Welcome to UVM Project ECHO Treatment of Chronic Pain

Facilitators: Mark Pasanen MD, Liz Cote

Faculty: Carlos Pino MD, Rich Pinckney, MD, Patricia Fisher MD, Charles MacLean MD, Amanda Kennedy PharmD, Sanchit Maruti, MD

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

Participating Sites (sample)

- Appletree Bay Primary Care
- Bayada HOME Healthcare
- Biologic Healthcare
- BlueCross BlueShield of Vermont
- Brandon/CHCRR
- Brattleboro Internal Medicine
- Collaborative Solutions – Second Spring Mental Health
- CT Valley Recovery Services
- Central Vermont Medical Center
  - Barre
  - Granite City
- Hogenkamp Family Practice
- Mt Ascutney Hospital
- Northshire Medical
- NOTCH – Swanton
- Ottaquechee Health Center
- Porter Primary Care – Bristol
- RES Physical Medicine and Rehab
- SMCS/Mountain Valley Med Clinic
- Thomas Chittenden Health Center
- UVMMC Family Medicine

CME disclosures

Northern Vermont Area Health Education Center (AHEC) is approved as a provider of Continuing Medical Education (CME) by the New Hampshire Medical Society, accredited by the ACCME. Northern Vermont AHEC designates this educational activity for a maximum of 1.5 Category 1 Credits toward the AMA Physician's Recognition Award.

Interest Disclosures:

- As an organization accredited by the ACCME to sponsor continuing medical education activities, Northern VT AHEC 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
- Joan Devine, BSN, RN
- Sarah Morgan, MD, Medical Director Planner
- Mark Pasanen, MD
- Charles MacLean, MD

Faculty:

- Mark Pasanen, MD
- Charles MacLean, MD
- Carlos Pino, MD
- Patricia Fisher, MD
- Richard Pinckney, MD
- Amanda Kennedy, PharmD
- Sanchit Maruti, MD
- Jill Warrington, MD

OBJECTIVES

- Understand current recommendations for best practices for opiate prescribing.
- Review options for assessing function in patients with chronic pain.
- Learn how to assess patients on chronic opiates for misuse.
- Understand the role of urine drug testing in patients with chronic pain, and improve skills in interpreting these tests.
- Discuss options for tapering opiates in patients who are (a) no longer candidates for opiates or (b) not benefiting from treatment.
- Review alternate treatment options for patients with chronic pain.
- Discuss the evidence for treating patients with interventional procedures.
- Discuss the evidence for cannabis in the treatment of chronic pain, including pros and cons.

Schedule

Session	Date	Topic
1	April 6	Orientation
2	April 20	Opiate-prescribing Best Practices
3	May 4	Functional Assessment
4	May 18	Assessment for Misuse
5	June 1	Urine Drug Testing
6	June 15	Compassionate Tapering
7	June 29	Non-opiate Treatments
8	July 13	Interventional Pain Management
9	July 27	Cannabis Use 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

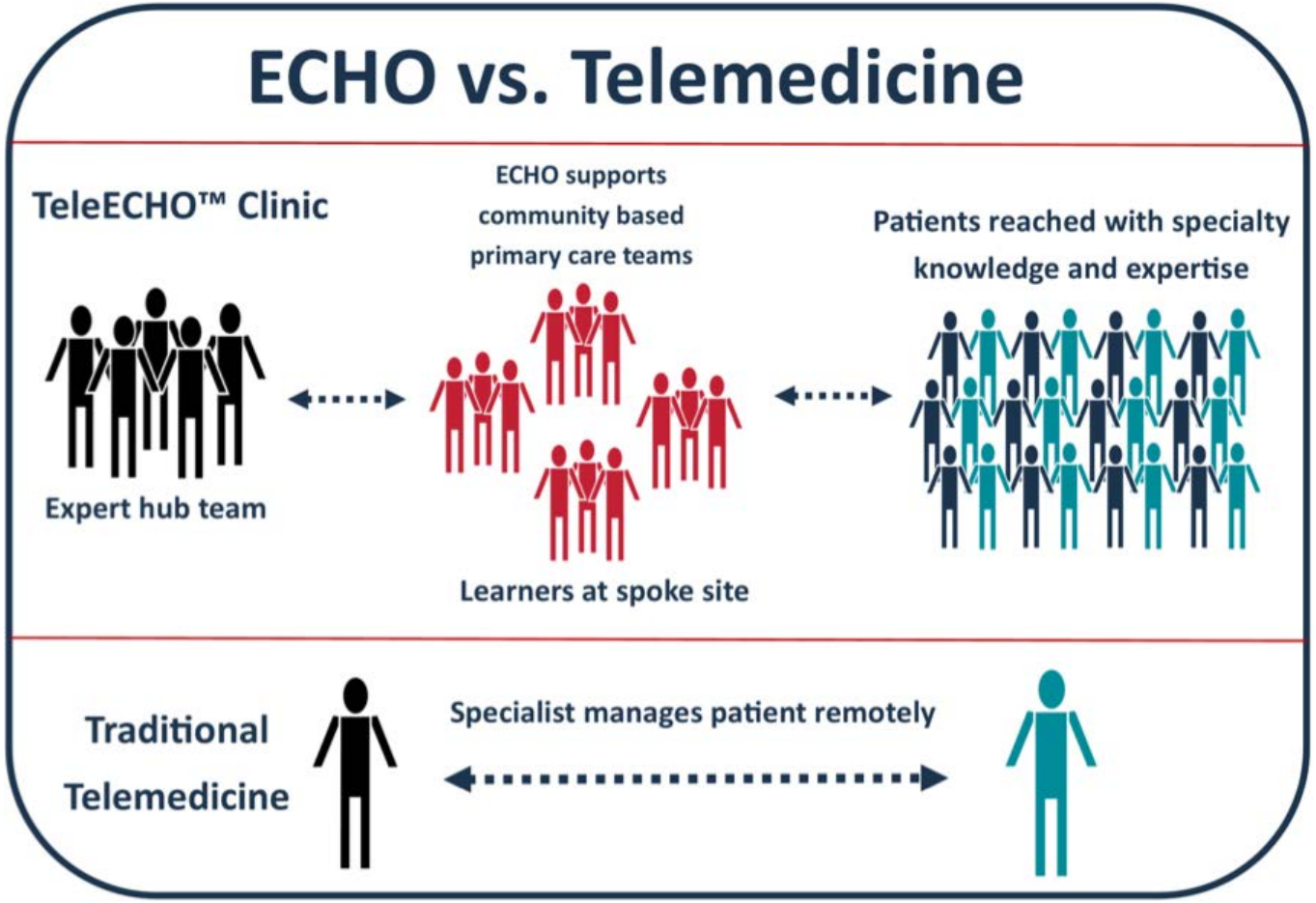
Project ECHO® is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best practice specialty care and reduce health disparities through its hub-and-spoke knowledge sharing networks

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 model **is not 'traditional telemedicine'**.

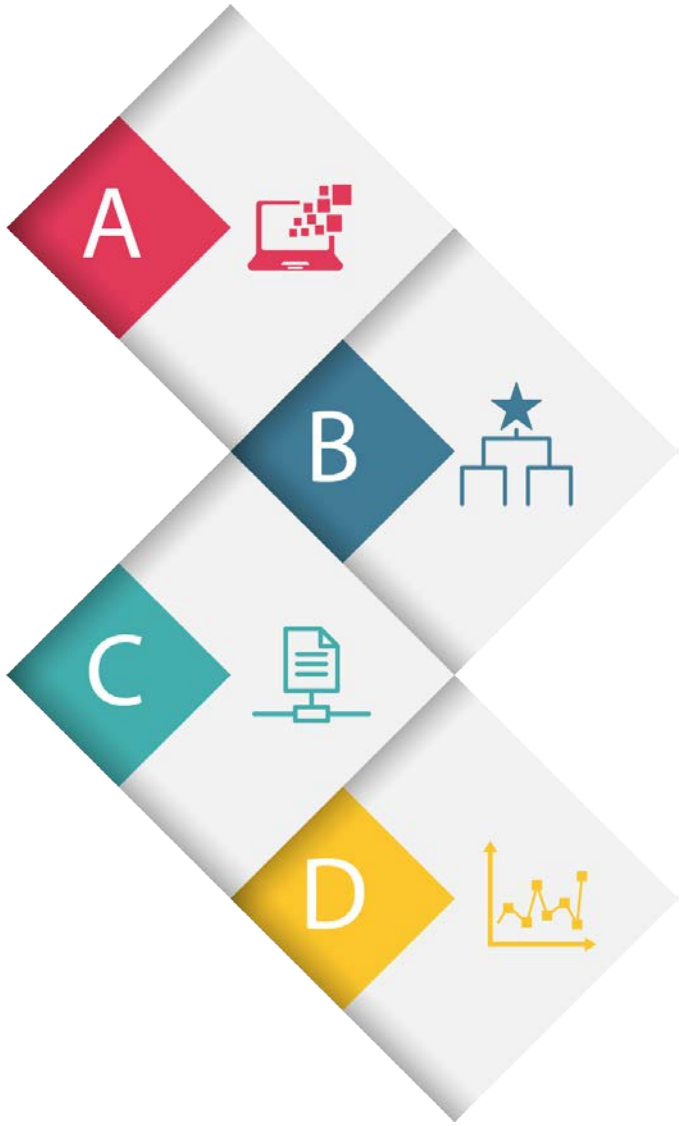
Treating Physician retains responsibility for managing patient.

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

ECHO Model

Amplification – Use **Technology** to leverage scarce resources



Share **B**est **Practices** to reduce disparity

Case-Based **Learning** to master complexity

Web-based **D**atabase to **Monitor Outcomes**

What is Best Practice in Medicine?

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

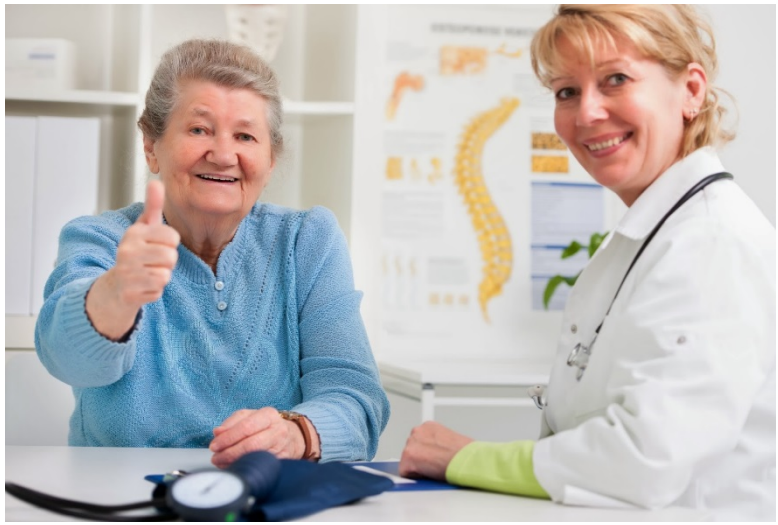
Is ECHO effective? (Scale 1-5)

Comments from ECHO Participants

- 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
- I apply what I have learned about best practices through Project ECHO to all of my patients with similar chronic diseases. 4.45
- 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 connected to and respected by the academic specialists in the ECHO telehealth clinic 4.4
- I am developing clinical expertise through participation in Project ECHO 4.48

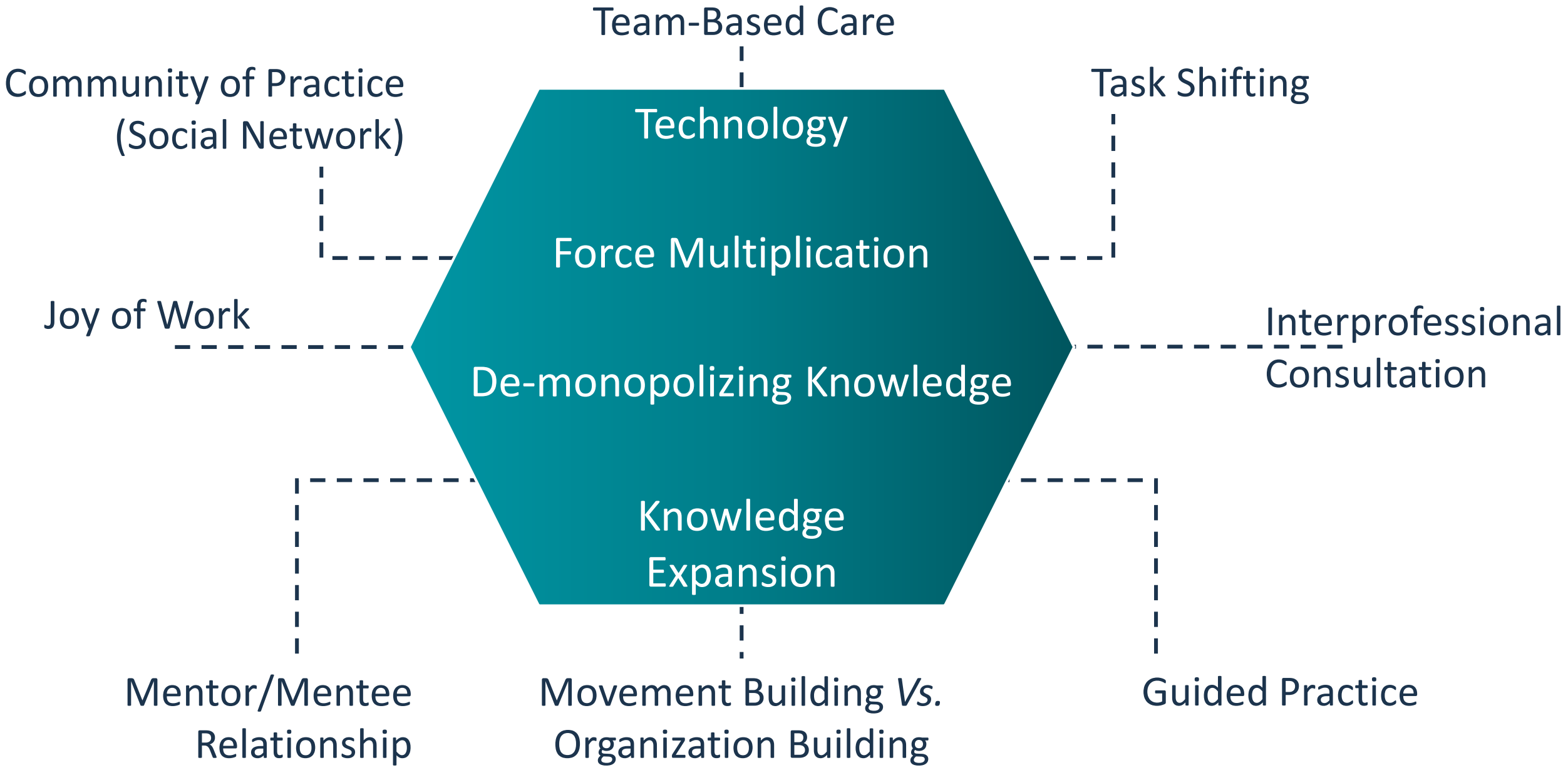
Other ECHO outcomes:

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



ECHO Hubs and Superhubs: United States

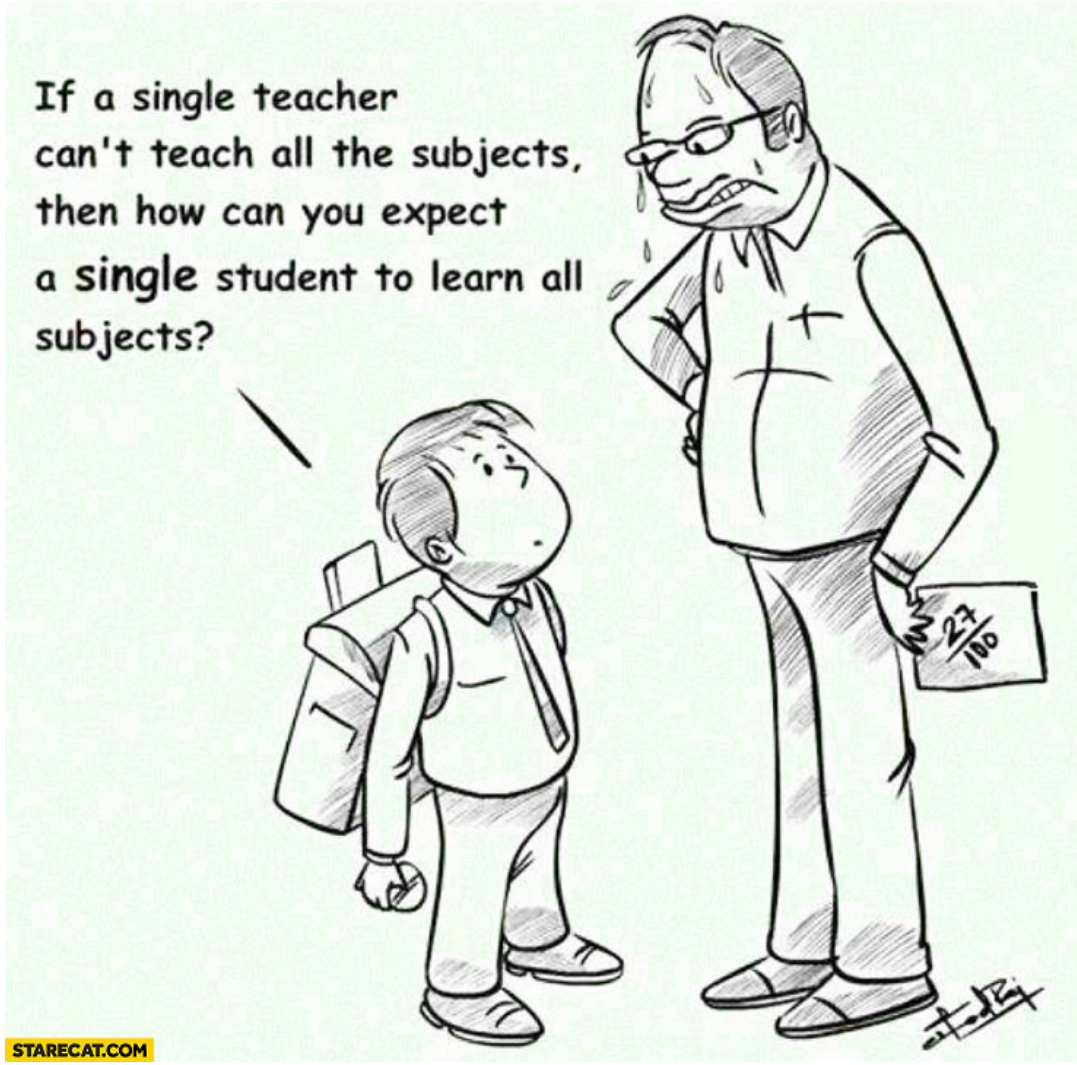
What Makes ECHO Work?



ECHO format

- Introductions
- Announcements
  - ZOOM etiquette
  - Review agenda
  - Follow-up
- Didactic (15-20 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



CDC – Guidelines 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

Vermont Guidelines – July 2017

1. Recommend non-pharm/non-opioid treatment
   a) NSAIDs, acupuncture, chiropractic, PT, yoga
2. Query VT Prescription Monitoring System (VPMS)
   a) Prior to first opioid prescription (> 10 pills, includes tramadol)
   b) At least annually (CDC every prescription, at least every 90 days)
   c) Any replacement prescription
3. Provide patient education/informed consent (incl acute)
4. Prescribe naloxone
   a) MME $\geq$ 90 mg or concomitant benzodiazepine
5. Two hours of CME every 2 years on “controlled substance prescribing”

JAMA | Original Investigation

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 Gravely, 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.

Annals of Internal Medicine

REVIEW

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 findings 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.

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REVIEW

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

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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 **Annals.org**

For author affiliations, see end of text.

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

Cases/HIPAA

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

Case # 1

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 mg TID

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
  - Use the case presentation form template
- Please complete evaluation forms for each session
  - CME will be processed once session evaluation form is received at UVM
- UVM Project ECHO materials available at www.vtahec.org
- Please contact us with any questions/concerns/suggestions
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