

Presenting Faculty

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- Shalini Shah, MD
- · Santhanam Suresh, MD
- · Kevin Vorenkamp, MD



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Faculty Disclosures

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- Shalini Shah, MD, has disclosed funded research with Pfizer
- Santhanam Suresh, MD, has disclosed consulting fees with Pacira
- James Rathmell, MD, and Kevin Vorenkamp, MD, have reported no relevant financial relationships with commercial interests



Learning Objectives

- 1 Summarize key concepts and practices in managing pain and preventing opioid misuse, abuse, and addiction
- Assess patients with pain to inform treatment planning, monitor treatment response, ensure safe use when opioid analgesics are appropriate, and detect opioid abuse or addiction
- 3 Develop individualized pain treatment plans, including nonpharmacologic and/or pharmacologic (non-opioid and opioid analgesics) as appropriate
- pharmacologic (non-opioid and opioid analgesics) as appropriate
 dlentify strategies to safely and effectively initiate, modify, and discontinue use of
 opioid analgesics
- Manage patients with opioid use disorder, or identify patients requiring referral to a specialist in addiction medicine



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Exit Tickets

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At the end of each section, you will be asked to complete one of the multicolored exit tickets located in your packet of handouts.



Once you complete an exit ticket, please pass it to your **right** and it will be collected.



How to Use Your Phone to Answer Polling Questions

FIRST start a new text message to this number: 22333

THEN type a message that says TFF3 and hit Send

You're ready to go!
Simply text A, B, C...to answer when you see a question slide pop up

ASA PAIN:
Anesthesiologists Tailored Approach to
Patient Safety Considerations When Using Opioid Analgesics

Let's test it!



TEST: How many cups of coffee did you have this morning? 1 2 3 4+

Based on the FDA's Risk Evaluation and Mitigation Strategies (REMS) ASA PAIN: Anesthesiologists' Tailored Approach to Patient Safety Considerations When Using Opioid Analgesics **Basics of Pain Management and** Opioid Use Disorder James Rathmell, MD American Society of Anesthesiologists asahq.org

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Pretest 1. Which of the following BEST describes neuropathic pain? Pain that is self-limited and associated with sympathetic nervous system activation Pain that persists after all tissue healing is Severe pain reported in response to a normally mildly painful stimulus (eg, a pin prick) Pain reported directly in an area of recent tissue injury (eg, pain at the site of a new surgical incision)

Pretest 2. Which term is defined by "impaired control over drug use, compulsive use, continued use despite harm, and/or craving"?

Physical dependence Addiction Misuse Abuse **Scope of the Problem**

NCHS 2017

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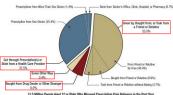
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- >70,000 drug overdose deaths
- 47.600 of the deaths involved opioids—a 45% increase from 2016
- On average,130 deaths per day from overdoses involving opioids
- NSDUH 2016
 - ~11.5 million Americans aged ≥12 years misused prescription pain relievers, most often hydroxycodone, oxycodone, and codeine products
 ~2.1 million Americans aged ≥12 years had OUD

ASA" PAIN:

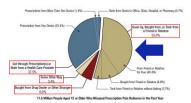
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Source of Prescription Pain Relievers in the Past Year: 2016





Source of Prescription Pain Relievers in the Past Year: 2016



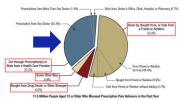


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Source of Prescription Pain Relievers in the Past Year: 2016

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Why Comprehensive Pain Education Is Needed

- Understanding risks associated with opioids provides opportunities to consider all pain management options
 - Nonpharmacologic
 - Pharmacologic: non-opioid and opioid
 - $\succ {\sf Consider\ opioids\ only\ when\ non-opioid\ options\ are\ inadequate\ and\ benefits\ outweigh\ risks}$
- Knowledge of the risks of opioid misuse and abuse can inform development of patient counseling and other strategies to reduce risks

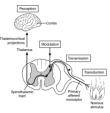


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What is pain? An objective, quantifiable physiologic response A subjective, quantifiable physiologic response A normal protective, physiologic response An abnormal, pathophysiologic response

Biological Significance of Pain

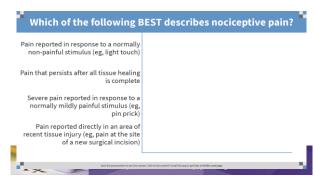


Acute vs Chronic Pain

- Acute pain
 - Provoked by a specific disease or injury
 - Serves a useful biologic purpose
 - Associated with skeletal muscle spasm and sympathetic nervous system activation
 - Self-limited
- Chronic pain
 - Persistent pain that may or may not have a known cause
 - Unhelpful; a disease state



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Nociceptive vs Neuropathic Pain

- Nociceptive pain
 - Adaptive response resulting from suprathreshold stimulation of nociceptors, which are specialized for detection of potentially harmful mechanical, thermal or chemical situations
 - Immediate physical response is reflexive, protective
 - Persists while the injurious agent remains or until healing occurs
 - Prolonged input can cause central hypersensitization and spontaneous or amplified pain

SAMHSA. Managing Chronic Poin in Adults With or in Recovery From Substance Use Disorders. Rockville, MD: Substance Abuse and Mental Health Service:



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Nociceptive vs Neuropathic Pain

- Neuropathic pain
 - Results from lesion in or dysfunction of the sensory nervous system
 - Triggered by
 - ➤ Nerve compression, injury or severance
 - > Disorders affecting the neural axis (eg, metabolic diseases, infections, autoimmune disorders, vascular diseases, neoplasia)

SAMHSA. Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Rockville, MD: Substance Abuse and Mental Health Service

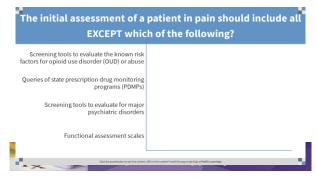


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Neuropathic Pain



Patient Sarety Considerations When Using Opioid Analgesics



Elements of an Initial Assessment of the **Patient With Pain**

- Patient history
- Physical examination
- Pain assessment
- Underlying cause

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- Location Pain level/intensity
- Chronic pain chronic neuropathic pain
- Query to state PDMP*
- Functional assessment • Psychological/social evaluation
- Status/intent regarding pregnancy or breastfeeding
- Diagnostic studies when needed
- Screening for risk of OUD

49 states have operational PDMPs (only Missouri does not). In Missouri, St Louis County offers a PDMP that include particip dictions. At last report 84% of the state population was covered by the PDMP (https://www.stln.iscn.com/Hasaih.aand.Missouri



Tools for Assessing Pain Level

	•	
Tool	Strengths	Weaknesses
Faces Pain Scale	Easy to use Usable in people with mild-to-moderate cognitive impairment Translates across cultures and languages	Visual impairment may affect accuracy or completion May measure pain affect, not just pain intensity
Numeric Rating Scale (NRS)	Easy to administer and score Can measure small changes in pain intensity Sensitive to changes in chronic pain Oral or written administration Translates across cultures and languages	Difficult to administer to patients with cognitive impairment because of difficulty translating pain into numbers
Visual Analog Scale (VAS)	Easy to use but must be presented carefully Precise Sensitive to ethnic differences Easily translates arross outlures and languages Horizontal may work better than vertical ("thermometer") orientation	Visual impairment may affect accuracy Can be time consuming to score, unless mechanical or computerized Low completion rate in patients with cognitive impairment Difficult to use in patients with cognitive impairments Cannot be administered by phone or email Subject to measurement error
Verbal Rating Scale/ Graphic Rating Scale	Easy to use High completion rate in patients with cognitive impairment High completion rate in patients with cognitive impairment Sensitive to change and validated for use with chronic pain Correlates strongly with other tools	Less sensitive than NRS or VAS

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Tools for Assessing Several Dimensions of Pain

Tool	Strengths	Weaknesses
Brief Pain Inventory (BPI)	Short form better for clinical practice Fairly easy to use Useful in different cultures Translated into and validated in several languages	Not easily used with patients with cognitive impairments
McGill Pain Questionnaire	Short form easier to administer Extensively studied	Measures pain affect Not appropriate for patients with cognitive impairment Translation complicated Meaning of pain descriptors may vary across racial and ethnic groups



Tool	Purpose	Resource
Katz Basic Activities of Daily Living Scale	Rates independence by assessing six areas of daily activities	University of Texas School of Nursing at Houston https://clas.uiowa.edu/socialwork/sites/cls.uiowa.edu.socialwork/files/NursingHome Resource/documents/Katz%20ADL_LawtonIADL.pdf
Pain Disability Index	Measures chronic pain and chronic pain interference in daily life	Pain Balance https://www.med.umich.edu/linfo/FHP/p acticeguides/pain/detpdi.pdf
Roland-Morris Disability Questionnaire	Measures perceived disability from low back pain	National Primary Care Research and Development Centre, University of Manchester, UK http://www.rmdq.org
WOMAC Index	Assesses pain, stiffness and physical function in patients with osteoarthritis	http://www.womac.org

Tools for Assessing Function



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Definition of Addiction

- Primary, chronic, neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestations
- Typically characterized by one or more of the "3 C's"
- Impaired <u>control</u> over drug use or compulsive use <u>Continued use</u> despite harm
- Craving



Which of the following is the DSM-5 definition for OUD? A problematic pattern of opioid use leading to clinically significant impairment or distress A problematic pattern of opioid use leading to harm to self or others A problematic pattern of opioid use characterized by daily opioid use A problematic pattern of opioid use characterized by intermittent symptoms of withdrawal

Opioid Use Disorder

- DSM-5 definition: a problematic pattern of opioid use leading to clinically significant impairment or distress
- Previously classified as opioid abuse or opioid dependence (DSM-IV)
- Also referred to as opioid addiction

Center for Disease Control. Module 5: Assessing and Addressing Opioid Use Disorder (OUD). CDC website. https://www.cdc.govidrugowerdose/training/oud/accessible/index.html. American Psychiatric Association. Diagnostic and Statiscian Manual of Mental Disorders. Sift ed. Washington, DC: American Psychiatri



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Neurobiology of OUD: Initial Changes

- Heroin and prescription opioids act primarily as μ -opioid receptor agonists with a relatively short duration of action
- Activation of the dopaminergic mesocortical, mesolimbic, and nigrostriatal systems appears to be a common neurobiological consequence of exposure to drugs of abuse





Changes After Initial Exposure

Activation in the dopaminergic mesocortical, mesolimbic, and nigrostriatal

Short-term regulatory changes at the mRNA or protein/peptide level in major neurotransmitter and neuropeptide systems

Long-term regulatory changes at the mRNA or protein/peptide level in major neurotransmitter and neuropeptide systems

Loss of neurotransmitters that mediate the ability to resist temptation

• Short- and long-term regulatory changes occur in major neurotransmitter and neuropeptide systems at the mRNA or protein level

OUD is a chronic, relapsing disease characterized by all

EXCEPT which of the following?

 Long-term regulatory changes persist even after prolonged drug-free periods and may underlie the chronic relapsing nature of addictive diseases



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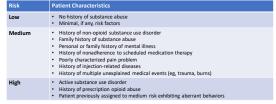
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Changes After Initial Exposure (Continued)

- Chronic exposure to drugs of abuse upregulates the K opioid receptor-dynorphin system
 - Thought to be the basis of aversion, dysphoria/anhedonia, and depression-like or anxiety-like neuropsychiatric states
 - May mediate negative reinforcement aspects of withdrawal
 - May exacerbate chronic relapsing nature of addictive diseases



Risk of Developing OUD



SAMHSA. Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Rockville, MD: Substance Abuse



Tools for Screening for OUD Risk

- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)
- CRAFFT Screening Interview (for adolescents)



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Opioid Risk Tool (ORT)

- Can be administered and scored in < 1 minute
- Validated in both male and female patients (but not in nonpain populations)

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

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Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-

- Validated in chronic pain patients
- < 10 minutes to complete
- Simple to score





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CRAFFT Screening Interview

- Developed specifically for use among adolescent medical patients¹
- Validated in patients ages 14-18 years seeking routine health care² (and in other adolescent populations)2
- Most thoroughly studied substance abuse screen for adolescents³

g: Each "ves" response in Part B scores 1 point. A total score of ≥ 2

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Diagnosing OUD: DSM-5 Criteria

Check all that apply	Criteria (within a 12-month period)
	Opioids are 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 opioid use
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects
	Craving or a strong desire or urge to use opioids.
	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
	Important social, occupational or recreational activities are given up or reduced because of opioid use
	Recurrent opioid use in situations in which it is physically hazardous
	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
	Exhibits tolerance*
	Exhibits withdrawa!*
Total checked:	D is diagnosed ≥ 2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe ≥ 6 criteria met).

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Diagnosing OUD: Definitions

Tolerance
- A need for markedly increased amounts of opioids to achieve intoxication or desired effect A markedly diminished effect with continued use of the same amount of an opioid

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Withdrawal

• Criterion A: Either of the following: 1) Cessation of (or reduction in) opioid use that has been heavy
and prolonged (several weeks or longer), or 2) administration of an opioid antagonist after a period
of opioid use

Criterion B: Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; naused or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloperection or sweating; diarrhea; yawning; fever; or insomala

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Answer each question as honestly as possible. There are no right or wrong answers. Respond to each question as: 0 = never, 1 = seldom; 2 = sometimes; 3 = often; 4 = very often

In the past 30 days...

- ow often have you had trouble with thinking clearly or had memory
- a apointments)

 wo vitem have you had to go to someone other than your prescribing hysician to get sufficient pain relief from medications? (ie, another octor, the emergency room, friends, street sources)

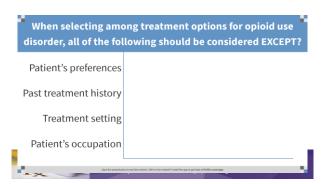
 tow often have you taken your medications differently from how they

- else?

 10. How often have you been worried about how you're handling your
- 10. In worker have you been worked about how you're handling you medications?
 11. How often have others been worried about how you're handling your medications?
 12. How often have you had to make an emergency phone call or show up at the clinic without an appointment?

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Interventions for OUD

- · Methadone, buprenorphine, naltrexone
- \bullet Setting is as important as drug selection: office-based opioid treatment vs. inpatient opioid treatment program
- Office-based opioid treatment (medication provided on a prescribed weekly or monthly basis) is limited to buprenorphine
- Psychosocial intervention is a critical component of opioid treatment programs
- Referral to a specialist in addiction medicine may be necessary

order: For Healthcare and Addiction Professionals Policymakers Patients and Families (Internet



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Conclusions: Key Takeaways

- Pain is a normal, physiologic, protective response to acute injury
- Pain may be acute or chronic, nociceptive and/or neuropathic
- Initial assessment of a patient in pain should include determination of the underlying cause and assessment of pain location and severity
- Consideration of opioids for the treatment of pain should take into account risk for developing OUD
- Screening tools to identify and monitor patients at risk for OUD are available and simple to use
 OUD is a disease with a well-identified underlying neurobiology
- Management of OUD must be tailored to each patient's needs, with careful selection of setting and medication for withdrawal management
- Multiple factors, including patient history, preferences and compliance, should be considered when deciding whether to refer to an addiction specialist



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Please complete your exit ticket...

...and pass it to the RIGHT





ASA" PAIN:



Break - see you in 30-min!





Pretest 3. Which of the following is the BEST reason for educating patients about never breaking, chewing, or crushing an oral long-acting or extended-release opioid? It will increase first pass liver metabolism, leading to lower blood levels It is required by FDA labeling It increases the potential for abuse It may lead to rapid release of the opioid

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Steps in Creating an Effective Pain Treatment Plan

- · Establish goals of treatment
 - Discuss degree of pain relief
- Discuss functional improvement
- Plan for periodic review of treatment goals
- · Consider nonpharmacologic interventions • Consider pharmacologic interventions, when appropriate
- · When prescribing opioids, establish prescriber and patient responsibilities and
- use of patient provider agreements (PPAs)

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Choosing Treatments Nonpharmacologic Interventions

- Psychological interventions
 - Preoperative education/expectation setting
 Guided imagery

 - Progressive relaxation
- Physical modalities
 - Physical therapy/occupational therapy
 Ice/heat/elevation/positioning
- Surgical interventions
- Medical device interventions
- Perineural electrical stimulation devices
- Complementary/alternative interventions

 - AcupunctureMassage
 - Reiki



Choosing Treatments: Non-opioid Analgesics*

- Acetaminophen (APAP)
- Nonsteroidal anti-inflammatory drugs (NSAIDs), eg, aspirin, celecoxib, ibuprofen, indomethacin, ketorolac, naproxen
- Drugs for treating neuropathic pain
 - Anticonvulsants, eg, carbamazepine, gabapentin, lamotrigine, valproate
 Antidepressants, eg, tricyclics (eg, imipramine, nortryptaline) and SNRIs (eg, venloxifine, duloxetine)



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Choosing Treatments: Non-opioid Analgesics*

- · Oral corticosteroids: prednisone, dexamethasone

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- Topical agents
 NSAIDs, eg, diclofenac

 - Corticosteroids, eg, betamethasone, hydrocortisone, triamcinolone
 Local anesthetics/nerve block agents, eg, benzocaine, lidocaine, bupivicaine

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When Should Opioid Treatment Be Considered?

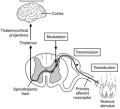
- For acute pain or trauma if non-opioid analgesics are insufficient, ineffective, or contraindicated
- $\bullet\,$ For chronic pain if all other pharmacologic and nonpharmacologic approaches have failed or there are medical contraindications to non-opioid analgesics
- For pain related to cancer or other advanced illnesses in those near end-of-life



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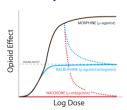
Opioid Analgesics: Mechanisms in Pain Relief

- Bind μ-opioid receptors in the periaqueductal gray region and the rostroventral medulla of the brain
- Increase descending inhibitory signals that modulate incoming pain signals



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Comparative Efficacy



American Society of Anesthesiologists

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Available Opioid Medications (Examples)

- Buprenorphine
- Buccal film (Belbuca) - Transdermal system (Butrans)
- · Fentanyl transdermal system* (Duragesic)
- Hydrocodone bitartrate
 - ER tablets (Hysingla†) - ER capsules (Zohydro)
- · Hydromorphone HCl
- ER tablets (Exalgo)
- Methadone HCl - Tablets (Dolophine)
 - Oral concentrate*
- Oral solution*

- CR tablets (MS Contin)
 ER tablets* (Arymo[†], MorphaBond[†])
 ER capsules* (Avinza, Kadian)
 - Morphine sulfate/naltrexone (Embeda†)
 - Oxycodone - CR tablets (OxvContin[†])*
 - ER capsules (Xtampza[†])
 - Oxymorphone HCl ER tablets (Opana)
 - Tramadol,* tramadol ER* (Ultram, Ultram ER, Conzip)

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Opioid Drug Interactions

Drug or Substance	Possible Effect	Examples
CNS suppressants	 Potentiation of opioid-induced sedation and respiratory depression 	Alcohol Benzodiazepines
Monoamine oxidase inhibitors	Increase in respiratory depression Serotonin syndrome	Selegiline Isocarboxazid
Diuretics	 Reduction in diuretic efficacy via induction of antidiuretic hormone 	Furosemide Hydrochlorothizide Spironolactone
Cytochrome P450 inhibitors/inducers	Increase or decrease in systemic opioid levels	Antiretroviral agents Clarithromycin Amiodarone Carbamazepine
Selective serotonin reuptake inhibitors (SSRIs)	 Suppress CYP-2D6 metabolism of prodrug opioids (eg, hydrocodone), rendering them less effective in reducing pain 	Citalopram Fluoxetine Paroxetine Sertraline

Long-Acting Opioids: Special Concerns

- Greater risk than short-acting opioids for overdose and abuse
- Oral tablets/capsules should not be broken, crushed, chewed or snorted; patches should not be cut or torn prior to use
 - May lead to rapid release and overdose/death

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• If patient cannot swallow a capsule whole, refer to PI to determine if the contents can be sprinkled on applesauce or given via feeding tube



Faculty Discussion

 Are abuse deterrent opioid formulations (ADFs) really abuse deterrent?



02

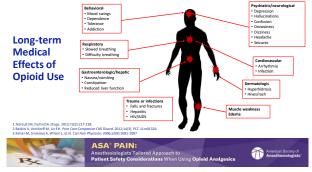
Opioid Analgesics: General Precautions^{1,2}

- Common side effects of opioids: sedation, dizziness, nausea, vomiting, constipation, respiratory depression, physical dependence, tolerance, withdrawal
- Risks of misuse, abuse, opioid use disorder (OUD), overdose, death even at prescribed doses
- Consult prescription drug monitoring program (PDMP) before deciding to prescribe opioids
- Consider OUD criteria (DSM-5) and concepts of abuse vs. misuse
- Consider concepts of tolerance vs physiological dependence vs OUD (addiction)
- Prolonged use/OUD has a direct relationship to duration of initial prescription³

Dowell D, Haegerich TM, Chou R. MMWR Recomm Rep. 2016;65(1):1-49.
 Manchikanti L, Kaye AM, Knezevic NN, et al. Poin Physician. 2017;20(25):S3-592



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Faculty Discussion

Opioid Pain Management – Considerations for Special Populations

- Possible pregnancy/pregnancy/post-partum
- Patients with renal or hepatic impairment
- Children and adolescents
- Older adults

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- Patients with sleep disorders
- Patients with psychiatric disorders
- Opioid-tolerant patients





Before Initiating Opioid Therapy

- Perform a comprehensive assessment and document it
- Establish an appropriate physical diagnosis (and obtain psychological diagnosis, if available). Consider imaging, physical diagnosis and psychological status, as appropriate, to corroborate subjective complaints
- Establish medical necessity based on average moderate to severe pain (≥ 4 on a scale of 0 10) and/or disability



Before Initiating Opioid Therapy

- Check the PDMP
- Consider baseline and periodic urine drug testing (UDT)
- Establish treatment goals including pain relief and improvement in function
- Educate patients and caregiver on efficacy and risks/adverse events)
- Obtain a robust opioid agreement to be followed by all parties (clinician-patient-caregiver)



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Initiating Opioid Treatment

- Start with short-acting drugs
 - Short course (3 7 days) for acute pain
- Recommend long-acting or high-dose opioids only in specific circumstances with severe intractable pain
- Prescribe the lowest effective dose
 - Low dose: ≤ 40 MME - Moderate dose: 41 - 90 MME
 - High dose: > 91 MME
- Titrate gradually to achieve best efficacy with few or no side effects
- Evaluate benefits and harms within 1 4 weeks of opioid initiation or dose escalation
- Re-evaluate benefits and harms every 3 months - If benefits do not outweigh harms, optimize other pain therapies and taper/ discontinue



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Key Safety Strategies

- Dosing instructions (with daily maximum)
- Concurrent drug or alcohol use
- · Age-related dose reductions
- · Naloxone products for home use
- Safe storage: inaccessible by children, friends, family members
- Intervention strategies for accidental poisoning vs. overdose (intentional harm vs. recreational use)
- Proper disposal

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Naloxone Guidance

- Clinicians should co-prescribe naloxone to individuals at risk for opioid overdose, including but not limited to:
 - Those on relatively high doses of opioids
 - Those who take other medications that enhance opioid complications
 - Those with underlying health conditions



How to give naloxone:





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DSM-5 Criteria for OUD

Check all that apply	Criteria (within a 12-month period)
	Opioids are 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 opioid use
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects
	Craving, a strong desire or urge to use opioids.
	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
	Important social, occupational or recreational activities are given up or reduced because of opioid use
	Recurrent opioid use in situations in which it is physically hazardous
	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
	Exhibits tolerance*
	Exhibits withdrawal*
Total checked:	D is diagnosed ≥ 2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe ≥ 6 criteria met).

ASA" PAIN:

Based on the FDA's Risk Evaluation and Mitigation Strategies (REMS) ASA PAIN: Anesthesiologists' Tailored Approach to Patient Safety Considerations When Using Opioid Analgesics Creating the Pain Treatment Plan: Case Review American Society of Anesthesiologists asahq.org

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2 min timer

PBL Instructions

Case 1: Elise

• A 26-year-old female presents in the ED with a distal left radius fracture after a fall. The fracture is nondisplaced and a cast is placed.

• What is your pain treatment plan?







2 min timer

Case 2: Ron

- 56-year-old male, hospitalized with rib fractures sustained in a motor vehicle accident.
- What is your pain treatment plan?





Conclusions / Key Takeaways

- Many minor, acute pain conditions can be successfully managed with nonpharmacologic and/or non-opioid pharmacologic approaches
- $\bullet\,$ Opioids remain useful tools when acute pain is not responsive to other therapies, but should be used when indicated for the shortest period of time necessary
- $\bullet\,$ Opioids can be used to manage chronic pain that is not responsive to other therapies or when other therapies are contraindicated
- All opioids have side effects that range from constipation to respiratory depression and
- Increased risk for long-term use of opioids is directly related to the duration of the initial prescription



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Please complete your exit ticket...



...and pass it to the RIGHT





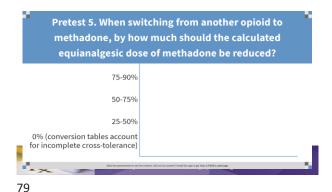
ASA PAIN:

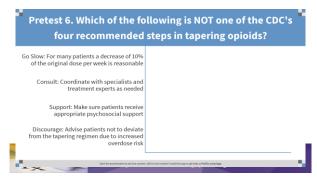


Based on the FDA's Risk Evaluation and Mitigation Strategies (REMS) ASA PAIN: Anesthesiologists' Tailored Approach to Patient Safety Considerations When Using Opioid Analgesics **Managing Patients on Opioid Analgesics** Shalini Shah, MD American Society of Anesthesiologists asahq.org

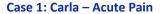
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- 26-year-old female with left radius fracture after a fall
- Initial treatment plan

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- Goal: relief of acute pain + sufficient pain control to permit sleep and normal ADL
- Treatment selection: IV or oral ketorolac in the ED, ketorolac 10 mg PO QID for five days followed by naproxen 375 mg PO BID PRN
- Review efficacy during orthopedic surgery office visit in 2 days for cast evaluation
- Elevate the extremity, consider using intermittent ice for the first 48 hours
- Provide educational material about expected healing process following fracture to reduce anxiety



Case 1: Carla - Current Status

- 2 days post-fracture
- · Patient feedback
 - Moderate to severe pain (7/10) despite ongoing naproxen treatment
 - Difficulty participating in physical therapy
- Physical exam shows swelling, local pain



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What is the best next step? Ensure that the cast is not too tight Recommend adjustments to physical therapy Switch to another NSAID Start a brief (7-day or less) trial of oxycodone + APAP Other

Acute Pain: When Opioid Treatment Is Appropriate (and When It Is Not)

- · Medical necessity of acute pain treatment
 - Allows the patient to meet functional goals of care - Facilitates recovery
- Physical examination consistent with limitation of movement due to pain inadequately controlled with non-opioid options
- Failure or contraindication of non-opioid (eg, regional block, epidural, etc.) and nonpharmacologic options
- General principle: Listen to your patient, follow the examination and exhaust all practical non-opioid approaches first



Guidance for Use of Opioids for Acute Pain

- Check the prescription drug monitoring program (PDMP)
- . Discuss benefits and risks of opioid use with the patient
- Choose from immediate-release opioids
 - Morphine immediate-release
 - Codeine
 - Oxycodone +/- APAP
 - Hydrocodone + APAP
 - Hydromorphone
- Prescribe the lowest effective dose, with no greater quantity than needed for the expected duration of severe pain requiring opioids
- ≤ 3 days is sufficient; > 7 days will rarely be needed



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Case 2: Mr. Coles - Chronic Pain



- Mr. Coles is a 55-year-old male referred by his PCP for chronic rectal pain secondary to Crohn's disease and complicated by several painful surgeries.
- He reports moderate-to-severe (7/10) pain, inability to work effectively as a data manager and pain that awakens him from sleep several times a night. He says he is desperate for any relief.
- · He has tried multiple pain medications over the past year, including naproxen, acetaminophen and gabapentin, without success. His gastroenterologist has maximized his Crohn's disease medications.



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Case 2: Mr. Coles - Chronic Pain (continued)

- Physical examination reveals he is unable to stay in a seated position for even a short time, with constant grimacing.
- As the encounter progresses, the patient becomes tearful and distraught. He reports significant anxiety due to constant pain and poor quality of life.
- The PDMP reveals a remote history of a short course of tramadol, likely



Case 2: Mr. Coles - Considering Opioids for **Chronic Pain**

- · Assessment of the patient's pain, function and quality of life prior to prescribing
- Assess baseline risk of opioid misuse (eg, using SOAPP, ORT or other screening tools)
- Determine if potential benefits of opioid analgesics outweigh potential risks (side effects, misuse, dependence/addiction)



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Opioid Risk Tool (ORT)

- Can be administered and scored in < 1 minute
- · Validated in both male and female patients (but not in non-pain populations)

Mark each box that applies	Pemale	Male
Family history of substance abuse		
Alcohol	1	3
Elegal drugs	2	3
Rodrugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Slegal drugs	4	4
Richigs	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
Francisco babalo		

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



ORT: Mr. Coles' Score = 1

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Hegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Hegal 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, schlzophrenia	2	2
Depression	1	(1)
Scoring totals		

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







 After a detailed conversation with the patient about the risks and benefits of opioid therapy, which would be the MOST appropriate next step?





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Case 2: Mr. Coles – Steps in Initiating Opioid Treatment

Select opioid

• Titrate

Naltrexone formulation or not?Abuse-deterrent formulation?

- As-needed vs. 24-hr c - Safe initial dose

Combine with a non-opioid analgesic?
 Consider dose/dose frequency

- Establish goals of treatment
 - Analgesia
 - Function (concrete goal)
- Discuss opioid risks
- Physical dependen
- Toxicity/adverse events
 Overdose and addiction
- Reach mutual agreement regarding opioid therapy
 - Opioid Patient-Provider Agreement (PPA)/informed conse
 - Adherence to clinic policies and procedures
 Urine drug testing
 - Storing opioids safely
 Plan for discontinuat

Plan for discontinuation—why/when/how







Universal Precautions in Chronic Pain Management

Step 1. Assess Risk	Step 2. Select Agent	Step 3. Dialogue with Patient	Step 4. Monitor Patients
Assess patients' risk for abbrevant behaviors riskring to mapped person (print or, just) or finituse, abbrevant in print patients of the print of the SADAP & Manaschar patients for principal additional risks, which may proceed an risks of opposit the representation of the printing of the printing of the printing of (PRIS 2) to assess depression (PRIS 2) to assess depression printing of the printing of the printing of printing of the printing of the printing of printing of the printing of the printing of printing of printi	Consider the patient's general condition, medical status and prior opioid experience. After the condition of experience and a condition of After deciding on an agent, consider an abuse-determent foresulation of that agent. Consult shading for the selected medication.	Discuss treatment espectation, including potential benefits and risks of their application of their policities for the policities of their policities agreement, explaining the patient's right and responsibles with respect to the opioid precorption agreement.	Regularly seasons the "A K" of a follow-up-in seasons the "A k" of

ASA* PAIN:
Anesthesiologists Tailored Approach to
Patient Safety Considerations When Using Opioid Analgesics

Anesthesiologists*

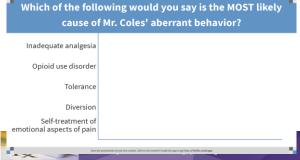
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Case 2 (Chronic Pain: Mr. Coles Follow-up)

- Mr. Coles is in the office for a regularly scheduled follow-up.
- He states that he has been tolerating short-acting opioid therapy (oxycodone 5mg TID) well for the last 6 months and reports that his pain is a "5/10."
- However, for the last 2 months, he has been requesting early refills.
- He also reports significant stressors at work requiring more frequent use of his pain medication.
- The PDMP demonstrates no suspicious activity.



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Faculty Discussion

• What is/are the likely reason[s] for Mr. Coles' aberrant behavior?





Management of Worsening Pain

Before changing the regimen

- Determine whether there is a change in the underlying condition
- Check adherence using the PDMP and questioning patient about their pattern of
- Screen for signs of OUD



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DSM-5 Criteria for OUD

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101

Check all that apply	Criteria (within a 12-month period)
	Opioids are 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 opioid use
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects
	Craving, or a strong desire or urge to use opioids.
	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
	Important social, occupational, or recreational activities are given up or reduced because of opioid use
	Recurrent opioid use in situations in which it is physically hazardous
	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
	Exhibits tolerance*
	Exhibits withdrawe!*
Total checked:	D is diagnosed (≥ 2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe (≥ 6 criteria met).



DSM-5 Criteria for OUD: Mr. Coles

Check all that apply	Criteria (within a 12-month period)
x	Opioids are often taken in larger amounts or over a longer period than was intended
x	There is a persistent desire or unsuccessful efforts to cut down or control opioid use
x	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects
	Craving, or a strong desire or urge to use opioids.
x	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
	Important social, occupational, or recreational activities are given up or reduced because of opioid use
	Recurrent opioid use in situations in which it is physically hazardous
	Continued opicid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
	Exhibits tolerance*
	Exhibits withdrawal*
Total checked: 4	DUD is diagnosed (≥2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe (≥6 criteria met).



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Management of Worsening Pain (Continued)

- Consider switching medications

 - Consider opioid-induced hyperalgesia
 Remember there is incomplete cross-tolerance when switching to another opioid
 Consider use (and limitations) of conversion and equianalgesic dosing tables

Faculty Discussion

• When might you consider switching medications?





Switching Opioid Treatment: Equianalgesic Dosing

	Equianalgesic Doses (mg)	
Drug	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

5-Step Conversion Chart Process

- Globally assess the patient's pain complaint. Determine the total daily dose of current long-and short-acting opioids.
- Decide which opioid analgesic will be used as the new agent, then refer to established conversion tables to determine the new dose.
- Individualize the dose based on patient assessment information gathered in step 1.

 Continually reassess patient for 7–14 days after the initial new dose.



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Equianalgesic Dosing and Conversion Tables: Limitations

- Multiple versions
- $\bullet \ \ Online\ calculators, eg, \\ \underline{https://opioidcalculator.practicalpainmanagement.com}$
- High variability
- · Starting point for drug rotation
- Use with caution
- · Consult drug PIs



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Choosing the Dose of the New Opioid



Reduce calculated equianalgesic dose

- Generally: 25-50% reduction
- Methadone: 75–90% reduction Use clinical judgment
- Receives a high dose of current opioid Elderly or medically frail

Is staying on current opioid but switching to a different administration route





ASA" PAIN:



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Case 2: Mr. Coles - Follow-up Visit



- He states he was recently seen in an urgent care facility for worsening rectal pain. He says he went there because he ran out of medications early, because the pain was unbearable.
- He describes his pain as a "constant 9/10" despite the increased dose
- He has also added neuropathic agents at their highest recommended dose but says that did not improve the pain.



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Case 2: Mr. Coles - When to Discontinue Opioids

- Have a frank discussion about the aberrant opioid use
- Discuss treatment goals - Pain relief or more pills?
- · Discuss the lack of benefit despite increased opioid dose
- Outline your intent to discontinue opioid therapy
 - Determine strategies for tapering by mutual cooperation and level of comfort
 - Clarify that you are not discharging him but will be using non-opioid for pain control in the
 - Reassure him that you will continue to manage his pain without opioids



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When to Taper Opioids

- Patient does not have clinically meaningful improvement in pain and function
- Patient is on dosages ≥ 50 MME/day without benefit or opioids are combined with benzodiazepines
- · Patient shows signs of substance use disorder
- · Patient experiences overdose or other serious adverse event
- Patient shows early warning signs for overdose risk, such as confusion, sedation or slurred speech



How to Taper Opioids*

patients "I know you can do this."

- Go Slow: A decrease of 10% of the original dose per week is a reasonable starting point
 Patients who have taken opioxis for a long time may need to taper more slowly
 Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose
 Consult*: Coordinate with specialists and treatment experts, as needed
 Use exit a caution during preparancy due to possible risk to the pregnant patient and to the fetus if the patient goes
- Support: Make sure patients receive appropriate psychosocial support
 If needed, work with mental health providers, arrange for treatment of opioid use disorder, offer na
- In freeded, work wan menia means provided, assessing the freeded, work of the prevention of the free menia of the free meniod of the free menia of the free meniod of the

*Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonpoloid medications.



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Case 3: James H. - "Legacy" Patient



- James presents to establish care with your practice through a referral from his PCP, who no longer wishes to prescribe opioids in his practice due to new state regulations.
- Chief complaint is chronic low back pain.
- · History includes multiple spinal surgeries
- Recent surgical consultation suggests nothing further can be done surgically



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Case 3: James H. - "Legacy" Patient (Continu



- He describes his pain as 8/10 globally, stating that "everything hurts, all the time." He says that his opioid regimen is "the only thing that allows me to function" and that he has been on opioids for many years.
- · Current regimen:

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- Transdermal fentanyl 75 mcg q 48h
- Oxycodone 15 mg QID
- Gabapentin 600 mg TID
- Alprazolam 1 mg BID - Trazadone 100 mg QHS for sleep



of this patient? Refuse to accept him as a patient

What is the MOST appropriate next step in your treatment

Maintain his current opioid dose Taper opioids to FDA dosing recommendations Develop a treatment plan in collaboration with the patient and referring provider Refer to an addiction medicine specialist

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What to Do with "Legacy" Patients

- Listen to the patient's entire story first to learn what they hope to gain from your care. Often (but not always) their hope is that you will maintain their current treatment plan.
- Determine if the treatment is effective.
- Focus the conversation on risks, known systemic and endocrine side effects, known pharmacology, and lack of true efficacy. Explain how our understanding of the risks associated with chronic opioid therapy have changed in recent years.

What to Do with "Legacy" Patients

- · When the treatment is ineffective or inappropriate, explain that their current regimen is not an approach you either use or recommend, and that you are not willing to continue, along with the reasons.
- · Outline your recommended short-term and medium-term treatment approach.
- Remember that referral by the prescribing PCP does not mean you have to endorse the therapy or take over prescription-writing. The original prescriber is obligated to maintain or safely taper their patient off opioids if they choose to no longer prescribe them.



ASA" PAIN:

Managing Opioid Use Disorder

- Detox with withdrawal management
 - Inpatient vs. outpatient
- Moderate-to-severe OUD: consider inpatient stabilization and involvement of a specialist in addiction medicine¹
- Severe OUD: consider medication assisted therapy (MAT)1
 - Can be implemented in outpatient settings
 - AAP offers eight-hour MAT course
 - MAT maintenance produces better outcomes than detox alone²

Volkow ND, Frieden TR, Hyde PS, et al. N Engl J Med. 2014;370[22]:2063-2066.
 Weiss RD, Potter IS, Fiellin DA, et al. Arch Gen Psychiatry, 2011;68(12):1238-124.



115

117

Deciding on Treatment Options

- Consider patient preferences, past treatment history, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone in the treatment of addiction involving opioid use
 - Use shared decision making



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Deciding on Treatment Option

- Setting is as important the medication selected
 - Intensive outpatient
 - Partial hospitalization within a specialty addiction treatment facility, community mental health center, or similar setting
 - Residential treatment facility or hospital



Treating Withdrawal Symptoms

- Opioid withdrawal medications are recommended over abrupt opioid cessation to avoid strong cravings
- Patients should be advised about risk of relapse and other safety concerns when opioid withdrawal medications are used as standalone treatment
- Assessment of patients undergoing opioid withdrawal management require close monitoring of opioid withdrawal-associated signs and symptoms



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Managing Opioid Use Disorder:





Efficacy of MAT Interventions

Long-term follow-up of patients treated with buprenorphine/naloxone for addiction to opioid analgesics

At 18 months:

- 50% reported abstinence

At 42 months (3.5 years):

- 61% reported abstinence

- 4 40 months (3.5 years):

- 61% reported abstinence

- 4 10% met diagnostic criteria for dependence on opioids

- 40 met diagnostic criteria for dependence on opioids

- 50% reported abstinence

- 4 10% met diagnostic criteria for dependence on opioids

- 40 met diagnostic criteria for dependence on opioids

- 50% reported abstinence

- 4 20% met diagnostic criteria for dependence on opioids

- 40% met diagnostic criteria for dependence on opioids

- 50% reported abstinence

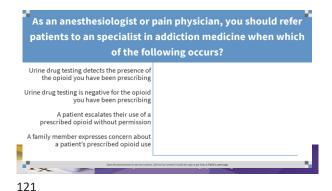
- 4 10% met diagnostic criteria for dependence on opioids

- 40% met diagnostic criteria for dependence on opioids

- 50% reported abstinence

- 4 20% met diagnostic criteria for dependence on opioids

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When to Consider Referral to a Substance Abuse Specialist

- Patient is using 80 to 100 MME
- Patient is using multiple sedatives (eg, benzodiazepines, muscle relaxants, anticonvulsant agents)
- Patient continually requires more opioids (verbal requests, early refills, emergency room visits)
- Patient is using non-authorized substances (illegal or non-prescribed drugs detected in urine)
- Patient is abusing or misusing the pain treatment regimen (as indicated by sedation, reduced functioning, third-party reports, missed appointments)
- Patient refuses nonopioid measures or reduction of opioid dosage

* Fatient Teruses monophola measures of Teaucitori of Opioia aosage

Tennant F When to Call in the Cavalov— When and Why to Refer a Patient, in Opioid Prescribing and Monitoring: How to Combat Opioid Misuse and Abu







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Conclusions: Key Takeaways

- · Opioid therapy is often unnecessary for managing acute pain.
- Initiation of opioid therapy for patients with chronic pain should be a deliberate and well-informed choice.
- As part of informed consent or a PPA, discuss pain management goals, functional goals, the length of opioid trial, and the plan for discontinuation.
- Monitor response to opioid treatment
- Monitor for signs of OUD
- When OUD treatment is needed, tailor it to patients' specific needs and/or refer to a specialist in addiction medicine



Please complete your exit ticket...



...and pass it to the RIGHT









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Pretest 7. Which of the following tools for assessing risk of opioid abuse was developed specifically for adolescent use?

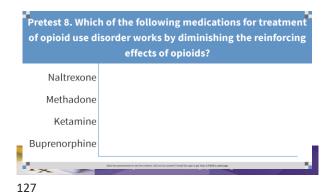
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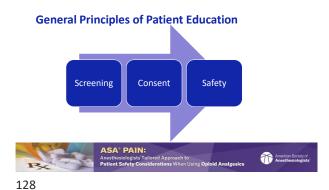
CRAFFT

DSM-5 Checklist

SOAPP-R

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Case Scenario: Kayla

Your patient is a 16-year-old female who presents to your office with left ankle pain. About three months ago, she fractured her medial malleolus while playing in a high school softball game. She was casted in the ED. For pain management, she was advised to elevate the foot and was given acetaminophen.

The cast was removed at six weeks, but the



pain continued.



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Initial visit







Do you think this teen is at risk for developing opioid use disorder?

Yes

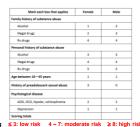
No

Possibly

131 132



- Can be administered and scored in < 1 minute
- Validated in both male and female patients (but not in non-pain populations)



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



Patient Name: Kayla C. Date: 03-18-19 ADD, OCD, bipolar, Degression







134 133

CRAFFT Screening Interview

- Developed specifically for use among adolescent medical patients¹
- Validated in patients ages 14-18 years seeking routine healthcare (and in other adolescent populations)²
- Most thoroughly studied substance abuse screen for adolescents³





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ASA PAIN:

Initial visit (continued)



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What else should you do/ask before prescribing?

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Educating Patients About Opioid Use: Key Topics to Cover

- Use exactly as prescribed
- Use smallest dose necessary for shortest amount of time
 Common side effects
- Risks of addiction and serious/deadly adverse events
- Known risk factors for serious adverse events
- Handling missed doses
 Importance of disclosing of all medications to all HCPs
- what not to do - Never share (and why) - Risk of theft
- Safe storage and disposal
- Tapering to avoid withdrawal
 How/when to use naloxone
 When to seek emergency treatment

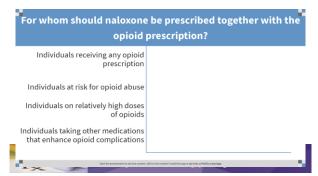
- Risks of use with alcohol, benzodiazepines,

- Product/drug delivery-specific directions:



140 139





per home it are now -ngth away it some stee has taken an speak readsine invoke breating, is short of breath, or

Naloxone Guidance

- Clinicians should co-prescribe naloxone to individuals at risk for opioid overdose, including but not limited to:
 - Those on relatively high doses of opioids
 - Those who take other medications that enhance opioid complications
 - Those with underlying health conditions



143 144

Practice Changes to Protect our Patients: Overdose Prevention and Reversal Specific strategies for poisoning

vs. intentional harm vs.

recreational use

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The much spicial medions in your body can cause your breaking to gage - which could need to death. The so-in probe for proper body after medicine that make

Awareness of potential for accidental exposure and overdose in children 0-5 yrs
 Increased availability of naloxone

ASA* PAIN: Anesthesiologists Ta Patient Safety Cons







Practice Changes to Protect Our Patients: Disposal

- Include disposal instructions at discharge
- Advise storage in locked cabinets
- Provide educational material about local disposal resources
- Organize/incentivize disposal at the main hospital, satellites
- Establish public/private partnerships
- Identify state-/county-/city-/suburb-level disposal locations

ASA" PAIN:





Informed Consent: It's Not Just About Addiction

- Tolerance
- Physical dependence
- Addiction
- Increased sensitivity to pain (hyperalgesia)
- Constipation
- Nausea, vomiting and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low testosterone/decreased libido/endocrinopathies
- · Itching and sweating
- Immune suppression/cancer?
- Clinic agreement as part of consent process



145 146

Follow-up call







147 148

One year later

- Kayla sustains another injury to her ankle
- X-ray showed no signs of fracture
- Splinted and sent home with acetaminophen
- 2 weeks post-injury, pain is 9/10
- Physical exam is positive for point tenderness over the lateral malleolus
- Asking for same pain medication as last year
- ORT score still = 1, but PDMP shows that she received 3 other opioid prescriptions in the past few months





ASA PAIN:
Anestheologist Tailored Approach to
Patient Safety Considerations When Using Opioid Analgesics
Anestheside

Visit one year later





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ASA" PAIN:



Suspension from school or job loss due to drug-related activity

Warning Signs of OUD • Frequent requests for opioid medication

- · Withdrawal from social and recreational activities
- Avoiding friends or family

Missing school or work

- Changes in behavior or mood
- Financial problems
- Bad or reckless decisionsAvoiding friends and family







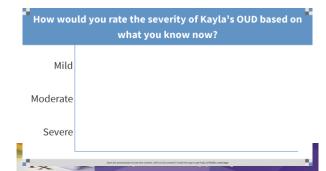
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DSM-5 Criteria for OUD

Check all that apply	Criteria (within a 12-month period)	
	Opioids are 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 opioid use	
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects	
	Craving or a strong desire or urge to use opioids.	
	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home	
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	
	Important social, occupational or recreational activities are given up or reduced because of opioid use	
	Recurrent opioid use in situations in which it is physically hazardous	
	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance	
	Exhibits tolerance*	
	Exhibits withdrawal*	
Total checked: If OUD is diagnosed (2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe (2-6 criteria met).		



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DSM-5 Criteria for OUD: Kayla

Check all that apply	Criteria (within a 12-month period)
x	Opioids are often taken in larger amounts or over a longer period than was intended
x	There is a persistent desire or unsuccessful efforts to cut down or control opioid use
x	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects
	Craving or a strong desire or urge to use opioids.
X	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
	Important social, occupational or recreational activities are given up or reduced because of opioid use
	Recurrent opioid use in situations in which it is physically hazardous
	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
	Exhibits tolerance*
	Exhibits withdrawal*
Total checked: If OUD is diagnosed (£2 criteria met), assess severity as mild (£3 criteria met), moderate (4-5 criteria met) or severe (£6 criteria met).	

Starting the Conversation About Ending Opioids

- Best approach: frank and direct conversation about the facts
- Discuss opioid-abuse behaviors in a nonjudgmental manner
- Focus on the behaviors that make you concerned
- Reiterate PPA policies
- Focus on patient safety and reiterate long-term effects of opioid medications
- Identify *practical* solutions



155 156

How to Taper Opioids*

patients "I know you can do this."

- Go Slow: A decrease of 10% of the original dose per week is a reasonable starting point
 Patients who have taken opiosis for a long time may need to taper more slowly
 Biscuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose
 Consult: Coordinate with specialists and treatment experts, as needed
 Use extra caution during preparancy due to position fix to the pregnant patient and to the fetus if the patient goes
- Support: Make sure patients receive appropriate psychosocial support
 If needed, work with mental health providers, arrange for treatment of opioid use disorder, offer nale
- In feeded, work with mental neutral provides, arrange on destination signals of the provided of t

*Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonpoloid medications.



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What's next for cases like Kayla's?

- · Develop a patient-provider agreement
- Switch patient to non-opioid pain management
- Try cognitive behavioral therapy to try to reduce pain
- Work closely with the pediatrician



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Managing Opioid Use Disorder

- Detox with withdrawal management
 - Inpatient vs. outpatient

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- · Moderate to severe OUD: consider inpatient stabilization and involvement of addiction specialist
- Severe OUD: Medication assisted therapy (MAT)



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Summary / Key Takeaways

- Patient/caregiver education is a critical aspect of opioid pain management to ensure adherence and reduce risks of opioid misuse and abuse
 - Patients and caregivers need to understand how to use, store and dispose of opioid analgesics
 - Patients and caregivers need to know how and when to use naloxone
- Patients and caregivers need to understand the benefits and risks of opioid pain management
- · Clinicians who prescribe opioids for pain management need to know
 - Warning signs of OUD
 - When and how to taper opioids safely
 - How to treat OUD or when to refer to an substance abuse specialist



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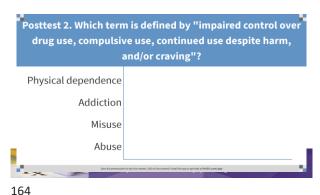
162

What's left to claim your credit?

- 1. Answer 8 posttest questions
- 2. Create an Action Plan
- 3. Complete the Paper Evaluation







Posttest 3. Which of the following is the BEST reason for educating patients about never breaking, chewing, or crushing an oral long-acting or extended-release opioid?

It will increase first pass liver metabolism, leading to lower blood levels

It is required by FDA labeling

It increases the potential for abuse

It may lead to rapid release of the opioid and to overdose or death

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Posttest 4. For which of the following patients would opioid treatment be most appropriate?

A patient whose acute pain is nonresponsive to non-opioid analgesia

A patient with recurrent episodes of severe, acute pain

A patient with chronic pain with no contraindications to opioids

A patient with chronic neuropathic pain unresponsive to NSAIDs

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Posttest 5. When switching from another opioid to methadone, by how much should the calculated equianalgesic dose of methadone be reduced?

75-90%
50-75%
25-50%
0% (conversion tables account for incomplete cross-tolerance)

Posttest 6. Which of the following is NOT one of the CDC's four recommended steps in tapering opioids?

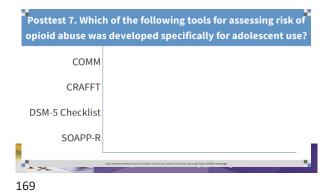
Go Slow: For many patients a decrease of 10% of the original dose per week is reasonable

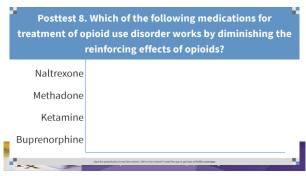
Consult: Coordinate with specialists and treatment experts as needed

Support: Make sure patients receive appropriate psychosocial support

Discourage: Advise patients not to deviate from the tapering regimen due to increased overdose risk

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Change

How to develop an ACTION PLAN



Describe your goal clearly

Measurable
How will you evaluate whether your goal is met?

Achievable
Is this goal achievable in your current environment?

Relevant
How will achieving your goal improve patient care?

When can your goal be achieved?

ASA PAIN:

Creating a "SMART" Action Plan:
Decide on One Specific Performance or System Gap You'd Like to

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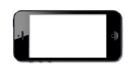
Take a few moments to create a plan

ASA" PAIN:



Access the Action Plan on your phone using the link below:







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Questions?

Please complete your evaluation!

All credit claiming instructions are located in your handouts.

