Do No Harm: Putting Safer Pain Management Guidelines into Practice – Module 5

1.1 Introduction

Welcome to the Oklahoma Primary Healthcare Improvement Cooperative's online course - Do No Harm: Putting Safer Pain Management Guidelines into Practice.

This Online Enduring Material educational program is designed for healthcare professionals. The contents of this program are based on the National Academy's Institute of Medicine's white paper Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use and the 2016 CDC, 2017 VA-DOD, 2017 Oklahoma State Department of Health Guidelines for Pain and Opioid management, and Oklahoma law.

The program was developed through a grant from the Oklahoma Department of Mental Health and Substance Abuse Services by the Oklahoma Primary Healthcare Improvement Cooperative of The University of Oklahoma Health Sciences Center and the OU-TU School of Community Medicine. It was released in August, 2019.

1.2 Overview

Hi, I'm Steve Crawford, and I will be your guide through Patient Engagement, the fifth module in the Do No Harm: Implementing Safer Pain Management in Practice.

This module will help you apply the principles of patient education and documentation of informed consent to use opioid medications as a component of a multi-modal chronic pain treatment plan. The module is designed to stand-alone among the other five modules of this course. Therefore, some of the slides and questions may be similar to those appearing in other modules.

The average time to complete this module is 30 minutes and ½ hour CME credit is available from OU Continuing Professional Development Office by registering, passing a small quiz, and evaluating the course. Directions will be provided at the conclusion of this module.

1.3 Planning and review Committees

The panel of experts who reviewed this course represent primary care clinicians, pharmacists, educators, and specialists in pain, addiction, and palliative care, and a national expert in the epidemiology of the opioid crisis.

1.4 Relevant Disclosure and Resolution

None of the members of the CME Planning committee have a relevant financial relationship or affiliation with commercial interests to disclose.

1.5 Relevant Disclosure and Resolution for Expert Review Panel

None of the expert reviewers have a relevant financial relationship or affiliation with commercial interests to disclose.

1.6

Conflict Resolution Statement:

The University of Oklahoma, College of Medicine Office of Continuing Professional Development has reviewed this activity's speaker and planner disclosures and resolved all identified conflicts of interest, if applicable.

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Accommodation Statement:

Accommodations are available by contacting Jan Quayle at 405-271-2350, ext. 8 or e-mail to: jan-quayle@ouhsc.edu.

1.7 Professional Practice Gap Being Addressed

The knowledge gap being addressed in this module is that Oklahoma healthcare providers may lack knowledge and confidence in their competence to engage patients in shared decision making, giving informed consent, and participating in their chronic pain care.

1.8 Objectives

After completing this module, you should be able to develop a patient-centered pain management plan that reinforces patient understanding and shared decision of the risks, benefits, and responsibilities of treatment. You will also learn how to negotiate a signed pain treatment agreement, provide patient education in the safe use, storage, and disposal of controlled

substance. You will be able to educate patients, caregivers, and family members how to recognize signs of intoxication, overdose, and how to use naloxone for rescue and resuscitation.

1.9 Patient and Practice Education

When opioid medications are prescribed for the first time for chronic pain, education includes the message that controlled substances have limited benefits for chronic pain and substantial risks for addiction including accidental intoxication injury and death.

Clinicians may have in their practice or be referred "legacy patients" who have been taking opioids in higher doses than current guidelines. Some may have satisfactory function and pain control at higher doses than guidelines recommend for safer opioid prescribing. Patient education for these patients involves establishing a trusting relationship in which the clinician agrees to help the patient live and function well, including continual assessment of risk and benefit of opioid therapy, careful monitoring of opioid use for adverse effects and tapering to safer doses.

Patient education includes helping patients understand their responsibility for safer use of opioids that includes a policy that lost or stolen medication will not be routinely replaced or refilled early. Concurrent use of sedating medications (such as benzodiazepines and muscle relaxants) increases the risk of intoxication, injury, and death and will therefore be judiciously managed or discontinued. Patients agree to contact their clinician if they have adverse effects. Finally, naloxone will be made available and family and friends whom staff and pharmacies will teach how to use it.

1.10 Pain Management Plan

Care for patients suffering from chronic pain begins with the clinician engaging the patient and, if appropriate, caregiver, in a shared decision making conversation. The clinician names the diagnosis and describes the prognosis for patient's life, functionality, and well-being. Clinicians help patients understand that the goal of chronic pain management is to improve function, and reduce pain's interference with daily function. Unfortunately, some patients have suffered with chronic painful and debilitating conditions for years and improvement in function will be modest at best. Multiple approaches will be used to do no harm, improve the overall health of the patient, incorporate mind-body therapy, and the judicious use of medications.

1.11 Informed Consent for Opioid Treatment

Oklahoma law requires clinicians to document a written Patient-Provider Agreement, which is a pain management agreement with informed consent to use opioid medications. The agreement describes the goals of treatment and the risks involved in taking opioid medications. It provides an opportunity to clarify patient and physician expectations for treatment and their mutual responsibilities. It enhances adherence, promotes a therapeutic alliance, and obtains informed consent, thereby serving the ethical obligations inherent in patient care. The agreement or consent provides documentation of the grounds for continuation or discontinuation of therapy thus providing a clear pathway for tapering and discontinuing chronic opioid therapy when risk exceeds benefit because of personal risk to the patient related to misuse, addiction, overdose, or risk to the public from diversion, or both. Patients must agree that ongoing assessment and treatment of mental health conditions are central to the plan, and that opioids may be tapered and discontinued if they refuse continuing mental health evaluation and therapies.

1.12 Consent to Knowing Risks of Opioid Use

The patient-provider agreement and informed consent to use opioids documents the patient's understanding of the limited benefits of opioid medications and the substantial risks of use, the components of which are listed on this slide. The patient treatment agreement includes patient responsibilities to read all instructions, take medications as prescribed, check labels to confirm the contents of the bottle and do not transfer medications to other containers. Never use expired medications, and properly dispose of unused or expired medication. Store controlled substances in a locked container. Call 211 for information on addiction diagnosis and treatment and post the poison control number (1-800-222-1222) on cell phones and land-line phones.

1.13 Safe Disposal of Controlled Substances

The Oklahoma campaign, "OK I'm Ready" has a listing of community prescription drug take-back locations. Pharmacies also may have medication disposal or deactivation pouches. When a take-back service is not available, controlled substances may be disposed in household trash by using a sealed plastic bag, and mixing the medicine with unpalatable or disgusting substances. Make certain to scratch out information on disposed prescription containers. Because of the danger of

having some medications in the trash the FDA has established a “Flush List” of medications that can be flushed only when take back options are not readily available.

1.14 Changing Direction for Legacy Patients

Most patients will be harmed by experiencing withdrawal syndrome when a chronic, stable opioid dose is interrupted or rapidly decreased. Withdrawal may be severe and may include cramps, vomiting, sweating, fever, anxiety, self-treatment, and drug-seeking if opioid use disorder has developed.

The suggested approach to changing direction for legacy patients is to first do no harm! DO NOT abruptly stop opioid medications or dismiss guideline discordant patients from your practice. Provide patient education about the new expectations and work closely with the patient to implement safer plans that include reduced dosing. Prescribe naloxone to prevent overdose deaths. Slowly taper opioids and discontinue risky combinations when possible. If progress is slow or plateaus, do not abandon your patient! Be compassionate and persistent. Carefully manage withdrawal symptoms if they occur, and remain vigilant for substance or opioid use disorders that may become apparent during the weaning process. Refer patients for addiction treatment services or prescribe dependence medications such as buprenorphine when indicated.

The video link on this slide offers additional case training in collaborative opioid tapering.

1.15 Monitor for Opioid Misuse

Inform patients that they will have face-to-face visits every 1 to 3 months when taking opioids, in order to monitor for the development of harms from opioids, particularly risk for overdose and the development of opioid use disorder. Screening for harm or misuse of opioids includes routine checking the *Oklahoma Prescription Drug Monitoring Database* for other prescribers and other controlled medication prescriptions, performing random in-office or laboratory *urine drug testing,* possibly performing random pill counts, and checking for aberrant behaviors to screen for developing opioid use disorder or other misuse. Many patients develop tolerance and may request dose increases. Tolerance or withdrawal symptoms can exist without a diagnosed opioid use disorder. However, along with other symptoms such craving, obsessive worry about having enough opioids, and appearance, behavior, and social changes, opioid misuse or disorder may be present and requires a thorough assessment. Patients who are misusing opioids, or are

developing opioid use disorder may be ashamed or reluctant to discuss their condition openly with their clinician. They may fear being cut off from their opioid supply. A non-judgmental, therapeutic approach discussing opioid use disorder to be a serious, but treatable medical condition, may support patient safety and honesty.

1.16 Signs of Possible Opioid Misuse

Patient and family education about the clues to developing opioid problems is important. You should inform patients and family that it may not be easy to tell if someone close is developing opioid problems, especially in the early stages. Anyone who uses opioids can become addicted, even when they are prescribed by a doctor. The family or patient may notice changes in moods or behavior or the family member's intuition may be suggesting a problem. Advise the family that speaking up could save the life of someone dear to you.

Some of the signs of a problem may include regularly taking an opioid in a way not intended by the doctor who prescribed it, including taking more than the prescribed dose or taking the drug for intoxication. Taking opioids "just in case," even when not in pain is an important clue. The person using opioids may be spending excessive time obtaining, using or recovering from them. They may begin craving opioids. They may continue opioid use even when it is associated with inability to fulfill responsibilities, or despite having persistent social or interpersonal problems. They may reduce involvement in social, occupational or recreational activities. Signs of opioid intoxication and increased risk for overdose include pinpoint pupils, drowsiness, and slurred speech.

Some addiction experts now recommend that doctors interview family members as part of routine follow-up care for a person taking opioid medications. Family should be advised not to wait to be asked before voicing concerns. A person addicted to opioids - or any substance - is much more likely to recover if his or her family refuses to ignore or tolerate the problem. If family thinks a loved one may be addicted to opioids, it is important to talk with his or her doctor right away. Together they can determine the best next steps. Patients or family may call 211 or visit OKImReady.org for more resources.

1.17 Supporting a Loved One in Recovery

The clinician's practice can educate loved ones of patients with opioid or other substance use disorder in how they might be helpful in supporting recovery. The first concept is that opioid use disorder is not a moral failing, but a serious chronic brain disease. We recommend calling 211 or visiting the OKIMREADY.org web site for treatment resources and free opioid overdose prevention medication, naloxone. The web sites on this page provide other helpful information for families.

The most important support for persons in recovery are improving overall HEALTH by helping the loved one make informed healthy choices that support physical and emotional well-being. Assuring a safe, stable HOME, possibly even a sober living house is important. Supporting a life PURPOSE is helping the loved one conduct meaningful daily activities and having the independence, income, and resources to participate in society. These are often available through the human resources referral to treatment by employers and by community resources for recovery. A recovery COMMUNITY supports the loved one to develop relationships and social networks that foster friendship, love, and hope. Peer support organizations for the recovering person and family members may be helpful in providing additional support.

1.18 DSM-5 Criteria for Opioid Use Disorder

You may wish to show patients and their family the criteria for diagnosis of Opioid Use Disorder. Explain that OUD is a problematic pattern of opioid use leading to clinically significant impairment. In order to confirm a diagnosis of OUD, at least two of the DSM-5 criteria should be observed within a 12-month period: Loss of control exhibited by (1) taking opioids in larger amounts or over a longer period than was intended; (2) having a persistent desire or unsuccessful efforts to cut down or control opioid use; or (3) spending a great deal of time in activities necessary to obtain, use, or recover from opioid effects. (4) *Craving* is having a strong desire or urge to use opioids. *Adverse consequences* include: (5) recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home; (6) continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids; (7) giving up or reducing important social, occupational, or recreational activities because of opioid use; (8) recurrent opioid use in physically hazardous situations; or (9) continued opioid use despite

knowledge that persistent or recurrent physical or psychological problem are likely to have been caused or exacerbated by the substance.

The last two diagnostic criteria, *tolerance and withdrawal,* without other symptoms*,* are not considered to be met for individuals taking opioids under appropriate medical supervision. *Tolerance*, is a need for markedly increased amounts of opioids to achieve intoxication or desired effect, or having a markedly diminished effect with continued use of the same amount of an opioid. There are two criteria for *Withdrawal Syndrome*: A) after stopping or reducing opioid dose following heavy or prolonged use, *or* after administering an opioid antagonist; and B) within minutes or days, three or more of the following develop: dysphoric mood, nausea or vomiting, muscle aches, lacrimation or rhinorrhea, pupillary dilation, piloerection, sweating, diarrhea, yawning, fever, or insomnia.

1.19 Managing Opioid Use Disorder

When OUD is suspected, the diagnosis should be confirmed with a thorough history and physical examination, urine drug screen and review of the prescription drug monitoring program. Patients may show no physical signs of opioid addiction. The diagnosis relies on respectful and supportive history of the patient's experience with opioids. Clinicians may use the DSM-5 criteria to make a diagnosis or arrange for an assessment by a specialist in addiction. Referrals for Oklahoma are found on the OKI'mReady.org website.

The DSM-5 criteria for diagnosis of t OUD as occurring on a continuum of severity. A scale for assigning severity was developed in DMS-5 and is based upon the number of criteria that have been met (2-3 for mild, 4-5 for moderate, and more than 6 for severe). This severity distinction has treatment implications.

When OUD is diagnosed, it is important to treat the patient like anyone with a serious, potentially fatal chronic illness. Patients may experience shame and abandonment when addiction is identified. Clinicians should state that they will not dismiss the patient from primary care and will continue to help manage their underlying or co-occurring diseases or conditions. Approaching the patient with compassion helps determine the effect opioid use has had on physical and psychological functioning. The therapeutic relationship will be enhanced by empathizing with the patient's experience and outcomes of past treatment episodes. Clinicians should express concern about the patient's potential for overdose. Risk factors for overdose include a past history of

overdose, a past history of substance use disorder, opioid dosages >50 MME/day, and concurrent benzodiazepine use. When one or more of these risk factors are present, clinicians should educate the patient and his or her family about the symptoms of opioid overdose and how to administer naloxone. For more information about naloxone, visit OKImReady.org. The clinician and practice staff should re-inforce the patient that OUD is a treatable, serious medical condition and arrangements for evidence-based treatment will be made.

1.20 Overdose - Save a Life

Patients, family members, and caretakers should be taught opioid overdose resuscitation. When a person is found down with evidence of prior use of opioids such as needle and syringe or bottle of pills, overdose is highly likely. Overdose may be more difficult to recognize when an older person with multiple medical problems and prescribed opioid medications is found to be confused or unarousable. Resuscitation steps are "shake and shout" calling the patient's name to wake up. If no response, lay the person on their side and call for help. Do not leave them alone. Call or have someone else call 911. Administer intranasal naloxone. If the person is not breathing, do rescue breathing and chest compressions. Stay with the person until help arrives.

1.21 NARCAN Training Video

1.22 OK I'm Ready

The Oklahoma campaign, "OK I'm Ready" launched by the Oklahoma Department of Mental Health and Substance Abuse Services hosts a website with public and patient information about the opioid crisis in Oklahoma. It contains information about preventing opioid problems, treating opioid use disorder, and responding to opioid overdose. Available resources across the state are provided.

1.23 Conclusion

In summary, a patient-centered management plan includes patient education on the risks, benefits, and responsibilities of using opioid medications to treat chronic pain and shared decision making to use opioid medications with its possible benefits and substantial risks. It includes negotiating and documenting a mutually agreed upon plan in a signed pain treatment agreement with informed consent, educating the patient, family and caregivers on the safe use, storage, and

disposal of controlled substances and the recognition of addiction, intoxication, overdose, and the rescue use of naloxone.

1.24 Instructions

Please answer the following self-assessment question by selecting the single best answer. You will receive immediate feedback and if you selected an incorrect response you may answer the question again.

1.25

Question 1

1.26

Question 2

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Question 3

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Question 4

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Question 5

1.30 Resources

The references on this slide and the next slide provide additional resources for making changes in practice systems needed to implement practice guidelines.

1.31 Resources

The references on this slide are provided for your additional information. Thank you for participating in this online program.

1.32 Closing Instructions

You may print a certificate of completion in order to meet the requirements for annual training by clicking on the reports tab.

In addition, the University of Oklahoma Office of Professional Development is providing CE credits. MDs are eligible for AMA PRA Category 1 Credit, Physician Assistants for AAPA Category 1 Credit, and Nurse Practitioners for AANC contact hours and Oklahoma pharmacology hours.

Until March 1, 2020, the University of Oklahoma will waive the $25 fee.

Click on the web link which will take you to the Office of Professional Development web site where you may register, take a test of knowledge, evaluate your learning experience, and print your CE certificate.