



Blueprint in Practice

Elevating Pain Management and Opioid Safety Across the Care Team

SYLLABUS & COURSE GUIDE

A free, 90-minute live activity

Premiere date: Wednesday, October 28, 2026

6:30 PM–8:00 PM ET



LOGIN

cmeoutfitters.com/WC160



FACULTY

Johnathan Goree, MD (moderator)
Carrie Hyde, MD
Sudheer Potru, DO, FASA, FASAM

Take advantage of our LIVE Q&A segment during this webcast!



Click on the Ask Question tab to type and submit a question.



Email a question or comment to questions@cmeoutfitters.com.



Call CME Outfitters at 877.CME.PROS.

Information for Participants

STATEMENT OF NEED

Effective pain management is more complex than ever. As opioid prescribing guidance continues to evolve, clinicians must stay current with the latest evidence to deliver safe and patient-centered care. The FDA Opioid Analgesic REMS Education Blueprint and the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain provide essential recommendations for responsible opioid prescribing, acute and chronic pain management, opioid safety, and the recognition and treatment of opioid use disorder (OUD). These resources also address persistent gaps in clinical practice and clarify misapplication of earlier recommendations that contributed to unintended patient harm. Despite these advances, clinicians and multidisciplinary care teams continue to face challenges translating guidance into everyday practice – particularly in emergency settings and opioid counseling.

This live Engage the Experts webcast from CME Outfitters will bring these principles to life through practical, real-world clinical decision-making. Through expert discussion, brief patient cases, patient perspectives, decision point polling, and live Q&A, learners will apply biopsychosocial assessment, validated pain tools, multimodal treatment, opioid risk assessment, safe prescribing and counseling, DSM-5 criteria for OUD, and evidence-based, non-stigmatizing communication. Patient experience checkpoints will reinforce shared decision-making and what patients need to understand at key clinical decisions.

LEARNING OBJECTIVES

At the conclusion of this activity, learners will be able to better:

- Identify physiologic and biopsychosocial factors that contribute to common pain etiologies and influence treatment selection
- Apply validated pain assessment tools to guide individualized, multimodal pain management decisions
- Integrate strategies from the 2022 CDC Clinical Practice Guideline for Prescribing Opioids to the development of safe, effective pain management plans for patients with acute, subacute, and chronic pain
- Counsel patients on multimodal pain management to support safe, effective treatment plans, including appropriate opioid storage and disposal
- Assess risk for opioid nonmedical use when developing multimodal pain management plans
- Utilize DSM-5 criteria to identify opioid use disorder (OUD) in patients prescribed opioids for acute and chronic pain
- Incorporate evidence-based communication strategies in practice to discuss potential OUD diagnosis and treatment options with patients

FINANCIAL SUPPORT

This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies. Please see [here](#) for a listing of REMS Program Companies. This activity is intended to be fully compliant with the Opioid Analgesic REMS education requirements issued by the U.S. Food and Drug Administration (FDA).

TARGET AUDIENCE

Physicians, nurse practitioners (NPs), physician associates (PAs), nurses, dentists, pharmacists, psychologists, and other HCPs in aligned specialties

Faculty

JOHNATHAN GOREE, MD (MODERATOR)

Chief of Staff

Neurosciences Service Line Director

Director, Chronic Pain Division

Professor of Anesthesiology

University of Arkansas for Medical Sciences

Little Rock, AR

Johnathan Goree, MD, is Chief of Staff, Neurosciences Service Line Director, director of the Chronic Pain Division, and a professor of anesthesiology at the University of Arkansas for Medical Sciences. He completed medical school and anesthesia residency at the Weill College of Medicine at Cornell University and chronic pain medicine fellowship at Emory University. He has published over 50 peer reviewed publications and given over 100 national and international lectures in his 11 years in academic medicine. Dr. Goree is an advocate for his patients and others and is currently a board member at large of the North American Neuromodulation Society.

CARRIE HYDE, MD

National Medical Director, Workforce Development & Strategy

Gentiva Hospice

Physician Acupuncturist

Carrie Hyde, LLC

Little Rock, AR

Carrie Hyde, MD, is the National Medical Director of Workforce Development & Strategy for Gentiva Hospice, where she provides physician leadership in clinical quality, workforce development, documentation excellence, regulatory compliance, and hospice eligibility across multiple states. She is board-certified in Internal Medicine and Hospice & Palliative Medicine and has additional training in medical acupuncture.

Dr. Hyde is nationally recognized for her expertise in hospice and palliative medicine, pain management, safe opioid prescribing, and serious illness communication. She has served as faculty for national conferences including PAINWeek and CME Outfitters, authored book chapters on opioid-induced hyperalgesia and chronic pain management, and led initiatives focused on physician education, documentation quality, and responsible opioid stewardship. Prior to her current role, she served as Chief Medical Officer of the Palliative Care Division at Gentiva, overseeing Illumia Health and Empatia Palliative Care.

Her clinical and academic interests include trauma-informed pain care, hospice eligibility and prognostication, palliative care innovation, clinician education, and integrating evidence-based pharmacologic and non-pharmacologic approaches to improve quality of life for patients living with serious illness.

SUDHEER POTRU, DO, FASA, FASAM

Director, Complex Pain Clinic

Atlanta VA Healthcare System

Atlanta, GA

Sudheer Potru, DO, FASA, FASAM, is a triple-board-certified anesthesiologist, pain medicine physician, and addiction medicine specialist at the Atlanta VA Medical Center in Georgia, where he serves as the director for the facility's complex pain management clinic. His primary clinical and research interests are in the intersection of opioid safety, substance use disorders, and empathetic communication in both outpatient and perioperative pain medicine. As an accomplished speaker, he has published extensively and lectured both nationally and internationally on these topics; he recently took over as the primary host of *Pain Matters*, the official podcast of the American Academy of Pain Medicine. He serves on national committees for the American Society of Anesthesiologists (ASA), the American Society of Regional Anesthesia (ASRA) Pain Medicine, and the American Academy of Pain Medicine.

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It is the policy of CME Outfitters, LLC, to ensure independence, balance, objectivity, and scientific rigor and integrity in all of their CE activities. Faculty must disclose to the participants any relationships with commercial companies whose products or devices may be mentioned in faculty presentations, or with the commercial supporter of this CE activity.

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FACULTY

Johnathan Goree, MD, reports the following financial relationships:

Consultant—Abbott; Saluda Medical; and Stratus Medical

Carrie Hyde, MD, reports no financial relationships to disclose.

Sudheer Potru, DO, FASA, FASAM, reports no financial relationships to disclose.

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Katherine Itacy, Esq—no disclosures to report

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Andrea Perseghin, EdD—no disclosures to report

Sandra Caballero, PharmD—no disclosures to report

Sharon Tordoff—no disclosures to report

All identified conflicts of interest have been mitigated.

Faculty of this CME/CE activity may include discussions of products or devices that are not currently labeled for use by the U.S. Food and Drug Administration (FDA). The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any uses not approved by the FDA) of products or devices.

Post-tests, credit request forms, and activity evaluations must be completed online (requires free account activation), and participants can print their certificate or statement of credit immediately (75% pass rate required). This website supports all browsers except Internet Explorer for Mac. For complete technical requirements and privacy policy, visit <https://www.cmeoutfitters.com/technical-requirements/>.

Credit Information



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This application-based activity is approved for 1.50 contact hours (0.15 CEUs) of continuing pharmacy credit (JA0007185-0000-26-117-L08-P).

NURSES (ANCC)

This activity is designated for 1.50 contact hours.

California Residents: Provider approved by the California Board of Registered Nursing, Provider # CEP 15510, for 1.50 Contact Hours.



IPCE CREDIT™

This activity was planned by and for the healthcare team, and learners will receive 1.50 Interprofessional Continuing Education Credit for learning and change.



PHYSICIAN ASSOCIATES (AAPA)

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Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

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CME Outfitters, LLC is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to the provider or to the Commission for Continuing Education Provider Recognition at [ADA.org/CERP](https://ada.org/CERP).

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ABIM MOC

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 1.00 MOC point in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.



MIPS

Completion of this accredited CME activity meets the expectations of an Accredited Safety or Quality Improvement Program (IA_PSPA_28) for the Merit-based Incentive Payment Program (MIPS). Clinicians should submit their improvement activities by attestation via the CMS Quality Payment Program website.



ROYAL COLLEGE OF PHYSICIANS

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.



PHYSICIANS (AAFP)

The AAFP has reviewed Blueprint in Practice: Elevating Pain Management and Opioid Safety Across the Care Team and deemed it acceptable for up to 1.50 live activity AAFP credit(s). Term of Approval is from 10/28/2026 to 10/28/2026. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

<div data-bbox="147 176 440 275">  </div> <div data-bbox="147 344 748 457"> <h2>Blueprint in Practice</h2> <h3>Elevating Pain Management and Opioid Safety Across the Care Team</h3> </div> <div data-bbox="147 499 753 533"> <p><i>This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies.</i></p> </div>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<div data-bbox="147 625 331 785">  </div> <div data-bbox="147 795 790 978"> <p>In support of improving patient care, CME Outfitters LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.</p> </div> <div data-bbox="781 989 841 1014">  </div>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<div data-bbox="134 1056 503 1096"> <h2>Activity Credit Types</h2> </div> <div data-bbox="147 1119 203 1163">  </div> <div data-bbox="212 1113 451 1163"> <p>This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education Credit for learning and change.</p> </div> <div data-bbox="147 1186 203 1215"> <p>Physicians (ACCME)</p> </div> <div data-bbox="212 1173 446 1232"> <p>CME Outfitters LLC designates this enduring material for a maximum of 1.5 AIAA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.</p> </div> <div data-bbox="147 1255 203 1283"> <p>Nurses (ANCC)</p> </div> <div data-bbox="212 1260 433 1276"> <p>This activity is designated for 1.5 contact hours.</p> </div> <div data-bbox="147 1327 203 1373">  </div> <div data-bbox="212 1312 448 1404"> <p>CME Outfitters LLC has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 1.5 AAPA Category 1 CME credits. Approval is valid until expiration date. PAs should only claim credit commensurate with the extent of their participation.</p> </div> <div data-bbox="500 1136 521 1180">  </div> <div data-bbox="563 1113 815 1209"> <p>Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.</p> </div> <div data-bbox="472 1251 552 1281">  </div> <div data-bbox="563 1222 808 1304"> <p>Completion of this accredited CME activity meets the expectations of an Accredited Safety or Quality Improvement Program (ASQIP) for the Merit-based Incentive Payment Program (MIPS). Clinicians should submit their improvement activities by attestation via the CMS Quality Payment Program website.</p> </div> <div data-bbox="472 1354 552 1381">  </div> <div data-bbox="563 1318 816 1415"> <p>Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 1.5 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.</p> </div> <div data-bbox="781 1436 841 1459">  </div>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<div data-bbox="134 1501 503 1543"> <h2>Activity Credit Types</h2> </div> <div data-bbox="147 1642 203 1688">  </div> <div data-bbox="212 1558 448 1688"> <p>ADA CERP: CME Outfitters, LLC, is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to the provider or to the Commission for Continuing Education Provider Recognition at ADA.org/CERP.</p> </div> <div data-bbox="212 1692 448 1719"> <p>CME Outfitters, LLC, designates this activity for 1.5 continuing education credits.</p> </div> <div data-bbox="212 1724 440 1776"> <p>Concerns or complaints about a CE provider may be directed to the provider, or to the Commission for Continuing Education Provider Recognition at ADA.org/CERP.</p> </div> <div data-bbox="147 1799 203 1824">  </div> <div data-bbox="212 1776 448 1856"> <p>Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.</p> </div> <div data-bbox="472 1577 548 1642">  </div> <div data-bbox="563 1566 815 1650"> <p>The AAPF has reviewed Blueprint in Practice: Elevating Pain Management and Opioid Safety Across the Care Team and deemed it acceptable for up to 1.50 Live AAPF Prescribed credit(s). Term of Approval is from 10/28/2026 to 10/28/2028. Physicians should claim only the credit commensurate with the extent of their participation in the activity.</p> </div> <div data-bbox="781 1879 841 1904">  </div>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

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Portions of this presentation were developed with the assistance of generative AI (OpenAI, ChatGPT, model 5.6), including drafting, organization of slides, and graphics.

In accordance with CME Outfitters policy, all AI-generated content was treated as a draft only. Prior to finalization, all information was fact-checked and verified against primary sources, and all content was reviewed for scientific accuracy, fair balance, and compliance.

AI was not used as the sole reviewer of any scientific or clinical content.

To Ask a Question

To submit a question, please go to the *Ask Question* tab at the bottom of the screen.



Johnathan Goree, MD (Moderator)

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Disclosures

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Thomas Heinrich, MD—no disclosures to report
Michael Franks, APRN, AGACNP-BC, FNP-BC—no disclosures to report
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Keshia Pitt, PhD (planning committee)
Lexie Oneca (planning committee)
Felicia G. Oyedepo, MD (planning committee)
Andrea Perseghin, EdD (planning committee)
Sandra Caballero, PharmD (planning committee)
Sharon Tordoff (planning committee)

All identified conflicts of interest have been mitigated.



LEARNING OBJECTIVES

- 1 Identify physiologic and biopsychosocial factors contributing to common pain etiologies and treatment selection
- 2 Apply validated pain assessment tools to inform individualized multimodal pain management decisions
- 3 Integrate strategies from the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain into treatment plans for acute, subacute, and chronic pain
- 4 Counsel patients on multimodal pain management to support safe, effective treatment plans, including appropriate opioid storage and disposal
- 5 Assess risk for opioid nonmedical use when developing multimodal pain management plans
- 6 Utilize *DSM-5* criteria to identify opioid use disorder (OUD) in patients prescribed opioids for acute and chronic pain
- 7 Incorporate evidence-based communication strategies in practice to discuss potential OUD diagnosis and treatment options with patients

Pain Care Requires Attention to Two Concurrent Public Health Needs

The Burden of Pain

- In 2023, 24.3% of U.S. adults reported chronic pain
- In 2023, 8.5% of U.S. adults reported high-impact chronic pain
- **Clinical implication:** pain can substantially affect function and quality of life

Prescription Opioid-Related Risk

- In 2024, 7.6 million people reported engaging in nonmedical use of prescription opioids in the past year
- In 2024, 7,989 drug poisoning deaths involved natural and semisynthetic opioid analgesics
- **Clinical implication:** prescription opioid-related risks remain important



Lucas JW, et al. *NCNS Data Brief*. 2024;(518): U.S. Food and Drug Administration [FDA]. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2026. <https://www.fda.gov/media/192014/download>.



Treat Pain. Reduce Harm. Preserve Care.



FDA. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2020. <https://www.fda.gov/media/132014/download>. Dowell D, et al. *MMWR Recomm Rep*. 2022;71(3):1-35.



<h3>Choose a Tool You Can Repeat</h3> <div> <div> <p>Brief Pain Inventory (BPI)</p> <ul style="list-style-type: none"> Assess pain severity and interference with function Useful for broader baseline assessment </div> <div> <p>PEG Scale</p> <p>Three-item tool derived from the BPI</p> <p>Pain intensity Enjoyment of life (interference) General activity (interference)</p> <p>Useful for quick follow-up over time</p> </div> <div> <p>Other Targeted Tools</p> <ul style="list-style-type: none"> Examples include body maps and PainDETECT Useful when location or mechanism needs clarification </div> </div> <p>More tools: DVPRS, MBM, PD-Q, PROMIS-P, EMA. Use a repeatable measure that helps track change over time. Pair a repeatable tool with one activity the patient wants to regain.</p> <p><small>BPI = Brief Pain Inventory; DVPRS = Delaware and Veterans Pain Rating Scale; BSA = Ecological Momentary Assessment; MBM = Michigan Body Map; PDQ = Pain Disability Questionnaire; PROMIS-P = Patient-Reported Outcomes Measurement System Pain Interference. Hosack SL, et al. J Gen Intern Med. 2022;47(12):125-135. Gorell D, et al. MMWR Recomm Rep. 2022;71(1):1-95. FDA. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2026. Hosack SL, et al. J Gen Intern Med. 2022;47(12):125-135. Gorell D, et al. MMWR Recomm Rep. 2022;71(1):1-95. FDA. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2026. Hosack SL, et al. J Gen Intern Med. 2022;47(12):125-135. Gorell D, et al. MMWR Recomm Rep. 2022;71(1):1-95. FDA. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2026.</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<h3>Patient Experience Checkpoint</h3> <p>Clinician Communication</p> <div> <p>Proposed Clinician Language "Your pain is real. The scan is one part of the assessment. Let us work out what is limiting your day and choose a plan we can reassess together."</p> </div> <div> <p>Acknowledge</p> <p>Mild imaging does not mean mild suffering</p> <p>Explain and Reframe</p> <p>Pain with movement does not always mean new damage; gradual activity can support recovery</p> <p>Ask</p> <p>What matters most to you? What activity do you want to regain?</p> <p>Agree</p> <p>Choose one feasible goal and a review date</p> </div> <p><small>Gorell D, et al. MMWR Recomm Rep. 2022;71(1):1-95. FDA. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2026. https://www.fda.gov/media/192014/download.</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<h3>Patient Case: Elena</h3> <div> <p>Elena, 47, has chronic knee OA pain that interferes with caring for her mother and standing at her retail job.</p> </div> <div> <ul style="list-style-type: none"> Would like to avoid opioids Clinician recommends a multimodal plan including exercise or physical therapy, weight management support, and appropriate nonopioid pharmacologic treatment Returns for follow up having not started PT </div> <div> <ul style="list-style-type: none"> Insurance requires a high copay Nearest covered PT facility is 35 minutes away Appointment times conflict with her work schedule Says: "I know I'm supposed to go for PT, but I can't keep missing work." </div> <p><small>OA = osteoarthritis; PT = physical therapy</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<h3>Audience Response</h3> <p>? What is the most appropriate next step?</p> <ol style="list-style-type: none"> Document nonadherence and reinforce that PT is necessary before other treatment options can be considered Continue recommending the same plan because access limitations should not change the preferred treatment Initiate opioid therapy because nonpharmacologic treatment is too challenging to access Reassess Elena's goals and barriers and collaboratively adapt the plan using evidence-based options she can access 	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

<h2>Patient Experience Checkpoint</h2> <p>Proposed Clinician Language "Which part of this plan would be hardest to fit into your life?"</p>  <ul style="list-style-type: none"> Confirm the Goal Caregiving and a tolerable workday Remove a Barrier Check benefits, copay, schedule, transport and digital access A referral is not the same as access to treatment. Adapt the Delivery Individualized home exercise or tele PT when suitable Reassess Together Track function, symptoms and whether the plan is usable <p><small>Kolesnieli SL, et al. <i>Arthritis Rheumatol</i>. 2020;72(2):220-230. Himmelfarb RS, et al. <i>Lancet</i>. 2024;403(10433):1297-1270. Dowell D, et al. <i>MMWR Recomm Rep</i>. 2022;71(3):1-85.</small></p> <p>CME <small>OUTFITTERS</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<h2>Patient Case: Robert</h2> <p>PT Robert, 63, presents to the emergency department after a fall at home with new severe low back pain and difficulty bearing weight.</p>  <p>Hx</p> <ul style="list-style-type: none"> Chronic osteoarthritis and lumbar pain Receiving stable long-term opioid therapy for several years No history of dose escalation, nonmedical use, or overdose Reports that his usual opioid dose is "not touching" this new pain <p>PHYSICIAN</p> <ul style="list-style-type: none"> Imaging shows no fracture PDMP review is concordant with his prescribed regimen No new information currently suggests opioid-related aberrant behavior <p><small>PDMP = prescription drug monitoring program</small></p> <p>CME <small>OUTFITTERS</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<h2>Audience Response</h2> <p>? What is the most appropriate next step?</p> <ol style="list-style-type: none"> Reassess his pain, function, injury findings, and safety before making any change to the opioid regimen Increase his baseline opioid dose because the new injury is causing a temporary flare Rotate to a different opioid at an equianalgesic dose to better cover the acute pain Begin tapering because an emergency department visit for pain raises concern for nonmedical use <p>CME <small>OUTFITTERS</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<h2>Opioid Decisions Depend on the Starting Point</h2> <div> <div> <h3>Starting an opioid for acute pain</h3> <ul style="list-style-type: none"> Benefit should outweigh risk IR, lowest effective dose Quantity matches expected severe pain Plan reassessment and stopping  </div> <div> <h3>Starting an opioid for chronic pain</h3> <ul style="list-style-type: none"> Nonopioid and nonpharmacologic therapy preferred Establish pain and function goals Plan for intermittent increases in pain; use a PPA when appropriate If initiating an opioid, use IR and the lowest effective dose Reassess within 1 to 4 weeks </div> <div> <h3>Existing Opioid Therapy</h3> <ul style="list-style-type: none"> Reassess pain, function, adverse effects, and benefit versus risk Review regimen, PDMP adherence, and clinical changes If pain worsens, evaluate the underlying condition, OUD, and possible opioid-induced hyperalgesia before escalating If reducing therapy, individualize and taper gradually Treat the new acute problem Coordinate return to baseline </div> </div> <p><small>IR = immediate release; OUD = opioid use disorder; PPA = patient-provider agreement. Dowell D, et al. <i>MMWR Recomm Rep</i>. 2022;71(3):1-85. FDA. <i>Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain</i>. 2026. https://www.fda.gov/media/19214/download</small></p> <p>CME <small>OUTFITTERS</small></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Opioid Analgesics Creates Distinct Safety Issues, Part 1

Agent	Formulation Examples	Mechanism and Clinical Use	Key Safety Data
Acetaminophen with Codeine	Oral IR	Prodrug converted to morphine via CYP2D6; analgesic response and/or toxicity can vary w/ CYP2D6 phenotype	Serious respiratory depression, acetaminophen hepatotoxicity including acute liver failure with elevated total bilirubin or multiple abnormal laboratory-containing products; coma/unconsciousness; contaminated children < 18 years of age; 10 years of age and older; 10 years after transdermal fentanyl/hydrocodone; avoid in adolescents < 12 years with additional respiratory risk factors
Buprenorphine	Transdermal system; buccal film	Partial μ opioid agonist; α₂ opioid antagonist. Transdermal and buccal formulations are used for severe persistent pain requiring extended control treatment when alternatives are inadequate, including IR opioids, non-IRN	Product-specific labeling and conversion requirements; may precipitate withdrawal symptoms from a full agonist; serious respiratory depression remains possible
Fentanyl transdermal	Transdermal	Opioid agonist. Only for opioid-tolerant patients with severe persistent pain requiring an opioid analgesic when other alternatives are inadequate, including IR opioids	Contaminated in opioid non-tolerant adults, or postop pain management; may precipitate withdrawal symptoms; avoid in adolescents < 12 years with additional respiratory risk factors
Hydrocodone	IR combinations; ER	Full μ opioid agonist. Product-specific indications differ by formulation	Acetaminophen/hepatotoxicity risk with acetaminophen containing IR combinations; clinically important CYP3A4 interactions
Hydromorphone	IR, ER	Opioid agonist. IR is indicated for severe pain when alternatives are inadequate. ER restricted to opioid-tolerant patients with severe and persistent pain requiring extended control treatment when alternatives are inadequate, including IRN	Medication error can cause serious harm; distinguish IR and ER formulations. Renal impairment increases hydromorphone exposures; lower initial dosing and close monitoring may be required with additional caution for ER therapy to prevent renal impairment
Methadone	Oral	Full μ opioid agonist; NMDA receptor antagonism has also been indicated, and its contribution to efficacy is unknown. Indicated for severe and persistent pain requiring an opioid when alternative options are inadequate, including IRN, non-IRN	QT prolongation; accumulation; delayed respiratory depression

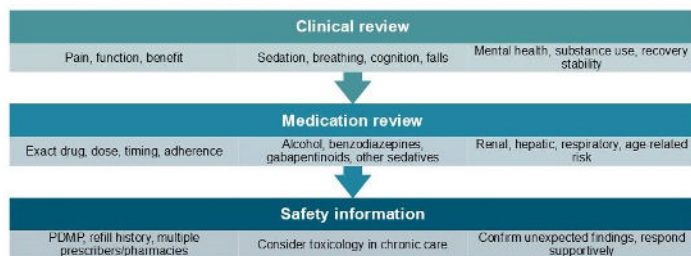
[illegible]

Opioid Analgesics Creates Distinct Safety Issues, Part 2

Agent	Formulation Examples	Clinical Use Distinction	Key Safety Point
Morphine	IR, ER	Full μ opioid agonist. IR: indicated for acute pain severe enough to require an opioid when alternatives are inadequate and for chronic pain in adults when alternatives are inadequate. ER: indicated for severe and persistent pain that cannot be adequately treated with alternatives, including IR opioids.	Serious respiratory depression, renal impairment can increase morphine exposure and accumulation of M3G and M6G metabolites. Hypotension, pruritus, and other manifestations of histamine release or peripheral vasodilation may occur.
Oxycodone	IR, ER	Full μ opioid agonist. IR: indicated for pain severe enough to require an opioid when alternatives are inadequate. ER: indicated for severe and persistent pain not adequately treated with alternatives, including IR opioids.	Serious respiratory depression; clinically important CYP3A4 interaction.
Oxycodone/morphine	IR, ER	Full μ opioid agonist. IR: indicated for acute pain requiring an opioid when alternatives are inadequate. ER: indicated for severe and persistent pain that cannot be adequately treated with alternatives, including IR opioids. Centrally acting analgesic; preclinical data show opioid receptor agonism and nonopioid analgesic activity; exact mechanism is unknown. IR: indicated for acute pain severe enough to require an opioid when alternatives are inadequate. ER: indicated for severe and persistent pain and severe and persistent neuropathic pain associated with CPN in adults, when an opioid is required and alternatives, including IR opioids, are inadequate.	Administer on an empty stomach; moderate or severe hepatic impairment is contraindicated; serious respiratory depression.
Tapentadol	IR, ER	Centrally acting analgesic; preclinical data show opioid receptor agonism and nonopioid analgesic activity; exact mechanism is unknown. IR: indicated for acute pain severe enough to require an opioid when alternatives are inadequate. ER: indicated for severe and persistent pain and severe and persistent neuropathic pain associated with CPN in adults, when an opioid is required and alternatives, including IR opioids, are inadequate.	Serious respiratory depression; serotonin syndrome and seizure risk; AChE inhibitor/anticholinergic.
Tramadol	IR, ER	μ opioid agonist + norepinephrine and serotonin reuptake inhibition. IR: indicated for severe pain when alternatives are inadequate. ER: indicated for severe and persistent pain that cannot be adequately treated with alternatives, including IR opioids.	Serotonin syndrome and seizure risk; clinically important cYP2D6/CYP3A4 interactions; pediatric restrictions apply.

[illegible]

Reassess Risk Without Using It to Punish



ALDIT-C = Alcohol Use Disorders Identification Test; Consumption; ORT = Opioid Risk Tool; SOA/PFR = Screener and Opioid Assessment for Patients with Pain; Rausied; TAPS = Tobacco, Alcohol, Prescription Use/Disorders, and Other Substance Use Tool.
 TAPS, C-UDAS, Education, Cigarette, and Likelihood, Case Prevalence
 DOI:10.7172/1105-1035.TAPS-2019 | <https://www.scribd.com/document/424614616/Screening-Tools-for-Substance-Use-Disorders-in-Pain-Practice-2019>
 DOI:10.7172/1105-1035.TAPS-2019 | <https://www.scribd.com/document/424614616/Screening-Tools-for-Substance-Use-Disorders-in-Pain-Practice-2019>



Patient Experience Checkpoint

Proposed Clinician Language
"Coming to the emergency department does not mean we have decided to stop your medicine."

-
- 1 Reassess the injury: treat the cause; do not stop at the first image
 - 2 Treat the acute episode: use appropriate multimodal analgesia and monitoring
 - 3 Limit any added opioid: individualize the rescue plan and return to baseline
 - 4 Name the next clinician: share changes, safety concerns, and follow-up

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(3):1-95. FDA. FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. 2026. <https://www.fda.gov/media/132014/download>



If Benefit Is Insufficient, Change the Plan Deliberately

Considering reduction

- ☐ Reassess benefit, harm, and patient priorities
- ☐ Individualize the pace
- ☐ Monitor pain, function, withdrawal, and mood
- ☐ Pause or adjust when needed

Considering rotation

- ☐ Treat equianalgesic values as estimates
- ☐ Account for incomplete cross tolerance
- ☐ Use product-specific guidance
- ☐ Monitor early after the change

When to involve additional expertise:

- **Pain:** complex pain or inadequately controlled pain
- **Behavioral health:** psychiatric symptoms or distress affecting care
- **OUD treatment expertise:** suspected or diagnosed OUD when treatment is not available in the current setting

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(10):1-95. FDA. *FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain*. 2026. <https://www.fda.gov/media/192014/download>.



Opioid Tapering After an Acute Pain Episode

Regimen Component	Approach for Opioid Naïve Patients	Approach for Patients Receiving Long-Term Opioids
Goals of opioid tapering	Limit excess opioid exposure and adverse events as pain improves; reduce persistent use and unused medication	Return toward the baseline opioid or MOUD regimen as acute pain improves; avoid persistent dose escalation and destabilization of OUD
Dose reduction at each step or taper	If opioids were taken around the clock for more than a few days, use a brief taper based on duration of exposure	Individualize reductions; slower steps may be needed to return safely toward baseline
Frequency of tapering	Match taper pace to duration of continuous use and withdrawal symptoms	Adjust to recovery, baseline regimen, and withdrawal symptoms rather than using a rigid schedule
Total duration of taper	Very short courses may not require a taper; longer continuous use may require a brief taper	Return toward baseline as soon as clinically feasible; duration varies with exposure and patient factors
Other considerations	Continue multimodal analgesia and discuss the taper plan before discharge	Continue multimodal therapy, psychosocial support, monitoring, and coordination with the usual prescriber



Do not abruptly discontinue or rapidly reduce opioids in patients who are physically dependent. Use shared decision-making and monitor for opioid withdrawal. **Pregnancy requires additional caution when opioid tapering is considered.**

MOUD = medications for opioid use disorder.
FDA. *FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain*. 2026. <https://www.fda.gov/media/192014/download>. Dowell D, et al. *MMWR Recomm Rep*. 2022;71(10):1-95. *Healthcare (Dallas)*. 2021;9(3):333.



Core Counseling for Safe Opioid Use



Serious opioid risks can occur at any dose and at any time.

Opioid Analgesic REMS. *What You Need to Know About Opioid Pain Medicines*. 2026. https://opiodanalgesicrems.com/Resources/Docs/Opioid_Analgesic_REMS_Patient_Guide_English_Updated.pdf. FDA. *FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain*. 2026. <https://www.fda.gov/media/192014/download>. FDA. 2019. <https://www.fda.gov/health/medication-product-safety/information/neurontin-gralise-horizant-gabapentin-and-lyrica-tylorol-or-pregabalin-drug-safety-communication>.



Overdose Safety Requires Access and a Response Plan



Opioid Analgesic REMS. *What You Need to Know About Opioid Pain Medicines*. 2026. https://opiodanalgesicrems.com/Resources/Docs/Opioid_Analgesic_REMS_Patient_Guide_English_Updated.pdf. FDA. *FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain*. 2026. <https://www.fda.gov/media/192014/download>. Naloxone hydrochloride nasal spray (package insert). https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/020598s0101x.pdf. Nalmefene nasal spray (package insert). https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/0217470Orig1s001.pdf.



Store Securely and Dispose Promptly





During treatment

- Lock the opioid supply
- Keep away from children, pets and visitors
- Track medication; never share



When no longer needed

- Use an authorized take-back location or a pre-paid drug mail-back envelope
- Ask the pharmacy about an in-home disposal option, when available



When take-back or mail-back is not available

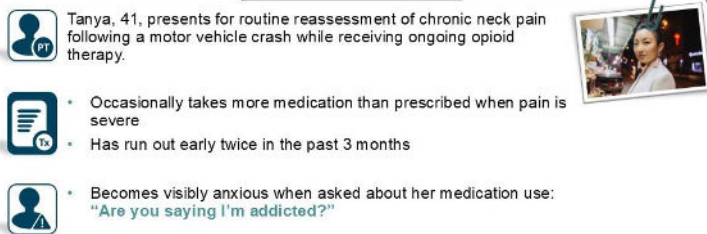
- Check the product instructions and FDA flush list
- Flush only medicines on that list
- Follow FDA guidance for other medicines

Keep overdose reversal medicine accessible to responders, not locked with the opioid supply.

Opinion Analgesic REHS: What You Need to Know About Opioid Pain Medicines, 2028. https://opioideprescriptions.com/resources/learn/Opoid_Analgesic_REHS_Patient_Guide_English. Updated post FDA, FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain, 2028. <https://www.fda.gov/oc/2024/04/24/fda-education-blueprint-for-health-care-providers-involved-in-the-treatment-and-monitoring-of-patients-with-pain>. FDA, 2024. <https://www.fda.gov/oc/2024/04/24/fda-education-blueprint-for-health-care-providers-involved-in-the-treatment-and-monitoring-of-patients-with-pain>. Drug Enforcement Agency (DEA). <https://www.dea.gov/takeback>. Accessed on 10/24/2024.



Patient Case: Tanya



Tanya, 41, presents for routine reassessment of chronic neck pain following a motor vehicle crash while receiving ongoing opioid therapy.

- Occasionally takes more medication than prescribed when pain is severe
- Has run out early twice in the past 3 months
- Becomes visibly anxious when asked about her medication use: "Are you saying I'm addicted?"



Audience Response

? What is the most appropriate next step?

- Diagnose OUD because repeated use above the prescribed dose indicates loss of control
- Refer Tanya to addiction medicine before continuing opioid treatment for her pain
- Assess Tanya for OUD using *DSM-5** criteria before determining the appropriate response
- Increase the opioid dose because the behavior may reflect inadequate pain control

*The March 2026 FDA Blueprint refers to *DSM-5*. *DSM-5-TR* (2022) is the current text revision; OUD diagnostic criteria and severity thresholds are unchanged. *DSM-5* = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.



These Terms Are Not Interchangeable

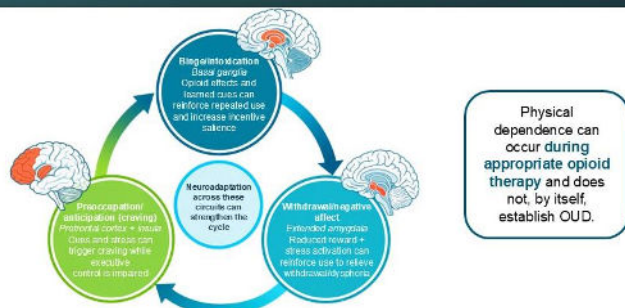


- Physical dependence:** physiologic adaptation that can produce withdrawal when opioids are abruptly stopped or substantially reduced. **Can occur during appropriate opioid therapy and does not establish OUD.**
- Tolerance:** reduced effect with continued exposure or need for a higher dose to achieve the same effect. **Can occur during appropriate opioid therapy and does not establish OUD.**
- Nonmedical use:** use of a medication in a way other than as directed by a health care provider. **Warrants assessment but is not synonymous with OUD.**
- OUD:** a problematic pattern of opioid use causing clinically significant impairment or distress. **Diagnosed from the *DSM-5-TR* criteria, not from one behavior.**

FDA, FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain, 2028. <https://www.fda.gov/oc/2024/04/24/fda-education-blueprint-for-health-care-providers-involved-in-the-treatment-and-monitoring-of-patients-with-pain>. CDC, 2024. <https://www.cdc.gov/overdose-prevention/hcp/clinical-care/opioid-use-disorder-diagnosis.html>. American Psychiatric Association. Opioid use disorder. In: *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. 2022. pp. 541-547. <https://www.psychiatry.org/psychiatrists/practice/dsm>.

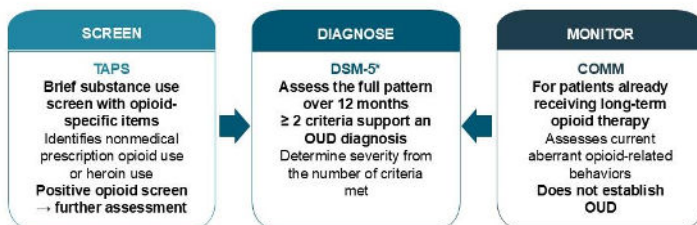


OUD Neurobiology: A Reinforcing Cycle



FDA, FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain, 2020. <https://www.fda.gov/media/192014/download>. CME OUTFITTERS

Screening and Monitoring Guide Further OUD Assessment



*The March 2020 FDA Request refers to DSM-5, DSM-5-TR (2022) is the current text revision. OUD diagnostic criteria and severity thresholds are unchanged. COMM - Current Opioid Misuse Measure, TAPS - Tolerance, Abstinence, Prescription, and Other Substance Use. FDA, FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain, 2020. <https://www.fda.gov/media/192014/download>. CME OUTFITTERS

DSM-5*: Opioid Use Disorder

Impaired control	1. Larger amounts or longer than intended 2. Persistent desire or unsuccessful efforts to cut down or control use 3. Much time spent obtaining, using, or recovering from opioids 4. Craving
Social impairment	5. Failure to fulfill major obligations 6. Continued use despite social or interpersonal problems 7. Important activities reduced or given up
Risky use	8. Recurrent use in physically hazardous situations 9. Continued use despite related physical or psychological harm
Pharmacological criteria	10. Tolerance* – need for markedly more opioid for the same effect or markedly diminished effect with the same amount 11. Withdrawal* – withdrawal syndrome or opioid use to relieve or avoid withdrawal

OUD requires ≥ 2 criteria within 12 months | Mild: 2 to 3 | Moderate: 4 to 5 | Severe: ≥ 6
For Tanya, running out early or taking more than prescribed is a clinical signal, not a DSM diagnosis. Ask what happened and assess the full 12-month pattern.

*DSM-5-TR (2022) is the current text revision of DSM-5; the diagnostic criteria and severity thresholds for OUD are unchanged from DSM-5. Tolerance and withdrawal are not counted when criteria are taken solely under appropriate medical supervision. American Psychiatric Association. Opioid use disorder. In: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. 2022. pp. 541-549. <https://www.psychiatry.org/psychiatrists/education>. CME OUTFITTERS

Patient Case: Tanya



At further assessment, Tanya provides additional information about her opioid use:

- She repeatedly takes more opioid than she intends, not only more than prescribed
- She has made repeated attempts to cut down or control her use, but has not been successful
- She describes a strong urge to use opioids even when her neck pain is relatively quiet



• Tanya remains worried about what the assessment means and asks: "Why are you asking me all of these questions?"



• How does this additional history change Tanya's assessment?



CME OUTFITTERS

Team-Based Approach for the Management of Pain

- Aligns pain and functional goals across the care team
- Coordinates medication review, interaction checks, and overdose reversal access
- Reinforces patient and caregiver education, teach-back, and follow-up
- Coordinates referral and connections to rehabilitation, behavioral health, addiction treatment, specialty care, and navigation support when needed
- One shared plan, named responsibility, and a confirmed next contact



CME
OUTFITTERS

Goals for Increased Interprofessional Pain Care



Establish clear channels for changes in pain, function, opioid therapy, safety concerns, and follow up



Align on evidence-based pain and opioid safety practices
Clarify who owns prescribing, monitoring, education, access support, and reassessment



Incorporate patient goals, treatment feasibility, caregiver input, and access barriers into the shared plan



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*Vance S, et al. J Interper Care. February 6, 2025 [Epub ahead of print]. Dorman KS, et al. Behav Anal Pract. 2021;14(4):1191-1208. Price JH, et al. Soc Policy. 2024;26(4):419-432.

SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

Put information into action! In the next 3 months...

- **Document at least one functional goal and one relevant biopsychosocial factor** in at least 75% of new or reassessed patients with pain.
- **Use a validated pain or function measure** when clinically appropriate and use the result to guide or reassess the treatment plan.
- **For at least 75% of patients starting or continuing opioid therapy**, review benefit, risk, interacting medications, PDMP information, and the plan for reassessment.
- **Use teach-back** with at least 5 patients receiving opioids to reinforce prescribed use, overdose risk and reversal, medication interactions, storage, disposal, and when to seek help.
- **For at least 75% of patients with concerning opioid use**, document DSM-5* assessment. If OUD is identified, discuss MOUD and document an agreed treatment, active referral, or follow-up step.
- **For at least 3 patients** whose preferred multimodal plan is limited by cost, transportation, scheduling, or availability, document one feasible alternative or access solution.

*The March 2026 FDA Blueprint refers to DSM-5, DSM-5-TR (2022) is the current text revision, OUD diagnostic criteria and severity thresholds are unchanged.

CME
OUTFITTERS

Faculty Discussion



Questions and Answers

Ask the Experts!

Additional Resources

Visit www.cmeoutfitters.com
for clinical information and
certified educational activities



Visit the Pain Management Hub

Free resources and education
for health care professionals and patients

<https://www.cmeoutfitters.com/practice/pain-management/>



Other activities in this series include:

Blueprint in Practice:

*The Inherited Regimen -
Reassessing Long-Term Opioid
Therapy Without Abandonment*

Blueprint in Practice:

*The 2 AM Stone - Treating
Severe Pain Without Creating a
New Safety Problem*

Blueprint in Practice:

*Beyond the Positive Screen -
Diagnosing and Treating OUD
Without Losing Trust*

Blueprint in Practice

*First Exposure - Managing Third-
Molar Pain Without Routine
Opioid Analgesics*

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