Use of Opioids in Patients with Cancer in North Carolina

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Disclosures

- None

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Learning Objectives

1. Explain factors and the current response of the opioid crisis over time
2. Identify best practices of opioid use for cancer-related pain
3. Describe alternative strategies and therapies for cancer-related pain

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Learning Objectives

1. Explain factors and the current response of the opioid crisis over time

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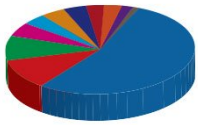
Prevalence of Chronic Pain in the US



- Low back pain-associated
- Diabetic neuropathy
- Shingles
- Cancer-related
- Spinal cord injury
- Causalgia and reflex sympathetic dystrophy
- HIV-associated
- Multiple sclerosis
- Phantom pain
- Poststroke
- Trigeminal neuralgia

-20% of the US population (50 million) with chronic pain
-8% with high impact pain
-Pain increases with age

CDC, 2016

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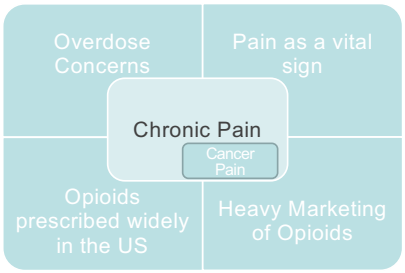
Chronic Pain & The Opioid Crisis



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Chronic Pain & The Opioid Crisis

Overdose Concerns

Pain as a vital sign

Chronic Pain

Opioids prescribed widely in the US

Heavy Marketing of Opioids

Cancer Pain

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Prevalence of Cancer-related Pain

Review Article

Update on Prevalence of Pain in Patients With Cancer: Systematic Review and Meta-Analysis

- 39% after curative treatment
- 55% during treatment
- 66.4% in advanced, metastatic, or terminal disease
- Overall, 30% with moderate to severe pain

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Concern about opioids?

- Risk of overdose
- Risk of abuse/misuse

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CDC develops new guidelines March 2016, revised

- CDC developed and published the *CDC Guideline for Prescribing Opioids for Chronic Pain* to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

- MMWR: CDC Guideline for Prescribing Opioids for Chronic Pain
- Factsheet: Calculating Total Daily Dose of Opioids for Safer Dosage
- Mobile App: CDC Opioid Guideline

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CDC Guideline Overview

- The CDC Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the Guideline include:

- **Determining when to initiate or continue opioids for chronic pain**
  - Selection of non-pharmacologic therapy, nonopioid pharmacologic therapy, opioid therapy
  - Establishment of treatment goals
  - Discussion of risks and benefits of therapy with patients
- **Opioid selection, dosage, duration, follow-up, and discontinuation**
  - Selection of immediate-release or extended-release and long-acting opioids
  - Dosage considerations
  - Duration of treatment
  - Considerations for follow-up and discontinuation of opioid therapy
- **Assessing risk and addressing harms of opioid use**
  - Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk
  - Review of prescription drug monitoring program (PDMP) data
  - Use of urine drug testing
  - Considerations for co-prescribing benzodiazepines
  - Arrangement of treatment for opioid use disorder

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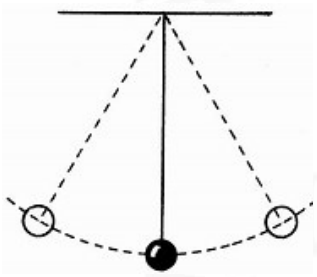
What happened next?



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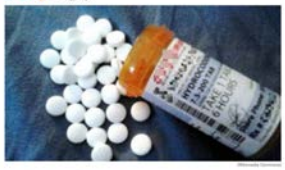
Revising Perspectives around Opioids

FDA

Seeking to Clarify Its Opioid Prescribing Guidelines, CDC Joins FDA in Decrying 'Mandated or Abrupt Dose Reduction'

The CDC's advice has been widely interpreted as requiring involuntary tapering of medication so it does not exceed an arbitrary threshold.



Acknowledging the suffering caused by "misinterpretation" of the opioid prescribing

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Opioids in the Cancer Setting

NIH NATIONAL CANCER INSTITUTE

1-800-4-CANCER

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The Opioid Epidemic and Cancer Pain Management: A Conversation with Dr. Judith Paice

Subscribe

July 16, 2018, by NCI Staff

Pain is a common symptom in cancer patients. It can be caused by cancer, its treatments, or a combination of factors. Although some pain lasts a relatively short time and will resolve on its own, cancer or its treatments can also lead to long-lasting, chronic pain. Opioid medications are an important component of managing some types of unrelieved cancer pain.

In this interview, Judith Paice, Ph.D., R.N., director of the Cancer Pain Program at Northwestern University's Feinberg School of Medicine, discusses the impacts of the opioid epidemic and how providers can address concerns about opioid misuse when managing cancer pain.

The opioid epidemic is affecting people with cancer who rely on opioids to help manage their pain.
Credit: iStock

First of all, what types of medications or other approaches are used to manage pain in cancer patients and survivors?

Any of the prescription opioid medications can be used for people with cancer. Non-opioid agents, including medications like acetaminophen (Tylenol) and ibuprofen (Motrin or Advil), are also used. For nerve pain, we may use antiseizure medications like gabapentin (Neurontin or Gralise) or antidepressant-type medications like duloxetine (Cymbalta).

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Effects on Patients & Providers

Patients

- Fear
  - Poor pain control
  - Abuse potential
- Access

Providers

- Screening
- Assessment
- Monitoring
- Documentation

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Management of Chronic Cancer Pain

Management of Chronic Pain in Survivors of Adult Cancers: American Society of Clinical Oncology Clinical Practice Guideline.

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Learning Objectives

2. Identify best practices of opioid use for cancer-related pain

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Opioid Screening & Mitigating Risk

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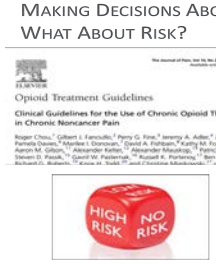
Selection and Risk

MAKING DECISIONS ABOUT PATIENT SELECTION – WHAT ABOUT RISK?



American Pain Society, 2009

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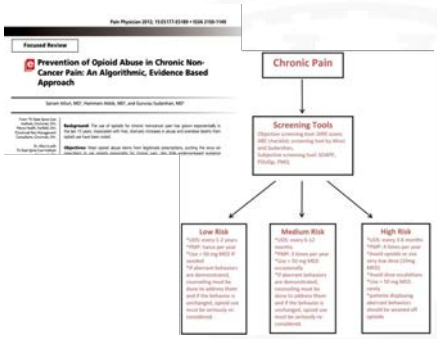
Screening and Monitoring



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Pain Contract / Pain Treatment Agreement

- Provider name
- Patient name
- Patient signature
- Date (updated yearly)
- 1 pharmacy
- 1 prescribing physician/clinic
  - For exception, approval beforehand
  - Following emergent hospitalization, alert within 48 hours of discharge
- Update all medications including opiates with other providers
- Keep all appointments, no-show policy
- Take all medications exactly as prescribed
- Self escalations not permitted
- No early refills

- Bring all opiate medications with original prescription bottle to each clinic visit
- Will not abuse alcohol or use illicit drugs
- Agree to urine, blood or other drug screenings
- Provider may perform criminal background check and track pharmacy prescriptions
- Refill not provided if lost or stolen (police report)
- Medication not continued if lost or stolen >1x
- If arrested or incarcerated related to legal or illegal substances, medication refills will be denied
- Refills require clinic visit
- Follow recommendations regarding multimodal pain management strategies (AT, PT, exercise prescriptions, pain psychology, MH follow up)

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Part 3 – Identifying at Risk Behavioral Aberrant behaviors

Most Common
- Preference for short acting medication
- Running out of medications early/unsanctioned dose escalations
- Obtaining pain medication from other physicians
- Borrowing pain medication from others

More Severe
- Obtaining prescription drugs from nonmedical sources (i.e. on the street)
- Concomitant abuse of related illicit drugs (marijuana or other)
- Recurrent prescription losses
- Injecting or inhaling oral formulation
- Prescription forgery

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Psychosocial Risk Factors for Opioid Misuse – At a Glance

- **Personal history of substance abuse**
- **Prior drug and/or alcohol rehabilitation**
- **History of criminal activity and/or legal problems including DUIs**
- Regular contact with high risk people or high risk environment
- Problems with past employers, medical providers, family members, and friends

- Risk-taking or thrill seeking behavior
- Heavy tobacco use
- **History of psychopathology including severe depression, suicidality, bipolar I disorder, severe anxiety, psychotic disorders, somatization, personality disorder**
- Psychosocial stressors
- Family history of substance abuse
- Poor social support

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Opioid Screening Tools

Review Article

Assessment and Treatment of Abuse Risk in Opioid Prescribing for Chronic Pain

Robert N. Jamison, Juliana Serrallier, and Edward Michna

1. Opioid Risk Tool (ORT)
2. Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R)
3. Current Opioid Misuse Measure (COMM)

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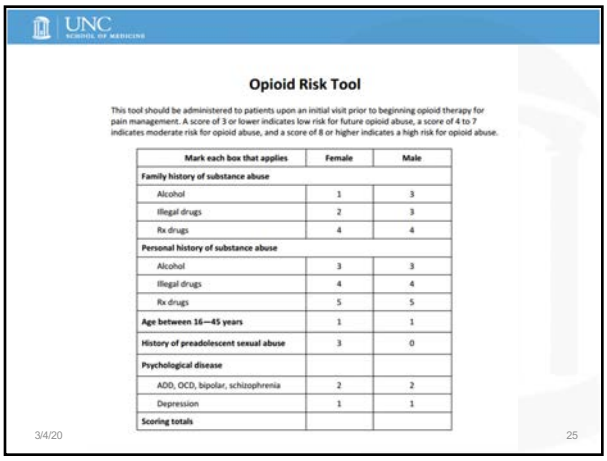

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

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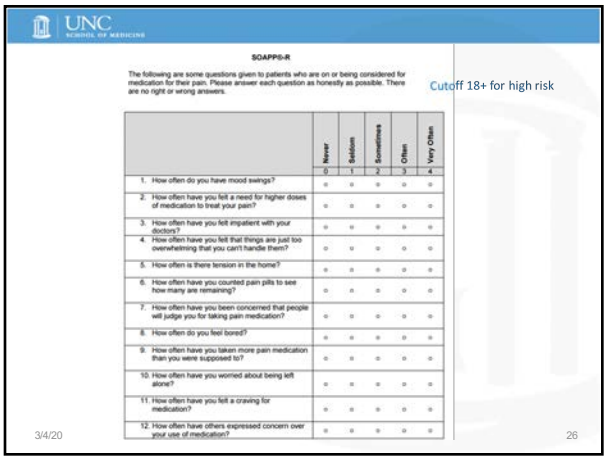

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Cutoff 18+ for high risk

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

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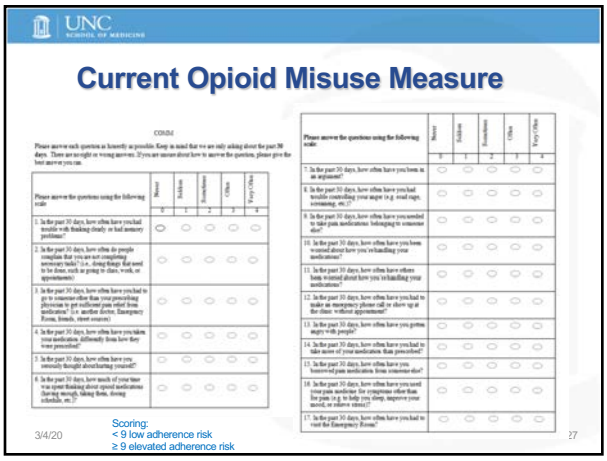

Current Opioid Misuse Measure

COMM

Scoring:
< 9 low adherence risk
≥ 9 elevated adherence risk

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Helpful Online Resources for Psychometrics

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Opioid Dependence – Opioid Use Disorder (OUD)

- F11.10 - Mild: 2–3 symptoms
- F11.20 - Moderate: 4–5 symptoms
- F11.20 - Severe: 6 or more symptoms

Specifiers
- Early Remission: no criteria for 3-12 months#
- Sustained Remission: no criteria for 12+ months#

1. Using more & for longer
2. Difficulty controlling/cutting down
3. Obtaining & using
4. Craving
5. Problems at work, school, home
6. Problems with people
7. Less time with functional /pleasurable activities
8. Continued in dangerous situations
9. Continued use despite MH and/or health problems
10. Tolerance
11. Withdrawal

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Opioid Contract & Behavioral Adherence Plan

Standard Opioid Agreement

Vs.

Extra behavioral goals that are considered mandatory
-mitigating risk

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Case Example 1

- Tanya
  - 56 yo AA female with breast cancer
    - s/p mastectomy and currently undergoing chemotherapy
    - Pmhx + for type 2 DM
  - Possible sources of pain
    - From cancer
    - Post surgical pain – post acute vs. chronic (nerve damage)
    - Chemotherapy
    - DM neuropathic pain

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Case Example 2

- Charles
  - 75 yo C male with h/o oropharyngeal cancer
    - s/p surgery and radiation therapy
    - 6 years in remission
  - Possible sources of pain
    - From surgery
    - From radiation
  - Other symptoms or concerns?

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Case Example 3

- Dennis
  - 35 yo C male with metastatic breast cancer
    - diagnosed years after pain started (stage III)
    - palliative radiation therapy for metastases to his skull, spine, and mediastinum
    - chemotherapy x 7 years
    - Hospice care x 2 with PCA and port
    - Fentanyl 150 mcg/hr and dilaudid 4mg q4 hr prn
  - Diversion potential
    - Port
  - Intrathecal pump?

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Opioid Dosing

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

www.cdc.gov

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Opioid Dose Calculator

Opioid (oral or transdermal):	mg per day:*	
Codeine		0
Fentanyl transdermal (in mcg/hr)		0
Hydrocodone		0
Hydromorphone		0
Methadone†		0
Morphine		0
Oxycodone		0
Oxymorphone		0
Tapentadol		0
Tramadol		0
	Total	0

*NOTE: All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mcg per hour

http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

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Opioid Dose Calculator

Hypothetical case example:
Oxycodone 5mg q6 hr, up to 4x/day = **30 mme**

Opioid (oral or transdermal):	mg per day:*	
Codeine		0
Fentanyl transdermal (in mcg/hr)		0
Hydrocodone		0
Hydromorphone		0
Methadone†		0
Morphine		0
Oxycodone	30	30
Oxymorphone		0
Tapentadol		0
Tramadol		0
	Total	30

http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

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Opioid Dose Calculator

Case example 3 (metastatic/palliative):
Fentanyl 150 mcg/hr + dilaudid 4mg 4x/day = **520 mme**

Opioid (oral or transdermal):	mg per day:*	
Codeine		0
Fentanyl transdermal (in mcg/hr)	150	360
Hydrocodone		0
Hydromorphone	40	160
Methadone†		0
Morphine		0
Oxycodone		0
Oxymorphone		0
Tapentadol		0
Tramadol		0
	Total	520

http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

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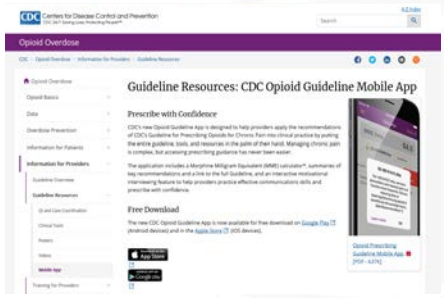
Dosing Guidelines



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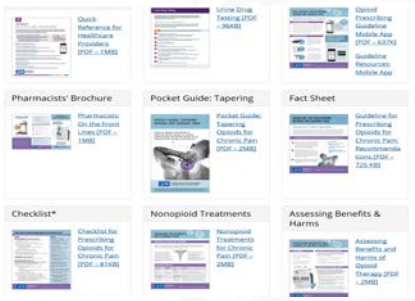
CDC Resources



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Learning Objectives

3. Describe alternative strategies and therapies for cancer-related pain

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The Evolution of Behavioral Therapies

1st wave

Classical conditioning and operant learning

2nd wave

Cognitive Therapy and Cognitive Behavioral Therapy (CBT)

3rd wave

Addresses metacognition, acceptance, mindfulness, dialectics, spirituality, and personal values

Acceptance and Commitment Therapy (ACT) and Mindfulness Based Stress Reduction (MBSR)

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Empirically Validated Therapies
(for chronic pain, depression, anxiety disorders)

Main Approaches

1. Cognitive Behavioral Therapy (CBT)
2. Acceptance and Commitment Therapy (ACT)
3. Mindfulness Based Strategies

Also Helpful

- Dialectical Behavior Therapy – for BPD and stress reactivity
- Behavioral sleep hygiene, CBTi – for sleep
- Trauma – CPT, EMDR, Prolonged Exposure
- MAT + behavioral therapies above – OUD and SA

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Search: Ebt for Adolescents and Adults with Mult Subtance Abuse Concerns
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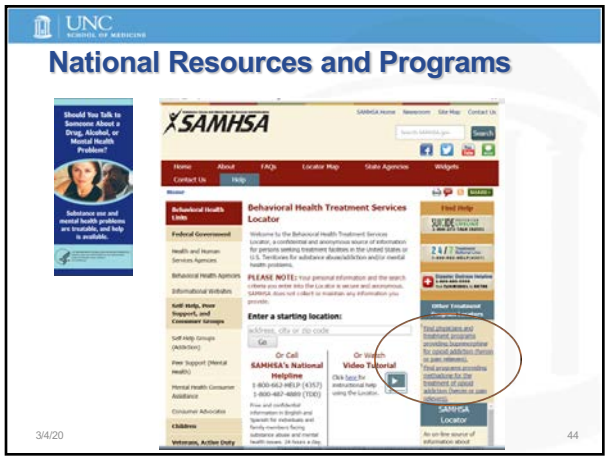
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National Resources and Programs
Should You Talk to Someone About a Drug, Alcohol, or Mental Health Problem?
Substance use and mental health problems are treatable, and help is available.
SAMHSA
Behavioral Health Treatment Services Locator
Enter a starting location:
SAMHSA's National Helpline
Video Tutorial
SAMHSA Locator
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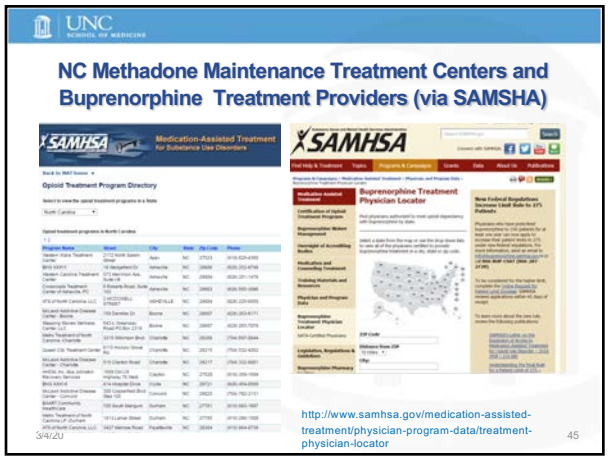
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NC Methadone Maintenance Treatment Centers and Buprenorphine Treatment Providers (via SAMSHA)
SAMHSA
Medication-Assisted Treatment for Substance Use Disorders
Opioid Treatment Program Directory
SAMHSA
Buprenorphine Treatment Physician Locator
http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
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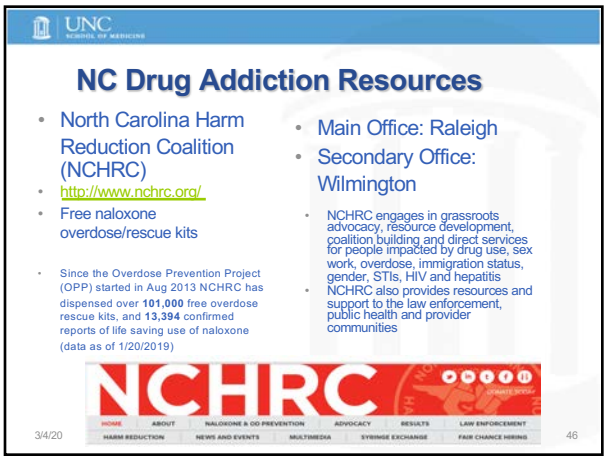
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NC Drug Addiction Resources
North Carolina Harm Reduction Coalition (NCHRC)
http://www.nchrc.org/
Free naloxone overdose/rescue kits
Since the Overdose Prevention Project (OPP) started in Aug 2013 NCHRC has dispensed over 101,000 free overdose rescue kits, and 13,394 confirmed reports of life saving use of naloxone (data as of 1/20/2019)
Main Office: Raleigh
Secondary Office: Wilmington
NCHRC engages in grassroots advocacy, resource development, coalition building and direct services for people impacted by drug use, sex work, overdose, immigration status, gender, STIs, HIV and hepatitis
NCHRC also provides resources and support to the law enforcement, public health and provider communities
NCHRC
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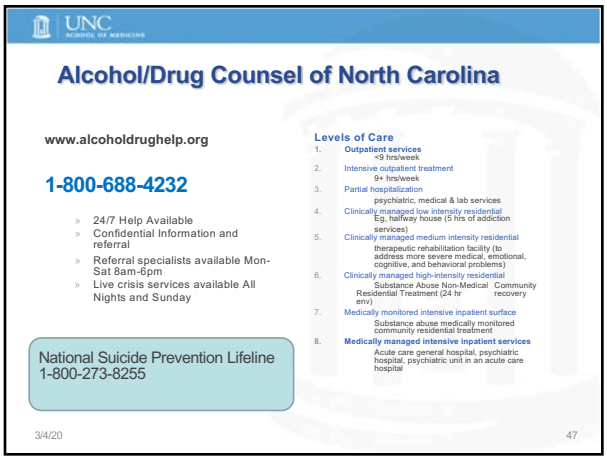
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Alcohol/Drug Counsel of North Carolina
www.alcoholdrughelp.org
1-800-688-4232
24/7 Help Available
Confidential Information and referral
Referral specialists available Mon-Sat 8am-6pm
Live crisis services available All Nights and Sunday
National Suicide Prevention Lifeline 1-800-273-8255
Levels of Care
1. Outpatient services <9 hrs/week
2. Intensive outpatient treatment 9+ hrs/week
3. Partial hospitalization psychiatric, medical & lab services
4. Clinically managed low intensity residential Eg, halfway house (5 hrs of addiction services)
5. Clinically managed medium intensity residential therapeutic rehabilitation facility (to address more severe medical, emotional, cognitive, and behavioral problems)
6. Clinically managed high-intensity residential Substance Abuse Non-Medical Community Residential Treatment (24 hr recovery env)
7. Medically monitored intensive inpatient surface Substance abuse medically monitored community residential treatment
8. Medically managed intensive inpatient services Acute care general hospital, psychiatric hospital, psychiatric unit in an acute care hospital
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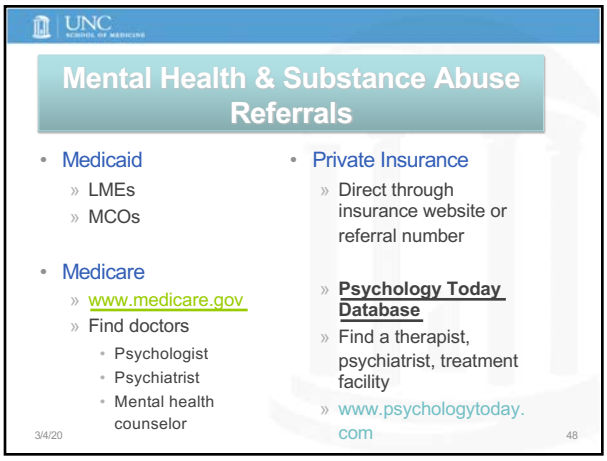
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Mental Health & Substance Abuse Referrals
Medicaid
LMEs
MCOs
Medicare
www.medicare.gov
Find doctors
Psychologist
Psychiatrist
Mental health counselor
Private Insurance
Direct through insurance website or referral number
Psychology Today Database
Find a therapist, psychiatrist, treatment facility
www.psychologytoday.com
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Referrals for Mental/Behavioral Health and Substance Abuse Treatment in North Carolina

****MEDICAID AND SELF PAY OPTIONS****

LME / MCO

These LME/MCO contacts connect patients with MH/Substance Abuse treatment facilities within their counties/region.

All Medicaid and uninsured patients must go through this route. These are also options for individuals with other insurance

Based on NC County

Cardinal Innovations Healthcare Solutions Office

Phone: 704-939-7700

Crisis Line: 800-939-5911

Counties Served: Alamance, Cabarrus, Caswell, Chatham, Davidson, Davie, Forsyth, Franklin, Granville, Halifax, Mecklenburg, Orange, Rockingham, Person, Rowan, Stanly, Stokes, Union, Vance and Warren

Alliance Behavioral Healthcare Office

Phone: 919-651-8401

Crisis Line: 800-510-9132

Counties Served: Cumberland, Durham, Johnston, Wake

https://www.ncdhhs.gov/providers/lme-mco-directory

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Referrals for Pain Psychology at UNC

- Ambulatory Referral to Pain Psychology
  - Order for full evaluation with pain psychologist - Outpatient
    - Amy Goetzinger, PhD
    - Seema Patidar, PhD
    - Skye Margolies, PhD
  - Coverage at UNC Southern Village Pain Clinic and Hillsborough outpatient
  - Pain Psychiatrist – Dr. Rebecca Bottom
- Inpatient Medical Center Referrals
  - To chronic pain service
    - Dr. Patidar available for behavioral health assessment and treatment Wednesday mornings only
    - Dr. Goetzinger available for OUD behavioral health assessment and treatment at UNC Hillsborough hospital on Friday mornings beginning Jan 2020

UNC Pain Management
Phone: 984-974-6688
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