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(248) Do self-reported analgesic barriers translate into objective analgesic adherence for cancer pain?

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Racial disparities in both prescription of analgesics for pain and their adherence by minority patients are widely documented. Interventions to improve analgesic adherence are based primarily on psychoeducational paradigm focusing on dismantling attitudinal barriers to cancer pain management. We investigated if self-reported analgesic barriers translate into objective adherence to analgesia for African Americans and Whites. African-Americans (n=102) and Whites (n=139) diagnosed with solid tumors having at least one prescription of around-the-clock analgesics were recruited from outpatient oncology clinics in the Mid-Atlantic region. Analgesic Adherence was captured using Medication-Event-Monitoring-System [MEMS®] over 3-months period (% of 'doses' taken compared with numbers prescribed). Analgesic Barriers were elicited using Barrier's Questionnaire (subscales: physiologic effects, fatalism, communication and harmful effects). African Americans reported significantly higher levels of cancer pain (p<.001), lower pain relief (p<.001), and greater pain-related functional-interference (p=.014). Despite significant pain, there were stark disparities between African Americans and Whites in analgesic adherence using MEMS® (55% vs. 74%, p=.000). Interestingly, while African Americans reported higher number of analgesic barriers when compared to Whites (p=.004), the relation of analgesic barriers to analgesic adherence was not straightforward. In separate multivariable regressions conducted with African Americans and Whites to identify unique predictors of adherence, none of the "self-reported analgesic barriers" accounted for analgesic adherence for Whites. For African Americans, only one barrier, i.e., tolerance fear, predicted actual analgesic adherence using MEMS; in adjusted analysis, the most powerful variables in predicting analgesic adherence were "intentional non-adherence" (i.e., stopping to use pain medications when feeling better or worse) and analgesic side-effects. These data suggests that our current understanding of the complex relations among barriers and adherence and if and how they contribute to pain outcomes are limited. Further, improving clinical management of pain may be central in ameliorating disparities in analgesic adherence for cancer pain. (Research support: NIHRC1NR011591).

(249) Adolescents' home pain management after laparoscopic appendectomy: unexpected findings

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Appendectomy is the most common surgical reason for emergent pediatric hospitalization. Yet, knowledge of children's analgesic use after discharge home is limited. As opioid use for the treatment of pain has become more common, prescription opioid diversion has too. Of adolescents who reported misusing prescription opioids, over 40% reported getting them from a friend or relative; and 20% reported getting them from physicians. One fifth of US adolescents self-reported sharing prescription drugs. Prescribers need more information regarding the trajectory of post-surgical pain to provide a sufficient amount of opioid analgesics for pain management without over-prescribing and inadvertently contributing to the problem of controlled substance diversion. The purpose of this investigation is to describe children's home opioid use after laparoscopic appendectomy. Subjects completed 14 day home pain management diaries; and their prescription opioid analgesics were dispensed with eCap technology. With only 26 children (mean age 13 years 8 months) enrolled, we have identified three types of unexpected findings: 1. Two cases of irregularities in prescription analgesic dispensing– One family reported not filling the prescription, but the prescription monitoring program indicates the drug was dispensed in the child's name. Another family could not provide state identification; so the drug was not dispensed by the pharmacy for the child's pain management. 2. Data discrepancies were found in the diaries, eCap data, and pill counts. Based on diary data, 10 of the 12 patients who completed all study procedures had a surplus of pills (mean of 8.5 pills, 4 to 26), but only 8 presented a surplus for pill count (mean of 7.8 pills, 3.5 to 25). 3. There were unexplained pill bottle openings – all on Fridays, Saturdays, or Sundays. These types of unexpected findings suggest barriers to appropriate pain management and provide evidence of the potential for prescription opioid diversion.

C05 Pain Clinics - Multidisciplinary

(250) Rapid triage evaluation: one initiative solves three pain clinic performance imperatives

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Multidisciplinary pain clinics face a growing number of challenges: Access to multidisciplinary pain care can take months. Opioid management has become increasingly complex as standards change and the risks of chronic opioid therapy are headlined. Co-occurring psychiatric conditions and substance use disorders can be barriers to successful treatment within a multidisciplinary framework. Reimbursement for multidisciplinary treatment is declining. Fairview Pain Management Center provides multidisciplinary pain management to over forty affiliated primary care clinics. We were faced with three imperatives: 1. Reduce the wait times for pain evaluations to less than two weeks and provide timely help and guidance to the referring primary care physician. 2. Enhance the screening of patients to assure that those we do treat are likely to participate fully and have successful outcomes, while avoiding enrollment of patients for whom multidisciplinary care is unlikely to be effective or practical. 3. Increase patient volumes (i.e. revenue) to meet the expectations of a health system that is facing budgetary challenges. The Rapid Triage Evaluation (RTE) was developed to address these challenges. Patients are scheduled within two weeks for a RTE without our customary preliminary screening. The RTE is a 20-30 min evaluation carried out by the pain specialist in order to get a quick assessment of the nature of the pain problem, suitability for multidisciplinary pain treatment, appropriateness of opioid therapy, and to identify other interventions that a primary physician can initiate without delay. No prescriptions are written and no procedures are carried out during the RTE. Comparing outcomes before and after instituting RTE, we demonstrate reductions in wait times, higher engagement among patients entering multidisciplinary care with fewer missed appointments, higher volumes, and increased satisfaction among referring physicians who are given immediate treatment recommendations and practical advice about opioids.

(251) Retrospective analysis of clinical and economic results of genotyping at-risk patients to guide narcotic detoxification

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Genotyping technology was used to guide narcotic detoxification efforts using Suboxone and other interventions and the clinical outcomes were determined. The patients were genotyped using the Proove Narcotic Risk Test using Real Time PCR TaqMan assay. Patients were enrolled in the NESP Suboxone narcotic detoxification program over a 90 day period with ongoing maintenance therapy based on genotype over two years. The subjects were chronic pain patients dependent on Rx narcotics [n=159] of which 82% [121 patients] had a successful outcome and of the 18% [27 patients] that were outside the category, 90% [24 patients] had a s successful initial outcome but due to subsequent medical problems or additional surgery by other healthcare professionals are now back on chronic Narcotic therapy. The remaining 3 relapsed for no medical reason the annual direct healthcare costs of these patients was reduced by $1.694M. The ROI was 0.28 or about $500,000 in the first year and 2.8 over two years. This compares favorably with other programs. Thus by genotyping patients and using the information to identify candidates for narcotic detoxification programs, the patient , physician and payer can benefit from improved clinical outcomes and cost savings over a multi-year period. This study was supported by a grant from Proove Biosciences Inc.