Successfully Managing Your Chronic Pain Patients

Tools For Primary Care

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Conflict of Interest Disclosure

The presenter has no real or apparent conflicts of interest to report
Objectives

To understand:

• The opioid abuse and misuse problem and what we can do to help.
• The new CDC guidelines for chronic pain management with opioids
• Tools available to help providers manage chronic pain patients.
  – iCentra tools for assessing patients and documentation.
  – Prescribing Naloxone for patients who are risk for overdose.
Problem and Scope

• From 2012 to 2014, Utah ranked **4th in the nation** for drug poisoning deaths behind West Virginia, New Mexico, and Kentucky.

• Every week in Utah, 6 people die as a direct result of overdosing on prescription opioids.

[Source: Utah Department of Health]
1. In 2010, one in every 20 people in the United States age 12 and older – a total of 12 million people – reported using prescription painkillers non-medically.

2. Almost 5,500 people start to misuse prescription painkillers every day.

3. Over half a million emergency department visits in 2010 were due to people misusing or abusing prescription painkillers.

4. Non-medical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.
How We’re Contributing

1. Leftover narcotics are the #1 source for first time recreational opioid use.
2. 70% of teenagers received their first opiate from a friend or family member.
2012 - 2015
Common Diagnoses Where Opioids Were Prescribed

LOWER BACK PAIN

Total Count of EMPI: 74,173
How Are We Doing?

Average and Total Number of Opioid Tablets Dispensed for Lower Back Pain per Patient Encounter

[Diagram showing the average and total number of opioid tablets dispensed from 2012 to 2015]
New CDC Guidelines

• Earlier this year the CDC released guidelines for prescribing opioids.

• Included in these guidelines is a checklist for providers.
PREScribing Opioids For CHronic Pain

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIODS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN. Consider 3x weekly chronic pain 3 months excluding chronic severe pain (see below for more details). Pain and Function

BEFORE PRESCRIBING

1. ASSESS PAIN & FUNCTION
   - Use a validated pain scale. Example: PCS scale where the score = average 3 individual questions scores. (0% = no pain; 100% = worst you can imagine)
     - Q1: What number from 0-10 best describes your PAIN in the past week? (0 = “no pain”, 10 = “worst you can imagine”)
     - Q2: What number from 0-10 best describes how, during the past week, pain has interfered with your Enjoyment of life? (0 = “not at all”, 10 = “complete interference”)
     - Q3: What number from 0-10 describes how, during the past week, pain has interfered with your GENERAL activity? (0 = “not at all”, 10 = “complete interference”)

2. CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE
   - Such as NASSAD, TCA, SNRAs, non-convulsants, exercise or physical therapy, cognitive behavioral therapy

3. TALK TO PATIENTS ABOUT TREATMENT PLAN
   - Set realistic goals for pain and function based on diagnosis.
   - Discuss benefits, side effects, and risks (e.g., addiction, overdose).
   - Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
   - Check patient understanding about treatment plan.

4. EVALUATE RISK OF HARM OR MISUSE, CHECK:
   - Known risk factors: illegal drug use, prescription drug use for nonmedical reasons, history of substance use disorders or overdose, mental health conditions, sleep-disordered breathing, prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
   - Urine drug screen to confirm presence of prescribed substances and to detect illicit prescription drug or illicit substance use.
   - Medication interactions. AVOID CONCURRENT OPIOID AND BZD/INSOMNIA USE WHEREVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW.

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≤ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain, prescribe ≤ 3 days; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused medications.

100 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:
- 100 mg of hydrocodone (10 tablets of hydrocodone/benzoyl peroxide 10/500)
- 33 mg of oxycodone (2 tablets of oxycodone sustained-release 15mg)

See below for MME converters. For MME conversion factors and calculator, go to TurnTheTide.org/treatment.

50 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:
- 50 mg of hydrocodone (10 tablets of hydrocodone/benzoyl peroxide 10/500)
- 33 mg of oxycodone (2 tablets of oxycodone sustained-release 15mg)
- 30 mg of hydromorphone (2 tablets of hydromorphone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER:
- Reassess benefits within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≥ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychological support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT).
- MAT combines behavioral therapy with medications for addiction, buprenorphine, and naloxone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTide.org/treatment and www.hhs.gov/opioids.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:
SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
www.samhsa.gov/pocket-guide
NIMH15:
www.drugabuse.gov/guidelines/medication-assisted-treatment
ENROLL IN MEDICARE: go.onto.gov/gtrnd

Most prescribers will be required to enroll or validate opt-out of Medicare for their prescriptions for Medicare patients to be covered. Deputy may prevent paid access to medications.

JOIN THE MOVEMENT
and commit to ending the opioid crisis at TurnTheTide.org.
When CONSIDERING long-term opioid therapy
1. Set realistic goals for pain and function based on diagnosis.
2. Check that non-opioid therapies have been tried and optimized.
3. Discuss benefits and risks (addiction, overdose) with patient.
4. Evaluate risk of harm or misuse.
5. Discuss risk factors with patient.
When CONSIDERING long-term opioid therapy

6. Check prescription drug monitoring program (PDMP) data. (CSD or DOPL)
7. Check urine drug screen.
8. Set criteria for stopping or continuing opioids.
9. Assess baseline pain and function (BPI or PEG).
10. Schedule initial reassessment within 1–4 weeks.
11. Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.
When REASSESSING at return visit -
Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm

1. Assess pain and function (PEG); compare results to baseline.
2. Evaluate risk of harm or misuse: Observe patient for signs of over-sedation or overdose risk. – If yes: Taper dose.
3. Check PDMP. (CSD or DOPL)
4. Check for opioid use disorder if indicated (difficulty controlling use). – If yes: Refer for treatment.
5. Check that non-opioid therapies optimized.
6. Determine whether to continue, adjust, taper, or stop opioids.
Opioid Use Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress.
When REASSESSING at return visit-

7. Calculate opioid dosage morphine milligram equivalent (MME).
8. If $\geq 50$ MME/day total ($\geq 50$ mg hydrocodone; $\geq 33$ mg oxycodone; Fentanyl 25 mcg is equal to 60), increase frequency of follow-up; consider offering naloxone.
9. Avoid $\geq 90$ MME/day total ($\geq 90$ mg hydrocodone; $\geq 60$ mg oxycodone), or carefully justify; consider specialist referral.
10. Schedule reassessment at regular intervals ($\leq 3$ months).
Clinical Recommendations for Prescribing Naloxone in the Outpatient Setting

Opioid overdose is currently the leading cause of injury death in Utah, with more than 10 Utahns dying each week from an overdose. Opioid overdose occurs when a person takes more opioids than their body can handle, causing their breathing to slow or stop completely. Naloxone can be expected to work in 3 minutes after administration as evidenced by restored breathing.

This guideline was created by a multidisciplinary team based on recently published literature (see bibliography on page 4). It outlines recommendations for prescribing naloxone (see Table 2 on page 2) to patients as well as family and friends of those at risk for opioid overdose. See page 3 for key messages for patient and family education.

- INDICATIONS (See sidebar for contraindications and adverse reactions)
  Naloxone hydrochloride is an emergency opioid antagonist that is FDA-approved for the treatment of opioid overdose. Naloxone is NOT a controlled substance and can be prescribed without liability according to Utah Code (see sidebar page 2).

- RISK-BASED PRESCRIBING RECOMMENDATIONS
  Recommendations are based on two levels of risk — increased risk and some identified risk — which are detailed in Table 1 below. Prescribing options include an intranasal kit, an intramuscular (IM) kit, Narcan® nasal spray, and an auto injector (Narcan®).

### Table 1: Risk Categories and Prescribing Recommendations

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Increased Risk (Offer kit to all)</th>
<th>Some Identified Risk (Consider offering kit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals who have:</td>
<td>Individuals who have:</td>
<td></td>
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<tr>
<td>Increased risk factors:</td>
<td>- High opioid doses (10 morphine milligram equivalents per day or higher) — see Table 2 on page 2</td>
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<tr>
<td>- Methadone</td>
<td>- Long-term use of opioids</td>
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<tr>
<td>- Low-dose methadone</td>
<td>- Opiates for chronic pain management</td>
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<tr>
<td>- Tapering opioid dosing</td>
<td>- Opiates for opioid use disorder (taking buprenorphine or entering a medication maintenance program)</td>
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<tr>
<td>- Recent treatment of an opioid overdose (e.g., a first response)</td>
<td>- A prescription for any opioid AND:</td>
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<tr>
<td>- Prescriptions for:</td>
<td>- Children in the home</td>
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<tr>
<td>- High-dose opioid use (10-50 morphine milligram equivalents per day) — see Table 2 on page 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>- Known or suspected use of alcohol or other substance</td>
<td></td>
</tr>
<tr>
<td>Long-term use of opioids</td>
<td>- Known or suspected use of alcohol or other substance</td>
<td></td>
</tr>
<tr>
<td>Opiates for chronic pain management</td>
<td>- Known or suspected, concurrent use of alcohol, benzodiazepines, sedatives, and opioids</td>
<td></td>
</tr>
<tr>
<td>Opiates for opioid use disorder</td>
<td>- Agitated or unsteady years old or cognitive impairment</td>
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<tr>
<td>- Recent treatment of an opioid overdose (e.g., a first response)</td>
<td>- Critically ill (emergency medical service not in proximity to a hospital)</td>
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<tr>
<td>- Prescriptions for:</td>
<td>- Recent hospitalization from opioid administration or mortality assistance program</td>
<td></td>
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<tr>
<td>Methadone</td>
<td>- Lost opioid tolerance and are likely to re-engage in opioid use (mean release from a correction facility)</td>
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</tr>
</tbody>
</table>

### CONTRAINDICATIONS

Hypersensitivity to naloxone hydrochloride

### ADVERSE REACTIONS

- May precipitate opioid withdrawal, which can cause nausea or vomiting.
- Adverse CV effects if abrupt discontinuation of opioid (e.g., chronic obstructive pulmonary disease, asthma, or other respiratory illness or obstruction)
- Focal dysfunction or hepatic disease
- Known or suspected, concurrent use of alcohol, benzodiazepines, sedatives, and opioids
- Agitated or unsteady years old or cognitive impairment
- Critically ill (emergency medical service not in proximity to a hospital)
- Recent hospitalization from opioid administration or mortality assistance program
- Lost opioid tolerance and are likely to re-engage in opioid use (mean release from a correction facility)
Prescribe Naloxone for those patients that are at high Risk

- Known or suspected illicit or non-medical opioid users (including heroin).
- Diagnosed with substance use disorder or use non-medical injectable drugs.
- Recipients of emergency medical care for acute opioid poisoning.
- Receiving medication-assisted therapy for opioid use disorder (taking buprenorphine or entering a methadone maintenance treatment program).
Consider prescribing Naloxone for the following patients:

- Prescriptions for High opioid doses (50 MME per day or higher)
- Methadone
- Long-acting opioids
- Opioids for chronic pain management
- Rotating opioid regimens
- A prescription for any opioid AND children in the home
- Known or suspected use above prescribed doses
- Breathing impairment related to sleep apnea, smoking, chronic obstructive pulmonary disease, asthma, or other respiratory illness or obstruction
- Renal dysfunction or hepatic disease
- Known or suspected, concurrent use of alcohol, benzodiazepine, sedative/hypnotic, antidepressants
- Age greater than 65 years old or cognitive impairment
- Difficulty accessing emergency medical services (not in proximity to a hospital)
- Been released from opioid detoxification or mandatory abstinence program
- Lost opioid tolerance and are likely to restart an opioid (recent release from a correctional facility)
How to prescribe Naloxone in outpatient setting

- Two different formulations
  - Intramuscular
    - IM kits available at Intermountain pharmacies
    - Branded product Evzio available
  - Intranasal
    - Intranasal kit with atomizer packaged by Intermountain
    - New branded Narcan intranasal product
Ordering Naloxone Kits

• Order sentences have been created in iCentra
Naloxone Prescribing

- Available at all Intermountain pharmacies without a prescription through the Pharmacy Collaborative Agreement
- Prices
  - Intermountain IM kit- $40
  - Intermountain Intranasal Kit- $100
  - Evzio- $2500 (coupon available for most patients which drop cost to 0.)
Workflow for Chronic Pain Patients on Opioids

Clinical Staff

• Previsit-
  – Print CSD report the night before
  – Confirm that they have a current MMA
  – Determine date of last USD

• At Time of Visit
  – Have patients complete the functional assessment (BPI or PEG) and enter results in iCentra
  – If not MMA or USD within last 12 months- prompt physicians to complete.
Provider Workflow

- Complete additional assessments and screening as needed
- Document using the Pain Management Workflow
Pain Management Workflow Demo
Questions?