

## Improving Pain Management in the Department of Veterans Affairs Part 2:

### Primary Care - Based Support for Managing Chronic Opioid Therapy

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## Nancy Wiedemer, RN, MSN, CRNP Disclosures

- No disclosures

*The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.*

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## Objectives/Agenda

- At the conclusion of this activity participants should be able to:
  - Present the "Opioid Renewal Clinic (ORC)" – an innovative solution- implemented in 2001 to assist Primary Care in the management of chronic opioids
  - Report on lessons learned: how the ORC is functioning NOW in the midst of the prescription drug addiction epidemic and inadvertent overdose/death
  - Review the biopsychosocial rehabilitation model of pain care and role of multidisciplinary team

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## Target Audience

- The overarching goal of PCSS-O is to offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.
- Our focus is to reach providers and/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, and program administrators.

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## Managing **PAIN** in Primary Care in 1998- early 2000



- Pain as the 5<sup>th</sup> VS:
  - VHA in 98 ---- JC in 2000
- Pharmaceutical Companies
  - Newer opioids with touted less risk
  - \$\$ for provider education
- *Opioids became equated with managing pain*
- Our experience and model for treatment → Cancer and Acute pain management

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## Managing **PAIN** in Primary Care in 1998- early 2000

*Inexperience in pain management and opioids in particular*

*Push by professional standards and guidelines for PCPs to prescribe opioids*



*Brief Visits*

*Complicated Patients*

*Compassion/ Frustration*

*Minimal Resources*

*Pressure*

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### Primary Care Management of Pain at the Philadelphia VA

- Group of Primary Care providers concerned about “ all of the patients we have coming to primary care on percocet” established a policy in 1999
  - Treatment Agreement (we called it a narcotic contract!)
  - Urine Drug Screens
  - Changed the patients to the “new long-acting opioid” Oxycontin because it was better than keeping patients on short-acting opioids
- Oxycontin use soared
- Wide variation in practice without following the established policy

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### Primary Care Management of Pain at the Philadelphia VA

- Dangers of Oxycontin (and the \$\$\$) hit the papers (2000-01)  
MANDATE: get your Oxycontin use down from 42% of all opioids prescribed to 3% !!!
- **Development of Opioid Renewal Clinic 2001**  
Clinical Pharmacist run program in Primary Care to manage high risk patients on chronic opioid therapy

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Goal: To support PCPs in managing patients with chronic pain requiring opioids

- **Assist with management of *challenging* patients requiring structured prescribing and monitoring of long-term opioid therapy**
  - Patients with aberrant drug related behaviors to r/o substance misuse vs. pseudoaddiction vs. addiction
  - Patients with h/o addiction, recent addiction, active addiction
  - Patients with complexity (e.g., psych co-morbidity)

Wiedemer NL, et al. *Pain Med.* 2007;8:573-584

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## Pharmacy Pain Management Clinic

### Procedure

- 1 FTE Clinical Pharmacist
- Eligibility
  - Work-up & Pain Diagnosis
  - Opioid Treatment Agreement
  - Baseline Urine Drug Test
- PCP CONTINUES TO BE RESPONSIBLE TO PRESCRIBE OPIOID

### Strategies

- Individualized Opioid Treatment Agreement
- Frequent Visits
- Prescribing opioids on short term basis
  - i.e. weekly or bi-weekly
- Random UDT
- Pill Counts
- Co-management with addiction services

Wiedemer NL, et al. *Pain Med.* 2007;8:573-584

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## What's in a Name ????

### The Opioid Renewal Clinic

Wiedemer,NL, Harden,PS, Arndt,JO, Gallagher,RM, The **Opioid Renewal Clinic**: A Primary Care,Managed Approach to Opioid Therapy in Chronic Pain Patients at risk for Substance Abuse. *Pain Medicine.* 2007;8:573-584.

Opioid Pain Care Clinic

Pharmacy Pain Management Clinic

Primary Care/Opioid Case Management Program

Proactive care management in PACT/Medical Home

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## Examples of patients referred

### 1. Joe referred 2001

53 yo Viet Nam combat veteran with PMH of PTSD, Diabetes, IV heroin abuse  
 Lumbar Laminectomy for epidural abscess 1996; cervical osteomyelitis 1998.  
 Severe lumbar stenosis, arachnoiditis and radiculopathy  
 Relapsed to heroin "due to severe uncontrolled pain"  
 PCP asked for help "we need to treat the pain or we are going to loose him"  
 →Managed in ORC on methadone for pain; co-managed with addiction psychiatrist  
 methadone 50 mg q 12 titrated along with addition of adjuvants and nonpharmacologic modalities

2. John 52 yo with PMH of polyneuropathy, diffuse arthralgia due to avascular necrosis secondary to chemo, XRT and high dose steroids. Remote history of ETOH abuse and occasional cocaine when drinking  
 Referred to ORC for periodic drug screens negative for prescribed opioids and running out early

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### Examples of patients referred

- High dose opioid for monitoring
- Difficult opioid rotation
- ABERRANT URINE DRUG SCREENS  
cocaine, marijuana, unprescribed medication  
negative urines
- History of addiction past or current ( and in  
addiction treatment) but compelling reason for  
treatment with opioids

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### Differential Diagnosis of opioid misuse

- Inadequate analgesia
- Disease progression
- Opioid resistant pain
- Opioid induced hyperalgesia
- Self-medication of psychiatric disorders
  - Organic mental disorder
  - Personality disorder
  - Depression/anxiety/situational stressors
- Substance Abuse Disorder
- Criminal intent - diversion

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### Outcomes

	2002-2006 DATA	2009 DATA	2012
Aberrant	47% (n=366)	50% (n=171)	67% (201)
Non- Aberrant	53% (n=418)	50% (n=170)	33% (99)

#### Outcomes in the Aberrant Group

	2002-2006	2009	2012
Resolved	40%	57%	60 %
Self Discharged	28%	26%	14 %
Clinic Discharged	25%	13%	19 %
Accepted referral for addiction treatment	7%	4%	7 %

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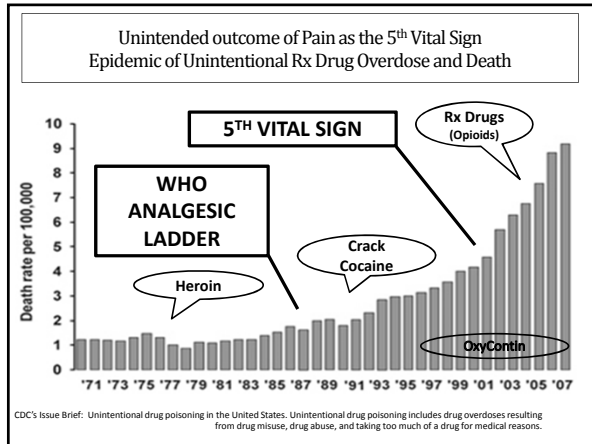
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Recent Research Identifies Risk for Inadvertent Opioid Drug Overdose

- History of Substance Use Disorders
- History of co-morbid mental Health disorder (Depression, PTSD, Anxiety Disorder)
- Benzodiazepine Use
- Underlying lung disease
- Underlying liver disease
- On 100 mg or more of Morphine equivalents per day
- Patients over 65

Reference: # 1,2,3,4,5

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Association of Mental Health Disorders With Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan

- Veterans with mental health issues were more likely to receive opioids, about 3X as likely with PTSD, about 2X as likely with other mental health issues
- Veterans with PTSD were more likely to receive higher-dose opioids, 2 or more opioids, sedative hypnotics, and get early refills
- Receiving opioids was associated with an adverse clinical outcome for all veterans, more pronounced in veterans with PTSD

(N= 291,205 soldiers who entered VA 2005-2008)

Reference # 6

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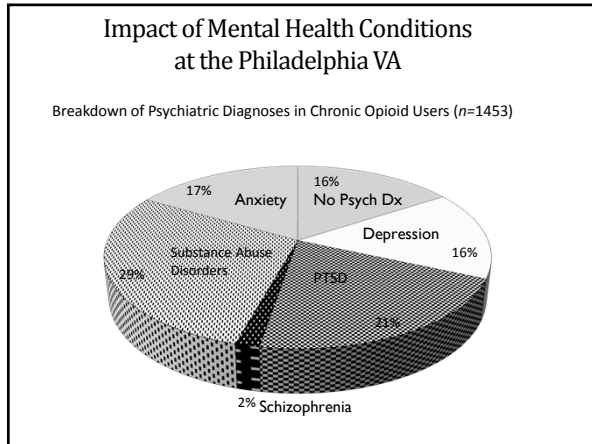
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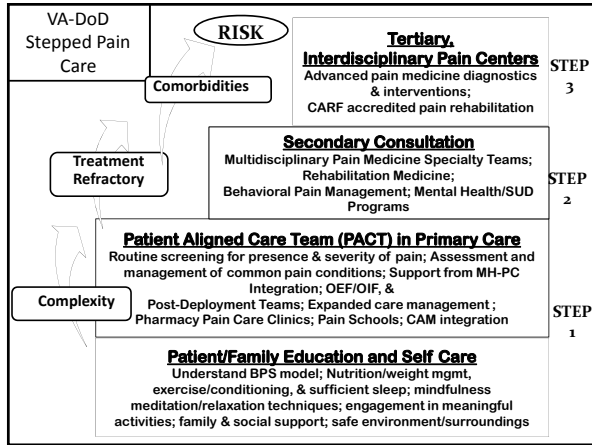
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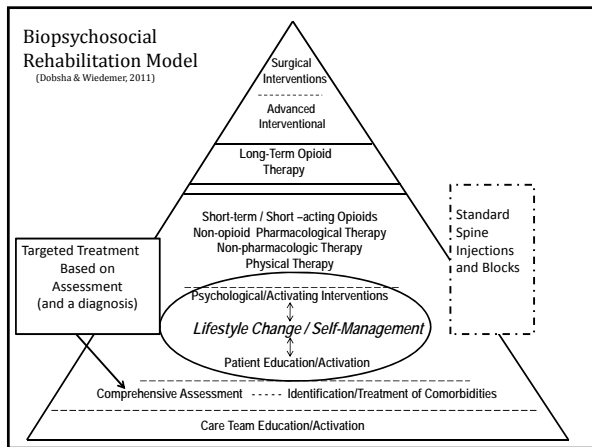
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**We need to change from a Culture of Cure to a Culture of Healing**



**Reliance on the biomedical model**

- Urgent and absolute pain relief: appropriate in acute and cancer pain

**Acute/Cancer strategies are inappropriate for chronic pain management**

**Strategies for Chronic Pain Management →**

Biopsychosocial Model of care

- Rehabilitation
- Restoring and preserving function

**pain**

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**Back to Joe in 2010**

- Now 62 yo with lumbar and cervical spinal stenosis, arachnoiditis, radiculopathy

No relapses, followed the program

Methadone titrated over time: 120 mg q 8

With all of the usual adjuvants etc

Referred to Pain Service for review due to increased pain

Workup ruled out red flags

Suggested to Joe that we start tapering his methadone

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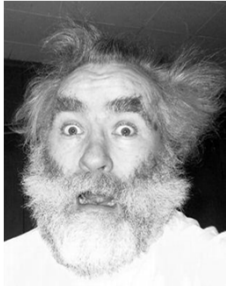
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**How to “screw up” a patient encounter?**

Provider to patient: “The government is cracking down on high dose opioids, we are going to have to lower your dose”



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### The Message

“Our goal for you is to get to a safer dose as we work together to add other treatments that will help to improve your quality of life”

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### COMMUNICATION and TRUST

- Chronic Opioid Therapy

Clinician	←→	Patient	Frustration Tension Mistrust Miscommunication
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- Can we preserve the therapeutic alliance when we do not agree with a patients demands for increasing opioids ?

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### COMMUNICATION and TRUST

- Reframing the issue as a balance of the benefits and harms of treatment
- Acknowledging: *Fear of life without opioids*
  - iatrogenic: for some patients, that's all they have been offered and complaints about pain have been met in the past with increasing doses
- Sharing that: “opioids are an imperfect treatment & often don't provide the benefits you and I were expecting”
  - Reassess the many factors that could be contributing to pain and reattempt to treat underlying disease & co-morbidities

Nicolaidis, 2011; Ballantyne & Mao, 2003

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## Communication and Trust

- SLOW TAPER
  - Share control around logistics of taper
  - Educate – Reassure
    - Slow taper will prevent frank withdrawal and give time to equilibrate at each level
    - Explain signs of withdrawal
      - pain will likely increase due to withdrawal
  - Focus on patient strengths & encourage counseling and other therapies for coping with pain

Nicolaidis, 2011

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## Opioid tapering

- As part of the VHA Opioid Safety Initiative, in Philadelphia, we are reviewing all patients on high dose opioids
- We discuss with patients the RISKS of long-term high dose opioids and suggest a taper
  - If there are no immediate safety concerns, we institute a slow taper
- **Retrospective review of 50 patients**
  - Average of 46% reduction in opioids in 12 month period
  - When compared to baseline:
    - 70% reported less or no change in pain**

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## Proactive Management of Chronic Opioid Therapy in Primary Care

### Standardizing opioid renewals in your setting

A Process that addresses

- Opioid prescribing practices
- Opioid Treatment Agreements
- Urine Drug Testing
- Proactive plan to address aberrancies

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Practice Strategies that are standardized and applicable to ALL patients

**"Universal Precautions"**

- Comprehensive Assessment**
  - Identification of Pain Diagnosis and co-morbidities
- Careful patient selection using Risk – Benefit framework**
  - Be aware of relative and absolute contraindications listed in VA/DOD guidelines
  - Do the benefits of opioid therapy outweigh the untoward effects and risks for this patient at this time

( we have an "Opioid Risk Evaluation" Note)
- TRIAL** of opioid therapy with adjuvant therapy
- Informed Consent/Treatment Agreement**
- Regular MONITORING:**
  - Regularly assess "4 A's" : Analgesia, Activity(FUNCTION), Adverse Reactions, Aberrant Behaviors
  - Urine Drug Testing
- DOCUMENTATION**

Gourlay & Heit, 2005; VA/DOD Chronic Opioid Therapy CPG, 2010

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**Proactive Management of Chronic Opioid Therapy in Primary Care**

2<sup>nd</sup> Step -> Models and Strategies to support Primary Care

Questions ??

- What Care Management Model or Models
- What professionals
  - Pharmacist, LPNs, RN, Advanced Practice Nurse, Psychologist, social workers ....
- How are you going to address management of
  - Stable patients
  - High risk patients
- How can you incorporate a biopsychosocial approach that promotes a self-management focus rather than reliance on passive modalities ( the quick fix mentality)

**Office Communication:** EVERYONE NEEDS TO BE ON THE SAME PAGE

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**Patient Centered Pain Management**  
*It takes a TEAM*

**Pain**

**Self-management Goals**

**Activity**

**Coping**

**Breathing**

**Yoga**

**Philates**

**TaiChi**

**Healthy Changes**

**Physical**

**Meditation**

**Swimming**

**Crafts**

**Art**

**Fishing**

**Dog-Walking**

**Simple**

**Positive**

**Lowing**

**Walking**

**Stretching**

**Make**

**Grandchildren**

**Dancing**

**Playing**

**Disability**

**Meditation**

**Distraction**

**Mindfulness**

**Living**

**Children**

**Golfing**

**Exercise**

**Gardening**

**Swimming**

**Healthy**

**Changes**

**Physical**

**Art**

**Yoga**

**Philates**

**TaiChi**

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**Make**

**Grandchildren**

**Dancing**

**Playing**

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## References

- <sup>1</sup> Dunn et al, Opioid Prescriptions for Chronic Pain and Overdose. Ann Int Med, 2010;152:85-92.
- <sup>2</sup> Gomes, et al Opioid Dose and Drug Related Mortality in Patients with Nonmalignant Pain. Arch Int Med, 2011;171(7):686-691.
- <sup>3</sup> Bohnert AS, Ilgen MA, Galea S et al. Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System. Med Care 2011;49:3936
- <sup>4</sup> Bohnert AS, Ilgen MA, Ignacio RV et al. Risk of death from accidental overdose associated with psychiatric and substance use disorders. Am J Psychiatry 2012;169:64-70.
- <sup>5</sup> Bohnert AS, Valenstein M, Bair MJ et al. Association between opioid prescribing patterns and opioid overdose-related deaths. Jama 2011;305:1315-21
- <sup>6</sup> Seal, K et al. JAMA. 2012;307(9):940-947

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## Resource:

### “Safe and Competent Opioid Prescribing For Providers Working with Veterans and Military Service Personnel”

- Developed by:  
Dan Alford, MD from Boston University School of Medicine  
Karen Seal, MD, Emily Sachs, PhD and Tracy Lin, PharmD from the San Francisco VA and UCSF

- [www.opioidprescribing.com](http://www.opioidprescribing.com)

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## PCSS-O Colleague Support Program

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.
- PCSS-O Mentors comprise a national network of trained providers with expertise in **addiction medicine/psychiatry and pain management**.
- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available at no cost to providers.

### For more information on requesting or becoming a mentor visit:

[pcss-o.org/ask-colleague](http://pcss-o.org/ask-colleague)

- **Listserv:** A resource that provides an "Expert of the Month" who will answer questions about educational content that has been presented through PCSS-O project. To join email: [pcss-o@aaap.org](mailto:pcss-o@aaap.org).

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**TRAINING**

**PROVIDERS' CLINICAL SUPPORT SYSTEM**  
For Opioid Therapies

**PCSS-O** is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: [www.pcass-o.org](http://www.pcass-o.org)  
For questions email: [pcass-o@aaap.org](mailto:pcass-o@aaap.org)

 **Twitter:** @PCSSProjects

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