Treating Pain Safely in Primary Care

Karen Isaacs 6/10/22

Disclosures

Objectives

- Standardize your approach to pain management, incorporating harm reduction
- Recognize policy around chronic opioid use
- Identify and utilize best practices for chronic opioid use

Pain

- Activation of nervous system's nociceptive and hypothalamic-pituitary-adrenal axis
- Aversive sensory and emotional experience typically caused by, or resembling that caused by, actual or potential tissue injury
- Complex due to diverse origins and subjective experience of sufferer; attitudes, emotional disposition, and belief systems can shape the experience of pain
- Types of Pain
  - Neuropathic (peripheral vs central)
  - Nociceptive (arises from actual/threatened damage to non-neural tissues and is due to activation of nociceptors)

McDonagh; CCNC: Project Lazarus

Harm Reduction

Strategies to reduce potential negative consequences associated with a behavior or drug use.

Case

Mr Thomas is a 55 year old male with chronic back pain.

You first met him when he came in for acute pain, after his orthopedic decided to “cut him off” and no longer prescribe his opioid regimen (roxi 5mg two tabs, four times daily prn). Prior PCP had not agreed to chronic pain management. His initial visit with you resulted in you recognizing:

1) He was in acute withdrawal
2) He was acutely anxious (tearful, crying, hard to redirect)
3) He reported pain, but seemed to be functioning ok
4) You had no records of his prior workup

You agreed to resume half his regimen (roxi 5mg two tabs, tid prn), and offered adjunct meds to help with withdrawal, with close follow-up.

Standardize your Approach to Pain Management

No universally adopted guidelines or recommendations for assessing pain! But it should be multidimensional, serial over time:

- Physiological features of pain
- Contributing factors…intensity, location, duration, factors that aggravate of alleviate the pain
- Function
- Quality of life
- Mental and emotional health

1) Pain Assessment
Ex: PEG Score:
- Pain on average
- Enjoyment of life
- General Activity interference

- Chronicity: Acute Vs **Chronic**
- Exam
- Prior workup, current workup
- Prior treatment, current treatment

3) Pain Management
-1st line: nonpharmacologic and non-opioids
-lowest effective dose for:
- For pain relief
- For functional improvement

2) Functional Assessment
Ex: Functional Goals

Coexisting Condition Screen
Ex: PHQ9, GAD7

AAFP

Nonpharmacologic Pain Management

- Yoga
- Relaxation
- Tai chi
- Massage
- Acupuncture
- Sleep hygiene
- Immobilization, heat/cold, elevation
- CBT
- TENS
- Weight loss, exercise, OPT/OT
- Interventional procedures

Non-Pharmacologic Treatments			
Therapy	**Indications[a]**	**Magnitude of Benefit[b]**	
		PAIN	**FUNCTION**
Exercise	Low back pain, neck pain, knee and hip osteoarthritis, fibromyalgia	Small to moderate	Small to moderate
Cognitive Behavioral Therapy	Low back pain, fibromyalgia	Small to moderate	Small to moderate
Massage/Acupuncture/ Spinal Manipulation	Low back pain, fibromyalgia, chronic headache, neck pain	Small to moderate	Small to moderate
Yoga/Tai Chi	Low back pain, fibromyalgia	Small	Small (fibromyalgia) Moderate (low back pain)

AAFP, 6/4/22

AAFP

Non-opioid Pharmacologic Pain Management

- Acetaminophen
- NSAIDs
- Topical analgesics
- Gabapentin, Lyrica
- Muscle relaxants
- Steroids
- Duloxetine, antidepressants
- Injections, blocks

Table D. Pharmacologic Treatments

Class of Medication	Indications[a]	Magnitude of Benefit[b]	
		PAIN	FUNCTION
NSAIDs (topical or oral)	Low back pain, asteoarthritis, inflammatory arthritis, acute musculoskeletal (MSK) pain	Small to noderate	None to small
Acetaminophen	Acute MSK pain	Small	None
Antidepessants	Diabetic peripheral neuropathy, fibromyalgia	Small	None
Anticonvulsants	Diabetic peripheral neuropathy, fibromyalgia	Small to moderate	None (neuropathic pain) Small (fibromyalgia)
Opioids	Acute MSK pain, chronic pain, neuropathy	Small to no benefit[c]	Small to no benefit[c]

AAFP, 6/4/22

AHRQ review: Non-opioids (SNRI, pregabalin/gabapentin, NSAIDs) resulted in small-moderate improvements in pain and function

AAFP; CDC: Nonopioid Treatments; McDonagh; Taube

Standardize your Approach to Pain Management

- Nociceptive:
  - 1st line NSAIDs
  - 2nd and 3rd line: Acetaminophen, topical agents (NSAIDs, lidocaine), opioids only when multimodal therapy is not enough or contraindicated

- Neuropathic:
  - 1st line: TCA or SNRI; gabapentin or pregabalin, sodium channel agents.
  - 2nd and 3rd line: Acetaminophen, topical agents (NSAIDs, lidocaine), opioids only when multimodal therapy is not enough or contraindicated

Taube

Harms of Non-Opioid Pain Management

- Acetaminophen: liver
- NSAIDs: GI, renal, HTN, cardiac
- Aspirin: GI
- Gabapentin, Lyrica: CNS
- Muscle relaxants: CNS
- Steroids: GI, endocrine
- Duloxetine, antidepressants: CNS

AAFP; CDC: Nonopioid Treatments

Harms of Opioid Pain Management

- Overdose
- Opioid dependence
- OUD
- Opioid diversion

Harm Reduction for Prescription Opioids

- Naloxone
- Safe opioid/benzo disposal
- Tapering opioids and/or benzos
- Buprenorphine

Naloxone

- Anyone prescribed opioids
  - especially >50 MME or on chronic treatment
  - with concurrent benzo use
- All patients in substance use treatment
- All patients with chronic pain
- Anyone actively using substances
- Anyone with a history of overdose
- All persons with family members/loved ones in these categories

Dowell

Safe Med Disposal

- “Drug Take Back”
- Flush down toilet?
- Dispose at home
  - Mix medication with unpalatable substance (cat litter, dirt, used coffee grounds)
  - Place mixture into sealed bag
  - Discard into your trash container
  - Delete/scratch off all personal information on the prescription label, then discard or recycle the empty bottle or packaging

FDA: Disposal of Unused Medicines

Case

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1) He was in acute withdrawal

2) He was acutely anxious (tearful, crying, hard to redirect)

3) He reported pain, but seemed to be functioning ok

4) You had no records of his prior workup

You agreed to resume half his regimen (roxi 5mg two tabs, tid prn), and offered adjunct meds to help with withdrawal, with close follow-up.

Is there anything you could have done more for harm reduction?

Nonpharmacologic options?

Non-opioid pharmacologic options?

Policy

NCMB Safe Opioid Prescribing Initiative (SOPI), 2016

- Aimed to reduce harm from misuse/abuse of prescription opioids by identifying and intervening to prevent excessive or inappropriate prescribing
- Board shall investigate if prescribers meets 1+ of the following:
  - Is in top 1% of those prescribing 100 MME per patient, per day
  - Is in top 1% of those prescribing 100 MMEs per patient, per day, in combination with any benzo and is within the top 1% of all controlled substance prescribers by volume
  - Has prescribed to 2+ patients who died in preceding 12 months due to opioid poisoning

Policy

NC Medicaid Lock-In Program

- Medicaid beneficiary identified for lock-in is restricted to single prescriber and pharmacy in order to obtain opioid analgesics, benzos, and certain anxiolytics (otherwise claim is denied)
- Lock-in period is 2 years. Criteria is 1+ of following:
  - >6 benzo or certain anxiolytic claims in 2 consecutive months, or >6 opiate claims in 2 consecutive months
  - Receiving rx for opiates and/or benzos and certain anxiolytics from >3 prescribers in 2 consecutive months

NC DHHS: Clinical Coverage Policy No 9

Policy

NCMB Policy for the Use of Opioids for the Treatment of Pain

- 1996; amended Jan 2017
- Any licensee prescribing opioids must be knowledgeable of benefits, risks, and potential harm associated with opioid treatment
- Failure to provide opioid treatment consistent with standard of care may subject licensee to disciplinary action by Board
- Board adopted/endorsed CDC's 2016 Guidelines for Prescribing Opioids for Chronic Pain

Policy

NCMB's Controlled Substances CME requirement (7/1/17):

CME on controlled substance prescribing practices and controlled substances for chronic pain management (includes training on signs of abuse or misuse of controlled substances, or non-opioid treatment options)

- Physician: at least 60 hours of Category 1 CME every 3 years; at least 3 hours of CME for controlled substance prescribing practices.
- PA: at least 50 hours of Category 1 CME every 2 years (or NCCPA current certification); at least 2 hours of CME for controlled substance prescribing practices

Policy

NC STOP Act (Strengthen Opioid Misuse Prevention)

- Targets Schedule II and III opioids
- Acute pain defined as ≤3 months, chronic pain as >3 months
- 1st time rx for acute pain is limited to ≤5 days (rx for post-op is limited to ≤7 days). Must have follow-up evaluation if further rx needed
  - Excluding hospital, nursing home, hospice, or residential care facility
- Prescribers must check CSRS for 1st time and then every 90 days (look back 12 months, document this in record). Delegate CSRS accounts may be used.
  - Excluded rx administered in hospital, nursing home, dialysis facility, or residential care facility; excluding rx for hospice or palliative care or for cancer pain treatment
  - DHHS may do periodic audits
- PAs/NPs in pain clinic setting must personally consult with supervising physician when starting opioid that is expected to exceed 30 days (and re-consult every 90 days)

NCMB: STOP Act

- Must electronically prescribe controlled substance
- Pharmacies must report rx dispense to CSRS by following day
- Amends Good Samaritan Law, to allow community distribution of naloxone through organizations with standing order
- Allows local funds to be used for syringe exchange

NCMB: STOP Act

Policy

NC Medicaid Opioid Safety Prior Authorization Criteria

- Updated Jun 2018
- Requires PA for opioid doses exceeding 90 MME per day, are >14 day supply of any opioid, or are non-preferred
- Now includes schedule III and IV opioids (tramadol), in addition to schedule II opioids already subject to criteria
- Also updated to reflect NC STOP Act:
  - PA required for short-acting opioids >5 day supply for acute pain, and 7 day supply for post-op acute pain

True or False

- Staff alert you that a 35 year old woman is slumped in a waiting room chair, and is unresponsive. Staff said she appeared very drowsy upon arrival and check-in.
- You do not personally or professionally know this women, but she is unconscious with shallow respirations.
- As you evaluate her ABCs, you consider if she is overdosing on opioids.

True/False: it is important to know her medical history before giving naloxone.

True or False

- Staff alert you that a 35 year old woman is slumped in a waiting room chair, and is unresponsive. Staff said she appeared very drowsy upon arrival and check-in.
- You do not personally or professionally know this women, but she is unconscious with shallow respirations.
- As you evaluate her ABCs, you consider if she is overdosing on opioids. She appears to be pregnant.

True/False: You should not give naloxone.

True or False

- Robert and Blake occasionally use heroin together. Blake prefers pills, but uses heroin when he cannot afford them. Robert has been using heroin more regularly.
- Robert shares some of his new bundle with Blake today, and they shoot up together. Within 10 minutes, Robert notices Blake is not arousable, with classic signs of overdose.
- Robert panics because he does not have any naloxone.

True/False: If Robert calls EMS, he risks being arrested himself for possession of drugs/paraphernalia.

Policy

Good Samaritan/ Naloxone Access law, effective April 9, 2013

- individuals who experience a drug overdose, or persons who witness an overdose and seek help for the victim, can no longer be prosecuted for possession of small amounts of drugs, paraphernalia, or underage drinking. The purpose of the law is to remove the fear of criminal repercussions for calling 911 to report an overdose, and to instead focus efforts on getting help to the victim.
- The Naloxone Access portion of SB20 removes civil liabilities from doctors who prescribe and bystanders who administer naloxone, an opiate antidote which reverses drug overdose from opiates, thereby saving the life of the victim.

NCHRC: 911 Good Samaritan

Policy

Death by Distribution law, effective Jan 1, 2020:

- Allows prosecutors to charge someone with 2nd degree murder if they sold a product to someone who then overdosed and died
- Medical professionals acting under standard of care are exempt, and the law targets those selling/distributing drugs. Law carries up to 20 years sentence (or 40 years if they have prior unlawful distribution conviction).
- NCHRC feels this law conflicts with/undermines the Good Samaritan Law and its immunities.

Newsome

NC Opioid and Substance Use Action Plan

- Implemented 6/2017; updated 5/2021
  - Broadened focus on polysubstance use, also centering equity and lived experiences
  - Prevent future addiction and address trauma (supporting children, families)
  - Increasing treatment access for justice-involved people
- Since launch:
  - 36% decrease in number of persons receiving dispensed opioids
  - 48% increase in uninsured and Medicaid persons who have received MOUD

Opioid Quality Measures

- CMS 506, NQF3316e:
  - patients with 2 opioids, or opioid + benzo, at time of hospital discharge
- HEDIS:
  - Percent of adults age 18+ who receive 2+ opioid rx on different dates of service with at least 15 total days covered by opioids during the measurement year
  - Percent of adults age 18+ who receive rx opioids for ≥15 days during measurement year from multiple providers
  - Percent of adults age 18+ who received high dose opioids (≥90 MME) ≥15 days during measurement year

Beatson; Salls

Best Practices for Chronic Opioid Use

Standardize your Approach to Pain Management

4) Opioid pain management (when benefits for pain and function outweigh risks)

- Assess for risk of substance misuse (ORT, DIRE)
- Create care plan with functional goals, risks/benefits/side effects, attention to dose escalation and reduction
- Start with lowest effective opioid dose (and not ER/LA to begin with)
- Counsel on naloxone
- Other routine risk mitigation: education, UDS, review CSRS, counting pills, more frequent visits, mental health screening, chronic pain agreement

Standardize your Approach to Pain Management

Reason to taper opioids:

- Patient desire
- Lack of improvement in pain and/or function
- Is on ≥50 MME/day without benefit, or has concurrent benzo use
- Nonadherence to treatment plan
- Signs of misuse and/or abuse of opioid or other substance
- Serious adverse events, or early signs of sedation/overdose risk

Individualize taper; goal to avoid/minimize withdrawal symptoms. Reduce dose by 10-20% every 1-2 weeks.

- Once at 1/3 of original dose, smaller decreases of 5% every 2-3 weeks

AAFP; CCNC: Provider Considerations for Tapering

Standardize your Approach to Pain Management

5) Prevent, detect, and treat OUD

4 Cs:

- Impaired **control** over drug use
- **Compulsive** use
- Continued use despite harms (**consequences**)
- **Craving**

AAFP

Case

- Mr Thomas was stable for nearly a year on the new regimen of 5mg two tabs roxicodone tid prn, soma 350 bid, Elavil 100mg. You also learned he was on topiramate for migraines by neurology, Xanax and Prozac for anxiety and depression by psychiatry.
- For the next 10 months, he reported ongoing uncontrolled back pain and asked about MRI. Worked in housecleaning.
- When you finally order his MRI:
  - He has bad venous stick for contrast resulting in arm pain that became chronic
  - MRI showed stable lumbar DDD
  - He had incidental stomach mass (GIST), removed; but perseverated on prior abdominal pain that “no one listened to”
- Violated pain agreement twice (ran out early twice)

What are your concerns? How do you address them?

True or False

- You take the opioid epidemic seriously.
- You have been reviewing your patient panel of those who receive long-term opioids from your clinic.
- You follow CDC's recommendations when it comes to a goal of <90 MMSE and/or concurrent benzodiazepine rx, and tapering protocols.

True/False: Tapering opioids may increase the frequency with which you see such patients.

Case

Recommend a taper this patient's opioid regimen, after 2 years of poor functional improvement?:

- Oxymorphone 10mg four times daily
- Hydrocodone-acetaminophen 10-325mg three times daily prn

Use opioid conversion calculator; probably easier to convert entire regimen to hydrocodone.

(oxymorphone 40mg po = 90mg po hydrocodone, including 25% cross tolerance) + 30mg hydrocodone = 120mg hydrocodone.

Reduce by 10-20% every 2 weeks.

2016 CDC Guidelines for Prescribing Opioids for Chronic Pain

1. Nonpharmacologic and non-opioid pharmacologic therapy are preferred for chronic pain. Only consider opioid therapy if expected benefits for pain/function outweigh risk, and add nonpharmacologic and non-opioid pharmacologic therapy.
2. Establish treatment goals (pain, function) before starting opioids for chronic pain
3. Before starting and periodically, discuss with patients risks/realistic benefits and each other's responsibilities for managing therapy
4. When starting opioids, choose immediate-release opioids (no ER/LA)
5. Start opioids with lowest effective dosage. Caution/carefully reassess if dose $\geq$50 MME/day; avoid dose $\geq$90 MME/day (or carefully justify)

Dowell

2016 CDC Guidelines for Prescribing Opioids for Chronic Pain

6. Opioids for acute pain should be lowest effective dose of immediate-release opioids; should be no more than needed (3 days or less is often sufficient; >7 days is rarely needed)
7. Evaluate benefits/harms with patients 1-4 weeks after starting or increasing opioid dose. Review benefits/harms at least every 3 months. If harms > benefits, optimize other therapies and work to taper opioids
8. Evaluate risk factors for opioid-related harms before starting and periodically after starting opioids. Incorporate risk mitigation, including naloxone if history of overdose, SUD, ≥50 MME/day, concurrent benzo use

Dowell

2016 CDC Guidelines for Prescribing Opioids for Chronic Pain

9. Review CSRS and history of controlled substance rx, to look for risk of overdose. Review CSRS when starting opioids and then periodically (at least every 3 months)
10. Use urine drug testing before starting opioid therapy, and at least annually thereafter
11. Avoid prescribing opioid pain medication and concurrent benzos if possible
12. Arrange evidence-based treatment for patient with OUD

Dowell

Proposed 2022 CDC Clinical Practice Guidelines for Prescribing Opioids

- No longer includes specific dosage ceilings
- No longer suggests that opioid treatment for acute pain be limited to 3 days
- Recommends multimodal and multidisciplinary approach to pain management (physical, behavioral, long term services and supports)
- Reiterates that opioids are not 1st line for chronic pain, nor subacute pain

Lee

Which of these opioid regimens has MME >90?

a) Morphine 10mg IV every 6 hours

b) Fentanyl 50mcg/hr TD every 3 days

c) Oxycodone 15mg PO bid with hydrocodone-acetaminophen 5-325mg PO tid prn

d) Hydromorphone 4mg PO tid

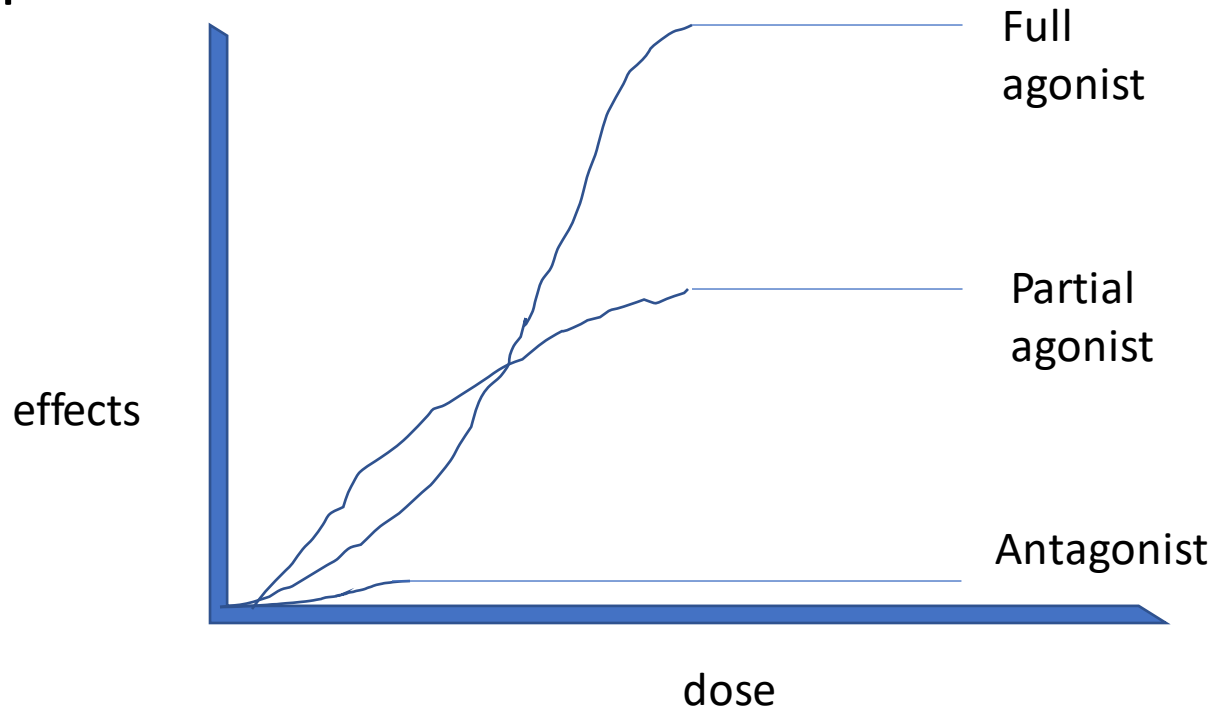
True or False

- John presents as a new patient from Kansas.
- He was on methadone tabs for chronic neck pain, despite attempt cervical fusion. MME = 105.
- He asks you to take over the management of his methadone, as there are few pain management specialists around.
- You screen him, and he demonstrates no evidence of OUD.

True/False: You can competently manage his pain.

Mu Effects

- Full agonist: Methadone, opioids
- Partial agonist: Buprenorphine
- Antagonist: Naltrexone



SAMHSA TIP 63; Rosenquist; Powell

Acute Pain in Adults with Treated OUD

- Methadone: continue baseline methadone, use multimodal nonopioid analgesic strategies, supplemented with incremental opioid prn
- Buprenorphine: continue baseline buprenorphine (though some still stop pre-op). May split baseline dose into tid or qid dosing, +/- temporary increase in dose. Use multimodal nonopioid analgesic strategies, supplemented with incremental opioid prn. May do better with fentanyl or hydromorphone
- Naltrexone: stop 3 days pre-op (or XR 1 month pre-op). Maximize non-opioid pain control and regional anesthesia.
- Abstinent: caution against return to use. If mild-moderate pain, can try buprenorphine for short term acute pain.

Coffa

Buprenorphine for Chronic Pain

- May be helpful for patient with high-risk opioid regimen, or for patient with concurrent OUD
  - Less opioid induced hyperalgesia, respiratory depression, overdose
- Be clear in documentation: are you treating chronic pain, OUD, or both?
- No DEA waiver needed for pain management purposes
- Patch or buccal film (generally lower strengths than OUD forms)
  - But, sublingual film and tabs, as in for OUD, can also be used off-label for chronic pain

Rosenquist; Powell

Buprenorphine Induction for Chronic Pain

Buprenorphine buccal film		Buprenorphine transdermal patch	
• Taper opioid regimen over 7 days to ≤30 MME per day; then stop when buprenorphine is started			
Those who were on <30 MME per day	Initial: 75mcg once daily or bid	Those who were on <30 MME per day	Initial: 5mcg/hr weekly
Those who were on 30-89 MME per day	Initial: 150mcg bid	Those who were on 30-79 MME per day	Initial: 10mcg/hr weekly
Those who were on 90-160 MME per day	Initial: 300mcg bid (film may not be enough for those on >160 MME per day)	Those who were on >80 MME per day	Initial: 20mch/hr weekly (this is max dose, but may not be enough)
	Titrate up every 4 days by 150mcg bid (max 900mcg bid)		Titrate up every 3 days by 5-10mcg/hr (max 20mcg/hr weekly)

Rosenquist; Powell

Buprenorphine Induction for Chronic Pain

Bernese Method (using sublingual buprenorphine, off-label for pain):

- Small repetitive doses
- Stop opioids (illicit or prescribed) after 8mg buprenorphine is begun
- **To avoid withdrawal**

Day 1: 0.5mg once a day
Day 2: 0.5mg twice a day
Day 3: 1mg twice a day
Day 4: 2mg twice a day
Day 5: 3mg twice a day
Day 6: 4mg twice a day
Day 7: 12mg (stop other opioids)

Randhawa

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