UVM ECHO -- Chronic Pain

Facilitators:
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• Liz Cote

Faculty:
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• Amanda Kennedy, PharmD
• Charles MacLean, MD
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• Rich Pinckney, MD, MPH
• Carlos Pino, MD
• Jill Warrington, MD
Introduction to ZOOM

• Mute microphone when not speaking
  • If using phone for audio, please mute computer
  • If using phone, *6 is used to mute/unmute

• Position webcam effectively (and please enable video)

• Test both audio & video

• Use “chat” function for:
  • Attendance—type name and organization of each participant upon entry to each teleECHO session
  • Technical issues

• We need your input!
  • Use “raise hand” feature; the ECHO team will call on you
  • Please speak clearly
Disclosures

Northern Vermont Area Health Education Center (AHEC) is approved as a provider of Continuing Medical Education (CME) by the New Hampshire Medical Society, accredited by the ACCME. Northern Vermont AHEC designates this educational activity for a maximum of 1.5 Category 1 Credits toward the AMA Physician’s Recognition Award.

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No relevant disclosures

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• RECORDING OF SESSION TO BEGIN
UVM ECHO Chronic Pain: Assessing for Misuse

Presenter:
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Some important terms

• **Opiate misuse** – any use of prescription in any way other than was intended by prescriber

• **Hazardous use** – Use that increases the risks of harmful consequences: physical, social, or psychological

• **Addiction/opiate use disorder** – Use characterized by impaired control over drug use, craving, compulsive use, and continued use despite harm

• **Aberrant behavior** – “use of medicine outside of the agreed upon treatment plan”
Summary of surveillance standards of care

• Treatment agreements
• Frequent office visits
• Vermont Prescription Monitoring System (VPMS)
• Current Opioid Misuse Measure (COMM)
• Pill counts (optional)
• Urine drug screening

Practice Universal Precautions!
Examples of aberrant opioid use

• Results from surveillance
  • Abnormal urine testing
  • Getting multiple prescriptions from different sources – detected by VPMS
  • Elevated COMM score

• Other behaviors
  • Losing a prescription
  • Early refill
  • Taking a spouse’s medication

• New behaviors
  • Not willing to taper below 90 MED (MME)
  • Not willing to try new therapies
General approach

There is a differential diagnosis for aberrant behavior
- Evaluate like you would any other medical problem
- Be transparent in your approach

Non-judgmental approach
- Addiction is a complication of medical treatment
- Avoid direct confrontation of lying or deceit

Watch for a tendency to prematurely make a diagnosis

All patients are suffering and need our compassion
The differential diagnosis of aberrant opioid behavior

• Normal adherence issues
• Undertreated pain (pseudoaddiction)
• Psychological
  • Psychological dependence
  • Maladaptive coping
  • Self treatment of other symptoms
• Hazardous
  • Opioid use disorder
  • Diversion
  • Recreational use
Stepwise process

• Review data
  • Prior and other aberrant behaviors – the quantity is very important
  • Review risk factors for substance use disorder
  • VPMS

• Interview
  • Patient explanation of behaviors
  • Review other high risk behaviors
  • Screen for substance use disorder – DAST-10
  • COMM
  • Assessment of coping skills
  • Functional assessment
Normal adherence problems

• Patient didn’t understand the plan
• Patients really do get meds stolen, lost, etc.
• Some people are chronically disorganized

• Clues:
  • Usually only one aberrant behavior
  • Disorganization is usually related to appointments
  • ADHD diagnosis
Pseudoaddiction

• Patient’s pain is undertreated

• Will get better with increasing the dose of the medication or changing the timing of the medication

• Desperation is the motivation for the behaviors

• Behaviors suggestive of pseudoaddiction
  • Early refills
  • Hoarding
  • Asking for medication by name
Psychological Coping

• Presentations
  • Anxious or depressive symptoms
  • Hopelessness
  • An illness narrative of suffering/loss of meaning
  • Treating opiates like they are ibuprofen
    • Treating other pains
    • Possibly treating emotions

• Practitioner tools
  • Pain diary is an excellent way to tease this out
  • Mindfulness and CBT
Addiction/opioid use disorder

- Key is loss of control of taking medication and impairment of function in key areas
Risk factors for addiction

• Risk goes up as progressively younger
  • Patients aged 18-30 are 16 times more likely than those ≥ age 65
• ≥ 2 psychiatric diagnoses
• > 120mg Morphine Equivalent Dose (MED) 6.7 times more likely
• High COMM score
• History of a substance use disorder
• Marijuana on UDS
• Smoker
• Family history of substance use disorder
• Incarceration
Behaviors suggestive of addiction

• Multiple aberrant behaviors
• Theft and other legal problems
• Multiple prescribers
• Prescription forgery
• Buying meds on the street
• Failing bubble pack pill counts
• Functional assessment shows a decline
Ways to explore addiction

Icebreakers
- DAST-10 questionnaire
- COMM questionnaire

Be transparent

Use explicit statements of caring/compassion
- “I am worried and just need to know”
- “I wouldn’t be doing my job if I didn’t ask..”
- “I just want you to know, no matter what is going on, I am here for you to help in any way I can”
Diversion

Difficult to distinguish from addiction

Tend to be more subtle – no loss of control
  • Failure to show to referrals and try other options
  • Fail pill counts
  • Urine tox screen positive for cocaine

Motivators
  • Feeding another addiction
  • Abuse – domestic/disabled/elderly
  • Financial
Human error – the health care team

If we are not careful, we can set up our patients for failure:

- VPMS error – confirm any concerns you see
- Misuse of urine testing
- “Hoop jumping”
- Receiving false reports
What if you can’t make a diagnosis

• Get another opinion
  • Mental health referral for further evaluation
  • Colleague consultation
  • Pain clinic? – exploring new models

• Increase the surveillance
  • Bubble packs with pill counts
  • Pain diary

• For the patient about whom you are unsure – bubble packed pill counts solve the mystery in about 80% of cases
Questions
• RECORDING TO BE STOPPED
Case Presentation
Case Presentation
Case Presentation
Case Presentation
**Echo Reminders**

- Volunteers to present cases
  - Use the case presentation form template
- Please complete evaluation forms for each session
  - CME will be processed once session evaluation form is received at UVM
- UVM Project ECHO materials available at [www.vtahec.org](http://www.vtahec.org)
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