



Module 1: Scope and Risk



Opioid Education

Module 1

- Scope and Risks of the Opioid Problem

Module 2

- Approach for Initiating Chronic Opioid Therapy (COT)
- Risk and Benefit Assessment
- Communication with patients

Module 3

- Approach for Ongoing COT Management and Assessment
- Tapering
- KPHC Tools and Resources
- Communication with patients



Module 1: Opioids Scope and Risks

Learning Objectives

- Within the context of the history of opioid prescribing, identify the scope of the opioid problem nationally
- Identify and reduce risk to patients, families, communities, providers and the medical group



Agenda: Module 1

Opioid Education Overview

Scope of the Opioid Problem

Risks of Opioid Prescribing

- Patients
- Family/Community
- Prescriber
- Medical Group

New Approach: Chronic Opioid Therapy Workflow

Tools and Resources to Help Prescribers and Patients





1 in 3 Americans has
Chronic Pain

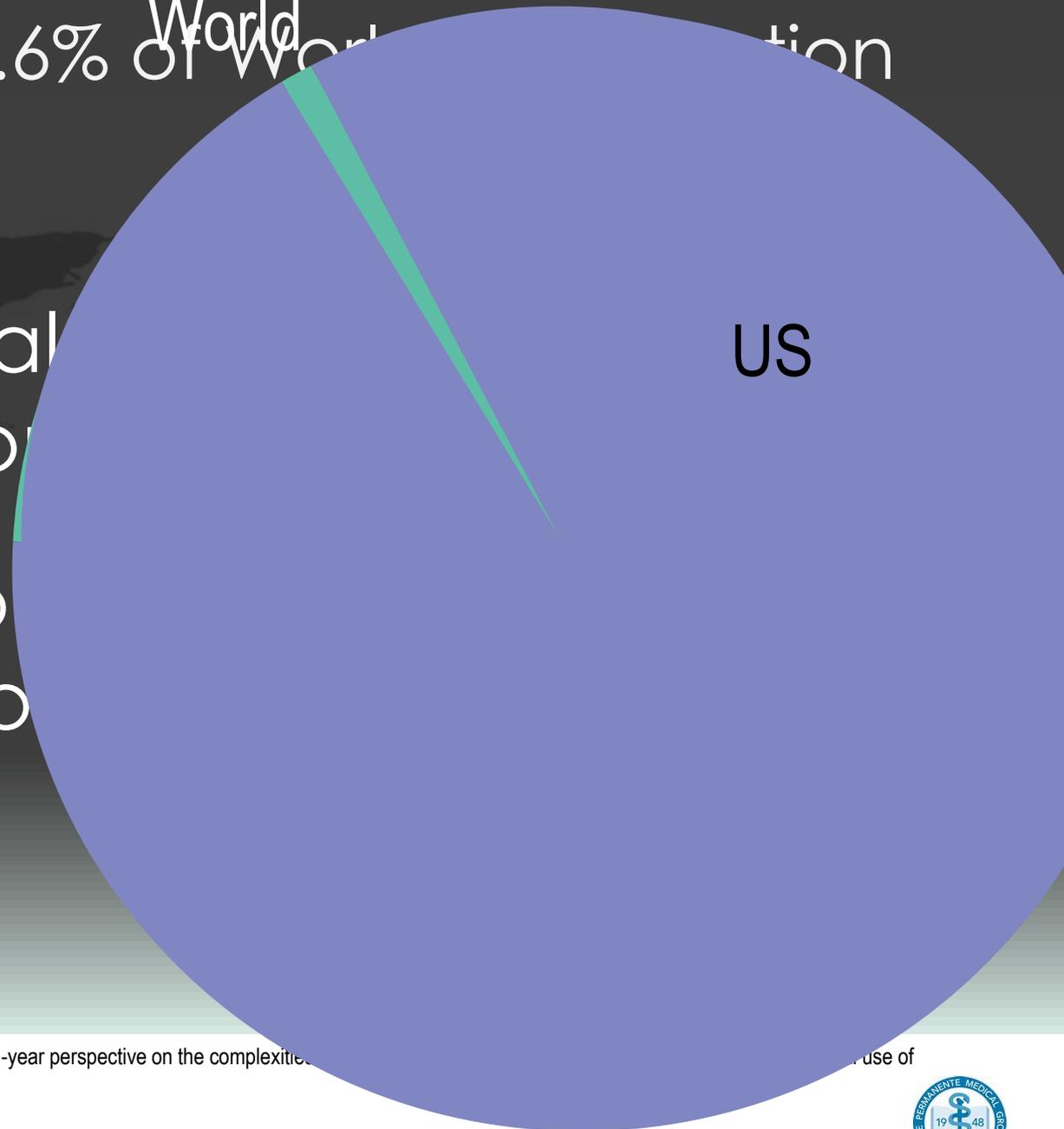
Institute of Medicine, Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press, 2011



Americans 4.6% of World Population

80% Global
Opioid Supply

99% Glob
Hydrocodo
Supply



Manchikanti, L., & Singh, A. (2008). Therapeutic opioids: a ten-year perspective on the complexities of use of opioids. *Pain physician*, 11(2 Suppl), S63-S88.



Prescribing Opioids

Recent Statistics

16,917 opioid related deaths

169,868 treatment admissions

1.4 million ED visits for misuse or abuse of pharmaceuticals

12 million nonmedical users



Center for Disease Control: <http://www.cdc.gov/homeandrecreationalafety/overdose/facts.html>

Substance Abuse and Mental Health Services Administration - Treatment Episode Data Set (TEDS) 2002 - 2012 National Admissions to Substance Abuse

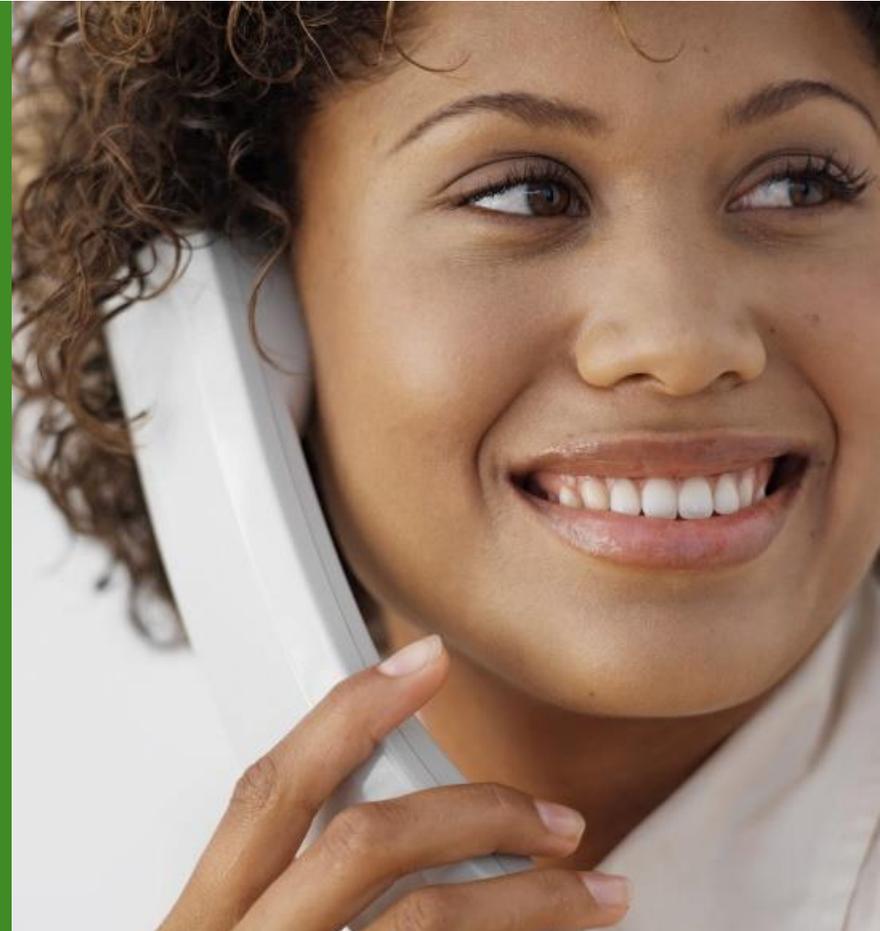
Treatment Services <http://www.samhsa.gov/data/2K14/TEDS2012NA/TEDS2012NTbl1.1a.htm>



Prescribing Opioids

What we know now

- Pain does not prevent addiction
- Chronic Pain: common co-morbidity w/ addiction or mental health diagnosis
- Pain is treatable and manageable
 - Functional improvement, pain reduction
 - Average pain score decreased 3 points
- Chronic Opioid Therapy (COT) requires ongoing management and assessment
- 90 day cliff



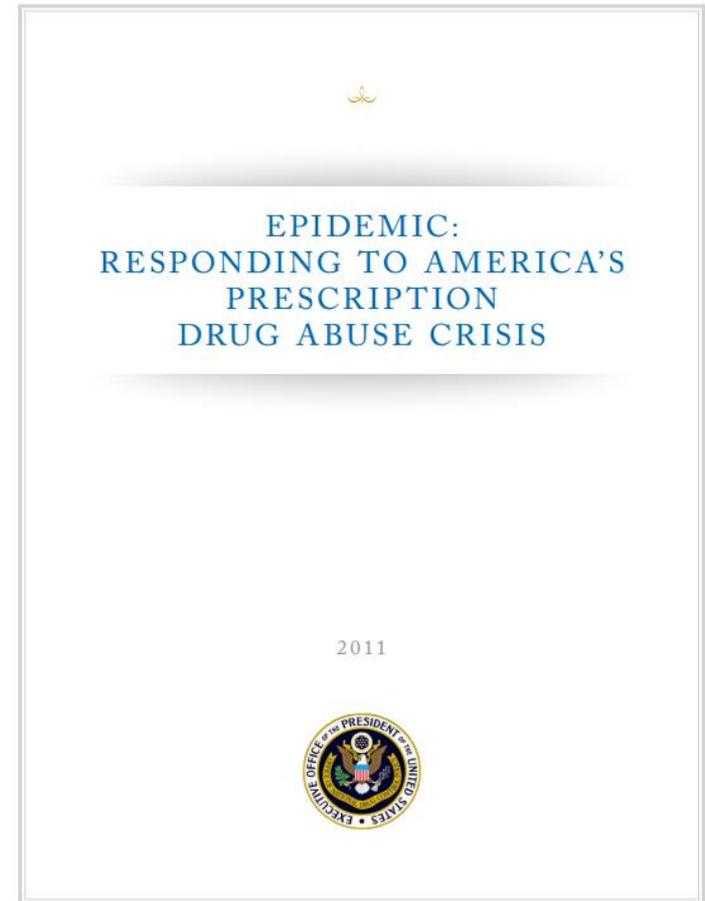
Federal Response



Office of National Drug Control Policy

Target areas to reduce prescription drug abuse

- Education for patients and prescribers
- Implementation of prescription drug monitoring programs
- Proper Medication Disposal
- Enforcement



Opioid Prescribing Risks

- Patients
- Family/Community
- Prescriber



Patient Risks

- Constipation
- Confusion/sedation
- Nausea
- Tolerance
- Physical Dependence / Withdrawal
- Addiction
- Overdose / death



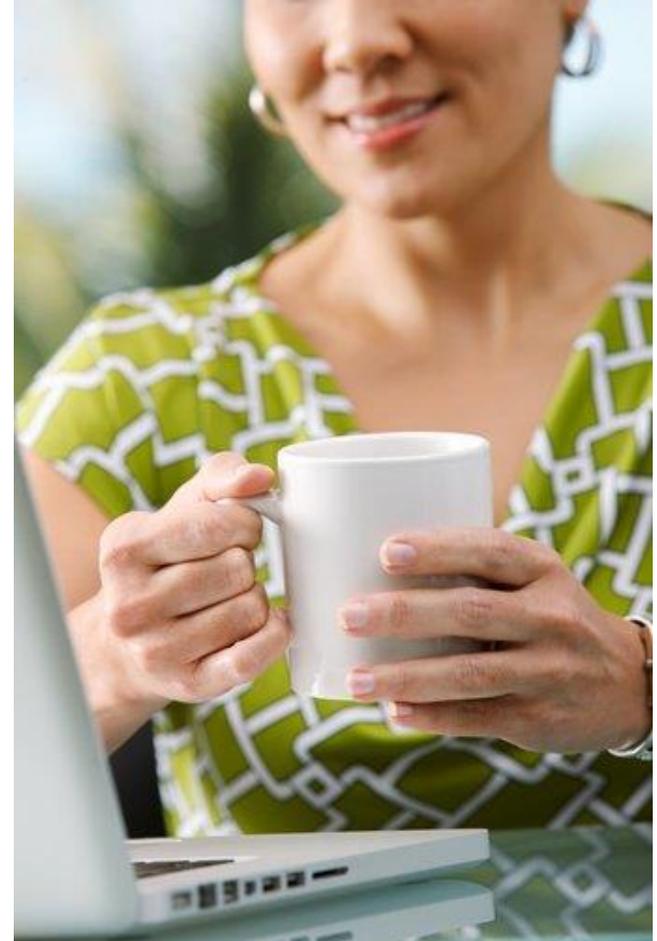
Patient Risks

- Respiratory depression
- Cognitive impairment
- Immunological effects
- Hyperalgesia
- Sleep Disturbance
- Hormonal changes¹
 - Sexual dysfunction
 - Osteoporosis
 - Reduced Energy



Patient Risks

- **Tolerance**
 - Adaptation, decreasing effects over time
- **Physical Dependence**
 - Withdrawal on abrupt cessation or reduction
- **Addiction** – *Three or more in 12 months*
 - Tolerance
 - Control of use impaired
 - Craving
 - Compulsion to use
 - Continued use despite harm



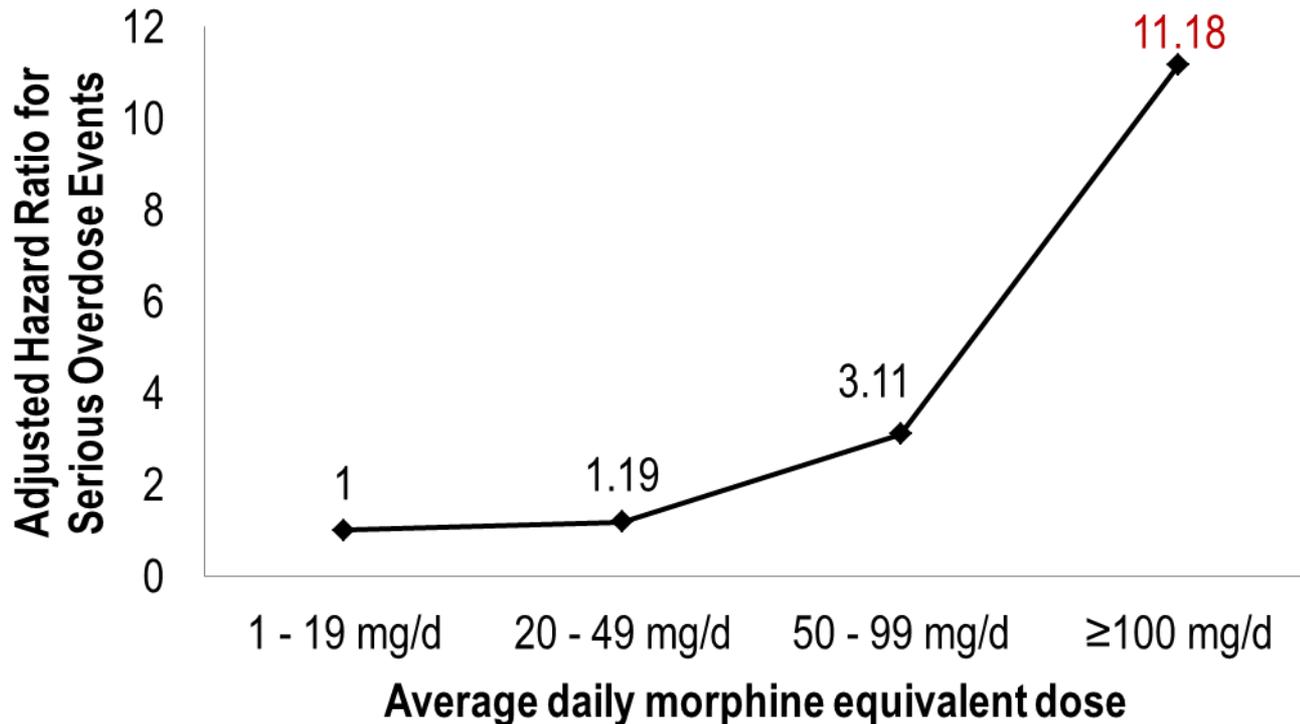
Patients with Increased Risk Factors for Problems with Opioids

- Personal / family history of drug abuse
- Untreated mental health issues
- Medical issues which increase side effects, e.g.
 - Pulmonary disease
 - Constipation
 - Dementia
- Use higher doses
- Smoker
- Take sedatives or multiple controlled substances



Opioid Dose and Overdose Risk

Dose Equivalence
100 MME
=
Ten 10 mg Vicodin
tablets



Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010 Jan 19;152(2):85-92.

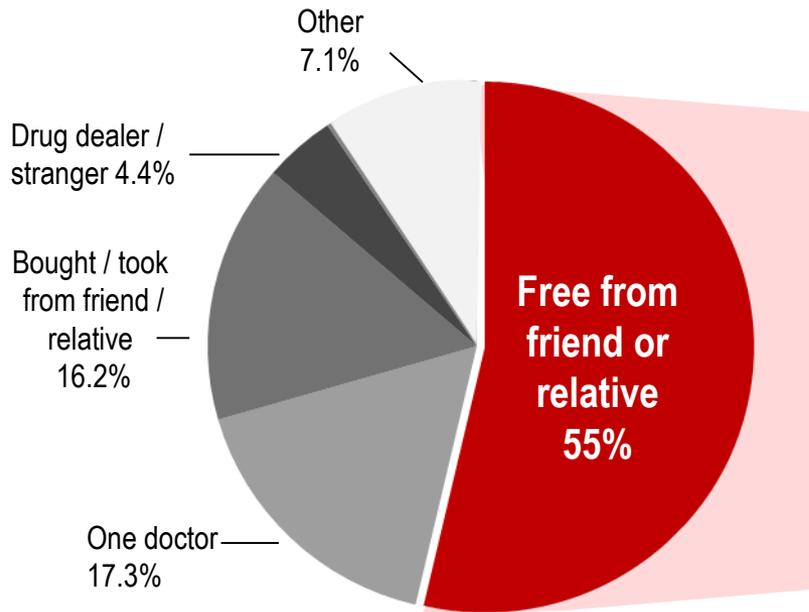


Risks to Families and Communities

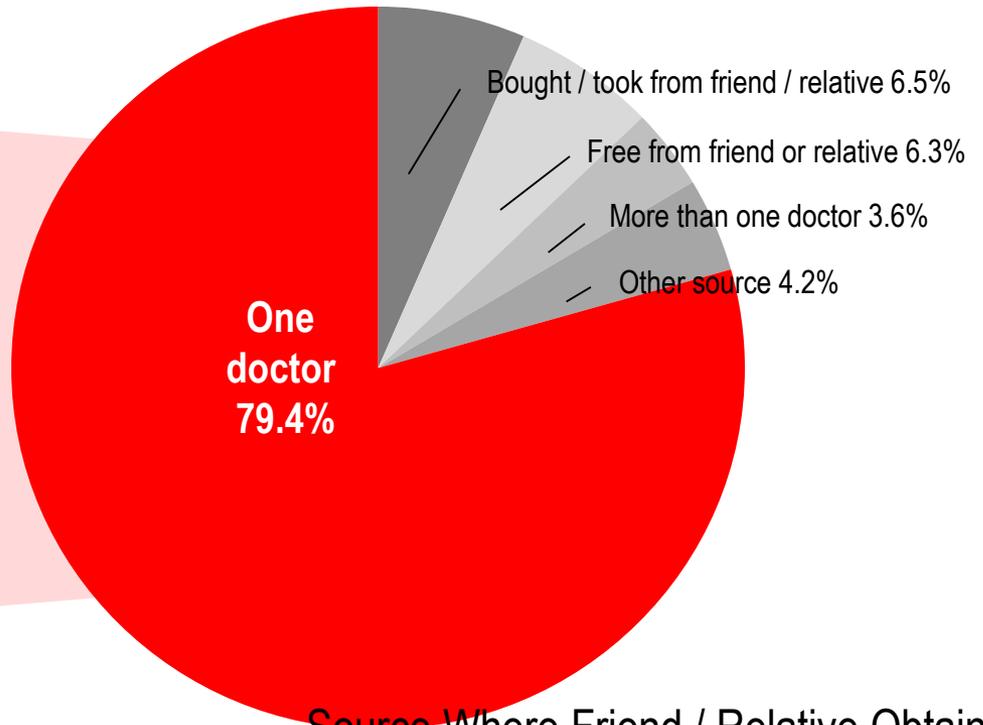
- Accidental ingestion
 - animals
 - small children
- Intentional ingestion
 - pre-teens / teens
 - others



Diverted Prescription Drug Source



Source Where Respondent Obtained



Source Where Friend / Relative Obtained

Sources of Diverted Pain Relieversm 2009-2010 (Source: NSDUH, 2010)



Risk to Physicians

- Medical Board Investigation
- Potential Liability - damage or death by patient while on opioids



California Medical Board Guidelines



- History / physical examination
 - Functional assessment: pain, physical, and psychosocial
 - Assessment of risk factors for abuse
- Care plan including treatment plan & objectives
- Informed consent
- Face-to-face visit every 6 months and annual urine drug screen + CURES
- Consultations/referrals to specialists, where appropriate

www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.aspx

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Guidelines for Prescribing Controlled Substances for Pain

Adopted Unanimously by the Board in 1994 and revised in 2007

Preamble

In 1994, the Medical Board of California formally adopted a policy statement titled, "Prescribing Controlled Substances for Pain." The statement outlined the board's proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement was the product of a year of research, hearings and discussions. California physicians and surgeons are encouraged to consult this policy statement and the guidelines below.

In May 2002, as a result of AB 487, a task force was established to review the 1994 Guidelines and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication, and over medication of a patient's pain." The task force expanded the scope of the Guidelines from intractable pain patients to all patients with pain.

Under past law, both Business and Professions Code section 2241 and Health and Safety Code section 11156 made it unprofessional conduct for a practitioner to prescribe to an addict. However, the standard of care has evolved over the past several years such that a practitioner may, under certain circumstances, appropriately prescribe to an addict. AB 2198, which became law on January 1, 2007, sought to align existing law with the current standard of care. Accordingly, a physician is permitted to prescribe, dispense, or administer

- Verify a License
- Outpatient Surgery Settings
- Public Documents
- Forms
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★ Quick Links

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Costs of Opioid Abuse

Estimated drug diversion costs
health insurers ¹

\$72.5 billion a year

Average annual direct health care costs
for opioid abusers vs. non-abusers²

8.7 times higher



1. Coalition Against Insurance Fraud. Prescription for peril: how insurance fraud finances theft and abuse of addictive prescription drugs. Washington, DC: Coalition Against Insurance Fraud; 2007.

2. White AG, Birnbaum, HG, Mareva MN, et al. Direct costs of opioid abuse in an insured population in the United States. J Manag Care Pharm 2005;11(6):469-479.

More info available at CDC's Primary Care and Public Health Initiative. Prescription Drug Abuse and Overdose: Public Health Perspective. October 24, 2012. Available at: <http://www.cdc.gov/primarycare/materials/opoidabuse/>. Last accessed July 29, 2013.



Challenges: Reflect and Discuss

2 minutes

Write your response to these questions:

- What is the most challenging part of assessing and managing patients with chronic pain?
- What would help you with these challenges?

5 minutes

Discuss your responses in small groups.



Challenges to Change Prescribing Practices

- Unconscious Bias
- Lack of knowledge
- Fear
- Time
- Communicating with patients
- Shifting therapy
- Documentation
- Lack of support
- System barriers
- Limited alternative options



TPMG Workflow and Resources

Tools and Resources Supporting Workflow Implementation

- CURES
- Patient education tools
- Communication Strategies



Summary

- Opioid misuse is an epidemic
- Evidence about the safe and effective use of opioid in chronic non-malignant cancer pain has changed
- There are risks associated with chronic opioid use to patients, families/communities, physicians and the medical group.
- We need to exercise good medical judgment
- A workflow, resources and tools have been developed to help you





Module 2: Initiating Chronic Opioid Therapy for Patients with Chronic Non-Cancer Pain

Opioid Education

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Module 2 Learning Objectives

- Identify how bias might impact your prescribing decisions
- Utilize assessment tools to determine the appropriateness of an opioid trial
- Make prescribing decisions for:
 - Conditions for which opioids are not appropriate for chronic non cancer pain
 - Patients for whom opioids are not appropriate
 - Patients who meet criteria for a trial of opioid therapy
- Create treatment plan
- Implement workflow
- Communicate the plan to patient



Agenda

Unconscious Bias and Prescribing

Contraindications to Opioids

Risk and Benefit Assessment for an Chronic Opioid Therapy Trial

No Start and New Start Documentation and Communication

KPHC Tools, Patient Resources and Local Resources/Workflows



Scope and Risk Recap



- Opioid misuse is an epidemic
- Evidence about the use of opioid in chronic non-malignant cancer pain has changed
- There are risks associated with chronic opioid use to patients, families/communities, physicians and the medical group.
- We need to exercise good medical judgment



Deciding to Prescribe Opioids



Addiction Risk

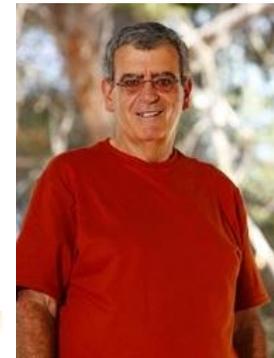
Which patient is at higher risk for developing addiction or abuse problems if you start them on opioids?



Addiction Risk

Which of these patients is at a higher risk for abuse?

Who would you prescribe / not prescribe opioids?



Unconscious Bias Impacts

- Assumptions about groups of people instantaneously without awareness
- Brain creates categories / patterns
 - Personal experiences
 - Patient experiences
 - Cultural beliefs
- Impacts on clinical decision making well documented
 - Racial and ethnic disparities in opioid prescribing



Discussion

Take a 1 – 2 minutes to think about your personal experiences and beliefs with regard to opioids. Share your reflections with a partner at your table.

What are your...

- personal experiences with friends or family taking opioids?
- patient experiences with opioids?
- personal and cultural beliefs about pain and pain relief?



Multimodal

Holistic

Chronic Conditions

Asthma Hypertension Diabetes Chronic Pain

Self-management

Control, not cure



TPMG Workflow definitions

Acute Pain

Non cancer pain lasting less than 3 months

Chronic Pain

Non cancer pain lasting more than 3 months

Chronic Opioid Therapy

Any opioid use greater than 90 days regardless of a short or long acting medication

	Acute Pain	Chronic Pain
Pain Duration	Less than 3 months	Greater than 3 months
Cause	Usually one specific cause	May involve multiple causes
Treatment Goal	Cure / healing of underlying cause	Pain management by reducing SOME pain and / or functional improvement



When do you perform an assessment?

Patient with Acute Pain

Has been on opioids for more than 3 months
You are considering continuing prescription

Patient with Chronic Pain for >3 months

Has tried non-opioids and non-medication therapy
You are considering opioid therapy trial

Patient with Chronic Pain

Has been on opioids for more than 3 months
without an initial assessment



Assessment

New Start - Chronic Pain Chronic Opioid Therapy (COT) Assessment

Chronic Opioid Therapy Assessment:

1. Patient hx, pain hx, physical exam
2. Validated patient self assessment tool
(ex: SOAPP, ORT)
3. CURES
4. Assess for alcohol dependence
5. Create Treatment Plan

If benefits outweigh risk:

1. Opioid Medication Agreement
2. Prescribe max 30 day supply



Assessing for...

- **Indications**
- **Contraindications**
- **Risks vs Benefits**

Risk versus benefits assessment

Conditions for which Opioids are not recommended¹

Adult chronic non-cancer pain (non end of life)

- Headaches*
- irritable bowel syndrome
- pelvic pain
- TMJ dysfunction
- atypical facial pain
- non cardiac chest pain
- mechanical low back pain
- whiplash, repetitive strain injury

Risks outweigh benefits

- Benign conditions with minimal objective findings, with no definite medical diagnosis, or non verifiable pain source
- Fibromyalgia¹



Risk versus benefits assessment

Conditions for which Opioids are not appropriate

Contraindications – patients for who the risk outweighs the benefit

Allergy to opioids

Severe respiratory instability

Drug to drug interaction – taking multiple drugs

Active and untreated psychiatric issues

Current addiction

Pregnancy*



Risk versus benefits assessment

Conditions for which Opioids are not appropriate

The risk **might** outweigh the benefit

Use of controlled medications

Not adequately trialed on non-opioid therapies

Not trying other therapies

Past hx of addiction +/or positive Fmh

SOAPP ≥ 4

+ Alcohol as a Vital Sign

Inconsistent CURES

Medical Marijuana

Patient considering pregnancy



Risk versus benefits assessment

Red Flags

- 1.Score associated with risk – validated risk assessment tool
(ex: SOAPP, ORT)
- 2.Unexpected UDS finding
- 3.Failure to follow Opioid Medication Agreement
- 4.Personal history of substance abuse
- 5.Opioid fills outside of KP (per CURES)
- 6.Use of any non-opioid controlled substance
- 7.Patients on ≥ 90 MME of opioids



New Start - Chronic Pain

Chronic Opioid Therapy (COT) Assessment

1. Patient hx, pain hx, physical exam
2. Validated patient self assessment tool (ex: SOAPP, ORT)
3. CURES
4. Assess for alcohol dependence
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If benefits outweigh risk:

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Patient history, pain history, and physical exam

Patient History / Pain History / Physical Exam

- History of present illness
- Pain / Physical/ Psychological Functional Assessment & Impact
- Prior Pain Treatment
- Prior workup/diagnostic studies

Patient Risk history

- Personal and family history of substance abuse
- Personal and family psychiatric history
- History of domestic violence or sexual abuse as a child
- Current medications
- Social history
- Smoking



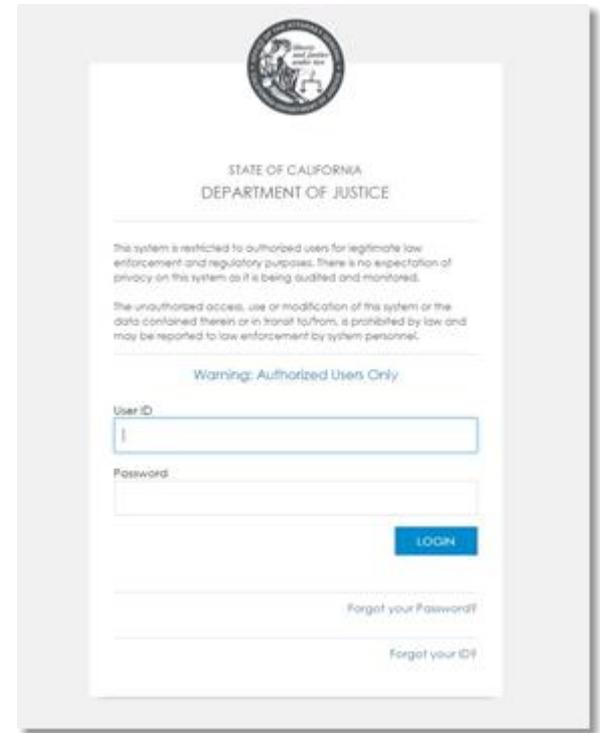
Validated patient self assessment tool

Use a validated patient self assessment tool such as SOAAP or ORT to determine if the patient is at increased risk for aberrant medication-related behavior



CURES Report

- Verify current and past opioid prescriptions:
 - Recent prescriptions filled
 - Prescribers – same or multiple?
 - Refill frequency
 - Multiple prescriptions? Long acting or short acting?
- ***Review and document your findings***
An inconsistent CURES report contains unexpected results... this is a red flag



The image shows a login page for the CURES system. At the top, there is the State of California seal and the text "STATE OF CALIFORNIA DEPARTMENT OF JUSTICE". Below this, there is a disclaimer: "This system is restricted to authorized users for legitimate law enforcement and regulatory purposes. There is no expectation of privacy on this system as it is being audited and monitored." and "The unauthorized access, use or modification of this system or the data contained therein or in transit to/from, is prohibited by law and may be reported to law enforcement by system personnel." A warning "Warning: Authorized Users Only" is displayed. The login form includes fields for "User ID" and "Password", a "LOGIN" button, and links for "Forgot your Password?" and "Forgot your ID?".



Department of Justice - Bureau of Narcotic Enforcement
Controlled Substance Utilization Review & Evaluation System

01/18/2011 11:04

**CONFIDENTIAL
DOCUMENT**

PATIENT/CLIENT ACTIVITY : CONSOLIDATED REPORT

Prescription Drug Transaction Details :

Number of Hits: 27		Start Date: 01/18/2010							End Date: 01/18/2011					
Date Filled	First Name	Last Name	DOB	Address	Drug Name	Form	Str	Qty	PHY Name	PHY#	Dr.'s DEA #	Dr.'s Name	RX#	Refill#
02/25/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	LORAZEPAM	TAB	0.5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03545731	2
03/22/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	LORAZEPAM	TAB	0.5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03665222	0
03/31/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	APAPIHYDROCODONE BITARTRATE	TAB	500 MG-5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03674447	0
04/09/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	APAPIHYDROCODONE BITARTRATE	TAB	500 MG-5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03681819	0
04/09/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	LORAZEPAM	TAB	0.5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03665222	1
05/10/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	LORAZEPAM	TAB	0.5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03682495	0
05/12/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	APAPIHYDROCODONE BITARTRATE	TAB	500 MG-5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03707756	0
05/21/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	APAPIHYDROCODONE BITARTRATE	TAB	500 MG-5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03714815	0
06/11/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	APAPIHYDROCODONE BITARTRATE	TAB	500 MG-5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03728899	0
06/11/2010	Lorem	Ipsium	07/12/1963	SUNNYVALE, CA, 94089	LORAZEPAM	TAB	0.5 MG	30	KAISER HEALTH PLAN MAIN PHY 381	PHY	AB1234567	Smith, Mary	03707500	0



Alcohol dependence

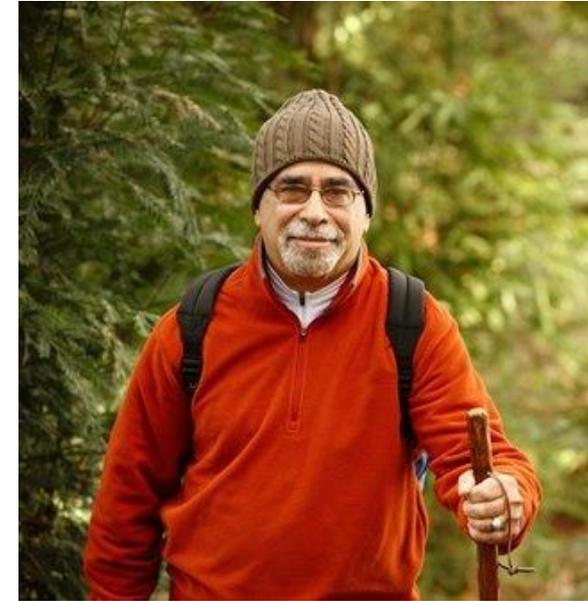


- Consider as a red flag
- Do not prescribe opioids, refer to treatment

Case:

52 year old male who has not been able to exercise for three months due to knee pain.

He has tried physical therapy and Advil, but still cannot exercise. He was able to walk quickly for 30 minutes when he tried one Vicodin from a friend. He is asking you to prescribe Vicodin for his pain.

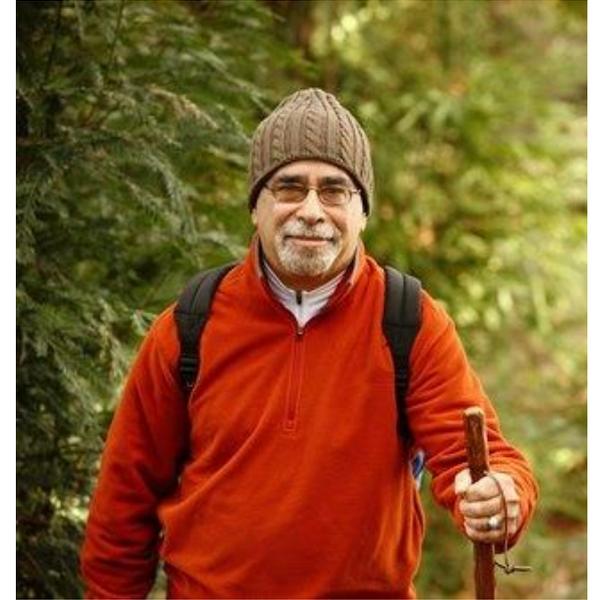


Discuss with a partner at your table

- *What is your gut reaction? Prescribe or do not prescribe?*
- *What do you tell him about his use of his friend's medication?*
- *What additional information do you need to make an informed decision?*

Case

He screens positive for risky drinking.



Group Discussion:

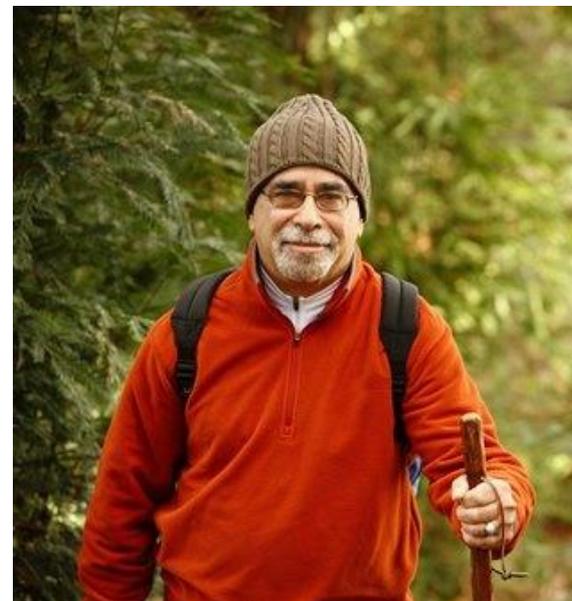
- How do these results impact your decision?
- What additional information do you need to know or ask about?

Case

You ask him to tell you more about how frequently he's drinking alcohol.

Scenario 1

He said he had 5 drinks at his daughter's wedding three weeks ago. It was a long day of celebrating that including a lunch, reception, and a family gathering back at his home.



Discuss with a partner what you will do and why

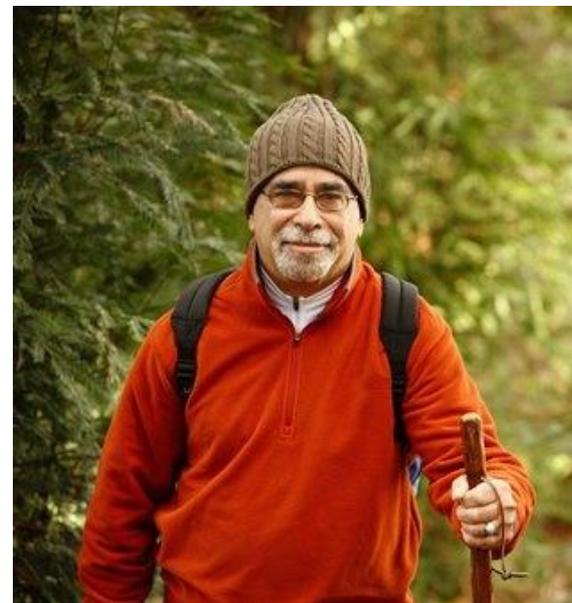
1. *Not prescribe*
2. *Prescribe and see back in 3 months*
3. *Other option?*

Case

You ask him to tell you more about how frequently he's drinking alcohol.

Scenario 2

He said he had 5 drinks last Friday night. He went out with coworkers to celebrate success on a completed project. When you ask how often these celebrations occur, he says every month or two.



Discuss with a partner what you will do and why

1. *Not prescribe*
2. *Prescribe and see back in 3 months*
3. *Other option?*



The decision to prescribe or not prescribe is yours!
Consider risk and benefits, contraindications and red flags
in your decision making.

Create Treatment Plan

What is your diagnosis?

Do the benefits outweigh the risks?

- Document a specific diagnosis
- Establish goals of therapy
- Establish expectations upfront



Create Treatment Plan

Treating Chronic Pain with Non Pharmacological Methods

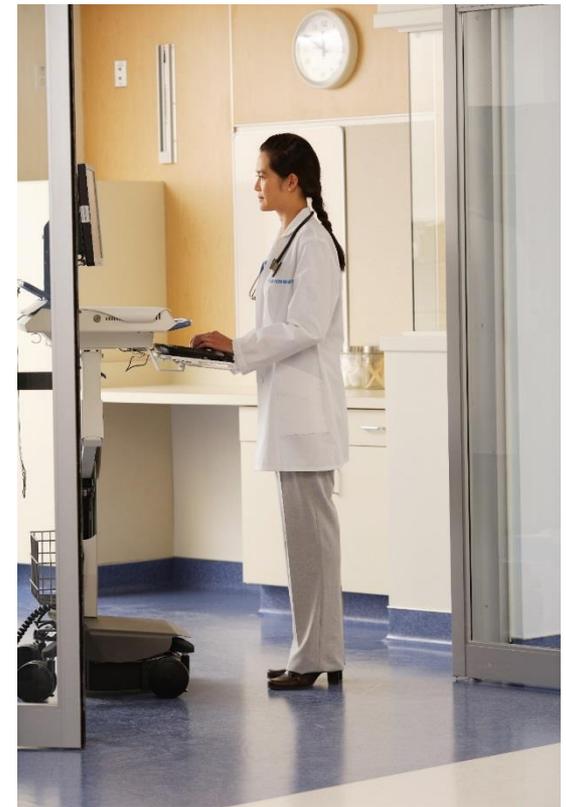
- Non-opioid medications
- Mind/body classes
- Anxiety / depression classes
- Physical therapy
- Acupuncture
- Other physical modalities such as ice, heat, stretching, massage, and daily physical activity



Create Treatment Plan

If Not Starting chronic opioid therapy, document in your progress note...

- Diagnosis
- Contraindications to opioids
- Other treatment options
- Follow up
- Referrals (if applicable)





Communication with Patients Not Starting Opioids

4 Habits model

1. Invest in the beginning
2. Elicit the patient's perspective
3. Demonstrate empathy
4. Invest in the end



Habit 1: Invest in the Beginning

- Tone of voice Ambady et al. Surgery 2002
- Shake hands, make eye contact, greet warmly, address the patient by name - Makoul et al, Arch Int Med 2007
- Sit down - Lin et al, Arch Int Med 2001. Johnson, Ann Emerg Med 2008



Habit 2: Elicit the Patient's Perspective

- Find out what the patient is concerned about, ask questions to gather more information
 - “You still seem to have concerns.”
 - “Tell me more.”
 - “How are you dealing with all this?”
- Listen actively without interrupting
- Respect diversity
- Plan the visit



Habit 3: Demonstrate Empathy

Empathy is: touch, gaze, facial expression, posture, tone, and SIMPLE ACKNOWLEDGEMENT OF THE WORDS AND FEELINGS

- “You still seem to have concerns.”
- “How are you dealing with all this?”
- “I’m glad you told me about your father’s stroke. Tell me more.”
- “It sounds to me you are worried this could happen to you, too.”
- “If I were in your shoes, I think I’d feel the same way.”
- “I can see how uncomfortable you are and how much you are hoping an prescription would help.”

Empathy is NOT: reassurance, medical explanation, support.



Habit 4: Invest in the End

- Close the interaction in a positive way
- Ask:
 - “Do you understand the plan?”
 - “Is there something else I can do for you?”
 - “Do you have questions?”
- Explain follow-up, how to contact you or make an appt, indications to return sooner/what to expect now

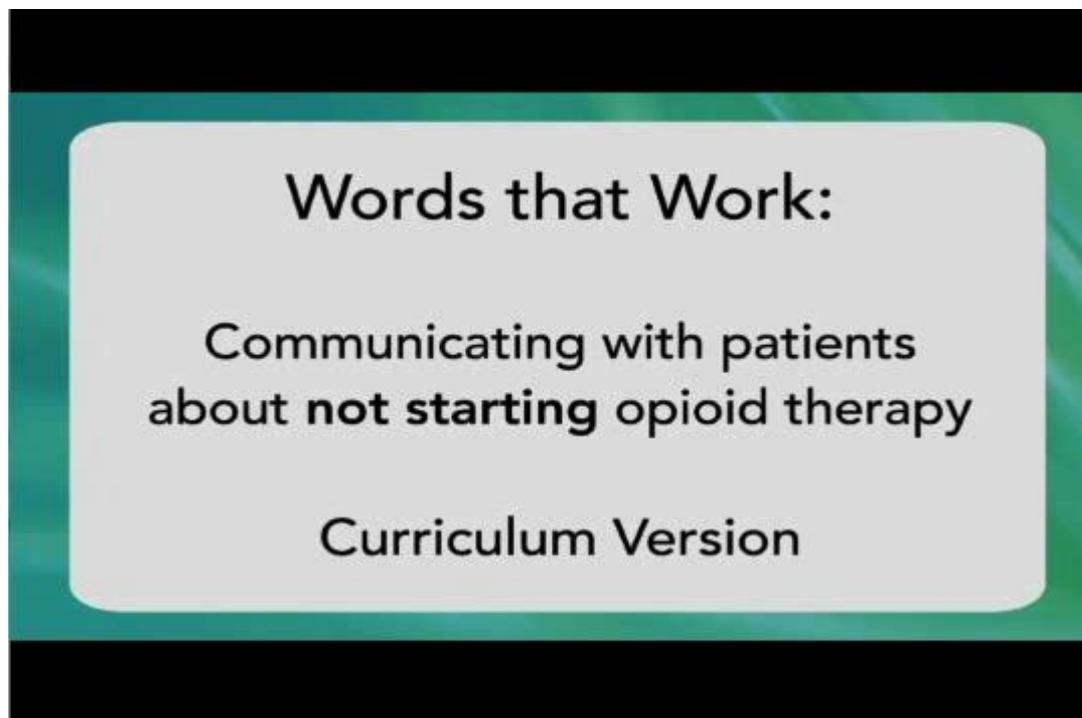


Communication Tips

- Stay patient-centered
- Focus on pain management goals
- Stress risk versus benefits
- Emphasize patient safety



Video: Communicating with patients about not starting opioid therapy



**Not an actual patient. All patient portrayals in this work are fictitious. Any resemblance to real persons, living or dead, is purely coincidental.*

Communication Tips

Communication strategies you can use with your patients

“We have a common goal.
We both want you to get healthy and feel better.”

“I don’t want to do anything that would harm you. “

“For you, this medication is more likely to be harmful than
helpful in the long run.”

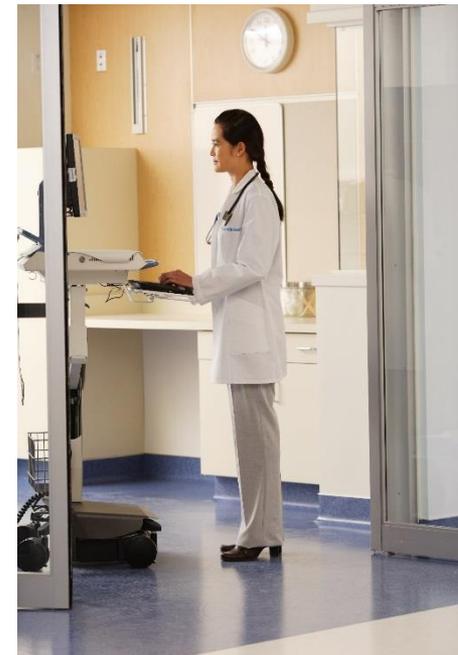


Creating a Treatment Plan

If starting chronic opioid therapy, document in your progress note...

- specific medical indication for the use of a controlled substance.
- Consider the therapy as a trial
- Establish goals of therapy
- Beware of the 90 day cliff ^{1 2 3 4 5}

1. Turk DC, Okifuji A. Pain Terms and Taxonomies of Pain. In: Loeser JD, editor. *Bonica's Management of Pain*. 3rd ed. Philadelphia: Lippincott Williams & Wilkins; 2001. pp. 17–25.
2. Braden, Jennifer Brennan, et al. "Trends in use of opioids by noncancer pain type 2000-2005 among Arkansas Medicaid and HealthCore enrollees: results from the TROUP study." *The Journal of Pain* 9.11 (2008): 1026-1035.
3. Von Korff, Michael, et al. "Defacto long-term opioid therapy for non-cancer pain." *The Clinical journal of pain* 24.6 (2008): 521.
4. Martin, Bradley C., et al. "Long-term chronic opioid therapy discontinuation rates from the TROUP study." *Journal of general internal medicine* 26.12 (2011): 1450-1457.
5. Volinn, Ernest, Jamison D. Fargo, and Perry G. Fine. "Opioid therapy for nonspecific low back pain and the outcome of chronic work loss." *Pain* 142.3 (2009): 194-201.



Creating a Treatment Plan

If starting chronic opioid therapy

- Discuss the Opioid Medication Agreement with the patient
- Set expectations and exit strategy
- Start low, go slow





Communication with Patients about Starting Opioids

Communication tips

- **Set expectations**

If opioid works, average pain reduction 30%

- **Create functional goals with the patient**

As a result of this therapy, what would you like to be able to do that you can't now?

- **Stress this is a Trial**

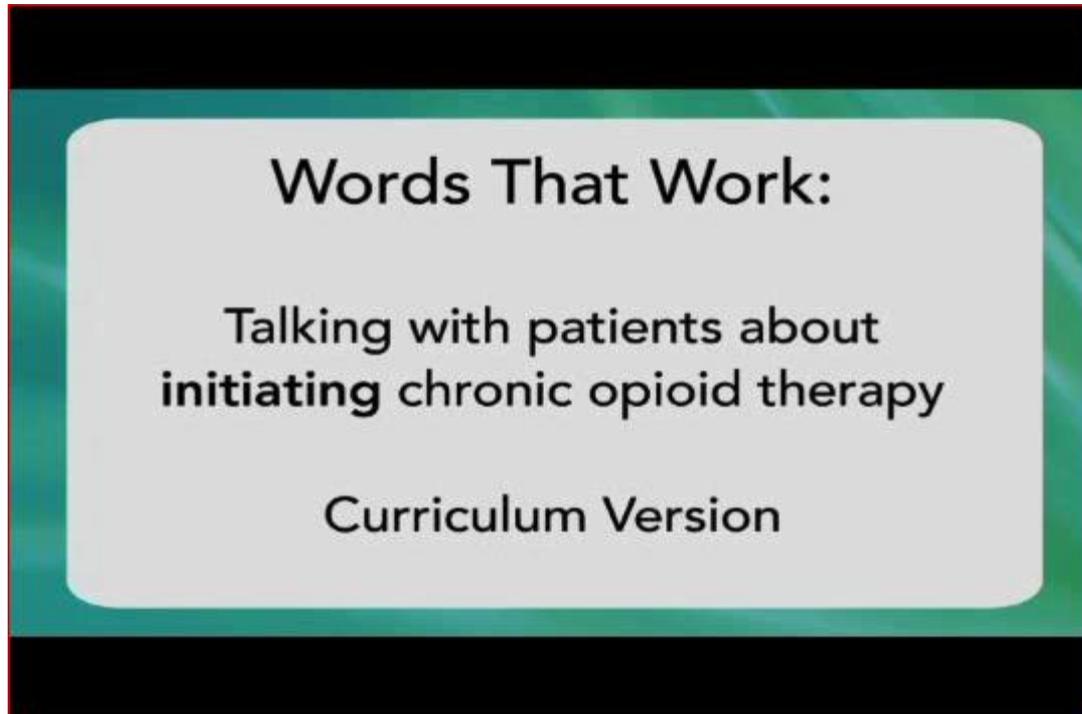
If you are not achieving your goals, the medication will be stopped.

- **Stress the Exit Strategy**

If the risks of the medication start to outweigh the benefits, the medication will be stopped.



Video: Talking with patients about initiating chronic opioid therapy



**Not an actual patient. All patient portrayals in this work are fictitious. Any resemblance to real persons, living or dead, is purely coincidental.*



Activity: Introducing the Medication Agreement

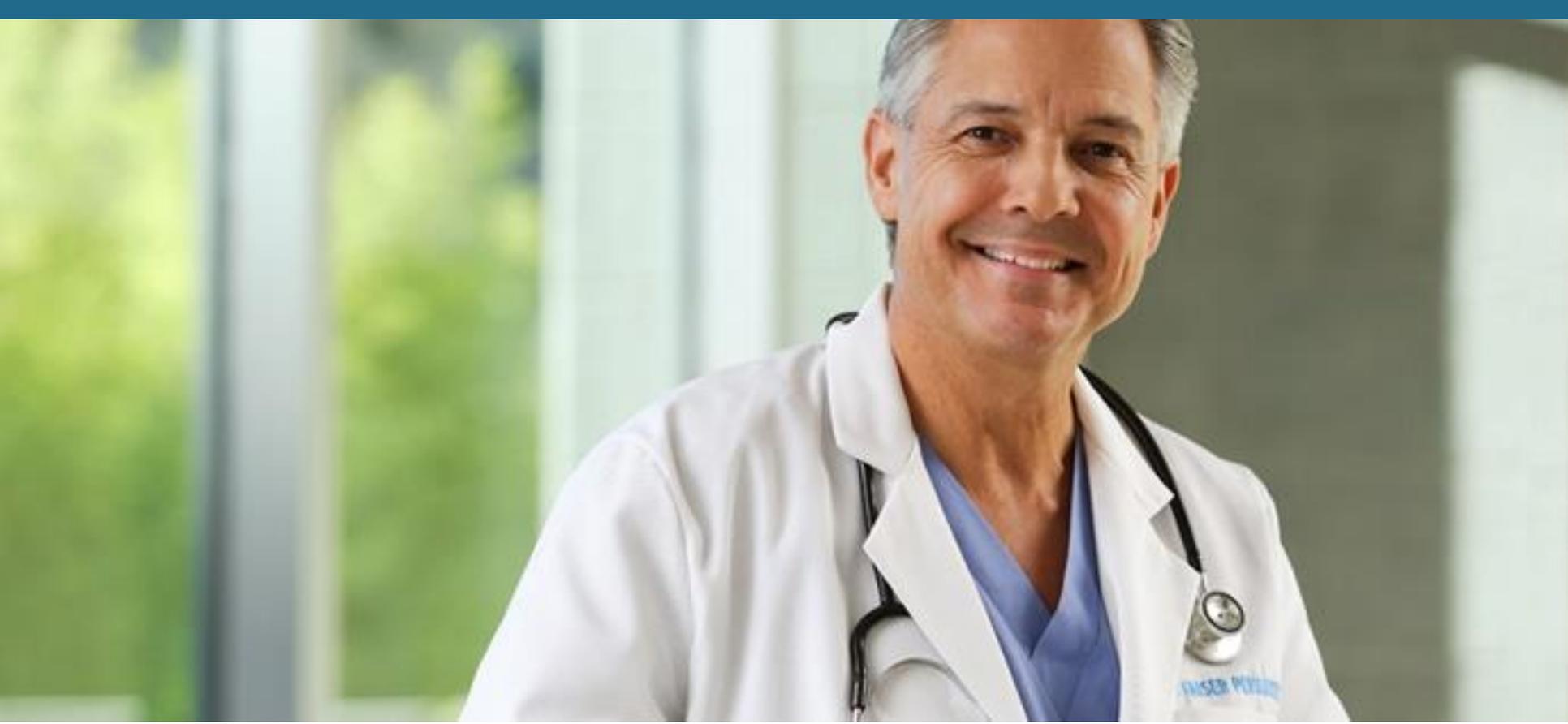
1. Take 5 minutes to read the Medication Agreement.
2. Circle or underline parts that you might highlight with patients
3. Form small groups of 2 – 4 and discuss the following questions:
 - What parts of the medication agreement would you highlight with your patients?
 - What would you say to a patient to introduce the agreement?
 - How might you use the agreement in future chronic opioid therapy visits?



Module 2 Key Points

- Treat chronic pain as a chronic condition
- Conduct a risk vs benefit assessment to determine if you should initiate chronic opioid therapy
- The first few months of chronic opioid therapy should be a trial
- Utilize patient centered communication principles
- Use the Medication Agreement to set expectations and goals
- The workflow steps ensure that physicians meet the Medical Board of California Guidelines and practice in a way that is safe, effective and consistent





Module 3:

Ongoing Management of Chronic Opioid Therapy

Opioid Education

Module 1

- Scope and Risks of the Opioid Problem

Module 2

- Approach for Initiating Chronic Opioid Therapy (COT)
- Risk and Benefit Assessment
- Communication with patients

Module 3

- Approach for Ongoing COT Management and Assessment
- Tapering
- KPHC Tools and Resources
- Communication with patients



Module 3 Learner Objectives

You will be able to:

- Utilize assessment tools to determine the risks and benefits of an opioid
- Use assessment data to identify:
 - Red flags
 - Patients who should be tapered
- Update treatment plan
- Communicate the plan to patient



Initiating Opioid Therapy for Patients with Chronic Pain Recap



- Conduct a risk vs benefit assessment to determine if you should initiate chronic opioid therapy
- The first few months of chronic opioid therapy should be a trial
- Treat chronic pain as a chronic condition
- Utilize the communication foundation principles
- Use the Medication Agreement to set expectations and goals
- The workflow steps ensure that physicians meet the Medical Board Guidelines and practice in a way that is safe, effective and consistent



Chronic Opioid Therapy

Key Definitions

- **Acute Pain**
Pain < 3 months
- **Chronic Pain:**
Pain > 3 months
- **Chronic Opioid Therapy (COT):**
Opioid use > 3 months



Chronic Opioid Therapy

Key Definitions

- **High dose chronic opioid therapy**
Patients on > 100 MME of opioids
- **MME (Morphine Milligram Equivalent)**
Approximates how much opioid the patient is on in terms of mg of morphine
- **Red flags**
Findings that raise concerns and may result in a change in your plan



Ongoing Assessment and Management of Chronic Opioid Therapy (COT) - Chronic Pain

1. Physical exam

2. 5A's Assessment

3. CURES

4. Assess for alcohol dependence

5. Urine Drug Screen

6. PHQ-9 or equivalent (PRN)

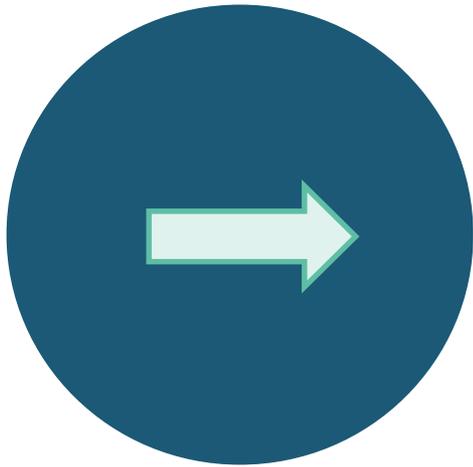
For patients who did not have a chronic opioid therapy assessment prior to beginning COT, ensure patient hx, validated self assessment tool, and Opioid Medication Agreement are completed.

7. Revisit treatment plan and modify as needed

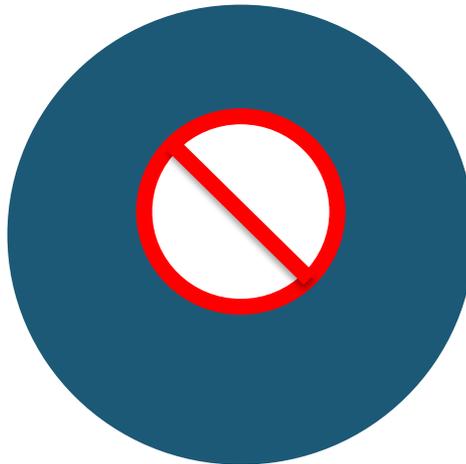


Chronic Opioid Therapy (COT) Workflow

Assessment for...



Indications



Contraindications



Risks vs Benefits

Physical exam

Assessing treatment & impact

- Function – revisit goals
- Pain – current pain level compared to baseline



Assessing Benefits and Risks: 5 A's



Analgesia
Self-reported pain
number



Adverse Events
Review medication
side effects



**Activities of
Daily Living**
Objective questions
about activity goals



**Aberrant Drug
Taking Behaviors**
Compliance with
medication
agreement



Affect
Changes in mood

CURES

- A risk assessment tool
- Review and document CURES report results in your note

An inconsistent CURES report has unexpected results; this is a red flag.



Assess for Alcohol dependence

- A risk assessment tool
- If patient screen positive for alcohol use, it is recommended to not prescribe opioids and refer to chemical dependency program.



Urine Drug Screen

- A risk assessment tool
- Identifies prescription and illicit substances that should or should not be in the urine
- Minimum once/year



Urine Drug Screen

True or False?

There is a correlation between dose and urine drug concentration.

False

Urine Drug Screen can be used to diagnose addiction.

False

Urine Drug Screens assess the drugs a patient is taking, both prescription and illicit.

True



Urine Drug Screen Interpretation

Expected Positive

the prescribed medication taken in past 1-3 days

Unexpected Positive

Unexpected substance (not prescribed by you) found

False or Unexpected Negative causes

- Bingeing
- Altered metabolism
- Inadequate specimen
- Opioid diversion



Urine Drug Screen Interpretation

Component Results

Opiat/Oxycod, Conf (Abnormal)

Positive for
Morphine
Hydromorphone

Result Narrative

DETECTED DRUG	POSSIBLE PARENT DRUGS	DETECTION WINDOW
Morphine	Morphine, Codeine, Heroin	2-3 days
Codeine	Codeine	2-3 days
Hydrocodone	Hydrocodone, Codeine, Dihydrocodeine	2-3 days
Hydromorphone	Hydrocodone, Hydromorphone, Morphine	2-3 days
Oxycodone	Oxycodone	2-3 days
Oxymorphone	Oxymorphone, Oxycodone	2-3 days

Confirmation cut-off: Codeine and Morphine=50 ng/mL

Hydrocodone and Hydromorphone=25 ng/mL

Oxycodone and Oxymorphone=20 ng/mL



Urine Drug Screen Unexpected Results

- Consult with the lab or the Medical Toxicologist about unexpected results
- Have a conversation about the results and explanations
- Assess for non-physical causes
- Be consistent with medication agreement and treatment plan
- Document results and actions taken



PHQ-9 or equivalent (PRN)

- Assess for depression and anxiety (affect)



Case: Elizabeth

Ongoing Chronic Opioid Therapy Assessment

You have had monthly TAVs (telephone visit) with your patient, Elizabeth, with back pain that you started on an opioid trial. She is now here for a 3 month follow up visit and has been taking dose/med for 90+ days.



Group Discussion

- What will your assessment include today?

Chronic Opioid Therapy (COT) Workflow

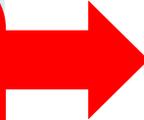
Ongoing Chronic Opioid Therapy

Chronic Opioid Therapy Follow Up Visits

Minimum 2 office visits per year

Assessment and Documentation:

1. Physical exam
2. 5A's Assessment
3. CURES
4. Assess for alcohol dependence
5. Urine Drug Screen
6. PHQ-9 or equivalent (PRN)



Assess for:

- Indications
- Contraindications
- Risks vs Benefits

For patients who did not have a chronic opioid therapy assessment prior to beginning COT, ensure patient hx, validated self assessment tool, and Opioid Medication Agreement are completed.

7. Revisit treatment plan and modify as needed



Case: Jennifer

Ongoing Chronic Opioid Therapy Assessment

You are seeing a 55 year old female for the first time. She is new to <your organization>, but has been on a stable dose of Norco (1 qid) for five years for rheumatoid arthritis. Her CURES report is consistent with expected results. Her alcohol screening results are negative.



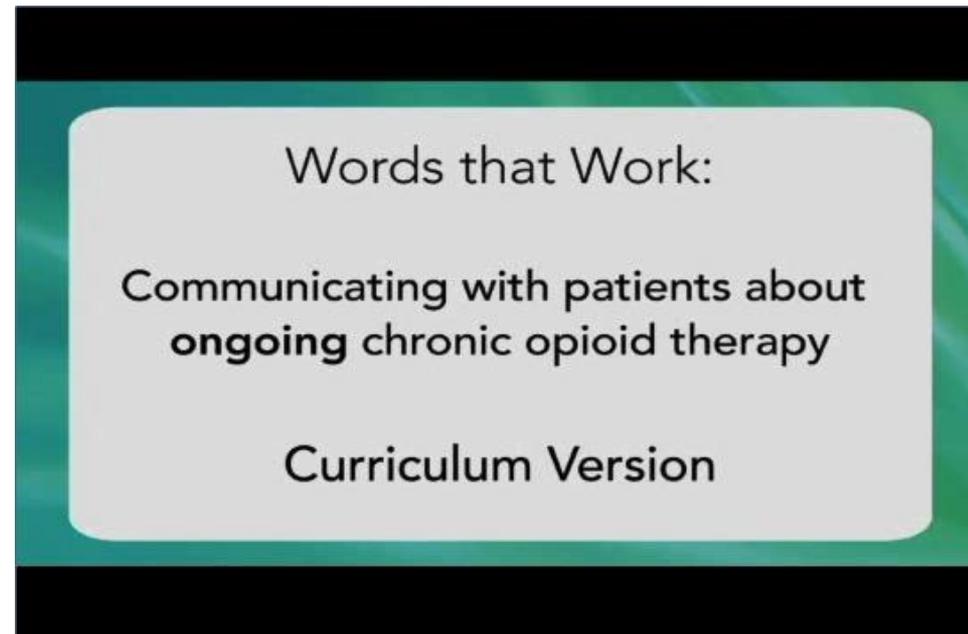
Discuss with a partner at your table:

- *What additional pieces of the assessment do you need to complete?*



Video: Communicating with patients about ongoing chronic opioid therapy

- **Stay Patient Centered**
- **Utilize the 4 Habits Model**
 - Invest in the beginning
 - Elicit the patient's perspective
 - Demonstrate empathy
 - Invest in the end
- **Focus on Pain Management Goals**
- **Stress Risk and Benefits**
- **Emphasize Patient Safety**



What strategies does Dr. Jung use with this patient?

Do a search on Google for "pain" or "opioids" in this work or find it. Any resemblance to real persons, living or dead, is purely coincidental.



REMEMBER: Perform an assessment!

*****For patients who did not have a chronic opioid therapy assessment prior to beginning COT, ensure patient hx, validated self assessment tool, and Opioid Medication***

- All patients on chronic opioid therapy need patient history, SOAPP-5, and a medication agreement **one time.**



Red Flags

- **Use your clinical judgment to determine next steps including:**
- -More frequent UDS, CURES and/or AOQ
- -More frequent visits
- -Referral to specialty departments (e.g. Psychiatry, CDRP, etc.)
- -Stop prescribing and taper
- -Drug Caution List**

—



Red Flags: Other Considerations

Patients at Risk

- > 100 MMEs
- On opioids and sedatives and/or muscle relaxants

Recommendations

- Taper opioid dose
- Discontinue sedatives and/or muscle relaxants
- Consider prescribing Naloxone



Case: Mike

Mike is a 45 y/o man with axial low back pain for 3 years. He has had imaging and went to physical therapy; he takes 60 mg Hydrocodone per day. Mike is here for his six month check in.



He continues to get analgesic relief and has returned to his prior activity level. He reports no adverse effects and has no aberrant drug taking behaviors.

With a partner, apply the 5A's Analysis.

- Analgesia
- Activities of Daily Living
- Affect
- Adverse Events
- Aberrant Drug Taking Behavior

Discuss your risk benefit determination and rationale for your assessment.

Benefits outweigh risks, continue on current plan

Benefits vs risks unclear, increase monitoring, schedule more frequent follow up

Risks outweigh benefits, taper and refer to CDRP or other indicated service



What if....

Mike is a 45 y/o man with axial low back pain for 3 years. He has had imaging and went to physical therapy; he takes 60 mg Hydrocodone per day. Mike is here for his six month check in.



He is not getting analgesic relief and has stable activity level. He reports constipation requiring high levels of stool softeners for relief. He has no aberrant drug taking behaviors.

With a partner, apply the 5A's Analysis.

- Analgesia
- Activities of Daily Living
- Affect
- Adverse Events
- Aberrant Drug Taking Behavior

Discuss your risk benefit determination and rationale for your assessment.

Benefits outweigh risks, continue on current plan

Benefits vs risks unclear, increase monitoring, schedule more frequent follow up

Risks outweigh benefits, taper and refer to CDRP or other indicated service



What if...

Mike is a 45 y/o man with axial low back pain for 3 years. He has had imaging and went to physical therapy; he takes 60 mg Hydrocodone per day. Mike is here for his six month check in.



He is not sure he's getting analgesic relief. He has returned to his prior activity level. He reports no adverse effects and has no aberrant drug taking behaviors.

With a partner, apply the 5A's Analysis.

- Analgesia
- Activities of Daily Living
- Affect
- Adverse Events
- Aberrant Drug Taking Behavior

Discuss your risk benefit determination and rationale for your assessment.

Benefits outweigh risks, continue on current plan

Benefits vs risks unclear, increase monitoring, schedule more frequent follow up

Risks outweigh benefits, taper and refer to CDRP or other indicated service



What if...

Mike is a 45 y/o man with axial low back pain for 3 years. He has had imaging and went to physical therapy; he takes 60 mg Hydrocodone per day. Mike is here for his six month check in.



He reports continued pain. He has stable activity level. He reports no adverse effects. He has needed early refills two times.

With a partner, apply the 5A's Analysis.

- Analgesia
- Activities of Daily Living
- Affect
- Adverse Events
- Aberrant Drug Taking Behavior

Discuss your risk benefit determination and rationale for your assessment.

Benefits outweigh risks, continue on current plan

Benefits vs risks unclear, increase monitoring, schedule more frequent follow up

Risks outweigh benefits, taper and refer to CDRP or other indicated service



Revisit treatment plan and modify as needed

- **Treatment Plan Decision**
- Based on information gathered from assessment
- Continue or modify treatment plan
 - Change dose, medication, and / or monitoring
 - Taper
 - Stop prescribing
 - Refer



Tapering and Patient Communication

Tapering



Quick



Moderate



Slow

Tapering Indications



Quick Taper

- The patient's UDT is inconsistent with expected results, or
- The patient's behavior suggests that s(he) might be misusing or diverting the medication. Such behaviors might include:
 - Selling prescription drugs
 - Forging prescriptions
 - Stealing or borrowing drugs
 - Frequently losing prescriptions
 - Aggressive demands for opioids
 - Injecting oral/topical opioids
 - Unsanctioned use of opioids
 - Unsanctioned dose escalation
 - Concurrent use of illicit drugs
 - Getting opioids from multiple prescribers
 - Recurring emergency department visits for chronic pain management



Tapering Indications



Moderate Taper

- Medication adverse effects indicate risks are greater than benefit. Adverse side effects may include:
 - Depression
 - Sleeping problems
 - Worsening pain
 - Sexual problems
 - Fatigue
 - Constipation
 - Falling/breaking bones
 - Itching
 - Nausea or vomiting
 - Breathing problems
- Comorbidities increase risk of complication, or
- Morphine equivalent dose exceeds recommended threshold



Tapering Indications



Slow Taper

- Function and pain are not improved, or
- Tolerance has developed with long-term opioid prescription, or
- Comorbidities minimally increase risk of complication, or
- Patient is no longer in pain



Tapering Schedule

Indications

Schedule

Quick

- The patient's UDT is inconsistent with expected results, or
- The patient's behavior suggests that s(he) might be misusing or diverting the medication.

15-33% over
3-7 days

Moderate

- Medication adverse effects indicate risk are greater than benefit, or
- Comorbidities increase risk of complication, or
- Morphine equivalent dose exceeds recommended threshold.

10% per week

Slow

- Function and pain are not improved, or
- Tolerance has developed with long-term opioid prescription, or
- Comorbidities increase risk of complication.

10% every 2-4
weeks



Treating Withdrawal

Target Symptoms	Medication	Dosing
Hypertension, tremors, sweats, anxiety, restlessness	Clonidine (Catapres)	.1 mg PRN
Anxiety, restlessness	Hydroxyzine (Vistaril) Diphenhydramine (Benadryl)	25 mg every 6 hours PRN
Insomnia	Hydroxyzine (Vistaril) Diphenhydramine (Benadryl)	25-50 mg every evening at bedtime
Nausea	Promethazine (Phenergan) Metoclopramide (Reglan)	25 mg every 6 hours PRN 10 mg every 6 hours PRN
Dyspepsia	Calcium Carbonate (Tums) Mylanta, Milk of Magnesia	500 mg 1-2 tabs every 8 hrs Follow package instructions
Pain, fever	Acetaminophen (Tylenol)	325 mg every 4 hrs

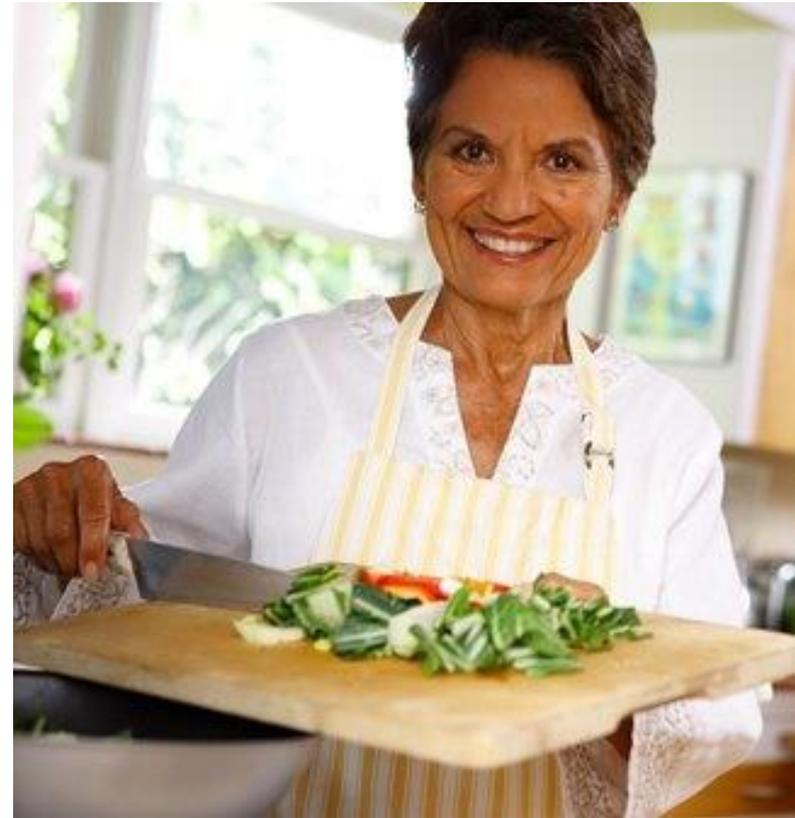


Sample Tapering Schedule - Slow

Patient on opioids for chronic knee pain after an accident. Has surgery with good results. No longer experiences daily pain.

Medication Therapy

- Morphine SR 30mg TID
- Transition to morphine SR 15mg 2 tab TID
- Decrease by 1 tablet every 2-4 weeks (~17% decrease)



Sample Tapering Schedule - Moderate

Patient is diagnosed with significant sleep apnea while on opioids.

Medication Therapy

- Morphine SR 60mg BID
- Transition to morphine SR 15mg 4 tab BID
- Decrease by 1 tablet every week (~12.5% decrease)



Sample Tapering Schedule - Quick

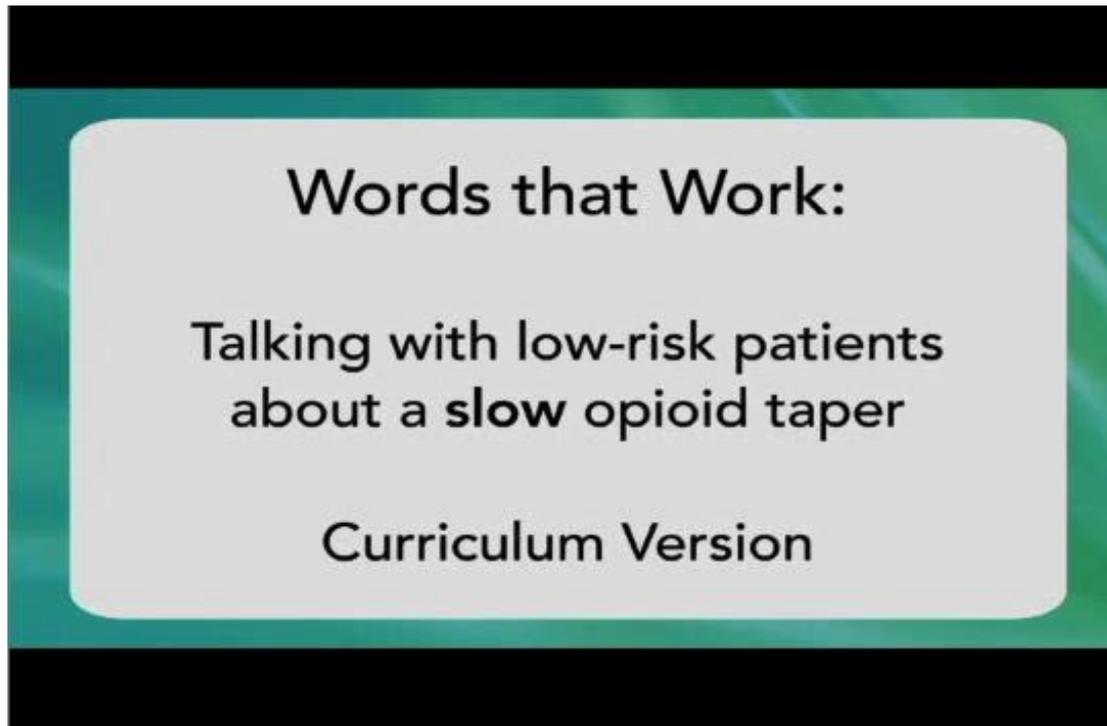
Patient has repeatedly tested positive for methamphetamines.

Medication Therapy

- Morphine SR 60mg BID
- Transition to morphine SR 30mg 2 tab BID, Limit quantity to amount needed to complete taper
- Decrease by 1-2 tablets every day (~25% decrease)



Video: Talking with your patients about initiating chronic opioid therapy



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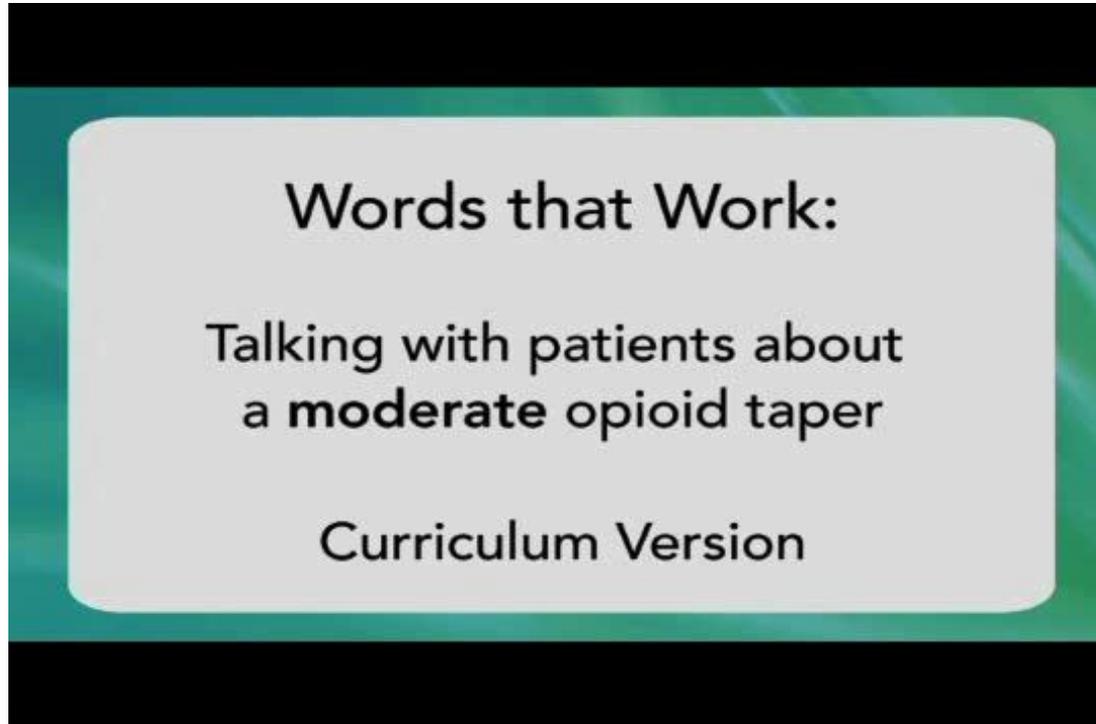


Debrief Video: Talking with your patients about initiating chronic opioid therapy

- What stage was this patient at the beginning of the conversation?
- What stage was she in at the end?
- What strategies did Dr. Jung use to help her progress through the stages?



Video: Talking with patients about a moderate opioid taper



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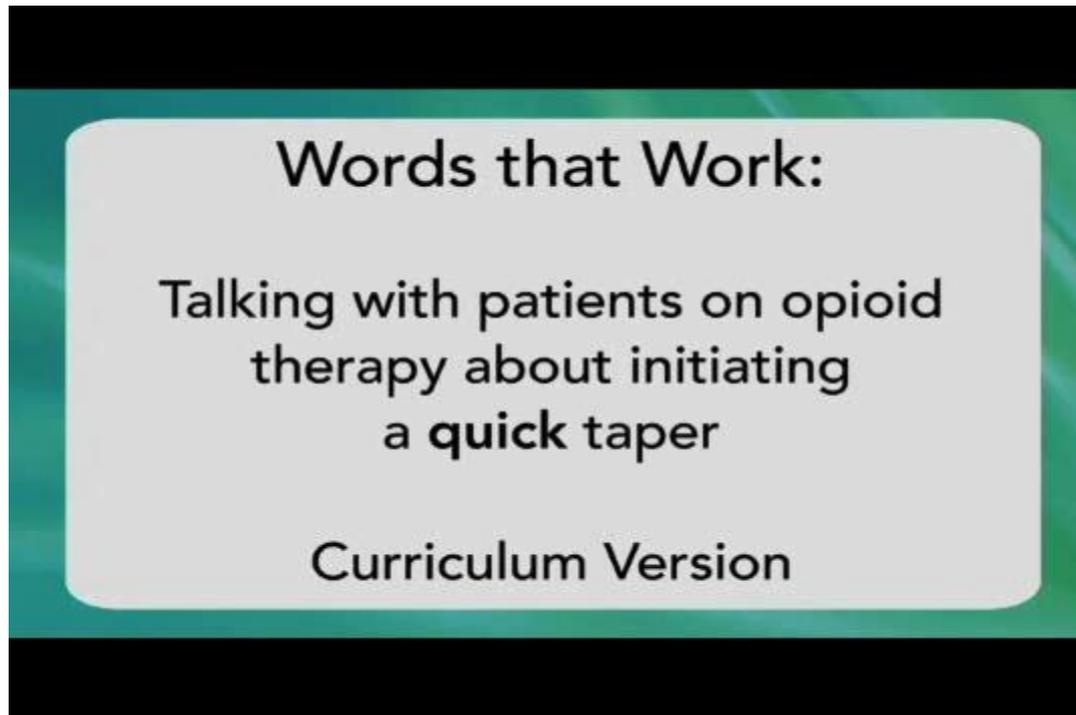


Debrief Video: Talking with patients about a moderate opioid taper

- What strategies would you like to try with your patients who are resistant to tapering their opioid dose?



Video: Talking with patients on opioid therapy about initiating a quick taper



**Not an actual patient. All patient portrayals in this work are fictitious. Any resemblance to real persons, living or dead, is purely coincidental.*



Talking with patients on opioid therapy about initiating a quick taper: Communication Practice

Find a partner at your table. Select roles. One person play the physician, the other person play the patient. Practice utilizing the communication strategies you've learned to discuss initiating a quick taper.

Physician 1: *Pay special attention to taking a firm stance.*

Switch roles and continue the conversation.

Physician 2: *Pay special attention to making a clear plan and ending with a sense of optimism and partnership with your patient.*

Patients: + UDS for illegal drugs, early refill requests, self adjusted dose.



Key Points Summary

- Approach chronic pain like other chronic conditions
- Conduct a risk v benefit assessment to determine if you should initiate chronic opioid therapy
- Consider the first few months of chronic opioid therapy should be a trial
 - Set functional goals; create your exit strategy
 - Be aware of the 90 day cliff
- Utilize the communication foundation principles
 - 4 Habits, patient centered, focus on safety and function,
- Use the Medication Agreement to set expectations and goals



Key Points Summary

- Perform regular assessments to determine if benefits outweigh risks
- Keep the total daily dose as low as possible
- Ensure that patients are engaged in non-opioid therapy
- Know when to discontinue opioid therapy
- Document, document, document
 - If it isn't documented, it didn't happen

