Clinical Decision Making at the Crossroads of Pain and Addiction

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Financial Relationship Disclosures for

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No relevant financial disclosures

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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?

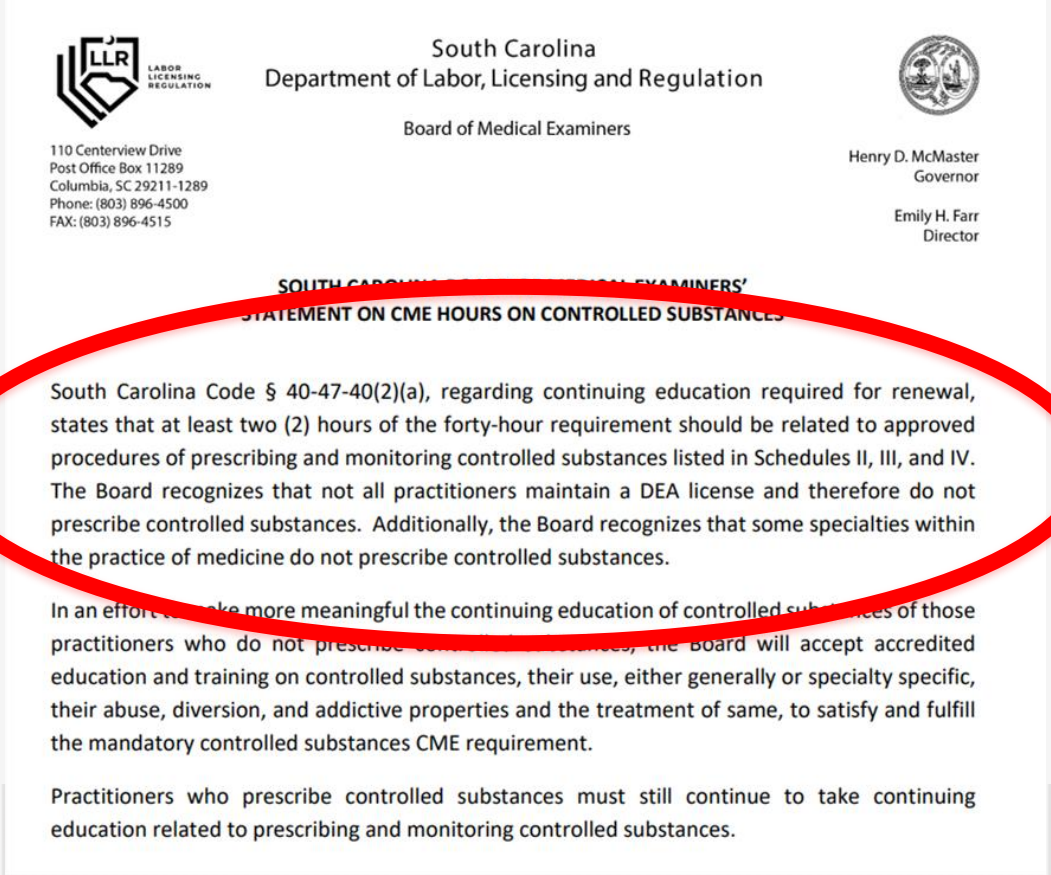
- All DEA-registered practitioners, with the exception of practitioners that are solely veterinarians.

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



South Carolina
Department of Labor, Licensing and Regulation

Board of Medical Examiners

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Henry D. McMaster
Governor

Emily H. Farr
Director

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?

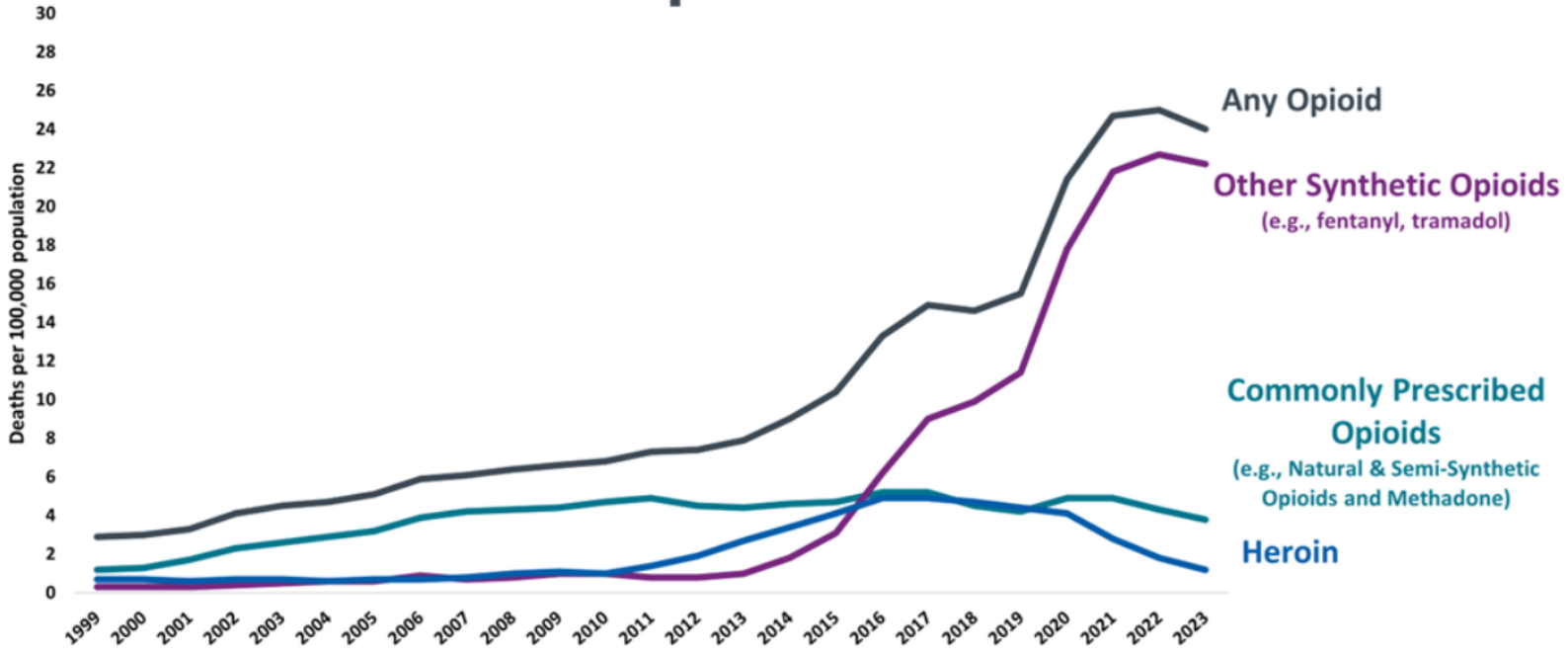
Goals and Objectives

01 Describe neurobiological and clinical overlap between pain and addiction

02 Apply evidence based guidelines to assess risk and determine when opioid therapy may be appropriate

03 Develop patient centered treatment plans that balance pain management with mitigation of misuse

Three Waves of Opioid Overdose Deaths



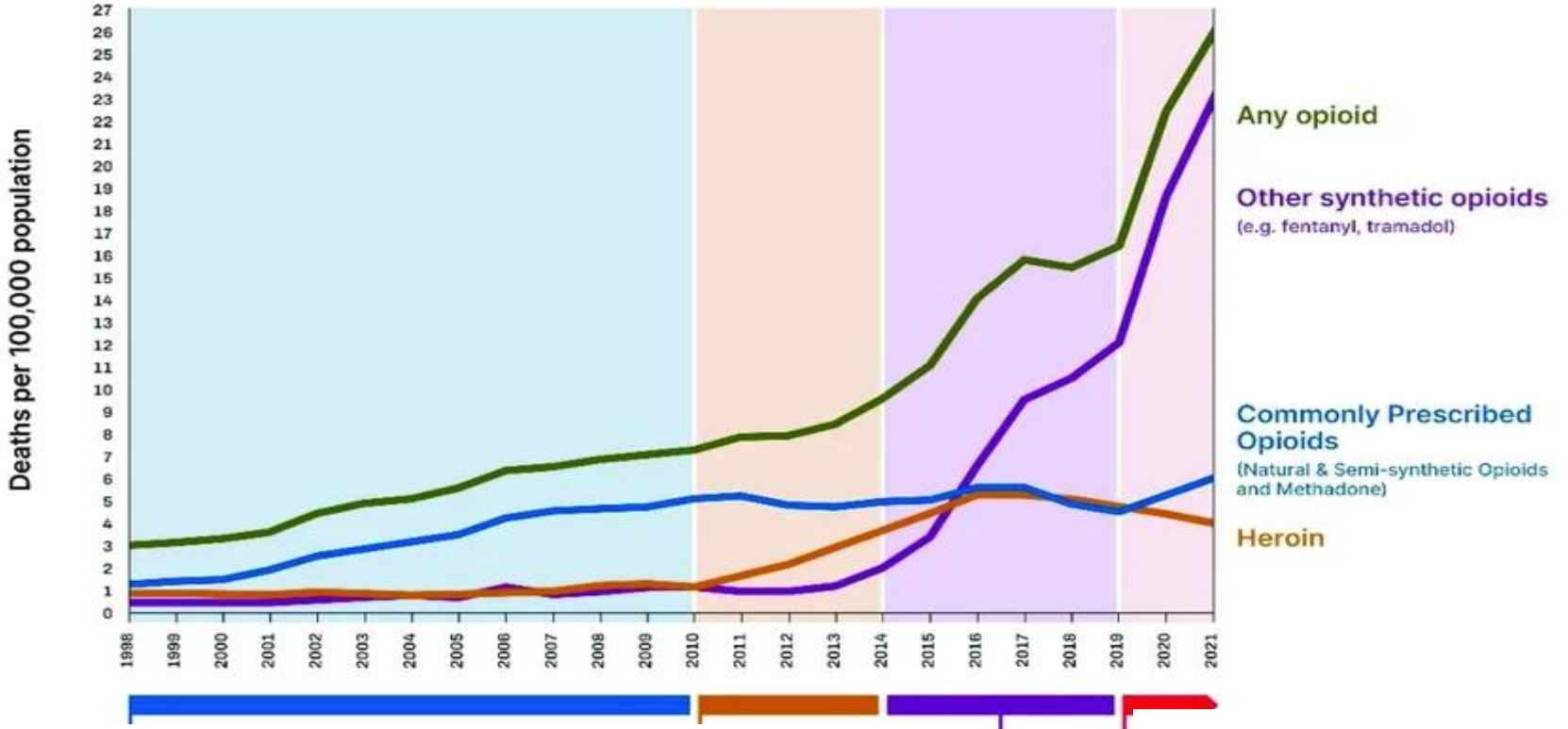
Wave 1: Rise in Prescription Opioid Overdose Deaths Started in the 1990s

Wave 2: Rise in Heroin Overdose Deaths Started in 2010

Wave 3: Rise in Synthetic Opioid Overdose Deaths Started in 2013

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2024. https://wonder.cdc.gov/.

CDC



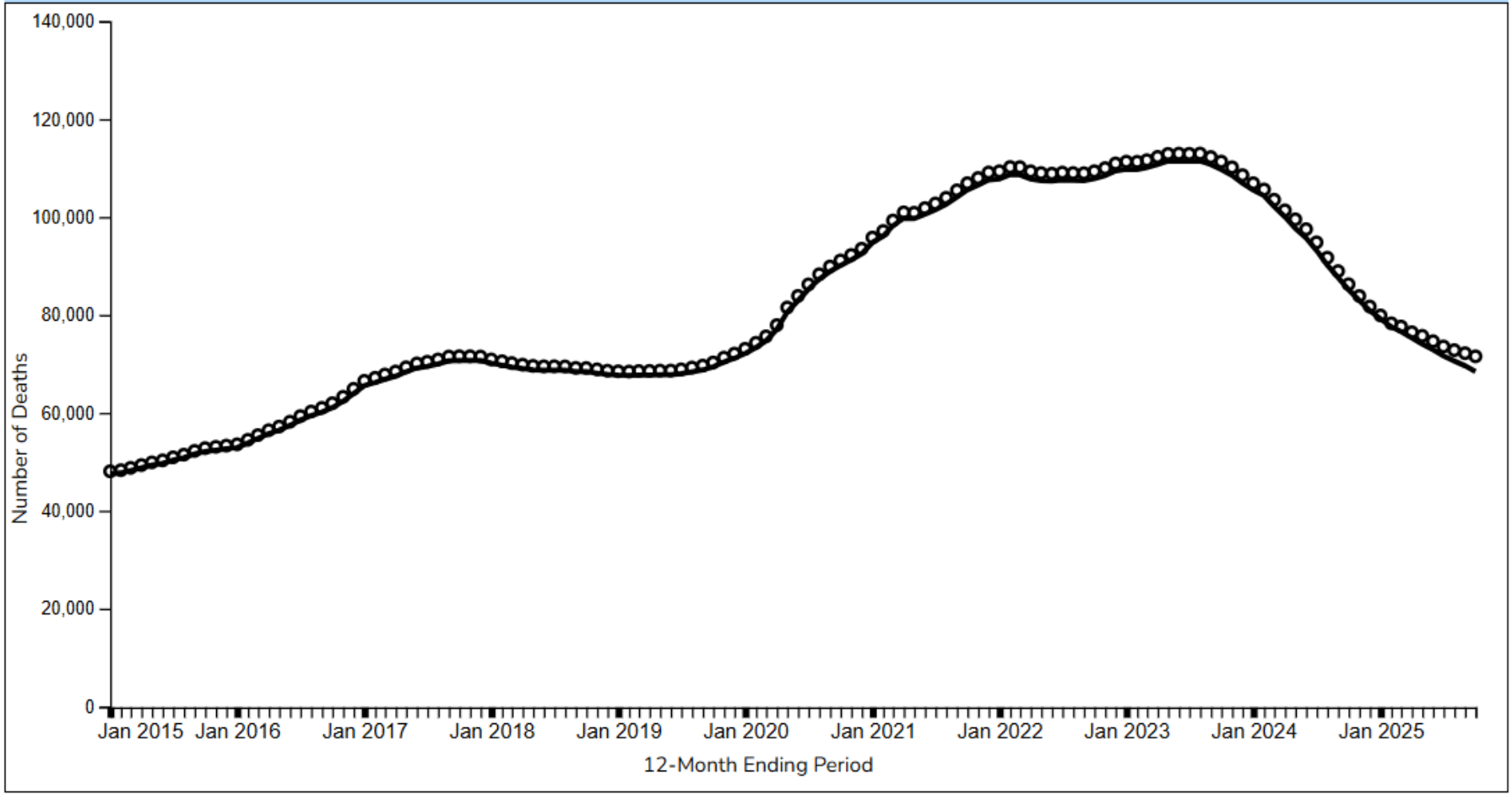
First Wave ‘98-’10
Rx opioid OD

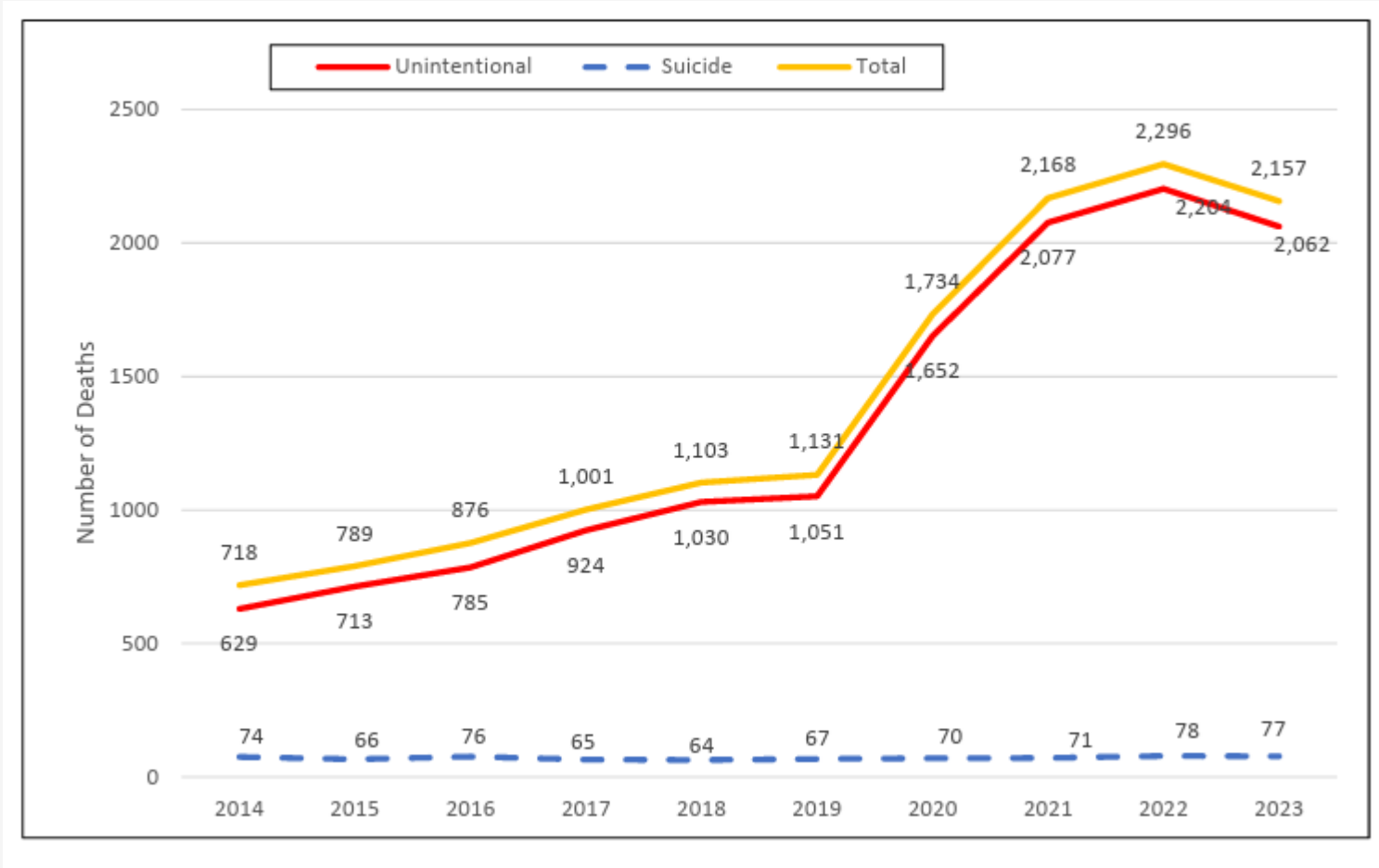
2nd Wave ‘10-’14
Heroin OD

3rd Wave ‘14-’19
Fentanyl OD

4th Wave ‘19-Now
Opioid + Stimulant

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States




Unintentional
Suicide
Total
Number of Deaths
2500
2000
1500
1000
500
0
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
629
713
785
924
1,030
1,051
1,652
2,077
2,204
2,062
718
789
876
1,001
1,103
1,131
1,734
2,168
2,296
2,157
74
66
76
65
64
67
70
71
78
77

Number of Drug Overdose Deaths by Drug Category
South Carolina, 2019-2023
Occurrence Data

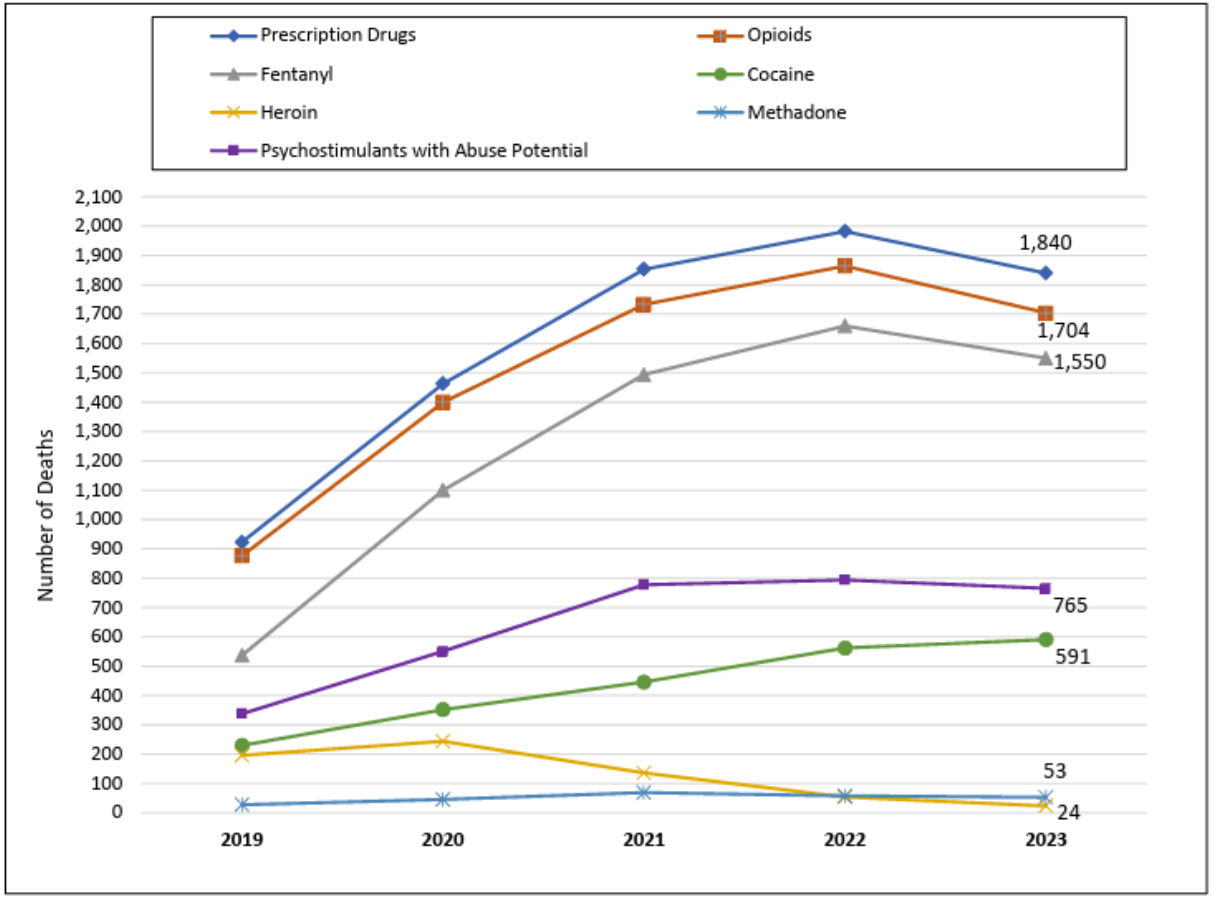
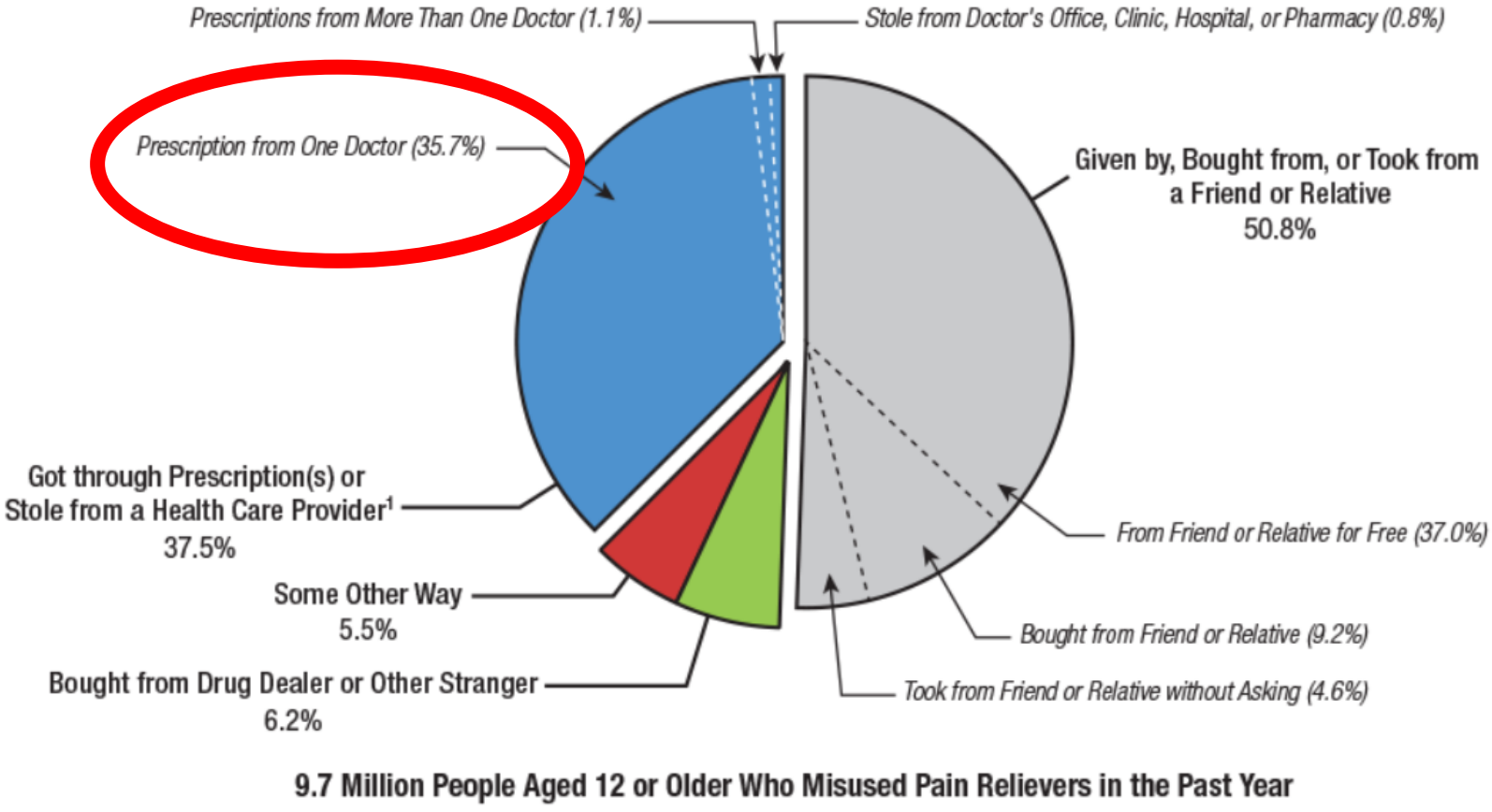


Figure 23. Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Pain Relievers in the Past Year: 2019



01 Pain and Addiction

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

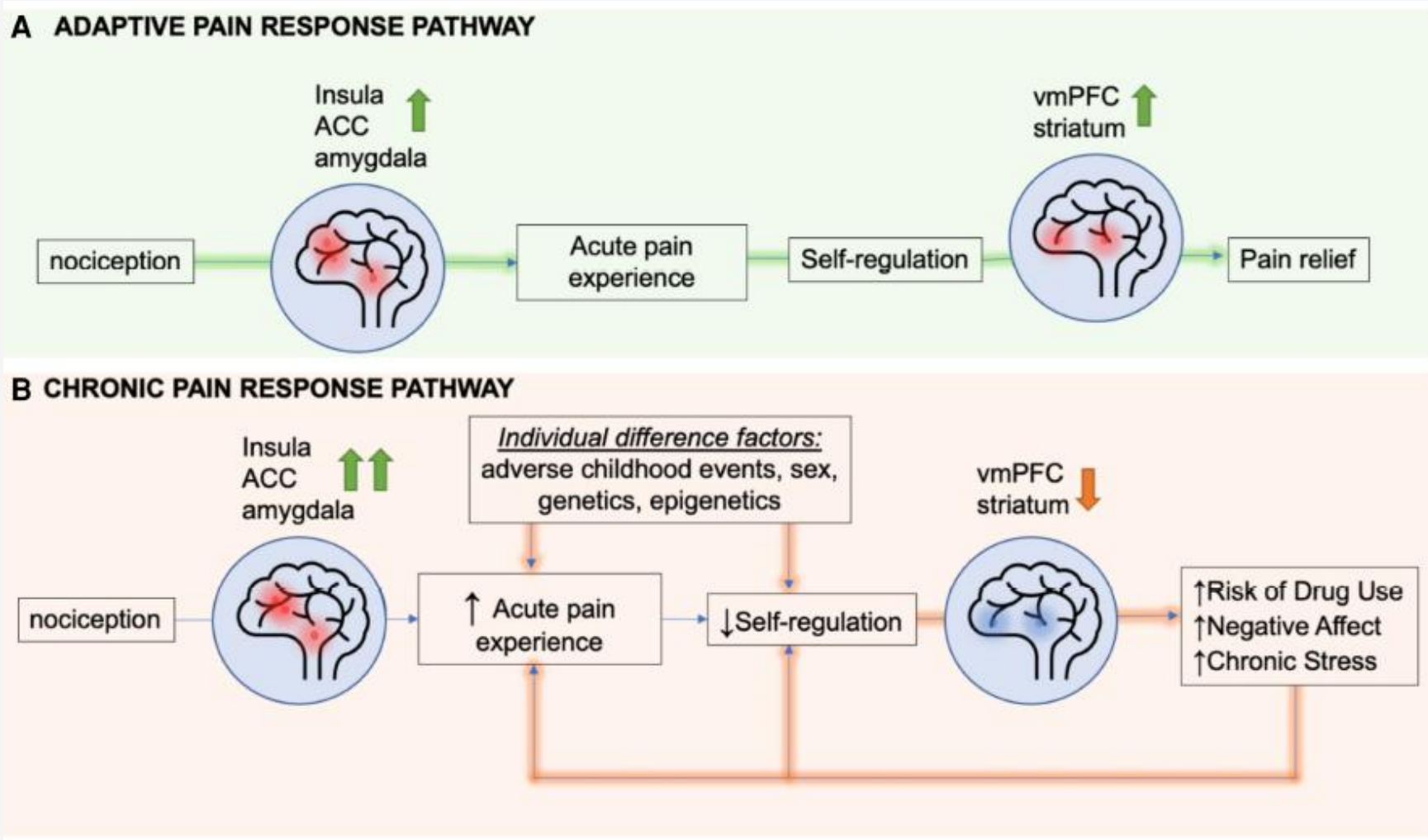
Chronic Pain

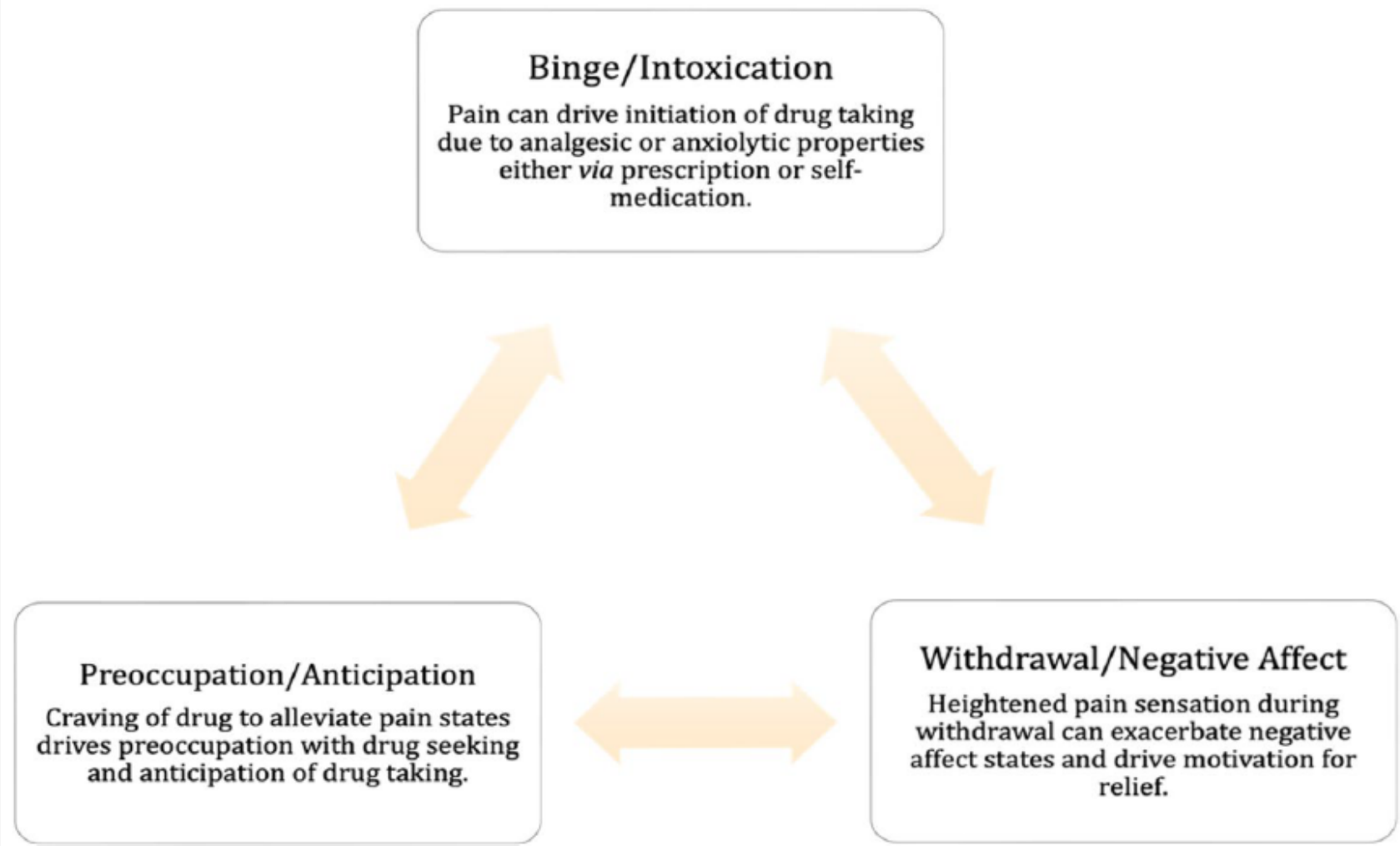
Estimated that up to 20% of the population suffers with chronic pain

Patients with chronic pain are twice as likely to die by suicide

87% of patients with illicit substance use history had chronic pain

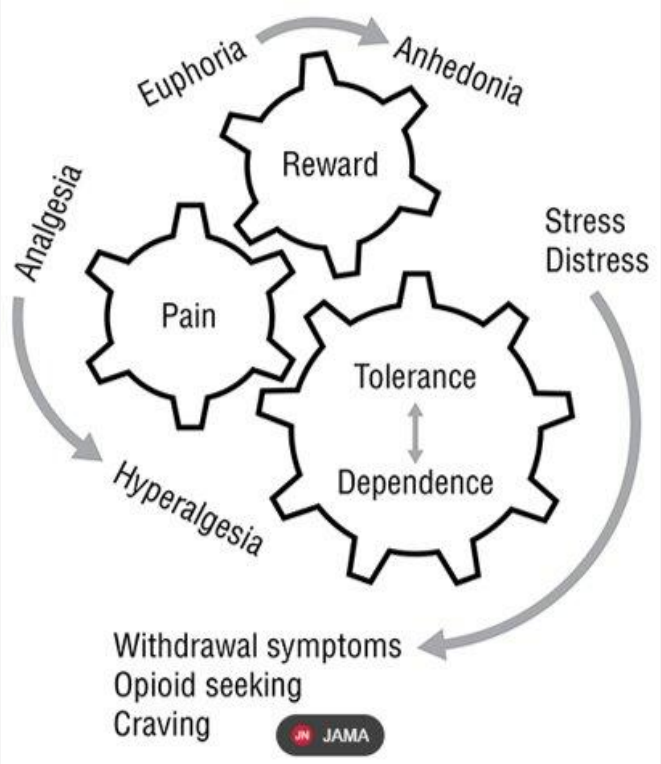
Up to 50% of patients on MOUD have chronic pain


A ADAPTIVE PAIN RESPONSE PATHWAY
Insula
ACC
amygdala
vmPFC
striatum
nociception
Acute pain
experience
Self-regulation
Pain relief
B CHRONIC PAIN RESPONSE PATHWAY
Insula
ACC
amygdala
Individual difference factors:
adverse childhood events, sex,
genetics, epigenetics
vmPFC
striatum
nociception
↑ Acute pain
experience
↓Self-regulation
↑Risk of Drug Use
↑Negative Affect
↑Chronic Stress

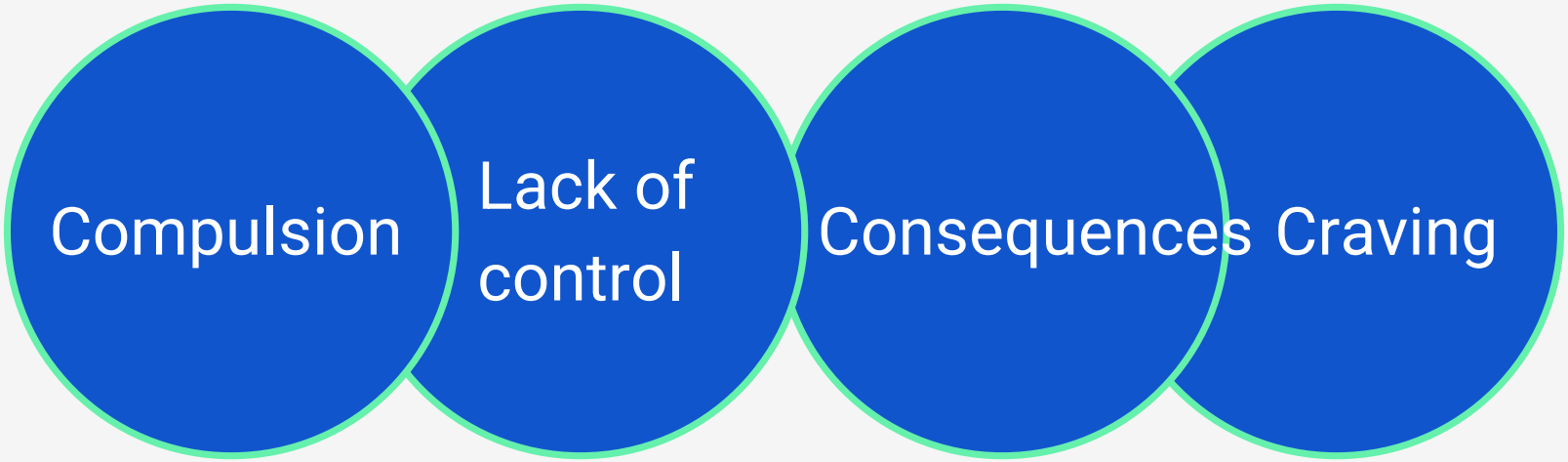

Binge/Intoxication
Pain can drive initiation of drug taking due to analgesic or anxiolytic properties either *via* prescription or self-medication.
Withdrawal/Negative Affect
Heightened pain sensation during withdrawal can exacerbate negative affect states and drive motivation for relief.
Preoccupation/Anticipation
Craving of drug to alleviate pain states drives preoccupation with drug seeking and anticipation of drug taking.

Pain and Opioids

Dependence: relying of medication to live normally
Tolerance: requiring more drug to have to same response
Withdrawal: physical symptoms when drug is stopped



Addiction



Tolerance + withdrawal does not equal addiction!

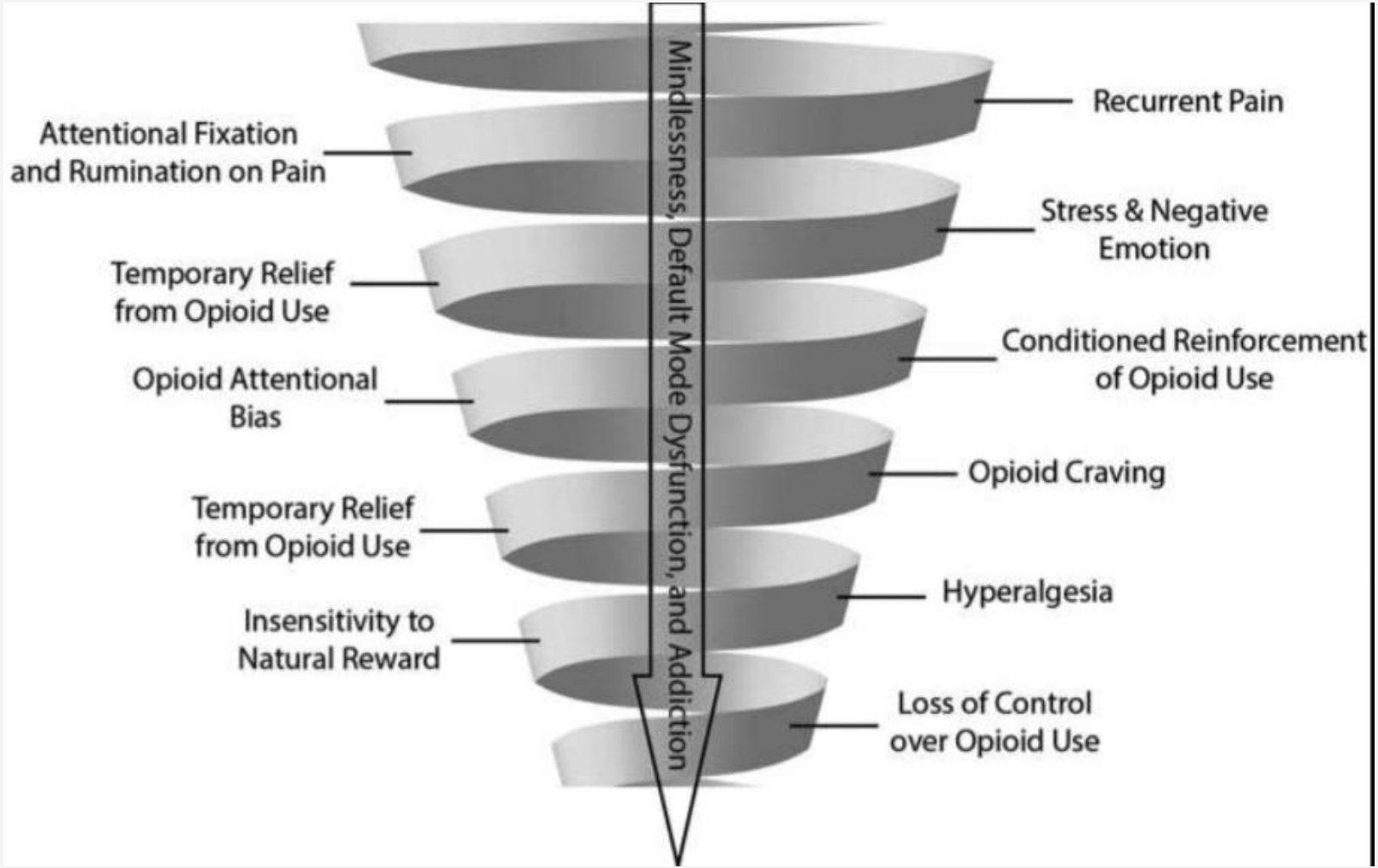
Chronic Pain and Addiction

Reward Deficiency

Impaired inhibitory control

Catastrophizing

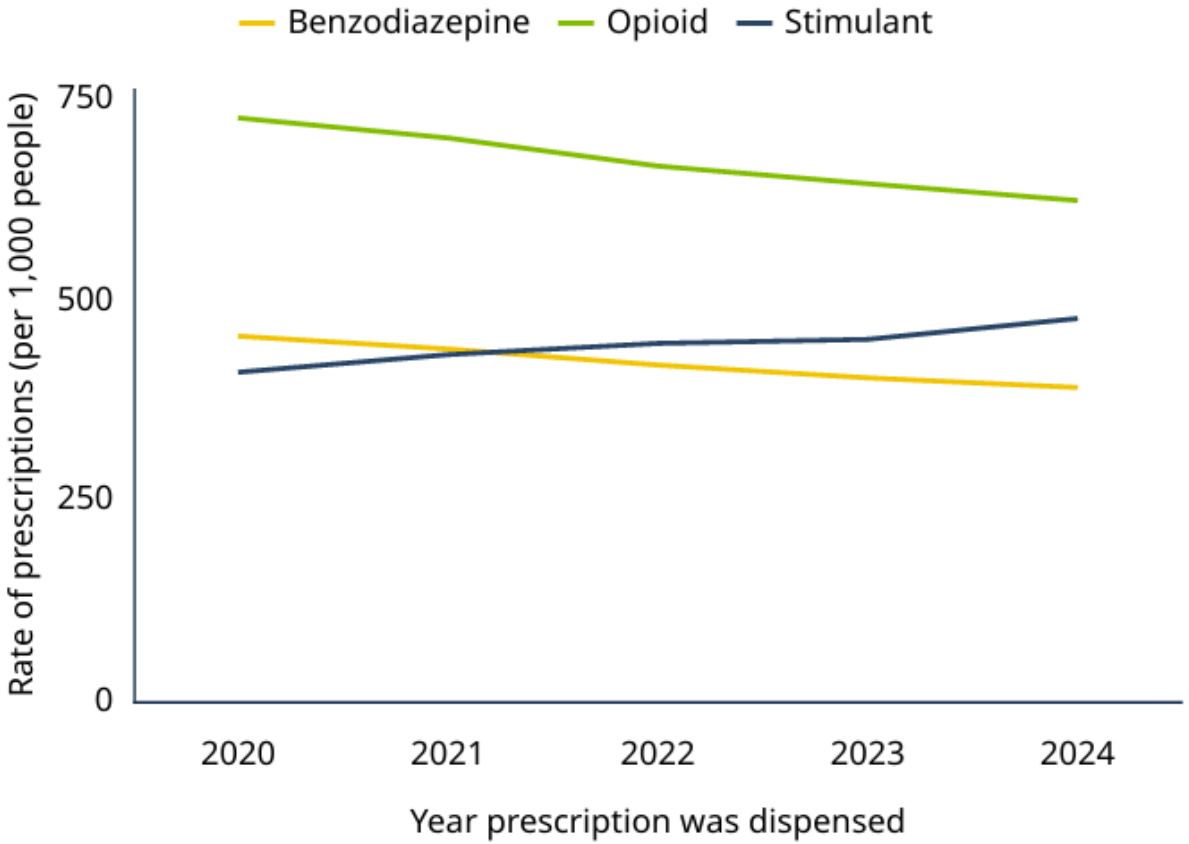
Opioid induced hyperalgesia


Mindlessness, Default Mode Dysfunction, and Addiction
Recurrent Pain
Attentional Fixation and Rumination on Pain
Stress & Negative Emotion
Temporary Relief from Opioid Use
Conditioned Reinforcement of Opioid Use
Opioid Attentional Bias
Opioid Craving
Temporary Relief from Opioid Use
Hyperalgesia
Insensitivity to Natural Reward
Loss of Control over Opioid Use

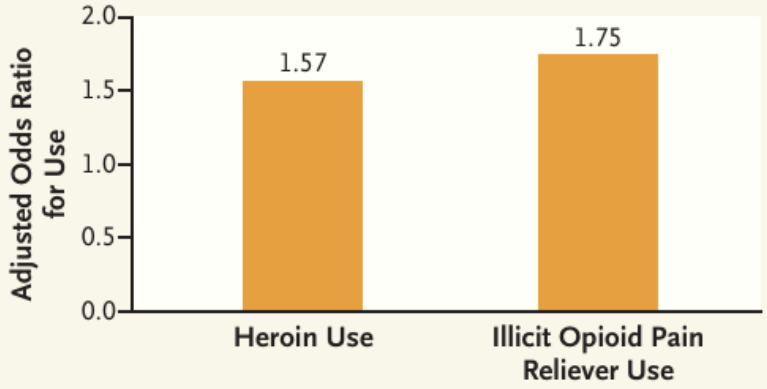
Family Physician’s Role in Chronic Pain

Witness
Prescriber
Stewardship
Education
Expectation Setting

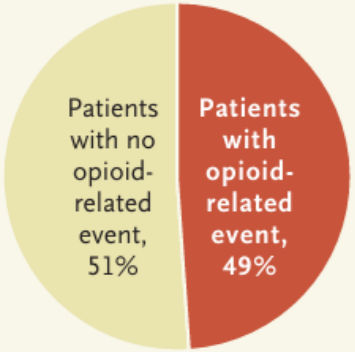
Figure 2. Rate of controlled substances dispensed by drug class, 2020 - 2024



A Illicit Opioid Use after Taper or Discontinuation of Long-Term Opioid Therapy

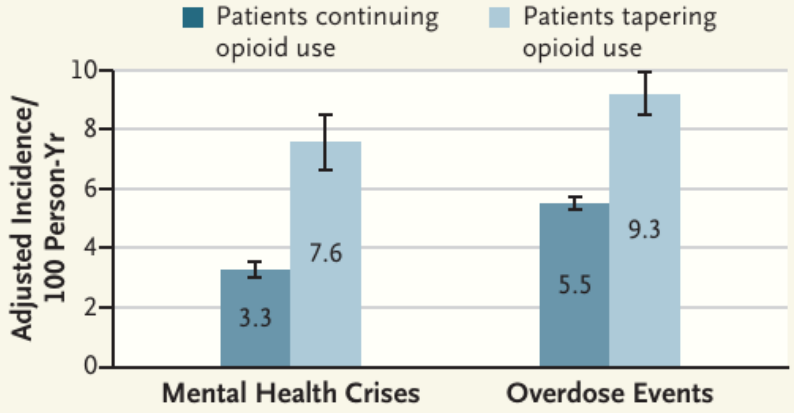


B Emergency Department Visits and Opioid-Related Hospitalizations after Taper or Discontinuation of Long-Term Opioid Therapy

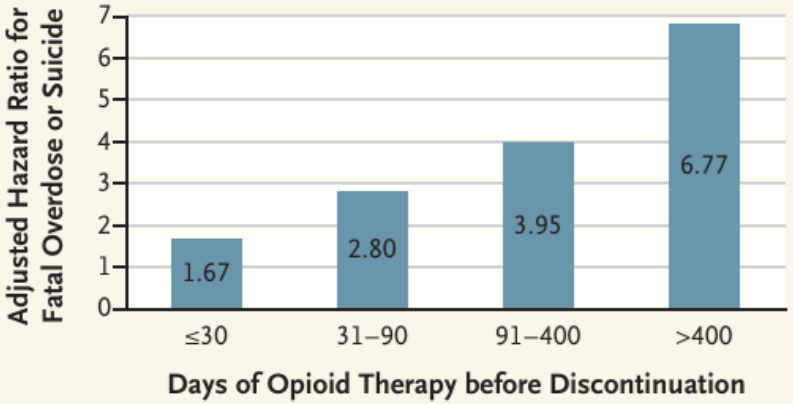


Each additional day of taper was associated with a 1% lower likelihood of an opioid-related event.

C Mental Health Crises and Overdose Events among Patients Continuing or Tapering Long-Term Opioid Therapy



D Death from Suicide or Overdose after Taper or Discontinuation of Long-Term Opioid Therapy



02

Risk Assessment and Opioid Prescribing

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

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

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

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?

Practice Recommendation #2

Multimodal and multidisciplinary care for chronic pain is preferred.

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

Opioids

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

Opioids have serious side effects including:

- Dependence
- Overdose/death
- Constipation
- Hyperalgesia

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.

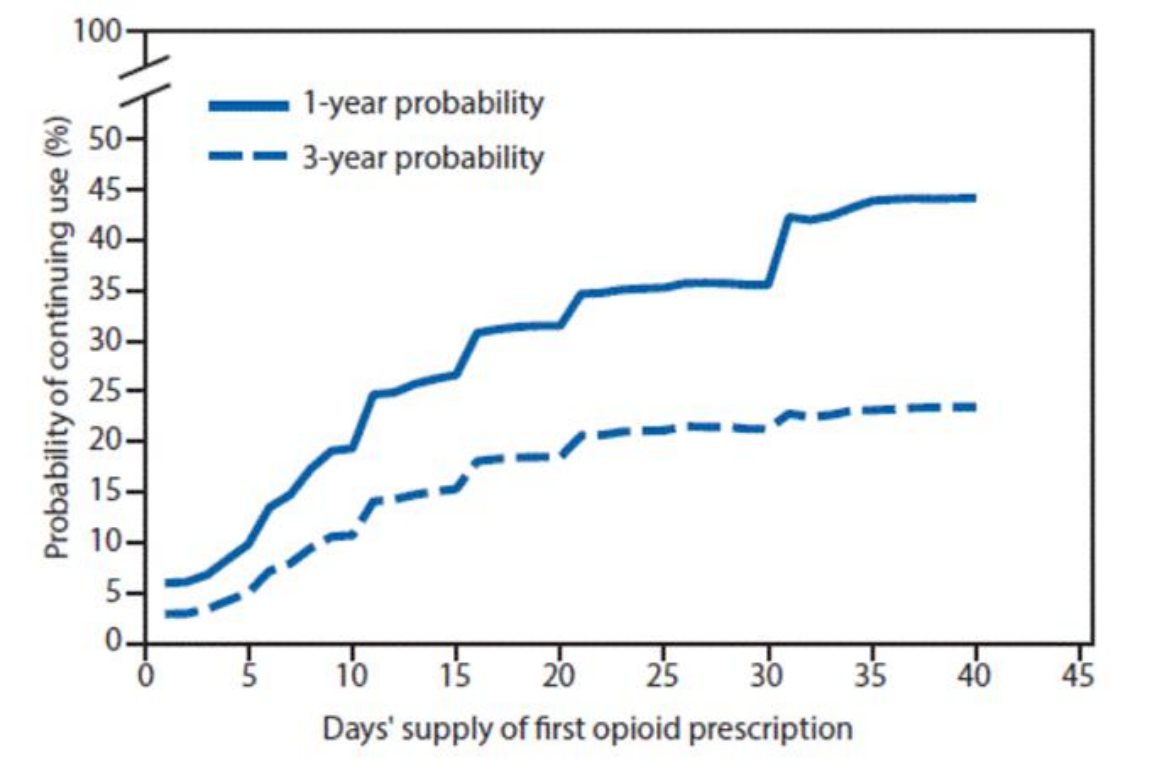
It is reasonable, however it is NOT best practice.

What are the risks of opioids?

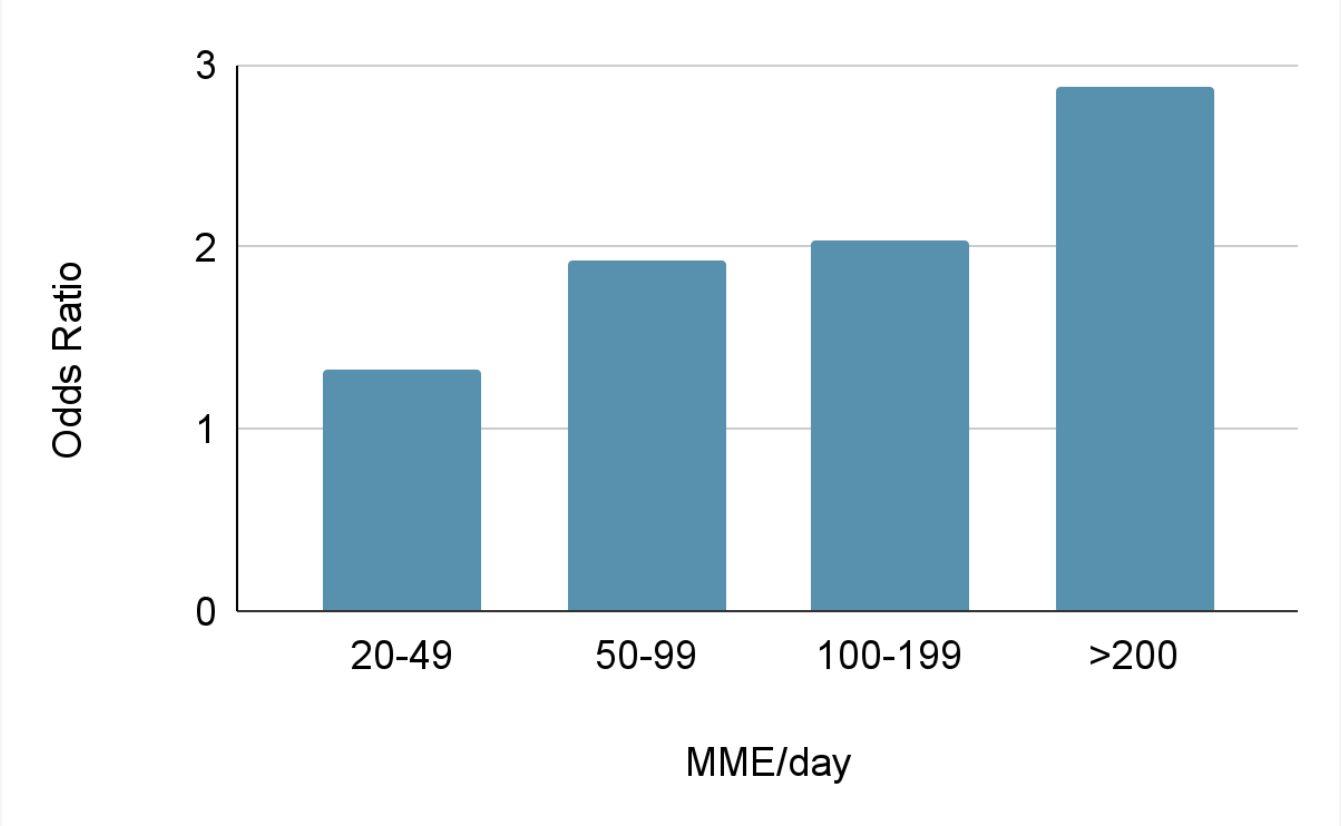
Dependence
Withdrawal
Addiction
Overdose
Hyperalgesia
Hypogonadism
Falls/fracture risk

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

Probability of continued use by days' supply of first Rx



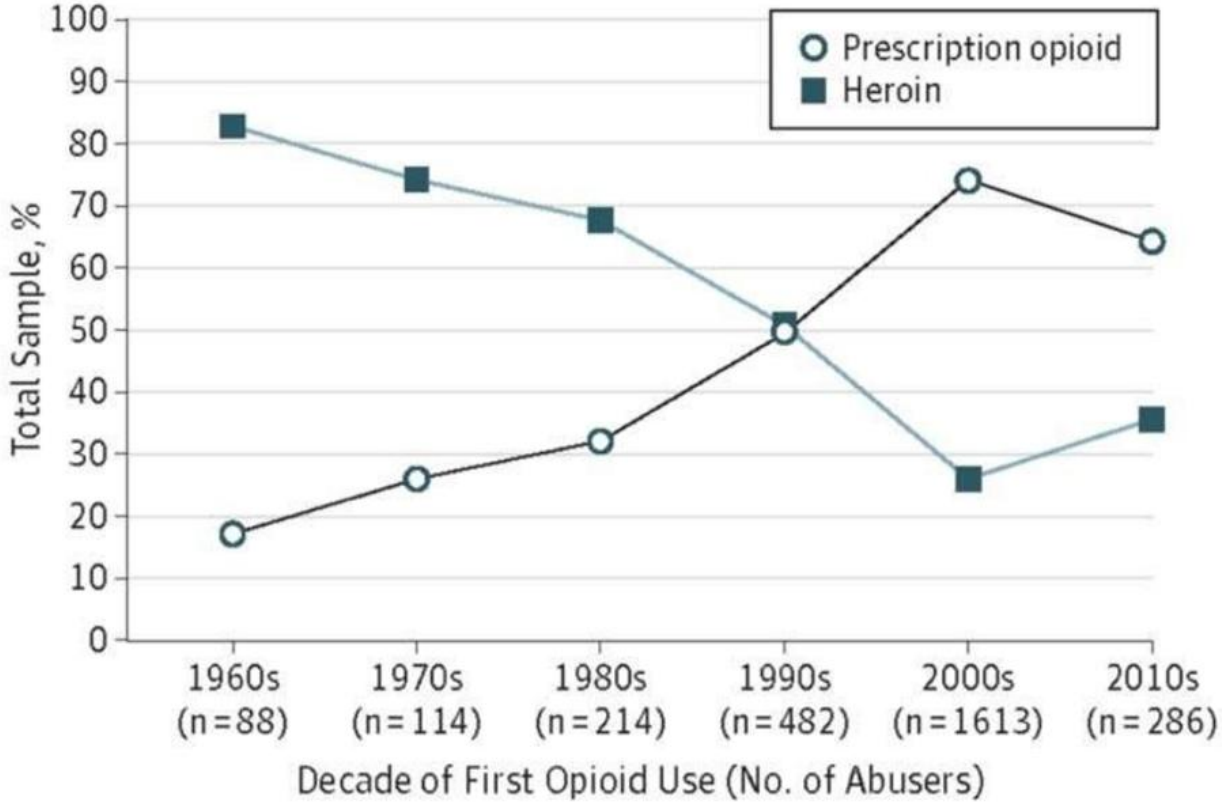
For patients with chronic pain, compared with no opioid use, opioid use was associated with increased risk for opioid overdose death.



Quick Reminder

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

Tolerance and withdrawal DOES NOT equal OUD



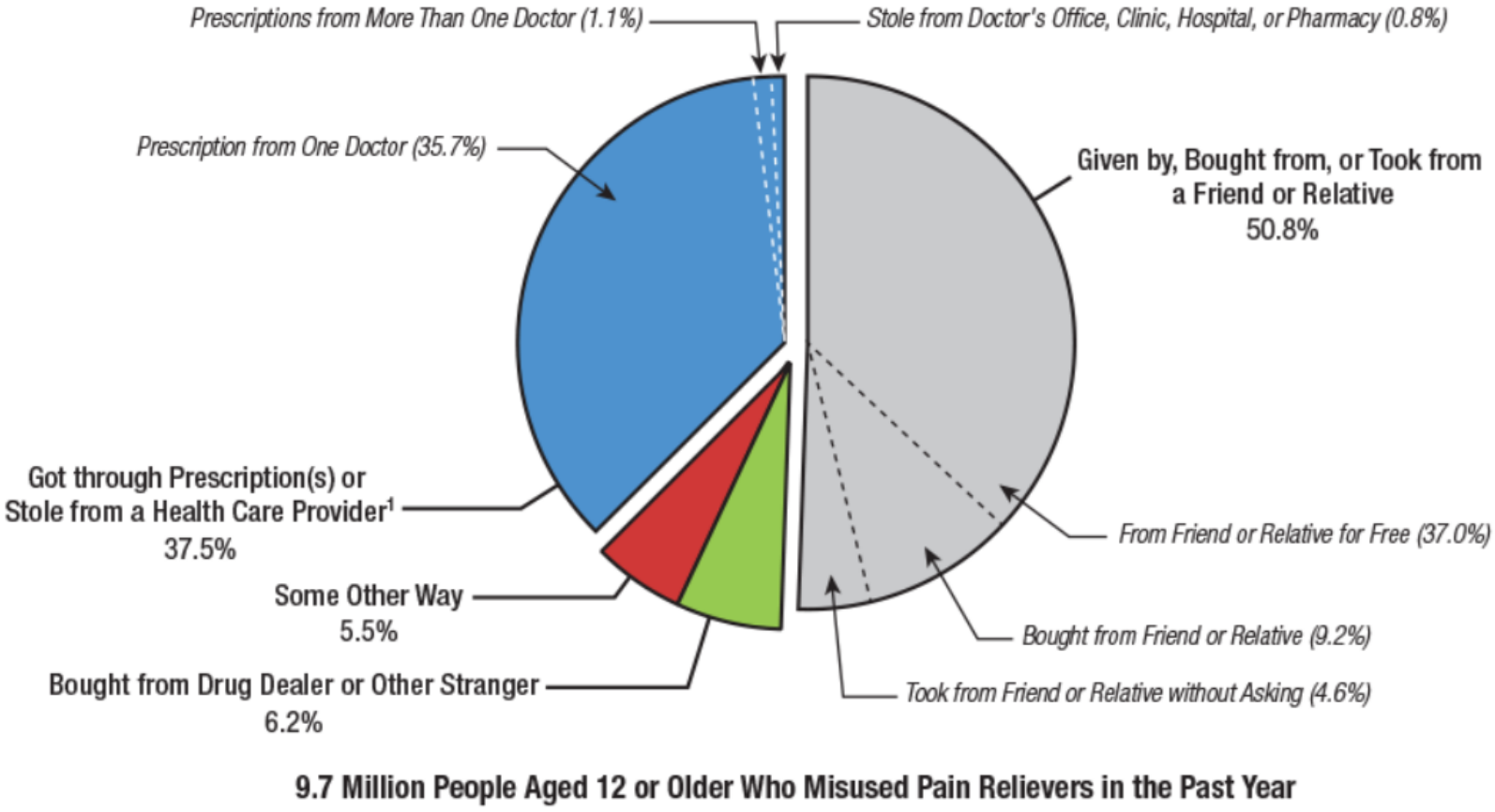
Source: Cicero et al., 2014

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.

Figure 23. Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Pain Relievers in the Past Year: 2019



Practice Recommendation # 4

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

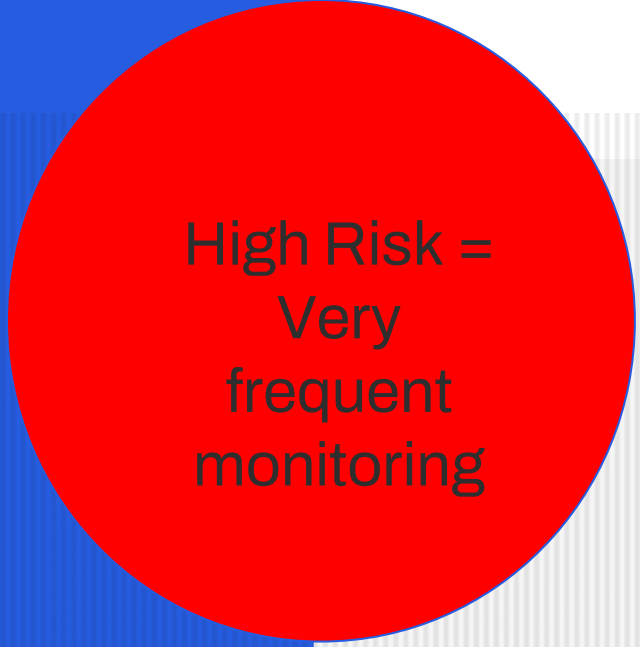
Assessment Tools

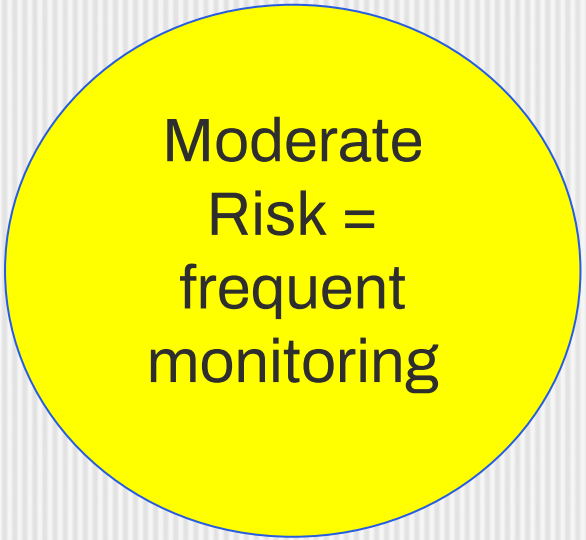
3 or less = LOW risk
4-7 = moderate risk
8 or greater = HIGH risk

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

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**

03 Cases - Balancing it all

Case 1

68yo man with PMH of CKD4, HTN, DM2, chronic neuropathic pain and radicular lumbar pain, here to establish care. Has been on oxycodone-acetaminophen 10-325mg q6hr prn (but really scheduled) x several years. Recently insurance has been hard about PA and pharmacist refused to fill. Also feels like it's not working as well as it once used to; struggles with ADLs.

What are your next steps?

Pain/Addiction Assessment

History of pain - duration, severity, location
Medication trials
Functional impact
Mental health status
Other substance use
Physical exam
PDMP review
Recent drug screens (if any)

Case 1 con’t

What about buprenorphine?

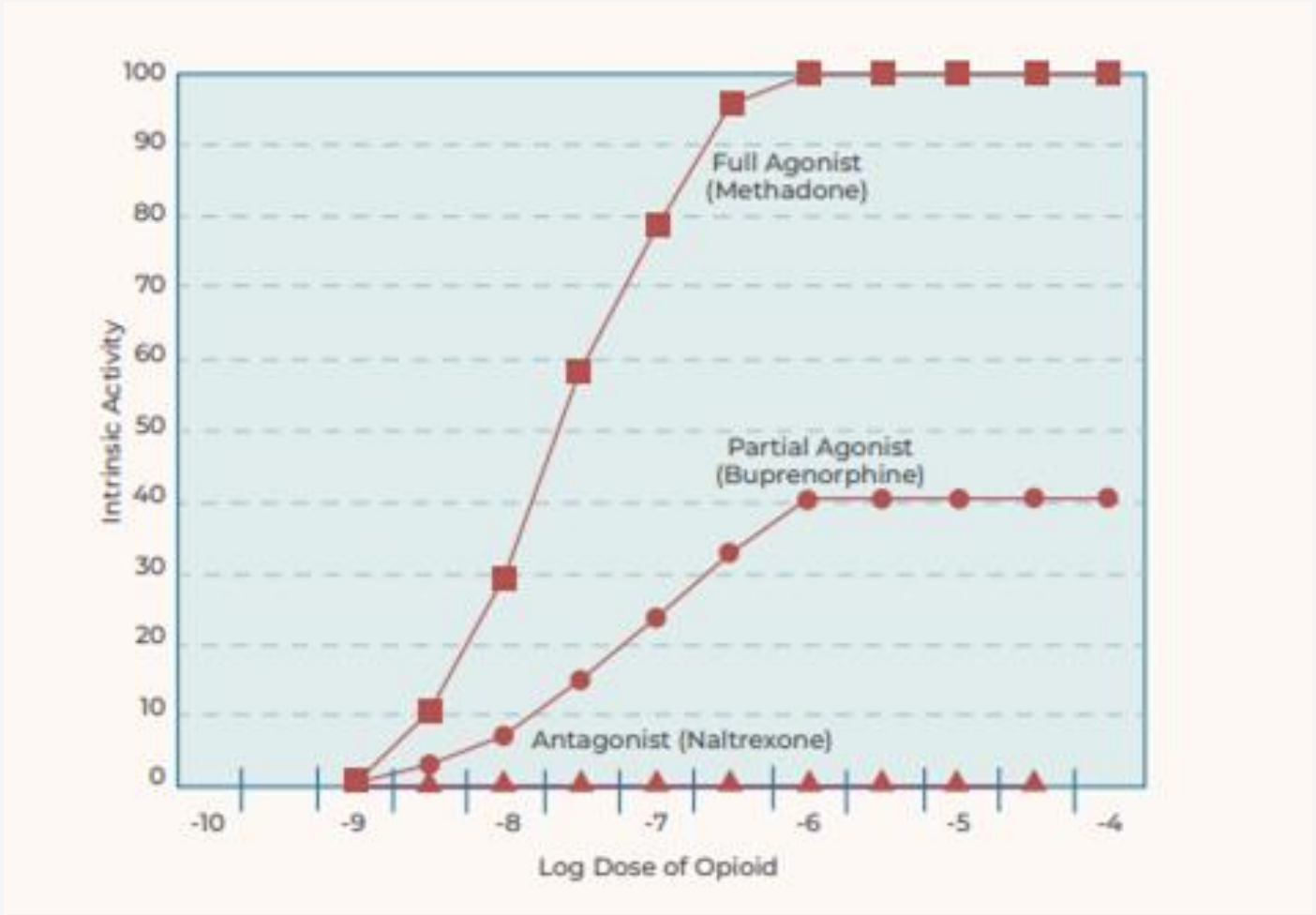
A word on buprenorphine

Partial agonist at mu opioid receptor

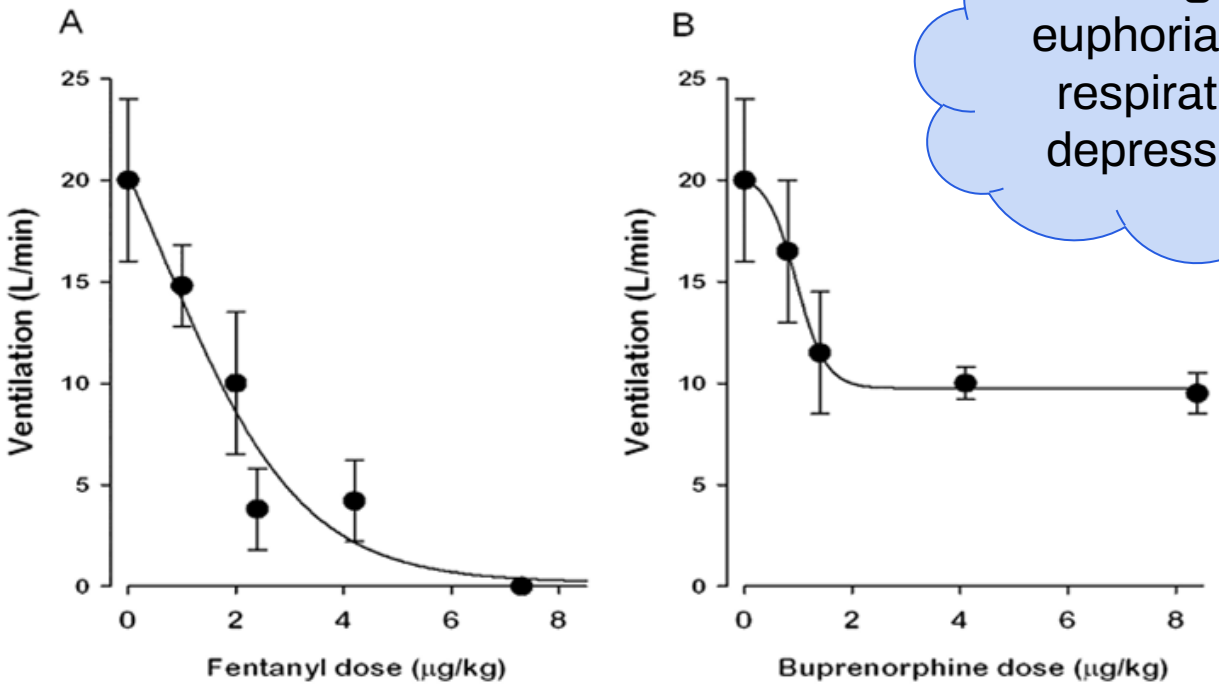
FDA approved as suboxone/subutex for OUD

Has been used for decades for chronic pain

Consider safe due to ceiling effect


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!

Case 1 con’t

Patient counseled about risks and decided to make the switch
Signed controlled substance agreement
Narcan rx given

Buprenorphine transdermal patch
5-10-15mcg/hr patch
If <30MME, use 5mcg; If >30MME, use 10mcg patch

Case 2

36yo woman with PMH of sickle cell-beta thalassemia who has been on chronic opioids for several years. Has hx of bone infarcts and chronic pain along with frequent crisis.

Takes methadone 20mg TID and oxycodone 15mg QID prn

Patient was still presenting in pain, with normal labs and had adjusted her own methadone dose.

Pain/Addiction Assessment

History of pain - duration, severity, location
Medication trials
Functional impact
Mental health status
Other substance use
Physical exam
PDMP review
Recent drug screens (if any)

Case 2 con’t

Counseled about risks of overdose and transplant hematologist recommended switch to buprenorphine due to concern for opioid induced hyperalgesia.

Patient was placed on PCA with 4hr max of 48mg dilaudid. Was still only marginally managing her pain.

Case 2 con’t

Suboxone was started.
Day 1: 1mg
Day 2: 2 mg
Day 3: 2mg BID
Day 4: 2mg TID
Day 5: 4mg TID
Day 6: 8mg TID
Day 7: 8mg QID + oxycodone prn (PCA stopped)

Case 3

68yo woman PMH of HTN, preDM, chronic pain and anxiety presents to establish care. Has been on oxycodone-acetaminophen 5-325mg TID prn and klonopin 0.5mg BID for over 10 years. Has been working well for her. Is able to complete ADL/IADLs. Still active gardener. Has no hx of mood disorder. Does smoke 1/2ppd.

What do you do?

Pain/Addiction Assessment

History of pain - duration, severity, location
Medication trials
Functional impact
Mental health status
Other substance use
Physical exam
PDMP review
Recent drug screens (if any)

Case 3 con’t

Drug screen positive for oxycodone, negative all else
PDMP consistent

Patient counseled about risks/benefits and wants to continue.
Rx for narcan sent

Start with more frequent follow up, then spaced out.

Case 4

29yo woman admitted due to left arm cellulitis and abscess. Admits to daily IV fentanyl use. Has been in hospital 18 hours; starting to feel withdrawal symptoms.

What are your options?

Pain/Addiction Assessment

History of pain - duration, severity, location
Medication trials
Functional impact
Mental health status
Other substance use
Physical exam
PDMP review
Recent drug screens (if any)

Case 4

Buprenorphine - (suboxone/subutex)

- Easy to transition outpatient
- Harder to start - wait for withdrawal

Methadone

- Easy to start
- Needs state ID, method of transportation -harder follow up

Full agonist - oxycodone

- Easy to start
- Feels uncomfortable for prescriber

Case 4 con’t

Buprenorphine - (suboxone/subutex)

- COWS > 8-12 = ok to start
- If withdrawal worsens
  - Give more
  - Wait 2-4 hours and reassess

Case 4 con’t

Methadone

- Starting dose 30-40mg daily
- Ok for prn dose later in the day
- If hx of heart conditions - check EKG and check QTc
- Can follow and adjust up 10mg per day in hospital
- Do not discharge on Saturday

Case 4 con’t

Full agonist - oxycodone

- Only for patients who are very undecided about MOUD at discharge
- Usually start oxycodone ER 20-40mg BID
- Can always give more
- Stop at discharge

Case 5

45yo woman with PMH of diffuse chronic pain, bipolar 2 disorder on meds and well controlled, HTN, preDM2. Previous MD had patient on oxycodone-acetaminophen 10-325mg q4hr prn however patient has been running out early. Says it’s just not working the same. Has episodes of severe spasms and needs more.

Pain/Addiction Assessment

History of pain - duration, severity, location
Medication trials
Functional impact
Mental health status
Other substance use
Physical exam
PDMP review
Recent drug screens (if any)

Case 5

Counseled about risks/benefits, patient is hesitant but agrees to switch to buprenorphine.

Cross taper:
Day 1: Full agonist + 2mg buprenorphine
Day 2: half full agonist dose + 4mg buprenorphine
Day 3: no full agonist + 4mg buprenorphine BID

Questions?