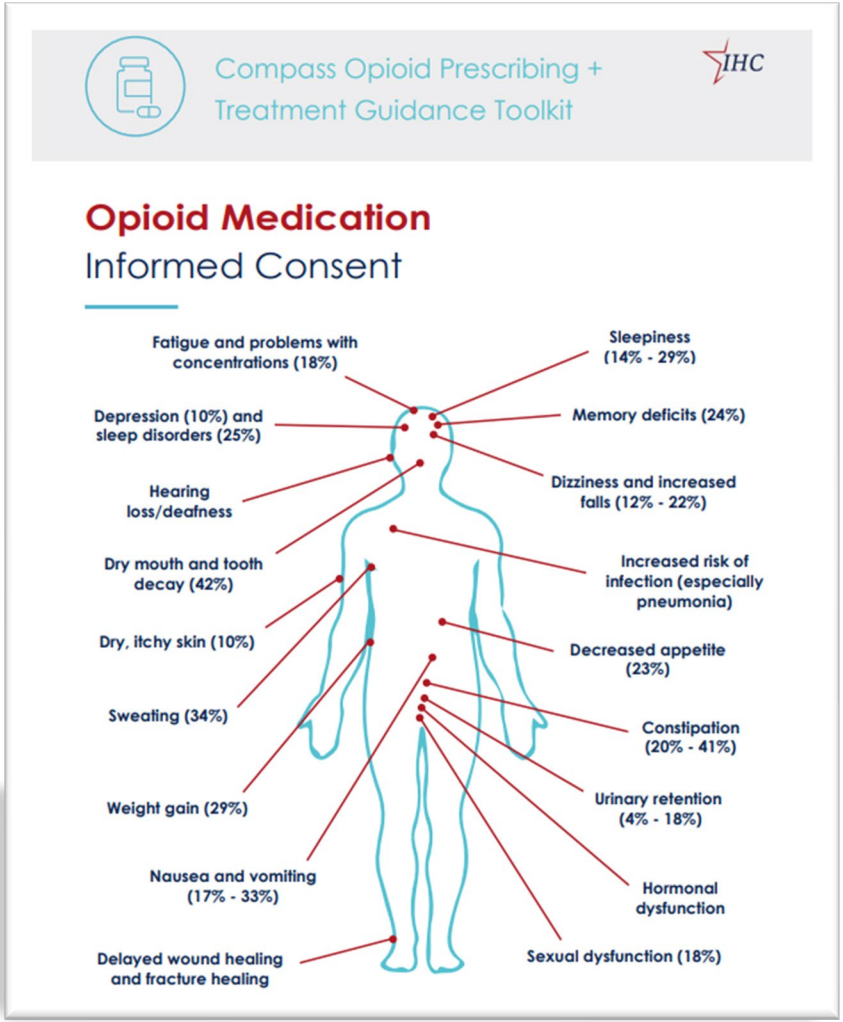
- **Lifestyle Modification:** exercise, diet/nutrition, weight management, sleep restoration, mindfulness-based stress reduction
- **Physiotherapy Options:** physical therapy, occupational therapy, therapeutic exercise, massage
- **Procedure-Based Interventions:** trigger point injection, dry needling, nerve block, steroid injection, ablation, TENS, ice, heat, compression, elevation, splinting, orthotics
- **Complementary and Alternative Treatments:** Acupuncture, manipulative therapy, herbals, dietary supplements, phyto-chemicals

Behavioral Treatment Options

- **Psychotherapy:** cognitive behavioral therapy, group therapy, individual counseling, breathing and relaxation exercises, biofeedback therapy, sleep hygiene psychoeducation
- **Substance Use Disorder Treatment:** medication assisted treatment referral,
- **Trauma-Related Care:** screening for domestic violence, child abuse, PTSD
- **Group-Based Education:** shared medical appointments, peer-to-peer meetings, preventive workshops

Patient Facing Resources

- Providing informed consent
- Supporting shared decision making
- Opportunities identified:
  - Promoting health literacy
  - Translation to Spanish



Pain Management– Patient Handbook

Controlled Substance Agreement: a mutual agreement between you and your healthcare provider that outlines the responsible use of prescription medications, ensuring your safety and the effectiveness of treatment while minimizing the risk of misuse or addiction.

PEG Scale: a three question scale will be utilized during your clinic visits to help your provider better understand your pain level and the impact on your life.

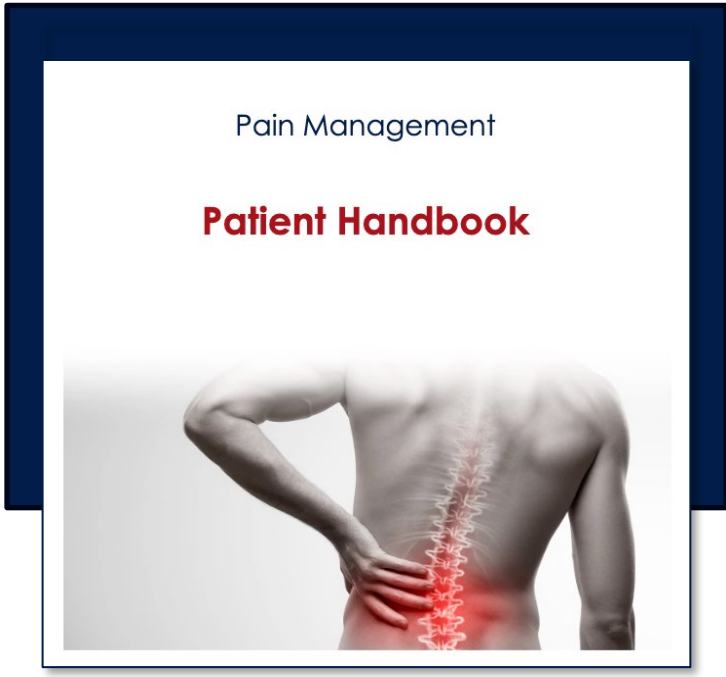
COMM: The Current Opioid Misuse Measure: a measure to help patients and healthcare providers understand the level of risk or concern regarding opioid misuse, allowing for more informed discussions and personalized strategies for safer and more effective pain management when opioids are prescribed.

Introduction to Pain: an overview of pain to help patients understand the difference between nociception, pain, suffering and acute versus chronic pain.

Non-Pharmacologic Treatment Options: alternative treatment options such as physical therapy, acupuncture, relaxation techniques, and exercises, which can help reduce pain and improve your overall well-being.

Buprenorphine: an opioid that is frequently used for pain management because of its effectiveness in relieving moderate to severe pain, particularly in cases where other opioids may pose a higher risk of addiction or misuse.

Pain Journal: a place to keep a detailed record of your pain symptoms, triggers, and treatments, which can help both you and your healthcare provider better understand and manage your pain over time.



Pain Management- Patient Handbook

PEG Scale

PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Computing the PEG Score.
Add the responses to the three questions, then divide by three to get a mean score (out of 10) on overall impact of points.

Using the PEG Score.
The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

Source.
Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738. http://doi.org/10.1007/s11606-009-0981-1

Current Opioid Misuse Measure (COMM)

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

Pain Management- Patient Handbook

Pain Journal

Month: _____

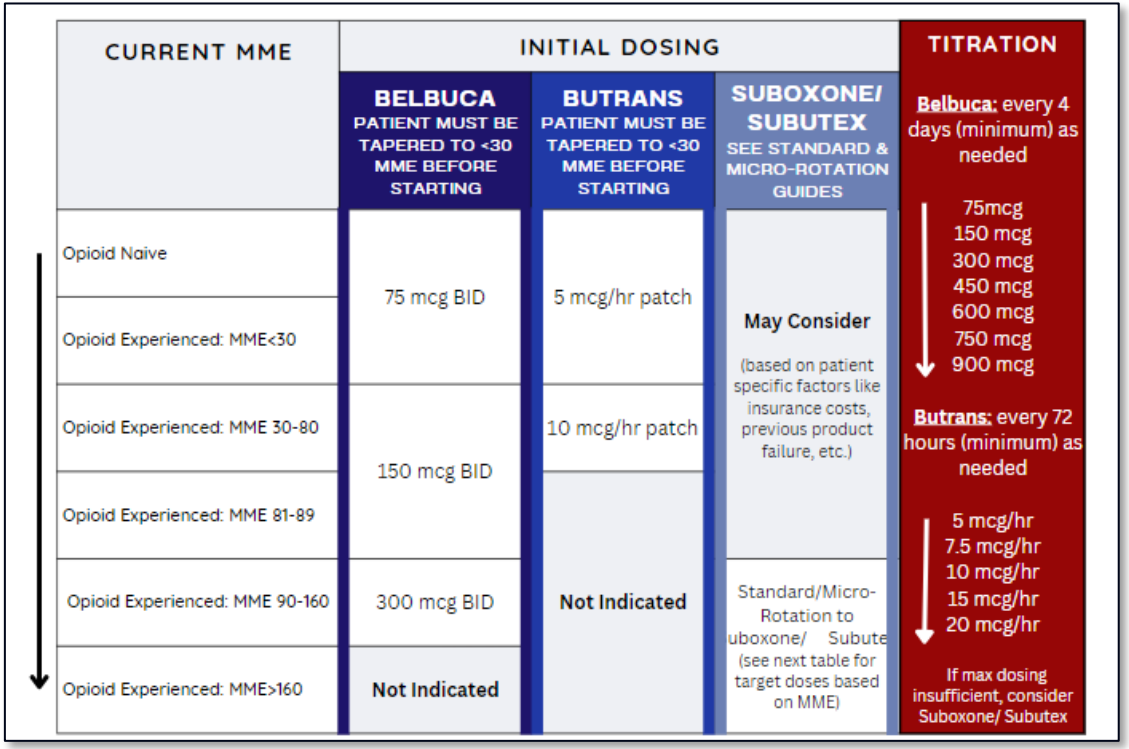
Use this journal to record the intensity, triggers, and any activities or treatments that affect your pain, helping you and your healthcare provider better understand and manage your pain over time.

Day	Hours of Sleep Last Night	Type of Exercise and Time Spent	Lowest Pain Score Today (1-10)	Highest Pain Score Today (1-10)	Average Pain Score Today (1-10)	Pain Triggers Today	Pain Medications Taken Today and How Much	Non- Pharmacologic Pain Treatments Today
1st								
2nd								
3rd								
4th								
5th								
6th								

Podcast Series

- Motivational Interviewing Podcast Series:
  Compass Opioid Stewardship Clinical Cases on Apple Podcasts
  - A counseling approach that involves a collaborative and empathetic conversation between the provider and the patient.
  - It is aimed at eliciting and strengthening the patient's own motivation and commitment to change through the exploration of values, goals and reasons for change.
  - It includes techniques such as: reflective listening, open-ended questioning and positive affirmations.

Buprenorphine for Pain: MME Based Decision Guide



CURRENT MME	INITIAL DOSING			TITRATION
	BELBUCA PATIENT MUST BE TAPERED TO <30 MME BEFORE STARTING	**BUTRANS** PATIENT MUST BE TAPERED TO <30 MME BEFORE STARTING	**SUBOXONE/ SUBUTEX** SEE STANDARD & MICRO-ROTATION GUIDES	**Belbuca:** every 4 days (minimum) as needed 75mcg 150 mcg 300 mcg 450 mcg 600 mcg 750 mcg 900 mcg **Butrans:** every 72 hours (minimum) as needed 5 mcg/hr 7.5 mcg/hr 10 mcg/hr 15 mcg/hr 20 mcg/hr If max dosing insufficient, consider Suboxone/ Subutex
Opioid Naive	75 mcg BID	5 mcg/hr patch	**May Consider** (based on patient specific factors like insurance costs, previous product failure, etc.)	
Opioid Experienced: MME<30				
Opioid Experienced: MME 30-80	150 mcg BID	10 mcg/hr patch		
Opioid Experienced: MME 81-89		**Not Indicated**		
Opioid Experienced: MME 90-160	300 mcg BID		Standard/Micro-Rotation to uboxone/ Subute (see next table for target doses based on MME)	
Opioid Experienced: MME>160	**Not Indicated**			

Buprenorphine for Opioid Use Disorder: Low Dose Induction

Transition to Buprenorphine and Microinduction:

- General Concept[2]
  - Precipitated withdrawal during buprenorphine induction is a common concern, especially if preceded by recent exposure to full opioid agonists. Therefore, traditional recommendations are to initiate buprenorphine once the patient is already showing signs of withdrawal.
  - To facilitate the transition from full opioid agonists to buprenorphine, consider introducing buprenorphine in a microinduction approach.
  - By utilizing buprenorphine's dose-dependent effects of mu-opioid receptor resensitization and upregulation, opioid tone is maintained while allowing a faster taper of full opioid agonists and posing minimal risk of precipitated withdrawal.
- Buprenorphine Microinduction
  - Introduce small doses of buprenorphine (0.25-2mg/day SL bup) and gradually increase the dose and frequency while co-administering full opioid agonists until a therapeutic dose of buprenorphine is reached.
  - Once therapeutic doses of buprenorphine are achieved, the full opioid agonist therapy can be discontinued or more quickly tapered than traditionally tolerated (5-10 days).
- Candidates
  - OUD, Previously failed attempts at opioid tapering, Suspected opioid-associated hyperalgesia, Needed quick taper (e.g. recent overdose), Patients fearful of withdrawing during taper
- Buprenorphine Microinduction Patient/Clinical Tool

2 – 0.5mg Suboxone Film

The first strip will be cut into 2 pieces

Half of it is then cut into 2 pieces (1/4 of a strip).

Take Suboxone According to the Table Below

Day 1: Begin to cut down your opioid use
Day 2 – 6: Continue to cut down on opioid use and utilize comfort medications
Day 7: Aim to stop other opioid use by this day

	AM	PM	Date (write in)
1	¼ film	-	
2	¼ film	¼ film	
3	½ film	½ film	
4	1 film	1 film	
5	1 ½ film	1 ½ film	
6	2 films	2 films	
7	2 – 3 films	2 – 3 films	

Time Point	Standardized Buprenorphine Microinduction Recommendation	
	Bup-nal Recommendation	Full Opioid Agonist Recommendation
Day 1 (Initial Appt)	0.5mg-0.125mg (¼ strip) SL daily	Continue current dose/use
Day 2	0.5mg-0.125mg (¼ strip) SL BID	Continue current dose/use
Day 3	1mg-0.25mg (½ strip) SL BID	Continue current dose/use
Day 4	2mg-0.5mg (1 strip) SL BID	Reduce dose/use by 25%
Day 5	3mg-0.75mg (1 ½ strip) SL BID	Reduce dose/use by 25%
Day 6	4mg-1mg (2 strips) SL BID	Reduce dose/use by 25%
Day 7 (Follow-Up Appt)	6mg-1.5mg (3 strips) SL BID	Reduce dose/use by 50%
Day 8	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	Reduce dose/use by 50%
Days 9-11	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	Reduce dose/use by 50-75%
Days 12-13	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	Reduce dose/use by 75%

1:1 Coaching

- Each of our providers are paired with a clinical coach
- Coaches provide
  - Customized tapers
  - Patient specific rotations to buprenorphine
  - Recommendations to improve practices
  - Other tools for success
- Opportunity identified:
  - Pilot on call service instead of office hours

Compass On Call

720.689.3778

AVAILABLE EVERY WEDNESDAY FROM 9AM-5PM EST

CALL OR TEXT

- Service begins January 3rd, 2024
- Calls will be directed to one of the Compass Clinical Coaches
- If the clinican is assisting someone else, please leave a message and your call will be returned within 30 minutes

Success Stories

Dr. N

- Flagged by CMS four times (2020, 2021, 2022, 2023)
- Joined Compass in July 2021
- Completed MAT training, coaching sessions, QI project and learning modules
- Graduated from the program in October 2023
- Achieved 37.4% reduction in opioid claims
- Reports 80-100% of patients rate their pain as controlled
- Implemented the following performance improvements in her practice:
  - Rotation to buprenorphine
  - Naloxone prescribing and harm reduction counseling
  - Utilization of controlled substance agreements with patients
  - Initiation of opioid tapers

Success Stories

Dr. G

- Flagged by CMS twice (2022 & 2023)
- Joined Compass in September 2022, and is still in the program
- Rural provider in underserved area with many patients limited by factors such as transportation, socioeconomic status, insurance/payor mix, lack of specialty services, lack of internet & phone lines, lack of electricity & water.
- IHC has worked with entire office staff, including several clinical pharmacists to enhance their ability to provide specialty services, including:
  - Chart reviews for several patients
  - Recommendations and technical assistance on clinical care
- Achieved 24.8% reduction in opioid claims, 32.5% reduction in high dose opioid claims (>50MME), and 26.6% reduction in opioid and benzodiazepine co-prescribing claims

Data and Analytics

- Self reported data collected from providers quarterly
- Customer service satisfaction data collected to inform efforts
- CMS Part D data used to monitor prescribing habits
- Provider dashboards to display demographics for patient population
- Use of population level data to drive mitigation strategies

Results to Date

Reduction in Opioid Prescribing

- 74,211 fewer opioid claims
- 18.11% reduction in opioid claims
- 3,394 fewer beneficiaries receiving opioids

Reduction in High Dose Opioid Prescribing - >50 MME

- 6,303 fewer claims >50 MME
- 20.76% reduction in opioid claims >50 MME
- 486 fewer beneficiaries receiving opioids prescriptions >50 MME

Reduction in Opioid and Benzodiazepine Co-prescribing

- 2,137 fewer co-prescription claims
- -2.29% reduction in co-prescription claims
- 119 fewer beneficiaries receiving opioid and benzodiazepine co-prescriptions

Cost Savings

- $5,806,940 saved in **opioid drug costs**
- $2,497,984 saved in medical costs related to **opioid use/OUD**
- $16,970 saved in additional medical costs related to **averted fatal opioid overdose**
- $1,683,424 saved in additional medical costs saved from. **averted non-fatal opioid overdose**
- 27.15 lives saved

Compass OPSS Team Contact Information

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CMS | OPIOID PRESCRIBER SAFETY AND SUPPORT OPSS | COMPASS OPIOID STEWARDSHIP PROGRAM

Questions?

Thank you

Discussion

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on February 8, 2024
from 1:00 – 2:00 p.m. ET

We invite you to register at the following link:
https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post assessment.

We will use the information you provide to improve future events.