Maine Substance Use Disorders Learning Community

Together increasing access to OUD/SUD Care

General Educational Guidelines from the Maine Substance Use Disorder Learning Community Faculty

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https://mesudlearningcommunity.org/

These are general educational guidelines only and should not replace the clinical judgment of the treating provider. These are not medical guidance and advice. The provider retains sole responsibility for selecting and implementing the care for their patients. These guidelines were developed quickly as educational guidance in response to a requested need in Maine. 11/8/2022 v1.9. T

Tips for Providers Inheriting Patients on Chronic Opioid Medications for Chronic Pain

Chronic pain management is a specialty unto itself. While most providers have experience with chronic pain, it is a challenging clinical situation, and most providers find additional training and guidance helpful. This Tip Sheet is just a list of key points. It is strongly recommended that those inheriting patients on chronic opioids spend one to two hours bolstering and refreshing their knowledge with continuing education training. In particular, we have provided links to online trainings and resources below. These are free, some provide CME, and the options are very flexible.

General Overview

- By and large, opioids are not indicated for the treatment of chronic non-malignant pain. There is no good evidence of functional gains from chronic opioids, and the benefits rarely outweigh the risks (CDC, 2016, Frieden and Houry,2016).
- Known risks include worsening depression, hypogonadism, constipation, substance use disorder, and respiratory depression with overdose death (respiratory disease and sleep apnea are relative contraindications to these medications). Moreover, chronic opioids increase pain, especially in those with central pain syndromes (fibromyalgia, phantom pain, complex regional pain syndrome, etc.) (Teater, 2015).
- **Target goal: ≤100 MME/day to achieve moderate risk dosing, <50MME to achieve lower risk dosing**: The risk of opioid-related fatal overdose increases with dose. The risk on any dose of opioids is 1/550 a median 2.6years after the first opioid prescription, while doses above 200 MME

bear a risk of 1/32 (CDC, 2016). While <100 MME is a reasonable initial goal, the risk of overdose significantly increases at ~50 MME, while effectiveness tends to plateau. Use caution with the pace of tapering, as fast tapers can produce harm (CDC, 2022).

- **Eliminate Polypharmacy with other Sedating Medications**: If the patient is also on a benzodiazepine, this increases the risk of fatal overdose ten-fold. The combination of opioids with gabapentin also may increase the risk of overdose. Gabapentin was involved in 90% of opioid overdose deaths in 2020, including 30-40% of *prescription* opioid-involved death (Mattson, 2022).
- **High-dose methadone has unique challenges**: Methadone's dose-response curve increases exponentially rather than linearly, like other opioids. Further, doses above 40 mg of methadone daily increase the risk of QTc prolongation. Consider detoxification admission to a local OTP to assist with tapering.

Treatment Tips

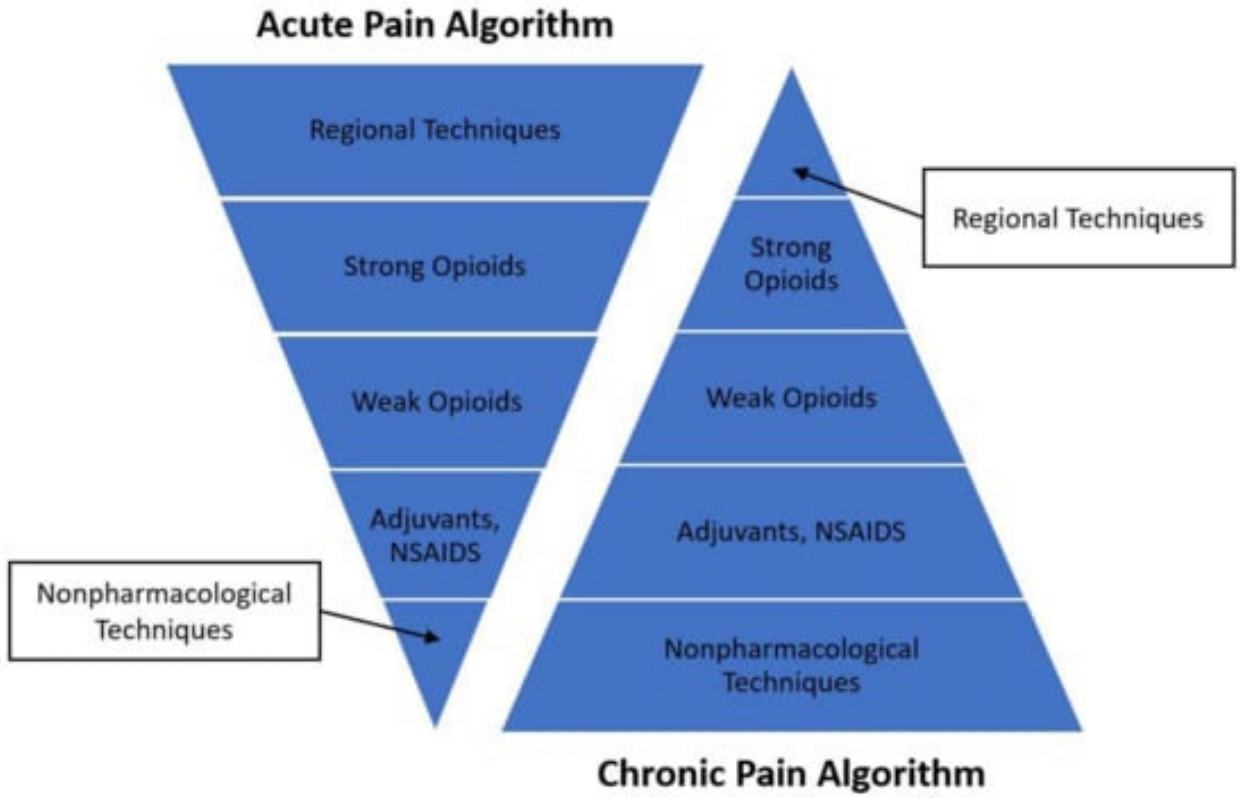
Again, we recommend refreshing and deepening knowledge on this subject through formal training however, here are a few pearls distilled from those with local expertise.

1. Evaluate each patient's primary pain concern(s). Mnemonics like OLD CARTS and others can help the thoroughness of the documentation.
2. Determine daily function by asking about the patient's "day in the life." "How do you spend your time?" and consider obtaining and monitoring a PEG score (see link below).
3. Evaluate psychosocial aspects of their life, including financial stability, who lives in the home, housing stability, and who emotionally supports the patient (if anyone).
4. Evaluate what has been done for the painful condition in the past, as well as any non-opioid medications that have been tried.
5. Asking questions 1-3 before asking about perceived benefits from their current medications may be helpful as the former are not complicated by emotional attachment to the medication.
6. Reassure the patient that you are going to take care of them even if the plan of care changes.
7. Test the waters by asking how the patient might feel about having the opportunity to be off chronic opioid medications. Many of the bulleted

facts above may not be known by the patient and could help them come to the decision to try tapering.

8. It is easier to provide a taper if there is “buy-in” from the patient. However, the provider can still decide to taper a patient who is less than willing if they feel that is the best balance of risk and benefit for the patient.
9. Much of the time, Opioid Use Disorder (OUD) will identify itself while tapering. This sometimes comes in the form of patients who use up their medications sooner than they should or through displays of other non-reassuring behaviors (threatening, formal complaints, threats of self-harm, dysregulated behavior, missed drug tests or medication counts, presence of other drugs or absence of prescribed medication in toxicology testing). These patients are advocating for medications that they feel they need to live, so interactions can be tense.
10. Revisit the standard of care for chronic pain, which includes a multimodal approach including regular movement or physical activity, physical treatments (i.e., massage, soft tissue mobilization), non-opioid medications, and psychotherapy for co-occurring mental health symptoms, including mood symptoms and non-restorative sleep.

Treating pain in patients with OUD



Wren, et al. (2019)

- High quality evidence supports treating acute and chronic pain in patients with and without OUD through the use of multimodal approaches. (CDC, 2016 & 2022) Non-opioid therapy choices include NSAIDs, acetaminophen, gabapentinoids, and SNRIs. The choice depends on the patient and the type of pain (i.e., gabapentinoids for neuropathic pain, NSAIDs/acetaminophen for tissue damage; SNRIs can be useful for both). Note some of the best evidence of efficacy for acute pain supports the use of combined ibuprofen and acetaminophen.
    - Typical ibuprofen doses are 200 - 400 mg q4h or 600 – 800mg q6 - 8h; max ibuprofen dose is 800mg q6h or 600mg q4h. While analgesic doses of ibuprofen can be as low as 200mg q6h, anti-inflammatory doses typically require at least 600mg TID. Use caution with renal insufficiency, advanced liver disease or increased bleeding risk. Typical acetaminophen doses are 500 - 1000 mg q6 – 8 hours; max monitored dose is 4,000mg/day, and self-care dose (OTC use) is 3,000mg/day (Teater, 2014).

- If a short course of opioids is required for acute pain, the patient should continue their partial or full agonist MOUD (i.e., methadone or buprenorphine) and treat with opioids in addition to their MOUD. The patient is expected to require higher doses than are typically used, due to both tolerance and opioid-induced hyperalgesia. Keep prescriptions short (3 days sufficient for most situations other than major trauma or surgery). Circumstances where this may be appropriate are post-operatively and post-serious injury.
- For more about managing acute pain in the setting of OUD therapy, please also see the Maine Opioid Response Clinical Advisory Committee document on Perioperative Management of Pain for Patients Receiving Buprenorphine for OUD, https://www.maine.gov/future/initiatives/opioids.

Resources for Prescribers Regarding Controlled Substance Prescribing and Responding to Disruptions in Care-Maine November 2022

Technical Assistance

- Individualized technical assistance, Maine SUD Learning Community, https://mesudlearningcommunity.org/coaching-and-technical-assistance/
- Individualized Academic Detailing on Tapering, Maine Independent Clinical Information Service, https://micismaine.org/contact/
- Controlled Substance Stewardship program, Schmidt Institute, https://theschmidtinstitute.org/contact-us/

Guidance Documents

- Clinical education guidance on tapering methadone, ME SUD Learning Community https://mesudlearningcommunity.org/document/methadone-for-chronic-pain-tapering/
- Clinical education guidance on deprescribing benzodiazepines, ME SUD Learning Community https://mesudlearningcommunity.org/document/deprescribing-chronic-benzodiazepines/
- CDC 2022 Clinical Practice Guideline for Prescribing Opioids for Pain, http://dx.doi.org/10.15585/mmwr.rr7103a1

- Treatment Improvement Protocol (TIP) 54, Substance Abuse and Mental Health Services Administration. Managing Chronic Pain in Adults with or in Recovery From Substance Use Disorders. Treatment Improvement Protocol (TIP) Series 54. HHS Publication No. (SMA). https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4671.pdf

Handouts

- "Universal Precautions," Maine Independent Clinical Information Service, https://micismaine.org/wp-content/uploads/2021-MICIS-qi-for-opioids-2021.pdf
- Assessing Benefits & Harms of Opioid Therapy: CDC, https://www.cdc.gov/opioids/providers/prescribing/pdf/Assesing-Benefits-Harms-of-Opioid-Therapy.pdf

Recorded Webinars / Online Training

- Recorded Webinar on Compassionate tapering when a patient loses their provider:, originally aired on 11/2/22, https://mesudlearningcommunity.org/resources/video-resources/?playlist=f0448f5&video=3e4dd08
- Online Webinars and Videos (CME): Boston University Scope of Pain https://www.scopeofpain.org/core-curriculum/online-training/ (core curriculum)
- You can scroll through short supplemental options (i.e., patient-centered approach to opioid tapering: https://www.scopeofpain.org/supplemental-training/)
- Online CME modules on Tapering, MMA Center for Quality Improvement, https://qclearninglab.org/all-courses/
- Online CME Module: Reducing Risk: Safer Prescribing for Acute Pain. Preventive Medicine Enhancement for Maine, MMC, 2021. Podcast-style module regarding management of acute pain, and the risk and role of opioids. https://mmc.instructure.com/courses/448 (click on Module 3)

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The Pain, Enjoyment of Life and General Activity Scale

https://health.gov/hcq/trainings/pathways/assets/pdfs/PEG_scale.pdf

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