UVM ECHO -- Chronic Pain

Facilitators:

- Mark Pasanen, MD
- Liz Cote

Faculty:

- Patti Fisher, MD
- Amanda Kennedy, PharmD
- Charles MacLean, MD
- Sanchit Maruti, MD
- 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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The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

No relevant disclosures

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- RECORDING OF SESSION TO BEGIN

UVM ECHO Chronic Pain: Assessing for Misuse

Presenter:

- Rich Pinckney, MD, MPH

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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

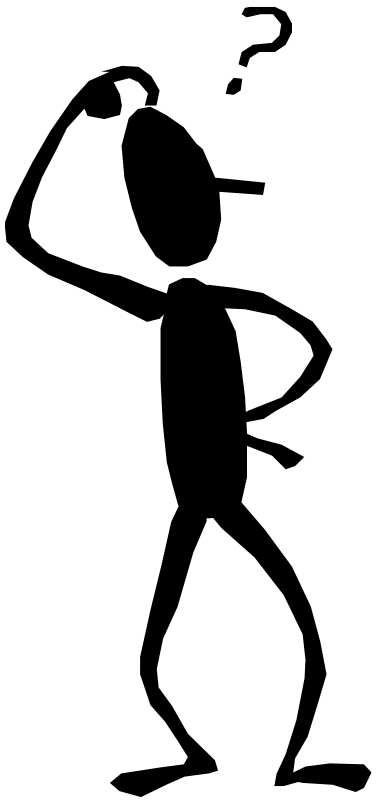
If we are not careful, we can set up our patients for failure:

- 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
- Please contact us with any questions/suggestions
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