

Welcome to UVM ECHO: Treatment of Chronic Pain

Facilitators: Mark Pasanen MD, Liz Cote

May 3, 2019



The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM

www.vtahec.org



Introduction to ZOOM

- Mute microphone when not speaking
- Position webcam effectively
- Test both audio & video
- Use “chat” function for:
 - Attendance—type name and organization of each participant upon entry to each teleECHO session
 - Technical issues
- Communicate clearly:
 - Use “raise hand” feature; the ECHO team will call on you
 - Speak clearly



CME disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this educational activity for a maximum of 1.5 AMA PRA Category 1 Credits. Participants should claim only the credit commensurate with the extent of their participation in the activity.

Interest Disclosures:

- As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.



No relevant disclosures

Planners:

- Elizabeth Cote
- Mark Pasanen, MD
- Charles MacLean, MD

Faculty/Guest Faculty:

- Mark Pasanen, MD
- Patti Fisher, MD
- Charles Maclean, MD
- Carlos Pino, MD
- Jon Porter, MD
- Mac Abernathy, MD



OBJECTIVES

- Review current recommendations for best practices for opiate prescribing and identify opportunities for improvement
- Discuss options for compassionate tapering opiates in patients who are
 - (a) no longer candidates for opiates
 - (b) not benefiting from treatment
- Incorporate function into assessment of patients with chronic pain
- Learn how to assess patients on chronic opiates for misuse
- Identify and treat psychological factors related to chronic pain
- Discuss the evidence for treating patients with interventional procedures
- Understand the role of urine drug testing in patients with chronic pain, and improve skills in interpreting these tests
- Understand the role of integrative therapies, including acupuncture
- Incorporate motivational interviewing into care of chronic pain patients
- Learn how to conduct group visits, including benefits and barriers
- Discuss the evidence for cannabinoids in the treatment of chronic pain



2019-2020 PROGRAM SCHEDULE

DATES (All Fridays, 11:30am to 1pm)	SESSION	DIDACTIC TOPICS (in addition to case review)
May 3, 2019	TeleECHO Session #1	<ul style="list-style-type: none"> • Orientation to Project ECHO • Program Overview • Anatomy of teleECHO Session • Opiate-prescribing Best Practices
June 7, 2019	TeleECHO Session #2	<ul style="list-style-type: none"> • Compassionate Tapering
July 5, 2019	TeleECHO Session #3	<ul style="list-style-type: none"> • Functional Assessment of Patients with Chronic Pain
Aug 2, 2019	TeleECHO Session #4	<ul style="list-style-type: none"> • Assessing for Misuse/Addiction
Sept 6, 2019	TeleECHO Session #5	<ul style="list-style-type: none"> • Psychological Factors Related to Chronic Pain
Oct 4, 2019	TeleECHO Session #6	<ul style="list-style-type: none"> • Role of Interventional Pain
Nov 1, 2019	TeleECHO Session #7	<ul style="list-style-type: none"> • Urine Drug Testing/Monitoring
Dec 6, 2019	TeleECHO Session #8	<ul style="list-style-type: none"> • Acupuncture for Chronic Pain
Jan 10, 2020	TeleECHO Session #9	<ul style="list-style-type: none"> • Use of Integrative Therapies for Chronic Pain
Feb 7, 2020	TeleECHO Session #10	<ul style="list-style-type: none"> • Motivational Interviewing
March 6, 2020	TeleECHO Session #11	<ul style="list-style-type: none"> • Conducting Group Medical Visits
April 3, 2020	TeleECHO Session #12	<ul style="list-style-type: none"> • Cannabinoids for Chronic Pain



Goals for Session 1

1. What is ECHO?
 - a. Impact on care
 - b. Impact on providers
 - c. Format
2. Become familiar with case presentation format
3. Discuss first case – opiate continuation
4. Identify cases for subsequent sessions
5. Elicit feedback



Project ECHO

Project ECHO® is a lifelong learning and guided practice model that **revolutionizes medical education** and exponentially **increases workforce capacity** to provide **best practice specialty care** and **reduce health disparities** through its **hub-and-spoke** knowledge sharing networks



People need access to specialty care for complex conditions



Not enough specialists to treat everyone,

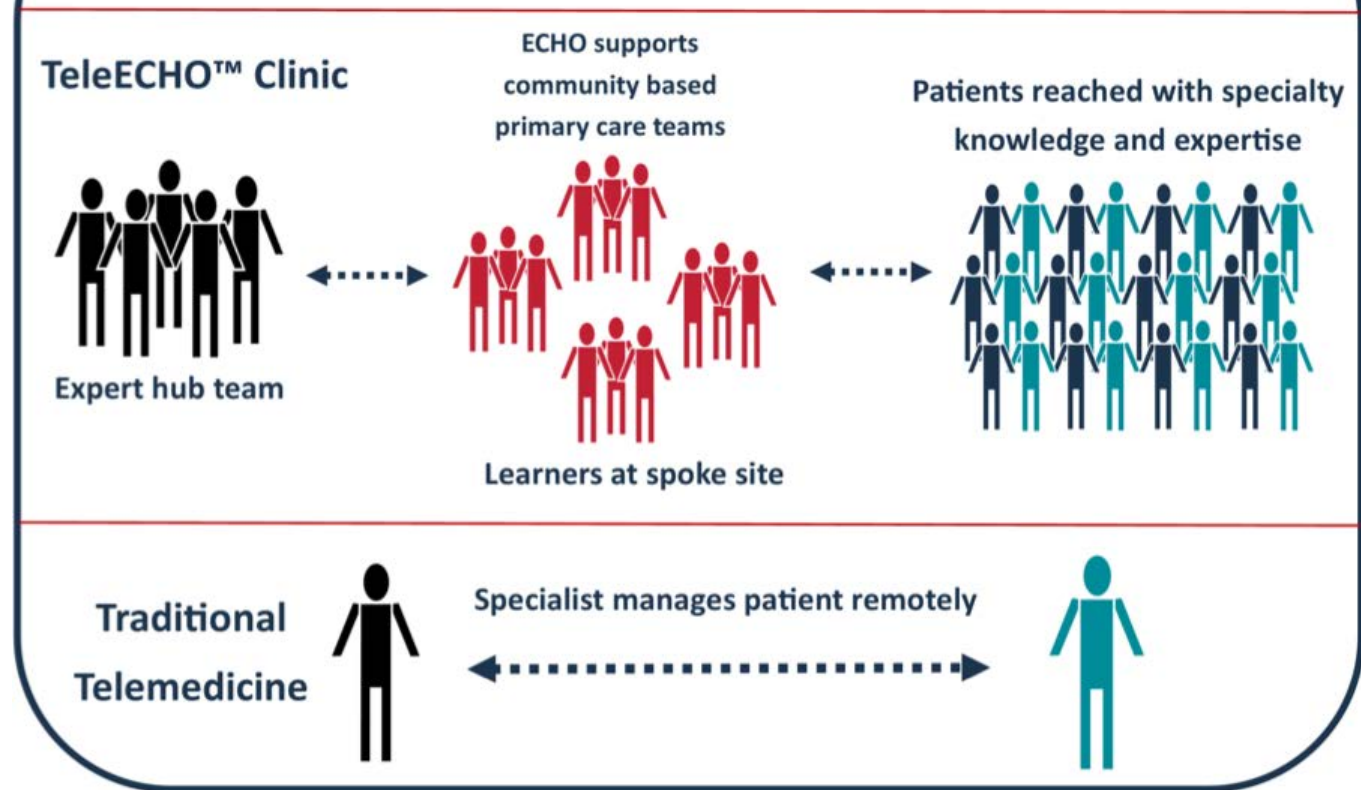


ECHO® trains primary care clinicians to provide specialty care services



Patients get the right care, in the right place, at the right time.

ECHO vs. Telemedicine



ECHO model is not ‘traditional telemedicine’.

Treating Physician retains responsibility for managing patient.

ECHO topics

- Common diseases
- Management is complex
- Evolving treatments and medicines
- High societal impact (health and economic)
- Serious outcomes of untreated disease
- Improved outcomes with disease management



What is Best Practice in Medicine

- Standardization
 - Algorithm
 - Check Lists
 - Process
- Wisdom Based on Experience
 - Case-based learning
 - Learn by doing
 - Volume of cases

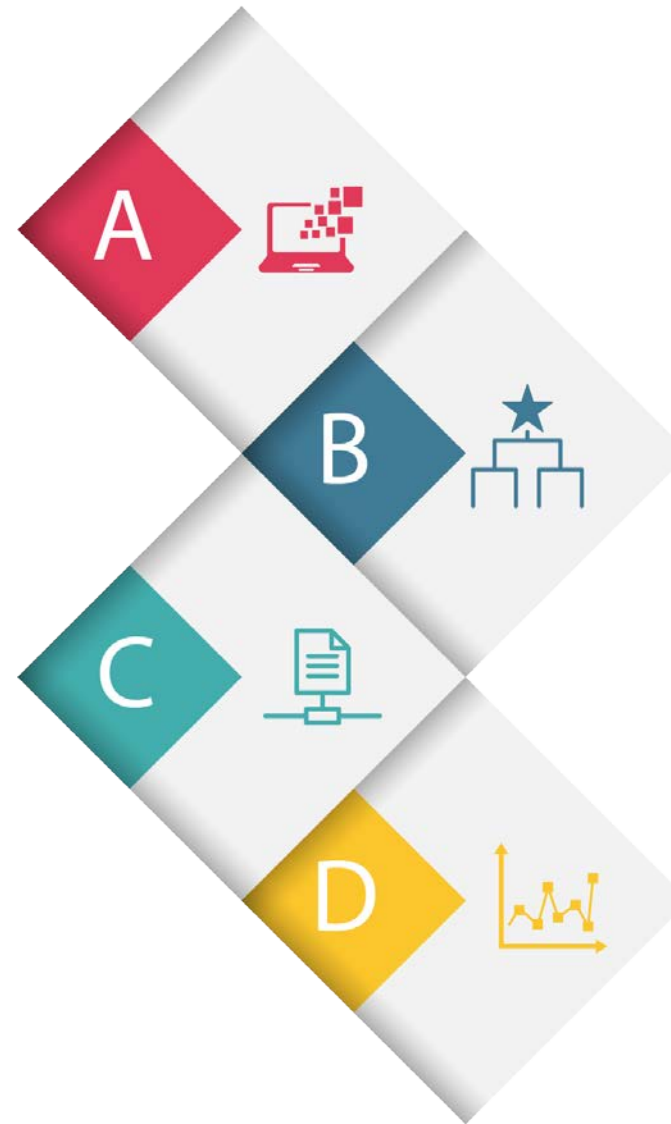
ECHO Model

Amplification – Use **T**echnology
to leverage scarce resources

Case Based Learning
to master complexity

Share **B**est Practices
to reduce disparity

Web-based **D**atabase to
Monitor **O**utcomes



Is ECHO effective? (Scale 1-5)

- My participation in Project ECHO benefits patients under my care whom I co-manage with ECHO specialists. 4.45
- The patients under my care whom I co-manage with ECHO specialists receive best-practice care. 4.43
- My participation in Project ECHO benefits the patients under my care whom I do not co-manage with ECHO specialists. 4.19
- Through the Project ECHO telehealth clinics, I am learning best-practice care in chronic disease. 4.68
- I am connected with peers in the ECHO telehealth clinic whose opinion I respect for professional advice and consultation 4.55
- I am developing clinical expertise through participation in Project ECHO 4.48

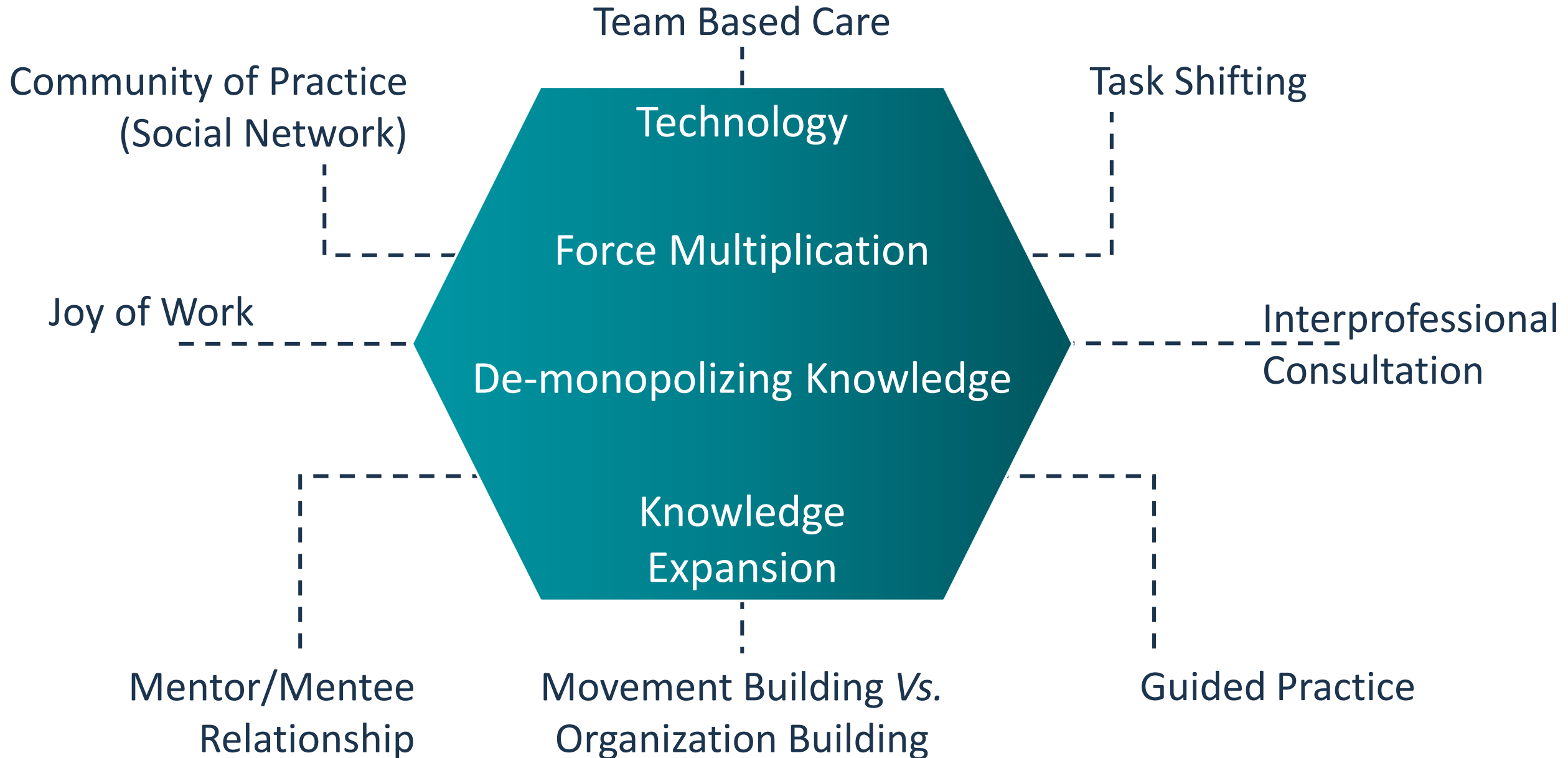


Other ECHO outcomes

- Enhances professional satisfaction
- Decreases professional isolation
- “Benefits my clinic”
- Expands access to treatment for patients
- Helps address limited access to specialists



What Makes ECHO Work?





ECHO Hubs & Superhubs: United States

Hub Locations

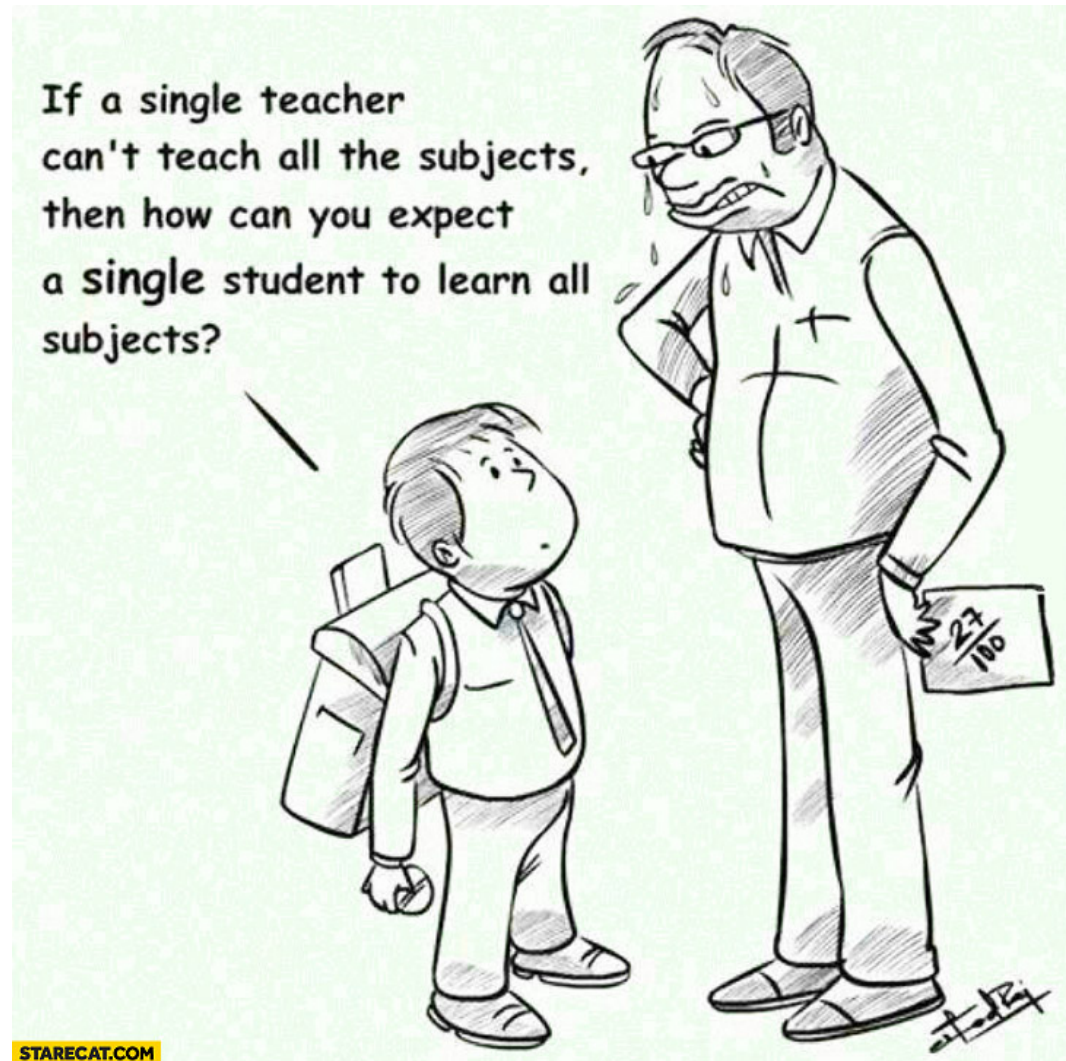


ECHO format

- Introductions
- Announcements
 - ZOOM etiquette
 - Review agenda
 - Follow-up
- Didactic (20-25 min)
- Case presentation
 - Spoke participant presents
 - Facilitator summarizes
- Clarifying questions
 - Participants – then hub
- Impression
- Recommendations
 - Participants – then hub
- Summary
 - Sent to presenter
- Closing Announcements
 - Submission of new cases
 - Completion of evaluations



ALL TEACH --- ALL LEARN



STARECAT.COM



The University of Vermont
LARNER COLLEGE OF MEDICINE



CDC – Guideline for Prescribing Opioids for Chronic Pain

1. Opioids are not first-line
2. Establish goals for pain/function
 - Includes plan to stop if not helping
3. Discuss risks and “realistic” benefits
4. Start with immediate-release
5. Use lowest effective dosage
 - Reassess for ≥ 50 MME
 - Rare use ≥ 90 MME
6. Short duration for acute pain
7. Evaluate benefits/harm regularly
 - Never longer than 3 months
8. Use strategies to mitigate risk
9. Review PDMP (VPMS)
10. Urine drug testing before/during treatment
11. Avoid opioids/benzos together
12. Treat opioid use disorder



CDC guidelines 2016

- Use alternatives to opioids if possible
- Explain the risks and benefits
 - Informed consent/treatment agreements
- Focus on function
- Start low and go slow
- Track progress carefully
 - Surveillance for misuse
- Avoid benzodiazepines

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When **CONSIDERING** long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If **RENEWING** without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When **REASSESSING** at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: What number from 0–10 best describes your **pain** in the past week?
0 = “no pain”, 10 = “worst you can imagine”

Q2: What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?
0 = “not at all”, 10 = “complete interference”

Q3: What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?
0 = “not at all”, 10 = “complete interference”



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

CS273808A

Vermont Guidelines – 2017

1. Recommend non-pharm/non-opioid treatment
 - NSAIDs, acupuncture, chiropractic, PT, osteopathic manipulation
2. Query VPMS
 - Prior to first opioid prescription (> 10 pills, includes tramadol)
 - At least annually (CDC every prescription, at least every 90 days)
 - Any replacement prescription
3. Provide patient education/informed consent
 - Includes acute pain
4. Prescribe naloxone
 - MME \geq 90 mg or concomitant benzodiazepine
5. Two hours of CME every 2 yrs on “controlled substance prescribing”
6. Exemptions: Cancer pain, nursing home



Other VT Prescribing Rules

- Acute pain limits
- VMPS annually
 - Every 4 months for non-deterrent opioids
 - Oxycodone > 30 mg
 - Hydrocodone > 40 mg
- Assessments of risk and function
- Lots of documentation
- Review treatment agreements Q year

Figure 1.0 – Opioid Limits for Adults Ages 18 Years Old or Older

Pain	Average Daily MME (allowing for tapering)	Prescription TOTAL MME based on expected duration of pain	Common average DAILY pill counts	Commonly associated injuries, conditions and surgeries
Minor pain	No Opioids	0 total MME	0 hydrocodone 0 oxycodone 0 hydromorphone	molar removal, sprains, non-specific low back pain, headaches, fibromyalgia, un-diagnosed dental pain
Moderate pain	24 MME/day	0-3 days: 72 MME 1-5 days: 120 MME	4 hydrocodone 5mg or 3 oxycodone 5mg or 3 hydromorphone 2mg	non-compound bone fractures, most soft tissue surgeries, most outpatient laparoscopic surgeries, shoulder arthroscopy
Severe pain	32 MME/day	0-3 days: 96 MME 1-5 days: 160 MME	6 hydrocodone 5mg or 4 oxycodone 5mg or 4 hydromorphone 2mg	many non-laparoscopic surgeries, maxillofacial surgery, total joint replacement, compound fracture repair
For patients with severe pain and extreme circumstance, the provider can make a clinical judgement to prescribe up to 7 days so long as the reason is documented in the medical record.				
Extreme Pain	50 MME/day	7 day MAX: 350 MME	10 hydrocodone 5mg or 6 oxycodone 5mg or 6 hydromorphone 2mg	similar to the severe pain category but with complications or other special circumstances

Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline

Roger Chou, MD; Richard Deyo, MD, MPH; Janna Friedly, MD; Andrea Skelly, PhD, MPH; Robin Hashimoto, PhD; Melissa Weimer, DO, MCR; Rochelle Fu, PhD; Tracy Dana, MLS; Paul Kraegel, MSW; Jessica Griffin, MS; Sara Grusing, BA; and Erika D. Brodt, BS

Background: A 2007 American College of Physicians guideline addressed nonpharmacologic treatment options for low back pain. New evidence is now available.

Purpose: To systematically review the current evidence on nonpharmacologic therapies for acute or chronic nonradicular or radicular low back pain.

Data Sources: Ovid MEDLINE (January 2008 through February 2016), Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and reference lists.

Study Selection: Randomized trials of 9 nonpharmacologic options versus sham treatment, wait list, or usual care, or of 1 nonpharmacologic option versus another.

Data Extraction: One investigator abstracted data, and a second checked abstractions for accuracy; 2 investigators independently assessed study quality.

Data Synthesis: The number of trials evaluating nonpharmacologic therapies ranged from 2 (tai chi) to 121 (exercise). New evidence indicates that tai chi (strength of evidence [SOE], low) and mindfulness-based stress reduction (SOE, moderate) are effective for chronic low back pain and strengthens previous find-

ings regarding the effectiveness of yoga (SOE, moderate). Evidence continues to support the effectiveness of exercise, psychological therapies, multidisciplinary rehabilitation, spinal manipulation, massage, and acupuncture for chronic low back pain (SOE, low to moderate). Limited evidence shows that acupuncture is modestly effective for acute low back pain (SOE, low). The magnitude of pain benefits was small to moderate and generally short term; effects on function generally were smaller than effects on pain.

Limitation: Qualitatively synthesized new trials with prior meta-analyses, restricted to English-language studies; heterogeneity in treatment techniques; and inability to exclude placebo effects.

Conclusion: Several nonpharmacologic therapies for primarily chronic low back pain are associated with small to moderate, usually short-term effects on pain; findings include new evidence on mind-body interventions.

Primary Funding Source: Agency for Healthcare Research and Quality. (PROSPERO: CRD42014014735)

Ann Intern Med. 2017;166:493-505. doi:10.7326/M16-2459

Annals.org

For author affiliations, see end of text.

This article was published at Annals.org on 14 February 2017.

Systemic Pharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline

Roger Chou, MD; Richard Deyo, MD, MPH; Janna Friedly, MD; Andrea Skelly, PhD, MPH; Melissa Weimer, DO, MCR; Rochelle Fu, PhD; Tracy Dana, MLS; Paul Kraegel, MSW; Jessica Griffin, MS; and Sara Grusing, BA

Background: A 2007 American College of Physicians guideline addressed pharmacologic options for low back pain. New evidence and medications have now become available.

Purpose: To review the current evidence on systemic pharmacologic therapies for acute or chronic nonradicular or radicular low back pain.

Data Sources: Ovid MEDLINE (January 2008 through November 2016), Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and reference lists.

Study Selection: Randomized trials that reported pain, function, or harms of systemic medications versus placebo or another intervention.

Data Extraction: One investigator abstracted data, and a second verified accuracy; 2 investigators independently assessed study quality.

Data Synthesis: The number of trials ranged from 9 (benzodiazepines) to 70 (nonsteroidal anti-inflammatory drugs). New evidence found that acetaminophen was ineffective for acute low back pain, nonsteroidal anti-inflammatory drugs had smaller benefits for chronic low back pain than previously observed, duloxetine was effective for chronic low back pain, and benzodiazepines were ineffective for radiculopathy. For opioids, evidence

remains limited to short-term trials showing modest effects for chronic low back pain; trials were not designed to assess serious harms. Skeletal muscle relaxants are effective for short-term pain relief in acute low back pain but caused sedation. Systemic corticosteroids do not seem to be effective. For effective interventions, pain relief was small to moderate and generally short-term; improvements in function were generally smaller. Evidence is insufficient to determine the effects of antiseizure medications.

Limitations: Qualitatively synthesized new trials with prior meta-analyses. Only English-language studies were included, many of which had methodological shortcomings. Medications injected for local effects were not addressed.

Conclusion: Several systemic medications for low back pain are associated with small to moderate, primarily short-term effects on pain. New evidence suggests that acetaminophen is ineffective for acute low back pain, and duloxetine is associated with modest effects for chronic low back pain.

Primary Funding Source: Agency for Healthcare Research and Quality. (PROSPERO: CRD42014014735)

Ann Intern Med. 2017;166:480-492. doi:10.7326/M16-2458

For author affiliations, see end of text.

This article was published at Annals.org on 14 February 2017.

Annals.org

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravelly, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

JAMA March 6, 2018 Volume 319, Number 9

DESIGN, SETTING, AND PARTICIPANTS Pragmatic, 12-month, randomized trial with masked outcome assessment. Patients were recruited from Veterans Affairs primary care clinics from June 2013 through December 2015; follow-up was completed December 2016. Eligible patients had moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. Of 265 patients enrolled, 25 withdrew prior to randomization and 240 were randomized.

INTERVENTIONS Both interventions (opioid and nonopioid medication therapy) followed a treat-to-target strategy aiming for improved pain and function. Each intervention had its own prescribing strategy that included multiple medication options in 3 steps. In the opioid group, the first step was immediate-release morphine, oxycodone, or hydrocodone/acetaminophen. For the nonopioid group, the first step was acetaminophen (paracetamol) or a nonsteroidal anti-inflammatory drug. Medications were changed, added, or adjusted within the assigned treatment group according to individual patient response.

RESULTS Among 240 randomized patients (mean age, 58.3 years; women, 32 [13.0%]), 234 (97.5%) completed the trial. Groups did not significantly differ on pain-related function over 12 months (overall $P = .58$); mean 12-month BPI interference was 3.4 for the opioid group and 3.3 for the nonopioid group (difference, 0.1 [95% CI, -0.5 to 0.7]). Pain intensity was significantly better in the nonopioid group over 12 months (overall $P = .03$); mean 12-month BPI severity was 4.0 for the opioid group and 3.5 for the nonopioid group (difference, 0.5 [95% CI, 0.0 to 1.0]). Adverse medication-related symptoms were significantly more common in the opioid group over 12 months (overall $P = .03$); mean medication-related symptoms at 12 months were 1.8 in the opioid group and 0.9 in the nonopioid group (difference, 0.9 [95% CI, 0.3 to 1.5]).

CONCLUSIONS AND RELEVANCE Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.



Managing Opioids Safely and within Vermont Rules

SUMMARY FOR MEDICAL AND DENTAL PRESCRIBERS

Recommend Non-Opioid and Non-Pharmacological Treatment

- Nonsteroidal anti-inflammatory drugs (NSAIDs) and/or acetaminophen
 - Acupuncture
 - Chiropractic
 - Physical therapy
 - Yoga
- Only prescribe opioids if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, combine with non-opioid alternatives.

Query the Vermont Prescription Monitoring System (VPMS)*

First-time Prescriptions:

- Prior to writing a first opioid prescription for greater than 10 pills (e.g. opioids, tramadol)
- Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
- Prior to starting a patient on a chronic opioid (90+ days) for non-palliative therapy

Re-evaluation: At least annually (at least twice annually for buprenorphine)

- Centers for Disease Control (CDC) recommendation: every prescription, or at least every 90 days

Replacement: Prior to writing a replacement (e.g. lost, stolen) of any scheduled II-IV controlled substance

Provide Patient Education and Obtain Informed Consent

Discuss Risks *in-person* with the patient or legal representative regarding potential side effects, risks of dependence and overdose, alternative treatments, appropriate tapering, and safe storage and disposal of opioids

- CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

Provide Written Patient Education: Use the Vermont Department of Health (VDH) Opioid Patient Information Sheet or a handout that contains all of the same information at a 5th grade reading level or lower.
www.healthvermont.gov/sites/default/files/documents/pdf/adap_opioid_patient_information.pdf

Obtain a Signed Informed Consent document from the patient or legal representative that contains all of the required elements stated in the Opioid Prescribing Rule, section 4.3.3.1.

Use Available Resources: The Opioid Patient Information Sheet and an example informed consent document are available in multiple languages and may be found online at: www.healthvermont.gov/news-information-resources/translated-information/language.

Additional resources may be found at: www.healthvermont.gov/alcohol-drugs/professionals/help-me-stay-informed and www.cdc.gov/drugoverdose

Prescribe Nasal Naloxone when Indicated

High Dose: 90+ Morphine Milligram Equivalent (MME) per day

Concomitant benzodiazepine: Patients prescribed both an opioid and a benzodiazepine (CDC recommends avoiding these combinations)

CDC: History of overdose, history of substance use disorder, 50+ MME per day prescriptions

Arrange for Evidence-based Treatment for Patients with Opioid Use Disorder

CDC: Offer evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

Morphine Milligram Equivalents

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

Cases/HIPAA

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #



Case # 1

See Case Presentation Form



Case # 1 Summary

37-year-old with chronic axial low back pain, depression

- MRI with disc herniation, foraminal narrowing
- S/P epidural steroids, medial branch block, RFA with some benefit
- Been on long-term MS IR 15-30 mg TID (MME 60 mg/day)

Questions:

- Continue opiates?
- If so, change to long-acting?
- Other interventions/meds that might help?
- What else do I need to be doing (UDT, VPMS, treatment agreements, screening for abuse)



Conclusion

- Volunteers to present cases (this is key to the Project ECHO model)
 - Use the case template form posted at www.vtahec.org
 - Return completed case forms to mark.pasanen@uvmhealth.org
- Please complete evaluation survey after each session
- Claim your CME at www.highmarksce.com/uvmmed
- Please contact us with any questions/concerns/suggestions
 - Mark.Pasanen@uvmhealth.org
 - Elizabeth.Cote@uvm.edu
 - ahec@uvm.edu

