Challenges in Chronic Pain Management

“Clinical & Medicolegal Landscape”
Disclosure

We, S. Hughes Melton, M.D. and Jerry Canaan, Esq. declare that we (including any member of our families) do not have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing medical education activity or with any corporate organization that might have an interest in the subject being presented.
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Our goals today are:

• To Answer: Why has chronic pain management become a difficult issue?
• Review the ten universal precautions
• Discuss two BOM cases
• Show prescribers how to stay out of trouble
• Discuss effective communication techniques with pain management patients
Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012
From: Nt’l Survey on Drug Use and Health, SAMHSA
http://www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.htm#2.16
Why do some prescribers prescribe unwisely?

• Dated
• Duped
• Disabled
• Dishonest
Heroin, cocaine, IV Dilaudid, Nicotine, Snorted/Injected Oxycontin (old formulation), Xanaz

Percocet, Immediate Release Morphine, Higher Proof Liquor, non-injected Oxycontin, Vicodin

Abused Methadone, Abused Buprenorphine, Lower Proof Alcohol, Marijuana

Methadone, Buprenorphine taken as directed
Disease Progression

Inherited Threshold for Addiction

ADDICTION STARTS AGE 36

Cumulative Dopamine Spikes

AGE 10 15 20 25 30 35 40 45
Inherited Threshold for Addiction

Addiction starts at age 24

Cumulative Dopamine Spikes

More frequent exposure
Inherited Threshold for Addiction

Addiction starts at age 20.

Onset of Addiction

Lower inherited threshold

Cumulative Dopamine Spikes

AGE 10 15 20 25 30 35 40 45 11
Inherited Threshold for Addiction

Starting Substance Use Earlier decreases the threshold

Onset of Addiction

Cumulative Dopamine Spikes

ADDICTION STARTS AGE 20
Ten Universal Precautions (UPs) in Pain Management

• Why are they necessary?
  – Can’t predict likelihood of substance abuse
  – Disease has serious consequences for patient and provider
  – Selective application of precautions stigmatizes patients
  – UPs uncover hidden substance misuse
  – Focus on what you as a provider can do
Ten Universal Precautions in Pain Management

1. Make a diagnosis with appropriate differential

2. Psychological assessment including risk of addictive disorders- ORT, SOAAP, etc…

✓ Family history of substance abuse
  • Positive history not a contraindication to care
  • Not an attempt to diminish pain
  • Honest answers lead to improvement in care
  • Who and what?

✓ Personal substance “use” history
  • When and what?
  • Social drinking and prescribed benzodiazepines
  • Safest level of use is “zero”

Risk Factors for Substance Misuse

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychiatric</th>
<th>Social</th>
</tr>
</thead>
</table>
| - Age ≤ 45 years
- Gender
- Family history of prescription drug or alcohol abuse
- Cigarette smoking | - Substance use disorder
- Preadolescent sexual abuse (in women)
- Major psychiatric disorder | - Prior legal problems
- History of motor vehicle accidents
- Poor family support
- Involvement in a problematic subculture |

How could anyone have missed this?
Ten Universal Precautions in Pain Management

3. Informed consent

4. Treatment agreement
   - Reinforce responsibility, enhance communication
   - Pill counts and PMP query
   - Toxicology testing (UDS, blood, saliva, etc.)
   - No controlled substances till past records arrive and 30 days in practice- Post that in your office!

It is our policy not to prescribe narcotics for chronic pain patients at their first visit. A thorough evaluation must occur, including contact with past providers, before controlled substances are considered (2-4 weeks).

Likewise for patient safety, we now have limits on maximum daily dose as well as restrictions as to the type of narcotic we will prescribe to any of our patients.
Ten Universal Precautions in Pain Management

5. Pre- and post-intervention assessment of pain level and FUNCTION
   a) Interval history - work, hobbies, etc.
   b) Testing - SF-36, Pain Disability Index, etc.

6. Appropriate trial for opioid therapy + adjunctive medication

Ten Universal Precautions in Pain Management

7. **Reassessment** of pain score and level of function

8. Regularly assess the 5 A’s of pain medicine
   – Analgesia
   – Activity
   – Adverse effects
   – Aberrant behavior
   – Affect

Ten Universal Precautions in Pain Management

9. Periodically review pain diagnosis and comorbid conditions, including addictive disorders

10. DOCUMENT!!
UNIVERSAL PRECAUTIONS FOR PRESCRIBING CONTROLLED SUBSTANCES[i]: EVERY PATIENT, EVERY TIME

1. Confirm the diagnosis (old records, diagnostic studies). Does the diagnosis justify controlled substance prescribing?
2. Try the less risky interventions for pain first: PT, NSAIDS, etc. TREATING PAIN WITH NON-NARCOTIC INTERVENTIONS IS TREATING PAIN.
3. Get informed consent: Controlled Substance Agreement.
4. Do a UDS and check your state’s Prescription Monitoring Program. This protects the patient AND YOU.
5. Assess Risk Factors for Substance Misuse Disorders
   – Family History (Addiction is a GENETIC disease)
   – Current Addictions (This includes smoking)
   – Behaviors symptomatic of a Substance Misuse Disorders (Legal problems, MVAs, DUs, etc)
6. Assess Functioning
7. Do a Time limited Trial (Expectations: No problematic behavior, IMPROVED FUNCTIONING)
8. Have an Exit Strategy (know how to wean what you start; know where to refer patients with SAD)
9. Periodic Reassessment
10. Give the fewest number of pills possible with the lowest abuse potential
11. DOCUMENT, DOCUMENT, DOCUMENT

THE BOTTOM LINE:
FUNCTIONING
IF YOU ARE TREATING PAIN, FUNCTIONING GETS BETTER
IF YOU ARE FEEDING AN ADDICTION, FUNCTIONING GETS WORSE

[i] Adapted from Gourlay

Mary G. McMasters, MD, FASAM
Five Domains of Care Structure

1. Setting of Care
2. Selection of Treatment
3. Supply of Medication
4. Supports for Recovery
5. Supervision of Care
# Five Domains of Care Structure

## Setting of Care

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Primary Care</th>
<th>Specialist Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Etiology</td>
<td>Straightforward</td>
<td>Unclear or complex</td>
</tr>
<tr>
<td>Psychiatric Disorder</td>
<td>None</td>
<td>Unstable</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>None</td>
<td>Current or within three years</td>
</tr>
<tr>
<td>Social Support</td>
<td>Good</td>
<td>Isolated</td>
</tr>
<tr>
<td>Activity</td>
<td>Rich and satisfying</td>
<td>Absent</td>
</tr>
</tbody>
</table>
Five Domains of Care Structure
Selection of Treatment

- Most benefit with the least risk
  - Remember non-pharmacologic options
  - Address medical co-morbidities - sleep, psychological, hunger, deconditioning

- Patient preference and ability
  - Cognitive or financial limitations

- Provider’s skills
PMP’s Morphine Equivalent Daily Dose (MEDD)

- 80% have < 100 MEDD account for 20% of overdose deaths
- 10% >100 MEDD & single prescriber = 40% of overdose deaths
- 10% >100 MEDD & multiple prescribers = 40% of overdose deaths

Five Domains of Care Structure
Supply of Medication

• Quantity
  – 7 vs. 120
  – “Bottomless bottle”
  – Safer (non-lethal supply)

• Scheduled vs. PRN

• Dispensing
  – Pharmacy, family or trusted surrogate
  – Potential resentment/conflict
Five Domains of Care Structure

Supports for Recovery

• Support Groups
• Sponsor
• Counselor - SA and psychiatric
• Faith community
• Family - group therapy
• Workplace
Five Domains of Care Structure

Supervision of Care

• Visit Frequency
  – Weekly to every 3 months

• Toxicology and PMP Data
  – Weekly to annually and randomly

• Addition of ancillary providers
  – Different than changing setting of care
  – More practical in rural area
  – Clinical pharmacy
  – Interventionalist
UDS

• Would you prescribe blood thinners without checking to see how thin the blood is?
• Would you prescribe insulin without checking a blood sugar?
• Would you prescribe controlled substances without doing a uds?
Remember 10%
Case A

- Orthopedic Surgeon
- In practice approximately 15 years
- In an urban area
Case A

The patient:

- Leg fracture and surgery
- Follow-up treatment for two years for chronic pain
- 12 office visits the first year
- No office visits the second year
- The physician wrote approximately 50 prescriptions for Percocet over 24 months.
Case A

• The patient died due to accidental overdose of Oxycodone, Diazepam and Trazadone.

• Who complained to the Board of Medicine?
  – The patient’s family
Case A

Board allegations:

- Failed to monitor use of narcotics and compliance:
  1. No opioid agreement
  2. Did not consult the PMP
  3. No UDS
Case A

Board Punishment:

• Put on probation with terms and conditions
  – Continuing education and prescribing, recordkeeping and addiction
Case A

Lessons learned:

a. Chronic pain management is chronic pain management! The environment is irrelevant.

b. Yes, the rules apply to you.

c. Pay attention

d. Staff needs to be empowered to speak up
Case B

- Internal Medicine Physician
- Practicing over 30 years
- Rural area
- About 15% of the physician’s practice is chronic pain management
Case B

• The physician religiously used:
  – PMP
  – UDS
    • In-house screen
    • Also sent to lab
  – Opioid agreements

• Who complained?
  – Anonymous
Case B

Board allegations:

• Involved 5 patients

• “You (or the mid-level under your supervision)”
  1. Failed to verify the patient’s source/complaint of pain
     a. Did not obtain other records prior to prescribing.
     b. Believed the patient.
     c. No diagnostic tests or studies ordered.
     d. Radiology reports were negative!
     e. Prescribed opioids on the first visit.
  2. Prescribed Adderall based on the patient’s self-report of a previous diagnosis of ADHD.
Case B

3. Failed to enforce terms of opioid agreement:
   a. Inconsistent UDS
      1. Negative for the meds prescribed.
      2. Positive for THC.
      3. Approximately 20 times over 4 years.
   b. Allowed patients to self-titrate opioid doses.

4. Prescribed opioids and benzos in escalating doses without a medical diagnosis warranting such prescriptions.

5. Patients got worse!

6. No referrals for signs of addiction, mental health or psych.
Case B

Board punishment:

• A reprimand and probation with terms and conditions including continuing education in prescribing, addiction, risk management, and diagnosing
Case B

Lessons to be learned:

a. If you use the tools, you must look at the data!

b. Pay attention to mid-levels.

c. Proper pain management takes time.

d. End the relationship!
Why do prescribers continue to get in trouble?

• Ignorance
• No courage
• Subjective reasoning
  – “being nice” is no substitute for the standard of care.
  – “being nice” trumps “do no harm”
  – Empathy overwhelms logic.
  – “I am stuck:”
    • With the patient
    • With the situation
    • With nowhere to refer
Why do prescribers continue to get in trouble?

• Believing the patient
  – Naiveté
  – Too trusting
  – “Know the family”

• Not acting on the data in front of you
  – Ignoring the psych element
  – Ignoring the signs of diversion
  – Ignoring addiction, pseudo addiction, tolerance, chemical coping
Communication:

• Confidence!
  – You control the terms of the relationship
  – You control when it begins and when it ends
  – You can use a powerful word: “No.”

• Use unequivocal language:
  – “I am not prescribing any medication today.”
  – Tell the patient exactly what you expect
  – “You signed an opioid agreement, you violated the agreement, and our relationship is over.”
Final Thoughts

1. Patients should not dictate the standard of care.

2. You are not required to continue the mistakes of a previous prescriber or continue the current prescribing regimen.

3. Abandonment rarely an issue.
Some Great Resources:

- PBI, Vanderbilt, Case Western, Harvard, US-San Diego Pace Program
- American Academy of Pain Medicine
- American Academy of Pain Management
- American Pain Society
- American Society of Addiction Medicine
- Pain Week Conference
- www.painedu.org
- Self-Query on PMP!
Sources of Information

- www.asam.org
- www.casacolumbia.org
- www.monitoringthefuture.org
- www.drugabuse.gov
- www.samhsa.gov
- www.health.org
- www.clubdrugs.org
- www.drugfreeamerica.org
- www.collegedrinkingprevention.gov
- www.jointogether.org/sa/news/features
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• Anton et al, Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence, The COMBINE Study: A Randomized Controlled Trial, JAMA 2006;295:2003-2017

• Federation of State Medical Boards
  – Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain 2013
  – Report of the Center for Substance Abuse Work Group
  – Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office

• Slides 27, 30, 38, 39 from David Lawrence DO, UVA
References


• Heit HA; Dear DEA, Pain Medicine Vol 5 #3, 2004, 303-308

• Buprenorphine in the Treatment of Opioid Dependence, www.aaap.org

• Slides 18,34,40,43,49,54 from Google Images

• Slide 45 from SAMHSA

• Slides 58,60,61 from ASACPT
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  http://www.surgeongeneral.gov/library/calltoaction/fact1.htm

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  http://www.cdc.gov/stltpublichealth/psr/prescription drug/index.html#4