Doc 2 Doc Dial-in Discussion Series

Session 2:

Pain Management and Prevention of Substance Use Addiction in Primary Care

Learning Objectives:

- Learn about evidence-based treatment protocols for pain management in primary care
- Learn how to assess for potential substance abuse, including whether a patient is in trouble with prescriptions
- Learn how to use formal agreements with patients when prescribing

What are the evidence-based treatment protocols for pain management in primary care?

Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases

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(Received 10 June 1985, accepted 28 October 1985)

Summary

Thirty-eight patients maintained on opioid analgesics for non-malignant pain were retrospectively evaluated to determine the indications, course, safety and efficacy of this therapy. Oxycodone was used by 12 patients, methadone by 7, and levorphanol by 5; others were treated with propoxyphene, meperidine, codeine, pentazocine, or some combination of these drugs. Nineteen patients were treated for four or more years at the time of evaluation, while 6 were maintained for more than 7 years. Two-thirds required less than 20 morphine equivalent mg/day and only 4 took more than 40 mg/day. Patients occasionally required escalation of dose and/or hospitalization for exacerbation of pain; doses usually returned to a stable baseline afterward. Twenty-four patients described partial but acceptable or fully adequate relief of pain, while 14 reported inadequate relief. No patient underwent a surgical procedure for pain management while receiving therapy. Few substantial gains in employment or social function could be attributed to the institution of opioid therapy. No toxicity was reported and management became a problem in only 2 patients, both with a history of prior drug abuse. A critical review of patient characteristics, including data from the 16 Personality Factor Questionnaire in 24 patients, the Minnesota Multiphasic Personality Inventory in 23, and detailed psychiatric evaluation in 6, failed to disclose psychological or social variables capable of explaining the success of long-term management. We conclude that opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse.

When are opioids indicated?

- YES — Pain is moderate to severe
- YES — Pain has significant impact on function
- YES — Pain has significant impact on quality of life
- YES — Non-opioid pharmacotherapy has failed
- NOT KNOWN — If already on opioids, is there documented benefit

How Good **are Opioids for Chronic Pain?**

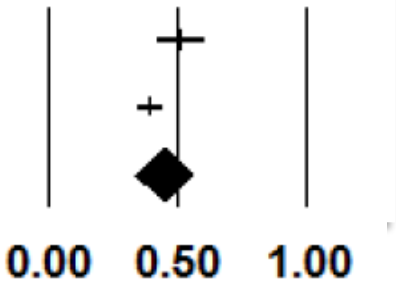
- Most literature: surveys and uncontrolled case series
- RCTs are short duration <8 months with small samples <300 patients
- Mostly pharmaceutical company sponsored
- Outcomes
  - Better analgesia with opioids vs. placebo
  - Pain relief modest
  - Mixed reports on function
  - Addiction not assessed

Ballantyne JC, Mao J. N Engl J Med. 2003 Nov 13;349(20):1943-53.
Kelso E, et al. Pain. 2004 Dec;112(3):372-80.
Eisenberg E, McNicol ED, Carr DB. JAMA. 2005 Jun 22;293(24):3043-52.
Furlan AD, et al. CMAJ. 2006 May 23;174(11):1589-94.
Noble M, et al. Cochrane Database Syst Rev. 2010 Jan 20;(1):CD006605.

Opioid Efficacy in Chronic Pain

- **Proportion of patients with at least 50% pain relief**
- **Oral opioids**
- **N = 442**
- **Follow-up 7.5 months (mean) to 13 months (1^2 77.3%)**

Study Name	Event Rate	Lower Limit	Upper Limit	Total	Proportion
Zenz 1992	0.510	0.413	0.606	51 / 100	
Allan 2005	0.392	0.341	0.445	134 / 342	
	0.443	0.333	0.559		



44.3% of participants had at least 50% pain relief

Noble M et al. Cochrane Systematic Reviews 2010

IR/SA Opioids

When to Consider

- No opioid tolerance/opioid naïve
- Intermittent or occasional pain
- Incident or breakthrough pain with ER/LA opioids

ER/LA Opioids

When to Consider

- Opioid tolerance exists
- Constant, severe, around-the-clock pain is present
- To stabilize pain relief when patient using multiple doses IR/SA opioids

High Dose Opioids

>100-200mg morphine equivalents

Considered higher dose opioid therapy by different authors[1,2,3]

Higher doses indicated in some patients

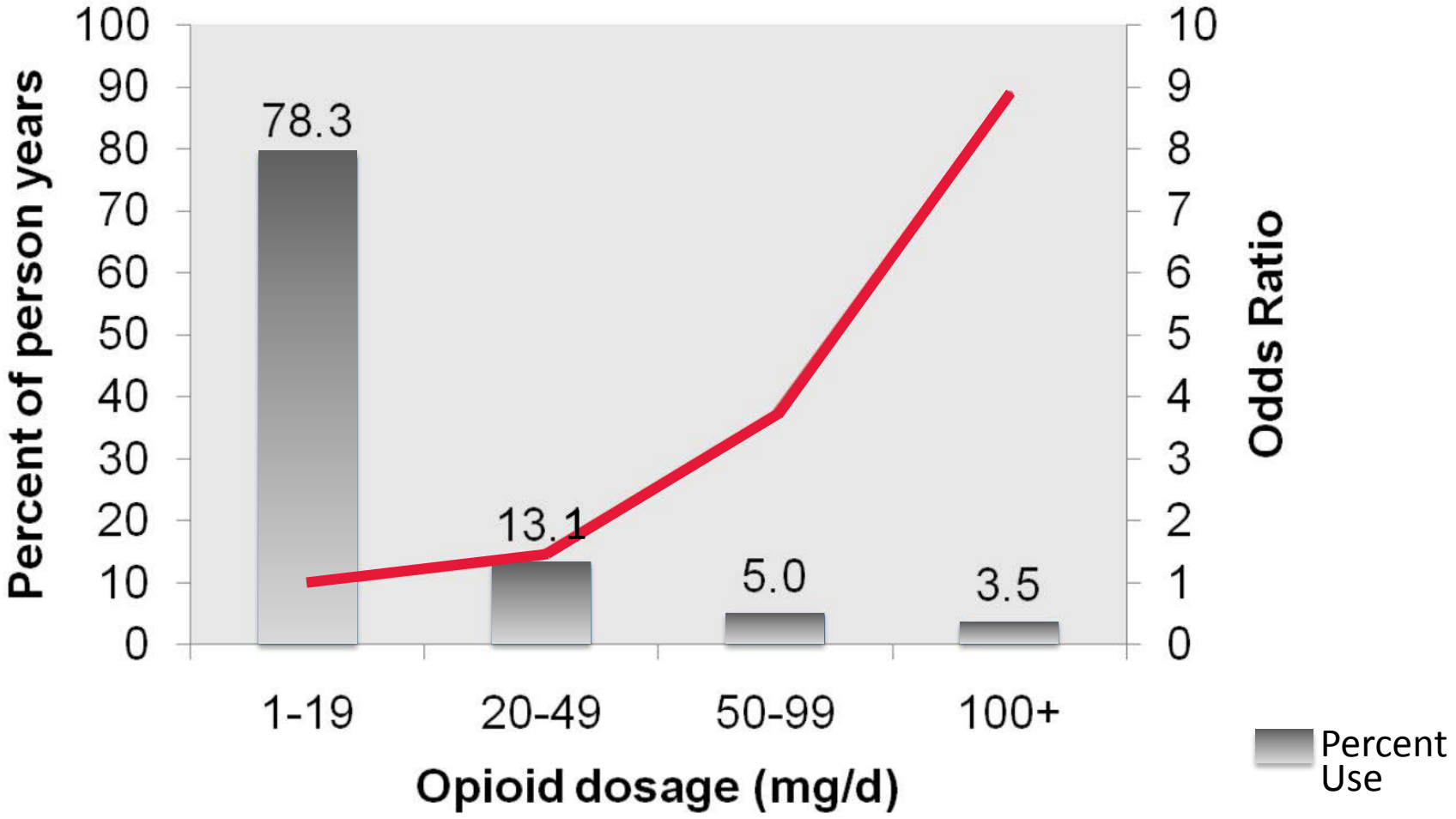
- **Manage as higher risk**
- **Increase monitoring and support**

Higher doses more likely associated with:

- **Tolerance[4]**
- **Hyperalgesia[5,6]**
- **Reduced function[7,8]**
- **Overdose[9-13]**

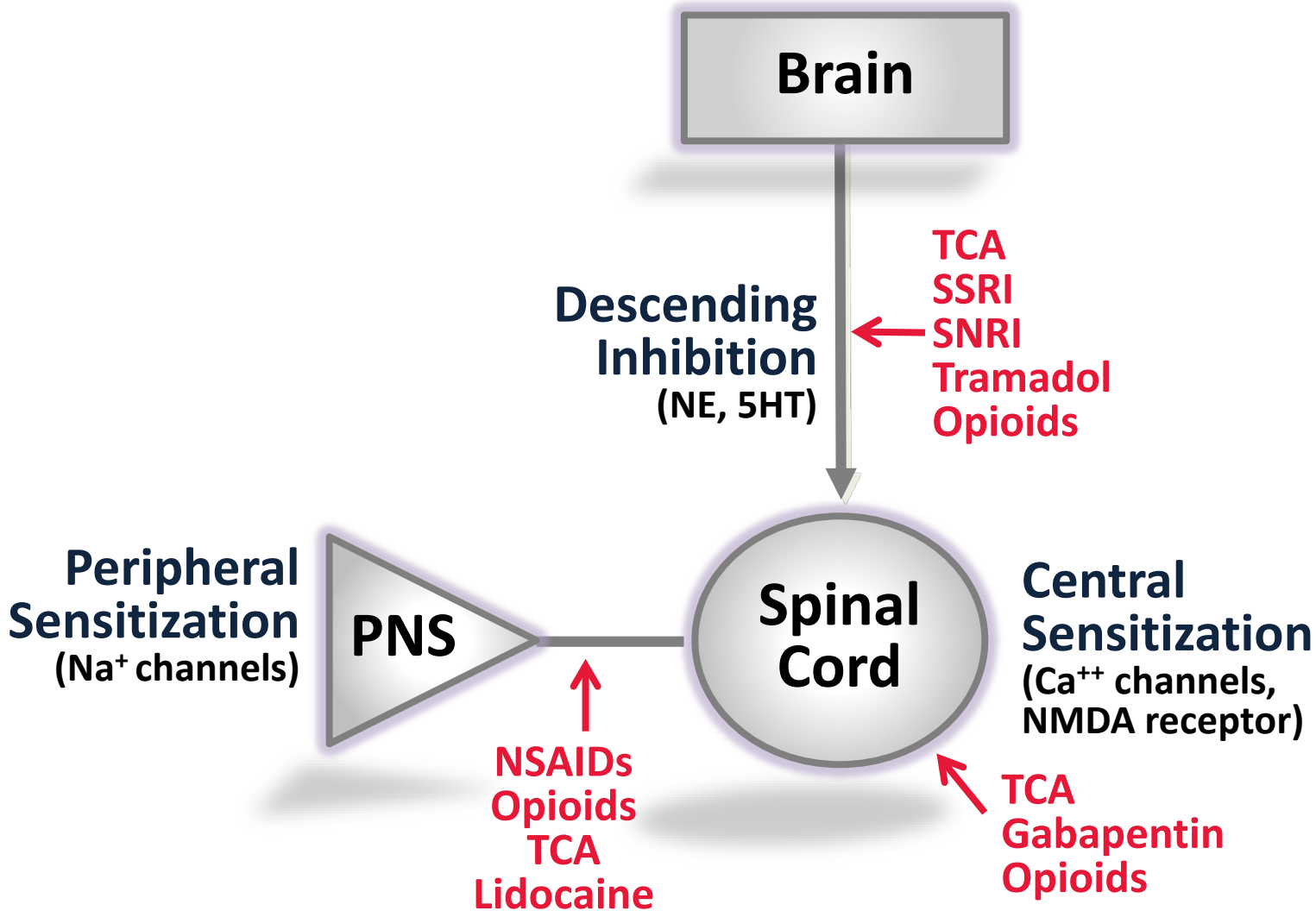
1. Chou R, et al. J Pain. 2009 Feb;10(2):147-59.
2. Ballantyne JC, Mao J. N Engl J Med. 2003 Nov 13;349(20):1943-53.
3. Kobus AM, et al. J Pain. 2012 Nov;13(11):1131-8.
4. Huxtable CA, et al. Anaesth Intensive Care. 2011 Sep;39(5):804-23.
5. Brush DE. J Med Toxicol. 2012 Dec;8(4):387-92.
6. Lee M, et al. Pain Physician. 2011 Mar-Apr;14(2):145-61.
7. Kidner CL, et al. J Bone Joint Surg Am. 2009 Apr;91(4):919-27.
8. Townsend CO, et al. Pain. 2008 Nov 15;140(1):177-89.
9. Dunn KM, et al. Ann Intern Med. 2010 Jan 19;152(2):85-92
10. Braden JB. Arch Intern Med. 2010 Sep 13;170(16):1425-32.
11. Bohnert AS, et al. JAMA. 2011 Apr 6;305(13):1315-21.
12. Gomes T, et al. Open Med. 2011;5(1):e13-22.
13. Paulozzi LJ. Pain Med. 2012 Jan;13(1):87-95.

Risk of Opioid Overdose



Dunn KM, et al. Ann Intern Med. 2010 Jan 19;152(2):85-92.

Rational Polypharmacy



Woolf CJ. Ann Intern Med. Mar 2004;140(6):441-51.

How do I assess for substance abuse potential?

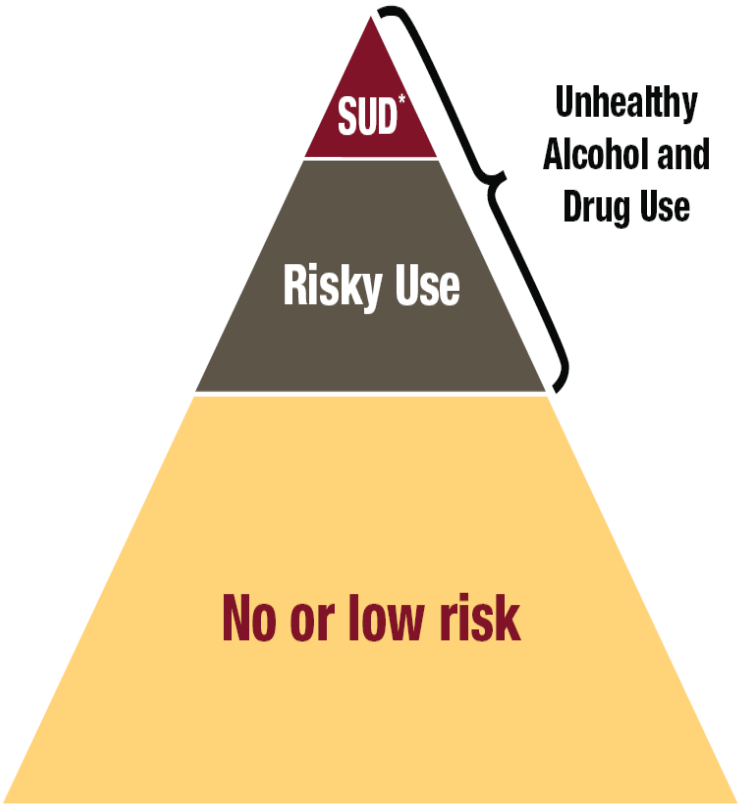
Opioid Addiction Risk

- True incidence and prevalence of addiction in chronic pain populations prescribed opioids is unknown due to different criteria used to define addiction in different studies

- The most commonly cited range is 4-26%

Højsted J, Sjøgren P. Eur J Pain. 2007 Jul;11(5):490-518.
Fishbain DA et al. Pain Med. 2008 May-Jun;9(4):444-459
Sehgal N et al. Pain Physician. 2012; 15:ES67-ES92

Screening for Unhealthy Substance Use



*Substance Abuse Disorders

Alcohol

"Do you sometimes drink beer, wine or other alcoholic beverages?"

"How many times in the past year have you had 5 (4 for women) **or more drinks in a day?"**

(+ answer: > 0)

Drugs

"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"

(+ answer: > 0)

Smith PC, et al. Gen Intern Med. 2009 Jul;24(7):783-8.
Smith PC, et al. Arch Intern Med. 2010 Jul 12;170(13):1155-60.
Image: SBIRT Clinician's Toolkit www.MASBIRT.org

Opioid Misuse Risk

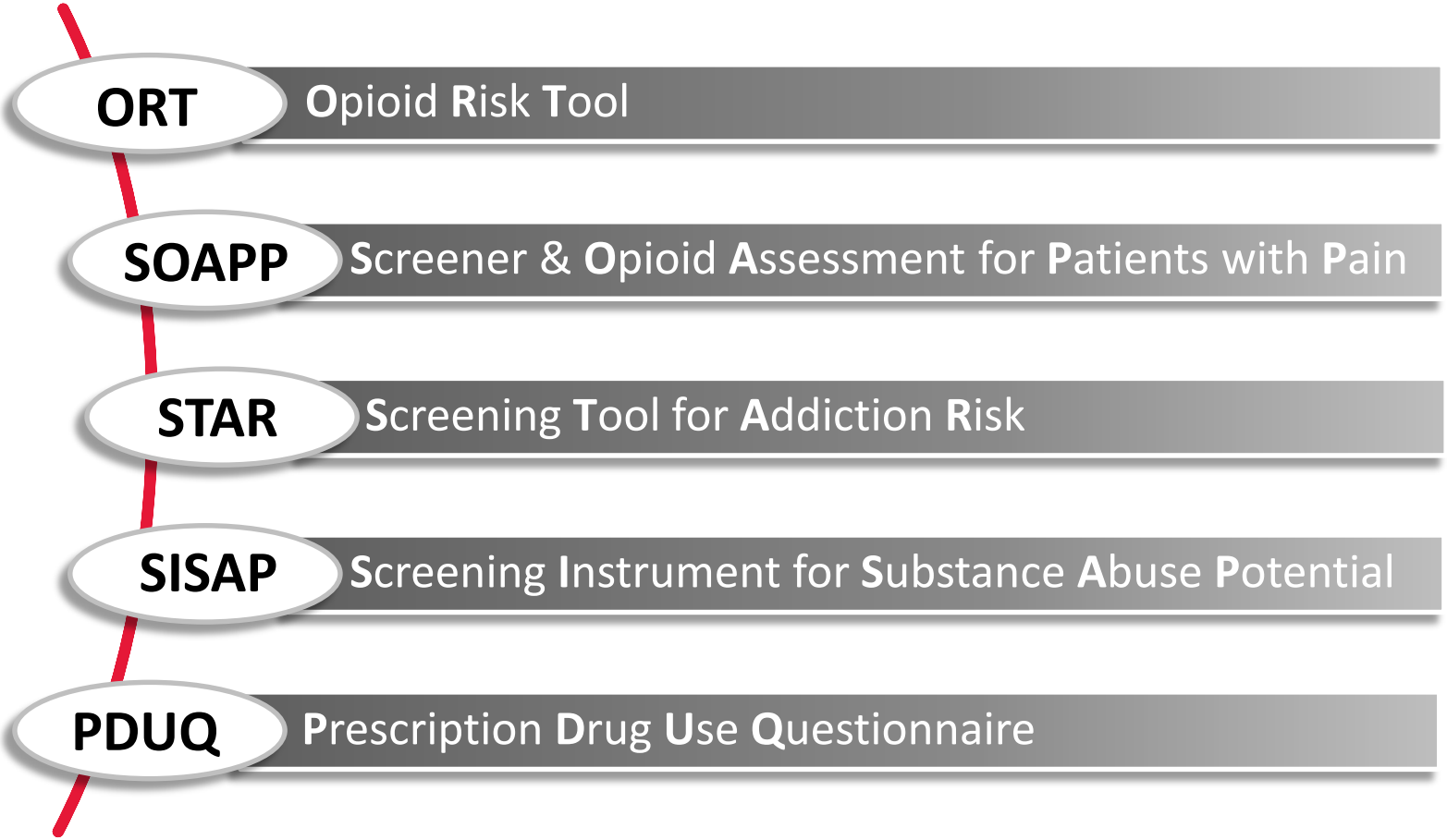
Known Risk Factors

Good Predictors for Prescription Opioid Misuse

- Young age (less than 45 years)
- Personal history of substance abuse
  - Illicit, prescription, alcohol, nicotine
- Family history of substance abuse
- Legal history
  - DUI, incarceration
- Mental health problems
- History of sexual abuse

Akbik H, et al. J Pain Symptom Manage. 2006 Sep;32(3):287-93.
Ives J, et al. BMC Health Serv Res. 2006 Apr 4;6:46.
Liebschutz JM, et al. J Pain. 2010 Nov;11(11):1047-55.
Michna E, et al. J Pain Symptom Manage. 2004 Sep;28(3):250-8.
Reid MC, et al. J Gen Intern Med. 2002 Mar;17(3):173-9.

Validated Questionnaires



No "Gold Standard"
All lack rigorous testing

Moore TM, et al. Pain Med. 2009 Nov;10(8):1426-33.

Opioid Risk Tool Score

		Female	Male
Family history of substance abuse			
	Alcohol	☑ **1**	❑3
	Illegal drugs	❑2	❑3
	Prescription drugs	❑4	❑4
Personal history of substance abuse			
	Alcohol	☑ **3**	❑3
	Illegal drugs	❑4	❑4
	Prescription drugs	❑5	❑5
Age between 16-45 years		☑ **1**	❑1
History of preadolescent sexual abuse		❑3	❑0
Psychological disease			
	ADHD, OCD, bipolar, schizophrenia	❑2	❑2
	Depression	❑1	❑1

SCORING

0-3 Low Risk

4-7 Moderate Risk

>8 High Risk

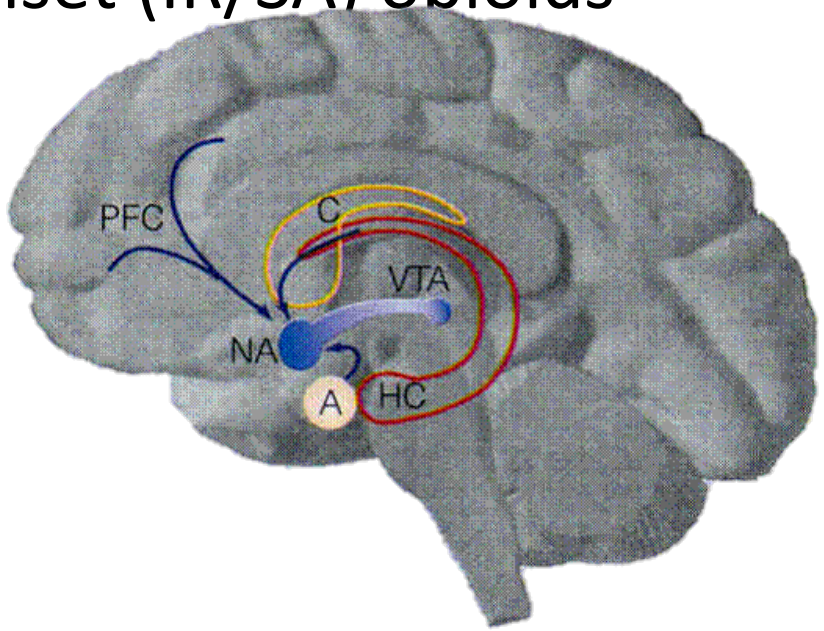
Webster LR, Webster RM. Pain Med. 2005 Nov-Dec;6(6):432-42.

How do I recognize behaviors that suggest a patient is in trouble with prescriptions?

Why Patients Become Addicted to Opioids

Opioids activate mu-opioid receptors in midbrain "reward pathway" causing euphoria

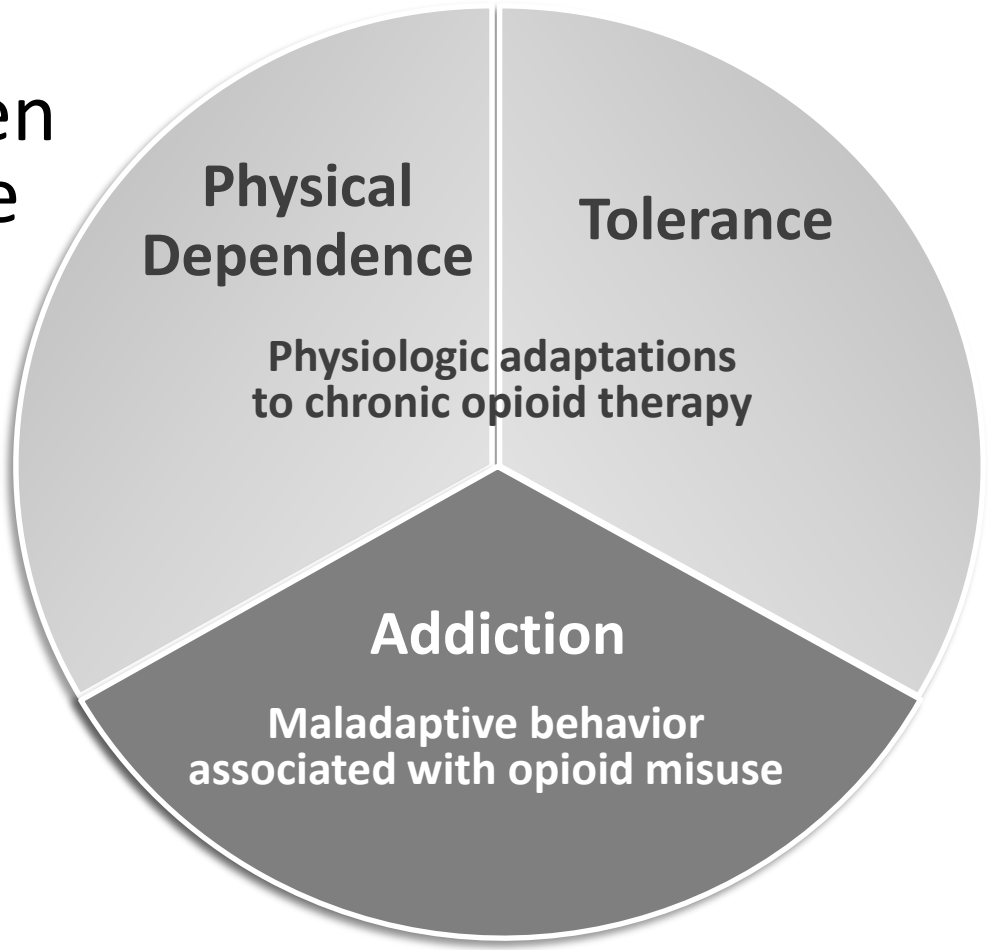
- Dopaminergic system that is very reinforcing
- Most rewarding are fast onset (IR/SA) opioids
- ER/LA should be less rewarding if taken as prescribed but are very rewarding if adulterated (e.g., crushed, chewed)



Kosten TR, George TP. Sci Pract Perspect. 2002 Jul;1(1):13-20.

Opioids and Misunderstandings

- Family members (and patients) often misunderstand the differences
- Need to re-educate



Savage SR, et al. J Pain Symptom Manage. 2003 Jul;26(1):655-67.

DDx **Drug Seeking**

Addiction

Clinical syndrome presenting as…

- ☐ Loss of **C**ontrol
- ☐ **C**ompulsive use
- ☐ **C**ontinued use despite harm
- ☐ **C**raving

Aberrant Medication Taking Behaviors
(pattern and severity)

Addiction is NOT the same as physical dependence

Savage SR, et al. J Pain Symptom Manage. 2003;26:655-667.

Concerning Behaviors for Addiction

Spectrum: Yellow to Red Flags

- Requests for increase opioid dose
- Requests for specific opioid by name, “brand name only”
- Non-adherence w/other recommended therapies (e.g., PT)
- Running out early (i.e., unsanctioned dose escalation)
- Resistance to change therapy despite AE (e.g. over-sedation)
- Deterioration in function at home and work
- Non-adherence w/monitoring (e.g. pill counts, UDT)
- Multiple “lost” or “stolen” opioid prescriptions
- Illegal activities – forging scripts, selling opioid prescription

Modified from Portenoy RK. J Pain Symptom Manage. 1996 Apr;11(4):203-17.

How do I introduce a formal agreement with patients when prescribing?

Universal Precautions in Pain Medicine

- **Predicting opioid misuse is imprecise**
  - Protects all patients
  - Protects the public and community health
- **Consistent application of precautions**
  - Takes pressure off provider
  - Reduces stigmatization of individual patients
  - Standardizes system of care
- **Resonant with expert guidelines**
  - American Pain Society/American Academy of Pain Medicine
  - American Society of Interventional Pain Physicians
  - Federation of State Medical Boards
  - Canadian National Pain Centre

Gourlay DL, Heit HA, Almahrezi A. Pain Med. 2005 Mar-Apr;6(2):107-12.

Common Universal Precautions

- Comprehensive pain assessment including opioid misuse risk assessment
- Formulation of pain diagnosis/es
- Opioid prescriptions should be considered a test or trial; continued based on assessment and reassessment of risks and benefits
- Regular face-to-face visits
- Clear documentation

Federation of State Medical Boards Model Policy 2013. www.fsmb.org/grpol_policydocs.html
Gourlay DL, Heit HA, Almahrezi A. Pain Med. 2005 Mar-Apr;6(2):107-12.
Chou R, et al. J Pain. 2009 Feb;10(2):147-59.

Common Universal Precautions

- Patient Prescriber Agreements (PPA)
  - Informed consent
  - Plan of care
- Monitoring for adherence, misuse, and diversion
  - Urine drug testing
  - Pill counts
  - Prescription drug monitoring program data PMP

Federation of State Medical Boards Model Policy 2013. www.fsmb.org/grpol_policydocs.html
Gourlay DL, Heit HA, Almahrezi A. Pain Med. 2005 Mar-Apr;6(2):107-12.
Chou R, et al. J Pain. 2009 Feb;10(2):147-59.

Patient Provider Agreement

Informed Consent: Potential Risks

- Side effects (short and long term)
- Physical dependence, tolerance
- Drug interactions/over-sedation
- Potential for impairment e.g., risk of falls, working with heavy machinery and driving
- Abuse, addiction, overdose with misuse
- Pregnancy and risk of Neonatal Opioid Withdrawal Syndrome
- Possible hyperalgesia (increased pain)
- Victimization by others seeking opioids

Paterick TJ, et al. Mayo Clin Proc. 2008 Mar;83(3):313-19.
Cheatle MD, Savage SR. J Pain Symptom Manage. 2012 Jul;44(1):105-16.

Patient Provider Agreement

Plan of Care: Expectations

- Engagement in other recommended pain care and other treatment activities
- Follow up visit and appointment policies
- Monitoring polices - urine drug testing and pill counts
- Permission to communicate with key others - providers, family members
- No illegal drug use, avoid sedative use
- Notifying provider of all other medications and drugs including OTC and herbal preparations

Fishman SM, Kreis PG. Clin J Pain. 2002 Jul-Aug;18(4 Suppl):S70-5.
Arnold RM, Han PK, Seltzer D. Am J Med. 2006 Apr;119(4):292-6.

Patient Provider Agreement

Plan of Care: Medication Management

- One prescriber, one pharmacy
- Use as directed *(dose, schedule, guidance on missed doses)*
  - No adulteration of pills or patches
  - ER/LA opioid tablets must be swallowed whole
- Don't abruptly discontinue opioids
- Refill, renewal policies
- Safe storage *(away from family, visitors, pets)*, protect from theft
- Safe disposal *(read product specific information for guidance)*
- No diversion, sharing or selling *(illegal; can cause death in others)*

Fishman SM, Kreis PG. Clin J Pain. 2002 Jul-Aug;18(4 Suppl):S70-5.
Arnold RM, Han PK, Seltzer D. Am J Med. 2006 Apr;119(4):292-6.

How does the prescription monitoring program assist in treating patients with chronic pain?

Massachusetts Online Prescription Monitoring Program

Click here if you are with a pharmacy looking for information on reporting data to the PMP.

Guidance on MA Online PMP Automatic Enrollment

The Massachusetts Online Prescription Monitoring Program (MA Online PMP) is a secure website that supports safe prescribing and dispensing. A licensed prescriber or pharmacist may obtain authorization, through completion and submission of an enrollment form, to view the prescription history of a patient for the past year. The MA Online PMP also assists state and federal investigative agencies in addressing prescription drug diversion by supporting ongoing, specific controlled substances-related investigations.

Login to the Virtual Gateway, including the MA Online PMP

Prescriber Guide to Interpreting Prescription Monitoring Program Data

NIDA screening tool

MA Online PMP Enrollment form for Prescribers

MA Online PMP Enrollment Form for Dispensers

Terms and Conditions for Prescriber and Dispenser Use of the Massachusetts Online Prescription Monitoring Program

Terms and Conditions for Investigative Agency Use of the MA Online PMP

Additional Resources

- MA PMP FAQ – Information for the General Public 2015
- MA PMP FAQ - Includes Information on the 2014 Regulations
- NIDA Opioid and Pain Management CMEs
- MA DPH Bureau of Substance Abuse Services (BSAS) Helpline:
  A confidential phone line that can help find the right substance abuse services, with or without insurance [800-327-5050] or [888-448-8321 (TTY, Toll Free)].

This information is provided by the Drug Control Program within the Department of Public Health.

Friendly URL:
www.mass.gov/dph/dcp/onlinepmp

www.mass.gov/dph/dcp/onlinepmp