

# Adopting guidelines for the appropriate treatment of pain in Southern Oregon

Oregon Pain Guidance group



# Oregon Pain Guidance

(formerly Opioid Prescribers Group)



Attendees: Physicians, Mid-level providers, Nurses, Substance Abuse Counselors, CCOs, Therapists, Pharmacists, Medical specialty (Pain Medicine, ED), Dental, Community Justice Partners

# Oregon Pain Guidance (OPG)

- Public Health initiative to reduce opioid morbidity and mortality
- Steering Committee
- CME and dinner provided
- Video conference with Josephine County
- OPG evolution:
  - Brainstormed >
  - Guidelines > Acceptance>
  - Case reviews and discussion



A Provider and Community Resource

# Pain Treatment Guidelines

If we don't solve this problem as a community, we are only passing it on to the next provider.



That's how you got your "legacy patients" in the first place!

It gives us some “external” courage



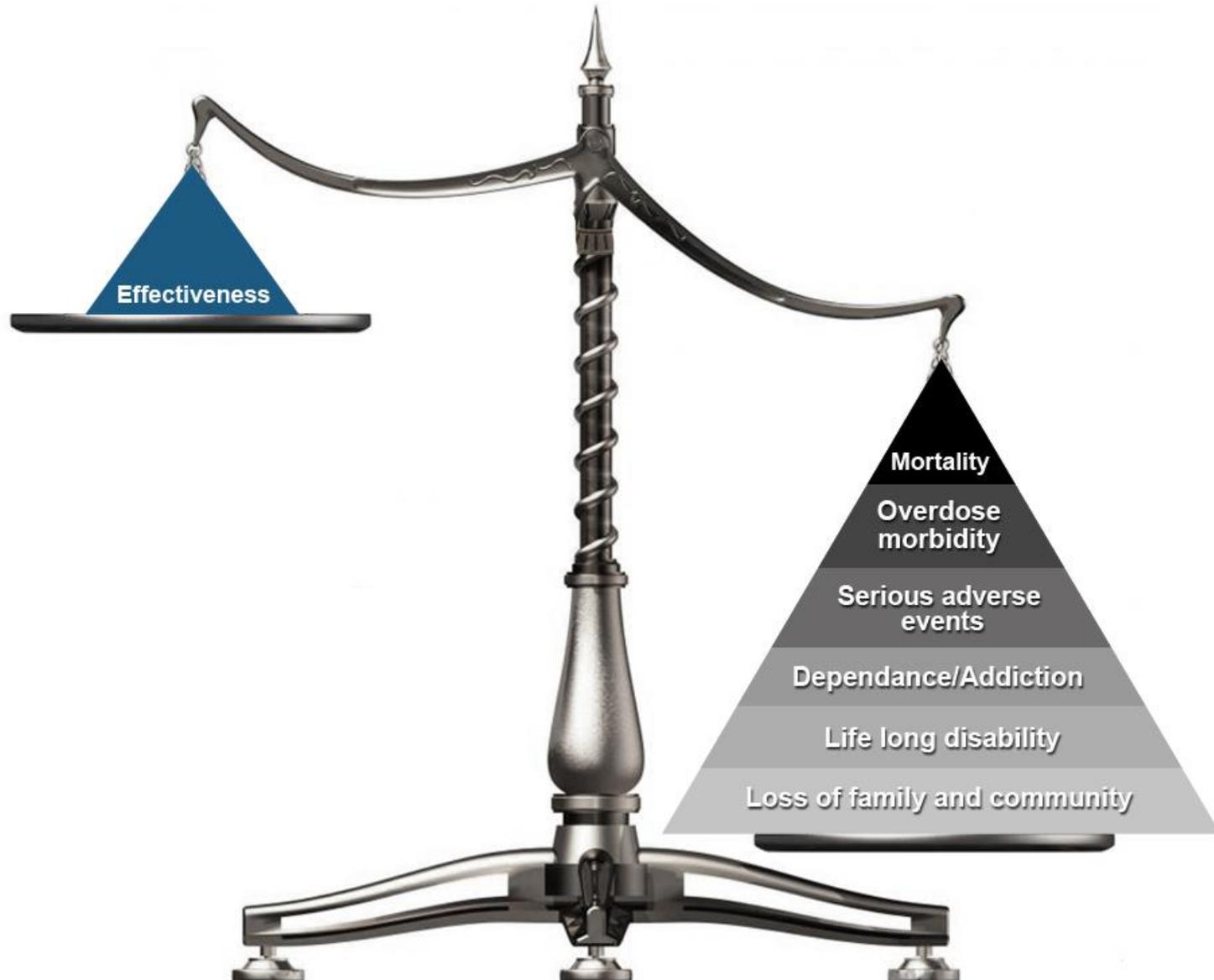
**"Tell your wife that the X-ray shows that you do have a backbone."**

# Provider Responsibility



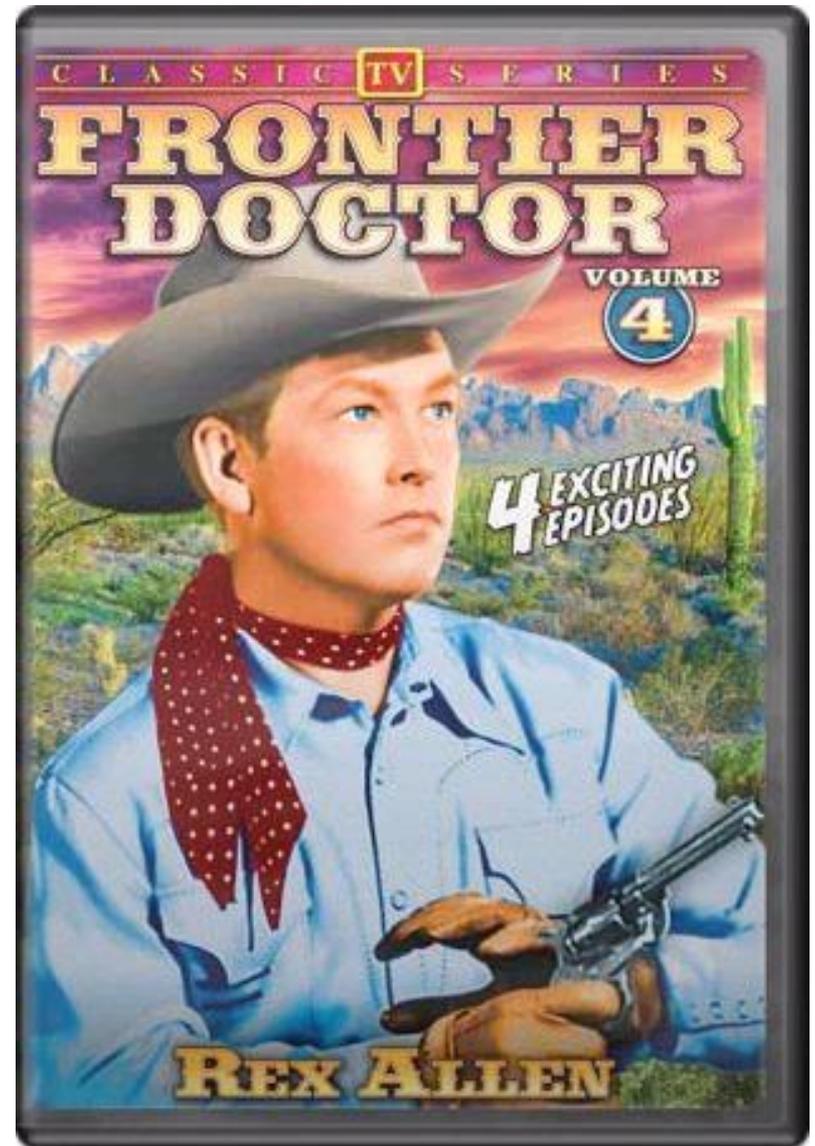
# Risk/Benefit of Opioids for Chronic Non-Cancer Pain

-Franklin; Neurology; Sept 2014-Position paper of the AAN-

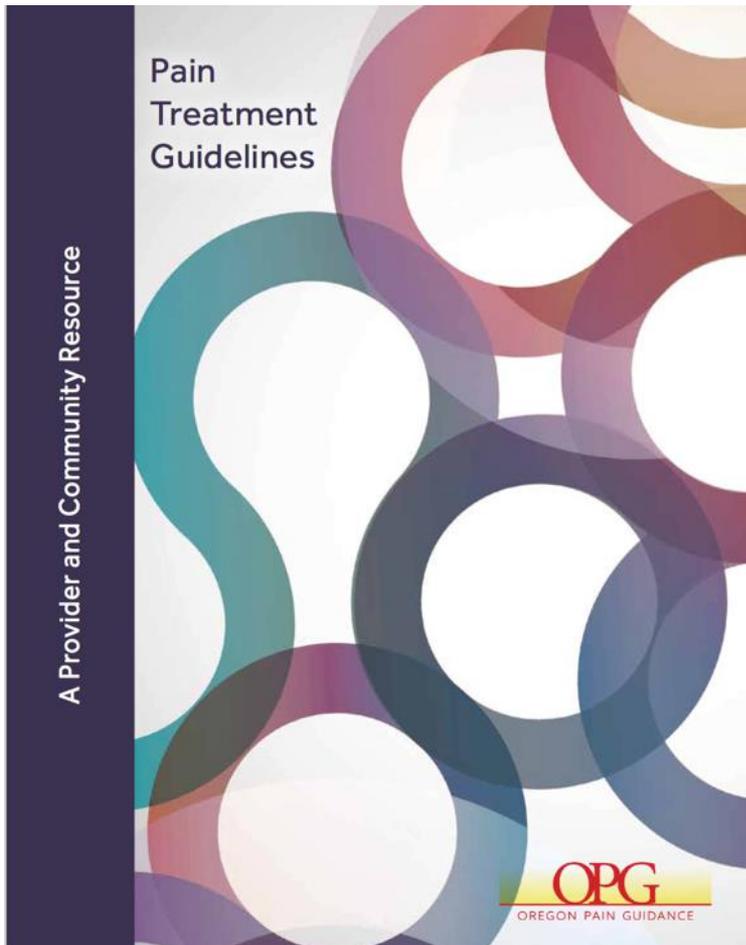


# Providers

- Some providers are isolated from current “best practices.”
- Prescribers often don’t really believe the data concerning opioid management.



# Revised OPG guidelines



- How is it different?
  - Operationalize the CDC guidelines
  - Focus on the practicing professional
  - All subjects updated with latest information
  - Recognition of the importance of: Acute Pain, Pain Specialty, Tapering and more

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## TREATING ACUTE PAIN (0–7 Days Following Trauma or Surgery)

In most cases, acute pain can be treated effectively with non-opioid or non-pharmacological options (e.g., elevation, ice). With more severe acute injury (e.g., significant trauma, fracture, crush injury, postoperative pain, extensive burns), short-term use of opioids may be appropriate. Initial opioid prescriptions should not exceed seven days for most situations, and two to three days of opioid medication will often suffice.<sup>7,8,9,10,11</sup> If an individual needs medication beyond three days (or beyond the average expected time for initial healing) a reevaluation of the patient should be performed prior to further opioid prescribing. Physical dependence on opioids can occur within only a few weeks of continuous use, so great caution needs to be exercised during this critical recovery period.

### Assessment

- › Review medical history, including records from previous providers, when available.
- › Administer a physical exam to determine diagnosis and appropriate care. Document baseline function and baseline pain.
- › Determine whether the injury can be treated without opioids or if the severity of the injury justifies the risks of opioid therapy.

### Non-Opioid Treatment

- › Help patients set reasonable expectations concerning recovery from the injury. Educate them about the healing process and the benefits of appropriate activity.
- › Reassure the patient that some pain is to be expected and that it will subside in time. Over-the-counter (OTC) medications will provide significant relief from pain in many situations and can be relied upon for ongoing pain relief after the acute period is over.
- › Patients should improve in function and pain and resume their normal activities in a matter of days to weeks, depending upon the diagnosis. Reevaluate those who do not follow the normal course of recovery.

### Opioid Treatment

- › If the severity of the injury indicates that limited opioid treatment is appropriate, *before prescribing*, you:
  - Should perform a simple screen for substance abuse (e.g., ORT). Individuals in active recovery are at high risk of being “triggered” by even small amounts of opioids, and you can inadvertently put them in harm’s way with your prescription. Those with a history of attempted suicide or overtaking opioids should be prescribed the least amount of medication necessary.

# Acute Pain Flow Sheet

FOR THE EVALUATION AND TREATMENT OF ACUTE PAIN



## TREATING CHRONIC PAIN (Pain Lasting More Than Three Months)

For almost 30 years, common medical wisdom held that most individuals experiencing chronic pain would benefit from daily doses of opioids. Medical knowledge has matured, and our understanding of the risk/benefit of chronic opioid use has changed, such that we now know the risks of chronic use are significant, and the benefits are often modest.<sup>14</sup> Most patients with chronic non-cancer pain can be managed with non-opioid modalities or occasional opioid use.

The problem we now face is the “legacy patients,” those who have been on high-dose daily opioids for years, sometimes passing from provider to provider. Many primary care practitioners care for these patients, though they may not have initiated the opioid treatment regimen. These individuals deserve compassionate care and may sincerely believe that they could not cope without continuing their medication regimen. However, current best practice suggests that a slow-dosage reduction will improve the quality of life for the majority of patients.

The characteristics that contribute to dose escalation for chronic pain patients are the same as those which predispose to addiction. When appropriate screening, safe monitoring, and dose reduction are instituted, some of these individuals will be found to have the true diagnosis of substance-use disorder. Co-occurring mental health disorders related to trauma, depression, and anxiety may be revealed, as well. Management of these emerging disorders may require a shift in treatment modalities or a specialty-care referral. A strong partnership with behavioral health experts is essential to managing these patients.<sup>15</sup>

Involvement in daily activities and improved quality of life are the goals of chronic pain treatment. Monitoring function, rather than simply measuring the perception of pain, is the method of assessing patient improvement. Many patients do better after tapering and are grateful to “have their lives back” despite their initial fears of dose reduction.

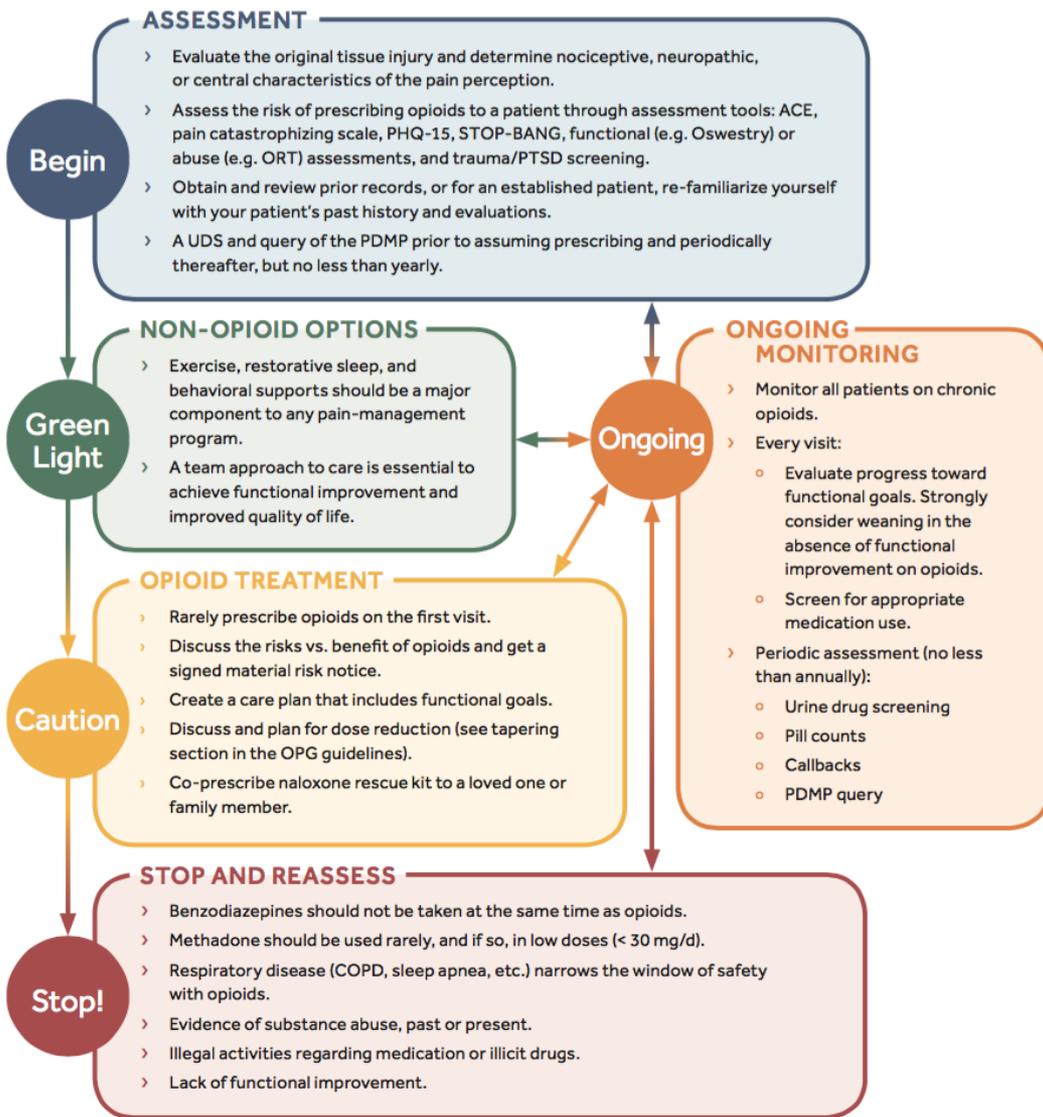
### Categorization of Chronic Pain Patients

It may be helpful to think of chronic pain patients as having pain belonging to one of three broad categories: peripheral (nociceptive), neuropathic, and central (non-nociceptive).

- › **Nociceptive pain:** Pain whose etiology is ongoing peripheral inflammation or damage. This pain may be responsive to medications or procedures.

# Chronic Pain Flow Sheet

FOR THE EVALUATION AND TREATMENT OF CHRONIC NON-CANCER PAIN



# Opioid Tapering Flow Sheet

## START HERE

Consider opioid taper for patients with opioid MED > 90 mg/d or methadone > 30 mg/d, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

- 1 Frame the conversation around tapering as a safety issue.
- 2 Determine rate of taper based on degree of risk.
- 3 If multiple drugs involved, taper one at a time (e.g., start with opioids, follow with BZPs).
- 4 Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

## OPIOID TAPER

### Opioids

Basic principle: For longer-acting drugs and a more stable patient, use slower taper. For shorter-acting drugs, less stable patient, use faster taper.

- 1 Use an MED calculator to help plan your tapering strategy. Methadone MED calculations increase exponentially as the dose increases, so methadone tapering is generally a slower process.
- 2 Long-acting opioid: Decrease total daily dose by 5–10% of initial dose per week.  
Short-acting opioids: Decrease total daily dose by 5–15% per week.
- 3 See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
- 4 After ¼ to ½ of the dose has been reached, with a cooperative patient, you can slow the process down.
- 5 Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

### MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and transdermal)
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone Chronic	4mg
Oxycodone	20mg
Oxymorphone	10mg
Tapentadol	75mg
Tramadol	300mg

**Morphine Equivalent Dosing (MED) Calculator:**  
[agencymeddirectors.wa.gov/mobile.html](http://agencymeddirectors.wa.gov/mobile.html)

# Benzodiazepine Tapering Flow Sheet

## START HERE

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, or concurrent opioid use.

- 1 Frame the conversation around tapering as a safety issue.
- 2 Determine rate of taper based on degree of risk.
- 3 If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with BZPs).
- 4 Set a date to begin and a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

## BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support will be critical. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

### SLOW TAPER

- 1 Calculate total daily dose. Switch from short-acting agent (alprazolam, lorazepam) to longer-acting agent (diazepam, clonazepam, chlordiazepoxide, or phenobarbital). Upon initiation of taper, reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
- 2 Schedule first follow-up visit two to four days after initiating taper to determine if adjustment in initial calculated dose is needed.
- 3 Reduce the total daily dose by 5–10% per week in divided doses.
- 4 After  $\frac{1}{4}$  to  $\frac{1}{2}$  of the dose is reached, you can slow the taper with cooperative patient.
- 5 With cooperative patients who are having difficulty with this taper regimen, you can extend the total time of reduction to as much as six months.
- 6 Consider adjunctive agents to help with symptoms: trazodone, hydroxyzine, neuroleptics, anti-depressants, clonidine, and alpha-blocking agents.

### RAPID TAPER

- 1 Pre-medicate two weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-benzodiazepines. Follow the usual safeguards (lab testing and blood levels) when prescribing these medications.
- 2 Utilize concomitant behavioral supports.
- 3 Discontinue current benzodiazepine treatment and switch to diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.
- 4 Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.

### Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg
Phenobarbital (barbituate)	53 – 118 h	30 mg

## SPECIALTY CARE FOR TREATING CHRONIC PAIN

Pain, in all its manifestations, is an aspect of most illnesses, as well as a normal part of the aging process. As such, its treatment is an essential component of primary care. The treatment of pain, especially acute pain, may at times require the use of opioids, which have significant risks in addition to their benefits. After years of misguided provider education, millions of patients in our healthcare system are on opioids for inappropriate diagnoses and at inappropriate doses (legacy patients or the lost generation). Even the most skilled providers may at times need specialty care to assist in the management of these complex patients. This guideline will address the following questions:

*What kinds of patients are most appropriate for specialty care?*

*What is the screening and evaluation expected for these high-risk patients?*

*What kind of oversight should exist to assure consistent and safe management of these patients?*

*Who is a pain specialist?*

*What kind of services should constitute a specialty-care clinic?*

*What are the expectations and long-term goals for such patients?*

### Patient Selection for Pain Specialty Care

- › Patients on high doses (>90 mg MED) or unsafe drug combinations (e.g., benzodiazepines + opioids) who either refuse dosage reduction, exhibit substance-use disorder behaviors, or have significant behavioral conditions beyond the scope of the provider, may require referral to a pain specialty program or substance abuse program for evaluation or ongoing care.
- › Any chronic pain patient beyond the expertise of the primary care provider.
- › The Oregon Medical Board (or similar state boards), UW “Tele-Pain” (or similar regional peer education), can be excellent resources for helping manage difficult patients in lieu of specialty referral.

### Screening and Evaluation

All patients being prescribed chronic opioids need screening for behavioral, respiratory, and other psychosocial risks because, by definition, the specialty-referral clients are at higher risk. A more thorough evaluation of such patients is to be expected:

- › Ongoing functional evaluation: PEG, Oswestry or similar, monitored over time.
- › Respiratory: **S T O P B A N G** or similar, with appropriate referral or further evaluation as necessary.

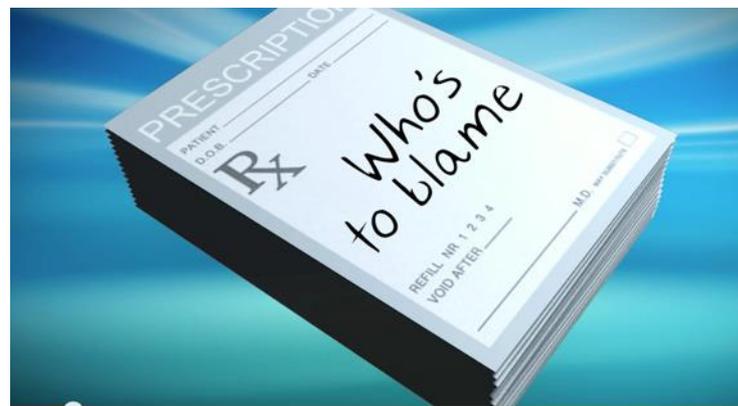
# The 3 legged stool for community engagement: The 3 Ps

- Providers
- Patients
- Public





# Public Education



# MOVING THROUGH CHRONIC PAIN A COMMUNITY FORUM

## WHEN

THURSDAY, MAY 19TH, 2016 4:00-8:00 PM

## WHERE

RAMADA HOTEL AND CONVENTION CENTER  
2250 BIDDLE ROAD, MEDFORD, OREGON 97504

## WHO

ANYONE AFFECTED BY CHRONIC PAIN

**FREE  
TO THE  
PUBLIC**

## SPEAKERS FOR THE EVENT

SAM QUINONES JOURNALIST AND AUTHOR "DREAMLAND- The True Tale of America's Opiate Epidemic"

DR. CSABA MERA MEDICAL DIRECTOR OF REGENCE BLUE CROSS

KEVIN VOWLES ASSOCIATE PROFESSOR OF CLINICAL PSYCHOLOGY, UNIVERSITY OF NEW MEXICO









## **The Dissemination concept**

Critical mass: If enough providers, and the public, understand the guidelines, word of mouth and peer pressure will lead to adoption.

**Pain management guidance and tools for patients, families and healthcare professionals.**



Since 2008 the number of deaths from overdoses has exceeded deaths due to motor vehicle accidents in the U.S.



Patients and Families

**SELECT »**



Healthcare Professionals

**SELECT »**



**Oregon Pain Guidance (OPG)** is a group of healthcare providers from Jackson and Josephine Counties in Southern Oregon, who are working together on standardizing community guidelines and best practices for treating patients with chronic pain. An improved quality of life for people with chronic pain can be achieved when patients and their families work closely with their healthcare providers. This website provides educational information, news, community resources and upcoming events for both the public and healthcare providers.

# Acceptance of the guidelines: Summary

- Educate the prescribers re current best science:
  - Outreach, conferences
- Provide additional non-opioid supports, and tools
  - Behaviorists, consultation (dog and pony), provide therapeutic alternatives
- Educate and support their patients (and staff)
  - Media, website, forum
- Assist them in data gathering: PDMP dashboard, CCO information, EMR data, etc
  - Can't solve what you can't see
- Institute and ensure adherence to broadly accepted guidelines (CCO, Prov, etc)
- Utilize licensing Board clout when necessary

# The paradigm shift

