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PAIN MANAGEMENT CONTINUES TO POSE CHALLENGES TO CLINICIANS

Nationwide, many of us are aware of the increase in patients with pain diagnoses and dramatic upswing in drug misuse, abuse and overdose. The press recently has publicized several high-profile celebrity drug overdoses. In 2013, the Oregon legislature adopted Senate Bill 384, which allows family members, emergency service personnel, or others who have received proper training to use automatic injectors of naloxone (opiate antagonist) to rapidly reverse respiratory suppression and avoid heroin overdose.

In 2010, almost one in 20 adolescents and adults—12 million people—used prescription pain medication when it was not prescribed for them. The National Institute of Drug Abuse (NIDA) reports that abuse of prescription medications risks heroin use and states that, "One out every 15 people who take a non-medical prescription pain reliever will try heroin within 10 years."

Oregon currently has the highest rate of opiate abuse among those under 25 in the nation. More than half of all drug overdoses in Oregon are associated with the prescription medications OxyContin and Vicodin. Of all prescriptions written in 2012, 50 percent were written specifically for opiates. This number equates to roughly one prescription for every resident in the state.

In 2011, the Oregon Prescription Drug Monitoring Program (PDMP) was established to provide clinicians the ability to review a patient's controlled substance prescription history to avoid over prescribing and diversion. However, since its implementation, many prescribers have been slow to utilize the database. A recent study (Feb 2013) conducted by Dr. Katherine Hammond DNP, FNP-C, Linfield School of Nursing, found that of those participants surveyed, only 25 percent were using the PDMP when they considered prescribing an opiate.

Understanding all of this, there are patients who have legitimate need for proper treatment of their pain and deserve compassionate evidenced-based care from advanced practice registered nurses (APRNs) with prescriptive authority. The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) published *The Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non Cancer Pain in 2012*. This evidence-based guideline made the following 14 specific recommendations for providers:

1. Conduct a complete **initial history and physical** with testing to define the patient problem. Further, determine the patient's risk for substance abuse, misuse, or addiction.
2. Inform patients of the risks and benefits associated with opioid therapy and conduct an initial discussion that

includes; treatment goals (patient and provider), expectations (patient and provider), the potential risks and harms, alternatives to opioid treatment, and the common opioid adverse reactions (constipation, nausea, sedation, and serious risks of abuse, addiction, and overdose).

a. Patients should be informed that, in addition to the opiate medication, there will be an expectation that they will also take part in a multimodal approach to care including physical therapy, massage, acupuncture, and other non-opioid based treatment approaches.
b. A **written plan and agreement** must clarify expectations for the patient, family members, and other clinicians. Provisions of the plan should include:
   i. One designated pharmacy.
   ii. One prescriber.
   iii. Random urine drug screens.
   iv. Specific follow up expectations.
   v. Enumeration of behaviors that will lead to discontinuation of opioids.

3. Initial treatment to be considered for a "trial period" ranging from several weeks to several months. **Clinicians need to review the therapy** based on the unique clinical outcomes of the patient and their progress toward meeting therapeutic goals. The **decision to continue with long-term therapy should be based on the success of the initial trial** meeting both patient and the providers' goals.
4. There is **no evidence to support one opioid over another** in choosing options for patients. It was strongly recommended to start at a low dose, titrate medication slowly, and that shorter acting agents are always preferred for initial therapy.
5. Patient monitoring during therapy should include **documentation of periodic reassessment** of all patient risks and benefits to include; recording the level of pain intensity and functionality, assessment of progress towards patient goals and the presence of adverse events including periodic urine drug screens to monitor adherence to avoid diversion.
6. For providers considering treating **high-risk patients**, or patients with a

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history of suspected former or current drug or substance abuse, significant psychiatric issues and or serious aberrant drug related behaviors, the **recommendation is to refer these patients** to the appropriate credentialed Mental Health, Addiction, and Pain Management specialists.

7. The panel stressed that **therapy should be discontinued if patients are, "known to divert opioids or those engaging in serious aberrant behaviors."** Further, they **recommended the use of PDMP** to help identify patients who obtain drugs from multiple providers and locations.
8. Adverse reactions to opioid therapy include:
   a. **Constipation** — Providers should start a bowel regimen prior to starting opioid therapy that includes; increased fluids, fiber, stool softeners, and or laxatives.
   b. **Nausea and vomiting** — This is common and clinicians should consider oral and rectal agents.
   c. **Sedation** — Patients must be warned about the levels of sedation that are potentially dangerous and life threating.
   d. **Respiratory depression** — This can occur with these drugs particularly if they are increased too quickly or combined with other agents. Patients with obstructive sleep apnea and other cardiopulmonary conditions are at a greater risk for respiratory distress and potential death.
9. Use of **multidisciplinary pain management modalities** should be considered whenever possible to include physical, vocational, or psychological therapies.
10. **Cognitive impairment is typical** with opioid therapy. APRNs need to make patients aware that they may be found criminally negligent for being impaired at work, or while driving, despite maintaining a prescription for the medication from their provider. This is particularly important for those who operative heavy equipment, bus drivers, and pilots.
11. Continuous access to a **primary care provider (PCP) gives patients continuity and care coordination.** PCPs are encouraged to consult with interdisciplinary teams for pain management when any additional skills or resources may be needed that the PCP is unable to provide.
12. **Little evidence supports the concept of "break through pain."** APRNs should avoid writing for "as needed" doses of additional opioid medications. If providers are finding that patients are having increased or continued pain, it is recommended to reevaluate the current treatment plan and consider additional testing, follow up visits, and consultation rather than additional "as needed" opioids. The provider should consider non-pharmacologic options and non-opioid medications prior to the addition of more opioid therapies.
13. **Women of childbearing age should be counseled about the risks of opioid therapy during pregnancy and after delivery.** If opioid therapy is going to be continued during pregnancy, the provider should

be prepared for complications of the newborn to include electrocardiogram changes (prolonged QT syndrome) and opioid withdrawals symptoms. Coordination of an appropriate neonatal care provider should be discussed prior to delivery of the infant.

14. **Maintain currency and knowledge** of federal and state laws, regulatory guidelines, and your local health agency policies in regards to opioid therapy and APRN scope of practice.

The Oregon Nurse Practice Act (NPA) has specific rules around prescribing for controlled substances and pain management in Division 56 under section **851-056-0026**. These rules are in congruence with many of the APS and AAPM guidelines.

Washington State's Agency Medical Director's Group (AMDG) in 2010 developed an opioid dosing guideline to address the crisis in drug abuse, misuse, and diversion in their state. Differences between the Oregon NPA and the Washington NPA include the requirement for Washington prescribers to complete:

1. Four hours of continuing education on pain management with every two yr. licensing cycle.
2. Mandatory consultation with pain management specialists, when patients reach a specific morphine equivalent dose (MED) higher than 120 mg. The commission developed a calculator that helps providers convert opioid medications to the morphine equivalent (Available at the AMDG website).

STAKEHOLDER MEETINGS PLANNED

Understanding this is a complicated and continually evolving issue, the Oregon State Board of Nursing (OSBN) is considering recommendations for possible revision to Division 56 around controlled substances and pain management. A stakeholder meeting was held on May 29 to gather feedback; another stakeholder meeting is scheduled July 31, 2014, from 2 - 4 p.m. at the OSBN office. Discussion will likely include:

1. Considering CE requirements for pain management tied to licensing renewal for APRNs
2. Incorporating a MED threshold for referral
3. Definition of "Pain Management Specialist"
4. Rule language recommendations for independent pain management practices
5. Rural and urban constraints
6. Required use of the PDMP

Invitation for the meetings will be sent through the OSBN Advanced Practice list-serv, however those interested may contact the OSBN at *ginger.simmons@state.or.us* if you would like to be included.

For more information on Pain Management, visit the following links:

- OSBN Division 56: *http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_056.html*
- OSBN Policy on Pain Management: *http://www.oregon.gov/OSBN/pdfs/policies/pain_management.pdf*
- Oregon Regulatory Statue 689.681 on Naloxone: *https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors689.html*
- Oregon Prescription Drug Monitoring: *http://www.orpdmp.com/*
- Washington State AMDG 2010 Policy: *http://www.agencymeddirectors.wa.gov/opioiddosing.asp*
- NIH National Institute on Drug Abuse: *http://www.drugabuse.gov/related-topics/trends-statistics/infographics/abuse-prescription-pain-medications-risks-heroin-use*