

Bring on the Pain (Contract)

Josy Hoff Rue, MD
Heart of America Medical Center, Rugby, ND

1

Chronic Pain

- More than 11.5 million Americans age 12+ report misusing prescription opiates in 2016
- Estimated 11% of adults experience pain daily

2

The Before

3

The Pain Management Agreement

The greatest success in chronic pain management comes when there is a partnership based on mutual respect between patient and doctor.

4

The Pain Management Agreement

The Promises the Doctor Makes

- Listen and try to understand the patient's experience living with pain.
- Accept the patient's reports of pain and response to treatment.
- Thoroughly assess the patient's pain and explore all appropriate treatment options, including those suggested by the patient.
- Explain what is known and unknown about the causes of the patient's pain.
- Explain the meaning of test results or specialty visits/consultations, and what can be expected in the future.
- Explain the risks, benefits, side effects and limits to any treatment.
- Respect the patient's right to participate in making pain management decisions, including the right to refuse some types of treatment.
- Make sure that the patient has access to acute care, even when the provider is not personally available.

5

The Pain Management Agreement

The Promises the Patient Makes

- Understand that opiate therapy is only a small part of treating chronic pain and is often not indicated.
- Attend recommended therapy sessions and do their best to make recommended lifestyle changes.
- Be willing to be involved in programs that can help improve social, physical, or psychological functioning.
- Be willing to learn new ways to manage their pain.
- Take medication only at the dose and times prescribed.
- Make no changes to the dose or how the medication is taken without first talking to the doctor.
- Not ask for pain medications from other providers.
- Tell any provider they see all medications they are taking, including the ED.
- Arrange for refills only through one doctor's clinic during regular office hours.
- Not ask for early refills.
- Protect their prescriptions and medications.
- This means keep all medicines away from children AND from people (even family members) who might steal them.
- Take medications only for their own use and NOT share them with others.

6

The Pain Management Agreement

The Informed Consent and Notice of Risks

- Sleepiness, confusion, difficulty thinking
- Nausea, vomiting, constipation
- Difficulty breathing, shortness of breath, wheezing
- Rash, itching
- Potential for allergic reaction
- Potential for interaction with other medications (increasing effects or side effects of drugs taken together)
- Potential for dose escalation/tolerance (need for higher doses for the same effect may occur with long-term use)
- Potential for dependence (after the body adjusts to these medications, they cannot be stopped abruptly without physical symptoms)
- Potential for withdrawal (stopping medications abruptly may cause nausea, vomiting, abdominal pain, sweating, aching, abnormal heartbeat or other symptoms that can be life threatening; medication changes should be under provider supervision)
- Potential for addiction (compulsive drug use not related to pain relief)
- Potential for impaired judgement and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
- Potential for testicular atrophy and impotence in men

7

The Pain Management Agreement

The Informed Consent and Notice of Risks

- I will limit my dose of medication to the dose prescribed. I will not change the dose without contacting my doctor.
- I am responsible for my medications. Lost, misplaced, or stolen prescriptions will not be replaced.
- No early refills will be given.
- No refills will be given after hours, on holidays, or on weekends.
- I will obtain all refills for these medications only at one pharmacy: _____
- I understand that my doctor may stop prescribing opiates or change the treatment plan if I do not show any improvement in pain from opiates or my level of functioning does not improve.
- I will not ask for pain medications from other doctors.
- I will tell any other doctor I see (including Emergency Room doctors) that I am taking opiate pain medications, and that I have a "Pain Management Agreement" with the Doctor at UND Center for Family Medicine.
- Prescribed medications are only for my own use, and I will not share them with others.
- I will keep all medications away from children.
- I agree to participate in any treatments recommended by my doctor that are designed to improve my social, physical, and psychological functioning.
- I will not use illegal or street drugs or another person's prescription.
- If my doctor is concerned and believes a referral to an addiction counselor is appropriate, I agree to go to an initial evaluation and to follow through with the recommendations given.
- If in treatment, I will request that a copy of the program's initial medication and treatment recommendations be sent to my doctor. I will also request a copy monthly, so that I can verify that I am continuing treatment.
- I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. I understand that I will be responsible for the cost of these tests.
- I understand that failure to follow these rules may result in no further prescriptions for opiates.
- The pain management team will review "Pain Management Agreement" periodically.

8

Clear Cut, Easy to Manage Clinic Policies

9

Policies

Who Gets Referred?

- Any patient whose Provider feels they would benefit from the committee's recommendations
- Any patient on more than 3 medications indicated for pain. This includes non-opiates.
- Any patient needing more than 7 days of opiate therapy

10

Policies

Risk Stratification

- We asked that all patients getting controlled substances be risk stratified.

11

Policies

Opioid Risk Tool

	Female	Male
Family History of Substance Abuse		
Alcohol	[1]	[3]
Illegal Drugs	[2]	[3]
Prescription Drugs	[4]	[4]
Personal History of Substance Abuse		
Alcohol	[3]	[3]
Illegal Drugs	[4]	[4]
Prescription Drugs	[5]	[5]
Age between 16 and 45	[1]	[1]
History of Preadolescent Sexual Abuse	[3]	[0]
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia	[2]	[2]
Depression	[1]	[1]

12

Policies
Screeener and Opioid Assessment for Patients with Pain

	Never	Seldom	Sometimes	Often	Very often
	0	1	2	3	4
1. How often do you have mood swings?	[]	[]	[]	[]	[]
2. How often do you smoke a cigarette within an hour after you wake up?	[]	[]	[]	[]	[]
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	[]	[]	[]	[]	[]
4. How often have any of your close friends had a problem with alcohol or drugs?	[]	[]	[]	[]	[]
5. How often have others suggested that you have a drug or alcohol problem?	[]	[]	[]	[]	[]
6. How often have you attended an AA or NA meeting?	[]	[]	[]	[]	[]
7. How often have you taken medication other than the one that it was prescribed?	[]	[]	[]	[]	[]
8. How often have you been treated for an alcohol or drug problem?	[]	[]	[]	[]	[]
9. How often have your medications been lost or stolen?	[]	[]	[]	[]	[]
10. How often have others expressed concern over your use of medication?	[]	[]	[]	[]	[]
11. How often have you had a craving for medication?	[]	[]	[]	[]	[]
12. How often have you been asked to give a urine screen for substance abuse?	[]	[]	[]	[]	[]
13. How often have you used illegal drugs (eg, marijuana, cocaine, etc) in the past five years?	[]	[]	[]	[]	[]
14. How often, in your lifetime, have you had legal problems or been arrested?	[]	[]	[]	[]	[]

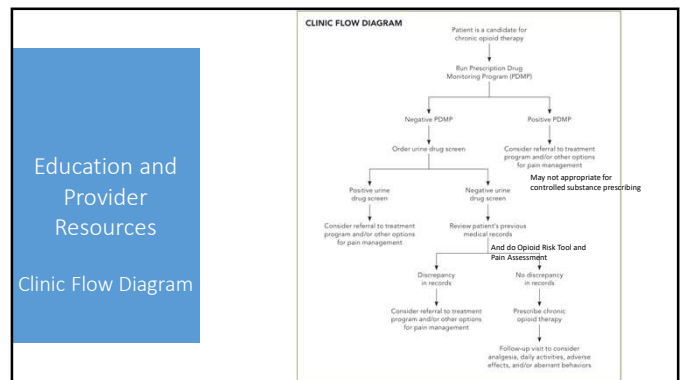
13

- Policies**
- We asked that patients with contracts be seen every 3 months
 - We required 28 day fills to avoid fills landing on a weekend
 - We asked that UDS be collected every three months for the patients who were taking daily doses of opioids.

14

Education and Provider Resources
 'The Resident Guide to Loving Chronic Pain Management'

15



16

Education and Provider Resources
 Patient Pain Assessment Form

Pain Assessment

Name: _____ Date: _____

Which side effects do you have?

	Not at all	Mild	Moderate	Severe
Upset Stomach	Not at all	Mild	Moderate	Severe
Vomiting	Not at all	Mild	Moderate	Severe
Constipation	Not at all	Mild	Moderate	Severe
Itching	Not at all	Mild	Moderate	Severe
Brain Fog	Not at all	Mild	Moderate	Severe
Sweating	Not at all	Mild	Moderate	Severe
Fatigue	Not at all	Mild	Moderate	Severe
Overly Tired	Not at all	Mild	Moderate	Severe
Other: _____	Not at all	Mild	Moderate	Severe

17

Education and Provider Resources
 Patient Pain Assessment Form

How often does pain affect the following?

	Never	Sometimes	Often	Always
Your ability to do things around the house	Never	Sometimes	Often	Always
Your job	Never	Sometimes	Often	Always
Your time with family	Never	Sometimes	Often	Always
Your time with friends	Never	Sometimes	Often	Always
Your mood	Never	Sometimes	Often	Always
Your sleeping pattern	Never	Sometimes	Often	Always
Your overall functioning	Never	Sometimes	Often	Always

What is your overall pain level over the past week? If 0 is no pain, 10 is most severe pain?

0 1 2 3 4 5 6 7 8 9 10

Are you happy with your overall pain control? Yes No

18

OPIOID METABOLISM

Education and Provider Resources

UDS Interpretation Cheat Sheets

19

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (50-90 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage: 50 MME) and maintenance of current dosage (average final dosage: 60 MME).

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national survey of Veterans Health Administration (VHA) patients who started pain-relieving opioids from 2004-2009, patients who had opioid medication were prescribed an average of 68 MME/day, or for other patients who received an average of 44 MME/day.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 90 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

90 MME/day	• 90 mg of hydrocodone (30 tablets of hydrocodone/butorphanol 5/500)	90 MME/day	• 180 mg of tramadol (9 tablets of hydrocodone/butorphanol 5/500)
• 90 mg of oxycodone (3 tablets of oxycodone 30/30)	• 60 mg of morphine (3 tablets of morphine 30/30)	• 60 mg of oxycodone (2 tablets of oxycodone/butorphanol 5/500)	• 120 mg of tramadol (6 tablets of tramadol 50/500)
• 90 mg of morphine (3 tablets of morphine 30/30)	• 30 mg of methadone (3 tablets of methadone 30 mg)	• 90 mg of methadone (3 tablets of methadone 30 mg)	• 120 mg of methadone (6 tablets of methadone 30 mg)

Education and Provider Resources

MME Information

20

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

- DETERMINE** the total daily amount of each opioid the patient takes.
- CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor (see table).
- ADD** them together.

Calculating morphine milligram equivalents (MME)

OPIOID (strength/concentration)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (by weight)	2.4
Hydrocodone	1
Hydroxyzine	4
Morphine	1
• 20 mg tablets	4
• 21-40 mg tablets	8
• 41-60 mg tablets	12
• 61-80 mg tablets	16
Morphine	1
Oxycodone	1.5
Oxycodone	3

CAUTION:

- Do not use the calculated dose as MMEs to determine change in converting one opioid to another—the new opioid should be lower to avoid unintentional overdose. Consult the manufacturer's prescribing information and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- Methadone:** Its conversion factor increases at higher doses.
- Fentanyl:** should be taught instead of mg/day and absorption is affected by heat and other factors.

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Identify patients presenting a level of opioid dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to 90 MME per day, such as:
 - Monitor and assess pain and function more frequently.
 - Discuss ongoing use or tapering and discontinuing opioids if benefits do not outweigh risks.
 - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to 90 MME/day.

Education and Provider Resources

MME Information

21

Education and Provider Resources

Charting Guide

- Very thorough H&P
- Check the PDMP and document that you did so
- Use a pain assessment tool
- Review the contract

22

- Clearly document the cause of the pain and associated diagnoses
- Pain type and intensity
- Previous diagnostic studies and their results
- Previous treatments
 - Therapies
 - Previous medications, doses, durations, why were they discontinued
- Document their physical functioning
 - Can they drive? How is their sleep? Employed? Do they live alone or have a family?
- Ask about depression, anxiety, psychiatric problems
- Assess their risk for drug abuse or diversion
 - Family history of substance abuse? – alcohol, illegal drugs, prescription drugs
 - Personal history of substance abuse? – alcohol, illegal drugs, prescription drugs
 - History of sexual abuse
 - History of ADD, OCD, Bipolar, Schizophrenia, Depression
- Request previous records
- Consider baseline UDS – especially if renewing or prescribing controlled substances
- Helpful to ask what time they last took their prescriptions if you are going to do a UDS

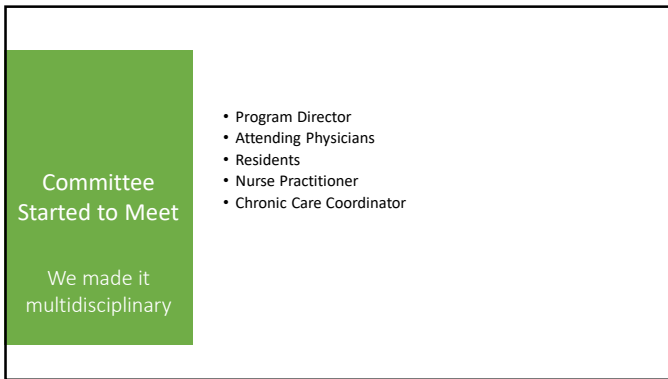
Education and Provider Resources

Charting Guide

23

Committee Started to Meet

24

A slide with a white background and a black border. On the left, there is a green rectangular box containing the text "Committee Started to Meet" and "We made it multidisciplinary". To the right of this box is a bulleted list of roles.

Committee Started to Meet

We made it multidisciplinary

- Program Director
- Attending Physicians
- Residents
- Nurse Practitioner
- Chronic Care Coordinator

25

A slide with a white background and a black border. A large grey rectangular area covers most of the slide, with the text "The After" centered within it.

The After

26