Opioid Pain Management & Dependency

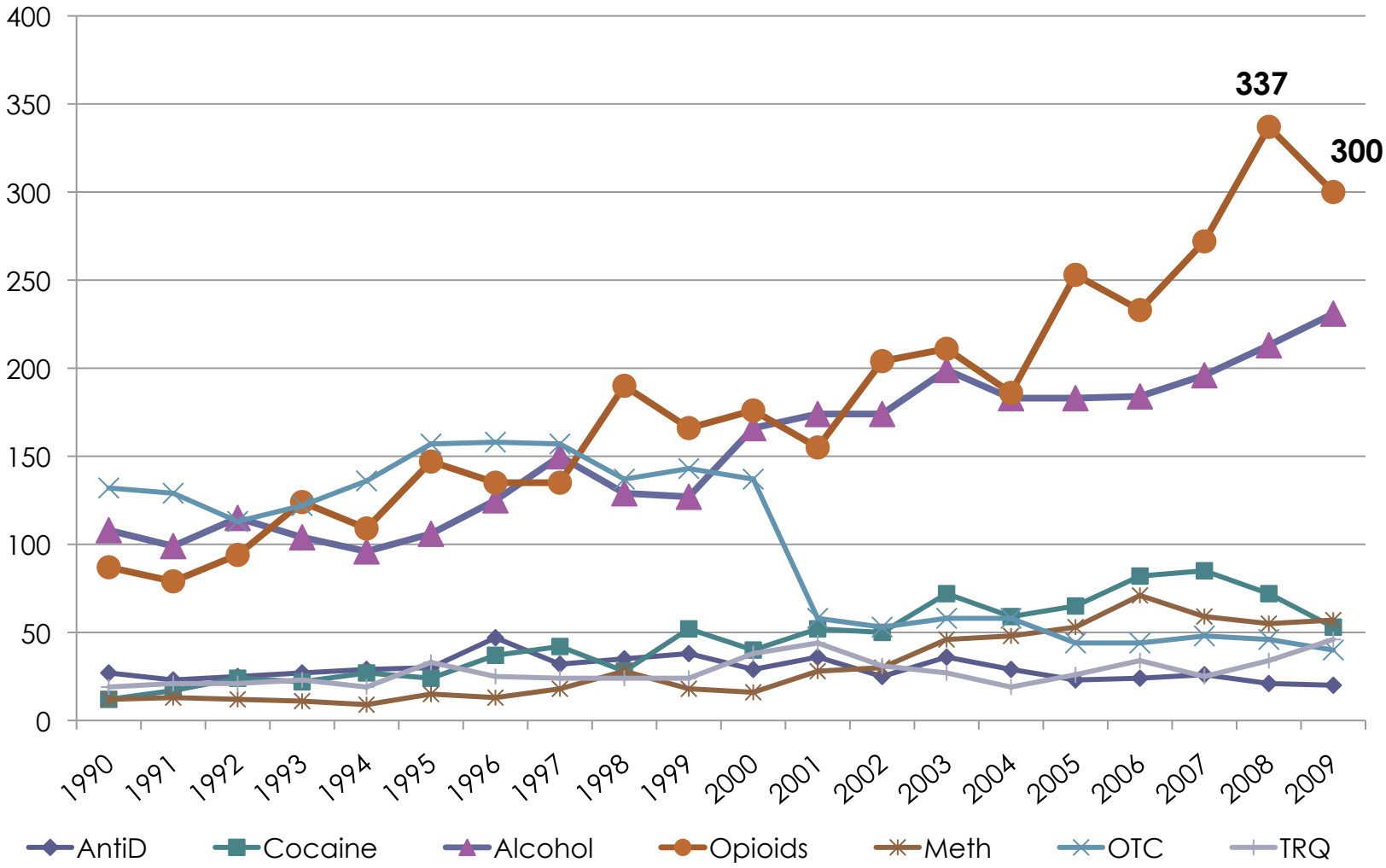
Scott Goold
November 9, 2012

At a Glance

- Prescription medicines accounted for 1.3 million ER visits in 2010:
  - 1.2 million visits for illegal drugs
  - 600,000 for alcohol and drugs combined
  - 200,000 for underage drinking
- Over 27,000 unintentional drug OD deaths; some 12,000 opioid analgesic OD deaths (CDC, 2007).
- Addiction can take hold in as little as two weeks.
  - Withdrawal symptoms: rapid pulse and breathing, high blood pressure, abdominal cramps, tremors, bone and muscle pain, vomiting, diarrhea, sleeplessness and depression.
- One baby is born addicted to prescription medicines every hour in the United States.

Sources: Detroit Free Press, "Revolutionary new drug Vivitrol offers new life to addicts," July 8, 2012, http://www.freep.com/article/20120708/FEATURES08/207080589/Revolutionary-new-drug-Vivitrol-offers-new-life-to-addicts
Omaha World Herald, "Babies born hooked on pain meds triples," May 1, 2012, http://omaha.com/article/20120501/LIVEWELL01/705019929/1161

NM Drug-related Deaths



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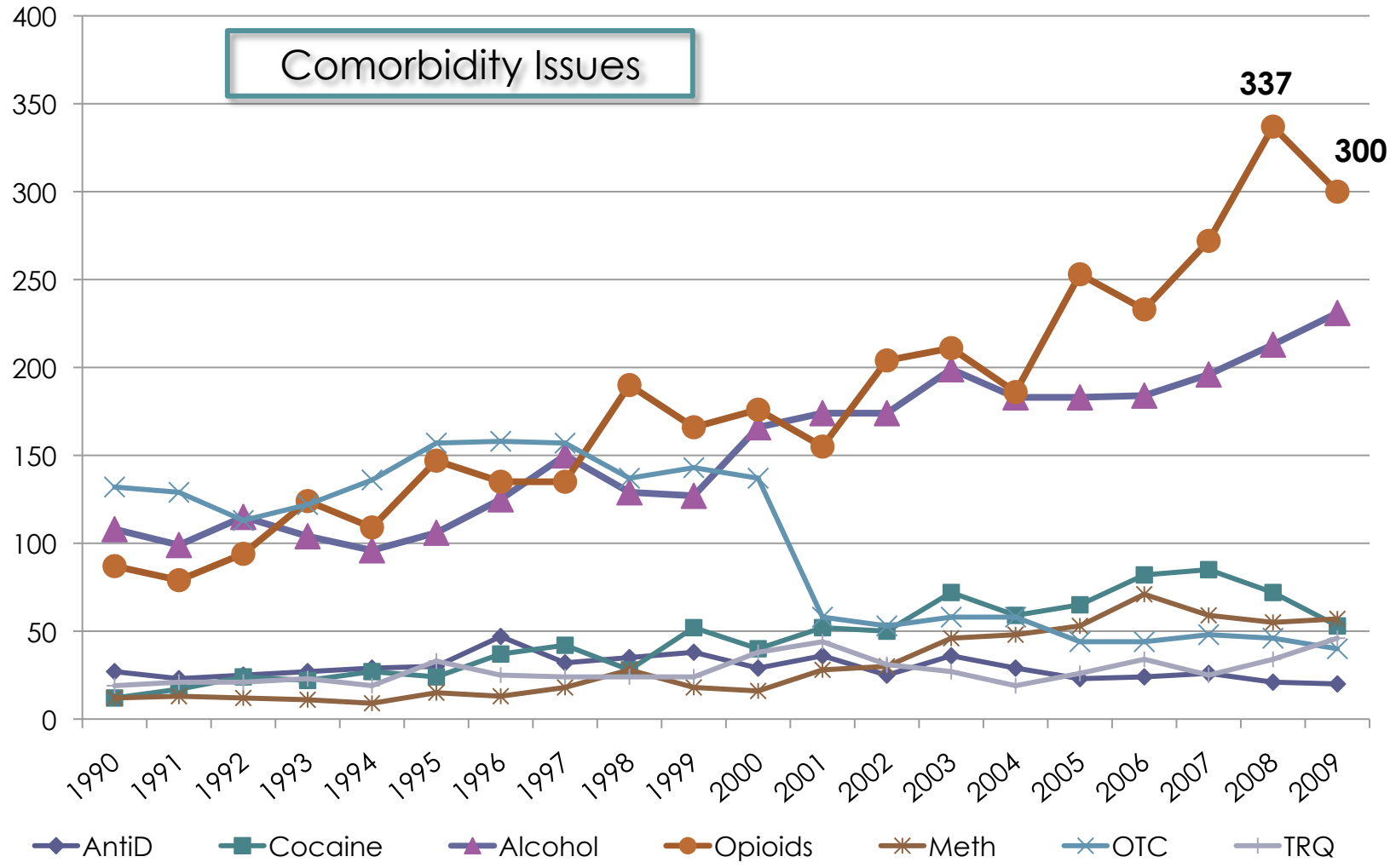


Accidental OD Happens

Heath Ledger

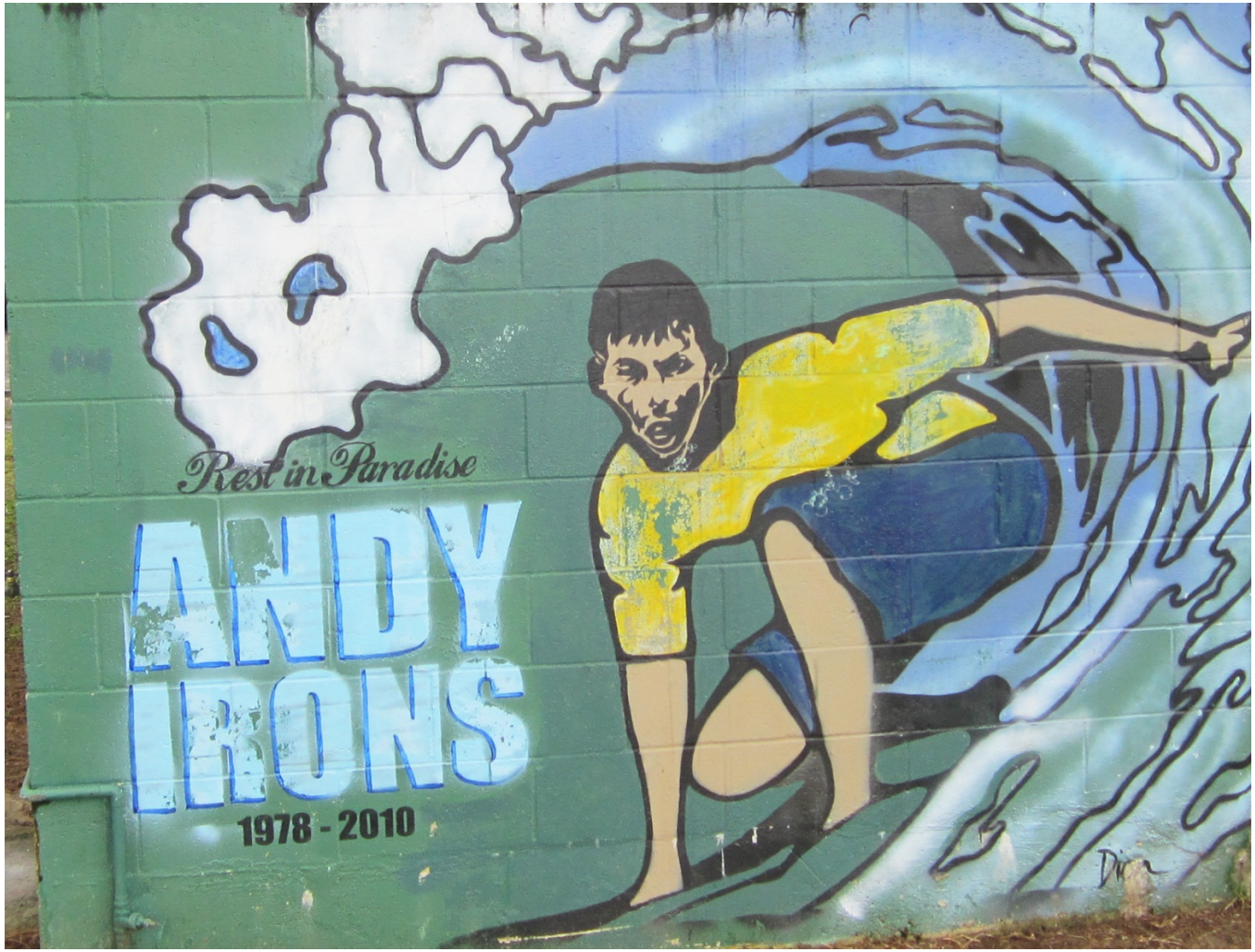
- April 4, 1979 – January 22, 2008
- Acute intoxication

  Oxycodone, hydrocodone, diazepam, temazepam, alprazolam, doxylamine

- No medications taken in excess
- Combining prescription medication, even at low doses, can lead to accidental death

AI: Disease?

AI: Prescription Drugs?



Andy Irons

"The guess is he probably took a sleeping pill to get a good night's sleep and get on the plane the next morning."

Randy Rarick told "Good Morning America"

- Alprazolam (Xanax), Zolpidem (Ambien), cannabinoids (marijuana), naproxen (anti-inflammatory), cocaethylene[1], methamphetamine, methadone and cocaine

  [[1]a chemical produced in the body when cocaine and alcohol are mixed that's linked to causing heart attacks in people under 40]

"The family believes Andy was in some denial about the severity of his chemical imbalance ... choosing to self-medicate with recreational drugs."

Sources: ABC News, "Speculation Into Death of Pro Surfer Andy Irons Intensifies Amid Reports of Prescription Drugs Found in His Room," November 4, 2011, http://abcnews.go.com/US/andy-irons-speculation-death-surfer-intensifies-prescriptions-found/story?id=12053334#.UI_xHGdbpI0
Endo, Tetsuhiko, Huffington Post, "Demystifying the Death of Andy Irons," September 14, 2011, http://www.huffingtonpost.com/tetsuhiko-endo/andy-irons-death_b_944688.html
TMZ, "Andy Irons' Death -- Drugs Contributed," June 10, 2011, http://www.tmz.com/2011/06/10/andy-irons-surfer-death-dallas-texas-medical-examiner-report-heart-disesase-cocaine-methadone/

Stigma

Finally coming to the realization that you may be addicted to prescription medication can be frightening and overwhelming.

After all, if you are truly addicted, you have been working very hard to hide it from family, friends and coworkers, and admitting it will inevitably cause feelings of embarrassment, guilt and regret.

Source: Eagle Advancement Institute, "Addicted to Pain Killers – Telling Your Family," June 30, 2012, http://eagleadvancementinstitute.biz/2012/07/addicted-pain-killers-telling-family/.

Common Opiate Medications

- Buprenorphine
- Codeine (1:0.15 ME)
- Fentanyl (1:100)
- Hydrocodone (1:1)
- Lortab (hydrocodone)
- Methadone (1:9)
- Morphine (1:1)
- OxyContin (1:1.5)
- Percocet (oxycodone)
- Tramadol (Ultram)
- Vicodin (hydrocodone)

ME: Morphine Equivalence

Avoid Benzodiazepines

- Alprazolam (Xanax, Paxal)
- Diazepam (Valium, Pax)
- Flurazepam (Dalmadorm)
- Lorazepam (Temesra)
- Prazepam (Centrax)

Deadly Cocktail
Vicodin, Xanax, Soma

Holy Trinity
Percocet, Xanibar, Soma

Harris Silver, MD: hsilver30@comcast.net

Sources:
http://www.opiates.com/opiates/opiate-library.html
http://en.wikipedia.org/wiki/List_of_benzodiazepines

Dependency and Abuse

- Addiction is a brain disease
  - Compulsive seeking and self-administration of a drug, despite obvious harm to self or others
  - Characterized by intense cravings and loss of control
  - Gateway(s)
  - Culture
- Dependency
- Abuse

Source: Eagle Advancement Institute, "One Thing Leads to Another," August 27, 2012, http://eagleadvancementinstitute.biz/2012/08/painkiller-abuse-drives-heroin-addiction/.

Dependency: 3 of 7 factors

- Tolerance
- Withdrawal
- Larger amounts and for longer periods than intended
- Repeated unsuccessful attempts to quit
- Much time/activity to obtain, use, recover
- Important social, occupational, recreational activities given up or reduced
- Use continues despite knowledge of adverse consequences

Source: Jeanne Block, RN, MS, "Introduction to Project ECHO," June 29, 2012.

Abuse: Any one factor

- Recurrent use resulting in failure to fulfill major role obligations at work, home or school
- Recurrent use in physically hazardous situations
- Recurrent substance related legal problems
- Recurrent use despite persistent social or interpersonal problems caused or exacerbated by substance

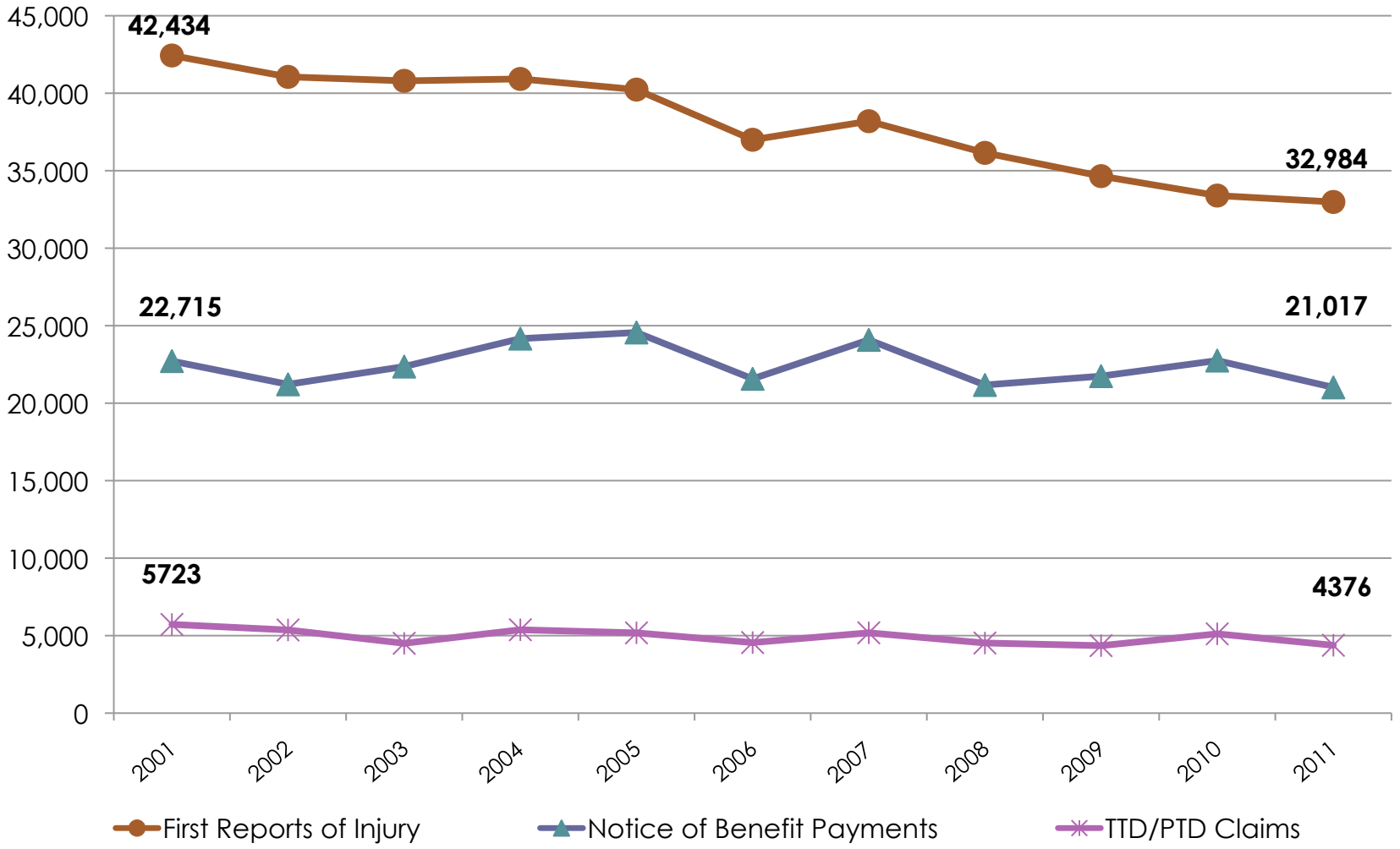
Source: Jeanne Block, RN, MS, "Introduction to Project ECHO," June 29, 2012.

Workers' Compensation

- Not uncommon to meet someone who has suffered an injury or illness and then becomes dependent on the drugs prescribed to deal with the pain.
- Patients are unaware prescription dependency could develop so quickly.

Source: Eagle Advancement Institute, "One Thing Leads to Another," August 27, 2012, http://eagleadvancementinstitute.biz/2012/08/painkiller-abuse-drives-heroin-addiction/.

NM Workers' Comp Injuries



Workers' Comp Realities

- Nearly 1 in 12 injured workers who were prescribed narcotic painkillers still using the drugs 3-6 months later.
- "There are workers who get these pills and go home and spend the whole day on the sofa. Most addiction experts would call that an addiction."

  Andrew Kolodny: President of Physicians for Responsible Opioid Prescribing
- "A lot of times we see opioid script after opioid script after opioid script without functional improvement. We want people getting better. If opioids aren't providing functional improvement, then they are providing more harm than good."

  Michael Gavin: Prium Medical Cost Management Services

Source: Journal Interactive, "Many injured workers remain on opioids, study finds," October 2, 2012, http://www.jsonline.com/features/health/many-injured-workers-remain-on-opioids-study-finds-km72v1g-172331511.html

Epidemic Sources

- 5% of people who abused prescription painkillers got their drugs from dealers or on the Internet.
- 70% got pills from friends and family.
- From 2001 to 2010, the sales of opioid pain relievers in New Mexico rose by 131 percent.

Source: The New Mexican, "State Medical Board to tackle painkiller epidemic," August 8, 2012, http://www.santafenewmexican.com/localnews/080912doctors#.UI7M_mdbpl0

Epidemic Symptoms

- One-third of prescriptions in Ohio WC were for powerful narcotics: a 37% increase in the use of such drugs
- Ohio WC has 7,000 injured workers taking opiate painkillers at levels that meet the definition for being physically dependent

  John Hanna: Pharmacy director at the Ohio Bureau of Workers' Compensation
- Factors: overzealous marketing of powerful painkillers and physicians who too readily prescribe them

Source: The San Francisco Chronicle, "Ohio injured workers fund battling painkillers," July 27, 2012, http://www.sfgate.com/news/article/Ohio-injured-workers-fund-battling-painkillers-3740685.php

At Risk Populations

- Males, persons aged 20–64 years, non-Hispanic Whites, poor and rural populations
- 80% of patients prescribed low doses by single practitioner (<100 mg ME dose/day).
  - 20% of opioid OD
- 10% of patients prescribed high doses by single practitioner (≥100 mg ME dose/day).
  - 40% of opioid OD
- 10% seek multiple doctors, high doses.
  - 40% of opioid OD
  - Likely to divert

Source: CDC: Morbidity and Mortality Weekly Report, "CDC Grand Rounds: Prescription Drug Overdoses — a U.S. Epidemic," January 13, 2012, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm

Catastrophic Claims

- WC claims that include opioid analgesic prescriptions for opioid painkillers are nearly **four times** more likely to develop into catastrophic claims.

  Journal of Occupational & Environmental Medicine

- Claims that include long-acting opioids are **9.3 times** more costly than claims without such prescriptions.
- Claims that include short-acting opioids are **2.8 times** more expensive.

Source: Business Insurance, "Claims that include opioid prescription more likely to become catastrophic: Report," August 29, 2012.
http://www.businessinsurance.com/article/20120829/NEWS08/120829882

Regulations: FDA

- "Misprescribing, misuse and abuse of extended-release and long-acting opioids are a critical and growing public health challenge."

  Dr. Margaret A. Hamburg: FDA Commissioner

- The FDA's Risk Evaluation and Mitigation Strategy (REMS) affects more than 20 companies that manufacture opioid analgesics:
  - Mandates educational programs made to prescribers and patients based on FDA blueprint
  - Requires periodic assessments of mitigation program implementation and success

Source: Business Insurance, "FDA approves plan to fight growing opioid abuse," July 10, 2012, http://www.businessinsurance.com/article/20120710/NEWS08/120719997

Regulations: State of NM

- Prescription Monitoring Program
- https://www.pmp.state.nm/pmpwebcenter
- Any registered user (requires DEA number) can go to site, enter patient's name and DOB and obtain list of all controlled substances for the last year
- Provider may designate someone else in office to look up PMP data
- May also enter alerts about patients suspected of diversion or other abuse

Contact: Larry Loring, RPh
505-222-9839
larry.loring@state.nm.us

Source: Jeanne Block, RN, MS, "Introduction to Project ECHO," June 29, 2012.

Regulations: Clinical

- Specialized patient education policy
- Prescribing Guidelines for Chronic Pain
- Patient Contract
- Clear expectations for patients
- Clear expectations for providers
- Self-Assessment Tools
- Consequences of violating Pain Contract

Source: Leslie Hayes M.D., El Centro Family Health Clinic, July 9, 2012.

Street Smart

Drug	Retail Price	Street Value
OcyContin 40mg	$6.89/tab	$20-$40/tab
Percocet 5/325	$0.60/tab generic $3.15/tab brand	$6-$8/tab
Lortab 5/500	$0.40/tab generic $1.10/tab brand	$4-$8/tab
Methadone 10mg	$0.55/tab	$10-$20/tab

Typical doctor shopper sees 5 to10 prescribers and generates $10,000 to $15,000 a year in drug and medical claims.

Source: Jeanne Block, RN, MS, "Introduction to Project ECHO," June 29, 2012.

Saving a Life: Naloxone

- Naloxone (Narcan), immediately reverses overdose of heroin or prescription pain medications like Oxycontin, even if these opioids are combined with alcohol or other sedatives.

- Non-addictive, does not cause harm if used in error, although can induce non-life-threatening withdrawal symptoms in people dependent on opioids.

Source: Time, "Preventing Overdose: Obama Administration Drug Czar Calls For Wider Access to Overdose Antidote," August 22, 2012, http://healthland.time.com/2012/08/22/preventing-overdose-obama-administration-drug-czar-calls-for-wider-access-to-overdose-antidote/#ixzz24Nt3Xho0

Recovery Options: Suboxone

- Methadone #1 opioid causing OD when a single agent is involved
- Buprenorphine/Naloxone
- MAT: Medical Assisted Treatment
- *Harm Reduction* strategy
- Opioid to control opioid dependency
- Office-based medication treatment
- Partial Agonist
- Easy taper/detox

Source: Morbidity and Mortality Weekly Report, 2012, 61: 493.

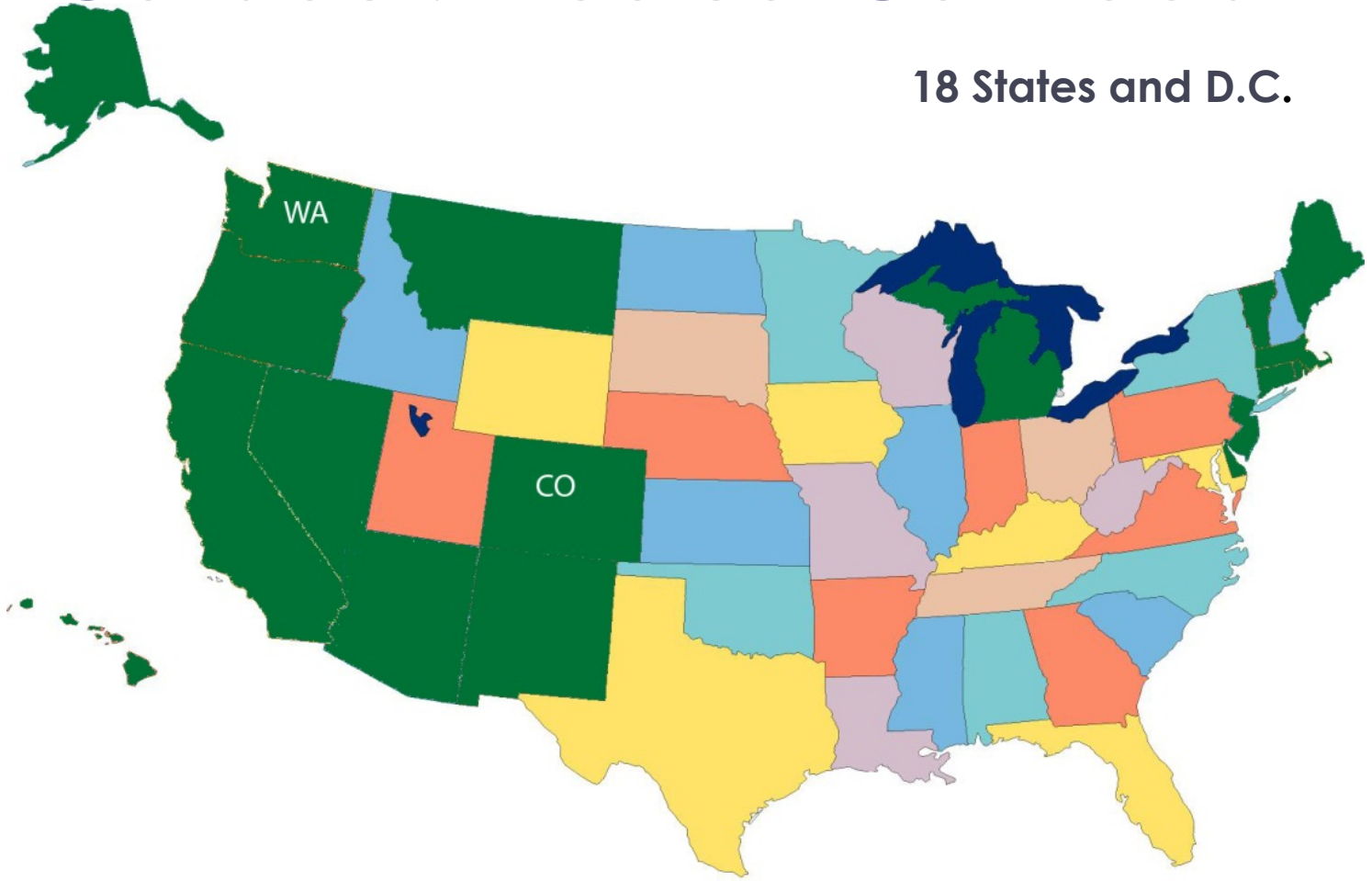
Recovery Options: Vivitrol

- Vivitrol, compared with other treatments, is more effective, has no potential for abuse and sale on the street, and can be prescribed by any doctor for addiction to heroin and prescription painkillers such as Vicodin and OxyContin.
- Drug's high cost—about $1,000 per injection for a monthly injection—remains controversial, as does using an injection to treat drug abuse instead of focusing more on long-term behavioral changes, as prescribed by 12-step programs.

Source: Detroit Free Press, "Revolutionary new drug Vivitrol offers new life to addicts," July 8, 2012, http://www.freep.com/article/20120708/FEATURES08/207080589/Revolutionary-new-drug-Vivitrol-offers-new-life-to-addicts

Consider: Medical Cannabis

18 States and D.C.



Case: Medical Cannabis

- Cooper Brown, a 14-year-old, uses marijuana to relieve complications associated with Dravet Syndrome (a severe form of epilepsy that begins in infancy). Cooper's mother, Rebecca Brown, says his seizures have drastically reduced since he began using marijuana. Rebecca relies on laboratories to select strains low in THC and high CBD (the cannabinoid associated with pain relief without feeling "stoned"). She does not permit him to smoke it and, instead, prepares it in his food.

Source: Detroit Free Press, "Medical marijuana brings relief for sick kids in Michigan but treatment is controversial," May 27, 2012, http://www.freep.com/article/20120527/NEWS15/205270523/Medical-marijuana-brings-relief-for-sick-kids-in-Michigan-but-the-treatment-is-controversial

Medical Cannabis

- Marijuana does not impair lung function—at least not in the doses inhaled by the majority of users, according to the largest and longest study ever to consider the issue, published in the Journal of the American Medical Association.
- Mounting evidence shows 'cannabinoids' in marijuana slow cancer growth, inhibit formation of new blood cells that feed a tumor, and help manage pain, fatigue, nausea, and other side effects.

Source: WebMD, "Marijuana Smoking Not Linked to Chronic Breathing Problems," January 10, 2012, http://www.webmd.com/lung/news/20120103/marijuana-smoking-not-linked_to-chronic-breathing-problems
The Daily Beast, "Marijuana Fights Cancer and Helps Manage Side Effects," September 6, 2012 http://www.thedailybeast.com/articles/2012/09/06/marijuana-fights-cancer-and-helps-manage-side-effects-researchers-find.html

Medical Cannabis & PTSD

- Manages hundreds of PTSD patients in NM Medical Cannabis Program.
- Most patients have other co-occurring psychiatric and/or medical issues which contribute to their symptoms.
- Evidence the endocannabinoid system is involved in the extinction of aversive memories and PTSD patients claim cannabis use helps them considerably.
- Cannabis is a safe and effective medication for treating PTSD, even when there are other co-occurring psychiatric disorders

Source: Krumm, Bryan, CNP, "Practical applications of cannabis in treating post-traumatic stress disorder," August 3, 2012,

EL CENTRO
FAMILY HEALTH

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July 9, 2012

Dear patient,

You are being given this letter because you receive a prescription for a controlled substance. As you may know, our clinic policy states that these prescriptions may only be given at an appointment.

I would like to make sure that you get your prescription on time. If you schedule your appointment before you leave the clinic, I will work with the front desk to make sure that you are scheduled in time to get your refill. You need to make sure that your prescription will last until your appointment. If your appointment time is after your prescription runs out, please let the front desk know and I will let them know when you can be scheduled.

It is your responsibility to schedule this appointment prior to leaving the clinic. If you do not schedule at the time of your appointment, you will need to take the next available appointment. This may mean that you will be short on medications. I will not give an early refill or overbook my schedule if you leave the clinic without scheduling your next appointment.

Thank you for your cooperation.

Yours truly,

Leslie Hayes M.D.

El Centro Family Health
Opiate Prescribing Guidelines for Chronic Pain

These guidelines apply to any patient who is treated with 15 tablets or more per month for at least 3 months of any of the following medications: oxycodone, hydrocodone, hydromorphone, oxymorphone, morphine, methadone, or tramadol. These guidelines do not apply to patients on palliative care.

1. **Primary Care Providers:** All patients on chronic opiates should choose a primary care provider who is responsible for implementing these guidelines for the patient. If the primary care provider is unavailable, the covering provider should check to make sure the guidelines are being followed, and, if so, it is recommended they continue the patient's medications if stable.

2. **Diagnosis:** Diagnosis must be clear and well documented. If the pathology underlying the symptom is known, it must be well documented. The most specific diagnosis should be documented. (Spinal stenosis confirmed by an MRI on x-ray is a more specific diagnosis than back pain.) . If an exact diagnosis is not known, studies and/or referrals should be done to ensure there is no underlying pathology that could be treated definitively. If the studies cannot be done for financial reasons or the studies are non-diagnostic, then presentation to the ECHO pain clinic or a pain specialist should be considered. Referral to a pain specialist or presentation to the ECHO pain clinic should also be considered if pain seems out of proportion to the underlying mechanism.

3. **Medications and refills**: Medications and refills must be clearly documented. Medications generally should be given for 1 month at a time. However, once a stable regimen has been established, patients may be given medications for up to 3 months at a time. Prescriptions can only be given when there is a face-to-face encounter with a provider. Opiate medications will not be refilled over the phone. Generally, opiate medication should not be prescribed early (even if stolen). However, at a provider's discretion, medication can be filled early if the circumstances warrant this. (Providers should be looking for a pattern of early refills. If the patient has a pattern of early refills, they should be evaluated for abuse of their medications and to see if their regimen is adequate.)

4. **Close follow-up**: Initially, follow-up should be every 1-4 weeks. It will take multiple visits to accomplish the objectives stated in the opiate guidelines. However, once an appropriate regimen has been established, the intervals between visits can be extended up to every 1-3 months. The primary care provider is responsible for ensuring that the patient has enough medication to cover until the next visit.

5. **Initial Evaluation for patients transferring into clinic.** All patients wishing to transfer care for management of their chronic pain must establish with ECFH as their primary care provider. Initial evaluation including complete history of their pain, including any work-up, surgeries, consultations, and prior treatments should be done. Provider needs to evaluate past medical history, including any medical diagnoses, current medications, and allergies. Provider needs to evaluate for current or past history of substance abuse. Focused physical exam should be done. Records from prior providers need to be evaluated, RUDS should be checked, and PMP data should be checked prior to any prescription being written. Chronic opiates will not be prescribed if 1) RUDS shows any non-prescribed drugs 2) PMP data shows prescriptions from multiple providers, or 3) records from prior provider document a pattern of on-going abuse or non-compliance with medications, concerns about diversion, or concurrent substance abuse. If the diagnosis is unclear, further work-up should be done according to the guidelines in #1.

5. **Interval Evaluation .** Once a stable regimen has been established, a series of brief questions is appropriate. At every visit, patient should be evaluated for efficacy of medication and side effects, as well as compliance with regimen. Patients should also be evaluated for adequacy of pain relief, change in their symptoms, and compliance with other aspects of the pain relief regimen, such as exercise and non-opiate medications. Patients should be evaluated at least quarterly by history for substance abuse and co-occurring psychiatric disorders, particularly depression or anxiety that may complicate management.

6. **Comprehensive management**: Management of chronic pain should be comprehensive and not rely solely on opiates. Other measures of pain control should be offered. These include the following:

a. **Other medications:** Acetaminophen, NSAID's, Gabapentin/Lyrica, Cymbalta/Savella.
b. **Trigger point injections**

e. **Exercise:** General conditioning, stretching or yoga for back pain, physical therapy
Modalities that have been tried but were not successful should be documented in the chart.

7. **Medications:** Patients may be treated with up to 4 short-acting opiates daily. If they require more than 4 short-acting opiates daily, it is recommended that the provider add on a long-acting opiate. If a provider has a patient who needs higher doses of medication than the equivalent of morphine 120mg daily to control their pain, it is recommended the patient be presented to the Chronic Pain teleconference. If a provider has a patient who would be appropriate for methadone for pain relief, it is recommended that the provider consult an experienced provider prior to starting it. It is not recommended that methadone be used in patients with a history of addiction because of the legal issues.

8. **Opiate agreement**: The opiate agreement is signed every year. As part of patient education, the drug contract is explained to the patient in detail, and this needs to be documented in the chart. Risk and benefits of medication should be included in this. In particular, there should be documentation of risks of addiction, risks of overdose, and risks of driving if sedated.

9. **Anxiety Meds:** Any patient on concomitant benzodiazepines should have a separate benzodiazepine agreement signed. The patient should be warned about the risk of interaction. There should be documentation of this.

10. **Urine Drug screening**: Urine drug screening should be done at least annually on all patients on chronic opiates.

11. **Prescription Monitoring Program:** All patients should have their prescriptions checked under the PMP at least annually.

12. **Compliance** The patient needs to be compliant in scheduling and keeping appointments.

13. **Patients with a history of addiction.** A history of addiction does not preclude chronic opiates, but it does require more careful monitoring. Patients should be actively participating in some sort of recovery activities. Providers may consider more frequent urine drug screens or PMP monitoring.

Contract for patient on chronic opiates

General information about chronic opiates

It is important to know about the medication you are taking. This is some general information about opiates. Please ask your provider if you have other questions or if you want to know how something might apply to you.

Opiates are sometimes used for pain when, despite using other therapies, patients still have so much pain it interferes with their ability to enjoy life. However, studies have shown that the pain relief from opiates is modest (about 2 points on the pain scale.)

There are substantial risks to taking opiates. These include:

1) Risk of addiction, overdose or death. This is greatest if opiates are combined with illicit drugs or alcohol, but can also occur if you take extra pills or combine opiates with prescribed pills like tranquilizers or other opiates.
2) Risk of sedation. It is very dangerous to drive if you feel sedated after taking opiates.
3) Risk of falls, with possible fractures or head injuries.
4) Risk of tolerance. These medications do not work nearly as well after you have been taking them for awhile as they do at first.
5) Risk of liver damage. Many opiates contain acetaminophen or Tylenol. These include Percocet, Darvocet, Lortab, and Vicodin. Combining these medications with extra Tylenol or alcohol, especially if you already have liver disease, can damage your liver.
6) Medical problems, including risk of your immune system not working as well, risk of decreased testosterone in men and menstrual problems in women, and risk of osteoporosis.
7) Increased sensitivity to pain.
8) Opiates are very dangerous to small children. One pill can be life-threatening.
9) Opiates are commonly abused, and young people and adults may take them to use recreationally.

There are also many side effects with opiates. These include nausea, constipation, and confusion.

Expectations for patients

This is what we expect patients taking chronic opiates to do.

1. I understand that opiates will not take my pain completely away but, if they work for me, should improve my pain a modest amount. _____
2. I agree to take my medication as prescribed. _____
3. If I am having a flare, I need to contact my provider to discuss the best way to manage it instead of taking extra medications. _____
4. If I take extra medication and run out early, my prescription will not be filled early. _____
5. I will not share or sell my medications. _____
6. I agree not to take illicit drugs or abuse alcohol. _____

7. I will not receive prescriptions for pain medications from other providers or from non-medical sources.
    a. If I have an acute injury or illness and receive medications for that, I will let the clinic know. _____
    b. If I am discovered to be receiving medications from other providers or non-medical sources, my opiate medication will be discontinued. _____
8. I will not drive or serve in any capacity related to public safety if I feel sedated while taking the medications. _____
9. I will follow up with any other treatments recommended by my provider. These may include other medications, physical therapy, a weight loss program, referrals to other physicians, and treatment of depression or anxiety if present. _____
10. My provider will check my urine at least once a year for the presence of illicit drugs. I agree to provide a urine sample without delay and pay any lab fees. _____
11. I will keep my appointments.
    a. If I miss my appointment for any reason, my medication will not be refilled until the next available appointment. _____
    b. Pain medications are never refilled on walk-in appointments or over the phone. _____
12. I will keep my medications in a safe place, out of reach of children and in a place where people who might abuse them cannot get them. _____
13. Opiates will not be replaced if they are lost or stolen. _____
14. I will not take extra acetaminophen or Tylenol unless discussed with my provider. _____
15. I will let my provider know if I become pregnant or plan to become pregnant. _____
16. If I commit any crimes with my medication, including selling my medication forging or altering a prescription, I will be reported to the police. _____
17. If there are concerns, my provider can talk to other providers or my family and friends. _____
18. I will treat my provider and the office staff with respect. _____
19. If I violate the above, my opiate medication will be discontinued. _____

Expectations for providers of patients on chronic opiates

Patients can expect their provider to do the following.

1. The provider will give me appropriate education about the medication, including risks, benefits, and possible side effects.
2. The provider will help me find additional ways to treat my pain, including physical therapy, exercise, weight loss, and other medications.
3. The provider will monitor for drug abuse or addiction and offer a referral for treatment if found.
4. The provider will work with me to improve my pain and function.
5. The provider will work with me to help alleviate any side effects.
6. The provider will help me to discontinue the medication in a safe manner if it is not working.
7. The provider will treat me with respect.

Signature patient _____ Date _____

Signature provider _____ Date _____

El Centro Family Health
Violations of the Pain Contract

1. Patient does not go for appropriate follow-up (e.g. does not get mri, go to pt, go for counseling etc.)

a. Provider should evaluate why patient did not go in for recommended tests or consultations. If problem is financial or with insurance, consider referral to appropriate agencies for assistance. If problem is related to transportation, refer to SafeRide if able. If problem is that the patient does not understand the importance of the test, educate about the test.

b. If patient continues not to follow through, discuss with them that medication will need to be discontinued, then do so at the next visit.

2. Patient has a positive urine toxicology screen:

a. Ascertain if the screen is legitimate (see urine toxicology information). The first step should be discussing the result with the patient. If the patient denies use and the provider plans to change the care based on the results, the test should be sent for gcms confirmation.

1) Review metabolites of drugs.

2) Know the limitations of the test (rule-out false positives).

b. If the test is truly positive for a non-prescribed drug, the provider should evaluate the patient's use :

1) Evaluate for addiction. If patient is addicted to a medication, offer appropriate treatment and referrals.

2)If diagnose of drug abuse is made, counseling should be done about risks. Consider referral for Brief Intervention if available.

3) If the urine drug screen confirmatory test is positive for cocaine, non-prescribed opiates, non-prescribed benzos, or methamphetamine, the opiate medication should be discontinued, regardless of whether the patient acknowledges use. It is up to the provider's discretion whether to discontinue medication at that time or wean medication over 1-2 months. The provider should offer continued care for other medical problems if desired. An alert should be placed in ECW. The problem should be placed in the problem list as 305.9 (Other, mixed, or unspecified drug abuse) with a note as to what occurred.

Exceptions:

a) If patient has a positive drug screen for marijuana, the provider needs to evaluate for frequency of use and signs of addiction. If use is only occasional and patient shows no signs of addiction, patient should be educated about risks of sedation, especially with driving, and encouraged to quit. It is at the provider's discretion whether to continue the opiates.

b) Many patients have received prescriptions in the past for other opiates or for benzodiazepines and do not realize the risk of using these prescriptions with their currently-prescribed opiates. The provider may choose to do education in this case. If the patient continues to use opiates or benzodiazepines that are not currently prescribed, the opiate prescription should be discontinued.

3. **Patient using alcohol.** Any patient found to be binge drinking (4 drinks or more at one time for women, or 5 drinks or more at one time for men) or drinking in an alcoholic manner should be taken off the medication.

4. **Patient has a urine toxicology screen that is not positive for the medication that has been given:**

Determine legitimacy of test as mentioned above. Consider sending for GCMS screening. The provider should discuss with the patient and decide if the patient is truly taking the medication. If the provider feels the test was a false negative, they should document this and retest within 1-2 months.

5 **The patient refuses or delays urine drug screen:**

Patient refuses. No medication should be given until urine sample is given. If patient leaves the clinic without providing a urine sample, the opiate medication should be discontinued.

Patient delays test. 1st delay: Patient should be educated about the importance of providing the urine sample in a timely manner and warned that further delays will lead to discontinuation of the medication. 2nd delay: Discontinue medication

El Centro Family Health
Violations of the Pain Contract

6. **The patient increases the dose of medication on their own and runs out of meds:**
   Another prescription cannot be given early.

7. The **patient has been selling the medication:**
   Medications should be discontinued completely, and the patient should be reported to the police or Board of Pharmacy.

8. **The patient does not follow-up for regularly scheduled appointments at the clinic:**
   No medication will be given until the patient comes in for a scheduled appointment. If this becomes a pattern, the provider will need to evaluate if patient should be continued on opiate medications.

9. **The patient has prescriptions from other providers listed on the Prescription Monitoring Program that they have not discussed with their primary care provider:**
   a. If there are only a small number of prescriptions for small amounts of medications, the provider may choose to discuss this with the patient. If the prescriptions seem appropriate, they should educate the patient about the risks of getting controlled substances from more than one provider and the importance of notifying the primary care provider of all prescriptions.
   b. If there are large numbers of prescriptions, prescriptions for large amounts of medications, or repeated prescriptions that were not discussed with the primary care provider despite the above education, the provider will discontinue the medication.

10. **The provider is disrespectful to the office staff or provider:**
   a. For minor infractions, such as being demanding or rude, the provider will educate the patient on the importance of courtesy towards all members of the staff and document this in the chart.
   b. For major infractions, including swearing at office staff, threatened or actual violence, or repeated impolite behaviors despite education, the provider will discontinue the medication and discuss with the Regional Administrator if the patient needs to be dismissed from the practice.

11. **The patient overdoses on medication:**
   Stop medication completely.

Whenever discontinuing medication, continue to stress importance of comprehensive care and continue to offer appropriate follow-up. Patients will not be refused care for other medical problems unless their behavior was threatening or illegal.

Giving In
Female, 16, Minneapolis
“Something inside of me that sparked the drive to be independently successful died, and I swallowed the pills.”

I was always a smart student. I did my homework, paid attention in class, and generally had enough drive to earn A's in the classes I took. I didn't have any need to take Adderall, and when people offered it to me, I always declined, thinking I was self-driven enough to achieve success without the use of drugs. My closest friends, who were a little bit less motivated than I was, raved about Adderall. Even my brother, a freshman in college, told me to take it. I kept declining and declining, convincing myself that people like me didn't need Adderall to help them get by. It wasn't until one week, when my homework load was particularly heavy, I considered using it. A kid in one of my classes sold Adderall and always offered it to me at least twice a week. To his surprise, and to mine, when he asked me that Tuesday morning if I wanted to buy some, I actually said yes. I bought two 20 mg pills from him for $6. That night when I went home and stared at the pills. I don't know if it was the lack of self-motivation, the chronic fatigue of school, or the sleep-deprivation, or a combination of all three, but something inside of me that sparked the drive to be independently successful died, and I swallowed the pills. Much to my dismay, I discovered that Adderall was everything people made it to be and more. I found a complete surge of adrenaline and ecstasy flow through my brain as I tackled factoring, science notes, and a four-page paper all in one night. And when that night's homework was done, I did the next night's. I was on a role, and I couldn't stop. After that, I began to use Adderall whenever I had a lot of studying to do. I also used it to help me focus during exams. Adderall is popular in my school, where it's highly competitive. Everyone is competing against each other for scholarships and it definitely gives you an extra edge over students who don't take it. As much as I was initally against Adderall, I cannot deny the fact that it's completely effective.

Morning Coffee
Female, 18, Sarasota, Fla.
“It's my morning cup of coffee, only nobody told me the insidious side effects.”

Adderall has been, on and off, a part of my life since sophomore year in high school. Currently, I am a rising sophomore at a top 20 university out of state, and the decision not to stay clean plagues me every time I take a pill in the morning. At first, I used it in the same way as many other students, to crank up study sessions or to meet a strict deadline. By junior year, it had progressed to something much more than that. I started taking Adderall every single morning, just to wake up, and to give me enough energy to last through the day. On those long, foggy days I'd forget to take it, my mind would be in sleep mode, dozing in class and drifting in thought. While I had no problem giving these "study pills" to friends, I'd always warn them of the side effects, the reliance, the memory problems that inevitably resulted, and the harsh mood swings that they often brought on. My warnings seemed about as hollow as their acknowledgments of them. I knew (and still know) that they do more harm than good, as my moods can change on a dime and my memory is worse and worse, but getting a decent grade on a test that others seem to effortlessly ace seems worth it. Adderall hasn't become a study drug to me, it's become a way of life. It's my morning cup of coffee, only nobody told me the insidious side effects. The standards of a top ranked school have that ability to cloud my judgement, and though I'm completely aware of it, I know there's not much I can do. Though I can feel my heart beating faster than normal when I take just half a pill, the thought that my habit could be ruining my body is only fleeting, and I return to my work, just like everyone else around me.

http://www.nytimes.com/interactive/2012/06/10/education/stimulants-student-voices.html