Balancing Relief and Risk:
Confronting the Duality of Chronic Pain and Opioid Addiction

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Financial Relationship Disclosures for

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DEA Registered-Practitioners

Dear Registr

On December 29, 2022, the Consolidated Appropriations Act of 2023 enacted a new **one-time**, eight-hour training requirement for all Drug Enforcement Administration (DEA)-registered practitioners on the treatment and management of patients with opioid or other substance use disorders. Below is information on this new requirement.

Who is responsible for satisfying this new training requirement?

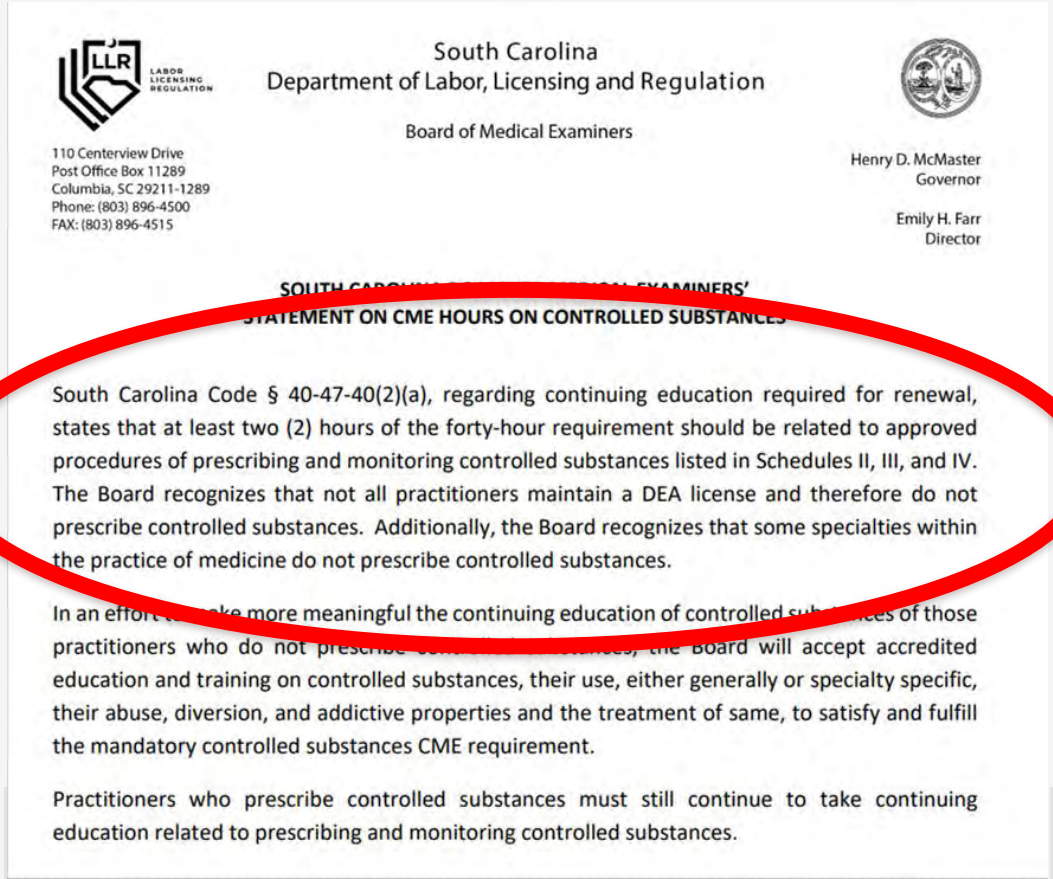
- All DEA-registered practitioners, with the exception of practitioners that are solely veterinarians.

How will practi ers be asked to report satisfying this new training requi ent?

- Beginning on June 27, 2023, practitioners will be required to check a box on their online DEA registration form—regardless of whether a registrant is completing their initial registration application or renewing their registration—affirming that they have completed the new training requirement.
- This one-time training requirement affirmation will not be a part of future registration renewals.

ALL Registrants by the time of next renewal MUST complete 8 hours of training on the treatment and management of opioid or other substance use disorders

SC Opioid CME Requirement



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STATEMENT ON CME HOURS ON CONTROLLED SUBSTANCES

South Carolina Code § 40-47-40(2)(a), regarding continuing education required for renewal, states that at least two (2) hours of the forty-hour requirement should be related to approved procedures of prescribing and monitoring controlled substances listed in Schedules II, III, and IV. The Board recognizes that not all practitioners maintain a DEA license and therefore do not prescribe controlled substances. Additionally, the Board recognizes that some specialties within the practice of medicine do not prescribe controlled substances.

In an effort to make more meaningful the continuing education of controlled substances of those practitioners who do not prescribe controlled substances, the Board will accept accredited education and training on controlled substances, their use, either generally or specialty specific, their abuse, diversion, and addictive properties and the treatment of same, to satisfy and fulfill the mandatory controlled substances CME requirement.

Practitioners who prescribe controlled substances must still continue to take continuing education related to prescribing and monitoring controlled substances.

DON’T USE OPIOIDS.

Thank you.
Any questions?

Goals and Objectives

01 ~~Diagnose OUD and begin treatment with support~~

02 Discuss risks/benefits of chronic opioids and how to mitigate

03 Understand the use of buprenorphine for chronic pain

First a patient:

59yo man presents with chronic low back pain. Has had pain since accident at work 15 years ago. Still working now. Says he has tried “everything” and the only thing that works for him is MS Contin 30mg BID and oxycodone/acetaminophen 10/325 q6hr prn. Pain is always there, radiates down his R leg sometimes. However, recently seems to be having more pain, meds not working like they used to.

What do you do?

01

Practice Recommendations for Chronic Pain

Pain Definitions

CDC defines three durations of pain:

1. Acute pain - duration of less than 1 month
2. Subacute pain - duration of 1-3 months
3. Chronic pain - duration >3 months

Types of Pain

Nociceptive

- Somatic
  - Examples: low back pain, arthritis, broken bone
- Visceral
  - Examples: myocardial infarction, peptic ulcer, pancreatitis

Neuropathic

- Examples: diabetic neuropathy, radicular pain, post herpetic neuralgia

Practice Recommendation # 1

Complete a comprehensive pain assessment in order to diagnose and treat chronic pain.

- History including: subjective pain scale, biopsychosocial assessment, mental health, and substance use hx
- Physical exam
- Imaging

Pain Assessment

Subjective pain scale

1. Quality
2. Duration
3. Severity

Biopsychosocial assessment

1. Sleep
2. Quality of life
3. Function

Mental health and substance abuse

1. Anxiety
2. Depression
3. Alcohol use
4. Drug use

Pain Severity

Pain Scale Data

Numeric pain scale is most widely used

- Easy and fast to administer
- This is only measuring severity - not disability, quality of life
- Correlates well with severity assessments in longer surveys
- Does NOT always correlate well with disability questions

Biopsychosocial Assessment

Quality of life and function are the important questions here

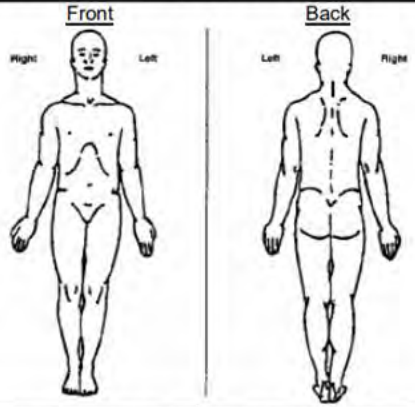
- How does the pain you experience affect your life?
- Are you able to complete the tasks you need or want to do?
- What does a typical day look like for you?

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

0% ☐ No Relief — 10% ☐ — 20% ☐ — 30% ☐ — 40% ☐ — 50% ☐ — 60% ☐ — 70% ☐ — 80% ☐ — 90% ☐ — 100% ☐ Complete Relief

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

B. Mood

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

C. Walking ability

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

D. Normal Work (includes both work outside the home and housework)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

E. Relations with other people

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

F. Sleep

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

G. Enjoyment of life

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Pain Assessment - PEG Scale

1. What number best describes your pain on average in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Mental Health Assessment

Depression

- PHQ2
- Followed by PHQ9 if positive
- Easy, fast
- Can be self-administered

- **USPSTF and CMS suggest to screen at least once per year!**

Anxiety

- GAD7
- Easy, fast
- Can be self administered
- Consider PTSD screen

PHQ-2

PHQ-2 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Scoring: A score of 3 or more is considered a positive result. The PHQ-9 (Table 3) or a clinical interview should be completed for patients who screen positive.

Mental Health Comorbidity

Condition	Prevalence In Patients with Chronic Pain	References
Depression	33 - 54%	Cheatle M, Gallagher R, 2006 Dersh J, et al., 2002
Anxiety Disorders	16.5 - 50%	Knaster P, et al., 2012 Cheatle M, Gallagher R, 2006
Personality Disorders	31 - 81%	Polatin PB, et al. 1992 Fischer-Kern M, et al., 2011
PTSD	49% veterans 2% civilians	Otis, J, et al., 2010 Knaster P, et al., 2012
Substance Use Disorders	15 - 28%	Polatin PB, et al. 1992 Cheatle M, Gallagher R, 2006

Why Mental Health Matters

Depression/anxiety is associated with:

- Worse quality of life
- Increased pain scores
- Poorer adherence with treatment
- Worse satisfaction with treatment

Less movement → More disability

Substance Use Assessment

USPSTF recommend screening for substance use in all adults.

- Best practice by many societies as well
- Can be short NIDA quick screen or more involved
- Co-occurring SUD are common in chronic pain patients → maladaptive response to painful stimuli

TAPS

Has been validated for use in primary care

- Length of survey depends on severity of use
- Can be self administered or provider administered
- If screen positive for problem use or SUD → refer for help!
- Sensitivity about 90%, specificity about 87%

NIDA Quick Screen aka TAPS

	Question
	In the past 12 months, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipe, or smokeless tobacco)?
For men:	In the past 12 months, how often have you had 5 or more drinks containing alcohol in one day?
For women:	In the past 12 months, how often have you had 4 or more drinks containing alcohol in one day?
	In the past 12 months, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
	In the past 12 months, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?

TAPS Part 2

If yes to any of the previous questions, you ask the TAPS 2 questions about that substance.

Question
Did you smoke a cigarette containing tobacco?
Did you usually smoke more than 10 cigarettes each day?
Did you usually smoke within 30 minutes after waking?
Did you have a drink containing alcohol?
Did you have 4 or more drinks containing alcohol in a day?
Did you have 5 or more drinks containing alcohol in a day?
Have you tried and failed to control, cut down or stop drinking?
Has anyone expressed concern about your drinking?
Did you use marijuana (hash, weed)?
Have you had a strong desire or urge to use marijuana at least once a week or more often?
Has anyone expressed concern about your use of marijuana?

Let’s go back to our patient:

59yo man presents with chronic low back pain. Has had pain since accident at work 15 years ago. Still working now. Says he has tried “everything” and the only thing that works for him is MS Contin 30mg BID and oxycodone/acetaminophen 10/325 q6hr prn. Pain is always there, radiates down his R leg sometimes. However, recently seems to be having more pain, meds not working like they used to.

What do you do?

Pain Assessment

Subjective pain scale

1. Quality - stabbing, constant LBP, radiates to leg
2. >15 years
3. He rates it a constant 7/10

Biopsychosocial assessment

1. PEG - 7
2. Sleep is poor

Mental health and substance abuse

1. GAD7 - 5
2. PHQ9 - 14
3. TAPS - SUD for tobacco, risky use for alcohol, risky use for THC, neg others

Diagnoses

Chronic lower back pain with R sided sciatica

- Impactful pain
- MSK + neuropathic components

Major Depressive Disorder

Tobacco Use Disorder

At risk use for alcohol and THC

Practice Recommendation #2

Multimodal and multidisciplinary care for chronic pain is preferred.

- Non-opioid medications
- Restorative techniques
- Interventional techniques
- Behavioral techniques
- Opioid medications

Non-opioids

NSAIDs

Ex: naproxen, meloxicam, ibuprofen

Acetaminophen

Max dose 3-4g per day

Anticonvulsants

Ex: gabapentin or pregabalin

TCAs

Ex: amitriptyline or nortriptyline

SNRIs

Ex: Venlafaxine, duloxetine, minalciparin

Muscle relaxers

Ex: baclopen, cyclobenzaprine, tizanidine

Non-opioids work!

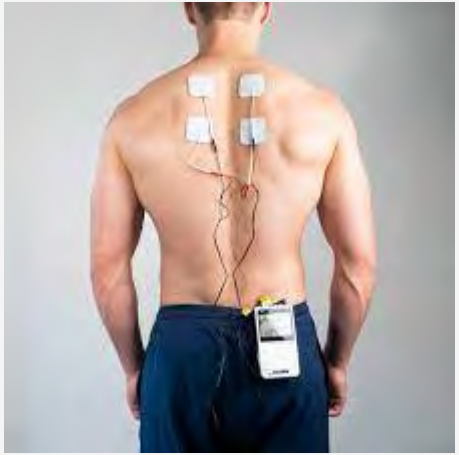
Summary of results B: Painful diabetic neuropathy – efficacy analyses for different outcomes

Drug	Dose	Number of		Percent achieving outcome with		RR	NNT
	(mg/day)	Studies	Participants	Drug	Placebo	(95% CI)	(95% CI)
Outcome: at least 50% pain intensity reduction							
Gabapentin	600 to 3600	4	829	40	23	1.8 (1.4 to 2.2)	5.8 (4.3 to 9.0)
Lacosamide	400	2	412	35	25	1.4 (1.01 to 1.9)	10 (5.2 to 120)
	600	2	407	28	25	1.1 (0.8 to 1.6)	*Not calculated*
Lamotrigine	200 to 400	3	773	26	24	1.1 (0.8 to 1.4)	*Not calculated*
Pregabalin	300	3	645	38	29	1.3 (1.1 to 1.6)	11 (6.1 to 54)
	600	4	1005	46	30	1.5 (1.3 to 1.8)	6.3 (4.6 to 10)

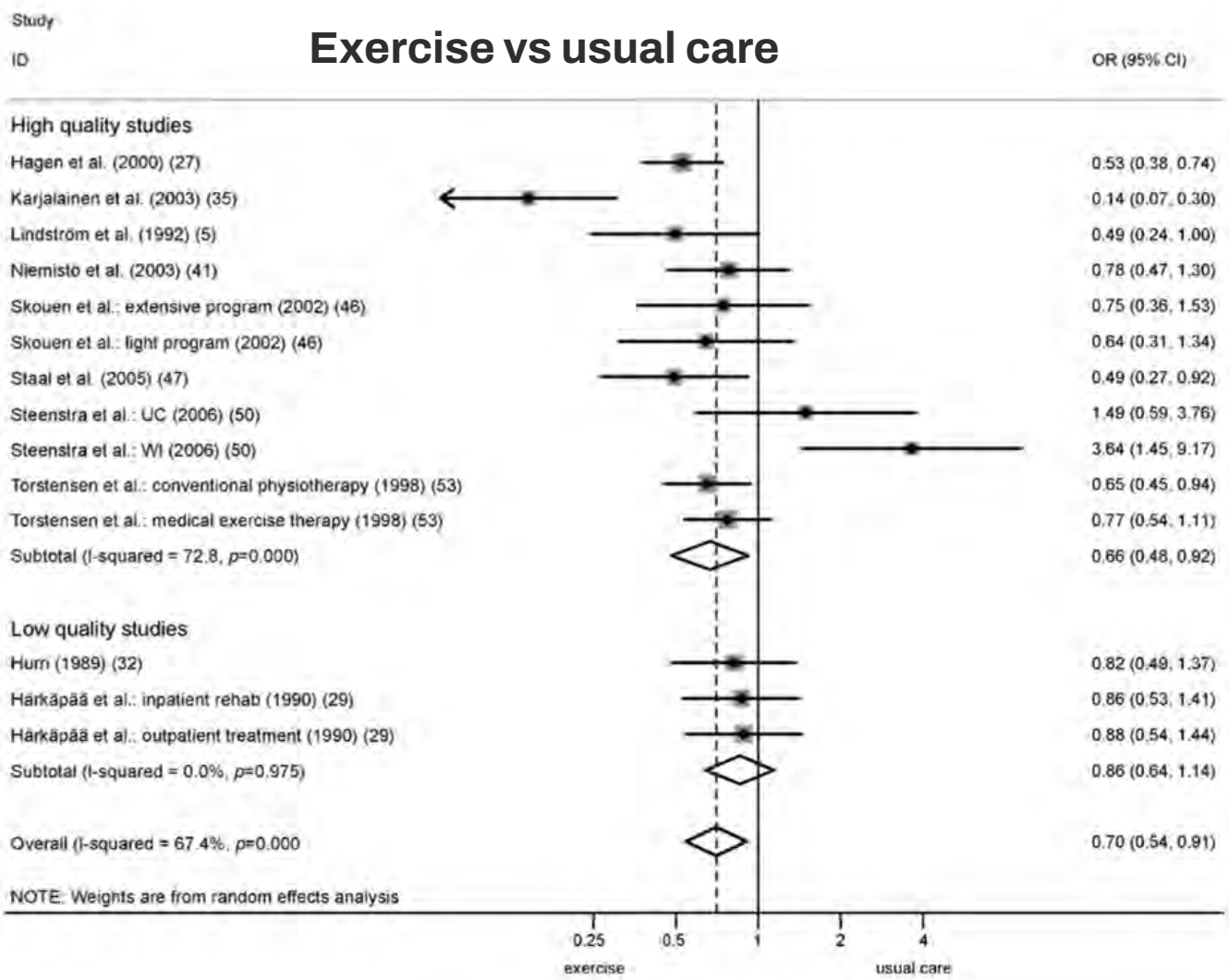
Restorative Options

Massage therapy
TENS units
Traction
Cold and heat
Therapeutic ultrasound
Bracing
Osteopathic manipulative treatment

...data is scarce!



Exercise vs usual care



Interventional Options

Primary care options:

- Trigger point injections
- Joint injections
- Peripheral nerve injections

Pain management options:

- Facet joint nerve blocks
- Epidural steroid injection
- Radiofrequency ablation
- Spinal cord stimulator and many more

Efficacy of joint injections

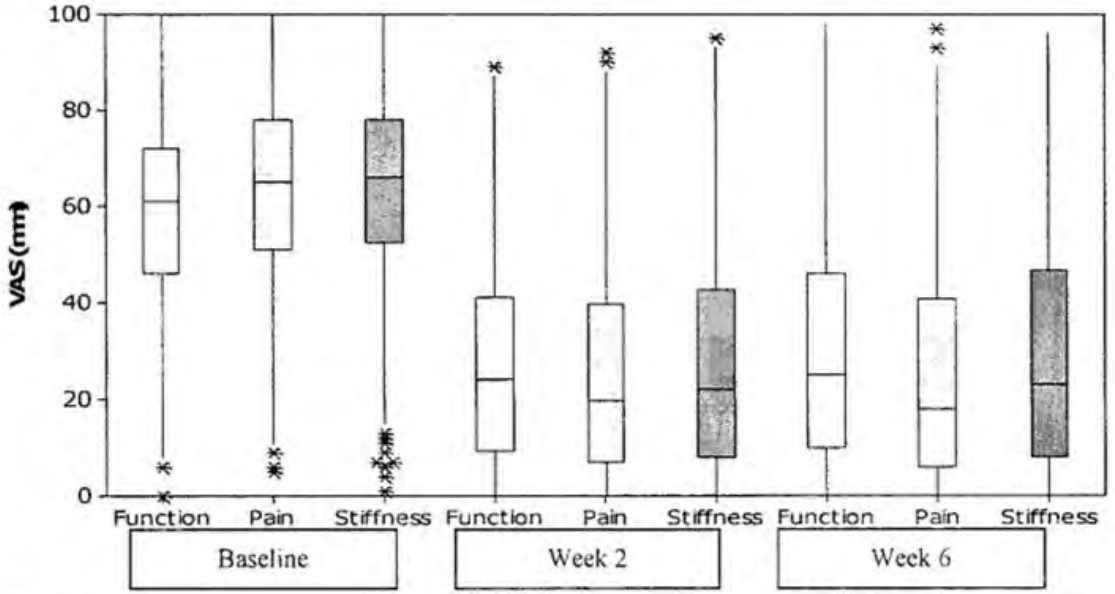


Figure 3. Patient's assessment of pain, function, and stiffness in the injected joint. A 100-mm visual analog scale (VAS) was used to record each patient's assessment of the injected joint at baseline and at 2 weeks and 6 weeks postinjection. Data are shown as box plots. Each box represents the 25th to 75th percentiles. Lines inside the boxes represent the median. Lines outside the boxes represent the 10th and the 90th percentiles. Asterisks indicate outliers.

Behavioral Options

Behavioral therapy
Cognitive behavioral therapy
Acceptance and commitment therapy
Mindfulness-based stress reduction
Emotional awareness and expression therapy
Biofeedback

CBT works!

Self-Blame	−1.14$_a$	(0.89)	−1.15$_a$	(0.90)	−1.08$_a$	(1.01)	−1.19$_a$	(0.90)	0.46
CSQ Catastrophizing	2.47$_a$	(1.49)	1.49$_b$	(1.37)	1.83$_c$	(1.49)	1.73$_{b,c}$	(1.45)	23.73
CSQ subscales (coping)									
Reinterpret Pain	0.96$_a$	(1.09)	1.74$_b$	(1.60)	1.59$_b$	(1.60)	1.70$_b$	(1.71)	16.46
Ignore Pain	2.19$_a$	(1.39)	3.04$_b$	(1.52)	2.83$_b$	(1.60)	2.97$_b$	(1.60)	18.82
Coping Self-Statements	3.73$_a$	(1.26)	4.50$_b$	(1.08)	3.99$_a$	(1.24)	3.96$_a$	(1.22)	18.66
Pray/Hope	3.14$_a$	(1.52)	2.89$_a$	(1.67)	2.44$_b$	(1.51)	2.43$_b$	(1.58)	21.69
Divert Attention	2.79$_a$	(1.38)	3.60$_b$	(1.33)	2.92$_a$	(1.42)	3.07$_a$	(1.48)	21.24
Increase Activities	3.04$_a$	(1.23)	3.71$_b$	(1.10)	3.20$_a$	(1.13)	3.28$_a$	(1.17)	16.72
CPCI (coping)									
Guarding	4.43$_a$	(1.76)	2.02$_b$	(1.88)	2.69$_c$	(2.10)	2.73$_c$	(2.19)	83.12
Resting	4.32$_a$	(1.63)	2.83$_b$	(1.75)	2.62$_b$	(1.71)	2.73$_b$	(1.97)	58.99
Ask for Assistance	3.24$_a$	(2.32)	1.20$_b$	(1.73)	1.97$_c$	(2.05)	2.04$_c$	(2.06)	46.60
Relaxation	2.40$_a$	(1.50)	4.72$_b$	(1.30)	3.12$_c$	(1.67)	3.10$_c$	(1.58)	117.62
Task Persistence	4.21$_a$	(1.65)	5.34$_b$	(1.44)	4.94$_c$	(1.67)	4.97$_{c,b}$	(1.77)	18.53
Exercise/Stretch	3.31$_a$	(1.92)	6.62$_b$	(1.01)	4.59$_c$	(1.72)	4.59$_c$	(1.83)	118.25
Seek Social Support	3.05$_a$	(1.68)	3.48$_b$	(1.54)	2.40$_c$	(1.81)	2.27$_c$	(1.73)	26.90
Coping Self-Statements	3.68$_a$	(1.87)	9.73$_b$	(1.58)	3.38$_a$	(1.96)	3.39$_a$	(1.98)	34.61
Outcome variables									
Patient–Roland	15.10$_a$	(4.94)	9.12$_b$	(5.70)	10.82$_c$	(6.03)	10.93$_c$	(6.51)	69.94
Significant other–Roland	15.77$_a$	(4.57)			11.53$_b$	(6.05)	12.00$_b$	(6.16)	24.50
Depression (CES–D)	25.11$_a$	(12.86)	16.47$_b$	(10.88)	21.01$_c$	(12.27)	19.34$_c$	(11.48)	28.16
Health care visits[b]	8.77$_a$	(11.60)			4.96$_b$	(8.89)	4.32$_b$	(7.82)	30.99
Average pain intensity	6.15$_a$	(1.51)	5.50$_b$	(1.65)	5.64$_b$	(1.95)	5.46$_b$	(2.15)	10.71

Opioids

Opioids have **little to no** evidence of benefit in **CHRONIC pain**

Opioids have serious side effects including:

- Dependence
- Overdose/death
- Constipation
- Hyperalgesia

Opioids DON'T work!

Table 2. Patient-Reported Primary and Secondary Outcomes Among Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain Randomized to Opioid vs Nonopioid Medication

Outcome	Opioid Group, Mean (SD) (n = 119)	Nonopioid Group, Mean (SD) (n = 119)	Between-Group Difference (95% CI)[a]	Overall *P* Value[b]
Pain-Related Function (Primary Outcome)				
BPI interference scale (range, 0-10; higher score = worse)[c]				
Baseline	5.4 (1.8)	5.5 (2.0)	−0.1 (−0.6 to 0.4)	.58
3 mo	3.7 (2.1)	3.7 (2.2)	0.0 (−0.6 to 0.6)	
6 mo	3.4 (2.1)	3.6 (2.4)	−0.2 (−0.8 to 0.4)	
9 mo	3.6 (2.2)	3.3 (2.4)	0.4 (−0.2 to 1.0)	
12 mo	3.4 (2.5)	3.3 (2.6)	0.1 (−0.5 to 0.7)	
Pain Intensity (Secondary Outcome)				
BPI severity scale (range, 0-10; higher score = worse)[d]				
Baseline	5.4 (1.5)	5.4 (1.2)	0.0 (−0.4 to 0.3)	.03
3 mo	4.3 (1.8)	4.0 (1.7)	0.3 (−0.2 to 0.7)	
6 mo	4.1 (1.8)	4.1 (1.9)	0.0 (−0.5 to 0.5)	
9 mo	4.2 (1.7)	3.6 (1.7)	0.7 (0.2 to 1.2)	
12 mo	4.0 (2.0)	3.5 (1.9)	0.5 (0.0 to 1.0)	

Practice Recommendation #3

Match the treatment modality to the type of pain you are treating

Non-opioids - Matching

Nociceptive pain:

- Acetaminophen (NNT = 3)
- NSAIDs
- Muscle relaxers
- Last line - TCAs

Neuropathic pain:

- TCAs (NNT =3)
- SNRIs (NNT = 5)
- Anticonvulsants (NNT =8)

Other modalities - matching

Restorative

Nociceptive - good for LBP, osteoarthritis

Interventional

Joint injections - nociceptive like arthritis
Epidural steroids - LBP with neuropathic components

Behavioral

Any and all!
Good for central sensitization as well

Opioids - matching

Opioids do work for acute or subacute pain secondary to surgery

For chronic pain, several guidelines recommend as last line in intractable pain from nociceptive or neuropathic pain.

It is reasonable, however it is NOT best practice.

Diagnoses

Chronic lower back pain with sciatica

- Impactful pain
- MSK + neuropathic components

Major Depressive Disorder

Tobacco Use Disorder

At risk use for alcohol and THC

Treatments

Opioids alone...

What do you want to do?

02

Opioid Prescribing and Tapering

Best Practices for Opioid Prescribing

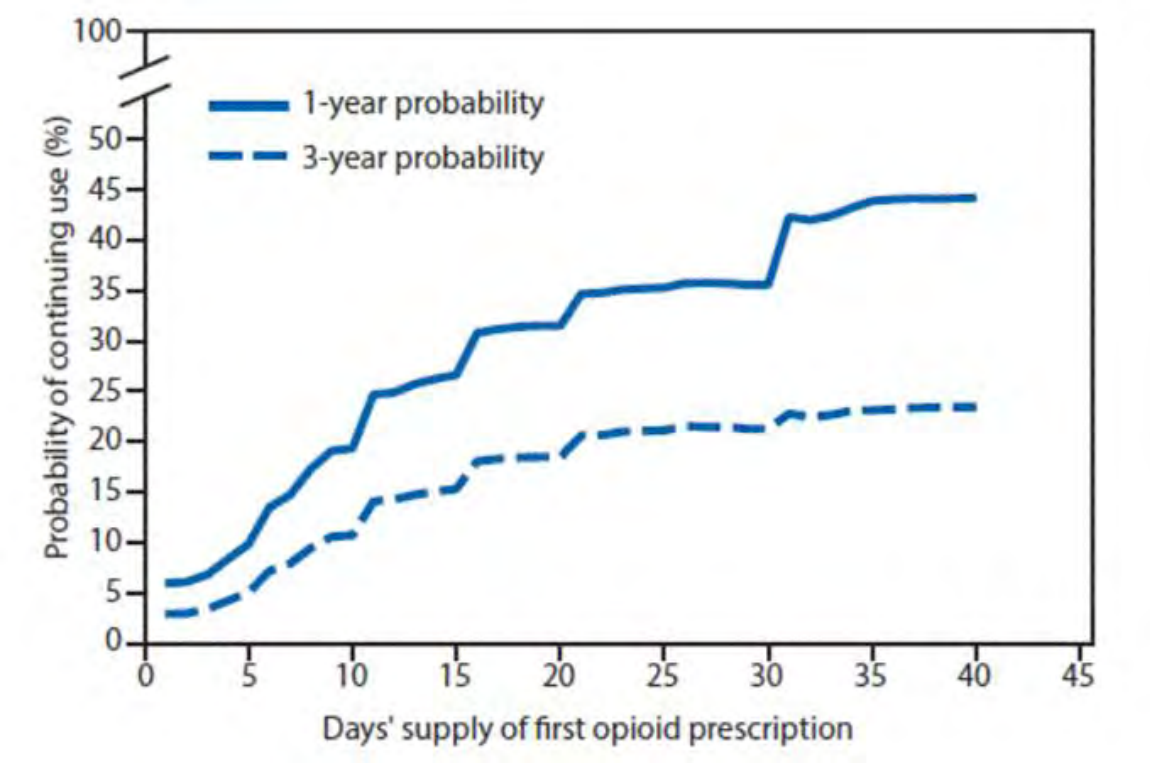
CDC 2022
HHS 2019
Pain Medicine Society response to CDC 2016
Anesthesia Guidelines
ACP Chronic Pain Guidelines
PCSS Chronic Pain Curriculum
Michigan Safer Opioid Prescribing Toolkit

What are the risks of opioids?

Dependence
Withdrawal
Addiction
Overdose
Hyperalgesia
Hypogonadism
Falls/fracture risk

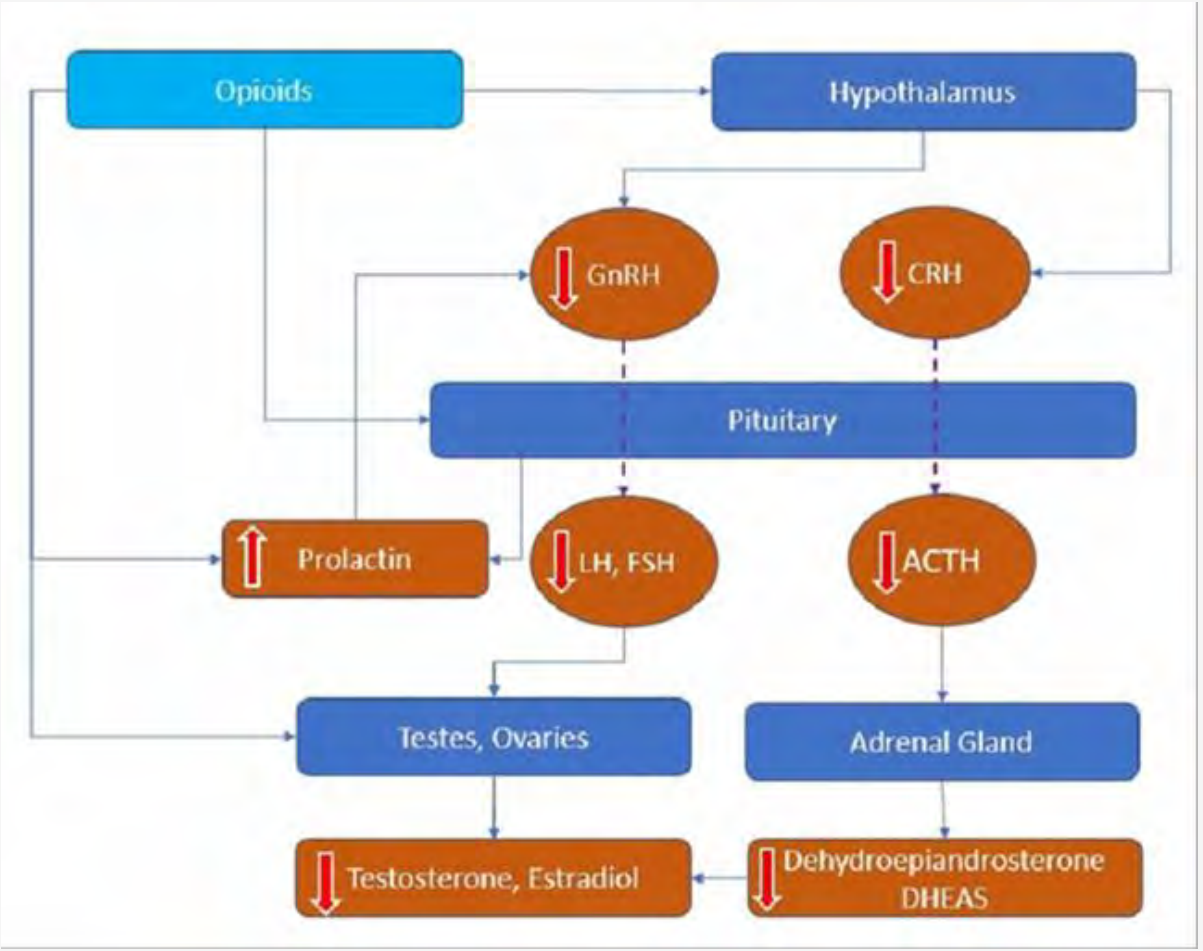
....do you talk about all of these every time?

Probability of continued use by days' supply of first Rx

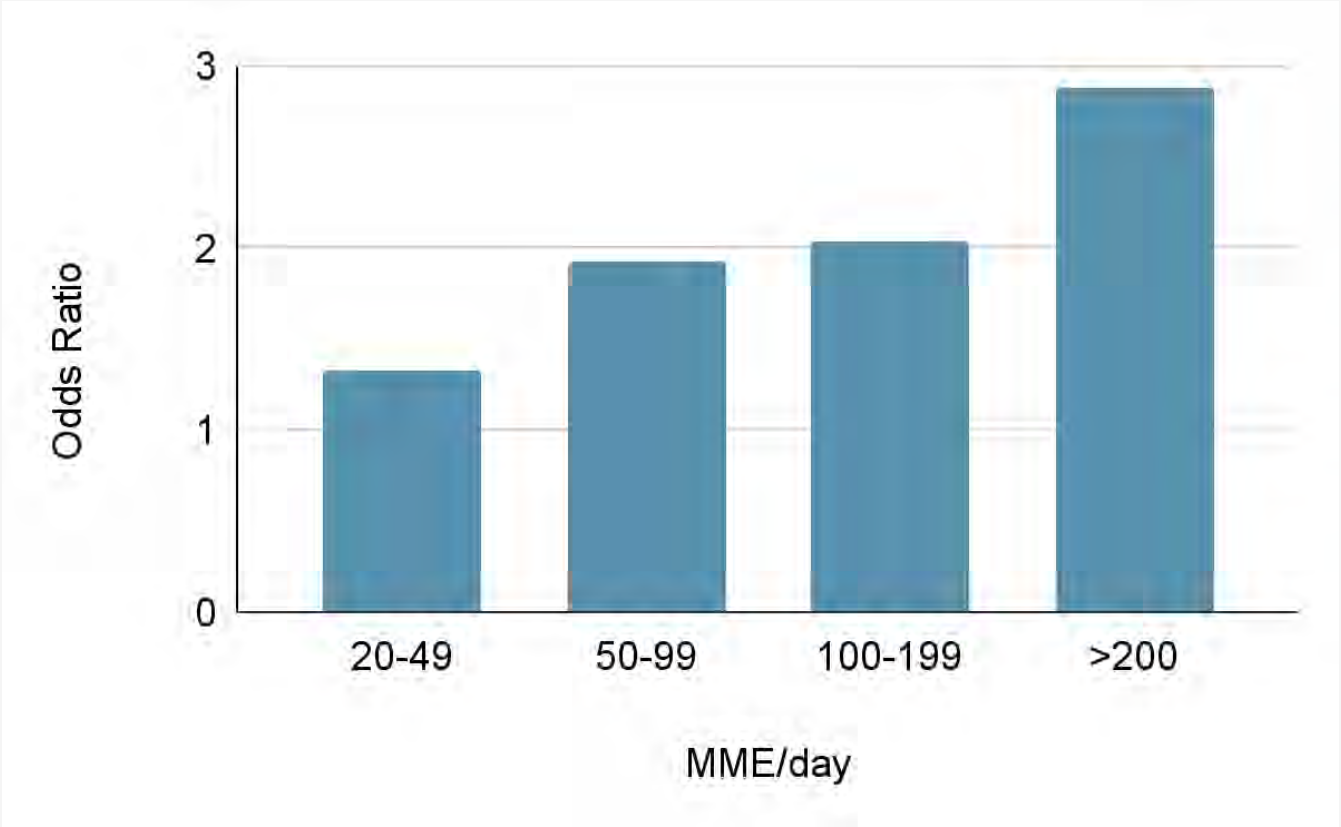


Opioids can cause central and peripheral hypogonadism

This can lower females' FSH and LH levels as well



For patients with chronic pain, compared with no opioid use, opioid use was associated with increased risk for opioid overdose death.



Substance Use Disorders in Primary Care Sample Receiving Daily Opioid Therapy

The Journal of Pain, July 2007 by Fleming et al
801 patients receiving opioids for chronic pain in primary care offices

Prevalence of substance abuse/dependence 9.7%
Prevalence of OUD was 3.8% (prevalence in general population was 0.9%)

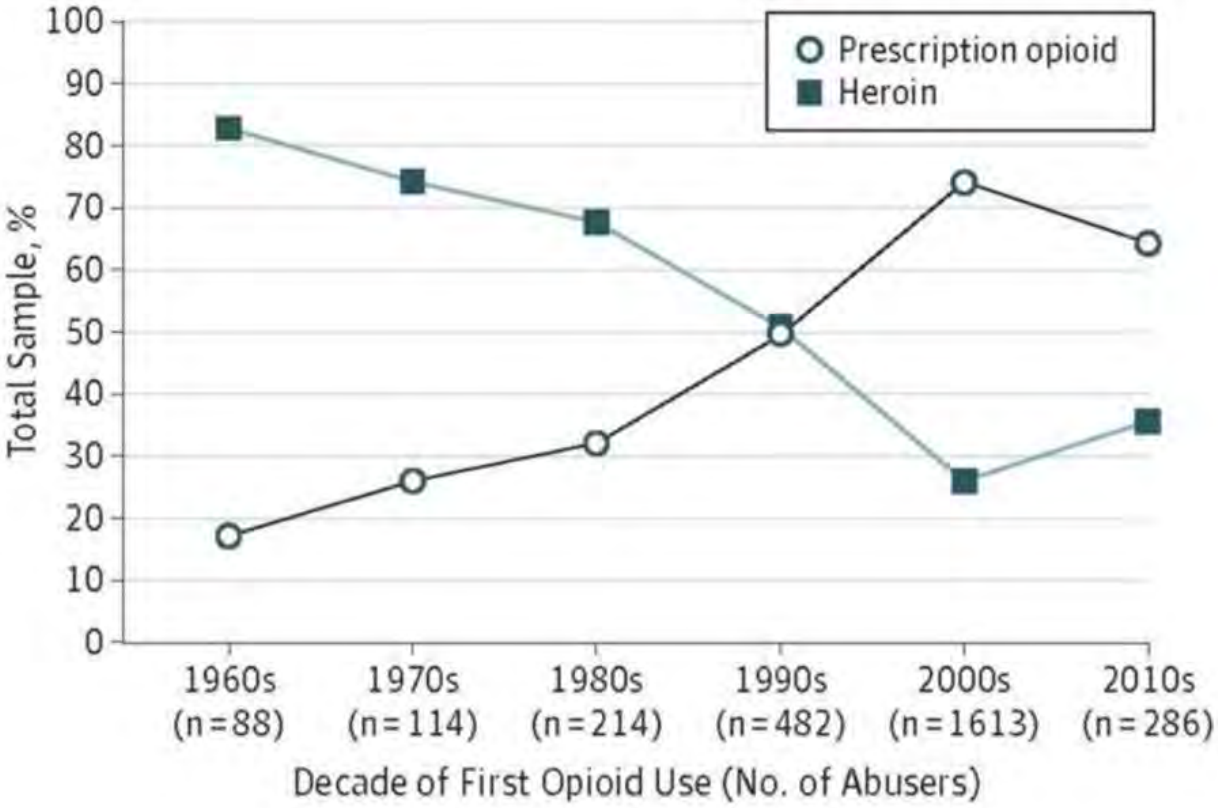
Current OUD was only associated with aberrant drug behaviors

- Purposefully over sedating oneself
- Using opioids for non pain reasons
- Increase opioid dose without authorization
- Felt intoxicated by dose

Quick Reminder

Opioid Use Disorder = loss of control + compulsive use despite negative consequences

Tolerance and withdrawal DOES NOT equal OUD



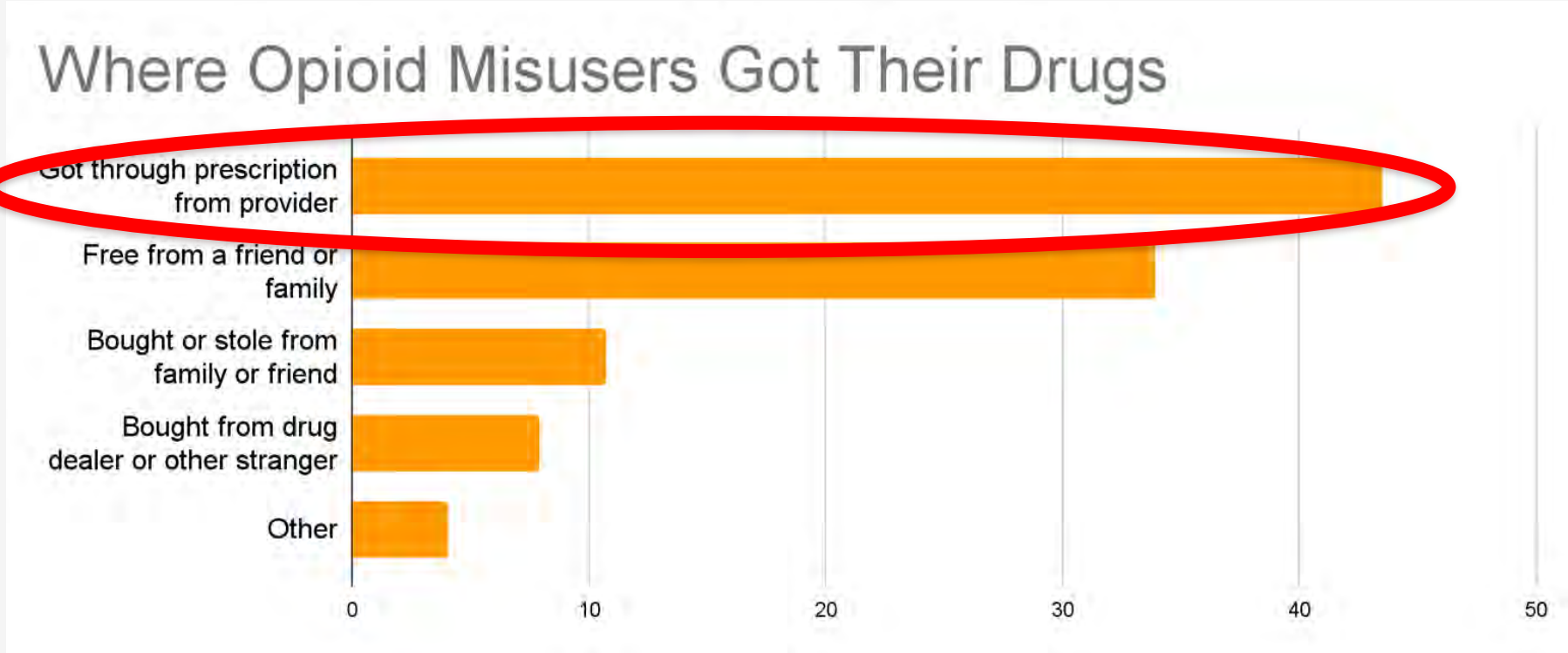
Source: Cicero et al., 2014

Percentage of the total heroin-dependent sample that used heroin or a prescription opioid as their first opioid of abuse. Data are plotted as a function of the decade in which respondents initiated their opioid abuse.

Figure 16. Past Year Prescription Pain Reliever Misuse: Among People Aged 12 or Older; 2015-2020

Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

Why I can’t stop talking about this:



Adverse Selection

Phenomenon well described in the literature where those most at risk for adverse effects are prescribed the highest doses

- Specifically in the TROUP and CONSORT studies
- Depression = 3x as likely
- Alcohol or non-opioid SUD = 4-5x as likely
- Hx of opioid abuse or dependence = 10x as likely

Practice Recommendation # 4

If considering opioids as a treatment option, complete an opioid risk assessment on your patient.

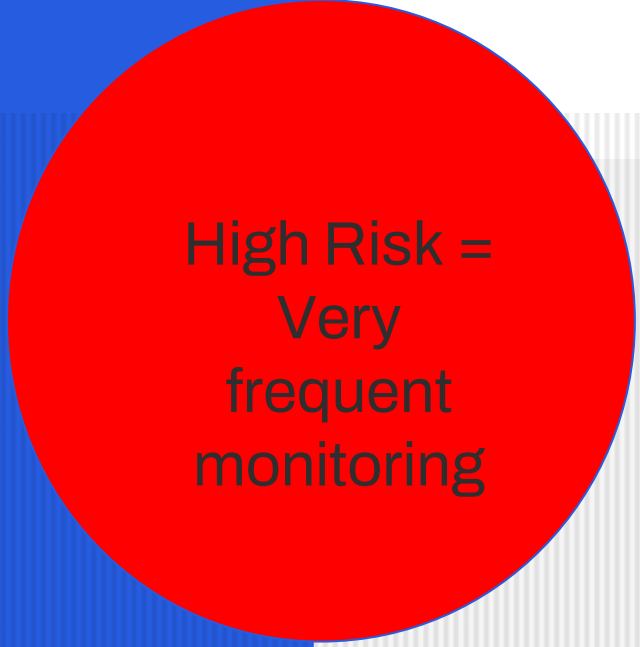
Assessment Tools

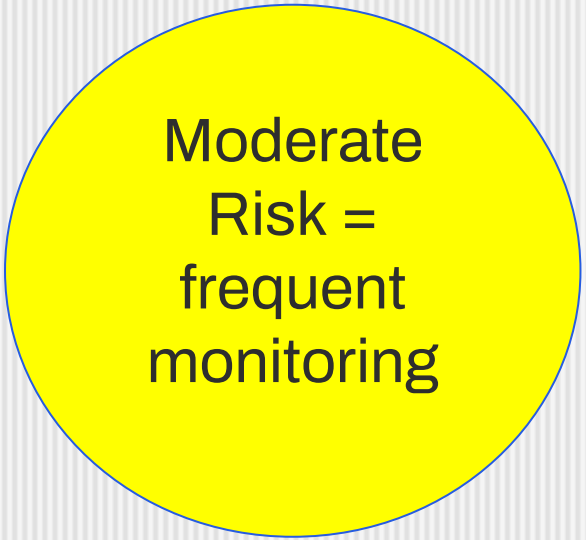
3 or less = LOW risk
4-7 = moderate risk
8 or greater = HIGH risk

Sensitivity/specificity
Around 82-85%

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		

We are judging the opioid treatment, not the patient!


High Risk =
Very
frequent
monitoring


Moderate
Risk =
frequent
monitoring


Low Risk =
less
frequent
monitoring

Our patient

ORT Score was 5 = MODERATE risk

How often do you want to see him?

What risk mitigation strategy do you take?

Risk Mitigation = Standard Work

Patient Provider Agreement

- Informed consent
- Plan of care → gives you an out

Urine Drug Screen

PDMP Query

Regular face to face visits - minimum q3 months

Pill counts

Informed Consent

Discuss risks

Lay out plan of care

- Requirements of other modalities (PT, non-opioids)
- Opioids as a “TEST” → set a SMART goal

Proper use, no sharing/diversion

Safe storage

Narcan

UDS

Frequency of Assessments

	Low Risk	Moderate Risk	High Risk
Patient Provider Agreement	Once every other year	Once every other year	Every year
Pain Assessment Visit	Every 3 months	Every 2-3 months	Every 14-28 days
Random UDS	Every 6-12 months	Every 6 months	Every few weeks to months
Pill Count	Once a year	Every 6 months	Every few weeks to months
Prescription Duration	30 days	30 days	14-28 days

Response to Therapy

Analgesia → how are you using during a typical day?
Activities → are you able to do what you need/want?
Adverse effects → any side effects?
Aberrant behaviors → have you used extra?
Adherence → are you following the plan? Is the plan working?
Affect → how is your mood?

Revise treatment plan if not working!

Urine Drug Screens

Patient’s self report of inappropriate use is unreliable

May improve adherence

Standard of care

- We monitor drug levels for other meds all the time
- Do it with all your patients consistently!

Another word on UDS

REMEMBER - all UDS are NOT created equal:

- Fentanyl is usually a separate test
- Opiate = morphine/codeine
- Oxycodone requires separate test
- Benzos are frequently false negative

If unsure, send for GC/MS!

PDMP

Do it, every time, every patient.

Easy to do in Epic - just add the tab to the top bar

Do not use the Risk Score

Look at actual fills

If any question, call the pharmacist!

Opioid Tapering

If the trial fails, **it is time to taper**

If risk > benefits, **it is time to taper**

Convert to Morphine → Multiply

Convert from Morphine → Divide

Calculating Morphine Milligram Equivalents (MME)*			
Opioid	**Conversion Factor** (convert to MMEs)	**Duration (hours)**	**Dose Equivalent Morphine Sulfate (30mg)**
Codeine	0.15	4-6	200 mg
Fentanyl (MCG/hr)	2.4		12.5 mcg/hr**
Hydrocodone	1	3-6	30 mg
Hydromorphone	4	4-5	7.5 mg
Morphine	1	3-6	30 mg
Oxycodone	1.5	4-6	20 mg
Oxymorphone	3	3-6	10 mg
Methadone†			
1-20 mg/d	4		7.5 mg
21-40 mg/d	8		3.75 mg
41-60 mg/d	10		3 mg
≥61 mg/d	12		2.5 mg

Our patient

MS Contin 30mg BID and oxycodone 10 q6hr prn.

MS Contin = 60 MME per day
Oxycodone 40mg/day x 1.5 = 60 MME

Total = 120 MME per day

Taper is for the long haul

Taper 10% per month until at 30% of original dose

- Then 10% per week until done
- If withdrawal → slow or stop taper
- If rebound → add on non-opioids

Decreasing the dose is a success!

Our patient

Currently on 120 MME per day

- We need to drop 12-15 MME per month

Month 1: 30mg MS Contin BID + take oxy down to TID

Month 2: 30mg MS Contin BID + oxy BID

Month 3: 30mg MS Contin qday, 15mg MS Contin qhs, + oxy BID

Month 4: 15mg MS Contin BID + oxy BID

Month 5: 15mg MS Contin BID + oxy qday prn

Month 6: switch to all oxycodone = oxy 10mg TID

Month 7: now qweekly taper!

03

Buprenorphine for Chronic Pain

Buprenorphine for Chronic Pain

Buprenorphine tabs or films = NOT FDA approved for chronic pain
Only FDA approved for OUD
Buprenorphine patch has been used for years for chronic pain

Literature is appearing in support of use tabs a/o films for chronic pain
OFF LABEL

FACTSHEET

THE PRESCRIPTION OPIOID ADDICTION TREATMENT STUDY (POATS): TREATMENT STRATEGIES FOR PRESCRIPTION OPIOID DEPENDENCE

blending initiative
NIDA•SAMHSA

Your Challenge: Improving outcomes among adult patients treated for prescription opioid dependence.

An Evidence-Based Approach: A buprenorphine taper intervention that includes an extended stabilization period prior to taper.

Where to Start: The NIDA/SAMHSA Blending Initiative offers a suite of tools and training materials that address opioid addiction, including the one described below.

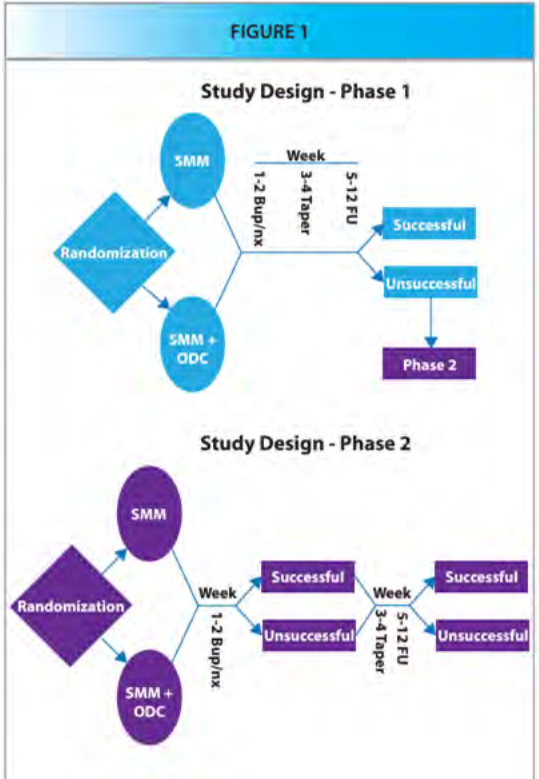
POATS: Treatment Strategies for Prescription Opioid Dependence is a package of tools and training resources for substance abuse treatment providers. The package describes how buprenorphine works and presents the results of a National Drug Abuse Clinical Trials Network (CTN) study that compared brief and extended buprenorphine treatments. The results of the study have implications for the treatment of adults dependent on prescription opioids. The POATS package is designed to help treatment providers incorporate study findings and recommendations into their practice.

This package is the latest addition to a suite of the Blending Initiative awareness and training products that address the effective use of buprenorphine to treat opioid dependence.

Why Buprenorphine for Prescription Opioid Dependence?

Opioids have been used for decades to treat chronic pain. However, concerns about prescription opioid abuse have increased in recent years. Several studies have examined treatment strategies for addressing this growing problem, but those studies have focused exclusively or predominantly on heroin users rather than prescription drug users. Recent research

FIGURE 1



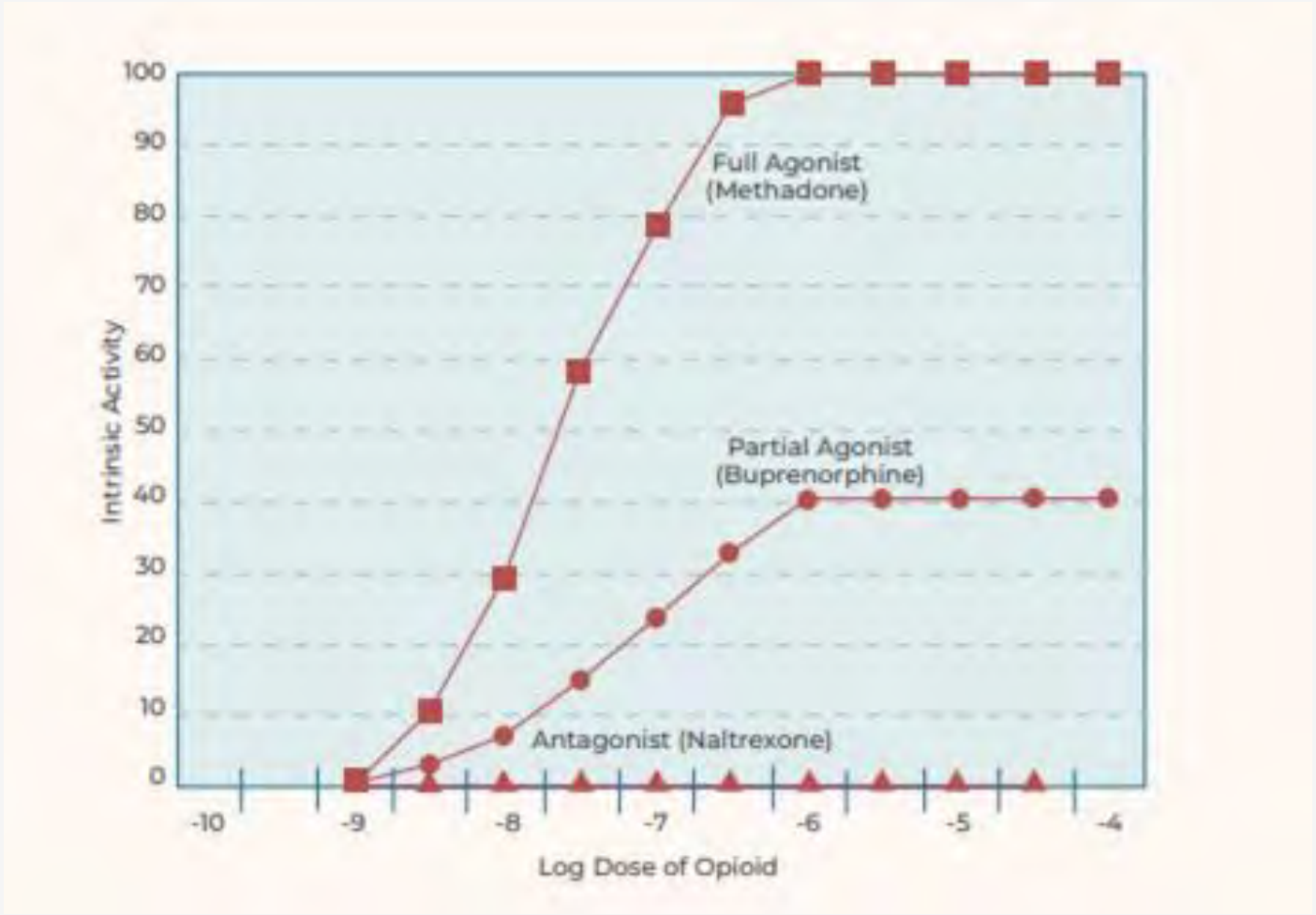
Practice Recommendation #5

Buprenorphine can be considered for treatment of chronic pain in select patients.

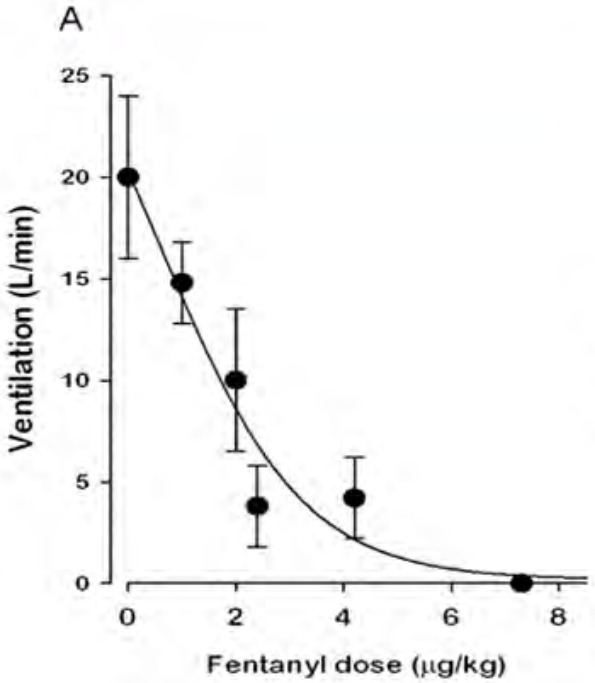
Louder for those in the back!

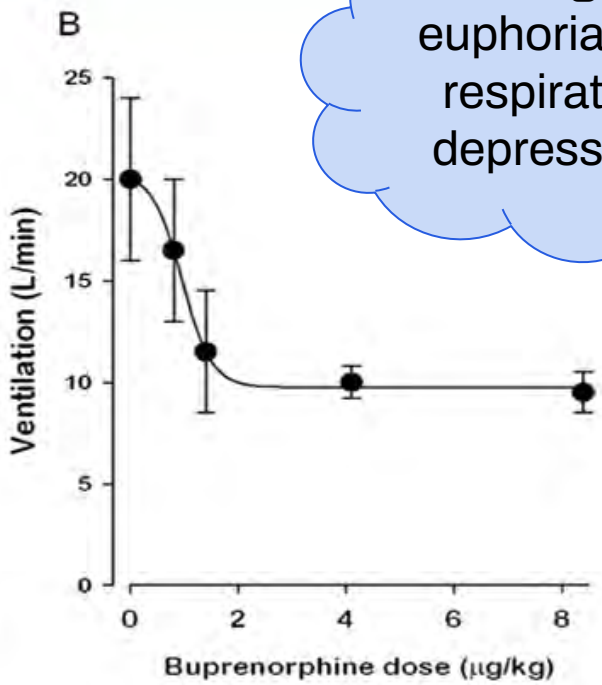
Opioid Use Disorder = loss of control + compulsive use despite negative consequences

Tolerance and withdrawal DOES NOT equal OUD


100
90
80
70
60
50
40
30
20
10
0
Intrinsic Activity
Full Agonist
(Methadone)
Partial Agonist
(Buprenorphine)
Antagonist (Naltrexone)
-10
-9
-8
-7
-6
-5
-4
Log Dose of Opioid

Dose-response Relationship for Respiratory Depression



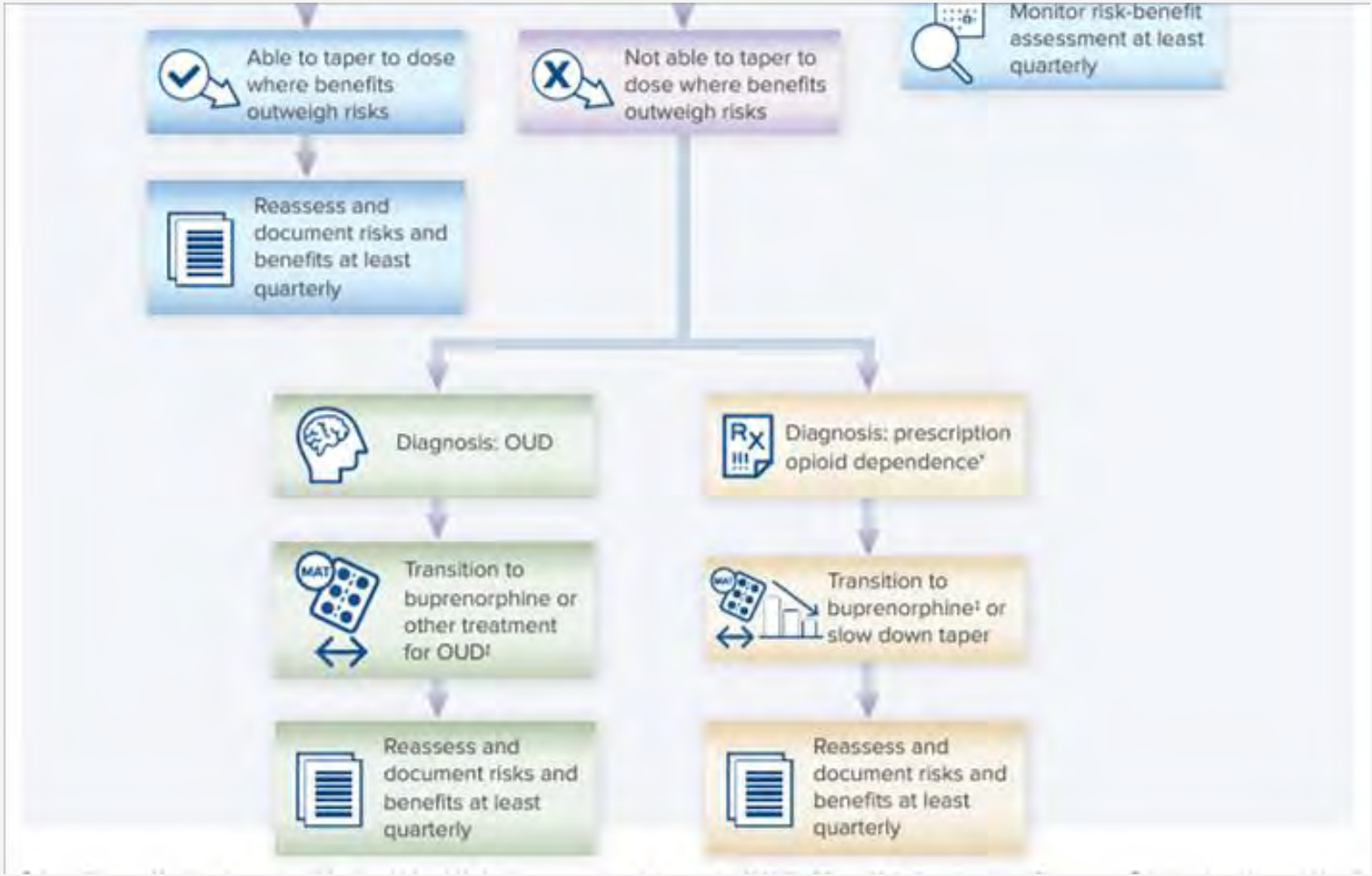


Ceiling for euphoria and respiratory depression!

When to consider the switch

Patient no longer benefiting from opioids
Patient experiencing harms from long-term opioids
Opioid naive who are high risk for OUD


Systematic assessment of risks and benefits of continuing opioid use at current dose
Risks outweigh benefits
Benefits outweigh risks
Discuss, suggest, explain. Initiate slow taper when ready*
Document risk-benefit assessment
Monitor risk-benefit assessment at least quarterly
Able to taper to dose where benefits outweigh risks
Not able to taper to dose where benefits outweigh risks
Reassess and document risks and benefits at least quarterly
Diagnosis: OUD
Diagnosis: prescription opioid dependence†
Transition to buprenorphine or other treatment for OUD‡
Transition to buprenorphine‡ or slow down taper
Reassess and document risks and benefits at least quarterly
Reassess and document risks and benefits at least quarterly


Able to taper to dose where benefits outweigh risks
Not able to taper to dose where benefits outweigh risks
Monitor risk-benefit assessment at least quarterly
Reassess and document risks and benefits at least quarterly
Diagnosis: OUD
Diagnosis: prescription opioid dependence*
MAT
Transition to buprenorphine or other treatment for OUD‡
Transition to buprenorphine‡ or slow down taper
Reassess and document risks and benefits at least quarterly
Reassess and document risks and benefits at least quarterly

Making the switch

Two ways:

1. Stop full agonist and wait for withdrawal then start
2. Overlap method

- Start low dose buprenorphine and continue full agonist
- Taper full agonist and increase buprenorphine

Our patient

Option 1:
Stop full agonist and prn oxy
Wait for withdrawal (approx 12-24hrs)
Start buprenorphine 2mg BID

Option 2:
Day 1: 0.5mg bup once
Day 2: 0.5mg bup BID
Day 3: 1mg bup BID
Day 4: 2mg bup BID
Day 5: 4mg bup BID and STOP full agonists

Can consider tapering full agonists starting on Day 4

Practice Recommendations

1. Do a comprehensive pain assessment
2. Multimodal and multidisciplinary is best
3. Match your treatment to type of pain
4. If using opioids, do an opioid risk assessment
5. Buprenorphine is a safer option for chronic pain in select patients

Questions?