SCOPE of PAIN: Safer/Effective Opioid Prescribing Education

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Episode 8

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Ilana Hardesty: Thanks for listening to Boston University Chobanian & Avedisian School of Medicine's Safer and Competent Opioid Prescribing Education: *SCOPE of Pain* Podcast Series. I'm Ilana Hardesty.

This series has eight episodes. If at any point you want more information on receiving credit, please visit our website, scopeofpain.org. There are also resources that accompany this series. All of it can be found at scopeofpain.org.

In this final episode, we'll speak with Dr. Erica Bial, Kristin Wason, and Dr. Daniel Alford.

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Let's open with our case study, Michelle. She's been doing well on her pain treatment plan, including oxycodone for her painful diabetic neuropathy and chronic hip pain, for 11 months. Her urine drug tests consistently returned expected results except once when it was opiate positive but negative for oxycodone, raising concerns for opioid misuse, including possible diversion. Michelle asserted that she had been taking her prescription on schedule and denies sharing or giving her oxycodone to others. A confirmatory test could not be done due to the urine sample being too small. She has forgotten to bring in her pill bottles for pill counts on two occasions. The PCP shares his concern with Michelle and tells her that since these instances put her at greater risk for harm, he'll be monitoring her more closely, including more frequent urine drug tests and pill counts. There were no additional unexpected test results over the next two months.

Dr. Bial, how would you talk to patients if you're worried they may be diverting some of their opioid pain medications?

Dr. Erica Bial: It can be a very tough conversation, and I think it's really an important one. So talking about possible diversion with our patients oftentimes starts with education. We should remind our patients that prescription drug diversion is one form of opioid misuse. So this will be defined as the giving, selling, or trading of prescription medications. So why do we care so much? Because surveys indicate that family and friends are actually the most common source of diverted opioids in our communities. So we want to discuss very openly and with great care and compassion why we're concerned about diversion. So, for example, if a patient comes in and the patient's urine drug screen was negative for the prescribed opioid, or there have been non-adherence with pill counts, or some other objective measure as to why you are concerned, talk about it openly. It's also important to be prepared to discuss your inability to continue to prescribe opioids if the opioid is being diverted to others.

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Ilana Hardesty: Two months later, Michelle is brought to the emergency department by ambulance after suffering an overdose. Her husband explains that he found her on the bathroom floor and administered naloxone, to which she responded. And then he called 911. Her husband reports that Michelle's pain has increased recently, resulting in her taking extra oxycodone pills and taking some of her father's morphine. She's been sleeping a lot and calling in sick to work. He acknowledges he may be in denial about Michelle's problem, and he's been trying to focus on work instead. He reports Michelle has not been able to visit with friends or engage in her hobbies, and he was rationalizing, assuming it was due to the pain and not the medications. He reports hearing a staff person at the ED refer to Michelle as a drug abuser, and he's upset by this characterization.

Let's turn to Kristin Wason, our primary care nurse. Kristin, what have you experienced around the use of stigmatizing language by members of the health care team? And how do you address the issue?

Kristin Wason: I try to address it right away. I find a lot of times it's not mal intended. A lot of times our care team members, our coworkers, are using language that is like well ingrained in them that they've been saying for decades. They don't realize how harmful it is actually, and how disrespectful it is to the patient and how it can be very counterproductive to forming a therapeutic relationship. And so why are you calling this patient with a substance use disorder an addict? It's something that we don't say like they're more than just their disease. They're a person first. And so we really need to sort of make sure that we're modeling that appropriate language for our patients. And a lot of times patients will still say things like addict or alcoholic. But in our setting, we don't say that. We're treating a medical condition and we need to make sure our patients know that this is a safe place where they're going to be respected. And we want to make sure we're not documenting that stigmatizing language either. Especially now patients have access to their chart. It can make it seem like we don't care about them when really we care a lot about them.

Ilana Hardesty: So, Michelle had an overdose. Dr. Alford, does her treatment plan change after this?

Dr. Daniel Alford: So my treatment plan would change. And at this point, it's important to highlight that there were a couple of studies recently published that identified some important treatment gaps following an opioid overdose. One is that opioids were dispensed to over 90% of patients after a non-fatal overdose, and that may be truly indicated. However, we need to realize that these patients are at particularly high risk for a subsequent overdose. What they found in this study was that there was a 7% repeat overdose rate in those patients who continued to get opioid prescriptions, and that the two-year cumulative incidence of a repeated overdose was as high as 17% for patients who were on high opioid doses after that index overdose. So really keep in mind that these patients are particularly high risk for a subsequent overdose. The second finding in these studies was that less than a third of opioid overdose survivors ended up receiving a life-sustaining medication for their opioid use disorder in the subsequent 12 months. And the reason why

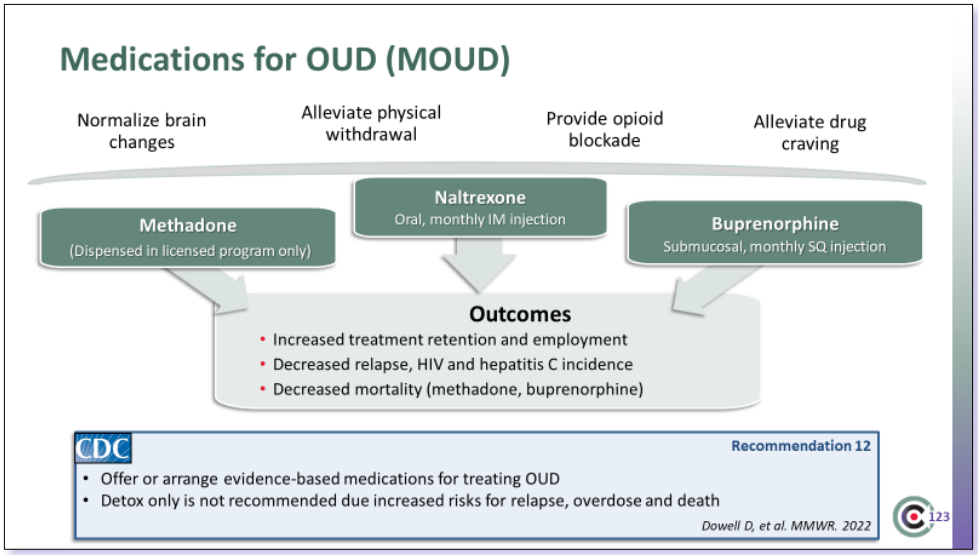
that's important is that those that did receive a medication for their opioid use disorder, there was a decrease in all cause and opioid-related mortality.

Now, we talked about how to diagnose an opioid use disorder by the DSM-5 criteria. But keep in mind that, in general, we should think about opioid use disorder as a chronic relapsing brain disorder that's characterized by compulsive use despite negative consequences. And it involves changes to the brain involved in the reward and stress and self-control pathways, and that these changes in the brain can persist even after the drug use has stopped. And like other chronic diseases or disorders, opioid addiction often involves cycles of relapse and remission, and that without treatment, opioid use disorder is progressive and can result in disability or premature death.

The good news is we have medications that we can use to treat opioid use disorders, and they're highly effective. Kristin, can you talk about the medications and what your experience has been in treating patients with them?

Kristin Wason: Yeah, this is a part of my work that I really, really enjoy. Working with patients with substance use disorders has been like truly one of the best things I have done with my career. It's amazing to see patients really engage in treatment and then, you know, the symptoms of their disease decrease and they thrive. You know, they feel so much better, they function so much better. And not only do their symptoms go away, but their life just gets so much better. And they're so grateful that you were able to sort of like work with them on that, that like really stigmatized condition. Right. And so the medications are highly effective.

We have three to treat an opioid use disorder: methadone, buprenorphine, and naltrexone, and all three of them can decrease cravings to use illicit opioids. All three of them can decrease use of illicit opioids. All three of them can be dosed like once a day. Naltrexone and buprenorphine also have once monthly injectable formulations available on the market now, which is really attractive to most patients who are looking for a simplified regimen. But methadone or buprenorphine in particular, like patients can start them pretty easily, just within about a day of last use of a substance like fentanyl. And instead of going into withdrawal like every 1 to 2 hours, which happens with fentanyl now, they can start treatment and they can feel normal all day. It's like amazing to them. And so it's really cool that like partner with patients on that and be a part of that journey with them.



Dr. Daniel Alford: Now I know you know, obviously buprenorphine and naltrexone can be prescribed in a primary care practice, but methadone cannot. Can you talk about that a little bit?

Kristin Wason: With methadone: it can be prescribed at a pharmacy for pain management, but for an opioid use disorder, patients really need to have that medicine dispensed to them. What we'll do is if a patient is identified as having an opioid use disorder, we'll talk to them about the three different forms of medication. Again, I like to make sure my patients are informed consumers and we give them a menu of services they can help choose what works best for them. And if they're looking, or we come to the conclusion that methadone is the best medicine for them, I really have to call a methadone clinic and try to facilitate a warm handoff because we can't just prescribe that methadone for their opioid use disorder. It really needs to be dispensed an opioid treatment program due to those federal and state regulations.

Dr. Daniel Alford: So speaking about naltrexone and buprenorphine, now there is no needed additional training or a waiver to be able to prescribe buprenorphine. There's still a reluctance among many to take this type of treatment on whether it be naltrexone or buprenorphine in primary care. Why do you think that is?

Kristin Wason: Yeah, it's interesting, right? For basically 20 years buprenorphine, if you wanted to prescribe it, you had to go, you know, federally-required and approved training and then essentially get a special DEA license in order to prescribe it. And so it's interesting that we have such a severe overdose epidemic. And then we have this condition that is very treatable with like highly effective medicine, but people had to like opt in to treat it. It wasn't sort of just like part of the standard of care. And so I think now people got very comfortable choosing not to opt in. They built up panels, they're busy, I get it. But at the same time, like again, this is an extremely rewarding condition to treat: people's lives get so much better. And so, you know, I really wish people now would be more apt to just like take this on. There is a lot of education out there for it. Our patients need our help.

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Ilana Hardesty: Michelle's PCP continues the buprenorphine started in the ED, but doses at three times per day rather than once per day in order to treat both her chronic pain and OUD. Months later, because Michelle's hip pain from her end stage arthritis is affecting her function and quality of life, she's scheduled for a right hip arthroplasty.

Now that Michelle is taking buprenorphine, how should her surgical pain and OUD be managed perioperatively?

Dr. Daniel Alford: So that is one of the most common questions that I get asked, as an addiction medicine specialist. There is growing consensus on perioperative pain management in patients on medications for opioid use disorders. And the best available evidence suggests that patients with an opioid use disorder history are often more sensitive to painful stimuli. The recommendation is to continue their methadone or their buprenorphine throughout the perioperative period And then we need to treat their pain,

their post-operative pain, with analgesics on top of the patient's daily medications for their opioid use disorder. And patients like this may need higher doses of opioid analgesics because of their increased pain sensitivity. We also know that ineffective pain management for these patients can absolutely result in disengagement in care.

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Ilana Hardesty: Michelle did well following the surgery with improved pain control of her right hip. Her painful diabetic neuropathy is well controlled on a combination of buprenorphine, duloxetine, and nortriptyline. Her gabapentin was discontinued due to the misuse risk. Her PEG scores remain between five and six on the ten-point scale, her OUD is in sustained remission with MOUD and outpatient addiction counseling. She regains employment and continues with regularly scheduled follow up visits.

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Thank you, Dr. Alford and Dr. Bial. And thank you to all our guests over this series: Kristin Wason, Patrick Kelly, and our patient, Don.

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I'm Ilana Hardesty. Thanks for listening.