Chronic Pain Management:
Long-Term Opioid Therapy –
Who, How When?

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Disclosure

Andrew Bertagnolli, PhD has no financial interest or other relationship with the manufacturers of any commercial product and/or providers of commercial services discussed in this educational presentation nor with any commercial supporters of this course.
Learning Objectives

1. Utilize effective, safe and culturally appropriate treatments to manage chronic pain
2. Use KP on-line patient education and treatment resources when caring for members with depression and chronic pain
# CMI Pain Management Advisory Group

<table>
<thead>
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Types of Pain

• Acute Pain
• Chronic Pain
  – cancer related
  – non-cancer related (benign)
Acute Pain

- Elicited by trauma (injury), surgery, procedures
- Short duration
- Remits when tissue is healed
- Improved with immobilization or rest
Chronic Pain

- Not always result of trauma
- Worsened by factors apart from original cause
- Long lasting
- Cancer-Related
  - associated with progressive disease
- Non-Cancer Related
  - often lack objective findings
Pain in past month among adults 20+, 1999-2002

- Age
  - 20-44 years
  - 45-64 years
  - 65 years and over

- Sex
  - Men
  - Women

- Race and Hispanic origin
  - White only, not Hispanic
  - Black only, not Hispanic
  - Mexican

- Percent of poverty level
  - Below 100%
  - 100%-less than 200%
  - 200% or more

SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2006, Figure 28.
Data from the National Health and Nutrition Examination Survey.
Pain Prevalence and Duration by Age

20-44 years
(25% reported pain)

45-64 years
(30% reported pain)

65 years and over
(21% reported pain)

Sources: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2006, Figure 29.
Data from the National Health and Nutrition Examination Survey.
The Pain is in the Patient’s Brain
(not imaginary in their head)

Sensory perception is a complex process of peripheral nerves and neurochemicals terminating in the brain.
Impact of Chronic Pain

• Routinely Associated with:
  – Decreased:
    • Physical functioning
    • Psychological functioning
    • Socio-occupational functioning
    • Workplace productivity
    • Quality of life
  – Increased:
    • Workplace absenteeism
    • Healthcare use
Learned Helplessness
Learned Helplessness

When an organism has been trained to behave helplessly.

**Learned helplessness theory** is the view that clinical depression and related prolonged emotional disruption result from a perceived absence of control over the outcome of a situation (Seligman, 1975).
Voices of Our Members

• Add mov file Here
The Concept of Complete Care

- Evidence-Based
- Patient-Centered
- Multi-Disciplinary
- Complete Continuum
- Emphasis on Self-Management
Overall Treatment Approach

• In deciding the best treatment approach, the following should be considered:
  – Maximizing functional status
  – Reducing pain
  – Addressing associated symptoms (eg: sleep, fatigue and mood)

• Designing a treatment plan should involve an individualized assessment and be multifactorial including:
  – Self-management
  – Physical activity/movement
  – Medications
  – Interventional approaches
  – Psychological approaches
  – Complementary-alternative (CAM) approaches
Chronic Pain Management Model

Cognitive Behavioral Therapy
Pharmacological Management and Other Rx

Physical Therapy
Complementary & Alternative Medicine

Patient Self Care

KAISER PERMANENTE® thrive
What makes Chronic Pain So Frustrating?

- Lack of objective findings
- Causal factor is often elusive
- The condition can effect multiple areas of function
  - socio-occupational
  - physical
  - sleep
  - psychological
- Not using a disease self-management approach
  - treating chronic pain with acute pain treatments
    - focusing on curing pain rather than improved function
    - over reliance on rest as treatment
Promote Good Communication

- Validate patient’s pain
- Set realistic treatment goals
  - being 100% pain free is not the goal
  - improved functional status and less suffering is the goal
- Address major barriers to pain management
Support the Active Role of the Patient

- Self-care is integral to successful pain management
- Encourage and support patient in active self-management therapies to:
  - improve symptom management
  - promote independent functioning
  - enhance psychosocial well-being
Tasks for Patients with Chronic Illnesses

- Medical management of the condition
  - taking medications, changing diet, etc.
- Creating and maintaining new meaningful life roles
  - jobs, family, friends
- Coping with the emotional sequelae of having a chronic condition
  - anger
  - fear
  - frustration
  - sadness
Specific Beliefs Impact Pain

- Patients who interpret pain as indicative of more damage (Vlaeyen, Kole-Snijders, Boern & van Eek, 1995)
  - more avoidant
  - more disabled

- Catastrophic interpretations of pain
  - higher levels of depression (Rosensteil & Keefe, 1983)
  - increased affective distress (Geisser, Robinson, Keefe & Weiner, 1994)
Key Messages

- Pain is Real
- Hurt ≠ Harm
- 100% pain free may be an unrealistic goal
- Can help improve pain MANAGEMENT
- People are not helpless in managing pain
- Pain does not have to be all encompassing

- Multidisciplinary treatments are most effective
- Treatment involves
  - Physicians
  - Psychologists
  - Physical Therapists
  - Nurses
  - Health Educators
Opioids Taming the Beast
Give me the PRECIOUS!
Typical Treatment Plan . . .
Or lack thereof

Not an Evidence-Based Approach!
Member Perspective

Insensitive Care Ward

John West
Pain Medication Facts

Prescription opioid analgesics, tranquilizers, and stimulants are frequently abused

Prescription medications are abused more frequently than cocaine, hallucinogens, inhalants, and heroin combined

Lack of Training:

• Primary Care in pain management and addiction issues
• Addiction Medicine and Psychiatry in pain management issues
  • Pain Medicine in addiction issues
Definition of Terms

• Physical Dependence
  – Normal physiological consequence of extended opioid therapy exposure
  – In isolation ≠ Addiction

• Tolerance
  – Physiological state resulting from regular use
  – Normal physiological consequence of extended opioid use
  – Even in conjunction with physical dependence ≠ Addiction
More Terms

• Addiction
  – Primary chronic, neurobiological disease with genetic, psychological, social and environmental factors influencing development and presentation
  – Not a predictable drug effect
    • Unlike tolerance and physical dependence
  – Idiosyncratic adverse reaction in biologically and psychosocially vulnerable individuals.
  – Characterized by:
    • Impaired control over drug use
    • Craving
    • Compulsive Use
    • Continued use despite harm
  – Function decreases as dose increases
Just One More.....

- Psuedoaddiction
  - Term to describe patient behaviors that may appear as a result of undertreated pain
  - May be symptoms that are also associated with medication misuse
  - These behaviors diminish when pain is adequately treated
  - Function increases as dose increases
Indications for Long-Term Opioid Therapy

• Moderate to severe pain which has failed adequate trials of non-opioid therapies or non-opioid therapies are contraindicated

• When short-term trials of opioids have evidenced functional status

• Should be complimentary to other therapies

• Not recommended as a sole therapeutic intervention
Opioid Therapy: Prescribing Principles

• Drug Selection: Elements to Consider
  – Severity of pain, previous exposure, availability, patient’s preference, renal/liver function, cost

• Dose to Optimize Effects
  – Fixed schedule (or around-the-clock) vs as-needed dosing; rescue doses

• Treat Side Effects
  – Goal: balance between analgesia and side effects

• Manage the Poorly Responsive Patient
  – Consider a variety of alternative strategies
Opioid Therapy: Drug Selection

- Advantages of Long-Acting Opioids
  - Fewer peaks and troughs
    - sustained pain relief
  - Dosed less often, improved adherence
  - Potentially improved patient satisfaction and quality of life
Problems with Short Acting Opiates

- Sedation, Euphoria, Dysphoria
- Pain Returns/Hypersensitization Tolerance Develops

Drug Level in System

Hours after administration:

- 0: Relief
- 4: Relief
- 8: Relief
- 12:

Kaiser Permanente thrive
Long Acting Opiates – Smoother Pain Control

Sedation, Euphoria, Dysphoria

Pain Returns/Hypersensitization Tolerance Develops

Drug Level in System

Relief

0 4 8 12
Hours after administration
Opioid Therapy: Managing Side Effects

- **Common**
  - Constipation
  - Somnolence, mental clouding

- **Less Common**
  - Nausea
  - Myoclonus
  - Itch
  - Urinary retention
  - Sweating
  - Amenorrhea
  - Sexual dysfunction
  - Headache
Methadone Benefits

• Benefits
  – Both a µ-opioid receptor agonist & NMDA receptor antagonist
    • May be less prone to cause hyperalgesia
  – Less constipation (perhaps)
  – Reduced tolerance to analgesic effects (perhaps)
Methadone Cautions

• Cautions
  – Elimination half-life (8-130h) is longer than duration of analgesic action (4-8h)
    • Requires up to 4x per day dosing – watch for systemic accumulation
  – Metabolized by hepatic cytochromes CYP3A4 & CYP2D6
    • Many common medications can inhibit metabolism
      – Ciprofloxacin, fluconazole, fluoxetine
  – Potent blocker of IKr channel
  – Associated with:
    • QTc prolongation
      – Unclear as to association with dose
    • Torsade de pointes
      – Clearer relationship to dose
  – Use caution in patients with decreased respiratory reserve
    • COPD, asthma, sleep apnea, severe obesity
  – Carefully select dose and slowly titrate
    • even in patients who are opioid-tolerant.
  – Closely monitor patients when:
    – Converting from other opioids to methadone
    – Changing the methadone dose
Risk factors for methadone-associated QT interval prolongation

Higher doses (>200 mg/day)

- Prior cardiac disease (cardiac conduction abnormalities, CHF bradycardia)
- Concomitant use of methadone with other drugs that prolong the QT interval
  - Antidepressants
  - Anti-psychotics
  - Mood stabilizers
  - Certain antibiotics
- Electrolyte disturbances
  - Hypokalemia
  - Hypomagnesemia
- Concomitant use of drugs that may cause electrolyte imbalances (eg: diuretics)
- Concomitant use with drugs which might act as inhibitors of methadone metabolism
Functional Pain Scale

- Gives meaning to the NRS
- Prevents “Catastrophizing”
- Helps you speak the same language
- Works for you
  - behavioral modification
- holds patient accountable
- aids in treatment planning

Christine Evans, PhD - SCAL
Pain Score Recorded in VITAL SIGNS
Pain Score over time in FLOWSHEETS
Brief Pain Inventory

• **What is it?**
  - A validated, self reporting tool to screen pain
  - Originally developed in 1989 by Dr Charles Cleeland at MD Andersen for use in Cancer pain patients.
  - Available in Long and Short form

• **Why use it?**
  - Trackable in Health Connect
  - Proven Validity
  - Available in more than 36 languages
  - Copyright obtained by KP
Brief Pain Inventory Scores in
QUESTIONNAIRES

[Image of a computer screen showing a questionnaire for the Brief Pain Inventory]
Patient Selection & Screening

- **Vulnerabilities for Opioid Misuse**
  - Personal history of substance abuse
  - More recent the history the greater the risk
  - Family history of substance abuse
  - Untreated psychiatric illness
    - Bipolar disorder, schizophrenia, etc.
  - Ongoing psychological distress
    - Depression, anxiety, etc
  - Cigarette dependency
  - Younger age
  - History of pre-adolescent sexual abuse
  - History of legal problems
  - Poor social support

- **Screening Tool**

- **Screener and Opioid Assessment for Patients in Pain (SOAPP-5)**
  - Should not be used to ‘screen patients out’
  - Not a lie-detector – use in conjunction with other clinical findings
  - Kaiser Permanente reached an agreement with copyright holder Inflexxion, Inc. to use throughout Program
  - Can be used to structure treatment
SOAPP®-SF

• In-serviced all clinicians
• Encouraged use in all patients on long-term opioid therapy
• Consistent documentation in EMR
• Proposed reportable metric
Follow Up Based Upon Risk Level

• High Risk
  – Consideration of other therapies or interventions prior to starting long-term opioids is strongly recommended (e.g.: psychological treatment, consultation with pain management specialists, etc.)
  – If long-term opioids are prescribed a strict follow-up procedure is strongly recommended. Which should include
    • use of medication agreements/opioid therapy plans
    • regular use of urine toxicology screening at each follow-up visit
    • initially refill intervals are recommended to be short in length (e.g.; every two weeks)
    • early signs of aberrant behaviors and violations of the medication agreement/opioid therapy plan should result in a re-evaluation of the treatment plan

• Low Risk
  – Careful and thoughtful planning is strongly recommended
  – Advising patients to use self-management strategies in conjunction with opioids if they are not already doing so is strongly recommended
  – Efficacy of opioid therapy recommended to be reassessed at least every six months
  – Urine toxicology screenings and update of the medication agreement/opioid therapy plan is recommended every 12 months
Education/Informed Consent & Role of Medication Agreements

- Patient Education and Informed Consent
  - Goals and Expectations for Treatment
    - Focus on Function NOT Pain Intensity
    - Studies show that 30% decrease in pain intensity is achievable with medications alone
  - Physical Dependency, Tolerance & Addiction
  - Other Adverse Events
    - Constipation, Drowsiness, Sexual dysfunction, Mood Disruption, Sleep Disturbance, Hyperalgesia
  - Patient Responsibilities
    - Monitoring prescriptions
    - Adherence to treatment plan
  - Legal Issues
  - How to take and safeguard medications
  - Prophylactic treatment of common adverse events
    - Constipation

- Medication Agreement
  - Review key informed consent issues
  - One prescriber
  - One pharmacy
  - How to take and safeguard medications
  - Daily dose parameters
  - Refill Procedure
  - Use of Routine Urine Drug Screenings
  - Consequence of Non-Adherence
Informed Consent for Opioid Therapy

Your doctor has determined that opioid therapy is right for you. The information below is part of the informed consent process. Please read it carefully. Be sure to ask your doctor about any part that you do not understand.

What are opioids?
Opioids are strong medicines that can help manage your chronic pain. They work best when you use them together with self-care and other treatments. The goal of opioid therapy is to lessen pain while helping you do everyday activities.

What are the benefits of taking opioids?
Opioids are an effective way to manage chronic pain. However, they are powerful medications and can be very dangerous if not taken the way your doctor tells you. If you cut back on or stop the medicine abruptly (cold turkey), you may develop withdrawal symptoms.

What are the risks of taking opioids?
Opioids can cause addiction. The risk is higher in people who have a history of addiction or other substances or a family history of addiction. If you have a personal history or family history of substance abuse or if you have questions about your opioid medication, talk to your doctor.

What if I can’t or don’t want to take opioids?
If opioids are not for you, work with your doctor for other medicines and treatments to help manage your pain.

What if I have other questions?
If you have questions or would like more information on opioids, call your doctor or another health professional.

What kind of opioid will my doctor prescribe?
Your doctor and you will decide which medicines will work best for you. There are two options:

- Short acting
- Long acting

**Short acting**
- Hydrocodone (Vicodin, Lorcet, Norco)
- Oxycodone (Percocet, Percodan, OxyContin)
- Imitrex (Sumatriptan)
- Xanax (Alprazolam)
- Benadryl (Diphenhydramine)
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Concept of Opioid Therapy Trials

• View opioid therapy as a trial with an N=1
  – Initiation Phase:
    • Objective: to find the medication(s) that provide the best pain relief with the fewest side effects to allow for improvements in functional status
  – Titration Phase:
    • Objective: to adjust the dose to achieve satisfactory pain relief and functional improvement and tolerable side effect profile
  – Maintenance Phase:
    • Objective: maintain reliable pain control, while evidencing improvements in functional status by repeating a routine schedule
Assessing Therapy

• Four A’s
  – Analgesia
    • Reminding patients that goal of therapy is not “0”
  – Adverse Events
  – Activities of Daily Living
  – Adherence
    • Aberrant Drug-Taking Behaviors
    • Illegal or Criminal Behavior
    • Dangerous Behavior
    • Behavior Suggesting Addiction
    • Behavior Requiring Increased Attention
The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

### Analgesia:
If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? 
2. What was your pain level at its worst during the past week?
3. What percentage of your pain has been relieved during the past week?
4. Is the amount of pain relief you are now obtaining from your Current pain reliever(s) enough to make a real difference in your life?
5. Query to clinician: Is the patient's pain relief clinically significant?

### Activities of Daily Living:
Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.*

(Please choose Better, Same, or Worse for each item below.)

1. Physical functioning
2. Family relationships
3. Social relationships
4. Mood
5. Sleep patterns
6. Overall functioning

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

### Adverse Events
1. Is the patient experiencing any side effects from the current pain reliever(s)?
2. Patient's overall severity of side effects?

### Potential Aberrant Drug-Related Behavior - Must be completed by the Physician.
(Please choose any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (e.g., appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.)

### Assessment - Must be completed by the Physician.
Is your overall impression that this patient is benefiting (e.g., benefits, such as pain relief, outweigh side effects)?

### Current Analgesic Regimen:

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**Specific Analgesic Plan:**

Comments:
Urine Drug Screens

- Verify medications that patient is taking.
- **Purpose is two fold:**
  1. Presence of Opioid Prescribed
  2. Absence of other substances
- **Recommended frequency varies**
  1. Random periodically
  2. Prior to each visit
- **Unexpected results requires frank conversation with patient**
Urine Drug Screen Detection Times

- Methamphetamine 1 - 3 days
- Amphetamine 1 - 3 days
- MDMA 1 - 3 days
- Mysoline (Primidone) Phenobarbital Up to 30 days
- Barbbiturate
  - Short-acting: 2-3 days
  - Long-acting: up to 30 days
- Benzodiazepines
  - Depends on what is taken Days to weeks
- Cocaine 2 – 4 days
- Heroin 2 - 4 days
- Codeine 2 - 4 days
- Morphine 2 - 4 days
- Hydrocodone 2-4 days
- Hydromorphone 2-4 days
- Morphine 2 - 4 days
- Methadone and metabolites 3 - 7 days
- PCP Days to weeks
- Propoxyphene 2 - 3 days
- Norpropoxyphene 4 - 7 days
- Marijuana Delta 9-THC Days to weeks
- Oxycodone 1 - 2 days
- Ritalin Not detected on KP drug screens
Urine Drug Screen Detection Times

• Chronic Heavy Users may stay positive longer
• Certain opioid must be “added on” to Drug Screen
  – Check with Local Lab.
• Methadone Users will have Methadone plus Metabolites.
  – Methadone ALONE means that it was added to the urine after collection.
• Chronic Morphine users may have small amounts of hydromorphone.
THE WHIZZINATOR XXX STRAP-ON

Each kit contains:
1 Whizzinator
1 Syringe
1 Synthetic Urine Sample
4 Heat Packs
Indications to Discontinue Opioid Therapy

• Serious Non-Adherence
  – Illegal, Criminal or Dangerous Behavior
    • Address safety issues and apply legal mandates
    • Referral to addiction medicine/chemical dependency or behavioral health
    • Immediate cessation of opioid therapy and treatment for withdrawal symptoms

• Severe and Uncontrollable Adverse Events

• Non-Effective
  – Lack of efficacy as judged by increased functional status
  – Patient Desires To Discontinue
Drug-Related Behavior Predictive of Addiction

• Probably More Predictive
  • Selling prescription drugs
  • Prescription forgery
  • Stealing or “borrowing” drug from another person
  • Injecting oral formulation
  • Obtaining prescription drugs from non-medical source
  • Multiple episodes of prescription “loss”
  • Concurrent abuse of related illicit drugs
  • Multiple dose escalations despite warnings
  • Repeated episodes of gross impairment or dishevelment

• Probably Less Predictive
  • Aggressive complaining
  • Drug hoarding when symptoms milder
  • Requesting specific drugs
  • Acquisition of drugs from other medical sources
  • Unsanctioned dose escalation once or twice
  • Unapproved use of the drug to treat another symptom
  • Reporting psychic effects not intended by the clinician
  • Occasional impairment
Addressing Aberrant Drug-Related Behavior

• General Management Principles
  • know laws and regulations
  • structure therapy to match perceived risk

• Proactive Strategies
  • communicate goals of therapy
  • provide written guidelines (treatment contract)
  • assess often

• Reactive Strategies
  • require frequent visits and small quantities of drug
  • use of urine toxicology
  • long-acting drugs with no rescue doses
  • relate to addiction-medicine community (sponsor, program, addiction-medicine specialist, psychotherapist)
Indications of Addiction To Prescribed Medications

• Screen for Substance Abuse
• Unable or unwilling to adhere to treatment plan
• Look for Key Characteristics
  – Impaired Control
    • Using a month’s supply in a few days or weeks
    • Early refill requests, obtaining medications from friends/family, other sources
  – Compulsive Use
    • Reliance on opioids as sole means of pain management
    • Poor compliance on other treatment modalities
  – Continued Use Despite Negative Consequences
    • Physical
    • Mental
    • Social
May 14 - Pain meds for sale - (West Hollywood) <<general

May 13 - Vicodin - $60 - (SB) <<general

May 11 - Need Pain meds? - (Orange County) <<general

Few LOCAL results found. Here are some from NEARBY areas...

Apr 28 - need vics - (Orange county) <<items wanted
need pain (sfv)

Date: 2010-02-02, 6:55PM PST
Reply to: sale-zomm-1583424081@craigslist.org

in need of pain meds, no insurance, lookin for oxy

Location: sfv
it's NOT ok to contact this poster with services or other commercial interests

PostingID: 1583424081
Pain Relief - $15

Date: 2010-01-26, 3:12AM EST
Reply to: sale-Skys2-1571003361@craigslist.org

Have 15 mg Roxicodones (oxycodone). Email for more info.

oxy or perc percocet vicodin opiate

it's NOT ok to contact this poster with services or other commercial interests

PostingID: 1571003361
Long-Term Effects of Opioids

• Opioid-induced endrocrinopathy
  – Decreased
    • Gonadal sex hormones (hypogonadism)
    • Growth hormone
    • Cortisol
    • Dehydroepiandrosterone sulfate (DHEAS)
  – Blunt
    • Cortisol response to corticotropin
Adverse Effects of Opioids

• Sex Hormone Deficiency
  – Anemia
  – Decreased libido
  – Decreased muscle mass
  – Depression
  – Erectile dysfunction
  – Fatigue
  – Menstrual irregularities
  – Osteoporosis
  – Vasomotor instability
  – Weight gain

• Cortisol Deficiency
  – Decreased response to stress

• Usually in doses > 100mg morphine or equivalents per day
Marijuana Use Issues

• Several states have laws permitting the possession and use of marijuana by those with a ‘legitimate medical need’
  – Requirements differ by state
    • All involve some level of physician documentation

• While these state laws exist, they run contrary to Federal laws

• Consult with legal counsel in your region
Caveat

• There are few published studies available
• Those that exist have small sample sizes and other methodological flaws
• Most use synthetic cannabanoids rather than inhaled marijuana
  – Although one small 2008 study
• Studies on inhaled marijuana are difficult to conduct
• Following statements should be reviewed with caution
What the Evidence Says

• Fair Evidence
  – Synthetic Cannabinoids
    • Sleep disruption in patients with MS
    • Neuropathic Pain in patients with MS
  – Inhaled Marijuana
    • Analgesic effect in those with heterogeneous neuropathic pain
Handling Requests from Members

• Adopt a patient-centered approach
  – Ask patients what they hope to gain by using marijuana for pain management
  – Encourage patients to focus on functional gains rather than solely on analgesia
  – Acknowledge patient goals and discuss alternate treatment options

• Discuss additional risks with marijuana use
  – respiratory problems
  – Decreased brain function including memory, concentration, and thinking
  – Prolonged use can increase risk of addiction to marijuana
  – Will impair ability to drive or operate other heavy machinery
  – Will test ‘positive’ to drug tests
Handling Requests from Members

• Inform patients that, while these laws exist there is a lack of scientific evidence to say for sure if marijuana is effective in the management of chronic pain.
• Talk about the importance of using multiple strategies for achieving improved pain control
• Emphasize, as with all treatments for chronic pain, demonstrable improvements in functioning are an indication that the treatment is helpful and beneficial.
• Gain agreement to talk with the patient again about marijuana use and discuss effectiveness and if additional treatment is necessary.
Tools for Providers
# Adult Chronic Pain - Home

## Clinical Guidelines

- Consensus Statement: Routine Electrocardiograms in Patients on Methadone
- Practice Resource: Intrathecal Drug Delivery Systems for Chronic Pain
- Practice Resource: Long-Term Opioid Therapy for Chronic Pain
- Practice Resource: Management of Chronic Low Back Pain in Adults
- Practice Resource: Management of Fibromyalgia in Adults
- Practice Resource: Management of Neuropathic Pain in Adults
- Practice Resource: Management of Osteoarthritis in Adults
- Practice Resource: Managing Time Off Work Requests
- Practice Resource: Spinal Cord Stimulators For Managing Chronic Pain

[View All Clinical Guidelines...](#)

## Member Education

- Acupuncture (PDF) [English](#)
- Arthritis (PDF) [English, Spanish](#)
- Back In Action (PDF) [English](#)
- Chronic Pain (PDF) [English, Spanish](#)
- Chronic Pain Medications (PDF) [English, Spanish](#)
- Epidural Steroid Injections (PDF) [English](#)
- Ergonomics and You (PDF) [English](#)
- Exercises to Help Your Back (PDF) [English, Spanish](#)
- Fibromyalgia (PDF) [English, Spanish](#)
- Glucosamine and Chondroitin (PDF) [English](#)
- Headaches (PDF) [English, Spanish](#)
- Insomnia (PDF) [English, Spanish](#)
- Managing Chronic Pain: You Play the Central Role (PDF) [English](#)
- Medial Branch Block Injections (PDF) [English, Spanish](#)
- Medicines and Dry Mouth (PDF) [English](#)
- Methadone Therapy for Controlling Pain (PDF) [English](#)
- Menopausal Pain Syndrome (PDF) [English](#)
Tools For Members
Mp3 downloads

To listen now
Click the "Listen" link.

To get your audio program "to go"
Want to listen later? To listen on your iPod or MP3 player, click the "Download" button. Links will open in a new window.

Guided imagery programs
Our guided imagery programs were produced by Health Journeys®. Guided imagery is a type of relaxation exercise designed to engage your mind, body, and spirit. Guided imagery programs are gentle, but powerful.

All you have to do is settle in, relax, and listen.

We have many programs to choose from:
- Ease Pain
  - Listen
  - Download
- Healthy Sleep
  - Listen
  - Download
Relaxation CD

• Track 1 - Basic Body Scan
• Track 2 - Guided Imagery Exercise
• 20 minutes per track
• Additional music to relax by
• Male and Female voice available
• Does NOT include progressive muscle relaxation exercise
• Available in Spanish
Partnership with American Chronic Pain Association

• Began in August 2007
• Currently have 6 groups running
  – Southern California (4 English & 1 Spanish)
  – Mid Atlantic (4 English)
• Hosted at KP facilities
• KP members trained to be group facilitators
• KP members encouraged to attend after discharge from intensive pain management programs
• Beginning to explore promotion to community at large
• KP staff comments:
  – Overall, both internally and with our members, this has been a very successful and beneficial partnership.
  – Remain enthusiastic about the concept and potential.

www.theacpa.org
Communication is key!

- Reluctant Provider = Reluctant Patient
- Listen…at least once
- Remember that your patient NEEDS
  - *to tell their story*
  - *to be believed*
  - *structure and direction*
- Have effective short statements ready to go BEFORE the visit (handouts/visuals)
- Write down what you say
- Ask the patient what they heard
Questions & Comments?
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