Pain Management and Safe Prescribing

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Why are we here today?
Today:
An “Epidemic of Opioid Overdoses in the United States and in Ohio?”
Number of Deaths from Motor Vehicle Traffic, Suicide and Unintentional Drug Poisonings by Year in Ohio 1999 – 2008
Contributing Factors to Rising Fatal Drug Death Rates

- Aggressive Marketing of Opioids
- Changes in Clinical Pain Management
- Direct-to-Consumer Marketing
- Growing Use of Prescription Opioids
- Self-Medicating Habits of Baby Boomers
- Diversion
  - Internet
  - Pill Mills
  - Deception/Scams
  - Theft
  - Friends and Family
Unintentional Fatal Drug Poisoning Rates and Distribution of Prescription Opioids in grams per 100,000 Population by Year - Ohio 1997 – 2007
Unintentional Drug/Medication Poisoning Death Rates per 100,000 by County 2004 – 2008
In Ohio:

Over 931,000 adult and 231,000 children with chronic malignant and non-malignant pain

*Ohio Compassionate Care Task Force, 2004*
The Provider’s Dilemma:

“Twin serpents in the Caduceus”

- Undertreated Pain and related costs:
  - Nationally 100 million Americans with chronic pain at a cost of >635 billion dollars

  IOM Report on Pain - 2011

- Opioid Abuse and related costs
  - Nationally > 6 million Americans abusing opioids at a cost of 70 billion per year

  Money Magazine
THE CHALLENGE: How to prevent abuse and diversion and still safely treat the over 1 million Ohioans who live with chronic pain
As the gatekeepers of prescription medications physicians are being charged with fighting on two fronts: combating pain while defending against misuse of opioid medications!

*Is Pharmaco Vigilance more than we can ask of Physicians??*
Examining the data more closely:

- Review of death certificates: majority of opioid related deaths involve other substances - marijuana, cocaine, alcohol
- Chronic pain patients not the ones dying from opioid overdoses
- Millions of opioid doses are reaching the wrong hands!!
“It is unclear how much abuse, diversion and addiction is the result of well meaning but under-educated or under-informed physicians.”

Fish, P8
Treating pain is a moral imperative

Improved efforts to prevent pain are needed

Increased research/education on pain is needed

A biopsychosocial model of pain management improves outcomes

A transformation is needed in our cultural view of pain
Eighty percent of patients presenting for health care have pain.

Undertreated acute pain may become chronic disabling pain: complex regional pain syndrome.

Under treatment of pain can lead to alcohol and substance abuse; isolation, depression, and institutionalization in the elderly.
“Physicians need training and experience in pain management if issues of access and under treatment are going to be addressed”

National Pain Care Policy Act of 2009 Incorporated into the Obama Healthcare Reform Bill

The real issue for prescribers in Ohio’s Pain Epidemic is not whether or not to treat pain but how!
Two imperatives:

- To treat pain in a manner that is safe and effective for the patient

- To understand and implement Ohio’s regulatory oversight in order to protect our prescriptive rights
Today’s Discussion

Regulatory Oversight in Ohio

Safe and Effective Pain Management
Regulatory Oversight

- CDC guidelines
- Ohio’s Automated Rx Regulatory System
- Ohio’s Intractable/Chronic pain law
- Emerging actions: Emergency Department Guidelines for Pain Management
CDC Guidelines: Epidemic: Responding to America's Prescription Drug Abuse Crisis

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3htm?cid=6101a3w

Specifically address the concern of access to care for patients and the need to address the significant concern and expense of untreated pain

These serve as guidepost for the states – they are specifically Guidelines and not Laws
CDC Guidelines

Epidemic: Responding to America's Prescription Drug Abuse Crisis,

The Administration's plan for addressing prescription drug abuse released in April 2011: four components:

- education,
- tracking and monitoring
- proper medication disposal,
- enforcement.
Ohio Automated Rx Regulatory System: OARxRS

Ohio Revised Code – 4729.75-4729.84

- Tool for prescribers, pharmacists to identify and prevent abuse and addiction
- Tool for law enforcement to deter diversion
- Pharmacists must enter data electronically weekly
- Reported drugs: schedule CII, CIII, CIV, V, Carisoprodol (Soma) & tramadol (Ultram)
OARxRS

Who can access OARRS?

- Pharmacist – own customer only
- Physician – current patient only
- Physician’s non licensed designee (HB93)
- Individual – own report
- Licensing boards – own licensee
- Law enforcement - only as part of a certified active investigation of suspected diversion, abuse or drug trafficking
OARxRS: HB 93 expanded use

- Physician’s designee may obtain data
- Physician dispensing reported drugs from office must enter data into OARRS
- Restricted dosage units furnished per month by prescriber
- Physician dispensing of reported drugs limited to a 72 hour emergency supply
HB 93 April 2012 expanded use of OARRS:

- Wholesalers must enter all sales
- Penalties for abuse/ misuse of OARRS
- Licensing boards must develop rules governing the use of OARRs by their licensees OSMA, OSBP, etc
- Coroners must report deaths
HB 93 April 2012 expanded required use of OARRS: Medical Board Rule 4731-11-11

Mandated OSMA to develop rules for when physicians must access OARRS:

1. If patient exhibiting signs of drug abuse or addiction
2. Treatment of patient with reported drugs >12wks
3. At least annually if using reported drugs 12wks or more per year
**HB 93 expanded use of OARRS:**
Medical Board Rule 4731-11-11 FAQ Document

**Signs of abuse or addiction:**
- Patient with unexpected drug screen
- Forging/adulterating script
- Stealing/borrowing meds
- History of illegal drug use/ conviction
Signs of Abuse/Misuse – Mandate

OARRS Check:

- Selling drugs
- Increasing the dose without permission
- Multiple prescribers identified/suspected
- Family member, friend or other professional raises issue of patient abuse/misuse
“Red Flags” – Suggested to check OARxRS but not mandated:

- History of chemical abuse/addiction
- Patient appears sedated /impaired in office
- Loosing scripts or requesting early refills
- ED visits for refills
- Sharing drugs
- Requesting drugs by name ???
The report is privileged health information (HIPPA), not a public record, not evidence.

You may not share the information with other professionals unless they use the same chart.

You may show the patient the data but not give it to them.

You must keep OARRS report in non reproducible part of chart.

You may not use OARRS to screen employees or potential employees.
OARxRS

Exemptions:

Prescribers of patients with a terminal illness
OARxRS is meant to be and is a useful tool in pain management!

OARRS can be a useful tool for initial or ongoing patient assessment.

OARRS is just one more piece of the clinical assessment; it does not replace your medical judgment.
Ohio Automated Rx Regulatory System: OARxRS

In 2011:

Ohio Population approximately 11 million
Scripts in OARRS: 46.9 million
# of patients in OARRS: 5.7 million

Time to get report: 98% within 23 seconds
5% 5mins -3hrs reports available 24/7
Lag time of 1-10 days from dispensing of medication until report available
Signing up for OARxRS

Google OARxRS
Home page – “Register”
- registration takes about 15 minutes

More information – Questions??
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Ohio’s Intractable (Chronic) Pain Law

Chapter 4731-21 Drug treatment of intractable pain

- Effective date: November 11, 1998
- Changed to “Chronic” in HB 93
- Currently under review with expected new rules to be developed by the Governor’s Cabinet Opioid Action Team
- Hotly debated issue: will recommendations of the team be “guidelines” or “rules”? – Should vs. Shall!
Ohio’s Intractable (Chronic) Pain Law

Current “Shalls” in the law:

- Initial evaluation documented in the record
- Medical diagnosis established
- Individualized treatment plan formulated and documented
- Appropriate consultation
- Signed consent to treatment and agreement to conditions of prescribing
Ohio’s Intractable (Chronic) Pain Law

- Patients shall be seen at appropriate intervals
- Documentation of effects of treatment on the functional capacity and efficacy of the treatment
- Monitoring for compliance if needed (drug screen, etc)
- Referral to addiction specialist if indicated
Ohio’s Intractable (Chronic) Pain Law

Exemptions: 4731-21-06

Treatment of patients with a terminal illness or treatment of pain associated with a progressive disease that in the normal course of progression may reasonably be expected to become terminal
Governor’s Opioid Action Team

Ohio Emergency and Acute Care Facility
Prescribing Guidelines: Opioids and Other Controlled Substances (OOCS)

These are guidelines, not rules: should and not shall

Developed to assist ED physicians who are struggling to deal with the impact of chronic pain patients on the ED, as well as the ever present drug diverter and abuser
Ohio Emergency and Acute Care Facility
Prescribing Guidelines: OOCS

- OOCS for pain will be prescribed only after evaluation of patient and risk of addiction

- OOCS should be given P.O., not IM/IV

- No Rx if patient seen within the last month or had Rx from another prescriber within last month for the same problem
Ohio Emergency and Acute Care Facility
Prescribing Guidelines: OOCS

- Meperidine (Demerol) use discouraged
- ED clinicians will not routinely provide replacement scripts for OOCS that were lost, stolen or destroyed
- Replacement doses of Suboxone, Subutex, or methadone will not be given for patients in treatment programs
Ohio Emergency and Acute Care Facility
Prescribing Guidelines: OOCS

Long acting or controlled release formulations such as oxycodone SR, fentanyl patches methadone will not be routinely provided
Ohio Emergency and Acute Care Facility  
Prescribing Guidelines: OOCS  

Prior to deciding whether or not to treat with an OOCS the ED clinician or the facility:  
+
Should access OARRS 
+
Check a photo ID or photograph patient for the chart  
+
Reserve the right to perform a drug screen
Ohio Emergency and Acute Care Facility
Prescribing Guidelines: OOCS

- ED clinicians should consider contacting the physician who routinely prescribes for the patient.

- Request a Palliative Care or pain consult, or other appropriate subspecialty service.

- Perform case management on patients repeatedly seen in ED.
Ohio Emergency and Acute Care Facility
Prescribing Guidelines: OOCS

- Request medical and prescription records from other hospitals/prescribers
- Require that the patient sign a pain agreement outlining expectations of the ED department regarding the patient’s use of the OOCS
- Use EMR to communicate with other providers regarding patient care
Limit the Rx of OOCS to a 3 day supply except in unusual circumstances

Discharge instructions to patients given an OOCS Rx should include information on addiction risk, dangers of misuse, appropriate storage/disposal of OOCS
Ohio Emergency and Acute Care Facility
Prescribing Guidelines: OOCS

ED and other facilities should maintain a list of clinics that provide primary care services and pain management.

ED and other facilities should display signage that reflects these prescribing guidelines and states the facility position regarding the prescribing of opioids and other controlled substances.
Ohio Emergency and Acute Care Facility
Prescribing Guidelines

Endorsed by:

- OOA
- OSMA
- OHO
- Ohio Pharmacists Association
- Ohio Chapter of the American College of Emergency Physicians
- Ohio Association of Health Plans
- Ohio Association of Physician Assistants
- Ohio BWC
8 Steps to Safe and Successful Pain Management

- Step 1: Reframing the discussion – realistic expectations
- Step 2: Utilizing a biopsychosocial model of pain management vs. the biomedical model
- Step 3 Evaluation of the pain patient
- Step 4 Evaluation of the pain patient
Steps for Successful Pain Management

Step 5 Multimodal pain management
Step 6 Initiating opioid therapy when needed
Step 7 Monitoring ongoing opioid therapy
Step 8 Celebrate Success!

Extracted in part from Scott Fish: Responsible Opioid Prescribing
Step 1: Set Realistic Expectations

• A good outcome is achieved if the patient’s pain is reduced by 30 points on a 100 point scale, or by 2-3 /10

• Success should be measured in terms of improvement in lifestyle and function

• Set realistic expectations from the start: what is it that the patient would like to do that pain is preventing? Take mini steps toward achieving goal
Step 2: Utilize a Biopsychosocial Model vs a Biomedical Model of Pain Management

What does this mean?

*Treat the patient instead of the pain!*
When evaluating patients do so in terms of the affects of the pain on lifestyle, function, productivity: ask the patient:

“How does this pain affect you – What can’t you do that you want to do? What can’t you do that you need to do?”
Assess the “meaning of the pain” to the patient:

- Secondary gain or alienation from family, work, or society may be hindering patient’s response to treatment.

- Patients living with pain have depression that is chemically medicated – depression is a proven biologic outcome of chronic pain – address openly with the patient!

- Assure the patient that you don’t think the pain is “all in his head”, but that addressing depression will be part of treatment plan.
Assess sleep, activity, sexual response in relation to the pain; fatigue will increase pain, pain is worse at night

- Actualize patients’ personal satisfaction in their ability to manage their pain’s psychosocial implications: reward gains in function and activity
- Utilize interdisciplinary case management as early as possible: pain psychologists, PT, OT, vocational counselors
Tools for assessing pain in terms of function and lifestyle:

- Pain / disability index
- Sickness Impact Scale

Documentation of improvement in function and activity as a result of using opioids justifies their use for reviewers
Step 3: Evaluation of the Chronic Pain Patient

• Requires time to evaluate the patient as well as the pain and to build a trusting relationship

• Requires utilizing staff and assessment tools when appropriate to evaluate the patient and the patient’s appropriateness for treatment
Patient Assessment

- One out of every ten patients with no history of addiction is at risk for opioid addiction
- Genetic incidence similar to prevalence for alcohol addiction
- Educate patients and families about genetic risk (use handouts from ODADAS) and take a history of family addictions
Tools to assess risk for addiction

- SBIRT
- Opioid Risk Tool (ORT)
- D.I.R.E. Score: patient selection for chronic opioid use
- CAGE-AID – alcohol assessment tool adapted to include drugs
- SOAPP-R – SODQ
Patient Assessment

Use OARxRS

Mandated Use:

1. If patient exhibiting signs of drug abuse or addiction
2. Treatment of patient with reported drugs >12wks
3. At least annually if using reported drugs.12wks
Patient Assessment

“Red Flags”: optional use of OARxRS

- OARxRS can be a useful tool for initial or ongoing patient assessment
- Document the use of tools in your medical record – may be mandated in state guidelines
- Patients with terminal illness/illness that may become terminal are exempted from OARxRS
Patient Assessment

Physical examination of the patient: never prescribe an opioid for a patient without documenting a physical exam

4731-21-02, O.A.C.
Step 4: Pain Assessment

In order to manage pain, the prescriber must be able to determine the anatomical origins of the pain; somatic, visceral, neuropathic.

Detailed history and listening to your patient’s describers of the pain will reveal its anatomical origin.
Patients with chronic pain will have more than one type of pain –

Ability to control pain depends on choosing the correct medication for each type of pain the patient describes.
Mnemonic for Pain Assessment

- **P** – palliating/precipitating
- **Q** – quality of the pain
- **R** – region/radiation
- **S** – severity
- **T** – temporal relationships
- **U** – impact of the pain on you
Anatomical Origins of Pain

- Somatic pain
- Visceral pain
- Neuropathic pain
- Complex neuronal pain
Anatomical Origins of Pain: What is Chronic pain??

Complex Neuronal Pain – Chronic pain

When patients live with pain, the brain’s response to the pain changes due to changes in neurotransmitters and neuroreceptors.

- Down regulation of Mu receptors (opioid receptors) up regulation of Delta, P, NMDA receptors (neuropathic receptors)

Therefore, in chronic pain, patients are less receptive to opioids and more receptive to neuropathic pain medications.
Complex Neuronal Pain

- Primary neuronal death
- Loss of myelin sheath
- Central sensitization
- Changes in neurotransmitters, neuroreceptors
  - Opioid receptor down-regulation
  - Increased importance of NMDA receptors, glutamate
Acute vs Chronic Pain

- Acute pain is very easy to localize and describe
- Up regulation of the sympathetic nervous system leads to physiologic response of the body that can be measured: increase in BP, pulse, respirations, anxiety
- In chronic pain: less response of the SNS
- Pain descriptors become more vague and pain more diffuse, patients use neuropathic pain descriptors and have flat affects
Step 4: Develop a treatment plan

- Use a biopsychosocial model of pain management: integrative medicine
- Select appropriate medications that address the patient's multifaceted pain
- Emphasize achievable goals directed at function that are taken in “baby steps”
- The sooner, in the course of the illness, the function is addressed and the patient increases activity, the more likely the treatment will be successful
Develop a Treatment Plan

+ Discuss the plan with the patient/family
+ Emphasize lifestyle
+ Set the rules – consider a pain contract/patient agreement, informed consent?
+ When you see a patient in acute pain, get the patient moving as quickly as possible!
Step 5: Utilize Multimodal Pain Management

Physicians often equate pain management with opioids or interventions by pain specialists.

Good pain management is “multimodal” and can be accomplished in the office of the attending physician.
Multimodal Medication Therapy

- Pure opioids, weak opioids and *Adjuvant* medications chosen to address the specific aspects of the patients “total pain” including psychosocial aspects of the pain (depression, sleep, anxiety)

- Initially treat without an opioid if possible, or with limited quantities of opioids
Analgesic Classes

- Non opioids
- Weak opioids
- Pure opioids
- Adjuvants
What are *Adjuvants in pain management*?

- **Adjuvants** may be analgesics themselves, or medications not commonly considered to be analgesics, such as anticonvulsants, anxiolytics, and antidepressants.
- Enhance or augment the main analgesic.
- Reduce the total opioid load if an opioid is needed.
- Address different aspects of the patient’s *total pain*.
Adjuvant Medications…

**NSAIDS:**
Examples: Naproxen, Motrin, Celebrex, Toradol
*relieves bone, muscle, or joint pain
* often better than Morphine for bone pain

**Antidepressants:**
Tricyclics – Examples: Elavil, Doxepin
*increases endomorphins
*helps neuropathic pain
*may provide appetite stimulation, mood elevation
SSRIs – Examples: Paxil, Prozac, Zoloft
*improve sleep, mood, appetite
*have not been shown to help neuropathic pain
SNRI – Example: duloxetine (Cymbals), venlafaxine

**Topical Agents:**
capsaicin, lidocaine patch, EMLA
Adjuvant Medications...

Anticonvulsants:
Examples: Tegretol, Dilantin, Neurontin
* relieves neuropathic pain

Steroids:
Examples: Decadron, Prednisone
* reduces swelling in brain or visceral lesion
* improves appetite
* may improve mood
* relieves neuropathic pain
* serves as an anti-inflammatory if NSAIDs are contraindicated to reduce joint or bone pain

Antianxiety Medications:
Examples: Ativan, Xanax, Haldol
* treats agitation, restlessness, extremely helpful in dyspnea, COPD, terminal delirium
* important adjuvant in controlling pain of all etiologies
Adjuvant Medications…

GABA Agonists
  * Baclofen

NMDA Antagonists
  * Dextromethorphan, ketamine

Scopolamine: Patch or SQ, Levsin PO, Atropine PO or SQ
  * treats terminal secretions, relieves death rattle, may help stomach, colic spasms
  * motion induced nausea, dizziness

Bisphosphates, Miacalcin, Arida, Zometa
  * bone pain
  * may retard bone fracture
  * treat hyperkalemia
  * hypercalcemia
Adjuvant Medications...

**Alpha 2 –adrenergic agonists:**
* Clonidine

*Adjuvants* may be analgesics themselves, or medications not commonly considered to be analgesics, such as anticonvulsants, anxiolytics, and antidepressants

**Neuroleptics**
* olanzapine
* Haloperidol
* mirtazapine

**Muscle Relaxants** – Flexeril, Baclofen
The Concept of Total Pain

Tumor – 60% of pain directly related to tumor
19-28% of pain is secondary to side effects of treatment

Pain from debilitation, malnutrition (bedsores)
Pre-existing Pain
Brain Mets
Visceral Mets
Bone Mets
Radiation
Surgery
Chemo
Total Pain
Oncology
End Stage Cardiac Disease

- Pleural Effusion
- Acute/Chronic Angina
- Peripheral Edema
- Depression
- Cardiac Cachexia
  - Wasting, Bedsores, Debilitation

Total Pain In Cardiac Disease

- Dyspnea
- Chest Wall Pain
- Ischemic Coronary Artery Disease
- Aortic Insufficiency – Chest Pressure
- Co-Morbidities
  - Ischemic Bowel
  - Peripheral Vascular Disease
  - Renal Neuropathies
  - Osteoporosis
  - Venous Insufficiency

- Medication Induced
  - Hypokalemia
  - Hyponatremia
Chronic Obstructive Pulmonary Disease

Pain in COPD is a combination of the pathophysiology of the primary process and the multiple common co-morbidities.

Chronic anxiety, depression

Wasting, cachexia, Chronic debilitation, bedsores

Osteoporosis

Venous insufficiency

Total Pain in COPD

Chest wall pain, chronic pleuritis

Tachypnea

Chronic racking cough

RHF – Chronic tissue edema hepatomegaly

Peripheral vascular disease

Pain from pre-existing etiologies
WHO 3-step Ladder

1 mild
- ASA
- Acetaminophen
- NSAIDS
- ± Adjuvants

2 moderate
- A/Codeine
- A/Hydrocodone
- A/Oxycodone
- A/Dihydrocodeine
- Tramadol
- ± Adjuvants

3 severe
- Morphine
- Hydromorphone
- Methadone
- Levorphanol
- Fentanyl
- Oxycodone
- ± Adjuvants

> 4 - ≤ 7

≥ 7
Treatment of Acute Pain

- Failure to treat acute pain preemptively can lead to development of chronic pain such as complex regional pain (RSD)
- Plan for successful management rather than reacting to failed treatment!
Treatment of Acute Pain Case Study

Case scenario: middle aged patient with ankle pain comes in the office on a crutch after an injury playing basketball. Patient rates his pain as a “6/10.” No history of opioid use or drug/alcohol abuse
Treatment of Acute Pain – case study:

+ Screen for abuse potential using appropriate tools

+ Check OARxRS if any “Red Flags” or just because “who can tell!”

+ Physical exam is compatible with the history; 2\textsuperscript{nd} degree ankle sprain
Treatment of Acute pain

Goal of treatment is to reduce the pain to the point that patient can remain functional and able to say that he can move about comfortably with minimal pain and is able to sleep through the night.

One recipe: Naproxen 500mg 2xday p.o RTC for 10 days, hydrocodone 5/500 Tab 1 q4hrs prn p.o. for severe pain breakthru – dispense 16 pills. Gabapentin 200mg qhs p.o to address the neuropathic component of the pain.
Treatment of Acute Pain

- Patient advised to call you ASAP if not meeting the expectations/goals described above

- See patient back in the office in one week - prescribe very few if any opioids and start PT/OT – set goals for return to activity
Treatment of Acute pain

This is “multimodal” because instead of using only the opioid/acetaminophen combination you are also using an anti-inflammatory for the somatic pain and gabapentin for the neuropathic component of the pain. You are scheduling the naproxen and using the hydrocodone/acet prn so that you are giving both RTC continuous relief but sparing the opioid use.
Treatment of Chronic Non Malignant Pain

Case scenario: Beth has chronic pancreatitis and a pancreatic pseudo cyst. She has had repeated surgeries and has abdominal adhesions. Beth is also diabetic and has significant peripheral neuropathy. She is frequently hospitalized, losing weight, depressed and sleeps poorly. Beth sees several specialists but looks to you to manage her pain.
Treatment of Chronic Pain

Does Beth qualify as having “intractable pain” under the guidelines of Ohio SHB 187, “The Intractable Pain Law”?

Does Beth have pathology that could result in a terminal condition?

If so, then you and Beth are excluded from the regulatory scrutiny of pain contracts, urine screens, pill counts.
Treatment of Chronic Pain

Document heavily, particularly the beneficial effects of your treatment on Beth’s lifestyle and function
Treatment of Chronic Pain

One multimodal recipe for Beth:

- Beth has been on oxy/IR 10 mg 6xday for several months, now her pain is worse and she wakes up at night with leg pain and numbness.
- Convert the oxy IR to oxycodone SR, 20mg 2x day; and continue the oxycodone IR for “break thru pain” every 2-4 hours prn,
- Start gabapentin for the neuropathic pain in her legs starting with 100mg 3xday, gradually titrate to comfort by increasing the dose in tolerated increments until acceptable relief of neuropathy pain is achieved, taking into consideration Beth’s GFR
- SRNI for neuropathic pain and depression and sleep
- Anticholangeric for bowel spasms
Use of the gabapentin will not only help the diabetic neuropathy, it will also potentiate the effect of the opioid and address the “complex neuronal pain” which develops when pain becomes chronic.

Use of the adjuvants reduces the total mgs of opioid needed to provide comfort.
Step 6: Initiating opioid therapy for Chronic pain when necessary

Criteria: goals without opioids have been disappointing, reason to believe they are indicated (pathology involved, physical exam, pt’s need for relief in order to obtain function)

Assessment of patient, screening indicates patient is appropriate candidate for opioid therapy

A pain contract, patient agreement, consent to treat as appropriate are in place and documented
Initiating opioid therapy for chronic pain

- Pretreatment urine screening if appropriate is complete and documented
- Educate the patient about the possible side effects of opioids and how to manage: sedation, confusion, itching, nausea, hypogonadism, secondary osteoporosis
- Initiate a “trial period” with set goals and expectations of the patient’s function
- Establish a plan to taper and d/c opioids when appropriate
Initiating Opioid therapy

- Discuss safe storage of medications and review concerns about diversion in the household by friends and relatives

- Discuss safe disposal of unused medications – office handout on these subjects
Step 7: Monitoring ongoing Opioid Therapy

- Utilize “Universal Precautions for Pain”
- Monitoring plan is in place and initiated prior to start of therapy
- Comply with established and evolving state and federal regulations
- Comply with OARxRs
- Document monitoring, compliance on part of patient, improvement in function, achievement in goals especially work related
Monitoring ongoing therapy

- Continue all integrative medicine as appropriate
- Continue to use a biopsychosocial model of patient and family management
- Positive reinforcement of patients improved coping and lifestyle skills
Step 8: Celebrate Success!!

- Document the improvement in terms of sleep, function, ADLs, independence in the elderly

- Taper and d/c opioids as patient’s overall condition and coping skills improve

- Positive feed back to patient, family and staff

- Have ODADAS send you handouts, signs for office and update info regularly
Safe and effective pain management

+ Trust your real patients, and if you don’t, don’t treat
+ Help your real patients who have substance use problems
+ Success is improvement in function/productivity
+ Use adjuvants to treat complex pain
+ Prescribe opioids in appropriate quantities and address issues of diversion/drug disposal with patients.
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