On Point with Pain Management, Leveraging Change for Positive Outcomes

CMEO Podcast Transcript

Steven Stanos:

Hello, I'm Dr. Steven Stanos. On behalf of CME Outfitters, I would like to welcome you and thank you for joining us for today's REMS educational activity entitled On Point with Pain Management, Leveraging Change for Positive Outcomes. This activity is supported by an independent educational grant from Opioid Analgesic REMS program companies, and is intended to be fully compliant with Opioid Analgesic REMS education requirements issued by the U.S. Food and Drug Administration.

Steven Stanos:

Today's activity is brought to you by CME Outfitters, an award-winning jointly accredited provider of continuing education for clinicians worldwide. So again, I'm Steven Stanos, I'm executive medical director for rehabilitation and Performance Medicine and medical director for Swedish Pain Services at the Swedish Health System here in Seattle Washington. I want to take this time now to welcome my colleague, Dr. David O'Gurek.

Steven Stanos:

Dr. O'Gurek is the associate professor and interim chair in Department of Family and Community Medicine at the Lewis Katz School of Medicine at Temple University. And he's also the medical director at The Trust Clinic in Philadelphia, Pennsylvania. Welcome, David, and thanks a lot really for joining me today.

David O'Gurek:

Thanks, Steve. I'm really delighted to be part of today's talk. It's definitely a very most important to topic, one that we see commonly across medicine, but particularly in primary care.

Steven Stanos:

Well, well said, and I think before we get into the meat of the presentation, it's probably obviously important to talk about the impact of COVID-19 on pain. And I wanted to get just your thoughts. I know it's posed to our clinic and our health system, as well as obviously our community, a number of challenges. But how has COVID impacted what you're seeing in primary care clinics?

David O'Gurek:

Certainly, it's impacted patients globally, but particularly thinking about patients experiencing pain, both acute and chronic pain has definitely affected them in many ways. On a positive note, sort of opportunity and adversity, the advantages and really forcing the system to go to telehealth practices definitely allowed for some continued care delivery for patients experiencing pain, making sure that acute pain could be addressed. But for some of the patients experiencing chronic pain, it certainly affected them in other ways as well, both positive and negative.

David O'Gurek:

I think really the effects of the pandemic was multifold, just looking at resource distribution, certainly, early in the pandemic, looking at the expense of care of pain, focus on other areas. Certainly, limited face to face access to services, as well as procedural interventions for people experiencing pain that needed pain management and relied on those procedures. Clearly the impact of the social isolation and how that may have further layered onto difficulties with underlying behavioral health conditions. As well as previous and existing trauma that happened throughout the pandemic. And definitely looking at the heightened impact on the health inequities.

Steven Stanos:

Yeah, I completely agree, yeah, we've seen it in our own clinic. I'm a pain management specialist and I run a pain rehab program. I agree on maybe one of the onus' only silver linings has been the transition to virtual health. We were able to do a lot of virtual visits even with pain psychology, and early on with our physical therapy and occupational therapy. So I do think that's kind of shifted the way we're going to practice, and that's probably going to... Parts of that'll be for here to stay.

Steven Stanos:

I know from our hospital, we really saw, I think, underscore the need for really more behavioral health resources for patients across the board. And it was interesting. I thought the patients that we had that already did part of our pain rehab programs and had a lot of these tools, they actually were a little better prepared during the pandemic with self-management whereas some of our other patients weren't prepared. So yeah, this has been a challenging time.

Steven Stanos:

I did want to show you too, I think you were going to comment as well on the issues around overdose and what that impact has had early on, especially with COVID.

David O'Gurek:

No, certainly, I think the inequity in care just in general, really highlighting the critical importance of the social and political determinants of health. And COVID certainly shed light, particularly on policy makers looking at how important those elements were. And specifically, when we look at the overdose crisis, seeing significant increase and fatal overdoses during the pandemic and ongoing, continuing. Certainly, affecting communities of color larger than other communities as well.

David O'Gurek:

The social isolation, socioeconomic effects that affected recovery capital for people using drugs was certainly heightened again during pandemic and worsen circumstances and situations there. And all of this should really highlight that it's critically important for us to deliver comprehensive care to people who use drugs, utilizing harm reduction measures grounded in evidence.

Steven Stanos:

I agree, especially around the harm reduction and increasing access, I think we've learned in our system too. It's not just the medication management part, but do they have access to virtual visits, behavioral health, those things that are so important. And I agree, we saw many of our patients and they lost that stability from work and everything else. And then with all the other stresses, unfortunately we saw an increase and misuse of medications as well.

Steven Stanos:

Well, thanks. With that, we actually wanted to move towards our first objective, David, and the goal being to apply our knowledge of acute and chronic pain pathways. So to understand that first, underlying mechanisms for clinical assessment and appropriate management for us. So we're going to spend a couple of minutes looking at pathophysiology of pain and then work our way through areas around personalized assessment and treatment of pain.

Steven Stanos:

The first is just to kind of level set, nociception can really be, I think, thought of how our bodies encode pain signals in the periphery, transmit that electrical activity, where those electrical signals are transmitted across the nervous system to the brain. So no susception is really something that's happening in the periphery, how we're sensing pain. Whereas pain self can be so complex. Pain, I think it was in 2020, we've updated what that classification is and I think of pain as this unpleasant sensory or emotional experience associated with or resembling that associated with actual or potential tissue damage.

Steven Stanos:

So we know this is a lot more complex, very biopsychosocially based. And within that pain, think of pain as the threat to the biologic integrity. Related to pain is suffering, suffering being threat to the person. They're no longer able to work, no longer able to function as well. And so that overlap between pain and suffering really highlights issues around anxiety, disturbed sleep, diminished function, levels of catastrophizing and other psychosocial factors.

Steven Stanos:

And so I think keeping that in mind is going to be important as we really try to understand those complexities in treating patients with pain and trying to understand what's going to be the safest treatment for them.

Steven Stanos:

Related to that, Dr. O'Gurek and I thought it would be good to really touch upon some of the terminology because sometimes I think there's confusion. Allodynia has been described as pain due to innocuous stimuli, so something like sunburn where you touch your skin and normally innocuous stimuli shouldn't hurt. But for those couple of days, your skin hurts, so that's pain painful. So that's Allodynia.

Steven Stanos:

Dysesthesia is a painful unpleasant sensation. Different from a parasthesia. A parasthesia is something like tingling in your hand, if you hit your funny bone or your ulnar nerve, and you get a zap down your hand. That's a parasthesia. A dysesthesia would be burning pain many times seen with neuropathic pain. So you have paresthesia and dysesthesia. Hyperalgesia painful stimulus is more painful. So the pain is not just sharp, it's very sharp.

Steven Stanos:

And that kind of underscores central sensitization and changes in pain processing, which we're going to touch upon briefly. Neuropathic pain. Neuropathic pain is where there's injury along the nervous system, whether it's the somatosensory system. Nociceptive pain is pain that arises from actual or threatened damage to the nociceptor that's causing pain. And a little bit, we're going to introduce this term called nociplastic pain, which is a third mechanistic classification. So we have neuropathic pain, nociceptive pain, and nociplastic pain, which will mention briefly.

Steven Stanos:

First though, acute pain is that pain lasting less than three to six months. Chronic pain is usually pain lasting more than three months. I think it affects probably 50 million Americans the last time this was studied. A new term that we want clinicians to be aware of is high impact chronic pain. High impact chronic pain is pain that is associated with restrictions of participation in work, social activities, self-care. And that's usually lasting more than six months.

Steven Stanos:

And those are probably the patients that are presenting to your clinic to be seen. So high impact chronic pain affects about 20 million Americans. And it probably gets our hands around the real impact from a societal level with those patients that need pain treatment. Sensitization, we'll touch upon is really kind of an increase in processing of pain signaling. And that can happen from a peripheral injury to changes in the spinal cord and to brain level. Those are important keys to be familiar with, and it's going to be important as well when we're talking to patients.

Steven Stanos:

The next was, we wanted to touch upon just a little bit about pain classification. And I mentioned the three different types, nociceptive pain, neuropathic pain. Nociceptive pain is pain arising from primarily a damaged, nociceptor in the periphery. And we talked about neuropathic pain. Nociplastic pain is pain arising from actually an altered pathway, but there's no real damage to the nociceptor itself.

Steven Stanos:

And so there's some type of sensitization along the nervous system that's causing increased pain. This was called pain hypersensitivity, mixed pain before, but the new term is nociplastic. And common examples would be like fibromyalgia, where there's central pain and amplification of pain processing, and many, many other types of neuropathic pain conditions may evolve into nociplastic. Irritable bowel syndrome, a GI representation of a similar concept.

Steven Stanos:

So we have these really three different ways you can look at pain, nociceptive, nociplastic and neuropathic. And I think in our clinic, and I think David can agree, we see patients that have a combination of these things.

Steven Stanos:

Interestingly, if you think of something like nociceptive pain like joint pain or knee pain, there's been studies now showing that even that pain signal from the nociceptive, from the joint point, the nociceptors in the knee. That persistent pain signal to the brain can cause sensitization of your nervous system in a sense that those patients with joint pain can develop nociplastic pain. So we're really starting to understand what are better and deeper understanding of pathophysiology of pain, not just from the periphery, but all the way to the brain.

Steven Stanos:

Really the complexities of the nervous system and making us appreciate how pain can be amplified, how patients can become depressed. And some of the other more multidimensional aspects of the pain experience. With that foundation, this is going to lead us into our second learning objective, and that's around focusing on actionable strategies that we can use for safe pain management in patients that minimizes the potential for abuse and diversion.

Steven Stanos:

So we're going to focus primarily around opioid management, but a lot of common themes around the complexities of understanding patients in an individualized way in developing treatment programs that can understand that. First to David, I was going to turn over this case that he could present, and we're going to try to weave this in to our discussion over the next number of minutes.

David O'Gurek:

No, thanks, Steve. And great segue into our case. I think case based learning is certainly always wonderful. Keeping an eye on the questions in the chat as well. And hopefully a lot of those questions you answered as they were popping up. So I think you were reading our audience's mind. But we want to look at Keith who's 37-year-old male with low back pain for the past three months from a work related injury.

David O'Gurek:

Most recently he's been initiated on hydrocodone-acetaminophen, five milligrams/325 milligrams up to three per day. His pain hasn't been stable and he hasn't regained mobility and function. And he's also reporting difficulty with sleeping and he's begun sleeping in recliner.

Steven Stanos:

Keeping that case in mind that David mentioned, we wanted to highlight too, the HHS Pain Management Inter-Agency Task Force Guidance that came out in actually I think September of 2019. And it highlighted five tenants of really where pain management needs to be, including medications, restorative therapies like physical therapy and occupational therapy. Interventional procedures, behavioral health interventions, and complimentary integrative.

Steven Stanos:

So really highlighting these five areas. And so with that, I wanted to then turn this over to David and how he would look at our patient, Keith in looking at these five tenets of pain management where he could go with this case. David.

David O'Gurek:

I think as we look at this and thinking about the details of the case, we have some basic information that was there. And many of you are probably thinking and have additional questions. There are things you want to know what happened in that first three months, what things have been trialed already? How have we approached both Keith's initial evaluation as well as ongoing evaluation? And this is all part of ensuring that we treat pain within the context of the individual experiencing pain.

David O'Gurek:

And this means not only prescribing medicine, but utilizing multimodal strategies to address physical functioning, behavioral health, and addressing existing and prior trauma. Part of our initial evaluation of Keith likely already included some assessments that may have addressed functionality. We may have used tools like the Brief Pain Inventory that sometimes we'll use in our clinic that give patient a sense to talk about their experience of pain and how it's affecting them.

David O'Gurek:

We may also have screened for depression. There's certain tools that could be utilized there, there's certainly a number of evidence based tools. In our practice, we'll often use the PHQ-9 with a segue into the... The PHQ-2 with a segue into the PHQ-9 as a screener, looking for underlying mood issues. And I think these components need to be regularly explored throughout the pain care, continuing that we ensure a comprehensive approach. Some practices may even look at trauma and past trauma.

David O'Gurek:

Certainly, the relationship between PTSD and people experiencing chronic pain or high impact chronic pain, there's certainly relationship there. So it's things we need to be thinking about and consider.

Steven Stanos:

Yeah, and it's interesting too, I think, and I'm glad you highlighted the five different areas. What I think was good about the HHS strategy too, is they really show there in the green risk assessment. And risk assessment isn't just medications, but restorative therapies, interventional procedures. We really need to be the thinking safety about patients across the board and also across looking at stigma. Stigma isn't just about prescribing, but access to restorative therapies.

Steven Stanos:

And so I like how the green four areas, risk assessment, stigma, access to care, and I think the last one, which I've really been happy with in our own hospital how we've been using in our clinic is really upping our game around patient education. But that takes time and I think it's going to take changes in how we practice as well. But thanks, David.

Steven Stanos:

We wanted to, with that in mind, and David presented a really I think a straightforward case or a common case that we may see. Not every case is straightforward. We wanted to go through the CDC guideline for chronic pain opioid-prescribing. And so if you recall, in 2016, I think it was in March of 2016, the CDC guideline published 12 recommendations. The 12 recommendations really broke down three areas. One, when to determine the need for opioids. Second opioid selection, dosage, and duration of therapy. And third, the last five recommendations were around assessing risk and addressing harm.

Steven Stanos:

Much of this information had been, I think, used before. It was best practice, but the CDC did a good job of putting those together. And because it was a federal document, I think it was able to get good pickup around the country. We're going to spend time going through the 2016 guidelines and help everyone understand that like any guideline, towards the end of this year and early next year, the guideline is going to be updated. And so we're going to show you areas of the CDC guideline they're going to be changing. And hopefully that's going to help to decrease some of the problems that came about with misinterpretation of the guideline.

Steven Stanos:

So with that, and like I mentioned with the guideline, I wanted to get David's comments on what was some of the things that he saw since 2016, some of the unintended consequences of the guideline. And then we'll be able to walk through a discussion of the 12 recommendations and I think some of the hopefully useful changes that have been made. David.

David O'Gurek:

No, thanks. I think as we well know, a lot of us are familiar with reading guidelines, looking at this. And any strong guideline clearly states within it that it's just that, a guideline and certainly doesn't substitute for the individualization of care, utilizing best evidence and circumstances for the patient that's in front of you. And I think unfortunately, the 2016 guidelines went too far one way where they clearly were codified in law in some circumstances that suggest and dictate the practice of medicine.

David O'Gurek:

And frustrated a lot of providers out there, who felt like their hands were tied now in terms of being forced to practice a certain way or do a certain thing. And certainly, overriding personal decisions that really interfere with the interpersonal relationship that's really essential across the board between us and our patients. But specifically for people who are experiencing chronic conditions, people experiencing chronic pain.

David O'Gurek:

And I think as a result, many people who were experiencing chronic pain and high impact chronic pain that were previously on chronic opioid therapy, despite the fact that they may have been stable, and doing well, and not having any concerns or issues or side effects. And the benefits were significantly outweighing the risks, automatically were treated and targeted as if they had a substance use disorder. And care was abandoned despite seeing these benefits outweighing the risks.

David O'Gurek:

And they were left to circumstances and difficulties. And I think this interference certainly led to an appropriate and understandable mistrust on the part of patient's experiencing chronic pain. They felt abandoned by a system who was supposed to help them.

Steven Stanos:

Yeah. I think you bring up some good points. I think the initial goals of the guideline were to really decrease overdose and really more safely prescribe. And I think one of the bigger issues was that different stakeholders and state legislators, and maybe outside medical groups confused what was supposed to be, how to start a patient on opioids versus those patients that are already on opioids. And so hopefully as we go through the draft of the upcoming guideline, the potential change, I think they're trying to highlight that and to really make more clarity.

Steven Stanos:

Because like you mentioned, we saw a lot of patients that may have been on stable doses, who all of a sudden, the payers or the pharmacy benefit plans were saying that patients had to be lower than 90 morphine equivalence. Things like that that just weren't really a true assessment or interpretation of the guideline. And then unfortunately what we saw were people that were destabilized, and those patients, many of which were higher risk for overdose and other problems.

Steven Stanos:

You talked about harm reduction early on, I think we learned a lot about harm reduction and really being careful about that with any pain that we're going to be working with. And so hopefully over the next couple of minutes, David and I will be able to go over the previous guideline and talk about possibly where the new guideline is going to go. Now, the CDC did put together a working group of about 23 providers that included psychologists, physicians, nurses, and they gave recommendations to the draft.

Steven Stanos:

We haven't seen the complete draft, but we were able to include the draft recommendations. And in red on the right side, includes some of the terminology that may have changed that hopefully is going to be a benefit or a plus to the new guideline.

Steven Stanos:

If we look at the first guideline and what we're going to do here is David and I will go back and forth and just trying to ,with the discussion of the guidelines, the 12 recommendations. The first guideline from 2016 was that nonpharmacologic and non-opioid therapy is preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risk to the patient.

Steven Stanos:

And they really highlighted that opioids should not be first line, but should really be part of a comprehensive program. David, what are your thoughts on the new interpretation?

David O'Gurek:

And looking at the new guideline as we compare, things don't exactly completely balance. So the new recommendation from 2021, the proposed recommendation is looking again at acute pain as well as chronic pain. And certainly, for the acute pain setting, showing that non-opioid therapies are preferred and then considering opioids for acute pain benefits are anticipated to outweigh risks, which I think is perfectly reasonable. I think this is probably commonplace in practices.

David O'Gurek:

There was a question earlier, I think from someone who was practicing in an urgent care setting for people who were presenting with acute pain, that the severity level was higher. And would this be a situation considering for opioids? And certainly, looking at the draft of the new guideline certainly allows for that, and allows for that decision making capacity from the provider, connecting with the patient based on the patient's individual circumstances.

Steven Stanos:

Okay. And actually moving through to the second recommendation, it talks about before starting therapy for chronic pain, established treatment goals with all patients, including realistic goals for pain and function. So again, highlighting the importance of not just a pain reduction, but really focusing on function, and we should consider how therapy would be discontinued. So when you're starting a patient, also having a discussion with them about how you may have to stop the treatment or how that would be done. David.

David O'Gurek:

The new guideline, the proposal from 2021, certainly, a lot of this is fairly consistent and certainly, non-opioid therapy is preferred for subacute or chronic pain. And certainly, having that discussion that includes both the risks as well as realistic benefits. And certainly, establishing treatment goals, and those should be mutual treatment goals. And it sets up that this is a partnership, this is a team effort, we're on this journey together.

David O'Gurek:

Looking at function and setting the stage for a circumstance where if opioid therapy certainly is leading to risks, but not achieving our goals, that it's something that would be discontinued. So don't see sort of a drastic change here. Certainly, the new recommendation is again, perfectly reasonable and I think common place for what a lot of people will do and currently in practice.

Steven Stanos:

And I think what they highlighted too, is this idea of subacute pain. And I know in the state of Washington as part of our pain rules and what's been legislated, this has been characterized as pain six weeks to three months. And trying to focus more on that early period, right before a patient may develop chronic issues around opioid use to really monitor those patients. So you'll see this acute, subacute and chronic prescribing. Again, really trying to limit the patients that need to continue.

Steven Stanos:

Maybe they need acute pain for a short time, but don't need to continue on opioids. So you'll start to see this idea of subacute pain, which we're not used to hearing that, right, David? In medicine usually it's acute or chronic. So that's just a newer term, but really trying to limit those people in subacute going on to chronic, or just being more vigilant about other care they may need.

Steven Stanos:

I think recommendation number three is pretty straightforward, it says, "When you're starting opioids for chronic pain using immediate release opioids versus extended release." And that would be to prevent a person that's opioid-naive or a person that's not used to being on opioids. And if you give them a long acting opioid and they are toxic, that could lead to more harm. So really trying to limit the use of extended release, but really starting with immediate release opioids. And so that really hasn't changed.

Steven Stanos:

I think it's important to remember that you can overdose on any opioid, whether it's short acting or long acting. And overdose is most commonly done with just taking too many pills, regardless of if it's a short acting or long acting.

Steven Stanos:

Number four, David, I wanted to get your thoughts on this. This is where I think there was a lot of controversy. They talked about when opioids are started, and I think this was where it was misinterpreted. Prescribe the lowest effective dose, reassess evidence of the individual benefits and risk when you're increasing a dose over 50. Avoid increasing a dose greater than 90 or carefully justifying a decision to titrate a dose greater than 90. David, what were your thoughts on that? Because I know that's where I think there was a lot of confusion from outside stakeholders.

David O'Gurek:

No, it's certainly a great point, and clearly looking at the numbers and the MME, and sort of drawing lines and making policy and even making laws around practice, looking specifically at the numbers. You can see as well, with the updated 2021 draft guideline, certainly, they're specifically taking out and making this recommendation specific for people with acute, subacute or chronic pain who are actually opioid-naive, so haven't used opioids before.

David O'Gurek:

Looking at these principles, I think like in many things, and in general, in primary care we're often taught and we often follow, you start low and go slow with things. But certainly, that reassessment and looking at the numbers. The differences between the two recommendations, looking at 2016 and the proposal for 2021 aren't drastically different. You see identification though in the new draft guidelines specifically looking at patients who are opioid-naive, as opposed to the previous guideline that was looking at starting. So circumstances may be different there.

Steven Stanos:

Yeah. And it's funny, I'll just try to touch upon some of the questions here. I know we're getting a lot of good ones. One of the questions came in about... There was a question about how many overdoses there were and it was close to 80,000, I think in 2020. But the increase in overdose tests is probably more related to a drug overdose epidemic and illicit fentanyl and heroin. The prescription opioids, prescribing actually continues to go down even before the CDC guideline.

Steven Stanos:

I think the high dose patients are over 90 is decreased by 40 to 50%. So we are seeing fewer people on higher doses, and we're going to talk about that in a little bit around how to get people to safer doses to potentially limit harm to them. That was just one quick question I was going to bring up that relates to what we're talking about.

Steven Stanos:

I'm going to continue with the next part of the guidance. The first, number five, and the second part talks about before starting or periodically during opioid therapy, clinicians should discuss the known risk and realistic benefits. And so really having this discussion with your patient and obviously documenting that, and setting the expectation. David, what's been your experience with that with patients?

David O'Gurek:

No, I think it's... Again, it really highlights some of the challenges that in primary care, a lot of times we experience and just across the board when patients experiencing chronic pain and in that process. I think one of the interesting things that really jumps out to me about the 2021 guideline really looks at optimizing other therapies, working with patients to taper opioids, where looking at the previous one, it makes it really clinician-centric.

David O'Gurek:

The direction around that, as well as the policies and the laws that came out of this. There was, like I mentioned earlier, some of the force tapering and those sorts of things were clearly in the draft guideline. This needs to be a team based approach. And I know we're going to talk about tapering a little bit later, so I don't want to steal the show a little bit too early here. But I think as you look at the updated guidelines, someone had asked the question, "Do we think that the changes in the guidelines really matter?"

David O'Gurek:

I do. I think there is an acknowledgement that some of the challenges of what happened previously have certainly led to unanticipated consequences on a large part. Now, will it see drastic revision in areas where those laws came about? But I do think you should see as you see the draft recommendations a little bit more patient-centricness, patient-centeredness to some of this. Where the patients included in the process and needs to be part of the journey and sitting it in the driver's seat. It's not all clinician-centric and us directing the show.

Steven Stanos:

Oh, good points, I completely agree. Number six, which I think was probably early on, there was some controversy or confusion was around acute pain prescribing. That you want to prescribe the lowest effective dose and use immediate released opioids. Usually you should prescribe no greater quantity needed for the expected duration of pain, which is really hard to predict. But they recommended three days or less will often be sufficient, more than seven days rarely needed.

Steven Stanos:

And really they're still sticking to that, David, I'm not sure. I think it helps in acute pain and being careful and not having a lot of unused medications out there. But if someone has a fracture, that's a little bit different than someone presenting with an ankle sprain. So I wanted to get your comments on trying to make recommendations for such a ubiquitous diagnosis of acute pain, which can really be a lot of different things.

David O'Gurek:

No, and again, I think this highlights and some of the comments that were in the chat and some of the things we think about and we. Or the concerns about the long term complications or concerns about prescribing opioids too early. And it highlights perhaps the importance of risk assessment and one of those elements of the five tenants from HHS, looking at risk assessment. And even at the level of acute pain, doing that risk assessment and better understanding of what are characteristics of individuals who are more likely to transition from an acute pain experience to a subacute pain experience, to a chronic pain experience and a high impact chronic pain experience?

David O'Gurek:

These circumstances and situations, I think again, across the board, it's perfectly reasonable for a good number of individuals. But as was highlighted from some of the questions and some of our comments earlier that there certainly may be individuals where the one to three days or less isn't really sufficient or they may need to be extended a little longer. There's variations in how people experience pain, as well as the severity of a musculoskeletal injury or a pain experience.

Steven Stanos:

Yeah, and it's interesting. I know we have a lot of questions here, but the one question just popped up was, "What do we do when a patient arrives at practice who is already on opioids and has a new acute injury?" Well, you would do the same assessment. You may have to use a higher dose or adjust what they're currently on for that short duration. I think a lot of times, even people going to surgery for planned knee replacement, they're already on pain medicines. They may actually be fearful that something's going to happen with their medicines or their pain won't be treated.

Steven Stanos:

So what I've learned, it takes just talking to the patient, educating them, and then they're more comfortable with what's going to happen. So with the acute pain patient, they're already on chronic opioids. You may just have to adjust what they're currently on and still use, like what David said, good assessment use other interventions. It's not just about increasing the opioid, what are other interventions that can help the patient?

Steven Stanos:

You've already touched upon number seven, which really highlights the importance of reevaluating patients and reassessing them. The eighth recommendation looked at incorporating strategies to mitigate risk, including offering Naloxone. And those are primarily when there's patients that are of increased risk for opioid overdose, such as a history of opioid overdose, a history of substance use disorder, an MME greater than 50, which actually is not too high or concurrent Benzodiazepine use. So that was recommended in 2016. Any comments, David?

David O'Gurek:

Yeah, I think, and later we're going to talk specifically about Naloxone and adding this. I think it's something that a lot of us have perhaps integrated into practice in many ways around caring for people experiencing both pain, chronic pain, as well as people experiencing substance use disorder or people who use drugs. And how we do the is really another talk in a later slide too, that we're going to address a little bit later. So preview of coming interactions.

David O'Gurek:

Certainly, looking at specific risk factors, that increased risk for overdose or where you would do this. There isn't necessarily harm in having the discussion with patients in general just about the benefits of Naloxone, having Naloxone on hand. Also thinking about where you practice, practicing in north Philadelphia, in a community where we see a high rates of overdose in general. It's good for the population to have Naloxone on hand and have it readily available and understand how to administer it.

David O'Gurek:

From a public health perspective, there's other elements of this too, that the pain piece of things, certainly looking at individuals with specific risk factors. But so certainly, this has to happen in the context of a larger discussion and making sure that people understand why we're doing this, talking about it. Utilizing the team as well and a team-based approach to understand education around using the Naloxone if needed, and when it would be needed, and when to administer.

Steven Stanos:

Yeah. And we'll mention it. Yeah, you're exactly right. I have one patient that has no real risk herself, but she's got a son at home that has a history of substance abuse. And so she, out of all my patients, and that day probably is the greatest risk to have an overdose in her house. So very different from what her actual morphine equivalent was. It was more related to her family member.

Steven Stanos:

And so, like you mentioned, almost having Naloxone in the house liken to wearing a seatbelt or having a fire extinguisher. So good. We're going to move on to the last part, which really was the last four recommendations around what to do from a safety standpoint. And so the ninth talks about reviewing the state prescription drug model entering program. Whether a patient's receiving opioid dosages or dangerous combination of drugs, that's recommended.

Steven Stanos:

They recommended early on that you should check every three months. Our state has different rules and probably different from Pennsylvania where David practices. David, what is your understanding and what are your thoughts about, the PDMP and the new recommendations potentially?

David O'Gurek:

This is an area where perhaps the recommendation and the guideline, unless it really changes some of the laws and the regulations around this, you may not see a major change or a major difference here. In Pennsylvania, we're mandated to check the PDMP each time we prescribe a controlled substance. So it's one of those things that the notion of periodically, if we're prescribing every month or every other week, we need to check every time. So that's already codified.

David O'Gurek:

And people need to be aware, I think of their state regulations and policies around this, because even though the guideline may come out, your laws are still going to stipulate what you need to do with your PDMP in your state, as well as perhaps checking in other states as well, depending upon where you practice.

Steven Stanos:

And I think you're right, especially around Naloxone. Checking the PDMP, we can... In our electronic macro, it takes two clicks. We can see all the controlled substances. So yeah, our rules in our state are, with any controlled substance we're supposed to check the PDMP. Hopefully that... I think it opens our eyes to some of the other substances patients are taking and they don't even realize are controlled substances too. And so that always is helpful for a clinician.

Steven Stanos:

The last couple, just for the sake of time, there's the mention of obviously the importance of doing urine drug testing, as well as avoiding opioid pain medications with benzodiazepines. There's been a little bit of change with, I think, expanding that beyond benzodiazepines. But do you want to comment on that drug-drug interaction potential for overdose as well as urine drug monitoring?

David O'Gurek:

Absolutely. And that's a whole talk and a whole evening unto itself, thinking about, because I know speaking with a lot of primary care colleagues, the questions around opioids and other CNS depressants is always a concern, what do you do? How do you manage this? How do you handle this? Particularly if you're having a patient hand it off to you from somewhere else that's on both, what do you do? I think in terms of the risks, again, getting into some of the education, some of the discussion around that and patient-informed decisions around their goals, the circumstances, the situation.

David O'Gurek:

Understanding that patient's context and how they got to that point. Utilizing urine drug testing as part of that too, particularly for people who are on both. Perhaps making sure that there's not other substances that are in there as well. Certainly, not just as part of the checking process to confirm, to make sure that the opioids you're prescribing are in the system, but are there other things?

David O'Gurek:

And picking up other cues and circumstances. People may have gotten a pill from a friend or something like that without actually realizing it was a press pill that had something else in it, and those sorts of things. And not jumping to conclusions just based on one simple urine drug test either with making assumptions that a urine drug test is diagnostic for a substance use disorder. All it really means is if it's truly in there, that someone used a substance that showed up positive within the time window for that specific test.

David O'Gurek:

I think it's an important tool. We need to be careful utilizing as a solo agent for making decisions based on the end-all be-all of what's happening around pain management and understanding what's happening in the patient context there.

Steven Stanos:

Yeah, and especially with doing urine drug monitoring, understanding the difference between the screens that are done that are mostly immune essays versus doing confirmation testing to really understand metabolites. I've seen, unfortunately, patients sometimes being falsely accused and the provider just didn't understand some of the nuances around interpreting urine screens. And also how do even do it? You want to ask the patient first, "When did us take your medicine? Do you smoke marijuana? Do you take other medicines?"

Steven Stanos:

Get them to answer those questions even before you offer them the cup? So it does take time, but many times it may be the first thing that you as a provider bounce into this problem that they have a substance abuse problem. And so it really opens the conversation, like David said, and you need to follow up on that.

Steven Stanos:

The last part was really about, number 12, David, and was around offering and arranging for evidence-based treatment for patients with opioid use disorder. So when things don't work out and patients not doing well, recommending the providers have the abilities to do that. What are your thoughts on that last recommendation?

David O'Gurek:

As a family physician who has my waiver, who prescribes, I'm really, really passionate about this. I think this is something that has been really monumental in my practice. I think having that as an available option and certainly either arranging for treatment. But it's something we can do in primary care in terms of that initiation where people don't need to be referred elsewhere, go elsewhere. That you can certainly offer that option.

David O'Gurek:

There was a question earlier in the chat about people who experience opioid dependence, but not really opioid use disorder. And certainly, medication for opioid use disorder are approved for opioid dependence and not just opioid use disorder, that it could be another option for those individuals. Again, making a clear distinction that there's a difference between dependents versus opioid use disorder.

David O'Gurek:

But certainly for individuals with opioid use disorder and specifically looking at office-based treatment with Buprenorphine. Buprenorphine, Naloxone is something that could be done in the primary care practices, as opposed to methadone that we'll talk about again later. But even extended release Naltrexone as well. So these options are evidence-based things that certainly belong and are monumental to primary care and could be done easily there.

Steven Stanos:

Okay. Well thank you. We got through the 12 recommendations and again, David and I want everyone to understand that these are draft recommendations, they may change. We really want you to be aware of it and obviously know the 2016 guideline. Still surprised that sometimes there wasn't a lot of communication about in the guideline and unfortunately providers may find out on the back end, which makes things more challenging.

Steven Stanos:

So we're actually going to shift a little bit and really look at more, beyond just medications. And I think David and I can both agree, obviously, most patients aren't going to just do well just on medication. There's so many other things we can offer patients. So we wanted to highlight the biopsychosocial models of pain management. We're going to touch a little bit upon pain reprocessing therapy, which is based on pain education.

Steven Stanos:

But David, I wanted you to cover that here and we'll have a kind of a quick discussion about how these kinds of nonpharmacologic interventions, behavioral health education can help patients as well.

David O'Gurek:

Thanks. Really, really essential components is the biopsychosocial model certainly ensuring the patient's experiencing pain are approached with this comprehensive approach. That we understand the impacts of pain on health and vice versa. I'll often talk with patients about the pain experience and how that affects your mood, and how the worsening mood could affect their worsening pain, which in turn worsens the mood. And it's this vicious, vicious cycle. And if we're only looking at one component of that wheel, we're missing the point.

David O'Gurek:

I think many individuals experiencing chronic pain have experienced trauma, some in the form of Adverse Childhood Experiences or ACEs. Some carry diagnosis of post-traumatic stress disorder, as well as other behavioral health conditions. And the impact of pain on behavioral health is significant and traumatizing in part due to its effects on those effective and motivational systems.

David O'Gurek:

So many of us are familiar with cognitive behavioral therapy and approaches. We can also implement many CBT exercises into our practice or have local, and now telehealth, behavioral health services available. Certainly, strategies such as pain reprocessing therapy, works on shifting patients' perceptions of their pain experience. And this particular technique is a brief intervention that's been utilized in studies and includes specific components to really accomplish that goal.

David O'Gurek:

Looking at these studies, specifically for PRT, it did demonstrate reductions in pain intensity, lasting effects, decrease in disability and anger, improvements in sleep and depression. So thinking back to Keith, where we started with our case, who was just starting on his hydrocodone-acetaminophen and was experiencing some issues with sleep and sleeping in a reclining chair. This certainly could have been a strategy to utilize, particularly in his circumstance situation.

David O'Gurek:

And as I understand, Steve, you've dabbled in this a little bit and used this in your practice.

Steven Stanos:

Yeah, and it's interesting that we had a great comment here about motivational interviewing. What this pain processing management is like, it's all similar to pain neuroscience education. And our physical therapists and our psychologists are trained in this, where you train patients about essential nervous system and how pain processing actually changes with chronic pain. We teach them about sensitization and that's what they did in this study. It was really just one hour of a lecture around sensitization and how their nervous system and how their body can respond to threat in the wrong way.

Steven Stanos:

And it teaches patients how to reconceptualize how they look at pain. And so it's great to see now that we're actually able to show that it can show a reduction in pain as well. And so it's really what's called pain neuroscience education, teaching them about sensitization. I always like the idea that the metaphor that we teach is the pain is generating like a false alarm. And so those false alarms don't mean harm. And then we try to get patients to understand that as they're doing their exercises they can advance better.

Steven Stanos:

I think with that quick background, David was able to show in the study what improvements they had. And it's pretty profound. And again, I think it takes away the threat. All of that affects pain processing and the amplification of pain. So thanks for introducing this to our attendees here.

Steven Stanos:

With that, we wanted to go back to our patient. David, you want to give us an update on how Keith is doing?

David O'Gurek:

Yeah. We're back with Keith, and as you recall, from last time we had initiated him on hydrocodone-acetaminophen, five milligrams, 325 milligrams, up to three to four per day. He's been on this for about a year. His pain has improved, he's adherent with his home exercise program, has taken up Tai Chi actually, which has been quite helpful for him. He notes, you may recall from last time he was having trouble sleeping, was sleeping in a recliner. His sleep is better.

David O'Gurek:

His mood he says is good and has been stable for a while now. And he's scheduled to return to work. And he's really feeling optimistic and positive about getting back to work, getting back to activity. So we're going to do an audience response question.

Steven Stanos:

I'll read the question and you read their responses, their choices. What would be your next step with Keith? Okay. I think David and I were betting on this before the show, and I think that's what we thought would be the number one answer. Not that only number two is correct, but yeah, this is a good segue. And we'll talk a little bit about tapering and what you could do. But number two does represent what a slow taper could be. Even though that could be used in many different ways from patient to patient.

Steven Stanos:

With some patients, we do reach this point where it's important that we have an opportunity to taper, whether they're on really high doses and you want to try to get them to a lower dose where it may be safer for the patient. You can undertake opioid tapering really only after there's a thorough assessment. And even if you inherited a patient or in this case with David, we're assessing... I mean, with Keith, what does he need?

Steven Stanos:

It sounds like in his case, he's doing better. He doesn't really need to be on opioids any longer. He's probably now opioid-dependent. So we want to slowly decrease him to eliminate any withdrawal effects. There's other reasons a patient may have. The benefits no longer outweigh the risks. Maybe they're having more problems with opioids. They may not reach criteria for opioid use disorder, but they're not functioning well.

Steven Stanos:

They're having other adverse effects and maybe it's time to really shift their treatment. And they may be a candidate for tapering for that reason. So there's a lot of reasons, it really needs to be mutually discussed with the patient and what you want to do. Again, you want to understand the underlying conditions and comorbidities, especially with decreasing patients' opioids. It may unmask their depression of their anxiety.

Steven Stanos:

Remember opioids just don't cause analgesia, they have anxiolytic effects, there may be some antidepressant effects. And so it may actually trigger other problems, so you want to be really careful with that and consider their other comorbidities. This flow chart is from the HHS report. It's really a nice five or six-page summary that I think outlines nicely different ways that you can approach tapering patients.

Steven Stanos:

And so here on the left, but you would assess the benefits and risk of continuing to opioids at the current dose. And so to the right, in this case, benefits outweigh risks. So we're documenting that we did the risk assessment, patient's doing fine, we're going to continue on that dose. To the left maybe the risk outweigh the benefits, so we're going to educate the patient about the taper. Many times I give patients information and tell them, "We're going to start a physical therapy program. You're going to see our behavioral health specialist, our psychologist. And then over time as you learn more skills, we're going to slowly start reducing your dose."

Steven Stanos:

So you can do this in many different ways. You want to give the patient other tools before you start tapering them in most cases. Many times you want to be able to pause the taper. If the patient's doing well, maybe you slowly undo the taper. And then for one or two months, you stop. And then two or three months later do an additional taper so their bodies can adjust. So the key is you can do this many, many different ways.

Steven Stanos:

Those patients that are struggling with the taper or maybe have an opioid use disorder, it may be easier to taper or transition that patient to someone that's trained to initiate buprenorphine for opioid use disorder. Or refer that patient to an addiction specialist. So I think the flow chart here from the HHS really just gives a nice summary on some of the broader strokes and what you can do it if you're going to taper a patient.

Steven Stanos:

Whether it's a patient that's doing well that no longer needs to be on opioids versus a patient that's developing problems. And you're going to really need to get more specialty care. They do talk about slow tapers, and slow tapers are around 10% per month. You can do a faster taper where it's 10% per week until you get down to 30% of that dose. And then you go down by 10%. I think patients are so used to the number of pills that they're taking that we have them... If they're getting 120 pills a month, we have them go down to 110.

Steven Stanos:

And just decrease the total number of pills and give them a little more flexibility for that month on how much they're going to use. So there's many different ways you can do that. The slower tapers are safer, faster tapers may make the patient unstable. And again, you really want to continue to reassess the patient as well.

Steven Stanos:

That was just a quick overview of tapering. We want to move on to our third learning objective, which is to identify risk factors in clinical presentation of opioid use disorder in those patients prescribed opioids for acute pain. And David and I also wanted to highlight, we're going to be using the same ideas and concepts in looking at anyone with substance use disorder. Whether it be alcohol and other substance use, you can use the same approach.

Steven Stanos:

David, before Keith was prescribed opioids, what should the primary care provider have been thinking about early on with Keith when they were initiating?

David O'Gurek:

As we talked about sort of some of that risk assessment happens with that initial evaluation, and part of your initial history is gathering information just in general. A comprehensive picture of their health, particularly if it's a brand new patient to you. Some of their past history, their family history, assessing your physical exam. As part of this, you are looking also, are there risks or signs of other perhaps substance use issues or perhaps other ongoing substance use disorder?

David O'Gurek:

And there could be tools and things that are helpful that feed into that risk assessment that have a better understanding of what's happening around the person's risk for developing a substance use disorder. Understanding their substance use history, their family history of any substance use issues or substance use disorder. This gets into perhaps some of the screening around things like adverse childhood experiences if you're going to implement that into your practice and utilize those things to address from a trauma-informed care practice to just get an overall picture for people's health.

David O'Gurek:

And certainly seeing individuals with increased adverse childhood experiences have a higher risk of a number of chronic diseases, including chronic pain, as well as substance use disorder. So something that may be of consideration and part of that risk assessment to decide on that journey, whether you're going to think about prescribing opioids. Does this person fall into a category of low risk, medium risk or high risk?

David O'Gurek:

And as we look at this, this is something that now recently with the changes, the United States Preventive Services Task Force recently changed their recommendation for adults on screening for substance use, from an A recommendation to a B recommendation. So this screening isn't specific for opioids, but really is an open discussion around substance use as part of our routine social history. Again, to get a comprehensive picture of the person's health.

David O'Gurek:

Certainly, there's been evidence based strategies that have been used in many different care settings like SBIRT, screening, brief intervention, and referral to treatment that show evidence for effectiveness. Particularly for individuals engaging in risky alcohol use. So when we think about the SBIRT principles and we think about the screening there, we're not really looking for someone who has alcohol use disorder. We're looking for someone who's engaging in risky alcohol use to prevent the progression to alcohol use disorder or to prevent the complications of that risky use.

David O'Gurek:

And it's important to recognize and realize that this is a screening for use alone. So a positive screening certainly isn't diagnostic of a substance use disorder, and a clear distinction must be made. But as we think about this and we have these conversations, clearly we're going to identify individuals who screen positive and do have report that they're using drugs. And having that conversation can sometimes be uncomfortable in the office. Steven, any tips?

Steven Stanos:

Well, I think you had mentioned it earlier too, especially talking about family history is really having that open conversation. I think sometimes we feel a little cautious that we're going to offend a patient. Really doing a good history, "What's your previous substance use history?" We're just meeting patients for the first time, they have many years of history. And so you want to ask pointed questions, "Have you had problems with alcohol?" Really doing a good social history in asking about family.

Steven Stanos:

And then I think they'll start to understand why you're doing this and the importance of this. For the sake of time, there's so many different tools that you can use like the Opioid Risk Tool, SOP Tool, Current Opioid Misuse Measure. So we wanted to comment on the Opioid Risk Tool, which has been validated, which I think really represents a good social history. And what the Opioid Risk Tool does, and we use this for our patients.

Steven Stanos:

Any patient that's going to be on opioids, we have them fill this out. It goes over five areas, family history of substance abuse, personal history of substance abuse, age between 16 and 45. We think those are higher risk between 16 and 45 for opioid use, so you get points for that. History of preadolescent sexual abuse. I'm amazed, David many times, this is the first time patients have ever been asked this question.

Steven Stanos:

And that in itself can open a really good area of treatment for that patient. It is scored whether you're female or male, and that's just based on how these tools were put together. But obviously females get three points, males get zero. They're probably less likely to report this, but if they report it, I count it. And then the last is psychologic disease. If you have bipolar disorders, schizophrenia, ADD, OCD, depression. All of those could make you at risk.

Steven Stanos:

And this is at risk for abhorrent behaviors, not for an addiction problem, but just for abhorrent behavior. So you score it up, zero to three is low, four to seven is moderate, and greater than eight is high. We use this tool to actually risk stratify all of our patients. And we also combine their medical risks, including pulmonary problems, respiratory problems, medical issues, and then other drugs. So we use this as part of our risk stratification for all of our patients. But I think this is really just a good social history that we would want to take for any patient.

Steven Stanos:

So with that, I wanted to turn it back to David. And just briefly, if you talk about, depending on the risk level, what advice would you give? How do you assess that? And then where would you assist to get them treatment? And then we want to move into the last part and have time to get to questions. David, what would be step three for you?

David O'Gurek:

This is really the opportunity where our motivational interviewing skills can come into play here and with identification that a person reports using a substance. I actually always like to explore what if anything they like about using it? What are the positives of using it? Understanding some of the whys behind that. Many people who have a substance use disorder will tell you the first time they used substance was the first time they felt "normal" in their lifetime. And who wouldn't want to feel that way?

David O'Gurek:

So understanding the positives about what they like about it. And then subsequently what, if any negative effects they perceive from it, and understanding those principles? I think we need to resist jumping into lecture mode and certainly being like, "Well, we need to tell you what all the negative effects are." And not assume that they don't already know those things because many people do.

David O'Gurek:

And utilizing a strategy where we're asking them, telling them, and then asking them. And certainly, this is a strategy within motivational interviewing where we ask permission to ask these questions. "Would it be okay if I shared with you some of the risks that I know related to use of blank? Or what some of the complications could be? And jumping in again with permission to share that and creating a culture where it's welcomed, it's open. And if someone's resistant, then we could move forward.

Steven Stanos:

I like the way you're talking, David. I already feel better just the way you said that. It's like, when was the last time we asked the patient, "Is it okay if I share this with you?" And especially if a patient feels stigmatized already. They just don't feel comfortable with you and you just gave a very different presentation to them.

David O'Gurek:

Absolutely. Changing-

Steven Stanos:

Sorry about that.

David O'Gurek:

Just a frame shift in our approach can really create... And not jumping to conclusions too, that the goal is for the person to stop. Sort of what are their goals around their substance use? And if their goal is to cut back or they'd like to come back, or they'd like to do it in a safer way or a different way, their strategies, we can do. We talk about harm reduction strategies to certainly address that in a very real way.

David O'Gurek:

So we find opportunities for intervention, and through motivational interviewing, finding the change that the person wants to make, as opposed to jumping to conclusions and us assigning tasks for that individual.

Steven Stanos:

And I think here, David, we just wanted to highlight just the areas around the language that you can use to reduce stigma or just have just a better, more, I think, constructive discussion with your patient. If you want to comment on those, just tips real quick on what terms you can use and just adjusting how you communicate.

David O'Gurek:

Yeah. Language matters. Simply put, language which matters. It's so important in building a culture within your practice. And it's not just you as the clinician, it's certainly everyone that greets the patient from when they walk in the door to when they leave around that approach. And hearing the way you talk or the words that you use so that we don't propagate stigma or traumatize our patients. Like anything, we should be using people first terminology. So a person who uses drugs or a person with substance use disorder.

David O'Gurek:

Just like we shouldn't be saying diabetic, we should say a person with diabetes. And transitioning our language really opens opportunities for rapport, connectedness with people using drugs to understand that they're use isn't going to be judged. That they can openly discuss it and explore options within the practice creates a setting again, where you can really make change.

Steven Stanos:

The next area we're going to go to is more on the FDA approved medications. We could probably talk two hours about this, but if you could give us a nice summary of... We really have old options, newer options, and I think evolving options, if you look at the pharmacotherapy. Obviously separate from the behavioral interventions.

David O'Gurek:

Yeah. Certainly, medications for use of treatment for opioid use disorder, and again, this goes back a little bit to the language where a lot of times in the past, these were called MAT or Medication Assisted Treatment. And the transition has been to call this MOUD or Medications for Opioid Use Disorder. I like to just call it treatment. We call insulin treatment for diabetes, why don't we just call this treatment for opioid use disorder?

David O'Gurek:

So certainly, methadone has been around the longest, and for most of us isn't something we're going to be prescribing in our practice specifically for the treatment of opioid use disorder. Something that can only be delivered at federally regulated treatment sites is the full opioid agonist. And then we have the buprenorphine products. The buprenorphine, as well as buprenorphine mixed with Naloxone. And those are the partial agonists that are available for delivery through office-based opioid treatment, which could and should be integrated into primary care.

David O'Gurek:

As of now, still requires a data waiver with an X number from your DEA across the board federally to be able to prescribe buprenorphine specifically for opioid use disorder. Some of you may prescribe buprenorphine for pain and some of the other formulations. That doesn't require a specific DEA X number. And then naltrexone, extended release naltrexone, injectable formulation using for treatment for opioid use disorder. And realizing too that this could be helpful for individuals with alcohol use disorder. So this is something that could be offered for those patients as well.

David O'Gurek:

And as we look at specifically buprenorphine and buprenorphine-naloxone, I think it's important to point out there was a recent change in the DEA SAMHSA requirements regarding the waiver. So previously you needed to complete eight hours of training, which could be in-person, it could be online. Or there were other ways to be able to qualify for the waiver training if you were boarded in addiction medicine or other things.

David O'Gurek:

With the most recent changes, you no longer need to have the training requirement. You do still need to go on to the SAMHSA website and actually register for your XDEA number. So you still need to do and have the waiver. Without the training, you can prescribe to up to 30 patients. But to go above that, and you would need to undertake training and complete the eight hour courses, which are available for free in some settings to complete online and some live courses are still available as well.

Steven Stanos:

I know we've had really some good questions. Some of the questions came up about pushback from payers. And I think when we talk about buprenorphine, there's been some problems, but hopefully it's getting better. That there's been more access because buprenorphine is, is BuTrans patch, and other types of buprenorphine are also indicated for chronic pain. We can write it off label for tapering patients as well.

Steven Stanos:

But hopefully over time with even the CDC guideline, there's going to be more access to buprenorphine getting approved. Because we're still struggling in our clinic for many of our patients separate from those that need it for opioid use disorder for chronic pain, getting some pushback. But hopefully that's getting better. I don't know about you David, but I understand that buprenorphine can also be indicated for chronic pain and that gray area is hopefully going to get better.

Steven Stanos:

I wanted to ask David, in their practice, how they're using Naloxone? In our state, it's based on their risk if a patient should be offered Naloxone. We obviously talk to all of our patients about Naloxone. But how has it been for you? Naloxone being a very powerful agent, an opioid antagonist that can reverse an overdose death, that can reverse respiratory depression and save people's lives.

Steven Stanos:

But in that small number of patients where this could be obviously death, could lead to death, it can be very valuable. But how do you prescribe Naloxone and what have you been some of your challenges with patients?

David O'Gurek:

Yeah, it's a great question, and I think there's unique challenges based on where you're practicing in term of access and cost and different circumstances. And a lot of that's being addressed. Certainly, again, as I alluded to earlier, practicing in Philadelphia, it's something... I talk with a lot of patients about it, just having it off hand for friends, for family members. It's atypical to find someone whose lives hasn't necessarily been touched by the overdose crisis.

David O'Gurek:

So certainly, having Naloxone on hand just from a public health principle and understanding this is, is a good thing. Specifically around co-prescribing really with using opioids for pain. Or as well as co-prescribing with buprenorphine, which I think is a critical thing and something that should be part of the standard practice when prescribing buprenorphine, you're also co-prescribing Naloxone as it certainly is an opioid as we mentioned.

David O'Gurek:

Having discussions with patients about why you're prescribing it, the utility, the benefits. This is too where you could bring in some team-based care if you have clinical pharmacists integrated into your practice or your local pharmacist could work on teaching for administration. Having some patient education that has some opportunities to teach about when to use, how to check for signs and symptoms.

David O'Gurek:

Certainly, the challenges sometimes are navigating the conversation, number one, and making sure that people understand when to use it, how to use it and why. The other challenge has somewhat been around cost and access issues. And I think it's getting better, I know in Pennsylvania. They've definitely been expanding programs to make sure that the copays get a lot cheaper for people. Some of the copays are still out of reach for some individuals.

David O'Gurek:

But it's something that I think is of good importance that in terms of the recommendations, looking at the risk factors and the MME level is one strategy. But just as good standard public health practice, I think it's good to have a discussion with everyone that you're prescribing opioids too.

Steven Stanos:

And I think in our practice too, and many times I will give patients information and say, "I want to give you information and your after visit summary today about Naloxone. Why don't you read it, go online, look and see what you think about. When you come back at the next visit, hopefully if you're with a family member," because many times you want to talk with a family member because they'll be administering the Naloxone, not the patient. There may be better buy-in.

Steven Stanos:

And also I try to recommend to patients if I do prescribe it, that when they go to the pharmacy to take a family member, and the pharmacist hopefully can help you in explaining to the family member about how intranasal is mostly what's available. I will say we haven't seen increased access. Most states have an open prescription that's written by the state health official that anyone can go up to a pharmacist and get Naloxone even without a prescription.

Steven Stanos:

Know what's going on in your state. Again, I think it's just really knowing your patient, and having that discussion with them and being open with them. I think they're going to know you want to help them and prevent harm.

Steven Stanos:

With that, we're going to go through our fourth objective and really overview this. And we've really had some great questions that I want to go over this with David and we can try to get through those as well. The fourth objective is around educating patients about their pain and to optimize safe and effective multimodal treatments. We really wanted to highlight, again, some of those non-pharmacologic interventions.

Steven Stanos:

We know chronic low back pain can affect function and biopsychosocial factors are going to be so important in that. There is a study we want to just briefly go through, where they actually help patients with goal setting. Different from you as a clinician, telling the patient do exercises, this was actually goal setting that was directed with the patient where they could individually focus on things. And the thing about goal-setting is it really helps patients with their own self-determination, their own self-efficacy.

Steven Stanos:

And then you can tailor what things they actually want to do. I think we wrongly thought in the past that our goals as a physician or provider are the same as the patient's and many times they're not. And so what this study did, it was a pilot study. It looked at a patient-led goal-setting, and it actually interestingly included pain neuroscience education. So they taught them about the complexity of their nervous system and how their nervous system can change with chronic pain. And then they really did guided goal-setting with the patients.

Steven Stanos:

And over this period, they we're actually able to show, even with patient goal-setting, compared to traditional models of just giving people full exercises. Patients actually did better with treating their chronic low back pain. So here it shows on the left, their pain intensity over baseline and light blue is with goal-setting initiative versus usual care. And actually they're able to show a similar reduction, and both of these were clinically meaningful with a change in disability.

Steven Stanos:

So the take home point is, I think making patients more active in their own care and setting up what their goals are for treatment can have a profound effect on these nonpharmacologic interventions. And so I'm so glad that someone brought up motivational interviewing, but it's kind of in the same family with motivational interviewing on the clinician side versus goal-setting. Which is really related to motivational interviewing and making patient-centered care and patient-centered decisions.

Steven Stanos:

So we really wanted just to highlight that goal-setting can be very important for your patients. David, I think any other comments about patient education and other tips that providers could use? Because this is really a different way of us thinking with regards to how we deliver care to patients.

David O'Gurek:

Yeah, I think at a very high level, your patient education always must be geared towards your population, understanding their needs. Perhaps asking questions around how do they learn best? And then providing education on those fronts, if people do better with pictures, if people do better with words. Certainly, there's a lot of available education materials that are already out there. For those in primary care that maybe have patient and family advisory councils.

David O'Gurek:

This is a nice task for those councils to really, from the patient perspective, provide educational tools that would really be valuable for the practice that certainly address health literacy issues and are appropriate under those settings. I think the other big piece, particularly when we're thinking about prescribing medication, certainly, with opioids, but this doesn't necessarily need to be limited to opioids either. It can certainly be with any controlled substance or other substances.

David O'Gurek:

Certainly, thinking about where you're storing your medicine, making sure that it's in a safe and secure location. As well as thinking about disposal of medications, particularly as we're thinking about perhaps a tapering process, and you're going through that, and someone may have extra medication laying around. There's other family members at home or young kids at home and those sorts of things. All things we want to be thinking about that seem so straightforward, but sometimes aren't part of those initial discussions as we're prescribing are on that journey.

David O'Gurek:

So certainly, looking at what's available in your local community with regards to medication take back programs. And then giving some specific advice around how to dispose of medicine in the household trash or drug deactivation pouches. Certainly, different strategies for how to discard medications, I think are important as part of the educational process that are unique. Maybe specific here around opioids, but I don't think are drastically different from other substances or other prescriptions that we may write for as well.

Steven Stanos:

And you're right. I've learned to really talk about asking patients where do they store their meds even from early on. So it's not something you're doing at the end when they're done taking their medicines. I think across the country, we've seen a significant reduction in just medicines... the number of pills prescribed after surgery for a simple surgical procedure. Instead of getting 60 pills, people getting maybe five and 10, and not having all these unused medicines.

Steven Stanos:

A lot of the problems that we saw early on were related to these unused meds, like you mentioned, left in medicine cabinets and an adolescent or a substance user or someone experimenting gets their hands on those pills. That kind of education's going to be important. I think now with the electronic medical records and your after visit summary. You can make dot phrases and have a lot of this content you can give to patients.

Steven Stanos:

And I think follow up on it too, "We're able to do this?" And really highlight the importance of these interventions. So thanks.

Steven Stanos:

Lastly with that, David, why don't we go over some of the SMART goals, those specific, measurable, attainable, relevant and timely? That'll give us hopefully around eight or nine minutes to go through some of the questions. So do you want to go through the first three?

David O'Gurek:

Sure. I think a lot of this is a summation of things that we've already talked about. Certainly, when utilizing our multimodal approach, aligning treatment choice to the type of pain, someone asked early on with one of the questions, "Why is it important to classify the type of pain?" And certainly, that can align choices in terms of options and treatment from the medication perspective that we're having discussions with.

David O'Gurek:

And can also help in discussion and in conjunction with the patient, remembering really that pain isn't just about the injury and addressing the biopsychosocial model to pain management, incorporating some of those other strategies and tools. And certainly, for patients with chronic pain who are stable on long term opioids, going with them, undertaking the tapering journey often with a thorough assessment of risk and benefit.

David O'Gurek:

And making sure the patient's included in that process and in that decision making. Not only at the beginning, but also throughout the process. And not that you set out on this goal and you're going to follow this specific strategy. And if there's not opportunities to slow down or go in a different direction or those sorts of things. So making sure that you're along with them for the journey is important.

Steven Stanos:

And I thought too, I wanted to remind people, we briefly brought up this idea of high impact chronic pain, which really is a pain affecting their function and their ability to do the things they like to do. Maybe more clearly defining those patients that we see in clinical practice and nociplastic pain, where pain arises from the altered nociception, despite no damage to that system. There's some kind of change in the nervous system and that underlying the sensitization issue.

Steven Stanos:

And I think we also highlighted too the importance around engaging patients about opioid treatment. And obviously I think talking about this, being a stigma-free discussion and understanding the beliefs that patients have, and where they come from and their culture and their background is going to be really important. Ensure that patients on opioids have knowledge and access to Naloxone. We talked about, or for their family members.

Steven Stanos:

So not just this is a patient issue, but a community issue and a family issue that we as clinicians are responsible for helping try to mitigate that risk. But I think also the whole idea about goal-setting and making patients more active. Not just talking about the medication side, but goal-setting for physical therapy and all the things that they want to do. So really making this more of a dynamic relationship between the provider and the patient versus a one way, you're the clinic, this is what you need to do.

Steven Stanos:

I think if we can practice in that more dynamic fashion. Hopefully our patients are going to learn more, they're going to have a better engagement with you. And then we can really provide a comprehensive care of patients that's really individualized as well.

Steven Stanos:

Again, thank you, David. We want get to the questions here. We did have a question. It says, "Why does one of the disposal methods states do not crush?" Well, early on, there's the question of if you crush an extended-release opioid and obviously if you took it, it then would turn into immediate release. That's where there'd be those dumping. I think they're talking about putting medicines in the trash in a distasteful substance like coffee grinds or kitty litter. So if someone did get in the trash, they wouldn't be able to use that medicine.

Steven Stanos:

There is this issue around flushing medicines, and some people think there's an effect on the environment. They've done a number of studies showing that that impact is minimal if at all. If you can't get a medicine back to a take back program or just a box. In the pharmacies now we see a lot of these take back boxes. The FDA feels that it may be safer to flush the medicine versus keeping in your medicine cabinet and someone getting their hands on it.

Steven Stanos:

Again, you want to have that conversation with your patient and know which meds can be flushed and which can't. Versus really, I think now they can go online and find out within a 10-mile radius where a take back program is. Most pharmacies now are starting to have those receptacles that they have, that meds can be returned.

Steven Stanos:

David, do you want to take the next one? There was about topical NSAIDs, and I think diclofenac gel came up. And is there a role for those? I know the presentation today was obviously more on opioid prescribing and in pain management, but what's the role for topicals in what conditions do you see that those could be effective? That topical, NSAIDs like diclofenac?

David O'Gurek:

Actually, there was a recent network medical analysis done, guideline that came out from ACP and AFP around treatment of acute musculoskeletal, non-low back pain that looked at utilization of topical NSAIDs with or without menthol. And the addition of menthol didn't seem to change the circumstances or the results that showed effectiveness. So for non-low back acute musculoskeletal pain, it seemed like that the topical NSAIDs were effective. Certainly, for people who have been experiencing more chronic pain, I'll utilize them. Sometimes with varying degrees of effectiveness.

David O'Gurek:

Certainly, for individuals who maybe can't take the NSAIDs for other reasons, dyspepsia issues, GI issues, bleed issues. It's certainly something to consider in trial. You get mixed efficacy for the individual and recognizing again, that it's just one component and part of the larger pain treatment system. So it's tough to gauge one specific strategy, its effectiveness for someone that's experiencing chronic pain or high impact chronic pain, unless you're doing this as part of a multimodal strategy. But certainly there has been efficacy, particularly in acute pain looking with topicals NSAIDs.

Steven Stanos:

And I would just comment, I think the American College of Rheumatology in 2020 released their new guidelines for hip and knee pain. And there's more evidence to use topicals earlier, and I think that's a great reference. And they really highlight the patient individual factors, other medical comorbidities when you're selecting those. So that may be a good reference as well. We actually have a question here, I think maybe summarizes a lot of the other issues because we have a couple minutes left here, David.

Steven Stanos:

This one, I really like. It says, "I work frequently as a locums physician, I have come across patients using methadone or buprenorphine with an opioid or a benzo who want us to refill the opioid or benzo. How should I handle this?" That's a tough one, yeah.

David O'Gurek:

It's a tough question. Some of the circumstances are interesting, so the methadone, remember they may be on methadone for pain management. So maybe they're on an opioid addition for some acute on chronic pain in addition to that, as opposed to being on methadone for treatment for opioid use disorder. Certainly, I think patients who are presenting that are part on methadone for treatment for opioid use disorder or buprenorphine, buprenorphine-naloxone for opioid use disorder.

David O'Gurek:

It's nice opportunity to talk with the patient if it's okay to have a conversation with their treatment provider around that and get permission first. And have a discussion around some of those treatments. Clearly with utilizing the PDMP, they're going to see what other prescriptions are written for, and there may be situations or circumstances where using opioids on top of buprenorphine, if someone recently had surgery or is an acute pain circumstance. But a lot of providers who are prescribing buprenorphine like to be part of that perioperative pain management strategy or circumstances around the benzodiazepines. We talked a little bit about that earlier.

David O'Gurek:

Certainly, the risks are there, but you do need to weigh the benefits versus the risks as well and get an understanding. If someone's being prescribed both a benzodiazepine and opioid, they're on methadone or on buprenorphine. Usually that's being done by someone who's a stable provider that's seeing them for a while and interconnected. And then clearly their prescriber who's writing for the methadone, or buprenorphine's aware of that as well through drug testing or PDMP.

David O'Gurek:

I think there isn't one easy answer to this to say, "Just continue or stop," but it's something to think about.

Steven Stanos:

And just a quick comment, there was a question about how do you convince a patient for the three to seven days of a medicine is enough for acute pain after postoperative pain? Again, I think the limits they had have been more from the pharmacy benefits plans will only approve a seven-day supply. So you may have to say in your note like in our state that they need this for 14 days because of X. And so in our state of Washington, you can get more than a three to seven-day supply, but you need to make a comment in the prescription.

Steven Stanos:

So I agree, there's probably issues where patients would need a longer day supply. I think they're just trying to limit the number of unused medicines. So it's going to be have to be more of a communication with the pharmacist, but that's a controversial question. I'm glad you brought that up.

Steven Stanos:

We're actually running out of time. I really want to thank David. I think we could have added another 30, 40 minutes, right? To get through all the questions. To receive your CME credit for today, or CE credit, complete the post-test evaluation and you'll be able to download and print your certificate immediately upon completing that task.

Steven Stanos:

Again, I really want to thank David for joining me for this really important discussion and thanks to the audience for your participation. We're sorry we couldn't get through more questions, but we really hope this was a value to you and value to your patients. And I want to thank CME Outfitters for really helping to put together a great CME event. So thank you very much.

