Managing Chronic Pain: Maximizing Benefits and Minimizing Risks Transcript

September 23, 2025

Webinar Support: Welcome to the Behavioral Health/Substance Use Disorder Integration Technical Assistance webinar, Managing Chronic Pain: Maximizing Benefits and Minimizing Risks.

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We're excited to share that we have more continuing education opportunities coming up for you. Please register for our new fall events. We'll go ahead and add those to the chat now so that you can take a closer look. We'll put them in in just a moment.

I am pleased to introduce you to today's presenter. Dr. Daniel Alford is Professor of Medicine and the Associate Dean of Continuing Education at Boston University and Boston Medical Center. He is on staff in the section of general internal medicine, and Dr. Alford is the course director of the Boston University Scope of Pain Program, which has trained over 310,000 clinicians across the country and in over 30 countries. The Scope of Pain Program received the White House Office of National Drug Control Policy Outstanding Prevention Effort Award. Dr. Alford's clinical, educational, and research interests focus on safer and more competent opioid prescribing for managing patients with pain and addiction and managing opioid use disorders.

It is now my pleasure to turn the webinar over to Dan. Dan, please go ahead.

Daniel P. Alford: Great. Thanks for having me. Welcome. Let's just talk about some objectives for this session. We are going to describe the benefits of multidimensional. That includes pharmacologic and non-pharmacological treatment for chronic pain. Applying evidence-based techniques to screen for and assess patients for chronic pain and for current behavioral health conditions and substance use disorders. Summarize a risk-benefit framework for the use of opioids that aligns with the CDC recommendations and their guideline, and apply communication strategies to effectively collaborate with patients on their management of chronic pain.

How are we going to do that? I'm going to talk a little bit about multidimensional care for chronic pain. Then I'm going to focus a bit on opioid analgesics. Then I'm going to talk about safer opioid prescribing, some of the skills that are necessary to do this in a safer way. Then we'll stop, and I'll answer your questions that you've put in the Q&A. Then we'll move on to a couple of case studies that we'll discuss some of the content that we reviewed in the presentation. All right. We're going to start. There are actually three polling questions. The first one, actually, you can answer as many choices as you want.

The question is, "What challenges are facing you at your health center in treating patients with chronic pain?" Assessing patients' pain, function, quality of life, initiating chronic pain management plans using a risk-benefit framework, treating pain with concurrent behavioral health or substance use disorders, managing challenging conversations regarding opioids, educating patients about the role of multimodal pain care, and maybe there are some others that I didn't list here that you can put in. I'm going to give you 15 seconds to click on your responses.

Again, if you pick other, you can enter it into the Q&A, and I will read them. Hopefully, you are voting. We're going to stop there, and let's see what responses we have. Quite a spread, I would say. The largest number was treating pain with individuals with concurrent behavioral health or substance use disorders. That is challenging, followed by having the conversation about opioids, followed by educating patients about the role of multimodal care. Great. As well as the others. We will discuss these, and certainly during the case discussion, we'll address these as well.

Bold question number two: What is your level of comfort in assessing for pain in patients with psychological or substance use disorders? What's your comfort level? Now you're just going to pick one response.

[pause 00:06:13]

Daniel: What are our answers? About half are comfortable, and about 42% are uncomfortable. It's about a half-and-half breakup, and this can certainly be challenging. We can address that as well. Let's move on. First, I want to give you a couple of slides on the state of pain. I think it's

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important to think about chronic pain different than we think about acute pain. Acute pain is an adaptive symptom that is life-preserving. That is, it prevents us from re-injuring ourselves. It also allows us time to heal. Acute pain is really life-sustaining.

Chronic pain, however, is really maladaptive, and it may present as a disease in and of itself. It's incredibly common. About a fifth of our adult population reports pain on most days or every day, and it's associated with concurrent psychiatric conditions and suicidality. It also costs billions of dollars in lost productivity, but also in just medical costs to treat. It's a significant problem in our society, and it's one of the most common things that we see in primary care, as well as in other settings like urgent care and emergency departments. How do we think about chronic pain?

I think it starts with self-care. We need to work with our patients so that they understand that they have a role in this. It may be that they need to pace themselves depending on what's causing their pain, or that they need to adhere to our recommendations and other therapies. Also, I think the next thing to think about is what are our goals? Certainly, we want to reduce pain. Oftentimes, we can't eliminate it. We want to restore function. We want to cultivate well-being, and we want to improve their quality of life. How do we do that? Certainly, there are different strategies.

I know that some of these are less available to your patients than others, but we need to think broadly and teach our patients to think broadly, too. There are certainly physical and restorative therapies like physical therapy, cold and heat, chiropractic care, massage, and so forth. Then there are behavioral and complementary, and integrative approaches like cognitive behavioral therapy, acceptance and commitment therapy, mindfulness, relaxation, acupuncture, yoga. Many of these have shown to be very effective in chronic pain. Then procedures.

Certainly, there are some chronic pain conditions that respond to nerve blocks or steroid injections or radio frequency ablation, or even spinal cord stimulators. Then, finally are the medications. There's a whole array of medications. It's not just opioids. We certainly have acetaminophen and NSAIDs, and some of the adjuvant medications like the anticonvulsants and antidepressants. It really behooves us to think broadly about treating pain. Oftentimes, our patients are overly focused on the medication, but we need to educate them about the other therapies if they can access them. Hopefully, that's becoming easier these days, but it's still not where we want it to be.

The final polling question is, are behavioral health and primary care providers in your clinic collaborating to treat patients with chronic pain? Yes, no, and it varies. I'll give you 10 seconds. This should be an easy one to quickly respond to. Let's see what the responses are. It varies is the most common, and that's not surprising. I think as we start to become more integrated in

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primary care, we have more behavioral health providers that are accessible to us. It looks like over a third actually do have a collaboration going, so that's great.

Now let's move on. There's the pain medication balance when we start thinking about treatment of pain. I think appropriate, holistic, compassionate care should be provided for patients with pain, and that we all know, we've learned this lesson, that opioid over-prescribing has contributed to harm, harm including increasing numbers of people addicted and then overdose and overdose deaths. We'll talk more about that. How can we create care plans with patients with chronic pain that support our trusted doctor-patient relationship or provider-patient relationship?

I think something that's really, really fundamental is this building of trust. My feeling is that after you've completed a thorough pain history, a focused physical exam, and appropriate diagnostic testing, we should express empathy for the patient's pain and suffering. I would say that 100% of the time, we should validate that we believe their pain and suffering is real. I think oftentimes patients feel that their pain isn't believed or their suffering isn't appreciated. This oftentimes is presenting when you say on a scale of 0 to 10, and they say it's a 20, or when you say, "What are you able to do?" They say, "I can't do anything."

I think they're just trying to impress upon you how bad their pain and suffering is. I would say validate right from the get-go that you believe them. The reason why I say that, and I will also say that there's 0% risk in believing them, the reason why I say there's 0% risk is because just because you believe the severity of the patient's pain, complaint, and suffering does not mean that opioids are indicated. That's actually where our clinical argument comes in. We shouldn't be struggling with, "Is this pain real or not?" It's real. The patient is suffering. Tell them so.

Then we decide, based on risk-benefit profile, what's the best therapy moving forward. Hopefully, it's multimodal or multidimensional if you can access those. Let's talk about opioid analgesics. Opioid analgesics provide analgesia. How? They target multiple sites in the pain pathway. We know that there is variability in how one patient responds to an opioid versus another, even for the same pain diagnoses. We know that not all patients respond to the same opioid in the same way. You might say, "Why is that?" We know that there are polymorphisms to the mu opioid receptor gene.

Each one of us has a slightly different mu opioid receptor, which is where the opioids act. There are also single-nucleotide polymorphisms where it changes the way an individual metabolizes or processes opioids, or even how opioids cross the blood-brain barrier. There's lots of variability in how patients respond to different opioids. We also know that opioids in general activate the reward pathway, which is a dopaminergic pathway in the midbrain, which is incredibly reinforcing and rewarding, it can cause euphoria. Therein lies part of the problem or the complexity around using opioid analgesics, that is, that some people will lose control or use them compulsively because of that reward pathway.

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The elephant in the room is, do opioids even work for chronic pain? What do we know about the efficacy? What we know is really spelled out in these meta-analyses. By the way, all the references to these slides are in this slide deck. They're at the end. It will say slide 15, and it will show you what the references are. There are meta-analyses that have shown that opioids versus placebo, using only high-quality evidence, showed a statistically significant, yet small, improvement in pain and function. Opioids were better than placebo. What about opioids versus non-opioids? Those were low to moderate-quality studies, and they showed similar benefits.

What's really important is, look at the follow-up. The follow-up was up to six months. What happens after that? Who knows? Really, when you start treating people with opioids for years, you're really in an evidence-unknown zone, where we really don't know what the benefits are. Certainly, in the short run, opioids have been shown to be better than placebo and equally good to non-opioids. Now, there was a randomized clinical trial published in JAMA that found that opioids were not superior to non-opioids for improving musculoskeletal pain-related function over 12 months. This was a longer-term follow-up study.

With any RCT (randomized controlled trial), you need to look at the methods and see would my patient sitting across from me be enrolled in this study? If the patient's on opioids already, they would have been excluded. It already is a different patient population than maybe ones that you're thinking about, who are already on opioids for chronic pain, and some of the patients who are eligible declined to be enrolled. Yes, it's an important study, gives us very important information, but you need to think about the generalizability to the patient sitting across from you.

There were two longer-term follow-up studies that found that 44.3% of patients on chronic opioids for chronic pain had at least 50% pain relief. That means 56% did not. If that is your goal is to have pain relief by 50%, then it's about half will and half won't. That's what we know about the efficacy of opioids for chronic pain. Now, we all know this story where we were prescribing lots and lots and lots of opioids. Starting in the mid-1990s, we became very opioid-centric. There were obviously lots of reasons that fueled this focus on prescribing opioids and increasing the dose of opioids over time.

In 2011, it decreased. It's been decreasing ever since. I think we needed to be educated. We needed to understand. The risks of opioids and the limited benefits of opioids. Then the prescribing has gone down. However, what I'm not showing you is another graph which shows overdose deaths over time. What you can see is that even with decreased over-prescribing, overdose deaths to opioids have continually gone up. They've gone up not because of prescription opioids, but they've gone up because of the illicit fentanyl analogs that are being manufactured elsewhere and being brought into this country.

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What are the opioid risks? Certainly, side effects are common. Patients can have nausea, sedation, constipation, urinary retention, sweating, to name a few. Organ toxicities, however, are rare. Certainly, there's suppression of the hypothalamic pituitary gonadal axis, which can cause a patient to become hypo gonad, which can adversely affect their bones and cause fracture risk. There's also, we've known this for a while, that opioids can cause immunosuppression. There have been a couple of observational studies that have shown an increased risk of invasive pneumococcal disease, and one that showed an increase in community-acquired pneumonia in those on chronic high-dose opioids.

We also know that opioids can do something strange, which is worsen pain in some patients. One is withdrawal-mediated pain. That is because patients on chronic opioids become physically dependent. They may go through episodes of withdrawal, and that withdrawal is experienced as worsening pain. Then they take the opioid, and they feel better. Are they treating the pain or are they treating the withdrawal? We also know that some patients develop opioid-induced hyperalgesia, which is a paradoxical response to the opioids. Unfortunately, we don't really know the true incidence of opioid-induced hyperalgesia, and we don't even have good diagnostic tools to diagnose it.

If someone's not doing well on an opioid and their pain is getting worse, you might start thinking about these two entities. We know that some patients will develop an opioid use disorder, and unfortunately, some will overdose and even die. What do we know about the rates of problematic opioid use? This was from a systematic review of about 38 studies. About a quarter were in primary care settings. About a half were in pain clinic settings, and the other were in other subspecialty clinics. The misuse rates were somewhere about a quarter, 21% to 29%.

Misuse in these studies was opioid use contrary to the way it was being prescribed. That is, you're prescribing an opioid for someone's back pain, and they take it for their headache. That would be considered an episode of misuse. The addiction rates were somewhere around 10%, 8% to 12%. Addiction was defined as continued use with experience of or potential for harm, that is, that they had impaired control over the drug use, they were using compulsively, and they continued to use despite harm. That's what we know about the rates.

Not all patients have the same risk factors for opioid-related harm. What are those risk factors? First, there are medication-related factors, that is, being on a higher opioid dose, being on chronic opioids, that is, greater than three months of being on opioids, being on an extended release long-acting opioid, the initial two weeks after starting a long-acting opioid, and certainly a combination of opioids and sedatives, that is, patients who are also being prescribed something like benzodiazepines. What about patient factors? A patient who has a mental health disorder, depression, or anxiety, puts them at higher risk for harm.

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Having a substance use disorder history, including having a tobacco or nicotine use disorder, puts them at higher risk. Having a family history of substance use disorder, having sleep disorder breathing, namely sleep apnea, whether it be obstructive or central sleep apnea, and then having a history of a prior opioid overdose puts them at incredibly higher risk for a repeat overdose, even when those overdoses are unintentional, which they usually are.

Now I want to talk about putting this all into practice. You'll notice that I didn't say safe opioid prescribing for pain. I said safer, and that was very intentional because it's impossible to be 100% safe, but we certainly can be a whole lot safer using some of these strategies. Before I start talking about these strategies, I just want to remind everybody, what is your role? Your role is really to be a clinician and to treat patients with therapies that hopefully have more benefit than harm, and then weighing that benefit and risk. Especially when we're talking about opioids, there's that severe risk for harm. We need to really keep that in mind.

We should not turn into police officers, DEA (Drug Enforcement Administration) agents, or judges. We're really judging the treatment. We're not judging the patient. First, one concept is called rational polypharmacy. We learn in training and school that polypharmacy is generally bad. We should minimize the amount of medications people are on. For pain, polypharmacy actually can be our friend. Why? Because all the medications that we have available to us act on different parts of the pain pathway, including the brain descending inhibitory pathway, the spinal cord, central sensitization, and the peripheral nervous system.

If you look on the list on the left, here are a lot of different types of medications that we use for treating pain, and they have different mechanisms. It turns out when you combine these medications, not only do you get better pain relief, but you actually are able to get better pain relief with lower doses of each medication. There really is this synergy and not just an additive effect. You should consider if someone doesn't respond to an NSAID, rather than stopping the NSAID, as long as they're tolerating it, you might want to add acetaminophen because they work together in synergy.

Now I'm going to have the next four slides. I'm really reviewing the recommendations in the 2022 CDC (Centers for Disease Control and Prevention) guideline on safer opioid prescribing. What do they say? They say maximize non-pharmacological therapies. We talked about that, including non-opioids. Certainly, some of the medications that are non-opioids, consider those. Only consider opioids if you think the benefits outweigh the risks for a particular patient, and discuss the realistic benefits and known risks with your patient, and establish treatment goals and how opioids will be discontinued if the risks outweigh the benefits. These are important conversations to have.

When starting an opioid, if you determine that the benefits outweigh the risks, use the short-acting, the immediate-release opioids first. Don't start with long-acting opioids because we already talked about the potential risk of those causing harm in someone who's opioid-naive.

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Prescribe the lowest effective dose, and use caution, however, at any dose. We used to talk about, "Okay, 90 morphine milligram equivalents or 100 morphine milligram equivalents were dangerous doses." Really, any dose can be dangerous to an individual, and we really should be focusing on using the lowest dose possible.

Avoid increasing doses above levels with diminishing benefit relative to risk. These are nice things to say. We certainly can talk about them in the question and answer, and certainly during the cases, like how do you actually figure this out in clinical practice? Not so easy. Then evaluate the benefits and risks one to four weeks after starting opioids, or after a dose escalation, and then regularly. It's not starting someone with opioids and seeing them maybe three months later. We really should be seeing them more frequently in the beginning or when we change the dose, again, for safety reasons.

For patients already on opioids, we should, again, weigh the benefits with the risks. This is new. This was added in 2022. It was not called out in the 2016 guideline, which people commented on. When patients are already on opioids, if the benefits outweigh the risks, it's okay to continue the opioids and continue to optimize other therapies, that multimodal therapy that we talked about. However, if the risks outweigh benefits, we should be optimizing other therapies and gradually taper the person off opioids.

Unless there's some life-threatening issue, like you're worried about an overdose, do not discontinue opioids abruptly or rapidly, especially when they're at higher doses, because you'll put people into withdrawal and you can destabilize somebody who's otherwise doing okay. You really want to be careful. We'll talk more about tapering in a moment. Then the final, the fourth slide here is, we should use strategies to try to mitigate the risk of harm, including naloxone co-prescribing, reviewing the prescription drug monitoring program data to make sure the patient is not getting medications from many different individuals that we're not aware of or that they have harmful polypharmacy that we're not aware of, and then urine toxicology testing.

Confirm that the person is taking the medication you're prescribing and hopefully not taking something else that could be risky. Use caution when concurrently prescribing opioids with other CNS (central nervous system) depressants. How do we implement all these recommendations in practice? I would suggest you use this concept of universal precautions. Why? Because predicting opioid risk is really imprecise. We should do it, but it's not foolproof. It also allows us to be consistent in our application of precautions and reduces stigma, and standardizes care. What are the precautions?

They include assessing and documenting the pain diagnoses and assessing and documenting the person's misuse risk based on their profile. There was a national study that found that 30% of charts where an opioid was prescribed, there was no pain diagnosis. I think we really need to be careful. If we're going to prescribe an opioid, it should be documented what the pain diagnosis is and why the opioid is indicated. We should prescribe opioids as a test or trial. We're

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not starting someone on opioid forever. We should only continue it or modify it, or even discontinue it based on the risk and benefits that we measure.

We should also use bidirectional patient-prescriber agreements. These are not contracts. They're not legal documents, but they include an informed consent and plan of care. They should be written at a grade level, namely the fifth-grade reading level, so that your patient can fully understand them. Monitor for benefit using a scale called the PEG scale, which I'm going to talk about in the next slide, I believe. Monitor for harm and risk using the urine drug test, using pill counts, and checking the prescription drug monitoring program. I mentioned the PEG scale, or the Pain, Enjoyment of Life, and General Activity scale.

This was validated in primary care settings by Erin Krebs. Again, the reference is in the back of the slide set. The three questions are: What number best describes your pain on average in the past week? No pain, 10, pain as bad as you can imagine. Two, what number best describes how, during the past week, pain has interfered with your enjoyment of life? That's the E, enjoyment of life. Doesn't interfere, completely interferes. What about enjoying or interfering with your general activity? Doesn't interfere, completely interferes. You can see with this three-question screener, you're asking about pain.

You're asking about quality of life, that is enjoyment of life. That's the E. You're asking about function or general activity. That's the G. I would encourage you to use this Pain, Enjoyment, and General Activity Scale. When do I continue opioids? I continue opioids, or before I write my next prescription, I convince myself that the benefits outweigh risks. When I think about benefits, I'm thinking about improvement in pain, I'm thinking about improvements in function, and I'm thinking about improvements of quality of life.

These are subjective assessments, granted. They really are. Despite the subjectivity of them, we should document them at each visit if we're going to be prescribing something that could potentially be lethal, like an opioid. Now, when do I think about decreasing or discontinuing opioids? First of all, you don't have to prove with 100% certainty that the person has developed an addiction or that they're giving their medication away diversion. You only need to assess and reassess the risk-benefit framework. If the patient's unable to take opioids safely or is non-adherent with the monitoring that you're putting in to keep them safe, then discontinuing opioids is appropriate, even if the setting of benefits.

You need to determine how urgent the discontinuation should be based on your level of concern, based on the risks and harms. Document, document, document the rationale for discontinuing opioids. Now, it's very important to note here that you are, under no circumstances, abandoning a patient. You're abandoning a therapy, a treatment that either isn't working or is causing harm. How do you do it? There's no validated protocol for tapering people off opioids when the opioids are for chronic pain. The goal may be actually just to decrease the dose, to get them on a lower dose, or taper off completely.

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There was a systematic review that found very low-quality evidence suggesting that several types of opioid tapers may be effective and that pain, function, and quality of life may actually improve in some patients with the opioid dose reduction. Remember, it could be opioid-induced hyperalgesia that you're improving their pain and function based on that. The CDC guideline recommends decreasing by 10% per month if the patient's been on opioids chronically for years or decreasing by 10% per week if the patient's been on opioids for weeks to months. These are just some general guidelines.

Now, there are some risks with opioid discontinuation that you need to keep in mind. There were observational studies that identified harms, namely suicide and overdose, that were associated with opioid tapering and discontinuation. Unfortunately, with these observational studies, we don't know why the tapering was being done. We just know that tapering was occurring and that some people committed suicide or overdose. There was a comparative effectiveness study of about 200,000 individuals on stable long-term opioid therapy, and stable opioid therapy was defined as no evidence of opioid use disorder or opioid misuse.

These are people who are not running into problems with their opioids. Those people who were tapered, despite being on stable therapy, there was an association with a small absolute increased risk of opioid overdose or suicide compared to those that were maintained on those stable doses. The author of that study, Dr. Marc LaRochelle, said tapering or discontinuing should not be considered a harm reduction strategy for patients receiving stable long-term opioid therapy who have no evidence of misuse. If there's misuse, that's a whole different situation. If someone is stable on their opioid, don't taper them just because you think you're doing something in terms of harm reduction.

I'm going to stop there, and I'm going to look in the Q&A for any questions that you have. I'm going to encourage you to put questions in the Q&A. I will read the question. When we do the case studies, we will then open it up for people to raise your hand and I'll call on you, and we'll hear your comments about the case. Oh, okay. This was just a comment about the other in that first poll was having issues in our system, Epic, to find a good report that shows daily morphine milligram equivalent dose. Yes, I think knowing the daily morphine milligram equivalent can be helpful, especially when you've got patients on different opioids and you want to know how does that compare.

Certainly, when you start seeing people on 50, 60, and higher doses, 50, 60 morphine milligram equivalents, you're starting to think about increased risk. We do know that there is a dose response. That is, as the dose of opioid goes up, as does the risk of overdose and overdose death. We should be mindful of that. Are there any other questions? While people putting questions in, please do, I'll just talk about that a little bit. I think part of the problem with people being on high-dose opioids, certainly none of us intended to put people on megadose opioids or intended to cause harm related to that.

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I think what happened was, as opposed to all the other medications that we prescribe for pain, they all have a ceiling analgesic effect. You would never prescribe more than 800 milligrams of ibuprofen TID (three times a day). Even if the patient came in and said, "I want 1,200 TID," you'd say, "No, there's no benefit in that. In fact, you're just going to have more risk and no additional benefit." Opioids are different. Opioids have no analgesic ceiling effect. We know that people who are in palliative care, end-of-life care, they continue to get some benefit with added dosing of the opioid.

There was no ceiling. We couldn't say, "Mr. Jones, you're on the maximum dose of opioids if they weren't benefiting from the dose they were on. We ended up on very, very high-dose opioids. We now know that there's a diminishing return in terms of diminishing benefit on the higher and higher doses as you go, and the risks start to go up. That's the risk-benefit profile. If I increase this opioid dose, there may be a little added benefit, and it's going to get less and less as higher and higher doses go. That, by the way, is similar to all the other medications we prescribe.

When you prescribe lisinopril for someone's high blood pressure, the biggest thing you get is from that first dose. It's the same. You get incrementally less benefit, but you're starting to see an increase in risk as the dose goes up. I do now tell patients, "You're on the maximum dose. You're on the highest dose based on your condition, based on your profile." They might say, "I used to be on a higher dose. I know people on higher doses." I say, "No, for you, you're on the maximum dose." I would encourage you to think along those lines as opposed to thinking, "If they're not benefiting on this dose, they just need to be on a higher dose."

Any other questions? We could move on to the cases, and that will probably generate some questions for sure. Why don't we do that? I have two case studies, and the first one is hopefully a patient who might be similar to someone who you have in your practice. A 55-year-old male high school teacher with chronic severe low back pain presents for a first visit to establish primary care as his previous primary care provider retired. He's had surgery on his back, lumbar decompression and spinal fusion surgery, without any benefit. Currently, he's taking ibuprofen 800 milligrams, acetaminophen 500 milligrams, gabapentin 300 milligrams three times a day, so rational polypharmacy.

He's also taking oxycodone 10 milligrams QID, or four times a day. He has not responded to physical therapy or to chiropractic treatments, and he's currently on medical leave from his teaching job due to his severe pain. Despite being on four different medications that are all acting synergistically, despite having surgery on a pass, he's not doing well. He's got terrible pain, and he's on leave. Function-wise, he's not doing well either. The questions for this case is how will you assess his risk for opioid misuse and harm, how will you assess him for benefit from your treatment, what are your goals of treatment, and if you decide to continue the oxycodone, how will you monitor him for opioid-related safety?

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We can answer any one of these questions, or we could start with how will you assess him for risk? I am going to be looking for people to raise their hand or have some comments. I hope we get some people willing. You can also put it in the Q&A. You can write in the chat if you don't feel like saying it out loud.

Webinar Support: If you'd like to utilize the raise hand feature, you'll see the raise hand icon at the bottom of your screen. It's next to the Q&A box.

Daniel: How will you assess his risk for opioid misuse harm? Remember, a school teacher with severe low-back pain on lots of different medications, what do you want to know to assess his risk for misuse of that oxycodone?

[pause 00:40:39]

Daniel: Remember, there are patient-related and medication-related. I've got some. Good. Previous history of substance use. Absolutely. The opioid risk screener. Thank you. There are some validated screeners, for sure. You could use them. If you could implement them in your practice, that's great. There's the SOAP. There's the ORT. They all have limitations. Hard for them to keep up with as we learn about more and more risk factors. If you use one, that's great. Keep in mind some of the things, like a history of substance use. Open to questions about how he's taking the medications. Good.

I think taking a 24-hour inventory of how someone is taking their medications is great. Tell me how you're taking your oxycodone, when you wake up, when you take your first dose. You can get some really interesting information that can be very, very helpful. How long has he been on the opioid? The chronicity of it. What dose did he start with? Did he get benefit when he first started taking it? Does he feel benefit after he takes that dose? Is there anything that he can tell you about how the opioid is working for him? Certainly, the monitoring, the PDMP (Prescription Drug Monitoring Program), which is interesting. I think it's a really important tool for us.

I will tell you that in primary care, it's pretty low yield. How do I know that? I don't know. If you've had experience checking the PDMP, and in my state, Massachusetts, we need to check the PDMP every time we refill an opioid. I can't even remember the last time I found an unexpected finding or something that was actionable. Yes, it's reassuring, for sure, but it does require some time to look up. Thankfully, in our state, we can delegate to others to look up on our behalf, which is great. When you look at the National Survey on Drug Use and Health National Survey, and they asked people who said, "Yes, I misused an opioid in the past year," and they asked them, "Where did you get that opioid?"

The majority got them from a family or friend, which is why we want to minimize over-prescribing so that people don't have lots of opioids in their medicine cabinet, especially after

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acute pain. We also want to talk to our patients about safe storage and disposal. When they asked them what percentage of people got it from going to multiple different doctors or prescribers, it was like 4%. It's really a small piece of the puzzle. It's not to say that we shouldn't be looking for it. Certainly, it's helpful to find that, "Oh, you're seeing an outside psychiatrist," and, "Oh, you're on benzodiazepines, you're on clonazepam. That's good for me to know, because that's another CNS depressant, and you need to be aware of that."

These are all excellent. Nobody mentioned urine drug testing. I think urine drug testing can be helpful, especially early on. Again, you're not trying to catch someone doing something wrong. You're just trying to see if there's risk. Sometimes patients feel, especially early on, they may not feel comfortable disclosing to you that, yes, they use cocaine on occasion. It's important for us to look for that. Ask him about any physical therapy exercise that possibly relieve pain better than others. Would any alternative treatment, such as a TENS (transcutaneous electrical nerve stimulation) device, be beneficial?

I think these are important questions. I think we're getting into assessing him for benefit, and what are the goals. Certainly, he said he tried physical therapy. If any of you have been through physical therapy, and I'm actually currently going through it right now for shoulder rotator cuff injury, one physical therapy is different than another physical therapist. Some are incredibly good. Plus, how long ago was the physical therapy that he had? His pain may be very different than it was then. We all are constantly changing. Different physical therapists, over time, it's worth probably retrying it.

Would alternative treatments, such as TENS device, be beneficial? It may be. This gets me into, when do I refer to a pain specialist? I know pain specialists are few and far between, but I don't send them to a pain specialist to take over opioid prescribing because they don't want to do that. I do, when I'm not really clear on what's the mechanism of this person's pain. Can you help me? Are there other treatments that are available that could help this person, like a TENS unit, perhaps, or a nerve block, or a spinal cord injection, or some behavioral therapy? I think there is a role for all that.

I think it's really important that we talk to our patients about why we're sending them to these other treatments. Oftentimes, patients become overly focused on medications, and some become overly focused on opioids. They feel like, "Oh, yes, I'll go to the physical therapist because I know I need to do that in order to get what I really want, which is to continue getting the opioid therapy." They feel it's just a test, or a trial, or something they need to do to achieve that, as opposed to understanding that this is going to be incredibly beneficial to you.

I'll tell you a perfect example of when I realized I hadn't done that well was when I had sent a patient to a psychologist for cognitive behavioral therapy. He came back furious, and he said, "I'm never going back to that guy." I was like, "My goodness. What happened?" He said, "He didn't even examine me." I said, "If a psychologist examined you, you could probably sue him."

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The expectation was that he was going to a pain specialist who was going to do a physical exam, as opposed to going to a psychologist to help him cope and understand how to pace and live with his pain. That taught me a very important lesson as well.

Let's move this over. How will you assess him for benefit from your treatment? What are your goals? Let's talk about goals. How do you set goals for something that's so subjective? It's not like the goal is to get someone's A1C down, or the goal is to get someone's blood pressure down. We're talking about the goals to achieve a subjective improvement. How do you do that? Certainly, I talked about the PEG scale as a useful tool, but how would you dive in more into what's a goal for a particular patient? How do you set goals? Does anyone have any strategies?

What about buprenorphine for pain management? We'll definitely get into that. We will definitely get into that, probably in the next case. I'm going to hold off on that one for a moment. I want to just touch upon setting goals, which is one of the more challenging things that we do. Pain tolerance. I think you're getting at, is pain tolerance improving? What are the three things he wants to be able to do that he currently feels unable to do? That's great. Is his pain improving, and is he able to be more functional? I would suggest that you use something like SMART goals.

SMART goals are that what this person wants to achieve are specific, are measurable, are action-oriented, are realistic, which is going to depend on the patient, and are time-sensitive. As opposed to, "I just want to feel better," or "I just want to do more things which you cannot measure," you want to ask, what are the things like going to the store, which is three blocks away, or doing my laundry, or doing cooking every night, or whatever, that's very specific, measurable, action-oriented, realistic potentially for a particular patient. If they say, "I want to go up on the roof and replace my roof," that may not be realistic for a patient.

Then time-sensitive, so that you can measure it on the next visit. I would use SMART goals. If you continue his oxycodone, how will you monitor him for opioid-related safety? I think we've talked about some of this, namely the PDMP, urine drug testing. Now, one thing that's not often done because it's labor-intensive is pill counts. I don't do them often, but there are some times where I will do them, where you have the person bring in their unused pills, and you're able to count them to make sure that the person is taking them exactly as prescribed.

That is that there isn't too few pills, that is, they're taking more than prescribed, or there aren't too many pills, that is, the person turns out doesn't need as much as being prescribed. I think those are important things that you can glean from a pill count. It is time-intensive, and sometimes we can delegate that to other people in our practice to help us with. I'm going to move on to the next case because it does address some of the more complicated issues that you guys brought up as challenging, and it also brings up the whole buprenorphine for pain.

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This is a 42-year-old female with severe opioid use disorder (OUD), active use, depression, anxiety, and type 2 diabetes, with an A1C, 7.5%, with severe pain from painful diabetic neuropathy, is presenting for a first visit, again, after moving from out of state. Pain is treated with gabapentin, 800, three times a day, acetaminophen, 500, every eight hours as needed, unable to tolerate NSAIDs due to GI symptoms, or tricyclic antidepressants due to over-sedation. Remember, anticonvulsants like the gabapentinoids and the antidepressants like tricyclic antidepressants and the SNRIs are really the treatment of choice for neuropathic pain. She's unable to tolerate TCAs.

Opioid user is actively using IV fentanyl, history of two overdoses, three detoxes, no history of the use of medications to treat OUD, is living with and caring for her chronically ill mother. The question is, in this person with active opioid use disorder, how would you manage her severe opioid use disorder, and how would you manage her severe chronic pain? I'm going to suggest, so we can move right into the second part and address the question that came up about buprenorphine for pain management, I would say her opioid use disorder requires a medication.

It could be buprenorphine, Suboxone. It could be methadone, which would be administered, that is, dispensed at a opioid treatment program. We can't prescribe methadone for the treatment of opioid use disorder in primary care. It has to be done in a licensed opioid treatment program, but we could prescribe buprenorphine in our primary care practice for treating opioid use disorder. The question is, what is she interested in for treating OUD, and is her desire to quit? Good. I think you do want to assess her motivation for decreasing or stopping her use and getting her treatment of OUD treated, and finding out what's fueling her motivation.

Let's say she's motivated, then absolutely, we should be offering her medications. The other medication that I didn't mention is naltrexone, which is also something we could prescribe in primary care for OUD. The problem is, the complexity is that she has also concurrent pain. How would you manage her severe chronic pain, as well as her opioid use disorder, simultaneously? Thoughts? This is a little challenging. Could you bring light to the patient that there are cases in which overusing opioids makes pain worse? Absolutely. It's possible that she has opioid-induced hyperalgesia because of her current illicit opioid use.

It's absolutely possible that she has withdrawal-mediated pain. That is, if you treat her opioid use disorder with once-a-day buprenorphine, maybe her pain will actually get better because you're getting rid of the withdrawal-mediated pain. Certainly, addressing mental illness is important as well. That's an important point as well. The way I would approach this is I would first start treating her opioid use disorder and put her on something like buprenorphine.

If it turns out that once her withdrawal is gone and she's doing well on the buprenorphine, and she says, "My pain is still really terrible," then you could split dose the buprenorphine and dose

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it three times a day because buprenorphine, and this was the original question that I didn't answer, buprenorphine has an analgesic half-life of eight hours, six to eight hours. In order to use buprenorphine to treat pain, you need to dose it three or four times a day. When you use buprenorphine to treat OUD, you only need to dose it once a day. The half-life, depending on what you're using it for, differs.

You could treat both the OUD and the chronic pain simultaneously with buprenorphine by just simply dosing it three times a day. Hopefully, that will treat both her OUD and her chronic pain. It would be hard to use naltrexone in a patient like this because to start naltrexone, you need the person to be opioid-free for 7 to 10 days, usually, because you'll precipitate withdrawal, and it's not going to address her chronic pain issue. Although maybe, as you had mentioned, her chronic pain is really being fueled by withdrawal or opioid-induced hyperalgesia.

There are different ways to approach this. Certainly, you want to first treat that OUD, which is life-threatening, which has a very high mortality rate. Starting someone on a medication like buprenorphine is actually life-saving. It's been shown in multiple studies to have a mortality benefit. I'm going to stop there because I know we're running out of time. I want to thank you for engaging in this conversation about these cases and for inviting me to be here. Thank you.

Webinar Support: Thank you so much, Dr. Alford. Wonderful.

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Thank you for your attendance. This concludes today's webinar. You may now disconnect. Take care.

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