(Awad et al., 2012). In order to study its effects as a pain management protocol in bariatric surgery patients, a retrospective chart analysis was completed of 285 bariatric surgery patients at a Midwestern hospital. Statistical analysis comparing surgical patients from October 1, 2015 to March 31, 2016 (Traditional Recovery) to patients from April 1, 2016 to September 30, 2016 (Enhanced Recovery) demonstrated a nonsignificant decrease in average pain scores (pre vs post, $p>0.05$). There was a statistically significant decrease in the length of stay in the enhanced recovery patients, compared to the traditional recovery group ($p<0.05$). While there was no statistically significant change in HCAHPS scores, there were noticeable increases in satisfaction for enhanced recovery patients. Due to the homogeneous nature of the samples, it is thought that much of the change was due to the protocol. However, there was no analysis of rates of chronic pain conditions between populations, which could have impacted the findings.

3E.3. Cognitive Behavioral Therapy for Spinal Cord Injury Patients with Chronic Neurogenic Pain

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The incidence of neuropathic pain after spinal cord injury (SCI) has been estimated at 75%. A common treatment for this pain is often ongoing opioid prescription medication despite limited evidence that these medication are effective for neurogenic pain. Recognizing the need to decrease the number of patients with SCI on continuous opioid medications, the often overlooked approach of Cognitive Behavioral Therapy (CBT) was tested in a group of six patients.

METHODS

A pilot group was started with 6 SCI patients, these patients were chosen due to their history of frequent requests for escalating doses of opiates and early refills. Outbursts of verbal abuse and threats against staff were common. The group met every two weeks and was led by a Pain Resource Nurse and Physician Assistant. Activities included guided imagery, meditation, and education about pain, pain medications, and other non-pharmacological pain management techniques.

RESULTS

Requests for early refills still occurred however, the patients handled this in a more appropriate manner by calling ahead of time and and discussing the issue with the Pain Management Nurse, this intervention provided an outlet to discuss the reasons for the need for the early refill and develop a plan for managing the pain without the early refill. Episodes of behavioral outbursts aimed at staff decreased and self-management of chronic pain symptoms was evident. Data from the Brief Pain Inventory assessment tool showed improvement in “pain at its worst in the last 24 hours” from an average of 9.75 at group initiation to 7.2 at four months post. Conclusions CBT is a beneficial tool for management of chronic pain in a small group of patients with SCI. It may not be as effective with larger groups.

4A Patient and Prescriber Anxiety about Benzodiazepines Combined with Opioids: Alternatives for the Non-Psychiatric Practitioner

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With the rise of public and professional attention on opioid overdose deaths, benzodiazepines (BZDs) have emerged as a significant risk factor for fatal overdose when combined with opioids. Studies vary in calculating a 4 to 10 fold increase in risk of death with combined opioids and benzodiazepines. At the same time, anxiety is a common comorbidity in chronic pain patients- as well as in many patients recovering from acute pain episodes. Side effects and risks of BZDs alone and in combination with opioids is explored in this session, along with recommendations for anxiety management including non-pharmacologic interventions and pharmacologic therapy with non-BZD medications. Understanding these principles can aid the pain management practitioner in communicating BZD risk and safer alternatives to patients and in discussion with other healthcare prescribers to foster a safe and effective team approach addressing the patient's physical and psychological needs.

4B Chronic Opioid Therapy in Persistent Pain: Patient Selection and Risk Reduction Strategies

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The aim of the presentation is to review safe opioid prescribing in the patient population of persistent chronic non-cancer pain within the CDC Guidelines for Prescribing Opioid. The method utilized is a convenience sample of subjects in a community based Comprehensive Pain Clinic. During the initial interview all patients were screened for comorbid conditions that increase the risk of unintended opioid overdose. In addition, current opioid analgesia, current medication list and prior pain therapies were reviewed. All patients, if on opioids, were assessed for dose lowering strategies. A particular emphasis was placed on patients at risk for adverse events related to opioid use, those with a morphine equivalent dose (MME) greater than 80 mg per day and patients that were pain treatment naïve. Patients with substance use disorder were excluded and referred for treatment. Patients agreeable for opioid lowering strategies were tapered at 10-15 % every 1-2 weeks while incorporating multimodal analgesia, physical reconditioning and cognitive behavioral therapy as indicated. The results of the study suggest that patients whose opioids were tapered to goal of less than or equal to 80 mg MME demonstrated an improvement in pain control and quality if life. In conclusion, patients with chronic persistent non cancer pain on opioid therapy, have better quality of life and less pain with opioids at less than or equal to 80 MME. The risk of unintended opioid related events are further reduced while incorporating strategies that look at patient selection with and implementing non opioid treatment strategies Opioid tapering at 10-15 % is safe, effective and well tolerated. Future studies to replicate these results should continue. Application of this study, can not be generalized to the primary care. Future study within primary care that targeting early intervention to prevent high dose opioid therapy should be considered.

4C Reducing Unintended Variation in Discharge Opioid Prescribing in a Pediatric Hospital Setting

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BACKGROUND AND AIM

In 2017, Children's Hospital Colorado finalized a clinical pathway to reduce unintended variation in opioid prescribing for pediatric patients with acute pain. Subsequently, the team aimed to analyze baseline prescribing data for Orthopedic Surgery inpatients and to design an improvement project to implement the pathway's recommendations. The improvement project will launch in early 2018 to increase compliance with the clinical pathway's recommendation to limit discharge prescriptions to a maximum of 7 days.

METHODS

A multi-disciplinary team conducted a retrospective review of prescribing data from January to December 2017. Based on the data, the team designed an improvement project to facilitate implementation of the clinical pathway at the bedside. Improvement strategies included dissemination of the pathway, enhanced substance use risk screening by nurses, EMR-based clinical decision support tools, education materials for patients/caregivers and pharmacist review of discharge opioid prescriptions exceeding 7 days.

RESULTS

At baseline, 1190 Orthopedic Surgery patients were discharged with opioids. The median patient age was 11, 48% were female and 26% were Hispanic/Latino. Patients were discharged with an average of 7.75 days' supply of opioids, with a range of .04 to 58 days prescribed. 51% ($n = 602$) of discharge prescriptions followed the recommended 7-day maximum. The pilot project will launch in March 2018 and aims to increase compliance with the 7-day maximum to 75% by July 2018. Outcome data will be available to report at the conference.

CONCLUSIONS

The clinical pathway and improvement project are innovative strategies for appropriate utilization of opioids for acute pain in pediatric patients. The pilot will expand to other departments in 2018. The initiative also highlights lessons for other healthcare entities, including: (1) building an