Hospital Based Opioid Management
A case based, peer discussion

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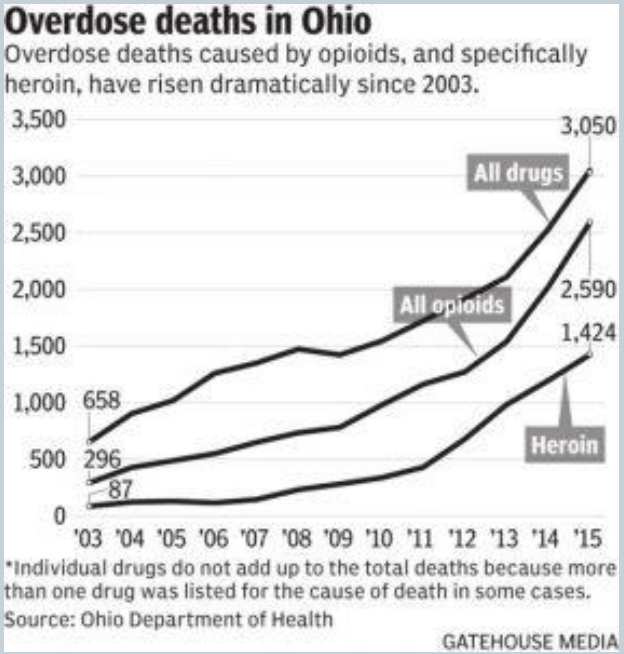
Disclosures

CDC Guideline for Prescribing Opioids for Chronic Pain, 2016

"Primary care clinicians report concern about opioid pain medication misuse, find managing patients with chronic pain stressful, express concern about patient addictions and report insufficient training in prescribing opioids"



Learning Objectives

- Peer Knowledge Sharing
- Opioid treatment options for acute on chronic pain during hospital admissions
- Non opioid pharmacologic augmentation treatment options in the acute setting
- Assessing psychosocial factors contributing to opioid use disorder
- Interpersonal communication in patients with opioid use disorder
- Introduction to motivational interviewing in opioid use disorder
- Treatment options for acute pain in patients with opioid use disorder
- Treatment options for patients with opioid use disorder in the acute care setting

Case Based- Observed Dialogue

Safe, non judgment based sharing of ideas

3 Patient Care Cases (details adjusted for HIPAA)

3 participants for discussion per case

Case 1

Case 1

52 year old female patient of yours with history of recurrent small bowel strictures with a history of 7 intra abdominal surgeries, is now admitted on post op day 1 for jejunal bowel resection and LOA for a recurrent obstruction. She also has a history of chronic pain related to back pain and fibromyalgia. She has been on chronic opioid therapy since 1994.

She is not yet tolerating oral intake.

Home Medication Regime

Oxycontin 30 mg twice daily
Oxycodone 15 mg three times daily as needed
Bentyl 10 mg every 6 hours as needed
Tizanidine 8 mg three times daily as needed
Neurontin 800 mg three times daily

Assessment

Pain intensity alone is insufficient and can lead to unsafe care!

Comprehensive assessment includes:

- Pain location and quality
- Aggravating and Alleviating factors
- Previous Treatments and their effectiveness
- Previous / Current Treatment Side Effects
- Physical and emotional functional assessment

Recommendations for Improving the Quality of Acute and Cancer Acute Pain. Quality of Care Task Force. 2005

Pharmacologic Pain Management Options
Slide 1 of 2: Opioids

Short – Acting

Codeine
Hydrocodone
Oxycodone**
Morphine**
Hydromorphone
Buprenorphine**
Tramadol

Long – Acting

Transdermal Fentanyl**
Extended Release Morphine
Extended release oxymorphone
Extended release oxycodone
Methadone

** Available in formulations for patients intolerant of PO or difficulty with absorption (eg. Short Gut Syndrome)

Pharmacologic Pain Management Options
Slide 2 of 2: Non- Opioid

NSAIDS
- mild- moderate, inflammatory pain
- best for non neuropathic pain
- consider history of gastritis, renal disease, age and cardiac risk

TOPICAL
- nsaids
- capsaicin
- lidoderm patch

TCA
- neuropathic pain
- work particularly well if co morbid anxiety, depression, or insomnia

Muscle relaxants
- watch for sedation and review med list for other sedating medications

SNRI
- Cymbalta
- Good for neuropathic pain, particularly when comorbid anxiety or depression

Anticonvulsants
- Neurontin, lyrica
- Generally have to fail neurontin for lyrica
- Watch for sedation and swelling
- Can sometimes help with co morbid mood disorders

Non-Pharmacologic Treatment

- Ice, heat, positioning, bracing, wrapping, splints, stretching
- Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, osteopathic neuromusculoskeletal medicine
- Biofeedback
- Directed exercise such as physical therapy

Non-Opioid Pharmacologic Treatment

Role in Therapy	Somatic (Sharp or Stabbing)	Visceral (Ache or Pressure)	Neuropathic (Burning or Tingling)
First Line	Acetaminophen, NSAIDs, Corticosetroids		Gabapentin/pregabalin/TCAs/ SNRIs
Alternatives	Gabapentin/pregabalin, skeletal muscle relaxants, SSRIs/SNRIs/TCAs	SNRIs/TCAs, dicyclomine	Anti-epileptics, baclofen, bupropion, low-concentration capsaicin, SSRIs, topical lidocaine

Assessment and management of chronic pain. Agency for healthcare research and quality. Aug 2016
"Acute Pain Prescribing Guidelines" OAFP. Last assessed Apr 3 2017.

A few tips…

Before adjusting chronic opioids:

1. Check with insurance formulary
2. Contact prescribing outpatient physician

Methadone specifically:

2.5 daily for elderly and other opioid naïve 2.5 every 8 hours
adjustment every 5-7 days
watch qtc
Liver metabolized, no renal adjustments
May need prn short acting during adjustment period

Consider a PCA

Watch for renal, cardiac, GI and liver co morbidities and medication interactions.

Address sleep

Address co morbid life stress and mental illness

College of physicians and surgeons Ontario
"Mathadone treatment for pain states" AAFP 2005
Society of Hospital Medicine: Institutional Best Practices Improving Pain Management for Hospitalized Patients

Ohio Guidelines for Emergency and Acute Care Facilities

Treatment of chronic pain or acute on chronic pain will not be given in injection

Clinicians will not provide lost or stolen Rx replacement

Avoid long acting opioids for acute pain

Check OARRs for all patients prescribing opioids for > 7 days

Except in rare cases, opioid prescriptions should be limited to 3 days

Case 2

Case 2

45 year old female with history of opioid use disorder is admitted with sepsis due to mitral valve endocarditis and bacteremia with MRSA. She is complaining of severe pain in her back and right shoulder. On imaging, she has been found to have lumbar discitis and osteomyelitis and right humeral osteomyelitis.

Non operative management has been recommended.

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13-year-old overdoses on heroin in Dayton, father arrested

By WDTN STAFF
Published: March 29, 2017, 11:36 am | Updated: March 29, 2017, 11:38 am

The Initial Evaluation or Disclosure

Focus on interpersonal communication skills

- The words we use PLUS

Patient centered care – patient engagement

- Understanding
- Empathy
- Relational Versatility

Acknowledge courage and motivating factors

- Can help with burn out and depersonalization

Am I going to worsen the opioid use disorder?

No evidence that treating acute pain worsens the status of opioid use disorder in the ambulatory setting

Lack of treatment can worsen opioid use disorder, as the uncontrolled pain and stress can be a trigger

Acute pain management in patients with opioid use disorder. American Journal of nursing. Sept 2015

Maintenance Therapy

Methadone and buprenorphine, when dosed for opioid agonist therapy, do not have sustained analgesic effects and are insufficient to treat acute pain

Multi modal therapy !

Methadone:

continue current dose

use short acting to augment

Buprenorphine:

high affinity, partial agonist

Options: divided dosing, short acting in addition, stop and substitute

Acute pain management in patients with opioid use disorder. American Journal of nursing. Sept 2015
Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy. Ann Intern Med. 2007

Opioid Use Disorder

Opioid Use Disorder
DSM5 Diagnostic Criteria

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
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. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of an opioid.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome
    b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Mild 2-3 symptoms
Moderate 4-5 symptoms
Severe 6 or more symptoms

Opioid Use Disorder, specified

Early Remission

>3 months, <12 months

Sustained Remission

>12 months

On Maintenance Therapy

Prescribed- methadone or buprenorphine

Also includes naltrexone

Case 3

Case 3

49 year old male veteran of Iraq is admitted for a COPD exacerbation yesterday afternoon. He was admitted to step down overnight, requiring bipap. This morning he was weaned to 4 L NC.

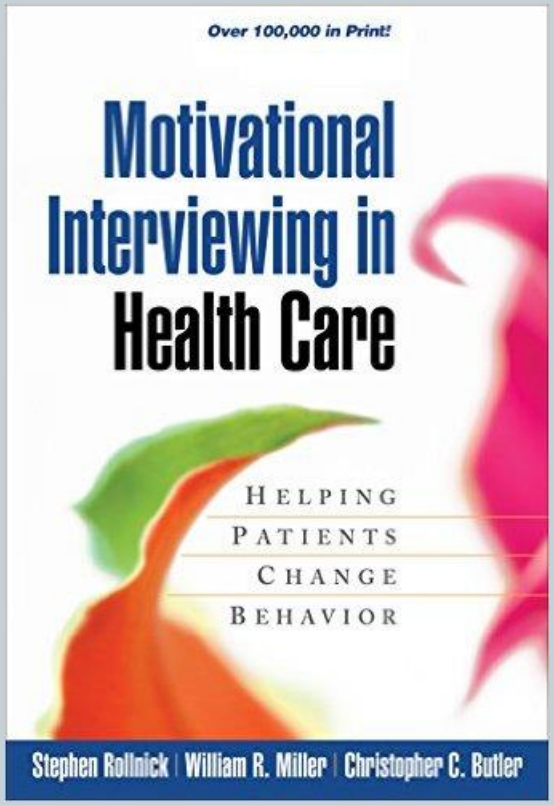
On morning rounds, he is sweating, uncomfortable and has had 2 episodes of diarrhea. He shares a history of opioid use disorder and asks for help. This was not discussed during the admission history and physical.

"The fun thing about this work is that you can be there when the light switch goes on for a patient," Brenner told me. "It doesn't happen at the pace we want. But you can see it happen."

The Hot Spotters, Atul Gawande
The New Yorker Jan 24, 2011

Motivational Interviewing

- Goal Oriented, Patient Centered
- Engages intrinsic motivation
- Addresses ambivalence
- Exploring importance and confidence



Leaving Against Medical Advice

Undertreated or untreated substance use disorders and mental health disease

Increased :

- readmission rates
- cost of care
- co morbidities
- antibiotic resistence

"Harm reduction in hospitals: is it time"

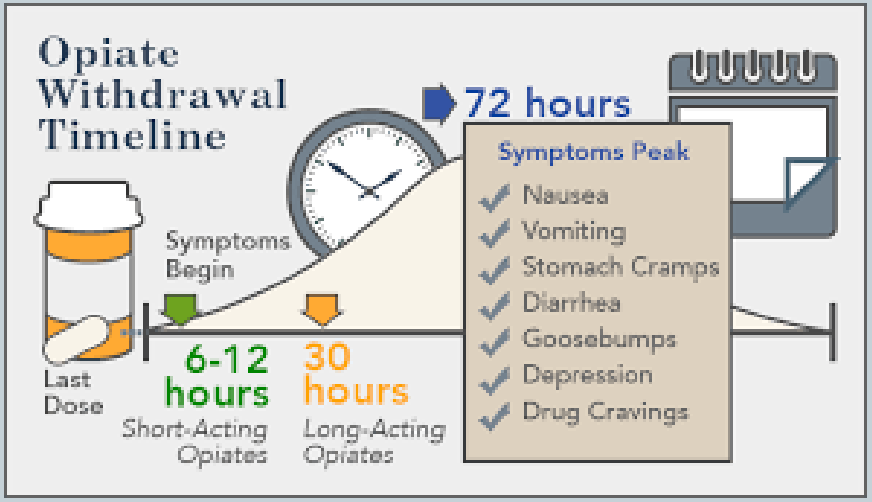
Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid DependenceA Randomized Clinical Trial. Jama 2015

Harm reduction in hospitals: is it time? Harm Reduction Journal 2009.

Opioid Use Disorder, Treatment Options

Withdrawal Protocol: Symptom Based

Clonidine
Immodium
Nsaids
Bentyl
Zofran



Maintenance therapy

Step 1: Establish Diagnosis
Step 2: Discuss outpatient feasibility
Step 3 : Methadone or Buprenorphine
- Methadone generally 20-30 mg d
- Buprenorphine: COWS + test dose + 8-16 mg

Legality "Title 21 of Code of Federal Regulations section 1306.07

"Managing Opioid Use Disorder During and After Acute Hospitalization: A Case Based Review Clarifying Methadone Regulation for Acute Care Settings"

Buprenorphine treatment for hospitalized, opioid-dependent patients: a randomized clinical trial. Jama 2014

"Managing Opioid Use Disorder During and After Acute Hospitalization: A Case Based Review Clarifying Methadone Regulation for Acute Care Settings" J addict behav 2015 Apr 30 : 4(2)

Community Resources

http://www.naohio.org/
http://www.aadaytononline.org/

Project CURE

Greene County

The Community Network

Christopher House

Women's Recovery Center

Others?

Improving the Quality of Care We Provide

Collaborative efforts with interdisciplinary teams

Physician leadership characterized by:

- Personal commitment
- Professional credibility
- QI behavior and skills
- Institutional Linkages

Recommendations for Improving the Quality of Acute and Cancer Acute Pain. American Pain Society Quality of Care Task Force. 2005

"The way in which you talk with patients about their health can substantially influence their personal motivation for behavior change. No person is completely unmotivated. We all have goals and aspirations. You can make a difference and have a long-term influence on your patients' health."

Motivational Interviewing in Health Care

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https://www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/Pain_Management_/best_practices.aspx

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