Show Notes and Transcripts for CO*RE REMS Podcast Episode 3

Show Title: *Striking a Balance: Understanding Pain & Opioids*

Episode Title: Managing Patients on Opioid Analgesics

Description/Episode Summary:

In this final episode, Amanda Latimore, PhD, discusses best practices for assessing, treating, and monitoring patients on long-term opioid therapy with Jarratt Pytell, MD, and Arianna Campbell, PA. They cover topics such as effective screening tools, patient education, choosing between opioid and non-opioid analgesics, monitoring and adjusting therapy, addressing opioid use disorder, and the importance of a comprehensive patient-centered approach. The key takeaways emphasize the need for careful consideration of individual patient factors, regular check-ins, adapting treatment plans as needed, and prioritizing patient education to optimize outcomes and minimize risks associated with long-term opioid therapy.

Speakers

- Jarratt Pytell, MD (Addiction Medicine physician)
- Arianna Campbell, MPH, PA-C (Emergency Department and Addiction Medicine PA)
- Amanda Latimore, PhD (Moderator, Epidemiologist)

Acronyms used in this podcast episode:

- ORT - Opioid Risk Tool
- SOAP - Screener and Opioid Assessment for Patients with Pain
- MME - Morphine Milligram Equivalents
- NMDA - N-Methyl-D-aspartate
- EKG – Electrocardiogram
- IR - Immediate Release
- ER - Extended Release
- LA - Long Acting
- NSAID - Nonsteroidal Anti-inflammatory Drug
- PPA - Patient Provider Agreement
- PDMP - Prescription Drug Monitoring Program
- CNS - Central Nervous System
- FDA - Food and Drug Administration
- GCMS - Gas Chromatography Mass Spectrometry
- DSM-5 - Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
- DSM-5-TR - Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision
- DIGS - Diagnostic Interview for Genetic Studies
- DEA - Drug Enforcement Administration

Chapters

- 12:54 Addressing Opioid Tolerance and Non-Tolerance in Therapy
- 15:20 Choosing Between Immediate, Extended, and Long-Acting Opioids
- 20:20 Incorporating Opioids into Comprehensive Treatment Plans
- 24:54 Monitoring and Responding to Adverse Events in Opioid Therapy
- 26:31 Ongoing Monitoring and Refill History Reviews
- 28:56 Addressing Emerging Needs in Long-Term Opioid Therapy
- 37:20 Managing Opioid Use Disorder in Long-Term Therapy
- 42:04 The Role of Patient Education in Long-Term Opioid Management
- 44:45 Concluding Thoughts and Key Takeaways

Resources

- Link to CE activity associated with this podcast in the e-Learning Center.
  ***Take the test after listening to all three podcasts. ***
- Screening Tools

CDC Clinical Practice Guidelines

- CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022
  - https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

- *The link below **is included for historical context only!!!!** – for CDC's current recommended practice, please refer the 2022 update of the guidelines*
  CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
  https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

CO*RE REMS Podcast Three with Arianna, Amanda & Jarratt: Managing Patients on Opioid Analgesics

[00:00:00] Introduction to the Final Episode

Amanda Latimore: Welcome back, everyone. This is our final episode in our podcast series on assessing, treating, and monitoring patients on opioid analgesics. In today's episode, we'll be discussing screening and patient education in ensuring safe and effective opioid therapy.

[00:00:16] Effective Screening Tools for Opioid Therapy

Amanda Latimore: Jarratt let's start with screening. What are some of the most effective tools available to support a patient in understanding risks before initiating treatment?

And if opioid therapy is appropriate, what are the key points to emphasize when sharing information with them and their caregivers?

Jarratt Pytell: So, when it comes to screening tools, there are several validated options available that can help guide clinicians' decision-making. Urine drug testing has a role, but those tests and toxicology tests in general are limited and therefore we should focus on using validated instruments that are based on patient self-report.

We should trust what our patients tell us. One commonly used tool is the Opioid Risk Tool, or ORT, which assesses factors such as personal and family history of substance use, age, mental health conditions, and history of Adverse childhood experiences. Another one that we often see is the screener and opioid assessment for patients with pain called SOAP.

It's another effective tool that evaluates other drug-related behaviors and potential risk factors for risky opioid use, and there are many others. And these screeners provide valuable insights into a patient's individual risk-enhancing factors and allow us to tailor our approach accordingly. There are some patients that have a higher risk profile, and we may need to consider more frequent check-ins, shorter prescribing intervals, and potentially even just starting and continuing alternative nonopioid therapies.

As we discussed in our last podcast, buprenorphine might be the safest medications for some patients with really high-risk profiles. And generally, I find that discussing the screeners and how I use it to guide treatment improves the patient self-report. I explain that these screeners can provide additional data that can help me care for them.

I also let patients know that it can improve their experience by focusing the visit on what they are feeling.

[00:02:08] Patient Education and Safe Opioid Use

Jarratt Pytell: And then I think once we've decided to initiate opioid therapy, patient education and continuous re-education is critical. We need to continue to emphasize the importance of taking the medications as prescribed and not adjusting the dose or frequency without first consulting with me or another trusted healthcare clinician.

For acute pain, we usually describe the goal as using the smallest effective dose possible for the shortest period of time in order for the medication to do its job and provide pain relief. But we're trying to avoid indefinite treatment with an opioid in the setting of acute pain. So, having a clear exit ramp is critical.

Another key point to stress is the danger of combining opioids with other central nervous system depressants. This includes alcohol, benzodiazepine, and gabapentinoids, which can greatly increase the risk of respiratory depression and overdose when combined with opioids. And we did talk about using gabapentinoids in podcast two as a nonopioid medication to address pain.

For some patients, the risk of combining these classes of medications outweigh the risk. And finally, we should continue to educate patients on safe storage and disposal practices to prevent accidental ingestion or the risk of the medication being taken or used by a different person.

Amanda Latimore: What I'm hearing is that screening is a tool to help guide decision making with the patient and providing information that can help make the process safe and effective.

So, Arianna, is there anything else you might share with us on the use and administration of opioid therapy?

Arianna Campbell: I'll just add that patients should be counseled to keep medication hidden away from kids, visitors, and pets. So, this is really crucial with toddlers for safety and teenagers due to the high risk of unintended use of these drugs.

You can get lockboxes online. Now, a point to discuss with patients is long-acting opioids should not be broken, crushed, or chewed. And if swallowing is an issue, there are some capsules that can be opened and mixed into something like applesauce. So, I can't overemphasize having naloxone on hand and ensuring that the patient's family and friends know how to use it in case of overdose.

Go over warning signs with patients like Heavy snoring, gargling breaths, nodding off, being difficult to arouse, and, of course, there are signs of cyanosis.

[00:04:22] Initiating Opioid Therapy for Acute Pain

Amanda Latimore: Now, I'd like to shift our focus to the process of initiating opioid therapy for acute pain management. So, when a patient presents with acute pain, what factors should a healthcare provider consider before working with the patient to decide if opioid therapy is the right choice for them?

And how do you determine the appropriate starting dose? And in what situations would you also prescribe naloxone for home use? Arianna, do you want to take this question?

Arianna Campbell: Sure. First, we really need to assess the severity and the duration of the pain. And again, I think we've mentioned this a lot before, but what is its impact on the patient's daily functioning? How is this affecting your patient? So, this helps us determine whether opioids are truly necessary or if there's nonopioid alternatives that are sufficient.

Next, we should evaluate the patient's medical history and include any prior opioid use, substance use disorders, mental health conditions that may increase the hazardous use of opioids or addiction.

It's also important to consider any contraindications or potential drug interactions that could make opioid therapy unsafe. Once we've determined that opioid therapy is appropriate, the next step is to select the lowest effective dose and shortest duration of treatment necessary to manage the patient's pain.

This typically involves starting with an immediate-release formulation, titrating the dose gradually based on their response, and monitoring for any adverse effects. As for naloxone, It's crucial to consider prescribing or actually providing, in hand, this opioid reversal agent for home use. And really, I consider every overdose completely preventable.

Naloxone should be widely available. We should consider that very few people actually fill prescriptions, so if there's any mechanism to get naloxone into the hands of people, as easy as possible, please do that. Consider this for anybody with a history of substance use disorder. Somebody who's taking high doses of opioids, or people just who are taking something that increases their risk of overdose, like another benzodiazepine, anything that could increase their risk of respiratory depression.

We should also educate patients and their family and friends. Make sure that they feel comfortable administering naloxone in any emergency. And then this is really important, after they administer naloxone, they must dial 911.

Amanda Latimore: Absolutely.

[00:06:37] Managing Chronic Pain with Opioids

Amanda Latimore: Now, let's think about the unique challenges of managing chronic pain with opioids.

Jarratt, I'd like you to take this one. So, when considering opioid therapy, how might things differ for a patient with chronic pain compared to one with acute pain? How might outcomes vary for patients with chronic pain, those receiving palliative care, or those in end-of-life care?

Jarratt Pytell: So, in a situation where we have a patient who had recent acute pain who was started on opioid therapy and now is crossing that three-month threshold to now be classified as having chronic pain, we have to decide if we are going to continue or adjust the opioid therapy that was started in the acute setting.

With chronic pain, we really need to take a more comprehensive approach that assesses not only the patient's pain intensity and functional limitations but also the psychosocial factors, coping strategies, mental health, and potential barriers to a comprehensive treatment plan. A key factor to consider is the patient's history of pain management and their response to previous treatments.

Questions such as, have they tried nonopioid therapies like physical therapy, cognitive behavioral therapy, or other nonopioid medications? And if so, what were the outcomes and what challenges did they face when trying those treatments? I often encourage patients to retry a therapy they might have had in the past.

Noting that just because it was minimally or not effective before doesn't mean it might not be effective now. This information about a patient's history can help guide our decision-making and really set realistic expectations for treatment. You know, it's important to have an open and honest conversation with patients with chronic pain about what they can realistically expect from opioid therapy.

And to emphasize the importance of that multimodal approach that includes nonpharmacologic treatments. Now, shifting a little bit our frameworks for treating patients who are receiving palliative care and those at the end of life, the goals of treatment shift even further. In these cases, the priority is often maximizing comfort and quality of life, even if that means accepting a higher level of side effects or potential risks.

An unfortunate downside of the healthcare system's desire to curb prescribing is that clinicians who treat patients who would truly benefit from opioid therapy, like those with cancer-related pain, feel fearful of prescribing. Some clinicians fear that they will be labeled as a quote-unquote high prescriber or have some fear of getting into trouble with some authority.

We really need to have compassion and empathy for all patients. And for those at the end of life, we need to be more flexible in our dosing and frequency of check ins to ensure that we are maximizing benefits and helping patients reach their goals. We should really strive to involve the patient's family and caregivers in decision-making, particularly around pain management because there's a lot of opioid phobia in the community. And sometimes, family members are afraid of administering opioids or accepting opioid treatment for a loved one.

Amanda Latimore: Great. Thank you, Jarratt.

[00:09:27] Opioid Dosing Strategies

Amanda Latimore: Next, I'd like to focus on opioid dosing strategy. Arianna, can you discuss the differences between as-needed and around-the-clock dosing for chronic pain patients? How do you determine, with the patient, which strategy is most appropriate?

I'm also curious how you approach converting from one opioid to another and ensuring a safe transition.

Arianna Campbell: So as-needed dosing, that's also, of course, known as PRN dosing, involves taking opioids only when the pain reaches a certain threshold or becomes completely unbearable. So, this approach can be appropriate for patients with intermittent or episodic pain that's not consistently severe.

Around-the-clock dosing involves taking opioids at regular intervals throughout the day, regardless of the current pain levels. So, this approach often is for patients with continuous or severe pain that impacts their daily functioning. So, the goal with around-the-clock dosing is to maintain a

steady level of pain relief and prevent these breakthrough pain episodes that are challenging their daily life.

So, to determine which approach is most appropriate for any given patient, we need to consider the pattern and intensity of their pain, their functional goals, and their ability to take these medications on a regular dosing schedule. Patients with more predictable pain patterns and those who are able to maintain a consistent daily routine may do better with this around-the-clock dosing.

However, patients who have more variable pain or those who have difficulty sticking to a more strict schedule may benefit from PRN dosing. Converting a patient who experiences chronic pain from one opioid to another requires careful planning and close monitoring to ensure that it's a safe and effective transition.

The first step is to determine the right dose. So, which dose provides the right amount of pain relief and the minimal amount of risk? There are conversion charts and calculators that can help with this process. It's important to note that these conversion tools are just a starting point and may not account for individual variations in opioid tolerance and metabolism.

So, when making the switch, start with a slightly lower dose of the new opioid. And gradually titrate up as needed, based on the patient's response.

Amanda Latimore: Jarratt, it looks like you might have more to share with our listeners about transitioning medications. Do you want to jump in?

Jarratt Pytell: Yes. Anytime we're making changes when we are doing a conversion from one opioid to another, for example, from oxycodone to hydromorphone, we have to account for the cross-tolerance, which means doing a 25 to 50 percent reduction in the MME equivalent, just to make sure that patients are safe. Since when we are changing classes, patients can be exposed to a higher opioid effect.

And I'll also note that anytime we change treatment. It is another moment to educate patients about signs of over-sedation, respiratory depression,

potential side effects, and risks of the new opioid or withdrawal symptoms. They should be educated as well on the importance of keeping with the prescribed amount and schedule and reporting any concerning symptoms to their healthcare provider. It may also be necessary to provide additional rescue medications for breakthrough pain until the new dose is stabilized.

Amanda Latimore: So, I'm wondering, are there any unique challenges in initiating opioid therapy in opioid-tolerant versus opioid-non-tolerant patients? Are there any differences in approach when selecting the initial dose?

Jarratt, do you want to take this one?

Jarratt Pytell: Patients who are not tolerant to opioids have often not been exposed to opioids regularly or have been using very low doses at an infrequent interval.

For these patients, the primary goal is to start with the lowest effective dose and gradually titrate up as needed to achieve the pain relief and functional goals while minimizing the risk of the adverse effects. The CDC guidelines recommend starting with the lowest dose possible, which is typically in the range of five to 10 milligram, morphine equivalents per day, and then reassessing the pain, its relief, and the impact on function regularly.

On the other hand, patients who are opioid tolerant are those who have been regularly using opioids at higher doses for an extended period of time. These patients have developed a certain degree of tolerance to the analgesic effects of the opioids, which means they may require higher initial doses to achieve adequate pain relief compared to patients who have not been exposed to opioids.

And when we're taking over care for these patients who have already been receiving long-term opioid therapy and therefore have some degree of tolerance, it's important to obtain a detailed history of their previous opioid use, including the specific opioids that they've used, the doses and the frequency of the administration.

This information can help guide selection of the initial dose that we will offer because it will consider their existing tolerance level. It's also crucial to recognize that opioid tolerance does not necessarily confer protection against the adverse effects of opioids, particularly respiratory depression.

In both patients who have not been exposed to opioids and do not have tolerance and those who have been exposed to opioids and have tolerance, high-quality longitudinal care with regular assessments to support the patient during the initiation phase of opioid therapy or changing an opioid therapy is really important.

This may involve frequent follow up visits in person or phone check ins to assess their pain relief, functional improvement, and again, making sure that we're addressing any signs of adverse effects that the patient is having.

Amanda Latimore: So, building on that, let's discuss the considerations for providers on which opioids they might consider between immediate-release, extended-release, and long-acting opioid formulations. How does a provider like yourself determine which one is most appropriate to discuss with a specific patient? Also, I'd like to discuss some of the precautions that the guidelines may have recommended for methadone or other products that might have special restrictions for individuals.

Arianna Campbell: A lot of the opioid administration prescribing I do is from the acute care setting. So, I am using a lot of immediate-release or IR opioids because they're typically used for acute pain, breakthrough pain, and they have this rapid onset of action, and shorter duration of effect. They could also be used for patients who have intermittent pain or need more flexibility in their dosing regimen.

Extended-release or, ER or long-acting LA opioids are designed to provide more consistent and prolonged pain relief over an extended period of time.

These agents are often preferred for patients who are experiencing chronic around the clock pain that does require a steady level of analgesia. ERLA formulations can help reduce the frequency of dosing and make it easier for patients to stick to the treatment plan. Which formulation is most appropriate for a specific patient?

It's important to consider their pain pattern, duration of pain, overall treatment goals. Again, talk to your patients. What are their treatment goals? For example, a patient with persistent moderate to severe pain that significantly impacts their daily functioning may benefit from an extended-release or long-acting formulation.

While a patient with short-term acute pain may do well with a more immediate release of opioid. But it's also crucial to assess the patient's ability to stick to the dosing schedule and if there's any potential barriers to their ability to stick to it. Some patients may have difficulty remembering to take their medication at regular intervals and, in, which case an extended-release or long-acting formulation with less frequent dosing may be more suitable.

Jarratt Pytell: if you just allow me, because I do a lot more long-term opioid treatment for patients with chronic pain and use these long-acting formulations in my practice, I want to discuss the special situation of methadone.

Methadone cannot be prescribed by a physician to treat opioid use disorder. But clinicians can prescribe methadone for pain. And it's actually a really great medication for some patients with chronic pain requiring long-term opioid therapy due to its unique properties and NMDA receptor antagonism. That means that patients actually can have great pain relief without developing tolerance to the analgesic benefits.

It's really important to take a couple of special precautions with methadone due to its pharmacokinetic and pharmacodynamic properties.

Methadone has a long and variable half-life, which can lead to accumulation if it's not carefully monitored, so that means just regular check-ins with patients to check for over-sedation. It can also have a complex metabolism and interact with other medications, just like any other opioid, so we just need to be careful and monitor for adverse events.

But when prescribing methadone, as with all opioids, it's just important to start with a low dose and titrate slowly based on a response. The doses that are used for pain are often much lower than the doses that we use for

opioid use disorder. And monitoring closely for the rare instance of QT prolongation, which is detected on the EKG.

This is particularly a problem for patients who are taking other QT prolonging medications. QT prolongation occurs when there's a delayed repolarization of the ventricle that really, in very rare cases, causes something called torsades which can be life threatening, but again, it is rare.

There are certain opioids that are higher dose long-acting or extended-release formations that are indicated only for patients with some degree of tolerance. This is because these products contain higher doses of opioids that could be dangerous or fatal if given to patients without tolerance. Opioid tolerance will develop over time with regular opioid use, allowing the patients to safely tolerate the higher doses that would otherwise cause significant adverse effects in patients without the tolerance.

And when prescribing opioids that are indicated for patients with opioid tolerance, it's just, again, crucial to verify the patient's level of tolerance and ensure that they've been using opioids that are regularly at a dose equivalent that is equivalent to the product that we are considering to prescribe.

[00:20:20] Choosing Between Opioid and Nonopioid Analgesics

Amanda Latimore: So, let's turn to this crucial decision between opioid and nonopioid analgesics.

How do you incorporate the medication that is chosen between the patient and the provider into a comprehensive treatment plan?

Arianna Campbell: So, when deciding between an opioid and a nonopioid analgesic for pain management, the first step is to really establish the cause and the type of pain. This involves assessing the patient's pain, severity, duration, and the underlying conditions.

And once we have a clear understanding of the pain characteristics, we can develop a multi modal treatment plan that considers all the available options, including nonpharmacologic and pharmacologic therapies. For mild

to moderate pain, or pain that's expected to be short-term, nonopioid options work great.

Acetaminophen, NSAIDs, and then topical agents can be initiated first as well. So, these medications generally have a lower risk profile and can be effective for many different types of pain. There's nonpharmacologic therapies; we've talked about this, physical therapy, cognitive behavioral therapies, lifestyle modifications should also be incorporated into the treatment plan so that we can optimize pain relief and again, improve a person's function.

Regularly assessing the patient's pain and their response to treatment is crucial. If nonopioid options and nonpharmacologic therapies are not adequate and if the pain is severe, persistent, significantly impacting quality of life. That's when we're considering opioids, but before prescribing opioids, we should carefully evaluate the patient's medical history.

We should figure out if there's been any previous opioid use or any problematic opioid use, any mental health conditions that could increase the risk of addiction or hazardous use of opioids. We also need to consider potential contraindications or drug interactions that could make opioids unsafe for certain patients.

If opioids are appropriate for this particular patient. It's really essential to communicate safety concerns, risks, and benefits to the patient. There are some recommendations for the use of a patient provider agreement, or a PPA, and this outlines the expectations and responsibilities of both the patient and the healthcare provider.

I do have to put it out there that the CDC has stated there's not sufficient evidence in the literature for PPAs, however, some people can utilize these just more for communication purposes. So, if a PPA is being considered, it would be adequate to document expectations and of course mention that you're communicating the risks, benefits, and any safety concerns.

And really, this should be something that a patient also has some ability to influence what's in the PPA. So as we incorporate opioids into the overall pain management plan, regular follow up is essential. We need to

continually reassess the patient's pain, watch for any signs of hazardous use, and adjust the treatment plan if it's necessary.

This could involve tapering opioids if the risks start to outweigh the benefits or explore alternative pain management strategies. Patients should also be empowered to take an active role in their pain management and report any concerns or challenges that they're experiencing.

[00:23:27] Monitoring and Adjusting Long-Term Opioid Therapy

Amanda Latimore: So, Jarratt, what are your thoughts on how often these reviews should occur, and are there any other considerations that you want to share about these periodic check-ins?

Jarratt Pytell: Once a patient's established on opioid therapy, these periodic reviews of their pain and functional goals, I think, generally should occur every one to three months, depending on the patient's risk factors and stability.

During these evaluations, key elements to assess include the pain intensity, the functional status, quality of life, how difficult or easy of a time the patient is having with the treatment plan and assessing patient's opioid and other substance use. Again, I highly recommend using validated assessments because it helps reduce our own biases and focuses the treatment on the patient's voice and experience.

I will say that historically, we have been taught that urine drug tests, pill counts, and checking for early refill requests to catch quote-unquote doctor shopping were how we should be monitoring patients. The newer CDC guidelines de-emphasize this type of gotcha medicine and really don't even mention pill counts.

We need to really move away from this type of practice. So, our goal should be that we have developed enough trust and therapeutic alliance with the patients that they ask us for help before things get out of control or are willing to accept our help when problems become clinically significant.

Amanda Latimore: So, let's move on to another critical aspect of ongoing opioid management: responding to adverse events. Arianna, can you please share your insights on what specific adverse events a provider might pay special attention to during a patient visit and how they could encourage open communication about any concerns?

Arianna Campbell: Sure. I do have to say we're going to focus here on constipation because this is the biggest one that I'm seeing. So, unlike other side effects that may improve over time, constipation is a persistent issue, and it really does require some proactive management. So, it's recommended to prescribe stimulant laxatives at the initiation of opioid therapy to prevent and treat this opioid-induced constipation effectively.

So, other adverse events to monitor include nausea, which is pretty common, sedation, respiratory depression, very important to monitor for this. And any signs of endocrine dysfunction such as decreased libido, fatigue, depression, all things to consider here. Encouraging open communication about any of these concerns can be achieved by asking some open-ended questions.

Make sure you're actively listening to a patient and really try to create this non-judgmental environment. Jarratt, I am sure I'm missing some things here. Do you want to add anything?

Jarratt Pytell: I just would add that adverse event reporting is really crucial for identifying patterns and improving patient safety. These issues don't necessarily come to attention unless clinicians are reporting concerns and healthcare providers can report adverse events through the FDA's MedWatch program and by contacting the drug manufacturer directly. And then certain institutions also might have reporting systems that are available to them.

Amanda Latimore: So many great points made by both of you. Thank you. So, building on the topic of ongoing monitoring, let's turn our attention now to another essential aspect of opioid management, and that is looking at the refill history and prescription drug monitoring program data. Jarratt, can you share your thoughts on how often these reviews should be conducted and what information healthcare providers should be looking for?

Jarratt Pytell: Ideally, refill history and the PDMP data should be reviewed before every opioid prescription, every refill, and every patient visit. These tools can help us keep track of not just when the opioids were prescribed but, but when they were actually filled at the pharmacy. Clinicians should be aware of concerning findings such as early refill requests, multiple prescribers, high daily opioid doses, and, going back to what we talked about before, the co-prescription of other CNS depressants like benzodiazepines.

Because the combination of benzodiazepines and opioids is particularly dangerous as it really can lead to severe respiratory depression and increased risk of opioid overdose. In fact, the CDC guidelines recommend that clinicians use caution when prescribing benzodiazepines concurrently with opioids and consider when the benefits outweigh the risks.

Clinicians should be aware of patients concurrently prescribed opioids and benzodiazepines and work with them to minimize the risks associated with this combination. This may involve exploring alternative treatment options, gradually tapering one or both of the medications or providing additional patient education and just really close monitoring and frequent check-ins.

I've had patients transition to buprenorphine from other full agonists to reduce these risks when they are concurrently receiving opioid and benzodiazepine prescriptions. An opioid may no longer be beneficial if the patient experiences inadequate pain relief despite dose escalation, where they're really experiencing significant adverse effects, or they are having functional deterioration.

Other factors to consider include the development of an opioid use disorder, in which case we should be offering treatment with buprenorphine on the spot or supporting the patient to enroll at an opioid treatment program to receive methadone. It's crucial to review the patient's medication list, including prescriptions from other providers, to identify potentially dangerous combinations.

The PDMP can be an invaluable tool in this process as it provides a comprehensive view of the patient's controlled substance prescriptions, the

history, and how they are dispensed across multiple prescribers and pharmacies.

Amanda Latimore: Great. Thank you. When a patient is on long-term opioid therapy and experiencing worsening pain, I'm curious, what steps would you consider taking in response to these emerging patient needs?

What sorts of things do you do to assess patient progression? And what factors would lead you to consider changing the dose or potentially transitioning to another medication altogether?

Jarratt Pytell: When patients who are receiving long-term opioid therapy experience worsening pain, I think that the first step is just to conduct a thorough evaluation to try and understand and identify the underlying cause.

We don't want to anchor on a diagnosis of opioid hyperalgesia or simply blame their underlying condition because we could potentially miss something. So, these assessments involve the progression of the pain, the progression of the original condition, development of new pain generators. It's also crucial to screen for signs of opioid use disorder, such as continued use despite harms, because, as we mentioned before, withdrawal can present with worsening pain.

And if the worsening pain is due to a disease progression or a new condition, adjusting the opioid dosage may not be the most appropriate solution. Instead, clinicians should explore alternative pain management strategies such as interventional procedures, physical therapy, and nonopioid medications.

Factors that warrant considering a change in opioid medication include inadequate pain relief despite the dose titration, intolerable side effects, or safety concerns such as respiratory depression or new risk factors for opioid overdose. In these cases, switching to a different opioid with a more favorable risk profile may be important.

We don't know which patients will benefit from a given therapy or intervention, so it's important to work with patients and get them on board with the process to find the best treatment for them.

Amanda Latimore: So, Arianna, let's assume that there was a decision made to change a patient's opioid medication. How does the concept of incomplete cross tolerance influence your dosing calculations and what are the limitations do you think of relying solely on the conversion charts when determining the new dose?

And what additional factors should be considered to ensure the best possible outcomes for patients during these transitions?

Arianna Campbell: Incomplete cross-tolerance refers to the fact that patients who have developed tolerance to one opioid may not have the same degree of tolerance to another opioid. So, this means that starting the new opioid, if we use a conversion chart at that same dosing based on this conversion chart alone, may lead to overdosing.

To account for incomplete cross-tolerance, it's generally recommended to start the new opioid at a lower dose. So, we want to start that new opioid at a lower dose than the calculated equal analgesic dose and then titrate up slowly. based on that patient's response. So conversion charts should be consulted as a starting point, but there's individual patient factors such as age, comorbidities, prior opioid exposure and experience that also should be considered.

So, let me give an example here that may be helpful. Let's say we have a 75-year-old patient who is taking 180 milligrams per day of morphine, and we're going to switch them to oxycodone. So, if we want to account for this incomplete cross-tolerance, we want to see what would be the appropriate dose of the oxycodone.

So, let's remember here that 30 milligrams of oral morphine is roughly the same as about 20 milligrams of long-acting oxycodone. So, we've used our conversion chart here. This means that the morphine to oxycodone equianalgesic ratio is approximately three to two. So, this patient now is taking 180 milligrams of morphine in 24 hours.

If we look at the conversion chart, there's a dose of approximately 120 milligrams of oxycodone in a 24-hour period. Now let's take into account the patient's age, that they're on this high morphine equivalence, and because of that, we should really do that full 50 percent reduction in that full 24-hour equal analgesic dose. That means the new dose would be the extended-release formulation of oxycodone, and we would give this person 30 milligrams orally every 12 hours. It's essential to monitor patients closely during this transition period. We want to make sure that there's no over-sedation or respiratory depression.

We certainly want to make sure that this patient has rescue medication for breakthrough pain. And we want to educate this person about the signs and symptoms of toxicity. This is really important for safety. So again, by calculating this equal analgesic dose, consider these individual patient factors Start at that lower dose and then slowly titrate.

Discuss the safety measures. Make sure that the patient has naloxone in hand. And we really want to focus on minimizing the risks associated with opioid rotation.

Amanda Latimore: All right. So, another key component of long-term opioid management is monitoring patient acceptability of the treatment plan that was hopefully co-developed with the patient.

What strategies can healthcare providers employ to effectively engage with the patient during this process of examining how well the treatment plan is working for a patient, and what role does urine drug testing, screening, and confirmatory tests play in this process?

Jarratt Pytell: Clinicians should have a regular check-in with patients to see how well they are taking their medications, missing any doses, or having trouble taking the medication as prescribed.

This is what we do for any medication, and we would do the same thing here for opioids for chronic pain. One effective strategy is to conduct regular medication reconciliations, comparing the patient's reported medication use with PDMP data; this can help identify any discrepancies

between concerning behaviors, such as early refills or obtaining opioids from multiple prescribers.

But let's be honest. Life is hectic sometimes and patients might forget that they took a medication, right? I can certainly empathize with that. So, it's all about helping patients. Patient's self-report can also provide valuable information about medication use, and we should again make sure we are focusing on helping them succeed.

Now, we said you're in drug testing, and I'll just say broadly that's toxicology testing. I think it's really important to recognize that toxicology tests are like any other medical test. We clinicians have to think about why we're ordering the test and what we are going to do with that information.

Clinicians also need to know about the different testing options and what the tests detect and the risks of false positives and false negatives. Urine drug tests have been the primary way patient toxicology has been monitored because of the ease of collection. And unfortunately, likely due to misinterpretation of results, patients have been harmed.

This is why the CDC guidelines state that clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medication as well as prescribed and non-prescribed controlled substances. And then they go on to state that these tests should not be used in a punitive manner.

There are different types of tests and screening tests, which are these simple immunoassays can rapidly detect the presence of opioids and other classes of substances, while confirmatory tests like the gas chromatography and mass spec, or GCMS, Provide more specific and quantitative results. Generally speaking, the screening immunoassays might be helpful if you want to assess just broad classes of substances, say, benzodiazepines or opioids.

However, this doesn't tell you what the specific substance is. And some labs do not include fentanyl, the substance that is primarily responsible for our current overdose epidemic. The quantitative tests give you the most accurate information, though with the downside of the test being more expensive, and they often take a longer time to come back.

Certainly, if a clinician is going to change therapy based on a toxicology test, it should be based on these quantitative tests. This is really what is recommended by the CDC guidelines. It's also important to discuss the rationale. For the toxicology tests with the patients and frame it as a routine part of opioid therapy to ensure that they're safe and we are optimizing their care.

Any unexpected toxicology test results should be discussed with the patient in a non-judgmental manner and used to guide treatment decisions and referrals if needed.

[00:37:20] Addressing Opioid Use Disorder

Amanda Latimore: Despite our best efforts, some patients on long-term opioid therapy may develop opioid use disorder. I'd like to think about what signs and symptoms healthcare providers should be thinking about to highlight that a patient could potentially need support for opioid use disorder, what interventions should be considered, and when specialists should be consulted to assist in these complex cases.

Arianna Campbell: So, there is DSM 5 criteria to establish that a person is experiencing an opioid use disorder. If somebody is taking opioids in larger amounts for a longer period of time than prescribed, if they see that there's a persistent desire or there's unsuccessful attempts to cut down or control their opioid use, if people are spending a lot of time obtaining, using, recovering from opioids, are they experiencing craving or this really strong desire to use opioids?

Okay. Is this recurrent opioid use resulting in a failure to fulfill their obligations? Is this affecting their life? Are they unable to do the things that they've set out to do? Are they continuing opioid use despite persistent, recurrent social or interpersonal problems? Are they giving up important social, occupational, recreational activities due to this opioid use?

Is recurrent opioid use causing them to be in physically hazardous situations? Are they continuing opioid use despite knowing that there is recurrent, physical, or psychological problems that are exacerbated by

opioids? Have they developed tolerance? So, what do we mean by tolerance and withdrawal? Yes, tolerance and withdrawal.

Jarratt actually pointed out previously tolerance and withdrawal as a part of taking opioids for a period of time. So, it's not just those two alone. But if this is paired with some of the other effects on their life, then, of course, opioid use disorder should be suspected. Now, there's a severity here.

If somebody has two or three of these symptoms, it would be considered mild opioid use disorder. If there's four or five of these, moderate. And if six or more of these symptoms are included, then it could be considered severe opioid use disorder. So, if opioid use disorder is suspected, a thorough assessment should be conducted, and there are validated tools.

So, there's the DSM 5 or TR criteria, Diagnostic Interview for Genetic Studies or the DIGS. Patients meeting the criteria for opioid use disorder shouldn't be cut off, right? They should be offered evidence-based treatment options, including medications for addiction treatment, buprenorphine, or methadone.

Again, buprenorphine can be prescribed by somebody who has a DEA license and can prescribe schedule-three medications. And they also consider behavioral therapies while continuing to address the person's pain. And again, Partial agonists like buprenorphine or a full agonist like methadone certainly can be utilized to address pain as well. I do want to emphasize that we should avoid cutting off patients from opioids.

This can put that person in a pretty high-risk situation. So, consider a change to a partial agonist for safety. It's important to engage patients in this conversation and emphasize safety and overdose concerns. So, certainly, consultation with an addiction specialist or referral to an addiction treatment program could be necessary for complex cases.

But we all need to develop some comfort with managing patients with buprenorphine as well. Factors that may prompt more medically directed opioid tapering include patient preference. If somebody says, I really want to get off of all these medications. If there's a lack of improvement in pain and function despite escalating doses, or, of course, if there's a presence of

serious adverse effects or safety concerns or if therapeutic function is achieved.

So, Jarratt, do you have anything you want to add here?

Jarratt Pytell: I would add that it's really essential for clinicians to approach patients with a suspected or confirmed opioid use disorder from their prescription opioids with empathy and understanding. Creating a non-judgmental and supportive environment is crucial.

For patients with opioid use disorder from their prescription opioids, I routinely recommend transitioning to buprenorphine. Some patients do not want to be on the medication for various reasons, in which case I explained that we will take our time with the buprenorphine. We can taper them over time to prevent them from having withdrawal.

And when discussing opioid tapering, it's really important to involve the patient in that decision-making process and develop a collaborative plan that addresses their concerns and priorities. If possible, the tapering really should be as gradual as possible with that close caring check-ins and adjusting as needed to minimize withdrawal symptoms and prevent, the returning to drug use.

It's also just, again, important to take a comprehensive approach to patients and refer to mental health professionals and support groups, which can be, helpful for some patients in addressing the psychosocial aspects of opioid use disorder and promoting long-term recovery.

Amanda Latimore: So, let's now turn to the critical role of patient education in long-term opioid management.

How can healthcare providers deliver effective patient education about realistic pain management goals, safe opioid use, and potential risks in long-term opioid therapy? What key points should be emphasized, and what role does naloxone play in this setting?

Jarratt Pytell: Setting the realistic expectations about pain management is very important for patients and in our process of educating them about the goals of treatment.

Clinicians should emphasize that the primary aim of the opioid therapy is to improve function and quality of life rather than eliminating pain completely. Of course, you'd like to see a decrease in pain, but it's really about that functional status. Patients should be encouraged to set achievable, measurable goals that focus on daily activities, social engagement, and overall well-being.

When reviewing dosing and, you know, the safe use practices, things that I like to cover include taking the medication as prescribed and not adjusting without discussing with me or another clinician, the potential side effects and what patients can do to manage them,

again, being aware of the risks of combining opioids with other CNS depressants like alcohol and benzodiazepines

and of course, really never to share their opioids with others. It's very dangerous and can expose patients to legal consequences, which we do not want to have happen.

Patients should also be educated about the risks for, the risky use of opioids, such as a personal or family history of having a substance use disorder, mental health disorders, and social stressors.

These are all kind of those risk-enhancing factors that patients should be aware of and really encouraging open communications about these risks in providing resources and support in treatment, on demand, and the development of an opioid use disorder or other substance use disorder.

Arianna Campbell: Yeah, and I'll just add to this, that regular follow-up visits provide opportunities to reinforce patient education and really assess.

understanding of that education. So, using teach back techniques where patients explain some of these key concepts, this can help ensure that

they've absorbed the information. It's also important to provide patients with written materials, such as medication guides and treatment agreements that outline the risks and responsibilities of opioid treatment.

So encouraging patients to ask questions, voice concerns that can foster a collaborative and transparent relationship. Motivational interviewing could also be helpful when discussing change. So, ultimately, effective patient education really does empower patients to be active participants in their pain management, and it equips them with the knowledge, the skills to use opioids safely and responsibly.

Amanda Latimore: Thank you both for sharing your insights and expertise.

[00:44:45] Key Takeaways and Final Thoughts

Amanda Latimore: As we wrap up this podcast, I'd like to ask each of you to share your key takeaways from this discussion.

Jarratt Pytell: I think the key takeaway for me is that managing patients who are receiving long-term opioid therapy requires a comprehensive patient-side approach.

This involves careful consideration of the individual patient, regular check-ins and reassessments, and the willingness to adapt the treatment plan as needed to help patients reach their goals. It's crucial to balance the potential benefits of opioids with the risks and involve patients in the decision-making process every step of the way.

Focusing on patients and what they're saying and not relying on toxicology tests or PDMP data alone when making clinical decisions. The practical advice for listeners would be to stay up to date on the latest guidelines and best practices and to never hesitate to seek guidance from colleagues or specialists when facing complex patient situations.

Arianna Campbell: I just want to add that we need to ensure that patients understand the risks and responsibilities inspired the patients of treatment with opioids, that they have the knowledge, they have the tools to be able to take these medications safely and appropriately. My advice to healthcare

providers would be to prioritize patient education, but also really building up that therapeutic alliance with patients, set realistic expectations with patients, provide resources for additional support if needed.

For working collaboratively with patients and empowering them to take an active role in their care, we can really optimize outcomes and minimize risks associated with long-term opioid therapy.

Amanda Latimore: Thank you both. I've learned so much, and I hope our listeners have as well. You both have shared important information that providers can use to support patients with pain, and I hope that they feel empowered to carry this information out in their own practice.