Chronic Pain Assessment and Management for Individuals with a History of Addiction within the Long Term Setting
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Objectives
I will be covering what patients say about:

1. When prescription opioids induce misuse
2. How patient loses control
3. What are the experiences of seeking healthcare

(I will also cover the TEDS data when there is referral for treatment and what their treatment outcomes are.)

I will be covering:
• Epidemiology of Pain and SUD
• The caregiver healthcare team
• Understand the initiation of prescription opioid abuse
• Understand their experiences as patients with coexisting SUD and pain interact with the caregiver healthcare team
• Identify appropriate assessment tools and strategies to provide safe and effective pain management.
• Treatment
Epidemic/Crisis in US

- Chronic Pain: 116 million people, cost: $635 billion
- Drug Abuse: 4.5 million users of nonmedical pain Rx;
  Cost: $467.7 billion/ year

US has:
- 4.3% world’s population
- 83% world’s oxycodone
- 99% world’s hydrocodone

(Report of International Narcotics Control Board, 2008)

Opioid Prescribing in the US

- Quadrupled over last 15 years
- Enough for every Adult American to have a bottle of pills.
Current State

- Opioid abuse has escalated
- Pain often unrelieved
- Increase healthcare utilization due to misuse
- Ambiguity: managing patients with addiction and pain
  - Ranking of education (0 = insufficient, 3 = very good)
    - MD = 0.35
    - NP/PA = 0.5

(Berg, et al., 2009; Upshur, et al., 2006; Wilsey, et al., 2008; Baldacchino, et al., 2010)

Is pain management effectively taught in prelicensure programs?

- Only 5 studies in literature examining pain knowledge in prelicensure environment and focus on EOL, palliative care or specialty populations
- Two studies from Canada and UK lend insights:
  - US study (Doorenboos et al., 2013) of 6 nursing programs note limited content
  - eg 8 hours over 2 years on pain in U Washington nursing program
Core Values and Principles

- Advocacy
- Collaboration
- Communication
- Compassion
- Comprehensive Care
- Cultural Inclusiveness
- Empathy
- Ethical Treatment
- Evidence-based Practice
- Health Disparities Reduction
- Interprofessional Teamwork
- Patient-Centered Care
Domains
Adopted from IASP Curricula

• **DOMAIN 1**
  - Multidimensional Nature of Pain: What is pain?

• **DOMAIN 2**
  - Pain Assessment and Measurement: How is pain recognized?

• **DOMAIN 3**
  - Management of Pain: How is pain relieved?

• **DOMAIN 4**
  - Clinical Conditions: How does context influence pain management?

Caregiver healthcare Team

- Healthcare team is interdisciplinary team
- Assisted Living providers
  - physician/NP/PA prescribe the opioids, non-opioids, and non-medicine modalities
  - pharmacists also provides direction and education on opioids.
  - caregivers, implement recommendations & understand foundation

What happens?

- Chronic pain and substance use disorder coexist.
  - Health complications above and beyond their pain and SUD
    - more psychiatric disturbances
    - higher utilization of health care services
    - lower quality of life
    - less social support

(Trafton, Olin, Horn, Winkel, & Humphreys, 2003)
Challenges for Patients

- Addiction
- Stigma
- Pain not well treated

(Campbell & Cramb, 2007; Trafton, et al., 2004)

Methadone Clinic Study

Coexisting Addiction and Pain in People Receiving Methadone for Opiate Addiction (2011-2012)

To examine the experiences of people with chronic pain who are receiving methadone for opiate addiction through narrative inquiry.

Participants

Ethnicity

- 17 African American
- 12 Caucasian
- 2 Caucasian and Native American
- 1 African American and Native American
- 1 Mexican Indian
- 1 Native American.
Chronic Pain Diagnoses (participants)

- Low back pain
- Injuries
  - Crush, Gunshot wounds, Fractures, Feet pain
- Rheumatologic
  - RA or OA, fibromyalgia or myofascial pain
- Interstitial cystitis and endometriosis
- Carpal tunnel
- Pancreatitis

Trajectory when Addiction First

- Introduced by friends
- Males: crime and episodic incarceration
- Females: domination by males, sex work, stealing
- Violence, injuries or illness
  - resulted from substance use
  - lead to further pain and suffering
- Pain Rx incorporated into drugs of abuse
- Escalated dose
- When pain became part of their lives, addictions became worse.

Trajectory when Pain First

- Health care providers: initial exposure (100%)
- Abusing prescription opioids
- Transitioned to illicit substances
- Abused both prescription opioids and illicit substances
Would they abuse PO Rx again?

- 77% of participants said yes
- Cycle of pain, drug abuse, healthcare
- Predisposing factors -- not reliable indicator

Healthcare Experiences When Pain and Substance Use Disorder Coexist

“Just Because I’m an Addict Doesn’t Mean I Don’t Have Pain”


Experiences with Health Care

Stigma
- “Tears me apart” (Bill)
- Felt like he wanted to use again (Franklin)
- Stereotyped: “drug seeking”, “pill seeking”
- Some did not want to keep their addiction a secret
  - “Secrets keep you sick”
- Discrimination (i.e. ED)
- Not feeling well cared for
Case

- Patient with recurrent kidney stones and pain
- Provider’s mistrust, suspicions, disbelief

“... I would’ve died because I was septic, and it was real and the doctors don’t think that when you first come in. They look at your sheet, first thing they see is ‘addict’ that sticks in their brain and nothing else helps.”

Experiences with Health Care Team

- Over prescribing
  - Large volumes
  - High doses
  - Little to no monitoring
  - No other interventions offered

Patients’ Perspective on Providers

- Prescriber and participant unprepared for this
  - Potentially life threatening
  - Want the same level of intensity of health care as their initial injury
  - Prescriber: assume responsibility for OD, rather than just “blame the victim”
Theme: Use of Deception

- 75% of participants related how they obtained PO from HCP
  - Behaviors activated or intensified their
    - Fake allergies
      - “I told the doctor I was allergic to ibuprofen just so I would get pain pills. You know, people do that.” (female participant)
    - Create injuries
      - “I didn’t want it fixed, I wanted to keep getting dope, it was like a jewel for me to go get dope.” (male participant)
    - Hide their addiction

The “Double Whammy”

- When addiction was out of control, pain was worse
- When pain was out of control, addiction was worse.
- Each caused a mutually reinforcing cascade


Perspective on Providers

- Confidence in health care team (50%)
- Best Outcome
  - “I’ve really great doctors that I’m working with now that understand my addiction and understand that I do need to control my pain.” (Helene)
- Supportive and caring relationship
  - Open and honest communication
Participants’ recommendations to prevent prescription opioid abuse

- “It’s the same pills you help me with that hurt me.” (Dennis)
- Higher level opioids
- Reduce opioids in steps
- Watch pain reduce
- Non-addictive analgesics
- Acupuncture
- Six days
- Relationship
- Support sobriety

The Experiences of People Living with Chronic Pain While Receiving Opioids To Manage Their Pain from Primary Care

(May, 2013-2014)

Funding: Nurse Practitioner Healthcare Foundation

Aim

To examine experiences, issues, and challenges that face people who live with chronic pain and who are receiving opioids to help manage their pain in primary care.
Inclusion Criteria

- Experienced pain for more than 6 months
- Received opioids for the treatment of pain in a primary care clinic in Midwest metropolitan area
- Willing to tell the story of their experiences

Method

- Narrative Inquiry
  - In-depth interviews
  - 90-minute interviews
  - Described experiences
    - Living with chronic pain and receiving opioids for pain
    - Healthcare experiences
    - Interview guide
- Thematic analysis

Demographics

- Gender = 50-50
- Ethnicity
  - Caucasian = 8
  - African American = 3
  - Hispanic = 1
**Theme**

**Difficult to obtain legitimate prescription opioids for pain**

- All participants felt they were mis-treated by physician in primary care or emergency room at one time or another.
- "If I’m not getting it from my doctor then I gotta find other ways to get it." (Participant #3)

**Protecting their sobriety**

- "Won’t use heroin because I’m more scared of that than anything, you know what I’m saying?" (Participant #6)
- "I don’t wanna screw up my sobriety. I don’t wanna get addicted. I was very frightened about getting addicted and frightened about craving [from prescription opioids for pain]." (Participant #2)

**Fears**

**Fear of SUD or relapse**

**Fear of losing access to opioids:**
- Participants stated that individuals who misuse their prescription opioids were “wrecking it for those who need it for pain.”
- They reflected that media coverage of people overdosing was why healthcare providers were “cracking down” on prescribing opioids for those with pain.
Non-medicine ways of managing pain

- “You can’t just treat yourself with drugs”
- Background noise
- Walking dogs
- Change of diet
- Exercise and stretching, Physical Therapy, Massage
- Healthy mind - counseling, meditation
- Fishing
- Developed protocol for medication taking
- Keeping company with healthy people, “If you hang with people that use, you’re a user.”

Recommendations from Participant

- Mandatory group therapy, every 3 weeks, as a condition for getting prescription opioids.
- AA, everyone has one thing in common
- This mandatory group therapy, everyone would have prescription opioid in common

Healthcare experiences while seeking relief for their pain

- Positive healthcare experience:
  - One participant stated: “... because they care, I care.”

- When they felt confident in healthcare, they experienced less stress, more ability to cope with pain even when pain intensity was high.
Healthcare experiences while seeking relief for their pain

- Negative healthcare experience:
  - Receiving inconsistent communication about their care, and feeling stigmatized.
  - Receiving “run around”
  - Abdominal pain in ED

Source of Referrals and Success Rates for Prescription Opiate Treatment Admissions: An Analysis Based on Data from the Treatment Episode Data Set

- Investigators:
  - Barbara St. Marie, PhD, ANP, GNP
  - Ethan Sahler, MA
  - Stephan Arndt, PhD

  Partial Funding by the Iowa Consortium for Substance Abuse Research and Evaluation, University of Iowa

Aim

- To determine how referral rates for treatment admissions for PO misuse by HCP compare to other referral sources
- To determine how completion success rates for PO admissions compare with other substances
Design

- Secondary analysis of existing data set (TEDS) regarding referral source and treatment outcome.
- Comparisons made between groups entering treatment because of PO or other substances.

Participants

- Treatment Episode Datasets - Discharge (TEDS-D)
- Demographic and characteristics of ~1.5 million annual admissions to treatment.
- Public and private treatment facilities.
- 5 years of d/c data.
  - Client admissions with no prior treatment.
  - N = 2,909,884.

Results

- Health Care Professionals account for <10% referrals into treatment for clients admitted for PO misuse.
- PO clients referred into treatment had lower treatment success compared to other substance clients.
- When referred by HCP had lower success rates.
- Need qualitative study to determine “why”...

Synthesis

- We understand patient experiences
- Initiation of pain from SUD behaviors
- Initiation of SUD following pain treatment (opioids)
  - Mutually reinforcing cascade
- Cycle of pain, SUD, healthcare, entry at any point
- Supports and stresses
- Some are helped by opioids for pain, some are hurt.
- Importance of HCP helping people protect sobriety

Synthesis

- Participant’s use of deception to obtain opioids
  - Meant drug cravings were out of control
- Health care providers
  - Little understanding or ability to help chronic pain
- Participants who abuse opiates again
  - Receive less care, poor treatment by the health care team, 
- Positive health care = help maintain sobriety
  - Instill confidence and caring

Assessment
Assess Risk of Abuse

- Prescription drugs
- Illegal Substances
- Alcohol & Tobacco
- Substance abuse hx does not prohibit treatment of pain with opioids
- Psychiatric history
- Family Hx of SUD and psychiatric disorder
- Social history
- Younger age 16-45

Assessment Tools for Risk

- ORT - Opioid Risk Tool 5 items
- SOAPP - Screener & Opioid Assessment for Patients With Pain 24, 14, 5 items
- COMM - Current Opioid Misuse Measure 17 items

Mark each box that applies

1. Family Hx of substance abuse: Alcohol 1 2
   Legal drugs 3
   Prescription drugs 4

2. Personal Hx of substance abuse: Alcohol 1
   Legal drugs 3
   Prescription drugs 4

3. Age between 16 & 45 yrs: 1
   5

4. Hx of preadolescent sexual abuse: 1
   3

5. Psychologic disease: Anxiety, OCD, bipolar
   Schizophrenia 2
   Depression 2
   Posttraumatic stress disorder: 1

Administer

On initial visit
Prior to opioid therapy

Scoring (risk)

- 0-3: low
- 4-7: moderate
- ≥8: high


Scoring Totals:
Patient Counseling

- Order hard copies: www.minneapolis.cenveo.com/pcd/SubmitOrders.aspx

The Dos and Don’ts of ER/LA Opioid analgesics

- Do
  - Read Medication Guide
  - Take your medicine exactly as prescribed
  - Store your medicine away from children and a safe place
  - Disposal of opioids
  - Call healthcare provider about side effects

Patient Counseling (cont.)

- The Don’ts
  - Do not give your medicine to others
  - Do not take medicine unless it was prescribed for you
  - Do not stop taking your medicine without talking to HCP
  - If ER/LA - don’t break, chew, crush, dissolve, snort, or inject your medicine
  - Do not drink alcohol while taking this

When to Consider Co-Prescribing Naloxone:

Those at a higher risk for opioid overdose including:

- Taking opioid high-doses for pain (50 mg/day equiv)
- Receiving rotating opioid medication regimes (at risk for incomplete cross tolerance)
- On opioid preparations with increased overdose risk
- With respiratory disease (COPD, emphysema, asthma)
- With renal or hepatic impairment
- Concurrent benzodiazepine use
Preventing Persistent Post-surgical Pain and Opioid Use in Veterans: ACT

Distress-based conditions, anxiety and depression
Distress-based conditions create high risk of persistent postsurgical pain
Persistent postsurgical pain and prolonged opioid use following surgery are highly correlated.
Orthopedic surgeries -- at risk for PPSP

Purpose: To determine the barriers and facilitators of engaging in a 1-day ACT intervention workshop for veterans anticipating orthopedic surgery and to describe their interaction with the content of the workshop.

Results:
ACT workshop overall impressions
- Lifestyle than pain
- Different approach to pain
- Manual reinforced content
Results (cont.)

- Skills gained from ACT Workshop
  - Setting priorities and goals
  - Thinking differently about life and pain
  - Medication use
  - Self-awareness
  - Choice awareness

Barriers to Engagement

- Relevance to pain not initially recognized
- Pain during workshop
- Skepticism of psychological strategies
- Refusal to believe and accept need

ACT -- Veterans

- Conclusion
  - How individuals responded to the content one week after attending
- Most participants
  - engaged well
  - learned -- perceive pain
  - manage depression, anxiety, and life
Prescriptive Decision Support for Pain and Risk for Opioid Misuse

Overview:

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Summary

- Complex
- Requires entire healthcare team
- Mandatory group therapy, every 3 weeks, as a condition for getting prescription opioids.
- Balance treatment with non-medicine modalities

Summary (cont.)

- Constant communication - Decrease stigma
- Constant partnering with patient
- Communication with Family
- Therapeutic Relationship
Thank you!