Pain Management for Physicians

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Bronson Battle Creek Cancer Care Center
Objectives

Take-aways from presentation

- Examine QOPI measures.
- Learn Bronson Cancer Care Center’s process.
- Discuss rational & interventions to improve outcomes.
- Share relevance and applicability to other clinics.
QOPI Pain Measures

**CORE 3-6e:**
- Pain assessed by second office visit (and most recent 2 visits)
- Pain intensity quantified by second office visit (and most recent 2 visits)
- Plan of care for moderate/severe pain quantified
- Pain addressed appropriately

**EOL 35-38:**
- Pain assessed on either of last two visits before death
- Pain intensity quantified
- Plan of care for moderate/severe pain quantified
- Pain addressed appropriately
The Why of Pain Management?

Better Medicine

- Increasing evidence that better symptom control leads to better survival
- 59% of patients undergoing anticancer therapy have pain
- 63% of patients with advanced or metastatic cancer have pain
- 33% of patients have pain after completion of curative treatment
- More than 1/3 patients rated pain moderate-severe

(Van den Beuken-van Everdigen et al., 2007)
Reimbursement
Better Reimbursement

O Value Based Reimbursement
  O 1. Pain addressed appropriately (Core #6d, #6e & End of Life #38)
  O 2. Smoking/tobacco cessation
  O 3. Hospice, palliative care referral/services

O MIPS
  O 1. Oncology: Medical and Radiation: Pain Intensity Quantified
LMOR Region

Pain addressed appropriately by second office visit and during the most recent office visits (measure 6e CORE module)

Source: ASCO-QOPI data: Fall 2014, Spring & Fall 2015, Spring 2016
LMOR Region

Pain addressed appropriately on either of the two visits before death (measure 38 End of Life Module)

Source: ASCO-QOPI data: Fall 2014, Spring & Fall 2015, Spring 2016
Results

Pain by 2nd Office Visit

Source: ASCO-QOPI data: By module, Spring 2014-Spring 2017
Results, continued

Pain at Two Most Recent Visits

Source: ASCO-QOPI data: By module, Spring 2014-Spring 2017
Results, continued

Pain Management at End of Life

- Pain assessed on either of the last two visits before death
- Pain intensity quantified on either of the last two visits before death
- Plan of care for moderate/severe pain documented on either of the last two visits before death
- Pain addressed appropriately (defect-free measure, EOL35, EOL36a, and EOL37)*

Source: ASCO-QOPI data: By module, Spring 2014-Spring 2017
Our process started . . .

Breast Program Leadership
DATE: July 14, 2016
NAPBC Standard 2.15 Support and Rehabilitation- Palliative Care

Support and rehabilitation services are provided by or referred to clinicians with specialized knowledge of diseases of the breast.

2015 Evaluation of Palliative Care Program

In 2015 #22 (twenty-two) breast cancer patients were seen by the Bronson Battle Creek Palliative Care Team. The Goal for 2015 included a Nurse Practitioner becoming part of the interdisciplinary team at the Cancer Care Center which was achieved. This individual developed a palliative care program to meet the specific needs of the population cared for at the Cancer Care Center.

1. Developed standardized process for patients transitioning in and out the hospital.
2. Developed tracking system that notifies Cancer Care Center team of patient admission.
3. Nomenclature change to Advanced Illness Management program to Bronson, reflective of a system change, integration, and approach to patient care.

2016 Goals for Support and Rehabilitation Specific to Palliative Care

- Started pain management aspect of care for (Breast) Cancer patients.
- Continue to integrate palliative care systems into routine Cancer Care for Breast Cancer patients. Includes multidisciplinary collaboration for symptom control and explanation of advanced directives.
March 11, 2016 EBP Pain Management Pathway discussed at Providers meeting

Recommendations taken to the providers meeting March 25, 2016 for review of preliminary pain pathway.

Pathway reviewed and supported at the March 31, 2016 Quality Committee

Pathway
- 1. Nurse reports pain scores to physician or APP
- 2. Physician/APP prescribe preferred medication
- 3. Follow up phone call made by provider’s RN 3 business days
- 4. Physician or APP makes dose adjustments as needed
- 5. Follow up phone call made by physician’s RN again 3 business days

Results analyzed 1 month out and then quarterly by Quality Committee, as well as re-education of staff on pain management updates.
RN Assessment Screen

Record Date and Time: 6/20/2017 11:02:25 AM

Has your rx been filled yet?:

Pain Intensity-Current:

Pain level acceptable:

Pain Comments:

Pain Management Options?:

Pain Pathways Will Be Added
# Pain Management Guidelines

1. Use a multi-modal drug approach. Combine opioids with non-opioids and adjuvant analgesics as indicated.

2. Rate administration schedule on the analgesic's duration of effect. Best to use sustained release opioids for scheduled dosing and always use immediate release opioids for rescue or breakthrough dosing. Do not crush or chew extended-release preparations.

3. In opioid naïve patients, start with low dose, short acting opioids and titrate for effect.

4. Avoid nonopioid analgesics (Demerol®) and the mixed agonist-antagonist opioids (e.g., butorphanol tartrate (Stadol®); nalbuphine hydrochloride (Nubain®); and pentazocine hydrochloride and nomefine hydrochloride (Talwin®)).

5. Acetaminophen (APAP) do not exceed 3000-4000 mg q 24 hours for adults; and for older adults do not exceed 2000 mg q 24 hrs. Use lower doses or omit APAP if liver disease, restricted prescribing combination products as well as over the counter (OTC) medications.

6. Non-invasive routes preferred. For severe pain or rapidly escalating pain, it may be necessary to provide intravenous analgesics until the patient is managed. If oral, rectal, or transdermal dosing is no longer practical or appropriate, continuous subcutaneous or intravenous infusions are indicated.

7. Mild Pain [rating 1-3]: When pain is managed with nonsteroidal anti-inflammatory drugs (NSAIDs), acetylsalicylic acid (ASA) or acetaminophen (APAP) with or without adjuvant analgesics as appropriate for [neuropathic pain].

8. Moderate to Severe Pain [rating 4-10]: When pain does not respond to nonopioid analgesics and adjuvants, consider adding an opioid. Drugs, with APAP, ASA or NSAIDs in combination with opioids limit flexibilidade of dosing and should be used for mild to moderate pain only.

9. Titrations: Increase by 15 to 50% for moderate pain; increase by 50 to 100% for severe pain. Calculate amount of opioid taken in last 24 hours (add breakthrough maintenance dose) and administer as new 24-hour breakthrough dose.

10. Breakthrough Pain Dosing: Scheduled dosing will maintain stable serum drug levels and provide consistent relief. Patients on long-acting opioids or continuous parenteral infusions must have an hour for breakthrough pain medication. Frequency generally more than 4; 12 hour breakthrough dosing requires a change in the scheduled sustained release drug dose. Oral breakthrough dose is 10-20% of the oral 24 hour baseline dose. Peak effect of immediate-release opioid is 1 hour, may repeat every hour if patient is not overly sedated. Until 80-100% of the IV/SQ rate. Peak effect of IV opioids is 10-15 minutes; may repeat every 15 minutes if patient not overly sedated. Peak effect of SQ opioids is 30 minutes; may repeat every 30 minutes if patient is not overly sedated. IV dosing is not recommended.

11. Opioid rotation may be warranted when escalating doses are ineffective in relieving pain or when adverse effects persist despite aggressive administration or route of administration. See chart on other side. From changing from one drug to another, the new drug may be more effective, because of differences in potency or bioavailability. Start at 50-75% of the amount calculated using the equianalgesic tables. Make sure breakthrough medication is available and titrate dose according to individual patient response. Consult pain or palliative specialist when switching to new medication.

12. Prevent and manage opioid side effects aggressively. Patients never become tolerant to the constipating effects of opioid. Always keep a laxative and stool softener combination with opioids.

13. To discontinue opioid taper gradually to patient response to avoid withdrawal symptoms. Always educate patients and caregivers about pain medications, side effect management and safe storage of drugs.

## Pain Sources

<table>
<thead>
<tr>
<th>Pain Sources</th>
<th>Pain Character</th>
<th>Drug Class/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mysofacial/Somatic</td>
<td>Constant and well localized</td>
<td>Acetaminophen, NSAIDs</td>
</tr>
<tr>
<td>Visceral</td>
<td>Injury to sympathetically innervated</td>
<td>Opioids</td>
</tr>
<tr>
<td>Bone</td>
<td>Axial skeleton with or without spine</td>
<td>Biophosphorus, Radiation</td>
</tr>
<tr>
<td>Neuropathic (Neural)</td>
<td>Results from damage to peripheral</td>
<td>Adjuvants</td>
</tr>
<tr>
<td>Nerve Damage (Neural)</td>
<td>or central nervous system or both</td>
<td>Anticonvulsants (Neurontin®), Pre gabamin (Lyrica®)</td>
</tr>
<tr>
<td>Dysesthesia</td>
<td></td>
<td>Tricyclic Antidepressants (Pinele, Desipramine)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SNRI Antidepressants (Cymbalta, Venlafaxine (Effexor)</td>
</tr>
<tr>
<td>Opioids</td>
<td></td>
<td>Topical Analgesic (Li docaine Patch)</td>
</tr>
</tbody>
</table>

## Opioid Side Effect Management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Opioid Side Effect Management (See NRE Symptom Card)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Tolerance to opioid related constipation does not occur. Start with combined agents as stimulant and doucecatin (Colase®,) as softener. May increase to 4 tabs bid. If no BM in 2 days add a laxative (budesol, lactulose, magnesium hydroxide (Milk of Magnesias), polyethylene glycol (Rifalax®) SQ 48 hours if other measures ineffective (only for opioid-induced constipation).</td>
</tr>
<tr>
<td>Oxydorine</td>
<td>Oxydorine ER - 5,10,15,20,30 mg</td>
</tr>
<tr>
<td>Naloxone</td>
<td>Naloxone ER - 5, 10, 15, 20, 30, 40, 60, 80, 120 mg</td>
</tr>
</tbody>
</table>

## Opioid Equianalgesic Table

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage Form/Strengths</th>
<th>Approximate Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Codeine</strong></td>
<td>Tablets: Codeine - 15,30, 60, mg</td>
<td>200 mg</td>
</tr>
<tr>
<td><strong>Fentanyl</strong></td>
<td>Parenteral</td>
<td>100 mcg patch (2-3 days)</td>
</tr>
<tr>
<td><strong>Hydromorphone</strong></td>
<td>Tablets:</td>
<td>1.5 mg - 7.5 mg</td>
</tr>
<tr>
<td><strong>Morphine</strong></td>
<td>Immediate Release</td>
<td>10 mg - 30 mg</td>
</tr>
<tr>
<td><strong>Oxycodone</strong></td>
<td>Immediate Release</td>
<td>5, 10, 15, 20, 30 mg</td>
</tr>
<tr>
<td><strong>Oxycodone/Acetaminophen</strong></td>
<td>Tablets:</td>
<td>5, 10, 15, 20, 30, 40, 60, 120 mg</td>
</tr>
</tbody>
</table>

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*Note: All dosages and equivalences are approximate and may vary based on individual patient response.*
3 Step Analgesic Ladder for Pain Management

Step 1: Mild pain (rating 1-3)

Step 2: Moderate (rating 4-6)

Step 3: Severe (rating 7-10)
Valuable Resources for Practices

- American Pain Society website: Pain management and dosing guide (free):
- American Pain Society, Principles of Analgesic Use, Pocket Guide:
  http://apps.americanpainsociety.org/Default.aspx?TabID=251&productId=11764514
- ASCO: Website/PDF & Iphone/tablet versions
- BCBS Compassion and Support @ EOL: free Guides and links:
  http://www.compassionandsupport.org/index.php/for_professionals/pain_management
- CAPC Links: (some free): https://www.capc.org/providers/palliative-care-resources/quick-links/
- City of Hope, Palliative Care: Website/PDF: http://prc.coh.org/default.asp
- City of Hope & Nursing Research & Education: (Free-what was used in presentation)
  http://prc.coh.org/NRE%20Pain%20Card%20revised%209.29.16.Final%20%20CR.pdf
- Fast Facts!!!! Amazing, most free, Iphone/Android: https://www.mypcnow.org/fast-facts
- (Free) Opioid Conversion Calculator: http://www.globalrph.com/narcoticonv.htm
- NCCN: Website/PDF & Iphone/tablet versions
Future Conferences

- American Academy of Hospice and Palliative Medicine, Annual Assembly: [http://aahpm.org/meetings/assembly](http://aahpm.org/meetings/assembly)


Thank you

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Ø Dr. Tim Sparling’s contact information: sparlint@bronsonhg.org, cell 269-720-8382
Assessment and Management of Acute Pain Treatment Algorithm

12. Somatic Pain treatment:
   - Acetaminophen
   - Cold packs
   - Corticosteroids
   - Local anesthetic (topical or infiltration)
   - NSAIDs
   - Opioids (via any route)
   - Tactile stimulation

13. Visceral Pain treatment:
   - Corticosteroids
   - Intraspinal local anesthetic agents
   - NSAIDs
   - Opioids (via any route)

14. Neuropathic Pain treatment:
   - Anticonvulsants
   - Corticosteroids
   - Neural blockade
   - NSAIDs
   - Opioids (via any route)
   - Tricyclic antidepressants

20. See ICSI Chronic Pain guideline and/or consider referral to pain specialist

21. Select an alternate treatment choice

19. Has pain persisted > 6 weeks?
   - no
   - yes

17. Still confident of pain mechanism?
   - no
   - yes

16. Adequate pain relief?
   - no
   - yes

22. Intolerable symptoms secondary to treatment?
   - yes
   - no

24. Follow-up/reassess

23. Side effect management

A = Annotation

18. Return to box #8 "Determine mechanism of pain" on previous page
Palliative Care Requirements

- COC: Standard 2.4: https://www.facs.org/quality-programs/cancer/coc/standards
Assessment and Documentation
OPQRSTU
- Onset
- Palliation/Precipitation
- Quality/Quantity
- Region/Radiation
- Symptoms/Severity
- Temporal/Timing
- U-how does it affect the patient?
Additional Resources (A. Vallerand, 2011)

Drug

Methadone  10 mg
Quick Bios: Dr. Cox

- Bachelor’s Degree: University of Michigan
- University of Rome, Rome, Italy
- Residency: St. John Hospital and Medical Center, Detroit
- Oncology/Hematology Fellowship: William Beaumont Hospital, Royal Oak
Quick Bios: Dr. Sparling

- Bachelor’s of Nursing University of Phoenix
- Doctorate of Nursing Practice: Wayne State University
- Board certified Adult-Gerontology Primary Care Nurse Practitioner
- Advanced Certification in Hospice and Palliative Nursing
- Post-Doc Study at City of Hope
- Certified End of Life Nursing Education Consortium teacher
- Part-time faculty at Ohio State University and Kent State University