The Anatomy of Chronic Pain and Opioid Misuse: Case Management, Treatment Decisions and Opioids

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Welcome!

Thank you for joining us for Paradigm’s 2012 webinar series. Replays of past webinars are available for viewing at www.paradigmcorp.com/webinars

The Anatomy of Chronic Pain and Opioid Misuse is a three-part series of webinars about pain

**TODAY**: Case Management, Treatment Decisions and Opioids

**Coming in August 2012**: Opioids and Cognitive Behavioral Therapy

Replays are available online of all of our past webinars, including *Clarification of Diagnosis and Opioid Addiction*, part one of this series
First a few housekeeping points....

- Slides will advance automatically
- Question & Answer period at end
- You may submit questions at any time
  - Q&A Panel is on the lower right side (If you don’t see it, click the “Q&A” button in the upper right)
  - Type a question into the lower section of the Q&A panel that appears
  - Ask “All Panelists” and be sure to click “Send”
  - If we cannot answer during the session, we will e-mail you
- Replay will be sent via email and the presentation was emailed to you this morning
- When the webinar ends, a short survey will pop up
  - There will be a CCMC section which must be completed to receive continuing education credits
- If you experience computer broadcast audio problems, please use the dial in number posted in the Chat panel

Housekeeping
Many patients are traveling at full speed toward substance use disorders...

How can we alter the course?
A clear diagnosis is imperative for understanding chronic pain and opioid misuse.

Key Points From Our March Webinar

- Inaccurate pain diagnosis, and reliance on subjective pain report over objective measures, will begin a treatment trajectory that may be based on trial and error procedural care, and often leads to emphasis on poly-pharmacy and narcotic escalation.

- The term “substance use disorders” encompasses all problematic use, not just addiction.

- Tolerance, dependence, hyperalgesia and withdrawal symptoms can perpetuate a cycle of side effects, persistent or escalated use, and aberrant use.

- Tolerance to analgesic effect is not a good reason for high-dose opioid treatment.
This Webinar

How does one decide which treatment approach is right for a given patient not being helped by opioids?

- What do guidelines say about effectiveness of opioids in chronic pain?
- How do you measure effectiveness of opioids?
- Proper opioid treatment monitoring
- Treatment options
  - Outpatient weaning
  - Rapid detoxification
  - Inter-disciplinary pain program
  - Replacement therapies
- Case management pointers
Today’s Presenters

Steven Moskowitz, MD
Senior Medical Director, Paradigm

- 28 years experience in physical medicine and rehabilitation and pain management
- 23 years experience in case management and healthcare administration
- Clinical expertise in complex musculoskeletal and neurological conditions
- Practiced for 16 years at a large multispecialty clinic in MA in the neurology department
- Paradigm Medical Director for 15 years

Fernando Branco, MD
Medical Director, The Rosomoff Comprehensive Rehabilitation Center
Medical Director, Paradigm

- 27 years experience in rehabilitation and pain management
- Board certified in physical medicine and rehabilitation, pain management and addiction medicine
- Member of the American Pain Society, American Board of Pain Medicine
- Extensive, award-winning research on spinal cord injury and sexual dysfunction
- Paradigm Medical Director since 2010
Next stop success: Managing the transition from prescription opioid user to non-user
Unpack the facts

According to the CDC, for every unintentional overdose death caused by opioids, how many emergency room visits are there?

a) 5  
b) 8  
c) 10  
d) 35
### When is Opioid Use a Problem?

Choosing an appropriate weaning option depends on the problem.

<table>
<thead>
<tr>
<th>When they are ineffective</th>
<th>When they are harmful</th>
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<tbody>
<tr>
<td>■ Lack of symptomatic improvement                                                         ■ Use disorders</td>
<td></td>
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<tr>
<td>■ Lack of functional improvement                                                          ■ Side effects (&gt; 60%)</td>
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<tr>
<td>■ Lack of objective quality of life improvement                                           ■ Bowel dysfunction</td>
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<td>■ When dose is escalating more than rarely                                                ■ Urinary retention</td>
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<td>■ When additional medications are continuously added                                      ■ Endocrine failure</td>
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<td>■ Immunosuppression</td>
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<td>■ Intoxication</td>
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<td>■ Behavioral disorders</td>
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|                                                                                         ■ Personal injury or risk to others
When Are Opioids Effective?

Effectiveness of opioids in chronic pain

Despite the marketing and extraordinary growth in sales...

Lack of reliable long-term proof of effectiveness (>16 weeks)!

- Neuropathic pain: Official Disability Guidelines: no reliable long-term studies. No studies on long-term use for neuropathic pain including lumbar root pain and CRPS. Not recommended as first line.

- Chronic back pain: Limited efficacy with short-term use. Limited evidence for use of opioids in chronic low back pain. Lifetime prevalence of substance use disorders as high as 36-56%.

- Headaches: not recommended; risk of medication overuse headache.


- Mechanical or compressive etiologies: rarely beneficial.
Monitoring Is Important and Necessary

“Set it and forget it” is not an option.

Serious drugs with serious side-effects

- Monitor to determine if condition has changed
  - History, physical examination
- Monitor effectiveness
- Document iatrogenic side-effects
- Monitor for use disorders including addiction, diversion, hyperalgesia
  - History
  - Urinary Drug Screen
  - Pill counts
- Have an end game

Know your destination, and check your route frequently!
Mr. Costa

- 48-year-old man who fell seven years ago, resulting in multiple mild spinal compression fractures. Extensive work-up negative for spinal nerve compression or instability. He has had a spinal cord stimulator placement.

- Takes hydrocodone and Nucynta at MED 180-230 mg/day, 2 muscle relaxants, Flexor patch, ibuprofen, Elavil; repeated injection therapy. Surgeon had offered spine surgery, fusion L2-sacrum “because nothing else helped.”

- Though he says he does not want his young daughter to see him in a disabled role, he exhibits a lot of pain behaviors and has applied to SSDI.

- Frequently attends car shows.

What is Mr. Costa’s best bet for detoxification?

Dr. Branco will discuss the options...
Full Speed Ahead: Effective Treatment Choices

Fernando Branco, MD
Medical Director, The Rosomoff Comprehensive Rehabilitation Center
Medical Director, Paradigm
Unpack the facts

Patients taking high dose opioids can be treated successfully by a standard drug detox program.

a) True
b) False
Treatment options we will address

- Outpatient weaning
- Inpatient weaning
- Replacement therapies
- Rapid detoxification

Must provide pain rehabilitation as well as detoxification

Remember, patients often need detoxification from multiple medications.
Outpatient Weaning

**Settings**
- Office
- Outpatient drug “detox” program
- Outpatient Comprehensive Pain Management Program (community weaning)

**Patient Characteristics**
- On lower opioid dose, simpler medication plan (1-2 meds), more gradual wean
- Motivated
- Low to medium psychosocial issues
- Community social support for plan

**Weaning Process**
- Speed of weaning: dose decrease by 20-25% every 10-14 days
- Monitoring: Urinary drug screen, pain behaviors, drug use and seeking, functional status
- Support: Meds for withdrawal (temporary), physical rehabilitation (functional approach), follow-up every 1-2 weeks, but available by phone daily, proactive check-in; cognitive behavioral approach

**Case Management**
- Actions: contact injured worker in person if possible, review treatment recommendations and symptoms management, contact treating team, return to provider if not able to assure compliance, do not approve increase in meds or new diagnostic evaluations or treatment changes unless recommended by current treatment team; disallow return to prior prescribers.
Inpatient Weaning

Settings
- Residential drug “detox” program
- Weaning as part of Comprehensive Pain Management Program*
- Rapid detox (addressed later)

Patient Characteristics
- On high doses of opioids and/or complex drug regimens or needs more rapid detox
- Not motivated or resistant to weaning
- Medium to high psychosocial issues; history of psychiatric diagnosis, prior failed detox
- Poor community social support for plan

Weaning Process
- Speed of weaning: dose decrease by 20-25% every 3 days
- Monitoring: Urinary drug screen, pain behaviors, drug use and seeking, functional status
- Support: Meds for withdrawal (temporary), physical rehabilitation (functional approach), follow-up every day, available by phone daily, proactive check-in, onsite problem resolution; aggressive physical rehabilitation to separate physical from drug issues; multiple modalities to treat withdrawal

Case Management
- Red flags: Increased pain complaints, limited participation, desire to quit program, family support not adequate or detrimental, core beliefs unchanged, anger at carrier, multiple addiction issues. Post-discharge issues.
- Actions: Family engagement, clear-cut discharge pre-planning regarding pharmacy limitation, approved physicians, day-to-day problem resolution using providers from pain program. Urine drug screens. Onsite psychological support, cognitive behavioral approach.
Replacement Therapies

**Settings**
- Outpatient: bridge to detoxification
- Methadone, Buprenorphine products

**Patient Characteristics**
- On high doses of opioids predominantly
- Indicated for addiction; very limited as a pain “solution”
- Motivated wean off current meds, agrees to terms of process or case who will not wean, out of control
- Low to medium psychosocial issues
- Good community social support for plan

**Weaning Process**
- Speed of weaning: induction requires care, but is relatively quick; subsequent taper is slow
- Monitoring: Urinary drug screen, pain behaviors, drug use and seeking, functional status
- Support: Functional restoration, cognitive behavioral therapies, support groups (AA, NA)

**Case Management**
- Red flags: Lower risk of abuse if no other meds prescribed; pain complaints likely to continue. Patient may advocate to go back on pain medications. Control.
- Actions: Consider inpatient or outpatient detoxification.
Rapid Detoxification

Not proven safe or effective

- **Indications:** Few, if any. Low doses of narcotics.

- **Claims:** Painless, cheaper, safe.

- **Realities:** Very risky (high death rate) from “coma” detoxification, does not treat root of the problem, severe withdrawals and craving on discharge without any support.

- **Risks:** Death, suicide due to severe withdrawals, pain not addressed, immediately resuming use of narcotics.

- **Ideal candidate:** Maybe patient with no addiction history who medically needs to be off meds ASAP.

- **ODG TWC 2012:** The data supporting the safety and effectiveness of opioid antagonist agent detoxification under sedation or general anesthesia is limited, and adequate safety has not been established. Given that the adverse events are potentially life threatening, the value of antagonist-induced withdrawal under heavy sedation or anesthesia is not supported.
Reversing the Locomotive...

Revisiting Mr. Costa, the 48-year-old man who fell 7 years ago and now takes multiple medications without relief...

- **Choice of detoxification setting:** Inpatient interdisciplinary pain program

- **Reasons for decision:** High dose opioids and other medications, high disability convictions, low functional status, no local provider who can/will do the detoxification and lack of comprehensive rehabilitation options nearby.

- **Progress:** Functional score improved from 44-97% of expected for age. Off all opioids, with surprising ease. Maximum medical improvement established. Home exercise program put in place.
Need to change course?
Consider each player:
Injured Worker Challenges in Case Management

Understand where the injured worker is in the change process

Consider life after detox, with an eye to maintaining durability

Plan for injured worker’s self management

Red Flags

- Poor or no communication with case manager
- Returning to old enabling doctor to seek meds
- Describing pain as “20 out of 10” and requesting specific procedures

Moving Forward
Provider Challenges in Case Management

Red Flags

- Resistant to stopping narcotics or restarts narcotics

Moving Forward

- Move toward at least passive agreement
- Consider advocating for change in provider
- Prevent recidivism
System Challenges in Case Management

- Disagreement regarding best setting for detoxification
- Desire for simple, quick solutions over long-term vision

Red Flags

Moving Forward

- Embrace the biopsychosocial model of care
- Understand challenges of workers compensation
- Be mindful of causation issues
Our August webinar considers the role of cognitive behavioral therapy as a tool in the treatment of chronic pain and substance use disorders.

To view replays of past webinars, including the first in our 2012 series of webinars about chronic pain, please visit our website at www.paradigmcorp.com.
Question and Answer Session

Please submit your questions for our panelists in the Q&A window on the right.

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