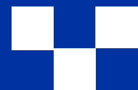
PCP: PAIN CARE PRIMER



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FACULTY DISCLOSURE

Stephanie Abel is a consultant for Wolters Kluwer (Lexicomp) for pain management, palliative care, and opioid use disorder-related content.

All other faculty have no relevant financial disclosures.

Need: The opioid crisis continues to have devastating impacts to individuals, families, and communities. Implementing evidence-based practice in pain management, risk mitigation and harm reduction strategies, addressing stigma, and identification and treatment of opioid use disorder improves patient and population health and outcomes.

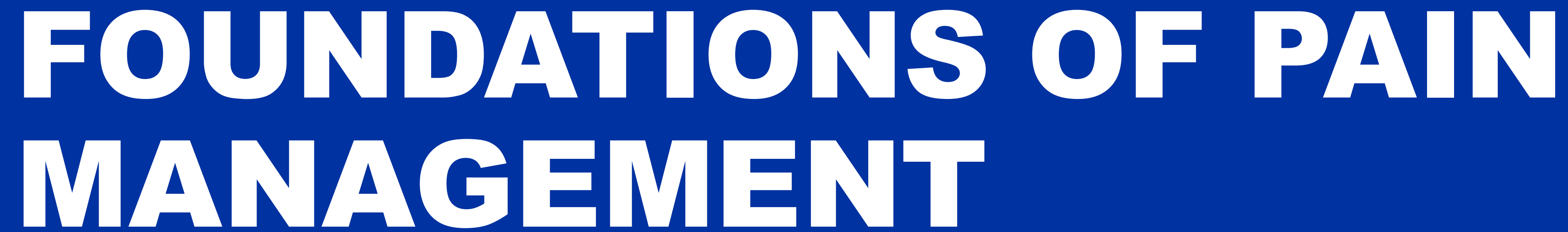
Gap: Education and training in these topics is often not embedded into healthcare profession curriculums. Stigma and implicit biases surrounding chronic pain and opioid use disorder negatively impacts how we engage with patients and contributes to poor patient care. Clinician education and training in these realms improves alignment with evidence-based practice, increases patient and provider satisfaction, and improves patient outcomes.

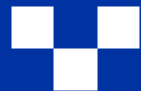
OBJECTIVES

- Discuss the importance of functional pain assessments and determining pain type(s) to inform your patient care plan
- Implement the biopsychosocial pain model to create a patient-specific pain management plan
- Describe the general principles of opioid use in pain management
- Identify signs of opioid addiction and demonstrate communication strategies shown to improve patient engagement in care

University of Kentucky

- Implementation of best practices for patients with pain management needs
- Confidence in identifying signs of opioid use disorder and using effective communication strategies to start the conversation with a patient
- Recognize the importance of offering and initiating medication for opioid use disorder and/or coordinating care with an addiction medicine specialist when needed





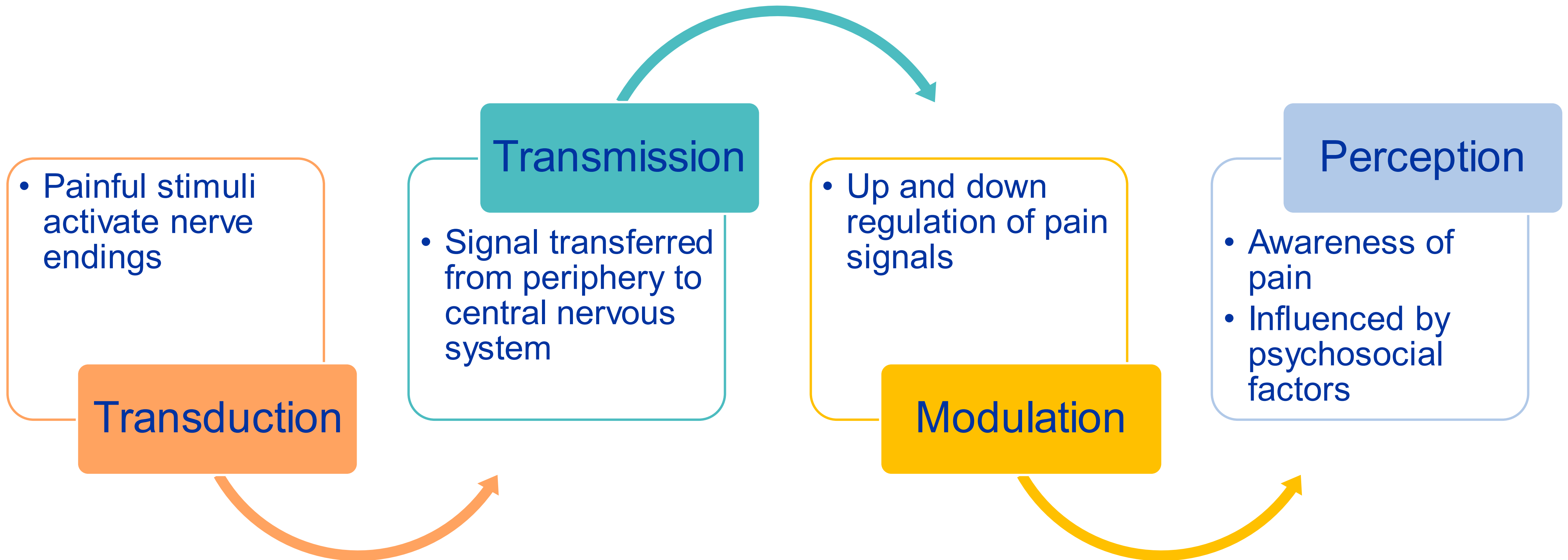
STEPHANIE ABEL, PHARMD, BCPS

PAIN DEFINITIONS

Acute pain	Subacute pain	Chronic pain
• Physiologic response to noxious stimuli • Sudden onset • Time limited (< 1 month) • Known cause (injury, trauma, medical treatment)	• Unresolved acute pain • 1 – 3 months • Can evolve into chronic pain	• > 3 months • Can result from underlying medical condition, treatment, injury, inflammation, or unknown cause

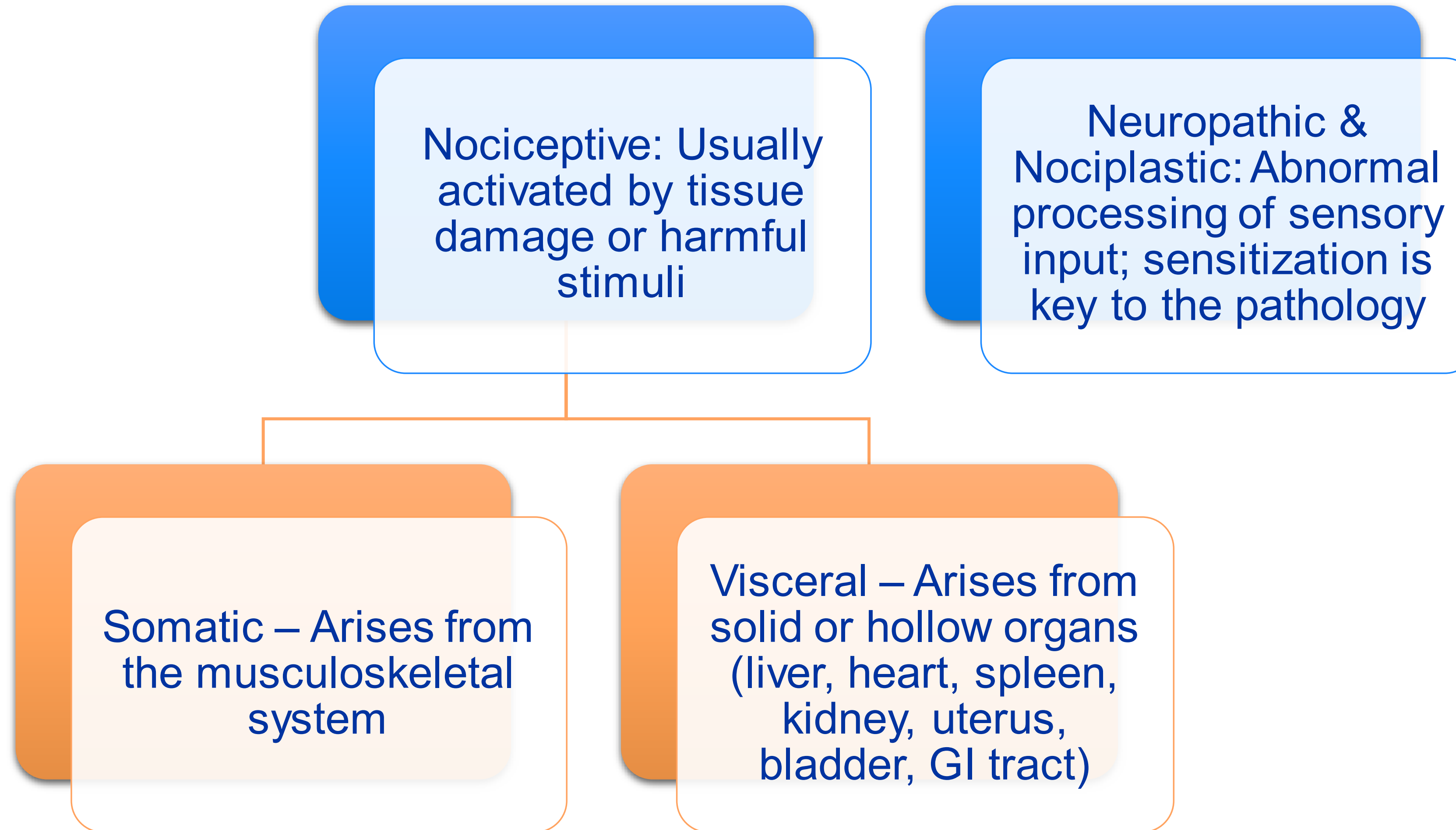
Dowell D et al. *MMWR Recomm Rep.* 2022;71(No. RR-3):1–95.

PAIN PATHWAY



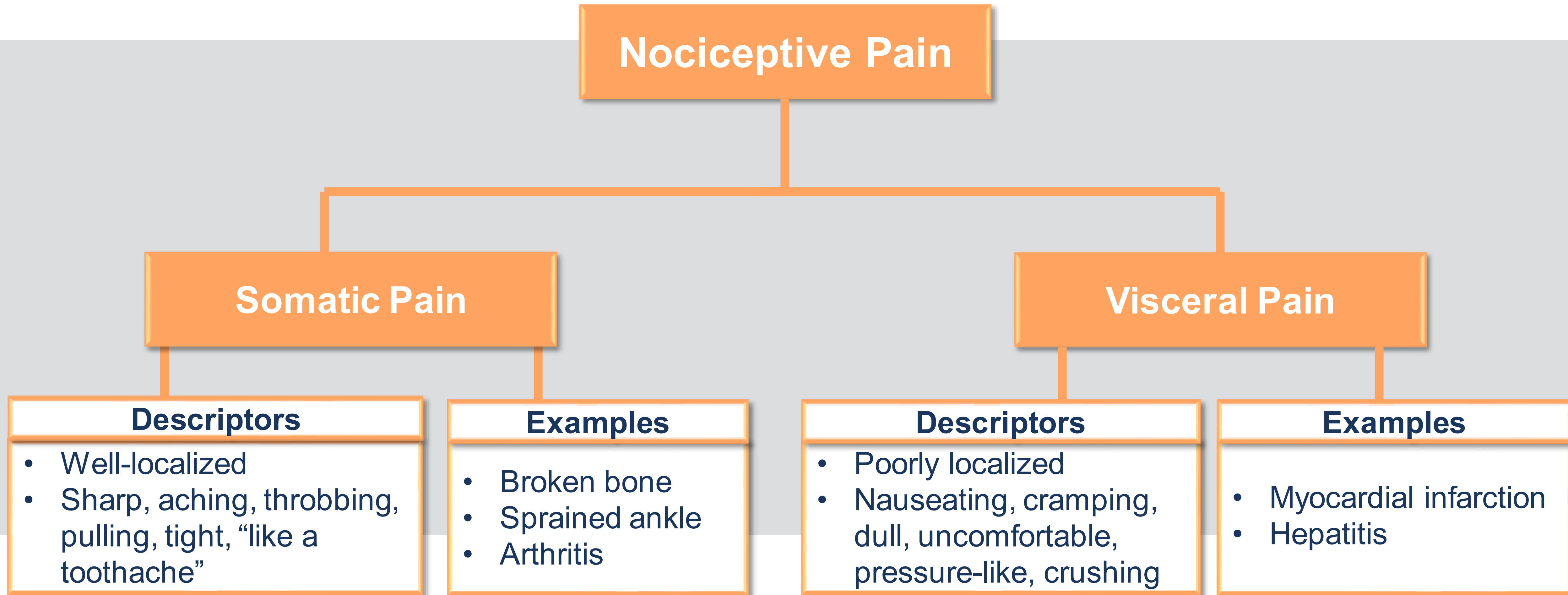
Institute of Medicine (US) Committee on Pain, Disability, and Chronic Illness Behavior; Osterweis M, Kleinman A, Mechanic D, editors. Pain and Disability: Clinical, Behavioral, and Public Policy Perspectives. Washington (DC): National Academies Press (US); 1987. 7, The Anatomy and Physiology of Pain. Available from: https://www.ncbi.nlm.nih.gov/books/NBK219252/

TYPES OF PAIN



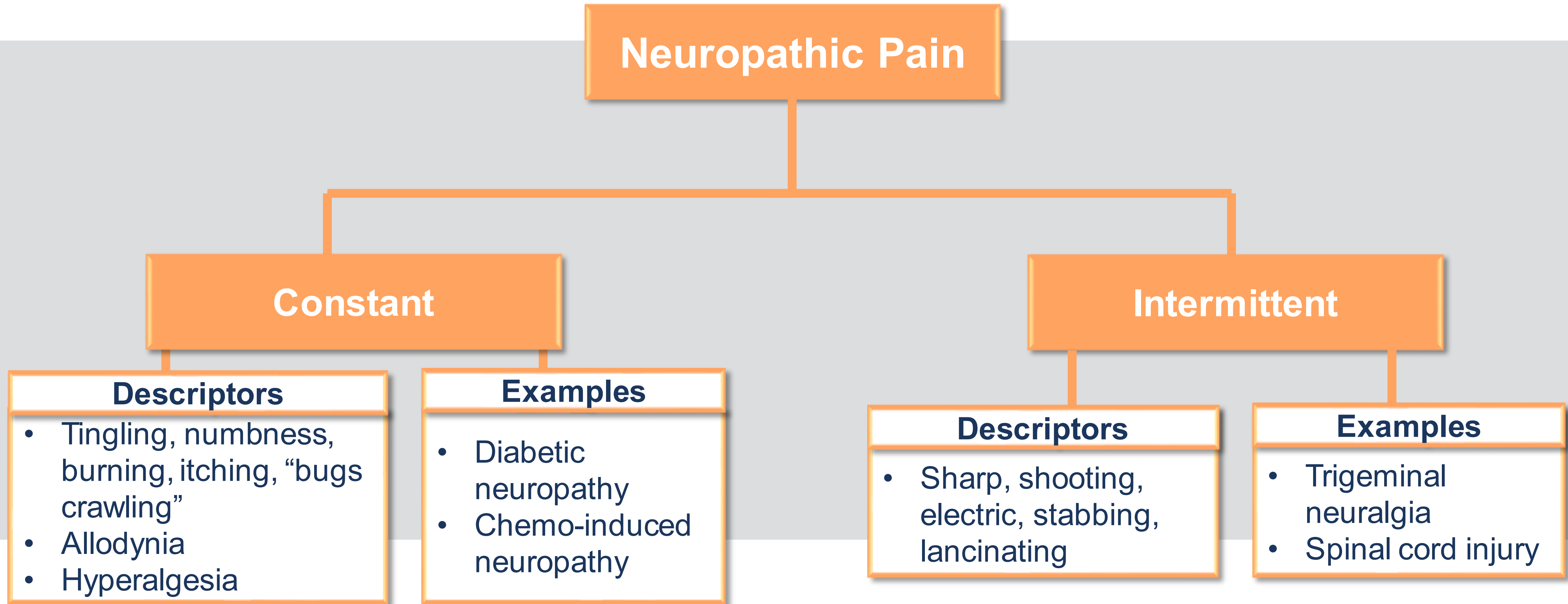
Benzon HT, et al. *Essentials of Pain Medicine, 4th Edition.* 2018.

PAIN DESCRIPTORS



Benzon HT, et al. *Essentials of Pain Medicine, 4th Edition.* 2018.

PAIN DESCRIPTORS



Benzon HT, et al. *Essentials of Pain Medicine, 4th Edition.* 2018.

CHRONIC PAIN TYPES

	Nociceptive Pain	Neuropathic Pain	Nociplastic Pain
Causes	Tissue or potential tissue damage	Disease or injury impacting CNS	Maladaptive changes affecting nociceptive processing & modulation → no objective evidence of damage
Examples	Osteoarthritis, trauma, pancreatitis	Carpal tunnel syndrome, diabetic peripheral neuropathy, post-herpetic neuralgia	Fibromyalgia, irritable bowel syndrome, tension headache, non-specific back pain
Descriptors	Throbbing, aching, pressure like	Lancinating, shooting, electrical, stabbing	Similar to neuropathic or visceral; possibly described as diffuse, gnawing, aching, sharp
Accompanying symptoms	↑ rates psychopathology (depression/anxiety) than controls	↑ psychological distress & disability than in nociceptive pain	Psychological distress affects most. Cognitive symptoms, insomnia, and fatigue common. GI complaints and sensitivity to sensory stimuli frequent

Adapted from Cohen SP et al. *Lancet.* 2021;397(10289):2082-2097.

PAIN ASSESSMENT

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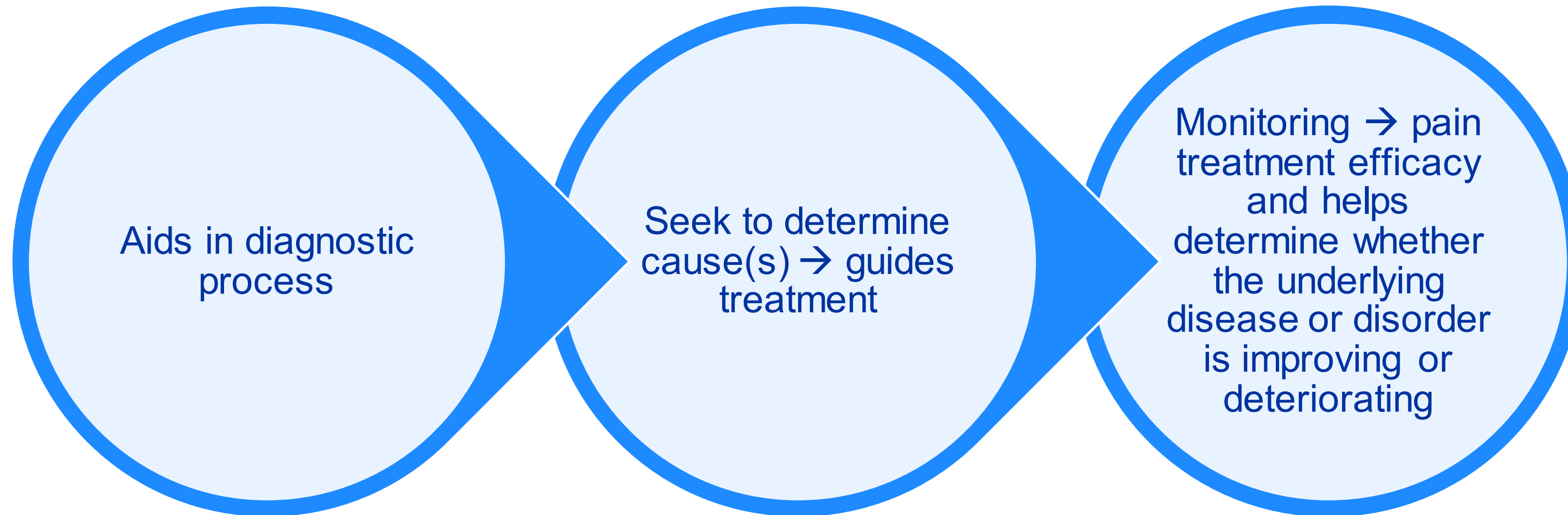
PURPOSE OF PAIN ASSESSMENT



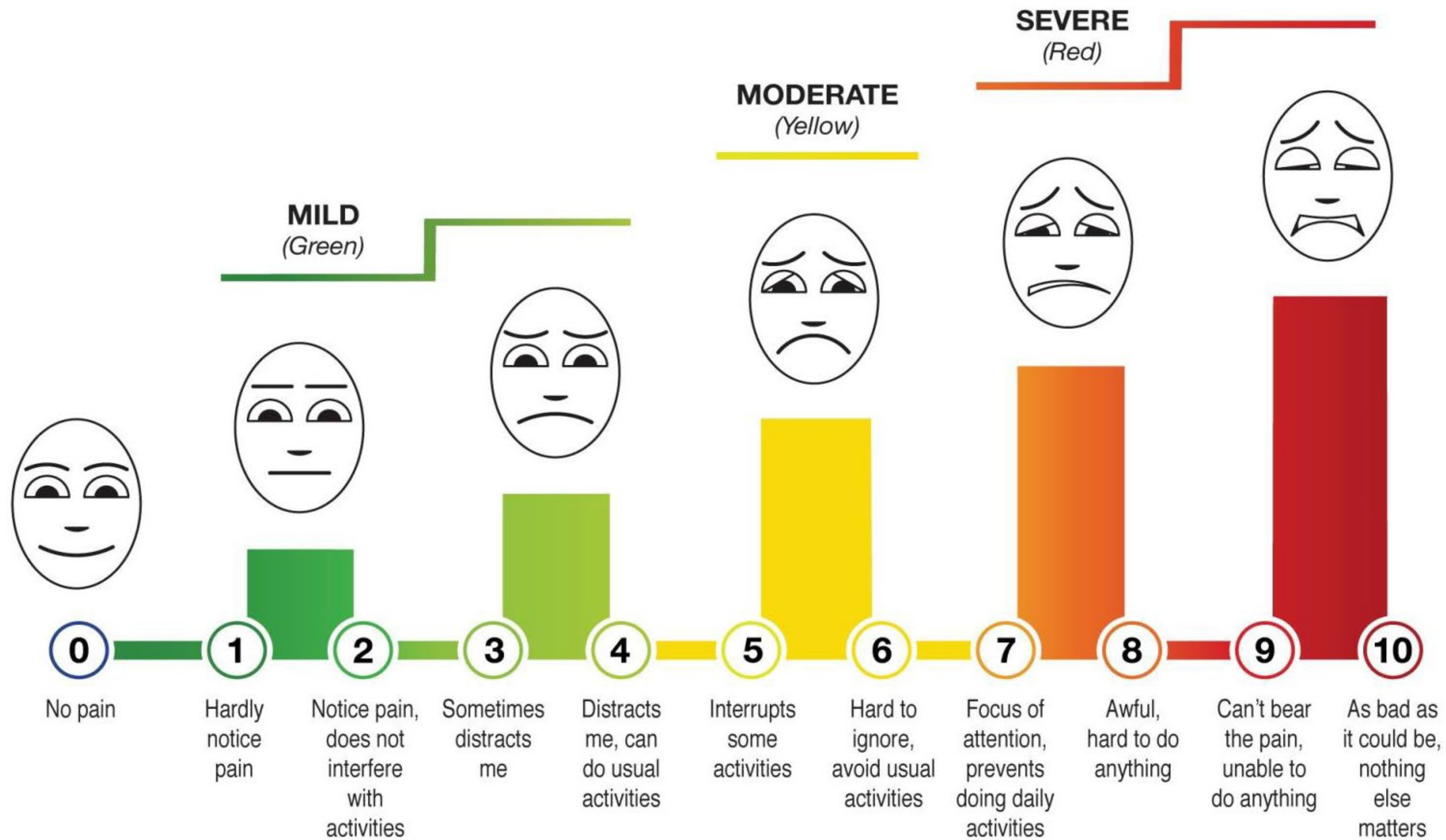
Pain management 3: the importance of assessing pain in adults. Nursing Times. 2015.

PAIN ASSESSMENT

PQRSTU	Question(s) to Consider
Provoking Palliative	What makes your pain worse? What makes your pain better?
Quality	What does the pain feel like? Provide suggestions if needed: “sharp” “burning”
Region Radiation	Where is your pain? (assess multiple sites independently) Does your pain move/radiate?
Severity	How would you rate your pain? (select appropriate pain scale) - at it’s best? after medication? at it’s worst?
Timing	How long have you had pain? Is the pain constant or does it come and go?
Treatment	What treatments have you tried for your pain? How long is your pain treatment lasting?
Understanding or How pain effects yoU	What do you think is causing the pain? What have other clinicians mentioned about your pain? How has it affected your usual activities or daily life?

- Brief Pain Inventory (Copyrighted)
- Clinically Aligned Pain Assessment (CAPA) Tool (Copyrighted)
- **Defense and Veterans Pain Rating Scale (Free of copyright)**
- **Geriatric Pain Measure (Free of copyright)**
- Pain Impact Questionnaire (PIQ-6) (Trademarked)
- **PEG (Free of copyright)**
- Pain Monitor (Copyrighted)
- Short Form-36 Bodily Pain Scale (SF-36 BPS) (Copyrighted)

Pain Manag Nurs. 2020 Oct;21(5):416-422.


Defense and Veterans Pain Rating Scale
MILD
(Green)
MODERATE
(Yellow)
SEVERE
(Red)
0
No pain
1
Hardly notice pain
2
Notice pain, does not interfere with activities
3
Sometimes distracts me
4
Distracts me, can do usual activities
5
Interrupts some activities
6
Hard to ignore, avoid usual activities
7
Focus of attention, prevents doing daily activities
8
Awful, hard to do anything
9
Can't bear the pain, unable to do anything
10
As bad as it could be, nothing else matters
v 2.0

DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute — Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.* v 2.0

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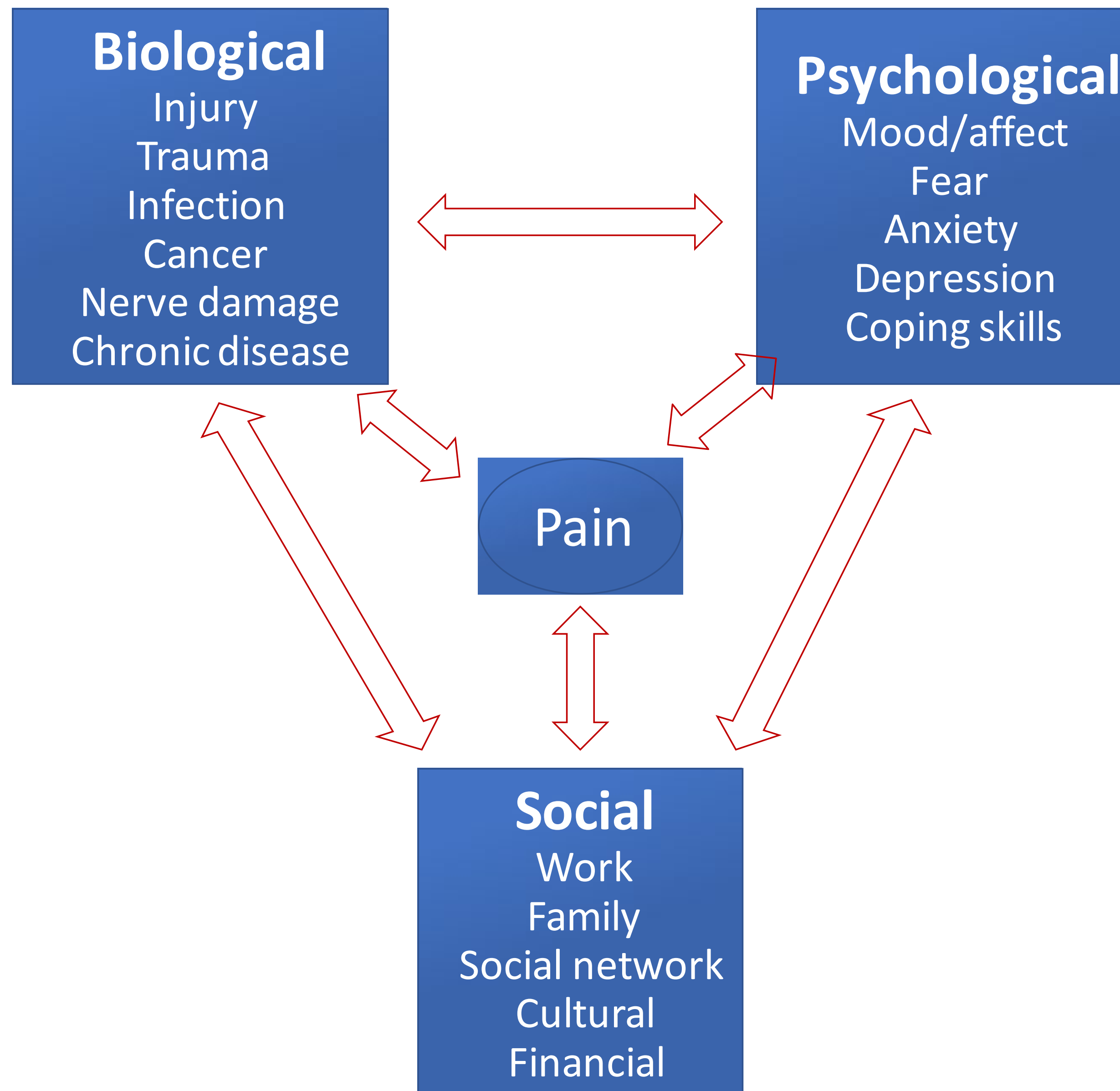
BIOPSYCHOSOCIAL PAIN MODEL



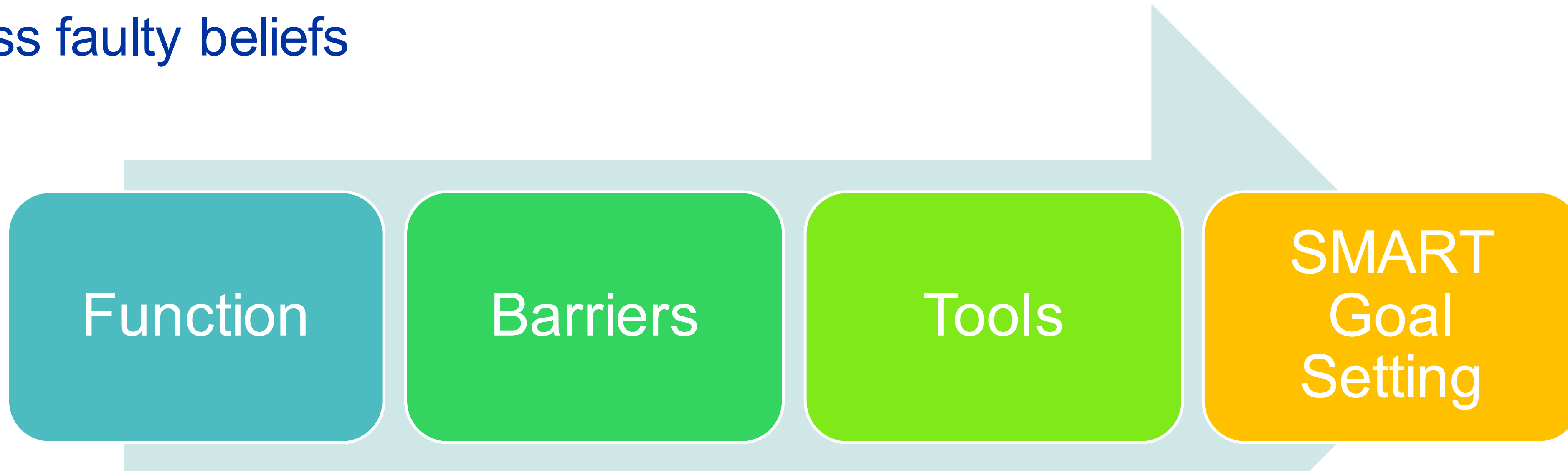
CREATING A PAIN PLAN USING BIOPSYCHOSOCIAL MODEL

- Set expectations
- Create collaborative pain goals
- Evaluate pain management options in context of individual patient
    - Pharmacotherapy
    - Non-pharmacological
    - Psychological
    - Physical medicine/rehab
    - Interventional

Deuñas M et al. *J Pain Res*. 2016;9:457-67.
Bair MJ et al. Pain Med. 2009; 10(7):1280-90.
HHS. Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations (accessed 2021 Mar 30).

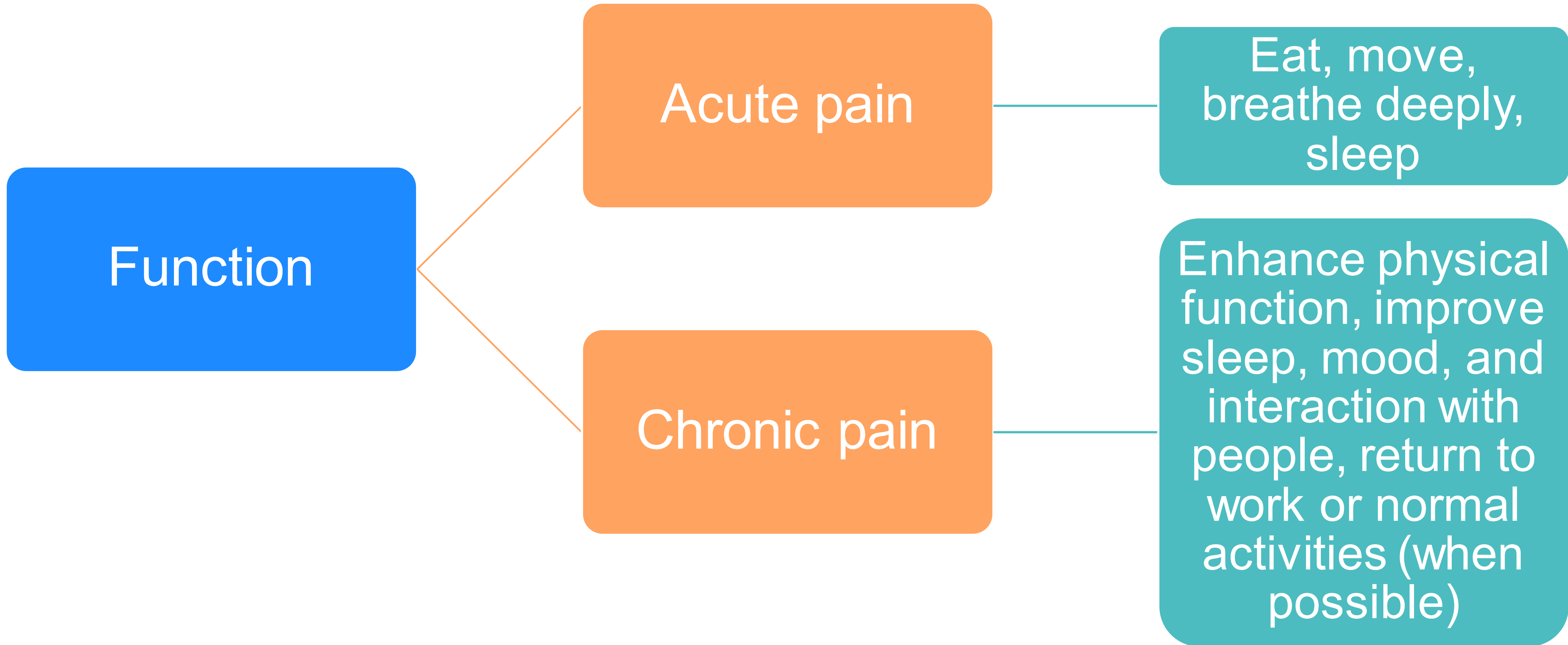
SETTING PAIN GOALS

- Should be collaborative and focus on function
  - Higher compliance than provider-mandated goals
  - Facilitates patient accountability & allows them some control
  - Pain reduction as only goal → ↑ risk for frustration, depression, ↓ participation in care
- Address faulty beliefs



Apfelbaum JL et al. Anesth Analg. 2003; 97(2):534-40.
Keltner JR et al. J Neurosci. 2006; 26(16):4437-43.
Department of Veterans Affairs. Goal Setting for Pain Rehabilitation (accessed 2021 Apr 9).

SETTING PAIN GOALS



Apfelbaum JL, Chen C, Mehta SS et al. Anesth Analg. 2003 Aug; 97(2):534-540.
Brigham and Women's Hospital. Patient Stories and Goals for Managing Pain. (accessed 2021 Apr 14).
Keltner JR, Furst A, Fan C et al. J Neurosci. 2006 Apr; 26(16):4437-4443.
Michigan OPEN. "Prescribing" and "Education" Tab Resources. (accessed 2021 Mar 30).

- HYPNOSIS
- ACUPUNCTURE
- MEDITATION
- MINDFULNESS
- INFORMATION GIVING
- RELAXATION
- GUIDED IMAGERY
- BREATHING TRAINING
- COGNITIVE REFRAMING
- DISTRACTION (VISUAL AND AUDITORY)
- MASSAGE
- BIOFEEDBACK
- PHYSICAL THERAPY
- TRIGGER POINT INJECTION
- NERVE BLOCKS
- NEUROSTIMULATORS

NON-OPIOID ANALGESIA

Acetaminophen & NSAIDS
- Acute pain – schedule both around the clock if not contraindicated

SNRI/TCA
- Neuropathic pain (TCAs - NNT 3.6; SNRIs - NNT 6.4)
- TCA Selection for pain: desipramine > nortriptyline > amitriptyline
- Venlafaxine is primarily SSRI until >200 mg/day
- Concomitant anxiety/depression

Gabapentinoids
- Neuropathic pain (NNT 7.2 – 7.7)
- Concomitant use with opioids ↑ risk of overdose

Topical
- Only effective for peripheral, localized pain

De Andres J et al. *Pain Manag.* 2015;5(3):167-173.
Finnerup NB, et al. *Lancet Neurol.* 2015;14(2):162-173.

NNT= number needed to treat; SNRI= serotonin-norepinephrine reuptake inhibitors; TCA= tricyclic antidepressant

Suggested Analgesic Class

Nociceptive Pain

Somatic

- Acetaminophen
- NSAIDs
- Corticosteroids
- Opioids

Visceral

- Acetaminophen
- NSAIDS
- Anticholinergics
- Injections

Neuropathic Pain

- Anticonvulsants
- Antidepressants
  - TCAs
  - SNRIs
- Lidocaine
- NMDA antagonists
- Capsaicin

Benzon HT, et al. *Essentials of Pain Medicine, 4th Edition.* 2018.

CHRONIC PAIN TREATMENT CONSIDERATIONS

Treatment	Nociceptive Pain	Neuropathic Pain	Nociplastic Pain
Anticonvulsants		X	X
Analgesic antidepressants	X	X	X
Image guided injections	X	X	
Behavioral interventions	X	X	X
Neuromodulation	X	X	
NSAIDs	X		
Opioids	X	X	
Exercise	X		X

Adapted from Cohen SP et al. *Lancet.* 2021;397(10289):2082-2097.

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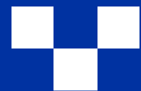
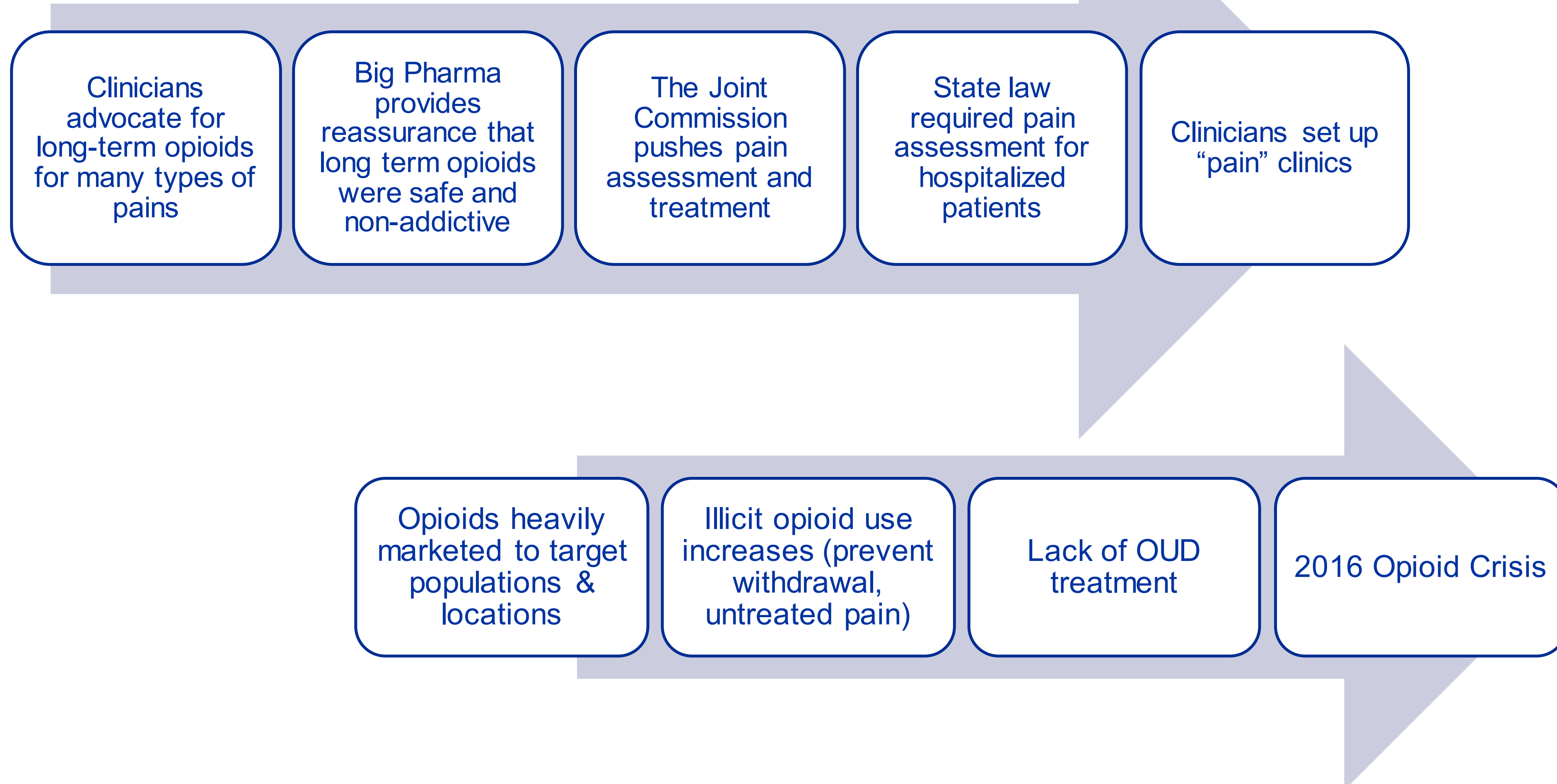
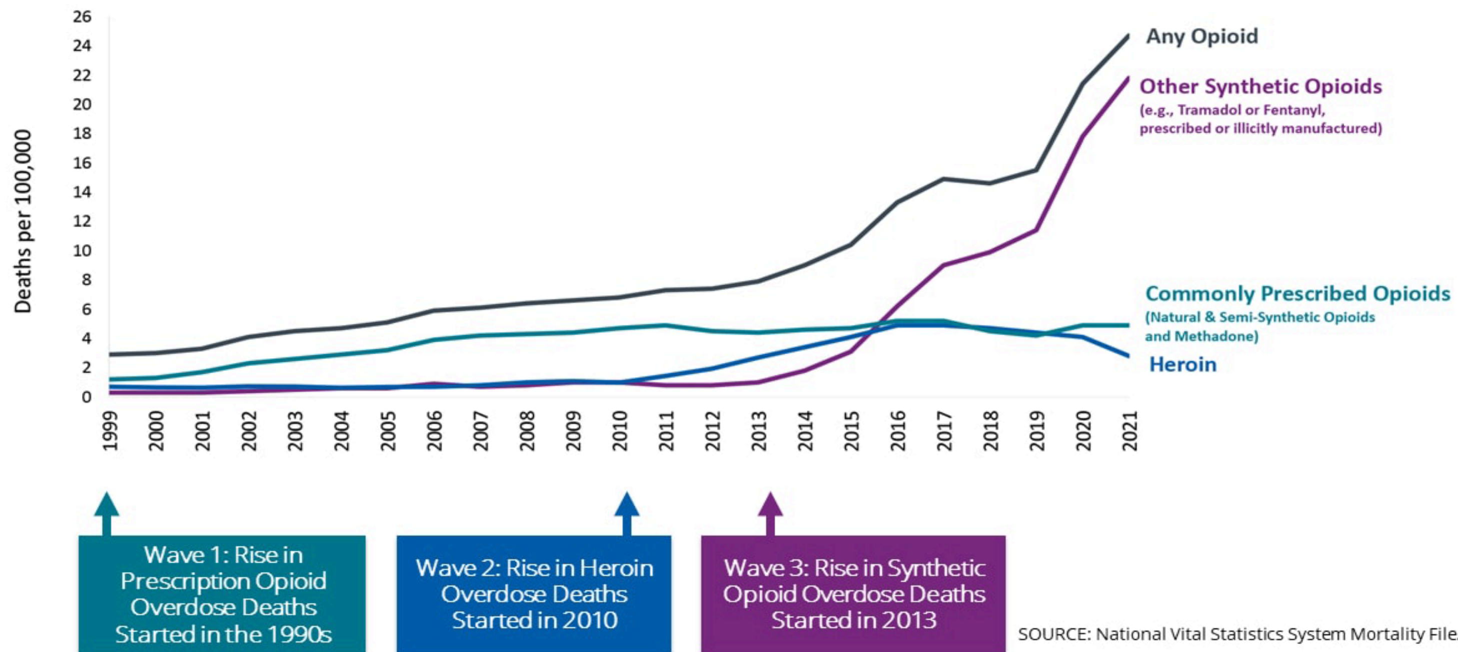


BRANDON KASBERG, PHARMD

Opioids as Part of a Pain Management Plan



Response to Opioid Crisis



Setting the Stage for ‘22

Evolving Guidance on Opioid Prescribing

2016

Centers for Disease Control and Prevention (CDC) Guidelines[2]

Focused on primary care providers

- Aimed to help with risk differentiation for opioids in treating chronic pain
- Resulted in decrease in opioid prescribing[3,4]
- Noted increase in use of nonopioid pain medications[3,4]
- However, state laws did not always align

2022

Centers for Disease Control and Prevention (CDC) Guidelines[4]

Expanded provider focus

- Addressed opioid prescribing for adult outpatients with pain
- Elaborated on various pain durations
- Did not address palliative, end-of-life, cancer, or sickle cell disease-related pain
- Emphasizes effective, safe, personalized, and equitable pain management

CDC 2022 Guidelines- The ‘Who’

- Scope:
  - Outpatients ≥ 18 years of age with acute, subacute, or chronic pain

- Excludes:
  - Sickle cell disease (ASH)
  - Cancer-related pain (ASCO, NCCN)
  - Palliative care
  - End-of-life care

- Not intended to be prescriptive, rigid, or define policy, legislation, etc.
  - "Although some laws, regulations, and policies that appear to support recommendations in the 2016 CDC Opioid Prescribing Guideline might have had positive results for some patients, they are inconsistent with a central tenet of the guideline: that ***the recommendations are voluntary and intended to be flexible to support, not supplant, individualized, patient-centered care."***

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- GRADE Workgroup
- Federal Advisory Committee Review and Recommendations
- Federal Partner Engagement
- Public Comment and Community Engagement
- Peer Review

- Recommendation Category:
  - A: most patients should receive the recommended course of action
  - B: different choices will be appropriate for different patients

- Evidence Type
  - Type 1: high confidence that the true effect is close to the estimate of the effect
  - Type 2: some uncertainty
  - Type 3: moderate uncertainty
  - Type 4: very little confidence; high uncertainty

CDC 2022 Guidelines- “Guiding Principles”

1. ***Acute, subacute, and chronic pain*** needs to be appropriately assessed and treated independent of whether opioids are part of a treatment regimen.

2. Recommendations are voluntary and are intended to support, not supplant, individualized, ***person-centered care.*** Flexibility to meet the care needs and the clinical circumstances of a specific patient is paramount.

3. A ***multimodal and multidisciplinary approach to pain management*** attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being of each person is critical.

4. Special attention should be given ***to avoid misapplying this clinical practice guideline beyond its intended use*** or implementing policies purportedly derived from it that might lead to unintended and potentially harmful consequences for patients.

5. Clinicians, practices, health systems, and payers should vigilantly ***attend to health inequities***; provide culturally and linguistically appropriate communication, including communication that is accessible to persons with disabilities; and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

Determining whether or not to initiate opioids for pain

Selecting opioids and determining dosages

Deciding duration of initial opioid prescription and conducting follow-up

Assessing risk and addressing potential harms of opioid use

CDC 2022 Guidelines- Determining whether or not to initiate opioids for pain

Recommendation 1

Nonopioid therapies are at least as effective as opioids for many common types of ***acute pain***. Clinicians should maximize use of ***nonpharmacologic and nonopioid pharmacologic therapies*** as appropriate for the specific condition and patient and ***only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks*** to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the ***realistic benefits and known risks of opioid*** therapy (recommendation category: B; evidence type: 3).

BK Interpretation

For pain < 1 month, let's:

- optimize non-pharm and non-opioid therapies in a patient specific manner
- weigh risk vs. benefit of opioids for each patient
- discuss realistic pain expectations, benefits, and opioid risks

CDC 2022 Guidelines-
Determining whether or not to initiate opioids for pain

Recommendation 2

Nonopioid therapies are preferred for ***subacute and chronic pain***. Clinicians should maximize use of ***nonpharmacologic and nonopioid pharmacologic therapies*** as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to ***establish treatment goals for pain and function***, and should ***consider how opioid therapy will be discontinued if benefits do not outweigh risks*** (recommendation category: A; evidence type: 2).

BK Interpretation

For pain > 1 month, let's:

- lean on non-pharm and non-opioid therapies in a patient & condition specific manner
- ensure expected benefits for pain and function are to outweigh risks of opioids
- discuss realistic pain expectations, benefits, opioid risks, goals (pain and function)
- establish an exit strategy

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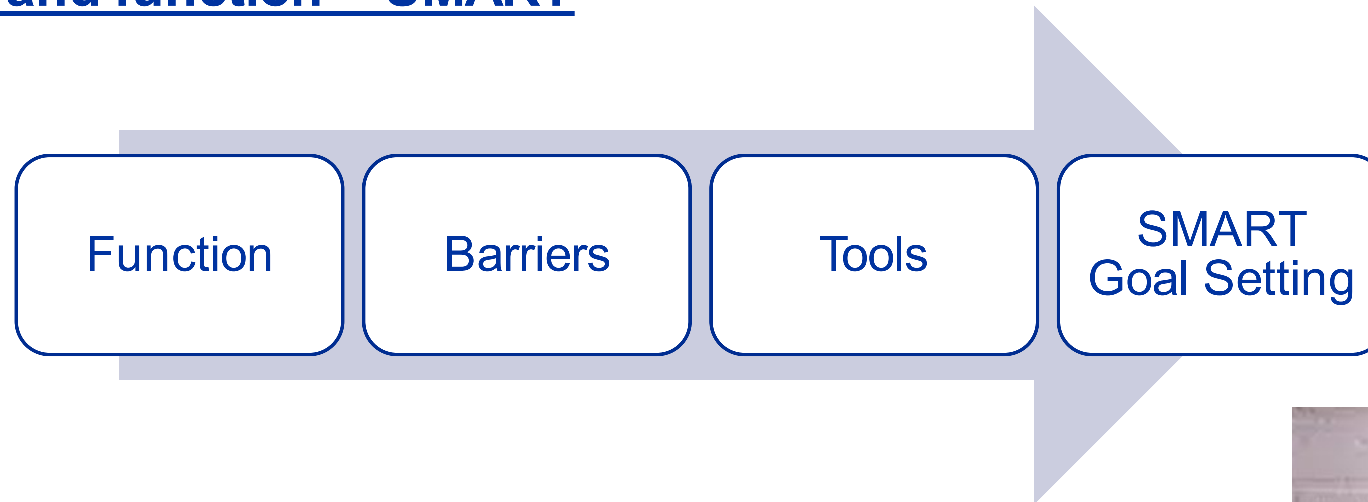
CDC 2022 Guidelines-
Determining whether or not to initiate opioids for pain

Patients with pain >1 month may look different

- Acute pain turned subacute and patient on opioids already >/= 30 days
- New pt to you, but on opioids already

Goals for pain and function = SMART



Exit strategy

- Off opioids completely vs. On opioids indefinitely
- Lowest effective dosage

Recommendation 3

When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe ***immediate-release opioids instead of extended-release*** and long-acting (ER/LA) opioids (recommendation category: A; evidence type: 4).

BK Interpretation

Starting an opioid?

- use immediate-release, short-acting opioids first
  - save the extended-release, long-acting opioids for severe, continuous pain
  - remember excluded populations (cancer/malignant pain, palliative care, sickle cell, hospice)

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CDC 2022 Guidelines- Summary Checkpoint
Determining whether or not to initiate opioids for pain

Why are ER/LA opioids not indicated for acute pain

- Opioid minimization
- Overdose risk
- Time to steady state

Why are ER/LA opioids not indicated for subacute/chronic (non-malignant, non-palliative/hospice) pain

- No benefit for many indications
- Overdose risk

When are ER/LA opioids ok to use?

- Severe, continuous pain that is not expected to resolve

and

- Trial of IR-opioids for at least one week

and

- Benefit of opioids established to be greater than risks

CDC 2022 Guidelines- Determining whether or not to initiate opioids for pain

Recommendation 4

When ***opioids*** are initiated for ***opioid-naïve patients*** with acute, subacute, or chronic pain, clinicians should prescribe the ***lowest effective dosage***. If opioids are continued for ***subacute or chronic pain, clinicians should use caution*** when prescribing opioids at any dosage, should carefully ***evaluate individual benefits and risks when considering increasing dosage***, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A; evidence type: 3).

BK Interpretation

- Any opioid start → lowest effective dosage
- Any opioid → always be cautious
- Dose increases? Risk v. benefit
  - Was there benefit at lower level? Is pain changing/resolving? Aberrant behaviors?

Determining whether or not to initiate opioids for pain

Selecting opioids and determining dosages

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Recommendation 5

For patients ***already receiving opioid therapy***, clinicians should carefully weigh ***benefits and risks*** and exercise care when ***changing opioid dosage***.

If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to **optimize nonopioid therapies while continuing opioid therapy**

If benefits do not outweigh risks of continued opioid therapy, clinicians should **optimize other therapies** and work closely with patients to **gradually taper to lower dosages** or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids

Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), ***opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages*** (recommendation category: B; evidence type: 4).

CDC 2022 Guidelines-
Selecting opioids and determining dosages

How do I taper?

- Determine initial goal (reduction vs. complete discontinuation)
- Longer duration of opioid therapy = Longer taper
- Slower tapers are often better tolerated

Slowest Taper (over years)	Slower Taper (over months-years)	Faster Taper (over weeks)	Rapid Taper (over days)
Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed Consider for patients taking high doses of long-acting op	Reduce by 5 to 20% every 4 weeks with pauses in taper as needed	Reduce by 10 to 20% every week	Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
Adapted from: https://pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf			

What if I can't taper further? Buprenorphine for pain?

- VA 2022 Chronic Pain Recommendation: "For patients receiving daily opioids for the treatment of chronic pain, we suggest the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse."

Sandbrink F,et al. VA/DoD Guideline Development Group. The Use of Opioids in the Management of Chronic Pain: Synopsis of the 2022 Updated U.S. Department of Veterans Affairs and U.S. Department of Defense Clinical Practice Guideline. Ann Intern Med. 2023 Mar;176(3):388-397. doi: 10.7326/M22-2917. Epub 2023 Feb 14. PMID: 36780654.

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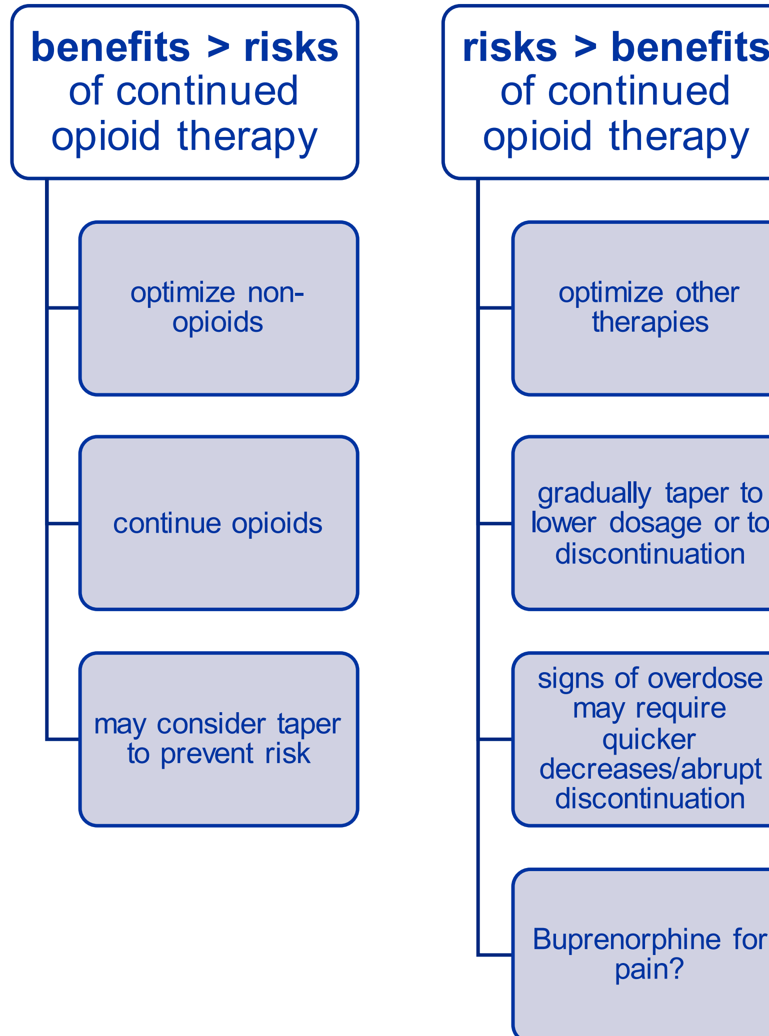
CDC 2022 Guidelines- Summary Checkpoint
Selecting opioids and determining dosages

BK Interpretation

- If already receiving opioids:



Determining whether or not to initiate opioids for pain

Selecting opioids and determining dosages

Deciding duration of initial opioid prescription and conducting follow-up

CDC 2022 Guidelines- Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

Recommendation 6

When opioids are needed for ***acute pain***, clinicians should prescribe no greater ***quantity*** than needed for the ***expected duration of pain severe enough to require opioids*** (recommendation category: A; evidence type: 4).

BK Interpretation

- Use clinical decision making (or use other educated estimations) for the usual duration of pain to determine quantity/duration of opioids
    - Injury type, surgery type

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Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

Procedure	Oxycodone 5mg tabs
Dental Extraction	0
Anti-reflux (Nissen) - Lap	0 - 5
Enterolysis - Lap	0 - 5
Excision of Rectal Tumor - Transanal	0 - 5
Thyroidectomy	0 - 5
Appendectomy - Lap or Open	0 - 10
Cholecystectomy - Lap or Open	0 - 10
Colectomy - Lap or Open	0 - 10
Donor Nephrectomy - Lap	0 - 10
Enterostomy Closure - Lap	0 - 10
Gastrorrhaphy	0 - 10
Hernia Repair - Major or Minor	0 - 10
Ileostomy/Colostomy Creation, Re-siting, or Closure	0 - 10
Pancreatectomy	0 - 10
Sleeve Gastrectomy	0 - 10

Procedure	Oxycodone 5mg tabs
Small Bowel Resection or Enterolysis - Open	0 - 10
Carotid Endarterectomy	0 - 5
Prostatectomy	0 - 10
Cardiac Surgery via Median Sternotomy	0 - 25
Hysterectomy - Vaginal or Lap/Robotic or Abdominal	0 - 10
Cesarean Section	0 - 20
Breast Biopsy or Lumpectomy	0 - 5
Lumpectomy + Sentinel Lymph Node Biopsy	0 - 5
Sentinel Lymph Node Biopsy Only	0 - 5
Wide Local Excision ± Sentinel Lymph Node Biopsy	0 - 20
Simple Mastectomy ± Sentinel Lymph Node Biopsy	0 - 20
Modified Radical Mastectomy or Axillary Lymph Node Dissection	0 - 30
Total Hip Arthroplasty	0 - 30
Total Knee Arthroplasty	0 - 50

OPEN: Opioid Prescribing Engagement Network. (2022). OPEN Prescribing Recommendations. Retrieved from https://doi.org/10.56137/OPEN.000054

Recommendation 7

Clinicians should evaluate benefits and risks with patients within ***1–4 weeks of starting opioid therapy for subacute or chronic pain*** or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients (recommendation category: A; evidence type: 4).

BK Interpretation

- Assess pain and the need for opioids regularly (1-4 weeks)
    - Re-evaluate risks & benefits; particularly in subacute/chronic pain; dosage adjustments
    - “Is opioid therapy best for my patient?”
    - “Have I discussed the patients pain expectations?”
    - “Do I have an exit strategy or goals in place?”

CDC 2022 Guidelines- Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

Long term opioid therapy (LTOT)

- 2024 scoping review aims to identify lesser-known side effects of long-term opioid use and increase awareness of them

Risks of LTOT	
Surgical complications, mortality and morbidity	Endocrine changes effects
Decreased bone formation, remodeling, healing	Cancer development & progression
Infection	Histamine & serotonin release
Hyperalgesia	Cardiovascular effects
Sleep disturbances	Bowel dysregulation
Renal effects	Cognition & mood changes

Dorna Kheirabadi et al., Best Practice & Research Clinical Rheumatology, https://doi.org/10.1016/j.berh.2024.101935.

Determining whether or not to initiate opioids for pain

Selecting opioids and determining dosages

Deciding duration of initial opioid prescription and conducting follow-up

Assessing risk and addressing potential harms of opioid use

CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 8

Before starting and periodically during continuation of opioid therapy, clinicians should **evaluate risk for opioid-related harms and discuss risk** with patients. Clinicians should work with patients to incorporate into the management plan strategies to **mitigate risk, including offering naloxone** (recommendation category: A; evidence type: 4).

BK Interpretation

- Risk mitigation should be incorporated while on opioid therapy
  - Risk discussion
  - Risk factors for OUD
  - Validated screening tools
  - Naloxone

CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Risk factors for OUD

- Mental health conditions (depression, anxiety, PTSD)
- Personal or family history of SUD/OUD (smoking, EtOH)
- Pain
- Stress, trauma
- Poor social support
- Abuse, childhood adversity
- History of legal problems

Risk factors for opioid overdose

- Sleep disordered breathing; sleep apnea
- Renal and hepatic insufficiencies
- Age >/= 65 years
- Mental health conditions
- OUD
- Concomitant use of CNS depressants
- Prior overdose
- Unemployment

Webster, Lynn R. MD. Risk Factors for Opioid-Use Disorder and Overdose. Anesthesia & Analgesia 125(5):p 1741-1748, November 2017. | DOI: 10.1213/ANE.0000000000002496

CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Opioid Risk Tool (ORT)

- Assesses **risk** of opioid misuse in patients with chronic pain on opioids
    - Not a diagnostic tool for OUD
- Can be administered and scored in < 1 minute
- Results should be used to adapt monitoring and support plans

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		

Scoring ≤ 3: low risk 4 – 7: moderate risk ≥ 8: high risk

Webster LR, Webster RM. *Pain Med.* 2005;6(6):432-442.

DSM-V OUD Criteria

Impaired Control

- Substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use the substance.

Social Impairment

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.

Risky Use of Substance

- Recurrent substance use in situations in which it is physically hazardous.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Pharmacological Criteria

- Tolerance, as defined by either: a need for markedly increased amounts of the substance to achieve intoxication or desired effect OR markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either: the characteristic withdrawal syndrome for the substance OR the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Mild OUD
(2-3)

Moderate OUD
(4-5)

Severe OUD
(6 or more)

American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 5th edn. Arlington, VA: American Psychiatric Association DSM-5; 2013.

CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Naloxone

Clinicians should offer naloxone when prescribing opioids, particularly to patients at ***increased risk for overdose***, including patients with a ***history of overdose***, patients with a ***history of substance use disorder***, patients with ***sleep-disordered breathing***, patients taking ***higher dosages of opioids*** (e.g., ≥50 MME/day), patients taking ***benzodiazepines with opioids*** (see Recommendation 11), and patients at risk for returning to a high dose to which they have ***lost tolerance*** (e.g., patients undergoing tapering or recently released from prison, naltrexone).

All patients with opioids? Children, friends, family, pets at risk? Stigma?

KGET.com

Narcan works on overdosing dogs
Walls volunteers learned at outrea

Fentanyl can also affect man's best friend, as a g
this week.

Feb 23, 2024

Motherly

Should Moms Carry Narcan? Experts Discuss

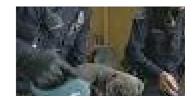
Opioids are now the leading cause of poisoning deaths in children, and accidental fentanyl exposure can be very dangerous for kids.

Dec 22, 2023

KTLA

Irvine police save puppy from overdosing on narcotics

Video shows the moment an eight-week-old puppy was rescued by police from



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CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 9

When prescribing ***initial opioid therapy*** for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program ***(PDMP)*** data to determine whether the patient is receiving opioid dosages or combinations that put the patient ***at high risk for overdose*** (recommendation category: B; evidence type: 4).

BK Interpretation

- Review the PDMP prior to every opioid prescription
  - Determine concomitant respiratory/CNS depressant medications
    - Benzodiazepine
    - Gabapentinoids
    - Muscle relaxants
    - Sedative hypnotics
  - May help determine opioid tolerance
  - Risk score
  - State sharing

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CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 10

When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of ***toxicology testing*** to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances (recommendation category: B; evidence type: 4).

BK Interpretation

Appropriate Toxicology	Inappropriate Toxicology
Inform & improve patient care	Used in a punitive manner
Assist with additional clinical info	Dismiss patients for “failing”
Consider before Rx opioids and annually?	Unstandardized practice; “assumptions”
Explain this is for safety	Explain results with judgement
Discuss standard practices with your patient	Avoid terms such as “dirty” or “clean” results

Recommendation 11

Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of **concurrent prescribing of opioids** and other central nervous system depressants (recommendation category: B; evidence type: 3).

BK Interpretation

- Use particular care when co-prescribing with opioids
  - Benzodiazepine
  - Gabapentanoids
  - Muscle relaxants
  - Sedative hypnotics

  - Check PDMP (recommendation 9)
  - Communicate with other prescribers

CDC 2022 Guidelines- Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 12

Clinicians **should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder (OUD).** Detoxification on its own, without medications for opioid use disorder (mOUD), is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death (recommendation category: A; evidence type: 1).

BK Interpretation

- Treat OUD and use mOUD (buprenorphine, methadone, naltrexone)
    - OUD is a chronic, treatable disease
        - Overdose death and all-cause mortality
    - DSM-5 criteria
    - Stigma, judgement
    - Phone-a-clinician
    - Co-occurring pain and OUD

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OPIOID CONVERSIONS

Opioid Conversions: 5 Step Process

1. Global pain assessment with a multidimensional pain scale (PQRSTU)
   a) Acute, Subacute, Chronic pain; OUD?
   b) Opioid tolerant or naïve
   c) Opioid responsive pain vs neuropathic/visceral
   d) Pain currently controlled, uncontrolled

2. Determine total daily dose of opioid (OME)
   a) May go straight to oral oxycodone equivalent since more widely used?
3. Determine new agent to use and consult a conversion table, calculator, expert
4. Individualize the dosage based on factors gathered in step 1
5. Follow-up pain assessment

Conversion Types:
Same opioid, but a change in oral dosage formulation

Case 1: AB is an 82 yom on oxycodone tablets 5mg Q4H with well-controlled pain. He can no longer swallow tablets. Convert to an oral solution.

1. Pain assessed and is well controlled
2. Oxycodone total daily dose (TDD)= 30mg oral oxycodone
3. Oxycodone oral solution requested and dose does not require conversion
4. Individualization – route of administration change, but oxy is oxy so no need to change the dose
5. Monitor response

What do you recommend:
- Oxycodone solution 5mg Q4H

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Same opioid, but a change in oral dosage formulation

Case 2: CD is a 72 yof from a LTC facility on morphine tablets 15mg Q4H with well-controlled pain. CD finds it cumbersome to take a medication Q4H. You want to convert to a longer acting morphine product.

What do you recommend:

A. MS Contin 15mg Q12H

B. MS Contin 45mg Q12H

C. MS Contin 30mg Q8H

D. MS Contin 60mg Q4H

Case 2:

1. Pain assessed and is well controlled
2. Morphine total daily dose (TDD)= 90mg oral morphine
3. Long-acting morphine requested and dose does not require conversion
4. Individualization – formulation change (MS Contin usually Q12H or Q8H if end of dose failure), but morphine is morphine so no need to change the total dose
5. Monitor response

Recommendation: MS Contin 45mg Q12H

Case 2: Short-acting/breakthrough

1. Pain assessed and is well controlled
2. Morphine total daily dose (TDD)= 90mg oral morphine so MS Contin 45mg Q12H
3. Each short-acting dose is typically 10-20% of the total long-acting dose
    - 90mg x 10%-20% = (9-18mg per dose)
    - MS IR comes in 15mg tablets
    - MS IR 15mg Q6H PRN + MS Contin 45mg Q12H
4. Individualization – formulation change (MS Contin usually Q12H or Q8H if end of dose failure)
5. Monitor response (PRN doses needed per day, per week)

New opioid, change in route of administration, new formulation

Case 3: EF is a 87 yom with multiple myeloma and diffuse bony mets on MS Contin 60mg Q12H + oral morphine solution 20mg Q4H PRN (taking 3 doses per day).

- Pain is well controlled after ~3 weeks on this regimen, but she has developed troublesome **visual hallucinations**.
- You review her labs and note **serum creatinine of 2.2mg/dL** and note that the adverse effect is likely due to accumulation of morphine metabolites
- You would like to switch to an oxycodone regimen
- What are your next steps?

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EQUIANALGESIC OPIOID CONVERSION TABLES

McPherson Version 1: 2010

Drug	Equianalgesic Doses (mg) Parenteral	Oral
Morphine	10	30
Buprenorphine	0.3	0.4 (sl)
Codeine	100	200
Fentanyl	0.1	NA
Hydrocodone	NA	30
Hydromorphone	1.5	7.5
Meperidine	100	300
Oxycodone	10*	20
Oxymorphone	1	10
Tramadol	100*	120

*Not available in the US

McPherson ML. *Demystifying Opioid Conversion Calculations: A Guide For Effective Dosing*. Amer Soc of Health-Systems Pharm, Bethesda, MD, 2010. Copyright ASHP, 2010. Used with permission. NOTE: Learner is STRONGLY encouraged to access original work to review all caveats and explanations pertaining to this chart.

McPherson Version 2: 2018

Drug	Parenteral	Oral
Morphine	10	25
Codeine	100	200
Fentanyl	0.15	NA
Hydrocodone	NA	25
Hydromorphone	2	5
Meperidine	100	300
Methadone	See Chapter 6.	
Oxycodone	10*	20
Oxymorphone	1	10
Tapentadol	NA	100
Tramadol	100*	120

Data Source(s)

- Postop pain, low doses, opioid naïve patients (wisdom tooth extraction, bunionectomy); single dose studies
- Chronic cancer pain, single dose studies
  - Chart review patients w/ opioid rotation
- "Newer" steady-state cross-over trials
  - Stable patients on an opioid, and switched

Main updates based on *Dr Reddy et al.*

- Hospitalized cancer patients from IV hydromorphone to PO morphine, PO hydromorphone, & PO oxycodone
- ***Bidirectionality***
  - IV hydromorphone to PO's = more conservative
  - PO to IV hydromorphone = more aggressive

Case 3

- Calculate TDD of morphine regimen
  - TDD MS Contin= 60mg x2 = 120mg
  - TDD morphine solution= 20mg x3 = 60mg

= 180mg morphine TDD

- Convert between morphine and oxycodone

$$\frac{\text{TDD current opioid} \times \text{Equianalgesic Factor of the opioid I'm converting to}}{\text{Equianalgesic Factor current opioid}} =$$

V1: 180mg oral morphine x (20 / 30) = 120 mg TDD PO oxycodone

V2: 180mg oral morphine x (20 / 25) = 144 mg TDD PO oxycodone

- New opioid and pain controlled (changing d/t ADE) so must reduce for **incomplete cross tolerance**
  - tolerance to one opioid may only partially extend clinically to another (0-50%)

Case 3

V1: 180mg oral morphine x (20 / 30) = 120 mg TDD PO oxycodone

- Reduce by 25-50% = 60-90 mg PO oxycodone daily
- LA should cover calculated daily opioid need (60-90mg); let's use Oxycontin 40mg Q12H
- SA should cover breakthrough pain; typically, 10-20% of total LA dose
  - 8-16 mg and is dosed Q4-6H PRN commonly; let's use oxycodone 10mg Q4-6H PRN

V2: 180mg oral morphine x (20 / 25) = 144 mg TDD PO oxycodone

- Reduce by 25-50% = 72-108 mg PO oxycodone daily
- LA should cover calculated daily opioid need (72-108mg); let's use Oxycontin 40mg Q12H
- SA should cover breakthrough pain; should be 10-20% of total LA dose
  - 8-16 mg and is dosed Q4-6H PRN commonly; let's use oxycodone 10mg Q4-6H PRN

Conversion Types:
New opioid, change in route of administration, new formulation

Case 4: IJ is a 79 yom with a head and neck cancer who is now unable to swallow tablets or solution.

- Pain is well controlled on his home regimen includes MS Contin 30mg Q8H + oxycodone 10 mg Q4H PRN (taking 5 doses per day)
- The provider would like to switch to a transdermal fentanyl (TDF)

- What do you need to consider?
    - Opioid tolerance, body habitus, fevers, pain control

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Case 4

Calculate TDD in oral morphine equivalents (OME)

- MS Contin 30mg Q8H = __ OME
  - 90 OME
- Oxycodone 10mg Q4H PRN (takes 5 doses/day) = __ OME
  - 50mg oxy x (25/20) = 62.5 OME
- TDD = __ OME
  - 152.5 OME
- **Generally give 50% of TDD oral morphine as TDF dose**
- TDF strengths: 12, 25, 50, 75, 100
- Recommendation:
  - TDF 75 mcg/hr Q72Hours

- Considerations? Timing?

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New opioid, change in route of administration, new formulation

Case 5: KL is a 64 yof with chronic cervical and lumbar back pain that responds to Percocet 5mg/325mg Q6H (if remembers to take all doses) otherwise pain becomes severe and debilitating to ADLs. She is concerned about opioids as she ages.

- You read somewhere about transdermal buprenorphine (Butrans; DEA schedule III) as an option for moderate-severe chronic pain in patients requiring ATC opioids (OA, LBP)

- You read that TD-buprenorphine may have advantages over TDF
  - Lower abuse potential, ceiling effect on many classic opioid side effects, less dangerous in an overdose, fewer withdrawal symptoms upon discontinuation
- You refresh yourself on some TD-buprenorphine pearls…

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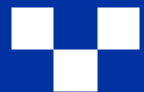
Case 5: Butrans

- Patch is to be worn for 7 days
- Application sites: upper outer arm, upper chest, upper back or side of chest
- Do not reuse site for 21 days
- Butrans strengths: 5 mcg/hr, 7.5, 10, 15, 20
- You also find another buprenorphine product indicated for chronic pain, buprenorphine buccal film; Belbuca
- You find a conversion table

Case 6: Butrans

- KL uses a 64 yof Percocet 5mg/325mg Q6H = oxycodone 20mg = 25 -30 OME

Buprenorphine	Oral Morphine Equivalent/24hrs (OME)								
	7	15	30	48	60	80	100	120	300
Transdermal (TD) patch	5mcg/hr q7days		10mcg/hr q7days	20mcg/hr q7days					
Buccal patch	75mcg daily	150mcg q12hrs	300mcg q12hrs	450mcg q12hrs	600mcg q12hrs	750mcg q12hrs		900mcg q12hrs	
Sublingual (SL) tabs						1mg BID (split 2mg tabs)		1mg TID	2mg TID



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ESTABLISHING A FRAMEWORK FOR DISCUSSING SUBSTANCE USE WITH PATIENTS

- Remove stigma
- Utilize motivational interviewing
- Build trust and show empathy

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

STIGMA

- **Where does it come from?**
    - Fear, negative attitudes, personal beliefs, lack of understanding
    - Embedded in culture, laws, systems, institutional practices, etc.
- **Why does it matter? Research shows:**
    - Stigma prevents us from ***offering*** help to people who need it
    - Stigma prevents people from ***asking*** for help
- **Who is affected?**
    - When I ***stigmatize***, I create a negative professional and social environment
    - When I ***experience stigma***, I don't ask for or receive the help I need
- **SUD-related stigma**
    - 75% of the public doesn't believe SUD is a chronic medical illness
    - ~50% believe SUD is caused by bad character or lack of moral strength
    - Healthcare providers have similar levels of stigma
        - Negative attitudes among providers worsen outcomes be decreasing engagement in treatment

Shatterproof Addiction Stigma Index. 2021. https://www.shatterproof.org/node/29116.
van Boekel L, et al. *J Drug and Alcohol Dependence.* 2013;131:23-35.
Wakeman S, et al. *Subst Abus.* 2016;37(4):635-641.

STIGMA ABOUT OUD

- **Stigmatizing assumption**: patients with OUD just want to "get high" or lack the will power to stop using
- **Scientific understanding**: OUD is a chronic, relapsing disease with relapse rates comparable to other chronic conditions

Substance Use Disorders	Hypertension	Asthma	Diabetes
40-60%	50-70%	50-70%	30-50%

McLellan A, et al. *JAMA*. 2000;284(13):1689-1695.
National Academies of Sciences, Engineering and Medicine. 2019.
NIDA. Treatment and Recovery. National Institute on Drug Abuse. 2023.

COMBATING STIGMA: LANGUAGE MATTERS

Choose language that:

- ★ Is person-first
- ★ Avoids negative connotations
- ★ Reflects a science-based understanding of SUD

Stigmatizing Term	Medical Term
Abuse (non-prescribed drugs)	Use
Abuse (prescribed drugs)	Misuse; use other than prescribed
Addict/Junkie/Drug abuser	Person with ________ use disorder
Clean	Abstinent; In recovery; In remission
Clean/Dirty Urine	Testing negative/positive; Detected/not detected
IV drug user	Person with injection use
High	Intoxicated
Medication-assisted treatment (MAT)	Medications for Opioid Use Disorder

NIDA. *Words Matter Terms to Use and Avoid When Talking About Addiction.* 2021.

- **Stigmatizing assumption**: medications like methadone and buprenorphine don't work; they're just a substitute for non-prescribed opioids
- **Scientific understanding**: MOUD stabilizes brain chemistry, blocks the euphoric effects of opioids, relieves physiologic cravings, and improves physical and mental health

Larochelle M, et al. *Ann Intern Med.* 2018;169(3):137-45.
Sordo L, et al. *BMJ.* 2017;357:j1550.
National Academies of Sciences, Engineering and Medicine. 2019.

- Treatment of OUD with methadone or buprenorphine **substantially reduces risk of both all-cause and overdose-related mortality**
- MOUD also associated with:
  - Lower rates of other opioid use
  - Improved social functioning
  - Decreased injection drug use
  - Reduced risk of HIV transmission/HCV infection
  - Improved quality of life
- **Unnecessary disruptions in treatment should be avoided given considerable risk**
- **All patients with untreated OUD should be offered a medication for OUD**

Larochelle M, et al. *Ann Intern Med.* 2018;169(3):137-45.
Sordo L, et al. *BMJ.* 2017;357:j1550.

PRINCIPLES OF ACUTE PAIN MANAGEMENT IN PATIENTS WITH OUD

Maximize non-opioid, adjuvant, and non-pharmacologic therapies

- Consider etiology and pain types involved

Start/continue a medication for OUD

- Consider increasing the dose and/or frequency to support pain control

If pain is severe, add short-acting opioids

- Expect higher dose requirements
- Identify and target particularly painful activities or procedures
- Consider follow-up/post-discharge ramifications

ASAM National Practice Guidelines for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med.* 2020; 14(3): 267.

METHADONE AND BUPRENORPHINE DOSING STRATEGIES FOR OUD VS. PAIN

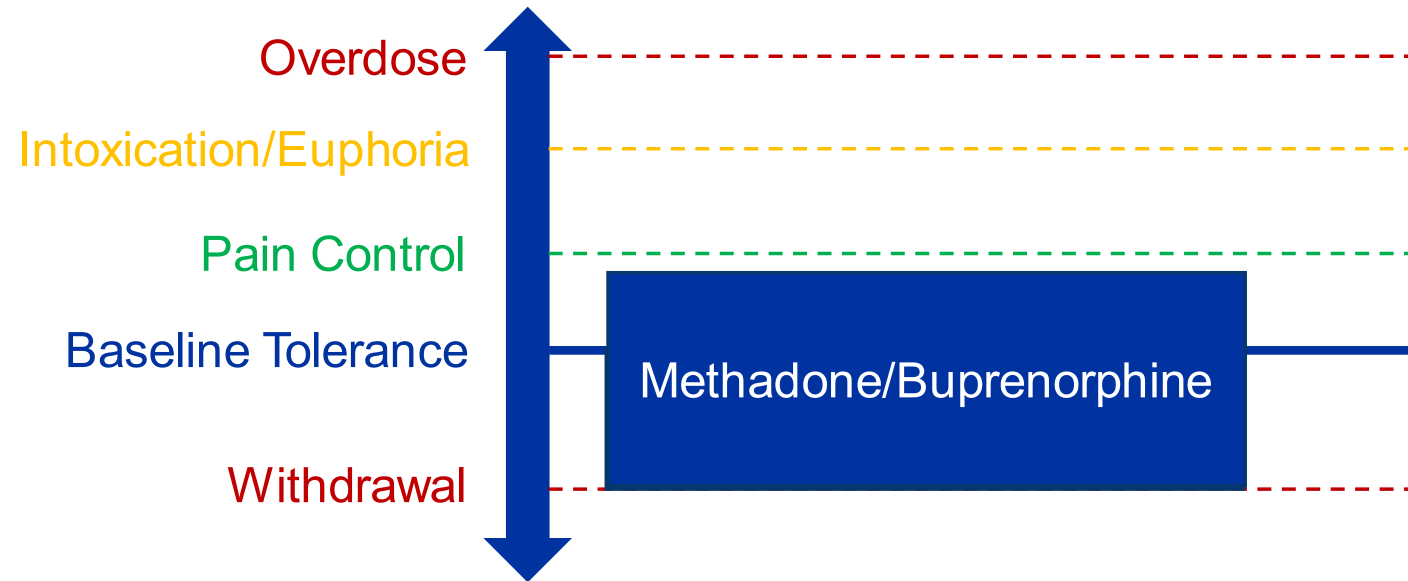
At minimum, home dose of methadone or buprenorphine should be continued to avoid emergence of opioid withdrawal

When treating OUD, buprenorphine and methadone protect against withdrawal symptoms and cravings for ~24 hours and are typically dosed every 24 hours

Increasing the dose and/or frequency of methadone or buprenorphine may be effective for managing acute pain

When treating **acute pain,** buprenorphine and methadone must be dosed more frequently to provide adequate analgesic effect

- Buprenorphine: every 6-8 hours
- Methadone: every 8-12 hours



ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med.* 2020;14(3):267.

MOTIVATIONAL INTERVIEWING

- **A patient-centered, collaborative conversation style intended to strengthen someone's motivation and commitment to change and willingness to accept treatment**
- **Benefits include:**
    - Patients recognize their autonomy in choosing their own path to recovery
    - Clinicians support patients to make meaningful changes to reach a mutually agreed upon goal
    - Clinicians validate their patients' internal and external barriers for change and assist them in helping their patient overcome those barriers to pursue treatment

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

- **Principles of motivational interviewing**
  - Express empathy through reflective listening
  - Explore the discrepancy between patient's goals or values and their current behavior
  - Avoid argument and direct confrontation
  - Adjust to patient resistance rather than opposing it directly
  - Support self-efficacy and optimism
- **Elicit change talk**
  - Desire: "Why would you want to make this change?"
  - Ability: "How would you do it if you decided?"
  - Reasons: "What are the reasons for change?"
  - Need: "How important is it? And why?"
  - Commitment: "What do you plan to do?"

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

- **Ask permission and provide options**
  - Let them know you care about them and want to partner with them in helping them seek treatment
  - Reassure them that they have the option of not answering a question if it makes them uncomfortable

Example of how to start the conversation

"Would it be alright with you if I asked you some questions about substance use?"

- **Normalize the conversation**
    - Tell your patient that any discomfort they are feeling is normal and that they are not alone

Examples of how to normalize the conversation

"This is not unusual. Many patients find it hard to talk about their substance use..."

"Talking about substance use can be uncomfortable."

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

- **Be transparent**
  - Explain that is important for you to ask specific questions because it is relevant to their treatment

Example of how to be transparent

"I need to ask about how much [opioid] you are using and how often to better understand your opioid tolerance to help guide treatment."

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

- **Work collaboratively with patients**
  - Remind your patient that recovery is possible and that paths to recovery look different for different people.

Example of how to work collaboratively

"It sounds like you found quite a bit of benefit from buprenorphine and had a period of abstinence while taking it, but that life got in the way, and you were not able to pick up your prescription that led to return to use. What are your thoughts about restarting buprenorphine? We could even think about an injectable form that only has to be given once a month."

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

- **Address confidentiality concerns honestly**
  - Let patients know that you respect their confidentiality and will comply with the protections provided by law for patients.
  - Tell patients of any limited instances when you are required by law to report threat of harm to self or others

Example of how to address confidentiality

"I want you to know that everything you share with me is confidential However, there are some limited exceptions under Kentucky law that require me to report threats of harm to self or others and I want to make sure you are aware that is intended to keep you healthy and safe."

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

- **Establish trust and show empathy**
  - Actively listen to your patient
  - Engage in a non-judgmental way
  - Treat your patient with respect and address their substance use disorder as the medical disease that it is
  - Help your patient understand that you intend to connect them comprehensive treatment services and that recovery is possible

Example of how to establish trust and show empathy

"I appreciate you sharing that information about your opioid use with me. What I have heard you say is that initially opioids helped with pain, but more recently it has caused more problems, and you are looking for help to get connected with treatment. Let's take a look at different options that are available and identify one that fits your goals."

CDC. Training: Effective Communication in Treating Substance Use Disorders. 2023.
Rastegar D & Fingerhood M. ASAM Handbook of Addiction Medicine. 2nd Edition. 2020.

CASE

- Joan is a 42-year-old female following up with you, her established primary care provider. Her past medical history is notable for cervical cancer that was effectively treated surgically and with chemoradiation. She has no evidence of disease for 2 years and her oncologist has been prescribing opioids for cancer-related pain but has asked that you take over her pain management as she will now only be following with oncology for surveillance. She is accompanied today by her husband.

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- You are precepting a medical student who has just seen the patient and presents the following relevant background information:
    - Frequent ED visits for exacerbated pain and withdrawal as patient runs out of medications early
    - Two calls in the last 6 months requesting new prescription due to opioids being stolen, no police reports filed
    - Oncologist tried tapering her regimen a few months ago and Joan did not tolerate it. She reported she didn't feel well, was in severe pain, and was adamant she needed opioids. At another visit, a slower taper plan was proposed and she became very anxious and refused to try tapering again.

CASE

Medical student: I am concerned that the patient might be an addict and is abusing her opioids.

How do you respond?

CASE

Physician: I have some concerns as well. I also want to take a moment to discuss the importance of language that we use when we talk about addiction. It's important to use person-first language, like **"person with an opioid use disorder"** instead of **"addict."** The change shows that a person "has" a problem, rather than "is" the problem and avoids negative associations, punitive attitudes, and individual blame. Similarly, swapping **"misuse"** or **"used other than prescribed"** for **"abuse"** avoids the association with negative judgment and punishment. Of all medical conditions, addiction has the highest rate of healthcare stigma and bias which profoundly impacts patient care and treatment retention. Let's discuss this a bit more later."

NIDA. *Words Matter Terms to Use and Avoid When Talking About Addiction.* 2021.

- During the appointment, the pain assessment reveals:
    - Over the past few months, Joan has self-escalated her dose and runs out of her medication prior to the expected timeframe
    - Reports a negative impact on her life – she has missed many days of work and is at risk of losing her job. She no longer attends her children's sports activities because she "needs more oxycodone"
    - Describes her need for opioids to help make life bearable
    - Her husband notes that recently his mother and a family friend had opioids taken from their medicine cabinets after the couple had visited and is concerned that Joan took them. At first, Joan looks surprised and angry, but after her husband expresses his concern and hope for help for Joan, she doesn't deny the allegation and looks down sadly.

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CONCERN FOR OUD

4 Diagnostic "Buckets"
(12-month period)

Impaired Control	Social Impairment	Risky Use	Withdrawal & Tolerance*
Opioids taken in larger amounts or over a longer period than was intended	Recurrent opioid use resulting in a failure to fulfill obligations at work, school, or home	Recurrent opioid use in situations which it is physically hazardous	Exhibits withdrawal
Persistent desire or unsuccessful efforts to cut down or control use	Continued opioid use despite persistent/recurrent social or interpersonal problems	Continued use despite knowledge of physical or psychological problems caused or exacerbated by opioids	Exhibits tolerance
Great deal of time spent in activities to obtain, use, or recover from effects	Important social, occupational, or recreational activities are given up or reduced due to opioid use		
Craving or strong desire/urge to use opioids			

*Not considered to be met for those individuals taking solely under appropriate medical supervision

American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 5th edn. Arlington, VA: American Psychiatric Association DSM-5; 2013.

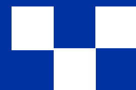
- We have diagnosed Joan with opioid use disorder based on DSM-V criteria.

How do you discuss the diagnosis with Joan?

- **Physician**: Sometimes people become too comfortable with medications and start to take them for reasons other than pain. Continuing the current medication is not a reasonable option due to the risks, but there are options for treating we call opioid use disorder, or OUD. I understand you have been struggling and know that discussing change can be distressing. My primary motivation is to provide care that leads to the healthiest version of "you" in the long term. Getting help for this is like getting help for any other chronic medical problem. I want to have the best possible care, and this difficult but productive conversation is a first step for us. We will work together to find a treatment plan that works best for you."

- After discussion of treatment options with Joan and her husband, Joan decides to pursue office-based opioid treatment with buprenorphine/naloxone. You also provide her with a prescription for intranasal naloxone and education for use. She credits the trusting, empathetic relationship you have established with her as an important factor in her decision to pursue treatment for her OUD.

SAMHSA. *Buprenorphine Quick Start Guide.* Updated March 2024.



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