Show Notes and Transcripts for CO*RE REMS Podcast Episode 1

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

Episode Title: The Basics of Pain Management and Assessing Patients in Pain

Description/Episode Summary:

This podcast episode is the 1st of 3 in a series on comprehensive pain management strategies that maximize treatment effectiveness while minimizing addiction risk and maintaining patient safety. In this episode, Arianna Campbell, PA, and Jarratt Pytell, MD, join Amanda Latimore, PhD to discuss a patient-centered approach to assessing patient's pain that aligns with the latest CDC guidelines and REMS programs. The conversation covers topics such as the importance of understanding the patient's perspective on pain, adopting a compassionate approach for individuals with chronic pain or substance use disorders, addressing the stigma associated with drug use, utilizing diagnostic studies effectively, and considering the unique needs of special populations. They provide valuable insights into creating trust and a therapeutic alliance with patients while navigating the challenges posed by pain management and the opioid epidemic.

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:

- CDC: Center for Disease Control
- PDMP: Prescription Drug Monitoring Programs
- PEG: Pain Enjoyment and General Activity
- GAD - 7: World Health Organization
- PHQ – 7: Patient Health Questionnaire
- PHQ – 9: Patient Health Questionnaire
- BPI: Brief Pain Index
- NOWS: Neonatal Opioid Withdrawal Syndrome
- ACE: Adverse Childhood Experiences
- MRI: Magnetic Resonance Imaging

Chapters

- 14:54 Addressing Racial Bias and Pain Perception
- 17:09 Navigating Opioid Prescribing Challenges
- 21:15 Educating Patients on Opioid Use and Risks
- 23:39 Utilizing Screening Tools and PDMPs in Patient-Centered Care
- 35:56 Special Considerations in Pain Management for Diverse Populations
- 43:03 Concluding Thoughts on Patient-Centered Care

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

Research Articles mentioned in the episode.

- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, *113*(16), 4296-4301.
- Kelly, J. F., Dow, S. J., & Westerhoff, C. (2010). Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms. *Journal of Drug Issues*, *40*(4), 805-818.
- Trawalter, S., & Hoffman, K. M. (2015). Got pain? Racial bias in perceptions of pain. *Social and Personality Psychology Compass*, *9*(3), 146-157.
- Trawalter, S., Hoffman, K. M., & Waytz, A. (2012). Racial bias in perceptions of others' pain. *PloS one*, *7*(11), e48546.

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 One with Arianna, Amanda & Jarratt: The Basics of Pain Management and Assessing Patients in Pain

[00:00:00] Introduction to REMS and the Opioid Crisis

Amanda Latimore: Welcome, and thanks for joining. Today, we're talking about the Risk Evaluation and Mitigation Strategies, or REMS, which is a program that provides education and guidance that aligns with the Food and Drug Administration, or FDA's blueprints, and the most recent Centers for Disease Control and Prevention clinical practice guidelines. These guidelines offer recommendations on how to treat pain and use opioids in a way that minimizes patient harm. Here to discuss these recommendations, we have Arianna Campbell and Dr. Jarratt Pytell. Dr. Pytell, is it okay for me to call you Jarratt?

Jarratt Pytell: Of course.

Amanda Latimore: Great. Thank you both for joining. So, let's start with introductions, Arianna.

Arianna Campbell: I'm really thrilled to be here. Thank you. I'm Arianna Campbell. I'm a PA. I recently finished my MPH at Johns Hopkins, and I am currently completing my doctorate at UOP. I've worked as a PA clinically for almost 25 years. Most of those have been in the emergency department, but I've spent the last seven years really focused on access to care for substance use disorder. And there's a particular emphasis on our opioid crisis as well. So, I co-founded, I'm principal investigator of Bridge, which is a program that's innovating our system of care to address substance use disorder from really any setting and to leverage emergency department interactions to initiate treatment.

Amanda Latimore: Great. Thank you, Jarratt.

Jarratt Pytell: As you'd mentioned, my name is Jarratt Pytell, and I'm an assistant professor of medicine at the University of Colorado School of Medicine. I'm an internal medicine and addiction medicine specialist and provide comprehensive primary care, including pain management and addiction treatment, at a federally qualified health center in the Denver Health System. Thank you very much for having me.

Amanda Latimore: Thank you. So, as you both know, well, the CDC guidelines were recently revised. So, this podcast really comes at a good time as we reflect on the changes and the guidance which has really evolved with the evidence and the recognition of the need for patient-centered care. Jarratt, can you please talk a little bit about the impact of the 2016 guidelines and how these revisions clarified the best evidence for the treatment of chronic pain?

Jarratt Pytell: So, in 2016, the Centers for Disease Control and Prevention CDC released guidelines to help guide long-term opioid treatment. Unfortunately, those guidelines were misunderstood, and some of the information in the guidelines was misconstrued to suggest that there should be dose limits or durations on chronic opioid prescribing. And this led to a decrease in opioid prescribing, including patients being tapered or their opioids discontinuing, which led to harms. So therefore in 2022, recognizing those harms, the CDC released updated guidance with a focus on individualizing care and weighing the risk and benefits and taking a personalized approach to treatment.

[00:03:16] The Evolution of the Opioid Epidemic

Amanda Latimore: I'm an epidemiologist, so I'd like to just start with the numbers, and sadly, the numbers tell us that more than 100,000 people are dying annually due to overdose-related deaths. Could you share some insights into how we got here? Jarratt?

Jarratt Pytell: The prescription opioid epidemic began in the 1990s with an increase in the prescription of opioids for chronic noncancer pain. And as the years went by, there was an increase in deaths from opioid overdoses. In the decade from 1999 to 2010, the U. S. witnessed a fourfold increase in three areas related to the opioid epidemic.

So first, the number of prescriptions written for opioid analgesics increased, the number of opioid overdose deaths, and the number of patients admitted for the treatment of opioid use disorder. Over time, the opioid epidemic has gone through three waves, with the first wave being the rise of prescription opioids. The second wave hit in 2010 with a rise in heroin use, but the third wave, which really started around 2013, is most alarming.

That's when we saw a huge increase in fentanyl and other synthetic opioid overdoses, and that is still a major problem today. And despite a dramatic decrease in the number of prescriptions written for opioids, which can be attributed to increasing education like the REMS course developed in 2012, There's been an increase in opioid overdose deaths.
This suggests that the current problem is not primarily prescription opioids but rather the high-potency synthetic opioids like illicitly manufactured fentanyl that are in the drug supply.

Amanda Latimore: Arianna, did you want to weigh in?

Arianna Campbell: Just for context here. So, I already mentioned I've been a PA for 24 or 25 years. I knew very little about pain and overdose when I completed my training in 1999. But there was only about 5, 000 overdose tests at that time. Fast forward to 2024, there's well over 100, 000 overdose deaths last year, and the landscapes changed. So must our practice. So, it's important to note that as we decreased opioid prescribing, and I started those efforts at my own hospital, I'd say in about 2015, 2016.

We have actually seen an increase in overdose tests that's related to high-potency synthetic opioids like illicitly manufactured fentanyl, just like Jarratt was describing. So, another important point to make here, though, is that opioid use disorder has a strong relationship with suicide as compared to other substance use disorders.

So, it's a complex history. It's led us to where we are today. And we're here really to discuss how we can address the needs of patients with pain in a person-centered way.

Amanda Latimore: Thank you. So, based on what you both are saying, that this is a really important topic. It's also very complicated, and so just thinking about this complicated history of where we are today with opioid-related deaths, some of that story includes advocacy around the need to better address patient pain. Arianna, can you talk a little bit more about that?

Arianna Campbell: Yeah, I think we just have to acknowledge that there's just this confluence of factors. So, there's not just one that contributed to the opioid crisis that we all witnessed. So, in no particular order, first, of course, there's well-meaning physicians, healthcare professionals, PAs, nurse practitioners, who really wanted to address pain, wanted to address suffering as well.

And there was this focus on that time on assessing pain, which really encouraged physicians, PAs, nurse practitioners to try and improve pain scores that became a big focus. And that happened over time with the tool that was working at that time, which was prescription opioids. At the same time, there was inaccurate marketing about the safety of prescription opioids.

And then, finally, in the background of all of this was a socioeconomic context that brought about a pain crisis, and people were seeking help from

their trusted healthcare professionals. So, all of these things together led to this rise in prescription-related deaths that we all witnessed.

Amanda Latimore: Thank you, Jarratt.

[00:07:31] The Role of Fentanyl in the Opioid Epidemic

Amanda Latimore: So, Arianna just mentioned fentanyl. Can you share a little bit more about high-potency, synthetic opioids and how they've influenced the overdose epidemic we see today.

Jarratt Pytell: Illicitly manufactured fentanyls are not the same fentanyl that we use in medical practice. And these fentanyls are now the primary substance in the opioid crisis, whether it's taken alone or in combination with other drugs like methamphetamine or adulterated with additives like xylazine.

We've never seen an opioid overdose epidemic like this in America, with hundreds of thousands of people dying in the last decade. And really, to understand the potency of fentanyl, consider this. If morphine is used as a reference point with a potency of 1, Heroin is twice as potent as morphine, while fentanyl is 100 times more potent, and some fentanyl analogs like Carfentanil are even more powerful, with a potency 10, 000 times that of morphine.

So, while prescription opioids still contribute to overdose deaths, the primary problem now lies with illicit opioids like fentanyl in these pill or powder forms.

Amanda Latimore: Thanks, Jarratt. So, we have these three waves related to the overdose crisis. And these waves have left many in its wake. Despite the fact that most of us know at least one person who's been affected by substance use disorder, the stigma and othering of people who use drugs is still very present in our society.

[00:09:02] Stigma and Language in Opioid Use Disorder

Amanda Latimore: So, what role do you think language plays in either perpetuating or reducing stigma? And how can we promote language that is compassionate, medically accurate, and patient-centered? Jarratt.

Jarratt Pytell: Amanda, you're right. You know, this has touched many people's lives. A recent paper in Rand that was published in the American Journal of Public Health found that over 40 percent of Americans have had their lives impacted by an overdose.

That is someone who they love having experienced an overdose. And it's important that we all, clinicians, politicians, media, and the public, think about the words we use. And language truly matters when it comes to reducing the stigma around opioid use disorder. Terms like addict and substance abuser can make people feel labeled and judged, pushing them away from seeking help.

And as healthcare professionals, we need to use medically accurate person first language, like saying a person with a substance use disorder. It's a small change, but it sends a message that we see the whole person and not just the disease. You know, a recent randomized clinical trial on the effect of an exposure to a visual campaign and narrative vignettes on addiction stigma among healthcare professionals showed that exposure to messages promoting non-stigmatizing language, especially when framed as personal narratives from someone with lived experience, can change attitudes among healthcare workers.

Visual campaigns combined with stories helped build understanding and empathy. So, if we want to create a healthcare environment that welcomes people with addiction, we've got to be intentional with our language. Taking

a hard look at the terminology we use, using compassionate language, and updating the materials we use are steps in the right direction.

As more and more of us in healthcare commit to changing our words, we can make it easier for people to walk through our doors and get the help that they need.

Arianna Campbell: Yeah, just to add to that, Jarratt, I have to say this was something that really impacted my practice. So just that the use of our own language and words can impact our patients so greatly. There was a study by Dr. John Kelly that dates back to 2010 that gave clinicians identical scenarios with people with substance use disorder, and all they changed was some simple language.

So, they either called them a substance abuser or a person with a substance abuse disorder. Now, we call that a substance use disorder, but just that little change of using the term substance abuser led to more punitive responses. So, I do often say that just change your language, and you can actually change outcomes. You can change the way that your patient is seen and the kind of treatment that your patient gets.

Amanda Latimore: So many good points there. And I think that once we get to a place where we're welcoming folks into spaces that are non-stigmatizing, we can really start to talk about really treating pain.

[00:11:57] Types of Pain

Amanda Latimore: So, let's delve into the fundamentals of pain management. And we can start by discussing some of the basics, like what is pain. How do you define it? What are the different classifications of pain? How do you distinguish these different types of acute versus chronic, nociceptive versus neuropathic?

Do you want to take this one, Jarratt?

Jarratt Pytell: Pain in the medical context is described as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. It's important to note that pain is subjective and varies from person to person. So essentially, we need to trust a patient when they report that they're in discomfort or distress.

It's helpful to think about the experience of pain through the biopsychosocial framework. People might have similar injuries and pathological processes but will have different experiences and expectations of the treatment. Acute pain is pain that has been present for less than a month and often has a sudden onset and is triggered by tissue damage or inflammation.

Chronic pain, on the other hand, persists for three months or longer and can gradually worsen over time, often persisting beyond the normal period of healing for an injury or condition. And for completeness, subacute pain is pain lasting longer than a month, but less than three months. Acute pain serves as a warning system for the body, signaling tissue damage or injury, whereas chronic pain persists beyond the normal healing period and may not have any identifiable cause.

And we try to place pain into three categories. Nociceptive pain, which arises from tissue damage or inflammation. This type of pain is typically acute. Examples include post operative pain, sports injuries, arthritis, sickle cell disease, and mechanical low back pain. Neuropathic pain involves damage to the nerve fibers themselves, which cause abnormal signaling.

Jarratt Pytell: Neuropathic pain is typically chronic. Examples include postherpetic neuralgia, trigeminal neuralgia, distal polyneuropathy, CRPS, sciatica, diabetic neuropathy, and neuropathic low back pain. And then nociplastic pain, which is usually chronic as well, comes from abnormal functioning of the pain pathways. This is like fibromyalgia, irritable bowel

syndrome, and nonspecific low back pain. And it's also possible for people to have an overlap between these types of pain.

Arianna, did I miss anything?

Arianna Campbell: All I have to say is there's different interventions that are available for different types of pain. So, I do think there was a point in medicine where we were giving opioids for all these different types of pain, but it's important to consider what type of pain it is and then really pair that with the best intervention. And we do this in other parts of medicine. So, it just makes sense to do this for something that we see all the time, which is pain. And I think when we approach it through that perspective, there's a lot that makes sense and we're able to address our patient's needs in a better way.

[00:14:54] Addressing Racial Bias and Pain Perception

Amanda Latimore: So, speaking of patient needs and differences between patients, some research suggests that racial bias might play a role in the assessment of pain. Are there myths and misconceptions surrounding race and pain perception that you think that we should really make sure to dispel?

Jarratt Pytell: You know, research has consistently shown that racial bias influences provider perception of patient pain, with both white and black individuals assuming that black people feel less pain than white people. And this bias is rooted in perceptions of status and privilege rather than race itself. There are false beliefs about biological differences between races, such as black people's skin is thicker than white people's skin. These things also contribute to the bias and are associated with racial disparities in pain assessment and treatment.

Amanda Latimore: Thanks Jarratt. I think it's important to note that some of these false beliefs are still present today. So, Arianna, what steps do you think physicians should take to mitigate this unconscious bias?

Arianna Campbell: Well, I think it's important to acknowledge that there's bias in all of us based on our different experiences.

And it's really important to, I mean, do your training. This is really important to recognize this unconscious bias that exists. And I often will check that at the door. So, you're recognizing it and then really still always adopting this very patient-centered, approach to care for all people. Also, it's important to not make assumptions. So, use validated measures of patient function and need. So, make sure that we are basing all of our interventions on things that are validated measures that really encourage that patient-centered approach and reduce and, hopefully eliminate bias in the things that we're doing.

Amanda Latimore: Right. And I think it's also important to note that race is a social construct. You know, the Human Genome Project clarified unequivocally that race and these classifications actually don't have enough sensitivity to support a biological basis for race. So, let's just assume that an unbiased assessment of pain has happened.

[00:17:09] Navigating Opioid Prescribing: Challenges and Strategies

Amanda Latimore: What challenges do you think providers face in balancing effective pain treatment and the risks and benefits of prescribing opioids? Jarratt.

Jarratt Pytell: Part of a comprehensive pain management approach is assuring that healthcare providers and patients understand the risks and benefits associated with opioid medications, as well as making sure patients know how to use them safely and effectively.

You know, an important distinction that needs to be made is between patients who are continuing opioids as a part of a long-term opioid therapy strategy and those who are coming in with new pain and have not received opioids. Sometimes, we refer to them as opioid naive. The relative risks and benefits are different for those situations.

For patients with pain who have not received opioids, clinicians need to consider all pain management options, including nonpharmacologic options and the pharmacologic options, and really only prescribe opioids when the nonpharmacologic options and nonopioid options are inadequate and when the benefits of using opioids outweigh the risks. Many clinicians might be reluctant to prescribe opioids because well-designed studies have not shown that opioids improve pain-related function compared to nonopioid therapies.

This research is at odds with our experience that some patients report improved function because of their opioid treatment. And it's a good reminder that our trials often are not generalizable to the patients we see in clinic, and therefore, we should continue to focus on patient-centered care.

And for patients with pain who are receiving long-term opioid therapy, the discussion often comes down to a harms versus harms assessment. That is the harms of continuing the prescription opioids and the harms of tapering or discontinuing the opioids. There's a preponderance of evidence that opioid tapers, particularly when they're physician-directed, are harmful to patients. At the same time, some patients might be experiencing significant side effects from the opioids and benefit from a dose reduction or taper. Also, patients on long-term opioid therapy might have developed risk-enhancing factors over time that impact a clinician's decision to modify opioid treatment.

And Arianna, I'm not sure if you have anything else to add on that complex situation.

Arianna Campbell: Thanks, Jarratt. Let me just add that the number we prescribe does matter in acute pain. Working in an emergency department for so long. I can tell you it's a fishbowl meaning people see what we do, on the inside and then we see on the outside.

And so, we see a lot of different prescribing practices for acute pain. And there's a lot of evidence, actually, that if we prescribe a very long course of opioids, it's very challenging for somebody to then transition off of those opioids. So, this is the conversation that I have with patients. Patients should be informed of the risks, the benefits of a new opioid prescription.

The conversation I will sit down and have is that I care about you, and so I'm having this discussion with you. I'm going to give you a short course of this opioid pain medication because I'm worried that if you take it too long, it's going to be more challenging to get off of.

And the reason that it's challenging is when you've been taking it for longer than, let's say, five days, when you discontinue it, then withdrawal actually looks like more pain. That's really tricky. So, having that conversation with a patient is really important. I also discuss different alternatives to opioids for acute pain management and just know that there's a lot of different algorithms out there and that can help guide practice as well. And when patients are feeling relief and when they know that the person that's treating them is really working to give them pain relief, it really leads to a better therapeutic relationship. So, patient-centered care should always be employed, and these conversations are important when you're discussing the risks and benefits of prescribing hopefully a short course of an opioid.

And then, always make sure you're discussing the precautions with your patients.

Amanda Latimore: Great. Thank you, I think we can all agree that patients should be able to make informed decisions. And that includes being

informed of the risks and benefits of various approaches to pain management.

[00:21:15] Educating Patients on Opioid Use and Risks

Amanda Latimore: So, why do you think opioid use education is crucial? How does informed patient counseling, for example, aid in mitigating the risks of problematic substance use?

And what key points should be emphasized in patient education and conversations? Jarratt.

Jarratt Pytell: When it comes to patients, counseling is essential for medicating opioid use risks. Patients need to be educated about the potential dangers of opioid use, medications, including the risk of developing an opioid use disorder and overdose. Key points to address during counseling include first, the importance of following prescribed dosages, to understanding the potential side effects.

This can include short-term and long-term side effects of opioid prescribing and informing patients that when opioids are taken at a high enough dose for a long enough period of time, they will develop dependency, and there's a risk of having opioid withdrawal if they suddenly stop. Open communication and trust between patients and healthcare providers is crucial for ensuring safe and effective pain management.

Arianna Campbell: Yeah. And just to add to that again, I always discuss what withdrawal looks like because it's actually amazing how many patients really don't know. So, I've had this discussion with patients: if you do take it for a period of time, again, longer than sometimes four or five days, it does vary depending on how often they're taking an opioid, but if you stop it, suddenly you may get sweaty, you may get goose flesh skin. You may start yawning, and really, you're going to feel significant all-over body pain. And

that gets tricky because so many people don't know what withdrawal looks like and may mistake this as, Oh, okay.

So, I still have this underlying pain that I need to treat. Not recognizing that this is part of withdrawal. So again, have these patient-centered conversations, inform your patients. So many people have no idea, including people who use drugs, often don't even know what withdrawal may necessarily look like. So, education is really important.

Amanda Latimore: I really appreciate the fact that both of you are emphasizing patient-centered approaches so much in your responses. And so, understanding where patients are coming from, is step one, right? Understanding what factors need to be considered.

So, the initial steps of assessing pain in patients is really important.

[00:23:39] Utilizing Screening Tools and PDMPs in Patient Care

Amanda Latimore: What are the crucial pieces in a patient's history that we should be looking at? And while we're at it, if you could share some insights on the screening tools that are available? Arianna.

Arianna Campbell: You do want to listen to what is the description of the pain itself. Where is it? How intense is it? What kind of quality of pain is it? Let people describe this to you. When does it happen? How long does it last? Are there variations, patterns, rhythms in this pain? And then what helps, you know, what relieves the pain?

Are there things that increase the pain? How is this pain affecting their life? So, this is something I do often ask. So, how does this get in the way of your regular activities? Is it affecting everyday work? Is it affecting your everyday activities, cooking? Etc. And What's worked? Are there things that you've tried that have helped?

Are there things that have not worked? This is really important. And then, of course, you want to include some psychosocial considerations. Some patients may share things like, I've been drinking alcohol to relieve this pain, and you can explore that.

Explore if somebody has been using tobacco. There may be people who share adverse childhood experiences. There may be people who share a family history of substance use or psychiatric disorders. So, you really want to consider the social determinants of health as well. And then, this may sound like a lot, but here's a little pearl.

If you sit down at the patient's bedside and you ask them to tell you about their pain, so much of this they will include, just give them a couple of minutes to talk. It's amazing what people share when they get uninterrupted time. And so often, if you sit at the bedside and you let them talk, so often they'll share it.

This is the first time anybody's ever listened to me. So, all of these things considered, listen and give people a couple of minutes to share. Now, there's also a lot of screening tools that you could use to identify risk factors associated with chronic pain and opioid use disorder. So, a couple of pearls out there, you can check out the patient health questionnaire.

There's a PHQ-2 or PHQ-9. Some people employ these in their practices. There's a brief pain index or a BPI. There's a Pain, Enjoyment, and General Activity, or a PEG scale, and there's a Generalized Anxiety Disorder scale that you can use as well. A lot of these are available in your electronic medical records, so these are different things that you can look at.

The PHQ-2, PHQ-9, and GAD-7 are helpful tools for screening for mental health issues like depression or anxiety. The presence of either or both of these conditions can affect the patient's experience of pain and be predictive of chronic pain as well.

So, you can access these screening tools by just following the links that are provided in the podcast show notes. So, these can be used to guide conversations. And again, these can be incorporated into what you use in your electronic medical record.

Amanda Latimore: And I think it's so important to note that you're using the tools to guide the conversation. And it's not about punitive responses or taking people off of medications. Again, if you're gonna have this patient-centered approach, it's about starting a conversation, not ending one. The Prescription Drug Monitoring Programs, or PDMPs, were developed as a response to the opioid overdose epidemic, and PDMPs are electronic databases that track controlled substance prescriptions for those who are not aware.

And the evidence on the efficacy of PDMPs is mixed, depending on the policies or procedures dictating the response to the PDMP data. And also depends on the outcome studied in the research. And what we've learned from research is that the implementation of PDMPs has been followed by a reduction in opioid prescribing, but it's also had some unintended consequences.

For example, an increased use of illicit market opioids. So how can PDMPs be used to provide patient-centered care while also avoiding some of the risks associated with PDMP use? What insights do PDMPs offer, and how do they shape the care landscape? Again, emphasizing patient-centered care. Arianna.

Arianna Campbell: I'm really glad that you brought this up because actually, when you're looking up a PDMP, when you're accessing this site, it offers healthcare providers a piece of information that is really helpful when making decisions and reviewing choices in pain management strategies. It can be really helpful to get this information, but it's extremely important to use this information in discussion with a patient. This is not a gotcha

moment, and I have seen it historically be used as a gotcha moment. It's really not good for a good alliance with your patients when it's used like that. Yes, sometimes we will see worrisome trends in these PDMPs, but that should direct a conversation towards addressing a substance use disorder, for example, rather than just denying somebody treatment.

So, it may just redirect your conversation. Now I talk about PDMPs when I'm discussing this with a patient as, hey, my job here is to create a plan for you that's as safe as possible and as effective as possible. So, there should be honesty when you're communicating the findings from a PDMP. So again, it's used as a conversation modality and really frame that in the interest of safety.

Also, think about it! PDMPs, they don't pick up street drugs. So, the thing that we're most worried about right now is fentanyl. And if that PDMP is used in a punitive way, you may miss that conversation, that all-important conversation about fentanyl. So, I'll give you an example. I had a patient that was actually coming to my emergency department repeatedly asking for large amounts of opioids.

And that's because this person had been previously prescribed a large amount of opioids and then was cut off. So, when referencing the PDMP, it was discovered that this person was getting more than what was safe in terms of an opioid. But because there was an honest discussion, that person was actually able to talk to me about this and said, "Yeah, I'm not getting enough. I've had to get fentanyl from the street to address my own pain." And once we talked about that, we were able to talk about a safer pain strategy. We actually ended up changing this patient over to buprenorphine because they had mixed picture chronic severe pain and an opioid use disorder. So, we just talked about a different way to go, and that patient was relieved when I was able to give them effective treatment that was safe.

So again, just developing those therapeutic relationships, utilizing that PDMP as a conversation piece.

Amanda Latimore: That's a really interesting story. Thank you for sharing that. Jarratt, do you have any reflections, examples that you can draw from your own experiences?

Jarratt Pytell: Yeah, I really appreciate what Arianna said. And I think, inherently, PDMP is data, and data is not good or bad. It's just about how it's used, and it's important not to use this data in a punitive fashion. To add, you know, increasingly, PDMPs are used to share more data outside of prescription drugs. For example, some states now have overdose warnings sent to clinicians when a patient experiences an overdose. I've also had patients be seen for acute medical issues but inaccurately received diagnoses of opioid overdose. I recall one such patient who was actually having a COPD exacerbation triggered by influenza, but the EMS team initial report was that it was an overdose, and that label stuck with the patient and impacted them and their care, including their ability to receive their prescription opioids.

So, it's just important to know that this is data and it’s not perfect. And therefore, we should be careful when we're making decisions based on it alone.

Amanda Latimore: Thanks, Jarratt. And I just want to lift up what you're saying. There's no good or bad data. Well, there's bad data, but your point is that it's really about how you use the data. So, as you continue to explore patient assessments in pain care, what are some of the commonly used pain scales and tools that providers can use to help understand a patient's pain experience? Going beyond pain intensity, what else should be assessed? For example, what about assessing a patient's functional status and gaining insights from a comprehensive physical examination?

Jarratt Pytell: Yeah. And this really goes back to some of the things we've been discussing before, you know, taking a comprehensive patient-centered approach to care.

Assessing a patient's functional status is crucial because the impact of pain on function can vary greatly among individuals. For some, pain may be a minor annoyance, while for others it can become a major focus of their life. And as a part of a routine assessment and monitoring, patient-reported outcome measures can help to provide information about a patient's response to treatment.

This measurement-based care approach is similar to the management of other chronic conditions where we collect data, objective data, to help guide decisions. The PEG is one tool that can be used to evaluate the effect of pain on a patient's daily life.

But I'll say that many tools exist and are often integrated into the local electronic health record. It's important to take a strengths-based approach, which can be helpful in-patient interactions. It's also important to remember the biopsychosocial framework and recognize the social determinants of health that should be considered when assessing a patient.

This also circles back to how we can reduce bias through the use of these validated patient reported outcome measures rather than just relying on our own judgments.

It's also important to conduct a thorough physical examination, which can help contribute to the overall assessment of a patient with chronic pain by providing objective data. This could include general observations of their vital signs, appearance, movement, and pain behaviors, but also is comprised of a comprehensive musculoskeletal exam.

It's important to assess function during the physical exam and look for other health conditions that could impact treatment. Addressing issues like undiagnosed sleep apnea or obesity should be incorporated into an individualized treatment plan.

Amanda Latimore: Great. Thank you. There's a lot of information here that could be collected to better support a patient in making well-informed decisions and providing good guidance on pain management. But what if patients don't want to provide the information? You know, we talked a lot about stigma at the top of this podcast, and you know, the country has a growth edge on addressing stigma. So, if patients don't want to provide information on a scale or assessment like these, what should providers do?

Jarratt Pytell: You raise a really important point, and this kind of circles back to what Arianna had mentioned about sitting with the patient and listening. You know, the most important thing is to have a really strong therapeutic alliance where the patient trusts their clinician.

It's important to note that just sometimes patients aren't ready or interested in providing this level of information with us.

And that's okay. I feel like it's our job to create a safe space for them to feel comfortable sharing sensitive information. It is important to note that many patients are fearful that the information that they provide during a visit could be used in a punitive manner to take away their prescription opioids. Indeed, it's probably happened to them in the past. I find that it's always important to be transparent about how you're going to use this information, explaining that this information can be used to individualize care and help the patient and the clinician over the long term, which is the goal. And making sure you communicate that this information is confidential, just like any other information that we collect in the context of health care.

Amanda Latimore: Thanks, Jarratt. For this next question, Arianna, I'm going to turn to you.

[00:35:56] Special Considerations in Pain Management for Diverse Populations

Amanda Latimore: So, there are many special populations with unique considerations for pain management. Do you think it's important to engage in family planning discussions with patients considered for opioid therapy? How can healthcare providers assist patients in making informed decisions about contraception, pregnancy intent, and managing chronic pain for those planning to breastfeed?

Arianna Campbell: Patients need to make informed decisions about choices in pain medications. And I need to acknowledge that there's a bias against women of reproductive age. So, if a woman is maintained on opioids during her pregnancy, it is true that her baby may experience opioid withdrawal after delivery. That's called NOWS, or Neonatal Opioid Withdrawal Syndrome. But there may be other options with less severe opioid withdrawal symptoms, such as buprenorphine.

Patients may, and often do, choose nonopioid analgesics. This is a choice that the patient can make, and again, it's a discussion with the patient regarding risks and benefits. So, this should be tailored to the patient's needs. That being said, pregnancy is not the time to discontinue opioids if a woman is on chronic opioids, whether that's from the street or prescribed.

So, you may have to have the conversation about transitioning a person to buprenorphine or methadone. The reason is there's a lower incidence of NOWS - Neonatal Opioid Withdrawal Syndrome. And it's important to educate pediatricians and OBGYNs as well on how to treat this because I can tell you at my own hospital, we initially were always transferring out

babies who were born when the mother was taking opioids, whether prescribed or from the street.

And when we employed a program for NOWS, which is called Eat, Sleep, Console, we've kept more than 75 percent of the babies with their moms at my rural hospital. So, Eat, Sleep, Console programs can cut the average length of stay or cut that in half for both mother and child, and it's just something to look into. So again, just education. Educate your providers in your hospitals, educate your pediatricians, OBGYNs, and educate patients on the standard of care for treating, with opioids during pregnancy.

Amanda Latimore: That's great. So nice to hear about the bright spots with programs like Eat, Sleep, Console. And of course, I'm sure in addition to reducing the length of stay, it actually is better for the mother and the child in terms of outcomes. So, there are a lot of considerations that you both have been talking about for providing patient-centered care. And whether you're talking about a pregnant individual with chronic pain or a person in pain with opioid use disorder. What does it mean to have a strength-based approach to providing pain management? What strategies can providers use to recognize the role of adverse childhood experiences, for example, in chronic pain, and provide trauma-responsive care?

Arianna Campbell: As a way of practice, I love the strengths-based approach in terms of really guiding toward a patient's strengths. I think that that's something that we can all focus on, and it empowers individuals. I also think it's important to acknowledge that ACEs or adverse childhood experiences can, unfortunately, also play a role in the development and the experience of chronic pain.

And this can be just more of a risk to a patient. So, we've mentioned the importance of getting a history of ACEs as a part of assessing a patient's risk for an opioid use disorder if those opioids were to be prescribed. But there

is an impact of ACEs on chronic pain. That detailed connection between ACEs and chronic pain is not explicitly discussed.

It's not because you've had this history of trauma; we can't prescribe you opioids. That's not how it should be used. It's important to discuss the real risks of opioid initiation with all patients. So, considerations should include age, severity of an injury, and really what it boils down to is having a trauma informed approach.

So, be sensitive to not traumatizing a patient by having them discuss their trauma. I say this all of the time. So, just being respectful that patient-centered care involves attention to language, environment, acknowledgement of potentially traumatic experiences. And really acknowledge that many people have experienced trauma in medicine.

So, acknowledging that and really finding a comfortable place for a person to share their own story. I mentioned, give them their two minutes. It's amazing what people will share with you when you show them respect, acknowledge their situation and let them talk and tell you what they think is affecting their pain.

Amanda Latimore: Thanks, Arianna, I really appreciate how you both have been talking, not just about how to gather data, but how to use the data effectively and in the most compassionate way. So, following that thread through a little bit, how do diagnostic study results guide treatment decisions and enhance patient outcomes. Could you, Jarratt, discuss the impact of diagnostic studies on shaping effective treatments?

Jarratt Pytell: We often use diagnostic studies, imaging studies such as CT scan, X-ray, MRI, or other studies like EMG to help guide treatment decisions and improve patient outcomes by confirming or ruling out certain conditions.

However, there's a risk of overusing imaging tests and abnormalities may be found in asymptomatic individuals which could cause stress and, findings may not always provide the valuable information for treatment, planning that we hope they might have, given us. Diagnostic studies also include urine toxicology tests, but we'll be discussing that in a future podcast.

Amanda Latimore: So, we know that providers have a lot of demands on their time. In practice, how can clinicians really increase the chances that these diagnostics are used in a way that helps more than hurts the delivery of pain management?

Jarratt Pytell: You're right. And as a primary care doctor, it's a lot easier to order a test than it is to sit down and do a physical exam and listen to a patient. And that's a common scenario across the United States. Any time information from things like imaging is collected, it is an opportunity to build a strong therapeutic alliance with patients.

If we've ordered a diagnostic study, then. We need to take the time to educate the patient about why we're ordering it and what the possible outcomes might be from expected findings. It's also important to let patients know that incidental and unexpected findings are common and don't necessarily always have clinical significance.

As we've touched on before, the experience of pain is very personal. And patient's pain experience does not necessarily correlate with the severity or lack of abnormalities on, our diagnostic tests and imaging. So, it's important for clinicians not to discount a patient's pain when those diagnostic studies are normal or only show mild abnormalities.

Amanda Latimore: Well, you both have provided a lot to think about during our conversation today.

[00:43:03] Concluding Thoughts on a Patient-Centered Approach to Assessing Pain

Amanda Latimore: We've discussed how the current overdose epidemic is multifactorial and complicated. One of the best ways that those involved in the treatment of pain can act is by providing patient-centered care and supporting patients in making informed decisions.

Providers can also be informed by understanding risks and benefits of medication, some of what we've covered today, as well as the benefits and limitations of various diagnostic tools. I'm also hearing loud and clear from both of you that listening and understanding your patients from a holistic perspective is key. So, as we conclude our podcast today, do either of you have any final words of wisdom or key takeaways that you'd like to share with our listeners?

Jarratt Pytell: I think it's important to talk to our patients; they have the information that we need. By collaborating with the patient, utilizing evidence-based strategies, and providing information about the risks and benefits of different treatment strategies, which could include opioid treatment, we can build trust or restore trust where it has been lost.

Arianna Campbell: And I will just add, there's tools out there, they can be used for building connection with your patient, building alliances with patients, and really not for punishment. So, tools have benefits, but they can be misused. Please use them as teaching points and, again, to engage patients in that therapeutic alliance. It's also important to establish boundaries and communicate expectations, but if a patient doesn't meet those expectations, it's appropriate to talk about what's triggering that and address the underlying issue, whether there's a use disorder, of course, you have to consider diversion, but also consider untreated pain and really take that patient-centered approach.

Again, patients have all the information you need. We just need to sit, listen, and build those connections and make it safe for them to share what's really going on.

Amanda Latimore: Thank you both.