Opioid Red Flags: Examining the Options and Taking the Next Steps

CMEO Podcast Transcript

Scott Howell:

Hello. My name is Scott Howell on behalf of CME Outfitters, I'd like to welcome and thank you for joining us for the third case of a three-part REMS CMEO briefcase series. Today's episode is titled *"Opioid red flags: Examining the options and taking the next steps*." Today's activity is part of a series of risk evaluation and mitigation strategies, or REMS education, covering the FDA blueprint. Opioid analgesics REMS education blueprint for healthcare providers involved with the treatment and monitoring of patients with pain. REMS compliant education is a critical component of ER, LA, opioid analgesics REMS program to provide education to clinicians on safe opioid practices, as well as current regulations and guidelines on treating pain and prescribe. Opioids appropriately. To meet the requirements for REMS, at the end of this activity complete the post-test and evaluation to receive your CME CE credit. CME Outfitters will submit your completed information to the FDA.

We hope that you will join us for the entire series cases. Case-based learning is a great way to illustrate not only the challenging patients you may see, but is also a great way to share experiences and strategies for overcoming those challenges. Watch your email for additional REMS compliant education from CME Outfitters. I am Scott Howell. I am currently the medical director for AIDS healthcare foundation in Los Angeles, California and board certified in family practice, preventive medicine and public health, along with addiction medicine where I've been an addictionologist for close to 30 years and practice at an academic medical center, also in Los Angeles, for addiction medicine.

Let's start with an overview of the activities and the goals for today. Our first learning objective is to identify risk factors and clinical presentation of opioid use disorder in patients prescribed opioids for acute and chronic pain. The second objective is to develop strategies for engaging patients in treatment for opioid use disorders. So, let's start our case. So we have a gentleman, his name is Jesse, he's 48 years old. He was injured at work about six months ago, resulting in chronic lower back pain. He is a plumber foreman for a large office building that's under renovation and he works from nine to five and states that his rest is helpful on the weekends, but because he has to go back to work on Monday through Friday, that rest cycle is just limiting in his recovery and this total relief of pain.

Subsequently he goes into the emergency room and gets prescribed oxycodone, gets a seven day supply, which is very good for a very limited number of days. And then in that emergency room, they ask them to do a follow-up with his primary care physician. That primary care physician, where we see it quite often, continues the prescription of oxycodone on a regular six hour basis. But then later on, he comes back and asks for an early refill, "Because of my schedule, I just can't seem to get ahead of the pain." And so there's multiple aspects within this case for Jesse. So one, he's got pain. Two, he came in early for a refill on something that should be prescribed on a regular basis. So a question comes up and the audience response would be to this question, what action would you take with Jesse? What can you take from the CDC guidelines for prescribing opioids for chronic pain to inform the decision for Jesse? And so when you look at the CDC guidelines for prescribing opioids for chronic pain, you can see that there's three different levels.

Scott Howell:

First, you have to determine if there's a need for opioids. If there is, then you got to determine the selection of which one, and then you've got to always have that continuing risk and you always have to address the harm of using chronic opioids. So the first part to it is determining the need. So for this gentlemen, for Jesse, we really have to understand what the mechanism of injury is. We have to see if there's any alternative therapies for pain management. We have to be able to see what his functional ability is. We have to be able to look at non opioid therapies that are there. Did this gentlemen how physical therapy? Was he prescribed nonsteroidals? Are there other, depending if it's neuropathic pain, [inaudible 00:04:53] a capability of a non-opioid therapy? Then if we then decide that opiates are the best selection, then we have to look at using immediate release for the immediate pain and then if we're going to go ahead and make that transition, then there's certain cutoff points of 50 MMEs and then 90 MMEs that really in truly have to be justified within that role of treating chronic pain.

And then you always have to look at that continuous follow-up. Is the pain getting better? Can we taper the medications? Can we discontinue? Can we add other non-opioid therapies to then lessen the amounts of opioids that are there? And then that continuously reassessing and addressing that risk is always there. Especially when you look at the CDC guidelines, [inaudible 00:05:49] and benzodiazepine really and truly increases the risk for potential bad outcome. Urine testing to make sure that there's no drug diversion that are being used, that many times patients have been getting opioid prescriptions and then selling them on the street. And then also looking at the overall databases within each state to make sure that there's not multiple drugs being prescribed by multiple doctors and then multiple pharmacies that are there.

When we look at a patient within the capacity of chronic pain, we don't want to just look in at one aspect of just the pain, but that pain is represented in an entire person. And looking at that entire person, we have to look at those biological factors, we have to look at the psychosocial factors, and we also have to then look at the social factors. Having been in chronic pain for one period of my life from a military accident, I'll tell you, the chronic pain that was going down my C6 neuropathic pain was just intense. It interrupted my sleep, it interrupted my relationships and interrupted my ability to work, and it interrupted that ability to feel refreshed. And only getting two hours of sleep in a given night was just not enough and going on for weeks at a time was just... It was unbearable.

So many times when we look at these patients with chronic pain, we want to look at how their mood is, if they have anxiety. I just remember being an aspect, that if I moved a certain way, there was so much anxiety about moving in a certain way that it just caused anxiety. My mood went down and so you have to look at an entire person, especially for this model of pain. And so every time that I look at a patient that has a potential opioid use disorder or chronic pain, I always get these additional psychosocial assessments. I do a GAD-7 on every visit. I do a PHQ-9 on every visit. And then not only that, but I like to track and trend these on a longitudinal scale in order to assess have we gotten into a better location, or the patient doing better. How are we doing? Have we added certain medications at certain points? Have we added some [inaudible 00:08:34]? At this point, has the mood improved? Has anxiety has gone down, et cetera.

Then not only that, but I also like to look at that opioid risk tool, that's important too, to see are we moving into a different sector of treating chronic pain, but then also moving into the aspect of maybe an opioid use disorder. And then looking at that pain and enjoyment of life and general activity. That's what we're really trying to do, is we're trying to improve someone's quality of life and maybe chronic opioids is the answer. Maybe the person has moved into an opioid use disorder. And so we have to really be able to make that correct diagnosis in order to improve this patient's life.

Scott Howell:

And then not only that, but how does that patient interact with society? How do they interact with their job? How do they interact with their family members? How is their mood? Are they just tied up at home, or are they out in public? Are they able to enjoy sports? Are they able to go to a ball game?

All of those types of things are exceptionally important to do as a follow-up in understanding the entire patient. Getting back to Jessie, it's interesting. Jesse returns for another early refill. Before going into the exam room, you go into one of the state databases and you see that a similar prescription was prescribed by another acute care clinic. So now we have two different physicians, we see maybe two different pharmacies and so now we have a tough situation and a discussion that we need to have with Jesse. And then you wonder if opiates are for pain or does Jesse have an opiate use disorder?

So, the most difficult conversations I feel with patients, and having seen patients for over 30 years, is to discuss whether a patient has issues with medication, whether that's legally prescribed medication or illicit medication or illicit drug use. And these are really and truly, I think, are some of the most difficult situations in order to have conversations with patients. And so going through this three step process of having that conversation, you really have to just go for it and just ask the patient about drug use, whether it's on prescribed medication where people say, "Well, this was prescribed by a doctor so that shouldn't be a problem." Or you're getting it from multiple doctors, multiple pharmacies, is this really and truly a problem? Or is it just an illicit drug use that people are obtaining illegally? And so that's a little bit easier of a conversation in my opinion.

And two, the second step, that you want to really determine is the risk level. Where are we within the spectrum of an opiate use disorder? And getting some of these questionnaires and getting a little bit of objectivity around it, using the CAGE or so bar, or the calm. You can get some degree of stratification. Where are these patients within that opiate use disorder? And then seeing where do you need to go from there. And as a primary care physician, having been on both fronts; as the primary care physician and then secondly the addiction specialist, I've been in both of these situations and many times the conversations are very, very good and they're non eventful and we can get into a good conversation. And other times people have just not accepted and you have to wait until the next interaction with this. And so this is a very tough conversation. And only until someone actually, has that ability to say, "You know what, I think there's an issue and we need to take that next step," there could always be denial that's there.

And then on the third step, depending on the risk factor we have to then advise, we have to assess and we have to assist. And then lastly we have to arrange. And so I'm usually on that arrangement component, where many of these patients, for me, the identification for someone with an opiate use disorder can be very tricky. I remember being at a high school soccer game. And there are some patients that I have known that look just like a very typical prototypical family, but in fact, they had $150 a day heroin problem. And so identifying this is so critical, and then engaging and that advice and then the assessment of doing that. And then I feel like I have an easier position within the spectrum, but many times that identification can be exceptionally tricky. And then for me, the treatment part sometimes goes according to guidelines and so sometimes it may be easier on my part. But that advise, assess and assist, and then finally that arrangement with an addiction specialist, is critical.

So one of the important parts is that when you're identifying these patients with the diagnostic criteria for DSM five, with opiate use disorder, I actually check off all the aspects where people meet the criteria. Are patients taking opioids longer or larger amounts than what they were intended to using? Is there a persistent desire to cut down, but they can't? Is there a great deal of time spent going to multiple doctors, multiple pharmacies? Are there cravings? Are there drug dreams? Are there failures to fulfill a major role, whether it's work, whether it's school?

Scott Howell:

Have they had issues with relationships because of the opioids? Have they had a DUI in the past? Have they been using them in hazardous situations? I've had police officers, I've had people that have been working at heights that have come in to me that are using opiates in hazardous environments. But one of the parts that when you look at the DSM five criteria, is that you see these two little asterisks that are down there.

One, it says exhibit tolerance, and the other one says exhibits withdrawal. So many times when people are using opiates for chronic pain, and that's the first diagnosis within your chart, then that would not count as part of an opiate use disorder because you're using long-term chronic opiates for the treatment of pain. So you've then determined that those long-term opiates, you can exhibit tolerance, you can exhibit withdrawal, but they are being used for the first diagnosis of chronic pain and using chronic long-term opiates to treat chronic pain. You don't want to have the capability of having in your notes opiate use disorder, and then using long-term chronic opiates. That's just a hazard in your charts. But if you, in fact, have someone that's on long-term opiates for the reason for chronic pain, then exhibit tolerance and exhibits withdrawal is part of that criteria that is not considered to be associated with opiate use disorder.

So Jessie in fact, we've determined he's been going to multiple doctors, he's been going to multiple pharmacies, and now we've determined that his pain can be treated with non-opiate use medications. And that now all of a sudden we realize that he in fact does have an opiate use disorder, there's certain medications that are available. The first one is methadone, and that's usually prescribed in a federally regulated treatment site. You usually have to go to the methadone clinic on a daily basis, after a period of time they can give you some take home doses. And then really from an addiction specialist component, many times in the past we would go ahead and just detox or wean people off in five days, say, "You're detoxed, you're done." And then from there, we would then say, "Good luck. You're opiate free."

But that detoxing capacity really and truly takes a long period of time. People aren't free from opiates and they're probably not free from opiates for six months, nine months, maybe in a year plus, depending on how many opiates they're actually using. And so many times we use buprenorphine or the buprenorphine Naloxone component to it, where they can be sublingual tablets or the film. And so that's a partial mu opioid agonist, antagonist. And so with that, we can use that for a longer period of time and then what happens is that over a period of time we can keep those patients on it for a long period of time, or when we can wean them off over time. But they've shown us that going in and using a five day detox and then saying, "Good luck," most people relapse over that. And so, a longer term period of buprenorphine, which is Subutex, and especially suboxone has shown better outcomes.

And then getting people stabilized is critical. Getting their jobs back, getting them oriented with the relationships, being able to go back to work. These are critical in the long-term use. Then lastly, you can have naltrexone, which is a mu opioid receptor antagonist and that can come in the extended releases used as an injectable suspension. And that is for over a month's period of time. And so that would just completely and totally sit on that mu receptor as an antagonist and so opioid would have no effect on that individual. The only problem that I see when I use that is, you need to have that close follow up because I've seen it where people have been using it for six months or so, and then they get lost to follow up and then they relapse with that. And so that's something that I like to keep very close, people with close follow-up anytime you know that I use that injectable.

Scott Howell:

And then lastly, anytime that someone has a long-term opiate course of treatment, they state that nearly 9 million people who are using higher dose opioid prescriptions, there's about 9 million people that would qualify for Naloxone. And that interaction between the safety and being able to use the nasal spray for the risk factors for overdose, is critical. And being able to have that in that concomitant use, especially with benzodiazepines if that's being prescribed, or being able to save someone's life on the street, because minutes count and seconds count on the street if there's an overdose that's out there.

So let's summarize and the SMART goals. SMART goals stand for specific measurable, attainable, relevant, and timely. Opiod use disorder is part of a continuum of a full spectrum of a patient that you want to definitely assess mood and anxiety. And then whether this person with chronic pain does, in fact, convert over to [inaudible 00:21:20] with a substance abuse disorder. Definitely look at the DSM five criteria for opiate use disorder, and then see how many of the criteria are being marked off. And then don't forget, exhibits withdrawal and exhibits tolerance. If you're determining that this patient requires long-term opiate for chronic pain, those two don't count. And then lastly, advise, assess, assist, and arrange for treatment and patients of need. That's where the patients can be followed up with an addictionologist or someone that has the waiver for buprenorphine. And then engage patients within that full spectrum, which includes medications that may be for non-opioid for pain. And then also the psychosocial support that's required for any addiction. And then make sure that if patients are using chronic opioids for chronic pain that we assess the risk for Naloxone for the nasal spray.

And so with that, I'd like to thank you for joining us today for episode three of our three-part REM CMEO briefcase series. To view additional case-based education on pain management, please visit www.cmeoutfitters.com. Please also visit us on the opioid educational hub. You'll find other REMs activity, as well as a broad range of educational activities and resources for healthcare providers and patients. As a reminder, to meet the requirements for REMs complete the post-test and evaluation to receive your CME CE credit. CME Outfitters will submit your completed information to the FDA. We hope that you'll be able to integrate these strategies into your clinical practice. Thank you.