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SAFE AND EFFECTIVE TREATMENT OF CHRONIC PAIN IN VERMONT

Vermont Medical Society Foundation White Paper

This report is the first in a series of reports from the VMS Foundation providing the views of Vermont physicians and other leaders on topics critical to the future of our state's health care system

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Safe and Effective Treatment of Chronic Pain in Vermont

The VMS Foundation in partnership with the Health Department's Division of Alcohol and Drug Abuse Programs (ADAP) and funding from The Physicians Foundation and Purdue Pharma conducted structured interviews with professionals who have first-hand knowledge about the challenges of providing safe and effective treatment to persons with chronic pain in Vermont.[1] This report is a compilation of what they said and provides valuable insight regarding the challenges faced every day by those who care for patients with chronic pain. The intent of this effort is to inform both policy debates and the actualization of policies designed to engineer a safe and effective system of care for persons with chronic pain in the state.

The report has seven sections. The first six sections offer actionable steps for improving the care system. The seventh section offers seven innovations each with potential to improve the treatment of chronic pain in the state. Treatment of chronic pain and the closely related public health issue of prescription drug abuse are extremely complex problems. The seven dimensions of this document represent a balance between this complexity and the overall intent of this document to be a useful tool to inform policy discussions and offer actionable change ideas.

1. **Create a single set of recommendations for treating pain in Vermont**
2. **Improve the VPMS to help practitioners be good practitioners**
3. **Educate the public to expect best medical practices**
4. **Evaluate the approach of professional oversight**
5. **Differentiate the role of law enforcement from the role of care giver**
6. **Discourage payment policies that encourage pill prescribing**
7. **Innovate**

1. Create a single set of recommendations for treating pain in Vermont

One State - One Approach

The most commonly expressed opinion among the more than 30 professionals that were interviewed is the need for a single comprehensive set of consensus recommendations for the management of chronic pain in Vermont.

The recommendations need to be accessible to practitioners in multiple ways: print, web-based, lectures, and academic detailing to name a few. The recommendations will establish a benchmark for care that should be met in all practices across the state for all patients all the time. This benchmark will allow us to measure what we are doing and each year help us make things better than they were year before. The initial content of the recommendations should address at least the topics listed in **Figure 1**. More detail on the initial recommendation topics and goals can be found in **Appendix 1**.

[1] **Appendix 4** contains information about the qualitative research technique of structured interviews used to collect the information on which this report is based.

PCPs need support treating chronic musculoskeletal pain

Why does Vermont need a single set of practice recommendations?

The treatment of chronic pain is an extremely complex medical problem. Chronic pain has become the bane of primary care and many specialty practices. Prior to the mid-1990's opioids were typically used only for short term episodes of pain like a broken bone or for patients with chronic pain from cancer - chronic malignant pain. Opioids were rarely used for chronic non-malignant pain, such as the pain of arthritis or diabetic nerve degeneration.

One State – One Approach

Treatment Recommendation Topics

- Shared Decision Making
- Consensus treatment for common chronic pain conditions
- Consensus treatment for common acute pain conditions
- Informed consent for opioid therapy
- Practical opioid treatment agreements
- Identifying drug seeking behaviors
- Assessing substance abuse risks
- Medical record sharing standards
- Safe and maximum opioid dosages
- Interpreting urine drug screens
- Recognizing drug dependence
- Detoxification of drug dependent patients
- Managing patients unable to adhere to treatment agreements
- Effective communication between pharmacists and prescribers
- Best practices for buprenorphine therapy

Figure 1

"Even physicians who are following best practices and are very well educated can have problems treating pain patients. It's extremely difficult."

– Health system manager

"The treatment of non-malignant chronic pain is the most difficult problem that primary care practitioners have to deal with."

– Primary care physician

"A statewide consensus of what is best practice would create a safe harbor for physicians to feel comfortable in."

– Health system manager

Chronic low back pain is a condition that is commonly treated by PCPs with opiods.

In the 1990's articles appeared in the medical literature endorsing the use of opioids for chronic non-malignant pain, with persistent low-back pain presenting a common challenge. What was not known at the time, but is becoming evident, are all the down sides of using opioids for chronic pain. This is particularly the case with newer, long-acting opioids like extended release oxycodone. It is now evident that there is a high risk of developing dependence and possibly an addiction to these newer opioids, and there is increased potential for diversion of prescribed drugs for illicit use. As a result some practitioners have become reluctant to use opioid therapy.

"Unfortunately, since we started using more opioids for non-cancer pain, our new knowledge of their use has only revealed drawbacks and potential harm. It is now more widely appreciated that opioids do not relieve all pain and that the risk of addiction is significant."

– Primary care physician

"Most people don't need to be on chronic pain medications. However, doctors went to medical school to help people and sometimes, due to lack of reimbursement for other alternative therapies and lack of time, writing a prescription to give the patient something to reduce their pain is sometimes the only and easier method to affect change. Different forms of therapy need to be equally accessible to all patients.

"Doctors have an emotional response to their patients and because of the lack of resources and treatment modalities that are not covered by insurance; the emotional response is to give a pill to help

"After years of practicing my philosophies of treating pain have changed. Now I believe we don't have to take away all pain; we need to think about 'what can be tolerated?' Treatment of pain has to change to equal functionality. How much pain can you tolerate to be functional?"

– Pain and addiction specialist

There is a big gap in medical knowledge about best treatment and a high degree of variation in practice. Sometimes long-term opioid therapy is the best choice for patients, but practitioners may use opioids as a default treatment plan because there are few treatment standards for treating chronic non-malignant pain. There is counterproductive variation among prescriber approaches both across practices and within practices.

"*There are not enough hard facts and reliable medical studies about how to treat the thousands of different pain scenarios that patients have. Often because of small numbers of patients and variations in symptoms there is no possibility for a comprehensive study to be performed.*

"I have recommended many if not all of these alternative medicine approaches to patients at times. However I would challenge anyone to show me the controlled clinical trials clearly proving efficacy of these approaches in the chronic pain population. I have reviewed the Cochrane Database of systematic reviews on these 'alternative' treatments within the last year. Information is limited.

"There need to be several consistent approaches to long-term interventions for pain. It needs to be done regionally and be consistent across communities."

– Interventional pain specialist

"I don't use urine screens because of issues with the variability among the different tests: what substances will be or won't be detected, varying conditions affecting reliability, etc. We could really use a good 'manual' to help select the proper lab and test for the particular circumstance. For instance, no blood level can tell you whether or not the person is taking a med as prescribed, and some tests don't pick up metabolites, so a number of hours after a dose, there may be metabolites missed and no drug level detected. They vary with their detection of other abused substances, as well."

– Pain specialist

"One of the biggest issues is inconsistency within practices on the use of opioids, particularly within the primary care community."

– Interventional pain specialist

"There is marked variability in the training and competence of those physicians with buprenorphine prescribing privileges. The current recommended training is much less than when the drug first became available and too superficial."

– Addiction specialist

"Primary care physicians in Vermont and New Hampshire in general are very well trained, smart, have a lot of insight and are very well prepared. Everyone could use more training, but overall physicians are well prepared and such good people."

– Pain specialist

"The current status quo of pain treatment needs to be improved. Patients are being both under treated and over treated. There is a wide spectrum in the quality of care. Physicians are not well versed in the nature or management of addiction nor how to management a patient in need of detoxification."

– Addiction specialist

Why develop regional standards? What will be gained?
Standardization of practice is the cornerstone of improving the treatment of chronic pain and its unintended public health and criminal consequences in Vermont. In fact, standardization is the cornerstone of improving nearly any process whether medical or not. These standards will establish a benchmark to allow us to measure what we are doing and improve outcomes. Developing a regional "standard" for care of chronic pain does not mean adopting a single inflexible approach to managing an individual's pain. Rather, the term standardization refers to an attempt to make care as uniform and predictable as possible across all practices for all patients across the entire population.

Standardization will help us measure outcomes against expectations, against benchmarks and goals that can be observed over time. Standardization can help us identify what is working and what is not. Standardization can decrease the frequency of errors. For example, if all patients are required to answer specific questions designed to identify their risk for addiction to opioids, high-risk patients are more likely to be identified before they are treated rather than after they develop complications of treatment.

The development and maintenance of a set of regional standards will create a structure for content experts and opinion leaders to develop a protocol for continually improving the treatment of chronic pain, the responsible use of opioids and minimize the threat of prescription drug abuse to the public's health and our social fabric.

"...There are a lot of comments in this report about opioid abuse and addiction, but the real issue is how to treat chronic pain. If we can generate specific statements about the treatment of chronic pain, how to limit opioid prescribing, and approaches that all of us in the state could take to prevent opioid prescribing on a chronic basis, the abuse and addiction issues fall out."

– Obstetrician

"The two biggest issues related to prescription drug abuse are: 1) Limited physician skill/knowledge re: detection and prediction of addiction and its potential; and 2) the stigma associated with opioid use that creates barriers to good care and appropriate patient behavior. The stigma a patient faces when they are on opioids causes providers to look at them askance, inhibiting physicians and other providers from engaging in appropriate evaluation and treatment.

"Health care professionals aren't skilled and don't have confidence in their ability to know which patients are likely to have problems with addiction and which are unlikely. It is difficult with younger patients to know who will become addicted and get in trouble with opioids; biological tendency to addiction becomes manifest by 40 or so, so a good history is all one needs to be fairly certain that opioids can be used without creating risk for addiction."

– Pain specialist

"Provider and pharmacists need to have closer working relationships so we can talk to each other in real time to help me know if this patient should or should not get more controlled substances."

– Pharmacist

"Another factor I have seen in my travels is a lot of misunderstandings on the part of providers about how to have crucial conversations with patients: 1) How to create a good treatment agreement with a patient that the patient actually appreciates; and 2) When concerning behaviors develop in a patient how to have a conversation with a patient so that improves your rapport with the patient rather than the opposite."

– Primary care physician

2. Improve the VPMS to help practitioners be good practitioners

Helpful Technology

Nearly every person interviewed commended the Vermont Prescription Monitoring System, (VPMS). The VPMS was the most frequent response when practitioners were asked what the most valuable innovation or tool existed that helped them follow best practices.

There were suggestions for making the VPMS better; but these were not criticisms, rather wishes from users on how to make the system better than it is. Suggestions were made in the spirit of making it easy for prescribers to be good prescribers. A summary of the goals for initial improvements to the VPMS are listed in **Figure 2**. More detailed information about initial goals can be found in **Appendix 2**.

Helpful Technology – VPMS

VPMS Improvement Goals

- Every year the VPMS will be easier to use than the year before
- Threshold reports will be PUSHED to providers
- Treatment agreements will be part of the VPMS
- History of misuse will be part of the VPMS
- Out of state prescriptions will be included
- VA prescriptions will be included
- Providers will know about the delegate option
- VPMS will facilitate communication between prescribers and pharmacists
- Implementation resources will be available to providers

Figure 2

"One of the most unpleasant aspects of medical practice is dealing with drug seeking behavior. The public does not understand the extent to which doctors must function as judge and jury when dealing with pain complaints. No one wants to accuse a patient with legitimate pain of being a drug seeker. The VPMS has proved invaluable in situations where the benefit of the doubt must go to the patient."

– Practicing physician

"Rarely, if ever, have I received a phone call from another prescriber to inform us about their intention to prescribe controlled substances to our mutual patient. "

–Orofacial Pain Dentist

"The registry is an important tool. There is no crystal ball to predict how patients will react to opioids and who will have problems. This issue can be misleading, because patients who want to sell their opioids may be the best-behaved patients in the practice. They may make sure to take enough pills to pass urine tests, and save enough to pass pill counts, and if they are well behaved in the office they can have an endless supply to sell. Physicians tend to trust the well-behaved patients."

– Interventional pain specialist

Real time access to prescription information from neighboring states and the VA

Vermont prescribers and pharmacists need access to controlled substance prescription information from neighboring states. This is particularly a problem in the Connecticut River Valley where most patients fill their prescriptions in New Hampshire. VA prescriptions are not included in the VPMS. The system needs to receive data from pharmacies in real time and both pharmacies and prescribers need real time access to current information.

"I understand that the VA is prevented by federal regulation from contributing to the VPMS database, but there would still be considerable value in asking their providers to consult the VPMS before prescribing regulated drugs."

– Practicing physician

Link VPMS data to other health information technologies

Improve the effectiveness and efficiency of healthcare by incorporating the VPMS data with other health information technology (HIT). Connecting IT systems would provide a more efficient way for prescribers and pharmacists to see a patient's entire health care history in one portal versus logging onto separate portals for the same patient. If information from the VPMS were easily accessible through interconnected HIT, the VPMS utilization would vastly increase by prescribers and pharmacists.

"Is it possible that the VPMS could be expanded to include information about pain contracts? This would significantly add to the practical value of the system."

– Practicing physician

"Seven days is too long; instantaneous uploading and access would be so helpful. The insurance companies have figured out how to give me real-time access to benefit coverage for patients, why can't the state give us real-time access to information about people that might be diverting opioids to our kids?"

– Pharmacist

"The lag time for pharmacies reporting is now only every week. Things are happening really fast for patients who you may be suspicious of. We need the system updated at least daily."

– Pharmacist

"The most exciting innovation would be to make the VPMS real time."

– Pharmacist

More providers need to know how to use delegates

Many physicians are not aware of the option for a VPMS-registered provider to assign a staff member (clinical or non-clinical) to become a VPMS registered delegate that can access VPMS information on their behalf. It is particularly useful in busy, high-volume care settings like primary care and the emergency room. The delegate option allows the delegate to run a patient query for a provider and prep the chart with the VPMS report in advance to assist the provider, saving the provider from having to stop practice in order to sit down and run a query. Delegates must register on a separate registration form and can be issued their own unique password and access information.

3. Educate the public to expect best medical practices

Informed Consumers

Many interviewees recommended that the State start a public health campaign to educate the public about the dangers of long-term opioid therapy. Specific mention was made of the need to get the message out to the middle and high school populations. Several interviewees also mentioned the positive impact of the drug take-back programs and suggested that this should be a 24/7/365 resource in every community. Initial goals of such a campaign are listed in **Figure 3**. More detailed information can be found in **Appendix 3**.

"This is a community wide public health socio-cultural problem. We need a public health approach much like what was done with tobacco."

– Primary care physician

Informed Consumers

Goals for a Public Health Campaign

- Public understanding of the consequences of prescription drug abuse
- Model Tobacco Cessation Campaign
- Focus on school population
- 24/7/365 pill disposal capacity in all communities
- Community specific drug abuse data PUSHED to communities

Figure 3

"Kids think prescription drugs are safe."

– Practicing physician

"Increased coverage in the media about the problem of prescription drug abuse has made it easier to make the case to an ER patient that chronic pain must be addressed by a single prescriber."

– Practicing physician

"The other side of the coin is that patients often have no idea about the public health issues of substance abuse so the prescriber is required to inform the patient about the laws of the state. The patient's attitude is a sense of 'I must be treated!' 'What about my pain management needs?' Commercials say 'ask your doctors about…. insert medication.' Other patients are asking questions about being treated for pain management. They are often fearful that their use of a controlled medication may be something that comes crashing down on them in the future. For example, a patient may have a minor surgical procedure and think he/she deserves a hundred Percocet to go home with. They want enough medication to cover any pain. On the other hand the provider might say 'you don't need any pain medication for this procedure.'. There continues to be a substantial amount of on-going confusion from all angles and sides of the issue."

– Orofacial Pain Dentist

"I am afraid that we will spend large sums of money, simply thrown at the problem, without monitoring properly for the desired effect. Do we live in an era of outcomes-based medicine or don't we? That seems to be all we hear lately from various boards, including the Green Mountain Care Board. To me as a chronic pain specialist, methadone programs are a very reactive answer, not a proactive one. If we really want to solve this problem of opioid addiction, we must get into the multi-dimensional, cultural aspects of this problem (as a public health problem) and begin the process of a well-planned, targeted approach to reduce prescription opioid abuse. One suggestion would be to identify pupils in our schools, and start in 5th or 6th grade to identify at risk individuals, and place interventions in place to help steer a few lives in a better direction. However, if we do this we must reassess periodically the effectiveness of what is being done. We have to admit when something is not working, and move on."

– Interventional pain specialist

Prescribing pills is expected by patients with pain

The public is asking practitioners more than ever for opioid treatment of pain. Behavioral change, when appropriate, can be very difficult as anyone who has ever tried to lose weight or quit smoking knows. Insurance coverage of alternative and complementary treatments is rare. Many patients are more willing to be treated with pills, than take on difficult behavioral changes or embark on treatment courses not covered by their medical insurance policies.

"Patients don't understand that complete pain relief is not a reasonable goal. Treatment requires behavioral modifications, exercise, weight loss and life style changes. Many patients are unwilling to try complementary alternative medicine and integrated medicine approaches. Patients and practitioners need to get away from the idea that opioids are the only route of treatment; at least not the first-line therapy. Opioids do play a role as a therapeutic alternative, but not as a first-line therapy. Patients and physicians need to be more aware of the downside of opioid therapy."

Many times this unwillingness is because of high copays that must be paid for several visits to see a chiropractor.

– Primary care physician

"There is too much emphasis on the idea that patients should be completely pain free all the time. This is unrealistic. Public education is needed to inform people that they have to be able to tolerate some pain before it gets better. Patients demand specific things like specific drugs."

– Obstetrician

"More education for the public about chronic pain; there is a prejudice and lack of education about people with addictions. Most people with chronic pain are seen as 'drug seekers.'"

– Pain and addiction specialist

Medication collection events

Physicians and pharmacists endorsed the medication collection events that law enforcement officials host. Their recommendation is for there to be more of these events. Optimally, there would be constant access to a disposal box in all communities.

"The prescription drug take back programs are very important. They should be a 24/7/365 resource in every community."

– Pharmacist

4. Evaluate the approach of professional oversight

Unintended Consequences

Prescribers, pharmacists and those that oversee professional conduct in the state all find themselves having to make judgments about adequate treatment of pain, inappropriate practice patterns and the potential misuse of controlled substances. Practicing prescribers and pharmacists both are of the opinion that there have been unintended consequences of the recent increase in professional oversight focused on the use of opioids for chronic pain. A repeated request was for the Vermont Board of Medical Practice to use a graded approach to working with prescribers and pharmacists that come to their attention if possible; alerting a practitioner when their prescribing practice is first trending toward outlier status and offering remedial support as a first level of interaction. While not condoning practice below community standards, practitioners felt that Board actions have made it more difficult for patients in need of chronic pain medications to receive appropriate care. Initial improvement goals for evaluating professional oversight are listed in **Figure 4.**

Unintended Consequences

Professional Regulation

Improvement Goals

- Oversight policies and procedures recognize the Vermont consensus treatment recommendations
- Oversight authority policies encourage proactive identification and supportive outreach to prescribers with outlier practice patterns in the use of controlled substances

Figure 4

"The recent increase in professional regulatory and law enforcement oversight of controlled substance prescribing patterns of physicians has had a chilling effect on access to needed pain treatment for patients."

– Addiction specialist

"A past effort in New York State requiring triplicate prescriptions for certain drugs focused on newer benzodiazepines (Valium-like drugs) resulted in physicians using older, more dangerous medications in an effort to not be tracked by the state."

– Pain and addiction specialist

"One of the important things in my town is people need to be appropriately treated for their pain. Sometimes patients with serious chronic pain will get less medication than people get for short-term pain relief."

– Pharmacist

"Pain specialists both psychiatric and non psychiatric are leaving state. The Vermont Board of Medical Practice should take note as increased oversight and hassles are part of the issue in addition to low incomes. Remaining specialists feel over worked. This patient population is already challenging: indigent, psychiatric co-morbidities, high risk for addiction, don't follow through on prescribed non-medical treatments. There is a high burnout rates among PCP's as well."

– Pain specialist

"I've been reviewed by the professional oversight boards in New Hampshire and Vermont and both were fair."

– Medical pain specialist

"A common practice in the university practice is for patients who prove difficult related to pain management to be dismissed from the practice. To me, this is not an ethical practice. It is one thing to make prescribing of controlled substances contingent on adherence to certain rules; it is quite another to completely deny health services to a person, especially when the physician practice/counseling/care may be far from ideal."

– Pain specialist

"*Practitioners do not have access to legal, mediation and risk management resources when patients break treatment agreements or community members report suspected diversion to practices."*

– Health system manager

"The former Medicaid Drug Utilization Board was so helpful in terms of looking at patient use of medications. We would send letters to prescribers whose patients met our criteria for being flagged as someone who had too many prescriptions. This was so helpful because you could actually see the usage going down after the letters were sent out. We also had feedback forms that providers had to mail back."

– Pharmacist

"This report is a very comprehensive and accurate report of the current practice environment. Most comments address the regulatory or restrictive aspect of opioid treatment. I think we also need more consensus on the medical benefit or lack thereof of opioid therapy, not just in affecting quality of life and function, but also the reduction of harm from pain-induced depression and isolation."

– Primary care physician on reviewing this report in draft form

5. Differentiate the role of law enforcement from the role of care giver

Between a rock and a hard place

"I'm seeing about one death a week from a recreational drug overdose."

– State medical examiner

Prescription drug abuse is a major threat to the fabric of Vermont society. Nearly everyone interviewed agreed that prescription drug misuse and abuse is increasing. However, there are physicians and other health practitioners that underestimate both the amount of illicit use of prescription drugs in their community and their contribution to the problem. This assessment is shared by both those involved in medical practice oversight and among practicing physicians themselves. That being said, it is very important to note that it is unclear to everyone how many of the pills that are used illicitly originate from within the state versus how many come into the state from elsewhere.

Between a Rock and Hard Place

Improvement goals

- Policy makers and policy implementers clearly identify the targets of new policy related to the diversion of controlled substances
- Policy makers and implementers consider potential consequences of new policy targeted on drug diversion on effective treatment of pain in the state
- New policies contain sun setting language unless evaluation of policy effect shows overall benefits.

There is tension between effective pain treatment with opioids and the risk to the public because of misuse and diversion of controlled substances. A repeated comment from several contributors after review of a draft version of this report is the need for the complexity of the issue to be made clearer, specifically that this is a multi-faceted issue and that pushing in on the balloon on one side may merely lead to an unintended bulge on the other side; we all need to be very clear about what aspect we are trying to fix with what remedy before anything is done in order to avoid unintended consequences.

"The absence of a steady opioid supply on street increases the use of heroin. It's cheaper and easier to get now that there is a tighter rein on controlled substances."

– Pain and addiction specialist

"Over the past 12 to 18 months, I've been seeing more deaths caused by injecting heroin and wonder if this is because prescribers are tightening up on access to controlled substances."

– Medical examiner

"Our practice will not accept patients on opioids who come from other catchment areas or from other practices."

– Community health center medical director

"The most pressing issue in my community and practice is the sense of adversarial confrontation between those who are treating and prescribing for chronic pain, government trying to figure out how to deal with the issues and law enforcement pressure to intrude into VPMS. There is an often one-sided media perspective on the issues and a lack of good sense dialog about the problems of pain and prescription drug abuse. We need to be sensible about how we approach these complex issues. I am concerned that we aren't looking objectively at the issues; people, often with good reason, become very emotional. Few people know what it's like to see someone who is addicted or overdosing from controlled substances unless they are an ER doctor in the hospital and know what the consequences look like."

– Orofacial Pain Dentist

"There are a few sides to this: 1) a recent Institute of Medicine report found chronic pain to be undertreated; 2) there is the public health issue of overuse; we don't want either the patient or the community to be harmed; and 3) there is the physician health issue, which is a real issue, because physicians can be intimidated by patients who fight with them to obtain opioids."

– Pain specialist

"Things are getting better. Little by little, like building a house. Until the profession comes together and gets on the same page we leave it to law enforcement. This could be prevented."

– Vermont pharmacist

"Abuse, misuse, diversion and addiction is the most pressing safety issue in my community. Physician safety is part of this, in terms of the stress caused by patients in clinics, patient threats, and the potential for actual physical injury. At our regional Pain Management Center they have three distress buttons in the clinic that will call security; a call happens almost every week."

– Medical pain specialist

"What I think needs to be clarified are the terms we use. Although the report is titled <u>Safe and Effective Treatment of Chronic Pain in Vermont</u>, much of what we are trying to fix by law enforcement is diversion. This is a big difference, and policy needs to reflect this.

"Do we have a problem with chronic pain? Are there too many people being treated for chronic pain, or is it how they are being treated. I support a multifaceted approach including behavioral management and a multidisciplinary team approach, but this is expensive.

"Most agree we have a diversion problem, as do most states. Improving the VPMS to be real time would help. Allowing the VPMS to contain information on contracts and previous problems with opioids would be hard to allow in the world of HIPPA. I agree completely on developing the capacity in every community to return and dispose of controlled substances on a 24/7/365 basis to get them out of houses.

"I think continued discussion is vital. This is a medical issue and needs legislative support but not a legislative solution only. Providers are aware of the problems in their community and need to work to fix them."

– Practicing physician

"The most pressing issue, I think still, is insufficient response from physicians using appropriate protocols for dealing with pain and being too afraid, or not willing to deal with pain problems. We often have to inform physicians that their patients are receiving multiple prescriptions from different pharmacies with multiple names apparently because they have not accessed the VPMS. The problem can be easily resolved by delegating the VPMS search to a designated member of the office staff.

"The second most pressing issue is the opioid addiction and diversion problem in the state. As a chronic pain management specialist in THE town in Vermont with the highest per capita addiction rate, and some of the highest levels of poverty and disability, I can honestly say that the issues of opioid addiction are multifaceted and complex, and do not have simple answers.

"Provider education is one of the most important starting points to fixing this problem, because very few providers in our state have any formal training about how to use any medications to treat chronic pain. And yet, pain is the most common reason a person seeks care from a doctor, and chronic pain will likely affect 33 percent of all American adults this year."

– Interventional pain specialist

6. Discourage payment policies that encourage pill prescribing

Follow the Money

Current payment policies discourage: 1) use of evidence-based complementary and alternative medicine treatments; 2) team approach to caring for chronic pain patients; 3) case management; and 4) spending appropriate time with complex patients. Initial goals for payment redesign are highlighted in **Figure 6**.

Follow the Money

Improvement goals

- Prior authorization policies will be modeled after the Vermont consensus recommendations
- Reimbursement policies for care givers will recognize the complexity of managing patients with chronic pain
- Coverage policies will encourage the use of treatment approaches for chronic pain that reduce or eliminate the use of controlled substances
- Payment policies will encourage the use of multi-disciplinary teams
- Reimbursement policies for care givers will make Vermont an attractive practice setting for practitioners specializing in chronic pain and addiction medicine

Figure 6

"Docs feel stuck without good options as to where to send them. Patients play on a physician's guilt and the physicians feel stuck. Patients threaten to buy drugs on the street, saying they have no choice."

– Hospital risk manager

"Prior authorization should not impede appropriate treatment regimens. Neither case management nor a team approach to care is encouraged by current payment policies. Ideally, care would be coordinated by a case manager and a team-based approach to care allowing for integrated care to occur all in one place: a chronic pain medical home including for example physical therapy, psychotherapy and dietary practitioners."

– Primary care physician

"One very big issue is how the insurance companies are actually driving a lot of the dependence on opioids. For example research shows that for chronic non-specific low back pain, chiropractic manipulation, acupuncture, and massage are all helpful. Yet many insurance companies won't cover these. But they will cover the Percocet, which has not been proven to be helpful in research."

– Primary care physician

Many PCPs recognize the effectiveness of chiropractic services but feel the frustration of insurance policies that have high patient cost sharing that financially inhibits the patient from seeking chiropractic care. They even blame the insurance company policies for driving a lot of the opiod dependence.

"Yes we use everything. It would be nice if there were a way to pay for treatments other than opioids. Medicaid pays for opioids, but it is difficult to even get PT covered for patients who need it long term. Acupuncture, massage, help some people, but it is hard, particularly for low-income people to access these treatments."

– Obstetrician

"A pressing issue in my practice is the painful burden and outright handcuffing of my ability to use several portions of a multidisciplinary pain treatment regimen, given the repeated, persistent and drastic cuts in payment for what I do. Controlled substances are given to patients by insurance payers without question, while pain alleviating, non-drug options such as procedures or physical therapies are denied coverage repeatedly, solely on the basis of expense. Is anyone among us really surprised that we have a prescription drug diversion issue now, given what I just stated. At times it has seemed to me that insurers want our patients addicted to medications; that this problem is something that is being created intentionally."

– Interventional pain specialist

The pressure to see as many patients as possible in a fee-for-service system plays a role in treatment decisions.

Pills are often the easiest and quickest treatment approach. Prescribing pills usually works in the short term. The current system of paying practitioners for the volume of work done, not the quality or safety of their work encourages quick fixes, not necessarily the best fixes. Insurance usually covers the cost of medications, but rarely an extended office visit allowing a thorough exploration of the patient's situation or long-term treatments not taken by mouth. Prior authorization processes can pose enough of a time barrier for practitioners that they opt for prescribing pills rather than more expensive alternative approaches.

"Under a fee-for-service model, I am a money loser for the system due to the labor intensive nature of these patients."

– Psychiatric pain specialist

"Alternative procedures such as cognitive behavioral therapy, acupuncture, exercise and prolonged physical therapy may not be reimbursed. Insurers may reimburse for four or five weeks of physical therapy or water therapy, but patients with chronic pain may need this therapy for the rest of their life, and may not be able to pay for it on their own. If other options (PT, chiropractic manipulation, intervential procedures)are not available or not covered, it is cheaper to order MSContin or any other opioid, and that becomes the only option available for the patient."

– Interventional pain specialist

"Physical therapy is also helpful, but the co-pay for PT is quite expensive, while the co-pay for Percocet is much smaller. I realize that insurance companies need to watch the bottom line, but I think they are actually costing the State of Vermont much more money in the long run with our heavy and unnecessary reliance on opioids."

– Primary care physician

"With respect to treatment of pain, most of the medical data supports a rational use of procedures, physical therapy and cognitive behavioral therapy. With respect to opioids, there is some data about treatment of cancer patients with opioids. This data was used to jump from treating patients with cancer to treatment of non-cancer pain without real data to support it. Newer data increasingly does not support use of opioids for non-cancer pain. There is not much data to support use of chiropractic, acupuncture or other alternative therapies for treatment of non-cancer pain, but again, patients are so diverse and there have not been many studies to prove or disprove these therapies. I often recommend them because these patients have very few options."

– Interventional pain specialist

"As we transition to the medical home model, it will be critical for the behaviorist and the primary care providers to work well together to manage chronic pain. Chronic pain management skills are a must for any behaviorist in these settings."

– Primary care physician

"What are the demographics of chronic pain? Generally speaking these patients have: 1) a much higher than average incidence of psychiatric disorders, including addiction; 2) very high levels of public insurance utilization, disability, and indigence; and 3) dysfunctional family and interpersonal relationships. Chronic pain patients are high burnout material. They fry providers and their staff. They strain the system to its limits. As a result these patients are repeatedly bounced around within our healthcare system, often with few answers, inconsistent approaches, poor understanding of the etiology of their problems, poor outcomes, and sometimes they experience truly hostile interactions with medical providers. I have seen this dynamic played out over and over again in recent years, and it is very real."

– Interventional pain specialist

Specialty referral should be timely; physicians with the necessary training are rare.

There are currently very few practitioners in the state with specialized training in pain treatment or addiction treatment. This small group of practitioners feels isolated and burnt out. There are fewer trained pain specialists in the state than there were ten years ago. Their reasons for leaving include the stress of practice and the opportunities for better pay and a more balanced work schedule. Increasing regulatory hassles in the state were also mentioned. The population of patients with chronic pain and/or addiction to prescription medications is the most challenging and intimidating patient population in the state. Many of these specialty practitioners cite the same challenges as their primary care peers and other medical and surgical specialists, including the lack of care coordination across communities and between practices and the lack of insurance coverage for non-opioid treatment of pain.

Patients diagnosed with substance abuse have to wait too long before they can be placed in a structured treatment setting. Ideally the transition would be seamless rather than the 3 to 4 week typical delay in the current system.

"*To my knowledge I am the only fellowship trained, board certified, pain management provider treating chronic pain fulltime in a very large portion of the state. There were several others when I got here in 2004. Most have left the state since then. In large areas of the state pain specialists simply do not exist. This is THE most pressing issue, in the safe and effective management of chronic pain patients in my area of the state."*

– Interventional pain specialist

"Primary care physicians need access to persons with specialized training in managing chronic pain and substance abuse."

– Psychiatric pain and addiction specialist

"If the 'hub and spoke' model has legs, data needs to be collected on the nature and frequency of requests from practitioners out on the 'spokes' to enable the system to continually improve and remain relevant to need."

– Pain and addiction specialist

"There is inadequate access to persons competent in detoxification."

– Addiction specialist

"At our tertiary care center they see everyone, but waiting times can be several weeks or months. It is easier to get in for procedures, than for pharmacological treatment."

– Medical pain specialist

"Adequate mental health treatment is not available in New Hampshire or Vermont. Referred patients don't seem to get appointments, but often the patients may not show up for the appointments. Because insurance doesn't reimburse for mental health treatment, patients with bi-polar disease, schizophrenia, and personality disorders can end up being treating inappropriately with opioids."

– Medical pain specialist

"In the community there is need for more clinicians who specialize in addiction, so that there will be treatment available when physicians treating pain identify patients who are misusing their drugs. I am a member of a committee at our tertiary care center that is attempting to standardize ways to treat patients with opioids. The committee is working on developing guidelines for primary care physicians and specialists, and standardized treatment contracts and tools. When patients are fired from practices, it creates a problem for another physician or the emergency department. Our institution does not want to fire patients, but instead offer them treatment options. But there are very few addiction specialists. There are few in Chittenden County and at least one of those is now closed to new patients."

– Interventional pain specialist

"Over the last few years there has been a concerted effort to educate clinicians. Most physicians are familiar with how to assess and treat pain, but they need support from behavioralists and addiction specialists. One of the problems is that there are not enough available, reimbursed treatment options."

– Interventional pain specialist

"Our pain clinic is the center of referral for most of Vermont. The lag time for a new patient visit is within the national standard with the 3rd available appointment with an interventional specialist offered to the patient generally within 25 days. It is more difficult to get an appointment with a psychiatrist for help in medication management for patients with chronic pain and psychiatric co morbidities. There is little access for new patients and a backlog of about one year.

"The problem is that primary care physicians often do not want to take their patients back once they have been stabilized on a regimen to continue to write opioids for them, so the patients stay in the pain clinic practice for years. My view is that the pain clinic psychiatrist, who is a highly specialized individual, should really be doing consults for practices and following only the most difficult and complex patients, like patients with bi-polar depression or schizophrenia who have pain."

– Interventional pain specialist

"Cognitive Behavioral Therapy, operated by the Department of Psychiatry, is a research program and the research groups in this program are closed. We need other practitioners performing cognitive behavioral therapy clinically."

– Interventional pain specialist

"One near-term solution to this problem would be to begin the process of bringing primary care providers up to speed in the treatment of chronic pain. This is something that few PCP's or specialists had any formal training in at any point in their careers. This is THE most pressing issue in the safe and effective management of chronic pain patients in my area of the state."

– Interventional pain specialist

7. Innovate

No one interviewed opined that the current state is acceptable and everyone had suggestions on how to improve the status quo. Many of their suggestions are nested in the preceding sections of the summary report. This final section highlights innovations of potential value that don't fit in one of the previous sections. Some of these innovative efforts are underway on a small scale in the state, others are suggestions to revive previous initiatives that helped, and the balance is new ideas. This final section highlights seven innovative suggestions that interviewees made.

Centralized urine screen testing

"Should we have a not-for-profit lab set up in the state? I hear that urine screens are expensive and inaccurate, too much time, etc. It might be worthwhile to see if there is something that could be done to try and figure out another method."

– Professional regulator

"The state already pays an enormous sum through Medicaid payments for urine screens. Maybe this sum could be spent both more efficiently and provide better service to providers and patients."

– Primary care physician

"I don't use urine screens because of issues with the variability among the different tests, what substances will be or won't be detected, varying conditions affecting reliability, etc. We could really use a good 'manual' to help select the proper lab and test for the particular circumstance.

"For instance, no blood level can tell you whether or not the person is taking a med as prescribed, and some tests don't pick up metabolites, so a number of hours after a dose, there may be metabolites missed and no drug level detected. They vary with their detection of other abused substances, as well."

– Pain specialist

Innovation

Change Ideas

- Single centralized urine screening capacity
- Meaningful use and integration of information technology
- Protocol based opioid treatment centers
- Hospital based opioid resource center
- Pain and addiction hot- line
- Pain management on-call service
- Telemedicine

Figure 7

Meaningful use of health information technology

"It would be great to be able to suggest that the application of technology, though electronic medical records, EMRs, etc., is helping to solve our pain management issues. I do think that the online prescription monitoring database (VPMS) is an example of a very good application of technology, although I do not know if it can be shown to have a meaningful impact on our opioid addiction problem."

– Interventional pain specialist

"An intent of EMRs is to help improve communication among providers, improve documentation, and reduce medical error. However, the current state of the art in software development of EMRs has not achieved these goals. I am hopeful that the next generation of EMRs will move us forward, and not relegate providers to being button pushers. What we really need are smart EMRs that tie us together, make us better team players and make practicing medicine truly more efficient and easier. That is not happening in today's world, and it really is a shame, because the technology currently exists to make it happen."

– Interventional pain specialist

"It's hard to remember the VPMS log-in. It would be great if VPMS were integrated with the PRISM EMR system so that when you logged in to a patient's chart you could access the VPMS without a separate log-in."

– Obstetrician

Protocol-based, mid-level provider run, cost-neutral opioid treatment clinics

"I am working on a project that is close to completion. It will include establishing protocol-based, mid-level provider run, cost-neutral opioid treatment clinics. These will be places where physicians can refer patients for assessments, monitoring and opioid prescriptions.

"There is a paper that describes the dilemma physicians face, and how time-consuming it can be to treat these patients who come in with new complaints that need to be evaluated, such as shoulder pain, seeking increased dosages of opioids. It is labor intensive to treat these patients.

"The project would provide assessments, monitoring and education for patients who would be triaged as low risk, moderate risk or high risk. Patients would be required to review web-based educational materials and answer questions about the material. The informed consent process would be accomplished via web-based videos as well, which would explain in addition to potential risks and benefits, permissible and impermissible behaviors. For example, if a patient tests positive for cocaine, he or she could not receive a prescription for opioids.

"Since the system would be protocol based, patients would understand that the physician assistants or ANRPs would be following the protocol and would not have discretion to vary it. Over time, this system could apply to all opioid prescriptions, for chronic pain in New Hampshire and Vermont. This does not include terminal pain patients or acute pain.

"Under the system, all patients would have a urine toxicology screen prior to treatment and would be required to review one video and answer questions at the end of the video verifying that they understood. This would be repeated annually. Moderate-risk patients would be required to watch additional videos and have three urine toxicology screens a year. High-risk patients would have toxicology screens every month and would have increased monitoring of their compliance."

– Medical pain specialist

Hospital based resource center in each community

"It would be great if there were a community person from the anesthesia department in each hospital where physicians could refer the patients they had questions about. The resource person could evaluate the patient and develop a plan for the patient, and send them back to the primary physician with the evaluation and plan, which generally would not include prescription of chronic opioids. The plan may suggest trying this and then trying that and if these things don't work, the patient should come back for further evaluation.

"Because this would be a local initiative, the physicians could learn from each other and all of them would become familiar with the patients in their communities who cause concern.

"To make this even better, the anesthesia resource people in each hospital in the state would agree on a consensus model for the best way to treat patients with pain, so that there would be a statewide agreed-upon system."

– Obstetrician

Pain and Addiction Hot-Line

"When Dartmouth Hitchcock Medical Center had a palliative care hotline, any doc could call anytime. Docs were calling from patients' homes in the middle of the night. Having a hotline for pain management consults is a great idea but might be hard to implement."

– Medical pain specialist

"Lack of resources is a problem. One thing that would be helpful would be a hotline staffed by a clinician who could walk a physician through the options for handling difficult cases and could help physicians address chronic pain and drug diversion. The clinician on the hotline could talk the docs through the various options. It would be very helpful to have this as a state-funded position that can assist docs by providing an ear to listen and to think about alternatives. The state spends a lot on buprenorphine and other controlled substances, and this might create savings for the state."

– Health system risk manager

Real–time medical management on-call service

"Pain clinics mostly focus on procedures, less on pharmacological management, although I have heard that this may be happening more. Primary care docs need help with pharmacological management. It would be great to have a network of six to eight people to share a beeper, who would be available real-time foro docs to consult. Perhaps the academic detailing system could work with DVHA to coordinate this. Also having a hub/spoke model for chronic pain patients who run into problems would be good. The hub could help with assessment and management ideas."

– Pain specialist

Telemedicine

"New Mexico has developed an interesting telemedicine system, where physicians set aside one hour a month (a week or day??) to participate in case consults by telemedicine. Physicians from rural areas fax in clinical issues to the academic center and there is a team at the university that includes a pain expert, psychiatrist, psychologist, physical therapist and others that discuss the case and how to handle it by telemedicine. The program was funded with state funds and a grant (http://echo.unm.edu).

"A program like this would enable primary care physicians from throughout the state to send in consultations and get guidance as to the initial therapies that should be tried. You would be amazed on how many patients come to the pain specialist for injections, even when none of the conservative therapy has been tried. This system could allow for initial input, followed by a treatment plan that could be reviewed regularly.

"In addition, a program like this would support the primary care clinician and would enable the primary care physician to have the support to take the patient back and follow the patient after consults with the pain clinic."

– Interventional pain specialist

Appendix 1 One State – One Approach

Each topic listed in Figure 1 is an area that an interviewee felt either herself or her peers needed help with. This appendix offers goals for each initial recommendation topic and a bit more guidance on the intent of the goal.

At the end of this appendix is guidance on the nature of the recommendations themselves based on the strength of the evidence base that supports it. Finally mention is made of the need for suggestions about how to measure the effectiveness of each recommendation in an effort to guide further the development of future educational efforts for providers and system improvements.

One State – One Approach

Treatment Recommendation Topics

- Shared Decision Making
- Consensus treatment for common chronic pain conditions
- Consensus treatment for common acute pain conditions
- Informed consent for opioid therapy
- Practical opioid treatment agreements
- Identifying drug seeking behaviors
- Assessing substance abuse risks
- Medical record sharing standards
- Safe and maximum opioid dosages
- Interpreting urine drug screens
- Recognizing drug dependence
- Detoxification of drug dependent patients
- Managing patients unable to adhere to treatment agreements
- Effective communication between pharmacists and prescribers
- Best practices for buprenorphine therapy

Figure 1

Goal 1 – Recommendations for shared decision making for the treatment of chronic pain
What are reasonable treatment goals for this patient? Does the patient understand the goals?

Goal 2 – Recommendations for treatment for common chronic pain syndromes
What treatment interventions might work for this patient? What is the evidence base for the various approaches?

Goal 3 – Recommendations for best treatment for common acute pain syndromes
What is the most appropriate medication for specific acute pain conditions and how many doses do I prescribe? What is the evidence base for the different options?

Goal 4 – Recommendations for informing patients about the risks of opioid therapy
Does this patient really understand the dangers of long-term opioid therapy?

Goal 5 – Recommendations for a practical and complete opioid care plan including a treatment agreement
What are the key aspects of a good opioid care plan?

Goal 6 – Recommendations on how to best differentiate patient motivations
Is this patient in need of pain treatment or is this someone seeking drugs for misuse?

Goal 7 – Recommendations for assessing risk of substance abuse in new patients
Is this patient at high risk for opioid misuse?

Goal 8 – Recommendations for timely record sharing across practices and communities
How can I get medical records from other practices caring for this patient?

Goal 9 – Recommendations on drug type, starting and maximum dosages and anticipated urine screen results
When appropriate, what is the best long-term opioid regimen for this patient?

Goal 10 – Recommendations for interpreting urine drug screens
What do these urine drug screen results mean? Are these results a valid indication of the patient's compliance to their controlled substance agreement?

Goal 11 – Recommendations for identifying behaviors suggesting drug dependence or addiction
Is opioid therapy helping or hurting this person? Are they developing problems with abuse or addiction?

Goal 12 – Recommendations for managing detoxification of drug dependent patients
What is the best approach to getting this person off opioids?

Goal 13 – Recommendations for managing patients unwilling or unable to adhere to treatment protocols
This patient has breached their treatment agreement. How should the prescriber proceed?

Goal 14 – Recommendations for timely effective communication between prescribers and dispensing pharmacists
I have questions. How do I communicate with the prescriber most efficiently?

Goal 15 – Best practices regarding buprenorphine treatment of addiction
Some physicians with a buprenorphine license are not adequately trained or supported. This concern was voiced mostly by pain and addiction specialists in more than one community.

What should the recommendations look like?

The target audience is the practitioner community. Recommendations should be web based and accessible at all practice locations. Recommendations should be based on existing national consensus recommendations but reviewed at least annually and endorsed by local professional opinion leaders and content experts. Standing committees of content experts and professional opinion leaders should own each topic. Recommendations should include performance improvement metrics for each area. Annual updates should be pushed to practitioners highlighting changes from previous year. Public funds should be used to compile, distribute and update this medical resource. Additional resources including "just in time" resources such as hot lines and FAQs should be easily accessible. Academic detailing, particularly focusing on the use of non-opioid treatment regimens has promise and should be evaluated as a strategy for initiating change in practice habits.

Each recommendation needs to include clearly stated action steps promising to lead to a measureable change in practice. Each recommendation should have a clearly stated goal, preferably defined in quantitative terms, i.e. a numeric value to be achieved. There should be a defined process for measuring the expected change before any intervention is taken.

Standardization does not mean cook book medicine. Consensus best medical practice is a set of recommendations graded in the amount of certainty in the effectiveness of a specific treatment. Three gradations of certainty are useful:

1. **Standards –** When there is a proven single best approach to a problem, this best approach is clearly stated as a standard. When a standard exists that is strongly supported by all available evidence, practitioners should follow the recommended approach almost always, rarely deviating from the recommendations. However, this is an uncommon situation in medicine, particularly in an area in which there is so little known as in the use of opioids for chronic non-malignant pain. In spite of the overall amount of uncertainty about what is the best approach to treating chronic pain, there are many aspects of treatment that can be standardized, such as scheduling follow up visits every 28 days instead of 30 days so patients always see the same care provider every time they visit the practice for their pain; opioid prescriptions can only be filled by a single provider; appropriate use of the community emergency room does not vary from one practice to another, to list a few examples.
2. **Guidelines –** When the preferred treatment approach for the vast majority of patients with a given problem is the same and not controversial, such a recommendation is typically referred to

as a "guideline." Small deviations from the recommended practice are common, but not large deviations. An example is the choice of pain medication for post-operative pain for a hip replacement including medication type, dose, frequency of use, number of doses prescribed and number of prescription refills if any. While the best choice of medication may be different for two different patients, the number of doses, refills and other aspects of the prescription can be the same; and

3. **Reasonable Approaches** – When very little is known about the best treatment either because of the unusual nature of the situation or the advent of new treatment alternative, the best practice may not be clear let alone an undisputed standard of care. In these situations, there often are reasonable approaches that can be suggested. There will not be cookie-cutter types of choices for the patient and practitioner, but there will be obvious approaches that are not in the patient's best interest and treatment approaches that are appropriate in the consensus opinion of content experts in the state.

Appendix – 2 Helpful Technology – VPMS

Helpful Technology – VPMS

VPMS Improvement Goals

- Every year the VPMS will be easier to use than the year before
- Threshold reports will be PUSHED to providers
- Treatment agreements will be part of the VPMS
- History of misuse will be part of the VPMS
- Out of state prescriptions will be included
- VA prescriptions will be included
- Providers will know about the delegate option
- VPMS will facilitate communication between prescribers and pharmacists
- Implementation resources will be available to providers

Figure 2

Goal 1 – Every year the VPMS will be easier to use than the year before

Goal 2 – Reports of drug use patterns of patients (VPMS Threshold Reports) will be PUSHED to prescribers and pharmacists on a regular schedule

Goal 3 – Prescribers and pharmacists will have access to any existing opioid agreement and care plan for any patient they treat

Goal 4 – Prescribers and pharmacists will have access to information about prior history of misuse, abuse or diversion for any patient they treat

Goal 5 – VPMS will include dispensed controlled substance prescriptions to Vermont patients from out-of-state pharmacies

Goal 6 – VPMS will explore including prescriptions of controlled substances from the VA

Goal 7 – All prescribers will be aware of the option of assigning delegates to access the VPMS

Goal 8 – Develop a communication strategy among prescribers and pharmacists when a patient is seeking or receiving prescriptions from more than one source

Goal 9 – All practitioners will have access to resources to assist them with integrating efficient, effective and timely use of the VPMS in their practice

Goal 10 – Real-time access to opioid care plans for all patients
Does this patient already have a opioid care plan already in place with another practice? Can this be incorporated into the existing Vermont Prescription Monitoring System?

Appendix 3 Informed Consumers

Educate the public to expect best medical practices

Goal 1 – The public will view prescription drug abuse as a public health concern

Goal 2 – Campaign will model the successful campaign addressing tobacco use

- **Statewide advisory council**
- **Media involvement - Public service announcements**
- **Treatment opportunities**
- **Evaluation strategy, e.g. Behavioral Risk Factor Survey**

Goal 3 – School population will understand the dangers of prescription drug misuse

Goal 4 – Pill disposal resources will be accessible in every community

Goal 5 – Community-specific information about prescription drug abuse

What is the extent of prescription drug abuse in my community?

Informed Consumers

Goals for a Public Health Campaign

- Public understanding of the consequences of prescription drug abuse
- Model Tobacco Cessation Campaign
- Focus on school population
- 24/7/365 pill disposal capacity in all communities
- Community specific drug abuse data PUSHED to communities

Figure 3

Appendix 4 Structured Interview Methodology

Approximately 40 professionals were asked to participate in the structured interview process that underlies the comments and recommendations in the white paper. The individuals were either someone who was known to the interviewers as having interest and expertise in treating chronic pain or someone that was suggested to them by another interviewee. No one asked refused to be interviewed except one law enforcement professional who did not feel that his input would be helpful. Not everyone willing to be interviewed was actually interviewed due to lack of time and resources.

After each interview a written summary of the interview was sent to each interviewee for review and editing. An initial draft of the white paper was written based on the aggregated interviews. The draft document was then sent to all interviewees for review; this was the first time that interviewees had the opportunity to see what others had said.

The final document does not differ from the draft except for one significant change. The original draft had only six sections. A seventh section - Differentiate the role of law enforcement from the role of care giver - was added in an effort to capture the complex interface between the need to treat individuals and the need to protect the public health.

The remainder of this appendix includes: 1) The letter of request for interviews; and 2) the structured interview itself. An overview article from UCLA on the technique of structured interviews including the pros and cons of the method is accessible at the following web link:
http://www.healthpolicy.ucla.edu/healthdata/ttt_prog24.pdf

Dear Colleagues:

The VMS Foundation, in partnership with the Health Department's Division of Alcohol and Drug Abuse Programs (ADAP), is interested in collecting information from you, an individual who has first-hand knowledge about the health care delivery system in your community and in particular the challenges of providing safe and effective treatment to persons with chronic pain. Your particular knowledge and understanding will provide insight that will help the Foundation and ADAP craft useful resources preparing and supporting physicians to best care for patients with chronic pain in the context of the ever increasing complexities of health care delivery and public health systems.

We anticipate the interview to last for 20 minutes. We'd like to complete all interviews by Friday June 29th.

Please let us know if you are interested in being interviewed and if there are specific days and times that work best for you. We will also be following up with you to help with scheduling a practical time for the interview.

Thank you in advance for your time and effort.

Key informant interview

A. General Questions about Managing Chronic Pain

1. **What is the most pressing issue that affects the effective and safe management of patients with chronic pain in your community?**

2. **If you are a direct care provider, what's the most pressing issue in your practice related to chronic pain patients?**

3. **What is the most exciting/appealing practice or community innovation that you are aware of that would help you?**

4. **What is the most pressing quality or safety issue in your practice? In your community?**

5. **Which of the following are barriers to addressing patients' pain?**
   - **Lack of knowledge or training on assessing and treating pain**
   - **Insufficient time with patients**
   - **Fear that patients will become addicted**
   - **Fear of discipline from licensing board for improper prescribing license**
   - **Hospice and palliative care services not readily available for patients**
   - **Pain management consultation is not readily available for my patients**
   - **Substance abuse and addiction Rx not readily available for patients**
   - **Other**

6. **Do you recommend any of the following non-pharmacological treatments to your patients to address pain**
   - **Acupuncture**
   - **Massage**
   - **Meditation**
   - **Relaxation**
   - **Spiritual**
   - **Exercise**
   - **Yoga**
   - **Non-prescription supplements**
   - **Other**

B. Educational Resources for Managing Chronic Pain

7. **What knowledge based education (best clinical practices) would be most helpful to you?**
   - **What would be the best venue/mechanism?**
     a. **Lectures/Grand Rounds**
     b. **Peers**
     c. **Professional association**
     d. **Journals**
     e. **Research literature**
     f. **Websites**
     g. **Other**
   - **Have you used any of the educational tools for pain management on the VMS website or on the ADAP website?**
     a. **If so have they been helpful?**

8. **What skills-based education is of most interest to you?**
   - **Leadership skills to manage change**
   - **Management skills to improve team work**
   - **Analyze and improve practice efficiency and safety**
   - **What would be the best way for you to access such resources?**

C. Prescription drug misuse/abuse

9. **Do you feel that prescription drug miscues/abuse is a problem in your community?**

10. **Do you feel that there is sufficient training being provided to you and other health care professionals in Vermont on prescribing controlled substances?**

11. **Have you registered to use the Vermont Prescription Monitoring System or have a registered delegate?**

    a. **If you have registered, have you used the VPMS? If yes, please provide details of times when you would use the system. If not, please provide information about what barriers you perceive there to be that would prevent you from using the system.**
    b. **As a prescriber or dispenser, talking with your patients is a very important aspect in the diagnostic and treatment process. Do you discuss information contained in a VPMS patient report with your patients in the normal course of treatment?**
    c. **Do you feel that the VPMS is a tool that can help to decrease opioid abuse, addiction and diversion?**
    d. **Do you feel people are less likely to abuse prescription drugs when they are being monitored?**
    e. **When treating a patient, how important is a KASPER patient report in helping a prescriber make a decision about which drug to prescribe?**

12. **Are there other tools you use (i.e. urine screens, opioid agreements, Vermont Medical Practice Board Guidelines on Opioid Prescribing) to assist you in identifying a patient that may be at risk for abuse or diversion? Do you feel that any of these have been helpful?**

13. **Do you feel confident about what resources in your community are available to you once you identify a patient that is addicted to prescription drugs or is diverting prescription drugs?**

14. **In your opinion, what is the best way to reduce prescription drug diversion?**

15. **Is there any additional information or comments that you'd like to offer?**