Managing Pain During a Time of Rising Opiophobia and Regulatory Changes

CHAPCA Session 1C

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The Opioid Epidemic: A National Public Health Emergency

- Number of prescription opioids jumped from 76 million in 1991 to 219 million in 2011
- 2015 National Survey on Drug Use and Health estimate that 3.8 million Americans use opioids for non-medical reasons every month
- 142 Americans die daily from drug overdoses (#1 cause of unintentional death; 52,000/year)
  - 2,350 Illinois statewide drug-related deaths during 2016 (80% opioid fatalities)
  - 79% increase compared to 2013 and 32% increase over 2015
  - 1/3 of respondents in an Illinois survey of 1,000 residents have known someone addicted to opioids
- 1,925 Opioid Overdose deaths in California in 2016 (23,684,377 opioid prescriptions)
Heroin Epidemic

- Majority of heroin users report opioid misuse began with prescription drugs
  - Lower price of heroin and decreasing access to prescription opioids increased heroin use
  - Abuse deterrent formulation of OxyContin made it harder to inject, causing some to switch to heroin
  - Heroin laced with fentanyl and other drugs has increased its lethality

Relationship between Opioid and Heroin Deaths

How did we get here?

- Pain Crusade during the 1980’s & 90’s: Education to de-stigmatize opioids and increase comfort in prescribing inadvertently contributed to the growth in opioid prescribing
  - 1980 Porter & Jick - 1 paragraph letter to Editor of NEJM stating that less than 1% of hospitalized patients became addicted to their pain medication was globally accepted and repeated as gospel
  - 1986 Case Report in J of Pain of 38 pts by Portenoy & Foley concluded that opioids were safe and more humane than surgical options or no treatment in those with no history of drug abuse
  - LA opioids (MS Contin 1984 and OxyContin 1995) were thought to be safe
  - Marketing by pharmaceutical companies (ex. Purdue Pharma and Endo)
  - Pill mills by unscrupulous prescribers started to pop up
  - The spread of Mexican heroin runners throughout middle America

- Two decades into the pain revolution, consensus emerged that opioids were unhelpful, even risky for some types of chronic pain (back, headaches, fibromyalgia)
Use urine drug testing to identify prescribed substances and line or routine therapy for chronic pain.

California Opioid Overdose Dashboard

and pain relief is the primary goal

Begin with immediate release opioids; do not prescribe ER/LA

Cautions physicians once 80 mg of morphine equivalents

Avoid concurrent opioid and benzodiazepine prescribing

• Opioid Prescribing Regulations

Prescribe the lowest dose and least amount needed

• opioids)

Establish treatment goals and risks & benefits of opioids

CDC Guideline for Prescribing Opioids for Chronic Pain (March 2016)

Note: Not intended for hospice and palliative care patients

- Opioids are not 1st line or routine therapy for chronic pain
- Establish treatment goals and risks & benefits of opioids
- Begin with immediate release opioids; do not prescribe ER/LA opioids for acute pain
- Prescribe the lowest dose and least amount needed
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent opioid and benzodiazepine prescribing
- Offer Narcan for those with substance abuse disorders, concurrent use of opioids and benzos, or opioid doses of ≥ 50/day

California Medical Board (MBC) Opioid Prescribing Regulations

- Intended for all physicians practicing in California, but are not meant for the treatment of hospice and palliative care or to limit treatment where improved function is not anticipated and pain relief is the primary goal
- Designed to educate physicians for improved patient outcomes and prevent overdose deaths
- No 5 or 7 day limits to first time prescriptions that other states are enacting (MBC endorses up to 45 days for initiating opioids)
- Cautions physicians once 80 mg of morphine equivalents (MMEs) are reached
- Required use of state prescription monitoring system (CURES)
- California Opioid Overdose Surveillance Dashboard
  https://pdop.shinyapps.io/ODdash_v1/
Case Study: Introduction

Rosemary is a 66 year old with breast cancer metastatic to bone and liver. Despite 3rd line chemotherapy, her recent abdominal MRI demonstrated worsening liver metastasis and a bone scan revealed new areas of metastasis in her ribs and spine. In the past 3 months, she underwent radiation for painful bone metastasis in her hip and spine. She continues to have pain despite around-the-clock use of an NSAID and Percocet 5/325 every 4-6 hours. She reports that she tries to limit her pain medication to 3 times a day (am, afternoon and bedtime), but her pain is making it hard for her to participate in her usual activities and to sleep at night.

Case Study: MD/NP/Nurse

You are the physician/PA/NP or nurse for Rosemary, a 66 yo woman with metastatic breast cancer whose disease is progressing despite 3rd line chemotherapy and radiation. Her recent bone scan showed areas of new uptake in her right ribs, humerus and T spine. An abdominal MRI also revealed worsening liver mets. Rosemary’s pain medicine (Percocet 5/325mg) is not sufficient to control her pain, yet when you suggest switching her to MS Contin with Percocet for breakthrough, the daughter expresses concerns about getting addicted to the medication and is vehemently opposed the idea.

Case Study: Daughter Molly

Rosemary’s daughter Molly is upset and frightened that her mother’s cancer is worsening despite treatment. She is her mother’s primary caregiver, but she also have 3 teenage children and a husband. She is upset seeing her mom in pain and has noticed that she seems more withdrawn and exhausted. Molly wants her mother comfortable, but all of the recent reports about addiction to opioids has her worried. One of her friend’s 25-year-old son died last month of an overdose of OxyContin. Molly does not want her mom hooked on these drugs and is looking for a safer solution.

When the doctor (nurse) suggests changing her mom’s pain medication to morphine and Percocet, Molly responds “Oh my God, Mom is already on too much medication, I don’t want her getting hooked on that stuff, you know all the things they are saying on the news these days!”
Case Study: Rosemary

Rosemary is a 66 year old who lives alone after being widowed 5 years ago. She has a daughter who lives a few blocks away who provides help when needed and attends doctor’s appointments. Eight years ago, Rosemary was diagnosed with stage 3 breast cancer. Two years ago, it spread to her liver and more recently, to her bones. She has been receiving chemotherapy but it makes her feel sick and according to her doctor, may not be working. She underwent radiation a few months ago for pain in her low back and hip. It helped initially, but now she has pain in her back again and her ribs hurt too. The pain keeps her awake at night and it is making it very hard for her to manage on your own. Lately, she doesn’t have the energy to go to her daughter’s house and she misses spending time with her grandchildren. The doctor prescribed pain medicine, but she tries to take it as sparingly as possible and it doesn’t seem to help anyway. Rosemary is worried that the cancer and your pain are only going to get worse. Her daughter doesn’t like you on these narcotic medications either.

Opiophobia

- Concerns among family caregivers and lack of understanding about pain medication are common and can be a barrier to prescribing.
- Fear about the use of opioids among patients, family members and prescribers rising
- Debate over use of opioids in the medical community (especially for chronic pain)
- Patients who truly need opioid treatment for pain are having difficulty finding anyone to prescribe it
- New CDC Guidelines and state prescribing regulations focused on addiction prevention, medication diversion, cautioning against use for chronic pain, and safe prescribing

Addressing Patient/Family Concerns

- Allow them to voice their concerns
- Optimize other therapies (such as NSAIDs, steroids, muscle relaxants, gabapentin) as well as non-pharmacological approaches
- Explain that addiction means that a person uses the drug to “get high,” and has lost control of the urge to take the drug.
  - Most patients’ with cancer or EOL pain do not “get high” from taking opioids, and addiction is unlikely if their risk for addiction is low
- Describe the benefits of pain management and voice concerns about needless suffering- goal is to improve QOL
- Remind them that all opioid prescribing guidelines have exceptions for those with cancer and palliative care. These drugs are intended for their use.
Script

“The opioid epidemic is a real and concerning problem, but under medical guidance, these medications can be used safely and are intended for people like your mom who has pain from her cancer. We have a lot of research that shows the benefits of using opioids for pain related to cancer or in end-of-life situations. All of the pain management guidelines make exceptions for those with cancer, recognizing the important role opioids have in safely managing pain for this population.”

Script

- “Your mom has no previous history of alcohol or drug abuse and has been using her pain medication responsibly these past few months. In fact, we are concerned that she is not taking her medication often enough—making it harder to control her pain.”
- “We will optimize other therapies as well. Your mom is currently taking an NSAID for her bone pain and we can explore the use of other types of therapies, but opioids work well and tend to be well tolerated. Our goal is for your mom to sleep through the night and be more functional during the day. A long-acting pain medication can help to achieve that.”

Safe Prescribing
Best Practices: Reduce Waste

- The majority of people do not keep their opioids in a locked container and most do not safely dispose of pills no longer needed
- Encourage destruction of medications no longer used BEFORE patient dies or when no longer needed
- Don’t order more medication than needed-
  - Assess supply before refilling
  - Order smaller day’s supply if patient’s condition is deteriorating
  - If in hospice, use med from Hospice “Emergency Kit” before placing order
- Assist with medication disposal (teach appropriate technique or educate about “take back” programs)

Best Practices: Prevent Diversion

- Proactive education and assessment about appropriate use and risks for opioid diversion or misuse
  - Consider using standard agreements with all patients that state clear boundaries of use, disposal, and consequences for misuse or diversion
  - Lock boxes and medication counts
  - e-prescribing -
    - 2-way verification process ensures correct prescriber is authorizing the prescription and prevents altering of script

Strategies to Promote the Safe Use of Opioids

All patients:
- Conduct Opioid Risk Assessment
- Identify who will control medication administration
- Opioid Safety Education
  - Side effects
  - Use only as prescribed
  - One prescriber only
  - Secure storage (lock boxes and medication counts)
  - Driving and other limitations
  - Who to call with questions
- Consider using standard agreements with all patients that state clear boundaries of use, disposal, and consequences for misuse or diversion
Strategies to Promote the Safe Use of Opioids

Low Risk Patients
• Continue Monitoring safe use of opioids
  • Reconcile opioids every RN visit
  • Safe storage
  • Review safety plan as needed

Moderate and High Risk
• For Patients:
  • How recent is the substance abuse?
  • What substance is being abused?
  • How significant is the abuse?
  • Reconcile opioids every visit
  • Maximum 2 weeks maximum supply
  • Avoid benzodiazepines, consider alternatives such as antidepressants, anxiolytics

• For Family Members:
  • Who is abusing substances?
  • How recent is the substance abuse?
  • What is being abused?
  • How significant is the abuse?
  • Is the abuser involved in care giving?
  • Emphasize safety for identified individuals
  • Deny access to the individual
  • Install lock box
Strategies to Promote the Safe Use of Opioids

**Additional Step for High Risk Patient**
- Emphasize safety
- Express concerns explicitly
- Limit supply to 1 week or less
- Frequent evaluations
- Identify family member to control opioid administration
- Consider the use of:
  - Prescription Monitoring Program
  - Urine drug-screen
  - Long acting opioids without short acting breakthrough opioids

**Highest Risk**
- Inform the patient and family that the plan has been violated and that the hospice must evaluate its options
- IDT review
- New plan
  - Prevent abuser’s access to opioids
  - Admit patient to controlled environment
  - Reduce limited supply further
  - Single reliable person to administer opioids

**Highest Risk**
- Additional Considerations
  - Ethics consult
  - Hospice will no longer manage/supply opioids
  - Hospice will discharge the patient
  - Contact law enforcement and/or adult or child protective services
### Opioid Risk Tool

1. Family history of substance abuse
   - Alcohol (1.5)
   - Illegal drugs (2.3)
   - Prescription drugs (4.4)
2. Personal history of drug abuse
   - Alcohol (1.5)
   - Illegal drugs (2.3)
   - Prescription drugs (4.4)
3. Age (mark if 16-45) (1.1)
4. History of preadolescent sexual abuse (3.0)
5. Psychological Disease
   - Attention-deficit disorder
   - Obsessive-compulsive disorder
   - Bipolar
   - Schizophrenia (1.1)
   - Depression (1.1)

- Scores differ between males and females. (Female, Male)
- Total the points __________
- Total score risk category
  - Low risk: 0-3
  - Moderate risk: 4-7
  - High risk: 8 or more

### Controlled Substance Standard Safety Agreement

- Written agreement explaining:
  - Risk/benefits
  - Addiction/Dependence
  - Number and frequency of prescriptions and refills
  - Compliance rules and violation with reasons for termination of therapy
  - CS by single MD, unless authorized and documented
  - Usually evaluated every 3 months (monitor efficacy, indications, progress to goals, compliance, etc.)

### Diversion

Options if Diversion occurs:
- Place lockbox in the home
- Limit the quantity dispensed
- Alter medication routes as appropriate (patch/pump)
- Consider alternate locations for safe storage
- Increase visit frequency
- Implement mandatory controlled substance counts and document them at every visit
- Delivery to the hospice
- Placement of patient to an alternate home
- Discuss potential discharge from hospice services with patient/caregiver
## Alternatives to Opioids

- **Non Pharmacological**
  - Acupuncture
  - Chiropractic and osteopathic manipulation
  - Physical Therapy and Exercise
  - Cognitive Behavioral Therapy
  - Music Therapy
  - Massage

## Alternatives to Opioids

- **NSAIDs**
- Antidepressants
- Anticonvulsants
- Capsaicin
- Topical Lidocaine
- Ketamine

## Opioids and Benzodiazepines in Hospice

- Opioids and benzodiazepines are commonly prescribed to manage symptoms in patients on hospice or other palliative programs

  - Patients NOT enrolled in hospice
    - Increased risk of serious side effects
    - FDA is increasing public awareness
Opioids and Benzodiazepines in Hospice

- Opioids- Used to reduce pain
- Benzodiazepines- Used to help with sleep, anxiety, seizures, or muscle spasms
- Side Effects- sedation, confusion, increased fall risk. Controlled by increasing the dose slowly
- Addiction- most pts do not get high from these medications and addiction rates in hospice are not known but thought to be low.
- Discontinuing/Withdrawal- important to taper, do not abruptly stop. Withdrawal symptoms do not mean the pt is addicted
- Overdose- uncommon if followed by hospice team; important to monitor when increasing dose. Signs of overdose include: slurred speech, poor balance, nodding off and slowed respirations

Narcan

- Used to reverse opioid overdose (note: will not reverse benzodiazepine overdose)
- Available as injection or nasal spray
- With proper titration of opioids and benzodiazepines, should not be needed in the home

Discussion

Contact information:
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References

- NY Times article: https://www.nytimes.com/2016/03/17/health/er-pain-pills-opioids-addiction-deaths.html?r