Managing Chronic, Nonmalignant Pain in Patients with a Substance Use Disorder

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A concurrent diagnosis of substance abuse complicates the management of chronic pain with a host of clinical and legal challenges. These VA providers have found success with a highly structured, multidisciplinary, opioid renewal clinic that combines close monitoring and follow-up with group patient education.

The use of opioids to control chronic, nonmalignant pain in patients with a history of substance abuse can be challenging.[1] Addiction and chronic pain are both chronic illnesses, and like other such illnesses, they are prone to remission and relapse.[2] And both are among the most costly diseases treated in the United States.[3,4]

In patients with the dual diagnoses of chronic pain and narcotic addiction, pain control is maximized when both conditions are addressed and treated. All too often, however, this is not the case. In our experience, we have observed that practices tend to gravitate to one of two extremes: either patients receive opioids for pain while their addiction is undertreated, or their treatment focuses mainly on the substance abuse to the detriment of their pain management.[5–7]

Recognizing this problem, clinicians from the primary care clinic of the Malcom Randall VA Medical Center, Gainesville, FL developed an opioid renewal clinic with the aim of combining the best practices of pain management and substance abuse treatment to improve pain control, patient satisfaction, medication safety, and compliance with regulatory agencies. The model we formulated is best described as a nurse-led, multidisciplinary treatment team utilizing regular drug testing and close follow-up. This service is delivered in a supportive, structured clinic environment. In this article, we describe our process of developing and implementing this approach, outline the current clinic operation, discuss some of its key features, and review its impact thus far.

At the time of this writing, **Dr. Sampson** was the primary care physician for the opioid renewal clinic and the chair of the medical center pain committee at the Malcom Randall VA Medical Center (MRVAMC), Gainesville, FL. He is now an urgent care physician (and still chair of the medical center pain committee) at the MRVAMC and a clinical associate professor in the department of psychiatry at the University of Florida, Gainesville. **Ms. Havens** is a mental health nurse practitioner, **Ms. Marsh** is the nurse team leader, and **Mr. Murrhee** is an addiction therapist, all for the opioid renewal clinic of the MRVAMC.

A SELF-CHARTERED QUALITY IMPROVEMENT TEAM

Our primary care clinic serves approximately 4,000 patients, about 300 of whom are receiving opioids and other analgesics for chronic, nonmalignant pain. In March 2003, we noticed an increase in the number of patients who were coming in without an appointment for "walk-in" visits, most of which were related to opioid therapy for chronic pain and many of which involved patients with a history of substance abuse.

We asked ourselves whether we could handle this situation more effectively, since we prefer to leave our walk-in appointment slots open for acute or urgent conditions. We set up a team meeting with physicians, nurses, social workers, an addiction psychiatrist, and substance abuse counselors to discuss how best to handle chronic pain management in patients taking opioid medications who have a history of substance abuse.

A prominent focus of our primary care team has been finding ways to improve care, and our prior quality improvement training helped us to establish a plan very quickly.[8–10] After diagramming our current practice, we reviewed medical literature on the topics of managing chronic, nonmalignant pain and substance abuse.[11–18] Using recommendations and guidelines for opioid prescribing,[19–21] we outlined a "best practices" approach. We then reviewed other resources to learn how best to implement these practices.[22–24]

This review led us to the concept of an opioid renewal clinic (Figure). After examining the pros and cons of this type of clinic, we found that the benefits seemed to outweigh the perceived problems. The major advantage was that, by allowing us to focus on one particular patient care process (the renewal of ongoing opioid prescriptions), this clinic format would provide the structured setting

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in which we could perform the type of close follow-up and regular monitoring recommended for patients with the dual diagnoses of chronic pain and substance abuse. In addition, by standardizing clinic procedures, we would reduce variations in care.

The clinic goals included easy cross-coverage of the clinic by different providers, incorporation of regulatory guidelines, and provision of a consistent standard of care (for example, we encourage the use of certain opioids over others based on research and clinical experience). We believed a team approach and a clear division of labor would reduce staff burnout and provide an opportunity for peer review. We wrote up our plan and presented it to our department head, who granted approval. Clinic space, staff, and time were allocated to implement the program.

OVERVIEW OF THE CLINIC

The clinic officially began in July 2003. As with any change, there was some initial staff apprehension, but after the first month the process became second nature.

On Tuesdays at 10 AM, our primary care team transforms into an opioid renewal clinic for two hours. The team—which includes a primary care physician, a primary care nurse, and a clinic pharmacist—is joined by an addiction counselor from the hospital's psychiatry department during this time. Instead of the customary 20- or 40-minute individual patient visits typical of the primary care clinic, the opioid renewal clinic uses a group appointment format, which generally accommodates 15 to 25 patients in a single block of time, allowing us to see more patients in less time.

Scheduled patients present first to the outpatient laboratory for blood and urine tests, which include toxicology screening. After the specimens are collected, the patients report to the primary care clinic for a brief, private nursing consultation and pain assessment. At this time, patients have the opportunity to bring up other issues or concerns they may have.

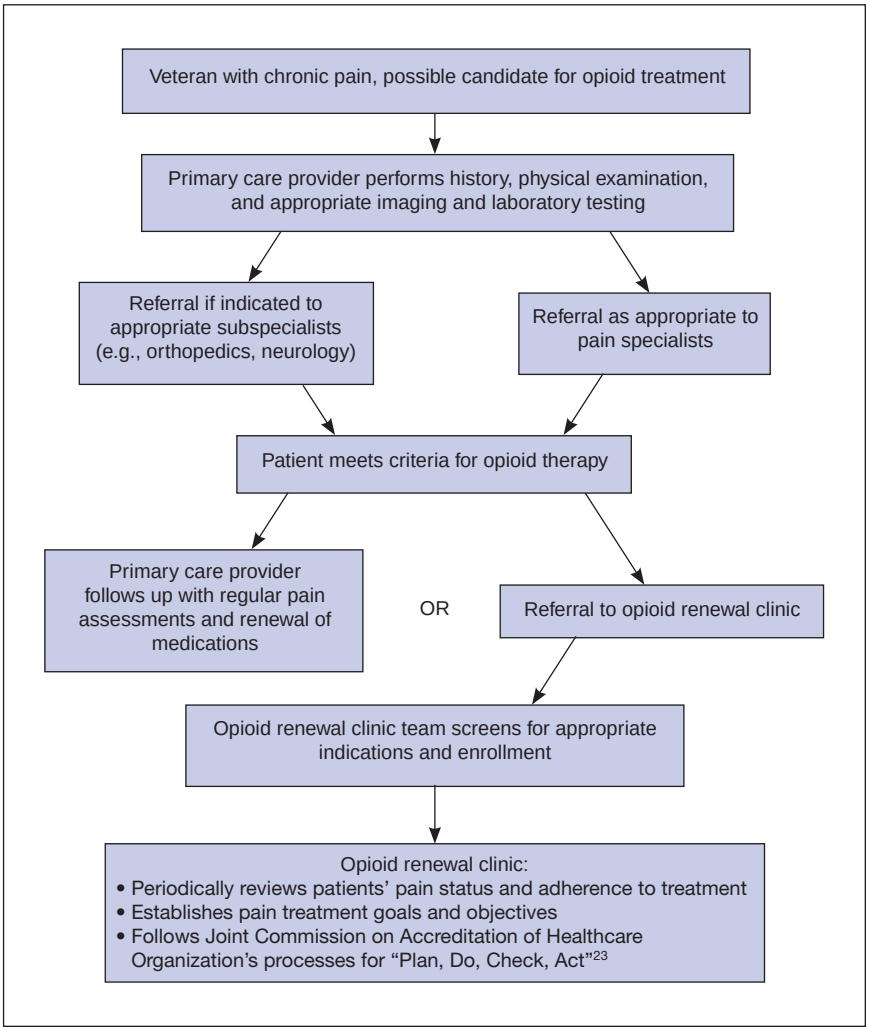

Figure. Performance improvement design process for opioid renewal clinic.[23]

Once the nursing assessment is completed, the patients gather in a conference room where staff members make any announcements and then a speaker—often from outside the clinic—presents a patient education program. The program changes monthly (Table) and is reassessed annually. Generally, it lasts about an hour or less, after which there is a 15-minute question and answer period.

While the educational program is being presented, the other clinic team members review laboratory results and identify any special patient needs or issues. For example, in one case, a patient's drug screening results came back positive for cocaine during the educational presentation. The physician instructed the pharmacy to hold the patient's opioid prescription, and when the presentation was over, the physician and the addiction counselor met privately with the patient to

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discuss the results. The patient admitted to using cocaine, and he was seen that same day for substance abuse counseling. He also was scheduled for treatment through the medical center's substance abuse treatment team. His opioid medications were held until he had a negative urine drug screen, after which they were to be released in one-week portions until the substance abuse treatment team felt he was ready to resume monthly refills.

If there are no problems, the primary care physician writes the opioid renewal prescriptions while reviewing and annotating the medical record, and then gives the prescriptions to the pharmacist for processing. Opioid prescriptions are renewed only at the current dosages. Patients who report that their pain is not adequately controlled by their current regimen or who report adverse effects from their current medications are assisted in making appointments with their primary care provider for reevaluation of their analgesic treatment plan.

After the group adjourns, patients may proceed to the outpatient pharmacy to pick up their medication or they may see the physician or addiction therapist to discuss any issues. We require patients to obtain their opioid medication from only one source (the hospital outpatient pharmacy) pursuant to an agreement the patient signs for the prescription of controlled substances, and we closely monitor dosages, quantities, and prescription renewal dates.

Although the main focus of our opioid renewal clinic is treating chronic pain in the context of current or past substance abuse, we have found it important to address other mental health conditions (such as bipolar disorder) and social issues (such as domestic violence) that can complicate opioid treatment. For some patients, these issues are even more prominent than the substance abuse, which may be intermittent or primarily in the past. We have thus added a psychiatrist to the clinic team and incorporated psychiatric screening tools into our assessments. We have found that the close monitoring and highly structured environment of the opioid renewal clinic is constructive in addressing these other mental health issues as well as substance abuse. A detailed discussion of our patients' concurrent diagnoses, however, is beyond the scope of this article.

Table. Sample schedule of patient education topics for an opioid renewal clinic

- July—Orientation to the Clinic and the Opioid Renewal Agreement
- August—The Anatomy of Pain
- September—Pain and Musculoskeletal Disorders
- October—Pain and Back Disorders
- November—Pain and Sleep Disorders
- December—Pain and Depression
- January—Nonpharmacologic Treatment of Pain
- February—Pharmacologic Treatment of Pain—Including Complementary and Alternative Medicine
- March—Pain and Coping Mechanisms/Cognitive Behavioral Therapy
- April—Pain and Spirituality
- May—Pain and Substance Abuse
- June—Pain and Regulatory Issues for Patients

USE OF DRUG TESTING

The military began drug screening in the 1970s, and this practice spread to other federal government agencies in 1988. By 1993, drug testing had expanded to industries regulated by the federal government.[25–27] Today employee drug testing programs have been implemented in private industry throughout the country.

Results of a 1992 cost-benefit analysis of preemployment drug screening in a cohort of U.S. Postal Service workers suggested that the Postal Service could save $162 per applicant hired by instituting this measure.[28] In the U.S. armed forces, surveys revealed that the prevalence of drug abuse among military personnel dropped from 47% prior to implementation of drug screening programs to 22% after random testing was started—and continued to drop yearly thereafter.[29] After six years of testing, the rate was only 2.5%, and in 1994, was less than 1%.[29] In private industry, employee drug testing has improved workplace safety, increased employee productivity, and decreased health care costs.[30]

Drug testing has been recommended for all patients receiving long-term opioid therapy for nonma-

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lignant pain.[31] Such testing provides evidence of adherence to pain therapy and yields helpful information about use of illegal drugs and other nonprescribed controlled substances. Nevertheless, one study found that only 8% of primary care physicians were ordering these drug tests for their patients.[32] Professional medical societies and model guidelines for the use of controlled substances in the treatment of chronic pain have outlined the rationale for drug testing.[33–36]

After some initial resistance, urine drug testing has become accepted in our clinic. The patients are asked to sign a pain contract stating that they will be subject to drug testing as a condition of their treatment. We perform drug tests routinely at opioid renewal clinic visits—and randomly, as deemed appropriate, at other medical center visits. Any abnormal findings are discussed with the patient.

We attempt to interpret test results within a clinically appropriate context. For instance, if a patient taking morphine ran out of medication several days prior to a urine drug screening, his or her drug test would be negative for opioids—which might cause us to suspect diversion of the medication. Before suspending this patient's refill, however, we would discuss with the patient why the medication ran out and try to correct the situation. We would then refill the prescription for only one week and retest the patient upon return to the opioid renewal clinic—or if the team felt comfortable with the reason the patient gave for running out of the medication, we might refill for a month but randomly test the patient during another medical center visit.

Other considerations include the fact that cannabinoids from marijuana are fat soluble and may cause a urine drug test to be positive for marijuana for several weeks, and that codeine will show positive for opioids while oxycodone usually will be negative. If a patient disputes the results of a drug test, we offer to repeat the test. Over time, trends or patterns emerge that solidify our impressions concerning whether a current substance abuse problem exists.

Before implementing drug screening in a particular practice, it's important to contact your laboratory and tell them the substances for which you would like the specimens tested in order to ensure the most beneficial results. The laboratory can recommend which tests are most appropriate and can help you understand how the results should be interpreted.

SUBSTANCE ABUSE COUNSELING

Patients whose screening tests are positive for illegal drugs are referred for substance abuse evaluation and counseling. Because some of these patients do not follow through with their scheduled appointments, we have arranged to have an addiction counselor and a psychiatrist available in our opioid renewal clinic every week. We have found that this practice enhances patient adherence to the conditions of the pain contract and increases group attendance. Along with the substance abuse counselors, social workers and the addiction psychiatrist have become an integral part of our multidisciplinary pain treatment team.[37] For those interested in learning more about the treatment of substance abuse and addictive disorders, ample information is available from peer-reviewed journals, web sites, and professional organizations.

OPIOID PRESCRIBING

In our opioid renewal clinic, we use positive reinforcement techniques to encourage constructive patient behavior and optimize the results of opioid therapy. We incorporate empathetic statements into our communications with patients; invite patient feedback; and do our best to facilitate the process of obtaining care consultations, appointments, and medications. Since the clinic includes a primary care physician, this individual often can help with many other medical concerns the patient might have, in addition to chronic pain.

Patients also are "rewarded"—in that they receive prescription renewals for a maximum of 30 days—if their drug tests have no abnormal findings. Prescriptions may be renewed for fewer days, such as for only one or two weeks, if we suspect the patient may be misusing or diverting their medications. Other conditions that might preclude a 30-day opioid prescription renewal include current substance-related impairment, drug screening results that are positive for illegal substances, drug screening results that reveal an absence of the prescribed opioid, other possible laboratory abnormalities (such as an adulterated specimen), or patient behavior or history that suggests a need for closer monitoring.

If a patient presenting to our clinic appears to be impaired by substance use, we do not renew that patient's opioid prescriptions on that day. We offer to reschedule the patient's clinic visit for another day when he or she can come in unimpaired. Since the clinic meets weekly and in a group format, we can be very flexible about rescheduling patients and we can accommodate far more patients in a single clinic day than we could in a traditional clinic.[38] Impaired patients are, of course, promptly referred for substance abuse counseling.

If a patient who has been referred for substance abuse treatment proves to be adherent to such therapy, limited renewal of prescribed opioids

may be considered, with diligent monitoring, in an attempt to balance adequate analgesic relief with safe prescribing practices. Patients who are nonadherent to substance abuse treatment regimens, who continue to abuse drugs or alcohol, or who have repeated abnormal drug screening tests are weaned off their opioids. For example, we frequently will refill the long-acting opioid medication but hold the short-acting opioid if an illicit drug is detected during urine screening. If the patient fails to follow up or to repeat the urine test, or continues to test positive, we will continue to wean the medication. The aim of this strategy is to avoid inducing opioid withdrawal. Eventually, if the problem does not resolve, the patient is discharged from the opioid renewal clinic and referred back to the primary care provider or to an appropriate specialist for evaluation and consideration of nonopioid pain management therapies.

PATIENT EDUCATION

What do patients with chronic pain want most from their providers? According to a recent survey of patients with chronic headaches and the specialists who treat them, the answer is education.[39] In this study, 86% of the patients rated having providers answer their questions as most important. Only 15% of the physicians, however, rated it as important. Research has shown that patients who cannot self-manage their pain tend to be frequent users of health care resources, whereas those who are taught methods of managing pain report less pain and disability.[40,41]

The Joint Commission on Accreditation of Healthcare Organizations standards relating to pain include patient education about pain management.[23] One standard requires the provision of patient education about pain that meets the specific needs of the patient, and another requires that the patient take an active role in their treatment process.

Our opioid renewal clinic incorporates patient education into every clinic visit, in the form of the programs presented during the group meeting. To ensure that we tailor our educational programs to our patients' needs, we solicit feedback from the patients in the form of an educational needs survey conducted about once every six months at the close of the group session. We also use depression screening tools[42] and other assessment instruments to enhance our understanding of patients' needs.

REGULATORY CONCERNS

Most state licensing boards have information and guidelines for prescribing opioids, and much of this information can be found on the internet.[43,44] We have reviewed the requirements of several regulatory agencies for prescribing opioids and found a consistent need for thorough medical record documentation. Mandatory documentation includes a history and physical examination and periodic follow-up notes at appropriate intervals. Medical literature suggests that follow-up appointments should be scheduled at least every 90 days—and more often if clinically necessary. Since our clinic meets once a week, our follow-up intervals are scheduled conveniently in multiples of one week (generally from one to four weeks), and this system has been working well. The medical record documentation also should include the laboratory workup, the diagnosis, and treatment plan. This is accomplished relatively easily with the team approach and division of responsibilities that we practice in our clinic.

OBSERVATIONS THUS FAR

A retrospective review, performed after we began regular drug testing, reveals that 33% of patients had at least one positive test for marijuana, cocaine, or alcohol. Current substance abuse was not associated with improved pain scores. Some patients were occasional or episodic users, but others had more serious underlying substance use disorders that required immediate treatment.

The opioid renewal clinic has succeeded in its original goal of minimizing walk-in primary care visits among patients with the dual diagnosis of chronic pain and substance abuse by bringing these patients back at regularly scheduled intervals. The clinic also has reduced episodes of aggressive patient behavior toward staff and increased patient participation in substance abuse treatment. Pain control is better, with fewer patients seeking to increase their opioid dosages. In fact, some patients are taking lower dosages of opioids—or are no longer requiring opioids at all. The clinic has been in operation for over two years, and its procedures have been adopted in several community-based clinics. In addition, it is listed as a best practice for our institution.[45]

SUMMING UP

Chronic pain and substance abuse are complex disorders. Although research continues to make inroads into effective treatment, challenges persist in the treatment of patients with both diagnoses. For these patients, it is almost impossible to treat one without the other. We have found that an opioid renewal clinic focusing on patient education, drug testing, and flexible prescribing can be effective in improving chronic pain management in populations who have a history of substance abuse. We recommend this approach to other clinicians looking

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for better ways to treat patients with the dual diagnosis of chronic, nonmalignant pain and substance abuse. ●

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