

PCSS O TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Opioid Therapies

**The Road Less Traveled:
Using Buprenorphine-Naloxone to Treat
High-Risk Chronic Pain Patients**

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Disclosures

- Conflicts of Interest for ALL listed contributors.
 - NONE

The contents of this activity may include discussion of off-label or investigational drug uses. The faculty is aware that it is their responsibility to disclose this information.  2

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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Educational Objectives

- Review the drug epidemic in West Virginia
- Classify and identify high-risk pain patients
- Describe the purpose, framework, and the interdisciplinary approach to this specific treatment program
- State the indication and rationale for using buprenorphine-naloxone

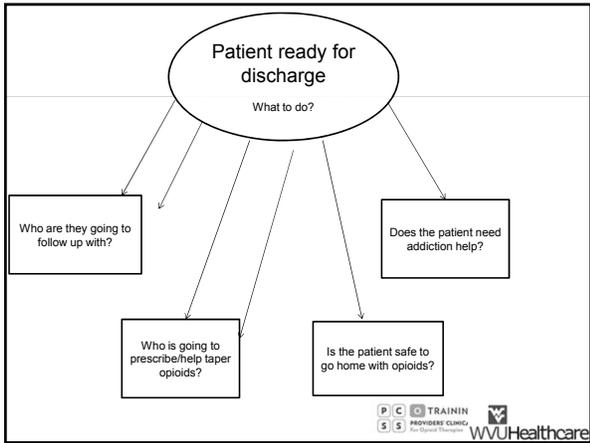
Introduction

- West Virginia University Healthcare
 - Morgantown, West Virginia
 - Serve both rural and non-rural communities
 - Only Magnet designated facility in WV
- Academic, Level 1 Trauma Center
 - 531 beds + 114 (spring '16)
- Run an inpatient consulting service
 - The Pain Resource Team



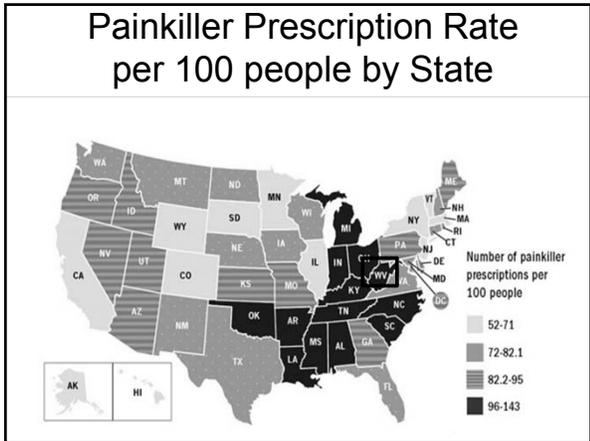
How did we get started?

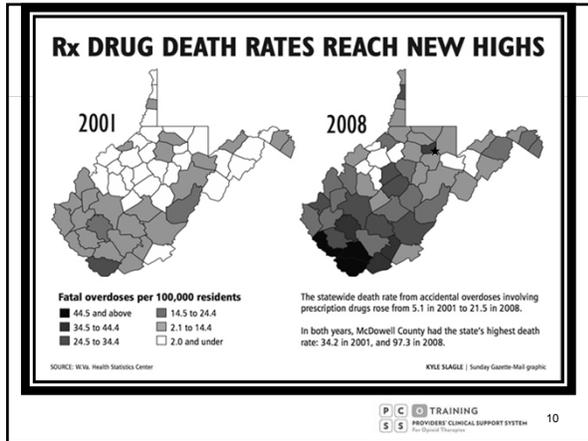
- 2013, developed and implemented inpatient nurse-driven pain management consult service
 - Issues with what to do with patients at discharge
 - High rates of chronic diseases and chronic pain
 - Pain providers decreasing in West Virginia
 - Patients dependent on or addicted to opioids
 - Buying pain pills off street, turning to illicit drugs, experiencing withdrawal

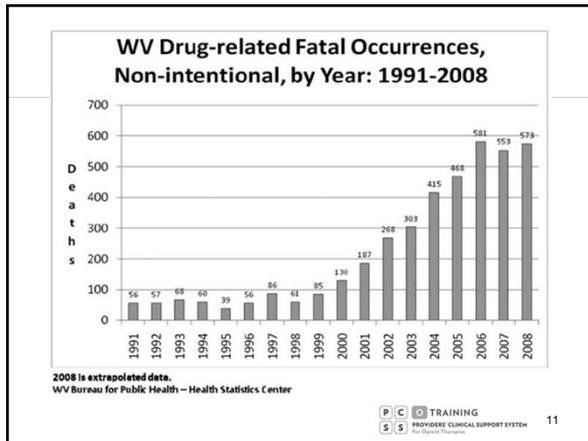


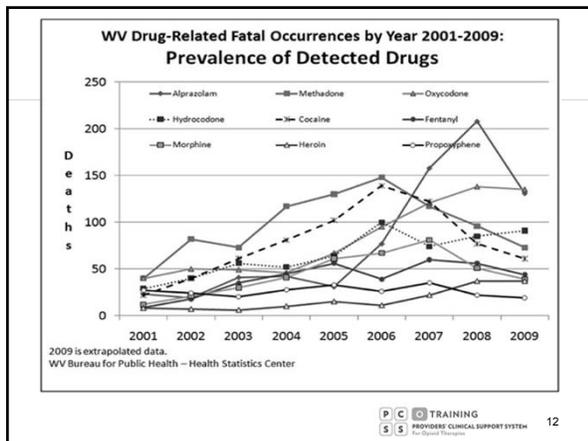
Drug epidemic in West Virginia

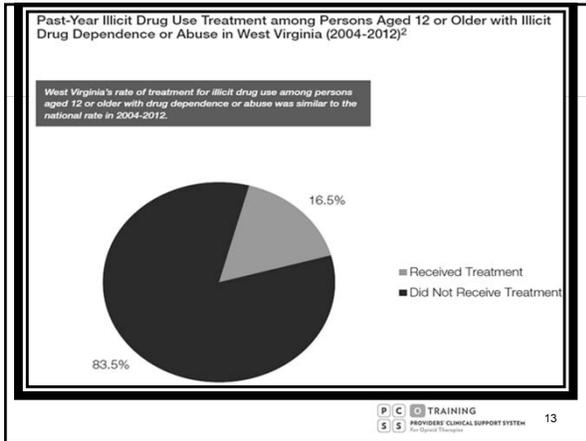
- West Virginia has highest rate of drug overdose fatalities with 28.9 per 100,000 people suffering (Healthy Americans, 2013)
- Majority of these are prescription drugs
- Outnumber heroin and cocaine overdoses
- Per the CDC July 2014 Vital Signs Report, West Virginia ranks third in nation for highest # of painkiller prescription rates per person

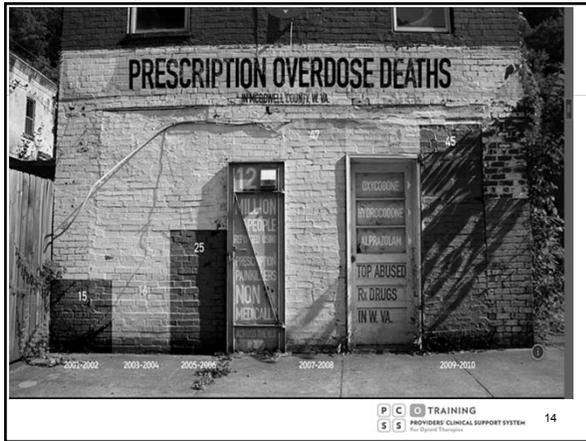














Evaluation of High-Risk

- Chart Review
- History and Clinical Assessment
- Opioid Risk Tool/ SOAPP-R
- Collateral from friends/family members
- Interdisciplinary communication



Opioid-Risk Tool

Meibscapen www.meibscapen.com

Item	Mark each box that applies	Item score if female	Item score if male
1. Family history of substance abuse			
Alcohol	<input type="checkbox"/>	1	3
Illegal drugs	<input type="checkbox"/>	2	3
Prescription drugs	<input type="checkbox"/>	4	4
2. Personal history of substance abuse			
Alcohol	<input type="checkbox"/>	3	3
Illegal drugs	<input type="checkbox"/>	4	4
Prescription drugs	<input type="checkbox"/>	5	5
3. Age (mark box if 16 to 45)	<input type="checkbox"/>	1	1
4. History of preadolescent sexual abuse	<input type="checkbox"/>	3	0
5. Psychological disease			
Attention deficit disorder, obsessive compulsive disorder, bipolar, schizophrenia	<input type="checkbox"/>	2	2
Depression	<input type="checkbox"/>	1	1
Total		—	—

Total score risk category: low risk (0-3); moderate risk (4-7); and high risk (8-13).

Source: South Med J © 2007 Lippincott Williams and Wilkins



Exhibit 2-14 SOAPP-R Questions

How often do you have **mood swings**?

How often have you felt a **need for higher doses** of medication to treat your pain?

How often have you felt **impatient with your doctors**?

How often have you felt that things are just **too overwhelming** that you can't handle them?

How often is there **tension in the home**?

How often have you **counted pain pills** to see how many are remaining?

How often have you been concerned that people will **judge you** for taking pain medication?

How often do you **feel bored**?

How often have you **taken more pain medication** than you were supposed to?

How often have you **worried** about being left alone?

How often have you felt a **craving** for medication?

How often have others **expressed concern** over your use of medication?

How often have any of your **close friends had a problem** with alcohol or drugs?

How often have others told you that you have a **bad temper**?

How often have you felt **consumed** by the need to get pain medication?

How often have you **run out** of pain medication early?

How often have others kept you from **getting what you deserve**?

How often, in your lifetime, have you had **legal problems** or been arrested?

How often have you attended an **Alcoholics Anonymous** or **Narcotics Anonymous** meeting?

How often have you been in an argument that was so out of control that **someone got hurt**?

How often have you been **sexually abused**?

How often have others suggested that you have a **drug or alcohol problem**?

How often have you had to **borrow pain medications** from your family or friends?

How often have you been **treated for an alcohol or drug problem**?

Reprinted from Butler et al., 2008. Validation of the revised screener and opioid assessment for patients with pain. Journal of Pain, 9, 360-372. Used with permission from Elsevier.



Addiction, Tolerance, or Dependence



“Monitoring patients for signs of abuse is also crucial, and yet some indicators can signify multiple conditions, making accurate assessment challenging.”

<http://www.drugabuse.gov/publications/research-reports/prescription-drugs/chronic-pain-treatment-addiction>

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Addiction



- A **primary** chronic neurobiological disease characterized by impaired control over drug use, compulsive use, continued use despite harm, and craving. (AAPM, APS, ASAM, 2001)

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Tolerance



- **Normal response** that occurs with a regular administration of an opioid
- Consists of a decrease in one or more effects of the opioid (e.g. decreased analgesia, decreased sedation or decreased respiratory depression)
- Tolerance to analgesia usually occurs in the first 2 weeks
- Disease progression, not tolerance to analgesia, appears to be the reason for most dose escalations
- Never develop a tolerance to constipation while taking opioids

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Dependence

- Normal, physiologic response that occurs with repeated administration of an opioid for more than 2 weeks
- State of adaptation manifested by withdrawal syndrome produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist (AAPM, APS, ASAM, 2001)

Fifty Shades of Risks



Case 1

- 27 year old male
- States he was hurt on the job resulting in necrotizing fasciitis of RLE
- 10/10 pain, requiring high doses of opioids
- Reports no previous opioid use or illicit drug use

Case 2

- 36 year old female
- Reports accidental needle stick in her palm causing infection
- Discharged from hospital with opioid taper schedule
- Returned one month later as outpatient consult

Case 3

- 53 year old male with chronic pancreatitis, severe abdominal pain x 7 months
- History of alcoholism, 30-pack on the weekends
- Visiting multiple ED's and clinics for pain
- UDS + for marijuana, benzodiazepines (not prescribed)
- Ran out of opioid prescriptions early



But, wait! How do you treat high-risk pain patients?

Chronic Pain Management

- Pain should be treated in a comprehensive, systematic, collaborative, patient-centered fashion
- Treatment options: interventional techniques, cognitive and behavioral methods, rehabilitation approaches, and the use of medications (non-opioids, opioids, adjuvants)
- Prescription opioids for chronic, intractable pain is appropriate when more conservative methods are ineffective and the treatment plan is designed to avoid diversion, addiction, and other adverse effects
- The possibility of addiction against the benefit of therapy must be weighed. Providers who misunderstand addiction and mislabel patients as addicts may result in unnecessary withholding of treatment with opioid medications

Initial Establishment of Clinic

- Term "pain refugee"
- Target population:
 - Chronic pain patients who are opioid tolerant
 - Experienced little relief with conservative treatment
 - Present or past history of risk factors for aberrant behaviors with opioids
 - Does not have active addiction

Clinic Staff

- A Psychiatrist, Addiction Specialist
- Two Nurse Practitioners
- A Nurse Clinician
- Psychologist
- Clinical Therapist
- Social Worker
- Additional Support: Medical Assistants, Call Center

Clinic Referrals

- Patients encountered by Pain Resource Team during hospitalization
- Patient's already receiving care at Chestnut Ridge Center (inpatient and outpatient)
- Referral from outside providers
- Referral by West Virginia University Pain Clinic (those deemed high risk, no intervention offered)

Clinic Assessment Forms

- Patient Pain History Form
- Pain Disability Index
- Pain Questionnaire
- Pain Catastrophizing Scale
- Beck Depression Inventory II
- Beck Anxiety Inventory

Clinic Requirements/Rules

- Patient is aware of expectations and risks associated with treatment/signs treatment agreement
- Treatment is contingent upon follow-up, compliance, participation in group therapy, established primary care provider
- Random UDS and strip counts

Clinic Requirements/Rules

- Clinic Follow-up: bi-weekly or monthly treatment group
- Required support group/group therapy
- If it is determined that the patient is currently displaying substance abuse/addictive behaviors, there is a treatment pathway that can lead to addiction treatment within same facility



Preventing and Monitoring Adverse Effects

- Risk of sedation and respiratory depression is possible with any opioid
- Concomitant use of other neuro-depressant drugs can result in serious adverse effects, including death
- List of medications that should not be used (i.e. benzodiazepines, opioids..) while being treated with buprenorphine-naloxone



Compliance Monitoring

- Patient assessment
- Attention to patterns of prescription requests
- Frequent follow-up and patient contact
- Random urine and/or blood drug screening
- Medication counts
- Periodic review of state controlled substance monitoring program



Clinic Goals

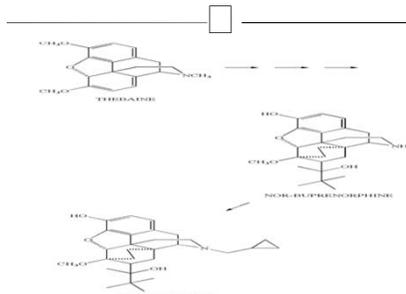
- Demonstrate improvement in analgesia, physical function, and quality of life
- Absence of significant adverse effects and maladaptive behaviors
- Address the physical, emotional and cognitive management of chronic pain, in conjunction with medical management
- Address the relationship between chronic pain and depression, anger and other emotional states
- Manage and educate on addictive behaviors and addictive thinking, as well as relapse prevention


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Buprenorphine




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Buprenorphine



- Several medications rolled into one
 - Partial agonist
 - Precipitate withdrawal
 - When other agonists on board
 - Prevent intoxication
 - When it is on board
 - Half life
 - Longer than short acting
 - Shorter than methadone

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Buprenorphine



- Why not use to treat addiction?
 - Alternative to methadone?
 - IV use causes euphoria
 - "heroin cure"
- What if we add naloxone?
 - Buprenorphine/naloxone in 4:1 ratio
 - In theory would perpetuate withdrawal
 - Suboxone ®
- CSA/DATA waiver
 - SAMSHA

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Buprenorphine



- Why not use to treat pain?



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Evidence

Author	Year	Study Design	Intervention	Comparison	Outcomes
Chen, L, Mao, J	2012	Retrospective cohort study	Buprenorphine-naloxone	Opioid analgesics	Reduction in opioid use, no increase in pain
...

Buprenorphine-naloxone therapy in pain management. **43**
Chen, L, Mao, J. PROVIDER CLINICAL SUPPORT SYSTEM For Opioid Therapies

Evidence

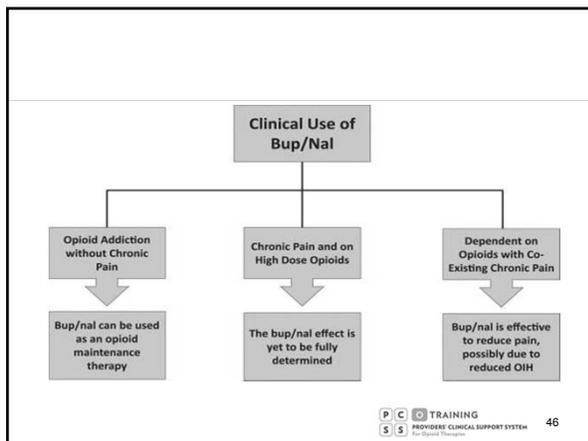
- Increasing number of studies
 - Still not enough
- Who?
 - Any patient
 - Dependent patients
 - Addiction patients with pain
 - Cancer Pain
 - Elderly
- How?
 - OIH
 - Partial agonist
 - mu, kappa, delta...

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Evidence

- Why
 - Safety
 - Not so much when sedatives on board
- Routes
 - IV, sl, IM, TD
 - Buprenorphine (Suboxone®), buprenorphine-naloxone (Subutex®), buprenorphine (Butrans®)
- When
 - Opioid naïve vs dependent
 - "Conversion"
 - Precipitating w/d
 - Acute pain
 - Traumatic or perioperative
 - With or against

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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

- **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.


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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
For questions email: pcass-o@aaap.org

 **Twitter:** @PCSSProjects

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