

Comparing opioid use characteristics amongst patients who were mandated to receive chronic pain e-consult versus those who were referred at UCONN Health.

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Background

In 2021, over 106,000 people died from illicit and prescription opioid overdose in the United States¹. Prescription opioid death rates rose from 3,442 deaths in 1999 to 16,706 in 2021¹. At UCONN Health, pain management e-consults have been implemented by an interdisciplinary team consisting of an addiction psychiatrist, pharmacist, and two primary care providers (PCP) to enhance quality of life, reduce pain, and optimize medication regimens to mitigate risk. These consults are provided at the request of PCP (referred) and for patients on high-risk regimens defined as morphine milligram equivalents (MME) > 90 or those who missed follow up (mandated). **The goal of this study was to evaluate if the origin of reason for eConsult affected the uptake of recommendations and improvement in safety metrics for high-risk patients on LTOT.**

Methods:

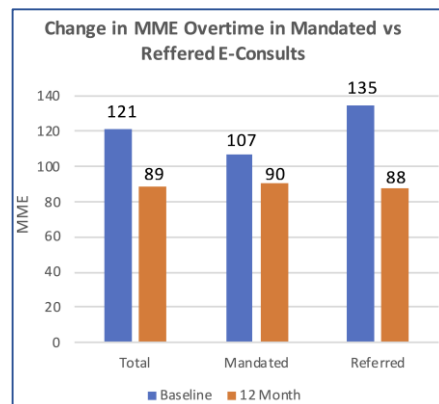
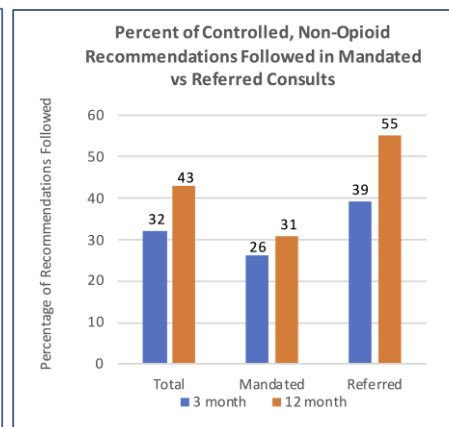
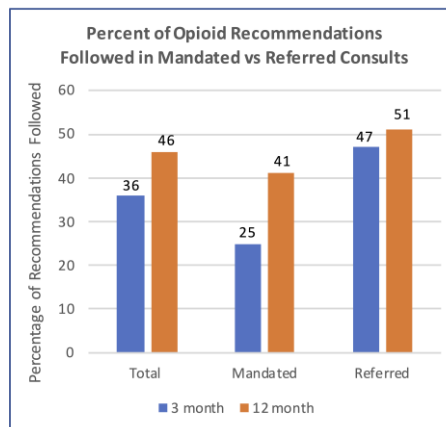
E-consults conducted at UCONN Health between 2019 - 2022 (n= 116) were reviewed and categorized as

- Mandated (consult prompted by MME > 90 or lack of follow-up)
- Referred (consult prompted by PCP referral)

Outcomes in mandated & referred patients were compared at 3-, 6-, & 12-months after initial e-consult to determine differences in:

- Percentage of recommendations followed
- MME
- Use of medication agreement
- Urine toxicology
- Naloxone prescriptions

Results



	% Followed Urine Toxicology Recommendation	
	Baseline	12 Months
Mandated	31%	37%
Referred	52%	48%

	% Followed Naloxone Prescription Recommendation	
	Baseline	12 Months
Mandated	29%	20%
Referred	28%	27%

	% Followed Med Agreement Recommendation	
	Baseline	12 Months
Mandated	64%	83%
Referred	54%	66%

Conclusions

Prescribers following opioid, controlled non-opioid, and non-controlled pharmacologic recommendations increased over time indicating that eConsults are effective to communicate comprehensive treatment options. Use of eConsult recommendations increased gradually over 12 months mirroring literature on behavioral change occurring over years. Use of medication agreement and MME reduction was most improved in both groups. Adherence to urine toxicology screening was more difficult to improve possibly due to the COVID pandemic making patient less likely to go to the lab to leave a sample. The requirement for a medical prescription for naloxone was removed during the study period which may have affected physician ordering. Both mandated and referred consults had a decline in MME over time and an MME < 90 at the 12-month follow up, which is an important safety metric related to overdose risk.

Implications

Overall, our study suggests that both mandated and referred consult methods are effective in improving chronic pain pharmacologic regimens, lowering MME, and increasing medication agreement adherence. Our data may also suggest that requesting a consult (referred) may have a quicker and more robust uptake of our recommendations, but this requires further study. Additionally, our study suggests that adjustment in approach may be needed to increase adherence to urine toxicology screening. Lastly, our study implies that prescription laws likely play a role in naloxone prescribing.

References

1. Drug Overdose Death Rates. National Institute on Drug Abuse: Trends and Statistics. Feb 2023. Accessed at: <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>
2. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: <http://dx.doi.org/10.15585/mmwr.rr7103a1>.