Pain Management vs. Diversion Part 2

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Disclosure/Conflict of Interest

I, Kenny Jackson, have no actual or potential conflict of interest in relation to this program.

Learning Objectives

- Part II
  - Explain appropriate use of opioids in the treatment of pain
  - Discuss provider implemented strategies to ensure safe and effective pain management for patients in addiction recovery
  - Demonstrate best practices in pain management, avoidance of addiction/diversion, and collaboration among healthcare providers

Our Patient

- WK is a 39 year old Caucasian male that presents to your clinic.
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  - Presents today with worsening pain in lower back (NRS 9/10)
- Height 6'4"; Weight 240 lbs; BMI 27.4; HR 70; BP 140/90
- Labs: LDL 180; HDL 35; TG 150; BMP WNL
- Medications
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    - Uses 3-4 times daily
  - Tiger Balm Muscle Rub PRN
    - Uses daily before work and bed
  - Famotidine 20 mg (OTC) PO QD
    - Uses most days
  - Acetaminophen 500mg (OTC) PO PRN
    - Uses only for headaches
  - HCTZ 50 mg PO once daily
  - Atorvastatin 20 mg PO once daily

What Would You Do?

- Patient has exhausted non-opioid pharmacotherapy and non-pharmacological options.
- What would you use and how would you prescribe?

Chronic Pain Treatment Paradigm

Physical

- Back exercises
- Aerobic exercise

Behavioral

- Stress management
- Mental Health

Pharmacotherapy

The WHO Ladder

Freedom From Cancer Pain

Step 3: Opioid for Moderate to Severe Pain

±Nonopioid

±Adjuvant

Pain persisting or increasing

Step 2: Opioid for Mild to Moderate Pain

+Nonopioid

±Adjuvant

Pain persisting or increasing

Step 1: Nonopioid

±Adjuvant

Pain

Source: WHO, 1990. Used with permission.

The WHO Analgesic Ladder

Step 1, Mild Pain: Pain intensity 1-3 on the numeric rating scale.

- Acetaminophen, Nonsteroidal anti-inflammatory drugs (NSAIDs)
- +/- Adjuvant Analgesics

Step 2, Moderate Pain: Pain intensity of 4-6 on the numeric rating scale.

- Simple analgesics (Acetaminophen, NSAIDs)
- PLUS “weaker” opioids (Codeine, Hydrocodone, Oxycodone)
- +/- Adjuvant Analgesics

Step 3, Severe Pain: Pain intensity of 7-10 on the numeric rating scale.

- Simple analgesics (Acetaminophen, NSAIDs)
- PLUS “Stronger” opioids (Morphine, Oxycodone, Hydromorphone, Fentanyl,
- Methadone, Levorphanol)
- +/- Adjuvants

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

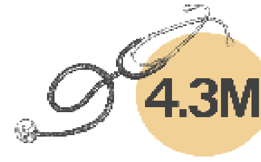
Promoting Patient Care and Safety

THE US OPIOID OVERDOSE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

More than 40 people die every day from overdoses involving prescription opioids.[1]

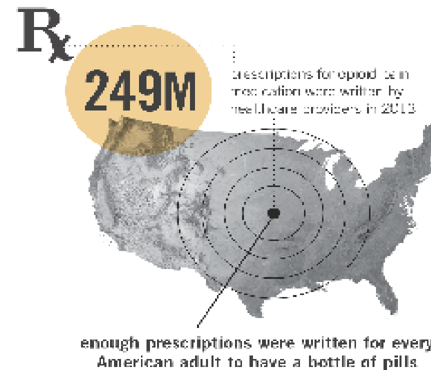
Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.[1]

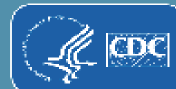


4.3 million Americans engaged in non-medical use of prescription opioids in the last month.[2]

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.





U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC Opioid Guidelines: Initiate Opioids for Chronic Pain

Recommendation 2: (category: A; evidence type: 4)

- Establish treatment goals
  - Realistic goals for pain & function
- Exit Strategy
  - How will opioid therapy be discontinued if benefits < risks
- Assess and treat psychological comorbidities
  - These often coexist with & can interfere with resolution of pain

Recommendation 3: (category: A; evidence type: 3)

- Discuss with patients known risks & realistic benefits of opioid therapy & patient & clinician responsibilities for managing therapy

CDC Opioid Guidelines: Continue Opioids for Chronic Pain

Recommendation 2: (category: A; evidence type: 4)

- Continue opioid therapy only if there is clinically meaningful improvement in pain & function
  - Must outweigh risks to patient safety
- Use validated instruments to assess and track patient outcomes
  - PEG Assessment Scale
- Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain & function.

Recommendation 3: (category: A; evidence type: 3)

- Discuss with patients known risks & realistic benefits of opioid therapy & patient & clinician responsibilities for managing therapy

PEG

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Krebs EE, Lorenz kA, Bair MJ, et al. Developing and Initial Validation of the PEG, a Three-Item Scale Assessing Pain Intensity and Interference. J Gen Intern Med. 2009. 24(6):733-8.

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Discussion Time:

- Pain Average in Past 5/10
- PEG Today
  - Pain 9
  - Enjoyment 10
  - General Activity 8
- What are Realistic Goals?

Monitoring Opioid Therapy

Critical outcomes

- Pain relief
- Function
  - physical
  - psychosocial
- Side effects
- Drug-related behaviors

The "4-A's of Pain"

- Analgesia
- Activities of daily living
- Adverse effects
- Aberrant drug-taking behaviors

Passik SD, Weinreb HJ. *Adv Ther.* 2000;17:70-83.

Aberrant Drug-taking Behaviors

Major

- Selling prescription drugs
- Prescription forgery
- Stealing or borrowing another patient's drugs
- Injecting oral formulation
- Obtaining prescription drugs from nonmedical sources
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose escalations
- Recurrent prescription losses

Minor

- Aggressive complaining about need for higher doses
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquisition of similar drugs from other medical sources
- Unsanctioned dose escalation 1–2 times
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician

Passik SD et al. *Oncology*. 1998;12(4):517-521,524.
Passik SD et al. *Oncology*. 1998;12(5):729-734,736.

Monitoring Aberrant Drug-Related Behaviors: 2-Step Approach

Step 1:

Are there aberrant drug-related behaviors?

Step 2:

If yes, are these behaviors best explained by the existence of a substance use disorder?

Opioid Therapy & Substance Abuse

Differential Diagnoses of Aberrant Drug-Related Behavior

- Addiction vs. Pseudo-addiction vs. Pseudo-tolerance
- Psychiatric disorders
  - e.g. borderline personality disorder
- Cognitive disorders
  - E.g. mild encephalopathy
- Family issues
- Criminal intent

CDC Opioid Guidelines Monitoring Recommendations

Recommendation 9: (Recommendation category: A; evidence type: 4)

- Review PDMP data when starting opioid therapy for chronic pain & periodically during therapy for chronic pain, ranging from every prescription to every 3 months.
- Review data to determine whether the patient is receiving opioid dosages or dangerous medication combinations (e.g. benzodiazepines) that put patient at high risk for overdose.
  - Avoid opioids & benzodiazepines concurrently whenever possible.
- Discuss safety concerns, including increased risk for respiratory depression & overdose if a patient has more than 1 prescriber or receiving medications that increase risk when combined with opioids Clinicians should consider the possibility of a substance use disorder & discuss concerns with their patient.

CDC Opioid Guidelines Monitoring Recommendations

Recommendation 10: (Recommendation category: B; evidence type: 4)

- Use urine drug testing (UDT) to assess controlled Rx and illicit substance use
  - Prior to starting
  - At least annually
- Be familiar with the drugs included in UDT panels used in your practice
  - Understand how to interpret results for these drugs
- Do not dismiss patients from care based on UDT results
  - This can have adverse consequences for patient safety, including missed opportunities to facilitate treatment for substance use disorder.

CDC Opioid Guidelines Patients with SUD

Recommendation 12: (Recommendation category: A; evidence type: 2)

- **If OUD suspected, discuss concerns with the patient & provide an opportunity for the patient to disclose related concerns or problems.**
  - **Patients concerns or behaviors**
  - **PDMP data**
  - **UDT Clinicians should assess for opioid use disorder using *DSM-5* criteria.**
- **Offer or arrange evidence-based treatment**
  - **Medication-assisted treatment (MAT)**
  - **Buprenorphine or methadone**
  - **Behavioral therapies**
- **If you are in a community without sufficient treatment capacity consider SAMHSA waiver to treat OUD with buprenorphine**
- **If you are unable to provide treatment arrange for patients with OUD to receive care from a SUD specialist**

CDC Opioid Guidelines Recommendation Highlights

Recommendation 8: (Recommendation category: A; evidence type: 4)

Potential benefit of Naloxone

Evaluate for potential opioid-related harms

- History of overdose
- History SUD
- Higher opioid dosages
- Concurrent benzodiazepine use

Evaluate patient factors

- Moderate or severe sleep-disordered breathing
- Pregnancy
- Impaired hepatic or renal function
- Age $\geq$ 65 years
- Presence of depression or mental health conditions

A TREATMENT IMPROVEMENT PROTOCOL

Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders

TIP 54

Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Treatment Team

- Primary Care Provider
- Addiction Specialist
- Pain Clinician
- Nurse
- Pharmacist
- Psychiatrist
- Psychologist
- Other Behavioral Specialists
  - MSW, Marriage/Family Therapist or Counselors
- Physical and/or Occupational Therapists

Screening Tools for Opioids & Substance Misuse – Patient Reported

- ORT: Opioid Risk Tool
  - Simple 5 Question Tool
- SOAPP: Screener Assessment for Patients with Pain
  - Proprietary
    - http://lwpainmanagement.com/uploads/3/1/9/2/3192998/soapp-r.pdf
  - Patient Reported
  - Multiple versions (8, 14, & 24 Question Versions)
- COMM: Current Opioid Misuse Measure
  - Proprietary
    - https://www.opioidprescribing.com/documents/09-comm-inflexxion.pdf
  - Patient Reported
  - 17 Questions

Screening Tools for Opioids & Substance Misuse – Clinician Administered

- DIRE: Diagnosis, Intractability, Risk, and Efficacy
  - Clinician administered
  - 7 Factors
  - Scores < 13 indicate may not be suited to long-term opioid management
  - http://www.emergingsolutionsinpain.com/content/tools/esp_9_instruments/pdf/DIRE_Score.pdf
- PADT: The Pain Assessment and Documentation Tool
  - Clinician administered
  - Fairly comprehensive
  - https://healthinsight.org/Internal/assets/SMART/PADT.pdf
- CAGE-AID: CAGE Adapted to Include Drugs
  - Simple 4 Question Tool

Steps After Assessment of a Substance Use Disorder

- Remote history of abuse and patient in long-term recovery
  - ***Verify & support recovery***
- Patient on Medication-Assisted Treatment (i.e. Methadone. Buprenorphine
  - ***Verify and continue MAT***
- Active substance abuse or Substance Use Disorder
  - ***Refer patient to substance abuse specialist for evaluation***

SAMHSA TIP 54
Passik and Kirsh 2004

Documentation – TIP 54

- History and Physical Evaluation
  - HPI, Medical Hx, Mental Status/Cognition, Diagnostic studies, Pain Score, Medication Hx, SUD/Addiction Hx, Screening Tool assessment
- Diagnostic/Clinical Indication for Prescribing Opioids
  - Most probably pathological explanation of chronic pain
- Treatment Plan
  - Pharmacotherapy and nonpharmacological treatments
  - Treatment goals and anticipated time course
  - Adherence measures (e.g. Pill counts, UDT)
- Informed Consent and Agreements for Treatment
  - Discussion of risks and benefits
  - Patient and Clinician responsibilities
- Periodic Review
  - Pain score/intensity
  - Function (e.g. physical, occupational, mood/sleep, family & social
  - Medications
  - Aberrant drug related behaviors
  - Mental status or cognitive changes
- Consultations and Referrals

SAMHSA TIP 54

Treating Chronic Non-Cancer Pain in Recovery

Patients in Long-term Recovery or SUD in distant past

- Use non-opioid analgesics as determined by pathophysiology
- Use nonpharmacological therapies
  - Examples: Cognitive–behavioral therapy [CBT]; Physical therapy; Therapeutic exercise; CAM
- Treat psychiatric comorbidities
  - Benzodiazepines not recommended
- Assess treatment outcomes
- Initiate opioid therapy with extreme caution:
  - ONLY if the potential benefits outweigh risk
  - ONLY for as long as it is unequivocally beneficial to the patient

SAMHSA TIP 54

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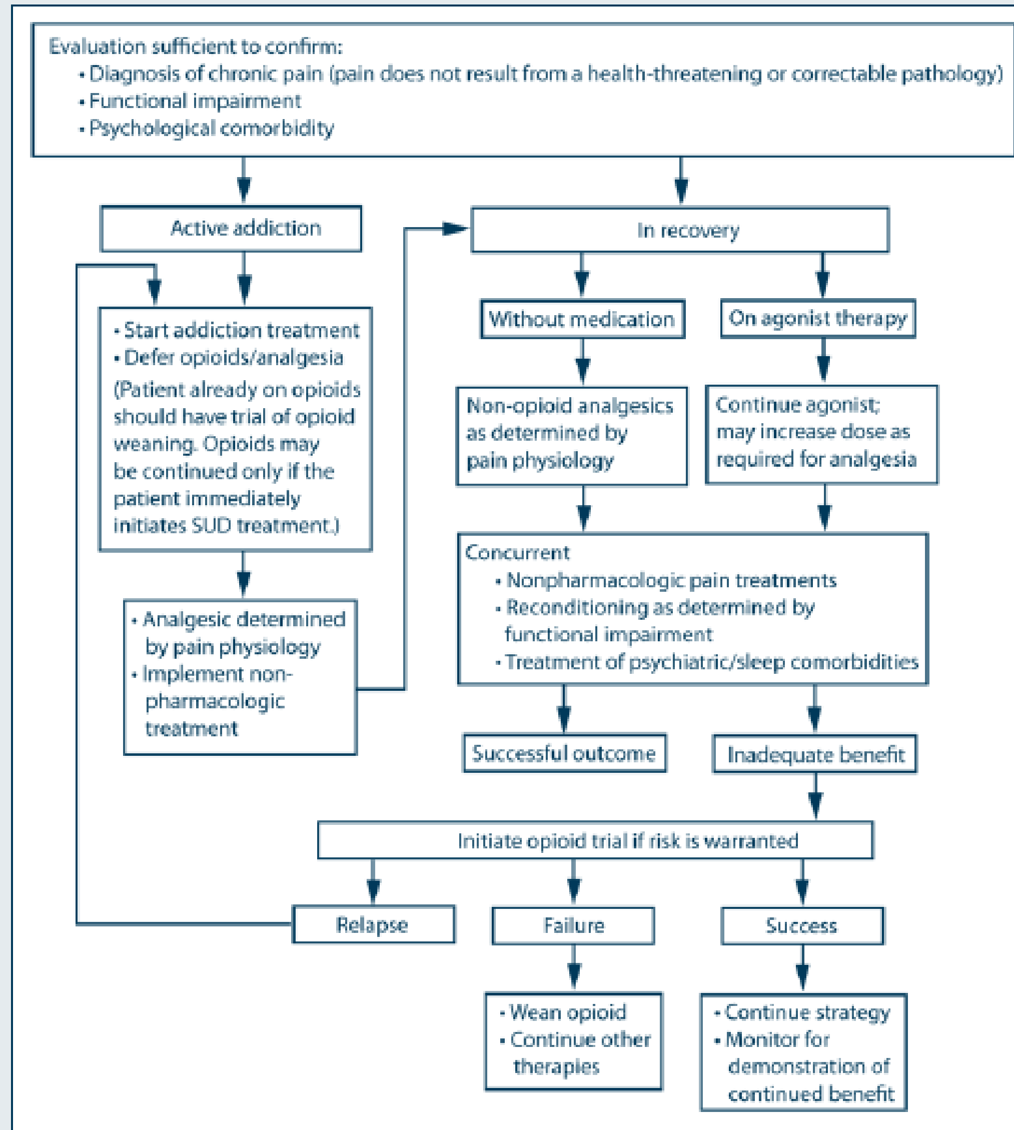
Discussion Time:

- Patient has a history of heroin use as a teen
- PDMP is appropriate
- UDT negative for opioids or illicit substances



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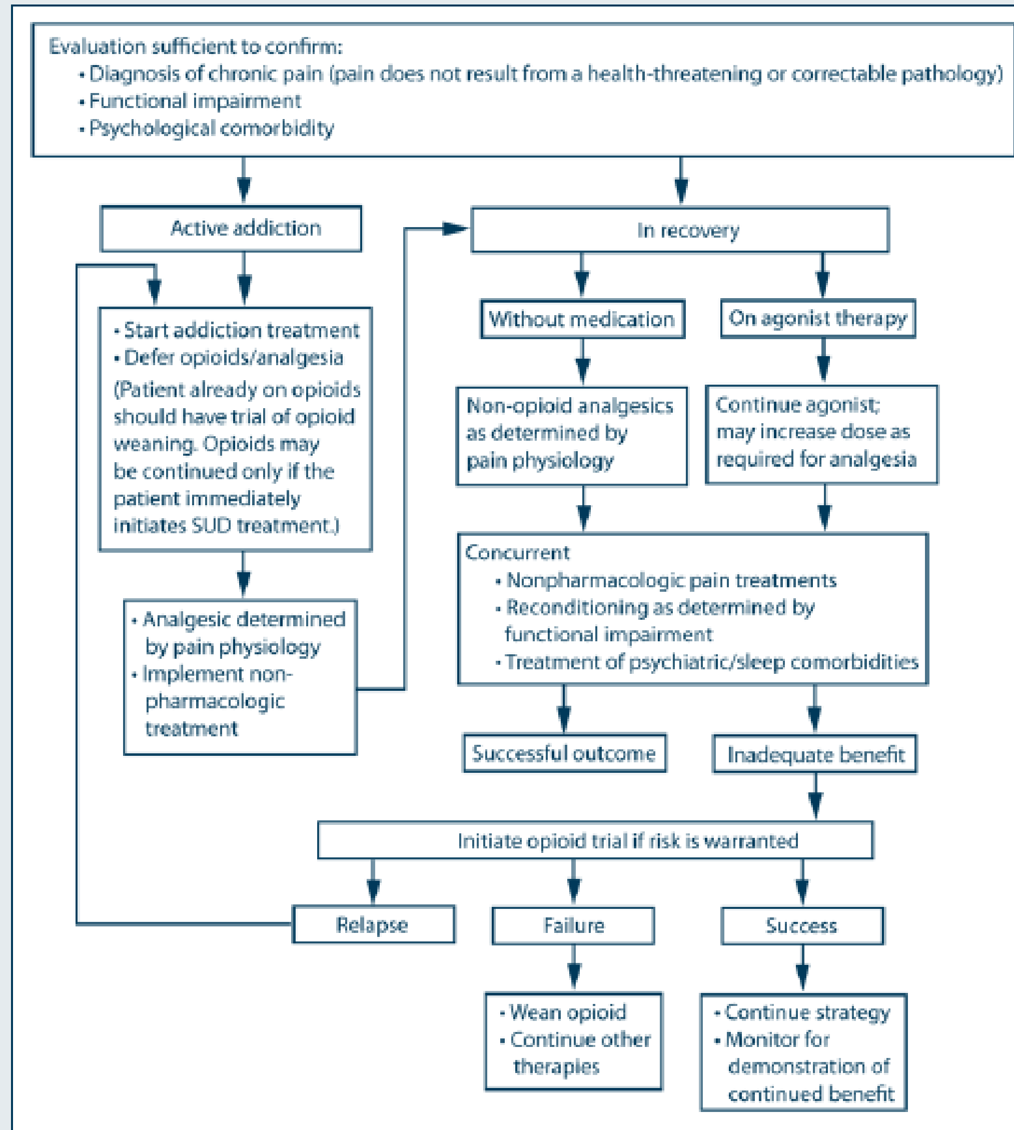
Discussion Time:

- Patient has a history of heroin use as a teen
- PDMP indicates opioids from other prescribers
- UDT positive for cannabis and cocaine



SAMHSA TIP 54

Opioid Selection

- Select opioids with minimal rewarding properties when effective
  - Examples tramadol, codeine
- Avoid prescribing supratherapeutic doses
  - Usually demonstrated by sedation, lethargy, functional impairment
- If higher potency opioids are required, prescribe slow-onset opioids with prolonged duration of action

SAMHSA TIP 54

CDC Opioid Guidelines
Opioid Pharmacotherapy

Recommendation 7: (Recommendation category: A; evidence type: 4)

- **Evaluate benefits & harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.**
- **Evaluate benefits & harms of continued therapy with patients every 3 months or more frequently.**
- **Consider lowering dose or taper and stop opioids**
  - **Lack of demonstrated benefit**
  - **Harms outweigh benefits**

Why taper?

- Lack of efficacy
  - No improvement in function/failed trial
  - Inadequate analgesia
  - Failure to reach treatment goals
- Therapy not needed any longer
  - Pain resolving(ed)
- Surgical setting
- Unacceptable risk
  - Adverse effects
  - Opioid-induced hyperalgesia & glial cell activation
  - Employer prohibits drugs that may affect motor coordination

- Behavioral concerns
  - Abnormal UDT
  - Noncompliance
    - Over or under utilization
  - Misuse/abuse of medication
    - Including diversion
  - Use for reasons other than pain
    - E.g. Anxiety, sleep

Taper or just stop?

Patients considered opioid tolerant are those receiving any of the following for 1 week or longer:

- 60 mg morphine/day
- 25 mcg transdermal fentanyl/hr
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day

Opioid Taper Guidelines

- American Pain Society & American Academy of Pain Medicine
  - 2009
- Veterans Affairs – Department of Defense
  - 2010
- Canadian National Opioid Use Guideline Group
  - 2010
- Agency Medical Directors Group
  - 2010
- American Society of Interventional Pain Physicians
  - 2012

Adjusting tapers

- Patients with anxiety & fear about tapering
  - May not be emotionally ready
- Recurrence or worsening of pain
  - Re-evaluate reasons for taper & minimum effective dose
- Withdrawal symptoms
  - Tends to occur at about 30-45mg/day MEDD
  - Taper is too fast, slow by 50%
  - OR hold current dose & treat symptoms

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✓ 6 Months later…
✓ Now receiving Morphine Controlled Release 60 mg PO Q12H
✓ Feels tired all the time
✓ PEG
  NRS 8/10
  Interfere Enjoyment 9/10
  Interfere with ADL 7/10