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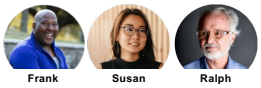
Pain Management & Opioids
A Patient-Centered Approach



Frank Susan Ralph

A Case-Based Curriculum

www.core-rems.org

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1

FACULTY INFORMATION

Rebecca Loveless, MHS, PA-C, DFAAPA

Rebecca Loveless, MHS, PA-C, DFAAPA graduated from the Quinnipiac University PA Program in 2000. She has practiced in orthopedics, emergency medicine, CT Surgery, ICU, and hospitalist medicine. She is currently the Director of Didactic Education for the Logan University PA Program in Chesterfield, MO.

Ms. Loveless has spent numerous hours lecturing to healthcare workers and law enforcement officials about responsible controlled substance prescribing, as well as the drug abuse epidemic that has taken over our country. She currently serves on the board of the Missouri Academy of PAs and is their Chief HOD Delegate.

In her free time, she spends time being a mom to her boys, Zeke and Keagan, and puppies, Skye and Maya. Traveling is their favorite activity!

AAPA American Academy of Physician Associates

DISCLOSURE:
No relevant relationships with ineligible companies to disclose within the past 24 months

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2

Dennis Rivenburgh, MS, ATC, PA-C, DFAAPA

Dennis Rivenburgh, MS, ATC, PA-C, DFAAPA, has been a practicing PA since graduating from the George Washington University PA Program in 1997. He currently works in Sports Medicine at Johns Hopkins University's Department of Orthopaedics. Previously, he served as the Program Director of the University of Maryland Baltimore PA Program and has experience in Sports Concussion, Primary Care/Sports Medicine, Emergency Medicine, and Orthopaedic Sports Medicine.

Throughout his career, Dennis has been a preceptor, clinical instructor, and certified athletic trainer. He has been an instructor in the CO*RE Opioid Curriculum for more than 8 years.

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ACKNOWLEDGMENTS

Presented by American Academy of Physician Associates (AAPA) a member of the CO*RE Collaborative, ten interdisciplinary organizations working together to improve pain management and prevent adverse outcomes. For more information about CO*RE, visit http://core-rems.org/.

This activity is supported by an independent educational grant from the Opioid Analgesics REMS Program Companies (RPC). This activity is intended to be fully compliant with the Opioid Analgesic (OA) REMS education requirements issued by the U.S. Food and Drug Administration. For more information about the Opioid Analgesics REMS, visit https://opioidanalgesicrems.com/RpcUI/products.u.

This course is based on the FDA Education Blueprint (Oct. 2023) and existing guidelines, including the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain.

Scan the QR code to go to the FDA OA REMS Blueprint

4

THE CO*RE COLLABORATIVE

This course does not advocate for or against the use of opioids.

We intend to help clinicians manage pain without putting vulnerable patients at risk for nonmedical use of opioids or opioid use disorder. The goal is to keep our patients, our communities, and ourselves SAFE.

AAPA American Academy of Physician Associates · CAFP California Academy of Family Physicians · AANP American Association of Nurse Practitioners · AAOS American Academy of Orthopaedic Surgeons · AOA American Osteopathic Association · American Society of Addiction Medicine ASAM · aahpm American Academy of Hospice and Palliative Medicine · IPMA Interstate Postgraduate Medical Association · American Academy of Family Physicians Strong Medicine for America · NPHF

5

TODAY'S CASES

Frank

45 y/o male, diabetic peripheral neuropathy

Susan

30 y/o female, MVA 10 years ago, self medicating, pregnant

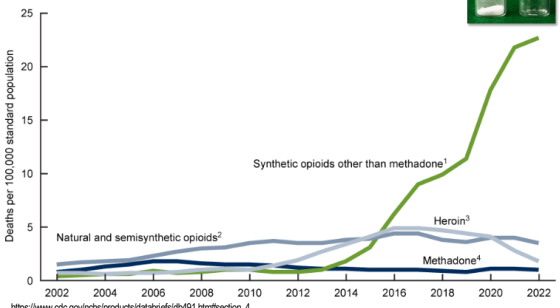
Ralph

70 y/o male, prostate cancer, metastatic to bones progressing despite antitumor treatment

6

OPIOID OVERDOSE DEATHS BY TYPE OF OPIOID

Figure 4. Age-adjusted rate of drug overdose deaths involving opioids, by type of opioid: US, 2002-2022



https://www.cdc.gov/nchs/products/databriefs/db491.htm#section_4

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7

LEARNING OBJECTIVES

EVALUATE
↓
DIAGNOSE
↓
TREAT/ EDUCATE
↓
ONGOING CARE

1. Recognize the origin(s) and types of pain as they relate to pain management and opioid use disorder (OUD).
2. Fully assess persons experiencing pain, including risk for OUD.
3. Develop safe and effective pain management plans using nonpharmacologic and pharmacologic (non-opioid or opioid) options.
4. Partner with patients to reduce risks when taking opioid therapy.

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8

EVALUATE

Frank
Diabetic peripheral neuropathy

Susan
Self medicates, Pregnant

Ralph
Prostate cancer metastatic to bones

MULTI-DIMENSIONAL EVALUATION OF A PATIENT WITH PAIN

9

HOW DO WE INITIATE DISCUSSION WITH A PATIENT?

- **How we talk affects our patients' response to us, our approach to treatment, and patient outcomes**
- Reframe your approach to avoid stigmatizing terms
- Ask permission:
  "Is it okay if I ask you about alcohol or drugs?"

TERMS TO AVOID	PREFERRED TERM
~~Addiction~~	Substance use disorder (SUD) or opioid use disorder (OUD)
~~Drug-seeking, aberrant behavior~~	Using medication not as prescribed
~~Addict/user~~	Person with a substance use disorder (SUD) or an opioid use disorder (OUD)
~~Dirty urine/failing drug test~~	Testing positive on a urine drug screen
~~Abuse or habit~~	Nonmedical or use other than prescribed
~~Substance abuse~~	Substance use


Susan

https://nida.nih.gov/research-topics/addiction-science/words-matter-preferred-language-talking-about-addiction
Kelly JF, Westerhoff CM. Int J Drug Policy. 2010 May;21(3):202-207.

10

HISTORY OF PRESENT ILLNESS

Scan to view CO*RE Tools

PRE-SCREENERS COLLECTED IN ADVANCE (PHQ-2/9, BPI)

DESCRIPTION OF PAIN

Location | Intensity | Quality | Onset/ duration | Variations/ patterns/rhythms

WHAT RELIEVES THE PAIN?

WHAT CAUSES OR INCREASES THE PAIN?

PATIENT'S LEVEL OF PAIN AND THE EFFECT OF THE PAIN ON PHYSICAL, EMOTIONAL, AND PSYCHOSOCIAL FUNCTION (eg, PEG, BPI, MPI)

Hogans, B., Barreveld, A. (Eds.). *Pain Care Essentials*, NY, NY: Oxford Univ. Press.2020.

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MEDICAL AND TREATMENT HISTORY


Susan

RELEVANT ILLNESSES

NONPHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

If past or current opioid use:
- Query your state's Prescription Drug Monitoring Program (PDMP) to confirm patient report
- Contact past clinicians and obtain prior medical records
- For opioids currently prescribed, note the opioid, dose, regimen, and duration
- Determine whether the patient is **opioid-tolerant**

BARRIERS TO PREVIOUS TREATMENT STRATEGIES

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OBTAIN A COMPLETE PSYCHOSOCIAL HISTORY

PSYCHOLOGICAL HISTORY

Screen for:

- Mental health diagnoses, depression, anxiety, PTSD, current treatments (using *PHQ-2, PHQ-9, GAD-7,* etc.)

Depression and anxiety can be predictors of chronic pain

- Alcohol, tobacco, and other drug use
- History of Adverse Childhood Experiences (ACEs) using *ACE Questionnaire*
- Family history of substance use disorder and psychiatric disorders

*Scan to view CO*RE Tools*

SOCIAL DETERMINANTS OF HEALTH (SDOH)

SDOH relate to pain in terms of

- Economic stability
- Education access & quality
- Health care access & quality
- Neighborhood & built environment
- Social & community context

Source/QR code: https://health.gov/healthypeople/priority-areas/social-determinants-health

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ADVERSE CHILDHOOD EXPERIENCES (ACEs): LONG-LASTING EFFECTS ON HEALTH AND WELLBEING

Frank

A shift in focus…

from

~~*"what's wrong with this patient?"*~~

to

"what happened to this patient?"

"what has been this patient's life experience?"

"what matters to you?"

Scan to view ACEs questionnaire

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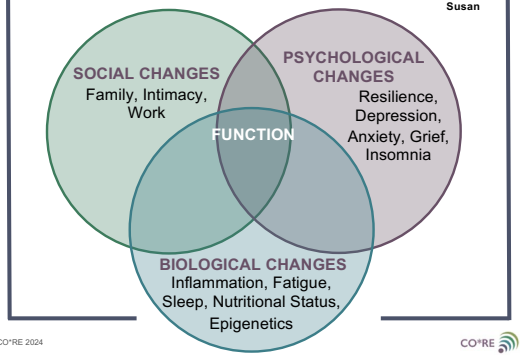
14

THE EXPERIENCE OF PAIN: A BIOPSYCHOSOCIAL MODEL

Susan



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PHYSICAL EXAM AND ASSESSMENT

Seek objective data → Conduct physical exam and evaluate for pain → Order diagnostic or confirmatory tests

- General: vital signs, appearance, and pain behaviors
- Neurologic exam
- Musculoskeletal exam
  - Inspection
  - Gait and posture
  - Range of motion
  - Palpation
  - Percussion
  - Auscultation
  - Provocative maneuvers
- Cutaneous or trophic findings

Hogans, B., Barreveld, A. (Eds.). Pain Care Essentials, NY, NY: Oxford Univ. Press. 2020.

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EVALUATION: FRANK

- 45 y/o male
- Diabetic peripheral neuropathy
- Pain is gradually worsening and is most bothersome at night
- No other aggravating or alleviating factors

Frank

Comorbidities
- Diabetes, Obesity, Depression

Psychosocial
- ACE Questionnaire for Adults: 5/10 positive responses

Physical Exam/Diagnostics
- Sensation/motor:
  - Loss of protective sensation in feet bilaterally.
  - No motor deficits noted with muscle strength 5/5 bilaterally
- BPI = 9

Previous Therapies
- Attempts at improved glycemic control, HgbA1c improved from 9% to 7.5% with addition of GLP-1 agonist to metformin
- Amitriptyline for pain & depression, but switched to fluoxetine due to weight gain
- Remote history of prescription drug use; experimented with prescription pills in adolescence.

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EVALUATION: SUSAN

- 30 y/o female
- MVA 10 yrs ago
- No one believed her, so self medicating for chronic nonspecific back pain
- Pregnant

Susan

Psychosocial
- Depression, anxiety, ACES, suicidal?
- Screen for Intimate Partner Violence
- Family support? Community support?
- Screen for SDOH
- Emphasize that she is as important in the care process as the infant

Physical Exam/Diagnostics
- Clinically significant findings for pain?
- Consider the physiologic changes as pregnancy progresses
- Draw inflammatory markers?

Medications Used
- Self medicates with nonprescribed oxycodone and acetaminophen; she takes 6-10/day every day

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EVALUATION: RALPH

- 70 y/o male
- Prostate cancer metastatic to pelvis and lumbar spine
- Progressing despite treatment

Comorbidities
- Type 2 DM with peripheral neuropathy
- Insomnia
- Vietnam veteran with history of PTSD and anxiety

Psychosocial
- Retired engineer
- Moved in with his daughter and teenage grandchildren
- Desires to avoid hospitalization as long as possible, if not entirely
- Moderate alcohol use, father was an alcoholic

Previous Therapies
- NSAIDs
- Gabapentin
- Muscle relaxant
- Palliative radiation therapy

Ongoing discomfort

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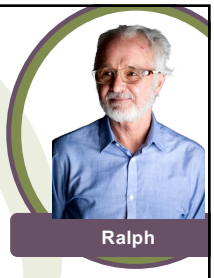
19

EVALUATION: RALPH (cont.)



Physical Exam/Diagnostics
- Hips full ROM but some discomfort reported and concomitant facial grimacing
- Tenderness lumbar spine deep palpation no muscle spasm noted and full ROM
- Overall slow gait but appears a little uncomfortable and reports discomfort
- Worst pain 9/10, best 4/10, average 7/10, right now 8/10
- Mild interference with mood, walking, relationship with others
- Moderate interference sleep and enjoyment of life

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20

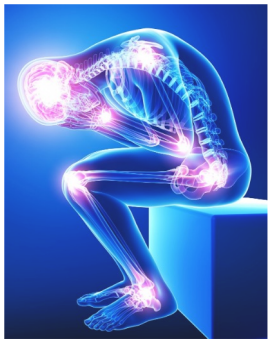
DIAGNOSE


Frank


Susan


Ralph

PAIN AND SUD: DEFINITIONS AND BIOLOGY



SUD-substance use disorder. OUD-opioid use disorder.

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21

PAIN

"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage."

IASP (July 2020)

ACUTE	CHRONIC
• Acute pain duration <1 month • Sudden onset, self-limiting • Ideally resolves with healing • Triggered by tissue damage and inflammation • Has protective value • Inflammatory mediation • **Subacute** (continues for 1-3 months) can become chronic	• Lasting 3 months or longer • Generally steady-state or worsening • Persists beyond normal healing period • Serves no value • Peripheral and central sensitization

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22

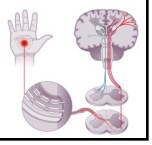
TYPES OF PAIN


Susan


Frank


Ralph

NOCICEPTIVE / INFLAMMATORY	NOCIPLASTIC	NEUROPATHIC	MIXED TYPES (NOCICEPTIVE / NEUROPATHIC)
Response to an injury or stimuli; *typically* acute	Arises from altered nociceptive function; *typically* chronic	Develops when the nervous system is damaged; chronic	Primary injury and secondary effects
Post-operative pain, sports injuries, arthritis, sickle cell disease, mechanical low back pain	Fibromyalgia, irritable bowel syndrome, nonspecific low back pain	Post-herpetic neuralgia, trigeminal neuralgia, distal polyneuropathy, CRPS, neuropathic low back pain	

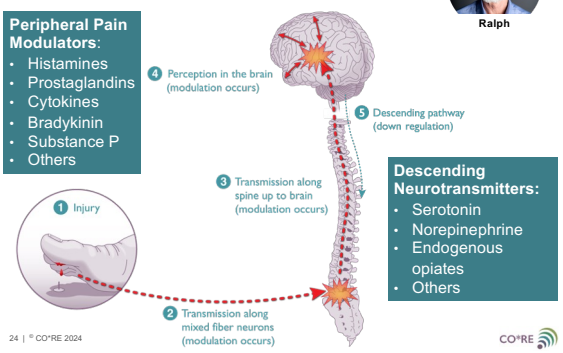


23

THE NEUROMECHANISMS OF PAIN


Ralph

Peripheral Pain Modulators:
- Histamines
- Prostaglandins
- Cytokines
- Bradykinin
- Substance P
- Others



Descending Neurotransmitters:
- Serotonin
- Norepinephrine
- Endogenous opiates
- Others

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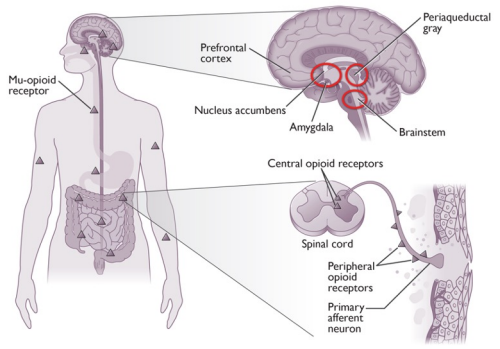
24

OPIOID RECEPTOR LOCATIONS



26

WHAT IS SUBSTANCE USE DISORDER (ADDICTION)?

Practical Definition

Addiction, referred to as *substance use disorder* in the DSM-V-TR, is the continued use of drugs or activities, despite knowledge of continued **harm** to oneself or others.

ASAM Definition

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

27

OPIOID USE DISORDER: DSM-5-TR CRITERIA

Be alert to these factors in patients on long-term opioid therapy:

Susan

1. Taking larger amounts and/or for longer periods than intended
2. Persistent desire or inability to cut down or control use
3. Increased time spent obtaining, using, or recovering
4. Craving/compulsion to use opioids
5. Role failure at work, home, school
6. Social or interpersonal problems
7. Reducing social, work, recreational activity
8. Physical hazards
9. Physical or psychological harm

2–3 = mild
4–5 = moderate
≥6 = severe

10. Tolerance ❖
11. Withdrawal ❖

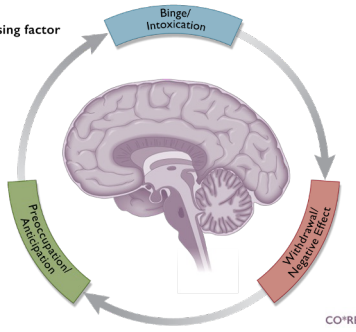
❖ **Not valid if opioid is taken as prescribed**

APA. Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). 2022

28

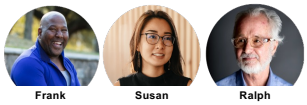
THE CYCLE OF SUBSTANCE USE DISORDER

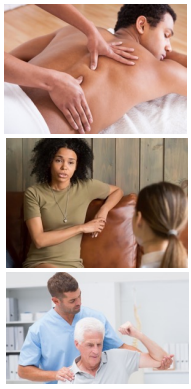
NEUROTRANSMITTERS
- Dopamine
- Opioid peptides
- Corticotropin-releasing factor
- Dynorphin
- Glutamate



29

TREAT





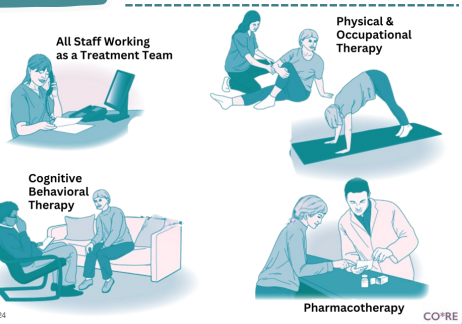
CREATING THE PAIN TREATMENT PLAN

30

COMPONENTS OF A MULTIMODAL TREATMENT PLAN

GOALS

Reduce Pain | Restore Function | Improve Quality of Life



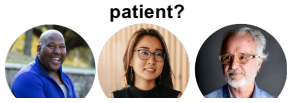
31

EVIDENCE-BASED NONPHARMACOLOGIC TREATMENTS

- CBT and ACT
- PT/OT/aquatic
- Massage therapy
- Acupuncture
- OMT

- Chiropractic
- Self-management: Tai Chi, Yoga, Exercise, Mindfulness meditation
- Neuromodulation or surgical approaches

What is appropriate for your patient?



Frank Susan Ralph

Interventional treatments are emerging. Scan for example on spinal cord stimulation.

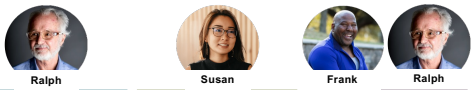
CBT-cognitive behavioral therapy; ACT-acceptance commitment therapy; OMT-osteopathic manipulative therapy

https://effectivehealthcare.ahrq.gov/products/noninvasive-nonpharm-pain-update/research

32

PHARMACOLOGIC TREATMENTS BY TYPE OF PAIN

Continue *Effective* Nonpharmacologic Options First



Ralph Susan Frank Ralph

NOCICEPTIVE / INFLAMMATORY	NOCIPLASTIC	NEUROPATHIC
Nerve blocks NSAIDs Opioids (IR) Topicals and patches	Anticholinergic Anticonvulsants TCAs and SNRIs Other serotonin agents **No Opioids***	Anticonvulsants IR and ER/LA opioids Gabapentinoids Nerve blocks TCAs and SNRIs Transdermal opioids

*Assumes no OUD; if patient has OUD, opioid agonist treatment may be appropriate.

33

DRUG CHARACTERISTICS TO CONSIDER BEFORE PRESCRIBING

Route of administration	Mechanism of action	Strength	Dosing interval
Key instructions (indications, uses, contraindications)	Specific drug interactions	Formulation	Product-specific safety concerns
Potential effects of sudden discontinuation	Specifics about product conversions, if available	ER/LA: Use **only** in opioid tolerant patients	Relative potency to morphine (MME)

Opioid product information available at https://opioidanalgesicrems.com/products.html

- **Immediate Release (IR)**: rapid onset of analgesia, relatively short duration of effect
- **Extended Release/Long-Acting (ER/LA)**: potentially longer onset of action, longer duration of effect; formulation allows for QD or BID dosing; less frequent dosing

34

SHARED DECISION-MAKING

The pain treatment plan should align with the patient's goals and incorporate:

- Analgesic & Functional Goals of Treatment
- Expectations
- Potential Risks
- Alternatives
- Patient's Understanding
- Partnering

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35

WHEN TO CONSIDER A THERAPEUTIC TRIAL OF IR OPIOID

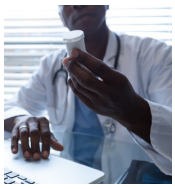

Frank


Ralph

Patient has failed to adequately respond to non-opioid and nonpharmacological interventions

Patient has moderate to severe nociceptive or neuropathic pain

Potential benefits are likely to outweigh risks



Chou R, et al. J Pain. 2009;10:113-130.
Dowell D et al. *MMWR Recomm Rep* 2022 Nov. 4;71(3):1-95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.
VA/DoD Clinical Practice Guideline. (2022). Use of Opioids in the Management of Chronic Pain Work Group. Washington, DC: U.S. Government Printing Office.

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36

RISKS VERSUS BENEFITS OF PRESCRIBED OPIOIDS

POTENTIAL RISKS

- Life-threatening respiratory depression, accidental overdose, death
- OUD/nonmedical use, diversion
- Interactions with other meds and substances
- Physiologic dependence and withdrawal

POTENTIAL BENEFITS

- Option for patients with contraindications for non-opioid analgesics
- May improve pain, function, and quality of life

Risks and benefits are different for sickle cell disease, cancer, and palliative or end-of-life care.

Chou R, et al. J Pain. 2009;10:113-130.
Dowell D et al. *MMWR Recomm Rep* 2022 Nov. 4;71(3):1-95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.
VA/DoD Clinical Practice Guideline. (2022). Use of Opioids in the Management of Chronic Pain Work Group. Washington, DC: U.S. Government Printing Office.

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37

OPTIONS TO ASSESS RISK FOR OPIOID USE DISORDER

ORT-OUD Opioid Risk Tool-OUD
DAST Drug Abuse Screening Test
NIDA Single-Question Screening Test (Self-Administered) "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?"
TAPS Tobacco, Alcohol, Prescriptions Medication and Other Substances Tool

Considerations

- All screening questions have limitations (CDC, 2022)
- Tools may not be validated in some populations
- Consider feasibility and resources to support findings
- **Establish a safe environment**

*Scan to view CO*RE Tools*

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A CLOSER LOOK AT THE ORT-OUD

Frank

Mark each box that applies	YES	NO
Family history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Personal history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16-45 years	1	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
Scoring totals	4	

Cheatle, M., Compton, P.A., et al. *J Pain* 2019; Jan 26.

Substance use disorder history does not prohibit treatment with opioids but may require additional monitoring and expert consultation or referral.

Scoring:

≤ 2: low risk

≥ 3: high risk

Scan to view ORT-OUD Video

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40

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Frank

Frank's PDMP: Sporadic short courses of opioids from ED & Urgent Care providers

A NON-PUNITIVE APPROACH TO PRESCRIBING ANALGESIC AGENTS

- Check when initiating opioid therapy, regularly when continuing therapy
- Improves patient communication, education, and safety
  - Confirm PDMP information with patient; do not dismiss from care
  - Identify drugs that increase overdose risk when taken together
  - Provide potentially life-saving information and interventions (safety concerns, provide naloxone)
- Discuss safety concerns with other clinicians
- Lowers rates of prescription opioid-related hospitalization and ED visits
- Most PDMPs allow you to appoint a delegate

Multiple prescriptions from different clinicians is most predictive of nonmedical use of opioids.

41 | © CO*RE 2024 Source: https://www.cdc.gov/opioids/healthcare-professionals/pdmps.html

41

CATEGORIZATION OF OPIOIDS

Scan to view DEA Drug Scheduling

NATURALLY OCCURRING OPIATES	SEMI-SYNTHETIC OPIOIDS	SYNTHETIC OPIOIDS
Codeine Morphine	Buprenorphine Hydrocodone Hydromorphone Oxycodone Oxymorphone	Alfentanil Fentanyl Methadone Remifentanil Tapentadol Tramadol

AGONISTS	PARTIAL AGONISTS	ANTAGONISTS
Codeine Methadone Morphine Oxycodone	Buprenorphine Nalbuphine	Naloxone Nalmefene Methylnaltrexone* Naloxogel*

*These represent PAMORA: peripherally-acting mu opioid receptor antagonist

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42

OPIOID SIDE EFFECTS AND ADVERSE EVENTS

SIDE EFFECTS	ADVERSE EVENTS
Respiratory depression	Death
GI effects: dry mouth, nausea/vomiting, **opioid-induced constipation** (most common; mitigate!)	Disability or permanent damage
Myoclonus (twitching or jerking)	Addiction/nonmedical use
Sedation, cognitive impairment	Overdose
Sweating, miosis, urinary retention	Hospitalization
Allergic reactions	Falls or fractures
Hypogonadism	Opioid-induced hyperalgesia
Tolerance, physical dependence	

Prescribers should report serious AEs and medication errors to the FDA: https://www.fda.gov/media/76299/download or 1-800-FDA-1088

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43

OPIOID-INDUCED RESPIRATORY DEPRESSION

MORE LIKELY TO OCCUR:

Ralph

- In older, cachectic, or debilitated patients
- If given concomitantly with other drugs that depress respiration (such as benzodiazepines*)
- In patients who are opioid-naïve or have just had a dose increase
- In patients with organ dysfunction
- In patients with conditions causing respiratory compromise (eg, obstructive sleep apnea)

Frank

HOW TO REDUCE RISK:

- Ensure proper dosing and titration
- **Do not overestimate** dose when converting dosage from another opioid product
  - Can result in fatal overdose with first dose
- Avoid co-prescribing benzodiazepines*
- Co-prescribe naloxone

***Greatest risk of respiratory depression is in combination with benzodiazepines.**

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44

OPIOID-INDUCED RESPIRATORY DEPRESSION

Patient Education

Distribute, dispense, or prescribe naloxone to patient or caregiver.

If not immediately recognized and treated, may lead to respiratory arrest and death.

Remind to swallow tablets/capsules whole.

Instruct patients/caregivers to:
- Screen for shallow or slowed breathing
- Deliver NALOXONE
- **CALL 911**

Instructions may differ if patient is on hospice or near end of life

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45

SIGNS OF ACCIDENTAL OPIOID POISONING

Patient Education

Person cannot be aroused or unable to talk

Any trouble with breathing, heavy snoring

Gurgling noises from mouth or throat

Body is limp, seems lifeless; face is pale, clammy

Fingernails or lips turn blue/purple

Slow, unusual heartbeat, or stopped heartbeat

CALL 911 & Administer Naloxone

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46

NALOXONE OPTIONS

Patient Education

- Intramuscular injection or nasal spray
- Store at room temperature
- Cost and insurance coverage vary (is OTC, may be free at some pharmacies, clinics, libraries, vending machines, or via mail)
- Teach proper administration using videos or live demonstration

Naloxone vials

Narcan nasal spray

Scan for FDA Information

Scan for 30-sec tutorial video

Trade name used for identification purposes only and does not imply endorsement.

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47

FOR SAFER USE: KNOW DRUG INTERACTIONS, PHARMACODYNAMICS, AND PHARMACOKINETICS

Benzodiazepines, other CNS Depressants, and Skeletal Muscle Relaxants
- Increased risk of respiratory depression, hypotension, profound sedation, or coma
- Avoid co-prescribing when possible

Caution with Tramadol:
Respiratory depression and serotonin syndrome can occur

Many opioids can prolong QTc interval, check package insert; **methadone** requires extra caution

Partial Agonists* or Mixed Agonist/Antagonists†
- Use caution with full opioid agonist
- May reduce analgesic effect and/or precipitate withdrawal

Anticholinergic Medication
- Concurrent use increases risk of urinary retention and severe constipation
- May lead to paralytic ileus

Diuretics:
Opioids can reduce efficacy

*Buprenorphine; †Pentazocine, nalbuphine, butorphanol
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48

DRUGS THAT INHIBIT OR INDUCE CYP ENZYMES

Metabolism of several commonly used opioids occurs through the cytochrome P450 system

Be aware of potential inhibitors (e.g., macrolides, azole antifungals) and inducers (e.g., carbamazepine)

Genetic and phenotypic variations in patient response to certain opioids

Refer to package insert before prescribing

https://dailymed.nlm.nih.gov/dailymed/index.cfm

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49

TRANSDERMAL/TRANSMUCOSAL DOSAGE FORMS

Do not cut, damage, chew, or swallow

Prepare skin: clip (not shave) hair and wash area with water

Rotate location of application

Use the entire film; do not apply if film is altered in any way

Note that metal foil backings are not safe for use in MRIs

Exposure to **heat** (fever or external source): watch for signs of increased opioid exposure

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50

MEDICATION FOR OPIOID USE DISORDER (MOUD)


Susan

- Important and evidence-based medication that saves lives
- You can start from your office, as an outpatient
- Some treatments for OUD are also effective for pain
- Patients with OUD have decreased mortality when treated – *you can save a life!*

Three medication options:

1. Buprenorphine (Schedule III)
2. Methadone (Schedule II)
3. Naltrexone (not a controlled substance)

Adopt an ongoing harm reduction approach through dialogue/discussion

51

BUPRENORPHINE

Most commonly prescribed pharmacotherapy for treatment of OUD

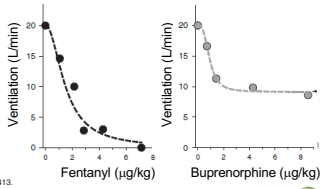
- Long-acting injectable and sublingual form indicated to treat withdrawal and craving

Approved for pain (7-day patch, buccal mucosal film BID)

Good efficacy and safety profile; "Plateau effect" for respiratory depression ***(see graphs)***

All DEA-licensed HCPs can prescribe without patient number caps

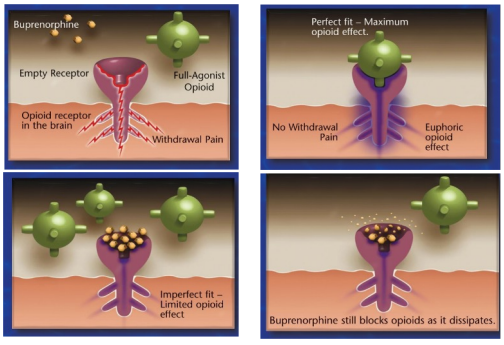
Scan for info on approvals for pain, OUD



Dahan A. *Palliative Medicine*. 2006; 20: s3/s8.
Spinella S, McCarthy R. *Am J Med*. 2024 May;137(5):406-413.

52

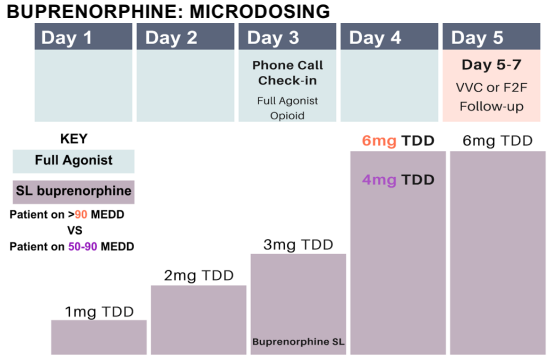
HOW BUPRENORPHINE WORKS



https://www.naabt.org/education/images/Receptors_HiRes.jpg, https://pubmed.ncbi.nlm.nih.gov/16547090/

53

BUPRENORPHINE: MICRODOSING



TDD-total daily dose.
Buprenorphine for the Management of Chronic Pain. National Guidance Document. March 2024. Adapted from: VA West CT Opioid Reassessment Clinic. Figure 1 in Edmond S et al. *Pain Medicine*. 2023; 23(6):1043-1046.

Scan for source and more info

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SPECIAL POPULATIONS: SUBSTANCE/OPIOID USE DISORDER

- Address *both* pain and OUD
  - Untreated pain is a trigger for return to use
- Avoid other potentially problematic medications
- Consider a multimodal pain program, including non-pharma options
- Enlist family/caregivers to secure and dispense opioids
- Recommend an active recovery program
- Use PDMP and screening methods (UDT, pill counts) to identify challenges and initiate discussion


Susan

Bailey J, et al. Pain Med 2010;11:1803-1818. https://academic.oup.com/painmedicine/article/11/12/1803/1943389

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SPECIAL POPULATIONS: WOMEN OF CHILDBEARING POTENTIAL

Neonatal opioid withdrawal syndrome (NOWS) is a potential risk of therapy

GIVEN THIS POTENTIAL RISK, CLINICIANS SHOULD:

- Discuss family planning, contraceptives, breastfeeding plans
- Counsel women of childbearing potential about risks and benefits of opioid therapy during pregnancy and after delivery
- Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks to fetus
- Refer to a qualified clinician who will ensure appropriate treatment for the baby


Susan

Perform universal screening to avoid NOWS

For women taking opioids daily, ACOG recommends buprenorphine or methadone

ACOG-American College of Obstetricians and Gynecologists.
Chou R, et al. J Pain. 2009;10:113-30; ACOG Committee on Obstetric Practice, August 2017

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SPECIAL POPULATIONS: OLDER ADULTS

RISK FOR RESPIRATORY DEPRESSION

Age-related changes in distribution, metabolism, excretion; absorption less affected


Ralph

ACTIONS

- Monitor
  - Initiation and titration
  - Concomitant medications (polypharmacy)
  - Falls risk, cognitive change, psychosocial status
- Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients
- Start low, go slow, but GO
- Routinely initiate a bowel regimen
- Patient and caregiver reliability/risk of diversion

VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain (2022). American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons. J Am Geriatr Soc. 2009;57:1331-46; Chou R, et al. J Pain. 2009;10:113-30.

57

SPECIAL POPULATIONS: PEDIATRICS

Scan for AAP resources (2024 Opioid Guideline)

- **2024 AAP GUIDELINE: DO NOT PRESCRIBE OPIOID MONOTHREAPY FOR ACUTE PAIN, AVOID CODEINE AND TRAMADOL IN MANY SITUATIONS**
- **SAFETY AND EFFECTIVENESS OF MOST OPIOIDS ARE UNESTABLISHED**
- **ER/LA OPIOID INDICATIONS ARE PRIMARILY LIFE-LIMITING CONDITIONS**
  - Consult pediatric palliative care team or pediatric pain specialist or refer to a specialized multidisciplinary pain clinic
- **ADOLESCENTS ages 12-21: Identify and treat for OUD *(use SBIRT)***

Scan for SBIRT resource

SBIRT-Screening, Brief Intervention, Referral to Treatment.
Hadland SE, et al. *Pediatrics* (2024) 154 (5): e2024068752. https://doi.org/10.1542/peds.2024-068752
Levy SJL, et al. *Pediatrics* (2016) 138 (1): e20161210. https://doi.org/10.1542/peds.2016-1210

58

SPECIAL POPULATIONS: OTHERS

Treatment considerations may differ for persons with:

- Sleep disorders or sleep-disordered breathing (sleep apnea)
- Dementia/nonverbal patients
- Obesity
- Renal/hepatic impairment
- Psychiatric disorders
- Life-limiting illness


Frank


Ralph

59

TREATMENT PLAN: FRANK

- 45 y/o male
- Increased pain from diabetic peripheral neuropathy

Frank

Previous Therapies
- Attempts at improved glycemic control by PCP, HgbA1c improved from 9% to 7.5% with addition of GLP-1 agonist to metformin
- Amitriptyline for pain and depression, but was switched to fluoxetine due to weight gain

Treatment Plan
- Weight loss program?
- Consider duloxetine or gabapentin?
- Opioid?

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TREATMENT PLAN: SUSAN

- 30 y/o female
- MVA 10 yrs ago
- Self medicating for chronic nonspecific back pain
- Pregnant

Susan

Treatment Plan
- Establish therapeutic relations
- Conduct conversations
- Promote honest exchange of information
- Provide age- and education- appropriate educational materials
- DO NOT terminate patient from practice
- Ensure access to naloxone
- Offer treatment: *Initiate treatment or refer. MOUD are GOLD STANDARD treatment in pregnancy.*

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61

TREATMENT PLAN: RALPH

- 70 y/o male
- Widely metastatic prostate cancer involving pelvis and lumbar spine

Ralph

Treatment Plan
- Physical therapy at outpatient center
- Osteopathic manipulative therapy (OMT)
- Massage
- Switch NSAIDS to steroids
- ORT 2-3 depending if put anxiety/PTSD as psychiatric condition
- Initiate short acting morphine 5mg as needed, inadequate control, increase to 10mg every 3-4 hours as needed

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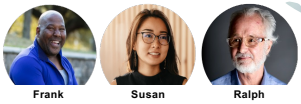
62



ONGOING, PATIENT-CENTERED CARE FOR THOSE TAKING OPIOID ANALGESICS

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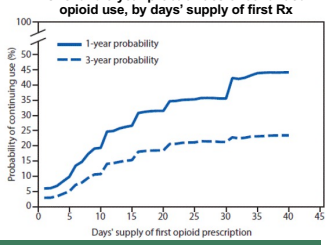
INITIATING IR OPIOIDS

Patient Education

- Discuss risk of possibility of continued opioid use
- Prescribe the **lowest effective dose** for the **shortest period of time** based on the individual patient's condition
- Always include dosing instructions, including daily maximum
- Be aware of interindividual variability of response

One- and 3-year probabilities of continued opioid use, by days' supply of first Rx



- ❖ Ensure shared decision making, documentation, baseline UDT
- ❖ Co-prescribe **naloxone** or other reversal agent, and stimulant laxative

https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

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URINE DRUG TESTING (UDT)

Scan for UDT details

- Urine testing is done **FOR** the patient, not **TO** the patient (not punitive)
- Helps to identify nonmedical use of drugs
- Assists in assessing and documenting adherence

CLINICAL CONSIDERATIONS

- Recommend UDT before first prescription (baseline), then intermittently, depending on clinical judgment and state regulations
- Document time and date of last dose taken
- Be aware of possible false positives or negatives
- Clarify unexpected results with the lab before confronting patient to rule out poor specimen or error

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EDUCATE AND DOCUMENT

Partner for Safe and Effective Opioid Use

Patient Education

Scan and use this Patient Counseling Guide

- Clarify treatment plans & goals
- Safeguards

Ralph

- Store away from children, family, visitors, and pets
- Extra precautions needed with adolescents in the home

- One prescriber
- Consider one pharmacy
- Notify prescriber of any event resulting in a pain medication prescription
- Follow-up plan including UDT
- Refill procedure
- Behaviors indicating need for discontinuation
- Exit strategy
- Signed by both

https://www.opioidanalgesicrems.com/Resources/Docs/patient_counseling_document.pdf

McDonald E, Kennedy-Hendrick A, McGinty E, Shields W, Barry C, Gielen A. Pediatrics. 2017;139(3):e20162161

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EDUCATE AND DOCUMENT (cont.)

Patient Education

Scan and use this Patient Counseling Guide

In addition to the *Guide*:

- Go over all side effects
- If a dose is missed: do not take extra, contact HCP
- If patient cannot swallow, determine if appropriate to sprinkle contents on applesauce or administer via feeding tube
- Use least amount of medication necessary for shortest time

Signs of Potential OUD

- Cravings
- Being unable to fulfill work/family obligations
- Nodding off
- Taking more than prescribed
- Sedation, cognitive impairment
- Falls and fractures

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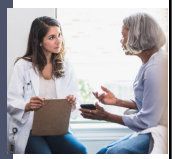
SHARED DECISION-MAKING IN ONGOING CARE

1. **How is the treatment plan working?**
   - Is the patient achieving functional goals?
   - Perform medication reconciliation
   - Evaluate for barriers
2. **Is care still in line with the patient's values and preferences?**
3. **Reassess underlying source of pain**
4. **Reassess risk of OUD**
   - Current Opioid Misuse Measure [COMM™] for patients on chronic therapy
5. **Explore patient willingness to engage with other modalities**
6. **Inquire about breakthrough pain or emerging psychiatric/medical conditions**
7. **Reset goals as needed, developing reasonable expectations**



*Scan to view CO*RE Tools*

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CONSIDERATIONS FOR RE-EVALUATING OPIOID USE

THERAPEUTIC GOALS ARE ACHIEVED	INTOLERABLE AND UNMANAGEABLE AEs	NO PROGRESS TOWARD THERAPEUTIC GOALS	RISKS OUTWEIGH BENEFITS

NONMEDICAL DRUG USE BEHAVIORS

- One or two episodes of increasing dose without prescriber knowledge
- Sharing medications
- Unapproved opioid use to treat another symptom (e.g., insomnia)
- Use of illicit drugs or unprescribed opioids
- Repeatedly obtaining opioids from multiple outside sources
- Prescription forgery
- Multiple episodes of prescription loss
- Diversion

Even at prescribed doses, opioids carry the risk of nonmedical use, opioid use disorder, overdose, death

*Scan to view CO*RE Tools*

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HOW TO IDENTIFY RISK OF OUD FOR MY PATIENTS

10%–26% of patients on chronic opioid therapy (COT) for chronic noncancer pain (CNCP) may develop OUD

What to look for:

- High dosages
- Prolonged use
- Low hedonic tone
- Mental health disorders
- Past history of substance use disorder

Clinical judgment is key.

Chou R, et al. Ann Intern Med. 2015;162:276-86

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PATIENT-CENTERED APPROACH TO TAPERING

No single approach is appropriate for all patients

- Ensure careful monitoring and psychosocial support for 2+ years after taper initiation due to sustained risks
- Discontinue through a taper schedule developed in collaboration with the patient
- May use a range of approaches, from a slow 10% dose reduction per week to a more rapid 25%-50% reduction every few days
- For patients physically dependent on opioids, consider medications to assist with withdrawal (clonidine, NSAIDs, antiemetics, antidiarrheal agents)
- Consider rotation to partial agonist (e.g., buprenorphine)
- If OUD suspected: begin MOUD, consider referral to specialist

Scan for HHS Guide on Tapering

Langford AV, et al. *Med J Aust*. 2023 Jul 17;219(2):80-89. doi: 10.5694/mja2.52002.
Fenton JJ, et al. *JAMA Netw Open*. 2022;5(6):e2216726. doi:10.1001/jamanetworkopen.2022.16726
Agnoli A, et al. JAMA. 2021 Aug 3;326(5):411-419. doi: 10.1001/jama.2021.11013.

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WHERE AND HOW TO DISPOSE OF UNUSED OPIOIDS

Patient Education

Scan for 45-sec FDA video

Prepaid Mail-Back Package from Pharmacy

Authorized Take-Back Site
- Search "drug disposal near me" for kiosk sites and events

In-home Options
- Flush (fold patch in half so sticky sides meet, then flush)
- Trash (mix with noxious element like kitty litter or compost)

FDA. Where and How to Dispose of Unused Medicines. https://www.fda.gov/consumers/consumer-updates/where-and-how-dispose-unused-medicines; EPA. How to Dispose of Medicines Properly. https://archive.epa.gov/region02/capp/web/pdf/ppcpflyer.pdf

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72

RE-EVALUATION & NEXT STEPS: FRANK

- Adherent to treatment plan
- Lost 20 lbs
- Neuropathic pain still bad
- UDT and PDMP consistent with prescribed medications
- OUD risk:
  - Initial ORT = 4
  - COMM® = 0

Frank

Changes to Treatment Plan
- Began opioid trial
- Mu reversal agent prescribed

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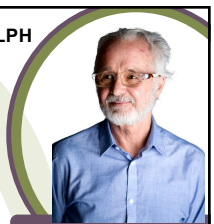
RE-EVALUATION & NEXT STEPS: RALPH

- Was using morphine 10mg up to 8 times a day; prescribed scheduled dosing using IR morphine
- Still having breakthrough pain and incident pain with scheduled 20mg every 6 hours and as needed (total daily dose 80mg)
- Seems to use extra prn when anxious



Ralph

Changes to Treatment Plan
- Change from IR to LA: start the LA morphine 30mg every 12 hours to see if get a better steady state and less need for breakthrough
- Keep prn 10mg IR
- Initiate duloxetine to help with neuropathic pain, anxiety, mood
- Need to schedule senna for OIC
- Decrease steroids to lowest dose possible

- Educate about opioids in house with granddaughter
- Naloxone script

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74

CHANGING FROM IR TO ER/LA OPIOID: REASONS

PRIMARY REASONS	OTHER POTENTIAL REASONS
• Maintain stable blood levels (steady state plasma) • Longer duration of action • Multiple IR doses needed to achieve effective analgesia • Poor analgesic efficacy despite dose titration • Less sleep disruption	• Patient desire or need to try a new formulation • Cost or insurance issues • Adherence issues • Change in clinical status requiring an opioid with different pharmacokinetics • Problematic drug-drug interactions

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CHANGING FROM IR TO ER/LA OPIOID: SAFETY

DRUG SELECTION IS CRITICAL

Some ER/LA opioids or dosage forms are only recommended for opioid tolerant patients (ER/LA in opioid-naïve patients is controversial)

- ANY strength of transdermal fentanyl
- Certain strengths/doses of other ER/LA products (*check drug prescribing information*)
- Consider transition to buprenorphine (patch, film)

INDIVIDUALIZE DOSAGE BY TITRATION BASED ON EFFICACY, TOLERABILITY, AND PRESENCE OF ADVERSE EVENTS

- *Check drug prescribing information* for minimum titration intervals
- Supplement with IR analgesics (opioid and non-opioid) if pain is not controlled during titration

Scan for drug prescribing info

❖ **MONITOR PATIENTS CLOSELY FOR RESPIRATORY DEPRESSION**
Especially within 24–72 hours of initiating therapy and increasing dosage

Chou R, et al. J Pain. 2009;10:113-130; https://pubmed.ncbi.nlm.nih.gov/3191741 8/; https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Collection_List_Provider_Education/Clinical.pdf

76

76

EMERGENCE OF OPIOID-INDUCED HYPERALGESIA

New FDA warning added in 2023

An increase in pain or sensitivity to pain

Usually occurs at high MME dosages and over long periods of time

A physiological phenomenon that can happen to anyone

Consider this explanation if:

- Pain increases despite dose increases
- Pain appears in new locations
- Patient becomes more sensitive to painful stimuli
- Patient is not improving in the absence of underlying cause or disease progression

Yi P, Pryzbylkowski P. Opioid induced hyperalgesia. *Pain Medicine*. 2015; 16: S32-S36.
2023 FDA warning: https://www.fda.gov/drugs/drug-safety-and-availability/fda-announces-new-safety-label-changes-opioid-pain-medicines

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OPIOID TOLERANCE


Ralph

If opioid tolerant, still use caution at higher doses

Patients considered opioid tolerant are taking at least:

- 60 mg oral morphine/day
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- An equianalgesic dose of another opioid

IMPORTANT

FOR 1 WEEK OR LONGER

1 WEEK

Also use caution when rotating a patient

Transdermal fentanyl is restricted to opioid tolerant individuals.

The Opioid Analgesics Risk Evaluation & Mitigation Strategy product search, https://opioidanalgesicrems.com/products.html

78

OPIOID TOLERANCE VERSUS PHYSICAL DEPENDENCE

TOLERANCE

- Occurs when increased dose is needed to maintain the functional status no longer achieved by current dose
- Remember CNS and respiratory depression can develop with dose increase

PHYSICAL DEPENDENCE

- Occurs when an individual only functions normally in the presence of the substance
- Abrupt discontinuation or dosage decrease causes uncomfortable symptoms of withdrawal

Both **tolerance** and **physical dependence** are physiological adaptations to chronic opioid exposure and **DO NOT** equal addiction or opioid use disorder

79

OPIOID ROTATION

DEFINITION

A change from an existing opioid regimen to another opioid with the goal of improving therapeutic outcomes or to avoid AEs attributed to the existing drug

CAUTIONS

- Equianalgesic tables are not associated with strong scientific evidence
- Opioid changes for chronic pain patients are associated with increased mortality

RATIONALE

Used when differences in pharmacologic or other effects make it likely that a switch will improve outcomes

- Effectiveness and AEs of different mu-opioids vary among patients
- Patient tolerant to first opioid might have improved analgesia from second opioid at a dose lower than calculated from an equianalgesic dosing table (EDT)

Treillet E, Laurent S, Hadjiat Y. *J Pain Res.* 2018;11:2587-2601. https://doi.org/10.2147/JPR.S170269.
Dowell D et al. *MMWR Recomm Rep* 2022 Nov. 4;71(3):1-95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

80

EQUIANALGESIC DOSING TABLES (EDTs)

Many different versions:

- Published
- Online calculators
- Smartphone apps

Vary in terms of:

- Equianalgesic values
- Whether ranges are used
- **Which opioids are included:** May or may not include transdermal opioids, rapid-onset fentanyl, ER/LA opioids, or opioid agonist-antagonists

81

GUIDELINES FOR OPIOID ROTATION

Scan and watch calculation video (3:21)

Calculate equianalgesic dose of new opioid from EDT

Due to incomplete cross-tolerance, REDUCE CALCULATED EQUIANALGESIC DOSE BY 25%–50%* BASED ON CLINICAL JUDGMENT

CLOSER TO 50% REDUCTION	CLOSER TO 25% REDUCTION
IF PATIENT… • Is receiving a relatively high dose of current opioid regimen • **Is an older adult** or medically frail	IF PATIENT… • Does not have these characteristics • Is changing route of administration

*75%-90% for methadone

82

GUIDELINES FOR OPIOID ROTATION (cont.)

IF SWITCHING TO **METHADONE**:

- Do **not** give methadone to opioid-naïve patients
- Standard equianalgesic dosing tables are less helpful in opioid rotation to methadone
- For opioid tolerant patients, methadone doses should **not** exceed 30–40 mg/day upon rotation
  - Consider inpatient monitoring; EKG monitoring controversial

IF SWITCHING TO **BUPRENORPHINE**:	IF SWITCHING TO **TRANSDERMAL FENTANYL**:
Consider cross-taper with buccal film or transdermal patch; see guidelines for switch to higher dose	Calculate dose conversion based on equianalgesic dose ratios included in the drug package insert

https://pubmed.ncbi.nlm.nih.gov/31917418/, https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/IB_1497_Provider_BupChronicPain.pdf https://accpjournals.onlinelibrary.wiley.com/doi/full/10.1002/phar.2676, CDC 2022 Guideline for Prescribing Opioids for Pain, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4078896/

85

BREAKTHROUGH PAIN (BTP)

PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP

- Due to disease progression or a new or unrelated pain
  - Target cause or precipitating factors
- Dose for BTP: Using an **IR, 5%–15%** of total daily opioid dose, administered at an appropriate interval
- **Never use ER/LA for BTP**

CONSIDER OPTIMIZING

- PRN IR opioid trial based on analysis of benefit versus risk
  - There is a risk for problematic drug-related behaviors
  - High-risk: Add only in conjunction with frequent monitoring
  - and follow-up
  - Low-risk: Add with routine follow-up and monitoring
- Consider non-opioid drug therapies and nonpharmacologic treatments

86

ABUSE-DETERRENT FORMULATION (ADF) OPIOIDS

Drug formulations designed to discourage nonmedical use

- An ER/LA opioid with properties to meaningfully deter nonmedical use of opioids (less likely to be crushed, injected, or snorted)
- Consider as one part of an overall strategy
- Mixed evidence on the impact of ADF on nonmedical use of opioids
- Overdose is still possible if taken orally in excessive amounts or altered
- These products are expensive with no generic equivalents

87

CONSULTING A SPECIALIST

- When you feel you cannot provide the level of care needed
- Ensure you have a reliable specialist to refer to
- Contact specialist and ask what is needed for referral
- To find a **pain specialist**:
  - Consult state boards
  - Consult colleagues
  - Use online resources
  - Consult payment source

ADDICTION SPECIALIST REFERRAL

ASAM Physician Finder

SAMHSA Find Treatment

AAAP Specialist Finder

TREATMENT RESOURCES

SAMHSA Training Materials & Resources

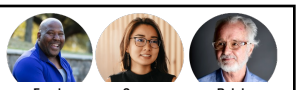
NIDA Treatment Resources

PCSS Providers Clinical Support System

NCCC National Clinical Consultation Center

88

IN SUMMARY



- Use multimodal therapies as part of the pain management care plan
- Screen for OUD risk with a validated instrument
- There is a place for opioids, but use caution
- Continually reassess patients who are receiving opioids
- Patient and family/caregiver education is essential
- If you suspect OUD, begin treatment

89

MAKE SURE your participation is counted.
Become an official "FDA Blueprint Completer"
by answering the post-test questions!

THANK YOU! 🤗

This education counts toward the MATE Act hours to renew your DEA License and your feedback is critical to improving future education.

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90